

Santa Cruz Avatar

Avatar SUD Treatment Plan

Table of Contents

Creating an Initial Treatment Plan	2
SUD Treatment Plan Due Dates.....	2
START ENTERING DATA INTO YOUR PLAN	4
Plan Naming Convention	6
Treatment Plans for Monolingual Clients	8
Problems Table.....	8
STEPS for the Problems Table	9
STEPS for the Plan Participants Table	11
Plan Builder Page.....	14
Complete Your Problems on the Plan Builder Page.....	14
Add a New Goal.....	19
Add a New Objective.....	20
Add a New Intervention	21
Once you have exited the plan (clicked “Submit”) you can view your plan in the chart Inquiry View	22
Printing a Copy of Your Treatment Plan	26
Printed Treatment Plan Workflows (what to do if you don’t have a signature pad).....	27
To View Your Scanned Treatment Plan	29
Treatment Plan Updates (Defaulting Plan Data from a Prior Plan).....	30
IF YOU MAKE A MISTAKE WITH YOUR AUTHORIZATION START DATE	32
Add New Goal(s), Objective(s), and/or Intervention(s) to Your Update	35
Remove and Resolve Problems, Goals, Objectives and Interventions That Are Not Needed	36
To Delete Goals Objectives and Interventions	36
To Resolve Any Problems That Are No Longer In Use.....	36
How to Correct When You Have Selected the Wrong Problem in a Treatment Plan	37

Santa Cruz Avatar

Creating an Initial Treatment Plan

The Initial Treatment Plan is the first treatment plan in the Episode. A client will only have one Initial Plan per episode. After creating an Initial Treatment Plan, updates are created per the guidelines for your program. Some programs require quarterly updates and others require monthly updates, or even more often. If there is a need to change plan content to reflect changes in treatment, the plan can be updated at any time.

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.

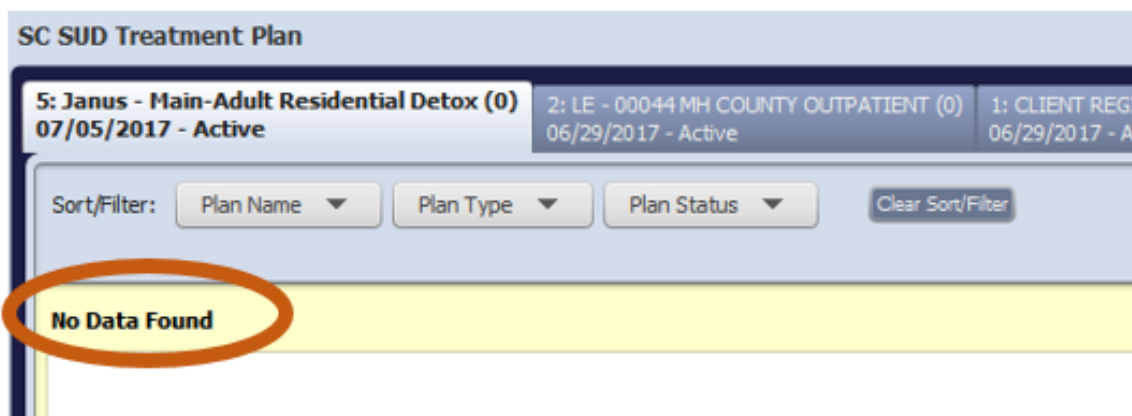
SUD Treatment Plan Due Dates

Program Level of Care (ASAM Criteria)	Initial Treatment Plan Deadline: Final signatures
Outpatient (ASAM 1.0)	Within 30 days from admission date
Intensive Outpatient (ASAM 2.1)	Within 30 days from admission date
Residential (ASAM 3.1-3.5)	Within 10 days from admission date
NTP/OTP/MAT (ASAM WM 1.0)	Within 28 days from admission date

STEPS to Create an Initial Treatment Plan:

1. **Open the client's chart.** If you have not already done so, open your client's chart. In the chart view, find a link for **SC SUD Treatment Plan**. Double-click on the link.

You always want to **open your plans from the chart** so that you can examine any existing plans. If you are doing an initial plan, make sure someone else hasn't started it.

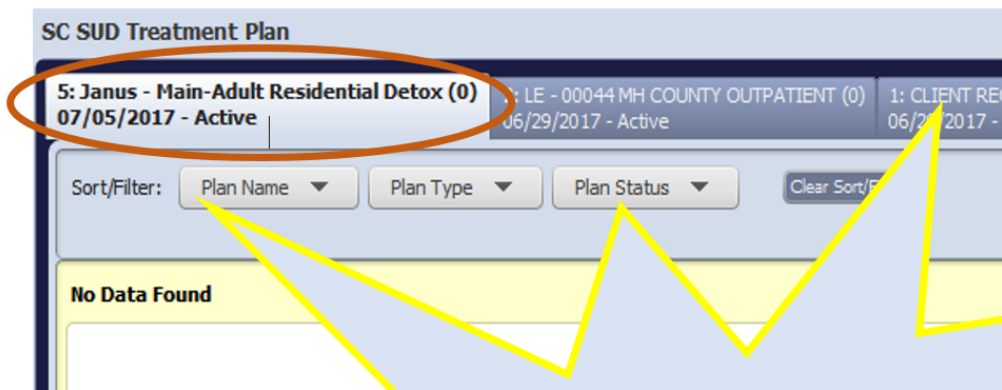
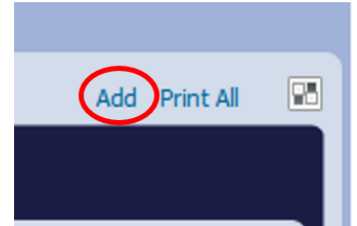


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2. **Click on the tab for your episode.** This will open up the display area or Inquiry View, for any previously written treatment plans. You should see a blank page because no treatment plan has yet been written for your client. You should see, "No Data Found," in the inquiry view.

Look at the opening date for your program. For example, if you work for Janus Residential Detox, look for the tab labeled, "Janus – Main-Adult Residential Detox," or, "Janus – Main-Adult Residential Detox SEQ." If you work for the Encompass Youth Services program, look for the tab labeled, "Encompass - Alto North-IOT (DayCare)," or, "Encompass - Alto North-IOT (DayCare) SEQ."

Click "Add." With your episode tab selected, in the far upper right hand corner of the chart view, click on **Add** to create the first treatment plan for your client. The first page of the Treatment Plan form will open.



Before clicking "Add," make sure you select the right episode tab.

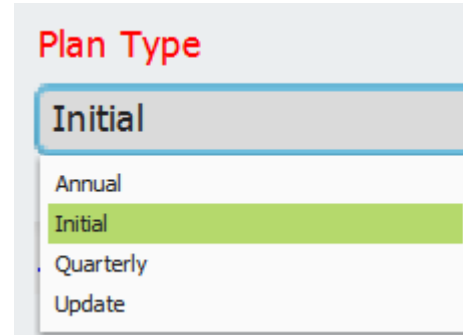
- 1) If you pick wrong, your plan will have to be deleted and you will have to redo the whole plan.
- 2) If your client is in a sequestered program, this is a breach of information that must be reported to County QI.

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START ENTERING DATA INTO YOUR PLAN

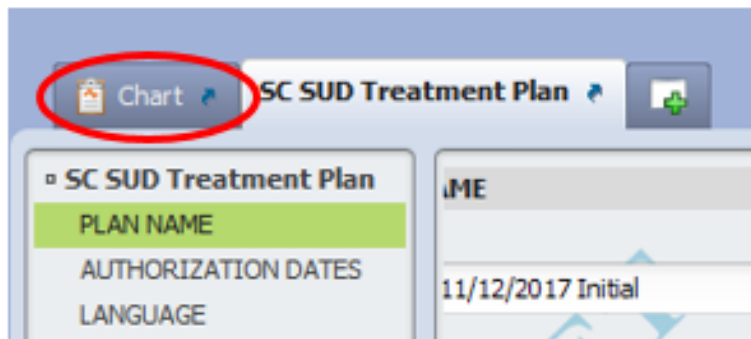
STEPS:

1. **Select the Plan Type.** In the **Plan Type** field, click the down-arrow to reveal the drop-down menu. Single-click to select **Initial**.



2. **Enter the Authorization Start Date.** In the **Authorization Start Date** field, enter the **beginning date** of the plan, which is the opening date to your episode for an Initial plan. Type in the Authorization Start Date or use the calendar icon to select a date. **Then press the Tab key.**

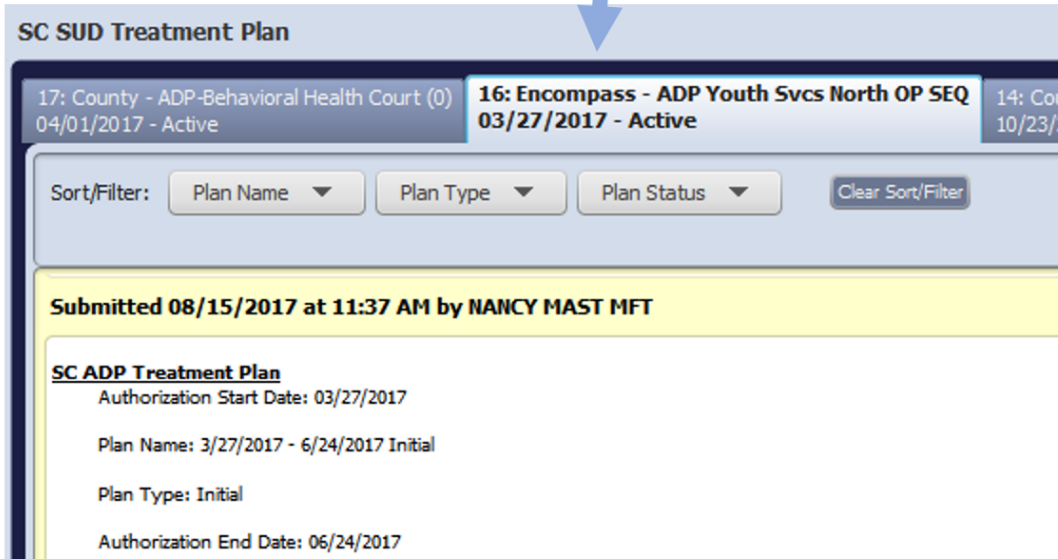
If you forget the episode opening date, you can click back into the chart at any time and look at the episode widget or chart tabs to find the opening date.



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The opening date for episode #16: Encompass – ADP Youth Svcs North OP SEQ, is 3/27/17.

That means that the Authorization Start Date for the initial plan will be 3/27/17.



Once you enter the Authorization Start Date, 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 89 days from the Authorization Start Date. The Next Review Date will be two weeks before the Authorization End Date.

▼ AUTHORIZATION DATES

Authorization Start Date 03/27/2017	Authorization End Date 06/24/2017	Next Review Date 08/25/2017
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At a minimum, updated Treatment Plans are due no later than 89 days after last Treatment Plan or when there is a change to the plan’s focus.

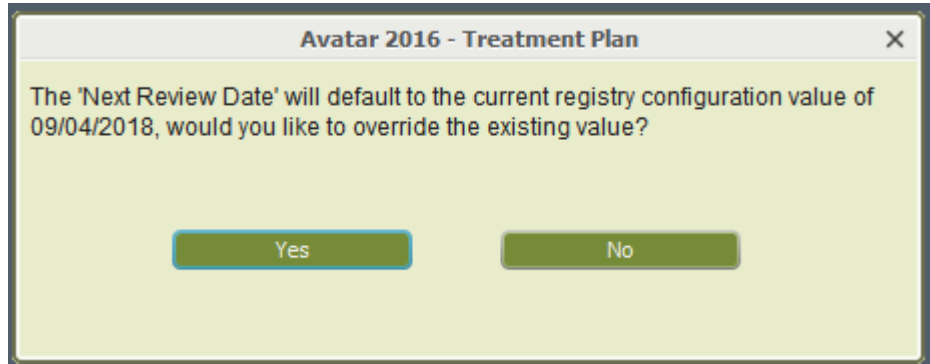
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To Change Your Authorization End Date

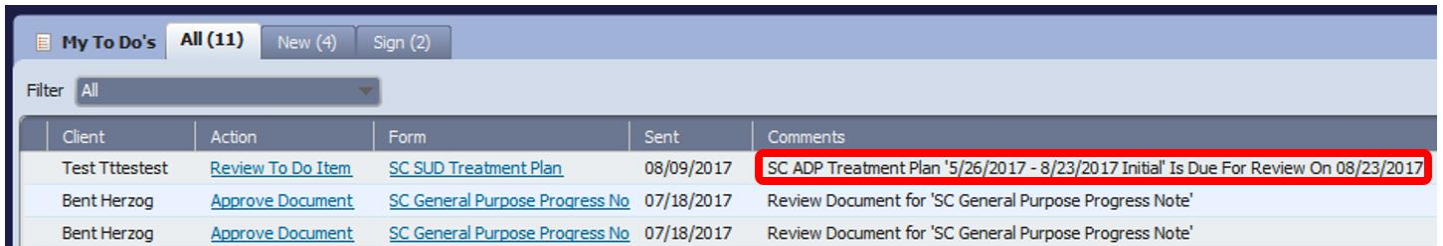
If you want your Authorization End Date to be something other than 89 days from the Authorization Start Date, erase the Authorization End Date, **type in the date you wish to use and press the Tab key**. For example, 28 days from the Authorization Start Date.

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.

Click "Yes."



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.



Client	Action	Form	Sent	Comments
Test Tttestest	Review To Do Item	SC SUD Treatment Plan	08/09/2017	SC ADP Treatment Plan '5/26/2017 - 8/23/2017 Initial' Is Due For Review On 08/23/2017
Bent Herzog	Approve Document	SC General Purpose Progress No	07/18/2017	Review Document for 'SC General Purpose Progress Note'
Bent Herzog	Approve Document	SC General Purpose Progress No	07/18/2017	Review Document for 'SC General Purpose Progress Note'

3. Enter the **Plan Name** (see below for plan naming info).

Plan Naming Convention

The first question in the plan asks for a plan name. Below are instructions on how to write this.

Plan Names indicate the authorization period for the plan (when the plan year starts and when it ends) and what type of plan it is (initial, quarterly, update).

Plan Name

3/27/2017 - 6/24/2017 Initial

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The basic convention for all plan names is below.

[Authorization Start Date] – [Authorization End Date] [Plan Type] [#]

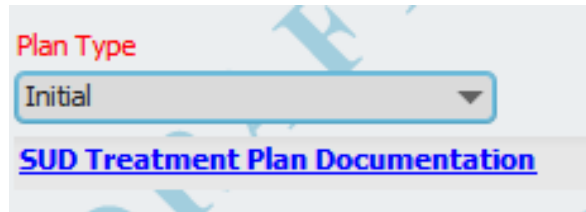
Because goals, etc... may be added at any time, it is important to give plans names that identify and differentiate them from each other.

Quarterly updates (or monthly updates, depending on the program) are labeled as such. Each time new goals are added, the plan is given a new name. Each new plan, with its new goals, interventions and/or objectives has a different name to separate it from the prior plan.

Examples of Plan Names

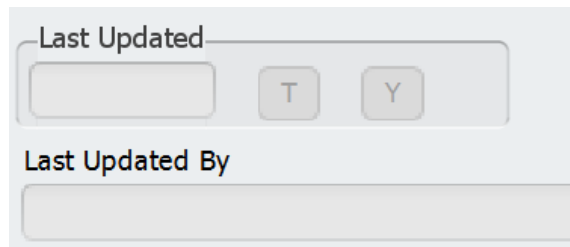
3/27/2017 – 6/24/2017 Initial
3/27/2017 – 6/24/2017 Update 1
3/27/2017 – 6/24/2017 Update 2
6/25/2017 – 9/22/2017 Quarterly 1
9/23/2017 – 12/21/2017 Quarterly 2
12/22/2017 – 3/21/2018 Quarterly 3

Note the “**SUD Treatment Plan Documentation**” link which points to helpful clinical information about filling out a Treatment Plan.



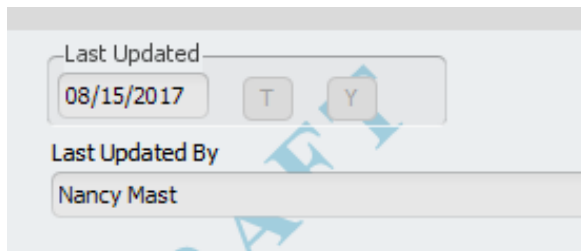
Plan Type
Initial
[SUD Treatment Plan Documentation](#)

At this point, the **Last Updated** field and the **Last Updated By** field are *disabled* and blank.



Last Updated
Last Updated By

Once you have saved the plan in draft, your name will be here and the date you updated the plan will be automatically entered.



Last Updated
08/15/2017
Last Updated By
Nancy Mast

This field will always have the name of the last person to open up the plan, until it is finalized. Then, it will have the name of the person who finalized the plan.

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4. **Answer the Language Question(s).** 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?**

Treatment Plans for Monolingual Clients

For clients 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.

Problems Table

You will add each of the client's problems as one line or row on the table.

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 (including the SC MH Episodic Treatment Plan). **You do not have to use these problems if they do not meet your SUD treatment needs.** 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.

Code	Description
14960!!64483	Alcohol dependence (SNOMED-66590003)
38359312!!64394	Alcohol dependence early remission/early partial ren
38359305!!64426	Alcohol dependence in a controlled enviornment (SNC
38359304!!64483	Alcohol dependence in controlled environment (SNO
52857199!!64483	Alcohol dependence in early full remission (SNOMED

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STEPS for the Problems Table

1. **Click the New Row button to begin entering the problem.** For each problem added, you must create a new row in the table. (If you want to use a problem that is already in the table, you do not have to add anything. Proceed to step 9 below.)
2. **Type in a problem in the column titled "Problem." Then click Enter on your keyboard.** A list of potential diagnoses/problems will pop up. You can enlarge this window containing the list of diagnoses by clicking and dragging in the lower right-hand corner of the pop up window.
3. **In the popup, click on the diagnosis/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 the data base of problems, which is internet based. 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.

4. **DO NOT USE THE TYPE FIELD.**

SNOMED CODES

- In Avatar SUD treatment plans, the problems you address can be Diagnoses, functional impairments or other problems. Examples: "loss of job," "poor motivation," "Failed prior treatment for drug use," or "Alcohol intoxication in relapsed alcoholic". A diagnosis or a functional impairment type SNOMED code may be used in your plan.
- Only an LPHA can approve Diagnoses for DMC-ODS to determine medical necessity.
- Non- LPHA staff (SUD counselors), use SNOMED codes that address a functional impairment associated with one of the client's diagnoses. For example, if your client has the diagnosis of "Opioid dependence" (SNOMED-755544000), you might choose the SNOMED code, "Loss of self-esteem" (SNOMED-267077006).

SPECIFY OTHER

- 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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- Double-click in the **Date Identified** field to activate the field. This is an optional field. Enter a date if appropriate.
- 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.**
- 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.)
- 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.
- Check the problems you want to use.** After adding any new problems (if needed), in the **"Include in this plan?"** column, **check the checkboxes for those problems you wish to include** in this treatment plan. You do not have to use all of the problems, only the ones you want to address in the treatment plan.

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.

Problems

	Include in this plan?	Problem	Other	Type	Date Identified	Date of Onset	Time Of	Status	Severity
2	<input type="checkbox"/>	Recurrent major depression (SNOMED-66344007)				01/01/1998		Active (A) (A)	
3	<input type="checkbox"/>	Moderate manic bipolar I disorder (SNOMED-82998009)				01/01/1978		Active (A) (A)	
4	<input type="checkbox"/>	Generalized anxiety disorder (SNOMED-21897009)				01/01/2012		Active (A) (A)	
5	<input checked="" type="checkbox"/>	Alcohol dependence (SNOMED-66590003)				01/01/1978		Active (A)	
6	<input type="checkbox"/>	Cannabis dependence (SNOMED-85085007)							

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.

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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.

STEPS for the Plan Participants Table

The Plan Participants table is where you enter everyone who signs the plan (client, LPHA, MD, etc...). Each of the plan participants is added as one line on the table.

Plan Participants

	Role	Staff ID	Participant Name	Plan Author	Notification	Signature
1	CLIENT (CL)		Lil' T Favreau	No (N)	No (N)	Sign
2	CERTIFIED STAFF (CERT)	KE'DENN,MASTER-T (00...	KE'DENN,MASTE...	Yes (Y)	Yes (Y)	Sign
3	REGISTERED STAFF (REG)	MAST,NANCY (001885)	MAST,NANCY	No (N)	No (N)	Sign
4	LPHA (Other than MD) (LPHA)	LOLLEY,CYBELE (006276)	LOLLEY,CYBELE	No (N)	No (N)	Sign
5	MD (MD)	DAZZLEFEATHER,MOON...	DAZZLEFEA THE...	No (N)	No (N)	Sign
6	STAFF (STAFF)	ICE,MIXX (000559)	ICE,MIXX	No (N)	No (N)	Sign

New Row

Delete Row

Enter a new participant by clicking the **New Row** button.

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TO ENTER YOURSELF:

1. Double-click in the **Role field** to activate the field. In the pop-up window, click either STAFF or CERTIFIED STAFF.
2. 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.
3. Enter **Yes** in the **Plan Author field**.
4. Enter **Yes** in the **Notification field**. By doing this, you will set up a notification reminder for when the treatment plan is due. This reminder will appear in your My To Do's on the Next Review Date.

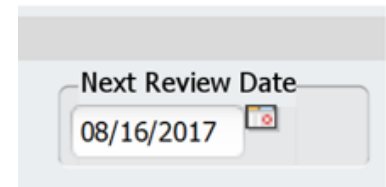
CERTIFIED AND REGISTERED STAFF DEFINITIONS

Per CCR, Title 9, Section 13005

- 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.

TO ENTER AN LPHA: If there will be a co-signer for your plan, then enter the name of your LPHA staff member. This will only work if the LPHA is a user in Avatar. Note that there is a separate category for MD.

1. Double-click in the **Role** field to activate the field. Click **LPHA (Other than MD)** 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:

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 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 YOUR CLIENT:

1. Double-click in the **Role** field to activate the field. Click **Client** in the pop-up window.
2. Skip the **Staff ID field**. (There won't be a staff ID because this is not a staff person.)
3. In the **Participant Name field**, type the name of the client.
4. Enter **No** in the **Plan Author field**.
5. Enter **No** in the **Notification field**.

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TO ENTER ANOTHER TYPE OF STAFF PERSON: For example, peer counselor.

1. Double-click in the **Role** field to activate the field. Click **OTHER (Include Name/Role)** in the pop-up window.
2. Skip the **Staff ID field**.
3. 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. Example: "Janet Williams, Peer Counselor"
4. Enter **No** in the **Plan Author field**.
5. Enter **No** in the **Notification field**.

Continue adding participants to the plan.

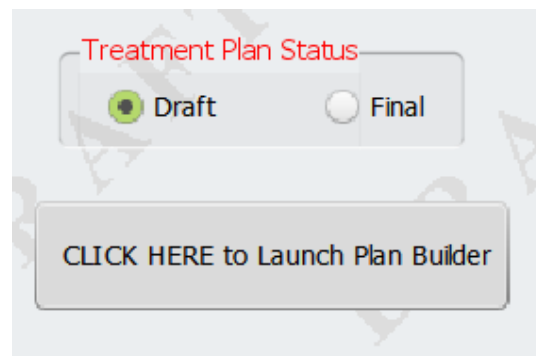
Plan Participants are anyone that signs the plan. Don't add anyone that doesn't need to sign the plan.

If you want to discuss other supports, such as a sponsor, family, etc...(people who don't sign the plan) add this information about the client's support system in the question, "**Additional Comments About Client's Support System.**"

Signature Field: Skip this for now. You will use this when the client signs the plan.

Continue filling in fields in the plan:

1. Add **Additional Comments About Client's Support System** as needed.
2. Fill in the question, **Days of Treatment/Step Level** if applicable.
3. Add information about the client'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 Strengths, Needs and Preferences. These are required questions.
4. 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.



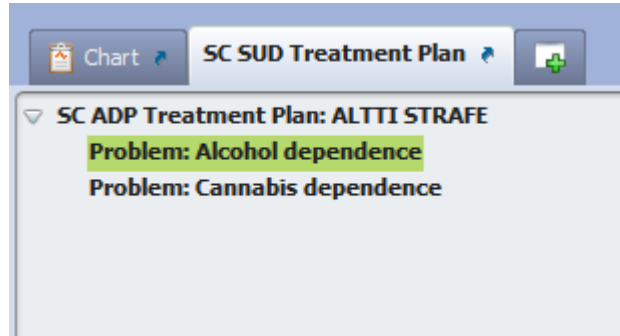
The image shows a screenshot of a web form. At the top, the text "Treatment Plan Status" is displayed in red. Below it, there are two radio buttons: "Draft" (which is selected, indicated by a green dot) and "Final" (which is unselected, indicated by a white dot). Below the radio buttons is a large, light gray button with the text "CLICK HERE to Launch Plan Builder" in blue.

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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.

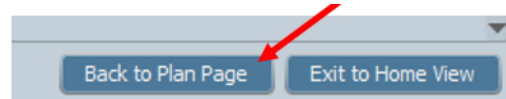
(TIP: If you don't see your problem, it's possible that you forgot to check it off in the problems table.)



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.

To Return to the Plan Page

On the Plan Builder Page, at bottom right, Click **Back to Plan Page** to return.



Complete Your Problems on the Plan Builder Page

1. **Click on one of your problems to highlight it.** The problem selected will be highlighted green.

On the lower half of the page, note the other fields that are relevant to the problem. Some of these fields will already be filled out, because they are coming from the Problems Table. Other questions you will need to fill out.

Santa Cruz Avatar

Chart SC SUD Treatment Plan

SC ADP Treatment Plan: ALTTI STRAFFE

Problem: Alcohol dependence

Add New Problem Add New Goal Add New Objective Add New Intervention Delete Selected Item

Problem Code
Alcohol dependence

Other

Date of Onset
01/01/1988 T Y

Status (Problem List)
Active

Problem (Including Statement of Problem as Identified by Client)
Alcohol dependence

Entry Date
08/15/2017 T Y

Staff
MAST,NANCY (001885)

ASAM Dimension

ASAM Severity Score

Back to Plan Page Exit to Home View

2. Edit the question, "Problem (Including Statement of Problem as Identified by Client)", to include the client "statement problem" and any additions to the problem you want to make to customize the problem.


SUD Medi-Cal requires a, "statement of the problem as experienced by client to be addressed as a focus of treatment planning." In other words, how the client views the problem needs to be incorporated into the treatment plan.

You will enter the client statement, either as a paraphrase or a direct quote, in this field as well as add your own additions to the problem.

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Initially, the only thing you will see in this field is the Problem Code. (See picture below.)

Problem (Including Statement of Problem as Identified by Client)

Alcohol dependence 

Separate the client statement by typing in in, "CLIENT STATEMENT."

If you wish to add other information to the problem, you can also do it here in this question. You might want to add other information to the problem to expand on it order to add information that is specific to this particular client. DO NOT erase the problem, just add some information to it if you wish.

After editing, your problem might appear as below. Notice that "Alcohol dependence," is still part of the problem. It has not been erased, but other information has been added.

Problem (Including Statement of Problem as Identified by Client) X

CLIENT STATEMENT OF PROBLEM: "I drink too much and I might get fired. My family is angry with me. It is making me depressed."

Alcohol dependence: Including increased tolerance for alcohol; Episodes of drinking alcohol to intoxication at least four times per week; blackouts; conflict the family members related to alcohol use; alcohol use is interfering with work; alcohol use is contributing to depressed mood.

Ok Cancel



The view above is from the **Text Editor**. If a question requires a lengthy answer that you cannot view in the text field, you can pop out the text editor to see more of the field by clicking the little pencil and paper icon near the upper right-hand corner of the field. C once you are done editing, click "Save" to close the popout and save your edits. If you do not click "Save," your edits will not be saved.

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In this example, the client statement has been incorporated into the problem statement. It has not been separated as with the prior example.

Problem (Including Statement of Problem as Identified by Client)

Methamphetamine abuse: Client reports he has been using methamphetamine daily for the last six months; has since lost his job; feels "down and out" and unable to cope with daily stressors without drugs; he attempted counseling but was unable to stop cravings.



3. **ASAM Dimension:** Enter the ASAM dimension from the ASAM form for this client. This is the ASAM dimension that informs the problem you are using. The ASAM is completed as part of the client's intake assessment and should be completed before the Treatment Plan.
4. **ASAM Severity Score:** Enter the severity score from the client's ASAM that is applicable to the problem.

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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.

Chart SC SUD Treatment Plan

SC ADP Treatment Plan: ALTTI STRAFE

Problem: Alcohol dependence: including increased tolerance for alcohol; episodes of the 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.

Problem: Cannabis dependence

Add New Problem Add New Goal Add New Objective Add New Intervention Delete Selected Item

Problem Code
Alcohol dependence

Date of Onset
01/01/1988

Other

Status (Problem List)
Active

Problem
Alcohol dependence: including increased tolerance for alcohol; episodes of the 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.

Entry Date
08/15/2017

Staff
MAST,NANCY (001885)

ASAM Dimension
4-Readiness to Change

ASAM Severity Score
1-Outpatient Services

Click and drag on these little dots to make the top and bottom sections of the page larger or smaller.

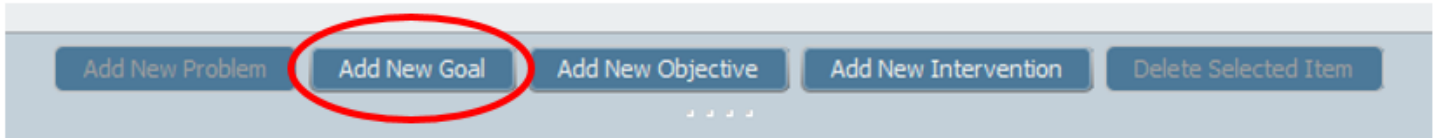
Click here to return to plan page (first page.)

Back to Plan Page Exit to Home View

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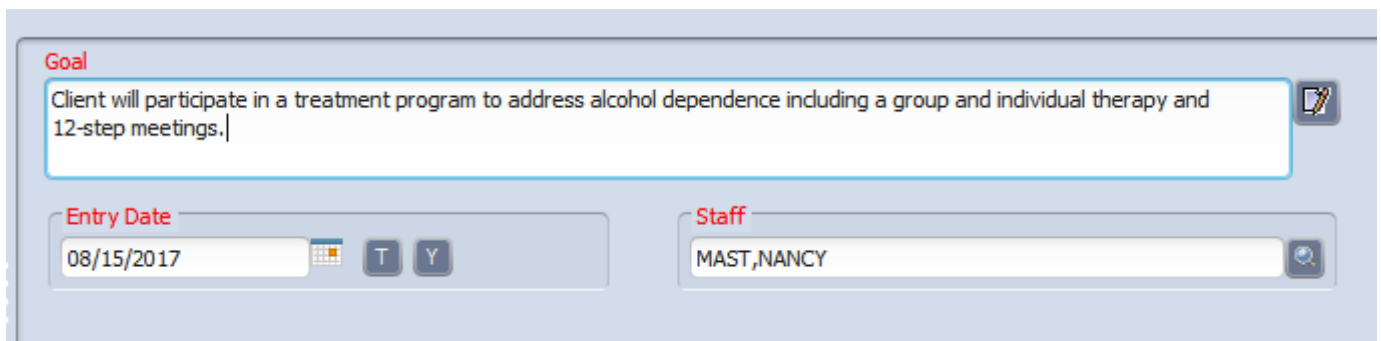
Add a New Goal

1. **With the Problem you want still highlighted in green, click Add New Goal** and a blank goal will pop up for you to write in.



IT IS VERY IMPORTANT TO CLICK ON THE PROBLEM, GOAL, OBJECTIVE ABOVE WHERE YOU WANT THE NEXT ITEM TO BE, SO THEY ARE ASSOCIATED CORRECTLY WITH EACH OTHER. In the example above, the Problem: Alcohol dependence, is highlighted in green. This must be highlighted like this to write a goal for this particular problem.

2. **Enter the text of the goal in the field titled Goal.**
3. **Entry Date:** This field will automatically populate to today's date.
4. **Staff Responsible:** You should see your name automatically added to this field.

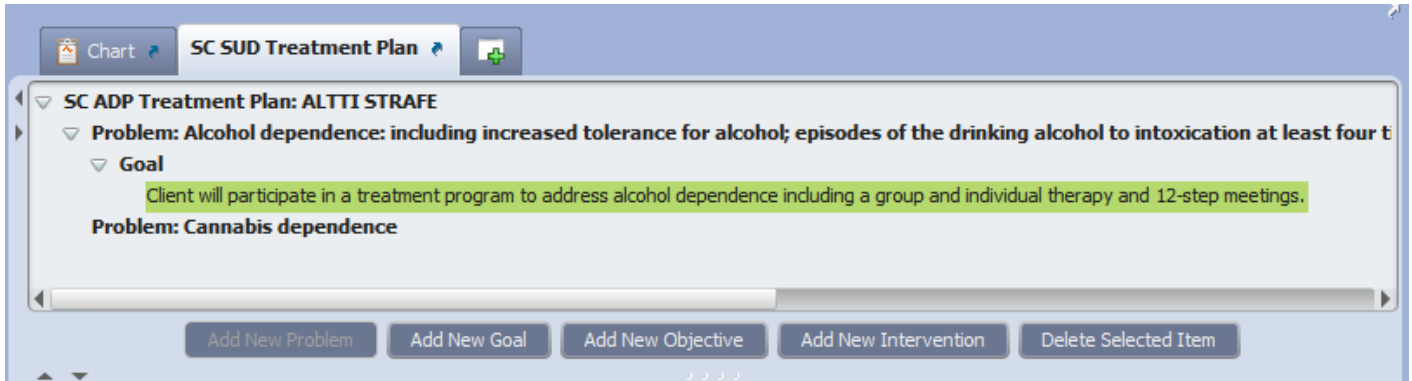


Santa Cruz Avatar

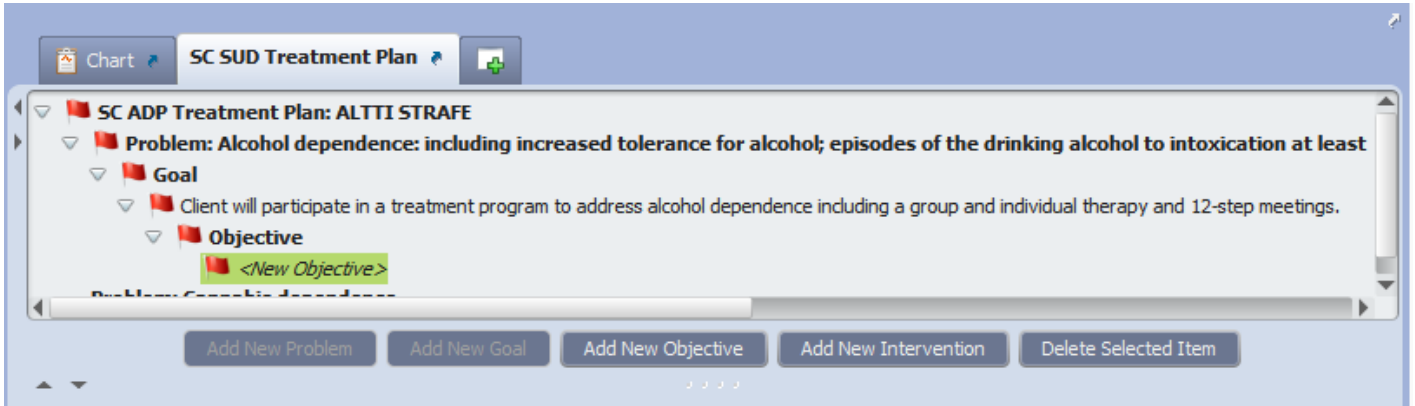
Add a New Objective

You will now add a new objective to the goal you just wrote.

1. **Click on the text of the goal you just wrote to highlight it.** The text of the goal should now be highlighted in green as shown below. This way, your new goal will be connected to the new objective.



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. **Click on the text in italics <New Objective> to enter your objective.** You will now see blank fields below where you can fill in the objective information.

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Objective/Action Steps, Including Baseline

Client will participate in treatment program for 90 min. daily in order to abstain from drinking alcohol and improve coping strategies to manage stressors that impact alcohol use.

Entry Date
08/15/2017

Target Date
11/12/2017

Staff
MAST,NANCY

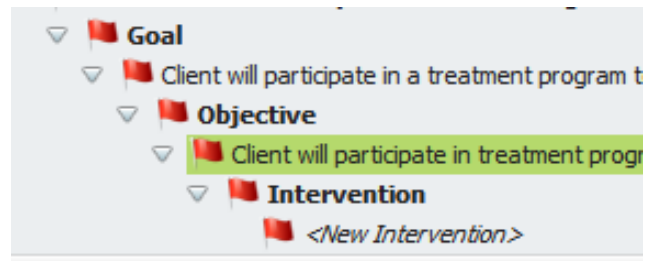
4. The **Entry Date** and **Staff** fields should automatically populate.
5. **Enter a Target Date if applicable.** Typically, this is the Authorization End Date for the plan. See your supervisor about whether or not you should fill in the Target Date question, and what date to add.

Add a New Intervention

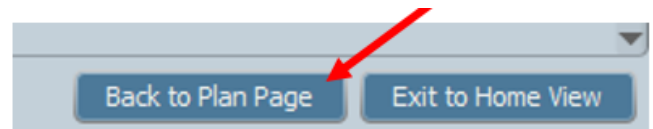
You will now add your Interventions to the Objective you just wrote. Make sure you click and highlight in green, the text from the Objective you just wrote, before clicking Add New Intervention.

Once you have added your goals, objectives and interventions, return to the Plan Page (the first page)

If you see any red flags next to your added items, you know that there is a field that is missing data. Note that you will not be able to finalize your plan if you have left any fields blank on this page.

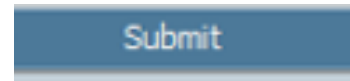


Click Back to Plan Page once you are done writing your goals, objectives and interventions.



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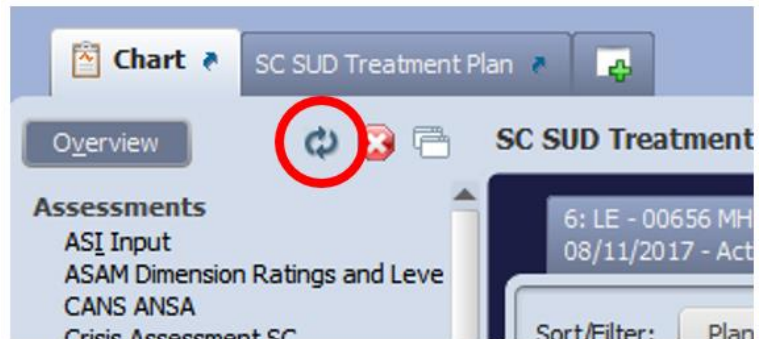
Once your plan is complete, click “Submit” to save and close until the client is present. When the client is present, then you can reopen the plan, review with the client and obtain the client’s signature.



Once you have exited the plan (clicked “Submit”) you can view your plan in the chart Inquiry View

Click on “SC SUD Treatment Plan” and then on your program tab.

The Refresh Button: You won't be able to see changes in the chart inquiry view until you click the refresh button.

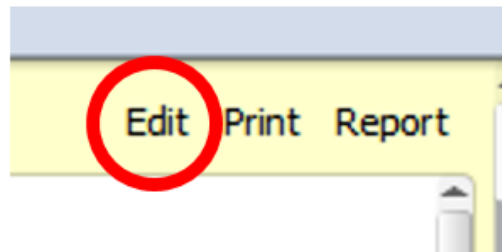


Use the Electronic Signature Pad to Obtain Signatures

When the client is present, use the electronic signature pad to obtain the signature.

To reopen your plan, open the chart, click “SC SUD Treatment Plan,” and then click on your episode tab.

In the upper right corner, on the margin strip for the plan, click the word “Edit” to open the plan.



STEPS:

1. **First, make sure that you have a signature pad and that it is plugged into your computer.**
2. **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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PARTICIPANTS / SUPPORTS						
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 (CL)		Aurora Glitterbre...	No (N)	No (N)	Sign

3. Hand the signature pad to the person you want to sign.
4. After the person has signed, Click "OK" to add the signature to the plan.

Signature

Please input a signature.



OK Cancel

Once the signature has been captured, you will see a check mark in the row with the name of the person who signed.

PARTICIPANTS / SUPPORTS						
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 (CL)		Aurora Glitterbre...	No (N)	No (N)	Sign ✓

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In the chart, and in printed copies of the plan, you will now be able to see the signature.

Participation
Role: CLIENT
Name: Aurora Glitterbreeze
Plan Author: No
Notification Required: No
Signature:
a. glitterbreeze

OPTIONAL: You may have the client date the signature if this makes sense for you in terms of workflow. If desired, you may also have the client write the date on the signature pad when signing. Although not required, this date is a confirmation of when the signature was obtained.

Participation
Role: CLIENT
Name: Aurora Glitterbreeze
Plan Author: No
Notification Required: No
Signature:
a. glitterbreeze
3/24/17

5. **Offer a copy of the plan to the client.** Once all needed signatures have been obtained, offer a copy of the plan to the client.
6. **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 client for signature. You will fill in this question later.)

Date client was offered a copy of the treatment plan

03/09/2017 Today Yesterday

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IMPORTANT: You must offer the client a copy of the plan and enter a date in this blank. This is a Medi-Cal requirement.

You may also save your plan as a draft and have the client sign at a later time. See the next section, [Printed Treatment Plan Workflows \(what to do if you don't have a signature pad\)](#) for more information.

If the client 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. client is too symptomatic or cannot be located.)

It is good practice to identify the strategies used to attempt to obtain the signature. If multiple attempts are made, document this in progress notes.

If client has not signed the treatment plan, please explain:

Client was not able to sign due to fatigue, withdrawal and depressive symptoms that interfere with ability to sign this document. Will continue to work with client to obtain signature.

If the client has signed a printed, paper copy, enter, "Client signed a printed copy of the plan. See scanned plan for signature."

If client has not signed the treatment plan, please explain

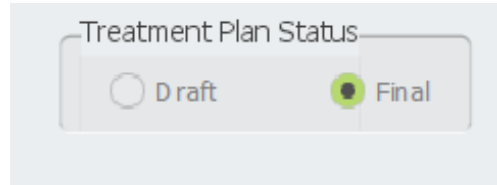
Client signed a printed copy of the plan. See scanned plan for signature.

You MUST explain why, if the client does not, or cannot, sign. If your client refuses to sign, you must document ongoing attempts to obtain the signature in your progress notes.

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Once the client signature has been obtained, in the **Treatment Plan Status** field, click **Final**.

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, when you finalize and submit, a picture of the Treatment Plan will be launched for you to proofread. After proofreading, you have three options: Accept, Reject or Reject and Route. You may route to a supervisor and other approvers.

Printing a Copy of Your Treatment Plan

1. Open the client's chart.
2. Click on **SC SUD Treatment Plan** to open the Treatment Plan Inquiry View.
3. Set the slider at bottom right to about 85% to print out in font that is manageable. If you leave the slider at 100%, the text in your printout will be very large.

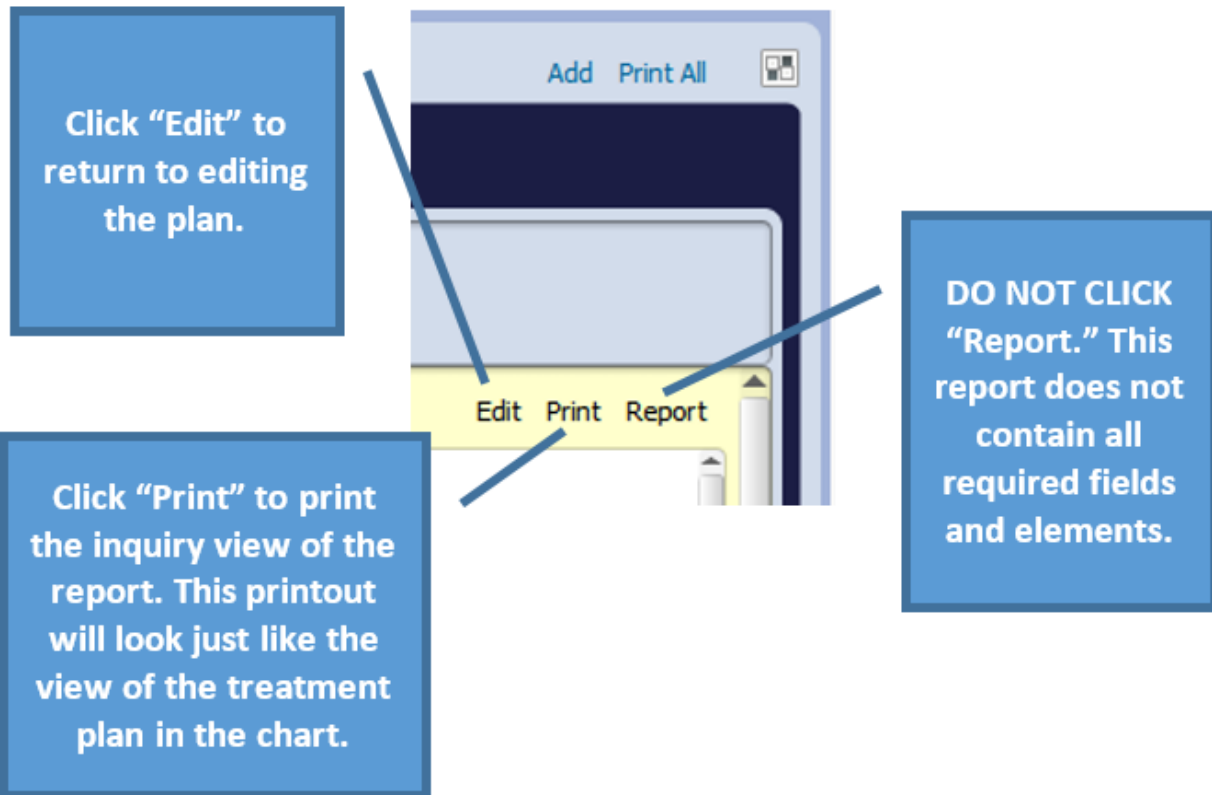
To Shrink or Enlarge Text in the Inquiry View, at bottom right in the inquiry view, you

will see a button that you can slide left and right to increase and decrease the size of the font in the inquiry view. This handy button is also on many forms.



4. Click **Print** at upper right.

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Printed Treatment Plan Workflows (what to do if you don't have a signature pad)

This workflow applies if you do not have a signature pad available. It might be that the client cannot come in to the office and you don't have a laptop with signature capture, or you simply do not have a signature pad at your location.



Steps:

1. Complete your treatment plan, leaving it in draft.
2. Leave the question, "Date client was offered a copy of the treatment plan," blank. You do not enter anything here until you obtain the signature.
3. **SAVE THE PLAN AS A DRAFT. DO NOT FINALIZE.** You want to wait to finalize until after you get the client signature.
4. Print out a copy of the plan, using the directions in the previous section.
5. Meet with the client to review the plan and obtain the signature.
6. 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.

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7. Reopen the Draft Treatment Plan in Avatar.
8. In the question, “**Date client was offered a copy of the treatment plan,**” enter the date the client signed.

Date client was offered a copy of the treatment plan

03/09/2017  Today Yesterday 

9. In the blank where it says, “If client has not signed the treatment plan, please explain,” explain that the client signed a paper plan that was then scanned in.

If client has not signed the treatment plan, please explain:

Client signed copy of paper plan. See scanned plan in chart.



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.

10. Finalize and submit the electronic Treatment Plan to Avatar. Do not forget to finalize the plan. If the plan is not finalized, it is not valid.

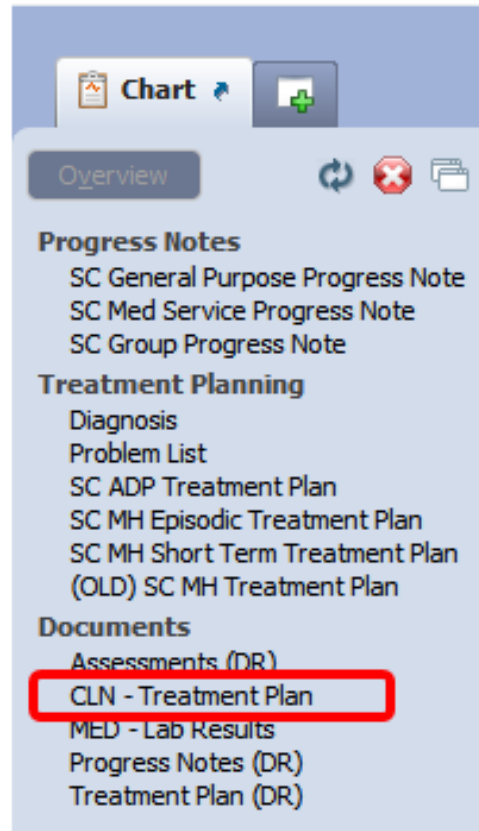
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To View Your Scanned Treatment Plan

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.



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Treatment Plan Updates (Defaulting Plan Data from a Prior Plan)

You will create an update when you want to modify the plan, or it is time for the **3-month (90 day)** or monthly update.

When you create an update, you are adding to a plan that already exists. You want to preserve the problems, goals, objectives and interventions that were previously added and then edit in your new version of the plan.

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 for editing.

STEPS:

1. **Open the client's chart** if you have not already done so.
2. **Click SC SUD Treatment Plan** in the list of forms on the left in the Chart Overview, then click on your LE tab. You should now see an **Inquiry view** of the client's Treatment Plan(s) for your LE. Make sure you click the right LE. If you pick wrong, you will have to rewrite your plan and then have the one under the wrong LE deleted.
3. **Find the Plan You Want to Default From:** Look through the plans to see which is the most recent shared plan. This is the plan you are going to add to. Make a note of the name and plan date.
4. **Determine Your Authorization Start Date Before You Open the New Plan:** Look at the Authorization End Date from the most recent plan. The Authorization Start Date for your plan will be the day after the Authorization End Date from the prior plan.

WHICH PLAN DO I USE FOR DEFAULT INFORMATION?

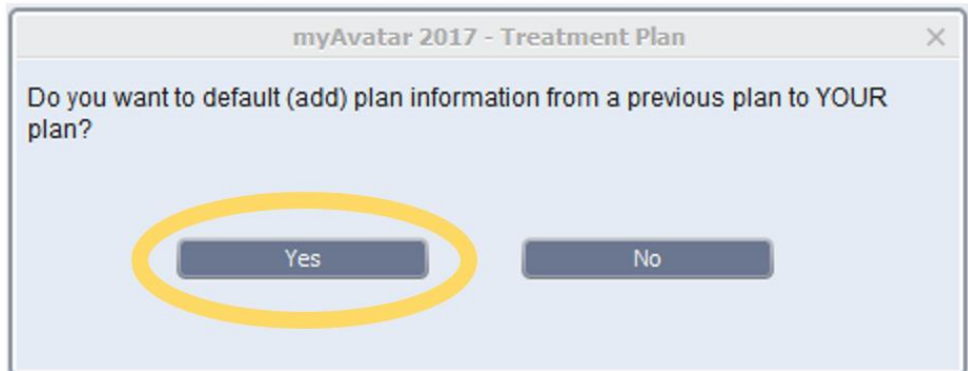
- When you create a Treatment Plan Update, you need to make sure that you choose the correct plan from which to default information. This should be the most previous plan. An example of a correct set of treatment plans, in sequence, is shown below.

- 3/27/2017 – 6/24/2017 Initial
- 3/27/2017 – 6/24/2017 Update 1
- 3/27/2017 – 6/24/2017 Update 2
- 6/25/2017 – 9/22/2017 Quarterly 1
- 9/23/2017 – 12/21/2017 Quarterly 2
- 12/22/2017 – 3/21/2018 Quarterly 3

5. **Once you have located the plan from which you want to default information, Click Add** in the upper right-hand corner of the screen to open a new form.

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6. **Click Yes** when you see the pop up asking if you want to, "**default (add) plan information from a previous plan to YOUR plan.**"

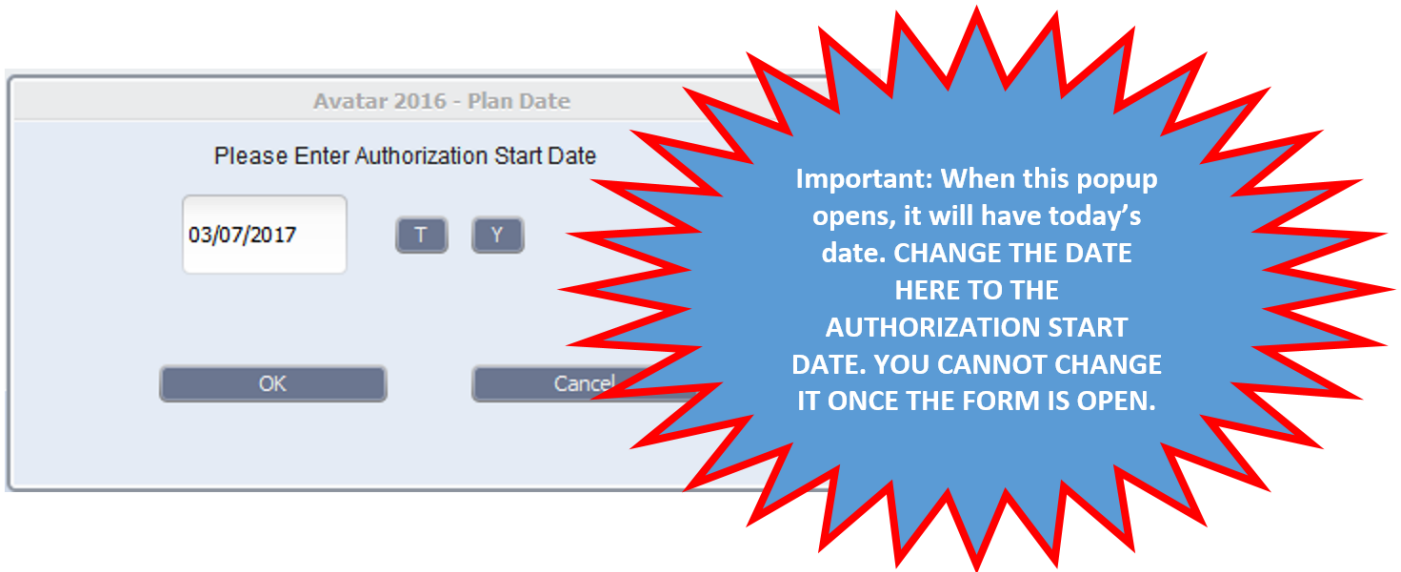


7. **Default From Previous:** You will see a second pop up that provides a list of previous Treatment Plans for the client (the long bar with the plan name on it). If there is more than one plan, you want to pick the most recent plan shared plan.



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8. **Enter Authorization Start Date:** You will see a third pop up asking you to enter the Authorization Start Date.



Avatar 2016 - Plan Date

Please Enter Authorization Start Date

03/07/2017 T Y

OK Cancel

Important: When this popup opens, it will have today's date. CHANGE THE DATE HERE TO THE AUTHORIZATION START DATE. YOU CANNOT CHANGE IT ONCE THE FORM IS OPEN.

9. Once you have entered the Authorization Start Date, click **OK**.

IF YOU MAKE A MISTAKE WITH YOUR AUTHORIZATION START DATE

To Correct the Problem:

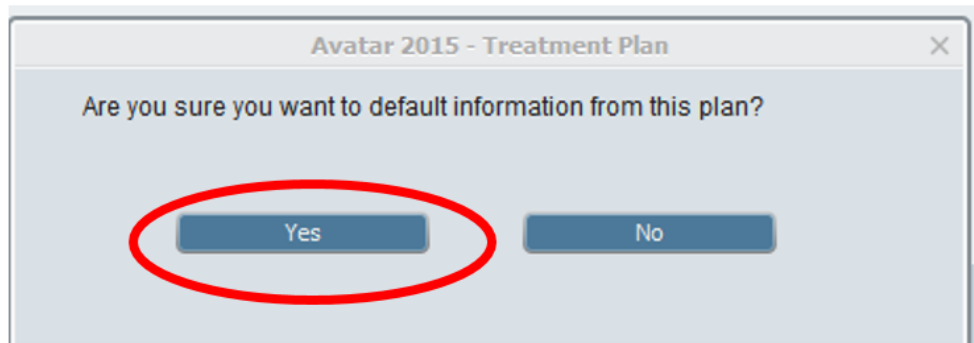
If the client has not yet signed the plan, it can be deleted. If it has been signed, it is a valid plan, despite the date error, and must be left in the chart. Regardless, you will need to recreate the plan with the correct date. Then, if applicable, submit a request for the plan with the wrong date to be deleted.

1. If your 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. Use the "Default" method to create a new plan that has all of the data from the plan with the wrong Authorization Start Date. (See, [Creating a Treatment Plan Update](#), for more information about defaulting from a prior plan.) 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: Client Name/Number, Plan Name, Authorization Start Date, Reason for Deletion, Episode Name/Number.

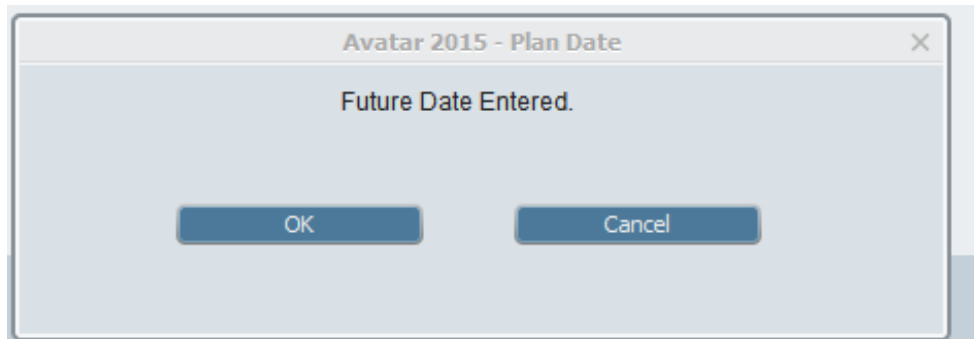
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CONTINUE ON WITH YOUR PLAN....

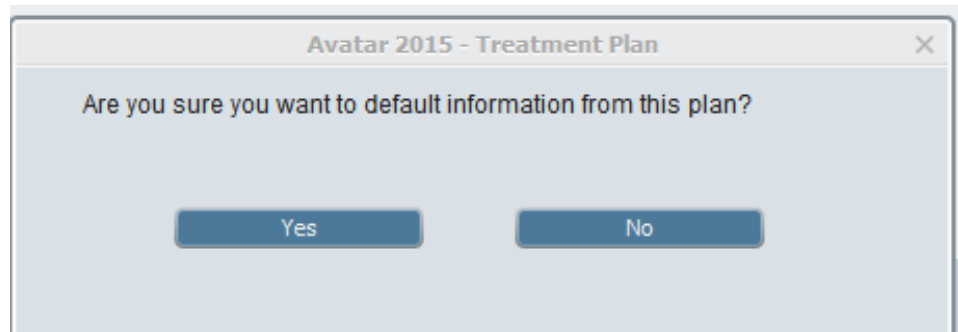
1. Once you have entered your plan date, you will see a pop up asking if you are sure you want to default information from a previous plan. **Click Yes.**



2. You will get a warning that you are entering a future date. This is OK. You may create an Annual plan up to 28 days prior to the anniversary date. Additionally, it is good practice to begin the plan well in advance of the deadline to allow time for coordination with other providers, editing, and obtaining needed signatures. **Click OK.**



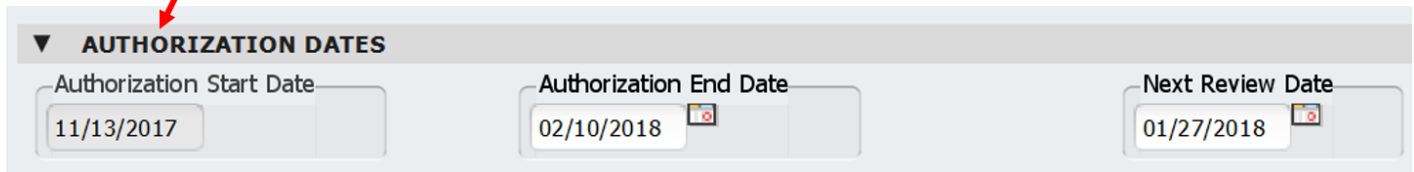
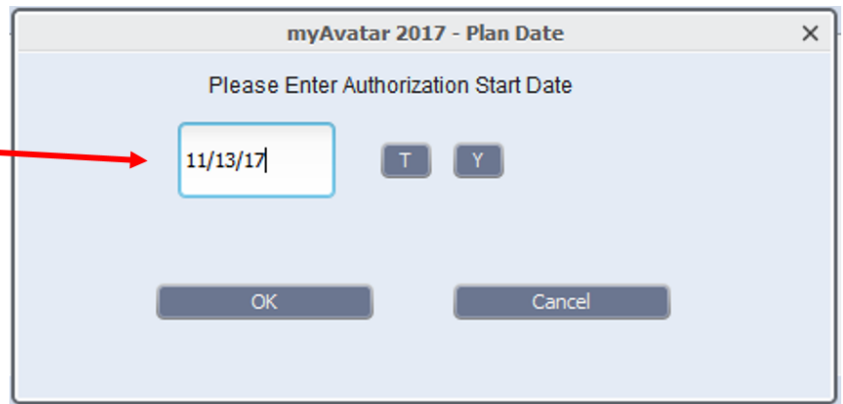
3. You will see another popup asking if you are sure you want to default information from a previous plan. **Click Yes.** The new plan will open.



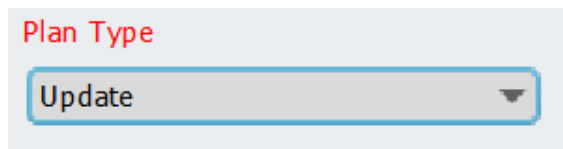
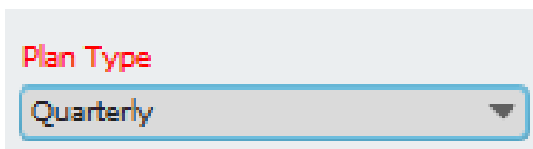
Your plan will now open. Notice the Authorization Start Date you entered in the popup is already in the plan. The Authorization End Date and Next Review Date have also been autopopulated.

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The Authorization Start Date is the date you typed into the popup before the plan opened. Note that it is disabled (greyed out) and you cannot change it. This is why it is important to enter this date correctly in the popup.



4. In the Plan Type field, select Update or Quarterly depending on your program needs.

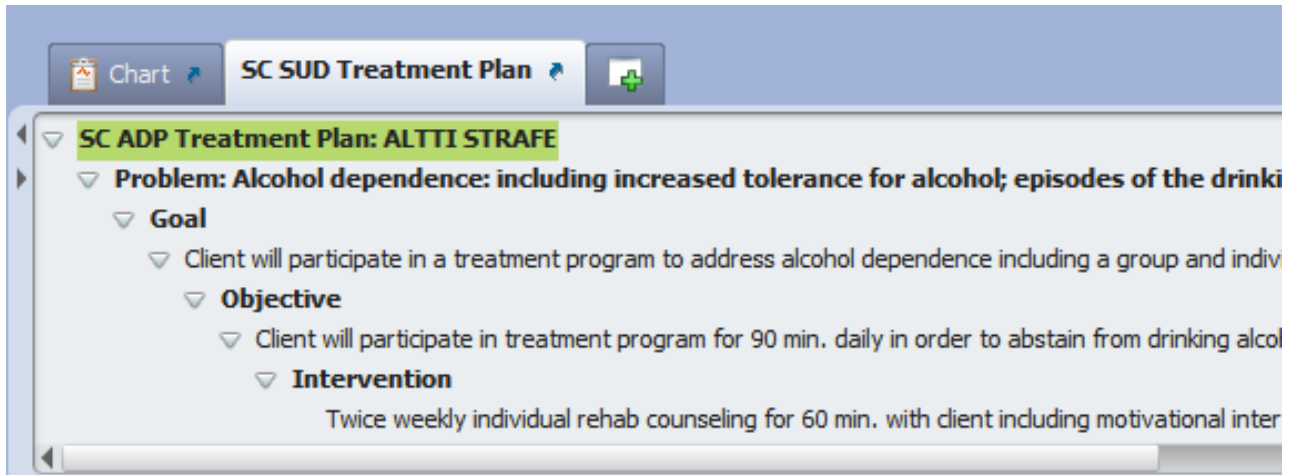


5. Enter the Plan Name. The plan name contains the authorization period, the plan type and a number if needed.
6. Was This Treatment Plan Discussed in a Language Other Than English? This question is pre-populated from the previous plan.
7. Problems Section (Table): In the Problems Section, you will see the client'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).
8. Plan Participants Section: If needed, add your name and any additional Plan Participants. To add yourself or other participants, click "new row."
9. Complete the rest of the fields on the Plan Page (first page), editing or adding information as needed.

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.

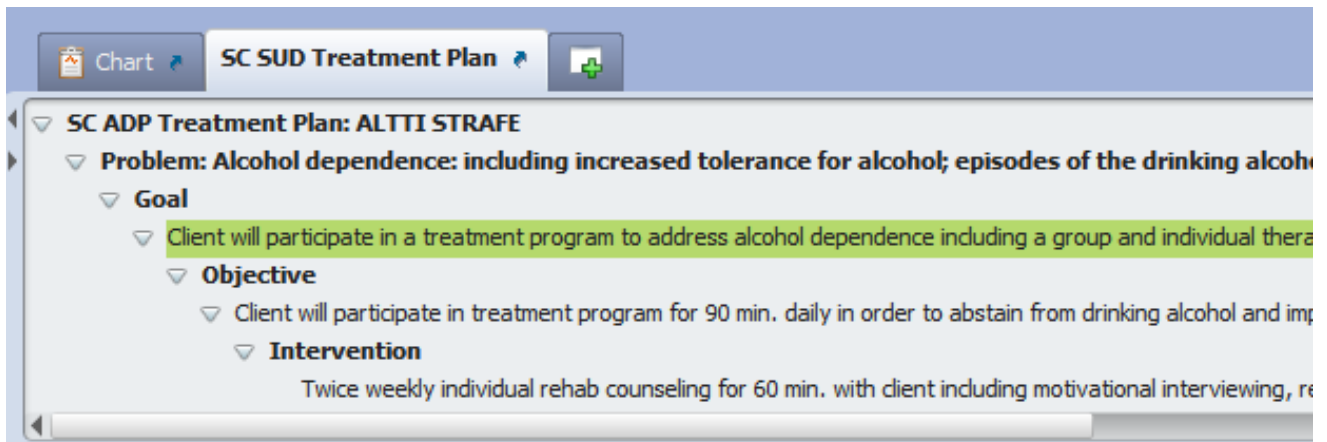
Santa Cruz Avatar



Add New Goal(s), Objective(s), and/or Intervention(s) to Your Update

IT IS VERY IMPORTANT TO CLICK ON THE PROBLEM, GOAL, OBJECTIVE ASSOCIATED WITH THE ITEM YOU WANT TO ADD, SO THEY ARE CONNECTED TO EACH OTHER.

In the example below, to add a new Objective to the Goal, "Client will participate in treatment program...", 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.

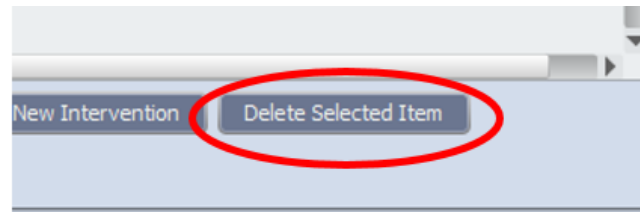


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Remove and Resolve Problems, Goals, Objectives and Interventions That Are Not Needed

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

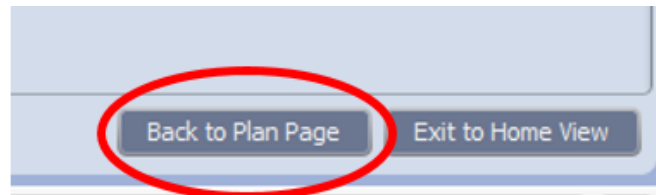


Selected Item is enabled. Click this button to delete the intervention. After you have finished deleting the interventions, delete the objectives, then the goals, then the problems.

To Resolve Any Problems That Are No Longer In Use

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 client'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 by changing the status of the problem from "Active" to "Resolved."

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.

Intervention?	Problem	Other Type	Date Ident	Date of Onset	Time Of	Status	Sew	Ch	Date Resolved	Action
1	Alcohol dependence (SNOMED-66590003)			01/01/1988		Active (A) (A)				
2	Cannabis dependence (SNOMED-85005007)			01/01/1982		Resolved (R)			08/15/2017	
3	Poor motivation (SNOMED-26413003)			01/01/1995		Active (A) (A)				
4	Paranoia (SNOMED-191667009)			01/01/2012		Active (A) (A)				
5	Depression (SNOMED-35489007)			01/01/1982		Active (A) (A)				

New Row Delete Row

Santa Cruz Avatar

There is column in the Problems Table where you can add any comments if needed.

NEXT...

1. **Obtain signatures** as described previously.
2. **Select Draft or Final and submit your plan.** Leave in Draft until you obtain the client signature. Then finalize and submit. Don't forget to answer the question, "Date Client 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](#)

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....

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 [Ctrl] + C to copy. Use [Ctrl] + 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.

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7. If the problem is a mistake and not appropriate for this client, 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