SmartCare Residential Guide V3

Contents

Client Search/Inquiry/New Client

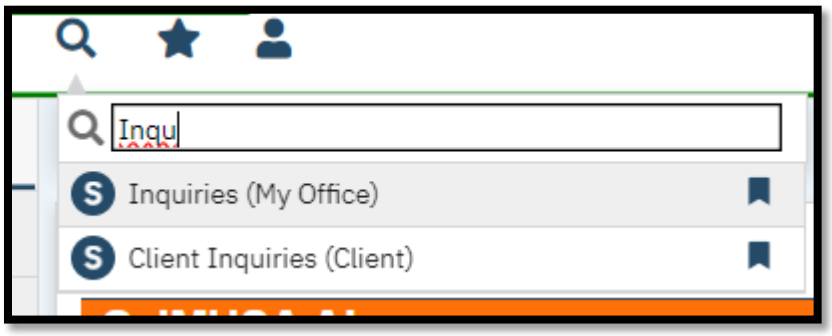
In SmartCare the proper sequence when receiving a new client is to:

1. Open an Inquiry
2. Search for the client to see if they are already in the system
3. Complete the Inquiry
4. Create the client if they were not already in the system

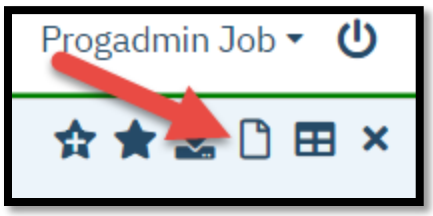
Open Inquiry

The Inquiry is a screen which allows the user to document a request for services.

1. Search for and select “Inquiries (My Office)”



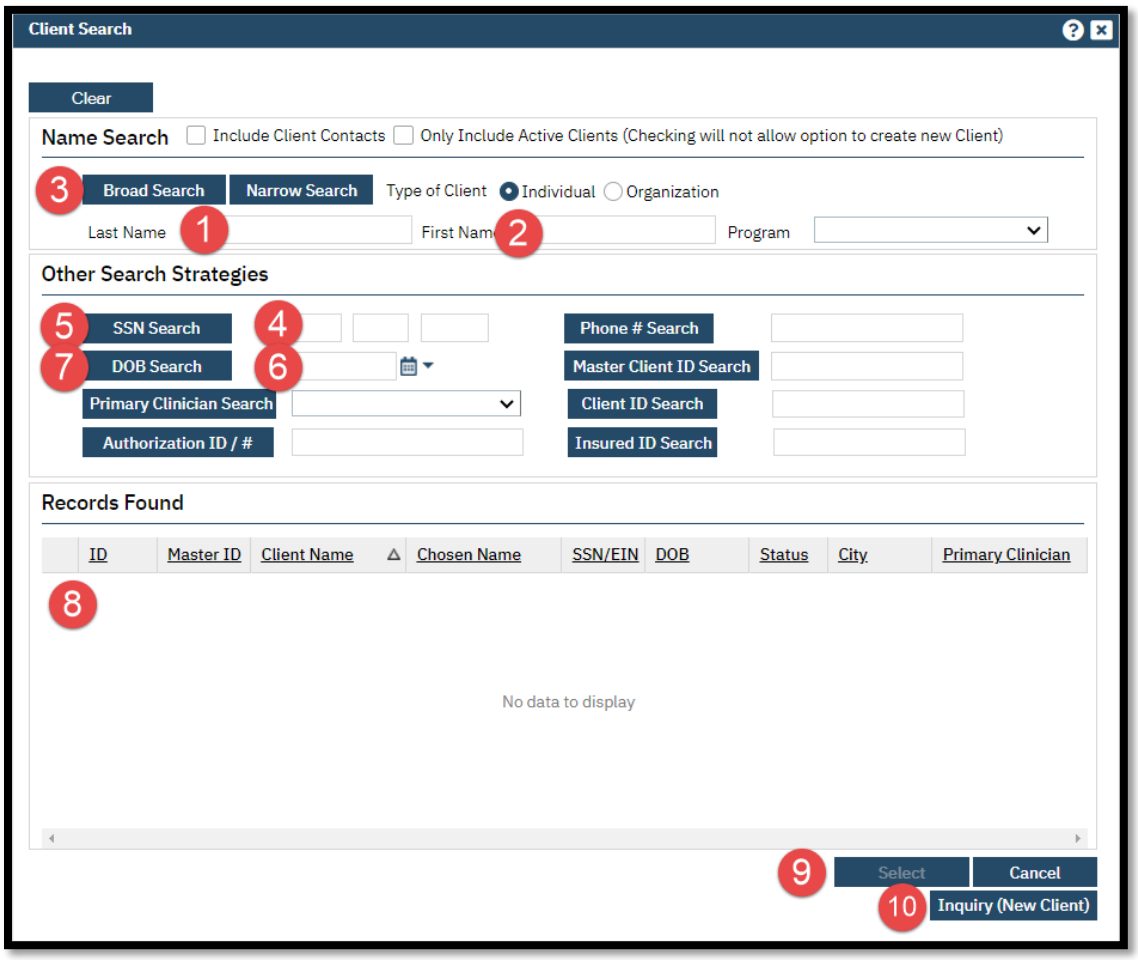
2. Click the New Icon



Client Search

If you have not already selected a client, the Client Search screen will open next.

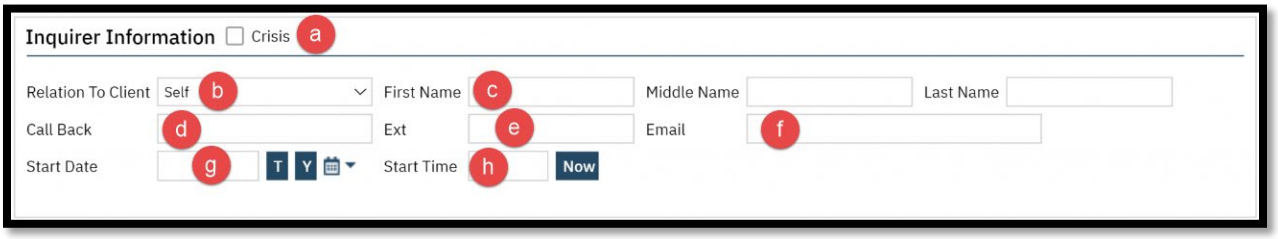
1. Enter a Last Name
2. Enter a First Name
3. Click Broad Search
4. Enter Social Security Number
5. Click SSN Search
6. Enter Date of Birth
7. Click DOB Search



8. Clients matching your search criteria will appear in the Records Found section
9. If a record matching the client appears, click Select
10. If no matching records are found, click Inquiry (New Client)

Complete Inquiry

Initial Tab



1. **Field Definitions: Inquirer Information**

    a. **Crisis Checkbox**: Select this checkbox to display the Crisis tab. Do not use this at this time. This has not been setup completely.

    b. **Relation to Client:** Indicates whether the potential client contacted your organization or if someone did so on the client's behalf. If the client made the contact, the information from the client search will also pull into the Client Information (Potential) section discussed below. Select the relationship between the potential client and the inquirer.

    c. **First Name, Middle Name, Last Name:** Enter the first, middle, and last name of the inquirer. If Self is selected in the Relation To Client field, this information populates from the Client Search window.

    d. **Call Back:** Enter the phone number to call the inquirer back should the call be ended prior to gathering all information. If Relation to Client = Self, this information will also pull into the Home Phone field in the Client Information (Potential) section of the Initial tab

    e. **Ext:** Pairs with the Call Back field to document an extension, if applicable

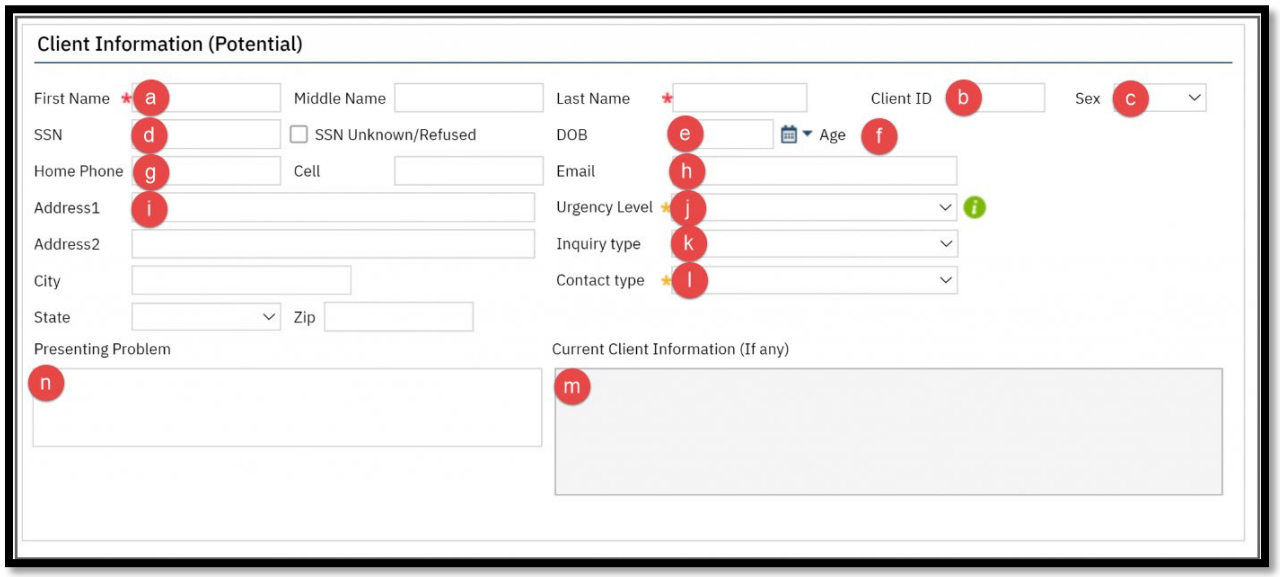
    f. **Email:** Enter an email address for the inquirer. If Relation to Client = Self, this information will also pull into the Email field in the Client Information (Potential) section of the Initial tab.

    g. **Start Date:** Enter the date that the Inquiry occurred.

        - This field also has paired buttons, T and Y, for today and yesterday, respectively. Click the T button to set the date to today. Click the Y button to set the date to yesterday.

- Enter the date in the mm/dd/yyyy format or click the calendar icon to select the date.
- Click the double caret (<< or >>) to navigate backward or forward by one year. Click the single caret (< or >) to navigate backward or forward by one month.
- For pre-set dates, click the applicable hyperlink in the Streamline Date/Time Language section at the bottom of the pop-up calendar. Click <<More>> to display a menu of shortcuts.

h. **Start Time:** Time that the Inquiry began. Next to the Start Time field is a Now button. Clicking this button sets the Start Time to the current time. You can also manually enter the start time and include AM or PM. If you do not enter a time, the system defaults to 12:00 AM.



2. Field Definitions: Client Information (Potential)

a. **First Name, Middle Name, Last Name**: If information exists in the client record for these fields, the data initializes and is not editable. If there is no information in the client's record to initialize and the field was not created via the client search, data can be entered into the field.

b. **Client ID:** If the client is pre-existing, an ID displays here as a hyperlink that can be used to navigate to the client record. If there is no pre-existing information, this field remains empty until the potential client becomes a client.

c. **Sex:** If information exists in the client record for this field, the data initializes. If there is no information in the client's record to initialize, a value can be selected from the dropdown. This pertains to the legal gender for billing insurance.

d. **SSN:** Select this checkbox to indicate a lack of documentable SSN for the client. If applicable, selecting this checkbox fulfills the requirement for a SSN. If the SSN Unknown/Refused checkbox is selected, the field remains empty until the Inquiry is saved and then the field is populated with the value 999-99-9999.

e. **DOB:** If information exists in the client record for this field, the data initializes. If there is no information in the client's record to initialize, a value can be entered.

f. **Age:** This field is populated after the DOB field is populated.

g. **Home Phone, Cell:** If information exists in the client record for these fields, the data initializes. If there is no information in the client's record to initialize, a value can be entered.

h. **Email:** Enter an email address for the client.

i. **Address, City, State, Zip:** If information exists in the client record for these fields, the data initializes. If there is no information in the client's record to initialize, a value can be entered.

j. **Urgency Level (Required)**: Select a value related to the client's urgency need relative to their request.

k. **Inquiry Type:** Select a value to categorize the type of Inquiry.

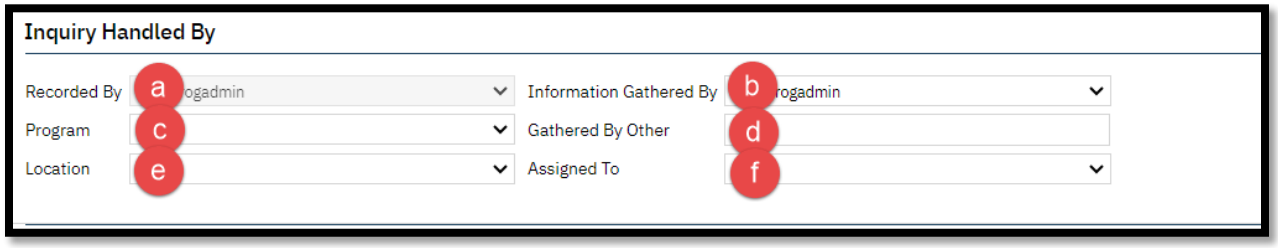
l. **Contact Type (Required):** Select a value to describe the mode of contact used by the client.

m. **Current Client Information** (If any): If the client for whom an Inquiry is being documented has previously been a client with the organization, the following information, if it is in the client's record, initializes here:

    - Client ID
    - Last Inquiry Date
    - Coverage History

- Episode Number from Episodes tab of client information
- Registration Date from Episodes tab of client information
- Discharge Date from Episodes tab of client information

n. **Presenting Problem:** Free text to enter the client's presenting problem.

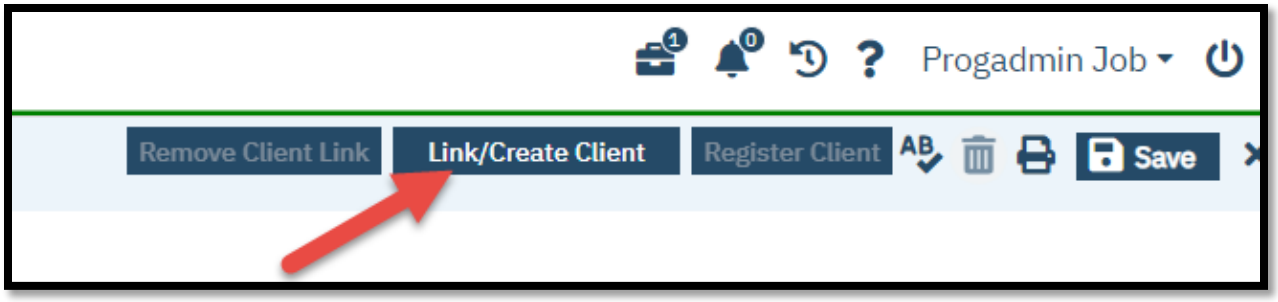


1. **Field Definitions: Inquiry Handled By**
    a. **Recorded:** Defaults to the logged in user and cannot be edited.
    b. **Information Gathered By:** Select which staff member gathered the information from the client. This is usually the same as Recorded By. However, if an Inquiry is received by one person and logged by another, this field is available.
    c. **Program:** Select which program information or services were being inquired about or by which program the Inquiry was handled.
    d. **Gathered By Other:** Enter text to note if the Inquiry was gathered by someone other than a staff member, such as a community partner.
    e. **Location:** Select where the client was calling from.
    f. **Assigned to**: Select to whom the Inquiry is assigned.
4. When finished entering information, click the Save button in the top right corner

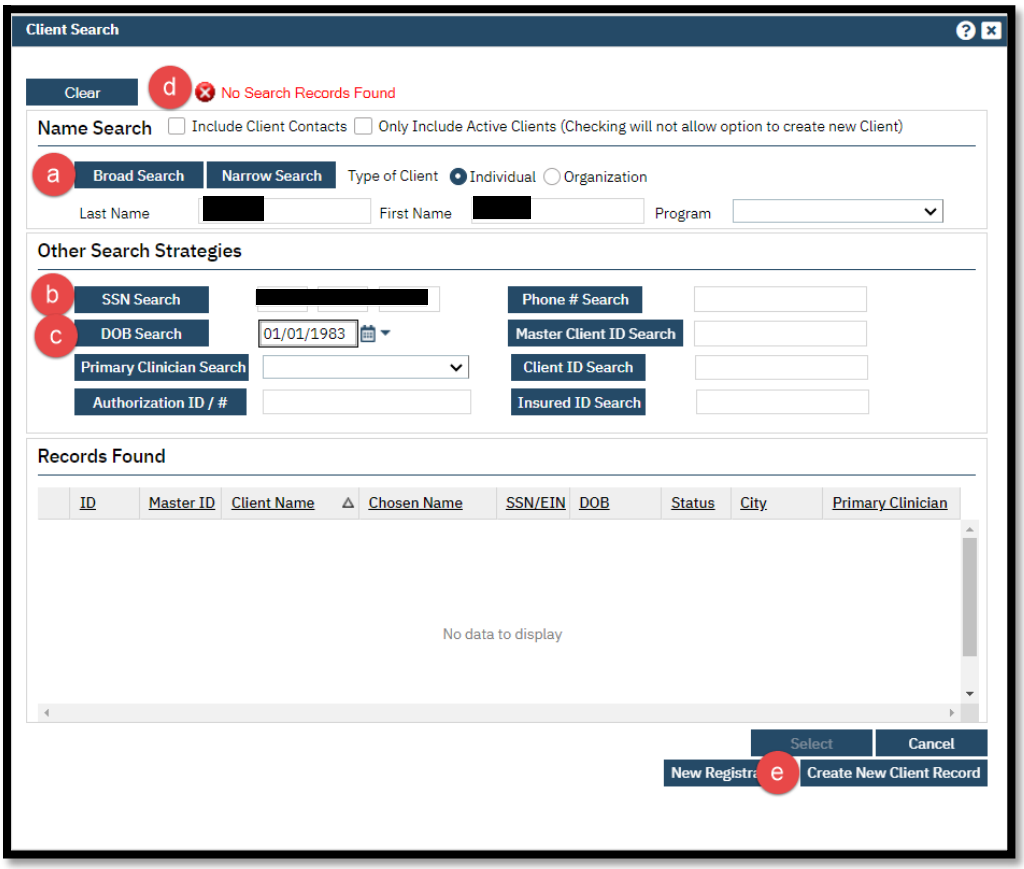
Create New Client If Needed

If the client was not found in the above client search, they must be created now.

1. Select the "Link/Create Client" button at the top of the Inquiry Details. This will bring up the client search window.



2. To verify that the client is not already in the system the search must be repeated.
    a. Click the Broad Search or Narrow Search button.
    b. Click the SSN Search button
    c. Click the DOB Search button
    d. If no records are found based on the search you do, an alert will show at the top of the window
    e. The Create New Client Record button will become active



3. Click the Create New Client Record button
4. The Client Search window will close and the new Client ID and Current Client Information fields will populate on the Inquiry Details.

Client has now been created but must be added to your program before documentation can occur.

Residential Bedboard

Residential Bedboard is a list page used by residential programs to manage beds. The Residential Bedboard list page shows all beds and identifies whether the bed is in use or not. You can use Residential Bedboard to manage new admissions and discharges, clients' attendance, and change beds and programs. Admitting a client using this Bedboard will automatically enroll the client in the designated Program.

How to Open the Residential (My Office) List Page

1. Click the Search icon.
2. Type 'Residential' into the search bar.
3. Click to select Residential (My Office).
4. Ensure that you have set the filter to today's date and the program you should be viewing.

How to Schedule Admission of a Client to a Bed

If you are uncertain if the client will actually be admitted to your program, you may choose to use the Schedule Admission function. This will add the client to your program in a Requested Enrollment status and allow you to document screening and any services provided before a decision to Admit has been made.

After you have selected the client you are going to admit to your program and navigated to the Residential (My Office) List Page:

1. Locate an empty bed in your facility on the Residential (My Office) List Page.
2. Click the down arrow in the Status column in the row for the target bed.
3. Choose the Schedule Admission link.
4. The Census Management – Schedule Admission screen will open.
    a. Verify the Scheduled Date is set to today
    b. Verify the correct Program is selected
        i. SUD Admission to different level of care at same facility:
            1. Uncheck the box for "Only show beds for selected program"
            2. In the dropdown for Program choose the correct Level of Care for the Client
    c. Choose the correct Client Type
    d. Choose the correct Admission Type

5. Click the Save Icon. A requested enrollment to the Program associated with the bed will be created automatically and documentation may proceed.
6. When the decision is made to Admit the client, return to the Residential Bedboard, locate the client and click the down arrow in the Status column
7. Choose the Admit link
    a. Verify the Admit Date and Time are correct
    b. Verify the correct Program is selected
        i. SUD Admission to different level of care at same facility:
            1. Uncheck the box for “Only show beds for selected program”
            2. In the dropdown for Program choose the correct Level of Care for the Client
    c. Choose the correct Client Type
    d. Choose the correct Admission Type
8. Click the Save Icon. The requested enrollment will be updated to Enrolled.

How to Admit a Client to a Bed

If you have decided to fully admit the client to your program you must complete the admission.

After you have selected the client you are going to admit to your program and navigated to the Residential (My Office) List Page:

1. Locate an empty bed in your facility on the Residential (My Office) List Page.
2. Click the down arrow in the Status column in the row for the target bed.
3. Choose the Admit link.
4. The Census Management –Admit screen will open.
    a. Verify the Admit Date and Time are correct
        i. Verify the correct Program is selected SUD Admission to different level of care at same facility:
            1. Uncheck the box for “Only show beds for selected program”
            2. In the dropdown for Program choose the correct Level of Care for the Client
    b. Choose the correct Client Type
    c. Choose the correct Admission Type
5. Click the Save Icon. An enrollment to the Program associated with the bed will be created automatically.

How to Make a Client Non-Billable

Clients are in a billable status by default. SmartCare will generate bed day services automatically as long as the client is admitted to your facility. If the client has not received services necessary for billing, their billing code must be manually adjusted to prevent the service from being created. There is a Billing for each day must be determined by midnight of that day. Any errors after the service is created must be corrected via MHBU.

1. From the Residential (My Office) List Page, locate the client.
2. Click the down arrow in the Status column.
3. Choose the Billing Code Change link.
4. The Census Management – Billing Code Change screen will open
    a. Verify the Start Date and Time is correct
    b. In the Billing Procedure dropdown, select Non-billable Bed Procedure
5. Click Modify to make the change.
6. The client must be changed back to the previous bed procedure for charges to resume.

Scenario	**Billing Status**	**Action**
Date of Admission With Service Provided	Billable	None system will create bed day
Date of Admission Without Service Provided	Non-billable	Make Client Non-billable
Date of Admission With Same Day Discharge	Billable	None system will create bed day
Any Day of Stay With Service Provided	Billable	None system will create bed day
Any Day of Stay Without Service Provided	Non-billable	Make Client Non-billable
Date of Going On Leave	Non-billable	None system will create Non-billable Bed Procedure
Date of Return From Leave With Service Provided	Billable	None system will create bed day
Date of Return From Leave Without Service Provided	Non-billable	Make Client Non-billable
Date of Discharge	Non-billable	None system will not create a service

Leave Procedure

Going On Leave

If the client is leaving your facility but you will be holding their bed until they return:

1. From the Residential (My Office) List Page, locate the client.
2. Click the down arrow in the Status column.
3. Choose the On Leave link.
4. The Census Management – On Leave screen will open
    a. Verify the Start Date is correct
    b. Verify the Billing Procedure dropdown shows Non-Billable Bed Procedure
5. Click the Save & Close icon.
6. The client will now show as On Leave in the Residential Board. It will not be possible to admit another client to this bed. Non -Billable Bed Procedures will be automatically created until the client is taken off Leave or is Discharged.

Return From Leave

When the client returns:

1. From the Residential (My Office) List Page, locate the client.
2. Click the down arrow in the Status column.
3. Choose the Return From Leave link.
4. The Census Management – Return From Leave screen will open
    a. Verify the Return Date is correct
    b. Verify the Billing Procedure dropdown shows the correct bed day procedure for the program
5. Click the Save & Close icon.
6. The client will now show as Occupied in the Residential Board. A bed day will be automatically generated by the system for this day if the client is still admitted as of midnight. If the client returned too late and did not receive services, they should be switched to non-billable How to Make a Client Non-Billable.

SUD - How to Change a Client to a Different Level of Care

1. From the Residential (My Office) List Page, locate the client.
2. Click the down arrow in the Status column.
3. Choose the Transfer link
4. The Census Management – Transfer screen will open
    a. Uncheck the box for “Only show beds for selected program”
    b. In the dropdown for Program choose the new Level of Care for the Client

c. If the client is moving to a new bed, select the new bed using the Bed dropdown

5. Click the Save icon in the upper right corner
6. The Enrollment for the previous level of care will be discharged automatically
7. An Enrollment for the new level of care will be created automatically

Safety Check Order

In order to make a link for the Safety Check appear on the Whiteboard, an order must be placed.

1. Click the Search icon
2. Type Client Orders in the search bar
3. Click to select Client Orders (Client)
4. Click the New icon in the top right corner
5. If there are no other active Orders, the CDAG Program Enrollment window will popup. Select the appropriate program with the correct enrollment date and click OK.
6. The Client Order screen will open.
    a. Order Entry Details
        1. Entered by should be the Staff entering the order
        2. Order Mode: Electronic
        3. Order Status: Active
        4. Ordering Physician: for this order it can be the
        5. Onsite Specimen Collection N/A
        6. Read back and verified N/A
    b. Order
        1. Type Safety in the search bar
        2. Select one of the Safety Check orders with the appropriate frequency
        3. Preference: N/A
        4. Discontinued: N/A
        5. Priority: Now
        6. Start: Other
        7. Start Date enter date the order should start on
        8. Start Time enter time the order should start
        9. Enter an end date and time if applicable (leave blank if order should continue until discontinued)
        10. Program: will prepopulate with the residential program
        11. Comments: if needed

7. Click Insert and the order will be inserted into the Order List
8. Click Sign. The order is now active and will populate the Next Check column of the Whiteboard.

Intake

After the client has been added to a Program, documentation may proceed. Any of the below may be done while the client is still in "Scheduled Admission" status.

Timeliness

SmartCare has 4 Timeliness documents available

How to Complete the MH Non-Psychiatric SMHS Timeliness Record
How to Complete the MH Psychiatric SMHS Timeliness Record
How to Complete the DMC Opioid Timeliness Record
How to Complete the DMC Outpatient Timeliness Record

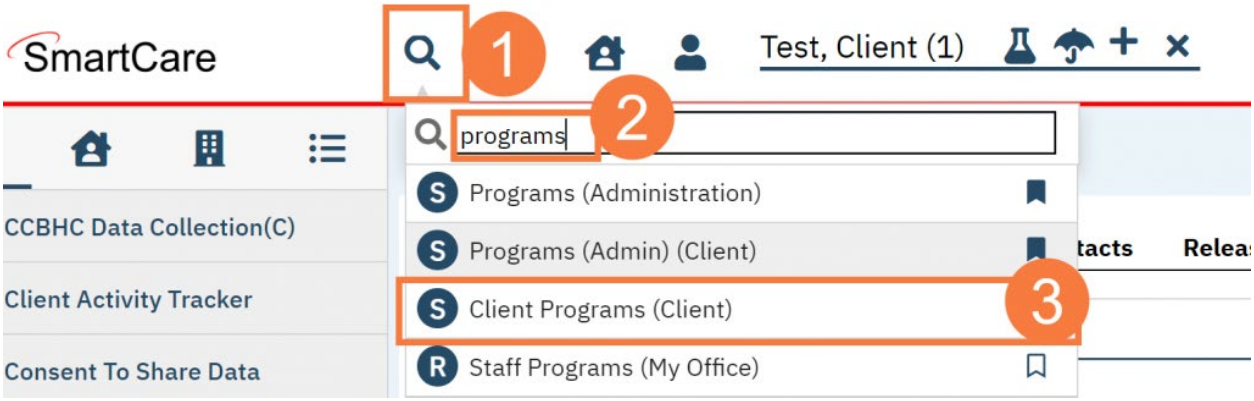
SUD: BQUIP

How to Complete a BQuIP SUD Screening Tool

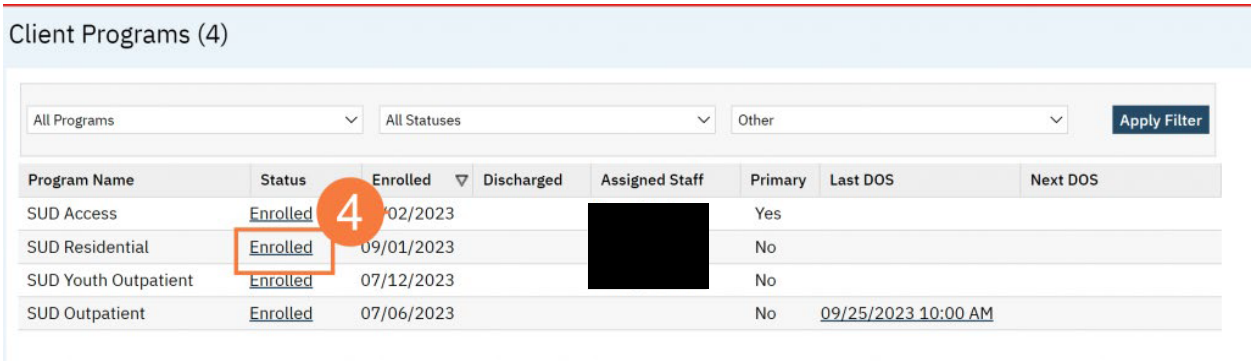
SUD – CalOMS

Before opening the CalOMS document, follow these steps to generate an FSN so it will be prepopulated in the CalOMS form:

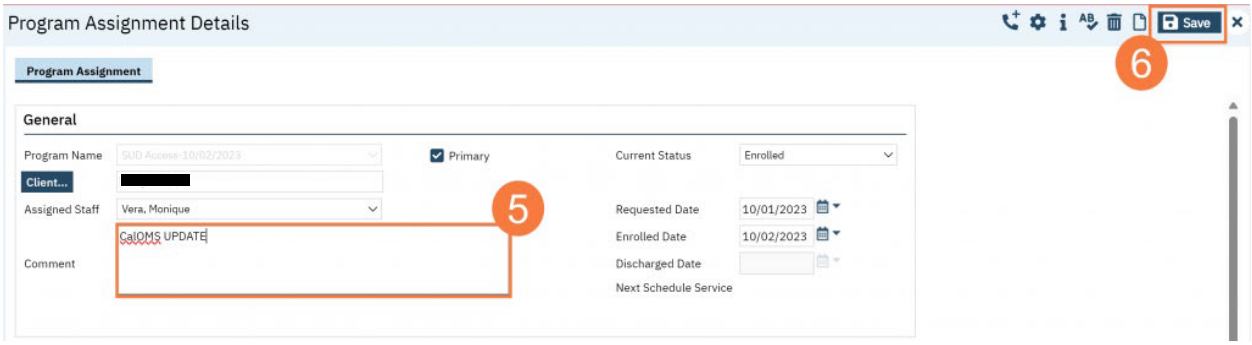
1. With the client open, **click the Search icon**.
2. **Type Programs** in the search bar.
3. **Click to select Programs (client)**.



4. On the Client Programs list page, **click the Enrolled hyperlink** for the appropriate program.



5. On the Programs Assignment Details page, navigate to the comment box and **enter a generic note**. For example, CalOMS UPDATE.
6. **Click Save**.



How to Complete a CalOMS Admission
How to Complete a CalOMS Referral/Transfer

MH – CSI Standalone Collection

How to Complete a CSI Demographic Record

Authorization

Program Request for Authorization

Use current paper submissions for Authorization. Optum will then enter the Authorization into SmartCare.

Documentation

LPHA/Non-LPHA

1. Diagnosis Document (LPHA)

How to Add a Diagnosis
How to Delete a Diagnosis
How to Modify and/or Re-Order a Diagnosis
How to Modify a Diagnosis After the Document is Generated
How to Save a Favorite Diagnosis
How to Pull a Diagnosis Forward from Another Program
Reordering Diagnoses List

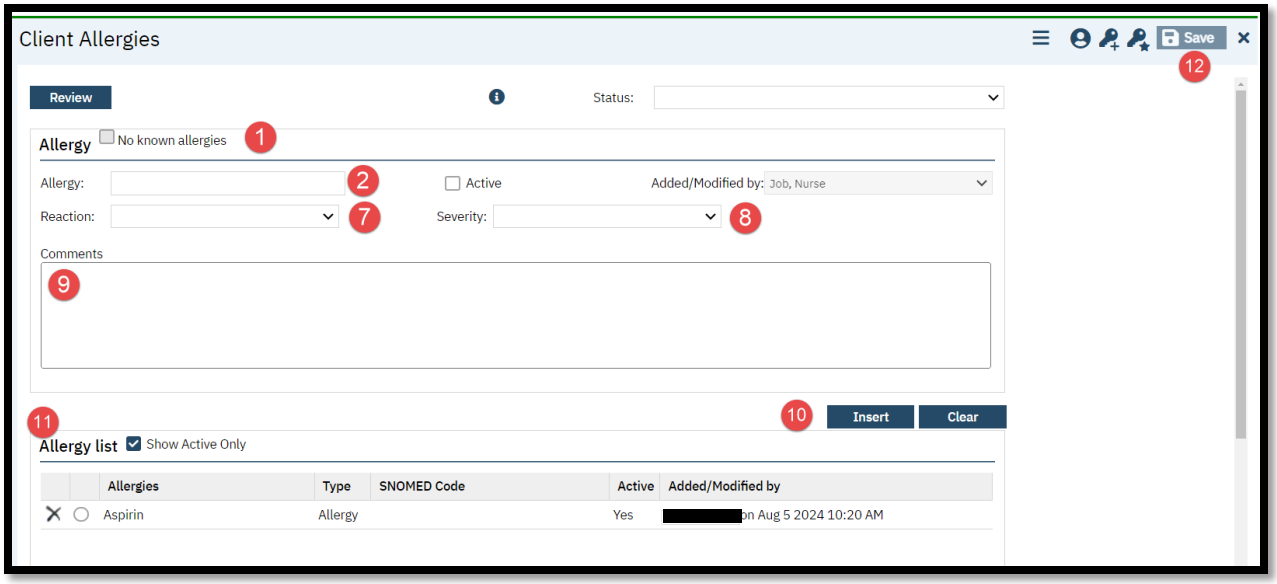
2. Assessment
    a. MH - CalAIM Assessment
       CalAIM Assessment
    b. SUD – ASAM/Problem List
       ASAM Assessment
3. MSE
   Mental Status Exam (MSE)
4. Safety
    a. Risk Assessment (if applicable)
        i. With the client open, click the Search icon
        ii. Type “Risk Assessment (client)” in the search bar
        iii. Select “Risk Assessment (client)” from the search results
        iv. The CDAG Program Enrollment window will popup. Select the appropriate program with the correct enrollment date.
        v. Click OK.
        vi. This will bring you to the Risk Assessment document screen. Complete the entire document.
        vii. If you are completing the Risk Assessment after the fact or are entering in the answers from a paper version, make sure your effective date is the date the assessment actually took place.
        viii. When you are finished with the document, click Sign.
        ix. This will bring you to the PDF. You may now click the Close icon.
    b. Safety/Crisis Plan (if applicable)
       How to Complete the Safety Plan
5. Valuables and Belongings
   How to Complete the Personal Effects Inventory (PEI)
6. Safety Checks (Whiteboard)
    a. Click the Search icon
    b. Type Whiteboard in the search bar
    c. Click to select Whiteboard (My Office)
    d. Click the time link to the next Safety Check in the Next Check column

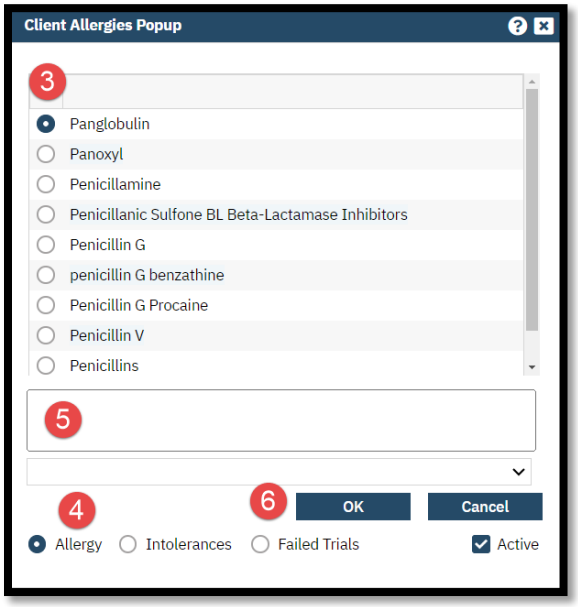
e. The Flowsheet Detail Popup screen will open
    i. Date/Time
        1. Ensure the correct Date/Time is entered
    ii. Safety Check
        1. Select Status Complete
        2. If the Check was performed by another Staff, change the Completed by to the correct name
        3. Enter a comment if applicable
    iii. Current Behavior / Client Status
        1. Select Status
        2. Select Activity
        3. Select Location
        4. Other/Comments free text as applicable
f. Click Save & Close when finished
g. Cancel without saving if needed
h. Safety Checks can be reviewed in the Flow Sheet

7. Shift Summary (Services/Notes)
   How to Document an End of Shift Summary

Nursing

1. Home medications
   Dr First training separate
2. Allergies
    a. To view Allergies
       Allergies (Client) List Page
    b. To enter Allergies
        i. Click on the Search icon, with the client open
        ii. Type “Client Allergies (Client)” in the search bar
        iii. Select “Client Allergies (Client)” from the search results
        iv. This will bring up the Client Allergies Screen





1. If client has No Known Allergies, check the box for No known allergies
2. If the client reports an allergy, type the allergy in the Allergy field and hit Enter.
3. Choose the correct substance in the Client Allergies Popup
4. Choose Allergy / Intolerances / Failed Trials
5. Enter a comment if needed
6. Click OK when finished
7. Enter a Reaction
8. Enter a Severity
9. Comments from (5) appear here, edit if needed

10. Click Insert
11. Allergy will appear in Allergy list
12. Click Save when finished

3. History and Physical form does not share documentation with other notes/assessments H&P also may be documented in the Nursing Evaluation Note
   History and Physical Standalone Form
4. Vitals
   How to Document Vitals
5. AIMS
   How to Complete the AIMS Assessment
6. Review MAR/Chart medications - Dr First training separate
7. Nursing Assessment
   Psych/Medical Note Training
   How to Complete the Psych/Medical Note
8. Other Nursing Notes
   How to Write a Progress Note for an Unscheduled Service
   a. Nurse Progress Note – Incident Documentation
   b. Shift Summary – End of shift documentation if program requires

Prescriber

1. Review Client Information
2. Diagnosis Document (if applicable)
   How to Add a Diagnosis
   How to Delete a Diagnosis
   How to Modify and/or Re-Order a Diagnosis
   How to Modify a Diagnosis After the Document is Generated
   How to Save a Favorite Diagnosis
   How to Pull a Diagnosis Forward from Another Program
   Reordering Diagnoses List
3. Assessment
   Prescriber Assessment E/M (OP) [90792]
   Psych/Medical Note Training
   How to Complete the Psych/Medical Note
4. Medication Reconciliation
   Dr First training separate

Service Entry

Group Services

How to Add a New Client to a Group
How to Add or Change a Staff Member in a Group
How to Set Up a Group
How to Write a Group Progress Note
Group Documentation Videos

Peer Services

How to Write a Progress Note for an Unscheduled Service

1. Behavioral Health Prevention Education service
2. Self-help/peer service

Medication Services

How to Write a Progress Note for an Unscheduled Service

1. Prescriber New E/M [99201-99205]
2. Prescriber Progress E/M [99212-99215]

Discharge

Update CalOMS

How to Complete a CalOMS Discharge

Update CSI

How to Complete a CSI Demographic Record

CalMHSA Discharge Summary

How to Complete the Discharge Summary

Discharge from Program

Discharge the client and remove them from the bed using the Residential Bedboard.

1. Click the Search icon.
2. Type ‘Residential’ into the search bar.

3. Click to select Residential (My Office).
4. Ensure that you have set the filter to today's date and the program you should be viewing.
5. Find the client to be discharged in and click the down arrow in the Status column
6. Choose the Discharge link
7. The Census Management – Discharge screen will open
    a. Ensure that the Discharge Date/Time are accurate
    b. Choose a Discharge Type
8. Click the Save icon
9. The client will now be discharged from the program and removed from the bed