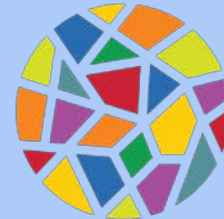


Agenda
Update Client Data
BHRS Client Financial Report

Progress Notes:
Face to Face Progress Notes, Append Progress Note, and Progress Note Error
Correction Requests.

Urgent Care Plan Bundle

Client Treatment Recovery Plan:
Client Treatment & Recovery Plan and Client Treatment Plan Addendum
Diagnosis



SAN MATEO COUNTY HEALTH
**BEHAVIORAL HEALTH
& RECOVERY SERVICES**

January 2021
Presented by BHRS
Quality Management

San Mateo Avatar
Mental Health Clinical Forms



Form Name Update Client Data

FAQs:

Q: How do I update my client's phone number or address?

A: The "Update Client Data" Form.

Q: Am I required to ask my client for their email address?

A: Yes, add it to the "Update Client Data" Form.

Q: Am I required to document the physical location in every phone/video session?

A: Yes, document in the Progress Note.

Home fake C

CLIENT,FAKE (001002110)
F, 21, 01/01/2000
Ht: -, Wt: -, BMI: -

Ep: -
Problem P: -
DX P: -

Chart

Overview

Client Information/Consent
URGENT CARE PLAN
Update Client Data
BHRS Client Relationships
Application for Services and Consent
Authorization for Use or Disclosure of
Verbal Authorization for Release of P
Verification of Consent to Medication

Assessments
Initial Contact Information
Initial Contact Screening (ICI)
ICI Contacts Note
ADULT Initial Assessment v2
ADULT Reassessment v2
Adult Assessment Addendum
YOUTH Initial Assessment v2
YOUTH Reassessment v2
Youth Assessment Addendum
AC OK COD for Adolescents / TAY
AC OK COD for Adults
GAD 7
Patient Health Questionnaire-9
Columbia Suicide Risk Screening

Client Demographics

Name: CLIENT, FAKE ID:1002110 Next Appointment:

[Update Client Data](#)

Address 1: 2020 SHELTER IN PLACE CIRCLE
Address 2:
City: SAN MATEO
State: CA
Zip Code: 94403
HOME: 650-987-6543
CELL:
WORK:
Race 1: No Entry
Race 2: No Entry
Ethnicity: Not Hispanic or Latino

Upcoming Appointments BHRS Client Relationships Client Demographics Past Appointments

STEP 2: Review data, click Update Client Data to make changes

Pro Tip

Check the client's phone number, address, and email address in every phone or video session.

Update it on the spot.

Chart Update Client Data

Update Client Data

Submit

Client Name
CLIENT, FAKE

Client Last Name
CLIENT

Client First Name
FAKE

Client Middle Name

Suffix
 Sr Jr III
 IV V VI

Prefix

Sex
 Female Male Unknown

Date Of Birth
01/01/2000

Client's Address - Street (NOT a PO Box)
2020 SHELTER IN PLACE CIRCLE

Client's Address - Zipcode
94403

Client's Address - City
SAN MATEO

Client's Address - County
SAN MATEO

Client's Address - State
CALIFORNIA

Client's Home Phone
650-987-6543

OK to contact/leave message (Home Phone)
 Yes No

Client's Work Phone

OK to contact/leave message (Work Phone)
 Yes No

Client's Cell Phone

Online Documentation

STEP 3: Update data, click Submit

Form Name
**BHRS Client
 Financial Report**

FAQs:

Q: How do I check the client's insurance?

A: Ask your admin or check the BHRS Client Financial Report.

STEP 1:
Click Here

STEP 2: Select client, Episode, click Process

Pro Tip

Program specialists and supervisors **ALWAYS** check the client's insurance before assigning staff to the client and before issuing a NOABD (only MediCal clients get NOABDs).

Medicare clients –we only get reimbursed for MD, prescribing NP, and LCSW.

San Mateo County BHR Client Financial Report
 12/31/2020

Client Name	Client ID	DOB	SSN	Family ID
CLIENT,FAKE	1002110	1/1/2000	123-45-6789	
200 Guarantor Name		Plan Name		Cov Eff Dates
MEDI-CAL		5 MEDI-CAL		11/1/2020
1600 NINTH STREET, Sacramento, CA, 95814-6414		Policy #		
		416E 123456789		
Assignment of Benefits				M cal CIN
Yes				98765432C

Form Name
**Progress Notes
with Face to Face**

FAQs:

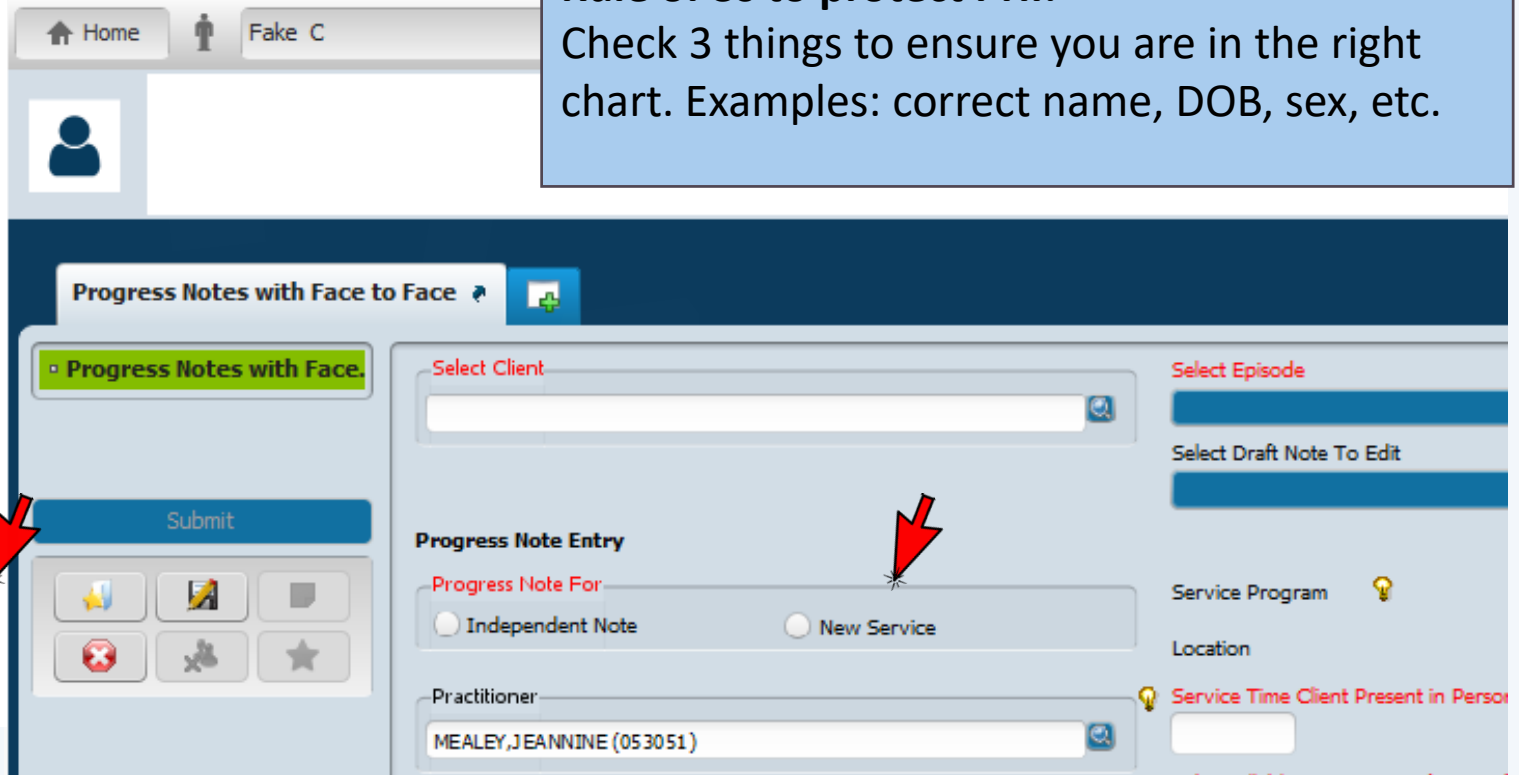
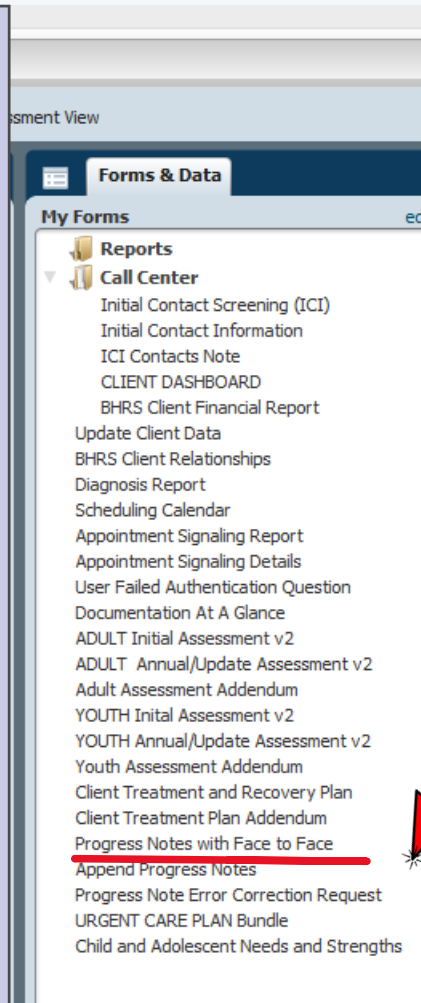
Q: What progress note form do staff use?

A: "Progress Notes with Face to Face"

Medical Staff also use the "Medication Administration Record" progress note for injections.

Q: Do staff use the ICI Contact Note?

A: No, only the Call Center uses ICI Contact Note.



Pro Tip

Protect PHI:

Always check to make sure that you are the selected practitioner and correct program.

Rule of 3s to protect PHI:

Check 3 things to ensure you are in the right chart. Examples: correct name, DOB, sex, etc.

"New Service" - use for open clients and select client
"Independent Note" - use for closed clients

Form Name
**Progress Notes
with Face to Face
Location**

FAQs:

Q: What determines if a service will be billed?

A: The service code, location code, type of service minutes and the client's insurance.

Q: Do I use the client's location, or my location?

A: If the client is in a lockout location, USE THE LOCKOUT- Client's Location, not your location. If the client is NOT in a lockout: Use the appropriate location code.

Progress Notes

Select Episode

Select Draft Note To Edit

Service Program

Location

Service Time Client Present in Person (Minutes)

Other Billable Service Time (Minutes)

Service Duration

Other Non-Billable Service Time (Minutes)

Number Of Clients In Group

Co-Practitioner Other Billable Service Time (Minutes)

Co-Practitioner Duration (Minutes)

Co-Practitioner Other Non-Billable Service Time (Minutes)

Pro Tip

MH Lockout Locations: Jail or Jail-like setting; IMD-like Napa SH; Psychiatric Hospital & PES Skilled Nursing Facility-Psych; Redwood House/Serenity House—Lockout; Redwood House/Serenity House—(MedSup/CM)

Location Codes: Common Non-Lockout Location Codes

OFFICE: Providing a service from your home office and/or work site (not on phone, not video, client is not in lockout)

PHONE: Phone service with client or another person (on phone or video) unless client is in a lockout location

TELEHEALTH: is VIDEO CONFERENCING with client unless client is in a lockout location.

MISSED VISIT: Use "missed visit" location code

VOICE MAIL/FAX/EMAIL: When documenting voice mail/fax/email/text –these are non-billable services

There are several other location codes that are billable

Form Name
Progress Notes
with Face to Face
Service Minutes

FAQs:

Q: What time is included in Service Time Client Present in Person?

A: This is only the time that client is physically present in person or by video

The screenshot shows a web form titled "Progress Notes". At the top right, there is a green button labeled "Progress Notes". Below the title bar, there are two dropdown menus: "Select Episode" and "Select Draft Note To Edit". Further down, there are two more dropdown menus: "Service Program" and "Location". Below these are several input fields with red arrows pointing to them: "Service Time Client Present in Person (Minutes)", "Other Billable Service Time (Minutes)", "Service Duration", "Other Non-Billable Service Time (Minutes)", "Number Of Clients In Group", and "Co-Practitioner Other Billable Service Time (Minutes)". At the bottom, there are two more input fields: "Co-Practitioner Duration (Minutes)" and "Co-Practitioner Other Non-Billable Service Time (Minutes)".

Pro Tip

For **group services** Avatar divides the service duration by the number of clients, you don't do that. The total number of minutes to write all progress notes is entered, e.g. 40 minutes for 4 notes, not 10 minutes

Service Time Client Present in Person: This is only the time that client is physically present in person or by video.

Other Billable Service Time: Charting billable progress note, travel, phone contact with client, collateral contacts, other services where the **client is NOT present by video/nor in person**.

Other Non-Billable Service Time: If the service is a billable service, you may include non-billable time and do not need to write a separate progress note: e.g. CPS reporting, group prep, listening to voicemail. If the entire service is 55, leave blank.

Number of Clients in Groups: Only for groups; this is the number of open clients represented. Family members of an open client are counted as one (1 client even if there are many family members present).

Co-Practitioner: Time is only billed for group services with more than one provider.

Form Name
**Progress Notes
with Face to Face-
Notes Field**

FAQs:

Q: Must a treatment plan goal always be selected for each progress note?

A: No, it is not required but it is recommended.

Q: I hear there are templates in Avatar to help me complete important sections of the progress note. Where can I find these?

A: Right click in the Notes Field or click on the pad and pencil.

Pro Tip

Use "System Templates" and ~~Speel~~ Spell Check



Select Treatment Plan Barrier That Note Addressess

Select T.P. Version
Client Treatment and Recovery Plan

Select T.P. Item Note Addresses

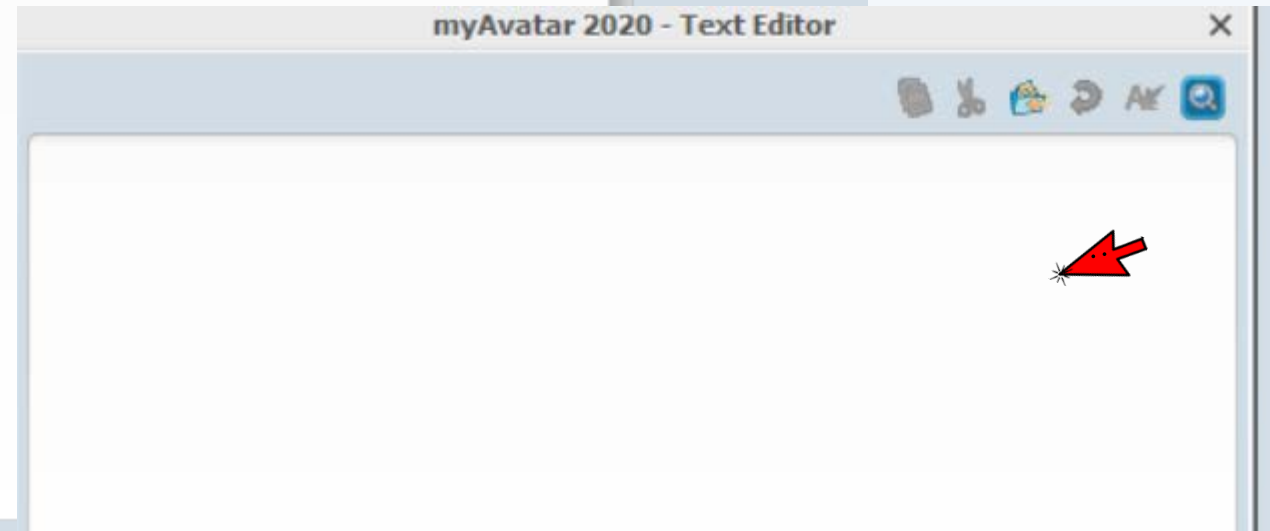
Clear 'Note Addresses Which Treatment Plan Problem' Text.

Note Addresses Which Treatment Plan Problem

Treatment Plan Items-> Auditory hallucinations leading to self-harm and hospitalization.

View Previous Progress Notes

Notes Field



Form Name

Progress Notes with Face to Face Other Items

FAQs:

Q: Are we required to document the language the services were provided in in every progress note?

A: Yes, Language is required, this is a Medical requirement.

Progress Notes with Face to Face

Progress Notes with Face to Face

Submit

Launch OrderConnect
ADULT Reassessment v2
YOUTH Reassessment v2
Client Treatment and Recov
Scheduling Calendar
DX from Assess. ADULT
DX from Assess. YOUTH

Other/Name of Family Member or Significant Other

Reason for Restricting Release of this Note

Reason for Disclosure w/o Consent/Not Treatment

Language Information for Contact

-Was this contact in English?

Yes

No

N/A-Client/Family Not Present

Language

Other Language

Language Services Offered?

Yes-Accepted

No

Yes-Declined

Provided By This Clinician/Staff

Other Interpreter

Finalize

-Draft/Final

Draft

Final

File Note

OPTIONAL - As Needed Periodic Client Rating of Symptom Severity (1 is better, 10 is worse)

Symptom #1

Rating Scale #1

1

2

3

4

5

6

7

8

9

10

Symptom #2

Rating Scale #2

1

2

3

4

5

6

7

8

9

10

Delete Draft/Group Default No

Anxiety

Auditory Hallucinations

Concentration

Depressive Symptoms

Hyperactivity

OCD Behaviors

Other

Self Harming Behavior

Pro Tip

Most will check Yes for service was in English.

If the service was not in English, you will be asked to complete the additional question. These fields will allow us to demonstrate we are meeting the client's language needs.

Rating of Symptoms is a good way to track progress over time.

Form Name
**Progress Notes
 with Face to Face-
 Disclosure
 Note Type**

FAQs:

Q: I had to make a mandated report and did not have client consent, what do I do?

A: Use progress "Note Type", "Disclosure W/O Consent."

Note Type
 (5) Disclosure W/O Consent

Disclosure w/o Consent/Not Treatment To
 CPS

Other/Name of Family Member or Significant Other

Reason for Disclosure w/o Consent/Not Treatment
 Abuse Reporting

Disclosure w/o Consent/Not Treatment To

- APS
- CPS
- DMV
- Family or Significant Other
- Other
- Police/Law Enforcement

Yes
 No
 N/A-Client/Family Not Present

Reason for Disclosure w/o Consent/Not Treatment

- Abuse Reporting
- Current Risk of Harm To Self
- Current threat of harm to others
- Death Reporting
- Gravely Disabled
- Health Concern/Mandated Report
- Lapses of Consciousness
- Other

Pro Tip

A disclosure without consent is when you share a client's PHI is when you share a client's PHI without client consent, for a reason other than current treatment, payment, or operations.

Disclosure w/o Consent/Not Treatment To

- CPS
- APS
- Police/law enforcement
- DMV
- Family or significant other
- Other
- For other and Family Member State Name of Person

Reason for Disclosure w/o Consent/Not Treatment

- Abuse reporting
- Current risk of harm to self
- Current threat of harm to others/duty to warn/protect
- Death reporting
- Gravely Disabled
- Health Concern/Mandated Report
- Lapses of Consciousness
- Urgent safety/crisis situation
- Welfare check
- Other
- For other reason

Form Name
**Progress
Notes with
Face to Face-
Restricted
Note Type**

FAQs:

Q: How do I make sure a progress note does not get released with sensitive information in it?

A: Use restricted progress note type

Q: What happens when I restrict a progress note in Avatar?

A: It puts a flag on the note.

Pro Tip

Restricting the note does not block access. Anyone with Mental Health Avatar access can see the note. The restriction is a “flag” or reminder to review the note for appropriateness prior to releasing the chart in case it contains info that should not be released.

Note Type: (3)Restricted(No Disclosure W/O Consent) *
User To Send Co-Sign To Do Item To: [Dropdown]
Disclosure w/o Consent/Not Treatment To: [Dropdown]
Other Reason: [Text Field]
Other/Name of Family Member or Significant Other: [Text Field]
Reason for Disclosure w/o Consent/Not Treatment: [Dropdown]
Reason for Restricting Release of this Note: [Dropdown] *
Language Information for Contact: [Text Field]
-Was this contact in English?

Reason for Restricting Release of this Note

- **Family member/significant support person/others shared confidential information but requested not to share with client. These notes cannot be shared with the client.**
- Sharing with client would be detrimental/might result in serious risk of harm to client or others.
- HIV status
- Information shared by an AOD Provider – 42 CFR Program
- Youth client's request to restrict-sexual history (not abuse) or AOD use/treatment or private/personal information



Form Name
Urgent Care Plan Bundle

FAQs:

Q: What “Custom Message” do I select?

A: For a message with no end date:

- “Care Alert” - this notice will appear on the chart “HIGH PRIORITY-Please review the Urgent Care Plan in Chart Review.”
- “Care Message” - to set an end date.”

Pro Tip

Complete the “Urgent Care Plan” with contact information and or instructions for other providers.

The screenshot displays the 'Client Alerts' form within a software interface. The form is titled 'Client Alerts' and shows a 'Type Of Alert' dropdown set to 'CARE ALERT'. The 'Custom Message' field contains the text 'HIGH PRIORITY-Please review the Urgent Care Plan in Chart Review'. There are radio buttons for 'Active' and 'Active for Date Range', and a 'Disabled' section with 'Yes' and 'No' options. A 'Submit' button is visible on the left. A modal dialog box titled 'Client Alert' is open, showing the same custom message and asking 'Continue?' with 'Yes' and 'No' buttons. Red arrows point to the asterisk icons on the 'Type Of Alert' dropdown, the 'Submit' button, and the 'End Date' field.

Form Name
**Urgent Care Plan
Bundle**

FAQs:

Q: What is the Urgent Care Plan used for?

A: To provide information about the client's current situation, such as current risk, safety issues, your contact information or other instructions.

More information about urgent care alerts is located here: https://www.smchealth.org/sites/main/files/file_attachments/bhrsavatarurgentcarealert.pdf?1503077336

Pro Tip

Disable the “Care Alert” when it is no longer needed.

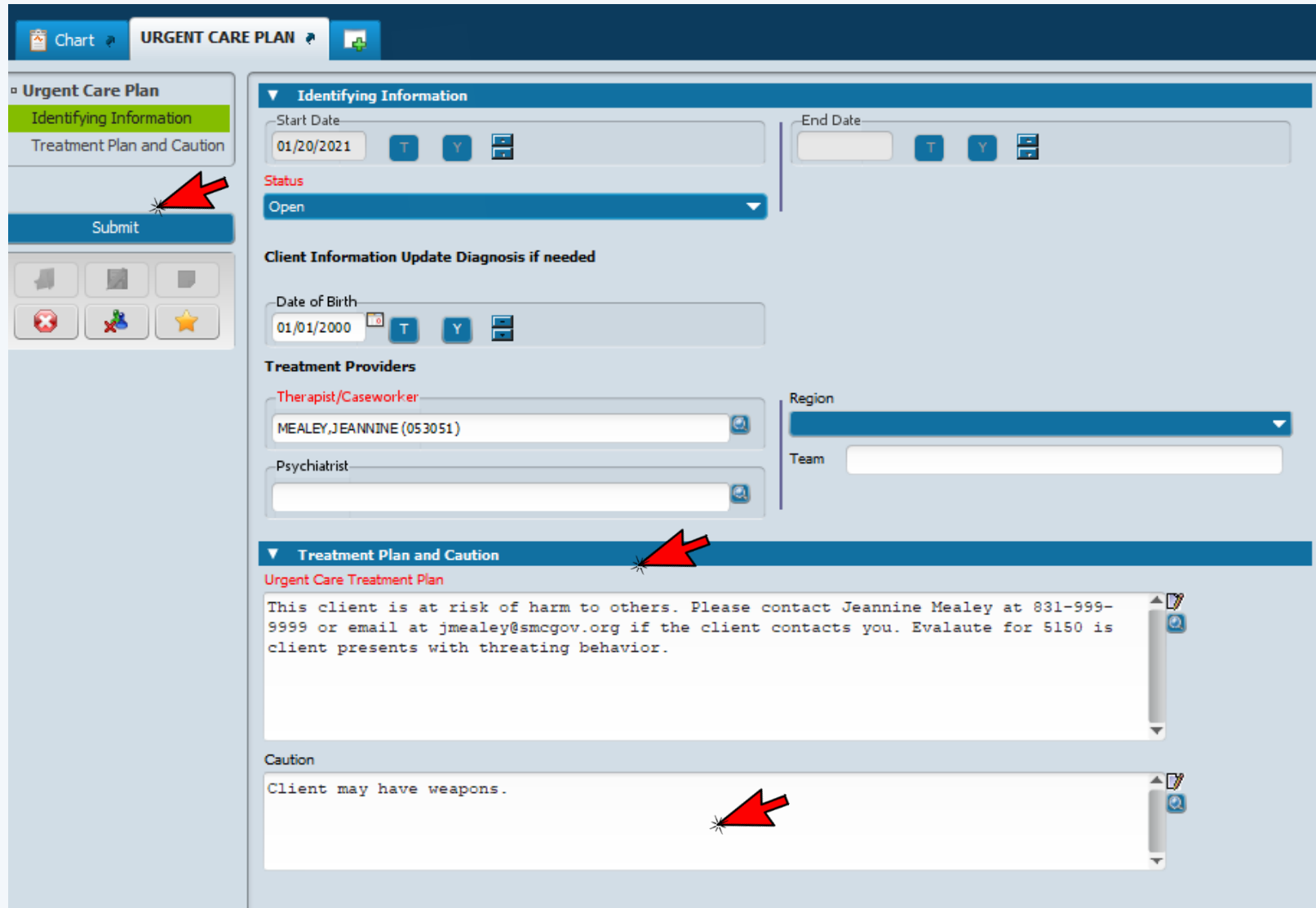


Chart **URGENT CARE PLAN**

Urgent Care Plan

- Identifying Information
- Treatment Plan and Caution

Submit

Identifying Information

Start Date: 01/20/2021 | End Date: | Status: Open

Client Information Update Diagnosis if needed

Date of Birth: 01/01/2000

Treatment Providers

Therapist/Caseworker: MEALEY, JEANNINE (053051)

Psychiatrist: | Region: | Team: |

Treatment Plan and Caution

Urgent Care Treatment Plan

This client is at risk of harm to others. Please contact Jeannine Mealey at 831-999-9999 or email at jmealey@smcgov.org if the client contacts you. Evalaute for 5150 is client presents with threatening behavior.

Caution

Client may have weapons.



Progress Notes with Face to Face-

*“Oops,
I made a mistake”*

FAQs:

Q: I realized I made an error on a progress note I submitted. How do I correct this?

A:

1. Use the “Append Progress Note” or
2. “Progress Note Error Correction Request” or
3. Write a new progress note.

Q: Can you delete a finalized progress note?

A: No

Progress Note Error Correction Request is for correcting billing information, such as:

- Date of Service
- Service Duration
- Service Charge Code/Type of Service
- # of Clients in Group
- Location Code
- Duplicate Entry
- Wrong Co- Practitioner, Wrong Episode, Wrong Client.

Any clinician/supervisor can correct a progress note, even if they did not write the original note.

Append Progress Note is for adding information to a completed progress note.

Appended information that is added is attached to the original note.

- Any clinician/supervisor can append a progress note, even if they did not write the original note.
- If information needs to be added or corrected to the content of a finalized note that required a co-signature, a new note must be written to address mistakes or additions of the original note’s content.

Pro Tip

Always correct progress note billing errors.

Email ASK QM if you are unsure if a correction is needed.

Form Name
**Progress
Note Error
Correction
Request**

FAQs:

Q: If I wrote a progress note in the wrong client's chart, after I complete the error correction request to remove this note from the incorrect client's chart, do I need to then re-enter it into the correct client's chart, or can Avatar do this for me?

A: Yes, you must re-enter the progress note into the correct chart in Avatar. Avatar will not do this for you.

The screenshot shows the 'Progress Note Error Correction Request' form. Three steps are highlighted with red arrows and callouts:

- STEP 1:** Put the date in. An arrow points to the 'Date of Request' field, which contains '01/21/2021'.
- STEP 2:** Select the note. An arrow points to the 'Original Note Information' section, which displays 'Jan 19 2021 -7-REHABILITATION - LOC-OFFICE -57 mins by JEANNINE MEALEY - NOTE ID NOT65764.001, Jan 20 2021 , 09:17 AM'.
- STEP 3:** Make the needed changes, then click submit. An arrow points to the 'Select Items to Change' section, where the 'Location' checkbox is checked.

Other visible fields include: 'NEW Date of Service', 'CORRECT Episode', 'NEW Location Code' (set to 'PHONE'), 'NEW Service Time Client Present in Person (Min)', 'CORRECT Client', 'CORRECT Co-Practitioner', 'Change Comments/Reason' (containing 'This service was on the phone.'), 'Requestor' (JEANNINE MEALEY (JMEALEY)), 'Program/Episode' (410301 CENTRAL COUNTY ADULT), 'Client Name' (CLIENT,FAKE), and a 'View Progress Notes' button.

Pro Tip

The correction request is routed to the billing department.

You will not see the change on the progress note.

The change is made in the billing table.

You may need to also complete an append progress note to add the corrected information to the progress note.

Form Name
**Append Progress
Note**

FAQs:

Q: I already submitted a progress note, but realized I forgot to add some information to it. Is there a way to add information to a progress note that has already been finalized?

A: Append the progress note to add the needed information.

STEP 1:
Select
note type,
and note



STEP 2:
Make the
needed changes, then
click submit



Pro Tip

“Append Note” CANNOT be used if a note originally required a co-signature.

To add a comment or correct the content of a co-signed note:

- Write another progress note
- Use the same service date as original note
- Reference the original progress note
- Code it 55


Form Name
**Append Progress
Note**

FAQs:

Q: I appended a progress note but I can't find the appended information, what happened?

A: The append information is added to the formal report.

Client Views

- 1. MH Client Dashboard
- 2. ADULT Assessments v2 (All)
- 2. Youth Assessments v2 (All)
- 3. Client Treatment Plan v2
- 4. Progress Notes 
- 5. ADULT Assessments v1 (All)
- 5. CHILD/YOUTH Assessments V1 (All)
- 5. P.I.N. Assessments v1 (All)
- 5. PRE to 3 Assessments v1 (All)
- Consent Tracking
- DX from Assess. ADULT
- DX from Assess. YOUTH



Progress Notes Report

Displays All Progress Notes on File (grouped by program)

CLIENT, FAKE (1002110) D.O.B. 1/1/2000

Service Information

Prog. Note For: New Service
Note Type: (5) Disclosure W/O Consent
Disclosure w/o Consent/Not Treatment: Family or Significant Other
Other/Name of Family Member or Significant Other: Father John
Reason for Disclosure w/o Consent/Not Treatment: Current threat of harm to others
Date of Service: 1/20/2021
Service Program: 410301 CENTRAL COUNTY ADULT (1)
Location: OFFICE
Service Charge Code: (55) UNCLAIMABLE SERVICE

Practitioner: MEALEY, JEANNINE
Service Time Client Present in Person (Min): 15
Other Billable Service Time (Min): 5
Service Duration (Min): 20
Other Non-Billable Service Time (Min): N/A

Progress Note

A disclosure is when you share a client's PHI without client's consent, for a reason other than current treatment, payment, or operations.


Was this contact in English? Yes

Electronically Signed By:

JEANNINE MEALEY MFT (MARRIAGE FAMILY THERAPIST), on 1/20/2021

Unique Note ID: NOT85784.002 1/20/2021 09:32 AM

Note Appended on: 1/21/2021

I'm adding missing information to this progress note. 

Electronically Signed by:

JEANNINE MEALEY MFT (MARRIAGE FAMILY THERAPIST), on 1/21/2021

Pro Tip

To view appended information on progress note:
print the progress note report

Form Name
**Client
Treatment
Plan**

FAQs:

Q: In the overall goal section, do you write down word for word what the client says?

A: That is best.

Q: Can the start and end date be changed *once inputted*?

A: No, try to make the date in the future if you are starting early. Try to finalize by the start date.

Q: I accidentally started a new treatment plan when I already had one in draft. Can I delete one of the drafts?

A: Yes, you can delete a draft.

The screenshot shows a web-based form titled "Client Treatment and Recovery Plan". The form includes several sections: "Plan Name" (text input), "Plan Type" (radio buttons for Initial, Annual, Update), "CLIENT'S OVERALL GOAL/DESIRED OUTCOME" (text input with "Have more freedom." entered), "Plan Start Date" and "Plan End Date" (calendar pickers), "Did Client sign the Treatment Plan?" (radio buttons for Signed Electronically, Verbal Approval, Did Not Sign, Signed Paper Copy, Will Sign Printed Version of this Plan), "Was Client offered a copy of the Treatment Plan?" (radio buttons for Yes-Accepted, Yes-Declined, No), "Comments" (text input), "Who is the signature for?" (radio buttons for Client, Parent/Guardian/Significant Other), "Signature Date" (calendar picker), "Signature for Client, Guardian, Parent" (text input), "Treatment Plan Status" (radio buttons for Draft, Pending Approval, Final), and "Send To for Co-Signature" (text input). Two callout boxes with red arrows point to the "Plan Start Date" and "Comments" fields. The first callout says "The dates are very important and control billing". The second callout says "Remember to add a reason for a missing client signature."

Pro Tip

If you are completing the treatment plan late, don't back date the start date.

The plan is considered completed once the LPHA signs.

If you can't get the client to sign and it is due, document why the client did not sign in the comments box and finalize the plan. Be sure to also write a progress note (and adding the date of the corresponding note on treatment plan).

Form Name
Client Treatment Plan

FAQs:

Q: Do all of the goals need to be medical necessity goals?

A: No, but only medical necessity goals can be billed to Medi-Cal.

Q: Do all of the interventions I plan to use need to be on the treatment plan?

A: Yes

Q: Do I need to add med support if I am not a medical staff but our MD will provide med support for this client?

A: Yes

The screenshot shows a web-based form titled "Client Treatment and Recovery Plan". A red circle highlights the "Medical Necessity Goal?" section, which includes a "Yes" radio button (selected) and a "No" radio button. A red arrow points to the "Yes" button. A white callout box with a blue border contains the text: "Medical Necessity Needs to be 'YES' if you plan to bill". Below this, the form contains several sections: "DIAGNOSIS / PROBLEMS / IMPAIRMENTS" with the text "Auditory hallucinations leading to self-harm and hospitalization."; "GOAL - Development of new skills/behaviors and reduction, stabilization, or removal of symptoms/impairments." with the text "Reduce auditory hallucinations and improve symptom management. Will participate in job placement activities through Vocational Rehab Services (VRS)."; "OBJECTIVES - Client's next steps to achieving goal. Must be observable, measurable and time-limited objectives that address symptoms/impairments to the primary diagnosis." with the text "From a baseline of 0, I will meet with MD 1x/month to discuss positive and negative impact of medication over the next 12 months. Within 12 months, I will identify at least 2 activities, from a baseline of 0 activities, that will help me not listen to negative voices. Within 12 months, I will have at least one friendly talk with peers 2-3 times per week, from a baseline of 0 friendly talks weekly."; "INTERVENTIONS-Describe in detail the interventions proposed for each service type: Individual Therapy, Rehabilitation, Collateral, Case Management (E.g. ? Clinician will provide individual therapy, utilizing cognitive-behavioral techniques, to assist client with decreasing his depressive symptoms.)" with checkboxes for "Medication Support", "Rehab/Rehab Group", "Individual Therapy", "Group Therapy", "Family Therapy", "Case Management", "Collateral", and "TBS". Below this are fields for "Medication Support Duration" (12 Months selected), "Medication Support Frequency" (Monthly), "Medication Support Agency/Provider" (Dr. Joe), "Medication Support Intervention Details" (Provide monthly medication support services to assess and monitor medication compliance.), "Rehab/Rehab Group Duration" (12 Months selected), "Rehab/Rehab Group Frequency" (Weekly), "Rehab Agency/Provider" (Central County Adult), and "Rehab Intervention Details" (Provide rehab services weekly to assist client in performing ADLs and reducing).

Pro Tip

There are "System Templates" for goals and objectives.

Fill in the intervention sections completely, adding as much detail as you can.

You are adding all of the interventions for your team/program, not just the ones that you provide.

Form Name
**Client
Treatment
Plan**

FAQs:

Q: I entered the goal and other information, but it did not save. What happened?

A: This is a common problem. Make sure that you File/Save each Diagnosis Goal set, one at a time, or you will lose your work.

Pro Tip

Don't just copy and paste the last plan. You must update the goal, objectives, and interventions.

Form Name
**Client Treatment
Plan**

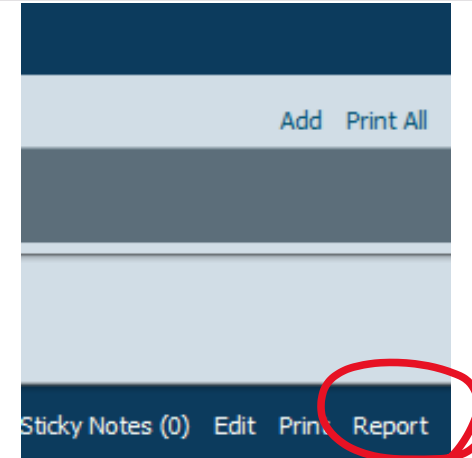
FAQs:

Q: How do I print a copy of the treatment plan for the client to sign?

A: From Chart --> Client Treatment and Recovery Plan --> Report

Pro Tip

Limit printing and/or completing paper PHI from home and off-site. Do this only when necessary. Only use hard copies and print documents if no other method is available to perform your work. **Keep printed/paper PHI-safe.** Lock it up. Take it to the office as soon as reasonably possible.



**Click Report to
print copy**



Form Name
**Treatment Plan
Addendum**

FAQs:

Q: Does the addendum expire when the treatment plan it is attached to expires?

A: Yes, the Addendum will expire when the Treatment Plan it is attached to expires.

Q: Is there a limit to the number of addendums that can be done for a treatment plan?

A: NO

Q: Does the client need to sign or at least verbally agree to the addendum?

A: The same rules apply as the main treatment plan.

Treatment plan addendums

- May be used at any time.
- Use to collect a signature
- Use to add/modify a goal, objective or intervention.
- Use to add Planned Service being provided that is not on the Treatment Plan, as **soon as possible**

The screenshot shows a web-based form titled "Client Treatment Plan Addendum". The form is for adding items to an existing treatment plan. It includes a date picker for "Date of Addendum", a dropdown menu for "Addendum to Treatment Plan (Select one)", and a large text area for "Comments". Below these are sections for "INTERVENTIONS-Describe in detail the interventions proposed for each service type". These sections include checkboxes for various services: Medication Support, Family Therapy, Rehab/Rehab Group, Case Management, Individual Therapy, Collateral, Group Therapy, and TBS. There are also radio button options for "Medication Support Duration" (12 Months, 9 Months, 6 Months, 3 Months), "Medication Support Frequency" (2 to 3 Tx Month, 3 to 5 Tx Week, Daily, Every 3 Months, Weekly, 2 Tx Week, 3 Tx Week, Every 2 Months, Monthly), "Rehab Group Duration" (12 Months, 9 Months, 6 Months, 3 Months), and "Rehab Group Frequency" (2 to 3 Tx Month, 3 to 5 Tx Week, Daily, Every 3 Months, Weekly, 2 Tx Week, 3 Tx Week, Every 2 Months, Monthly). At the bottom, there are text input fields for "Medication Support Agency/Provider", "Rehab Agency/Provider", "Medication Support Intervention Details", and "Rehab Intervention Details".

Pro Tip

If a service is added to the treatment plan or addendum but not provided:

Document this change in a progress note and state that the service was offered and declined.

(For example, you added group therapy but the client decides that they don't want to attend).

My Views

FAQs:

Q: Is there an easy way to see what planned services are approved on the treatment plan?

A: Yes, look at "My Views"

More information about Avatar "My Views" is located here

<https://www.smchealth.org/sites/main/files/file-attachments/avatarmyviewsfeature.pdf?1611172229>

Pro Tip If you are billing under someone else's treatment plan you are required to review the treatment plan. Notify the clinician if your service type is missing and decide who will add the additional service type.

My Views: 1-Clinical View **2-Clinical View** Assessment View Selected Client: C

Client Staff Site Forms & Data Treatment Plan Interventions

My Clients edit
Client, Fake (001002110)

My Forms edit
Update Client Data
BHRS Client Relationships
Scheduling Calendar
User Failed Authentication Question
Documentation At A Glance
ADULT Initial Assessment v2
ADULT Annual/Update Assessment
Adult Assessment Addendum
YOUTH Initial Assessment v2
YOUTH Annual/Update Assessment
Youth Assessment Addendum
Progress Note Error Correction Req
Client Treatment and Recovery Plan
Client Treatment Plan Addendum
Progress Notes with Face to Face
Append Progress Notes
Progress Note Error Correction Req
URGENT CARE PLAN Bundle
Child and Adolescent Needs and Str

Recent Forms
Client Treatment and Recovery Plan

Episode: 1 Program: 410301 CENTRAL COUNTY ADULT

Medication Support Duration: 12 Months
Medication Support Frequency: Monthly

Rehab Group Duration: 12 Months
Rehab Group Frequency: Weekly

Individual Therapy Duration: 12 Months
Individual Therapy Frequency: Weekly

Case Management Duration: 12 Months
Case Management Frequency: 2 to 3 Tx Month

Start Date: 01/01/2021 End Date: 12/31/2021

Treatment Plan Overdue for Caseload

Diagnosis

Primary DX
No Dx on File

FAQs:

Q: The widget on the first page of the chart, shows in red “no diagnosis on file”. However, we did completed the assessment and diagnosis.

A: You have selected a diagnosis without a DSM-5 diagnosis, which is needed.

Billable Diagnosis:

https://www.smchealth.org/sites/main/files/file-attachments/billabledx-enclosures_2_in_18-053_icd-10.pdf?1597249807

Pro Tip

To correct a diagnosis, complete the **Reassessment**, check **Update**, and fill in the diagnosis AND include symptoms that meet criteria for diagnosis.

- Unspecified Mental Disorder F99 is not billable - DO NOT USE
- SELECT ONLY Diagnoses that have a DSM-5 diagnosis descriptor
- Check the ICD10 codes if you are not sure if it is billable, see attachment.
- Notify HS_BHRS_ASK_QM@smc.gov if there is no billable diagnosis

Look at this column for ICD-10

Look at this column for DSM5

Diagnosis	ICD-9	ICD-10	DSMIV	DSM5
Depression	311	F32.9	Depressive disorder NOS	Unspecified depressive disorder
Depression affecting pregnancy	648.40	O99.340		
Depression affecting pregnancy in first trimester, antepartum	648.43	O99.341		
Depression affecting pregnancy in second trimester, antepartum	648.43	O99.342		
Depression affecting pregnancy in third trimester, antepartum	648.43	O99.343		
Depression affecting pregnancy, antepartum	648.43	O99.340		
Depression affecting pregnancy, postpartum	648.44	O99.345	Major depressive disorder, single episode with postpartum onset	
Depression as late effect of cerebrovascular accident (CVA)	438.89	I69.398		
Depression complicating pregnancy in first trimester, antepartum	648.43	O99.341		
Depression complicating pregnancy in second trimester, antepartum	648.43	O99.342		
Depression complicating pregnancy in third trimester, antepartum	648.43	O99.343		

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