MONTEREY COUNTY BEHAVIORAL HEALTH

Avanzando Juntos Forward Together

SUBSTANCE USE DISORDER (SUD) SERVICES

Avatar User Guide

July 2024

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HOW TO LOG IN TO MYAVATAR

LOCATION	DESKTOP ICON
PURPOSE	Launches electronic health record, My Avatar. You can customize your home view to quickly see the information you need to manage client care, including upcoming appointments in an easy-to-read calendar and reminders in a To Do list.
RULES	Individuals who have been granted access to the electronic health record, must follow all confidentiality policies: state, federal, and County policies. Usernames and Passwords are issued to individuals whose credentialing process has been approved. Usernames and Passwords may never be shared and all precautions to secure username and passwords shall be taken. Passwords are valid for 90-days; you will be prompted to change your password every 90 days, or as applicable. For MCBH employees, your <u>USERNAME</u> is the same as your NTID (how you first log in to your computer)
STEPS	1. Click on the Avatar icon located on your desktop. 2. Enter your issued System Code, Username and Password

AVATAR

Netsmart Technologies Incorporated

Starting, please wait...

Below is a brief description on what an Avatar screen/form may look like.

1. **SECTIONS** are different sections within a form.
2. **REQUIRED FIELDS** will be in red. This means that required information must be completed prior to submitting a form. If a required field is missing, the form will not submit/finalize.
3. **RADIO BUTTONS** will allow for the selection of only one entry. To erase an entry, use the F5 function.
4. **DATE FIELD**: you can press T for today or Y for yesterday.
5. **GRAYED OUT SECTIONS** cannot be changed.
6. **TIME FIELD**: you can press the current button to get the current time.
7. **LIGHT BULBS** contain helpful hints that will help you better understand the question or the type of information.
8. **DROP DOWN MENUS** will only allow you to choose one item.
9. **SEARCH BAR** or Smart Search; will allow you to enter alpha numeric or Text when searching.
10. **PROCESS SEARCH**: once you enter information in a search bar, press this button to process your search.
11. **TEXT EDITOR**: Double click on this icon to open the text editor which will allow you to check for spelling.
12. **TEXT BOX**: this field allows you to enter up to eight (8) pages of information. You may also copy from Microsoft office Word and paste on to this Text box.

Did You Know section displays:

New Avatar enhancements
Facts that help Staff work faster and efficiently.

Click ➡ to display the next message.
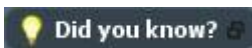
In the 🏠 **Home** View, click a widget to open.
Or select the widget and drag from the Home View tray to open.
Click and drag an open widget to resize.

Click to float the widget.
Click to minimize the widget to the Home View tray.

The following buttons display on most Avatar forms.

Closes the form without saving data.

Removes client from the My Clients section, closes any forms associated with the client.

Prints data entered in the form.

Adds the form to the My Forms section.

Adds the client to the My Clients section.

Zooming

Avatar allows Staff to change the size of text and fields in a Form by zooming.
The zoom bar is located at the bottom right of an open Form. There are different ways to zoom:

Click and hold the zoom slider.
Click the plus or minus buttons to zoom in or out by 10%.
Click the zoom level to display the Zoom Level screen.

FORMS AND DATA

Forms can be accessed from the Home View using the Forms & Data Widget.
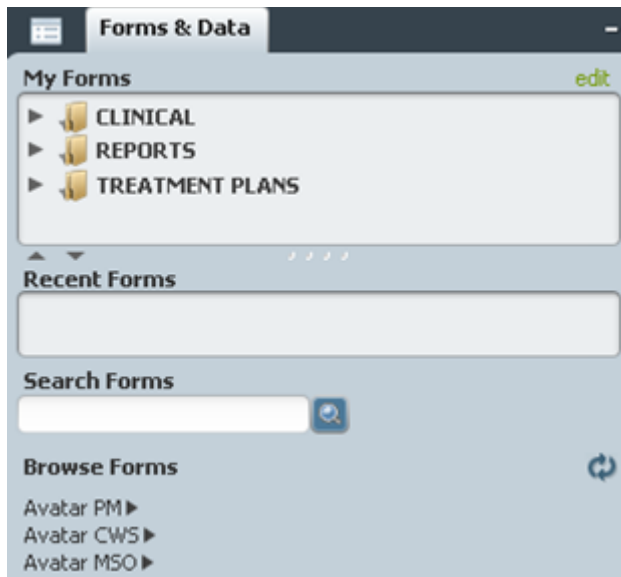
Dragging a form to the My Forms section adds that form as a favorite.

Forms can be accessed from an open form:

Clicking the icon displays the My Forms screen.

- In the Search Forms field, enter the form name, click enter.

  Select the form.
  Or click the menu below Browse Forms to navigate to the form.
  Click a form to open.
  Drag forms to reorder.

- The Recent Forms section displays previous form searches.

Browse Forms
In the Browse Forms section, click a menu heading to navigate to a form.

CREATING MY FORMS

The purpose of adding/creating my forms is to keep all your frequently used forms and reports in to an easy to access location.

STEPS	1. In your Forms & Data widget, click on Edit. 2. Type the name of the form you want to add. 3. Select the form by double clicking on the row. 4. Click on Add Form – your form will be added at the bottom. 5. SAVE 6. Click on the refresh button on the Forms & Data widget (two arrows that follow each other)
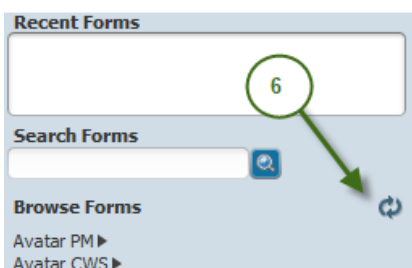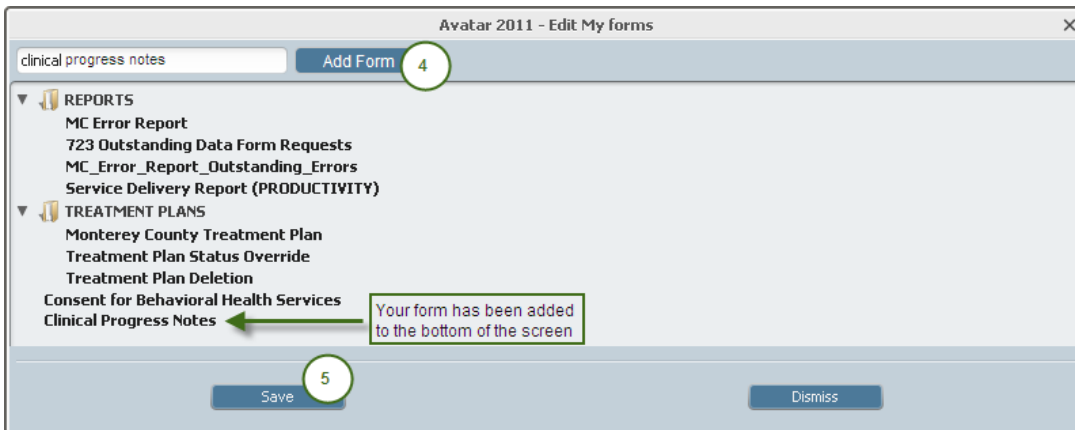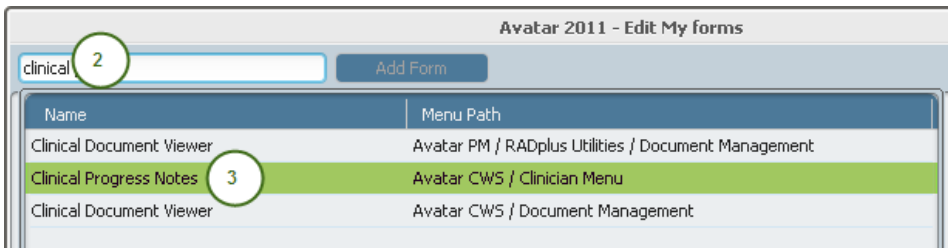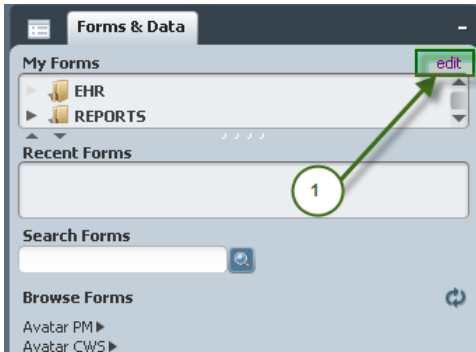
The *Preferences* Form can be accessed in the menu bar on the top right of your screen.

| 🏠 Home | 👤 | | Courses | Preferences | Lock | Sign Out | Switch | Help | 🔳 |
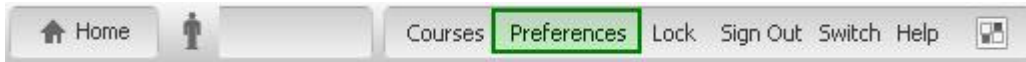
This Form allows Staff to define basic *Avatar* functionality.

- Spell Checking
- Printer Settings
- Themes
- Calendar
- Widgets
- Chart

Spell Checking:

| Spell Checking | Printer | Themes | Calendar | Widgets | Chart |

Available Spell Checkers

- ⚪ Use Standard Spell Checker
- 🔘 Use Microsoft Word Spell Checker

Edit Standard Spell Checker User Dictionary

Words: Other word:

Nepean

Nepean
Riverstone
SSCE
WSI
Wintertree

Options

- ☑ Check spelling from start of text.
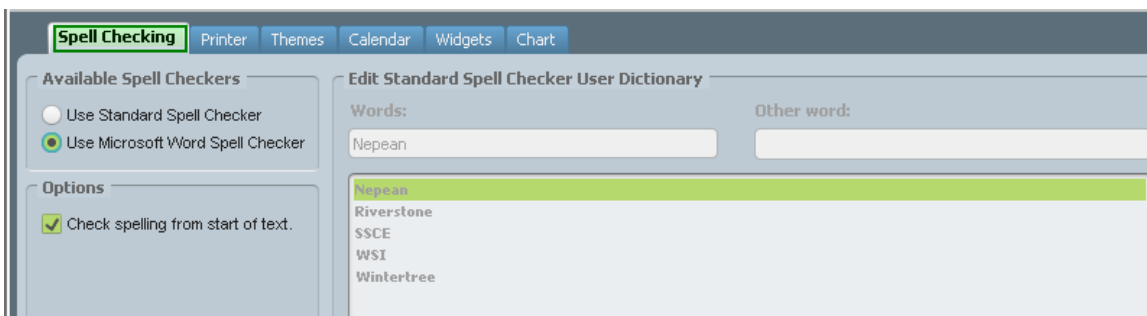
The available Spell Checker choices are to the Standard or Microsoft Word Spell Checker. (Select "Use Microsoft Word Spell Checker")

- Fields with spelling errors are underlined in red.
- Click F7, or right-click a misspelled field, and select Spellcheck.

Themes:

The *Themes* tab allows you to select a default color theme for the Avatar application. For the new theme to display, you must log out of the *Avatar* session, close the browser and re-launch the Avatar system. Restart Avatar to see the new theme.

| Spell Checking | Printer | **Themes** | Calendar | Widgets | Chart |

Themes

Choose a color theme from one of the following:

- 🔘 Default
- ⚪ Spring
- ⚪ Autumn
- ⚪ Winter

Note: Changes to the color theme will not take affect until you restart the application.

| Apply | | Dismiss |

Calendar:

The *Calendar* tab allows you to select Outlook to include personal appointments in the Avatar calendar display. In addition to showing your Avatar appointments, you can choose to display your Outlook appointments.   This is only a display or view of another calendar. This does not substitute using the Avatar Appointment Scheduler Option.

> Press the *Add Source* button to add a new calendar source. The current choices available are My Outlook, Microsoft Exchange, and Gmail. Select My Outlook
> In the *Select External Source* dialog, choose the email source.
> Click *Ok*.
> Click Apply
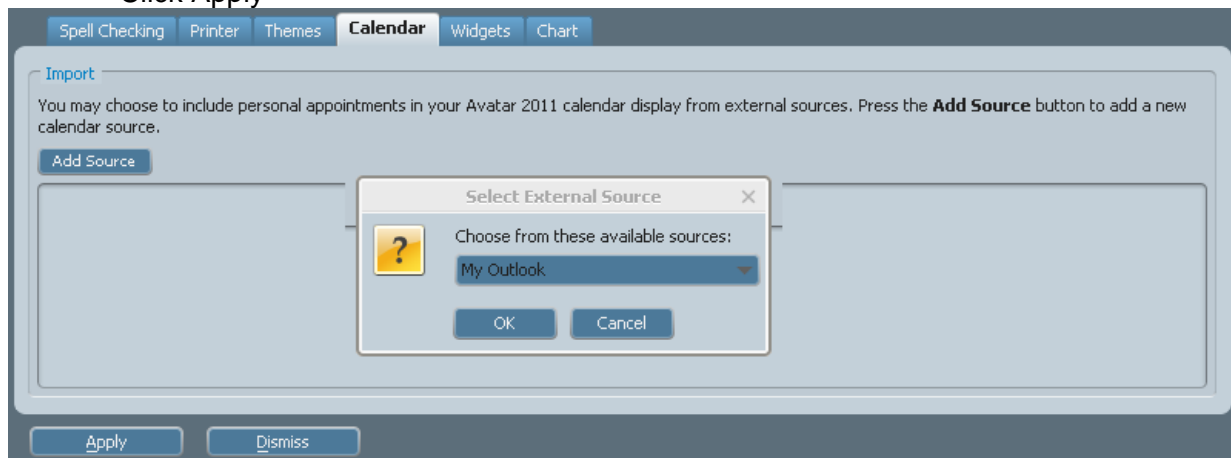
The *Calendar Widget* will now display the appointments from Outlook, as shown below. In addition, the Calendar integration with the *Appointment Scheduling* module can be seen when scheduling appointments for the Staff.
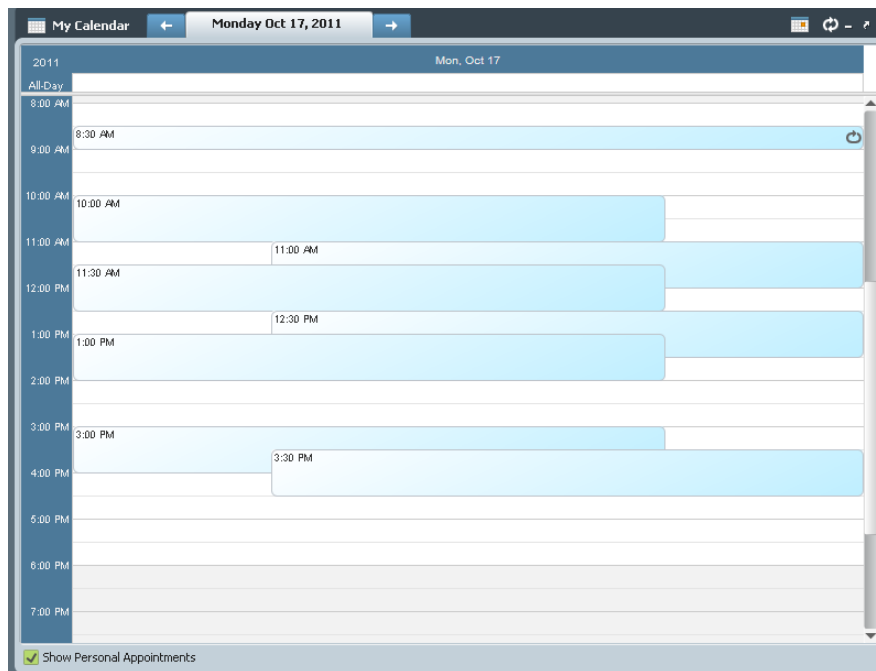
Note⇒ This is a view option only. Other staff that has access to view your Outlook Calendar will not be able to view it through Avatar.

Clicking the "**Alt**" KEY on your keyboard displays Avatar keyboard shortcut keys.
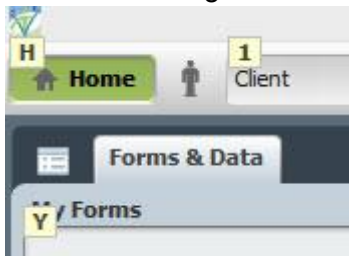
ALT – H: Will Display the Home view, which is your home page.

ALT – S: Will Submit a form

Use the **Function Keys** for the Following

F5 – Clears the selection in a drop down list Bi-Weekly or a radio button field:

F6 – Will highlight the forms section. Use the arrow keys to navigate from one section to the next.
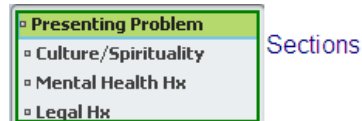
F8 – Will Lock Avatar

F9 – Log out from Avatar

Note⇒ Different keyboard combinations may display, depending on the form or widget being displayed.

AVATAR WIDGETS
WHAT IS A WIDGET?

A widget is a window view of information available on the Home View or Chart View that contains stored data from Avatar.

🏠 Home

EXAMPLES OF WIDGETS ARE:

☒ My Calendar   ☒ Coming In Today   ☒ Did you know?   ☒ Client & Staff   ☒ Forms & Data   ☒ My To Do's
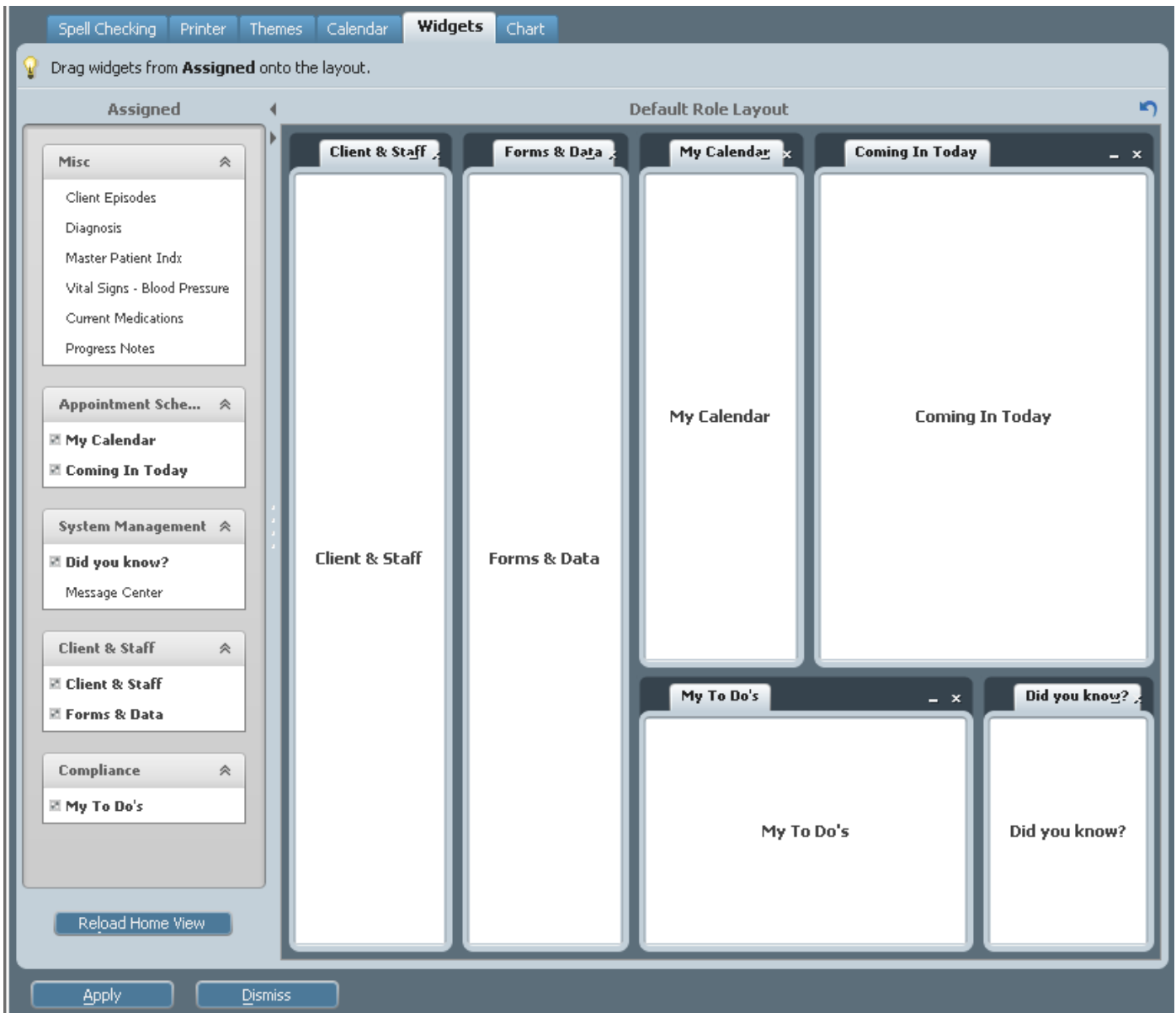
The *Client/Staff Widget* provides the ability to display a list of current clients and staff.

The **CLIENT WIDGET** will display a list of all clients assigned to the Practitioner's Caseload. This assignment is done through the admitting or attending practitioner on the admission screen. Assignment can also be done using "add supporting staff to client caseload".
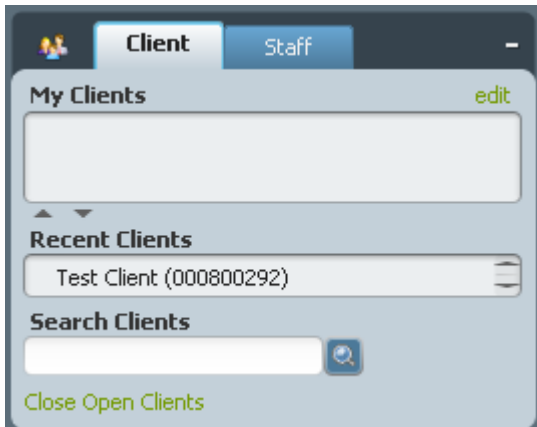
RECENT CLIENTS: is a List of clients you have accessed in this session. This list will be reset at log out. You can Right mouse click to Display Chart or Remove from List. You can drag and drop a staff from your Recent Client list up to the My Staff list and it will permanently add that staff person to your list of staff.

The Home View is associated with a Staff Role. Definitions of Staff roles are:

> MD
> Clinician
> Supervisor
> Manager
> Director
> Administrative

The Home View can be accessed any time by clicking [🏠 Home]

- **Preferences** - displays the Preferences screen.

Lock - locks Avatar

Courses Preferences Lock Sign Out Switch Help

The Avatar Sign-In screen displays.

Enter the same system code, Staff name, and password used to login to Avatar. Click Unlock.

myAvatar Locked

Enter login information below then press *Unlock* button.

System Code

Username

Password

Unlock

Sign Out - displays the Sign-out Confirmation dialog. Click Yes to log out.
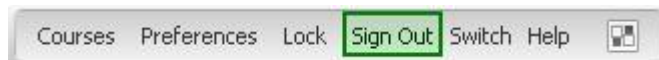
Courses Preferences Lock Sign Out Switch Help

Sign-out Confirmation   ✕

?   Are you sure you want to sign-out?

Yes   No
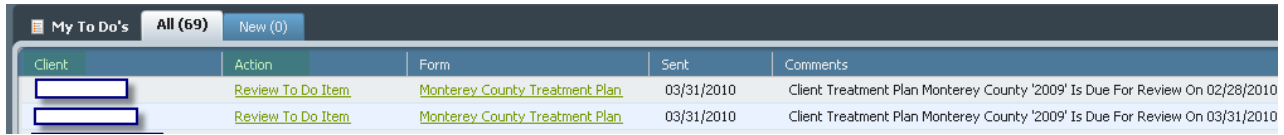
Client Data Bar

Displays when a client is selected for any client form.
Displays client demographic and health related information.

TEST CLIENT (000800292)   Allergies (0)
M, 41, 07/23/1970
Ht: 6' 1", Wt: 185 lbs, BMI: 24.5

MY TO DO S

Display the Staff's To-Do items.

Columns

- Client - The associated client.
- Action – brief description of what staff needs to do.
- Form - The associated form. Click to open the form.
- Sent - The date the information was sent.
- Comments - Associated comments.
- Note-to-self - Enter information associated with the note.

Note⇒ If the column is blank, the action may be associated with the Group Default Note form (Avatar CWS).

Right-click menu

- View Detail - Displays a report for the To-Do item.
- Reassign - Reassign To Do Item - opens the Reassign To Do item form.

Send a To-Do item to another Avatar Staff.

Have an error on this list?

If you need assistance on how to remove your To Do List after you have reviewed or co-signed documents, Go to **Error Reporting** to submit an error report.

MY CALENDAR
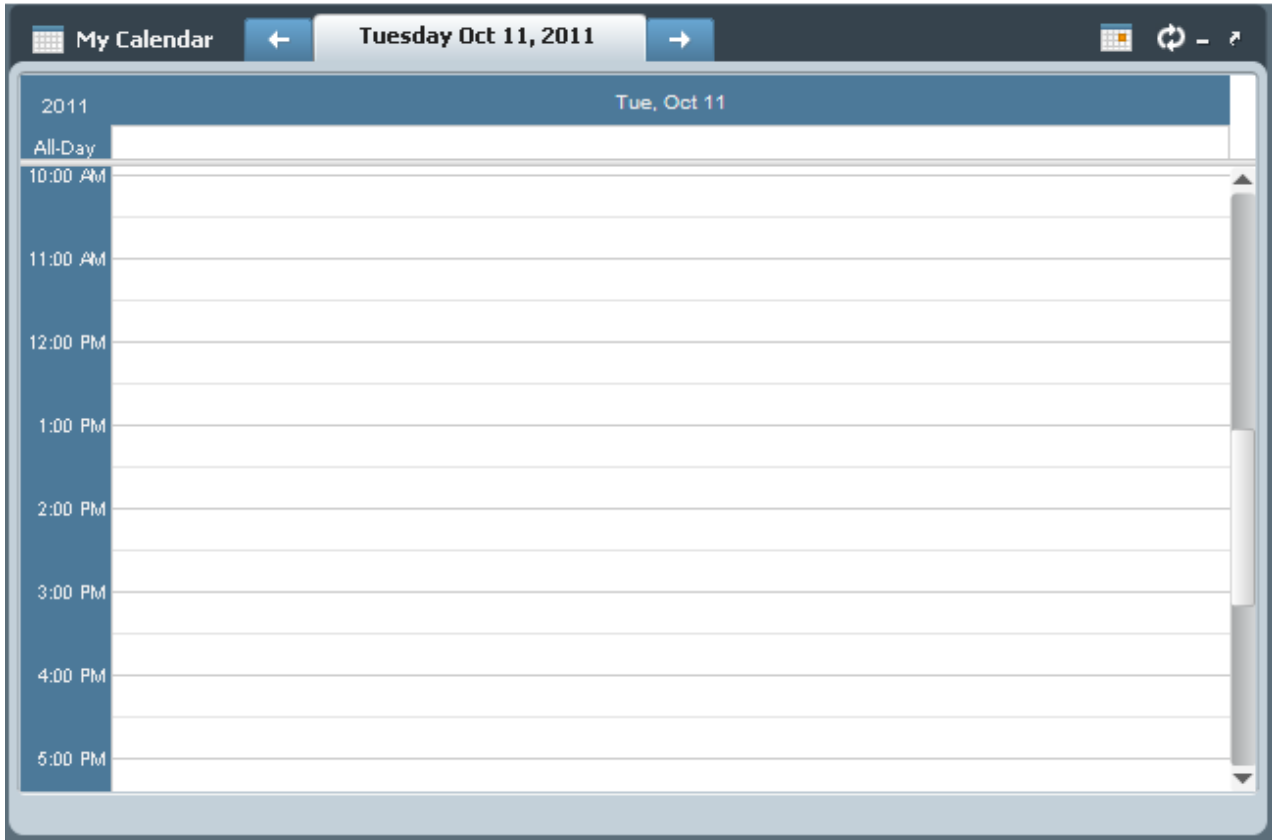
- An appointment must be scheduled for a client associated with the STAFF.
- To add a new appointment to the **AVATAR** Calendar, please utilize "Scheduling Calendar"*.*
- To add a personal appointment to the Calendar, please update the personal calendar (**Outlook)** which will update the My Calendar widget in My Avatar. (**Outlook**)
- Drag an appointment to change the appointment time.
- Right click an appointment to edit the appointment summary.
- Click Show Personal Appointments to display appointments associated with Microsoft Outlook.

Displays the current date.

Moves the calendar view to the next day.

Moves the calendar view to the previous day.

Clients can be added to Avatar through the Admission form.

To search for a client, from the **🏠 Home** view

    0. In the Search Clients field, you can search for a client using:
- 1. Client last name
- 2. Client ID
- 3. Clients Social Security Number
- 4. Date of Birth (using this format **MM/DD/YYYY**)
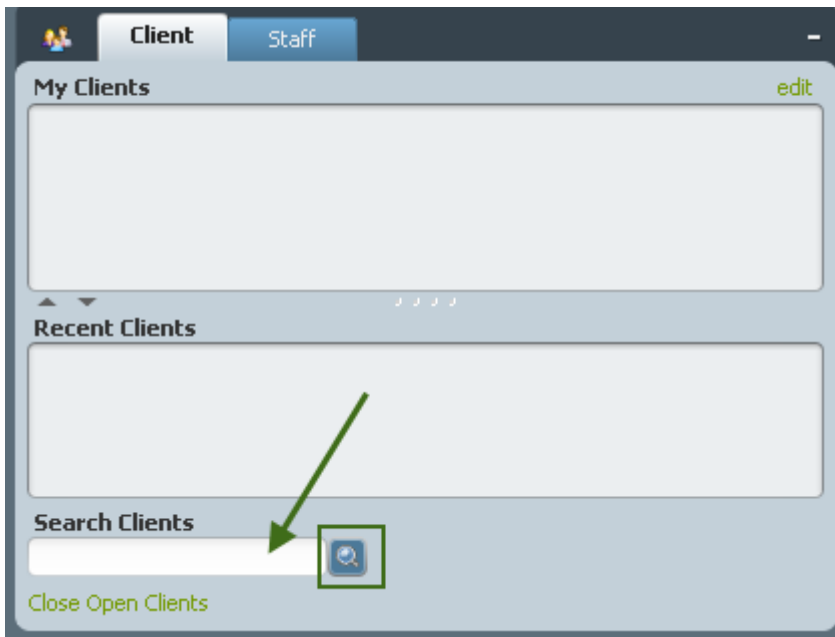
A client will be permanently added to the My Clients list for Staff if:
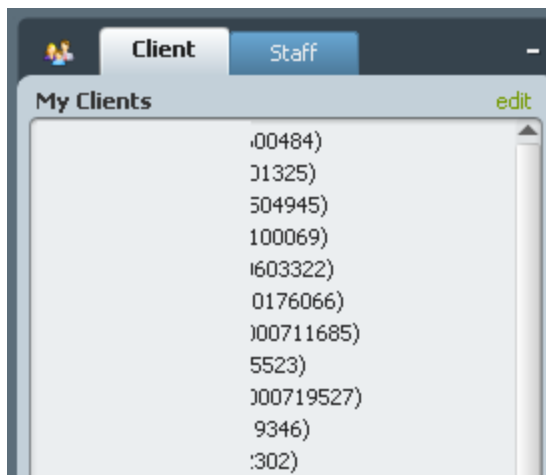
Staff is listed as the Attending Practitioner
Staff is listed as the Admitting Practitioner

- If Staff clicks the edit link and adds a client to the My Clients list, that client will be added to the list for the Staff's session. If the Staff logs out of their Avatar session and logs back in, the client will not display in My Clients.

To close all open client-related forms, Click Close Open Clients
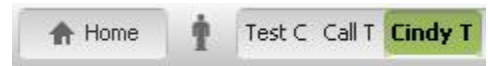
These CLIENTS are displayed on the Client Data Bar, next to

Or click Edit to display the Edit My Clients Screen.
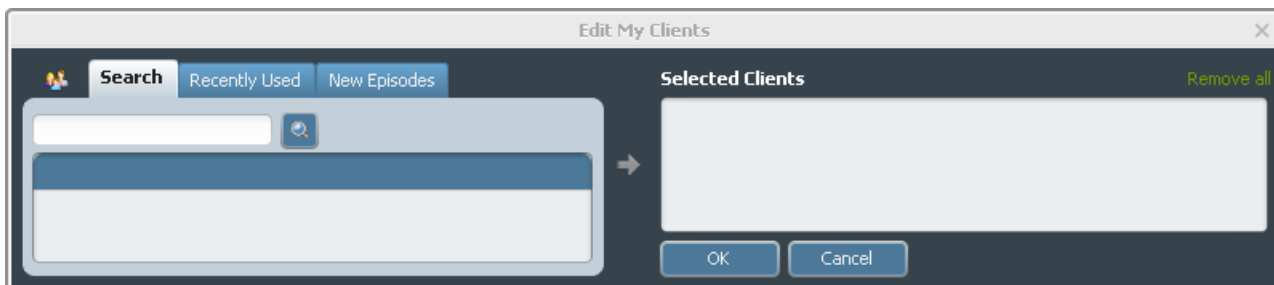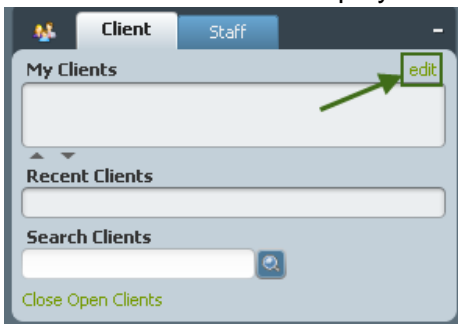
Right-click a client

- Select Chart to display the client's chart.
- Select Remove From List to delete the client from the list.
- Double-click a client to display the client's chart.
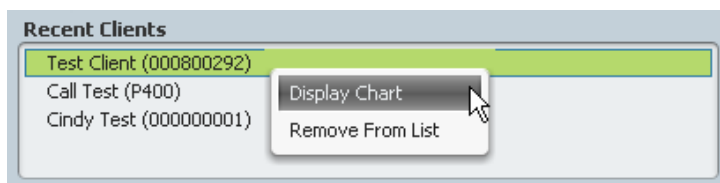
The **CHART** is an interactive screen that displays a client's medical record.
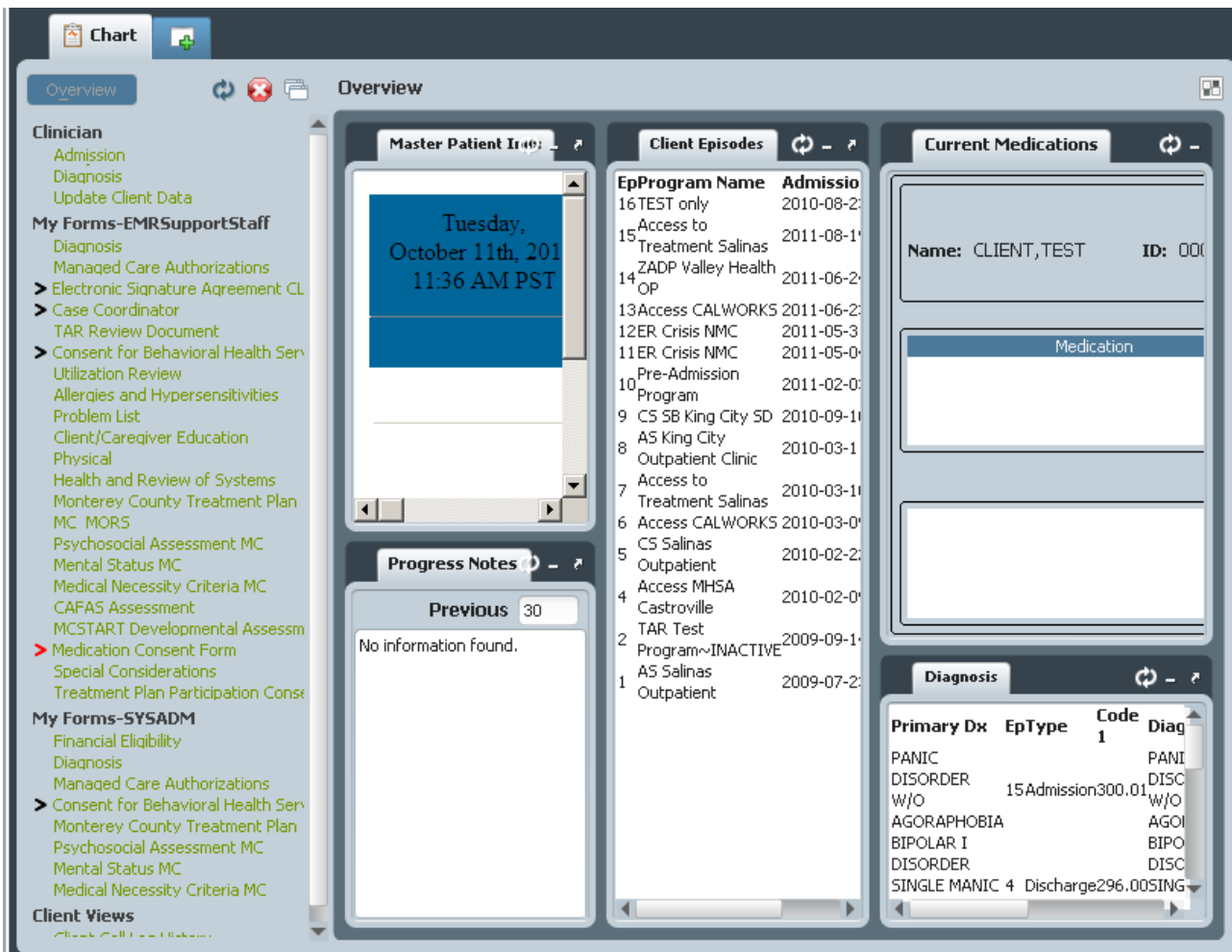
Access a Chart

13. Double-Click a client in the My Clients view.
14. Right-Click a client in the My Clients Section.
15. Choose Display Chart

OR

OVERVIEW - displays the Chart main view.

- If Quick Forms have been setup, links display on the left side of Chart.
- Click a form link to open the form in Chart.

OPEN A NEW FORM WHILE IN CHART VIEW
Click on this Icon to search and open a Form while in Chart View

Select this icon to open a
new form for this client

Enter the name of the Form you
are searching for in this section.

REFRESH CHART VIEW
After selecting to open a client's Chart, Staff can refresh the view at any time. This is especially necessary when adding new information into Forms while within Chart View. The refresh button will bring any recently filed data into display.

OVERVIEW TO GO BACK TO CHART VIEW
In addition, when viewing Form data included in Chart View, the Overview button can be used to bring Staff back to the original Chart View display with the previously defined Widgets.
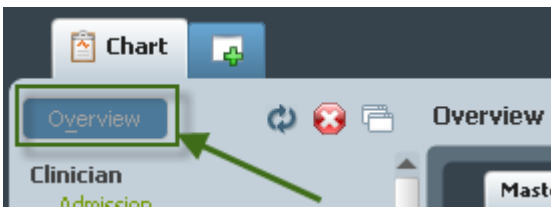
EXIT CHART VIEW
At any point, Staff can choose to exit the Chart View using the exit button.

ERROR REPORTING

LOCATION	CWS → Clinician Menu → Error Reporting
PURPOSE	This form is used to report errors to Quality Assurance for corrections and to make suggestions. We use this form to organize requests.
RULES	• USERID must be in all caps
STEPS	1. Enter your avatar USERID in all caps.
	2. Enter the date of request.
	3. Select from the drop-down box the type of error. You may click on the light bulb to view a description of the type of categories available.
	4. If the request type is Delete Service/Edit service, this information will be needed to complete this request. Service information can be found on the progress note.
	5. If the request type is Scanning Error type, this information will be needed to complete request. This information can be found in the clients "clinical document viewer."
	6. If the request type is Treatment Plan Deletion, we will need the name of the treatment plan and plan date.
	7. Enter the reason for the request and any additional information that will be helpful for the QA staff to complete your request.
	8. Enter your contact phone number, QA staff may call you with additional questions prior to completing your request.
	9. If you are an Administrative staff and are entering error reports for a clinical staff, enter clinical staff name here

HOW TO CHECK THE STATUS OF YOUR ERROR REPORT

LOCATION	CWS → Clinician Menu → Error Reporting
PURPOSE	View the status of entered error reports
RULES	Do not type in the "Error Completion" tab. Do not submit when you are viewing notes about the completion of the error
STEPS	16. Enter your STAFFID in all caps. 17. Look for a date resolved in the pre display screen. 18. Click Edit If you would like to view the details the person correcting the error wrote. Click on the Error Completion section. Click on the X to exit after you have read the notes
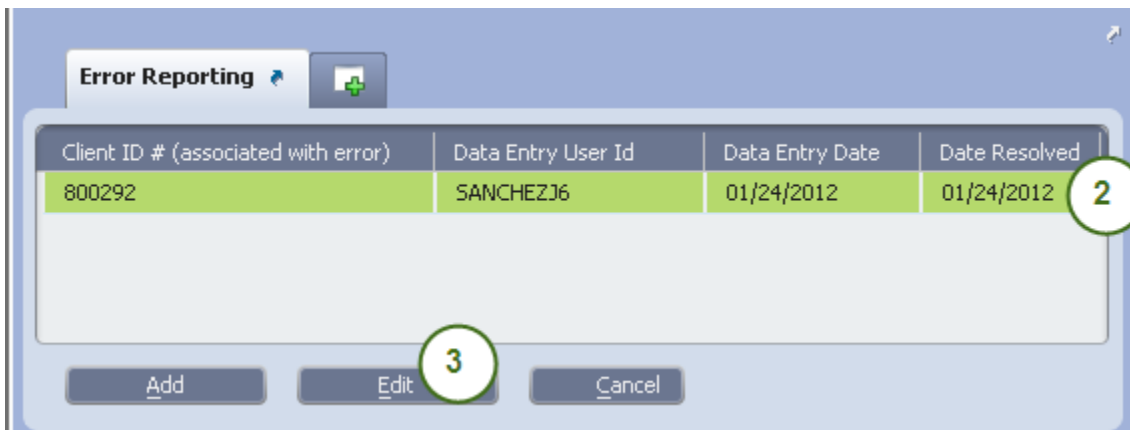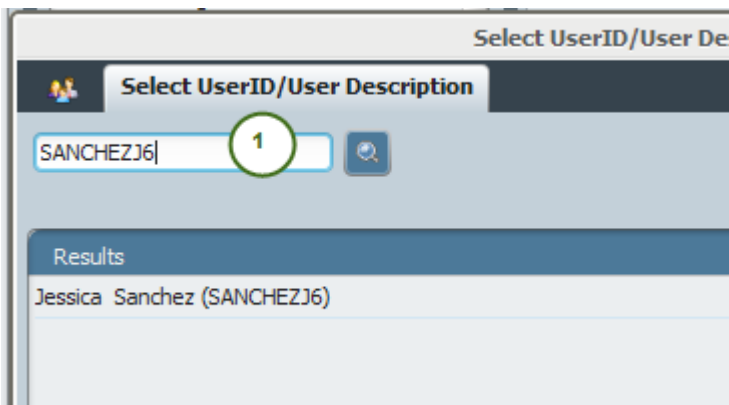
ERROR REPORTING CATEGORIES

- **Delete Note -** Use this category when you need a note deleted such as a duplicate note, note written for the wrong client, and note written on the wrong date. Reminder: Take necessary action such as entering the note under the correct client, enter the note under the correct date of service, reenter the correct note type, or enter note under the correct service date. Please be sure to include the following information:
  - Client number
  - Date of service (date of incorrect date)
  - Duration
  - Time and date note was written.
- **Group Notes Error -** Use this category to report any group errors for example if you forgot to include a client, remove a client, or duplicate group billing.
- **Treatment Plan needs to be deleted -** Use this category to request a treatment plan deletion. Please be sure to include in the error report the **exact name** of the treatment plan and the start date of the treatment plan. Once a treatment plan is deleted, we are unable to get it back therefore it is crucial for you to provide accurate information.
- **Scanning Error -** Use this category to have a scanned document deleted. If you see that a document is in the wrong client chart, print the document and have a PSR scan it into the right chart then make the error report request to have this document deleted from the incorrect chart. Please be sure to provide the **exact** document name to avoid deleting the incorrect document. Note: Document names cannot be changed therefore the document will need to be rescanned with the correct name and you will need to make a request to have the document with the incorrect name deleted.
- **Change treatment plan back to draft -** Use this category to request a finalized treatment plan be changed back to draft status. Keep in mind that even if the treatment plan is switched back to draft you will not be able to make any edits to the plan start date.
- **Crystal report error -** Use this category to report any crystal report error such as information on the report is incorrect or if a report is not running.
- **To do list error -** Use this category to have old items deleted, or items which do not pertain to your caseload.
- **Appointment scheduler error -** Use this category to report any problems with appointment scheduler such as not having access to your location or not being able to schedule appointments.
- **Undo episode closure -** Use this category to request an episode be reopened. This may be needed if you need to submit a draft note, if the episode was accidently closed, or if you need to submit a note which you forgot to enter prior to discharge.
- **Other client related error -** Use this category to report any issues related to the client's medical record. Some examples are client has two client numbers, client psychosocial needs to be deleted or switched to draft, and client medical necessity needs to be deleted or switched to draft.
- **Other avatar error -** Use this to report errors related to avatar that are not related to a specific client.
- **Avatar change -** Use this category to report changes such as a staff member showing up under the incorrect team, work location change, no longer employed staff.
- **QI Questions -** Use this category for any QI Questions
- **Client Merge -** Use this category when you have found one client with two client numbers

ADD/REMOVE SUPPORTING STAFF FROM CLIENT CASELOAD

LOCATION	Avatar PM → Client Management
PURPOSE	These forms will be used to Add Supporting Staff to Client Caseload and to Remove Supporting Staff to Client Caseloads.
RULES	• When a Staff ID or Staff Name is added to Caseload, the PATID and Client Name WILL appear on the My Clients widget. • When the PATID is on the caseload, the Staff will NOT receive non-caseload access messages from Avatar. • PATIDs can be assigned one or many Supporting Staff • When a Staff ID or Staff Name is REMOVED from Caseload, the PATID and Client Name will NO LONGER appear on the My Clients widget. • When the PATID is REMOVED from the caseload, the Staff will receive non-caseload access messages from Avatar
STEPS	Select the client. 1. Search a Client for and Select and Click on the form 'Add Supporting Staff to Client Caseload.' 2. Enter the date when you want the Supporting Staff to be ADDED to the Client's caseload. 3. Enter the Staff Name (first name or last name) and select the appropriate Staff member. 4. Click the Submit button to save the Add Supporting Staff form. 5. Verify that Client is on the Staff member's My Clients widget. 6. When you are ready to remove a Staff member from the Client's caseload, search for a Client and Select and Click on the form 'Remove Supporting Staff to Client Caseload.' 7. Enter the date when you want the Supporting Staff to be REMOVED to the Client's caseload. 8. Enter the Staff Name (first name or last name) and select the appropriate Staff member. 9. Click the Submit button to save the Remove Supporting Staff form. 10. Verify that the Client has been removed from your My Clients widget

218 OTHER SUPPORT STAFF REPORT

REPORT NAME AND NUMBER	218 Other Support Staff Report
LOCATION	Avatar CWS >> Clinical Reports >>> Caseload Reports
PURPOSE	This report lists the clients where you are the assigned "Other Support Staff" as part of the clients Support Team. Although this report is currently a draft version of the Report which will include the Other Support Staff last date of service for each client, you are able to use it with the basic information. Aside from the Client ID and Client Name, the Case Coordinator information is provided to identify who you will need to collaborate with when it comes to the clients care.
ACCESSABLE TO STAFF	Clinicians, Other Support Staff

Monterey County Health Department
Behavioral Health Divison
218 Other Support Staff Caseload Report
For: ▮▮▮▮▮▮▮▮▮▮▮

Client ID	Name	Case Coordinator

CASE COORDINATOR

LOCATION	CWS →CLINICIAN MENU →CLIENT CASE COORDINATOR
DOCUMENTATION GUIDE LOCATION	Chapter 1: Introduction
PURPOSE	Behavioral Health operates under a care coordination model; meaning that each client is assigned a "Case Coordinator" who is responsible for the completion of a coordinated treatment plan and assessment documentation on an annual basis. The purpose of care coordination is to ensure that clients are receiving necessary services without duplication. The case coordinator can be county staff or contract provider staff.
RULES	Each open client must have a case coordinator. A case coordinator can be a county employee or a contract provider. The Case Coordinator ensures client is receiving necessary services without duplication. The case coordinator is responsible for completing all necessary documents, on an annual basis, or as need to ensure client receives medically necessary service. The date of coordination is from the start of a coordinated care episode or outpatient service
STEPS	Select the client or if the client is in your recent clients section, make sure he is the selected client (it will be highlighted). 19. Enter the date you were assigned case coordinator for the client. 20. Select Staff by entering the name or staff ID, then process search 21. If you are no longer the client's case coordinator enter the date of discharge or the date you transferred the client to a new case coordinator 22. Submit

ADMISSION

LOCATION	PM→ Client Management→Episode Management →Admission
PURPOSE	An admission is required to open/or assign a client into a program and initiate billing. The services available depend on the program which the client qualifies for.
RULES	• The following sections are NOT required for admission "Other Client Data" and "CADDS." • The **Admitting Practitioner** field generates the caseload list. • The current case manager or case coordinator should be listed in the admitting practitioner field. This field can be updated at any time to change a clinician's caseload. • The **Attending Practitioner** field should be used to record the client's psychiatrist. If the client does not have a psychiatrist/physician assigned, please leave this field blank. • If the client has preexisting admission, you will get a pre-display. If you are creating a **New Episode**: Click on Add. If you are entering an Admission for a new client (no previous episodes), you will NOT get the pre-display screen; the form will open directly. • **To Edit an Existing Episode**: Select the episode you want to view/edit, Click on Edit • **For Client with prior episode history**: Information will default into the admission form.
STEPS-ADMISSION	1. To Search for the Client, enter the name of the client. At least three (3) data elements are required to activate the search option. If the client is not found in the system, select NEW CLIENT. 2. Select YES to auto assign the client a NEW Identification Number 3. Enter the Pre-admit/Admission Date (you can select T for today or Y for Yesterday) 4. Enter the Pre-admit/Admission Time (you can select current) 5. From the drop-down menus, select the Program, Type of Admission, and the Source of Admission (click on light bulbs for help text) 6. Enter client name (naming convention: Last name, first name) 7. Select the client Sex assigned at birth. 8. Enter the client Date of Birth 9. Enter the Admitting Practitioner 10. Enter the Attending Practitioner (If applicable, Only for Psychiatrists/physicians) 11. If required, enter practitioner type as "Staff." 12. Select if the client has an Advanced Directive 13. If the client has an advance directive, enter some details here. Be sure to scan the advance directive into the clients chart. 14. Enter the client Social Security Number (naming convention: 113-22-0745 with dashes; if the SS# is unknown enter zeros 000-00-0000) 15. Select if the client is Pregnant. For SUD treatment programs, this is required for Perinatal rate reimbursement. Staff can edit admission form as necessary for completed pregnancy or if client becomes pregnant after admission to program). 16. Enter the Presenting Problem. If applicable, select the secondary and tertiary problems; a diagnosis form will be completed separately. 17. Select the client Living Arrangements 18. Select the Disposition if known. 19. Select up to 3 Disabilities.

STEPS-DEMOGRAPHICS	1. Client Name will default from previous section.
	2. Select the client identified Sexual Orientation
	3. Select the client's Religion.
	4. Enter the client's Place of Birth
	5. Select the client's Country of Origin
	6. Enter Client's Maiden name, if applicable
	7. Select from the drop downs the client's Marital Status, Education, Employment Status, Occupation and Smoker Status. Once the smoker status is selected the "smoking status assessment date" becomes required. For the Smoking status assessment date enter the date you are asking the client if they smoke.
	8. Enter the client's address. For homeless individuals, enter the clinic address where the client is receiving services.
	9. Enter the client's Phone Numbers
	10. Enter the client's Email Address
	11. Select the client's Communication Preference
	12. Select the Primary Language. Note: some reports use this language field to determine if they will print in English or Spanish. Select the client's Race and Ethic origin.
	13. Enter client Alias(s), if applicable
	14. Enter the mother's Maiden Name

Alias		Alias 6	
PRIMO			
Alias 2		Alias 7	
LUPITO			
Alias 3		Alias 8	
Alias 4		Alias 9	
Alias 5		Alias 10	

Mother's Maiden Name ⑭

INPATIENT/PARTIAL/ DAY TREATMENT	1. If the admission program is a residential program this section will need to be filled out for capacity purposes

STEPS-DEMOGRAPHICS	1. Identify if client has Allergies. If so, enter a description of the allergies.
	2. Select the Sources of Information for the admission.
	3. Select Agencies the client is involved with if applicable.
	4. Select if the client is a veteran. If so, select the branch of service.
	5. Select the school of attendance, if the applicable
	6. For SUD programs: If the client is pregnant, enter the Pregnancy Start Date, Last Menstruation Date, and Date of Initial Prenatal Visit. (data convention: If client has not had a prenatal visit, Enter the same date as the Date of Admission episode.
	7. For Narcotic Treatment programs, enter the client Height, Weight, Hair Color, Eye Color and Distinguishing Marks such as scars and tattoos

UPDATE CLIENT DATA

LOCATION	CWS → Clinician Menu → Update Client Data
PURPOSE	This form is used to make any changes to client information such as address, phone number, name change, etc.
RULES	DO NOT use the # sign in the address; use comma (,) instead. Keep this up to date as many people rely on this information. Billing staff may change information to reflect that of Medi-Cal information. Be mindful of ethnicity/race – too many clients with unknown, creates a challenge
STEPS	Select the client. 5. Update the necessary information. 6. Submit the form

Maiden Name

maybe

Marital Status   Single / Never Married ▼

Education   16 Years ▼

Employment Status   Not In Labor Force - Student ▼

Occupation   Preschooler Or Student ▼

Smoker 💡   Unknown If Ever Smoked ▼

┌─ Smoking Status Assessment Date ─────────────────────┐
│ 11/07/2017 📅 [T] [Y] [⇅]   │
└──┘

Alias

PRIMO

Alias 2

LUPITO

Alias 3

Alias 4

Alias 5

Alias 6

Alias 7

Alias 8   ┌─ Protection Indicator ─────────────────────────┐
                                                 │ ○ Yes   ✗   ○ No   │
                                                 └──┘
Alias 9   ┌─ Protection Indicator Effective Date ──────────┐
                                                 │ [   ] 📅 ✗ [T] [Y] [⇅]   │
                                                 └──┘
Alias 10   ┌─ Name Qualifier ───────────────────────────────┐
                                                 │ ○ Keep Private   ○ Unspecified   │
                                                 └──┘

SPECIALTY TEAMS

LOCATION	CWS → Clinician Menu → Specialty Team
PURPOSE	This is used to flag individuals on specialty team. (i.e., mental health programs may include Katie A. populations; Substance Use Disorder programs may include individuals under AB 109)
RULES	• Used to track specialty teams with specific funding streams. • Individuals are part of a larger program episode
STEPS	1. Enter start date. 2. Specialty Team/Service (select the specialty team participation from the drop-down menu 3. Enter end date (this is used when the individual no longer participates in specialty team

CAL OMS DATA FORMS
CAL OMS ADMISSION PART 2 (AOD ADMISSION)

LOCATION	Avatar CWS☐Clinician Menu☐AOD☐☐Admission Part 2 AOD (CalOMS Admission)
RULES	Cal- OMS is a statewide client-based data collection and outcomes measurement system that enables the Department of Health Care Services (DHCS) to manage and improve the provision of Substance Use Disorder (SUD) services at the state, county, and provider levels more effectively. CalOMS automates the process of inputting and retrieving treatment outcomes data necessary to: • Meet federal reporting requirements. • Document prevention and treatment population demographics • Identify alcohol and other drug trends and risks. • Demonstrate service effectiveness. • Demonstrate that services are cost effective. • Identify the most effective practices to improve service delivery

STEPS	Select the client or if the client is in your recent section, make sure the client is selected (It will
	  be highlighted) and the CalOMS admission form will appear if that is the only CalOMS episode.
	
	Client Identification and Demographic Data
	1. Birth First Name
	   What is the client's birth first name?
	2. Birth Last Name
	   What is the client's birth last name?
	3. Current First Name
	   What is the client's current first name?
	4. Current Last Name
	5. What is the client's current first name? SSN
	   What is the client's social security number?
	   Nine-digit social security number
	   99902 None or not applicable
	   Detox only program
	     99904 Client unable to answer.
	6. Zip Code At Current Residence
	   What is the client's zip code at their current residence?
	
	   Enter value '00000' Homeless only if Current Living Arrangements is 'Homeless'.
	
	   Detox only program
	     99904 Client unable to answer.
	7. Race
	   What is the client's race?
	   If 'Client declined to state' is selected on Race 1, then no other values for race can be selected for
	   Race 2, 3, 4, 5
	8. Place of Birth – State
	   What is the client's county of birth if born in California?
	9. Place of Birth – County
	   What is the client's state of birth if born within the United States?

STEPS	10. Driver's License Number
	What is the client's driver's license number? If the client does not have a driver's license, what is the client's state ID card number?
	Value for Driver's License Number must be provided if Driver's License State is provided.
	None or not applicable is 99902.
	Detox only programs
	99904 Client unable to answer.
	11. Driver's License State
	For which state does the client have a valid driver's license or state ID card?
	If Driver's License Number is 99902, then Driver's License State must be None or not applicable.
	Detox only programs
	Client unable to answer 99904.
	12. Mother's First Name
	What is the first name of the client's mother, or individual the client considers to be as their mother?
	If a client is unable to provide a name, enter value 'mother' or 'mom'

STEPS	13. Ethnicity
	What is the client's ethnicity?
	14. Veteran
	Is the client a U.S. veteran?
	Detox only programs
	15. *Client unable to answer* Consent.
	Is there a consent form allowing future possible contact, signed by the client, on file within your agency?
	16. Disability
	What type of disability /disabilities does the client have, if any?
	Only one value is allowed.
	Detox only programs
	Client unable to answer 99904.
	17. Flag for Cal-OMS Submission
	'Yes', should always be checked

STEPS	**Transaction Data**
	18. Admission Transaction Type

STEPS	Admission Data
	19. Source of Referral What is the client's principal source of referral? 20. Days Waited to Enter Treatment How many days was the client on a waiting list before being admitted to this treatment program? *Detox only programs* *Client unable to answer.* 21. Number of Prior Episodes What is the number of prior episodes in any alcohol or drug treatment/recovery program in which the client has participated? *Detox only programs* *Client unable to answer.* 22. CalWORKs Recipient Is the client a CalWORKs recipient? 23. Substance Abuse Treatment Under CalWORKs Is the client receiving substance abuse treatment under the CalWORKs welfare-to-work plan? *Value can only be 'yes' if CalWORKs Recipient is also 'Yes'.* 24. County Paying for Services If the client's treatment services are being delivered on behalf of another county, what is the code of the county for which the services are being performed? *Always None or Not Applicable* 25. Special Services Contract ID What is the special services contract ID number under which the client's services were provided? *Always 99902 None or Not Applicable*

STEPS	Alcohol And Drug Use

	26. Primary Drug (Code)
	   What is the client's primary alcohol or drug problem?
	27. Primary Drug Name
	   Provide Drug Name if prompted What is the client's primary alcohol or drug problem?
	28. Primary Drug Frequency
	   How many days in the past 30 days has the client used the primary drug?
	29. Primary Drug Route of Administration
	   What is the client's usual route of administration they use most often for their primary drug of abuse?
	30. Primary Drug Age of First Use
	   What was the client's age of first use for the primary drug of abuse?
	31. Secondary Drug (Code)
	   What is the client's secondary alcohol or drug problem?
	32. Secondary Drug Name
	   What is the client's secondary alcohol or drug problem?
	33. Secondary Drug Frequency
	   How many days in the past 30 days has the client used the secondary drug of abuse?
	34. Secondary Drug Route of Administration
	   What is the client's usual route of administration they use most often for the secondary drug of abuse?
	35. Secondary Drug Age of First Use
	   What was the client's age of first use for the secondary drug of abuse?
	36. Alcohol Frequency
	   How many days in the past 30 days has the client used alcohol?
	37. Needle Use
	   How many days has the client used needles to inject drugs in the past 30 days?
	   Detox only programs
	   Client unable to answer.
	38. Needle Use in the Last 12 Months
	   Has the client used needles to inject drugs in the past twelve months?
	   Detox only programs
	     Client unable to answer

Chart | **Admission Part 2 AOD (CalOMS Admission)**

- Client Identification and D
- Transaction Data
- Admission Data
- **Alcohol And Drug Use**
- Employment Data
- Criminal Justice Data
- Medical/Physical Health D
- Mental Illness
- Family/Social Data

Submit

Online Documentation

▼

Primary Drug (Code) 26

Primary Drug Name 27

Primary Drug Frequency 28

Primary Drug Route of Administration
○ Oral
○ Smoking 29
○ Inhalation
○ Injection (IV or intramuscular)
○ None or Not Applicable
○ Other

Primary Drug Age of First Use 30

Secondary Drug (Code) 31

Secondary Drug Name 32

Secondary Drug Frequency 33

Secondary Drug Route of Administration
○ Oral
○ Smoking
○ Inhalation 34
○ Injection (IV or intramuscular)
○ None or Not Applicable
○ Other

Secondary Drug Age of First Use 35

Alcohol Frequency 36

Needle Use 37

▼

Needle Use in the Last 12 Months
○ No
○ Yes 38
○ Client unable to answer

STEPS	Employment Data

	39. Enrolled in School
	   Is the client currently enrolled in school?
	   Detox only programs
	     Client unable to answer 99904.
	40. Highest School Grade Completed
	   What is the client's highest school grade completed? What is the client's primary alcohol or drug problem?
	   Detox only programs
	     Client unable to answer 99904.
	41. Employment Status
	   What is the client's current employment status?
	   If client is 14 years old or less, then employment status cannot be 'Employed Full Time (35 hrs. or more)
	42. Enrolled in Job Training
	   Is the client currently enrolled in a job training program?
	   Detox only programs
	     Client unable to answer 99904.
	43. Work Past 30 Days
	   How many days was the client paid for working in the past 30 days?
	   Detox only programs
	     99904 Client unable to answer

STEPS	Criminal Justice Data

	44. Criminal Justice Data
	What is the client's criminal justice status?
	Must not select 'No criminal justice involvement', if Source of Referral is one of the following.
	'SACPA/Prop 36/OTP/Probation or Parole.'
	'Post-release Community Supervision (AB 109)'
	'Adult Felon Drug Court'
	'Non-SACPA Court/Criminal Justice'
	Detox only programs
	  Client unable to answer.
	45. Number of Arrests Last 30 Days
	How many times has the client been arrested in the past 30 days? Number of Jail Days Last 30 Days?
	Detox only programs
	  Client unable to answer.
	46. Number of Jail Days Last 30 Days
	How many days has the client been in jail in the past 30 days?
	Detox only programs
	  Client unable to answer.
	47. Number of Prison Days Last 30 Days
	  How many days has the client been in prison in the past 30 days?
	  Detox only programs
	    Client unable to answer.
	48. Parolee Services Network
	  Is the client a parolee in the Parolee Services Network (PSN)?
	  Detox only programs
	    Client unable to answer.
	49. FOTP Parolee
	  Is the client a parolee in the Female Offender Treatment Program (FOTP)?
	  Detox only programs
	    Client unable to answer.
	50. FOTP Priority Status
	  What is the client's FOTP Priority Status?
	  Detox only programs
	    Client unable to answer.
	51. CDCR Number
	What is the client's CDCR Identification Number?
	99902 None or not applicable if Criminal Justice Status is 'No criminal justice involvement.'
	Unless the following
	If PSN is 'Yes', then a CDCR Number must be provided.
	If FOTP Parolee is 'Yes', then a CDCR Number must be provided

STEPS	Medical/Physical Health Data
	52. Medi-Cal Beneficiary
	Is the client a Medi-Cal beneficiary?
	Detox only programs
	Client unable to answer.
	53. Emergency Room Last 30 Days
	How many times has the client visited an emergency room in the past 30 days for physical health problems?
	Detox only programs
	Client unable to answer.
	54. Hospital Overnight Last 30 Days
	How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems?
	Detox only programs
	Client unable to answer.
	55. Medical Problems Last 30 Days
	How many days in the past 30 days has the client experienced physical health problems?
	Medical Problems must be greater than 0 if Emergency or Overnight last 30 days are greater.
	than 0.
	Detox only programs
	Client unable to answer.
	56. Pregnant At Admission
	If the client is not male, is the client pregnant at the time of admission?
	57. Medication Prescribed As Part of Treatment
	What medication is prescribed as a part of treatment?
	58. Communicable Diseases: Tuberculosis
	Has the client been diagnosed with Tuberculosis?
	Detox only programs
	Client unable to answer.
	59. Communicable Diseases: Hepatitis C
	Has the client been diagnosed with Hepatitis C?
	Detox only programs

Client unable to answer.

60. Communicable Diseases: Sexually Transmitted Disease
Has the client been diagnosed with any sexually transmitted diseases?
Detox only programs
61. *Client unable to answer* HIV Tested
Has the client been tested for HIV/AIDS?
Detox only programs
Client unable to answer.
62. HIV Test Results
Does the client have the results of the HIV/AIDS test?
Detox only programs
Client unable to answer.

STEPS	Mental Illness
	63. Mental Illness Has the client ever been diagnosed with a mental illness? 64. Emergency Room Use / Mental Health *How many times in the past 30 days has the client received outpatient emergency services for mental health needs?* *Detox only programs* *99904 Client unable to answer.* 65. Psychiatric Facility Use How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? *Detox only programs* *99904 Client unable to answer.* 66. Mental Health Medication In the past 30 days, has the client taken prescribed medication for mental health needs? *Detox only programs* *Client unable to answer*

STEPS	Family/Social Data

	67. Social Support
	How many days in the last 30 days has the client participated in any social support recovery activities such as:
	12-step meetings
	Other self-help meetings
	Religious/faith recovery or self-help meetings
	Meetings of organizations other than those listed above.
	Interactions with family member and/or friend support of recovery?
	
	68. Current Living Arrangements
	Select 'Homeless' only when Zip Code at Current Residence is '00000.'
	
	69. Living with Someone
	How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?
	Detox only programs
	  99904 Client unable to answer.
	
	70. Family Conflict Last 30 Days
	How many days in the past 30 days has the client had serious conflicts with members of their family?
	Detox only programs
	  99904 Client unable to answer.
	
	71. Number of Children
	How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not?
	Detox only programs
	  99904 Client unable to answer.
	
	72. Number of Children Aged 5 Years Or Younger
	How many children does the client have age 5 or younger?
	Value must be less than or equal to Number of Children
	Detox only programs
	  99904 Client unable to answer.
	
	73. Number of Children Living with Someone Else
	How many of the client's children aged 17 and under are living with someone else because of a child protection court order?
	Value must be less than or equal to Number of Children
	Detox only programs
	  99904 Client unable to answer.
	
	74. Number of Children Living with Someone Else and Parental Rights Terminated
	If the client has children living with someone else because of a child protection court order, for how many of these children aged 17 or under have the client's parental rights been terminated?
	Value must be less than or equal to Number of Children
	Detox only programs
	  99904 Client unable to answer.
	
	75. Submit completed CalOMS Admission form

| Chart | Admission Part 2 AOD (CalOMS Admission) | |

- Client Identification and D
- Transaction Data
- Admission Data
- Alcohol And Drug Use
- Employment Data
- Criminal Justice Data
- Medical/Physical Health D
- Mental Illness
- Family/Social Data

Social Support **(67)**

Current Living Arrangements
○ Homeless   ○ Dependent Living
○ Independent Living **(68)**

Living with Someone **(69)**

Family Conflict Last 30 Days **(70)**

Number of Children **(71)**

Number Of Children Aged 5 Years Or Younger **(72)**

Number of Children Living with Someone Else **(73)**

Number of Children Living with Someone Else and Parental Rights Terminated **(74)**

Submit **(75)**

CAL OMS DATA FORMS	
CAL OMS DISCHARGE PART 2 (CAL OMS DISCHARGE)	
LOCATION	**Avatar CWS☐Clinician Menu☐AOD☐ Discharge Part 2 (CalOMS Discharge)**
RULES	Cal-OMS is a statewide client-based data collection and outcomes measurement system that enables the Department of Health Care Services (DHCS) to manage and improve the provision of Substance Use Disorder (SUD) services at the state, county, and provider levels more effectively. CalOMS automates the process of inputting and retrieving treatment outcomes data necessary to: • Meet federal reporting requirements. • Document prevention and treatment population demographics • Identify alcohol and other drug trends and risks. • Demonstrate service effectiveness. • Demonstrate that services are cost effective. • Identify the most effective practices to improve service delivery

STEPS	Select the client or if the client is in your recent section, make sure the client is selected (It will
	be highlighted) and the CalOMS discharge form will appear if that is the only CalOMS episode.
	
	Cal-OMS Discharge
	1. Discharge Status
	2. Consent
	Is there a consent form allowing future possible contact, signed by the client, on file within your agency?
	3. Disability
	What type of disability /disabilities does the client have, if any?
	Only one value is allowed.
	Detox only programs
	   Client unable to answer.
	4. Current First Name
	What is the client's current first name?
	5. Current Last Name
	What is the client's current last name?
	6. Social Security Number
	What is the client's social security number?
	Nine-digit social security number
	99902 None or not applicable
	Detox only program
	   Client unable to answer 99904.
	7. Zip Code At Current Residence
	What is the client's zip code at their current residence?
	Enter value '00000' Homeless only if Current Living Arrangements is 'Homeless'.
	Detox only program
	   99904 Client unable to answer

STEPS	Alcohol and Drug Use Data
	8. **Primary Drug (Code)** What is the client's primary alcohol or drug problem? 9. **Primary Drug (Other)** *Provide Drug Name if prompted.* *What is the client's primary alcohol or drug problem?* 10. **Primary Drug Frequency** How many days in the past 30 days has the client used the primary drug? 11. **Primary Drug Route of Administration** What is the client's usual route of administration they use most often for their primary drug of abuse? 12. **Secondary Drug (Code)** What is the client's secondary alcohol or drug problem? 13. **Secondary Drug (Other)** What is the client's secondary alcohol or drug problem? 14. **Secondary Drug Frequency** How many days in the past 30 days has the client used the secondary drug of abuse? 15. **Secondary Drug Route of Administration** What is the client's usual route of administration they use most often for the secondary drug of abuse? 16. **Alcohol Frequency** How many days in the past 30 days has the client used alcohol? 17. **Needle Use** How many days has the client used needles to inject drugs in the past 30 days? *Detox only programs* *Client unable to answer*

STEPS	**Employment Data**

	18. Employment Status
	What is the client's current employment status?
	19. Work Past 30 Days
	How many days was the client paid for working in the past 30 days?
	Detox only programs
	  99904 Client unable to answer.
	20. Enrolled in School
	Is the client currently enrolled in school?
	Detox only programs
	  Client unable to answer.
	21. Enrolled in Job Training
	Is the client currently enrolled in a job training program?
	Detox only programs
	  Client unable to answer.
	22. Highest School Grade Completed
	What is the client's highest school grade completed? What is the client's primary alcohol or drug problem?
	Detox only programs
	  Client unable to answer

STEPS	Criminal Justice Data

	23. Number of Arrests Last 30 Days
	How many times has the client been arrested in the past 30 days? Number of Jail Days Last 30 Days
	Detox only programs
	   Client unable to answer.
	24. Number of Jail Days Last 30 Days
	How many days has the client been in jail in the past 30 days?
	Detox only programs
	   Client unable to answer.
	25. Number of Prison Days Last 30 Days
	How many days has the client been in prison in the past 30 days?
	Detox only programs
	   Client unable to answer

STEPS	Medical/Physical Health Data
	26. Emergency Room Last 30 Days
How many times has the client visited an emergency room in the past 30 days for physical health problems?
Detox only programs
Client unable to answer.
27. Hospital Overnight Last 30 Days
How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems?
Detox only programs
Client unable to answer.
28. Medical Problems Last 30 Days
How many days in the past 30 days has the client experienced physical health problems?
Medical Problems must be greater than 0 if Emergency or Overnight last 30 days are greater.
than 0.
Detox only programs
Client unable to answer.
29. Pregnant At Any Time During Treatment
If the client is not male, is the client pregnant at the time of admission?
30. HIV Tested
Has the client been tested for HIV/AIDS?
Detox only programs
Client unable to answer.
31. HIV Test Results
Does the client have the results of the HIV/AIDS test?
Detox only programs
Client unable to answer

STEPS	**Mental Illness**
	32. Mental Illness Has the client ever been diagnosed with a mental illness? 33. Emergency Room Use / Mental Health How many times in the past 30 days has the client received outpatient emergency services for mental health needs? *Detox only programs* *99904 Client unable to answer.* 34. Psychiatric Facility Use How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? *Detox only programs* *99904 Client unable to answer.* 35. Mental Health Medication In the past 30 days, has the client taken prescribed medication for mental health needs? *Detox only programs* *99904 Client unable to answer*

STEPS	Family/Social Data

	36. Social Support
	How many days in the last 30 days has the client participated in any social support recovery activities such as:
	12-step meetings
	Other self-help meetings
	Religious/faith recovery or self-help meetings
	Meetings of organizations other than those listed above.
	Interactions with family member and/or friend support of recovery?
	37. Current Living Arrangements
	What is the client's current living arrangement?
	Select 'homeless' only when Zip Code at Current Residence is '00000.'
	38. Living with Someone
	How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?
	Detox only programs
	99904 Client unable to answer.
	39. Family Conflict Last 30 Days
	How many days in the past 30 days has the client had serious conflicts with members of their family?
	Detox only programs
	   99904 Client unable to answer.
	40. Number of Children
	How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not?
	Detox only programs
	   99904 Client unable to answer.
	41. Number of Children Aged 5 Years Or Younger
	How many children does the client have age 5 or younger?
	Value must be less than or equal to Number of Children
	Detox only programs
	   99904 Client unable to answer.
	42. Number of Children Living with Someone Else
	How many of the client's children aged 17 and under are living with someone else because of a child protection court order?
	Value must be less than or equal to Number of Children
	Detox only programs
	   99904 Client unable to answer.
	43. Number of Children Living with Someone Else and Parental Rights Terminated
	If the client has children living with someone else because of a child protection court order, for how many of these children aged 17 or under have the client's parental rights been terminated?
	Value must be less than or equal to Number of Children
	Detox only programs
	   99904 Client unable to answer.
	44. Submit completed CalOMS Discharge form

Chart | **Discharge Part 2 (CalOMS Discharge)**

- Cal-OMS Discharge
- Alcohol and Drug Use D...
- Employment Data
- Criminal Justice Data
- Medical/Physical Health...
- Mental Illness
- Family/Social Data

Submit (44)

Social Support (36)

Current Living Arrangements
- ◯ Homeless
- ◯ Independent Living (37)
- ◯ Dependent Living

Living With Someone (38)

Family Conflict Last 30 Days (39)

Number of Children (40)

Number Of Children Aged 5 Years Or Younger (41)

Number of Children Living With Someone Else (42)

Number of Children Living With Someone Else and Parental Rights Terminated (43)

CAL OMS DATA FORMS
CAL OMS YOUTH/DETOX DISCHARGE ONLY FOR YOUTH OR DETOX CLIENTS

LOCATION	Avatar CWS☐Clinician Menu☐AOD☐ Cal-OMS Youth/Detox Discharge
RULES	Cal-OMS is a statewide client-based data collection and outcomes measurement system that enables the Department of Health Care Services (DHCS) to manage and improve the provision of Substance Use Disorder (SUD) services at the state, county, and provider levels more effectively. CalOMS automates the process of inputting and retrieving treatment outcomes data necessary to: • Meet federal reporting requirements. • Document prevention and treatment population demographics • Identify alcohol and other drug trends and risks. • Demonstrate service effectiveness. • Demonstrate that services are cost effective. • Identify the most effective practices to improve service delivery

STEPS	Select the client or if the client is in your recent section, make sure the client is selected (It will
	  be highlighted) and the CalOMS Youth/Detox Discharge form will appear if that is the only CalOMS episode.
	
	 Cal-OMS Youth/Detox Discharge
	 1. Discharge Status
	 2. Consent
	 Is there a consent form allowing future possible contact, signed by the client, on file within your agency?
	 3. Disability
	 What type of disability /disabilities does the client have, if any?
	 Only one value is allowed.
	 Detox only programs
	   Client unable to answer.
	 4. Current First Name
	 What is the client's current first name?
	 5. Current Last Name
	 What is the client's current last name?
	 6. Primary Drug (Code)
	 What is the client's primary alcohol or drug problem?
	 7. Primary Drug (Other)
	 Provide Drug Name if prompted.
	 8. What is the client's primary alcohol or drug problem? Primary Drug Frequency
	 How many days in the past 30 days has the client used the primary drug?
	 9. Primary Drug Route of Administration
	 What is the client's usual route of administration they use most often for their primary drug of abuse?
	 10. Secondary Drug (Code)
	 What is the client's secondary alcohol or drug problem?
	
	 11. Secondary Drug (Other)
	 What is the client's secondary alcohol or drug problem?

STEPS	12. Secondary Drug Frequency
	How many days in the past 30 days has the client used the secondary drug of abuse?
	
	13. Secondary Drug Route of Administration
	What is the client's usual route of administration they use most often for the secondary drug of abuse?
	
	14. Alcohol Frequency
	How many days in the past 30 days has the client used alcohol?
	
	15. Pregnant At Any Time During Treatment
	If the client is not male, is the client pregnant at the time of admission?
	16. Employment Status
	What is the client's current employment status?
	17. Enrolled in School
	Is the client currently enrolled in school?
	Detox only programs
	Client unable to answer.
	18. Number of Arrests Last 30 Days
	How many times has the client been arrested in the past 30 days? Number of Jail Days Last 30 Days?
	Detox only programs
	  Client unable to answer.
	19. Mental Illness
	Has the client ever been diagnosed with a mental illness?
	20. Social Support
	How many days in the last 30 days has the client participated in any social support recovery activities such as:
	12-step meetings
	Other self-help meetings
	Religious/faith recovery or self-help meetings
	Meetings of organizations other than those listed above.
	Interactions with family member and/or friend support of recovery?
	21. Current Living Arrangements
	Select 'homeless' only when Zip Code at Current Residence is '00000.'
	22. Zip Code At Current Residence
	What is the client's zip code at their current residence?
	
	Enter value '00000' Homeless only if Current Living Arrangements is 'Homeless'.
	
	Detox only program
	  99904 Client unable to answer.
	23. Submit completed Cal-OMS Youth/Detox Discharge form

Chart | **Cal-OMS Youth/Detox Discharge**

Cal-OMS Youth/Detox D...

Submit (23)

Online Documentation

Discharge Status (1)

Consent (2)
○ No   ○ Yes

Disability (3)
☑ None
☐ Visual
☐ Hearing
☐ Speech
☐ Mobility
☐ Mental
☐ Developmentally Disabled
☐ Other
☐ Client declined to state
☐ Client unable to answer

Current First Name   CLIENT (4)

Current Last Name (5)
NAME

Primary Drug (Code) (6)
Alcohol

▼

Secondary Drug Route of Administration
○ Oral
○ Smoking (13)
○ Inhalation
○ Injection (IV or intramuscular)
○ None or Not Applicable
○ Other

Alcohol Frequency (14)

Pregnant At Any Time During Treatment
● No
○ Not Sure/Don't Know (15)   ○ Yes

Employment Status
○ Employed Full Time (35 hrs or more)
○ Employed Part Time (less than 35 hrs) (16)
○ Unemployed Looking For Work
○ Unemployed - (Not seeking)
● Not in the labor force (Not seeking)

Primary Drug (Other) (7)

Primary Drug Frequency (8)
10

Primary Drug Route of Administration
● Oral
○ Smoking (9)
○ Inhalation
○ Injection (IV or intramuscular)
○ None or Not Applicable
○ Other

Secondary Drug (Code) (10)

Secondary Drug (Other) (11)

Secondary Drug Frequency (12)

Enrolled in School (17)
○ No   ○ Yes
○ Client declined to state   ○ Client unable to answer

Number of Arrests Last 30 Days (18)

Mental Illness
○ No (19)   ○ Yes
○ Not Sure/Don't Know

Social Support (20)

Current Living Arrangements
○ Homeless (21)   ○ Dependent Living
○ Independent Living

Zip Code At Current Residence   93906 (22)

CAL OMS DATA FORM
CAL OMS ADMINISTRATIVE DISCHARGE

LOCATION	Avatar CWS☐Clinician Menu☐AOD☐ Cal-OMS Administrative Discharge
RULES	Cal-OMS is a statewide client-based data collection and outcomes measurement system that enables the Department of Health Care Services (DHCS) to manage and improve the provision of Substance Use Disorder (SUD) services at the state, county, and provider levels more effectively. CalOMS automates the process of inputting and retrieving treatment outcomes data necessary to: • Meet federal reporting requirements. • Document prevention and treatment population demographics • Identify alcohol and other drug trends and risks. • Demonstrate service effectiveness. • Demonstrate that services are cost effective. • Identify the most effective practices to improve service delivery
STEPS	Select the client or if the client is in your recent section, make sure the client is selected (It will be highlighted) and the Cal-OMS Administrative Discharge form will appear if that is the only CalOMS episode. **Cal-OMS Administrative Discharge** 1. Discharge Status *Select from the list.* 2. Disability What type of disability /disabilities does the client have, if any? *Only one value is allowed.* *Detox only programs* *Client unable to answer.* 3. Current First Name What is the client's current first name? 4. Current Last Name What is the client's current last name? 5. Primary Drug (Code) What is the client's primary alcohol or drug problem? 6. Primary Drug (Other) Provide Drug Name if prompted. What is the client's primary alcohol or drug problem? 7. Primary Drug Frequency How many days in the past 30 days has the client used the primary drug? 8. Primary Drug Route of Administration What is the client's usual route of administration they use most often for their primary drug of abuse? 9. Pregnant At Any Time During Treatment If the client is not male, is the client pregnant at the time of admission? 10. Submit completed Cal-OMS Administrative Discharge form

Cal-OMS Administrative ...

Submit (10)

Online Documentation

Discharge Status (1)
Left before completion w/ Unsatisfactory Progress/Administrative

Disability
- ☑ None (2)
- ☐ Visual
- ☐ Hearing
- ☐ Speech
- ☐ Mobility
- ☐ Mental
- ☐ Developmentally Disabled
- ☐ Other
- ☐ Client declined to state
- ☐ Client unable to answer

Current First Name (3)
CLIENT

Current Last Name (4)
NAME

Primary Drug (Code) (5)
Alcohol

Primary Drug (Other) (6)

Primary Drug Frequency (7)
10

Primary Drug Route of Administration
- ◉ Oral (8)
- ○ Smoking
- ○ Inhalation
- ○ Injection (IV or intramuscular)
- ○ None or Not Applicable
- ○ Other

Pregnant At Any Time During Treatment
- ◉ No (9)
- ○ Not Sure/Don't Know
- ○ Yes

CAL OMS ANNUAL UPDATE

LOCATION	Avatar CWS☐Clinician Menu☐AOD☐ Cal-OMS Annual Update
RULES	Cal-OMS is a statewide client-based data collection and outcomes measurement system that enables the Department of Health Care Services (DHCS) to manage and improve the provision of Substance Use Disorder (SUD) services at the state, county, and provider levels more effectively. CalOMS automates the process of inputting and retrieving treatment outcomes data necessary to: • Meet federal reporting requirements. • Document prevention and treatment population demographics • Identify alcohol and other drug trends and risks. • Demonstrate service effectiveness. • Demonstrate that services are cost effective. • Identify the most effective practices to improve service delivery

STEPS	Select the client or if the client is in your recent section, make sure the client is selected (It will
	be highlighted) and the Cal-OMS Annual Update form will appear if that is the only CalOMS episode.
	Cal-OMS Annual Update
	1. Annual Update Date
	2. Current First Name
	What is the client's current first name?
	3. Current Last Name
	What is the client's current last name?
	4. SSN
	What is the client's social security number?
	Nine-digit social security number
	None or not applicable enter 99902.
	Detox only program
	Client unable to answer 99904.
	5. Consent
	Is there a consent form allowing future possible contact, signed by the client, on file within your agency?
	6. Disability
	What type of disability /disabilities does the client have, if any?
	Only one value is allowed.
	Detox only programs
	Client unable to answer 99904.
	7. Zip Code At Current Residence
	What is the client's zip code at their current residence?
	Enter value '00000' Homeless only if Current Living Arrangements is 'Homeless'.
	Detox only program
	99904 Client unable to answer.
	8. Submit completed Cal-OMS Annual Update form

STEPS	Alcohol and Drug Use Data
	9. Primary Drug (Code)
	What is the client's primary alcohol or drug problem?
	If 'Alcohol' is selected, Alcohol Frequency field will automatically be 99902 None or Not Applicable
	10. Primary Drug (Other)
	Provide Drug Name if prompted.
	What is the client's primary alcohol or drug problem?
	11. Primary Drug Frequency
	How many days in the past 30 days has the client used the primary drug?
	12. Primary Drug Route of Administration
	What is the client's usual route of administration they use most often for their primary drug of abuse?
	13. Secondary Drug (Code)
	What is the client's secondary alcohol or drug problem?
	14. Secondary Drug (Other)
	What is the client's secondary alcohol or drug problem?
	15. Secondary Drug Frequency
	How many days in the past 30 days has the client used the secondary drug of abuse?
	If 'None' is selected, Secondary Drug Frequency, Secondary Drug Route of Administration, Secondary Drug Age of First Use fields will automatically be 99902 None or Not Applicable
	16. Secondary Drug Route of Administration
	What is the client's usual route of administration they use most often for the secondary drug of abuse?
	17. Alcohol Frequency
	How many days in the past 30 days has the client used alcohol?
	18. Needle Use
	How many days has the client used needles to inject drugs in the past 30 days?
	Detox only programs
	Client unable to answer.

STEPS	**Employment Data**
	19. Employment Status What is the client's current employment status? 20. Work Past 30 Days How many days was the client paid for working in the past 30 days? *Detox only programs* *99904 Client unable to answer.* 21. Enrolled in School Is the client currently enrolled in school? *Detox only programs* *Client unable to answer.* 22. Enrolled in Job Training Is the client currently enrolled in a job training program? *Detox only programs* *Client unable to answer.* 23. Highest School Grade Completed What is the client's highest school grade completed? What is the client's primary alcohol or drug problem? *Detox only programs* *Client unable to answer.*

STEPS	Criminal Justice Data
	24. Number of Arrests Last 30 Days How many times has the client been arrested in the past 30 days? Number of Jail Days Last 30 Days *Detox only programs* *Client unable to answer.* 25. Number of Jail Days Last 30 Days How many days has the client been in jail in the past 30 days? *Detox only programs* *Client unable to answer.* 26. Number of Prison Days Last 30 Days How many days has the client been in prison in the past 30 days? *Detox only programs* *Client unable to answer*

STEPS	Medical/Physical Health Data

	27. Emergency Room Last 30 Days
	How many times has the client visited an emergency room in the past 30 days for physical health problems?
	
	Detox only programs
	   Client unable to answer.
	28. Hospital Overnight Last 30 Days
	How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems?
	
	Detox only programs
	   Client unable to answer.
	29. Medical Problems Last 30 Days
	How many days in the past 30 days has the client experienced physical health problems?
	
	Medical Problems must be greater than 0 if Emergency or Overnight last 30 days are greater.
	
	than 0.
	
	Detox only programs
	   Client unable to answer.
	30. Pregnant At Any Time During Treatment
	If the client is not male, is the client pregnant at the time of admission?
	31. HIV Tested
	Has the client been tested for HIV/AIDS?
	Detox only programs
	
	   Client unable to answer.
	
	32. HIV Test Results
	Does the client have the results of the HIV/AIDS test?
	Detox only programs
	
	   Client unable to answer

STEPS	Mental Illness
	33. **Mental Illness** Has the client ever been diagnosed with a mental illness? 34. **Emergency Room Use / Mental Health** How many times in the past 30 days has the client received outpatient emergency services for mental health needs? *Detox only programs* *99904 Client unable to answer.* 35. **Psychiatric Facility Use** How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? *Detox only programs* *99904 Client unable to answer.* 36. **Mental Health Medication** In the past 30 days, has the client taken prescribed medication for mental health needs? *Detox only programs* *Client unable to answer*

STEPS	Family/Social Data
	33. Social Support
	How many days in the last 30 days has the client participated in any social support recovery activities such as:
	12-step meetings
	Other self-help meetings
	Religious/faith recovery or self-help meetings
	Meetings of organizations other than those listed above.
	Interactions with family member and/or friend support of recovery?
	34. Current Living Arrangements
	Select 'homeless' only when Zip Code at Current Residence is '00000.'
	35. Living with Someone
	How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?
	Detox only programs
	99904 Client unable to answer.
	36. Family Conflict Last 30 Days
	How many days in the past 30 days has the client had serious conflicts with members of their family?
	Detox only programs
	99904 Client unable to answer.
	37. Number of Children
	How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not?
	Detox only programs
	99904 Client unable to answer.
	38. Number of Children Aged 5 Years Or Younger
	How many children does the client have age 5 or younger?
	Value must be less than or equal to Number of Children
	Detox only programs
	99904 Client unable to answer.
	39. Number of Children Living with Someone Else
	How many of the client's children aged 17 and under are living with someone else because of a child protection court order?
	Value must be less than or equal to Number of Children
	Detox only programs
	99904 Client unable to answer.
	40. Number of Children Living with Someone Else and Parental Rights Terminated
	If the client has children living with someone else because of a child protection court order, for how many of these children aged 17 or under have the client's parental rights been terminated?
	Value must be less than or equal to Number of Children
	Detox only programs
	99904 Client unable to answer.
	41. Submit completed CalOMS Annual Update form

Chart | **Cal-OMS Annual Update**

- □ Cal-OMS Annual Update
- □ Alcohol and Drug Use D...
- □ Employment Data
- □ Criminal Justice Data
- □ Medical/Physical Health...
- □ Mental Illness
- □ Family/Social Data

Submit (45)

Social Support (37)

Current Living Arrangements
- ○ Homeless
- ○ Independent Living (38)
- ○ Dependent Living

Living With Someone (39)

Family Conflict Last 30 Days (40)

Number of Children (41)

Number Of Children Aged 5 Years Or Younger (42)

Number of Children Living With Someone Else (43)

Number of Children Living With Someone Else and Parental Rights Terminated (44)

CLIENT RELATIONSHIPS

LOCATION	CWS ⬜ Clinician Menu ⬜ Client Relationships
PURPOSE	The client relationships option is the central point for all client contacts. Use this form to document emergency contact information. including emergency contacts or other providers involved in the client's care.
RULES	• Authorization for Disclosure is necessary for Emergency Contact person. • May be update as necessary. • Ensure to enter at least one method to contact individuals

STEPS	Select the client.
	
	1. Enter the date of entry (today) or click "T" for today and continue to the section.
	2. Click on Relationships section on the left.
	3. Click on the Add New Item button as seen in the image below, this will add a new row to allow information to be entered.
	4. Select the Type of Relationship from the drop-down box AND Enter the persons Last Name/ Agency Name & the persons First Name
	5. Enter the person's address, City, State and Zip Code Information
	6. Click on this button if you would like to see a historical report of the client's contact information.
	7. Enter the person's telephone information and Email address if available.
	8. Enter relationship Start and End Dates, and the best time to reach contact.
	9. Select from drop down menu "Release Available?" and release of information dates.
	10. Select from the drop-down menu for the following questions:
	    a. Legal Guardian?
	    b. Emergency Contact?
	    c. Next of Kin?
	    d. Enter any notes if necessary.
	11. Submit

- Entry Date
- **Relationships**

Submit ⑪

List of All Client Relationships

Type of Relationship	Last Name / Agency Name	First N...	Cell Ph...	Work Ph...	Relationship Start Date	Relationship End Date
Foster Parent	BAN	RAY	831-6...	963-528...	07-01-09	
Friend	DOE	JANE	831-6...	856-269...	2009	
Spouse	DOE	JOHN	856-3...	954-856...	2011	

Add New Item ③ | Edit Selected Item | Delete Selected Item

Type of Relationship ④ **Last Name / Agency Name**

Other Relationship | First Name

Address - Street ⑤ City

Address - Street 2 | State

Zip Code

⑥ Historical Emergency Contact Information

Home Phone
6319-965-7458

Cell Phone
856-3214-3652 ⑦

Work Phone
954-856-3695

Email Address

Relationship Start Date
2011

Relationship End Date ⑧

Best Number/Time to Contact

Release Available? Legal Guardian?

Release Start Date
T | Y ⑨

Release End Date
T | Y

Emergency Contact? ⑩

Next of Kin?

Notes

ONSET OF SERVICES

LOCATION	AVATAR CWS→CLINICIAN MENU→ONSET OF SERVICES
PURPOSE	This form is used to obtain informed consent from the client when they initiate services. This form is to be signed by a minor age 12 or older. You will only need to complete this form ONCE, not on an annual basis. The only circumstance where this form will need to be completed again is if a client has been discharged and not had any case coordinated services for more than 365 consecutive days. When you Submit the form, a report will generate based on the selections of the report. You are also able to run a standalone report if needed – 134 Onset of Services Report To view generic versions of the reports for any specific section, click on the blue hyperlinks that are located at the top of each section within the Onset of Services Form. As you begin to complete this form you will notice that some of the fields will be deactivated, and depending on the selection made, other fields will be required.
RULES	Complete each of the sections within the form: • Informed Consent • Minor Consent • Consumer Rights • Notice of Privacy Practices • Authorization to Use, Exchange and/or Disclose Confidential Behavioral Health Information WITHIN Monterey County Behavioral Health • Revoke Authorization (This needs to complete ONLY if there is a need to revoke the authorization) • Problem Resolution

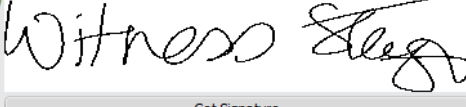|	

STEPS - INFORMED CONSENT	*Once you have selected the client you will be taken directly into the form.*
	1. **Was the informed consent scanned?**
	    a. If Yes, the rest of the informed consent will deactivate except for the following:
	        i. Date
	        ii. Staff Name
	        iii. Time
	    b. If No, the rest of the informed consent section will be required.
	
	2. **If applicable, was the informed consent interpreted/translated in the client's/representative's preferred language?**
	    a. If Yes, you will need to complete the following required questions:
	        i. What is the client or representative's preferred language? (if other than English or Spanish)
	        ii. Notes on interpretation of informed consent
	    b. If N/A the following will be deactivated:
	        i. What is the client or representative's preferred language? (if other than English or Spanish)
	        ii. Notes on interpretation of informed consent
	
	3. **By signing below the client of their representative acknowledges understanding the informed consent for MCBH services, complete the following fields:**
	    a. **Client/Representative Signature:** If the client is unable to sign; their representative will sign the consent.
	    b. **Name of representative completing this form:** Enter the name of the representative if they signed the informed consent.
	    c. **Relationship to client:** Enter the relationship if any, between the representative and the client.
	    d. **Date:** This field is always required
	4. **Client or representative refuses to sign informed consent for MCBH services.**
	    a. If yes, you will need to complete the following:
	        i. Client or representative's reason for refusing to sign informed consent.
	    b. If N/A, the following field will be deactivated.
	        i. Client or representative's reason for refusing to sign informed consent.
	5. **Witness (Staff) signature:** this field needs to be signed by the staff completing the form.
	6. **Staff Name:** This is a required field. Enter the name of the staff completing the form.
	7. **Date (Staff Signature):** the Date of when the Witness (staff) signed the informed consent.
	8. **Time:** Enter the time the informed consent was signed.
	9. **The printed Informed Consent will be in:** Select the language the client would like to have the informed consent printed. The options are English or Spanish.

RULES	This form is to be filled out by a minor age 12 or older in addition to the Informed Consent Section.

**STEPS -
MINOR
CONSENT**
	1. **Is this applicable?**
	    a. If this section does not apply to the client, please select "No". Once No is selected the remainder of the Minor Consent Section will be deactivated and you can continue to the Consumer Rights section of the Form.
	    b. If this section is applicable to the client continue filling out the Minor consent section.
	2. **Was the Minor consent scanned?**
	    a. If Yes, the rest of the minor consent will deactivate except for the following:
	        i. Date
	        ii. Staff Name
	        iii. Time
	    b. If No, the rest of the minor consent section will be required.
	3. **I can give my own consent to these services because I am a minor that is (select one):** The client will select one of the following reasons.
	    a. I am a minor seeking "sensitive" services *(e.g., outpatient mental health services and/or substance abuse treatment)*
	    b. I am emancipated *(e.g., married, active U.S. military, or by court order)*
	    c. I am a self-sufficient minor *(15 years or older, living separate and apart from parent/legal guardian and managing my own finances)*
	4. **If applicable, was the Minor Consent interpreted/translated in the client's preferred language?**
	    a. If Yes, you will need to complete the following required questions:
	        i. What is the client or representative's preferred language? (if other than English or Spanish)
	        ii. Notes on interpretation/translation of Minor Consent
	    b. If N/A the following will be deactivated:
	        i. What is the client or representative's preferred language? (if other than English or Spanish)
	        ii. Notes on interpretation/translation of Minor Consent
	5. **By signing below, the client acknowledges understanding the Minor Consent for MCBH Services.**
	    a. **Client Signature:** this must be signed by the Minor if the client is 12 or over.
	6. **Client refuses to sign Minor Consent for MCBH Services**
	    a. If yes, you will need to complete the following:
	        i. Client's reason for refusing to sign Minor Consent section.
	    b. If N/A, the following field will be deactivated.
	        i. Client's reason for refusing to sign Minor Consent section.
	7. **Witness (Staff) signature:** this field needs to be signed by the staff completing the section.
	8. **Staff Name:** This is a required field. Enter the name of the staff completing the section.
	9. **Date (Staff Signature):** the Date of when the Witness (staff) signed the minor consent.
	10. **Time:** Enter the time the minor consent was signed.
	11. **The printed Minor Consent will be in:** Select the language the client would like to have the minor consent printed. The options are English or Spanish.

Chart **Onset of Services**

- Informed Consent
- **Minor Consent**
- Consumer Rights
- Notice of Privacy Practi...
- Authorization to releas...
- REVOKE Authorization
- Problem Resolution

Submit

▼

Minor Consent (English)   *Minor Consent (Spanish)*

Is this applicable?
1 ● Yes   ○ No

Was the Minor Consent scanned?
2 ○ Yes   ● No

▼

I can give my own consent to these services because I am a minor that is: (select one)
3 ● seeking sensitive services
   ○ emancipated
   ○ self-sufficient

▼

4 If applicable, was the Minor Consent interpreted/translated in the client's preferred language?
   ● Yes   ○ N/A

What is the client's preferred language?   spanish

Notes on interpretation/translation of Minor Consent
will print spanish

▼

By signing below, the client acknowledges understanding the Minor Consent for MCBH Services

5 Client Signature

Get Signature

6 Client refuses to sign Minor Consent for MCBH Services
   ○ Yes   ● N/A

Client's reason for refusing to sign Minor Consent

7 Witness (Staff) signature   8 Staff name
                                                   MARCHEBOUT,ROSA (002354)

Get Signature

9 Date   10 Time
   02/03/2014 T Y ⬍   10:08 AM   Current   H ⬍ M ⬍ AM/PM ⬍

▼

11 The printed minor consent will be in
    ● English   ○ Spanish

RULES	This form must be offered to clients receiving services.

STEPS – CONSUMER RIGHTS	1. **Date Consumer Rights offered to client? –** This is the date that the form was offered to the client
	2. **If applicable, was the Consumer Rights interpreted/translated in the client's/representative's preferred language?**
	   a. If Yes, you will need to complete the following required questions:
	      i. Client or representative's preferred language? (if other than English or Spanish)
	      ii. Notes on interpretation/translation of Consumer Rights
	   b. If N/A the following will be deactivated:
	      i. Client or representative's preferred language? (if other than English or Spanish)
	      ii. Notes on interpretation/translation of Consumer Rights
	3. **Client or representative accepted copy of Consumer Rights?**
	   a. If Yes, you will need to complete the following required field.
	      i. Client's or representative's reason for refusing copy of Consumer Rights
	   b. If No, the following will be deactivated:
	      i. Client's or representative's reason for refusing copy of Consumer Rights
	
	   c. **Client Signature:** this must be signed by the Minor if the client is 12 or over.
	4. **The printed Consumer Rights will be in:** Select the language the client would like to have the consumer rights printed. The options are English or Spanish.

Chart | **Onset of Services**

- Informed Consent
- Minor Consent
- **Consumer Rights**
- Notice of Privacy Practi...
- Authorization to releas...
- REVOKE Authorization
- Problem Resolution

Submit

Consumer Rights (English)   *Consumer Rights (Spanish)*

1 Date Consumer Rights offered to client
01/17/2014 | T | Y

2 If applicable, was the Consumer Rights interpreted/translated in the client's/representative's preferred language?
○ Yes   ○ N/A

Client or representative's preferred language?
test

Notes on interpretation/translation of Consumer Rights
test

3 Client or representative accepted copy of Consumer Rights?
○ Yes   ○ No

Client's or representative's reason for refusing copy of Consumer Rights

4 The printed Consumer Rights will be in
○ English   ○ Spanish

RULES	This form must be GIVEN to clients receiving services.

STEPS – NOTICE OF PRIVACY PRACTICES	1. **Date Notice of Privacy Practice GIVEN to client? –** This is the date that the form was GIVEN to the client
	2. **If applicable, was the Notice of Privacy Practices interpreted/translated in the client's/representative's preferred language?**
	    a. If Yes, you will need to complete the following required questions:
	        i. Client or representative's preferred language? (if other than English or Spanish)
	        ii. Notes on interpretation/translation of Notice of Privacy Practices
	    b. If N/A the following will be deactivated:
	        i. Client or representative's preferred language? (if other than English or Spanish)
	        ii. Notes on interpretation/translation of Notice of Privacy Practices
	3. **The printed Notice of Privacy Practices will be in:** Select the language the client would like to have the Notice of Privacy Practices printed. The options are English or Spanish.

RULES	The completion of this document authorizes the use or release of confidential behavioral health information about the client. It is important that they complete this Authorization prior to receiving services from the Monterey County Behavioral Health (MCBH) to use, exchange, or disclose confidential behavioral health information about the client within Monterey County Behavioral Health programs and with any clinician who works within the program, regardless of discipline, for the purpose of enabling the program and its staff:
	1. To evaluate the client's need for behavioral health services, including participation in a co-occurring disorders program, and
	2. To provide and coordinate the care the client receives which may include both mental health and substance abuse treatment.

STEPS – AUTHORIZATION FOR USE, EXCHANGE, AND/OR DISCLOSURE OF CONFIDENTIAL BEHAVIORAL HEALTH INFORMATION WITHIN MONTEREY COUNTY BEHAVIORAL HEALTH	1. **Was the Authorization for Use, Exchange, and/or Disclosure of Confidential Behavioral Health Information WITHIN MCBH scanned?**
	    a. If Yes, the rest of the Authorization… will deactivate except for the following:
	        i. Date
	        ii. Staff Name
	        iii. Time
	    b. If No, the rest of the Authorization… section will be required.
	
	2. **This authorization is being completed by?** The report will print information based on the selection made on this section.
	    a. Adult client or representative
	    b. Minor client of consenting age or representative
	    c. Parent of minor not of consenting age
	    d. Representative of minor not of consenting age
	3. **Client or representative is authorizing** - Select *who will be disclosing the information.*
	    a. MCBH AOD Provider = this is strictly an Alcohol and Other Drug provider
	    b. MCBH MH Provider = this is strictly Mental Health Provider (which does not even offer any dual diagnosis of substance abuse counseling within its services)
	NOTE: Both boxes should be checked for disclosure of services provided through MCBH since our electronic health record contains information about mental health services and substance abuse services.
	
	4. **I understand the MCBH utilizes and electronic health records system and all the providers who may be involved in my or my child's care may access that record.** (Select One) This selection is to determine when the authorization will no longer be in effect.
	5. **If applicable, was the Authorization for Use...interpreted/translated into the client's/representative's preferred language (**besides English or Spanish**)**
	    a. If Yes, you will need to complete the following required questions:
	        i. Client or representative's preferred language? (if other than English or Spanish)
	        ii. Notes on interpretation/translation of Authorization for Use…
	    b. If N/A the following will be deactivated:
	        i. Client or representative's preferred language? (if other than English or Spanish)
	        ii. Notes on interpretation/translation of Authorization for Use…
	6. **Client Signature –** Client or representative will sign authorization.

a. **If not client, name of representative completing this form –** Enter the name of the person completing this section IF the client is unable to sign or complete this section. Enter in this format: **LASTNAME,FIRSTNAME**

b. **Relationship to client -** Enter the relationship between the client and the representative if any.

7. **Client or representative refuses to sign Authorization for Use…**
    a. If yes, you will need to complete the following:
        i. Client's reason for refusing to sign Authorization for Use…
    b. If N/A, the following field will be deactivated.
        i. Client's reason for refusing to sign Authorization for Use…

8. **Witness (Staff) signature:** this field needs to be signed by the staff completing the section.

9. **Staff Name:** This is a required field. Enter the name of the staff completing the section.

10. **Date –** Enter the date this section was completed.

11. **Time:** Enter the time this section was completed

12. **The printed Authorization for Use… will be in:** Select the language the client would like to have the Authorization printed. The options are English or Spanish.

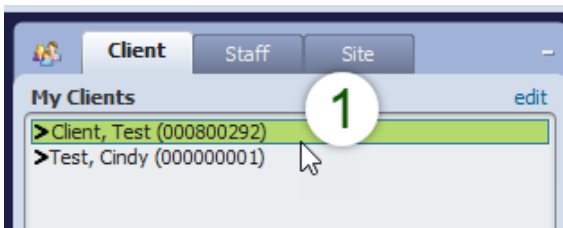**Chart** | **Onset of Services**

- Informed Consent
- Minor Consent
- Consumer Rights
- Notice of Privacy Practi...
- **Authorization to releas...**
- REVOKE Authorization
- Problem Resolution

Submit

Authorization for Use, Exchange, and/or Disclosure of Confidential Information WITHIN MCBH (ENGLISH)　　*Authorization for Use, Exchange, and/or Disclosure of Confidential Information WITHIN MCBH (SPANISH)*

1 — Was the Authorization for Use, Exchange and/or Disclosure of Confidential Information WITHIN MCBH scanned?
○ Yes　　● No

2 — This authorization is being completed by
○ Adult client or representative
○ Minor client of consenting age or rep
● Parent of minor not of consenting age
○ Rep of minor not of consenting age

3 — Client or representative is authorizing
☐ My/my child's MCBH AOD Provider
☑ My/my child's MCBH MH Provider

to use, exchange, or disclose confidential behavioral health information about me or my child within Monterey County Behavioral Health programs and with any clinician who works within the program, regardless of discipline, for the purpose of enabling the program and its staff:

1. To evaluate my need for behavioral health services, including participation in a co-occurring disorders program, and
2. To provide and coordinate the care I receive which may include both mental health and substance abuse treatment.

I specifically authorize the use, exchange or disclosure of information pertaining to my or my child's medical history, mental health, HIV and/or substance abuse treatment information.

4 — I understand that MCBH utilizes an electronic health record system and all the providers who may be involved in my or my child's care may access that record.

○ This authorization for inclusion...　　This authorization for inclusion of all of my or my child's behavioral health information in one file expires when the record is removed from the system at the end of the County's record retention period.

● This authorization expires 90...　　This authorization expires 90 days after my or my child's treatment ends or when there is no longer any need for access by Monterey County Behavioral Health treatment program providers whichever is sooner.

Submit

0

5 If applicable, was the Authorization for Use, Exchange, and/or Disclosure of Confidential Information WITHIN MCBH interpreted/translated into the client's/representative's preferred language

( ) Yes   ( ) N/A

Client or representative's preferred language

Notes on interpretation/translation of Authorization for Use, Exchange, and/or Disclosure of Confidential Information WITHIN MCBH

By signing below, the client or their representative acknowledges understanding the Authorization for Use, Exchange, and/or Disclosure of Confidential information WITHIN MCBH

6 Client signature

Auth Client

Get Signature

If not client, name of representative completing this form

TEST,TEST

Relationship to client

test

7 Client or representative refuses to sign Authorization for Use, Exchange, and/or Disclosure of Confidential information WITHIN MCBH

( ) Yes   (•) N/A

Client's or representative's reason for refusing to sign Authorization for Use, Exchange, and/or Disclosure of Confidential information WITHIN MCBH

8 Witness (Staff) signature

Auth Witness

Get Signature

9 Staff Name

MARCHEBOUT,ROSA (002354)

10 Date

01/17/2014 T Y

11 Time

04:05 PM Current H M AM/PM

12 The printed Authorization will be in

(•) English   ( ) Spanish

RULES	This section of the Onset of Services will be completed when and if there is a need to REVOKE the existing Authorization for Use, Exchange, and/or Disclosure of Confidential information WITHIN MCBH

STEPS – REVOKE AUTHORIZATION	1. **Was this revoked Authorization scanned?**
	    a. If Yes, you will need to complete the following required questions:
	        i. Date authorization revoked - This is the actual date the client relayed the information of revoking the authorization.
	        ii. Staff Name - Enter the STAFF name of the person who is receiving the information that the client is revoking this Authorization.
	        iii. Notes on revocation of authorization- Enter the reason why the client is revoking this authorization.
	
	If the Revoke Authorization was not scanned, the questions are not required. However, if you receive the notification from the client verbally you will need to complete all questions.

RULES	Clients will not be subjected to discrimination, intimidation, or any other retaliation for expressing concerns, filing a Grievance or Appeal. If a client is unhappy with any issue related to the mental health services they are receiving, they have options that may help them with the resolution of these issues. This form will be offered to client.
STEPS – PROBLEM RESOLUTION	1. **Date Problem Resolution was offered to the client - Enter** the date staff offered this form to the client.
	2. **If applicable, was the Problem Resolution Form interpreted/translated into the client's/ representative's preferred language -**
	a. If Yes, you will need to complete the following required questions:
	i. Client or representative's preferred language? (if other than English or Spanish)
	ii. Notes on interpretation/translation of Problem Resolution
	b. If N/A the following will be deactivated:
	i. Client or representative's preferred language? (if other than English or Spanish)
	ii. Notes on interpretation/translation of Problem Resolution
	3. **Client or representative accepted copy of the Problem Resolution Form**?
	a. If Yes, the following question will be deactivated.
	i. Client's or representative's reason for refusing copy of Problem Resolution form.
	b. If No, the following question will be required.
	i. Client's or representative's reason for refusing copy of Problem Resolution Form.
	4. **The printed Problem Resolution will be in:** Select the language the client would like to have the Problem Resolution printed. The options are English or Spanish.

DOCUMENT CAPTURE

This chapter will cover how to import a document from a file on your computer or an attachment from an email. This feature allows you to scan historical paper charts into a current electronic medical record system. A benefit of using document imaging is that documents are unalterable and become part of the client's electronic medical record.   Staff can process medical records requests in an efficient and timely manner to better serve our clients.

LOCATION	AvatarPM → Radplus Utilities → Document Management
PURPOSE	The purpose of the "Document Capture" form is to be able to import scanned documents into the client's electronic health record and integrate both paper documents and electronic documents. Our goal is to assure that all clinical information is shared internally in an effective and efficient manner.

RULES	• Document Capture must be launched from the client chart overview (double click on the client ID/Name)
	• All documents must be imported as NON-EPISODIC
	• Scanning categories for County staff do not have a prefix. Contracted providers start with the agency name or their Abbreviated agency initials. (see below)
	   ▪ Community Human Resources = CHS
	   ▪ Door To Hope = DTH
	   ▪ Interim Inc = Interim
	   ▪ FSA of San Francisco =PREP
	   ▪ Pajaro Valley Prevention Agency = PVPSA
	   ▪ Sun Street Centers = SSC
	   ▪ USC Telehealth = USCT
	   ▪ Valley Health Associates = VHA
	   ▪ The Village Project = Village
	   ▪ Young Women's Christian Association = YWCA
	• In the description enter the following:
	   o Title of the document you are scanning.
	   o The date that is in the document, such as assessment date, IEP date, lab date, consent date, etc. (NOT the date you are scanning)
	   o Where the document is coming from
	      ▪ Example: "Lab Report 3/1/2016 LabCorp"

STEPS	1. Search for the client – double click on the client name/number to get to the client chart OVERVIEW. 2. Once in the chart overview, select "Document Capture." 3. When prompted to select Episode Number, click OK. **DO NOT SELECT an episode.** 4. If you are prompted "How would you like to capture documents?" Select "Import"

STEPS	5. You can capture a document 2 different ways
	a. Click on "Capture" located on the top left corner.
	b. Or, click on the large paper icon located in the center of the screen
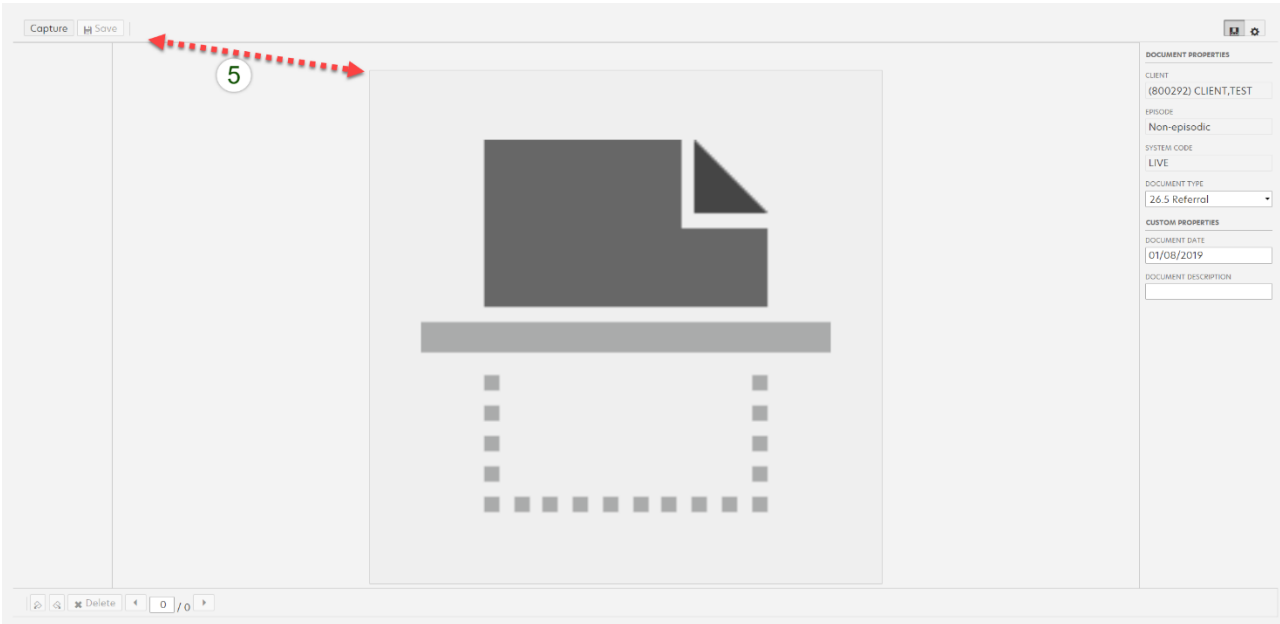
STEPS	6. in the "Select Files" box, click on Browse.
	7. Select the document you are uploading for the selected client.
	8. Click on "Open"

STEPS	9. Verify that the file has been selected, then press "Done"
	10. Verify the Document Properties are correct.
	11. **Document Type**: Use the drop down menu to select a category
	12. **Document Date**: Leave this field alone. The date will default in for the day you imported the document
	13. **Document Description**: Enter the description of the scanned document. Such as
	     a. Name of the document
	     b. Date in the document
	14. Once you have verified the document has been imported and you have entered the items 11-13, click on **Save.**
	15. Once you see "Save was successful" and "Document Added to Avatar!" the document has been successfully imported into the client chart.
	
	To add additional documents for the same client, repeat the steps. Otherwise, to view the documents captured, click on Overview then refresh ↻

Select Files
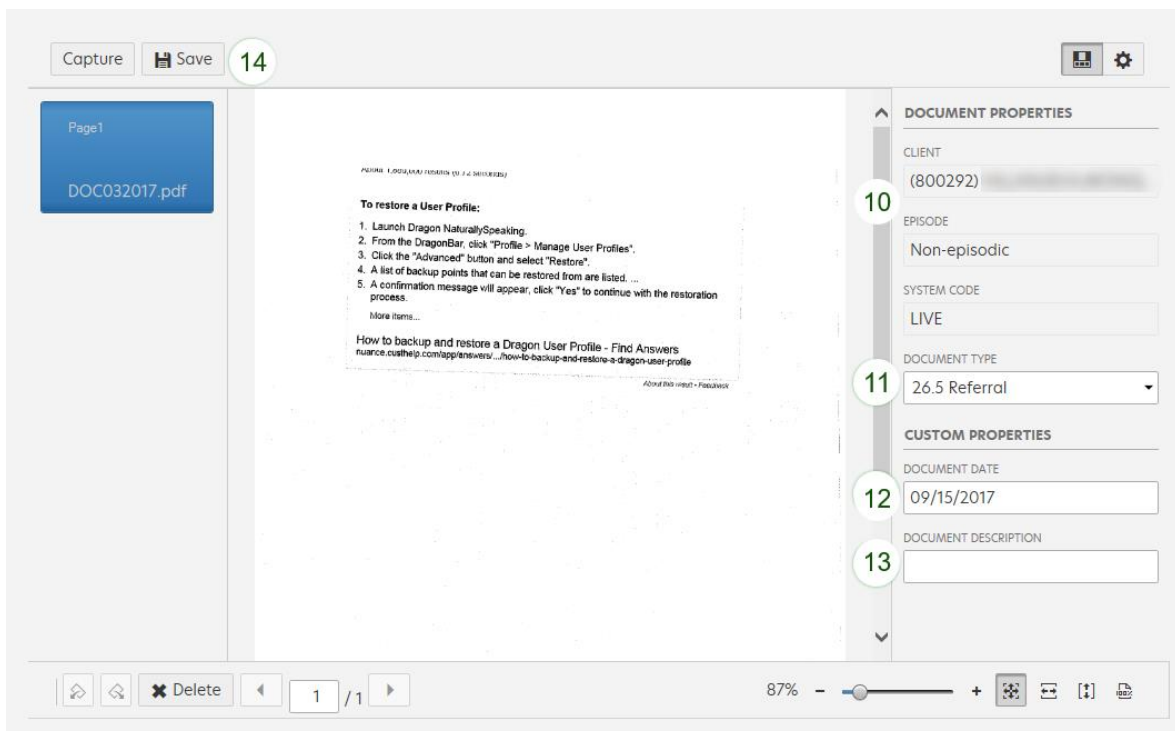
Browse or drag and drop files here.

1 files selected. (9)

Cancel   Done

Capture	Save (14)		

Page1

DOC032017.pdf

About 1,000,000 results (0.72 seconds)

To restore a User Profile:

1. Launch Dragon NaturallySpeaking.
2. From the DragonBar, click "Profile > Manage User Profiles".
3. Click the "Advanced" button and select "Restore".
4. A list of backup points that can be restored from are listed. ...
5. A confirmation message will appear, click "Yes" to continue with the restoration process.

More items...

How to backup and restore a Dragon User Profile - Find Answers
nuance.custhelp.com/app/answers/.../how-to-backup-and-restore-a-dragon-user-profile

About this result - Feedback

DOCUMENT PROPERTIES

CLIENT

(800292) (10)

EPISODE

Non-episodic

SYSTEM CODE

LIVE

DOCUMENT TYPE

(11) 26.5 Referral

CUSTOM PROPERTIES

DOCUMENT DATE

(12) 09/15/2017

DOCUMENT DESCRIPTION

(13)

× Delete   ◄ 1 /1 ►   87% – ○—— +

Capture | Save |

15

✅ Save was successful.   ✕

✅ Document Added to Avatar!   ✕

⬆ ⬇ ✖ Delete ◀ [0] / 0 ▶   75% – ●

- **26.5 REFERRAL:** For 26.5 referrals from the schools
- **ACCOUNT ADJUSTMENT:** Account Adjustment form received from the billing department when a clinician/PAR is adjusting the clients UMDAP information.
- **ADJUNCT ASSESSMENTS:** such as Assessments from the Crisis Unit
- **AOD**: Alcohol and Other Drug Program Information
- **APS/CPS MANDATED REPORTS:** Adult Protection Services and Child Protection Services – mandated reports
- **BH CONSENT**: Signed consent forms
- **CLINICAL DOCUMENTS**: Other documents not covered in the EMR that are generated from clinical staff.
- **CONTROLLED SUBSTANCE PRESCRIPTIONS:** For medication prescriptions that require a controlled substance prescription be handed to the client.
- **COURT/LEGAL DOCUMENTS:** Conservatorship documents, court orders, 5150, CPS reports, APS reports, CNC court updates, probation documentation, booking info, and attorney letters.
- **CRISIS ASSESSMENT:** All Crisis Assessments are to be scanned under this category.
- **FINANCIAL:** For clients financial information
- **HISTORICAL CHART:** information previously in the paper chart
- **PHOTO IDENTIFICATION:** Copy of the client's driver license or valid ID
- **IEP (INDIVIDUALIZED EDUCATION PLAN):** for the Copy of the Individualized Education Plan
- **INCOMING CORRESPONDENCE:** Documentation related to client's physical health care such as documents from primary care physicians and Letters coming into the clinic related to the client, **NOT** including legal correspondence or documents from service providers.
- **INSURANCE, MEDI-CAL & MEDICARE CARD:** Copy of client's insurance cards, private, including Medi-cal and Medicare.
- **INTERIM:** Documents from our Interim programs
- **LABS**: Labs received from multiple sources
- **MEDICATION CONSENT:** Various medication consents signed by client given by MD.
- **MEDICATION PROGRESS NOTES**: Is used for historic progress notes that were in the client's paper chart.
- **OUTGOING CORRESPONDENCE:** Letters sent from behavioral health office, such as letters from clinical staff.
- **PRIMARY CARE DOCUMENTATION:** Documents received from clients primary care physician office.
- **PROVIDER DOCUMENTATION**: Treatment plans from outside providers, treatments updates from providers, letters or other or other documentations related to services from a service provider (e.g., Interim Inc., Kinship center, Manzanita, CHOMP, NMC discharge info. Crisis intake info, etc.)
- **REFERRAL:** Use this category for all Referrals except for the 26.5 Referral
- **PSYC TESTING MATERIALS:**
- **RELEASE OF INFORMATION**: The purple form signed by clients.
- **SAFETY PLAN**:
- **SSA LETTERS:** Letters or documents from The Social Security Administration related to benefits, and the request of medical records.
- **STRENGTHS ASSESSMENT:** Strengths assessments
- **TAR PACKET:** Treatment Authorization Requests that are received from hospitals.

This will allow you to easily access Document Capture from within the client's chart overview.

STEPS-ADDING DOCUMENT CAPTURE	Go to your clients Chart Overview. 1. Click on "Customize Forms" 2. Click on the green plus sign on the right of the screen. 3. Name the form group: Document Capture - Scanning 4. Add the form by clicking on the green plus sign. 5. Search for the form Document Capture. Select by double clicking on the form name. 6. Click "Submit"
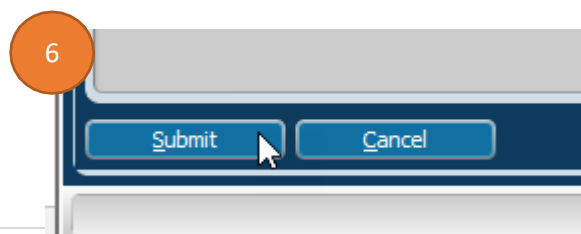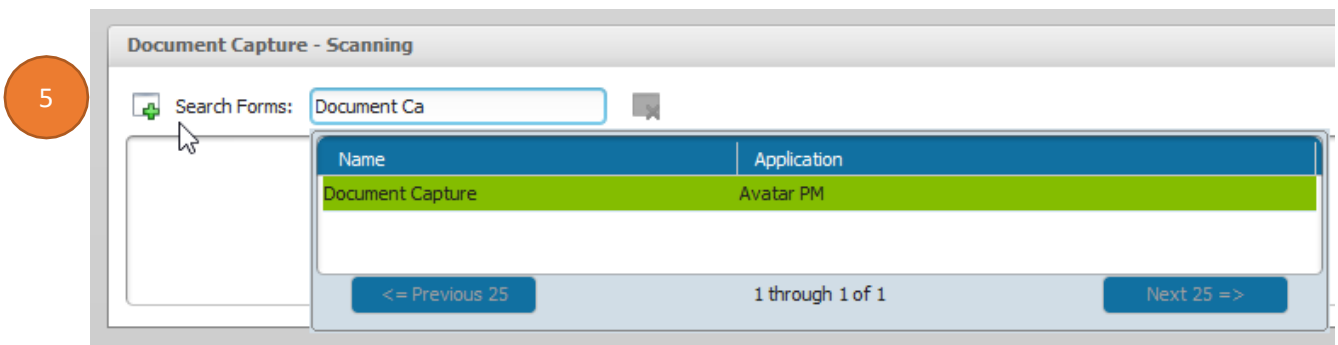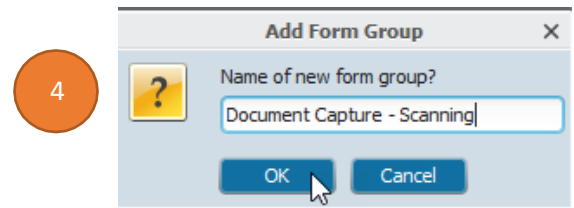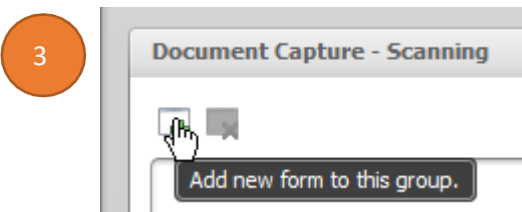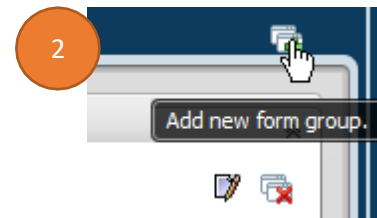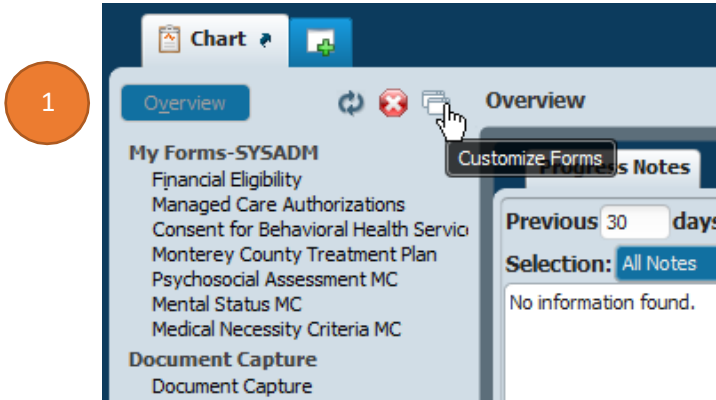
VIEWING SCANNED DOCUMENTS FROM CHART VIEW

You can view scanned documents From CHART VIEW.

STEPS-VIEWING SCANNED DOCUMENTS	Go to your clients Chart Overview. On the left side of the screen, you will see a **Documents** Category.
	7. Click on My Avatar Scans
	8. Select the documents you want to view or Print.
	9. Press on the View button or on the Print Selected to Print
	10. To close and go back to the chart view section

My Avatar Scans

Non-Episodic (3)

| 16: TEST only (0) 08/23/2010 - Active | 15: Access to Treatment Salinas (0) 08/19/2011 - 08/23/2011 | 14: ZADP Valley Health OP (0) 06/24/2011 - Active | 13: Access CS (0) 06/23/2011 D11 | 12: E 05/31 |
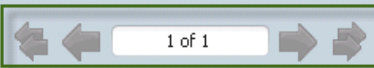
1 of 1   50 %

To rotate the page

My Avatar Scans

To move from one page to the other

To minimize or maximize the screen

Please answer the following questions regarding your event:	Yes	
Will event be open to the public?		
Will admission be charged?		
Will event generate revenue or be a fundraiser?		
If yes, please provide City of Roseville Business License #		
Will your event have alcohol?		
Will you be selling alcohol?		
Will you be serving food?	✓	
Will you be selling food?		

Document List   ☒ CLIENT, TEST (800292) - My Avatar Scans

View   Print   Close All Documents   4

VIEWING SCANNED DOCUMENTS FROM CLINICAL DOCUMENT VIEWER	
LOCATION	Avatar CWS → Document Management →Clinical Document Viewer
STEPS-VIEWING SCANNED DOCUMENTS	1. Select type: "Client." 2. Select All or Individual Chart: "Individual" 3. Enter the client ID or Client Name of the person you want to view the scanned documents for 4. For Episode: Select Non Episodic (Documents are scanned on a client level) 5. Click on Process 6. Select the documents you want to view. 7. Press on the View button. 8. To close and go back to the chart view section

Clinical Document Viewer

View	Client ID	Client Name	Episode	Document Description	Document Date	Document Status	Form Name	User	Do Not Release
✓	800292	CLIENT,TEST	Nonepisodic	My Avatar Scans	Oct 12, 2011	Final	My Avatar Scans	Rendell Requiro	
	800292	CLIENT,TEST	Nonepisodic	My Avatar Scans	Oct 18, 2011	Final	My Avatar Scans	Rendell Requiro	
	800292	CLIENT,TEST	Nonepisodic	My Avatar Scans	Oct 21, 2011	Final	My Avatar Scans	Rosa E March...	
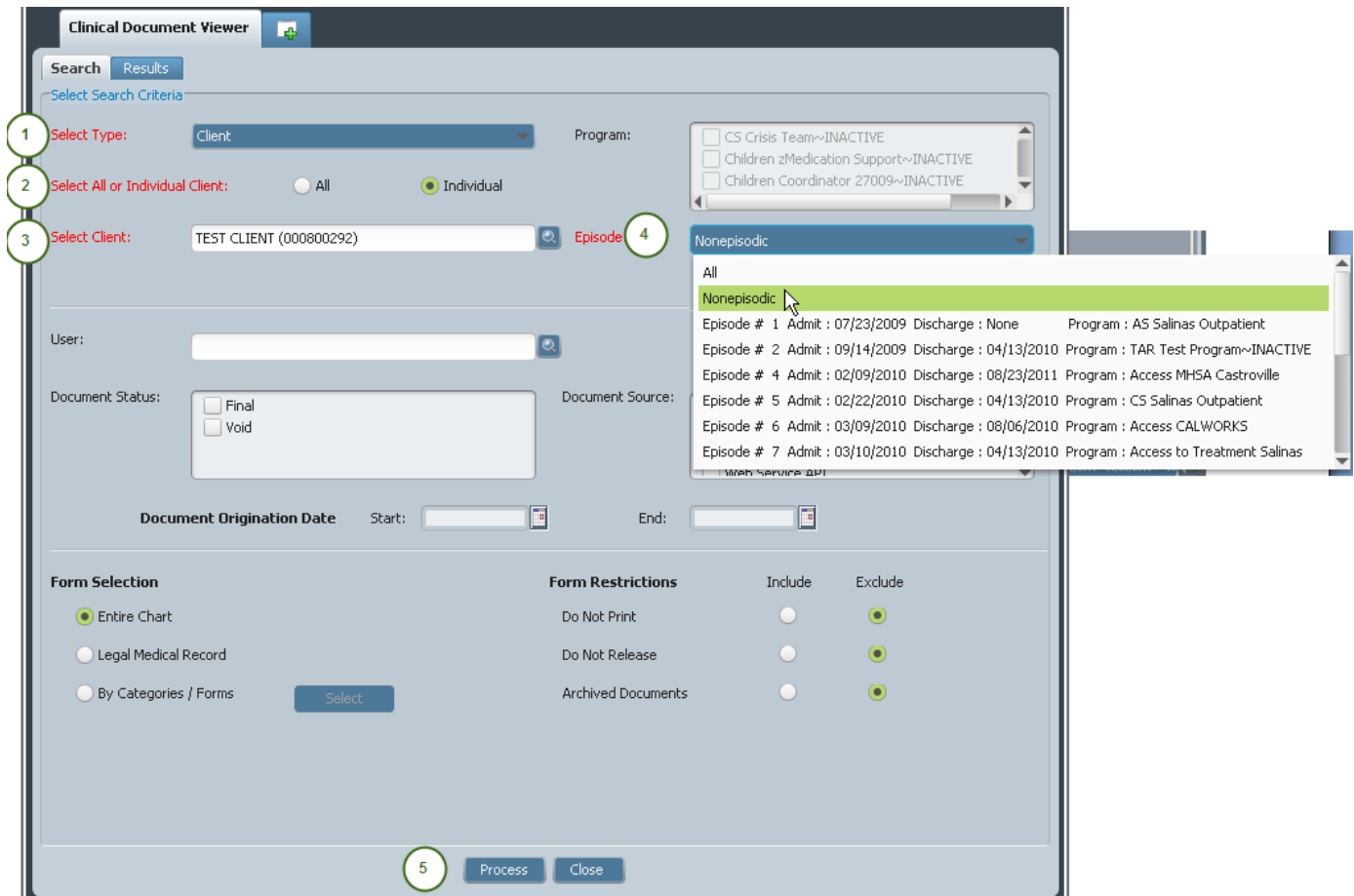
Search Results
- Client
  - CLIENT,TEST
- Form Categories
  - Clinical Documentation

Document List

6 **7** View   Print   Void   Close All Documents

My Avatar Scans

Print All

Non-Episodic (3) | 16: TEST only (0) 08/23/2010 - Active | 15: Access to Treatment Salinas (0) 08/19/2011 - 08/23/2011 | 14: ZADP Valley Health OP (0) 06/24/2011 - Active | 13: Access CALWORKS (0) 06/23/2011 - 08/23/2011 | 12: ER Crisis NMC (0) 05/31/2011 - 08/23/2011 | 1 05

1 of 1   50 %   **To rotate the page**

My Avatar Scans

To move from one page to the other   **To minimize or maximize the screen**

Please answer the following questions regarding your event:	Yes	No
Will event be open to the public?		✓
Will admission be charged?		✓
Will event generate revenue or be a fundraiser?		✓
If yes, please provide City of Roseville Business License #		
Will your event have alcohol?		✓
Will you be selling alcohol?		✓
Will you be serving food?	✓	
Will you be selling food?		✓

Document List   ☒ CLIENT,TEST (800292) - My Avatar Scans

8

To Print records   View   Print   Close All Documents

ACCIDENTAL/INCORRECT CLIENT ACCESS

LOCATION	AVATAR CWS→CLINICIAN MENU→ACCIDENTAL/INCORRECT CLIENT ACCESS
PURPOSE	To protect client's confidentiality only those individuals who are authorized to access the client's health information for treatment purposes may do so. It is our policy that no staff member may access a client's health record for their own personal gain. We recognize that there may be times when a staff member enters a client number incorrectly and gains access to a client's record in error. As a result, we have developed this form to more accurately document when a client's health record has been accessed in error. This form will be used for audit purposes to evaluate who has accessed the record and for what purpose. This form may also help staff members recall the reason the record was accessed and when the error occurred, if this is ever in question.
RULES	This form shall be completed by the staff member who accessed the client's health record in error. The staff member will enter a brief description of the error (i.e., wrong client number entered). **Do not enter another client's name in the description.**
STEPS	1. Select Accidental/Incorrect Client Access 2. Enter your NTID (your Avatar USERNAME) and select. 3. The first time you enter data into this form it will default open to the form. If you have previously entered data, from the pre-display select ADD to enter new information or Edit to make changes to an existing entry. 4. Enter the date of the Incorrect client was accessed. 5. Enter the Client ID or Name of the INCORRECT client. 6. Enter the Client ID or Name of the CORRECT client. 7. Enter a description of why or how you accessed INCORRECT client. (i.e., wrong client number entered). 8. Submit.

ACCOUNT OF DISCLOSURE

LOCATION	Avatar CWS → Quality Assurance → Account of Disclosure
PURPOSE	Track Information released from record.
RULES	This form is required when information is released.
STEPS	Select the client. If there are previous entries, you will see a pre-display screen- To enter a new disclosure click "Add." 1. Enter the Date of Disclosure 2. Enter the information of the Agency you are disclosing the information to 3. Enter a description of the information that was disclosed. 4. Enter a reason why the information was disclosed. 5. Is there an authorization to release this information? Select yes or no. 6. Enter the Name of the Staff that release the information. 7. Enter any comments if necessary. 8. Submit

GENERAL AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION	
LOCATION	CWS →CLINICIAN MENU →GENERAL AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION
PURPOSE	This form is used to obtain client consent prior to disclosure of information in accordance with regulations.
RULES	Complete an authorization for everyone PRIOR to any disclosure. Follows confidentiality regulations for permissible disclosure of protected health information
STEPS	Select the client or if the client is in your recent clients section, make sure he is the selected client (it will be highlighted). 1. Select whether form was scanned (completed on paper and scanned in health record) 2. Enter the entity(ies) or individual permitted to disclose the information. 3. Select the type of health information that may be disclosed. 4. Enter the amount and kind of information to be disclosed. 5. Enter the names of the individuals to WHOM information may be disclosed. 6. Enter the entity(ies) to WHOM the information may be disclosed. The client has a **treating provider relationship** with this entity. a. Treating Provider Relationship means a provider who can assess, diagnose, and treat. 7. Enter the **purpose** for the disclosure. 8. Client initials. Use signature pad by clicking "get signature" button. 9. Select when authorization to expires. 10. Client signature to authorize disclosure. To get client signature by clicking on "get signature" and date of signature. If a representative is signing for the client; indicate their name and relationship. 11. Indicate whether authorization was interpreted/translated in language other than English/Spanish 12. Indicate if copy of authorization was accepted to client/representative. 13. Designate the language which this document will print

Chart | **GENERAL Authorization for Disclosure of Confidential Health Information**

- **Authorization**
- **Revoke**

Submit

Was the authorization scanned? — **1**
- ○ Yes
- ● No

Entity(ies), or individual(s) permitted to disclose the information identified — **2**

The following health information may be disclosed — **3**
- ☐ HIV test results
- ☐ Mental health treatment information
- ☐ The following SUD information

Amount and kind of information to be disclosed — **4**

Named Individual(s): Information identified may be disclosed to the following named individual(s) — **5**

Treating Provider Relationship: The information identified may be disclosed to the following named entity(ies) with which I have a treating provider relationship — **6**

or choose treatment providers from this list
- ☐ CHS-Mental Health Program
- ☐ CHS-Substance Use Program
- ☐ DTH-Mental Health Program

Third Payer(s): Information identified may be disclosed to the following named third-party payer(s)

The information identified may be disclosed for the following purpose(s) (please explicitly identify the purpose(s) for which you are authorizing disclosure): — **7**

I hereby confirm my understanding that this authorization is subject to revocation at any time, except to the extent that the part 2 program or other lawful holder of patient identifying information that is permitted to make the disclosure has already acted in reliance on it. Acting in reliance includes the provision of treatment services in reliance on a valid authorization to disclose information to a third-party payer.

Client initials

8

Get Signature

This authorization expires **9**

○ 90 days after treatment ends

◉ OTHER

Authorization expires on following date, event or condition

Patient's Rights and Warnings:

(a) I may refuse to sign this authorization. My refusal could affect my ability to obtain services under this specific program, but efforts will be made to offer services under other programs.

(b) I may inspect or obtain a copy of the health information of which I am authorizing the disclosure.

(c) I may revoke this authorization at any time, either verbally or in writing. If I revoke in writing, I understand that I may submit my revocation to my treatment provider My revocation will take effect upon receipt, except to the extent that others have acted in reliance upon this authorization.

(d) I have a right to receive a copy of this authorization and will be offered a copy.

(e) Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure is in some cases not prohibited by California or federal law (e.g. HIPPA)

(f) Substance use disorder information may not be re-disclosed unless another authorization for such disclosure is obtained from me, or unless such disclosure is specifically required or permitted by law.

When required for a patient who is incompetent or deceased, the signature of an individual authorized to sign under 42 CFR §2.15

If signed by a person other than the patient, pursuant to 42 CFR §2.15, identify the relationship of the person authorized to sign

Client or Representative signature

10

Get Signature

If signed by someone other than the client, please indicate name

If signed by someone other than the client, please indicate relationship

Date

T   Y

Time

Current   H   M   AM/PM

This form was translated/interpreted for me in my preferred language (Other than English/Spanish): — 11
○ Yes   ○ N/A

Language other than English/Spanish

Notes on translation/interpretation

Copy of authorization accepted by client or representative? — 12
○ Yes   ○ No

Reason copy not accepted by client or representative

13 — The printed Authorization will be in
○ English   ○ Spanish

STEPS	1. Indicate if form was scanned in health record.
	2. Date authorization was revoked; staff completing revocation; and reason for revocation

Chart   GENERAL Authorization for Disclosure of Confidential Health Information

▫ Authorization
▫ Revoke

Was this revoked authorization scanned? — 1
○ Yes   ○ No

Notes on Revocation of Authorization

Date Authorization Revoked
[   ] T Y

Staff Name

Submit

2

LOCATION	CWS →CLINICIAN MENU →WITHIN AUTHORIZATION FOR DISCLOSURE OF CONFIDENTIAL HEALTH INFORMATION
PURPOSE	This form is used to obtain client consent to save information within the Monterey County Behavioral Health electronic health record, Avatar. As a behavioral health system, a holistic treatment of care is ideal.
RULES	Complete the "WITHIN" authorization for each individual as they enter treatment. The "WITHIN" authorization is placed within the onset of services form and is also available as a stand-alone form. PRIOR to any disclosure Must be completed at least once at time of admission. May be completed by multiple programs, however, only required to be completed once at start of services or when there is a break in all services for 365 days or greater. The "WITHIN" authorization has been prefilled to meet the sharing of information between MCBH and its contracted providers. May be revoked at any time. **Contact MCBH QI at 755-4545 to request disclosure protection if the client refuses or revokes the "WITHIN" authorization.** Follows confidentiality regulations for permissible disclosure of protected health information
STEPS	Select the client or if the client is in your recent clients section, make sure he is the selected client (it will be highlighted). This section has been pre-filled to meet the needs of the integrated record; however, you may add additional program information as necessary) 1. Select whether form was scanned (completed on paper and scanned in health record) 2. Enter Specific entity, program, or individual who is permitted to disclose information. 3. Select the type of health information that may be disclosed. a. Additional information is necessary for **Substance Use Disorder** services; amount and kind of information must explicitly be identified. 4. Enter the names of the individuals to WHOM information may be disclosed **(there is NO treating provider relationship)** Generally, this section will be left blank for the "WITHIN" authorization because MCBH and its contracted providers have a "treating relationship" with the client (see #5 below) 5. Enter the entity(ies) to WHOM the information may be disclosed. The client has a **treating provider relationship** with this entity. a. Treating Provider Relationship means a provider who can assess, diagnose, and treat. 6. Enter "third-party" information. 7. Enter the explicit **purpose** for the disclosure. 8. Client initials. Use signature pad by clicking "get signature" button. 9. Select when authorization to expires. 10. Client signature to authorize disclosure. To get client signature by clicking on "get signature" and date of signature. If a representative is signing for the client; indicate their name and relationship.

| **STEPS** | 11. Select when the authorization expires. |
| | 12. Notify client of their rights and warnings |

STEPS – REVOKE AUTHORIZATION	1. **Is the client requesting to revoke this Authorization for Use, Exchange, and/or Disclosure of Confidential Information WITHIN MCBH?** Select Yes or No **Was this revoked Authorization scanned?**
	     a. If Yes, you will need to complete the following required questions:
	         i. Date authorization revoked - This is the actual date the client relayed the information of revoking the authorization.
	         ii. Staff Name - Enter the STAFF name of the person who is receiving the information that the client is revoking this Authorization.
	         iii. Notes on revocation of authorization- Enter the reason why the client is revoking this authorization.
	     b. If No, skip these questions.
	 11.

BENZO/METHADONE/SUBOXONE CONSENT

LOCATION	CWS →CLINICIAN MENU →Benzo/Methadone/Suboxone Consent
PURPOSE	The purpose of this form is to documents consent to risks and benefits of these medications
RULES	Scan completed document in "Consents" category. For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date consent was completed. 2. Select if the consent was scanned. 3. Enter the date the consent was scanned

OTP ADMISSION CRITERIA CHECK LIST

LOCATION	CWS →CLINICIAN MENU →OTP ADMISSION CRITERIA CHECKLIST
PURPOSE	This optional form is used by OTP programs who choose to scan the program's checklist document.
RULES	Optional Scan program document in "Program Specific Documentation" category For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date the check list was completed. 2. Select if the check list was scanned. 3. Enter the date the check list was scanned

OTP CONSENT TO TREATMENT

LOCATION	CWS →CLINICIAN MENU →PHYSICAL EXAM
PURPOSE	This optional form is used by OTP programs
RULES	Scan document in "Consents" category For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date consent was completed. 2. Select if the consent was scanned. 3. Enter the date the consent was scanned

OTP MULTIPLE REGISTRANTS/VISITING PATIENTS

LOCATION	CWS →CLINICIAN MENU →OTP MULTIPLE REGISTRANTS/VISITING PATIENTS
PURPOSE	Opioid Treatment Programs (OTP) are required to demonstrate evidence of verification to ensure an individual is not receiving OTP/NTP services within a 200-mile radius prior to admission to OTP/NTP program. Documentation must also include advisement on program's responsibility of the patient. Temporary dosing responsibilities require proper documentation prior to taking patient responsibility. A signed authorization for disclosure must be obtained prior to contacting OTP/NTP programs, in accordance with Part 2 regulations.
RULES	• Select the agency from whom the information will be requested. • Scan OTP consent form in "multiple registrants" category • For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date the form was sent. 2. Select the agency from whom the information is being requested. 3. If agency is not on list, enter the name of the agency in the "other agency" section. 4. Enter the fax number for the program who the information is being requested. 5. Select if the request was scanned in the health record. 6. Enter the date the form was scanned in the health record. 7. Enter the name of the staff sending the request. Click SUBMIT to save the information entered on the form. **For Results:** When results are received, enter information in the results section of this form. 8. Open the form, click on "results" section of the form (left hand side of form) 9. Select if the results documents were scanned. 10. Enter date the result was scanned in health record. 11. Enter the staff name who received the results. Click SUBMIT to save the information entered on the form.

Chart | **OTP Multiple registrants/visiting patients**

- **Multiple Registrants**
  RESULTS

  Submit

Date sent _____ [T] [Y] ⊞ ①

Agency sent to
- ○ Janus of Santa Cruz
- ○ South County Clinic-Santa Clara
- ○ Valley Health Associates ②
- ○ Janus South County
- ○ CHS-Off Main Clinic

Other agency
_____ ③

Agency sent to fax number _____ ④

Was the request scanned?
- ○ Yes   ○ No ⑤

Date scanned
_____ [T] [Y] ⊞ ⑥

Sent by
_____ 🔍 ⑦

▼ **RESULTS**

Result
- ○ Yes - receiving services
- ○ No - not receiving services ⑧

Were the results scanned?
- ○ Yes   ○ No ⑨

Date Scanned
_____ [T] [Y] ⊞ ⑩

Received_by
_____ 🔍 ⑪

OTP PHYSICIAN ADMISSION ORDERS

LOCATION	CWS →CLINICIAN MENU →OTP PHYSICIAN ADMISSION ORDERS
PURPOSE	Physician's orders must include evidence of physical dependence and addition to opiates. Including evidence of observed signs of physical dependence or results of initial rests or analysis of illicit drug use, evidence confirming history of at least 2 years of unsuccessful attempts in withdrawal, etc. Detox treatment episode regulations apply, when applicable
RULES	Scan these documents in the "Physician Orders" category. For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date the order was completed. 2. Select if the order was scanned. 3. Enter the date the order was scanned

OTP COWS

LOCATION	CWS →CLINICIAN MENU →OTP COWS
PURPOSE	The optional form is used by OTP programs; program level decision
RULES	Scan form in these "OTP COWS" category For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date document was completed. 2. Select whether document was scanned. 3. Enter the date the document was scanned

OTP STEP LEVEL JUSTIFICATION

LOCATION	CWS →CLINICIAN MENU →OTP STEP LEVEL JUSTIFICATION
PURPOSE	This form is used to capture information on step-level schedules for Take-Home medication privileges.
RULES	Program-level form will be used to document this. Progress note reflecting discussion with patient should be made. Scan documents in "Step Level" category For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date the form was completed. 2. Select if the form was scanned. 3. Enter the date the form was scanned

SUD SCREENING

LOCATION	Avatar PM → SUD → SUD SCREENING
PURPOSE	The SUD Screening Tool may be conducted by individuals who completed the ASAM Training and: • Monterey County Behavioral Health: ○ a Social Worker III or Licensed Practitioner of the Healing Arts (LPHA) to determine which level of care may best serve the needs. • DMC- ODS Provider: ○ A registered or certified drug and alcohol counselor or Licensed Practitioner of the Healing Arts (LPHA) to determine which level of care may best serve the needs.
RULES	This screening tool should be completed on the same day the beneficiary requests services.
STEPS	Select a client. • Search **"SUD Screening"** in the "search forms" box. • Select the episode number.

STEPS	**DMC-ODS Screen section: (complete all required fields in red)**
	• **Draft/Final:** finalize form once all fields are complete.
	• Date of Request
	• Time of Request
	• Type of Contact
	• Perinatal Client
	• Urgent
	• Referral Source

SUD Screening — DMC-ODS Screen

Brief Screener for Substance Use Treatment Services

Draft/Final: ● Draft ○ Final

Perinatal Client? ○ Yes ○ No

Date of Request: [ ] T Y

Urgent: ○ Yes ○ No

Time of Request: [ ] Current H M AM/PM

Referral Source: Faith Based Org

Type of contact: ○ Phone ○ Walk-in ○ Referral

STEPS	Complete Dimension 1 – Withdrawal / Detoxification Potential

DIMENSION 1. WITHDRAWAL/DETOXIFICATION POTENTIAL

Are you experiencing any current severe withdrawal symptoms? (If YES, consider immediate referral to the nearest Emergency Dept. and STOP SCREEN)
¿Está teniendo algún síntoma de abstinencia grave en este momento?

○ Yes ○ No

Are you under the influence of any substances right now? (If YES, consider Withdrawal Mgmt)
¿Está bajo la influencia de alguna sustancia en este momento?

○ Yes ○ No

If NO, what date did you last use?
Si la respuesta es NO, ¿Cuál fue la última fecha en que consumio alguna sustancia?

[ ] Today Yesterday [-]

If YES, have you continuously used for 5 or more days?
En caso afirmativo, ¿ha consumido continuamente durante 5 días o más?

○ Yes ○ No

STEPS	Complete Dimension 2 – Biomedical Conditions and Complications

DIMENSION 2. BIOMEDICAL CONDITIONS AND COMPLICATIONS

Are you having a medical emergency or need hospitalization? (If YES, consider immediate referral to nearest Emergency Dept. and STOP SCREEN)

¿Está teniendo una emergencia médica o necesita hospitalización?

○ Yes   ○ No

Do you require any special accomodations (e.g., wheelchair, sensory impairment)?

¿Necesita algún alojamiento especial (por ejemplo, silla de ruedas, discapacidad sensorial)?

○ Yes   ○ No

If YES, specify:

[   ]

Do you have any current severe physical health problems?

¿Tiene actualmente algún problema grave de salud física?

○ Yes   ○ No

Do you have any memory or motor difficulties?

¿Tiene dificultades de memoria o motoras?

○ Yes   ○ No

Do you have a primary care doctor?

¿Tiene un médico de atención primaria?

○ Yes   ○ No

STEPS	Complete Dimension 3 – Emotional / Behavioral / Cognitive Conditions and Complications

DIMENSION 3. EMOTIONAL/BEHAVIORAL/COGNITIVE CONDITIONS AND COMPLICATIONS

Are you currently having thoughts of hurting yourself or others? (If YES, consider referring to Emergency Services and Stop Screen)

¿Está teniendo actualmente pensamientos de lastimarse a sí mismo o a otros?

○ Yes   ○ No

Are you currently having any severe mental or emotional issues or distress? (If YES, consider referring to mental health services)

¿Tiene actualmente algún problema o angustia mental o emocional grave?

○ Yes   ○ No

Do you feel unstable with any of your mental health problems? (If YES, consider referral to residential treatment)

¿Se siente inestable con alguno de sus problemas de salud mental?

○ No   ○ N/A   ○ Yes

STEPS	Complete Dimension 4 – Readiness to Change

DIMENSION 4. READINESS TO CHANGE

Do you feel coerced into substance use treatment or object to receiving treatment?
¿Se siente obligado a someterse a un tratamiento por consumo de sustancias o se opone a recibir tratamiento?

○ Yes   ○ No

How ready are you to change some aspect of your alcohol or substance use?
¿Qué tan preparado está para cambiar algún aspecto de su consumo de alcohol y/o sustancias?

○ Not Ready   ○ Somewhat Ready   ○ Considerable Ready

Are you seeking treatment to avoid a negative external consequence (i.e. probation, family demands, job requirements)?
¿Está buscando tratamiento para evitar una consecuencia externa negativa (es decir, libertad condicional, demandas familiares, requisitos laborales)?

○ Yes   ○ No

Are you concerned about your alcohol or substance use?
¿Le preocupa su consumo de alcohol o sustancias?

○ Yes   ○ No

STEPS	Complete Dimension 5 – Relapse / Continued Use Potential

DIMENSION 5. RELAPSE/CONTINUED USE POTENTIAL

Have you used on most days (15 or more days) in the past 30?
¿Ha consumido continuamente (durante 15 días o más) en los últimos 30 días?

○ Yes   ○ No

Are you likely to continue to use alcohol and/or substance without treatment?
¿Es probable que continúe consumiendo alcohol y/o sustancias sin tratamiento?

○ Yes   ○ No

STEPS	Complete Dimension 6 – Recovery Environment

DIMENSION 6. RECOVERY ENVIRONMENT

Do any of your daily situations and/or your current substance use put you or others in danger?
¿Alguna de sus situaciones diarias y/o su consumo actual de sustancias lo ponen a usted o a otros en peligro?

○ Yes   ○ No

Is your current living situation unsafe or contributing to harmful alcohol and/or substance use?
¿Su situación de vida actual es insegura o contribuye al consumo nocivo de alcohol y/o sustancias?

○ Yes   ○ No

Do you struggle to obtain food, shelter, and clothing?
¿Tiene dificultades para obtener comida, refugio y ropa?

○ Yes   ○ No

Are you currently experiencing homelessness?
¿Se encuentra usted actualmente sin hogar?

○ Yes   ○ No

STEPS	• Complete Medication for Addiction Treatment (MAT)

MEDICATION FOR ADDICTION TREATMENT (MAT)

In your life, have you ever taken medication for addiction treatment (MAT) for substance use?
¿Alguna vez en su vida ha tomado medicamentos para el tratamiento de adicciones (MAT) por el consumo de sustancias?

○ Yes   ○ No

If yes, who was the prescriber, what did you take (include dose) and for how long?
En caso afirmativo, ¿quién se lo recetó, qué medicamento tomó (incluya la dosis) y durante cuánto tiempo?

Are you currently taking medication for addiction treatment (MAT) for substance use?
¿Está actualmente tomando medicamentos para el tratamiento de adicciones (MAT) por el consumo de sustancias?

○ Yes   ○ No

If yes, who is your medication for addiction treatment (MAT) prescriber?
En caso afirmativo, ¿quién le prescribe el medicamento para el tratamiento de adicciones (MAT)?

What medications for addiction treatment are you currently prescribed (include dose?
¿Cuáles medicamentos para el tratamiento de adicciones (MAT) le recetan actualmente (incluya la dosis)?

If not currently taking medication for addiction treatment (MAT), are you interested in me connecting you directly to MAT services to meet with a doctor to determine the best course of treatment?
Si actualmente no está tomando medicamentos para el tratamiento de la adicción (MAT), ¿está interesado en que lo conecte directamente con los servicios de MAT para reunirse con un médico y determinar el mejor curso de tratamiento?

○ Yes   ○ No   ○ Not Applicable

STEPS	• **Complete Level of Care Inquiry**

Level of Care Inquiry:

Type of substance use treatment you are interested in?
¿Qué tipo de tratamiento para el consumo de sustancias le interesa?

- [ ] a. Narcotic Treatment Program/Medication for Addiction Treatment (NTP/MAT)
- [ ] b. Outpatient- LOC 1
- [ ] c. Intensive Outpatient- LOC 2.1
- [ ] d. Residential Withdrawal Management- LOC 3.2
- [ ] e. Clinically Managed Low-Intensity Residential- LOC 3.1
- [ ] f. Clinically Managed High Intensity + Population Specific Residential - LOC 3.3
- [ ] g. Clinically Managed High-Intensity Residential- LOC 3.5
- [ ] h. Medically Monitored Intensive Inpatient Services- LOC 3.7
- [ ] i. Medically Managed Intensive Inpatient Services- LOC 4.0
- [ ] j. Recovery Services
- [ ] k. Prevention- LOC .5

Are you interested in a referral to mental health services?
¿Está interesado en una derivación a servicios de salud mental?

○ Yes   ○ No

Are you interested in a referral to primary care services?
¿Está interesado en una derivación a servicios de atención primaria?

○ Yes   ○ No

STEPS	**Complete Level of Care Disposition** 1. Screener recommendation LOC: Determined by staff conducting screening tool. 2. Actual Substance Use Treatment LOC: the accepted LOC accepted by beneficiary.

Level of Care Disposition:

Screener recommendation for Substance Use Treatment Level of Care

- [ ] a. Narcotic Treatment Program/Medication for Addiction Treatment (NTP/MAT)
- [ ] b. Outpatient- LOC 1
- [ ] c. Intensive Outpatient- LOC 2.1
- [ ] d. Residential Withdrawal Management- LOC 3.2
- [ ] e. Clinically Managed Low-Intensity Residential- LOC 3.1
- [ ] f. Clinically Managed High Intensity + Population Specific Residential - LOC 3.3
- [ ] g. Clinically Managed High-Intensity Residential- LOC 3.5
- [ ] h. Medically Monitored Intensive Inpatient Services- LOC 3.7
- [ ] i. Medically Managed Intensive Inpatient Services- LOC 4.0
- [ ] j. Recovery Services

Actual Substance Use Treatment Level of Care

- [ ] a. Declined Services
- [ ] b. Narcotic Treatment Program/Medication for Addiction Treatment (NTP/MAT)
- [ ] c. Outpatient- LOC 1
- [ ] d. Intensive Outpatient- LOC 2.1
- [ ] e. Residential Withdrawal Management- LOC 3.2
- [ ] f. Clinically Managed Low-Intensity Residential- LOC 3.1
- [ ] g. Clinically Managed High Intensity + Population Specific Residential - LOC 3.3
- [ ] h. Clinically Managed High-Intensity Residential- LOC 3.5
- [ ] i. Medically Monitored Intensive Inpatient Services- LOC 3.7
- [ ] j. Medically Managed Intensive Inpatient Services- LOC 4.0
- [ ] k. Recovery Services
- [ ] l. Prevention- LOC .5

STEPS	• **Complete Additional Outcomes Program Referrals (if applicable)**

Additional Outcomes Program Referrals(s):

What Recovery Supports/Resources were provided?

- [ ] 12 Step Meetings
- [ ] Emergency Shelter Referral
- [ ] Food Resources

Other

Were interim services offered?
( ) Yes   ( ) No

Were interim services accepted?
( ) Yes   ( ) No

STEPS	**Complete Next Steps for Timeliness (for new beneficiaries only):**
	a) Date of 1st offered appointment: in most cases, this is the date the SUD Screening Tool was administered with the beneficiary.
	b) Date of 1st offered follow up appointment:
	i) **For DMC Providers:** this may be the next offered appointment including Case Management (with the beneficiary present), Assessment, or Group/Individual Counseling.
	ii) **For MCBH**: Any billable service (case management, mental health rehab, individual/group therapy, assessment, etc.) while the client is being linked to the DMC ODS provider OR this may be the next offered SUD appointment with the DMC ODS Provider.
	c) MCBH & its DMC ODS contracted Providers are required to follow the timeliness standards outlined in Policy 148 Network Adequacy and Timeliness Standards.
	i) Beneficiary requesting Outpatient Services
	(1) Non-Urgent: 1st offer appointment within 10 business days from request.
	(2) Urgent: Offer appointment within 48 hours of request, 96 hours for service requests that require prior authorization (i.e., Residential)
	(3) Follow-up: offered within 10 business days from the 1st rendered service.
	ii) Beneficiary requesting Opioid Treatment Services (NTP/MAT)
	(1) Non-Urgent: Offer appointment within 3 business days from request.
	(2) Urgent: Offer appointment within 48 hours of request.

Next Steps:

1st Offered Appointment
07/01/2024   [T] [Y] [▤]

1st Follow Up Appointment
_____   [T] [Y] [▤]   💡

Additional Notes

Completed by
MARCHEBOUT,ROSA (002354)

STEPS	**Complete the Substances Used by Client section (if applicable)**
	1. Add new item. 2. Select "Substance Used" from the dropdown menu. 3. Select the "Method of Use" from the dropdown menu. 4. Enter the "Date Last Used" 5. Enter the "Amount Used" 6. Enter the "Frequency of Use" 7. Enter the number of "Days used in the past 30." 8. Enter the "Age of First Use" Once all fields have been completed, you may **submit** the form.

SUD RESIDENTIAL/INPATIENT AUTHORIZATION

LOCATION	PM → CLINICIAN MENU → SUD RESIDENTIAL/INPATIENT AUTHORIZATION
PURPOSE	Providers shall complete an SUD Screening Tool **immediately** at the time of the phone call, walk-in or referral. Providers shall complete necessary documentation in accordance with access criteria, prior authorization requirements, and scope of practice prior to submitting a request for residential/inpatient authorization to MCBH.

RULES	1. The following documents must be completed in AVATAR prior to submitting a residential/inpatient authorization request to MCBH to consider the request complete and valid:
	  • SUD Screening Tool.
	  • Within Authorization for Disclosure of Confidential Health Information
	  • ICD-10 code set (may use Z55-Z65 or Z03.89) completed by the LPHA.
	  • Authorization Request Form.
	
	2. Providers shall submit authorization request for residential/inpatient stays to
	  • 415-SUD@countyofmonterey.gov
	  • In Subject Line:
	    a) Authorization Request for Residential Services.
	    b) Authorization Request for Inpatient Services.
	    c) Authorization Request for Residential/Inpatient Services for Perinatal, as applicable
	  • Body of Message: Include the Client ID, level of care being requested, and the provider's contact information.
	
	3. MCBH SUD Authorization Team will review documentation for appropriateness of level of service being requested when making the decision for authorization and notify the provider of the decision within 24 hours from receipt of a complete and valid request, including on weekends and holidays.

STEPS	Select a client.
	1. In search forms, enter "SUD RESIDENTIAL/INPATIENT AUTHORIZATION" Form. 2. Select the Episode. 3. If you are adding a new entry the form will automatically open to the first section. Otherwise, to add a new row, select ADD.

Search Forms

SUD Residential/ ① 🔍

Name	Menu Path
SUD Residential/Inpatient Authorization	Avatar PM / Clinician Menu

<= Previous 25	1 through 1 of 1	Next 25 =>

🏠 Chart   **SUD Residential/Inpatient Authorization**

Name: TEST CLIENT
ID: 800292
Sex: Male
Date of Birth: 07/15/1956

Episode	Program	Start	End
45	Access AB109	06/06/2024	06/06/2024
44	CS Medication Support	02/22/2024	
43	Access to Treatment Coastal Region	01/20/2023	01/20/2023
42	Access AB109	08/19/2022	08/19/2022
41	Access to Treatment Salinas	07/29/2022	07/29/2022
40	SUD Door to Hope OP Intensive	07/13/2022	09/16/2022
39	SUD Sun Street Residential	07/16/2018	

②

OK	Cancel

CLIENT, TEST (000800292)
M, 67, 07/15/56
Ht: 5' 5", **Wt:** 180 lbs, **BMI:** 30
Address: Homeless HOMELESS homeless hOMEleSS, ...

Ep: -
Phone #: 831-999-9999

DX P: -
Attn. Pract.: -
Adm. Pract.: -
Preferred Name: testbest

⚠ Allergies (5)
Allergies Reviewed=Yes (06/19/2020)

🏠 Chart   **SUD Residential/Inpatient Authorization**

Date of Request	Data Entry By (Login)
10/11/2023	Jessica Sanchez

③

Add	Edit	Delete	Cancel

| STEPS | 4. Date of Request (defaults)
5. SUD Screening Tool: select from the dropdown menu.
6. Diagnosis: select from the dropdown menu.
7. Within Authorization: select from the dropdown menu.

PERSON REQUESTING AUTHORIZATION
    8. Person Requesting Authorization: Enter the name of staff requesting this authorization.
    9. Notes: enter any notes, if applicable.
       (SUBMIT form)

COUNTY AUTHORIZATION TEAM
    10. Enter County Authorization Reviewer Date
    11. Enter County Authorization Reviewer staff.
    12. Select Eligibility
    13. Enter County Authorization Reviewer Notes, if applicable.
    14. Entry Date (defaults)
    15. Time Stamp (defaults) |

SUD RE AUTHORIZATION FORM

LOCATION	PM → HIDDEN → SUD RE AUTHORIZATION FORM

PURPOSE	Prior to the expiration of the 90th day of the residential/inpatient treatment stay, SUD providers shall complete a re-authorization request no later than 10 calendar days prior to the 90th day, and for each additional re-authorization request, SUD providers shall complete a re-authorization request 10 calendar days prior to the 30th day of the additional extension.
	1. The re-authorization request shall clearly document/justify the need for a re-authorization of residential/inpatient treatment services.
	   a. Making progress but goals not yet attained.
	   b. Not making progress but showing capacity; or
	   c. Making progress, but there is a new problem that needs to be addressed.

RULES	1. The following documents must be completed in AVATAR prior to submitting a residential/inpatient re-authorization request to MCBH to consider the request complete and valid:
	  • Within Authorization for Disclosure of Confidential Health Information (verbal consent will no longer be accepted during the re-authorization period)
	  • Re-Authorization Request form with explanation for re-authorization.
	  • Providers shall submit re-authorization requests for residential/inpatient stays to: 415-SUD@countyofmonterey.gov
	  • In Subject Line:
	    a) Re-Authorization Request for Residential Services.
	    b) Re-Authorization Request for Inpatient Services.
	    c) Authorization Request for Residential/Inpatient Services for Perinatal, as applicable.
	  • Body of Message: include the Client ID, level of care being requested, and the provider's contact information.
	
	2. MCBH SUD Authorization Team will review documentation for appropriateness of continuation of residential/inpatient services and notify the provider of the decision within 24 hours from receipt of a complete and valid request, including on weekends and holidays.

STEPS	Select a client. 1. In search forms, enter "SUD Re Authorization Form." 2. Select if the form was scanned. 3. Enter Date Completed. 4. Select the Level of Care. **PERSON REQUESTING AUTHORIZATION** 5. Enter the Number of Days in Residential Treatment. 6. Select the Eligibility for Reauthorization. 7. Enter the staff name of Person Requesting Authorization. 8. Enter a brief Explanation / Reason for Reauthorization. (SUBMIT form) **COUNTY AUTHORIZATION TEAM**

9. Enter County Authorization Reviewer Date
10. Enter County Authorization Reviewer staff name.
11. Eligibility for Reauthorization findings
12. County Authorization Reviewer Notes
13. Current time (defaults)
14. Entry Date (defaults)

Search Forms

Name	Menu Path
SUD Re Authorization Form	Avatar PM / HIDDEN

<= Previous 25   1 through 1 of 1   Next 25 =>

SUD Re Authorization Form

Name: TEST CLIENT
ID: 800292
Sex: Male
Date of Birth: 07/15/1956

Episode	Program	Start	End
45	Access AB109	06/06/2024	06/06/2024
44	CS Medication Support	02/22/2024	
43	Access to Treatment Coastal Region	01/20/2023	01/20/2023
42	Access AB109	08/19/2022	08/19/2022
41	Access to Treatment Salinas	07/29/2022	07/29/2022
40	SUD Door to Hope OP Intensive	07/13/2022	09/16/2022
39	SUD Sun Street Residential	07/16/2018	

OK   Cancel

Re-Authorization Form

Person Requesting Autho...
County Authorization Tea...

Submit

3 Date Completed

T Y

4 Current Level of Care
○ 3.1   ○ 3.5

5 Number of Residential Days in Treatment

▼ Person Requesting Authorization

6 Eligibility for Re-Authorization
○ A-Making progress goals not yet attained
○ B- Not making progress; shows capacity
○ C-Making progress; new problem

7 Person Requesting Authorization

8 Explanation/Reason for Re-Authorization

Re-Authorization Form

Person Requesting Autho...
County Authorization Tea...

Submit

▼ County Authorization Team Reviewer

9 County Authorization Reviewer Date

T Y

10 County Authorization Reviewer

11 Eligibility for Re-Authorization Findings
○ A- Eligible   ○ B - Eligible   ○ C - Eligible
○ Discharge A   ○ Discharge B   ○ Discharge C
○ Discharge D   ○ Other

12 County Authorization Reviewer Notes

13 Current Time
10:33 AM   Current   H   M   AM/PM

14 Entry Date
07/11/2024   T   Y

SUD ASSESSMENT	
LOCATION	CWS →CLINICIAN MENU →SUD ASSESSMENT
PURPOSE	This form is used to document the assessment for substance use disorder treatment services. Each dimension addressed different elements with an area to document rating for the dimension. This assessment is used to establish medical necessity and determination of level of care.
RULES	SUD assessment is used to document medical necessity and determination of level of care. May be completed by SUD Counselors and/or LPHAs. When completed by SUD Counselor, face-to-face consult with LPHA must take place; LPHA reviews, confirms medical necessity is established, and assessment is signed and finalized by LPHA. SUD assessments not meeting above requirement is considered invalid. The SUD assessment incorporated the "Immediate Risk Assessment" section for evaluation risks which may need immediate action
STEPS	Select the client or if the client is in your recent clients section, make sure he is the selected client (it will be highlighted). 1. Select the SUD episode/program. 2. Assessment date defaults to the date of entry; this date may be changed to accurately reflect the date assessment was conducted. 3. Assessment status defaults to draft. The assessment status should be marked as "Final" once the SUD assessment is completed. The "Final" form prevents additional edits. 4. Practitioner defaults to the staff member who is completing the SUD Assessment 5. Immediate Need Risk Assessment section: To select, make sure item contains a ☑. 6. The summary shows information on the selections made above. This section contains information on actions that may be taken.

DIMENSION 1	7. Complete Dimension 1: Acute Intoxication and/or Withdrawal Potential 8. Use the **Substance Used** section to enter alcohol and substance use details. 9. Some selections will activate and require text box fields for additional details. 10. Select severity for Dimension 1; 0-4 scale: (0) none to (4) severe

SUBSTANCES USED	1. Click the button "Add New Item" this will add a new row into the multiple iteration table. The row will store information entered below. Multiple rows may be added. 2. Select the substance used from list; if not found, type in the name of the drug used 3. Select the method of use. 4. Enter the last date substance was used. 5. Enter the amount and frequency of use. 6. Enter the number of days the drug was used in the past 30 days. 7. Enter the age at first use

DIMENSION 2	12. Select all items that apply under Dimension 2: Biomedical Conditions 13. Enter information on "chronic medical problems or disabilities" and "ER or Hospital Admissions." 14. Enter estimated dates of onset of conditions for items selected above. 15. List any allergies to medications and enter information on head injuries, when applicable 16. Select severity for Dimension 2

Dimension 2 : Biomedical Conditions and Complications (11)

.

- [ ] (a) Client has chronic medical problems or disabilities?
- [ ] (b) In the past 30 days the client has been to an urgent care clinic, emergency room, or hospital for medical issues.
- [ ] (c) Hepatitis C diagnosis?
- [ ] (d) STD's Diagnosed?
- [ ] (e) Seizures Diagnosed?
- [ ] (f) Allergies Diagnosed?
- [ ] (g) Tuberculosis diagnosed?
- [ ] (h) Hypertension Diagnosed?
- [ ] (i) Client tested for HIV/AIDS?
- [ ] (k) Client allergic to any medications?
- [ ] (l) Client treated for head injury?

Describe chronic medical problems or disabilities

Describe ER or Hospital admissions (12)

Hepititis Diagnosis Date | T | Y

STDs Diagnosis Date | T | Y

Seizure Diagnosis Date | T | Y

Tuberculosis Diagnosis Date (13) | T | Y

Allergies Diagnosis Date | T | Y

Hypertension Diagnosis Date | T | Y

List Medications Client is Allergic to (14)

Describe Head Injuries

Dimension 2 Severity

(15)

DIMENSION 3	17. Complete Dimension 3: Emotional, Behavioral, or Cognitive Conditions and Complications; Include information on mental illness and treatment, as applicable. 18. Use the **Client Medication List** section to enter a list of the client's medications. 19. Select severity for Dimension 3

CLIENT MEDICATION LIST	1. Click the button "Add New Item" this will add a new row into the multiple iteration table. The row will store information entered below. Multiple rows may be entered. 2. Enter information on medications Select the medication name. 3. Enter medication dosage. 4. Enter prescription date. 5. Enter name of prescriber

DIMENSION 4	19. Complete Dimension 4: Readiness-To-Change
	20. Select severity for Dimension 4

DIMENSION 5	21. Complete Dimension 5: Relapse, Continued Use, Or Continued Problem Potential
	22. Select Dimension 5 Severity

Dimension 5 : Relapse, Continued Use, Or Continued Problem Potential (21)

- [ ] (a) Use of alcohol and/or other drugs places the Client or others at serious risk for negative consequences and/or harm?
- [ ] (b) Client is currently experiencing cravings or urges to use alcohol or other drugs?
- [ ] (c) Client has coping skills that can help reduce the possibility of relapse, continued substance use and/or reduce the potential for onse

Dim 5 Cravings

Dim 5 Coping Skills

Dim 5 Severity (22)

| DIMENSION 6 | 23. Complete Dimension 6: Recovery/Living Environment |
| | 24. Select Dimension 6 Severity |

Chart | **$UD** **Assessment**

$UD Assessment Main...
Assessment Main S....
▫ Substances Used
▫ Client Medication List

Submit

Dimension 6 : Recovery/Living Enviroment (23)

Living Arangements

[dropdown]

.
☐ (b) Client has frequent contact with friend, family members, or spouse/partner that use alcohol of other drugs?
☐ (c) Client resides with or has daily contact with individuals who use alcohol or other drugs?
☐ (d) Client attends social/cultural events within the community?
☐ (e) Client is currently employed, enrolled in school, or participates in a vocational training program.
☐ (f) Client has a car or other form of transportation.

Who supports Clients efforts to become sober?

Legal Involvement

☐ (1) Parole
☐ (2) Probation
☐ (3) Awaiting Trial/sentencing
☐ (4) DSS/CPS
☐ (5) Other (describe)

Describe other legal involvement

Barriers preventing goals being met

☐ (1) Occupational Problems
☐ (2) Housing Problems
☐ (3) Financial Problems
☐ (4) Primary Support Group
☐ (5) Access to health care
☐ (6) Transportation
☐ (7) Legal Issues or Involvement with Criminal Justice System
☐ (8) Other (Describe)

Describe other barriers

Dim 6 Recovery Severity (24)

SUD LEVEL OF CARE/SUMMARY	25. Information on severity of Dimensions previously selected are displayed here.
	26. Select whether individual requires narcotic treatment services through Narcotic Treatment Program (NTP)
	27. Enter information in Clinical Summary section. This section should cohesively present information regarding the assessment, clearly identify level of need, identify level of care, and other clinically relevant data. This is the opportunity to succinctly bring the information together and present the case for the level of care based on the functional impairments.
	28. Select the appropriate level of care based on the SUD assessment.
	29. Finalize form when complete.
	30. Submit document

DIAGNOSIS	
LOCATION	AVATAR PM→CLIENT MANAGEMENT→CLIENT INFORMATION→DIAGNOSIS
PURPOSE	A diagnosis must be present for the county to submit a claim for services. A primary diagnosis must be indicated and updated at least once every 12 months
RULES	• Only staff that have authorization to enter a diagnosis can perform an update to an existing diagnosis. • All clients must have an admission diagnosis – An "Admission Diagnosis" should **_NEVER_** be edited. • For mental health programs, when a mental health diagnosis and a substance use/abuse diagnosis are both present, the mental health diagnosis **_must_** be the "**_primary diagnosis_**" and **Bill Order 1.** • For substance use disorder programs, when a substance use/abuse diagnosis and a mental health diagnosis are both present, the substance use/abuse diagnosis **_must_** be the "**_primary diagnosis_**" and **Bill Order 1** • F or each of the diagnosis in the diagnosis table, you must select "yes" to add items to the problem list. Selecting "yes" will activate the onset date field, which indicates the onset date for the items in the problem list. Accurate client problem lists are valuable tools for improving the quality of care, enabling clinical decision support, and facilitating research and quality measurement.
STEPS	TO ENTER AN ADMISSION DIAGNOSIS: Select the client and then select the Diagnosis Form 1. Click on admission diagnosis. When an admission diagnosis is selected, the date of diagnosis will be auto assigned by the system (Do NOT modify this date) 2. Click on **Current** for the time of diagnosis. 3. Select **New Row** and verify that the **Bill Order is 1** and that the ranking of the diagnosis is **Primary.** 4. Search for the diagnosis by entering the term to describe the client's condition or by entering the diagnostic code. Use your **"Enter"** key or click on the search button to begin the search – make sure that the diagnosis contains an DSM-5 and ICD-10 code set - double click on the diagnosis to make your selection. 5. Select Active for the status. 6. Select the classification. **Mental Health:** A mental health program should have the primary diagnosis classified as a Mental Health classification. **Substance Abuse:** A substance use disorder treatment program should have the primary diagnosis classified as a Substance Abuse classification. **Environmental:** This used to be categorized in the Psychosocial and Environmental Problems previously captured under Axis-IV. This category is used to indicate other clinically significant issues and provide additional context for a clinical formulation. **Medical:** Use of this category is OPTIONAL; however, all mental health programs continue to be required to complete the General Medical Condition located within section 2 of the diagnosis form titled Additional Diagnosis Information which contains CSI information 7. Verify that the Ranking is primary and that the bill order is 1. 8. Select the diagnosing practitioner by entering the first few letters of the last name into the search box and by clicking on the search button. 9. Select yes on **add to problem list.** 10. Enter estimated onset date for problem list entry.

11. Verify that the diagnosis contains a DSM-5 and ICD-10 code set in the code cross-mapping box. If one of the required codes is missing from the code cross-mapping box, change the search terms to select a related diagnosis that has the required codes. • To add additional diagnosis, repeat steps 3 – 10 – additional diagnosis will not have a ranking of primary or a bill order of 1
12. Go to Additional Diagnosis Information tab and Enter CSI data (required for state reporting purposes)
13. Submit the form

ROLL OVER DIAGNOSIS FROM A PREVIOUS EPISODE	1. Select the type of diagnosis. 2. Enter the date of diagnosis. 3. Enter the time of diagnosis. 4. Click on the "select episode to default diagnosis information from" drop down to select the episode/program where you would like to copy the diagnosis from 5. Click on the "select diagnosis entry to default information from" drop down to select the diagnosis entry to copy from 6. Continue to complete diagnosis and submit.

SUD PROBLEM LIST

LOCATION	AVATAR PM → SUD → SUD Problem List
PURPOSE	
RULES	1. **All beneficiaries shall have a problem list.** 2. Staff may use the 161 Problem List Hist by Client DMC_ODS

STEPS	Select a client.
	1. In Search forms, type SUD Problem List
	2. Select an Episode (program)
	3. Select "Problem List
	4. Select Add New Item (to add, repeat step 4-14)
	
	5. Problem: Enter the text or the code. Click on the magnifying glass 🔍 to activate the search.
	    1. Ensure the problem entered has both an ICD-10 and a DSM-V code.
	6. Type: select Primary or Secondary
	7. Status: (Select one of the following)
	    1. Active
	    2. Auto Delete from Treatment Plan
	    3. Inactive
	    4. Monitoring
	    5. Resolved
	    6. Unresolved
	    7. VOID:
	8. Severity (Select one of the following)
	    1. Incapacitating
	    2. Mild
	    3. Moderate
	    4. Severe
	9. Chronicity
	    1. Acute
	    2. Chronic
	    3. Undetermined
	10. Action
	    1. Treating
	    2. Not Treating
	11. Enter Date Identified
	12. Enter Date of Onset
	13. Enter Time of Onset
	14. Specify Other: Enter the additional information related to the problem

Search Forms

SUD PROB ① 🔍

Name	Menu Path
SUD Problem List	Avatar PM / SUD

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EDITING A PROBLEM

	AVATAR PM → SUD → SUD Problem List
STEPS	Select a client.
	1. In Search forms, type SUD Problem List
	2. Select an Episode (program)
	3. Select "Edit"
	4. Select "Problem List"
	5. Click once on the row you would like to edit.
	6. Select "Edit Selected Item"
	Update necessary fields.
	Submit

Search Forms

SUD PROB | 1 | 🔍

Name	Menu Path
SUD Problem List	Avatar PM / SUD

<= Previous 25   1 through 1 of 1   Next 25 =>

SUD Problem List

Name: TEST CLIENT
ID: 800292
Sex: Male
Date of Birth: 07/15/1956   2

Episode	Program	Start	End
44	CS Medication Support	02/22/2024	
39	SUD Sun Street Residential	07/16/2018	
37	SUD CHS OP Intensive Monterey	07/02/2018	
36	SUD CHS Methadone Clinic Recovery Svcs	07/02/2018	
34	SUD CHS OP Int Monterey Rec Svcs	07/01/2018	
29	SUD CHS Methadone Clinic	02/16/2018	
14	Bienestar King City~INACTIVE	03/30/2015	
9	AS King City Outpatient Clinic	08/26/2014	
2	TEST only (used for PROVIDER SYSTEM CODE	08/27/2012	

SUD Problem List

Episode
44

3

Add   Edit   Cancel
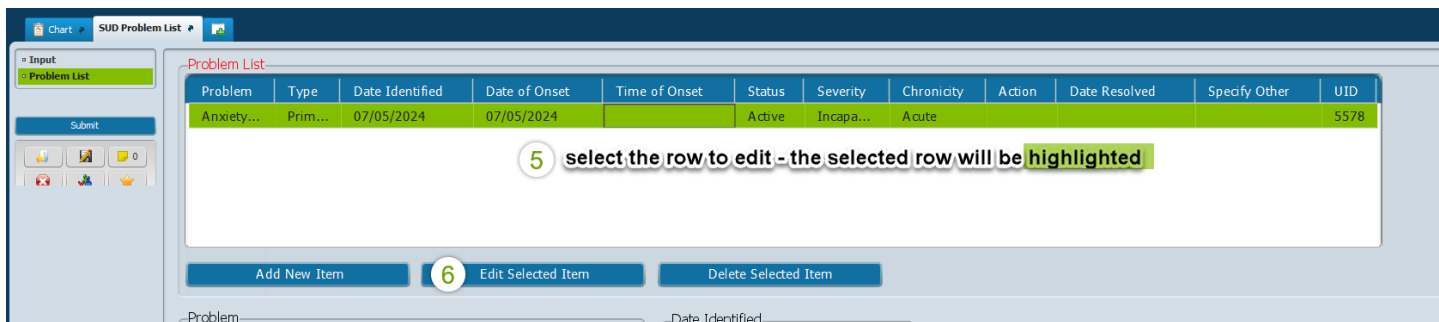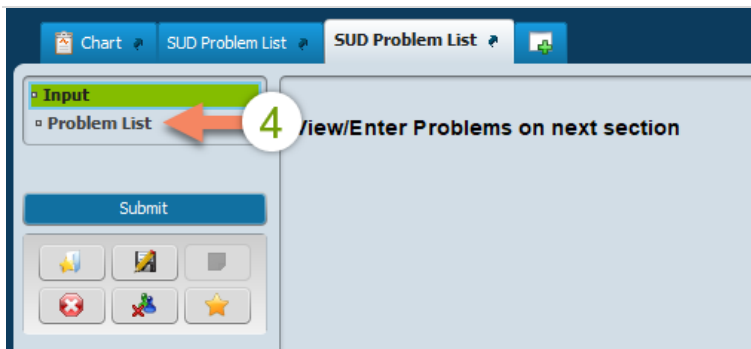
REPORT: 161 PROBLEM LIST HIST BY CLIENT DMC_ODS

1. Select a client.
2. In Search forms: search for "161 Problem List Hist by Client DMC_ODS"
3. Select the Type of print out and **Process.**
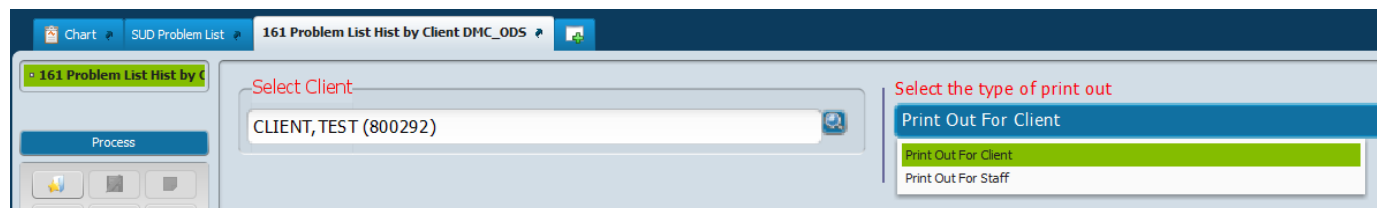
4. The report will come up for review. Sample below.

MONTEREY COUNTY BEHAVIORAL HEALTH
Avanzando Juntos Forward Together

My Care List Summary
Print Date: 7/5/2024

(800292) - CLIENT,TEST

Description	Date Added
Poisoning by other opioids, accidental (unintentional), initial encounter	10/3/2023
Anxiety disorder, unspecified	7/5/2024
Other specified health status	

SUD TREATMENT PLAN

LOCATION	Avatar CWS → Treatment Planning → SUD Treatment Plan
PURPOSE	• If there is **no previous treatment plan**, you will be taken directly to the Treatment Plan form, then skip to step 3. • If a client has an **existing active/current SUD Treatment Plan that is marked FINAL** <u>and you want to update and/or add new treatment goals to the plan</u>, <u>then select "ADD"</u> and default the information from the finalized treatment plan when prompted (shown in snapshot 2 below). This will create a copy of the finalized plan that may be updated and/or new treatment goals may be added (currently, the "client's overall goal in their own words" section and the treatment start, and end dates will not default in—the treatment plan dates MUST remain the same as the finalized treatment plan you used to create this draft plan). • If a client **was closed to all services and is being reopened** and <u>has a</u> **SUD Treatment Plan** on file (which is NOT currently active) you choose "ADD" a treatment plan to create a new treatment plan and you decide whether it is pertinent to default the previous treatment goals, or not. *Note: Treatment Plan dates MUST coincide with the "original date of coordination"—please refer to "Treatment Plan" section of the Documentation Guide for an explanation of treatment dates.*

RULES	Treatment plan requirements are as follows:
	
	1. Life Goals and Aspirations (Note: will not be scored in a utilization review)
	   a. Future desires
	2. Challenge or Barrier (Problem) (Note: will not be scored in a utilization review)
	   a. Barriers to achieving the goal and connected to the condition(s) identified in the assessment.
	3. Hope (Goal) (Note: will not be scored in a utilization review)
	   a. Hope stated in beneficiaries' own words.
	4. Action Steps (Objectives)
	   a. Action steps/objectives, if achieved, would help beneficiary reach their goal and are related to the mental health needs and functional impairments.
	   b. Action steps/objectives are specific, observable, and/or quantifiable.
	5. Supports (Interventions)
	   a. Supports are specific and includes proposed interventions, frequency, and duration.
	   b. Supports are developed around one or more barrier (symptom or functional impairment).
	6. Goal Management
	   a. The Plan is developed at onset and is updated a least annually and/or when there are significant changes and clinically appropriate.
	7. Beneficiary Participation
	   a. Evidence beneficiary and/or or caregiver participated actively in process.
	   b. Participation must be documented in the Plan Development progress note.

STEPS	Select the client.
	1. Select an Episode
	2. If you would like to default information from an existing plan select Yes, otherwise select No to create a new plan.

SUD TREATMENT PLAN

STEPS – SUD TREATMENT PLAN	3. Enter the Plan Name
	4. Select the Plan Type
	5. Enter the Clients overall goal (in their own words)
	6. Enter the Plan Date (coincides with original date of coordination)
	7. Enter the Next review date (45 days before treatment plan expires)
	8. Enter the Plan End Date of the Treatment Plan
	9. Enter the status-
	a) Final (will not allow future changes),
	b) Draft (allows for future changes),
	c) or Pending Approval (will not allow for future changes)
	10. If Status Pending Approval, select Team Member from drop-down list to be Notified

CHALLENGE OR BARRIER

STEPS – CHALLENGE OR BARRIER	11. Select the Challenge or Barrier from the drop-down list for which you will link the goal (if none on list, complete this field) 12. The Date Opened field will default with the current day, but changes to this date are allowed. 13. Enter name of staff responsible for helping client with this goal 14. Staff Assigning defaults with the information of the staff completing plan. 15. File and continue to My Hope/Goal

HOPE/GOAL

STEPS – MY HOPE/GOAL	16. Select the Challenge or Barrier from the drop-down list for which you intend to link with the goal.
	17. Select the status of the Challenge or Barrier
	18. Enter My Hope Goal or select one with an "*" from the drop-down list.
	19. Ensure the date is accurate – this defaults to the current date.
	20. Staff Assigning defaults to the staff completing the treatment plan but may be edited.
	21. Enter the Staff Responsible
	22. File and continue to the "My Action Steps" section

ACTION STEPS

STEPS – MY ACTION STEPS	23. Select the Hope/Goal from the drop-down list. 24. Select the status of the action step. 25. Enter the Client Action Steps (Objectives) 26. Ensure accuracy of date 27. Staff Assigning defaults to the staff completing the treatment plan but may be edited. 28. Enter the Staff Responsible 29. File and continue to the Supports section

SUPPORTS

STEPS – SUPPORTS	30. First, select the **Action Steps** you are working with. 31. Select the status. 32. Enter the "Supports" (interventions) 33. Verify Date Opened. SUD Treatment plan Start Date defaults. 34. Enter the Staff Responsible 35. Staff Assigning defaults to the staff completing the treatment plan but may be edited. 36. File and continue to the Support Team section

SUPPORT TEAM

STEPS – SUPPORT TEAM	37. Select a row from Select Team member.
	38. Select the "Role" from the drop-down list of categories (this list is intended to include anyone who may be helping the client to reach their goals)
	39. *NOT* county staff - Enter the name of the support person in the Name field.
	40. **County Staff** - Enter the name of the support person in the "Select Staff Member" to begin the search and make your selection.
	41. Select Yes or No if the team member is the plan author and if a notification is required (to remind staff that treatment plan will soon expire)
	42. File (return to SUD Treatment Plan to update the status (draft, final, pending approval))
	43. Submit

CLINICAL PROGRESS NOTES MC (OUTPATIENT)

LOCATION	CWS → Clinician Menu → Clinical Progress Note MC
PURPOSE	The progress note is used to record the services that result in claims and to provide the treatment team with the most accurate information on treatment progress. Notes must accurately reflect the services/interventions provided and must be a medically necessary service.
RULES	- Must be completed within 72 business hours of service. - Clearly identify the intervention and be medically necessary - Duration of service provided must be in minutes. - All progress notes must be finalized

STEPS	Select the client.
	1. Select the Episode or Program and click "Ok."
	2. New Service will automatically select for you in the "Progress Note For" box, if it is not automatically selected then select "New Service."
	3. Enter the date of service, this is the date you provided the service.
	4. from the drop down, select the **Location** where the service was provided.
	5. Enter the Service Charge Code (if the client's chart is not in compliance the Service Charge Code will automatically change to a 330 service code and it will lock not allowing you to modify the Service Charge Code)
	6. Enter the Service Duration
	7. Select the Note Type from the drop-down box.
	8. If the type of note is "Co-Signature Required" in this field, you will select the staff member who will be co-signing the note.
	9. Click on Select T.P Item Note Addresses to open clients Treatment Plan
	
	      Select T.P. Item Note Addresses
	
	10. Select the Intervention linking to this progress note. If you chose the incorrect intervention and wish to reselect the intervention, click on
	
	      Clear 'Note Addresses Which Treatment Plan Problem' Text.
	
	11. Type your notes in the Notes Field (Function, Intervention, Response, Plan will default). If the clients preferred Language is other than English, it will default "Services provided in clients preferred language via" in the Notes Field box.
	In the "Additional Information" section (duration is entered in minutes)
	12. Enter Travel Duration if any.
	13. Enter Documentation Duration
	14. From the drop down, select the Evidence Based Practice
	15. By selecting Restricted Disclosure, you are notifying the QI team that the progress note contains sensitive information that should be reviewed prior to disclosure.
	16. The Client Signature is designated for certain teams. (Please consult with your supervisor should you have any questions re this box)
	17. Select "Draft" if the note is incomplete or needs edits. Select "Final" if the note is complete.
	18. Submit the note

Clear 'Note Addresses Which Treatment Plan Problem' Text.

11 Notes Field

Services provided in Spanish via

Chart | Clinical Progress Note MC

- Ambulatory Progress N...
  Add-On Service
- Additional Information

Submit

12 Travel Duration

13 Doc Duration

Evidence Based Practice

14

Restricted Disclosure

Client Signature

Online Documentation **15**

16 Get Signature

INPATIENT PROGRESS NOTE MC (INPATIENT/RESIDENTIAL)

LOCATION	CWS → SUD → Inpatient Progress Note MC
PURPOSE	The progress note is used to record the services that result in claims and to provide the treatment team with the most accurate information on treatment progress. Notes must accurately reflect the services/interventions provided and must be a medically necessary service.
RULES	• Must be completed within 72 business hours of service. • Clearly identify the intervention and be medically necessary • Duration of service provided must be in minutes. • All progress notes must be finalized
STEPS	Select the client. 1. New Service will automatically select for you in the "Progress Note For" box, if it is not automatically selected then select "New Service." 2. Enter the date of service, this is the date you provided the service. 3. Enter the Service Charge Code 4. from the drop down, select the **Location** where the service was provided. 5. Enter the Service Duration 6. Select the Note Type from the drop-down box. 7. If the type of note is "Co-Signature Required" in this field, you will select the staff member who will be co-signing the note. 8. Type your notes in the Notes field.

STEPS	9. Select SUD T.P. Version by selecting:
	Select T.P. Item Note Addresses
	Item Note Addresses to open clients Treatment Plan
	10. Select the Intervention linking to this progress note. If you chose the incorrect intervention and wish to reselect the intervention, click on
	Clear 'Note Addresses Which Treatment Plan Problem' Text.

STEPS	In the "Additional Information" section (duration is entered in minutes)
	11. Enter Travel Duration. **If none enter 0**.
	12. Enter Documentation Duration. **If none, enter 0.**
	13. From the drop down, select the Evidence Based Practice
	14. By selecting Restricted Disclosure, you are notifying the QI team that the progress note contains sensitive information that should be reviewed prior to disclosure.
	15. The Client Signature is designated for certain teams. (Please consult with your supervisor should you have any questions re this box)
	16. Select "Draft" if the note is incomplete or needs edits. Select "Final" if the note is complete.
	17. Submit the note

HOW TO VIEW PROGRESS NOTES

LOCATION	Avatar CWS → Progress Notes→ Progress Note Viewer
PURPOSE	This form is used to view progress notes for the selected client, episode, date range and note type
RULES	• This option allows you to view notes by episode for the selected client
STEPS	1. Select the client. 1. Select the Episode or Program you would like to view progress notes for and click "Ok." 2. Enter a start date. 3. Enter an end date. 4. Select the type of notes to be viewed (to select ALL, hold down the Control Key and press on the A key once) 5. Click on the "print progress notes" button to view progress notes

GROUP NOTES

There are three parts in creating group notes.

- Section 1 will explain how to register a group and add clients to the group.
- Section 2 will show you how to enter your group default note and add or remove clients that were not present in your group.
- Section 3 will show you how to edit the individual clients progress note.
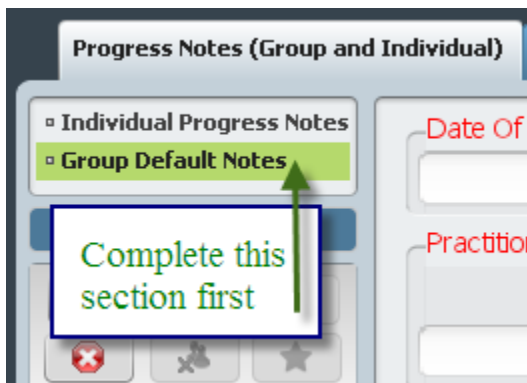
<table>
<tr><td colspan="2">GROUP REGISTRATION</td></tr>
<tr><td>LOCATION</td><td>Avatar CWS → Group Note→Group Registration</td></tr>
<tr><td>PURPOSE</td><td>The first thing you need to do is create a group by registering it in the "Group Registration". Here you can enter the name of the Group and add the clients that you know will be attending this group. In the Group Registration section, you can continue to add new clients once they join the group. You can remove clients when they have completed their sessions or have dropped the group. You can enter Client ID/names to a group to enable easy management. To enter the client ID/names to a group, the group must be registered beforehand. The purpose of registering clients into the group is to have the client's auto fill when you are ready to write the group notes.</td></tr>
<tr><td>RULES</td><td>Used for interventions offered to two or more clients.
One to three eligible practitioners may provide these services.
Only one progress note for each client is written, even when more than one practitioner leads the group.
Progress notes written ONLY for client's who participated in group.
Duration of service is measured in minutes</td></tr>
<tr><td>STEPS</td><td>Enter the name of the Group and click on   (to process search) then click on New Group to proceed in registering the group.
Select Yes to Assign the new group an ID number.
Enter the name of the Group and Enter the date the group was registered (created)
Continue to the Group Member Assignment Section
Click on Add New Item
Enter the Client's Name or Client ID number, Under episode Number select the episode you will be working under (note: you cannot select a closed episode or a pre-admission episode) then Select a group assignment start date (The date client will enter the group)
To add another client, click   Add New Item   and repeat the process to develop a group list, when finished, click   Submit</td></tr>
</table>

GROUP DEFAULT NOTE

LOCATION	Avatar CWS → Group Note→Progress Notes (Group and Individual)
PURPOSE	This section of the progress note can be looked at as the "Functional" and some of the "Intervention" sections of the FIRP format used for progress notes. This section of the progress note will default into every client's progress note written for this group.
RULES	**GROUP DEFAULT NOTES** section needs to be completed before the Individual Progress Notes. - <u>DO NOT</u> move between section or you will lose all information. - Complete Group Notes before saving data. - You <u>CANNOT</u> leave Group Notes in Draft.
STEPS PROGRESS NOTES - GROUP	1. Enter the Date of the Group 2. Enter the name or staff ID of the Practitioner coordinating the group. 3. Select New Service for Progress Note For section. 4. Enter the Group Name or Number 5. Enter the duration of the Group (Include Preparation, Group time and Post Group Time) 6. Select the Service Program 7. Select the Location of the Group 8. Enter the Service Charge Code 9. Select the Note Type. If Co-signature required, select the name of the staff from "User to send Co-Sign to Do Item to". "Staff to send scratch note to do item to" will default from Practitioner entry. 10. To Add a client to the group - click on Add Client to Group – this will enable the search field. - Enter the Name or Client ID of the client you are adding to the group. - Select the episode make sure to select a program you can bill under 11. To Remove a client from the group - Click on Remove Client from Group - Select the name from the drop-down menu. 12. Write the Note in this section (note should be in a FIRP format) 13. Select the Evidence Based Practice/Evidence Based Service Strategy List from the drop down. 14. File the Note 15. Go to Individual Progress Notes section after the note has been filed.

EDIT INDIVIDUAL NOTE	
STEPS PROGRESS NOTES – INDIVIDUAL PROGRESS NOTES	1. Enter the Group Name or Number 2. Enter the Date the Group Note was written. 3. Select the note you want to Edit (Click on the drop down menu to select the client you are editing the note for 4. Location will default from Group Default Note entry 5. If a co-signature is required the staffs name will default from Group Default Note entry 6. Date of Service, Service Charge Code, Service Program, Service Duration and Practitioner will default from Group Default Note entries. 7. Notes Field: type the note for the specific client in this section. 8. Click on Select the Treatment Plan Version 9. Select on Treatment Plan Item Note Addresses → after you have selected the treatment plan item, it will be displayed to the right. 10. Click on Clear "Note Addresses Which Treatment Plan Problem" text if you need to erase the treatment plan item note addresses. 11. File Note – ➢ **Once you file the Individualized Progress Note, select the next client, and repeat steps 3-11 until all the notes have been completed for all clients that attended the group.** 12. All the information in this section will default from Group Default Note Entry- **Do Not Change information in this section**

Progress Notes (Group and Individual)

- **Individual Progress Notes**
- **Group Default Notes**

Submit

Online Documentation

Group Name or Number — **1**

Note Date — **2**

Select Note To Edit — **3**

Location — **4**

User To Send Co-Sign To Do Item To — **5**

Notes Field — **7**

Select T.P. Version — **8**

9 — Select T.P. Item Note Addresses →

10 — Clear 'Note Addresses Which Treatment Plan Problem' Text.

11 — File Note

Date Of Service — T — Y — **6**

Service Charge Code

Service Program

Service Duration

Practitioner

PEREZ,HILDA (002428)

Note Addresses Which Treatment Plan Problem

Progress Note Entry

Progress Note For — **12**

- ○ Existing Service   ○ Existing Appointment
- ○ Independent Note   ○ New Service

Select Client

Select Episode

Note Addresses Which Existing Service/Appointment

Note Type

File Note

DISCHARGE SUD

LOCATION	CWS →CLINICIAN MENU →DISCHARGE SUD
PURPOSE	This form is used to capture information on Discharge Pan and Discharge Summary. • Discharge **Plan**: Completed when an individual is being discharged from care (voluntary or involuntarily) • Print-out of signed discharge plan shall be provided to the individual. • Discharge S**ummary**: Completed when program has *lost contact* with the individual. "Right-Click" templates are available to ensure documentation of minimal information is captured.
RULES	15. Completed to discharge a client from program/episode. 16. Completed once the "CalOMS Discharge" has been submitted
STEPS	Select the client. 1. Enter the date the discharge plan or discharge summary is completed. 2. Select Discharge Plan (voluntary or involuntary discharge) **or** Discharge Summary (loss of contact) 3. **Right click** in the white box (Discharge Plan/Summary) and select a template and fill in the Discharge Plan/Discharge Summary 4. Select whether a copy was given to the client. 5. If NO copy is given to the client, enter notes on why a copy was not given to the client. 6. Get client Signature if applicable (Necessary for Discharge Plan) 7. Enter the Date of client signature. 8. Enter Name of Staff completing the form

CHAPTER 5   DISCHARGE

LOCATION	CWS → Clinician Menu → Discharge
PURPOSE	This form is used to discharge a client from a specific program or episode.
RULES	• Do not enter # signs into the address section. • Enter discharge progress note prior to completing discharge. • Make sure there are no pending draft notes prior to discharge. • Assign an end date to the client case coordinator form if applicable
STEPS	Select the client. 1. Select the episode/ program and click Ok. 2. Enter the date of discharge. 3. Enter the time of discharge. 4. Select from the drop down the type of discharge. 5. Enter your clinician number or name (last name first) 6. Enter any additional comments or remarks in this notes section. 7. Go to the demographics section to update client demographics if needed. 8. Review all the fields to make sure they reflect the client's current information at discharge (scroll all the way down) 9. Click on the CSI section. 10. Select from the drop down the patient status code. 11. Select from the drop down the legal class. 12. click submit

Discharge

Name: TEST CLIENT
ID: 800292
Sex: Male
Date of Birth: 07/23/1970

Episode	Program	Start	End
16	TEST only	08/23/2010	
15	Access to Treatment Salinas	08/19/2011	08/23/2011
14	ZADP Valley Health OP	06/24/2011	
13	Access CALWORKS	06/23/2011	08/23/2011
12	ER Crisis NMC	05/31/2011	08/23/2011
11	ER Crisis NMC	05/04/2011	05/31/2011
10	Pre-Admission Program	02/03/2011	08/23/2011
9	CS SB King City SD	09/10/2010	02/22/2011
8	AS King City Outpatient Clinic	03/11/2010	03/11/2010
7	Access to Treatment Salinas	03/10/2010	04/13/2010
6	Access CALWORKS	03/09/2010	08/06/2010
5	CS Salinas Outpatient	02/22/2010	04/13/2010
4	Access MHSA Castroville	02/09/2010	08/23/2011
2	TAR Test Program~INACTIVE	09/14/2009	04/13/2010
1	AS Salinas Outpatient	07/23/2009	

OK   Cancel

RECURRING CLIENT CHARGE INPUT
ADDING DAILY CHARGES

LOCATION	Avatar PM → Services → Ancillary → Ambulatory Services → Recurring Client Charge Input
PURPOSE	
RULES	
STEPS	As an example, daily charges are being added for 1 month. Section **"Recurring Client Charge Input**." 1. Enter the date range you want to enter services for (example 3/01/2024 to 3/31/2024) 2. Select whether you want to exclude weekends. • Selecting **Yes** will not include weekends in the list of dates. • Selecting **No** will include weekends in the list of dates. 3. Select the dates you want to enter charges for (dates the client was present) • To select all dates: click on the 1st date check box then using your keyboard, select the keys "Ctrl" and "A". 4. Select "Client Charge Input.

STEPS	Section **"Client Charge Input"**
	5. Enter Client ID.
	6. Select the episode.
	7. Enter the service code for the daily charge.
	8. Enter the staff ID/name (this is the staff providing the service)
	9. Enter "1" for minutes.
	10. Submit the form. Once submitted, the daily charges will be added to the billing tables.
	11. Click "Yes" to "Do you wish to return to the form?" (to enter board and care charges, if any)

ADDING BOARD & CARE CHARGES

The information previously entered has remained on the form. Avatar will take you back to the first section to verify the date range. In this scenario we will add the board and care charges to the same dates previously entered for the daily charges. Therefore, no changes were made the Recurring Client Charge Input section.

STEPS	Section **"Client Charge Input"**
	12. Click on "Client Charge Input. 13. Update the service code to board and care services. 14. Submit.
	Run report 113 Client Service Summary to view the charges

Select "No" to exit the form.

HEALTH QUESTIONNAIRE SUD

LOCATION	CWS →CLINICIAN MENU →HEALTH QUESTIONNNAIRE SUD
PURPOSE	This is a self-administered physical health document
RULES	- Form provided by program. - Results shall be discussed with individual. - Supports treatment planning. - Scan completed document to "Health Questionnaire" category. - For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date the questionnaire was completed. 2. Select if the questionnaire was scanned. 3. Enter the date the questionnaire was scanned

PHYSICAL EXAM

LOCATION	CWS →CLINICIAN MENU →PHYSICAL EXAM
PURPOSE	The purpose of this form is to capture a history of physical exams scanned into Avatar
RULES	• Completed at least on admission and annually, thereafter. • If no physical examination is present • The program physician may complete one. • The program shall add this as a goal within the treatment plan and provide support to help client obtain physical examination (if no physical examination is noted within 3-months of admission, the program shall demonstrate evidence of supporting the client in obtaining as evidenced by identification of barriers and referrals. • Scan completed document in "Physical Exam" category. • For directions on scanning see: Document Capture
STEPS	Select the client. 1. Select if the client has had a physical exam in the past 12 months prior to admission. 2. Enter the date of the physical 3. Select if the physical was scanned. 4. Enter the date the physical exam was scanned

LABORATORY TESTING

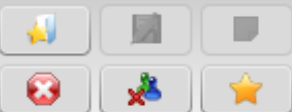|	
LOCATION	CWS →CLINICIAN MENU →LABORATORY TESTING
PURPOSE	This form is used to capture information on laboratory testing by the program, incoming from another clinic, and/or drug screening refusals.
RULES	• Tracks when laboratory testing was ordered by the program or when laboratory tests were obtained from another clinic. • Scan lab order/results in the "Labs" category • Drug Screening Refusal: for programs using this option, complete this section to document client's refusal to drug testing. • For directions on scanning see: Document Capture
STEPS LAB TESTING SECTION	Select the client. 1. Select the type of lab work. 2. If "other" is selected, enter the type of lab work ordered/obtained. 3. Enter the Date Specimen was collected. 4. Enter the Date Specimen was sent to the lab. 5. Enter the Name of the staff who sent the specimen to the lab. 6. Select Date lab order was scanned into Avatar. Click SUBMIT to save the information entered on the form. **For Results:** When results are received, enter information in the results section of this form. Open the form, click on "results" section of the form (left hand side of form). 7. Enter the Date the Results were Received. 8. Select the Lab Results 9. Select whether Results were Scanned into Avatar 10. Enter the Date Results were scanned. 11. Name of Staff who received results

DRUG SCREEN REFUSAL SECTION	**Drug Screen Refusal**: This section is completed by programs who use this option.
	1. Enter the Date of Refusal
	2. Type the Month of Refusal
	3. Click "Get Signature" to get clients signature using a signature pad.
	4. Enter the Date of Client Signature
	5. Click "Get Signature" of staff completing form.
	6. Enter the Date of staff signature.

CLIENT INVENTORY

LOCATION	CWS →CLINICIAN MENU →CLIENT INVENTORY
PURPOSE	The purpose of this form is to capture information pertaining to client belongings at time of entry to program. Generally, this is a program level decision for residential treatment programs.
RULES	• Each agency may use their program's form. • Scan document in "Personal Inventory" category • For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date the client inventory form was completed. 2. Select if the inventory form was scanned. 3. Enter the date the inventory form was scanned

PRN AUTHORITY LETTER

LOCATION	CWS →CLINICIAN MENU →PRN AUTHORITY LETTER
PURPOSE	This is a program-level physician order form. This form shall be completed by program physician when deemed appropriate to allow PRN of a medication(s). This form is generally used in residential treatment programs.
RULES	• This form shall be completed by program physician. • Scan these questionnaires into the "PRN Orders" category. • For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date the PRN letter was completed. 2. Select if the letter was scanned. 3. Enter the date the letter was scanned

CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD

LOCATION	CWS →CLINICIAN MENU →CENTRALLY STORED MEDICATION AND DESTRUCTION RECORD
PURPOSE	This form is used by programs who store medications
RULES	• Scan these documents in the "Program Specific Documentation." • For directions on scanning see: Document Capture
STEPS	Select the client. 1. Enter the date the log was completed. 2. Select if the log was scanned. 3. Enter the date the log was scanned

RESOURCES

Information and updates are located on the following Monterey Count Behavioral Health Quality Improvement website pages:

User Guides: https://www.countyofmonterey.gov/government/departments-a-h/health/behavioral-health/quality-improvement/user-guides

Substance Use Disorders (SUD): https://www.countyofmonterey.gov/government/departments-a-h/health/behavioral-health/quality-improvement/contract-providers/substance-use-disorder-sud

For questions or comments contact 415-SUD@countyofmonterey.gov

For password issues, please contact (831) 755-4545 from 8 AM to 5 PM Monday – Friday, excluding holidays.