Avatar – Therapist			
Time	**Topic/Workflow & Objectives**	**Subtopics and Training Points**	**Notes & Domain Specifics**
	Introduction & Class Rules	**General Housekeeping Rules** • No food or drink • Muting of cell phones • No use of portable devices during class • Sign-in so you get credit for your efforts. • Return promptly from breaks • Parking Lot ▪ Questions without definitive answers will be placed in the parking lot **Acknowledgement** • Extreme appreciation and understanding of: ▪ difficulty of this task ▪ contribution you are making **Instruct participants to take actions only on patients provided for training.** • Practice patients will be provided after training	
	Dragon	**Dragon Dictation**	
	Navigation	• How to log into MYAVATAR • Username is the same as your NTID • Home Screen ▪ Widgets – Icons – “Hover to Discover” ▪ Clients – Search – Recent – My Clients ▪ Forms and Data – Accessing; Search, Browse ▪ Calendars ▪ My To Do’s	

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		▪ Keyboard Shortcuts – ‘alt” key • My Views ▪ Home View ▪ Orders Console ▪ EMAR ▪ Chart View • Chart view ▪ Demographic Bar ▪ Program/Episode ▪ Sections of Chart – List of forms – How to access a form – Icons – How to add a form to the chart – Inquiry View – Filters – Print	
	Concepts of Form	• Basic Concepts of Forms ▪ Sections ▪ Icons – Hover to Discover Hyperlinks to Additional Forms ▪ Required Fields – Red – Multi-iteration table • Only required if you select Add New Item • Allows multiple entries in list format ▪ Radio Buttons	

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		– One entry – F5 will erase selection ▪ Date/Time Fields ▪ Question Logic – Enables or disables (grayed out) documentation based on answers/documentation ▪ Multi-iteration Table – Documentation of multiple entries in list format ▪ Light Bulbs – Hints to ask – What to document ▪ Drop Downs – One entry ▪ Search Bar – Can enter numbers or text – ICD Codes ▪ Text Editor – Spell check ▪ Text Box – Enter 8 pages of information – Copy paste from Word – Dragon Dictation ▪ Zooming Change size of font in forms	
	Pre-Admit Addendum (OP)	• Central Intake completes From and submits as draft • Therapist reviews/edits • Final/Submit	**Woman's Health Workflow** Screen BPS MSE DX Treatment Care Plan Pre Admit Addendum

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	Diagnosis	• How to view DX
		• How to access form
		• Episode/Program
		• Type of Diagnosis
		  ▪ Admission
		    – Date defaults to Day of Admission
		  ▪ Discharge
		  ▪ Update
		• Add New Row to Enter
		  ▪ Search Diagnosis
		  ▪ Status
		  ▪ Diagnosing Practitioner
		  ▪ Bill Order Ranking
		    – determines which diagnoses are attached to services first
		    – For SUD services, make first diagnosis a substance use disorder
		    – For Mental Health services, make first diagnosis a mental health diagnosis.	

	Release of Information	• Completed anytime you need to speak to someone other than the client
		• Sections
		  ▪ Red/Required
		  ▪ Purpose of Disclosure
		  ▪ System Template
		    – Effective Date of Authorization and Revocation
		    – Patient Rights and other Important Information
		    – Verbal Release of Mental Health Info
		• Client/Witness Signature
			ROI is separate from consents

	Managed Care Auth Form	• Obtain authorization • Handout provided by PM	

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	Calendars	• My calendar ▪ Displays scheduled patients ▪ Arrows page previous or next day • Scheduling Calendar Form ▪ How to access your clients to document individual and groups that are scheduled. ▪ Filters – Site – Team – Provider – View · Day · Week · Month – Calendar – Find Existing Appointments – Refresh ▪ Right click for actions – Group Note – Individual Note	
	Group Notes and Routing	• Group Note ▪ Access from Scheduling Calendar ▪ Right click for action - Group Note ▪ Start with begin Group Note (2nd section) ▪ Document – Date of Group – Practitioner – Progress Note For – Existing Appointment – User to Send Scratch Note To-Do Item To; Defaults to You – Note Type · Group Note – Note Addresses Which Existing	

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		Service/Appointment ***Note: You must select the appropriate "Service/Appointment." Do Not just select the first "Service/Appointment."*** Once you select the correct "Service/Appointment" the clients checked in for this group will display under "Client Who Attended Group." If the client did not attend group you can uncheck the check preceding their name. – Note · Document the Group i.e.; Community or Specific Lecture. · ***Note: You will individualize the note to the patient in group later.*** Notice the Service Program, Service Charge Code and Time Default in. This is pulled from the schedule. This also affects billing. ▪ File Note ▪ Submit Go To My To Do's Widget on the Home Screen. Locate the Group Note. ***Note: Do Not check Review To Do Item for Group Note. Click on the Group Note.*** • Click Group Note • Navigate Group Progress Note Section ***Note: The fields you completed in the group note default.***	

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		• Note Field ▪ This is where you can individualize the note ▪ Nursing Care Plan/Treatment Care Plan can be pulled into Note • Final • File Note • Document Routing ▪ Proof read ▪ Accept – File as Final ▪ Accept and Route – Send to Supervisors/Approvers ▪ Reject – Return to draft status for additional editing • Trauma Group Note (IP Only) • ***Completed through the scheduling calendar the same way a Group Note is completed only the Note Type is Trauma Group Note***	
	Comprehensive Biopsychosocial Assessment	• How to open • Multi-contributor form • Program/Episode • "Add" to pull information forward from Admissions and Nursing ▪ Review accuracy prior to signing • Sections ▪ Trauma ▪ Related Trauma ▪ Grief Loss ▪ Psychosocial ▪ Employment Military ▪ Legal	

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		▪ Financials ▪ Living/Social ▪ Woman's Health – Living ▪ Woman's Health – Loss ▪ Goals/Strengths ▪ Narrative/Summary ▪ Others as deemed necessary • Review concepts of form ▪ Hyperlinks ▪ Question Logic ▪ Multi Iteration Tables – Only required if "Add New Item" selected ▪ Free text boxes – Type – System Templates – Dragon Dictation ***Note: Use Client Update form to update information.***	
	BPS Review	• Red/Required ***Note: Used when a patient moves from one program to another. Ensure you have a Release of Information (ROI) signed prior if patient is moving between SUD and MH.*** **Example: Patient moving from PHP to IOP.**	
	Safety Plan	• Sections • Safety Plan ▪ Red/Required ▪ Question Logic ▪ Lightbulb- how to answer the ? Participants	

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	Screen	• Documentation calculates score • Enter "0" to tally ▪ GAD7 ▪ Edinburgh ▪ ACE	
	Mental Status Exam (MSE)	• Complete as directed by policy for user/facility • Radio Button ▪ One entry ▪ F5 to erase • Checkboxes Multi-select	
	Treatment Care Plan	• Red/Required ▪ Plan Date ▪ Plan Type ▪ Treatment Plan Status – Draft ▪ Launch Plan ***Note: You Must put Plan in "Draft" to Launch Plan*** • Library – Open all components below ▪ Detox ▪ Mental Health ▪ Nursing ▪ Substance Abuse ***Note: To Add a Problem from the library You Must drag and drop to top line of Treatment Care Plan on right side from the library on the left side.*** ***The Library contains defaulted problems, goals, and objectives. To use a defaulted goal or objective drag the goal or objective to the problem line.*** • Red/Required ▪ Complete all required fields for	Mirmont workflow (IP) Detox completes initial Treatment Plan Stepdown completes Comprehensive Treatment Plan w/in 72hrs Route treatment plans to Clinical Supervisor and Provider

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		each problem, goal, objective, intervention and individualize to client ▪ Problem code ▪ Date of Onset ▪ Status (Problem List) ▪ Problem ▪ Date Opened ▪ Status ***Care Plans need to be individualized to the Patient.*** To further Individualize the treatment care plan select any of the following and enter a personalized problem, goal, objective or intervention. • Add New ▪ Problem ▪ Goal ▪ New Objective ▪ New Intervention ▪ Delete Selected Item ***Nursing will no longer complete Treatment Care Plan for Detox. It will be the responsibility of the Therapist to complete*** • Free Text ▪ Strengths ▪ Limitations ▪ Discharge Planning • Patient Signature • Finalize/Submit • Document Routing ▪ Proof Read ▪ Accept and Route to Psychiatrist/Provider	

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Time	**Topic/Workflow & Objectives**	**Subtopics and Training Points**	**Notes & Domain Specifics**
		– Password ▪ Add Supervisor/Psychiatrist/Provider ▪ Submit ***Note: If you do not finish the Treatment Care Plan you may submit as Draft and return to it later. To locate the draft Treatment Care Plan; Navigate to the home screen and locate "My To Do's" widget. Do Not click on Review. Click on the Treatment Care Plan.*** How to Update the Treatment Care Plan. • Chart View • Plans > Treatment Care Plan ▪ Episode/Program ▪ Add – *Alert – Do you want to default information from previously entered plan – Yes* – *Alert - Default from Previous Program – Select Program – Ok* – *Alert Enter Plan Date – Ok* – *Alert – Are you sure you want to default information from this plan?* ▪ Red/Required ▪ Launch Plan and Update ▪ Submit ▪ Route	
	Individual Notes • Scheduled • Independent • Behavioral Contract	• Individual Note ▪ Access from Scheduling Calendar ▪ Right click for action - Individual Note ▪ Red/Required ▪ Progress Note for Existing Appointment	

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		Note: You must select the appropriate "Service/Appointment." Do Not just select the first "Service/Appointment." ▪ Nursing Care Plan/Treatment Care Plan can be pulled into Note – Select Plan Version – Select Plan Items Note addresses · Select plan elements the service you provided addresses – Clear Note addresses which treatment plan item – removes text ▪ File Note ▪ Document Routing ▪ Proof read ▪ Accept – File as Final ▪ Accept and Route – Send to Supervisors/Approvers ▪ Reject – Return to draft status for additional editing ▪ Submit ***Note: If you are unable to finish your note you can put in draft and file note. It will be under your My To Do's to complete*** • Behavioral Contract ▪ Individual Note ▪ Independent Note ▪ Note Type – Behavioral Contact – Workflow to right in notes	**Behavioral Contract Workflow** **Therapist** 1. Day shift addressed by Therapist 2. Prepare Behavior Contract – meet w/client 3. Client signs contract 4. Behavioral Contract loads to safety/widget **Clinical Aide** 1. Witness inappropriate behavior 2. Huddle w/Nursing 3. Pass Down Note 4. Call AOC 5. Communicate w/client action to be taken 6. Monitor **Nursing** 1. Witness inappropriate behavior 2. Huddle w/clinical team 3. Individual Note 4. Call AOC 5. Communicate w/client action to be taken 6. Monitor

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	How to View **Allergies** **Vital Signs**	• How to open from Chart View • Sections of Chart ▪ **Other Chart Entry** – Allergies – Vital Signs ▪ **Plans** – Treatment Care Plan • Filters • Add Form Results Review from chart view – To view labs	
	POC	• Sections ▪ 12 Panel Urine Drug Test ▪ Buprenophine Urine Drug Test ▪ Fecal Occult Blood Test ▪ Urine Pregnancy ▪ Urine ChemStrip ▪ Breathalyzer	
Break			
	Internal Client Referrals (IP Only)	• Type Category – Team • Referral Type Requested ▪ Nutrition Screen ▪ Pain Management ▪ Psychiatric Evaluation ▪ Tobacco Cessation ▪ Transportation – Launches Transportation Request ▪ Trauma ▪ Medical – Nursing Focused Assessment Must also be completed • Initiate Internal Referral Process ▪ Review Referral Date – Add ▪ Complete Red/Required • Submit ▪ Routes to Team	**Psych Eval Workflow** **Clinicians** – triage patient, complete internal referral form **Reviewer** (Val) – review internal referral list Yes – prioritize. No – note why referral declined. Communicate alternative plan with referral source **Unit Secretary** – Coordinate with psychiatrist and schedule **Psychiatrist** – evaluates & documents on Psych Eval Form. Review/update Dx. Places orders. Schedules f/u prn. Updates After Care Plan and Discharge Summary Forms **Nurse** - Reviews/implements new orders

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		• Internal Referral Widget
		  ▪ Referral Displays
		• Process Internal Referral Form
		  ▪ Select type of Referral it is
		  ▪ Only see referrals assigned to you
		  ▪ Click on person – read and accept and process internal referral
		  ▪ Removes client from Internal Referral Widget
		  Referral Approved or need additional information you will get a To Do on My To Do List
		• Inpatient waitlist Form
		  ▪ Need to be seen – not a priority for today	

	Aftercare Plan	• Aftercare Plan is Multi-contributor
		• Therapist completes Sections
		  ▪ Follow up Treatment
		  ▪ Aftercare Support Group/Referrals
		  ▪ Signature
		• Provider completes
		  ▪ Special Instructions
		  ▪ Follow up Treatment Psych Services
		• Nursing completes
		  ▪ MAT
		  ▪ Reviews Special Instructions
		  ▪ Signature
		  ▪ Provide Copy to Client	

	Discharge Summary	• Select Episode/Program • Review Discharge Summary completed by Provider • Complete Therapist Discharge Summary • Red/Required ▪ Summary Date	

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		▪ Discharge Type ▪ Discharge Reason ▪ Note Type – Discharge Note ▪ Discharge Note ▪ Final ▪ Submit • Document Routing ▪ Proof read ▪ Accept – File as Final ▪ Accept and Route – Send to Supervisors/Approvers ▪ Reject – Return to draft status for additional editing	
	PM Forms	• Bed Management (View Only) ▪ *Allows user to check which room belongs to which patient* • Official Census Management Report ▪ *Replaces old census report. Lists all patients and basic information* • Current Legal Status ▪ *Update or view information from any legal entity/person i.e. parole officer* • Detail of Admission by Program ▪ *Lists all admissions(patients) by Program for both Inpatient and Outpatient* • Client Contact Information • Mirmont Consents ▪ *SUD and MH*	