Netsmart

Netsmart Sandbox Tour Guide Script

April

2013

This document is to be used in conjunction with the Netsmart Sandbox environment as a guide. Following the steps included in this guide will allow you to get a sense for the general workflow for your role and how you will interact with the Netsmart solutions, once your own system build is completed. It will provide you with a foundation for understanding the required data collection and making any design decisions associated with the project.

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Intern Guide

CWS - Intern

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Purpose

This exercise will help provide you with an experience of how an intern may use Avatar. Steps you will complete in the process:

- **Create an Admission**
  Using the Admission form you will admit a client into a program (level of care) and also gather some demographic information about them. This step is the first and most important in the billing process because all services a client will receive are linked to the episode that the client is admitted into.

- **Record Substance Abuse History**
  This form allows you to record the history of substance abuse on your new client.

- **Perform a Mental Status Assessment**
  This form is used to assess your client's current mental status.

- **Define a Client Treatment Plan**
  This form allows you to define the treatment methodology for your new client.

- **Scheduling Calendar**
  You can view and manage appointments at multiple sites for staff members, clients, and groups.

- **Document Ambulatory Progress Notes**
  You will evaluate the client's treatment goals and their use of treatment services to help determine the current and future needs for treatment.

Terminology

- **Forms** – the data entry screens in Avatar that are used to track medical record information.

- **Widgets** – windows of information that display information about key Avatar functionality, a client, a program, or your organization.

- **Home View** – a user's main navigation screen. The Home View allows a user to view their caseload, search for clients, access forms, or navigate to the client Chart View.

- **Chart View** – a view for quick access to the client's stored medical record information. The Chart View is comprised of three main sections:

  - **The Chart Widget View** – like the Home View, displays windows of information pertinent to the client and their overall status.

  - **The Chart Overview** – located on the left side of the Chart View, the Chart Overview provides links to forms in Avatar pertinent to the user's workflow. This allows the user to quickly navigate to stored data and forms they use in their job on a daily basis for an individual client.

  - **The Chart Inquiry View** – works in conjunction with the form links in the Chart Overview. When a form link is clicked by a user, the Chart Inquiry view becomes available to the user and they are able to see any stored data on file for the client for that specific form. From the Chart Inquiry View, a user can easily edit an existing record or add a new record.
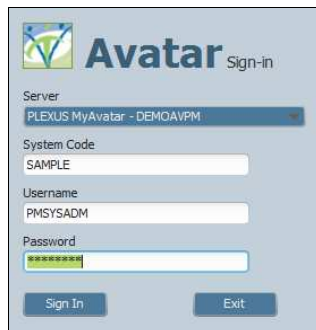
- **Episode** – In Avatar, a client is admitted into an episode of care. An episode starts with a new Admission (Inpatient or Outpatient) and ends with a Discharge that follows that Admission. Many client activities (services, assessments, treatment plans, progress notes) may happen within one episode.

- **Admission (Outpatient)** – the form utilized to admit clients into an outpatient program. Using this form will create an Outpatient episode for a client in Avatar.

- **Scheduling Calendar** – Avatar functionality that provides the user the ability to manage appointments at multiple sites for staff members, clients and groups.

- **Progress Notes** – Evaluate a client's treatment goals and their use of treatment services, to help determine the current and future needs for a client's treatment. They are included in the client's chart, and are used for medical record purposes. Avatar has 4 main types of progress notes- Independent Note, Ambulatory Progress Note, Inpatient Progress Note, and the Group & Individual note.

- **Clinicians/Practitioners/Staff** – Persons that render services or treat clients directly.

![Netsmart logo]

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Logging into Avatar

1. Launch Avatar form the provided url address: https://sandbox.asp.ntst.com/plexus/pm

2. Click the **Start** button to launch the application.
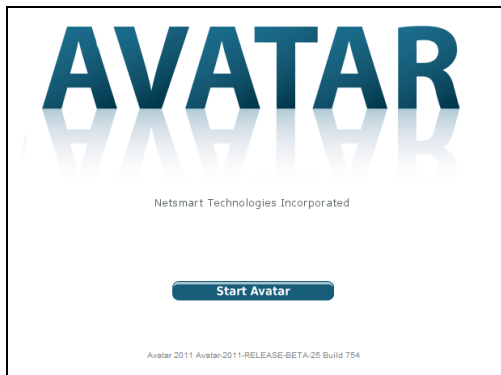
3. Log in by selecting the **Server** you are going to log in.

4. Type "SAMPLE" into the **System Code** field.

5. Type in a clinical Username: INTAKE1, INTAKE2, INTAKE3, INTAKE4, or INTAKE5.

6. Type in the Password for the CLINICIAN username (they all use the same): INTAKE99.

7. Click the **Sign In** button.

Exercise Recap:

You have now logged into Avatar. The user you have logged in has access to client medical record information and also Avatar forms utilized in the billing or claims process. In the next step of this exercise, you will admit a new client into Avatar.

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Admission (Outpatient)

The Admission form is utilized in Avatar to admit clients into an outpatient program or episode of outpatient care.

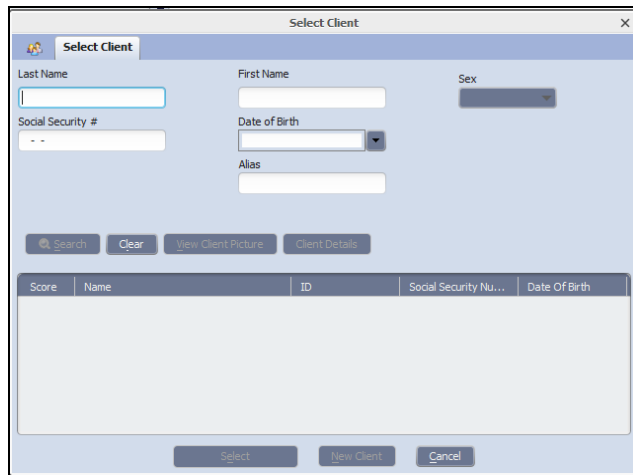1. On the Home View, locate the **Forms and Data** widget.
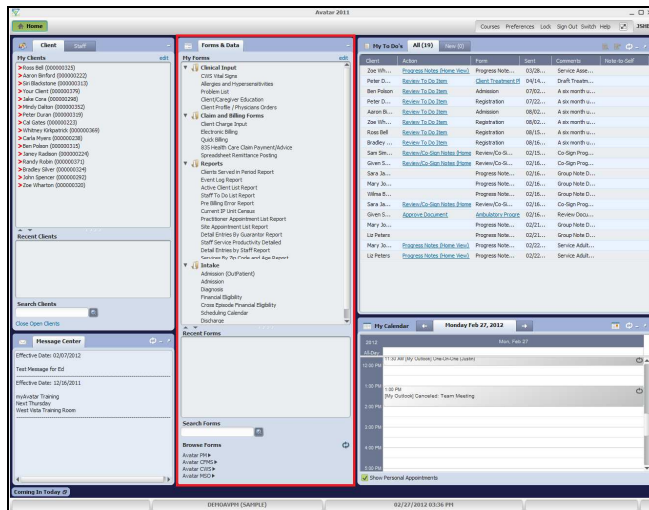
2. In the Forms and Data widget, type "Admission" in the **Search Forms** field.

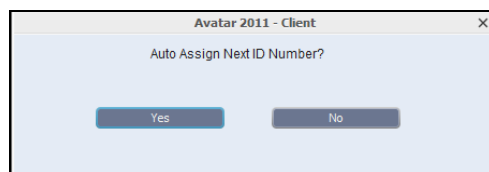3. Double click on the **Admission (OutPatient)** form name**.**
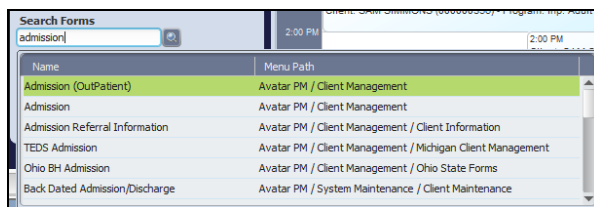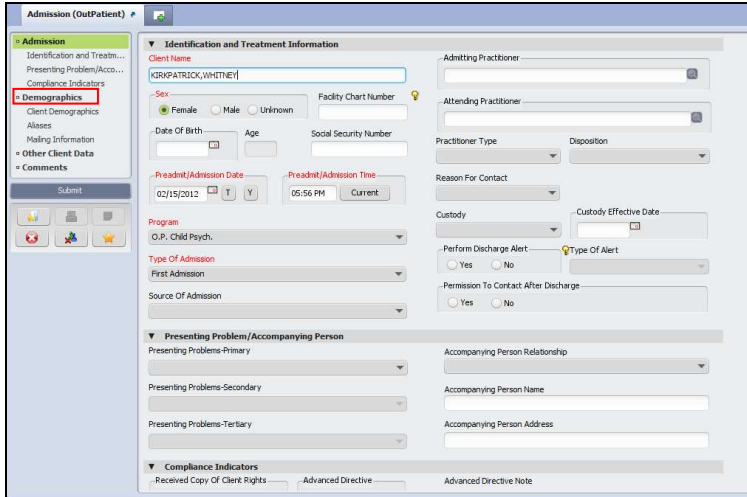

4. The Select Client window will appear.

   Note: Avatar requires that you search for the client you want to complete the admission record for. This ensures that the patient is not already entered into the system to avoid duplicate entries.
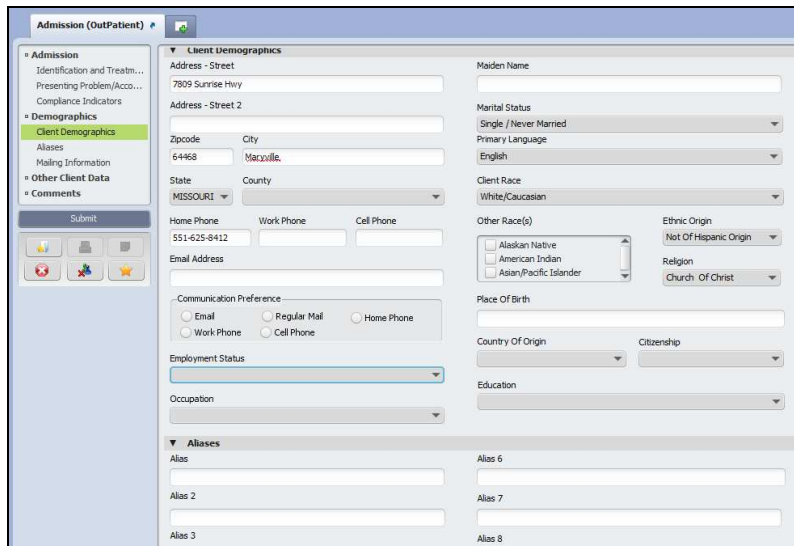
5. Enter a last name and a first name for a client you want to admit into an episode of care in Avatar.

6. Click the **Sex** scroll-down list.

7. Select a sex for your client.

   Note: You must have three fields completed before search button becomes enabled.

8. Click **Search**.

9. Click **New Client**.

10. A message will appear asking if you want to auto assing the next ID number. Click **Yes**.

    If you click **No**, you will need to manually assign a numeric identifier to the client.

11. Write down your client's assigned Avatar ID number & last name: _____

12. The Admission form will open.

13. Enter the date of birth in the **Date of Birth** field. For example: 01/10/1971

14. Hit the **Tab** key.

    *Note: Age will automatically populate in the **Age** field.*

15. Enter a Social Security number in the **Social Security Number** field.

16. Enter the first day of the previous month in the **Preadmit/Admission Date** field.

17. Client **Current** in the Preadmit Admission Time.

18. Click **Program** drop-down list.

19. Select one of the following programs:

O.P. Child Psych

O.P. Mature Adult Psych

O.P. Adult S.A.

20. Click the **Type of Admission** drop-down list.

21. Select **First Admission**.

22. Click on the **Demographics** section in the form tree on the left side of the screen.

23. Enter an address for your client. You may use 111 Center Rd Ann Arbor MI 48105

24. Click **Submit** to complete the form and save your client's admission.

Exercise Recap:

You have now created a new client and placed the client into an outpatient episode in Avatar. Remember your client's name Avatar ID number as you will use it throughout the entire exercise.
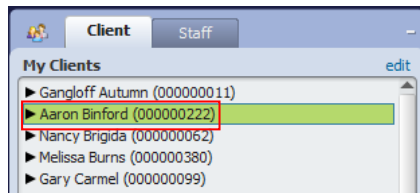
Your client now has the following information saved in Avatar:

✓ Admission Record

Substance Abuse History

Substance Abuse History is utilized to record a client's history of substance abuse.

1. On the Home View, locate the **Client and Staff** widget.

2. Select your client by clicking on the name under **My Clients** to highlight it.

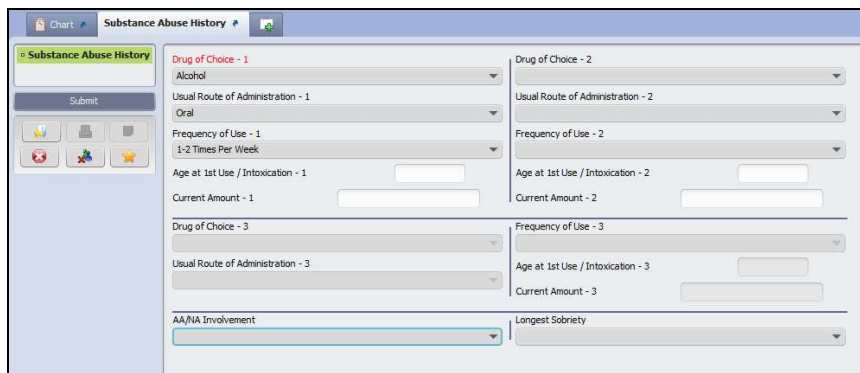3. In the **Forms & Data** widget, click in the Search Forms field.
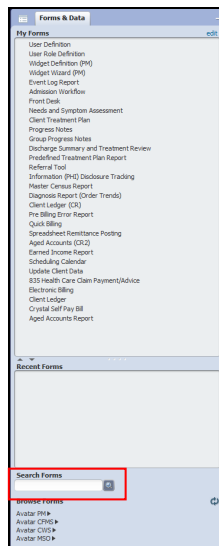
4. Type "Substance Abuse History" in the **Search Forms** field.

5. Select the form by double clicking on it using your mouse or using the arrow key to highlight the form and press enter to select.
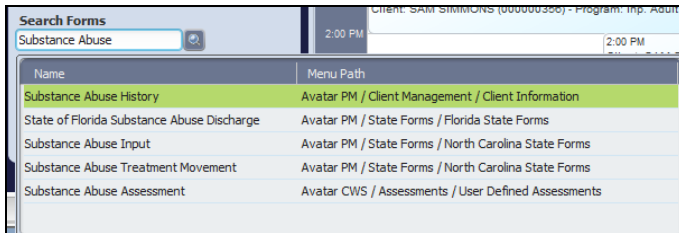
6. The Substance Abuse History form will open.

7. Click the **Drug of Choice – 1** drop-down list.

8. Select **Alcohol**.

9. Click the **Usual Route of Administration – 1** drop-down list.

10. Select **Oral**.

11. Click the **Frequency of Use – 1** drop-down list.

12. Select **1-2 Times Per Week**.

13. Click **Submit** to complete the form.

Exercise Recap:

You have now created documented substance abuse history for your new client you created.
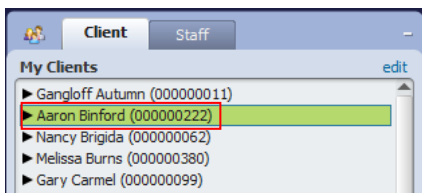
Your client now has the following information saved in Avatar:

- ✓ Admission Record

- ✓ Substance Abuse History

Mental Status Assessment

Mental Status Assessment records the presence and extent of a client's mental impairment.

1. On the Home View, locate the **Client and Staff** widget. Double click the name of a client under **My Clients** to launch the client's chart view.

2. The client's chart overview will open. Here you can view the client's problems, vital signs, and episodes. It also displays the user's To-Do's for that client.

3. On the left side of the chart is the Chart Overview. The Chart Overview contains links to frequently used forms for a user's workflow.


4. Click **Mental Status Assessment** link in the chart overview on the left side of the chart screen in the Chart Inquiry view.

5. To navigate to the Mental Status Assessment form, click **Add** in the Chart Inquiry view by clicking the green plus button.
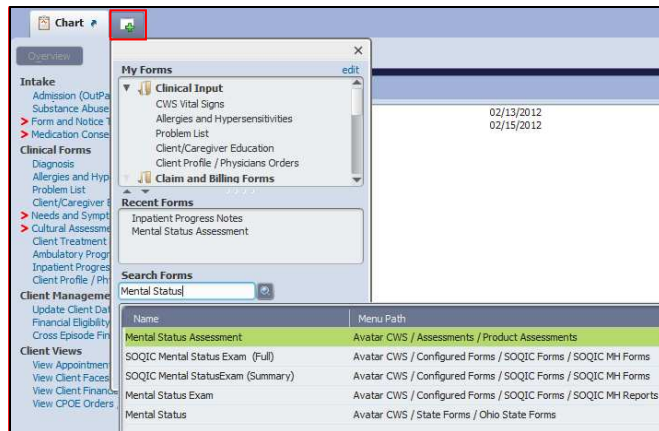
Comment [LM1]:

6. Type "Mental Status Assessment" in the **Search Forms** field. Double click **Mental Status Assessment**.

7. The Mental Status Assessment form will open.
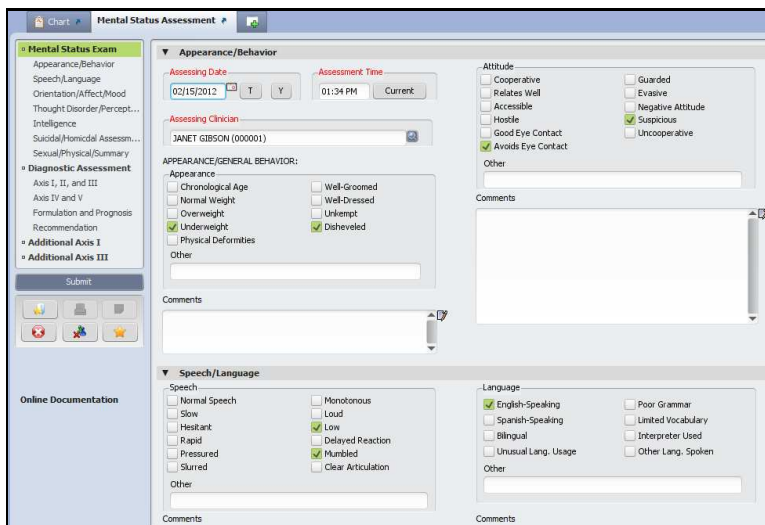
8. Click the **T (Today)** button in the **Assessing Date** field.

9. Click the **Current** button in the **Assessing Time** field.

10. Type "Gibson" in the **Assessing Clinician** field.

11. Select Janet Gibson.

12. Complete the Mental Status Exam.

13. Click **Submit** to complete the form.

Exercise Recap:

You have now completed a mental status exam for your new client that you created.

Your client now has the following information saved in Avatar:

- ✓ Admission Record

- ✓ Substance Abuse History

- ✓ Mental Status Assessment

Client Treatment Plan

The Client Treatment Plan in Avatar is used to capture your client's treatment goals while receiving services from your organization. This treatment plan is customizable to fit your organization's needs.

1. On the Home View, locate the **Client and Staff** widget. Double click the name of a client under **My Clients** to launch the client's chart view.
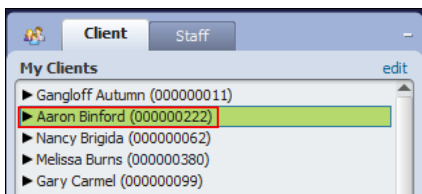

2. The client's chart overview will open. Here you can view the client's problems, vital signs, and episodes. It also displays the user's To-Do's for that client.

3. On the left side of the chart is the Chart Overview. The Chart Overview contains links to frequently used forms for a user's workflow.
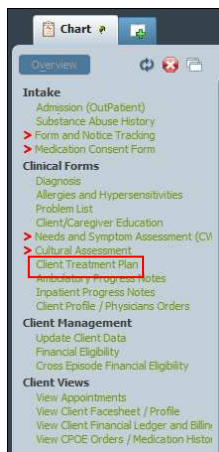
4. Click **Client Treatment Plan** link in the chart overview on the left side of the chart screen in the Chart Inquiry view.
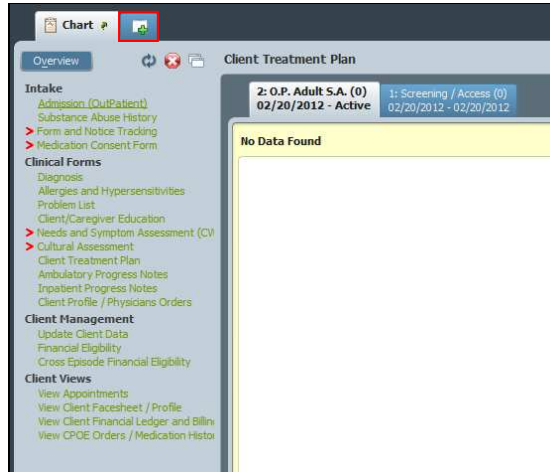
5. To navigate to the Treatment Plan form, click **Add** in the Chart Inquiry view by clicking the green plus button.
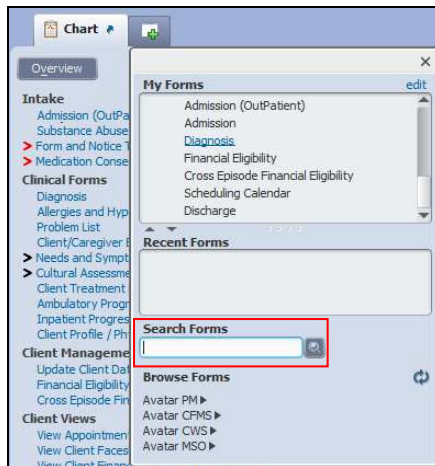

6. Click **Client Treatment Plan** or type "Client Treatment Plan" in the **Search Forms** field.

7. Double-click **Client Treatment Plan**.

8. Avatar will ask you if you "want to default plan information from a previously entered plan". This means that if your client has already at least one treatment plan on file the system can automatically pull the information from the previously entered treatment plan and use it as a base for the new treatment plan you are creating. For the purpose of this exercise, we will create a new treatment plan.

9. Click on the **No** button to open the **Client Treatment Plan** form.
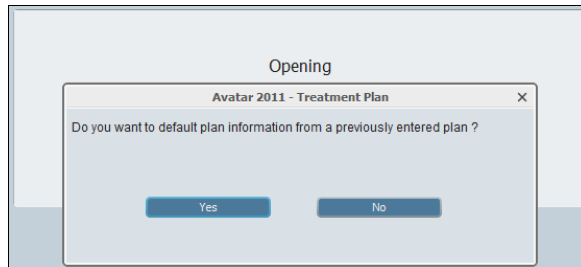

10. The **Client Treatment Plan** form has six sections. Every section builds upon the one before. It means that Avatar will not display values when you to go to the next section until the required values of the previous section have been entered.
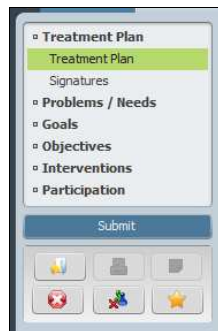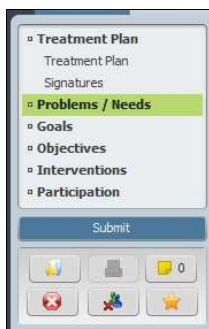

Treatment Plan

11. Please enter the following values into the Treatment Plan section:

   For the **Plan Date** field type in **t-30**. The system will subtract 30 days from today's date and input that date.

12. Select **Initial (within 30 days)** as the value for the **Plan Type** drop-down menu. Finally choose a **Plan Name** for your treatment plan.
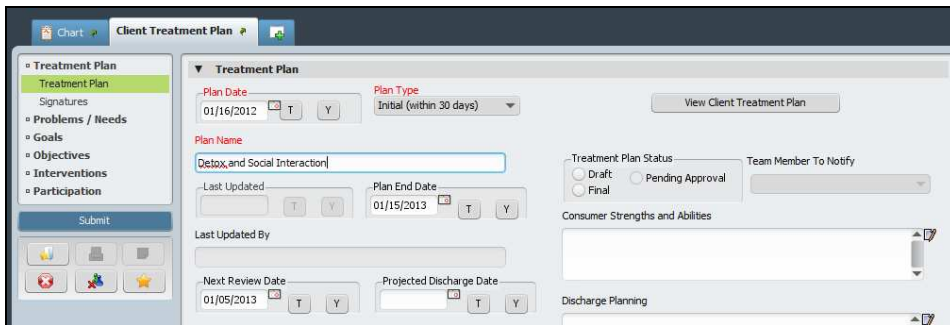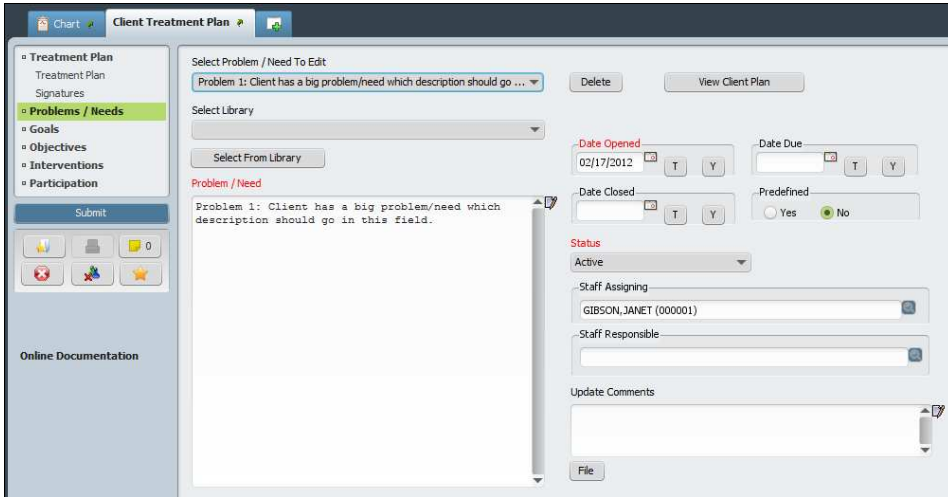
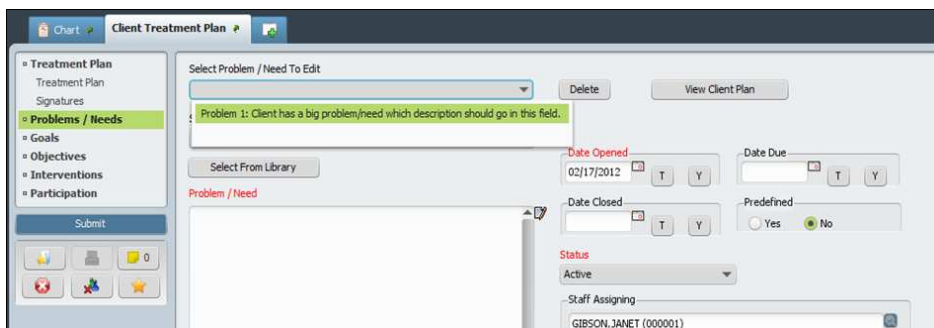13. Click on the **Problems/Needs** section.

Problems/Needs section.

14. This section will hold all the problems that this treatment plan addresses. There are three required fields: **Problem/Need**, **Date Opened**, and **Status**.
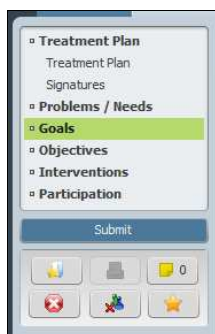
15. Enter your client's problem into the **Problem/Need** field

16. Enter the date the problem was 'opened' or the date you'd like to note that that client will start working on it. Click **T** to enter today's date.

17. Enter the **Status** of the problem. Select **Active** from the drop down.

18. Once you have finished typing in the problem or need and the required dates have valid values typed in DO NOT SUBMIT.

    Don't click on the **Submit** button on the left side but click on the **File** button [File] on the bottom right corner to file the problem in the treatment plan to save the information in the Problem section of the plan. You must save the information now so it feeds into the next section of the plan- Goals.

19. Once you've saved the Problem by clicking **File**, the Problem is now available to you in the Problem drop down field.

20. Click on the **Goals** section.

Comment [LM2]: For Goals, Objectives, and Interventions repeat the edits made in Problems for each section.

21. This section will hold all the goals for the treatment plan. Most of the required fields are already populated; however you still need to type in a description in the **Goal** field. Notice that the problem you just created in the **Problems/Needs** section has been already selected. Every goal needs to be linked to a problem.
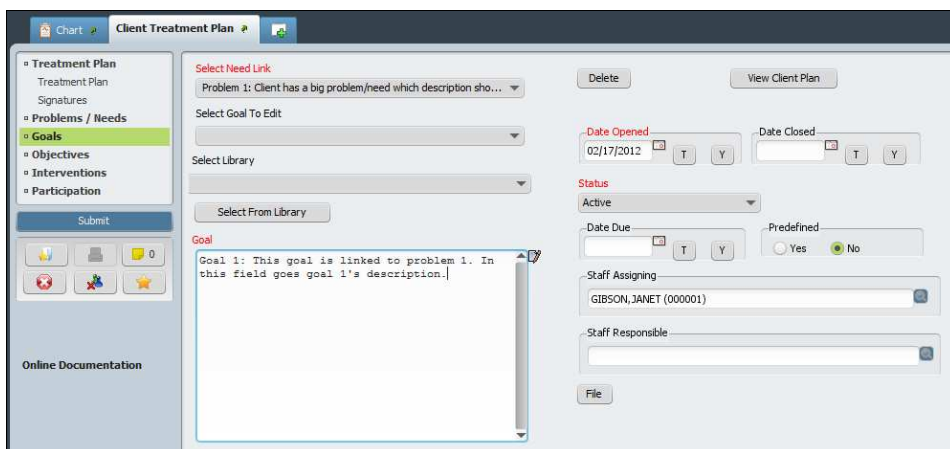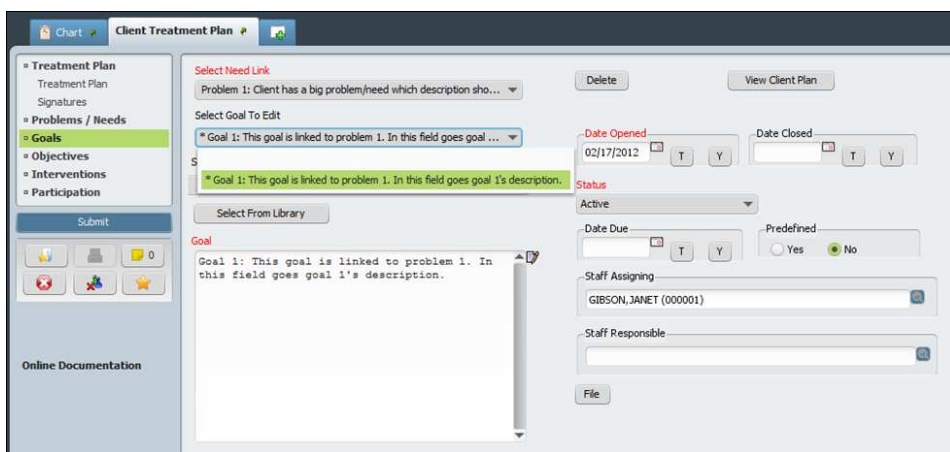

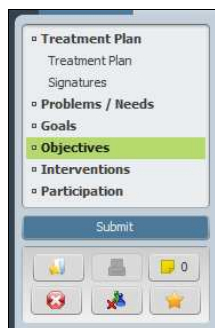22. Enter your client's goal into the **Goal** field.

23. Enter the date the goal was 'opened' or the date you'd like to note that that client will start working on it. Click **T** to enter today's date.

24. Enter the **Status** of the goal. Select **Active** from the drop down.

25. Once you have finished typing in the goal and the required dates have valid values typed in <u>DO NOT SUBMIT</u>. Don't click on the **Submit** button on the left side but click on the **File** button [File] on the bottom right corner to file the goal in the treatment plan to save the information in the Goal section of the plan. You must save the information now so it feeds into the next section of the plan- Objectives.

26. Once you've saved the Goal by clicking **File**, the goal is now available to you in the **Select Goal To Edit** drop down field.
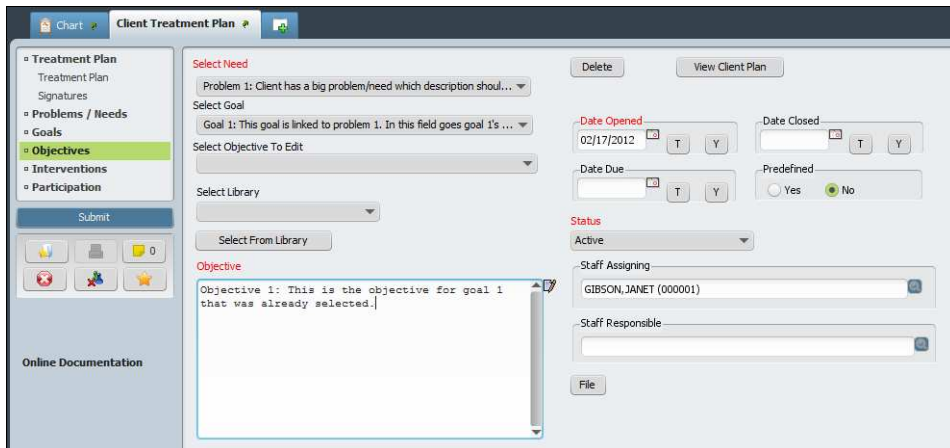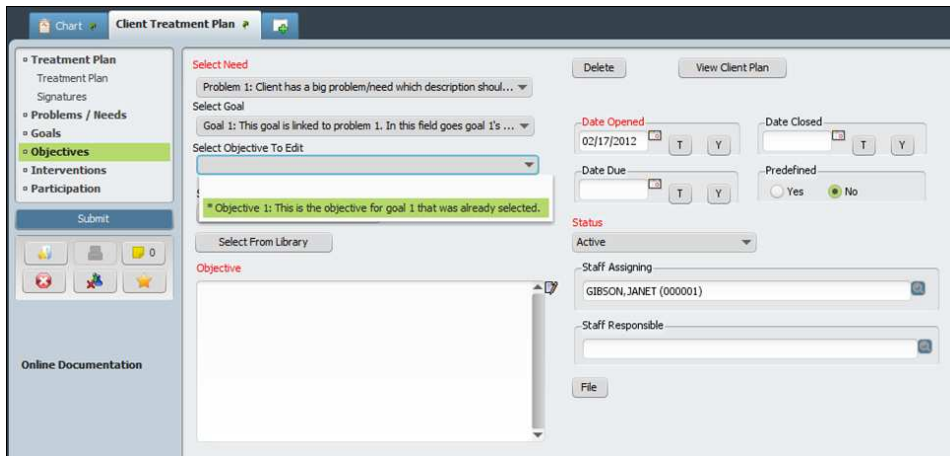

27. Go to the **Objectives** section.

Objectives section.

28. This section will hold all the objectives for the treatment plan. Most of the required fields are already populated; however you still need to type in a description in the **Objective** field. Notice that the problem and the goal you just created in the previous sections have been already selected. Every objective needs to be linked to a goal which needs to be linked to a problem.

29. Enter your client's objective into the **Objective** field.

30. Enter the date the objective was 'opened' or the date you'd like to note that that client will start working on it. Click **T** to enter today's date.

31. Enter the **Status** of the objective. Select **Active** from the drop down.

32. Once you have finished typing in the objective and the required dates have valid values typed in DO NOT SUBMIT. Don't click on the **Submit** button on the left side but click on the **File** button [File] on the bottom right corner to file the objective in the treatment plan to save the information in the Objectives section of the plan You must save the information now so it feeds into the next section of the plan- Interventions.

33. Once you've saved the Objective by clicking **File**, the Objective is now available to you in the **Select Objective To Edit** drop down field.
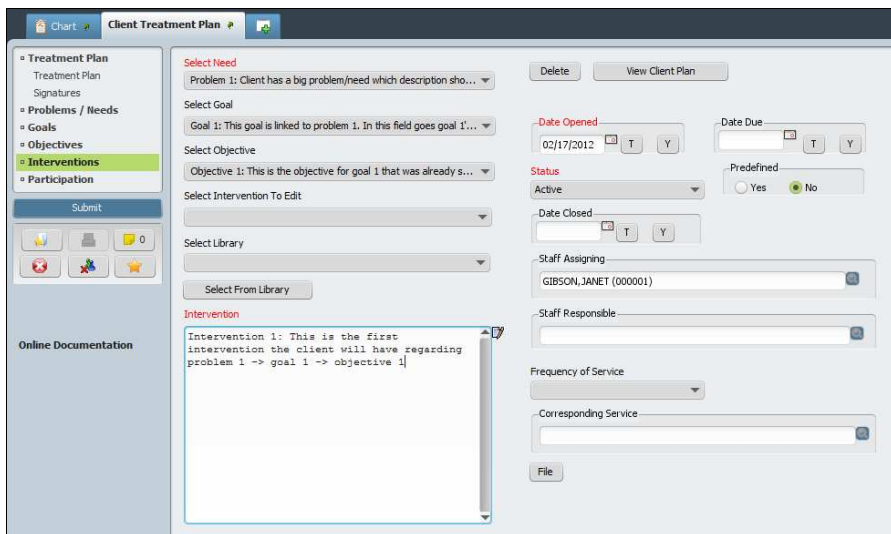
34. Click on the **Interventions** section.

Interventions section.

35. This section will hold all the interventions for the treatment plan. Most of the required fields are already populated; however you still need to type in a description in the **Intervention** field. Notice that the problem, the goal and the objective you just created in the previous sections have been already selected. Every intervention needs to be linked to an objective which is linked to a goal which needs to be linked to a problem.

![Netsmart logo]

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36. Enter your client's intervention into **Intervention** field.

37. Enter the date the intervention was 'opened' or the date you'd like to note that that client will start working on it. Click **T** to enter today's date.

38. Enter the **Status** of the intervention. Select **Active** from the drop down.

39. Once you have finished typing in the intervention and the required dates have valid values typed in <u>DO NOT SUBMIT</u>. Don't click on the **Submit** button on the left side but click on the **File** button [File] on the bottom right corner to file the intervention in the treatment plan to save the information in the Intervention section of the plan.

40. Once you've saved the Interventions by clicking **File**, the Intervention is now available to you in the Intervention drop down field.
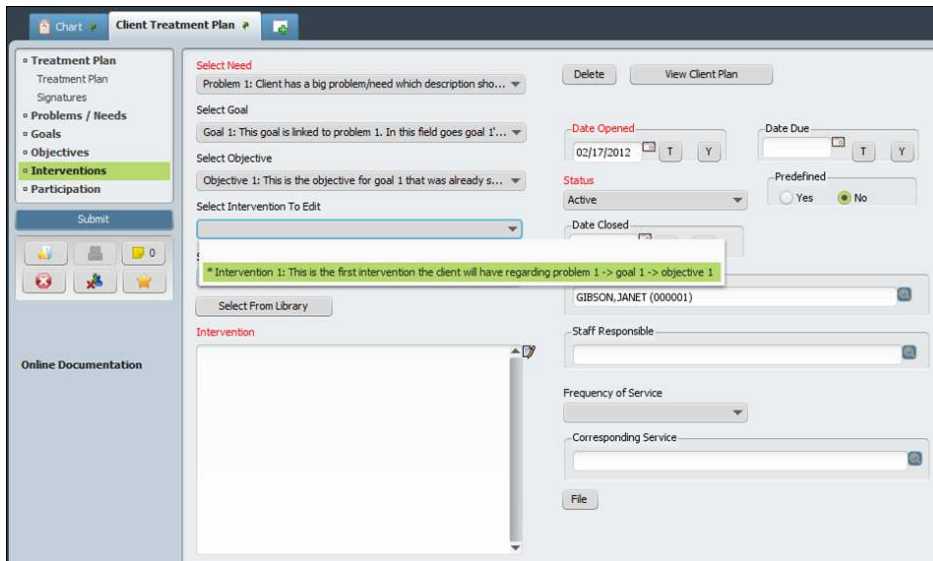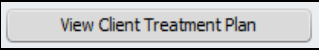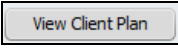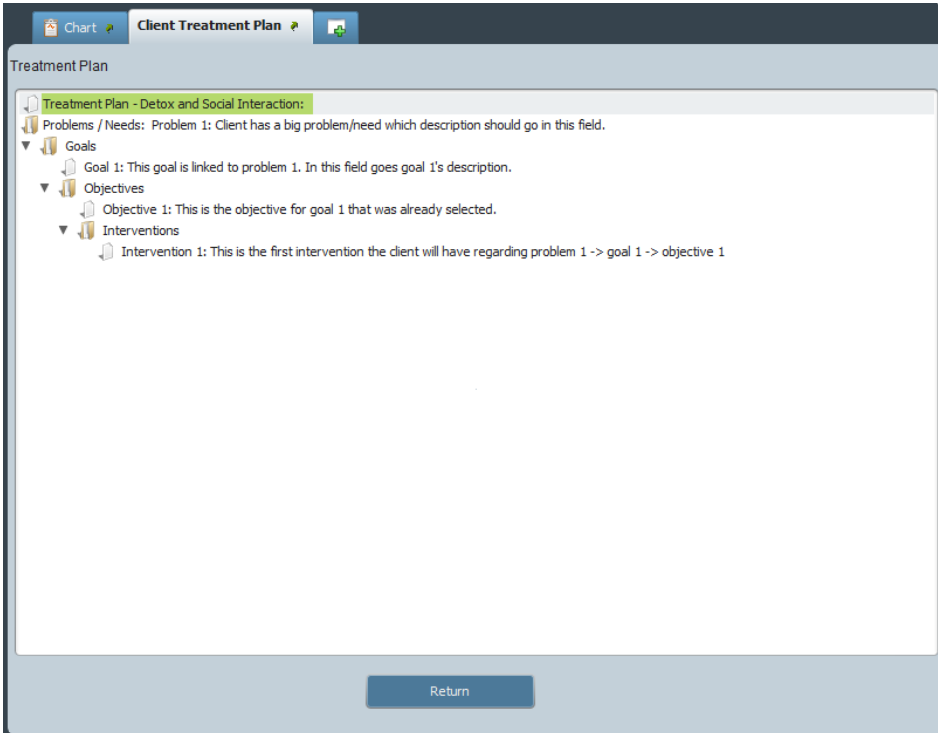
41. Click on the **Participation** section.
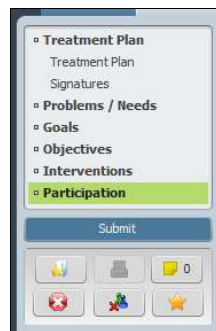
Participation section.

42. This section will hold all the participants involved in the client's treatment plan. To add participants to the treatment plan just select the person's **Role** and type in the person's **Name**.
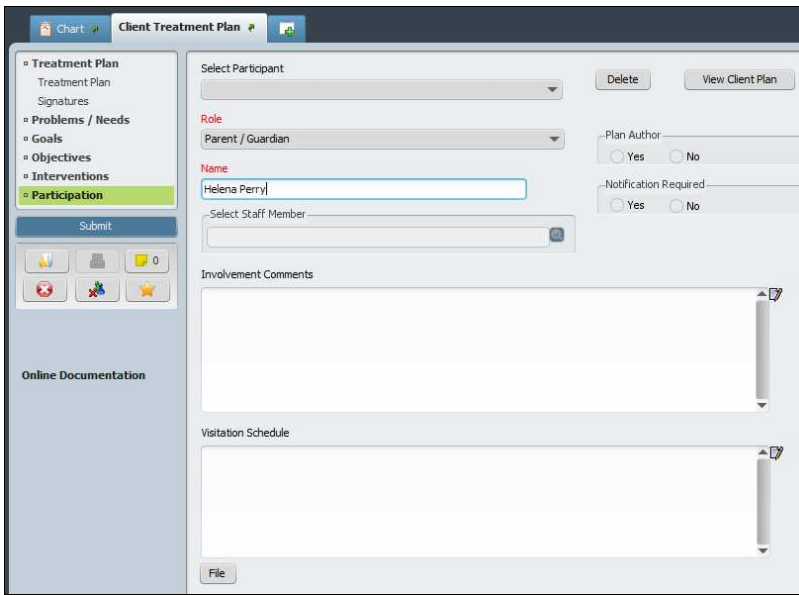
43. Once you have finished typing in the participant's information <u>DO NOT SUBMIT</u>. Don't click on the **Submit** button on the left side, but click on the **File** button ![File] on the bottom right corner to file the participant in the treatment plan.

44. At this point in the process you can click on the **View Client Treatment Plan** ![View Client Treatment Plan] or **View Client Plan** ![View Client Plan] button to view the entire treatment plan.

45. Click on the **Return** button to go back to the **Client Treatment Plan** form.

46. The Treatment Plan is now complete.

47. Click on the **Submit** button [Submit] to save and return to your **Home View** Screen.

Exercise Recap:

You have now created a treatment plan methodology for your new client, establishing problems, goals, objectives, and interventions.
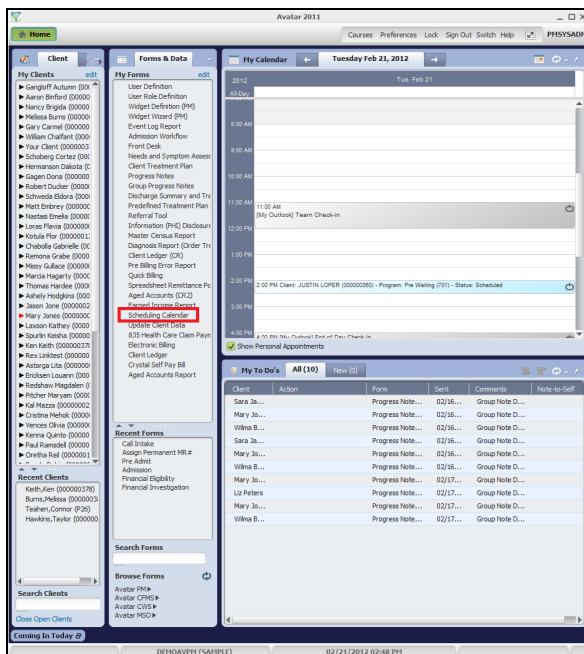
Your client now has the following information saved in Avatar:

✓ Admission Record

✓ Substance Abuse History

✓ Mental Status Assessment

✓ Treatment Plan

Intern Guide

Scheduling Calendar

Scheduling Calendar gives the user the ability to manage appointments at multiple sites for staff members, clients, and groups. In the Scheduling Calendar, you can create appointments, check clients in and out for their appointments, and set up individual appointments or group appointments. You can also assign multiple practitioners to an appointment.

1. Click on **Scheduling Calendar** under My Forms, in the Forms & Data widget on the Home View.

2. The Scheduling calendar will open.

Exercise Recap:

You have now navigated to the Scheduling Calendar. In the next exercise, you will schedule an appointment for your client.

Your client now has the following information saved in Avatar:

✓   Admission Record

✓   Substance Abuse History

✓   Mental Status Assessment

✓   Treatment Plan
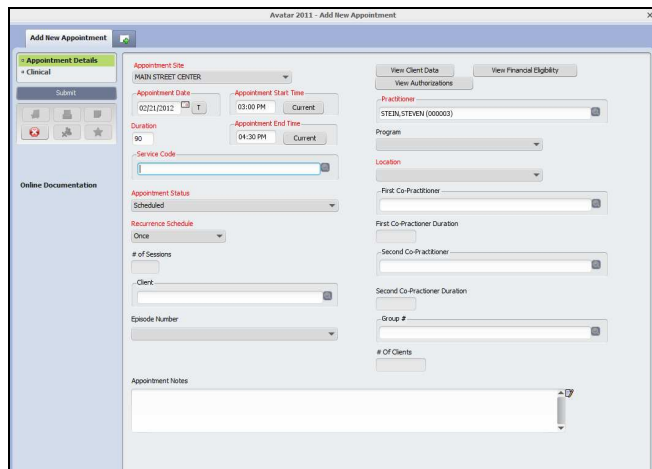
Scheduling an Individual Appointment

1. You are going to add a new appointment on today's date for clinician Steven Stein. Select Steven's name in the Clinician list on the left side of the Scheduling Calendar.
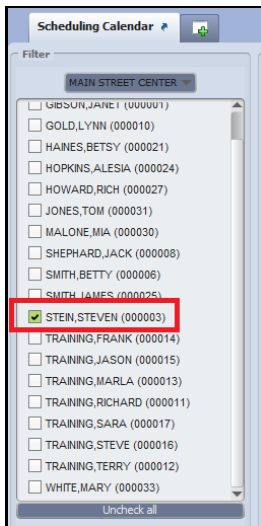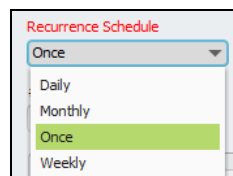

2. Click on the calendar at the desired appointment time.
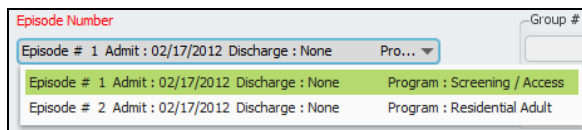3. Drag the mouse to the desired end time. A gray box will appear.
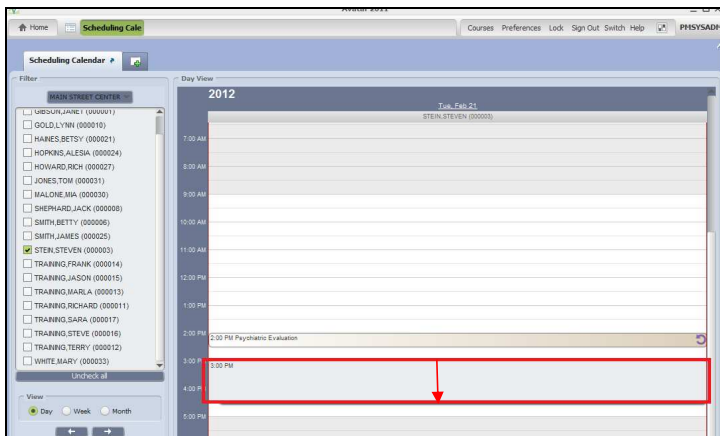
4. Right Click on the appointment and select **Add Appointment.**

5. The Add New Appointment form will open.

6. Type "**1000**" in the service code field.

7. Click the **Recurrence Schedule** drop-down menu.

8. Select **Once.**

9. Type your client's last name in the **Client** search field.

10. Click the **Episode Number** drop-down menu.

11. Select Episode 1.

12. All other required fields will be automatically populated.

13. Click the **Submit** button on the left side of the screen to save your appointment information.

Exercise Recap:

You have now scheduled an appointment for your new client you created.

Your client now has the following information saved in Avatar:

- ✓ Admission Record

- ✓ Substance Abuse History

- ✓ Mental Status Assessment

- ✓ Treatment Plan

- ✓ Scheduled Appointment

Ambulatory Progress Notes

Progress Notes are utilized to evaluate a client's treatment goals and their use of treatment services, to help determine the current and future needs for a client's treatment. They are included in the client's chart, and are used for medical, legal, and billing purposes.

1. On the Home View, locate the **Client and Staff** widget.

2. Double click the name of your client under the **My Clients** widget to launch the client's chart view.
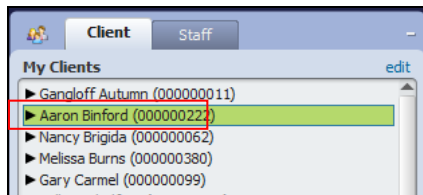

3. The client's chart overview will open. Here you can view the client's problems, vital signs, and episodes. It also displays the user's To-Do's for that client.

4. On the left side of the chart is the Chart Overview. The Chart Overview contains links to frequently used forms for a user's workflow.
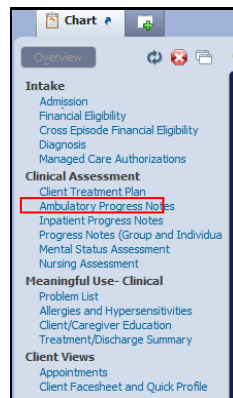
5. Click **Ambulatory Progress Notes** link in the chart overview on the left side of the chart screen in the Chart Inquiry view.
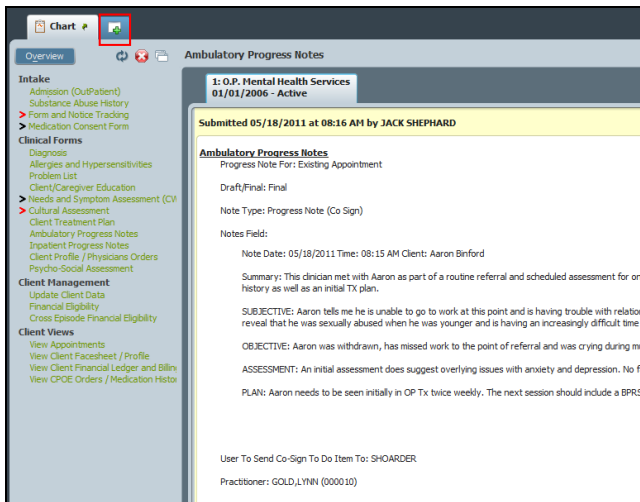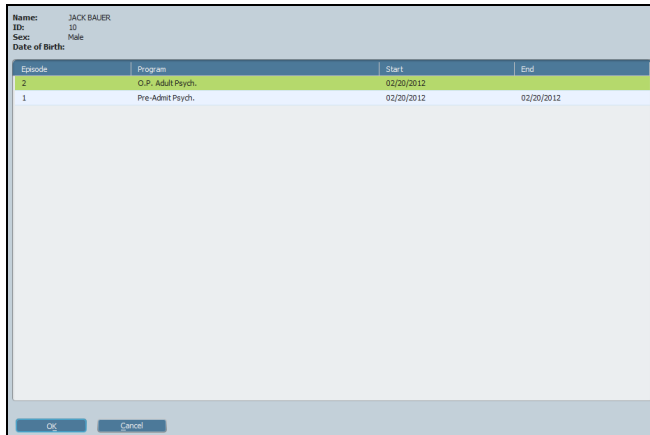
6. To navigate to the Ambulatory Progress Notes form, click **Add** in the Chart Inquiry view by clicking the green plus button.
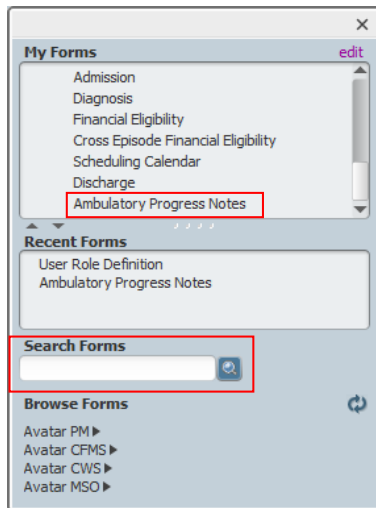
7. Click **Ambulatory Progress Notes** or type "Ambulatory Progress Notes" in the **Search Forms** field.
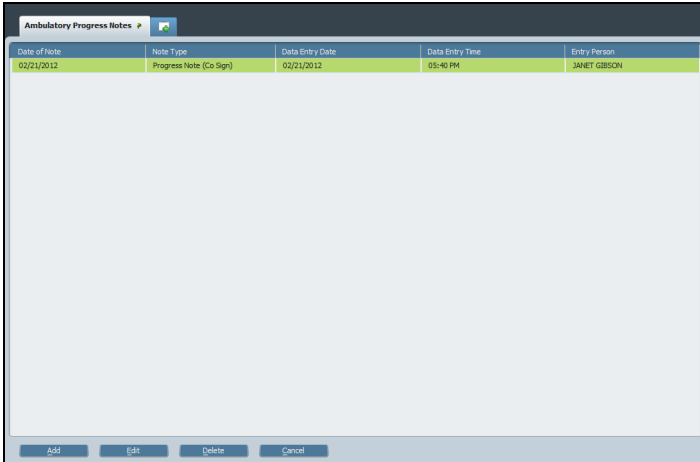
8. If a previous episode is available, the Episode Selection pre-display screen will appear. If not, skip steps 8 & 9 and continue at step #10.

9. Make sure the most recent Episode is selected, in this case with a Program of **O.P. Adult Psych**.

10. Click the **OK** button at the bottom of the screen.

Name:	JACK BAUER		
ID:	10		
Sex:	Male		
Date of Birth:			

Episode	Program	Start	End
2	O.P. Adult Psych.	02/20/2012	
1	Pre-Admit Psych.	02/20/2012	02/20/2012

OK   Cancel

11. The Note Selection pre-display screen will open. If it doesn't open, bypass steps 1 & 12 and proceed to step #13.

12. Make sure the most recent Note is selected, in this case there is only one, highlight it.
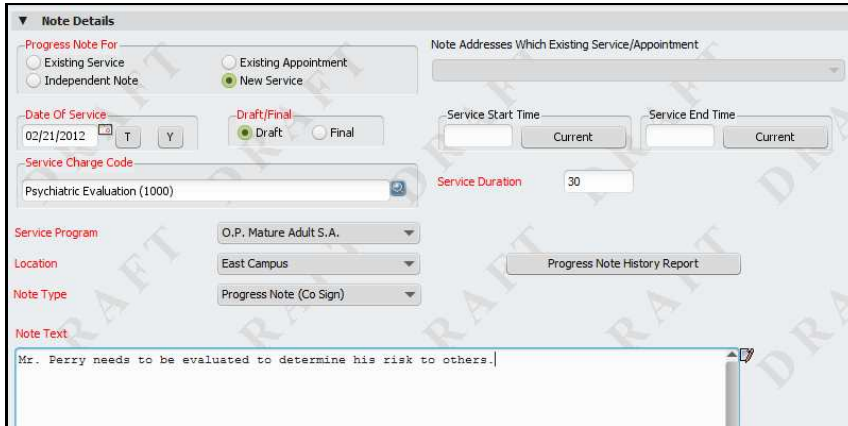
13. Click the **Edit** button at the bottom of the screen.

14. The Individual Progress Notes form will open.

15. Click the **New Service** radio button in the Progress Note For field.

16. Select "T" for today in the **Date of Service** field.

17. Click the **Draft** radio button in the Draft/Final field.

18. Click the **Note Type** drop-down list. Select **Progress Note (Co Sign)**.

19. Type "30" in the **Service Duration** field.

20. Type "1000" in the **Service Charge Code** field. Select **Psychiatric Evaluation (1000).**

21. Click the **Service Program** drop-down list. Select **O.P. Mature Adult S.A.**

22. Click the **Location** drop-down list. Select **East Campus**.

23. Select a Practitioner by typing in the practitioner's last name into the field – in this example we will use Janet Gibson.
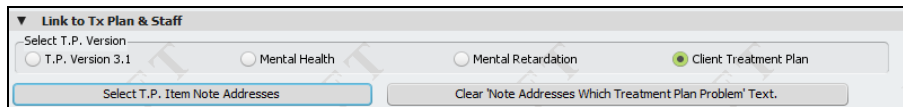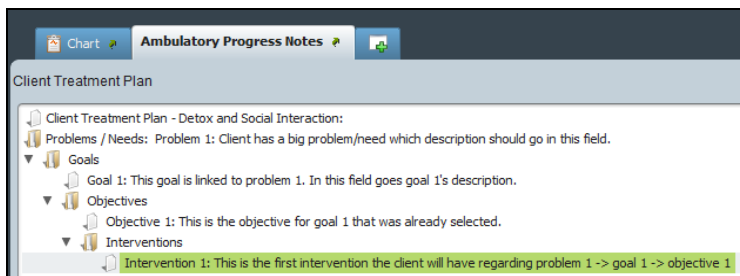

24. Put any notes necessary into the Notes Field.

![Netsmart]

Intern Guide

25. Select the **Client Treatment Plan** radio button in the "Select T.P. Version" field.

26. Click the **Select T.P. Item Note Addresses** button. A new window will open with the Treatment Plan Tree.

27. Select the lowest choice, in this example **Intervention 1**. Then click the **Return** button at the bottom to return to the form.

28. Information will have now filled the "Note Addresses Which Treatment Plan Problem" field.

Note Addresses Which Treatment Plan Problem

```
Problems / Needs->  Problem 1: Client has a big problem/need which description should go in
this field.
Goals->  Goal 1: This goal is linked to problem 1. In this field goes goal 1's description.
Objectives->  Objective 1: This is the objective for goal 1 that was already selected.
Interventions->  Intervention 1: This is the first intervention the client will have regarding
problem 1 -> goal 1 -> objective 1
```

29. Click the **Submit** button on under the form tree on the left side of the screen.

Submit

Exercise Recap:

You have now evaluated a client's treatment plan and recorded an ambulatory progress note for your client.

Your client now has the following information saved in Avatar:

- ✓ Admission Record

- ✓ Substance Abuse History

- ✓ Mental Status Assessment

- ✓ Treatment Plan

- ✓ Scheduled Appointment

- ✓ Ambulatory Progress Notes

SANDBOX NOTES