Santa Cruz County Behavior Health Avatar

Avatar Clinicians Manual

2023 Update

Introduction

The manual provides information on use of Avatar forms. Clinical information (i.e. what to write) is not specifically covered. You should consult with your supervisor or your QA department for more information about clinical content.

This manual is continually updated as changes are made to Santa Cruz Avatar. You should check back periodically for changes and updates.

In this version of the manual, new updates and information are highlighted in BLUE. See the sections on Progress Notes, Treatment Planning and the Problem Lise.

On the Santa Cruz County Health Services Avatar Information Resources Pages, you will find a copy of this document along with supporting documentation on other specialized topics such as Supervisor information and Group Progress Notes.

How to Use this Document

In the **table of contents** (next page), click on any subject and you will be taken to the appropriate page.

Or **click [crtl] + [F]** to search this document. (This works on any page on the Internet.)

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Logging In to Avatar

1) **Open the Link to Avatar on your computer desktop.**

   If you don't have a link, enter the web address into your browser directly.

   > For the LIVE environment, it is https://santacruz.netsmartcloud.com.

   > For the UAT environment (our testing and training environment) it is https://santacruzuat.netsmartcloud.com.

   > UAT Login Troubleshooting: See Appendix I at the end of this document.

   > **UAT VS. LIVE**
   >
   > Santa Cruz County Avatar has two completely separate systems. The UAT system is for training and testing. The LIVE system is used in the course of your work for entering actual PIC information.
   >
   > If you have gone to an Avatar training, you likely logged into UAT, and not LIVE.
   >
   > If you are having trouble logging in, make sure you are trying to log into the correct system. Your desktop link, system code and password will be different each system.

2) Click **Start Avatar**.

3) **IF AVATAR DOES NOT LAUNCH,** see the section titled **Java Errors and Problems Logging In** for more information.

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4) **The sign in popup should load.**
5) Enter your **System Code** (ALL CAPS).
6) Enter your **username** (all lowercase).
7) Enter your **Password** (case sensitive).
8) Click **Sign In**.

For your **first log in**, you will be given a temporary password. Once you click "Sign In" you will be immediately prompted to change your password.

Your password must be between 8 and 12 characters, have one capital letter, and one number. It *may* contain special characters (#$%&). It is recommended that you use special characters to ensure password security.

System Codes by System and Program

Agency/Program	System Code Suffix	UAT System Code	LIVE System Code
All Mental Health Programs	MH	UATMH	LIVEMH
County SUDS (Substance Use Disorder Services)	AD	UATAD	LIVEAD
Encompass SUDS	EN	UATEN	LIVEEN
Janus	JN	UATJN	LIVEJN
New Life	NL	UATNL	LIVENL
PVPSA SUDS	PV	UATPV	LIVEPV
Sobriety Works	SW	UATSW	LIVESW

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If You Forget Your Password

After five tries, Avatar will deactivate your user account and you will no longer be able to log in, even with your correct password.

If this happens, your supervisor or an IT person can either reactivate your account so you can try again, or they can set a new password for you.

If your supervisor or someone else at your agency cannot help you, contact the computer helpdesk at **x4657** or **HSA.MhCompAssist@santacruzcounty.us**

Screen Sign Out

If you need to step away from your desk, sign out. This will prevent unauthorized users from viewing information in Avatar (HIPAA).

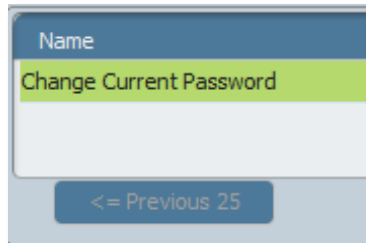**You will lose any unsaved data when you sign out, so make sure you save and close all open forms.**

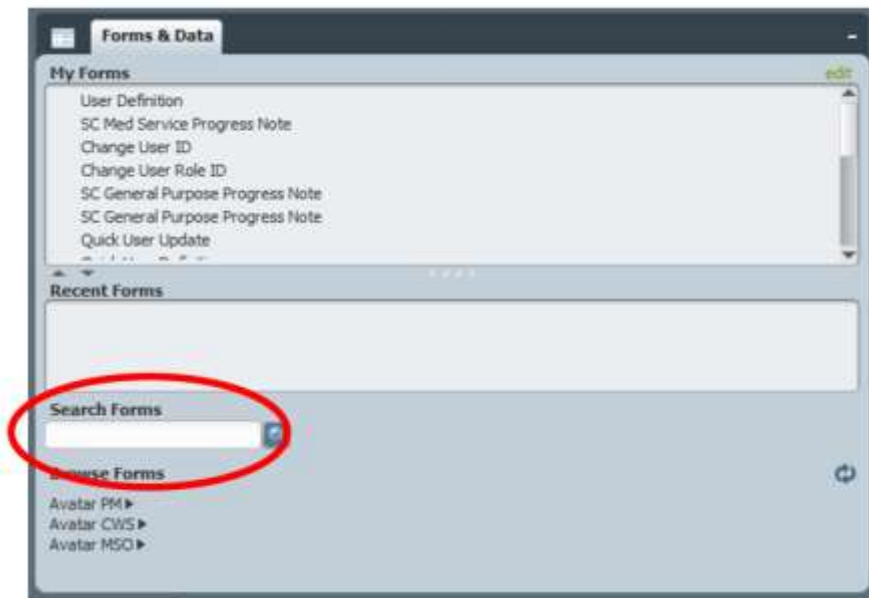*Always save when possible, to avoid losing work to any surprises such as power surges*

To Change Your Current Password

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1) Locate the Forms & Data widget on your home view.

2) Click in the Search Forms field and type Change

Current Password. Double click on the form name to open up the form.

3) In the **Current Password** field, enter your current password.

4) In the **New Password** field, enter your new password.

5) In the **Re-Enter New Password** field, enter your new password again.

6) On the left hand side of the screen, **click on the Submit Button**.

Submit Button

Throughout Avatar, you will see the Submit button on most forms (or the "File" button for progress notes). Submit = Save & Close. DO NOT click the red and white "X". If you do this, the form will close without saving your data.

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Java Errors and Problems Logging In
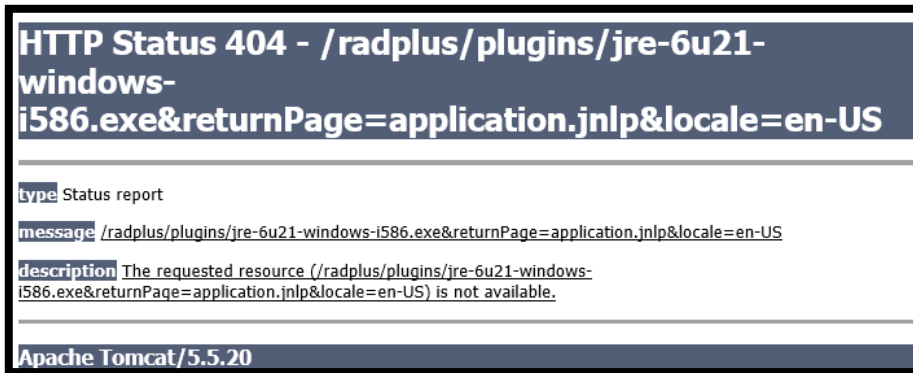
Below is information on how to troubleshoot Java errors.

Alternately, contact your IT department or the County HSA computer helpdesk at **x4657** or HSA.MhCompAssist@santacruzcounty.us

Depending on recent updates, Avatar might not run on the most recent version of Java. If your computer prompts you to update your Java, DO NOT UPDATE JAVA without checking with your supervisor or an IT person. Avatar might not run if you do this.

If you think you need to update Java anyway, consult your IT person before proceeding.

If you see the warning below, your Java may not be set up properly.

HTTP Status 404 - /radplus/plugins/jre-6u21-windows-i586.exe&returnPage=application.jnlp&locale=en-US

type Status report

message /radplus/plugins/jre-6u21-windows-i586.exe&returnPage=application.jnlp&locale=en-US

description The requested resource (/radplus/plugins/jre-6u21-windows-i586.exe&returnPage=application.jnlp&locale=en-US) is not available.

Apache Tomcat/5.5.20

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Try restarting Avatar and make sure you click "Run this time," at the Java Prompt.
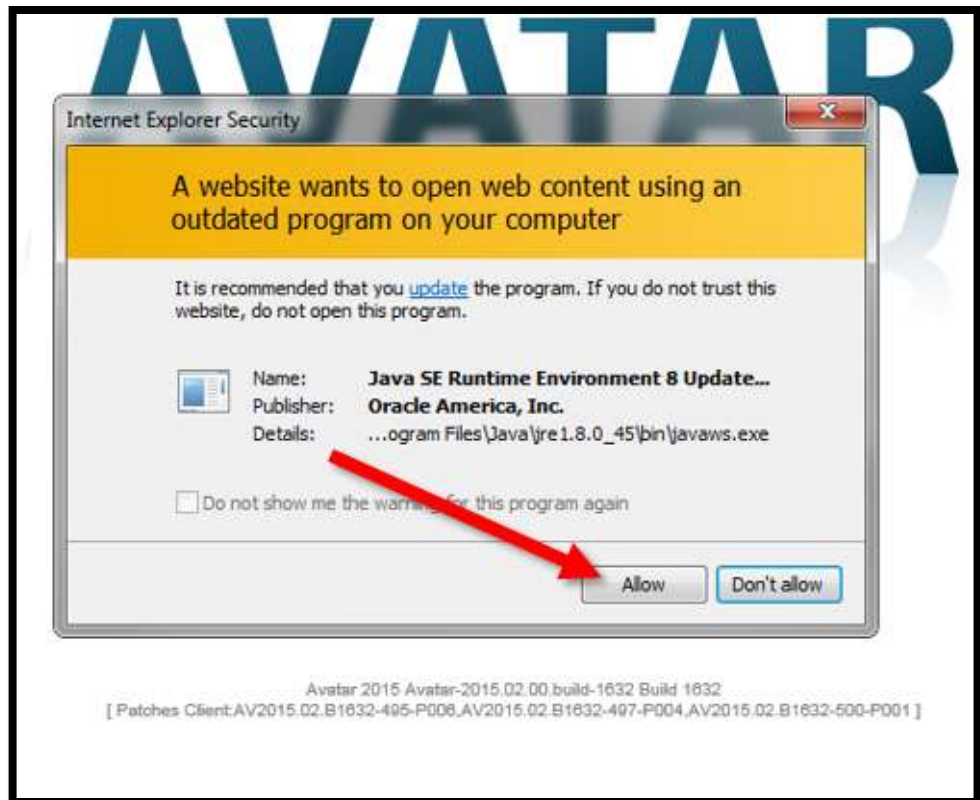
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You may see another Java Update prompt. If you do, click the checkbox where it says, "Do not ask again until the next update is available." Then click, "Later."
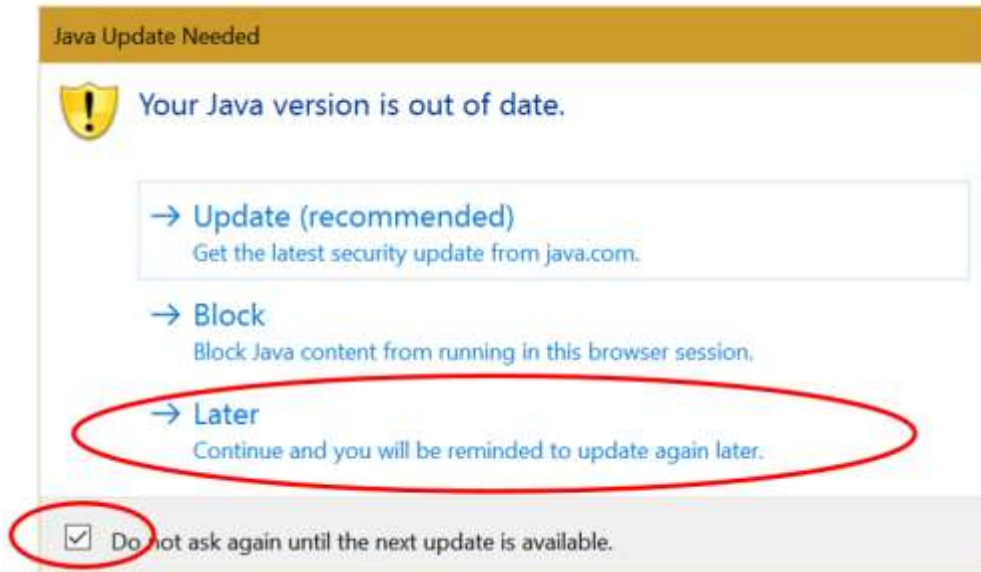

If you see the message at right, click Allow.

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If you receive the popup below, click Save and then click Open.

Do you want to open or save **application_jnlp** (8.41 KB) from **santacruzuat.netsmartcloud.com**?   Open   Save ▼   Cancel   ✕

If Avatar is telling that you need to update Java (seen usually at the login screen), you can try make these messages disappear:
1. Go to the Avatar login screen.
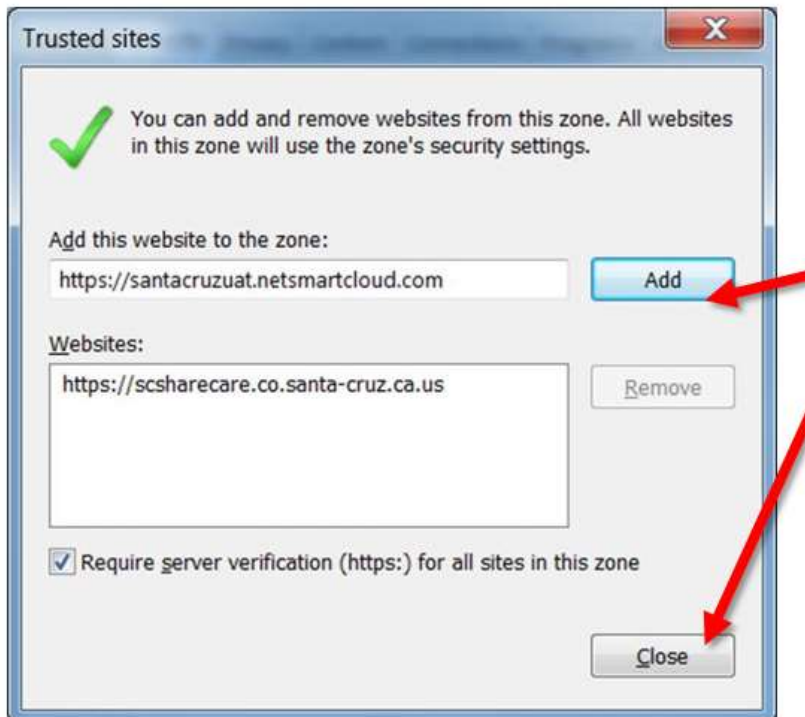2. Go to the go to Tools → Internet Options
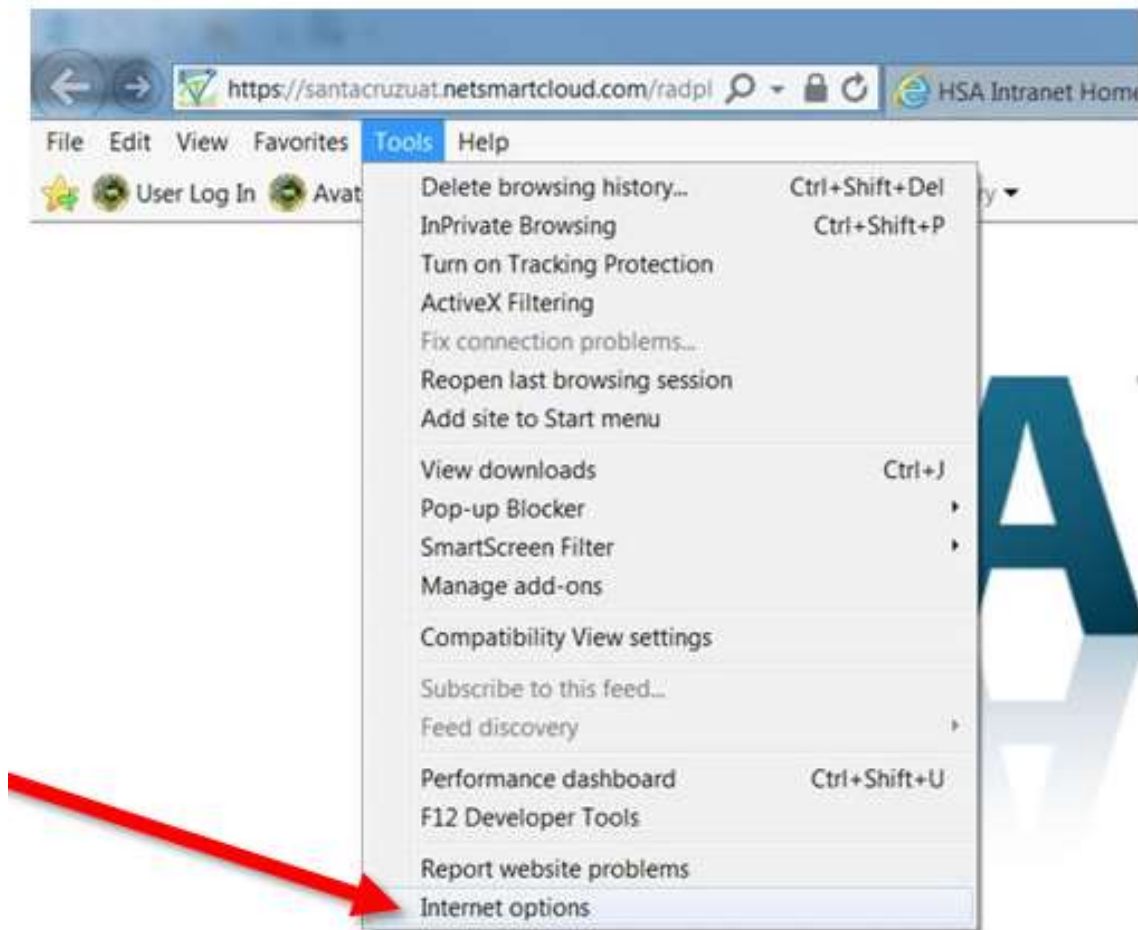
3. Click on the Security Tab → Trusted Sites → Click on Sites

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You should see the Avatar address in the window that appears (shown below is the UAT address, you may want to enter the LIVE address). Click on Add, then click Close.

If none of these steps help or if you need further assistance, contact your IT department or the computer helpdesk at **x4657** or HSA.MhCompAssist@santacruzcounty.us

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Quick Tips and Shortcuts

1) **Lightbulbs** on forms: These symbols are a link to helpful clinical information about filling in a particular question or field.

2) List Fields

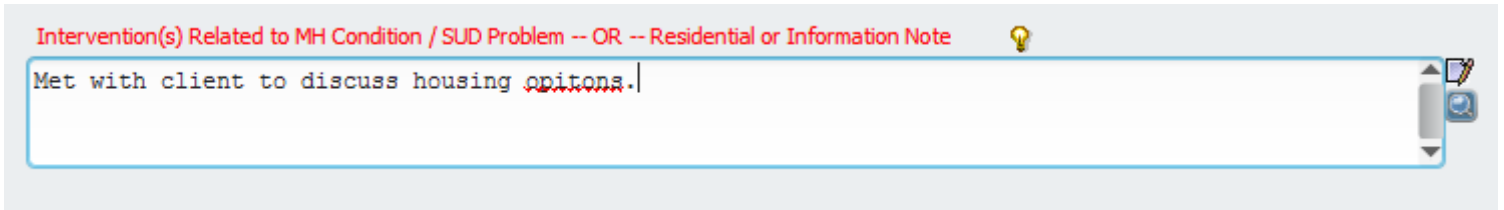   Use the **space bar** to check or uncheck a box or button in a list of items or *List Field*.

   Use the arrow keys to move back and forth between check boxes, buttons or list items in a dropdown field.

3) **To clear a radio button, checkbox, or list item** in a question (you want the question to be totally blank), **click any of the buttons in the question, then click F5 on your keyboard**, which will clear the field. If you have done this right, none of the buttons in this field will be clicked. If this is a list item type question, the question will appear blank.

4) **To auto populate a new form with Person in Care (PIC or client) data**, before selecting your PIC, on Home Console, click once on PIC name to select the PIC. Then open the form (works on many forms).

5) **Client Search**: Search by name, PIC number or DOB.

6) **Date fields**

   - Use T for today instead of entering a date.
   - Use Y for Yesterday.
   - Use math to enter a date that is a specific number of days in the future or in the past. For example, "T-30" gives you a date 30 days in the past. "T+90" gives you a date 90 days in the future. After you enter the formula, press "enter" or "tab" and Avatar will calculate the date for you.
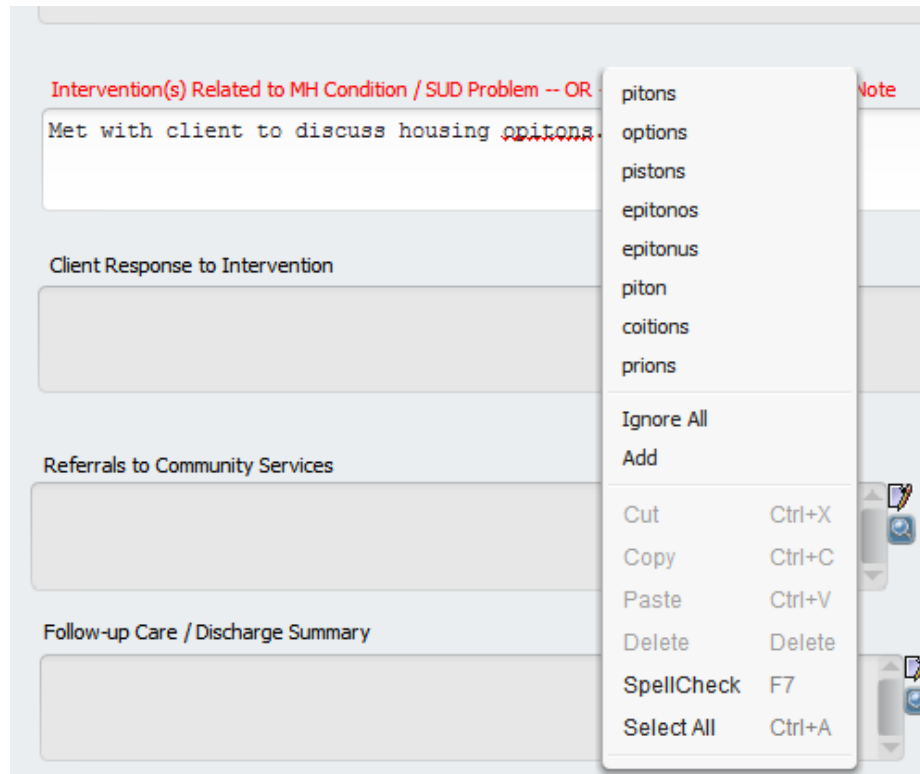
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Spell Check and Automatic Correction

Avatar has spell check that you can use in most fields. Misspelled words will have a red, wavy line underneath them.

Intervention(s) Related to MH Condition / SUD Problem -- OR -- Residential or Information Note

Met with client to discuss housing opitons.

Right-click on the misspelled word to pull up a menu of spellings. Left click on the one you want. To add a word to the dictionary, click Add.

Press F7 on your keyboard to start spell check.

Intervention(s) Related to MH Condition / SUD Problem -- OR -- Note

Met with client to discuss housing opitons.

| pitons |
| options |
| pistons |
| epitonos |
| epitonus |
| piton |
| coitions |
| prions |

Ignore All
Add

Cut	Ctrl+X
Copy	Ctrl+C
Paste	Ctrl+V
Delete	Delete
SpellCheck	F7
Select All	Ctrl+A

Client Response to Intervention

Referrals to Community Services

Follow-up Care / Discharge Summary

Create a shortcut phrase for longer words and phrases that you use regularly. This is similar to how autocorrect works in Microsoft Word. To use this feature, go to Preferences, in the upper right of your home screen. **Note: If you set this up, be sure to use codes that are not common in regular language or contained within a word, otherwise when you do your spell check you may add phrases in places you do not want them to be! Note: this will only work on the machine that**

you have set up the dictionary on. If you use a different computer, your phrases will not be there.
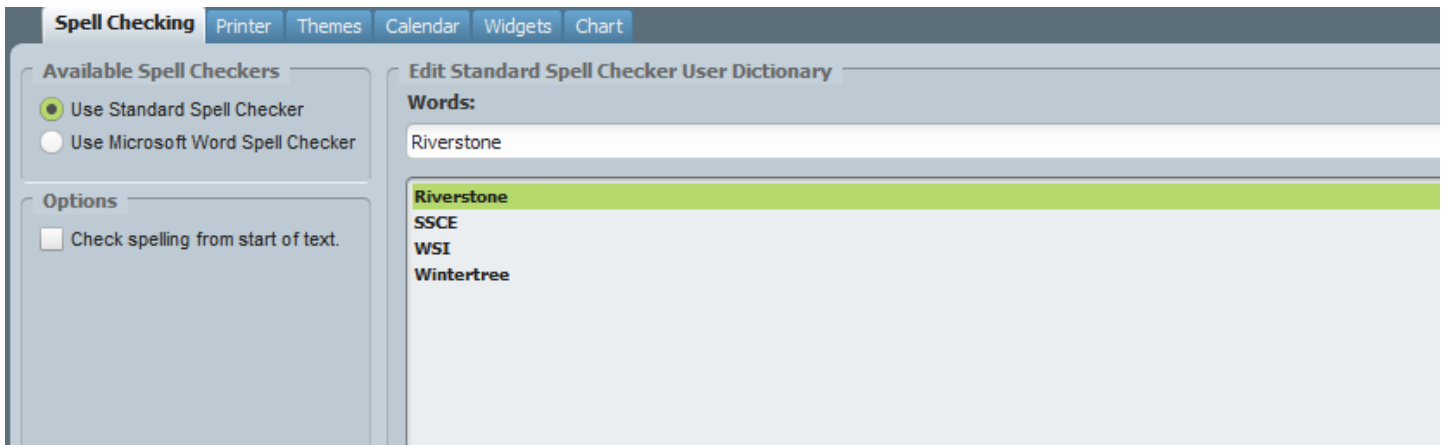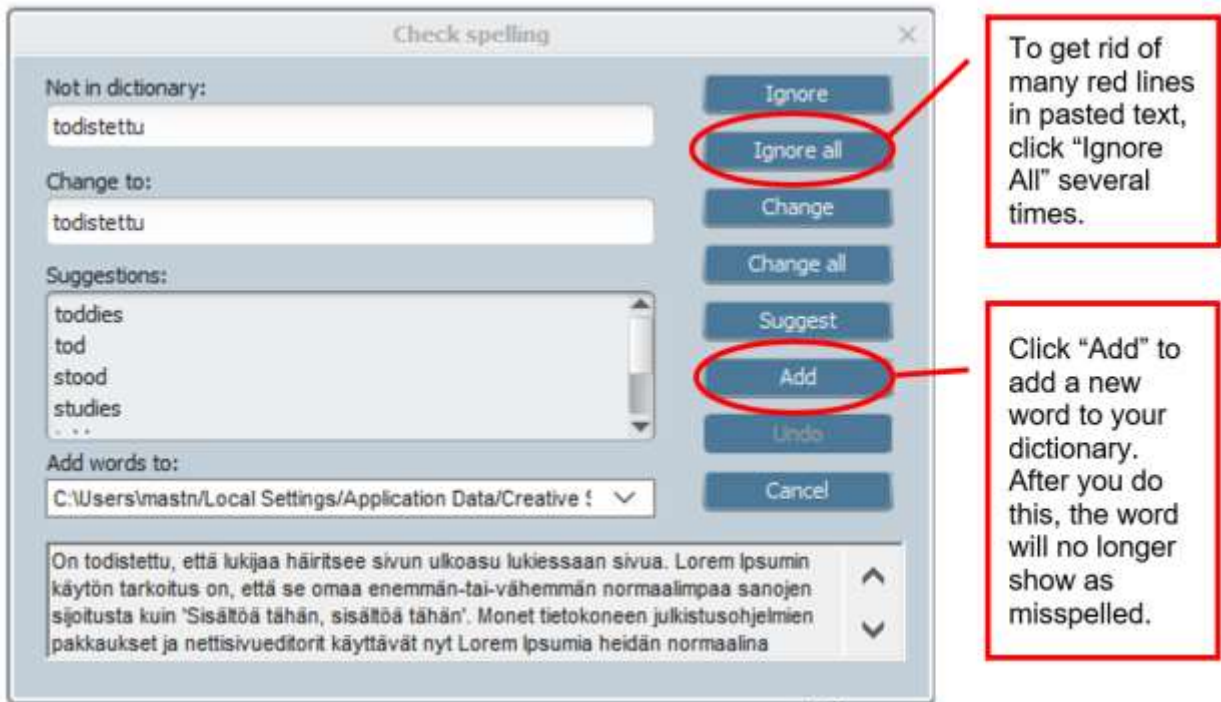

To remove spell check red, wavy underlines - There may be times when you want to cut and paste text from another document into Avatar. When you do this, you might get a lot of red wavy lines underneath your pasted text. Avatar thinks these are spelling errors.
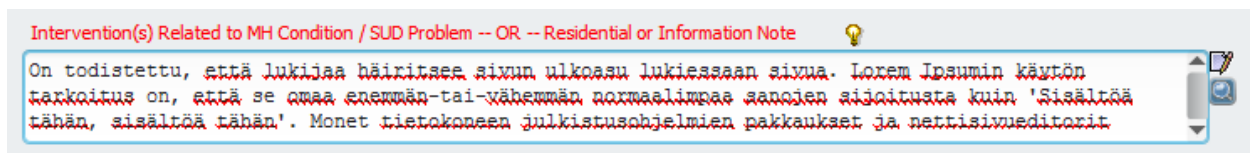

To get rid of the red lines, first, press F7 to call up spell check. Then, click "Ignore all" multiple times to get rid of the red lines.

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To get rid of many red lines in pasted text, click "Ignore All" several times.

Click "Add" to add a new word to your dictionary. After you do this, the word will no longer show as misspelled.

When you are done, a popup will appear letting you know that spell check is complete. Click OK.
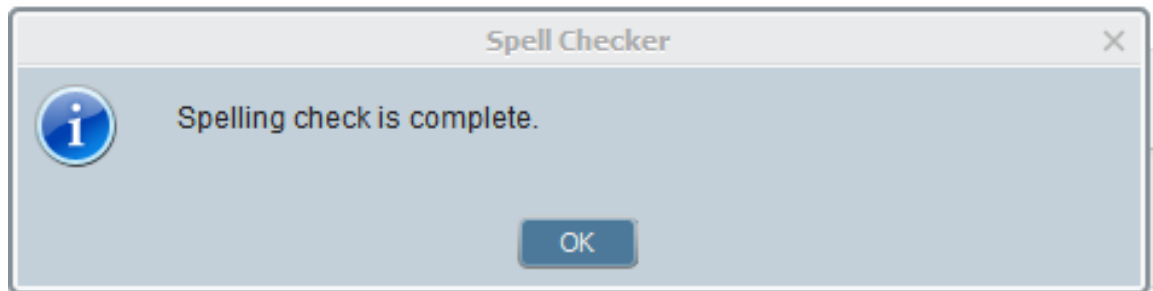
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Avatar Help and Other Resources

1. Your first source of support should be your supervisor or other Superusers at your agency or in your workgroup. A Superuser is someone who has had extra training in Avatar and may be able to help you.
2. QI email (AskQI@santacruzcounty.us)
3. Computer help desk (HSA.MhCompAssist@santacruzcounty.us)
4. Written documentation posted on the Santa Cruz County HSA Avatar Resource Pages http://www.santacruzhealth.org/hsahome/hsadivisions/behavioralhealth/avatarresources.aspx

    You can also navigate to the County Avatar website by typing in Avatar Resources into the Search Forms blank on your Forms Widget. If you click in the link, this will take you to the website.
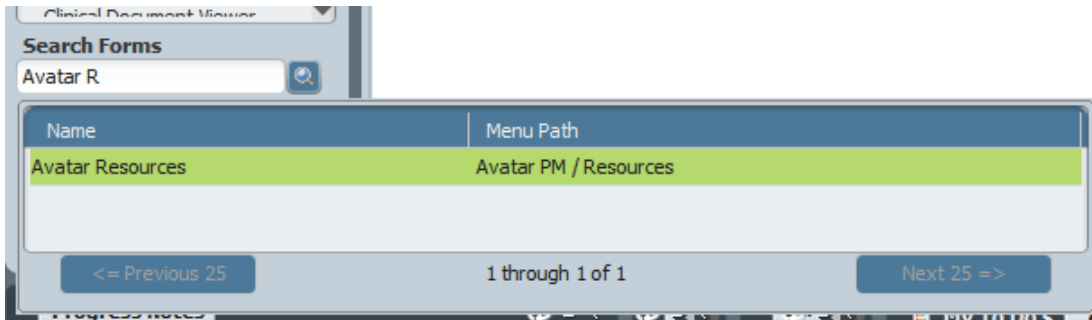
5. Avatar Training Videos

Title	Topic	YouTube Link
Avatar Diagnosis Form-Admission	Avatar Diagnosis Form-Admission	https://youtu.be/MroRNHY_KXs
Use Staff Messaging to Manage Caseload	Use of staff messaging to request that a PIC be added or removed from your caseload.	https://youtu.be/NlShR-upCAk
Avatar Diagnosis Form-Update	Avatar Diagnosis Form-Update	https://youtu.be/Esj_J_wlMwY
Avatar Med Progress Note (from blank note)	Avatar Med Progress Note (from blank note)	https://youtu.be/b8Jli3fwgUM
Signing Into Avatar	How to Sign In Plus Sign In Troubleshooting	https://youtu.be/2xg-y6MtA30

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Avatar Home View and Menu Bar

**Home View:** The first screen that appears is the *Home View*.

Widgets, rectangles with PIC information and other data are arrayed on your desktop. (See the Widgets section below for more information.)
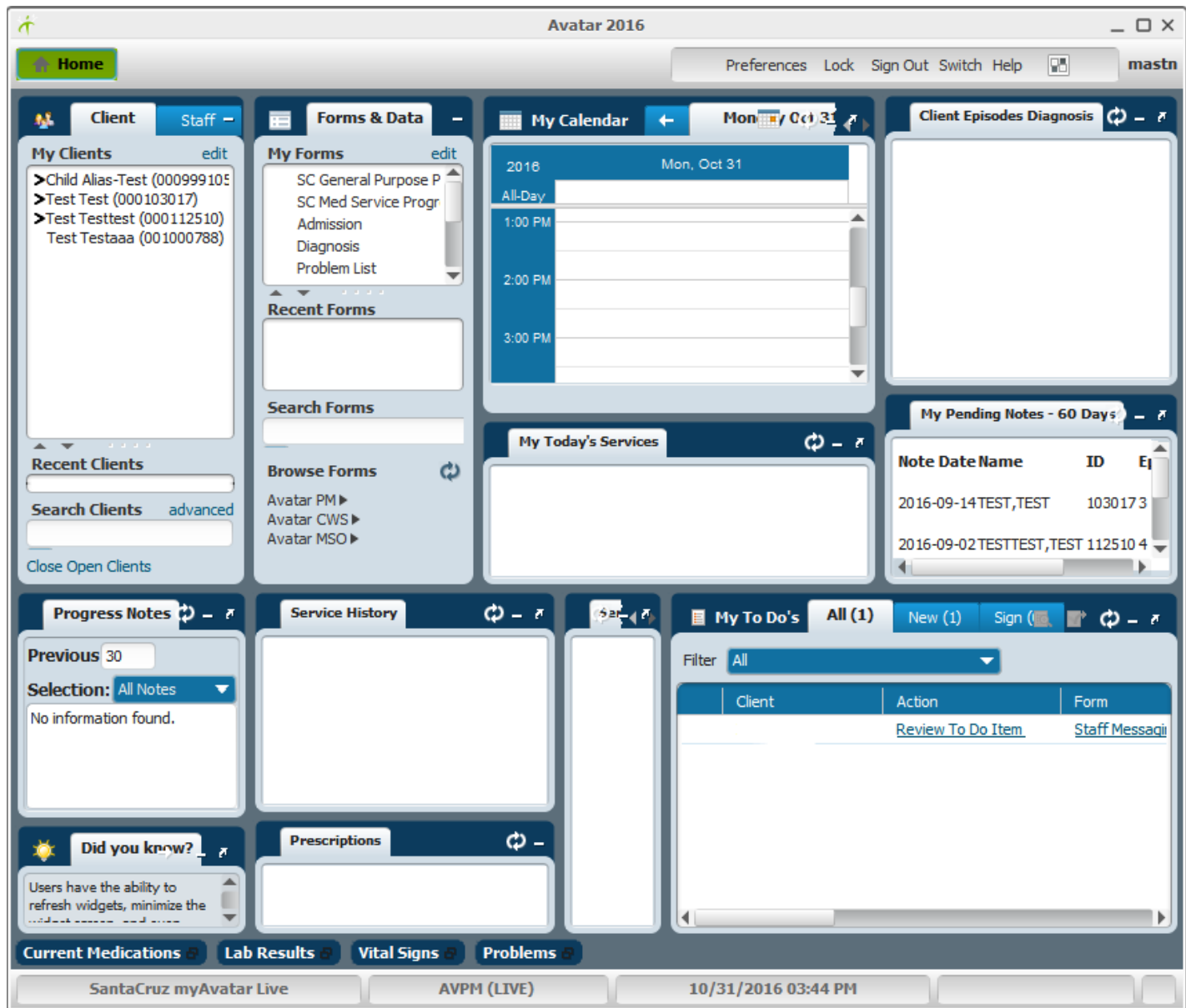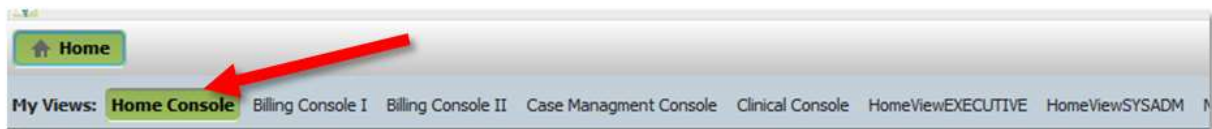
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Menu Bar: The *Menu Bar*, located at the top of the Avatar Home screen, allows you to navigate among Forms, Chart Views, and your Home view. The Menu Bar contains the **Home Button that returns you to your Home View.**

No matter where you are in Avatar, the Menu Bar displays any Forms or Charts that you have open. Click to go to the form or chart.
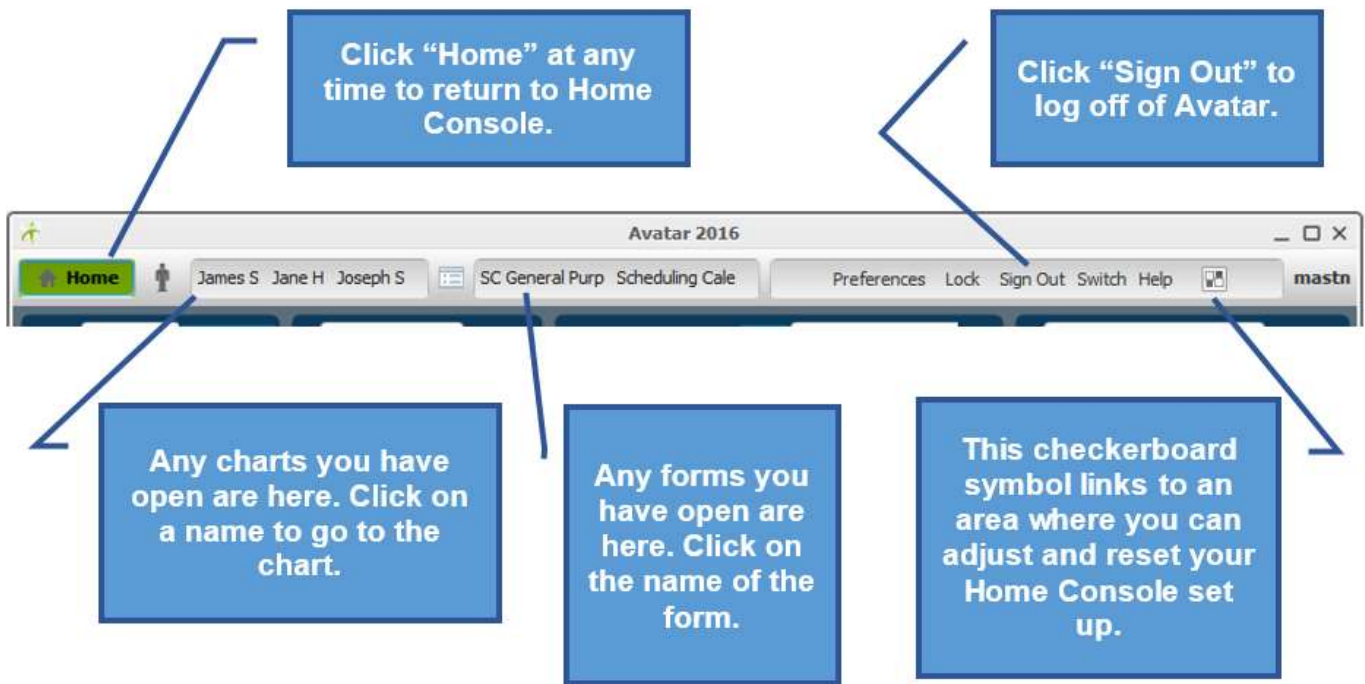
Consoles or Multiple Home Views: Depending on how your access is set up, you may have more than one view. These views are known as *Consoles* and are displayed in a row next to My Views. To switch between views, just click on the Console name. In the example, the Home Console is selected (highlighted in green).

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Widgets

Widgets are the small rectangles on your *Home View* and in the *Chart Overview*. Widgets show views of information from Avatar. Some Widgets provide handy views of commonly used information, like the Service History Widget. Other Widgets are interactive, like the My Calendar Widget and the My To Do's Widget.

One way to think of a Widget is like a window or door in a house. If you look through the window, you can see into the house, although you cannot interact with anyone in the house. Some Widgets work like this. You can view information, but you cannot interact with it. Other Widgets are like a door, where information travels in and out of the house. They allow you to have interaction with the Avatar database.

The Widgets you see may vary depending on your Avatar setup.

Widget Features and Changing Your Widget Setup

Enlarge and Shrink Widgets

Make widgets larger or smaller by clicking and dragging on the edges. Hover your cursor over the line between two widgets until the cursor turns into a double sided arrow.

Then click and drag to resize.

Turn a Widget into a Toggle Button at the Bottom of Your Home Console

There are some widgets that you may not need to see most of the time. You can change them into a button at the bottom of your home screen to make space for the widgets you most commonly use and reduce visual clutter.

Once you do this, you can click the button to see widget contents. Click it again to close it.
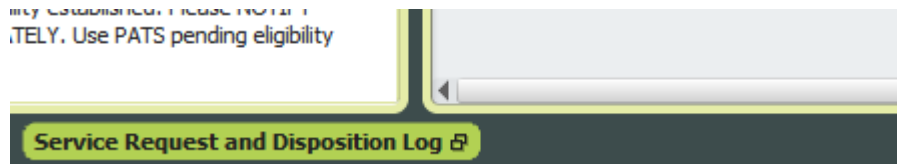
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For example, you may not want to look at the contents of the Service Request and Disposition Log Widget all of the time.

To change a widget into a toggle button, click on the little minus sign in the upper right hand corner of the widget.
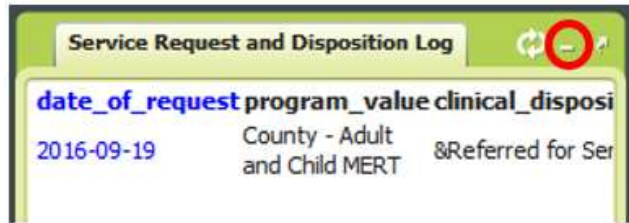
At the bottom of your Home console, see how the widget is now a rectangular button.

Click the button to open and close the widget.

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Dock and Undock Widgets

Sometimes, you might want to pop a widget out of your home console and create a separate window.

1. **Click the little curved arrow in the upper right-hand corner** of the widget.

2. **Drag with widget to center if needed.** Click on the grey bar at the top of the widget and drag.

3. **Click the square in the upper right corner of the widget to enlarge to full-screen.**

4. **Pop the widget back into your Home Console, by clicking curved arrow again.**

Use the Refresh Button to Update Data in a Widget

The Refresh Button: If you have made changes to any of the data displayed in a widget, you won't see it until you have clicked the refresh button. You will also find the refresh button in your PIC charts. If you write a progress note or fill out another type of form in Avatar, you won't be able to see it in the chart until you click the refresh button.

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How to Reset Widgets

If you have made changes to the layout of your widgets on your Home Console, or in Charts, and want to return to the default layout, do the following.

1. On your Home Console, click on the little **checkerboard icon** (upper right on Home).
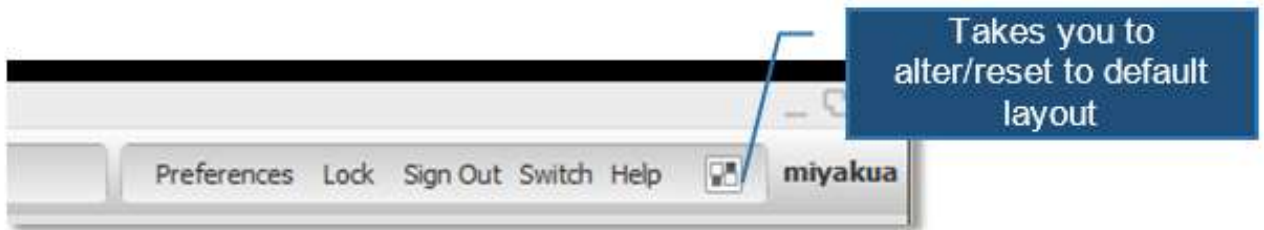
2. Click **Reload Home View** and then **Apply** to restore the widgets to their default layout.
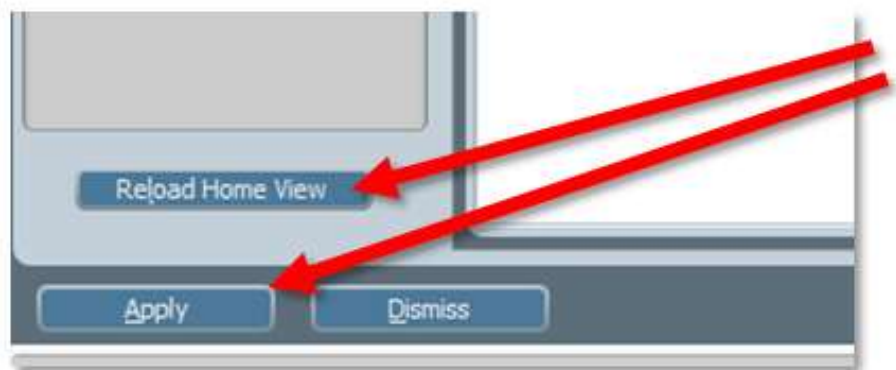
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Forms & Data Widget

This Widget allows you to access forms in Avatar. There are several ways to search for forms using this Widget.

My Forms: Here, you will see a list of forms that have been assigned to you, based on your *Role*. This is a list of forms that you will likely use *most often*, but it does not include all forms you can use. See below for information on how to add a form to this list using the Edit feature.

Recent Forms: If you have recently opened a form, it will appear in Recent Forms.

Browse Forms: Click on Browse Forms to see a list of forms sorted by categories. Search for clinical forms in "Avatar CWS."

Search Forms: You can also use the Search Forms box to find forms. Once you start typing, the matching forms will display dynamically.
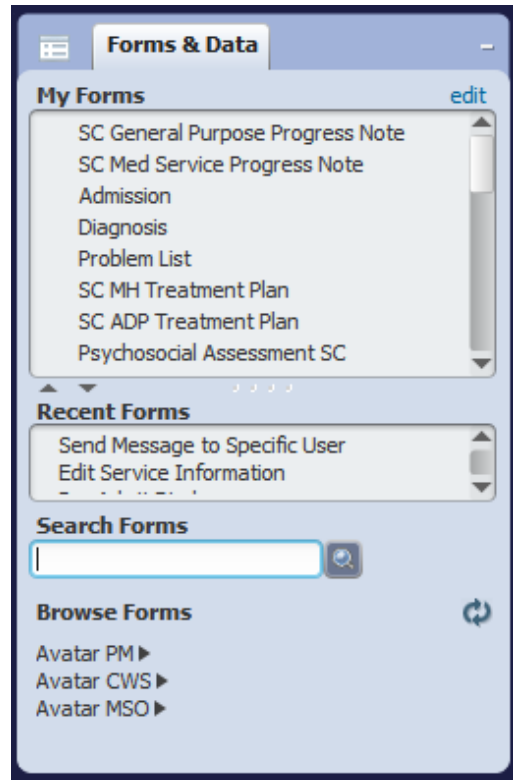
If there is a form that you think you should have access to, but you cannot find it, there may be something that needs to be changed in your setup. If you think that your setup needs to be changed, contact the computer helpdesk at **x4657** or **HSA.MhCompAssist@santacruzcounty.us**
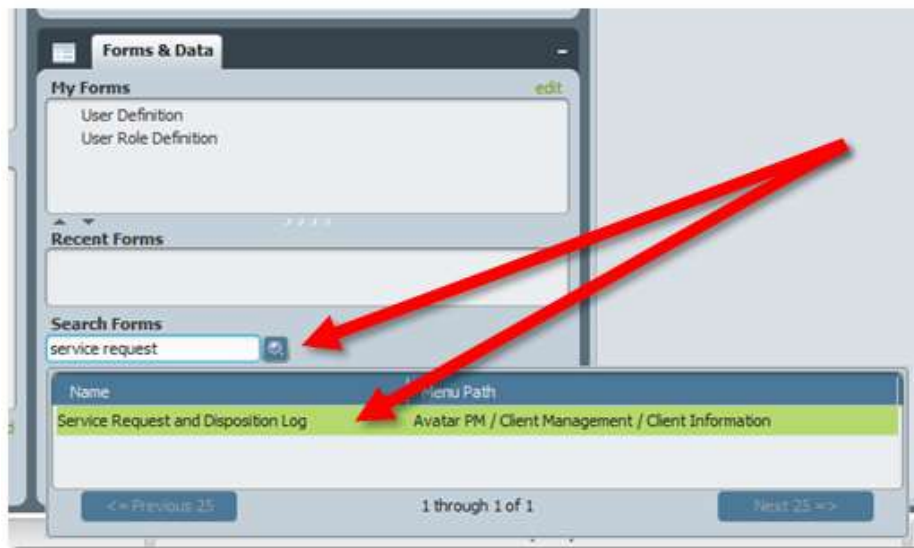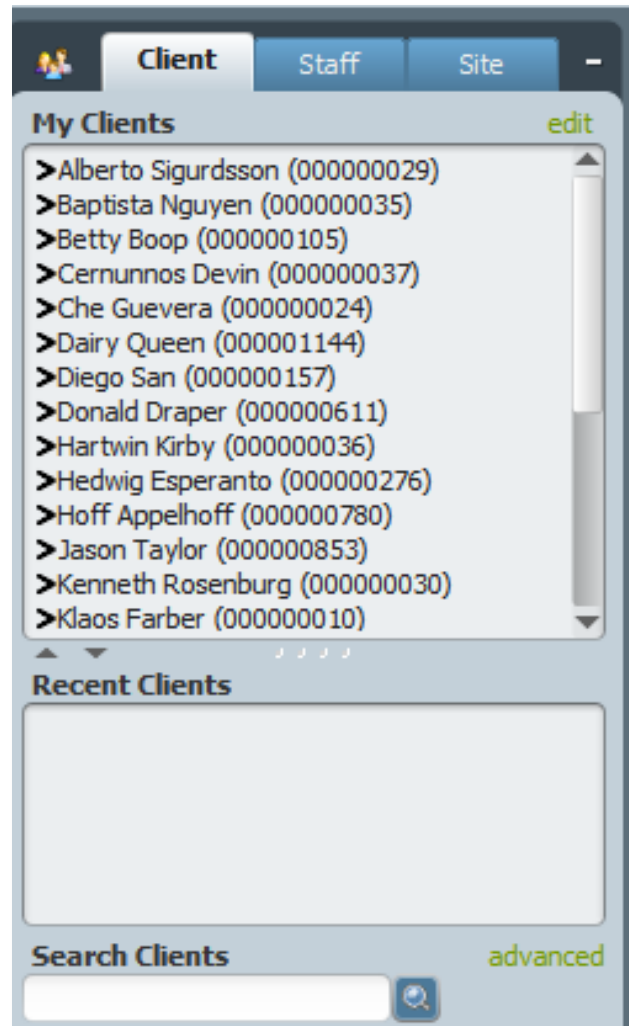
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Adding Forms to My Forms: There are two ways to add a form to your My Forms list.

1. Click and drag a form from Recent Forms up to the My Forms section.

2. Click on Edit, located in the upper right of the widget.
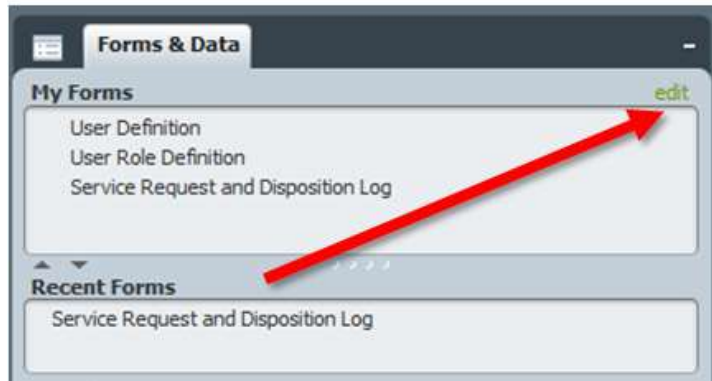
   This will open a new window. Type in the name of the form that you wish to add, then click on Add Form.
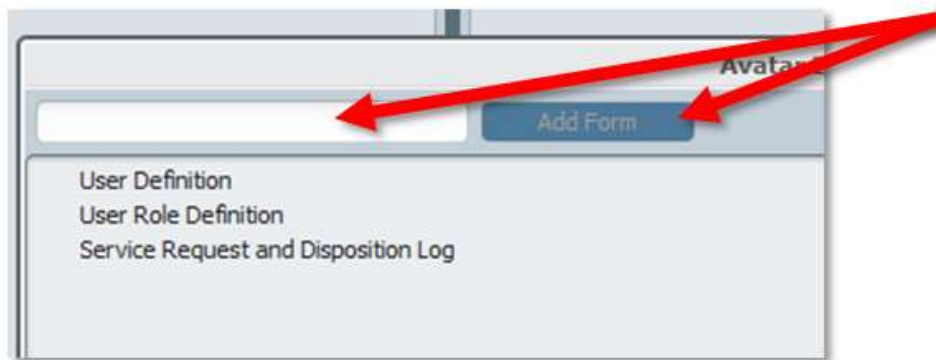
While in this window, you can also right click anywhere and add folders to organize your forms. Once you Right Click in the window, click Add Folder.

If there is a form that you think you should have access to, but you cannot find it

There may be something that needs to be changed in your setup. If you think that your setup needs to be changed, contact the computer helpdesk at **x4657** or **HSA.MhCompAssist@santacruzcounty.us**

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My Clients Widget

This Widget contains your caseload, charts you have recently opened, and a search field for PICs. This widget functions similarly to the Forms & Data Widget, with sections and links allowing different types of searches.

My Clients: The PICs assigned to you in the "My PICs" section.

Recent Clients: PICs whose charts you have viewed during your current Avatar session. If you log out and log back in, PIC's in this window will disappear. PICs in Recent PICs can be any PICs that you have recently looked at whether or not they are on your caseload.

Search Clients: Type in the last name or first name of your PIC to search. You will get a list of potential matches. Double click on the PIC name to open the chart.

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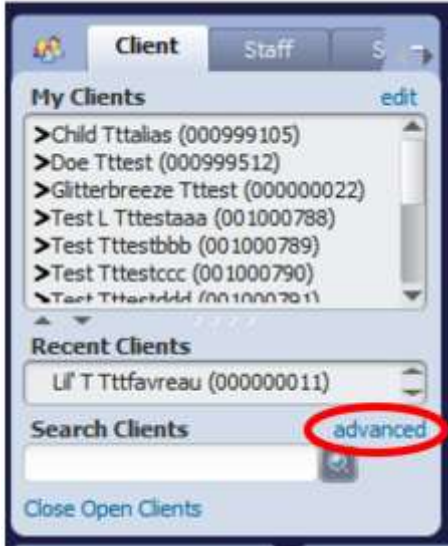
Advanced Search: Click on "advanced" to open up a window that allows a more targeted search for a PIC.

You must **enter at least three pieces of information to search** (for example, last name, first name and date of birth).
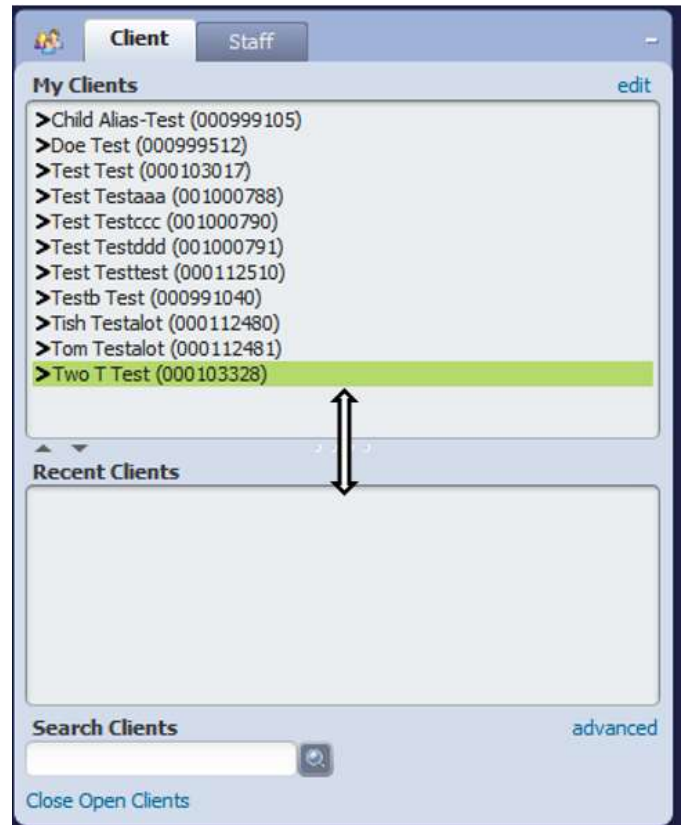
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I can't find my Recent Clients
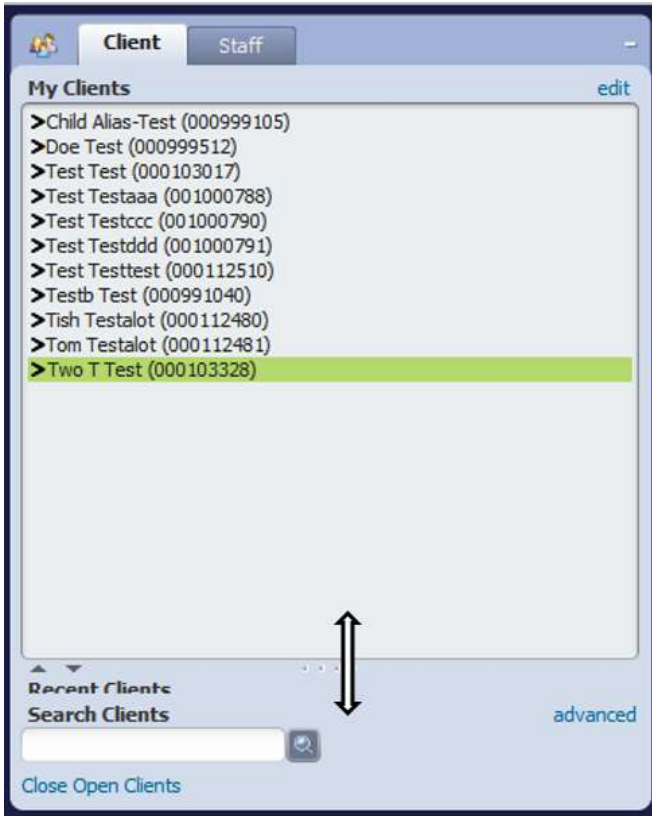
When you open Avatar, you might see something like this, where your recent clients area appears to be missing.

If this is the case, hover your cursor over the area between the Recent Clients section of the widget and the My Clients section of the widget. Then, click and drag to expand the Recent PICs section.

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Non-Caseload Access Warning Popup

If a PIC is not on your caseload, when you search for the PIC or open up the chart, you will get a warning that says that the PIC is not on your caseload.
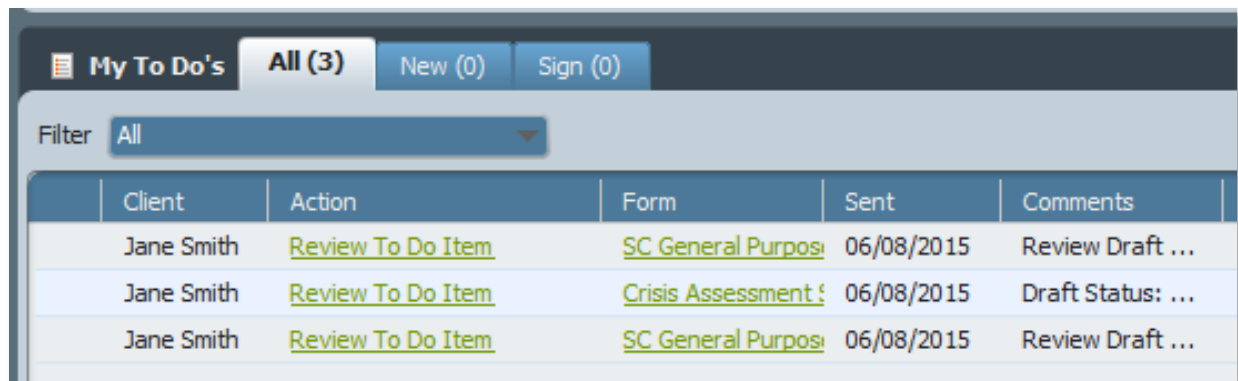
Click, "Yes," and then enter the reason why you need to look at the chart. To stop this warning,

have the PIC added to your caseload. See the section titled, "Caseload Assignment Request Instructions."
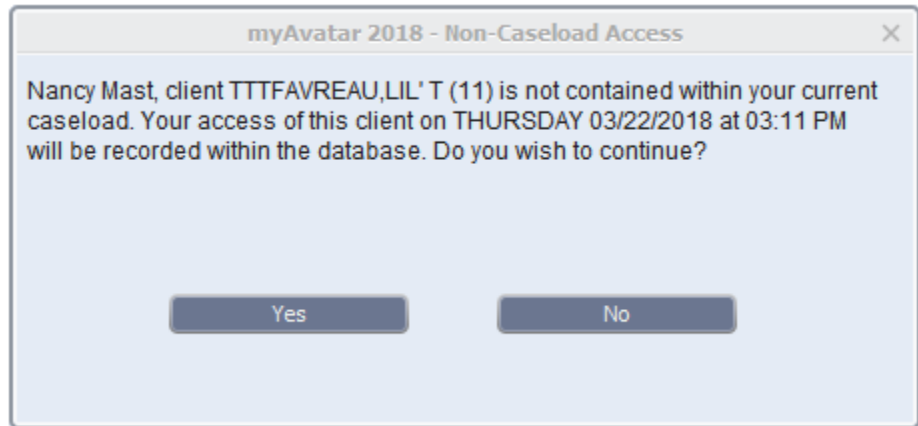
Some people might have these popups turned off. This is typically done for people who don't have a typica longstanding caseload or who work somewhere with a high client turnover such as Crisis Stabilization. Clinical supervisors who co-sign progress notes and other documentation also have this turned off. Contact askqi@santacruzcountyca.us for more information.

The My To Do's Widget

Your My To Do's will show you forms that are saved in draft mode (i.e. documents that you need to complete) and messages from other staff. Most items, except for simple messages, are associated with a task that you need to complete. You must complete the task, such as completing a draft progress note, in order for the item to go away. See the section on Staff Messaging for more information.

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My Calendar Widget

<mark>Please Note: My Calendar Widget is NOT the Scheduling Calendar.</mark>

See the Scheduling Calendar Section for more information.

The My Calendar Widget shows your daily schedule from the Scheduling Calendar.

Click on the arrows next to the date to move one day ahead or back.

The My Calendar Widget allows you to directly launch a progress note from an appointment. The Progress Note will be prepopulated with all of the appointment information, such as the PIC name, the date of the appointment and the service code.
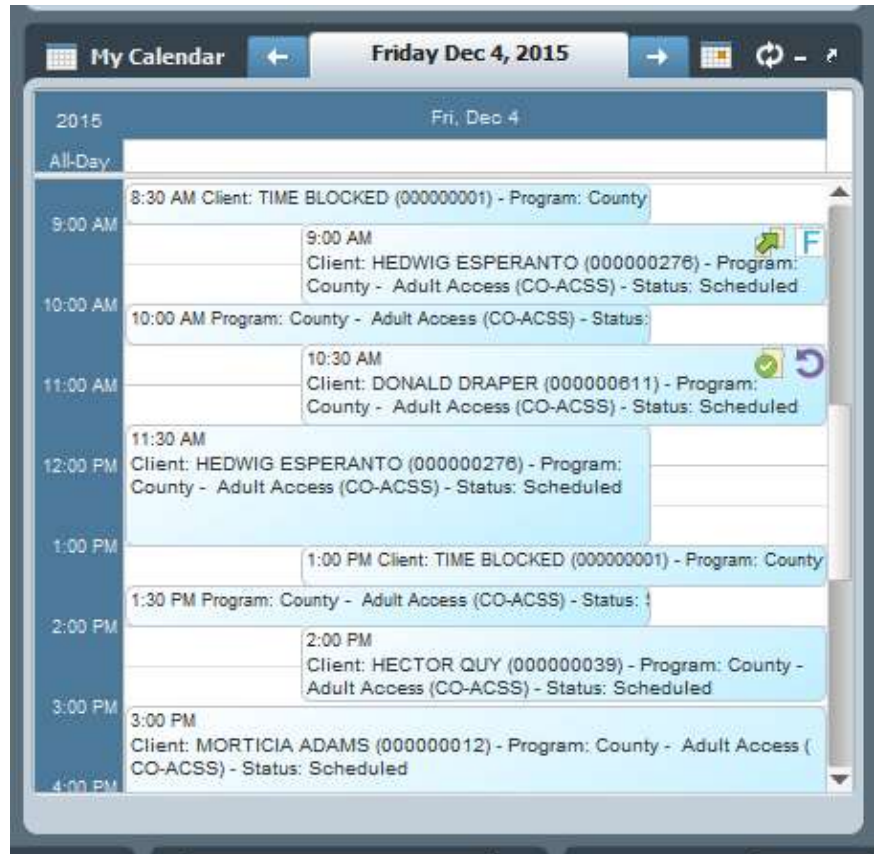
Service Request and Disposition Log Widget

This widget shows entries from the Service Request and Disposition Log, which is a call log for noting requests for services and other contacts with PICs who are not yet enrolled in services.

To use the widget:

1) Select a PIC in the Client Widget. Do not open the chart.
2) Once you select a PIC, the widget will show you links to all the log entries for a single PIC.
3) In the widget, click the date (in blue) to open a call log.

   See the Service Request and Disposition Log (SRDL) section for more information.

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Service History Widget

This widget is on your *Home Console.* It is a quick view of recent services that you can conveniently access without having to open the PIC's chart. Note that a PIC <u>must</u> be selected (highlighted in green) in order to view the information in the Widget. Click *once* to highlight a PIC in your My Clients Widget (clicking twice will launch the chart, which you don't want to do with this case). A PIC must have already had some services, or the widget will be blank.

Date	Status	Start Time	End Time	Staff Name	Program	Service Code	Duration	Cost	Location
06-21-2015	No Entry			MAST,NANCY	County - Adult Access	M431	290	0	51-Inpatient Psychiatric Facility
06-16-2015	No Entry			MAST,NANCY	County - Adult Access	M471	100	0	Office
06-02-2015	No Entry			MAST,NANCY	County - Adult Access	M401	30	0	Office
06-01-2015	No Entry			MAST,NANCY	County - Adult Access	M401	60	0	Office

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Progress Note Widget

This widget is in PIC charts and shows all progress notes for a PIC.

The Progress Note Widget compiles notes from most programs. All notes are shown, in order, by entry date (not service date).

There is another way to view progress notes separated Program or Episode and can be filtered in a variety of ways. See the Chart View section for more information.

The default for this widget is to show the last 30 days of notes.

Expand the date range by typing in the number of days, and then pressing the ==TAB== KEY.

IMPORTANT: Remember to press tab after you type in the number of days, or you won't be able to see all of the notes you want. (Pressing "Enter" won't work.)
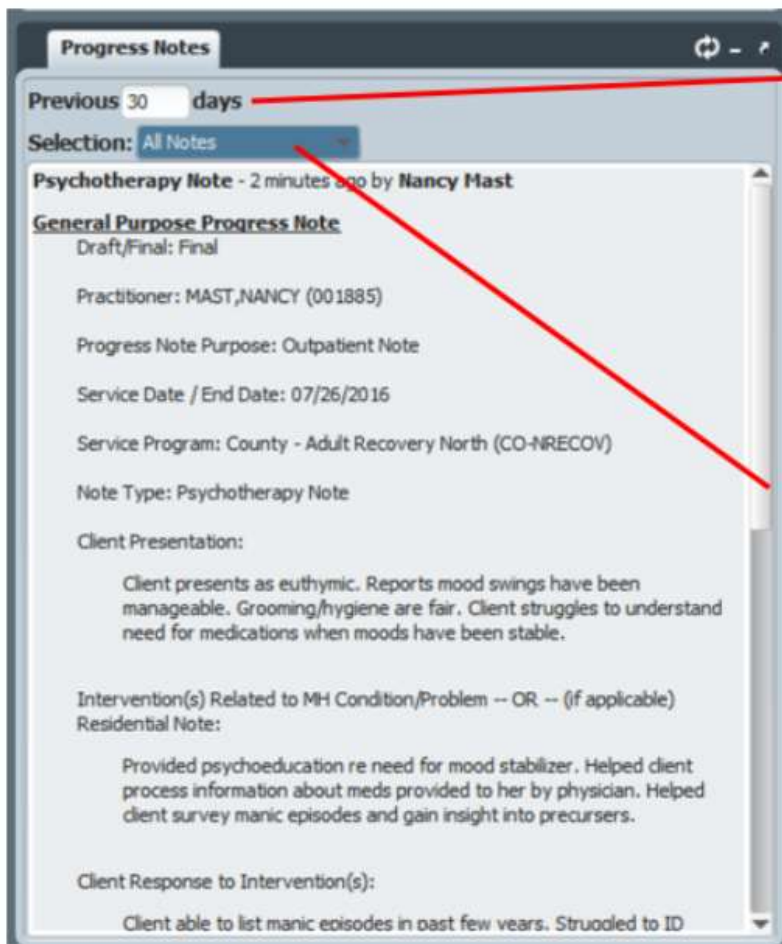
To see more notes, erase the number 30 and type in the number of days you want to view.

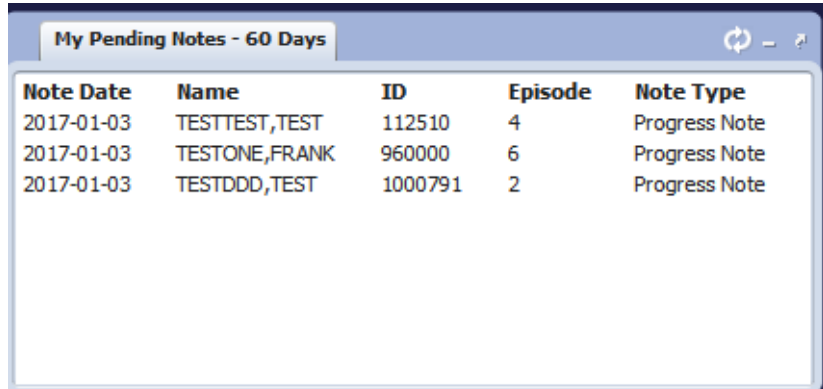Then press tab. You must press tab for this to work.

Use this drop down to filter notes.
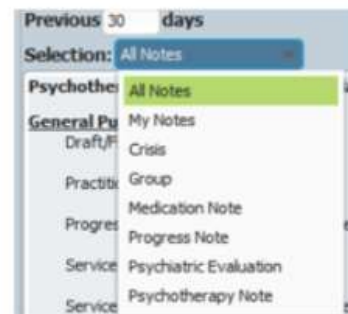
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My Pending Notes – 60 Days Widget

This widget shows you any draft notes that you still need to complete. It only shows the last 60 days of notes. Draft notes that are older than 60 days won't be here. To find these older notes, you will have to look in the PIC chart.
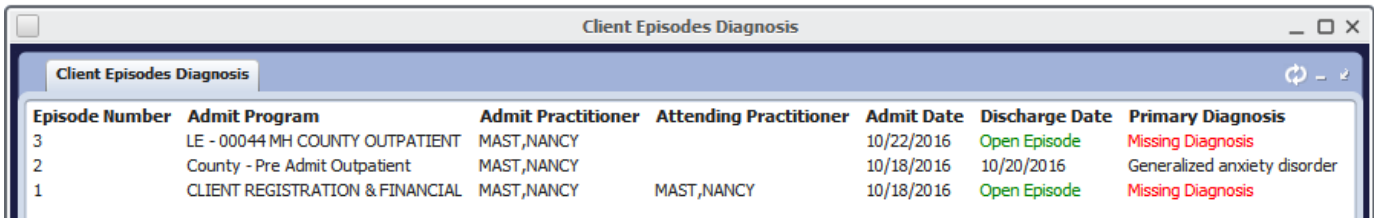
There isn't a link to the note in this widget. To open up the draft note you either need to find a link in your My To Do's, or find the note in the chart. See the section titled, "Reopening a Draft Progress Note," for more information.

My Pending Notes - 60 Days				
Note Date	**Name**	**ID**	**Episode**	**Note Type**
2017-01-03	TESTTEST,TEST	112510	4	Progress Note
2017-01-03	TESTONE,FRANK	960000	6	Progress Note
2017-01-03	TESTDDD,TEST	1000791	2	Progress Note

Client Episodes Widget

This widget shows all Episodes for a PIC, both current and historical.

Look for the green, "Open Episode," to see which episodes are still active or open.

Below, you can see that the PIC has been opened to a few different episodes. Episode #2 is closed. The other two episodes are still open.

Client Episodes Diagnosis

| Episode Number	Admit Program	Admit Practitioner	Attending Practitioner	Admit Date	Discharge Date	Primary Diagnosis
3	LE - 00044 MH COUNTY OUTPATIENT	MAST,NANCY		10/22/2016	Open Episode	Missing Diagnosis
2	County - Pre Admit Outpatient	MAST,NANCY		10/18/2016	10/20/2016	Generalized anxiety disorder
1	CLIENT REGISTRATION & FINANCIAL	MAST,NANCY	MAST,NANCY	10/18/2016	Open Episode	Missing Diagnosis

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Chart Views

To Open a Chart

1) **Select a PIC**. You can select from Recent Clients, search for a new PIC under Search Clients, or click a PIC from your caseload.
2) **Double click on the name to open the Chart View**.

If a PIC is not on your caseload, when you open up the chart, you will get the Non-Caseload Access warning.

Click "Yes," and then type in why you are opening the chart in the next popup.
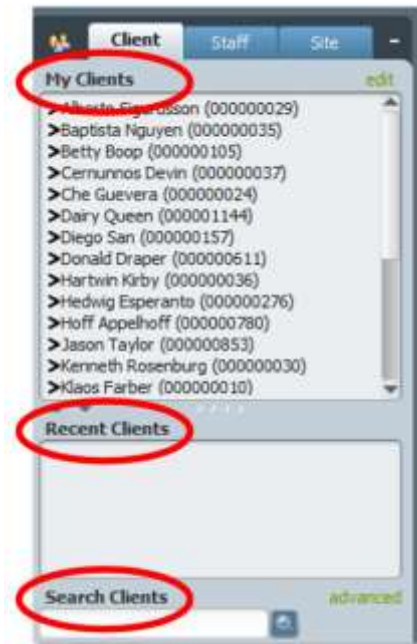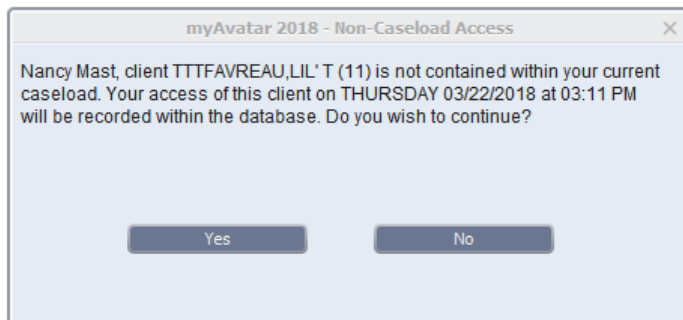
Santa Cruz County Behavior Health Avatar

Chart Overview

There are two main views in the chart, the Chart Overview and the Chart View.

When you first open the chart, you will see an array of widgets on the right, and a list of forms on the left.

If you need to enter information into a form that is not listed, you can open forms by clicking on the box that has a green cross on it. This will open the My Forms Widget (from your Home console). See the section, "Add a Form that is Not Listed to Your Chart View."

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Chart View

Click on any form to get to the chart view. The Chart View shows you all of the documents of a certain type, sorted by episode.
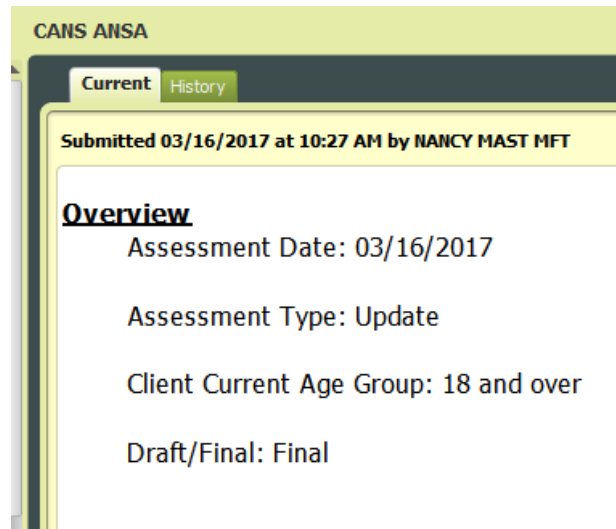
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Definition of Episodic versus Non-Episodic Forms

Episodic Forms: Episodic forms in Avatar are attached to an episode. Examples are our progress notes and the psychosocial assessment. In the chart you can see the open episode tabs arrayed across the top of the progress note view.
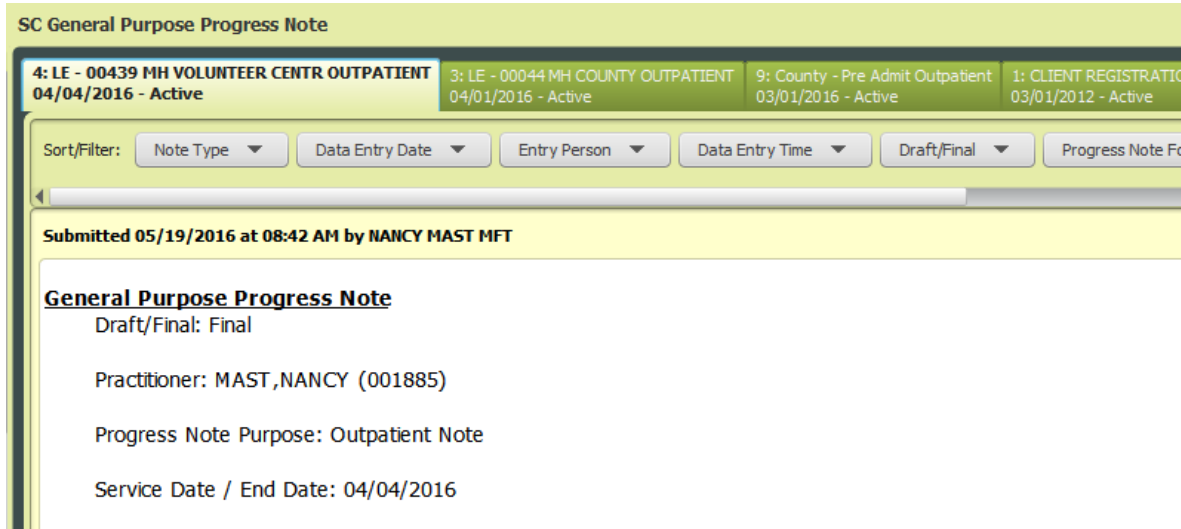
Non-Episodic Forms: Non-episodic forms are not attached to any episode. CANS ANSA is a non-episodic form. In the chart you can see that there are no EPISODES attached to the form.

The Current/History tabs show the current (most recent) version and past versions of the form but no episodes.

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Admission Programs vs. Episodes

Sometimes *Admission Programs* are referred to as *Episodes*. These terms are often used interchangeably, but there *is* a difference between these two terms. An Admission Program is simply the name of the program. An *Episode* is a single instance of an admission program. There can be multiple episodes for a single admission program.

For example, a PIC who is new to the system is opened to an Admission Program for the first time. Then, the PIC moves away and is closed entirely to services. Then, the PIC moves back and is admitted for a second time to the same Admission Program. Each of instance of the opening (and later a closing) to an *Admission Program* is called an *Episode*. In the example described here, there are *two Episodes of a single Admission Program*.

How to Scroll Through Chart Tabs

If the PIC has several programs in the chart, you won't be able to see all of the Episode tabs. Click on the very tiny triangles at the upper right to scroll back and forth among the chart tabs.
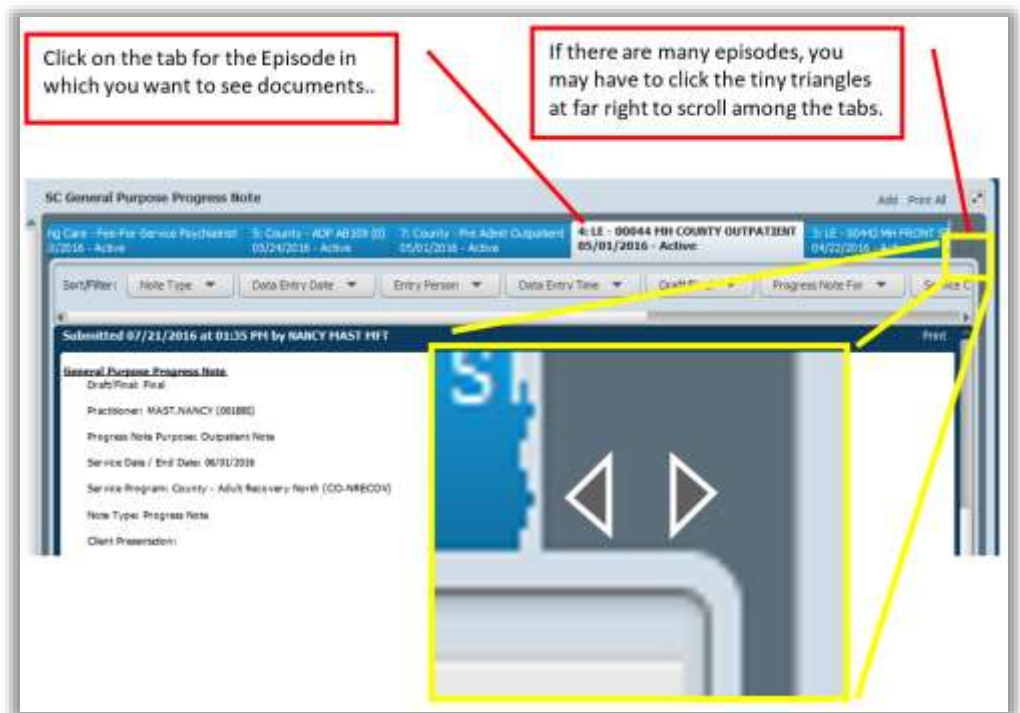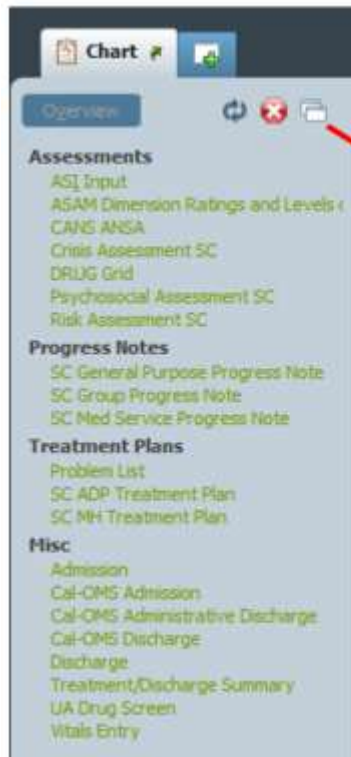

To Enlarge Text in the Chart View

At bottom right in the Chart View, you will see a button that you can slide left and right to increase and decrease the size of the font in the Chart View. This handy button is also on many forms.
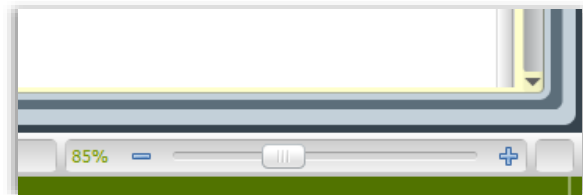
## Add a Form That is Not Listed to Your Chart View

If you need to add a form that is not listed in your Chart View, use the following procedure.

In this example, the Diagnosis form is not in the Chart View. When you look at the forms listed on the left hand side of the chart, you cannot see the diagnosis form.

To add a form to the chart, first click on the "Customize Forms" symbol at upper left. This will take you to the "Add/Remove Forms" area, where you can add forms to the list at the left of the Inquiry View.

Next, find the section to which you want to add a new form. In this example, let's add the Diagnosis form to the Assessment group. Click the little green "+" underneath the word "Assessments" to add a form to the Assessments group. A "Search Forms," field will open up.
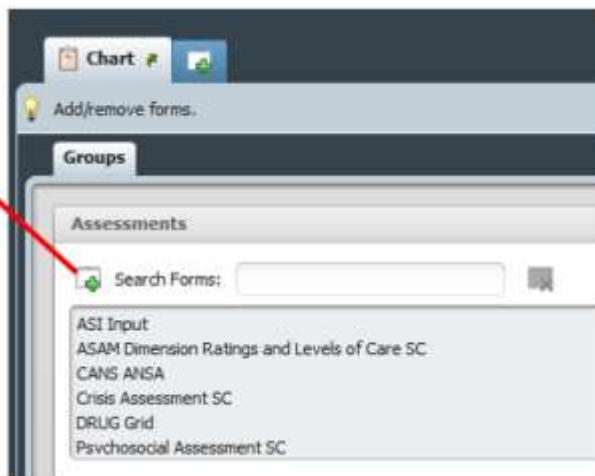
Santa Cruz County Behavior Health Avatar
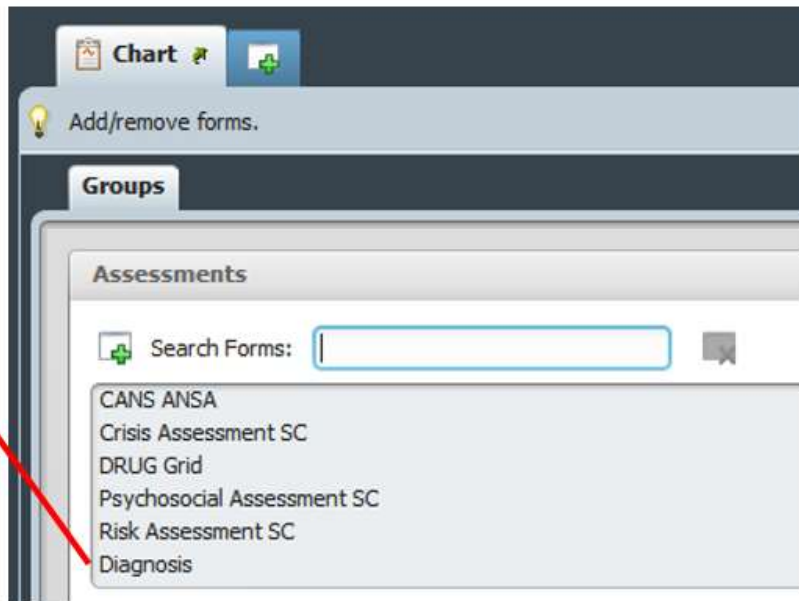
Type in the word "Diagnosis" in the blank provided. A list of forms matching what you typed in will pop up. The diagnosis form is unique in that there are two form paths. Double click on the form that says, "Avatar PM," under, "Application." (If you select the CWS version, it won't stay in the chart. The PM version will.)
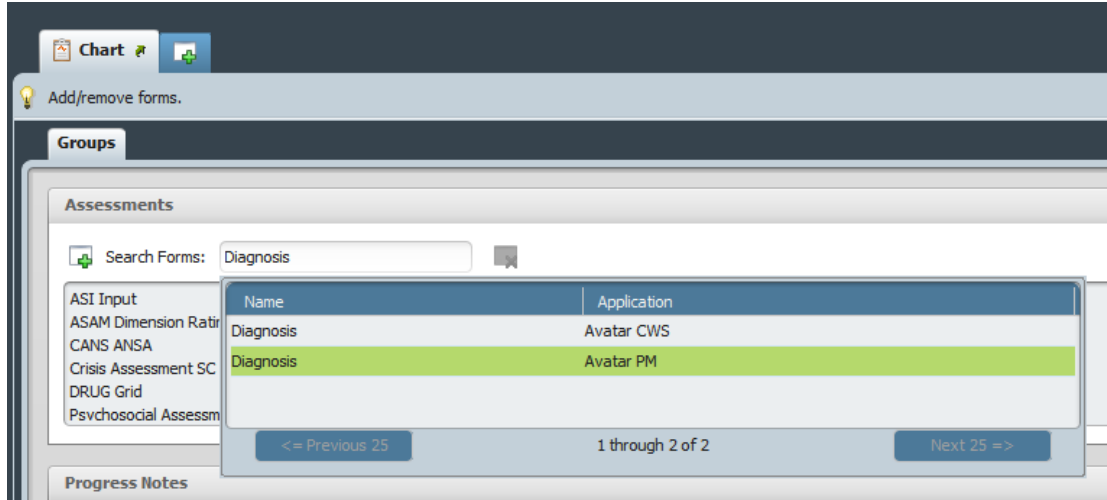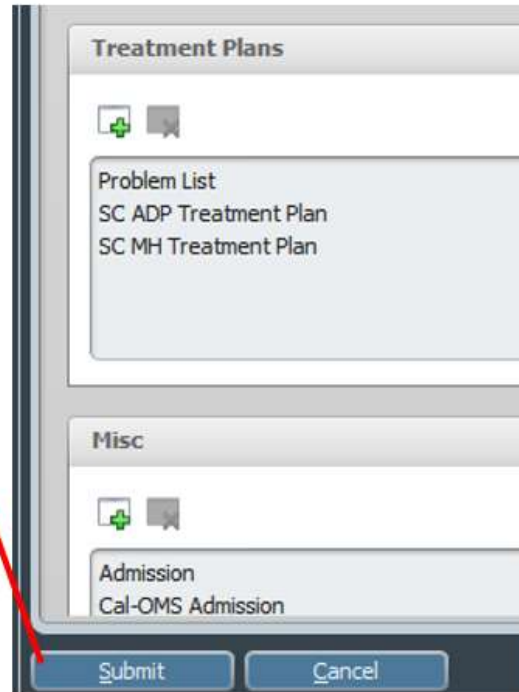

The diagnosis form has been added to the Assessments group.

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Click, "Submit" at bottom left to save your change and leave the Add/remove forms area. You will return to the chart Inquiry View. You will now see the diagnosis form on the left in the Assessments Group.

Click on "Diagnosis" to view diagnoses that have been added to the chart.
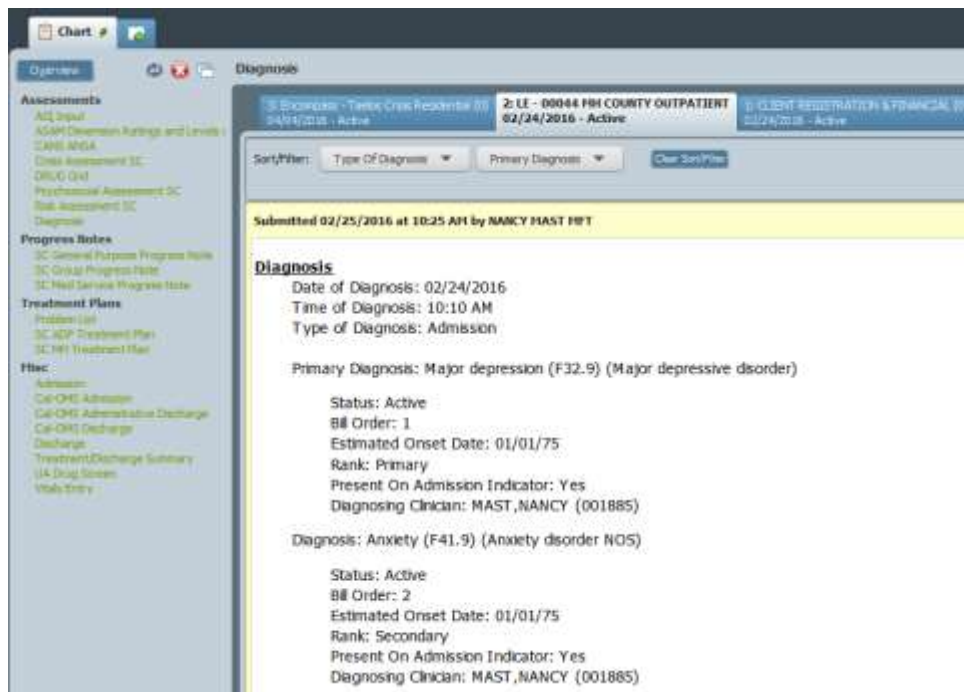
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To Print from the Chart View

Many forms can be printed directly from the Chart View. Some forms have a formatted report that you may prefer instead of printing from the Chart View. The Psychosocial is an example of this.

To print from the Chart View, locate the form you want to print, and then click "print" at upper right.

Note that the text in the Chart View prints out quite a bit larger than what you see on the screen. Use the slider bar to adjust the view before printing. 85% gives you a printout with font size that is about 10 or 11 points.
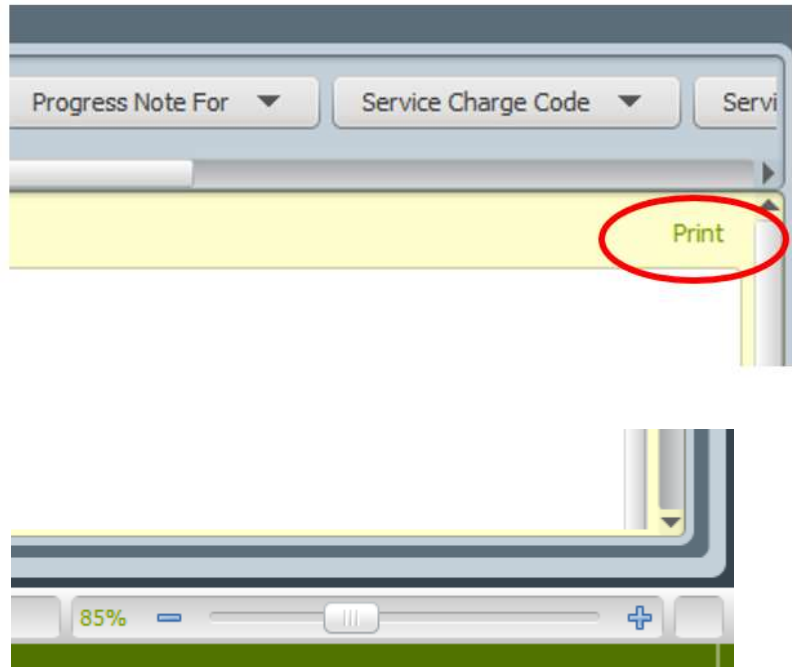
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Viewing Scanned and Routed Documents in the Chart

Documents can be "filed" in a PIC's chart in two ways. They can be created electronically from a form an electronic form in Avatar as you have seen, or they can be scanned and then added to the PIC's chart.

Links to routed and scanned documents can be found in the chart in the **Documents section** at the bottom of the forms list. Documents are arranged by category.

Scanned documents start with a three letter designation such as LGL or CLN.

Categories with a (DR) at the end are routed documents.

If you don't see the Documents section at all, this means that there are no routed or scanned documents in this particular chart. You will only see the Documents section if there are documents in it.
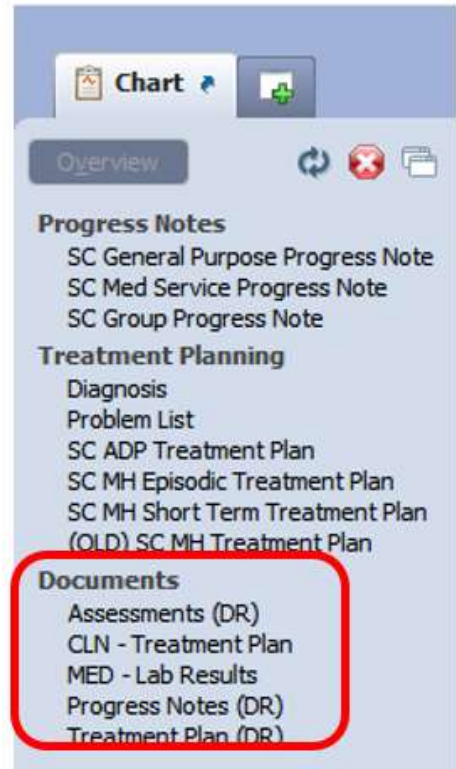
Categories that end with (DR) are routed documents.

Scanned documents start with a three letter designation such as LGL or CLN.

Routed Documents (DR) contain the signature date and credentials of the co-signer (if there is one).
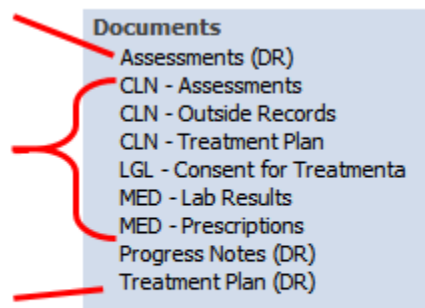
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What is a Routed Document?

Before you sign a completed electronic form, like a progress note, you are shown a picture of the document to review. Avatar saves this picture (called a .tif) electronically. One reason for this is if there are changes do the document, the original will be preserved.

Below is an example of a .tif from a progress note.

Santa Cruz Avatar Clinicians Manual
Updated: 7/5/2023   NKM
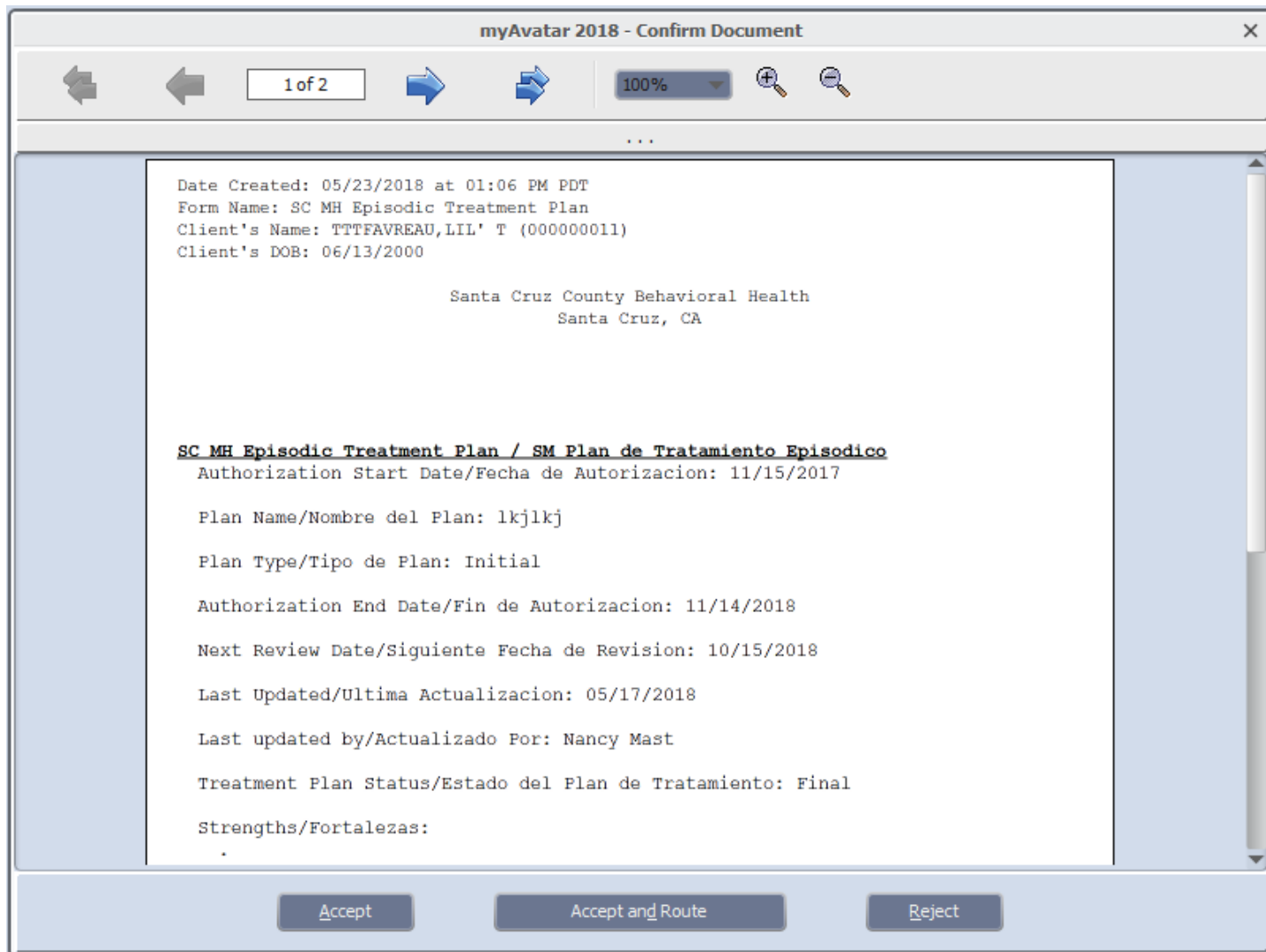
LPHA Signature

If an LPHA has co-signed a document, the date of the LPHA signature can be found in the routed document, at the very end.


```
Date Created: 05/24/2018 at 03:11 PM PDT
Form Name: SC MH Episodic Treatment Plan
Client's Name: FAVREAU,LIL' T (000000011)
Client's DOB: 06/13/2000

                    Santa Cruz County Behavioral Health
                             Santa Cruz, CA


     Staff / Personal: ROGERS,CARL

     Plan Author/Autor del Plan: No

     Notification/Notificacion: No
     _____

Signed: NANCY MAST MFT on 05/24/2018 at 03:11 PM Author
     _____

Signed: CARL ROGERS LCSW on 05/24/2018 at 03:14 PM Supervisor
```

This date won't be visible in the normal chart view, as shown at right. This view only has the name of the approver, but not the signature date or the credential (which is required by Medi-Cal).

Document Routing
> Status: Final
>
> Approvers:
>
> > CARL ROGERS-Supervisor (Accepted)

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To View a Routed or Scanned Document

Start by clicking on the type of document you wish to view.

You will see a list of documents as shown below.

For example, click "Progress Notes (DR)" to open up a list of routed progress notes.

Documents
- Assessments (DR)
- CLN - Assessments
- CLN - Outside Records
- CLN - Treatment Plan
- LGL - Consent for Treatmenta
- MED - Lab Results
- MED - Prescriptions
- Progress Notes (DR)
- Treatment Plan (DR)

Click your episode tab.

Click to select the document you want to see in the "View" column.

Click "View" here to launch a picture of your document.

Printing Routed and Scanned Documents

Most people do not have the ability to print scanned and routed documents. If you need to print one of these documents, contact the QA department.

Santa Cruz County Behavior Health Avatar

List of Scanned Document Categories and Contents

Assessment (DR)*see footnote.
    Assessments
Progress Notes (DR)
    Progress Note
Treatment Plan (DR)
    Treatment Plans
CLN-Assessments
    Clinician Assessments
    Crisis Contact Form from Access
    Access Assessments
    Disability Assessment
    Social Security Assessment
    Jury Duty Assessment
    Children Assessments (many types)
    Children Team Meeting Notes
    IEPs
CLN-CSP Documents
    Outside Records from Telecare CSP
only
CLN-Outgoing CPR (SUD)
    Client Progress Report
CLN-Outside Records
    Hospital Records--Admission and
Discharge Summary
    Medical Records--Summary Records
    Other Agency Assessments
CLN-Progress Notes
    Clinician Progress Notes (other than
those recorded in Avatar)
CLN-Treatment Plans
    Clinician Treatment Plans--those with
signatures
    Access Treatment Plans
    Multi-Directional Medi-Cal Transition
Form
    Service Plans
FIN-Benefit Rep Documents

Client Insurance Information
    Copy of Driver's License
    MHE25 Insurance Coverage
    Social Security Authorizations
FIN-Client Registration
    Client Registration
    Receipt of Privacy Notice
    Change of Address
    MHE Admission Form
FIN-Proof of Income
    Income Documentation
    Service Adjustment Form
    Share of Cost Authorization
    UMDAP Forms
LGL-Consent for Treatment
Consent for Mental Health Services
    Consent for Exchange of Info
    Authorizations to Release Info
    Other Consent Documents
LGL--Conservatorship Documents
    Conservatorship Documents
LGL-Informed Medication Consents
    Informed Medication Consents
MED-Lab Results
    Lab Results
Med-Physical Health Documents
    Physical Health Documents
    Physical Assessments
MED-Prescriptions
    Prescriptions
    Summary of Prescriptions
    Summary of Medications
    Letters on Medications
SCT-CAGE AID
    CAGE AID documents
SCT-CANS ANSA
    CANS ANSA documents

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Staff Messaging

Avatar has a messaging system that is entirely contained within Avatar. It is a bit antiquated, but is useful for sending secure messages when encryption is not available. Also use it to request that clients be added to your caseload.

1) **Open the Staff Messaging Form:** To send a message, you must first open the Staff Messaging form. Open the form in your Forms & Data Widget.

2) A window will appear called **Select User ID/User Description**. Type in your last name and then double-click on your name. **IMPORTANT: You must TYPE IN YOUR OWN NAME, NOT THE RECIPIENT. The recipient is the person you are sending the message to. (Think of it as "logging in" so you can send your message.)**
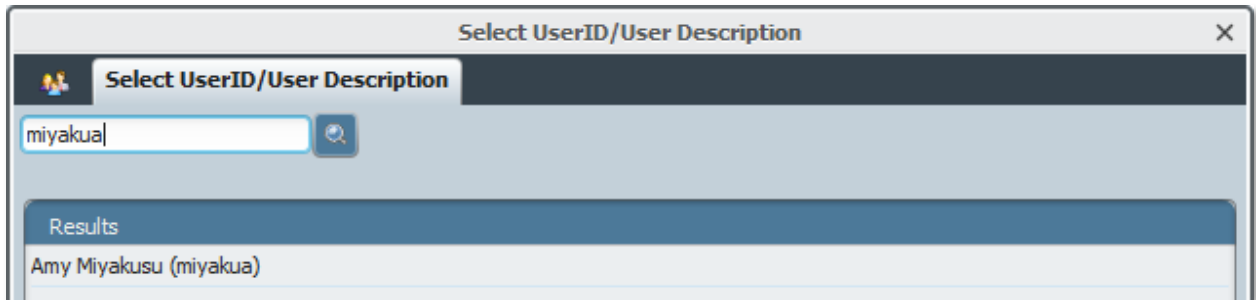
3) **Click Add** when you see the Pre-Display for the form.

Pre-Display

As with many forms in Avatar, before opening a form, Avatar will show you a *pre-display*. If you are filling out a PIC form, like an assessment, a pre-display will show you all episodes for the PIC. At other times, the pre-display will show may show you instances of this form being completed. For some forms, you will see a list of all instances when all staff have filled out the form. For other forms, you may only see all of the instances associated with a particular PIC. In the case of the Staff Messaging form, you will see only the times *you* have filled out the form.

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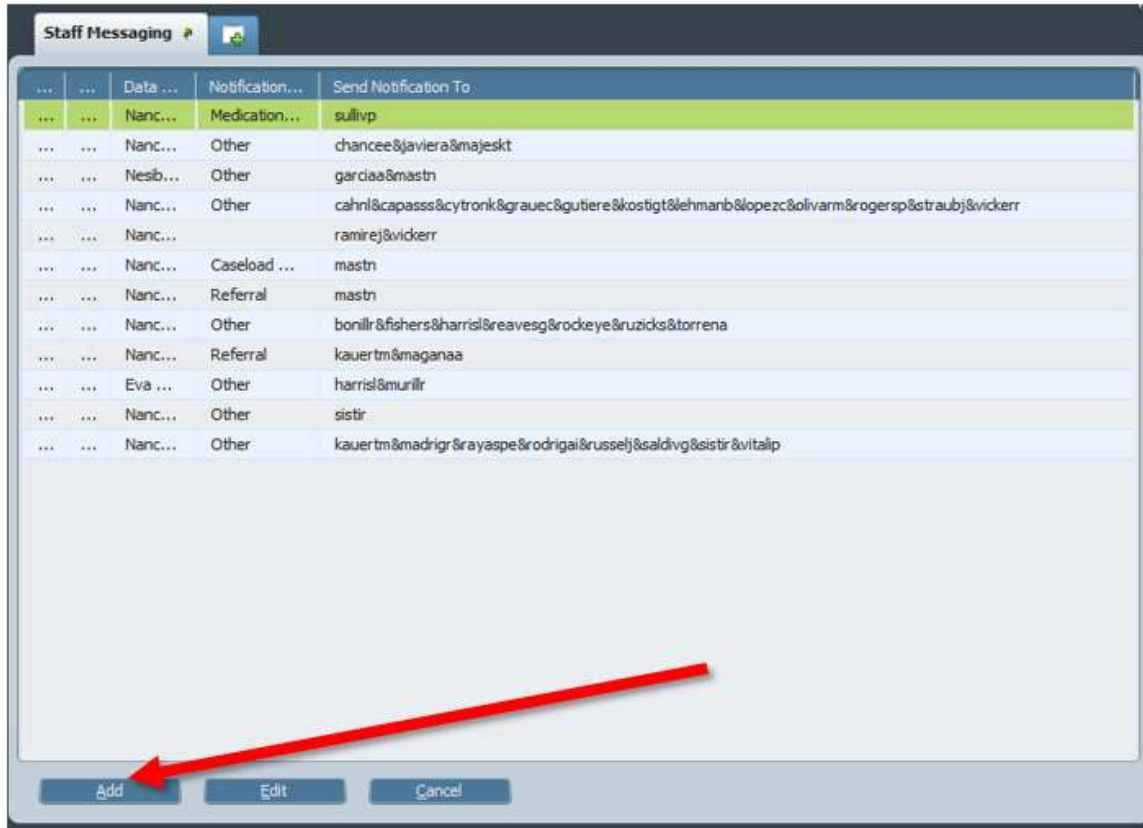
4) A blank Staff Messaging form will open up.
   a. Enter the **Date** and the **Subject**.
   b. In the **Send Notification To** field, click on the people to whom you wish to send the message. You may send a single message to multiple recipients. Note that recipients cannot see each other in the message. Essentially, when you send a message to multiple recipients, you are "blind copying" all of them.

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Required items: The labels for the Date, Subject and Send Notification To fields are in red font. In Avatar, red questions on forms are required.

> **RED IS REQUIRED:** When filling out Avatar forms, some questions are in red. These items are required. You will not be able to complete the form without completing these questions.

5) In the Staff Messaging form, you also have the option of adding a specific PIC's name, the program to which the PIC was referred, and detailed comments. Once you have entered all of the information you want, click Submit to send.

To Retrieve or Open a Message That Has Been Sent to You

Open your messages in the My To Do's Widget. Unlike all other forms, you open a message by clicking, "Review To Do Item." (For all other forms, you click on the name of the form.)

STEPS:

1) **Click Review To Do Item** and the Review To Do Item portion of the form will open.

2) **Click View Detail** to see the content of the message.

Santa Cruz County Behavior Health Avatar
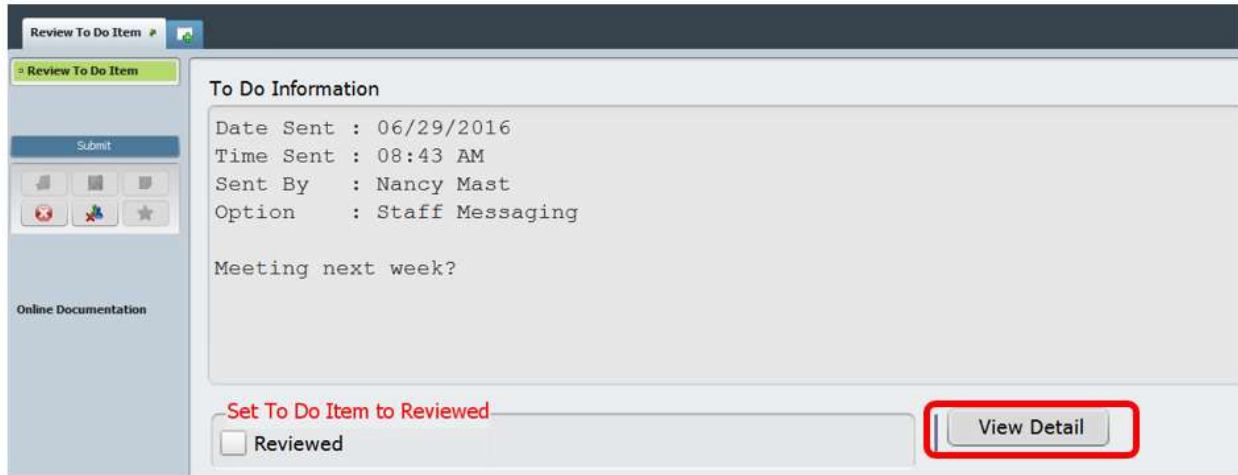
3) **Read your message. When finished, click Dismiss** in the lower right hand corner of the screen. You will be taken back to the Review To Do Item screen.

4) **Click Reviewed** to remove this item from your My To Do's and then click **Submit**.
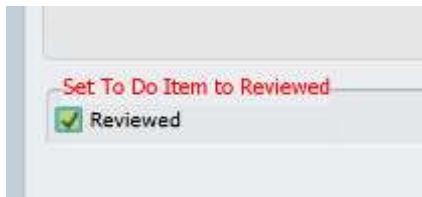
IMPORTANT: DO NOT CLICK "REVIEW TO DO ITEM" FOR ANY FORMS OTHER THAN MESSAGES. If do this, you will not open the form you need and you will start down a path do delete the link to the form in your My To Do's. For some forms, like group progress notes, there is no other way to open drafts. You cannot open a draft group progress note from the chart.

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Notification Users Form: How to Set Up Staff Messaging

If you are unable to send a Staff Message, it's possible that your list of other "Users" is blank. Use this form to add all users to your profile, so that you can send messages to everyone.
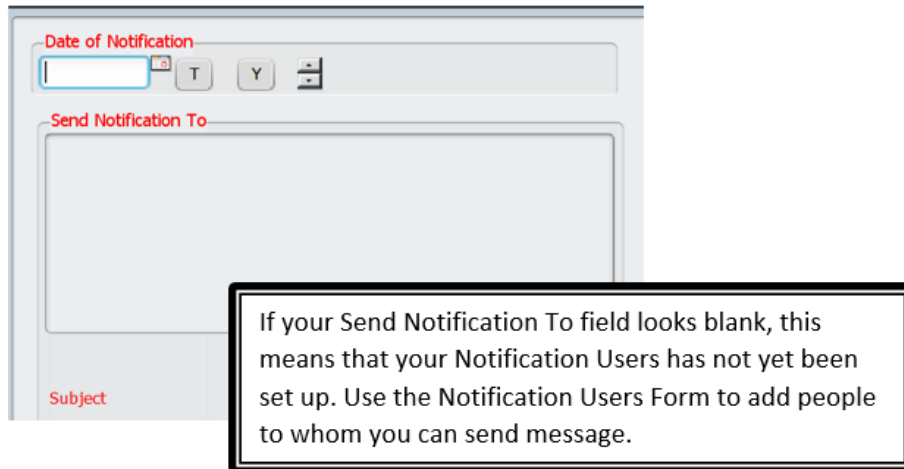
This form is used to set up **Staff Messaging**. Without this set up, your staff members will not be able to send messages. Avatar requires that users have identified recipients, which is what this form allows you to create. Although Notification Users allows adding individual recipients to a users' profile, Santa Cruz Avatar has a convenient list that contains all users. In this way, you will not have to add individual users for your staff, but simply add the list. Below are directions on how to add this list.

Menu Path (Location in Avatar): Avatar CWS> Radplus Utilities > Workflow Management > Notification Users

1. Search for **Notification Users** from the Search Form field in the Forms & Data Widget and select it.
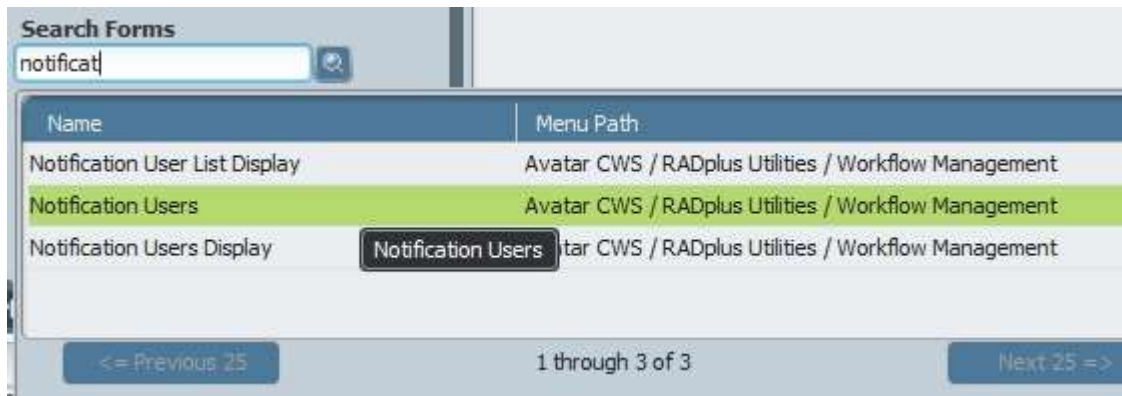
2. Select a user from the Workflow Notification Users pull down menu.
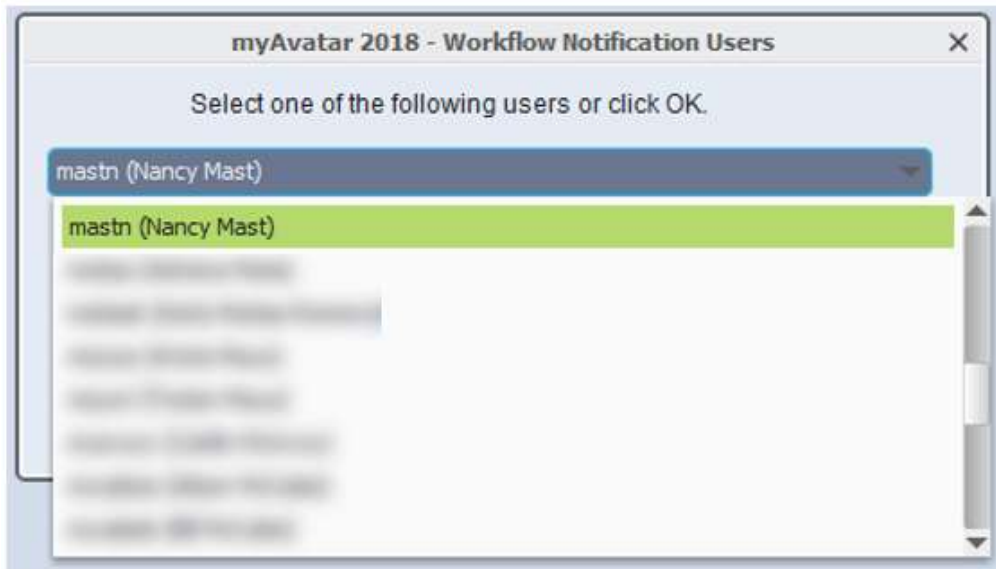
3. The Notification Users form will open. You won't need to do anything on the first tab or page, Workflow Notification Users.

4. Skip to the tab titled Lists. Click on the word Lists on the left to get this tab.
5. Once you are on the List tab, click Add New Item to create a new row in the list.

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6. Then click, Select List to open up a menu of lists.
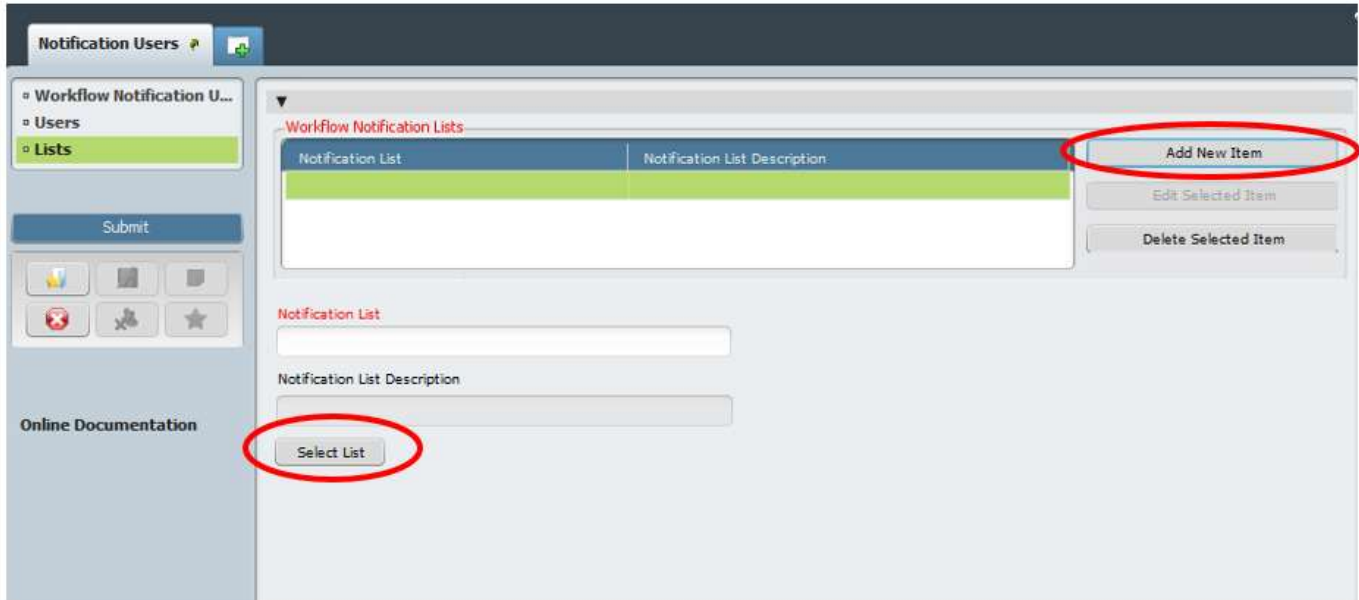
This pull down list box will appear.
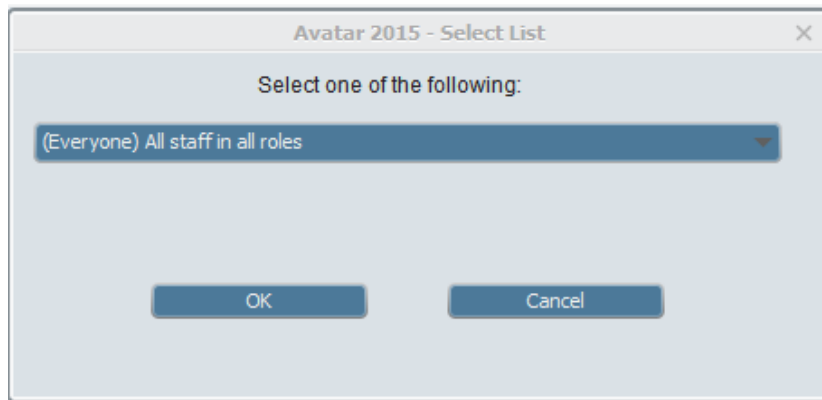
7. Click in the pull down menu and then highlight and select **(Everyone) All staff in all roles.** There may be only one list, but if not, make sure you select the list titled "All staff in all roles."

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You will now see the list, All Staff in all Roles added to the table.
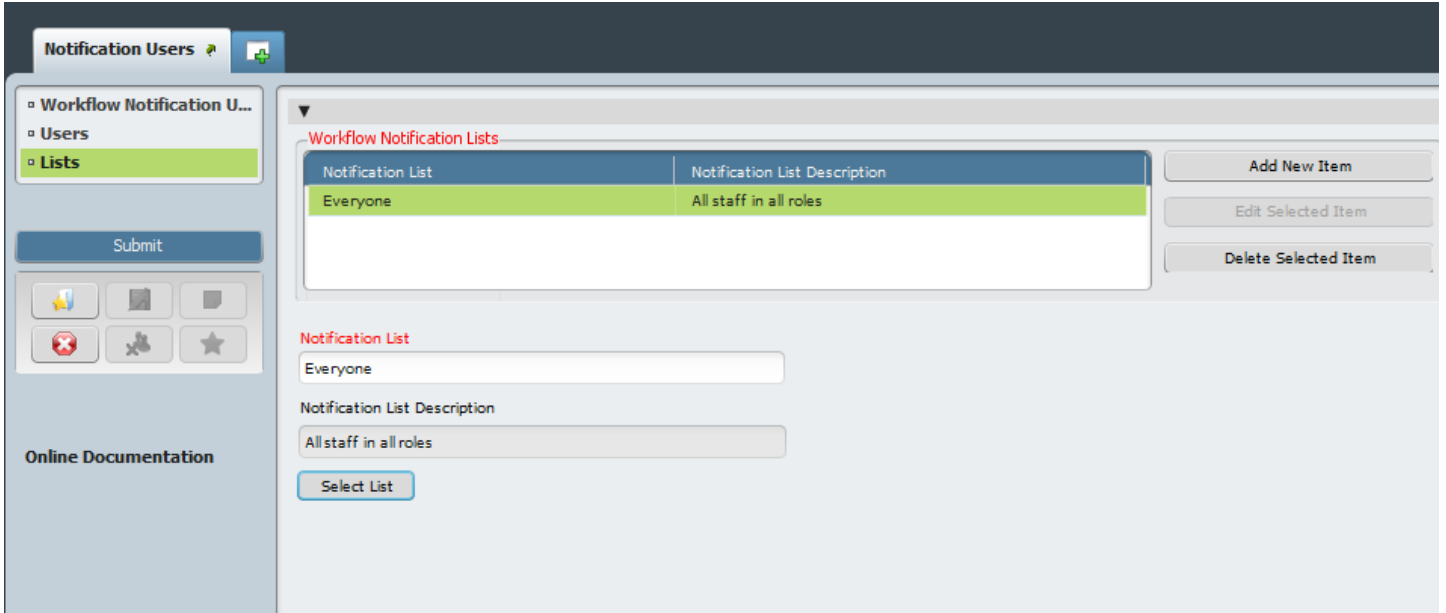
8. Select **Submit**.
    1. IMPORTANT – Now that you have added a list using Notification Users, these steps automatically add the members of the list to the "Send Notification To" field in the **Staff Messaging** form.

9. To verify the operation was successful, you or the person you set up, should search for and open **Staff Messaging** from the Search Forms Widget (see Step 1).
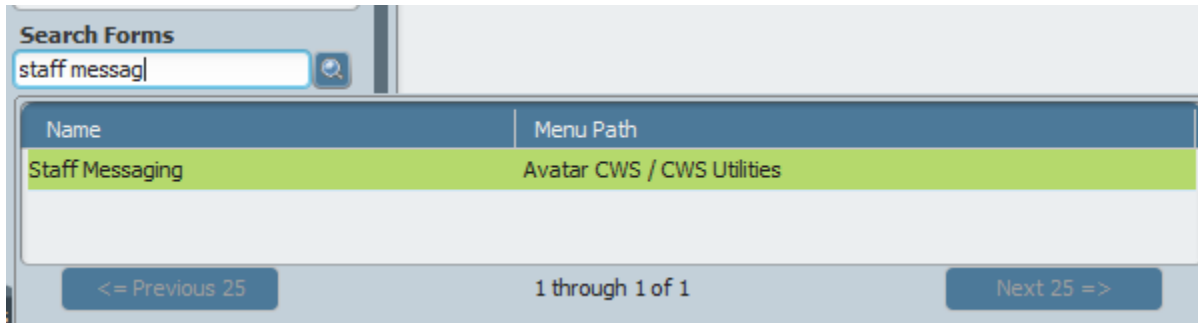
10. Select user from the search field.
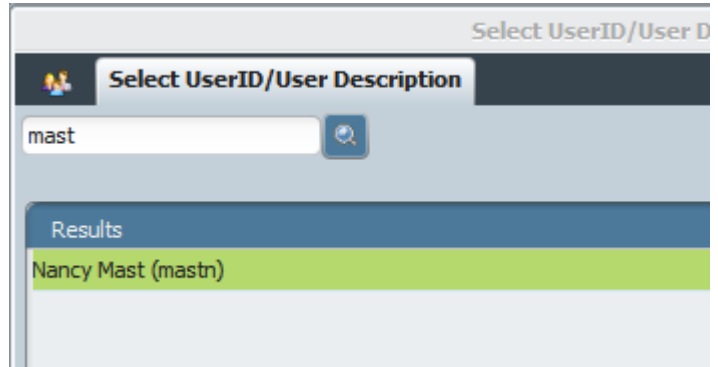
11. Users from the list **(Everyone) All staff in all roles** which was added with the **Notification Users** form will appear here.
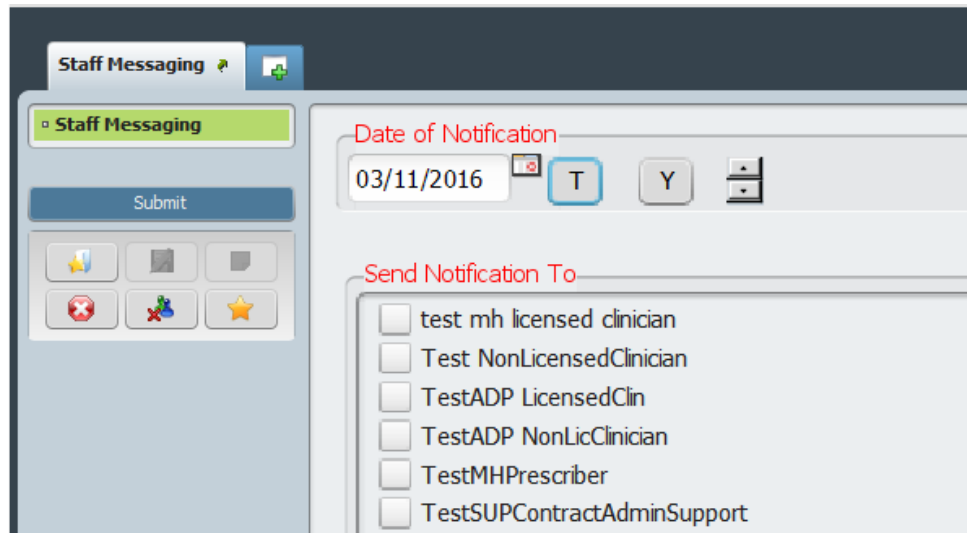
Santa Cruz County Behavior Health Avatar

Caseload Assignment Request Instructions

If you need a PIC added or deleted from your caseload, send a staff message to Sylvia Vairo in Data Entry who will make the change for you.

To Have a Single Individual Added to Your Caseload

To help us add a PIC to your caseload, we need the following information.

Action to Take (Add/Remove): Add
Clinician Name:
Clinician User Number:
PIC Name:
PIC Number:
Service Program (use exact wording*):
Type of Assignment**:

*Your Service Program or Program of Service is the team under which you typically bill services. When you do progress notes, this is what you enter in the "Service Program" blank. Examples: County – Adult Recovery North, County – Child Community Gate, County – South FQHC Psychiatry, Encompass – ADP Youth Svcs North-YES, Front – Adult Willowbrook Residential. (Sorry to be so picky, but the form we use for this won't work without this info! ☺)

** Choose from the following: Primary Contact, Psychiatrist/Nurse Practitioner, Nurse, Trainee, Therapist, Substance Abuse, Housing Staff, Educational/Employment Staff, Peer Advocate, Benefit Representative, Field Responder, Other. If Other, please explain.

EXAMPLE:

Action to Take (Add/Remove): Add
Clinician Name: Nancy Mast
Clinician User Number: 891011
PIC Name: Patrick Star
PIC Number: 12131415
Service Program (use exact wording*): County – Adult Recovery North
Type of Assignment**: Primary Contact

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To Have a Multiple Individuals Added to Your Caseload

Fill out the template below. List PIC Name and PIC Number for all of the clients you need added.

Action to Take (Add/Remove): Add
Clinician Name:
Clinician User Number:
Service Program (use exact wording*):
Type of Assignment**:
PIC Names (numbers):

EXAMPLE:

Action to Take (Add/Remove): Add
Clinician Name: Nancy Mast
Clinician User Number: 12345
Service Program (use exact wording*): County - Adult Recovery North
Type of Assignment**: Primary Contact
PIC Names (numbers):

Diana Prince (123456)
Dora Marquez (7891011)
Homer Simpson (12131415)

*Your Service Program or Program of Service is the team under which you typically bill services. When you do progress notes, this is what you enter in the "Service Program" blank. Examples: County – Adult Recovery North, County – Child Community Gate, County – South FQHC Psychiatry, Encompass – ADP Youth Svcs North-YES, Front – Adult Willowbrook Residential. (Sorry to be so picky, but the form we use for this won't work without this info! ☺)

** Choose from the following: Primary Contact, Psychiatrist/Nurse Practitioner, Nurse, Trainee, Therapist, Substance Abuse, Housing Staff, Educational/Employment Staff, Peer Advocate, Benefit Representative, Field Responder, Other. If Other, please explain.

To Have a PIC Removed From Your Caseload

To remove a PIC to your caseload, send a staff message to Sylvia Vairo in Data Entry. Your message should have the following information only. We do not need the Service Program or Type of Assignment.

Action to Take (Add/Remove): Remove
Clinician Name:
Clinician User Number:
PIC Name:
PIC Number:

Santa Cruz County Behavior Health Avatar

Understanding Admissions and Workflow Through the System

Admission Programs and Service Programs

Avatar has two types of programs, **Admission Programs** and **Service Programs**. For Mental Health programs, there might be several Service Programs connected to a single Admission Program. Substance Use Treatment programs have a 1:1 relationship – one Admission Program to one Service Program. See information below.

Mental Health Programs

For Mental Health programs, an *Admission Program* can cover many different types of services provided in an agency.

A *Service Program* is narrower and is somewhat like a treatment team.

PICs are not "opened" to Programs of Service. Once the appropriate Admission Program is opened, service delivery from any service program can begin. The appropriate Service Program is noted in the progress notes.

Above, you can see two different Mental Health Admission Programs and their associated Service Programs.

Admission Program
LE - 00044 MH COUNTY OUTPATIENT

- Service Program County - Adult Recovery North
- Service Program County - North FQHC Services Psychiatry
- Service Program County - Child School
- Service Program County - North FQHC Therapy Services
- Etc....

Admission Program
LE - 00656 MH PARENTS CENTER OUTPATIENT

- Service Program Parent Ctr - Child Family Counseling
- Service Program Parent Ctr - Child North Outpatient

Santa Cruz County Behavior Health Avatar

Definition of Legal Entity or LE

With a few exceptions, Mental Health plans are shared by all providers within a Legal Entity or LE. An LE defines an agency under which different teams, programs and providers operate. The SC MH Episodic Treatment Plan is created under an LE. That means, if you have other users under your LE who are also working with the PIC, you will share a treatment plan with those users.

You will not share a plan with others who provide services under a different LE.

Example: If there is a county case manager and a county therapist, they will both contribute so the same plan under LE – 00044 MH COUNTY OUTPATIENT. If the same PIC is getting day services and housing support from Encompass, those providers will have their own unique plan under LE – 00440 ENCOMPASS OUTPATIENT.

All Santa Cruz County Avatar LE's are as follows.

- LE – 00044 MH COUNTY OUTPATIENT
- LE – 00440 MH ENCOMPASS OUTPATIENT
- LE – 00442 MH FRONT STREET OUTPATIENT
- LE – 02136 MH HAVEN OF HOPE
- LE – 00657 MH PARENTS CENTER OUTPATIENT
- LE – 00656 MH PVPSA OUTPATIENT
- LE – 00439 MH VOLUNTEER CENTR OUTPATIENT

Substance Use Disorder (SUD) Programs

Programs for Substance Use Disorder (SUD) treatment work differently than Mental Health (MH) treatment.

In MH treatment, an Admission Program is a broad "episode" that encompasses the entire time a PIC receives services from an agency. It can go on for many years with many different types of services provided.

In SUD treatment, due to different confidentiality regulations, the Admission Program is narrower and only specific to the particular treatment facility or program where the PIC is getting services.

For each SUD Program, there are two mirror Admission Programs. PICs who do not wish to share their information with all Santa Cruz Avatar users are admitted to a *sequestered* program. Data in the sequestered program can only be seen by users who work in that program.

In order for all Avatar users to view SUD program data, the PIC must sign the Consent for the Exchange of Confidential Mental Health and Substance Use Disorder Treatment Information. This permits all Santa Cruz Avatar users to share data and the PIC is admitted to the non-sequestered

program. If a PIC changes their mind during treatment, data can be shifted from the sequestered to the non-sequestered program and vice-versa.

Janus Main - Adult Residential Detox	Encompass CS - Alto North Outpatient	ADP Family and Children Svcs
Admission Program Janus Main - Adult Residential Detox	Admission Program Encompass - Alto North Outpatient	Admission ProgramADP Family and Children Svcs
Admission Program Janus Main - Adult Residential Detox SEQ	Admission Program Encompass - Alto North Outpatient SEQ	Admission Program ADP Family and Children Svcs SEQ

This Admission Program, and associated data, can be seen by all users.

This *Sequestered* Admission Program can only be seen by users who work at that program.

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Client Registration & Financial Admission Program
Client Registration & Financial is the first Admission Program for all Clients in Avatar. No services are associated with this Admission Program. It exists to allow the PIC to be entered into the system and assignment of a PIC number only.

 Be careful to not add progress notes, assessments, etc...under this Admission Program. If you do this, the data will have to be deleted and you will have to rewrite everything.

In order to provide billable services, the PIC needs to be opened to another Admission Program (e.g. LE00044 MH COUNTY OUTPATIENT or County ADP Prevention HSA).
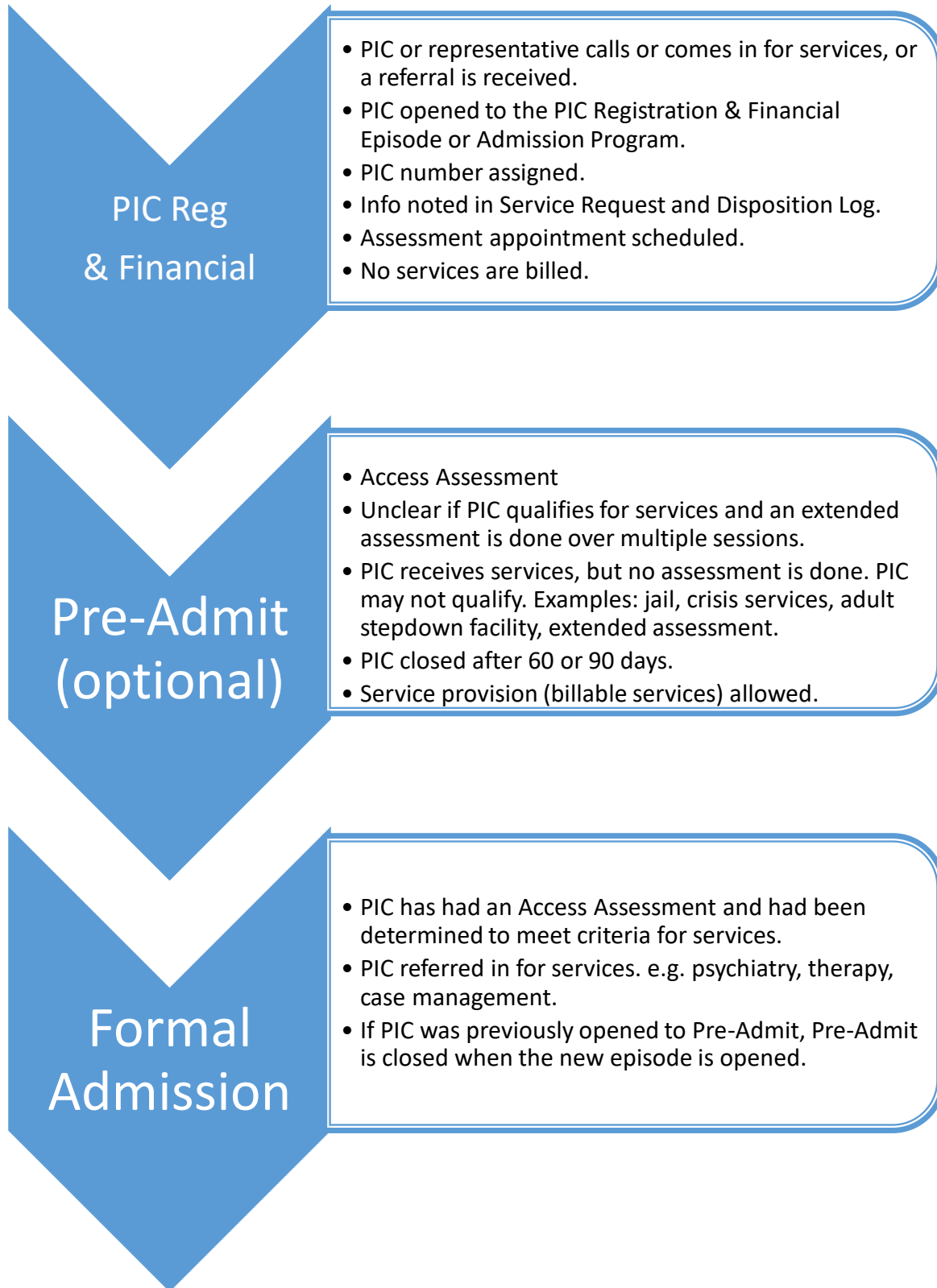
Pre-Admission Programs

Pre-Admission programs allow clinicians to start gathering information on a PIC before formal services start. They are useful in identifying PIC who are receiving specific and targeted treatment vs. PICs who are still in the assessment process. (The client may not qualify and get referred elsewhere.)

County – Pre Admit Outpatient Admission Program

This unique Mental Health Admission Program allows for limited service provision prior to the PIC receiving an Access Assessment and formally entering treatment through county services. This allows for extended assessment periods for PICs, as well as services for individuals who may never qualify for treatment, but require acute or crisis services. Some examples of the type of service provided under County – Pre Admit Outpatient:

- Field crisis for a non-open PIC
- Jail crisis or juvenile hall
- Crisis residential services
- Extended assessments for children under 5.

Santa Cruz County Behavior Health Avatar

PIC Reg & Financial

- PIC or representative calls or comes in for services, or a referral is received.
- PIC opened to the PIC Registration & Financial Episode or Admission Program.
- PIC number assigned.
- Info noted in Service Request and Disposition Log.
- Assessment appointment scheduled.
- No services are billed.

Pre-Admit (optional)

- Access Assessment
- Unclear if PIC qualifies for services and an extended assessment is done over multiple sessions.
- PIC receives services, but no assessment is done. PIC may not qualify. Examples: jail, crisis services, adult stepdown facility, extended assessment.
- PIC closed after 60 or 90 days.
- Service provision (billable services) allowed.

Formal Admission

- PIC has had an Access Assessment and had been determined to meet criteria for services.
- PIC referred in for services. e.g. psychiatry, therapy, case management.
- If PIC was previously opened to Pre-Admit, Pre-Admit is closed when the new episode is opened.

Santa Cruz County Behavior Health Avatar
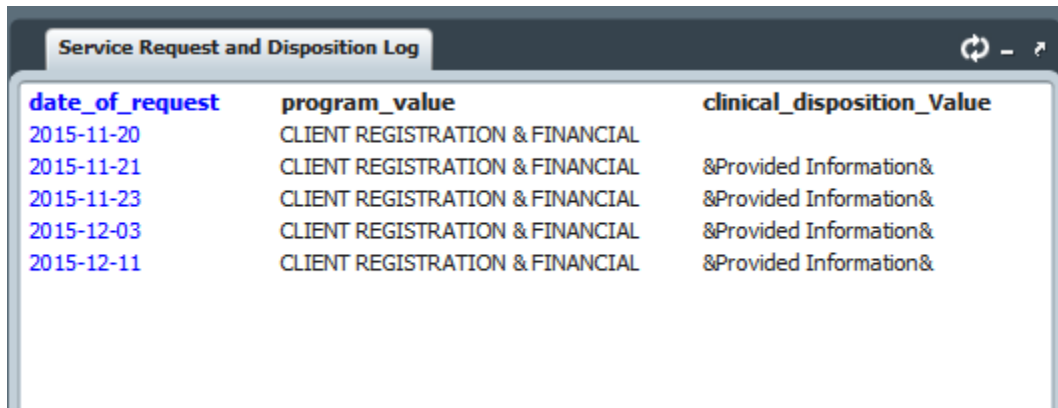
Service Request and Disposition Log (SRDL)

If you are assigned a PIC that is new to services, there may be information in the SRDL Widget that will be helpful to you.

In previous EMR systems, the Service Request and Disposition Log was called the Access Log or Call Logging.

Services are initiated by either the PIC, or a representative (parent, guardian, hospital, contract agency). When the PIC or a representative contacts a program with a request for services, this must be noted in the Service Request and Disposition Log. This is a state requirement.

There are clerical and clinical sections on the form. The person filling out the clerical section of the form files it in "draft" format. The clinician completing the form, re-opens the draft and then completes the clinical sections of the form. (Depending on the program, clinicians might fill out the entire form.)

There is an associated widget, The **Service Request and Disposition Log Widget** where all entries in the SRDL are shown for a particular PIC. Clicking on an entry in the SRDL widget opens a single log entry for viewing or, if the entry has not been finalized, for editing. (Click on the blue date, which is where the link to the form is.)

For more information about the SRDL, see the Avatar Service Request and Disposition Log Manual on the on the Santa Cruz County Health Services Avatar Information Resources Pages.

Santa Cruz County Behavior Health Avatar

Admission, Discharge, Update Client Data and Associated Forms

<mark>Although not all questions in these forms are red/required, you should do your very best to answer *all* questions, since this data is required by the State of California.</mark>

Many questions required for state data collection are not red/required because, depending on circumstances, you may not be able to obtain the information at the time.

For example, if PIC is symptomatic or uncooperative you may only be able to answer a few questions on the Admission form. If you are not able to gather all of the data at admission, work with the PIC to get the information into Avatar as soon as possible. Input new data using the Update PIC Data form and CSI Information form.

Once the Admission and CSI Admission forms are complete, PIC information can be at any time.

When to Update Client Data

When Are Updates Done?

CSI information is collected at admission and then updated annually.

However, PIC information can and should be updated any time, on an as needed basis. When the information changes, any user can update the data. This is especially important with addresses and phone numbers.

Annual PIC Data Updates

The primary clinician for each PIC is responsible for checking PIC demographic data at least annually and updating if needed.

See the section, "How Can I Tell If PIC Information Needs Updating?," for more information.

Santa Cruz County Behavior Health Avatar

Admission Form

Search for the PIC

1. **Open the Admission form.** Go to your **Forms & Data Widget** and search for the **Admission form.** Type "admission" into the Search Forms field. Double click on the form when it appears on the list. Note that you want to select **"Admission."** There are other forms with similar names that you do not want to choose.
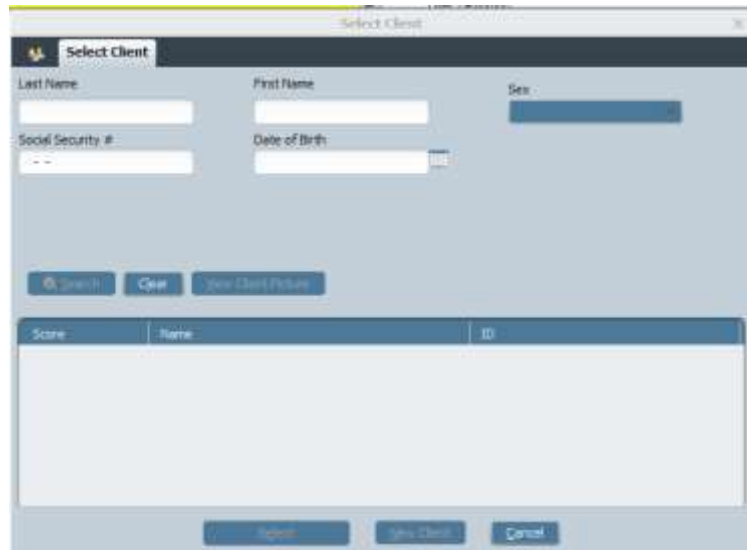

A **Select Client Window** will pop up. Before Avatar opens the Admission form for you, you will need to search for the PIC. This is because you want to see if the PIC is already in the system before admitting the PIC.

Be careful to not create a duplicate PIC. If you do, the duplicate PIC will have to be deleted and all of the information in this duplicate chart will need to be reentered into the correct chart.

If you accidentally create a duplicate chart, send a message to askqi@santacruzcountyca.gov and ask to have the two charts merged.

2. **Enter PIC data into the Select Client popup.** You must type in at least three pieces of information in order to search for the PIC. For example, Last Name, First Name and Date of Birth. Once three pieces of information are entered, the Search button will activate.

3. **Click Search**.

   If there are matches to your search, names will appear and you can either double click on a name to select a PIC, or click on the name, then click the Select button.

4. **No Matches Found:** If there are no PICs that match your search criteria, you will see a pop up that says, "No matches found." **Click "OK"** in the pop-up.
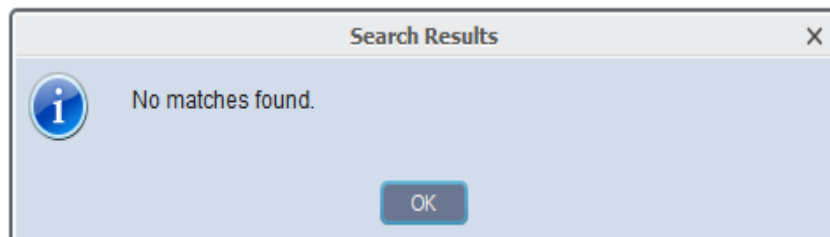
Santa Cruz County Behavior Health Avatar

5. **New PIC:** If no PIC matching your search parameters is found, the "New Client" button at the bottom of the Select Client window will become enabled. **Click "New Client,"** on the Search Client window, to launch the Admission form.

6. Avatar will ask if you want **Auto Assign Next ID Number**. Click **Yes**. Avatar will now open the Admission form. If you look at the top of the admission form, you will see the PIC's number.
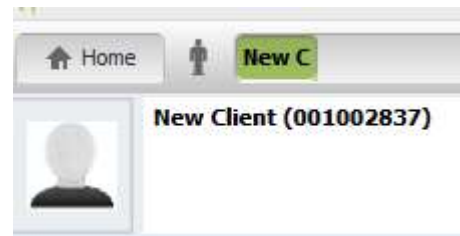
Complete the Admission Form

Once the Admission form is opened, start filling out the form. Remember, you will not be able to submit (save and finalize) the form unless the red/required questions are answered.

The Admission form has two tabs, Admission and Demographics.

Santa Cruz County Behavior Health Avatar

Admission tab

Sub Section: Identification and Treatment Information

a. **Client Name** will be auto populated from the Search Client window. You will not be able to change it once the form is open. **If you made a mistake and need to change the name, after you close the Admission form, use the form Update Client Data to change the name.**

b. **Gender** will be auto populated from the Search Client window if you used this parameter to search for the PIC.

c. **Date of Birth:** Although not a required question, do your very best to gather this information. This will help identify the PIC and prevent duplicate charts.

d. **Preadmit/Admission Date:** Enter the date the PIC was admitted to the program. Do not enter "today" unless the admission date is today. If services were provided already to the PIC, anything done before the admission date you enter will not be billable. **The admission date should be on or before the first date of services.**

e. **Preadmit/Admission Time:** Unless your program has a special need to note the exact time of admission, the easiest way to make sure your services are covered with regard to the time, is to enter the diagnosis time as 12:00 am. (TIP: Type "0000" and press enter.)

f. **Epic Client ID:** Enter if known. Epic is the software program used by the county health clinics.

g. **Social Security Number:** Although not a required question, do your very best to gather this information. This will help identify the PIC and ensure the chart is not a duplicate.

h. **Program:** Enter the name of the program to which you want to admit the PIC. Remember, for a brand-new PIC, the very first episode is going to be **Client REGISTRATION & FINANCIAL.** Once Client Registration & Financial is opened, then you may open the PIC to your program or "LE."

i. **Is this a Transition in Care? Skip this question for now.** This question is intended to denote whether this is an incoming referral from an eligible provider. The question is associated with meaningful use measures. We currently do not have a workflow for this question, but we may use it in the future.

j. **Type of Admission:** If this is the first time the PIC has ever been admitted to the program, enter "First Admission." All subsequent admissions are entered as "Re-Admission." Do not use Pre-Admission. If you want to open the Client to County – Pre Admit Outpatient, admit the PIC to this program.

k. **Source Of Admission:** Although not red/required by Avatar, this item is required for CSI data collection. Do your very best to answer this question if at all possible.

l. **Initial Point of Contact:** If you are the Initial Point of Contact, **enter your ID** here by typing in your last name and pressing Enter. Then double click on your name. Typically, the Initial Point of Contact is the first **clinical staff person** encountering the PIC. Ask your supervisor about whose name should be in this field.

m. **Lead Provider:** This is the person who will eventually be working with the PIC and the main contact person. Enter this information if you know who this person is. If you do not know who this person is, then leave the question blank. Avatar will only allow Licensed/Waivered/Registered users to be entered into this field.

n. **Perform Discharge Alert:** Do not use this question. Talk to your supervisor if there is critical client information that needs to be communicated to other staff.

Admission tab (Continued)

Sub Section: Living Arrangements/Disabilities

1. **Client's Living Arrangements**: Enter where the PIC was most recently living. If unsure, enter the selection that best answers the question, "Where did the PIC stay last night?"
2. **Disabilities – 1,2,3:** Enter up to three disabilities. If none, select "None."

Admission tab (Continued)

Sub Section: Compliance Indicators

1. **Received Copy Of Client Rights:** Enter whether or not you provided this information to PIC.
2. **Advanced Directive:** Enter whether or not you provided the PIC with Advanced Directive information. If needed, enter a comment in the question, "Advanced Directive Note."
3. **Optional Comments:** Enter any information that might be relevant to filling out the admission. For example, if PIC was impaired or otherwise unable to participate in the admission interview, you can note that information here.

If the admission form is incomplete, you can update client information later using the form Update Client Information.
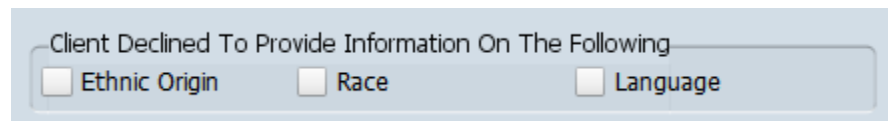
Admission tab (Continued)

<u>Sub Section: Team Assignment</u>

If Assigned Teams are used in Avatar, enter the team here.

Demographics tab

Many of these questions are required for California State Reporting. **This section is not optional.** The questions have been left as not red/required, only because there are times when, due to PIC status, level of cooperation, etc....you may not be able to obtain this information. Answer as many questions as you can.

Questions about Language, Race and Ethnicity are required by California State Reporting. If you are not able to gather this information, at least answer the question, "Client Declined To Provide Information On The Following."

Below is information about a selection of other items on this tab. Many questions are self-explanatory and are not covered here.

Client's Preferred Phone: Enter the phone that the PIC most prefers to use here, whether it is cell phone, work phone or home phone. This phone number will appear that will appear in the PIC Info & Missing CSI Widget for easy reference.
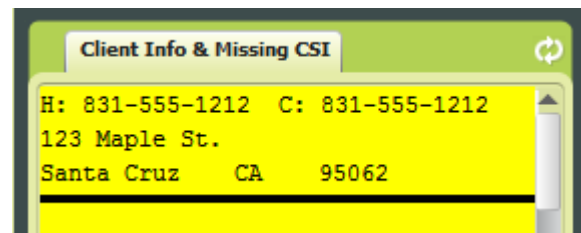
Approval to Leave Confidential Message: Enter "Yes" if the PIC is okay with someone leaving a message that may have confidential information in it, such as appointment information or information about medications.

Sexual Orientation question, "Are you heterosexual, lesbian, gay, bisexual, or do you question your sexual orientation?" This question is about sexual orientation. There is also a question about gender, which is on the admission tab.

Alias questions: Enter any alias for the PIC, last name first. When users search for the PIC, Avatar will look for any name you enter here. You can also enter a single name and this name will be part of a search for either last or first name.

<mark>DO NOT add a space in front of the first name. This will prevent the name search from working.</mark>

Alias 1
FLITTERBEAM, FLORENCE
Alias 2
FLUTTERBEAM
Alias 3
FLITTERBEAM, ALICE

YES → **Alias 1** JONES,JESSICA

NO → **Alias 2** JONES, JESSICA
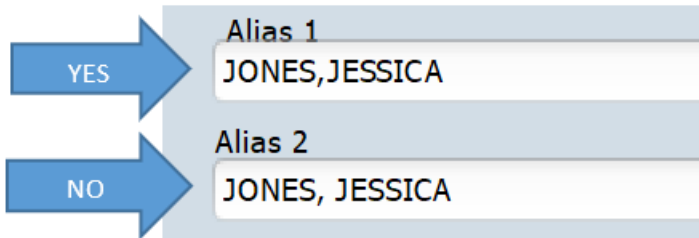
Protection Indicator: Select whether or not the PIC's information may be shared with others. If "Yes," enter the date that this protection should begin in the **Protection Indicator Effective Date** field.

Name Qualifier: This field is not currently used, but may be used in the future. This question can inform other users about whether or not there are restrictions on disclosing the PIC's name.

Discharge Form

Be careful not to close the episode if other providers at your agency are still working with the PIC.

For more information on discharging, see the section, Discharging PICs.

Discharge tab

1. **Date of Discharge**: Enter the date the PIC has discharged from the program.
2. **Discharge Time:** Enter 11:59 PM, unless it is important to note the specific time the PIC discharged. (TIP: Type "2359" and press enter.)
3. **Type of Discharge:** Enter the reason that the PIC is discharging.
4. **Discharge Practitioner:** Enter the name of the person completing the discharge form.
5. **Discharge Remarks/Comments:** Enter anything that is relevant to the discharge. Do not enter clinical information. This should be entered in the final progress note for the PIC.

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6. **Discharge Instructions:** Enter information here if relevant.

Demographics tab

This section contains identical items from the Admission form. This is your chance to update any PIC information, including contact information before you close the PIC. That way, if the PIC returns, the most current information for this PIC will be available.

For information on specific items, see instructions for the Admission form.

<u>Sub Section: CSI</u>

Patient Status Code: Select the best fit for where the PIC went after discharge.

Discharge Legal Class: Select the best fit for the PIC's legal status. Most of these questions have to do with conservatorship or legal guardianship.

These questions must be answered for California State reporting.

They have not been made red/required, but you must attempt to gather this information.
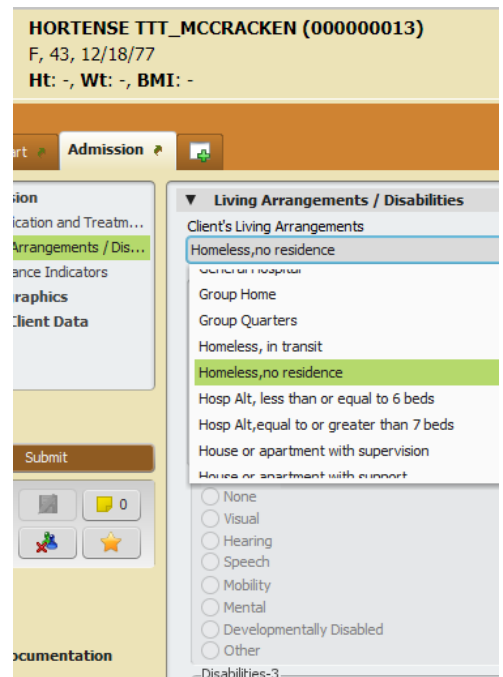
Updating the Admission Form

There are certain questions that cannot be updated using the Update Client Data form.

To update questions like this, you must open the admission form to edit. You are not creating a new admission, but just re-opening the Admission form for your episode, editing, and then saving.

The most common reason to do this is to update the PIC Living Situation question. This question must be up-to-date because it captures homeless information that is required by the State of California.

1) Click on the Admission Form link in the chart view. If you don't see the Admission form in your chart view, see the section, "Add a Form that is Not Listed to Your Chart View."

2) Click "Edit" in the upper right corner of the chart view.
3) Update information in the form as needed. For example, the PIC's phone number, address or living arrangements.
4) Click "Submit."
5) You should now see the updated information in the PIC's chart.

CSI Admission Form

The CSI Admission form in Avatar is for inputting demographic data for **Mental Health Services only**. SUD Service Providers do not use this form.

There is an associated widget in the chart that shows some of the key information in this form. See the section, "Client Info & Missing CSI Widget," for more information.

The CSI Admission form is completed at admission. This information is entered when the PIC is initially opened to services, and then annually by the primary clinician. Staff providing direct service delivery, such as coordinators and therapists, complete annual updates.

If you are the person completing the Access or Intake Assessment, you may need to complete a CSI Admission form. Unless a clerical person has already done this for you, you will need to do the form yourself.

Do your best to answer the questions on the form. Most of the questions on the form are required for California state reporting. Most questions are not red/required because you may not be able to gather all of this information intake. If you are unable to complete the form, you must update it once you obtain the rest of the information. **GATHER AT LEAST:** Last Name, First Name, DOB, SSN, gender. This way, we can insure that this is not a duplicated PIC.

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Questions on the CSI Form

1. **Birth Name (Last, First, Middle):** If you already entered the name in the Admission form, you will see it here. Enter the middle name if known.

2. **Year Or Month/Year Of Birth:** If you already filled in a birthdate in the admission form, you will see that information here. Otherwise, when the complete date of birth is unknown, as much of the date as is known shall be reported. At a minimum, an approximate year of birth must be reported. If only the age is known, enter the estimated year of birth in the format of "YYYY". If the month and year of birth are known, and the exact day is not, report the month and year only, in the format of "MM/YYYY".

3. **Birth Name (Suffix):** Enter as indicated.

4. **Mother's First Name:** Enter if known. This helps us identify the PIC if they have a common name, or if there is little demographic information available.

5. **Fiscally Responsible County For Client:** Typically, this will be Santa Cruz County, but may be another county, especially for children.

6. **Place of Birth – County:** Enter the county if it is in California, otherwise leave blank. If you accidentally clicked this question, and then realized that you don't want to answer it because the PIC was born out-of-state, see the instructions in the box above, "To Clear a Question You Didn't Mean to Answer."

7. **Place of Birth – State:** Enter if the PIC was born in the US. Otherwise, leave blank.

8. **Place of Birth – Country:** Enter if known.

9. **CSI Ethnicity:** Enter as indicated.

10. **Special Population:** Enter as indicated if your PIC fits in any one of these categories. If you are unsure, see your supervisor.

11. **Legal Class:** Enter as indicated.

12. **County School:** Enter if PIC is a child and is enrolled in school. If you do not see your PIC's school here, contact the computer helpdesk at **x4657** or **HSA.MhCompAssist@santacruzcounty.us**. Let them know that there is a school that needs to be added to this list.

13. **District County Code:** Enter the county that the school is in, typically Santa Cruz.

14. **District/Site Code:** Enter the District/Site Code. If you click the light bulb, you will see a list of codes and schools. If you do not see your school here, contact the computer helpdesk at **x4657** or **HSA.MhCompAssist@santacruzcounty.us**.

15. **Admission Necessity Code:** Enter if applicable. Otherwise click, "Unknown/Not Reported."

> ### To Clear a Question You Didn't Mean to Answer
>
> - There are several questions on the form that might not apply to your PIC. For, example, if your PIC was born out of state, you do not answer the question about County of Birth. To clear a radio button, checkbox or list item in a question (you want the question to be totally blank), click any of the buttons in the question, then press F5 on your keyboard, which will clear the field. If you have done this right, none of the buttons or boxes will be checked or clicked. If this is a list item type question, the question will appear blank.

16. **Is Substance Abuse Affecting Mental Health?:** Enter as indicated.

17. **Are Developmental Disabilities Affecting Mental Health?:** Enter as Indicated.

18. **Are Physical Health Disorders Affecting Mental Health?:** Enter as Indicated.

19. **Conservatorship/Court Status:** This question relates to the PIC's conservatorship status. If the PIC is not conserved, a court dependent or under payeeship, enter "Not Applicable."

20. **Preferred Language:** Enter the PIC's preferred language. For children, this needs to be the PIC's preferred language, and not the preferred language of the parent.

21. **Race (Select Up To Five):** Enter as indicated.

22. **Number of children less than 18 years of age that the PIC cares for/is responsible for at least 50% of the time:** Enter as indicated.

23. **Number of dependent adults 18 years of age and above that the PIC cares for, is responsible for at least 50% of the time:** Enter as indicated.

Client Info & Missing CSI Widget

NOTE: This widget "points" to the most recent OPEN episode in the chart.

This Widget is in the PIC chart and tells you if key information about the PIC still needs to be collected. If the background of the Widget is yellow, there are items missing.

Update Client Data Form

If you click the link, "Update Client Data," in the widget, this will launch the Update Client Data form. Where you can add or update information from the Admission form.

CSI Information

This link takes to you to the CSI Admission form, where you can update information.

Once all the questions have been answered, the widget will turn **green** as shown below.

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If this widget is yellow and you have answered all the questions below the black line, make sure you have entered the address and preferred phone.

Updating CSI Admission Information

How Can I Tell If CSI Information Needs Updating?

Once a year, the primary clinician working with the PIC should look at the form and see if there is anything that needs updating.

You can access the form in three different ways:

1. From the Search Forms field on the Home Console. (See next section for more information.)
2. From the PIC's chart. (TIP: Add the form to your PIC charts and you will be able to easily look at this information in the Chart View whenever you need it. See the section, "Add a Form That is Not Listed to Your Chart View.")
3. In the Missing Info & Missing CSI widget, there is a link to this form. Use the link labeled "Update Client Data" to open the CSI Admission form.

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To check the data, first look in the Client Info & Missing CSI widget. If it is yellow, answer the questions that still need data. If it is green, there still might be information that needs updating.

Next, check the most recent version of the CSI Admission and Update Client Data forms. You can look at the information in these forms just like you look at any other forms, like progress notes, in the PIC's chart. This view is called the Chart View.

If you do not see the CSI Admission form in the Chart View, see the section titled, "Add a Form That is Not Listed to Your Chart View."

Cal-OMS Admission and Cal-OMS Discharge Forms

The Cal-OMS Admission and Cal-OMS Discharge forms in Avatar are not only for collecting demographic data from each SUD service recipient. The forms also serve to collect treatment data which illustrates the positive influence SUD services has on SUD PICs as well as facilitates the improvement of service delivery.

The forms contain questions about PIC demographics, substance use, social supports and other factors that can impact treatment.

When to complete these forms

The CalOMS Admission is completed after the regular Admission form.
The CalOMS Discharge form is completed after the regular Discharge from the episode.
The Cal-OMS Administrative Discharge is used when the PIC leaves abruptly and cannot be contacted to complete the discharge interview.

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Client Cal-OMS Information Widget
There is an associated widget in the chart that shows some of the key information in this form. When all of the information has been added to the Cal-OMS Admission form, the widget turns pale green as seen at right.

If you are the person completing the intake for the PIC, you may need to complete the CalOMS Admission form. Unless someone else in your workflow normally completes this, you will need to do the form yourself.

Do your best to answer the questions on the form. The questions on the form are <mark>required for California state reporting</mark>. Most questions are not red/required because you may not be able to gather all of this information at intake. If you are unable to complete the form, you must update it once you obtain the rest of the information. <mark>**GATHER AT LEAST:**</mark> Last Name, First Name, DOB, SSN, gender. This way, we can insure that this is not a duplicated PIC.

For more information on how to answer questions in the CalOMS forms, see the DHCS document, "The California Outcomes Measurement System Treatment (CalOMS Tx) CalOMS Tx Data Collection Guide NNA Contract – Document 3J," or other documentation available at your workplace.

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Client Resources Form

The Client Resources form allows support people, family and outside providers such as medical doctors to be entered into Avatar. In addition, there is a question where you can indicate an Emergency Contact.

The form is useful in that you have an easily referenced place to keep contact information for individuals that are important to the PIC.

If you work with children, Medi-Cal requires that you have parent/guardian information. Use this form to enter the information.

At right is an example of what the form looks like in the chart Chart View. The most recently saved resource, in this case, the probation officer, is shown on the "Current" tab. Other resources are on the "History" tab.

If you are working on a Psychosocial Assessment, you will be prompted to use the Cliet Resources form when you enter information about the PIC's primary care provider.
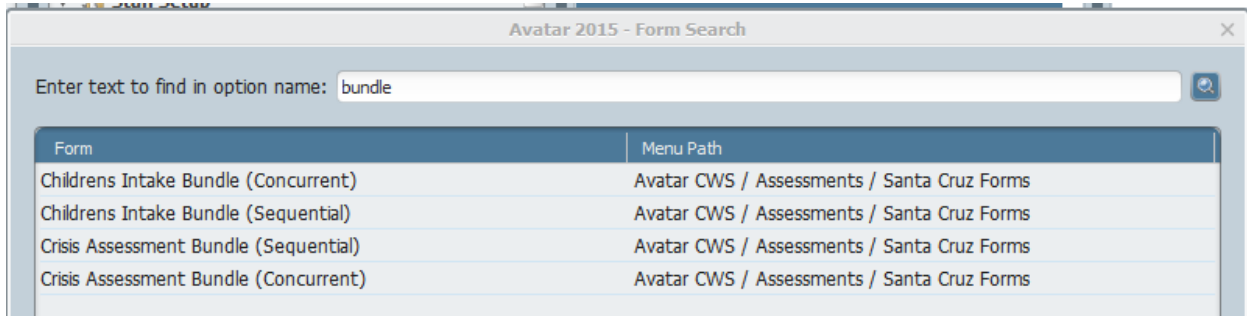

If you don't see the PIC Resources form in the PIC chart, you can add it to your Chart View or chart view. (See the section titled, "Add a Form that is Not Listed to Your Chart View.")

Form Bundling

Groups of associated forms can be opened up automatically using bundling.

Type in the word Bundle in the Search Forms field in your Forms & Data Widget on your Home Console to see the various bundles that are available. Note the various sequential and concurrent bundles available. Sequential bundles are done one at a time. Concurrent bundles open up all of the forms at the same time.

Avatar 2015 - Form Search		✕
Enter text to find in option name: bundle		
Form	**Menu Path**	
Childrens Intake Bundle (Concurrent)	Avatar CWS / Assessments / Santa Cruz Forms	
Childrens Intake Bundle (Sequential)	Avatar CWS / Assessments / Santa Cruz Forms	
Crisis Assessment Bundle (Sequential)	Avatar CWS / Assessments / Santa Cruz Forms	
Crisis Assessment Bundle (Concurrent)	Avatar CWS / Assessments / Santa Cruz Forms	

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## Santa Cruz Psychosocial Assessment Form

Tabs: Each tab has related questions that that address related types of information. For example, there are separate tabs for Mental Health History, Legal History and Trauma History.

It is recommended that you move through the form tabs in order on your "first pass" to make sure you don't skip over questions. You may return to a tab to add information at any time.

> **For information about assessment content (what to write), see the Santa Cruz County Behavioral Health Documentation Manual.**
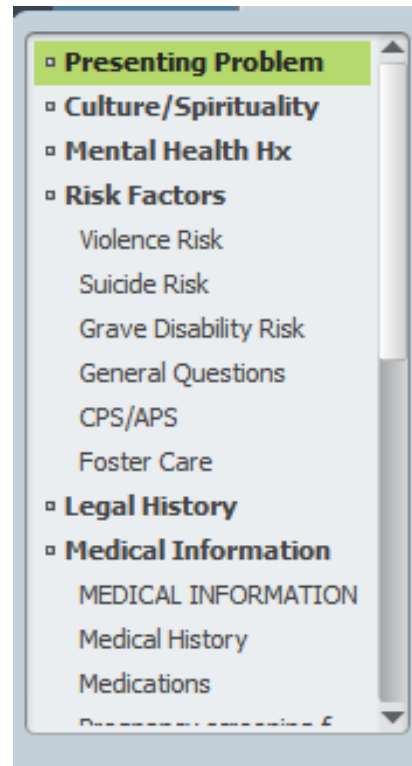
Sections: Tabs may be subdivided into *sections,* set apart with gray bars. Click on the triangle at the left of each section divider to open up or collapse the section.
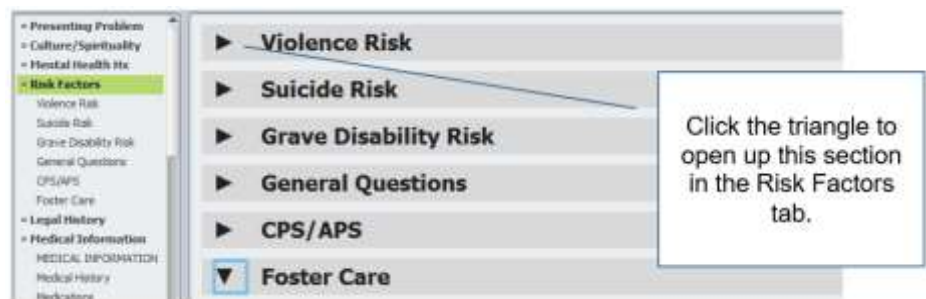
Required Questions: In the Psychosocial Assessment, some questions are required and others are optional, although you are strongly encouraged to answer as many questions as possible, including those that are optional. Questions in **red** are required to finalize and submit the form.

Lightbulbs: Throughout this and other documents, you will see a small light bulb symbol. If you hover over the symbol, you will see instructions on how to answer the question.

Question Logic: Some questions are required depending on the answers to other questions. For example, in the **Legal History tab**, the first question is required. In the example below, because the clinician clicked "No" to the first question about any legal involvement, all the other questions are

not required and in fact are "grayed out" or *disabled*. No information can be entered into these questions.

The Backup Form button will save the form while it is open. EVEN THOUGH THE PSYCHOSOCIAL HAS THIS BACKUP BUTTON, YOU SHOULD STILL CLICK "SUBMIT" TO SAVE AND CLOSE WHEN YOU EXIT THE FORM.

<mark>When closing your assessment, DO NOT click the red and white "X". If you do this, the form will close without saving your data. Click SUBMIT to SAVE AND CLOSE.</mark>
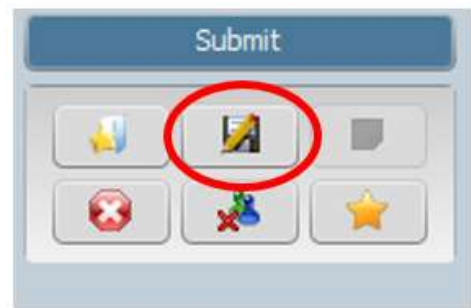
Text Editor: If the text box requires a lengthy answer, you can pop out the text editor to see more of the field by clicking the associated icon. Click "Save" to close the popout and save your edits. If you do not click "Save," your edits will not be saved.
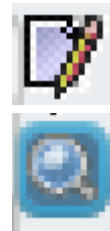
Search Function: Click the tiny magnifying glass to search for a word or phrase in your text.

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Psychosocial Assessment Forms Checklist

Remember, in order to complete a psychosocial assessment, you will need to complete a combination of the forms below.

☐Psychosocial Assessment SC (main form)
☐Risk Assessment SC: Required depending on certain questions about danger to self/suicidality, danger to others, grave disability.
☐Diagnosis: Must be completed each time psychosocial is completed, but only licensed, waivered, or registered clinicians may complete it. Non-licensed staff should coordinate with licensed staff/supervisor to get this done.
☐Mental Status SC (MSE): Must be completed each time, but only licensed, waivered, or registered clinicians may complete it. Non-licensed staff should coordinate with licensed staff/supervisor to get this done.
☐Progress Note(s): required to document the service

See the section, "For Non-LPHA's: Where to put the MSE and Diagnosis," for more information about completing the diagnosis and MSE.

Psychosocial Assessment SC Requirements

- Only Mental Health Programs complete the Psychosocial Assessment SC.
- Previously this assessment was required annually. Currently the psychosocial should be updated when there has been significant change.
- The psychosocial can be done in any episode, by any staff person to meet the annual update requirement. If someone else in another program has already done one this year, you are not required to update.
- If you are not an LPHA, you will need to coordinate with LPHA staff to make sure the MSE and diagnosis are updated.

To begin your Psychosocial Assessment SC, review any prior assessments first. Open the PIC's chart and then select the Psychosocial Assessment SC from the list of forms on the right. Then click on the tab for your Admission Program, e.g. ME – 00044 MH County Outpatient.

IMPORTANT: This form is episodic, that is, it is attached to an episode. Make sure you select your episode carefully. If you write the assessment under the wrong episode, it cannot be moved, and you will have to write it all over again.

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Presenting Problem Tab

1. Enter the Assessment Date. Click "Today" or "Yesterday", or for a different date, type it in. If you typically meet with a PIC for more than one assessment session, enter the date of your first assessment session with the PIC.

IMPORTANT: Make sure you select the correct date. Once you save the form in draft, you will not be able to change this date. All other questions are editable if you close and reopen.

2. In the **Type of Assessment** field, select the appropriate type of assessment.

3. In the **Assessment for what population field**, select the appropriate population.

   Question Logic for population: Note that there is a great deal of question logic associated with the "population" question, so <mark>make sure you click the correct box for this item</mark>. Various questions are required or disabled depending on the answer. If you change the answer to this question mid-way thought the assessment, some text boxes may clear and you will lose your data.

4. **Draft/Final:** Once you have answered the questions, *Assessment Date*, *Type of Assessment* and *Assessment for What Population*, <mark>skip to the very end of the assessment, to the last question at the bottom of the Summary Tab.</mark> Select Draft in the Draft/Final field radio button. **At this point you have completed all the tasks necessary to save your document as a draft.** You can submit the document and return to it at a later time. Now return to the Presenting Problem Tab to continue with your assessment.

5. **Complete the Presenting Problem** (What made Client/child come for services?) and **Describe any functional Impairments** fields.

   Culture/Spirituality Tab
   Complete data entry for the "Describe the Client's/child's cultural practices and spiritual beliefs," question and the, "Describe the Client's/child's gender roles and sexuality," question.

   Mental Health Hx Tab
   Source(s) of current clinical information field: This brief field is a chance to **list** the types of information you are using to complete the assessment. Examples: PIC report, hospital records, family. You only have about 20 characters in this field. If you need to discuss sources of information more thoroughly, use the larger narrative box in this section.

   ## For Non-LPHA's: What to do about the MSE and Diagnosis

   The MSE and Diagnosis must be completed each time a Psychosocial Assessment is completed. Licensed/waivered/registered staff or LPHA's should use the separate Mental Status SC form and the separate Diagnosis form to enter this information. If you are not an LPHA, you will not be able to use these forms.

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MSE

An MSE must be completed by an LPHA when the psychosocial assessment is completed. Look in the chart to see if there is a current MSE. If not, work with your supervisor to make sure that there is a MSE in the chart. If the PIC has a psychiatric provider, a written MSE in the text of a psychiatry note is sufficient to meet the MSE requirement as long as the note was done in the past year. If there is no current MSE in the chart, then an LPHA will need to complete the MSE.

Diagnosis

A diagnosis form must be completed by an LPHA when the psychosocial is completed. See your supervisor for the workflow regarding coordination with an LPHA for the diagnosis. Even if the diagnosis has not changed, the Diagnosis form must be completed annually.

Licensed Waivered Registered Staff:

You are required to complete the Mental Status SC and diagnosis each time you complete a psychosocial.

For more information on the diagnosis form, see the sections, Admission Diagnosis and Diagnosis Update.

If the diagnosis has not changed since the last assessment, you must still complete the form, but the procedure is fairly simple in that you essentially copy the prior diagnosis into a new Diagnosis form, and then finalize the form. See the section "Complete a Diagnosis Update When the Diagnosis Has Not Changed," for more information.

Of course, if the diagnosis has changed, feel free to reflect those changes when you complete the diagnosis form.

Because non-LPHA staff may be completing psychosocials and cannot complete the diagnosis form, you may be asked to coordinate with these staff members on getting the diagnosis done. See your supervisor for more information.

Risk Factors Tab

The Risk Factors Tab contains question logic that turns various questions on and off. In addition, answering "yes" to certain questions launches another form, the Risk Assessment Form. If you answer "Yes" to either of the three questions about CURRENT DTS, DTO or GD, you must complete the Risk Assessment. Information about PAST DTS, DTO or GD does not trigger the Risk

Assessment. You do not have to complete the Risk Assessment if DTS, DTO or GD is in the past, but not current.

EXAMPLE: In the Risk Factors Tab, in the Violence Risk Section click "Yes" to the question, "Current danger to others/homicidal ideation." A pop-up will direct you to open up the Risk Assessment. If this is an error or you want to come back to the Risk Assessment later, you may click "No" and return to the Psychosocial Assessment form. You will need to complete the Risk Assessment form at some point if answered "Yes" to any of the trigger questions.

Grave Disability and Children: If your PIC is a child or youth, you will notice the question about GD is disabled or greyed out. This is because it is extremely rare for children, who have caretakers, to be legally considered GD. If you need to discuss GD, do so when you complete the Risk Assessment.

Legal History Tab

Note the embedded logic for current and past legal involvement. The first question about history of, or current legal involvement, activates or deactivates the rest of the questions in the section.

Medical Information Tab

Client Resources Form

The question regarding primary care provider launches a window to the Client Resources form.

The Client Resources form allows support people, family and other providers such as medical doctors to be entered into Avatar. If you don't have it, you can add the Client Resources form to your Chart View to see this information (see the section titled, "Add a Form that is Not Listed to Your Chart View.")
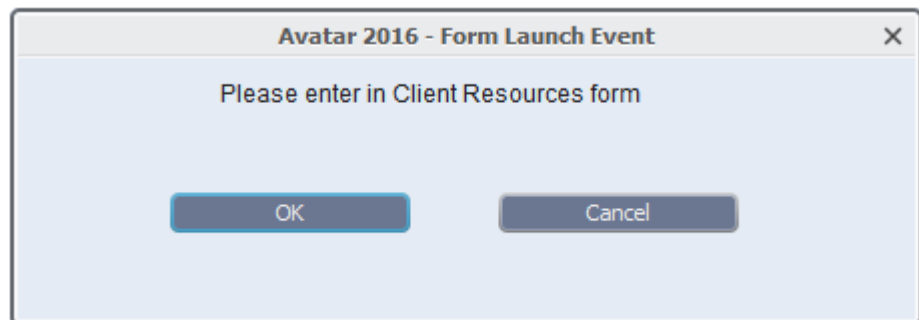
See the section, "Client Resources form," for more information about completing this form.

Developmental History Tab
Answer these questions as appropriate. These questions are required for children/youth, but you are encouraged to answer these questions for adults if you have the information.

Substance List Tab

The Substance List Tab contains a *multi-iteration list*. Information about each substance the PIC currently uses/abuses has its own line in the list. To add a substance to the list, you must first create a new line by clicking, Add New Item.

List all substances used, not just those abused. For example, if the PIC drinks one cup of coffee per week, and this use is not medically contraindicated, the PIC's use of caffeine/coffee should still be noted.

Medi-Cal requires that we ask about the following: alcohol, caffeine, tobacco/nicotine, CAM (complementary and alternative medications), OTC drugs, and illicit substances and note any use information.

If the PIC does not use a particular substance at all, you do not have to list it.

STEPS to Complete the Substance List Tab:

1. **Click Add New Item:** Begin by adding a new row to the *table or multi-iteration list* by clicking *Add*
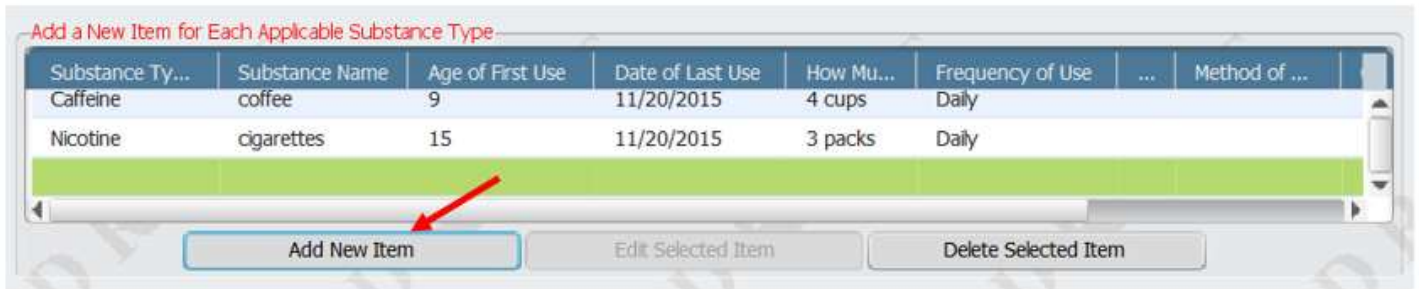
New Item to start a new row. (For each new substance, you will begin by adding a new row.)

2. **Fill out the rest of the row, entering information into the blanks below the table.** Note that you will need to answer the questions for each substance in order, for the list to work properly.

TO EDIT A ROW: In order to edit a row, you need to first select it. Double-click on the row that you want, or click once on the row, and then click Edit Selected Item. If you do not select the row, you will not be able to edit the information in it.

TO DELETE A ROW: In order to delete a row, you need to first select it. Double-click on the row that you want to delete, or click once on the row, and then click Edit Selected Item. Then click Delete Selected Item.

TIP: **Make sure that you don't accidentally added an extra line in the table.** It's easy to do by clicking on the button labeled, *Add New Item* too many times. If you accidentally add an extra row, you might overlook it because it is blank. Unfortunately, Avatar sees any blank lines that you leave

in this table as unanswered required questions. You will not be able to submit your Psychosocial, either in Draft or Final, if you leave blank lines in this table.

If you see this warning when you attempt to finalize your psychosocial, you know that you have blank lines in your Substance List.
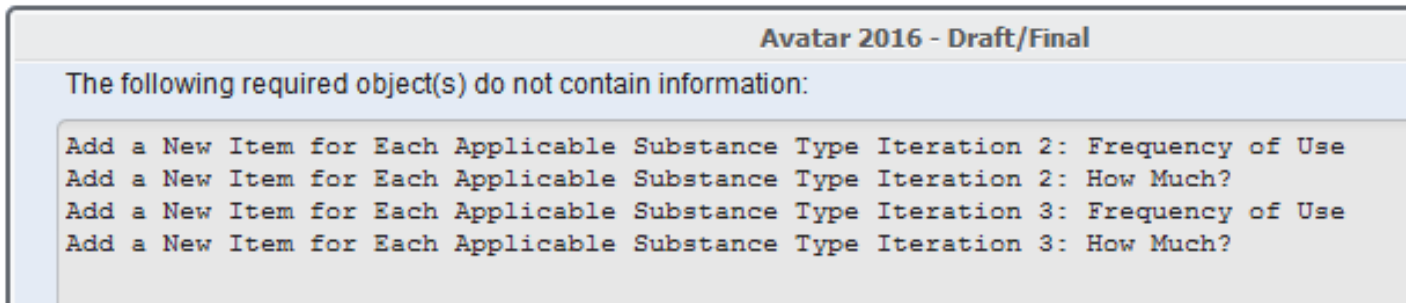
If Your PIC Does Not Use Any Substances At All

You must still complete one line in the table.

1) PIC "New Item" to add a blank row to the table.
2) In the "Substance Type" question, click "None."

Everything else on the page will be greyed out/disabled and you are now done with this tab.

Substance Use Hx Tab
Note the question logic based on the answer to the first question on the page.

Trauma History Tab

Does the Client/child have a history of trauma? This question is required. Depending on the circumstances surrounding the assessment, your PIC may not be willing or able to answer questions about this topic. For example, for a psychotic individual who is currently hospitalized, this may not be the time for this discussion. Enter "Unknown" if you do not have sufficient information to answer the question. For assessments that take place over a number of sessions, you may be able to gather this information later and can add it to the assessment at that time. If you suspect, but do not have confirmation of abuse, you can discuss this in the text field below the question.

Strengths Tab

Describe Client's/child's current or past strengths to achieve goals: This question is for documenting strengths specific to the PIC's anticipated ability to achieve treatment plan goals. Examples are resiliency, motivation, positive social supports.

Describe what the Client/child feels is important in their life: This question is appropriate for noting what motivates the PIC and other issues that are important to the PIC. It allows the clinician

to enter items that may be personally motivating for the PIC, but may not be appropriate for the prior question such as: playing video games, smoking, hobbies.

Work/School Tab: Answer questions as appropriate.

Family/Social Tab: Answer questions as appropriate.

Summary Tab

Note that there are two "Clinical Summary" fields. Either one or the other is activated depending on your answer to the question, "Is client being referred to/reauthorized for services?" Both will not be activated at the same time on the form.

IMPORTANT: If you write your summary, and then change your mind and click the other button, everything in your summary will be erased.

At right, the PIC is recommended for services. "Is PIC being referred to/reauthorized for services?" has been answered with "Yes."

The clinician has written the summary in the first of the two text fields for the summary.

If the question, "Is Client being referred to/reauthorized for services?" is now clicked "No," the entire text in the summary field is greyed out, and all of the information is lost. MAKE SURE THAT YOU DO NOT MAKE THIS MISTAKE.

Clinical summary of recommended services: This field is activated if the PIC is authorized or reauthorized for services. This is where the justification for referral into services (or reauthorization for services) is entered. Although no diagnosis is entered in the psychosocial assessment, discussion of diagnostic formulation is appropriate for this field.

Even if this is a long-term PIC, you must still document why the current level of service or care is still appropriate for the PIC.

Clinical Summary, explain reason for denial…This field is activated if the PIC is determined to not meet medical necessity and will be referred out. The reasons for this are documented here.

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Where is the diagnosis?

Remember that assessments in Avatar are made up of multiple of forms. A Psychosocial Assessment consists of the main Psychosocial Assessment form, plus the Diagnosis form, Risk Assessment, MSE, and Drug Grid (Children's). Only licensed/waivered/registered staff complete the Diagnosis form (and the MSE).

If you are not licensed/waivered/registered, review the diagnosis in the chart and then reference this in the Mental Health tab. See the section, "For Non-LPHA's: Where to put the MSE and Diagnosis," for more information.

Licensed Waivered Registered Staff:

Once you complete your psychosocial, complete the Mental Status form. If required, complete a diagnosis.

You are required to complete the Mental Status and Diagnosis form each time you complete a psychosocial, which must be updated annually. Even if the diagnosis has not changed, you must complete the diagnosis form. See the section, "Complete a Diagnosis Update When the Diagnosis Has Not Changed," for more information.

How do I bill for the service?

There is no place to enter service or billing information on the psychosocial. You will write a progress note documenting the service. See the section titled, "Writing a progress note to document your service for an Assessment or Treatment Plan," for more information about how to write this note.

Finalizing and Submitting the Psychosocial

At the end of the Summary tab, Select Final.

If you have missed one or more required fields, a window will pop up telling you which questions you still need to answer.

If all required fields are answered, the Confirm dialog box will be presented. Select OK. The Draft watermark will be removed. Select Submit. The Confirm Document dialog box and TIFF (picture of the completed assessment) is displayed.

As with the Progress Note form, you will have the opportunity to proofread. You may:
1. **Accept** the psychosocial as final and file it,
2. **Reject** the psychosocial so that you can return it to draft status and edit some more,
3. **Accept and Route** the psychosocial to a supervisor and/or approver(s). See the section, "Document Routing," for more information.
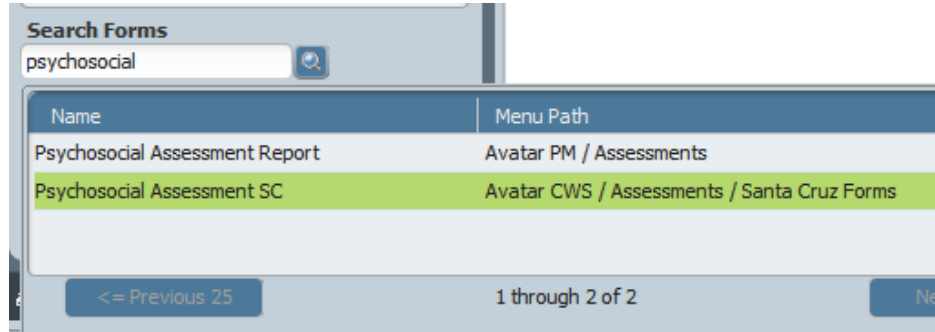
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How to Reopen a Draft Psychosocial Assessment Form

You may not be able to finish your psychosocial in one session. If you need to reopen your draft to continue editing, you can open up your draft from your Home Console or from the chart.

Open a Draft Psychosocial Assessment from your Home Console

1. From your Home Console, type in the word "psychosocial" into the Forms Search blank in your Forms & Data widget.
2. Double-click on "Psychosocial Assessment SC." Do not click on the Psychosocial Assessment Report. This goes to a printout of the assessment that you do not want at this point.

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3. Enter your PIC name or number in the Select PIC pop up and double-click on the PIC name. You will see a *Pre-display* of all of your PIC episodes.
4. Select your Admission Program from the pre-display. Either double-click on the Admission Program or click once to highlight and then click "OK."
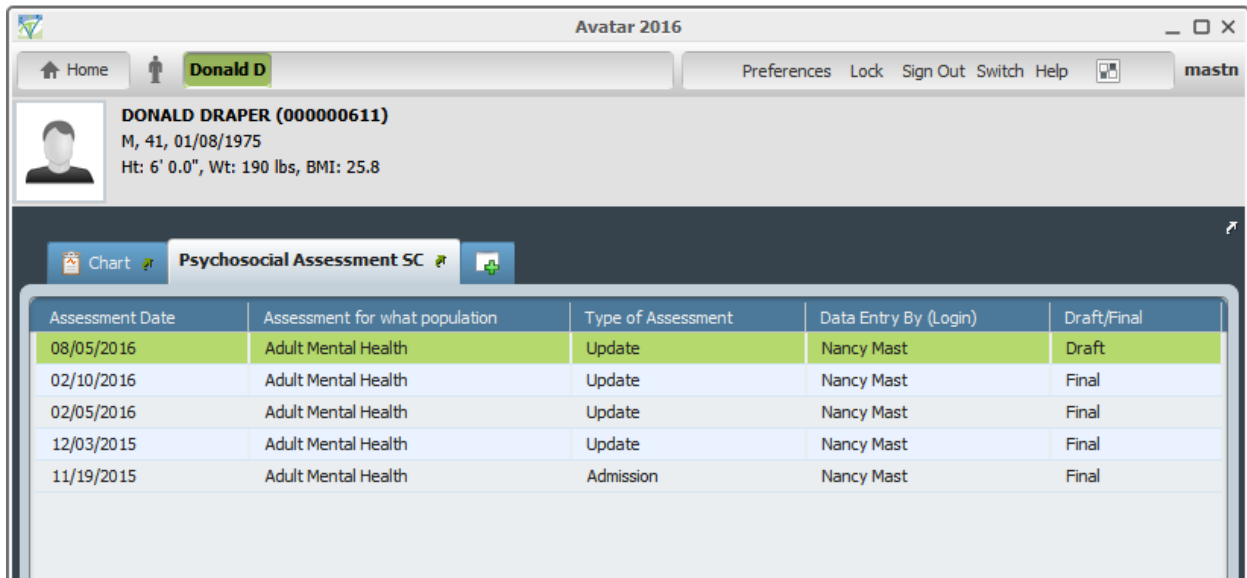

5. You will see a list of assessments that have been done under your Admission Program for this PIC. Double-click on your Draft Assessment to open it.

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6. When opening up a new psychosocial assessment, may get a warning that says that you have an unsubmitted backup of the form. You may get this if you have a previous draft of the form that you did not submit in the normal way. This is a complicated way of asking you whether or not you want to save and use the information that you previously entered into the form. **Click "Yes."**
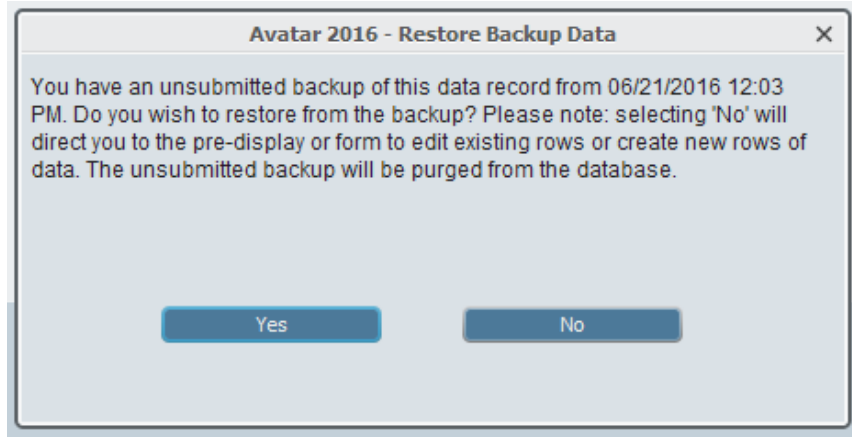
IF YOU CLICK "NO," YOU WILL LOSE ANY UNSAVED DATA FROM THE LAST TIME YOU WERE IN THE FORM.

Open a Draft Psychosocial Assessment from the Chart

1. Open the chart and click on the link on the left, "Psychosocial Assessment SC."
2. Click on the tab associated with your Admission Program.
3. Click on the word "Edit" at the upper right. (It is in the border next to the word "Print.")

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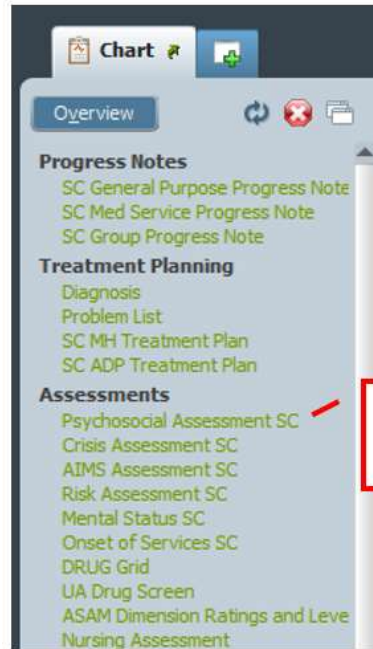## How to View a Completed Psychosocial Assessment (or any other form) in the Chart View

1. Open the chart and click on the link on the left, "Psychosocial Assessment SC."
2. Click on the tab associated with your Admission Program.
3. View the psychosocial assessments for your program. Note that both drafts and final forms are available for viewing.

Click here to view the psychosocial assessments.

Click on the tab for the admission program (episode).

If there are many episodes, you may have to click the tiny triangles here to scroll among the episodes.
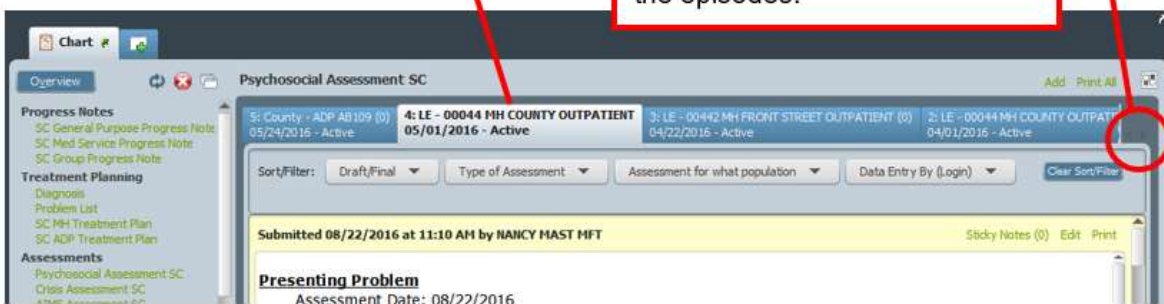
Santa Cruz County Behavior Health Avatar

Assessment Updates

- Every assessment must be a stand-alone document and provide a current picture of the PIC.
- **When updating, review the chart and update the to reflect current status and events since the last assessment. DO NOT simply copy from the prior assessment without editing or at least reviewing the information.**
- Some information from prior versions of the form may be *defaulted* or pulled forward to the current version. If you think that defaulted information is not correct or needs an update, you have the choice to re-use the information or start fresh. You can always edit or delete any information that has been brought forward.

If your PIC has had a previous Psychosocial Assessment under your Admission Program, information from the prior assessment will be auto populated into your current assessment automatically when you open a new one. You may then edit the document, updating the previous information.

If the PIC has had more than one Psychosocial Assessment under your Admission Program, Avatar will present a list of all of the PIC's prior Assessments in your Admission Program. You may then select which prior assessment to use to populate your new assessment.

Note that this only works within one Admission Program. For example, if there is a psychosocial done under County – Pre Admit, you will not be able to automatically add information into an assessment under LE – 00044 MH COUNTY OUTPATIENT.

To select an assessment from which to auto populate your new assessment

1. Select the Psychosocial Assessment SC form in your Forms & Data Widget.
2. You will see a window listing all of the open episodes for the PIC. Select the episode associated with the services you provide.
3. You will then see Pre-Display listing all of the prior assessments for your PIC. Click **once** on the assessment you want to use to highlight it in green.
4. Then click Add, in the lower left hand corner of the window.

CalAIM Assessment

A simplified assessment form is coming soon and will eventually replace the Psychosocial Assessment SC.

Risk Assessment Form

When to complete the form:

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When completing the Psychosocial Assessment, The Risk Assessment is completed when questions about **current** danger to self/suicidality, danger to others/homicidality, and grave disability are answered "Yes."

The Risk Assessment is always required when completing a Crisis Assessment.

The Risk Assessment may also be used in other instances. For example, ongoing assessment of a PIC with frequent suicidal ideation. Consult with your supervisor if you think using this form might be helpful in your clinical work.

Make sure you ask PICs about access to weapons such as firearms when discussing a plan to harm themselves or others. Discuss in the Comments section(s) of the form.

Mental Status Exam (MSE) Form

When to complete the form: The MSE is always required when completing the Crisis Assessment. It is also required for the Psychosocial Assessment if you are licensed/waivered/registered (LPHA).

If you are not licensed, waivered, registered and the PIC has a psychiatric provider, a written MSE in the text of a psychiatry note is sufficient. If there is no MSE in the chart or in a psychiatry note, then an LPHA will need to complete the MSE.

The MSE may also be used in other instances. For example, ongoing assessment of a therapy PIC, so that changes in status and presentation can be compared from session to session.

This form consists primarily of check boxes. ***Note that text fields at the end of sections are optional.*** Supplementary questions in the **Questions Tab** are also optional.

CANS/ANSA Form

The Child Assessment of Needs and Strengths (CANS) and the Adult Needs and Strengths Assessment (ANSA) are combined in one form in Santa Cruz County Avatar.

This multi-purpose tool has been developed for behavioral health services to support decision making, including level of care and service planning, to facilitate quality improvement initiatives, and to allow for the monitoring of outcomes of services.

The form also helps to facilitate the linkage between the assessment process and the design of individualized service plans including the application of evidence-based practices.

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When to complete the form: The CANS/ANSA form in Avatar is completed in conjunction with the Access Assessment and then every six months after that.

A paper version of the form is available for field use. Once you return to the office, enter the data into the Avatar form.

Question Logic: This form has many items that have *question logic*. It is important that you complete all of the questions in this form in order because of question logic. The way you answer earlier questions, affects how other questions downstream act. The way you answer one question, may affect whether or not other questions are red/required, enabled or disabled (greyed out). In order to complete the form, required (red) questions must be answered. You cannot finalize and submit the form unless you answer all required questions. Disabled questions appear with a grey background and you cannot enter data into them.

Monolingual Spanish Speaking PICs: Currently, there is no Spanish form in Avatar. If your PIC speaks Spanish, use the pre-Avatar paper form. You should fill out this form and then turn it in to data entry.

Steps to filling out the form:

1. **Open the form** either from the Chart View in the PIC's chart, or from the Search Forms blank in your Forms & Data Widget.
2. **Complete Overview Tab:** The first tab on the form is the "Overview." The Overview tab has questions about basic PIC information relevant to the rest of the questions on the form. As in any other form, required items appear in red, optional items appear in black and disabled items appear in gray. On the Overview tab, fill in the **Assessment Date**, which is the date you complete this assessment.
3. **Assessment Type:** The first assessment for your PIC will be an "Admission." For subsequent updates, click "Update." Ask your supervisor if doing a Discharge CANS/ANSA is part of your workflow. If so, and you are completing the CANS/ANSA as part of the discharge, click "Discharge."
4. **Age Group:** Click the appropriate age group for your PIC. Three separate age groups have been integrated into one form in Avatar (0-5, 6-17, and 18+). When you select the age group, the form activates questions throughout the form that apply only to that specific age group. All other items are disabled or greyed out.

IMPORTANT: Make sure that you click the correct age group. If enter the wrong age group and then correct the mistake later, you will lose data that you have already entered in the form.

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Shown below, the question, "Client Current Age Group," is entered as "0-5" some questions on the next tab, Strengths Domain, are red/required, and others grayed out or *disabled*.

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If the question, "Client Current Age Group," is entered as "21 and over," different questions on the Strengths Domain tab, are red/required, and different questions are grayed out or *disabled*.

5. **Caregiver's Relationship to Client:** Answer this question for both children and adults. For adults, if there is not a primary caregiver, enter "N/A." If PIC has a caregiver for which none of the selections in this question apply, click "Other," then enter the type of relationship in the question below ("If Other, Enter Type of Relationship Here"). Example: In home support worker.

6. **Caregiver Name:** If you have entered any response other than, "N/A" or "PIC has no known caregiver," to the Caregiver Relationship question, you will need to enter the name of the caregiver here. If the caregiver is associated with an agency, you may enter the information.

7. **Draft/Final:** Note that this question is on the first tab rather than at the end of the form as in other Avatar documents. When you complete the form, you may find yourself looking for this question on the last tab. Remember that it is here.

8. **Complete the remaining questions on the form in order.** It is important that you complete all of the questions in order because there is significant *question logic* in this form. That is, the way you answer some questions, will affect how other questions appear.

   The modules of the CANS/ANSA are integrated into the body of the form. If a trigger question for a module is scored 1, 2 or 3, the items of the module will be activated, and the required items will be highlighted in red.

   For example, the question, "Developmental Milestones" affects how questions appear in the, "INTELLECTUAL/DEVELOPMENTAL MODULE" below it.

   If the, "Developmental Milestones" question, is entered as a "3," then three questions in the associated module below are enabled/required.

If the, "Developmental Milestones" question, is entered as a "0," then the questions in the associated module below it are disabled/grayed out.

CANS/ANSA Defaulting for Updates

CANS/ANSA updates are created every six months. When you create an update, Avatar gives you the opportunity to add information from a previously completed CANS/ANSA to your current one, which you then edit.

When you default from a prior CANS/ANSA, you essentially make a copy of that CANS/ANSA. This new copy will be in draft, and you can edit as needed. Once you are done with your update, finalize as usual.

STEPS:

1. Open the PIC's chart.
2. Click on CANS ANSA in the list of forms on the left-hand side of the chart.
3. Look to make sure that there is a prior CANS/ANSA, and that the most recent version doesn't have any errors or problems before proceeding. If you find an issue, contact askqi@santacuzcounty.us to get help before proceeding.
4. Click the link to the CANS ANSA form on the left side of the chart.
5. Click "Add" in the upper right hand corner of the chart, to launch a new CANS/ANSA.
6. You will see a "Pre-display" of prior versions of the CANS/ANSA that have been completed by previous Avatar users. Click the most recent CANS/ANSA, which should be at the top of the list.
7. The form will open. The data from the last CANS/ANSA is now in your new form. Edit as needed and then finalize and click "Submit."
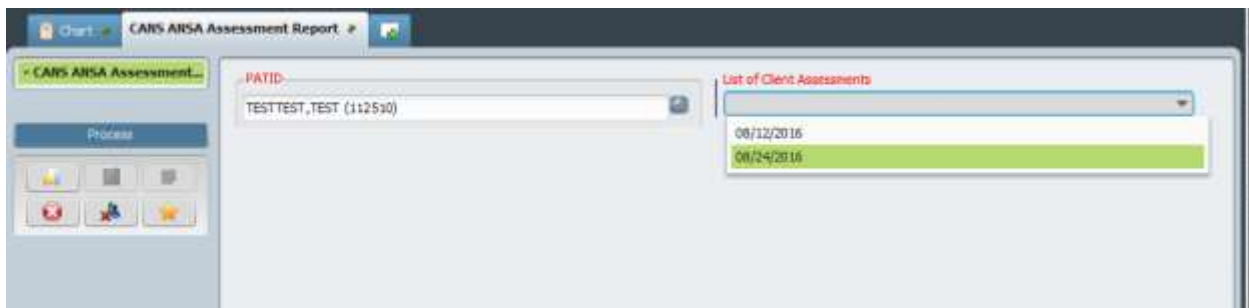
Santa Cruz County Behavior Health Avatar

CANS/ANSA Reports

CANS/ANSA Assessment Report

The CANS/ANSA Assessment Report can be opened from the chart or from the Home Console. Use this to print a formatted copy of a single completed CANS/ANSA to give to the PIC.

1. Search for the form, *CANS ANSA Assessment Report*, from the PIC chart or the Home Console.
2. Click on the name of the form to open it.
3. If you have pre-selected the PIC, the PIC's name will appear in the "PATID" blank. Otherwise, enter the PIC ID.
4. From the List of Client Assessments dropdown, select the form you want to print. Forms are listed by date only, so make sure you know the date of the CANS/ANSA you want to print.


5. Click "Process" to generate a report for the form. Note that the report may take several minutes to generate.
6. If the report doesn't pop up, click on the large Avatar symbol at the bottom of your Windows desktop to view it.

7. To print, click on the little picture of the printer in the upper left-hand corner of the report screen.

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The CANS/ANSA Graph Report can be opened from the chart or from the Home Console. Use this to print the data from multiple CANS/ANSA's in a graph format to see PIC changes over time. The Graph Report below shows information from three different CANS/ANSAs over a period of three years.
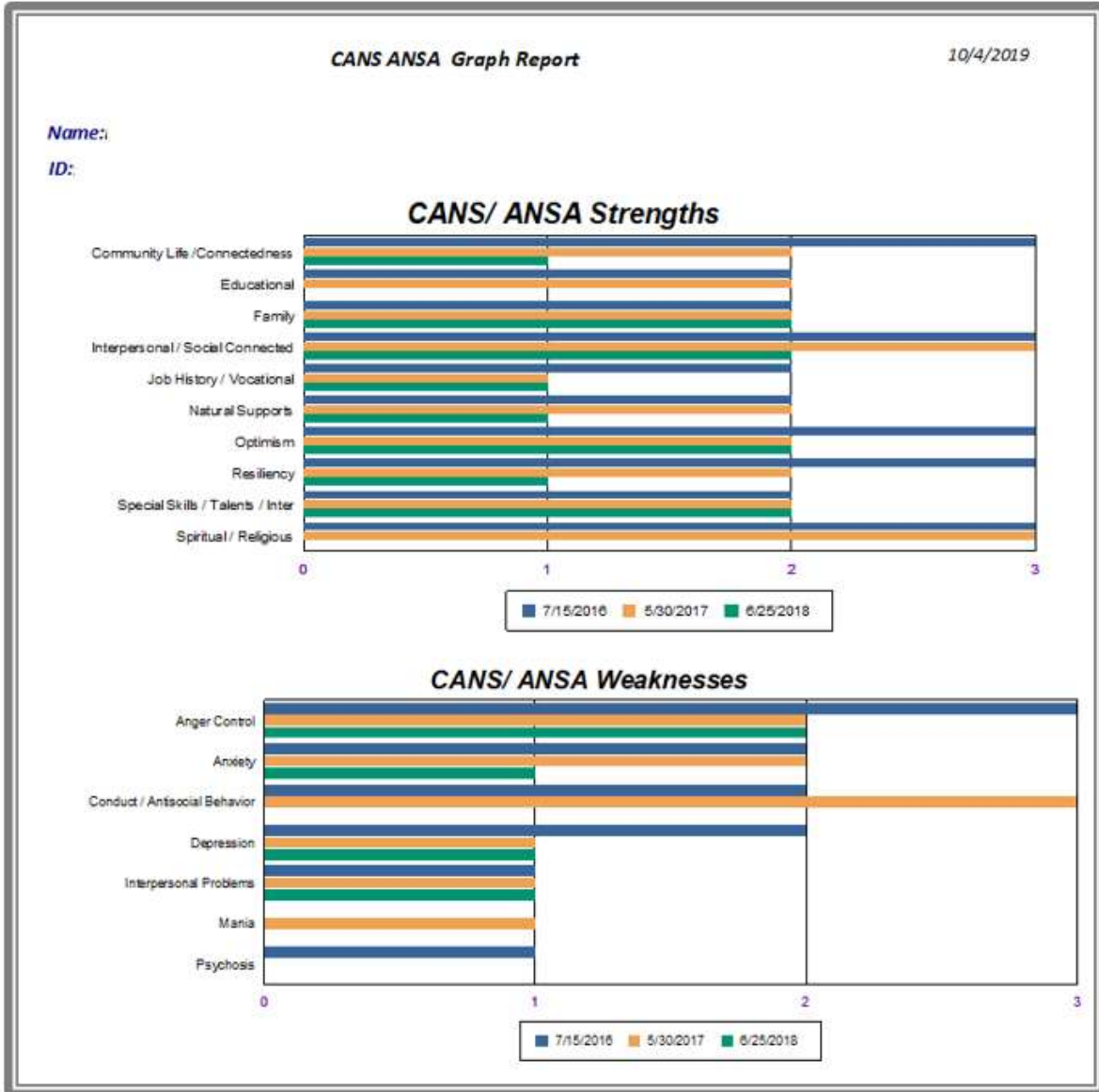
Santa Cruz County Behavior Health Avatar

ASAM and ALOC Forms

Introduction: The American Society of Addiction Medicine Criteria (ASAM Criteria) assesses the PIC for placement and facilitates creation of substance abuse treatment plans. It is used primarily by ADP treatment programs. If PICs have consented to share their SUD records, the ASAM results will be viewable in Avatar. The ASAM assesses five broad levels of treatment. These levels are medical management, the level of structure, safety, security and intensity of treatment.

ASAM criteria addresses the PIC's needs, obstacles and liabilities, as well as the PIC's strengths, assets, resources and support structure.

Santa Cruz Avatar has three different ASAM forms. The ASAM Reassessment form is for updates. The two ALOC (ASAM Level of Care) forms, one for adults and one for adolescents, is for doing the initial ASAM assessment.

Adult Episodic ALOC Assessment

This is the initial ASAM for an adult (18+) PIC. It is done as part of the intake process.

Adolescent Episodic ALOC Assessment

This is the initial ASAM for an adolescent (under 18) PIC. It is done as part of the intake process.

ASAM Reassessment SC

This ASAM type is completed periodically while the PIC is in treatment. For medication assisted treatment, this is done every three days. For other programs this is completed weekly or every other week. Overall, it is a much simpler form than the two ALOC's, which are meant to be more comprehensive intakes done at admission only.

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Pediatric Symptom Checklist (PSC – 35)

About the Pediatric Symptom Checklist (PSC-35)

The Pediatric Symptom Checklist (PSC) is a 35-item screening questionnaire designed to identify difficulties with psychosocial functioning in children, from the caregiver's perspective.

The state of California requires all counties to use the PSC-35 when evaluating children who receive mental health services.

Note that only Santa Cruz County Children's Mental Health staff need to fill out this form. Adult MH and SUD services are currently exempt.

> The PSC-35 is designed to be completed by parents and caregivers (as opposed to clinical staff). Currently, parents/caregivers complete a paper version of the form, and then data is entered into Avatar by clinical or clerical staff.

At a future date, we may be able to have caregivers input data directly into the web-based form.

For more information about the PSC-35 state requirements, see the State of California—Health and Human Services Agency Department of Health Care Services, MHSUDS INFORMATION NOTICE NO.: 17-052, SUBJECT: Early and Periodic Screening, Diagnostic and Treatment (EPSDT) – Specialty Mental Health Services Performance Outcomes System Functional Assessment Tools for Children and Youth.

Which PICs Need the PSC-35?

Mental health PICs, ages 4-17. **Once the PIC turns 18, you no longer have to complete this form.**

When to Complete the PSC-35

Both the CANS and PSC-35 assessment tools need to be completed **at the beginning of treatment, every six months following the first administration of the PSC-35, and at the end of treatment.**

These assessments may also be completed at other times to document a significant change in status.
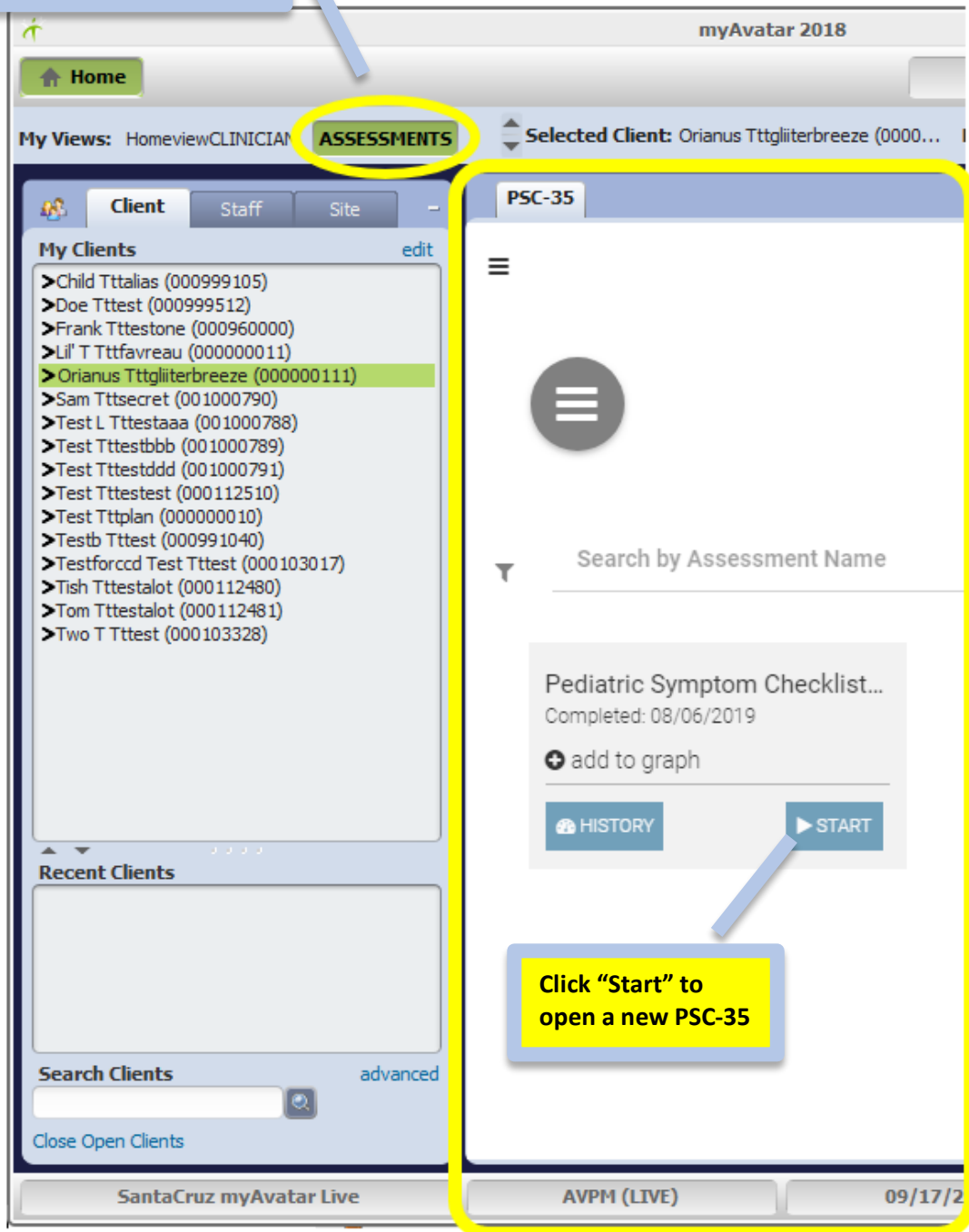
Santa Cruz County Behavior Health Avatar

PSC-35/Avatar Interface

The PSC-35 questionnaire is web-based, but Santa Cruz Avatar has a widget that will link you to the questionnaire. Clicking inside the widget will launch the PSC-35.

Access the PSC-35 widget from a new homeview, ASSESSMENTS.

**Click "Start" to open a new PSC-35**

Santa Cruz County Behavior Health Avatar

If the ASSESSMENTS Console/View is Missing

When you open Avatar, you should see a link to the new ASSESSMENTS console in the upper left-hand corner. If you don't see this, contact the computer help desk at HSA.MhCompAssist@santacruzcounty.us.

To find the PSC-35 widget, click on the word ASSESSMENTS and you will be taken to the assessment console. You should see the widget.

If you do not see the widget, reset your widgets using the following procedure.

3. On your Home Console, on the right side of the menu bar, up at the top of the page, click on the little checkerboard icon as shown below. This takes you to an area where you can reset your widgets.
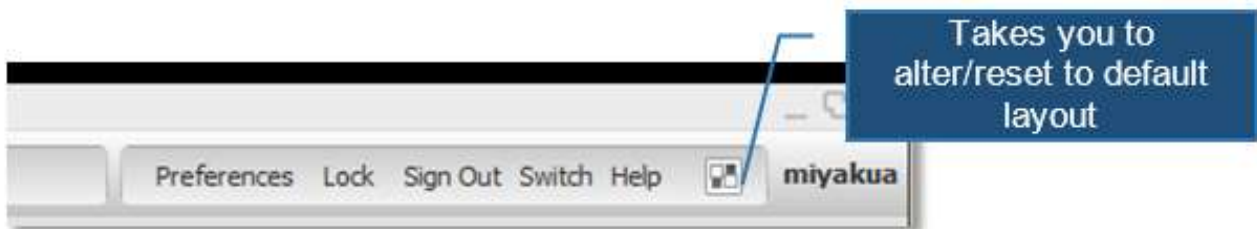
4. Click **Reload Home View** and then **Apply**. (Find these buttons in the lower left-hand corner.)
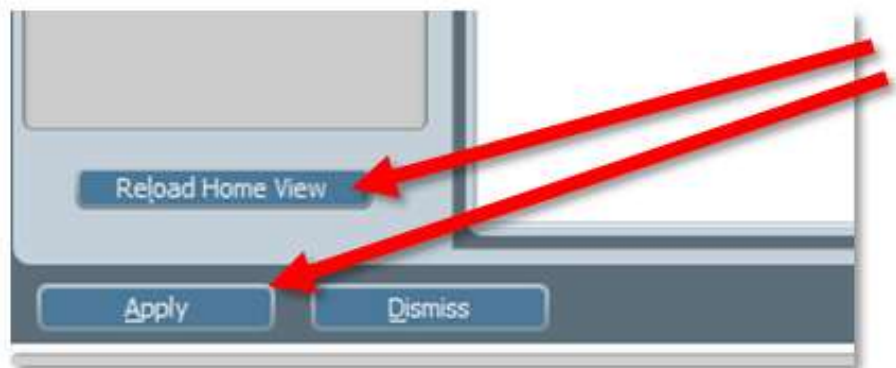
After following this procedure, if you still do not see the PSC 35 widget, contact IT support.

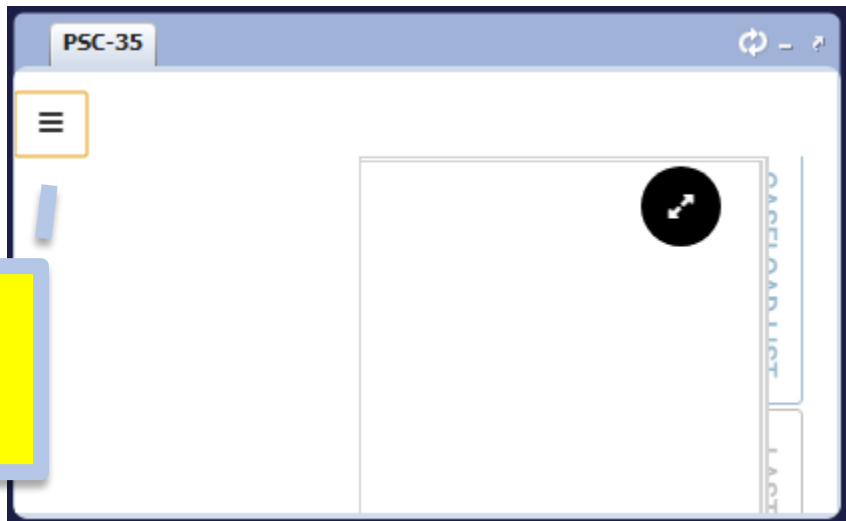# Santa Cruz County Behavior Health Avatar

Opening a New PSC-35

From the Avatar Home Console, click ASSESSMENTS in the upper left-hand corner.

Access the PSC-35 widget from a new homeview, ASSESSMENTS.
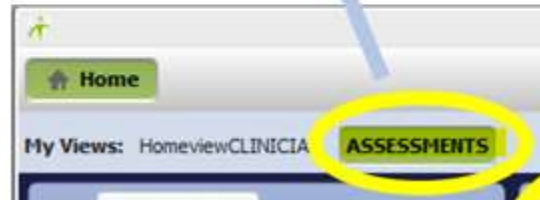
If the PSC-35 widget looks blank, as shown here, click the little menu icon to open up the interface.

1) **Search for your PIC**
   a. Start with the PIC you wish to assess highlighted in the Client Widget. The PSC-35 widget will pull up your PIC's data and you will see a start button to open up the PSC 35. Click the start button to launch the form.

Click the start button to launch the form.

b. You can also search for PIC in the PSC-35 widget.

Enter data here and then click "SEARCH" to find your PIC.

Click here to launch the PSC-35 for your PIC.

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Form Status Section (First Section)

The assessment has 3 sections. We will be entering data into the first 2.

In the first section, fill in the 3 fields and then click "Continue."

Form Status

Assessment Date *

mm/dd/yyyy

> This is the date that the assessment was completed. Most of the time, it won't be "today."

CareGiver

> Parent/Caregiver providing this information.

Form Status *

- Initial
- Subsequent
- Annual
- Discharge
- Administrative Close

> - **Initial = 1st PSC-35**
> - **Subsequent = 6-month follow-up**
> - **Annual = Yearly**
> - **Discharge = Done at Discharge**
> - **Administrative Close = Use if PIC drops out**

Select a reason if assessment is declined

- Minor Consent / No Known Caregiver
- Parent/ Caregiver refused or declined to complete form
- Parent/Caregiver unavailable to complete form

continue

> Once you have answered all the questions, click "continue," to go to the next section of the form.

Santa Cruz County Behavior Health Avatar

PSC-35 Questions (Second Section)

The next section of the PSC-35 contains questions about the child's behaviors.

You are entering information from the paper form that has been filled out by the parent or caregiver.

> **IMPORTANT:** DO NOT CHANGE OR MODIFY answers from the paper form.

> **Fill in checkmarks for all 35 questions, then click "continue" at the bottom of the page.**

TIP: To make it easier to answer the questions, make the window smaller. If you do this the check boxes will be closer to the actual question.

PSC-35 Questions (Third Section)

Click "continue" to skip this section.
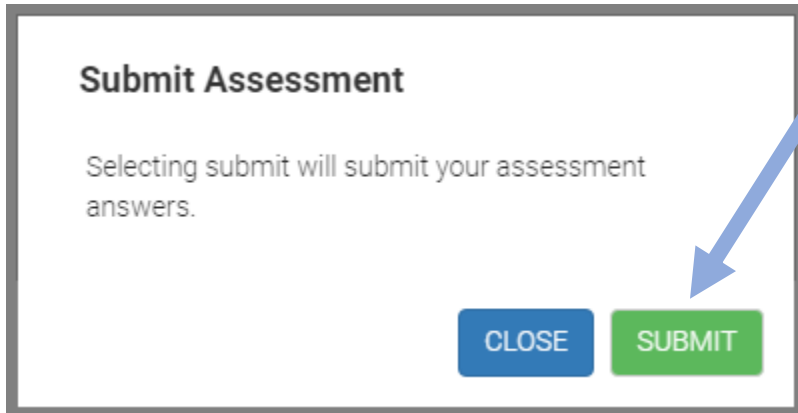
> **We are not using this third section. Click "continue" to skip.**

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The screen fades and a new "Submit Assessment" window appears, click SUBMIT.
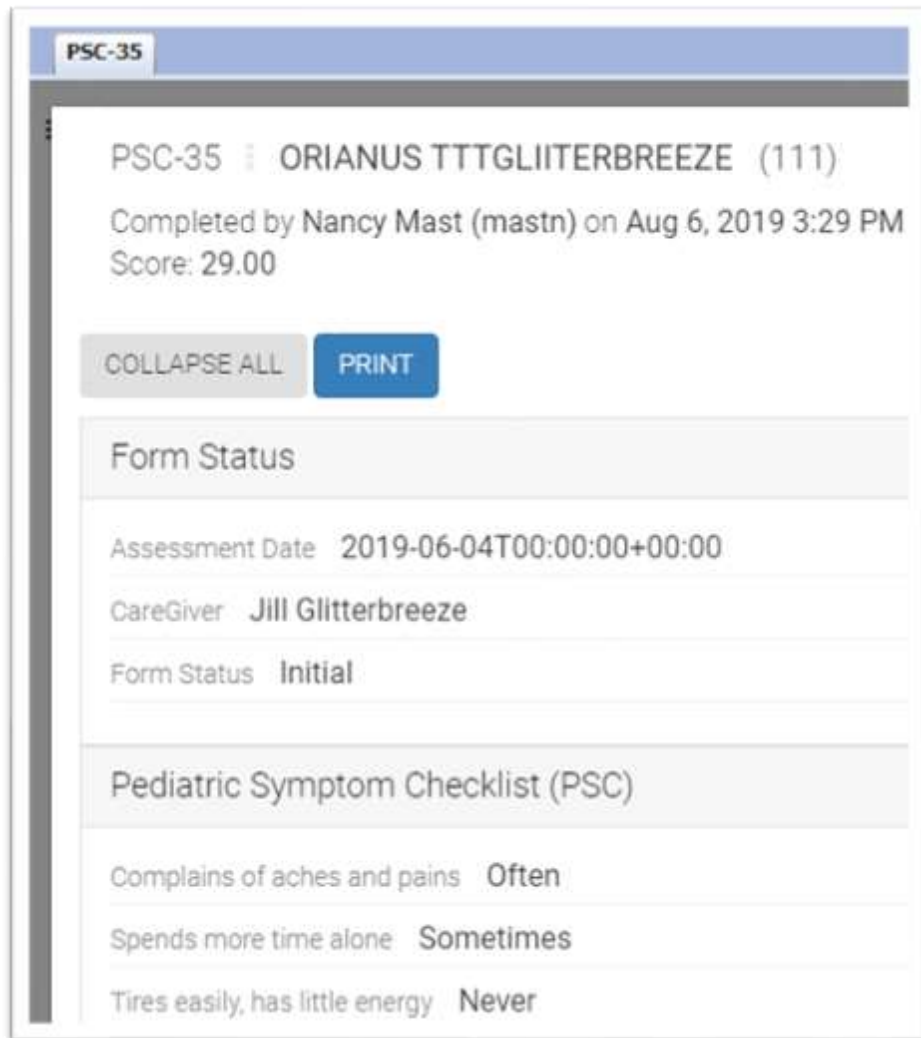
The information from the PSC-35 that you just completed can be seen in a new window.

Check to make sure that the PIC name, assessment date and overall score is correct before continuing.

Scroll down to the bottom of the page and click on DONE to finish with this PIC.

Click PRINT to print a copy.

ver

netimes

ople's feelings   Sometimes

roubles   Never

ng to him or her   Sometimes

es

Click "DONE" to finish.

Click "PRINT" to print a copy.

PRINT   DONE

Santa Cruz County Behavior Health Avatar

Use the PSC-35 Graph to Keep Track of Changes Over Time

The PSC-35 is completed at intake and then at least once every six months. It can be completed more frequently when there is a significant change for the PIC.

Over time, PSC-35's create a data set that can be graphed to create a visual of how the PIC is changing over time.

To View the Graph Report

Click "add to graph" on the PSC tile to see the results in a graph format.

Pediatric Symptom Checklist...
Completed: 08/07/2019

⊕ add to graph

🏛 HISTORY   ▶ START
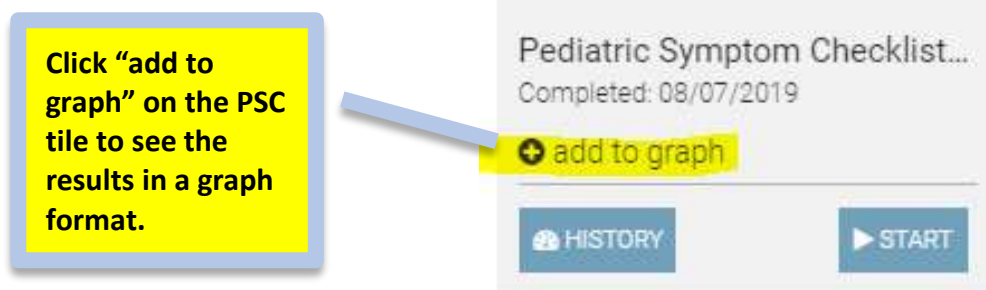
In the example below, there are seven PSC-35's in the graph. Over time, you can see how the score changes to show improvement in behaviors.

Each point represents a PSC-35 score for a specific date.
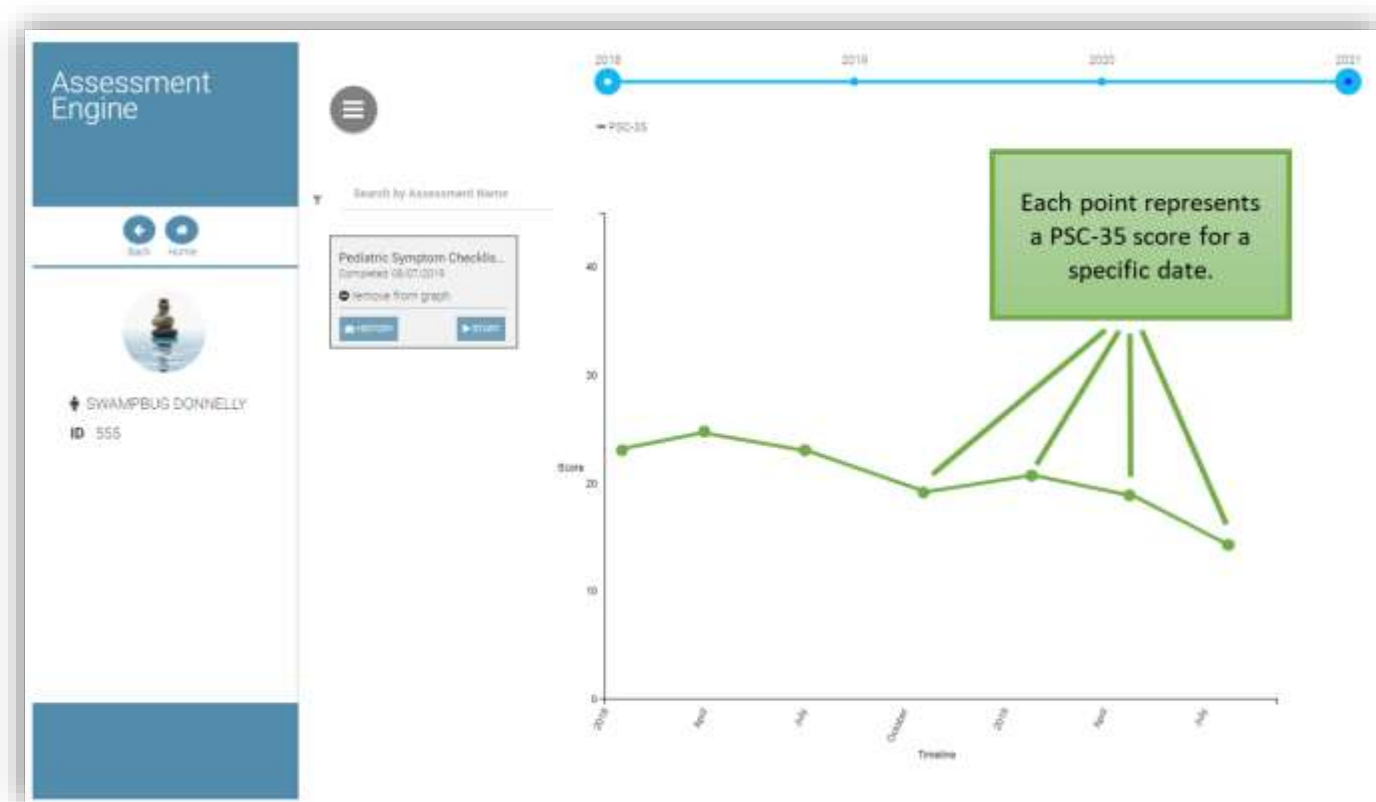
Santa Cruz County Behavior Health Avatar

NOTE: The data in the graph report is displayed by date of entry, rather than the date of assessment. This means that the graph may look wrong if several PSC-35's are entered at the same time, for the same PIC. For example, if you have three forms from three different months, but enter them on the same day, the data points won't be spread out. As we catch up with entering data from 2018/2019, the graphs will gradually look as they should. At first, though, you might see something that looks like the picture below.

Entering Data from a Paper Form When the Data is Unclear

You will most likely be entering data from a paper form that has already been filled out by a caregiver. Sometimes on paper forms, there may be questions left blank. Sometimes marks on the paper form may be ambiguous. In this case, it is difficult to know what to enter in the electronic form.

When the data on a paper form is unclear, use the following rules to help you decide what to enter:

1. If two boxes are selected on the same line, choose the one on the right. ("Sometimes" will be picked over "Never." "Often" picked over "Sometimes.")
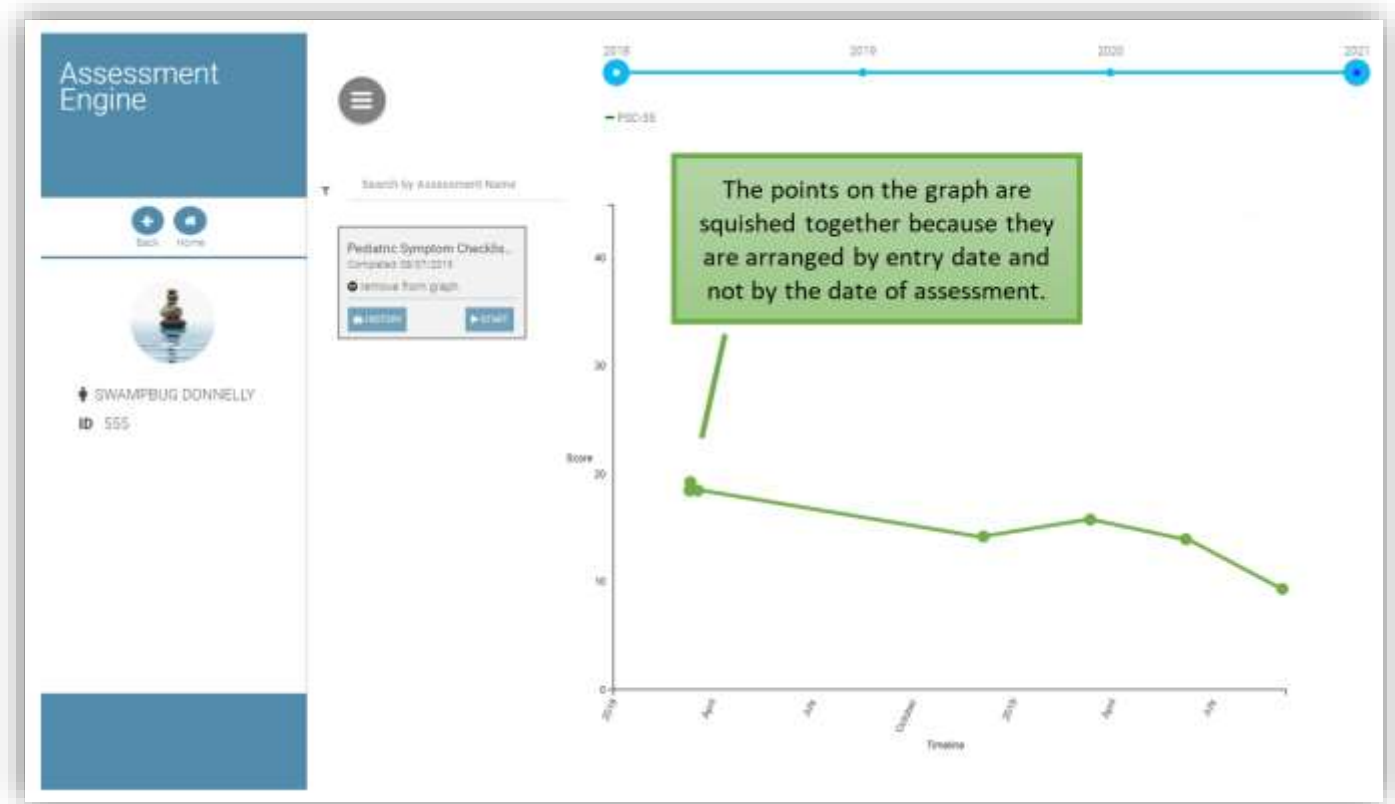2. If there is a mark on the paper form between two options, (e.g. meaning more than never, less than sometimes) it is not possible to pick both, so we will also choose the option on the right. ("Sometimes" will be picked over "Never." "Often" picked over "Sometimes.")
3. If some questions on the paper form are left blank, also leave those blank on the electronic form.

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PSC35 Entered Report: Use to Check Data

If you want to double check quality for your work session, use this report.

Use this report to check that all entries were properly saved.

To launch the report, simply enter the "Begin Date," and click "Process."
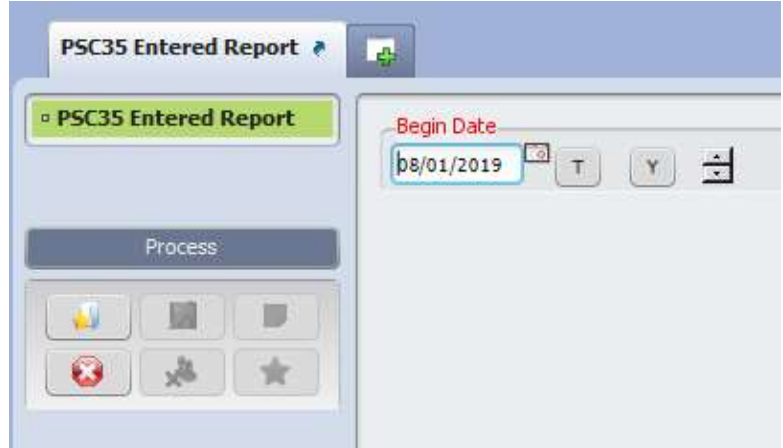
ClientID	Client Name	Score	Assess Date	Data Entry By	Data Entry Date
		31.00	7/10/2019	Unknown	8/2/2019
		34.00	7/8/2019	Unknown	8/2/2019
		32.00	8/8/2019	Unknown	8/12/2019
		25.00	7/29/2019	Unknown	8/6/2019
		29.00	6/14/2019	Unknown	8/5/2019
		44.00	1/1/2018	Unknown	8/7/2019
		9.00	7/30/1919	Unknown	8/6/2019
		18.00	8/2/2019	Unknown	8/6/2019
		10.00	7/31/2019	Unknown	8/6/2019
		46.00	7/16/2019	Unknown	8/7/2019
		29.00	8/7/2019	Unknown	8/12/2019
		24.00	7/23/2019	Unknown	8/5/2019
		14.00	7/19/2019	Unknown	8/2/2019

PSC-35 Report

Total 13

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Deleting a PSC-35

Once you enter a PSC-35 into Avatar (by clicking "Done" on the last page), you cannot go back and change the answers to any questions. **If you make a mistake, unfortunately, the whole form must be deleted and then you must start over.**

Steps to Delete a PSC-35:

1. Open the ASSESSMENTS area (console) in Avatar.
2. Select the PIC for whom you wish to delete a PSC-35. When you do this, you will see a little rectangle that says "Pediatric Symptom Checklist…"
3. Click the HISTORY button to see the list of completed PSC-35's for the PIC.

4. Click "DELETE ITEM."
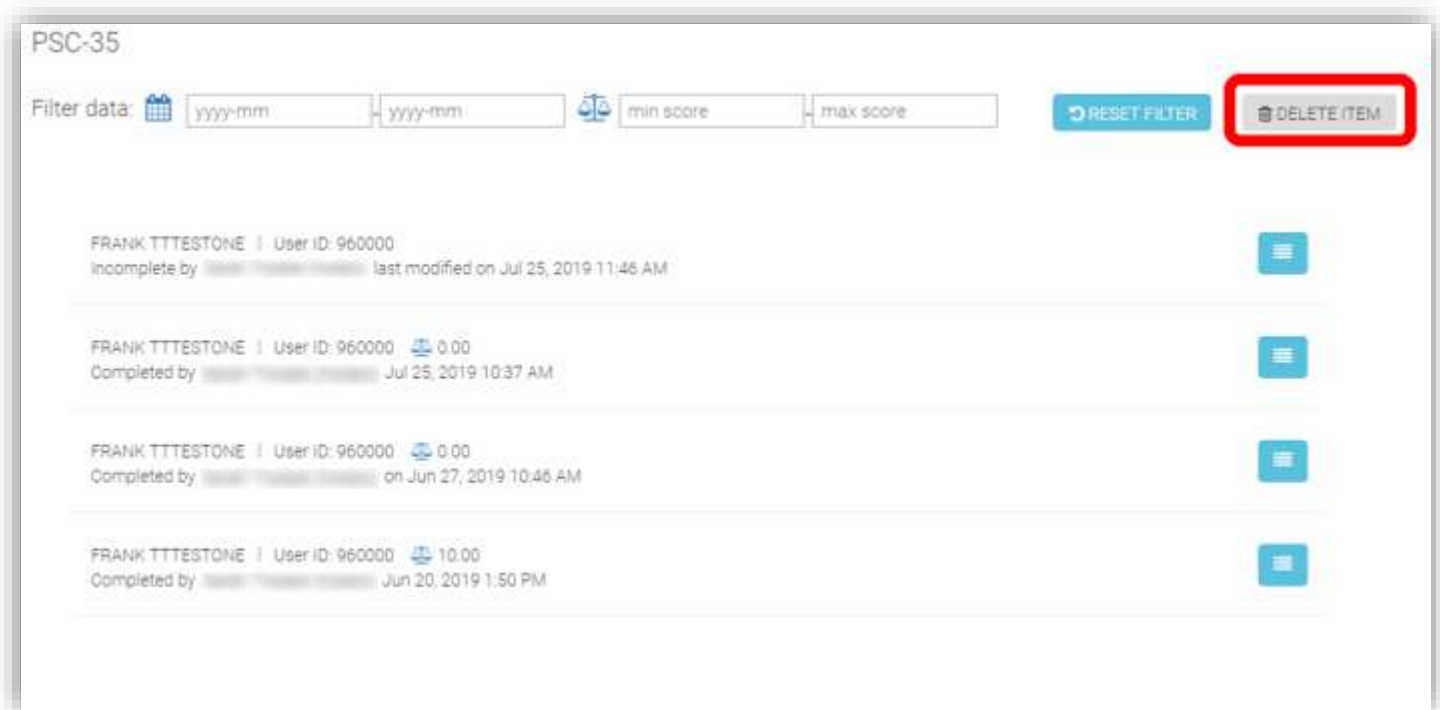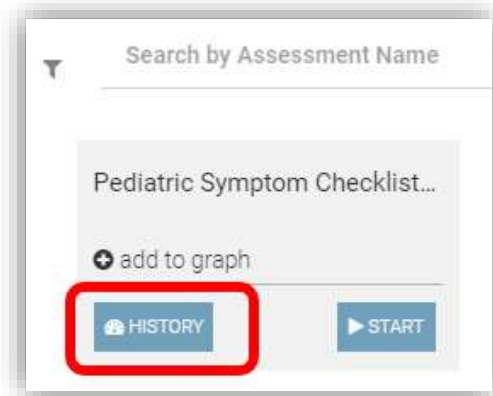
5. The symbol to the right of each assessment will turn into a little trashcan. Click the trashcan symbol next to the PSC-35 you want to delete. Note there is no Delete confirmation, once the wastebasket icon is clicked the assessment is deleted. You will know your PSC-35 has been deleted because it will no longer see it on the list.
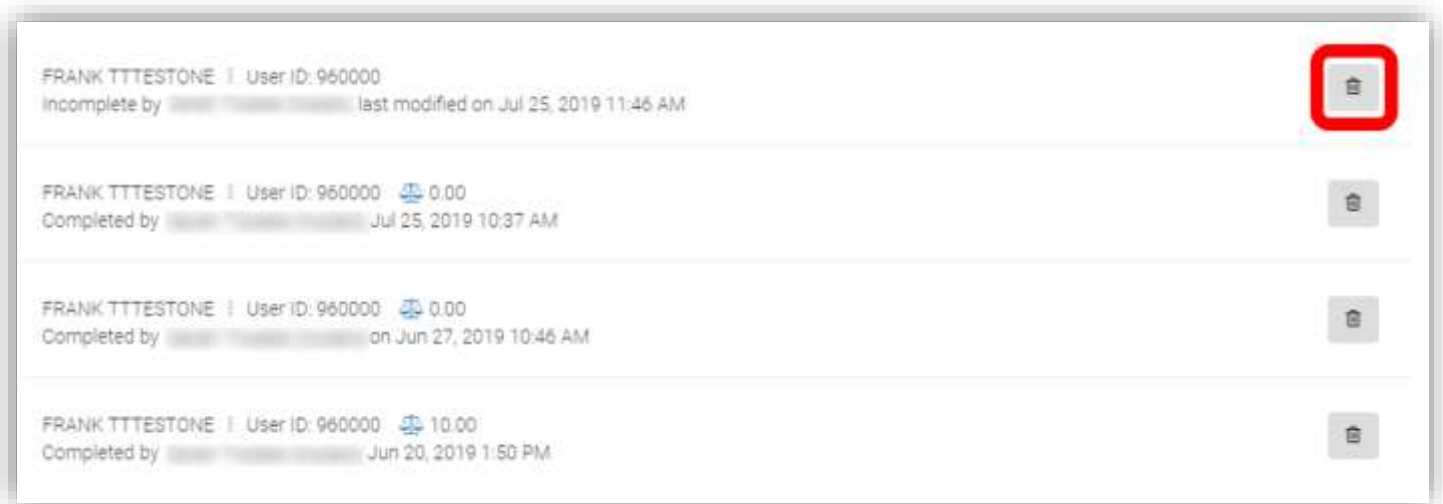
Please NOTE: If you can't see either button, the screen might need to be resized, slide the right border of the widgets on the left, towards the left side to make the right panel wider.

6. When you are ready to exit, click "DONE" to enter another PSC-35, or move onto another task.
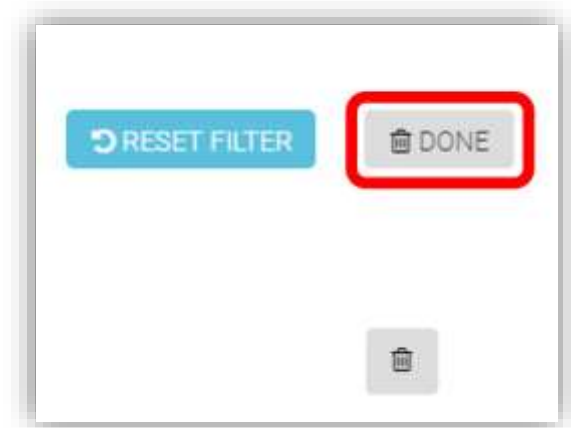
Santa Cruz County Behavior Health Avatar

Diagnosis - Admission

When to complete the Diagnosis form

 Every episode requires a diagnosis. Without a diagnosis, no services can be billed. The date and time of the Admission Diagnosis must be on or before the date and time of first billed services.

For example, a PIC is admitted on September 2nd at 10:00 AM and seen for services on that day. If the diagnosis is date is entered as September 6th, all services between September 2nd and the 6th will not bill. So the diagnosis date should be September 2nd. The time should be before 10:00 AM. Unless your program has a special need to note the exact time of diagnosis, the easiest way to make sure you are covered with regard to the time, is to enter the diagnosis time as 12:00 am. (TIP: Type "0000" and press enter.)

The Diagnosis form in Avatar must be completed in conjunction with the Access (Intake) Assessment. In addition, each admission must have its own diagnosis. If your PIC already has an Avatar diagnosis for your episode, it is not necessary to complete a new diagnosis when the annual assessment is due. If the diagnosis has not changed, it is sufficient to let the admission diagnosis stand. (Note this in the Mental Health History question in the Psychosocial.)

The diagnosis may be updated at the time of the annual assessment or at any time. See the next section for more information.

Check the chart to see if there is an existing diagnosis before proceeding with service delivery.

Each episode must have its own diagnosis. You may open a diagnosis from the PIC's chart, or from the Home Console. Below are directions on how to open a new diagnosis form from the chart. When completing an update, you will first want to look in the chart for prior diagnoses.

To View a PIC's Current Diagnosis

1. Open the PIC's chart.

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2. Select the Diagnosis form in the list of forms on the left to open the Chart View. (If you do not see the Diagnosis form, you may need to add it to the chart. See the section titled, "Add a Form that is Not Listed to Your Chart View.")
3. You will see series of tabs across the top of the Chart View that shows all of the PIC episodes. Click the tab that corresponds to the Admission Program or episode under which you provide services. For County Mental Health PICs, the Admission Program is LE – 00044 MH COUNTY OUTPATIENT, or possibly, County – Pre Admit Outpatient. You can now view the current diagnoses to see if you want to update or not.

Below are instructions on how to add a diagnosis for a PIC that does not have a previous diagnosis. (See the next section for how to do a diagnosis update.)

Steps to Complete the Diagnosis Form

1. **Open the chart** for your PIC and then **click the Diagnosis link** on the left.
2. Click the tab for your **Admission Program**.
3. **Verify that the PIC does not have a diagnosis** for your current open episode for your Admission Program. If there is already a diagnosis, review the diagnosis. You may choose to add to it at this point. See the next section for instructions.
4. **Click, "Add"** in the upper right hand corner of the chart view. A blank Diagnosis Form will open.
5. **Diagnosis Type = Admission**
6. **Enter Date of Diagnosis**. Since this is an admission diagnosis, the **date of diagnosis will be the opening date for the episode**. The date of diagnosis is automatically populated as the admission date for an admission diagnosis.
7. **Enter 12:00 AM for the time of diagnosis**. (For most programs, it is fine to enter the diagnosis time as 12:00 AM. Check with your supervisor if you think you might need to enter the time exactly.) (Tip: If you type "0000" the time will automatically enter as 12:00 AM.)

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If you are creating the first diagnosis for your episode, YOU MUST CLICK ADMISSION FOR THE DIAGNOSIS TYPE. If you click Update, Discharge or Onset, you won't be able to bill for services.

8. Begin entering your diagnosis by adding a new row to the Diagnosis table. Click the "New Row" button underneath the table. In this form, you do not add information directly to the table. There are fields below the table where you enter your diagnosis information.
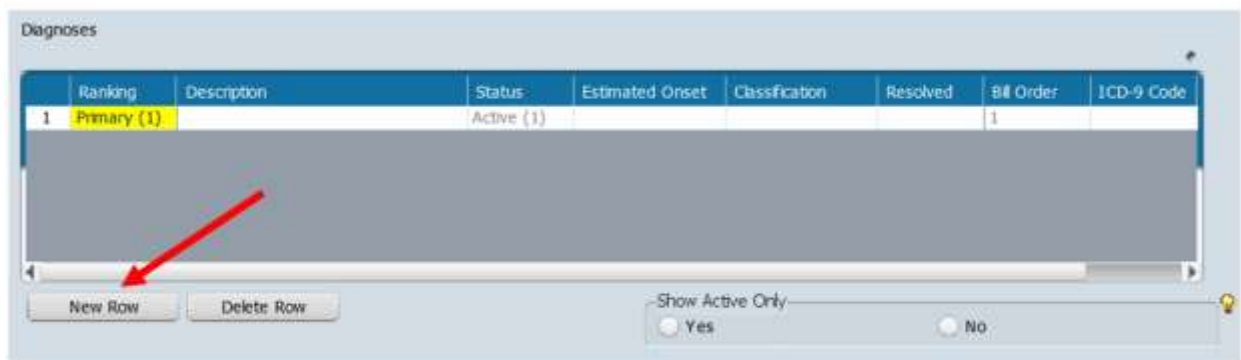
9. Type in a diagnosis in the **Diagnosis Search** field, then click "Enter" on your keyboard.
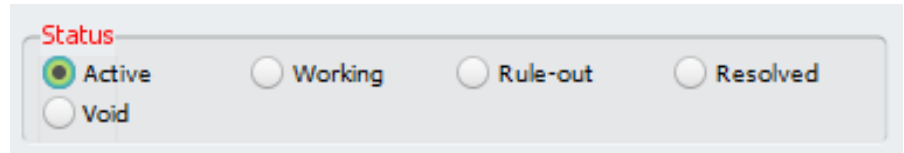
IMPORTANT: Take your time typing your diagnosis and then pause for a second after you press "Enter" on your keyboard. Avatar is searching a web-based data base of more than 15,000 diagnoses and this takes a bit of time.
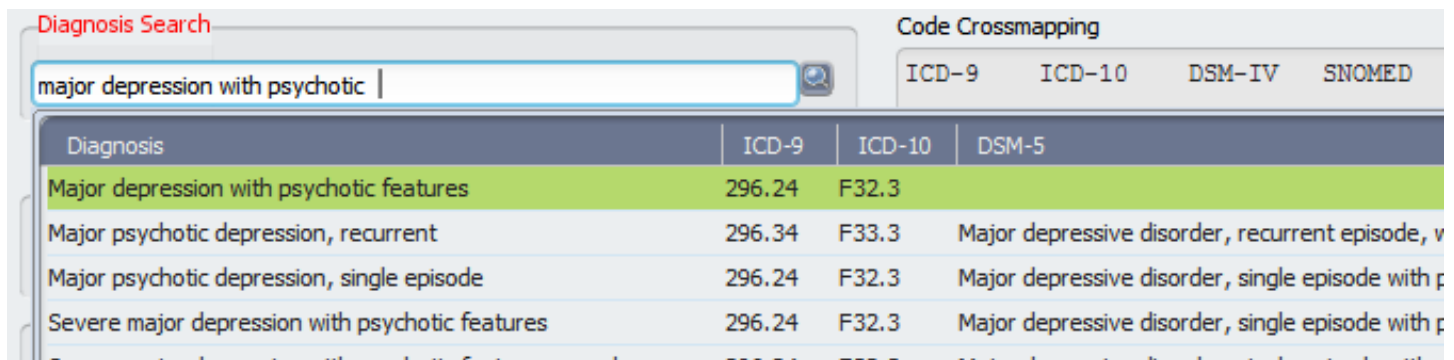
Double-click on the most appropriate diagnosis entry. To narrow down your diagnosis and get a smaller list from which to choose, type in as accurate a diagnosis as you can. For example, type "major depression" rather than just "depression" to narrow down your selections.

10. **Enter the Status Field.** The Status field defaults to "**Active.**" Note that the primary diagnosis must be Active. In addition, any diagnosis for which you are providing services must be Active. If a diagnosis no longer applies to the PIC, you can update the diagnosis to resolve it.

11. Enter **Estimated Onset Date.** Although this question is not required here, it is required for the treatment plan, so you will want to enter this information.

> Typically, it is very difficult to identify an exact date of onset for a psychiatric diagnosis, so use the following convention: Enter Jan. 1 for the month and date. Enter the closest approximate year. e.g. 01/01/1990. ONSET DATE **IS NOT** THE OPENING DATE FOR THE EPISODE.

12. Enter **Present on Admission Indicator,** if applicable.
13. **A DO NOT ENTER Classification. THIS NO LONGER APPLIES.**
14. Enter the required **Diagnosing Practitioner (this is you)**, the Ranking, and any appropriate Remarks.

    The **Bill Order** will default to 1.

    The bill order determines which diagnoses are attached to services first.

    For Mental Health services, make sure that the first diagnosis is an included mental health diagnosis. For example, schizophrenia, bipolar illness, depression.

    For SUD services, make sure that the first diagnosis is an included substance use disorder diagnosis. For example, alcohol dependence.

    For subsequent diagnoses, the bill order should default to 2 or 3. If not, you should type in the Bill Order in the Bill Order blank.

    Note that Avatar wants the bill order and the ranking to match. If they don't, you will not be able to complete the form.

After you add your first diagnosis, the Diagnosis table will look like this.

15. **ADD THIS DIAGNOSIS TO PROBLEM LIST?** Enter **Yes**. By clicking **Yes** you add this diagnosis to the problem list (also called the Problems Table) that is used in creating the treatment plan. (It populates the Problems Table in the Treatment Plan.) Typically, you will click **Yes** when answering this question.

16. Skip the **Additional Diagnosis Information** section. This section is not used in Santa Cruz Avatar.

17. Complete the Additional CSI Questions on the Second Tab, Additional Diagnosis Information

Diagnosis CSI Questions (Second Tab)

1. Click on the tab, "Additional Diagnosis Information at upper left."
2. The questions you need to **answer, all have "(CSI)" at the end of the question**. Ignore the other questions.
3. If the PIC has a substance abuse diagnosis, when you enter it in the CSI question, make sure this diagnosis is also in the diagnosis table in the first tab.
4. Click "Submit" to save and close the diagnosis form.

Diagnosis - Update

When to Complete a Diagnosis Update

1) Complete a Diagnosis Update when there is already a diagnosis in your current episode and the diagnosis has changed.
2) There must be a diagnosis in each episode and it must be accurate. The diagnosis should reflect the client's needs and acuity.
3) If the client was given a preliminary diagnosis when they entered services, it must be updated when more is known. I.e. a diagnosis of "observation" should not be the current diagnosis five years later.

For training purposes, pick a PIC that has a previous diagnosis. The previous section describes how to complete an initial diagnosis.

You may open a diagnosis from the PIC's chart, or from the Home Console. Below are directions on how to open a new diagnosis form from the chart. When completing an update, you will first want to look in the chart for prior diagnoses.

To View the PIC's Current Diagnosis in the Chart

Before completing a Diagnosis, you always want to check the chart to see what Diagnoses are there.

1. Open the PIC's chart.
2. Select the Diagnosis form in the list of forms on the left to open the Chart View. (If you do not see the Diagnosis form, you may need to add it to the chart. See the section titled, "Add a Form that is Not Listed to Your Chart View.")
3. You will see series of tabs across the top of the chart view that shows all of the PIC episodes. Click the tab that corresponds to the Admission Program or episode under which you provide services. For County Mental Health PICs, the Admission Program is LE – 00044 MH COUNTY OUTPATIENT. You can now view the current diagnoses to see if you want to update or not.

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Steps to Update the Diagnosis

1. In the chart, in the far upper right hand corner, click on Add to create a new diagnosis. A blank Diagnosis Form will open.
2. **Type of Diagnosis** = Update
3. Enter the **Date of Diagnosis** and the **Time Of Diagnosis**
4. **Select Episode To Default Diagnosis Information From:** You may select Your Admission Program or any other program that has a diagnosis. If there is a prior diagnosis under your own admission program, you want to use that. If you don't have a diagnosis to choose from, you MAY use a diagnosis from a different program. Alternately, if you are licensed/waivered/registered, you can add your own diagnosis, based on your clinical findings from interviewing/assessing the PIC. See your supervisor if you are unsure what to do.

5. **Select Diagnosis Entry To Default Information From:** Typically, you will select the most recent diagnosis. The diagnoses in the list are labelled with the date and time they were entered.

6. Once you select your default diagnosis, you will get a popup warning you, "All unsaved data will be lost. Do you want to continue?" Click, "Yes."
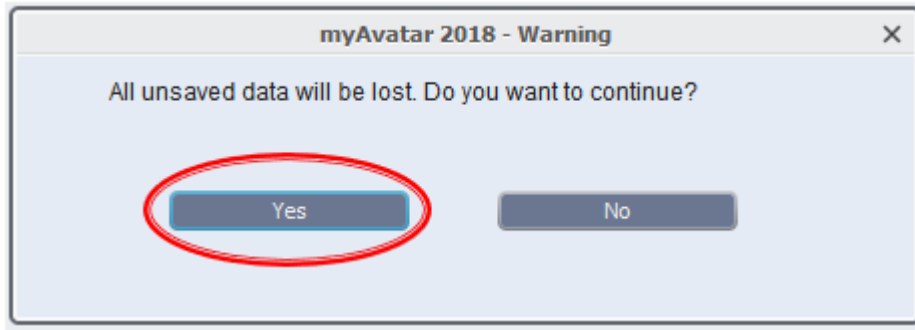
Now, the previous diagnosis you selected will be populated into the Diagnosis table. Edit the diagnoses in the table as needed. Add additional diagnoses or resolve/void current diagnoses.

To Add a New diagnosis:

Once you have added the prior diagnoses to your form, click, "New Row," and follow the instructions from the section, "Steps to Complete the Diagnosis Form."

To Resolve a Diagnosis

Note that you cannot edit a completed (submitted) diagnosis form. If you wish to resolve a prior diagnosis, you must start with a blank diagnosis form. Then, add the prior diagnoses that you wish to resolve. See "Steps to Update the Diagnosis," above for instructions on how to add a prior diagnosis to the current form you have open.

Resolve a diagnosis when it no longer applies (do not void). Save voiding a diagnosis for diagnoses that were entered in error.

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1. Open a blank diagnosis form.
2. Add the diagnosis you wish to resolve to the form. See "Steps to Update the Diagnosis," above for instructions on how to add a prior diagnosis to the current form you have open.
3. Click anywhere in the row that contains the diagnosis you wish to resolve. You should see one of the cells in the row highlighted in yellow. When you do this, the fields below the diagnosis table will be auto-populated with information from the selected diagnosis.

4. Move down the page to the questions below the diagnosis table.
5. In the **Status** field, click "Resolved."

6. Enter today's date in the **"Resolved Date"** field.

7. **You will need to remove the "Ranking" and "Bill Order"** so that the resolved diagnosis no longer bills. You want billing associated with your new diagnosis.

To Remove the Ranking, click on any of the radio buttons in this question, then click F5, which will clear the field. (TIP: This works on any field in Avatar that has boxes, buttons or drop down list items.) If you have done this right, none of the radio buttons in this field will be clicked.

Change the Bill Order number. This question is required and thus must have data in it. Enter a high number such as "100."

If you wish to add a new diagnosis, once you have resolved the diagnosis/diagnoses you don't want, add the new diagnosis/diagnoses as shown previously and then click "Submit."

To Void a Diagnosis

Void the diagnosis when the diagnosis was added in error (it was a mistake). For example, a diagnosis of schizophrenia was added to the chart, but it should have been schizoaffective disorder.

You cannot edit a completed (submitted) diagnosis form. If you wish to void a prior diagnosis, you must first open up a blank diagnosis form and add in the prior diagnoses you wish to void. See "Steps to Update the Diagnosis," above for instructions on how to add a prior diagnosis to the current form you have open.

1. Open a blank diagnosis form.
2. Fill in the date and time of diagnosis. The status will be "Update."
3. Add the diagnosis you wish to resolve to the form. See "Steps to Update the Diagnosis," above for instructions on how to add a prior diagnosis to the current form you have open.

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4. Click anywhere in the row that contains the diagnosis you wish to resolve. You should see one of the cells in the row highlighted in yellow. When you do this, the fields below the diagnosis table will be auto-populated with information from the selected diagnosis.

Diagnoses

	Ranking	Description	Status	Estimated Onset	Classification	Resolved	Bill Order	ICD-9 Code	ICD-10
1	Primary (1)	Schizophrenia	Active (1)	01/01/2015			1	295.90	F20.9

5. In the **Status** field, click "Void."

6. The **Resolved Date, Ranking and Bill Order fields** will be cleared and disabled. You do not need to enter anything here.

7. If you wish to add a new diagnosis, once you have resolved the diagnosis/diagnoses you don't want, add the new diagnosis/diagnoses as shown previously.

8. Click "Submit" to save and close.

Diagnosis Search

Schizophrenia

Status
- Active
- Working
- Rule-out
- Resolved
- ● Void

Estimated Onset Date
01/01/2015 | T | Y

Resolved Date
| T | Y

Ranking
- Primary
- Secondary
- Tertiary

Bill Order

ADD THIS DIAGNOSIS TO PROBLEM LIST?
- Yes
- No

IMPORTANT: If you are voiding the only included (billable) diagnosis, make sure that you date your new diagnosis appropriately so that services are covered. For example, if the episode was opened on 1/15/22, you will most likely want to date your diagnosis 1/15/22. You should at least date your diagnosis on or before the first day of billable services.

Basically, don't leave any dates not covered by a diagnosis. Avatar will not be able to process any billing done on dates where there is no valid diagnosis.

Scheduling Calendar

The Scheduling Calendar is different than the Calendar Widget. In the Scheduling Calendar, appointments are managed. Scheduling, moving, cancelling and deleting appointments happens here, just like in any other electronic calendar. Progress notes can be launched from the calendar.

In contrast, The Calendar Widget only allows you to perform a few functions like launching progress notes.

When to use your calendar: Most County Mental Health staff are required to use the calendar for all services provided. Talk to your supervisor about whether or not you should use the Scheduling Calendar.

Scheduling an Appointment in the Scheduling Calendar

Use this tutorial to practice scheduling an appointment in your calendar.

1. **Open the Scheduling Calendar:** Use the Forms Search to search for **Scheduling Calendar**. (HINT: Spelling counts! If you type in the word, "Schedule," Avatar will not pull up the form.)

   If you get a warning that says that your username is not set up to see other practitioner calendars, this probably means that your supervisor has not yet set up your calendar. If your calendar is not set up, you will not be able to open your calendar at all. Let your supervisor know that they need to set up your hours in your calendar so you can use it.
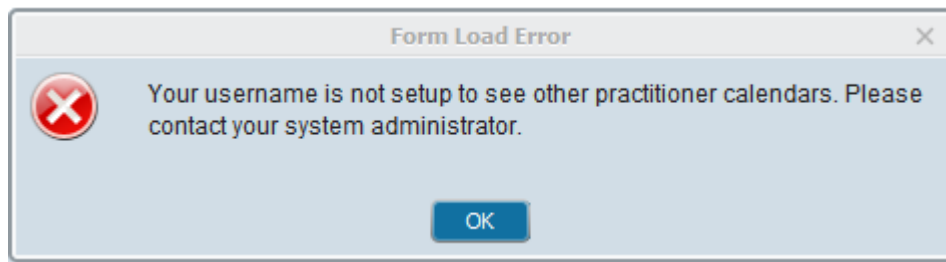
2. Once you open your calendar, you should see your name at upper right. **Make sure the little checkbox next to your name is checked** or you won't be able to see your appointments.
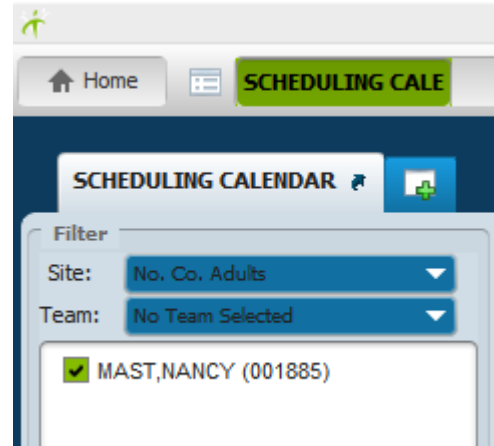
3. **Click on the Day, Week or Month view:** The default view shows you one day, today. Click on the "Week" view to see a week's worth of appointments. Click on "Month" to see a whole month's worth of appointments.
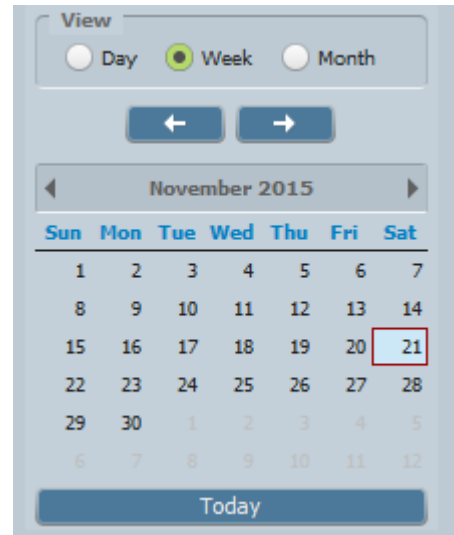
You may see a list of several clinicians to the right of the calendar. If this is the case, click **your name** from the Clinician list on the left side of the Scheduling Calendar.

Site: A Site can be a workgroup or a location. If you don't see your name, you may not be viewing the correct Site. Click on your assigned site to find your name.

Team: Santa Cruz Avatar does not use the Team designation. Leave the question titled "Team" as "No Team Selected."
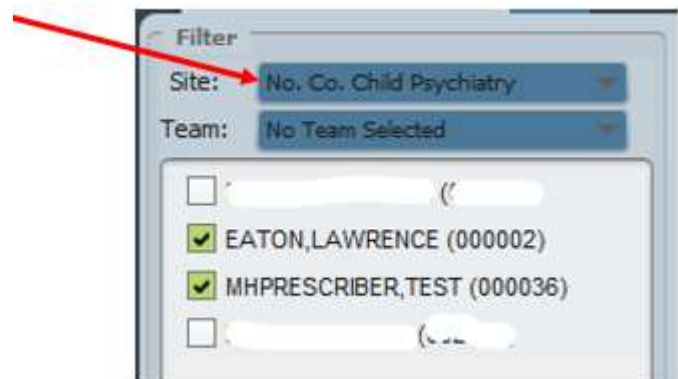
4. Right Click on the calendar at the desired appointment time and then click "Add Appointment."

(Don't worry too much about getting the appointment into the exact right spot. After you schedule the appointment, you can easily adjust it by moving the appointment around with your mouse.)
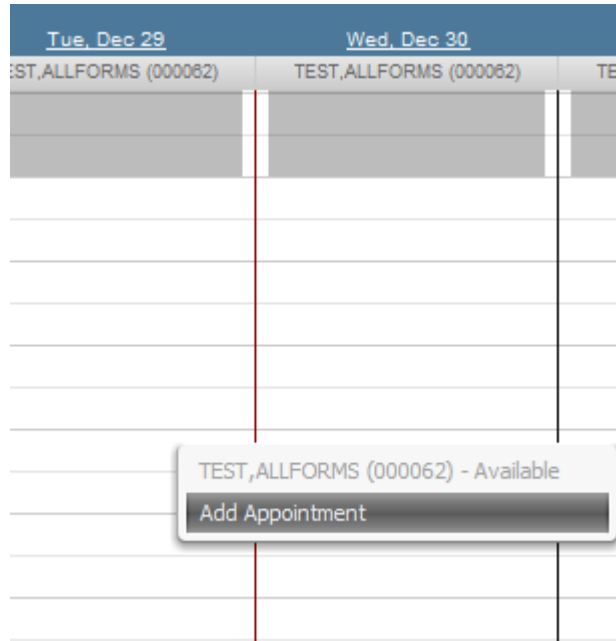
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The Add New Appointment form will open. Fill out the form.

Several questions will be pre-filled. Fill out the rest of the form, except for a few question we don't use, as described below.

If you wish to change the appointment time or duration, you may do so at this point. If you change the duration for the appointment, the End Time will automatically recalculate.

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To Fill Out the Add New Appointment Form:

1. **Client:** Enter the Client name and...
2. **Episode: You must enter the client name before the episode.** Avatar won't know what Episodes you have to pick from if you don't select the Client first.
3. **Program:** This is the **Service Program** under which you provide services. For most mental health programs, this will be different than the episode name. For example, if the episode is LE – 00044 MH COUNTY OUTPATIENT, the service program might be one of the following, County – Adult Recovery North, County – Child School. For SUD programs the program will have the same name as the episode.
4. **Location Code:** For most programs, the **Location code** will auto-populate to "Office." Change if needed.
5. **Service Code:** Select the Service Code. Note that you must first select the Program before the Service Code. This is because Avatar won't know what Service Codes are available without knowing the Service Program. (E.g. only psychiatry can provide medication services.)
6. **Practitioner:** Practitioner name should automatically populate.
7. **Appointment Site:** Should automatically populate.
8. **Appointment Date, Start Time, Duration, End Time:** These are auto-populated from the calendar, but you may change these as desired.
9. **Appointment Site:** Auto-populates from calendar.
10. Enter **CO-PRACTITIONER(S)** if applicable.
11. Enter **RECURRING APPOINTMENT** Fields as needed.
    a. Enter **Once** for a one time appointment.
    b. **Recurring appointments:**
        i. **Enter Weekly** for a weekly appointment.
        ii. The **Recurrence End By** field will open up.
        iii. Selecting **End After** allows you to elect to end the series after a certain number of sessions. Enter the number of sessions in the blank.

        iv. **To schedule an appointment every other week,** enter "Other" under Recurrence Schedule and then "14" in the blank for Days.

v. Selecting **No End** schedules the recurring appointments for a year. Note that appointments don't actually get scheduled into infinity. If your recurring group or appointment goes on for more than a year, you will need to go back into your calendar and set up the appointment series again, after a year has gone by. (See the next section on how to delete individual appointments from a series.)

12. **Click "Submit"** to enter your single appointment or series in your calendar. Notice the circular arrow in the upper right hand corner of each series appointment. Appointments that are not part of a series do not have this circular arrow.
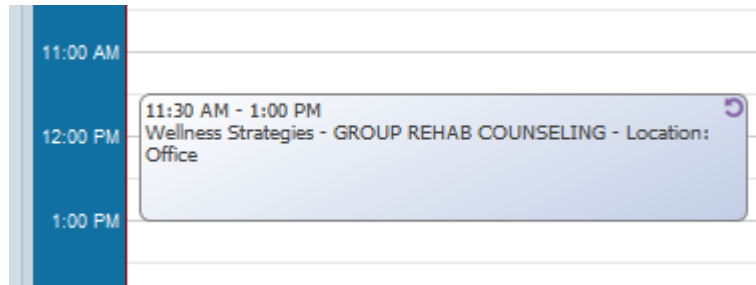
If you have scheduled a series, you can go back and **delete all or part of a series** at a later time.

How To Delete Individual Appointments in a Series

An example of when you might do this is if you have scheduled a series as having no end date, but now you want to end the series. In your Scheduling Calendar, find one of the appointments in the series. Right click on the appointment. Select "Delete." A list of all appointments in the series will pop up. You can then select which ones you want to delete. (HINT: If you want to delete all or most of the remaining appointments in the series, press CRTL + A on your keyboard to select all appointments in the series. You can then "uncheck" any appointments you want to keep.)

To Adjust One Appointment in a Series

You can change the time of an appointment in a series without changing any of the other appointments in the series. First, right click on the appointment and click "Details/Edit." You will get a popup asking of
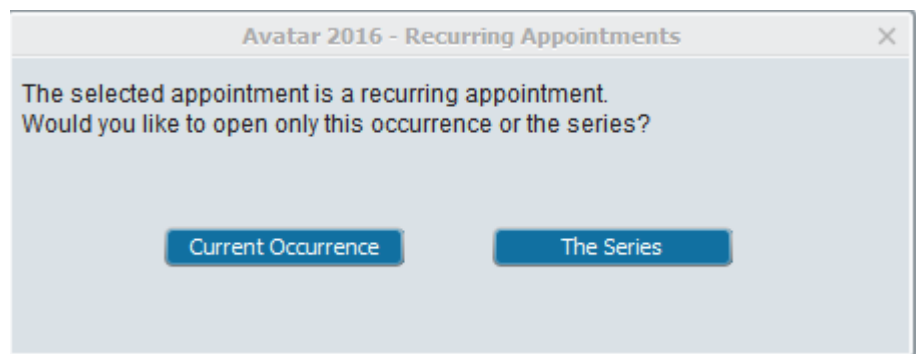
you want to edit this occurrence or the series. Click, "Current Occurrence." At this point, you can adjust the time or the Appointment Status. Note that you won't be able to change the appointment date. To change the date of one appointment in a series, you must delete the appointment by changing the status to "Cancelled," and then reenter the appointment as a single appointment on a different day.

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View Your Appointment in the Scheduling Calendar. Once you have closed the appointment, you will see it in your calendar.

1. You can adjust the appointment time and date, or even the length of the appointment by clicking and dragging. If you have access to multiple calendars (e.g. reception or supervisors), you can even move appointments from one person's calendar to another, by clicking and dragging the appointment.
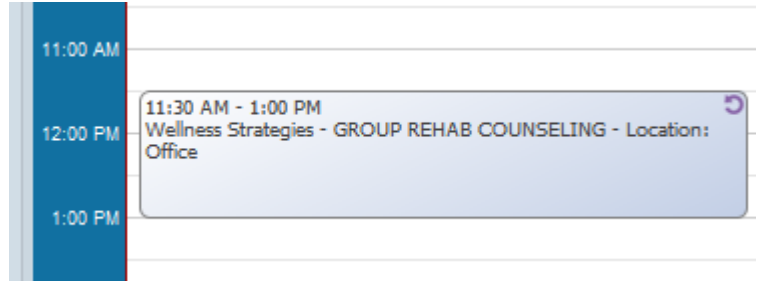
2. **To open a progress note from an appointment.** Launch a progress note from your calendar by right clicking on the appointment and then selecting your note type. The progress note form will open with all of the information from the appointment is already added to the note, so you do not have to enter it again.
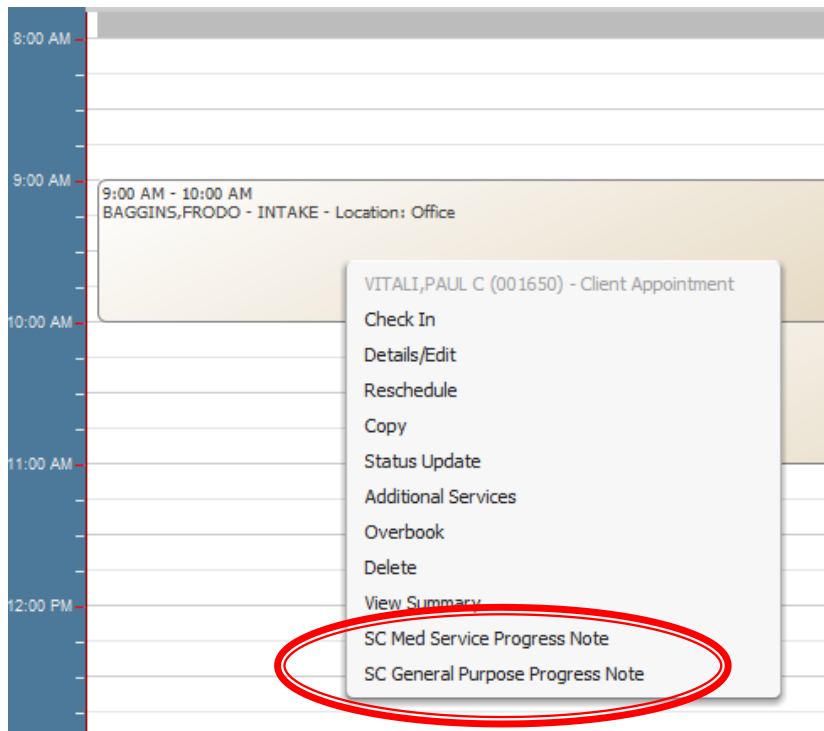
3. When you are finished with the calendar, click on Dismiss at the bottom of the form.

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Finding an Existing Appointment in the Scheduling Calendar

Unless you are a supervisor or in certain clerical roles, you will not have access to other staff members calendars. Even if you cannot view other people's calendars, you can still check to see if a specific PIC has an upcoming appointment, or look for open appointments.

Steps

1. Open your Scheduling Calendar.
2. In the lower right-hand corner, look for the link to the **Find Existing Appointments** form. (Below the Today button.)
3. **Search Sites:** Once the form opens, you will see many questions designed to narrow down your search. For example, if you are looking for psychiatry appointment for North County Adults, click No. Co. Adult Psychiatry.
4. To find a scheduled appointment for a specific PIC, enter the PIC's name in the Client field.
5. To find an open psychiatry Intake or Same Day/Next Day, appointment, search for the PIC "RESERVED TIME". Appointments in Avatar must be scheduled with a PIC. RESERVED TIME is a "placeholder" PIC used to set aside Intake and Same Day/Next Day psychiatry appointments in the calendar. Below, the Find Existing Appointments form is filled out to search for the RESERVED TIME PIC.

6. Below you can see the next 10 open appointments for Medication Management. They have all been scheduled with the "Client" RESERVED TIME.

Click "Cancel" at the bottom of the appointment list to close.

Finding a New Appointment in the Scheduling Calendar
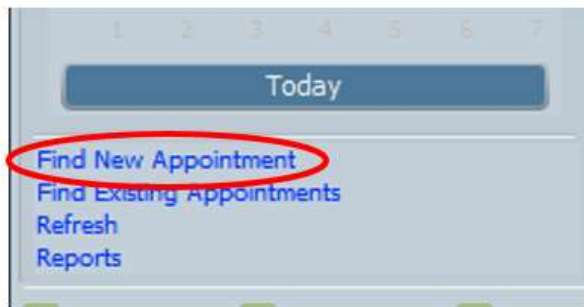
Use the link to the form, "Find New Appointment" to look for blank, open spots in a single calendar or for an entire site, such as 1-No. Co. Adult Psychiatry.

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Staff Daily Schedule: Print Out Your Appointments for One Day

At the beginning of the workday, you can create a printout of your appointments for the day, using the form Staff Daily Schedule. (For one week of appointments, use Staff Weekly Schedule.)

NOTE: This printout only contains appointments where you have not completed a linked progress note. If you have seen the PIC an then written the progress note from your calendar, the appointment will not show up on this report.

1. Open Staff Daily Schedule from your Forms & Data Widget.
2. Enter your Site, for example, 1-No.Co. Adult Psychiatry, or No. Co. Adults. If you do not know what your site is, open your Scheduling Calendar and see your site in the upper left corner of the calendar.
3. Individual Or All Practitioners: Select "Individual"
4. Practitioner: Type your last name and click on yourself.
5. Click "T" for Start Date and End Date
6. Display Cancelled Appointments: Click "N" (Clicking "Y" does not display cancelled appointments.)
7. Click Process to view your schedule.
8. To enlarge the view, click where it says "100%" to pull up a menu.
9. To Print, click "Print" at lower right and use the popup to direct to the printer you want to use.
10. Click the red and white "X" to exit.

Santa Cruz County Behavior Health Avatar

Staff Weekly Schedule: Print Out Your Appointments for One Week

To create a printout of your appointments for the week, use the form Staff Weekly Schedule.

1. Open Staff Weekly Schedule from your Forms & Data Widget.
2. Enter your Site, for example, 1-No.Co. Adult Psychiatry, or No. Co. Adults. If you do not know what your site is, open your Scheduling Calendar and see your site in the upper left corner of the calendar.
3. Individual Or All Practitioners: Select "Individual"
4. Practitioner: Type your last name and click on yourself.
5. Week Of: Enter any date in the week you want to print. Avatar will give you a Monday – Friday schedule.
6. Display Cancelled Appointments: Click "N" (Clicking "Y" does not display cancelled appointments.)

7. Click Process to view your schedule.
8. To flip through the pages of the schedule, click the page number (bottom left) or click the "Next > >" and "< < Prev" buttons.
9. To enlarge or shrink the view, click where it says "100%" to pull up a menu.
10. To Print, click "Print" at lower right and use the popup to direct to the printer you want to use.
11. Click the red and white "X" to exit.

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Progress Notes

Opening a New Progress note

There are several ways to open a new progress note.

1. **From an existing appointment in the Scheduling Calendar**: This is done by right clicking on the appointment and then clicking SC General Purpose Progress Note.
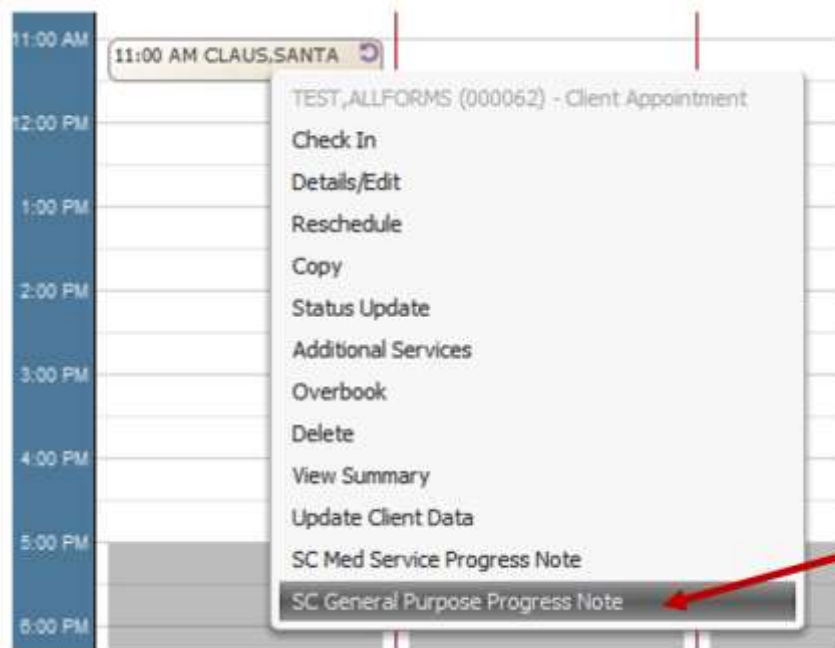
2. **From the My Calendar Widget**
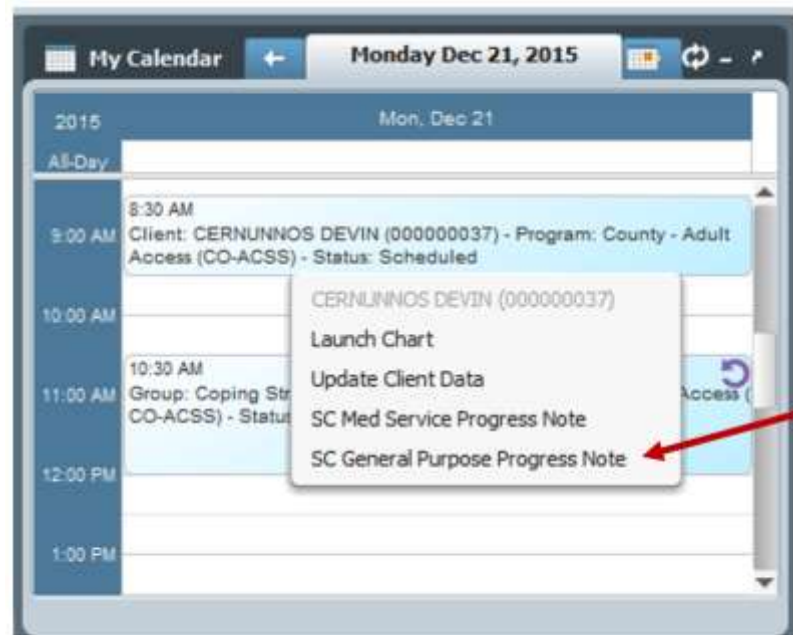
3. **From the Chart Overview**, in the far upper right corner, click "add" to open a new progress note. (The "add" link is very tiny and faint.)
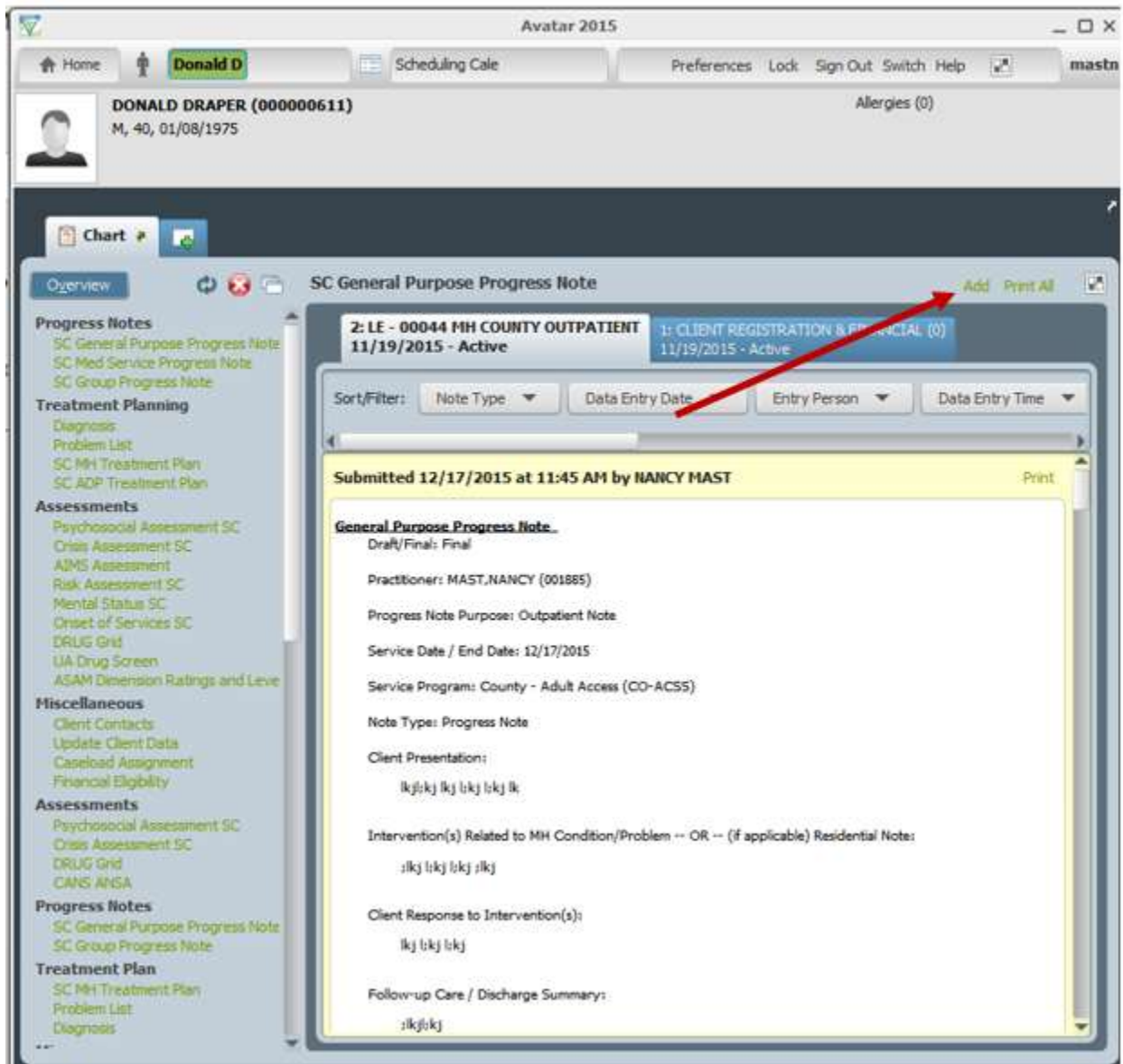
All of the above methods will open up a note for a preselected PIC. When you open up a note using one of the above methods, the PIC's name and (if any) appointment information will be automatically added to the progress note.

A blank progress note can also be opened by simply double-clicking the progress note form in the Forms & Data Widget.

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Writing a New SC General Purpose Progress Note
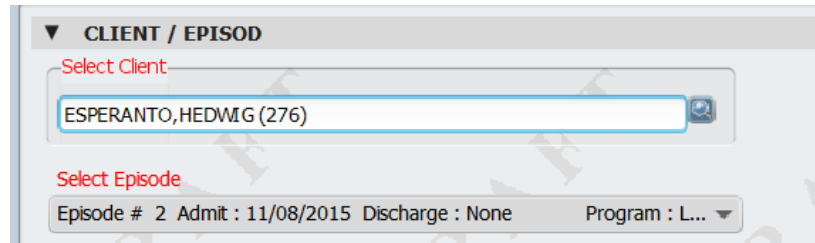
IMPORTANT: You must enter information and click items in order, or the form may not function correctly.

<mark>If the progress note has been launched from an Avatar Scheduling Calendar Appointment, some of these questions will already have been answered.</mark>

1. **Select Client:** Type the PIC's name, last name first, or type the PIC number. (If opened from an Avatar calendar appointment, the PIC's name will already be in the note.)

2. **Select Episode (Admission Program)**
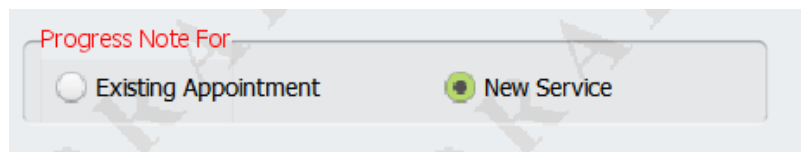
   If needed, select the Episode. If opened from the chart or from an appointment, this information will already be in the note.

   In the Drop-down list, select the Admission Program, e.g. LE00044 MH COUNTY OUTPATIENT or County ADP Prevention HSA.

   IMPORTANT: <mark>Make sure you select the correct episode for your note.</mark> Your note will be misfiled under the wrong program if you make an error with the Admission Program, and you probably won't be able to finish it.

3. **Progress Note For:** Indicate whether this is an Existing Appointment or a New Service.

   a. If you use the Avatar Scheduling Calendar, "Existing Appointment" will already be selected. Do not change this.
   b. If you do not use the Avatar Scheduling Calendar, click "New Service."

4. **Progress Note Purpose:** Indicate either Outpatient Note, Residential Note or Information Note. Depending on which one of these you select, different parts of the progress note will be enabled or disabled.

5. **PRACTITIONER(S)/TIME:** Your name will be in the Practitioner field. Do not change it.

Time Fields: Enter a duration for both Direct Time as well as Documentation & Travel Time. Enter the time in minutes.

Direct Service Time includes
- Meeting directly with the client
- Meeting with collateral sources and other service providers on behalf of the client.

Direct Service Time Does Not Include
- Travel time, administrative activities, time spent writing notes, and other documentation,
- Chart review (except for LPHA review of records for assessment purposes – unfortunately non-licensed staff cannot bill for this activity.)
- Services provided at a location such as jail or psychiatric inpatient

Documentation & Travel Time includes
- Time spent writing notes and other documentation
- Time spent traveling to and from a service location.
- Time spent on non-billable administrative tasks, e.g. arranging for a taxi for your client, faxing, filling out forms.
- Although we do not get paid for documentation and travel time (the state does not pay for this) we still want to keep track. At some point, things may change and we may be able to get paid for this. Also, it helps you to document time spent on non-billable activities, so your supervisor can get a full picture of your activities throughout the day.

6. Residential Daily Summary Notes: Some programs write one daily summary progress note instead of separate notes documenting each service. For these programs, daily summary notes are entered for each date of service.

    For more information on residential and withdrawal management daily progress note billing see DMC-ODS and MHP Residential / WM Daily Progress Note Billing Guidance on the Santa Cruz Avatar web pages.
    • Appropriate Billing Codes for Residential / WM Daily Summary Progress Notes
    • Correct minutes for Residential /WM Daily Summary Progress Notes
    • Appropriate Time to Utilize a Non-Billable Code
    • Billing for Residential Housing (A130 Room and Board); DMC-ODS ONLY"

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Service Information: You must enter data in this section in the following order, or the form will not work: Date => Location => Service Program => Service Charge Code

Date: This is the date you provided the service.

Service Start Time and Service End Time: SUD programs only. Enter the start and end time for direct service. It should match the direct service time. MH programs do not use these fields.

Service Program: Enter the Service Program. For MH programs, you may have more than one choice. Make sure you pick the correct one.

Location: This field will automatically populate to "office." Change the field if needed.

Location code

- It is important to use the correct location code so that Avatar knows what is and is not billable. Services at certain locations might not be billable, for example, jail or psychiatric inpatient.
- Unless providing services using telehealth or phone, use the location of the *client* regardless of where you are. Do this even when speaking with someone else on behalf of the client, for example, speaking on the phone with a family member. Your note should explain why talking to this person is part of your client's care.
- **Phone** - use that location regardless of where you or your client are.
- **Telehealth, client ONSITE** - Client has come to your office but you still see the client over video.
- **Telehealth** - Any other telehealth situation, e.g., client is at home and you are at the office.

Santa Cruz County Behavior Health Avatar

Service Charge Code:

The field for Service Charge Code will provide a list of options once you begin typing. You can type in a search word or phrase, like "case management," or type in all or part of the code. For example, type "1017" to pull up "T1017 Targeted Case Management (MT1017)" for a list of all mental health codes that are available to you.

Service Codes

- The service code you pick is based on what you do during "direct time."
- Familiarize yourself with service code names that describe direct time service activities. It can be helpful to keep a short list of the codes you most commonly use.

Add-On Codes

- Many services have a maximum amount of time you can use.
- There is a separate area of the progress note form to enter an add-on code, which allows you to enter more time (see next section).
- Add-on codes are also used for noting treatment complexity and interpretation services.

More information

- There are several guides that cover different types of staff working in either substance user treatment or mental health programs. See the Avatar Resource Page. https://www.santacruzhealth.org/HSAHome/HSADivisions/BehavioralHealth/AvatarResources/CalAIM.aspx

If there is a service program or service code that you think you should be able to enter, but it does not pop up when you enter data, contact the computer help desk at **x4657** or **HSA.MhCompAssist@santacruzcounty.us**

7. **Evidence Based Practices/Service Strategies:** enter the appropriate practices and strategies based on the requirements of your workflow. Check with your supervisor to find out if any of these apply.

8. **Language:** Enter the language in which the service was provided. Click "No" for English. Click "Yes" for other languages. If you click Yes, indicate whether or not an interpreter was used, and the language.

Santa Cruz County Behavior Health Avatar

9. **Treatment Plan Elements section:** If there is a treatment plan for the PIC, you will select which plan elements the service you provided addresses.

If you DO NOT require a separate standalone treatment plan, skip this section.
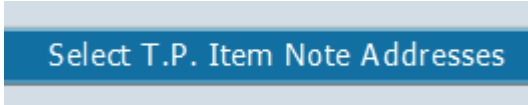
Most programs do not use standalone treatment plans. Instead, these programs write care planning notes and add problems to a problem list. Find out from your supervisor if you should be using a standalone treatment plan. As of the date of this publication, programs that use standalone plans include NTP programs and specialized Children's Mental Health programs (ISS, ICC, IHBS).

a. Click on grey bar below the question "**Select Treatment Plan Version**," and a menu will pop up with the various treatment plan types. Select the treatment plan type that is used by your program. Tzz

b. **Click Select T.P Item Note Addresses**, which will open a view of the treatment plan.

c. **Click once on the Treatment Plan intervention you want to use to highlight in green, then click Return.** Avatar will add everything above what you select, up through the associated problem.

SC MH Episodic Treatment Plan

- SC MH Episodic Treatment Plan - 2/18/2017 - 2/17/2018 Initial - Authorization Start Date: 02/18/2017 (Plan Type: (
- Problems: Severe mood dysregulation disorder: resulting in mood lability, difficulty maintaining healthy relationships,
  - ▼ Goals
    - Increased mood regulation
      - ▼ Objectives
        - Client will display positive coping skills to mood, especially anger, 2 out of 4x daily when experiencing ang
          - ▼ Interventions
            - Collateral Non-Family 1x monthly 30 minutes to review client progress and barriers in using mood mana
            - Group Therapy 1x weekly for 90 minutes to provide psychoeducation with focus on emotion identificat
            - Individual Psychotherapy 1x week for 60 minutes to address improvement in client's ability to express
        - Client will, 2 out of 4x daily, when experiencing emotional distress, utilize internal positive coping skills (su
          - ▼ Interventions

d. **Click Return** to see the items you selected in the box labeled **Note Addresses Which Treatment Plan Problem** box.
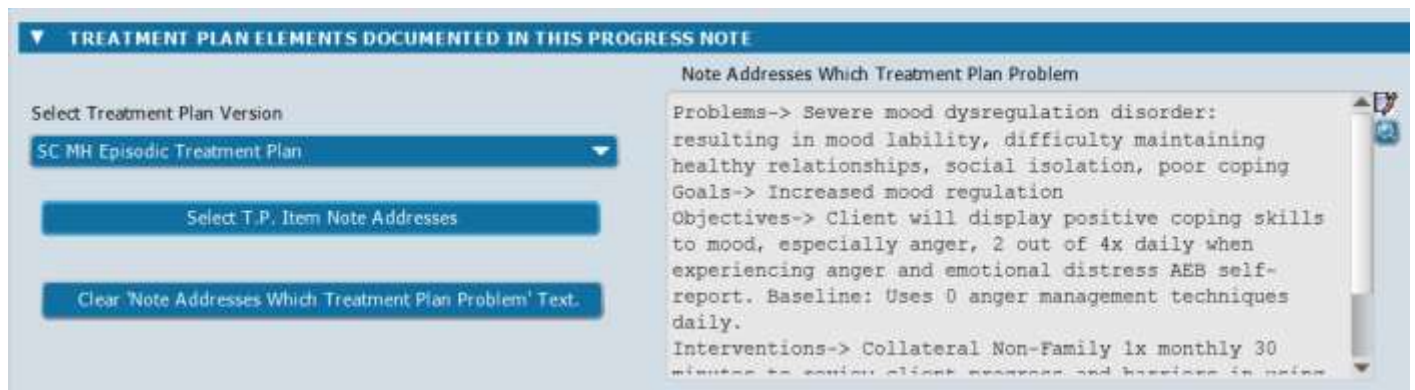
The **Clear 'Note Addresses Which Treatment Plan Problem' Text** button allows you to clear the treatment plan item you selected if you made an error.

10. **Note Type:** Select the type of note.

11. Write the note text in the available fields.
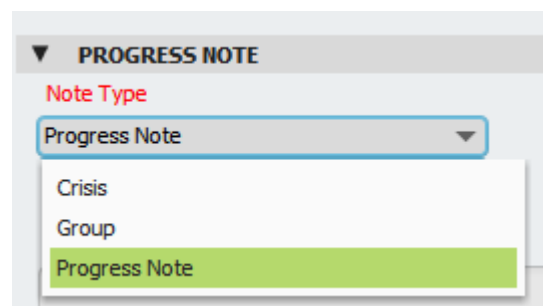
Santa Cruz County Behavior Health Avatar

PROGRESS NOTE TEXT FIELDS

- **Narrative Description of Service:** Focus the note on your intervention (what you did) and how it addressed the PIC's needs (symptoms, conditions, diagnosis and/or risk factors, case management needs. Any discussion of the PIC's status and presentation should be brief, should show why the service was needed, and show how the PIC was included/participated.
- **Response:** Optional.
- **Referrals to Community Services:** Optional.
- **Follow Up Care / Transition Plan / Other Related Documentation:** Plan, next steps, action steps by the provider\PIC, collaboration (with PIC or others), problem list update

▼ **PROGRESS NOTE**

Note Type 💡

Progress Note ▼

Client Presentation (Optional) 💡

Narrative Description of Services 💡

Provided initial intake assessment with client. Gathered assessment information about the reason for seeking treatment from the client's perspective. Also explained purpose of assessment when PIC became agitated. Elicited a commitment from PIC to engage with the

Client Response to Intervention (Optional) 💡
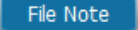
Referrals to Community Services (Optional)

Draft/Final
◉ Draft ○ Final

Follow-up Care / Transition Plan / Other Related Documentation 💡

Meet with client in two days to begin skill-building interventions. Consult with LPHA to identify and develop targeted interventions for PIC.

File Note

PROGRESS NOTE CONTENT: DESCRIBING SERVICES
(or WHAT TO WRITE)

- Keep notes clear and brief. Avoid jargon or abbreviations to keep the notes person-friendly. Use professional language with clear and specific examples. Think about another clinician, an auditor or the PIC reading your notes. Will this person be able to understand the information quickly and easily?
- Focus on the interventions and the services provided (what you did), and how they addressed the person's behavioral health need(s) (e.g., symptom, condition, diagnosis and/or risk factors).
- Check the problem list and add to it to reflect the topics of the sessions as needed. It is good practice to have an idea of what you want to work on and what problems you are addressing before you meet with the client. If the problem list does not have a problem that fits what you did, you might need to update the list (some services like crisis intervention do not require a problem on the problem list).
- Include the plan, or next steps, including but not limited to, planned action steps by the provider or by the person in care, collaboration with the person in care, collaboration with other provider(s) and any update to the problem list as appropriate

MORE PROGRESS NOTE RESOURCES

- Talk to your supervisor.
- [Santa Cruz County Behavioral Health Quality Improvement CalAIM Guidance Page](#)
- [Santa Cruz County CalAIM Guides: Progress Notes for the Mental Health Plan](#)
- [Santa Cruz County CalAIM Guides: Progress Notes for DMC-ODS](#)
- Send a message to County BH QI Ask.QI@santacruzcountyca.gov

==FIXING ERRORS:== If you make a mistake when writing a progress note and have already finalized it, you cannot make changes. Request to have the note reverted back to draft so can make corrections. For some data items like service codes, we can change information for you, without the note being

reverted to draft. This is useful if reverting to draft would make the note late. See the section at the end of this document "Corrections: What To Do If You Make a Mistake."

12. **Draft/Final and File Note:** Once the note has been written, you may select Draft or Final and then click file note.

   a. **Draft:** An item will be added to your *To Do List* to remind you to complete and finalize the note. Clicking on the Form Name in your To Do items will launch your draft the progress note for you to complete.

   IMPORTANT: In your My To Do's **DO NOT click Review To Do Item**. This will not launch the progress note. In addition, you have started down a path that will delete the reminder without your completing the note. Also, if the chart is still open, this function will not work. (The chart must be closed for the draft notes to be relaunched.)

   b. **Final:** if you select Final, a picture that will be launched for you to proofread. Use the large blue arrows at top left to page through the document.
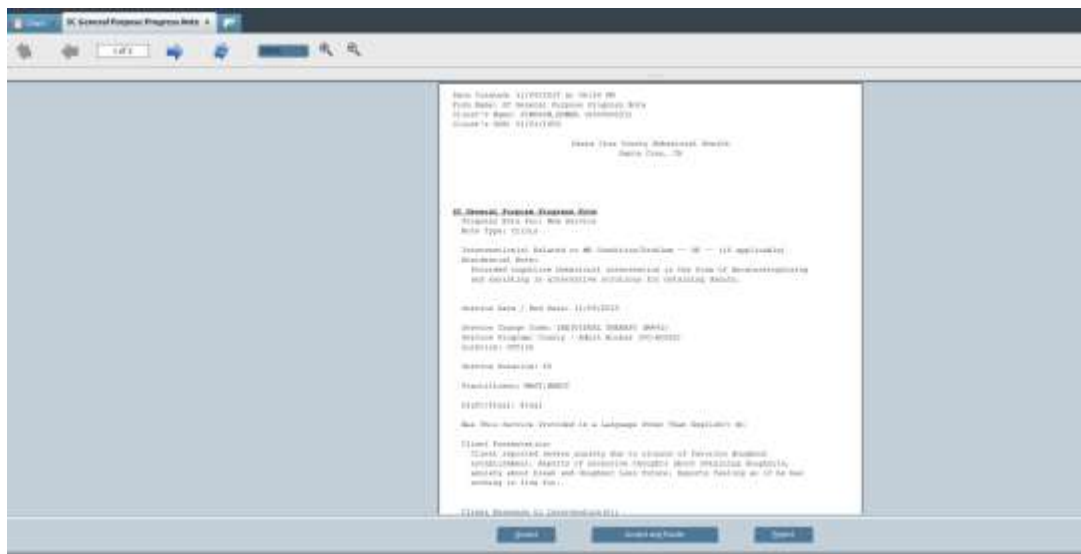
After proofreading, you have three options:
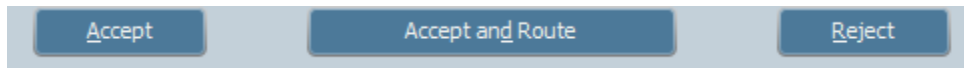
1) **Accept:** Accepts the note as final. You will now see a prompt asking you to enter your password. Type in your password to sign the note. Once you sign, you are done with the note.

2) **Reject:** Rejects the note so that you can return it to draft status for editing. Once you get back to the note, click "Draft," to continue editing.

3) **Accept and Route**

   Accepts the note and routes it to a supervisor and/or one or more approvers for a co-signature.

   See the next section for more information on Document Routing.

Document Routing

In Avatar, you can route a document to one or more people to review the document and co-sign.

Talk to your supervisor about whether or not you should be routing documents to her or to someone else.

Typically, if you are not an LPHA (licensed, waivered or registered) you will need to route documents to your supervisor or another licensed person for co-signature.
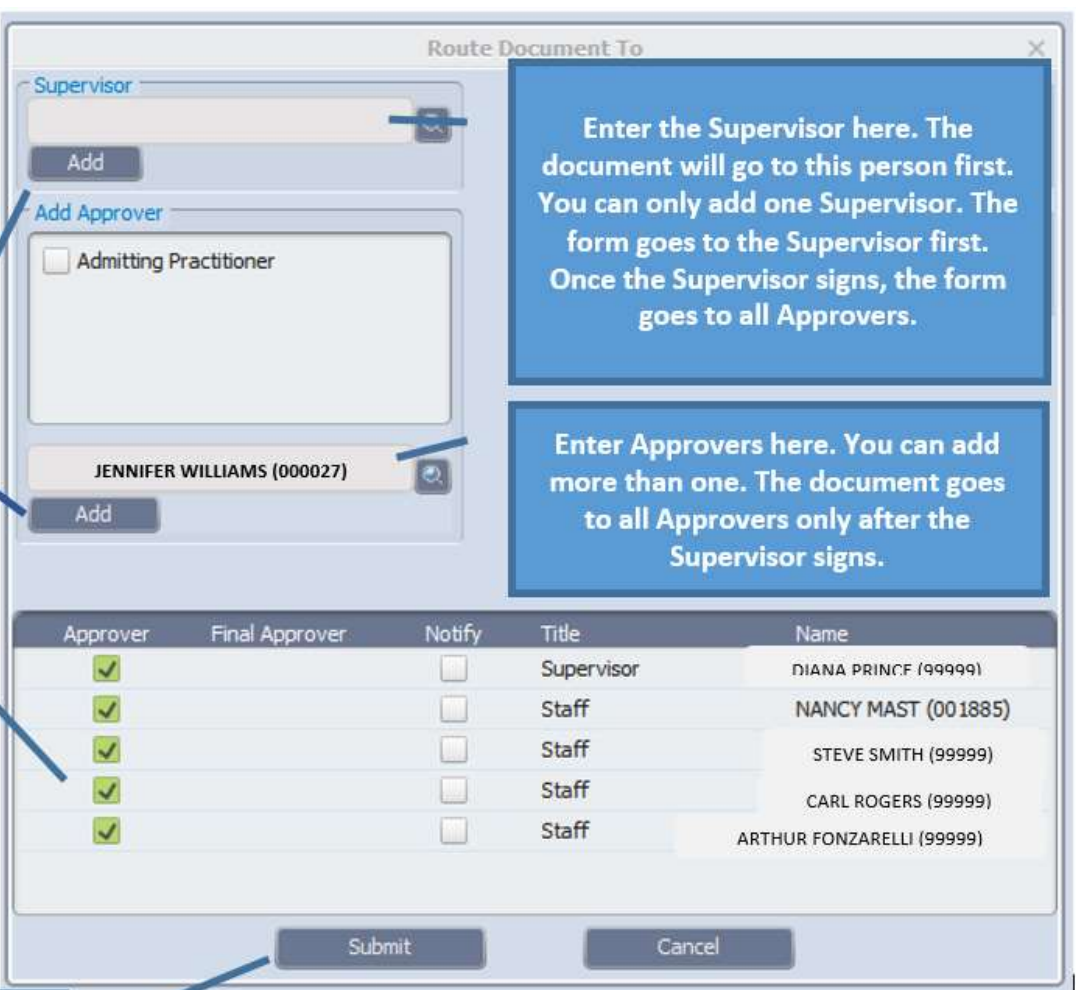
Santa Cruz County Behavior Health Avatar

How Do Supervisors and Approvers Work in Document Routing?

When you are done writing a progress note, click Final and then File Note, you have the option to Accept and Route the document to one or more cosigners. Clicking Accept and Route opens up the dialog box shown below.

Once routing has been set up, click submit.

Santa Cruz County Behavior Health Avatar

Print a Copy of a Progress Note

In Avatar, as with other electronic medical record systems, it is not necessary to print your note. Avatar keeps your notes and other documentation secure. If you do need a copy, use the following directions. After you are finished using your printed copy, shred it as it contains confidential information.

1. **Open the PIC's chart.**
2. **Click the link for the progress note type you want to view.** On the left side of the chart overview, you will see a list of progress note types. Click either SC General Purpose Progress Note, SC Med Service Progress Note or SC Group Service Progress Note.
3. **Click on the Admission Program tab** at the top of the screen. This will bring up a pre display where you can select a Progress Note to print.
4. **Use the Sort/Filter buttons to help narrow down the search if there are a lot of notes.**
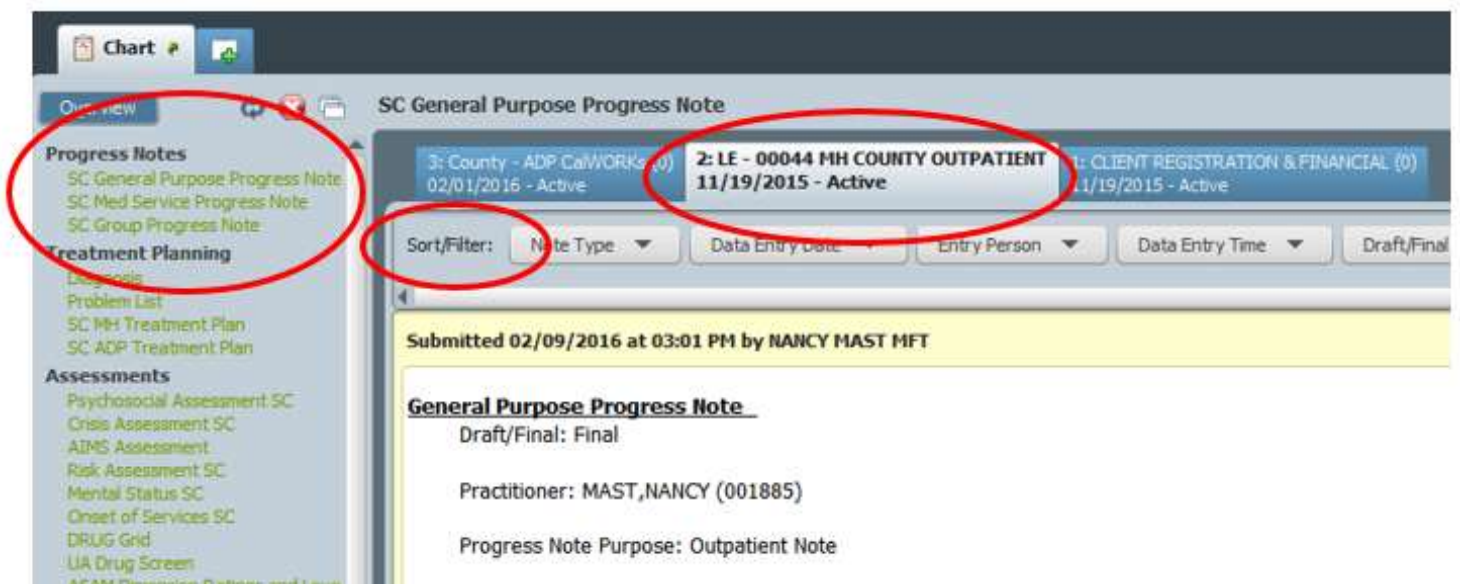
5. **Click Print.** At top left of the note, you will see the word "Print." Click this to print the document.
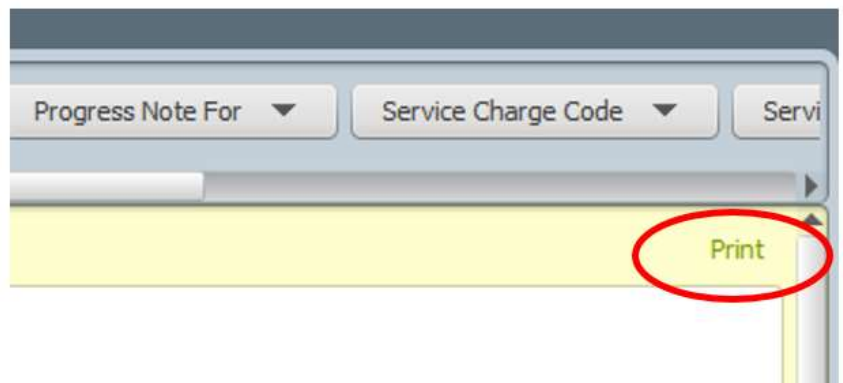
Santa Cruz County Behavior Health Avatar

How to Tell If There are Draft Progress Notes in a Chart

The next few sections of this manual address Draft Progress Notes. This section explains how to figure out whether or not there are outstanding draft notes in a chart. You might want to do this if you have accidentally deleted the link to your draft notes from your My To Do's. Or, you are trying to close the episode, want to make sure that there aren't any outstanding draft notes before you do this. Draft notes cannot be completed once the episode is closed.

STEPS:

1. Open the PIC's chart.
2. Click on the link on the left for one of the three Santa Cruz Avatar Progress Note types, for example, SC General Purpose Progress Note. You will now see an Chart View for this progress note type.
3. Click on the episode where you want to look for draft notes.
4. In the Sort/Filter buttons at the top of the Chart View, click the rectangular button labeled, "Draft/Final."
5. If there are Draft notes in the episode you've selected, you will see a Draft option to click. If there aren't any Draft notes, you won't see this option, all you will see is Final.
6. Click, "Draft," to view the draft notes for this PIC, this episode.
7. If these are your draft notes, click, "Edit," in the upper right, to complete the note. See below for more information.
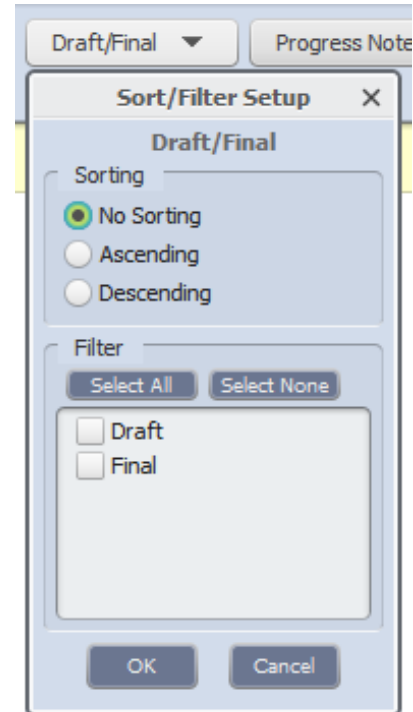
Reopening a Draft Progress Note

If you save your note in draft, a link to the draft note will be sent to your My To Do's. You can open up the draft note from there to complete it. Note **that if the chart is still open, the link in your My To Do's will not work**. (The chart must be closed for the draft notes to be relaunched.)

IMPORTANT: When reopening documents, such as draft notes, in your My To Do's **DO NOT click Review Draft Item**. This will not launch the note. In addition, you have started down a path that will delete the reminder without your completing the note.

Santa Cruz County Behavior Health Avatar

If the link to your draft progress SC General Purpose Progress note or your SC Med Service Progress Note is not in your My To Do's, you will have to open it up from the chart.

Unfortunately, you cannot open draft group notes in this manner.

STEPS

1. **Open the PIC's Chart**
2. **Click on the link for the progress note type.** In the example below, the SC General Purpose Progress Note link is clicked. This will bring up a the Chart View where you can see the notes.
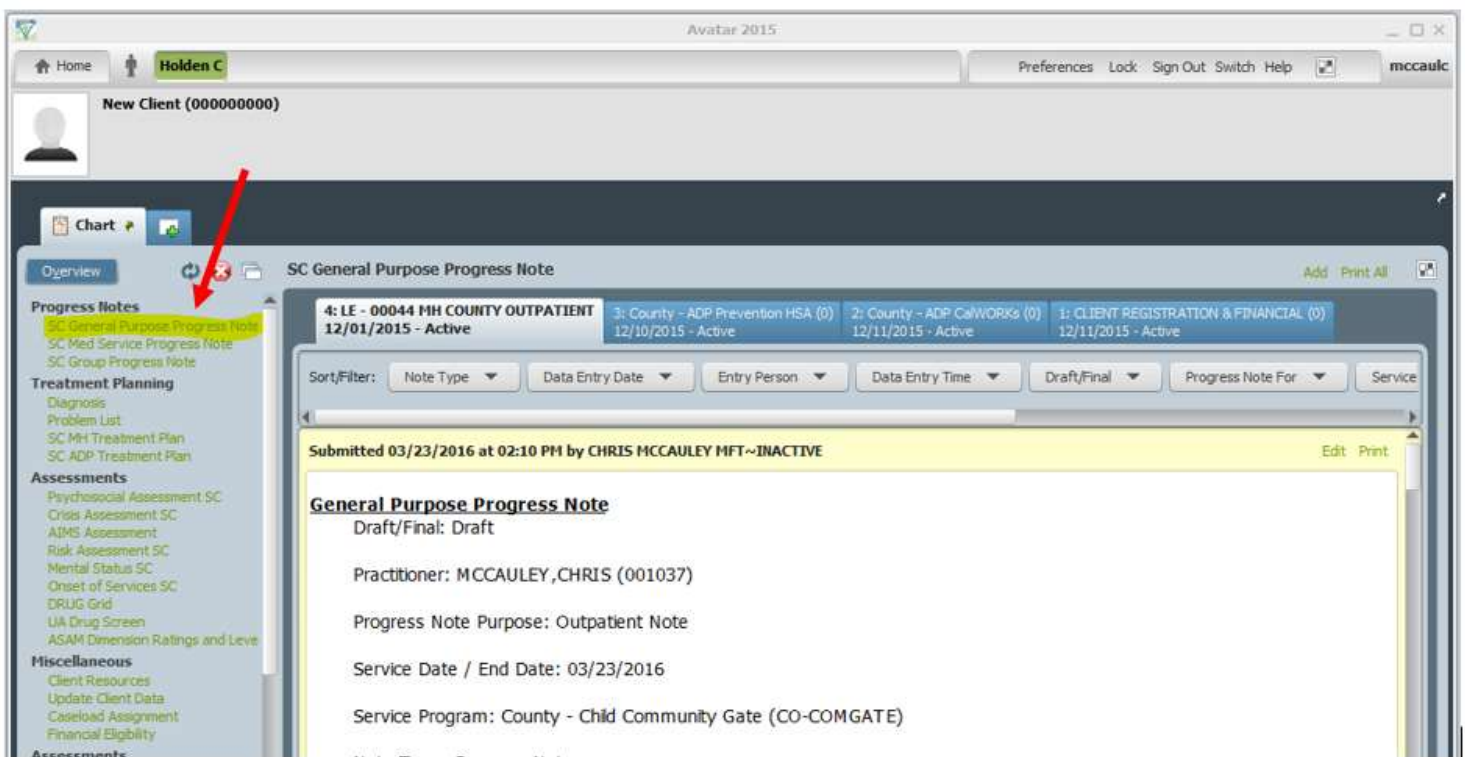
3. **Click on the tab for your Admission Program.** In the picture below, the selected admission program is episode 4: LE - 00044 MH COUNTY OUTPATIENT. You may need to use the tiny triangles at the upper right to scroll among tabs.
4. Locate the Draft Progress Note you would like to delete and select "Edit".
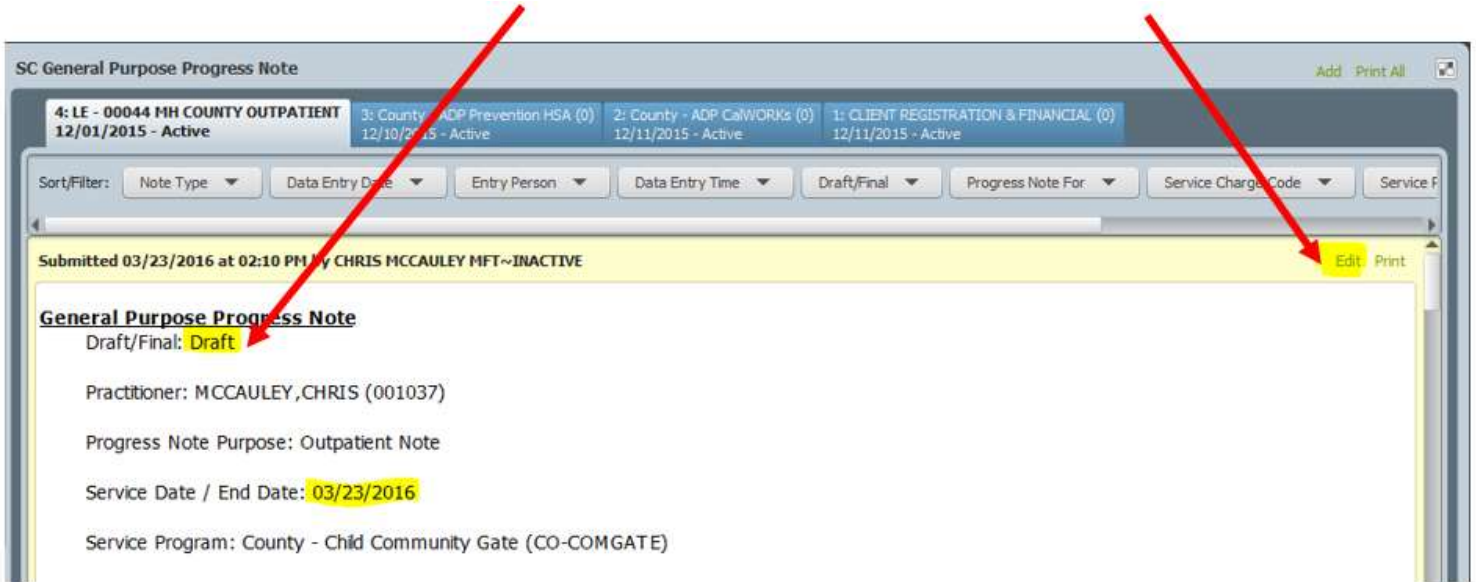
The Progress Note will open. Observe the highlighted areas (PIC name, episode, draft note information) and verify that this is the Draft Progress Note you want to edit.
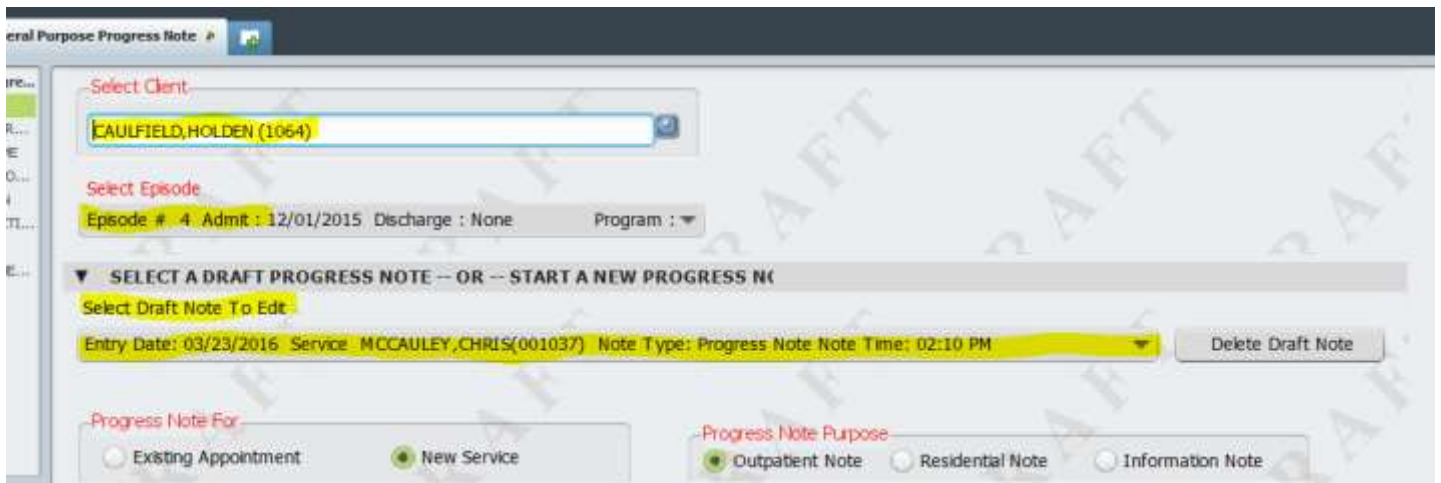
5. **Complete your note.**
6. **Select "Final"** at the bottom of the page.
7. **Select "File"** and follow the steps to sign and/or route the note.

Santa Cruz County Behavior Health Avatar

What To Do if the Link to Your Draft Progress Note is Missing From the Chart

If you save your note in draft, a link to the draft note will be sent to your My To Do's. If you accidentally delete this link, or it disappears, normally, you can open up the draft from the chart, by clicking, "Edit."

Sometimes, this "Edit" link disappears. If this happens, you can try searching for it from an open blank progress note, using the "Select Draft Note To Edit," field.

The "Edit" link is missing. It should be here for a draft note.

STEPS

1. Open the PIC's chart and click on the Progress Note Type at upper left.

2. Then click the Episode Tab where the note is.
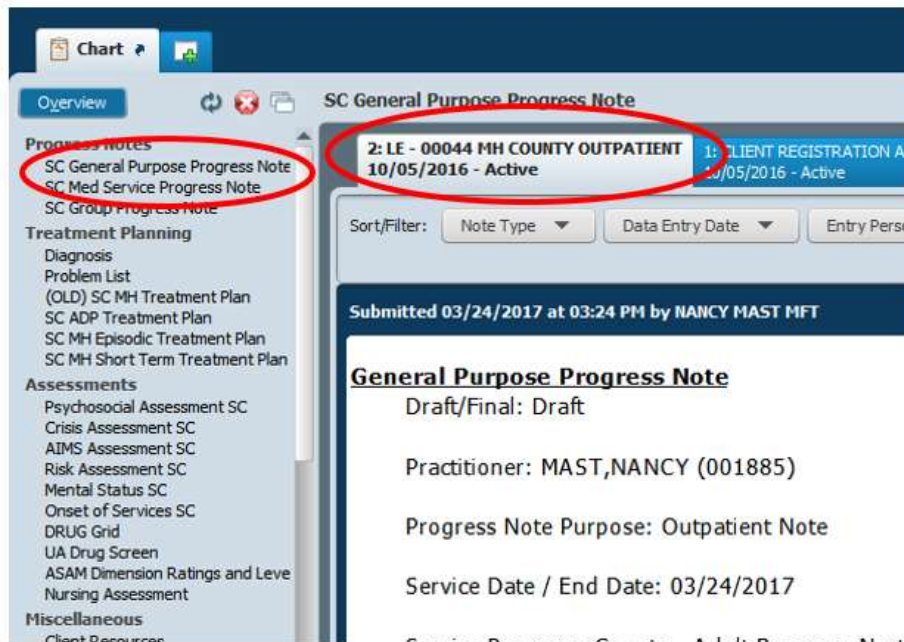
3. Click "Add" in the upper right-hand corner of the chart. This will open a new, blank, progress note.

4. Click, "Select Draft Note To Edit." This will open up a menu of available draft notes for this PIC, this episode.
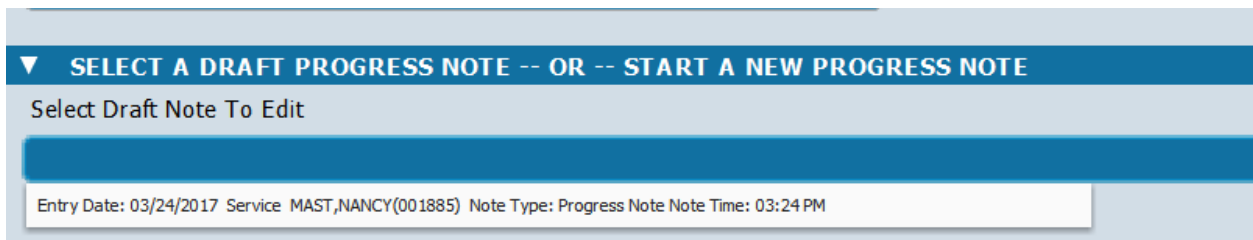
5. In the menu, click on your draft note to load it into the form. You will now see your note information displayed in the "Select Draft Note To Edit" drop down and the data from your draft note should now be loaded into the progress note form.
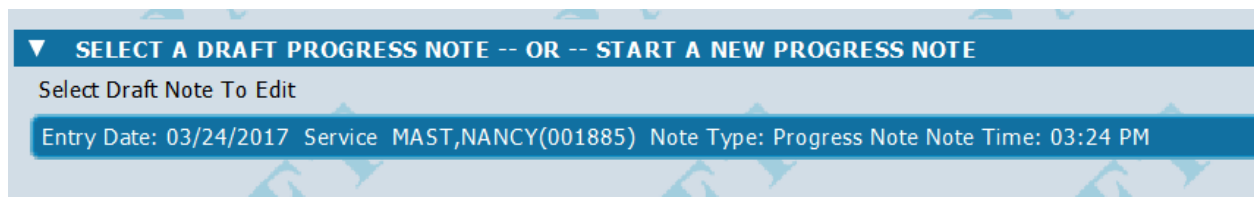
6. Edit your note.

How to Delete a Draft SC General Purpose Progress Note or SC Med Service Progress Note

If you make an error and your progress note is still in Draft form, you can delete the note yourself.

There are a couple of things that you should know about this process:
1. This will only work for the SC General Purpose Progress Note or the SC Med Service Progress Note. (Group notes cannot be deleted this way. See the section titled, "Group Progress Note Corrections," for more information.)
2. Only the original author of the draft note can delete the note in this manner. The helpdesk or QA cannot delete it for you.

3. If you have a note that has been Finalized and Filed, you will need to send a message to askqi@santacruzcounty.us to have the note deleted. You cannot delete it using the following method.

Avatar sends draft notes to your My To Do's. If the note is still in your My To Do's you can open up the note from there to delete it.

If the reminder in your My To Do's as disappeared, you will need to open up the note from the chart.

1. Open your draft note. (See the previous section, "Reopening a Draft Progress Note," for more information.)
2. Select "Delete Draft Note" to delete.
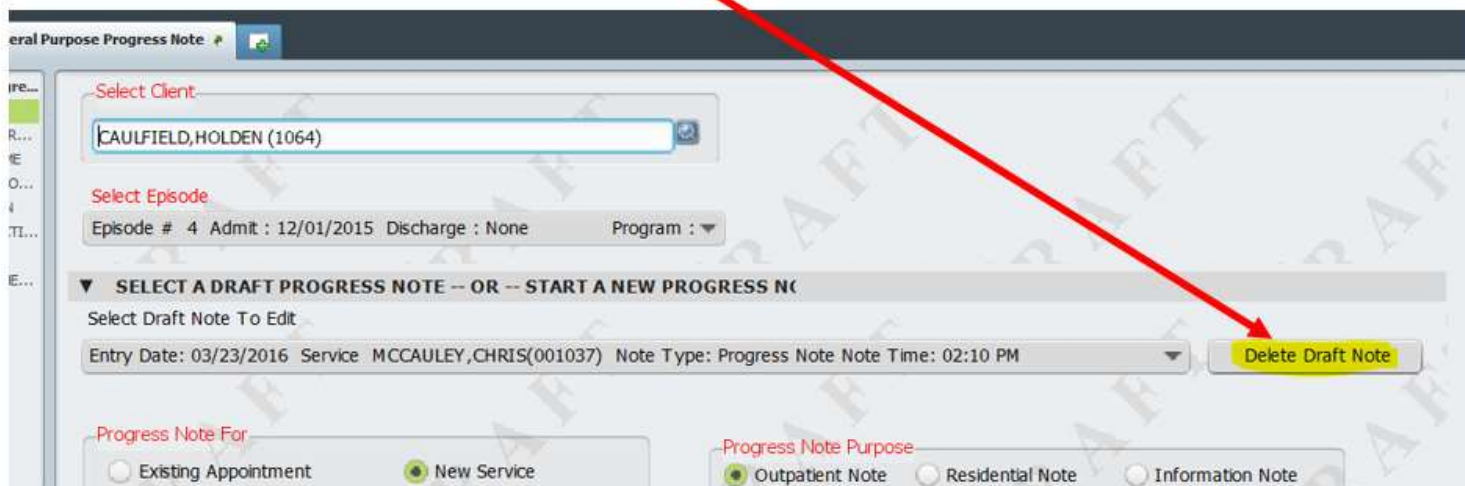
How to Delete a Draft SC Group Progress Note

For group note deletions the entire group will need deleting and then must be re-entered.

Group draft notes cannot be deleted by the clinician. (There is no "Delete" button in draft notes.) If you need group draft notes deleted, you must finalize the notes first and then request a deletion. Put NA or Void in the text blanks of the note.

See the section titled, "Group Progress Note Corrections," for more information.

Santa Cruz County Behavior Health Avatar

Using the Append Documents Form to Add to a Progress Note

First, to avoid having to add to or make changes to services, it is important to take time to look over your notes before finalizing them. But if you are looking in this section of this manual, you have probably already realized that.

If you have already filed and signed a note (and any co-signers have also signed), Avatar does provide an opportunity to add to the text of the note, or note content, using the Append Documents form. Service information, like time spent and service code cannot be altered this way.

Once the Append Documents form has been completed, the added text will appear as an addendum at the end of the Progress Note in Avatar.

See the picture below.

> **OTHER WAYS TO FIX DOCUMENTS**
>
> The Append Documents form isn't a fix for all types of note problems. See the section titled, "Corrections: What To Do If You Make a Mistake."

ADDITIONAL DOCUMENT NOTE - 12/28/2018 at 12:00 PM by Nancy Mast

ADD TO FOLLOW UP: Requested that client bring homework to next meeting.

STEPS

1. **Before You Start:** Find the note you want to append in the PIC's chart. Note the "Submit" date and time on the note.
2. Open the **Append Documents Form**.
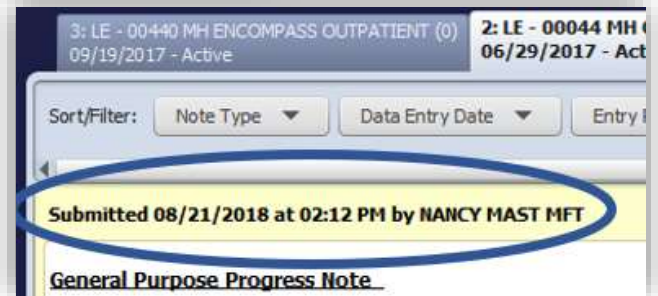
Santa Cruz County Behavior Health Avatar

3. In the **Form Type** field, select *Progress Notes (DR)*.
4. In the **Entity** field, enter the PIC name or number.

> **IMPORTANT: The form will not work on documents pending a co-signature.**
>
> If you have routed a progress note to a supervisor and are waiting for a co-signature, the progress note will not appear in the List of Notes. Ask your supervisor to "Reject" the note, which will put it back in your My To Do's in Draft form. You can then make your changes and submit the note again, without having to "append" the note

5. In the **From Date** field, enter the start date of the timeframe you want to use to search for your note.
6. In the **To Date** field, enter the end date of the timeframe you want to use to search for your note.

7. **Select the note you want to append. Click the long gray bar to the right of the label List of Documents.** You will see a list of the PIC's notes within your selected timeframe. Note that you are only going to see notes that you have written yourself. You won't see anyone else's notes, and you cannot append notes written by anyone else.

8. **In the New Comments to Be Appended to the Original Document section, add your comments.** You may want to add a notation about which section of the note your comments belong to because your addendum will be at the very end of the note.

9. **Click Submit.**

Once you have submitted the form, your changes will show at the end of the note when viewed in the chart.

Santa Cruz County Behavior Health Avatar

Group Progress Notes

In Avatar, group progress notes are done using a separate form, SC Group Progress Notes. This is different than the SC General Purpose progress note.

This form has it's advantages, but is fairly complex, so there is separate document explaining how to create Group Progress Notes on the Santa Cruz Avatar Webpage.

Click the link above to see the Group Progress Note tutorial for for more information.

Indirect (MAA) Service Note

Consult with your supervisor about whether or not you should be using this note.

MAA Billing is used by staff when performing activities that inform eligible or potentially eligible individuals about Medi-Cal services, including explaining how to access these services, describing the range of benefits covered, and how to obtain services. They are not for direct services with PICs already enrolled in services.

MAA notes should **not** contain clinical information about the **PIC**, but rather describe the outreach activities by the **clinician**. These notes do not connect to any particular PIC chart – only to the practitioner.

Santa Cruz County Behavior Health Avatar

STEPS:

1) **Open the Indirect (MAA) Service Note.** Click in the Search Forms field in your Forms & Data Widget and type Indirect (MAA) Service Note. Double click on the form name to open up the form.
2) Enter **Date of Service**, **Practitioner** (your name), **Program**, **Service code** (indirect MAA service) and **Duration**.
3) **Fill in the Indirect Service Note field if needed.** Consult with your supervisor about whether or not you need to write anything in the "Indirect Service Note" field. Avatar does not require you to fill out this field to complete the note. This field is intended to record a brief summary of the indirect services provided by the clinician. It is not a clinical note and should not contain PIC information.
4) **Click Submit.**
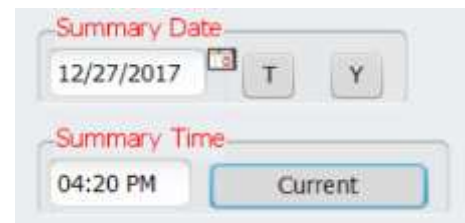
Treatment/Discharge Summary

This form is a special type of progress note that does not have a billing component. You might use this form to summarize treatment when you don't have a final session with the PIC (and therefore, there are no billable services). For, example, the PIC drops out or is unexpectedly hospitalized.

> SUDS programs are required to use this form to summarize treatment IF the PIC completes the program. If the PIC does not complete the program (drops out, goes AWOL) you do not have to complete this form.
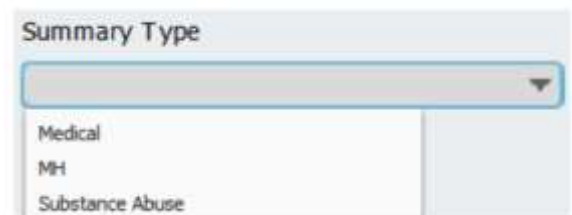
Review Section:

1) **Enter the summary date and time.** The Summary Date should be within a few days of the discharge date. It is the day you start working on the summary. It does not have to be the exact date of discharge because sometimes the discharge date can change. Enter Summary Time as current. Note that if you save the Treatment/Discharge Summary as a draft, you won't be able to change it when you go back to edit the form.
2) **Enter the Summary Type.**
3) **Click "Draft" for the Summary Status.**
4) **Enter the Review Type as "Discharge."**
5) **Reason for Discharge:** Select from the list if applicable. If not, enter the reason briefly in the question....
6) ....**Other Reason for Discharge.** If you need to discuss this further, use the next question....

7) **Review of Client's Treatment.** In this field, briefly discuss PIC's progress (or lack of progress) toward treatment plan goals. There is a summary section where you can discuss this further if desired.

8) **Mental/Physical State At Review:** Discuss the most recent information you have about PIC status, relevant to treatment provided and program goals.
9) **Review/Discharge Plan For Care:** Enter referrals and plans/recommendations for further care and treatment post discharge.

Notification, Transportation and Follow Up Section

This section is optional. Enter information here if it is relevant to your program and discharge procedures. Otherwise, you may leave the questions in this section blank.

Note

Enter the Note Type and Summarize the PIC's treatment in the "Review/Discharge Note" question.

Referral Tab: This tab is not used.

Santa Cruz County Behavior Health Avatar

Changes to Treatment Planning Under CalAIM (2023)

Beginning in 2022, the California Medi-Cal system underwent a significant transformation, which included changes in treatment planning.

For most programs, the requirement to do a separate stand-alone treatment plan is went away. Stand-alone treatment plans were replaced with simply adding problems to a Problem List, and then writing a progress note to document planning activities.

In addition, for case management services, for Mental Health programs only, instead of a separate treatment plan, clinicians now write a progress note with a short statement describing the plan for providing Targeted Case Management (previously Case Management).

For more information about this CalAIM changes, see the County Avatar Resource CalAIM web page, and also the California Mental Health Services Authority CalAIM webpage.

Santa Cruz County Behavior Health Avatar
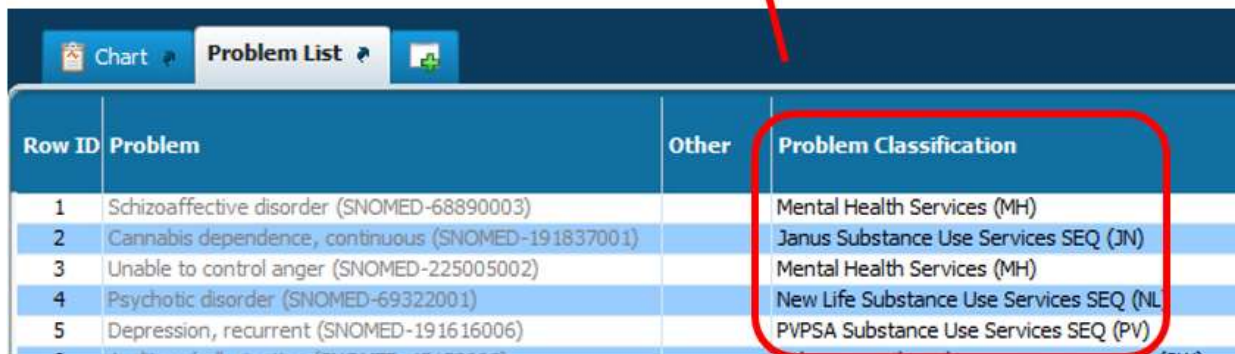
Avatar Problem List

NEW QUESTION/COLUMN: Problem Classification

When you look at the Problem List in Avatar, you will see a new
column, **Problem Classification**. It allows us to sequester problems.
(To find out more about sequestration, see the Avatar Clinicians Manual,
page 58.)

The Problem Classification question allows us to sequester certain rows to the SUD program, if needed.

Only people working in that program will see the row.

Row ID	Problem	Other	Problem Classification
1	Schizoaffective disorder (SNOMED-68890003)		Mental Health Services (MH)
2	Cannabis dependence, continuous (SNOMED-191837001)		Janus Substance Use Services SEQ (JN)
3	Unable to control anger (SNOMED-225005002)		Mental Health Services (MH)
4	Psychotic disorder (SNOMED-69322001)		New Life Substance Use Services SEQ (NL
5	Depression, recurrent (SNOMED-191616006)		PVPSA Substance Use Services SEQ (PV)

Santa Cruz County Behavior Health Avatar

For *Sequestered* Substance Use Disorder Services

Santa Cruz County Behavior Health Avatar

For Non-Sequestered Substance Use Disorder Services

Choose **Non-Sequestered Substance Use Services (NS)** if your SUD client consents to documentation being non-sequestered. Use this item for all SUD programs, regardless of agency.

For All Mental Health Programs

For all Mental Health programs, regardless of agency, select **Mental Health Services (MH)**.

Santa Cruz County Behavior Health Avatar

How to Use the Avatar Problem List

Good News: Avatar already has a problem list. If you have ever created a treatment plan in Avatar, you're already familiar with it. You are probably used to seeing the problem list in a treatment plan (below), but this form can be opened without first opening a treatment plan.

Santa Cruz County Behavior Health Avatar

Open the Problem List from the Forms & Data Widget ➔

← Or from the chart

The Problem List form has two pages. To see the actual Problem List, after you open the form, click "View/Enter Problems."

How to View Existing Problems
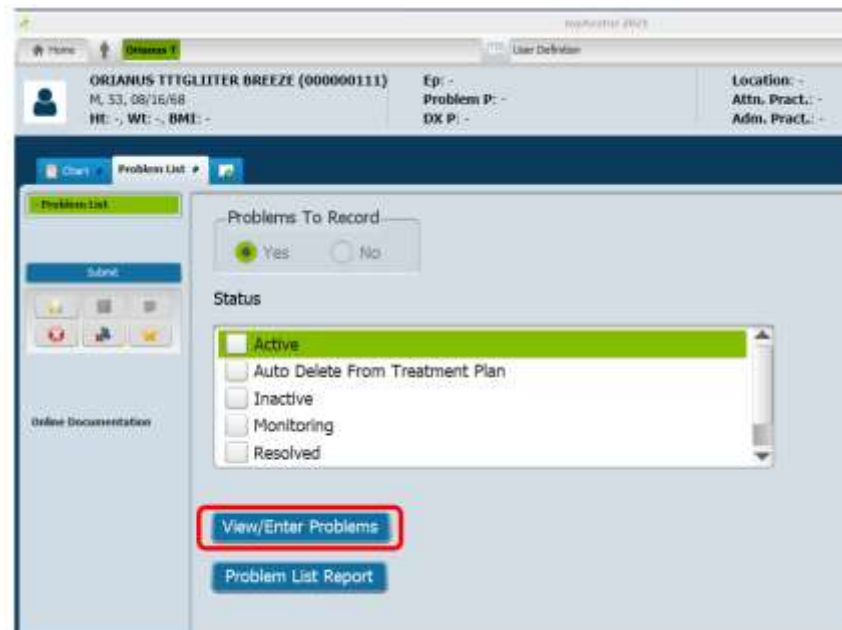
When you open the Problems Table, some of the information will be cut off on the right.

Click and drag the dividing lines between columns to make it easier to see an entire row.

Click and drag the slider bar at the bottom to move back and forth.
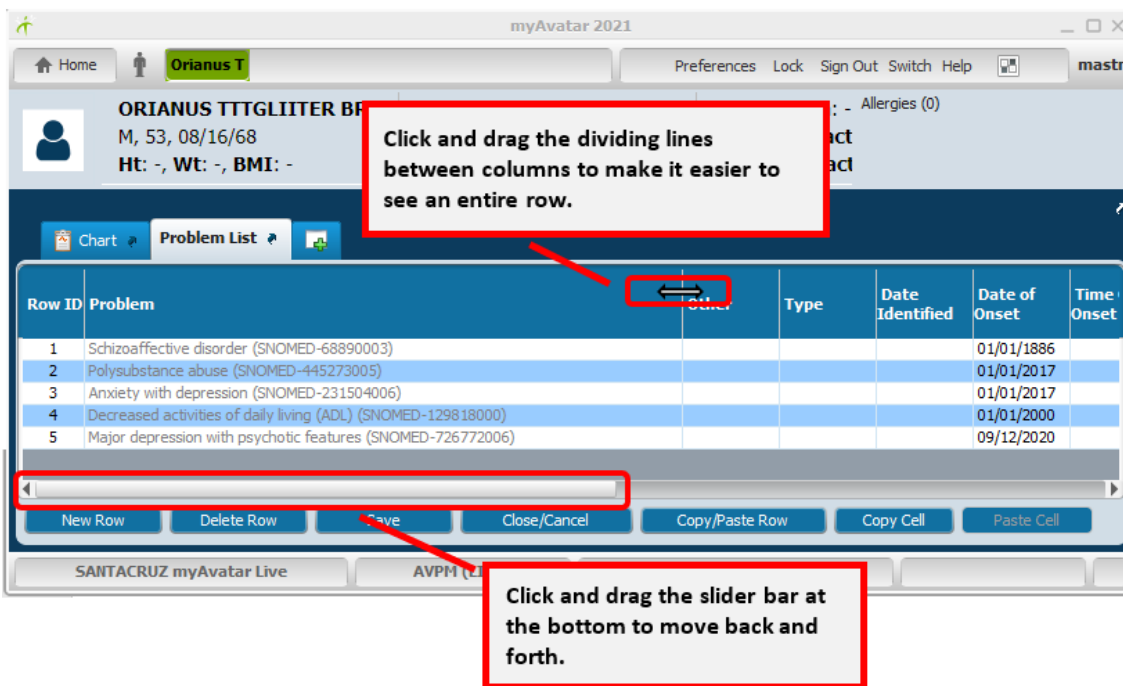
Santa Cruz County Behavior Health Avatar

Enter Problems into the Problem Table

The problem list is shared across all programs in Avatar. You may see problems that have been added by other clinicians, either working in your agency, or at another agency in another part of the county.

<mark>Everyone adds problems to the same list.</mark> You are encouraged to collaborate with other providers when updating the Problem List.

Each of the problems is entered as one line or row in the list.

Description of Columns in the Problem List

This section describes what information to enter in each column on the Problem List. Some columns/questions in the Problem List are required. Some are not. (See below.)

Problem (REQUIRED): This is the problem you are working on with the person in care.

Enter problems based on your scope of practice.

LPHAs may add: Any clinically appropriate problem, diagnosis or not.
Paraprofessionals (non-LPHA) may add: Any clinically appropriate problem other than a diagnosis. Exception, paraprofessionals may enter a "Z-code" diagnosis to be used prior to formal assessment and identification of the final diagnosis. (Guidance on this is coming soon. Look for information on how to use the Diagnosis Form for Paraprofessionals.)
See Appendix for more information on SNOMED codes.

Other: If you pick the "Specify Other" Problem Code you will need to describe the problem in this field. You are discouraged from using this. Instead, try to find a problem that fits for the person in care. There are over 20,000 problems to choose from, so you should be able to find something that works.

Type: Do not use.

Date Identified (REQUIRED): This is the <u>date you met with the client / guardian and together identified the problem(s)</u>. This is not the date that the actual problem started, e.g. when the person in care started

feeling depressed. The date the problem started is the **Date of Onset** (below).

Row ID	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity
1	Sheltered homelessness (SNOMED-32911000)			11/06/2021	07/01/2021		Active (A) (A)		
2	Family conflict (SNOMED-81935006)			11/06/2021	01/01/2010		Active (A) (A)		
3	Psychological trauma history (SNOMED-161472001)			01/15/2022	01/01/2008		Active (A) (A)		
4	Disorganized thought process (SNOMED-736319003)			01/15/2022	01/01/2018		Active (A) (A)		
5	Mild methamphetamine use disorder (SNOMED-699449003)			02/10/2022	01/01/2015		Active (A) (A)		
6	Schizoaffective disorder, unspecified (SNOMED-68890003)			04/22/2022	01/01/2020		Active (A) (A)		

Date of Onset (REQUIRED): Date the problem started. Best practice is to use the date the client/guardian identifies as the start date, but use your clinical judgement.

Row ID	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity
1	Sheltered homelessness (SNOMED-32911000)			11/06/2021	07/01/2021		Active (A) (A)		
2	Family conflict (SNOMED-81935006)			11/06/2021	01/01/2010		Active (A) (A)		
3	Psychological trauma history (SNOMED-161472001)			01/15/2022	01/01/2008		Active (A) (A)		
4	Disorganized thought process (SNOMED-736319003)			01/15/2022	01/01/2018		Active (A) (A)		
5	Mild methamphetamine use disorder (SNOMED-699449003)			02/10/2022	01/01/2015		Active (A) (A)		
6	Schizoaffective disorder, unspecified (SNOMED-68890003)			04/22/2022	01/01/2020		Active (A) (A)		

Time of Onset: Do not use.

Row ID	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity
1	Sheltered homelessness (SNOMED-32911000)			11/06/2021	07/01/2021		Active (A) (A)		
2	Family conflict (SNOMED-81935006)			11/06/2021	01/01/2010		Active (A) (A)		
3	Psychological trauma history (SNOMED-161472001)			01/15/2022	01/01/2008		Active (A) (A)		
4	Disorganized thought process (SNOMED-736319003)			01/15/2022	01/01/2018		Active (A) (A)		
5	Mild methamphetamine use disorder (SNOMED-699449003)			02/10/2022	01/01/2015		Active (A) (A)		
6	Schizoaffective disorder, unspecified (SNOMED-68890003)			04/22/2022	01/01/2020		Active (A) (A)		

Status (REQUIRED):

Row ID	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity
1	Sheltered homelessness (SNOMED-32911000)			11/06/2021	07/01/2021		Active (A) (A)		
2	Family conflict (SNOMED-81935006)			11/06/2021	01/01/2010		Active (A) (A)		
3	Psychological trauma history (SNOMED-161472001)			01/15/2022	01/01/2008		Active (A) (A)		
4	Disorganized thought process (SNOMED-736319003)			01/15/2022	01/01/2018		Active (A) (A)		
5	Mild methamphetamine use disorder (SNOMED-699449003)			02/10/2022	01/01/2015		Active (A) (A)		
6	Schizoaffective disorder, unspecified (SNOMED-68890003)			04/22/2022	01/01/2020		Active (A) (A)		

EXPLANATION OF STATUS MENU ITEMS

Santa Cruz County Behavior Health Avatar

ACTIVE: This means the problem is current and you (or another clinician) are working on it with the person in care.

NTSTTPVOID: Do not use unless instructed to do so. (This is a special status for fixing glitched problem lists.)

INACTIVE: This means that the problem exists, but is not currently being treated.

MONITORING: Do not use.

RESOLVED: This means that the problem is resolved – the person in care no longer has this problem or problem is in remission.

UNRESOLVED: Do not use unless you are reactivating a problem that was previously resolved. Avatar will not allow you to add a problem that already exists, even if that problem is resolved.

If a problem re-surfaces for the person in care, and you need to work on the problem again, follow these steps:

1) Change the status on the resolved problem to UNRESOLVED.
2) Close and save the Problem List.
3) Reopen the Problem List.
4) Change the status of the problem to ACTIVE.

HOW TO REACTIVATE A RESOLVED PROBLEM
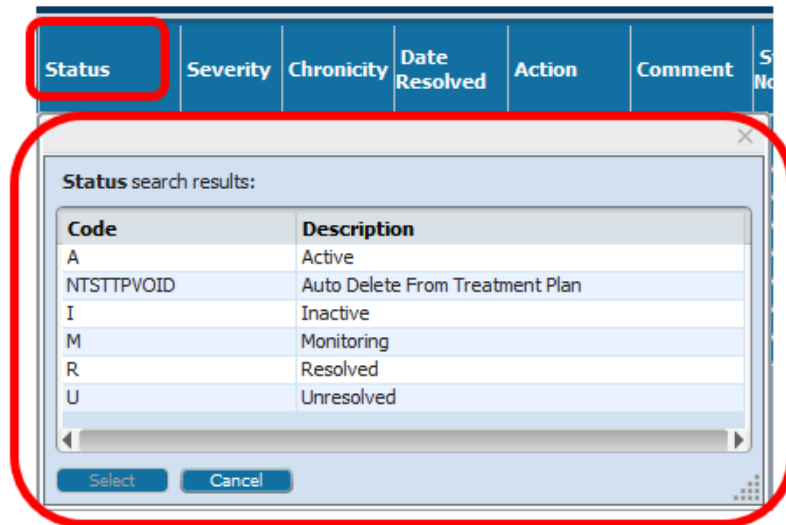
Severity and Chronicity: Do not use.

Row ID	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity
1	Sheltered homelessness (SNOMED-32911000)			11/06/2021	07/01/2021		Active (A) (A)		
2	Family conflict (SNOMED-81935006)			11/06/2021	01/01/2010		Active (A) (A)		
3	Psychological trauma history (SNOMED-161472001)			01/15/2022	01/01/2008		Active (A) (A)		
4	Disorganized thought process (SNOMED-736319003)			01/15/2022	01/01/2018		Active (A) (A)		
5	Mild methamphetamine use disorder (SNOMED-699449003)			02/10/2022	01/01/2015		Active (A) (A)		
6	Schizoaffective disorder, unspecified (SNOMED-68890003)			04/22/2022	01/01/2020		Active (A) (A)		

Date Resolved:
- Date the problem ended.
- If status is RESOLVED, this field is required.

Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved	Action	Comment	System Notes	Problem Information	Problem Plan
11/06/2021	07/01/2021		Resolved (R)			03/12/2022			View	ⓘ	View
11/06/2021	01/01/2010		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2008		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2018		Active (A) (A)						View	ⓘ	View
02/10/2022	01/01/2015		Active (A) (A)						View	ⓘ	View
04/22/2022	01/01/2020		Active (A) (A)						View	ⓘ	View

Note about Resolving Problems: Before you resolve, review the problem with the person in care to ensure they agree that the problem has been resolved. **If another clinician mistakenly resolves a problem that you are working on, it can be reactivated as described above.**

Action: Do not use.

Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved	Action	Comment	System Notes	Problem Information	Problem Plan
11/06/2021	07/01/2021		Resolved (R)			03/12/2022			View	ⓘ	View
11/06/2021	01/01/2010		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2008		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2018		Active (A) (A)						View	ⓘ	View
02/10/2022	01/01/2015		Active (A) (A)						View	ⓘ	View
04/22/2022	01/01/2020		Active (A) (A)						View	ⓘ	View

Comment: Optional. This text field is for supplemental information. It is preferred that you enter this information in a progress note, not here.

Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved	Action	Comment	System Notes	Problem Information	Problem Plan
11/06/2021	07/01/2021		Resolved (R)			03/12/2022			View	ⓘ	View
11/06/2021	01/01/2010		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2008		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2018		Active (A) (A)						View	ⓘ	View
02/10/2022	01/01/2015		Active (A) (A)						View	ⓘ	View
04/22/2022	01/01/2020		Active (A) (A)						View	ⓘ	View

System Notes: Coming soon! This field will tell you who added or updated the problem, and when.

Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved	Action	Comment	System Notes	Problem Information	Problem Plan
11/06/2021	07/01/2021		Resolved (R)			03/12/2022			View	ⓘ	View
11/06/2021	01/01/2010		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2008		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2018		Active (A) (A)						View	ⓘ	View
02/10/2022	01/01/2015		Active (A) (A)						View	ⓘ	View
04/22/2022	01/01/2020		Active (A) (A)						View	ⓘ	View

Problem Plan: Do not use.

Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved	Action	Comment	System Notes	Problem Information	Problem Plan
11/06/2021	07/01/2021		Resolved (R)			03/12/2022			View	ⓘ	View
11/06/2021	01/01/2010		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2008		Active (A) (A)						View	ⓘ	View
01/15/2022	01/01/2018		Active (A) (A)						View	ⓘ	View
02/10/2022	01/01/2015		Active (A) (A)						View	ⓘ	View
04/22/2022	01/01/2020		Active (A) (A)						View	ⓘ	View

Diagnosis Form / Adding Provider's Diagnosis to the Problem List

Automatically add your diagnosis to the problem list when entering a diagnosis in the Avatar Diagnosis From.

Ranking
- ● Primary
- ○ Secondary
- ○ Tertiary

Bill Order: 1

ADD THIS DIAGNOSIS TO PROBLEM LIST?
- ● Yes
- ○ No

In the diagnosis form, for the question, **ADD THIS DIAGNOSIS TO PROBLEM LIST?** Enter **Yes**.

Clicking **Yes** will add the diagnosis to the problem list

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About Santa Cruz Avatar Treatment Plans

TREATMENT PLAN TYPES IN SANTA CRUZ AVATAR

There are three treatment plan forms in Santa Cruz Avatar. (The (OLD) SC MH Treatment Plan is no longer used.) You will use one of these forms to create your treatment plans.

SC MH Episodic Treatment Plan

- The SC MH Episodic Treatment Plan is no longer used, but you can still view old plans in the clients chart. Beginning in July 2023, along with other CalAIM changes, this plan type was retired. Most programs now use a combination of adding problems to a problem list and writing specialized progress notes for certain types of care planning.

SC MH Short Term Treatment Plan

- This plan is used by a few programs that provide acute, short-term outpatient services. Do not use this treatment plan unless you have been told by your supervisor that yours is one of the programs that uses this treatment plan form.

SC SUD Treatment Plan

- This plan is used by SUD treatment programs and is shared only among providers within a specific treatment program.

Using Defaulting to Create Sequential Plans

When adding to a shared plan, clinicians may collaborate so that everyone adds to the same draft plan. If the current plan is already finalized no one can add to the current version. Instead, to add to a plan that has already been signed and finalized, you essentially make a copy of the current plan and then edit as needed.

For example, a PIC has a mental health case manager. A therapist wants to add new goals, etc...to cover therapy services. To add new goals, etc..., a copy of the plan (using the "default" method that will be explained later) is created. Then new goals, etc...are added to the plan. In this way, all of the providers stay in the shared plan. The most recent plan will contain goals, objectives and interventions added by all providers.

Avatar Treatment Plans: Plan Page and Plan Builder Page

There are two pages to the

Treatment Plan form.

On the **first page**, the ==PLAN PAGE==, contains everything except the actual goals, objectives and Inter-ventions.

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The **second page** of the plan, the **PLAN BUILDER PAGE**, is where goals, objectives and interventions are added.

The **Plan Builder page** is opened by clicking the "Launch Plan Builder" button. Note that you must click "Draft" to go to the Plan Builder page.

Treatment Plans for PICs Who Do Not Speak English

For PICs who do not speak English, the clinician should type **both English and Spanish** (or other language) into the plan. The format is [English text] / [Spanish translation text]. For each item, the English first, then a slash, then the Spanish text.

You might ask, "Why does the plan have to have English at all, if the PIC does not speak English?" The English in the plan is there for auditing purposes, in case the auditor does not speak the same language that the PIC does. In addition, having English allows for collaborating providers to read and understand the plan, even if they do not speak Spanish.

Creating an Initial Treatment Plan

The Initial Treatment Plan is the first treatment plan in the Episode or Admission Program. A PIC will only have one Initial Plan.

The instructions below assume that this is a new PIC to Avatar, with no prior treatment plans.

STEPS:
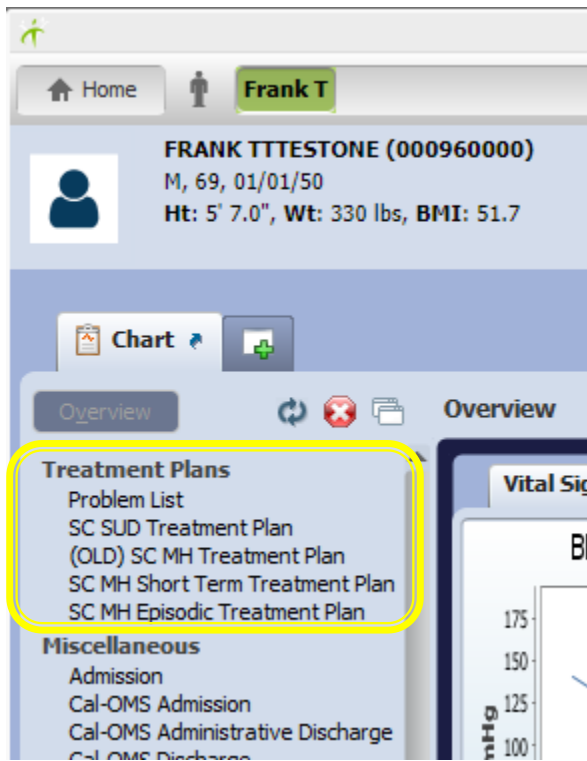
1.   If you have not already done so, open your PIC's chart. In the chart view, find a link the treatment plan form you want to use. Double-click on the link.

2. Click on the tab for your Episode or Program. This will open up the display area or Chart View for any previously written treatment plans. For a brand new PIC, you should see a blank page because no treatment plan has yet been written for your PIC. You should see, "No Data Found," in the Chart View.
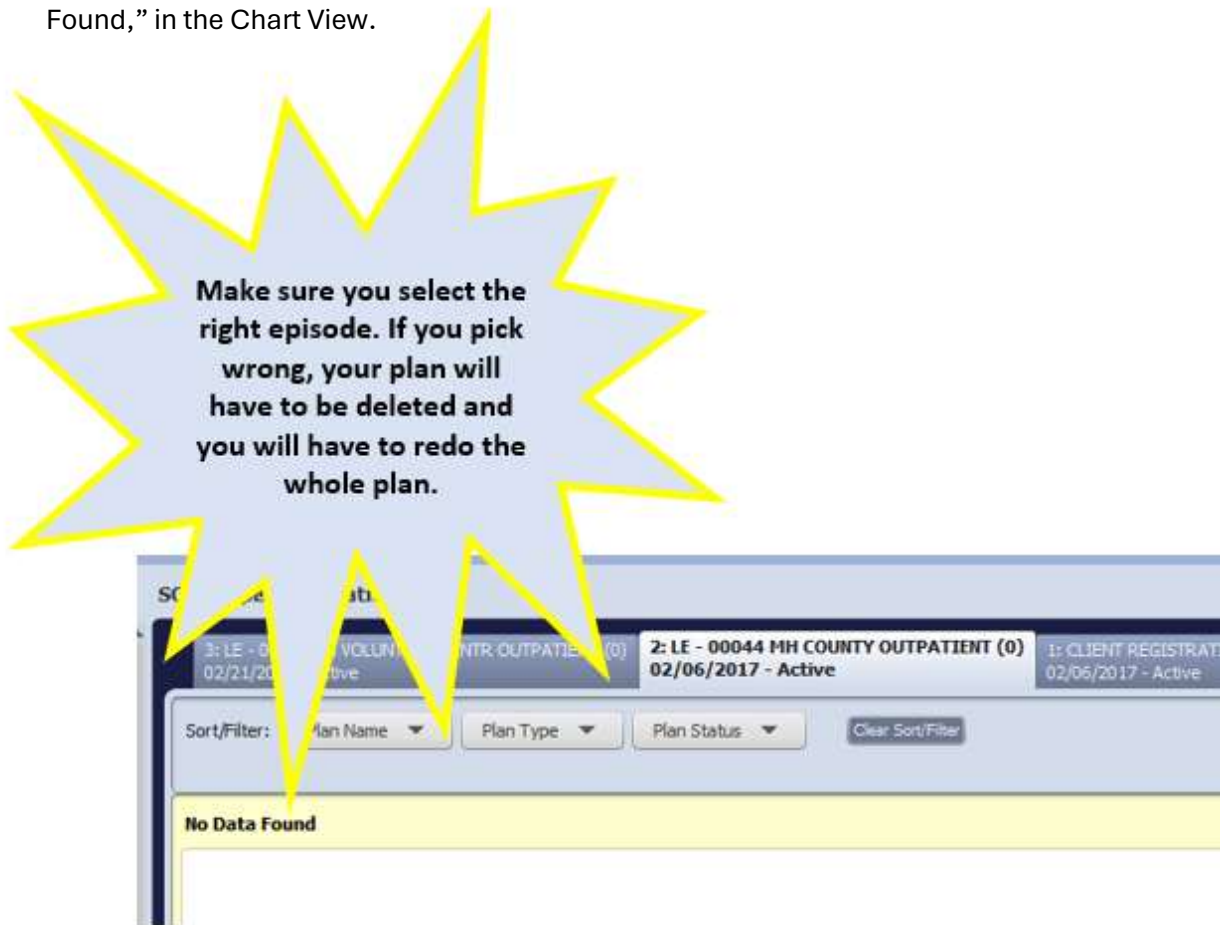
3. With your tab selected, in the far upper right hand corner of the chart view, click on **Add** to create the first treatment plan for your PIC. The first page of the Treatment Plan form will open.
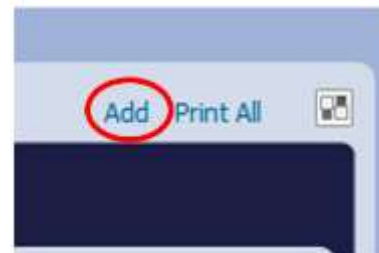
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4. Double Check Your Episode

TIP: Once you have your plan open, look at the Episode information at the top of the chart, next to the PIC's name. This is a good double check to make sure you have selected the right episode.
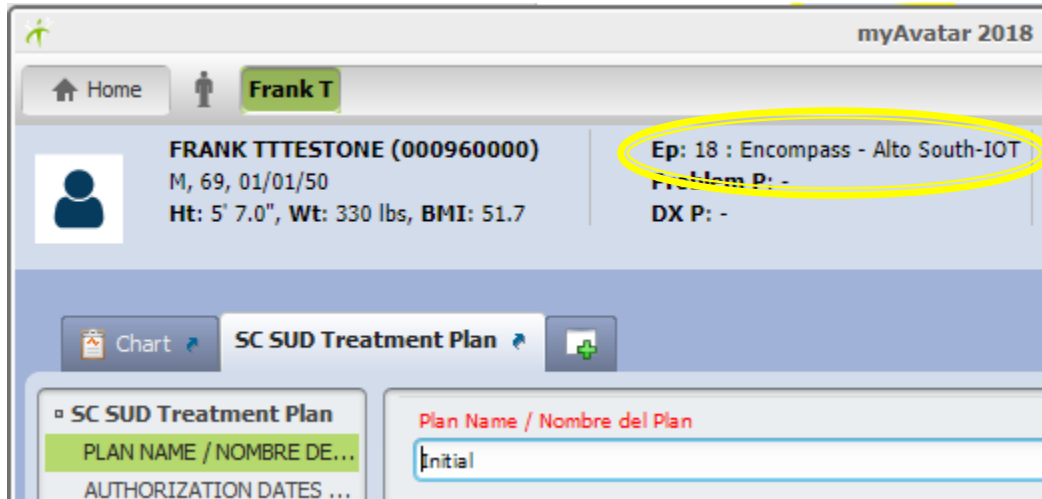
STEPS:

1. In the **Plan Type** field, click the down-arrow to reveal the drop-down menu. Single-click to select **Initial**.

   For all form types, the Plan Type is Initial for the first treatment plan.
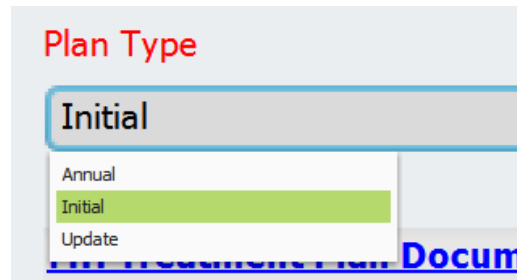
Santa Cruz County Behavior Health Avatar

> ## TREATMENT PLAN DATES
> *The different Treatment Plan forms have different methods and conventions for entering dates.*

For the Initial plan, enter the opening date to your program in the Authorization Start Date field. (See the chart tabs to get the date if you forget.) Type in the date or use the calendar icon to select a date, then tab or click out of the field. The **Authorization End Date and Next Review Date should auto-populate** after tabbing out of the Authorization Start Date field. The Authorization End Date will automatically be entered as 90 days from the start date. The Next Review Date will be two weeks before the Authorization End Date.

On the Next Review Date, a message will be sent to you in your My To Do's, reminding you that the plan is due.

PLAN DATES

Authorization Start Date	Authorization End Date	Next Review Date
02/05/2017	02/04/2018	01/05/2018

UPDATES: After the Initial Treatment Plan, subsequent plans start one day after the end date of the previous plan.

TIP: If you forget what the end date for the last plan is, click back to the chart overview and look at the episode tab to find the admission date.

Chart   SC SUD Treatment Plan
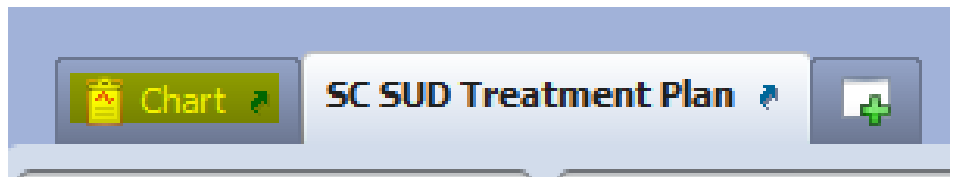
Plan Dates for the SC SUD Treatment Plan

Prior to creating the first treatment plan, the ASAM Assessment should be completed. The ASAM Assessment will inform the problems, goals, objectives and interventions in the plan.

SUD Treatment Plan Due Dates

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For the Initial plan, enter the opening date to your program in the Authorization Start Date field. (See the chart tabs to get the date if you forget.) Type in the date or use the calendar icon to select a date, then tab or click out of the field. The **Authorization End Date and Next Review Date should auto-populate** after tabbing out of the Authorization Start Date field. The Authorization End Date will automatically be entered as one year minus one day from now. The Next Review Date will be one month before the Authorization End Date.

On the Next Review Date, a message will be sent to you in your My To Do's, reminding you that the plan is due.

UPDATES: After the Initial Treatment Plan, subsequent plans start one day after the end date of the previous plan.

TIP: If you forget what the end date for the last plan is, click back to the chart overview and look at the episode tab to find the admission date.

ONCE THE PLAN DATES, PLAN NAME AND PLAN TYPE ARE ENTERED, CONTINUE WITH THE PLAN

1. Answer the *required* question **Was This Treatment Plan Discussed in a Language Other Than English?** If Yes, complete the required fields **Language and Interpreter or Bilingual Provider?**

2. **Skip the questions, "Date Client was offered a copy of the treatment plan," and "Additional Comments About Client's Support System."** You will get back to these later.

3. Enter and/or select problems you want to use for your plan as described below.

Problems Table

Each of the PIC's problems is entered as one line or row on the table.

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When you open up the plan, you may find that there are already problems in the Problems Table. These problems come from the diagnosis form, prior episodes and prior treatment plans. You do not have to use these problems if you don't want to. You may add problems as shown below. You may use a combination of pre-existing problems and new problems that you add.

Use the scroll bar on the bottom of the table to navigate across each row in the table.

> You MUST have an "Active" status for any problems you use in your plan. DO NOT select "Monitoring" or "Inactive." If you do this, your plan will be invalid and services will be denied.

	Include in this plan?	Problem	Other	Type	Date Identif	Date of Onset	Time Of	Status	Severity	
2		Recurrent major depression (SNOMED-66344007)				01/01/1998		Active (A) (A)		
3		Moderate manic bipolar I disorder (SNOMED-82998009)				01/01/1978		Active (A) (A)		
4		Generalized anxiety disorder (SNOMED-21897009)				01/01/2012		Active (A) (A)		
5	✓	Alcohol dependence (SNOMED-66590003)				01/01/1978		Active (A)		
6		Cannabis dependence (SNOMED-85005007)								

New Row   **Delete Row**

> Click "New Row" to add a new problem.

> If you do not see the Date of Onset and Status fields, use the scroll bar at the bottom of the table to see questions on the right.

> You must enter the Date of Onset and Status (outlined in red) to check off a problem.

AVOID USING THE "SPECIFY OTHER" SNOMED CODE

- You are STRONGLY DISCOURAGED from using the "Specify Other" Problem Code in the Treatment Plan.
- Most problems will be covered by an available SNOMED code. You can find a list of common search words for SNOMED codes on the Avatar Website.
- Problems of "Other" type (and NOS diagnoses) should be used sparingly, if at all.
- Using the default, "Specify Other" is an issue with regard to meaningful use. Using specific problems helps us and Drug Medi-Cal know that we are treating specific, targeted and qualifying problems.

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STEPS for the Problems Table

Enter a new problem by clicking the **New Row** button. For each problem added, you must create a new row in the table.

1. **Type in a problem in the column titled "Problem." Then click Enter on your keyboard.** A list of potential problems will pop up. You can enlarge the window containing the list by clicking and dragging in the lower right-hand corner. Click on the problem you want in your table. The selected/chosen problem will be entered in the Problem field.

   Be patient when typing your problem. It can take a few seconds or so for Avatar to search for the problem. Make sure you press, "enter" after you type the problem.

   Notice that the Date of Onset and Status fields are outlined in red. This is because these fields are required. You will not be able to finalize and submit your treatment plan of these fields are empty.

2. DO NOT USE THE **TYPE FIELD.**
3. Double-click in the **Date Identified** field to activate the field. This is an optional field. Enter a date if appropriate.
4. Enter the **Date of Onset**. **THE DATE OF ONSET IS NOT THE OPENING DATE FOR YOUR PROGRAM.** Typically, you will not know the exact date of onset. **Pick the closest approximation that you can for the year.** Month and day are January 1st. **For example, 01/01/1972.**
5. **Status field:** For a new problem, the status will be **ACTIVE. This is a required field. DO NOT put "Monitoring" or "Inactive" as the status for your problems. If you do this, any goals, objectives or interventions associated with this problem will be invalid.** (If you no longer need a problem, you can resolve it.)
6. **Severity field:** This item is optional. To activate the field, double-click on the entry of your choice, or single-select the item of your choice and click the Select button.
7. After adding problems (if needed) in the **"Include in this plan?"** column, **check on all the checkboxes for those problems you wish to include** in this treatment plan. Note that you do not have to use all of the items in the problems table, only the ones you want to address in the treatment plan.

SNOMED CODES
(Systematized Nomenclature of Medicine Codes)

- In Avatar treatment plans, the problems you address can be Diagnoses or functional impairments such as "disorganized thought process," "poor motivation," or "social isolation."
- For SUD Treatment Plans only, problems may also address case management needs such as, ""Maladaptive health behaviors affecting medical condition," "Poor nutrition," or "Loss of Job."
- The SNOMED codes that you add to your plans cover both diagnoses and functional impairments.
- For MH Plans, only licensed/waivered staff can add or treat Diagnoses. If you are licensed/waivered, you can use either a diagnosis or a functional impairment type SNOMED code in your plan.
- For SUD plans, licensed/waivered, as well as registered staff may address SUD diagnoses.
- If you are not licensed/waivered/registered, use SNOMED codes that address a functional impairment associated with one of the PIC's diagnoses. For example, if your PIC has the diagnosis of depression, you might choose the SNOMED code, "social isolation."

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IMPORTANT: You must add your problems to the problems table. DO NOT add problems on the plan builder page, which is the next page, where you add your goals, objectives and interventions. If you add problems to the plan builder page, your plan may not work properly.

	Include in this plan?	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Seve
1	✔	Recurrent major depression (S...				01/01/2000		Active (A)	
2	✔	Generalized anxiety disorder (S...				01/01/2000		Active (A)	
3	✔	Low motivation (SNOMED-2641...				01/01/2000		Active (A)	
4		Cannabis dependence, episodic...				01/01/2000		Active (A)	

New Row   Delete Row

STEPS for the Plan Participants Table

Plan Participants

	Role	Staff ID	Participant Name	Plan Author	Notification	Signature
1	STAFF (STAFF)	MAST,NANCY (0...	MAST,NANCY	Yes (Y)	Yes (Y)	Sign
2	CLIENT (CLIENT)		Poseidon Stavros	No (N)	No (N)	Sign
3	CONSERVATOR ...		Arthur Smith, LP...	No (N)	No (N)	Sign

New Row   Delete Row

The Plan Participants table is where you enter everyone who signs the plan (PIC, parent, guardian, conservator, MD, LPHA, etc...). Each of the plan participants is added as one line on the table.

Enter a new participant by clicking the **New Row** button.

TO ENTER YOURSELF:

1. **MH PLANS** Double-click in the **Role field** to activate the field. Click **STAFF** or **LPHA** in the pop-up window.

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2. **SUD PLANS** Double-click in the **Role field** to activate the field. Click **CERTIFIED PRIMARY STAFF, REGISTERED PRIMARY STAFF,** or **LPHA (OTHER THAN MD)** in the pop-up window. If none of these categories fits your role, use **STAFF** for your role.

<table><tr><td>FOR SUDS PLANS
CERTIFIED AND REGISTERED STAFF DEFINITIONS
Per CCR, Title 9, Section 13005</td></tr><tr><td>•A Certified SUD Counselor is an individual certified by a certifying organization recognized by DHCS and who's certification is active and in good status.
•A Registered as SUD counselor is an individual registered with any certifying organization to obtain certification as a SUD Counselor within five years of registration.</td></tr></table>

3. In the **Staff ID** field type in your last name and click enter. If you are the only person with that last name, your name should automatically auto populate into **Staff ID and participant Name fields**. Otherwise, you will see a list of names. Double-click on your name to enter yourself into the table.
4. Enter **Yes** in the **Plan Author field.**
5. Enter **Yes** in the **Notification field.** By doing this, you will set up a notification reminder for when the treatment plan is due next year. This reminder will appear in your My To Do's on the notification date.

TO ENTER AN LPHA:

If you are not an LPHA (licensed/waivered) there will be an LPHA co-signer for your plan. Create a new row in the Participants table and enter the name of your LPHA staff person who is going to co-sign your plan. This will only work if the LPHA is a user in Avatar.

1. Double-click in the **Role field** to activate the field. Click **LPHA** in the pop-up window.
2. In the **Staff ID** field type in the last name of the LPHA and then double-click on the name.
3. Enter **No** in the **Plan Author field.**
4. Enter **No** in the **Notification field.**

TO ENTER AN MD:

This typically applies to SUD plans where services are physician directed, such as Medicated Assisted Treatment.

1. Double-click in the **Role field** to activate the field. Click **MD** in the pop-up window.
2. In the **Staff ID** field type in the last name of the MD and then double-click on the name.
3. Enter **No** in the **Plan Author field.**
4. Enter **No** in the **Notification field.**

TO ADD YOUR PIC:

1. **Click New Row.**
2. Double-click in the **Role** field to activate the field. Click Client in the pop-up window.
3. Skip the **Staff ID field.** (There won't be a staff ID because this is not a staff person.)
4. In the **Participant Name field,** type the name of the PIC.

5. Enter **No** in the **Plan Author field.**
6. Enter **No** in the **Notification field.**

TO ADD A PARENT, GUARDIAN, CONSERVATOR OR OTHER PARTICIPANT:

1. **Click New Row.**
2. Double-click in the **Role** field to activate the field. Click **PARENT/GUARDIAN, CONSERVATOR OR OTHER** in the pop-up window. Use **OTHER** for anyone who does not fit in the PARENT/GUARDIAN or CONSERVATOR category.
3. Skip the **Staff ID field.**
4. In the **Participant Name field,** type the name of the participant, and their role. Type in the name AND a word or short phrase to explain who this person is if this is not clear from the role type. Examples: "Janet Williams, Social Worker" - OR – "Lisa McDougall, LPS conservator."

Make sure you add the correct role for these participants, and any needed descriptive information in the Participant Name field. YOU may know that the Jennifer Gonzalez is the mother, but other people may not. If it is not clear who these people are, then we don't know if the plan is valid.

5. Enter **No** in the **Plan Author field.**
6. Enter **No** in the **Notification field.**

Continue adding participants to the plan. It is appropriate to add parents, foster parents and legal guardians. Add anyone who is going to sign the plan. Plan participants are anyone who holds the privilege for the PIC as well as anyone who is actively working with the PIC on progress toward the PIC's goals and objectives. Examples are: parent, guardian, conservator.

Plan Participants are anyone that signs the plan. Don't add anyone that doesn't need to sign the plan.

If you want to discuss other supports, such as a day program, school staff, sponsor, etc...(people who don't sign the plan) add this information about the PIC's support system in the question, **"Additional Comments About Client's Support System."**

Signature Field: If you have an electronic signature pad available, once you have added all of your goals, objectives and interventions, you will click "Sign" to activate the signature pad for your PIC and/or guardian to sign. Once people sign on the signature pad, Avatar will import the signature(s) into the document. However, don't obtain the signature(s) until you have completed the plan.
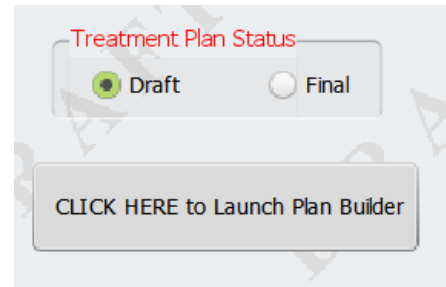
IF YOU DO NOT HAVE A SIGNATURE PAD: If you are using a laptop, your PIC may sign using the scratch pad on the laptop.

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IF A SIGNATURE PAD IS NOT AVAILABLE OR YOU CANNOT USE A COMPUTER (E.G. jail, hospital): Once you have completed a draft of the plan, print out a copy of the plan, have the PIC/guardian and LPHA (if needed) sign the printed copy. The plan can then be scanned into the PIC's chart. See the next section for more information about workflows with printed treatment plans.

Continue filling in fields in the plan:

1. Add **Additional Comments About Client's Support System** as needed.
2. **Complete the remaining questions on the Plan Page.**
   a. **SC EPISODIC TREATMENT PLANS** and **SHORT TERM TREATMENT PLANS:** Add information about the Client's **Strengths** and **Challenges** in the appropriate fields. You will not be able to move on to the second page of the Treatment Plan unless you fill in these fields.
   b. **SHORT TERM TREATMENT PLANS:** Complete the **DISCHARGE PLANNING section**, answering the two questions contained therein.
   c. **SUD PLANS** Skip the Discharge section for now: Add information about the PIC's **Strengths**, **Needs, Abilities and Preferences.** You will not be able to move on to the second page of the Treatment Plan unless you fill in the Strengths, Needs and Preferences fields.
3. In the **Treatment Plan Status field**, select **Draft** status radio button. Then click the **CLICK HERE to Launch Plan Builder** button. This will take you to the second page of the form, the Plan Builder Page. This is where you will add your goals, objectives and interventions.
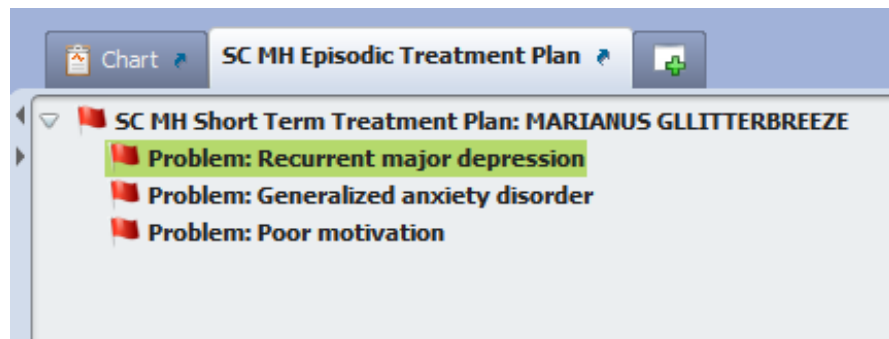
Plan Builder Page

Complete Your Problems on the Plan Builder Page

You should now see the **Treatment Plan Builder** portion of the form with your problems from the Problems Table on the first page displayed.

TIP: If you don't see your problem, it's possible that you forgot to check it off in the problems table.

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Click "Back into Plan Page," to return to the previous page and edit the Problems Table. The button is in the lower right-hand corner
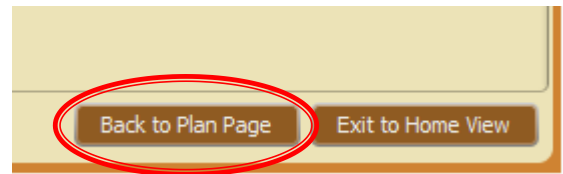
IMPORTANT: Remember, do not add problems on this page. If you decide you need another problem, go back to the first page and add your new problem into the problems table.

Red Flags: The red flags you see tell you that the item has not been completed. As you write the treatment plan goals, objectives and interventions, use the red flags to help you see items you may have missed. **All of the red flags must be gone before you can finalize and submit your treatment plan.**

STEPS to EDIT A PROBLEM

1. **Click on one of your problems to highlight it.** The problem selected will be highlighted green. You will see various questions below that must be filled out before proceeding.
2. **SUDS PLANS ONLY**: Statement of problem

   For SUDS plans only, fill in the question "Statement of problem...," with a direct statement or statements, in quotations, that describes the PIC's perception of the problem and/or need for treatment.

   Statement of Problem as Identified by Client / Declaracion del problema identificado por el cliente
   "I drink too much and I might get fired. My family's angry with me. It is making me depressed."

3. **PROBLEM:** In a field in the lower half of the page, you will see your problem written out.

   You may add to this problem to make it more specific if you like, but DO NOT ERASE THE PROBLEM. Add text to the problem as shown below.

   Your problem might start out looking like this.

   Problem / Problema
   Depression

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Do not erase it. You may edit it as shown in the example below. By adding more information to the problem, it is clearer how it is related to functional impairment and leads more naturally to the objectives and interventions you add underneath the problem.

Problem / Problema

Depression: functional deficits related to depression include impaired social functioning, social isolation, poor motivation, poor task orientation

Another example:

Initial problem

Problem / Problema

Alcohol use disorder, severe|

Edited problem:

Problem / Problema

Alcohol use disorder, severe, including increased tolerance for alcohol; episodes of drinking alcohol to intoxication at least four times per week; blackouts; conflict with family members related to alcohol use; alcohol use is interfering with work; alcohol use is contributing to depressed mood.|

4. **SUDS PLANS ONLY**: ASAM Dimension and ASAM Severity Score
   a. ASAM Dimension: Enter the ASAM dimension from the ASAM form for this PIC. This is the ASAM dimension that informs the problem you are using. The ASAM is completed as part of the PIC's intake assessment and should be completed before the Treatment Plan.
   b. ASAM Severity Score: Enter the severity score from the PIC's ASAM that is applicable to the problem.

5. **Entry Date:** This field will automatically populate to today's date.
6. **Staff Responsible:** You should see your name automatically added to this field.

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Click and drag on these little dots to make the top and bottom sections of the page larger or smaller.

Click here to return to plan page (first page.)

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1. **Click on the problem you want to add a goal to, so it is highlighted in green.** Clicking and highlighting the problem lets Avatar know which problem you want to add a goal to.

SC SUD Treatment Plan / Plan de Tratamiento de Uso de S
Problems / Problemas: Alcohol use disorder, severe
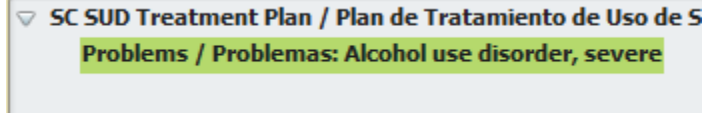
2. **Click Add New Goal** and a blank goal will pop up underneath the problem for you to write in.

Add New Problem   Add New Goal   Add New Objective   Add New Intervention   Delete Selected Item
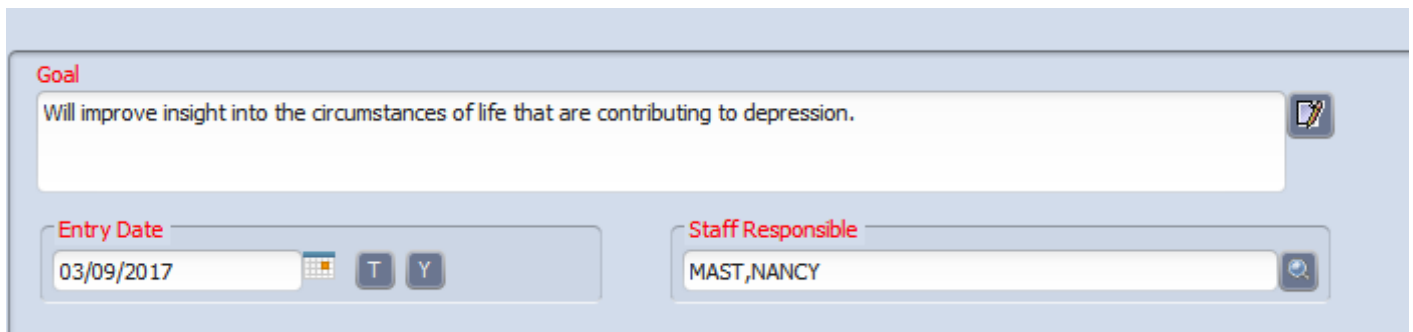
Before you add a new item, IT IS VERY IMPORTANT TO CLICK ON THE PROBLEM, GOAL, OR OBJECTIVE ABOVE WHERE YOU WANT THE NEXT ITEM TO BE, SO THEY ARE CONNECTED TO EACH OTHER CORRECTLY.

3. Enter the text of the goal in the field titled **Goal.**

   Entry Date: This field will automatically populate to today's date.

   Staff Responsible: You should see your name automatically added to this field.

Goal
Will improve insight into the circumstances of life that are contributing to depression.

Entry Date
03/09/2017   T Y

Staff Responsible
MAST,NANCY

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Add and Edit Your Objectives on the Plan Builder Page

You will now add a new objective to a goal. You must have at least one goal before you can add an objective.

1. Click on a goal to highlight it. Click the text of your goal at the top of the page. The text of the goal should now be highlighted in green. Do this before you add your new objective so that it will be connected to the goal.
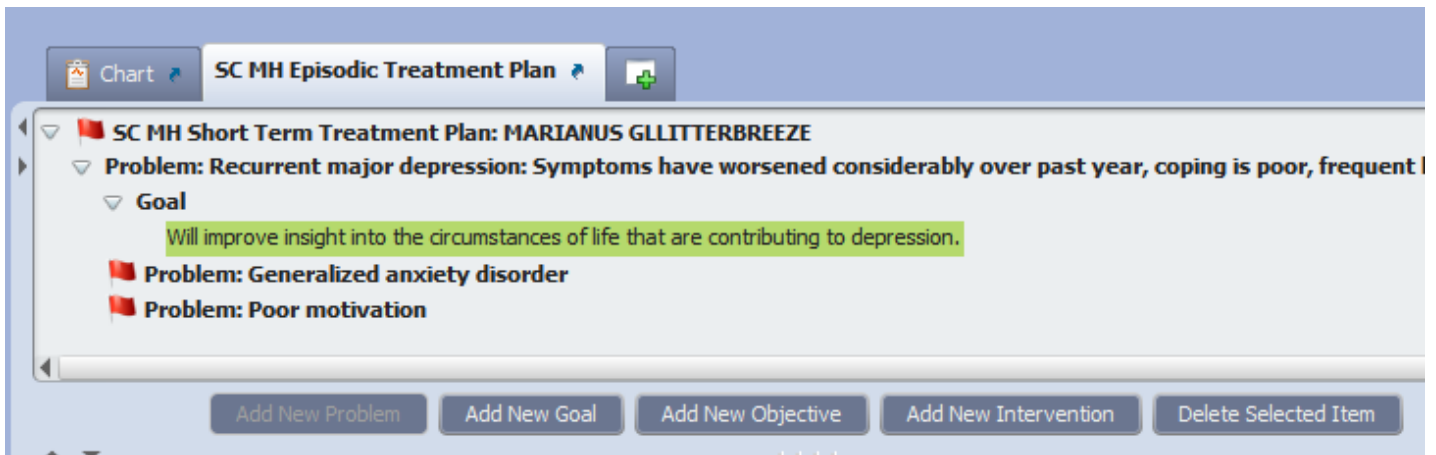
2. Click the **Add New Objective** button to open a blank objective. Notice how the new objective is underneath your goal and is indented. This tells you your objective is connected to the goal

above it.

3. Fill in the text field for your objective, including the baseline for the behavior you want to help the PIC change. The baseline serves as a guide to whether or not the PIC is making progress with the objective.

4. **Entry Date:** This field will automatically populate to today's date.

5. **Staff Responsible:** You should see your name automatically added to this field.

6. **SUDS PLANS ONLY**: Enter the Target Date, which is typically the expiration date for your plan.

Add and Edit Your Interventions on the Plan Builder Page

You will now add a new intervention to an objective. You must have at least one objective before you can add an intervention.

1. Click on an objective to highlight it. Click the text of your objective at the top of the page. The text of the objective should now be highlighted in green. Do this before you add your new intervention so that it will be connected to the objective.

2. Click the **Add New Intervention** button to open a blank intervention. Notice how the new intervention is underneath your objective and is indented. This tells you your intervention is connected to the objective above it.
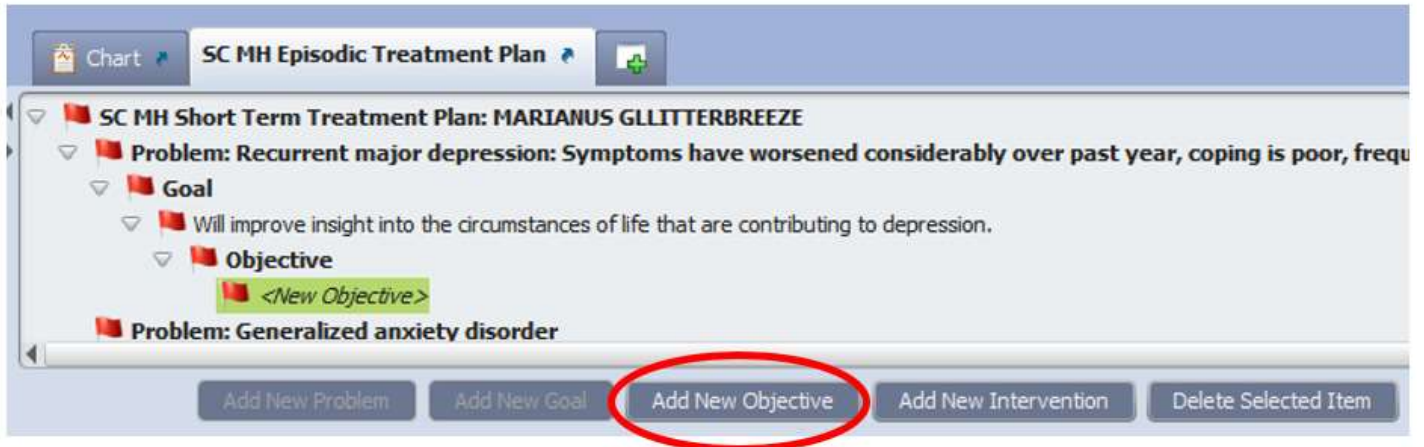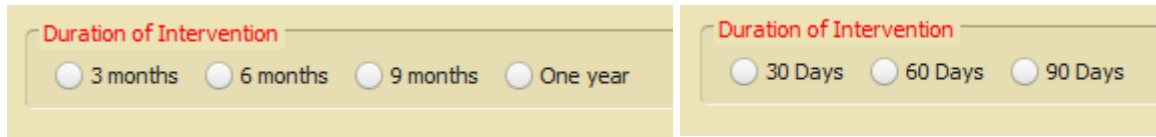
3. Fill in the text field for your intervention. Make sure you include the type of service you will provide (e.g. Case management) and frequency for the intervention (e.g. 1x/week).

4. **Entry Date:** This field will automatically populate to today's date.

5. **Staff Responsible:** You should see your name automatically added to this field.

6. **SUDS PLANS ONLY**:

    a. Enter the Target Date, which is typically the expiration date for your plan.
    b. If the plan is for MAT services, enter the Current Medication Assisted Treatment Dose. Otherwise leave blank.

7. **SC MH SHORT TERM TREATMENT PLAN:** Click the corresponding radio button for the duration of the intervention. Typically, the duration will correspond to the length of the treatment plan.

Duration of Intervention: ○ 3 months ○ 6 months ○ 9 months ○ One year

Duration of Intervention: ○ 30 Days ○ 60 Days ○ 90 Days

Once you have added your goals, objectives and interventions, return to the Plan Page (the first page)

1. Click **Back to Plan Page** once you are done writing your goals, objectives and interventions. Remember, all of the red flags should disappear if you have filled in all the required fields.

   Note that you will not be able to finalize your plan if you have left any required fields blank on this page.

2. **SC SUD TREATMENT PLANS ONLY:** If you are not an LPHA, you will need to sign the treatment plan using the signature pad. When you sign, you will also need to add the date. For more information on how to sign using the signature pad, see the next section.

3. Click Submit to save and close your draft plan.
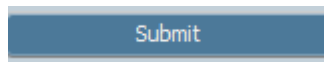
4. Depending on your workflow, before you get signatures, you may want to have your supervisor review the plan. If you need to make edits, you want to do this before the plan is signed by the PIC/guardian. Changing a plan after the PIC/guardian signs is fraud.

5. When you are ready, with the PIC and/or parent/guardian present, reopen the plan and obtain signatures as described below.

Use the Electronic Signature Pad to Obtain Signatures

When the PIC, parent, guardian, etc...are present, reopen the draft plan and use the electronic signature pad to obtain signatures.

You might also need to sign using the signature pad. See information for the specific plans below.

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Some programs require dates for signatures. If a date is needed, simply write the date after the signature on the signature pad. In the chart, a signature with the date looks like the picture at right.

For all plans, the PIC/guardian signature is required. Without this signature, the plan is not valid. Below is information and requirements about signatures for various programs.

Signature Requirements for Treatment Plans

SC MH SHORT TERM TREATMENT PLANS

Staff Signatures:

- You do not have to sign the plan in the Plan Participants table, because when you finalize and submit the plan, you sign it then.
- If you are not an LPHA, you will route the plan to this person who will co-sign. There is no need for the LPHA to sign using the Plan Participants table either.

PIC/Guardian Signatures:

- PIC/guardian signature is required, but the signature does not have to be dated. You may do so if desired however.

SC SUD TREATMENT PLANS

Staff Signatures:

- If you are not an LPHA, **sign and date** the plan using the signature pad, then route the document to the LPHA.
- If you are an LPHA, you sign and date the plan when you finalize and submit the plan, so you do not have to sign using signature pad.
- Note that if you require an MD signature on the plan, the MD is also an LPHA. If this is the case in your program, talk to your supervisor about whether or not you should also route to them, as well as the MD.

PIC Signatures:

- PIC signature is a required in the Plan Participants table, and it **must be dated**.

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1. First, make sure that you have a signature pad and that it is plugged into your computer.

2. Reopen the draft plan.

3. Go to the Plan Participants Table.

4. Hand the signature pad to the person you want to sign. (Or just pick up the pad if you are going to sign it.)

5. Click the word, "Sign," at the end of the row in the Plan Participants table. This will launch the signature window.

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6. After obtaining the signarure, Click "OK" to add the signature to the plan.

Once the signature has been captured, you will see a check mark in the row with the name of the person who signed.

In the chart, and in printed copies of the plan, you will now be able to see the signature

You may add a date the signature. Some programs require dates on various signatures. See the section "Signature Requirements for Treatment Plans" above for more information.

IMPORTANT: We have found that when adding multiple signatures, make sure to click on the correct line. If you click "Sign" on a line where there is already a signature, that signature will be erased.

7. Once all needed signatures have been obtained, offer a copy of the plan to the PIC/guardian.

8. In the question, "Date client was offered a copy of the treatment plan field," enter the date of signature. See the end of this section for printing instructions. (Leave blank if you are going to take a printed copy of the plan to your PIC for signature. You will fill in this question later.)

IMPORTANT: You must offer the PIC a copy of the plan and enter a date in this blank. This is a Medi-Cal requirement.

Date client was offered a copy of the treatment plan

03/09/2017 | Today | Yesterday

9. **If the PIC/guardian does not sign the treatment plan at all**, enter the reason why in the next field labeled, "If Client has not signed the treatment plan, please explain." (e.g. PIC is too symptomatic or cannot be located.)

If client has not signed the treatment plan, please explain

> Client was not able to sign due to psychiatric symptoms that interfere with ability to sign this document. Will continue to work with client to obtain signature.

If the PIC/guardian has signed a printed, paper copy, enter, "PIC signed a printed copy of the plan. See scanned plan for signature."

If client has not signed the treatment plan, please explain

> Client signed a printed copy of the plan. See scanned plan for signature.

==You MUST explain why, if the PIC does not, or cannot, sign.== Example: "PIC was not able to sign due to psychiatric symptoms that interfere with ability to sign this document. Will continue to work with PIC to obtain signature." If your PIC refuses to sign or you cannot locate the PIC/guardian for signature, you must document ongoing attempts to obtain the signature in your progress notes.
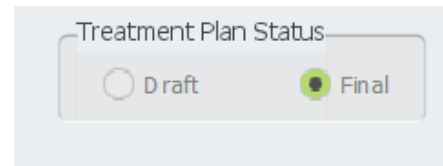
10. If the signature is delayed, don't leave the plan in draft for too long. After a period of time, if you still haven't gotten the signature, go ahead and finalize the plan. You can create another copy if you have another opportunity to get the signature(s).

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SC SUD TREATMENT PLANS and **SC MH SHORT TERM TREATMENT PLANS** ONLY:

1. In the **Treatment Plan Status** field, select the **Final** radio button. Do this after you get the signature(s).

2. Select the **Submit** button in the Navigation panel on the left to save and close your treatment plan.

   As with other Avatar forms, like Progress Notes, if you select Final, a picture of the Treatment Plan will be launched for you to proofread. After proofreading, you have three options: Accept, Reject or Accept and Route. You may route to a supervisor and other approvers.

   If you are not an LPHA, you will need to route your document to your supervisor for co-signature.

Don't forget to write your plan development progress note. Your last step is to write a progress note to document your service. You want to get credit for the work you have done!

Printing a Copy of Your Treatment Plan
1. Open the PIC's chart.
2. Click on **SC MH Episodic Treatment Plan** to open the Treatment Plan Chart View.
3. **To Shrink or Enlarge Text in the Chart View,** at bottom right in the Chart View, you will see a button that you can slide left and right to increase and decrease the size of the font in the Chart View. This handy button is also on many forms.

4. Click **Print** at upper right.

Click "Edit" to return to editing the plan.

Add   Print All

Edit   Print   Report

DO NOT CLICK "Report." This report does not contain all required fields and elements.

Click "Print" to print the inquiry view of the report. This printout will look just like the view of the treatment plan in the chart.
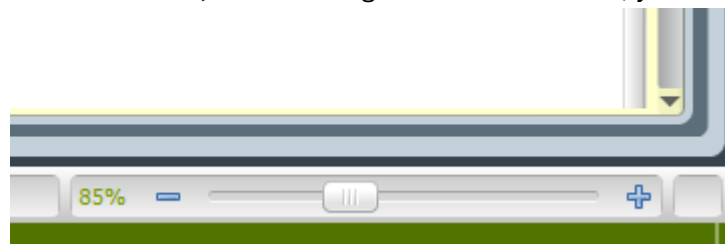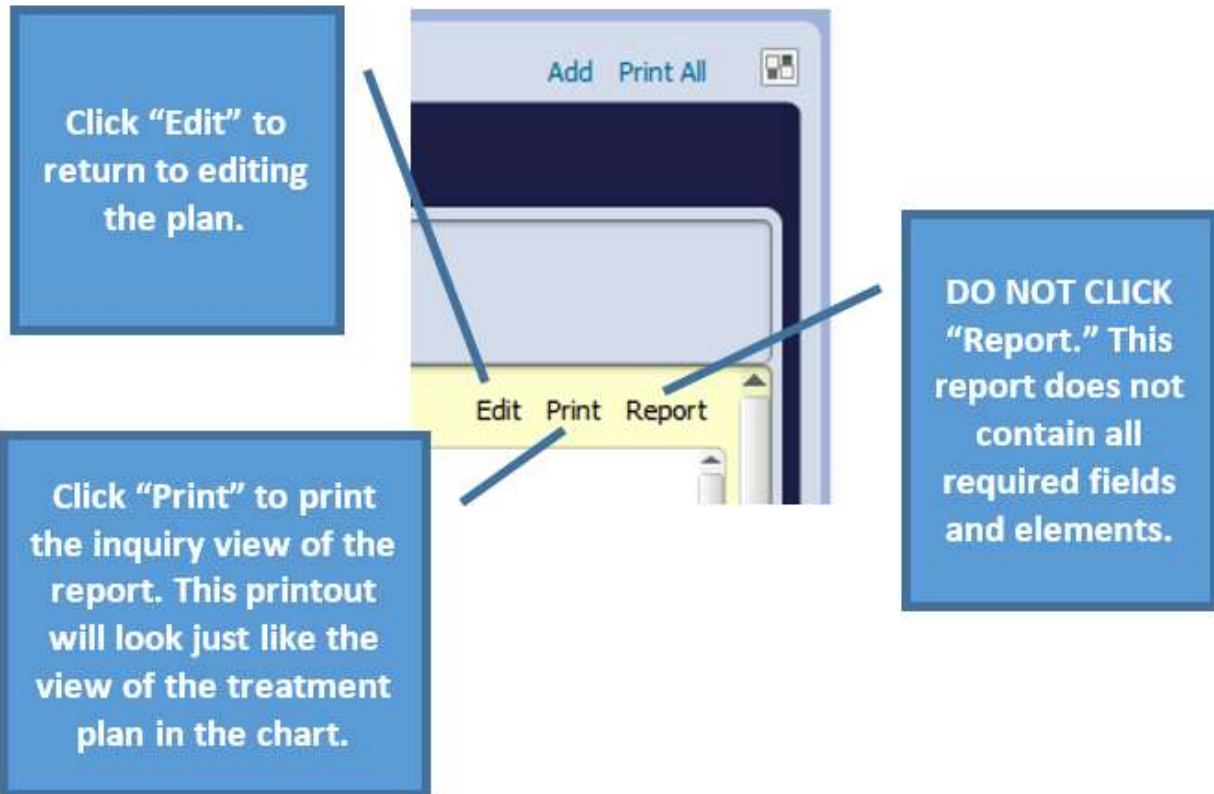
Printed Treatment Plan Workflows (what to do if you don't have a signature pad/computer)

This workflow applies if you do not have a signature pad available. It might be that the PIC cannot come into the office and you don't have a laptop with signature capture, or you simply do not have a computer at your location (for example, jail).

STEPS:

1. Complete your treatment plan, leaving it in draft.

   Leave the question, "Date PIC was offered a copy of the treatment plan," blank. You do not enter anything here until after capturing signature(s).

   SAVE THE PLAN AS A DRAFT. DO NOT FINALIZE.

2. Print out a copy of the plan, using the directions in the previous section.
3. Meet with PIC, guardian, etc.. to obtain the signatures. Sign the plan if required. Have your LPHA sign the plan if needed.

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4. The plan is scanned into the chart. County staff should turn in the plan in to the chart room for scanning. You do not need to scan the plan yourself. Contractor staff should consult with a supervisor to find out about scanning procedures.

<mark>YOU ARE NOT DONE AT THIS POINT, YOUR HAVE A FEW MORE STEPS.</mark>

5. Reopen the Draft Treatment Plan in Avatar.
6. In the question, **"Date Client was offered a copy of the treatment plan,"** enter the date the PIC signed.

Date client was offered a copy of the treatment plan

03/09/2017   Today   Yesterday

7. In the blank where it says, "If Client has not signed the treatment plan, please explain," explain that the PIC signed a paper plan that was then scanned in.

Important: Do not leave this question blank. You want to make it easy for people to find the signature. Without a signature, your plan is not valid and your services are not covered.

If client has not signed the treatment plan, please explain:

Client signed copy of paper plan. See scanned plan in chart.

8. Finalizing the Plan

In the **Treatment Plan Status** field, select the **Final** and then **Submit** the plan.

If you are not an LPHA, you will need to route your document to your supervisor for co-signature.

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To View Your Scanned Treatment Plan

Links to scanned documents are located in a chart section called "Documents."

Look for the link that says, "CLN – Treatment Plan," and click to open. (If you do not see this link, or the documents section at all, you will know that there are no scanned treatment plans in the chart.)

Plans are filed by episode. Click on the tab for your Admission Program to find the scanned plans for your program.
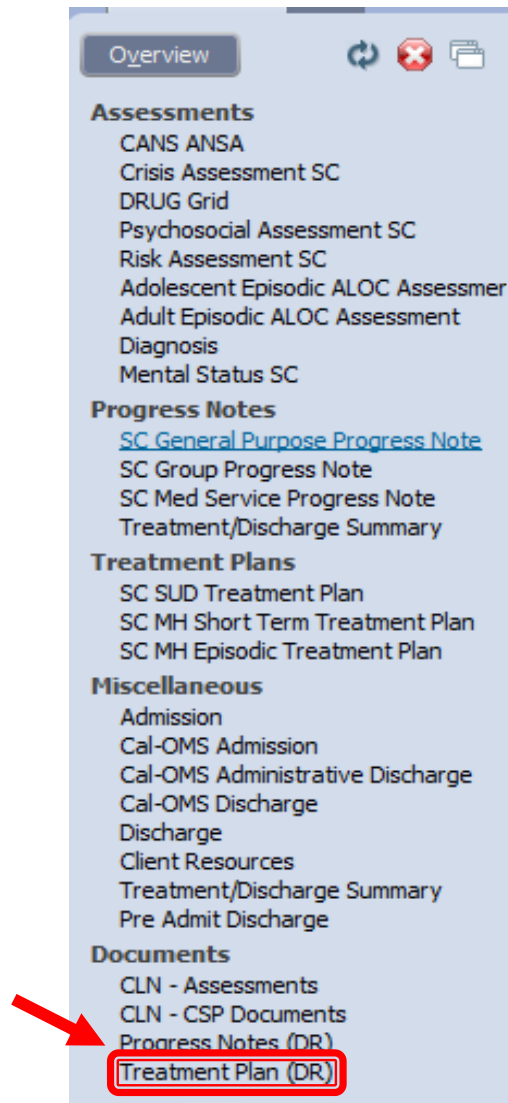
Santa Cruz County Behavior Health Avatar

Creating a Treatment Plan Update

START DATES FOR TREATMENT PLAN UPDATES

SC MH Short Term Treatment Plan	• After the Initial Treatment Plan, subsequent plans start one day after the end date of the previous plan. • TIP: If you forget what the expiration date from the last plan is, click back to the chart overview and look at the episode tab to find the admission date.
SC SUD Treatment Plan	• After the Initial Treatment Plan, subsequent plans start one day after the end date of the previous plan. • TIP: If you forget what end date from the last plan is, click back to the chart overview and look at the episode tab to find the admission date.

About Defaulting to Update Your Treatment Plan

When you create an update, you are adding to a plan that already exists. If other providers have already started the plan, you want to preserve the problems, goals, objectives and interventions that they have added. You have seen how treatment plan elements are added to progress notes. If you do not bring all current items into your plan, these items won't be available to add to progress notes.

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When you do an update, because the current plan is finalized, you cannot open it up to edit it. Instead, you use DEFAULTING. When you default from the prior plan, you essentially make a copy of that plan. This copy will be in draft, and you can add your own items to it. Once you are done with this update, you get signatures and finalize the plan.

If you neglect to bring forward treatment plan items by others, you run the risk of your plan being deleted.

STEPS to Create a Treatment Plan Update

1. **Open the PIC's chart** if you have not already done so.

2. **Click the treatment plan form you want,** in the list of forms on the left in the Chart Overview.

3. Click on your episode tab. You should now see an **Chart View** of the PIC's Treatment Plan(s) for your episode. Make sure you click the right program. If you pick wrong, you will have to rewrite your plan and then have the one under the wrong program.

YOU DON'T HAVE TO WAIT UNTIL YOUR PLAN IS ABOUT TO EXPIRE TO DO AN UPDATE.

You can update the plan whenever when you want to add new services or change the plan.

Example: PIC already has a case manager at your agency who has been working with the PIC for six months. You are starting therapy with the PIC.

Example: Your PIC, who has a history of outbursts, has improved significantly and no longer has these episodes. You want to remove goals relating to outbursts and add something that is more relevant to the PIC's current status.

BEFORE STARTING YOUR TREATMENT PLAN UPDATE

Before starting your update, look at the chart to see what plans, if any, are already there in your episode. This is a good opportunity to see if there is anything problematic that needs to be fixed. Treatment plans can be complex and there are sometimes errors. You don't want to add to the wrong plan or add to a plan that has been created incorrectly. If you have questions, contact the QI help desk at askQI@santacruzcounty.us or call 454-4468.

4. Look through the plans to see which is the most recent plan. Note if anyone besides you has added to the plan. This is the plan you are going to add to. Make a note of the name and plan date/start date.

5. **SC SUD TREATMENT PLAN ONLY** Make sure that you understand what your Start Date is going to be for your plan. You only get one chance to enter this date, and if you make an error, you will have to recreate your plan and have the one with the wrong date deleted.

6. **Once you have located the plan from which you want to default information, Click Add** in the upper right-hand corner of the chart to open a new treatment plan form.

7. **Click Yes** when you see the pop up asking if you want to, "**default plan information from a previously entered plan**."

8. **Default From Previous:** You will see a second pop up that provides a list of previous Treatment Plans for the PIC (the long bar with the plan name on it). If there is more than one plan, you want to pick the most recent plan shared plan.
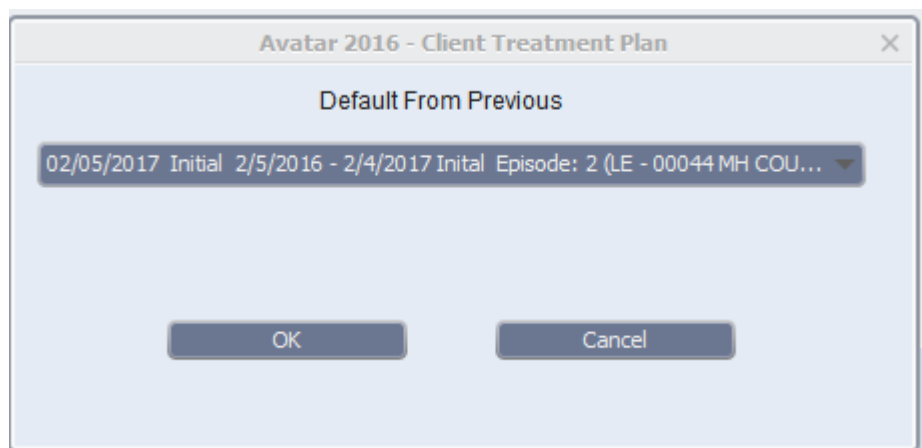
9. **SC SUD TREATMENT PLANS ONLY** **Enter Authorization Start Date:** You will see a third pop up asking you to enter the Authorization Start Date. The Authorization Start Date will be the day after the expiration date of the previous plan.

10. Once you have entered the Authorization Start Date or First Edit Date, click **OK.**
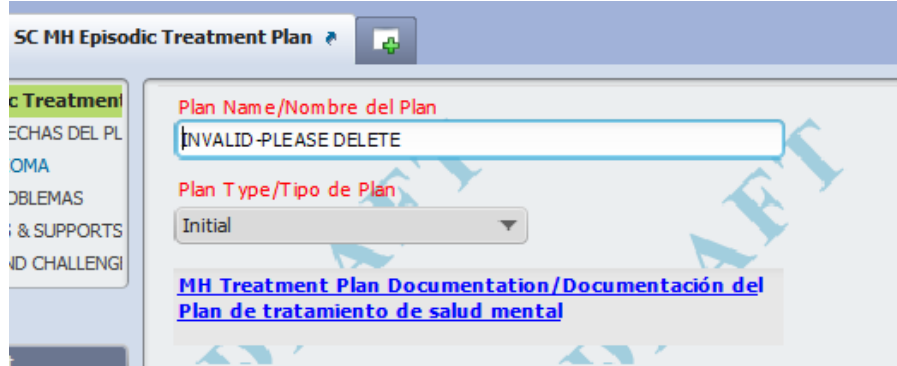
IF YOU MAKE A MISTAKE WITH YOUR START DATE

To Correct the Problem:

If the PIC has not yet signed the plan, it can be deleted. If it has been signed, it is a valid plan, and despite the date error, must be left in the chart. Regardless, you will need to recreate the plan with the correct date. Then, if applicable, submit a request for the plan with the wrong date to be deleted.

1. If you plan is still in draft, change the title to, "INVALID" or "DELETE." This helps the person who is deleting the plan find it. (We don't want to delete the wrong plan!)

2. If the plan with the wrong date is still in draft, finalize the plan. This ensures that no one in else adds any information to it, further complicating the situation.

3. **SC SUD TREATMENT PLANS ONLY:** Use the "Default" method to create a new plan that has all of your plan data in it. When you default from the plan with the wrong Authorization Start Date, you won't have to retype everything in your plan. You will just have to redo a few questions.

4. Send a message to askqi@santacruzcounty.us requesting the deletion. We need: PIC Name/Number, Plan Name, Authorization Start Date, Reason for Deletion, Episode Name/Number.

CONTINUE WITH YOUR PLAN….
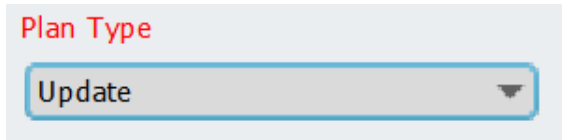
1. Once you have entered your Start/First-Edit Date, you will see a pop up asking if you are sure you want to default information from a previous plan. Click **Yes**.
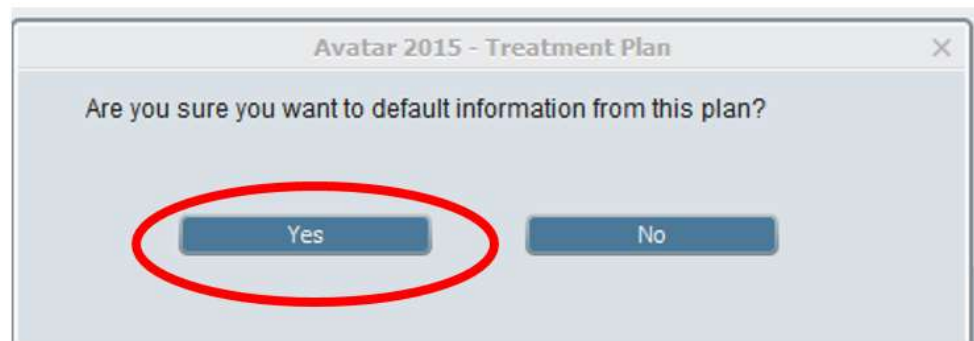
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2. Enter the **Plan Name**

3. Select Your Plan Type.

Plan Type

Update ▼

4. Check to make sure the End Date for your plan is correct. Sometimes Avatar will calculate the end date incorrectly. If this has happened, see below for how to fix this.

   Depending on your program, you may need to change the end date for the plan. To start, Avatar calculates the end dates for the **SC MH SHORT TERM TREATMENT PLAN and the SC SUD TREATMENT PLAN** as 90 and 89 days from the start date, respectively. For some programs, you may need to shorten this.
   For example, the Telos program is 30 days maximum, therefore, the end date of the plan needs to be 30 days from the start date.

   Avatar will initially calculate the end date for the Short Term Treatment Plan as the start date +89 days.

   STEPS TO CHANGE THE PLAN END DATE OR EXPIRATION DATE

   a. Erase the end date
   b. Type in the end date you want and press the tab key on your keyboard.
   c. You will get a warning that essentially says that Avatar is going to recalculate the Next Review Date, which, as you recall, is 14 days prior to the Authorization End Date.

   Avatar 2016 - Treatment Plan ✕

   The 'Next Review Date' will default to the current registry configuration value of 09/04/2018, would you like to override the existing value?

   Yes   No

   d. Click "Yes."
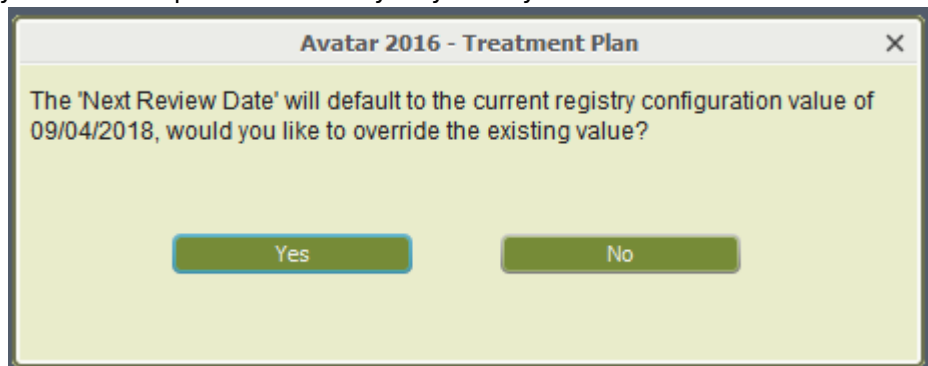
5. **Was This Treatment Plan Discussed in a Language Other Than English?** This question is pre-populated from the previous plan.
6. **Problems Section (Table):** In the Problems Section, you will see the PIC's previously entered problems/diagnoses. You may choose to leave this section as is, add a problem, or check off a problem that was previously left off of the Treatment Plan. Select or add problems according to your treatment needs. You won't be able to "uncheck" any problems because they are "in use" for the previously written goal(s), objective(s) and intervention(s).

7. **Plan Participants Section:** If needed, add your name and any additional Plan Participants. **To add yourself or other participants, click "new row."**
8. Complete the rest of the fields on the Plan Page (first page).

CONTINUE ON TO THE PLAN BUILDER PAGE:

Click **Draft** and then click the **CLICK HERE to Launch Plan Builder** button to go to the Treatment Plan Builder portion of the form. If you have added any new problems, you will see these on this page. You will also see the previous goals, objectives and interventions from the prior version of the plan.
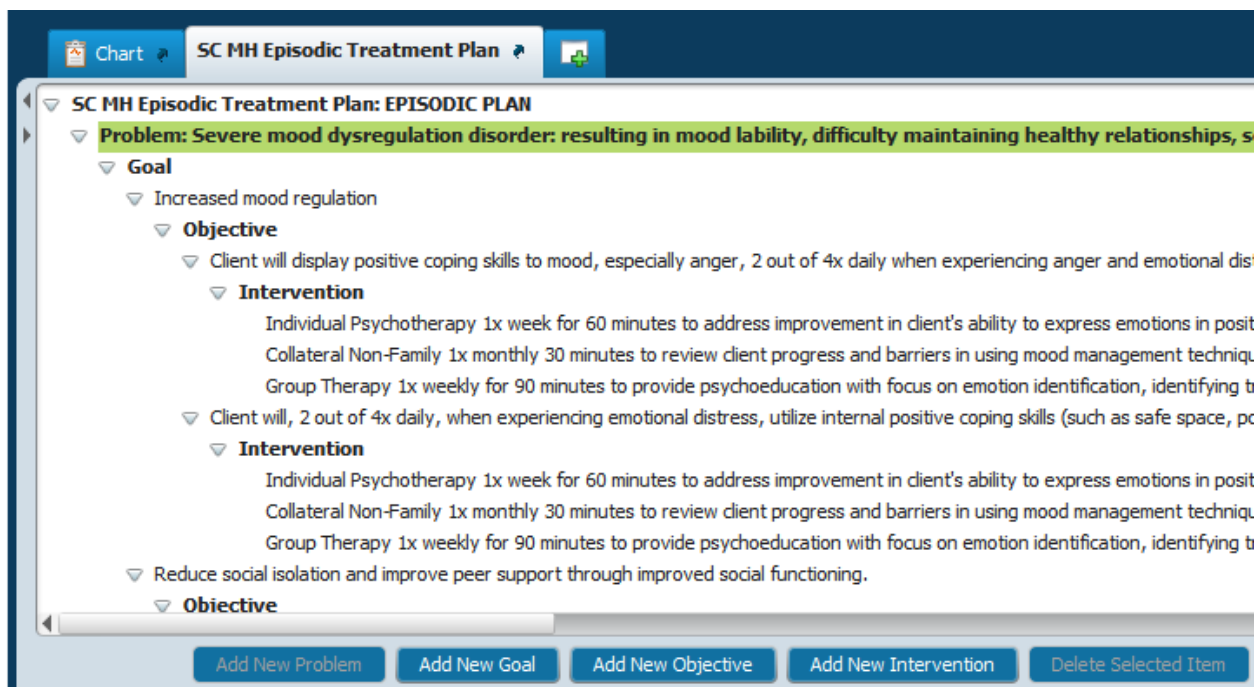
Add New Goal(s), Objective(s), and/or Intervention(s) to Your Update

IT IS VERY IMPORTANT TO CLICK ON THE PROBLEM, GOAL, OBJECTIVE <u>ASSOCIATED WITH THE ITEM YOU WANT TO ADD</u>, SO THEY ARE CONNECTED TO EACH OTHER.

In the example below, to add a new Objective to the Goal, "Increased mood regulation," click on the text of the goal so that it is highlighted in green. The goal you want to add the objective to must be highlighted like this so that the objective is connected to the goal.

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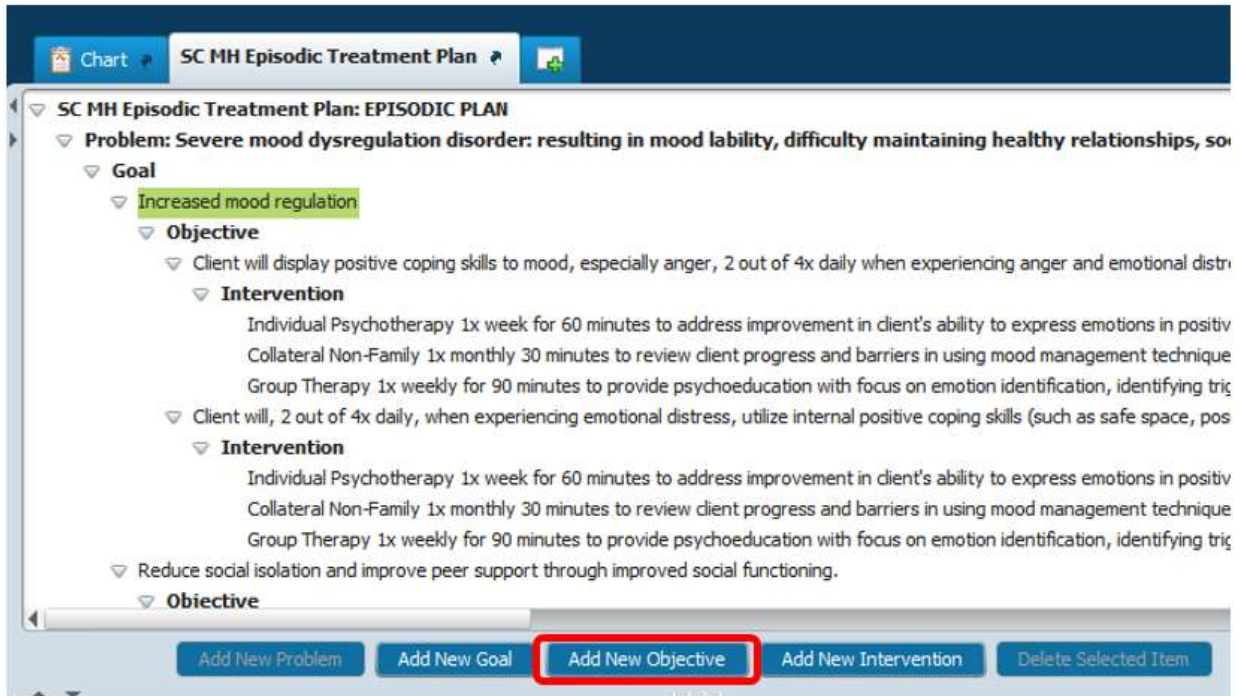
Remove and Resolve Problems, Goals, Objectives and Interventions That Are Not Needed

To Delete Goals Objectives and Interventions:
You must do this from the "bottom up." First, click on one of the interventions you no longer need. When you do this, you will notice that the button, Delete Selected Item is enabled. Click this button to delete the intervention. After you have finished deleting the interventions, delete the objectives, then the goals, then the problems.

If this is not your name, see your supervisor before deleting this item. It may still be in use by someone else!
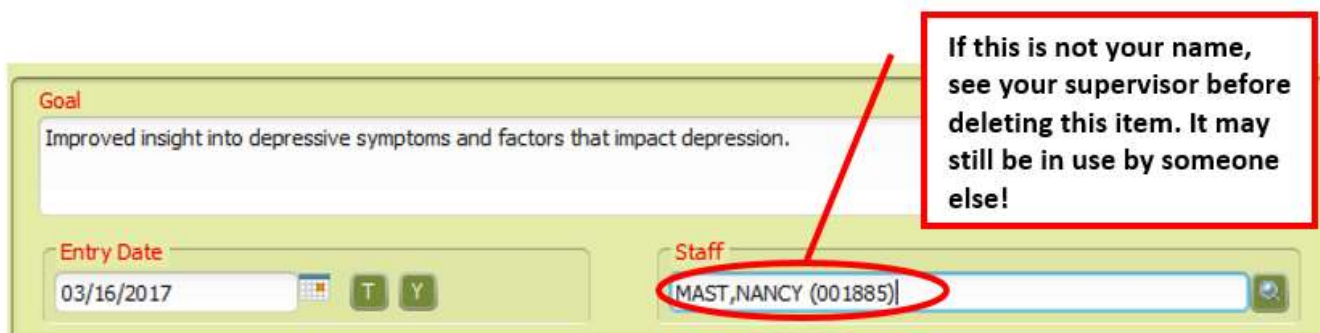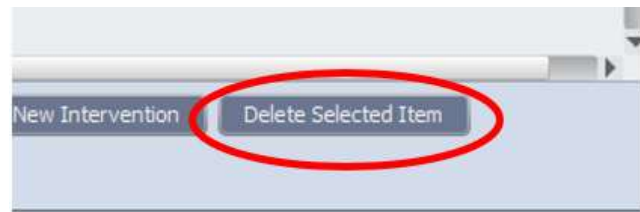
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<u>To Resolve Any Problems That Are No Longer In Use</u>

First, delete them on the Plan Builder Page. Note that even though you delete problems on the Plan Builder Page, they won't disappear from the Problems Table on the Plan Page. These problems are kept because they show a history of the PIC's treatment and previous problems that have been addressed.
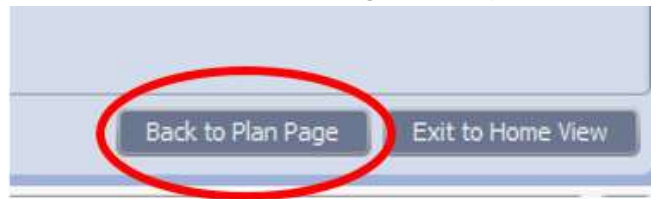
Once you are done updating on the Plan Builder Page, return to the Plan Page by clicking, "Back to Plan Page."

Resolve the problem in the Problems Table. Note that Avatar will only let you do this if there are no other goals, etc. attached to this problem. It is still "in use," you will not be up to resolve it.

In the Problems Table, in the row that has the problem you want to resolve, click in the status column and change the status to "Resolved."

Then, enter the Date Resolved.

There is column in the Problems Table where you can add any comments if needed.

	Problem	Other	Type	Date Identified	Date of Onset	Time Of Onset	Status	Severity	Chronicity	Date Resolved	Action	Comment	System Notes
1	Schizoaffective disorder (SNOMED-68890003)				01/01/...		Active (A) ...						View
2	Phobia (SNOMED-386808001)				01/01/...		Active (A) ...						View
3	Pica (SNOMED-14077003)				10/07/...		Resolv...			05/19/2017			View
4	Severe mood dysregulation disorder (SNOMED-46206005)				01/01/...		Active (A) ...						View
5	Problems with communication (SNOMED-278919001)				01/01/...		Active (A) ...						View

NEXT...

1. Obtain signatures as described in the previous sections.

2. Select Draft or Final and submit your plan. Leave in Draft until you obtain signatures. Then finalize and submit. Don't forget to answer the question, "Date PIC Was Offered a Copy of the Treatment Plan." If you used a paper printout to obtain signature (s), don't forget to fill in the question, "If Client has not signed, please explain." If Client/guardian did not sign at all, you will also need to fill in this question.

How to Correct When You Have Selected the Wrong Problem in a Treatment Plan

Unfortunately, in a Treatment Plan, you cannot change a problem after you have selected it and added goals, objectives, and interventions to it.

If you have selected the wrong problem, you will need to add the correct problem (the problem you want), create new blank goals, etc...for this problem, and then cut and paste from the existing goals, etc....

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Note that you won't be able to delete the "bad" problem if someone else has added goals, objectives or interventions to this item, but you will be able to add your goals, etc. to the problem that you want.

Steps:

1. In the Problems Table, either add the new problem that you wish to use, or, if it is already in the table, check the checkbox next to the problem.
2. Open the Plan Builder page by clicking, "CLICK HERE to Launch Plan Builder." You should now see the problem you wish to use added to the plan on the Plan Builder page.
3. Add new/blank goal(s), objective(s) and intervention(s) underneath the new problem. They should match the goals, etc. that you want to move.
4. Copy and paste the goals, etc....you wish to move from underneath the "bad" problem that you don't want, into the blank goals, etc. that you just created. (NOTE: Right clicking won't work to copy and paste. Use keyboard shortcuts instead. Use [Crtl] + C to copy. Use [Crtl] + V to paste.)
5. Once you are done copying and pasting, delete the items from underneath the "bad" problem. You must do this from the "bottom up."
   a. First, click on one of the interventions. When you do this, you will notice that the button, "Delete Selected Item" is *enabled*. Click this button to delete the intervention.
   b. After you have finished deleting the interventions, delete the objectives, then the goals in the same manner.
   c. Finally, delete the problem on the plan builder page.
6. Then, return to the Plan Page and find the "bad" problem in the problems table.
7. If the problem is a mistake and not appropriate for this PIC, change the status to "Resolved."
8. Write a note in the "Comments" column explaining what happened.
9. "Uncheck" the problem to make it stop appearing on the Plan Builder Page.

IMPORTANT: DO NOT DELETE GOALS, OBJECTIVES OR INTERVENTIONS THAT ARE BEING USED BY OTHER PEOPLE. ONLY DELETE YOUR OWN ITEMS.

If you have questions, contact askqi@santacruzcounty.us

Don't forget to write your plan development progress note. Your last step is to write a progress note to document your service. You want to get credit for the work you have done!

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SC SUD Treatment Plan – Discharge Section

The **SC SUD TREATMENT PLAN** is unique in that it has a discharge section meant to be written with the PIC just prior to the PIC completing treatment. It is designed to provide a roadmap for the PIC toward continuing their recovery journey after they leave the program.
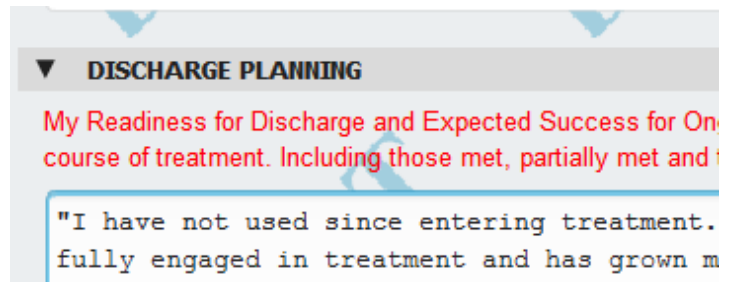
The discharge plan anticipates and describes the PIC's individual strategies to deal with triggers, their support system, and summarizes the PIC's progress as well as future prognosis.

If the PIC fails to complete the program (i.e. drops out, AWOL's) do not use the SC SUD Treatment Plan. Instead, use the Treatment/Discharge Summary form.

Only use this special DISCHARGE section in the SC SUD Treatment Plan if the PIC completes treatment.
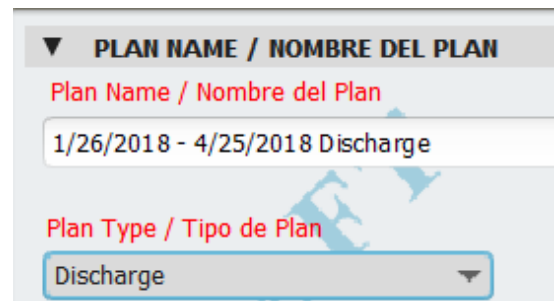
The discharge plan questions are in a separate section at the bottom of the plan page (first page) of the SC SUD Treatment Plan.

If you scroll down to the bottom of the first page of the treatment plan form, you will see a section with several questions titled, DISCHARGE PLANNING.

To activate the questions in the discharge section, at the top of the page, select "Discharge" as the Plan Type. This will activate all of the questions in the section. Otherwise, they will all be disabled or "grayed out."

DO NOT DEFAULT from the prior plan, because you do not want to carry over all of the goals,
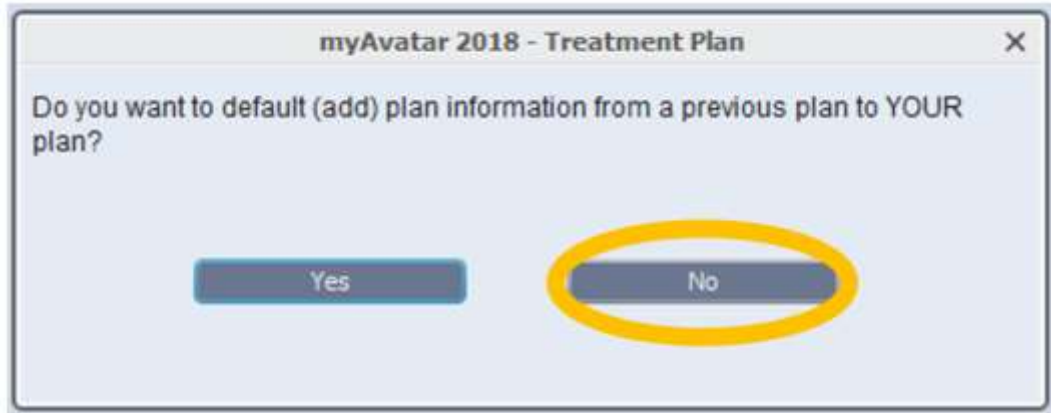
etc… from the last plan. The plan builder page (the second page with all of the goals, etc…) should remain blank when creating a discharge plan.
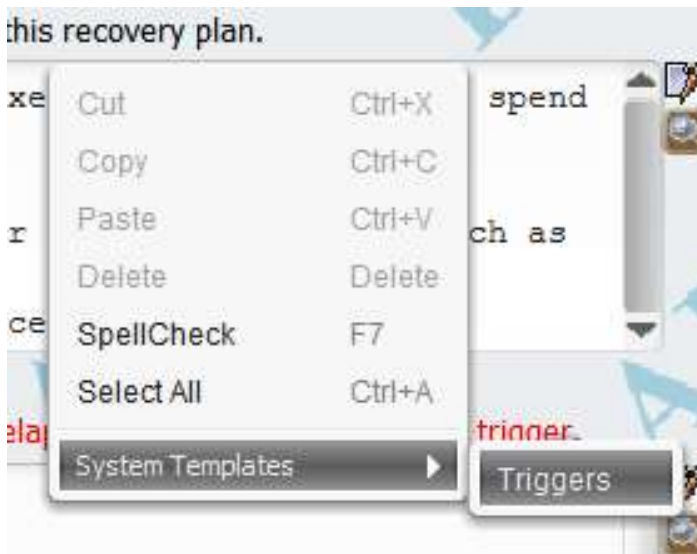
Once the Discharge Summary is completed along with other questions on the first page, have the PIC sign and then finalize as usual.

For some of the questions, you will find handy templates to help you fill in the question. In the text box for the question, right click in the blank text field and then click on "templates," in the menu that appears. Then select, the template to add it to the template to the text field. This text is fully editable. Use it to help guide you in answering the question.

For example, in the question, "My Trigger Relapse Plan…," use the template titled "Triggers," to help outline the unique triggers the PIC has identified and what coping skills the PIC has learned to apply for each trigger.

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My Trigger Relapse Plan: Describe each relapse trigger. For each trigger out

```
Trigger #:
Name/Description:
Prevention Plan to Avoid Relapse:
```

Enter the Anticipated date of Discharge, if known. If the PIC ends up discharging date, that is okay. This is simply your best estimate for the date the PIC will be discharging. The actual date of discharge may vary.

Anticipated Date of Discharge

10/04/2019   Today

Permission to contact: This treatment program has my permission to contact me during the next 12 months as a follow-up to
◉ Yes   ○ No

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Discharging

Before discharging a PIC, talk to your supervisor and members of your team to find out what specific procedures you should follow. Below is a general outline of how to discharge a PIC from Avatar.

1. **Complete a Final Note. Use either the [SC General Purpose Progress Note](#) (or Med Service Progress Note) and/or [the Treatment/Discharge Summary form.](#)**

   Mental Health Services: Complete a Progress Note <u>OR</u> complete a Treatment/Discharge Summary Form (not both) to summarize treatment, progress toward treatment plan goals, referrals and recommendations. You only have to complete one of these forms. You do not have to do both.

   If billable services are provided in the final contact with the PIC, use the SC General Purpose Progress Note to document your service and as well as create a service charge. Include the discharge date in the note. Only use a billable service code if you have an interaction with the PIC on the date of closing that meets documentation criteria for Medi-Cal Specialty MH Services.

   Substance Use Disorder (SUD) Services:
   a. Complete a Treatment/Discharge Summary.
   b. If the PIC completes the program (does not drop out). Complete:
      • A Final Progress Note,
      • A Discharge Plan,
      • And a CalOMS Discharge.
   c. If the PIC drops out, you do not have to complete a final progress note or discharge plan, just the Treatment/Discharge Summary and a CalOMS Discharge or CalOMS Administrative Discharge.

   TIP: The Treatment/Discharge Summary form is one of the few forms that you can complete after the episode is closed.

2. **Send a message to county data entry (Sylvia Vairo) to have the PIC removed from your caseload.** For more information, see the section, [“To Have a PIC Removed From Your Caseload.”](#)

3. **Check to make sure no one else is working with PIC in your program.** For Mental Health Programs, there might be a variety of clinicians in a variety of roles working with PIC such as psychiatry, case management, therapy. For Substance Use Treatment, it's going to be clearer who is working with the PIC, but still, make sure no one else needs the episode to remain open.

4. If appropriate, send a message to anyone else who is working with the PIC to notify them that you are closing services.

5. **Complete the Discharge form to close the episode. For most programs, use the "Discharge" form.** See the section, <u>"Discharge Form"</u> for more information. For **Pre Admit Programs only**, use the **"Pre Admit Discharge" form.**

6. **Before closing the program:**
   a. **Check to see if there are any outstanding draft notes.** Notes left in draft cannot be completed if the program is closed. Consult with your supervisor about what to do if there are draft notes that haven't been completed yet by someone other than yourself. The easy way to look for draft notes is in the chart, where you can use the sort/filter button that says "Draft/Final" to filter for draft notes.
   b. **If the PIC has been attending groups** remove the PIC from the Group Registration. "No shows" (M400/A400) associated with groups will prevent the episode from being closed. Any type of note or service, even if it is non-billable, will prevent closing.

7. **If this is a Mental Health PIC, review the Update Client Data form to make sure that the information is still accurate. If not, update the information.** (If the PIC returns, we will have the most recent information possible, in the chart.)

8. **DO NOT CLOSE THE Client REGISTRATION AND FINANCIAL EPISODE** - This episode stays open forever, no matter what the PIC status.

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Corrections: What To Do If You Make a Mistake

IMPORTANT: <mark>If you send confidential information, you need to **encrypt or send via Avatar Staff Messaging**.</mark>

Definitions to Help with Corrections

Episode (Admission Program) Number

For episodic forms, we need the episode (admission program) number, not just the name of the program. To find it, look at the program tab in the PIC chart where your document is, or look at the Client Episode Widget. There will be a number before the program name. This is the number we need.

Example of the Episode Number in a Program Tab a Chart

Example of the Episode Number in the Episode Widget

Client Number

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This is the PIC's Medical Record Number. **FRANK TTTESTONE (000960000)**

Service Date

This is the date on which you provided the service we are deleting or correcting. If you make a mistake with the date, we need the date you actually entered, the date that was a mistake. We do not need the date that you wanted it to be. This does not help us. We need this information to find the note so we can delete it.

Data Entry Date

This is the date you finalized the form. This is not the Service Date. Find this in the chart Chart View, in the separator bar at the top of each document.

> 3: LE - 00440 MH ENCOMPASS OUTPATIENT (0) 09/19/2017 - Active
> 2: LE - 00044 MH CC 06/29/2017 - Activ
>
> Sort/Filter: Note Type ▼ Data Entry Date ▼ Entry Pe
>
> Submitted 08/21/2018 at 02:12 PM by NANCY MAST MFT
>
> **General Purpose Progress Note**
> Progress Note For: Existing Service
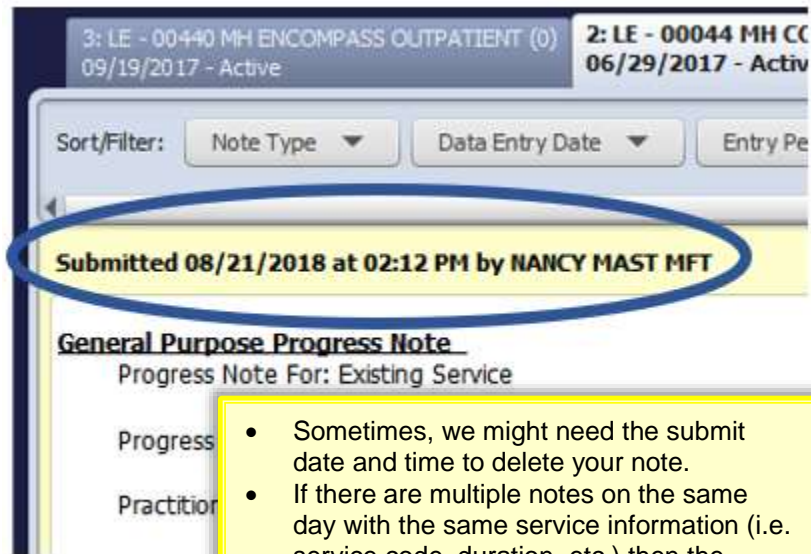
Data Entry Time

This is the time when you finalized the note or the document. We don't need this all the time, but sometimes this might be the only thing we can use to figure out which note you want us to correct or delete. If you make a mistake, and then redo the note right afterward, we usually need this information. Another example: You do multiple groups in one day with the same PICs.

- Sometimes, we might need the submit date and time to delete your note.
- If there are multiple notes on the same day with the same service information (i.e. service code, duration, etc.) then the submit date and time might be the only way we can figure out which note to delete. We don't want to delete the wrong note.
- You can find the submit date and time in the PIC's chart in the Chart View for the note.
- ADVANCED SKILLS: you can copy and paste the submit information directly from the chart.

Total Duration Time

> ▼ PRACTITIONER(S) / TIME
> Practitioner — MAST,NANCY (001885)
> Face-to-Face ---- Other Time - Total Duration (minutes)
> 30   5   35
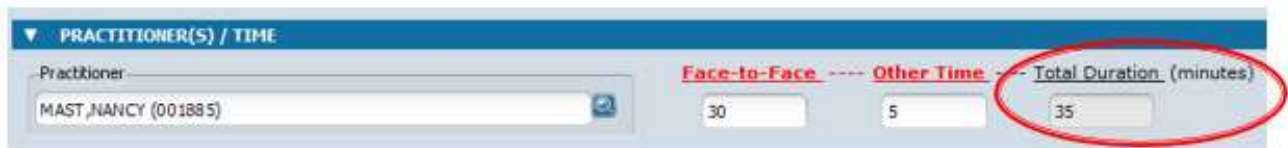
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This is the total amount of time spent. We do not need the separate Face-To-Face or Other Time. We only need the Total Duration.

Progress Note Service Edits

If you make a mistake in a progress note, we can change some data items for you.

- Service Code
- Direct Service Time
- Service Program
- Location
- Episode (Admission Program)

To change other items, ask for the progress note to be reverted to draft IF your note is an individual progress note, not a group note.

Group notes cannot be reverted to draft.

Individual Progress Note Corrections

Use the procedure below to have **SC General Purpose Progress Notes** and **SC Med Service Progress Notes** deleted or reverted to draft. Group notes act a little bit differently and there are different procedures for deleting and correcting Group Progress Note mistakes, which you can find in the next section.

Send your correction message to askqi@santacruzcounty.us

Draft progress notes cannot be deleted.
Notes pending supervisor co-signature cannot be deleted.

See the section, "How to Delete a Draft Progress Note," for more information. (See the next section on how to deal with draft **group** progress notes. They cannot be deleted this way.)

If the PIC name is wrong, we will need to delete the note and you will rewrite it. The name cannot be changed once the note has been submitted.

For other changes, the note can be reverted to draft for you to correct and re-submit. Notes reverted to draft will appear in your My To Do's.

Alternately, we can correct the information for you without reverting to draft. See the previous section that explains what we can and cannot change for you.

Use the template below to provide information about the note(s). If you are re-entering your note, and not just having it deleted, copy and paste the information from your note into a Word document. That way you can paste it back in to Avatar when you re-create your note.

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Progress Note Deletion and Revert to
Draft Template (fill out completely)
PIC name & number:
Episode number & name:
Service Date:
Data Entry Date and Time*:
Total Duration time:
Service code:
Is the episode still open (Y/N):
Clinician:
Action requested (delete, revert to draft, etc.):
Reason:
Is this a group note? (Y/N): N

*We might need the data entry date/time to distinguish your note from others in the chart. If your note is unique, then we don't need this information.

Group Progress Note Corrections

Group Progress Note Deletions

Send your correction message to askqi@santacruzcounty.us

<mark>For group note deletions we need information on the entire group, so that we can change the Group Count for the remaining notes.</mark> This is because of how Avatar calculates the time for Group Progress Notes.

Draft group progress notes cannot be deleted at all, either by the clinician, or by the help desk. If you need group notes deleted, put NA or VOID in the intervention field, and then finalize. (This helps us find the note.) Once the notes are finalized, we can delete them for you.

If the PIC name is wrong, we will need to delete the note and you will rewrite it. The name cannot be changed once the note has been started.

If the date is wrong, this cannot be changed. Either the entire group must be deleted and redone, or use the Append Documents form to explain the date error.

Use the template below to provide information about the note(s).

Copy and paste the template below into a message to askqi@santacruzcounty.us

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If you are re-entering your note(s), and not just requesting a deletion, copy and paste the information from your note into a Word document. That way you can paste it back into Avatar when you re-create your notes.

Group Progress Note Deletion Template (fill out completely)
PIC name & number:
Episode number & name:
Service Date:
Data Entry Date and time*:
Total Duration time:
Service code:
Clinician:
Action requested: Deletion
Reason:
Is this a group note? (Y/N): Y
How many people in the group?:

*We only need the data entry date and possibly the data entry time if there are multiple notes in chart with the same service information, i.e. service code and total duration.

Please include the above information for every group participant. **You must finalize the note first and then request a deletion. We cannot delete draft notes. Put NA or VOID in the intervention blanks of the notes.***We might need the data entry time if the PIC has gone to multiple groups in the same day. It may be the only way we can figure out which note to delete.

Group Progress Note Data Changes

It is not recommended that Group Progress Notes be reverted to draft for changes, unless there is no other way to make the correction.

Use the template below to indicate what change you need in your note.

Group Progress Note Correction Template (fill out completely)

PIC name & number:
Episode number & name:
Service Date:
Data Entry Date and time*:
Total Duration time:
Service code:
Clinician:
Action requested:
Reason:
Is this a group note? (Y/N): Y
How many people in the group?:

*We only need the data entry date and possibly the data entry time if there are multiple notes in chart with the same service information, i.e. service code and total duration. Y

Treatment Plan Deletions

Plans that are not valid can be deleted. If you need a treatment plan deleted, follow these instructions.

1) If the plan is still in draft, change the Plan Name so that it has the word INVALID in it somewhere. This helps the person who is deleting the plan.
2) If the plan is still in draft, finalize the plan. This ensures that no one in else adds any information to it, further complicating the situation.
3) Fill out the template below.
4) Send a message to askqi@santacruzcounty.us with the information in the template.

Treatment Plan Deletion and Revert to Draft Template (fill out completely)

Treatment Plan Form (pick one):
[ ] SC SUD Treatment Plan
[ ] SC MH Episodic Treatment Plan
[ ] SC MH Short Term Treatment Plan

PIC name & number:
Episode number & name:
Plan Type:
EXACT Plan Name:*
Authorization Start Date:
Clinician:
Action requested (revert to draft, other correction):
Reason:

*Plan name must be exact. We don't want to delete the wrong plan!

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Reverting Treatment Plans to Draft

Plans that are not yet signed by the PIC/parent/guardian can be reverted to draft. Send a message to askqi@santacruzcounty.us requesting that the plan be reverted to draft. Use the template below to provide the information we need to evaluate your request.

> Treatment Plan Deletion and Revert to Draft Template (fill out completely)
>
> Treatment Plan Form (pick one):
> [ ] SC SUD Treatment Plan
> [ ] SC MH Episodic Treatment Plan
> [ ] SC MH Short Term Treatment Plan
>
> PIC name & number:
> Episode number & name:
> Plan Type:
> EXACT Plan Name:*
> Authorization Start Date:
> Clinician:
> Action requested (revert to draft, other correction):
> Reason:
>
> *Plan name must be exact. We don't want to delete the wrong plan!

Reverting a Service Request and Disposition Log (SRDL) Back to Draft

SRDL's can be reverted to draft. Once this is done, you can change any needed details, including the PIC name. The only thing you cannot change in the draft SRDL is the Date of Request and the Program Name. Once your SRDL has been reverted to draft, you can also delete it from the pre-display. Fill out the template below and then send it in a message to askqi@santacruzcounty.us requesting it be reverted to draft.

Note that date of the SRDL and the Service Program cannot be changed. If the error is with one of these items, redo the SRDL and then request that the one with the wrong information be deleted.

> SRDL Corrections Template (fill out completely)
> Service Program:
> PIC name & number:
> Date of SRDL:
> Clinician:
> Reason:

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Other Documents, Deletion and Revert to Draft

Some other types of documents besides treatment plans and progress notes can be deleted or reverted to draft. Send a message to askqi@santacruzcounty.us requesting that the document be deleted with the reason, date, staff name/number, and episode number.

> Document Deletion/Revert to Draft Template (fill out completely)
> Form Type (e.g. Psychosocial Assessment, CANS/ANSA):
> PIC name & number:
> Episode number & name (if applicable):
> Date of form or note:
> Date and time submitted:
> Action (delete or revert to draft):
> Clinician:
> Reason:

Re-Opening Episodes

Episodes can be reopened. The most common reason is that a PIC has discharged, but there are still notes in draft that need to be completed. To have an episode re-opened, send a message to askqi@santacruzcounty.us with the information below.

> Episode Reopening Template
> PIC number:
> PIC name:
> Episode name and number:
> Reason for reopening the episode:

If you are requesting a reopening to complete notes, once you have completed your notes, use the Discharge form (or Pre-Admit Discharge form) to close the episode ASAP.

Deleting Episodes

Sometimes an episode is opened accidentally. If there is no data in the episode, it can be deleted entirely.

Before you send in your request, close the episode (using the Discharge form) so that no data gets accidentally entered into the episode. Then fill out the template below and send a message to askqi@santacruzcounty.us requesting that the episode be deleted.

Episode Deletion Template
PIC number:
PIC name:
Episode name and number:
Reason for deleting the episode:

Program Transfer

Request a program transfer to switch an episode from Sequestered to non-Sequestered.

Program Transfer Template
PIC number:
PIC name:
Episode name and number:
Change Episode name to:
Reason for deleting the episode:

If you have added a document other than a progress note to the wrong Admission Program or LE

Examples: Psychosocial assessment, UA Drug Screen. Unfortunately there is no way to move most documents from one program to another. If you have accidentally added a document to the wrong program, it will have to be deleted and rewritten under the correct program. If this has happened, do the following.

1) Save a copy of your document in Word so that you can cut and paste it back in after the document is deleted.

2) Send a message to askqi@santacruzcounty.us requesting the deletion. Include in your message:

Document Deletion Template
Document name/type:
PIC name & number:
Date:
Episode number & name:
Clinician:
Reason for Deletion:

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Scanning Errors

If a scanned document gets added to the wrong chart, it can be deleted. We need the following information to find the document and delete it.

Send a message to askqi@santacruzcounty.us requesting the deletion. Include in your message:

Scanned Document Deletion Template **(FILL OUT ACCURATELY)**
PIC name & number:
Document Category or Form Name*:
Document Description (be EXACT)**:
Document Date:
Episode:
Reason:

*e.g. CLN – Outside Records or MED – Lab Results
**This is the name the scanned document was given, e.g. 112510 Lab Result.

I have A LOT of corrections. Can I put them in a spreadsheet instead?

This is no problem as long as your spreadsheet has all the fields in the template. Also, please do not just send in a copy of information from the Service Activity Report. This does not have all of the information we need.

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I finalized a document and forgot to route it to my supervisor. Can it be routed to my supervisor?

Yes and No. ☺ If you accidentally route a document to the wrong person, we can re-route your finalized document. We can also add approvers. Unfortunately, we can only *change* the name of the supervisor. If you forgot to route the document completely, we cannot route for you. If you did not route the document to anyone, ask to have the document reverted to draft. Then you can finalize it and route it to your supervisor. Use the template below to send a message to askqi@santacruzcounty.us

Document Routing/Rerouting Template

Document Type:
Plan Type (for treatment plans):
PIC number:
PIC name:
Service Date (for progress notes):
Authorization Start Date (for treatment plans):
EXACT Plan Name (for treatment plans):
Data Entry Date and Time:
Total Duration time (for progress notes) :
Service code (for progress notes):
Episode name/number:
Clinician's name and user number:
Reason for rerouting:
Action:

- ☐ Reroute to other supervisor. (Change who this document is going to.)
  Current supervisor on document:_____
  Supervisor to replace with: _____
- ☐ Add another Approver to the list of people who will receive document: _____

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APPENDIX I: Troubleshooting for logging into UAT.

I reset your UAT password. Here is your UAT login information.

UAT LOG IN INFORMATION
System Code: UATMH   UATJN   UATEN   (System Code is ALL CAPS)
Username: Same as LIVE username   (Username is no caps)
Temp Password: Avatar123!
Avatar will ask for a new, unique password once logged in.

Link to UAT: https://santacruzuat.netsmartcloud.com//radplus/index.jsp

If you run into problems logging in, see the troubleshooting information below. If you *still* cannot log in, let me know.

1) When logging in, **make sure you are trying to log into UAT and not LIVE**. (Remember, UAT is separate from LIVE and has a different URL.) You may or may not have a link to UAT on your computer desktop. If you don't have that, use the this link.
https://santacruzuat.netsmartcloud.com//radplus/index.jsp

If you are trying to login to LIVE, you will see "LIVE" in the Server Name (see picture below). If you see this, you are trying to log in to LIVE and not UAT.
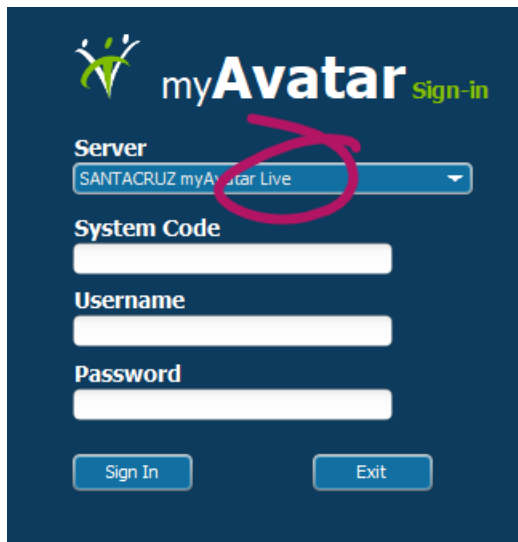
For UAT, you will see UAT in the Server Name. Also, Avatar starts the System Code entry for you. You will see UAT in the system code.

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2) **Make sure you add your "suffix" to the System Code, and that when you add it, you don't accidentally erase the "UAT."** Your system code should start with UAT, and then have whatever suffix you normally use. For example, if you normally log in LIVEMH, when logging into the LIVE system, for UAT, you will use the system code UATMH.

3) **If you need a refresher on signing in to Avatar**, see this video.

https://youtu.be/2xg-y6MtA30