CalMHSA
California Mental Health Services Authority

Clinical Documentation User Manual

Table of Contents

About this User Manual

This user manual is designed to provide a how-to guide of the features and functionality of SmartCare. It will outline how to complete each workflow in a step-by-step format with related screenshots that will make understanding how to complete each workflow easy. Through this guide, you will learn about SmartCare's comprehensive suite of tools and advanced technologies to enter client data securely and efficiently.

We hope that by following these instructions you will gain a better understanding of the capabilities of SmartCare so that you can start using the system right way with confidence.

Audience

This manual is intended for use by anyone who will use the SmartCare EHR to support Specialty Mental Health Services or Substance Use Disorder clinical documentation.

Computer Literacy Assumptions for Understanding this User Manual

- Ability to perform basic word processing such as typing and searching for documents in files
- Understands data entry techniques into electronic forms and documents
- Familiarity with running a windows operating system or other popular programs like Mac OS.
- Basic knowledge of how to use internet browsers like Microsoft Edge and Google Chrome

IT Support Requests:

Please call our Help Desk at:(916) 214-8348 or submit a live chat question to https://2023.calmhsa.org/

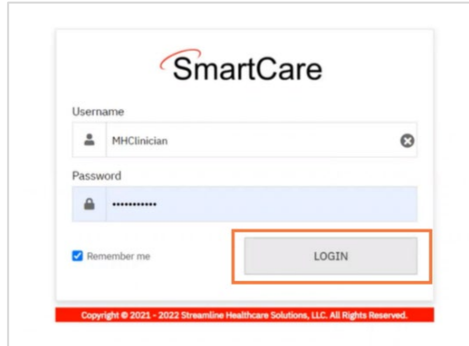
Note: Before beginning to use the same system, make sure you have a compatible internet browser like Microsoft Edge and Google Chrome. CalMHSA recommends Google Chrome for best user experience.

LMS Related Support:

Please email: moodle@calmhsa.org

Logging in to SmartCare

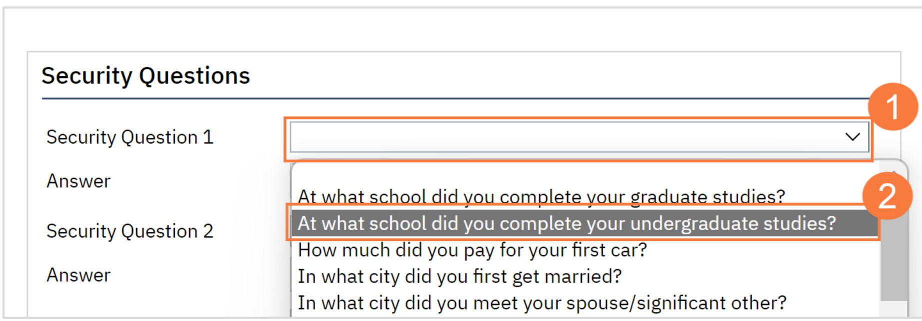
1. From the desktop, open your internet browser
2. Enter the SmartCare URL
3. Enter your username and password
4. **Click Login**



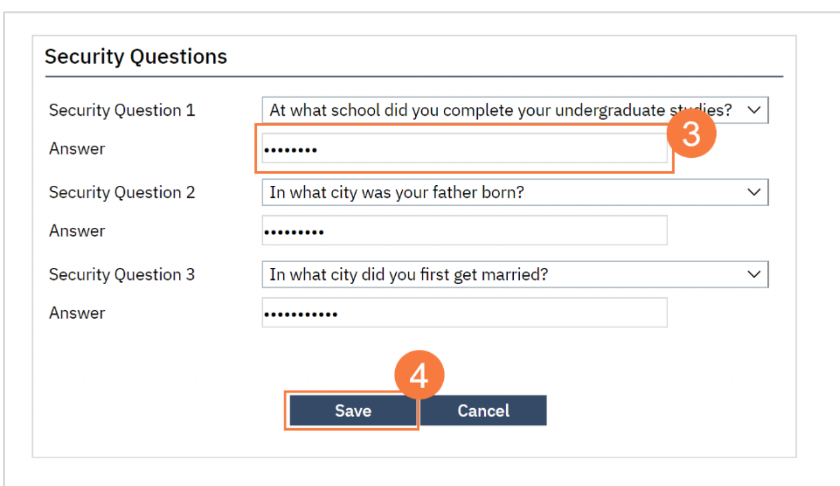
First Time User Login Process

When you first login you will have to set up 3 security questions.

1. **Click the drop-down menu** next to each security question
2. **Click to select** the security question you want to use

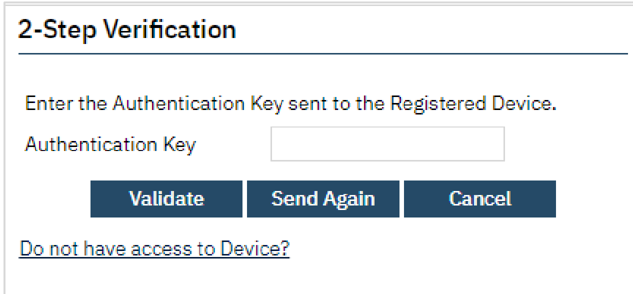


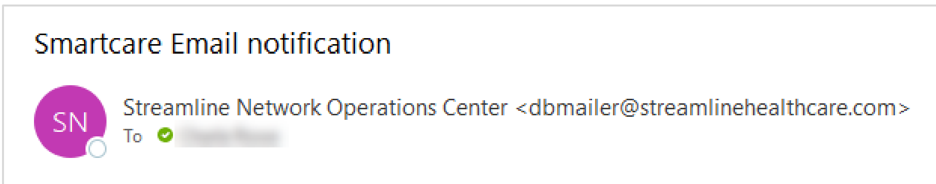
3. In the Answer field, **type the answer** to your chosen security question
   a. Repeat this for the remaining two questions
4. **Click Save**



Subsequent Logins

SmartCare uses multi-factor authentication, or MFA. This means that when you log in, you'll receive an email with a code that you'll need to enter. Your system administrator will set up how often this needs to happen.





Basic Navigation and Functionality

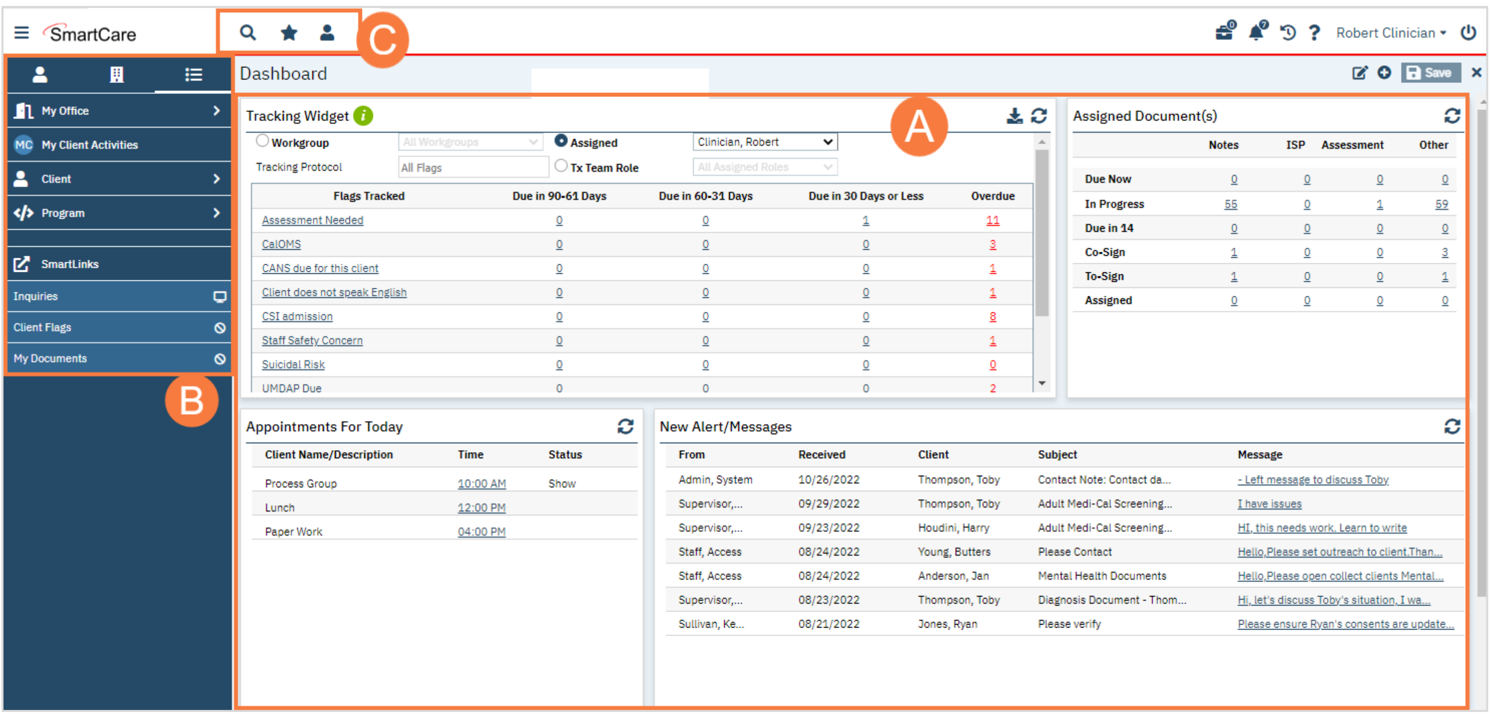
This section will cover basic SmartCare functionality, terminology, and navigation.

Home Screen

When you first login to SmartCare you will land on the Home Screen. You will have a home screen unique to your role to make it easier to navigate to the work that applies to you.

The Home Screen consist of 3 main components:

A. The Work Area
B. The Menu Bars
C. The Search Bar



Icons

The **Header,** pictured below, consists of several icons.

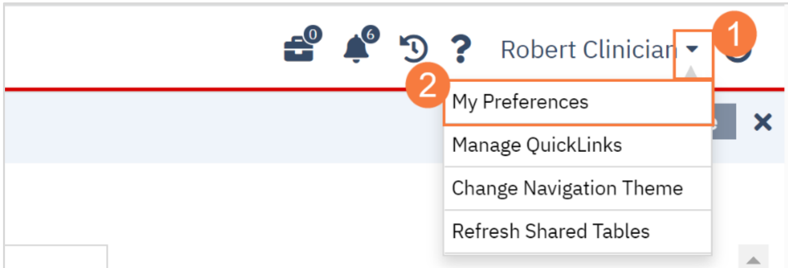
The **Icons and Functionality** table below describes each icon.

Icons and Functionality	
	The **Menu icon** will open and close the Navigation Filters bar
	Clicking on the **SmartCare icon** will bring you back to your Home Page
	The **Search icon** will allow you to quickly search for screens and list pages within SmartCare
	The **Favorite icon** will allow you to search for screens and list pages that you have save in your favorites
	The **Person Search icon** will allow you to search for a client by their name or ID number
	The **Unsaved Changes icon** will display a list of screens that you made changes to but navigated away from before saving
	The **Notification icon** will display a list of system notifications. The number that appears in the icon correlates to the number of notifications you have
	The **History icon** will open a window that displays the last 13 patients and QuickLinks you have accessed in your current session
	The **Help icon**, will take you to the SmartCare Online Help webpage
	The **Logout icon** will log you out of SmartCare

Preferences

In order to access your user preferences, follow the steps below:

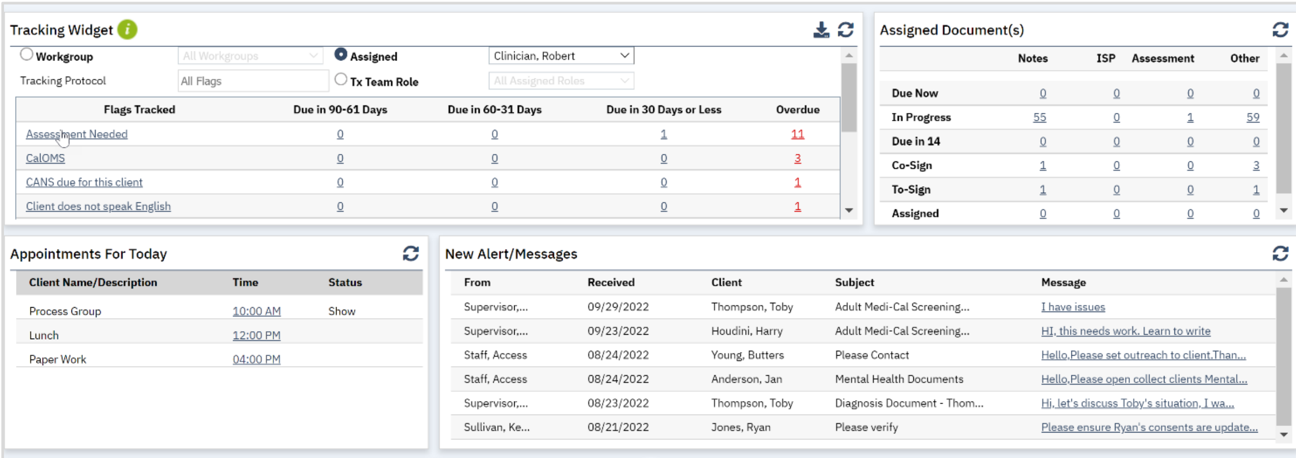
1. From the Header, **click the drop-down menu after your name** in the upper right-hand side.
2. A menu will open, **select Preferences** from the menu options



Note: Your preferences window will open, here you will be able to update your password, contact information, security questions, push notifications, etc.

Widgets

SmartCare has widgets that are multi-functional and interactive. They allow you to see and act on information most relevant to your role and daily tasks. The widget will appear on your Home Screen when you first login.



The Tracking Widget

The Tracking widget is a tool that shows you any documents or tasks that you need to complete. You can scroll down on the widget to view all tasks and documents that are due. Each document or task is hyperlinked to take you to the "To Do List" so you can complete it. The Tracking widget will default to you as the user, but you can switch to view your items by *Workgroup* or by *Treatment Team Role* if you are in a supervisor.

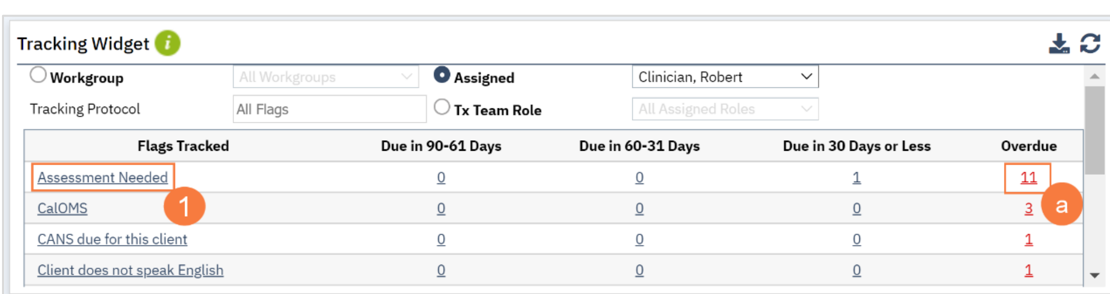
Tasks are grouped into 4 categories for easy prioritizing,

- Due in 90-61 Days
- Due in 60-31 Days
- Due in 30 Days or Less
- Overdue

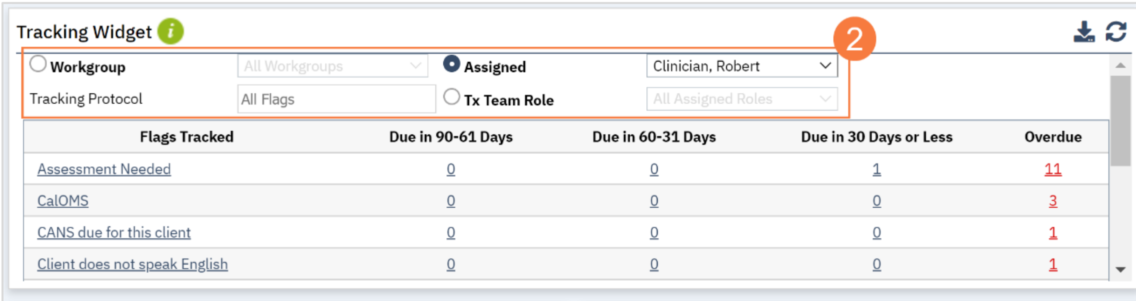
If a document doesn't have a due date, but hasn't been completed, it will show

Note: Clicking on the hyperlinked number will take you only to the tasks or documents that are due within that time category. Clicking on the task or document hyperlinked name will take you to all tasks in that category. To use the Tracking widget, follow the steps below:

1. **Click the hyperlinked name** of the task or document.
    a. You can also **click the hyperlinked number**.

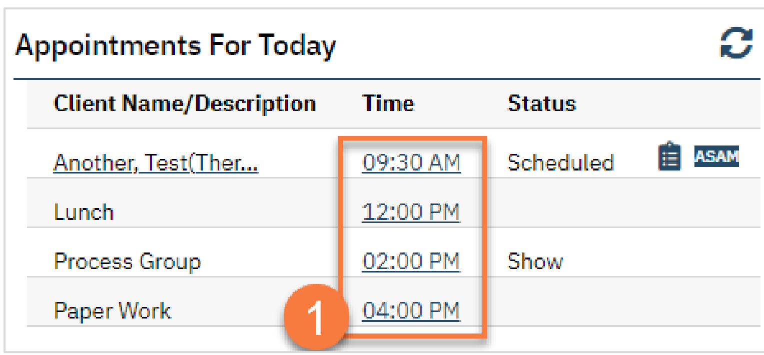


2. For Supervisors, you can change between Workgroup, Assigned, and Tx Team Role by clicking on the radio button to the corresponding field.

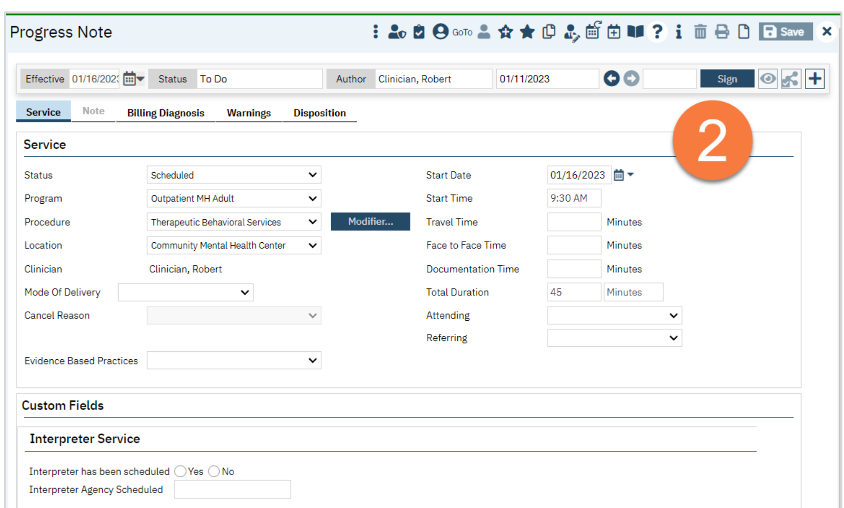


The Appointments For Today Widget

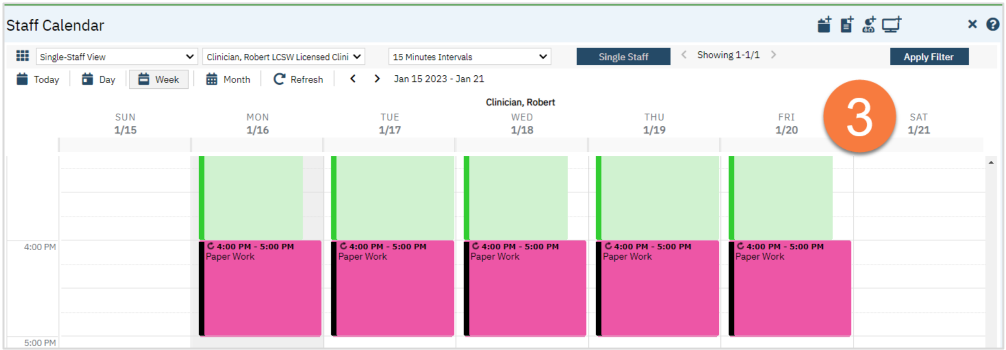
1. This widget allows you to see your daily schedule at a glance. This includes non-client time, such as meetings and time off, as well as client appointments. Clicking on the link will take you to that appointment.



2. For client service appointments, this link will take you to the service details, where you can quickly write a note.

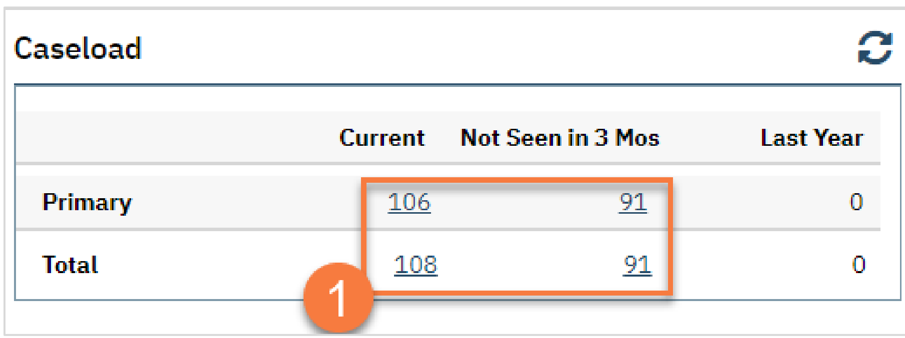


3. For non-client appointments, like meetings, this link will take you to the Staff Calendar.

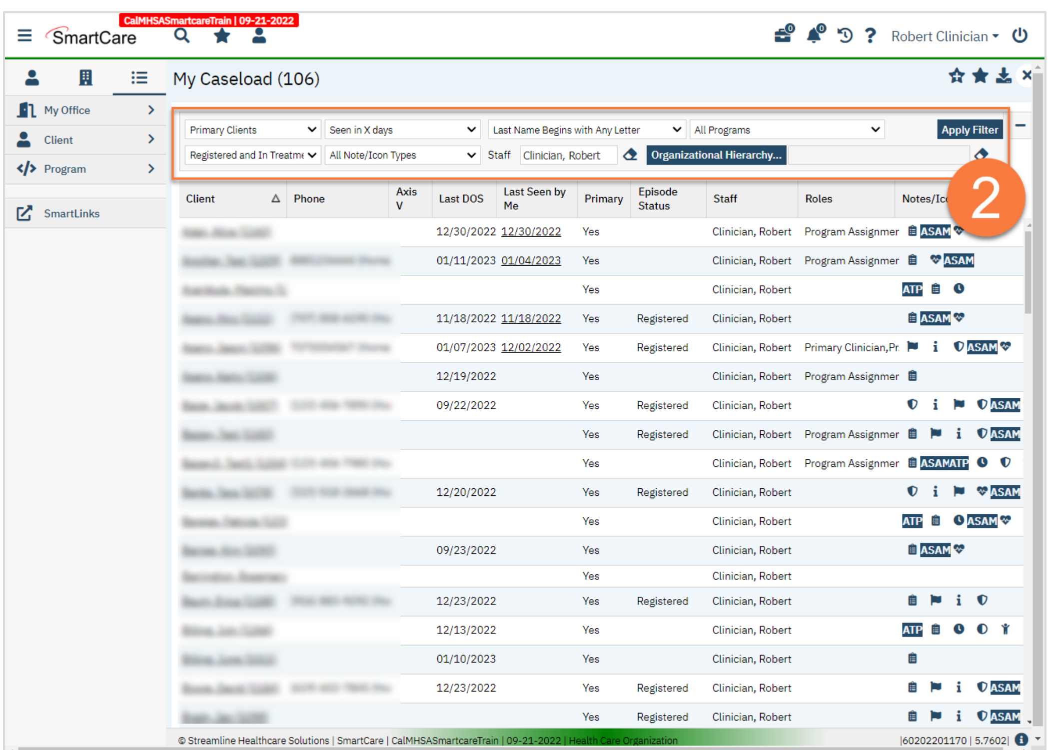


The Caseload Widget

1. This widget allows you to easily see your caseload. Clicking on any of the links will take you to the My Caseload list page.

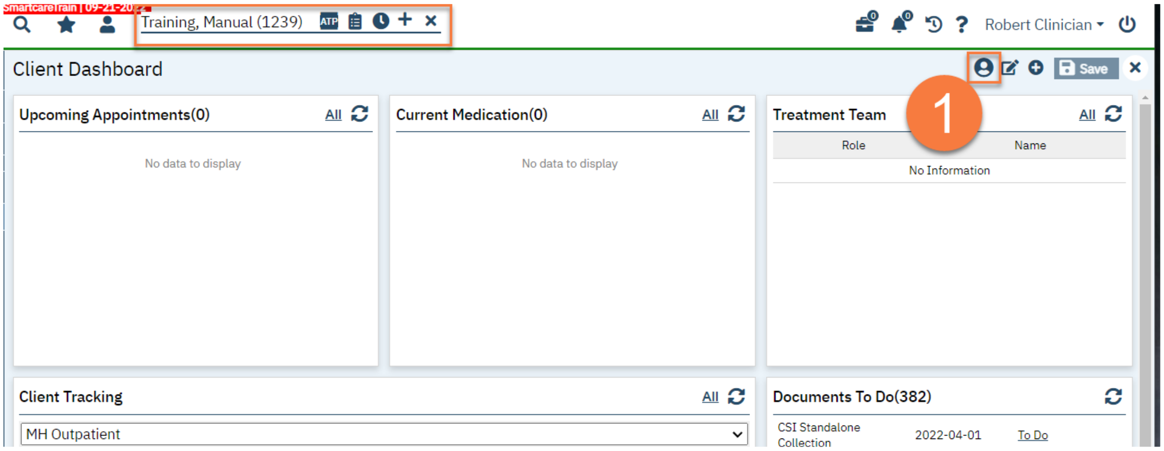


2. Just like any list page, you can use the filters at the top of the page to narrow the results as needed. Depending on the link you clicked from your dashboard, some filters may already be in place.

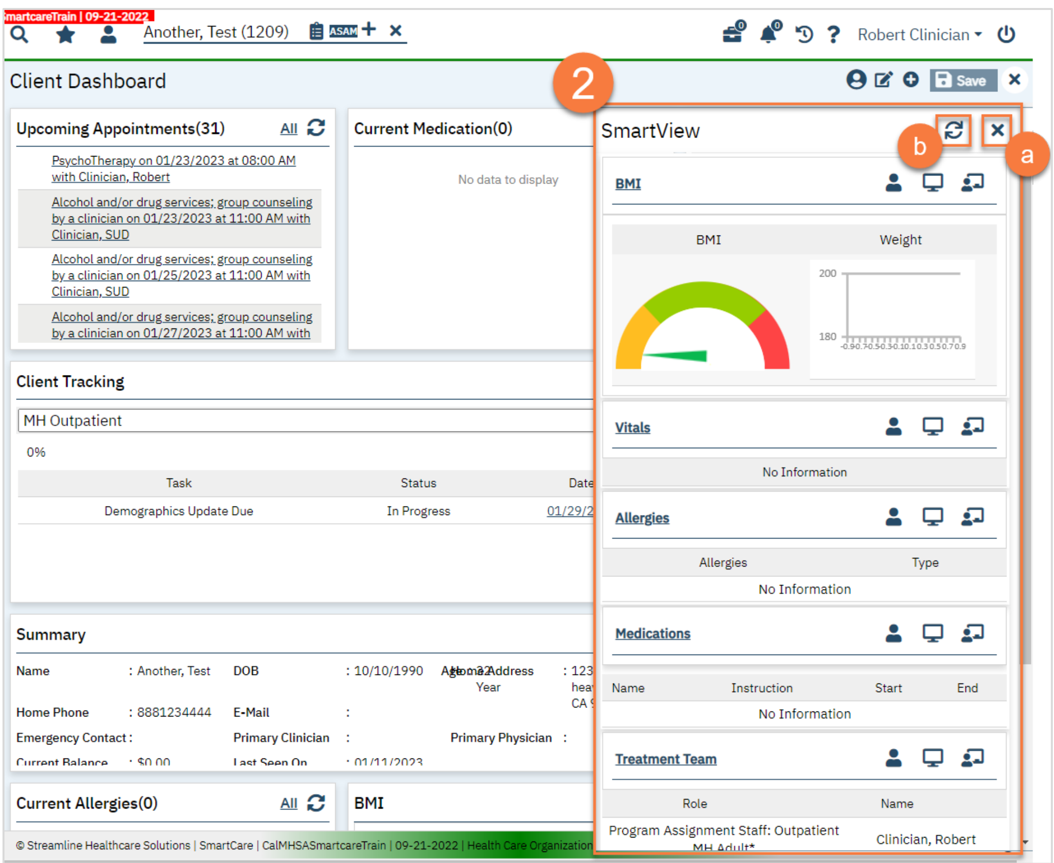


The SmartView

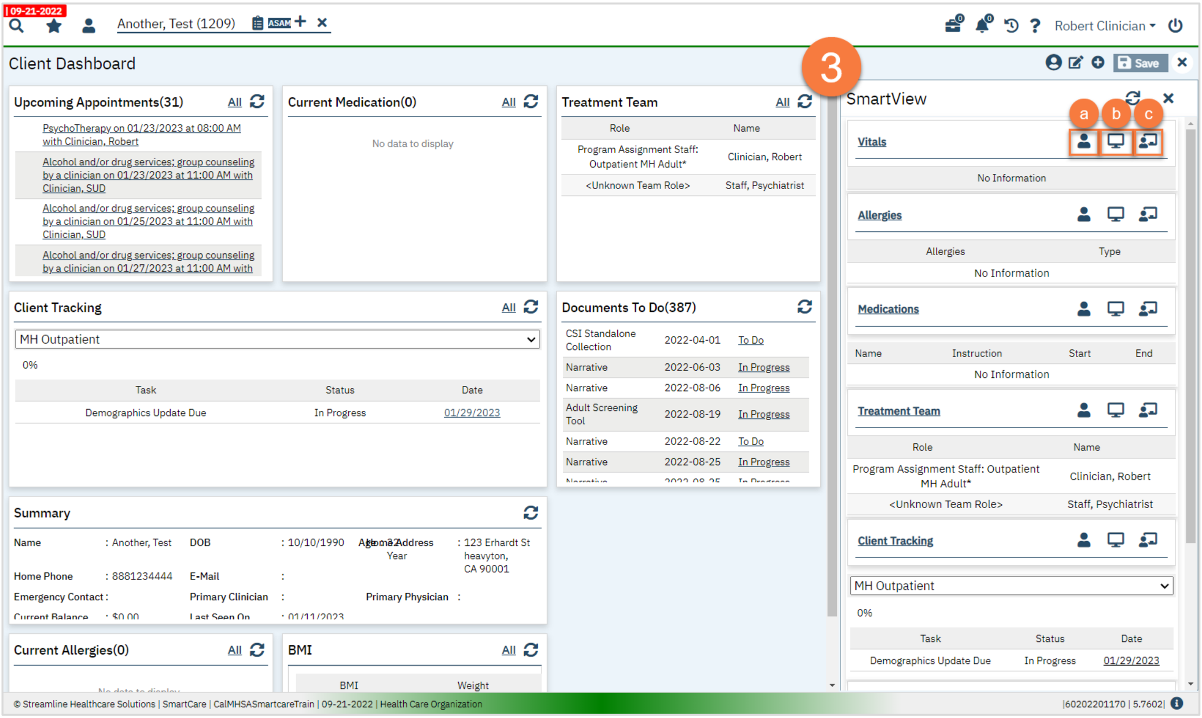
1. When you have the client open, click on the SmartView icon in the upper right corner of the screen.



2. This opens up the SmartView side panel. This will remain open while you navigate the client's chart. The SmartView widgets include links that will take you to the related screen.
    a. To hide this, click the X in the upper-right.
    b. To refresh the information on the SmartView widgets, click the Refresh icon.



3. You can pin the SmartView so that it's not overlapping the other parts of the screen. The below screenshot shows the pinned version. You can select 1 of 3 options for pinning the screen:
    a. Pin to the client – will always be pinned when opening this client.
    b. Pin to the screen – will always be pinned when on this screen.
    c. Pin to the screen and the client – both a & b.



Screens vs. Document

Screens are forms that, when updated, only show the most recent information. Documents, on the other hand, will save the finalized version in a pdf in order to capture data at a point-in-time.

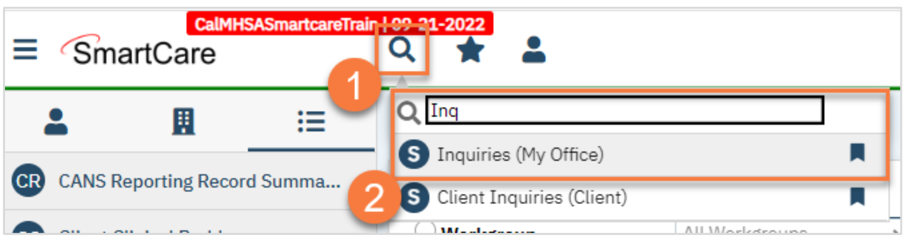
Life Cycle of the Client: Request for Services

There are many methods used to initialize services, but all start with some sort of request for services. This section will go into how to document these types of requests and how to move a client through the initialization process. Each county has an Access Line that's available 24/7 for people to call for information about services and to request services. Each county also has a Crisis Line that's available 24/7 for people to call when they're in crisis. Some counties may have walk-in clinics where a person can simply drop-in and request an assessment. Sometimes people requesting services may call another behavioral health phone number or walk into an office that doesn't provide screening, assessment, or crisis services and they need to be redirected. We'll cover all of these scenarios in this section.

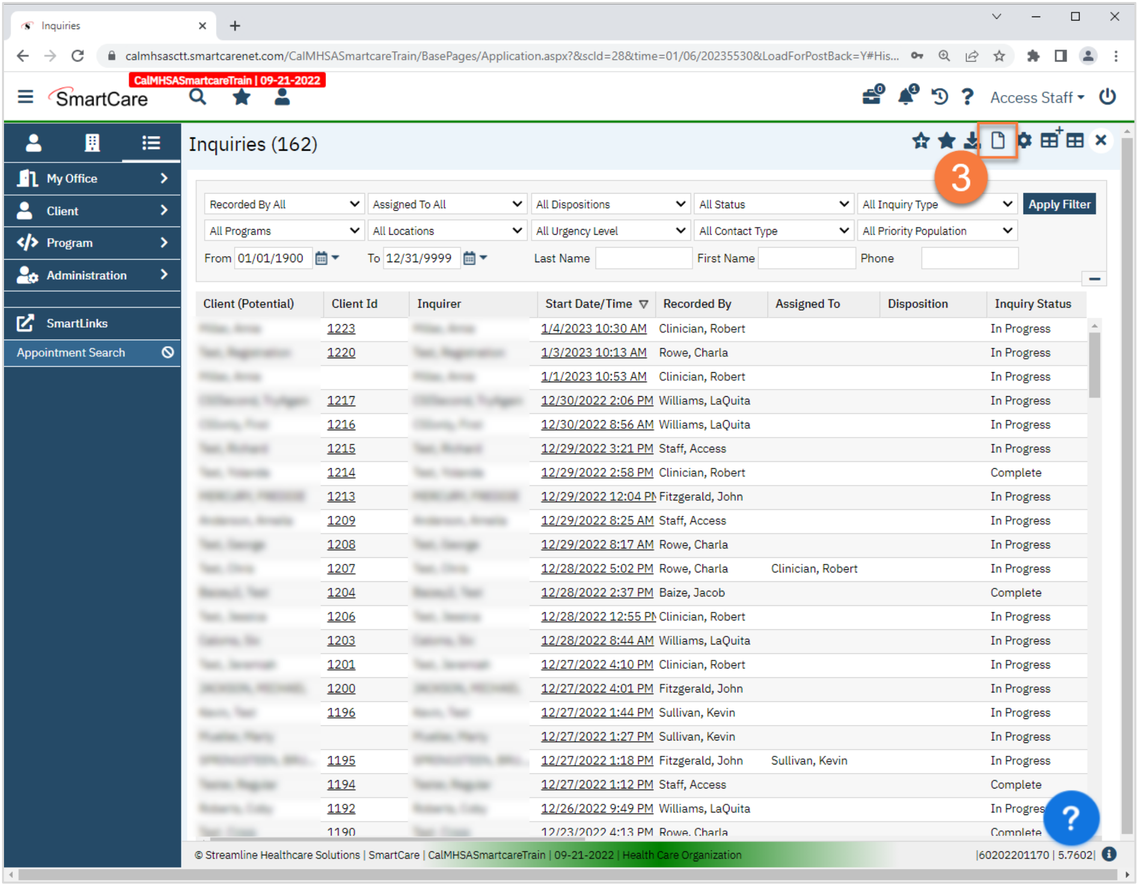
How do I document a request for services received via the Access Line?

Access Line calls are documented on the Inquiry screen.

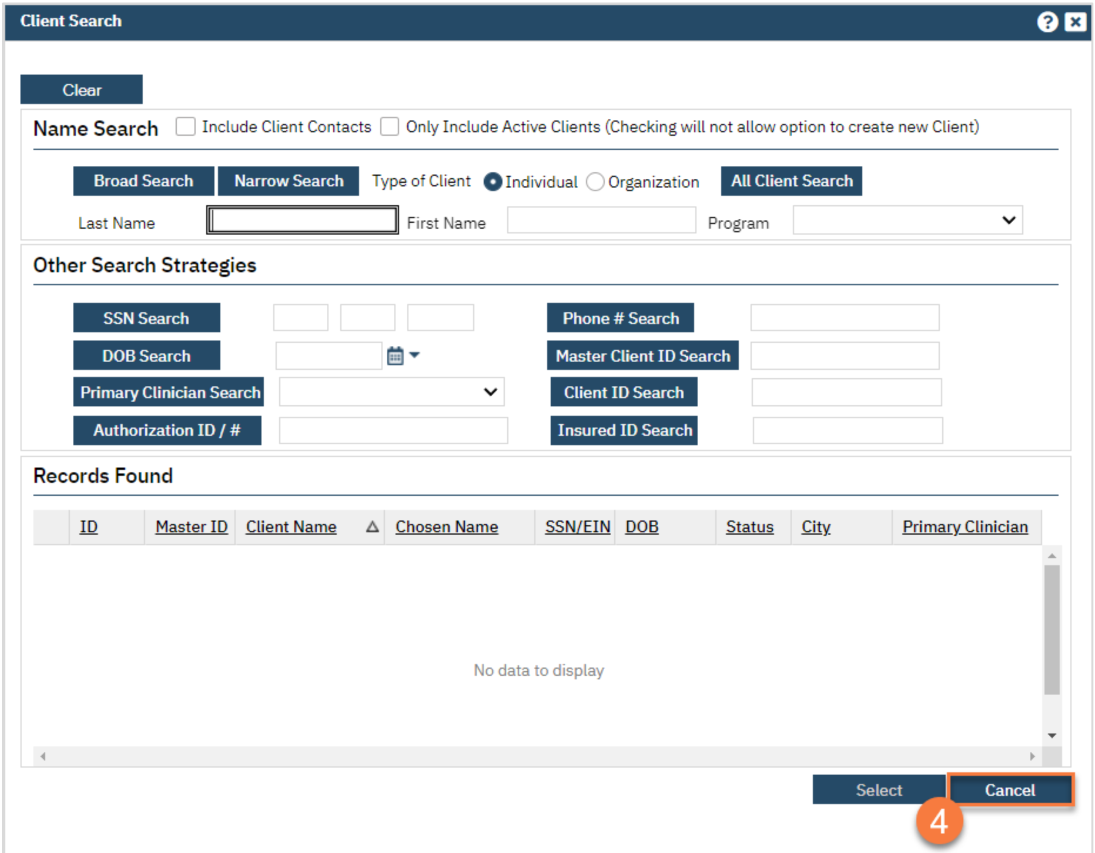
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



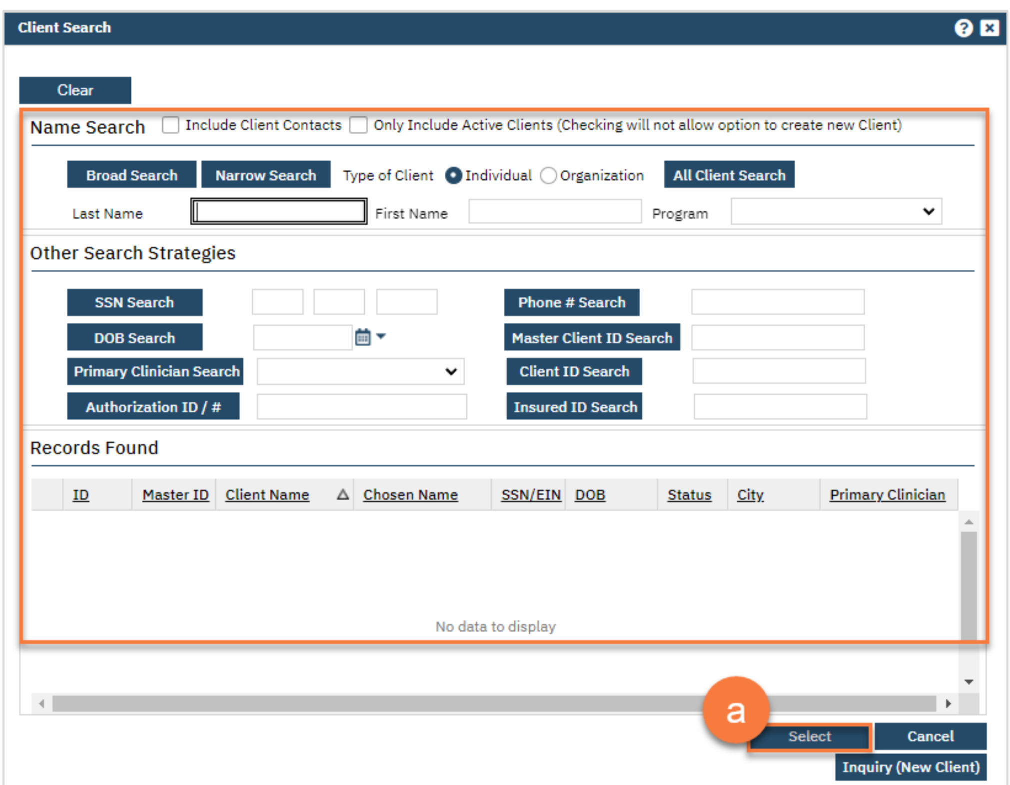
3. This will bring you to the Inquiries list page. **Create a new inquiry** by using the new icon.



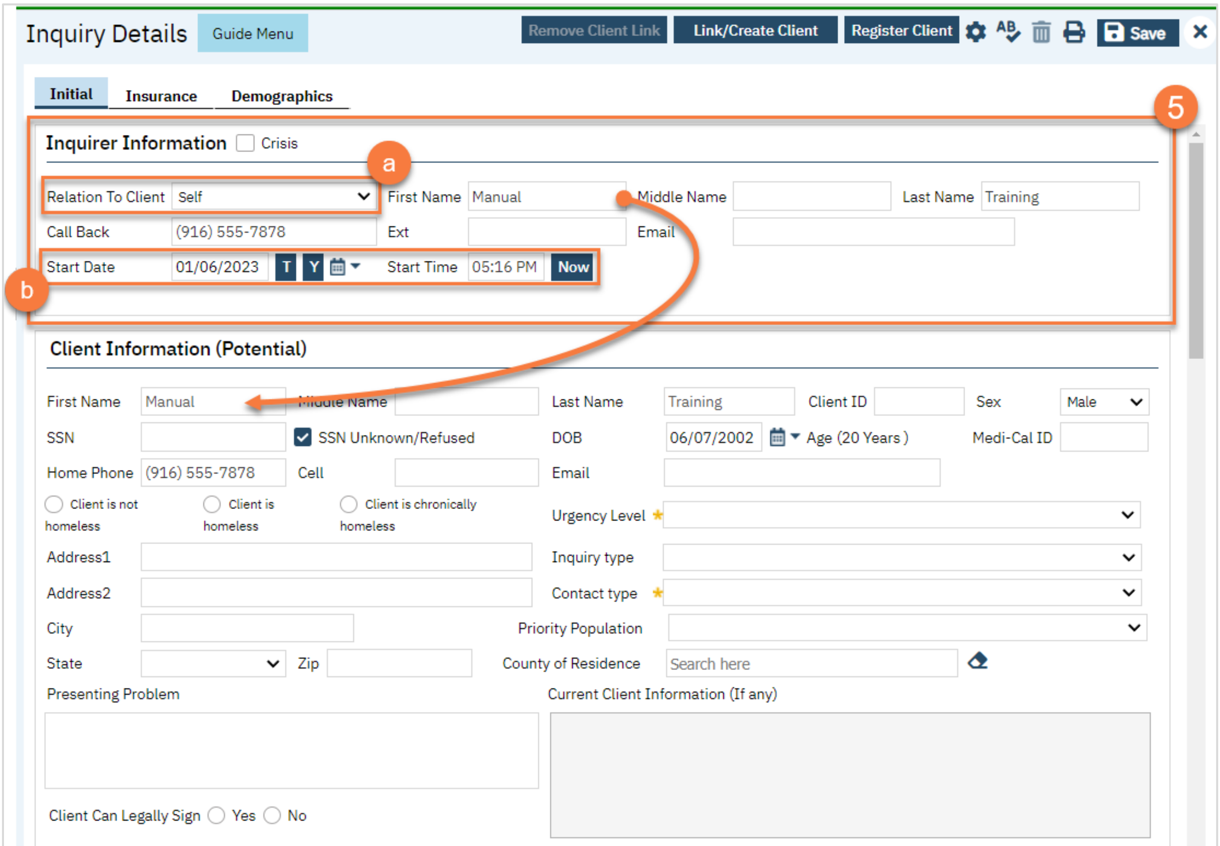
4. This will bring up the client search window. **You may search to determine if the person is a current client**. If person is a new client, or you cannot find them in the system, **click "Inquiry (New Client)".**



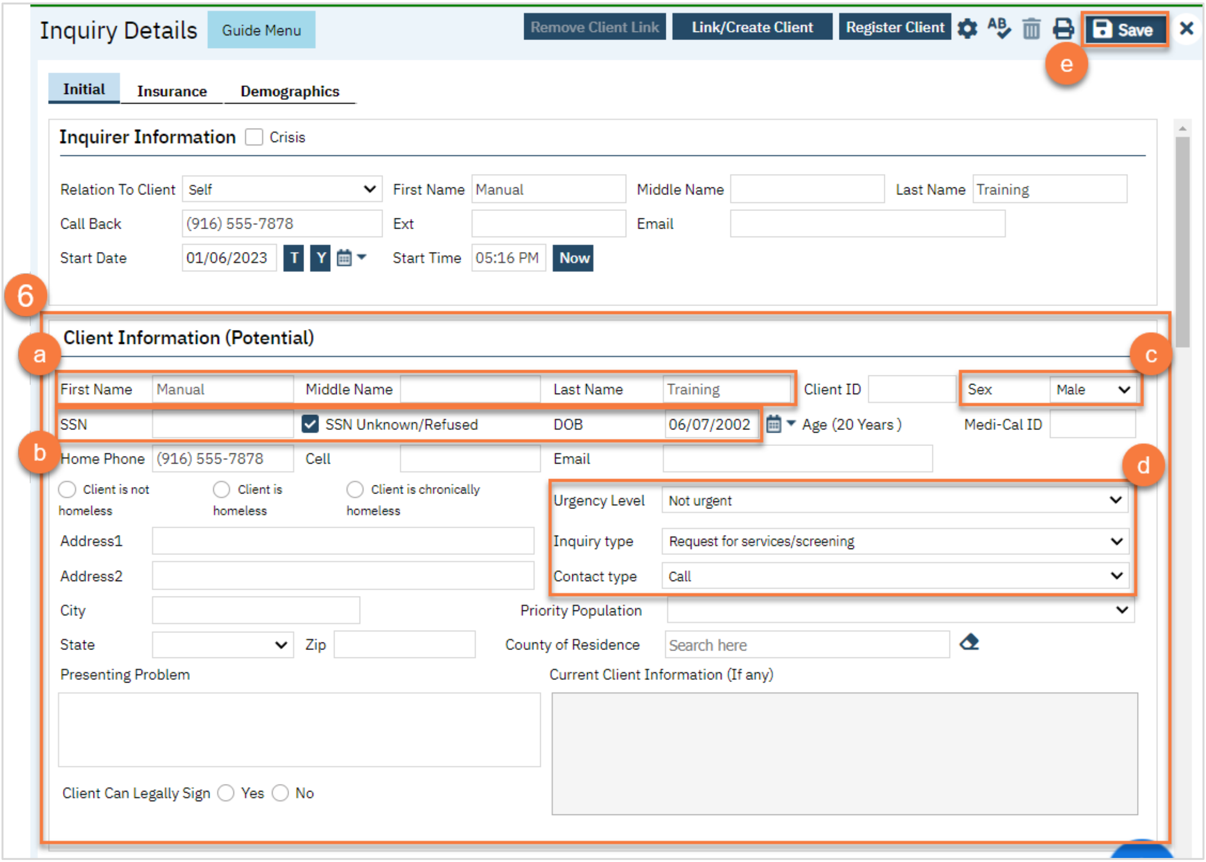
a. To search for a client, enter their name and click "Broad Search." You can also search by SSN by entering their social security number and clicking "SSN Search." You can do the same with date of birth (DOB), phone number, etc. If you find the person in the system, meaning they show in the Records Found section, click "Select" to bring their information into the Inquiry screen.



5. This brings you to the Inquiry Details screen. **Complete the information about the caller, or "Inquirer"**.
    a. If the client is calling for themselves, select "Self" under "Relation to Client." This way, as you enter the caller's information, it will push this information automatically into the "Client Information" section.
    b. Make sure to input the start date and time of the call. There are buttons for "T" (today) and "Now" to help make this quick and easy.



6. **Complete the information about the potential client**.
    a. **Complete the First Name and Last Name fields.** Middle Name is not required but can be added as necessary.
    b. **Complete the SSN and DOB fields.** This is for the client's social security number (SSN) and date of birth (DOB), respectively. If the client refuses to share, or doesn't know, you can simply check the box "SSN Unknown/Refused." Once saved, this will fill in the SSN with "999999999", which is SmartCare's version of "no SSN".
    c. **Complete the Sex field.**
    d. **Complete the Urgency Level, Inquiry type, and Contact type fields.** The options for each field are listed in the tables below. This includes a description of when to use each option.
    e. **Click Save.**

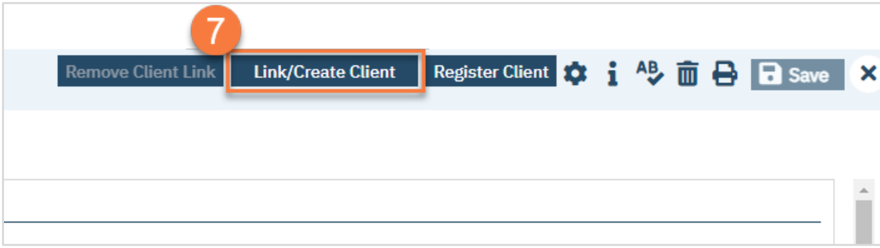


Urgency Level	Description/Use Case	Timelines
Emergent	Use if the call is an emergency	Addressed immediately
Not Urgent	Use if the call is a routine request for services	Appointment within 10 business days
Urgent	Use if the call is an urgent request	Appointment within 72 hours

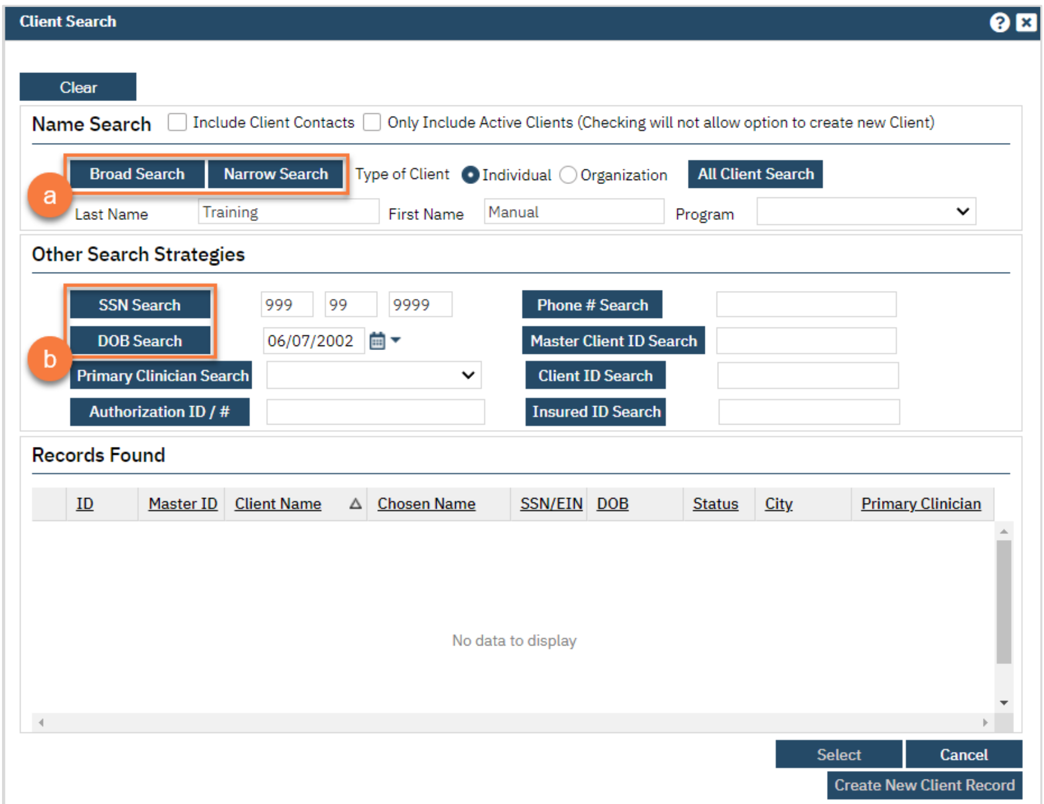
Inquiry Type	Description/Use Case
Requests for services/screening	Use when the reason for the call is a request for new services
Crisis	Use when the reason for the call is for crisis services
Information	Use when the reason for the call is for information
Discharge/Transition Coordination	Use when the reason for the call is for another provider to coordinate transition of care to/from your agency
Jail Diversion	Use when the reason for the call is related to Jail Diversion programs
Consultation	Use when the reason for the call is for an outside provider seeking a consultation
Other	Use when the reason for the call is not addressed by any of the above

Contact Type	Description/Use Case
Call	Use when the inquiry was complete via telephone
Face to Face	Use when the inquiry was completed via in-person, such as a walk-in
Form	Use when the inquiry was completed via form, such as a referral that was sent to the county
Teleconference	Use when the inquiry was complete via teleconference, such as Zoom, FaceTime, Webex, or other video-audio conferencing software

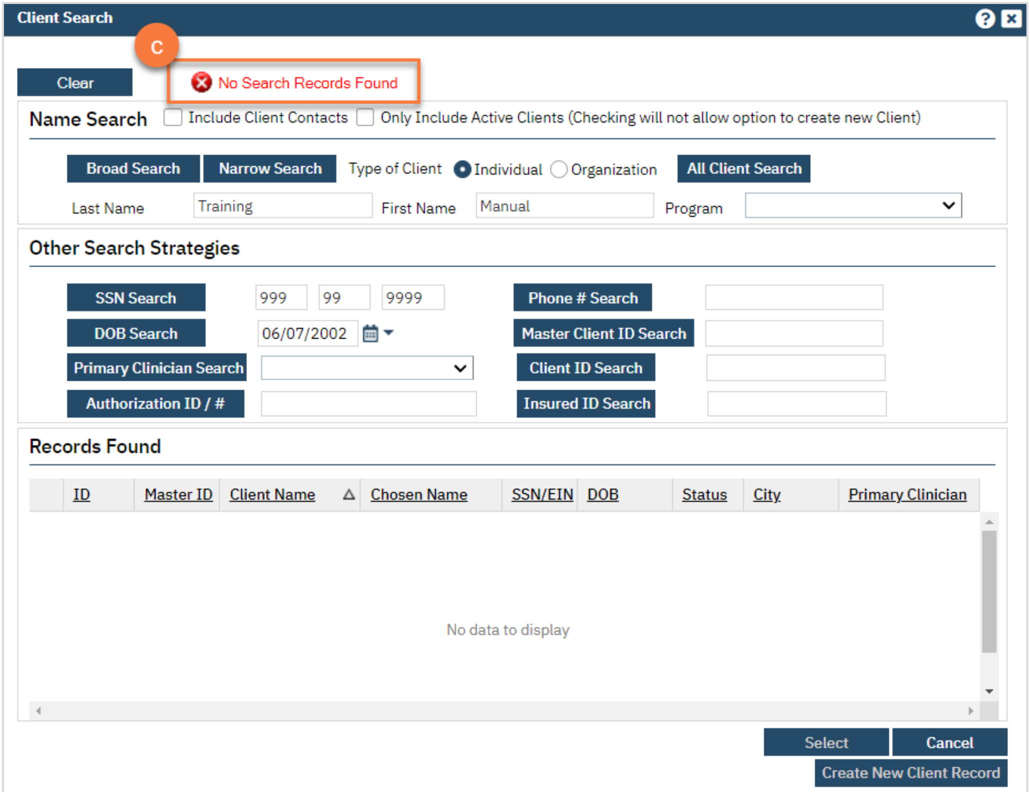
7. **Select the "Link/Create Client" button**. This will bring up the client search window, with a few extra buttons at the bottom.



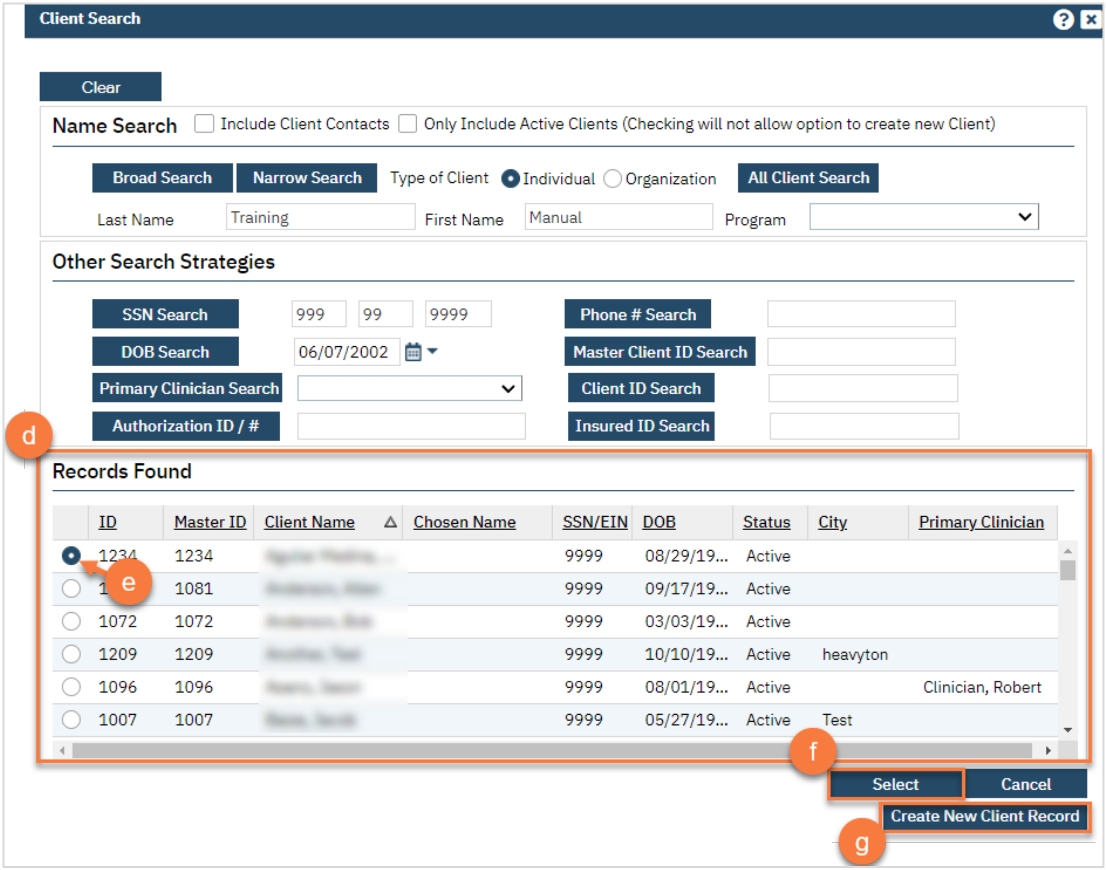
a. You must **search by name** by clicking on either "Broad Search" or "Narrow Search".
b. You must also **search by SSN and DOB** by clicking on those respective buttons.



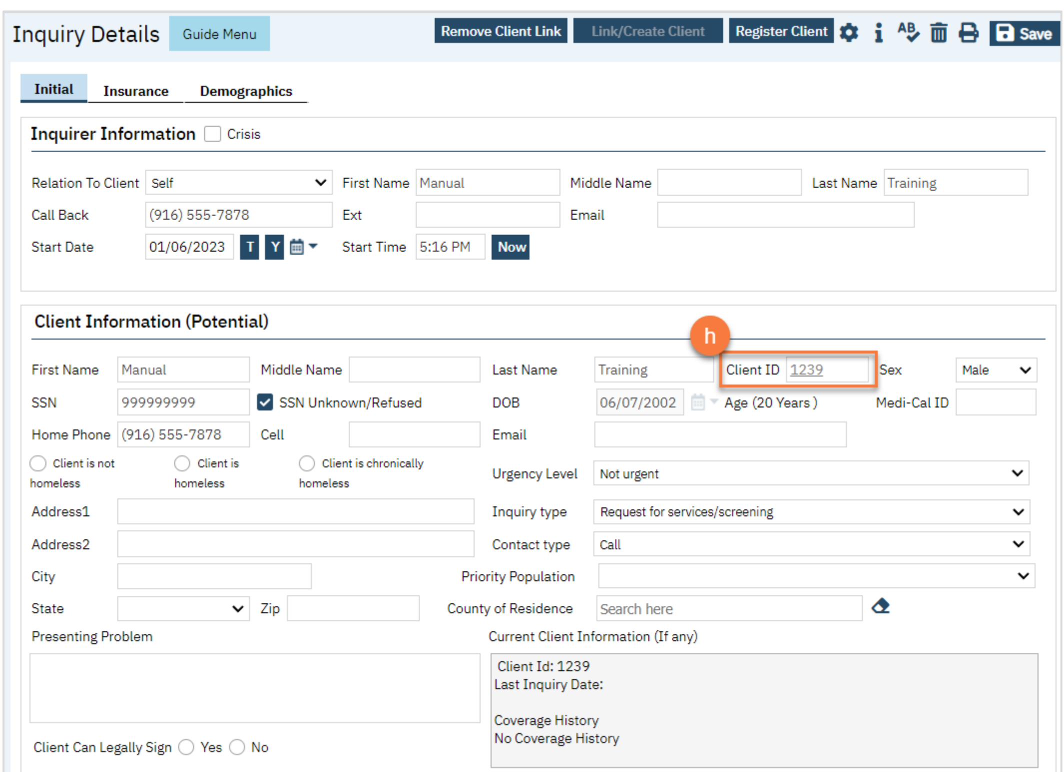
c. If no records are found based on the search you do, an alert will show at the top of the window.



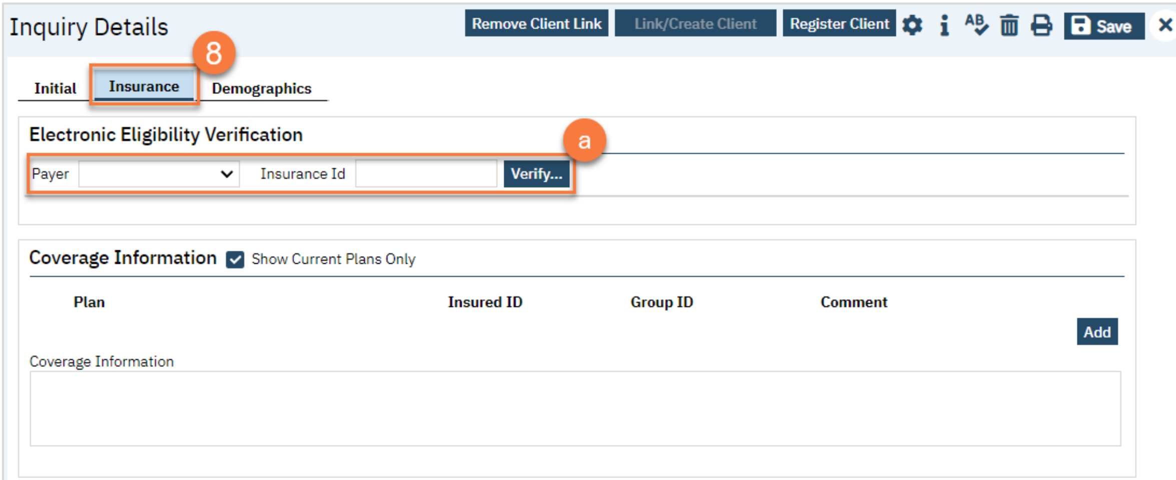
d. Any search results will show in the “Records Found” area. **Review the Records Found** to determine if the person is already in the system as a client.
e. If the person is already a client in the system, **select the button next to the appropriate record.**
f. **Click “Select”** to link the Inquiry to the selected client.
g. If the person is not a client, meaning no records were found matching the client’s information, **click “Create New Client Record.”**



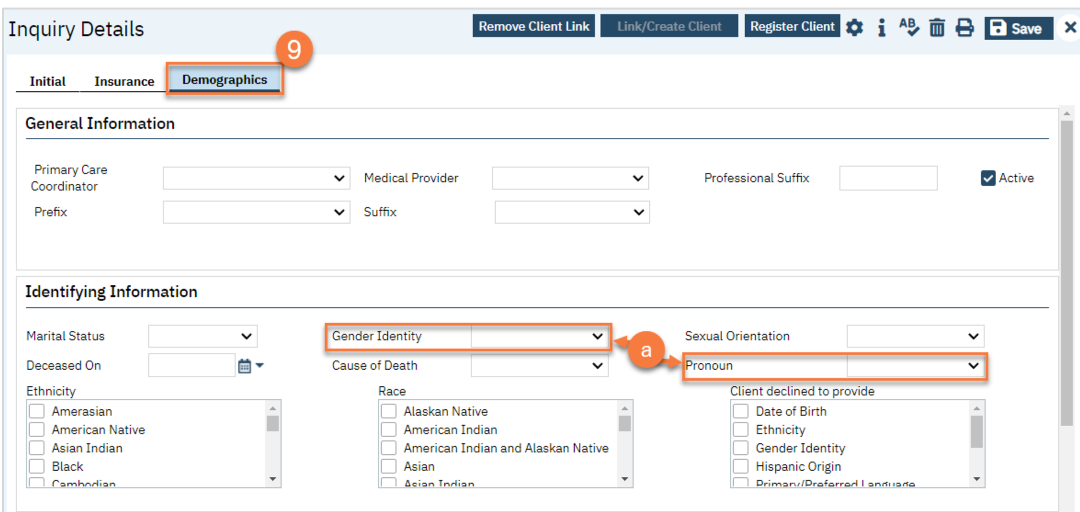
h. This will take you back to the Inquiry screen but now a client ID number will be added.



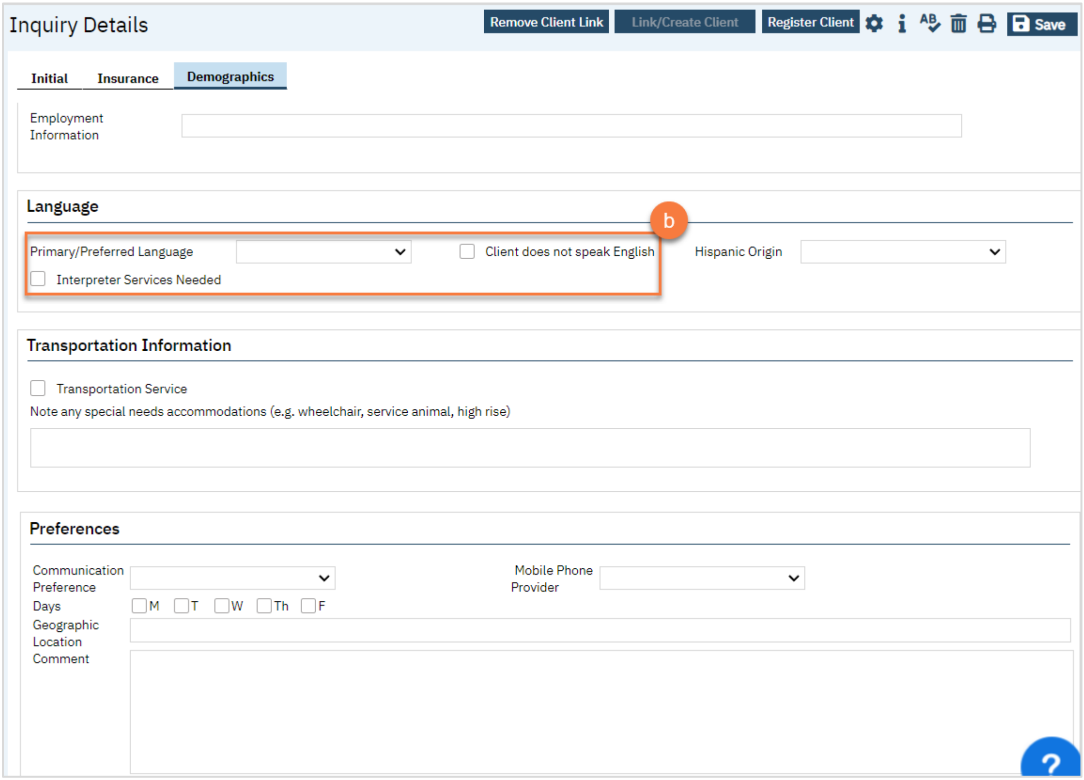
8. Click on the “Insurance” tab.
   a. Select “Medi-Cal” from the “Payer” drop-down and enter the client’s Medi-Cal number (CIN) in the “Insurance ID” field. Click “Verify” to verify the client’s Medi-Cal insurance.



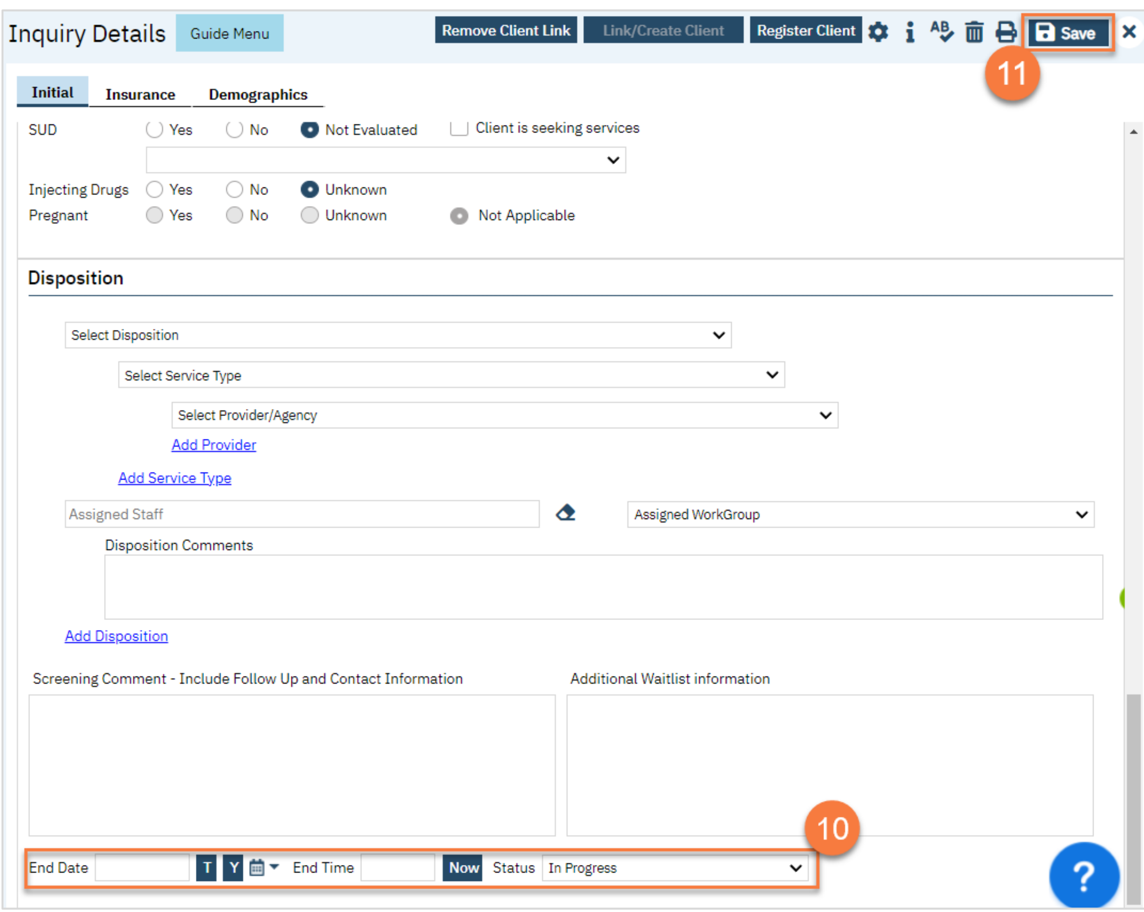
9. Click on the "Demographics" tab.
    a. We recommend **completing the "Gender Identity" and "Pronoun" fields** to ensure the person is not misgendered as additional staff engage with the client.



    b. **Complete the "Primary/Preferred Language" field.** If the client does not speak English or requires an interpreter, make sure to check the appropriate checkbox.



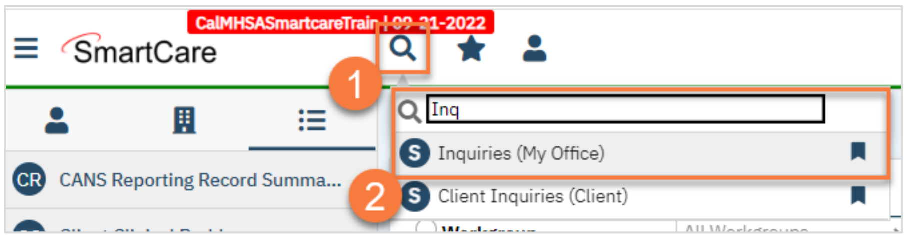
10. You may enter any additional information in any of the tabs, but none are required. Once complete, **enter the end date and time of the Inquiry and change the status to "Complete".** Once again, there are "T" (today) and "Now" buttons to make this easier.
11. **Click Save.** You may now close the Inquiry and move on to Screening.



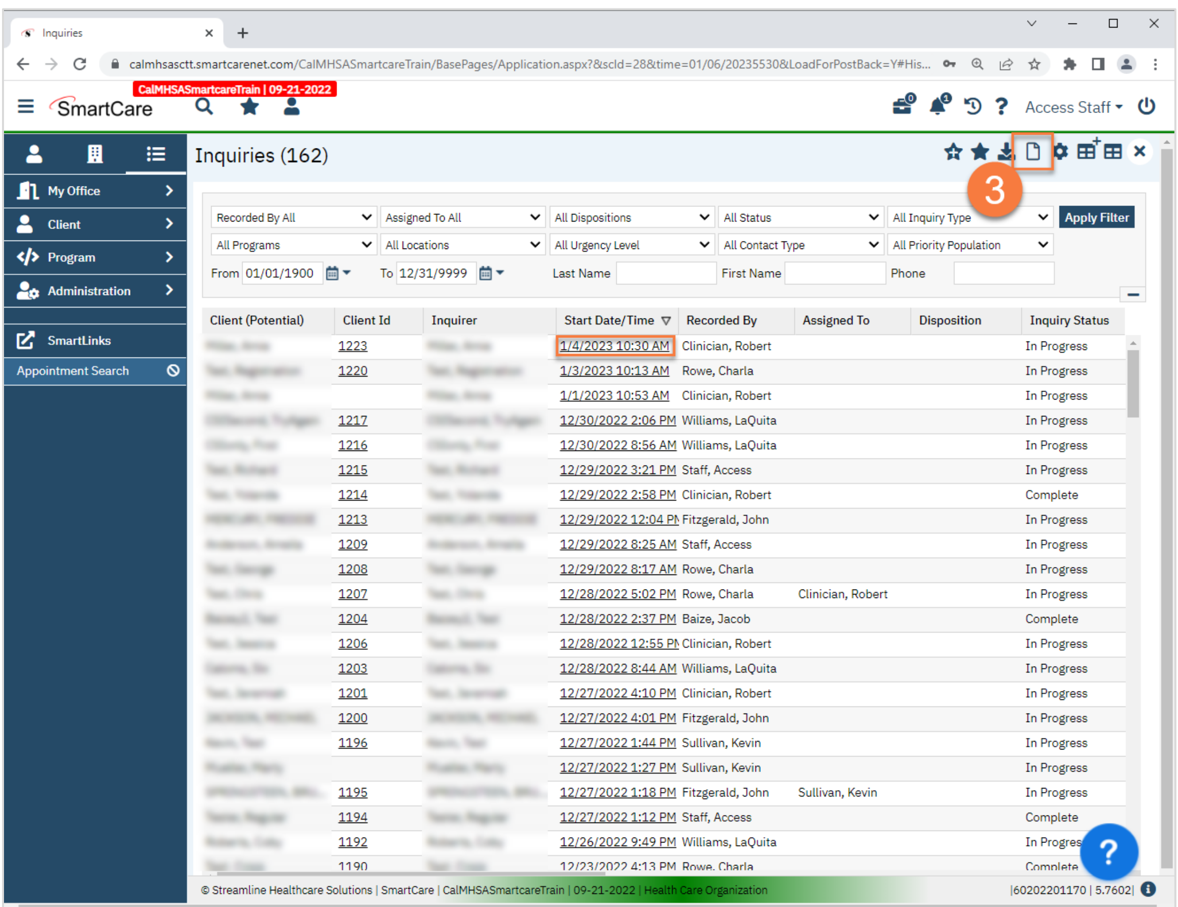
How do I document calls to the Crisis Line?

Crisis Line calls are documented on the Inquiry screen. This is simply how to document a call. Follow your county's procedures for handling crisis situations. Also consider the context of your crisis call when asking for information. Address the client's most pressing needs before attempting to gather information such as demographics or date of birth.

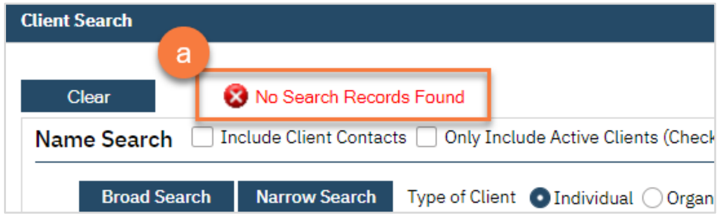
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



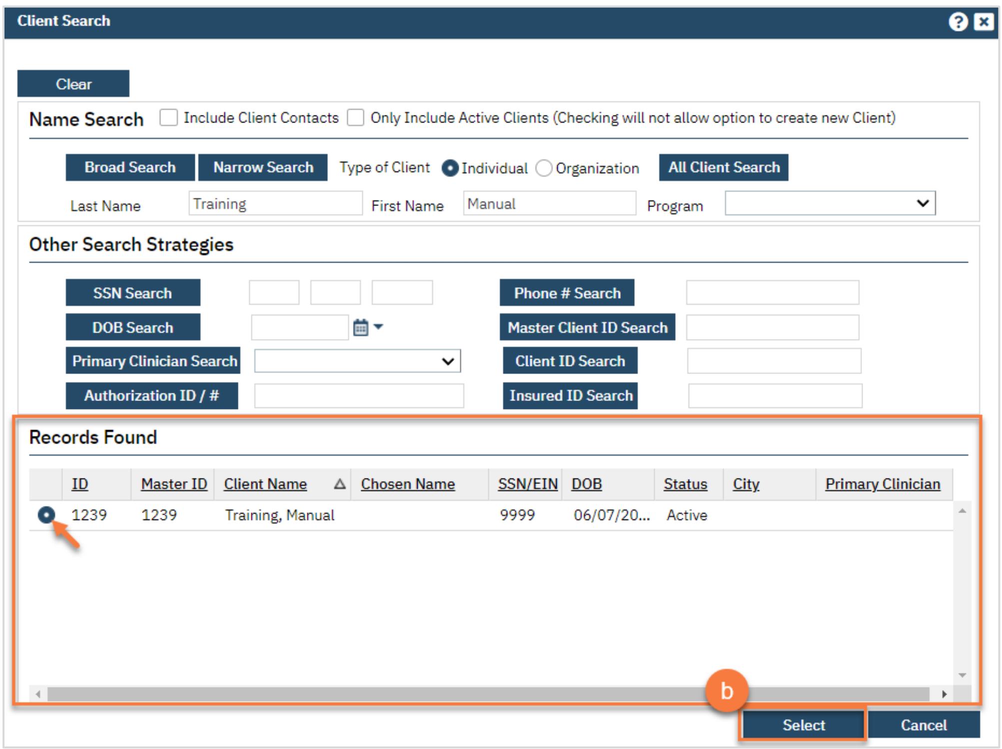
3. This will bring you to the Inquiries list page. If this call was transferred to you, search the list page to determine if an inquiry has already been started for this client. If so, **click the link in the Start Date/Time column**. If an inquiry has not been started, or if the call was direct to the crisis line, **create a new inquiry** by using the new icon.



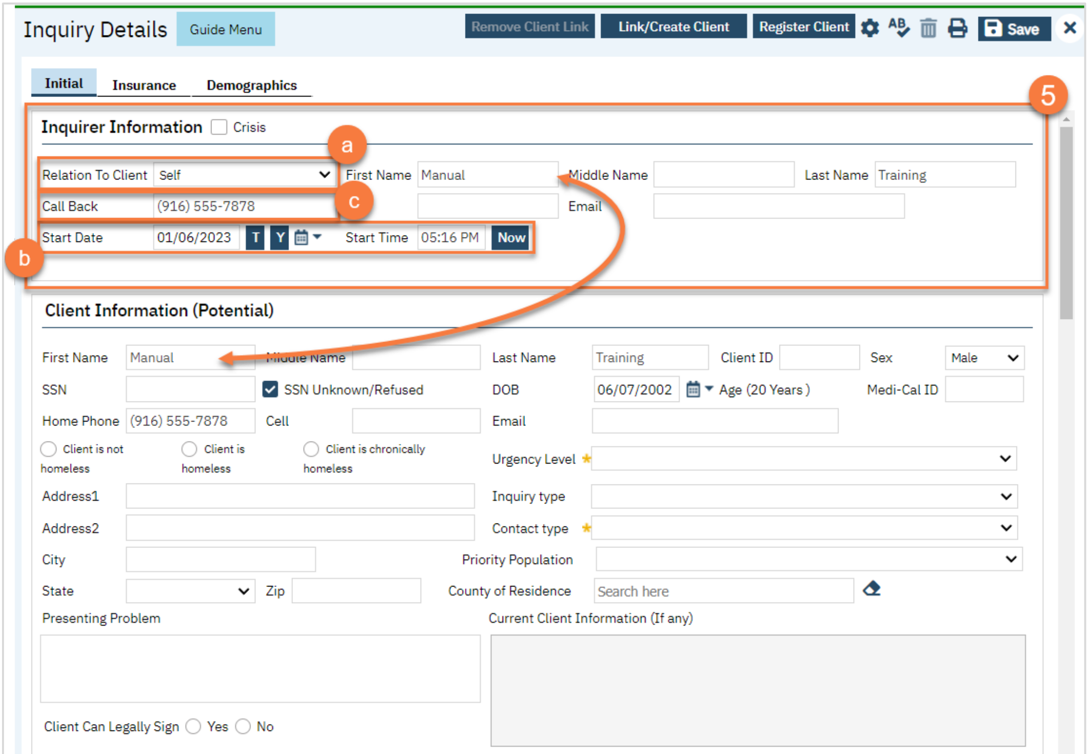
4. This will bring up the client search window. **Search to determine if the person is a client in the system**. The search includes both current and past clients. You can also **skip this step by selecting "Inquiry (New Client)"** if you know for certain this person is not a client in the system (e.g. they don't have a SmartCare client ID).
    a. If there are no matching records, an alert will show at the top of the Client Search window. You may want to try searching by DOB or SSN. **If there are no results, select "Cancel."** This will take you to the Inquiry screen.



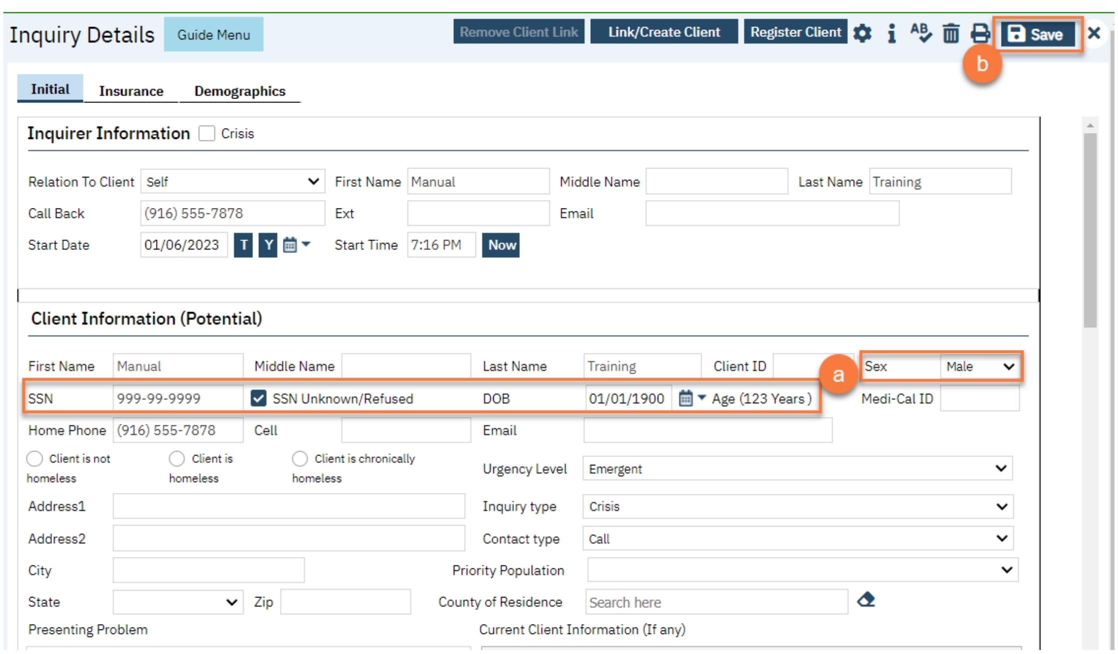
    b. Any search results will show in the "Records Found" area. **Review the Records Found** to determine if the person is already in the system as a client. If the person is already a client in the system, **select the button next to the appropriate record. Click "Select"** to link the Inquiry to the selected client. This will take you to the Inquiry screen and pre-populate the Client Information section.



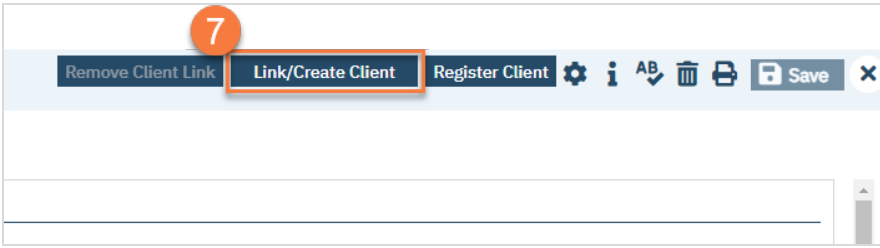
5. **Complete the information about the caller, or "Inquirer"**.
    a. Complete the **"Relation to Client" field.** If the client is calling for themselves, select "Self". If you've already selected a client, this section will auto-populate with the client's information. If the person is not already a client, as you enter the caller's information, it will push this information automatically into the "Client Information" section.
    b. **Enter the start date and time of the call.** There are buttons for "T" (today) and "Now" to help make this quick and easy.
    c. You may also **consider getting a call back number**, in case the client is disconnected or hangs up.



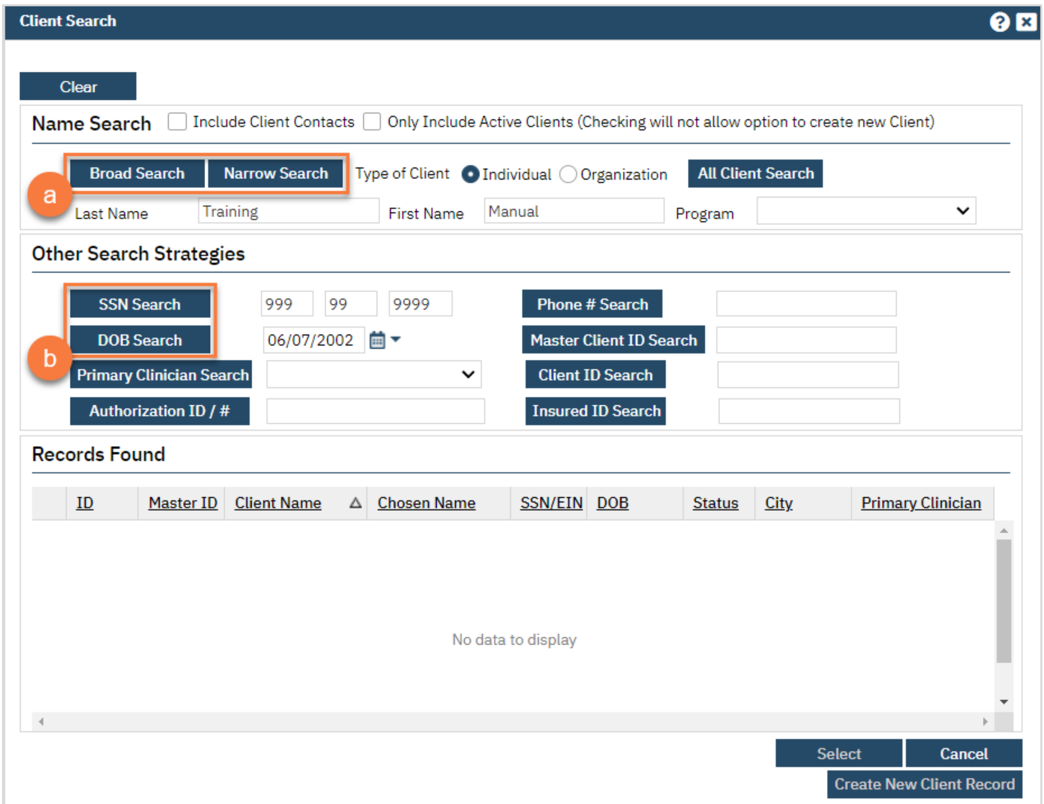
6. If the person is not a current client, add them as a client. To do this, **complete/confirm the client's First Name and Last Name fields**.
    a. **Complete the SSN, DOB, and Sex fields.** If the client refuses to share their SSN, doesn't know their SSN, or is not in a situation to answer, you can simply check the box "SSN Unknown/Refused." Once saved, this will fill in the SSN with "999999999", which is SmartCare's version of "no SSN". If the client is unable to provide their date of birth, enter your county's standard response to indicate "unknown DOB". All of these fields can be updated at a later date.
    b. **Click Save.**



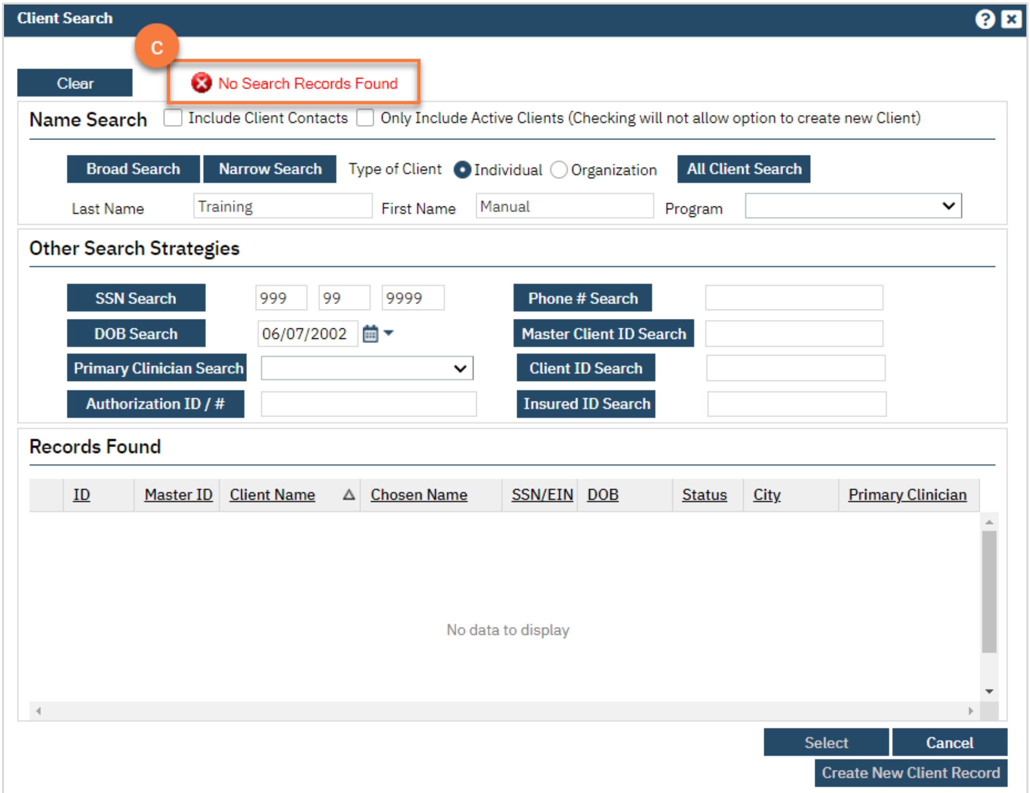
7. **Select the "Link/Create Client" button**. This will bring up the client search window, with a few extra buttons at the bottom.



a. You must **search by name** by clicking on either “Broad Search” or “Narrow Search”.
b. You must also **search by SSN and DOB** by clicking on those respective buttons.



c. If no records are found based on the search you do, an alert will show at the top of the window.

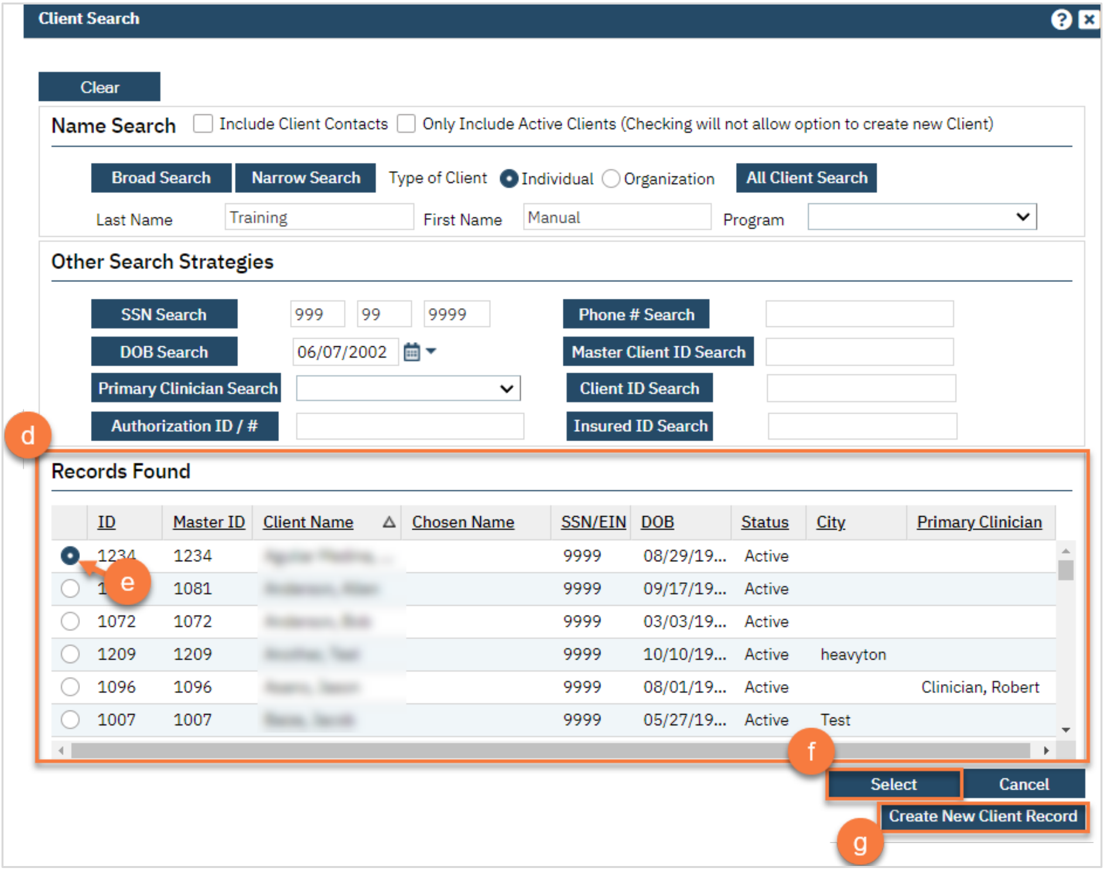


d. Any search results will show in the “Records Found” area. **Review the Records Found** to determine if the person is already in the system as a client.

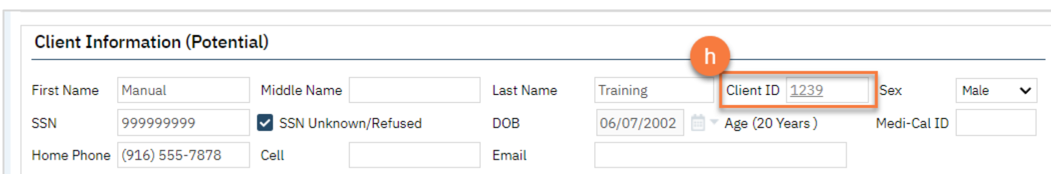
e. If the person is already a client in the system, **select the button next to the appropriate record.**

f. **Click “Select”** to link the Inquiry to the selected client.

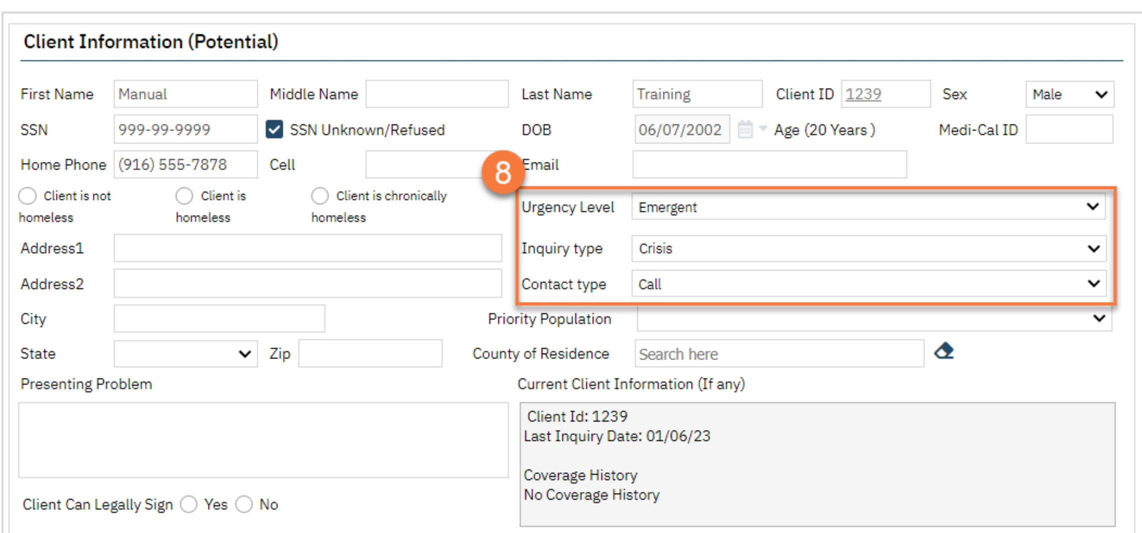
g. If the person is not a client, meaning no records were found matching the client’s information, **click “Create New Client Record.”**



h. This will take you back to the Inquiry screen but now a client ID number will be added.



8. Assess the urgency of the call, as sometimes people call the Crisis Line by mistake. **Complete the Urgency Level, Inquiry type, and Contact type fields.** The options for each field are listed in the tables below. This includes a description of when to use each option.

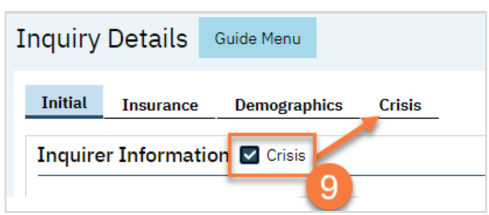


Urgency Level	Description/Use Case	Timelines
Emergent	Use if the call is an emergency	Addressed immediately
Not Urgent	Use if the call is a routine request for services	Appointment within 10 business days
Urgent	Use if the call is an urgent request	Appointment within 72 hours

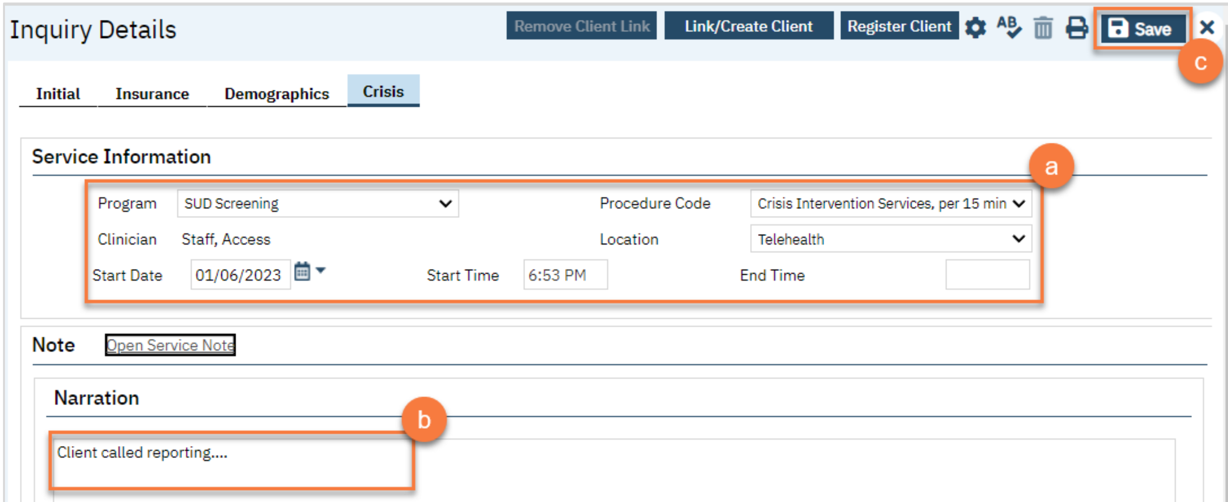
Inquiry Type	Description/Use Case
Requests for services/screening	Use when the reason for the call is a request for new services
Crisis	Use when the reason for the call is for crisis services
Information	Use when the reason for the call is for information
Discharge/Transition Coordination	Use when the reason for the call is for another provider to coordinate transition of care to/from your agency
Jail Diversion	Use when the reason for the call is related to Jail Diversion programs
Consultation	Use when the reason for the call is for an outside provider seeking a consultation
Other	Use when the reason for the call is not addressed by any of the above

Contact Type	Description/Use Case
Call	Use when the inquiry was complete via telephone
Face to Face	Use when the inquiry was completed via in-person, such as a walk-in
Form	Use when the inquiry was completed via form, such as a referral that was sent to the county
Teleconference	Use when the inquiry was complete via teleconference, such as Zoom, FaceTime, Webex, or other video-audio conferencing software

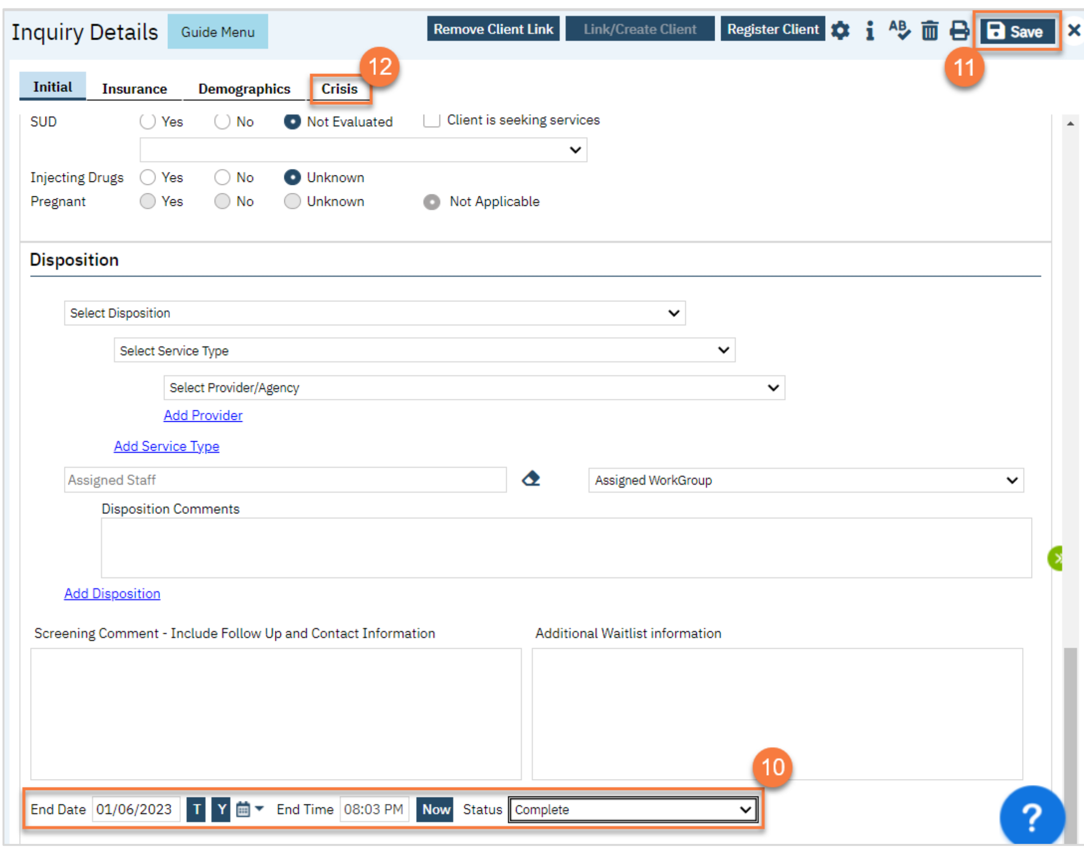
9. If the person is actually in crisis, **select the checkbox labeled "Crisis"** at the top of the screen. This opens a new tab where you'll document your call with the client. If the client is not actually in crisis, document the call as appropriate. If the client is requesting services, we recommend following the steps in How do I document a request for services received via the Access Line?



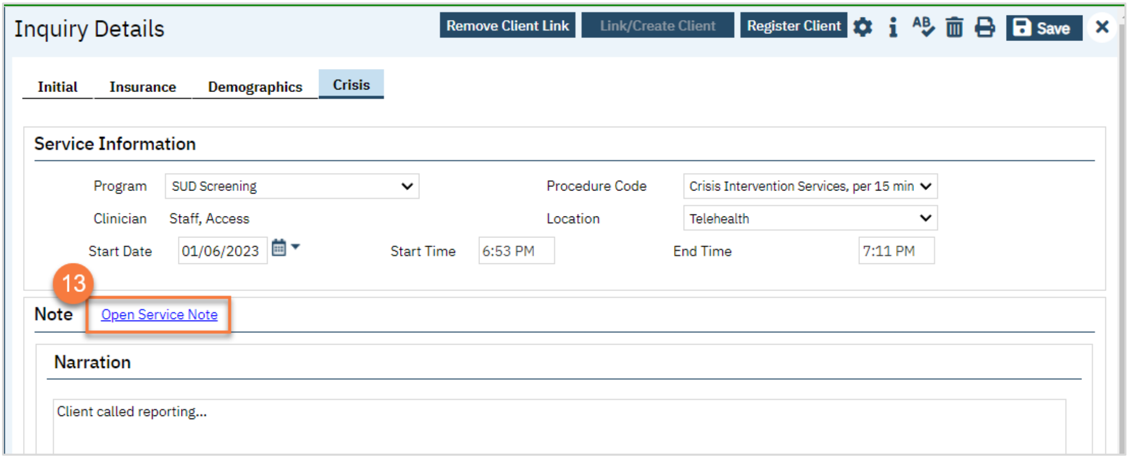
   a. In the Crisis tab, **enter the service information.** This will then open a text field for you to enter the note.
   b. **Enter narrative information in the Narration field**.
   c. **Click Save**.



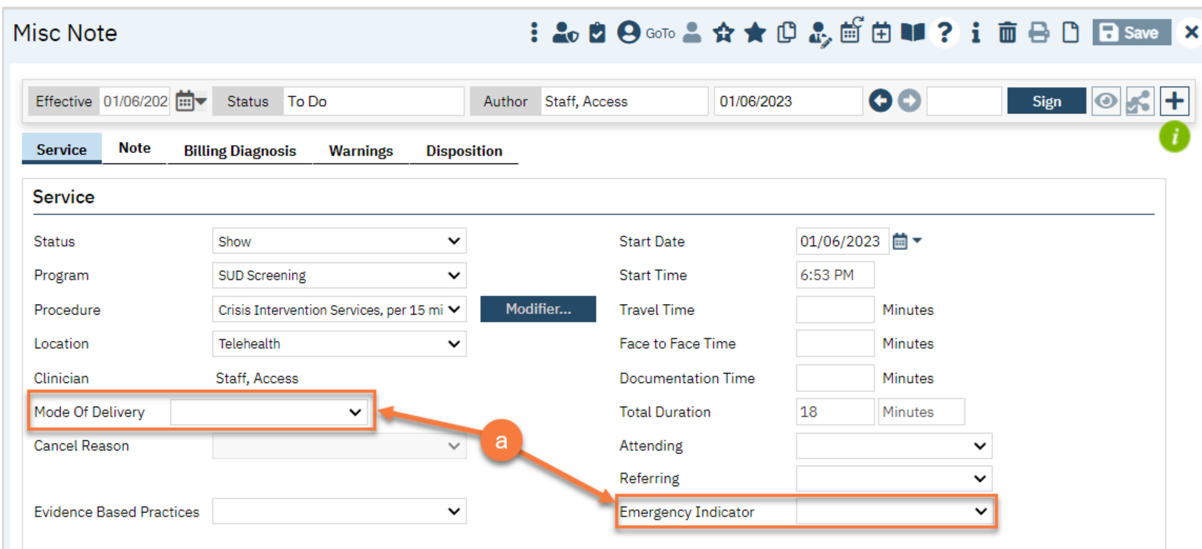
10. When you're finished with the crisis call, navigate back to the Initial tab and scroll to the bottom of the page. **Enter the end date and time of the Inquiry and change the status to "Complete".** Once again, there are "T" (today) and "Now" buttons to make this easier.
11. **Click Save**.
12. **Navigate back to the Crisis tab**.



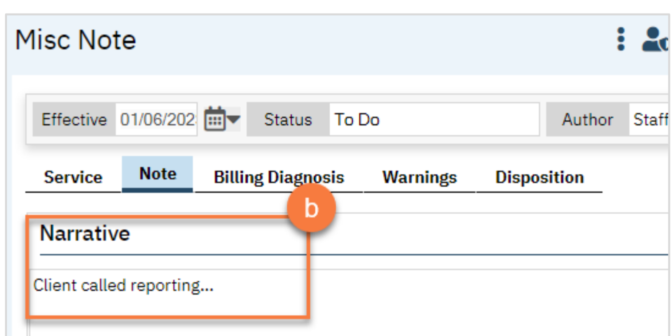
13. **Click the newly available link for Open Service Note**.



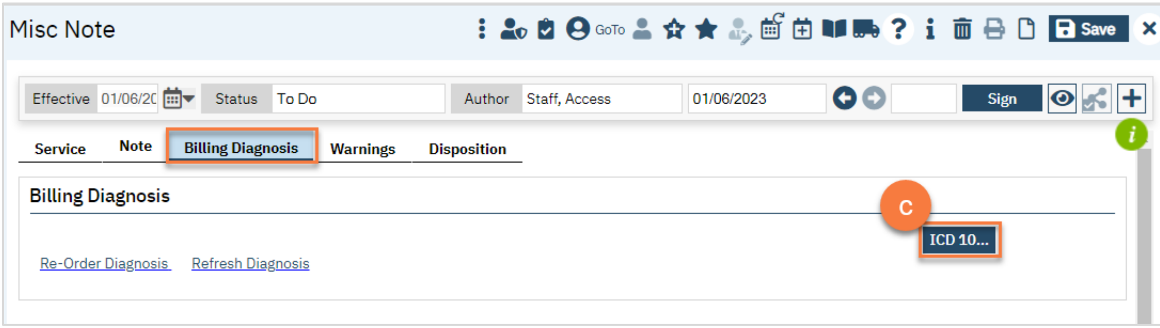
a. This brings up a service note screen. It will pull most information forward, including creating a total duration, based on start and end times. **Enter Emergency Indicator and Mode of Delivery**, as well as any other necessary fields.



b. **Click on the Note tab to confirm your narrative note was pulled forward.** Add any additional information as needed.



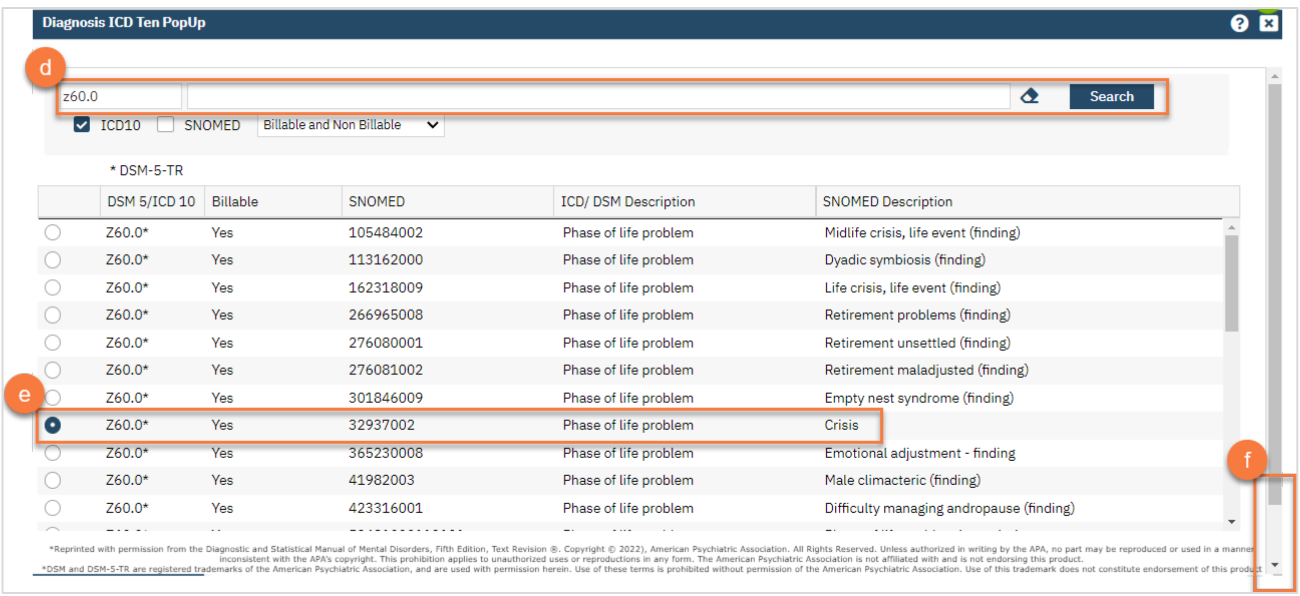
c. **Click on the Billing Diagnosis tab.** If the client already has a diagnosis, you can leave this section as is. If this client does not have a diagnosis, **click on the ICD 10 button.**



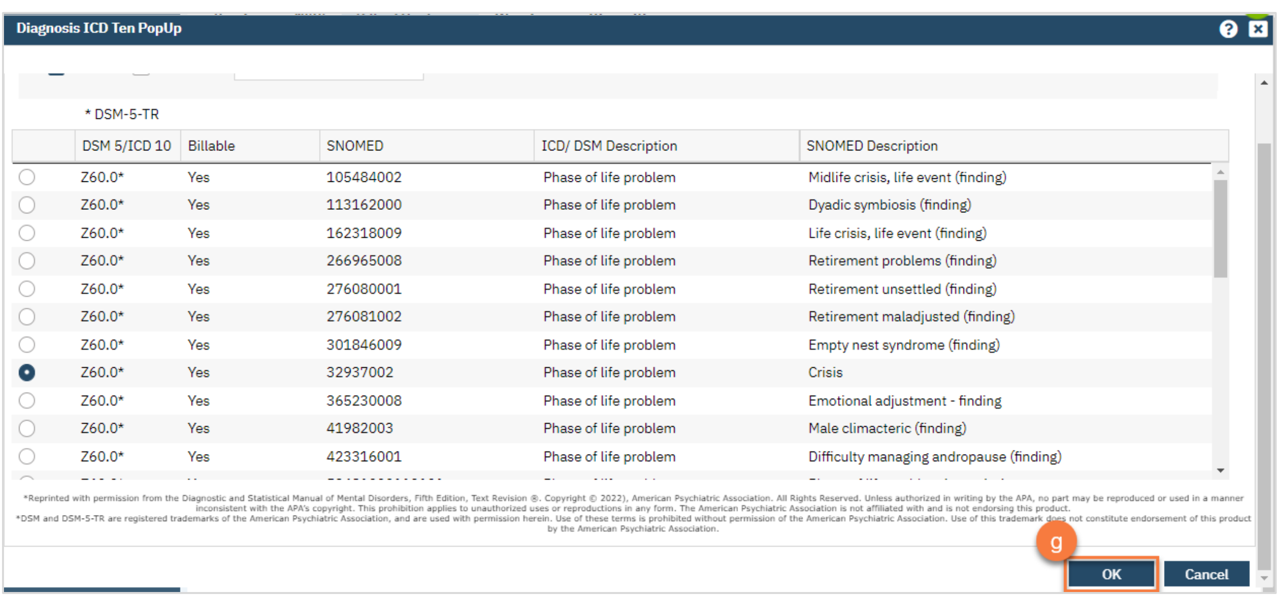
d. This brings up a Diagnosis pop-up window. **Search for a diagnosis using the code field or description field.** If you are an LPHA, you may use "Z03.89 Encounter for observation for other suspected diseases and conditions ruled out". If you are not an LPHA, you can select an appropriate Social Determinant of Health, such as "Z60.0 Phase of life problem – Crisis".

e. **Select the code you want to use.**

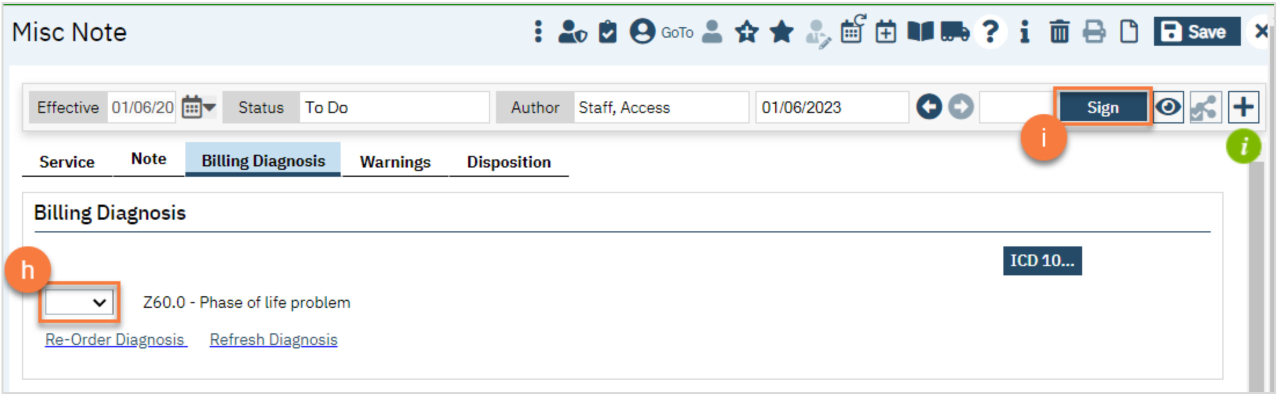
f. **Scroll to the bottom of the screen.**



g. **Click OK.**



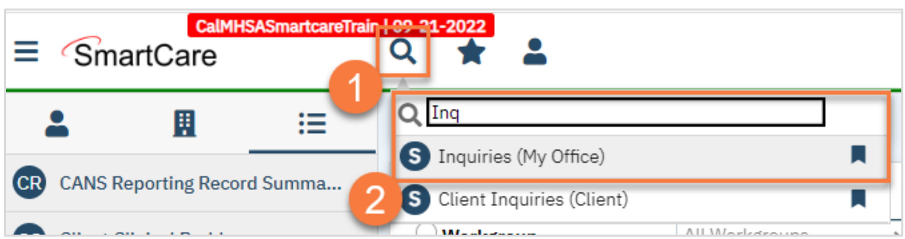
h. This brings you back to the Billing Diagnosis tab on the note. **Select "1" from the drop down next to the newly added ICD-10 code**.
i. Once you've completed all pieces of the service note, **click Sign**. You are now finished and may close any open screens.



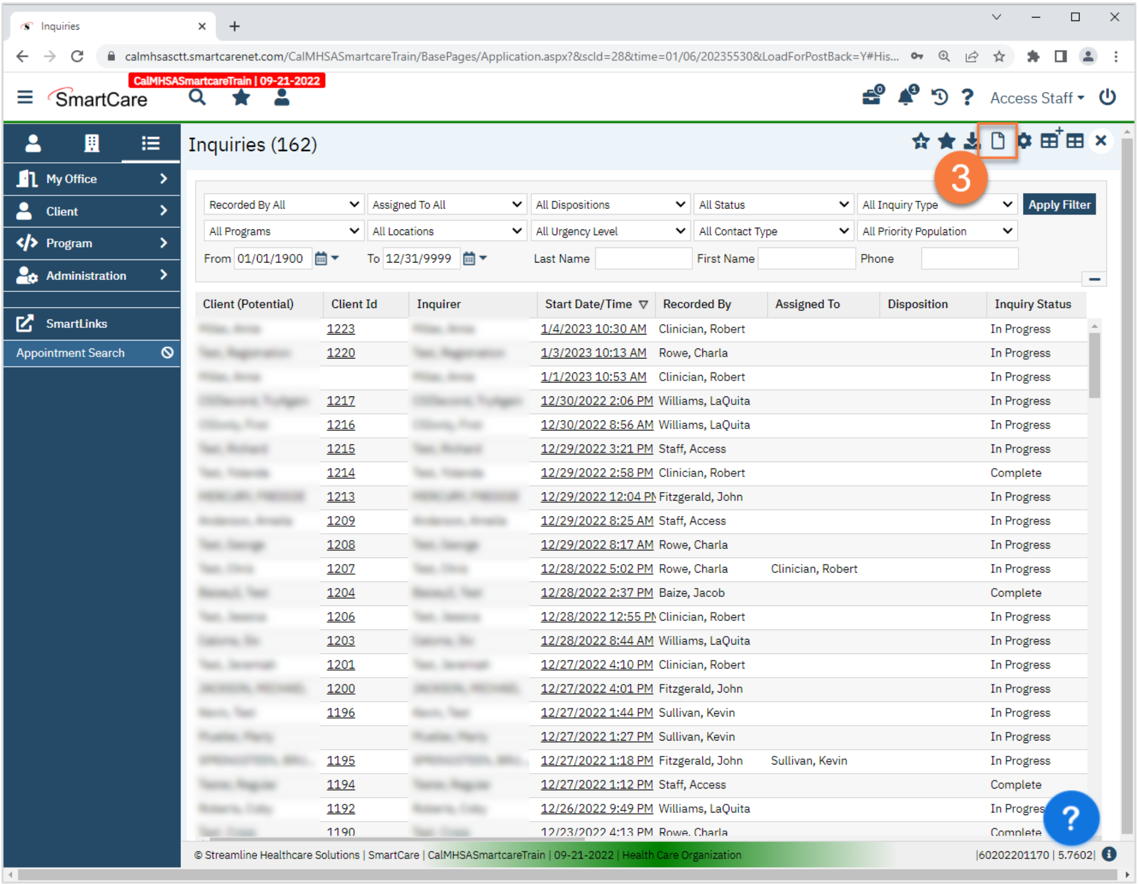
What do I do when I receive a paper referral from a partner agency?

Paper referrals, meaning referrals that are received via a form, fax, paper, etc. are documented on the Inquiry screen.

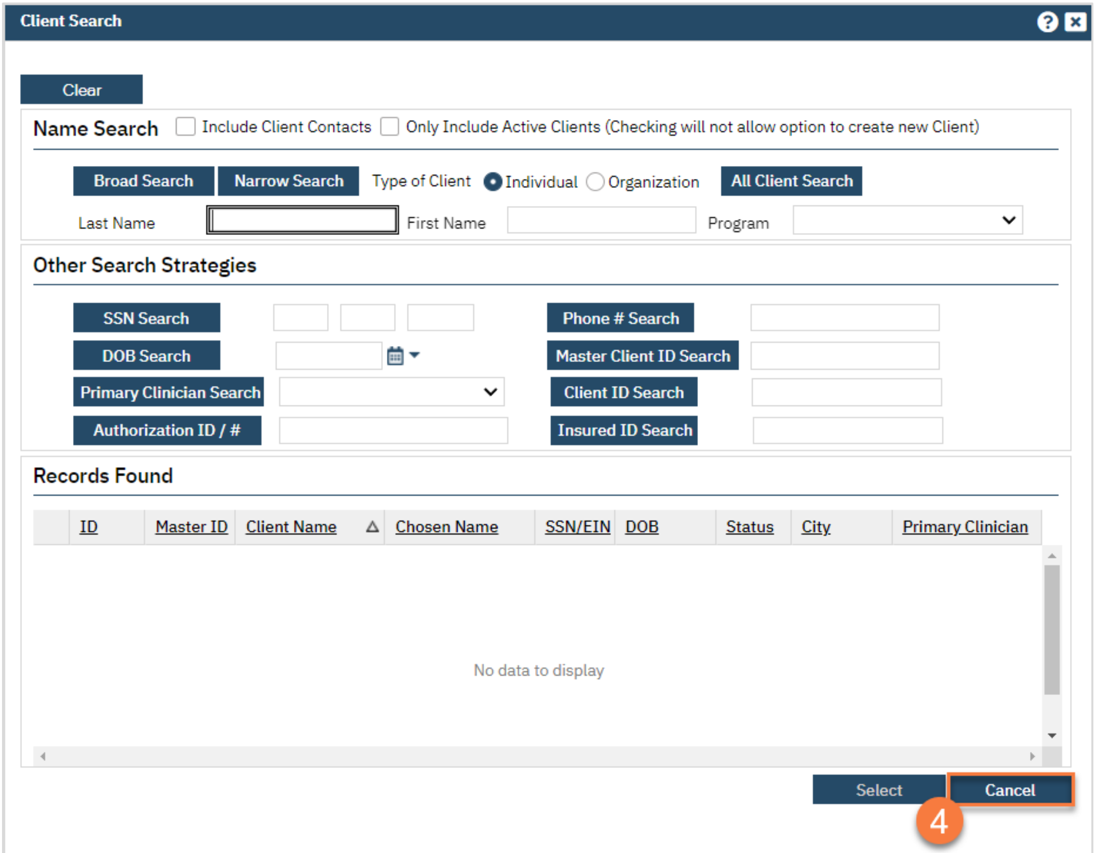
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



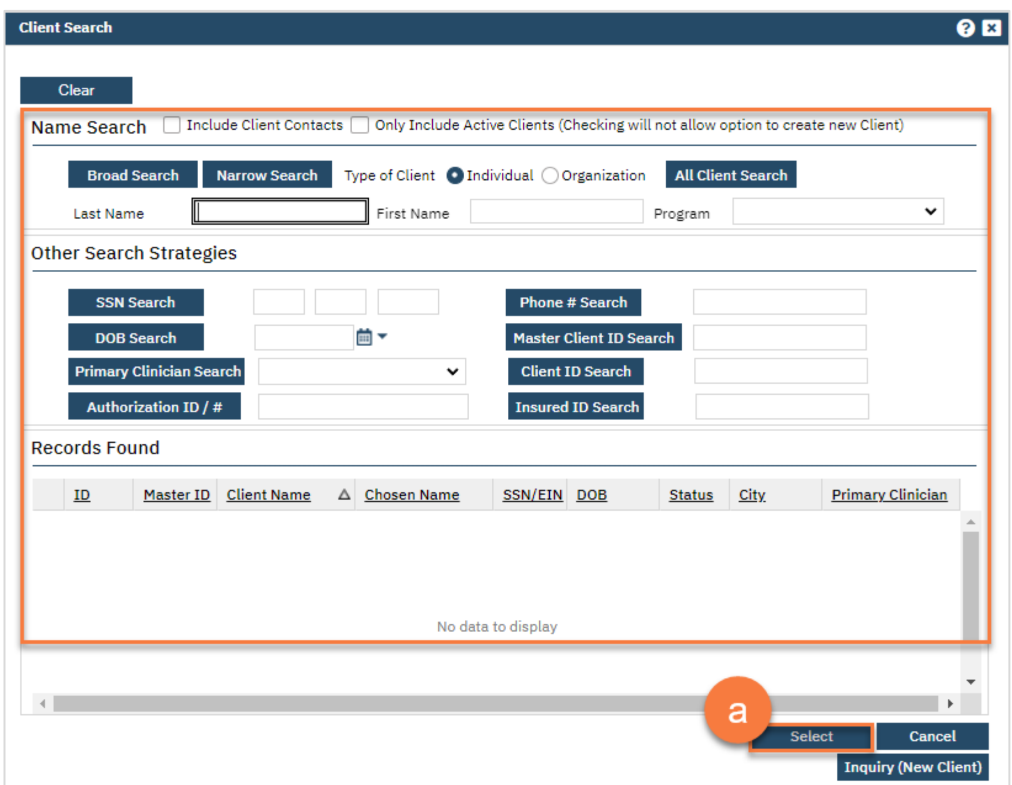
3. This will bring you to the Inquiries list page. **Create a new inquiry** by using the new icon.



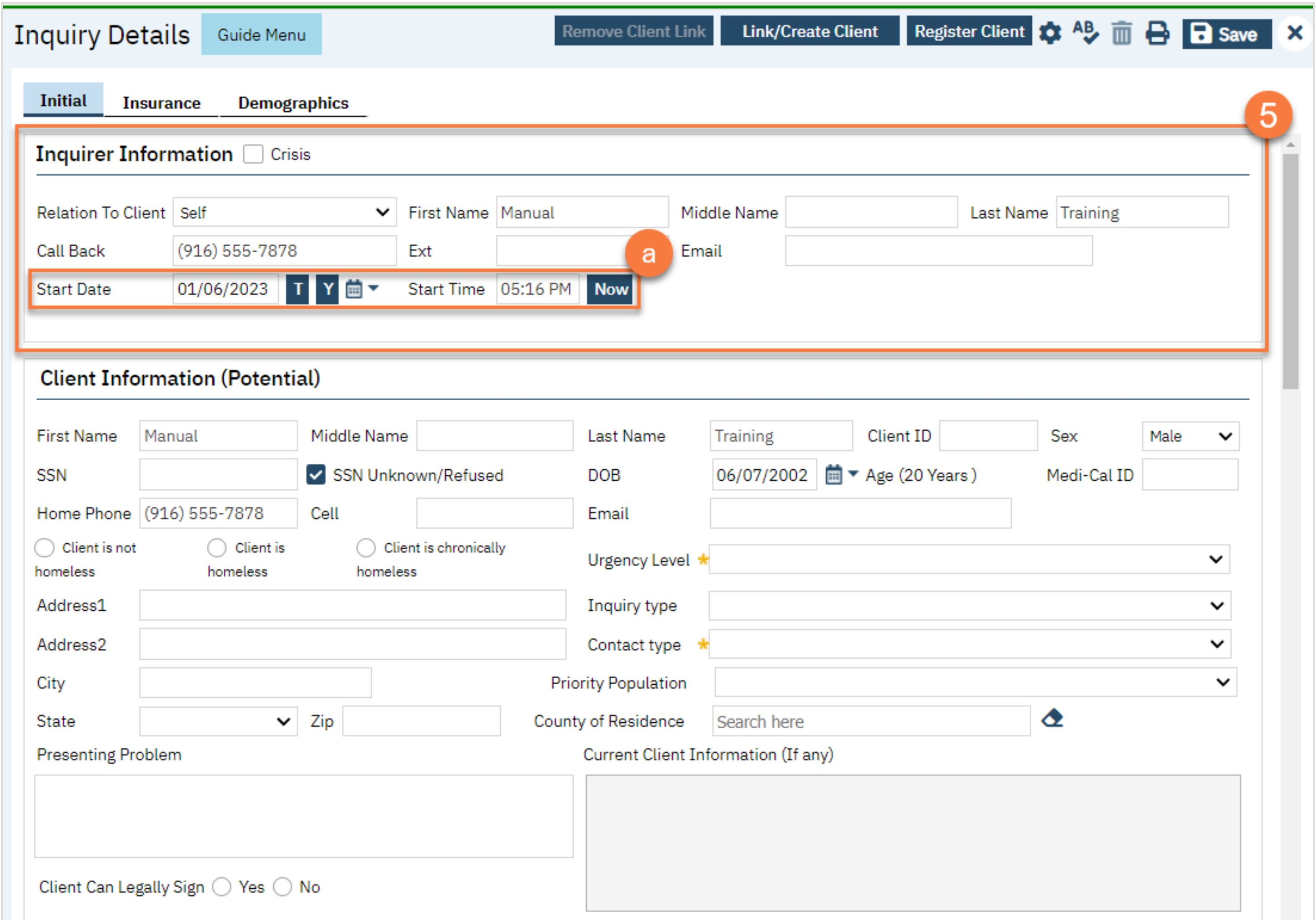
4. This will bring up the client search window. **You may search to determine if the person is a current client**. If person is a new client, or you cannot find them in the system, **click "Inquiry (New Client)".**



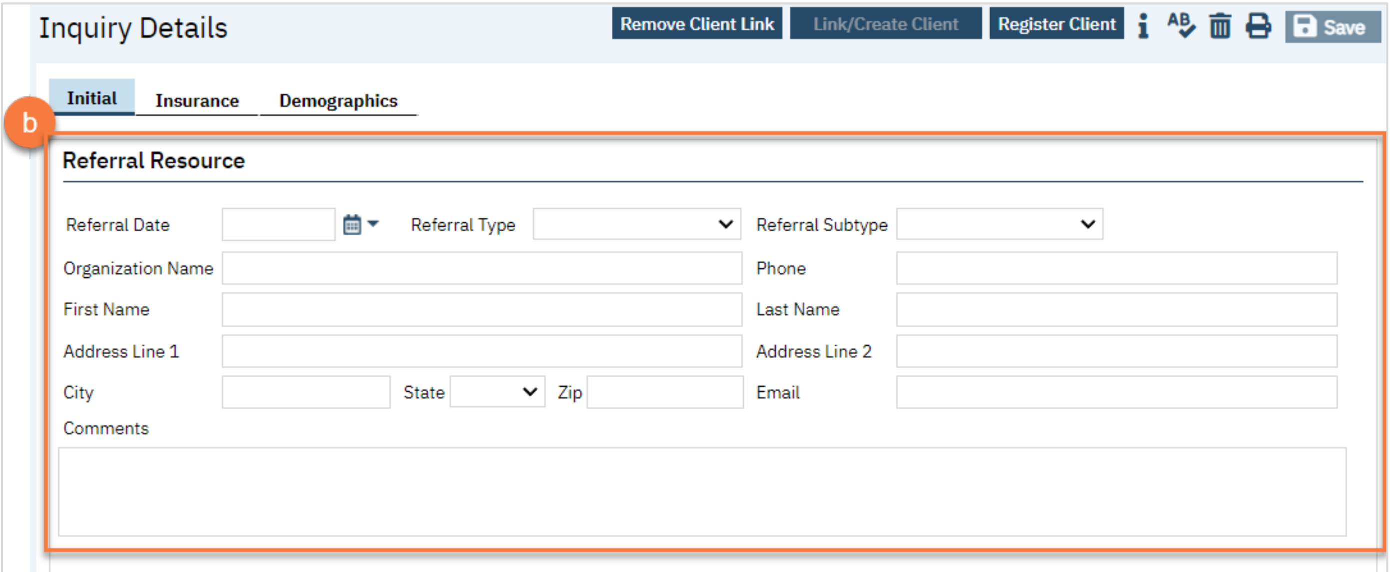
a. To search for a client, enter their name and click "Broad Search." You can also search by SSN by entering their social security number and clicking "SSN Search." You can do the same with date of birth (DOB), phone number, etc. If you find the person in the system, meaning they show in the Records Found section, click "Select" to bring their information into the Inquiry screen.



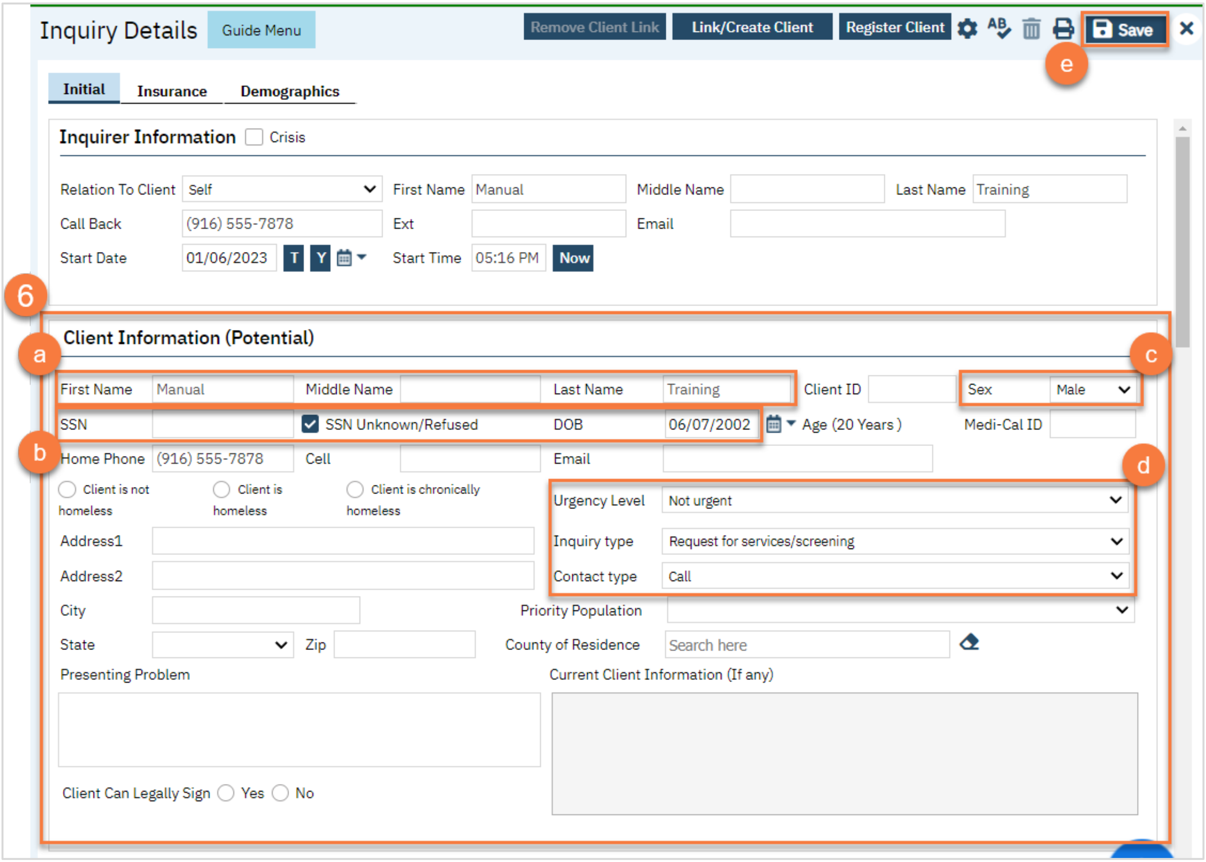
5. This brings you to the Inquiry Details screen. **Complete the information about the person requesting services, or "Inquirer"**.
    a. Make sure to input the date and time you received the referral in Start Date and Start Time. There are buttons for "T" (today) and "Now" to help make this quick and easy.



    b. To complete the rest of the referring agency's information, navigate to the Referral Resource section further down on the page. Your county may choose to leave the inquirer information blank and simply enter the agency information, along with contact person, in this section. This section's information currently does not show on the list page, however.



6. **Complete the information about the potential client.**
   a. **Complete the First Name and Last Name fields.** Middle Name is not required but can be added as necessary.
   b. **Complete the SSN and DOB fields.** This is for the client's social security number (SSN) and date of birth (DOB), respectively. If the client refuses to share, or doesn't know, you can simply check the box "SSN Unknown/Refused." Once saved, this will fill in the SSN with "999999999", which is SmartCare's version of "no SSN".
   c. **Complete the Sex field.**
   d. **Complete the Urgency Level, Inquiry type, and Contact type fields.** The options for each field are listed in the tables below. This includes a description of when to use each option.
   e. **Click Save.**



Urgency Level	Description/Use Case	Timelines
Emergent	Use if the referral is an emergency	Addressed immediately
Not Urgent	Use if the referral is a routine request for services	Appointment within 10 business days
Urgent	Use if the referral is an urgent request for services	Appointment within 72 hours

Inquiry Type	Description/Use Case
Requests for services/screening	Use when the referral is a request for new services
Crisis	Use when the referral is for crisis services
Information	Use when the referral is for information
Discharge/Transition Coordination	Use when the referral is for another provider to coordinate transition of care to/from your agency
Jail Diversion	Use when the referral is related to Jail Diversion programs
Consultation	Use when the referral is for an outside provider seeking a consultation
Other	Use when the referral is not addressed by any of the above

Contact Type	Description/Use Case
Call	Use when the inquiry was complete via telephone
Face to Face	Use when the inquiry was completed via in-person, such as a walk-in
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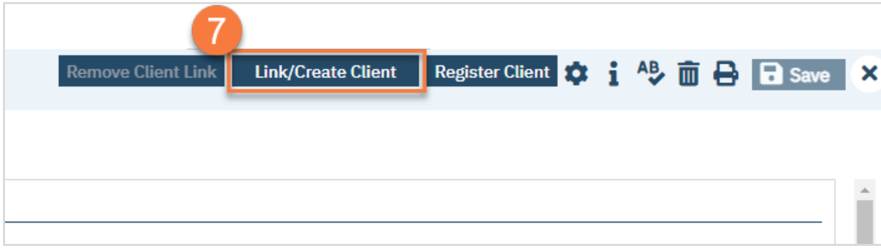
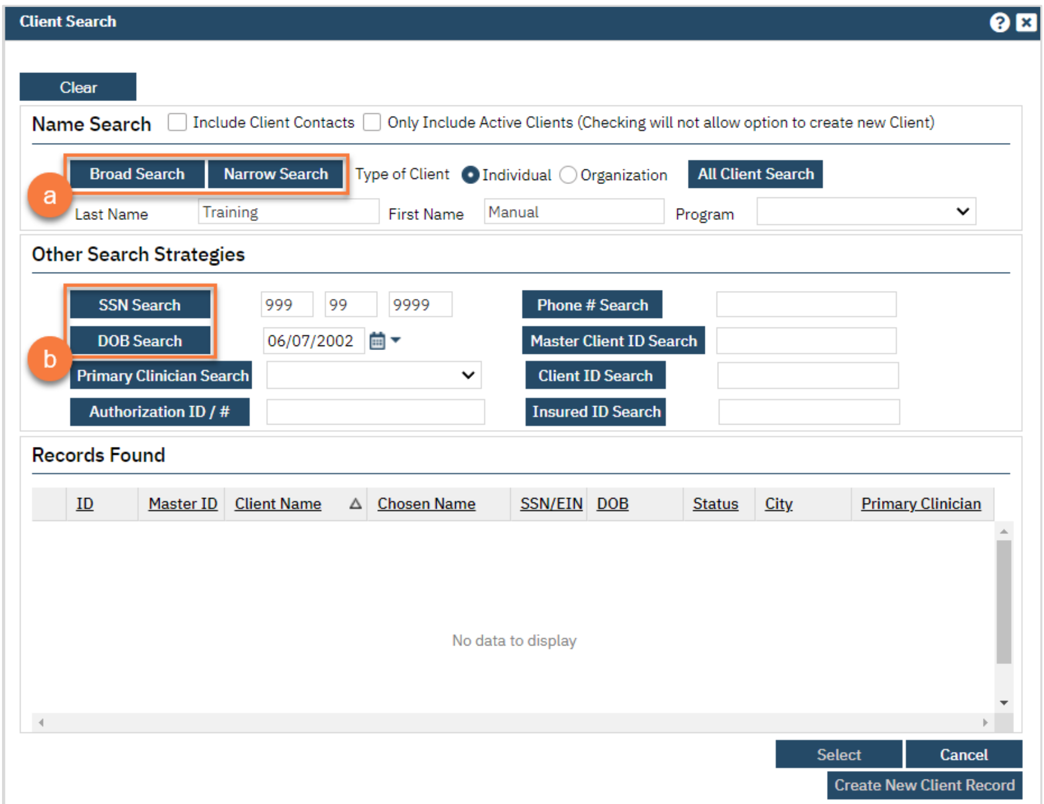
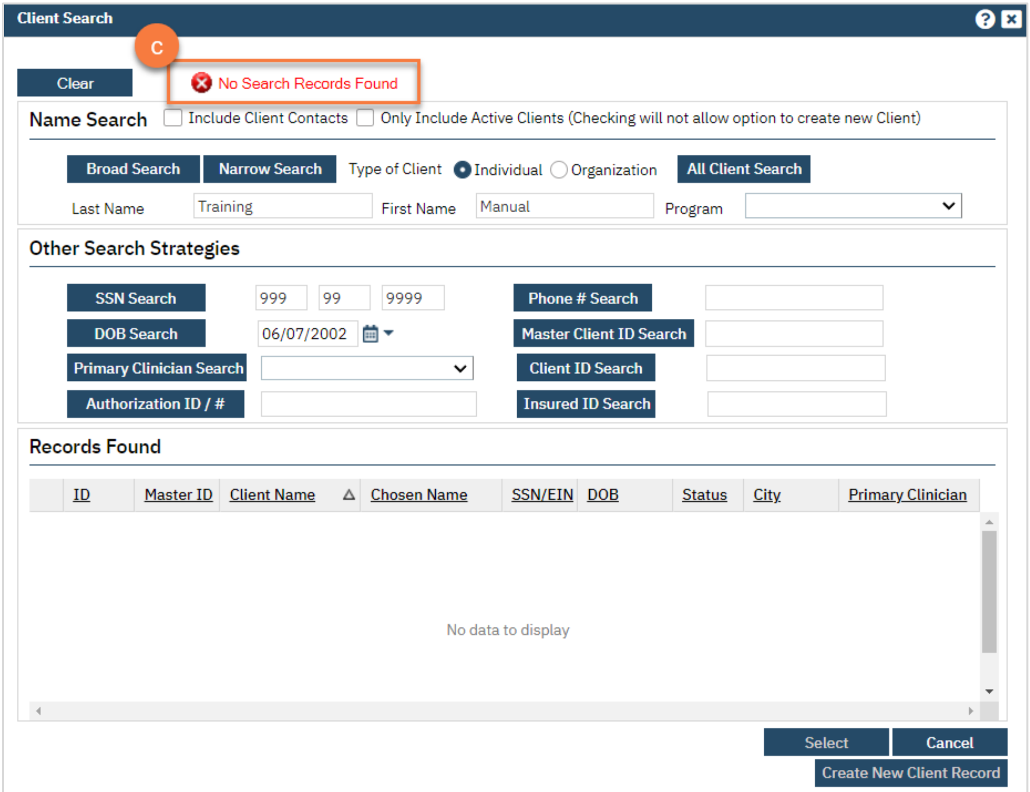
7. **Select the "Link/Create Client" button**. This will bring up the client search window, with a few extra buttons at the bottom.



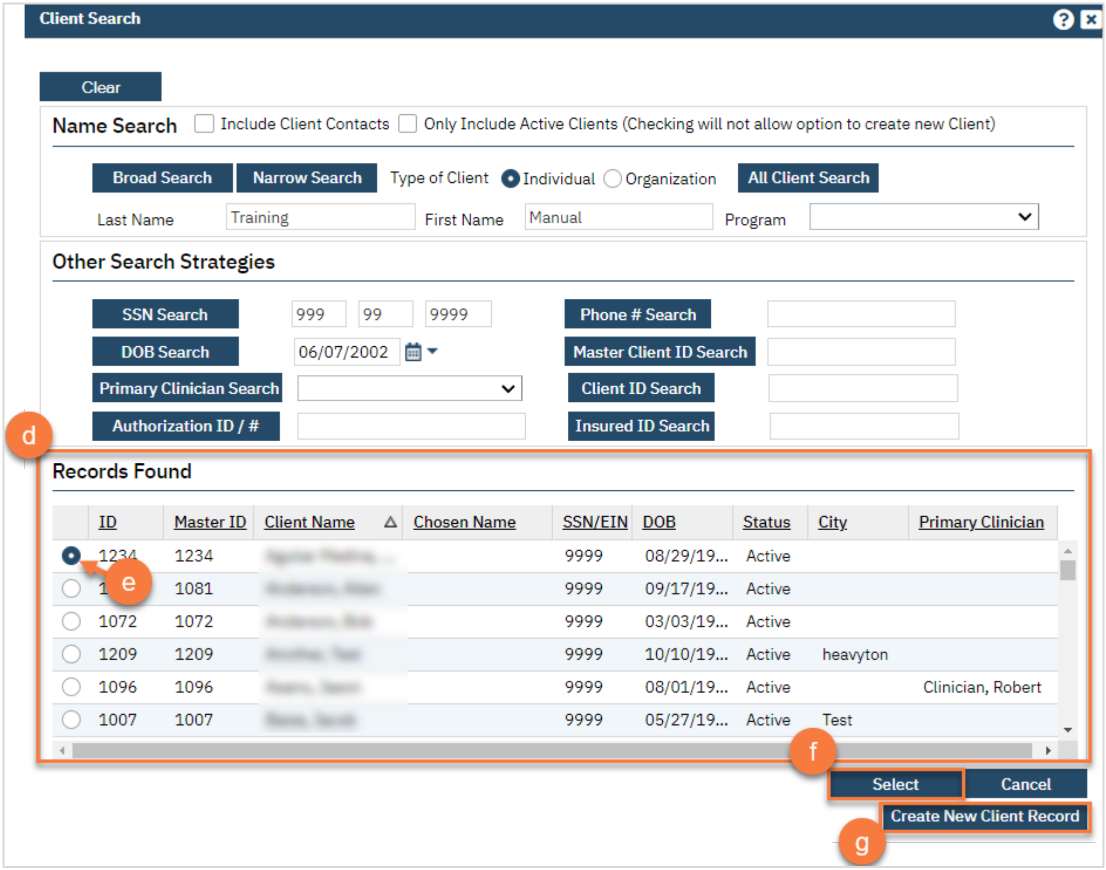
a. You must **search by name** by clicking on either "Broad Search" or "Narrow Search".
b. You must also **search by SSN and DOB** by clicking on those respective buttons.



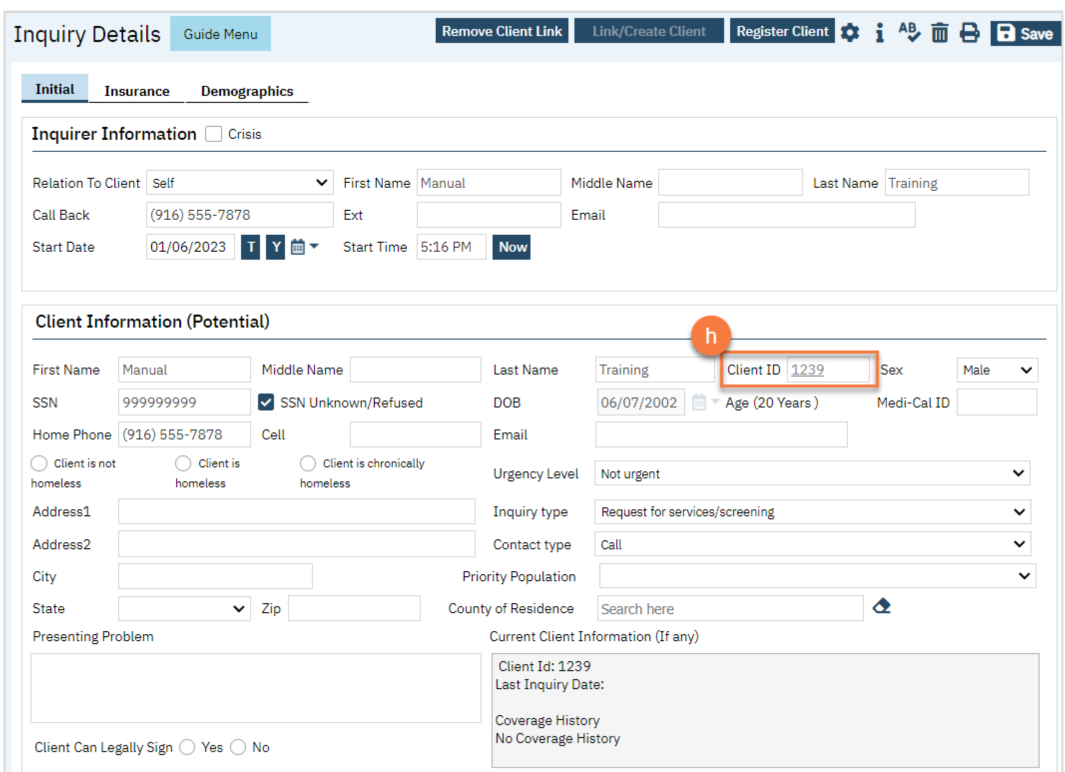
c. If no records are found based on the search you do, an alert will show at the top of the window.



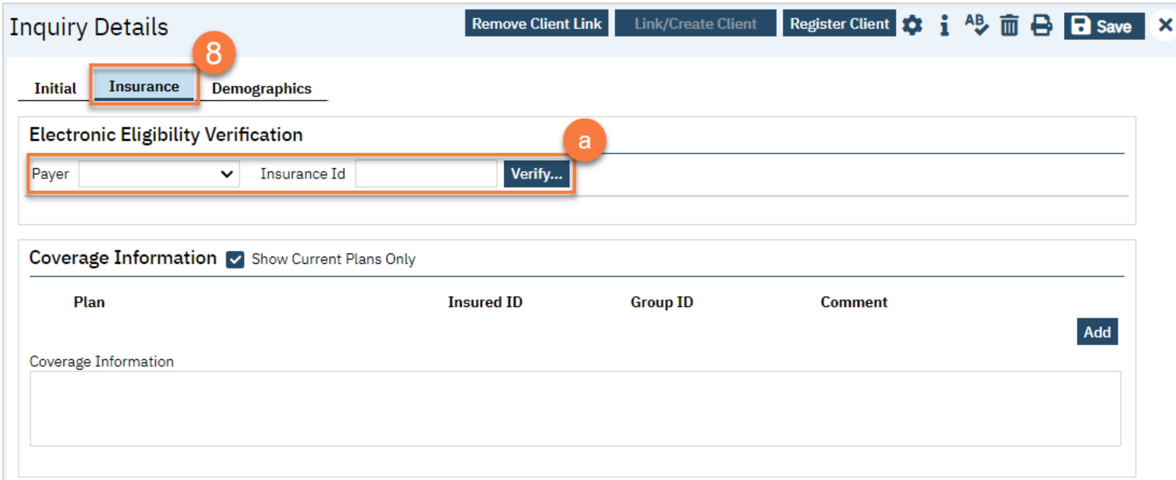
d. Any search results will show in the "Records Found" area. **Review the Records Found** to determine if the person is already in the system as a client.
e. If the person is already a client in the system, **select the button next to the appropriate record.**
f. **Click "Select"** to link the Inquiry to the selected client.
g. If the person is not a client, meaning no records were found matching the client's information, **click "Create New Client Record."**



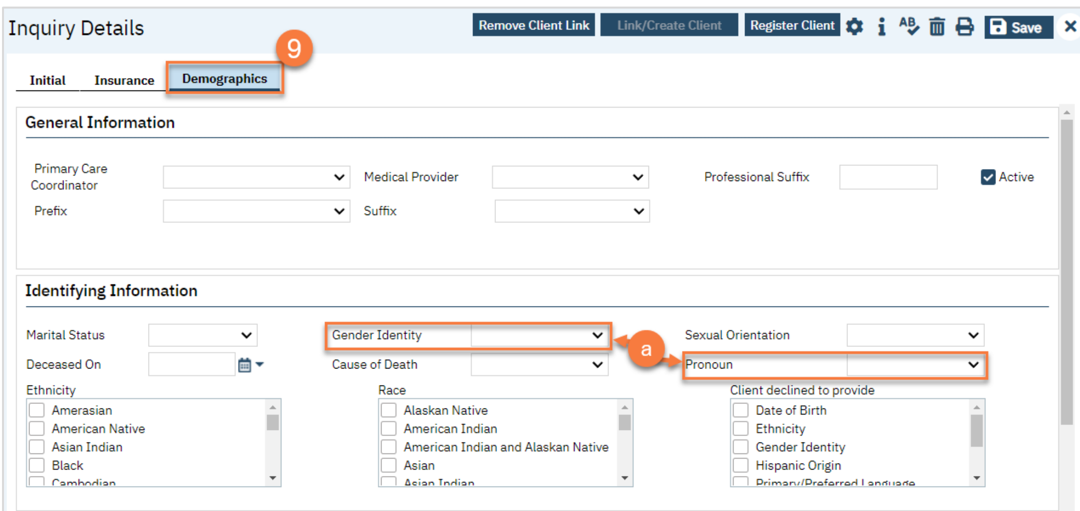
h. This will take you back to the Inquiry screen but now a client ID number will be added.



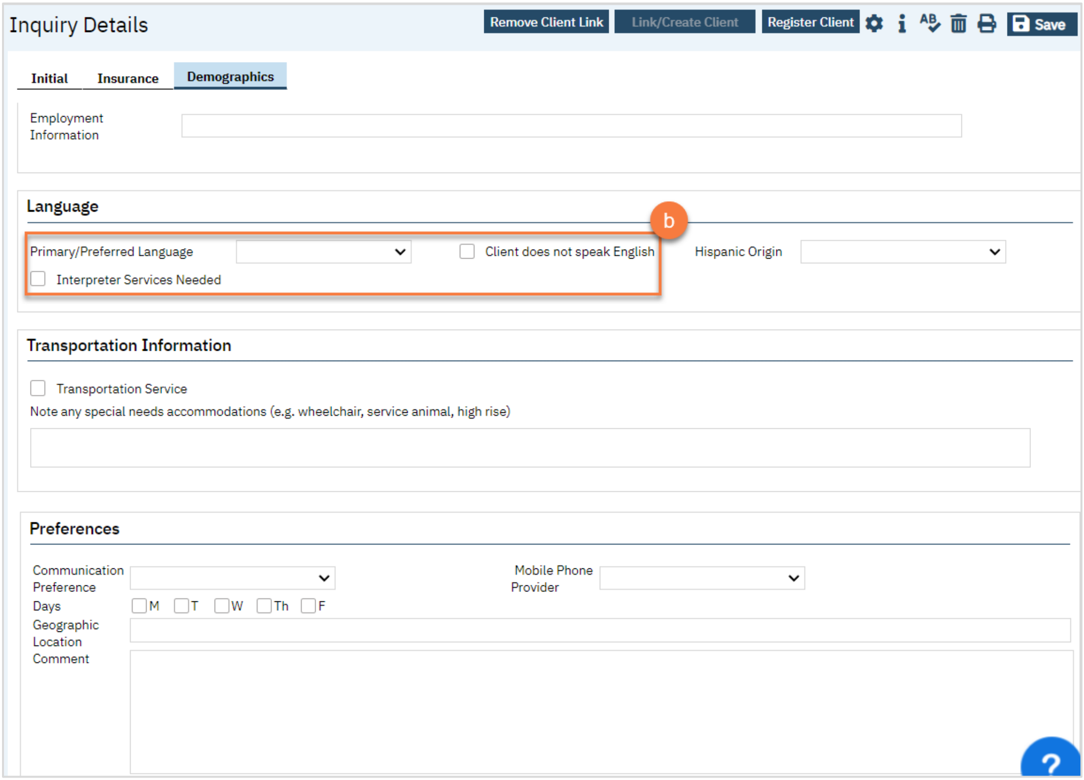
8. Click on the "Insurance" tab.
   a. **Select "Medi-Cal" from the "Payer" drop-down and enter the client's Medi-Cal number (CIN) in the "Insurance ID" field. Click "Verify"** to verify the client's Medi-Cal insurance.



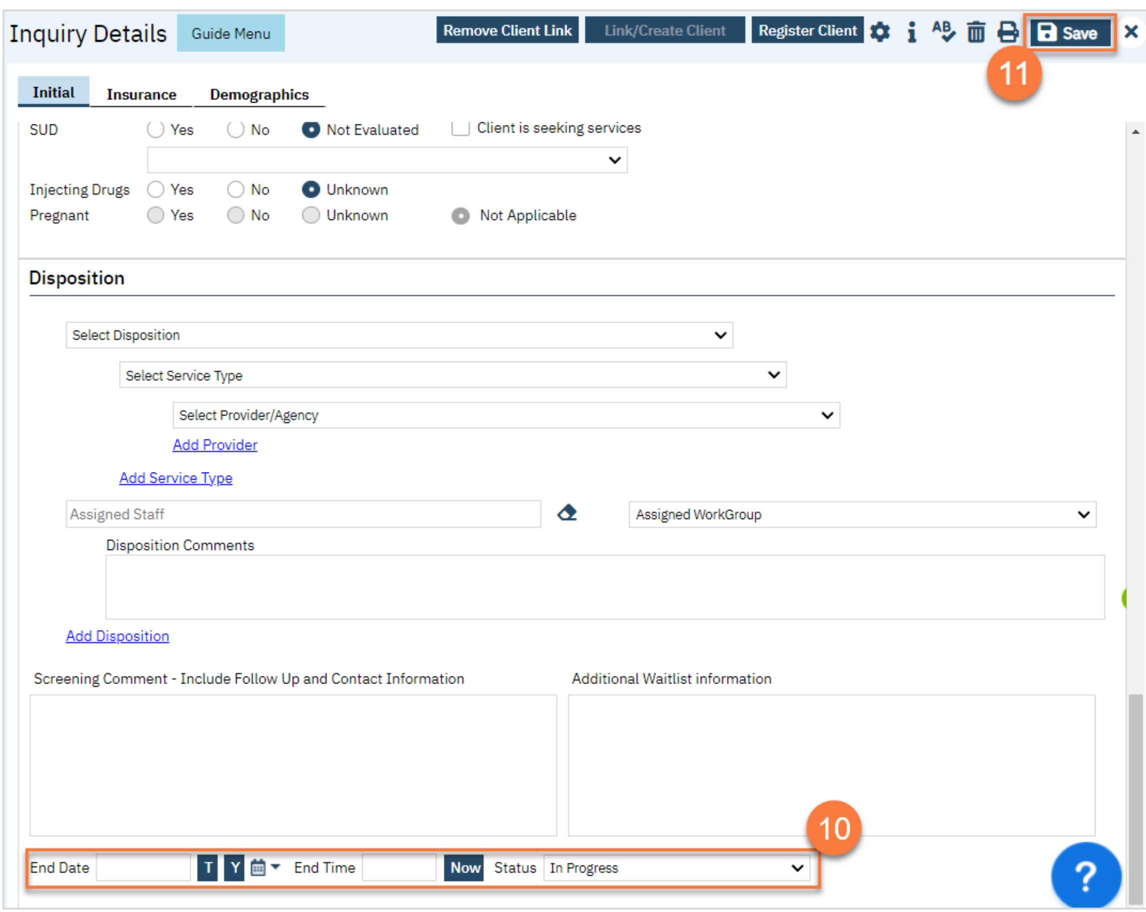
9. Click on the “Demographics” tab.
    a. We recommend **completing the “Gender Identity” and “Pronoun” fields** to ensure the person is not misgendered as additional staff engage with the client.



    b. **Complete the “Primary/Preferred Language” field.** If the client does not speak English or requires an interpreter, make sure to check the appropriate checkbox.



10. You may enter any additional information in any of the tabs, but none are required. Once complete, **enter the end date and time of the Inquiry and change the status to "Complete".** Once again, there are "T" (today) and "Now" buttons to make this easier.
11. **Click Save.** You may now close the Inquiry and move on to Screening.



What do I do when someone walks in for an assessment?

Walk-in assessments can skip the Inquiry and Screening steps and go straight to Intake and Assessment.

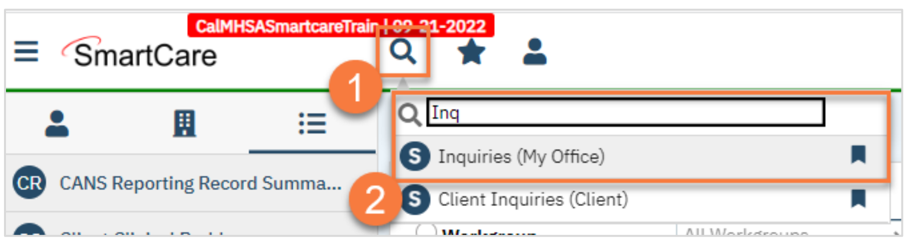
What do I do if someone calls a non-crisis line and says they're in crisis?

When someone calls a non-crisis line saying they're in crisis, transfer them immediately to crisis services per your county's policies and procedures. It's ok if you've started an inquiry. Simply save the inquiry. The crisis services staff can continue the inquiry from their computer.

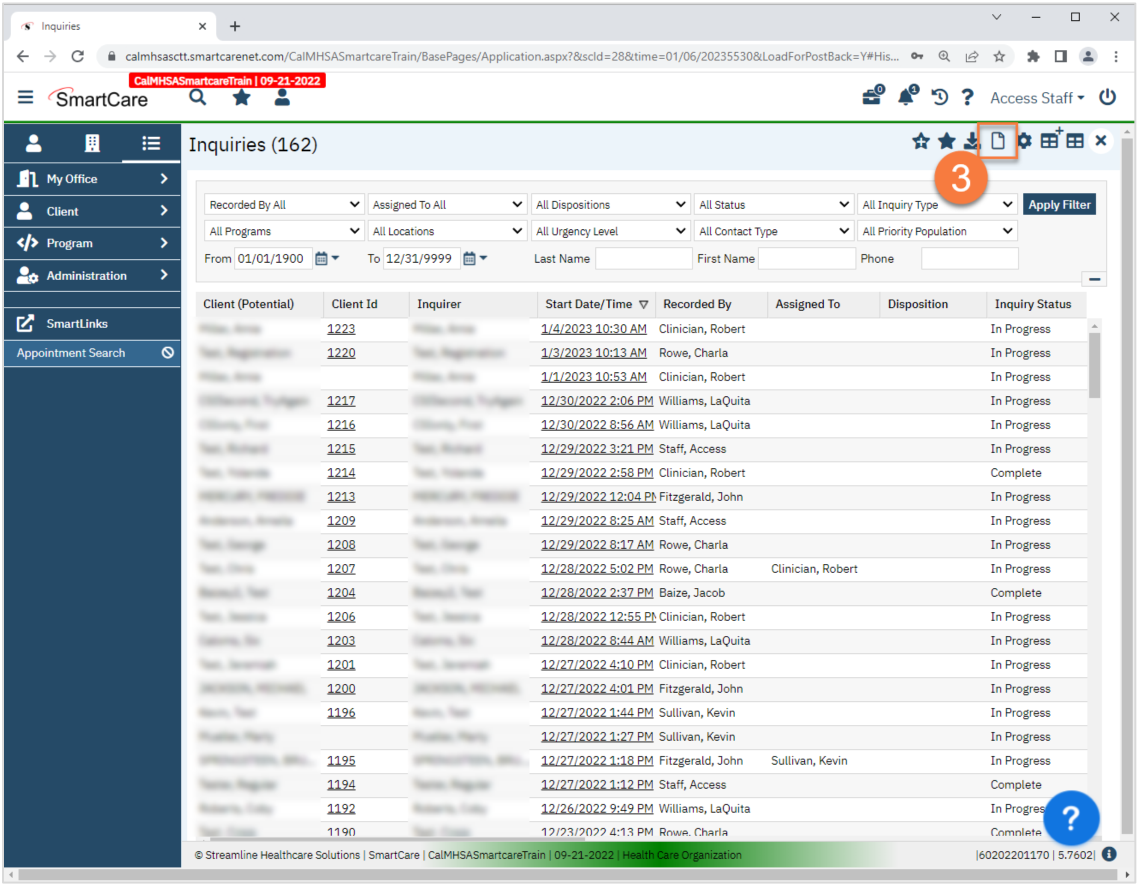
What do I do if someone calls requesting services, but I don't provide crisis or screening services?

Even if you don't provide screening or crisis services, you can still document the request for services. This is done on the Inquiry screen.

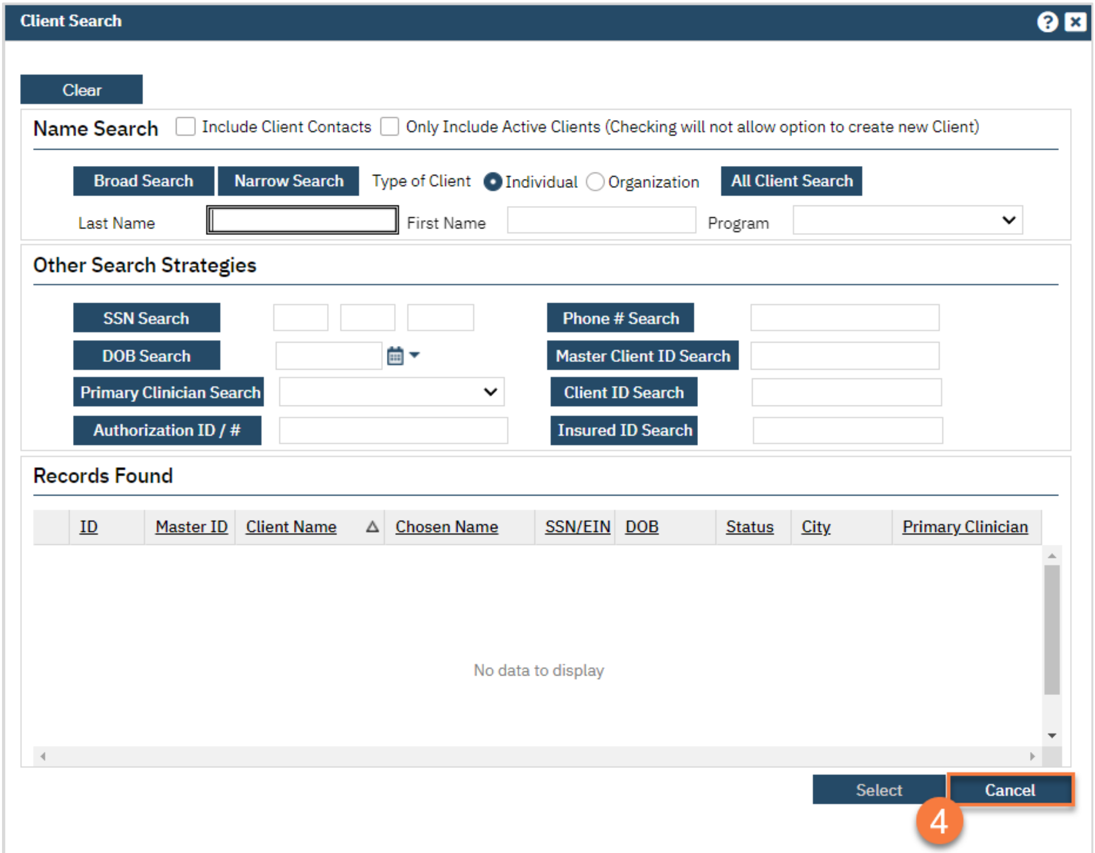
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



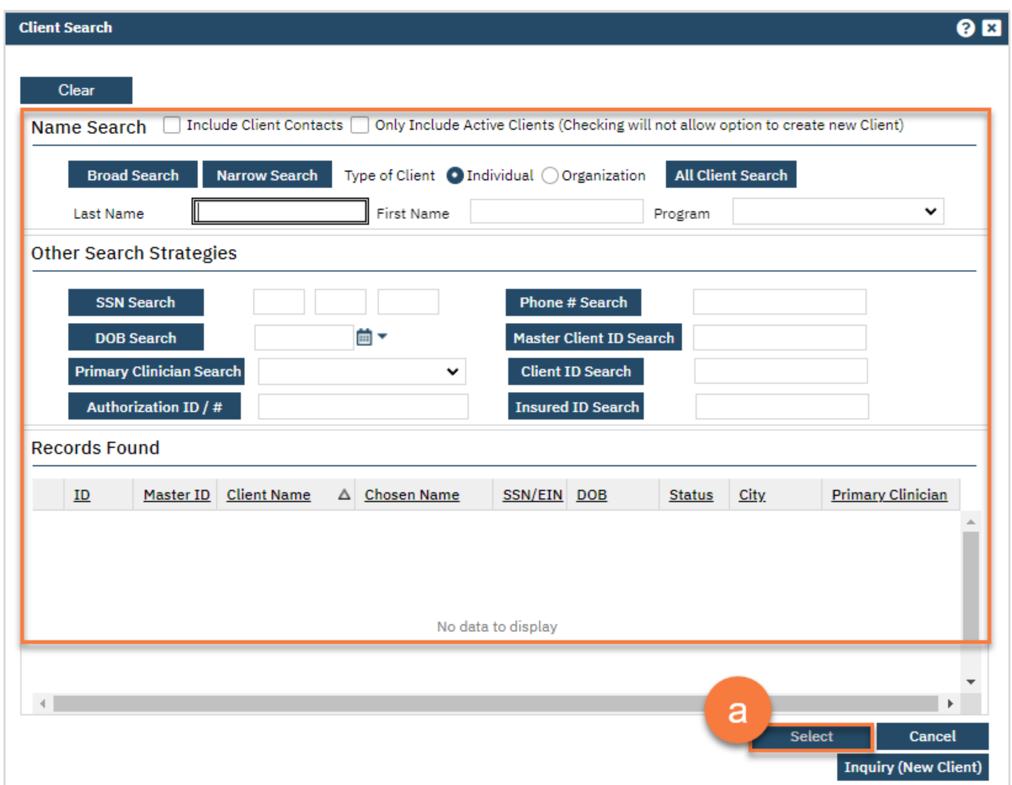
3. This will bring you to the Inquiries list page. **Create a new inquiry** by using the new icon.



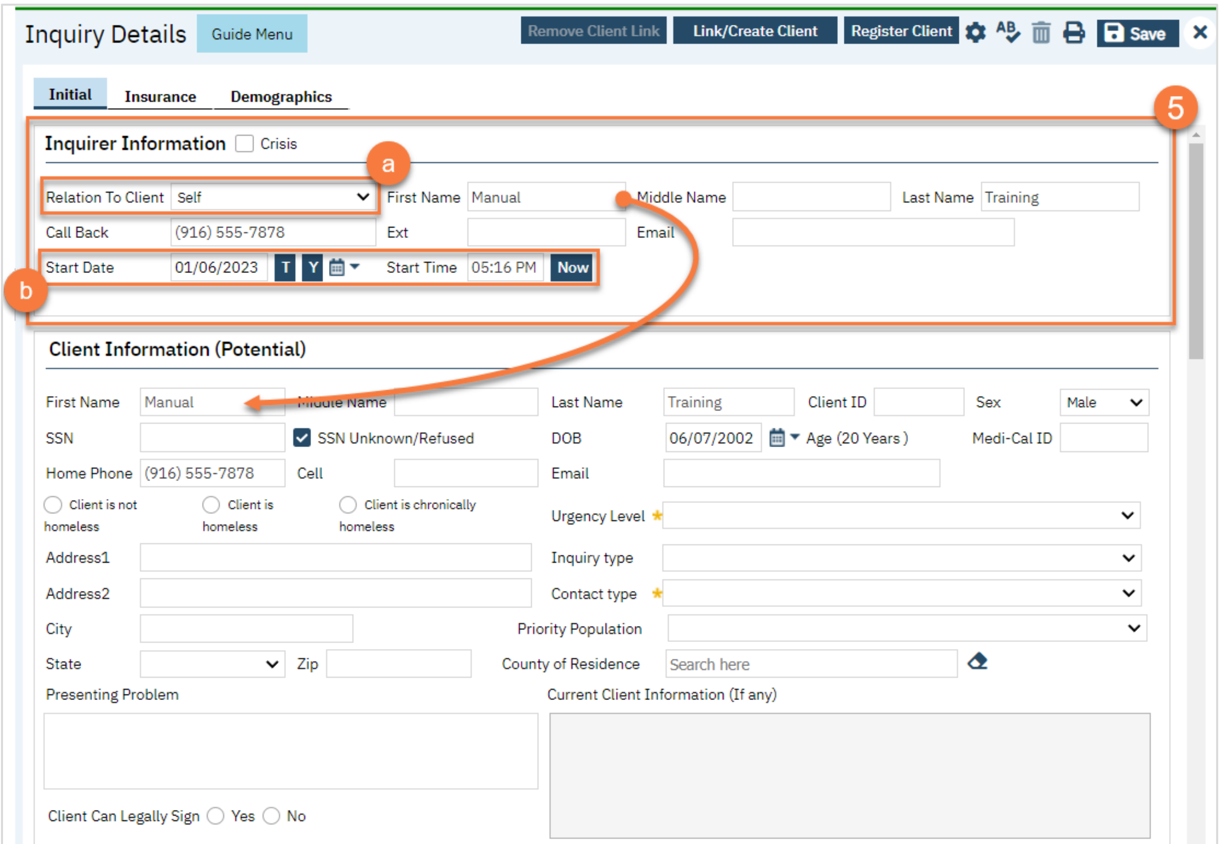
4. This will bring up the client search window. **You may search to determine if the person is a current client**. If person is a new client, or you cannot find them in the system, **click "Inquiry (New Client)"**.



a. To search for a client, enter their name and click "Broad Search." You can also search by SSN by entering their social security number and clicking "SSN Search." You can do the same with date of birth (DOB), phone number, etc. If you find the person in the system, meaning they show in the Records Found section, click "Select" to bring their information into the Inquiry screen.



5. This brings you to the Inquiry Details screen. **Complete the information about the caller, or "Inquirer"**.
   a. If the client is requesting services for themselves, select "Self" under "Relation to Client." This way, as you enter the caller's information, it will push this information automatically into the "Client Information" section.
   b. Make sure to input the start date and time of the call. There are buttons for "T" (today) and "Now" to help make this quick and easy.



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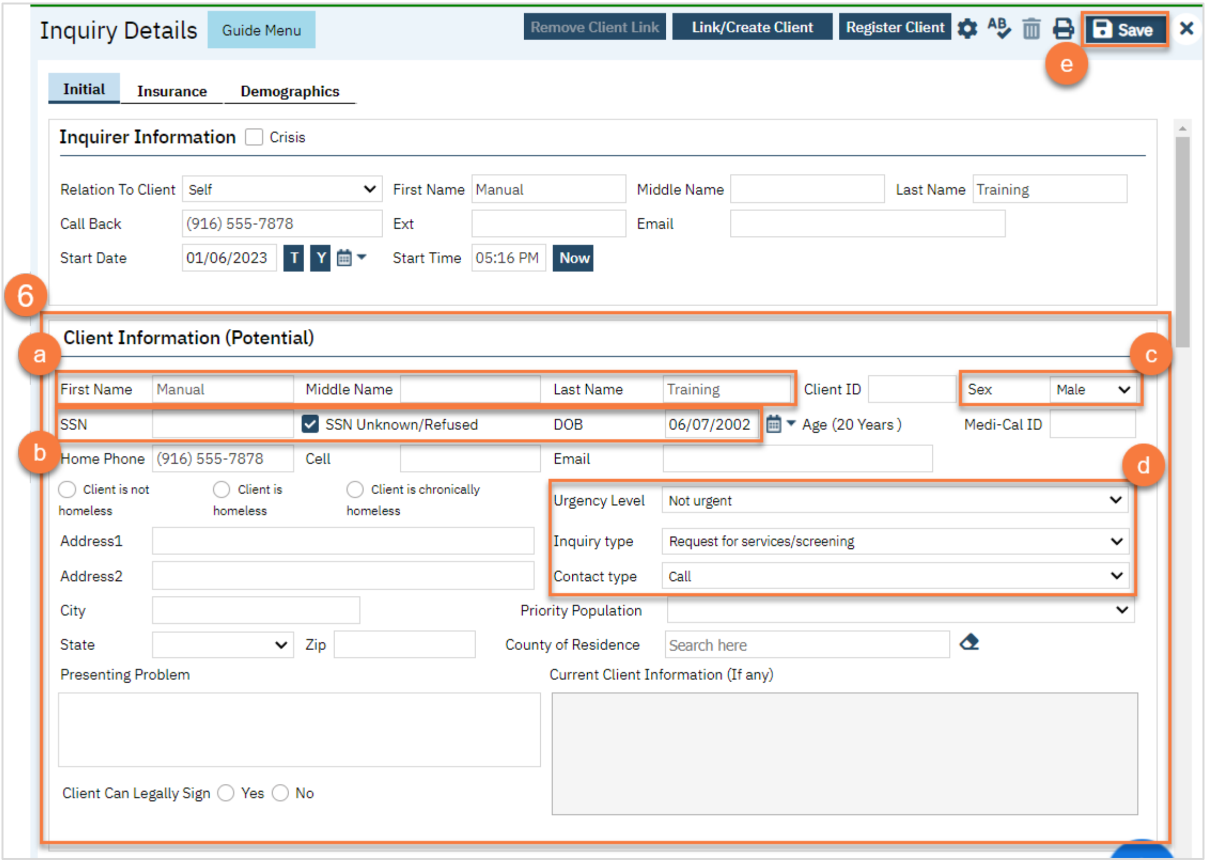
   c. **Complete the Sex field.** This field can be changed in the future if necessary.
   d. **Complete the Urgency Level, Inquiry type, and Contact type fields.** The options for each field are listed in the tables below. This includes a description of when to use each option.
   e. **Click Save.**



Urgency Level	Description/Use Case	Timelines
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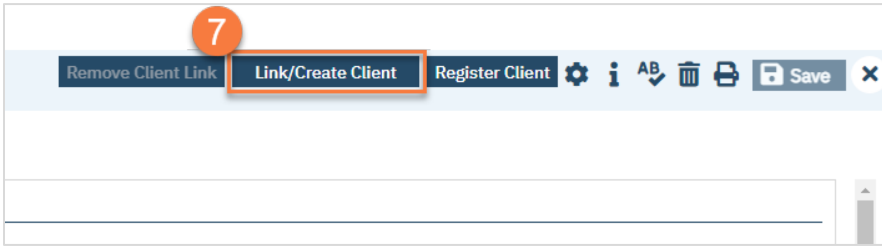
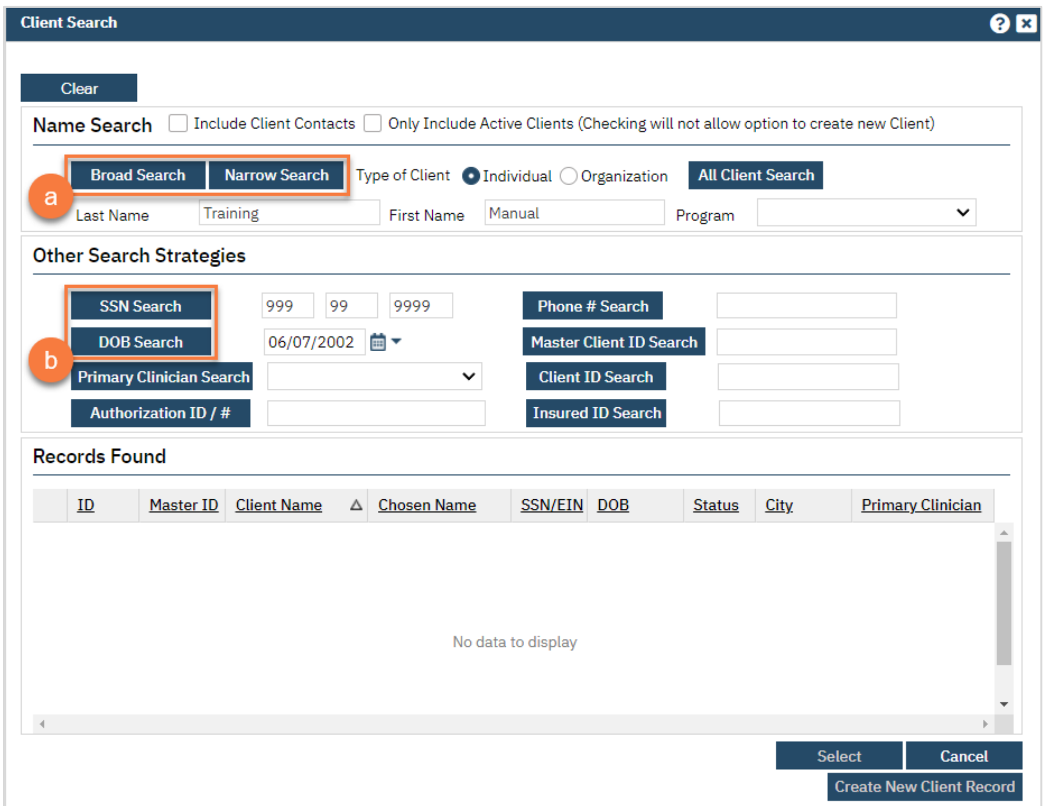
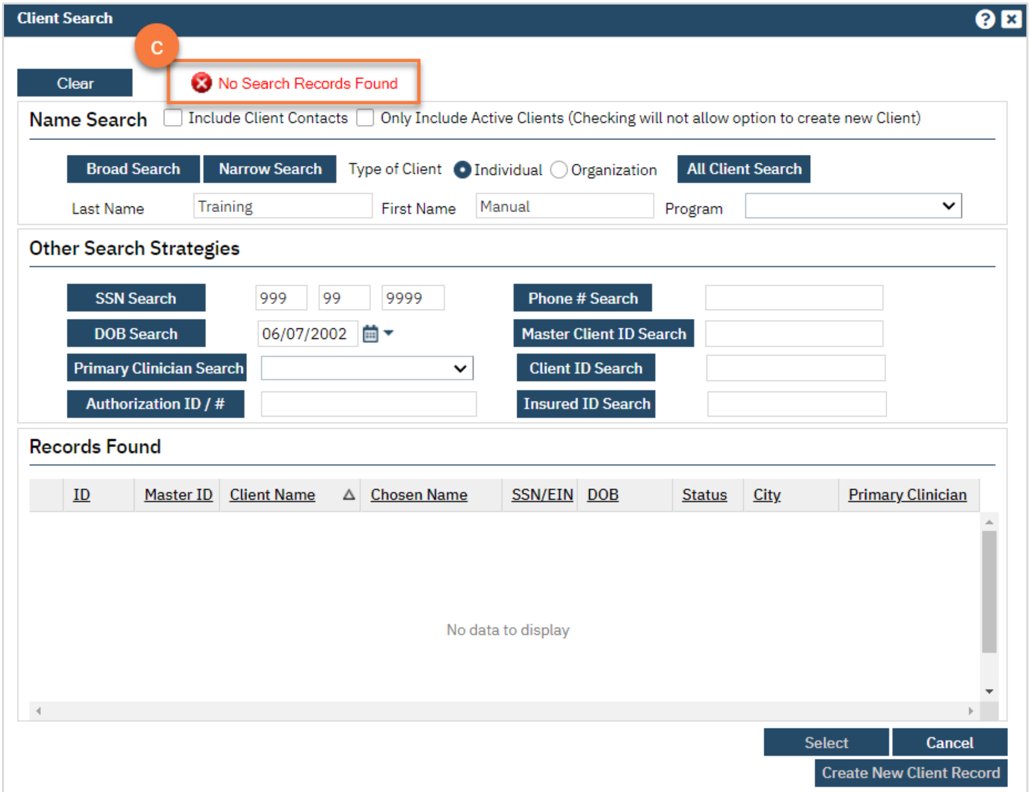


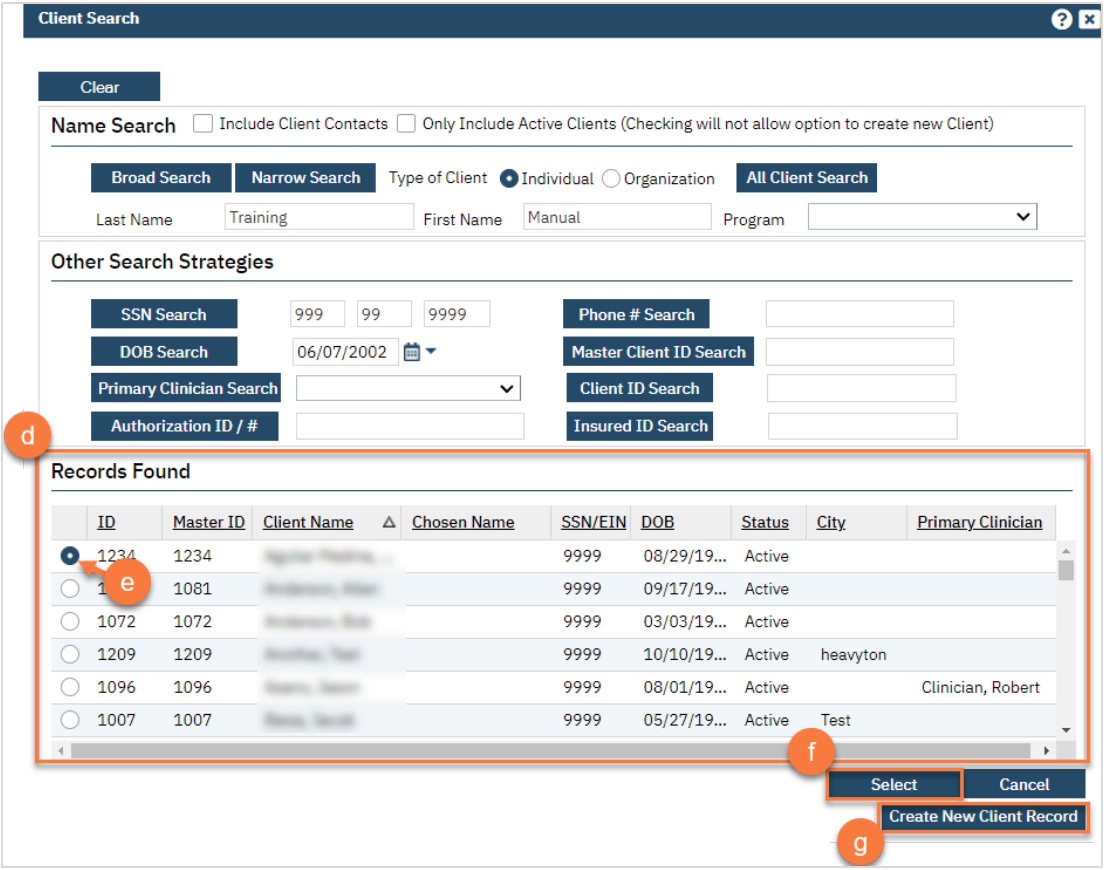
   a. You must **search by name** by clicking on either "Broad Search" or "Narrow Search".
   b. You must also **search by SSN and DOB** by clicking on those respective buttons.



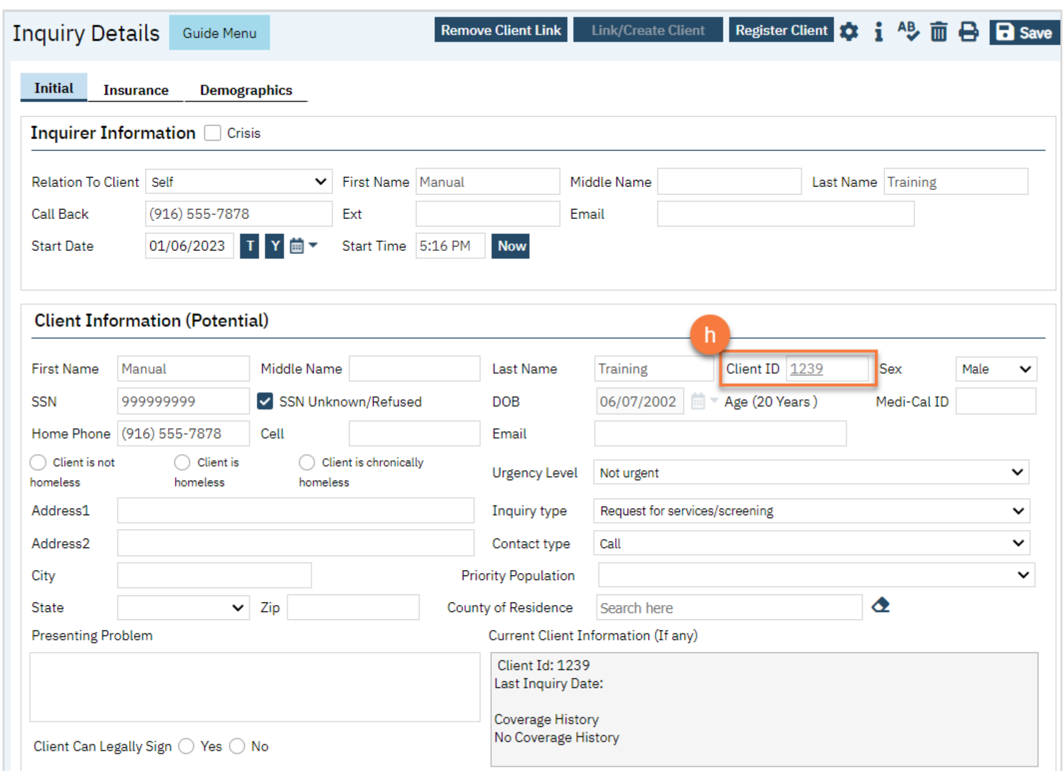
   c. If no records are found based on the search you do, an alert will show at the top of the window.



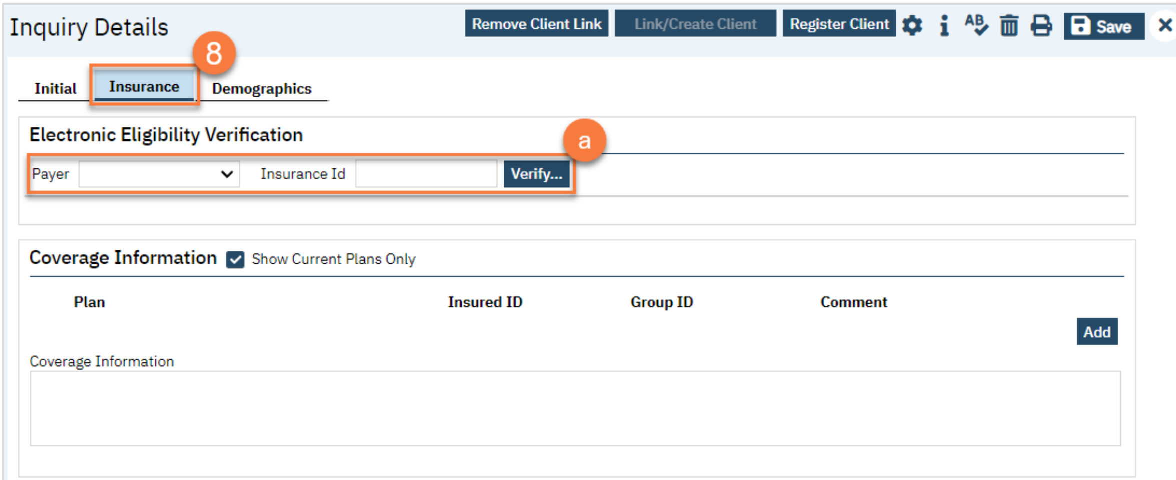
d. Any search results will show in the "Records Found" area. **Review the Records Found** to determine if the person is already in the system as a client.
e. If the person is already a client in the system, **select the button next to the appropriate record.**
f. **Click "Select"** to link the Inquiry to the selected client.
g. If the person is not a client, meaning no records were found matching the client's information, **click "Create New Client Record."**



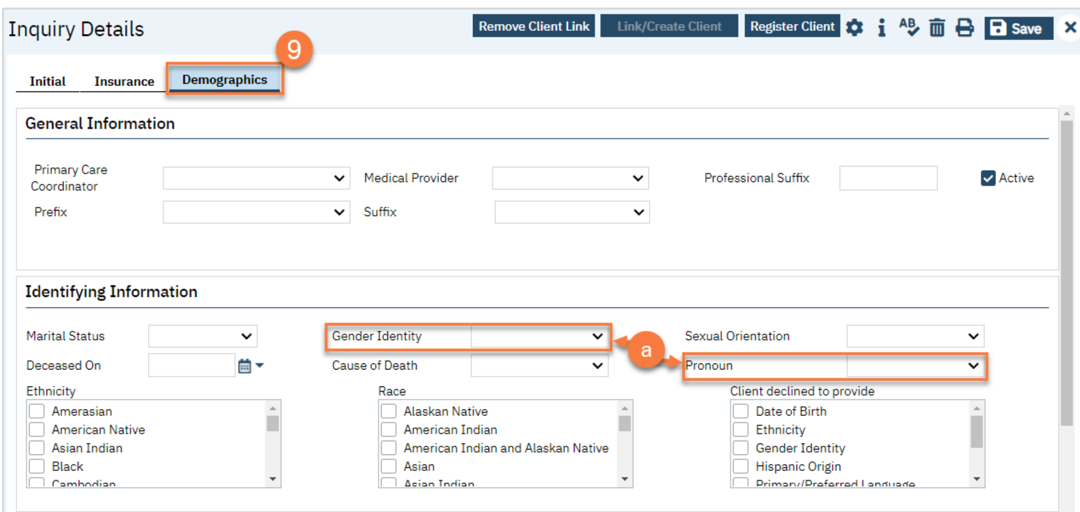
h. This will take you back to the Inquiry screen but now a client ID number will be added.



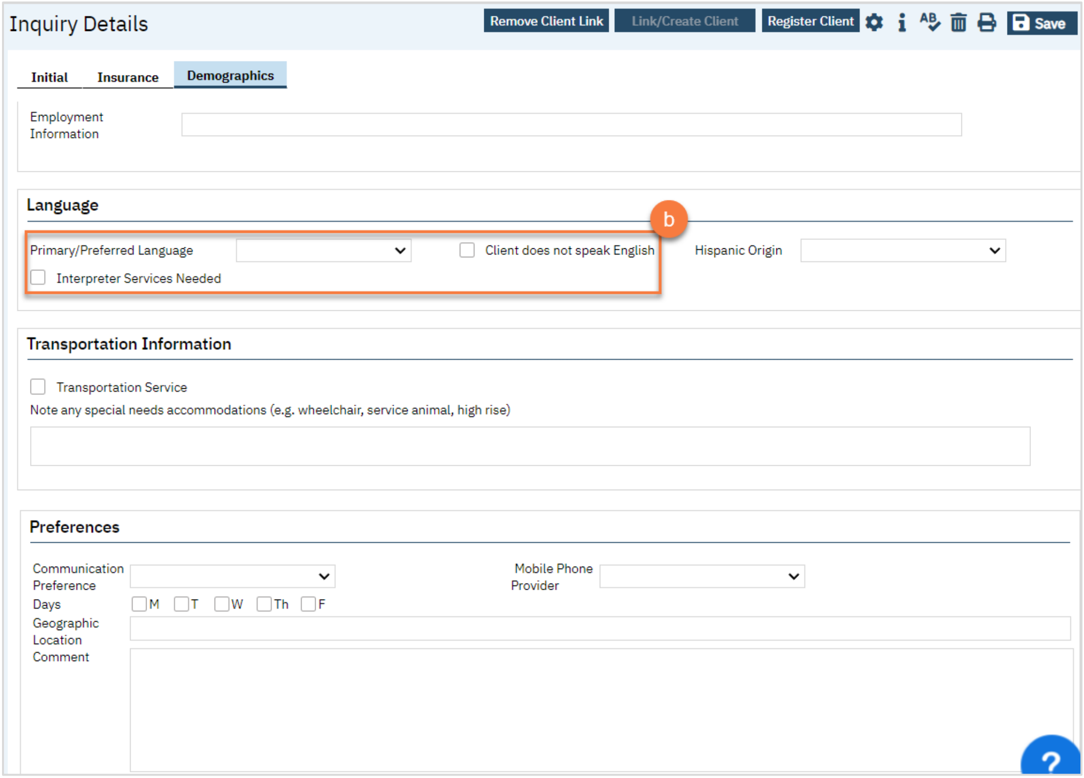
8. Click on the “Insurance” tab.
   a. Select “Medi-Cal” from the “Payer” drop-down and enter the client’s Medi-Cal number (CIN) in the “Insurance ID” field. Click “Verify” to verify the client’s Medi-Cal insurance.



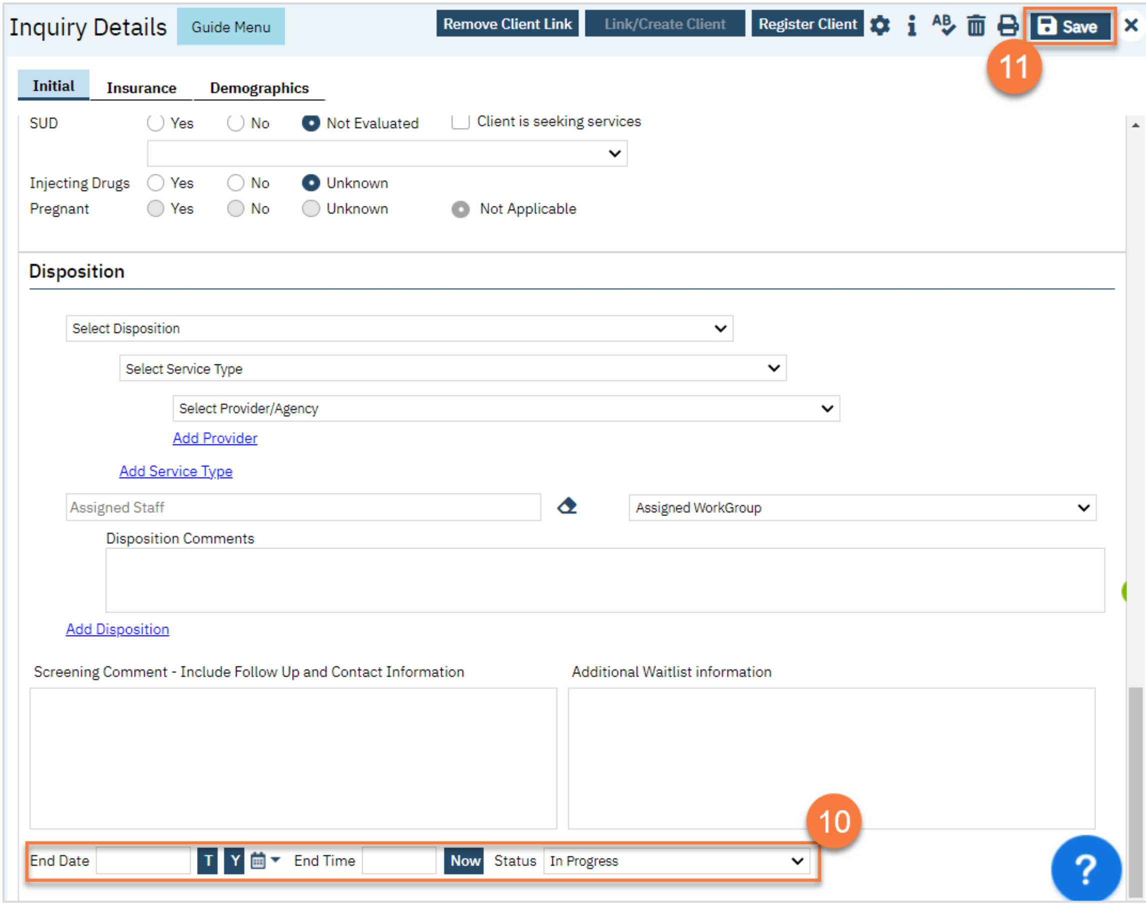
9. Click on the "Demographics" tab.
    a. We recommend **completing the "Gender Identity" and "Pronoun" fields** to ensure the person is not misgendered as additional staff engage with the client.



    b. **Complete the "Primary/Preferred Language" field.** If the client does not speak English or requires an interpreter, make sure to check the appropriate checkbox.



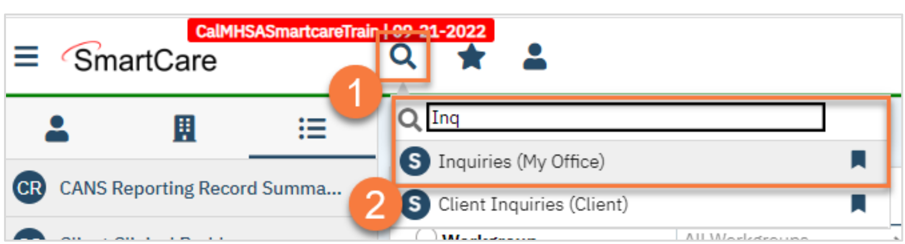
10. You may enter any additional information in any of the tabs, but none are required. Once complete, **enter the end date and time of the Inquiry.** Once again, there are "T" (today) and "Now" buttons to make this easier. **Leave the status as "In Progress".**
11. **Click Save.** You may now close the Inquiry. Your Access Team will likely have procedures to monitor the Inquiries list page to address any that are in progress. If your county does not have these procedures, we recommend that you notify the appropriate person per your county's procedures.



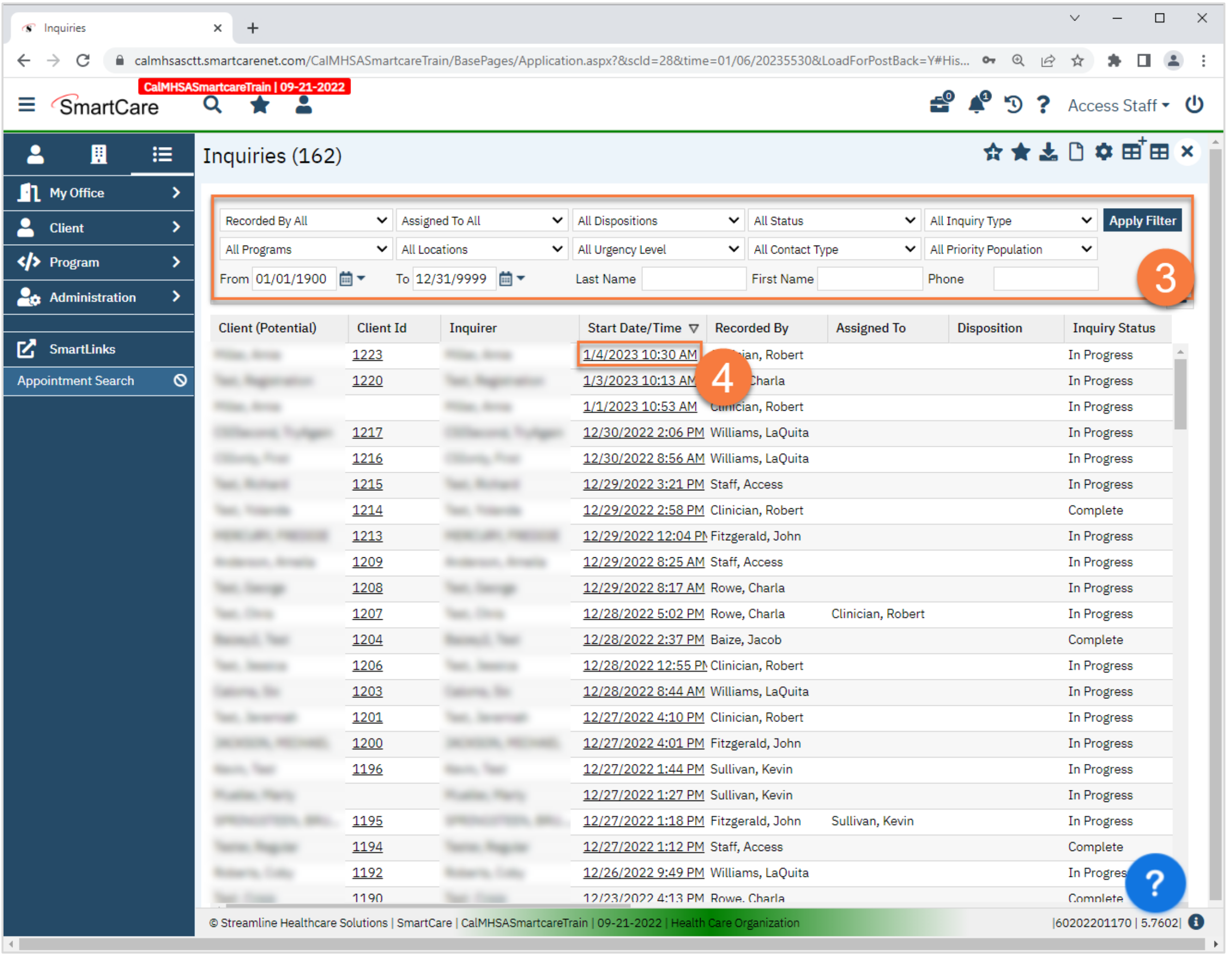
How can I view requests for services that are pending?

Viewing all inquiries, both completed and pending, is done in the Inquiries list page.

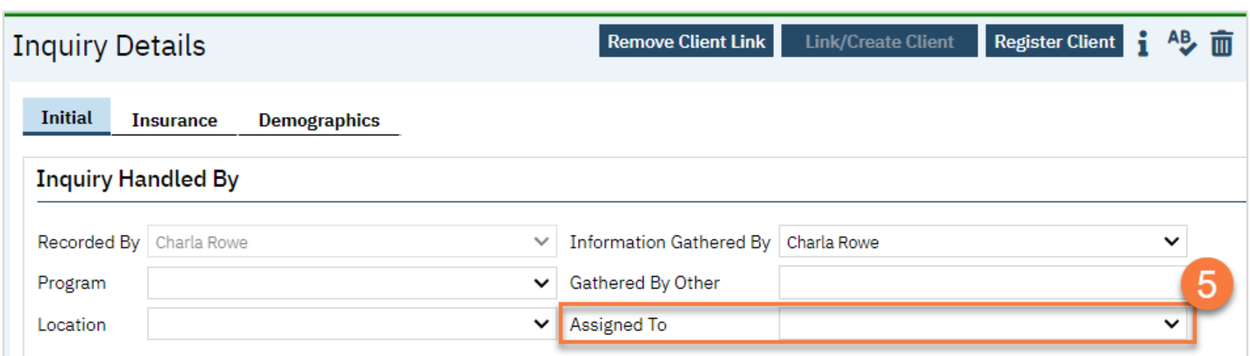
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



3. This will bring you to the Inquiries list page. **Use the filters as necessary**, such as filtering the status to show only "In Progress". The "Recorded By" column indicates who created the inquiry. The
4. To see the details of an inquiry, **click on the link in the "Start Date/Time"** column.



5. Once in the Inquiry Details screen, you can assign the inquiry to a staff member by navigating to the "Inquiry Handled By" section and **use the "Assigned Staff" field**. This field shows on the Inquiries list page, meaning staff can sort by inquiries that are assigned to them.



Life Cycle of the Client: Screening

Generally speaking, after a request for services is made, the client is screened to determine if they are appropriate for the types of services the county and its providers offer. There are three main screening tools used for this:

1. Adult Medi-Cal Mental Health Screening Tool – Created by DHCS, this tool is used to determine if an adult client (age 21+) is appropriate for Specialty Mental Health Services or if they'd be better served by one of the county's Managed Care Plans.
2. Youth Medi-Cal Mental Health Screening Tool – Created by DHCS, this tool is used to determine if a youth client (age 0-20) is appropriate for Specialty Mental Health Services or if they'd be better served by one of the county's Managed Care Plans.
3. BQuIP SUD Screening Tool – Commissioned by DHCS and created by UCLA, the Brief Questionnaire for Initial Placement, or BQuIP, is a screening tool that generates recommendations for initial placement for individual seeking treatment for substance use disorders.

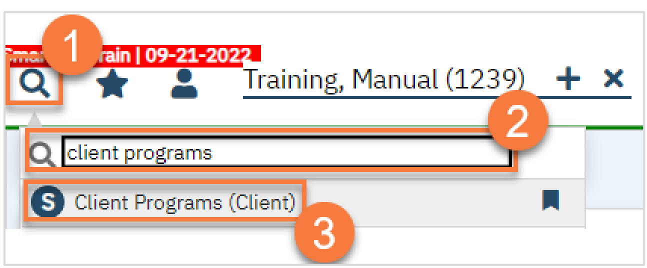
Note: There are times a screening can be skipped and a client moved directly to the assessment phase. This is often the case for programs that work directly with partner agencies to expedite the access process. For example, Child Welfare Services may request an assessment on a foster youth without requiring a screening first. Review your county's policies and procedures for more details.

Most often, the screening will be completed when the client calls the county's Access Line. Most Access Line staff are trained to do a screening, or the client can be immediately transferred to someone who is trained. In some cases, however, a screening may be assigned to a staff member to complete after the initial call. For example, if the client calls the a number other than the Access Line.

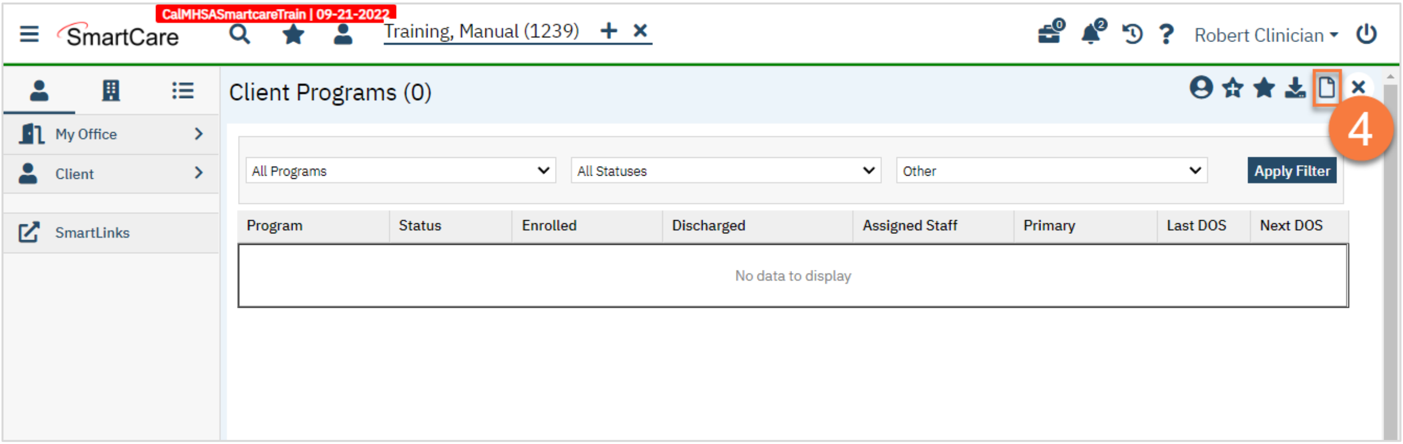
Set up for Screening

Before doing a screening tool, you need to enroll the client in a program. We recommend using an Access program for this.

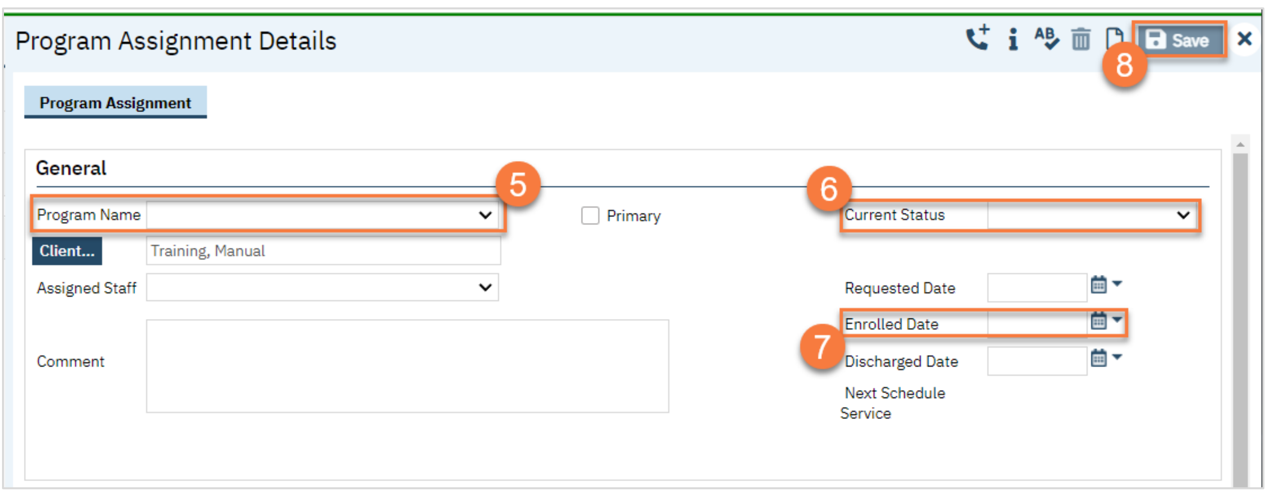
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Programs** into the search bar.
3. **Click to select Client Programs (Client).**



4. This takes you to the Client Programs list page. **Click on the "new" icon**.

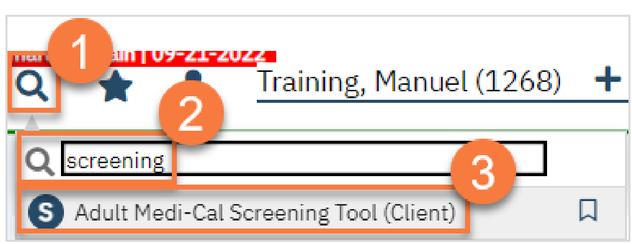


5. Select the program your county uses for screening services.
6. Change the Status to “Enrolled”.
7. Enter the Enrolled Date.
8. Click Save.

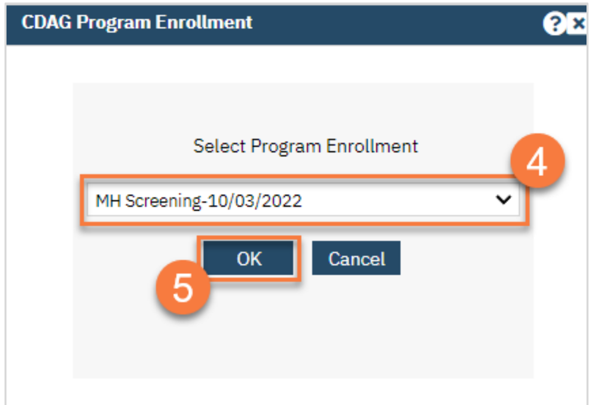


How do I complete an Adult Medi-Cal Screening Tool?

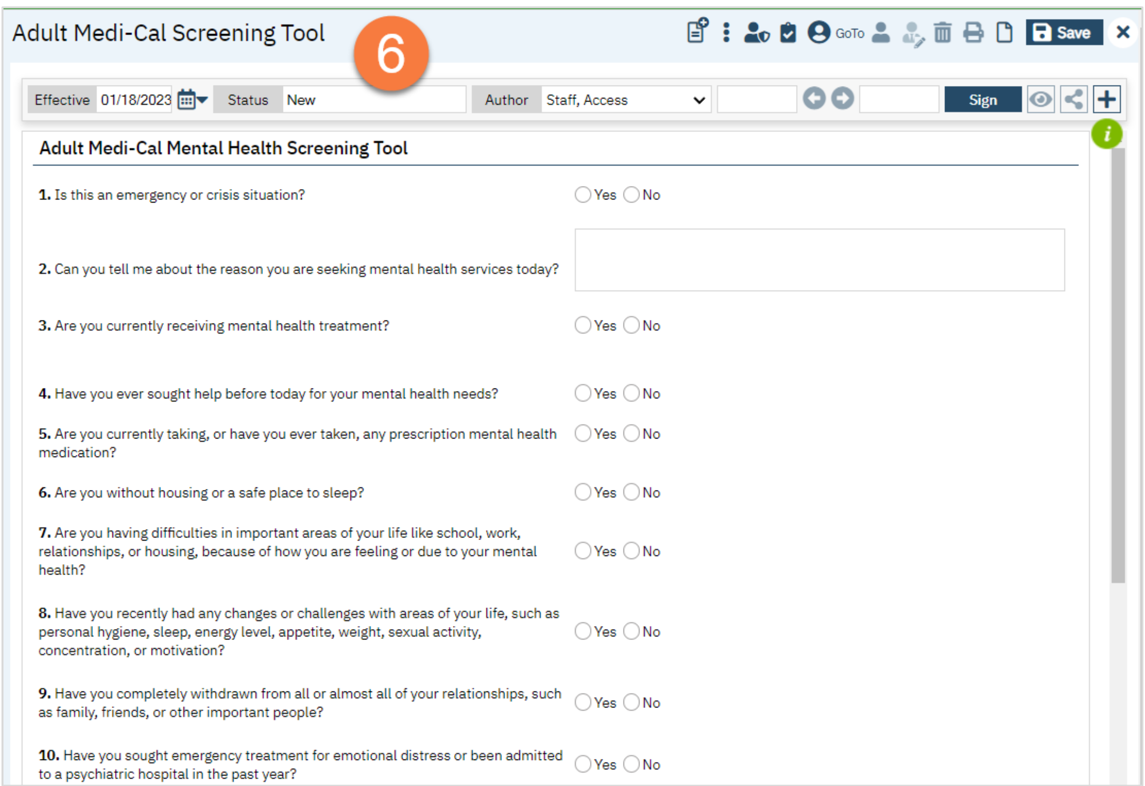
1. You must first have the client open, then **click the Search icon**.
2. **Type Adult Medi-Cal Screening Tool** into the search bar.
3. **Click to select Adult Medi-Cal Screening Tool (Client).**



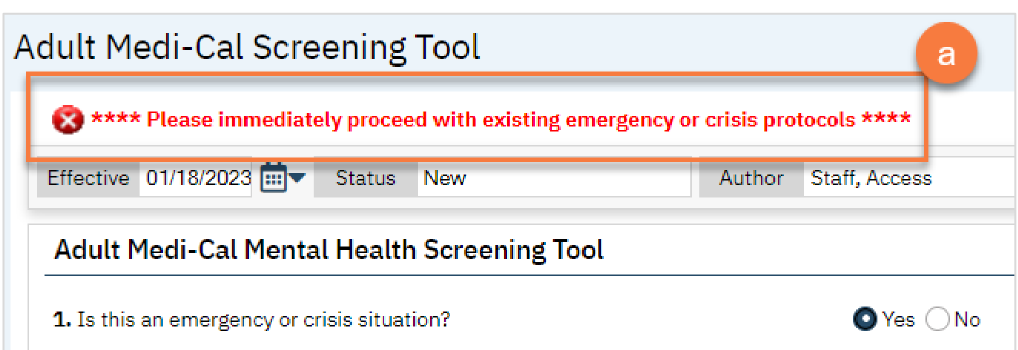
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



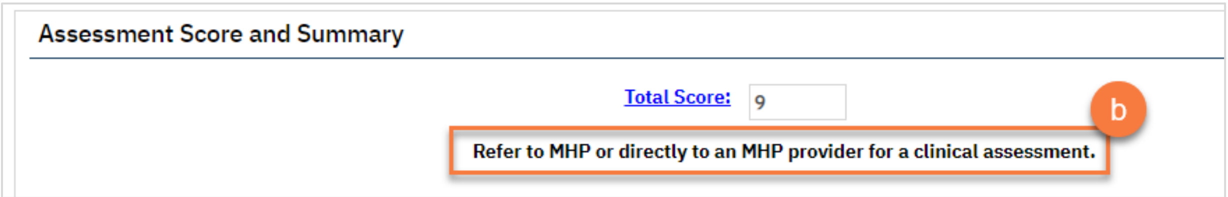
6. The Adult Medi-Cal Screening Tool document will open. **Complete the document**.



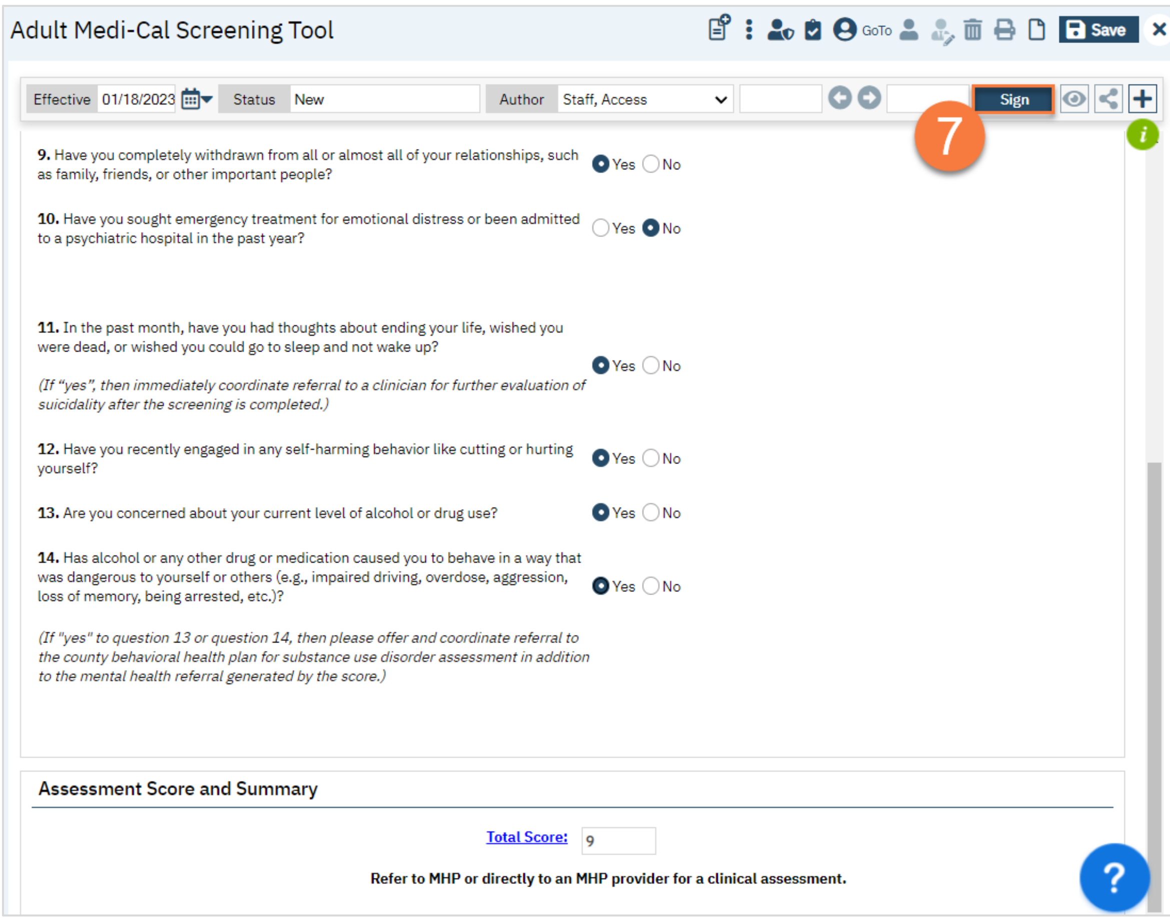
a. Any alerts will show at the top of the page.



b. Any recommendation will show at the bottom of the page.

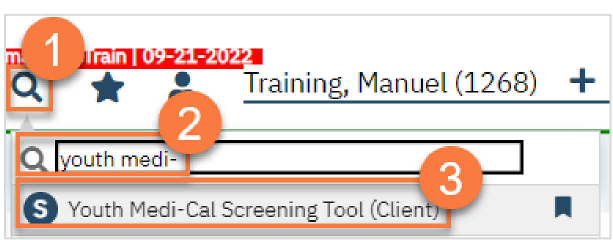


7. **Click Sign** to complete and generate the document.



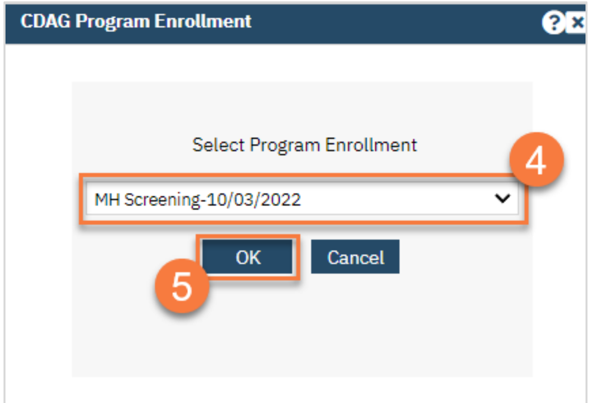
How do I complete a Youth Medi-Cal Screening Tool?

1. You must first have the client open, then **click the Search icon**.
2. **Type Youth Medi-Cal Screening Tool** into the search bar.
3. **Click to select Youth Medi-Cal Screening Tool (Client).**

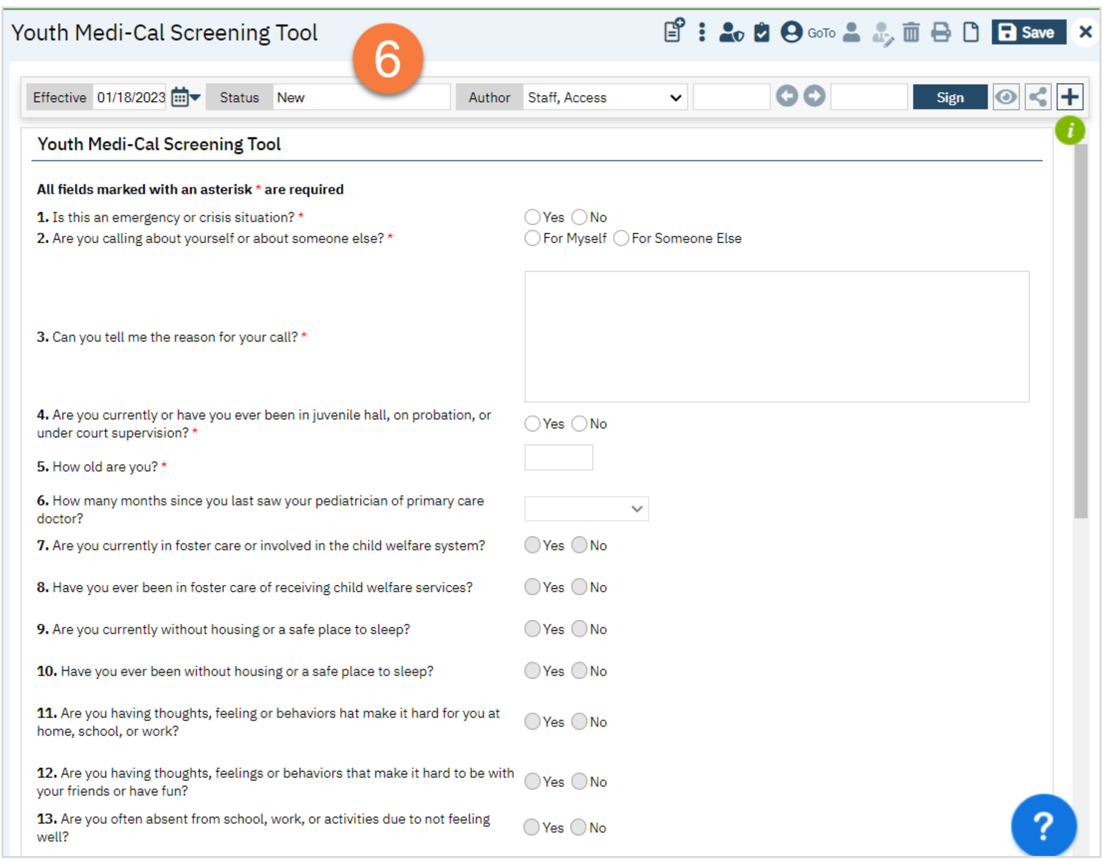


4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.

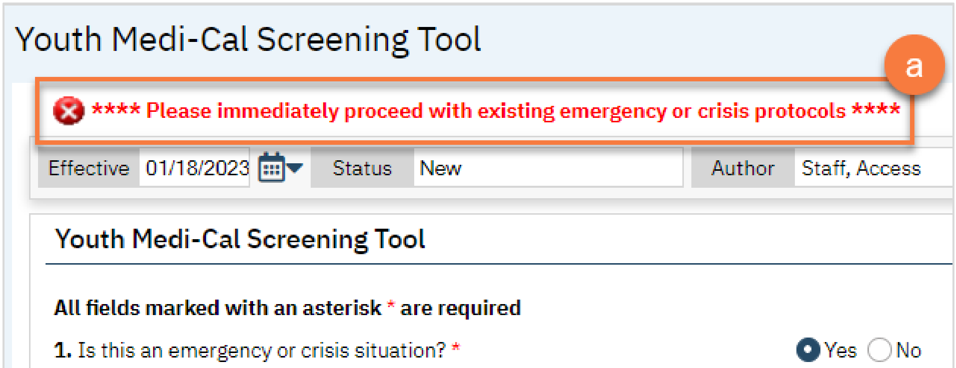
5. **Click OK** to continue.



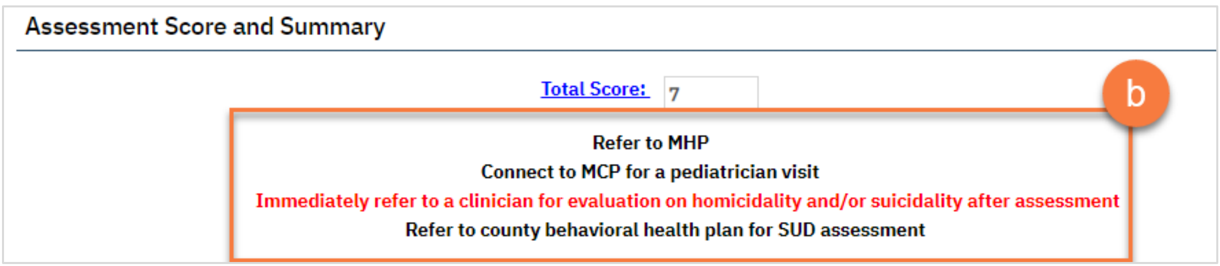
6. The Youth Medi-Cal Screening Tool document will open. **Complete the document**. The wording of the questions varies slightly depending on if you're screening the youth directly or gathering information from a parent or guardian. The system will automatically alter the language to match the appropriate DHCS form.



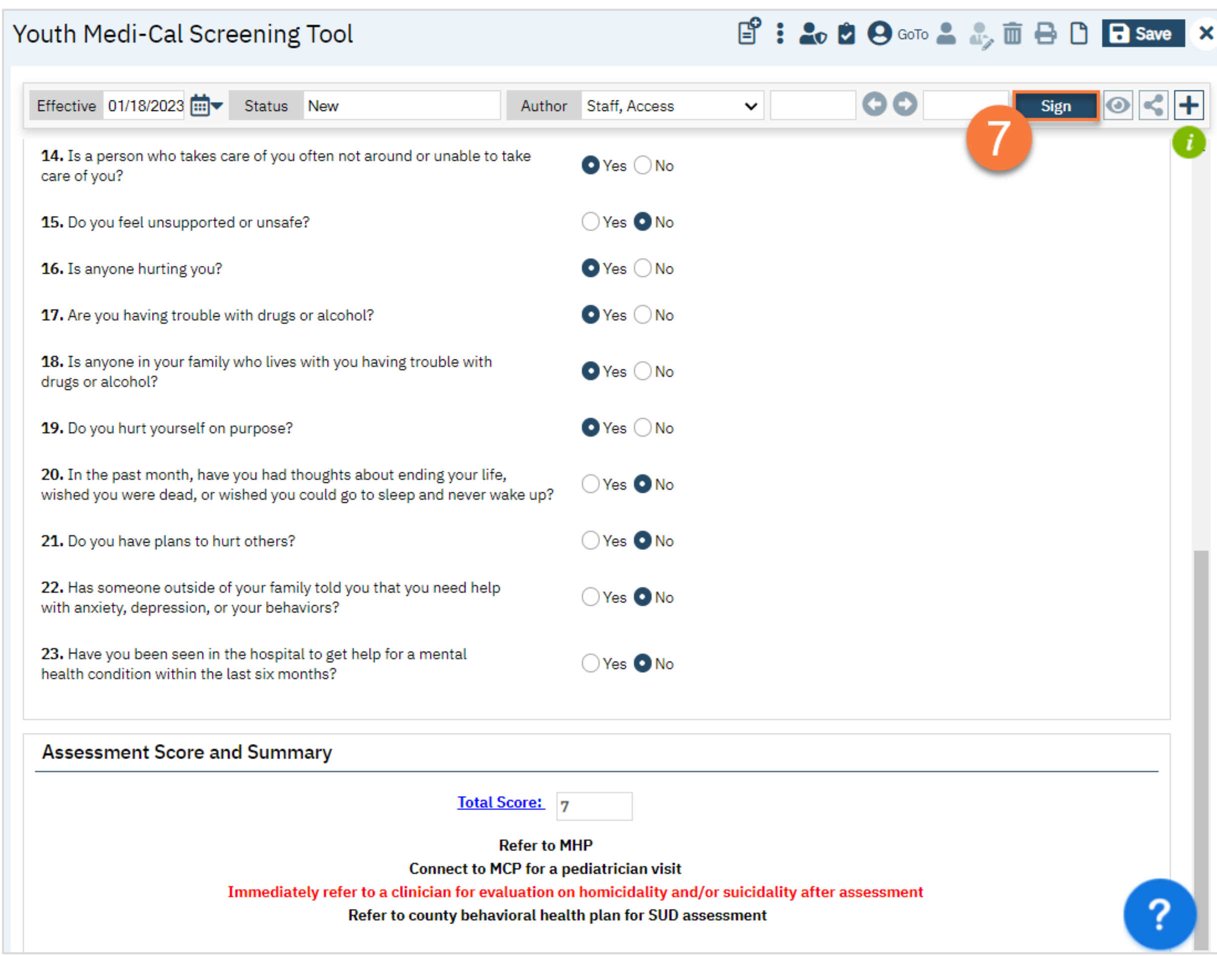
a. Any alerts will show at the top of the page



b. Any recommendations will show at the bottom of the page.

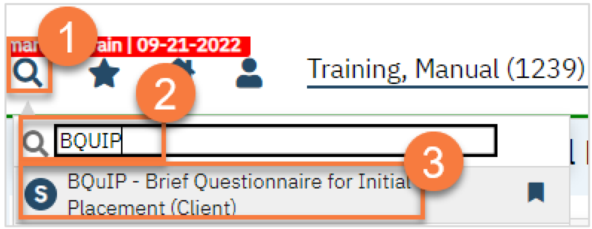


7. **Click Sign** to complete and generate the document.

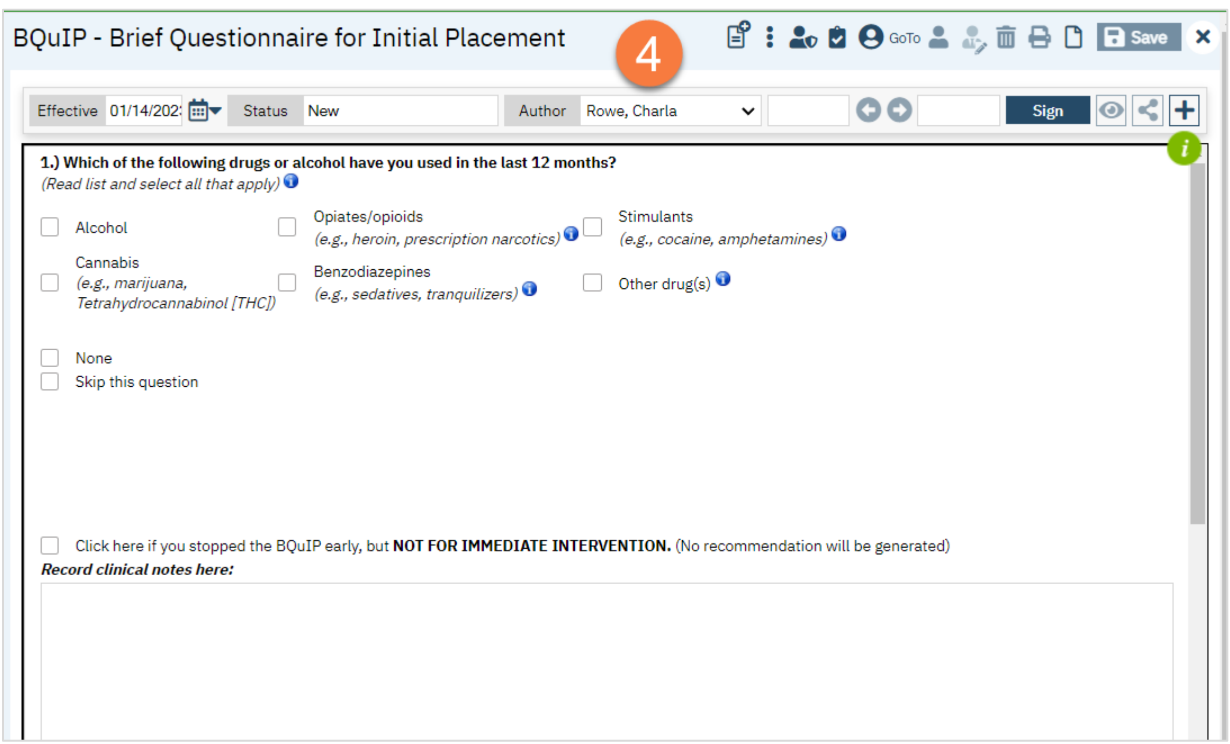


How do I complete a BQuIP SUD Screening Tool?

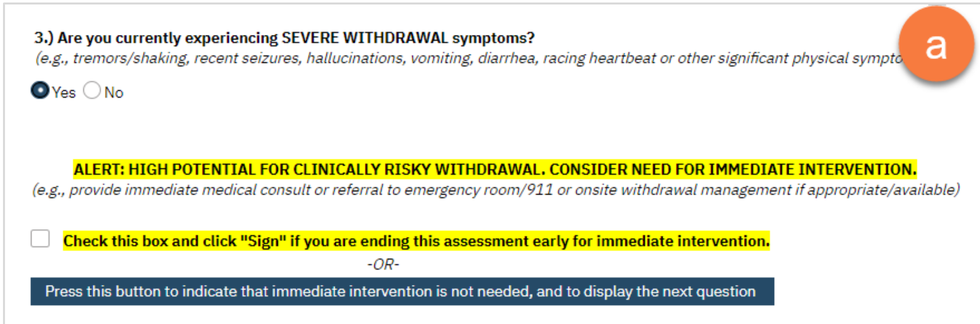
1. You must first have the client open, then **click the Search icon**.
2. **Type BQuIP** into the search bar.
3. **Click to select BQuIP – Brief Questionnaire for Initial Placement (Client).**



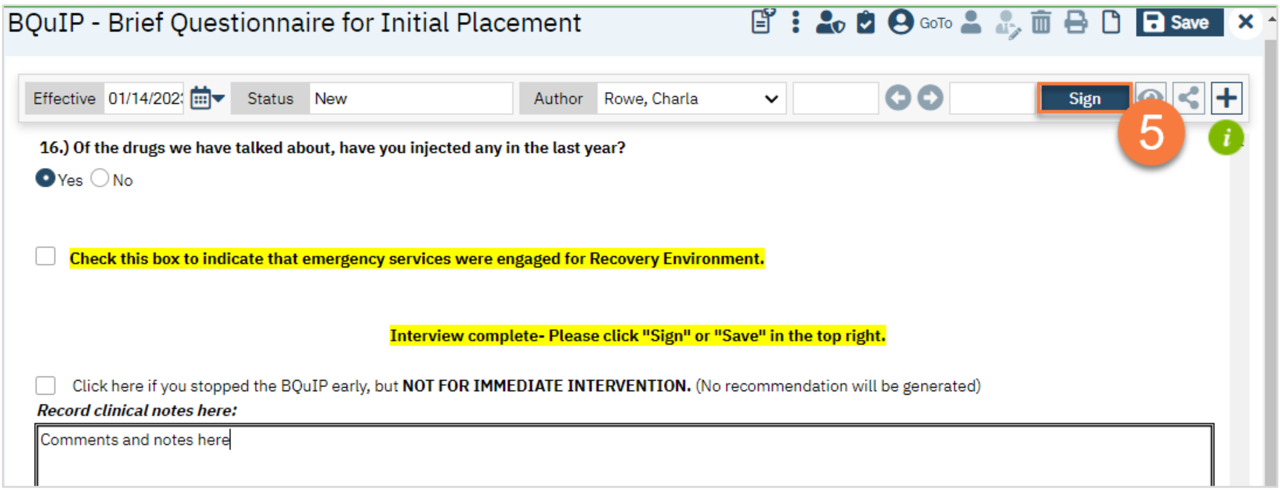
4. The BQuIP document will open. **Complete the document**. Not all questions are visible, as only the next question will show. This allows you easier access to the Clinical Comments field for taking notes as you're working through the screening. As you answer questions, you may be alerted to stop the screening and follow crisis protocols, based on the client's answers.



   a. Alerts will be highlighted and give you directions as you answer questions.



5. Once complete, **click Sign** to complete and generate the document.

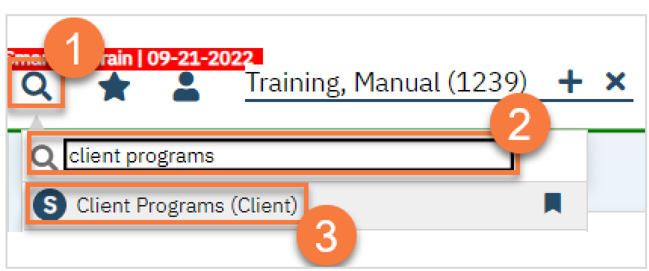


What do I do if the screening indicates that the client should be referred to the County's (MHP) system of care?

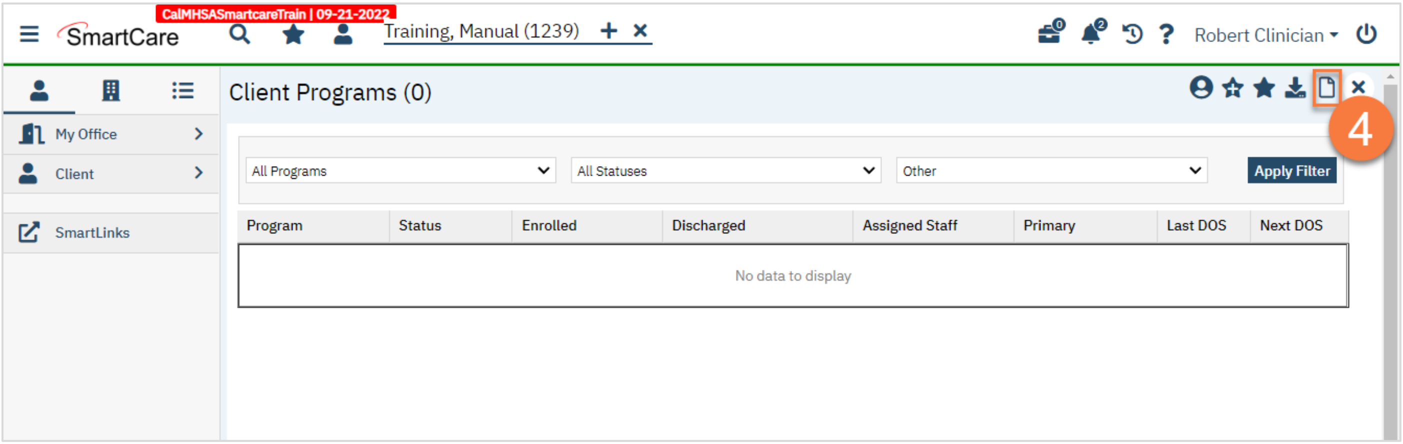
Since the MHP's system of care includes county owned and operated programs as well as contracted providers, you'll have to first determine if the provider you'll be referring to uses the county's instance of SmartCare or not.

How to refer to a county or contractor program that uses SmartCare:

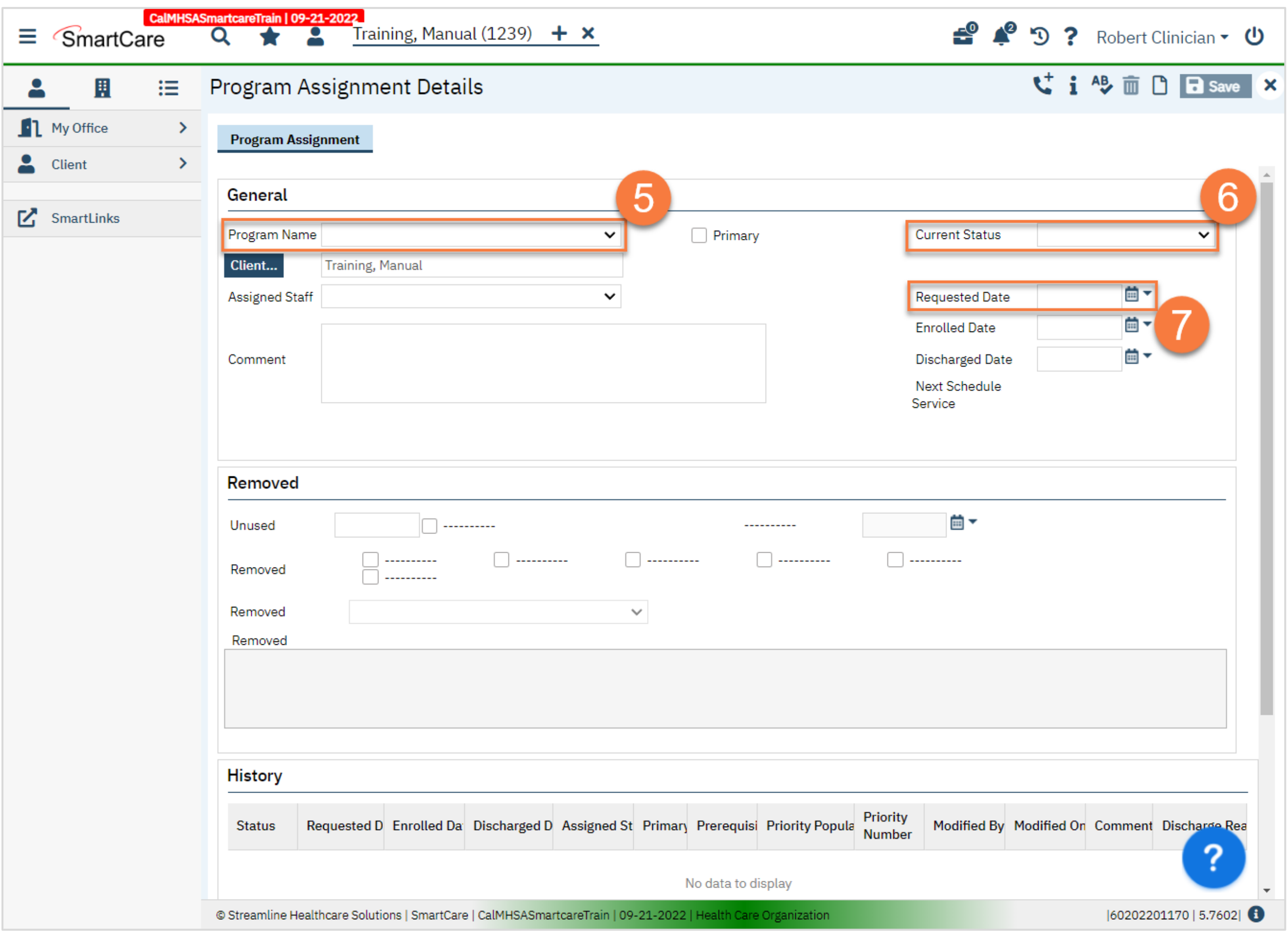
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Programs** into the search bar.
3. **Click to select Client Programs (Client).**



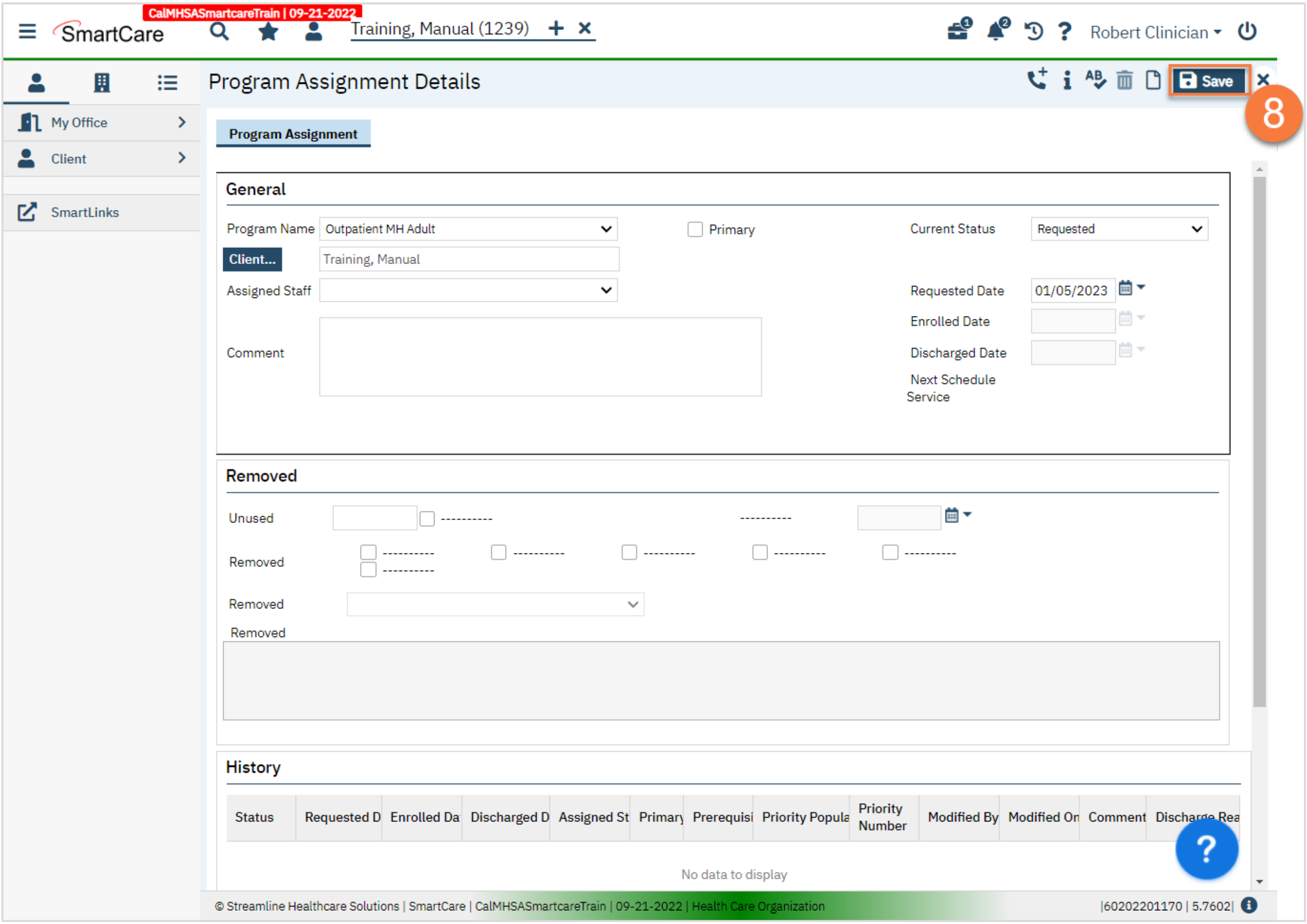
4. This takes you to the Client Programs list page. **Click on the "new" icon**.



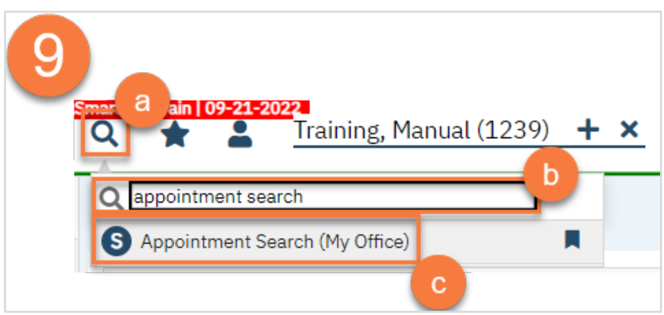
5. Select the program you're referring to.
6. Change the Status to "Requested".
7. Enter the Requested Date.



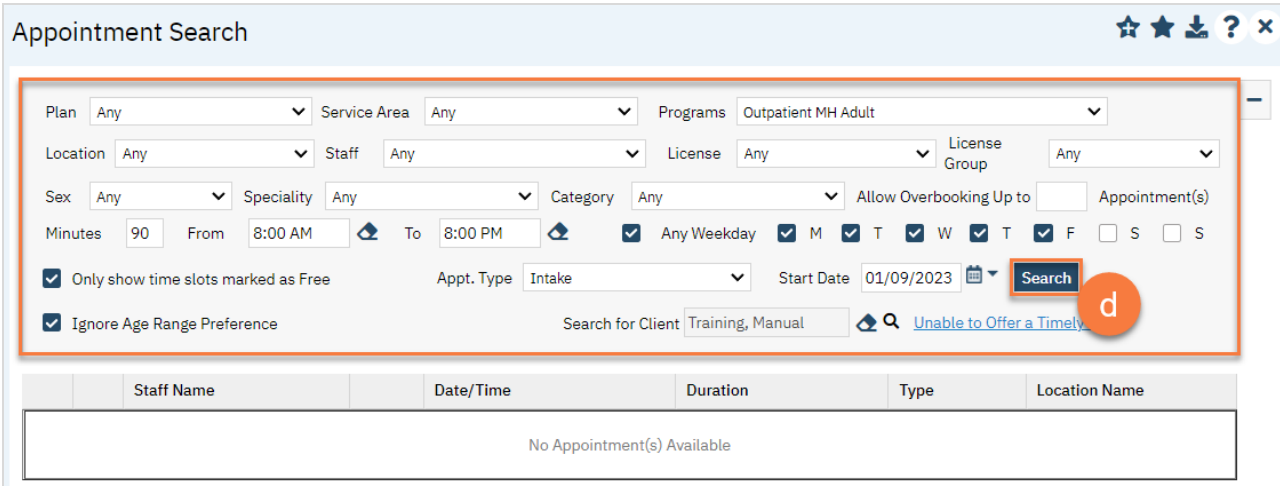
8. Click Save.



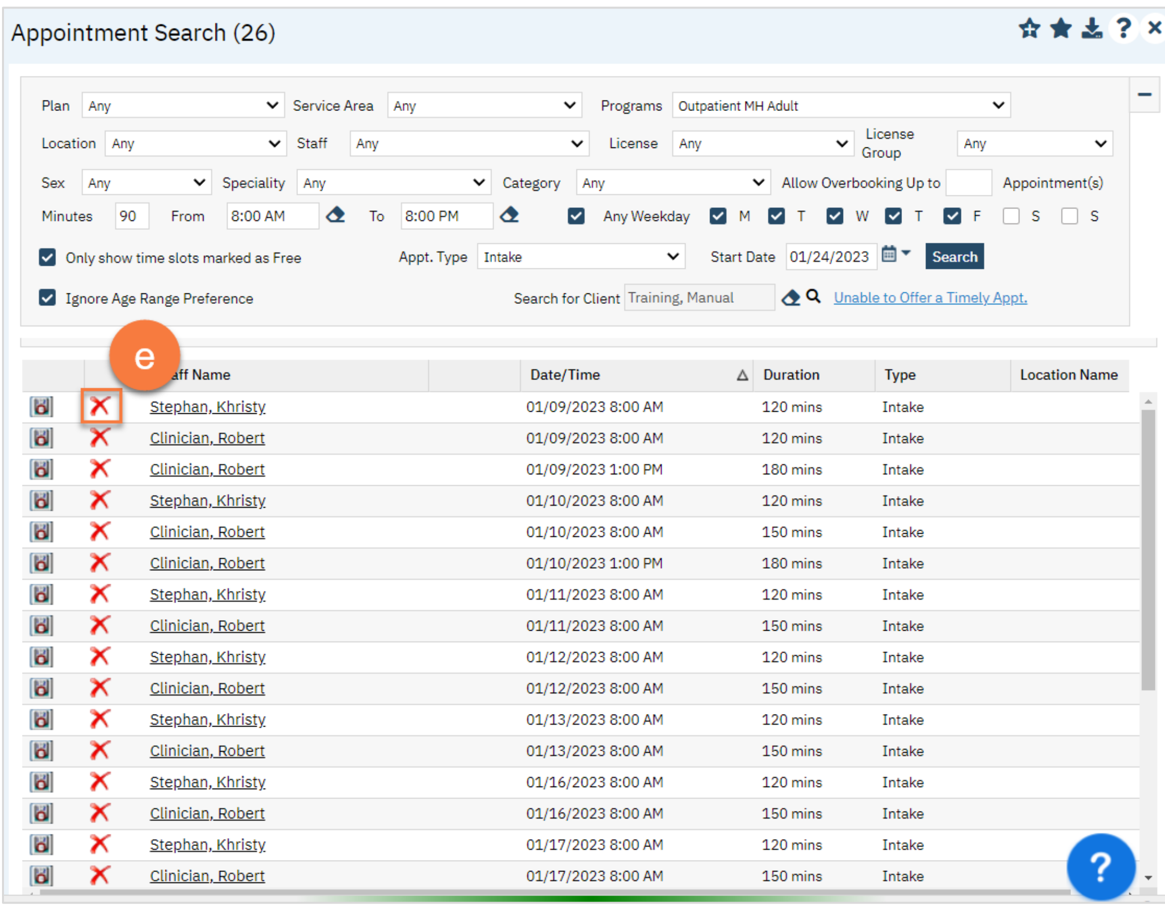
9. **If this program allows you to schedule intake assessments on their behalf, open the Appointment Search screen.** If this program does not allow you to schedule intake assessments on their behalf, you're finished and may close.
   a. **Click the Search icon.**
   b. **Type Appointment Search** into the search bar.
   c. **Click to select Appointment Search.**



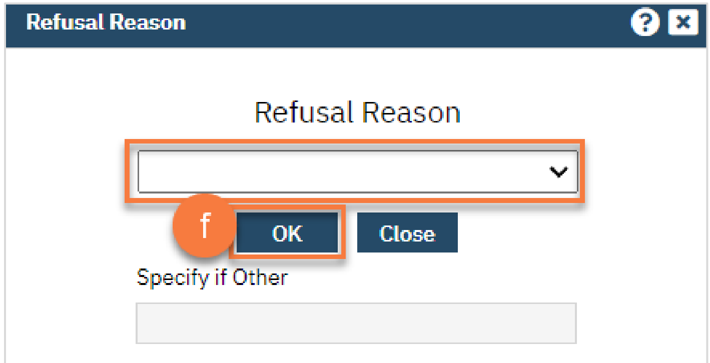
   d. **Use the filters to limit the search** to intake appointments for that program and any other requests the client has, such as client's availability. Then **click Search**.



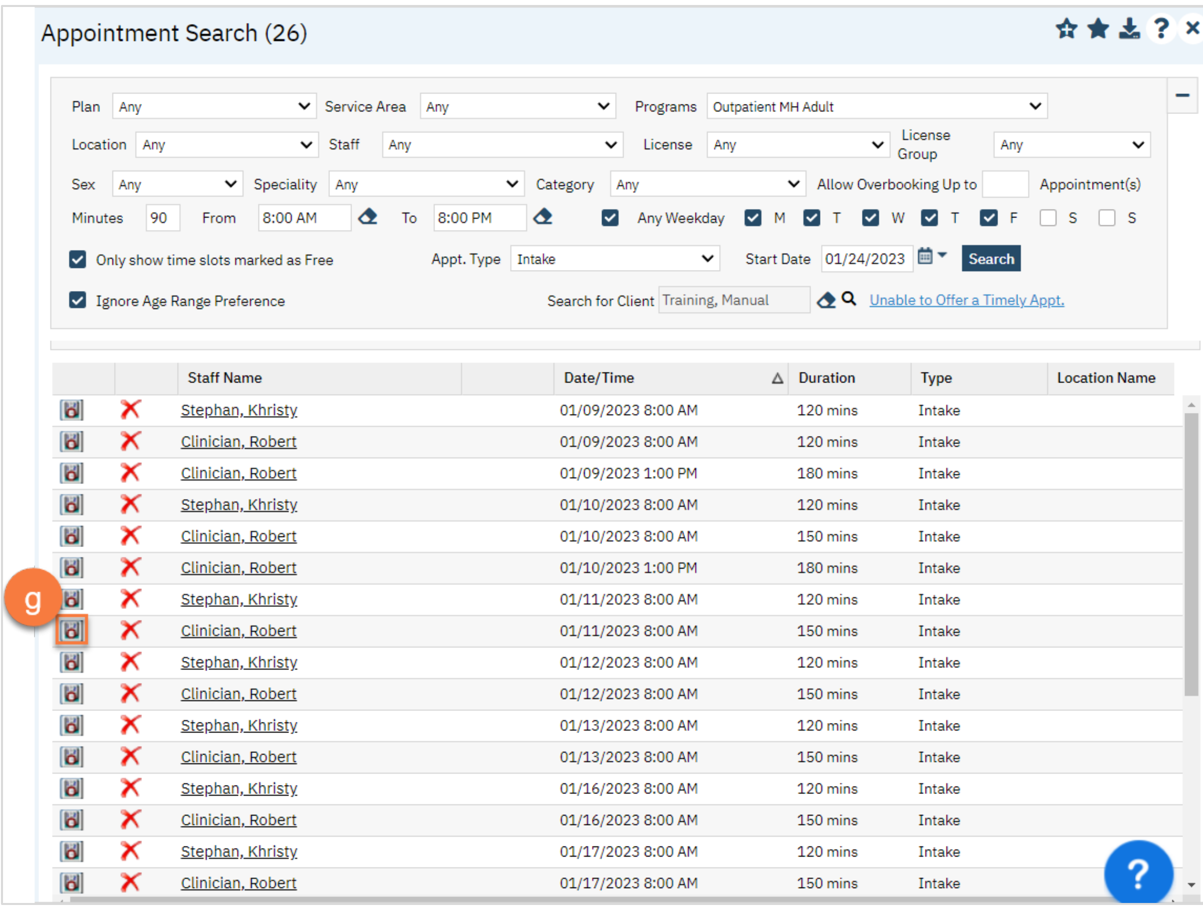
e. This will bring up a list of available appointments. **If the client declines the first few available appointment dates, click on the "Client Refuses Appointment" icon**. This will be used for tracking timeliness. Note: you only need to decline 1 appointment per day. In the below example, there are 3 available appointments on 1/9/23 and 3 available appointments on 1/10/23. You would only need to decline one of these appointments on each date, so you would only decline 2 total appointments, not all 6.



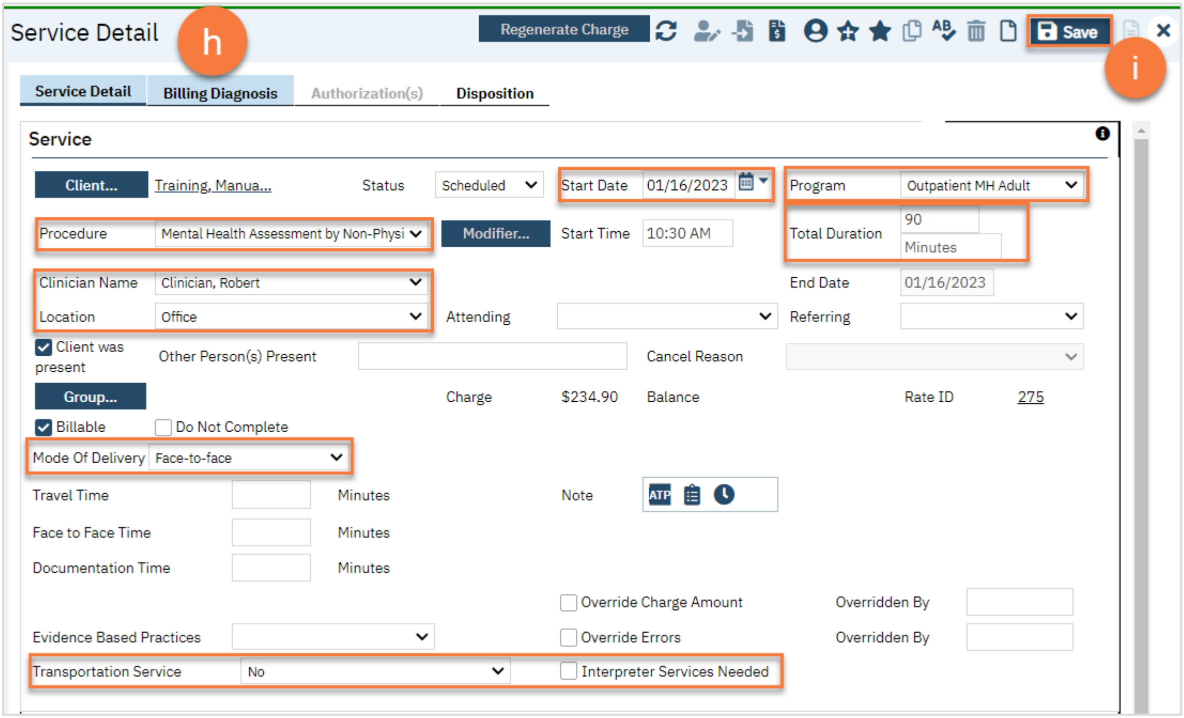
f. Clicking on the "Client Refuses Appointment" icon will bring up a pop-up window. **Enter the Refusal Reason and then click "OK"**.



g. **For the appointment that the client chooses, click on the "Schedule Appointment" icon**.

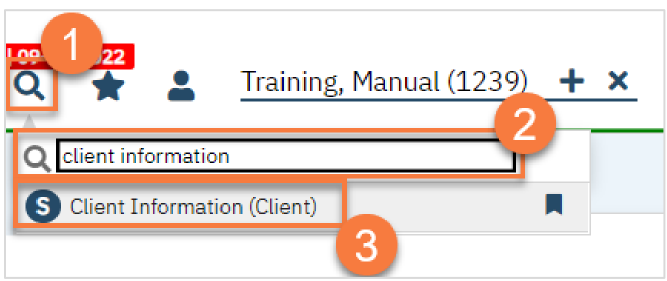


h. This takes you to the Service Detail screen. **Confirm/enter the appointment information**. You can also denote if the person needs transportation or interpretation services.
i. Once complete, **click Save**. The appointment is now scheduled and you are finished.

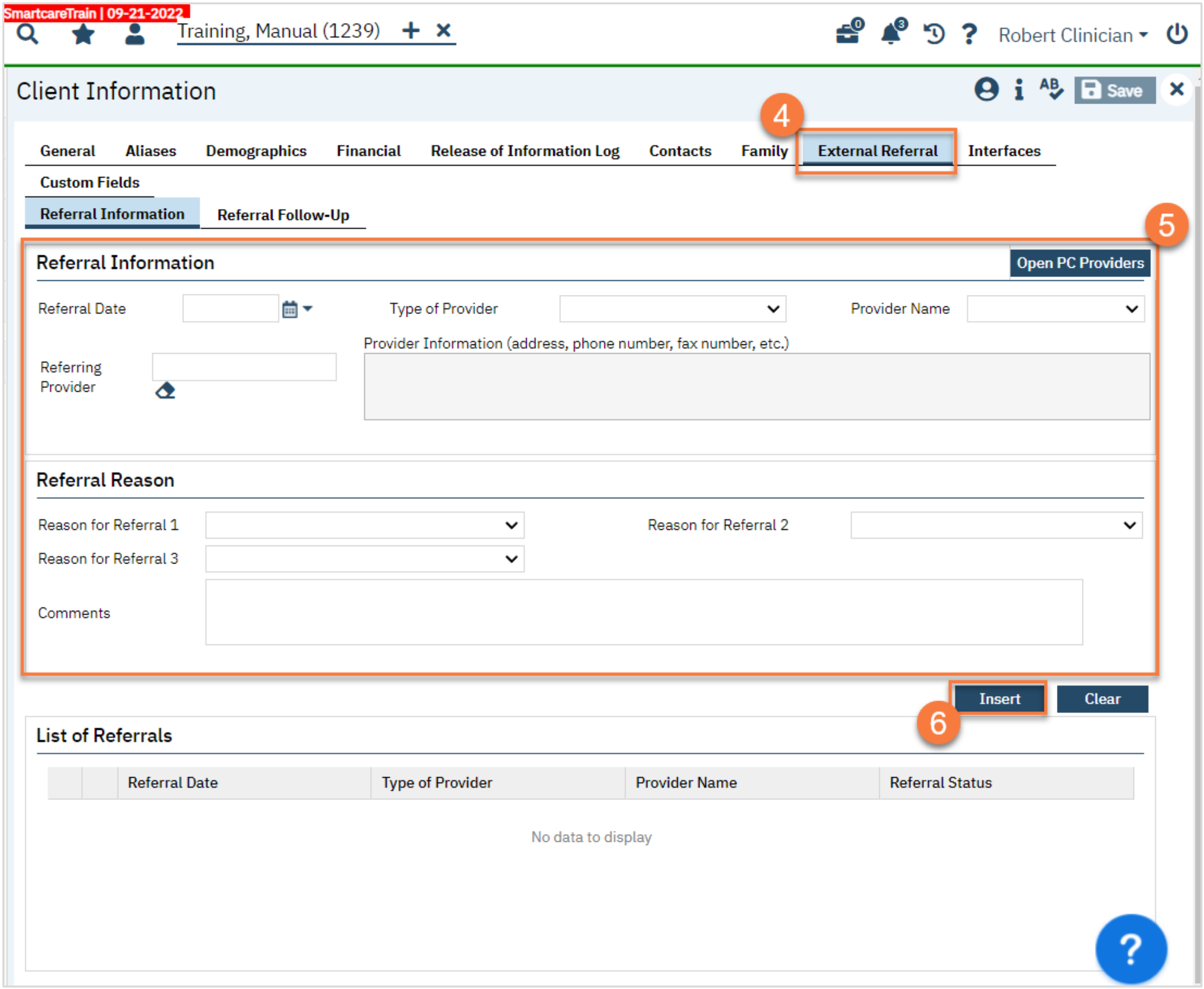


How to refer to an agency or program that doesn't use SmartCare:

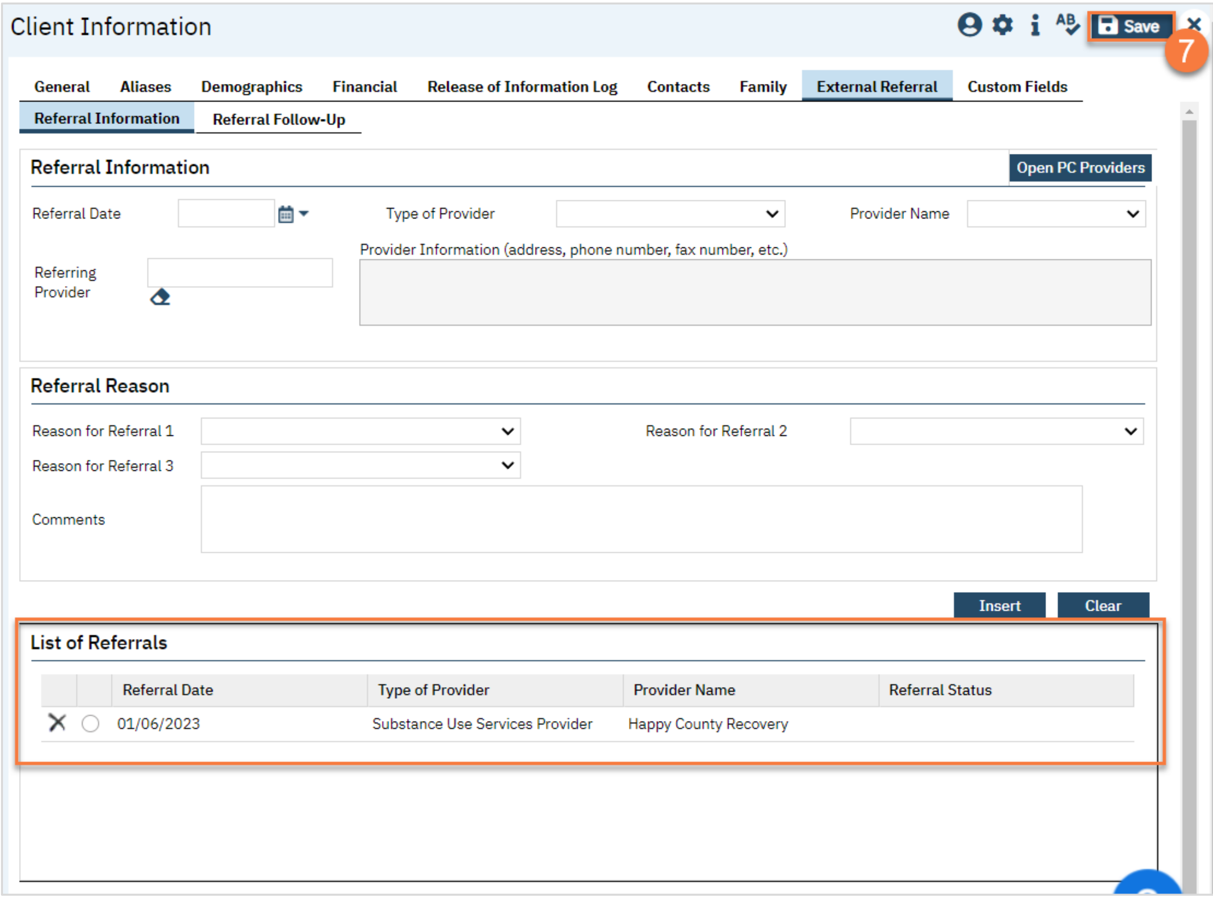
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**



4. **Navigate to the "External Referral" tab**.
5. **Complete the information about the referral** you're providing. Put yourself as the Referring Provider.
6. **Click "Insert"**.

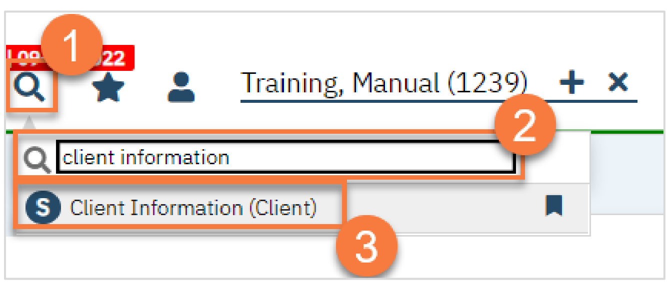


7. Your referral should now show in the List of Referrals section. **Click Save**.

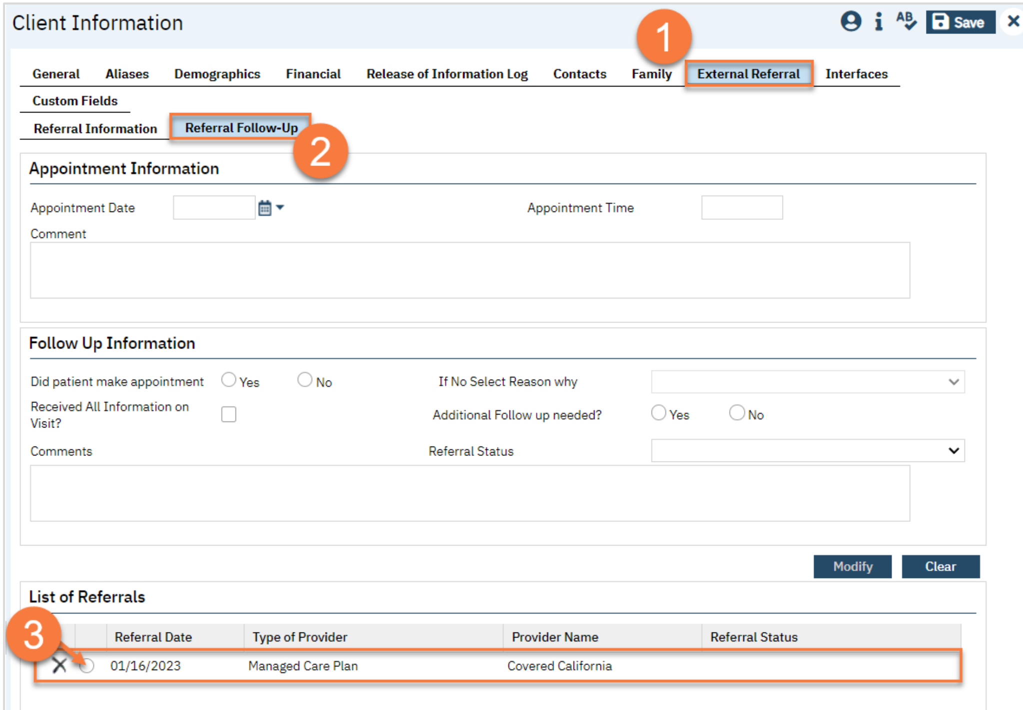


How do I document follow-up done on an external referral?

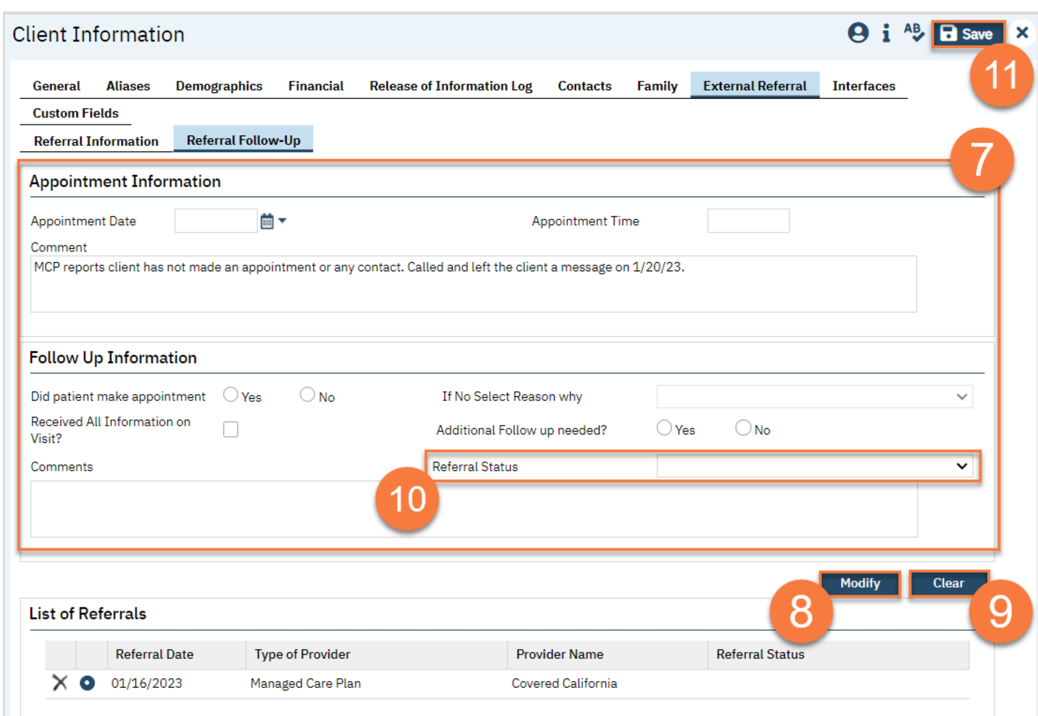
1. To document follow-up on a referral in SmartCare, you must first have the client open, then click the Search icon.
2. Type Client Information into the search bar.
3. Click to select Client Information (Client).

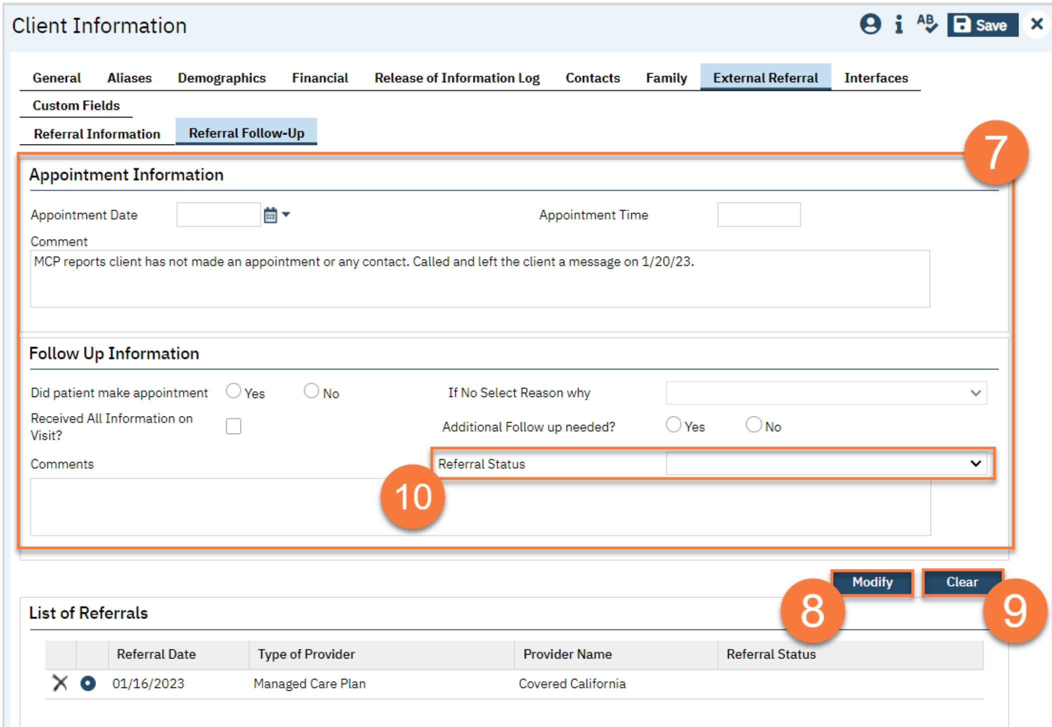


4. Navigate to the "External Referral" tab.
5. Click on the Referral Follow-Up tab.
6. Select the referral you want to follow up on from the List of Referrals.



7. If there's any information already added to this referral, it brings up the information in the top part of the screen. From here, **enter your follow up information.**
8. **Click Modify** to save your changes.
9. If you selected the wrong referral, click clear.
10. Once the client has successfully completed the referral process, enter "Complete" in the Referral Status.
11. Once you've finished entering any follow ups, **click Save**.

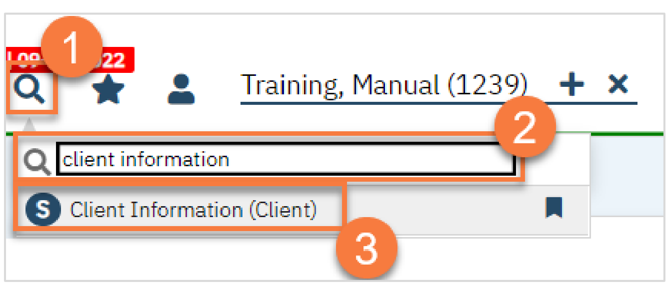




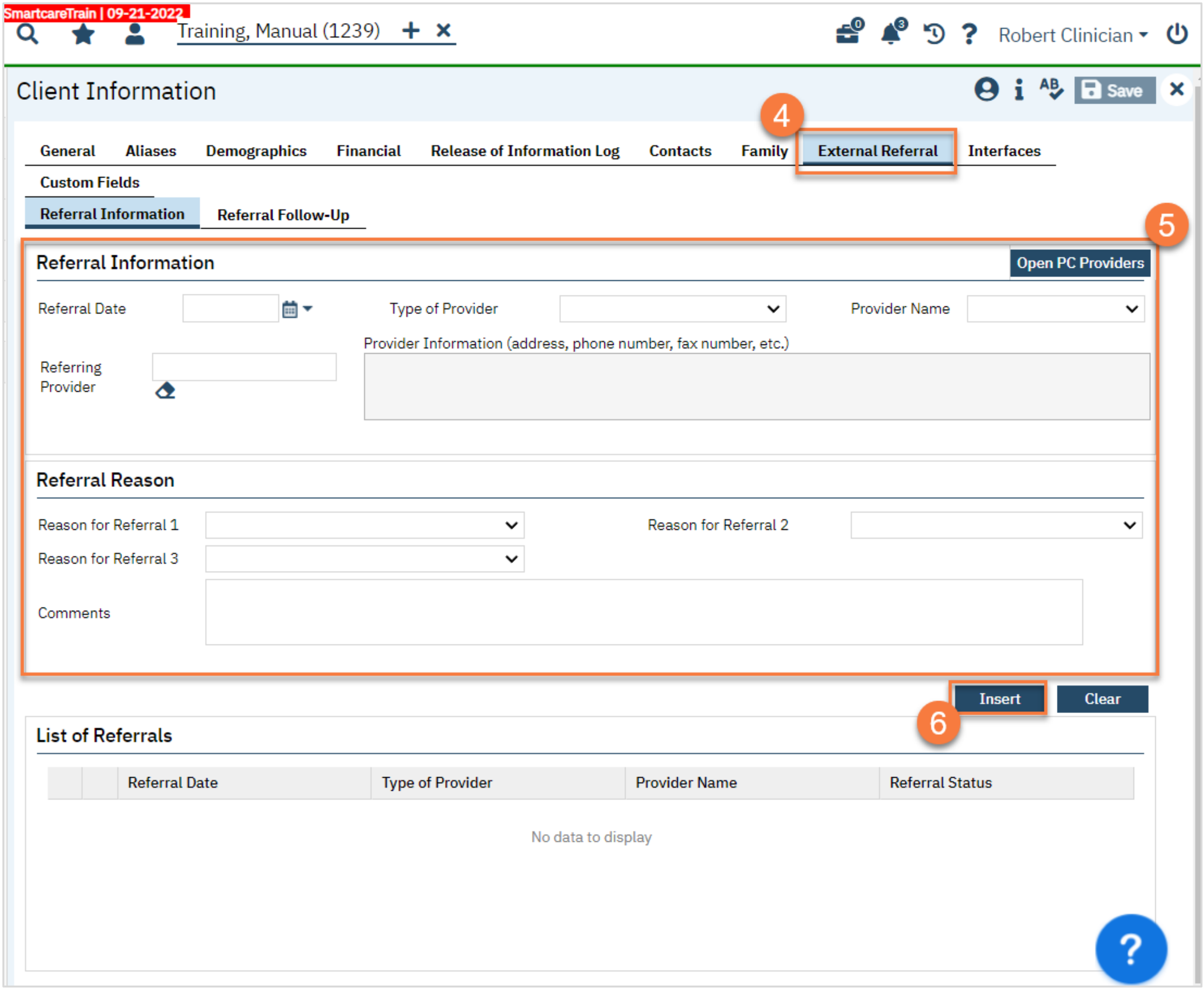
What do I do if the screening indicates that the client should be referred to the Managed Care Plan (MCP)?

If the screening indicates that you need to refer the client to the MCP, follow your county's current procedures for referring to the MCP.

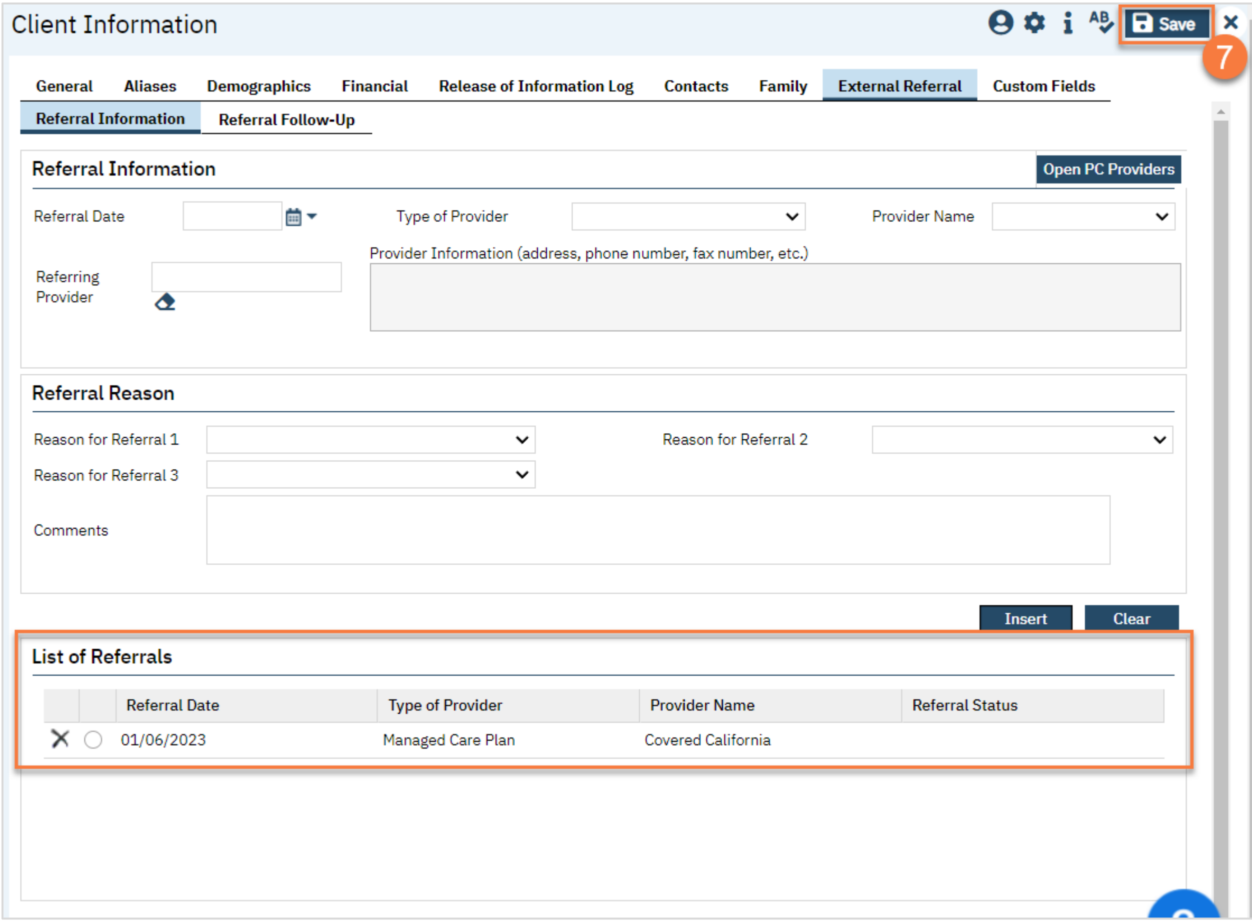
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**



4. **Navigate to the "External Referral" tab**.
5. **Complete the information about the referral** you're providing. For a referral to the Managed Care Plan, select Managed Care Plan from the Provider Type dropdown. Put yourself as the Referring Provider.
6. **Click "Insert"**.



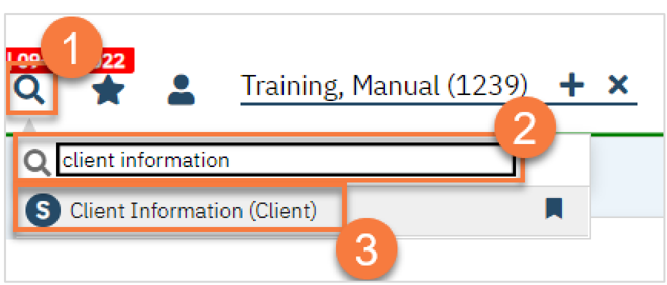
7. Your referral should now show in the List of Referrals section. **Click Save**.



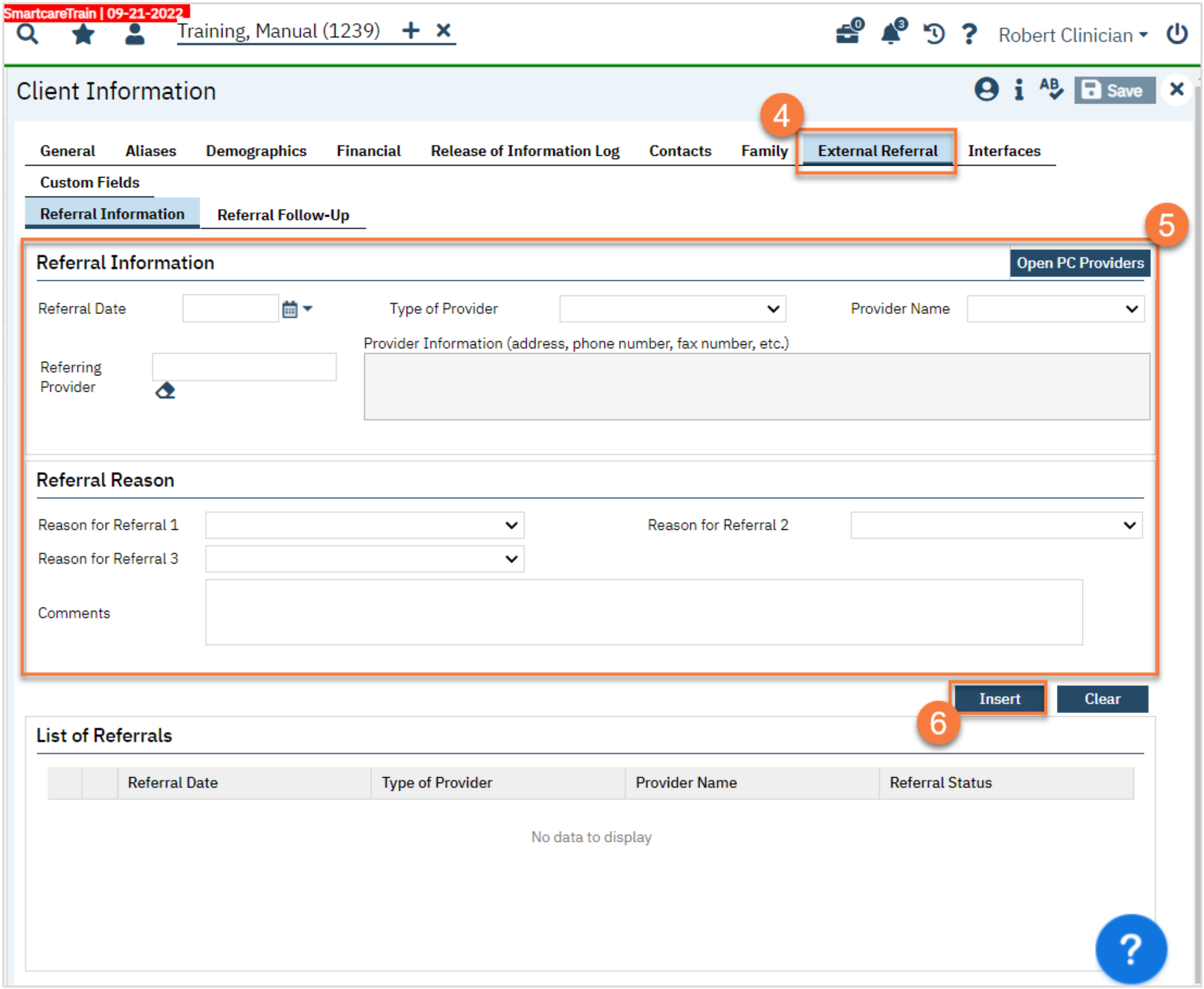
What do I do if the screening indicates that the client should be referred to additional services, such a Primary Care Physician?

If the screening indicates you need to refer to additional services with providers that do not use your county's instance of SmartCare, follow your county's procedures for sending these referrals.

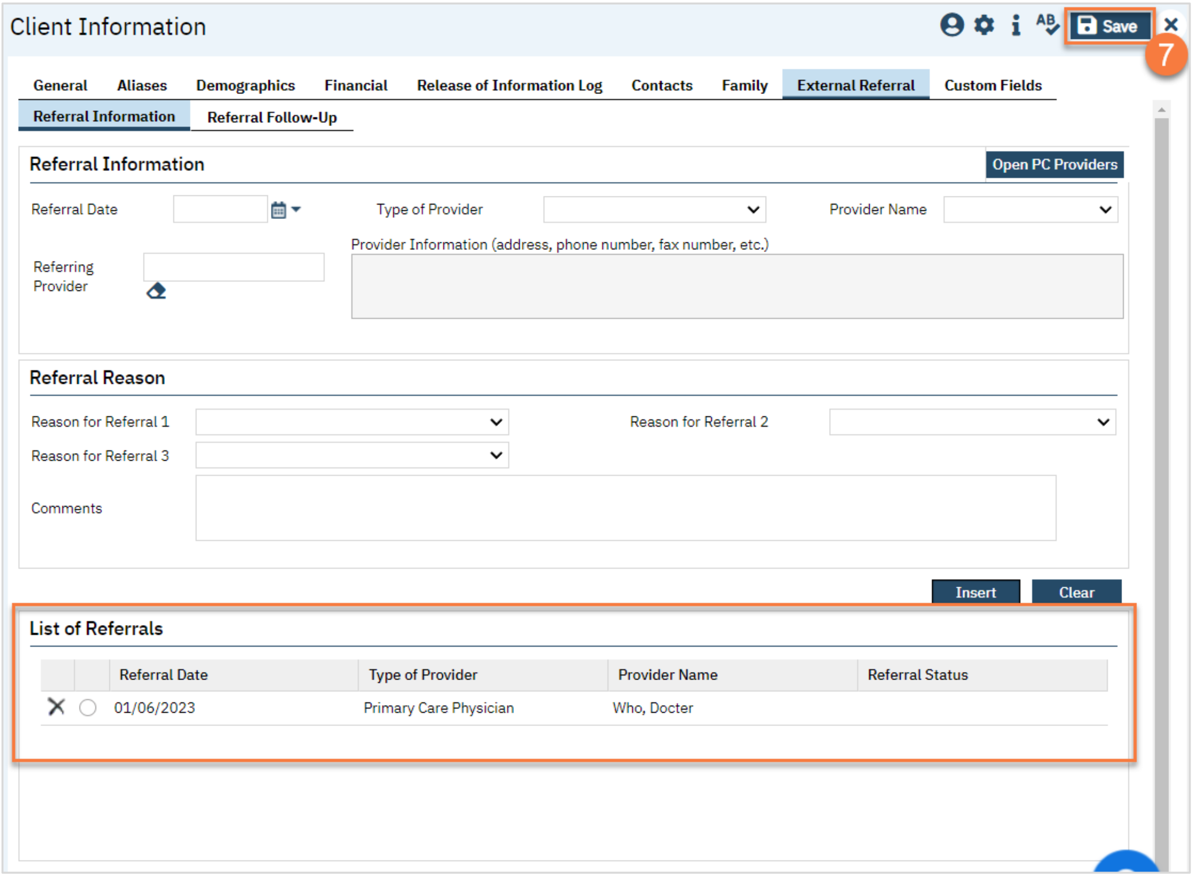
8. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
9. **Type Client Information** into the search bar.
10. **Click to select Client Information (Client).**



11. **Navigate to the "External Referral" tab**.
12. **Complete the information about the referral** you're providing. Put yourself as the Referring Provider.
13. **Click "Insert"**.



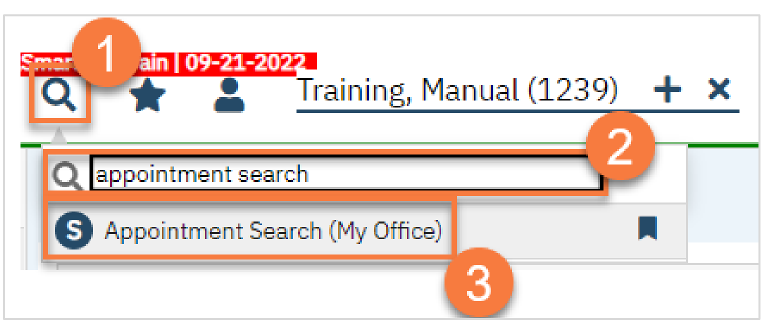
14. Your referral should now show in the List of Referrals section. **Click Save**.



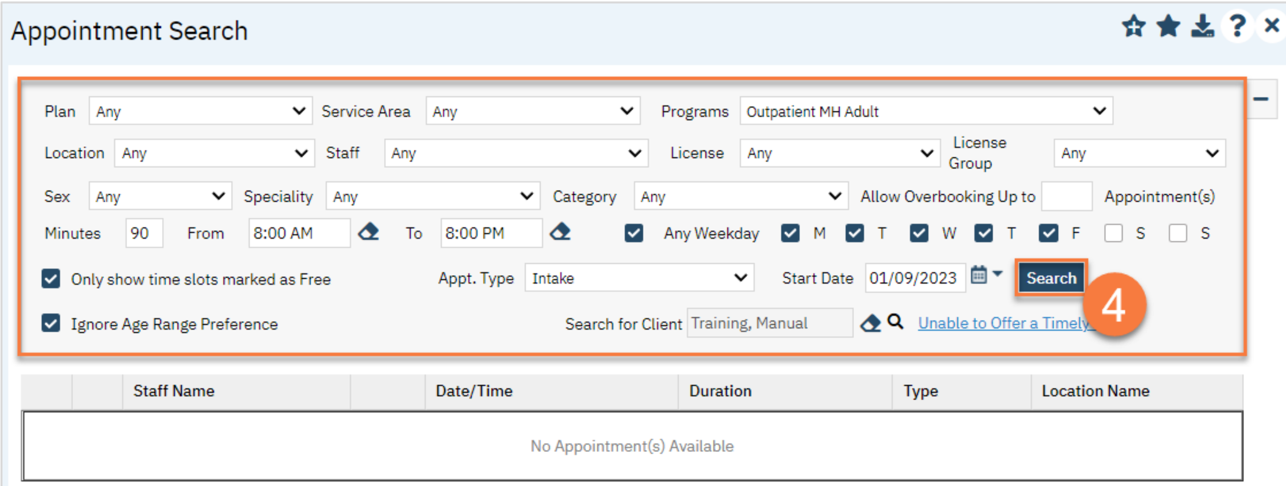
Supervisor/Front Desk: What do I do when there's a program enrollment request for a program that manages its own scheduling?

Some programs in your county may not allow other staff to schedule intake appointments, instead keeping this task solely within this program. When someone requests enrollment in this type of program, you will be expected to schedule the initial intake appointment.

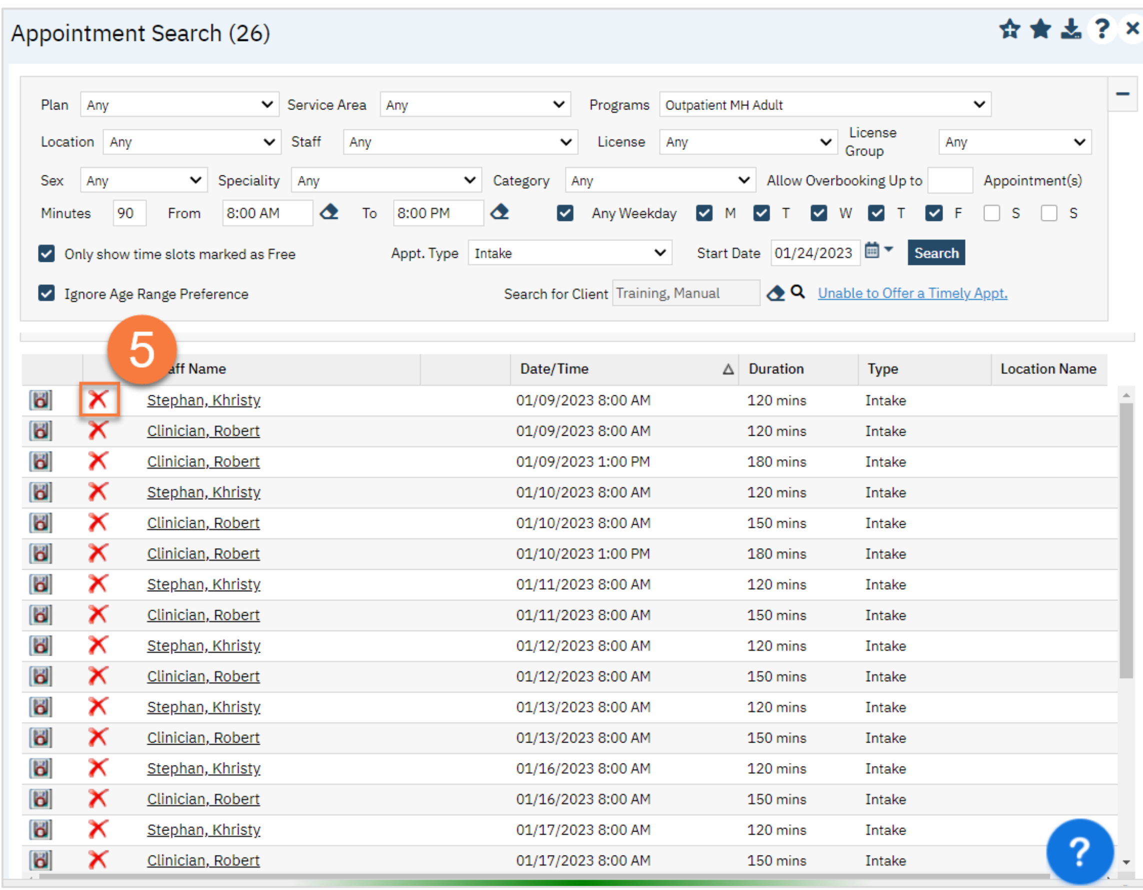
1. You must first have the client open, then **click the Search icon**.
2. **Type Appointment Search** into the search bar.
3. **Click to select Appointment Search.**



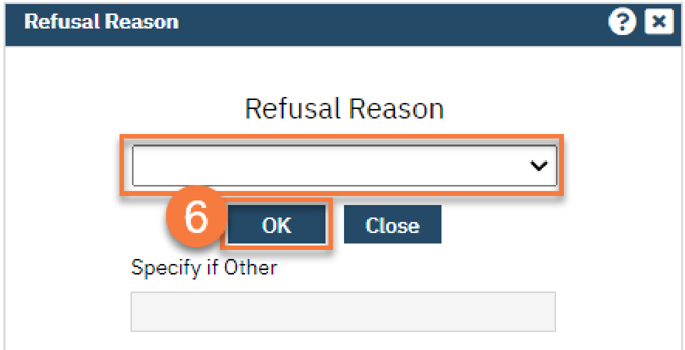
4. **Use the filters to limit the search** to intake appointments for that program and any other requests the client has, such as client's availability. Then **click Search**.



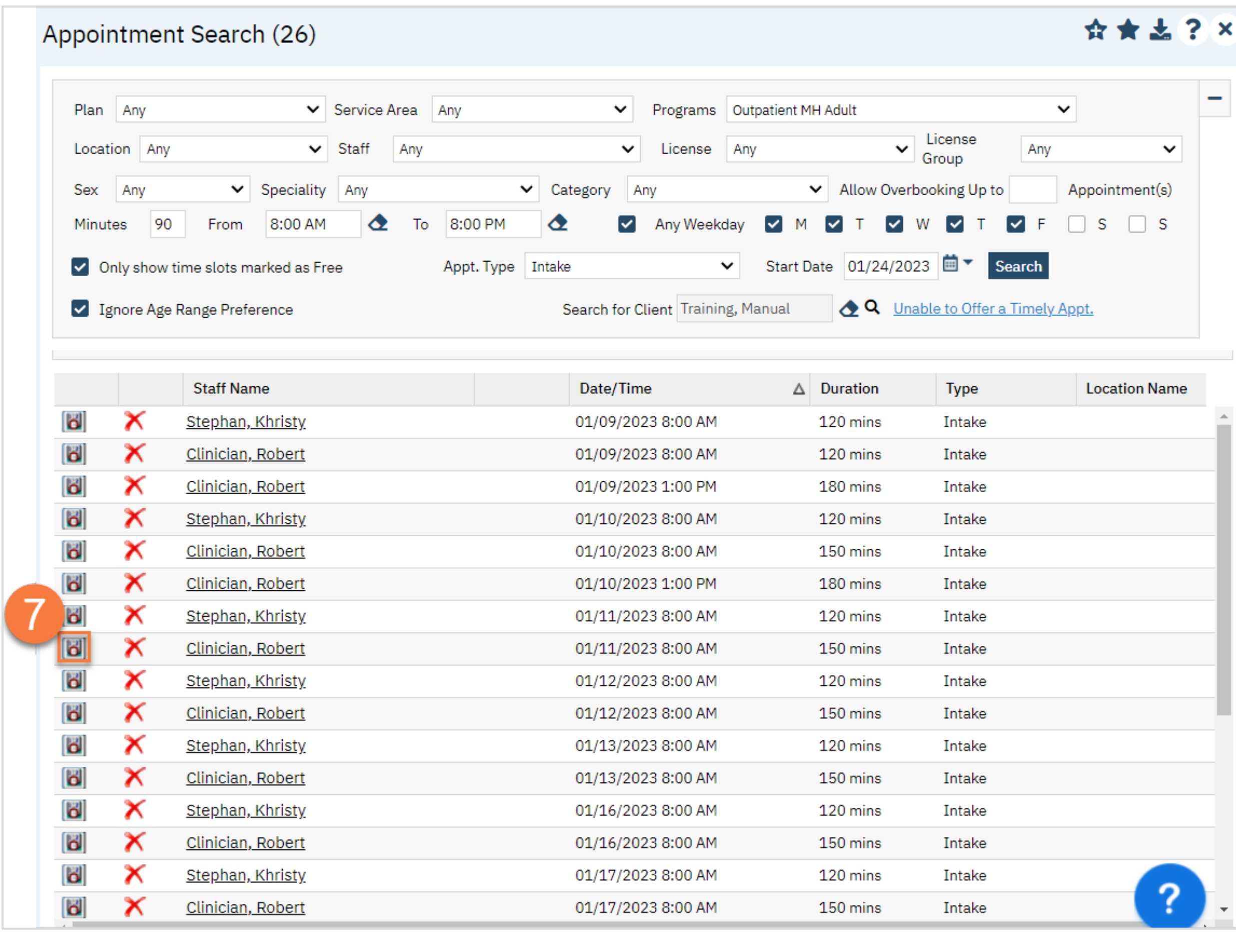
5. This will bring up a list of available appointments. **If the client declines the first few available appointment dates, click on the "Client Refuses Appointment" icon**. This will be used for tracking timeliness. Note: you only need to decline 1 appointment per day. In the below example, there are 3 available appointments on 1/9/23 and 3 available appointments on 1/10/23. You would only need to decline one of these appointments on each date, so you would only decline 2 total appointments, not all 6.



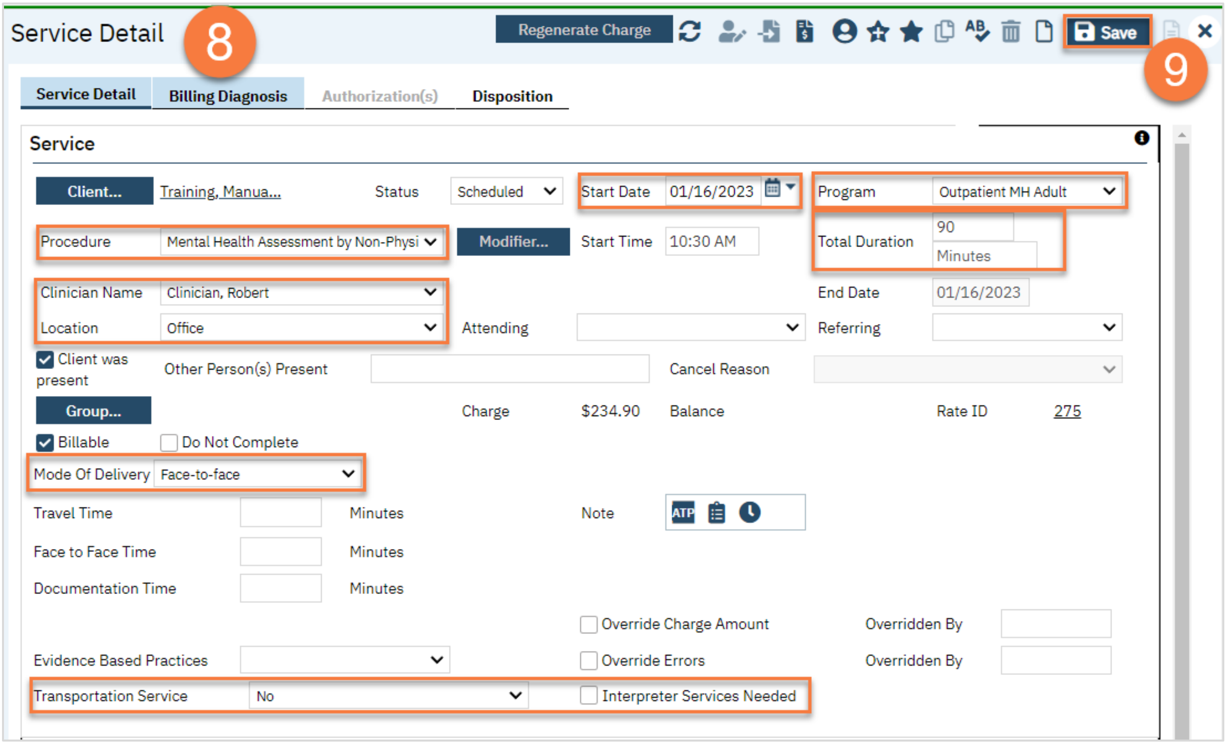
6. Clicking on the "Client Refuses Appointment" icon will bring up a pop-up window. **Enter the Refusal Reason and then click "OK"**.



7. For the appointment that the client chooses, click on the “Schedule Appointment” icon.



8. This takes you to the Service Detail screen. **Confirm/enter the appointment information**. You can also denote if the person needs transportation or interpretation services.
9. Once complete, **click Save**. The appointment is now scheduled and you are finished.


Service Detail
8
Regenerate Charge
Save
9
Service Detail
Billing Diagnosis
Authorization(s)
Disposition
Service
Client...
Training, Manua...
Status
Scheduled
Start Date
01/16/2023
Program
Outpatient MH Adult
Procedure
Mental Health Assessment by Non-Physi
Modifier...
Start Time
10:30 AM
Total Duration
90
Minutes
Clinician Name
Clinician, Robert
End Date
01/16/2023
Location
Office
Attending
Referring
Client was present
Other Person(s) Present
Cancel Reason
Group...
Charge
$234.90
Balance
Rate ID
275
Billable
Do Not Complete
Mode Of Delivery
Face-to-face
Travel Time
Minutes
Note
Face to Face Time
Minutes
Documentation Time
Minutes
Override Charge Amount
Overridden By
Evidence Based Practices
Override Errors
Overridden By
Transportation Service
No
Interpreter Services Needed

Life Cycle of the Client: Intake and Assessment

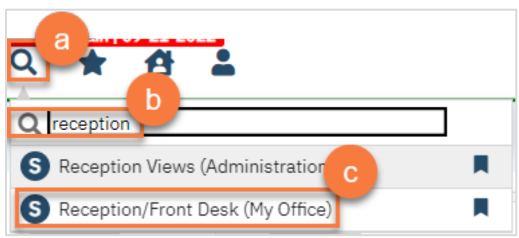
Once a person has been screened and is referred to a county, the next step is a full clinical assessment. However, there is also an intake process in order to enroll the client in the appropriate program and complete necessary program and legal documentation. In this section, we'll start with the basic intake process, then cover how to complete the intake paperwork packet, and then cover the clinical assessment and diagnosis.

Intake and Assessment Process Steps:

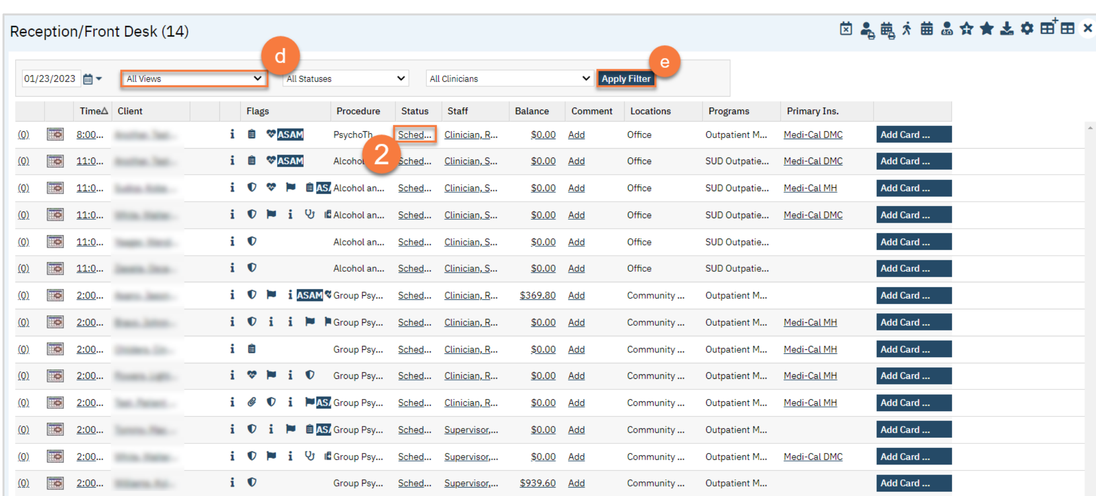
1. Find or create the client in SmartCare.
2. Enroll the client in the assessment program.
3. Confirm/enter the client's information, such as contact information, insurance, and basic demographics.
4. Complete the necessary intake documentation for your program.
5. Complete the clinical assessment.

Front Desk: A client has arrived for their intake/assessment appointment. What do I do?

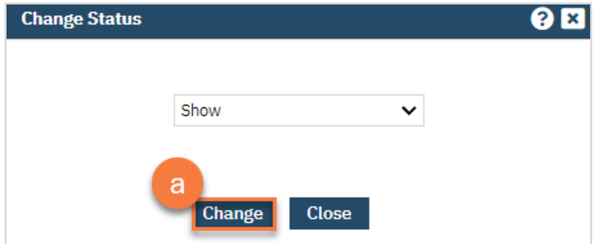
1. **Open the Reception view**, if not already done so.
   a. **Click the Search icon**.
   b. **Type "Reception"** in the search bar.
   c. **Select "Reception/Front Desk (My Office)"** from the search results.



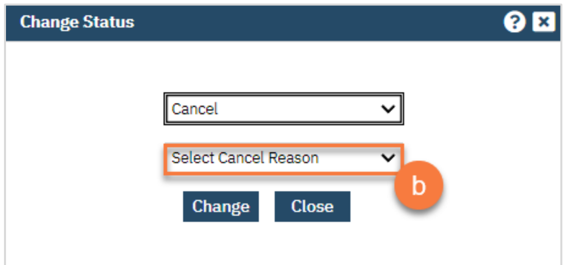
   d. This will bring up the Reception/Front Desk view. **Select your program from the Views dropdown menu**. Your system administrator can set up the appropriate list for your location. If you've used this screen before, it should populate from the most recent view you used.
   e. **Click Apply Filter** to apply the view filter.
2. To check in a client, **click the link in the Status column**.



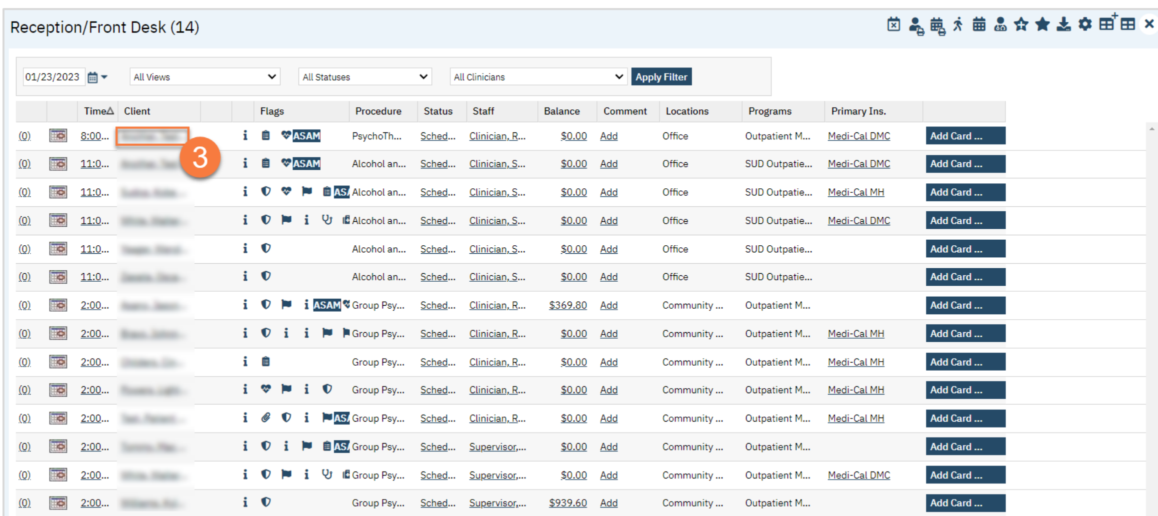
   a. This will bring up a pop-up window which auto-populates to "Show." **Click Change** to check the client in.



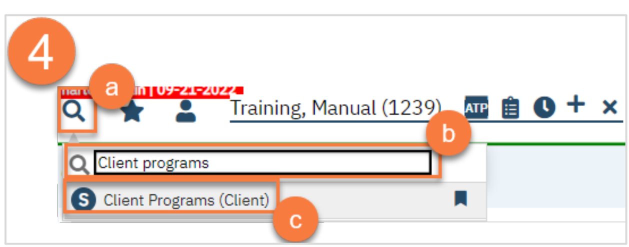
b. You can also use this to cancel the appointment or mark the client as a no-show. If you mark this as “Cancel,” you’ll need to enter the reason for cancellation. If you mark this as “cancel” or “no show,” you can NOT undo this.



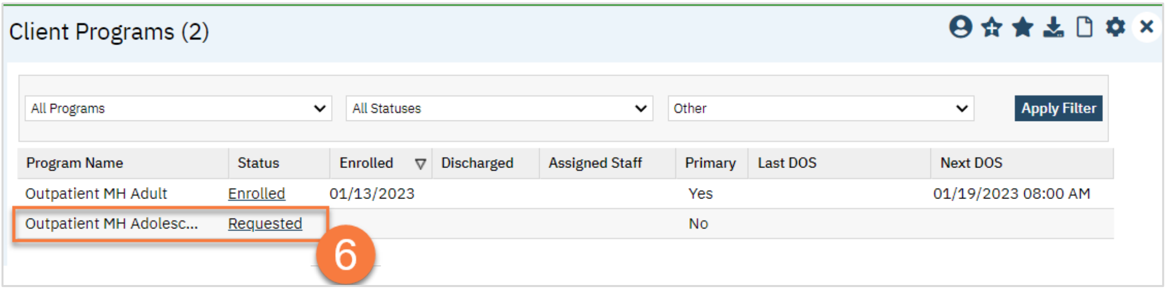
3. To open the client’s chart, **click on the link in the Client** column.



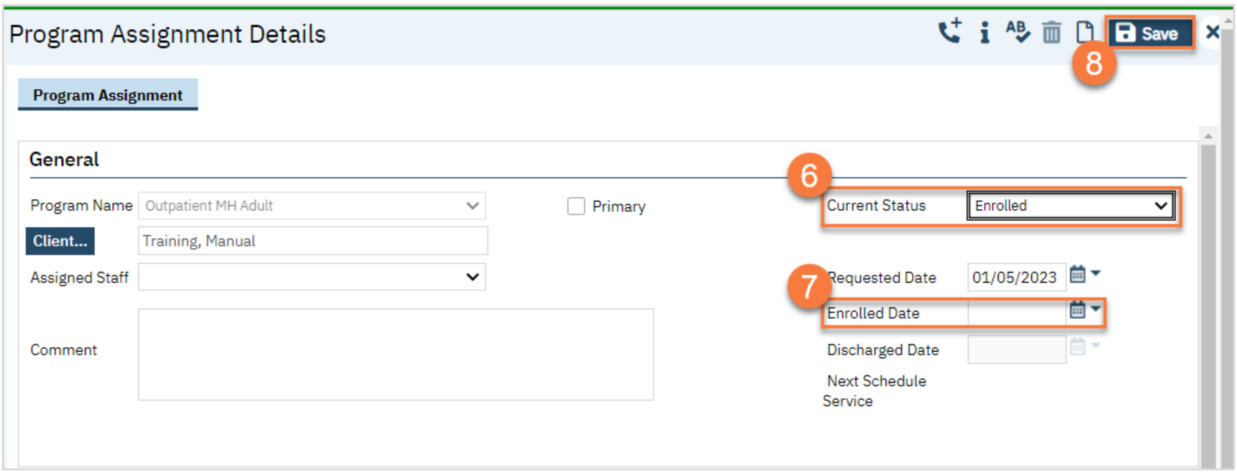
4. **Open the Client Programs list page**.
   a. **Click the Search icon**.
   b. **Type “Client Program” in the search bar.**
   c. **Select “Client Programs (Client)” from the search results.**



5. Find your program on the list and **click on the link in the Status column**, which should be listed as “Requested.”



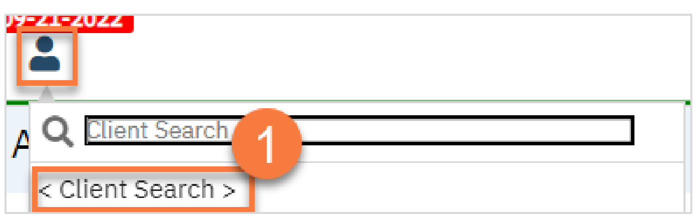
6. This takes you to the Client Program Details screen. **Change the Status to "Enrolled"**.
7. This unlocks the Enrollment Date field. **Enter today's date in the Enrollment Date field**.
8. **Click Save**.



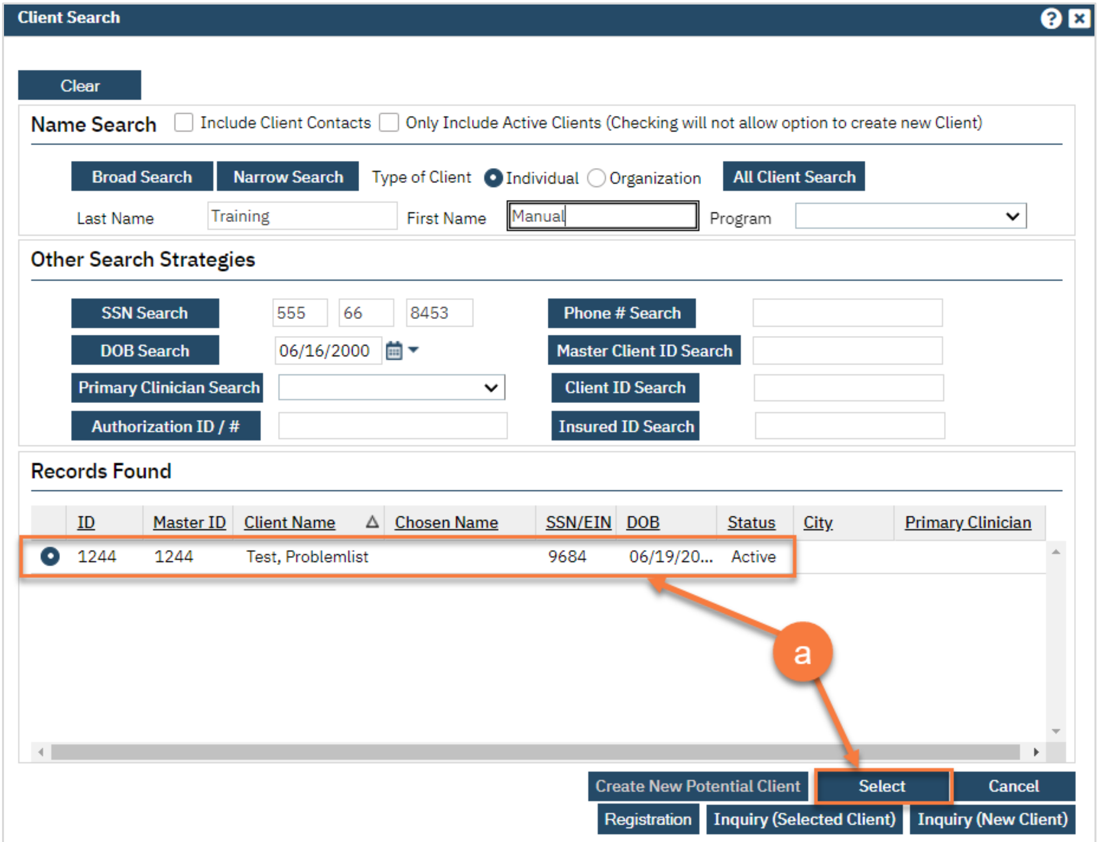
9. The next steps in the process are to complete the intake documentation packet, confirm the client's information, and for the clinician to complete the clinical assessment. **Complete the documents you are responsible for**. Follow the steps in How do I complete Intake Documents?. If you have documents that were completed on paper that need to be scanned in to SmartCare, see How do I scan a document into the client's record? If you need additional information on a specific form, see their respective section (e.g. Privacy and Consents; Clinical Documents; Intake and Other Forms; State Reporting).

Front Desk: A person has walked in for an assessment at a walk-in clinic. What do I do?

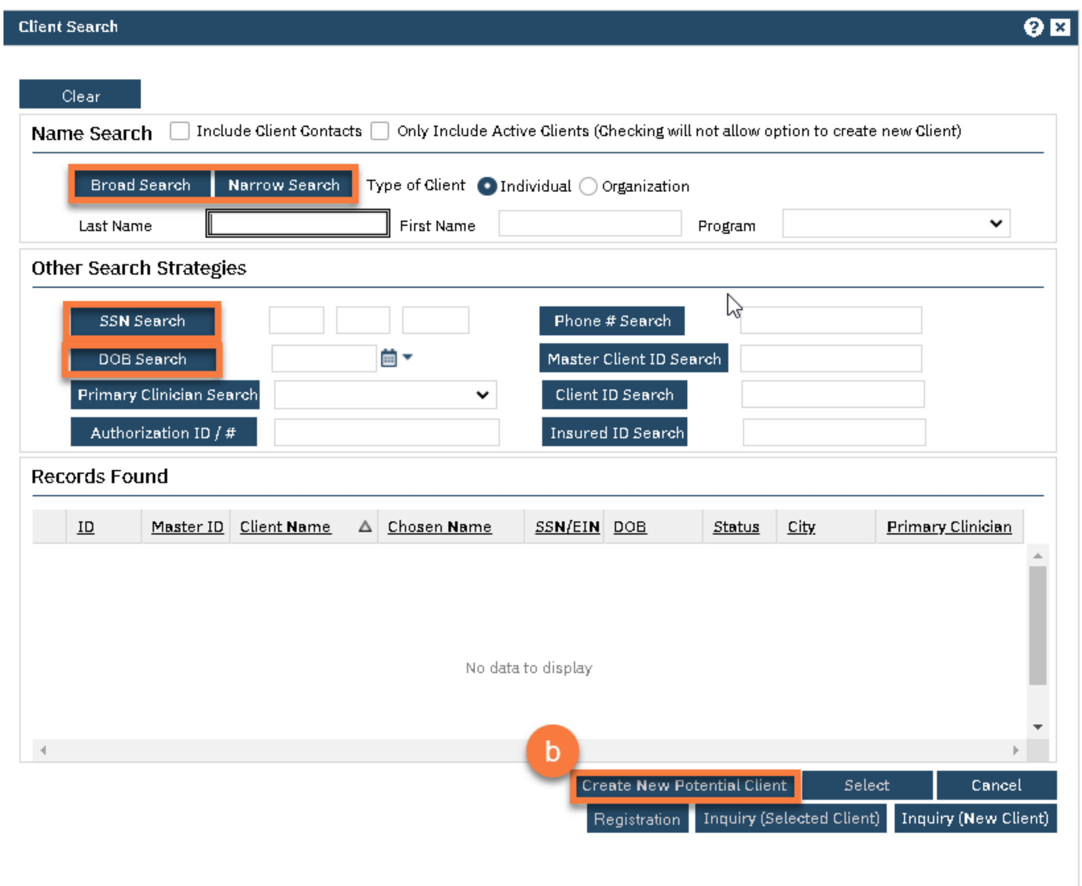
1. **Use the Client Search** screen to determine if the person is a client already in the system.



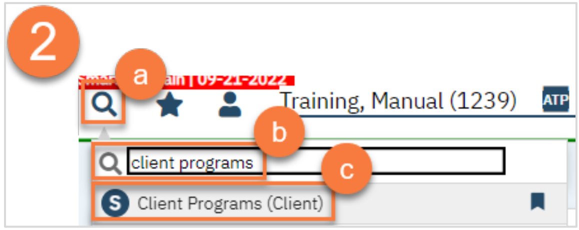
   a. If they are already a client in the system, select them to open their record.



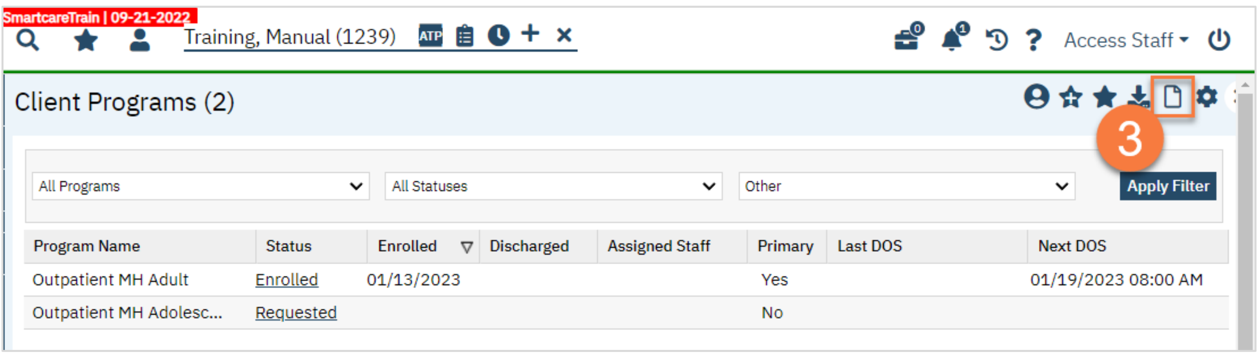
b. If they are not a client in the system, click “Create New Potential Client”. You’ll have to search individually by name, date of birth (DOB), and social security number (SSN) in order to create a new client.



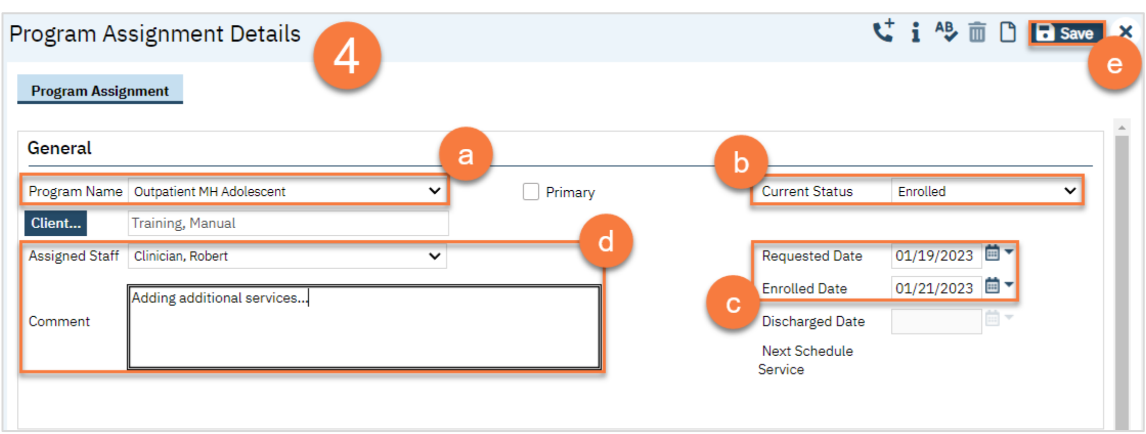
2. **Open the Client Programs list page**.
    a. Click the search icon.
    b. Type in “Client Programs”
    c. Select “Client Programs (Client)” from the search results.



3. Confirm the client needs an assessment. If you just created a new client, obviously they’ll need an assessment. However, if the person was already a client in the system, you’ll want to check to see if they already are connected to services. Look at the Client Programs to see if the client is already open to a program that can share an assessment with your program. If the client does need an assessment, enroll them in your program by **clicking the New icon.**



4. **Complete the Client Program Details screen**.
    a. **Select your program** from the dropdown menu.
    b. **Enter the status of the program as “enrolled”.**
    c. **Enter the enrollment date.** This will be today’s date. You may leave the requested date blank.
    d. **If known, enter the assigned staff.** You can also enter any comments related to this program enrollment.
    e. **Click Save.**



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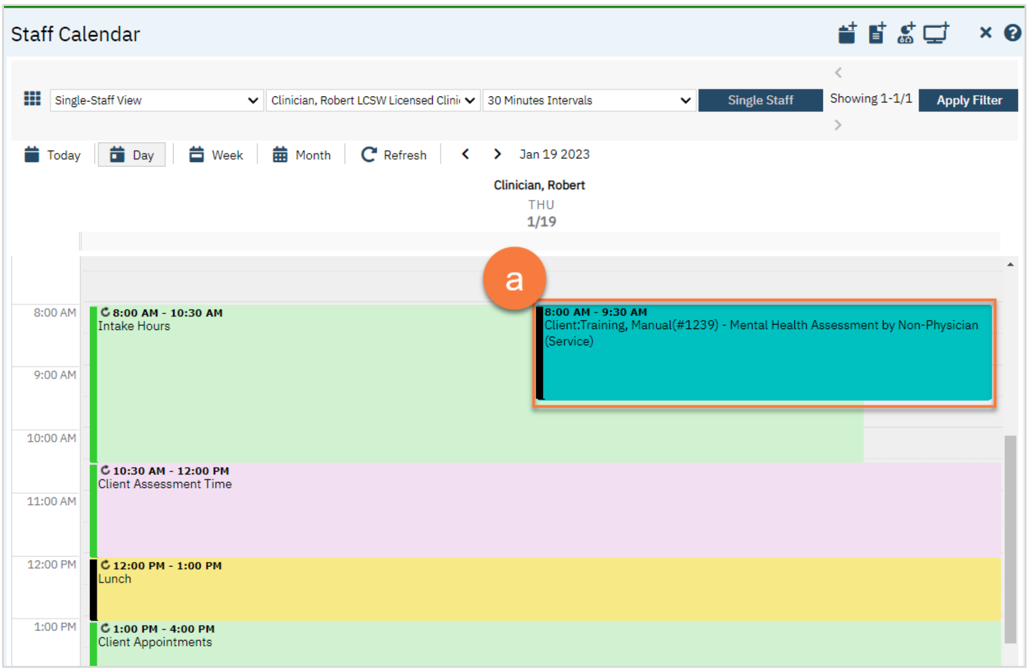
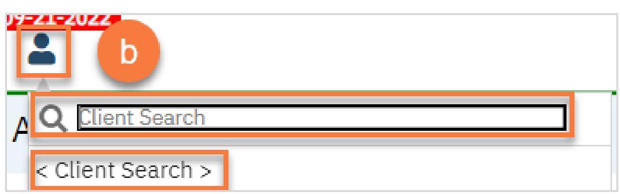
additional information on a specific form, see their respective section (e.g. Privacy and Consents; Clinical Documents; Intake and Other Forms; State Reporting).

Clinical: A client has arrived for their intake/assessment appointment at a program where we don't have a receptionist checking clients in. What do I do?

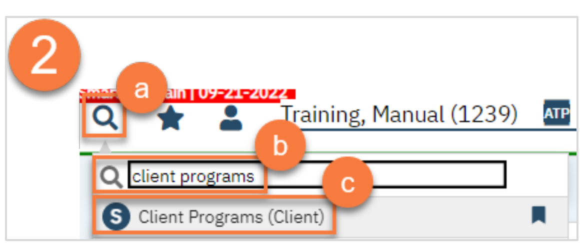
1. Open the client's record, if not already done so.
    a. You can do this from your Staff Calendar by selecting their appointment on your calendar.



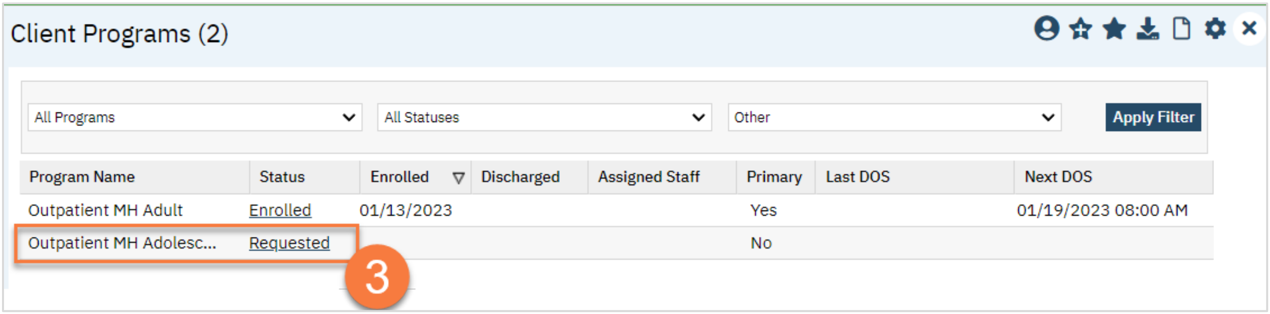
    b. You can also do this using the Client Search screen.



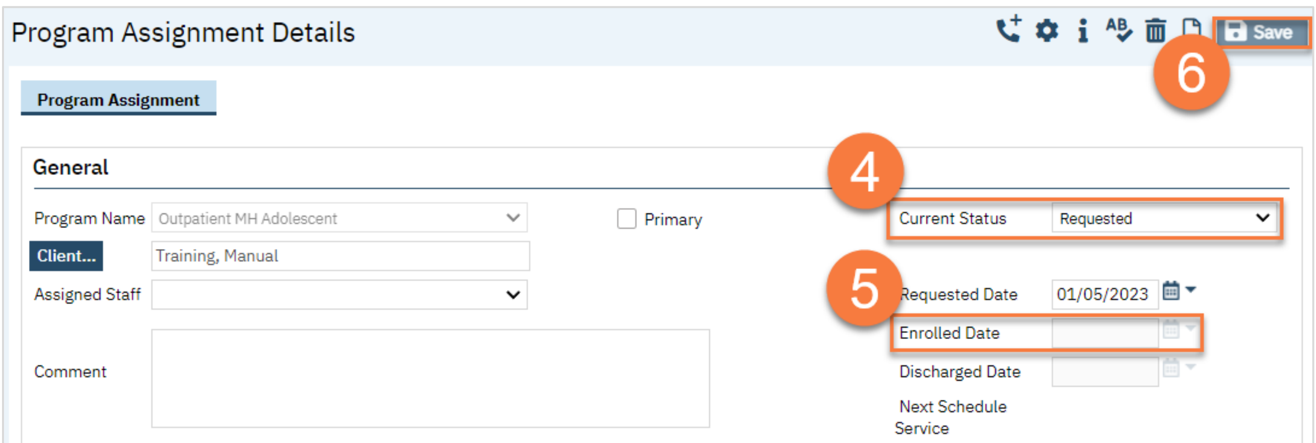
2. Open the Client Programs list page.
    a. Click the Search icon.
    b. Type "Client Program" in the search bar.
    c. Select "Client Programs (Client)" from the search results.



3. Find your program on the list and click on the link in the Status column, which should be listed as "Requested."



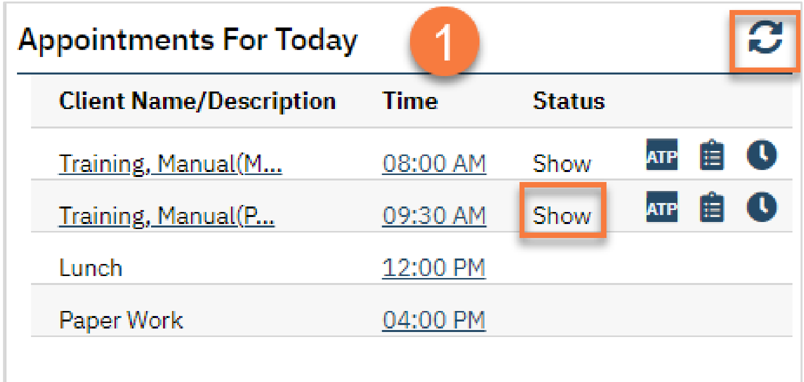
4. This takes you to the Client Program Details screen. **Change the Status to "Enrolled"**.
5. This unlocks the Enrollment Date field. **Enter today's date in the Enrollment Date field**.
6. **Click Save**.



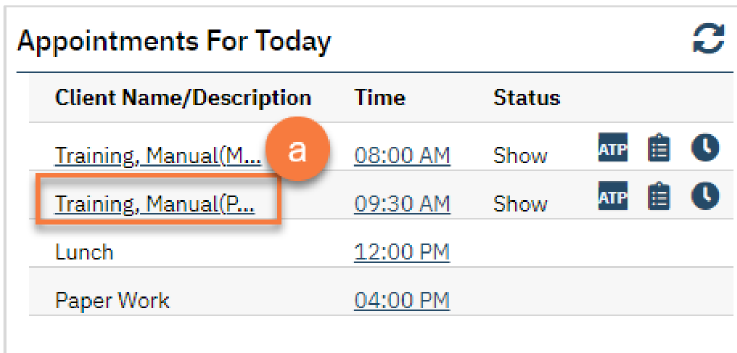
7. **Complete your required documents**. Depending on your program, this may include intake forms in addition to clinical assessment documents. Follow the steps in How do I complete Intake Documents?. If you have documents that were completed on paper that need to be scanned in to SmartCare, see How do I scan a document into the client's record? If you need additional information on a specific form, see their respective section (e.g. Privacy and Consents; Clinical Documents; Intake and Other Forms; State Reporting).

Clinical: A client has arrived for their intake/assessment appointment at a program where we have a receptionist checking clients in. What do I do?

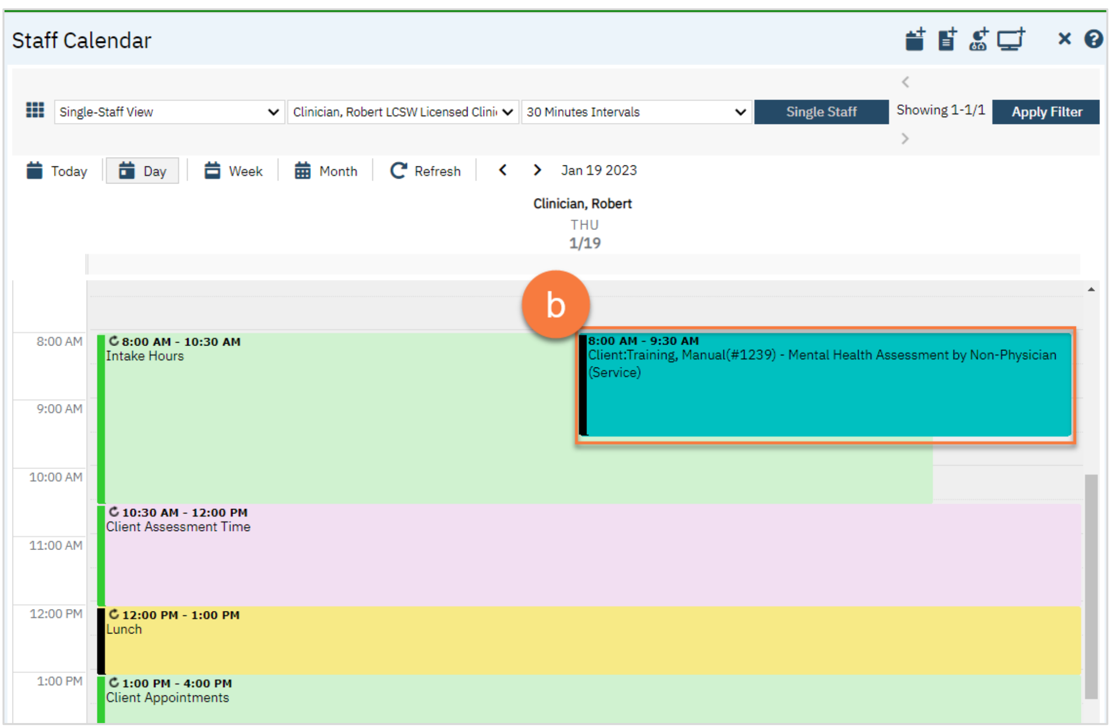
1. The receptionist will have already checked in the client, which includes enrolling them in your program. You should be able to see this on your Appointments for Today widget. Make sure to click the refresh icon throughout the day for updates.



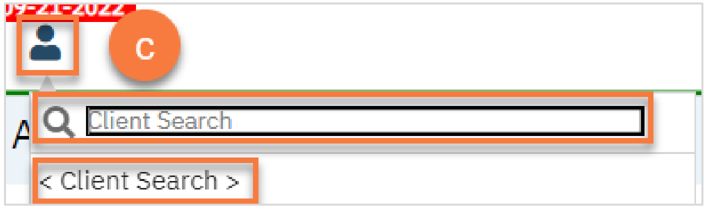
2. **Open the client's record**, if not already done so.
    a. You can do this from your Appointments for Today widget by clicking on the client's name.



    b. You can do this from your Staff Calendar by selecting their appointment on your calendar.



    c. You can also do this using the Client Search screen. This would be recommend for clients who have walked-in for an assessment.



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Clinical: A person has walked in for an assessment at a walk-in clinic, and we don't have a receptionist to check clients in. What do I do?

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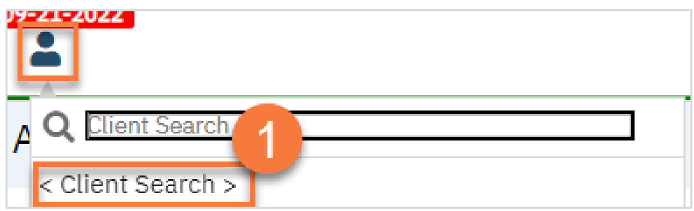
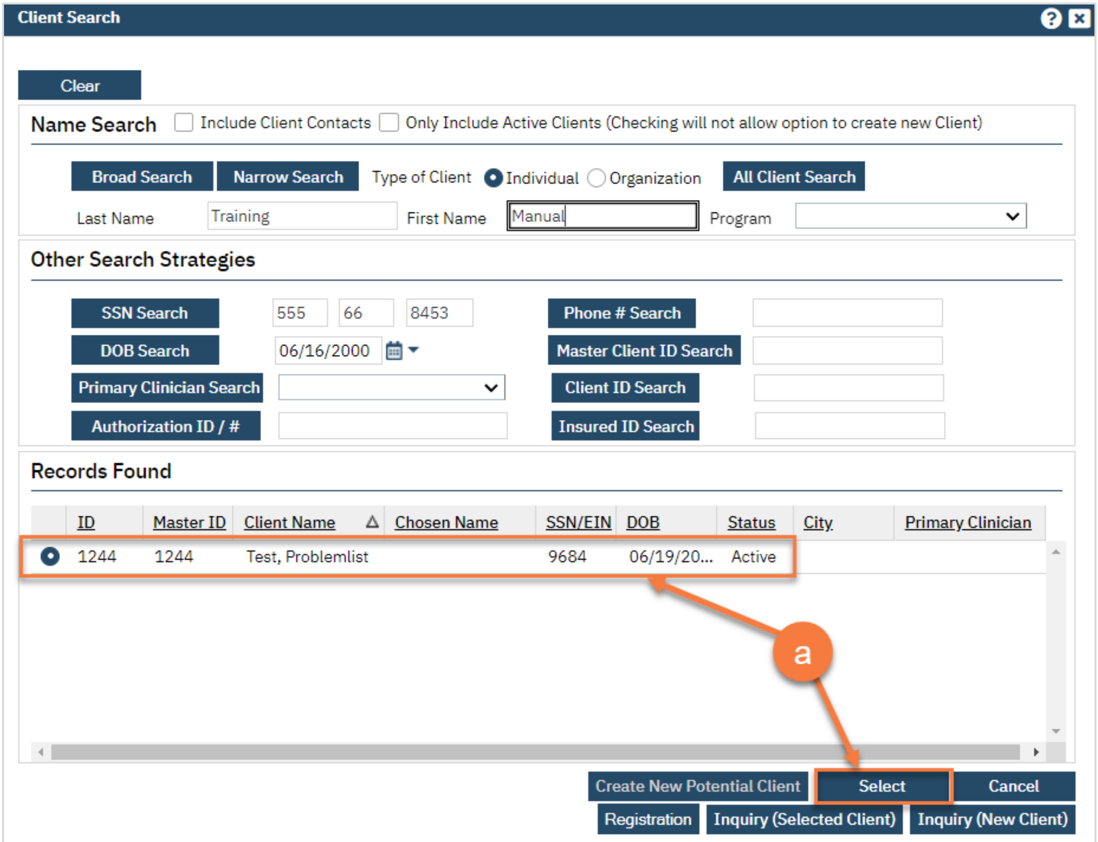
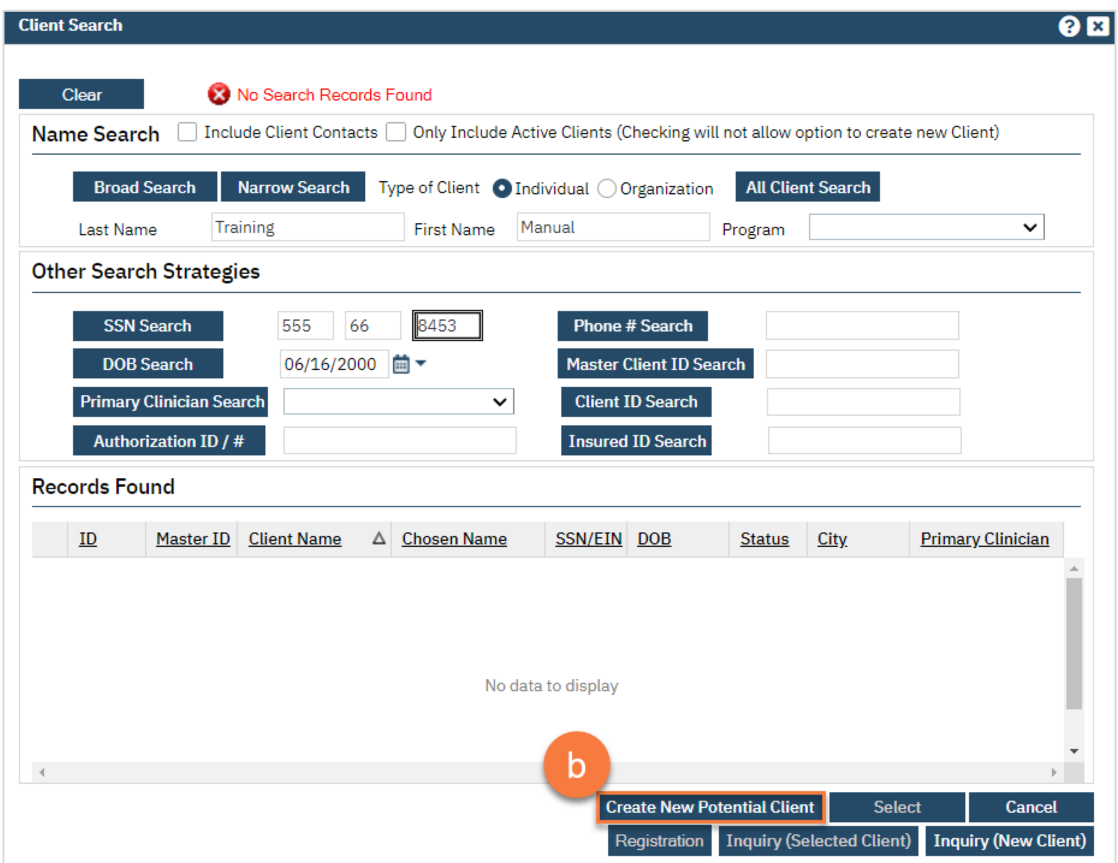


   c. If they are already a client in the system, select them to open their record.



d. If they are not a client in the system, click "Create New Potential Client". You'll have to search by name, date of birth (DOB), and social security number (SSN) in order to create a new client.



2. **Open the Client Programs list page.**
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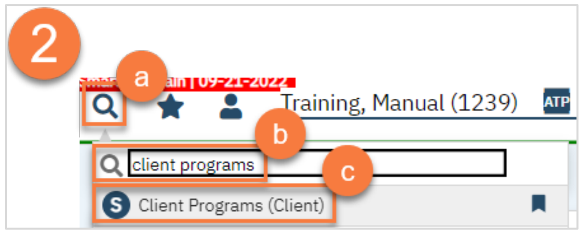

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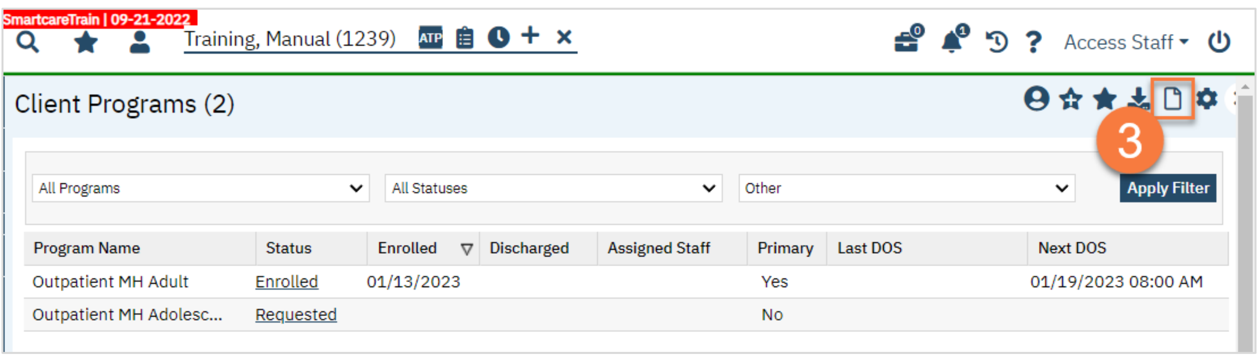
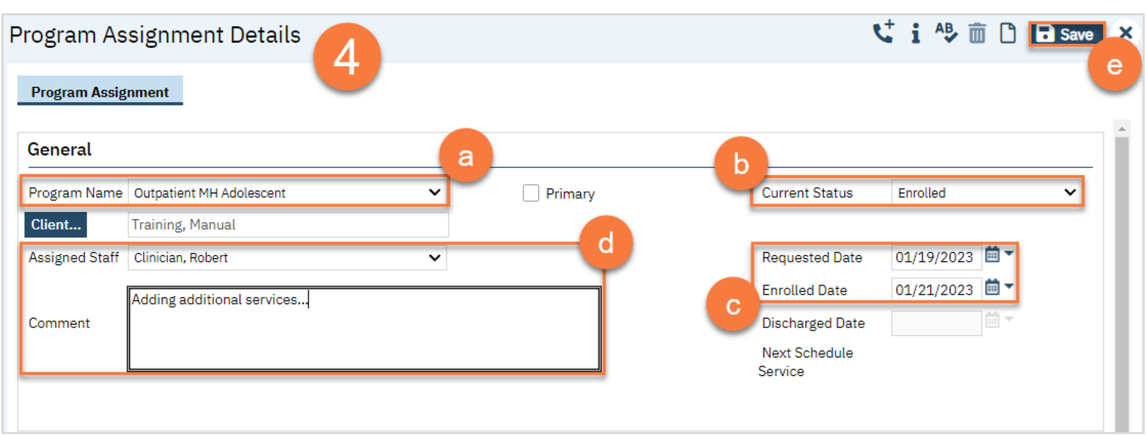


4. **Complete the Client Program Details screen.**
    a. **Select your program** from the dropdown menu.
    b. **Enter the status of the program as “enrolled”.**
    c. **Enter the enrollment date.** This will be today’s date. You may leave the requested date blank.
    d. **If known, enter the assigned staff.** You can also enter any comments related to this program enrollment.
    e. **Click Save.**

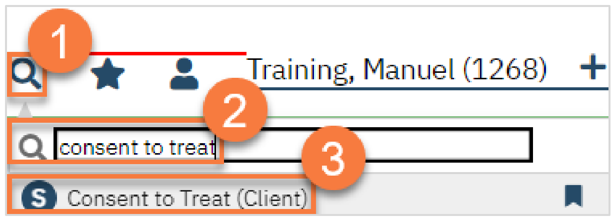


5. The next steps in the process are to complete the intake documentation packet, confirm the client’s information, and for the clinician to complete the clinical assessment. **Complete the documents you are responsible for.** Follow the steps in How do I complete Intake Documents?. If you have documents that were completed on paper that need to be scanned in to SmartCare, see How do I scan a document into the client’s record? If you need

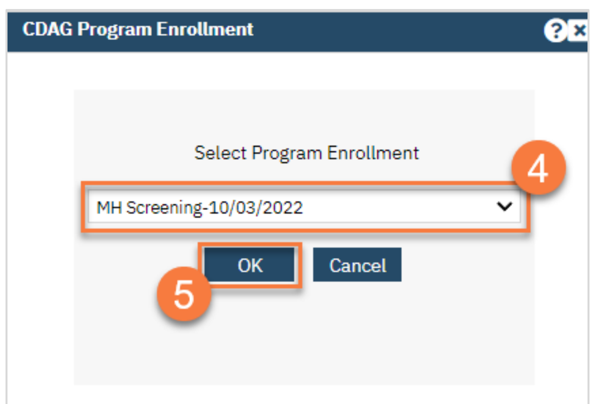
additional information on a specific form, see their respective section (e.g. Privacy and Consents; Clinical Documents; Intake and Other Forms; State Reporting).

How do I complete Intake Documents?

1. You must first have the client open, then **click the Search icon**.
2. **Type the document's name** into the search bar.
3. **Click to select the document** from the search results.



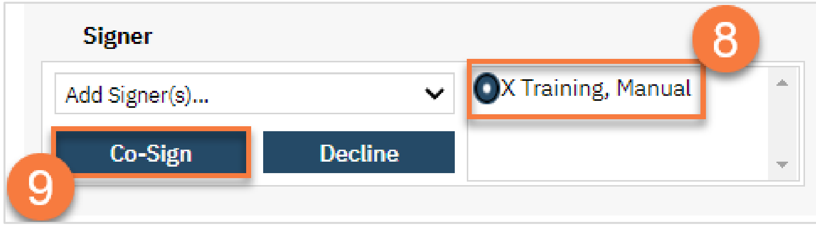
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



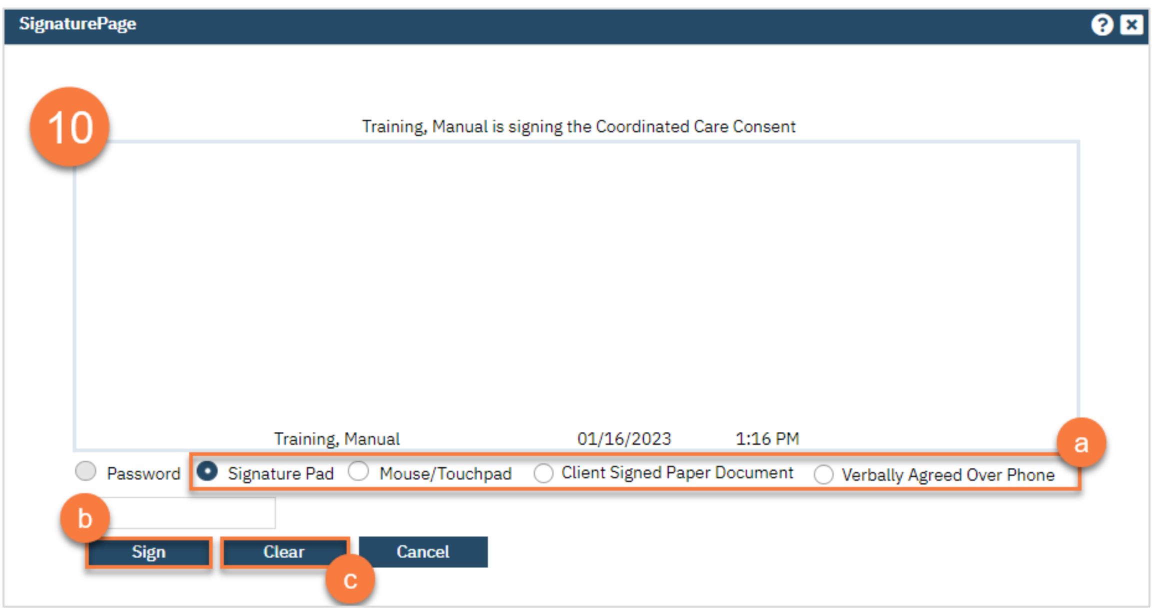
6. The document will open. **Complete the document** based on the client's responses. Once completed, **click Sign**.

7. This will create the PDF version of the form. **Click the Plus icon** in the upper right corner of the PDF viewer.

8. This opens the signature details. **Select the client and/or guardian from the Signer field**. You will need to select each cosigner one at a time, so repeat these steps as needed.
9. **Click Co-Sign**.



10. This brings up the Signature Page pop-up window. The co-signer can now sign using a signature pad, a mouse, or a touchpad to capture their signature. You can also designate that the client has signed on a paper version of the document or that they client verbally agreed and was unable to sign. If the client has signed a paper version of the form, that form should be scanned in. See How do I scan a document into the client's record?
    a. **Select the method of capturing the signature**.
    b. Once the co-signer is happy with their signature, **click the Sign button**. If the client has signed a paper version of the form or has agreed verbally and is unable to sign electronically at this point, these are other options.
    c. If the cosigner needs to start over, click the Clear button to erase the current signature.



Once signed by all required people, you are finished with this document and may move on to the next.

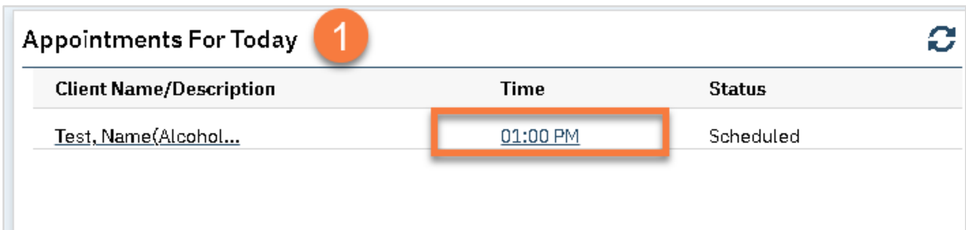
Life Cycle of the Client: Services

Now that the Intake process is complete, you can begin providing services. This is the bulk of the life cycle of the client. This section includes documenting the services you provide to the client, making ongoing clinical decisions about what services the client needs, and transitioning the client through programs as they take steps toward recovery.

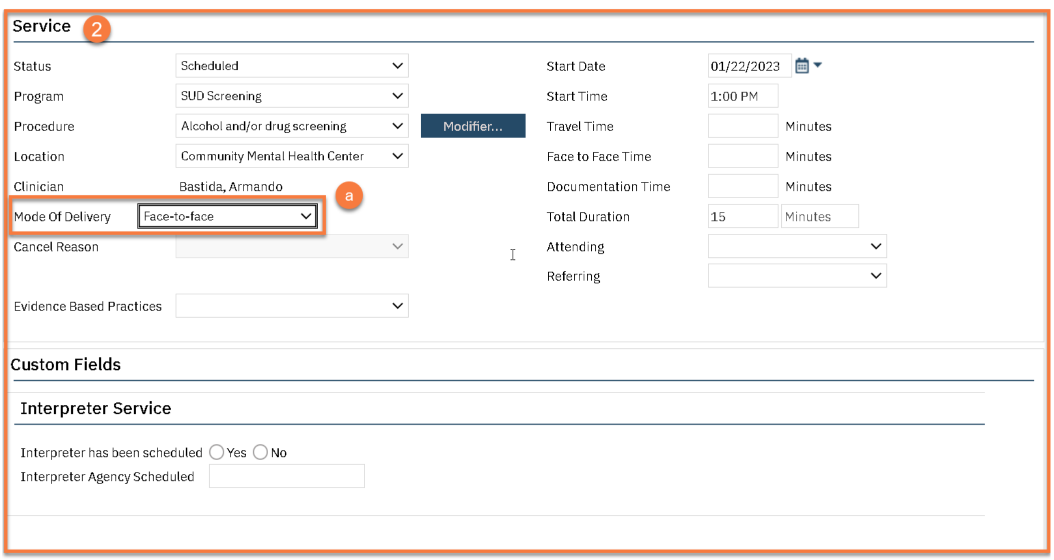
How do I write a progress note for a scheduled service?

Note: to document a progress note for a group, see How do I write a group progress note?

1. **On your Appointments for Today widget, click on the time link for the service you're documenting**.



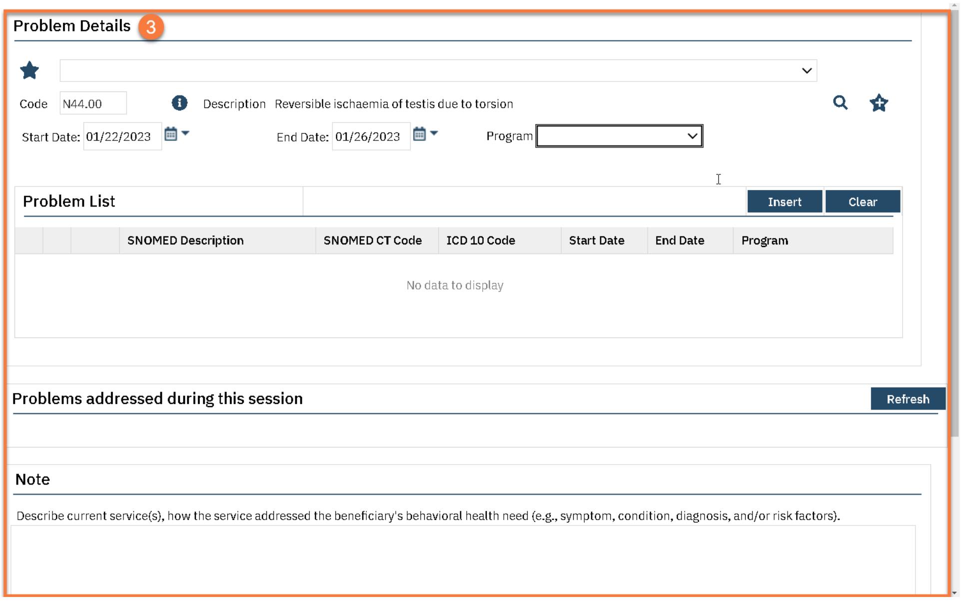
2. This opens the service note. **Complete the service details**.
   a. **Confirm/Enter Mode of Delivery**.
   b. **Enter Face to Face Time.** Under CalAIM Payment Reform, this is what is used for billing. **Enter Travel Time and Documentation Time** if applicable.
   c. **Enter Evidenced-Based Practices** if applicable.



   d. If this is a note for a crisis service, an Emergency Indicator field will appear. **Enter whether this was an emergency or not.**

Screenshot with crisis intervention selected

3. **If the status is show, you may now click on the Note tab. Complete the progress note tab**. This note type may look different depending on the procedure code you have chosen. Most will include 3 fields: the Problem List section, the Note section, and the Care Plan section.
   a. If you want to add problems to the problem list, you can do so here. Follow the instructions in How do I add a problem to the Problem List?.



b. **Select with problems you addressed** in today's session.

screenshot

c. **Enter your note** in the Note section. This should include all your usual clinical information, such as your interventions and the client's response to the interventions.

screenshot

d. **Enter your plan of care** in the Care Plan section. For services that require a treatment plan, this is where the treatment plan is entered. This information will pull forward from the most recent service note in the same program. There may be text templates available for specific treatment plan requirements.

screenshot

4. The Billing Diagnosis tab will show you which diagnoses will be pulled onto the billing. You should generally ignore this tab for ongoing services. However, if you need to change the billing order, for example you want this note to focus on the secondary diagnosis, you can re-order the diagnoses to match your service without changing the overarching diagnosis form.

[screenshot]

5. When you are complete, **click Sign**.

[screenshot]

How do I write a progress note for an unscheduled service?

1. **Click the search icon**.
2. **Type in "New Service Note" in the search bar**.
3. **Click on "New Service Note"** in the search results.

[screenshot]

4. This opens the service note. **Complete the service details**.
    a. **Select your program from the dropdown menu**. This will determine which procedure codes you can select.
    b. **Select the procedure code** from the dropdown menu.

c. **Select the location and mode of service**.
d. **Enter the date of the service**.
e. **Enter the time(s) of the service**. Face to face time is required, as this is used for billing. We recommend completing the travel and documentation as well, though these are not required for billing.

[screenshot]

5. **Click on the Note tab**. Complete the progress note section. This note type may look different depending on the procedure code you have chosen. Most will include 3 fields: the Note field, where you will enter the main part of your note, the Care Plan field, which will pull from the most recent note in you program and where you will make updates to any plan of care, and the Problem List section, where you can add problems directly from the note.
6. The Billing Diagnosis tab will show you which diagnoses will be pulled onto the billing. You should generally ignore this tab for ongoing services. However, if you need to change the billing order, for example you want this note to focus on the secondary diagnosis, you can re-order the diagnoses to match your service without changing the overarching diagnosis form.
7. When you are complete, click Sign.

I need to amend a note. What do I do?

1. **Find and open the note you need to amend**.
   a. Make sure you have the client open. **Click on the search icon and type "documents" in the search bar**. **Click on "Documents (Client)"** from the search results to open a list of documents that have been completed for the client.

   [screenshot]

   b. **Use the list page filters** to find the note you're looking for.
   c. **Click on the note you want to amend**. This should open the pdf.

   [screenshot]

2. **Click the Edit icon** in the upper right corner of the PDF viewer.

[screenshot]

3. A pop-up will appear, letting you know that this will create a new version of this document. **Click OK**.

[screenshot]

4. The service note screen will now appear. Some pieces you may not be able to edit due to billing having already been completed for this service. However, you should be able to **navigate to the Note tab**. From here, feel free to **edit the note as necessary**. The older version will still remain in the system for audit purposes, meaning anything you write or delete here will not affect the original version.
5. Once you're finished, **click Sign**.

[screenshot]

6. The new, corrected version will show in the PDF viewer. If needed, you can look at the previous version of this document by clicking on the version link in the upper left corner of the PDF viewer. When people open this document, the most recent (corrected) version will be what they are shown.

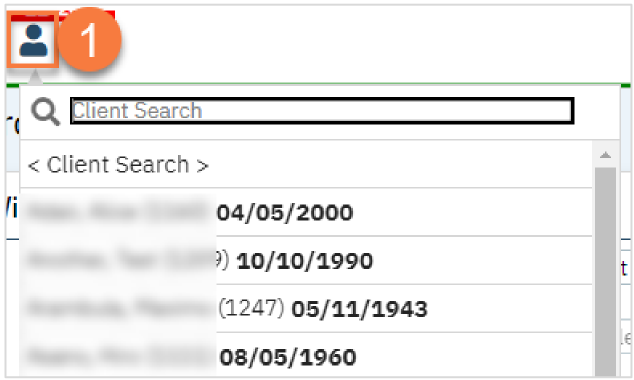
[screenshot]

How do I refer to an additional program?

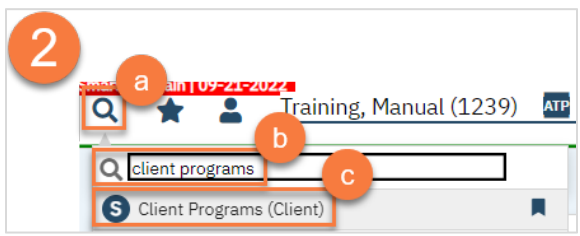
Under Construction

How do I add the client to my program?

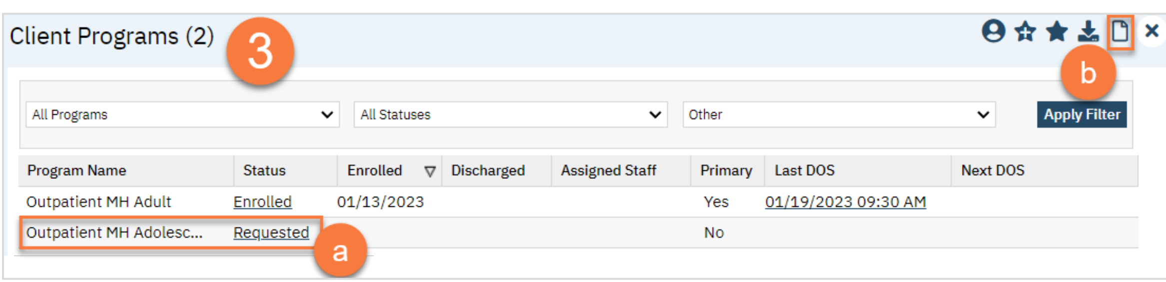
1. **Open the client's record**, if not already done so. You can do this using the Client Search screen.



2. **Open the Client Programs list page**.
    a. **Click the Search icon**.
    b. **Type "Client Program"** in the search bar.
    c. **Select "Client Programs (Client)"** from the search results.

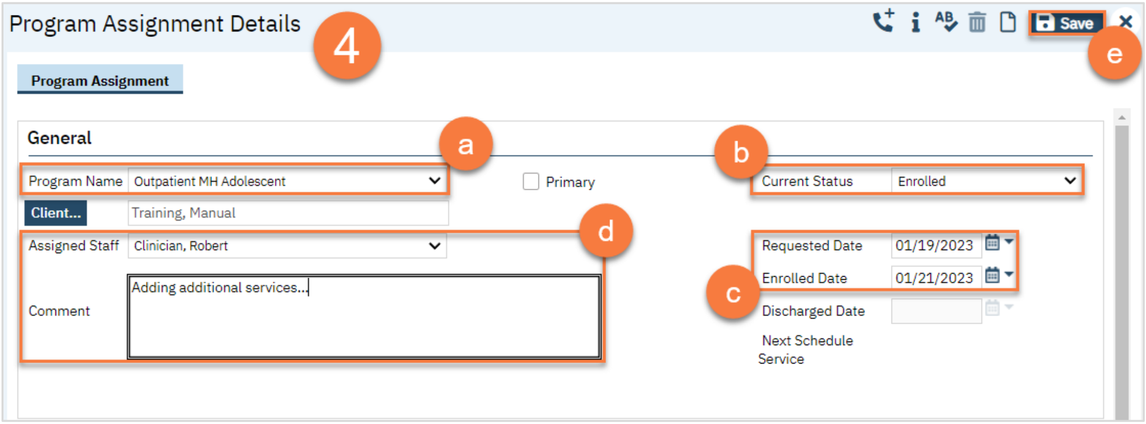


3. This opens the Client Programs list page.
    a. If your program is on the list, **click on the link in the Status column**. The status is likely Requested, if the referral process has been started. If the status is Discharged, do not edit this enrollment and instead add your program as if it's a new program by clicking on the New icon.
    b. If your program is not on the list, **click on the New icon**.



4. Complete the Client Program Details screen.
    a. If not already done so, **select your program** from the dropdown menu.
    b. **Enter the status of the program as "enrolled"**.
    c. **Enter the enrollment date.** This will be today's date. You may leave the requested date blank, if it is not already entered.
    d. **If known, enter the assigned staff.** You can also enter any comments related to this program enrollment.

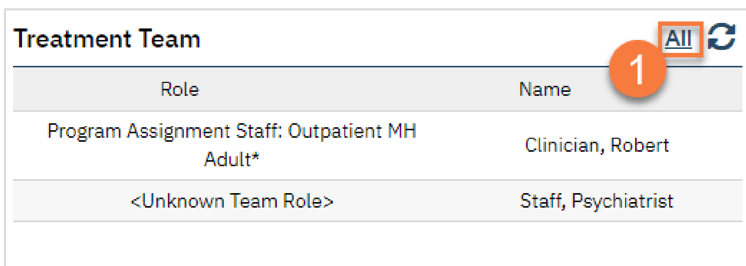
e. Click Save.



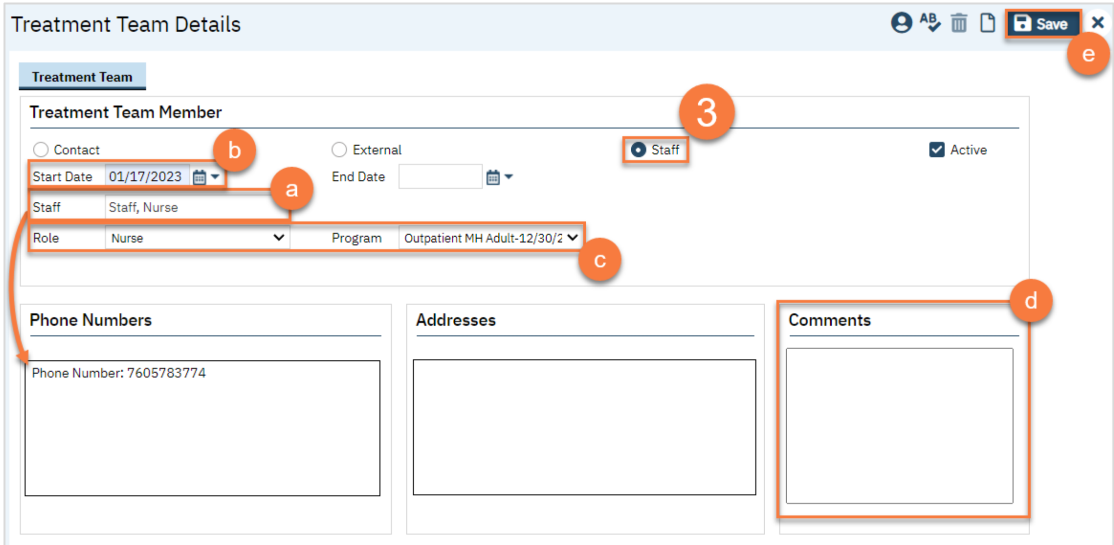
5. The next steps in the process are to **complete any documents needed** to enroll in your program. Follow the steps in How do I complete Intake Documents?. If you have documents that were completed on paper that need to be scanned in to SmartCare, see How do I scan a document into the client's record? If you need additional information on a specific form, see their respective section (e.g. Privacy and Consents; Clinical Documents; Intake and Other Forms; State Reporting).

How do I view who's on the client's treatment team?

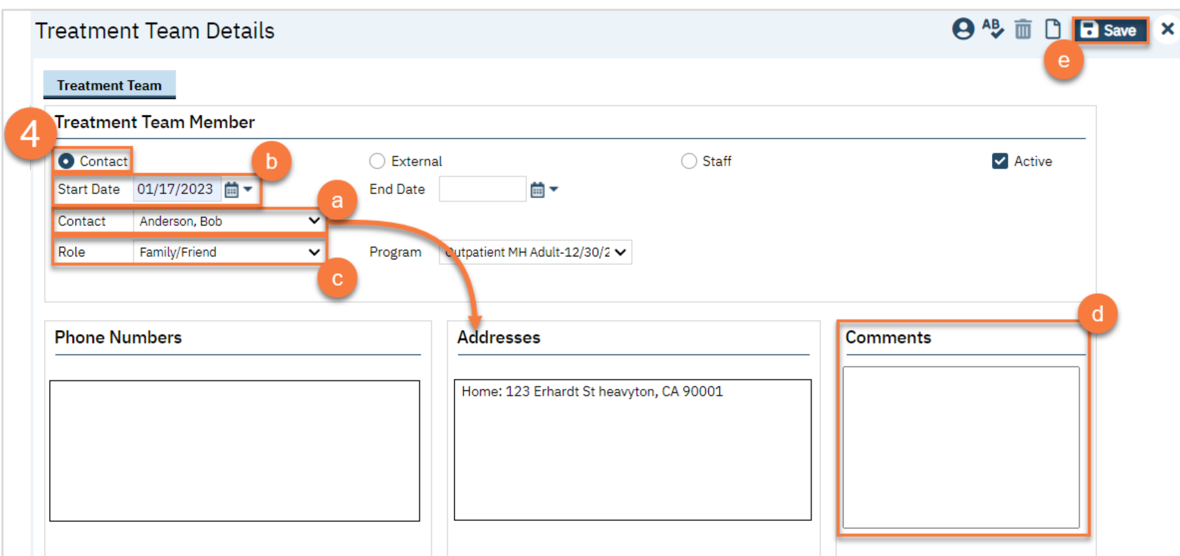
1. Make sure you have the client open. In the Treatment Team widget, click on the All link.



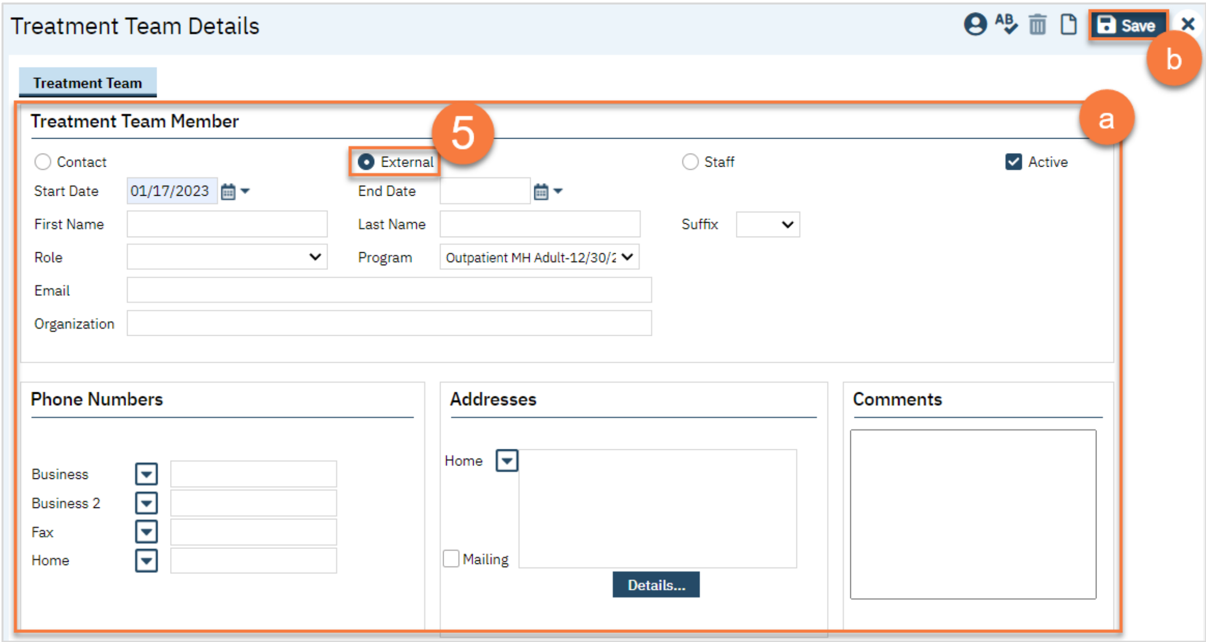
2. This takes you to the Treatment Team list page. To add a treatment team member, **click the New icon**. This takes you to the Treatment Team Details screen. Select what type of contact person this is.
3. **If the person you're adding is a SmartCare user, select Staff**.
    a. Enter the staff's name and select them from the search results. This will pull forward any information, such as phone number or address, that's tied to the staff in their staff set-up.
    b. Enter the start date, which is when this person became a member of the treatment team.
    c. Enter their role as well as what program they work in.
    d. Add any comments.
    e. Click Save.



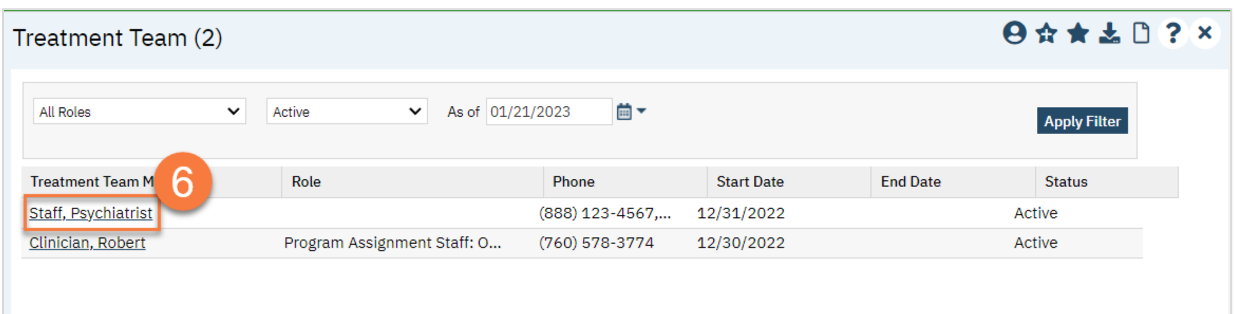
4. **If the person you're adding is a contact person that's already in the Client Information screen, select Contact**.
    a. Select the contact person from the dropdown list. This will pull forward any information, such as phone number or address that has been entered for them in the Client Information screen.
    b. Enter the start date, which is when this person became a member of the treatment team.
    c. Enter their role.
    d. Add any comments.
    e. Click Save.



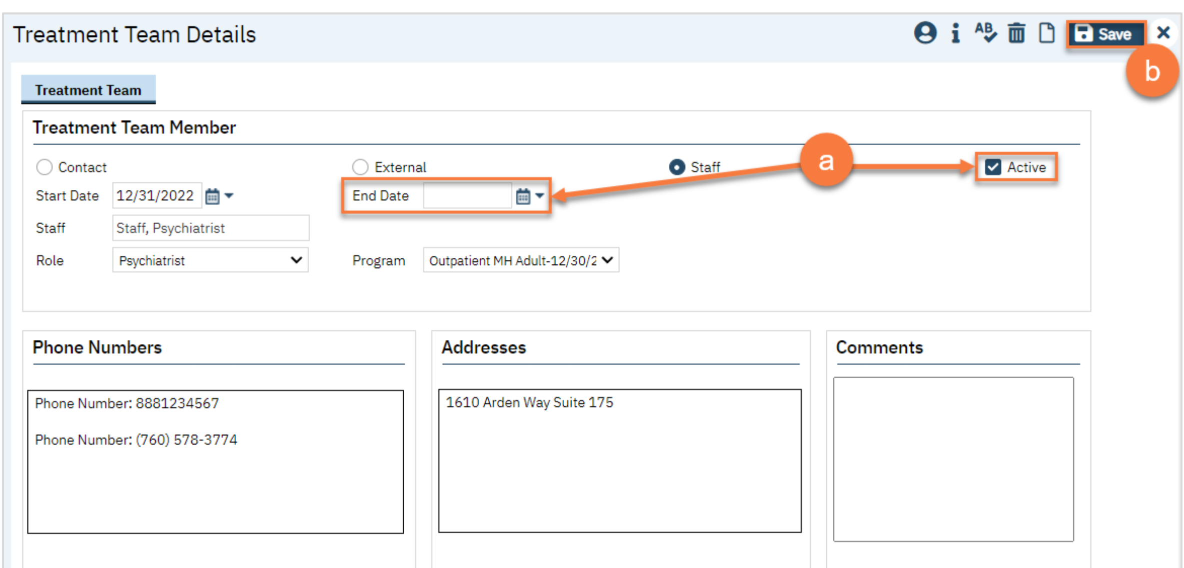
5. **If the person you're adding is an external resource, that has not yet been added to the Client Information screen, select External**.
    a. Enter the information, including name, role, start date, organization, and contact information.
    b. Click Save.



6. **To edit or remove a treatment team member, click on their name from the Treatment Team list page**. This takes you to the Treatment Team Details page.



a. To remove a treatment team member, make sure to add an end date and de-select the "Active" checkbox.
b. Once you've finished making your changes, click Save.



How do I request authorization for services?

Under Construction

Life Cycle of the Client: Discharge

As the client progresses through treatment, their services will begin to diminish. In this section, we will cover how discharge a client from a program, as well as how to transfer a client from one program to another.

How do I close a client to a program?

1. Make sure you have the client open. Then **click the Search icon**.
2. **Type in "Client Programs" in the search bar**.
3. **Click on "Client Programs (Client)"** in the search results.

screenshot

4. This brings you to the Client Programs list page. **Select the program** you want to close to by clicking on the link in the Status column.

screenshot

5. This brings you to the Program Details screen.
    a. **Change the status to "Discharged".** This unlocks the Discharge Date field.
    b. **Enter the Discharge Date**.
    c. **Click Save**. You're now finished.

screenshot

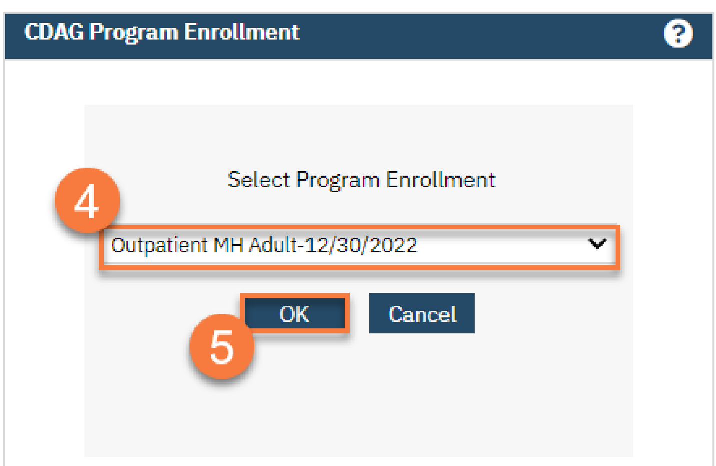
How do I get a summary of care?

A Summary of Care is a document that pulls information from different places in the client's chart.

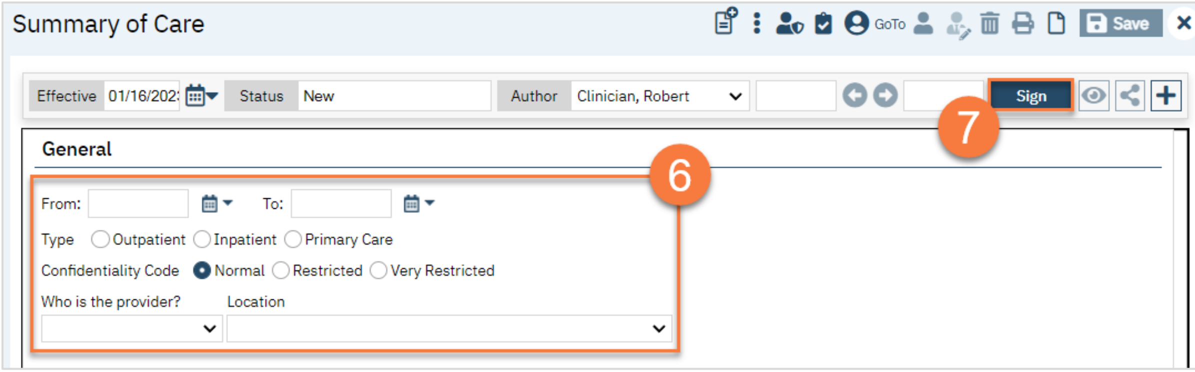
1. Make sure you have the client open. **Click the Search icon**.
2. **Type in "Summary of Care" in the search bar**.
3. **Click on "Summary of Care (Client)"** in the search results.

screenshot

4. **Select your program** from the dropdown menu.
5. **Click OK**.



6. This opens the Summary of Care document. **Enter the parameters for your summary of care**.
7. **Click Sign**. This produces a PDF, which includes information from the client's chart.



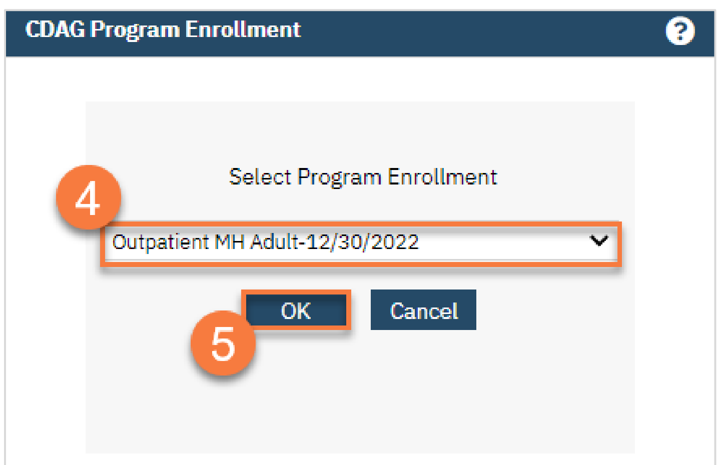
How do I get a discharge summary?

A Discharge Summary is a document that pulls information from different places in the client's chart.

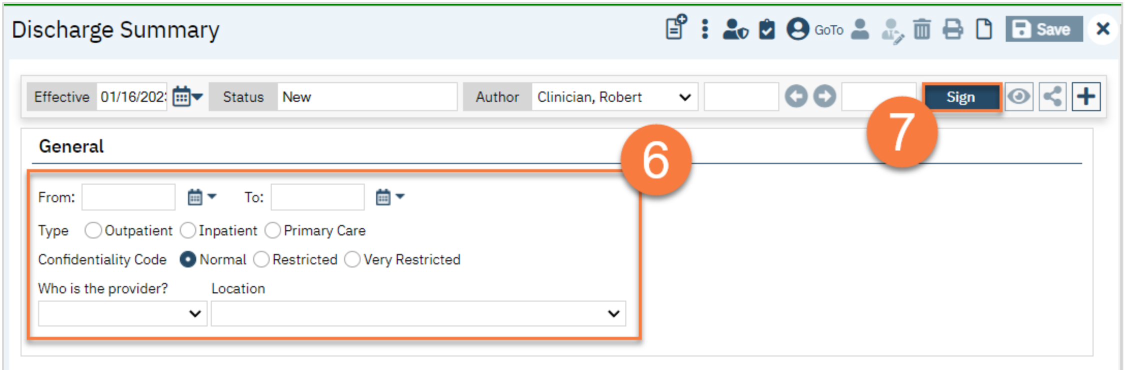
1. Make sure you have the client open. **Click the Search icon**.
2. **Type in "Discharge Summary" in the search bar**.
3. **Click on "Discharge Summary (Client)"** in the search results.

screenshot

4. **Select your program** from the dropdown menu.
5. **Click OK**.



6. This opens the Summary of Care document. **Enter the parameters for your summary of care**.
7. **Click Sign**. This produces a PDF, which includes information from the client's chart.



Discharge Summary
GoTo
Save
Effective 01/16/202
Status New
Author Clinician, Robert
Sign
7
General
6
From:
To:
Type Outpatient Inpatient Primary Care
Confidentiality Code Normal Restricted Very Restricted
Who is the provider?
Location

Privacy and Consents

Information in SmartCare is generally considered confidential. There are multiple laws and regulations that programs must follow, depending on their specific treatment services. However, the client can provide consent to share information. This section reviews these topics, as well as the documents utilized to record a client's consent.

Clinical Access Data Group (CDAG)

SmartCare includes both mental health and substance use disorder treatment records. In order to abide by Title 42 of the Code of Federal Regulations, part 2 (42 CFR), SmartCare uses Clinical Access Data Groups, or CDAG, to limit what users can see. Your CDAG will be determined by the programs you work in and are set up by your system administrator.

Most of the time you are creating a document in the system, you'll have to select which program that document is associated with. This allows the system to limit viewability of client documents based on a user's CDAG.

You'll still be able to search for any client, as some may not be open to any programs yet, and some might be open to programs that you don't have access to. This minimizes the option of creating duplicate clients in SmartCare. However, once in a client's chart, you'll only be able to see information related to programs that are included in your CDAG.

How do I know what CDAG I have?

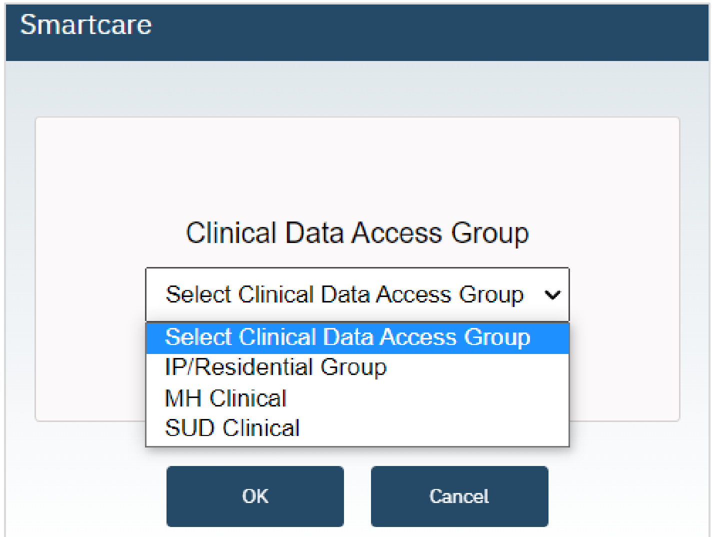
Your System Administrator will set up your CDAG and which programs you are able to see. CalMHSA recommends three basic CDAG options:

1. Mental Health CDAG – Includes all Mental Health programs; would be assigned to mental health staff.
2. Substance Use Disorder CDAG – Includes all Substance Use treatment programs; would be assigned to substance use treatment staff.
3. Administration CDAG – Includes all programs in SmartCare; would be assigned to any staff that provide administrative support, such as billing, medical records, quality improvement, and management.

Your county may employ additional groupings, based on how your county is set up. They may also limit which programs you are able to see, even if they're within the same CDAG.

What happens if I work in both SUD and MH programs?

If you work in multiple programs, your system administrator will assign you multiple CDAGs. In this case, when you log in you'll select which CDAG you're logging in under. This will ensure that you're only able to see client information based on the role you're currently serving. This would also be the case if you work at two different agencies that have access to SmartCare.



What if the client wants me to be able to talk to other programs/people/agencies?

Best practices mean coordinating care with all of a client's providers, as well as other agencies and persons the client is working with. However, due to privacy rules, there are some limitations on what a provider can share with these entities. This is all based on the client's preferences. The client can consent to you sharing treatment information. This is generally known as a Release of Information or an Authorization to Disclose Protected Health Information. Historically, each entity you want to exchange information with requires a separate Release of Information/Authorization to Disclose Information. This is still the case when you're exchanging information with an agency or person that doesn't have access to your county's instance of SmartCare. However, CalMHSA has created a disclosure authorization that encompasses all persons and agencies who have access to your county's instance of SmartCare. If signed, this allows county programs to better coordinate care for the client.

Note that this Coordinated Care Consent only authorizes the exchange of information within your county's instance of SmartCare. Other counties using SmartCare are not included in this authorization, nor are agencies who also use their own instance of SmartCare. This consent also does not authorize the exchange of information with all providers or agencies the client is working with. Standard Releases of Information/Authorizations to Disclose Information are needed in these cases.

Redisclosure: Just because you have access to 42 CFR information because the client signed the Coordinated Care Consent does NOT give you permission to redisclose information from SUD programs.

What happens when a client signs the Coordinated Care Consent?

By default, SmartCare enforces privacy regulations, including HIPAA and 42 CFR. This means that people working in mental health programs are not able to see any of the client's treatment information for substance use programs and vice versa. This limitation is enforced by each user's CDAG. In essence, there is a wall between CDAGs.

When a client signs the Coordinated Care Consent, this wall is removed. Users will be able to see *all* the client's treatment information, regardless of their CDAG. This includes historical information and future appointments. You'll still be required to select your program when creating a new document. This is to ensure that all documents are appropriately sorted in case the client revokes their consent, as is their right.

What happens when a client revokes their Coordinated Care Consent?

When a client has signed a Coordinated Care Consent, all SmartCare users can see all of the client's information. Basically, the CDAG rules drop, allowing users to view information regardless of their CDAG. When a client revokes their Coordinated Care Consent, the system will re-impose all CDAG rules. This means that information you previously were able to view will no longer be visible to you. You won't see any redaction marks; you simply won't be able to find any indication that the information was ever in the system.

Will I be alerted if a client revokes a consent?

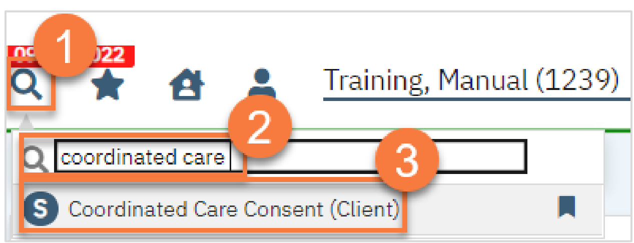
You will not be alerted if a client revokes a Coordinated Care Consent, as that would defeat the purpose of keeping information separate. However, you will no longer be able to see information outside of your CDAG.

If the client revokes a standard Release of Information/Authorization to Disclose Confidential Information (ROI/ADCI), you can create a flag to notify other treatment team members that the client no longer allows sharing with that entity. They will only be able to see information in their CDAG, which may not include your flag or the ROI/ADCI.

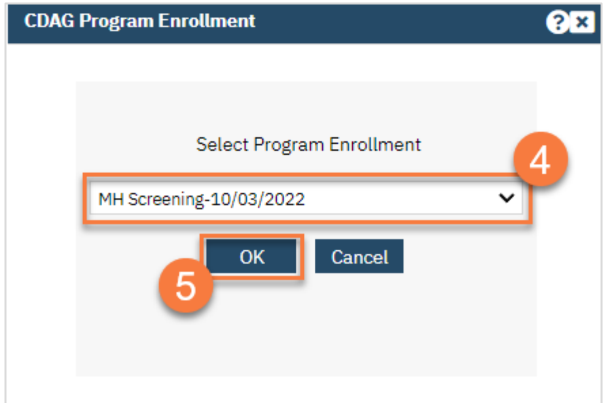
Coordinated Care Consent & Authorizations to Disclose Information

How do I complete a Coordinated Care Consent?

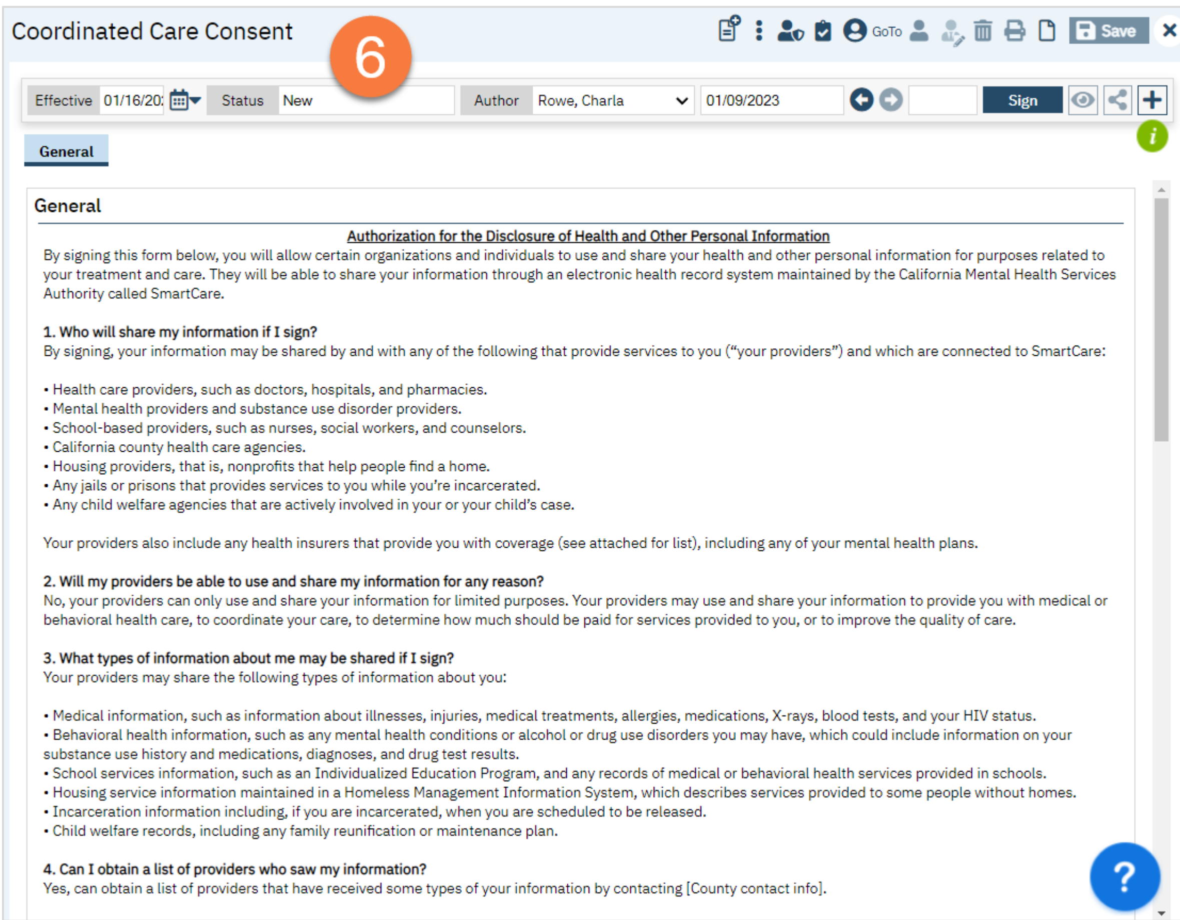
1. You must first have the client open, click the Search icon.
2. Type Coordinated Care Consent into the search bar.
3. Click to select Coordinated Care Consent (Client).



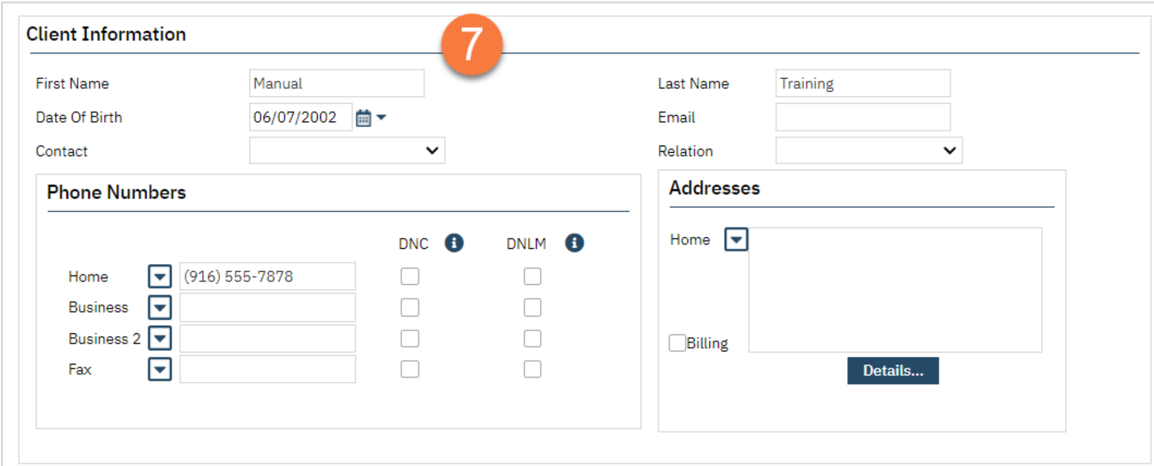
4. In the CDAG Program Enrollment window pop-up, click the drop down and click to select the appropriate program.
5. Click OK to continue.



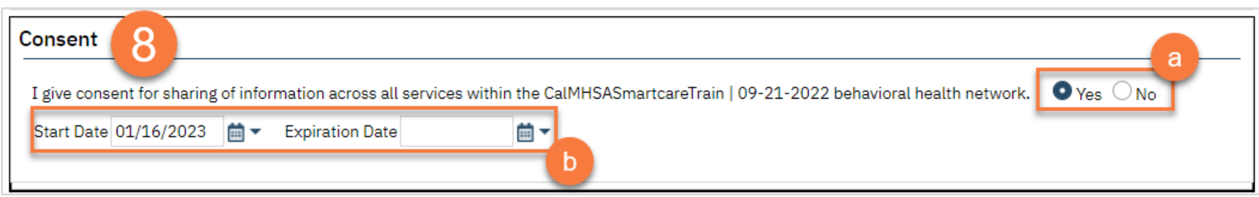
6. Most of the consent is wording. **Review this with the client**.



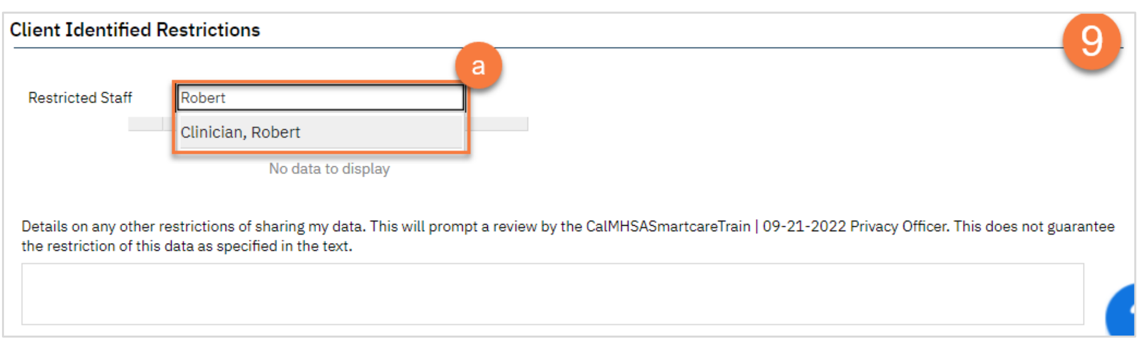
7. The Client Information section will pull information from the Client Information screen. You do not need to add any information here. If you need to update the information, we recommend doing that in the Client Information Screen.



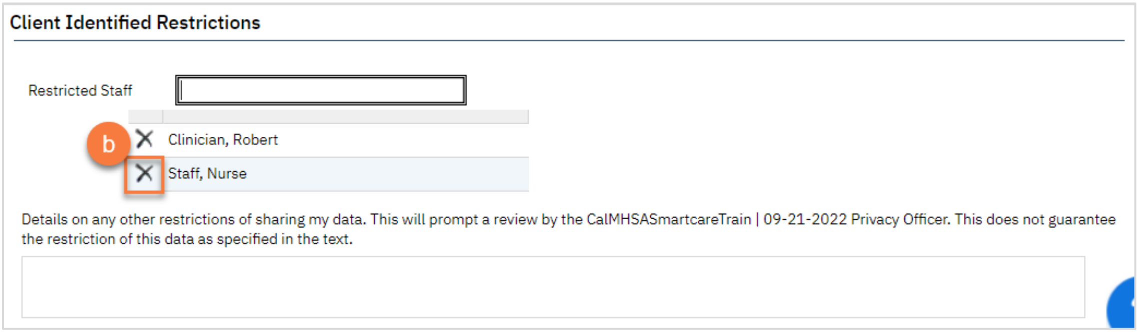
8. In the Consent section, the client should indicate whether they want to consent to sharing information within SmartCare or not.
    a. Selecting "Yes" will allow the sharing of information across SmartCare. Selecting "No" will keep the information users see limited to their CDAG.
    b. The Start Date will automatically populate to today's date. We recommend leaving the Expiration Date blank, unless the client explicitly indicates that they would like this consent to last for a short time.



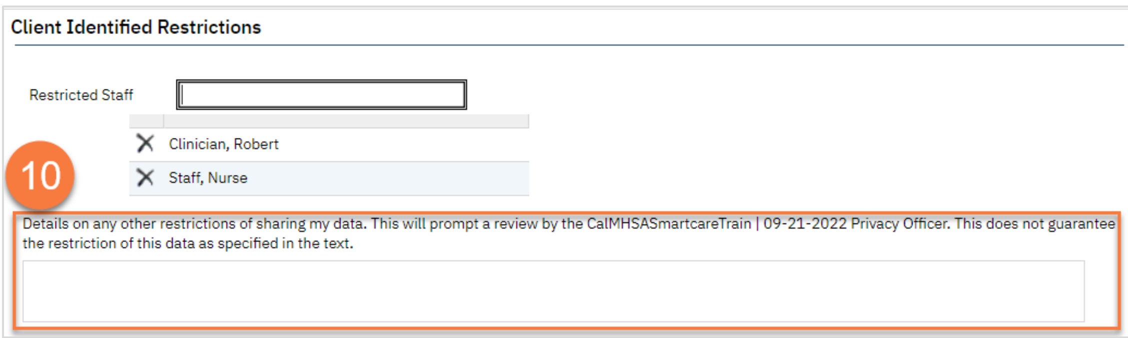
9. If the client wants to keep their chart private from specific individuals, you can add them in Restricted Staff. You can enter more than one staff as needed.
    a. Type the staff's name in the Restricted Staff box. This will search for users. Select the appropriate staff from the search results.



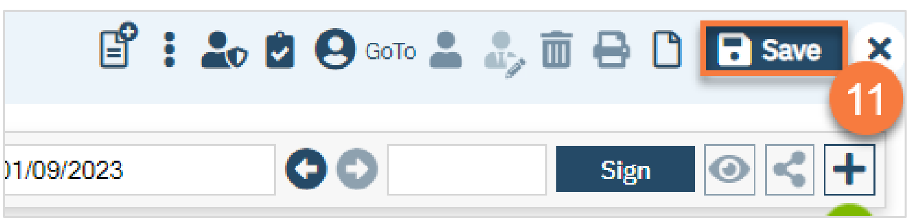
    b. This will add the user to the form. If you selected the incorrect user, you can click on the Delete icon to remove them from the form.



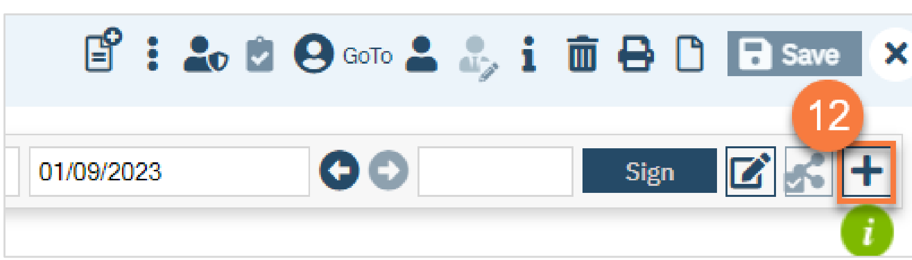
10. There is also a text box if the client wants additional restrictions. This will send a notification to the Privacy Officer, as denoted in SmartCare, to contact the client to discuss the limitations the client is requesting.



11. **Click Sign**.

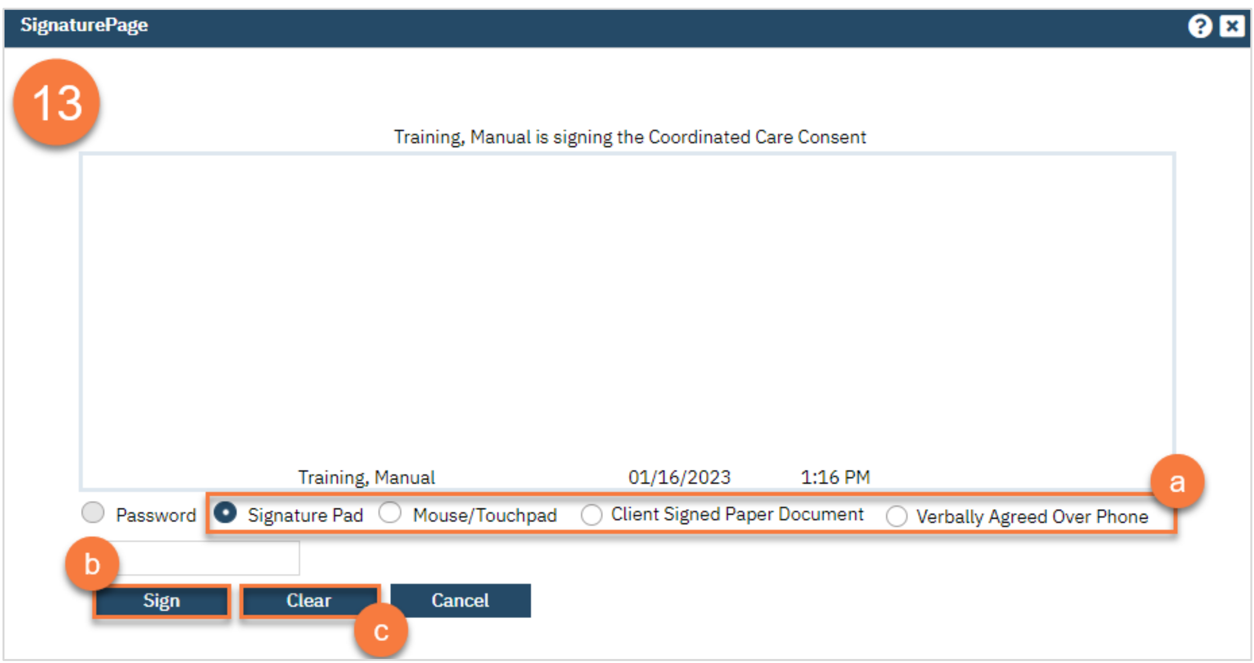


12. This will create the PDF version of the form. **Click the Plus icon** in the upper right corner of the PDF viewer.



13. This opens the signature details. **Select the client and/or guardian from the Signer field**. You will need to select each cosigner one at a time, so repeat these steps as needed.
14. **Click Co-Sign**.

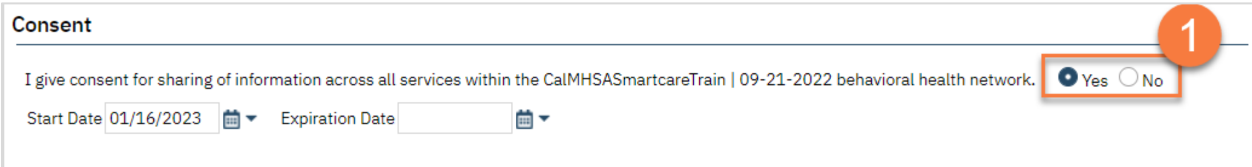
15. This brings up the Signature Page pop-up window. The co-signer can now sign using a signature pad, a mouse, or a touchpad to capture their signature. You can also designate that the client has signed on a paper version of the document or that they client verbally agreed and was unable to sign. If the client has signed a paper version of the form, that form should be scanned in. See How do I scan a document into the client's record?
    a. **Select the method of capturing the signature**.
    b. Once the co-signer is happy with their signature, **click the Sign button**. If the client has signed a paper version of the form or has agreed verbally and is unable to sign electronically at this point, these are other options.
    c. If the cosigner needs to start over, click the Clear button to erase the current signature.



Once signed by all required people, you are finished.

What do I do if the client wants to revoke their Coordinated Care Consent?

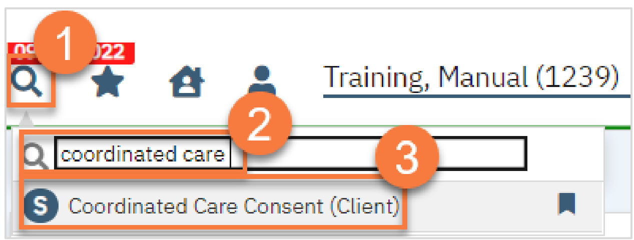
1. To revoke a Coordinated Care Consent, simply create a new Coordinated Care Consent but mark "No" in the Consent section. This will automatically add an end date to the previous Coordinated Care Consent.



Where can I find out if the client has signed a Coordinated Care Consent?

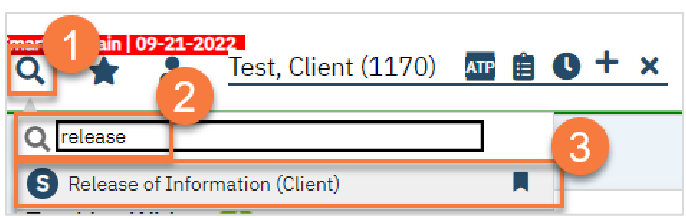
The easiest way to find out if the client has a Coordinated Care Consent is to search for the document using the Search icon. If there is a Coordinated Care Consent already signed in a CDAG that you can view, the PDF will pull up. If not, it will take you to a blank new Coordinated Care Consent.

1. You must first have the client open, click the Search icon.
2. Type Coordinated Care Consent into the search bar.
3. Click to select Coordinated Care Consent (Client).

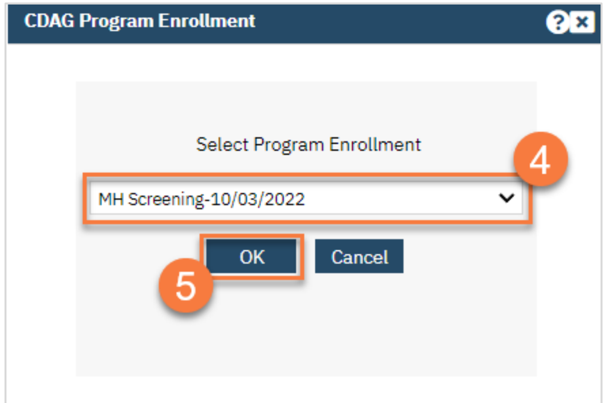


How do I complete a Release of Information (Authorization to Disclose Confidential Information)?

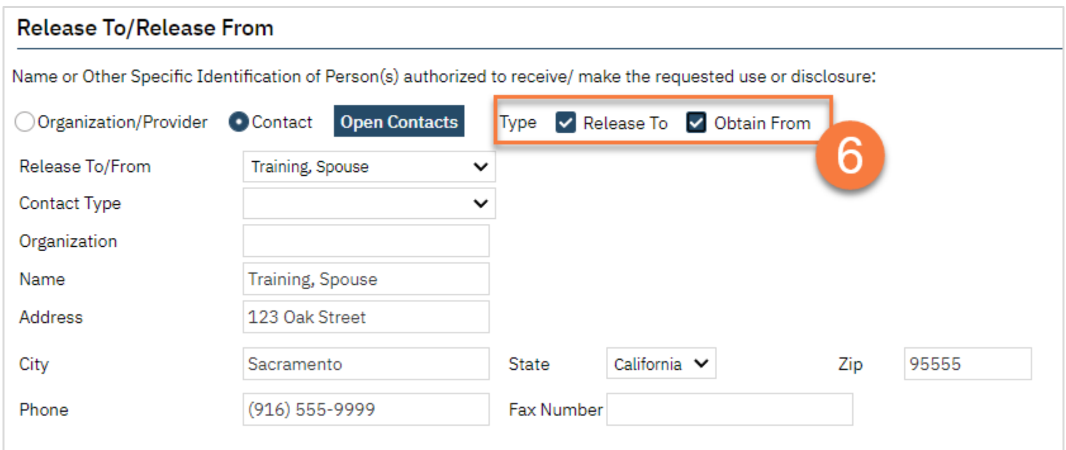
1. You must first have the client open, click the Search icon.
2. Type Release of Information into the search bar.
3. Click to select Release of Information (Client).



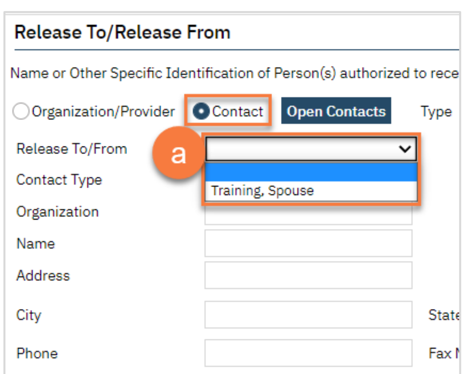
4. In the CDAG Program Enrollment window pop-up, click the drop down and click to select the appropriate program.
5. Click OK to continue.

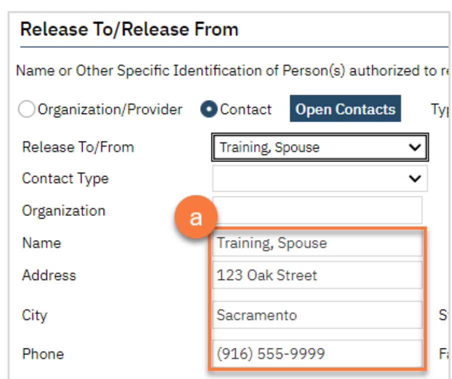


6. **Complete the Release To/Release From section.** Make sure to select whether this authorization is to allow you to release information to this entity and/or obtain information from this entity.

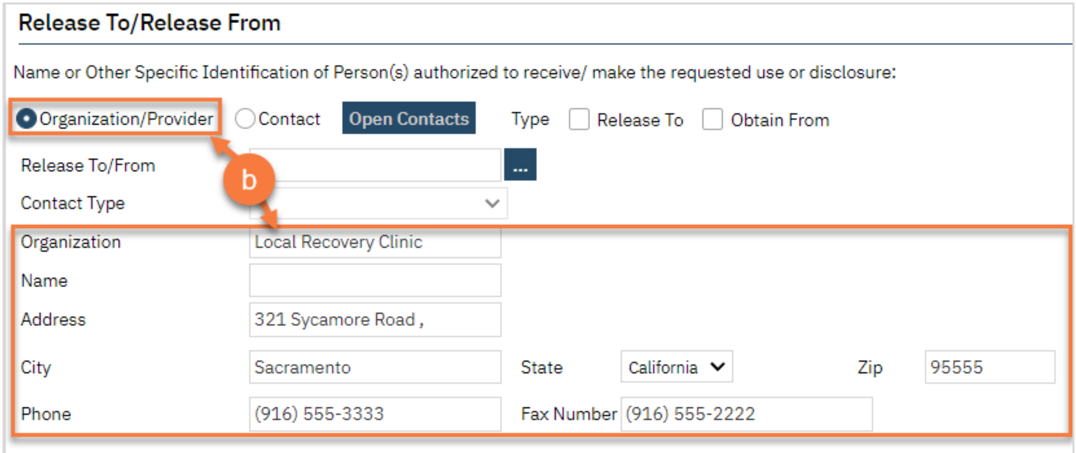


   a. If the person you're completing this release for is already entered as a contact in the Client Information Screen, select "Contact" and then select the person from the drop down list "Release To/From". This will bring in the contact person's information.

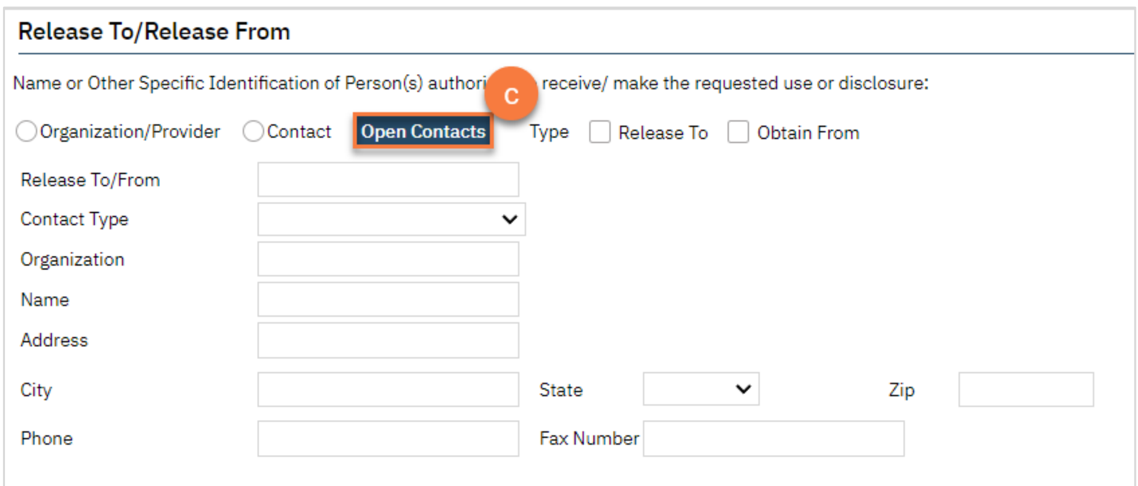




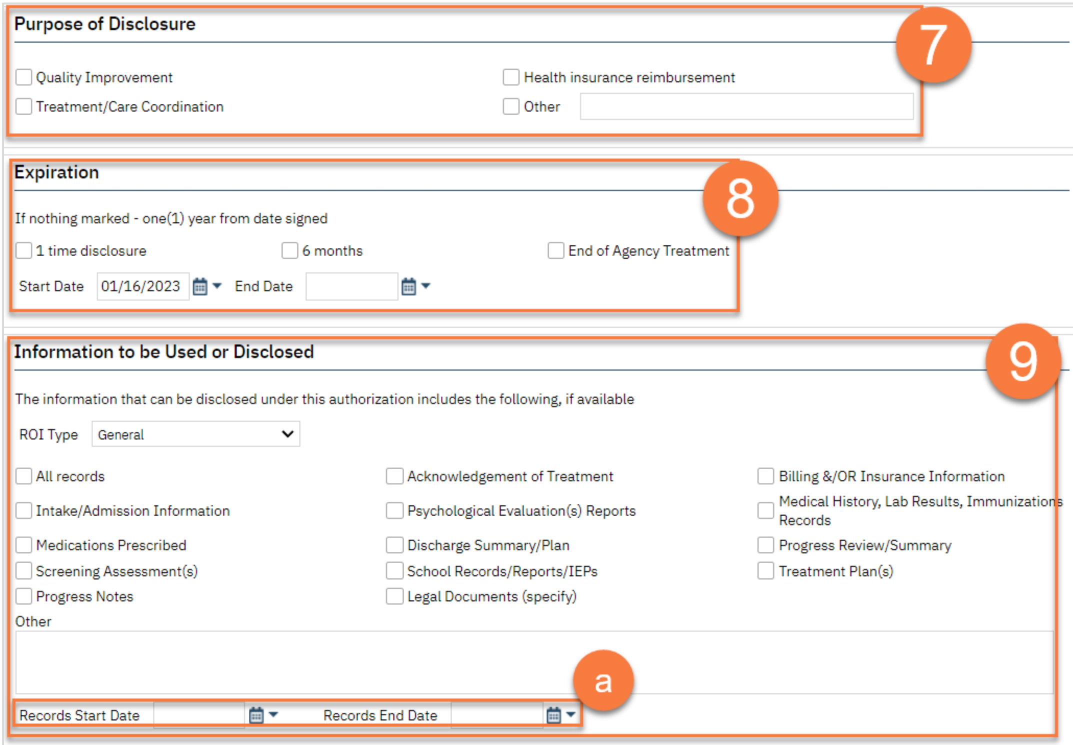
   b. If you're completing a release for an organization, such as Social Services or a school, select "Organization/Provider". This opens a button next to the Release To/From field. Clicking this brings up a pop-up window where you can enter the organization's information. Click save. This will push this information to the ROI and save this information for future ROIs. Enter the organization's information.



c. If you're completing a release for a contact person that is not currently entered as a contact in the Client Information Screen, selecting "Contact" will create an opportunity to select the button "Open Contacts". This will take you to the Client Information Screen, where you can add additional contact.



7. **Complete the Purpose of Disclosure section**. Most authorizations to disclose information are for treatment and/or care coordination, but others may apply. Select the appropriate boxes. If you select "Other", make sure to clarify.
8. **Complete the Expiration section**. The start date automatically fills with today's date. If you don't change anything in this section, the document will automatically expire 1 year from today's date.
9. **Complete the Information to be Used or Disclosed section**. Select all records that are authorized for disclosure per the client's request.
    a. If the client requests that only records from a certain time frame be shared, include the start and end dates.


Purpose of Disclosure

7

☐ Quality Improvement
☐ Treatment/Care Coordination
☐ Health insurance reimbursement
☐ Other

Expiration

8

If nothing marked - one(1) year from date signed

☐ 1 time disclosure
☐ 6 months
☐ End of Agency Treatment

Start Date 01/16/2023
End Date

Information to be Used or Disclosed

9

The information that can be disclosed under this authorization includes the following, if available

ROI Type General

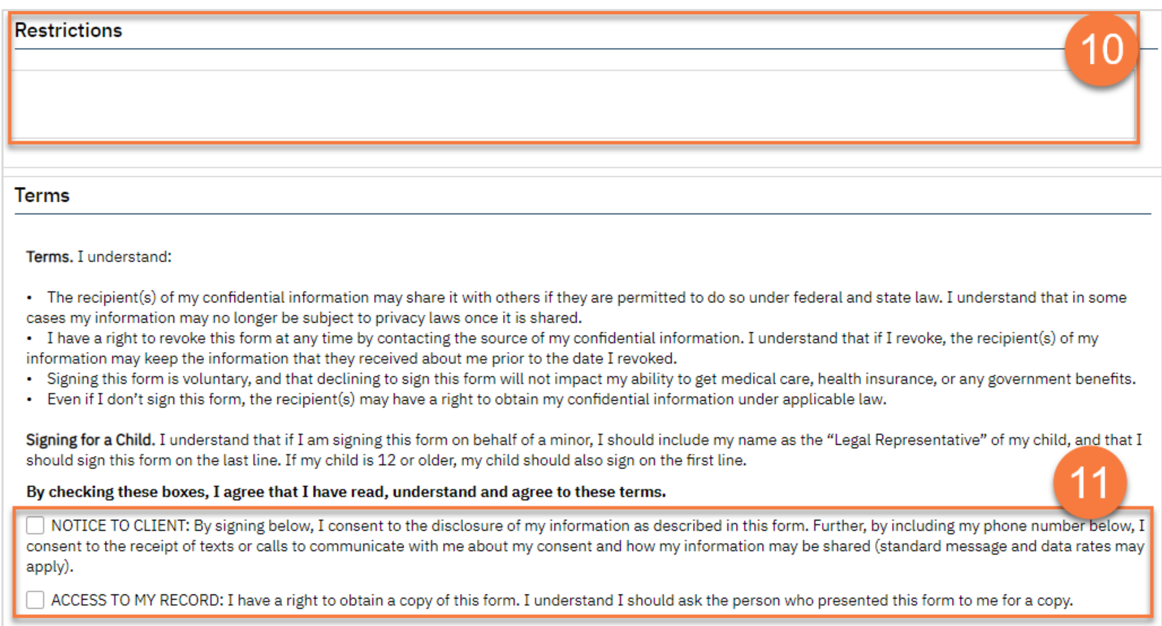
☐ All records
☐ Acknowledgement of Treatment
☐ Billing &/OR Insurance Information
☐ Intake/Admission Information
☐ Psychological Evaluation(s) Reports
☐ Medical History, Lab Results, Immunizations Records
☐ Medications Prescribed
☐ Discharge Summary/Plan
☐ Progress Review/Summary
☐ Screening Assessment(s)
☐ School Records/Reports/IEPs
☐ Treatment Plan(s)
☐ Progress Notes
☐ Legal Documents (specify)

Other

a

Records Start Date
Records End Date

10. If the client wishes to put any restrictions on this authorization, enter those in the Restrictions section.
11. The terms section provides the client with information about the authorization they're signing. Make sure to **check both boxes** to demonstrate you've reviewed this information with the client.


Restrictions

10

Terms

Terms. I understand:

- The recipient(s) of my confidential information may share it with others if they are permitted to do so under federal and state law. I understand that in some cases my information may no longer be subject to privacy laws once it is shared.
- I have a right to revoke this form at any time by contacting the source of my confidential information. I understand that if I revoke, the recipient(s) of my information may keep the information that they received about me prior to the date I revoked.
- Signing this form is voluntary, and that declining to sign this form will not impact my ability to get medical care, health insurance, or any government benefits.
- Even if I don't sign this form, the recipient(s) may have a right to obtain my confidential information under applicable law.

Signing for a Child. I understand that if I am signing this form on behalf of a minor, I should include my name as the "Legal Representative" of my child, and that I should sign this form on the last line. If my child is 12 or older, my child should also sign on the first line.

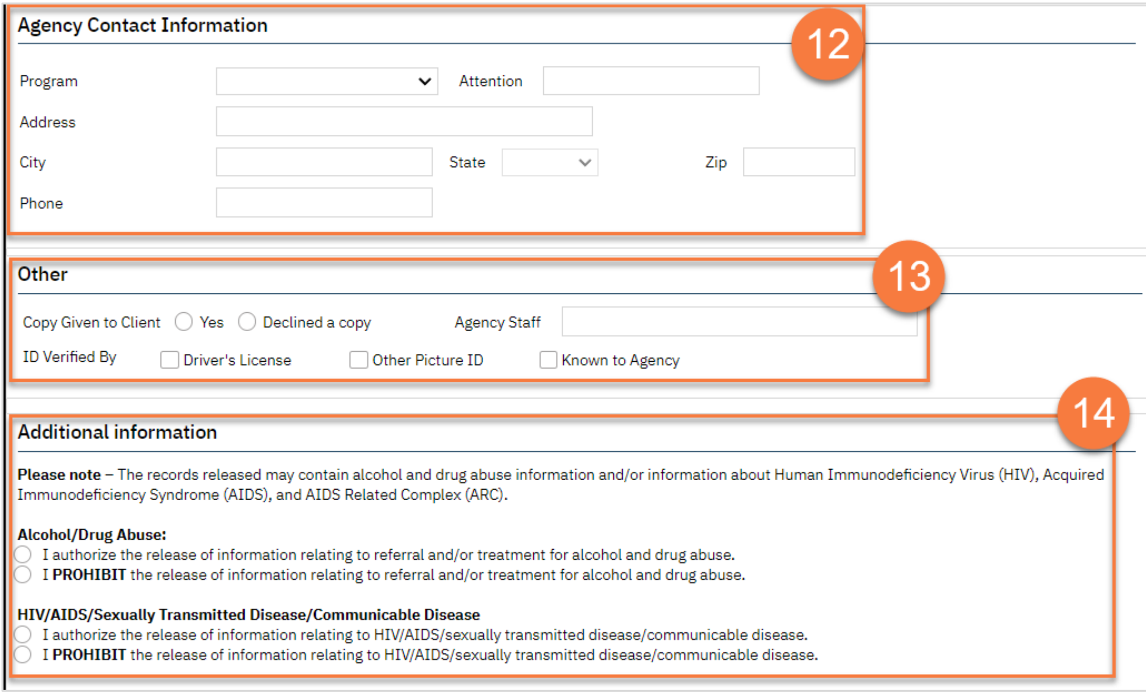
By checking these boxes, I agree that I have read, understand and agree to these terms.

11

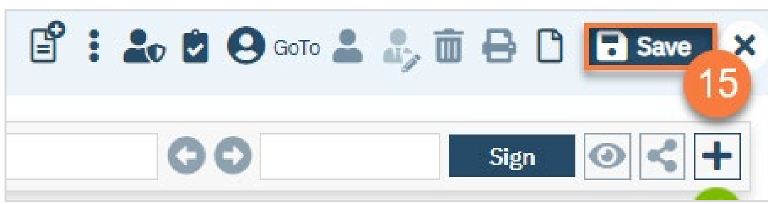
☐ NOTICE TO CLIENT: By signing below, I consent to the disclosure of my information as described in this form. Further, by including my phone number below, I consent to the receipt of texts or calls to communicate with me about my consent and how my information may be shared (standard message and data rates may apply).

☐ ACCESS TO MY RECORD: I have a right to obtain a copy of this form. I understand I should ask the person who presented this form to me for a copy.

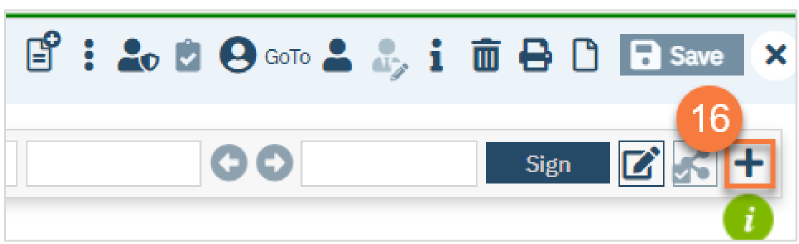
12. **Enter your agency's information in the Agency Contact Information section**.
13. The Other section allows you to document if the client received or declined a copy of the document. It also allows you to document how you verified the client's identity as the appropriate person to sign this document.
14. **The Additional information section must be completed** to document the disclosure of certain types of information. The client must opt to either authorize or prohibit each of these specialty types of information.



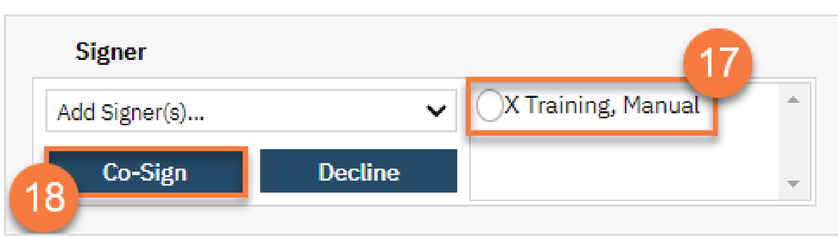
15. **Click Sign** to complete and generate the document.



16. This will create the PDF version of the form. **Click the Plus icon** in the upper right corner of the PDF viewer.



17. This opens the signature details. **Select the client and/or guardian from the Signer field**. You will need to select each cosigner one at a time, so repeat these steps as needed.
18. **Click Co-Sign**.



19. This brings up the Signature Page pop-up window. The co-signer can now sign using a signature pad, a mouse, or a touchpad to capture their signature. You can also designate that the client has signed on a paper version of the

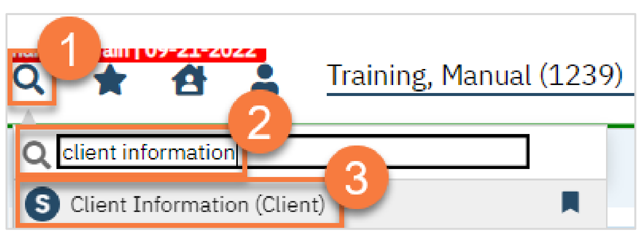
document or that they client verbally agreed and was unable to sign. If the client has signed a paper version of the form, that form should be scanned in. See How do I scan a document into the client's record?

a. Select the method of capturing the signature.
b. Once the co-signer is happy with their signature, click the Save button. If the client has signed a paper version of the form or has agreed verbally and is unable to sign electronically at this point, these are other options.
c. If the cosigner needs to start over, click the Clear button to erase the current signature.

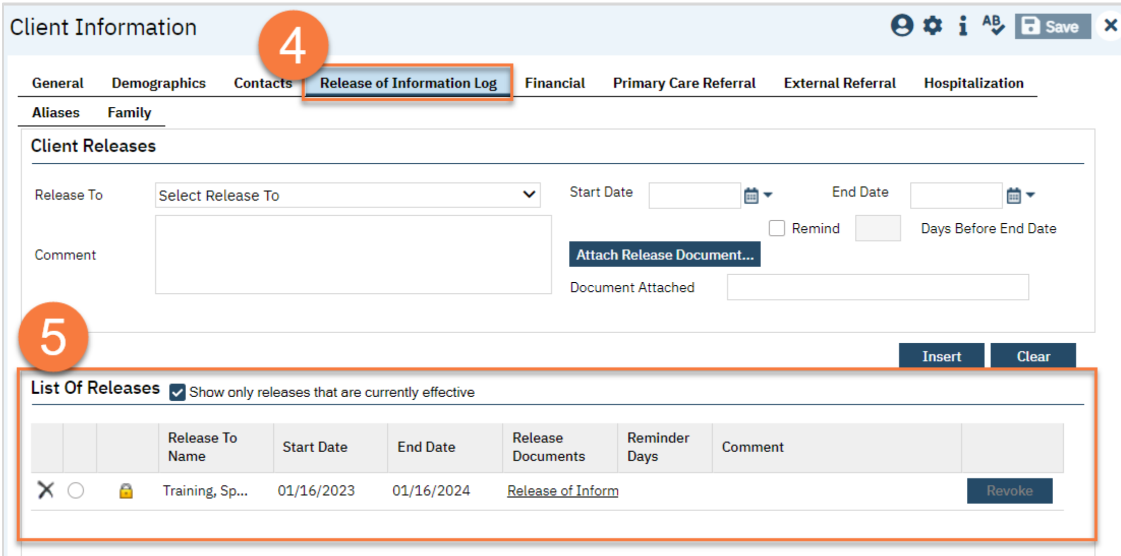
Once signed by all required people, you are finished.

What do I do if the client wants to revoke a Standard Release of Information/Authorization to Disclose Information?

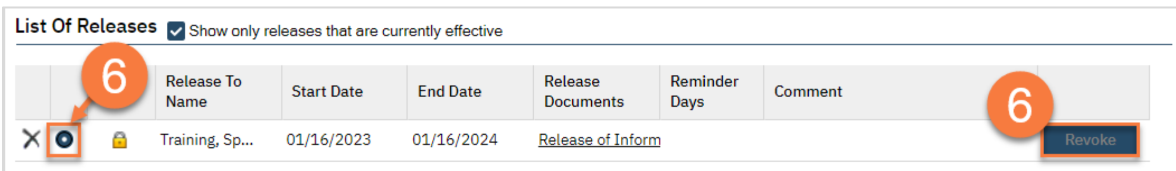
1. With the client open, click the Search icon.
2. Type in "Client Information" in the search bar.
3. Select "Client Information (Client)" from the search results.



4. Navigate to the Release of Information Log tab.
5. You can view the current releases on file in the List of Releases section.



6. To revoke an authorization, **select it from the List of Releases section, then click the Revoke button**.

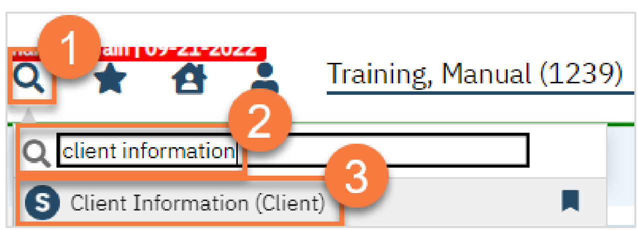


7. BUG – button is currently locked.

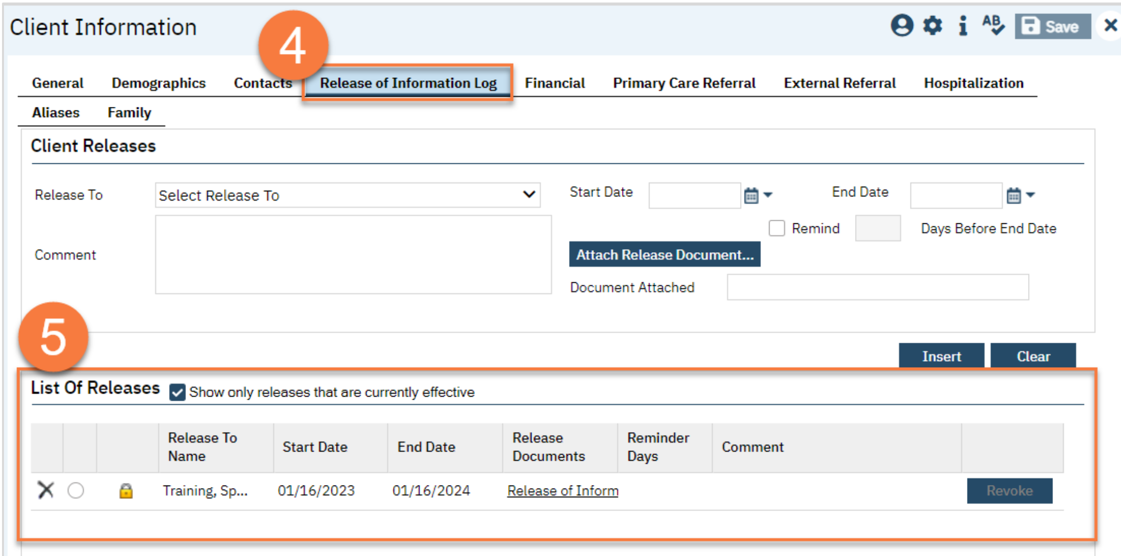
How can I find out what disclosure authorizations the client has signed?

To view the client's list of current disclosure authorizations on file, open the Client information screen and navigate to the Release of Information Log tab.

1. With the client open, click the Search icon.
2. Type in "Client Information" in the search bar.
3. Select "Client Information (Client) from the search results.



4. Navigate to the Release of Information Log tab.
5. You can view the current releases on file in the List of Releases section.



Other Consents

There are multiple types of consents that a client may complete as part of their treatment. SmartCare currently includes the following consent forms:

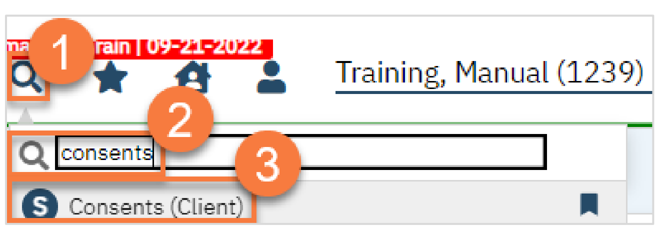
1. Consent to Treat *(sometimes called "Informed Consent")*
2. Consent to Telehealth
3. Consent to Email Communication
4. Consent to Text Communication

The Consent to Treat includes information about limits of confidentiality, working as a registered associate, privacy practices, and about processes such as the grievance and appeal process.

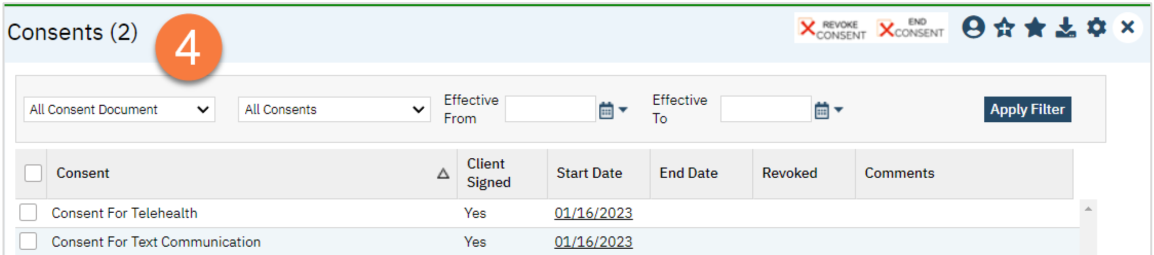
Other consent-like documents, such as Admission Agreements or Advisements are custom for each program. For this reason, these documents are currently done on paper and scanned into the client's chart.

Where can I see what consents a client has signed?

1. You must first have the client open, **click the Search icon**.
2. **Type "Consents"** into the search bar.
3. **Click to select "Consents (Client)"** from the search results.

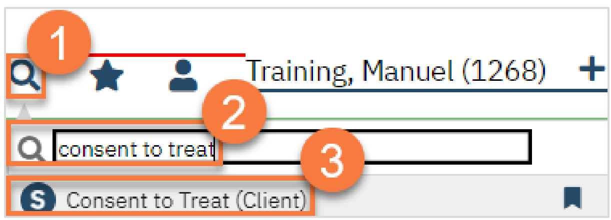


4. This brings you to the Consents list page, where you can see what consents the client has on file. To view the document itself, simply click on the document's name to view the PDF version of it. Note: you'll only be able to view consents that are in your CDAG.

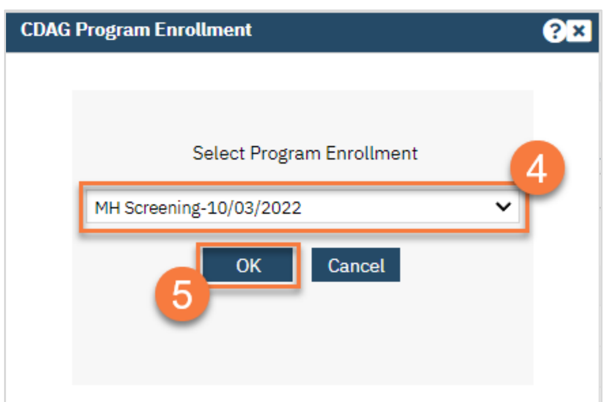


How do I complete a consent form?

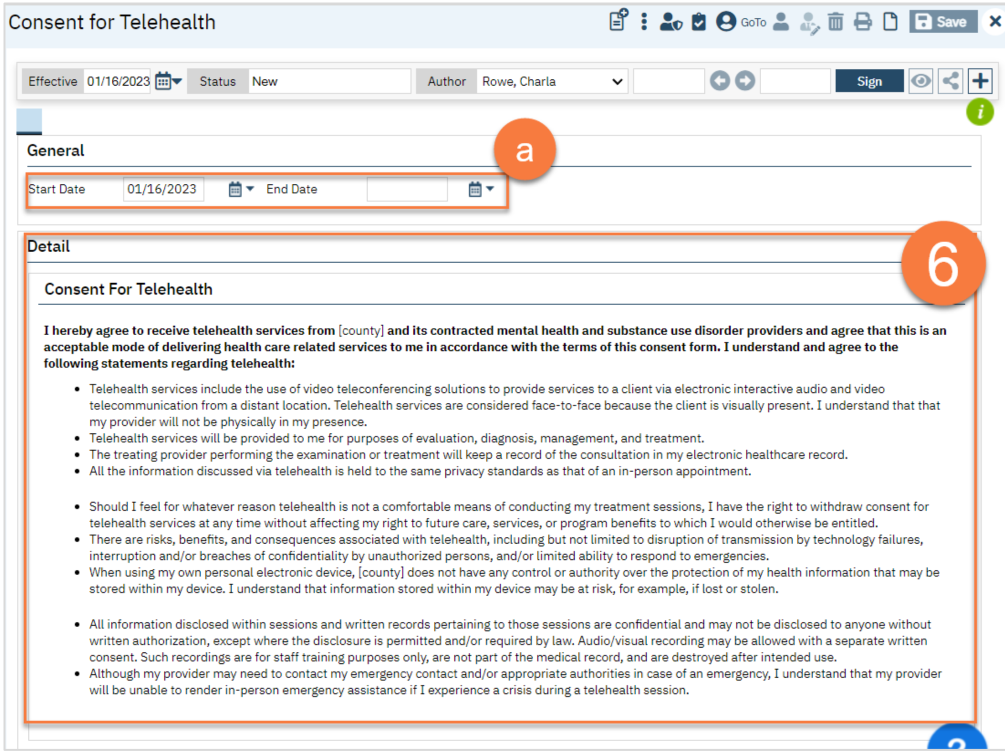
1. You must first have the client open, click the Search icon.
2. **Type the name of the consent** into the search bar.
3. **Click to select the appropriate consent** from the search results.



4. In the CDAG Program Enrollment window pop-up, click the drop down and click to s**elect the appropriate program**.
5. **Click OK** to continue.



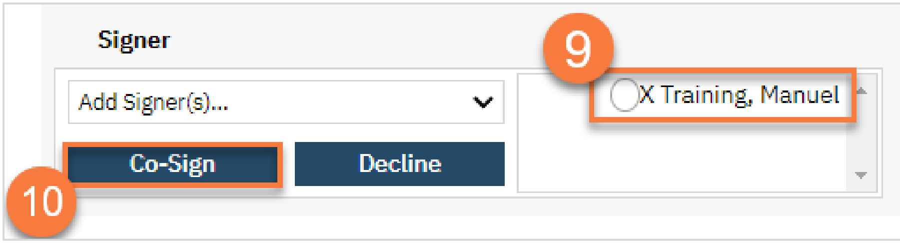
6. The consent document will open. **Review the consent with the client**. The example used below is the Consent for Telehealth.
   a. There will be a start date and end date field, if needed. The start date will automatically populate with today's date. We recommend leaving the end date blank.



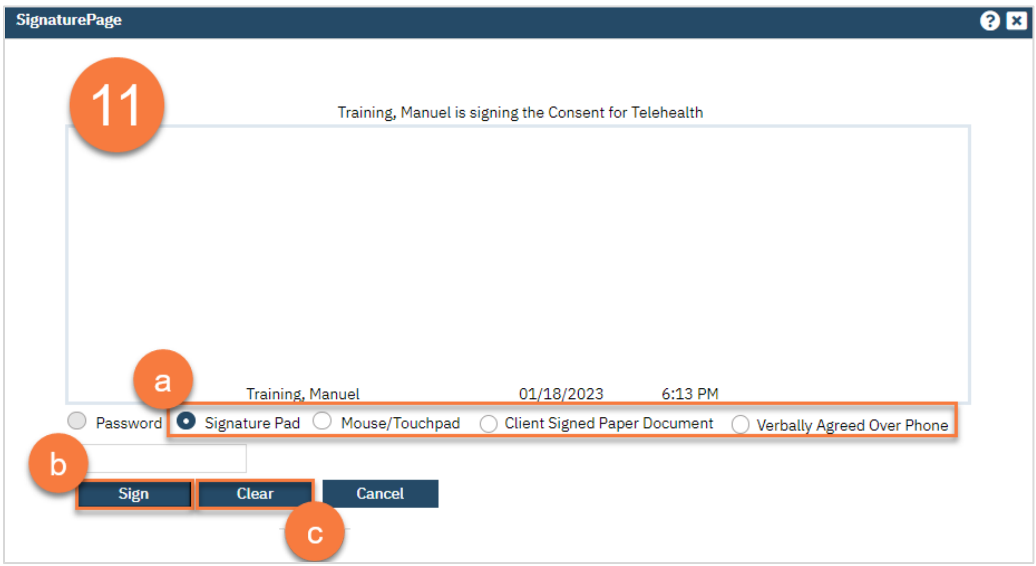
7. Once ready, **click Sign**.

8. This will create the PDF version of the form. **Click the Plus icon** in the upper right corner of the PDF viewer.

9. This opens the signature details. **Select the client and/or guardian from the Signer field**. You will need to select each cosigner one at a time, so repeat these steps as needed.
10. **Click Co-Sign**.



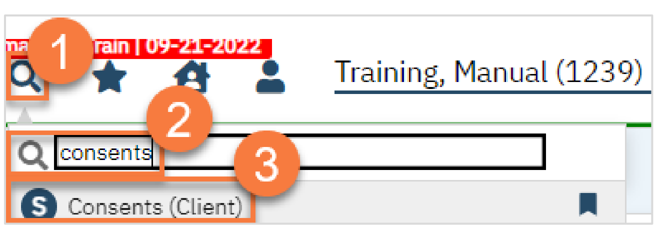
11. This brings up the Signature Page pop-up window. The co-signer can now sign using a signature pad, a mouse, or a touchpad to capture their signature. You can also designate that the client has signed on a paper version of the document or that they client verbally agreed and was unable to sign. If the client has signed a paper version of the form, that form should be scanned in. See How do I scan a document into the client's record?
    a. Select the method of capturing the signature.
    b. Once the co-signer is happy with their signature, click the Sign button. If the client has signed a paper version of the form or has agreed verbally and is unable to sign electronically at this point, these are other options.
    c. If the cosigner needs to start over, click the Clear button to erase the current signature.



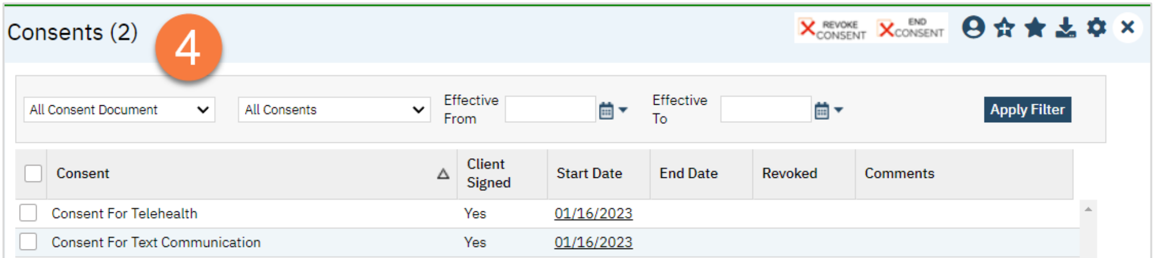
Once signed by all required people, you are finished.

A client wants to revoke a consent. What do I do?

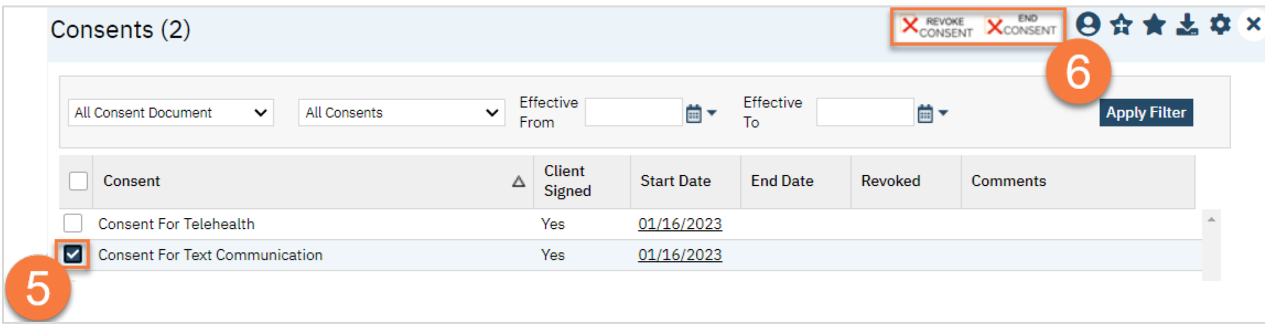
1. You must first have the client open, click the Search icon.
2. Type "Consents" into the search bar.
3. Click to select "Consents (Client)" from the search results.



4. This brings you to the Consents list page, where you can see what consents the client has on file. To view the document itself, simply click on the document's name to view the PDF version of it. Note: you'll only be able to view consents that are in your CDAG.



5. Select the consent you want to revoke.
6. Click the “Revoke Consent” or “End Consent” button.
    a. Revoking a Consent removes the consent.
    b. Ending the consent adds an end date to the consent.



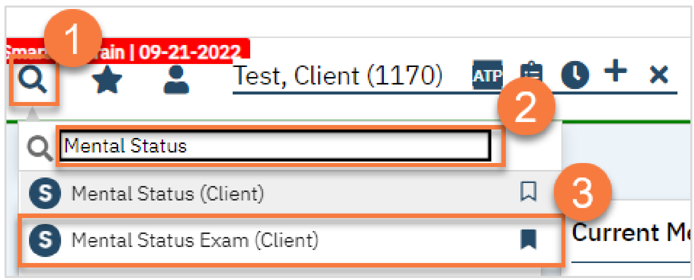
Clinical Documents

In this section, we'll review the documents that are clinical in nature.

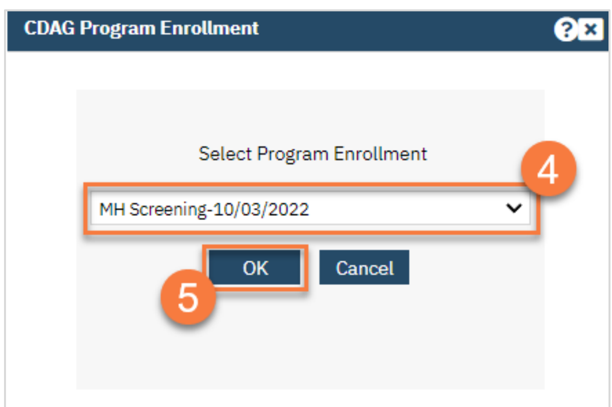
Mental Status Exam (MSE)

The Mental Status Exam, or MSE, is a document that's often included in other clinical documents as a tab, but the standalone form is also available.

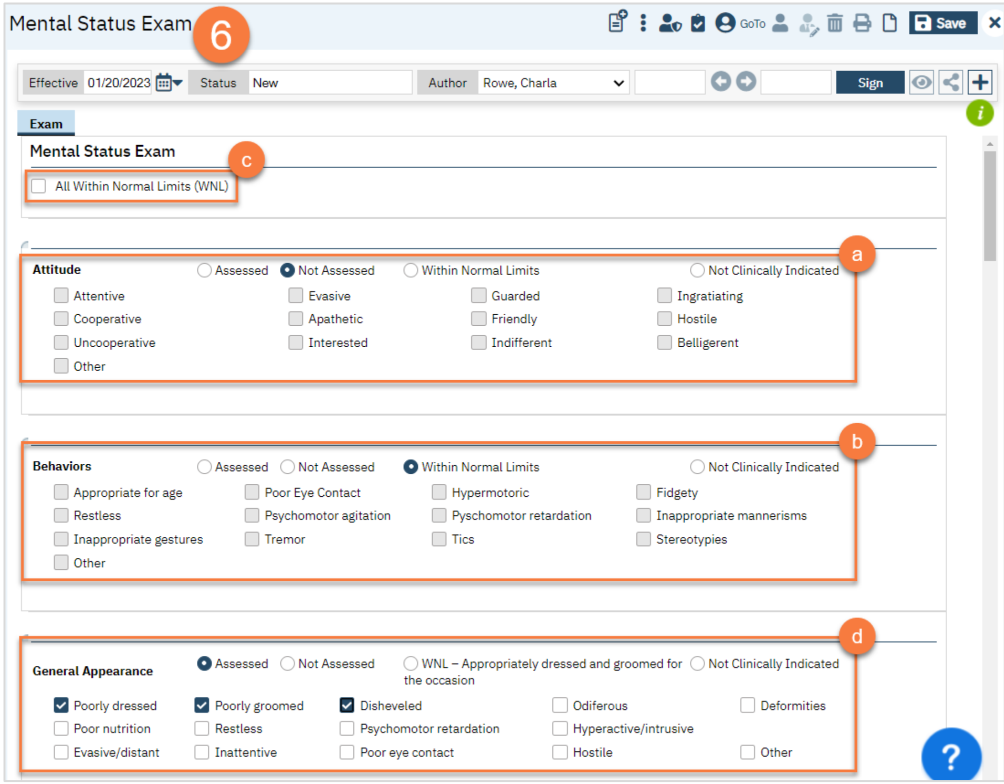
1. You must first have the client open, **click the Search icon**.
2. **Type Mental Status Exam** into the search bar.
3. **Click to select Mental Status Exam (Client).**



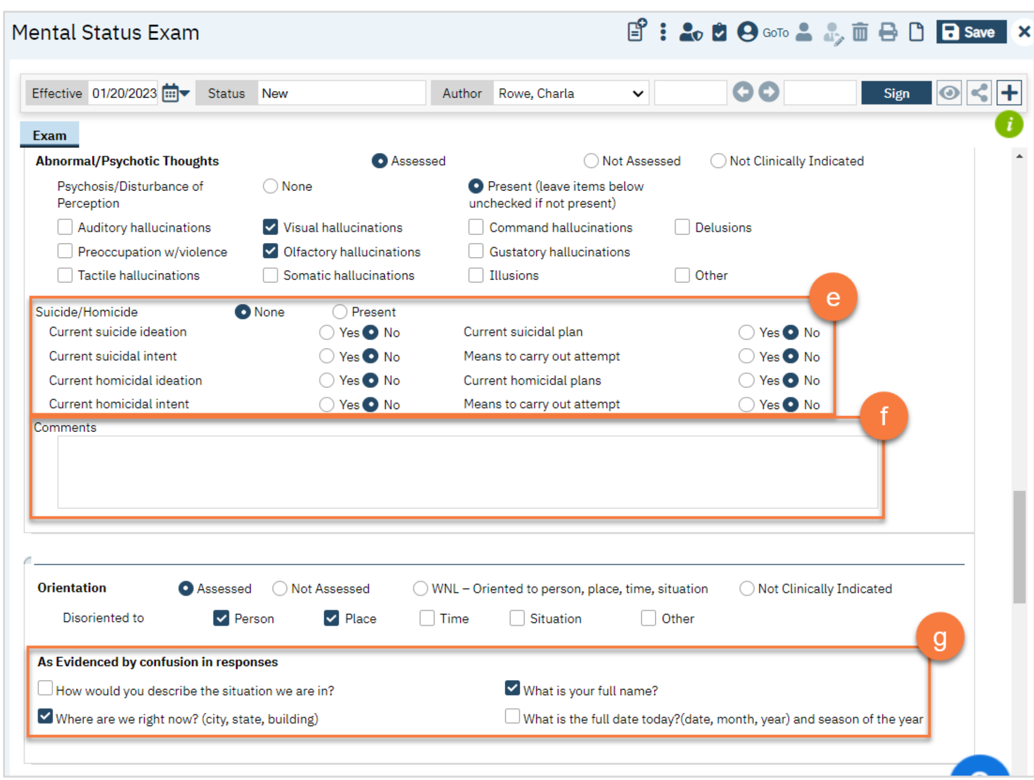
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



6. The Mental Status Exam document will open. **Complete the document.** If a previous MSE was completed, it will pull forward the most recent information. Otherwise, all sections will default to "Not Assessed."
   a. If you did not assess that section, select "Not Assessed." This will lock your ability to check any of the boxes.
   b. If you find that the person is within normal limits (WNL) for a section, you can simply check the "WNL" radio button at the top of the section. This will lock your ability to check any of the boxes, as this designation covers the requirements.
   c. Helpful Tip: If the person is within normal limits for all sections, you can select "All Within Normal Limits (WNL)"
   d. If you assessed a section, select all options that apply. If you select "Other", make sure to complete the text field.



e. Some sections, such as Suicide/Homicide, are single select and must be completed. However, if clicking "None" then the options will mark all as "No" or grey out, depending on the section.
f. Some sections, including the Suicide/Homicide section, also have a Comments section for you to add more detail.
g. Some sections, such as orientation, request evidence of the clinician's determination.

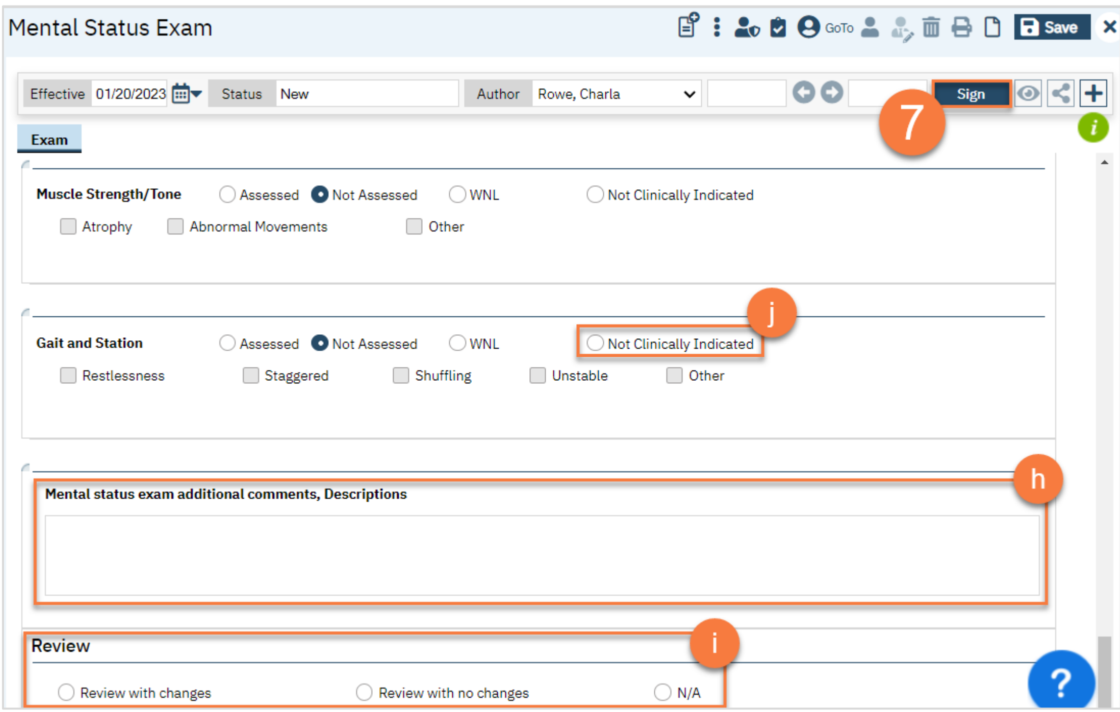


h. There is a section at the very end for additional comments. You can also use this box to summarize the MSE results.

i. There is also a Review section. This is for MSEs that are completed frequently. This allows you review the most recent MSE and make minor changes without having to re-enter all the sections. You can select N/A if you started over.

j. You can use "Not Clinically Indicated" when you're completing frequent MSEs and a section does not need to be completed every time.

7. Once completed, **click Sign** to complete and generate the document.

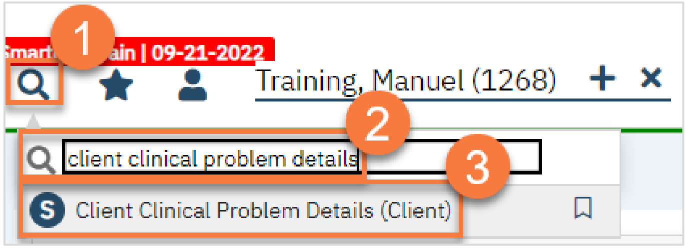


Problem List

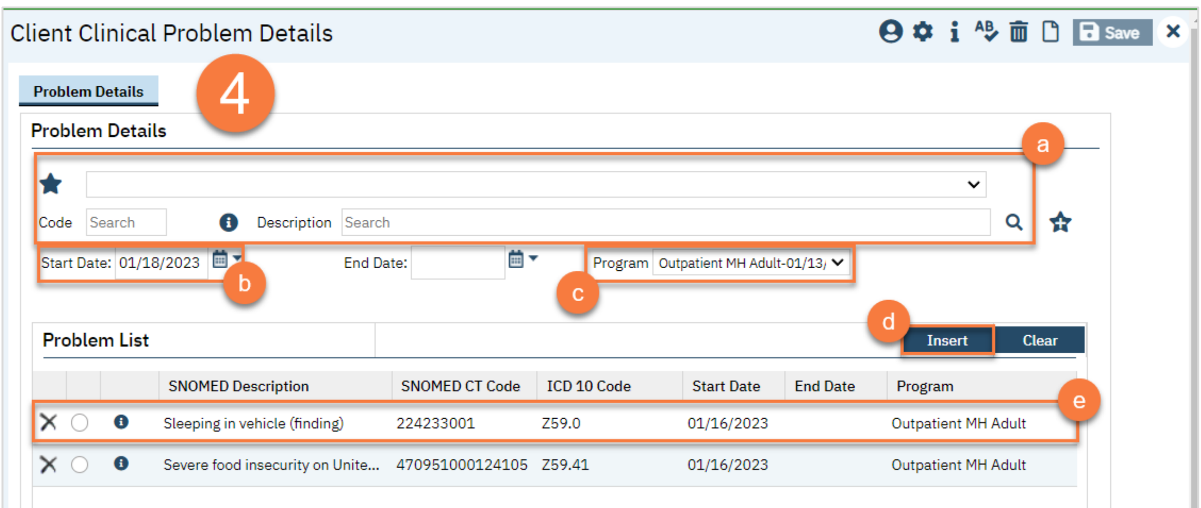
The Problem List is a module that is embedded in multiple documents in the system. For example, it's included in the CalAIM Assessment and most progress notes. These are all connected, so if you add a problem from one document, it will add it to the overarching Problem List and will therefore be available when you open a different document. You can also open the Problem List in a standalone manner. The Problem List is a living document, so information should not be deleted unless entered in error. You will only be able to see problems within your CDAG if the client has not signed a Coordinated Care Consent.

How do I add a problem to the Problem List?

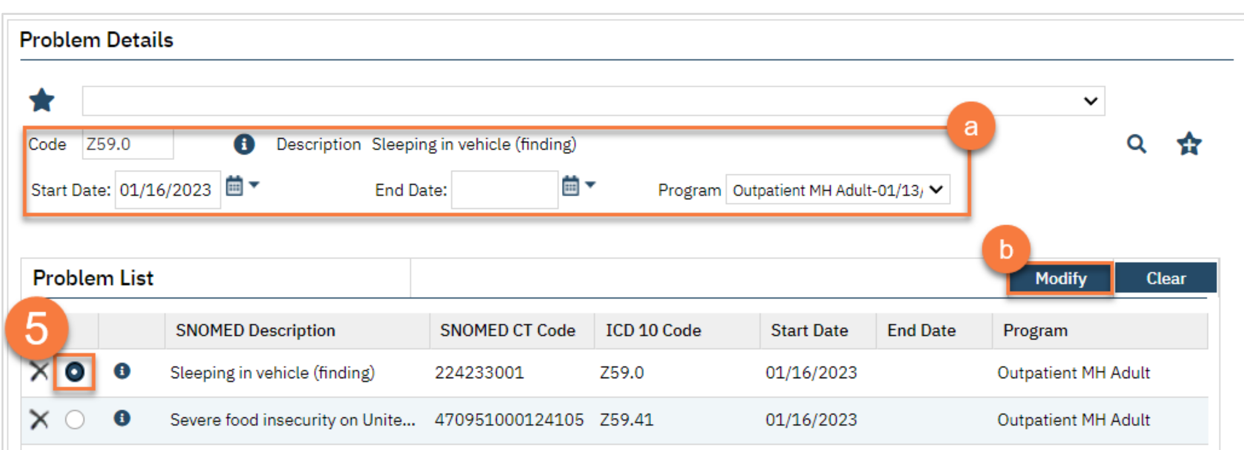
1. You must first have the client open, then **click the Search icon**.
2. **Type Problem** into the search bar.
3. **Click to select Client Clinical Problem Details (Client).**



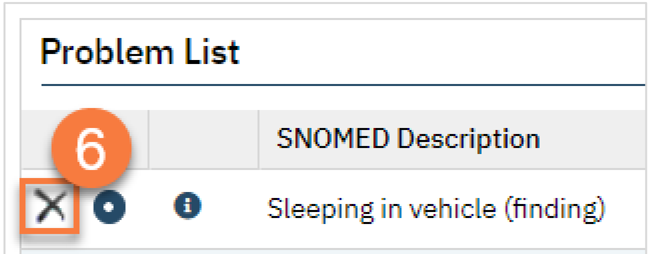
4. This brings you to the Client Clinical Problem Details screen. Add a problem using the steps below. You can enter as many problems as you need to.
   a. **Search for the problem** using the ICD-10 code, or the DSM-5 code. You can also search by typing in the Description field. You can also select from your favorites by clicking on the dropdown.
   b. **Enter the start date** of the problem. This is the date the problem started, not the date you were made aware of the problem.
   c. **Select your program** from the dropdown menu.
   d. **Click Insert**.
   e. This will add it to the Problem List section.



5. If you made a mistake, you can select an item from the Problem List.
   a. This brings the information to the top part of the screen. **Make your edits**.
   b. When finished, **click Modify**.



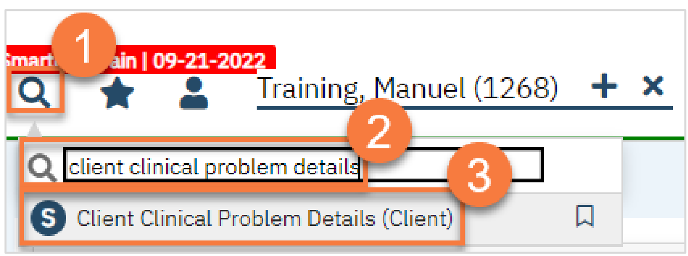
6. If you need to simply delete a problem that was added in error, click the Delete icon next to the appropriate problem in the Problem List section.



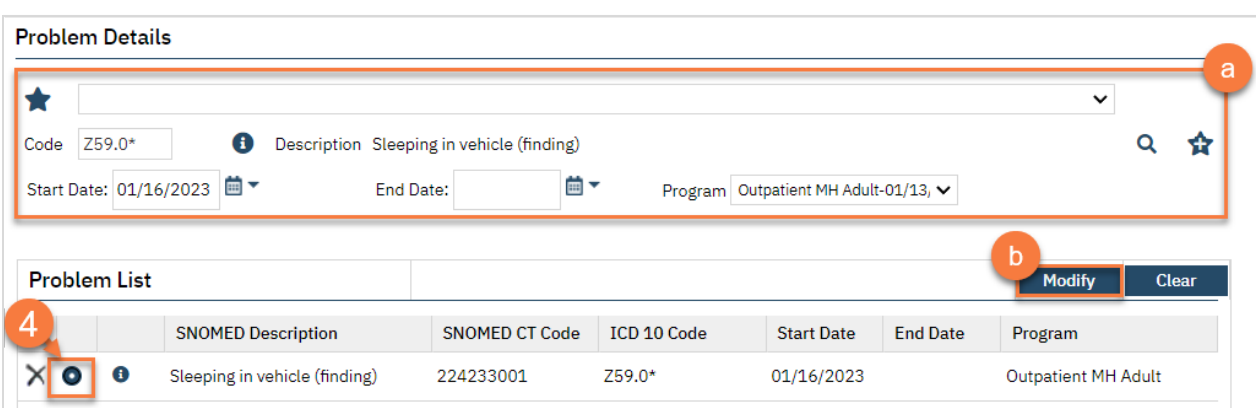
7. When you're finished, **Click Save**.

How do I remove a problem that's been resolved?

8. You must first have the client open, then **click the Search icon**.
9. **Type Problem** into the search bar.
10. **Click to select Client Clinical Problem Details (Client).**



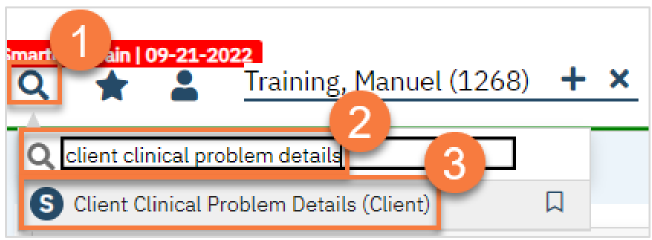
11. This brings you to the Client Clinical Problem Details screen. To remove a problem that's been resolved, **select the item from the Problem List section**.
    a. This brings the information to the top part of the screen. **Add an end date**. The end date should be when the problem was resolved, not the date you learned the problem was resolved.
    b. When finished, **click Modify**.



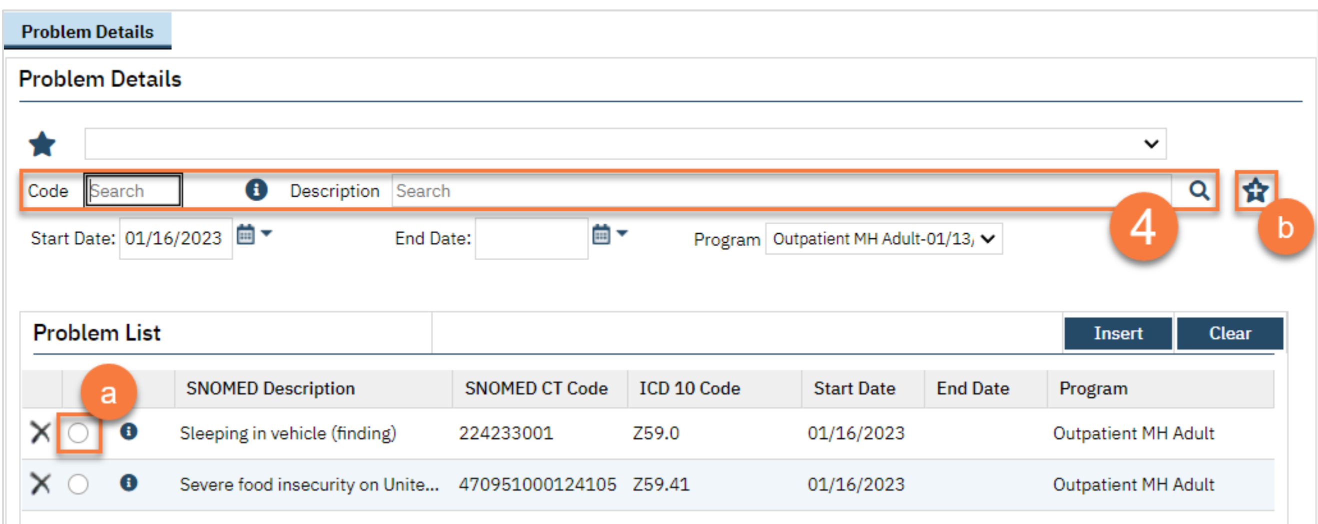
12. When you're finished, **Click Save**.

How do I add favorites to my Problem List screen?

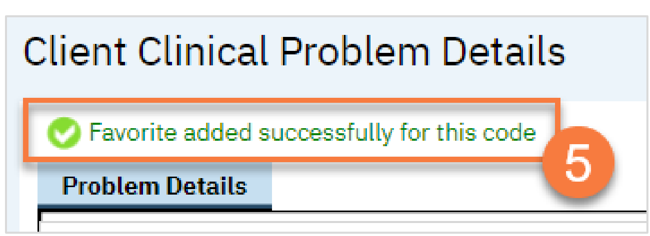
1. You must first have the client open, then **click the Search icon**.
2. **Type Problem** into the search bar.
3. **Click to select Client Clinical Problem Details (Client).**



4. This brings you to the Client Clinical Problem Details screen. Search for the problem you want to add.
    a. If it's already in the problem list, you can also select it from the Problem List section.
    b. **Click the Add Favorite icon**.

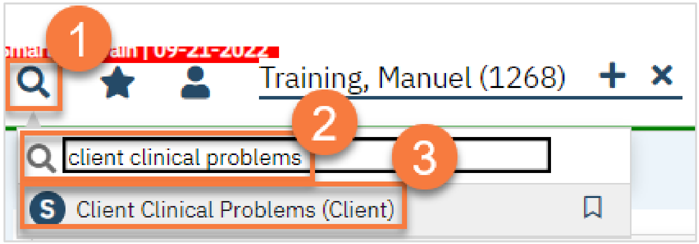


5. You'll see a notification at the top of the screen letting you know it's been added to your favorites.

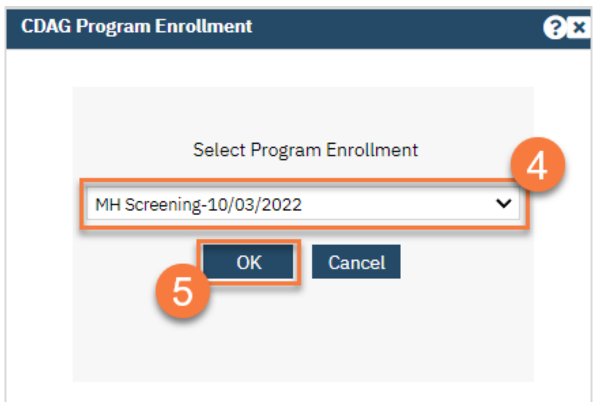


I want to be able to sort through the client's problem list, rather than seeing just the current information. How do I do that?

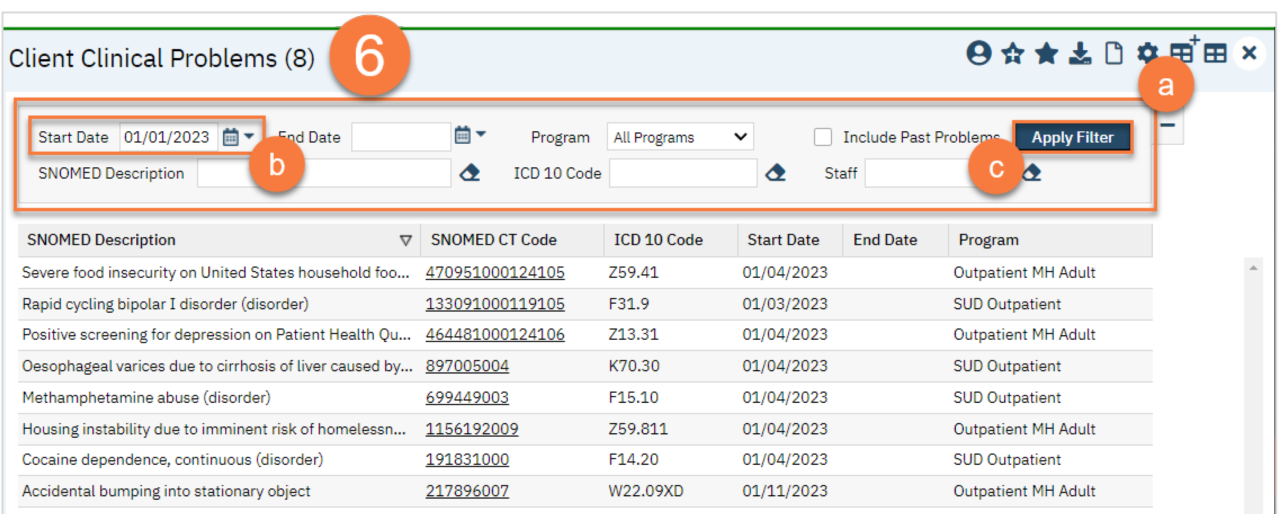
1. You must first have the client open, then **click the Search icon**.
2. **Type Problem** into the search bar.
3. **Click to select Client Clinical Problems (Client).**



4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



6. This takes you to the Client Clinical Problems list page.
    a. Use the filters at the top to find what you're looking for.
    b. Start Date is required.
    c. After entering in your filters, you'll need to click "Apply Filter".

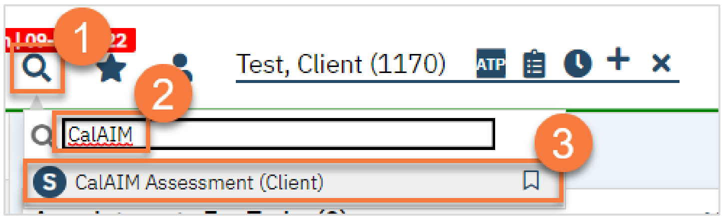


CalAIM Assessment

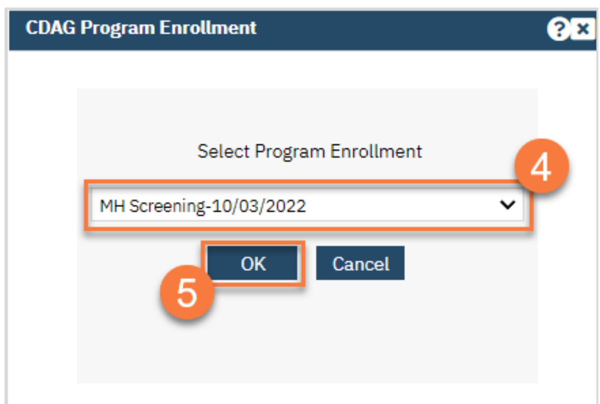
The CalAIM Assessment is the new 7-domain assessment that DHCS initialized in July 2022. Please reference the CalMHSA Documentation Guides for more details on what clinical information should be included. In SmartCare, it also includes the Problem List module, allowing you to add problems directly from the assessment.

How to complete a CalAIM Assessment:

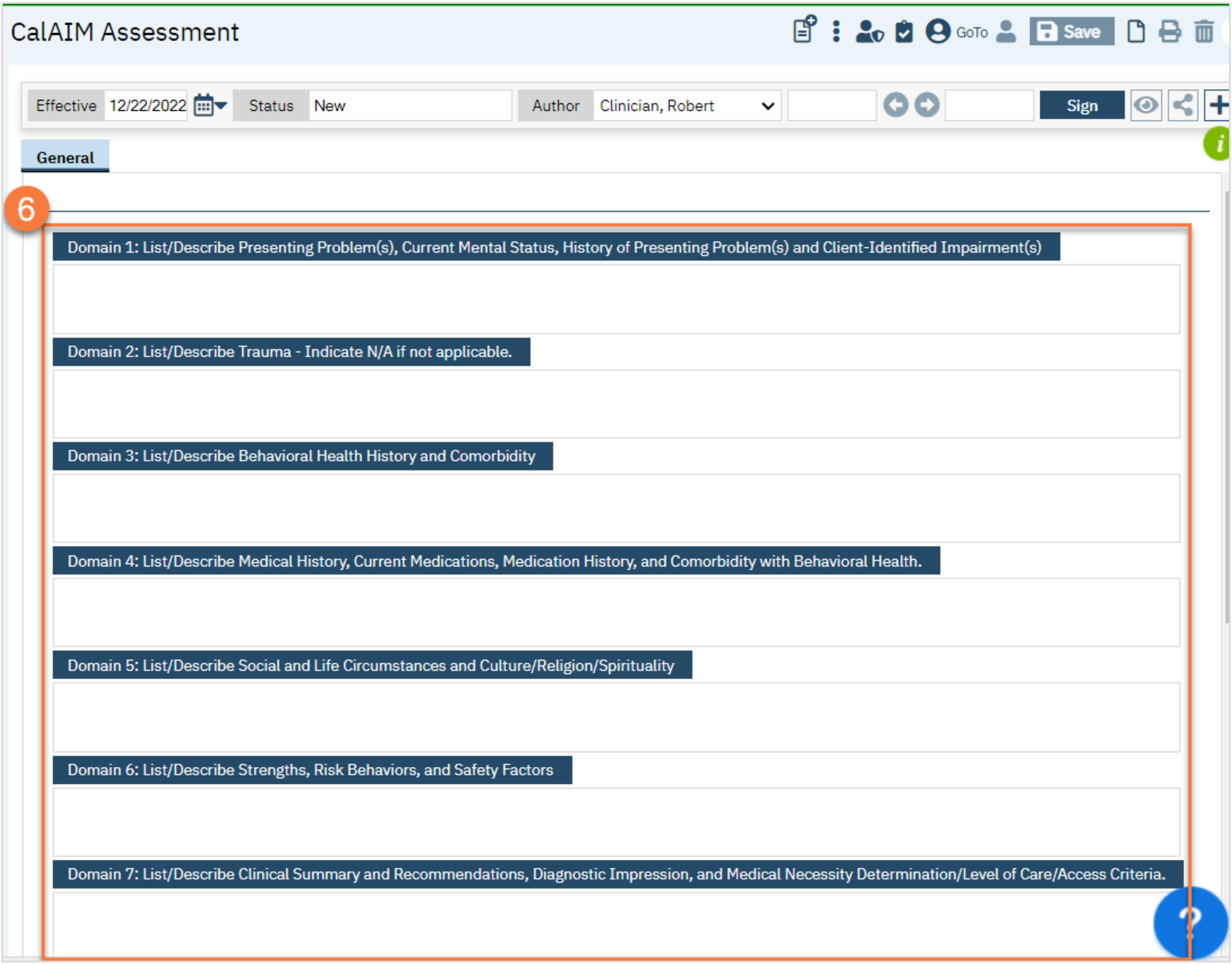
1. You must first have the client open, **click the Search icon**.
2. **Type CalAIM Assessment** into the search bar.
3. **Click to select CalAIM Assessment (Client).**



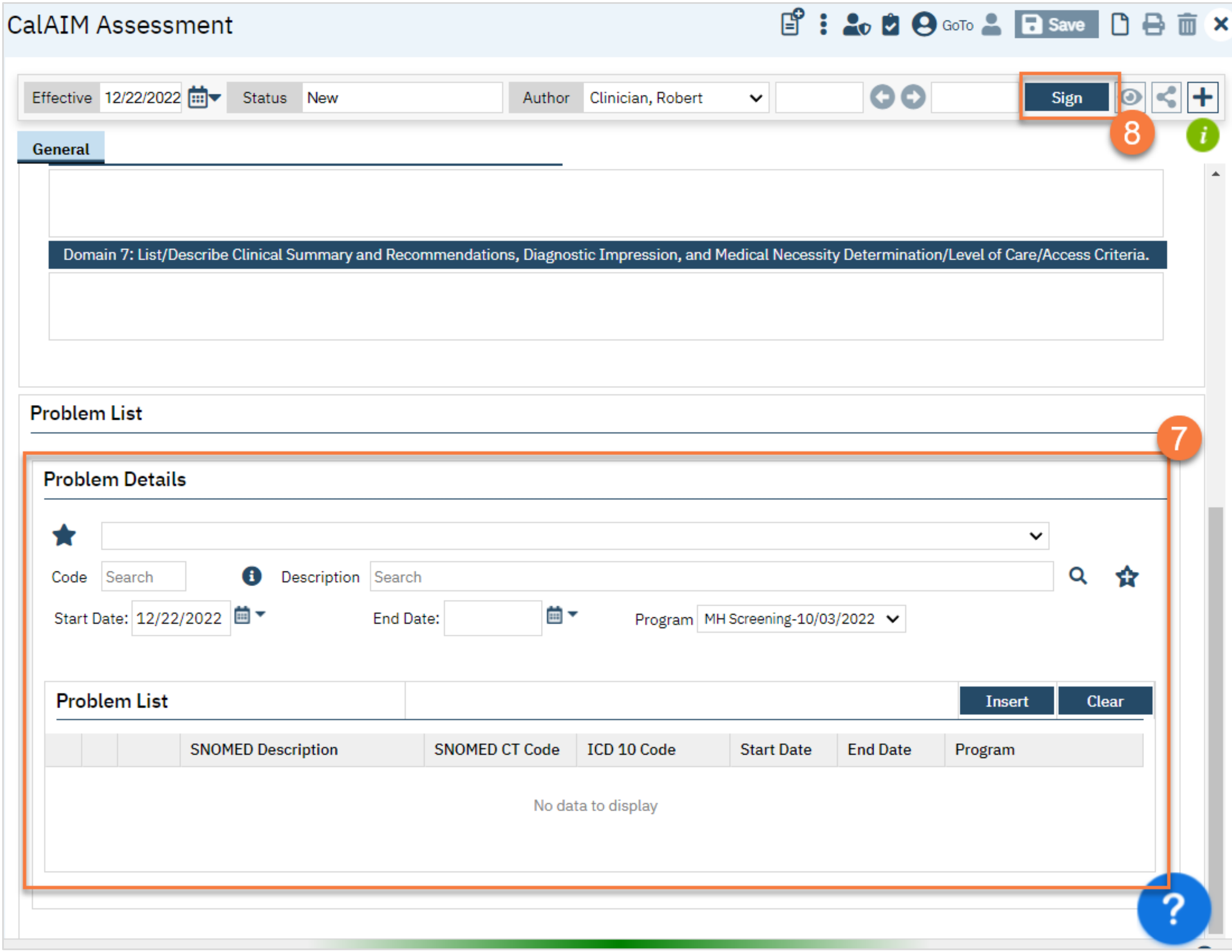
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



6. The CalAIM Assessment document will open. **Complete the document**. All 7 domains are required.



7. **Add problems to the Problem List as desired**. See Problem List section for more information on how to complete the Problem List in SmartCare.
8. **Click Sign** to complete and generate the document.

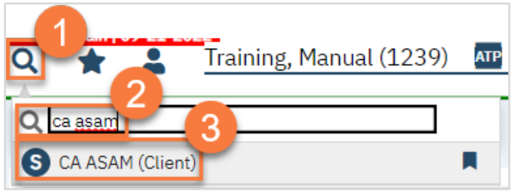


ASAM Assessment

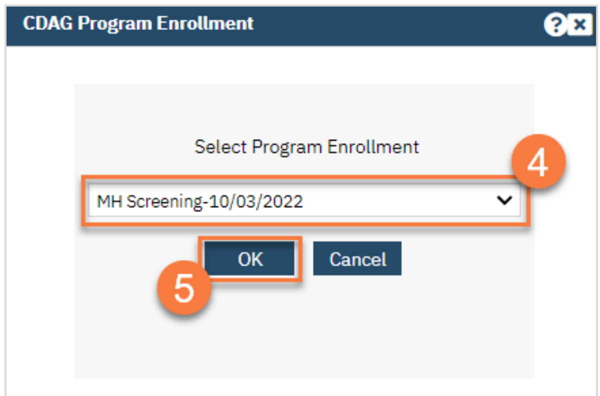
The American Society of Addiction Medicine (ASAM) has created an assessment that they simply call the ASAM Criteria. Generally, this assessment is usually just shortened to "ASAM" in the substance use treatment world. In SmartCare, the form is called "CA ASAM" to represent that this is the form the California SmartCare customers are using.

There are many different interview questions that providers use to determine the ASAM Criteria results. CalMHSA is not currently including interview questions in the EHR, as many are cumbersome and lengthy. If your county has a recommended ASAM Interview Tool, feel free to use it. DHCS also has a free ASAM Interview Tool that's available on their website. To complete the CA ASAM, follow the steps below.

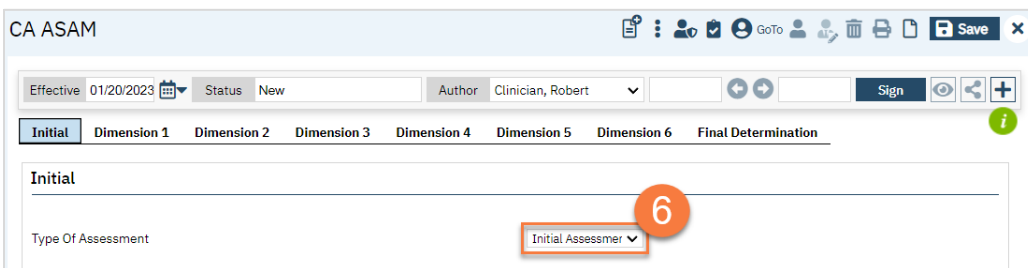
1. You must first have the client open, **click the Search icon**.
2. **Type "CA ASAM"** into the search bar.
3. **Click to select CA ASAM (Client)** from the search results.



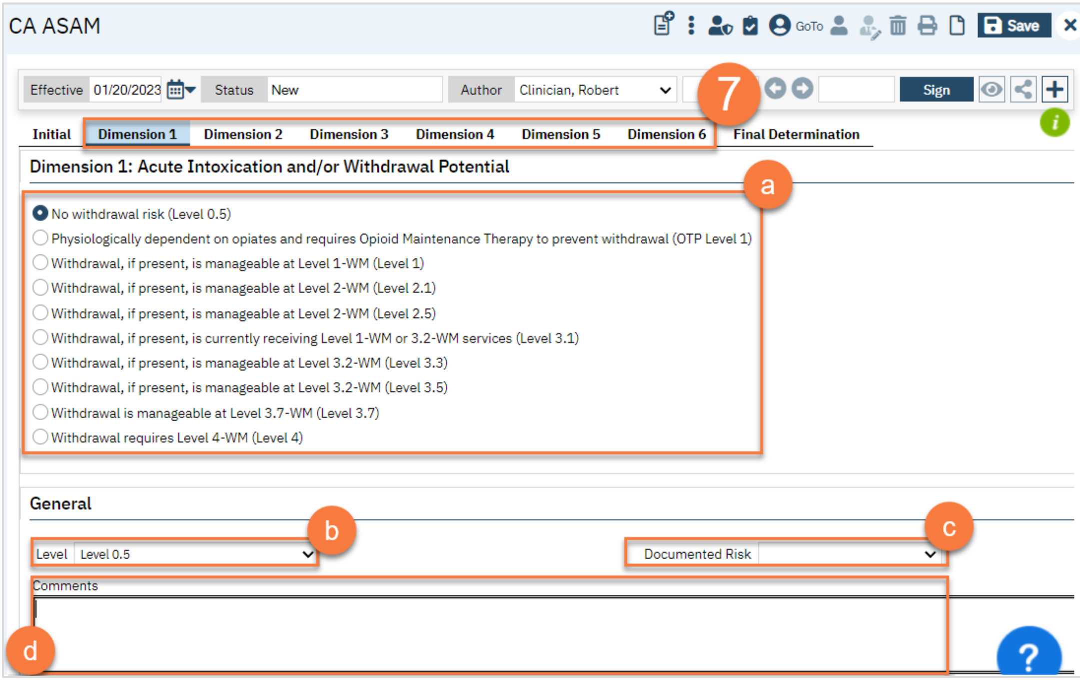
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



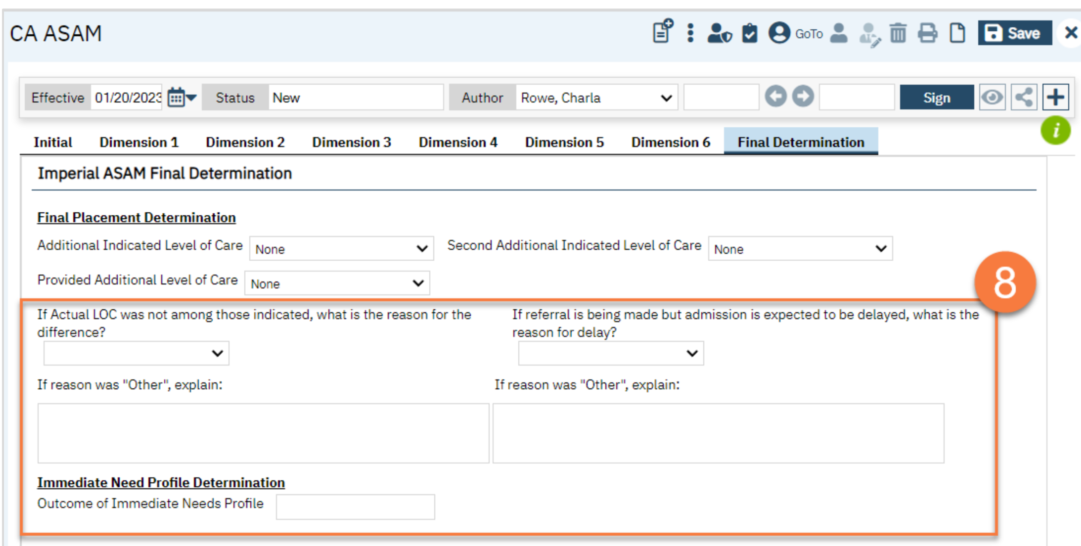
6. The ASAM document will open. In the Initial tab, **enter the type of assessment** this is.



7. **Complete each Dimension tab.**
   a. Each will have a section for you to **enter the risk level**.
   b. This will auto-populate the level in the General section of the tab.
   c. **Enter the documented risk** (low, moderate, or high).
   d. **Enter your comments.**

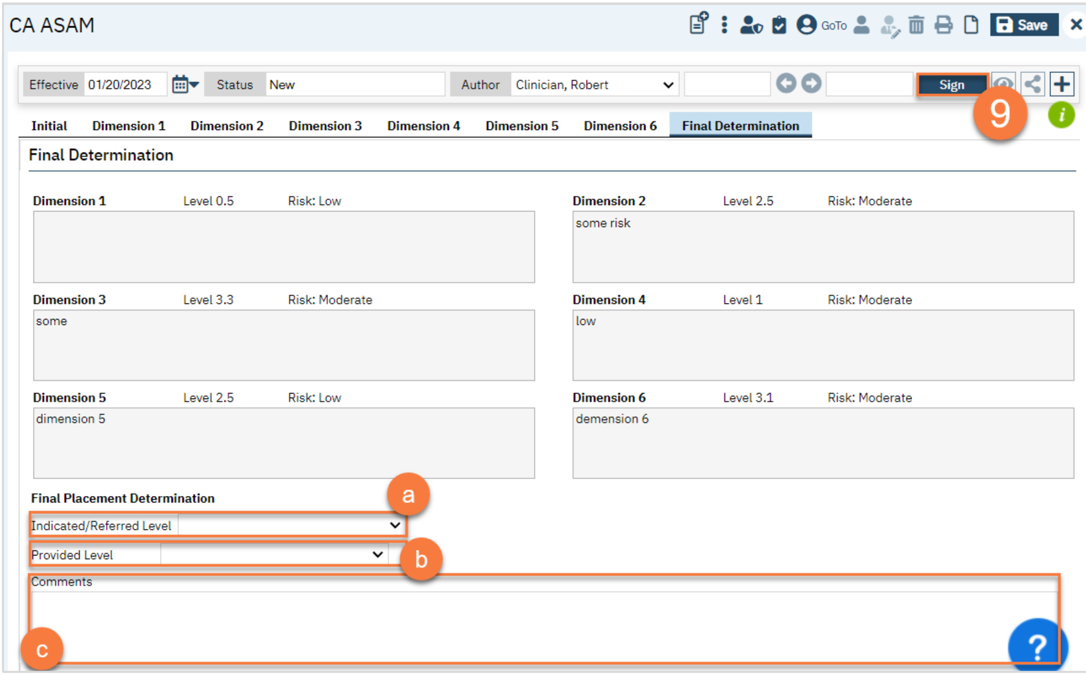


8. **Navigate to the Final Determination tab**. This will pull in the information you entered in all the dimension tabs, including your comments. **Enter the Final Placement Determination**.



   a. **Enter the Indicated/Referred Level**. This is the level you think the client needs, based on ASAM criteria.
   b. **Enter the Provided Level**. This is the level you actually referred the client to.
   c. **Enter your comments**, including a justification if there is a discrepancy between the indicated level and the provided level.

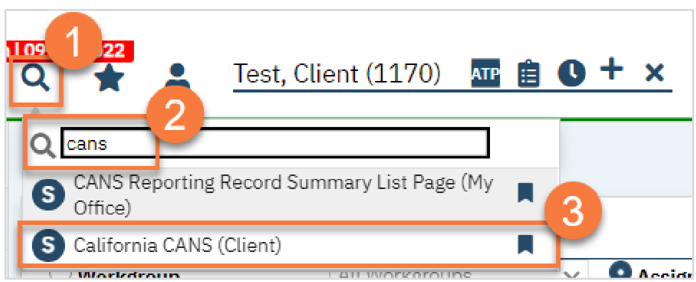
9. **Click Sign** to complete and generate the document.



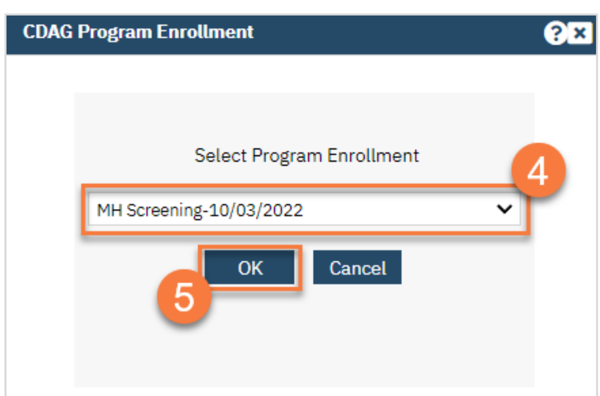
Child and Adolescent Needs and Strengths (CANS) Tool

The Child and Adolescent Needs and Strengths tool, or CANS, is required for youth mental health clients ages 6-20.

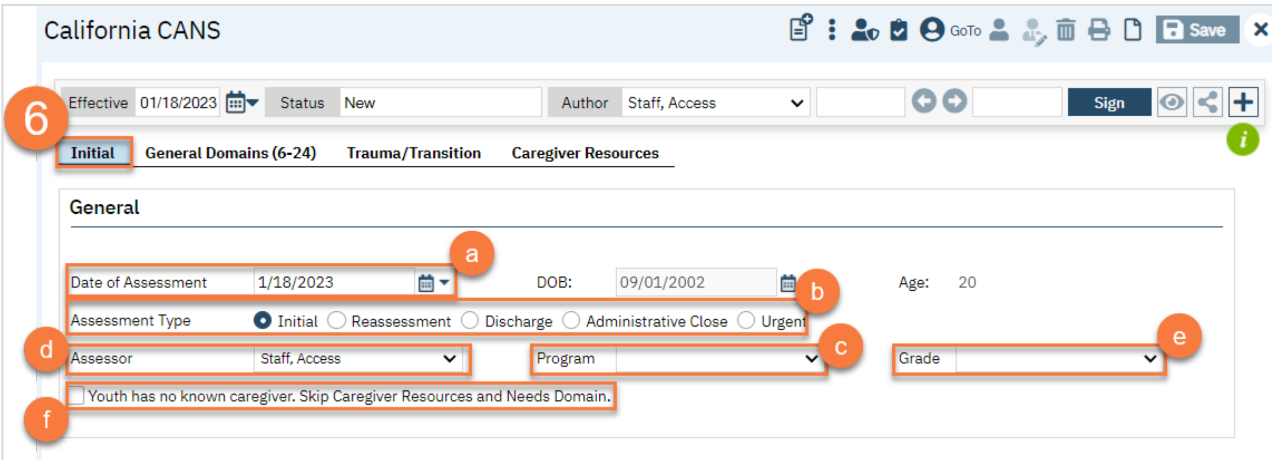
10. You must first have the client open, **click the Search icon**.
11. **Type CANS** into the search bar.
12. **Click to select California CANS (Client).**



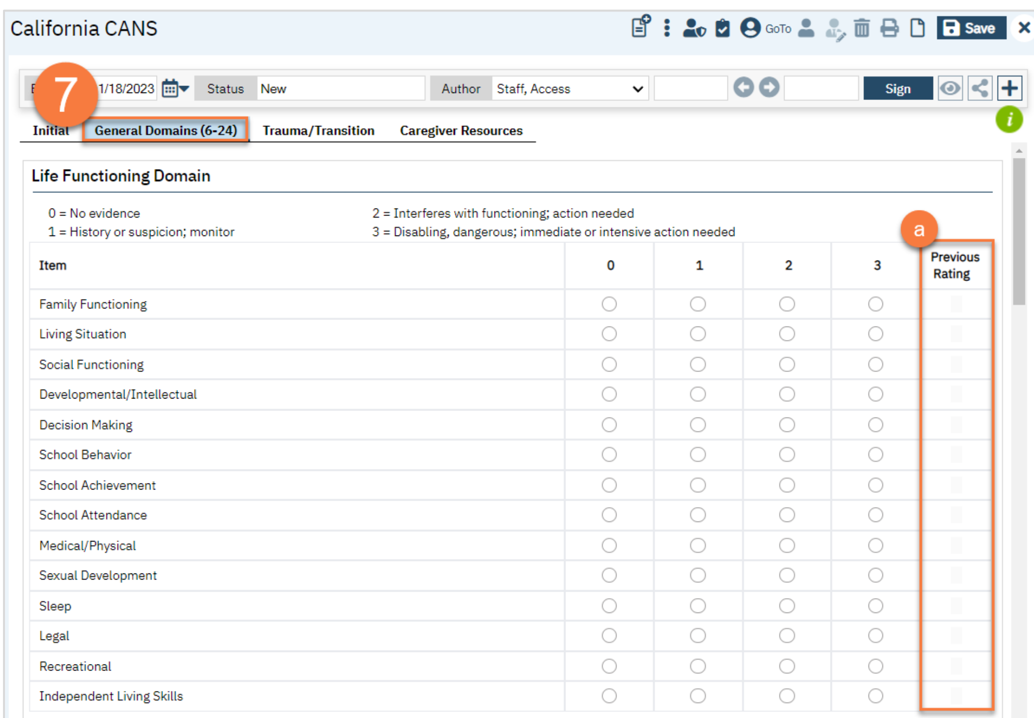
13. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
14. **Click OK** to continue.



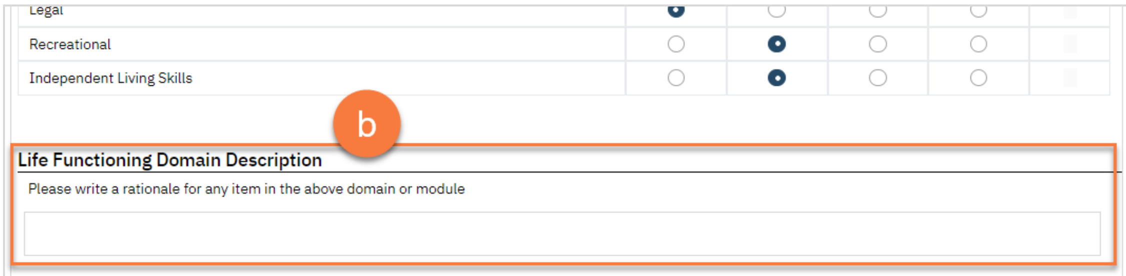
15. The CANS document will open. **Complete the general information** about the CANS in the Initial tab.
    a. **Enter the date of the assessment**. This auto-populates to today's date, but may be changed as necessary.
    b. **Select the Assessment type**.
    c. **Enter your program**.
    d. If you're entering the CANS as a proxy for someone else, you may also change the Assessor field.
    e. Enter the client's grade.
    f. If the client does not have a caregiver, check the box. This will hide the Caregiver Resources tab.



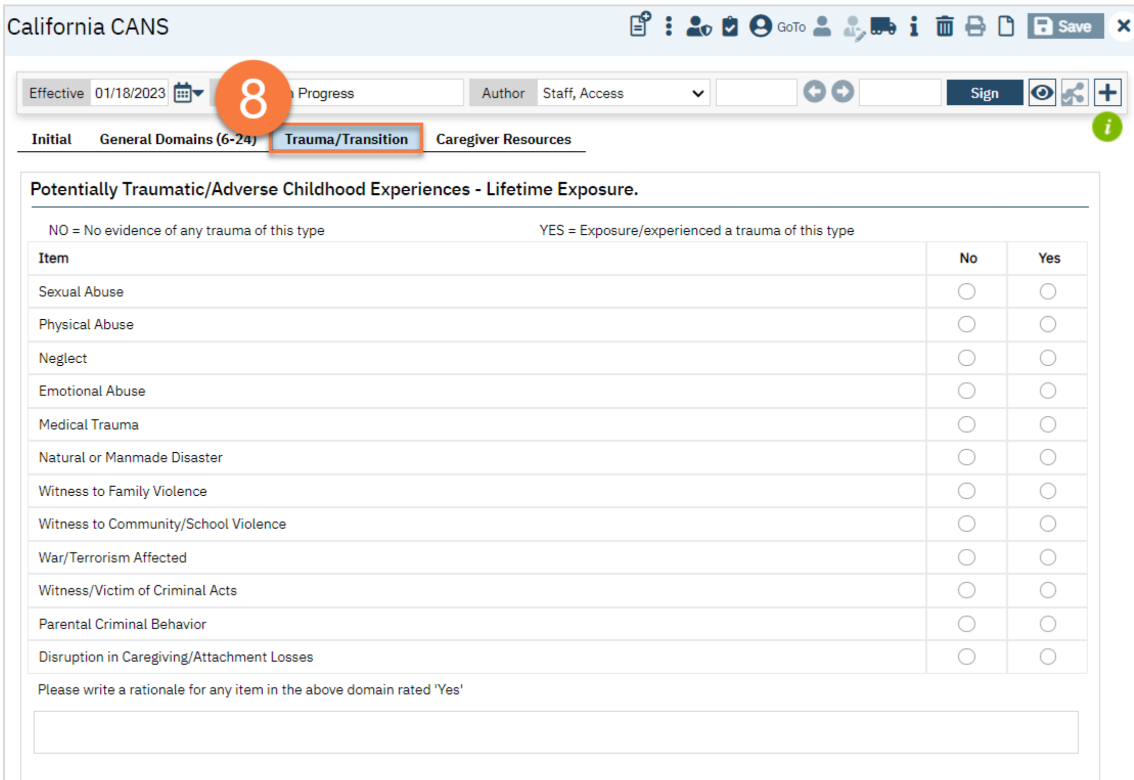
16. **Navigate to the General Domains** tab and complete the CANS tool.
    a. If this is not an initial assessment, the most recent CANS scores will show to provide you with additional information.



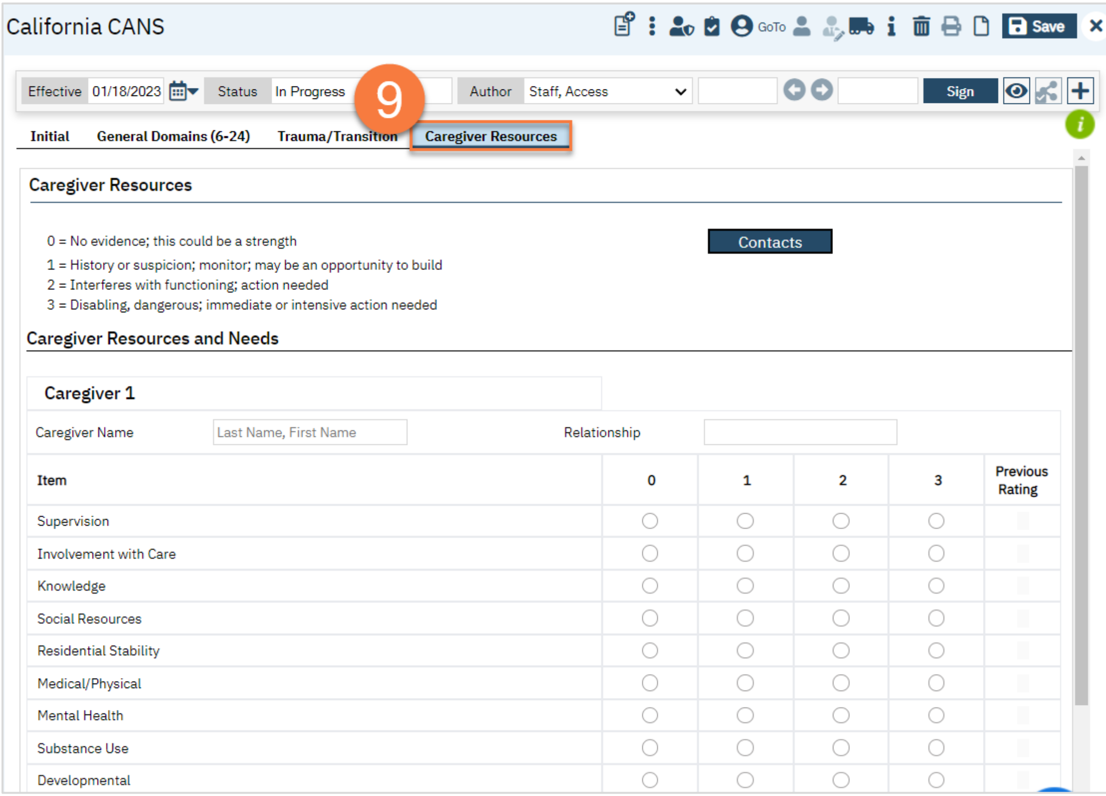
    b. At the end of each section is a comment box for your clinical notes.



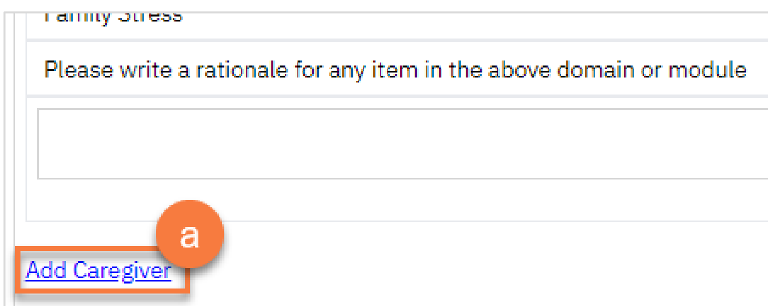
17. Navigate to the Trauma/Transition and complete this section.



18. If available, navigate to the Caregiver Resources tab and complete this section.



a. You can add multiple caregivers by clicking on the "Add Caregiver" link at the bottom of the page.



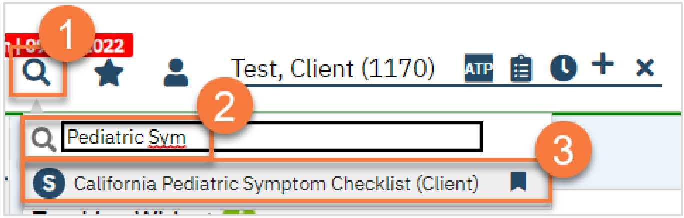
19. **Click Sign** to complete and generate the document.

Pediatric Symptom Checklist (PSC)

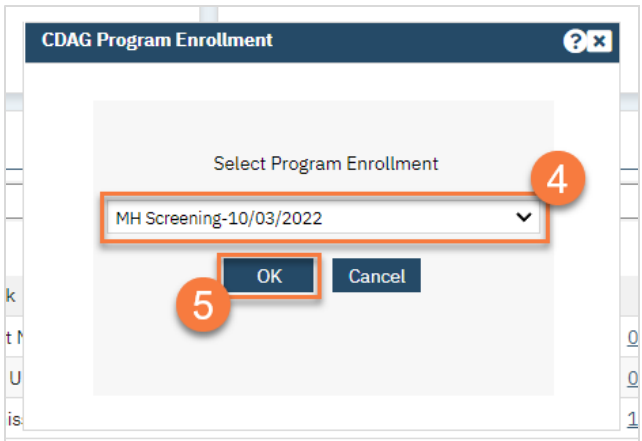
The Pediatric Symptom Checklist, or PSC or PSC-35, is required for youth mental health clients ages 0-18.

1. You must first have the client open, **click the Search icon**.
2. **Type Pediatric Symptom Checklist** into the search bar.

3. **Click to select California Pediatric Symptom Checklist (Client).**



4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



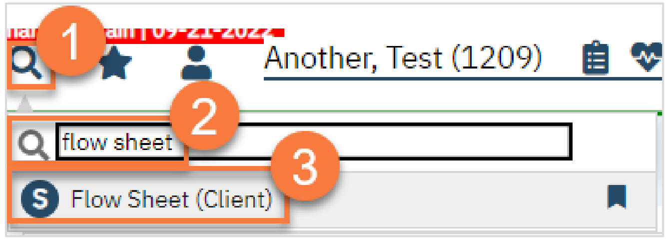
6. The PSC document will open. **Complete the document**. The PSC-35 is a form that is completed by the youth's caregiver. This may be done on paper and entered into this document for better tracking. You may also want to scan in the paper version the guardian completed. If so, see How do I scan a document into the client's record?

[screenshot]

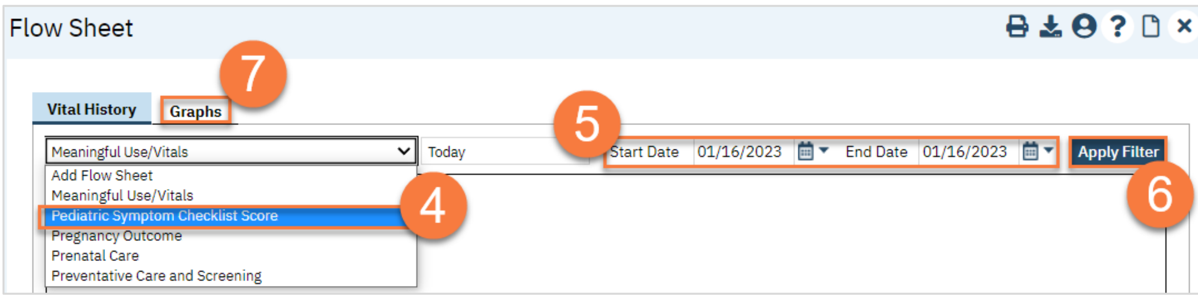
7. **Click Sign** to complete and generate the document.

How do I view the PSC scores over time?

1. Have the client open. **Click on the Search icon**.
2. **Type "Flow Sheet"** in the search bar.
3. **Select "Flow Sheet (Client)"** from the search results.



4. This takes you to the Flow Sheets page. **Select the Pediatric Symptom Checklist Score** from the dropdown menu.
5. **Select your start and end dates** that you'd like to see.
6. **Click Apply Filter**.
7. You can also view this information in graphical form by clicking on the Graphs tab.



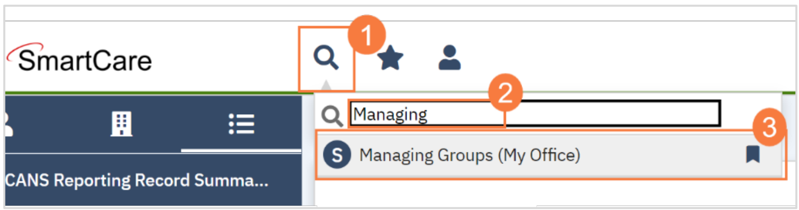
Group Documentation

Introduction to group documentation will go here…

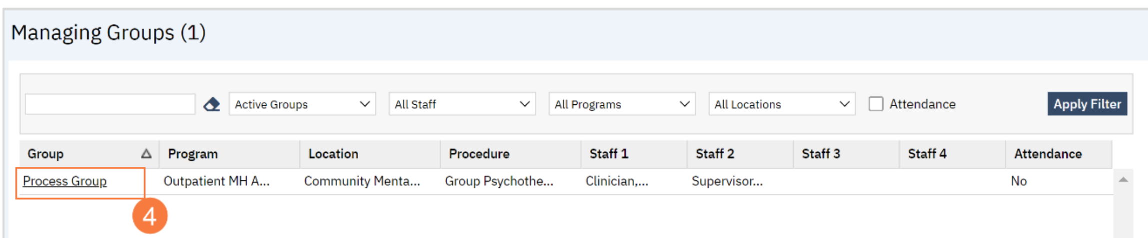
How to Add a New Client to a Group

To add a new client to a Group, follow the steps below:

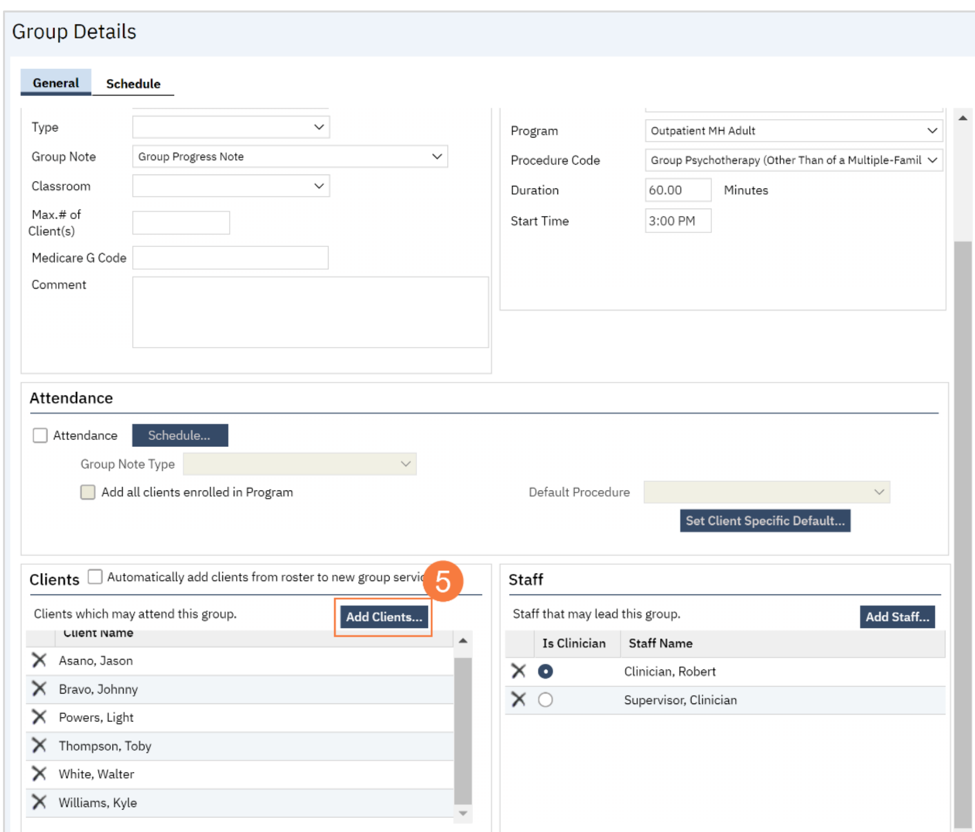
1. **Click the Search icon**.
2. **Type Managing** into the search bar.
3. **Click to select Managing Groups (My Office).**



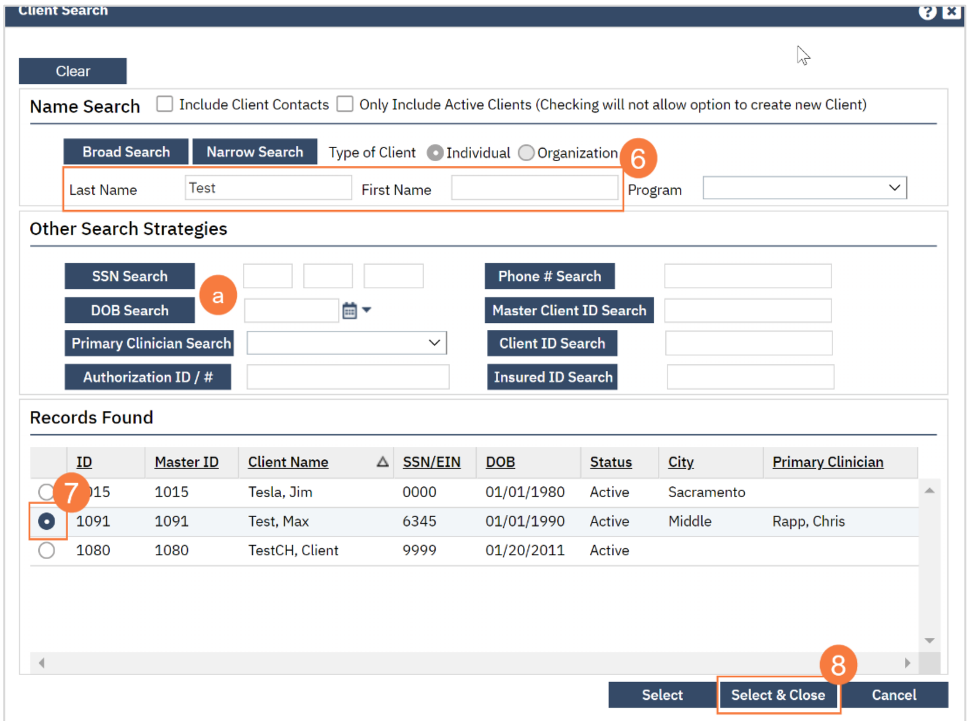
4. **Click to select the Process Group** you will be adding the client to.



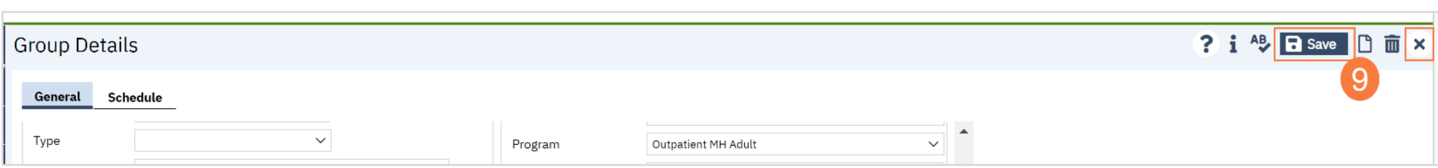
5. Locate the Client section towards the bottom of the Group Details screen. **Click Add Clients**.



6. The Client Search window will open, **click in the Last Name and First Name fields** to enter the corresponding information. **Select Enter** on your Keyboard to populate search results.
    a. You can also use the Other Search Strategies fields to search by SSN, DOB, etc.
7. **Click the radio button** to left of the client you want to select.
8. **Click Select and Close.** This client will be added to the group**.**



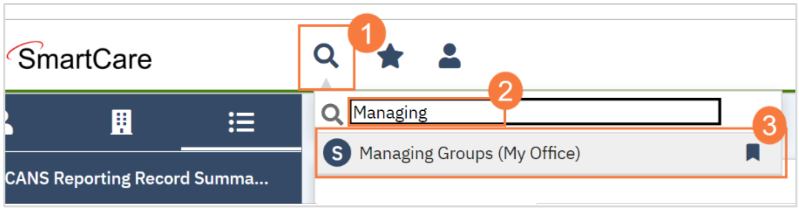
9. **Click Save. Click the X** to close the screen.



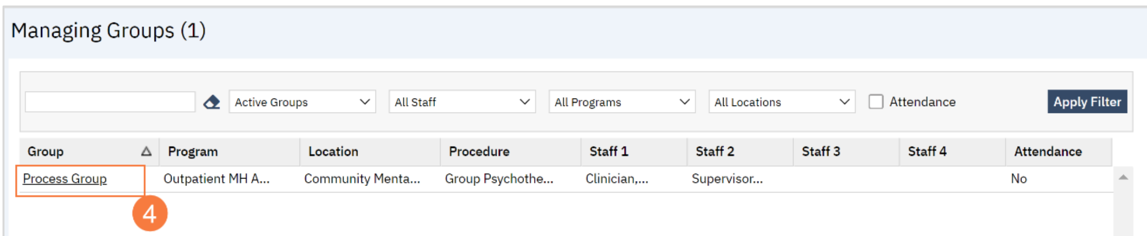
How to Add or Change a Staff Member in a Group

To add or change a staff member in a group, follow the steps below:

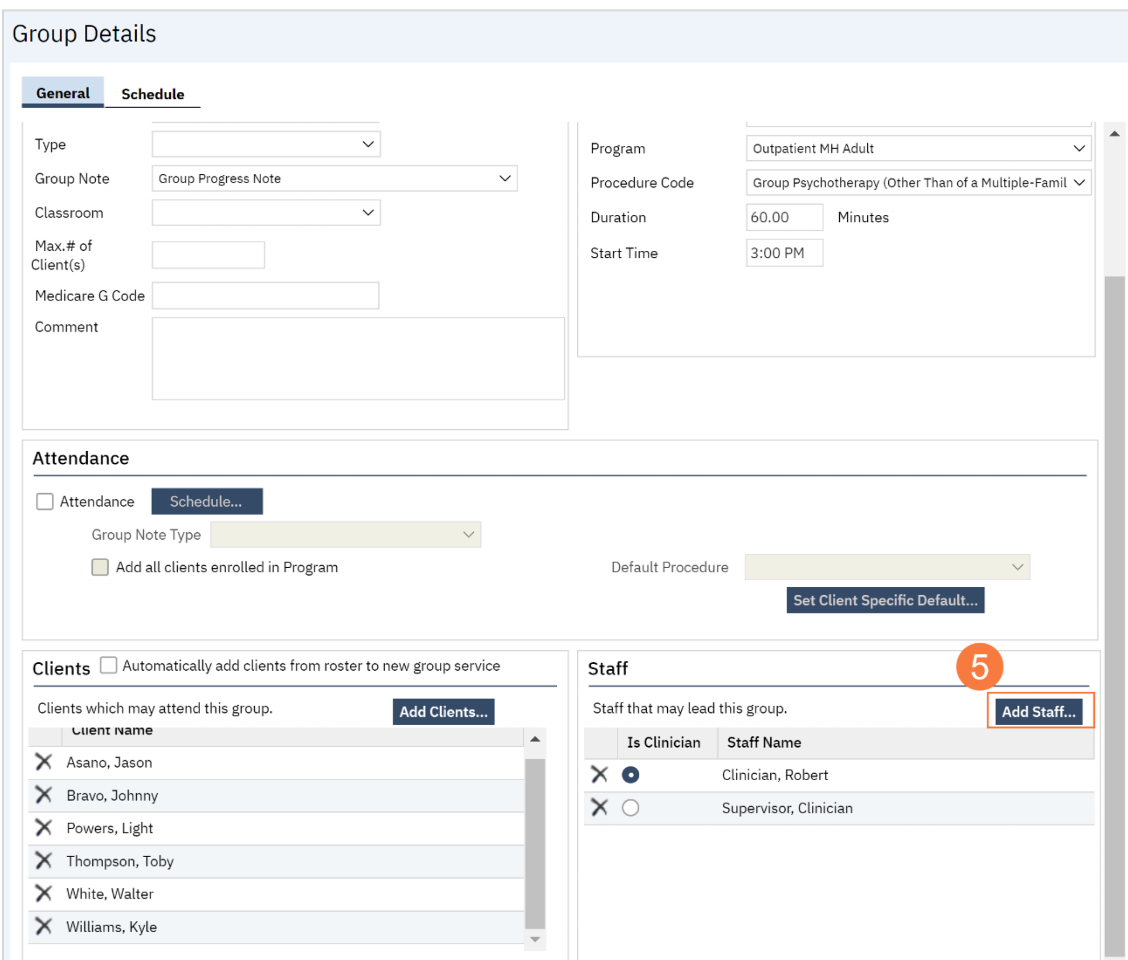
1. Click the Search icon.
2. Type Managing into the search bar.
3. Click to select Managing Groups (My Office).



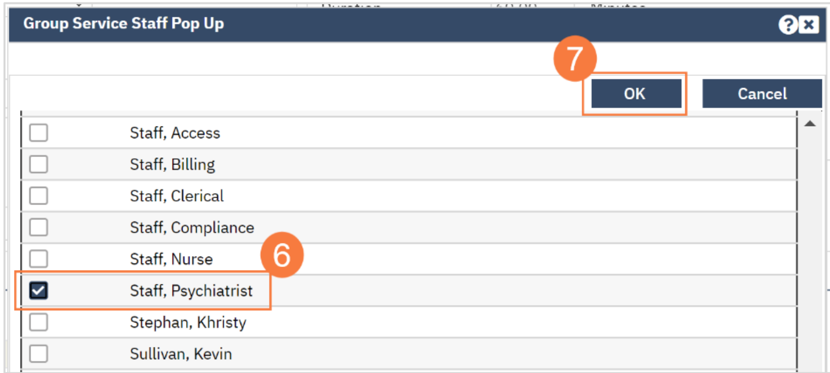
4. Click to select the Process Group you will be adding the client to.



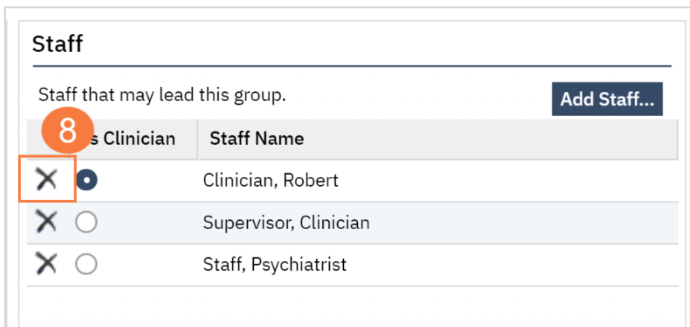
5. Locate the Staff section towards the bottom of the Group Details screen. Click Add Staff.



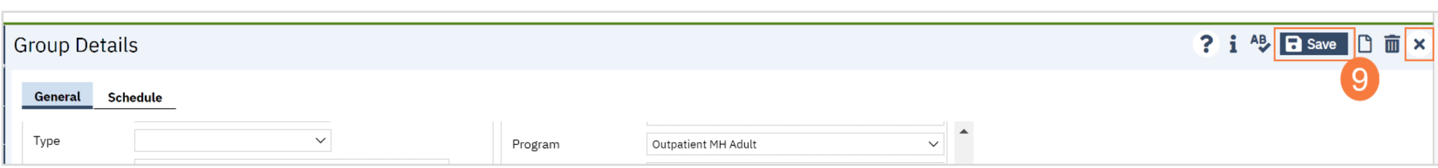
6. **Click to select** the correct staff member to add.
7. **Click OK**.



8. And/or, if you need to remove a staff member, **click the X** to the left of the staff member you want to remove.



9. **Click Save. Click the X** to close the screen.

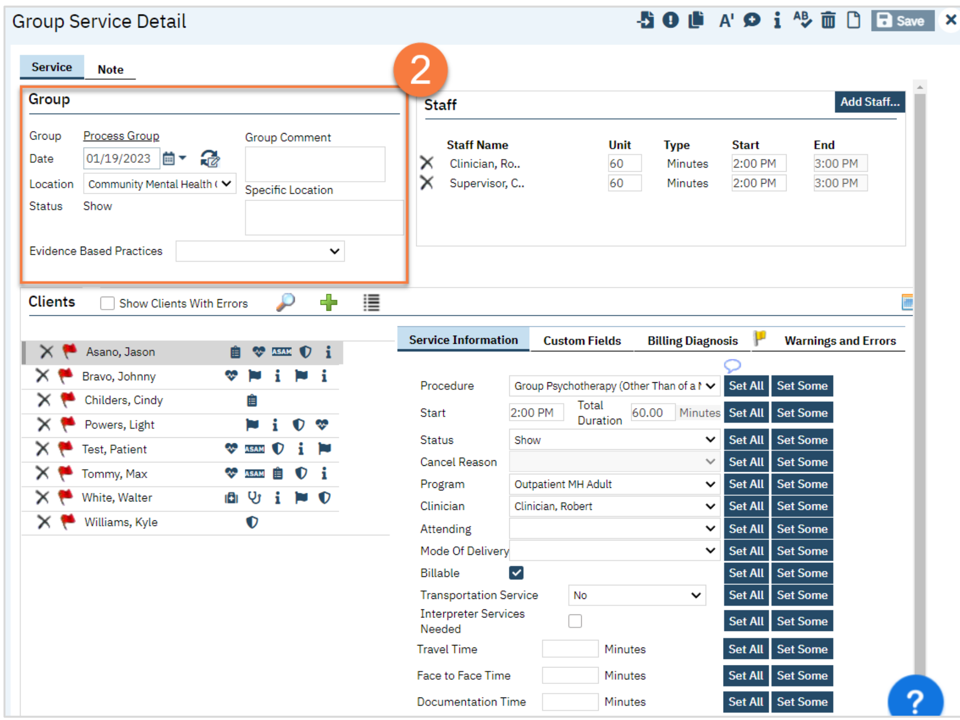


How do I write a group progress note?

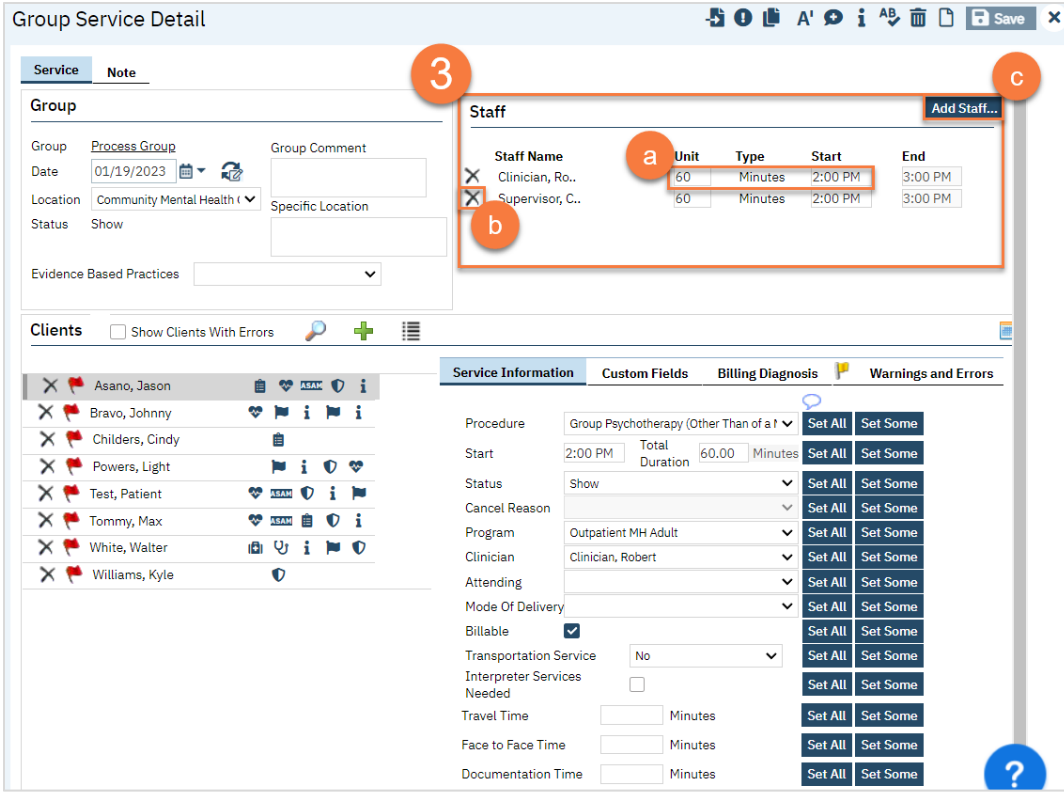
6. **On your Appointments for Today widget, click on the link for the time of the group you're documenting**.

screenshot

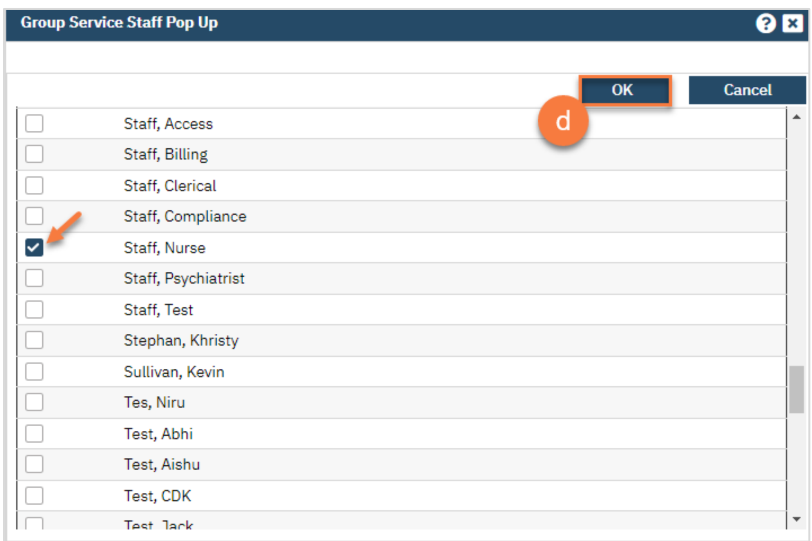
7. This opens the Group Services Detail screen. In the upper left, you'll see the group information. Confirm the information and **add any additional information regarding the entire group**.



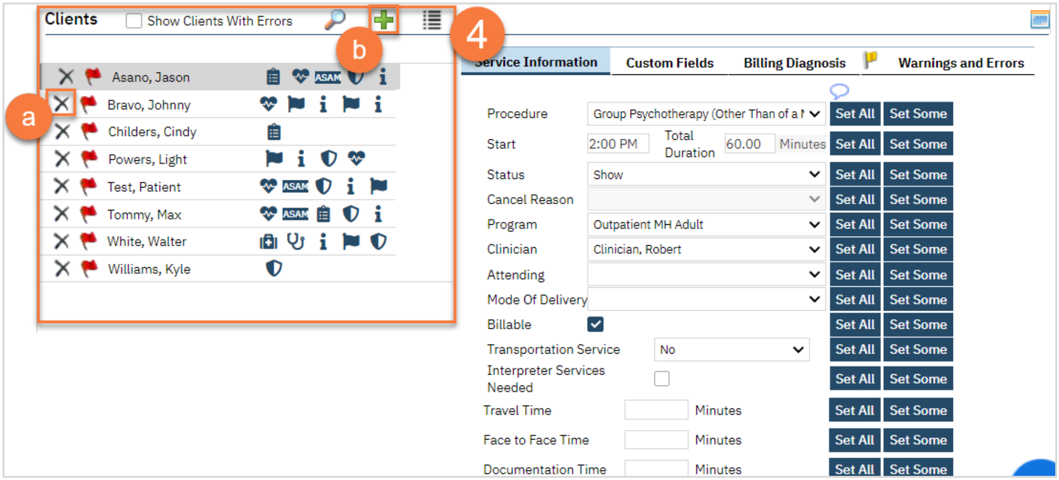
8. In the upper right, you'll see the staff members that are set as facilitators for this group.
   a. **Make edits to which staff members were present**. For example, if a staff was only present for half of the group time, indicate this by editing the Unit (how many minutes they were present) and the Start Time to match what actually happened.
   b. **If a staff member was not present, click the Delete icon** next to their name to remove them from this service.
   c. **If an additional staff member was present who is not listed, click the Add Staff button**.



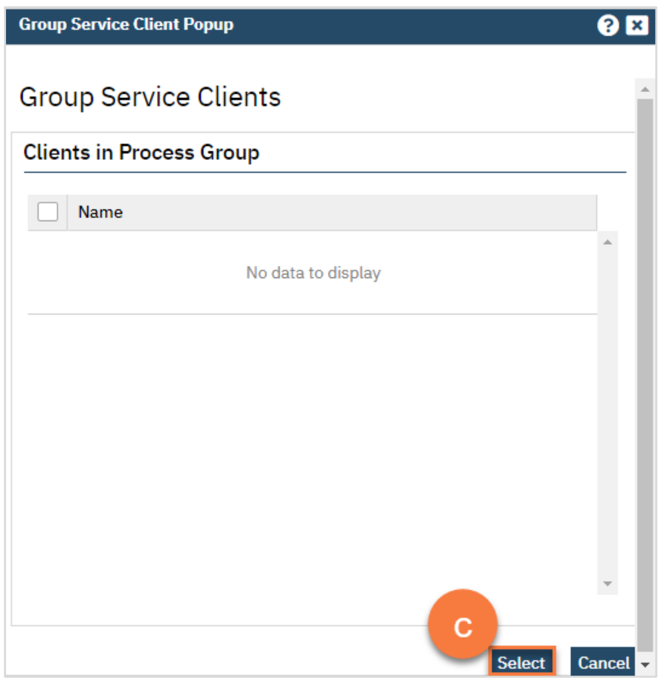
d. This brings up the Group Service Staff Pop Up. **Select the staff member(s) you want to add and click OK**.



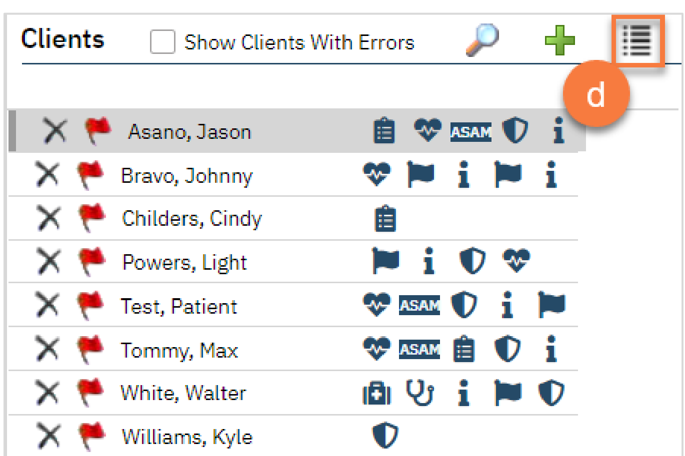
9. On the middle left side of the screen, you'll see the list of clients enrolled in this group. **Make edits to this list to confirm the group roster**.
    a. **To remove a client from the roster, click the Delete Service icon**. DO NOT do this if they are simply a no-show. Only do this to remove them from this service's roster entirely.
    b. **To add a client who has already been enrolled in this group, click the Plus icon**.



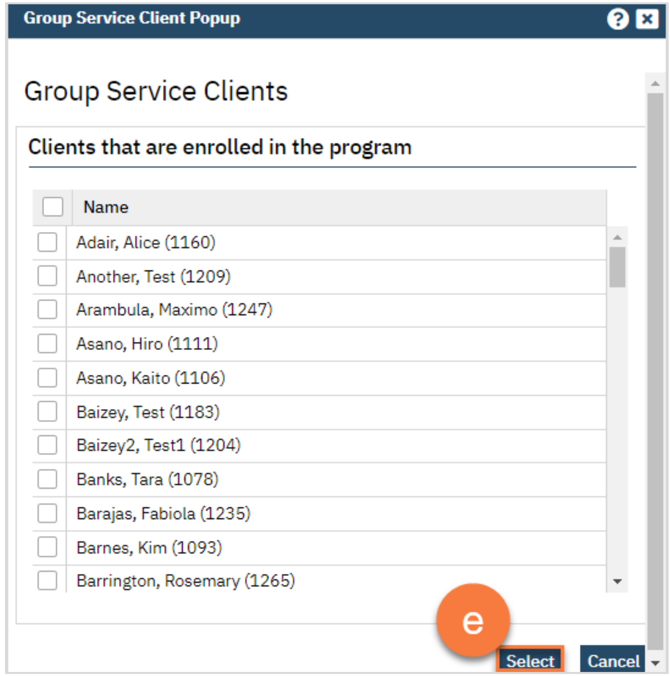
c. This will open up the Group Service Client Popup, which will list any additional clients that are enrolled in this group. **Select the client and then click Select** to add them to this service.



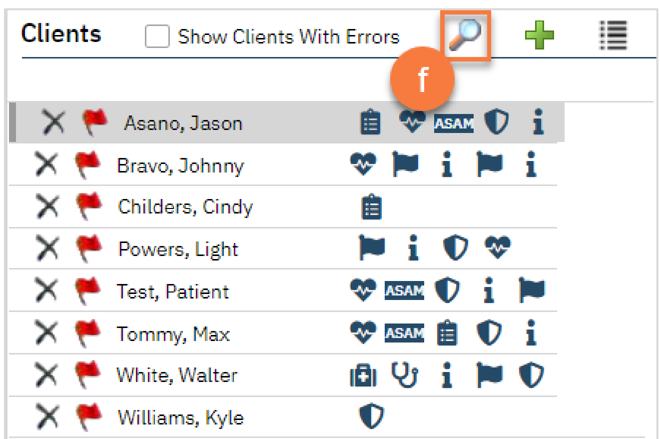
d. **To add a client who is enrolled in this program but not yet enrolled in this group, click the List icon.**



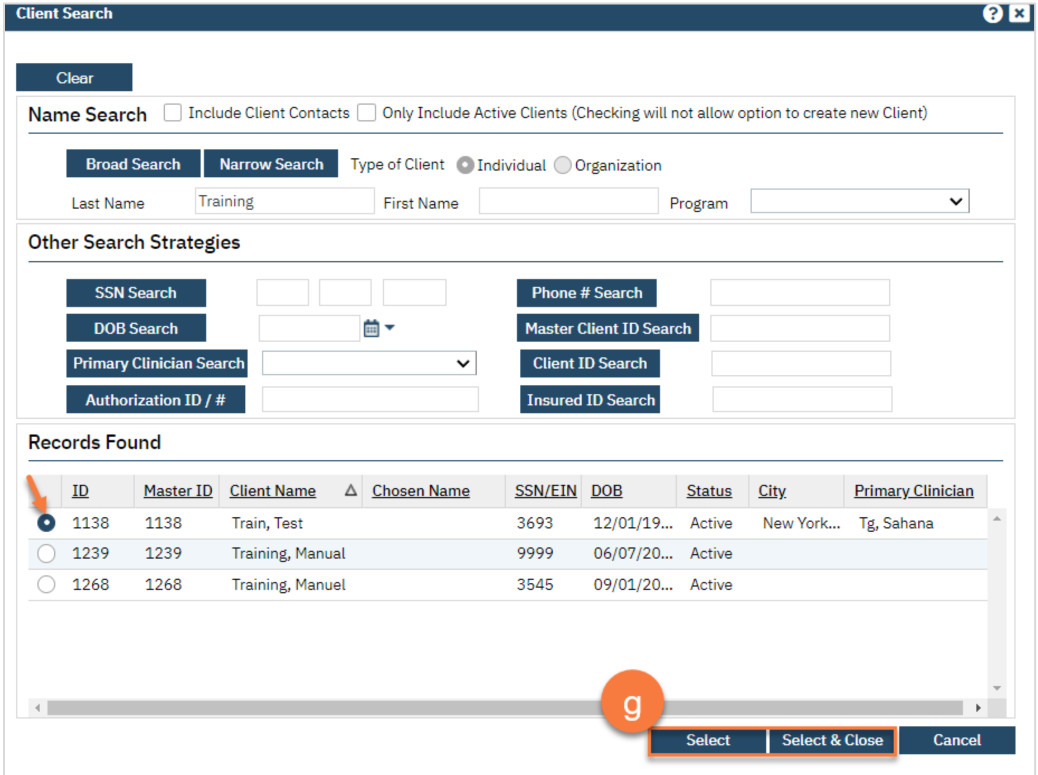
e. This will open up the Group Service Client Popup, which will list any clients that are enrolled in this program but are not yet enrolled in this group. **Select the client(s) you want to add and click Select** to add them to this service.



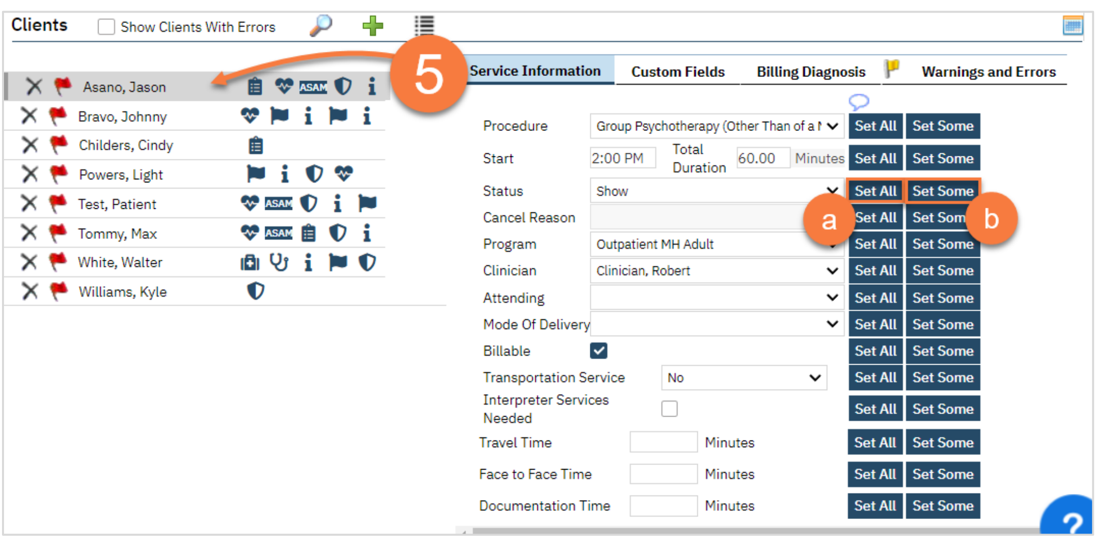
f. **To add a client from another program, click on the Magnifying Glass icon**.



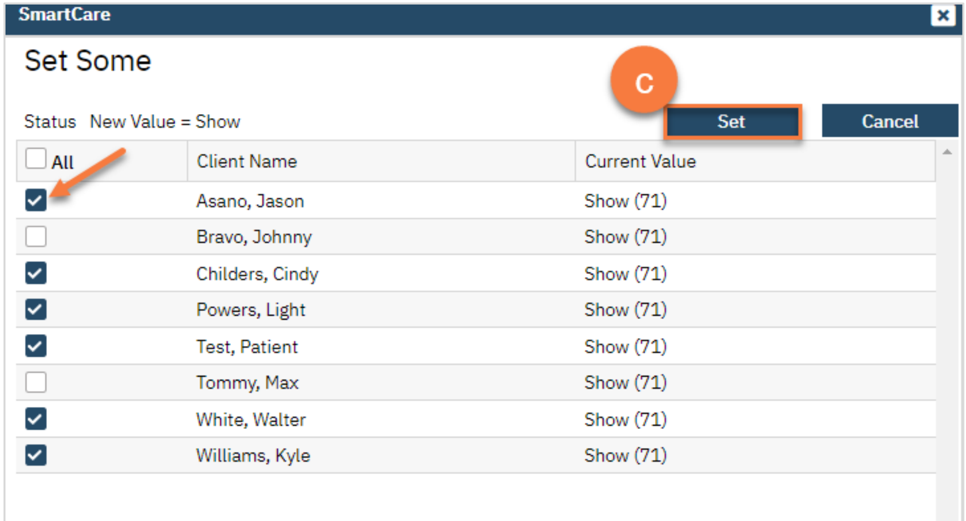
g. This will bring up the client search function. **Search for the client you want to add and click Select & Close**. If you want to add more than 1 client, you can simply click Select and then search for the next client you want to add.



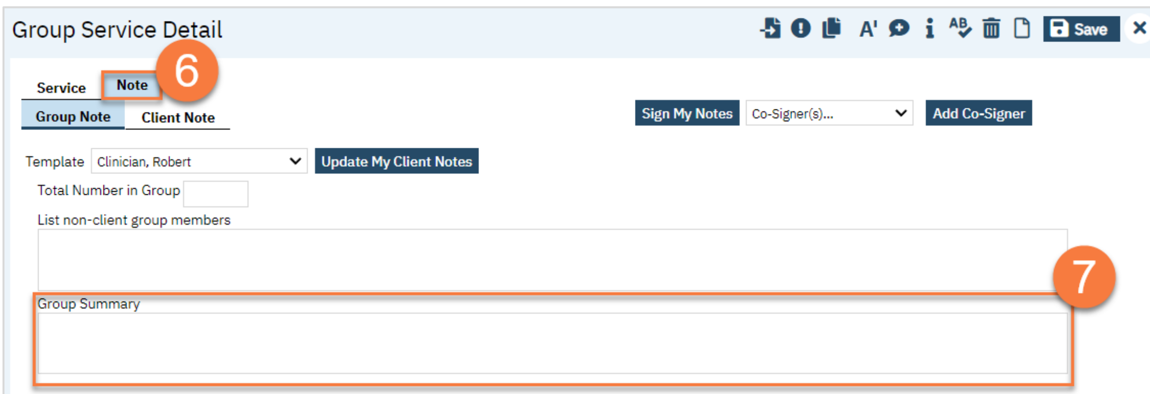
10. Once you have your group roster set up, move to the service information section. The first client will be highlighted. As you make changes, this will update this particular client. This is where you mark whether clients who were a no-show for the group, or who canceled.
    a. If you want **to set this information for all of the clients, click the “Set All” button**. You can do this for each item in the service information section.
    b. If you want **to set this information for more than one client, but not all of them, click the “Set Some” button**.



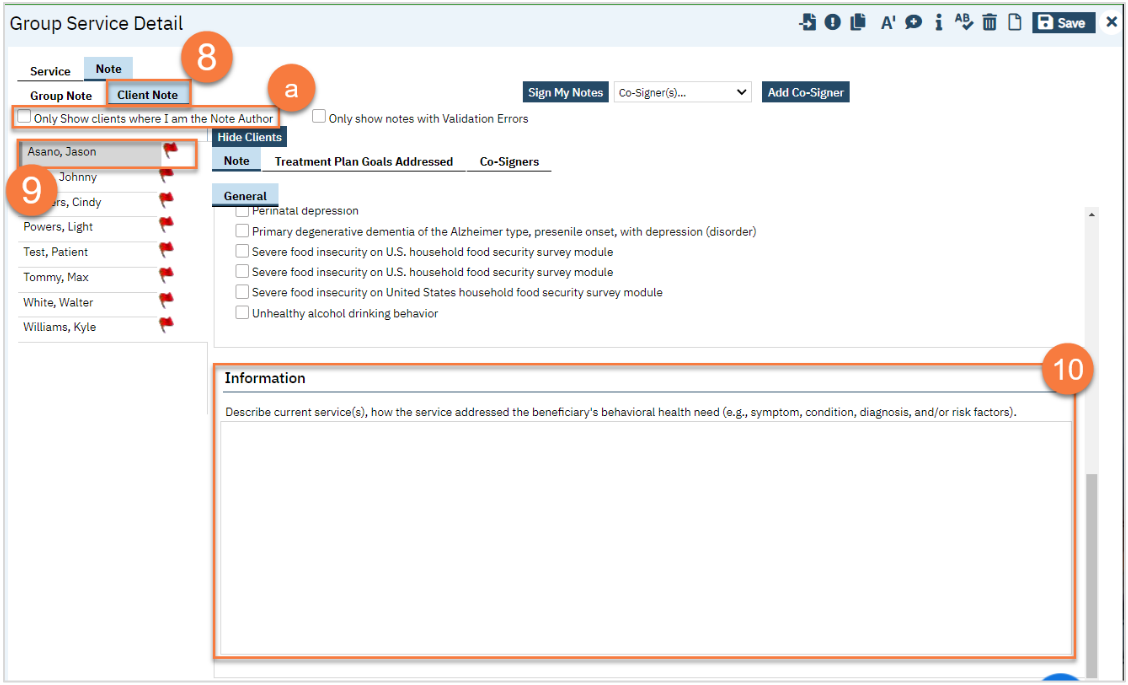
    c. This will bring up the Set Some pop-up window. **Select the clients you want to include in this change** (e.g. all the clients who you want to mark as “show”). Then **click Set**.



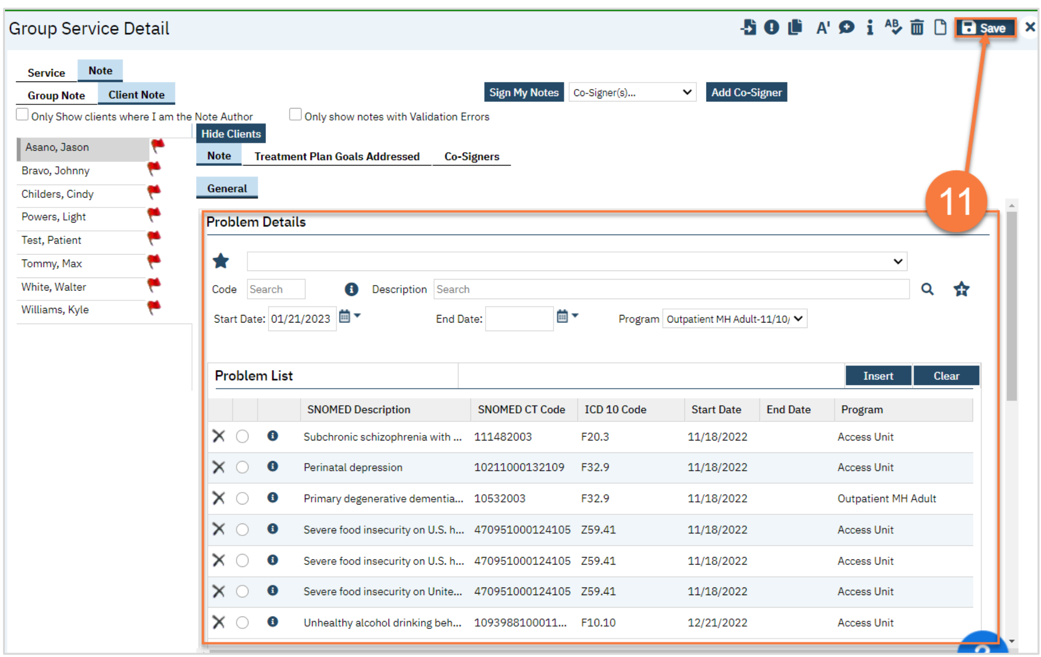
11. Once you've completed the service information, **navigate to the Note tab**.
12. **Enter the group note summary**. This will be pushed to all of the group member's notes.



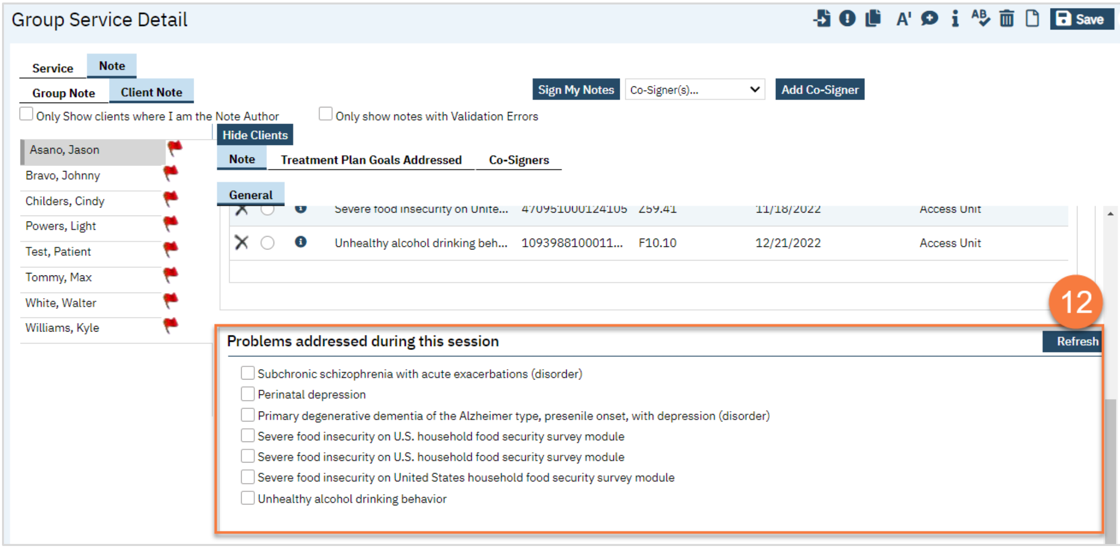
13. **Navigate to the Client Note tab**.
14. On the left side of the screen, **select the client** you're writing the note for.
    a. You can **click on the checkbox "Only Show clients where I am the Note Author"** to limit the clients on the list.
15. On the right side of the screen, **enter the individual client's note** for this group service.



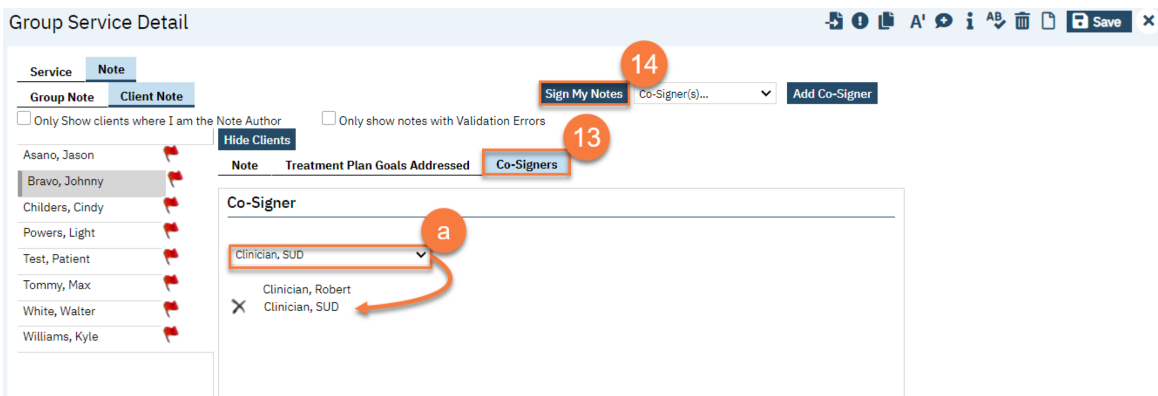
16. **Add problems to the problem list as necessary**. See Problem List for more information. After adding any problems, make sure to click Save.



17. **Select problems that were addressed in today's session**. If you've added any problems to the problem list during this note writing, click Refresh to update this list.



18. To add Co-Signers as necessary, **navigate to the Co-Signers tab**.
    a. **Select the staff from the dropdown menu**. This will add them to the list of people who will be asked to co-sign the note.
19. Once you're finished with all of your notes, **click "Sign My Notes."**



Referrals and Transfers

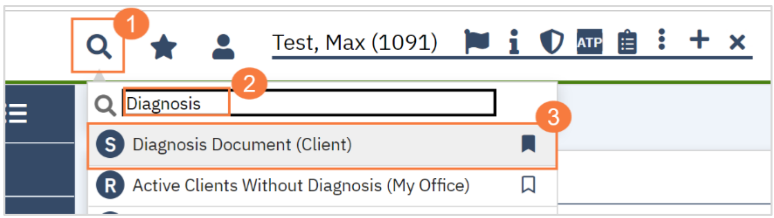
Diagnosis Entry

In this section, you will learn how to add a diagnosis, update a diagnosis, deleted a diagnosis, and how to favorite a diagnosis.

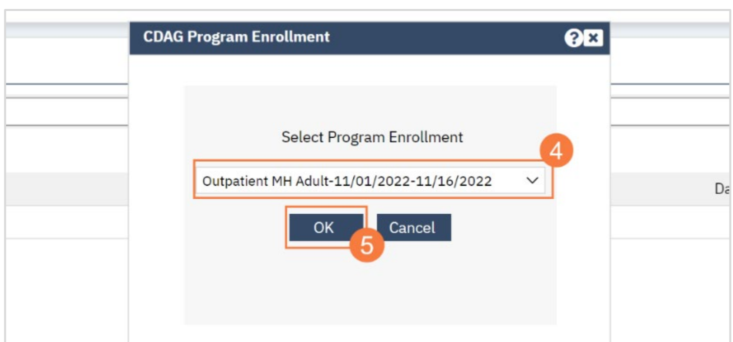
How to Add a Diagnosis

To add a diagnosis, follow the steps below:

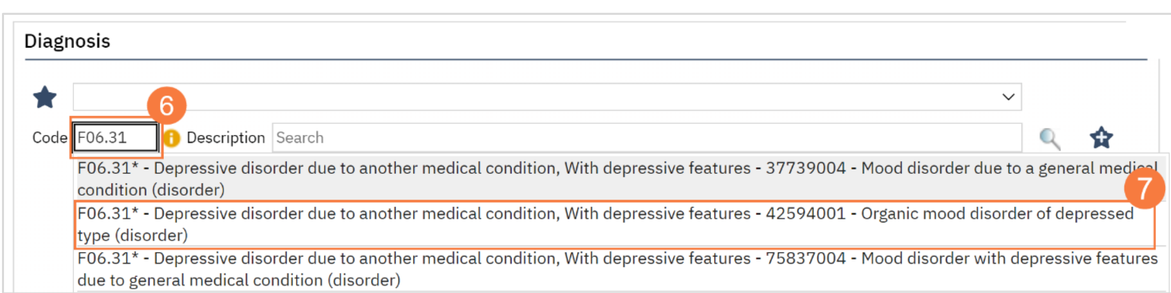
1. You must first have the client open, **click the Search icon**.
2. **Type Diagnosis** into the search bar.
3. **Click to select Diagnosis Document (Client).**



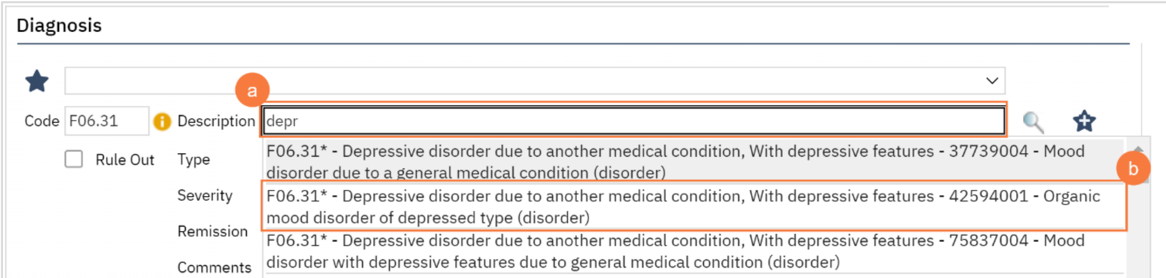
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



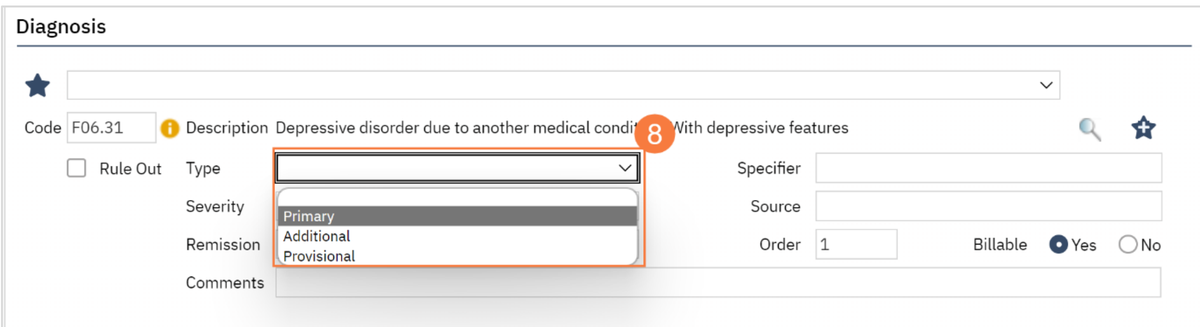
6. The Diagnosis Document screen will open, **click in the code field** and **enter the diagnosis code**.
7. A list of matching diagnoses will populate, **click to select** the appropriate diagnosis



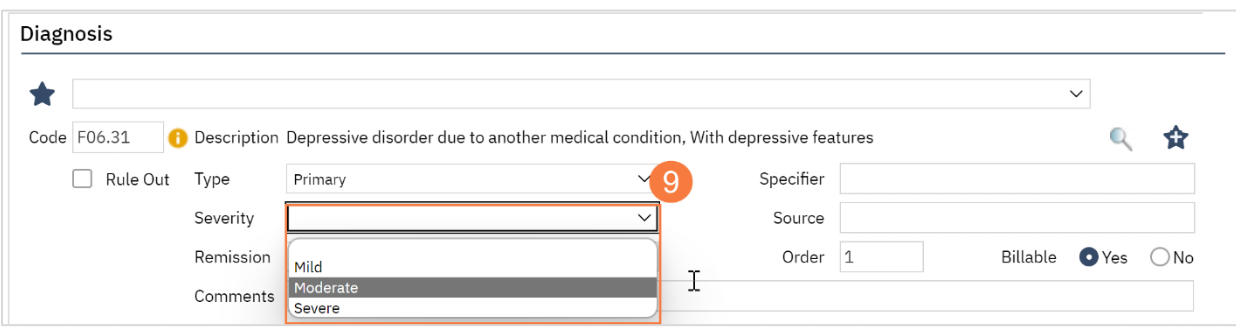
a) Alternatively, you can **click in the Description filed** and **enter the diagnosis description**.
b) A list of matching diagnoses will populate, **click to select** the appropriate diagnosis



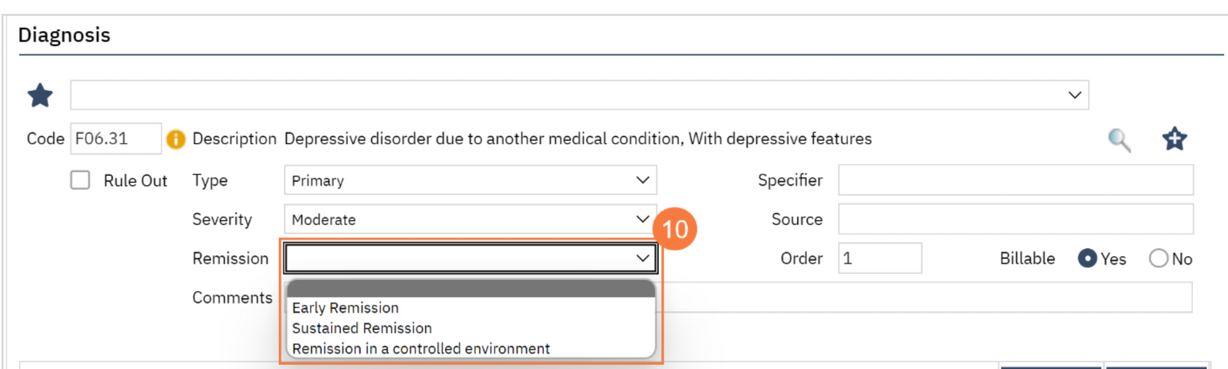
8. You must document if the diagnosis is Primary, Additional, or Provisional. **Click the drop-down menu in the Type field** and **select** the appropriate option.



9. If a severity level is appropriate, **click the drop-down menu in the Severity field** and **select** the appropriate option, mild, moderate, or severe.

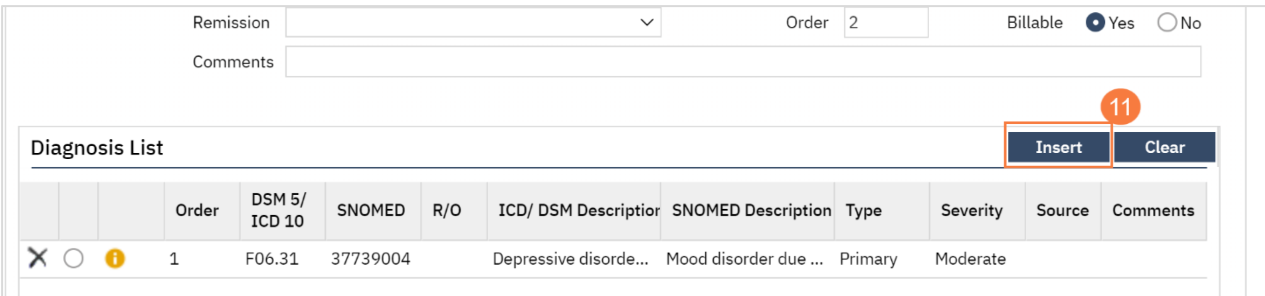


10. To document that the client is in remission, **click the drop-down menu in the Remission field** and **select** the appropriate option.



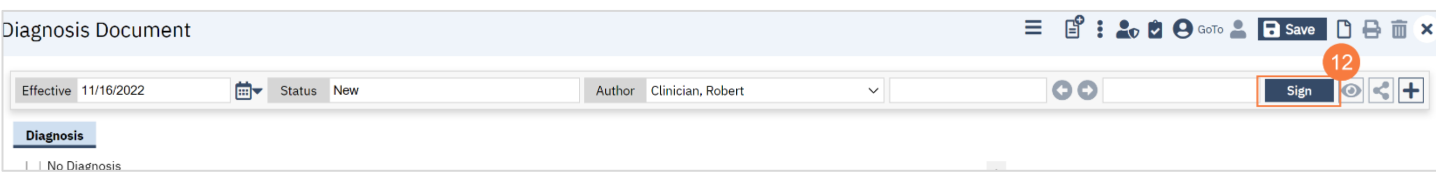
a. If this diagnosis is informational only and not a billable diagnosis, **click the No radio button in the Billable field**.

11. **Click the Insert button** to add the diagnosis. It will appear in the Diagnosis List grid below

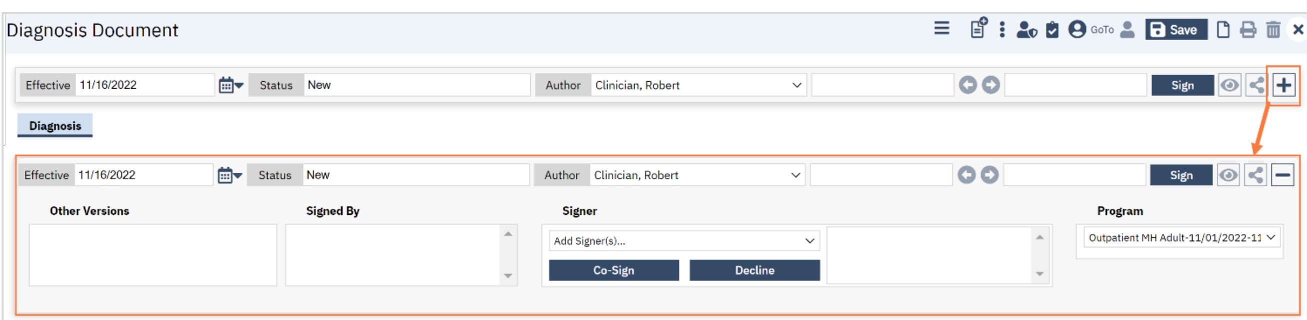


a) Repeat steps 1-12 for remaining diagnoses.

12. **Click Sign** to complete and generate the document.



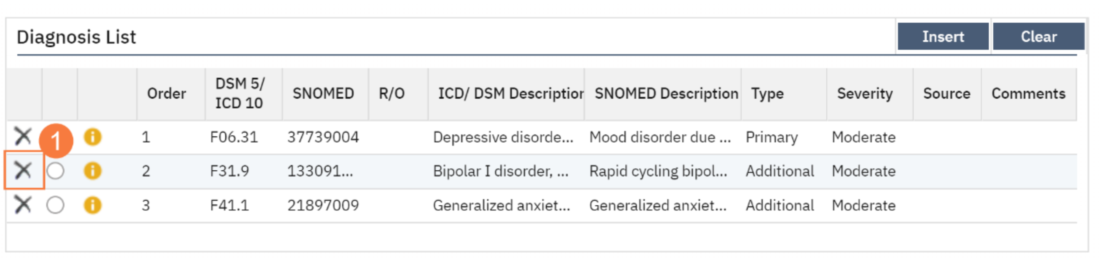
Note: If you need to review the programs the patient is enrolled in, **click the More Detail icon** at the top of the window.



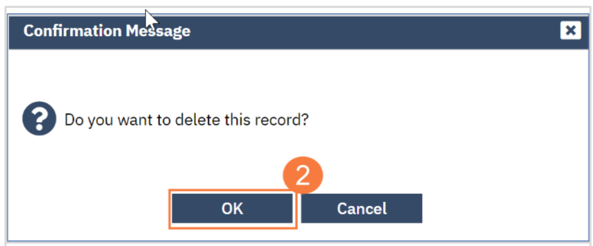
How to Delete a Diagnosis

To delete a diagnosis, follow the steps below:

1. **Click the X icon** to left of the diagnosis you want to delete.



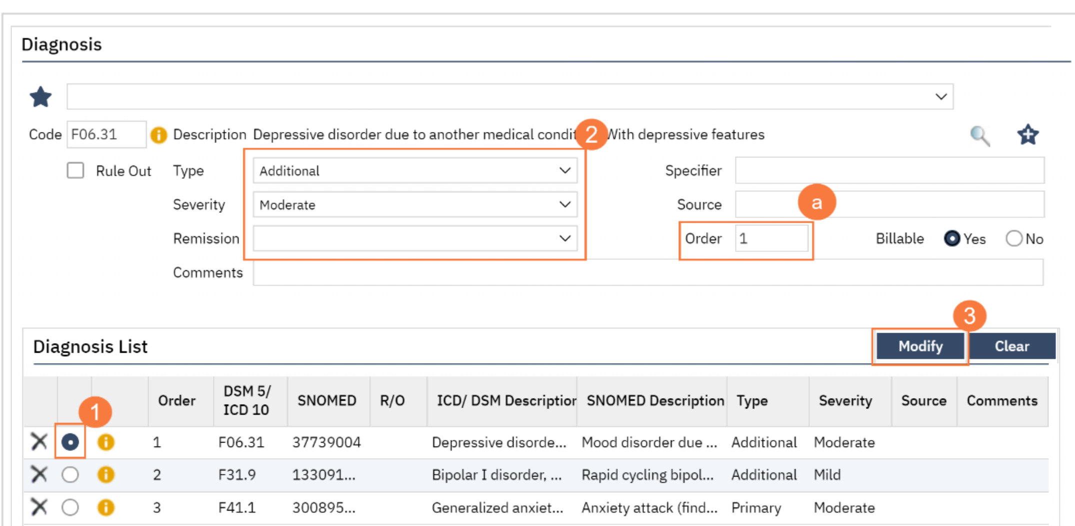
2. A prompt will appear and confirm you want to delete, **click OK.**



How to Modify and/or Re-Order a Diagnosis

To modify or re-order a diagnosis, follow the steps below:

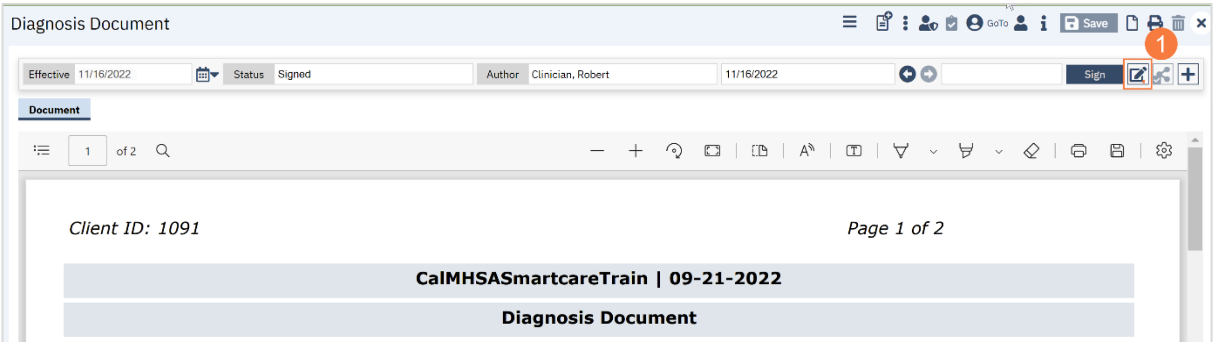
1. **Click the radio button** to the left of the diagnosis you need to update.
2. Make updates to the appropriate fields above.
   a. If you need to re-order your diagnosis, **click in the Order field** and enter the number you would like the diagnosis to appear in.
3. **Click Modify** to save your changes.



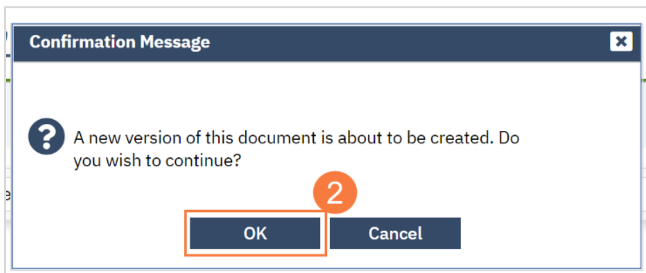
How to Modify a Diagnosis After the Document is Generated

To modify a diagnosis after the Diagnosis Document has been generated, follow the steps below:

1. Navigate to the Diagnosis Document, **click the Edit icon** at the top of the screen.



2. A confirmation window will open, asking if you want to proceed with making changes to the document. **Click OK.**

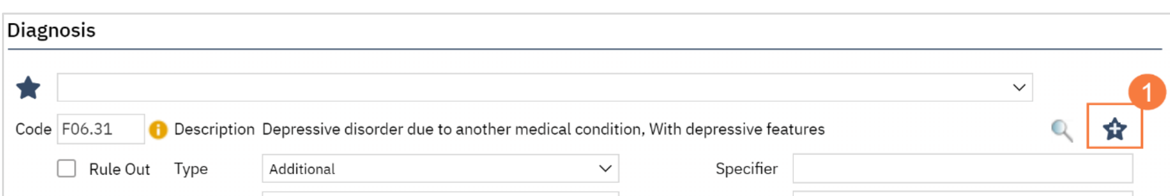


3. Make the necessary changes and click the Sign button when you are finished to regenerate the document.

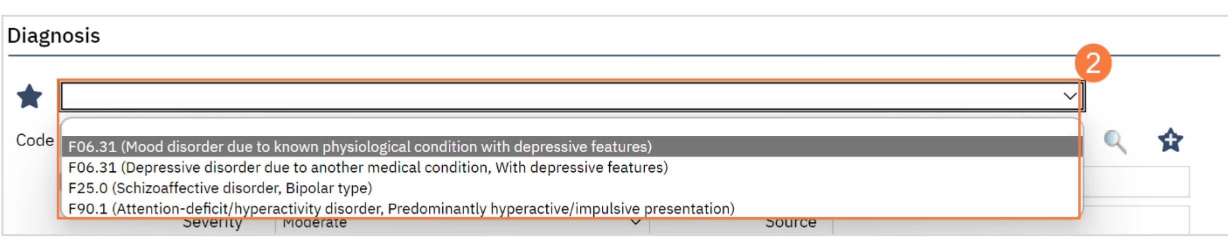
How to Save a Favorite Diagnosis

To add a diagnosis as a favorite, follow the steps below:

1. **Click the Add Favorite icon**, to right of the diagnosis.



2. To use the favorite diagnosis in the future, **click the drop-down menu** next to the favorite icon and select it.



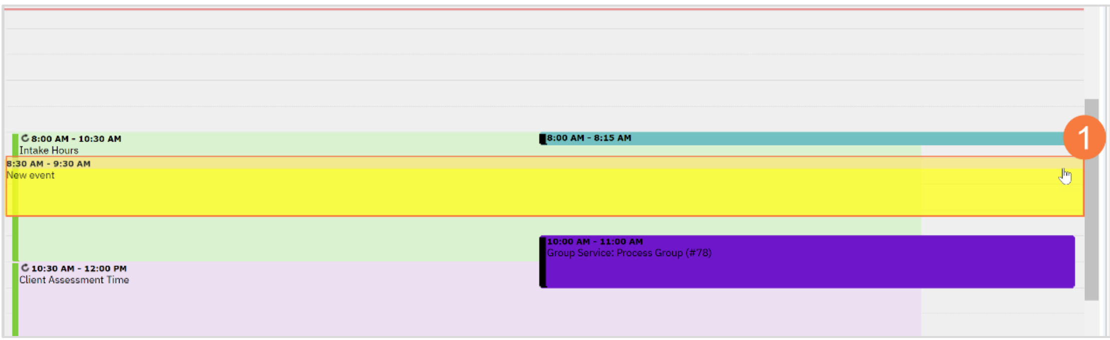
My Calendar Management

In this section you will learn how to create a client appointment, reschedule an appointment, and create non-client facing time on your schedule for paperwork, training, etc.

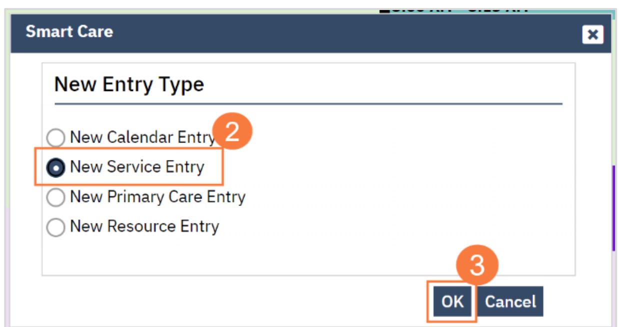
How to Create an Appointment from Your Calendar

To create an appointment from your schedule, follow the steps below,

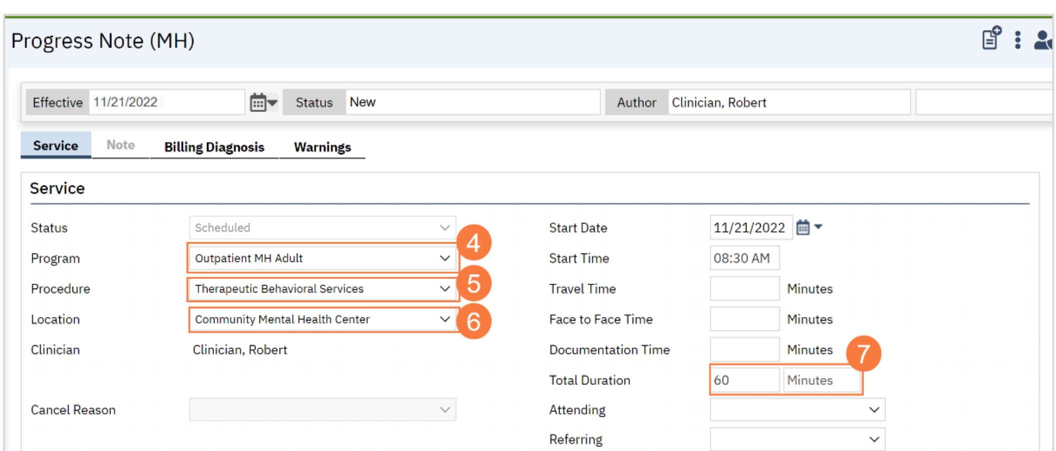
1. From the Staff Calendar screen, **click and drag your mouse on the calendar timeslot** you want to book.



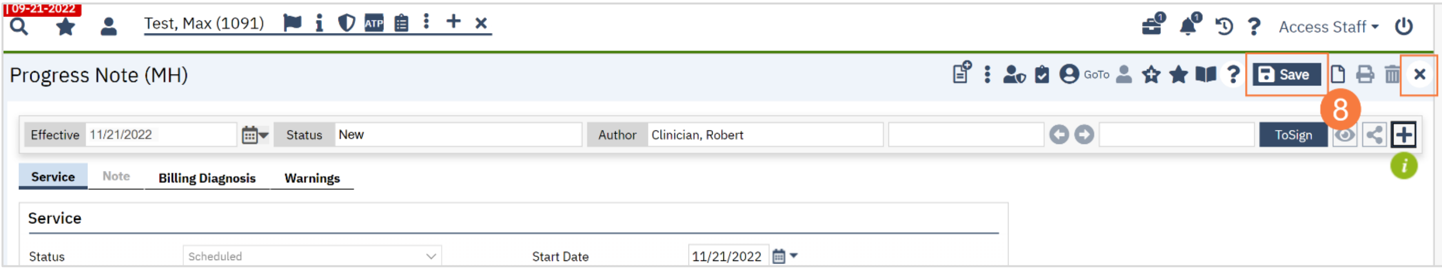
2. In the New Entry Type pop-up, **select the New Service Entry radio button.**
3. **Click OK**.



4. In the Service Notes screen, **click the drop-down menu** in the program field and **select the appropriate program**
5. **Click the drop-down menu in the Procedure field** and **select the appropriate procedure**.
6. **Click the drop-down menu in the Location field** and **select the appropriate location**.
7. **Click in the Total Duration field** and **enter the duration of the appointment.**



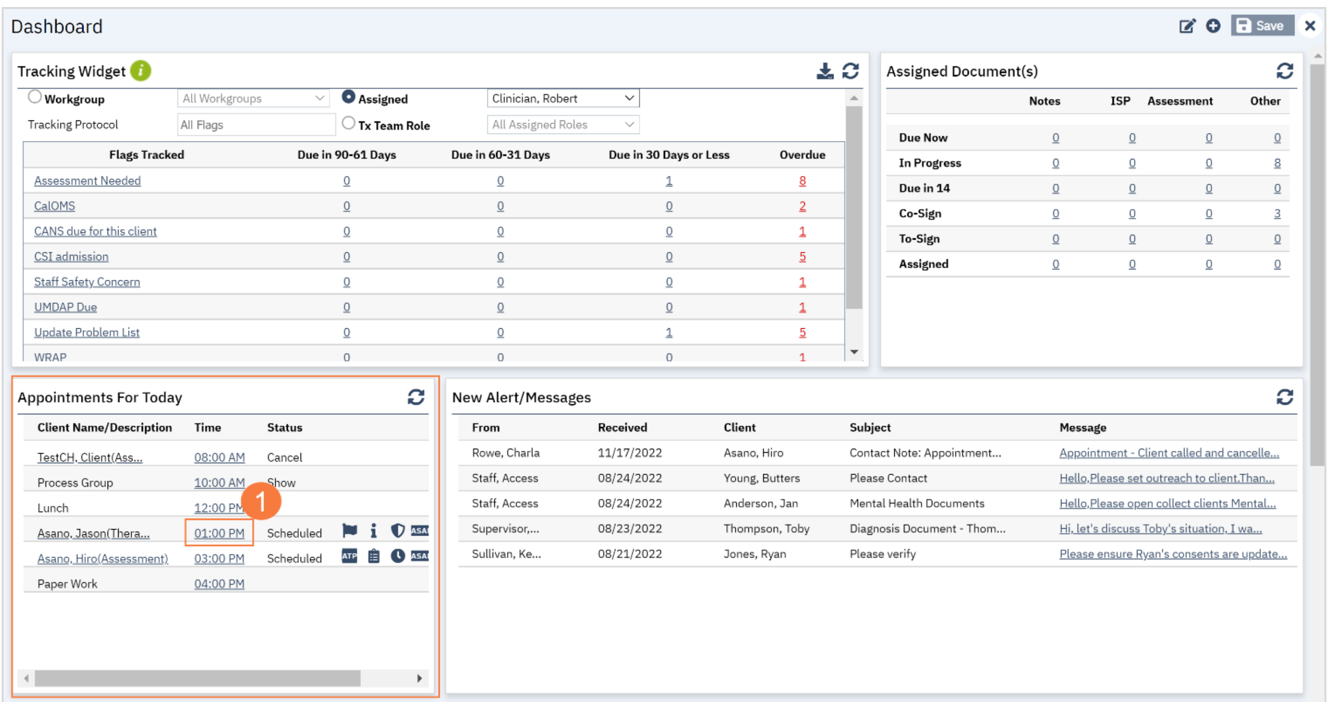
8. **Click the Save icon**. **Click the X icon** to close the screen.



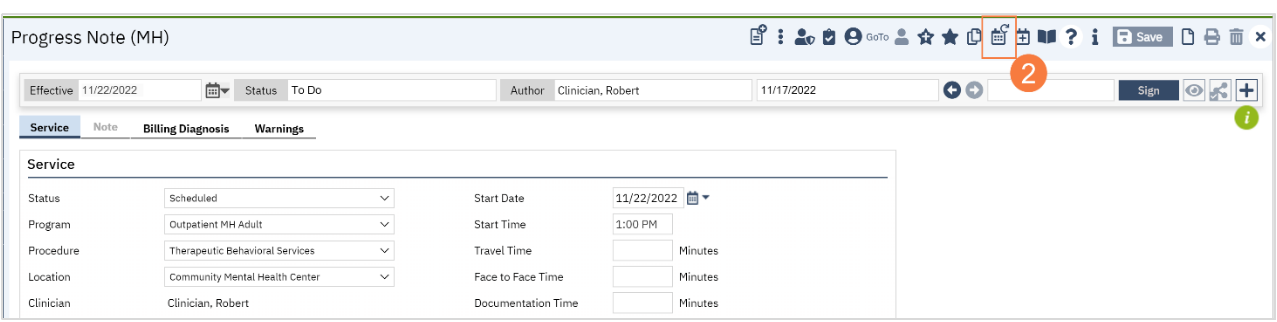
How to Reschedule a Client's Appointment

To reschedule a client's appointment from your calendar, follow the steps below:

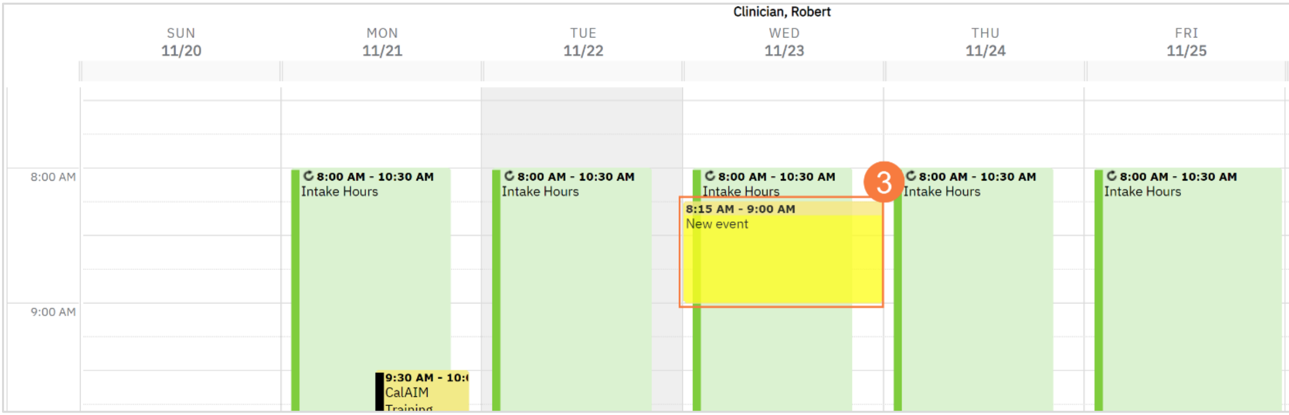
1. From your SmartCare home page, locate the Appointments for Today widget. **Click the appointment time** to the right of the patient you need to reschedule.



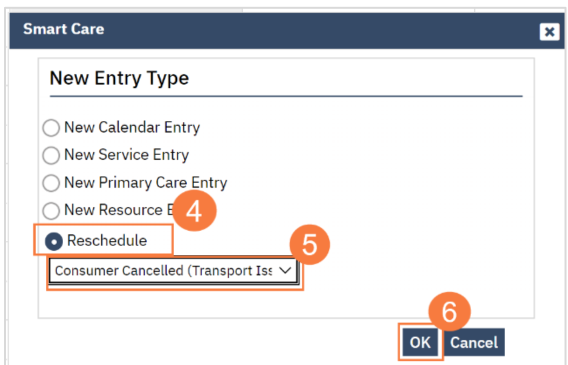
2. In the Progress Note screen, **click the Reschedule icon**.



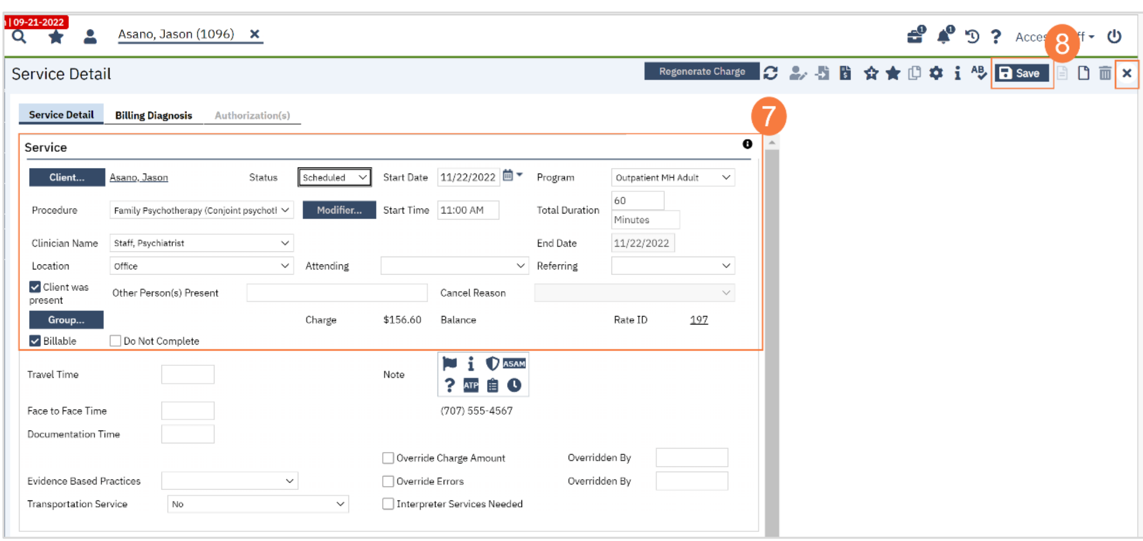
3. Your Staff Calendar screen will open, **click and drag your mouse on the calendar timeslot** you want to book.



4. In the New Entry Type window, click the radio button for Reschedule.
5. Click to select the reason for the reschedule.
6. Click OK.



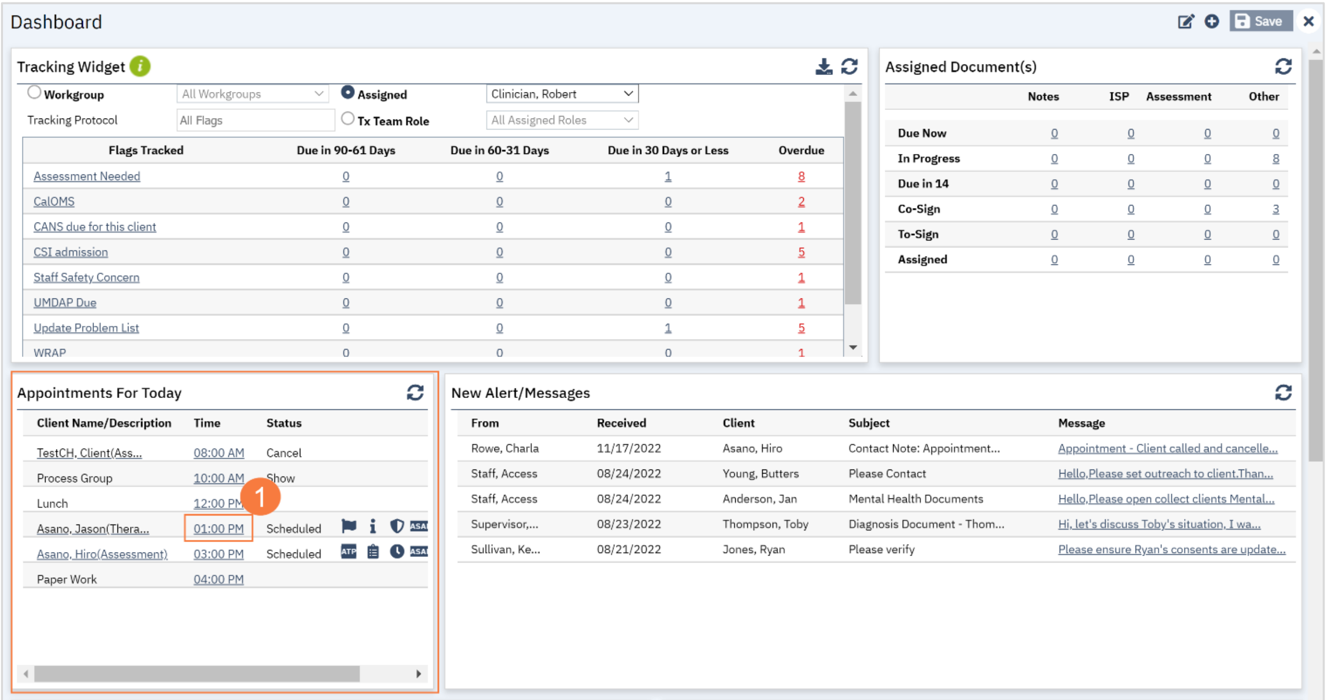
7. The Service Entry window will open, ensure all the information in correct
8. **Click Save** to reschedule the appointment. **Click the X** to close.



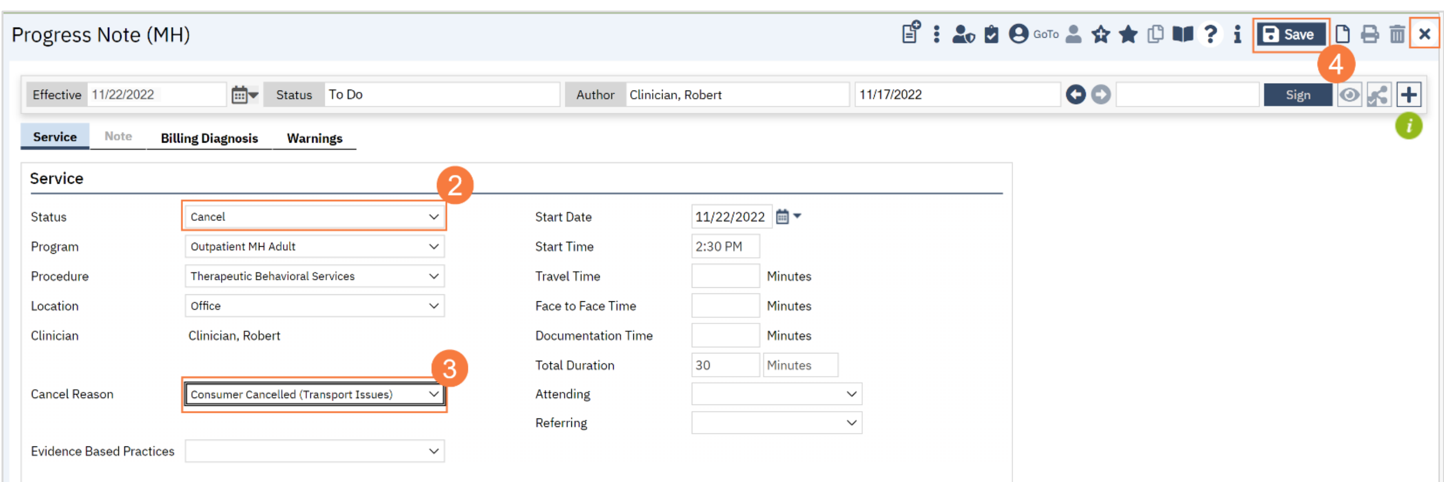
How to Cancel a Client's Appointment

To cancel a client's appointment from your calendar, follow the steps below:

1. From your SmartCare home page, locate the Appointments for Today widget. **Click the appointment time** to the right of the patient you need to cancel.



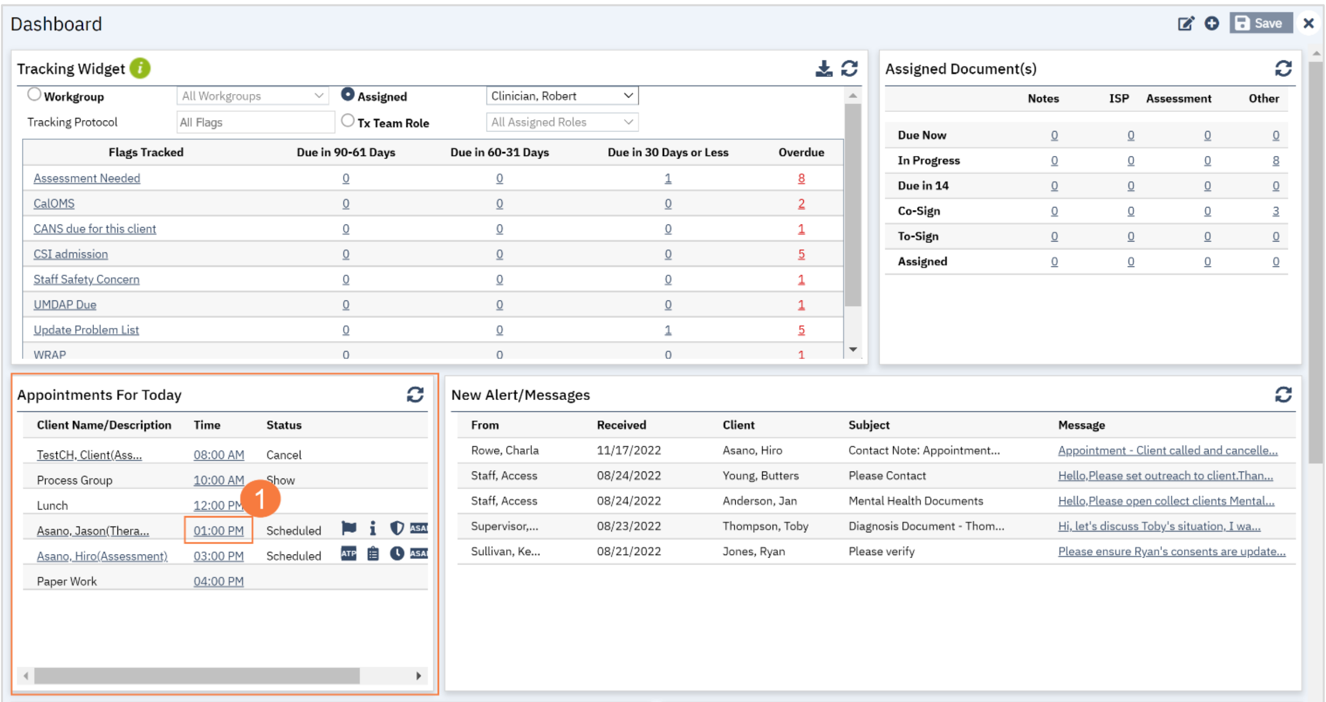
2. The Progress Note screen will open, **click the drop-down menu in the Status field** and **select Cancel.**
3. **Click the drop-down menu in the Cancel Reason field** and **select the appropriate reason.**
4. **Click Save** to cancel the appointment. **Click the X** to close.



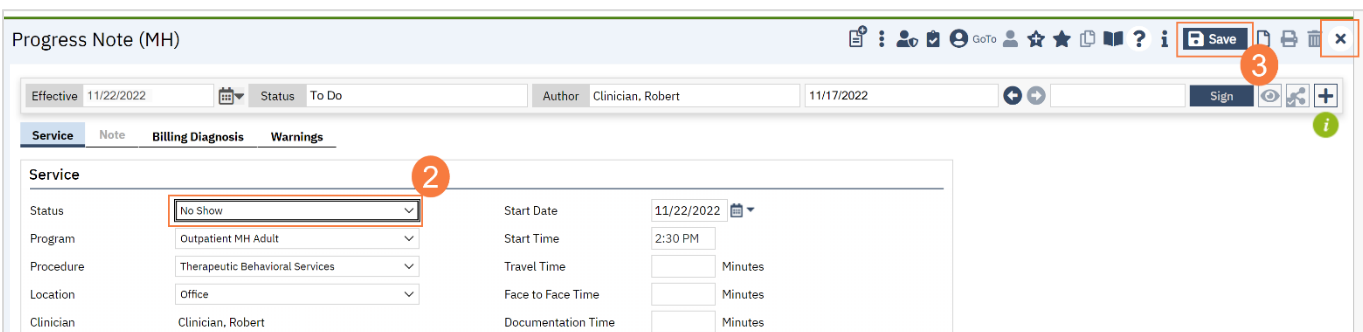
How to Document a No-Show Appointment

To document a No-Show Appointment, follow the steps below:

1. From your SmartCare home page, locate the Appointments for Today widget. **Click the appointment time** to the right of the patient you need to cancel.



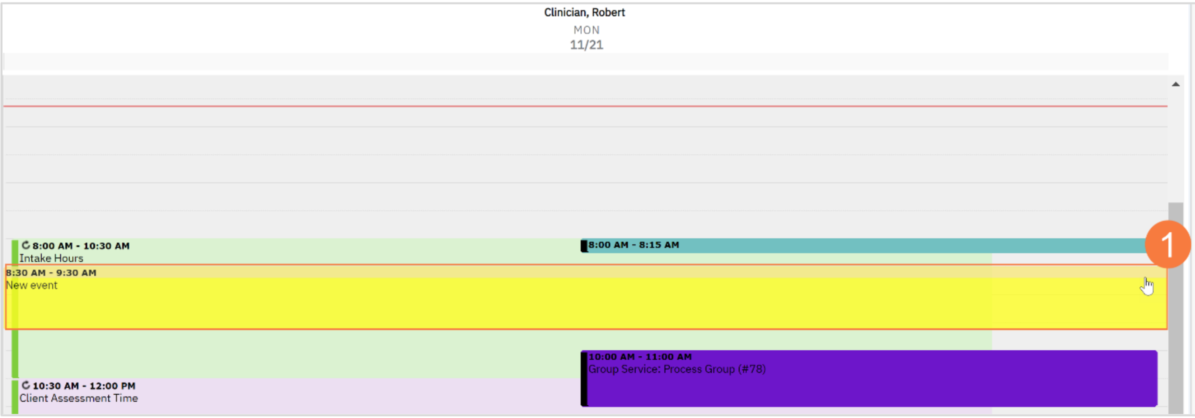
2. The Progress Note screen will open, **click the drop-down menu in the Status field** and **select No Show.**
3. **Click Save** to cancel the appointment. **Click the X** to close.



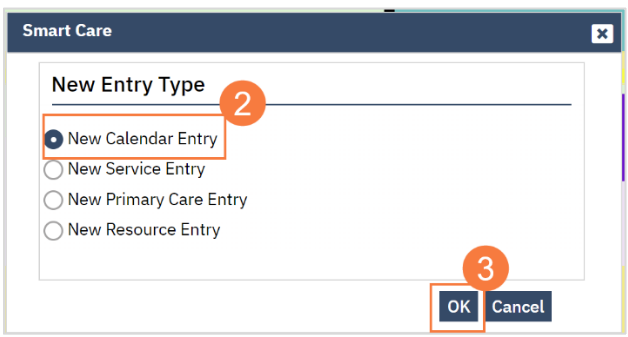
How to Schedule Non-Client Time on Your Calendar

To schedule non-client time on your calendar such as paperwork time, meetings, supervision, training, holiday, etc., follow the steps below:

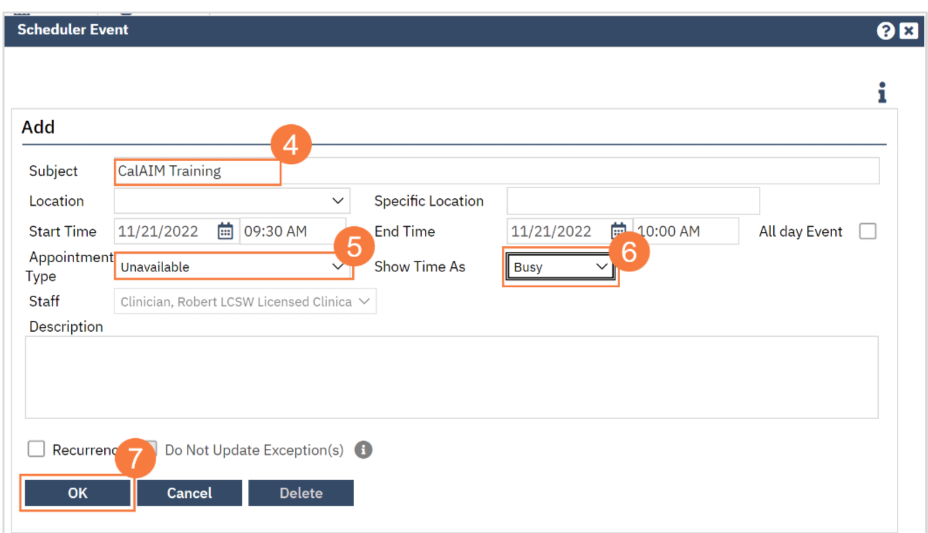
1. From the Staff Calendar screen, **click and drag your mouse on the calendar timeslot** you want to book.



2. In the New Entry Type pop-up, **select the New Calendar Entry radio button.**
3. **Click OK.**



4. The Scheduler Event window will open, **click in the subject Field** and **enter the subject** for the calendar entry
5. **Click the drop-down menu in the Appointment Type field** and **select the correct option**.
6. **Click the drop-down menu in the Show Time As field** and **select the correct option**.
7. **Click OK.**



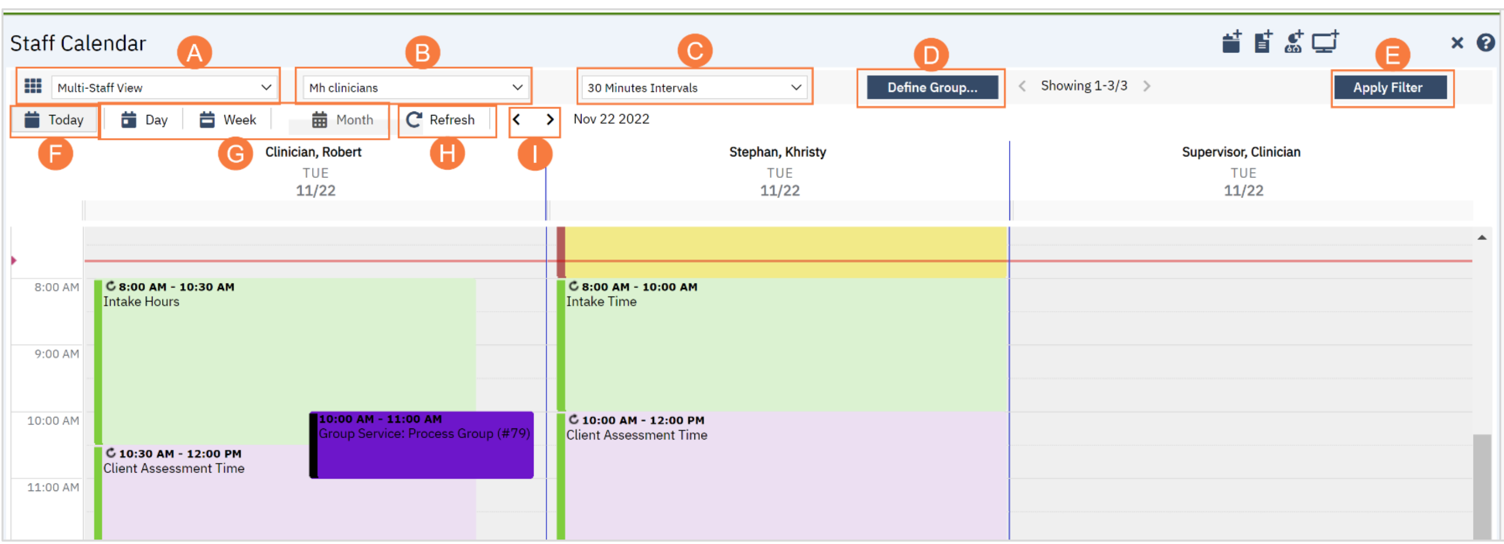
Front Desk Workflows

Here will be introduction to front desk….

Basic Navigation of the Staff Calendar

Use the guide below to learn how to navigate the Staff Calendar screen,

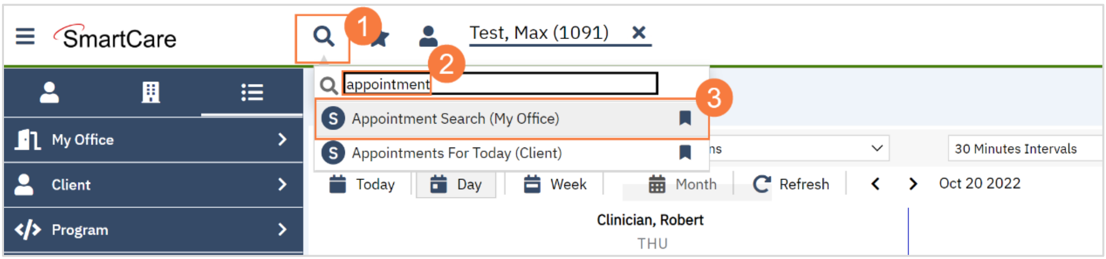
A. The View drop-down menu will allow to switch between calendar views of a single-staff, multiple-staff members based on a pre-defined group, or multiple-staff members that you can select.
B. In the multiple-staff view, this will allow you to choose between pre-defined groups. In single-staff view, this will allow you to switch between staff members.
C. The Intervals drop-down menu will allow you to tell SmartCare the time intervals you want the calendar to display. in. For example, if you select 30 minutes there will be two time slots in each hour on the calendar.
D. The Define Group button will allow you to create your own customized staff group.
E. The Apply Filter button will need to be clicked any time you make changes to A-C (listed above) in order for it to update the calendar below.
F. The Today button will bring you back to today's date when you have navigated away to a different date.
G. The Day, Week, and Month buttons will allow you to change between daily view, weekly view, or monthly view.
H. The Refresh button will refresh the calendar and show you the most up-to-date information.
I. The Forward and Back buttons will take you forward a day and back a day.



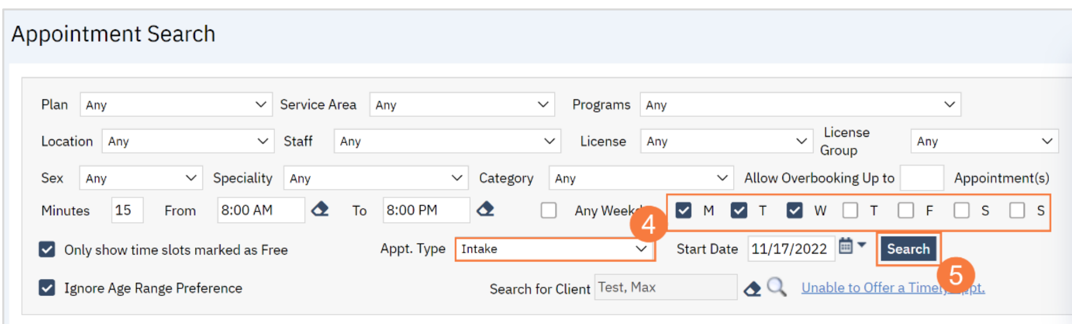
How to Schedule an Appointment

To schedule an appointment, follow the steps below:

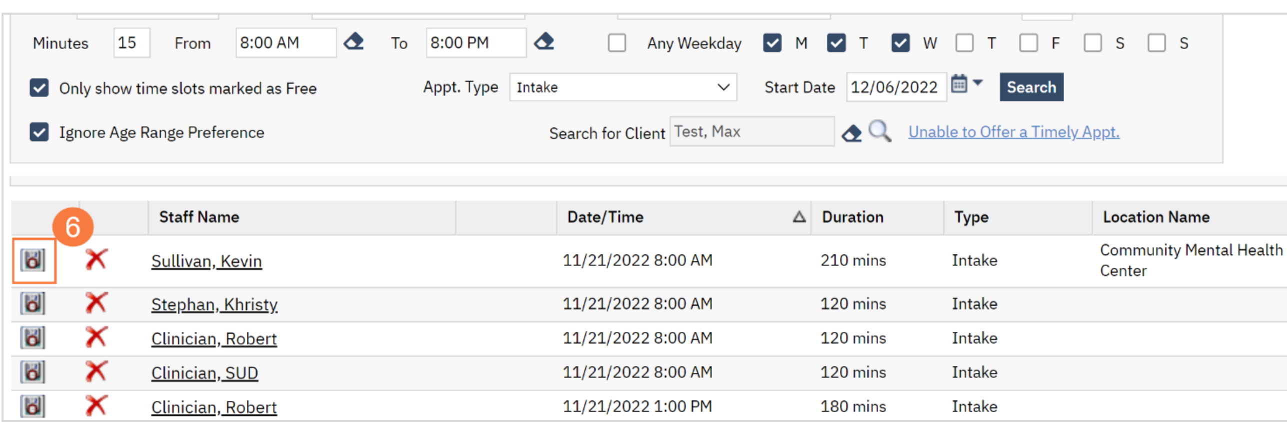
1. With the client open, **click the Search icon.**
2. **Type Appointment** in the search bar.
3. **Click to select** Appointment Search (My Office).



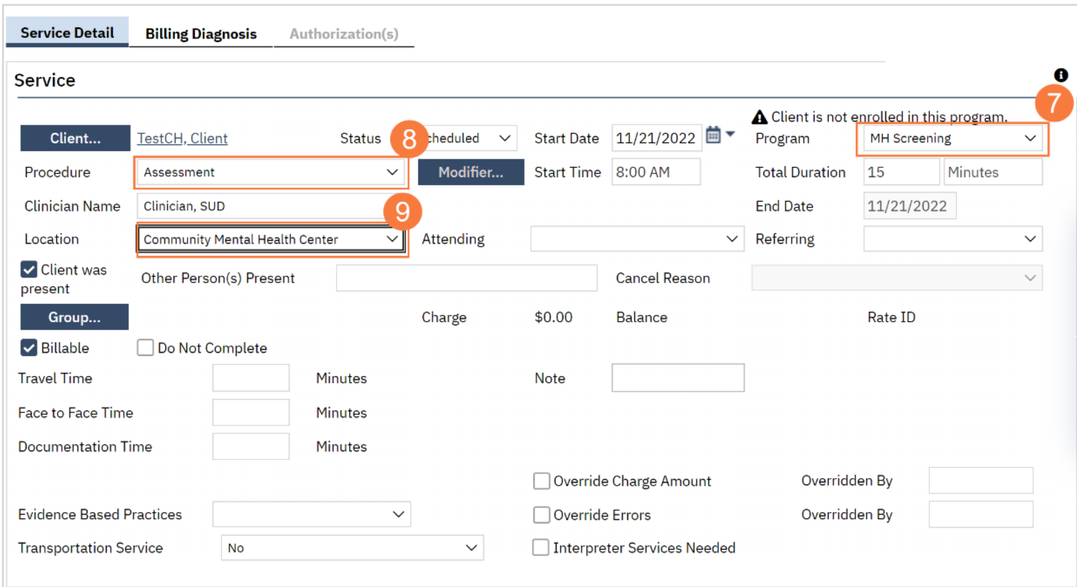
4. In the Appointment Search screen, select the parameters for your search, such as:
   - Appointment type
   - Days of the week
   - Clinician, etc.
5. **Click Search.**



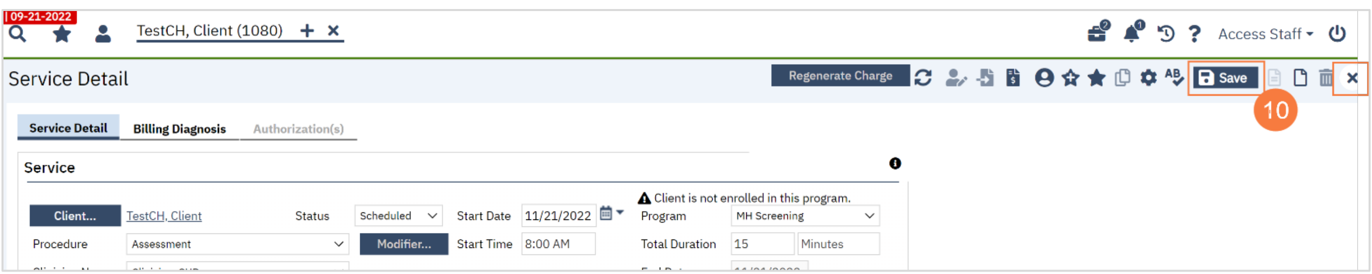
6. A list of available appointments will populate below, **click the Schedule Appt icon** next to the appointment time you want to choose.



7. The Service Detail window will open, **click the drop-down menu in the Program field** to select a program.
   - Note: If a client is not yet enrolled in the program, an alert will pop up. This will not keep you from scheduling this appointment.
8. **Click the drop-drown menu in the Procedure field and** select the appropriate option.
9. **Click the drop-down menu in the Location field and** select the appropriate location**.**



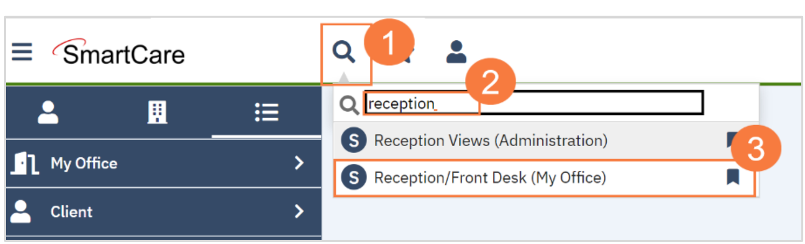
10. **Click Save** to schedule the appointment. **Click the X icon** to close this screen.



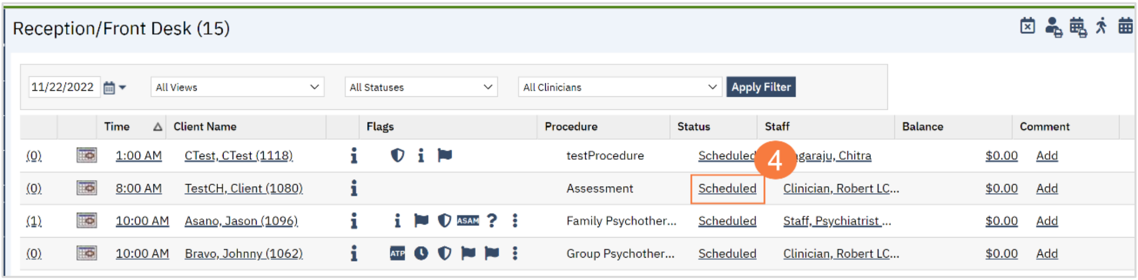
How to Cancel an Appointment

To document a cancelled appointment, follow the steps below:

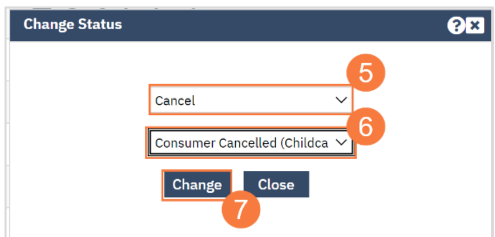
1. **Click the Search icon.**
2. **Type Reception** in the search bar.
3. **Click to select** Reception/Front Desk(My Office).



4. In the Reception/Front Desk screen, locate the correct client along with correct staff and appointment time. **Click on the Status field and the word Scheduled**.



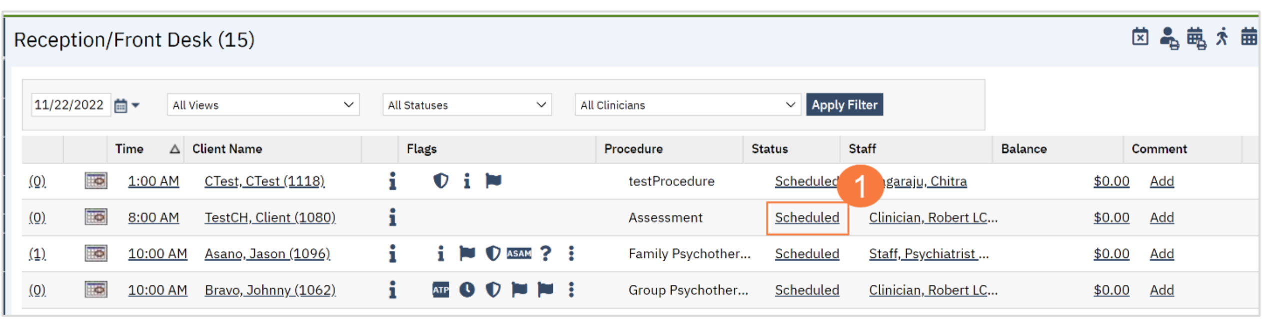
5. The Change Status window will open, **click the drop-down menu** and **select Cancel**.
6. Next you will be prompted to enter a cancel reason, **click the drop-down menu** and select the **appropriate option**.
7. **Click Change** to cancel the appointment. The status will now show as Cancelled.



How to Document a No-Show Appointment

To document a No-Show Appointment, follow the steps below:

1. In the Reception/Front Desk screen, locate the correct client along with correct staff and appointment time. Locate the Status field **and click the word Scheduled**.



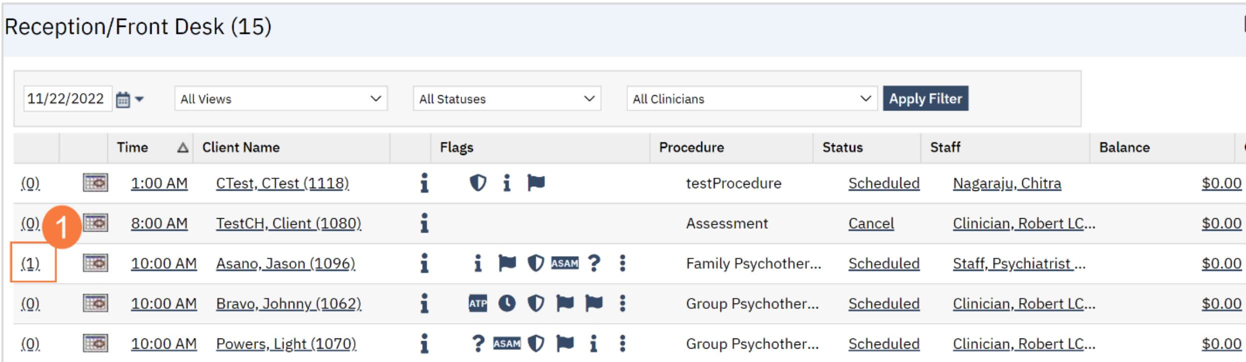
2. The Change Status window will open, **click the drop-down menu** and **select No Show**
3. **Click Change** to cancel the appointment. The status will now show as No Show.

How to Reschedule an Appointment

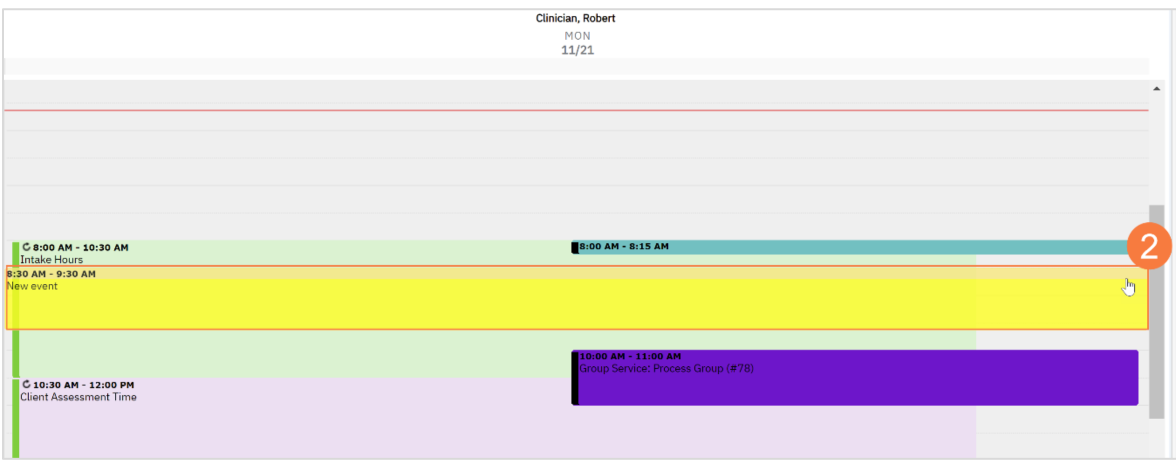
To reschedule and appointment, follow the steps below:

1. In the Reception/Front Desk screen, locate the correct client along with correct staff and appointment time. **Click the number in parenthesis** to the left of the appointment time.

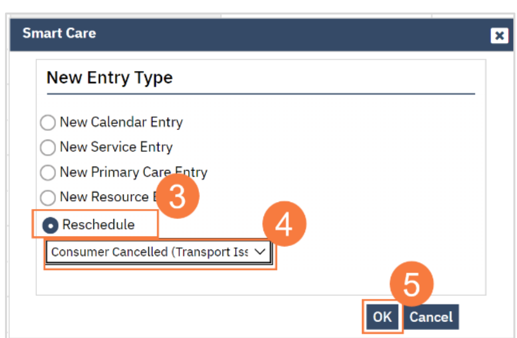
   Note: This number indicates the number of times this appointment has been rescheduled.



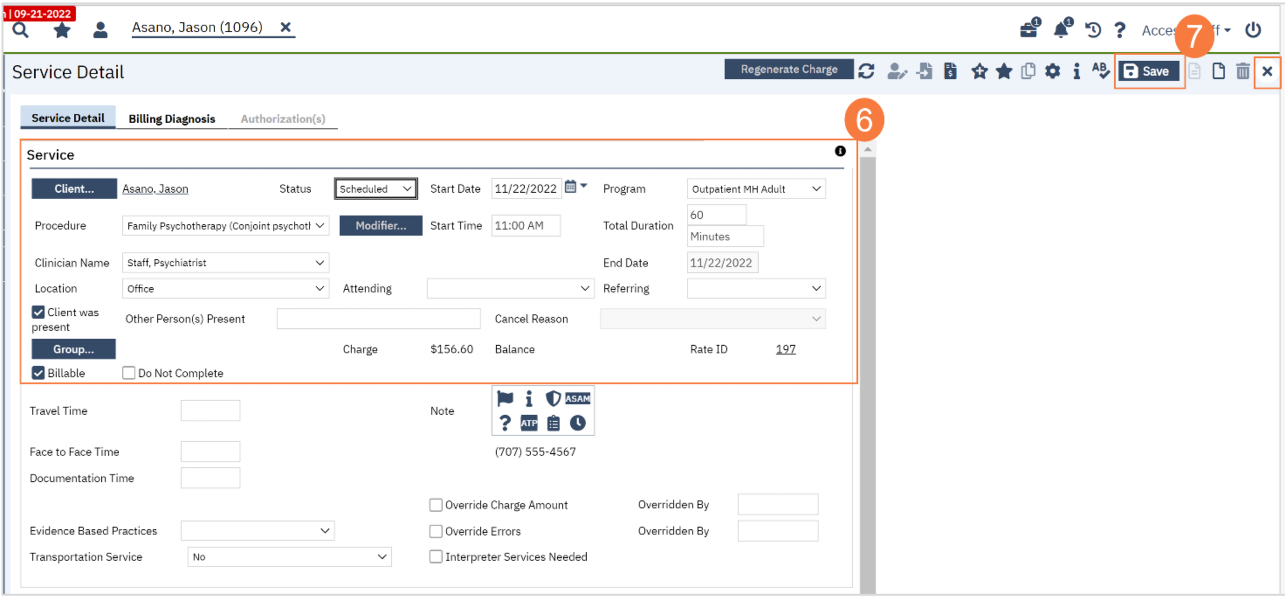
2. This will take you to the Staff Calendar screen to allow you to select a new appointment time. **Click and drag your mouse on the calendar timeslot** you want to book.



3. In the New Entry Type window, **click the radio button for Reschedule**.
4. **Click to select the reason** for the reschedule.
5. **Click OK**.



6. The Service Entry window will open, ensure all the information in correct
7. **Click Save** to reschedule the appointment. **Click the X** to close.



How to Handle Client Intake

Front Desk: A client has arrived for their intake/assessment appointment. What do I do?

f. Open the Staff Calendar, if not already done so.
a. Click the Search icon.
b. Type “Staff Calendar” in the search bar.
c. Select “Staff Calendar (Staff)” from the search results.
g. Find the client’s appointment on the Staff Calendar and click on it to open.
h. This opens the service note. Change the status from “Scheduled” to “Show.” This will create an alert in the provider’s SmartCare letting them know that their appointment has arrived.
i. Open the Client Programs list page. Find your program on the list and click on the link in the Status column, which should be listed as “Requested.”
j. This takes you to the Client Program Details screen. Change the Status to “Enrolled”. This unlocks the Enrollment Date field. Enter today’s date in the Enrollment Date field. Click Save.
k. The next steps in the process are to complete the intake documentation packet, confirm the client’s information, and for the clinician to complete the clinical assessment. Complete the documents you are responsible for. The following instructions will walk you through the basics of completing any document in SmartCare. If you need additional information on a specific form, see their respective section (e.g. Privacy and Consents; Clinical Documents; Intake and Other Forms; State Reporting).
a. Search for the document by clicking the Search icon, typing in the document name, and selecting the document from the search results.
b. Complete the document based on the client’s responses. You are able to jump back and forth between documents, even if you haven’t saved the document. Any unsaved documents can be easily accessed using the Unsaved Changes icon. You can also use the History icon to jump to recent screens and documents.
c. Once you’ve completed the document, click Sign. This will save the document as a pdf.

d. If the client and/or guardian needs to sign the document, click the Plus button to show the signature ribbon.
e. Select the co-signer from the list and click Co-Sign.
f. This brings up the pop-up signature window. The co-signer can now sign using a signature pad, a mouse, or a touchpad. Select the method of capturing the signature. If the cosigner needs to start over, click the Clear button to erase the current signature. Once the co-signer is happy with their signature, click the Save button. If the client has signed a paper version of the form or has agreed verbally and is unable to sign electronically at this point, these are other options.
l. If you have documents that were completed on paper that need to be scanned in to SmartCare, [INSERT INSTRUCTIONS ON HOW TO SCAN IN DOCUMENTS]

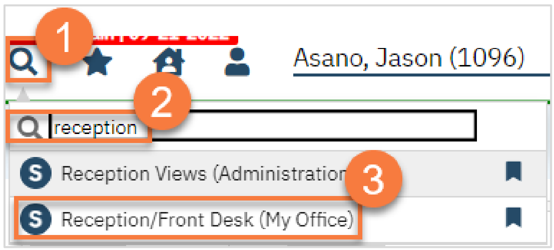
Front Desk: A person has walked in for an assessment at a walk-in clinic. What do I do?

2. Use the Client Search screen to determine if the person is a client already in the system.
   e. If they are already a client in the system, select them to open their record.
   f. If they are not a client in the system, create a new client.
3. Confirm the client needs an assessment. If you just created a new client, obviously they'll need an assessment. However, if the person was already a client in the system, you'll want to check to see if they already are connected to services.
   a. Look at the Client Programs to see if the client is already open to a program that can share an assessment with your program.
   b. Look at the client's Documents list page to see if they already have a valid assessment.
4. If the client does need an assessment, enroll them in your program.
   a. Open the Client Programs list page.
   b. Click the New icon.
   c. Complete the Client Program Details screen.
5. The next steps in the process are to complete the intake documentation packet, confirm the client's information, and for the clinician to complete the clinical assessment. Complete the documents you are responsible for and let your clinical staff know that there is a client awaiting a clinical assessment. The following instructions will walk you through the basics of completing any document in SmartCare. If you need additional information on a specific form, see their respective section (e.g. Privacy and Consents; Clinical Documents; Intake and Other Forms; State Reporting).
   a. Search for the document by clicking the Search icon, typing in the document name, and selecting the document from the search results.
   b. Complete the document based on the client's responses. You are able to jump back and forth between documents, even if you haven't saved the document. Any unsaved documents can be easily accessed using the Unsaved Changes icon. You can also use the History icon to jump to recent screens and documents.
   c. Once you've completed the document, click Sign. This will save the document as a pdf.
   d. If the client and/or guardian needs to sign the document, click the Plus button to show the signature ribbon.
   e. Select the co-signer from the list and click Co-Sign.
   f. This brings up the pop-up signature window. The co-signer can now sign using a signature pad, a mouse, or a touchpad. Select the method of capturing the signature. If the cosigner needs to start over, click the Clear button to erase the current signature. Once the co-signer is happy with their signature, click the Save button. If the client has signed a paper version of the form or has agreed verbally and is unable to sign electronically at this point, these are other options.

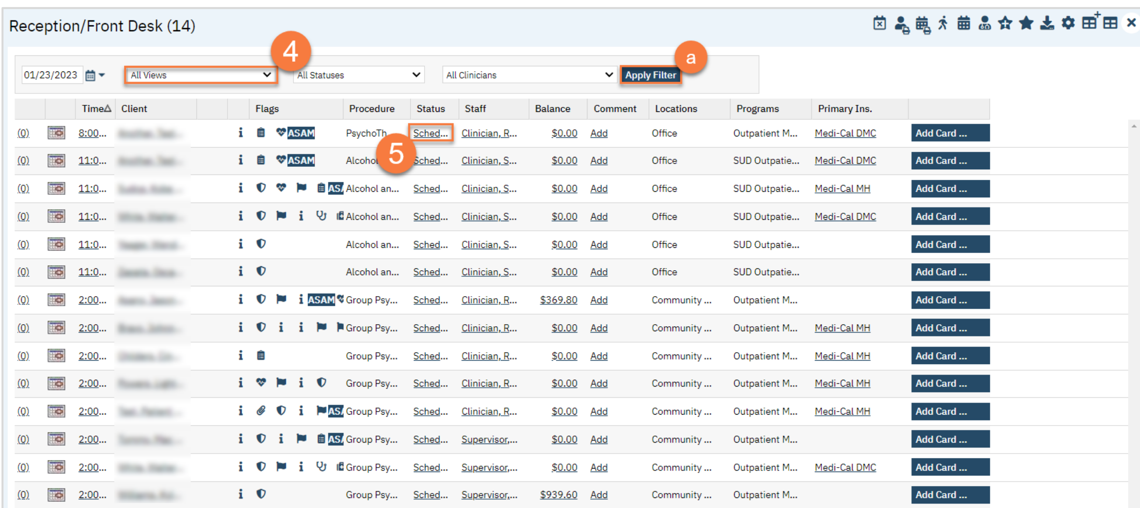
6. If you have documents that were completed on paper that need to be scanned in to SmartCare, [INSERT INSTRUCTIONS ON HOW TO SCAN IN DOCUMENTS]

Reception View

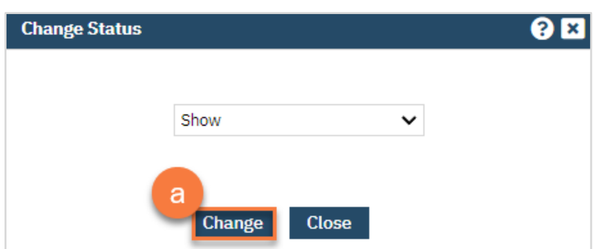
10. **Click the Search icon**.
11. **Type "Reception"** in the search bar.
12. **Select "Reception/Front Desk (My Office)"** from the search results.



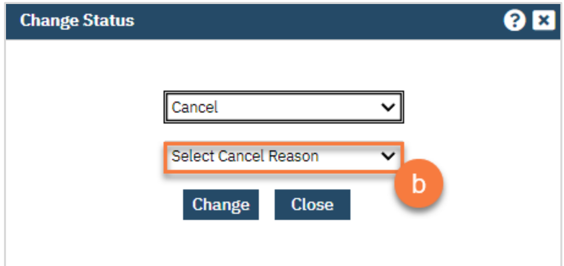
13. This will bring up the Reception/Front Desk view. **Select your program from the Views dropdown menu**. Your system administrator can set up the appropriate list for your location. If you've used this screen before, it should populate from the most recent view you used.
    a. **Click Apply Filter** to apply the view filter.
14. To check in a client, click the link in the Status column.



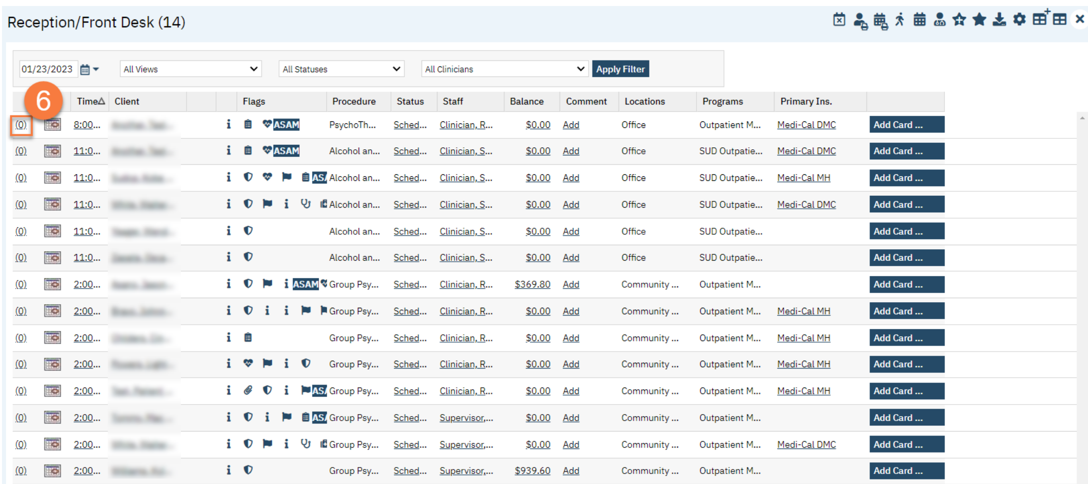
a. This will bring up a pop-up window which auto-populates to "Show." **Click Change** to check the client in.



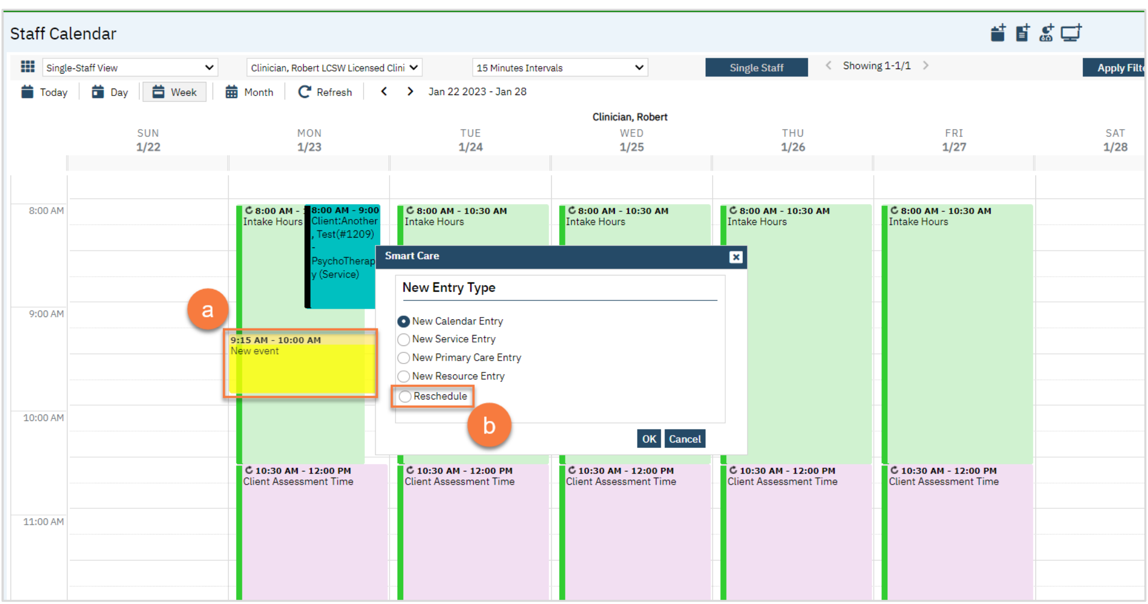
b. You can also use this to cancel the appointment or mark the client as a no-show. If you mark this as "Cancel," you'll need to enter the reason for cancellation. If you mark this as "cancel" or "no show," you can NOT undo this.



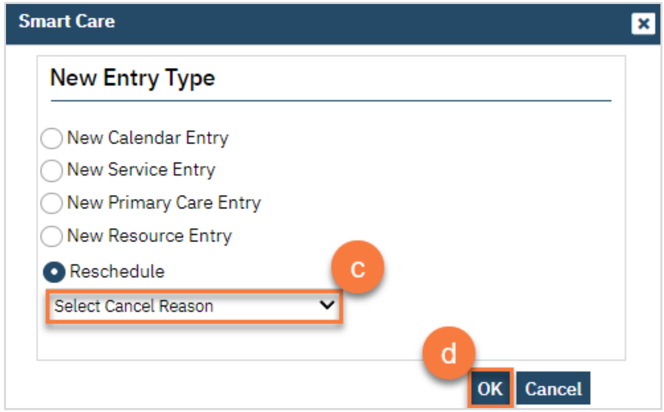
15. If you need to reschedule an individual appointment, click on the left-most link. This will open the Staff Calendar, where you can enter in the new appointment time.



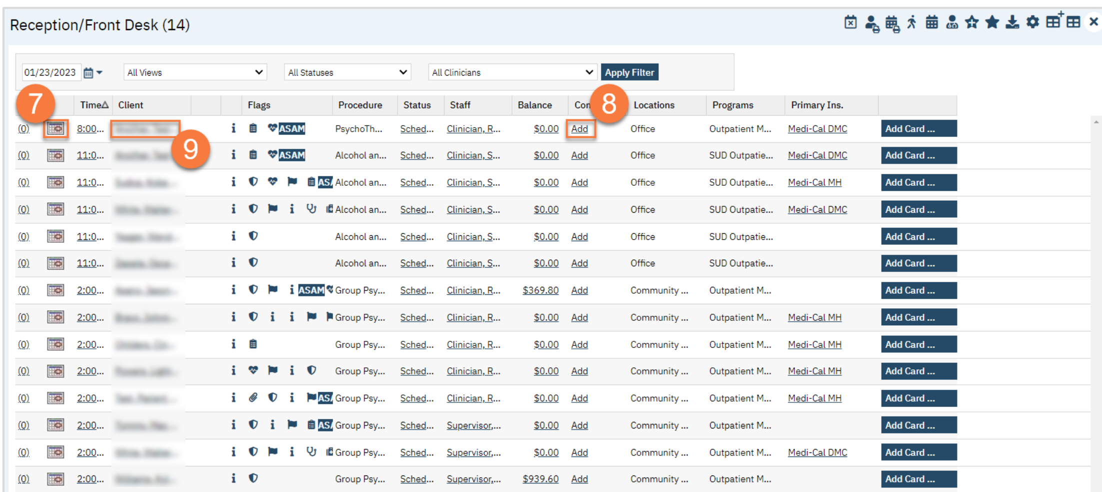
a. **Select the new appointment time**.
b. This brings up a pop-up that now has "Reschedule" as an option. **Select Reschedule**.



c. **Select the reason** for the cancellation.
d. **Click OK** to bring forward the old service information to this new service entry.



16. To schedule a follow-up for the client, click on the calendar icon. This will bring you to the Staff Calendar, where you can enter in a follow-up appointment.
17. You can add a comment to the service by clicking on the link in the Comment column.
18. To open the client's chart, click on the link in the Client column.



State Reporting

Under Construction

CSI

Under Construction

How do I complete the CSI demographic record?

Under Construction

How do I complete the CSI Assessment Data record?

Under Construction

CalOMS

Under Construction

How do I complete the CalOMS Admission?

Under Construction

How do I complete the CalOMS Referral/Transfer?

Under Construction

How do I complete the CalOMS Discharge?

Under Construction

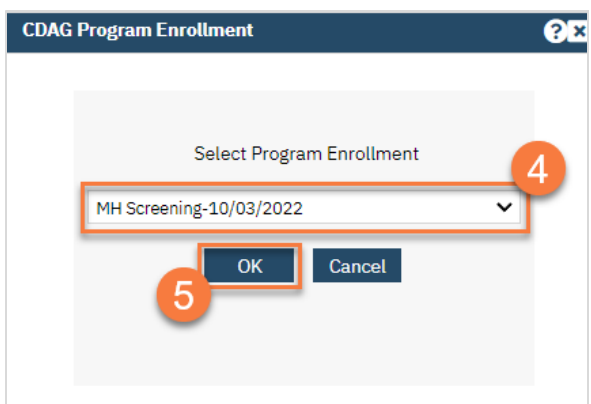
Full-Service Partnership (FSP)

Clients who are identified as Full-Service Partnership (FSP) clients under the Mental Health Services Act (MHSA)have additional reporting requirements. These do not replace the need for a CSI or CalOMS report, but are in addition to them. In this section, we'll cover the required FSP documents. Depending on your county, this information will either be extracted from SmartCare and uploaded into the State's database or will have to be manually entered into it. Check with your county to determine what your process for FSP data is.

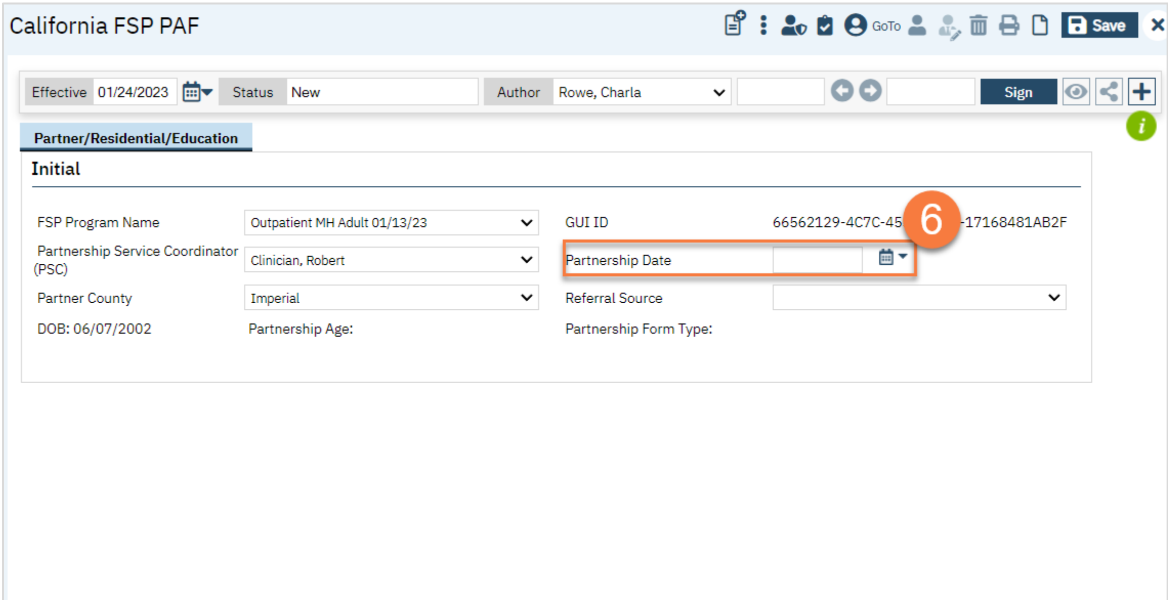
How do I complete a PAF?

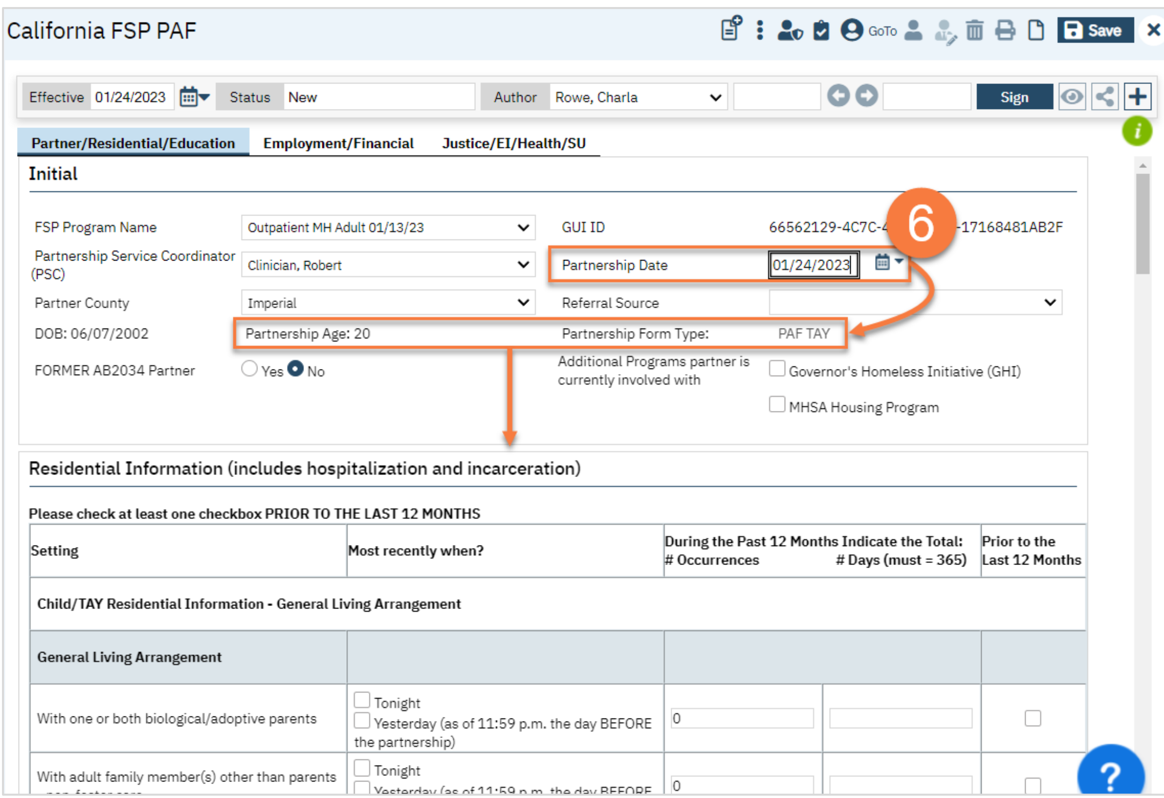
1. You must first have the client open, then **click the Search icon**.
2. **Type "FSP"** into the search bar.
3. **Click to select "California FSP PAF (Client)"** from the search results.

4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.

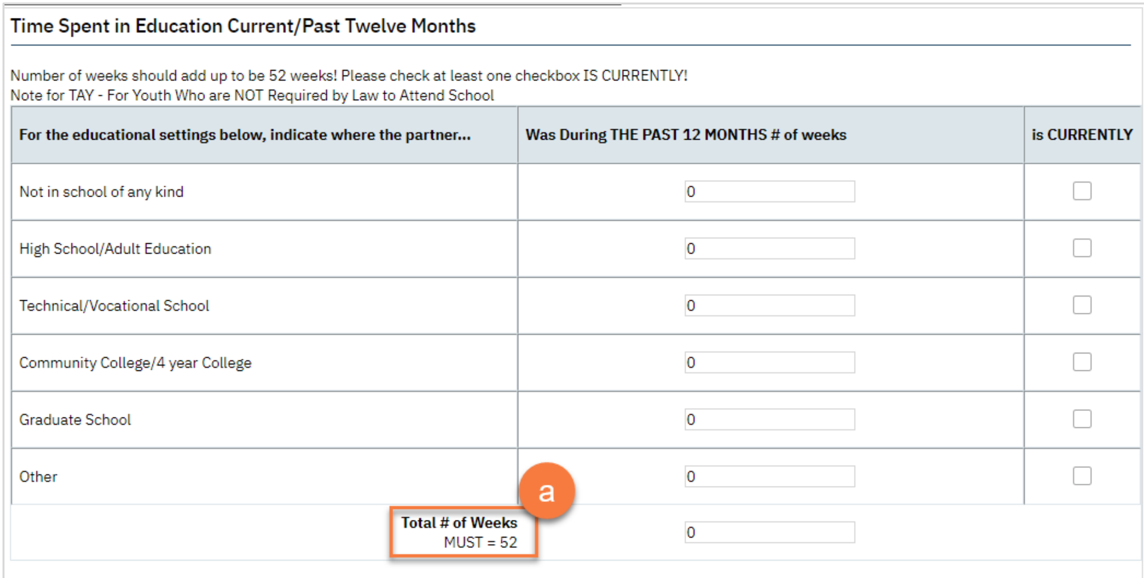


6. The PAF document will open. Most of the screen will be blank until you enter the partnership date. This will determine what your client's PAF form will look like.

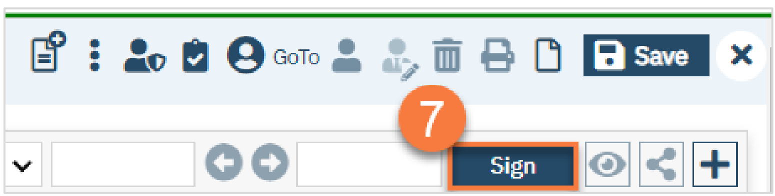




a. There is a lot of logic built into the form. If you need help understanding how to complete this form, talk to your supervisor or FSP manager for assistance. We have put in tips to try to help, but these forms may be overwhelming for some.

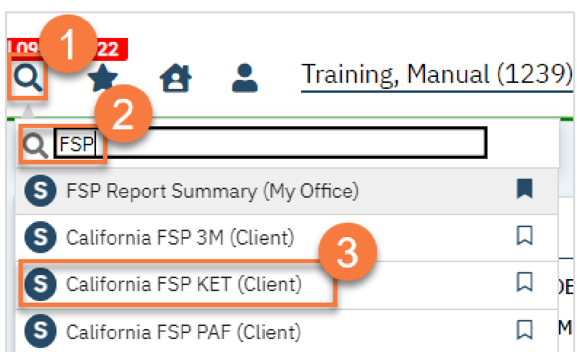


7. Once you've completed all fields on all tabs, **click Sign** to complete and generate the document.

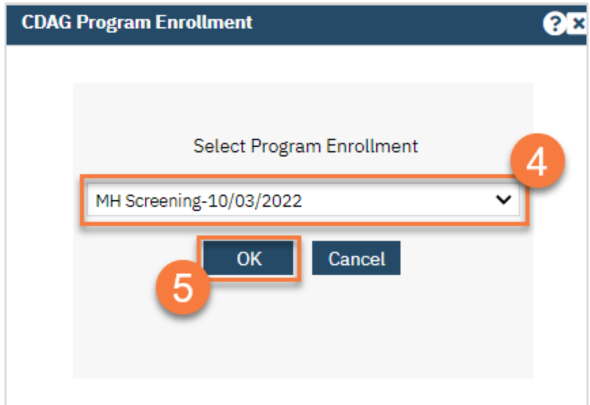


How do I complete a KET?

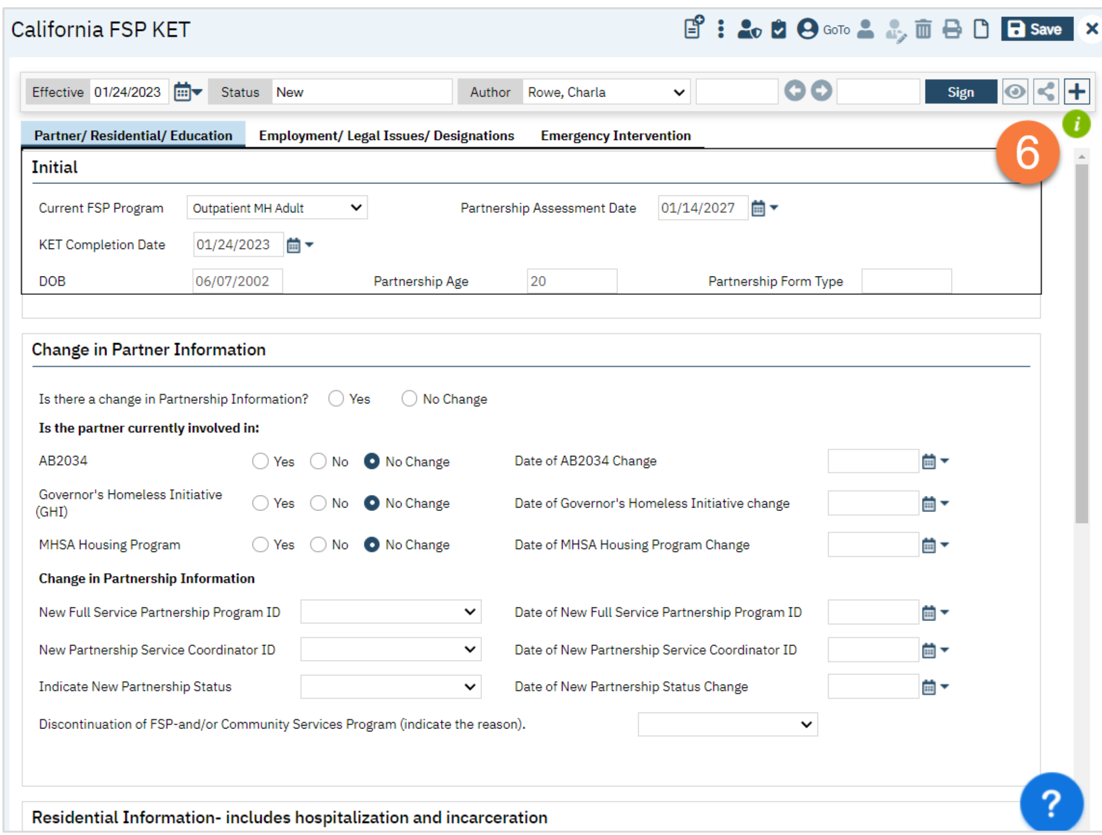
1. You must first have the client open, then **click the Search icon**.
2. **Type "FSP"** into the search bar.
3. **Click to select "California FSP KET (Client)"** from the search results.



4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



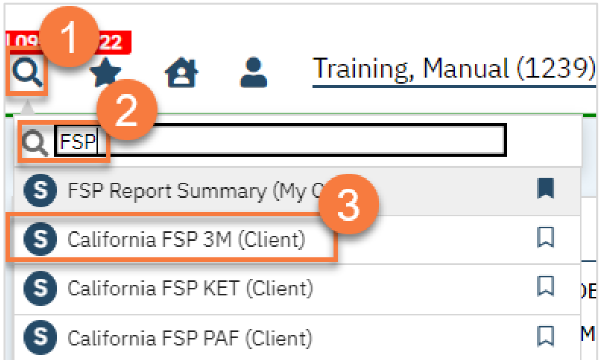
6. The FSP KET document will open. **Complete the document**. There is logic built into the form, based on the FSP KET reporting rules. If you need help understanding how to complete this form, talk to your supervisor or FSP manager for assistance.



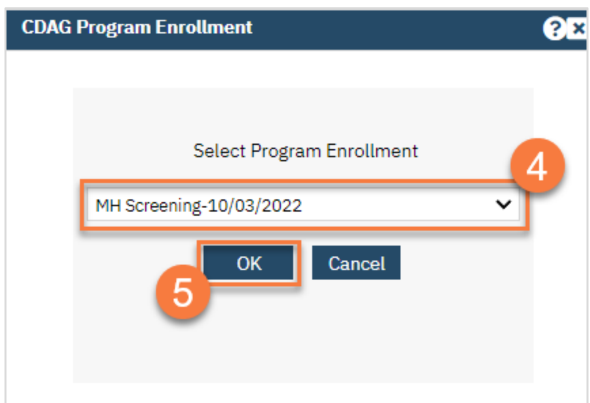
7. Once you've completed all fields on all tabs, **click Sign** to complete and generate the document.

How do I complete a 3M?

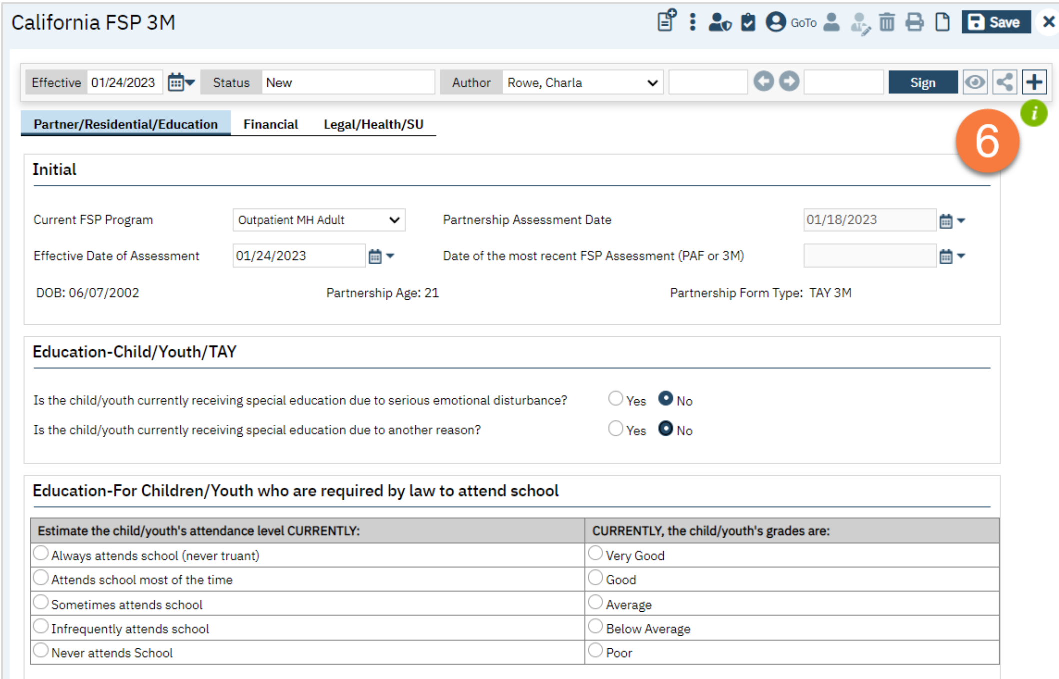
1. You must first have the client open, then **click the Search icon**.
2. **Type "FSP"** into the search bar.
3. **Click to select "California FSP 3M (Client)"** from the search results.



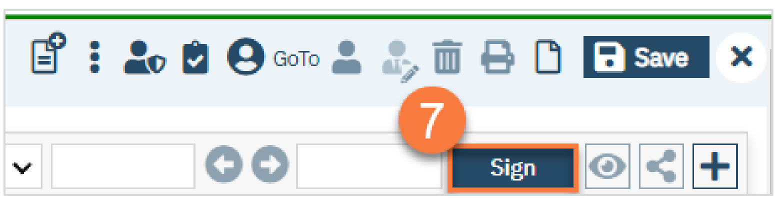
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



6. The FSP 3M document will open. **Complete the document**. There is logic built into the form, based on the FSP 3M reporting rules. If you need help understanding how to complete this form, talk to your supervisor or FSP manager for assistance.



7. Once you've completed all fields on all tabs, **click Sign** to complete and generate the document.

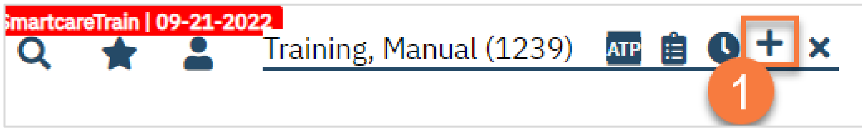


Other Functionality

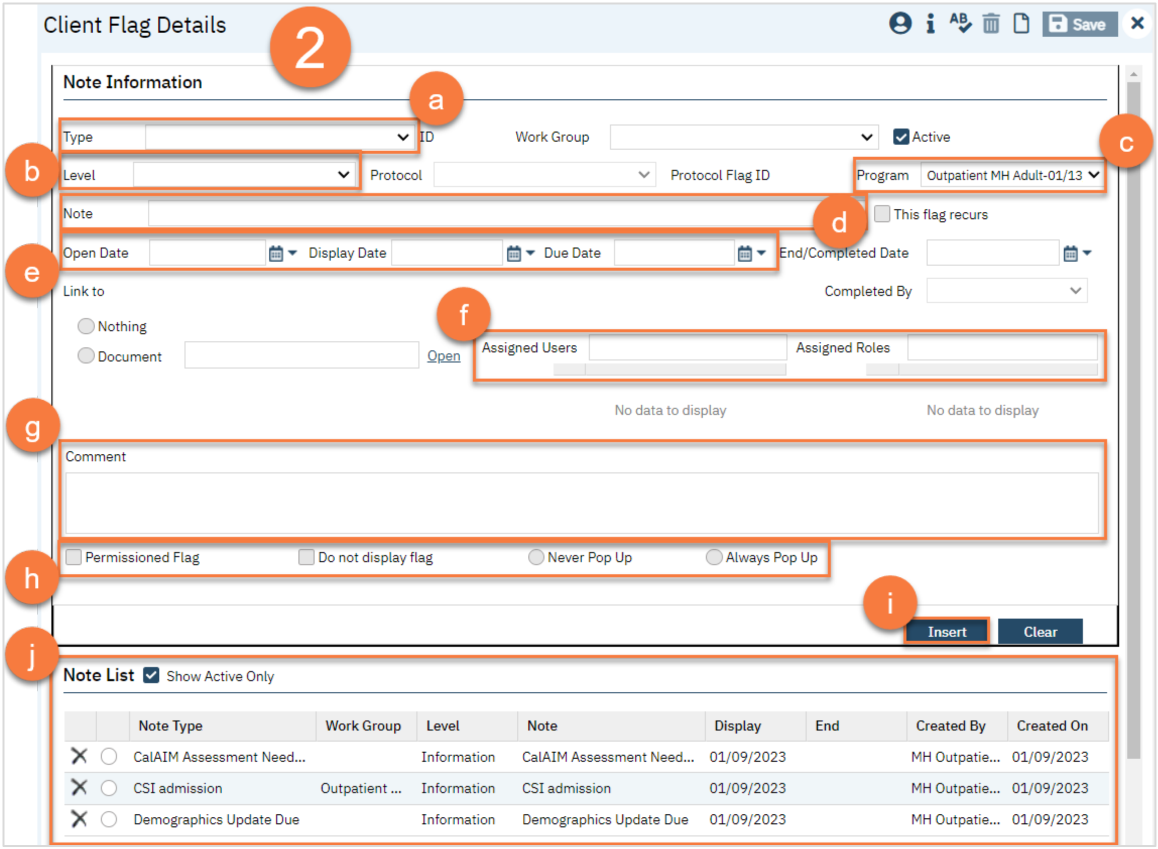
Introduction?

How do I create a flag to alert treatment team members to important client information?

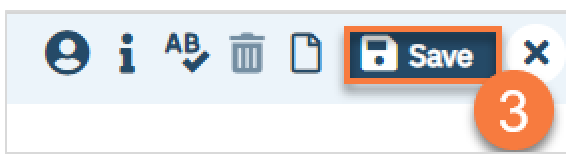
1. Make sure you have the client open. Click the plus icon next to the client's name.



2. This takes you to the Client Flag Details screen. **Add the relevant information in the Note Information section**. Your user role may only allow certain information to be completed. For example, a supervisor may have additional permissions that a clinician does not.
    a. **Select the type of flag**. Your system will have a list of flags to choose from.
    b. Make sure to **include your program**. This will ensure client privacy is upheld.
    c. **Select the level of the flag**. The options are: Information, Urgent, and Warning.
    d. Enter the specific language of the flag in the Note field.
    e. **Enter the display date**. If there is a due date, enter the Open Date (date it became available) and the Due Date (the date the task is due).
    f. If you need to assign this task to a specific user, you can enter that information in. You can also assign this task based on the treatment team role. An example would be to alert all nurses working with the client of a lab that's due.
    g. Enter any additional comments as needed.
    h. You can also choose how the flag is displayed. If you want this flag to show as a pop-up when opening the client's chart, make sure to mark "Always Pop Up."
    i. Once you've entered all the information, **click Insert**.
    j. This adds the flag to the Note List section at the bottom of the screen.



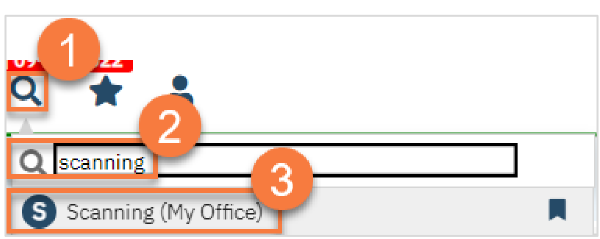
3. Once you've added all flags, **click Save**. You are now finished and may close this screen.



How do I scan a document into the client's record?

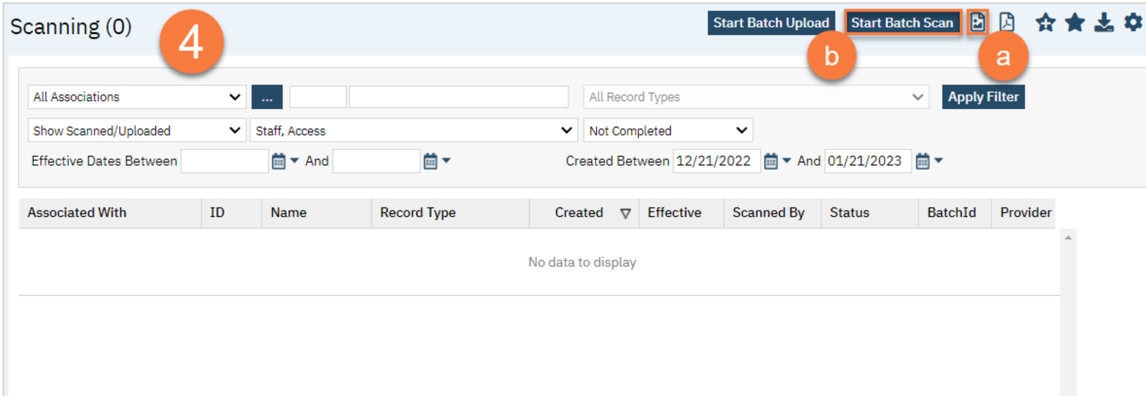
Sometimes documents are completed on paper, but need to be included in the client's record. In this section, we'll cover how to scan a document into the client's record.

1. Click the Search icon.
2. Type "Scanning" in the search bar.
3. Select "Scanning (My Office)" from the search results.



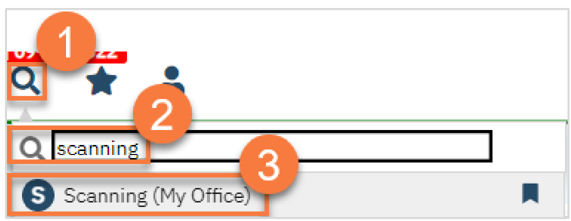
4. To scan, you need a scanner attached to your workstation. Scanning will use your scanner's software but save it in SmartCare.
    a. To scan a single document, click the "Scan New Images" icon.

b. To scan multiple documents in a batch, click the “Start Scan Upload” button.

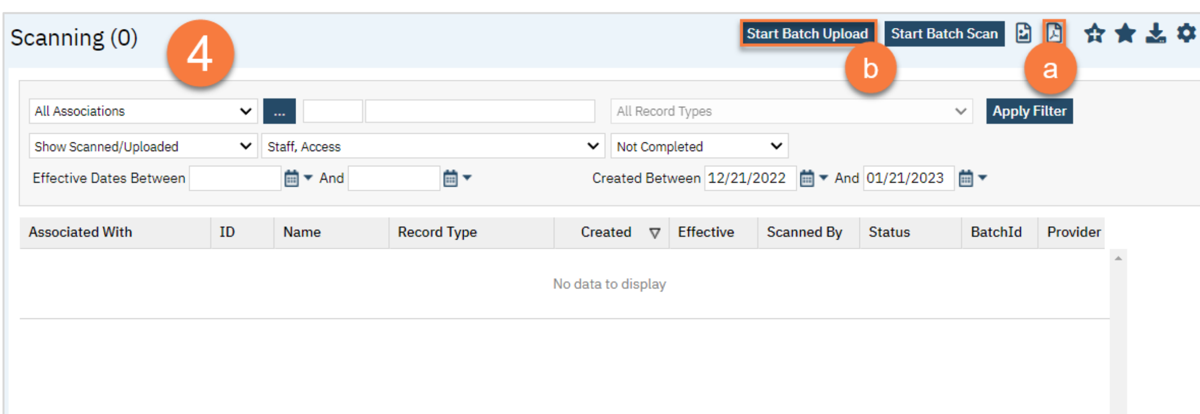


How do I upload a document into the client’s record if I don’t have a scanner?

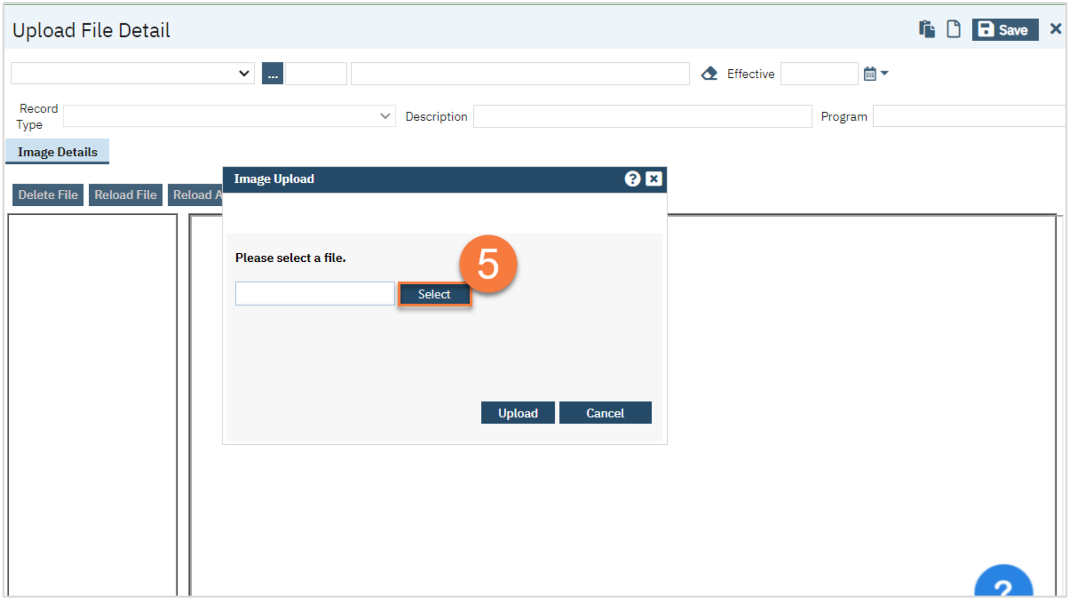
1. **Click the Search icon**.
2. **Type “Scanning”** in the search bar.
3. **Select “Scanning (My Office)”** from the search results.



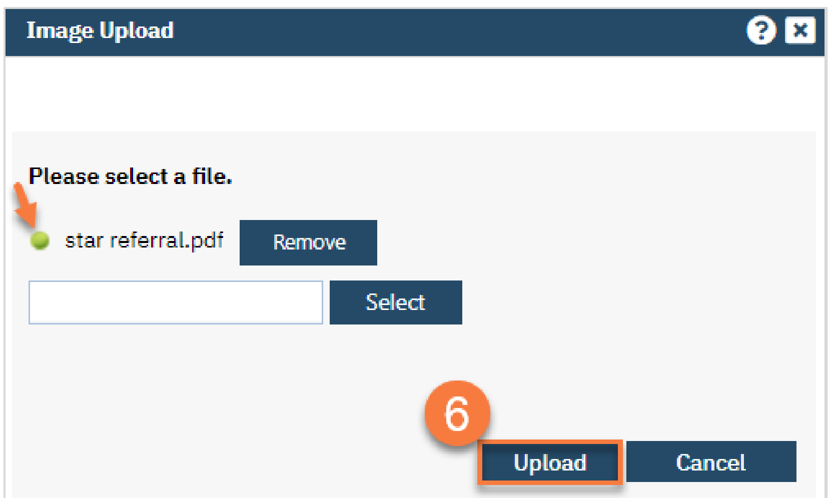
4. You can upload documents one at a time or as a batch.
   a. To upload a single document, click the “Upload New Images” icon.
   b. To upload multiple documents in a batch, click the “Start Batch Upload” button.



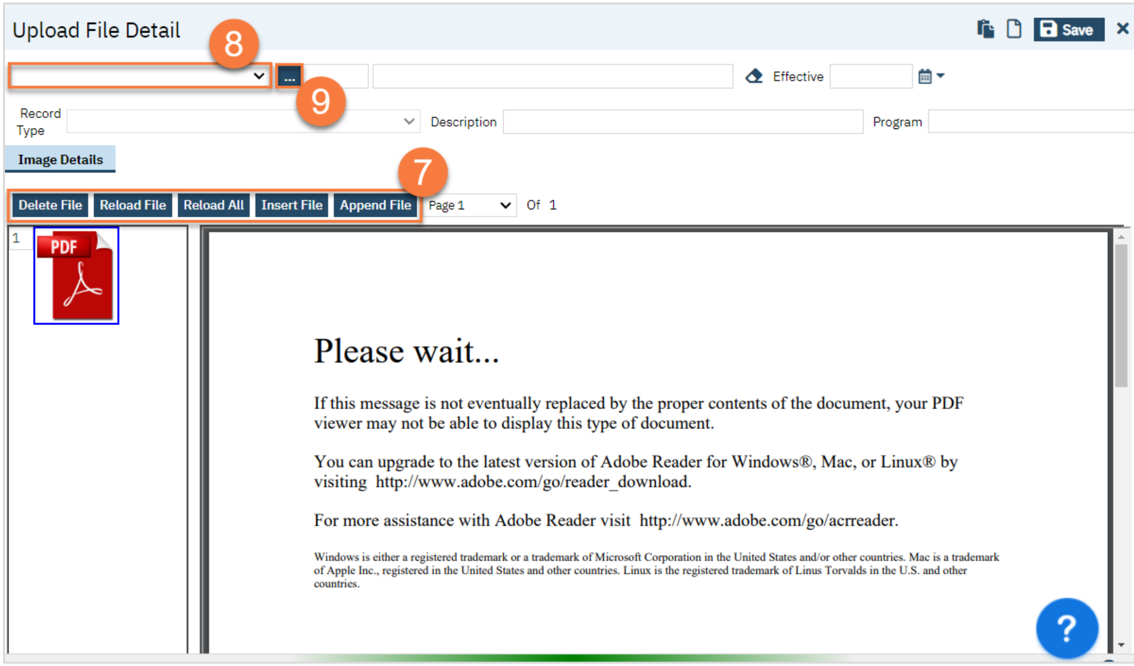
5. Choosing upload will open the Upload File Detail screen. This will include a pop-up. **Click Select** to find the file on your computer.



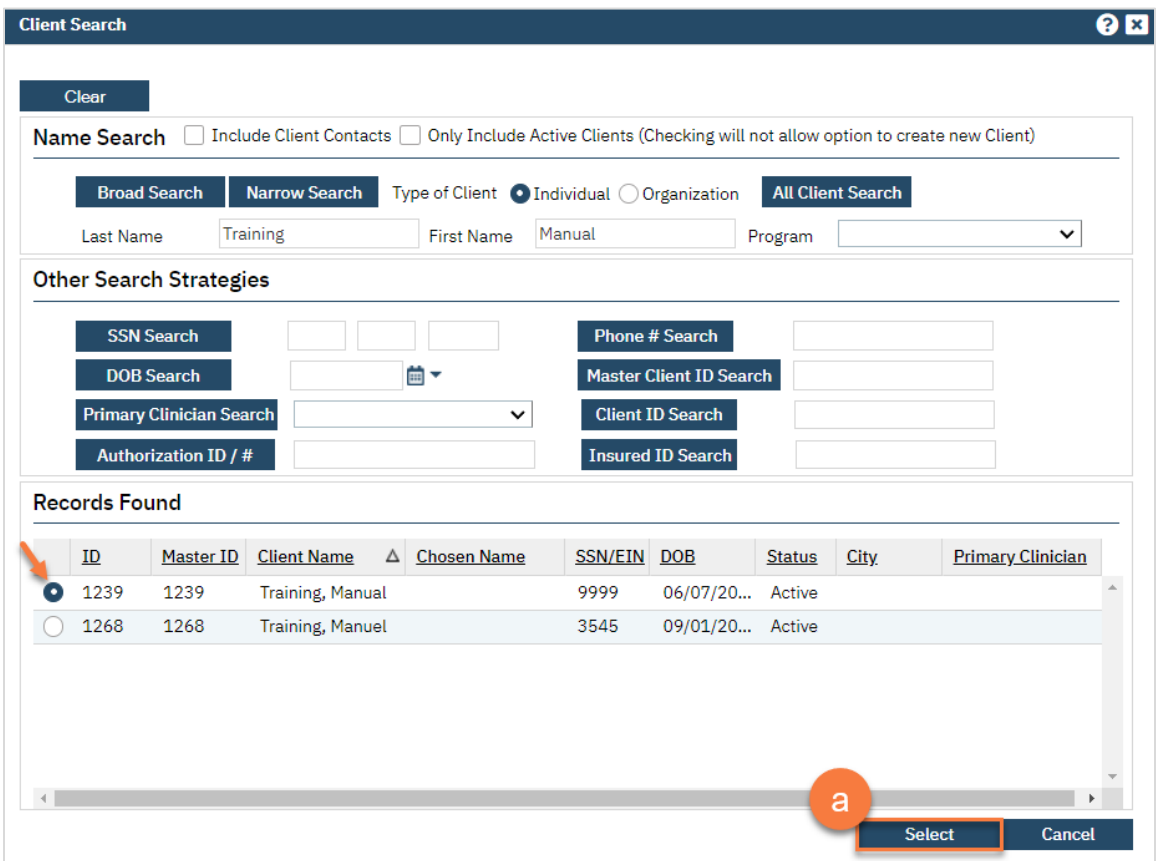
6. Once it's ready, a little green circle will appear next to it. **Click Upload**.



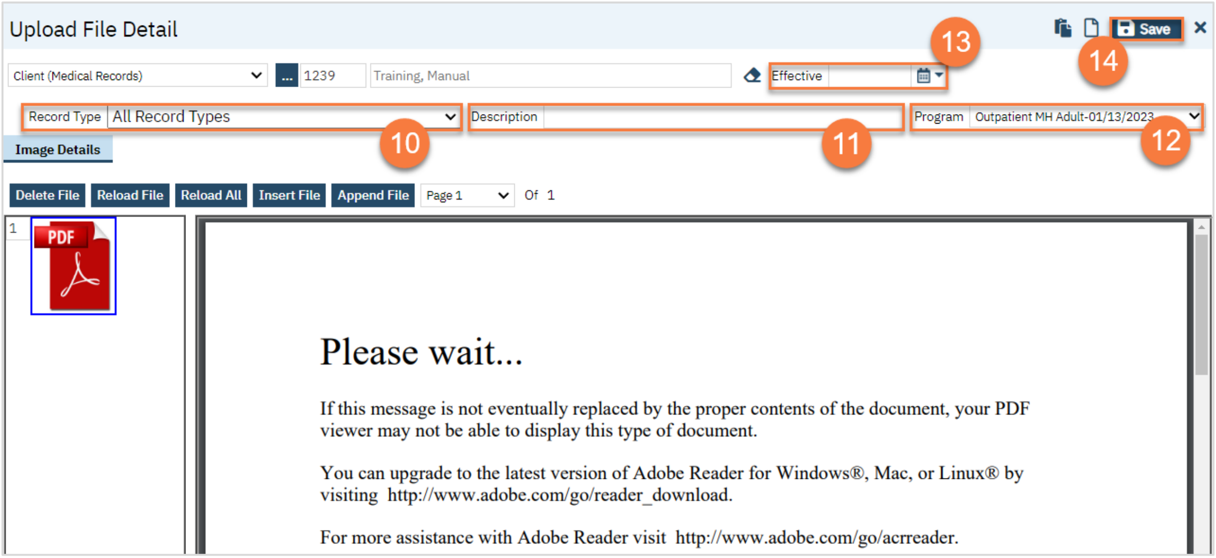
7. This will show you the PDF. Confirm you uploaded the correct document. **Make corrections as needed** using the buttons at the top of the PDF viewer.
8. **Select "Client (Medical Records)" from the first dropdown menu**.
9. **Click on the "…" button** to find the client.



a. This will bring up the client search. Use the client search to find the client. Click Select when you've located the client.



10. **Select the Record Type**.
11. **Enter the description** of the document.
12. **Enter the program** the document is associated with.
13. **Enter the Effective date** of the document.
14. **Click Save.**



Upload File Detail
Save
Client (Medical Records)
1239
Training, Manual
Effective
Record Type
All Record Types
Description
Program
Outpatient MH Adult-01/13/2023
10
11
12
13
14
Image Details
Delete File
Reload File
Reload All
Insert File
Append File
Page 1
Of 1
PDF
Please wait...
If this message is not eventually replaced by the proper contents of the document, your PDF viewer may not be able to display this type of document.
You can upgrade to the latest version of Adobe Reader for Windows®, Mac, or Linux® by visiting http://www.adobe.com/go/reader_download.
For more assistance with Adobe Reader visit http://www.adobe.com/go/acrreader.