Avatar User Guide:
Adult/Older Adult MH Treatment Plan of Care

February 11, 2016
Overview

• **Purpose:** The purpose of the manual is to walk you through the new Adult/Older Treatment Plan of Care in the Avatar EHR System.

• **Rational:** The reason for moving to a new version of the treatment plan is to bring us into alignment with optimizing our use of electronic records with a focus on being able to use standardized fields in order to communicate in a meaningful way across our system.

• **Menu Path:** Avatar CWS>Treatment Planning>*Adult/Older Adult MH Treatment Plan of Care*
Starting the Adult/Older Adult MH Treatment Plan of Care

Plan Effective Date: 05/15/2015
Plan End Date: 5/15/16
Plan Type: Select "Initial" or "Update"
Client was linked to culture specific and/or linguistic services: Yes/No
Client has been informed of the Grievance/Appeal process at least annually: Yes/No
Client has been informed of the DPH Notice of HIPPA Privacy Practices at least annually: Yes/No

Last Updated: [Field]
Last Updated By: [Field]
Treatment Plan Status: Draft, Final, Pending Approval
Team Member To Notify (for Pending Approval): [Field]
The federal government, as part of Meaningful Use, have required that problems be listed in a standardized format. They have adopted the Standardized Nomenclature Of MEDicine (SNOMED) codes. You can push a diagnosis to the problem list from the Diagnosis screen. It is also possible to add Problem codes here or once you launch the plan.
Diagnosis
Optional: Plan Participants

1. Double click in the Role box and then double click on the correct role.
2. You can search for Staff ID by entering staff ID or by last name, first.
3. Click Tab.
4. A list of matches will appear.
5. Double click on the Staff Name you would like to enter.
6. Yes or No
7. Yes, to receive a to do item
   No, if not
Optional: Plan Participants

• You can enter other participants, for example, other staff members, family members, etc.
Strengths, Impairments, and Plan for Discharge
Treatment Plan – Problem

Problem: Depressive disorder

- Date of Onset: 01/15/2016
- Status (Problem List): Active

Treatment Plan Problem Description:

Depressive disorder

- Date Problem Identified: 02/05/2016
- Status: Active
Components of the Problem Section

• The following sections will populate the Problem List

**Problem Code** (see next page)

**Other** only becomes active if the Problem Code is “Other”

**Date of Onset** can be date of assessment

**Status** if Inactive or Resolved are selected they will drop off the list in future TPOCs
Components of the Problem Section

• Problem Code: You can search by DSM IV, DSM 5, ICD 9, ICD 10 description or code. It will display a SNOMED code.
Treatment Plan – Adding Additional Problems

Click the highlight the name of the Treatment Plan, then click "Add New Problem."
Treatment Plan - Adding a Goal

Goal related to Problem (Include client's own words)
Reduce symptoms of anxiety.

Status
Active
Inactive
Resolved

If Resolved is selected, you will be asked to enter "Date Closed".
Treatment Plan – Adding an Objective

Client will decrease the number of times she has to leave group unexpectedly due to symptoms of anxiety from 3 times per week to 1 time per week.

If "Met" is selected, you will be asked to enter Date Met.
Treatment Plan – Adding an Intervention

Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self-regulation of anxiety.

If “Discontinue” selected, you will be asked to enter Date Discontinued.
Treatment Plan – Editing Items

Individual therapy once per week with therapist in order to address trauma, Group therapy three times per week with group therapists in order to practice skills related to self regulation of anxiety.
Treatment Plan – Deleting Items

You must delete starting from the bottom. In order to delete an objective, you must first delete the intervention that is attached to it.

Click to highlight the bottom level item and then select "Delete Selected Item"
Treatement Plan – Submitting and Saving
Printing the TPOC

![Image of TPOC search forms and sample treatment plan]

San Francisco Department of Public Health
Community Behavioral Health Services

Adult/Older Adult MH Treatment Plan of Care

Confidential Patient Information

- Name: TESTCLIENTAVATAR, SUMMARYONE
- Client ID#: 999047242
- Episode #: 1
- Episode Opening Date: 1/10/2015
- Episode Program: CBHS Pharmacy (38CXRX)
- Print Date: 8/17/2015

- Date Treatment Plan Started: 8/12/2015
- Date Treatment Plan Finalized:
- Plan End Date: 8/12/2016
- Last Updated: 8/17/2015
- Plan Type: Initial
- Plan Status: Draft
- Discharge Date:
Progress Notes – Selecting TP item Note Addresses

Select T.P. Version

Adult/Older Adult MH Treatment Plan of Care
CYF 0-4 Treatment Plan Of Care
CYF 0/18 Treatment Plan of Care
CYF Treatment Plan of Care

Select T.P. Item Note Addresses

Clear 'Note Addresses Which Treatment Plan Problem' Text.
Progress Notes – Selecting TP item
Note Addresses (cont)
Progress Notes – Selecting TP item
Note Addresses (cont)

Note Addresses Which Treatment Plan Problem

Problems-> Senile dementia with depression
Goals-> Reduce Depression
Objectives-> reduce depression...