



Avatar Client Plan Tip Sheet

This Tip Sheet may change as our trainings and systems are updated. Please visit our website <u>https://dhs.saccounty.gov/BHS/Avatar/Pages/Avatar.aspx</u> for the most updated version. If any additional help is needed you can contact us at <u>Avatar@saccounty.net</u>.

This guide is designed to be a tool to help users navigate through the newly designed Client Plan form in Avatar. For any questions regarding documentation requirements when filling out this form please contact <u>QMInformation@saccounty.net</u>.

CLIENT PLAN					Submit	Discard	Add to Favorites
Client Plan Plan Participants Signatures	Plan Date *			Last Updated			
Online Documentation	Plan Name *			Last Updated By			00;
	Plan End Date		• • • • •	Next Review Date			00:
	Plan Type * Select	* 🗸		Treatment Plan Status	Pending Approval		
				C Final	C. Lanad Address		
	✓ Plan Participants						

- 1. Enter your Plan Date. Once you enter in a plan date the End Date and Next Review Date will automatically populate. The Plan End Date will default to one year from your Plan Date and the Next Review Date will default to 45 days before the Plan End Date.
- 2. Enter a Plan Name and choose a plan type.
- 3. Choose your Treatment Plan Status. This should remain in Draft until it is completed, then it can be switched to Final or Pending Approval if you require a Co-signature.
- 4. Click on the Launch Plan button. Steps 1-3 must be completed before you are able to choose Launch Plan.





CLIENT PLAN FORM: TEST, LENORE (78847	5547)
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	Return to Plan Return to Home View

5. Click on Add New Problem

CLIENT PLAN FORM: TEST, LENORE (78847554	47)			
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Housing Plan Library Nursing Care Plans				
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6. The Select Problem to Edit drop-down will be blank unless a problem was added in the CORE assessment. If you are choosing an existing problem select that problem from the drop-down. If it is a new problem select the blank line.





7. Under the SNOMED ICD type in the SNOMED ICD code you are addressing. The field is a look up field so options will populate as you enter in data. For example, if you type "Anxiety" into the field, all codes that include the word Anxiety will populate. The more detailed of a search you enter the more narrow your search results will be. If you type in the ICD 10 code, it will crosswalk to the SNOMED code. Please note once the plan has been submitted in either Draft or Final status the SNOMED code cannot be changed.

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1043912!!66077) Anx SNOMED-52910006)	kiety disorder due to multiple medical problems	
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- 8. The Date of Onset field is not required, however you are able to enter a date if applicable.
- 9. Under the Problem field address your client's reason for service. Make sure your reason for service meets all documentation requirements per Quality Management.
- 10. Enter the Status of the plan under Status and Status (SNOMED ICD). The Status (SNOMED ICD) has only one choice available, Active status.
- 11. Enter the Date Opened. The Date Due and Date Closed are not required.
- 12. Enter the Staff Responsible, Staff Assigning, and Non-Staff Responsible Party.
- 13. Indicate the Functional Area/Life Domain for this reason for service.
- 14. Enter the Clients Reason for Services in Their Own Words. This field is not marked red and required to save the form, however; it is required per QM's documentation requirements.
- 15. Indicate all Sources of Information that apply for this reason for service.
- 16. Once you have completed this section click on Add New Goal. See screen shot below. It is important that you enter each piece in order. For example, you would want to enter your goal before your objectives and interventions, that way they are linked to the goal.





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	Problem		
	Enter reason for services		

- 17. Enter the client's Goal, make sure to follow all documentation guidelines per Quality Management.
- 18. The Date Opened will populate based on what you entered in the previous screen.
- 19. Due Date and Date closed are not required.
- 20. The Staff Assigning will automatically populate to your name. Enter the staff responsible in the Staff Responsible field, this may be you or may be a supervisor.
- 21. Enter the client's Strengths and Barriers to Recovery and Client's Goals in Their Own Words. These fields are not marked red and required to save the form, however; they are required per QM's documentation requirements.





The screen shot below shows the Goal Section. Once you have entered your Goal click on Add New Objective.

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- 22. Enter the client's Objective make sure to follow all documentation guidelines per Quality Management.
- 23. The Date, Status, and Staff fields are the same fields that are found in the Goals section.
- 24. Enter the Client's Objectives in their own words. This section is not red and required to save the form, however; it is required per QM's documentation requirements.
- 25. Additional Objectives can be added to your goal. To do this you would click on your Objective in the display above and then click on Add New Objective once you have completed the Interventions for the first Objective.

Filters	A Client Plan: LENORE TEST
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	 Intervention
	+ Intervention #1
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 Nursing Care Plans 	∓ Intervention #3
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- 26. Click Add New Intervention to add an Intervention to your Objective.
- 27. Enter the Intervention make sure to follow all documentation guidelines per Quality Management.





- 28. Indicate the Type of Intervention
- 29. Enter the Duration and Frequency of the Intervention.
- 30. Additional Interventions can be added to your objective. To do this you would click on Add New Intervention once you have completed your first Intervention.
- 31. Additional Goals can be added to your Reasons for Services. After entering the Objective and Intervention you can click on your Reasons for Services at the top of the plan and then click Add New Goal.

CLIENT PLAN FORM: TEST, LENORE (788	475547)		
Filters Age Group Gender Selected Programs Search Housing Plan Library Nursing Care Plans			
	Wrap Text Add flow Problem Select Problem To Edit Select a value SNOMED ICD (1001522!!66077) Anxiety with depression (SNOMED 231504006)	Add New Coal Add New Objective Add New Intervention Delete :	Selected Item

A New Goal section will be added to your Plan. You are able to follow those same steps to add additional Objectives or Interventions.

32. The same process is done if a new reason for service needs to be added. Click on the Client Plan name on the top of your plan and then click Add New Problem.

CLIENT PLAN FORM: TEST, LENORE (78847)	5547)
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Housing Pan Library Nursing Care Plans	Wrap Text Add New Proble Add New Coal Add New Objective Add New Intervention Delote Selected Texes





33. If at any point a section needs to be removed you can highlight the section above and then click on the Delete Selected Item button. Please note if a section needs to be deleted it has be deleted from the bottom up. For example, if a Goal needs to be deleted you would need to first delete the Intervention, then the Objective, and finally the Goal.

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34. Each time you add a new item red flags will appear at the top until you have entered all red and required fields for that item.

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	Type of Intervention		6	Frequency of Intervention		
	Select a value					

35. Once all of the red and required fields in that section have been completed the red flags will go away.





Filters	A Client Plan: LENORE TEST J. Problem: Enter reason for services		Í
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Gender	This is where the Goal is written		
Selected Programs	Objective		
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		Return to	Plan Return to Home View
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36. Once you have completed your client plan click the Back to Plan Page button on the bottom right of the page. On the Plan Page enter in your Plan Participants.

Plan Participants Client Treatment Plan x x Client Treatment Plan x x Client Treatment Plan x x x Client Treatment Plan x <t< th=""><th>lient Plan</th><th>Plan Type *</th><th></th><th>Treatment Plan Status</th><th>•</th><th></th></t<>	lient Plan	Plan Type *		Treatment Plan Status	•	
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Index Role = Staff ID = Participant Name = Plan Author = Notification = Is a Release on File =						
		Plan Participants				

- 37. Double click on the Role field and choose the participant role.
- 38. Double click on Staff ID and enter the staff ID of the participant if the participant is a staff member or enter last name, first name (no spaces) and tab or hit Enter to populate the field.
- 39. Double click on Participant Name and type in the participants name into the text box. Click Ok. If the participant is a staff member this will automatically populate based on what you entered into Staff ID.





- 40. Double click on the Plan Author field and indicate whether the participant is the plan author by selecting Yes or No.
- 41. Double click on Notification and indicate whether this participant should be notified on the Next Review Date by selecting Yes or No.
- 42. Double click on Is a Release on File and indicate whether a release of information is on file for this participant by selecting Yes or No.
- 43. To add a new participant click New Row below the table.

CLIENT PLAN						Draft	Submit	Discard	Add to Favorites
Client Plan Pian Participants Signatures Online Documentation	Plan Typ Client	e * reatment Plan	x v		Treatment Plan S Draft Final Launch Plan		nding Approval		
	V Plan Pa	ticipants							
	Index	Role Staff Member - Internal	Staff ID ¢ TRAINER,NINE (015252)	Participant Name TRAINER,NINE	Plan Author (Yes (Y)		Notification ©	Is a Release on Fil No (2)	e o
		w Row Delete Row	•						•

- 44. Scroll down the page and enter the client's Discharge Planning.
- 45. At the very bottom of the page you will sign the plan, and have the client, and caregiver if applicable sign the plan, click on the Signature button to open the signature box. If they are not able to sign the plan choose a reason from the drop-down. If you choose Other, the Reason-Other box will become enabled. The client signatures should be completed after the client plan has been completed.
- 46. The client should be offered a copy of the Client Plan. Indicate the date a copy was offered and indicate whether the client accepted it.



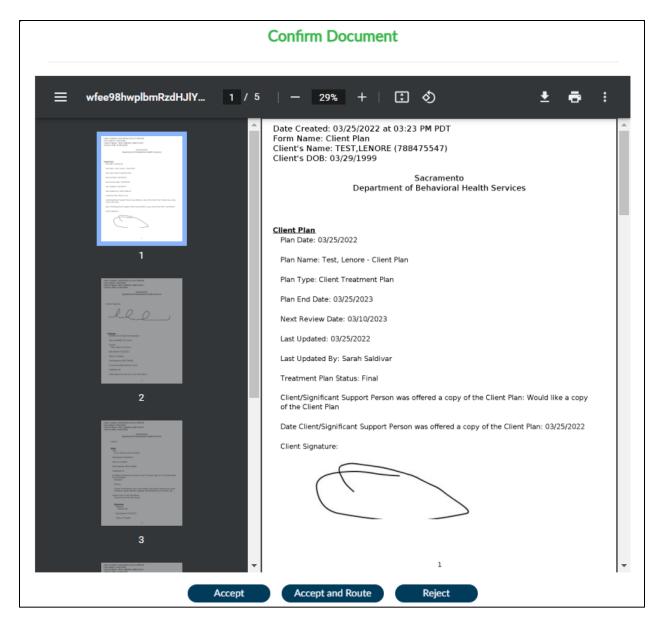


CLIENT PLAN		/ Draft	Submit	Discard Add to Favorites
Client Plan Plan Participants	✓ Signatures			
Signatures				
Online Documentation	Client/Significant Support Person was offered a copy of the Client Plan * O Would like a copy of the Client Plan O Declines a copy of the Client Plan	Date Plan was Offered *		• • • • • • • • • • • • • • • • • • •
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	Signature 1		Signature 3	
	Reason No Client Signature was Collected Select. × ×	Reason No Caregiver Signature was Select	s Collected	
	Reason - Other	Reason - Other		
	Clinician Signature			
	Signature 2			

- 47. Once the plan has been completed, scroll back up to the top of the page, change the status from Draft to Final. Submit to save.
- 48. If you require a co-signer you will be prompted to Accept and Route your plan once you click Submit. You can review your plan from this screen. If you wish to send it to your supervisor click Accept and Route, if you wish to make any changes click Reject and it will take you back to the Client Plan.







49. A box will appear which will allow you to choose who to route the document to. Click on the Supervisor field and enter your supervisor's last name. Single click on their name on the drop-down.





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THREE TRAINER (010561)		
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50. Click the Add button below the supervisor's name. This will drop them down to the Approver box. Click Submit to route the document to your supervisor.

Add Approver
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Supervisor (018558)