Clinical Documentation User Guide

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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

Reach out to your county's System Administrator for assistance. If needed, they will escalate to the CalMHSA Help Desk.

You can also reach CalMHSA's Help Desk at: (916) 214-8348 or submit a live chat question to https://2023.calmhsa.org/

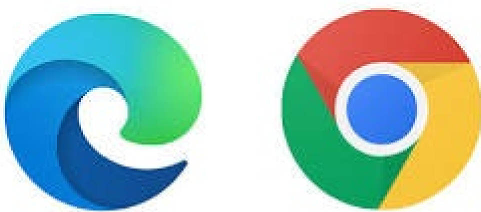
Note: Before beginning to use the system, make sure you have a compatible internet browser like Microsoft Edge and Google Chrome. CalMHSA recommends Google Chrome for best user experience.

LMS Related Support

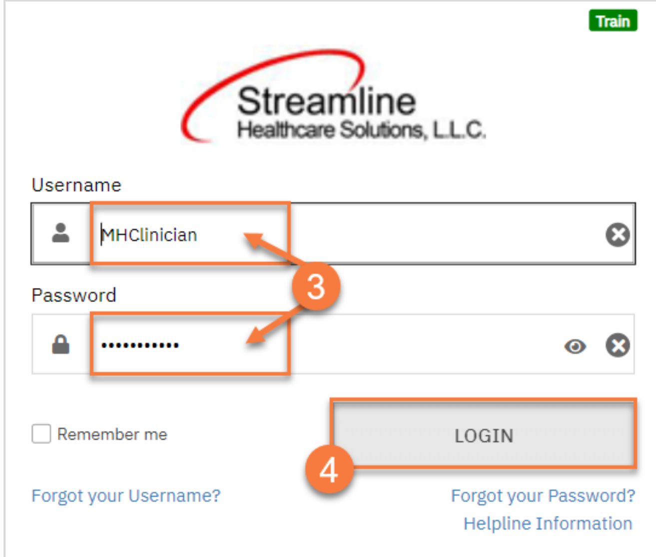
Please email: moodle@calmhsa.org

Logging in to SmartCare

1. From the desktop, open your internet browser (SmartCare supports Chrome and Microsoft Edge)



2. Enter the SmartCare URL provided by your System Administrator
3. This takes you to the login screen. **Enter your username and password**. For your first login, these will be provided by your System Administrator.
4. **Click Login.**

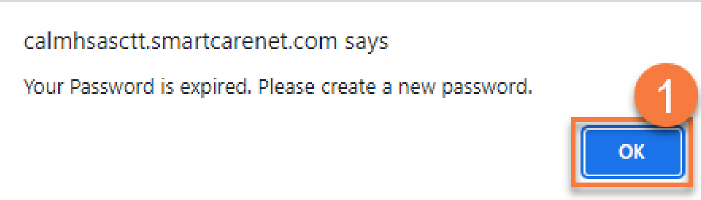


First Time User Login Process

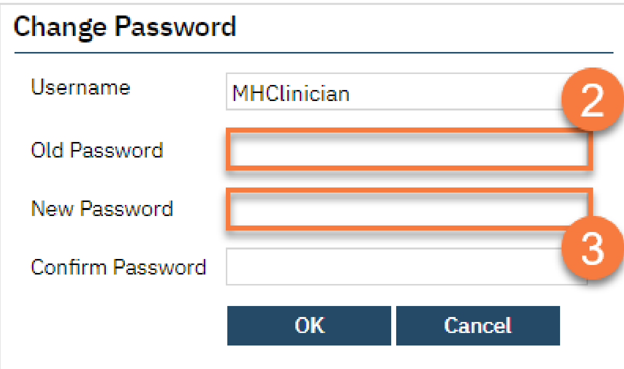
Changing Your Password

The first time you log in, you will have to change your temporary password provided to you by your System Administrator.

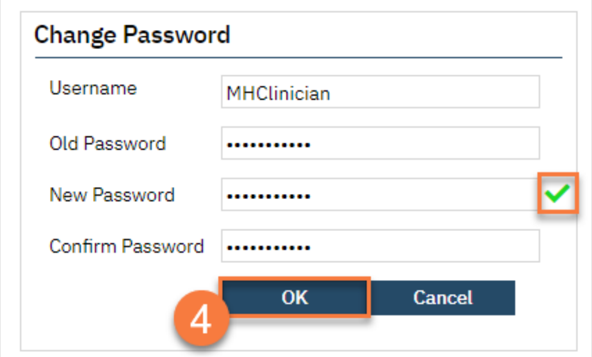
1. You will see a pop-up that indicates your password has expired. Click OK.



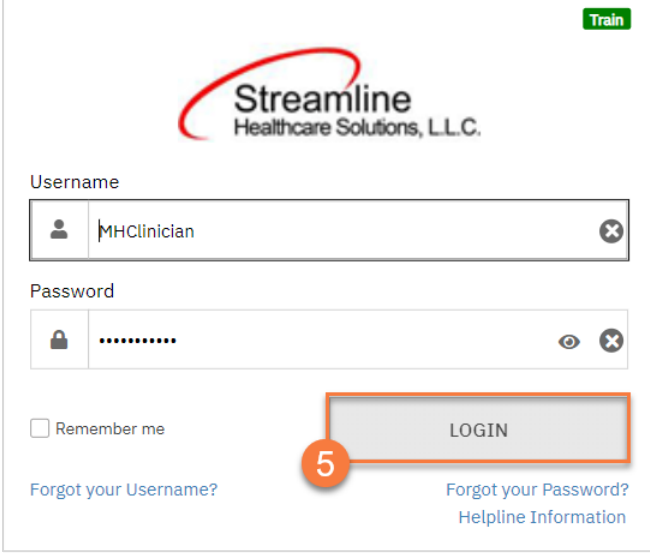
2. This takes you to the Change Password screen. Enter your old password (the one your System Administrator provided for you).
3. Create and enter a new password. Check with your System Administrator for password requirements. You'll need to re-enter it in Confirm Password.



4. If your password meets the system requirements, you'll see a green check next to the New Password field. Click OK.



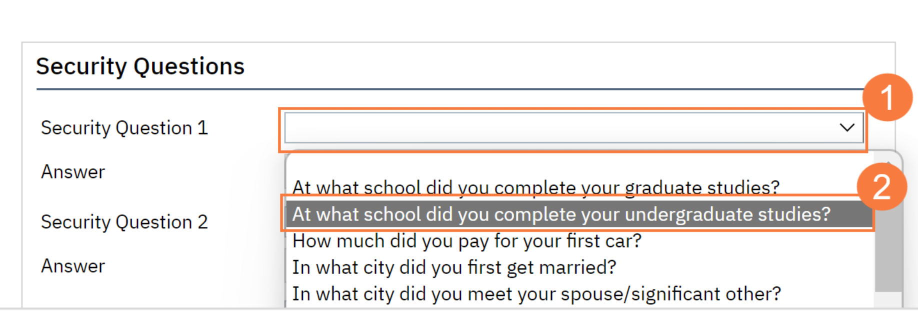
5. This takes you back to the login screen. Your new password has already been entered. Simply click Login.



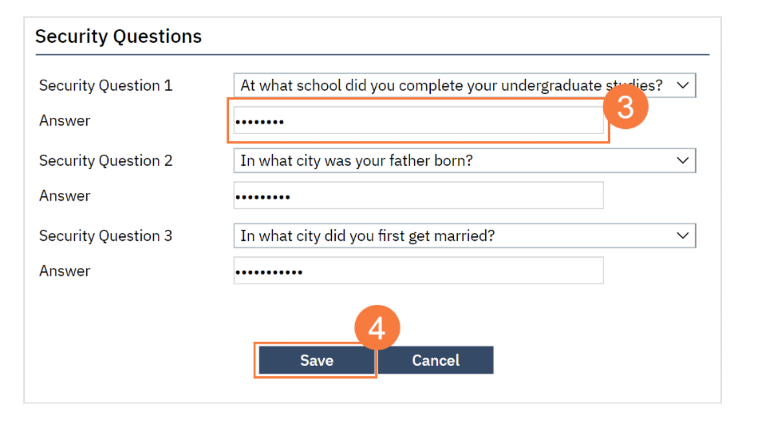
Setting up Your Security Questions

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

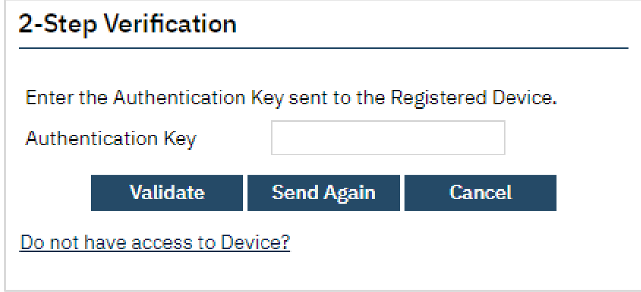


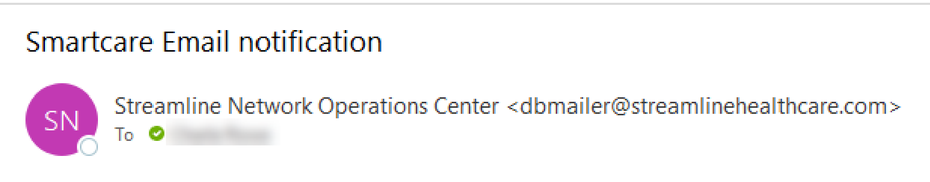
3. In the Answer field, **type the answer** to your chosen security question
    a. Repeat this for the remaining two questions
4. **Click Save**



Subsequent Logins

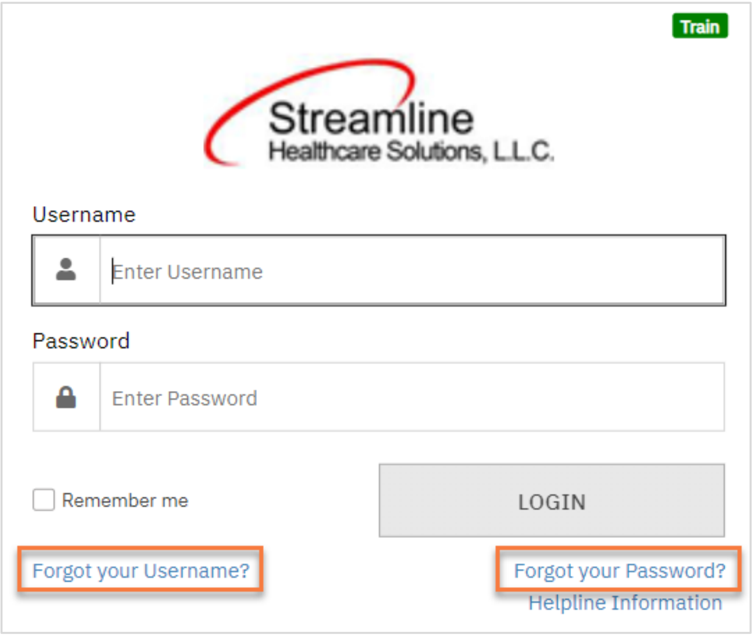
SmartCare uses multi-factor authentication, or MFA. This means that when you log in, you'll receive an email with a code that you'll need to enter. Your system administrator will set up how often this needs to happen.



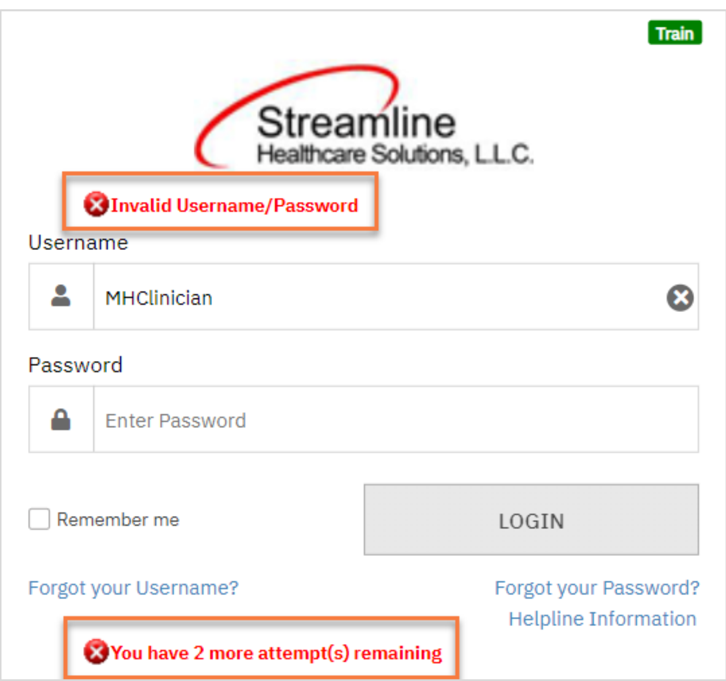


Login Help

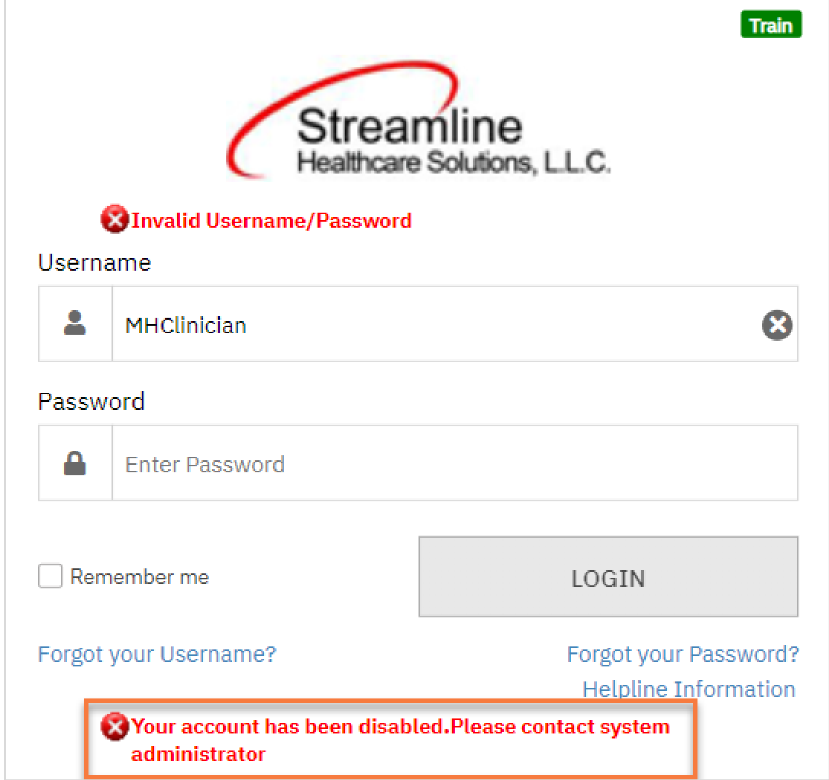
On the login screen, there are links for when you forget your username or password. The system will lock you out after 3 failed login attempts, so we recommend using these links prior to failing your 3rd login attempt.



The system will alert you when you've failed a login attempt and let you know how many attempts you have remaining.

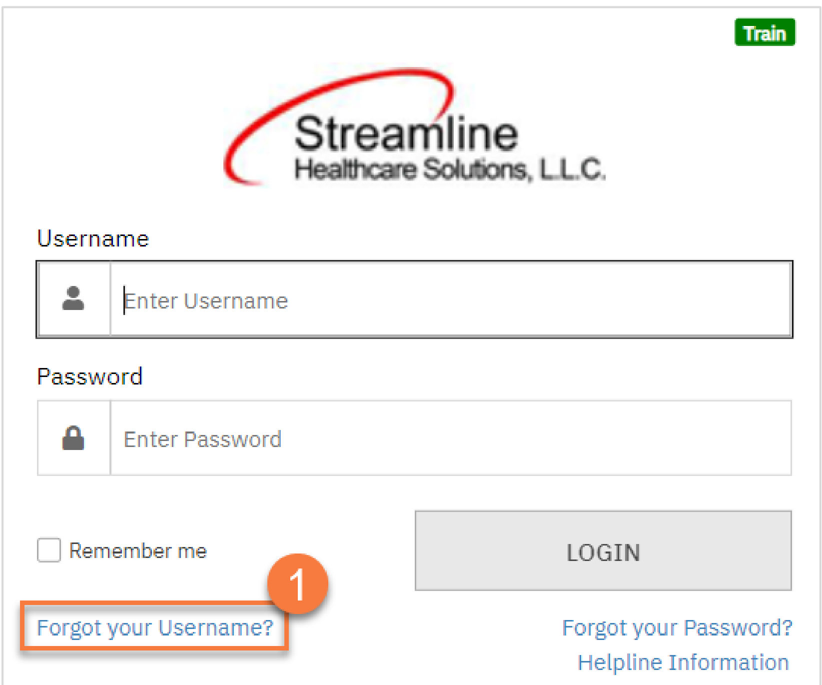


After 3 failed login attempts, your account will be locked. The system will alert you to this. Reach out to your county's System Administrator to unlock your account.

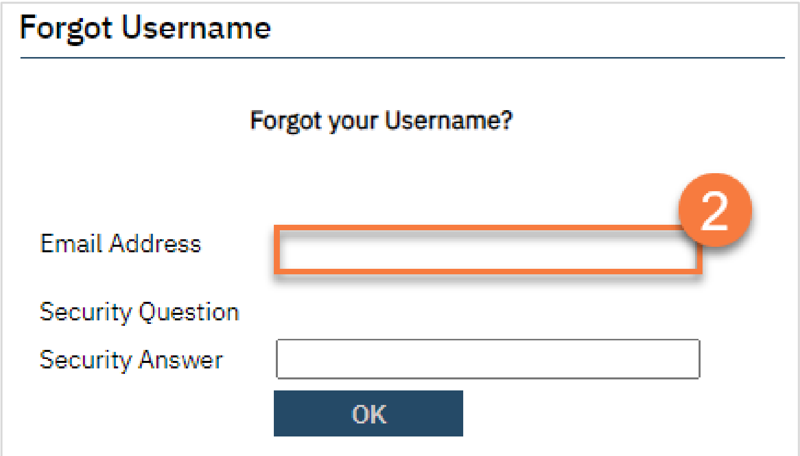


How to Recover Your Username

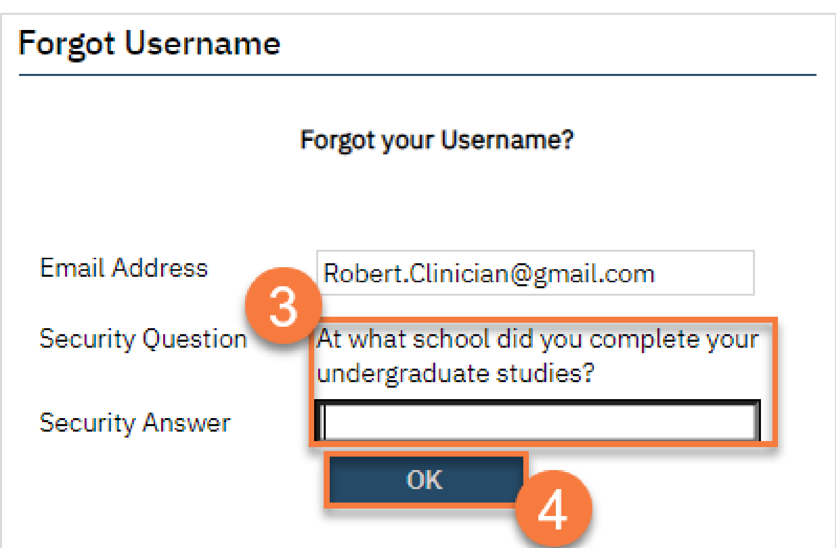
1. On the login screen, click the link "Forgot your Username?"



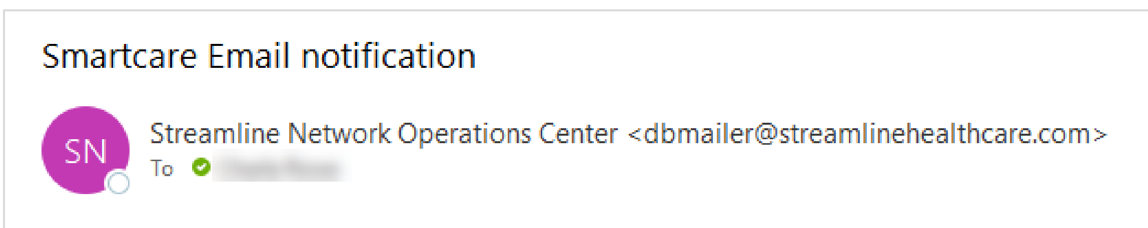
2. This brings you the Forgot Username screen. **Enter your email address.** This is the email address associated with your SmartCare account.



3. **After entering your email address, hit the tab key.** This will bring up one of your three security questions. **Enter the answer to your security question.**
4. **Click OK**.

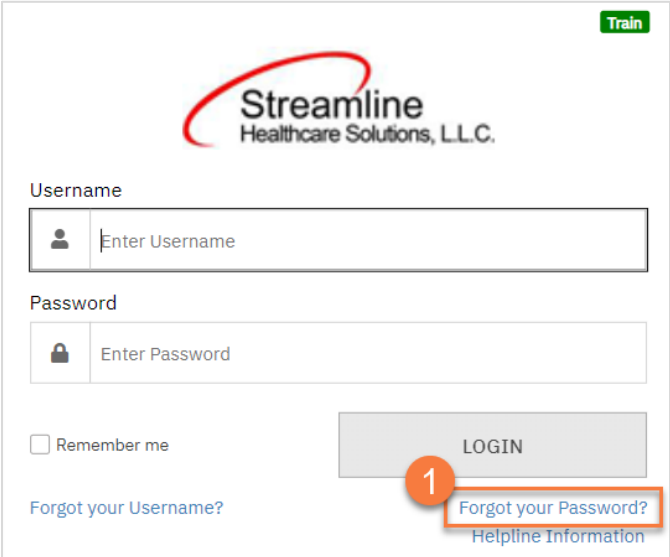


5. You will receive an email from Streamline with your username. The email will look something like this:

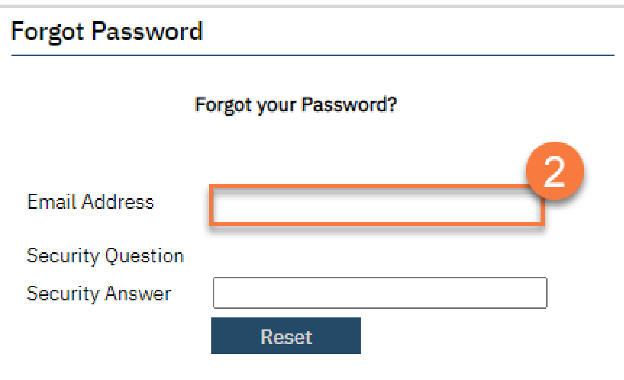


How to Reset Your Password

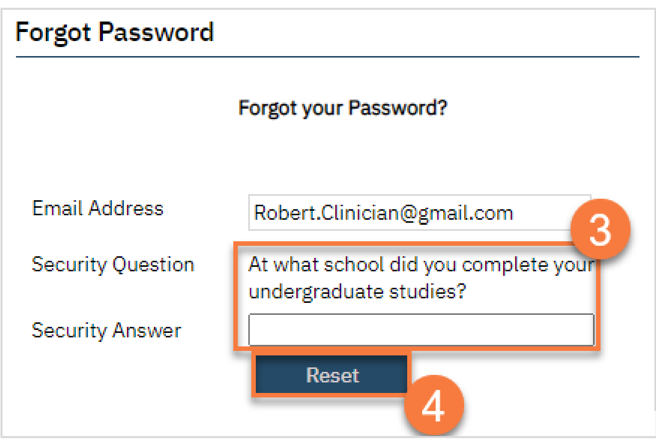
1. On the login screen, **click the link "Forgot your Password?"**



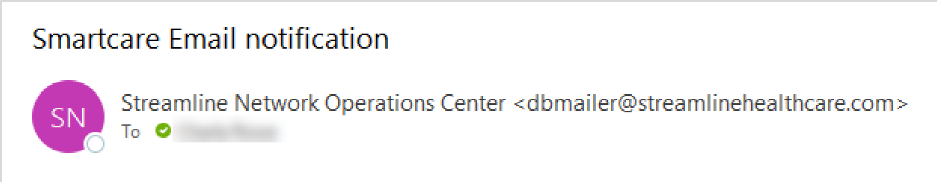
2. This brings you the Forgot Username screen. **Enter your email address.** This is the email address associated with your SmartCare account.



3. **After entering your email address, hit the tab key.** This will bring up one of your three security questions. **Enter the answer to your security question.**
4. **Click OK**.

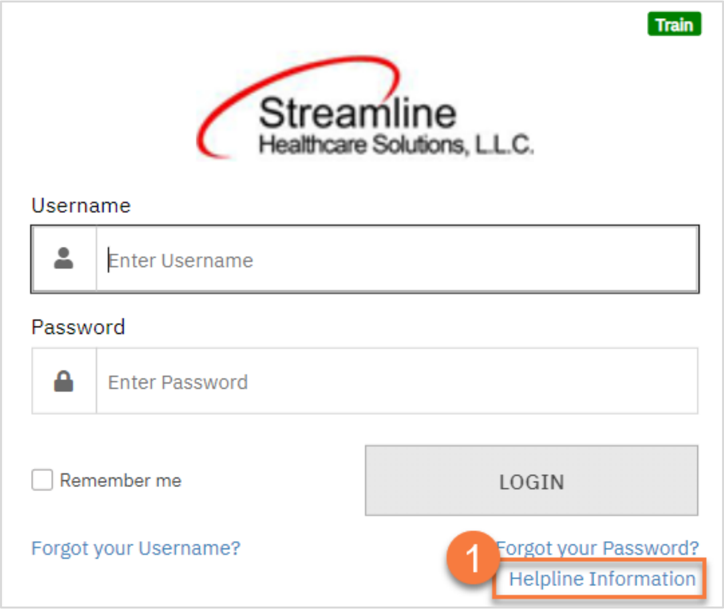


5. You will receive an email from Streamline with your new password. The email will look something like this:



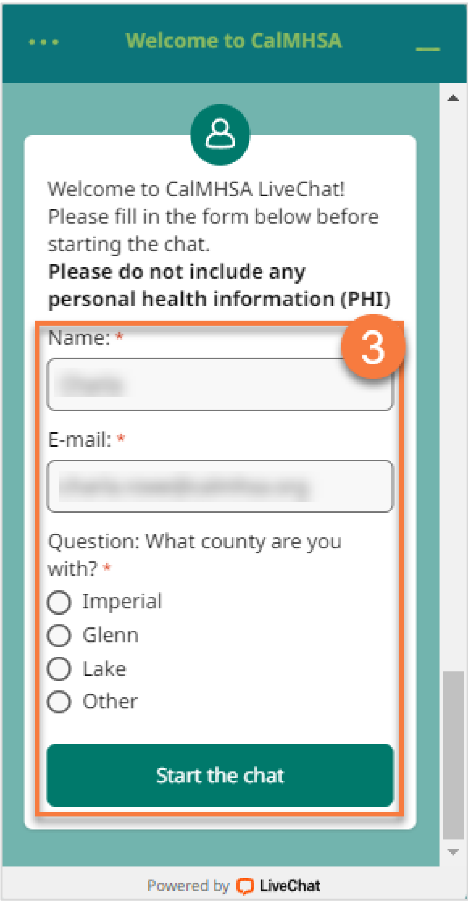
How to Get Additional Login Assistance

1. If you're still not able to login or have locked yourself out of your account, click the Helpline Information link.

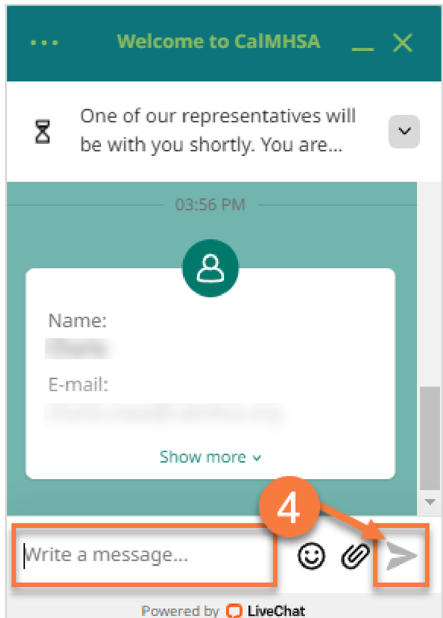


2. This should take you to the CalMHSA helpdesk website. Click on the Live Chat icon in the lower right corner to start a chat with CalMHSA's Help Desk.

3. This will bring up a pop-up chat window. **Enter your information and click "Start the chat"**.



4. This will open the chat window. **Enter your question and click the Send icon**. Someone from CalMHSA's Help Desk will pick up your chat and help troubleshoot your issue.



Basic Navigation and Functionality

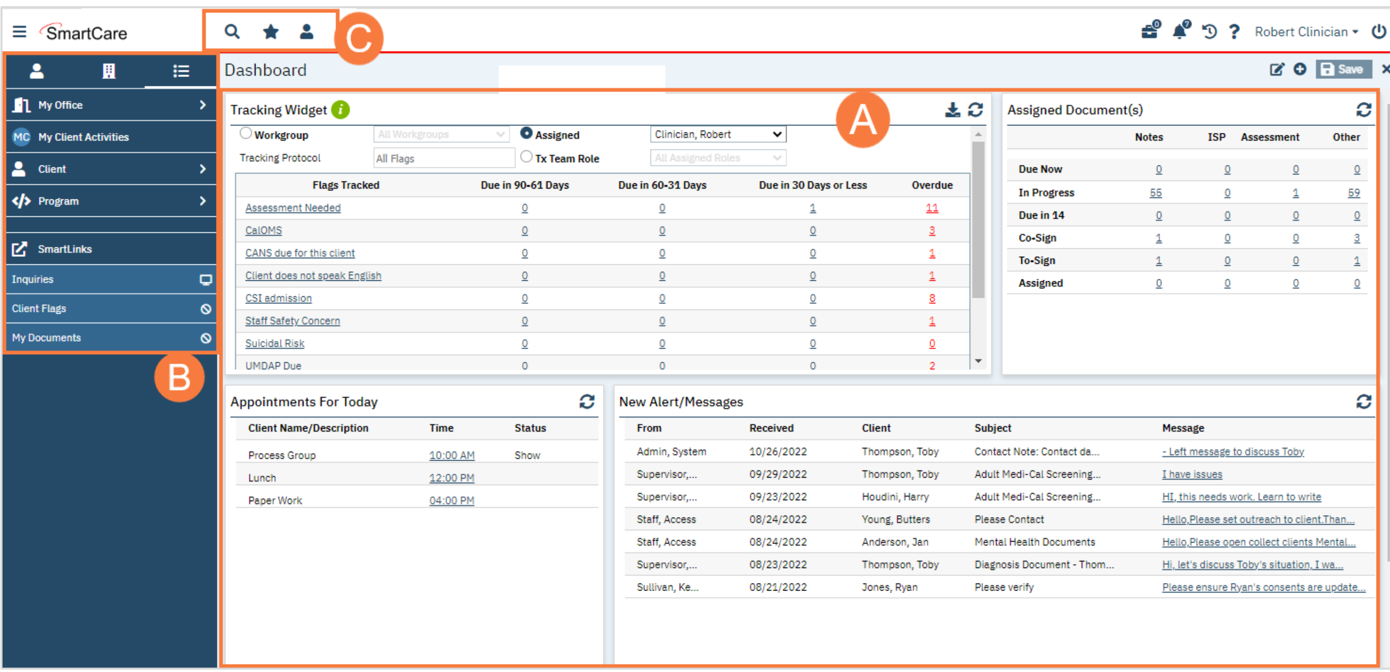
This section will cover basic SmartCare functionality, terminology, and navigation.

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.

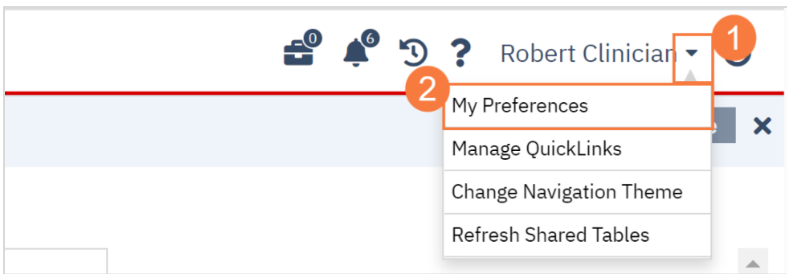
The **Icons and Functionality** table below describes each icon.

Icons and Functionality	
☰	The **Menu icon** will open and close the Navigation Filters bar
SmartCare	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
0	The **Unsaved Changes icon** will display a list of screens that you made changes to but navigated away from before saving
6	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:

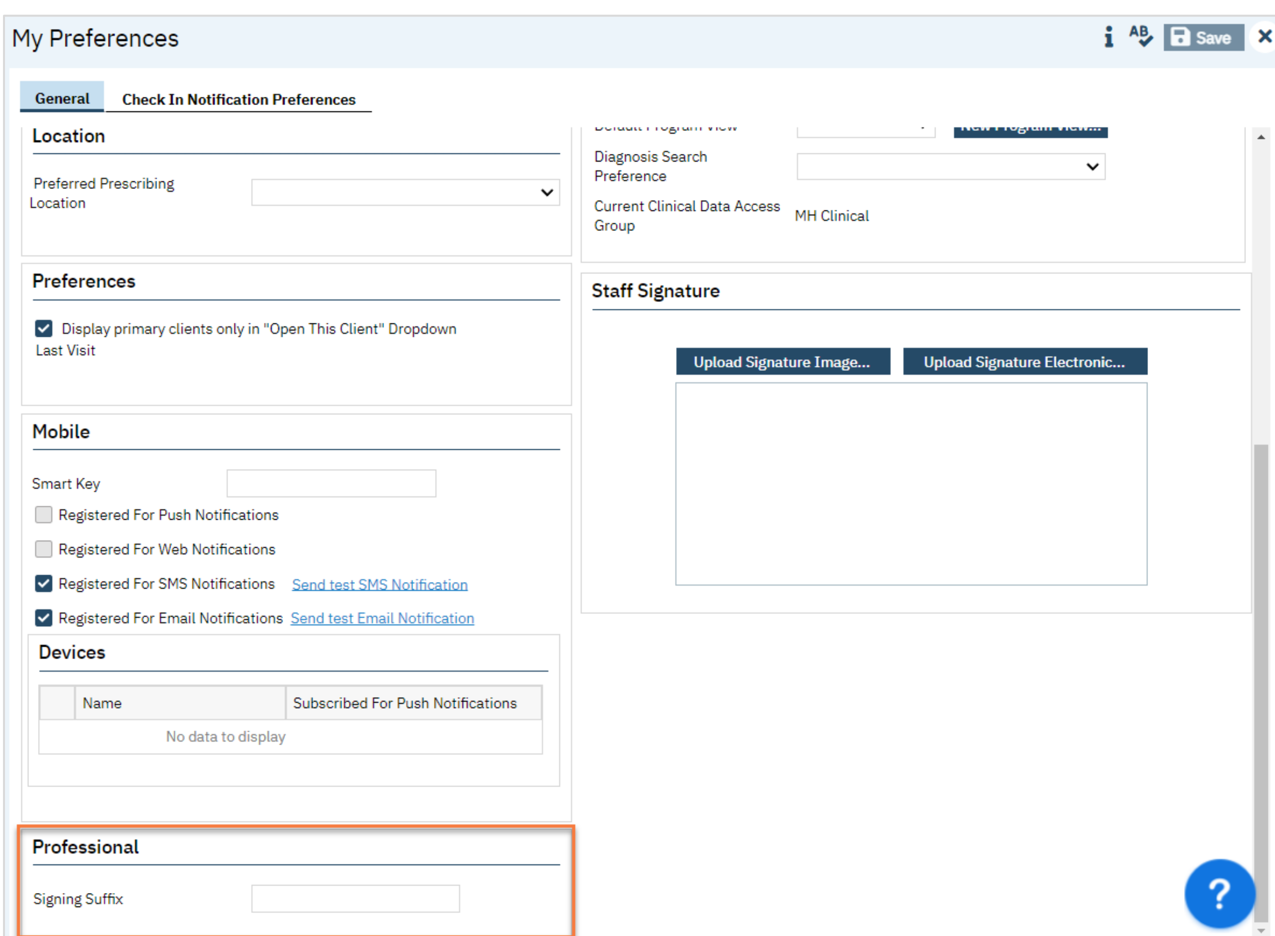
1. From the Header, **click the drop-down menu after your name** in the upper right-hand side.
2. A menu will open, **select Preferences** from the menu options



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

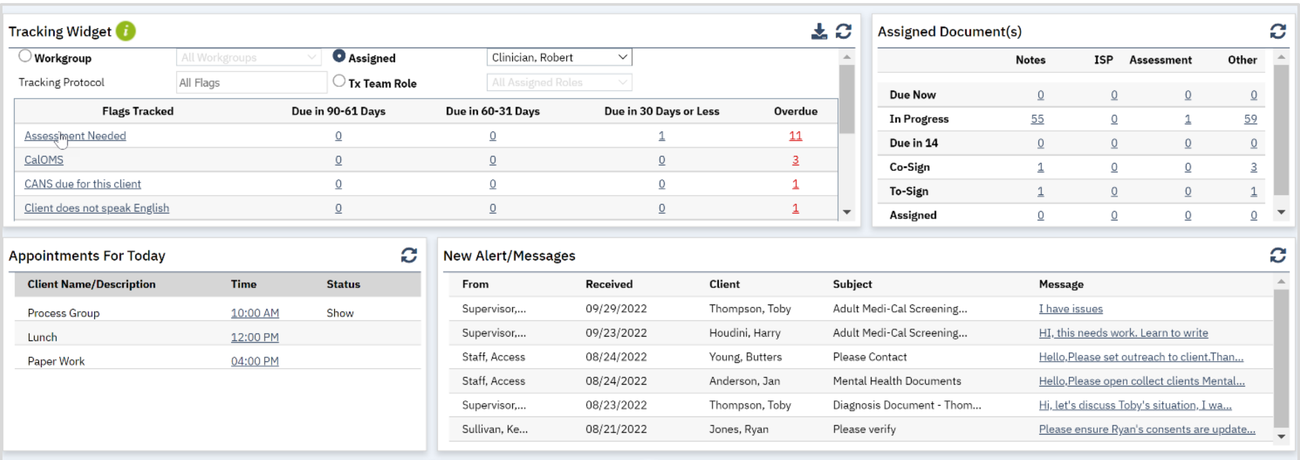
How to Add or Update Your Signing Suffix

Navigate to your My Preferences using the steps above. Scroll to the bottom of the page. You can enter in your signature suffix, such as “LMFT” or “Certified Peer Support Specialist”.



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.

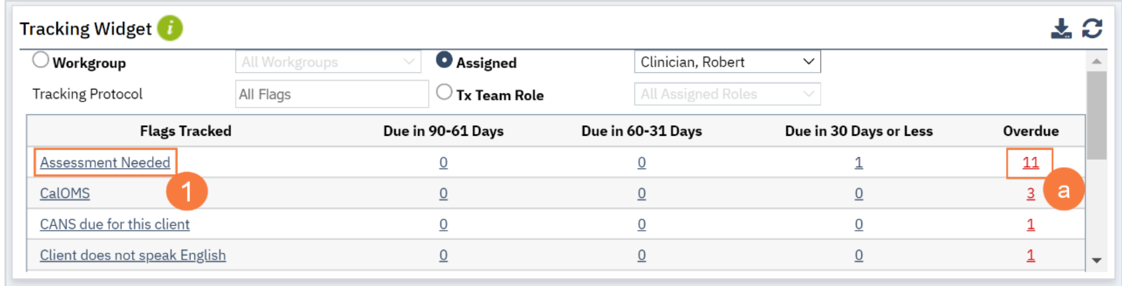
Tasks are grouped into 4 categories for easy prioritizing,

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

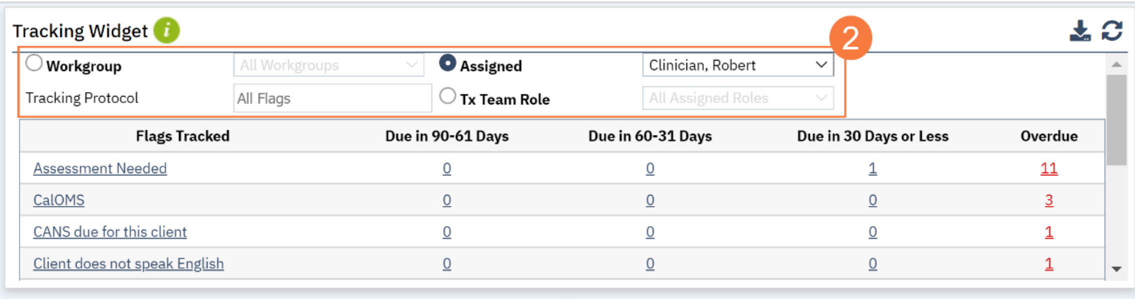
If a document doesn't have a due date, but hasn't been completed, it will show

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**.

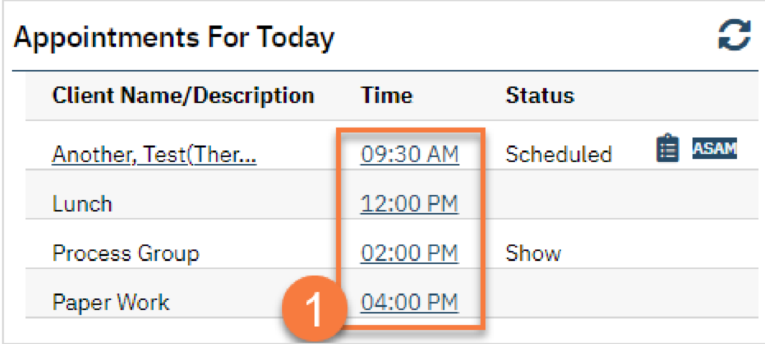


2. For Supervisors, you can change between Workgroup, Assigned, and Tx Team Role by clicking on the radio button to the corresponding field.

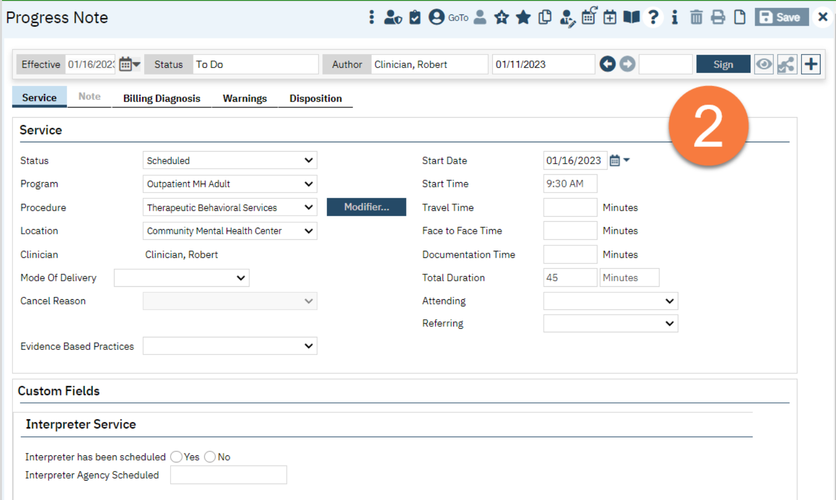


The Appointments for Today Widget

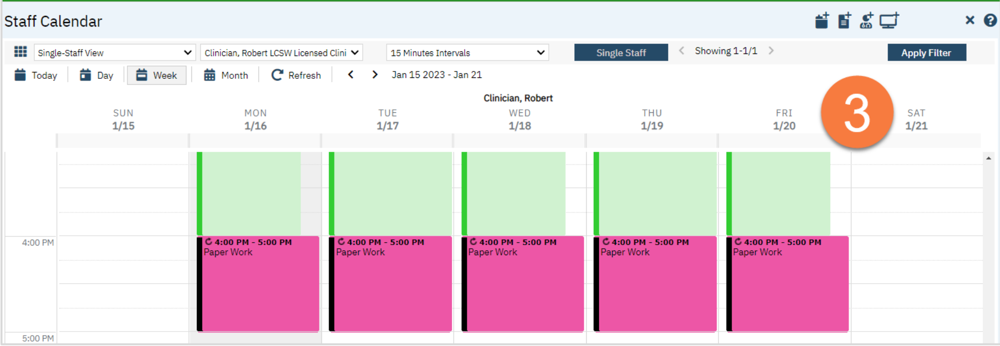
1. This widget allows you to see your daily schedule at a glance. This includes non-client time, such as meetings and time off, as well as client appointments. Clicking on the link will take you to that appointment.



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

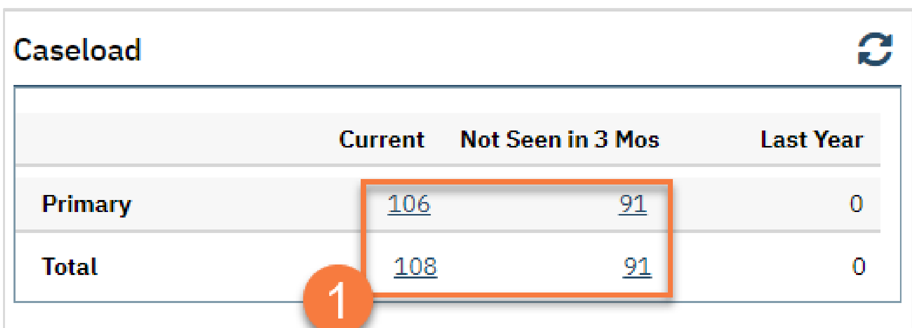


3. For non-client appointments, like meetings, this link will take you to the Staff Calendar.

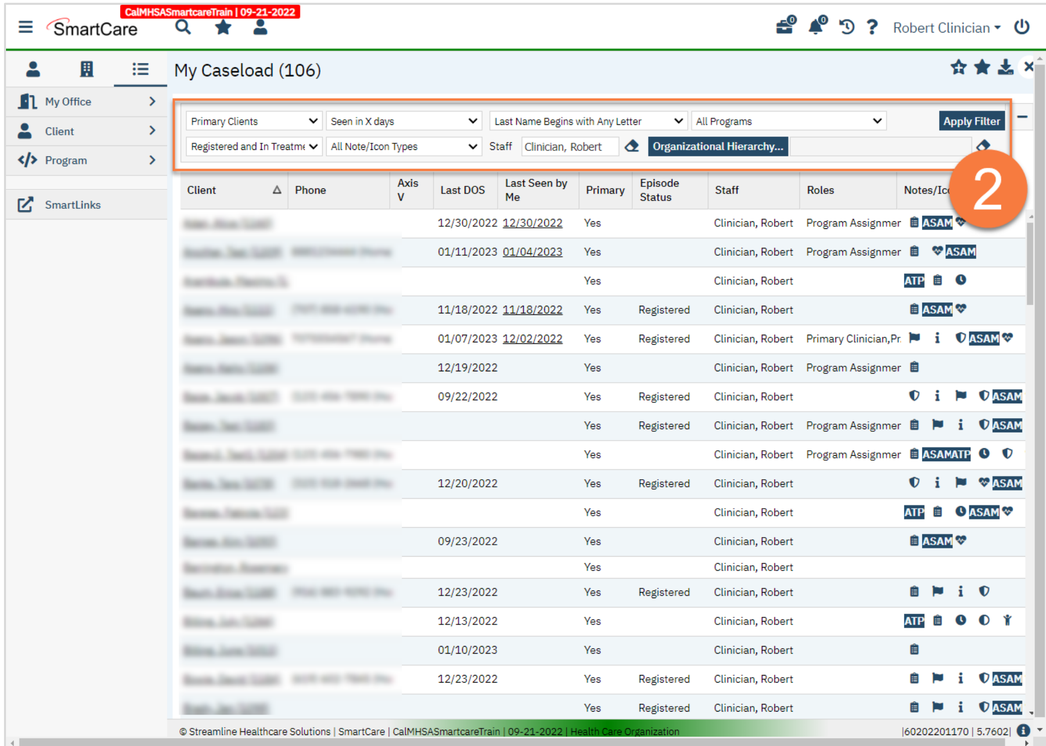


The Caseload Widget

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.

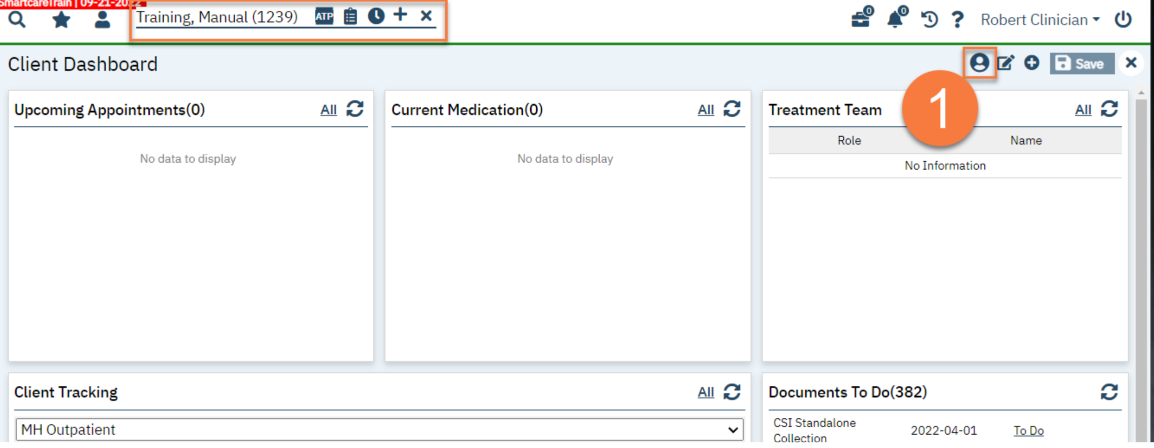


2. Just like any list page, you can use the filters at the top of the page to narrow the results as needed. Depending on the link you clicked from your dashboard, some filters may already be in place.

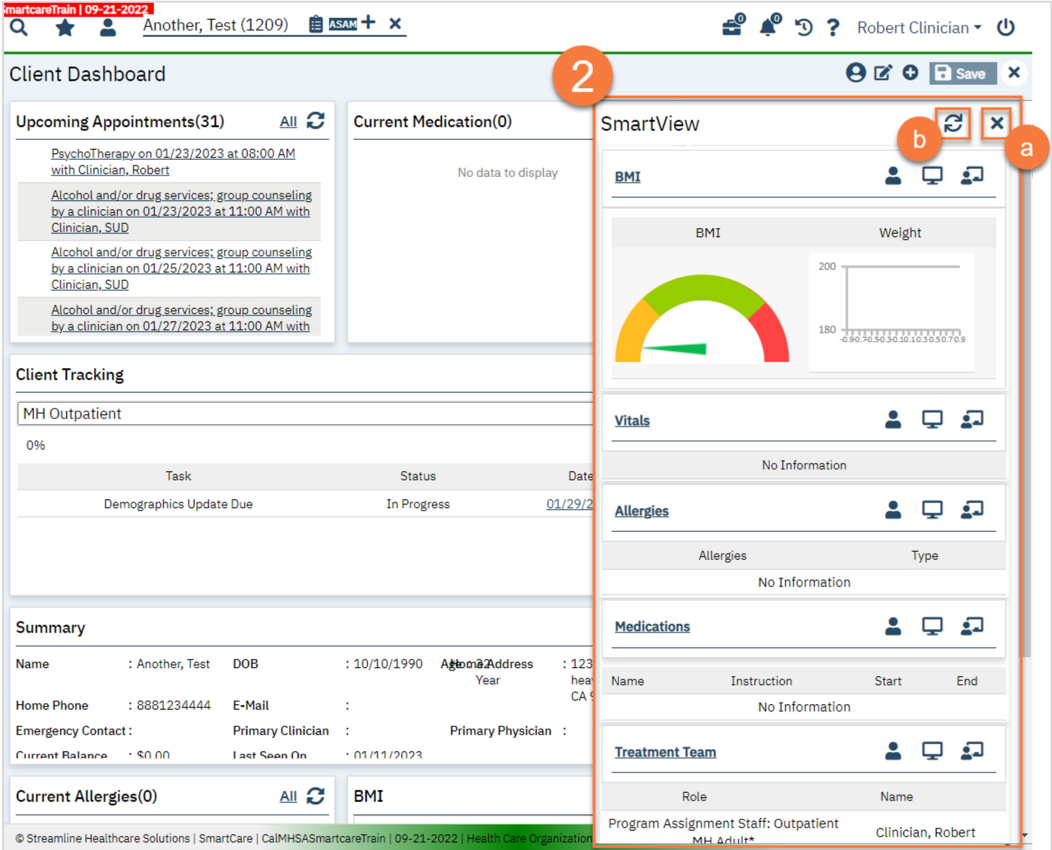


The SmartView

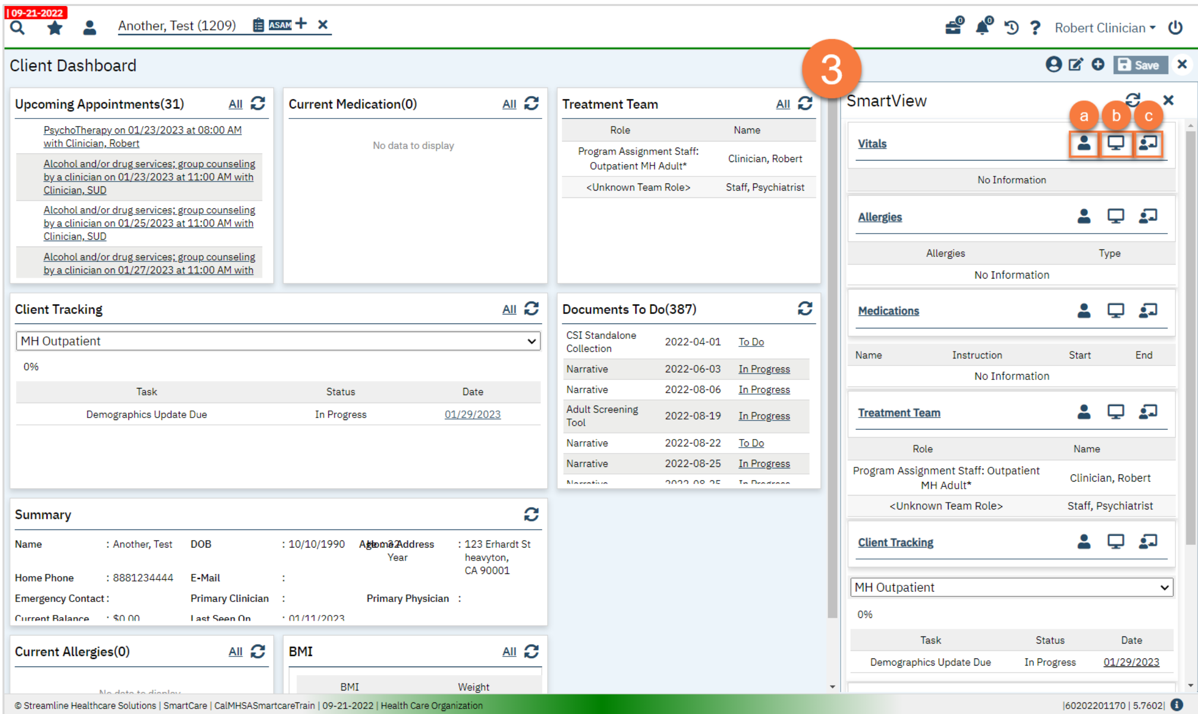
1. When you have the client open, click on the SmartView icon in the upper right corner of the screen.



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.

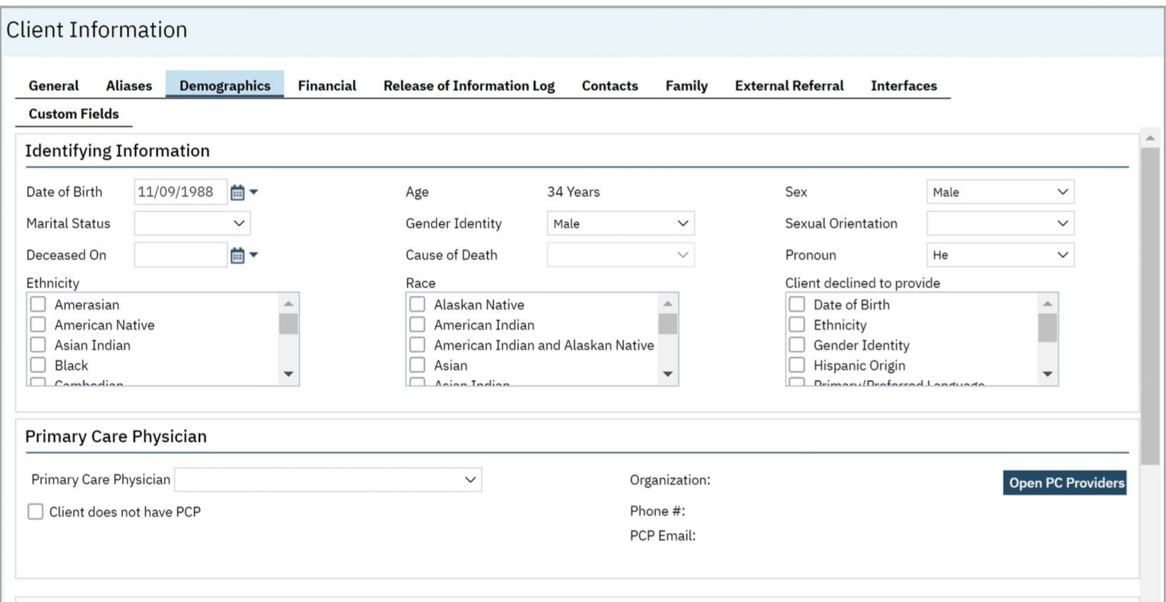


Screens vs. Documents

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.

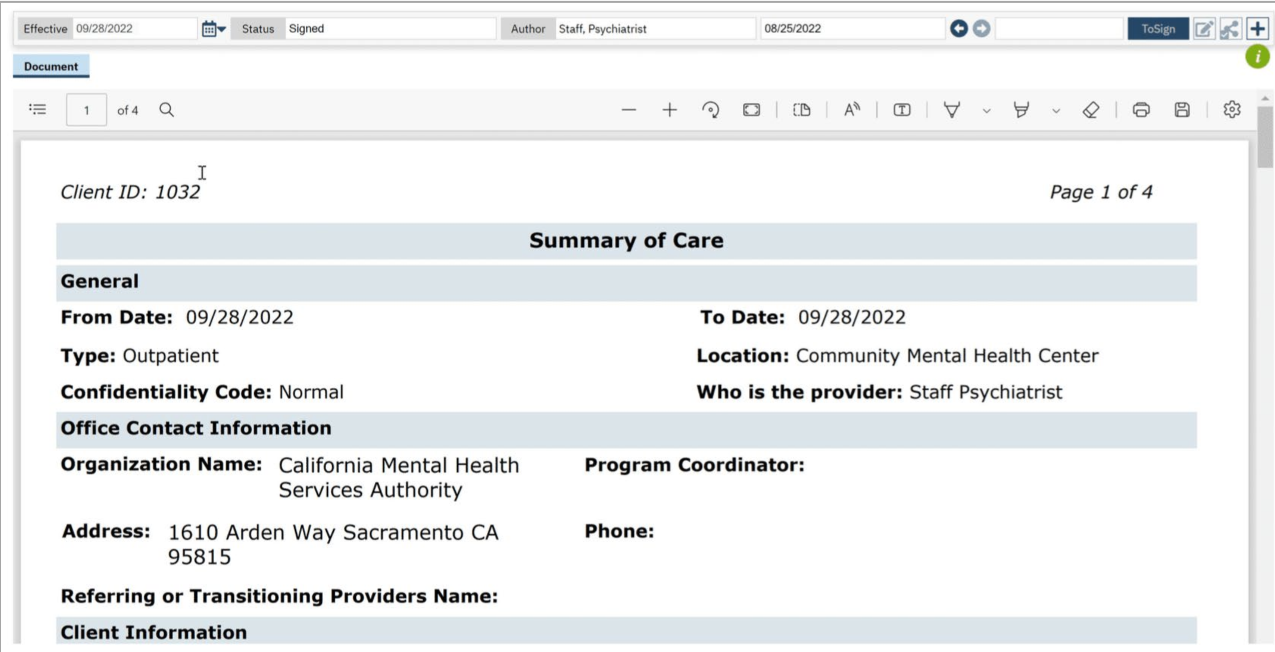
Screens

When referring to screens in SmartCare, we are referring to forms that are editable and display the data most recently entered.



Documents

When referring to documents in SmartCare, we are referring to PDF documents that have been saved in the client's chart that can no longer be edited once they have been generated and are references for historical data.

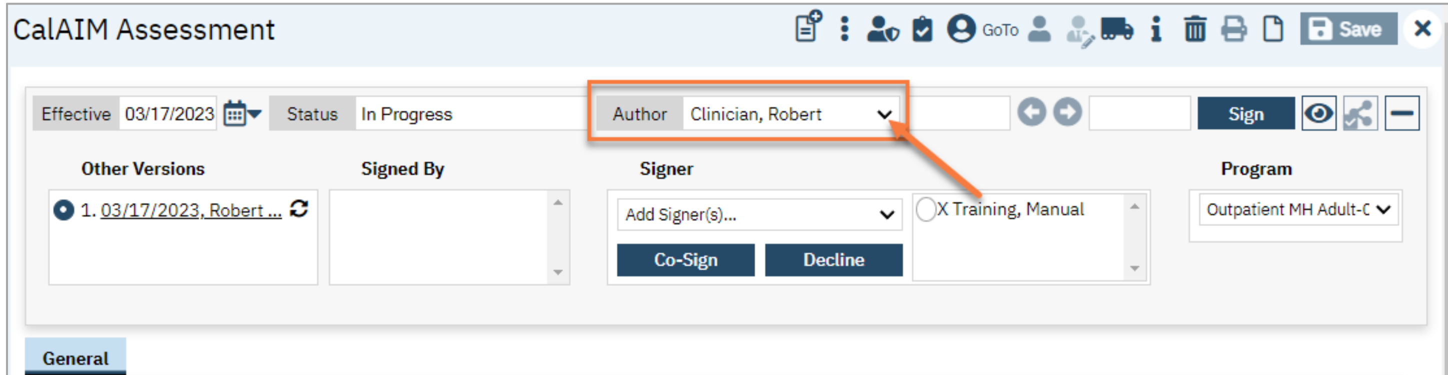


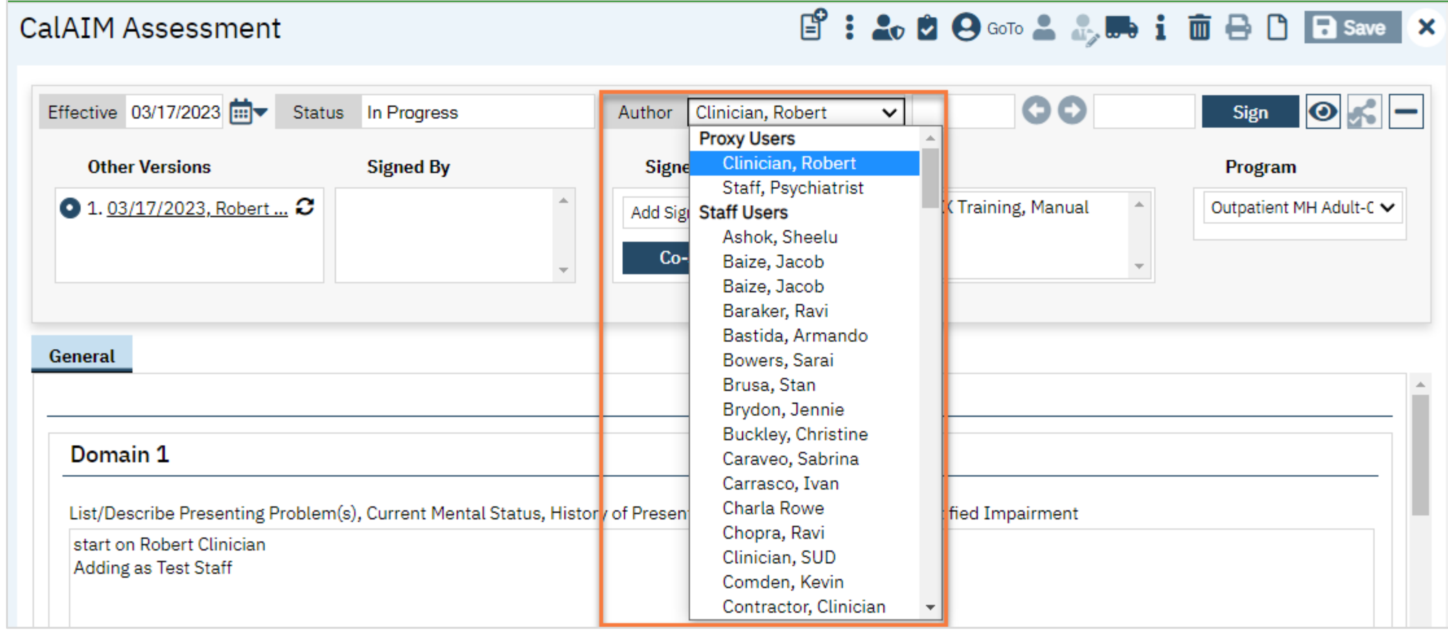
All documents have the document ribbon at the top of the screen. To expand the ribbon, click on the Plus icon.

The Effective date is the date of the document. This automatically populates as today's date.

The Status will be "In Progress" until the document is signed. This automatically updates as you complete the document.

The Author is the person who can edit the document. This automatically populates to the person who created the document. Documents can only have 1 author at a time. If you need to pass a document on to someone else, the author can be reassigned. If you are the author, you can select someone else by selecting the author dropdown in the document ribbon. Any users you are a proxy for will show at the top of the list. All other staff will show lower. Once you select the new author and click save, you will no longer be able to edit this document.





If you are not the author but have permission to reassign, you would use the Caseload Reassignment to change the author. This is covered in the Supervisor section.

Other Versions show previous versions of the document. When you edit a document, the system will create a new version of the document but save the old version for audit purposes. You can make whatever edits you need to in the new version, as these changes will not impact the original at all. The system will always show the most recent version when initially viewing the document, but you can select another version to view that in the PDF viewer area.

Signed By shows who has signed the document. This will include any cosigners that have already signed.

Signer allows you to add co-signers. Anyone who has been set as a co-signer but has not yet signed the document will show in the window on the right. To have someone sign, you would select them from this window and click "Co-Sign" to open the signature window. Once they've signed, they will be removed from the Signer window and move to the "Signed By" window.

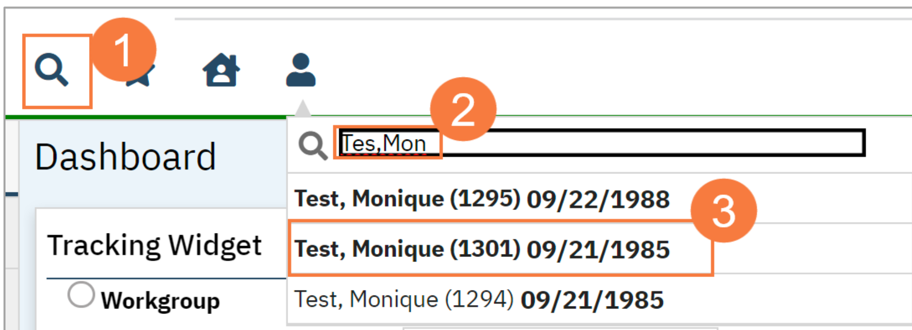
Program shows which program this document is tied to. Each document must be tied to a program in order for privacy rules to be enforced in the system. While the document is still "In Progress", the program can be updated by clicking on dropdown and selecting the appropriate program. You'll only be able to select programs that you're associated with. If you don't see a program that you work in, talk to your System Administrator to confirm your user setup.

Client Search

In SmartCare there are several ways to search for a client. In this section we will outline the different methods you can use to look-up a client. It is important to note there is a difference between using the client search icon and using the client search window to search for clients.

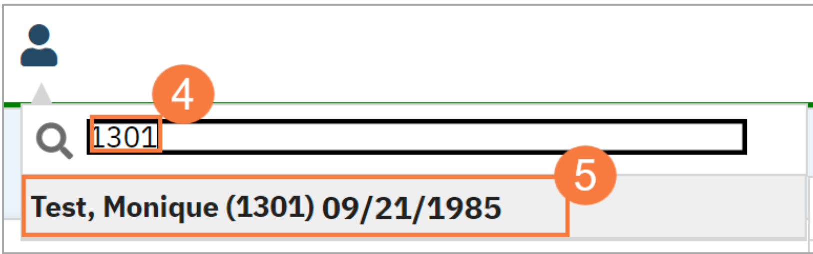
How to Use the Client Search Icon

1. Click the Client Search icon.
2. In the Search bar,
   - Type the first few letters of the client's last name.
   - Add a comma,
   - and the first few letters of the first name.
     a. **For example:** a patient named Monique Test, you would type, "Tes,Mon"
     b. **Note:** To search by first name only, make sure to enter a comma first ",Monique".
3. Click to select the correct client.



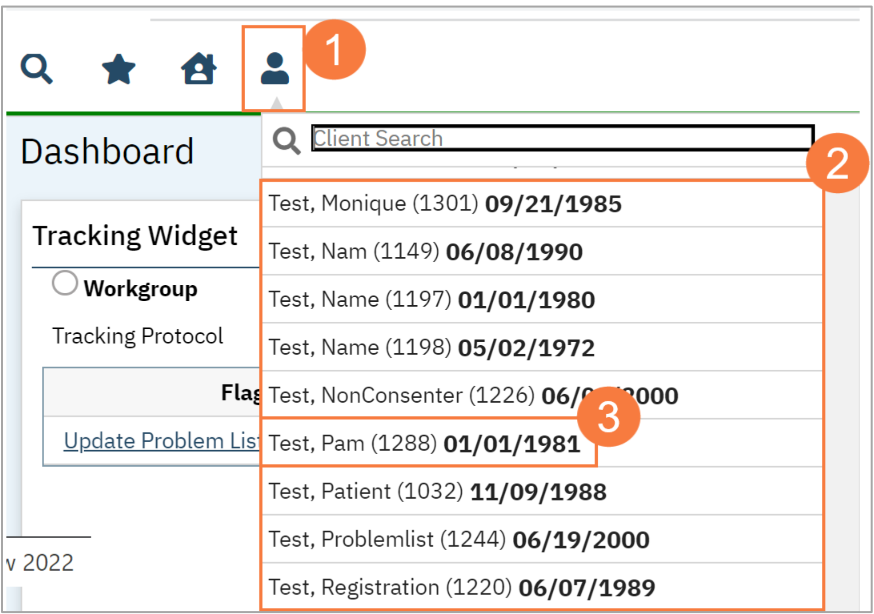
OR

4. In the Search bar, type the client ID number.
5. Click to select the correct client.



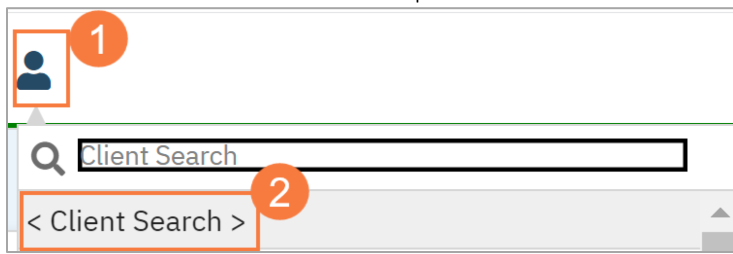
How to Use the Client Search Icon to Search to Find Client's in Your Caseload

1. **Click the Client Search** icon.
2. A list of clients in your caseload will populate.
3. To select a client, **click their name.**

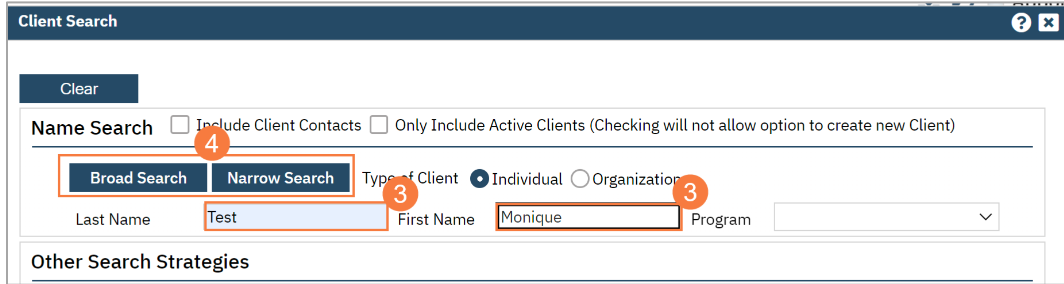


How to Use the Client Search Window

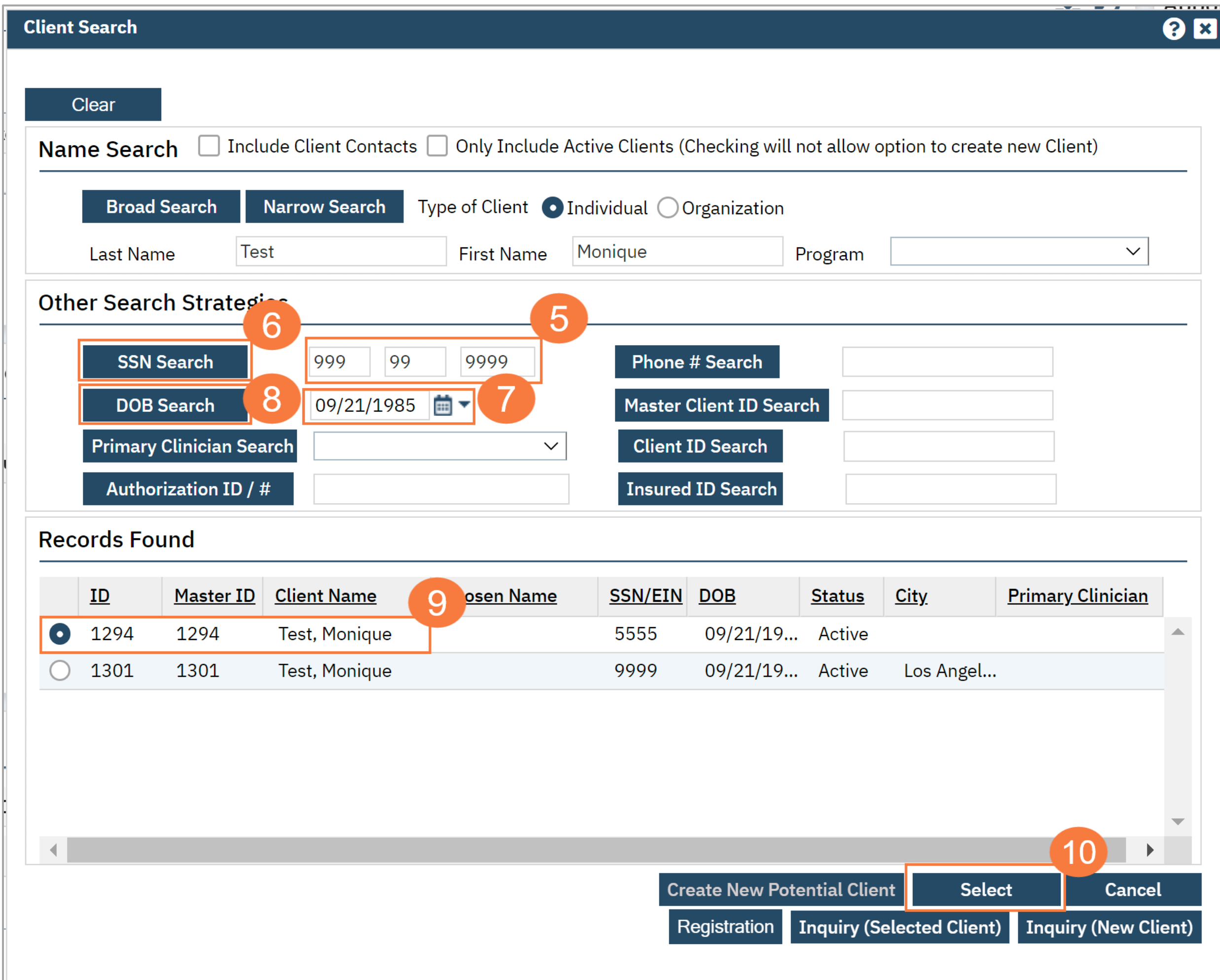
1. **Click the Client Search icon.**
2. **Click to select Client Search**. The Client Search window will open.



3. Type the client's Last Name and First Name in the corresponding fields.
4. **Click the Narrow Search** to be more specific in your search. **Click Broad Search** to widen your search results.



5. If you are still unable to locate the client, **enter the SSN** in the corresponding field.
6. **Click SSN Search**.
7. If you are still unable to locate the client, **enter the DOB.**
8. **Click DOB Search**.
9. When you locate the client, **click the radio button next to the client**.
10. **Click Select**. The Client Dashboard will open.



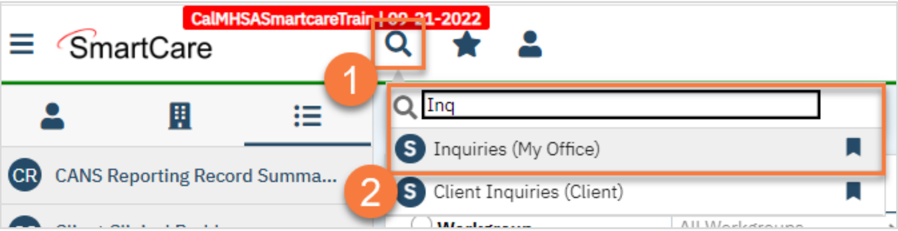
Life Cycle of the Client: Request for Services

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.

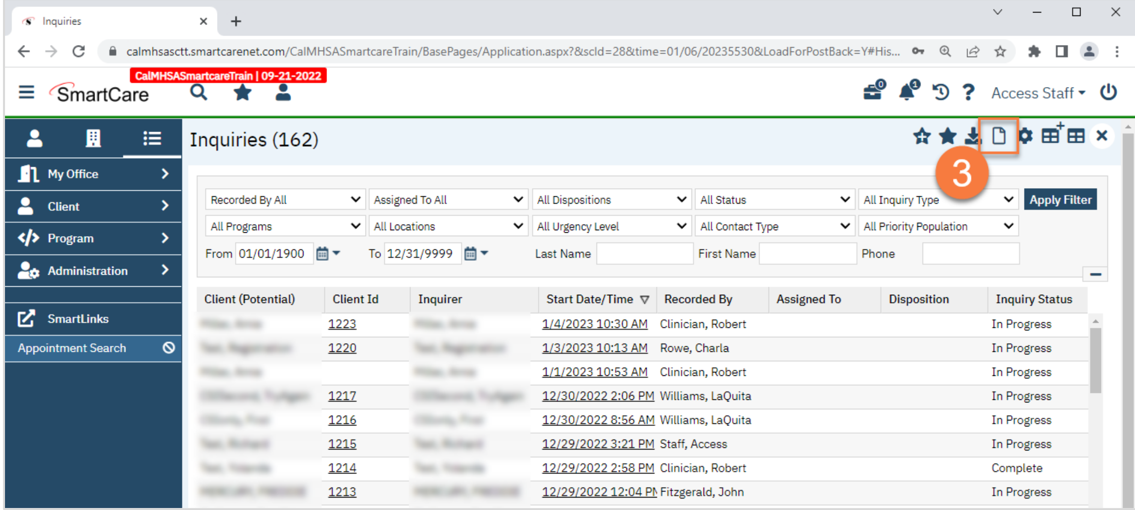
How to Document a Request for Services Received via the Access Line

Access Line calls are documented on the Inquiry screen.

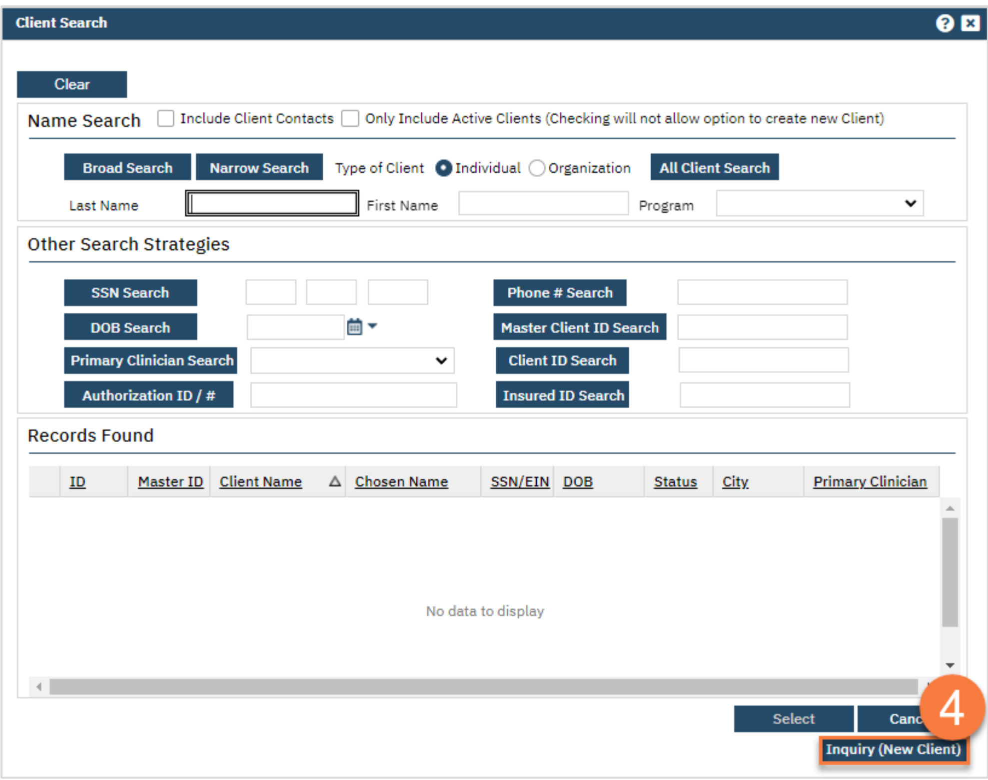
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



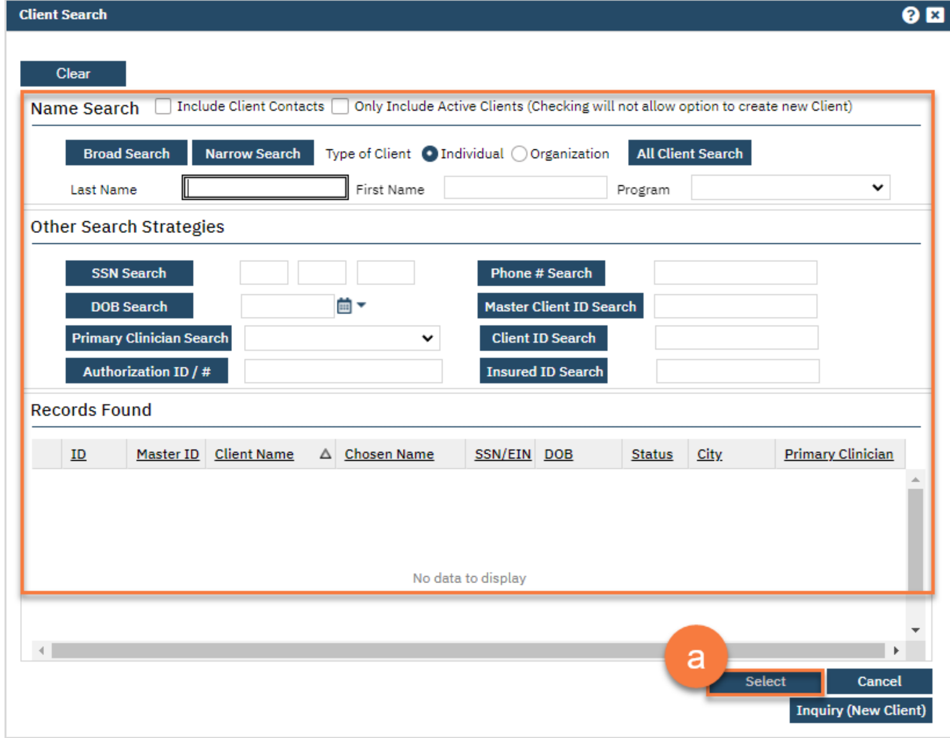
3. This will bring you to the Inquiries list page. **Create a new inquiry** by using the new icon.



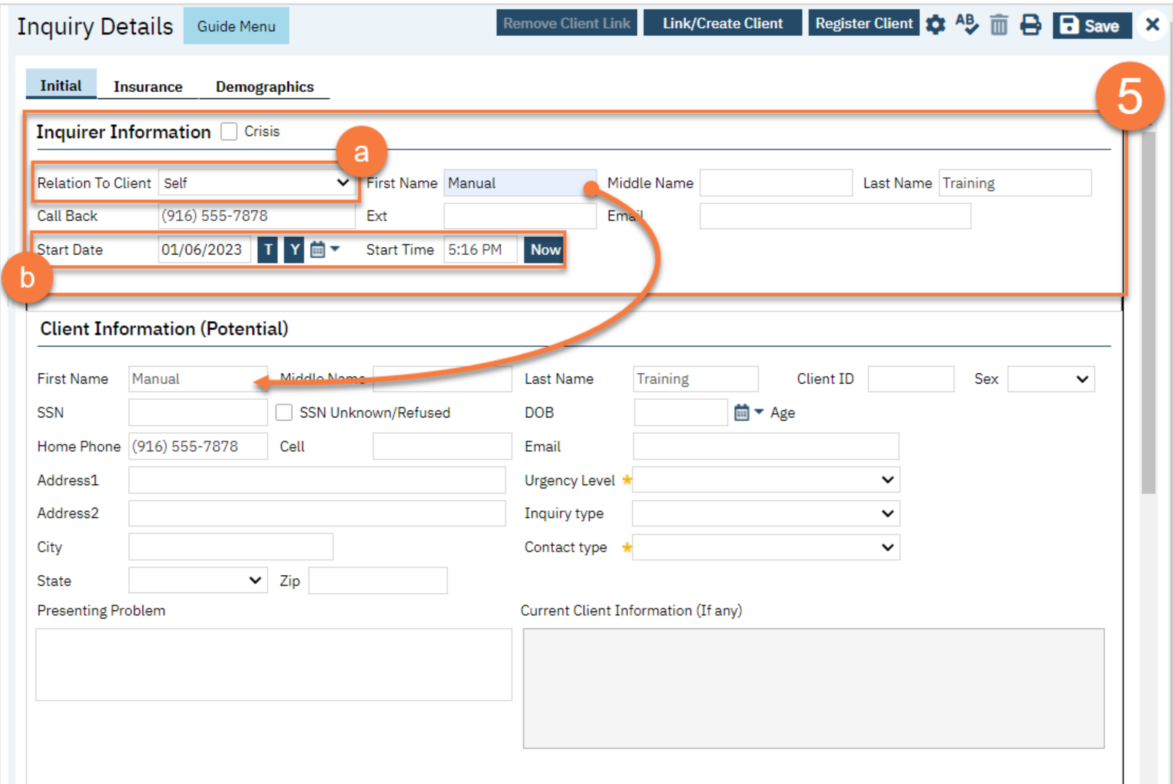
4. This will bring up the client search window. **You may search to determine if the person is a current client**. If person is a new client, or you cannot find them in the system, **click "Inquiry (New Client)".**



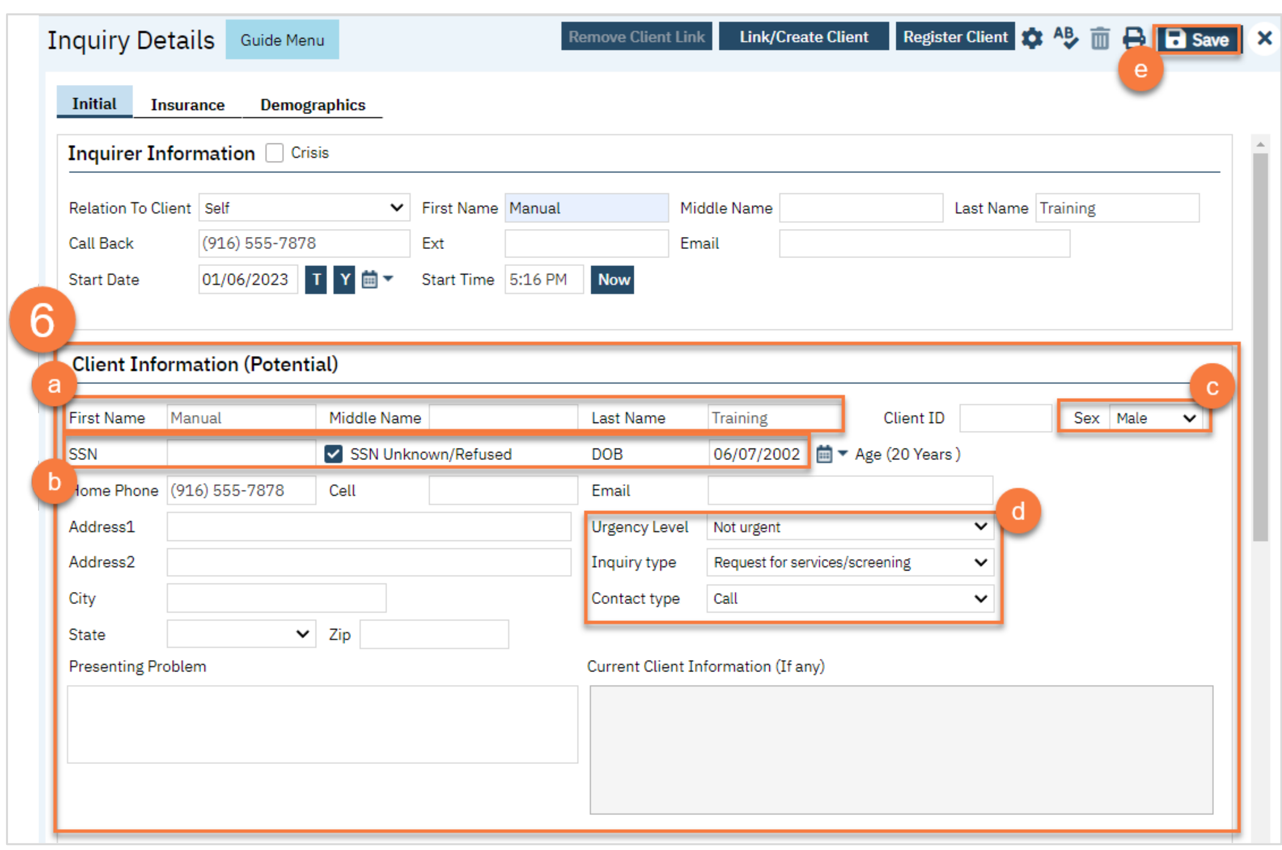
a. To search for a client, enter their name and click "Broad Search." You can also search by SSN by entering their social security number and clicking "SSN Search." You can do the same with date of birth (DOB), phone number, etc. If you find the person in the system, meaning they show in the Records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

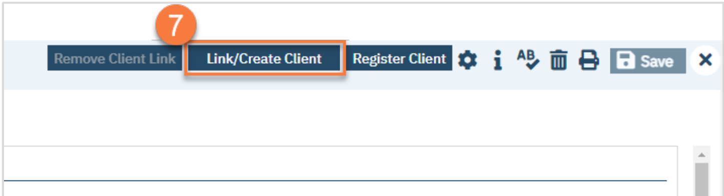


Urgency Level	Description/Use Case	Timelines
Emergent	Use if the call is an emergency	Addressed immediately
Not Urgent	Use if the call is a routine request for services	Appointment within 10 business days
Urgent	Use if the call is an urgent request	Appointment within 72 hours

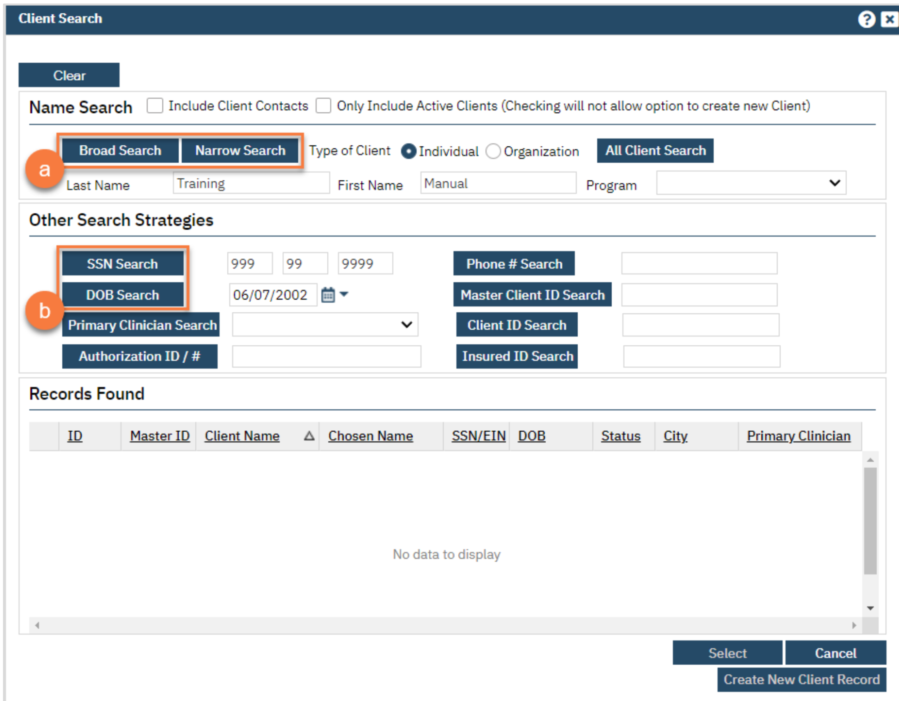
Inquiry Type	Description/Use Case
Requests for services/screening	Use when the reason for the call is a request for new services
Crisis	Use when the reason for the call is for crisis services
Information	Use when the reason for the call is for information
Discharge/Transition Coordination	Use when the 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

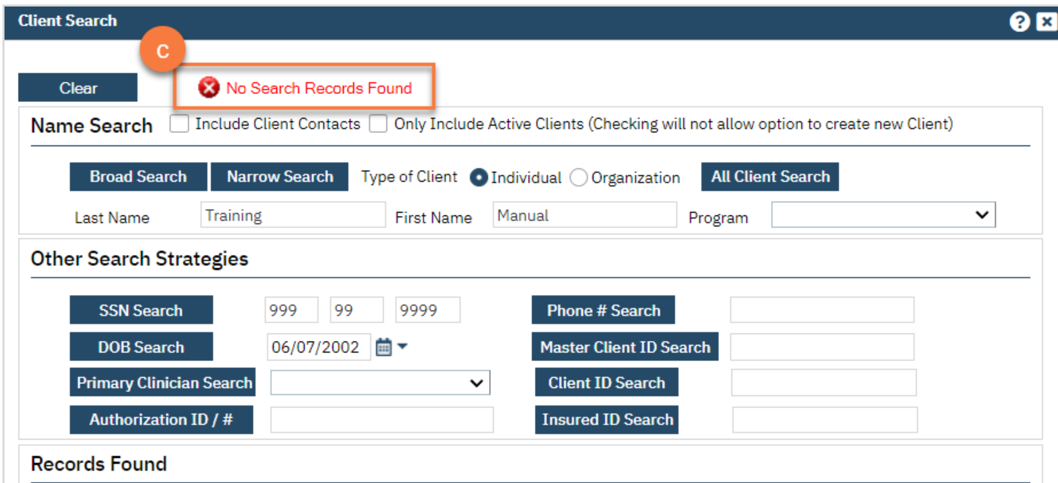
7. **Select the "Link/Create Client" button**. This will bring up the client search window, with a few extra buttons at the bottom.



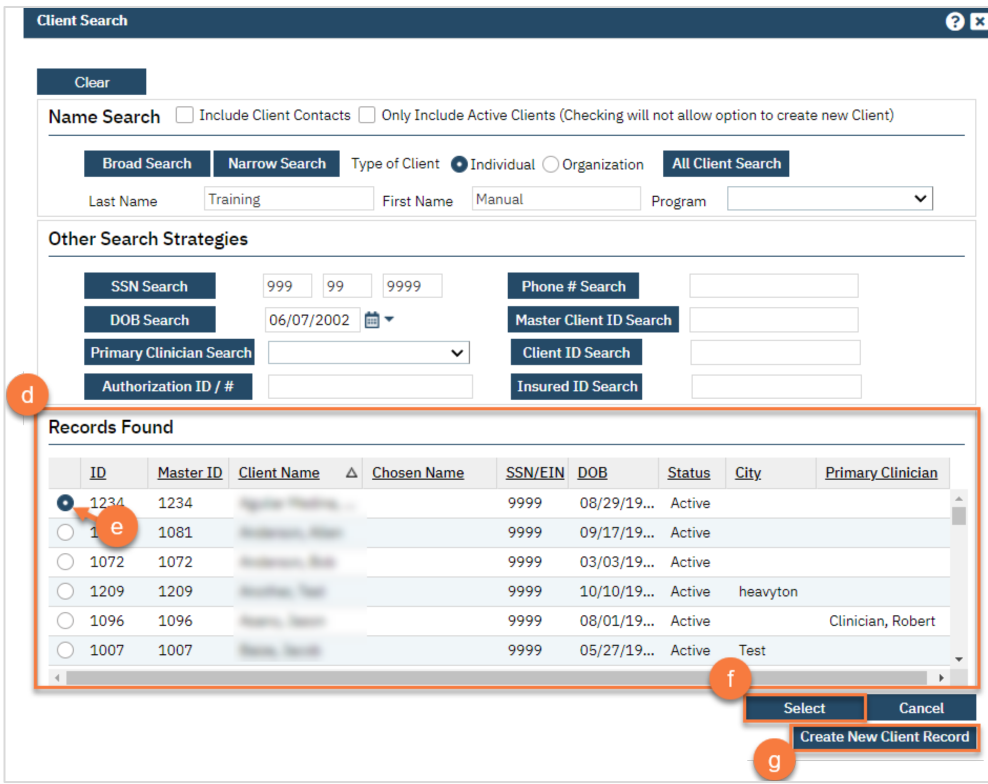
a. You must **search by name** by clicking on either "Broad Search" or "Narrow Search".
b. You must also **search by SSN and DOB** by clicking on those respective buttons.



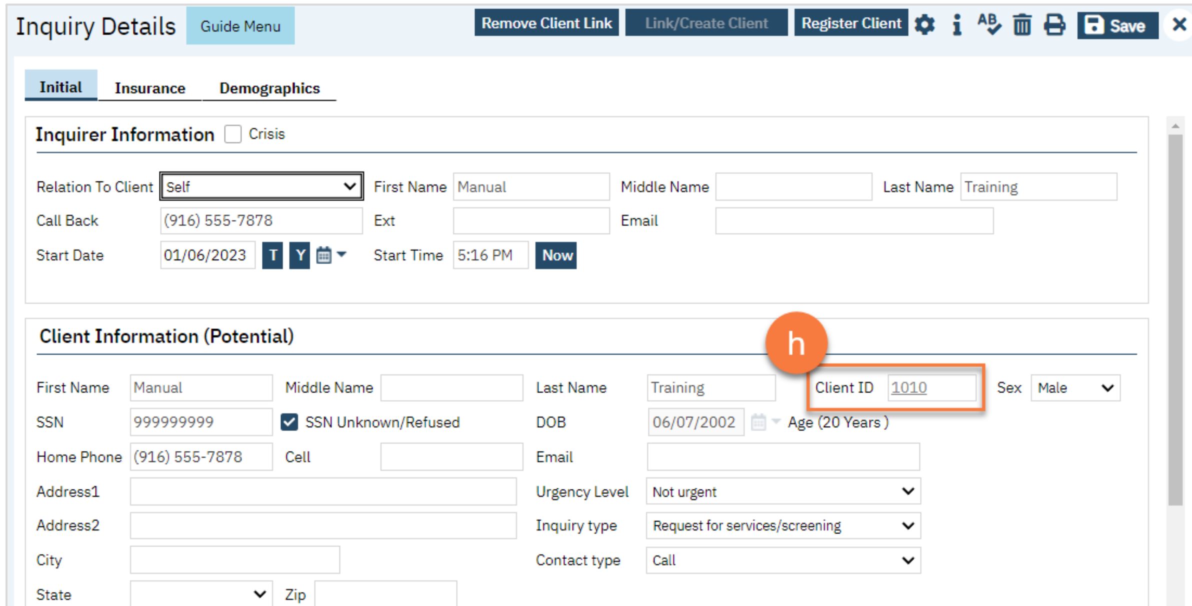
c. If no records are found based on the search you do, an alert will show at the top of the window.



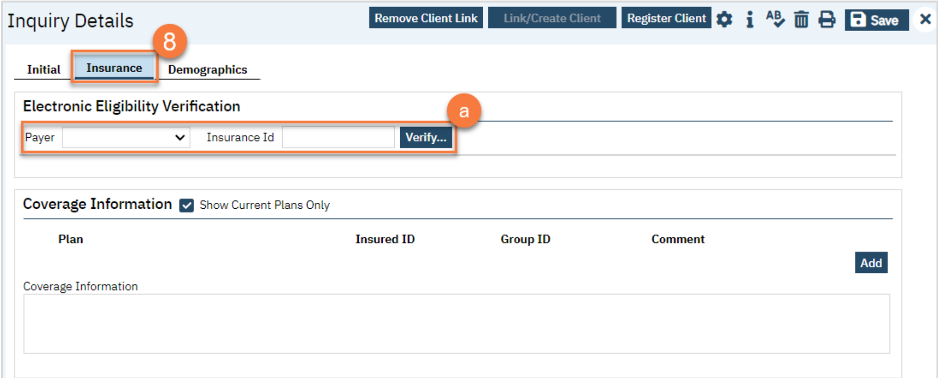
d. Any search results will show in the “Records Found” area. **Review the Records Found** to determine if the person is already in the system as a client.
e. If the person is already a client in the system, **select the button next to the appropriate record.**
f. **Click “Select”** to link the Inquiry 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.”**



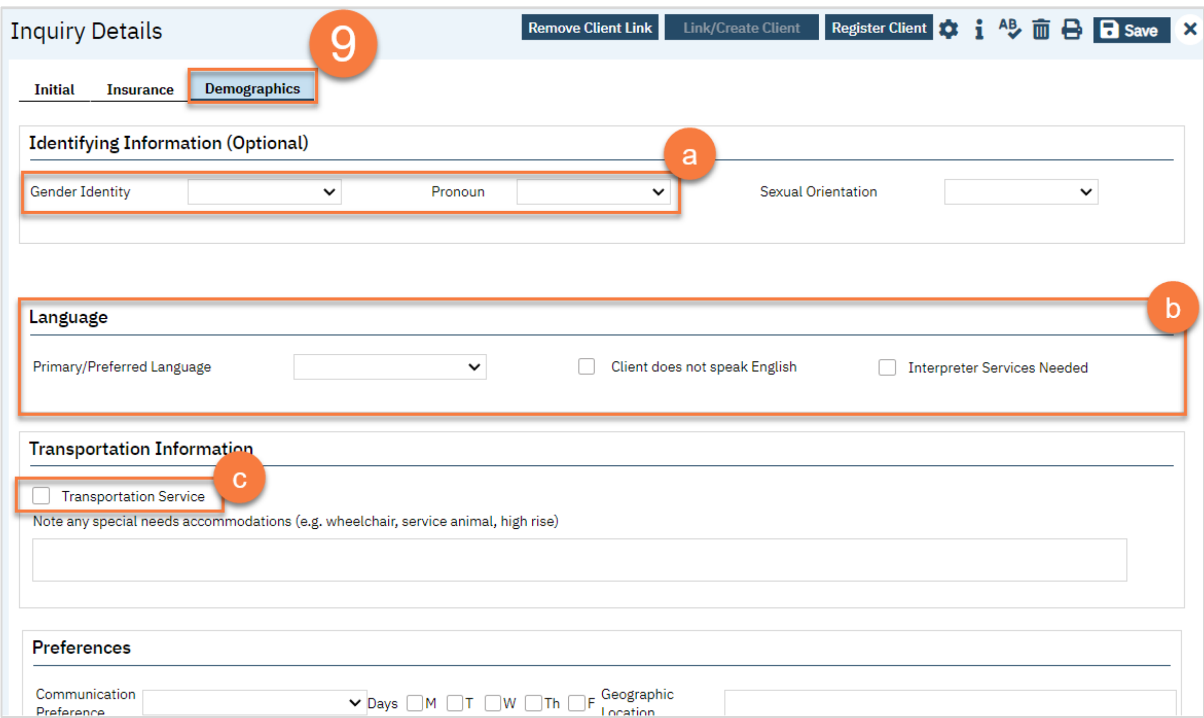
h. This will take you back to the Inquiry screen but now a client ID number will be added.



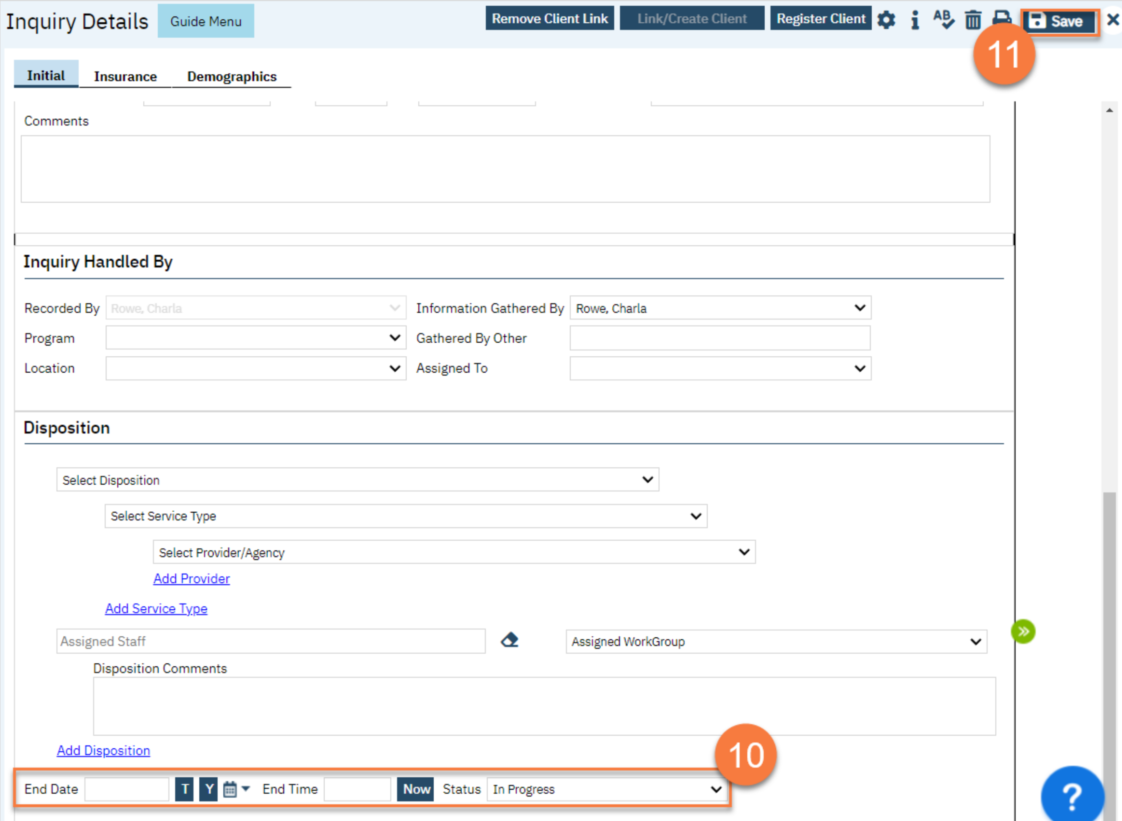
8. Click on the “Insurance” tab.
    a. **Select “Medi-Cal” from the “Payer” drop-down and enter the client’s Medi-Cal number (CIN) in the “Insurance ID” field. Click “Verify”** to verify the client’s Medi-Cal insurance.



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.
    c. If the client has any transportation issues and will need transportation to and/or from appointments, **check the Transportation Service checkbox.**



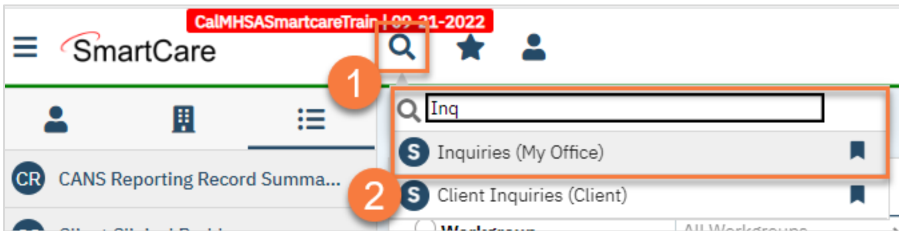
10. You may enter any additional information in any of the tabs, but none are required. Once complete, **enter the end date and time of the Inquiry and change the status to "Complete".** Once again, there are "T" (today) and "Now" buttons to make this easier.
11. **Click Save.** You may now close the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



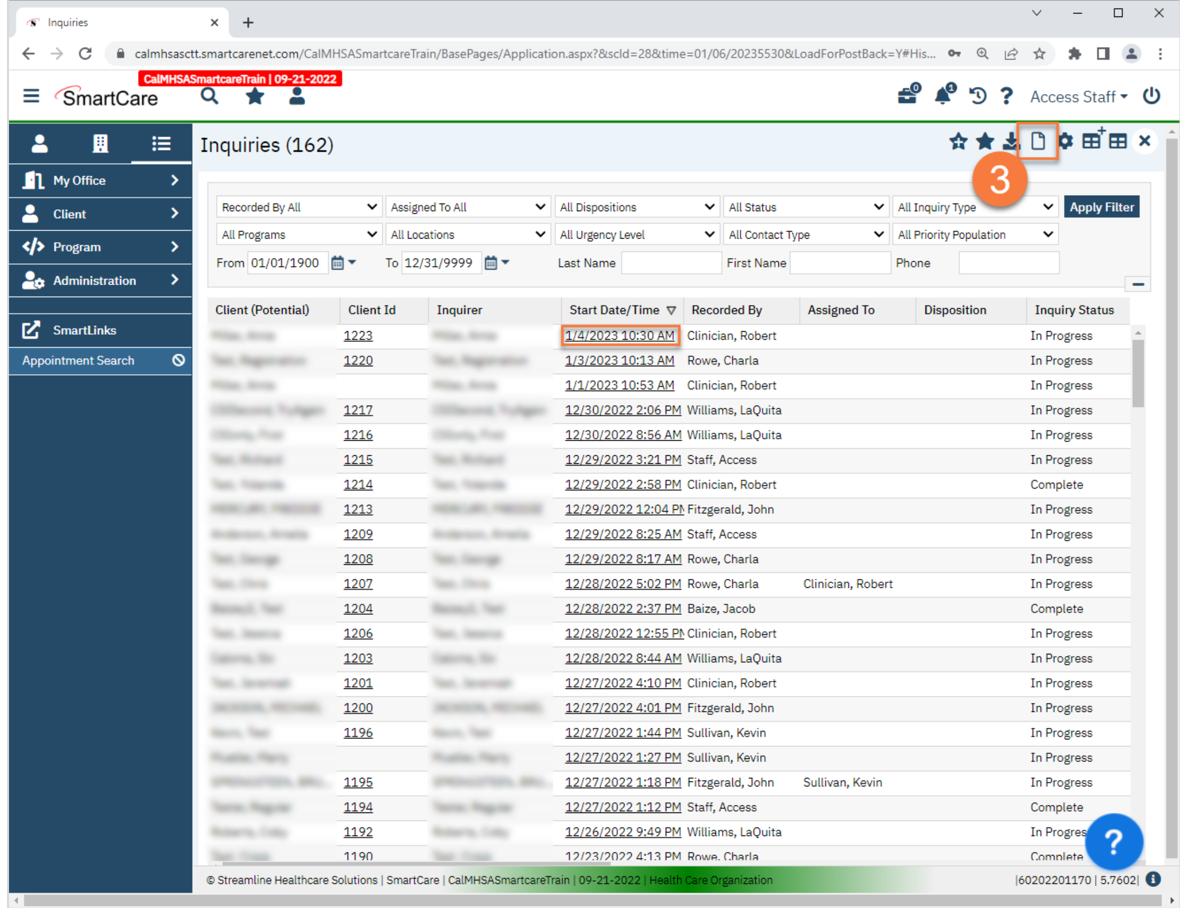
How to Document Calls to the Crisis Line

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.

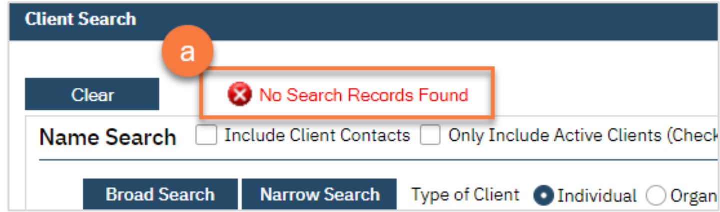
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



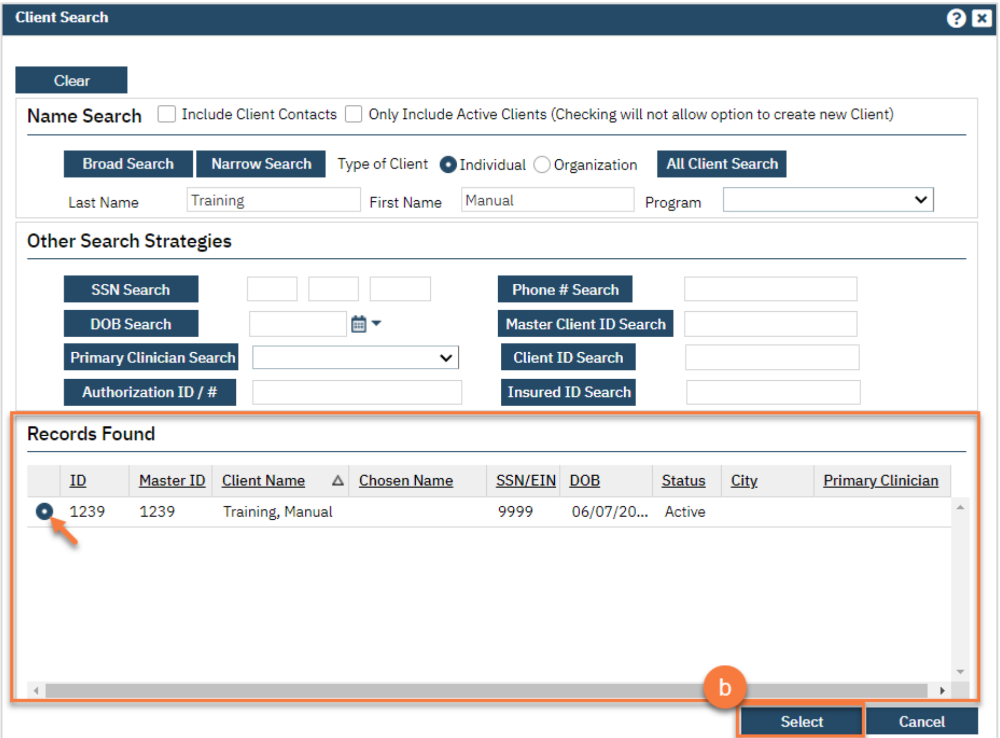
3. This will bring you to the Inquiries list page. If this call was transferred to you, search the list page to determine if an inquiry has already been started for this client. If so, **click the link in the Start Date/Time column**. If an inquiry has not been started, or if the call was direct to the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



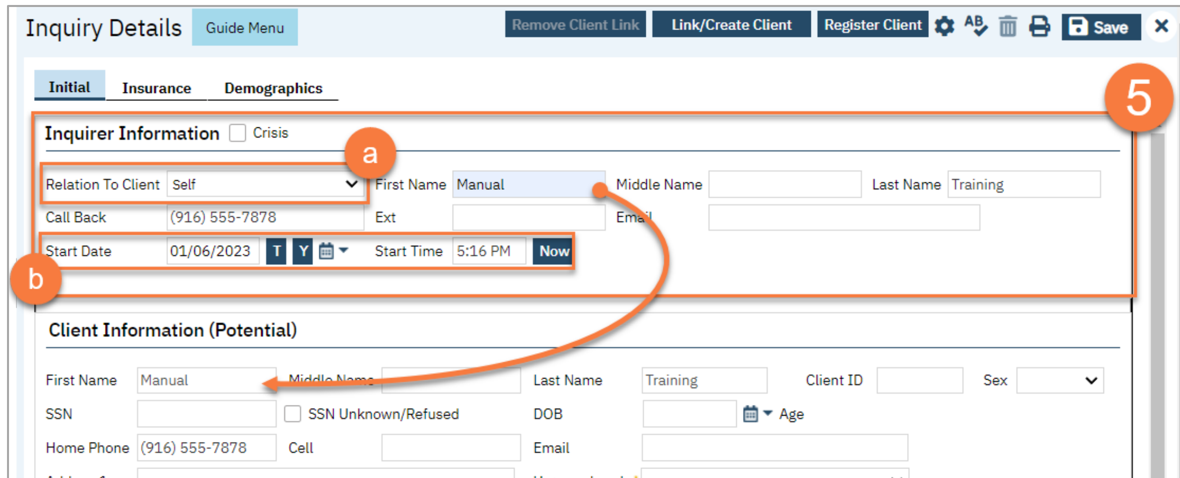
4. This will bring up the client search window. **Search to determine if the person is a client in the system**. The search includes both current and past clients. You can also **skip this step by selecting "Inquiry (New Client)"** if you know for certain this person is not a client in the system (e.g. 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.



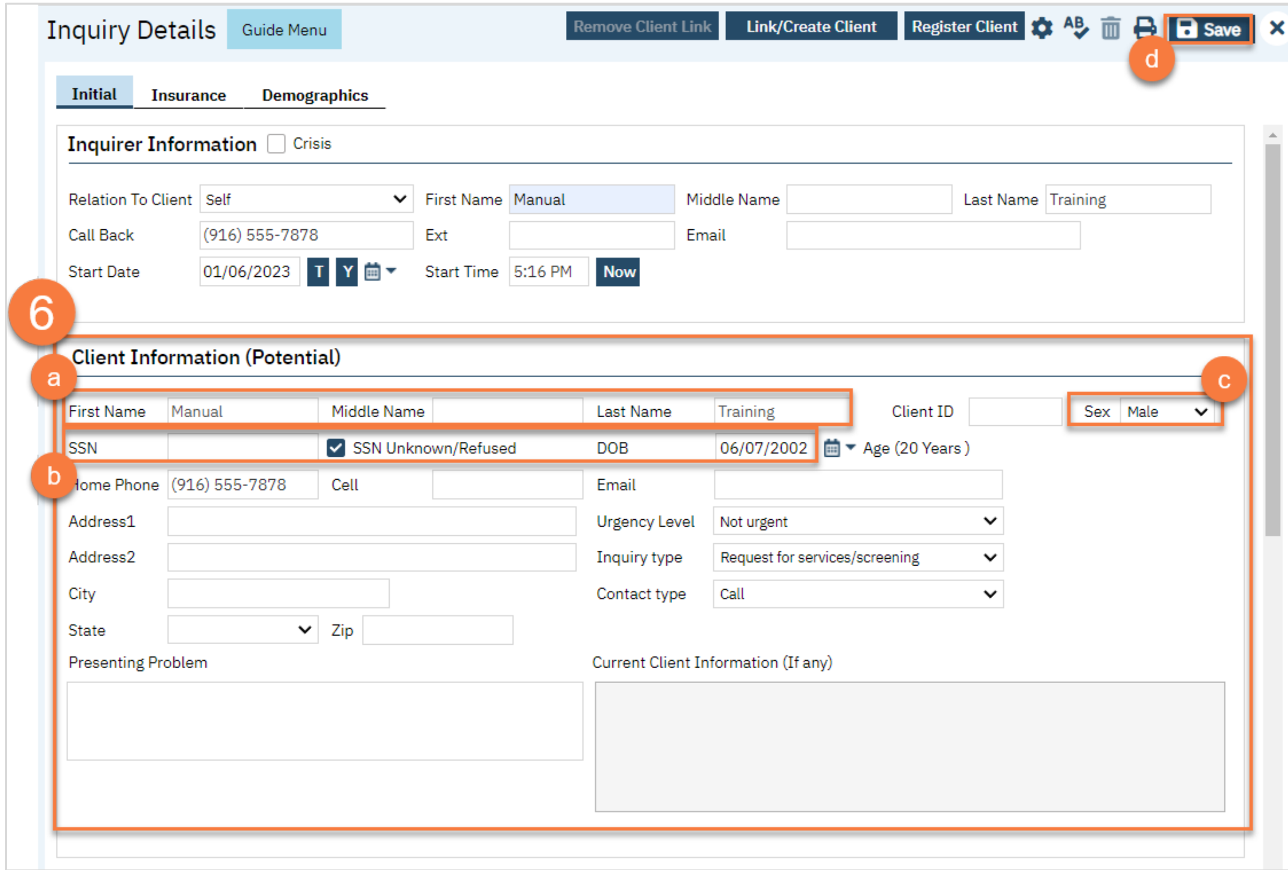
b. Any search results will show in the “Records Found” area. **Review the Records Found** to determine if the person is already in the system as a client. If the person is already a client in the system, **select the button next to the appropriate record. Click “Select”** to link the Inquiry to the selected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



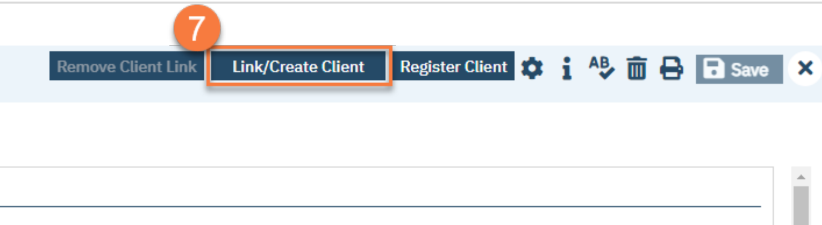
5. **Complete the information about the caller, or “Inquirer”**.
   a. Complete the **“Relation to Client” field.** If the client is calling for themselves, select “Self”. If you’ve already selected a client, this section will auto-populate with the client’s information. If the person is not already 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.



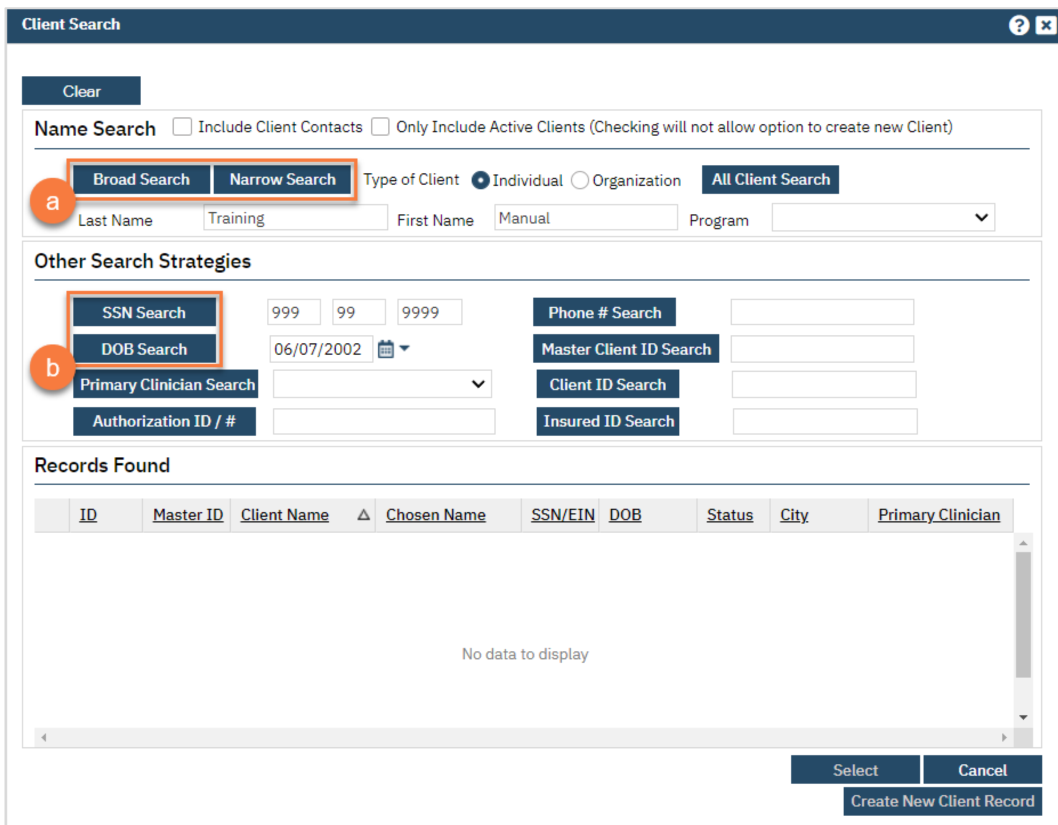
6. If the person is not a current client, add them as a client. To do this, **complete the information about the potential client**.
    a. **Complete the First Name and Last Name fields.** Middle Name is not required but can be added as necessary.
    b. **Complete the SSN and DOB fields.** This is 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. **Click Save.**



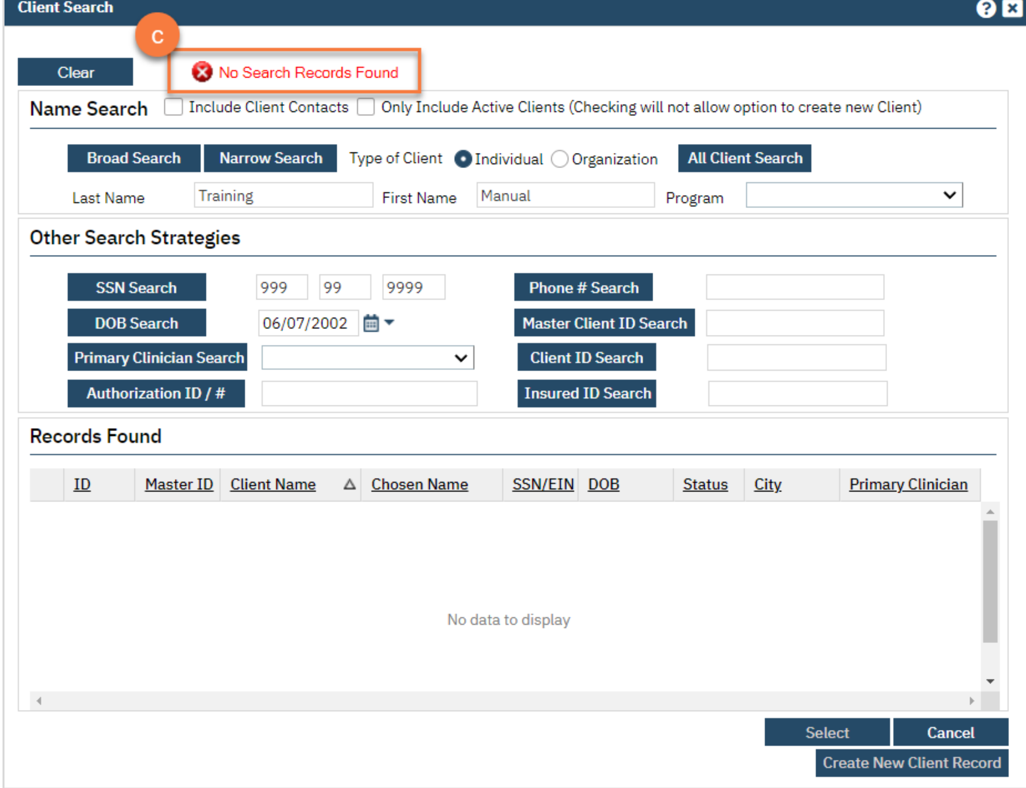
7. **Select the "Link/Create Client" button**. This will bring up the client search window, with a few extra buttons at the bottom.



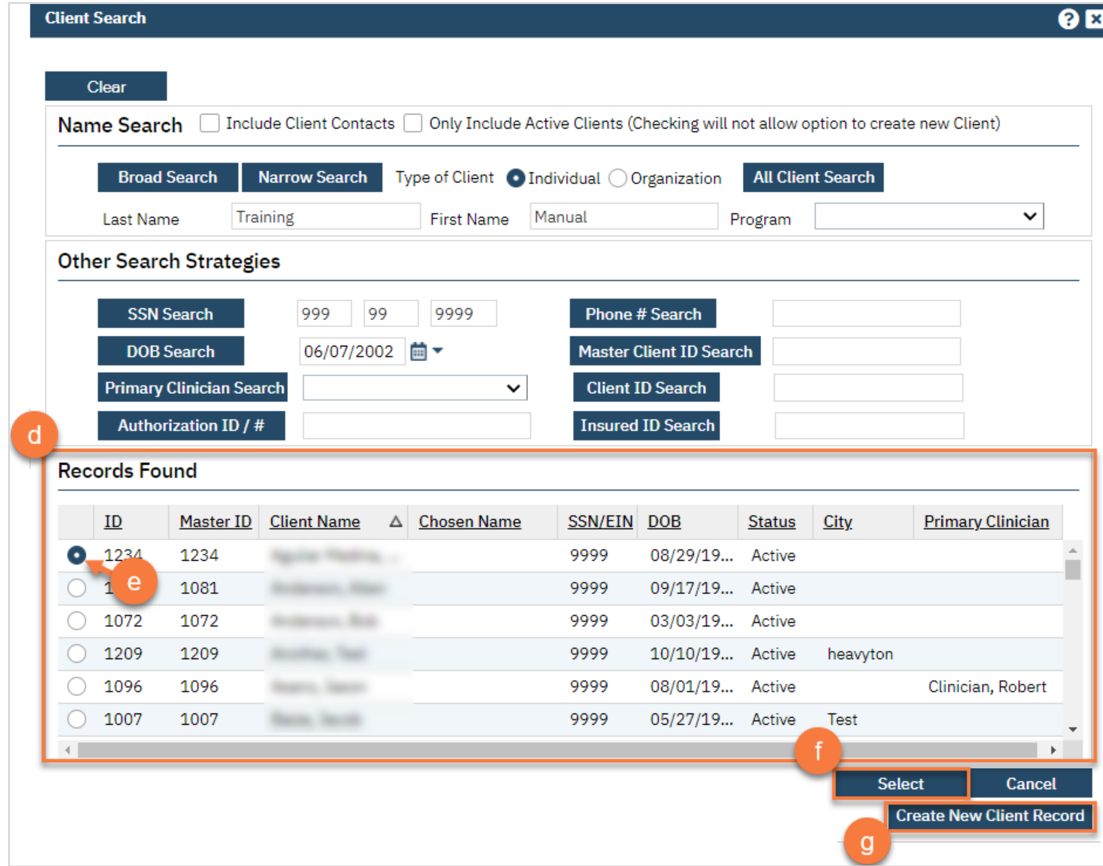
a. You must **search by name** by clicking on either “Broad Search” or “Narrow Search”.
b. You must also **search by SSN and DOB** by clicking on those respective buttons.



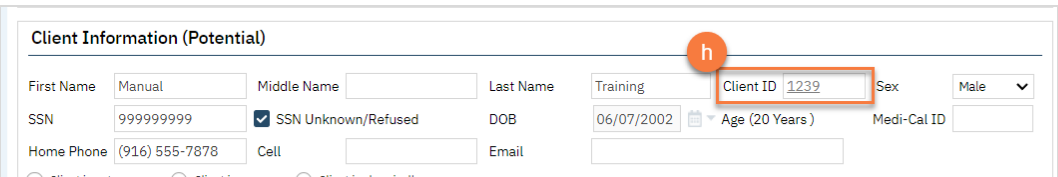
c. If no records are found based on the search you do, an alert will show at the top of the window.



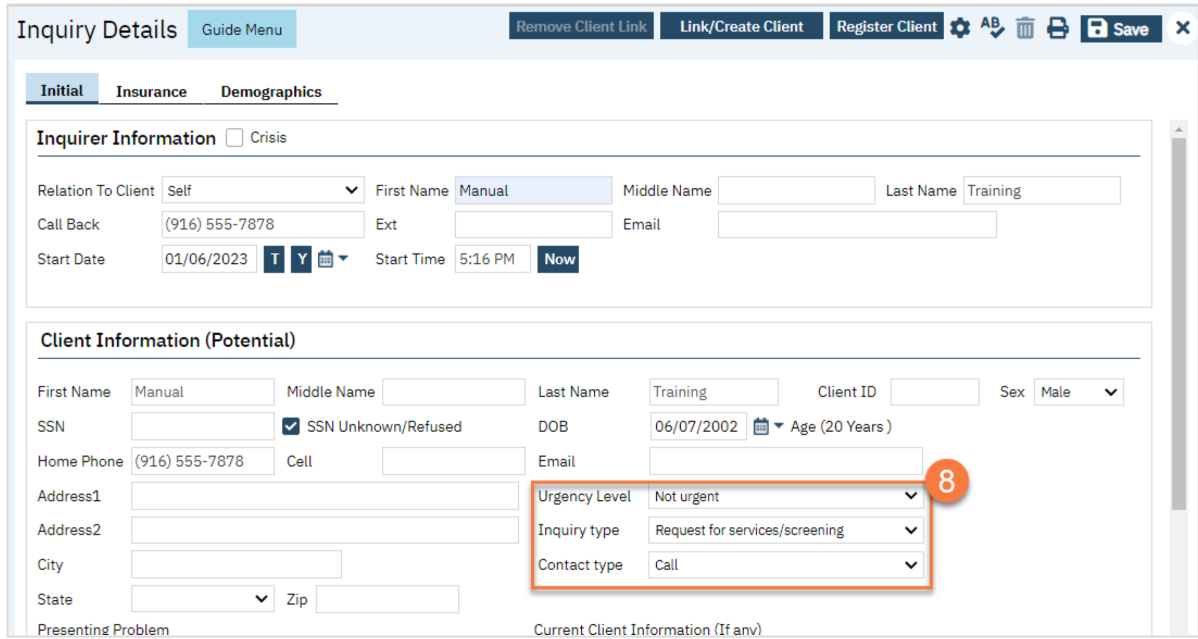
d. Any search results will show in the "Records Found" area. **Review the Records Found** to determine if the person is already in the system as a client.
e. If the person is already a client in the system, **select the button next to the appropriate record.**
f. **Click "Select"** to link the Inquiry 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
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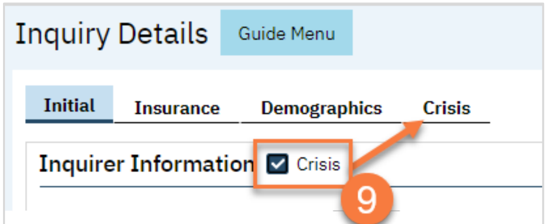
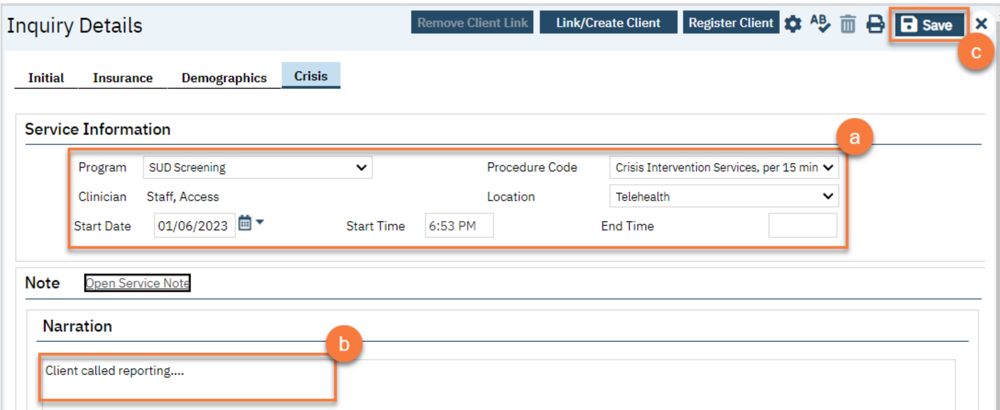
Other	Use when the reason for the call is not addressed by any of the above

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

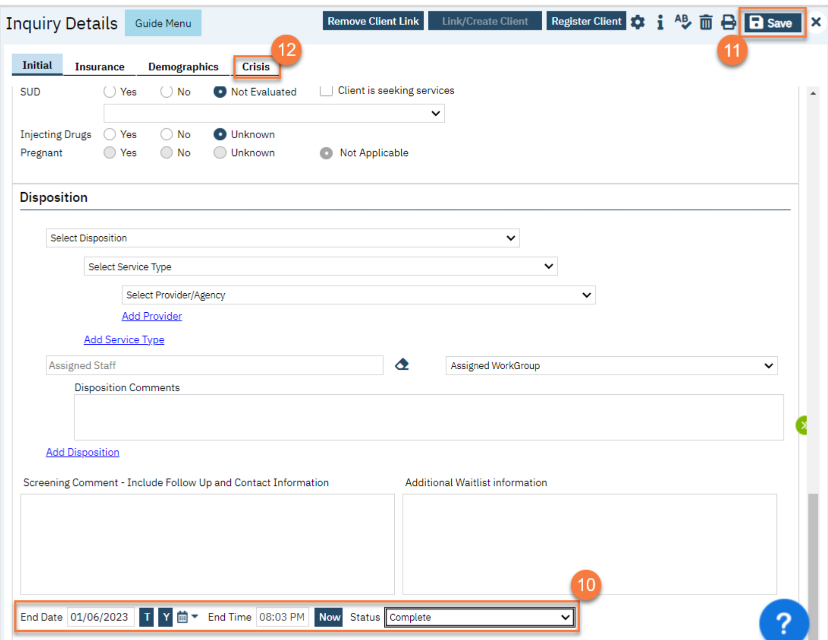
9. If the person is actually in crisis, **select the checkbox labeled "Crisis"** at the top of the screen. This opens a new tab where you'll document your call with the client. If the client is not actually in crisis, document the call as appropriate. If the client is requesting services, we recommend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



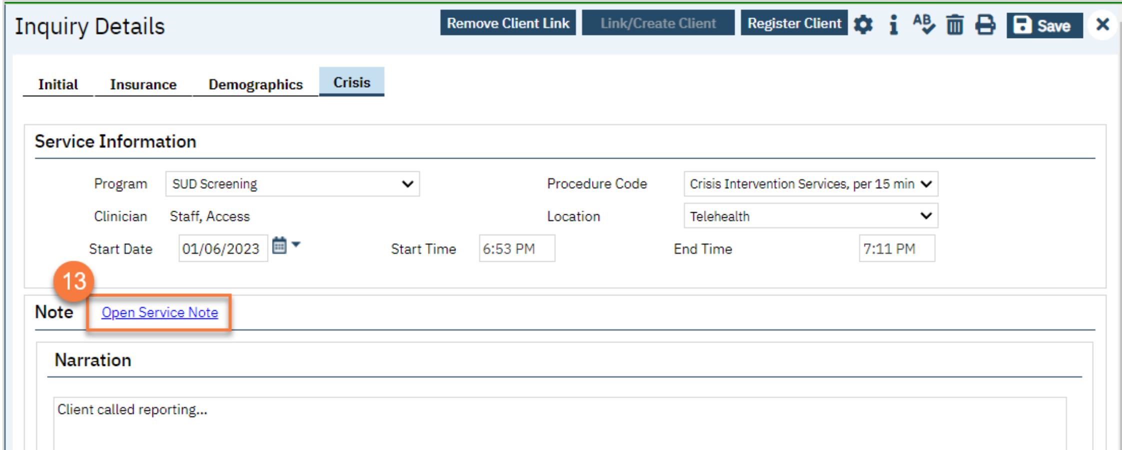
   a. In the Crisis tab, **enter the service information.** This will then open a text field for you to enter the note.
   b. **Enter narrative information in the Narration field**.
   c. **Click Save**.



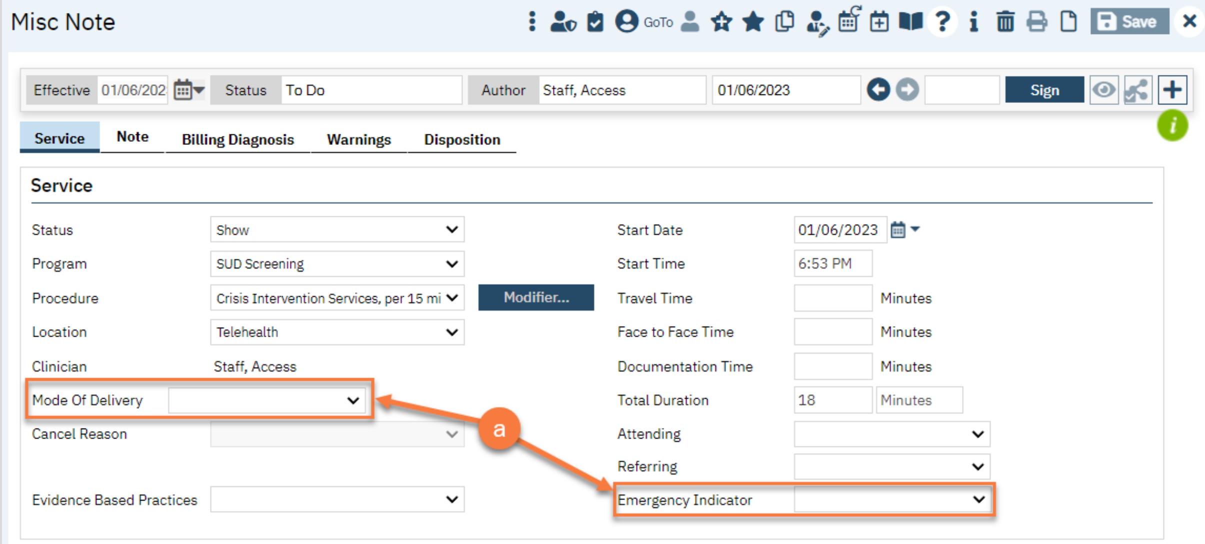
10. When you're finished with the crisis call, navigate back to the Initial tab and scroll to the bottom of the page. **Enter the end date and time of the Inquiry and change the status to "Complete".** Once again, there are "T" (today) and "Now" buttons to make this easier.
11. **Click Save**.
12. **Navigate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



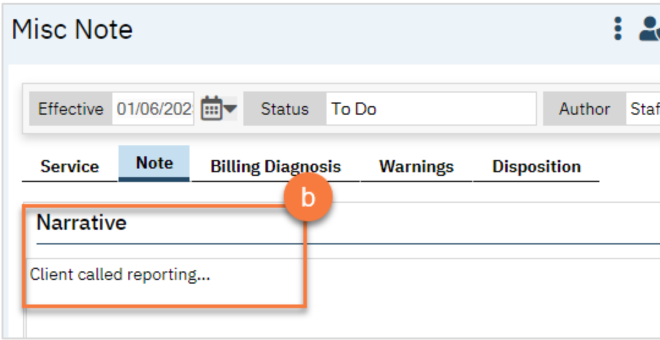
13. Click the newly available link for Open Service Note.



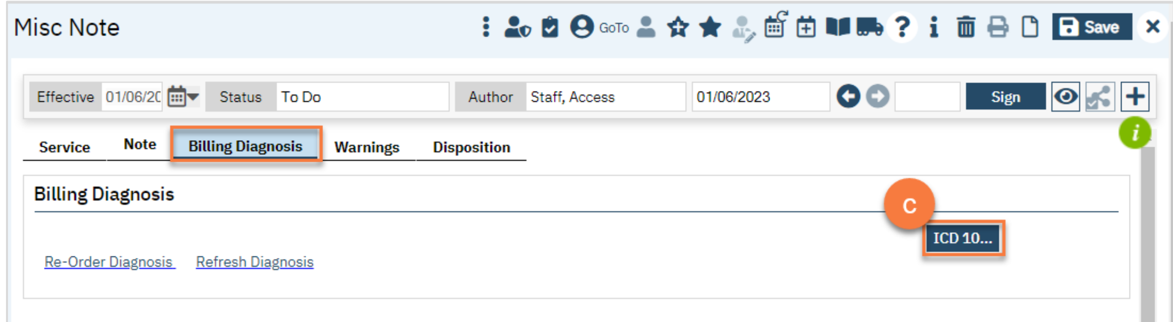
a. This brings up a service note screen. It will pull most information forward, including creating a total duration, based on start and end times. Enter Emergency Indicator and Mode of Delivery, as well as any other necessary fields.



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



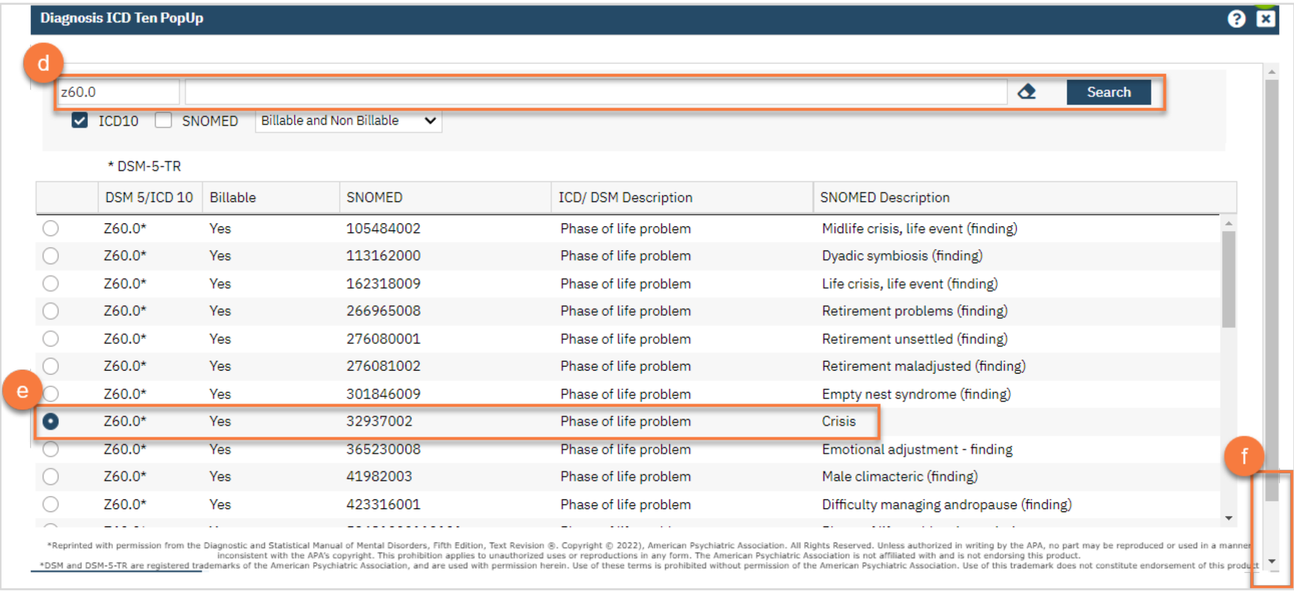
c. **Click on the Billing Diagnosis tab.** If the client already has a diagnosis, you can leave this section as is. If this client does not have a diagnosis, **click on the ICD 10 button.**



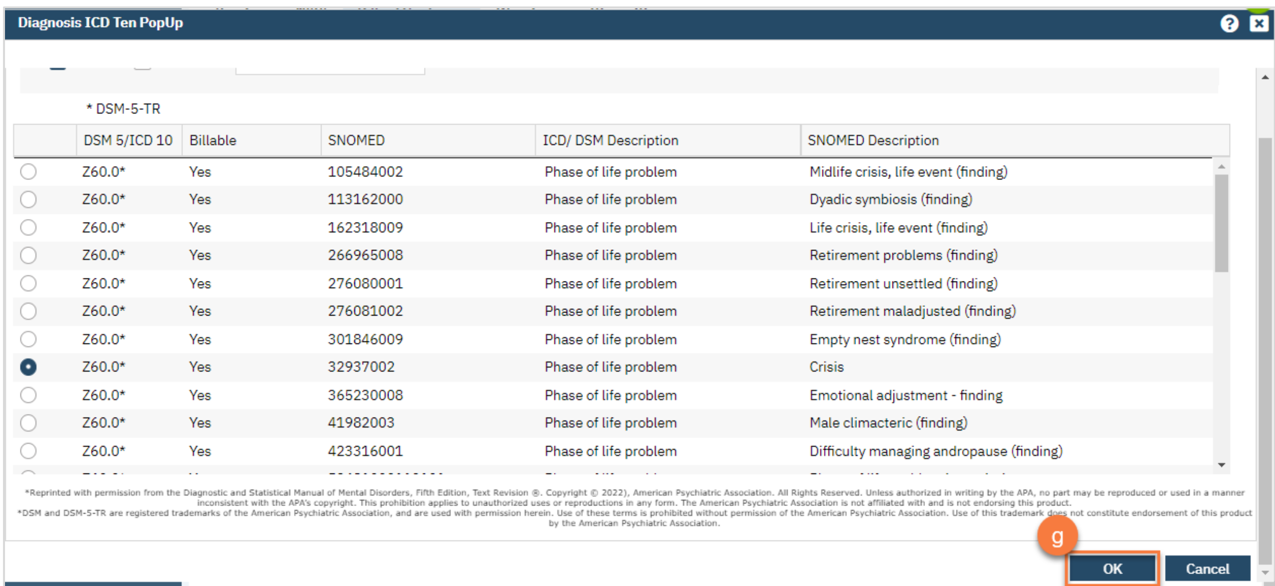
d. This brings up a Diagnosis pop-up window. **Search for a diagnosis using the code field or description field.** If you are an LPHA, you may use "Z03.89 Encounter for observation for other suspected diseases and conditions ruled out". If you are not an LPHA, you can select an appropriate Social Determinant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

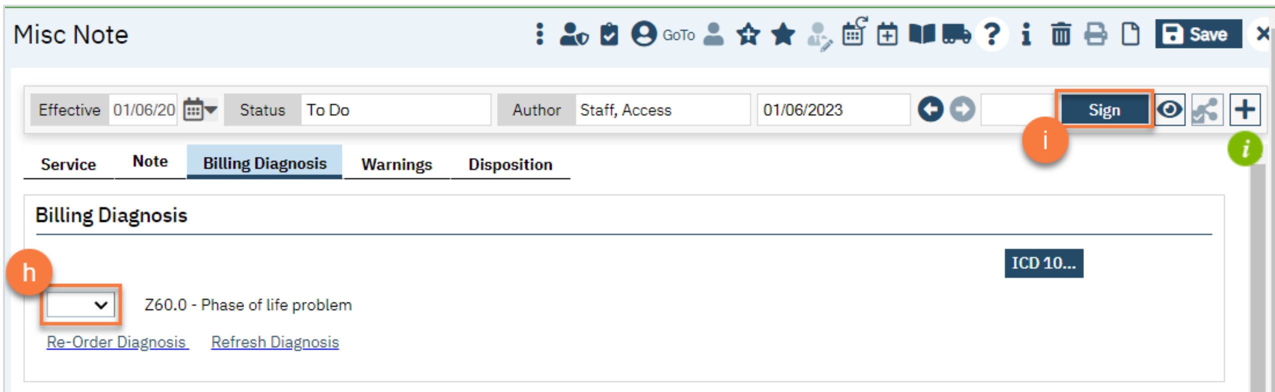


g. Click OK.



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**.

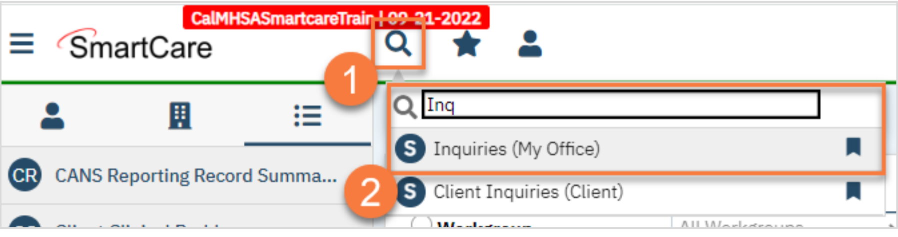
i. Once you've completed all pieces of the service note, **click Sign**. You are now finished and may close any open screens.



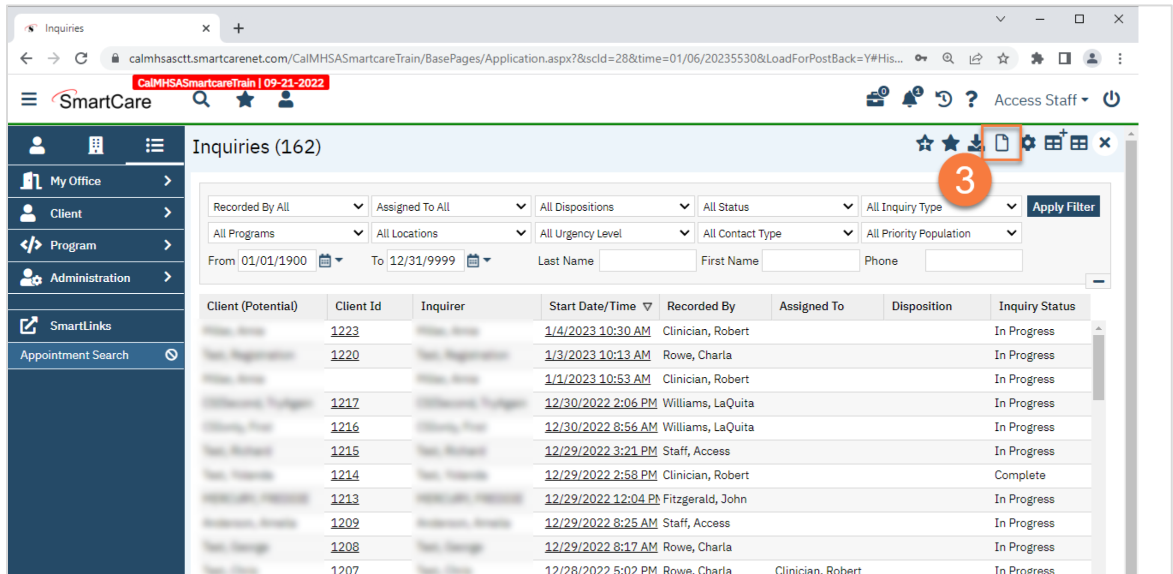
How to Document a Paper Referral from a Partner Agency

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

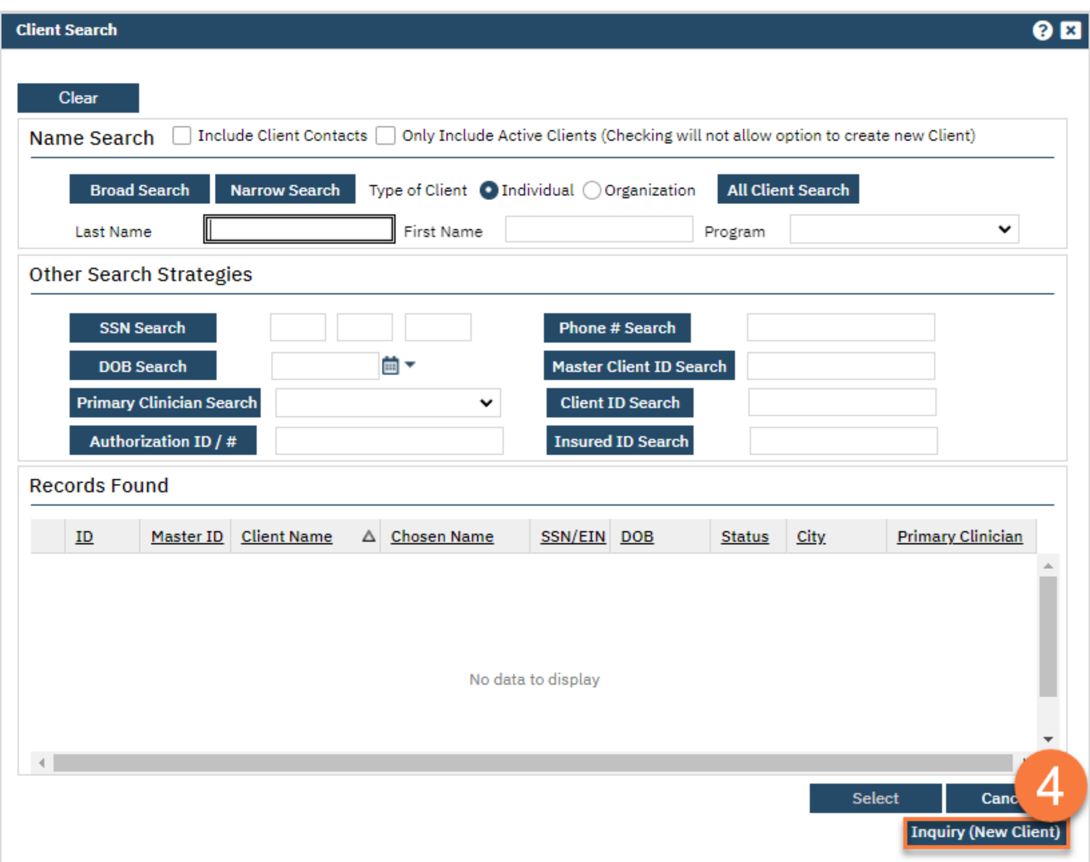
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



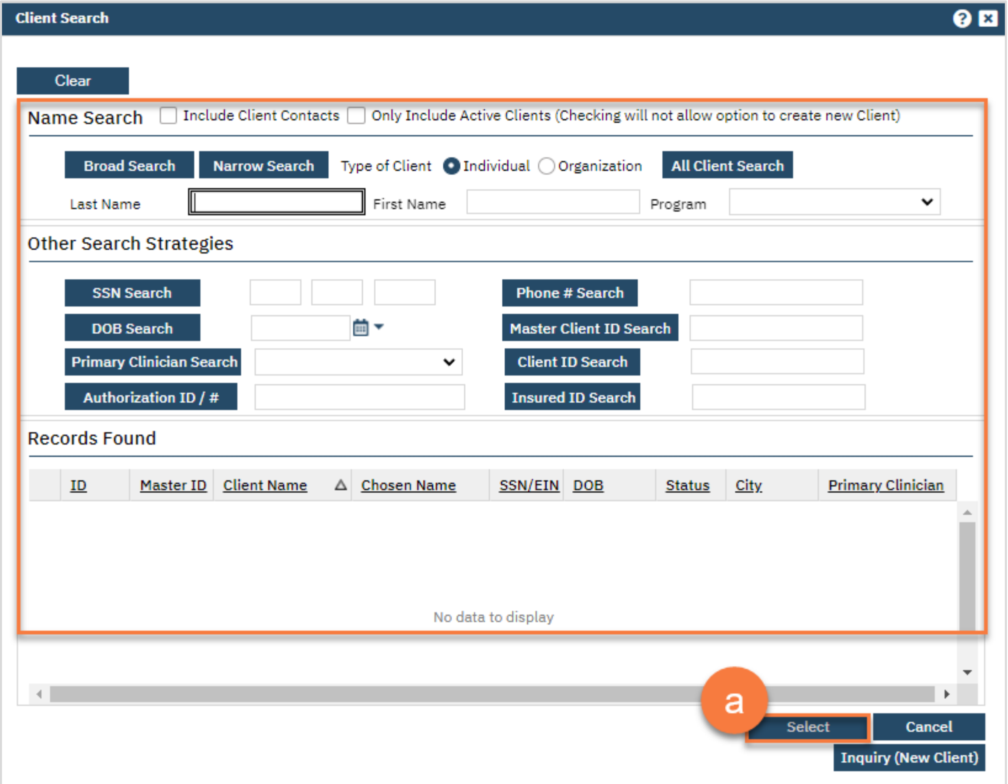
3. This will bring you to the Inquiries list page. **Create a new inquiry** by using the new icon.



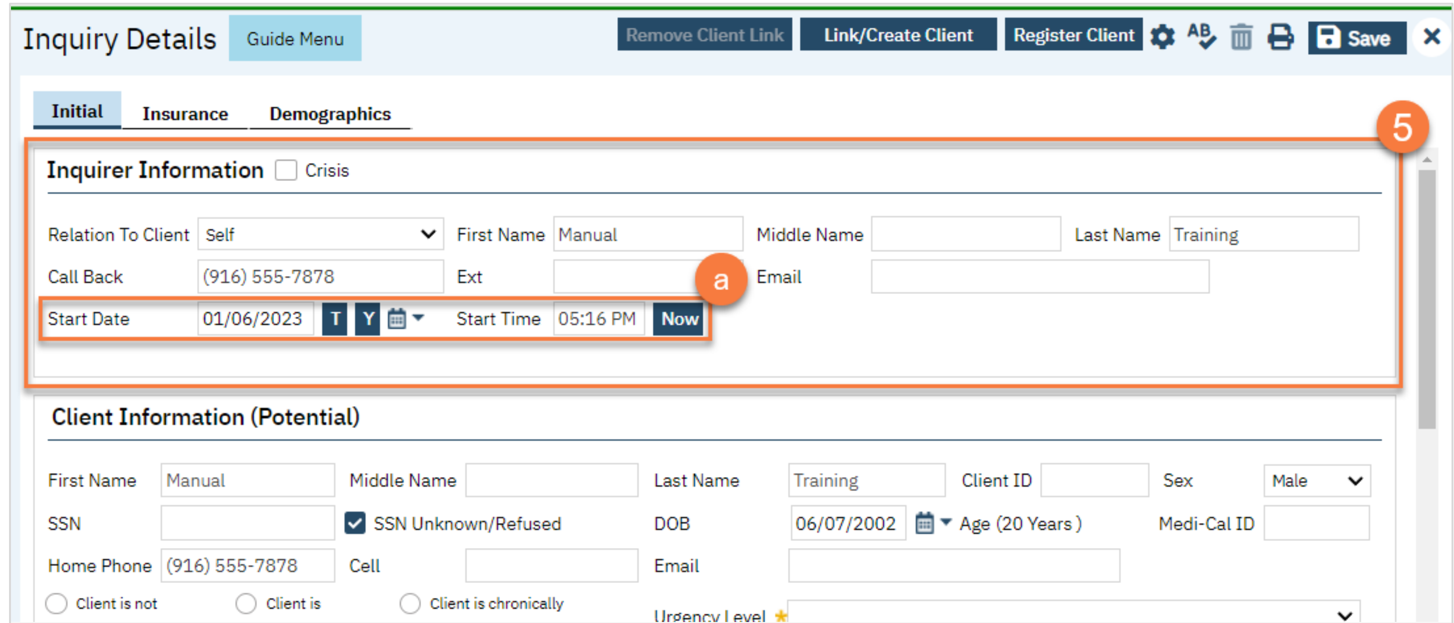
4. This will bring up the client search window. **You may search to determine if the person is a current client**. If person is a new client, or you cannot find them in the system, **click "Inquiry (New Client)".**



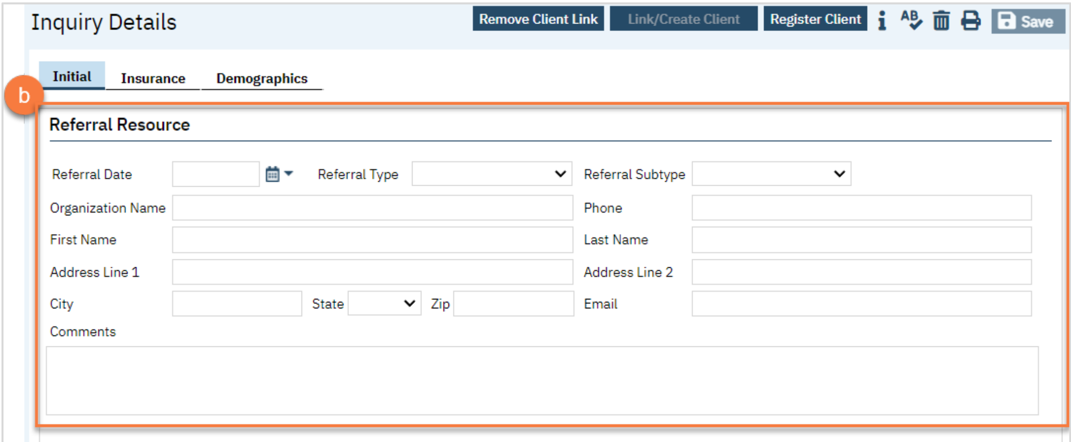
a. To search for a client, enter their name and click "Broad Search." You can also search by SSN by entering their social security number and clicking "SSN Search." You can do the same with date of birth (DOB), phone number, etc. If you find the person in the system, meaning they show in the Records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



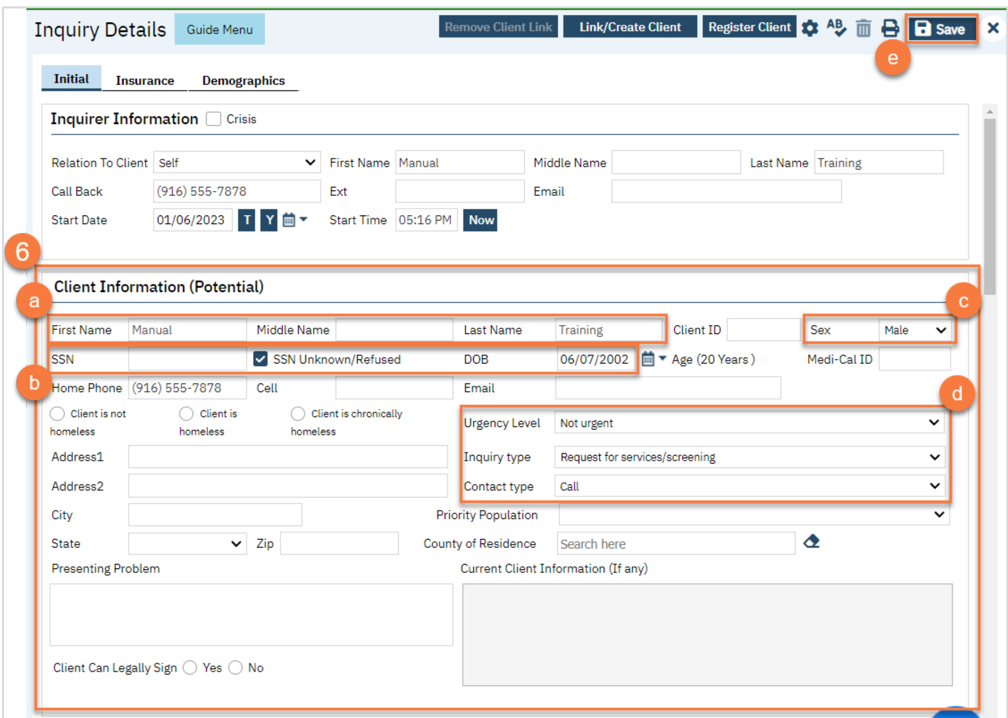
5. This brings you to the Inquiry Details screen. **Complete the information about the person requesting services, or "Inquirer"**.
   a. Make sure to input the date and time you received the referral in Start Date and Start Time. There are buttons for "T" (today) and "Now" to help make this quick and 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
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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
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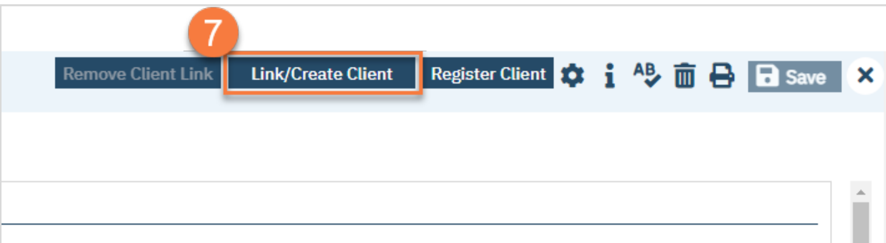
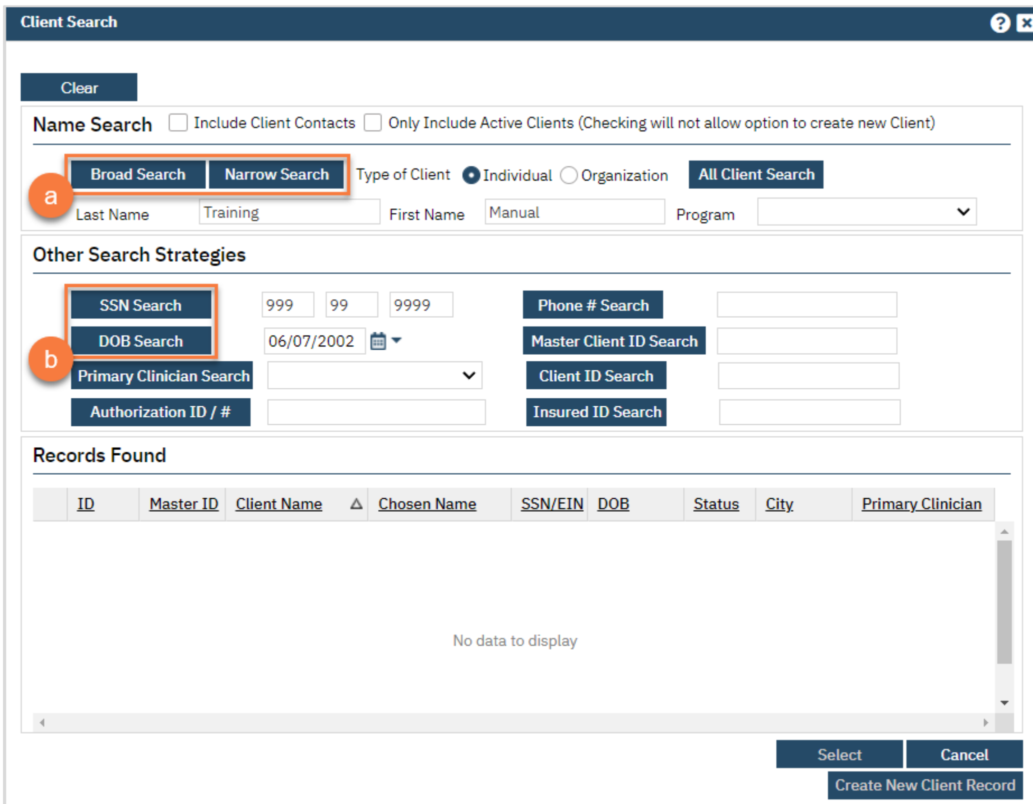
Teleconference	Use when the inquiry was complete via teleconference, such as Zoom, FaceTime, Webex, or other video-audio conferencing software

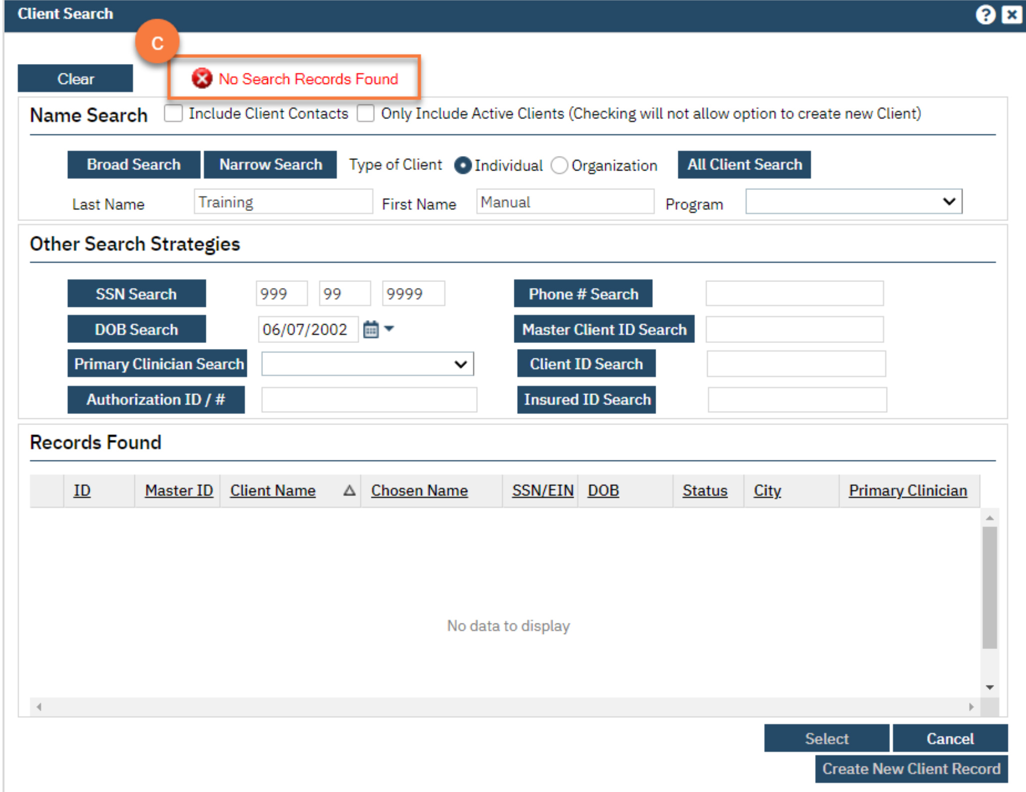
7. **Select the "Link/Create Client" button**. This will bring up the client search window, with a few extra buttons at the bottom.



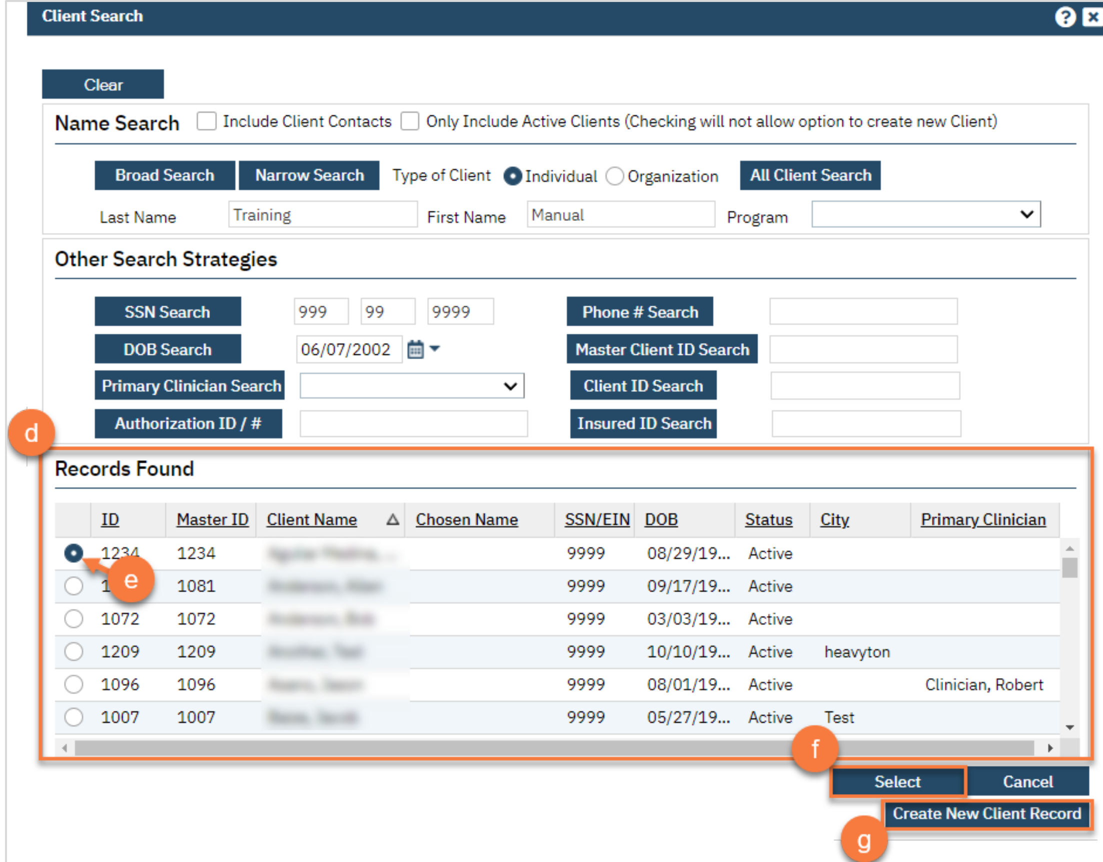
a. You must **search by name** by clicking on either “Broad Search” or “Narrow Search”.
b. You must also **search by SSN and DOB** by clicking on those respective buttons.



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.

Inquiry Details Guide Menu Remove Client Link Link/Create Client Register Client Save

Initial Insurance Demographics

Inquirer Information Crisis

Relation To Client Self First Name Manual Middle Name Last Name Training

Call Back (916) 555-7878 Ext Email

Start Date 01/06/2023 T Y Start Time 5:16 PM Now

Client Information (Potential)

h

First Name Manual Middle Name Last Name Training Client ID 1239 Sex Male

SSN 999999999 SSN Unknown/Refused DOB 06/07/2002 Age (20 Years) Medi-Cal ID

Home Phone (916) 555-7878 Cell Email

Client is not homeless Client is homeless Client is chronically homeless Urgency Level Not urgent

Address1 Inquiry type Request for services/screening

Address2 Contact type Call

City Priority Population

State Zip County of Residence Search here

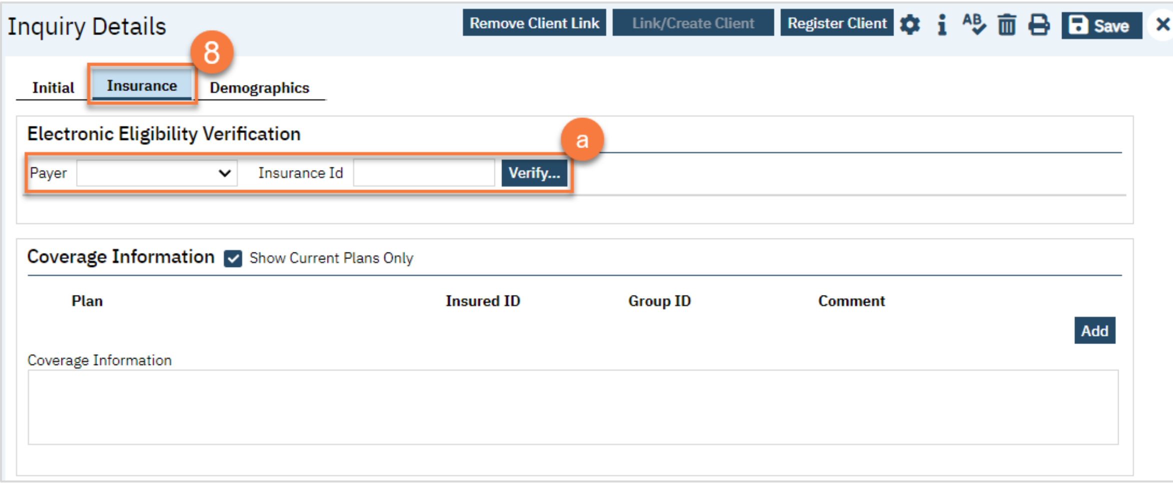
Presenting Problem Current Client Information (If any)

Client Id: 1239
Last Inquiry Date:

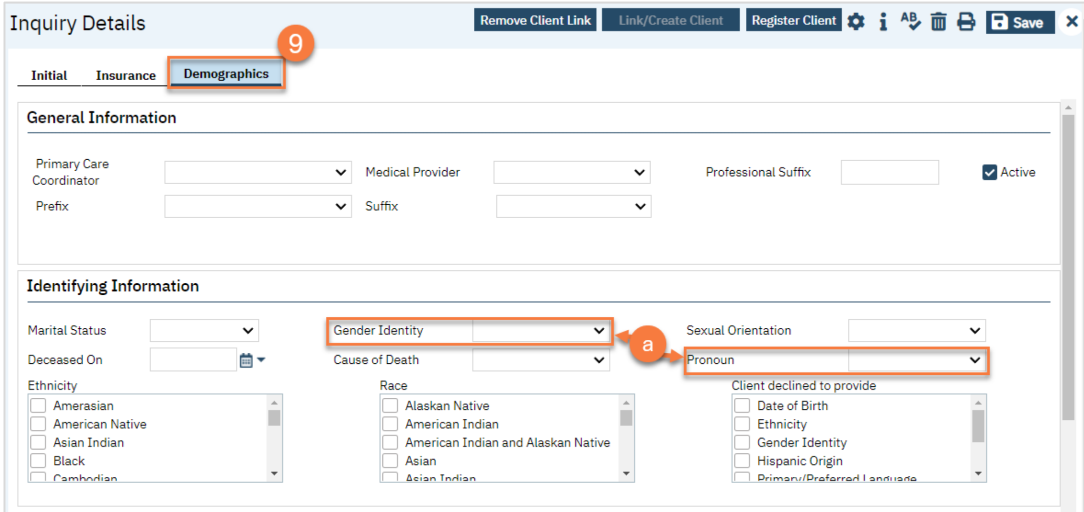
Coverage History
No Coverage History

Client Can Legally Sign Yes No

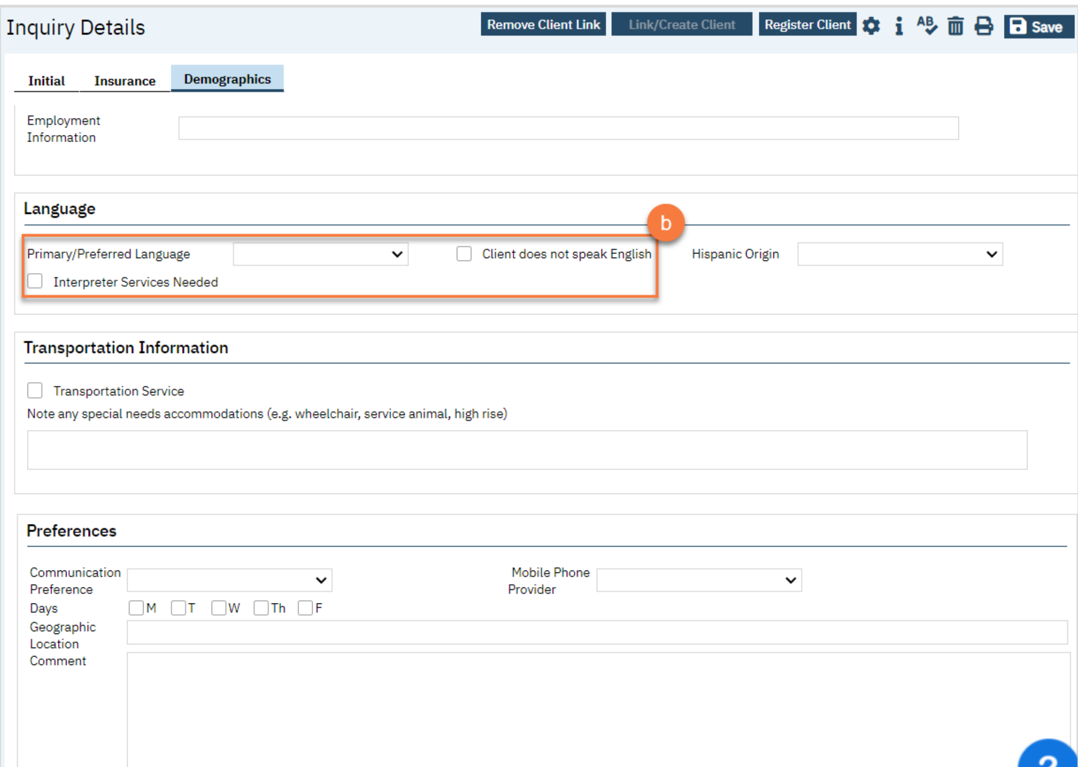
8. Click on the "Insurance" tab.
   a. Select "Medi-Cal" from the "Payer" drop-down and enter the client's Medi-Cal number (CIN) in the "Insurance ID" field. Click "Verify" to verify the client's Medi-Cal insurance.



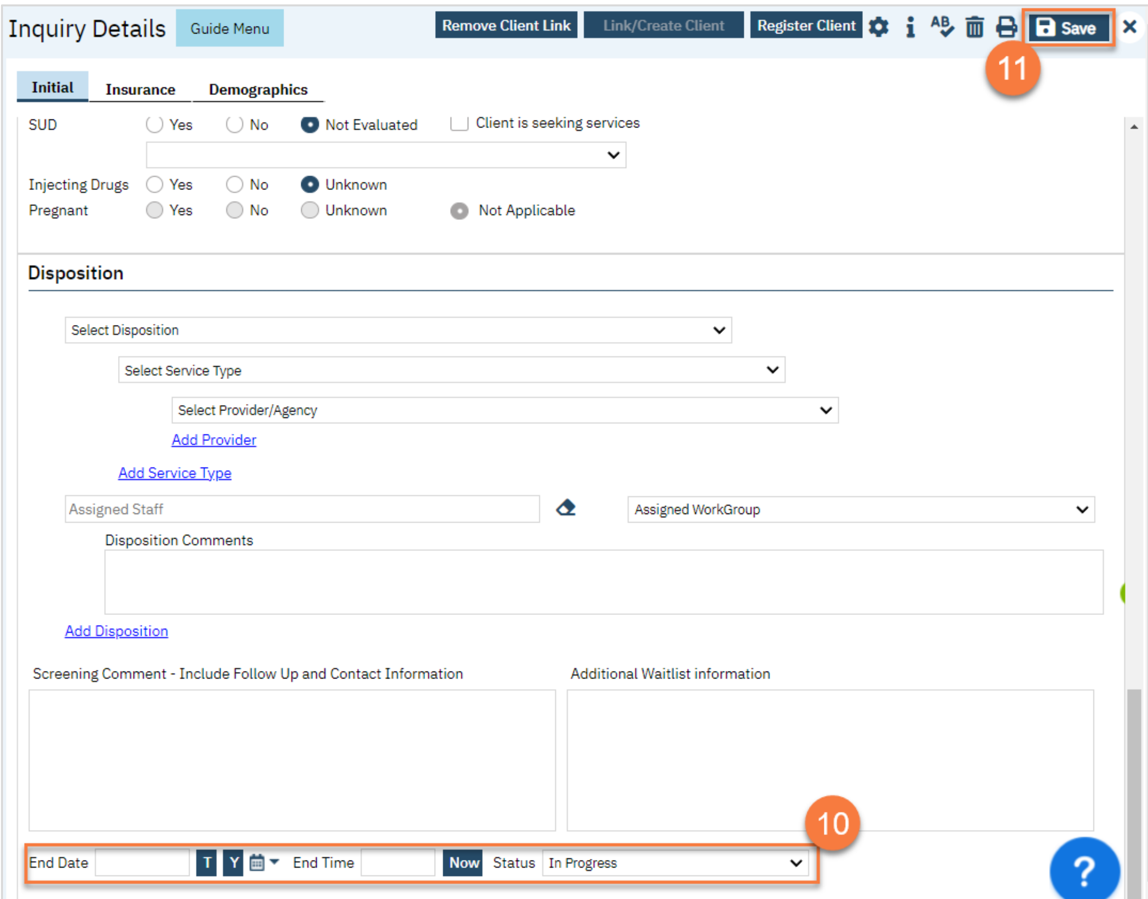
9. **Click on the "Demographics" tab.**
    a. We recommend **completing the "Gender Identity" and "Pronoun" fields** to ensure the person is not misgendered as additional staff engage with the client.



    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 to Document When Someone Walks in for an Assessment

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

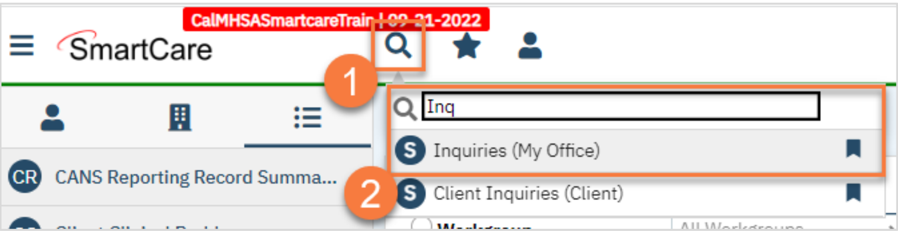
How to Handle Calls on a Non-Crisis Line and Client Says they're in Crisis

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.

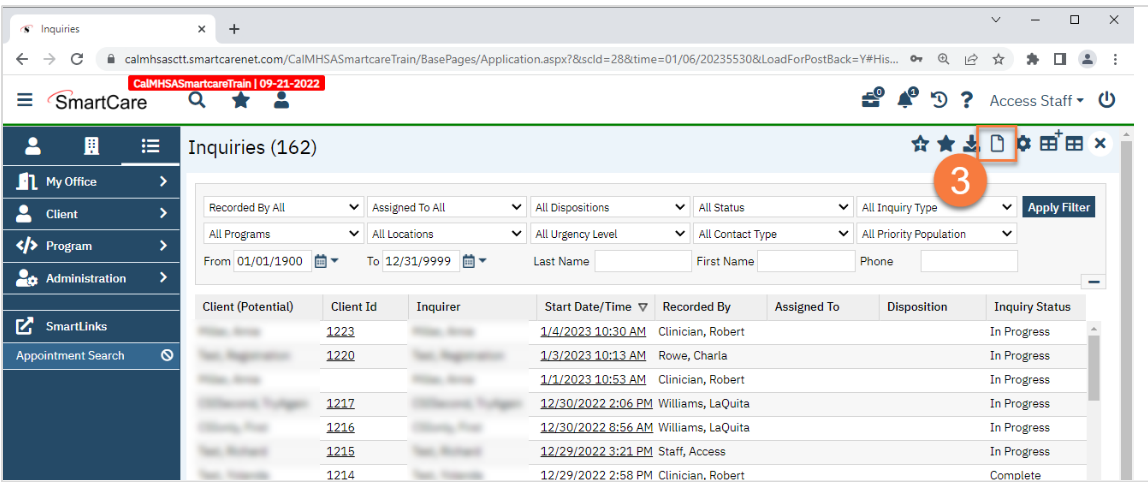
How to Document a Call When You Don't Provide Services Yourself

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.

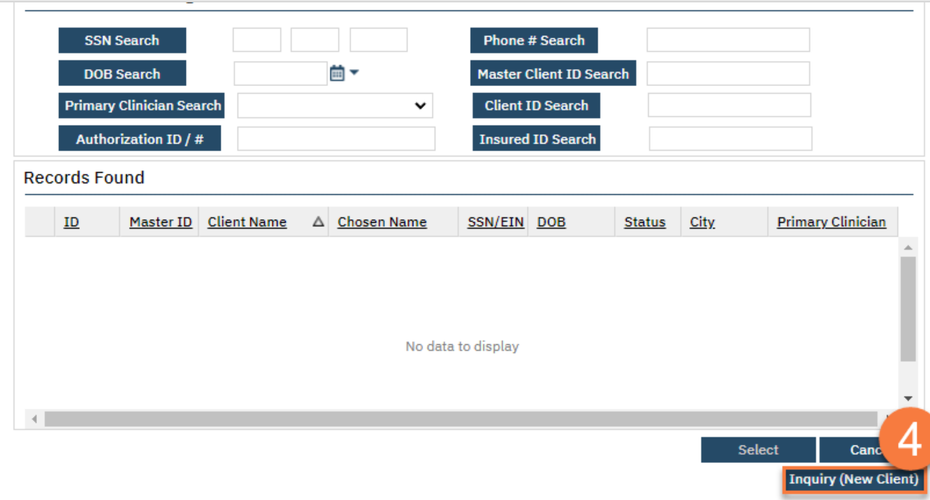
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



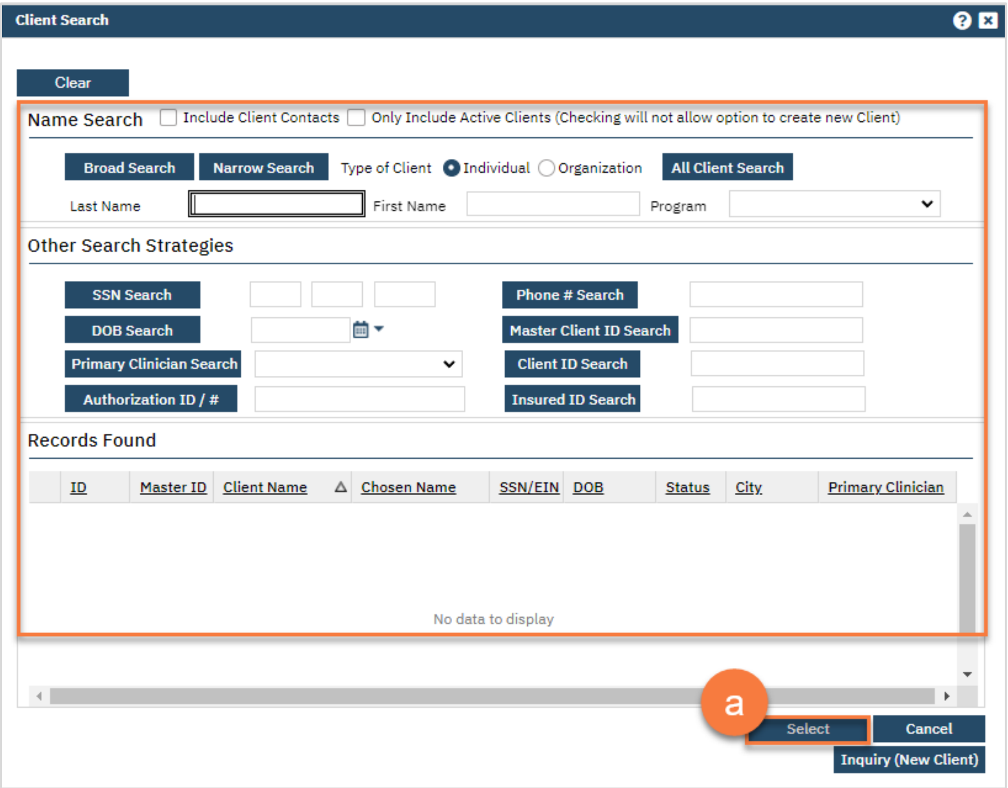
3. This will bring you to the Inquiries list page. **Create a new inquiry** by using the new icon.



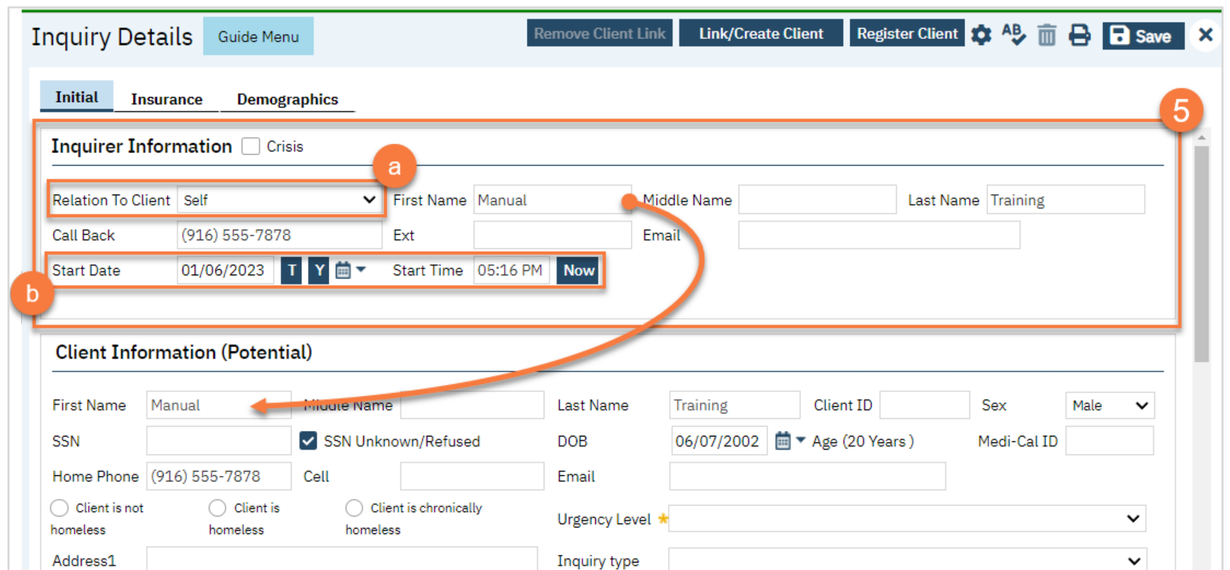
4. This will bring up the client search window. **You may search to determine if the person is a current client**. If person is a new client, or you cannot find them in the system, **click "Inquiry (New Client)"**.



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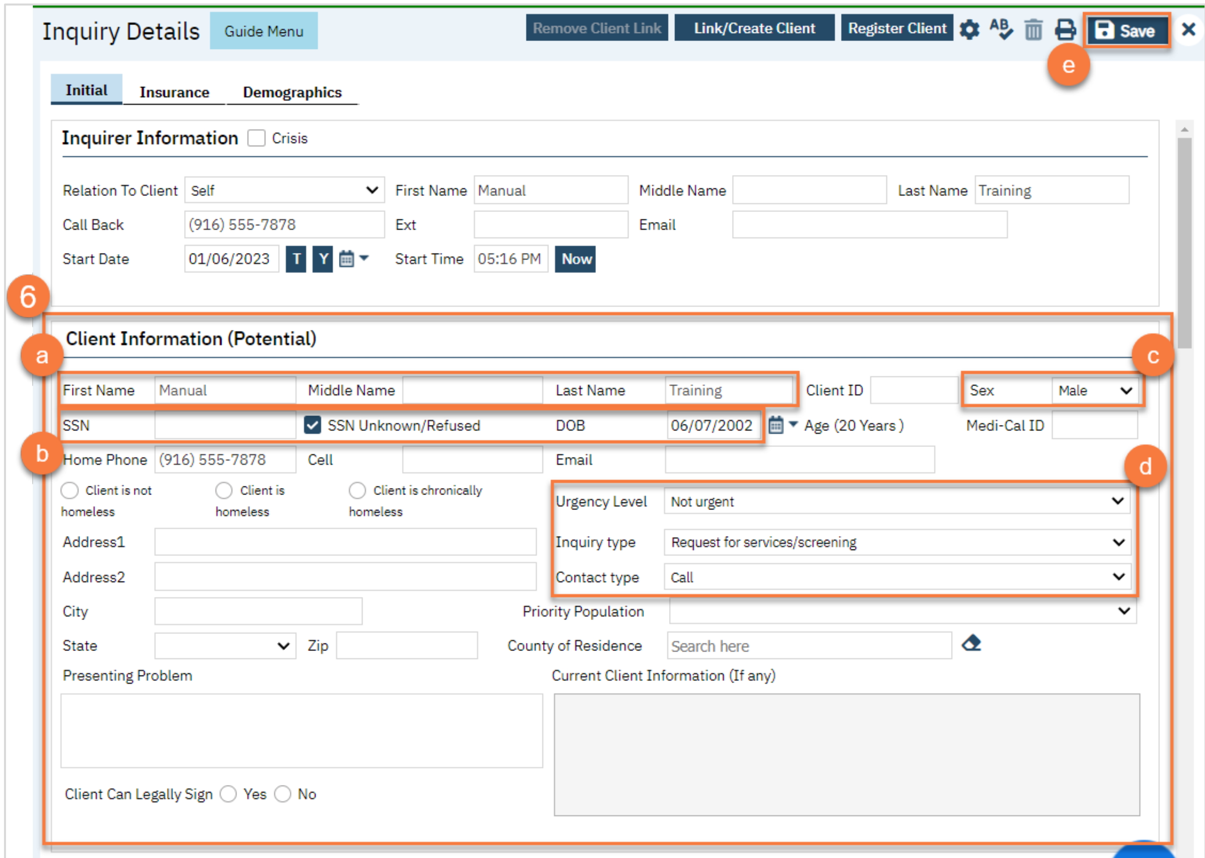
    c. **Complete the Sex field.** This field can be changed in the future if necessary.
    d. **Complete the Urgency Level, Inquiry type, and Contact type fields.** The options for each field are listed in the tables below. This includes a description of when to use each option.
    e. **Click Save.**



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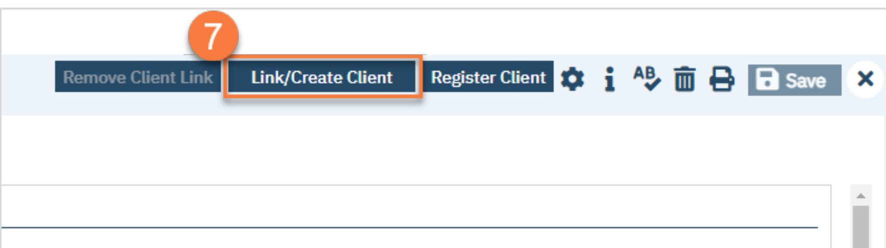
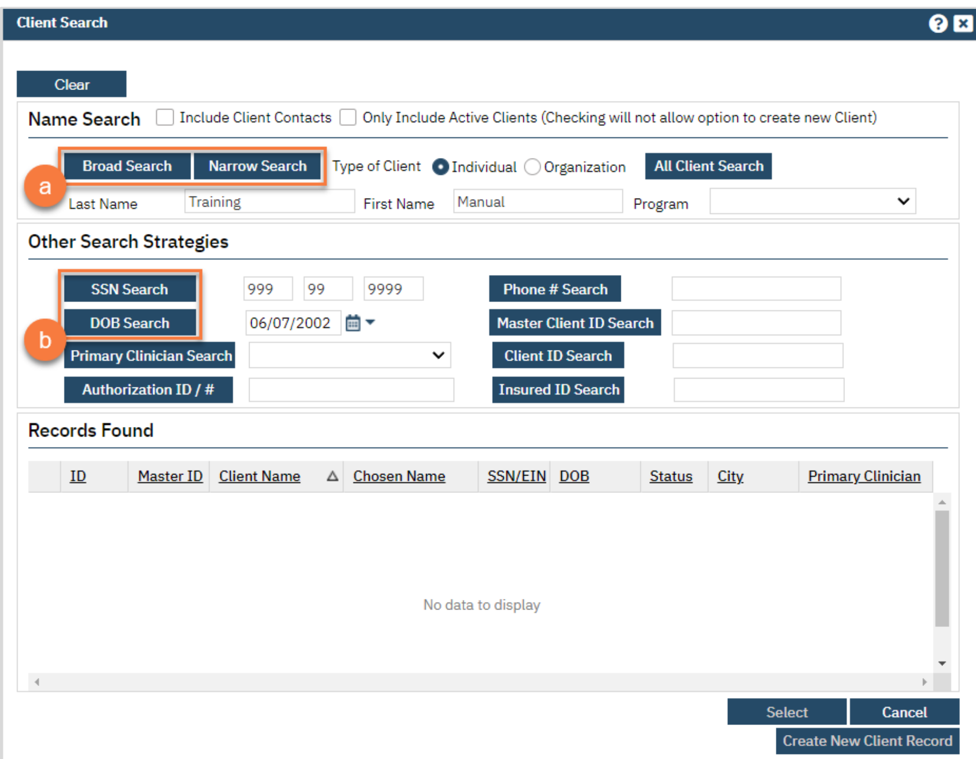
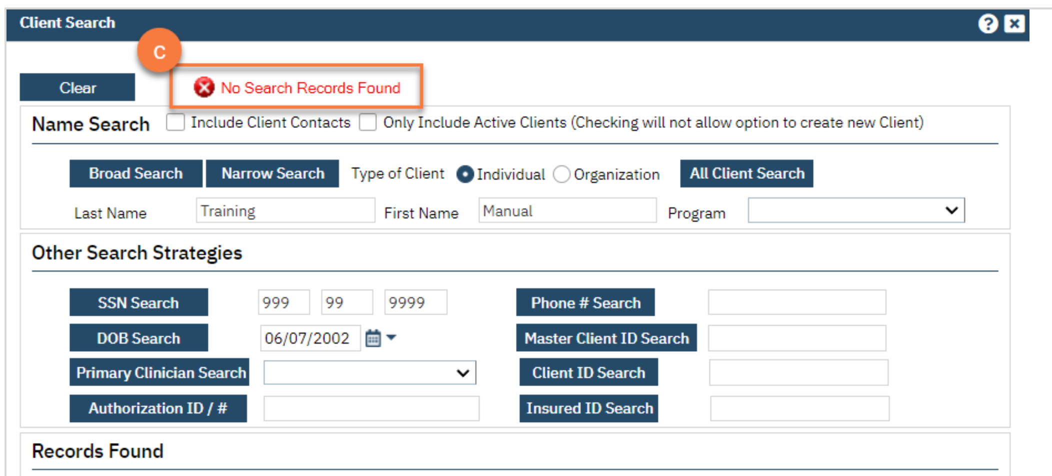


a. You must **search by name** by clicking on either "Broad Search" or "Narrow Search".
b. You must also **search by SSN and DOB** by clicking on those respective buttons.



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

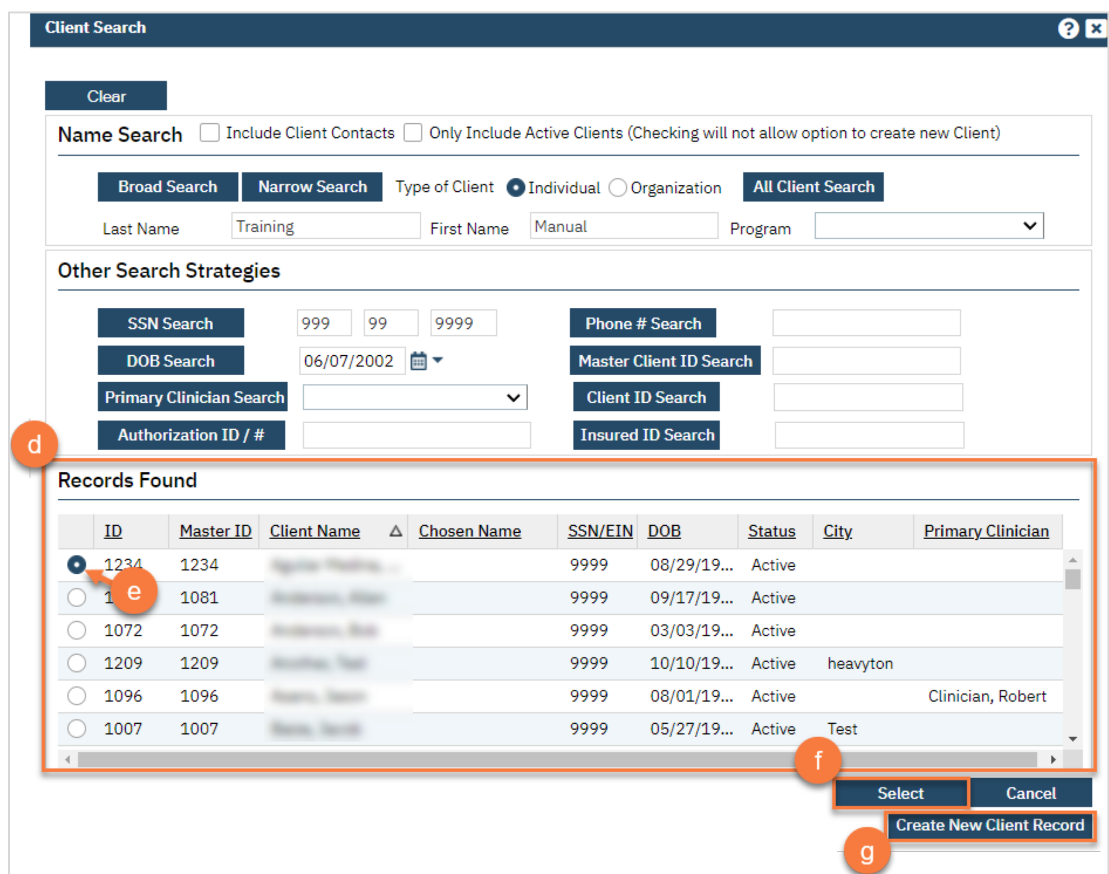


d. Any search results will show in the "Records Found" area. **Review the Records Found** to determine if the person is already in the system as a client.

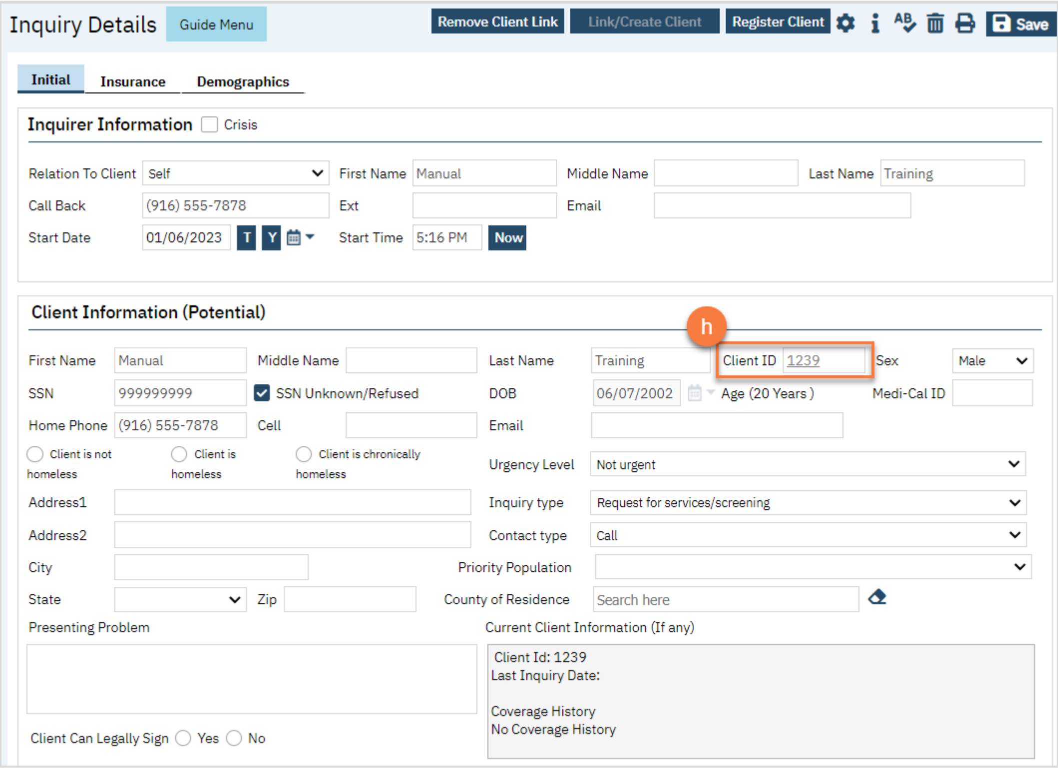
e. If the person is already a client in the system, **select the button next to the appropriate record.**

f. **Click "Select"** to link the Inquiry to the selected client.

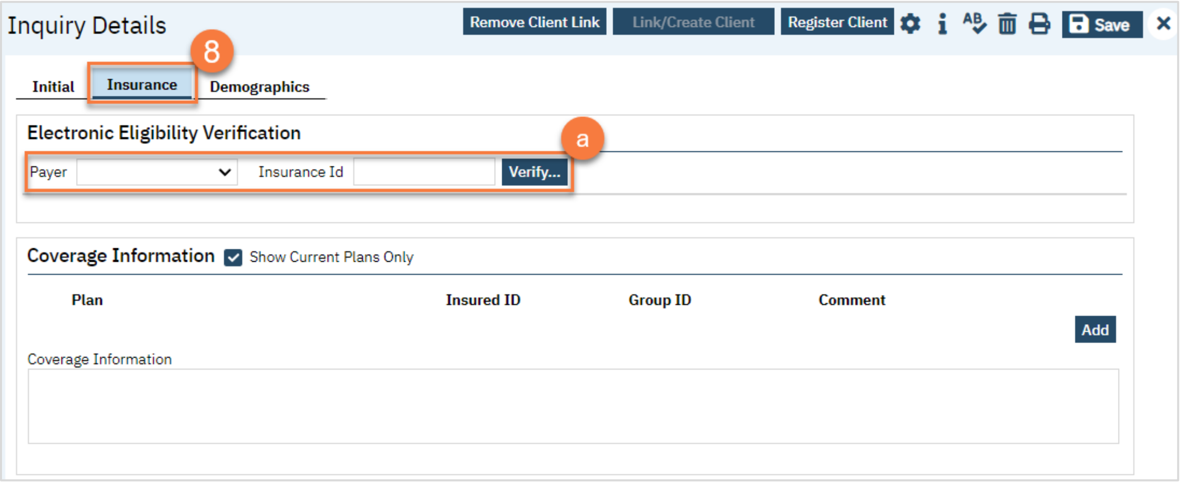
g. If the person is not a client, meaning no records were found matching the client's information, **click "Create New Client Record."**



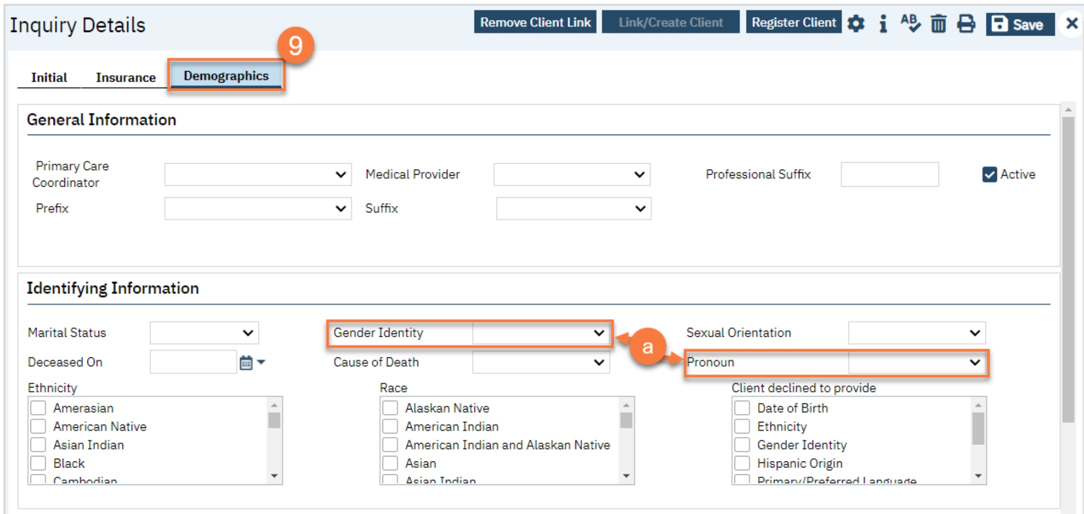
h. This will take you back to the Inquiry screen but now a client ID number will be added.



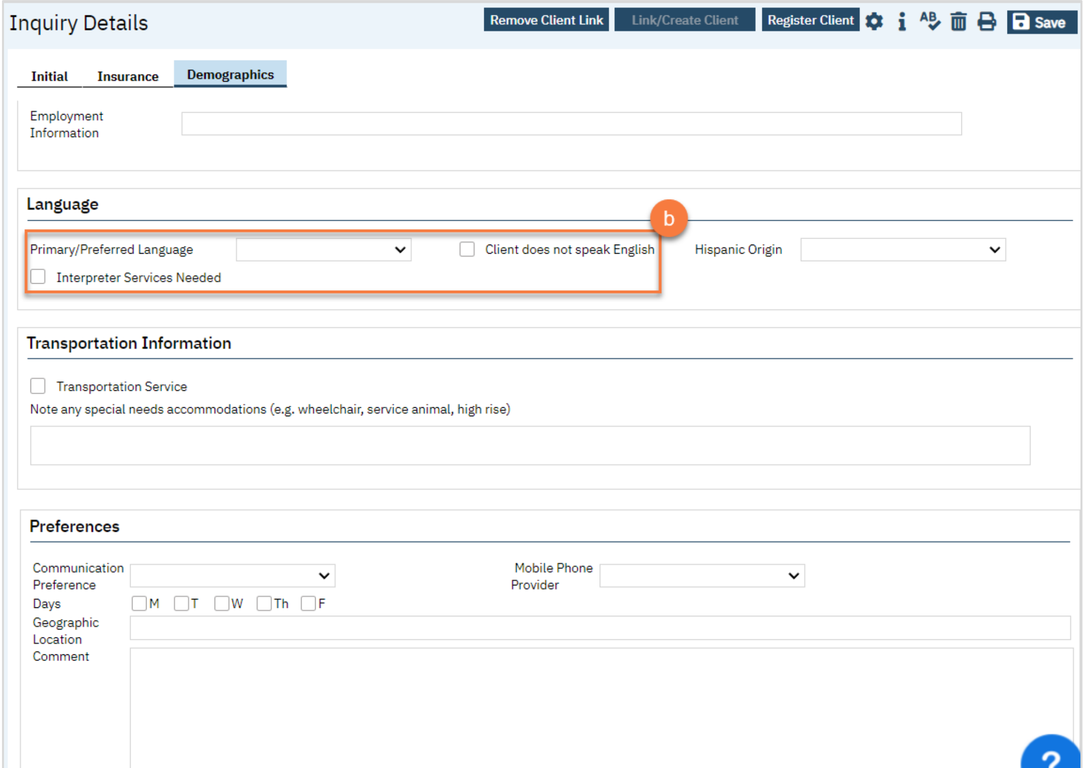
8. Click on the “Insurance” tab.
    a. **Select “Medi-Cal” from the “Payer” drop-down and enter the client’s Medi-Cal number (CIN) in the “Insurance ID” field. Click “Verify”** to verify the client’s Medi-Cal insurance.



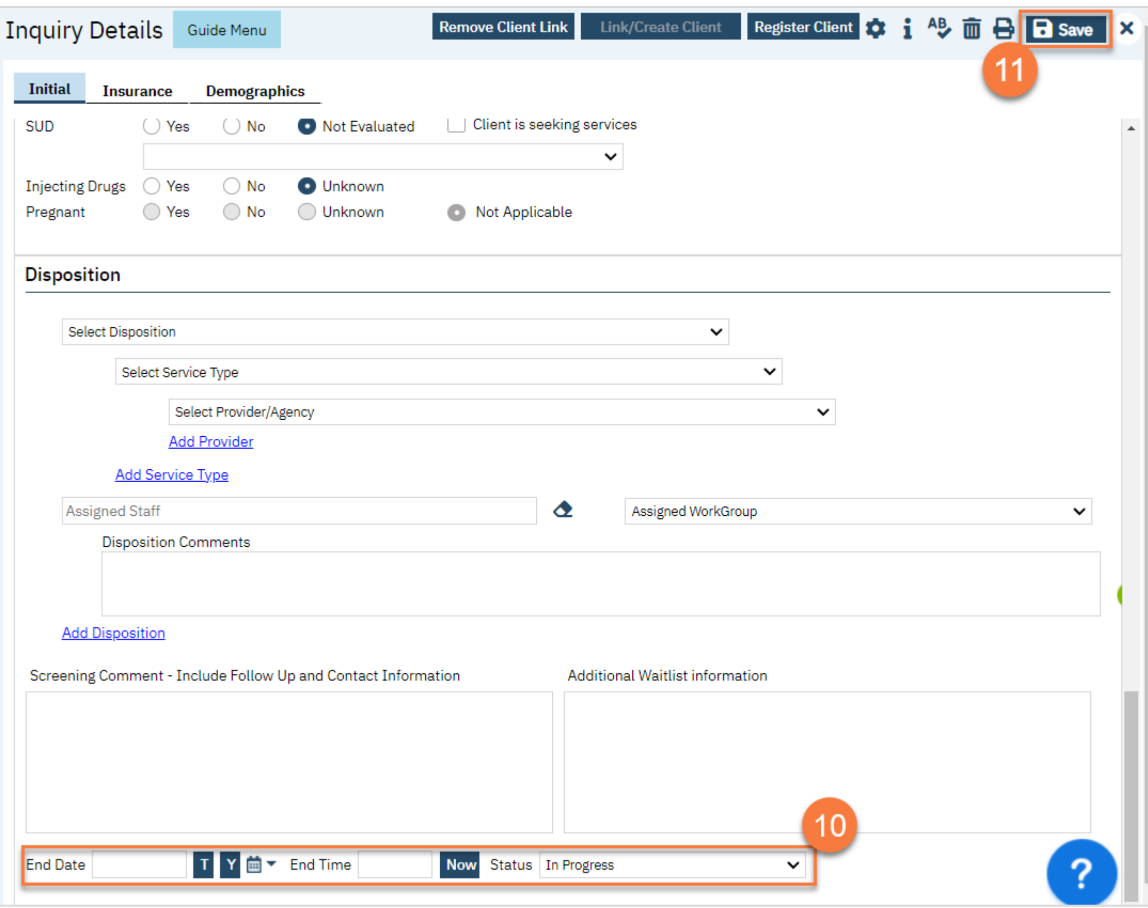
9. Click on the “Demographics” tab.
    a. We recommend **completing the “Gender Identity” and “Pronoun” fields** to ensure the person is not misgendered as additional staff engage with the client.



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.



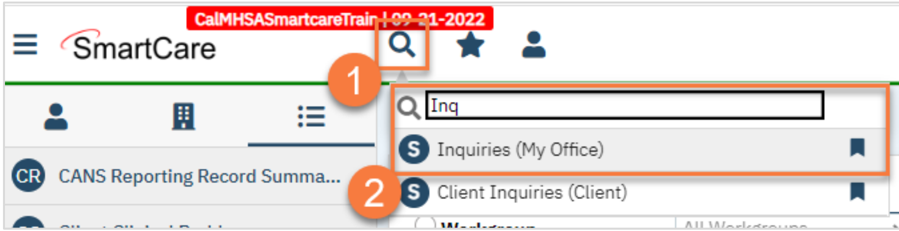
10. You may enter any additional information in any of the tabs, but none are required. Once complete, **enter the end date and time of the Inquiry.** Once again, there are "T" (today) and "Now" buttons to make this easier. **Leave the status as "In Progress".**
11. **Click Save.** You may now close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



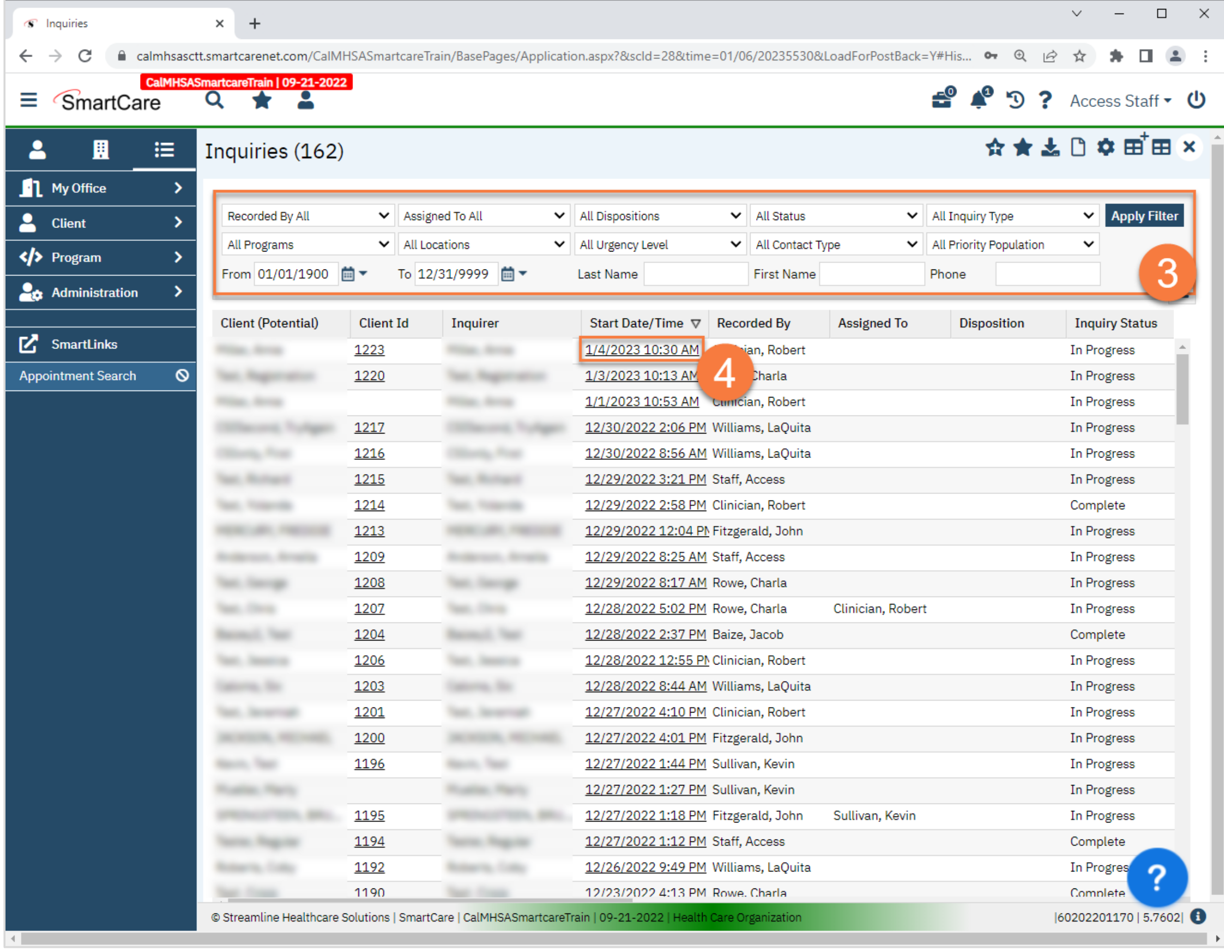
How to View Requests for Services that are Pending

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

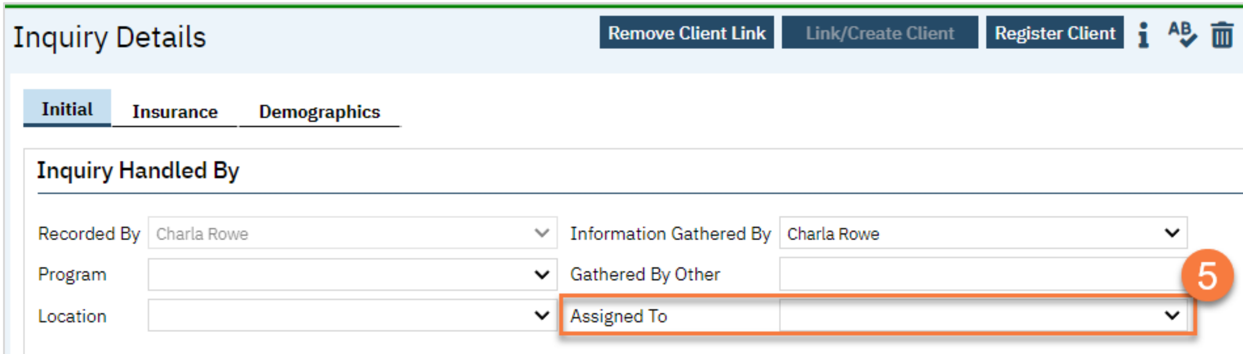
1. **Search for the Inquiry screen** using the search icon.
2. **Select "Inquiries (My Office)"**



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.

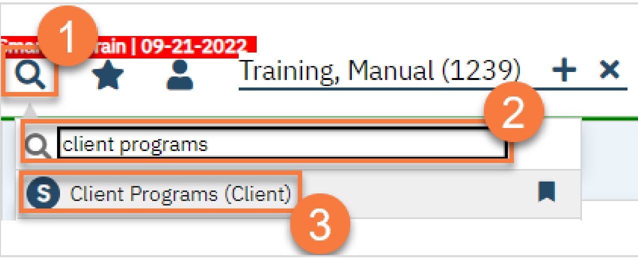
Note: There are times a screening can be skipped and a client moved directly to the assessment phase. This is often the case for programs that work directly with partner agencies to expedite the access process. For example, Child Welfare Services may request an assessment on a foster youth without requiring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

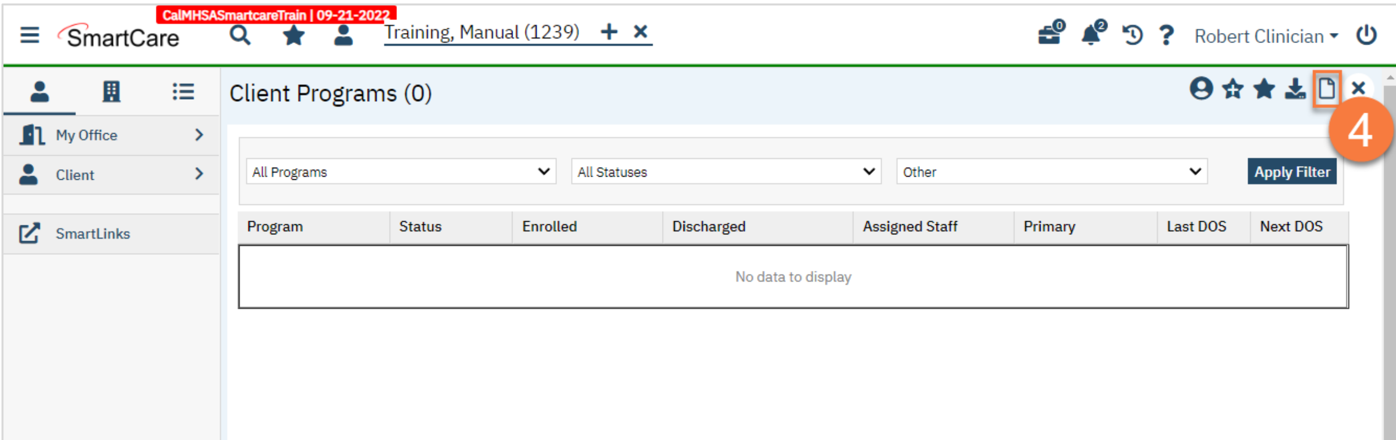
How to Enroll the Client in an Access Program (Screening Setup)

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

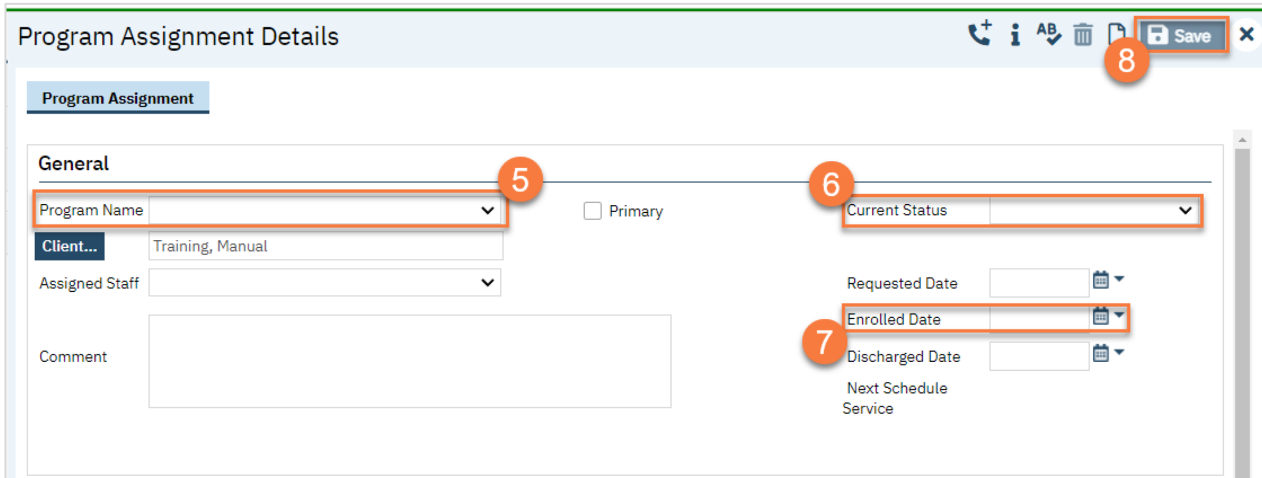
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Programs** into the search bar.
3. **Click to select Client Programs (Client).**



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

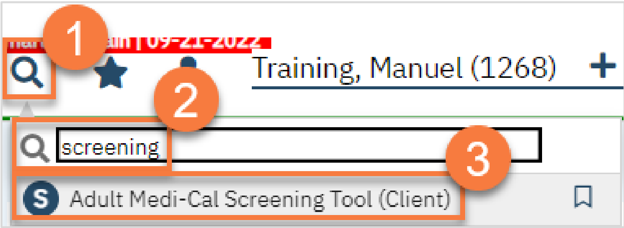


5. **Select the program your county uses for screening services**.
6. **Change the Status to "Enrolled"**.
7. **Enter the Enrolled Date**.
8. **Click Save**.

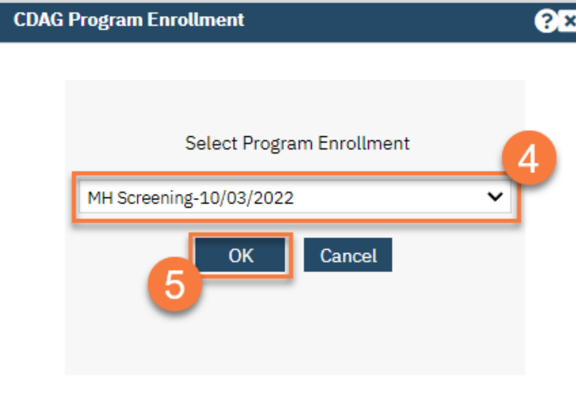


How to Complete an Adult Medi-Cal Screening Tool

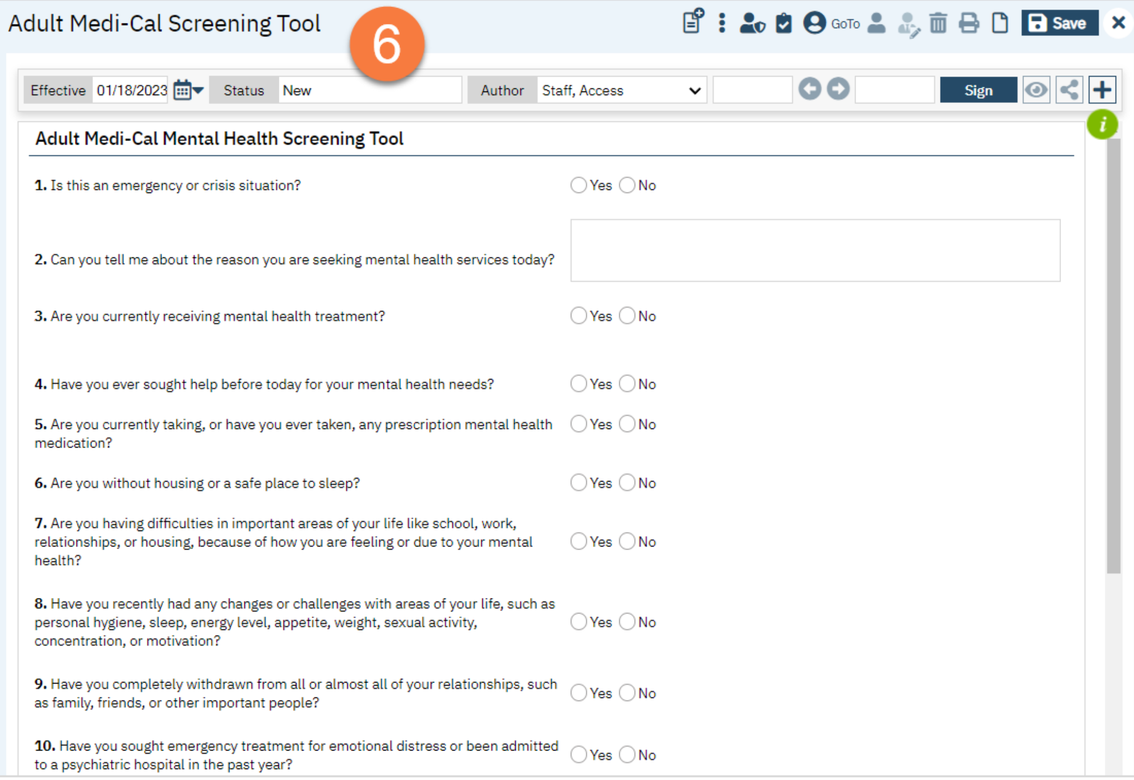
1. You must first have the client open, then **click the Search icon**.
2. **Type Adult Medi-Cal Screening Tool** into the search bar.
3. **Click to select Adult Medi-Cal Screening Tool (Client).**



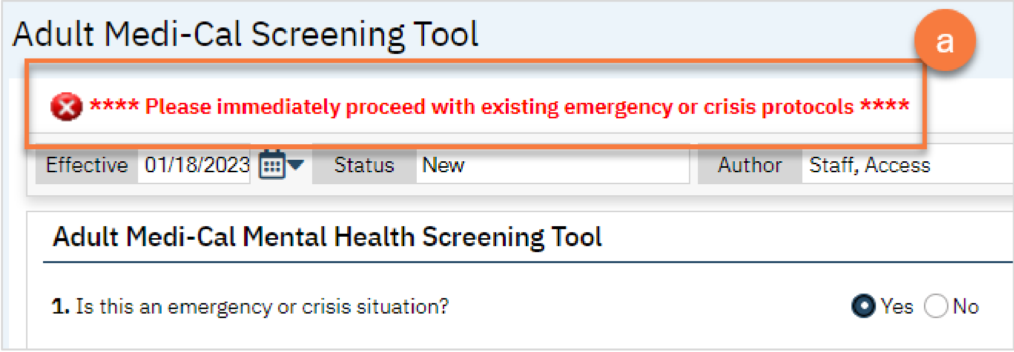
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



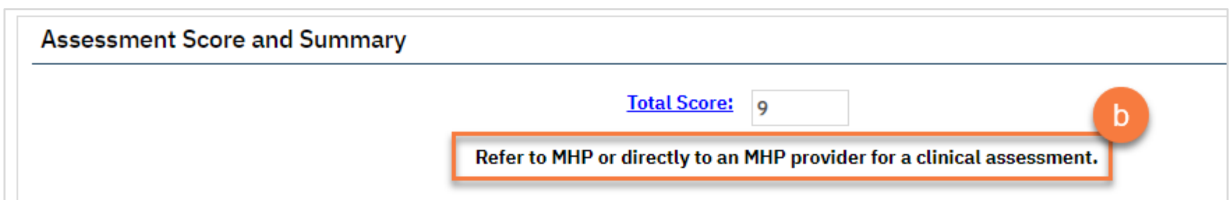
6. The Adult Medi-Cal Screening Tool document will open. **Complete the document**.



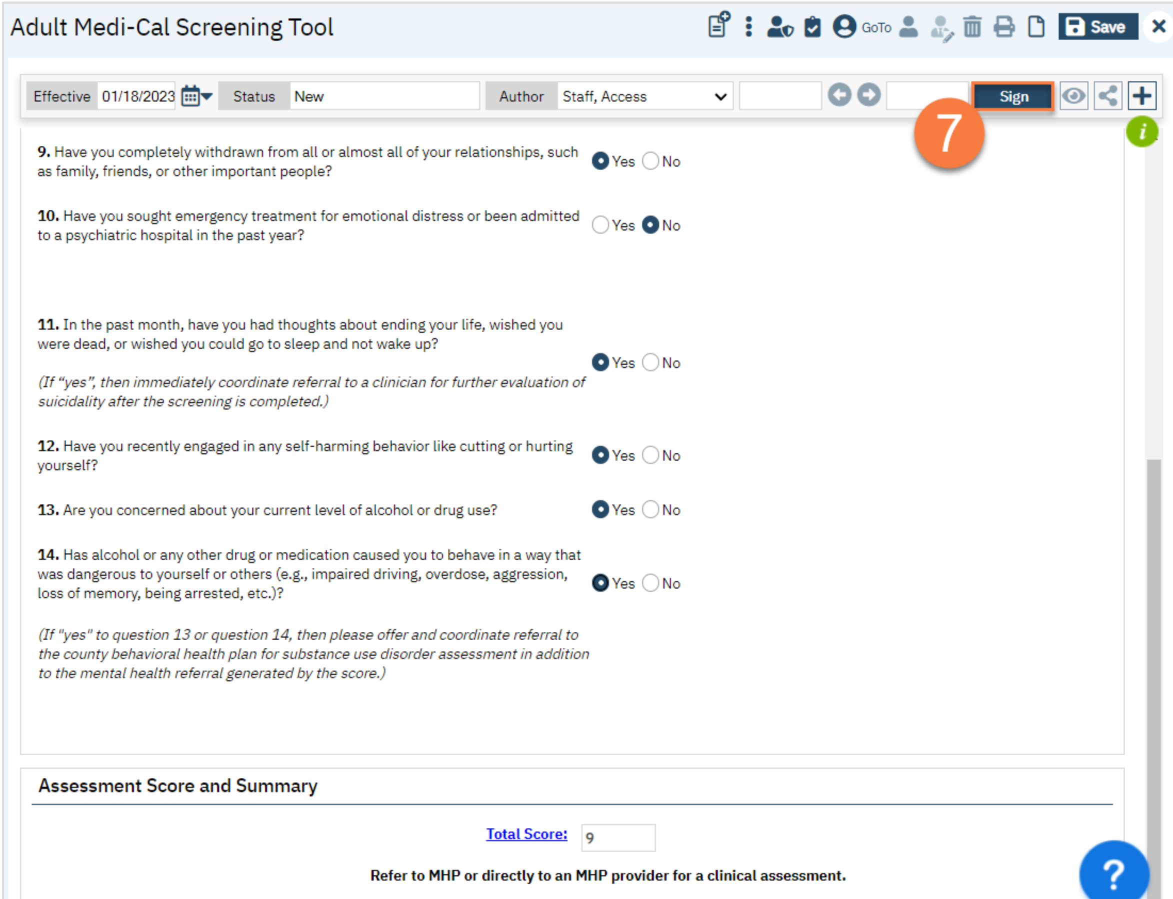
   a. Any alerts will show at the top of the page.



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

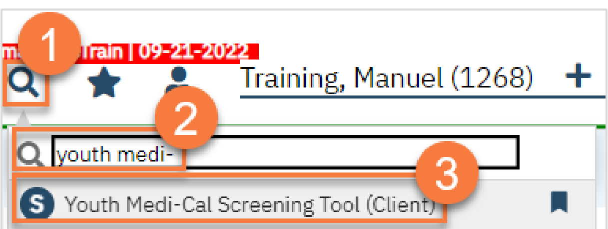


7. **Click Sign** to complete and generate the document.

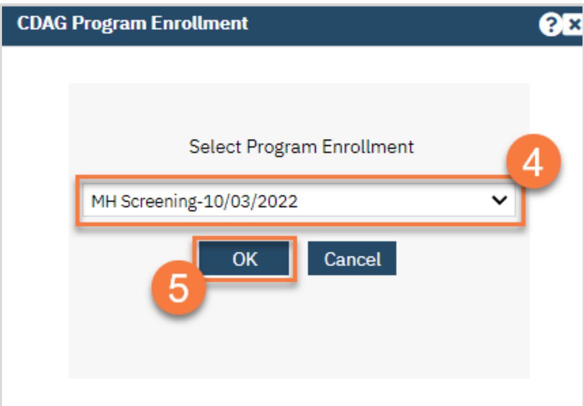


How to Complete a Youth Medi-Cal Screening Tool

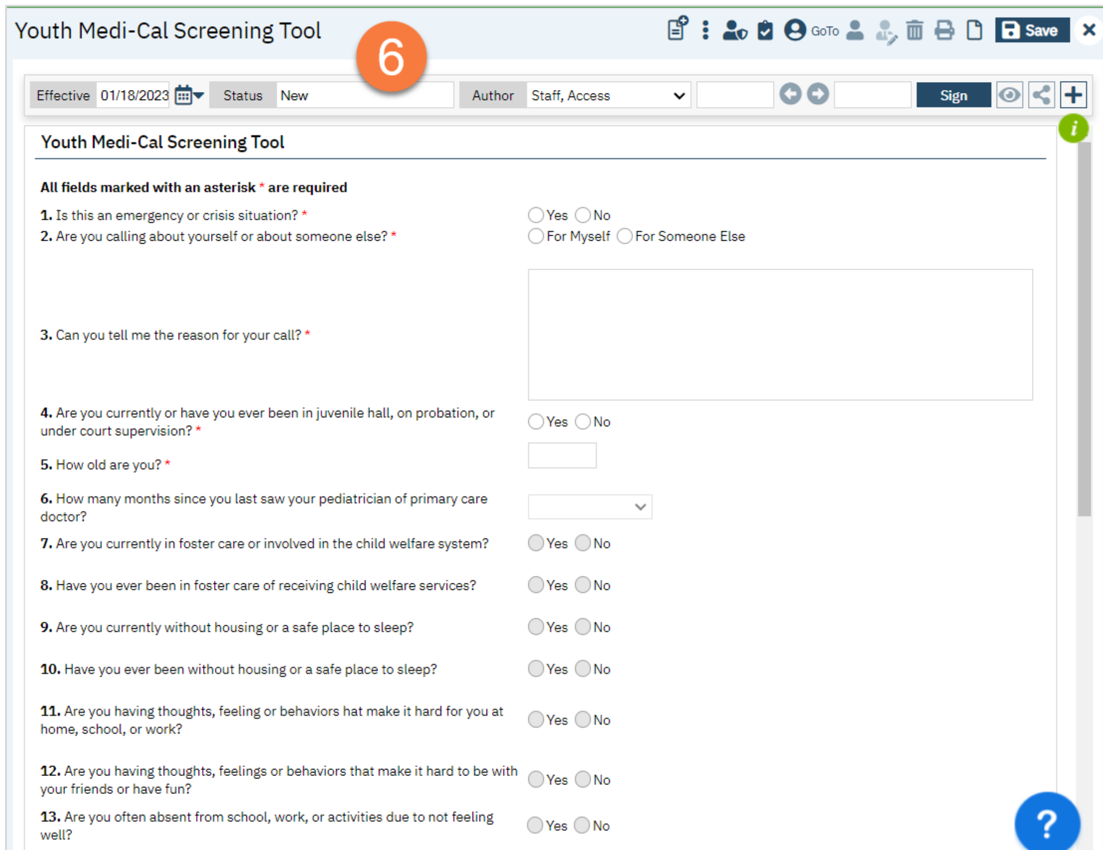
1. You must first have the client open, then **click the Search icon**.
2. **Type Youth Medi-Cal Screening Tool** into the search bar.
3. **Click to select Youth Medi-Cal Screening Tool (Client).**



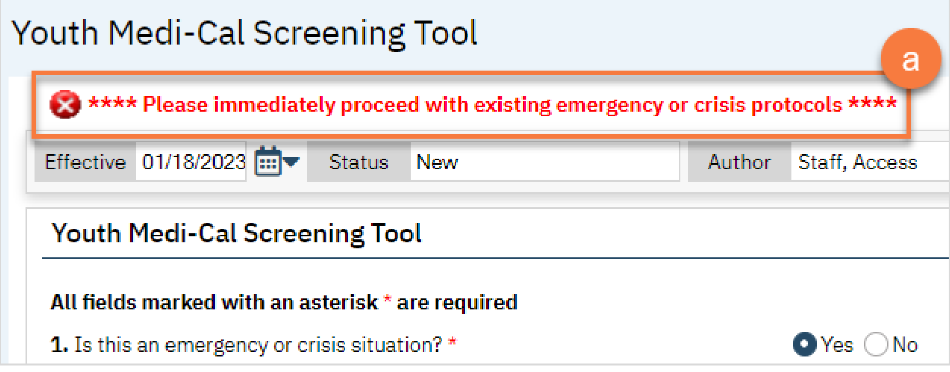
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



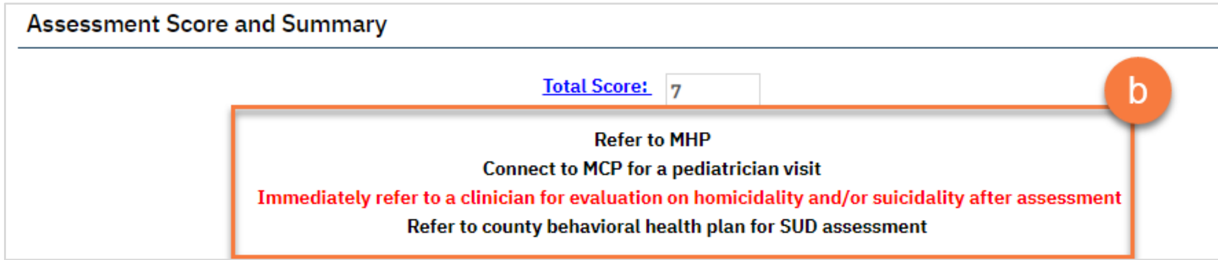
6. The Youth Medi-Cal Screening Tool document will open. **Complete the document**. The wording of the questions varies slightly depending on if you're screening the youth directly or gathering information from a parent or guardian. The system will automatically alter the language to match the appropriate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



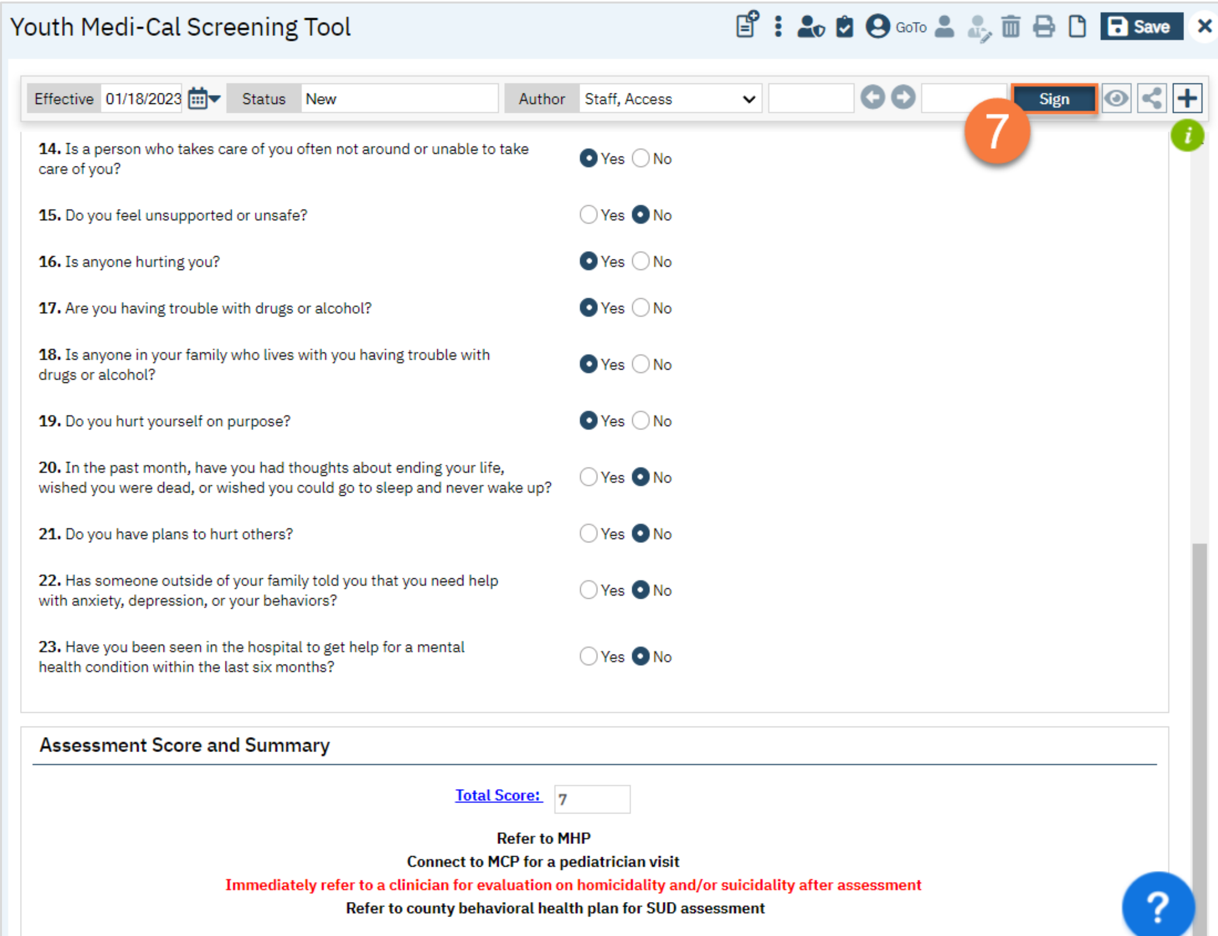
a. Any alerts will show at the top of the page



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

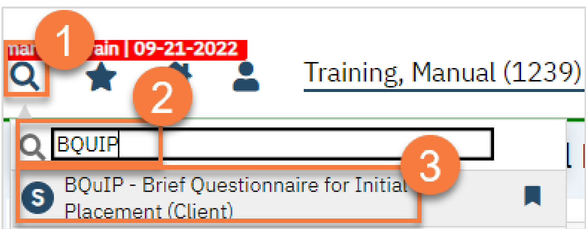


7. **Click Sign** to complete and generate the document.

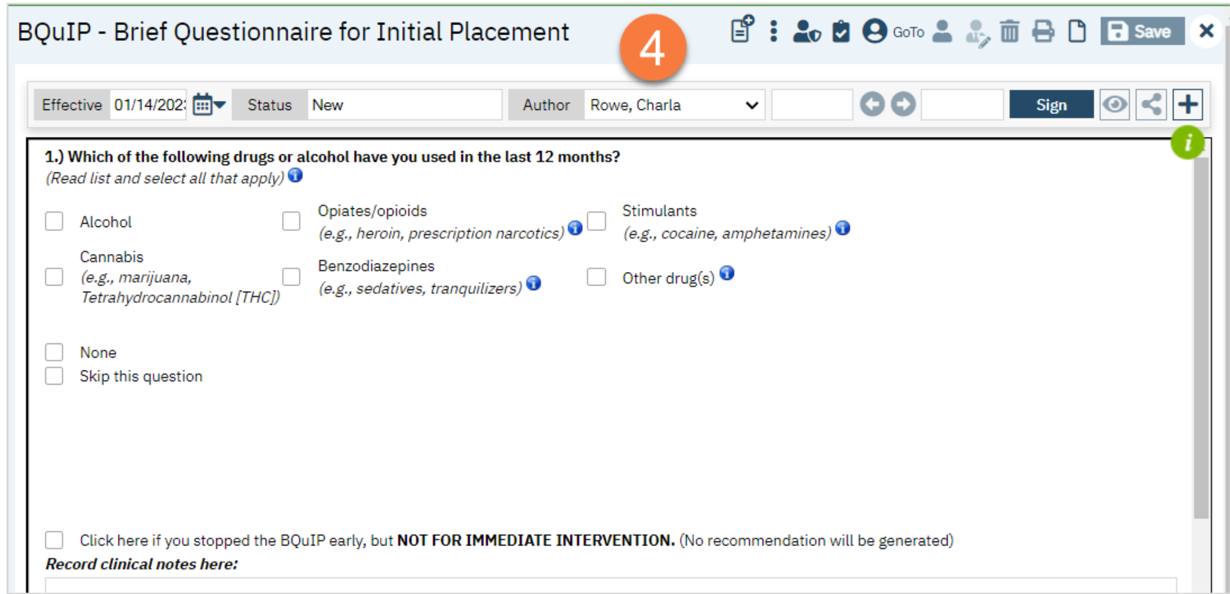


How to Complete a BQuIP SUD Screening Tool

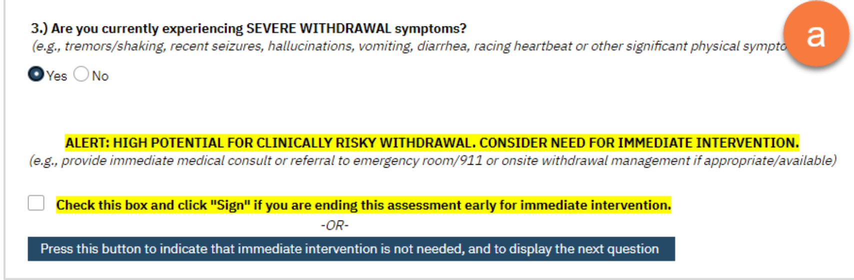
1. You must first have the client open, then **click the Search icon**.
2. **Type BQuIP** into the search bar.
3. **Click to select BQuIP – Brief Questionnaire for Initial Placement (Client).**



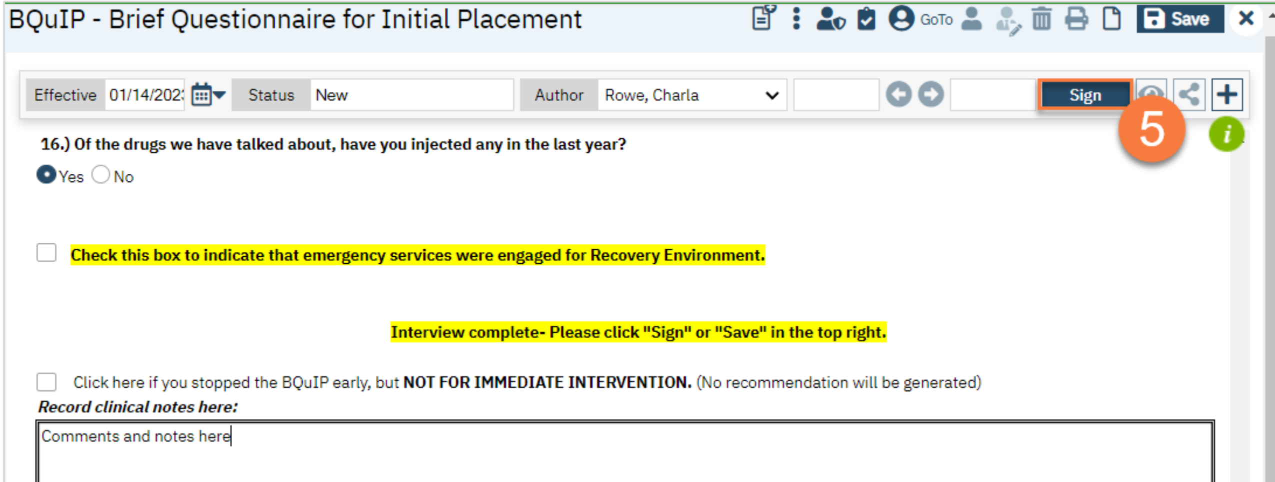
4. The BQuIP document will open. **Complete the document**. Not all questions are visible, as only the next question will show. This allows you easier access to the Clinical Comments field for taking notes as you're working through the screening. As you answer questions, you may be alerted to stop the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

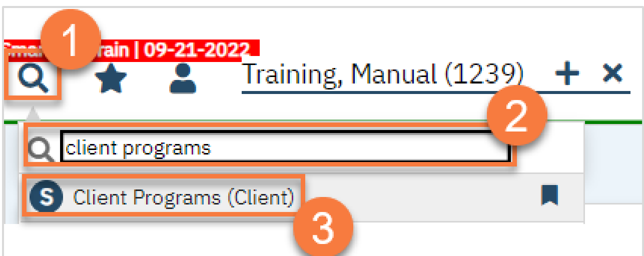


How to Refer the Client to the County's (MHP) System of Care

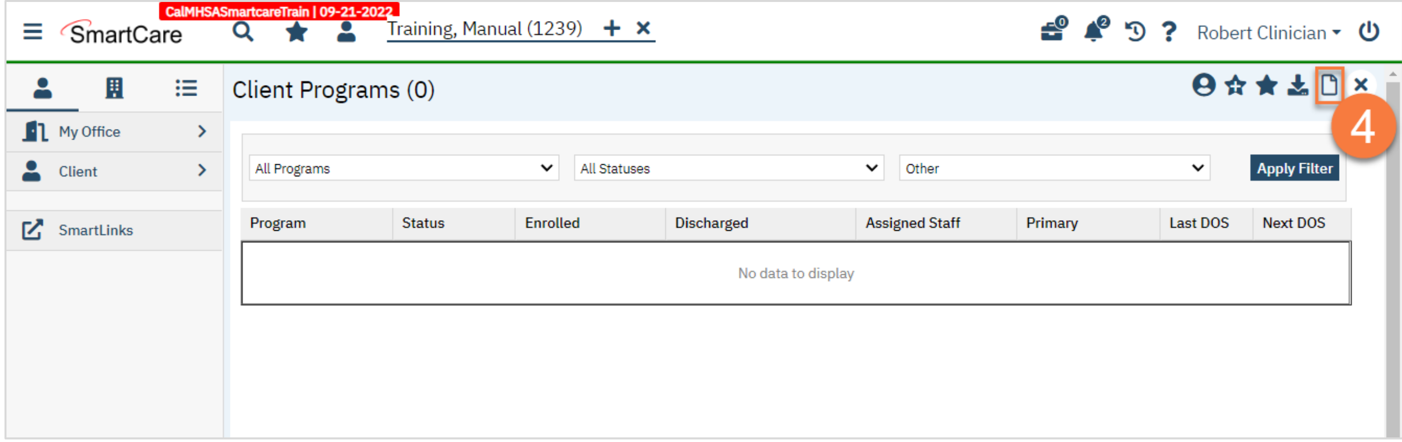
Since the MHP's system of care includes county owned and operated programs as well as contracted providers, you'll have to first determine if the provider you'll be referring to uses the county's instance of SmartCare or not.

How to Refer to a County or Contractor Program that Uses SmartCare

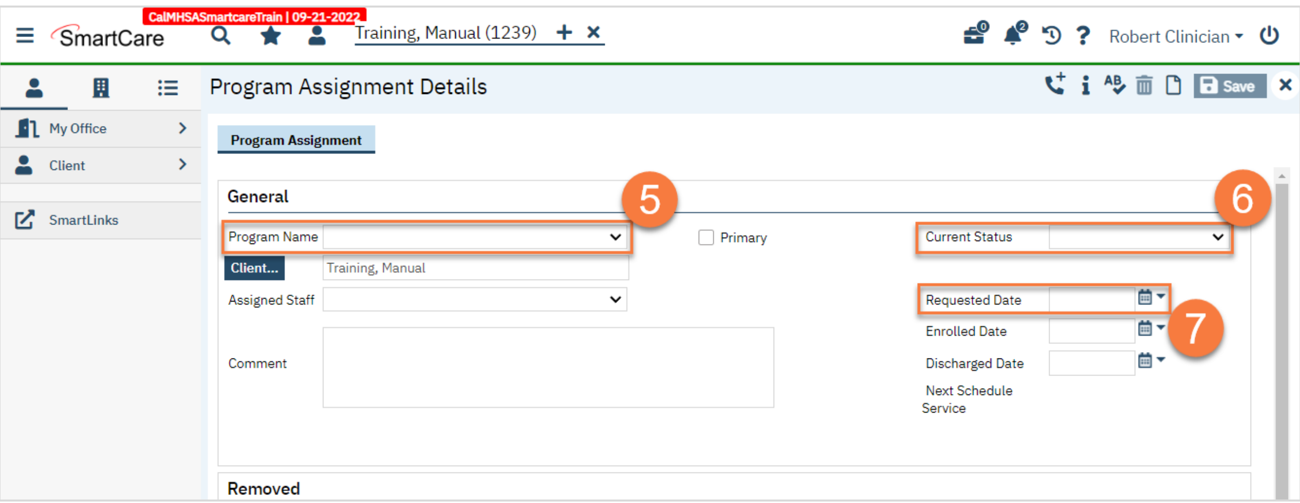
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Programs** into the search bar.
3. **Click to select Client Programs (Client).**



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

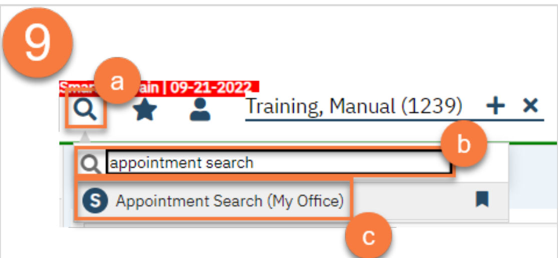


5. Select the program you're referring to.
6. Change the Status to "Requested".
7. Enter the Requested Date.

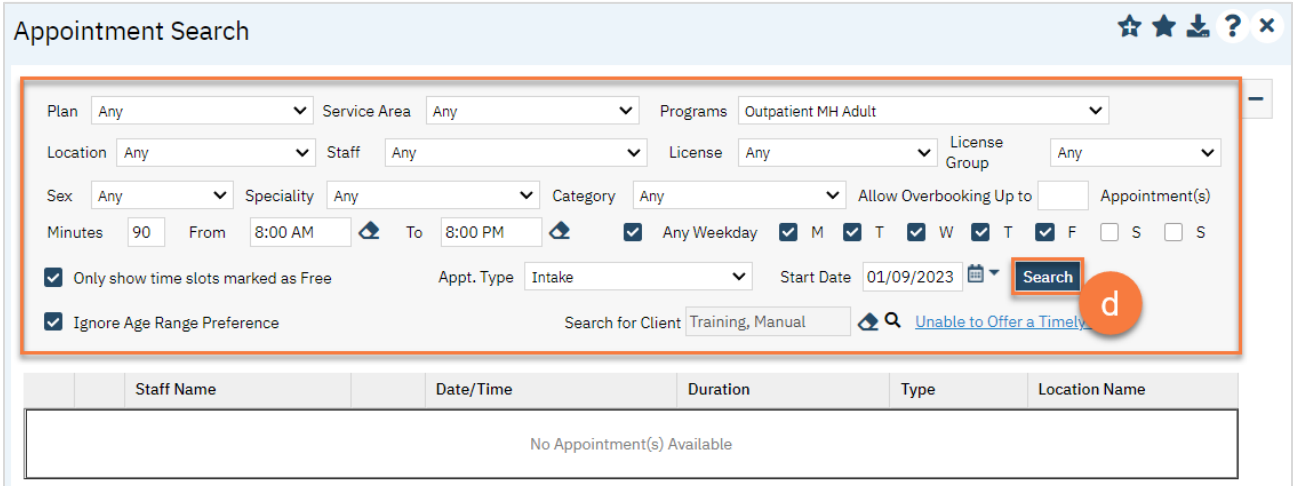


8. Click Save.

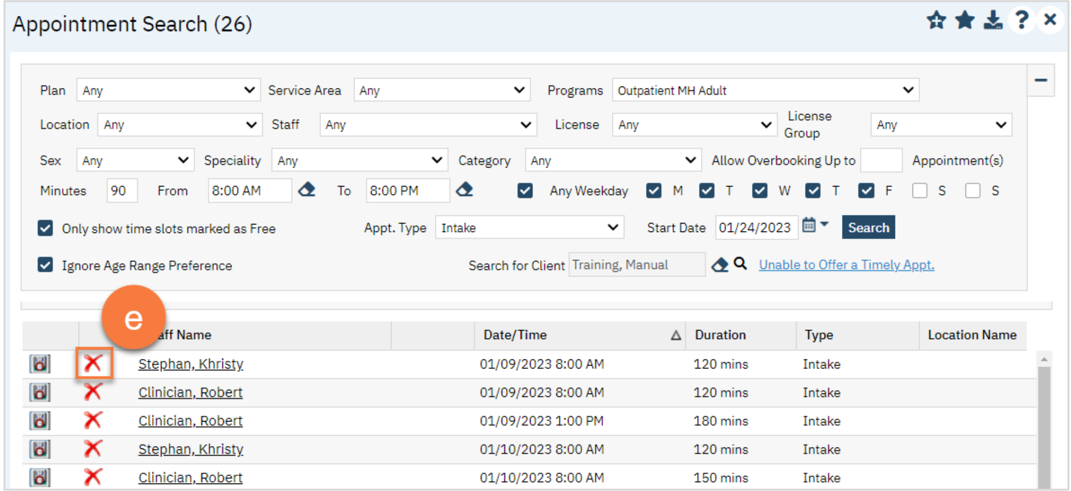
9. **If this program allows you to schedule intake assessments on their behalf, open the Appointment Search screen.** If this program does not allow you to schedule intake assessments on their behalf, you're finished and may close.
    a. **Click the Search icon**.
    b. **Type Appointment Search**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



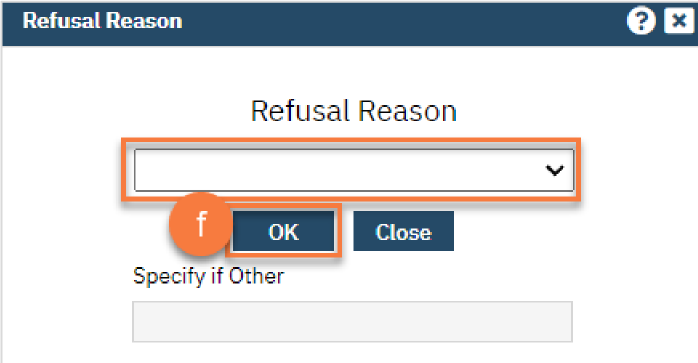
    d. **Use the filters to limit the search** to intake appointments for that program and any other requests the client has, such as client's availability. Then **click Search**.



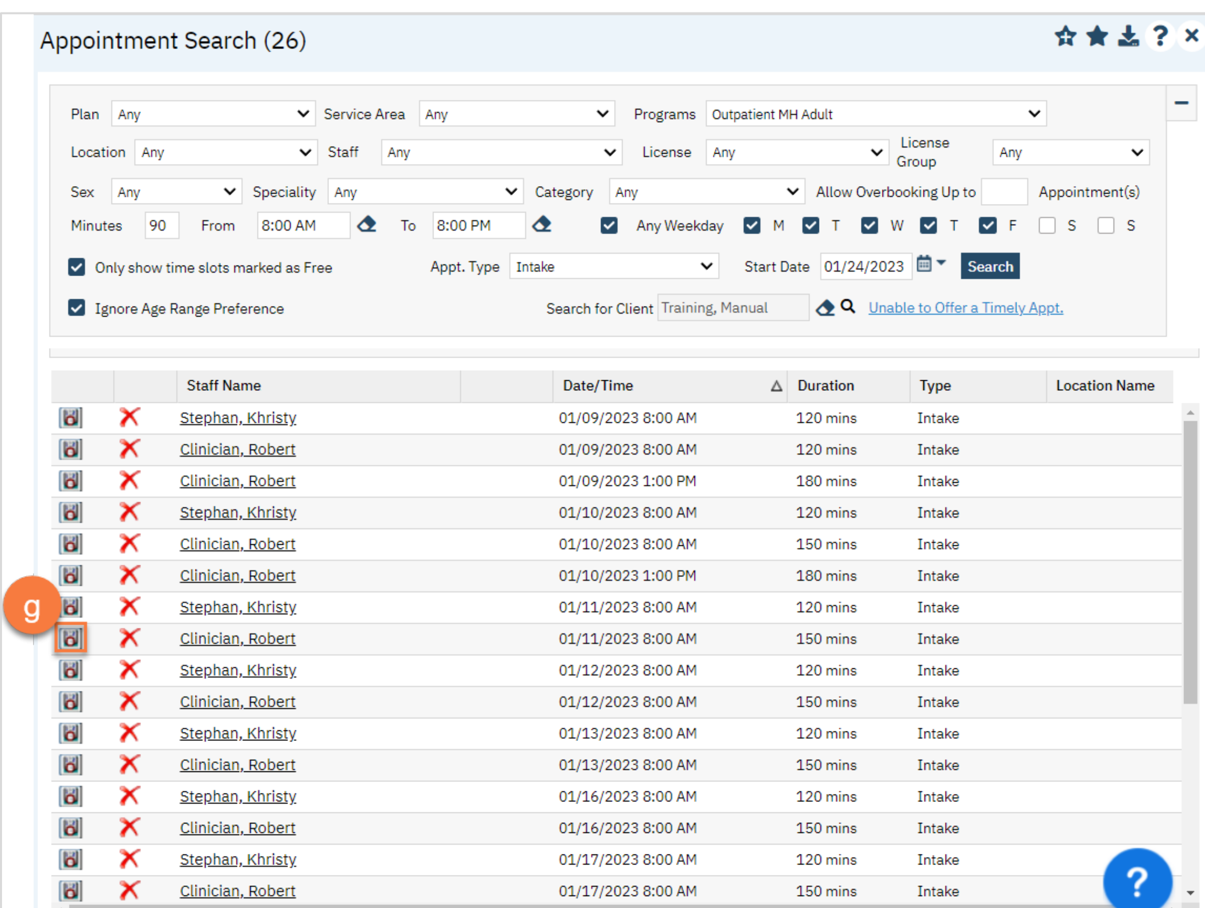
    e. This will bring up a list of available appointments. **If the client declines the first few available appointment dates, click on the "Client Refuses Appointment" icon**. This will be used for tracking timeliness. Note: you only need to decline 1 appointment per day. In the below example, there are 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.



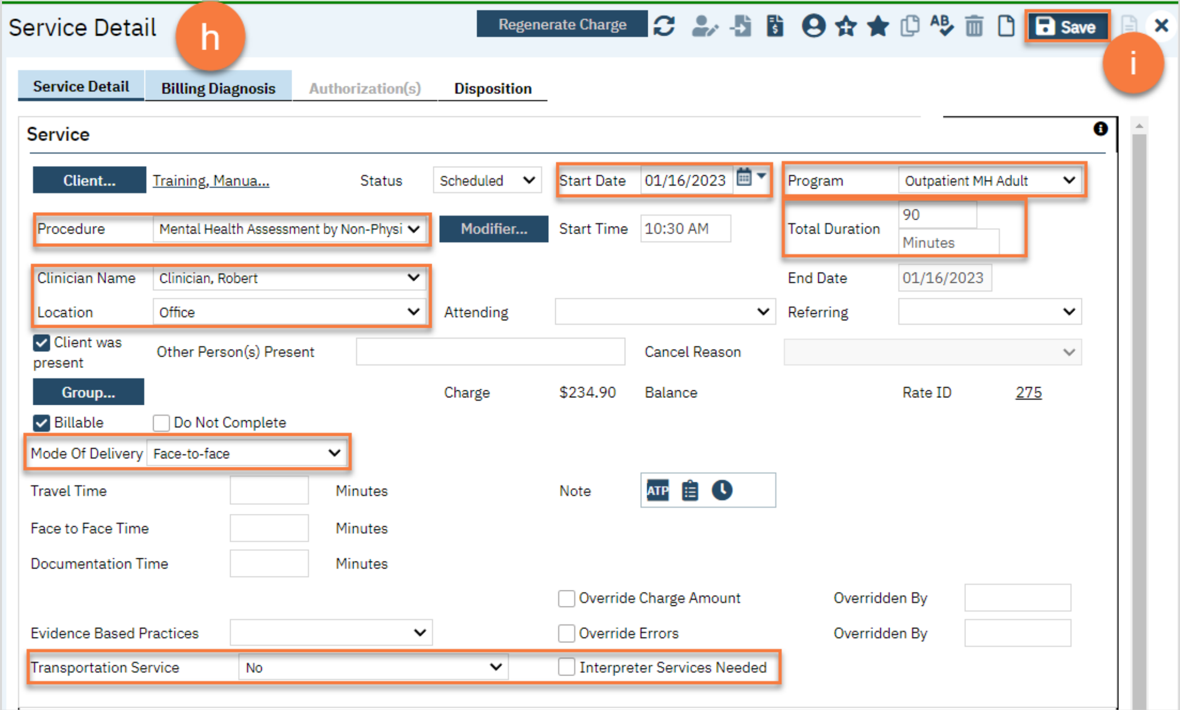
f. Clicking on the “Client Refuses Appointment” icon will bring up a pop-up window. **Enter the Refusal Reason and then click “OK”**.



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

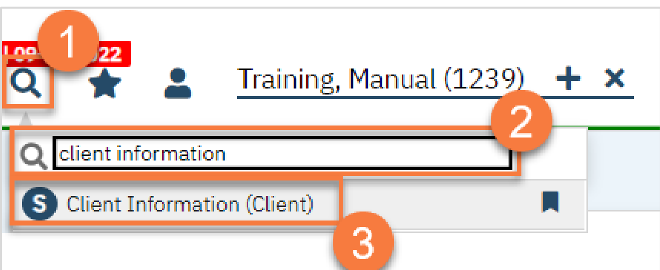


h. This takes you to the Service Detail screen. **Confirm/enter the appointment information**. You can also denote if the person needs transportation or interpretation services.
i. Once complete, **click Save**. The appointment is now scheduled and you are finished.

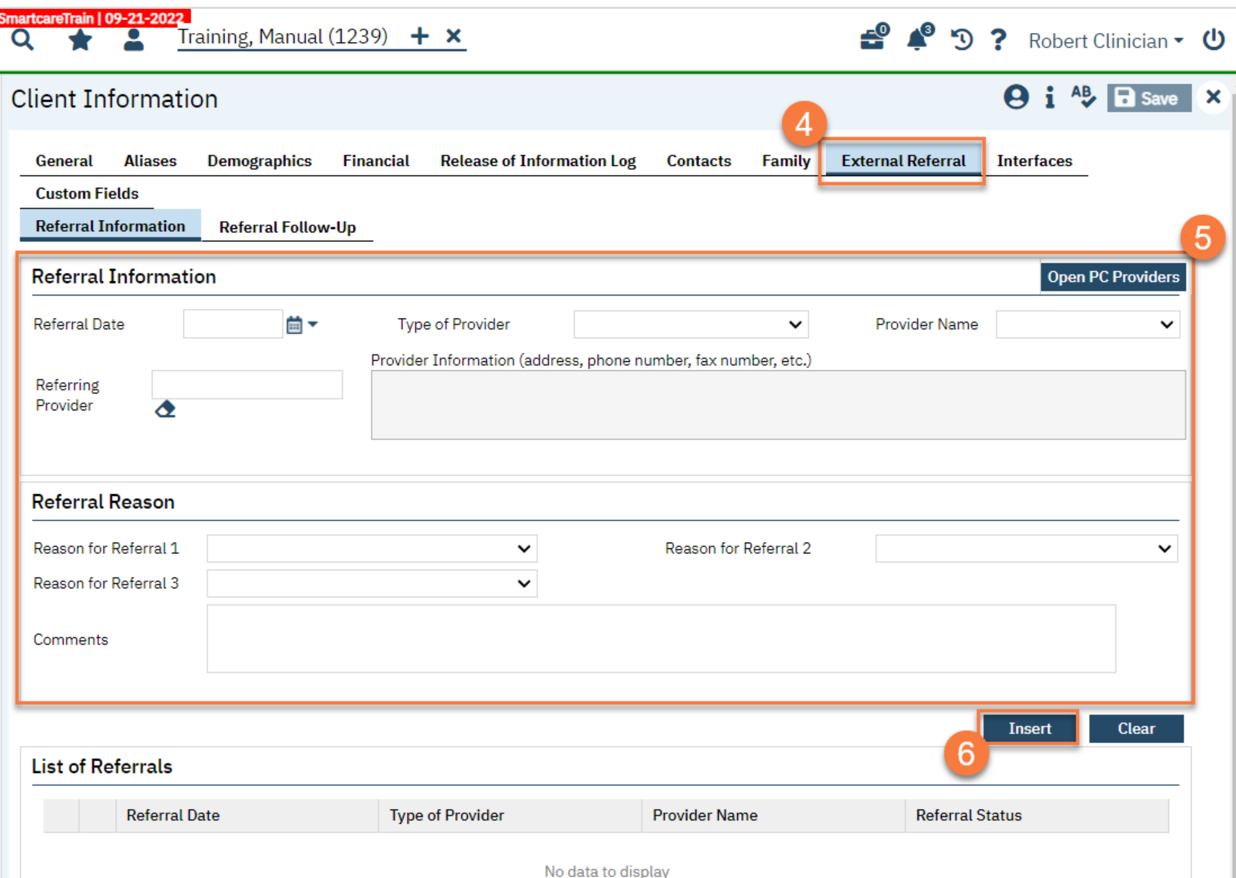


How to Refer to an Agency or Program that Doesn't Use SmartCare

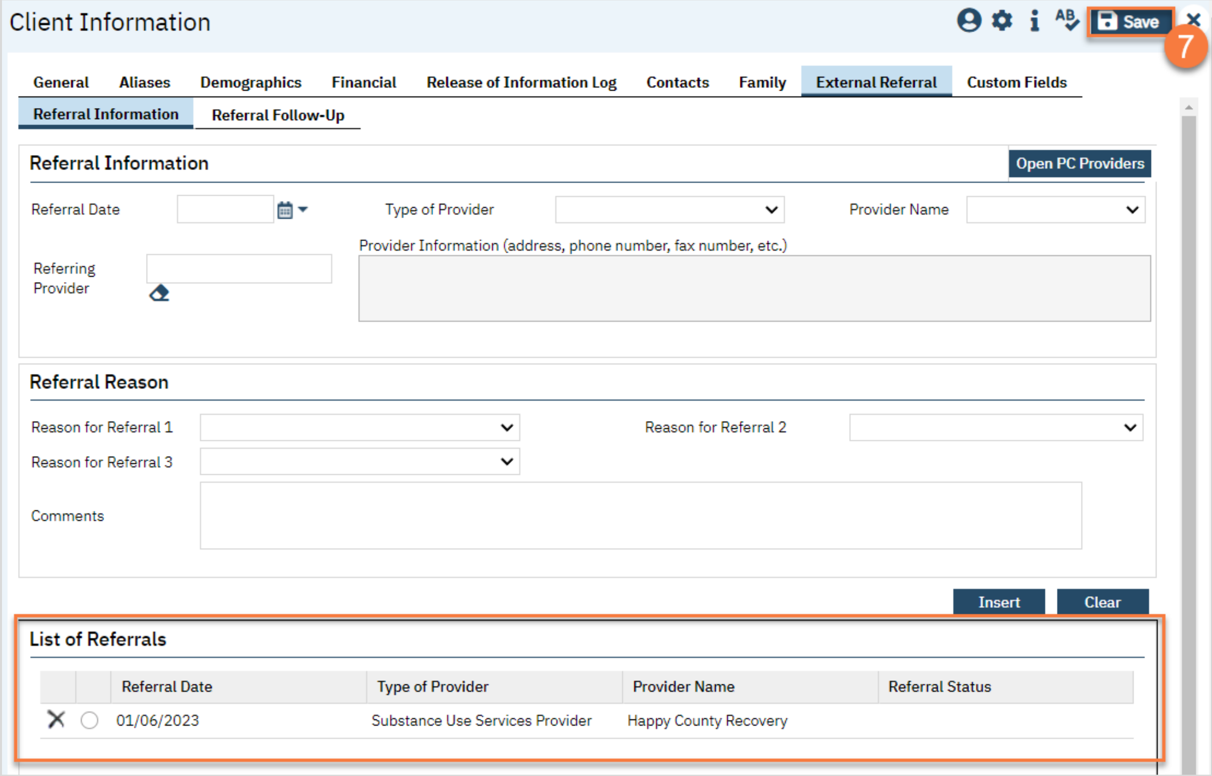
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**



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"**.



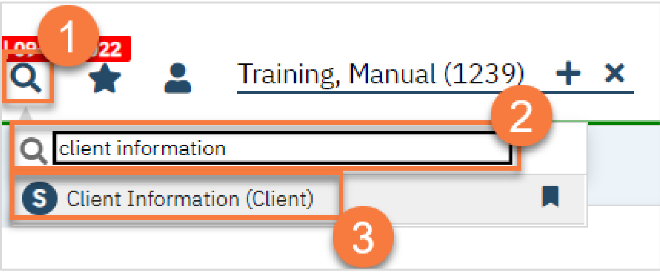
7. Your referral should now show in the List of Referrals section. **Click Save**.



How to Refer the Client 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).**



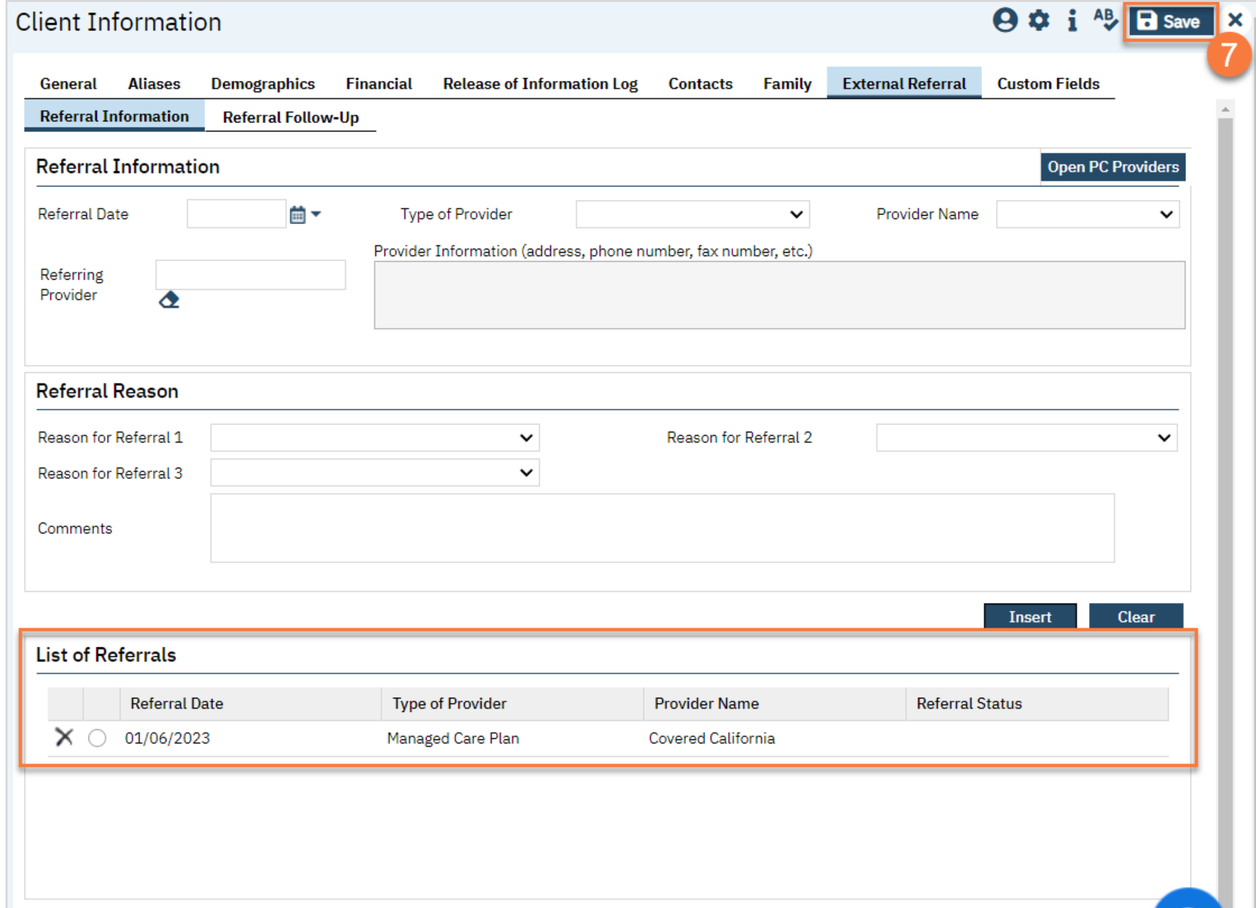
4. **Navigate to the "External Referral" tab**.
5. **Complete the information about the referral** you're providing. For a referral to the Managed Care Plan, select Managed Care Plan from the Provider Type dropdown. Put yourself as the Referring Provider.
6. **Click "Insert"**.

SmartcareTrain | 09-21-2022
Training, Manual (1239)
Robert Clinician
Client Information
Save
4
General Aliases Demographics Financial Release of Information Log Contacts Family External Referral Interfaces
Custom Fields
Referral Information Referral Follow-Up
5
Referral Information
Open PC Providers
Referral Date
Type of Provider
Provider Name
Provider Information (address, phone number, fax number, etc.)
Referring Provider
Referral Reason
Reason for Referral 1
Reason for Referral 2
Reason for Referral 3
Comments
Insert
Clear
6
List of Referrals

		Referral Date	Type of Provider	Provider Name	Referral Status

No data to display

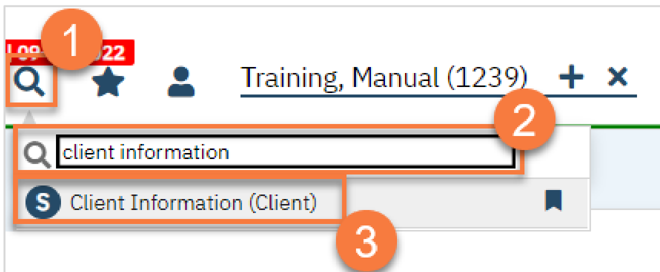
7. Your referral should now show in the List of Referrals section. **Click Save**.



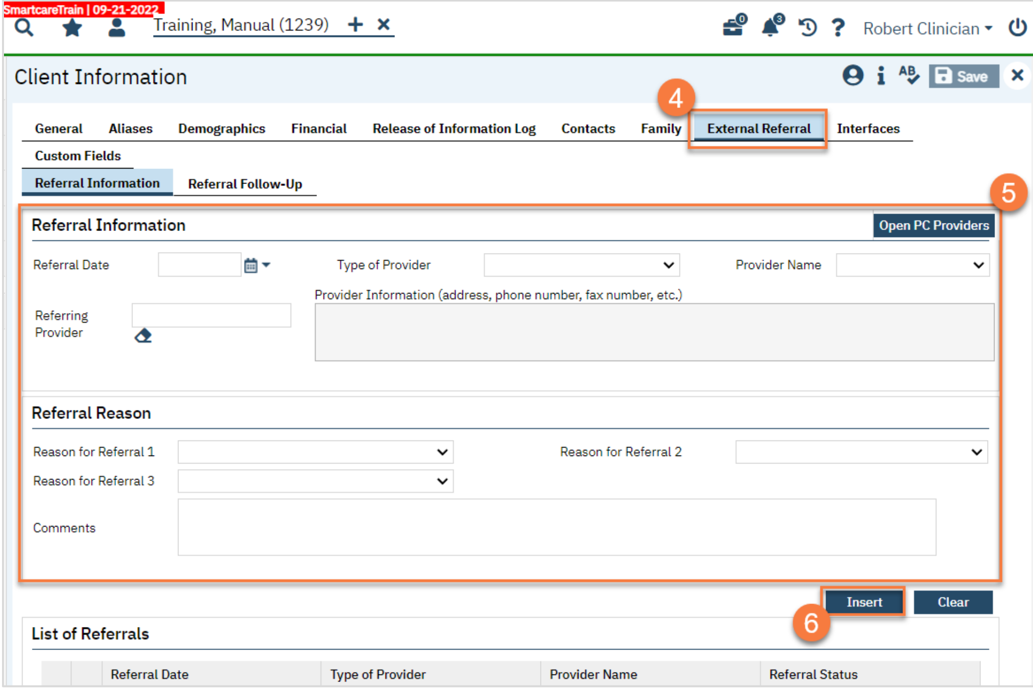
How to Refer the Client to Additional Services, Such a Primary Care Physician

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.

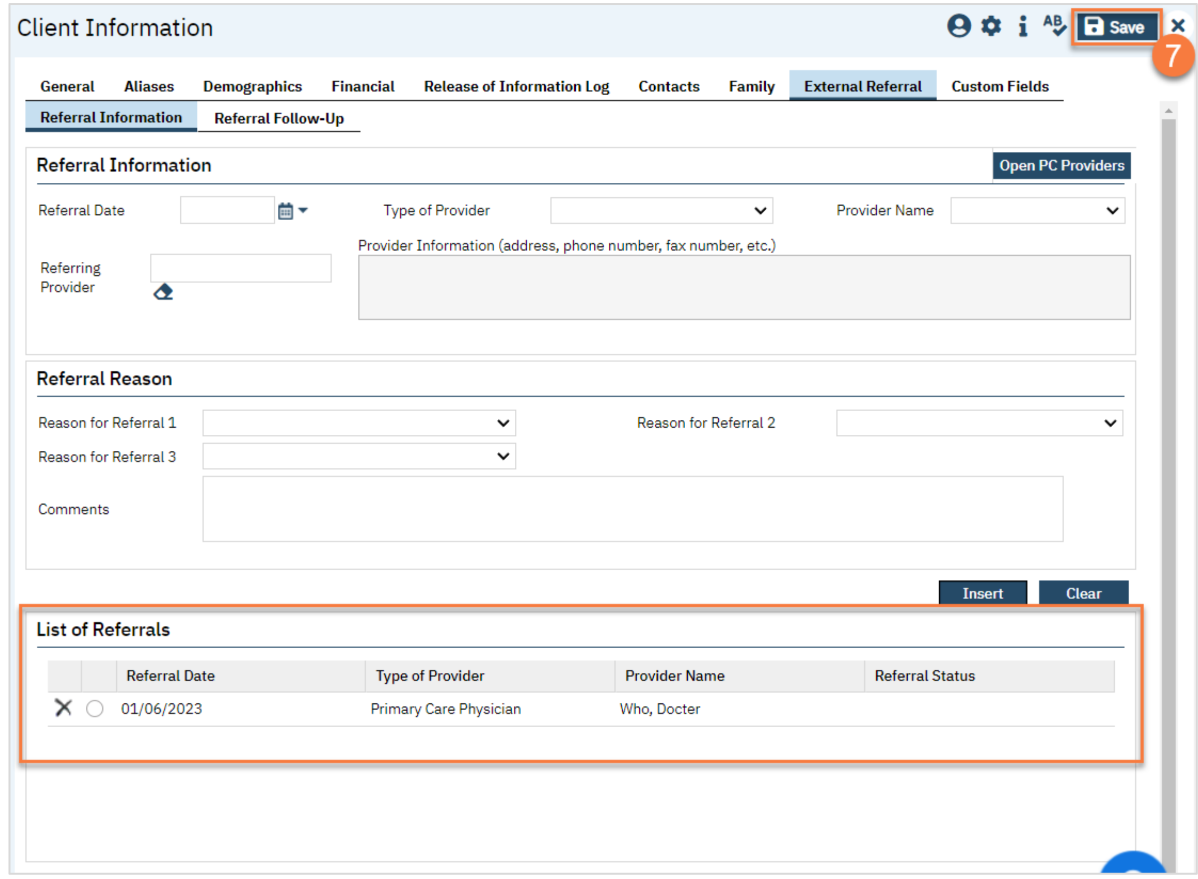
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**



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”**.

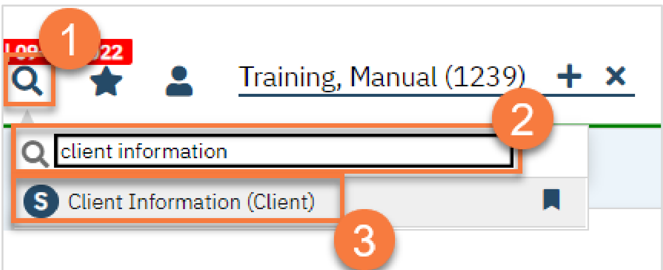


7. Your referral should now show in the List of Referrals section. **Click Save**.

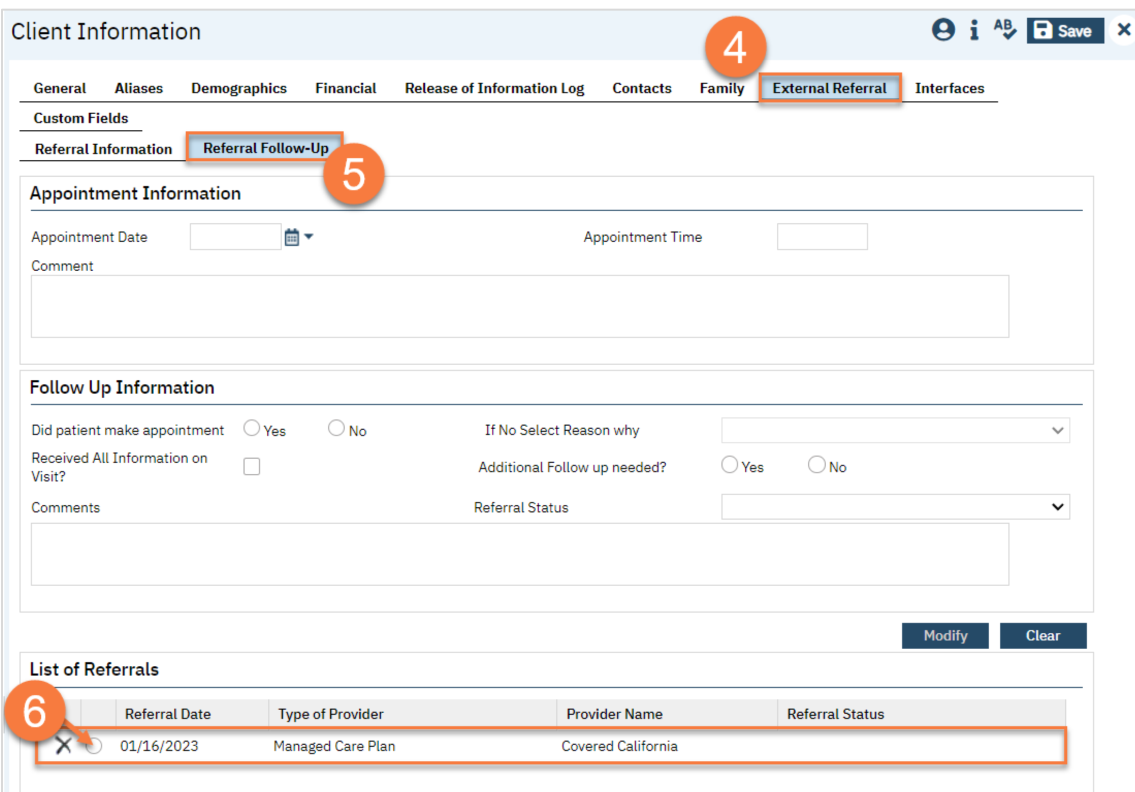


How to Document Follow-up Done on an External Referral

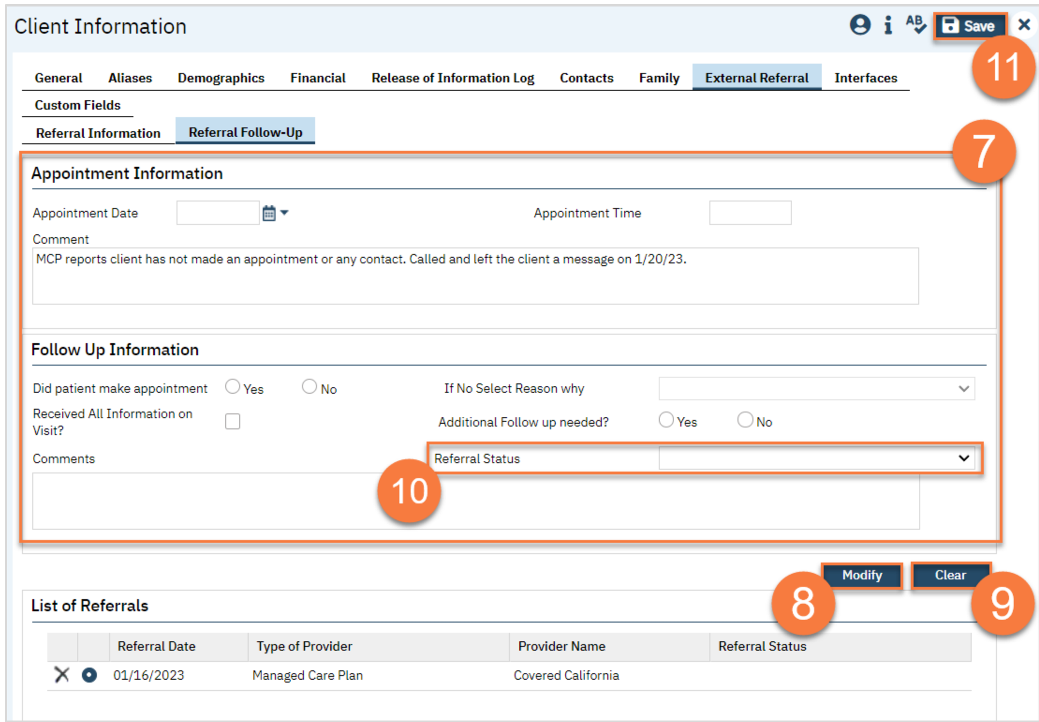
1. To document follow-up on a referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**

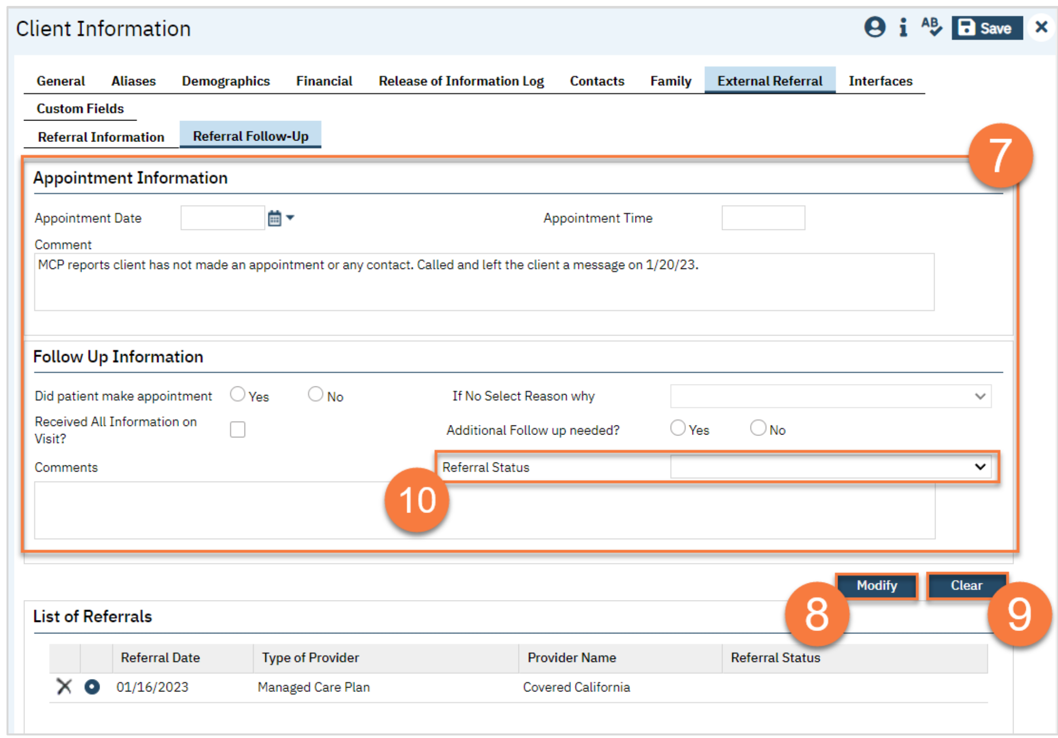


4. **Navigate to the "External Referral" tab.**
5. **Click on the Referral Follow-Up tab.**
6. **Select the referral you want to follow up on from the List of Referrals.**



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**.

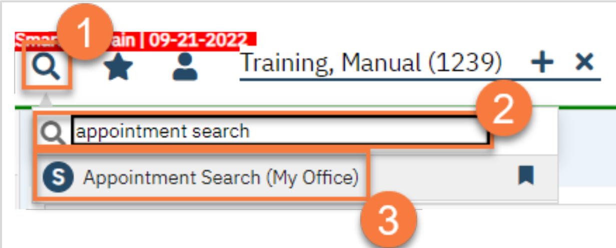




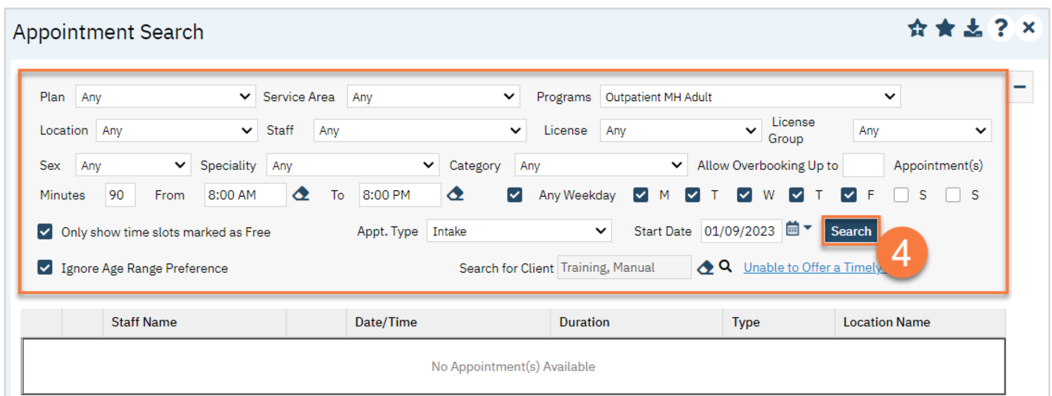
How to Schedule an Intake Appointment for a Program You Manage

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.

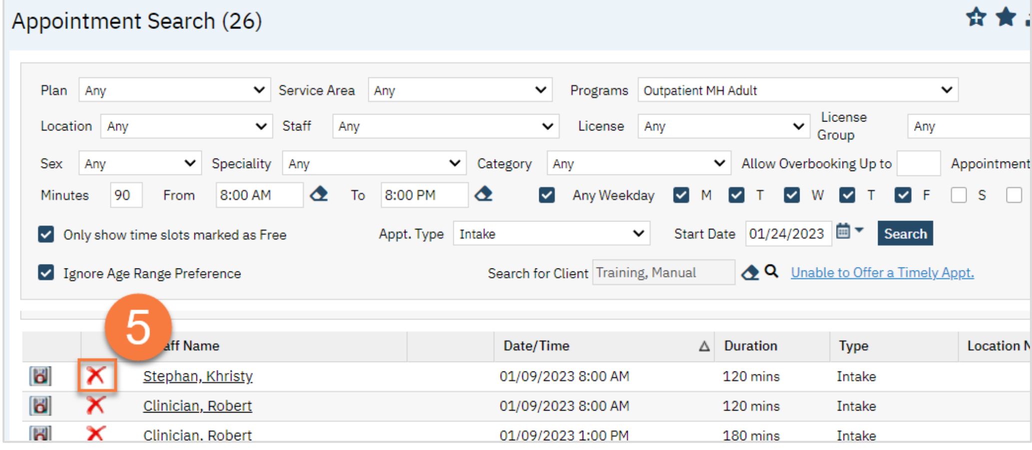
1. You must first have the client open, then **click the Search icon**.
2. **Type Appointment Search** into the search bar.
3. **Click to select Appointment Search.**



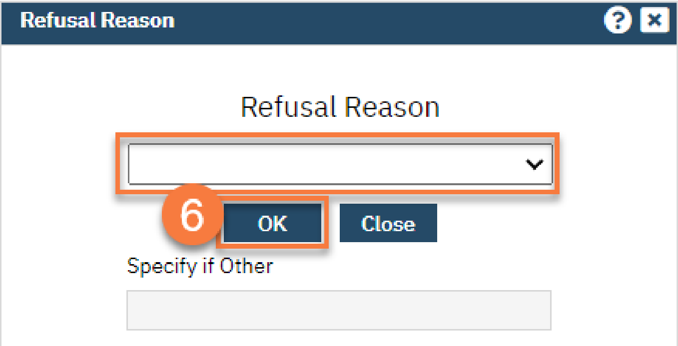
4. **Use the filters to limit the search** to intake appointments for that program and any other requests the client has, such as client's availability. Then **click Search**.



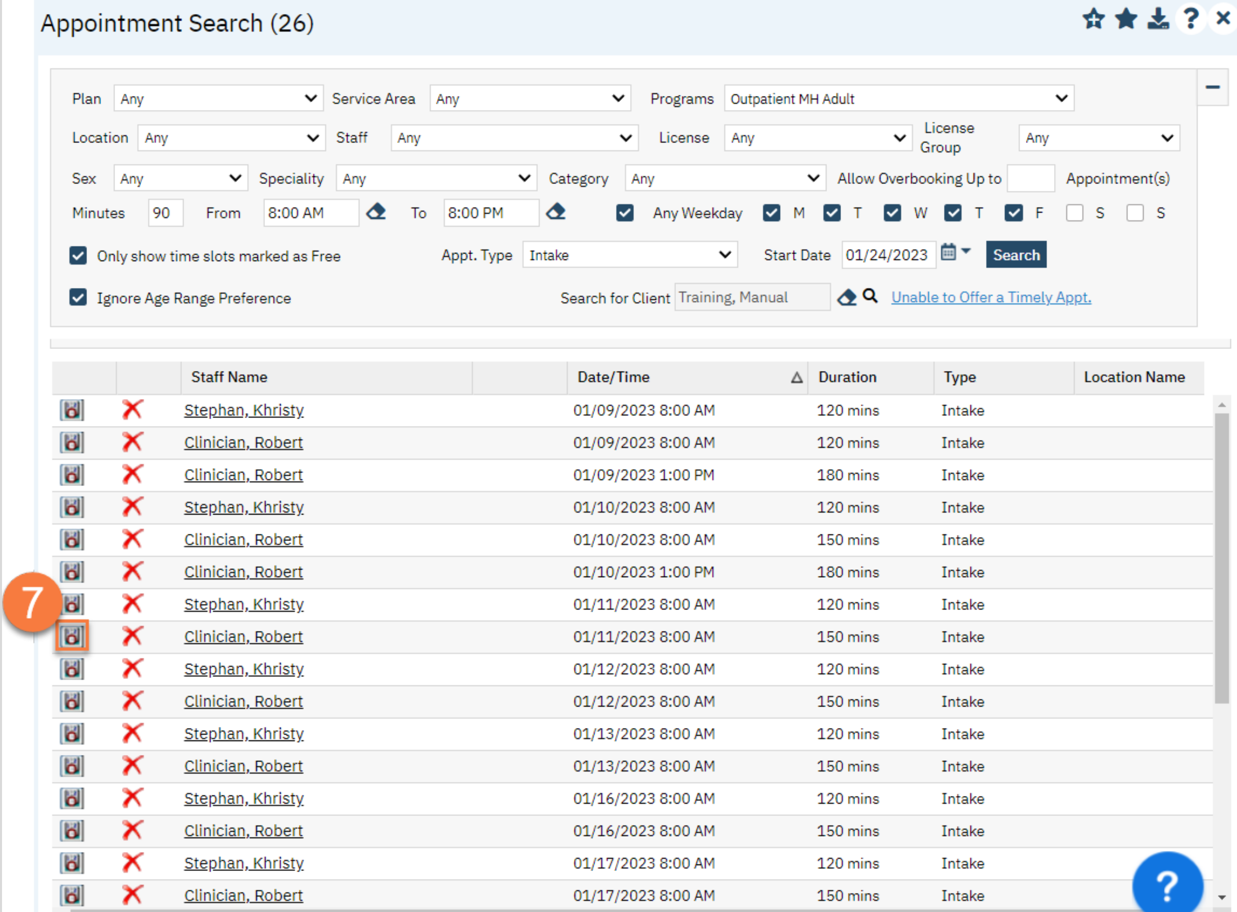
5. This will bring up a list of available appointments. **If the client declines the first few available appointment dates, click on the "Client Refuses Appointment" icon**. This will be used for tracking timeliness. Note: you only need to decline 1 appointment per day. In the below example, there are 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.



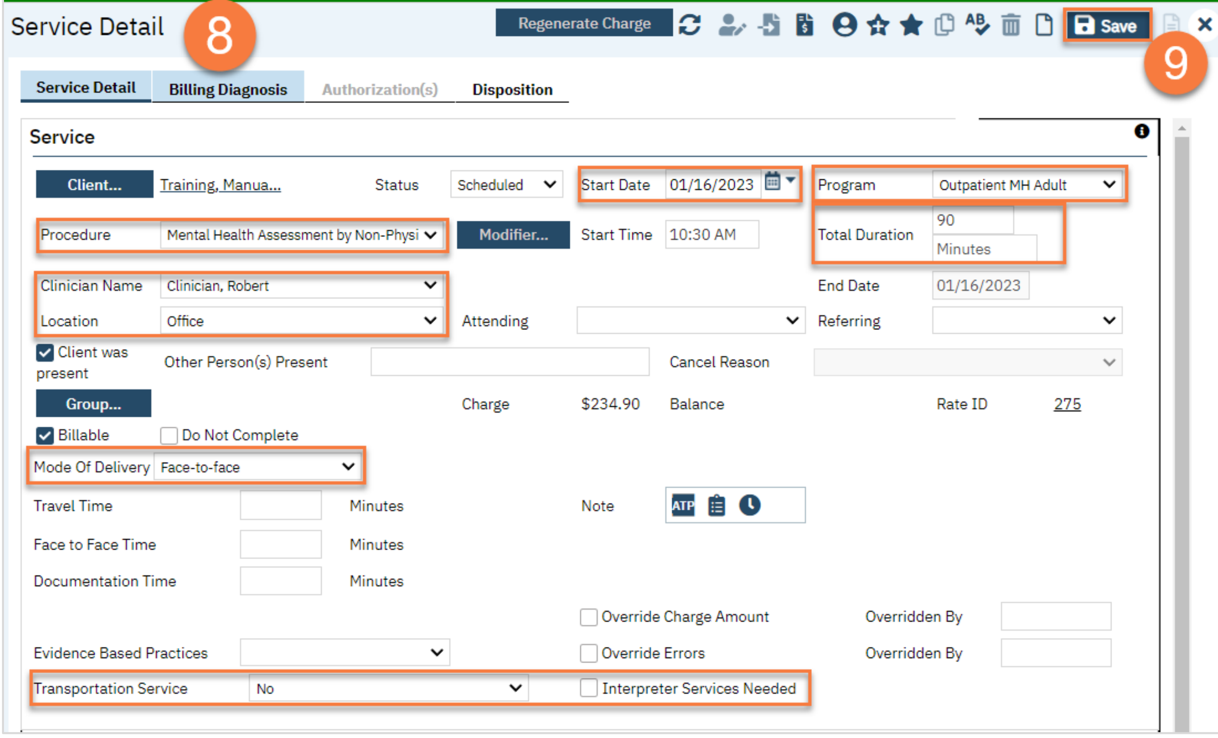
6. Clicking on the “Client Refuses Appointment” icon will bring up a pop-up window. **Enter the Refusal Reason and then click “OK”**.



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.



Life Cycle of the Client: Intake and Assessment

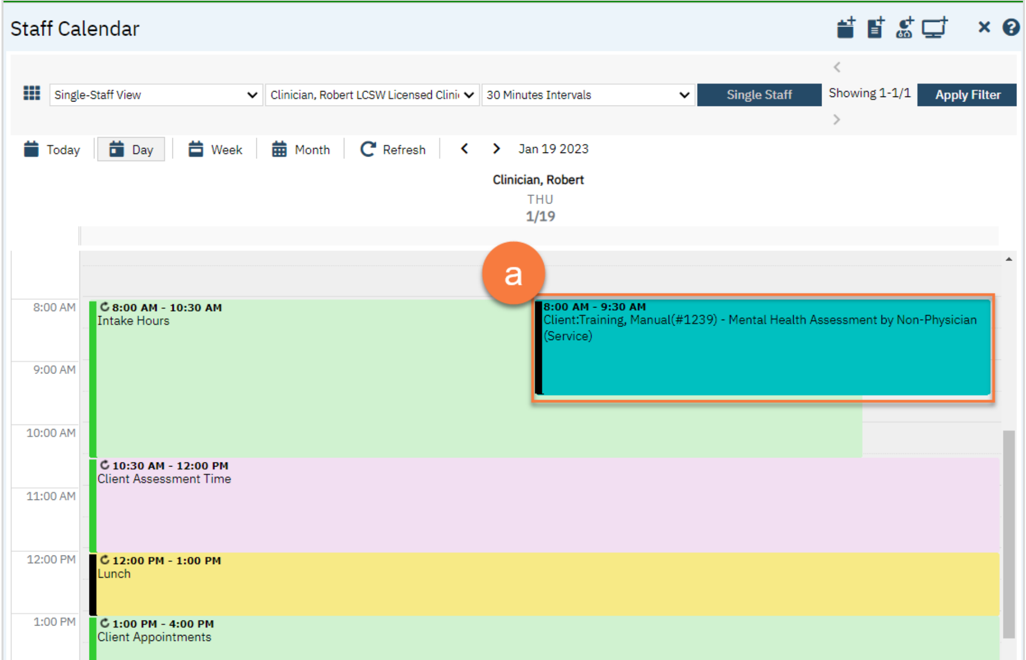
Once a person has been screened and is referred to a county, the next step is a full clinical assessment. However, there is also an intake process in order to enroll the client in the appropriate program and complete necessary program and legal documentation. In this section, we'll start with the basic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

Intake and Assessment Process Steps:

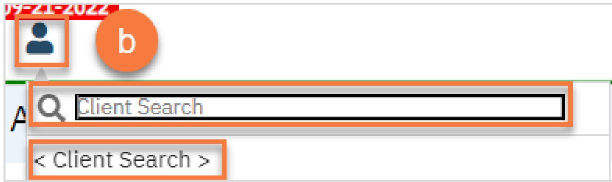
1. Find or create the client in SmartCare.
2. Enroll the client in the assessment program.
3. Confirm/enter the client's information, such as contact information, insurance, and basic demographics.
4. Complete the necessary intake documentation for your program.
5. Complete the clinical assessment.

How to Check-in a Client for their Intake/Assessment Appointment at a Program the Doesn't Have a Receptionist

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.

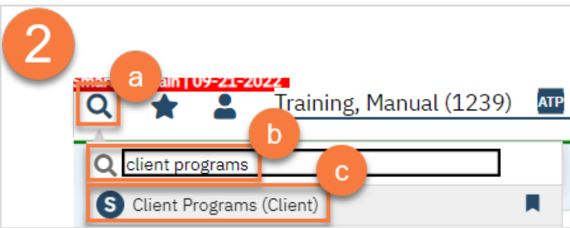


    b. You can also do this using the Client Search screen.

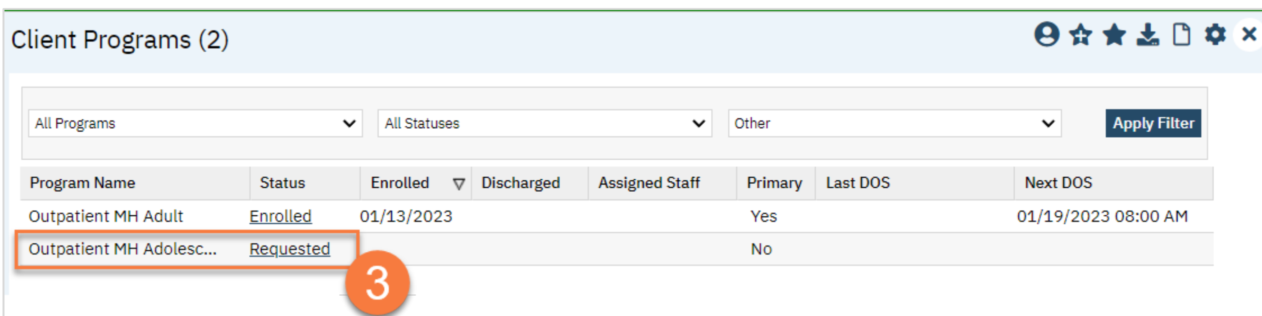


2. **Open the Client Programs list page**.

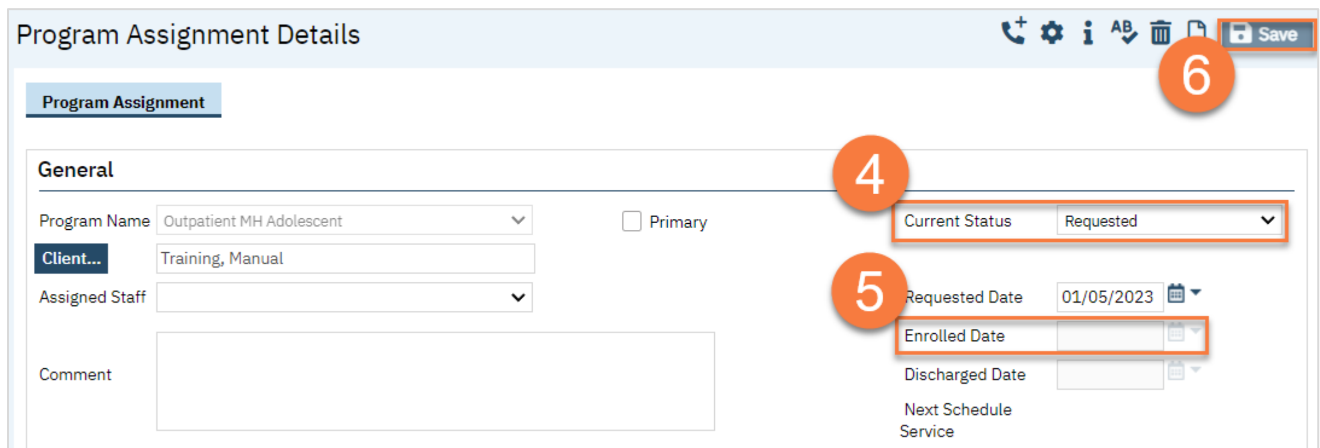
a. Click the Search icon.
b. Type “Client Program” in the search bar.
c. Select “Client Programs (Client)” from the search results.



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



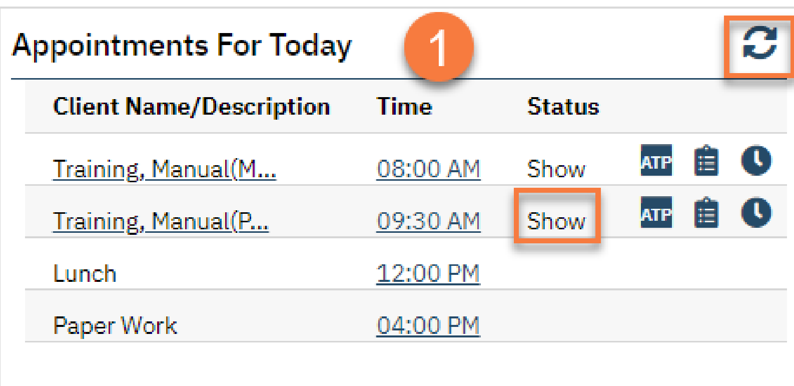
4. This takes you to the Client Program Details screen. **Change the Status to “Enrolled”**.
5. This unlocks the Enrollment Date field. **Enter today’s date in the Enrollment Date field**.
6. **Click Save**.



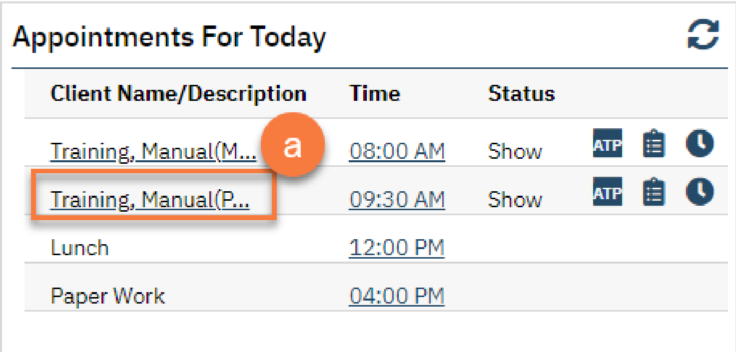
7. **Complete your required documents**. Depending on your program, this may include intake forms in addition to clinical assessment documents. Follow the steps in How do I complete Intake Documents?. If you have documents that were completed on paper that need to be scanned in to SmartCare, see How 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).

How to Initiate an Assessment for a Client Already Checked in by a Receptionist

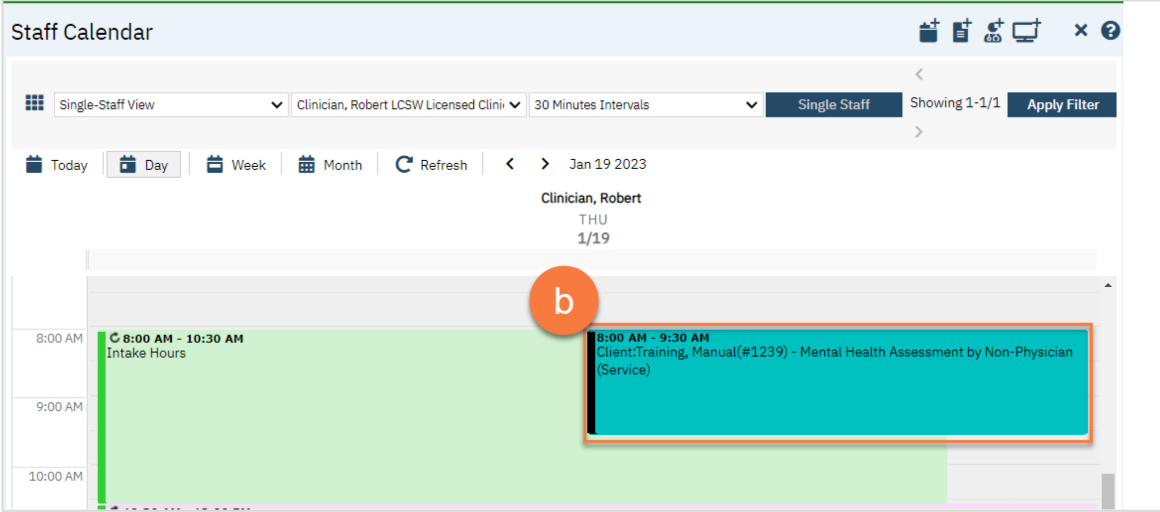
1. The receptionist will have already checked in the client, which includes enrolling them in your program. You should be able to see this on your Appointments for Today widget. Make sure to click the refresh icon throughout the day for updates.



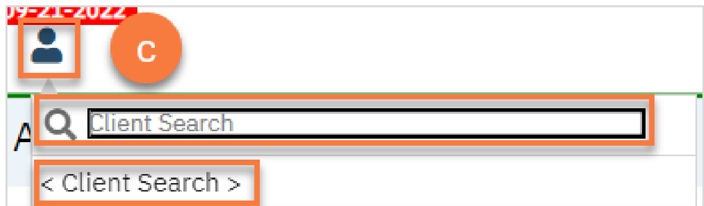
2. **Open the client's record**, if not already done so.
   a. You can do this from your Appointments for Today widget by clicking on the client's name.



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



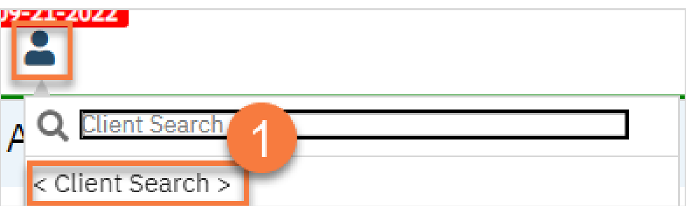
c. You can also do this using the Client Search screen. This would be recommended for clients who have walked-in for an assessment.



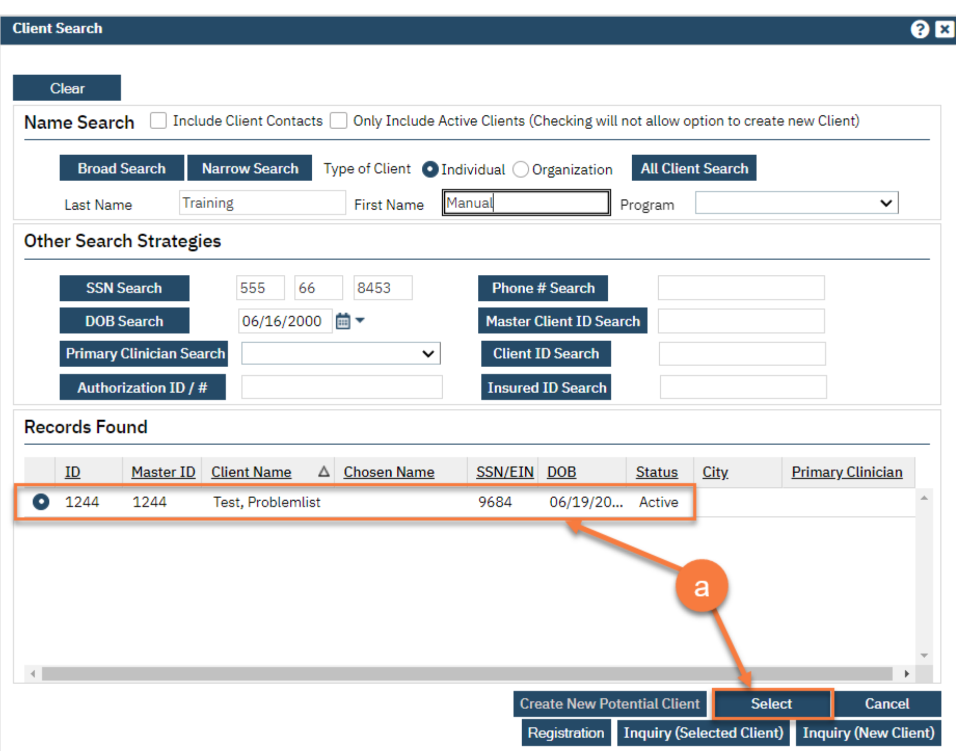
3. **Complete your required documents**. Depending on your program, this may include intake forms in addition to clinical assessment documents. Follow the steps in How do I complete Intake Documents?. If you have documents that were completed on paper that need to be scanned in to SmartCare, see How 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).

How to Complete a Intake/Assessment for a Walk-In Client in a Program Without a Receptionist

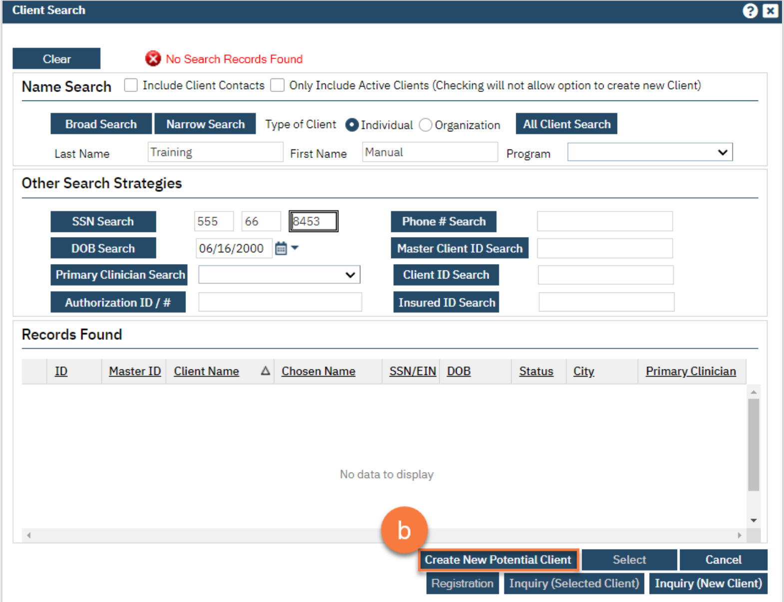
1. **Use the Client Search** screen to determine if the person is a client already in the system.



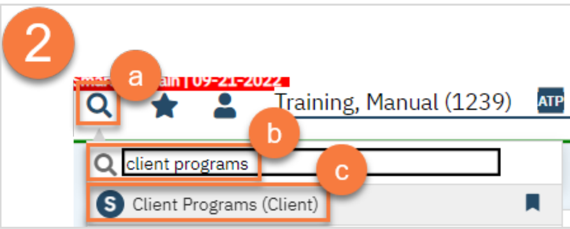
a. If they are already a client in the system, select them to open their record.



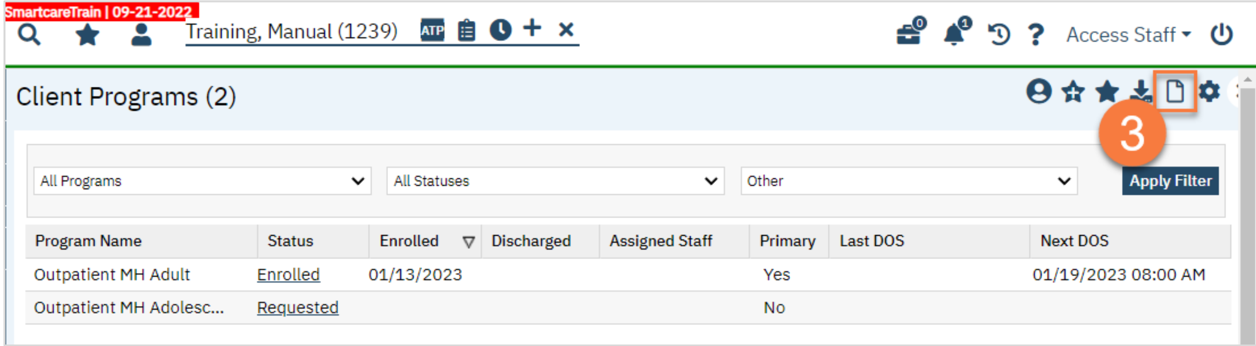
b. If they are not a client in the system, click “Create New Potential Client”. You’ll have to search by name, date of birth (DOB), and social security number (SSN) in order to create a new client.



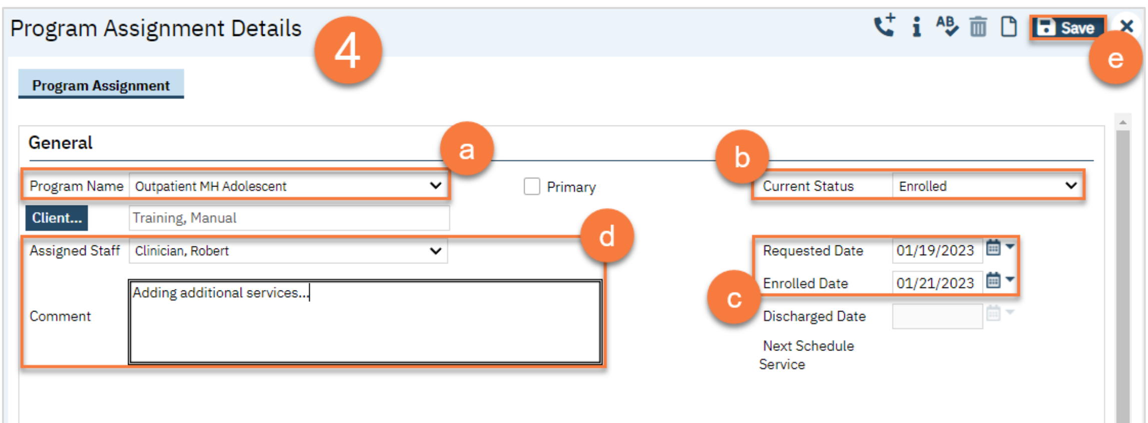
2. **Open the Client Programs list page**.
    a. Click the search icon.
    b. Type in “Client Programs”
    c. Select “Client Programs (Client)” from the search results.



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.** If the client is already receiving services, contact their current provider.



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.**



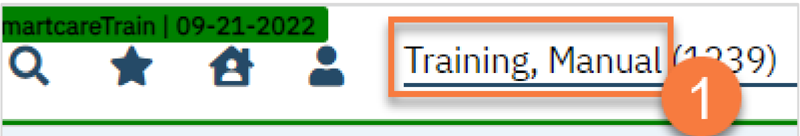
5. The next steps in the process are to complete the intake documentation packet, confirm the client's information, and for the clinician to complete the clinical assessment. **Complete the documents you are responsible for**. Follow the steps in How do I complete Intake Documents?. If you have documents 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 to View and Update the Intake Document Task List

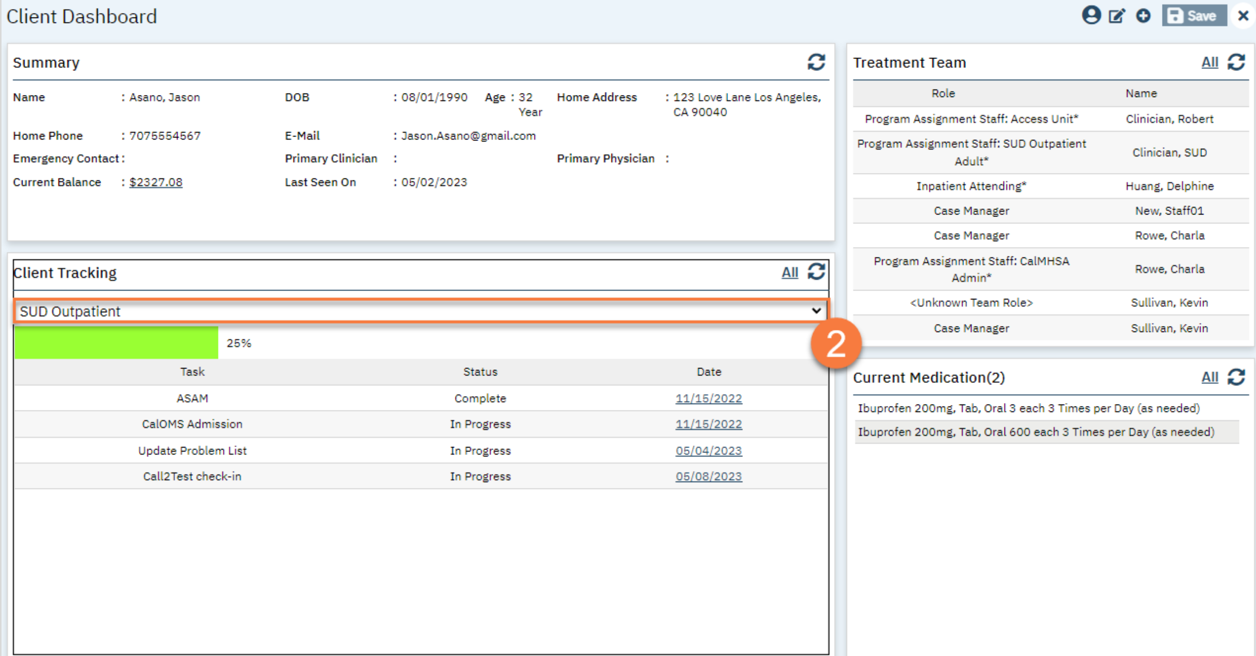
Your System Administrator can set up Intake Document Tasks Lists, called "Tracking Protocols" for your system. This allows you to track documents that are completed in SmartCare, documents that are completed outside of SmartCare, and even tasks that aren't tied to documents at all. Tasks are denoted as "flags" in SmartCare.

How to View the Intake Document List

1. Open the client's record. This should take you to Client Dashboard. If you already have the client open, click on their name to quickly navigate to the Client Dashboard.



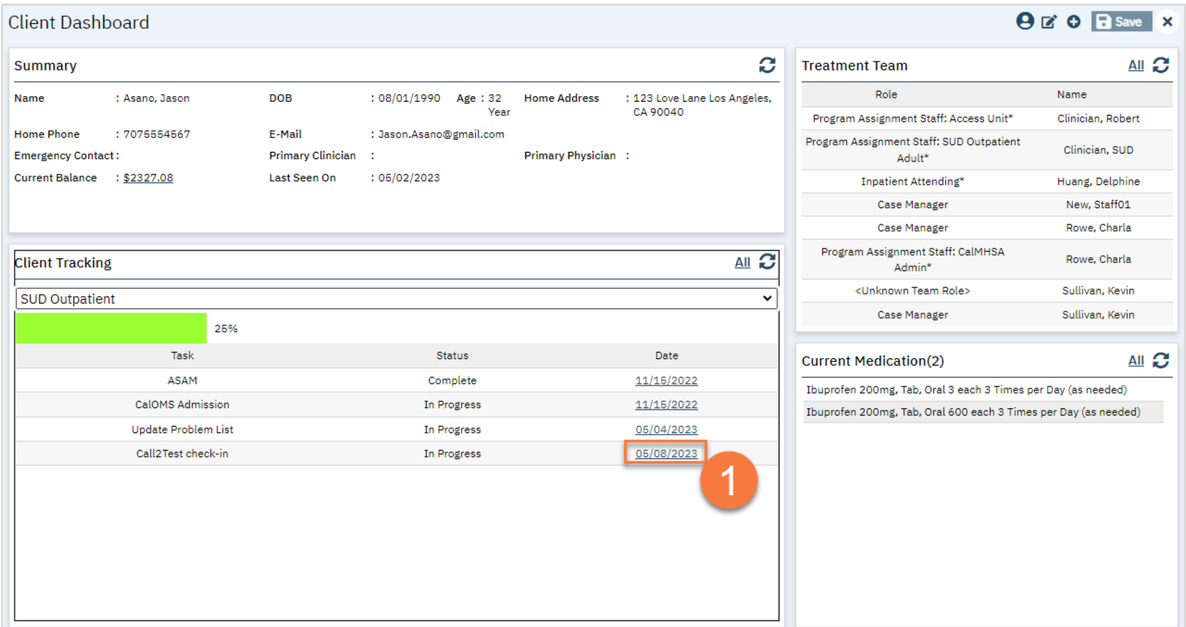
2. Navigate to the “Client Tracking” Widget and select your program from the drop-down menu. This shows you all the flags (tasks) associated with that program.



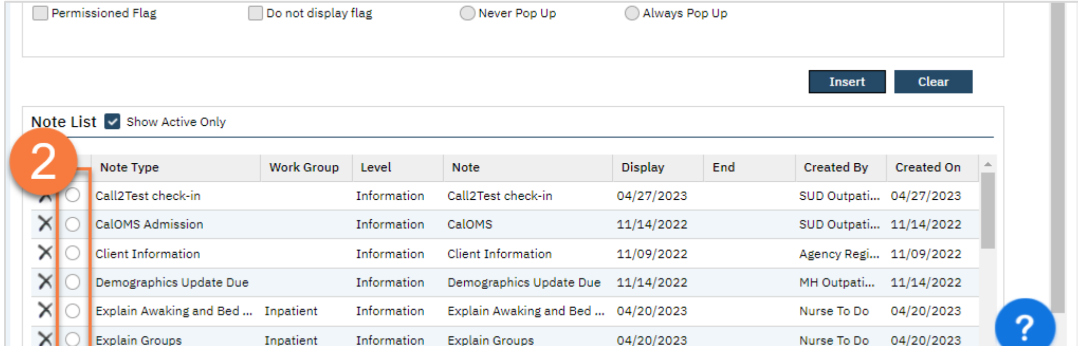
How to Mark a Flag as Complete

If a task (flag) is tied to a document in SmartCare, when you complete that document, the task will automatically be marked as complete. For tasks that aren’t tied to a SmartCare document, you’ll have to manually mark them as complete.

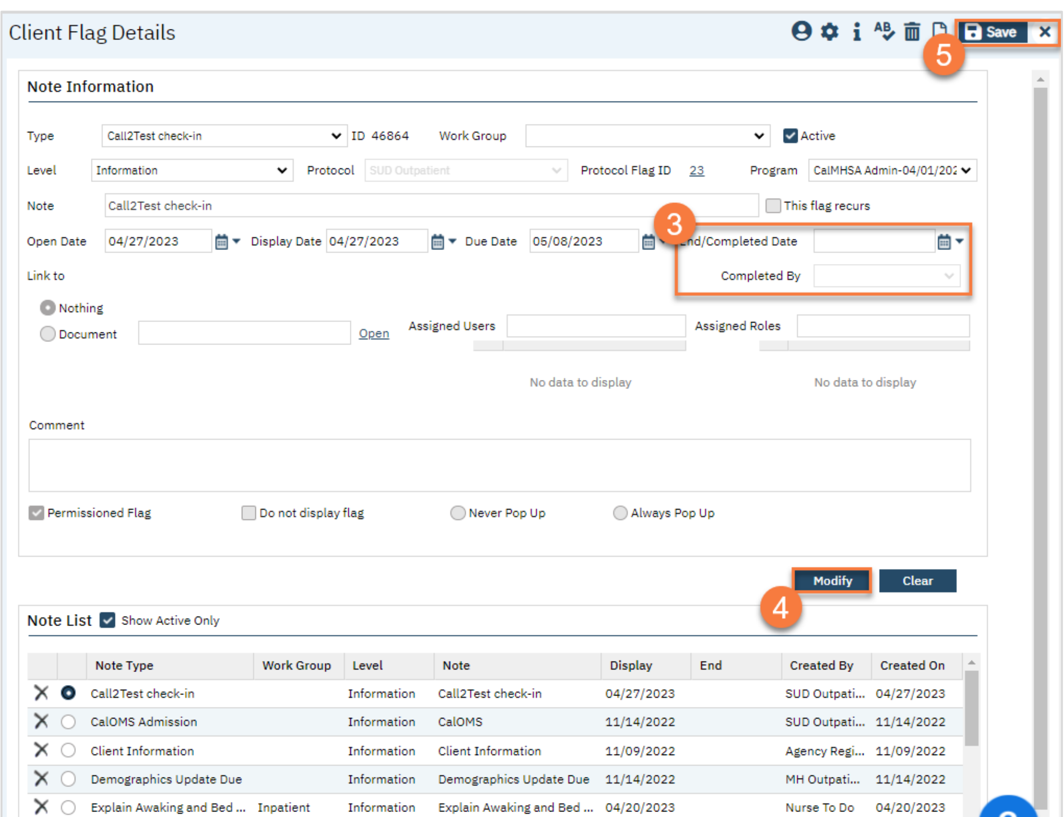
1. Click on the link in the Client Tracking widget.



2. This takes you to the Client Flag Details screen. Select the flag you want to complete.

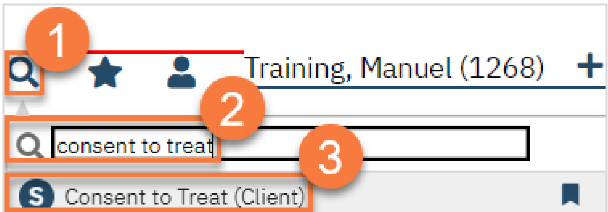


3. This brings the information to the top half of the screen. Enter the “End/Completed Date” and the “Completed By” fields.
4. Click “Modify”. This marks the flag as complete.
5. Click Save and close.

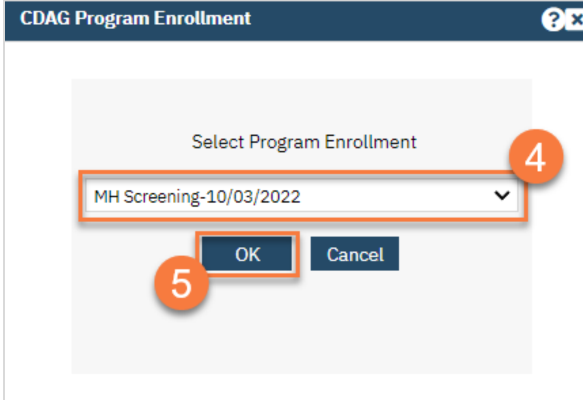


How to Complete Intake Documents

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.

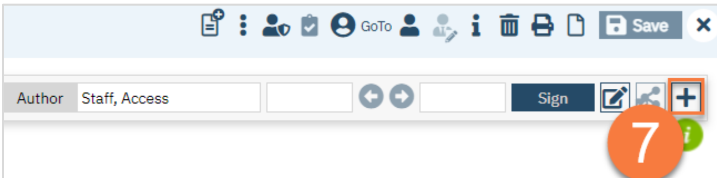


4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.

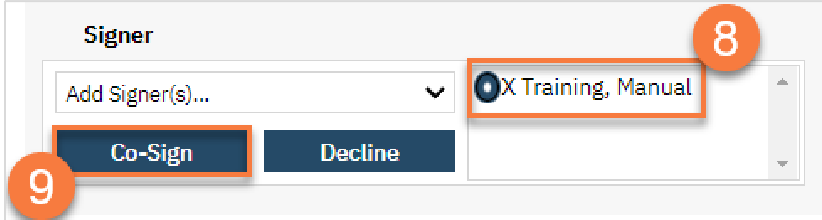


6. The document will open. **Complete the document** based on the client's responses. Once completed, **click Sign**.

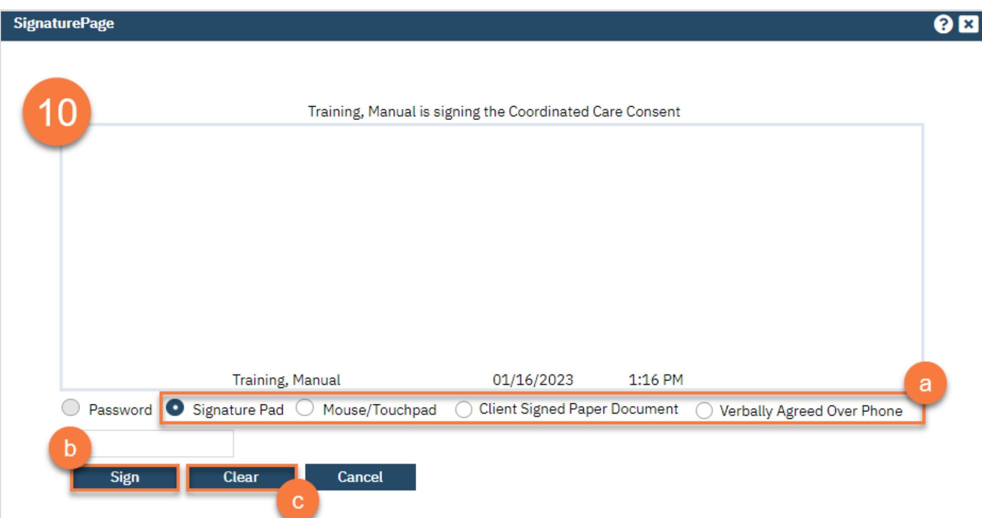
7. This will create the PDF version of the form. **Click the Plus icon** in the upper right corner of the PDF viewer.



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 in a document to the client's chart?
    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.



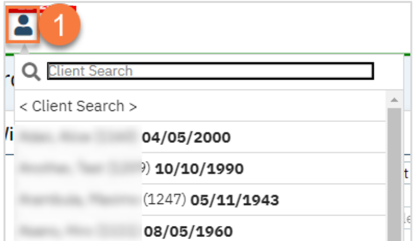
Once signed by all required people, you are finished with this document and may move on to the next.

Life Cycle of the Client: Services

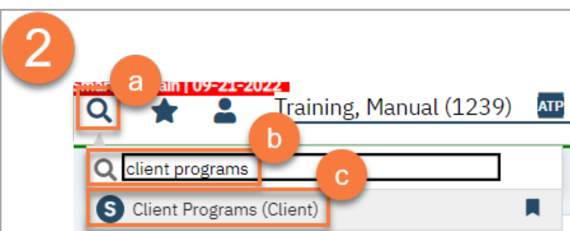
Now that the Intake process is complete, you can begin providing services. This is the bulk of the life cycle of the client. This section includes documenting the services you provide to the client, making ongoing clinical decisions about what services the client needs, and transitioning the client through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

How to Add the Client to Your Program

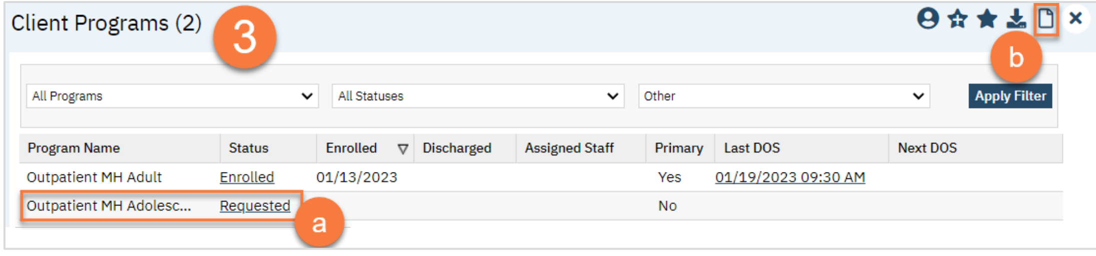
1. **Open the client's record**, if not already done so. You can do this using the Client Search screen.



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.

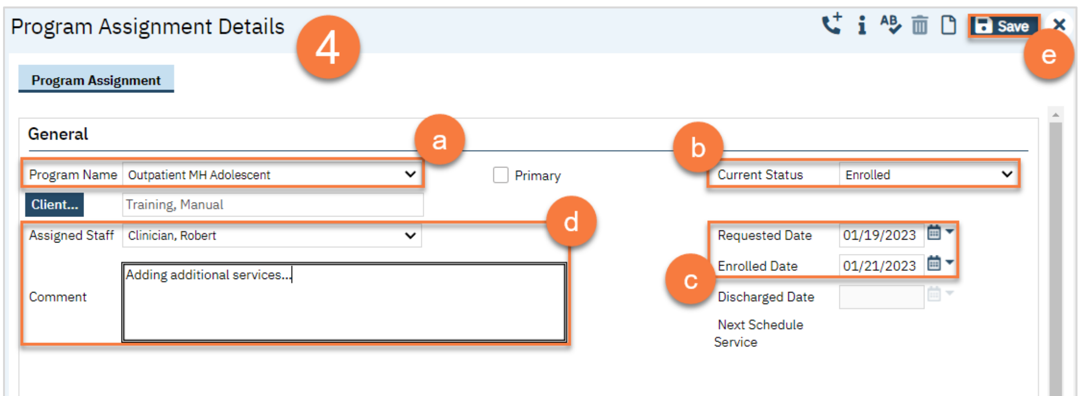


3. This opens the Client Programs list page**.**
    a. If your program is on the list, **click on the link in the Status column**. The status is likely Requested, if the referral process has been started. If the status is Discharged, do not edit this enrollment and instead add your program as if it's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

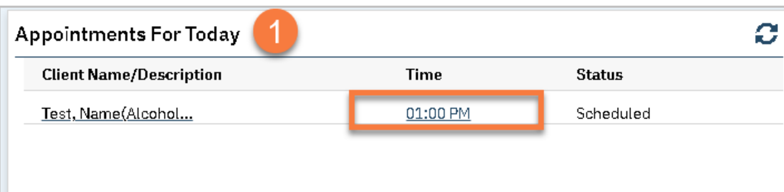


5. The next steps in the process are to **complete any documents needed** to enroll in your program. Follow the steps in How do I complete Intake Documents?. If you have documents that were completed on paper that need to be scanned in to SmartCare, see How do I scan a document into the client's record? 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).
Note: You'll need to create a diagnosis document for each program that the client is open to, as this pushes to the service notes and subsequent billing claims for that program. See Diagnosis Entry for more information.

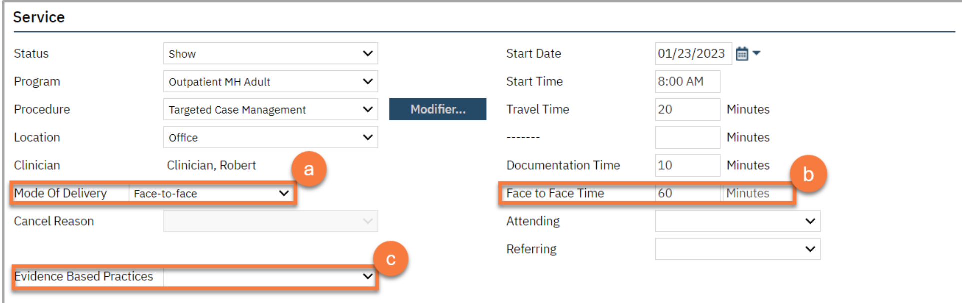
How to Write a Progress Note for a Scheduled Service

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

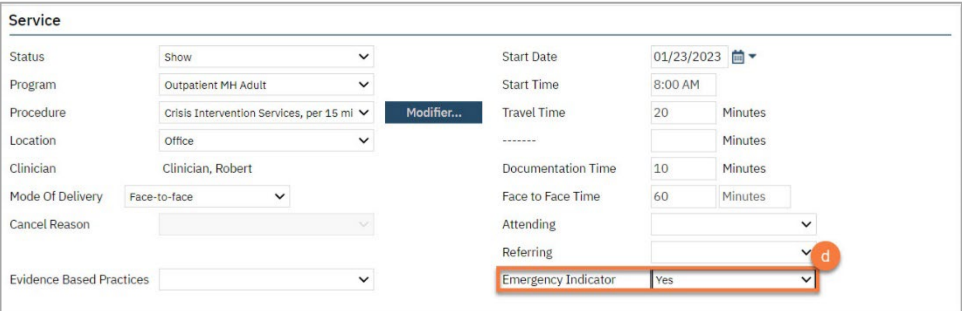
1. **On your Appointments for Today widget, click on the time link for the service you're documenting.**



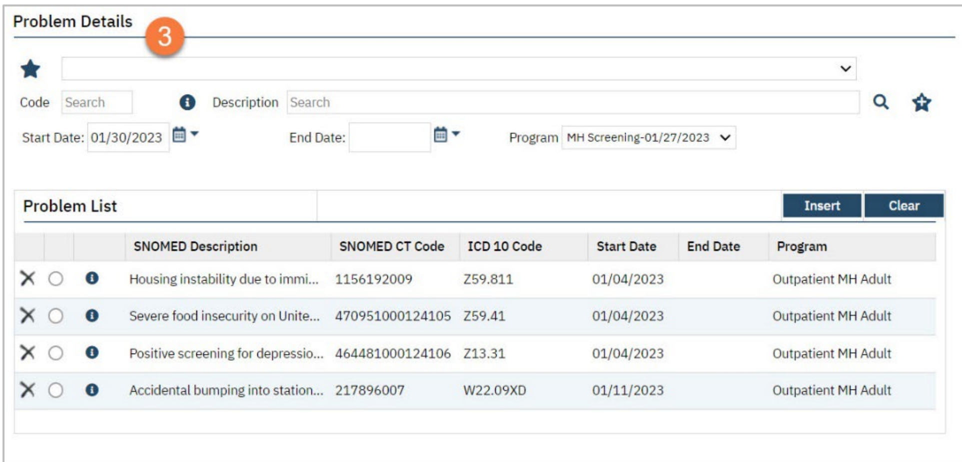
2. This opens the service note. **Complete the service details.**
   a. **Confirm/Enter Mode of Delivery.**
   b. **Enter Face to Face Time.** Under CalAIM Payment Reform, this is what is used for billing. **Enter Travel Time and Documentation Time** if applicable.
   c. **Enter Evidenced-Based Practices**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



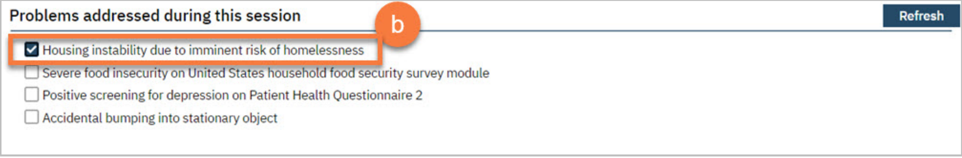
d. If this is a note for a crisis service, an Emergency Indicator field will appear. **Enter whether this was an emergency or not.**



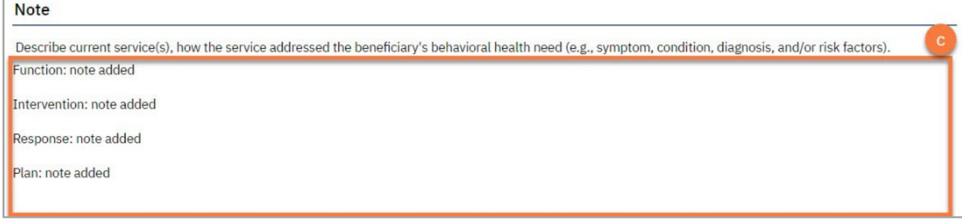
3. **If the status is show, you may now click on the Note tab. Complete the progress note tab**. This note type may look different depending on the procedure code you have chosen. Most will include 3 fields: the Problem List section, the Note section, and the Care Plan section.
   a. If you want to add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



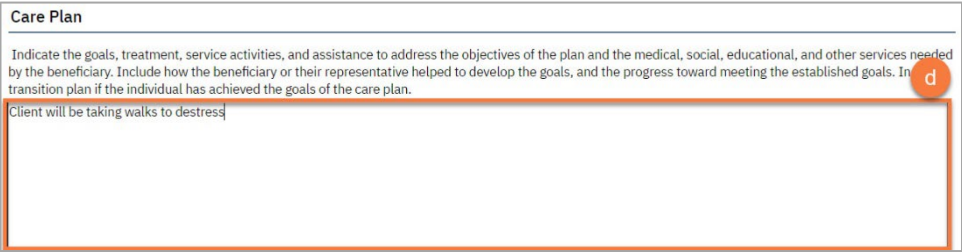
   b. **Select which problems you addressed** in today's session.



   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.

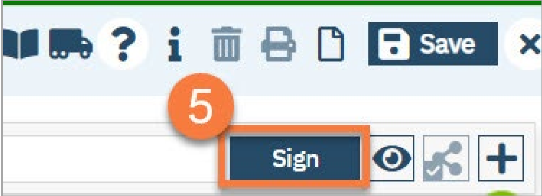


d. **Enter your plan of care** in the Care Plan section. For services that require a treatment plan, this is where the treatment plan is entered. This information will pull forward from the most recent service note in the same program. There may be text templates available for specific treatment plan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



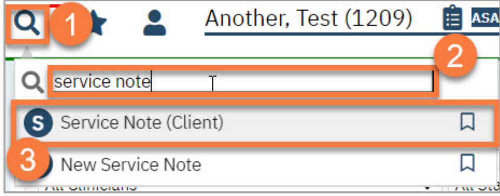
4. The Billing Diagnosis tab will show you which diagnoses will be pulled onto the billing. You should generally ignore this tab for ongoing services. However, if you need to change the billing order, for example you want this note to focus on the secondary diagnosis, you can re-order the diagnoses to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

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



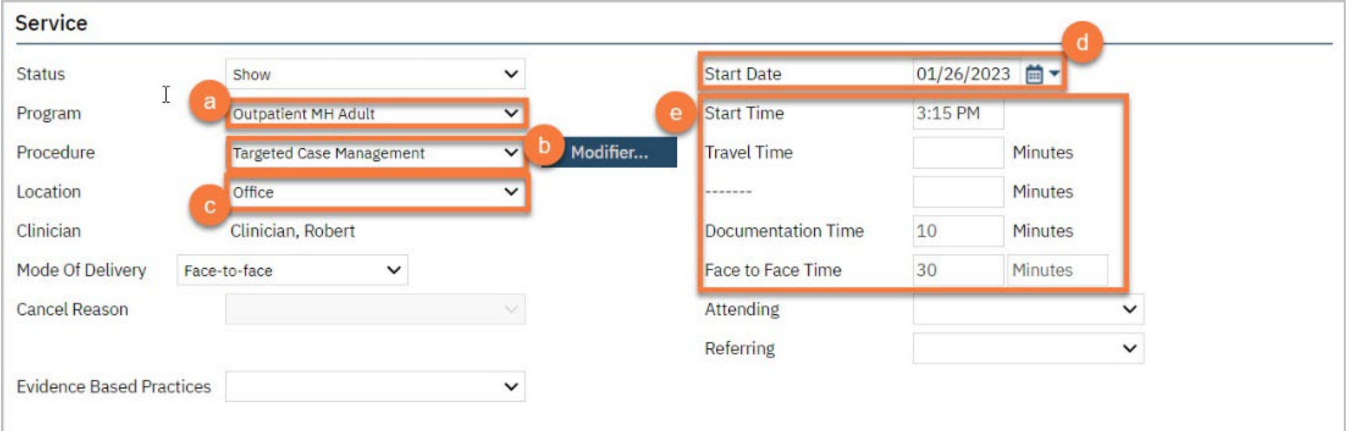
How to Write a Progress Note for an Unscheduled Service

1. **Click the search icon**.
2. **Type in "Services/Notes" in the search bar**.
3. **Click on "Services/Notes (Client)"** in the search results.

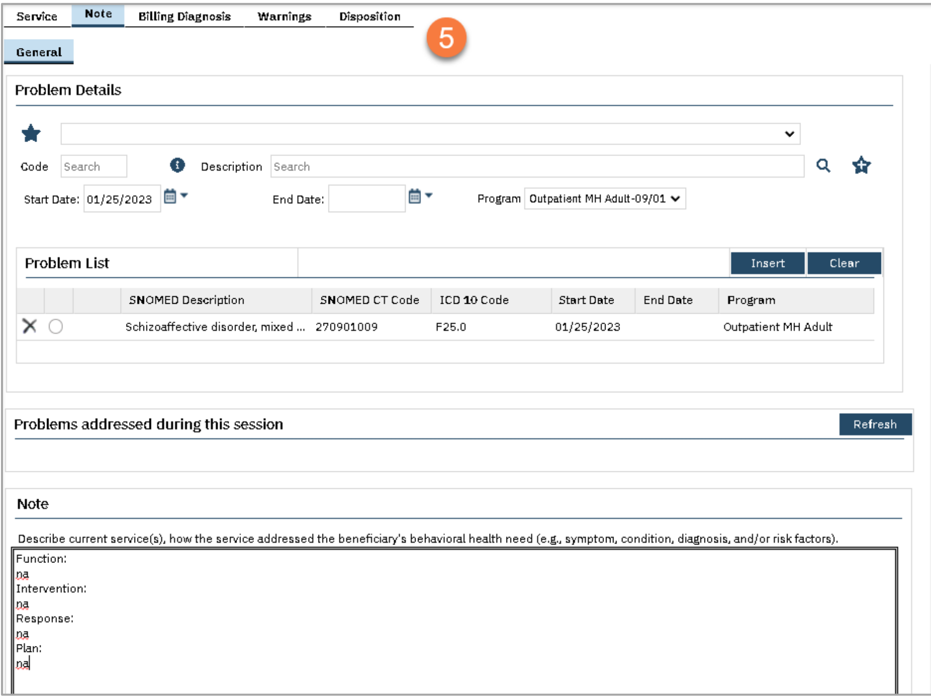


4. This opens the service note. **Complete the service details**.
   a. **Select your program from the dropdown menu**. This will determine which procedure codes you can select.
   b. **Select the procedure code** from the dropdown menu.
   c. **Select the location and mode of service**.
   d. **Enter 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.

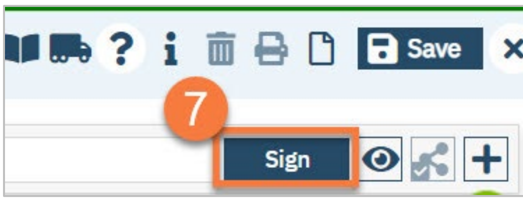


5. **Click on the Note tab**. Complete the progress note section. This note type may look different depending on the procedure code you have chosen. Most will include 3 fields: the Note field, where you will enter the main part of your note, the Care Plan field, which will pull from the most recent note 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.

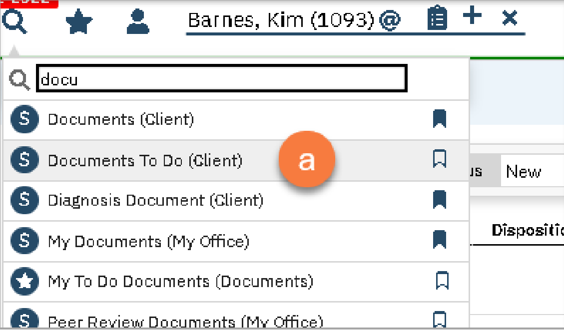
7. When you are complete, **click Sign**.



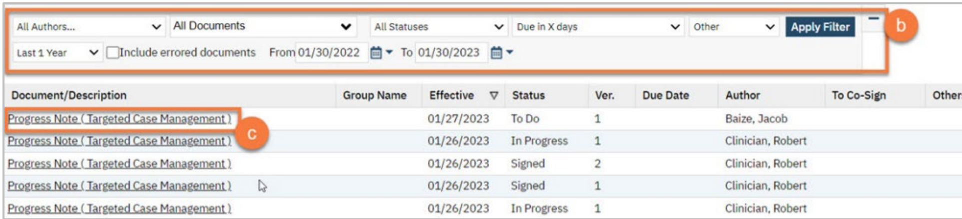
How to Amend a Note

Please be aware: you can only amend a note you have entered in the system.

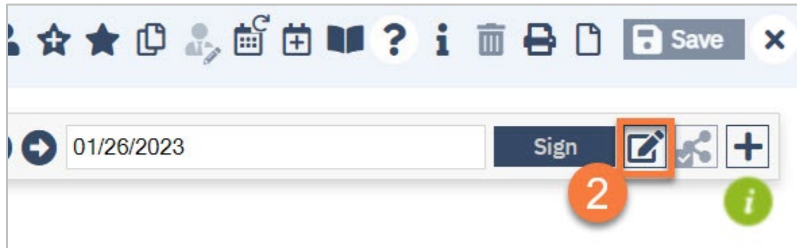
1. **Find and open the note you need to amend**.
   a. Make sure you have the client open. **Click on the search icon and type "documents" in the search bar**. **Click on "Documents (Client)"** from the search results to open a list of documents that have been completed for the client.



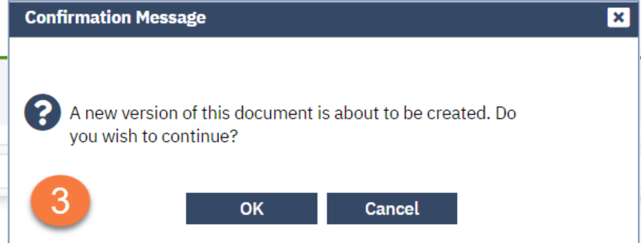
   b. **Use the list page filters** to find the note you're looking for.
   c. **Click on the note you want to amend**. This should open the pdf.



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

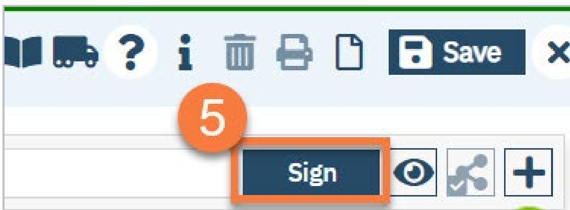


3. A pop-up will appear, letting you know that this will create a new version of this document. **Click OK**.

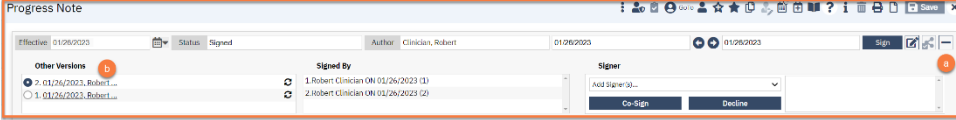


4. The service note screen will now appear. Some pieces you may not be able to edit due to billing having already been completed for this service. However, you should be able to **navigate to the Note tab**. From here, feel free to **edit the note as necessary**. The older version will still remain in 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**.



6. When people open this document, the most recent (corrected) version will be what they are shown.
   a. If needed, you can look at the previous version of this document by clicking on **more detail.**
   b. The other versions will display in the upper left corner.

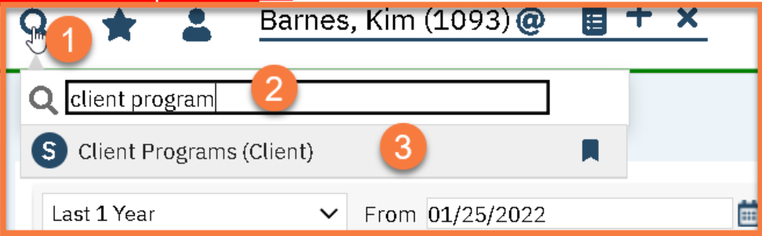


Life Cycle of the Client: Discharge

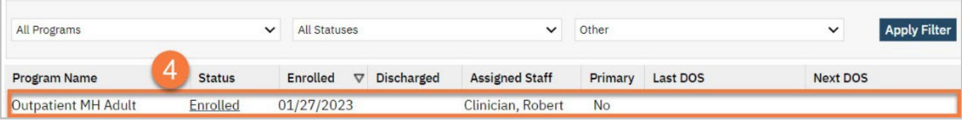
As the client progresses through treatment, their services will begin to diminish. In this section, we will cover how discharge a client from a program, as well as how to transfer a client from one program to another.

How to Close a Client to a Program

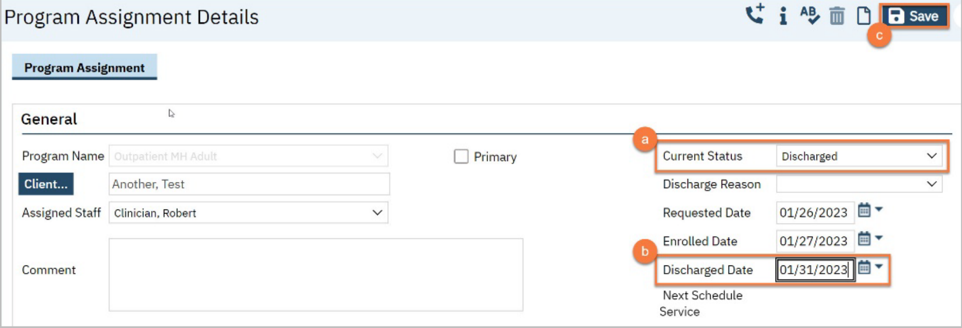
1. Make sure you have the client open. Then **click the Search icon**.
2. **Type in "Client Programs" in the search bar**.
3. **Click on "Client Programs (Client)"** in the search results.



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.



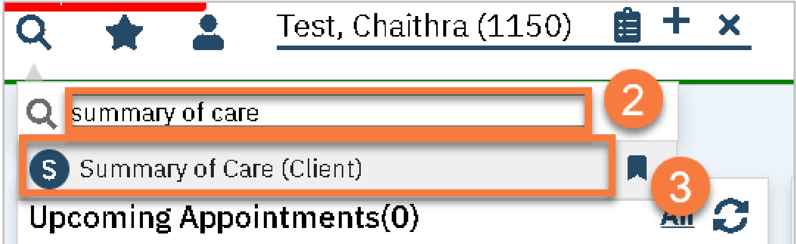
5. This brings you to the Program Details screen.
   a. **Change the status to "Discharged".** This unlocks the Discharge Date field.
   b. **Enter the Discharge Date**.
   c. **Click Save**. You're now finished.



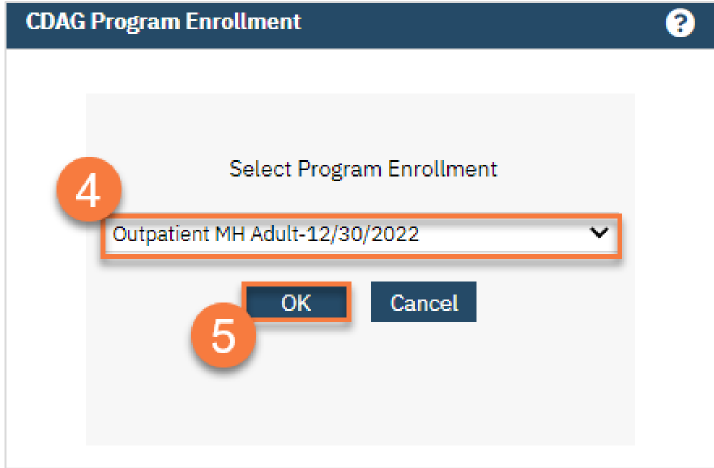
How to Get a Summary of Care

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

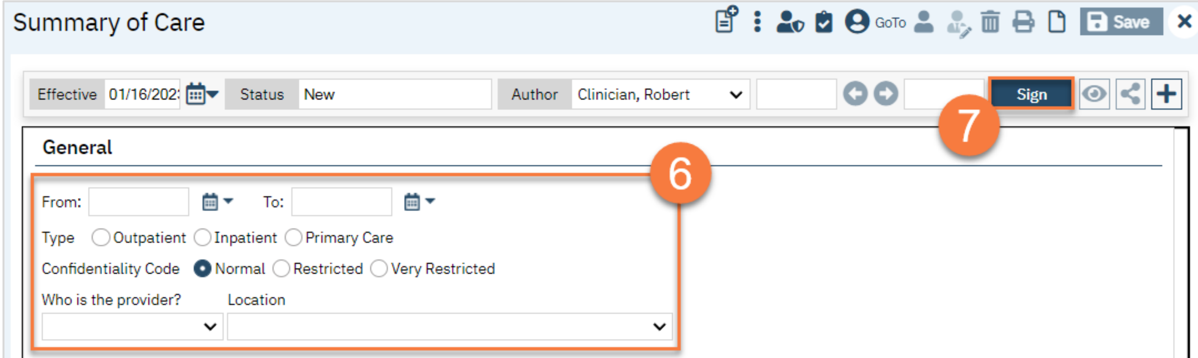
1. Make sure you have the client open. **Click the Search icon**.
2. **Type in "Summary of Care" in the search bar**.
3. **Click on "Summary of Care (Client)"** in the search results.



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



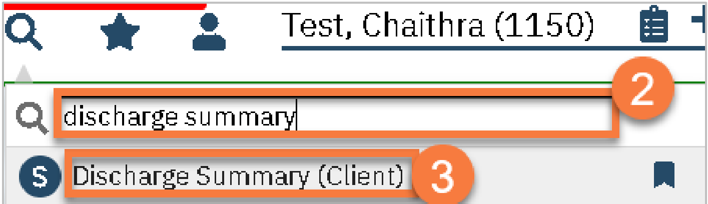
6. This opens the Summary of Care document. **Enter the parameters for your summary of care**.
7. **Click Sign**. This produces a PDF, which includes information from the client's chart.



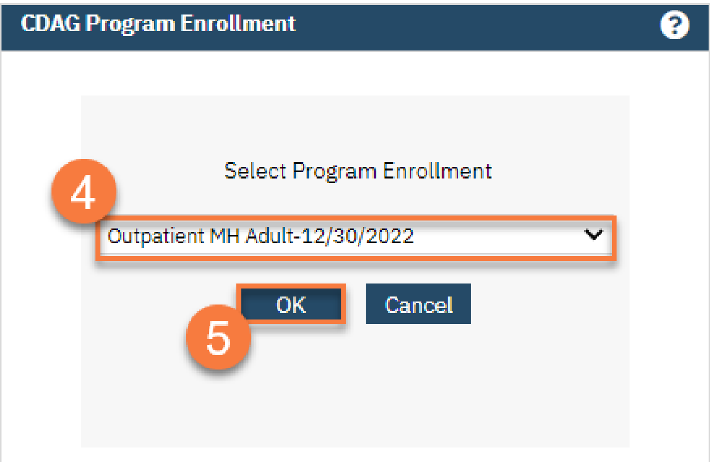
How to Get a Discharge Summary

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

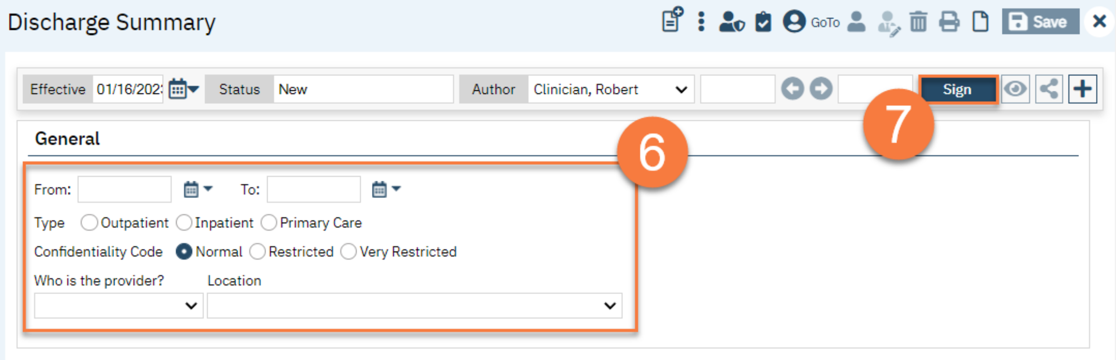
1. Make sure you have the client open. **Click the Search icon**.
2. **Type in "Discharge Summary" in the search bar**.
3. **Click on "Discharge Summary (Client)"** in the search results.



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.



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 Data Access 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 Data Access 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 to Determine What CDAG You Belong To

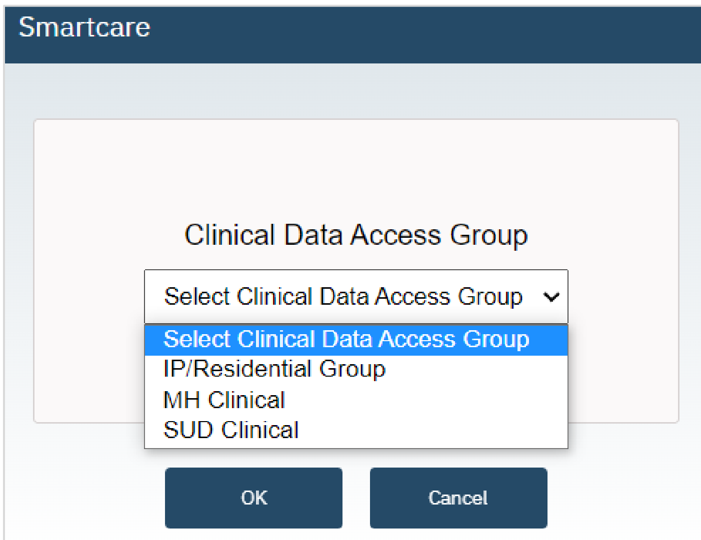
Your System Administrator will set up your CDAG and which programs you are able to see. CalMHSA recommends three basic CDAG options:

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. For example, due to 42 CFR regulations, each SUD provider (meaning legal entity) should have their own CDAG to avoid breaching 42 CFR by sharing information with other providers (other legal entities). 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.

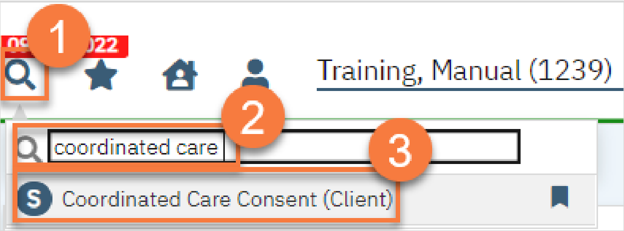
If the client revokes a standard Release of Information/Authorization to Disclose Confidential Information (ROI/ADCI), you can create a flag to notify other treatment team members that the client no longer allows sharing with that entity. They will only be able to see information in their CDAG, which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

Coordinated Care Consent & Authorizations to Disclose Confidential Information

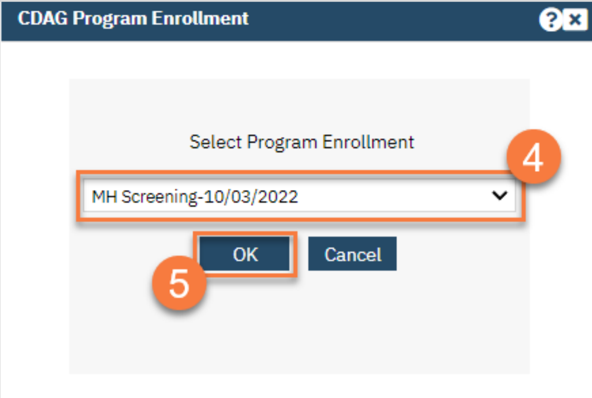
In this section, we will cover the Coordinated Care Consent, which allows sharing amongst SmartCare users, and the Release of Information, also known as an Authorization to Disclose Confidential Information, which allows sharing with non-SmartCare users.

How to Complete a Coordinated Care Consent

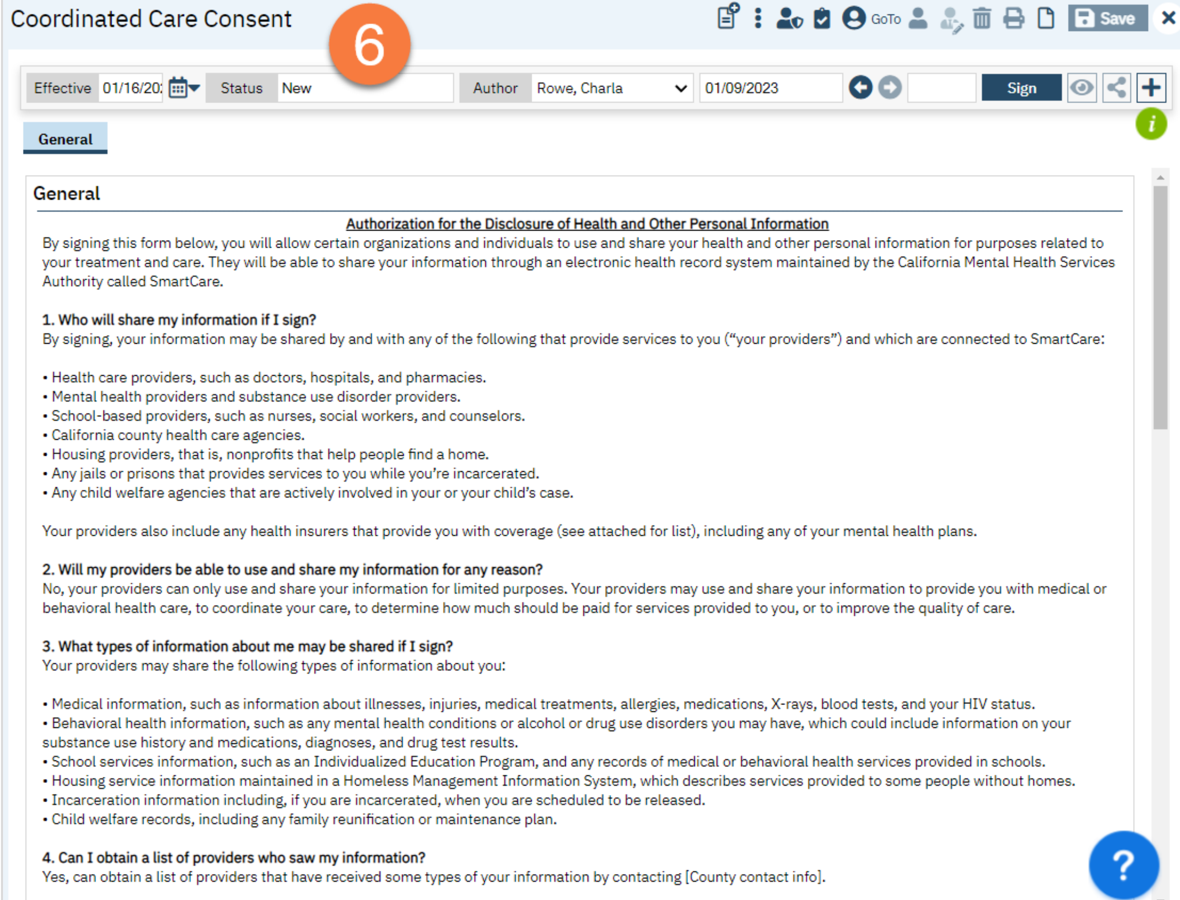
1. You must first have the client open, **click the Search icon**.
2. **Type Coordinated Care Consent** into the search bar.
3. **Click to select Coordinated Care Consent (Client).**



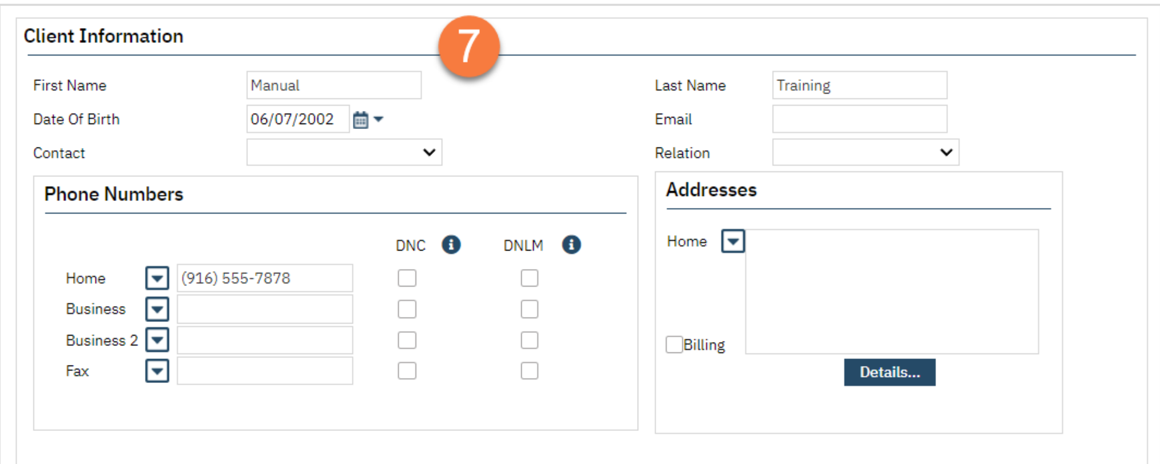
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



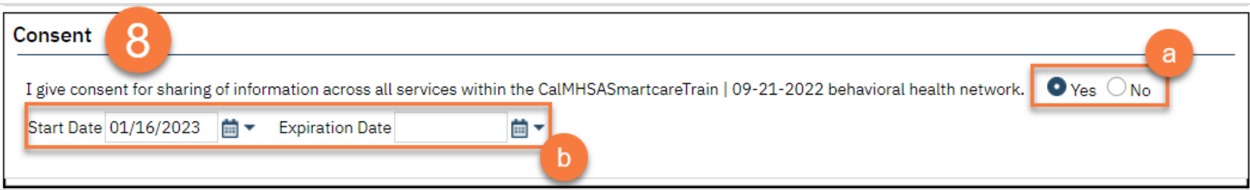
6. Most of the consent is wording. **Review this with the client**.



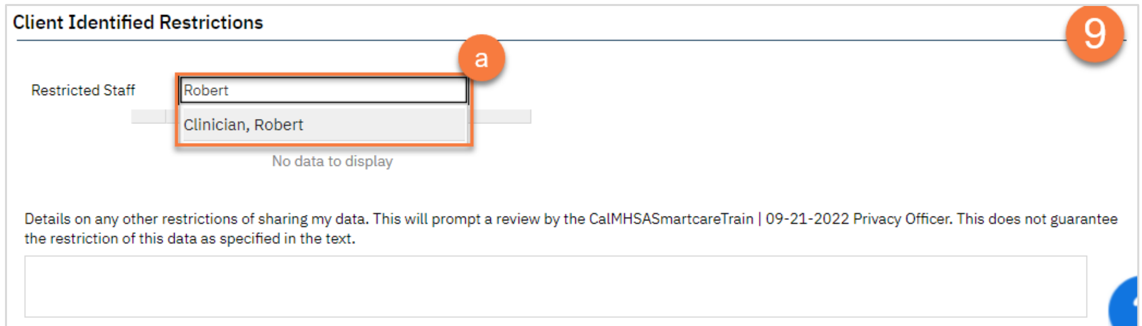
7. The Client Information section will pull information from the Client Information screen. You do not need to add any information here. If you need to update the information, we recommend doing that in the Client Information Screen.



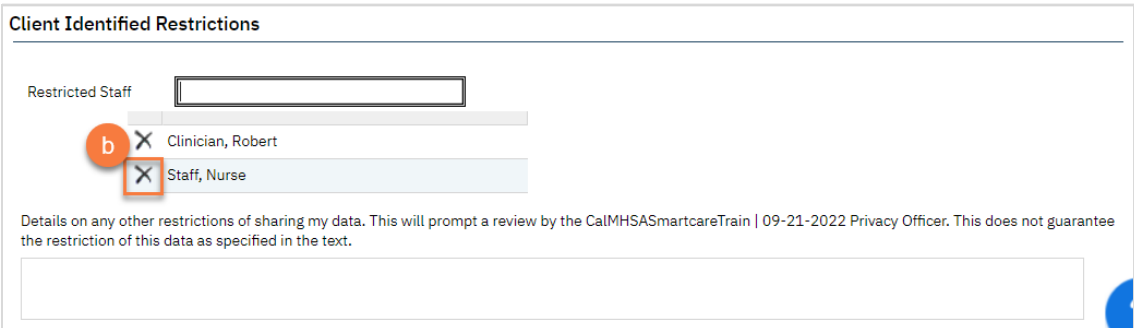
8. In the Consent section, the client should indicate whether they want to consent to sharing information within SmartCare or not.
    a. Selecting "Yes" will allow the sharing of information across SmartCare. Selecting "No" will keep the information users see limited to their CDAG.
    b. The Start 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.



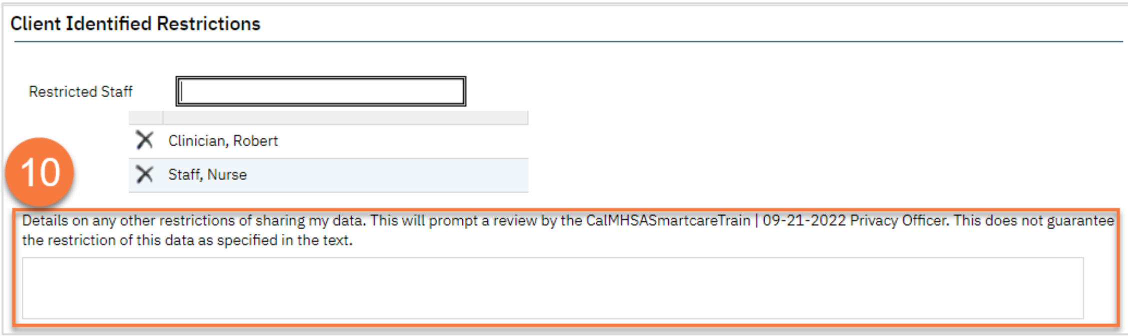
9. If the client wants to keep their chart private from specific individuals, you can add them in Restricted Staff. You can enter more than one staff as needed.
    a. Type the staff's name in the Restricted Staff box. This will search for users. Select the appropriate staff from the search results.



    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.

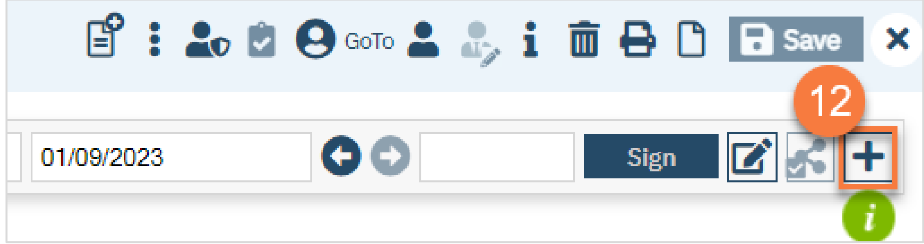


10. There is also a text box if the client wants additional restrictions. This will send a notification to the Privacy Officer, as denoted in SmartCare, to contact the client to discuss the limitations the client is requesting.



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.



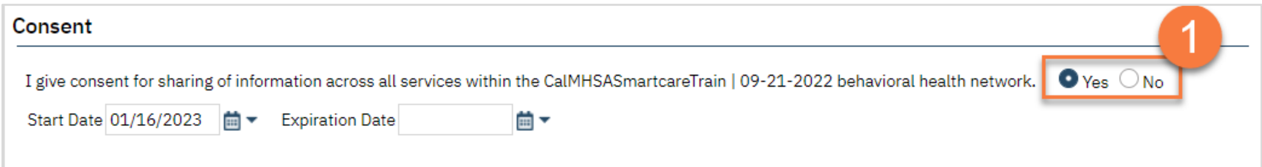
13. This opens the signature details. **Select the client and/or guardian from the Signer field**. You will need to select each cosigner one at a time, so repeat these steps as needed.
14. **Click Co-Sign**.

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 in a document to the client's chart?
    a. **Select the method of capturing the signature**. **NOTE:** Regulations require a signature for documents related to releasing information, so you should not select the "Verbally Agreed Over Phone" option on this document.
    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?

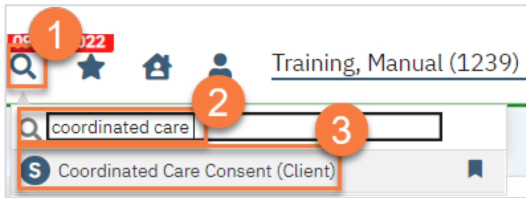
1. To revoke a Coordinated Care Consent, simply create a new Coordinated Care Consent but mark "No" in the Consent section. This will automatically add an end date to the previous Coordinated Care Consent.



How to Determine if the Client has Signed a Coordinated Care Consent

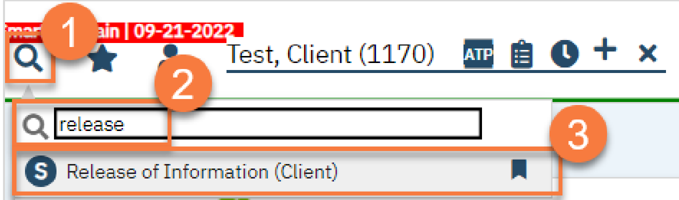
The easiest way to find out if the client has a Coordinated Care Consent is to search for the document using the Search icon. If there is a Coordinated Care Consent already signed in a CDAG that you can view, the PDF will pull up. If not, it will take you to a blank new Coordinated Care Consent.

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).**

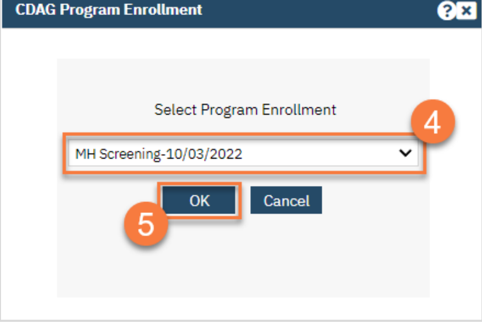


How to Document a Release of Information (Authorization to Disclose Confidential Information)

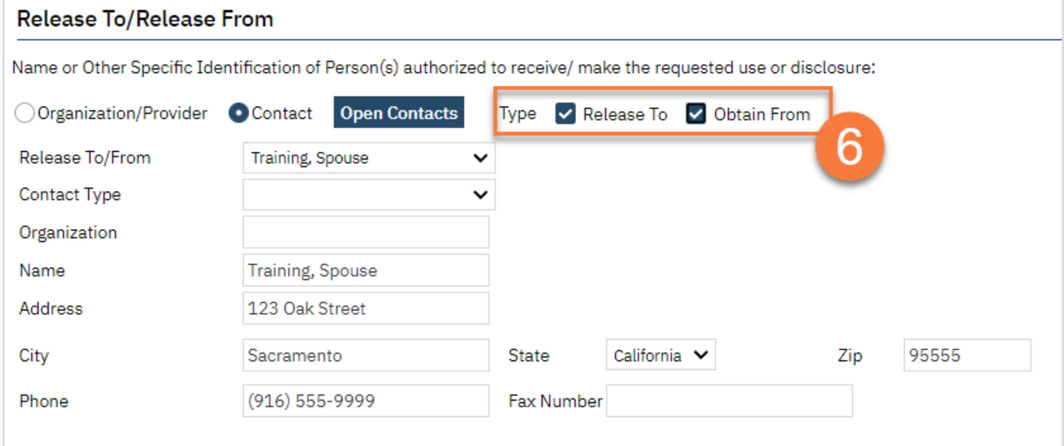
1. You must first have the client open, **click the Search icon**.
2. **Type Release of Information** into the search bar.
3. **Click to select Release of Information (Client).**



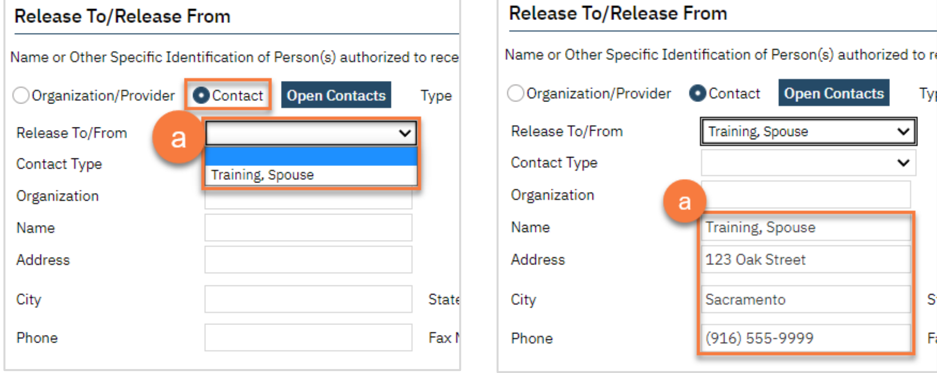
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



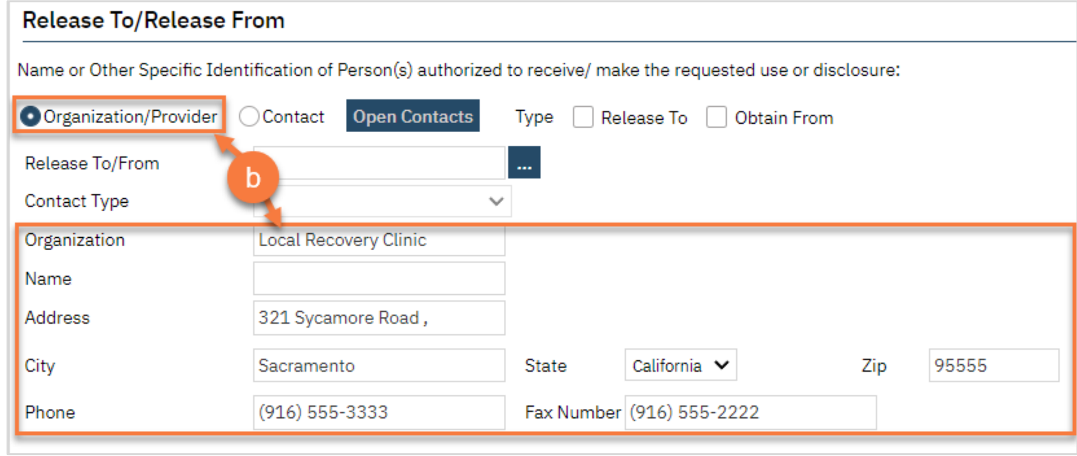
6. **Complete the Release To/Release From section.** Make sure to select whether this authorization is to allow you to release information to this entity and/or obtain information from this entity.



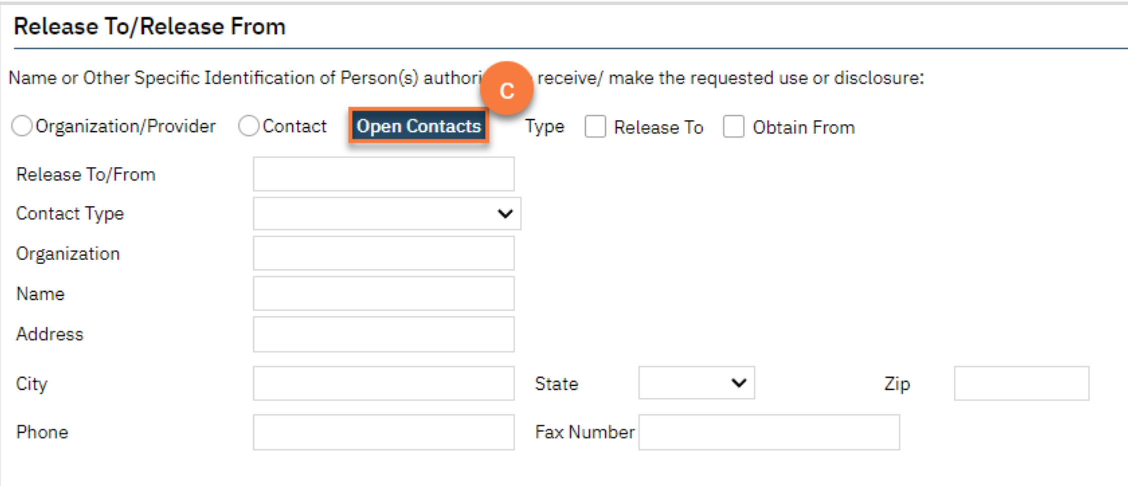
   a. If the person you're completing this release for is already entered as a contact in the Client Information Screen, select "Contact" and then select the person from the drop down list "Release To/From". This will bring in the contact person's information.



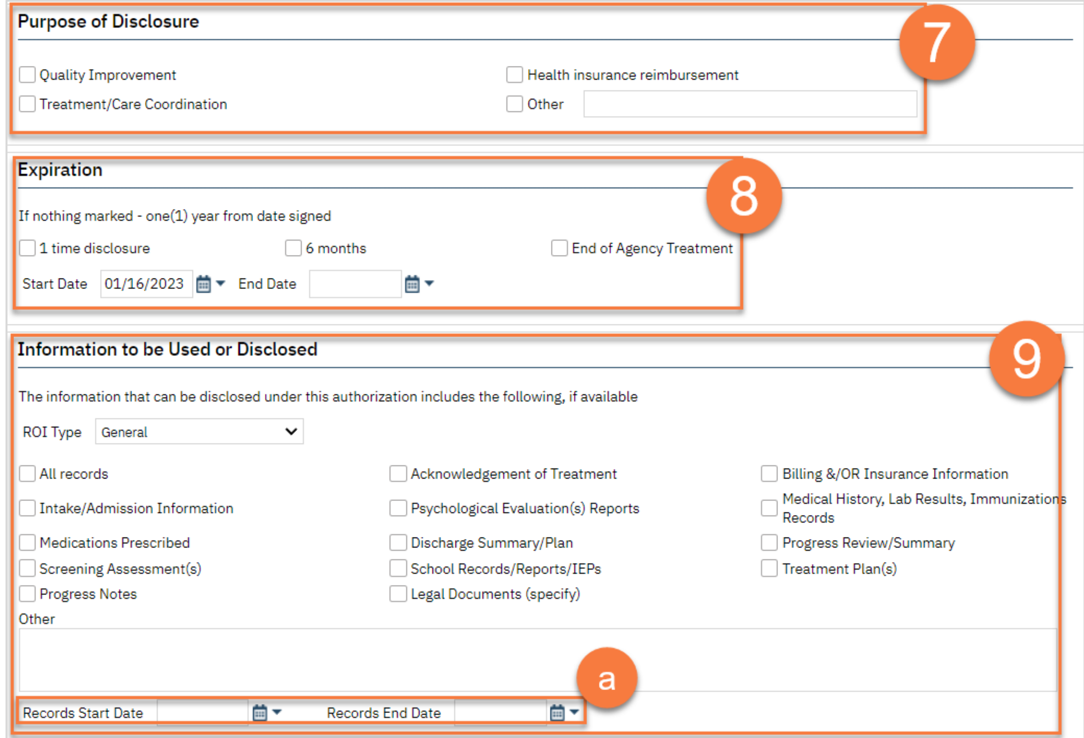
   b. If you're completing a release for an organization, such as Social Services or a school, select "Organization/Provider". This opens a button next to the Release To/From field. Clicking this brings up a pop-up window where you can enter the organization's information. Click save. This will push this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



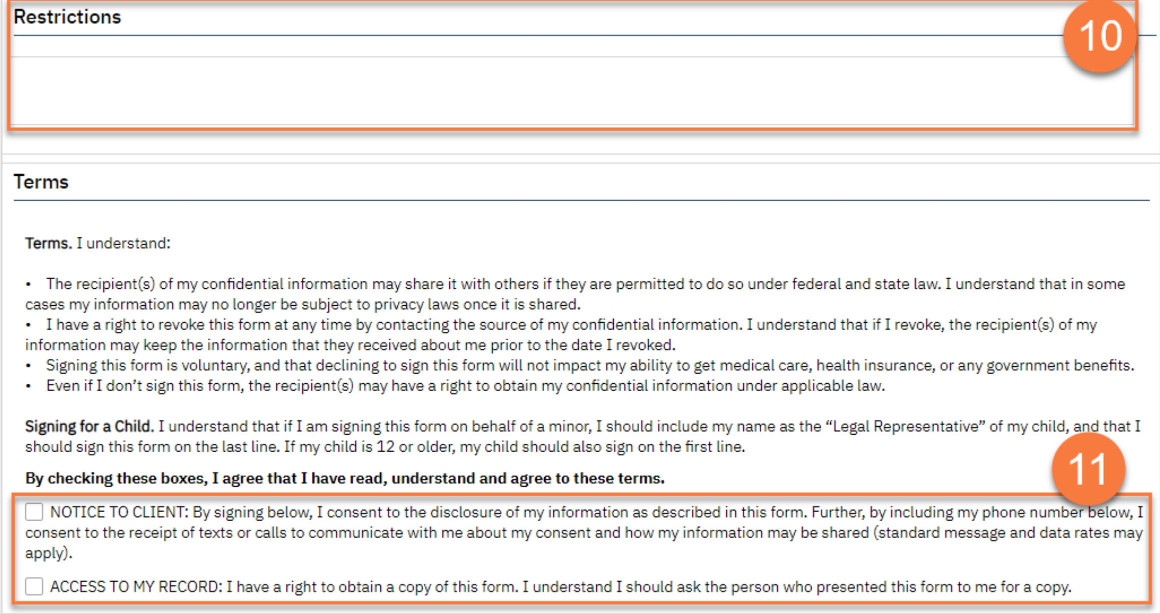
c. If you're completing a release for a contact person that is not currently entered as a contact in the Client Information Screen, selecting "Contact" will create an opportunity to select the button "Open Contacts". This will take you to the Client Information Screen, where you can add additional contact.



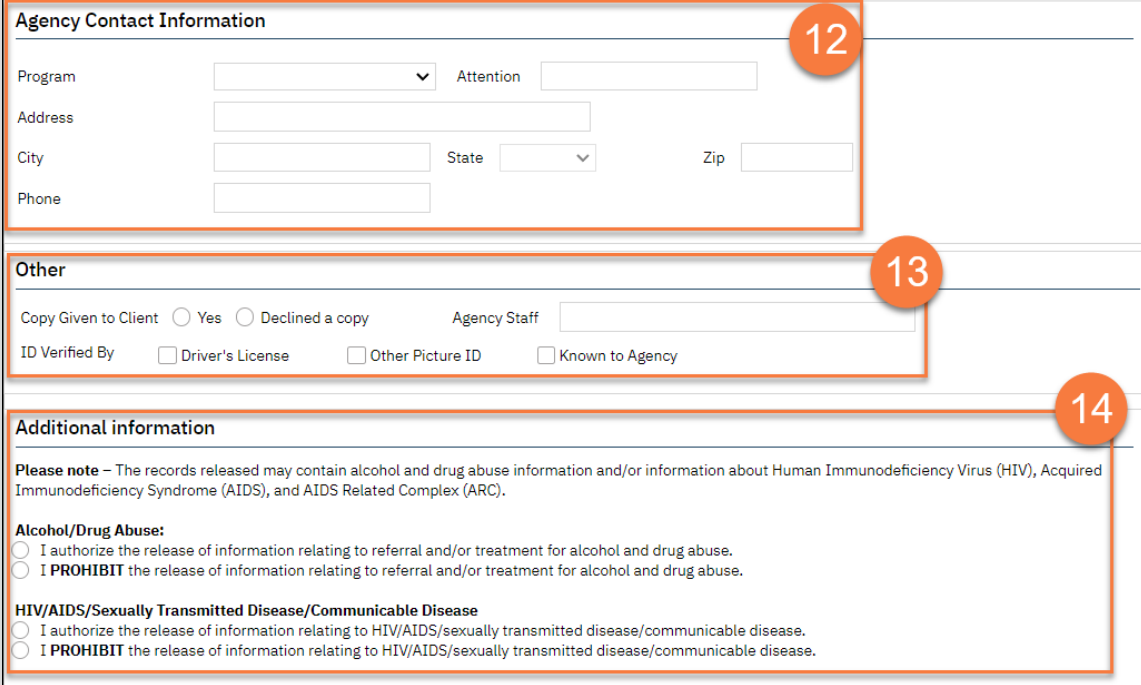
7. **Complete the Purpose of Disclosure section**. Most authorizations to disclose information are for treatment and/or care coordination, but others may apply. Select the appropriate boxes. If you select "Other", make sure to clarify.
8. **Complete the Expiration section**. The start date automatically 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.



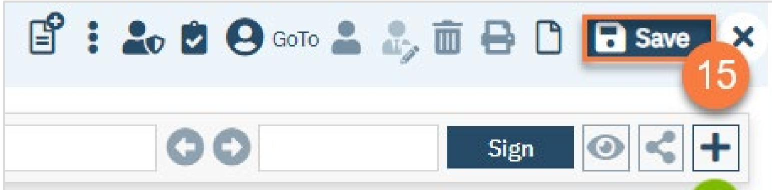
10. If the client wishes to put any restrictions on this authorization, enter those in the Restrictions section.
11. The terms section provides the client with information about the authorization they're signing. Make sure to **check both boxes** to demonstrate you've reviewed this information with the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



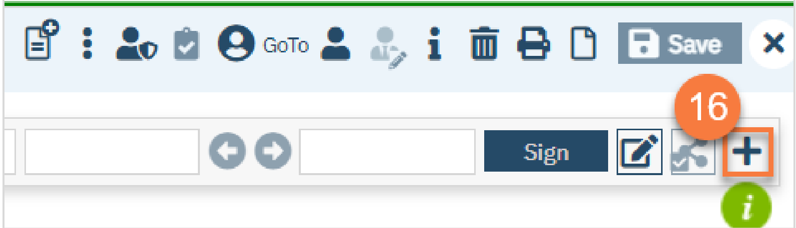
12. **Enter your agency's information in the Agency Contact Information section**.
13. The Other section allows you to document if the client received or declined a copy of the document. It also allows you to document how you verified the client's identity as the appropriate person to sign this document.
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.



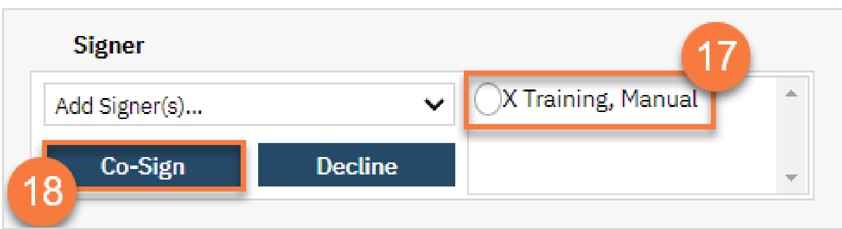
15. **Click Sign** to complete and generate the document.



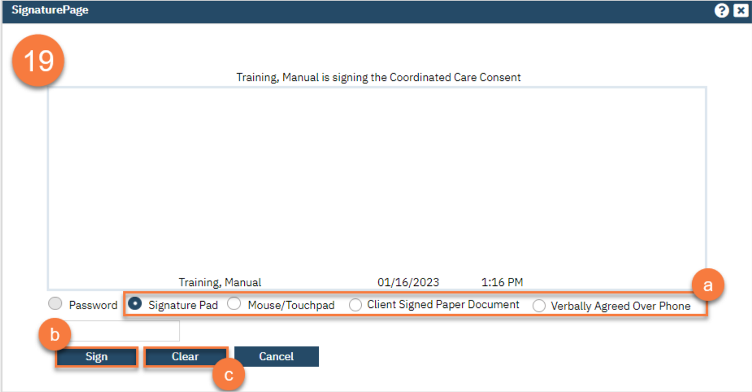
16. This will create the PDF version of the form. **Click the Plus icon** in the upper right corner of the PDF viewer.



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 in a document to the client's chart?
    a. **Select the method of capturing the signature**. **NOTE:** Regulations require a signature for documents related to releasing information, so you should not select the "Verbally Agreed Over Phone" option on this document.
    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.

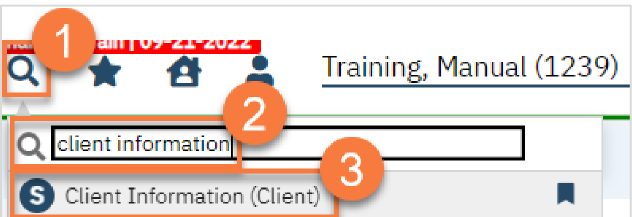
How to Document a Multi-Agency ROI

CalMHSA does NOT recommend having multiple agencies on a single release of information, as this is often legally challenging. Some counties may be using Multidisciplinary Team (MDT) versions of an ROI for clients that have a group of agencies collaborating on care.

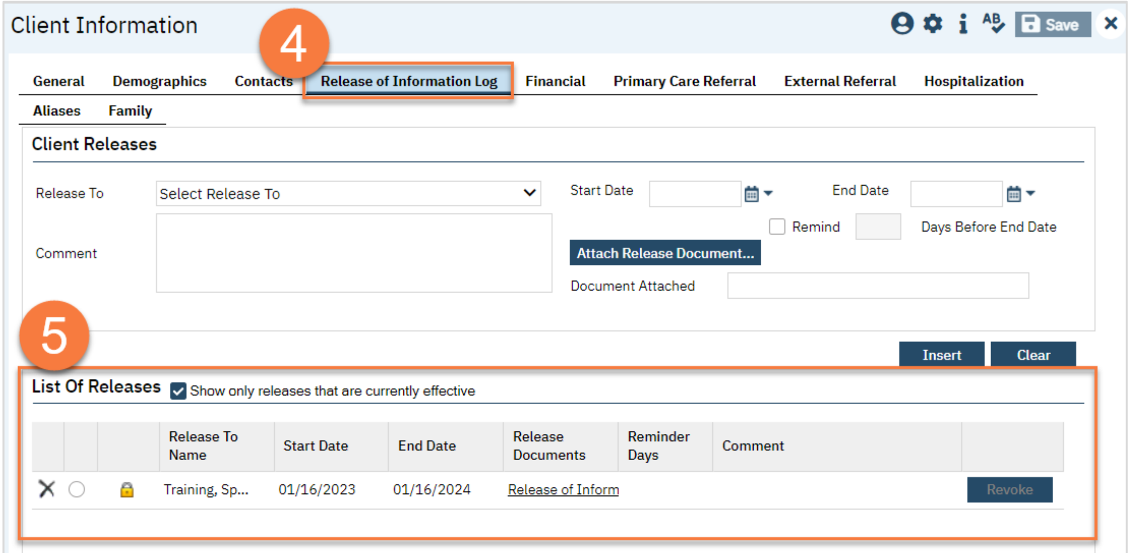
CalMHSA does not have an MDT-ROI in SmartCare. You can scan external ROIs, such as those completed on paper, into the client's record. See "How to Add an External ROI to the Client's Chart".

How to Revoke a Standard Release of Information/Authorization to Disclose Information

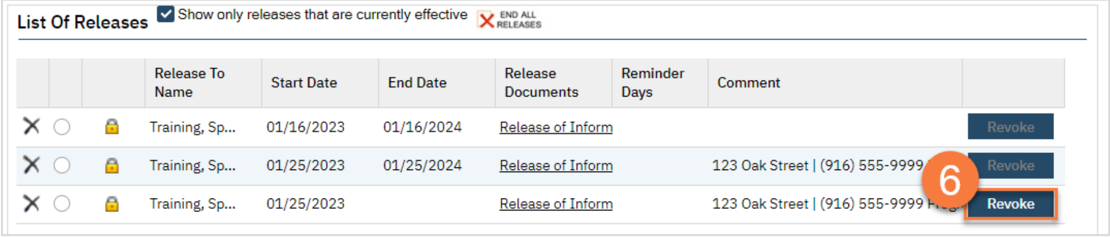
1. With the client open, **click the Search icon**.
2. **Type in "Client Information"** in the search bar.
3. **Select "Client Information (Client)"** from the search results.



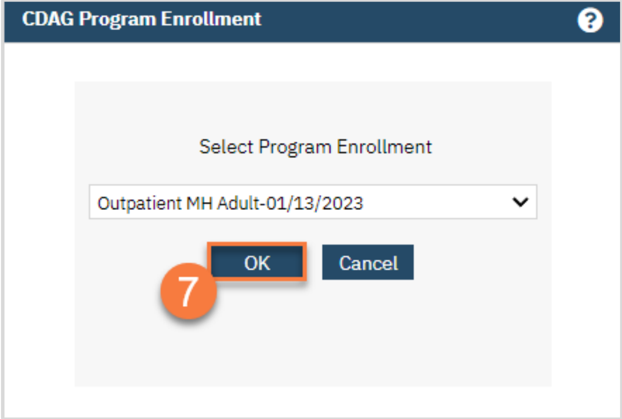
4. **Navigate to the Release of Information Log tab**.
5. You can view the current releases on file in the List of Releases section.



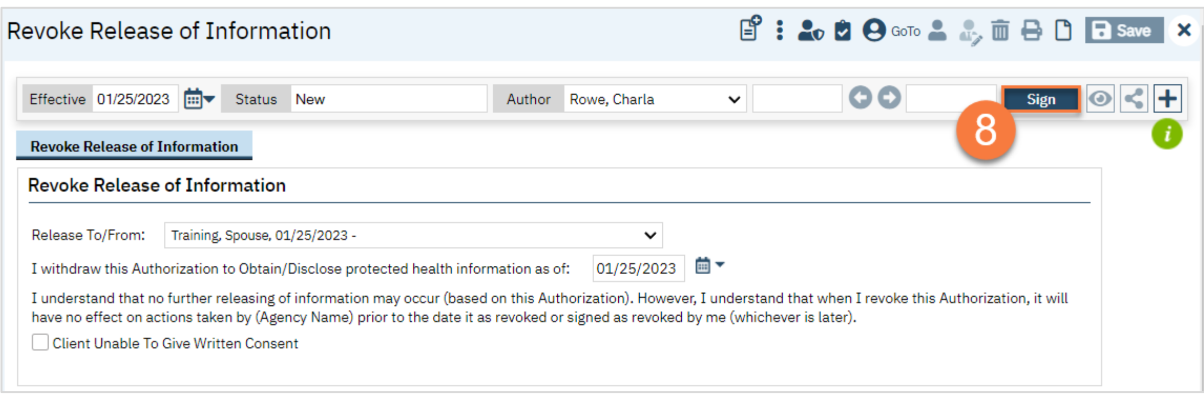
6. To revoke an authorization, **click the Revoke button**.



7. In the CDAG pop-up, **select your program and click OK**.



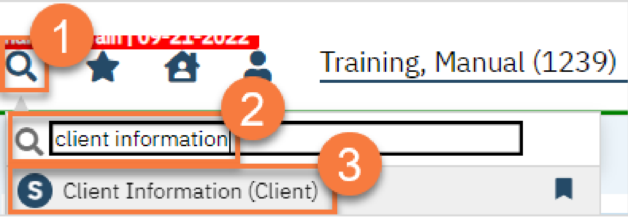
8. Complete the revocation and sign. Have the client co-sign if available.



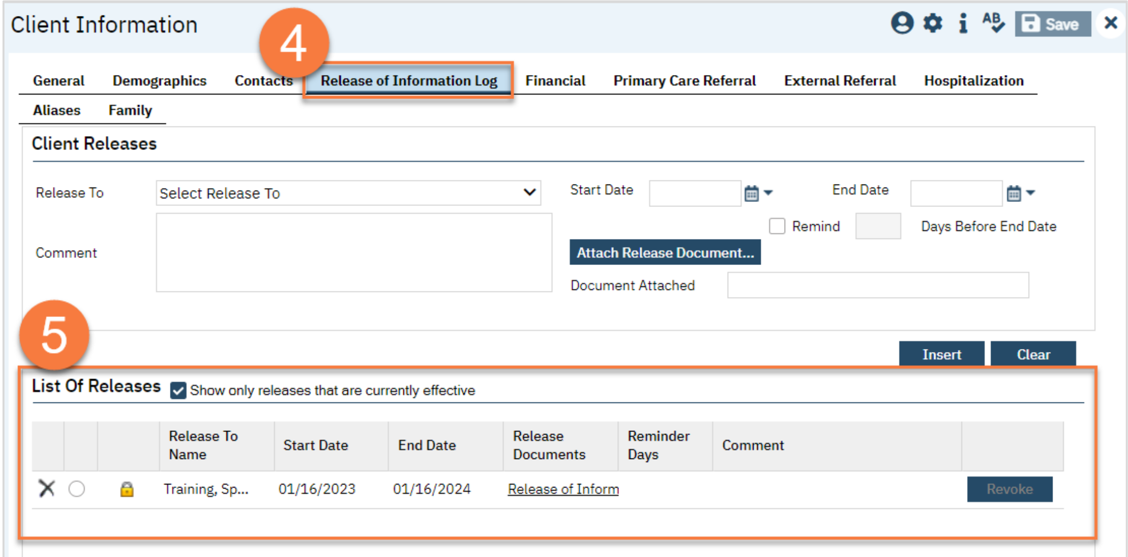
How to Determine What Disclosure Authorizations (Release of Information) the Client has Signed

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:

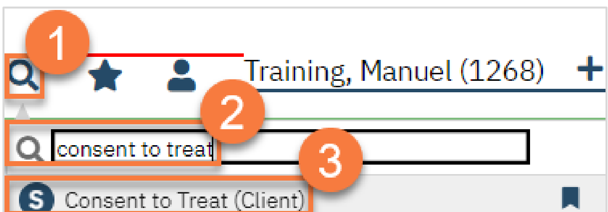
1. Consent to Treat *(sometimes called "Informed Consent")*
2. Consent to Telehealth
3. Consent to Email Communication
4. Consent to Text Communication

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.

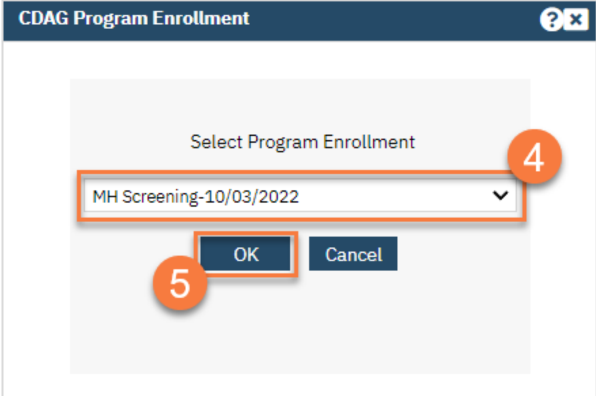
Other consent-like documents, such as Admission Agreements or Advisements are custom for each program. For this reason, these documents are currently done on paper and scanned into the client's chart.

How to Complete a Consent

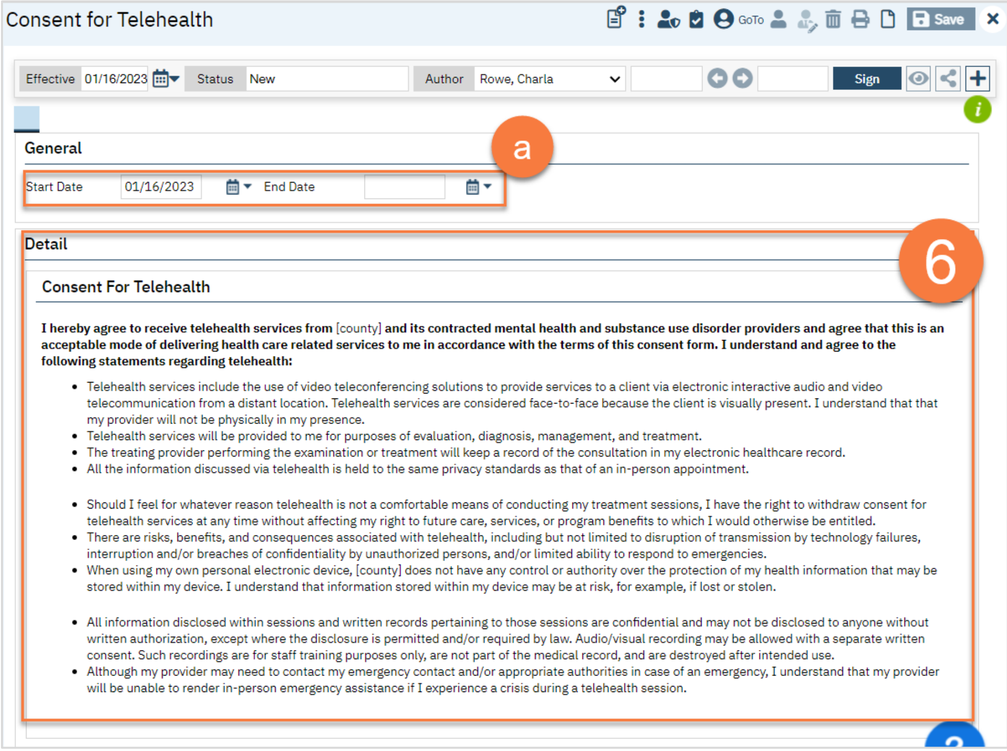
1. You must first have the client open, click the Search icon.
2. **Type the name of the consent** into the search bar.
3. **Click to select the appropriate consent** from the search results.



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.

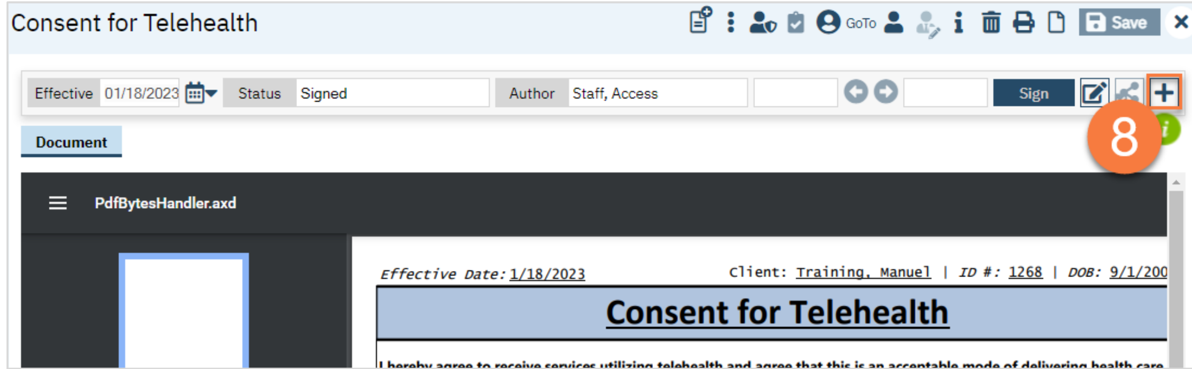


6. The consent document will open. **Review the consent with the client**. The example used below is the Consent for Telehealth.
    a. There will be a start date and end date field, if needed. The start date will automatically populate with today's date. We recommend leaving the end date blank.

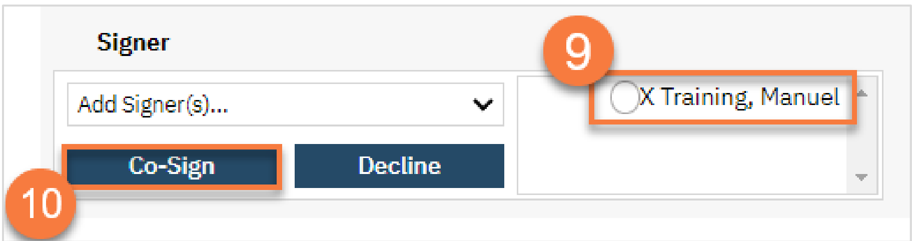


7. Once ready, **click Sign**.

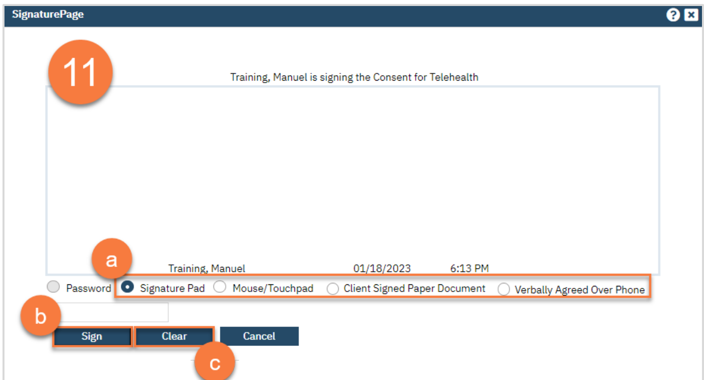
8. This will create the PDF version of the form. **Click the Plus icon** in the upper right corner of the PDF viewer.



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**.



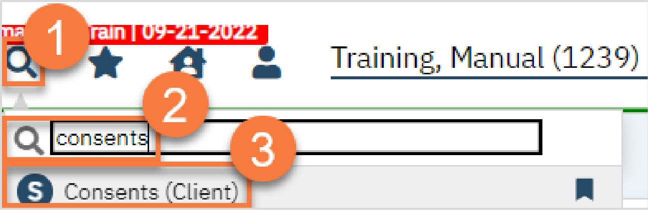
11. This brings up the Signature Page pop-up window. The co-signer can now sign using a signature pad, a mouse, or a touchpad to capture their signature. You can also designate that the client has signed on a paper version of the document or that they client verbally agreed and was unable to sign. If the client has signed a paper version of the form, that form should be scanned in. See How do I scan in a document to the client's chart?
    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.



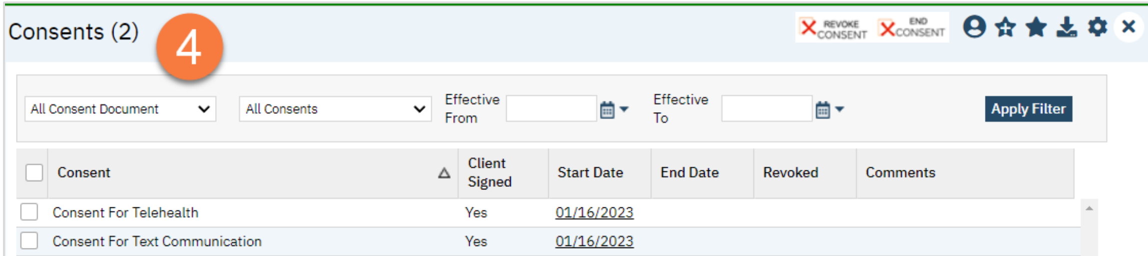
Once signed by all required people, you are finished.

How to View 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.



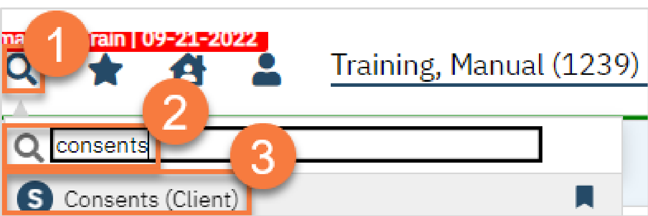
4. This brings you to the Consents list page, where you can see what consents the client has on file. To view the document itself, simply click on the document's name to view the PDF version of it. Note: you'll only be able to view consents that are in your CDAG.



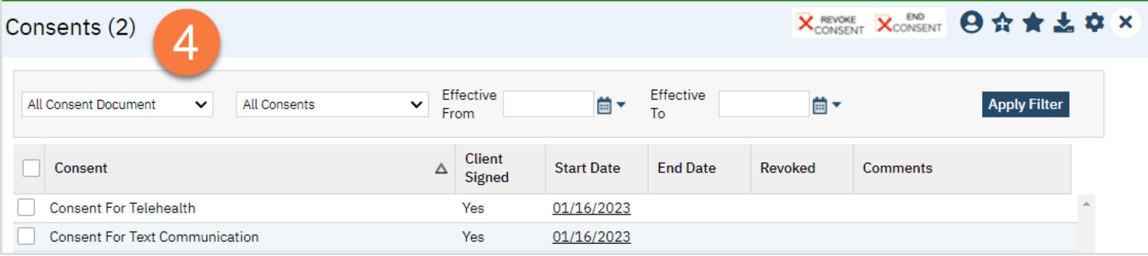
Note: Currently SmartCare does not display a large stamp or watermark on the pdf of a consent that has been revoked. CalMHSA is working to make the revocation more visible on the pdf. It is for this reason that we recommend you review the list page for the status of the consent, rather than searching for the document directly.

How to Document a Revoked Consent

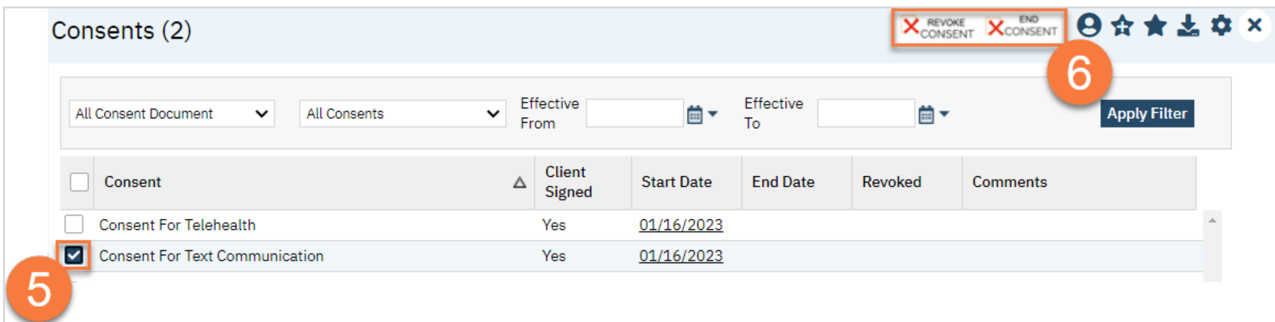
1. You must first have the client open, click the Search icon.
2. Type "Consents" into the search bar.
3. Click to select "Consents (Client)" from the search results.



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.



How to Add an External Release of Information to a Client's Chart

See Front-Desk User Guide.

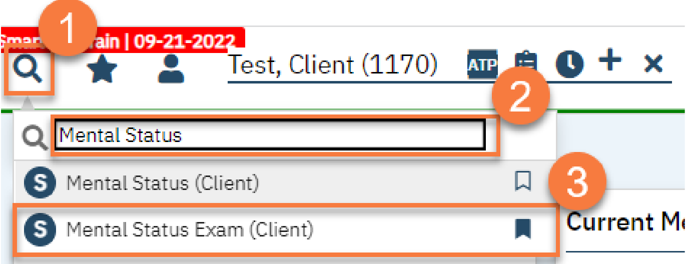
Clinical Documents

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

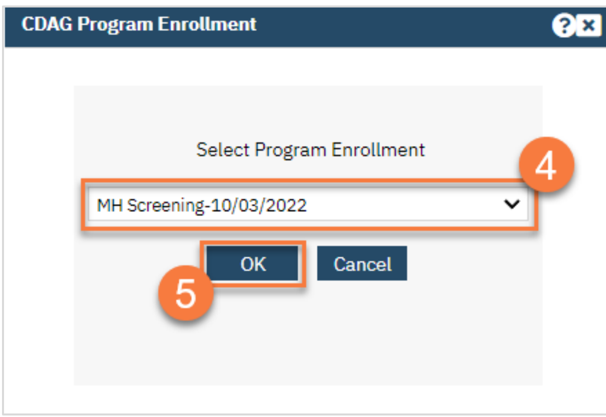
Mental Status Exam (MSE)

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.

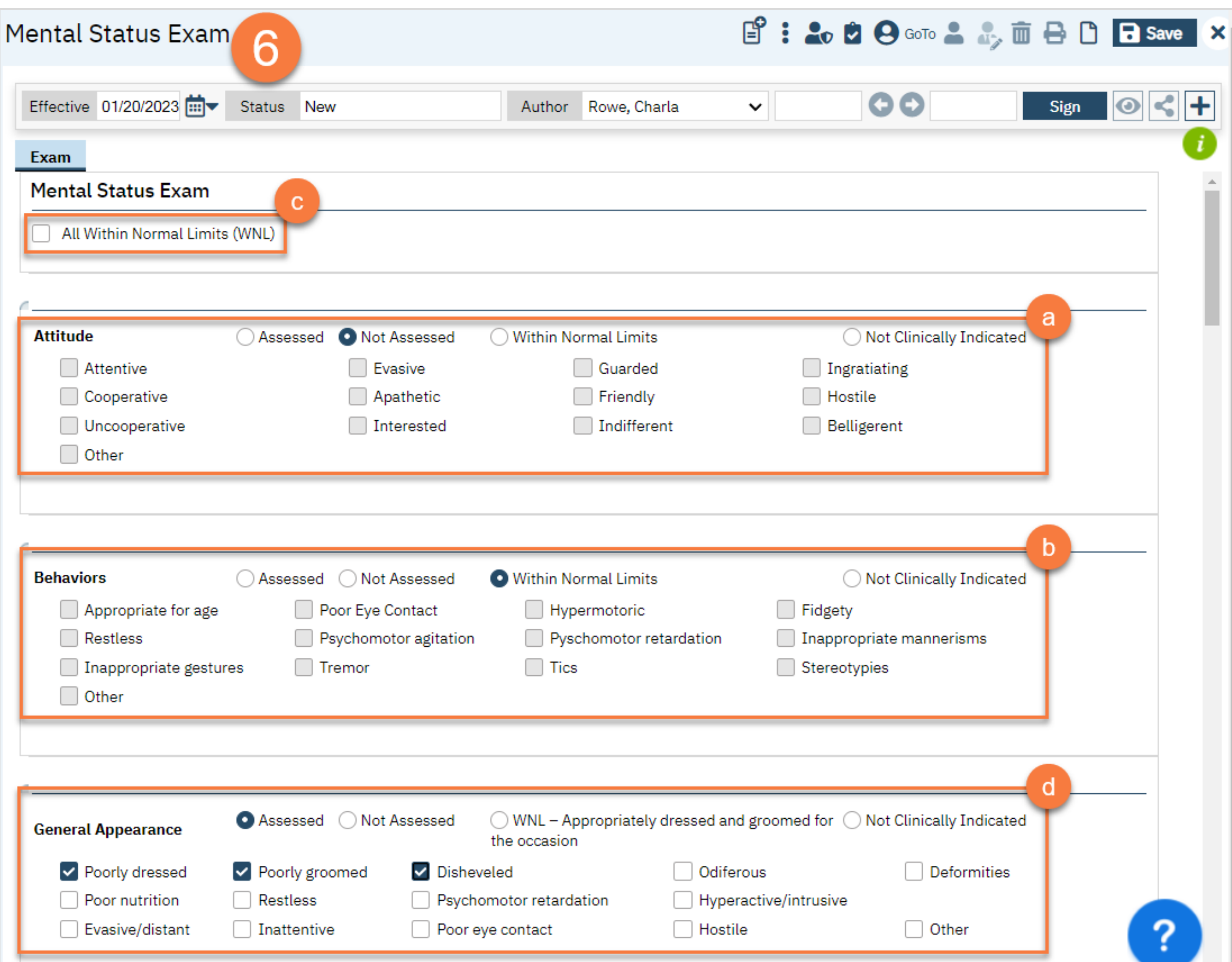
1. You must first have the client open, **click the Search icon**.
2. **Type Mental Status Exam** into the search bar.
3. **Click to select Mental Status Exam (Client).**



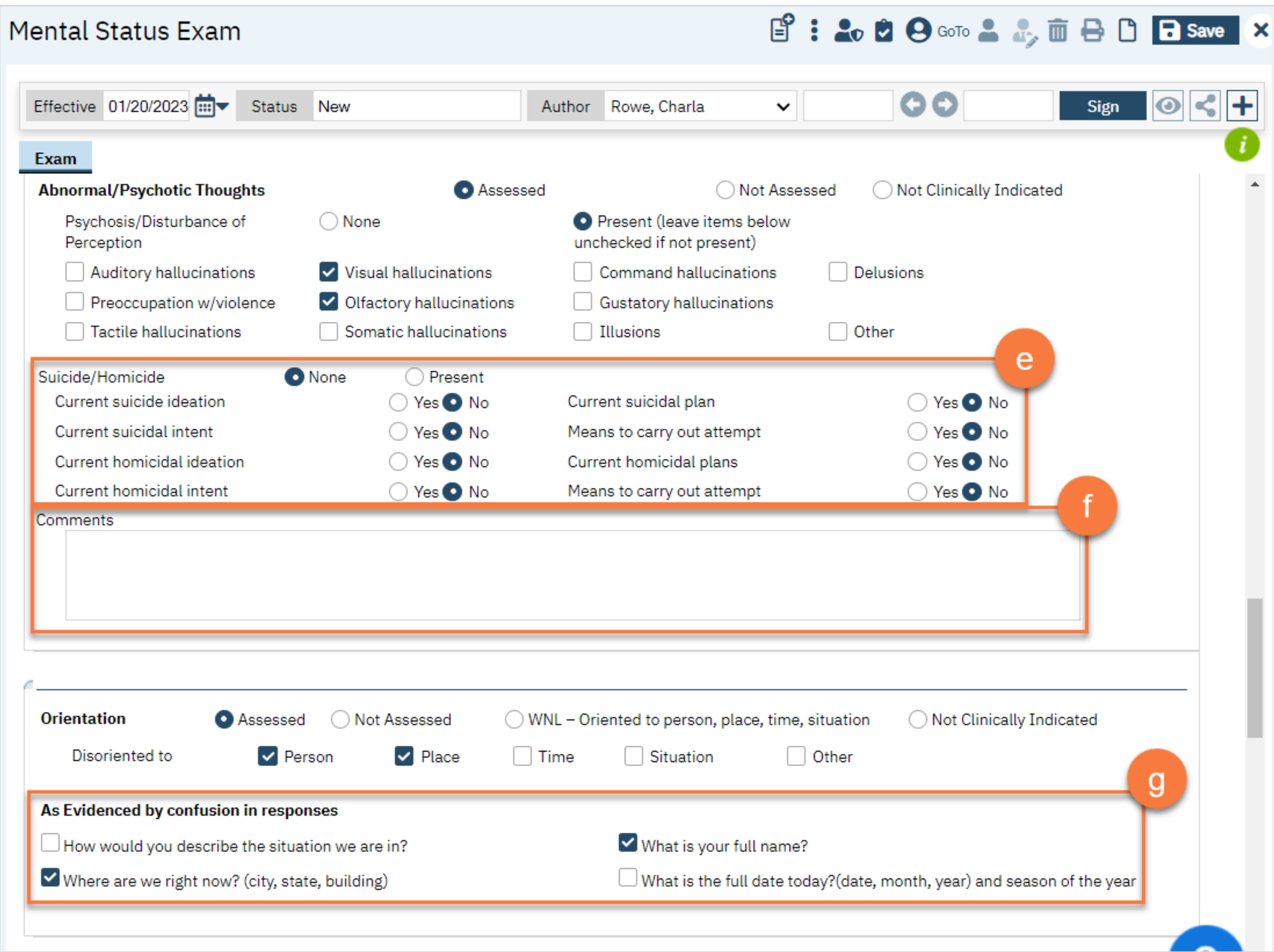
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



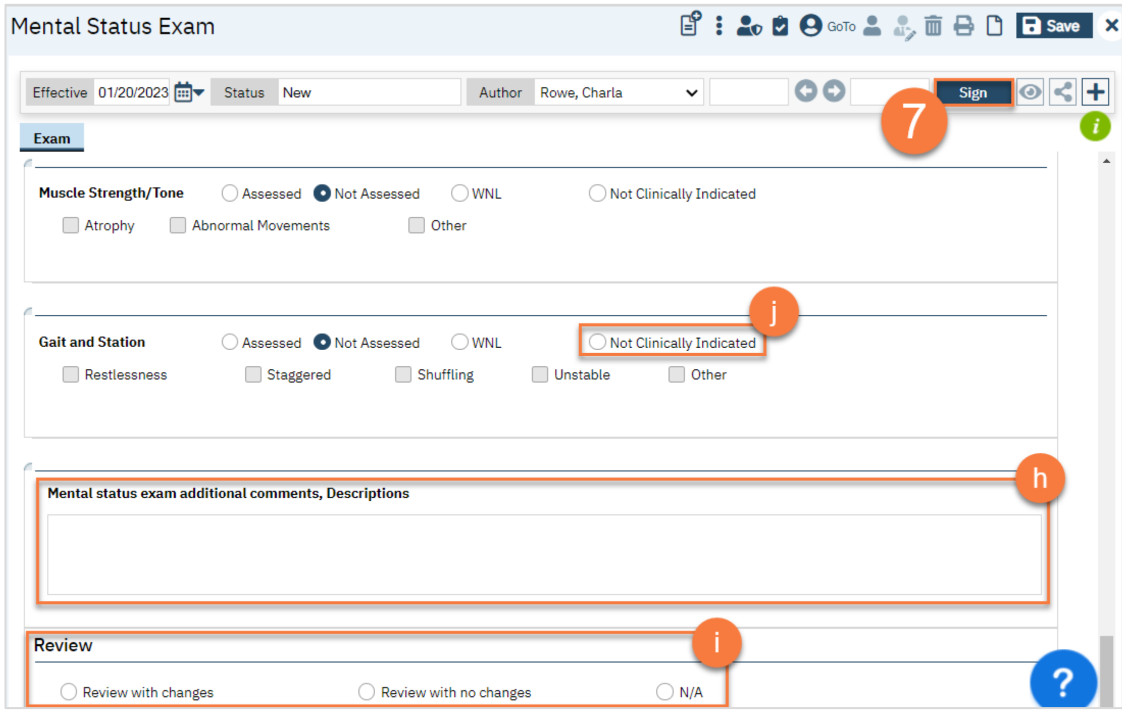
6. The Mental Status Exam document will open. **Complete the document.** If a previous MSE was completed, it will pull forward the most recent information. Otherwise, all sections will default to "Not Assessed."
    a. If you did not assess that section, select "Not Assessed." This will lock your ability 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.



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

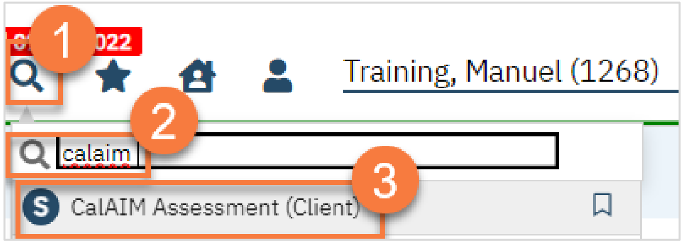


CalAIM Assessment

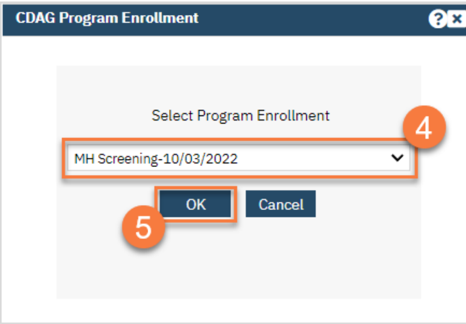
The CalAIM Assessment is the new 7-domain assessment that DHCS initialized in July 2022. Please reference the CalMHSA Documentation Guides for more details on what clinical information should be included. In SmartCare, it also includes the Problem List module, allowing you to add problems directly from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

How to complete a CalAIM Assessment:

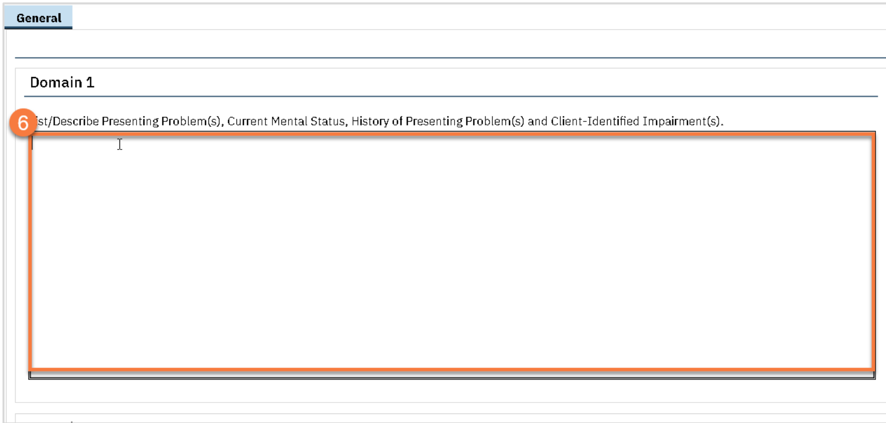
1. You must first have the client open, **click the Search icon**.
2. **Type CalAIM Assessment** into the search bar.
3. **Click to select CalAIM Assessment (Client).**



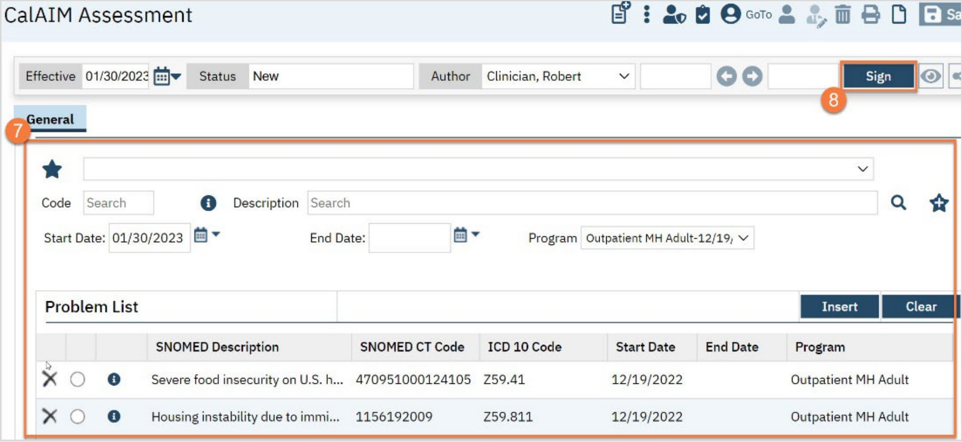
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



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



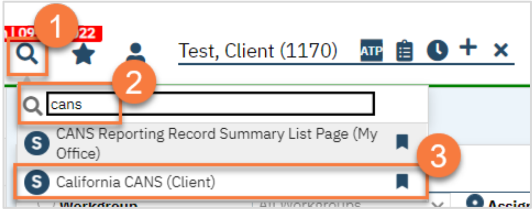
7. **Add problems to the Problem List as desired**. See Problem List section for more information on how to complete the Problem List in SmartCare.
8. **Click Sign** to complete and generate the document.



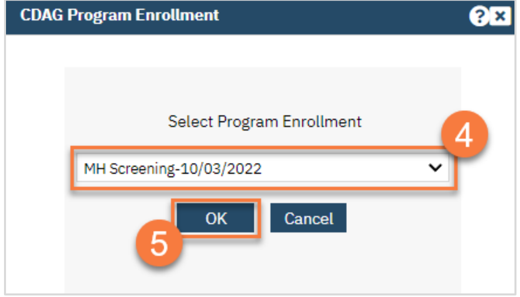
Child and Adolescent Needs and Strengths (CANS) Tool

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

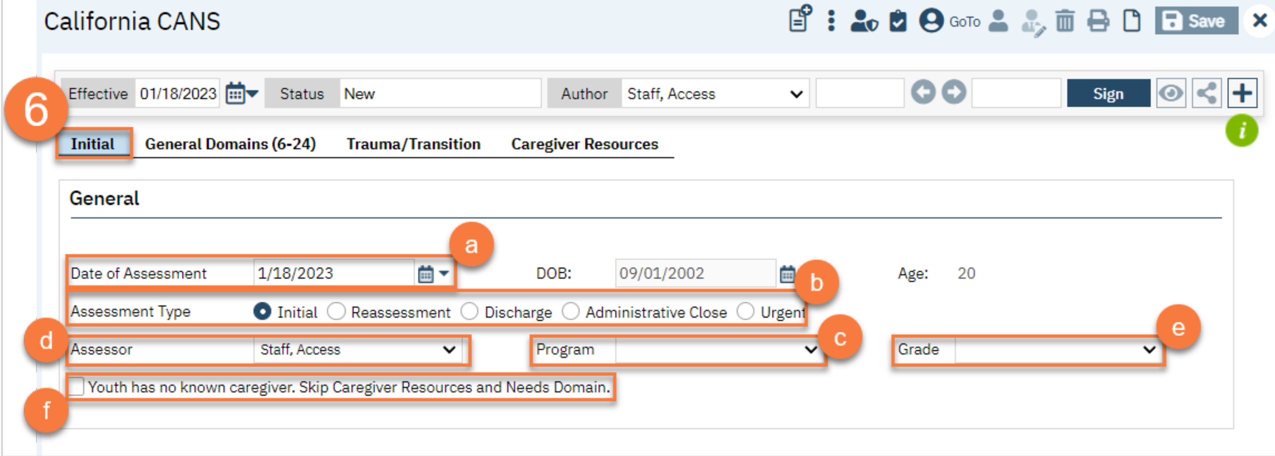
1. You must first have the client open, **click the Search icon**.
2. **Type CANS** into the search bar.
3. **Click to select California CANS (Client).**



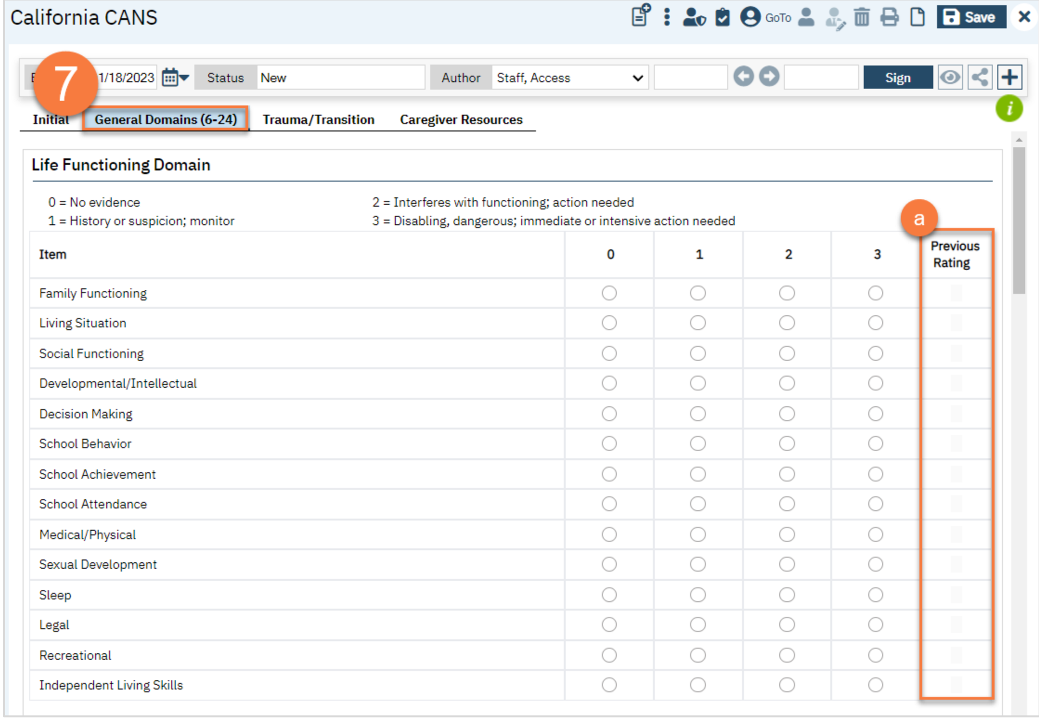
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



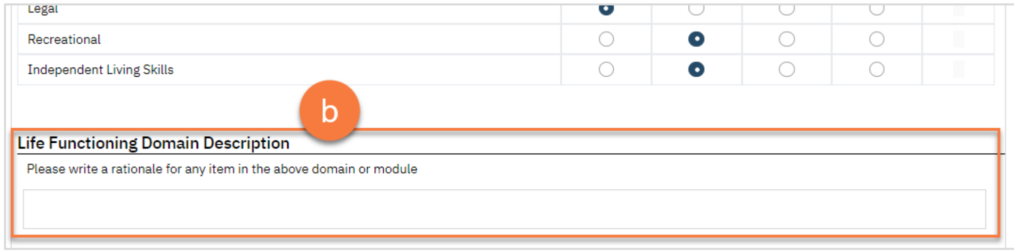
6. The CANS document will open. **Complete the general information** about the CANS in the Initial tab.
   a. **Enter the date of the assessment**. This auto-populates to today's date, but may be changed as necessary.
   b. **Select the Assessment type**.
   c. **Enter your program**.
   d. If you're 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.



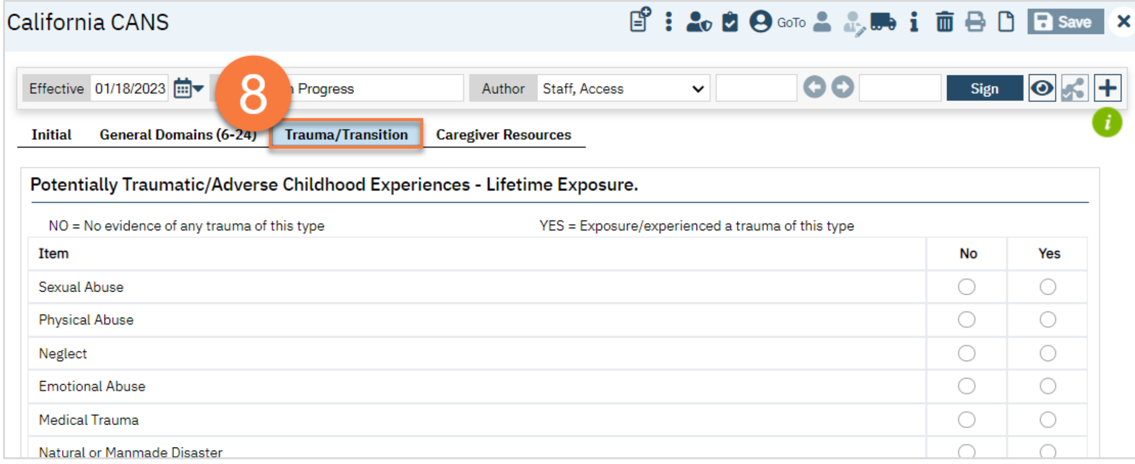
7. **Navigate to the General Domains** tab and complete the CANS tool.
    a. If this is not an initial assessment, the most recent CANS scores will show to provide you with additional information.



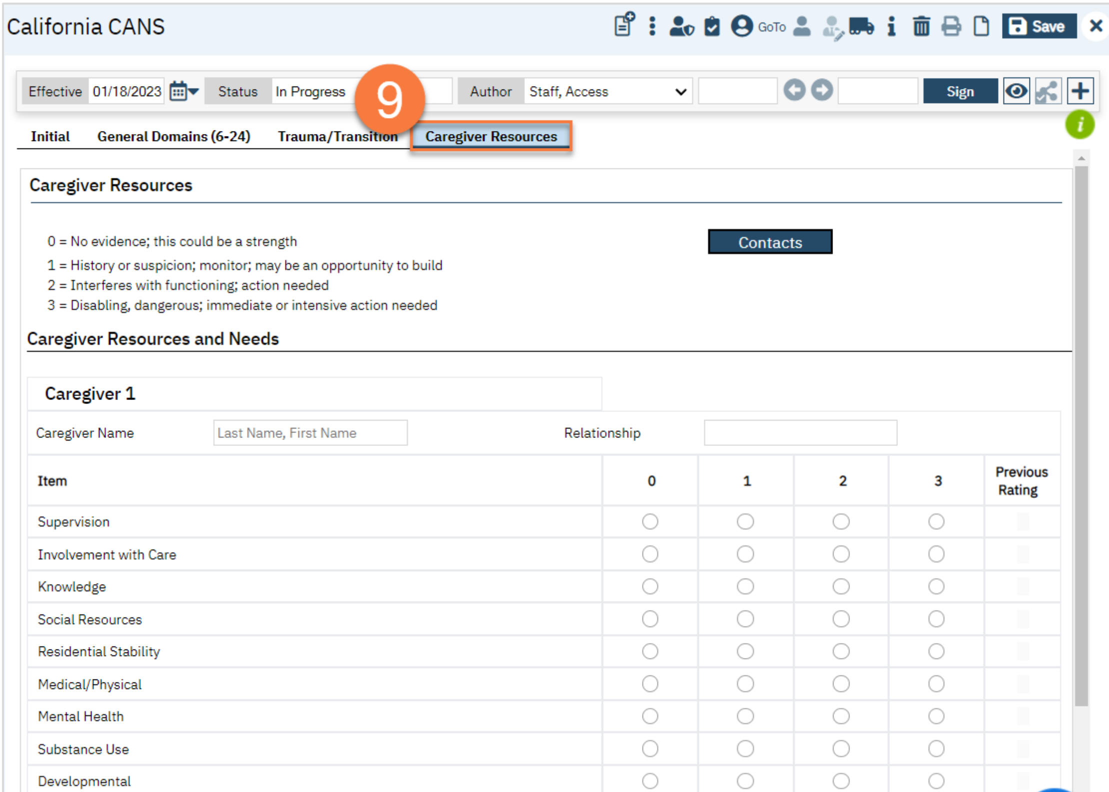
    b. At the end of each section is a comment box for your clinical notes.



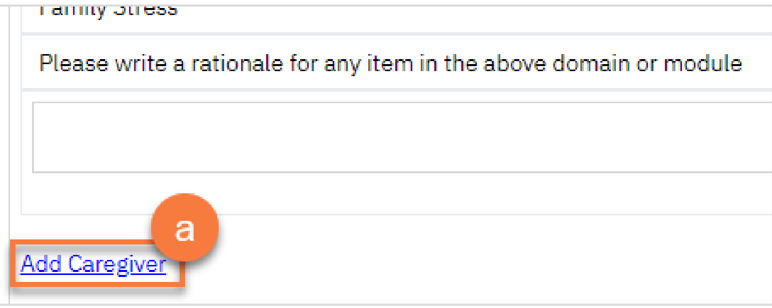
8. Navigate to the Trauma/Transition and complete this section.



9. 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.

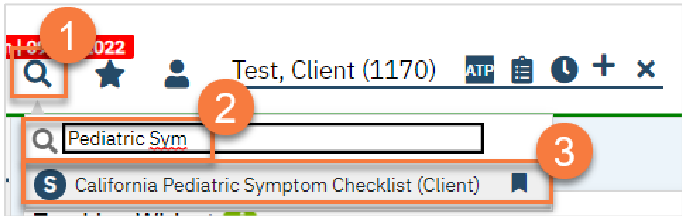


10. **Click Sign** to complete and generate the document.

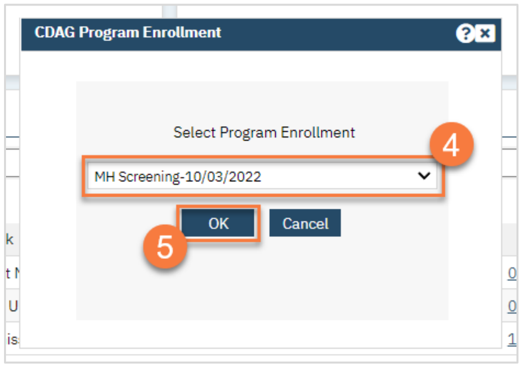
Pediatric Symptom Checklist (PSC)

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

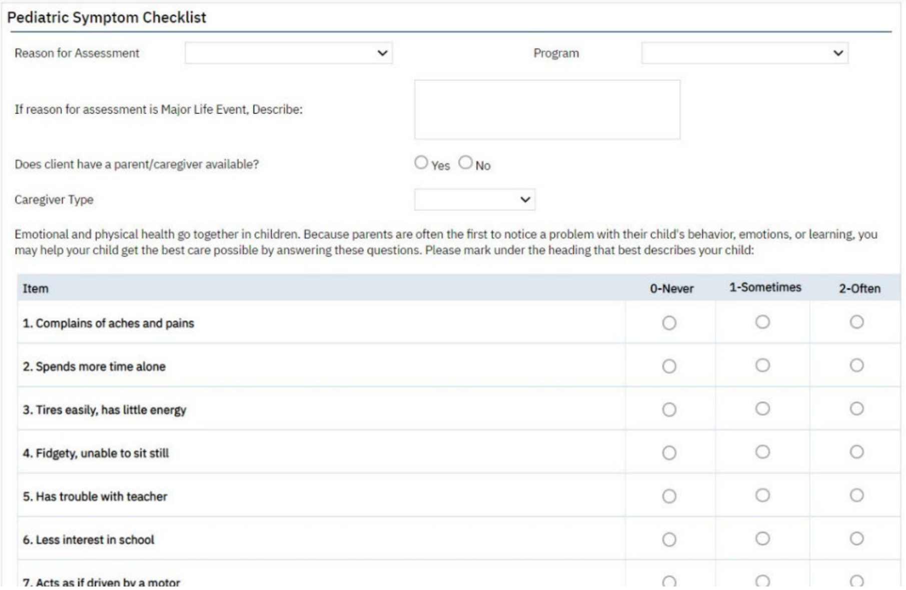
1. You must first have the client open, **click the Search icon**.
2. **Type Pediatric Symptom Checklist** into the search bar.
3. **Click to select California Pediatric Symptom Checklist (Client).**



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.



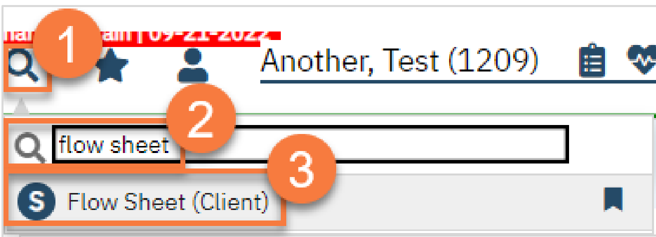
6. The PSC document will open. **Complete the document**. The PSC-35 is a form that is completed by the youth's caregiver. This may be done on paper and entered into this document for better tracking. You may also want to scan in the paper version the guardian completed. If so, see How do I scan a document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



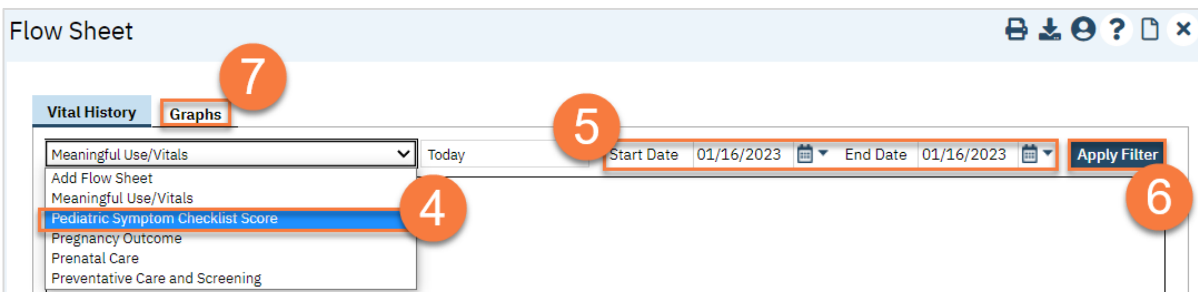
7. **Click Sign** to complete and generate the document.

How to View 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.

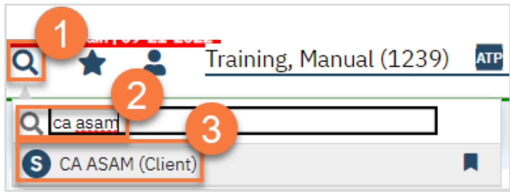


ASAM Assessment

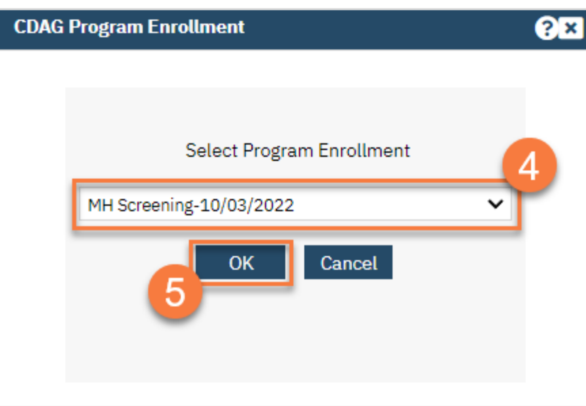
The American Society of Addiction Medicine (ASAM) has created an assessment that they simply call the ASAM Criteria. Generally, this assessment is usually just shortened to “ASAM” in the substance use treatment world. In SmartCare, the form is called “CA ASAM” to represent that this is the form the California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

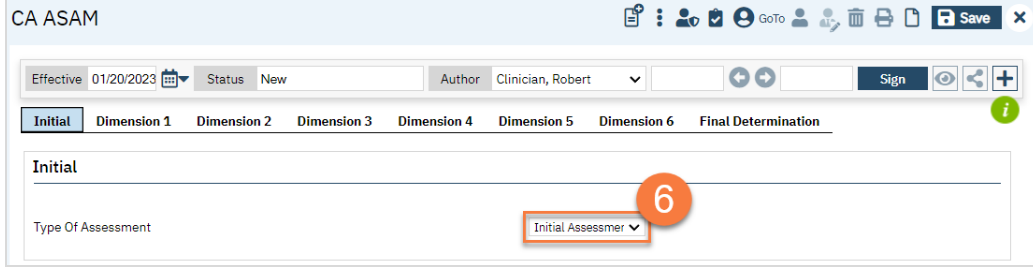
1. You must first have the client open, **click the Search icon**.
2. **Type “CA ASAM”** into the search bar.
3. **Click to select CA ASAM (Client)** from the search results.



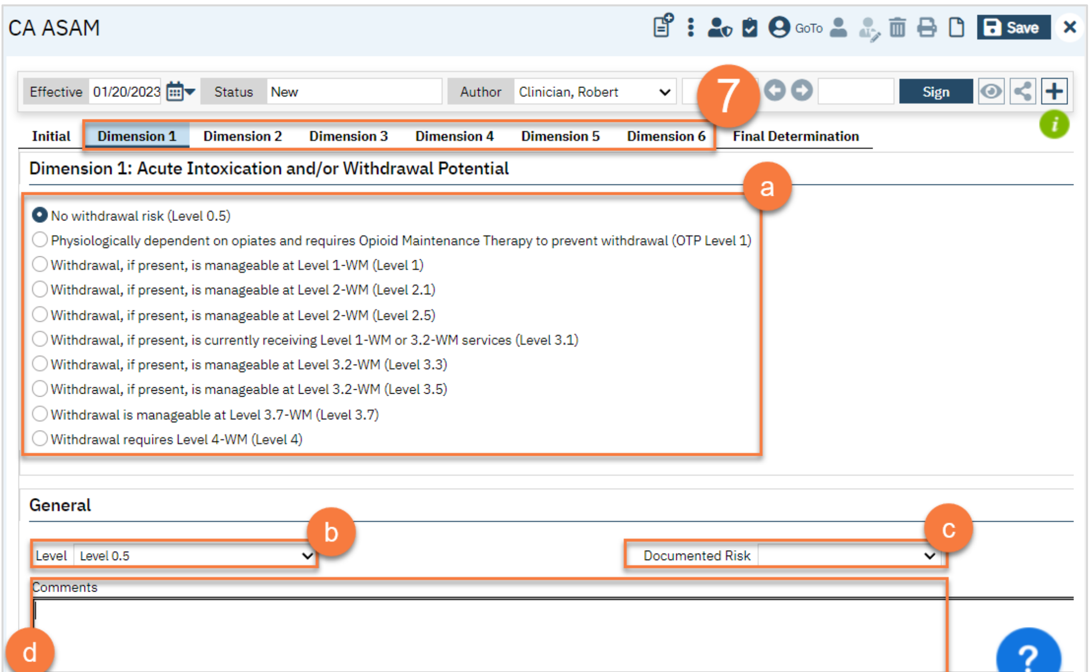
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



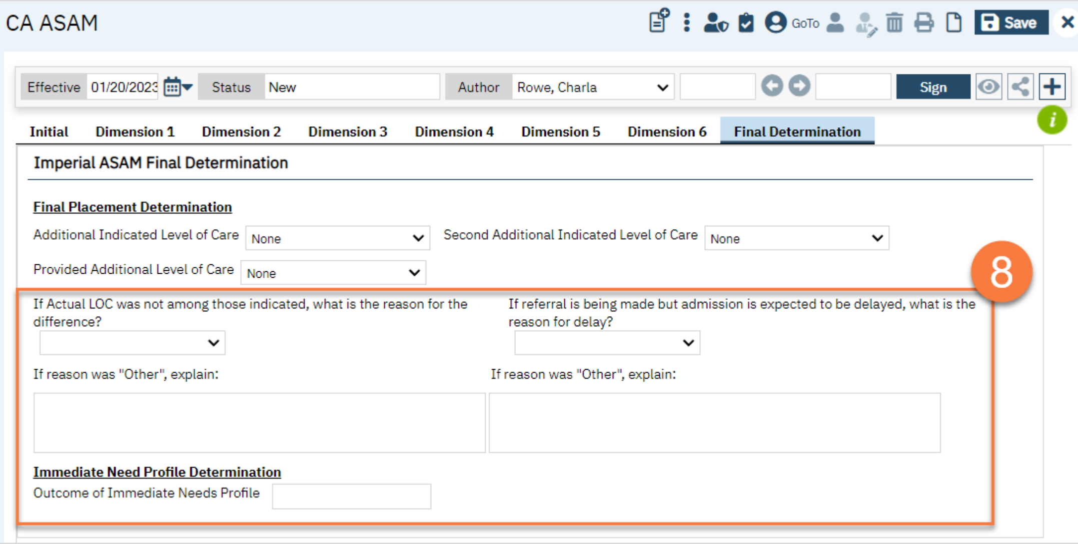
6. The ASAM document will open. In the Initial tab, **enter the type of assessment** this is.



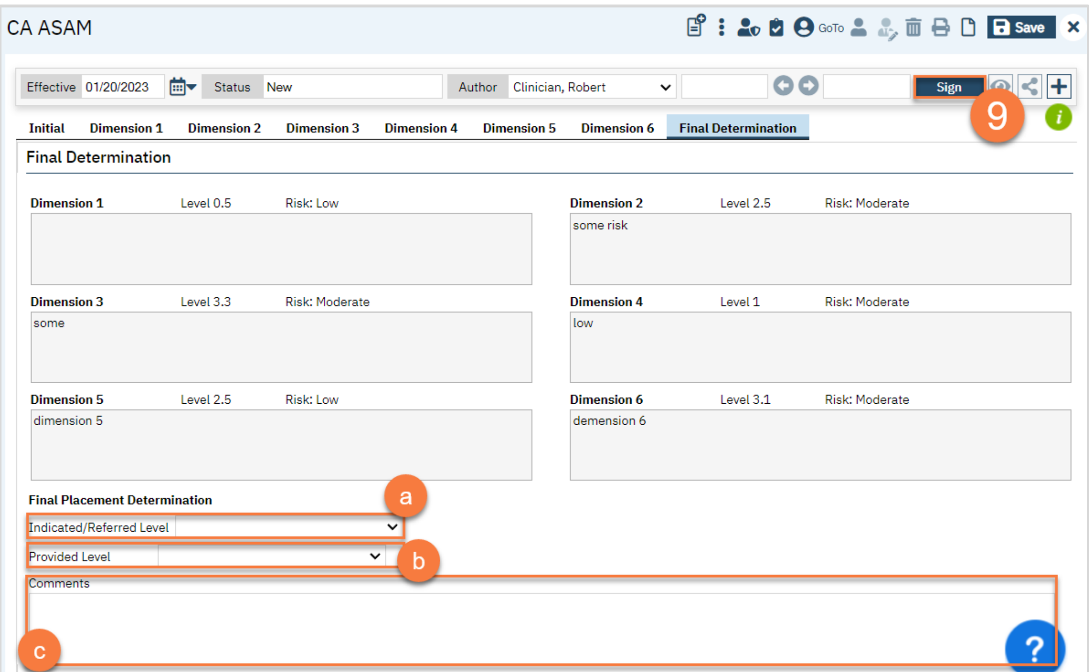
7. **Complete each Dimension tab.**
    a. Each will have a section for you to **enter the risk level**.
    b. This will auto-populate the level in the General section of the tab.
    c. **Enter the documented risk** (low, moderate, or high).
    d. **Enter your comments.**



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**.



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

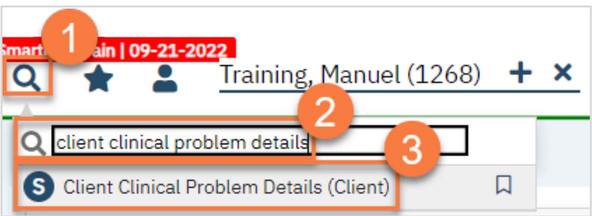


Problem List

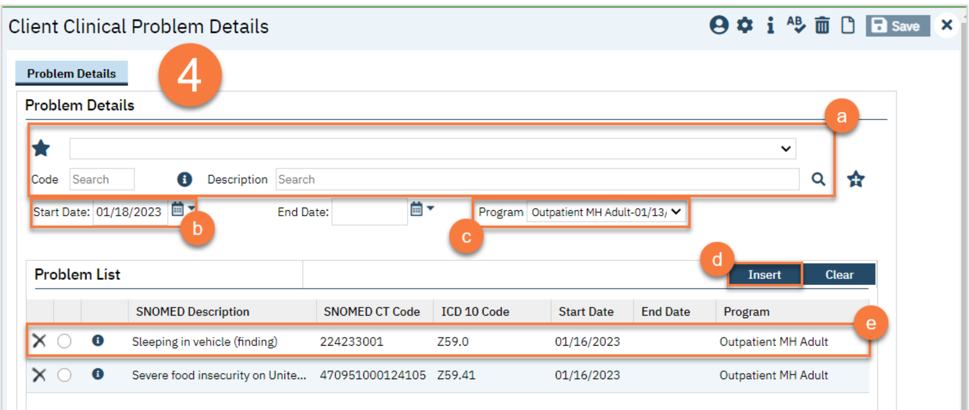
The Problem List is a module that is embedded in multiple documents in the system. For example, it's included in the CalAIM Assessment and most progress notes. These are all connected, so if you add a problem from one document, it will add it to the overarching Problem List and will therefore be available 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 to Add a Problem to the Problem List

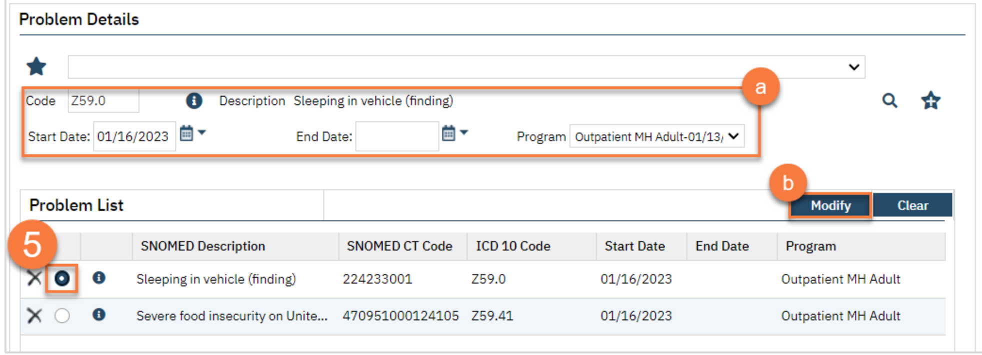
1. You must first have the client open, then **click the Search icon**.
2. **Type Problem** into the search bar.
3. **Click to select Client Clinical Problem Details (Client).**



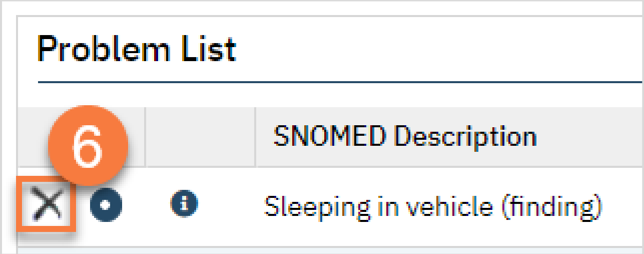
4. This brings you to the Client Clinical Problem Details screen. Add a problem using the steps below. You can enter as many problems as you need to.
    a. **Search for the problem** using the ICD-10 code, or the DSM-5 code. You can also search by typing in the Description field. You can also select 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**.



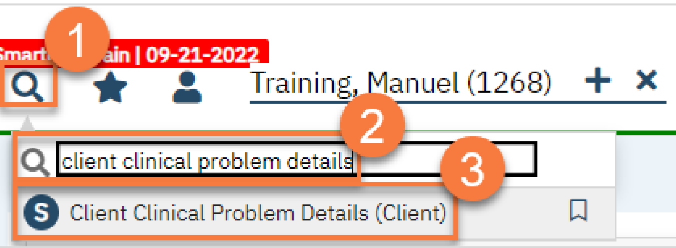
6. If you need to simply delete a problem that was added in error, click the Delete icon next to the appropriate problem in the Problem List section.



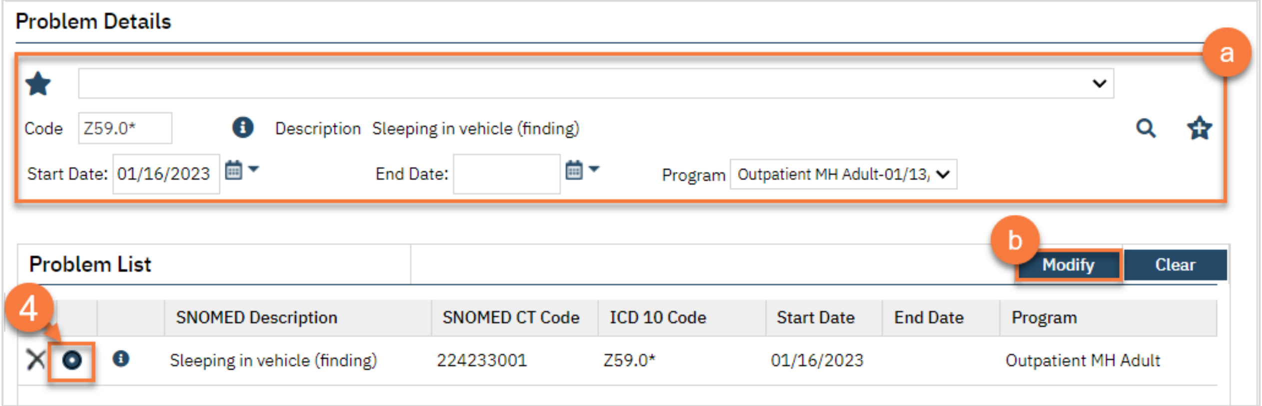
7. When you're finished, **Click Save**.

How to Remove a Problem That's Been Resolved

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).**



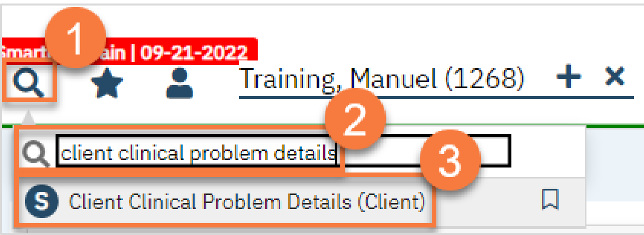
4. This brings you to the Client Clinical Problem Details screen. To remove a problem that's been resolved, **select the item from the Problem List section**.
   a. This brings the information to the top part of the screen. **Add an end date**. The end date should be when the problem was resolved, not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



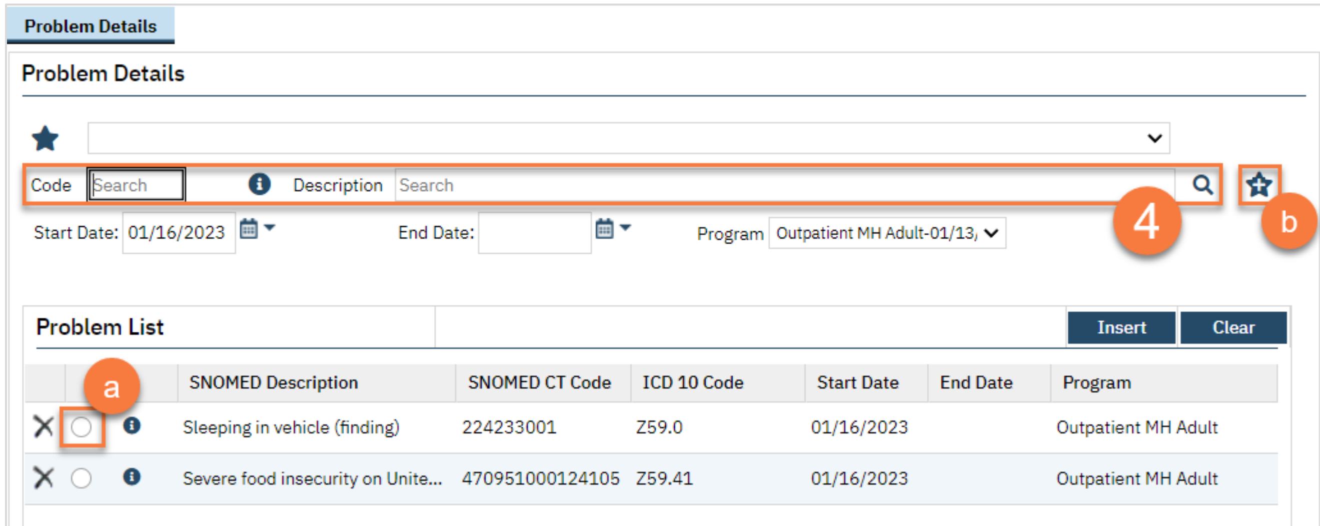
5. When you're finished, **Click Save**.

How to Add Favorites to the Problem List Screen

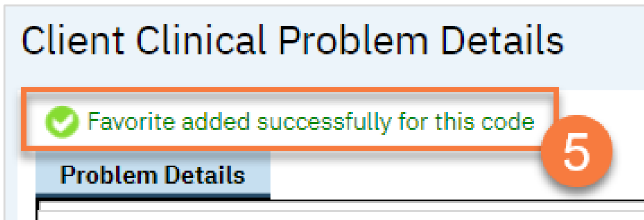
1. You must first have the client open, then **click the Search icon**.
2. **Type Problem** into the search bar.
3. **Click to select Client Clinical Problem Details (Client).**



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**.

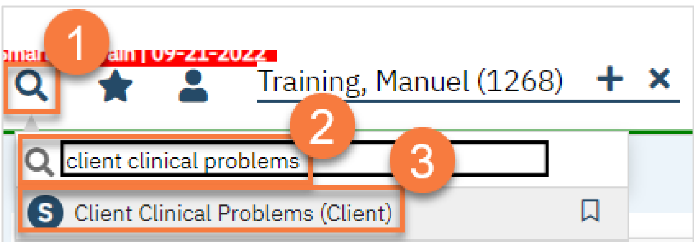


5. You'll see a notification at the top of the screen letting you know it's been added to your favorites.

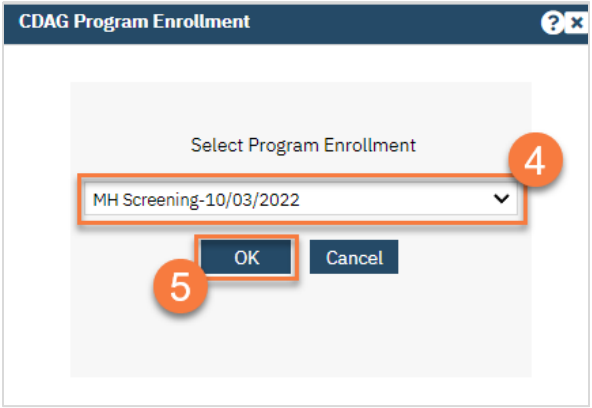


How to Filter/Sort a Client's Problem List

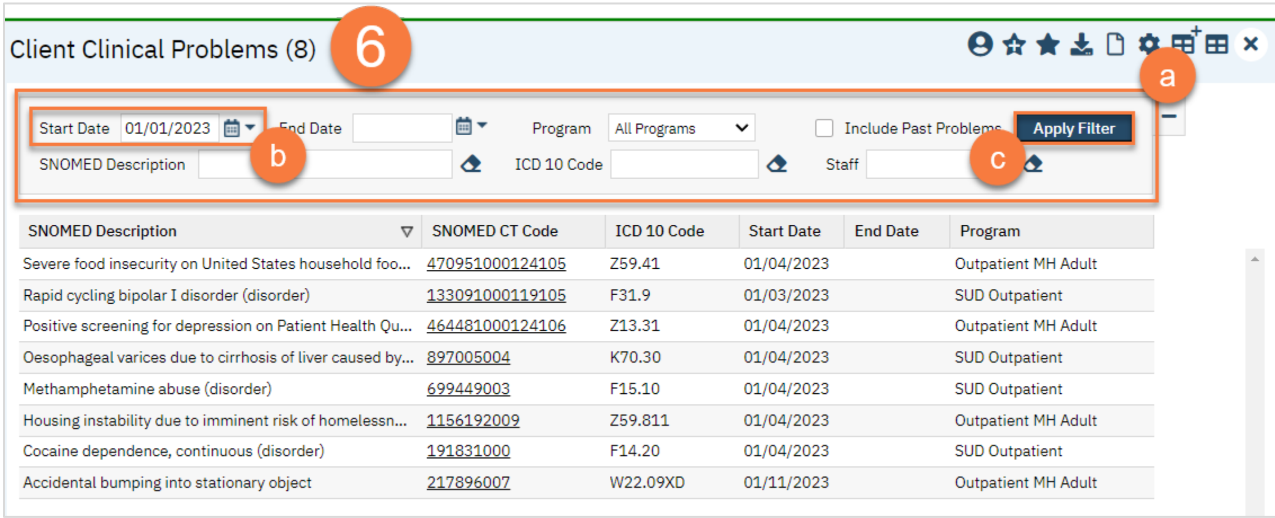
1. You must first have the client open, then **click the Search icon**.
2. **Type Problem** into the search bar.
3. **Click to select Client Clinical Problems (Client).**



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".



SNOMED Description	SNOMED CT Code	ICD 10 Code	Start Date	End Date	Program
Severe food insecurity on United States household foo...	470951000124105	Z59.41	01/04/2023		Outpatient MH Adult
Rapid cycling bipolar I disorder (disorder)	133091000119105	F31.9	01/03/2023		SUD Outpatient
Positive screening for depression on Patient Health Qu...	464481000124106	Z13.31	01/04/2023		Outpatient MH Adult
Oesophageal varices due to cirrhosis of liver caused by...	897005004	K70.30	01/04/2023		SUD Outpatient
Methamphetamine abuse (disorder)	699449003	F15.10	01/04/2023		SUD Outpatient
Housing instability due to imminent risk of homelessn...	1156192009	Z59.811	01/04/2023		Outpatient MH Adult
Cocaine dependence, continuous (disorder)	191831000	F14.20	01/04/2023		SUD Outpatient
Accidental bumping into stationary object	217896007	W22.09XD	01/11/2023		Outpatient MH Adult

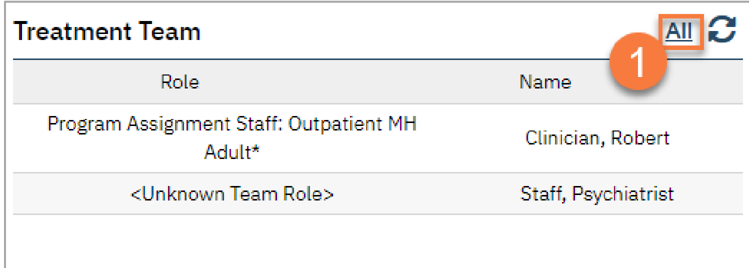
Care Coordination

As part of treatment, clients often are seen in multiple programs. In this section, we'll review how to refer to different programs, refer to external agencies, and request authorization.

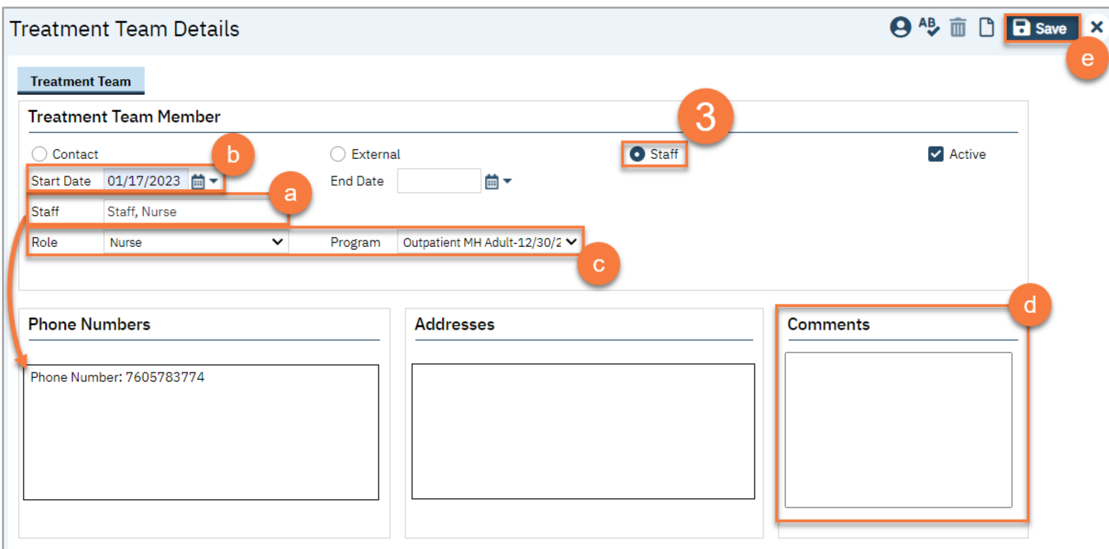
CalMHSA is working on development that will greatly improve care coordination in SmartCare. For now, this section will include information on how these are addressed currently in SmartCare. Some processes may still occur outside of SmartCare, depending on your county's processes.

How to View Who's on the Client's Treatment Team

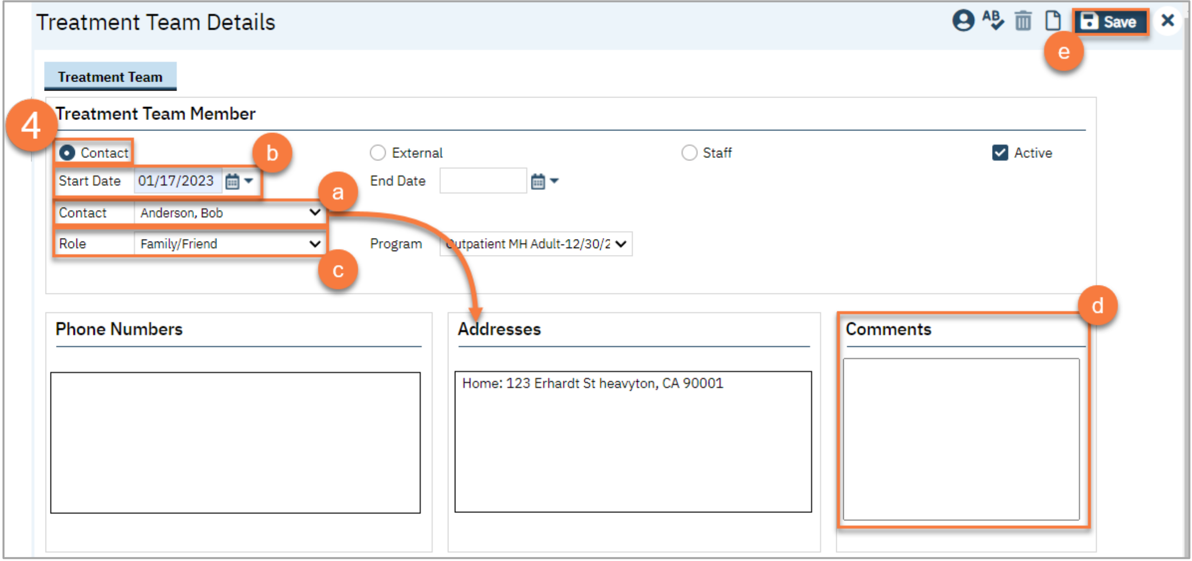
1. Make sure you have the client open. In the Treatment Team widget, click on the All link.



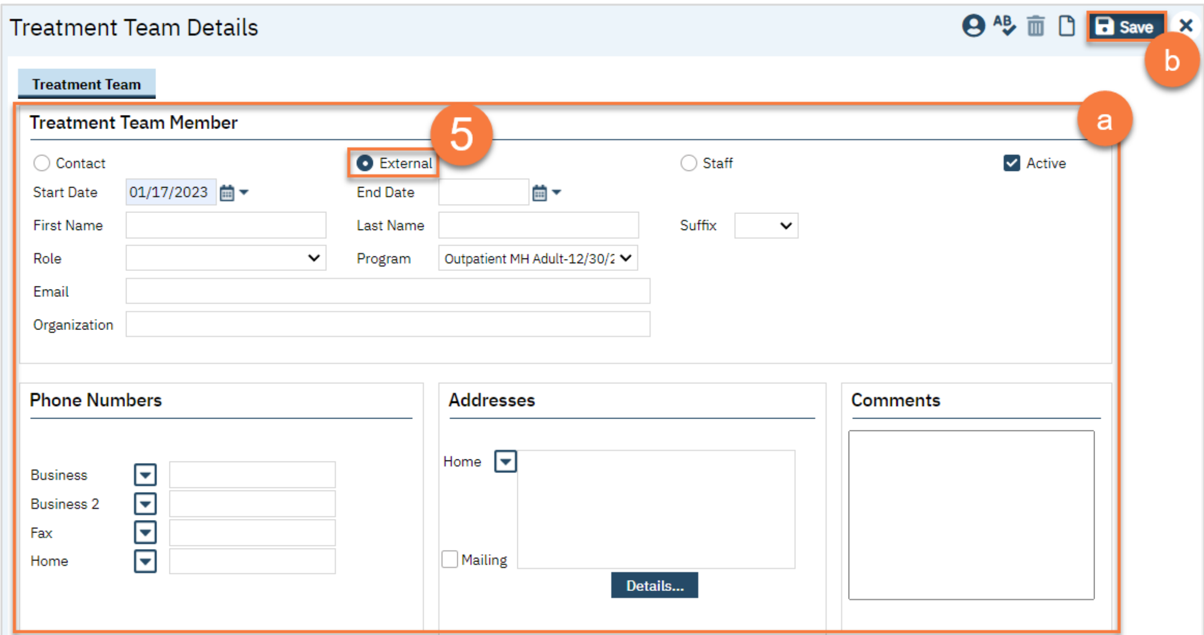
2. This takes you to the Treatment Team list page. To add a treatment team member, **click the New icon**. This takes you to the Treatment Team Details screen. Select what type of contact person this is.
3. **If the person you're adding is a SmartCare user, select Staff**.
    a. Enter the staff's name 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.



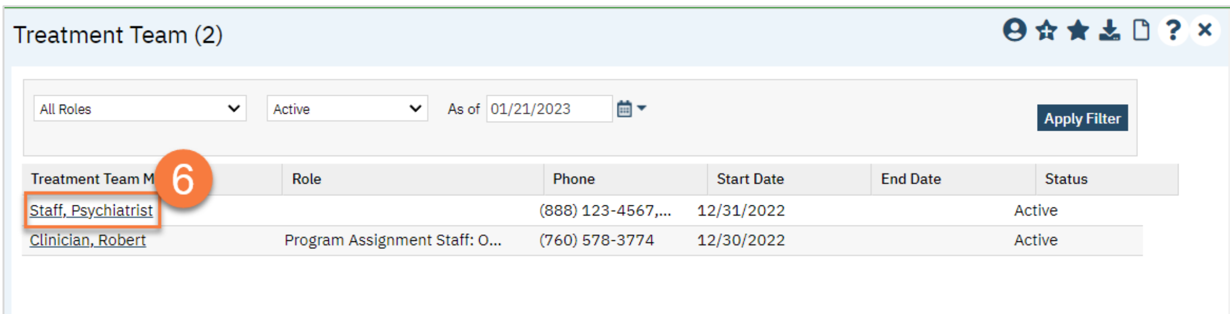
4. **If the person you're adding is a contact person that's already in the Client Information screen, select Contact.**
    a. Select the contact person from the dropdown list. This will pull forward any information, such as phone number or address that has been entered for them in the Client Information 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.



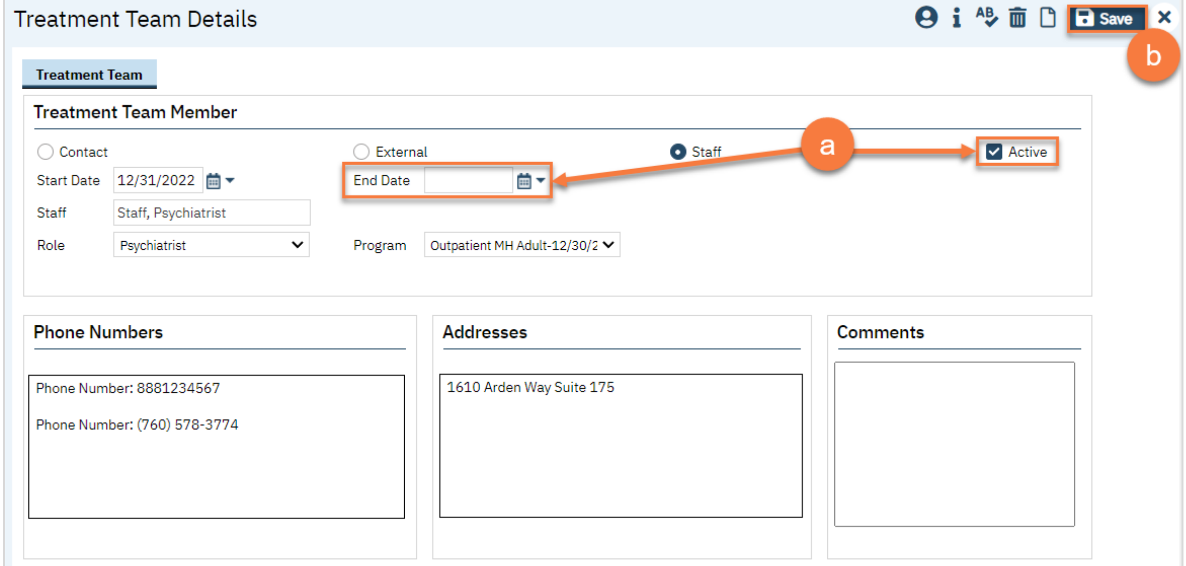
5. **If the person you're adding is an external resource, that has not yet been added to the Client Information screen, select External.**
    a. Enter the information, including name, role, start date, organization, and contact information.
    b. Click Save.



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 to Document Treatment Team Meetings

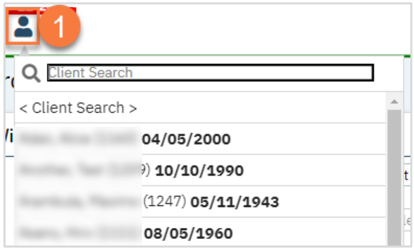
Currently, each treatment team member that plans to bill for their time spent discussing the client with other treatment team members must create their own service note. Currently, SmartCare does not have a method of creating multiple billing claims for a single treatment team note, but CalMHSA is looking into this functionality.

How to Refer to an Additional Program

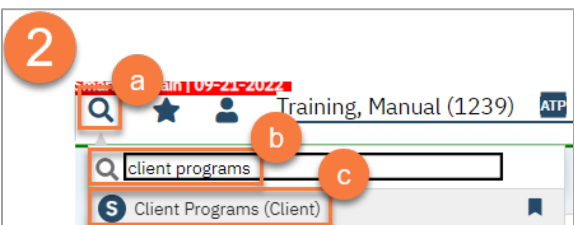
Depending on your county processes, you may have a specific referral form you use. CalMHSA is currently developing a process called "Care Coordination" which will address referrals both internal and external. However, this process is still in development. We recommend using your current forms for referring to additional programs and services if applicable.

We also recommend using the "Request Program Enrollment" process in SmartCare to track these requests.

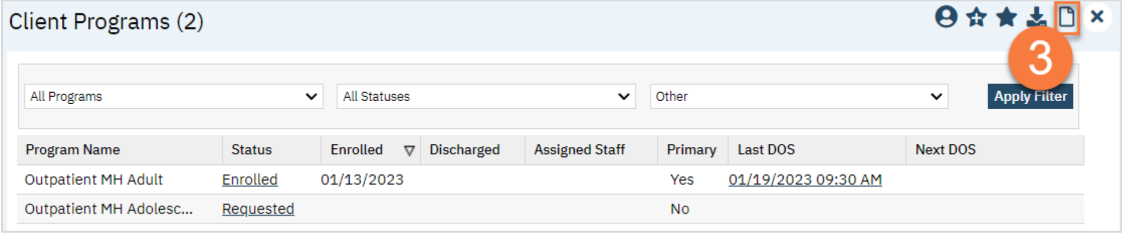
1. **Open the client's record**, if not already done so. You can do this using the Client Search screen.



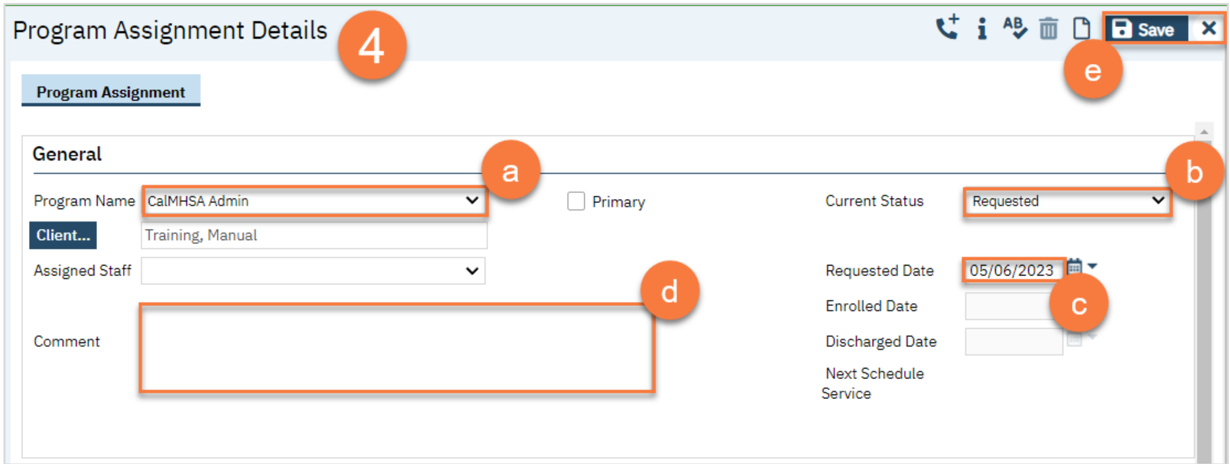
2. **Open the Client Programs list page**.
    a. **Click the Search icon**.
    b. **Type "Client Program"** in the search bar.
    c. **Select "Client Programs (Client)"** from the search results.



3. This opens the Client Programs list page. **Click on the New icon**.



4. Complete the Client Program Details screen.
    f. **Select the program** from the dropdown menu.
    g. **Enter the status of the program as "requested".**
    h. **Enter the requested date.** This will be today's date.
    i. **Enter any comments related to this program request**.
    j. **Click Save and close.**



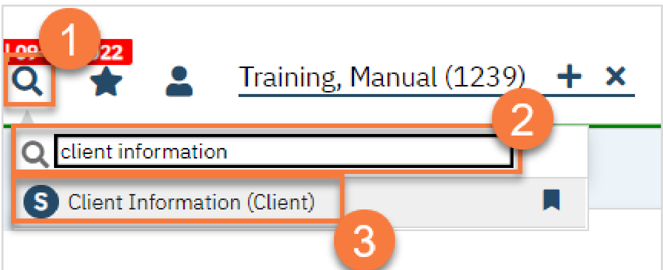
How to Request Authorization for Services

This will be handled using the Care Coordination module, which is still in development. Please use your current county processes and forms until this is completed.

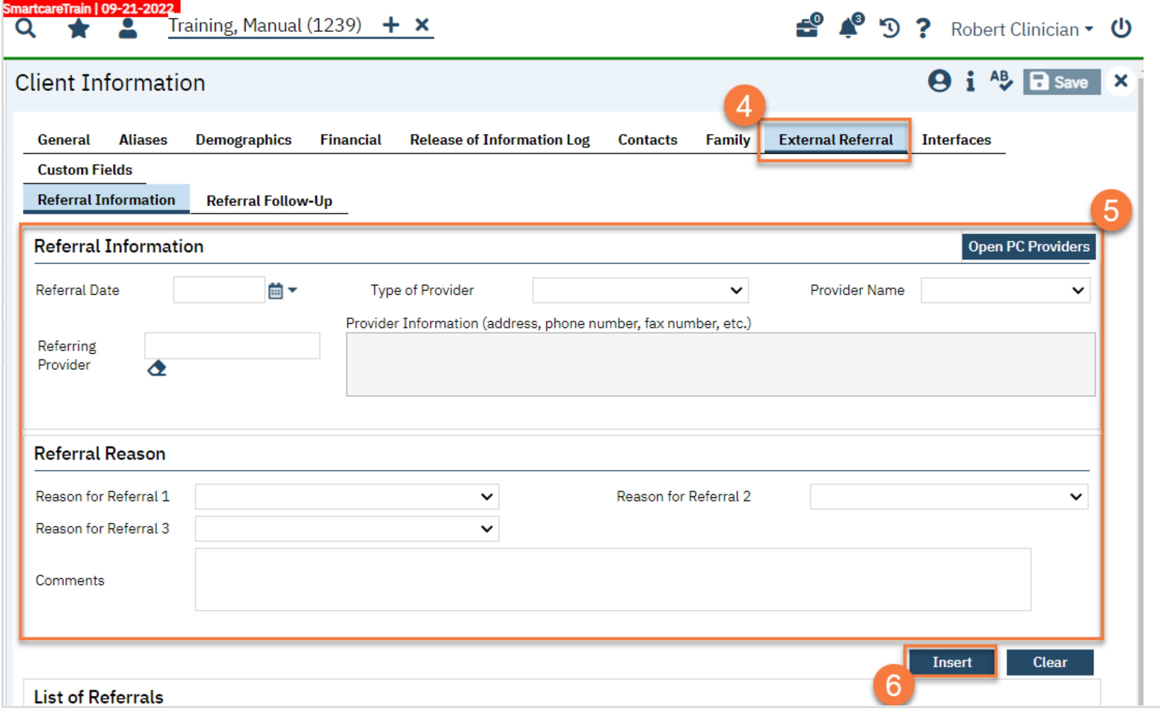
How to Refer the Client to Additional Services, Such a Primary Care Physician

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.

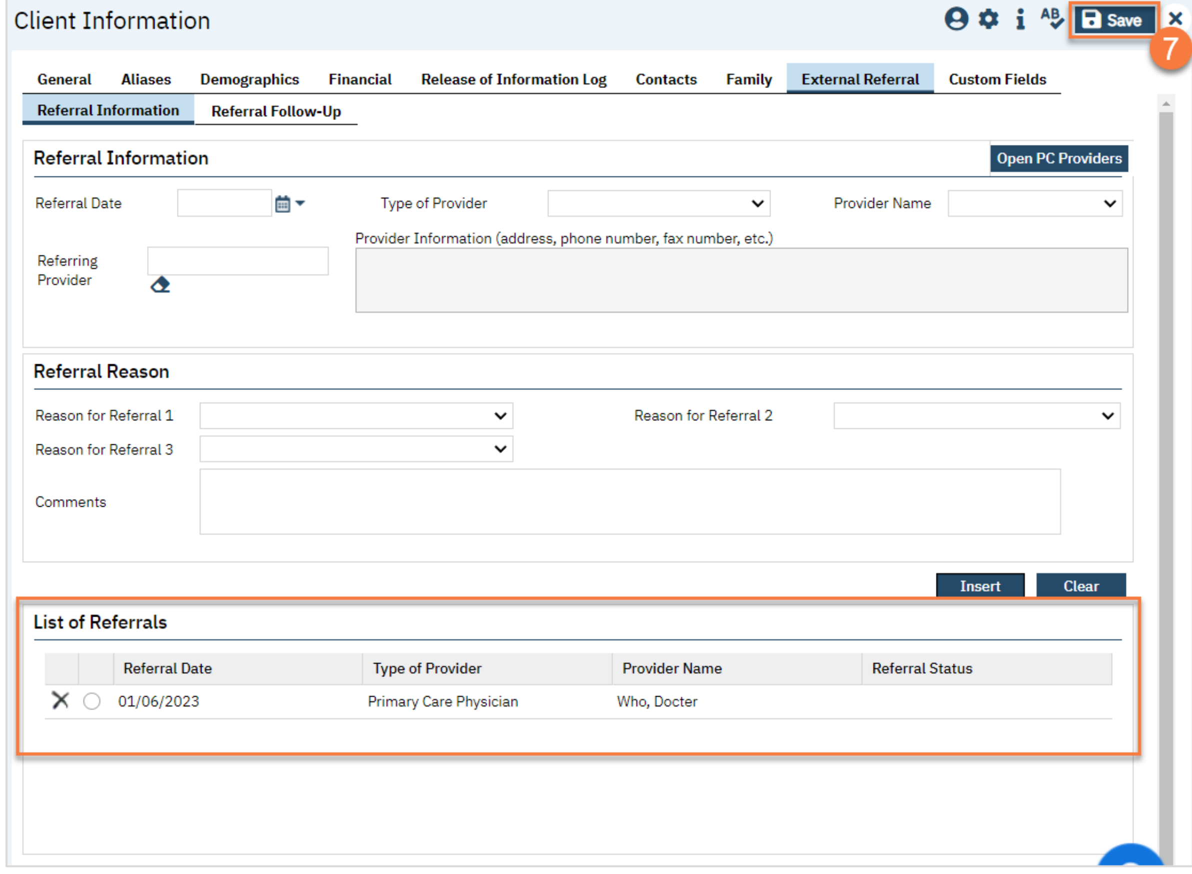
1. To document the referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**



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"**.

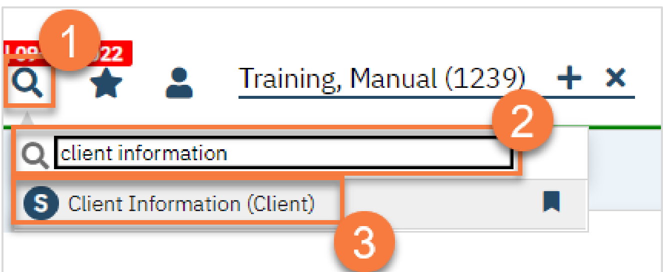


7. Your referral should now show in the List of Referrals section. **Click Save**.

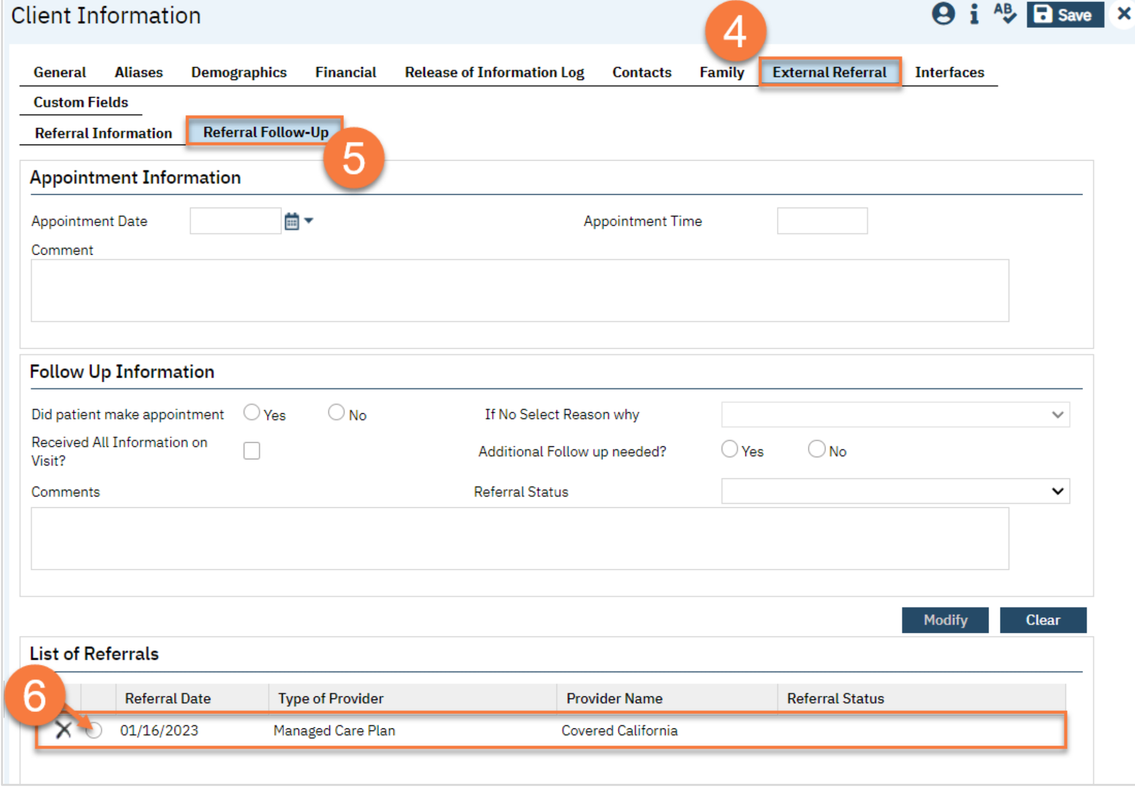


How to Document Follow-up Done on an External Referral

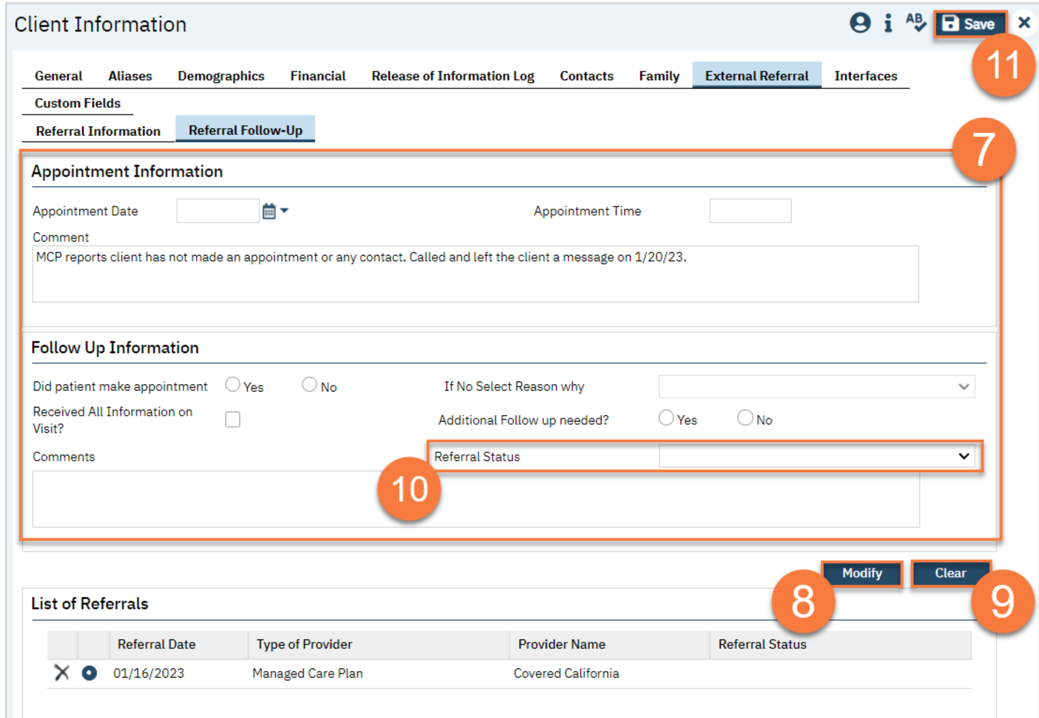
1. To document follow-up on an external referral in SmartCare, you must first have the client open, then **click the Search icon**.
2. **Type Client Information** into the search bar.
3. **Click to select Client Information (Client).**

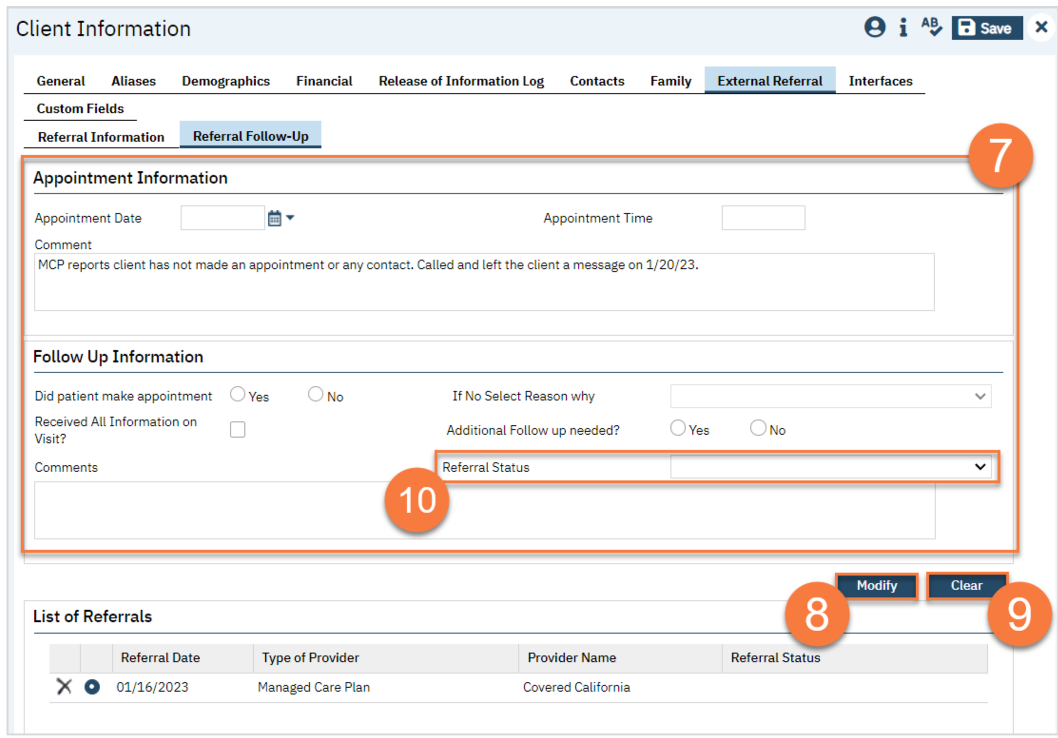


4. **Navigate to the "External Referral" tab.**
5. **Click on the Referral Follow-Up tab.**
6. **Select the referral you want to follow up on from the List of Referrals.**



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**.

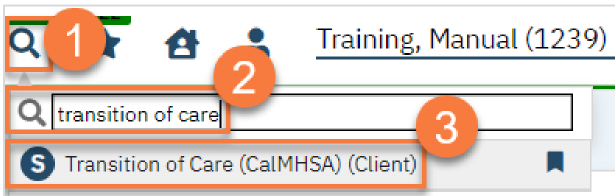




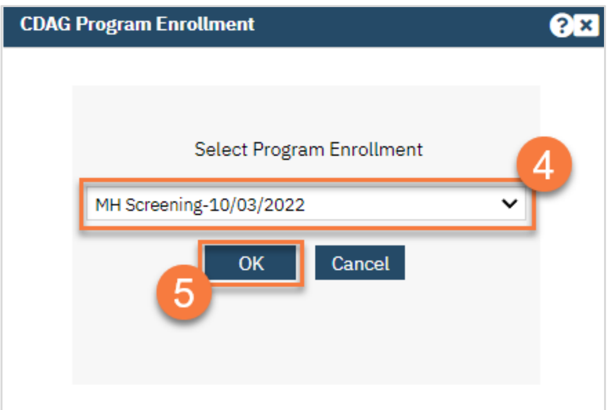
How to Transfer the Client to the MCP

When a client has been receiving Specialty Mental Health Services but needs to step down to a lower level of care provided by the Managed Care Plans, you must complete the Transition of Care Tool.

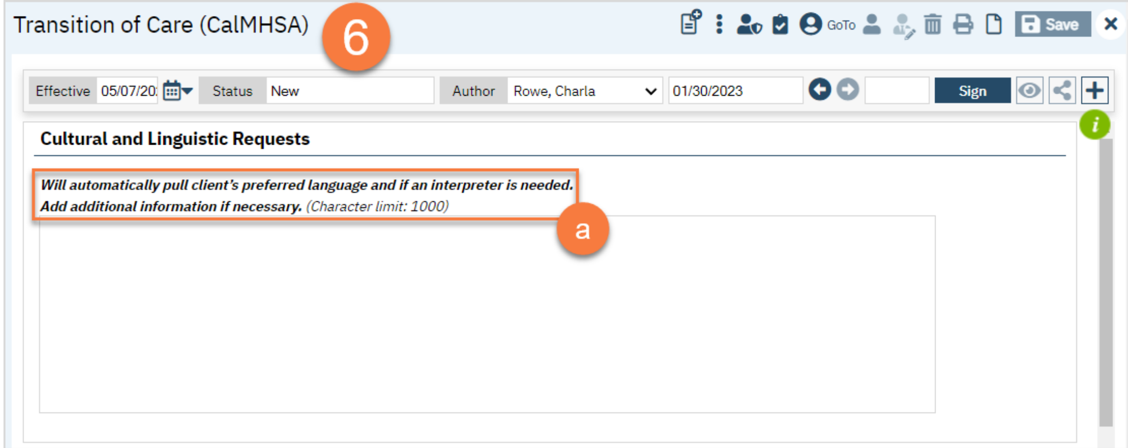
1. **Click the Search icon.**
2. **Type in "Transition of Care"** in the search bar.
3. **Select "Transition of Care (CalMHSA) (Client)"** from the search results.



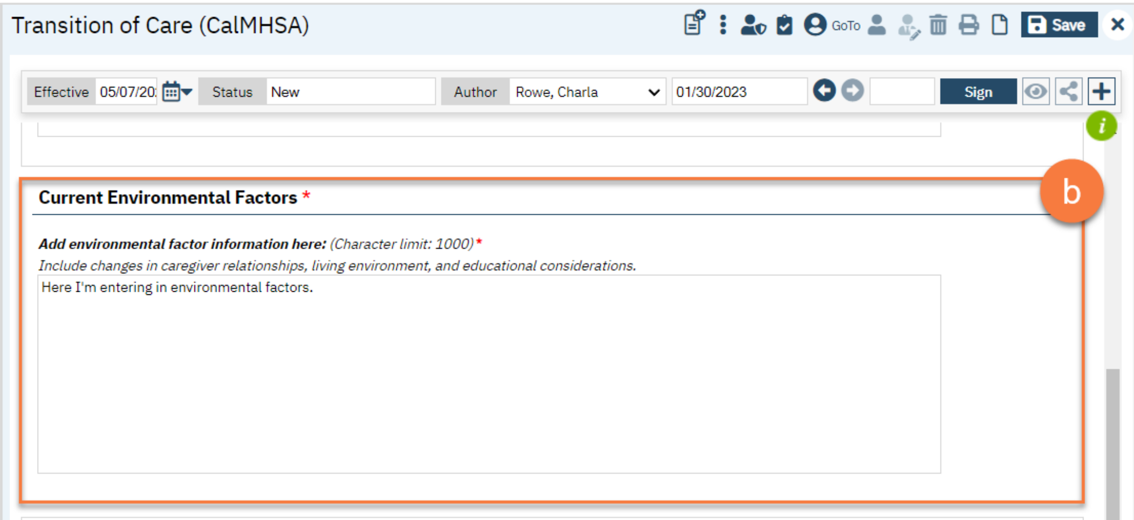
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



6. This brings you to the Transition of Care document. **Complete the document.**
   a. This document was created to match the DHCS required document when printed. However, the data entry screen only presents fields for information that you need to complete, or fields that you may want to add additional information to. For the rest of the fields, this document will automatically pull in information from the client's record, as well as attaching certain documents.



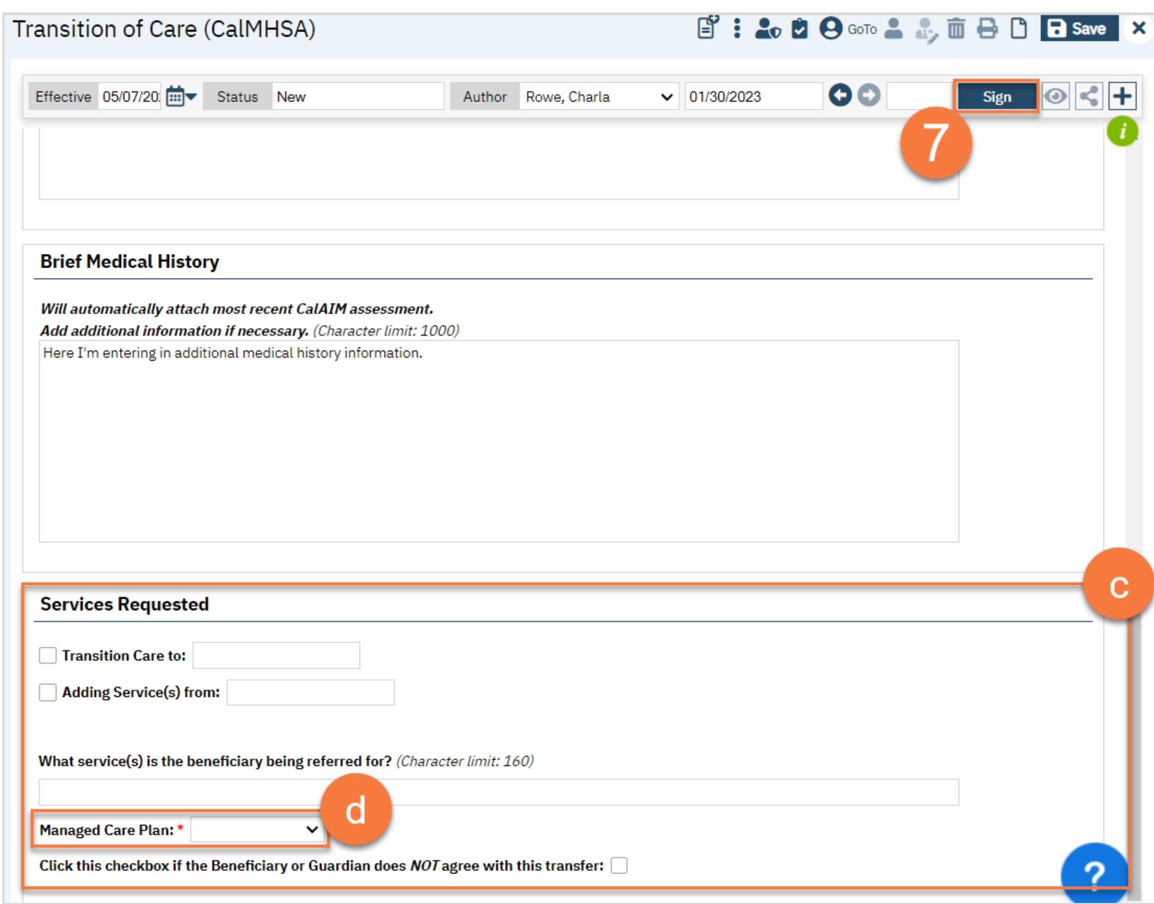
b. Some fields aren't pulling in any information from the client's record and are required. These are denoted by a red asterisk (*).



c. Make sure to complete the bottom section about the transfer itself. These fields are straight from the DHCS document.

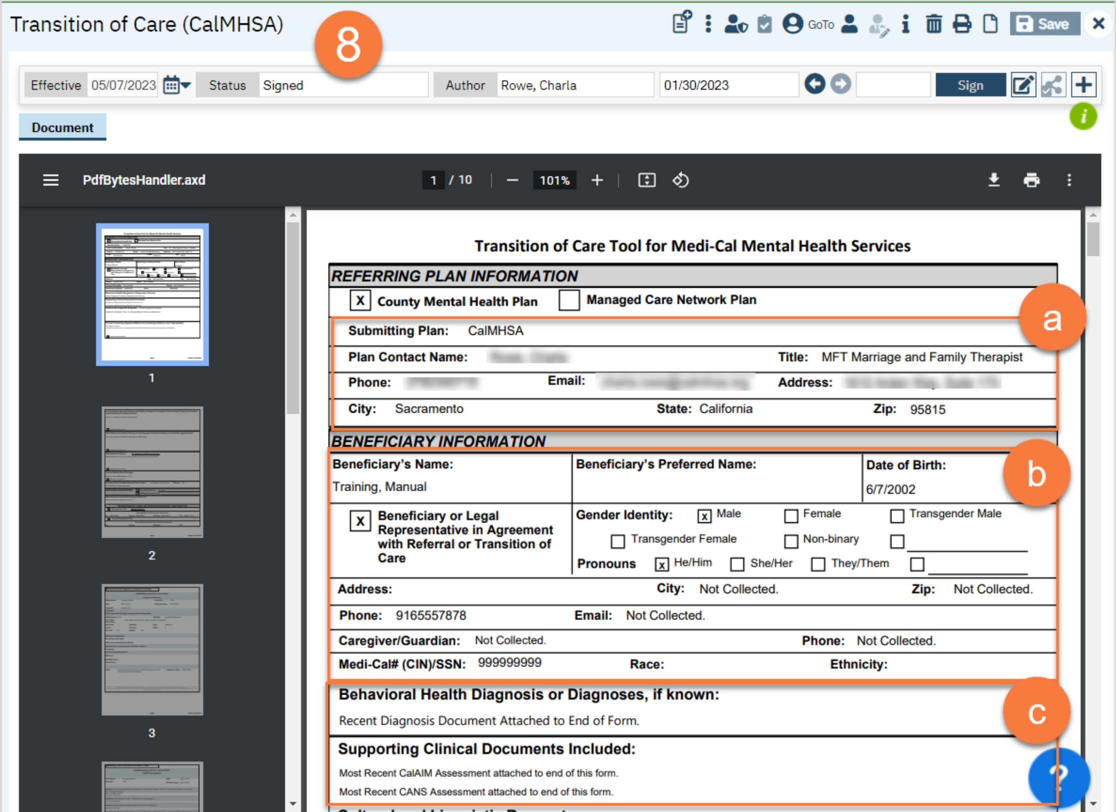
d. Select the client's MCP from the dropdown. Your System Administrator maintains this list. If there is an MCP that's missing, talk to your System Administrator to update the list.

7. When you're finished, **click Sign** to complete and generate the document.



8. The finished document will look like the DHCS document and include all attachments.

a. The author's information will be pulled in for the referring information section.
b. The client's information will be pulled in for the Beneficiary Information section.
c. The form will also denote that certain documents are attached to provide the requested information.



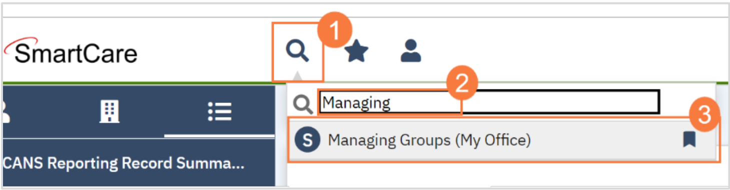
d. The following documents are attached if the client has them on file. All documents will be from the program the Transition of Care Tool is associated with (the program you selected in step 5) unless otherwise specified.
    i. Most recent Diagnosis Document
    ii. Most recent CalAIM Assessment
    iii. Most recent CANS
    iv. Current problem list (Client Clinical Problems) (all programs in the MH CDAG)
    v. Current medication list from Rx module (not tied to any program)
    vi. Current treatment team list (all programs in the MH CDAG)

Group Documentation

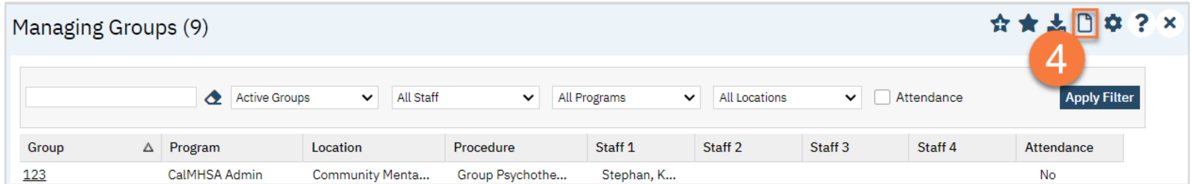
Although services are covered above, there are unique attributes to services provided in a group format. We'll cover all group-related documentation in this section.

How to Set Up a Group

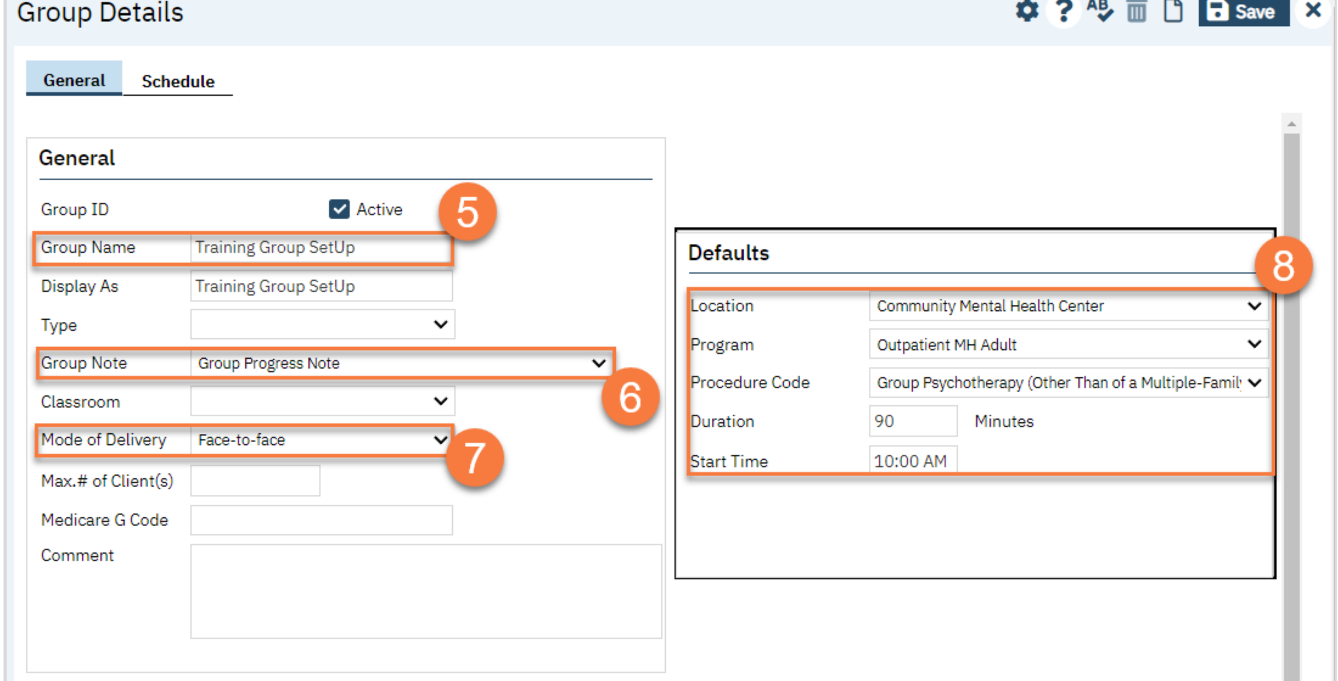
1. **Click the Search icon**.
2. **Type Managing** into the search bar.
3. **Click to select Managing Groups (My Office)**.



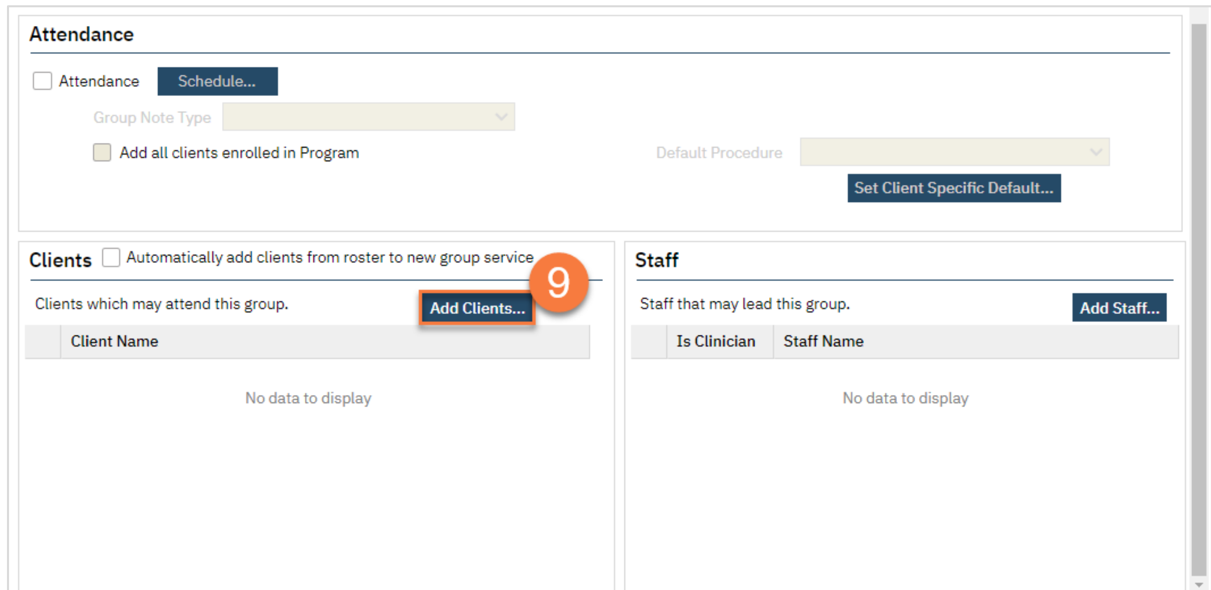
4. This takes you to the Managing Groups list page. **Click the New icon**.



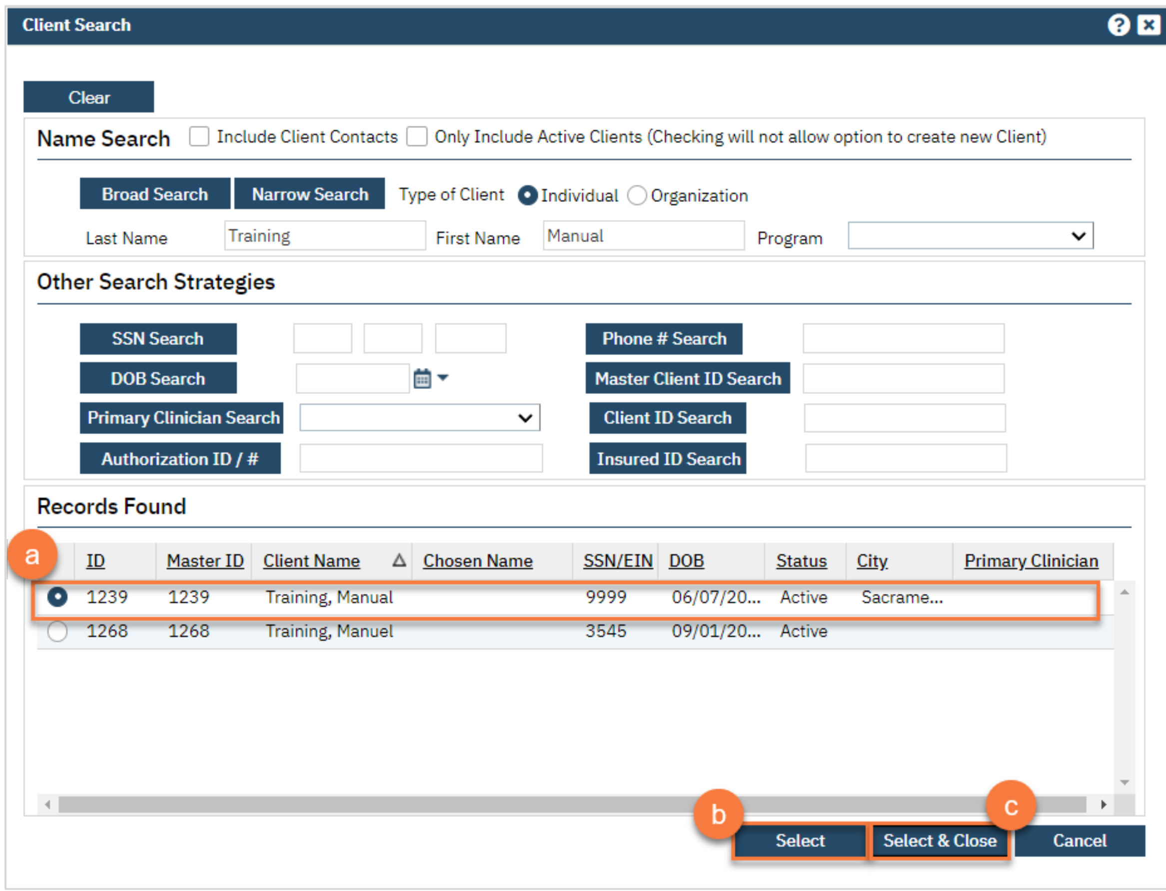
5. This takes you to the Group Details screen. **Enter the group's name.** This will auto-populate the "Display As" field, which you can change if necessary.
6. **In the Group Note drop-down, select "Group Progress Note"**.
7. **Enter the mode of delivery**.
8. **Enter the service information about the group in the Defaults section.**



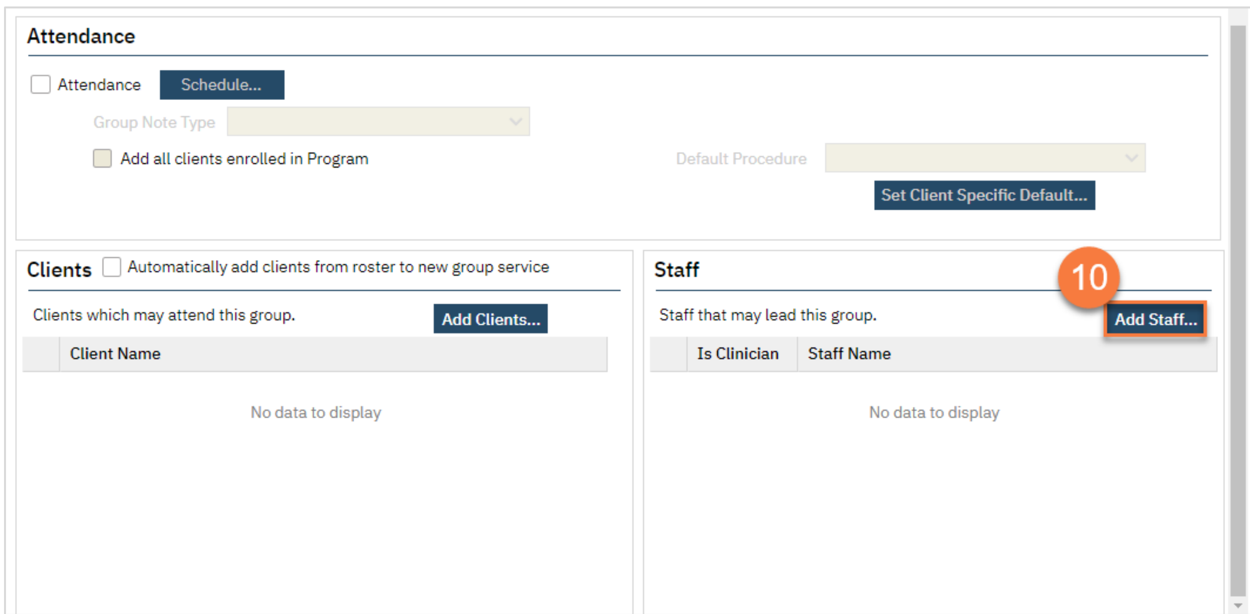
9. Add Clients, as applicable. For some groups that are drop-in, you may not have any clients to include. If this is a closed group, or an ongoing group, we recommend adding the clients here. **Click Add Clients**.



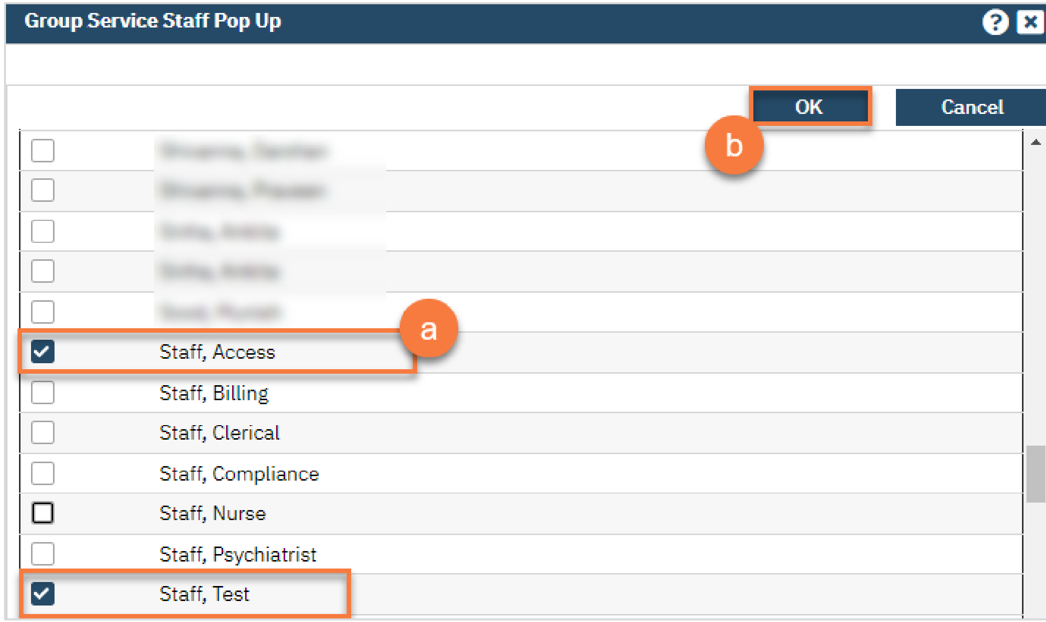
a. This brings up the client search pop-up. Search for the client you want to add to the group. **Select the client from the Records Found section**.
b. **Click "Select."**
c. When you've finished adding all clients, you can **click "Select & Close"**.



10. Add the group facilitators. You can have more than one facilitator. **Click Add Staff.**



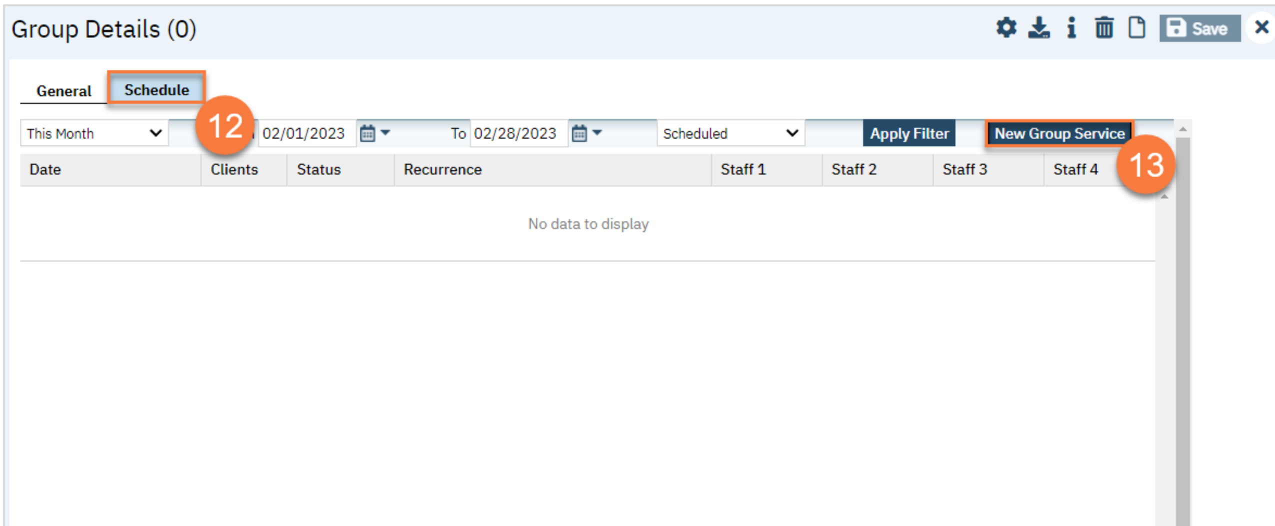
   a. This brings up the Group Services Staff Pop Up. **Select the facilitator(s) from the list**.
   b. **Click OK**.



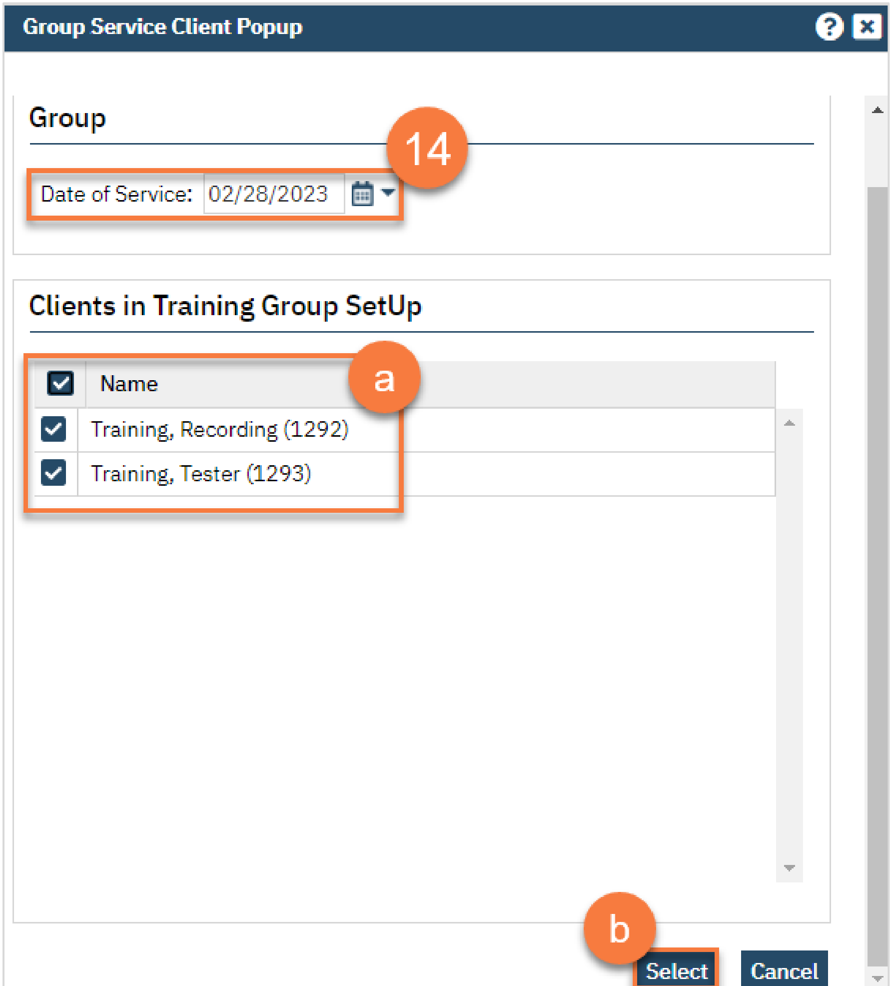
   c. This takes you back to the Group Details page. **Select the primary staff member** by selecting them under "Is Clinician".

11. **Click Save**.

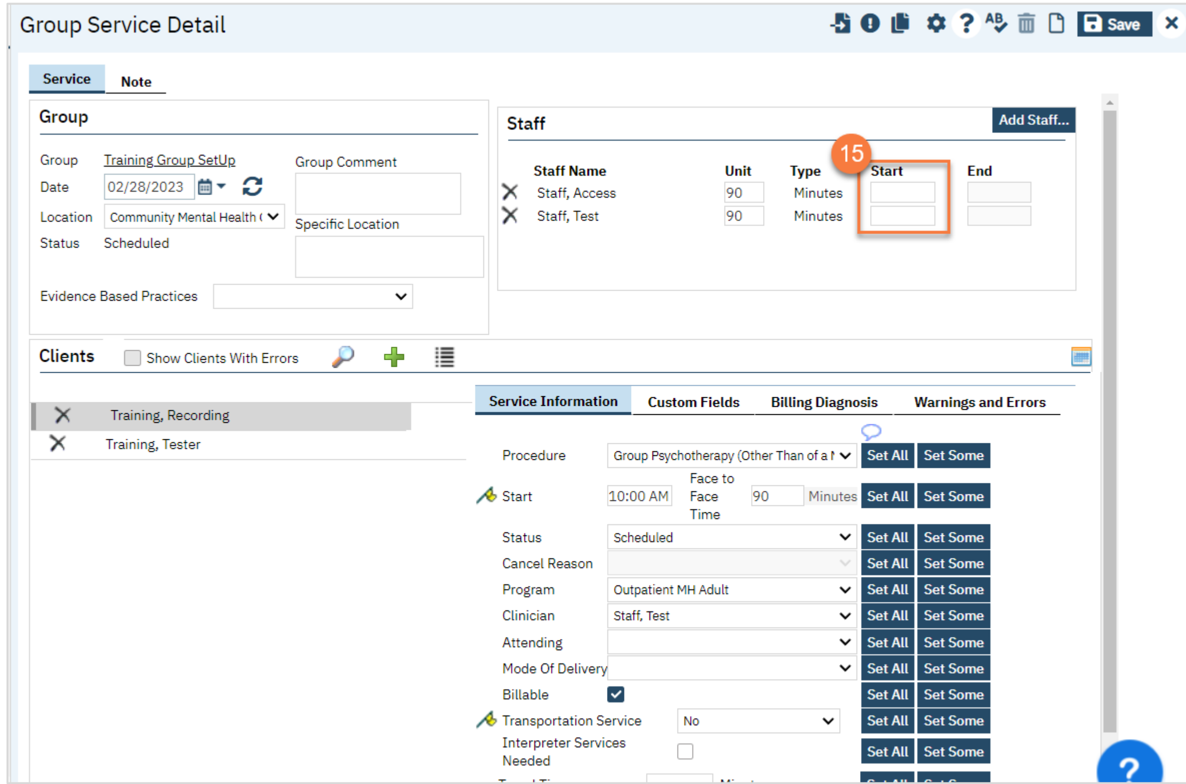
12. Navigate to the Schedule tab.
13. Click "New Group Service"



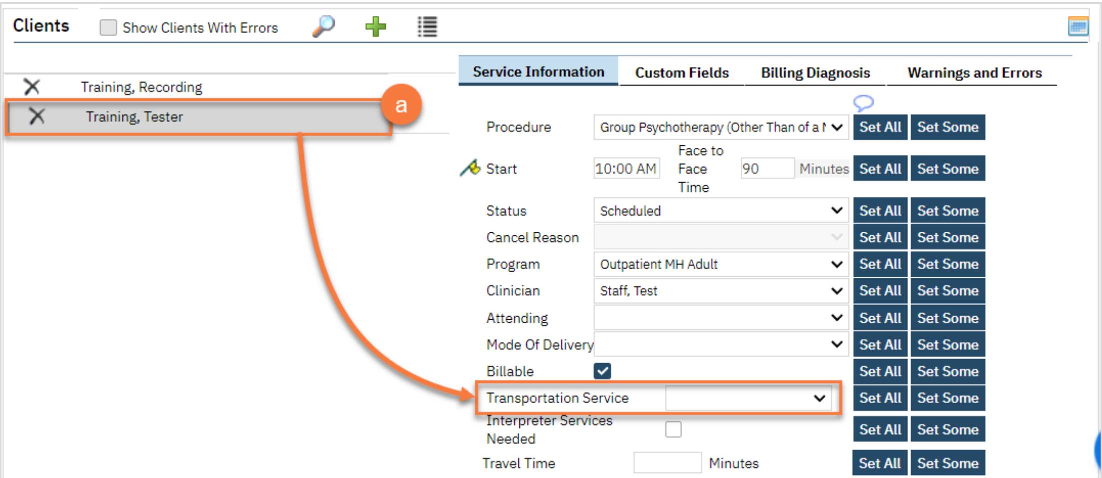
14. This brings up the Group Service Client Popup window. Enter the first date of the group.
    a. Select the clients you're expecting to attend. You can click the top-most checkbox to select all the clients.
    b. Click "Select."



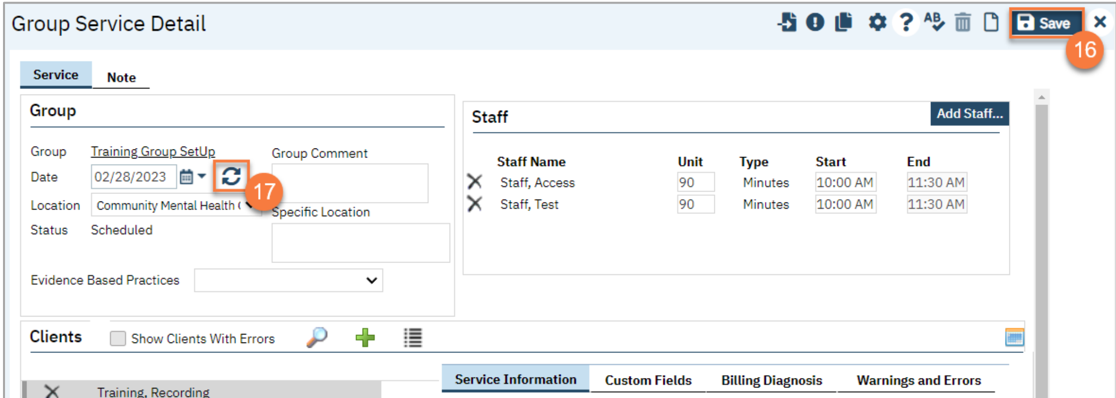
15. This takes you to the Group Service Detail screen. **Confirm the group information**. **Enter the staff's start time for both facilitators**.



   a. **If any of the clients require transportation**, make sure to enter that by clicking on the client's name and entering their specific information in the service information section.



16. **Click Save**.
17. To set this up as a recurring group service, **click the recurrence icon**.

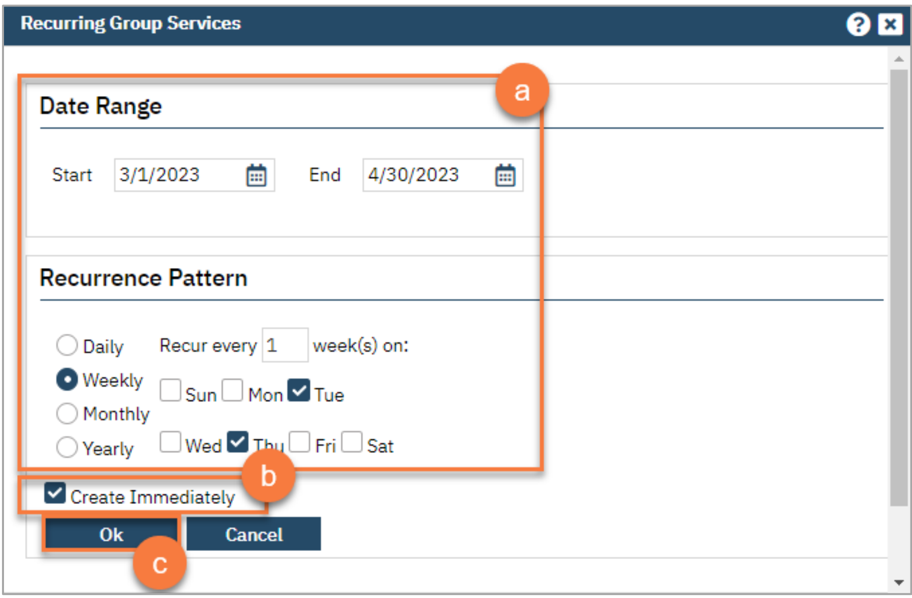


a. This brings up the Recurring Group Services pop up window. **Enter your recurrence information**.
b. **Click to select the "Create Immediately"** checkbox if it applies.

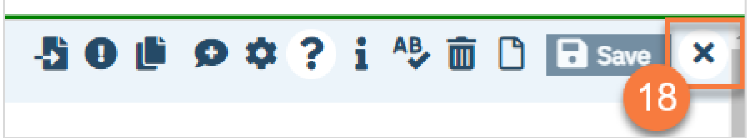
Important Note: If this is a closed group where group facilitators and group members will not often change then we recommend that you select the "Create Immediately" checkbox. This will create the specified series of events on the staff calendar. Keep in mind that by doing this any changes that need to be made to this series would need to be made individually and will not be pushed to the group recurrence.

If you anticipate this to be an open group and there to be many group member changes and/or staff member changes then you would want to leave this option unchecked. That way when you make changes they will be pushed to future events. In this case, a place holder will be on the staff calendar instead of the actual event.

c. **Click OK**.



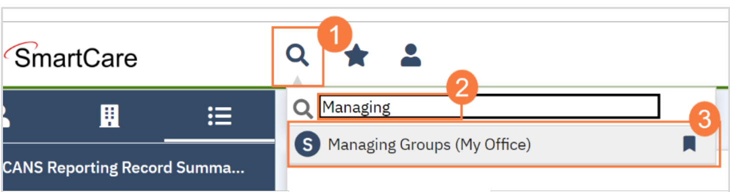
18. You are finished and may now click the X icon to close.



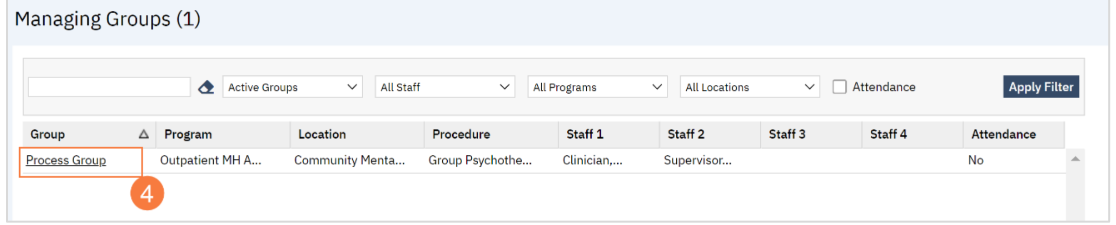
How to Add a New Client to a Group

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

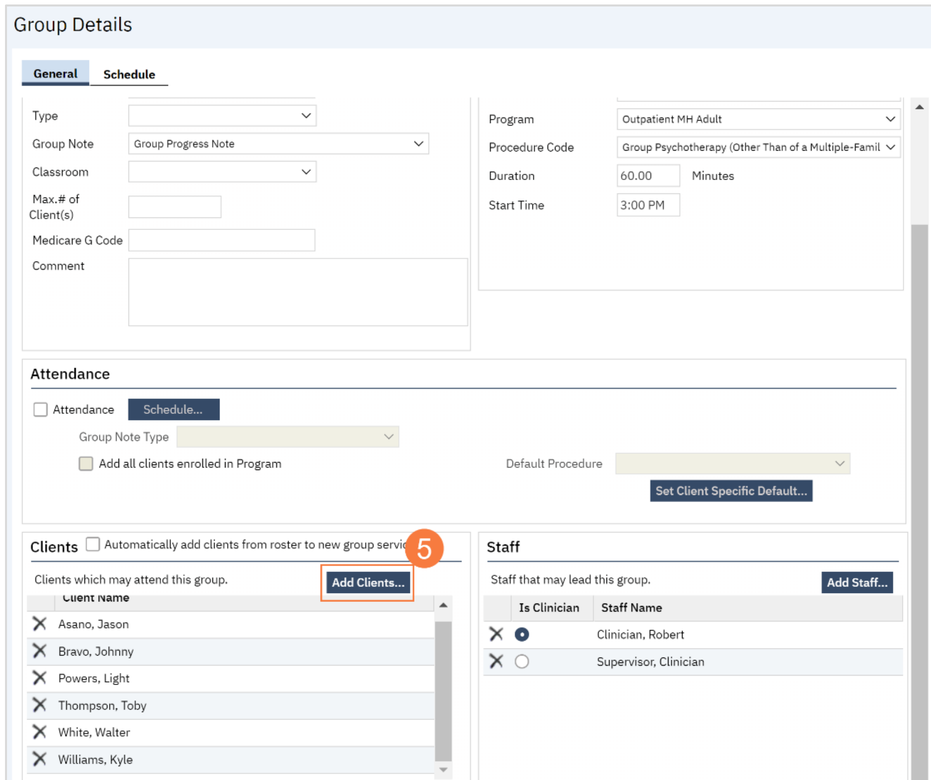
1. **Click the Search icon**.
2. **Type Managing** into the search bar.
3. **Click to select Managing Groups (My Office).**



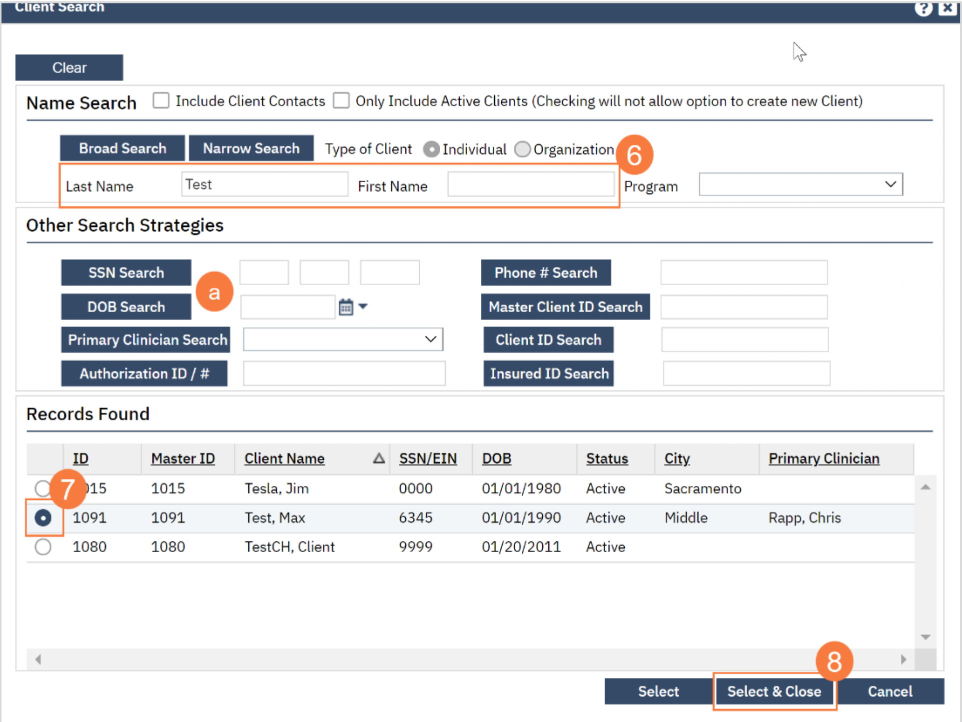
4. **Click to select the Process Group** you will be adding the client to.



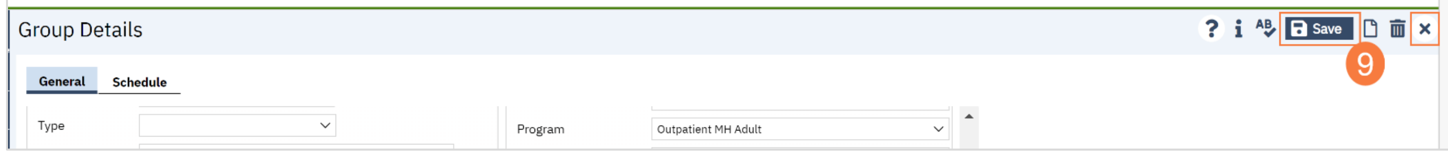
5. Locate the Client section towards the bottom of the Group Details screen. **Click Add Clients**.



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.



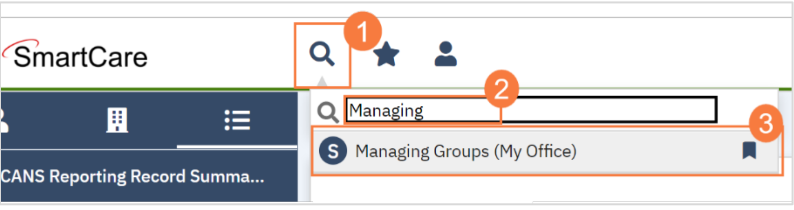
9. **Click Save. Click the X** to close the screen.



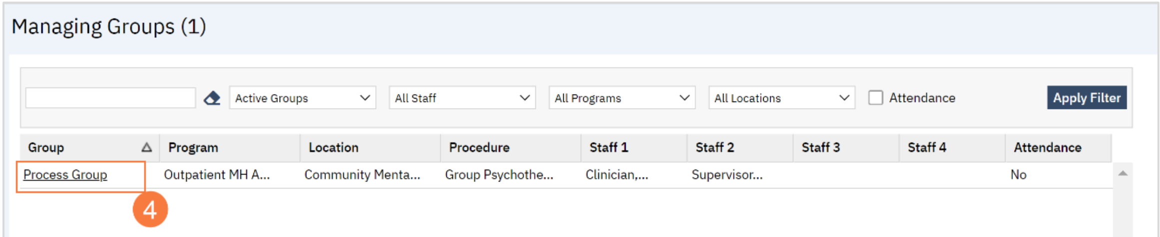
How to Add or Change a Staff Member in a Group

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

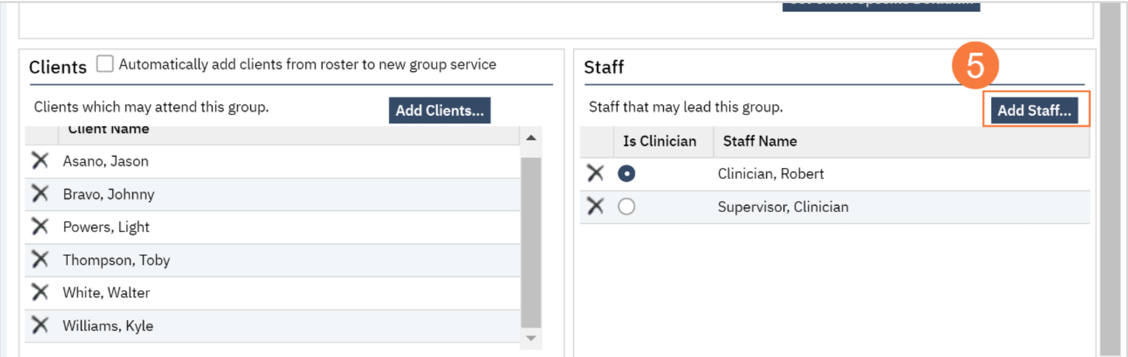
1. **Click the Search icon**.
2. **Type Managing** into the search bar.
3. **Click to select Managing Groups (My Office).**



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

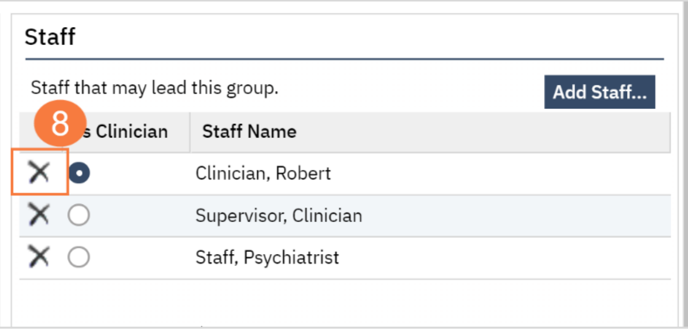


5. Locate the Staff section towards the bottom of the Group Details screen. **Click Add Staff.**



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

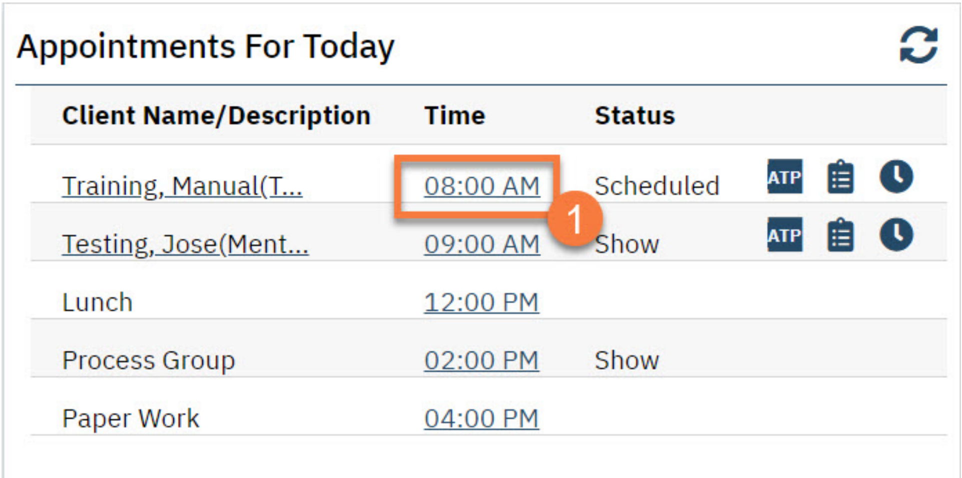
8. And/or, if you need to remove a staff member, **click the X** to the left of the staff member you want to remove.



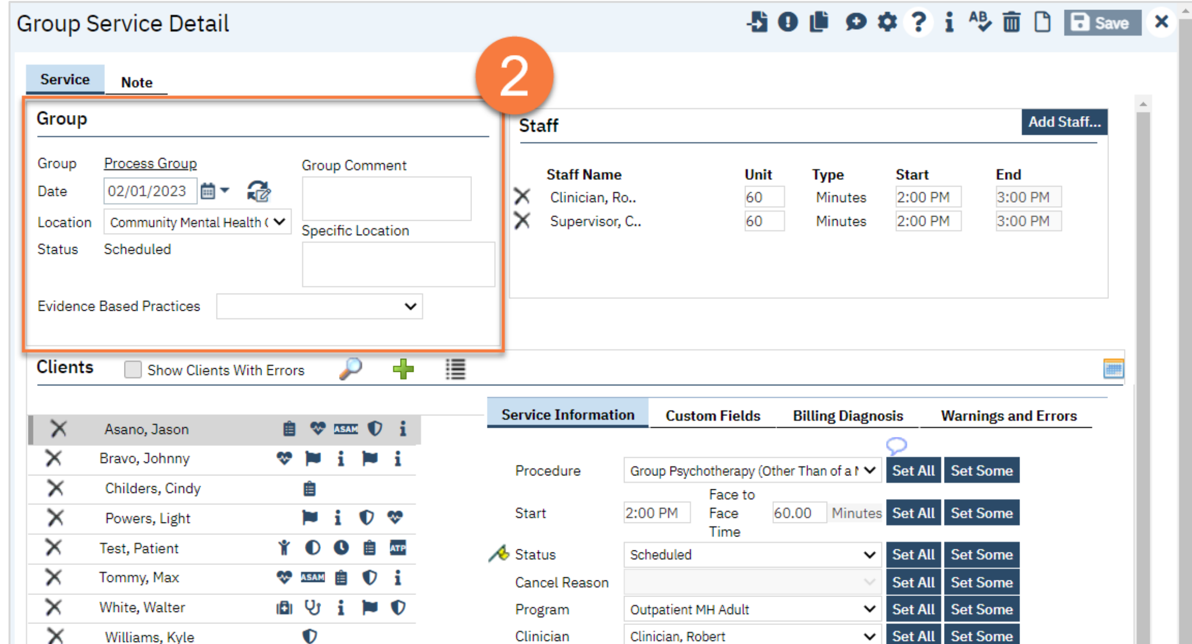
9. **Click Save. Click the X** to close the screen.

How to Write a Group Progress Note:

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

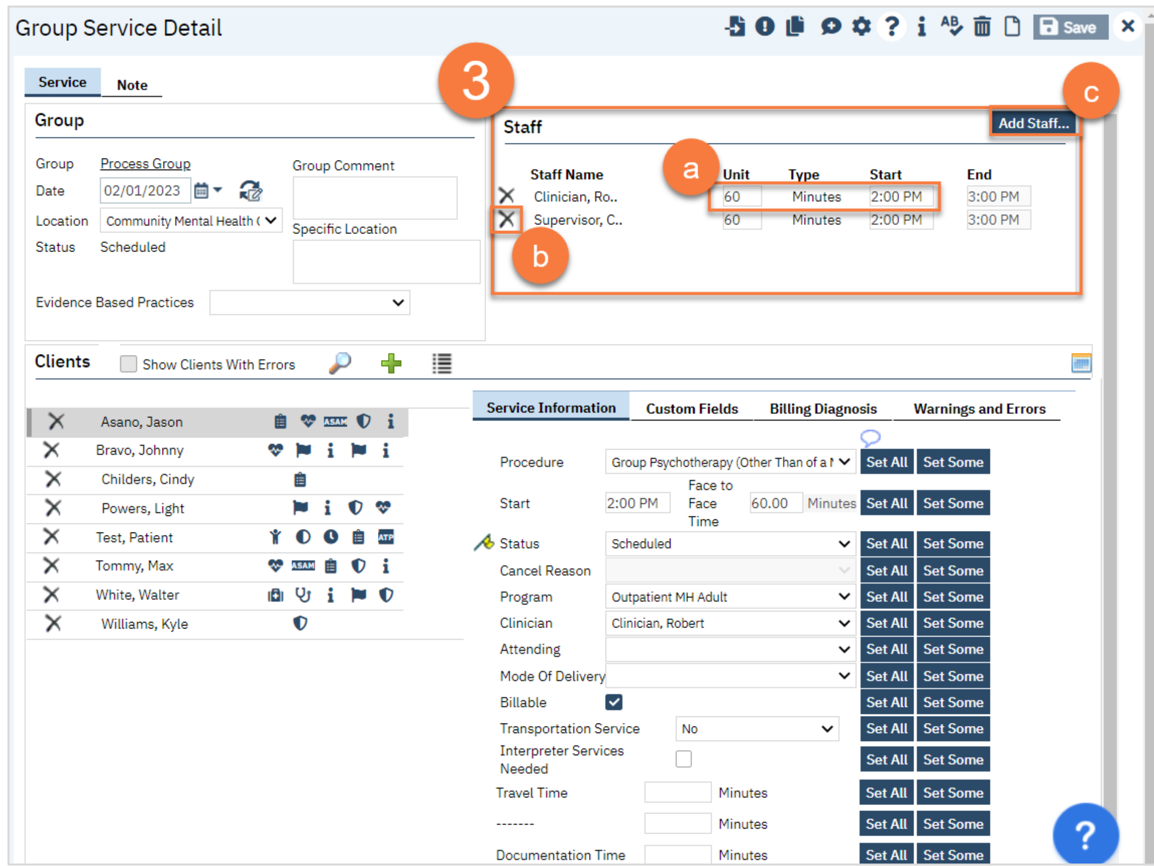


2. This opens the Group Services Detail screen. In the upper left, you'll see the group information. Confirm the information and **add any additional information regarding the entire group**.

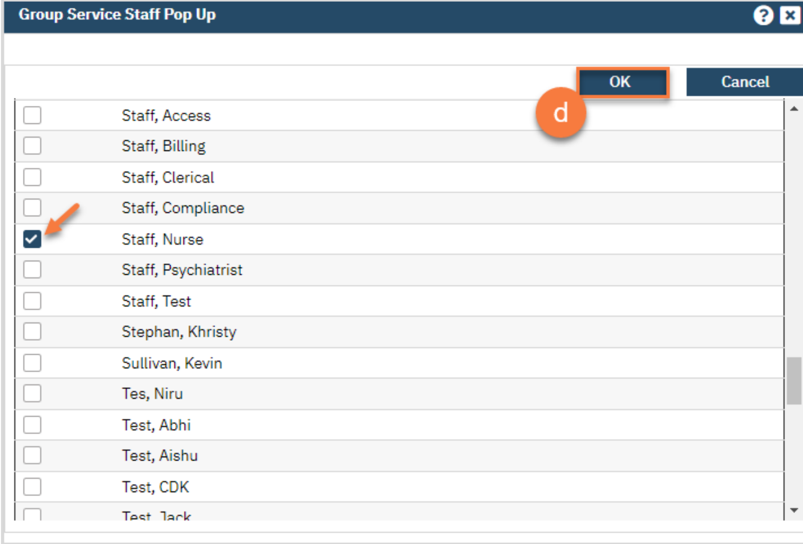


3. In the upper right, you'll see the staff members that are set as facilitators for this group.
   a. **Make edits to which staff members were present**. For example, if a staff was only present for half of the group time, indicate this by editing the Unit (how many minutes they were present) and the Start Time to match what actually happened.

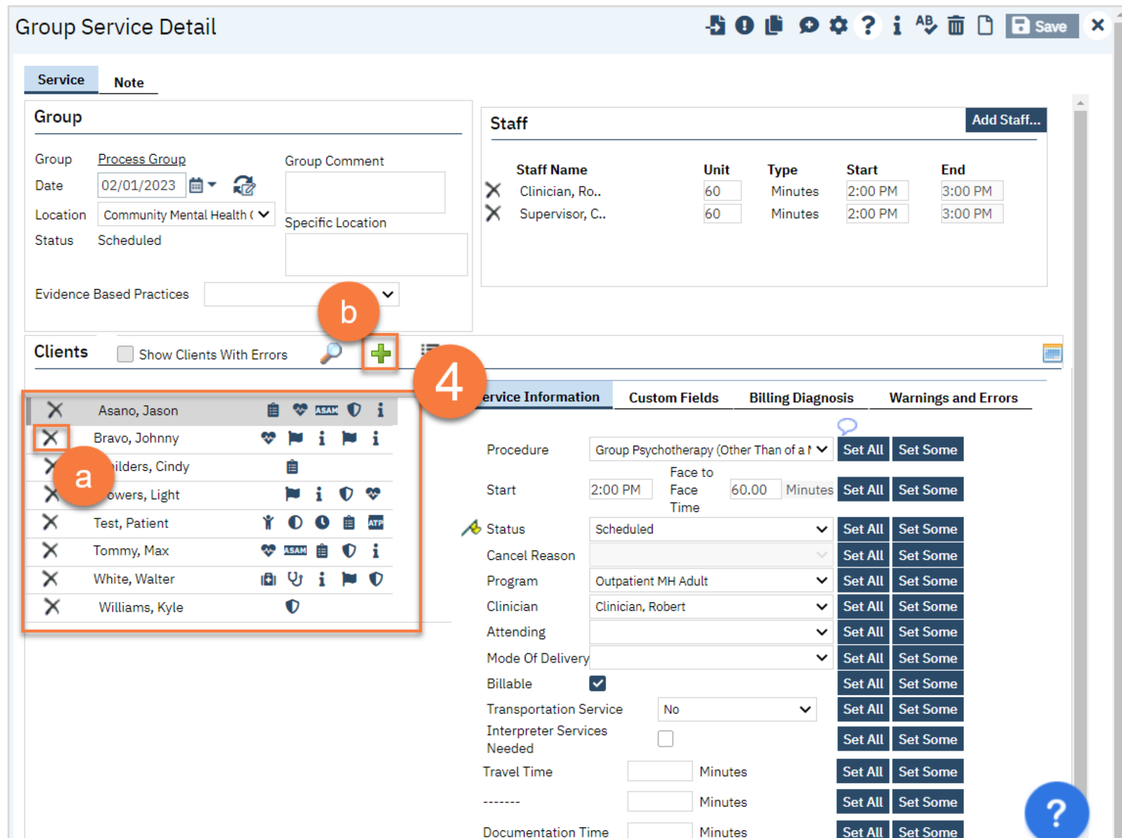
b. **If a staff member was not present, click the Delete icon** next to their name to remove them from this service.
c. **If an additional staff member was present who is not listed, click the Add Staff button**.



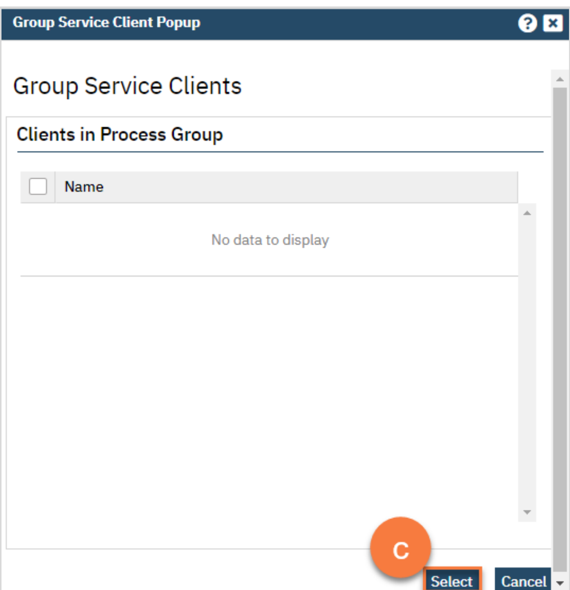
d. This brings up the Group Service Staff Pop Up. **Select the staff member(s) you want to add and click OK**.



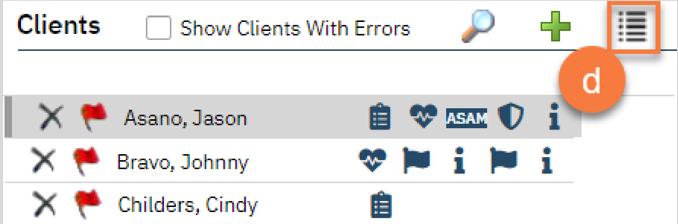
4. On the middle left side of the screen, you'll see the list of clients enrolled in this group. **Make edits to this list to confirm the group roster**.
    a. **To remove a client from the roster, click the Delete Service icon**. DO NOT do this if they are simply a no-show. Only do this to remove them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



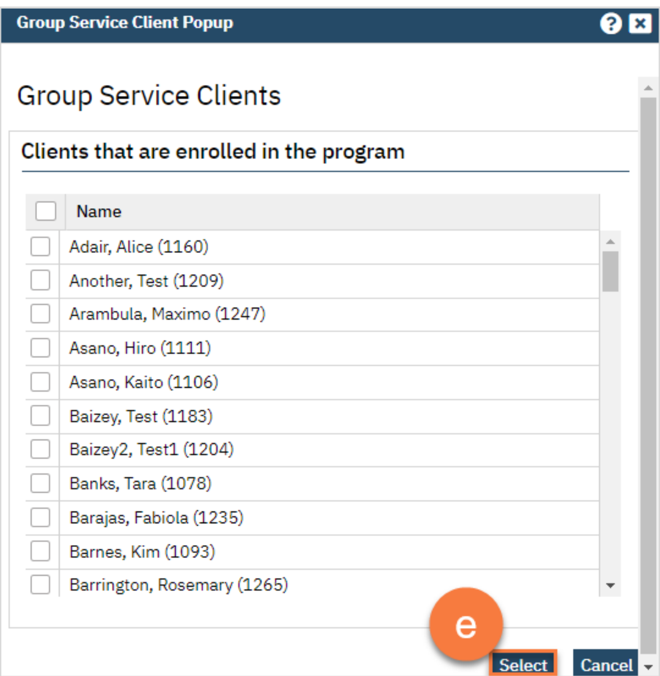
    c. This will open up the Group Service Client Popup, which will list any additional clients that are enrolled in this group. **Select the client and then click Select** to add them to this service.



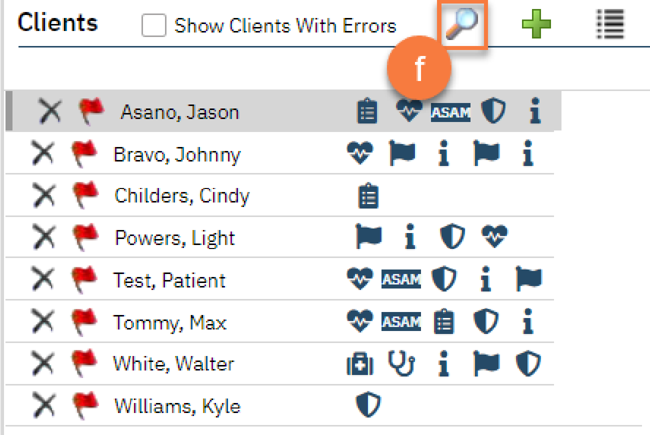
d. **To add a client who is enrolled in this program but not yet enrolled in this group, click the List icon.**



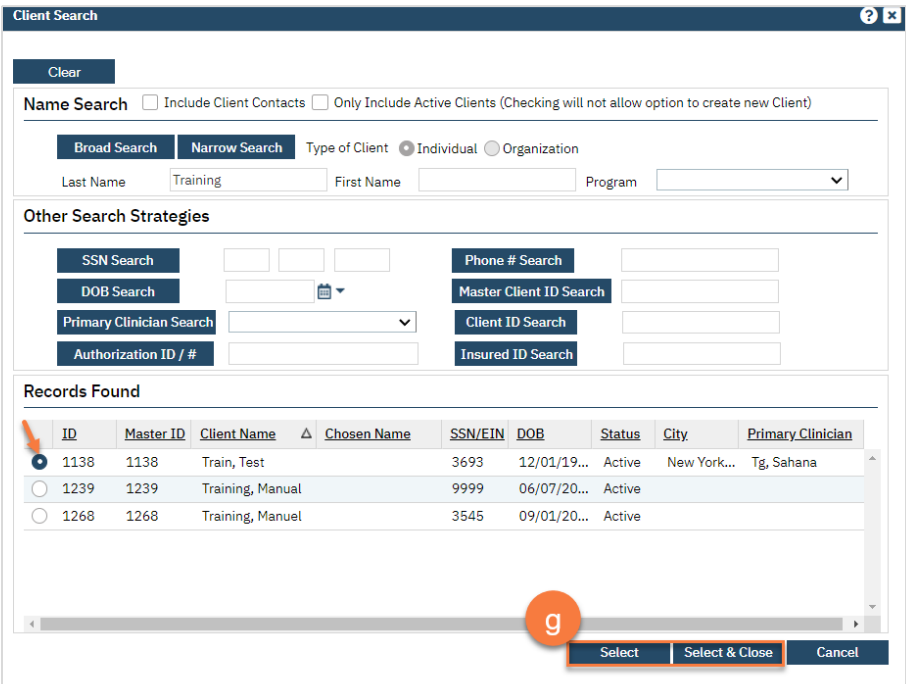
e. This will open up the Group Service Client Popup, which will list any clients that are enrolled in this program but are not yet enrolled in this group. **Select the client(s) you want to add and click Select** to add them to this service.



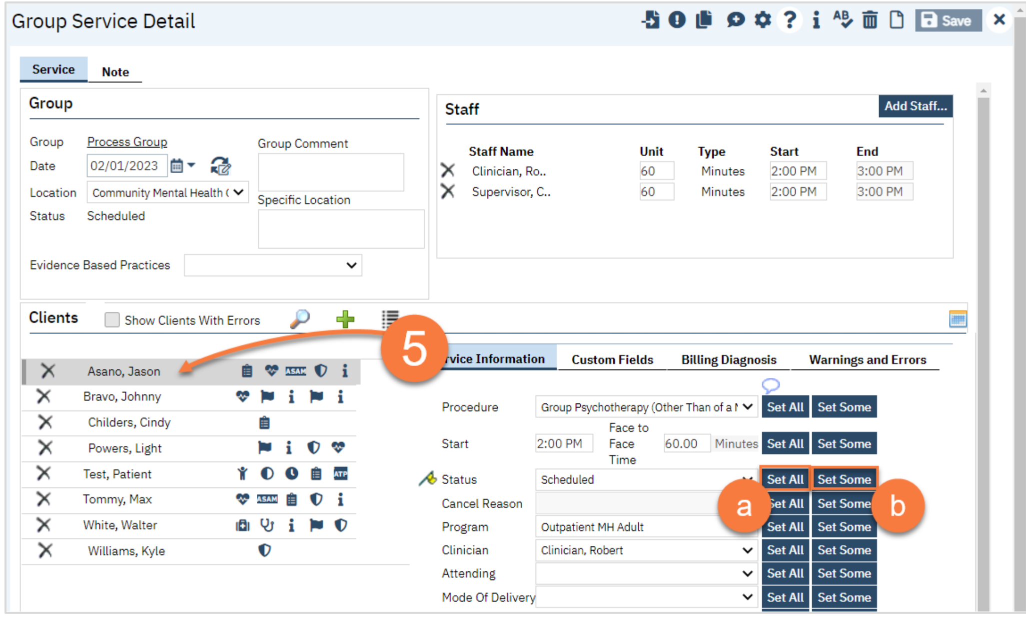
f. **To add a client from another program, click on the Magnifying Glass icon.**



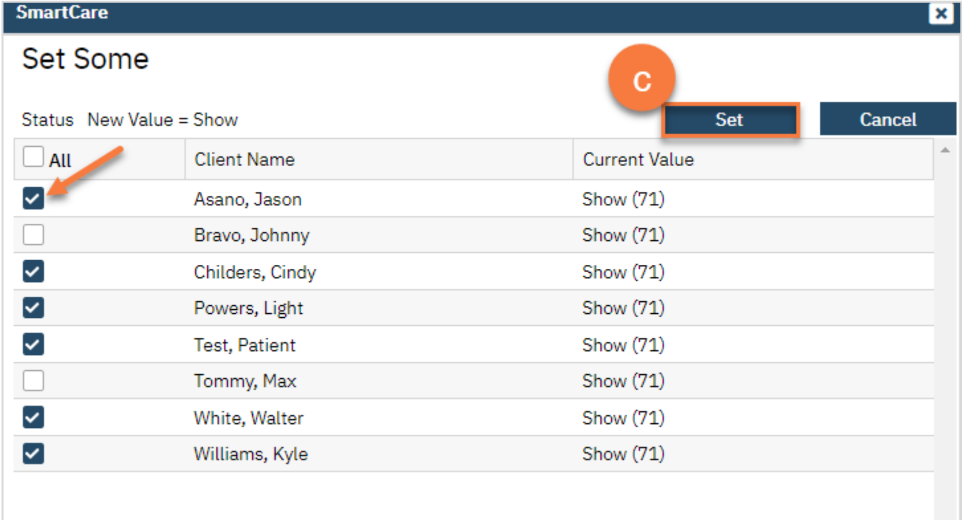
g. This will bring up the client search function. **Search for the client you want to add and click Select & Close**. If you want to add more than 1 client, you can simply click Select and then search for the next client you want to add.



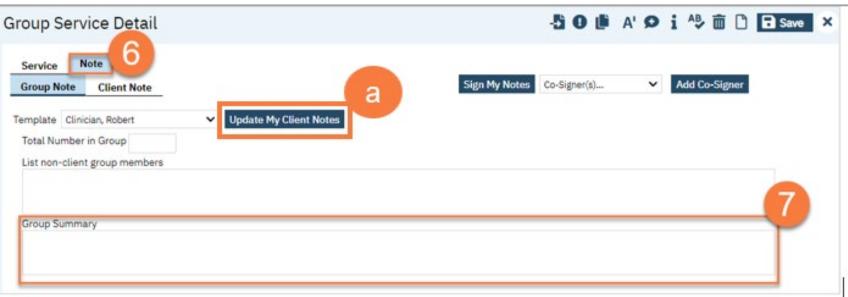
5. Once you have your group roster set up, move to the service information section. The first client will be highlighted. As you make changes, this will update this particular client. This is where you mark whether clients who were a no-show for the group, or who canceled.
    a. If you want **to set 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**.



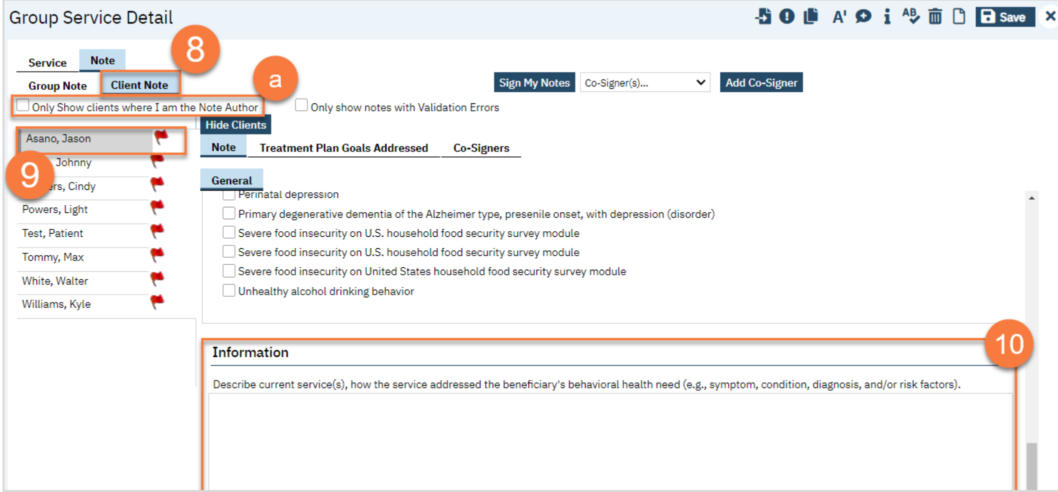
c. This will bring up the Set Some pop-up window. **Select the clients you want to include in this change** (e.g. all the clients who you want to mark as "show"). Then **click Set**.



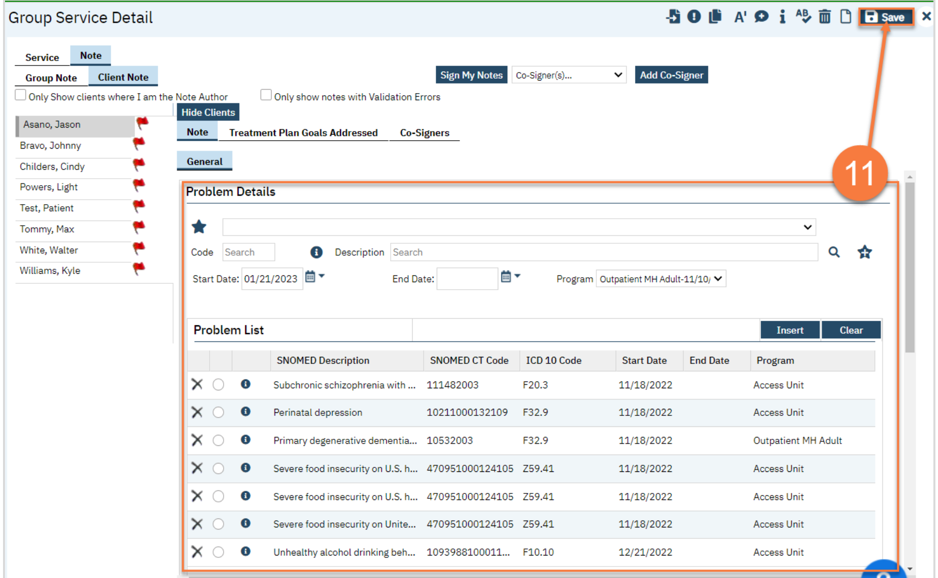
6. Once you've completed the service information, **navigate to the Note tab**.
7. **Enter the group note summary**.
    a. **Click the Update My Client Notes button**. This will be pushed to all of the group member's notes.



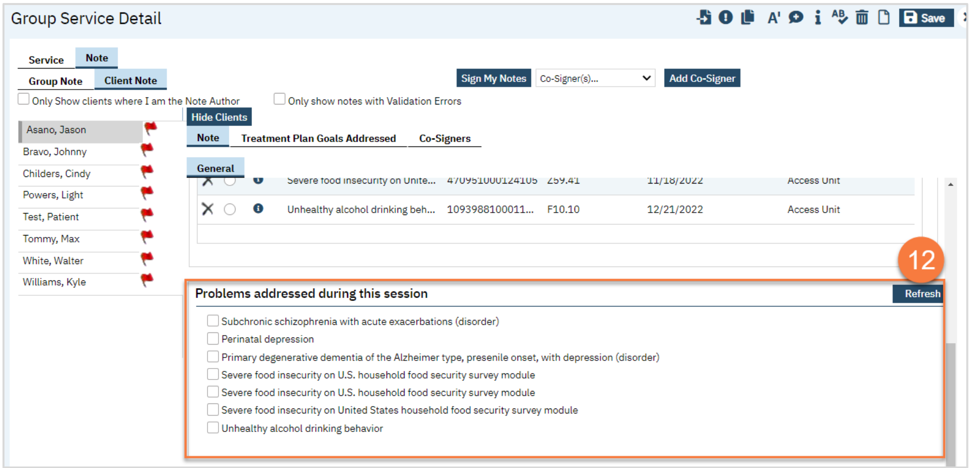
8. **Navigate to the Client Note tab**.
9. On the left side of the screen, **select the client** you're writing the note for.
    a. You can **click on the checkbox "Only Show clients where I am the Note Author"** to limit the clients on the list.
10. On the right side of the screen, **enter the individual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



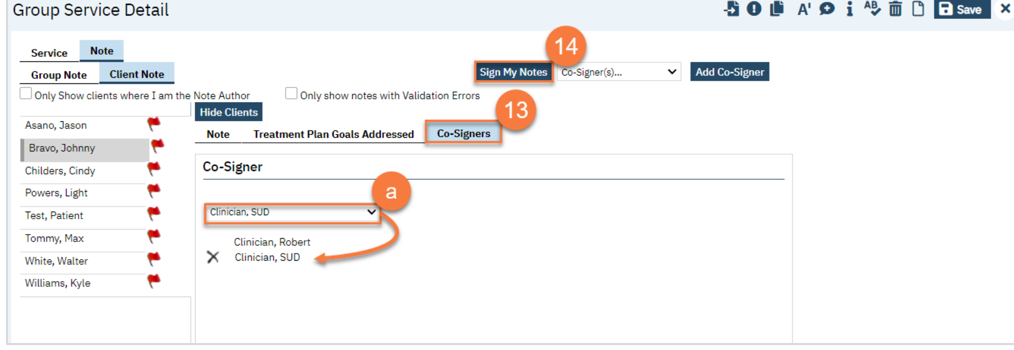
11. **Add problems to the problem list as necessary**. See Problem List for more information. After adding any problems, make sure to click Save.



12. **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.



13. 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.
14. Once you're finished with all of your notes, **click "Sign My Notes."**



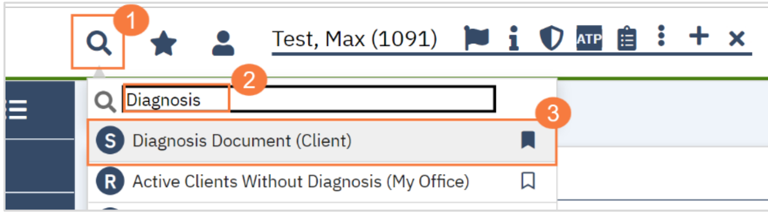
Diagnosis Entry

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

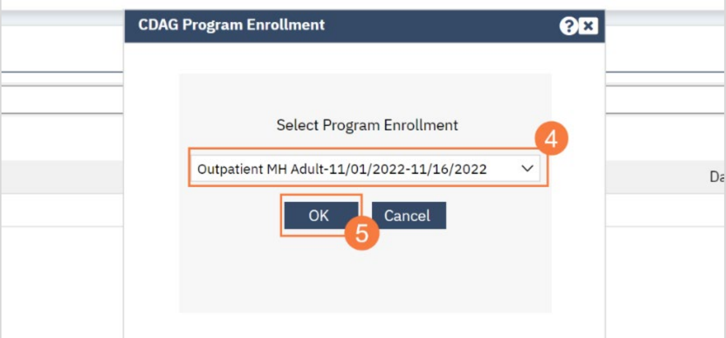
How to Add a Diagnosis

To add a diagnosis, follow the steps below:

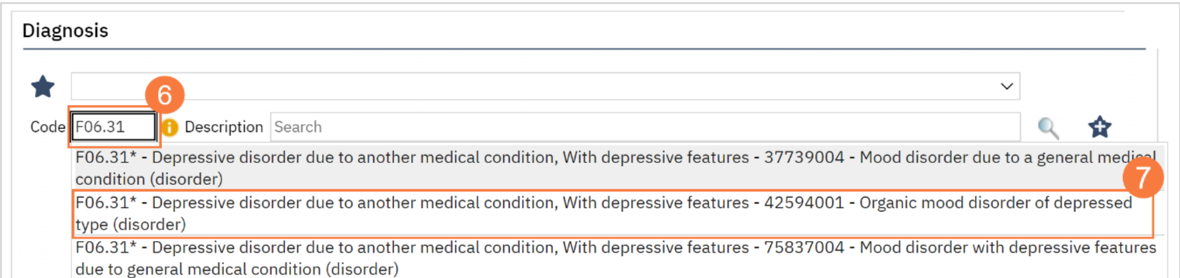
1. You must first have the client open, **click the Search icon**.
2. **Type Diagnosis** into the search bar.
3. **Click to select Diagnosis Document (Client).**



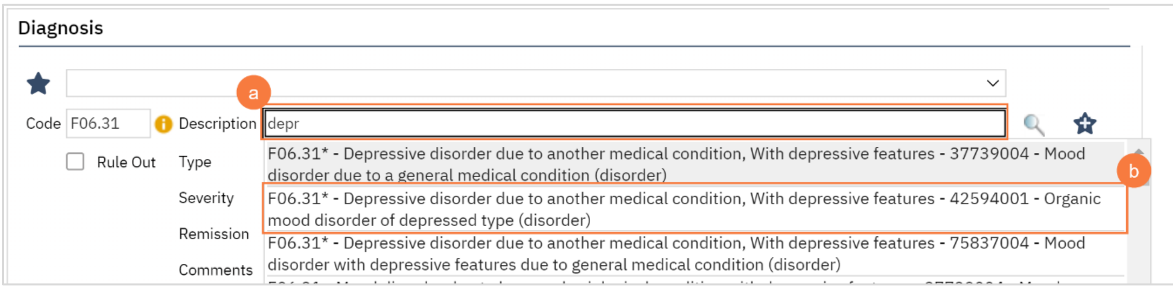
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



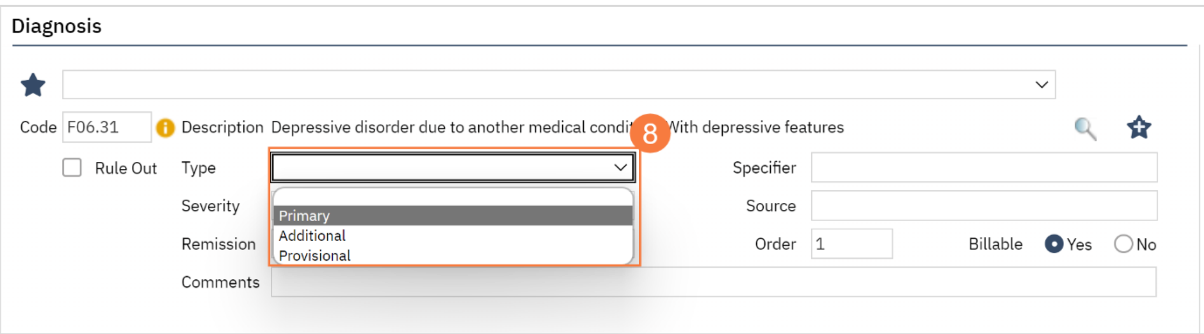
6. The Diagnosis Document screen will open, **click in the code field** and **enter the diagnosis code**.
7. A list of matching diagnoses will populate, **click to select** the appropriate diagnosis



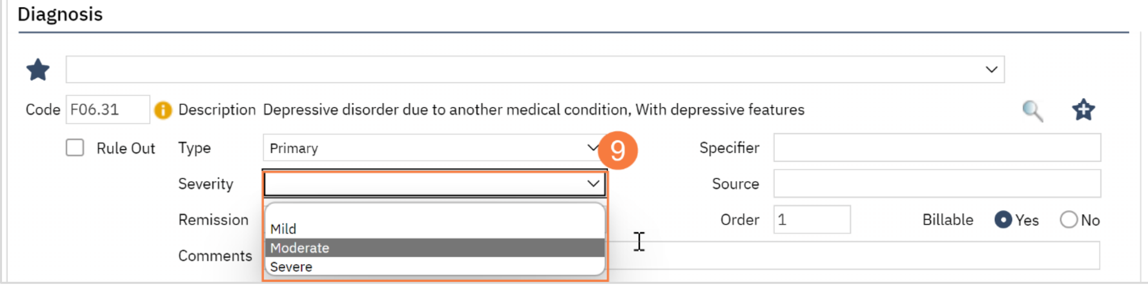
a. Alternatively, you can **click in the Description filed** and **enter the diagnosis description**.
b. A list of matching diagnoses will populate, **click to select** the appropriate diagnosis



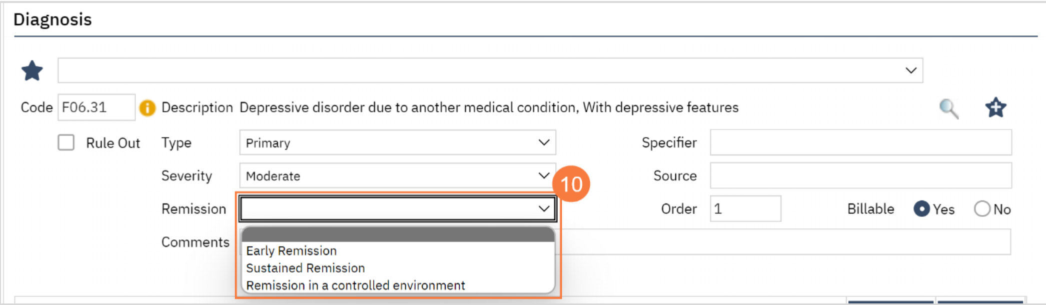
8. You must document if the diagnosis is Primary, Additional, or Provisional. **Click the drop-down menu in the Type field** and **select** the appropriate option.



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.

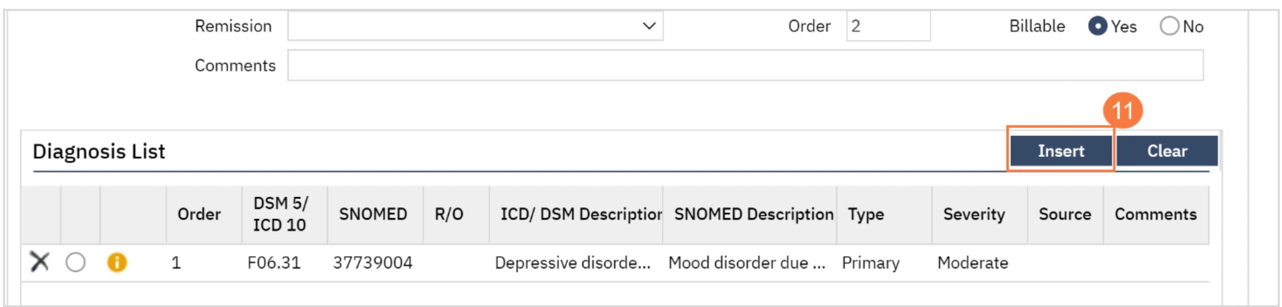


10. To document that the client is in remission, **click the drop-down menu in the Remission field** and **select** the appropriate option.

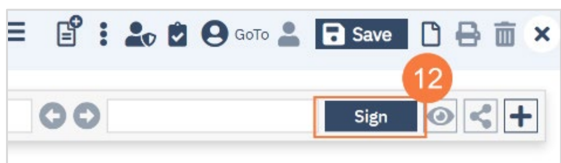


a. If this diagnosis is informational only and not a billable diagnosis, **click the No radio button in the Billable field**.

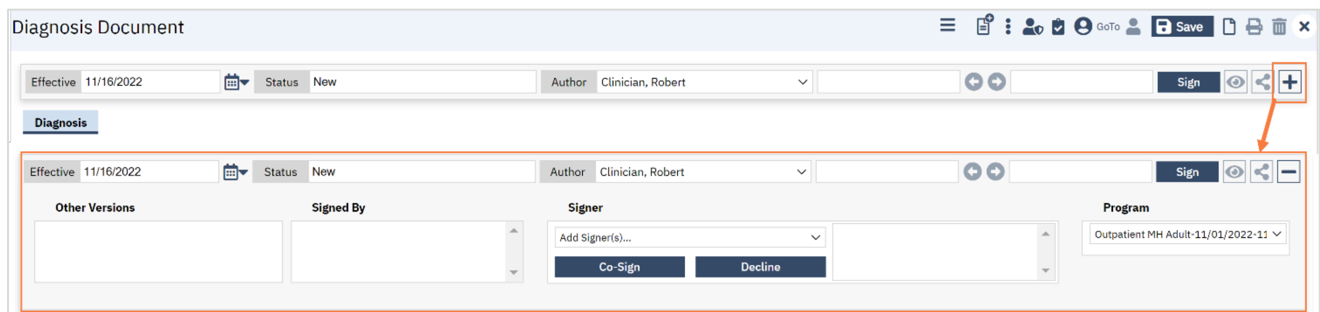
11. **Click the Insert button** to add the diagnosis. It will appear in the Diagnosis List grid below. Repeat steps 1-12 for remaining diagnoses.



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



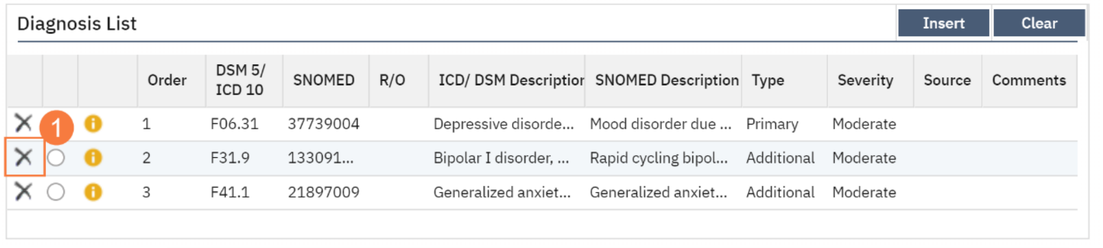
Note: If you need to review the programs the patient is enrolled in, **click the More Detail icon** at the top of the window.



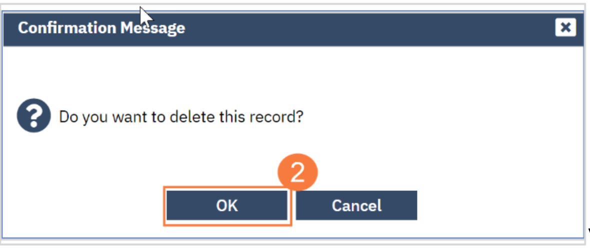
How to Delete a Diagnosis

To delete a diagnosis, follow the steps below:

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



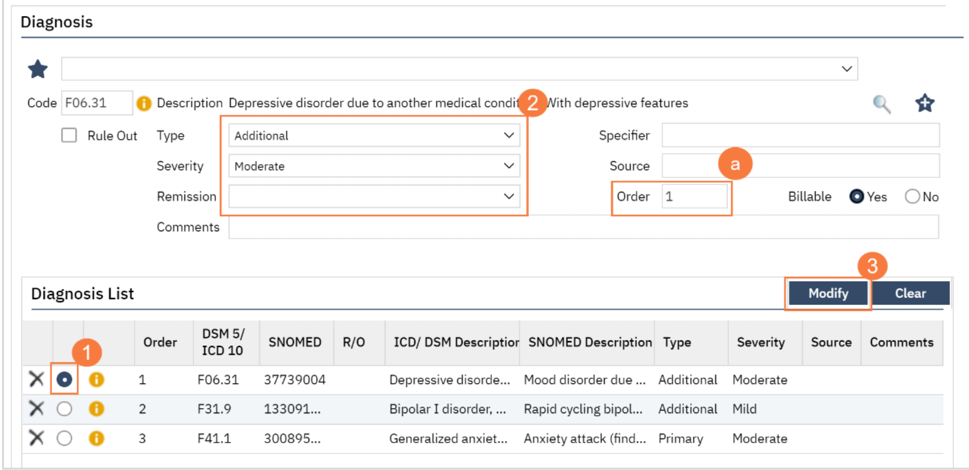
2. A prompt will appear and confirm you want to delete, **click OK.**



How to Modify and/or Re-Order a Diagnosis

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

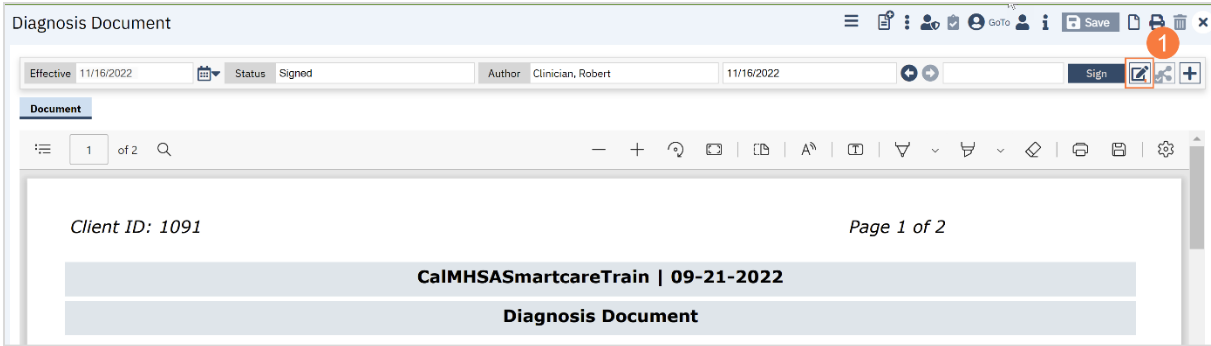
1. **Click the radio button** to the left of the diagnosis you need to update.
2. Make updates to the appropriate fields above.
    a. If you need to re-order your diagnosis, **click in the Order field** and enter the number you would like the diagnosis to appear in.
3. **Click Modify** to save your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



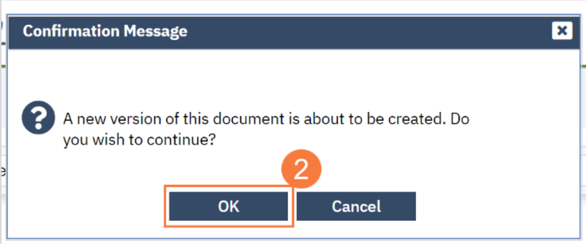
How to Modify a Diagnosis After the Document is Generated

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.**

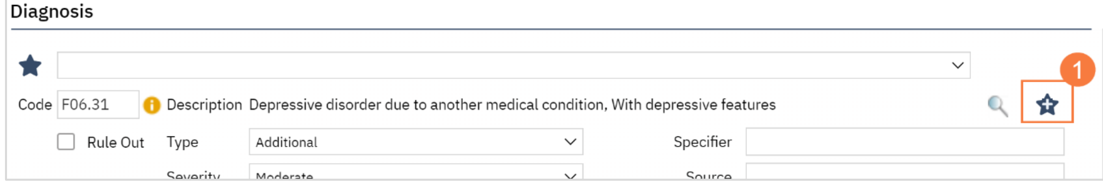


3. Make the necessary changes and click the Sign button when you are finished to regenerate the document.

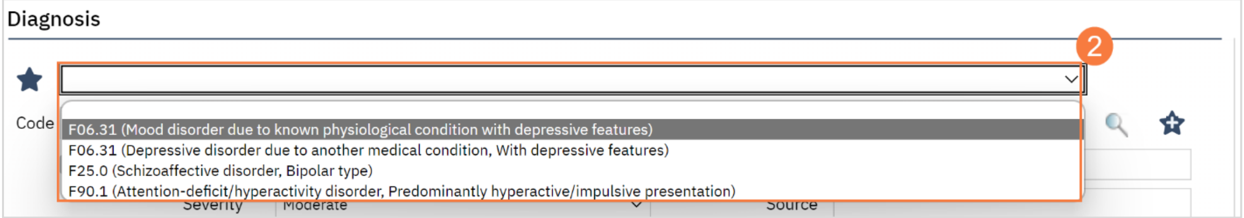
How to Save a Favorite Diagnosis

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.



State Reporting

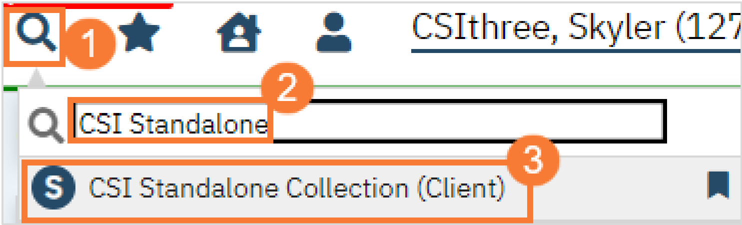
The California Department of Health Care Services, or DHCS, requires reporting to be completed for clients receiving behavioral health services. There are different types of reports based on the services the client receives. We'll cover the required reports that are uploaded to the State here.

CSI

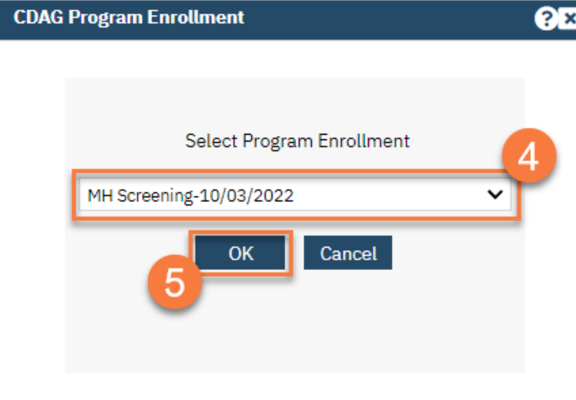
For clients receiving mental health services, the required state reporting includes demographic information, timeliness to service information, and discharge information. In this section, we'll go over how to enter this information as well as how to report this to the State.

How to Complete a CSI Demographic Record

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

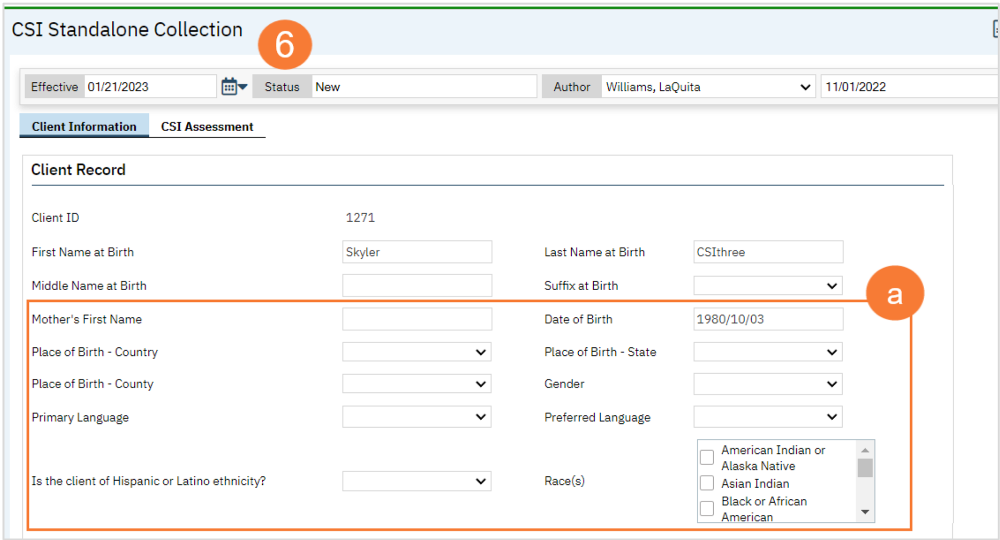


4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



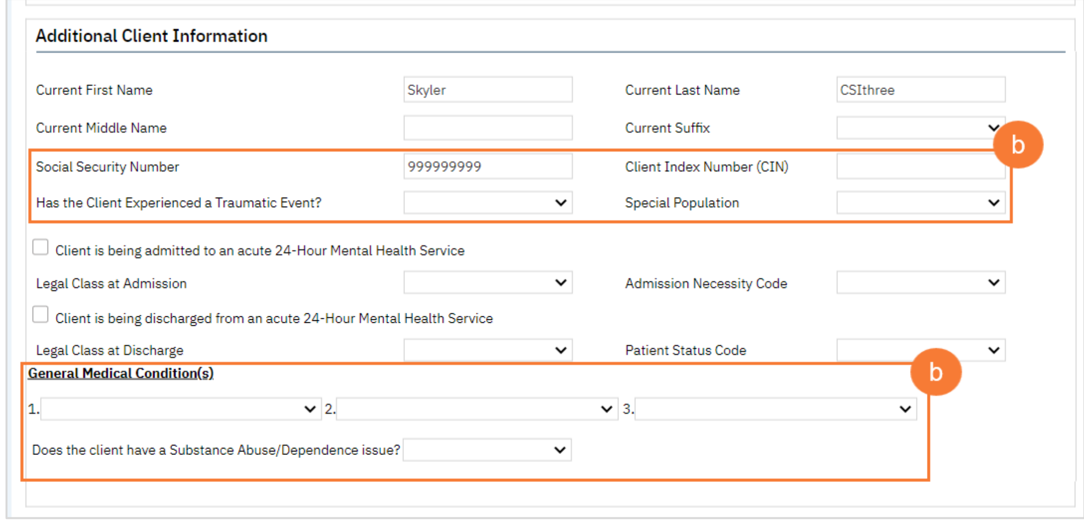
6. The CSI Standalone Collection document will open. **Complete the document**. Use the Tab key to navigate between fields.
    a. In the Client Record section, **the following fields are mandatory:**
        - **Mother's First Name** - **Type Mother's Name**, If Mother's Name is Unknown, **Type Unknown**.
        - **Place of Birth-Country** – Select from the drop-down menu.

- **Place of Birth-State** - Select from the drop-down menu.
- **Place of Brith-County** - Select from the drop-down menu.
- **Gender** - Select from the drop-down menu.
- **Primary Language** - Select from the drop-down menu.
- **Preferred Language** - Select from the drop-down menu.
- **Is the Client Hispanic or Latino ethnicity?** – Select from the drop-down menu.
- **Race(s)** – Select from the options within the box.



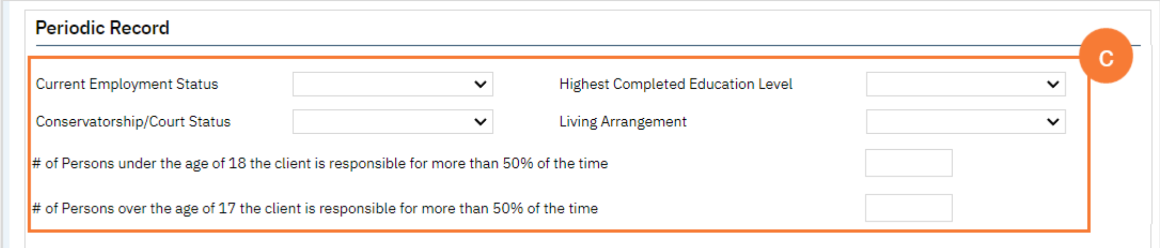
b. In the Additional Client Information section, **enter the following fields:**

- **Client Index Number (CIN)** – Type CIN#.
- **Has the Client Experienced a Traumatic Event?** – Select from the drop-down menu.
- **Special Population** - Select from the drop-down menu.
- **General Medical Condition(s)**
  These fields can't be blank. Therefore, if the client only has 1 General Medical Condition, the other 2 boxes must be filled out by **selecting No general medical condition**.
- **Does the client have a Substance Abuse/Dependence issue?** – Select from the drop-down menu.

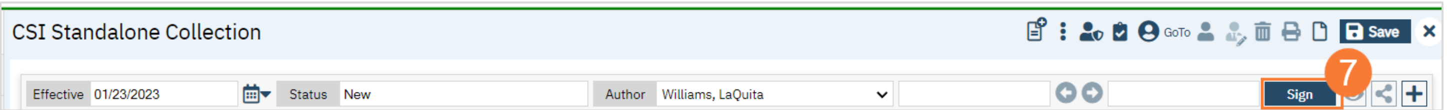


c. In the Periodic Record Section, **enter the following fields**:

- **Current Employment Status** – Select from the drop-down menu.
- **Highest Completed Education Level** - Select from the drop-down menu.
- **Conservatorship/Court Status** - Select from the drop-down menu.
- **Living Arrangement** - Select from the drop-down menu.
- **# of Persons under the age of 18 the client is responsible for more than 50% of the time** – Type #.
- **# of Persons over the age of 17 the client is responsible for more than 50% of the time** – Type #.

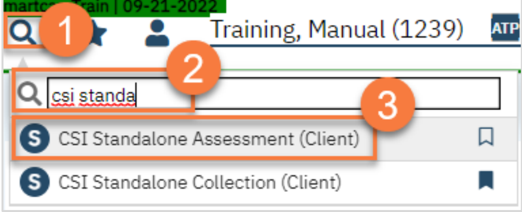


7. **Click Sign** to complete and generate the document.

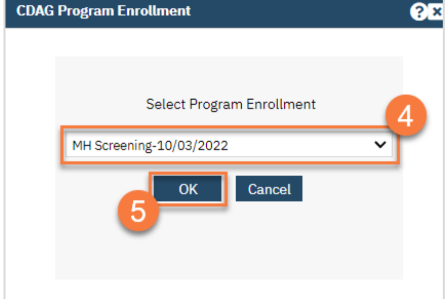


How to Complete a CSI Assessment Data Record

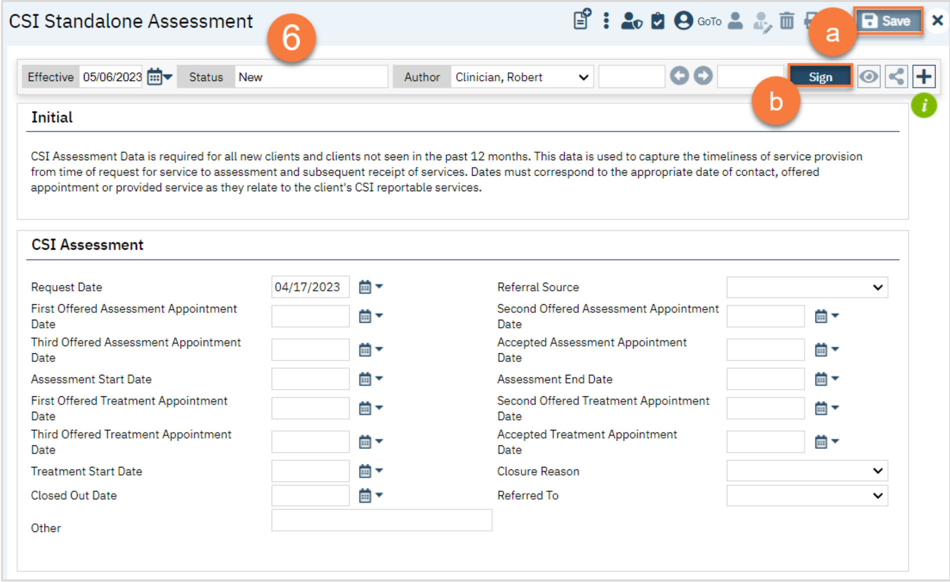
1. You must first have the client open, then **click the Search icon**.
2. **Type "CSI Standalone Assessment"** into the search bar.
3. **Select "CSI Standalone Assessment (Client)"** from the search results.



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 CSI Standalone Assessment document will open. **Complete the document**. This document has logic built in that will automatically pull in some information. Make sure to check any information already included for accuracy.
    a) Since the CSI Assessment Data Record is edited often before being completed, click Save each time you enter information.
    b) Only once the form is fully completed should you click Sign.



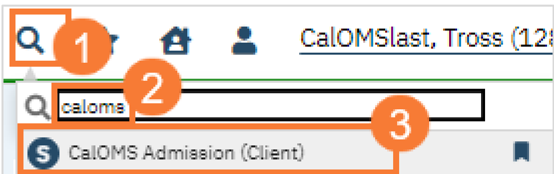
CalOMS

For clients receiving substance use treatment services, the required state reporting is done at each program intake and discharge, whether that discharge results are transferring to a new program or closing the client to all programs. A unique number called the (FSN) Form Serial Number will be assigned to the client CalOMS records for admission to the program.

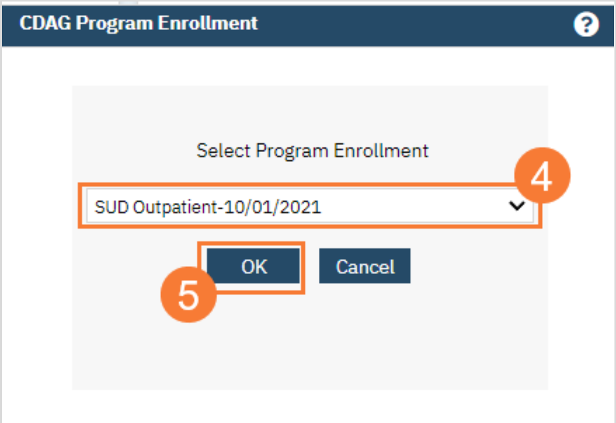
Each Admission will be assigned a new FSN and that is attached to all records up to discharge. When the client is admitted to a new CalOMS program a new FSN will be created for that admission.

How to Complete a CalOMS Admission

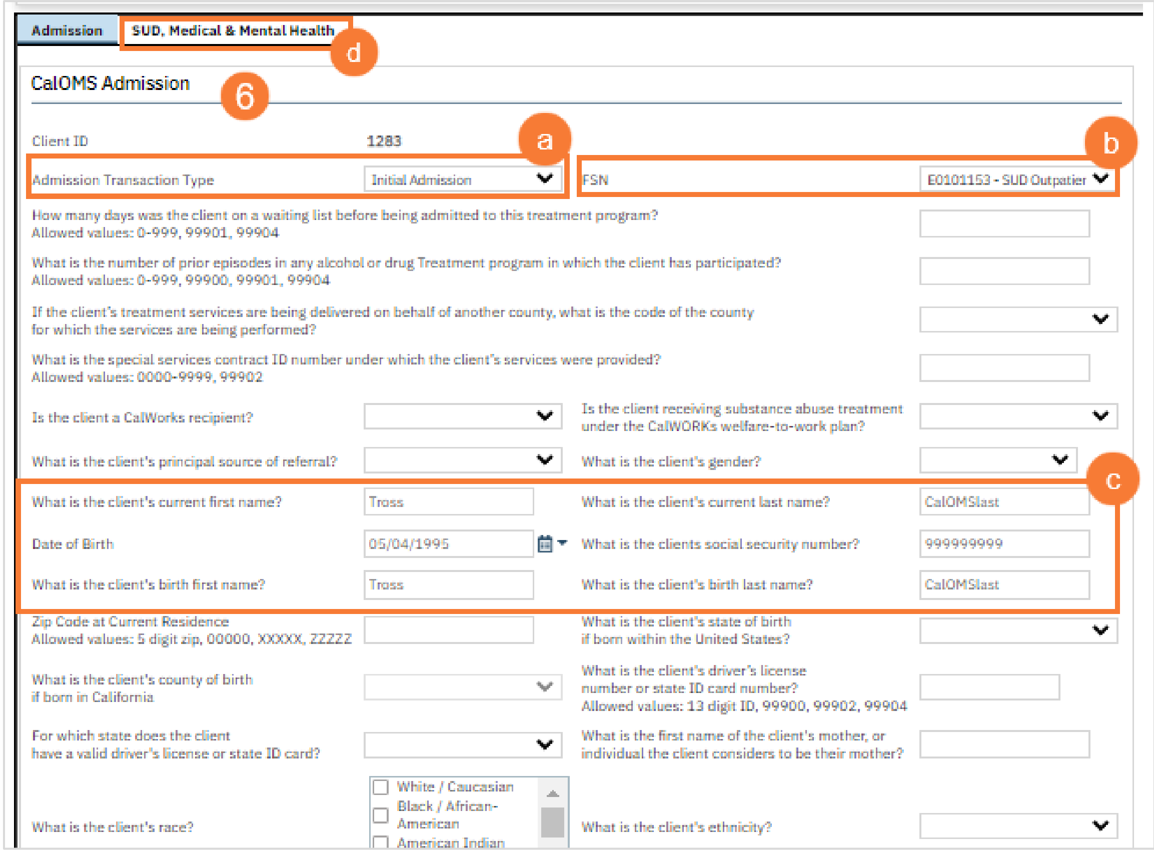
1. You must first have the client open, then **click the Search icon**.
2. **Type CALOMS** into the search bar.
3. **Click to select CalOMS Admission (Client).**



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 CalOMS Admission document will open in the Admission tab. **Complete all fields**. You can use the Tab key to navigate between fields.
   a. In the Admission Transaction Type field, **select Initial Admission**.
   b. In the FSN field, **select the Form Serial Number (FSN)** from the drop-down menu.
   c. These fields auto populated from the client's record.
   d. **Click on the SUD, Medical & Mental Health** tab. Complete all fields.



Admission | **SUD, Medical & Mental Health**

d

Drug and Alcohol Information

Primary Drug Information

What is the client's primary alcohol or drug problem?

Please specify:

How many days in the past 30 days has the client used the primary drug? Allowed values: 0-30

What is the client's usual route of administration they use most often for their primary drug of abuse?

What was the client's age of first use for the primary drug of abuse? Allowed values: 5-105, 99904

Secondary Drug Information

What is the client's secondary alcohol or drug problem?

Please specify:

How many days in the past 30 days has the client used the secondary drug of abuse? Allowed values: 0-30, 99902

What is the client's usual route of administration they use most often for the secondary drug of abuse?

What was the client's age of first use for the secondary drug of abuse? Allowed values: 5-105, 99902

Additional Drug Information

How many days in the past 30 days has the client used alcohol? Allowed values: 0-30, 99902

How many days has the client used needles to inject drugs in the past 30 days? Allowed values: 0-30, 99900, 99904

Has the client used needles to inject drugs in the past twelve months?

Employment Information

What is the client's current employment status?

Is the client currently enrolled in school?

What is the client's highest school grade completed? Allowed values: 0-30, 99900, 99904

How many days was the client paid for working in the past 30 days? Allowed values: 0-30, 99900, 99904

Is the client currently enrolled in a job training program?

Legal Information

What is the client's criminal justice status?

How many times has the client been arrested in the past 30 days? Allowed values:0-30, 99904

How many days has the client been in prison in the past 30 days? Allowed values:0-30, 99904

Is the client a parolee in the Female Offender Treatment Program (FOTP)?

What is the client's CDCR Identification Number? Allowed values: 6 digit string, 99900, 99901, 99902, 99904

How many days has the client been in jail in the past 30 days? Allowed values:0-30, 99904

Is the client a parolee in the Parolee Services Network (PSN)?

What is the client's FOTP Priority Status?

Medical/Physical Health Information

Has the client been tested for HIV/AIDS? Yes

Does the client have the results of the HIV/AIDS test? No

If the client is not male, is the client pregnant at time of admission? No

How many times has the client visited an emergency room in the past 30 days for physical health problems?
Allowed values: 0-99, 99904

How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems?
Allowed values: 0-99, 99904

How many days in the past 30 days has the client experienced physical health problems?
Allowed values: 0-99, 99904

Mental Health Information

Has the client ever been diagnosed with a mental illness? No

In the past 30 days, Has the client taken prescribed medication for mental health needs?

How many time in the past 30 days had the client received outpatient emergency services for mental health needs?
Allowed values: 0-30, 99904

How many days in the past 30 has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs?
Allowed values: 0-30, 99904

Family/Social Information

What is the client's current living arrangement? Dependent Living

How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?
Allowed values: 0-30, 99900, 99904

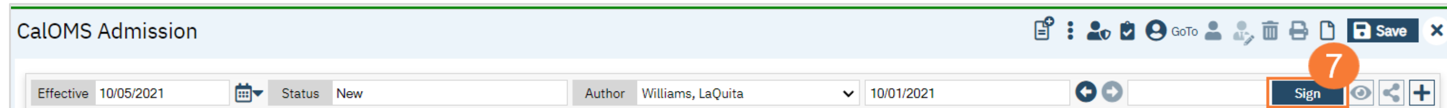
How many days in the past 30 days had the client had serious conflicts with members of the family?
Allowed values: 0-30, 99900, 99904

How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not? 0
Allowed values: 0-30, 99904

How many children does the client have age 5 or younger? 0
Allowed values: 0-30, 99904

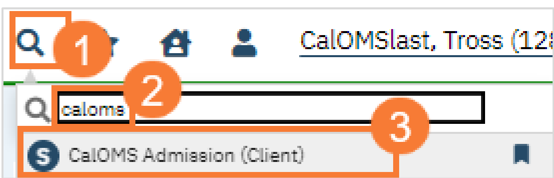
How many of the client's children age 17 and under are living with someone else because of a child protection court order? 0

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

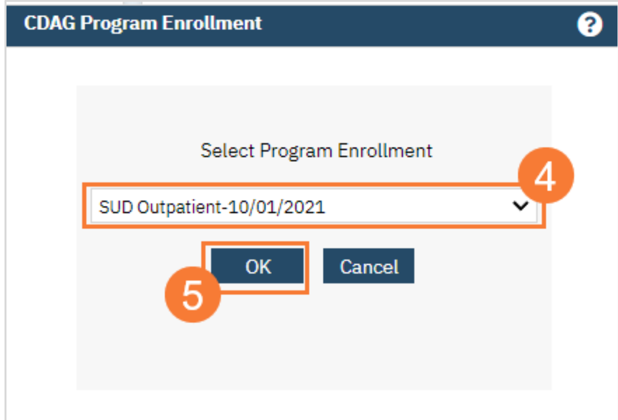


How to Complete a CalOMS Referral/Transfer

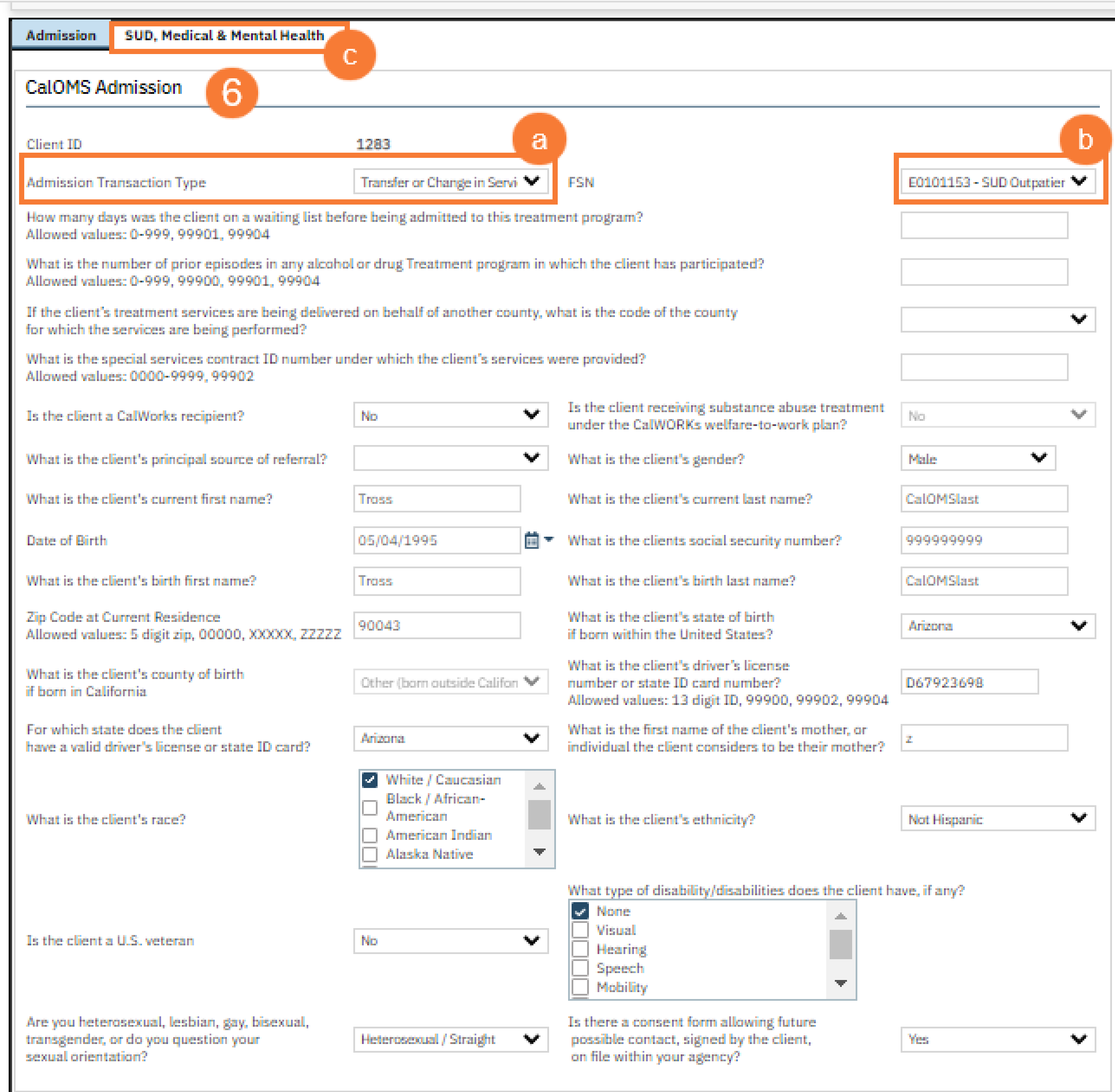
1. You must first have the client open, then **click the Search icon**.
2. **Type CALOMS** into the search bar.
3. **Click to select CalOMS Admission (Client).**



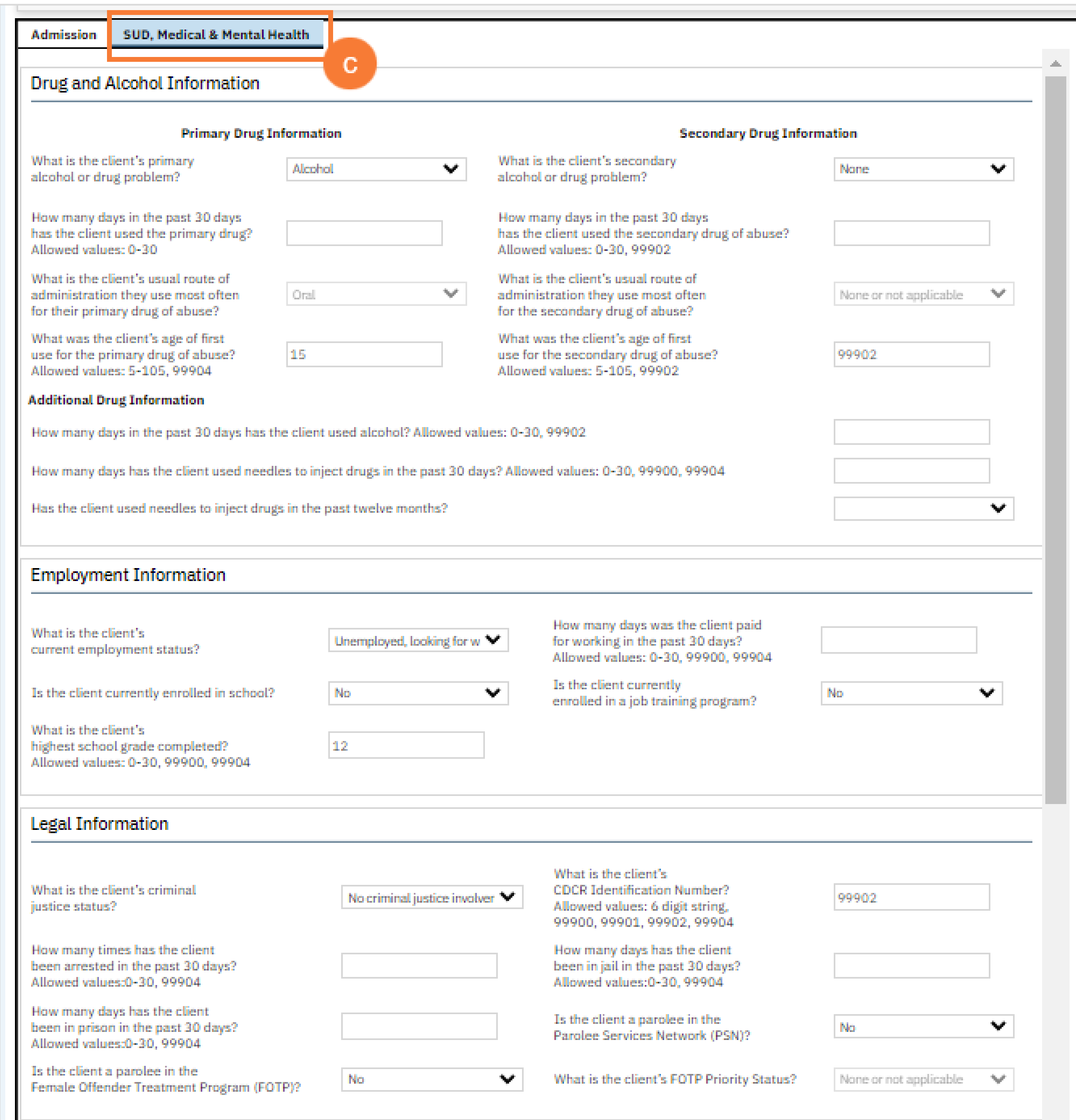
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



6. The CalOMS Admission document will open. Some fields will have pre-populated data from the CalOMS Admission, all other fields need to be filled out. **Complete the document.** Use the tab key to navigate between fields.
   a. In the Admission Transaction Type field, **select Transfer or Change in Service** from the drop-down menu.
   b. In the FSN field, **select the (FSN) Form Serial Number** from the drop-down menu.
   c. **Click on the SUD, Medical & Mental Health** tab, complete all fields.



Admission
SUD, Medical & Mental Health
c
CalOMS Admission
6
Client ID
1283
a
b
Admission Transaction Type
Transfer or Change in Servi
FSN
E0101153 - SUD Outpatier
How many days was the client on a waiting list before being admitted to this treatment program?
Allowed values: 0-999, 99901, 99904
What is the number of prior episodes in any alcohol or drug Treatment program in which the client has participated?
Allowed values: 0-999, 99900, 99901, 99904
If the client's treatment services are being delivered on behalf of another county, what is the code of the county for which the services are being performed?
What is the special services contract ID number under which the client's services were provided?
Allowed values: 0000-9999, 99902
Is the client a CalWorks recipient?
No
Is the client receiving substance abuse treatment under the CalWORKs welfare-to-work plan?
No
What is the client's principal source of referral?
What is the client's gender?
Male
What is the client's current first name?
Tross
What is the client's current last name?
CalOMSlast
Date of Birth
05/04/1995
What is the clients social security number?
999999999
What is the client's birth first name?
Tross
What is the client's birth last name?
CalOMSlast
Zip Code at Current Residence
Allowed values: 5 digit zip, 00000, XXXXX, ZZZZZ
90043
What is the client's state of birth if born within the United States?
Arizona
What is the client's county of birth if born in California
Other (born outside Califon
What is the client's driver's license number or state ID card number?
Allowed values: 13 digit ID, 99900, 99902, 99904
D67923698
For which state does the client have a valid driver's license or state ID card?
Arizona
What is the first name of the client's mother, or individual the client considers to be their mother?
z
What is the client's race?
White / Caucasian
Black / African-American
American Indian
Alaska Native
What is the client's ethnicity?
Not Hispanic
What type of disability/disabilities does the client have, if any?
None
Visual
Hearing
Speech
Mobility
Is the client a U.S. veteran
No
Are you heterosexual, lesbian, gay, bisexual, transgender, or do you question your sexual orientation?
Heterosexual / Straight
Is there a consent form allowing future possible contact, signed by the client, on file within your agency?
Yes


Admission
SUD, Medical & Mental Health
C
Drug and Alcohol Information
Primary Drug Information
What is the client's primary alcohol or drug problem?
Alcohol
How many days in the past 30 days has the client used the primary drug? Allowed values: 0-30
What is the client's usual route of administration they use most often for their primary drug of abuse?
Oral
What was the client's age of first use for the primary drug of abuse? Allowed values: 5-105, 99904
15
Secondary Drug Information
What is the client's secondary alcohol or drug problem?
None
How many days in the past 30 days has the client used the secondary drug of abuse? Allowed values: 0-30, 99902
What is the client's usual route of administration they use most often for the secondary drug of abuse?
None or not applicable
What was the client's age of first use for the secondary drug of abuse? Allowed values: 5-105, 99902
99902
Additional Drug Information
How many days in the past 30 days has the client used alcohol? Allowed values: 0-30, 99902
How many days has the client used needles to inject drugs in the past 30 days? Allowed values: 0-30, 99900, 99904
Has the client used needles to inject drugs in the past twelve months?
Employment Information
What is the client's current employment status?
Unemployed, looking for w
How many days was the client paid for working in the past 30 days? Allowed values: 0-30, 99900, 99904
Is the client currently enrolled in school?
No
Is the client currently enrolled in a job training program?
No
What is the client's highest school grade completed? Allowed values: 0-30, 99900, 99904
12
Legal Information
What is the client's criminal justice status?
No criminal justice involver
What is the client's CDCR Identification Number? Allowed values: 6 digit string, 99900, 99901, 99902, 99904
99902
How many times has the client been arrested in the past 30 days? Allowed values:0-30, 99904
How many days has the client been in jail in the past 30 days? Allowed values:0-30, 99904
How many days has the client been in prison in the past 30 days? Allowed values:0-30, 99904
Is the client a parolee in the Parolee Services Network (PSN)?
No
Is the client a parolee in the Female Offender Treatment Program (FOTP)?
No
What is the client's FOTP Priority Status?
None or not applicable

Medical/Physical Health Information

Question	Response	Question	Response
Is the client a Medi-Cal Beneficiary?	Yes	If the client is not male, is the client pregnant at time of admission?	No
What medication is prescribed as part of treatment?	Other (only for medications	Has the client been diagnosis with Tuberculosis?	No
Has the client been diagnosed with Hepatitis C?	No	Has the client been diagnosed with any sexually transmitted diseases?	No
Has the client been tested for HIV/AIDS?	Yes	Does the client have the results of the HIV/AIDS test?	No

How many times has the client visited an emergency room in the past 30 days for physical health problems?
Allowed values: 0-99, 99904

How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems?
Allowed values: 0-99, 99904

How many days in the past 30 days has the client experienced physical health problems?
Allowed values: 0-99, 99904

Mental Health Information

Question	Response	Question	Response
Has the client ever been diagnosed with a mental illness?	No	In the past 30 days, Has the client taken prescribed medication for mental health needs?	

How many time in the past 30 days had the client received outpatient emergency services for mental health needs?
Allowed values: 0-30, 99904

How many days in the past 30 has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs?
Allowed values: 0-30, 99904

Family/Social Information

What is the client's current living arrangement? Dependent Living

How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?
Allowed values: 0-30, 99900, 99904

How many days in the past 30 days had the client had serious conflicts with members of the family?
Allowed values: 0-30, 99900, 99904

How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not? 0
Allowed values: 0-30, 99904

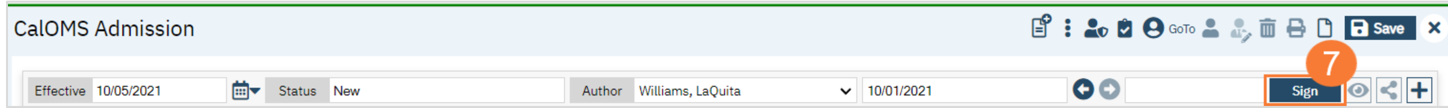
How many children does the client have age 5 or younger? 0
Allowed values: 0-30, 99904

How many of the client's children age 17 and under are living with someone else because of a child protection court order? 0
Allowed values: 0-30, 99904

If the client has children living with someone else because of a child protection court order,
for how many of these children aged 17 or under have the client's parental rights been terminated? 0
Allowed values: 0-30, 99904

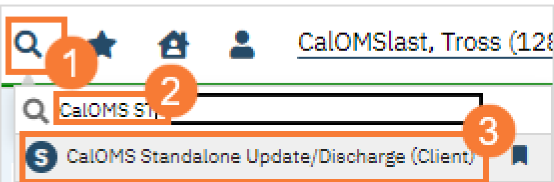
How many days in the last 30 days has the client participated in any social support recovery activities such as:
12-step meetings, Other self-help meetings, Religious/faith recovery or self-help meetings, Meetings of organizations
other than those listed above Interactions with family member and/or friend support of recovery?

7. **Click Sign** to Complete and Generate document.

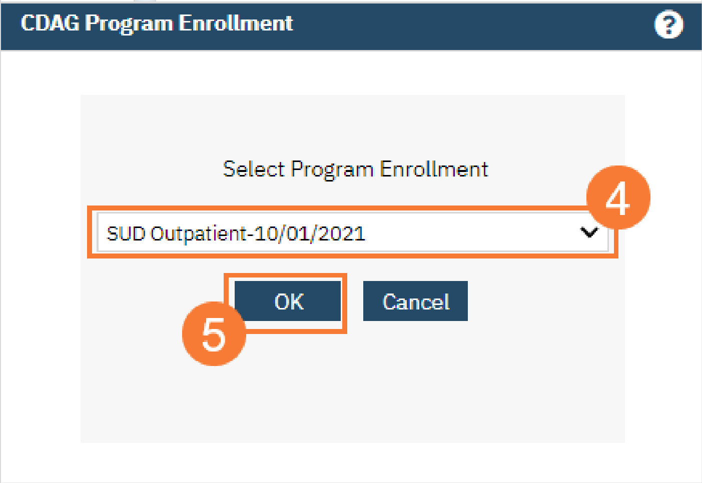


How to Complete a CalOMS Discharge

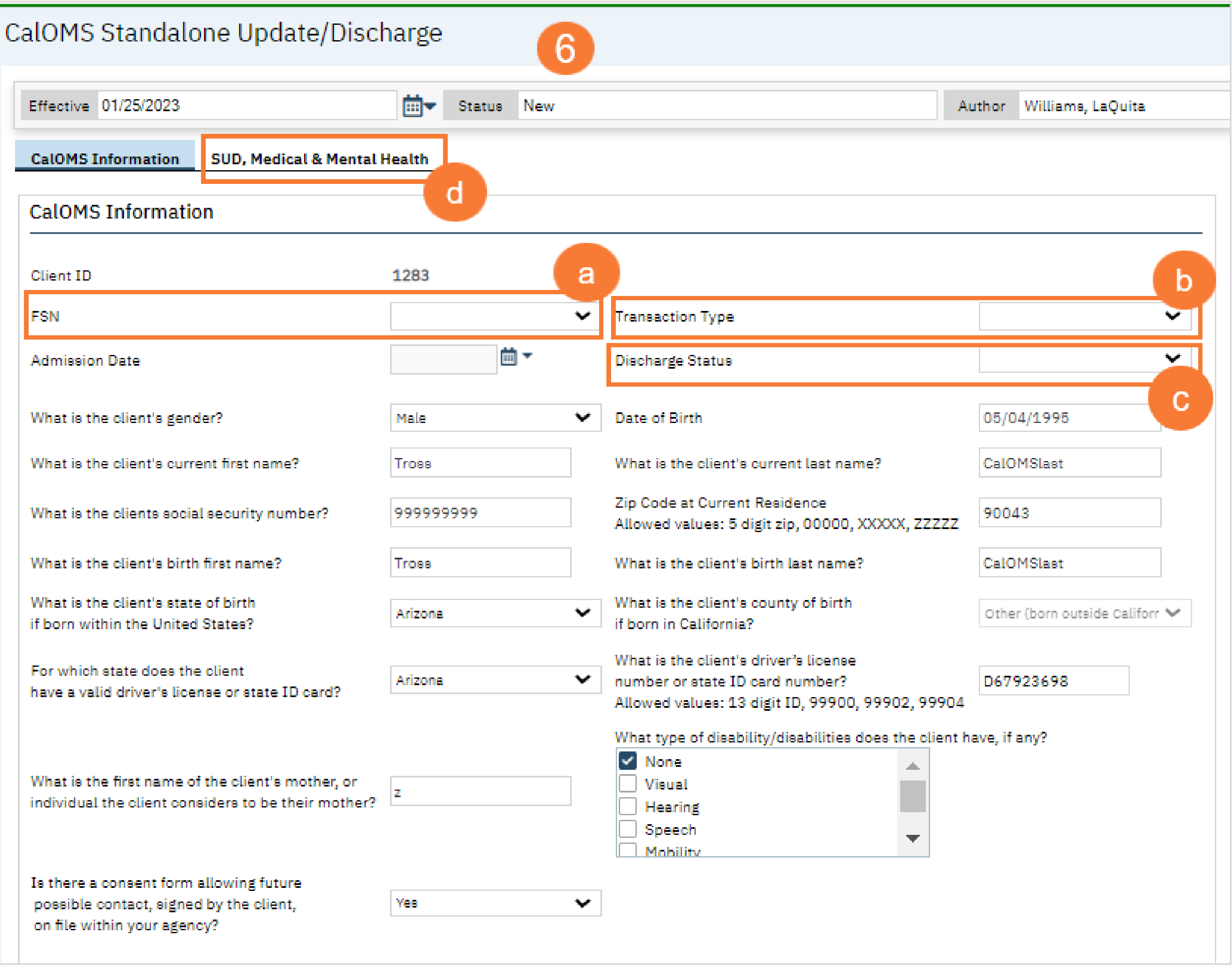
1. You must first have the client open, then **click the Search icon**.
2. **Type CalOMS** into the search bar.
3. **Click to select CalOMS Standalone Update/Discharge (Client).**



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 CalOMS Standalone Update/Discharge (Client) document will open. **Complete the document**. Use the tab key to navigate between fields. Some fields are prepopulated from the CalOMS Admission form, fill out all other fields.
   a. FSN – **Select the (FSN)** Form Serial Number from the drop-down menu.
      Once you select the FSN the **Admission Date** will auto populate.
   b. Transaction Type – **Select** one of the **Discharge options** from the drop-down menu.
   c. Discharge Status – **Select** one of the **Discharge Status** options from the drop-down menu.
   d. **Click on the SUD, Medical & Mental Health** tab, complete all fields.


CalOMS Standalone Update/Discharge
6
Effective 01/25/2023
Status New
Author Williams, LaQuita
CalOMS Information
SUD, Medical & Mental Health
d
CalOMS Information
Client ID 1283
a
FSN
b
Transaction Type
Admission Date
Discharge Status
c
What is the client's gender? Male
Date of Birth 05/04/1995
What is the client's current first name? Tross
What is the client's current last name? CalOMSlast
What is the clients social security number? 999999999
Zip Code at Current Residence
Allowed values: 5 digit zip, 00000, XXXXX, ZZZZZ
90043
What is the client's birth first name? Tross
What is the client's birth last name? CalOMSlast
What is the client's state of birth
if born within the United States?
Arizona
What is the client's county of birth
if born in California?
For which state does the client
have a valid driver's license or state ID card?
Arizona
What is the client's driver's license
number or state ID card number?
Allowed values: 13 digit ID, 99900, 99902, 99904
D67923698
What type of disability/disabilities does the client have, if any?
None
Visual
Hearing
Speech
What is the first name of the client's mother, or
individual the client considers to be their mother?
z
Is there a consent form allowing future
possible contact, signed by the client,
on file within your agency?
Yes

CalOMS Information | SUD, Medical & Mental Health

d

Drug and Alcohol Information

Primary Drug Information

What is the client's primary alcohol or drug problem? Alcohol

How many days in the past 30 days has the client used the primary drug? Allowed values: 0-30, 99902

What is the client's usual route of administration they use most often for their primary drug of abuse? Oral

Secondary Drug Information

What is the client's secondary alcohol or drug problem? None

How many days in the past 30 days has the client used the secondary drug of abuse? Allowed values: 0-30, 99902

What is the client's usual route of administration they use most often for the secondary drug of abuse? None or not applicable

Additional Drug Information

How many days in the past 30 days has the client used alcohol? Allowed values: 0-30, 99902

How many days has the client used needles to inject drugs in the past 30 days? Allowed values: 0-30, 99900, 99904

Employment Information

What is the client's current employment status? Unemployed, looking for wc

How many days was the client paid for working in the past 30 days? Allowed values: 0-30, 99900, 99904

Is the client currently enrolled in school? No

Is the client currently enrolled in a job training program? No

Legal Information

How many times has the client been arrested in the past 30 days? Allowed values:0-30, 99904

How many days has the client been in jail in the past 30 days? Allowed values:0-30, 99904

How many days has the client been in prison in the past 30 days? Allowed values:0-30, 99904

Medical/Physical Health Information

Has the client been tested for HIV/AIDS? Yes

Does the client have the results of the HIV/AIDS test? No

If the client is not male, is the client pregnant at time of admission? No

How many times has the client visited an emergency room in the past 30 days for physical health problems?
Allowed values: 0-99, 99904 — 0

How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems?
Allowed values: 0-99, 99904 — 0

How many days in the past 30 days has the client experienced physical health problems?
Allowed values: 0-99, 99904 — 0

Mental Health Information

Has the client ever been diagnosed with a mental illness? No

In the past 30 days, Has the client taken prescribed medication for mental health needs? No

How many time in the past 30 days had the client received outpatient emergency services for mental health needs?
Allowed values: 0-30, 99904 — 0

How many days in the past 30 has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs?
Allowed values: 0-30, 99904 — 0

Family/Social Information

What is the client's current living arrangement? Dependent Living

How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?
Allowed values: 0-30, 99900, 99904 — 0

How many days in the past 30 days had the client had serious conflicts with members of the family?
Allowed values: 0-30, 99900, 99904 — 0

How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not?
Allowed values: 0-30, 99904 — 0

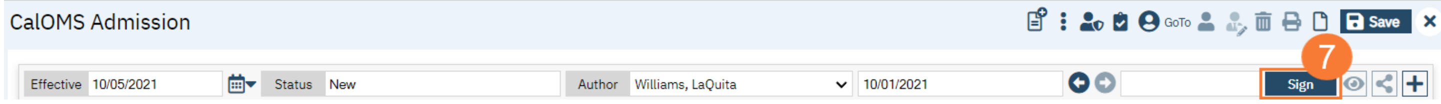
How many children does the client have age 5 or younger?
Allowed values: 0-30, 99904 — 0

How many of the client's children age 17 and under are living with someone else because of a child protection court order?
Allowed values: 0-30, 99904 — 0

If the client has children living with someone else because of a child protection court order,
for how many of these children aged 17 or under have the client's parental rights been terminated?
Allowed values: 0-30, 99904 — 0

How many days in the last 30 days has the client participated in any social support recovery activities such as:
12-step meetings, Other self-help meetings, Religious/faith recovery or self-help meetings, Meetings of organizations other than those listed above Interactions with family member and/or friend support of recovery? — 25

7. Click Sign to complete and generate the document.

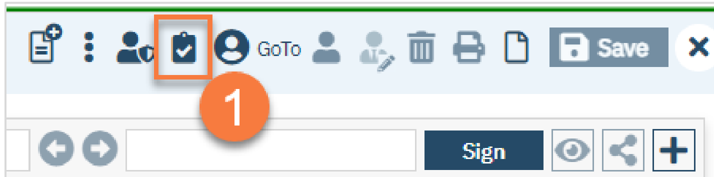


Full-Service Partnership (FSP)

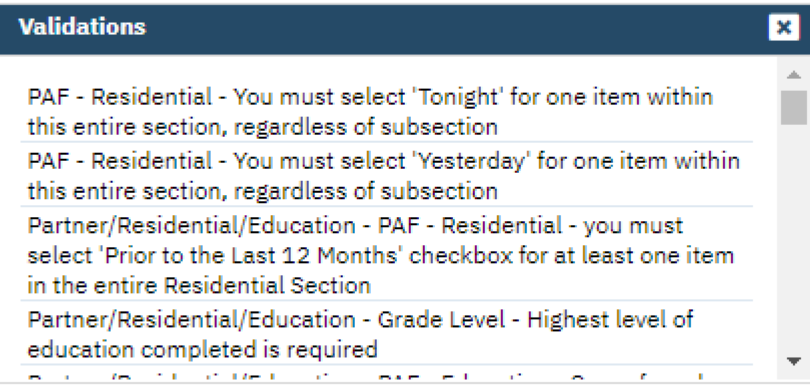
Clients who are identified as Full-Service Partnership (FSP) clients under the Mental Health Services Act (MHSA)have additional reporting requirements. These do not replace the need for a CSI or CalOMS report, but are in addition to them. In this section, we'll cover the required FSP documents. Depending 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.

The logic associated with the collection of Full-Service Partnership records is very complex. It involves a combination of field-specific validation, validation which compare values in one field versus values entered in other fields, and still additional validation evaluating the record as a whole. The screens in SmartCare associated with the California FSP data collection have been configured to apply all of these validations. These validations can either be applied/invoked by the user on an as-needed basis, or will be applied by the system upon saving or signing the record. Given how complex the data collection for these FSP records can be, we suggest that users periodically invoke the validation checks as they complete the data input screens.

1. To execute a validation check, **click the Validate icon** in the upper right corner of the screen.

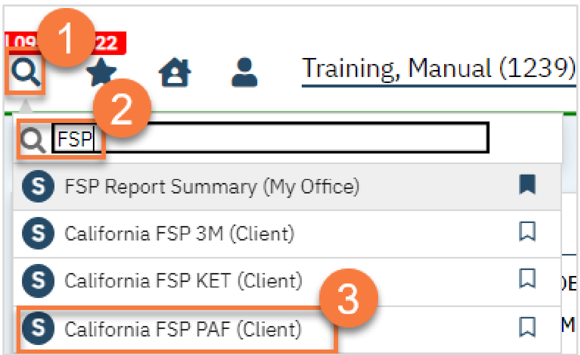


2. If errors are present, a "Validations" pop-up window will appear in the upper left corner of the screen. The list of errors will be displayed in the order of their appearance on the screen. The validation messages will provide the name of the tab, the section, and a message explaining the validation error.

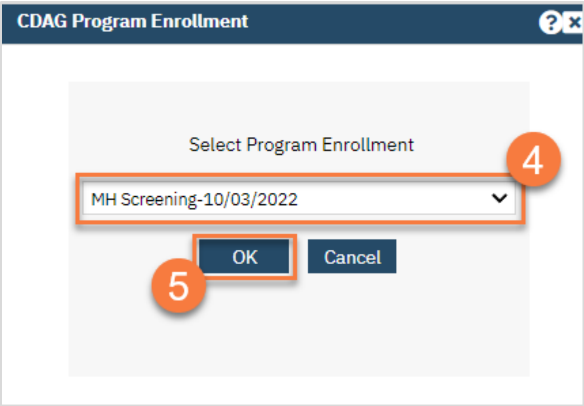


How to Complete a PAF

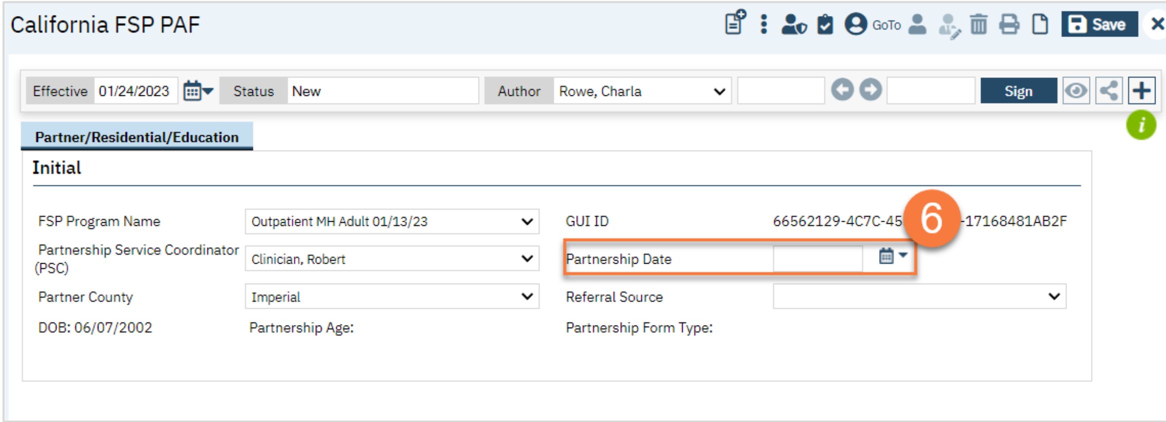
1. You must first have the client open, then **click the Search icon**.
2. **Type "FSP"** into the search bar.
3. **Click to select "California FSP PAF (Client)"** from the search results.

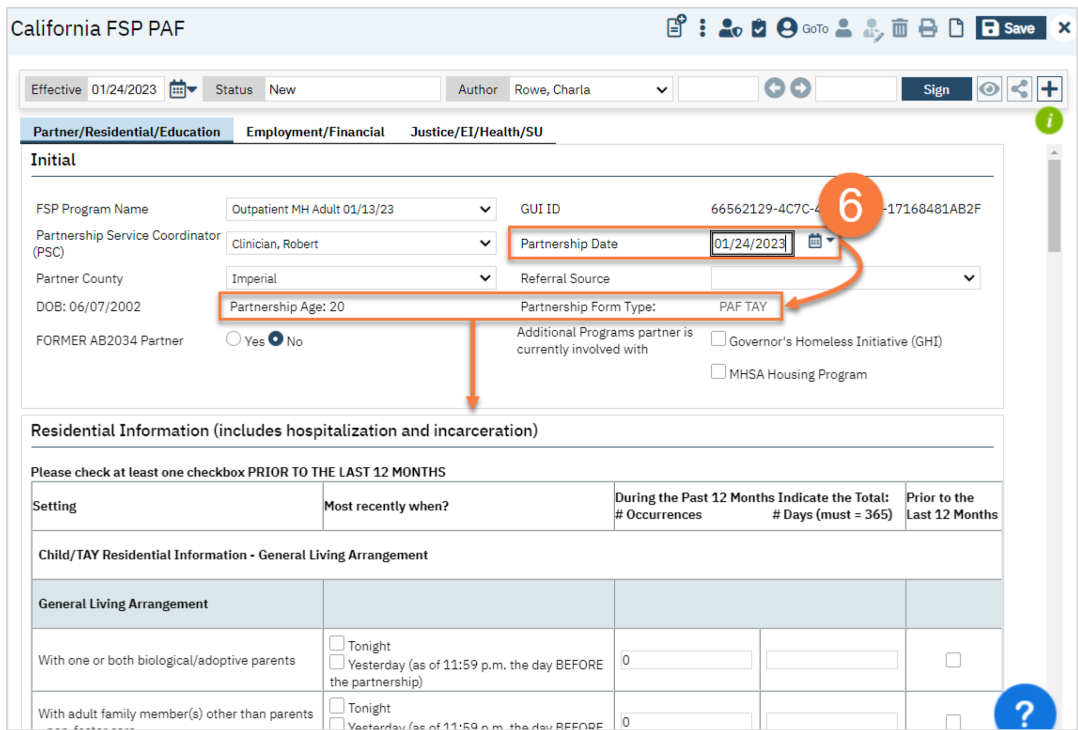


4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.

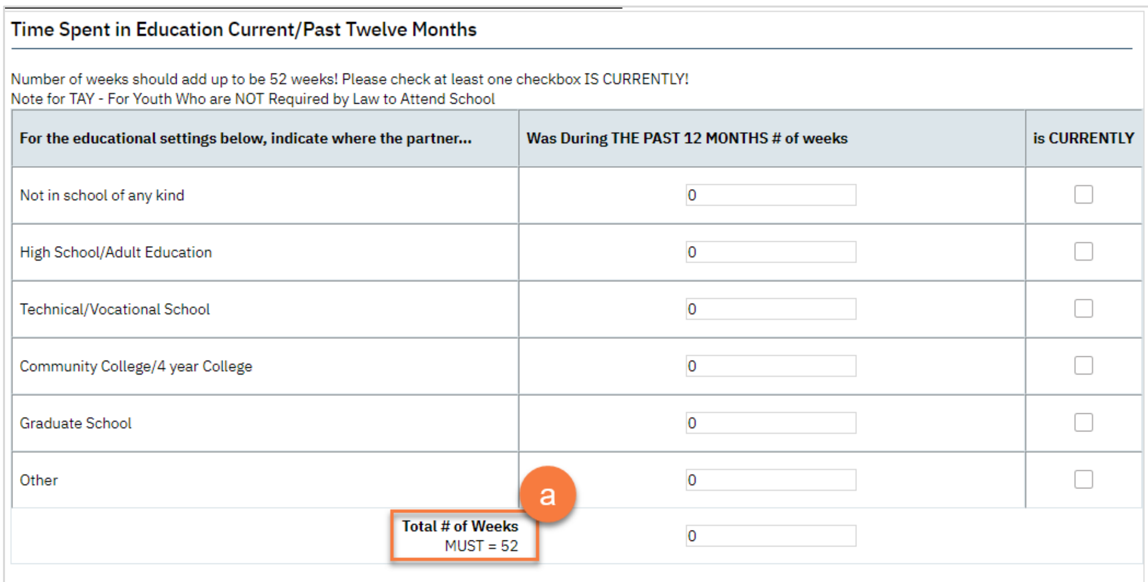


6. The PAF document will open. Most of the screen will be blank until you enter the partnership date. This will determine what your client's PAF form will look like.

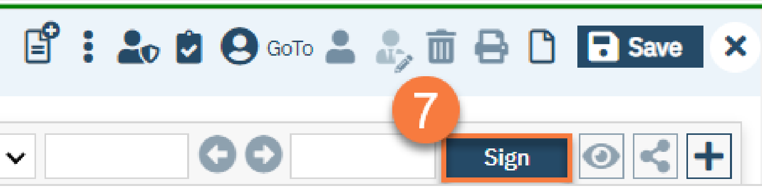




a. There is a lot of logic built into the form. If you need help understanding how to complete this form, talk to your supervisor or FSP manager for assistance. We have put in tips to try to help, but these forms may be overwhelming for some. Remember to use the validation button as needed.

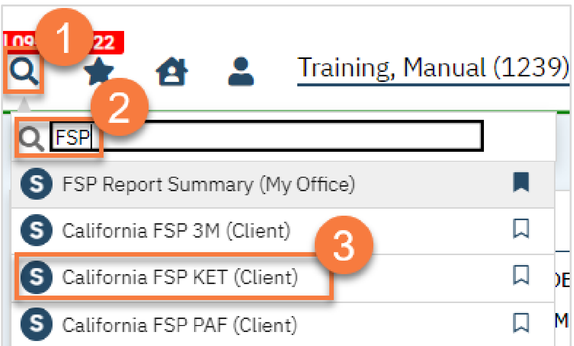


7. Once you've completed all fields on all tabs, **click Sign** to complete and generate the document.

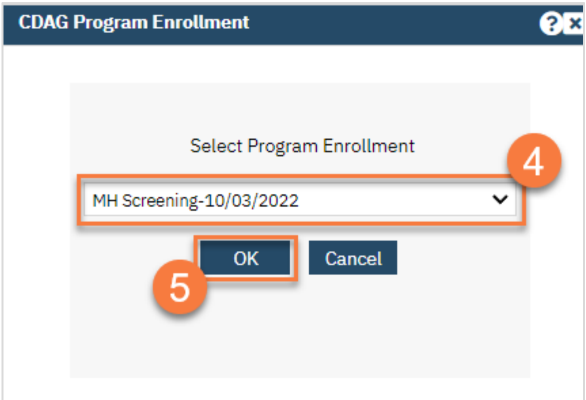


How to Complete a KET

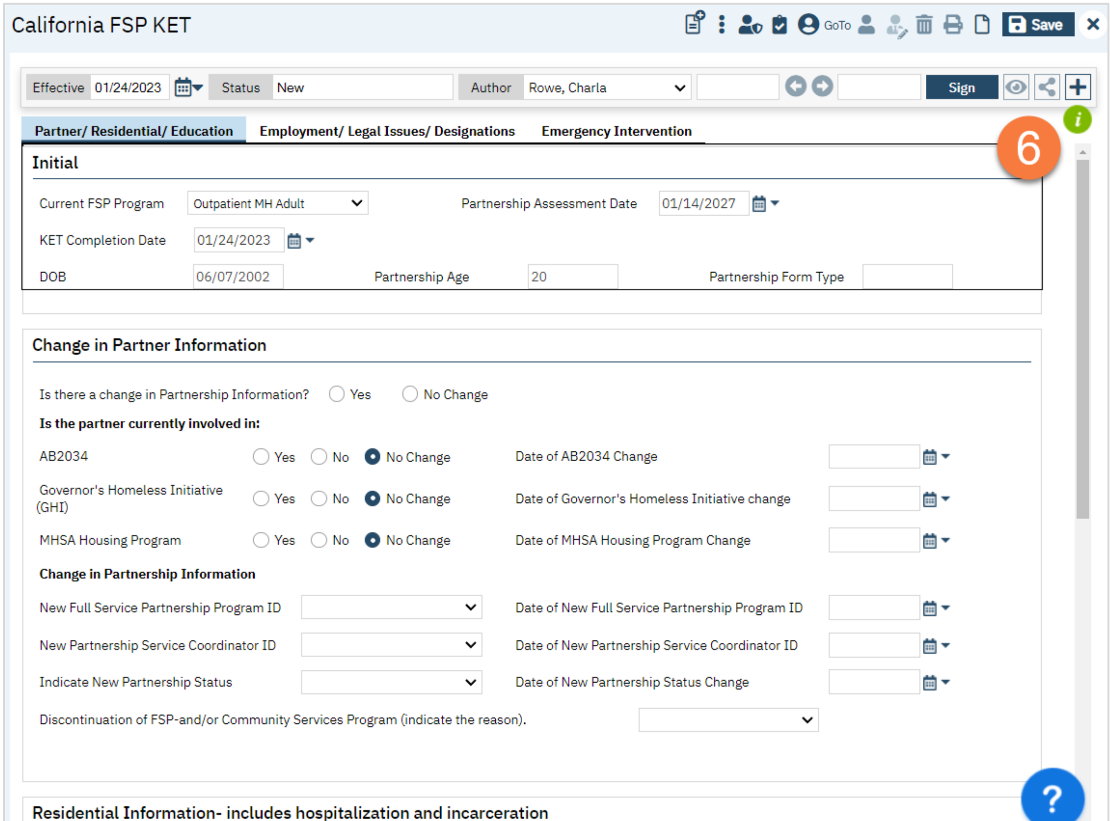
1. You must first have the client open, then **click the Search icon**.
2. **Type "FSP"** into the search bar.
3. **Click to select "California FSP KET (Client)"** from the search results.



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.



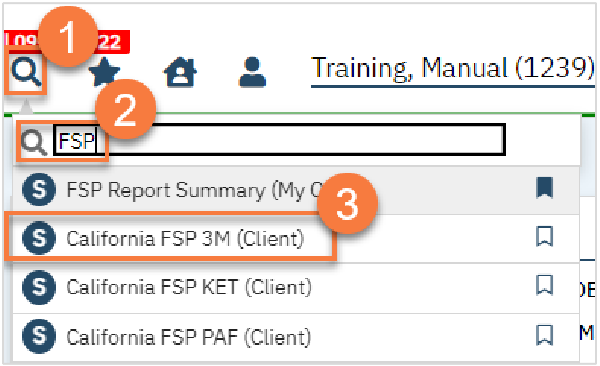
6. The FSP KET document will open. **Complete the document**. There is logic built into the form, based on the FSP KET reporting rules. If you need help understanding how to complete this form, talk to your supervisor or FSP manager for assistance. Remember to use the validation button as needed.



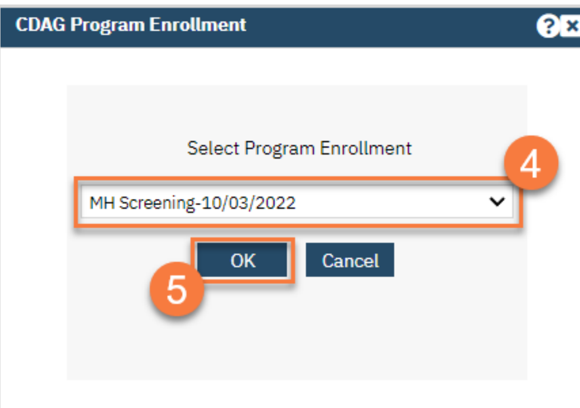
7. Once you've completed all fields on all tabs, **click Sign** to complete and generate the document.

How to Complete a 3M

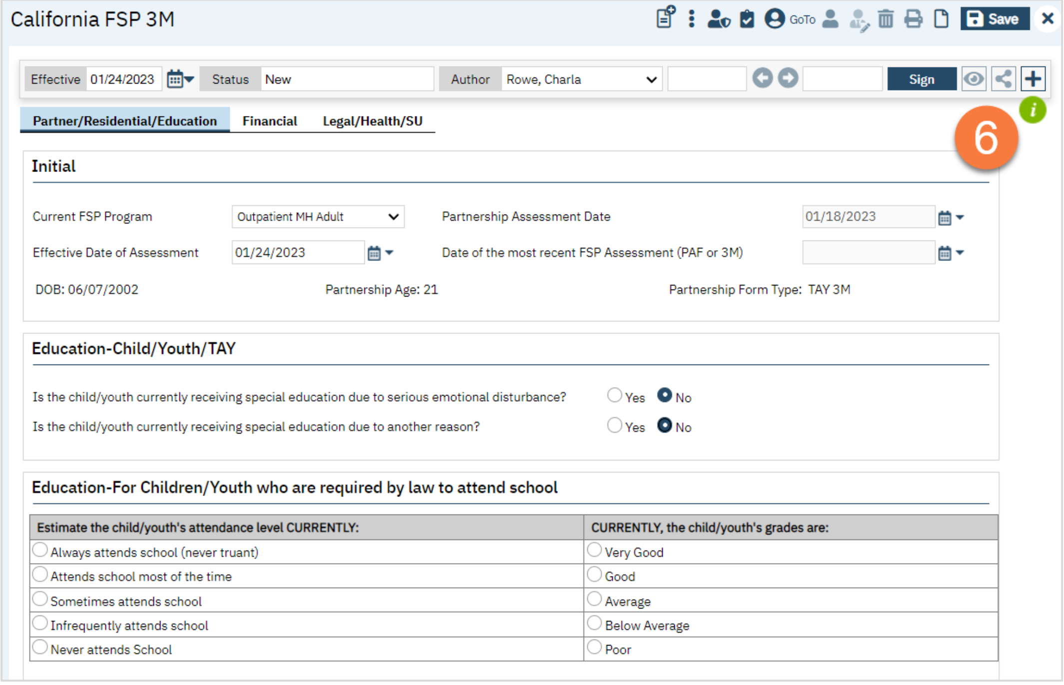
1. You must first have the client open, then **click the Search icon**.
2. **Type "FSP"** into the search bar.
3. **Click to select "California FSP 3M (Client)"** from the search results.



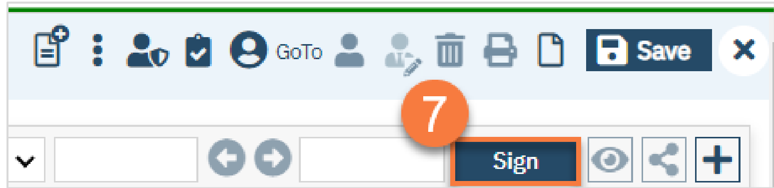
4. In the CDAG Program Enrollment window pop-up, **click the drop down** and **click to select** the appropriate program.
5. **Click OK** to continue.



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. Remember to use the validation button as needed.



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



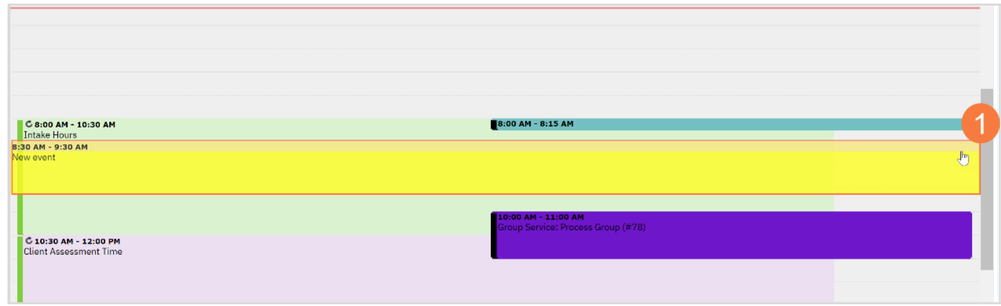
My Calendar Management

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.

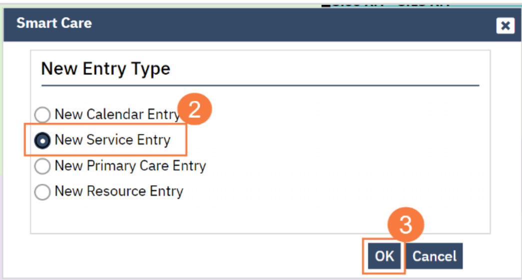
How to Create an Appointment from Your Calendar

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

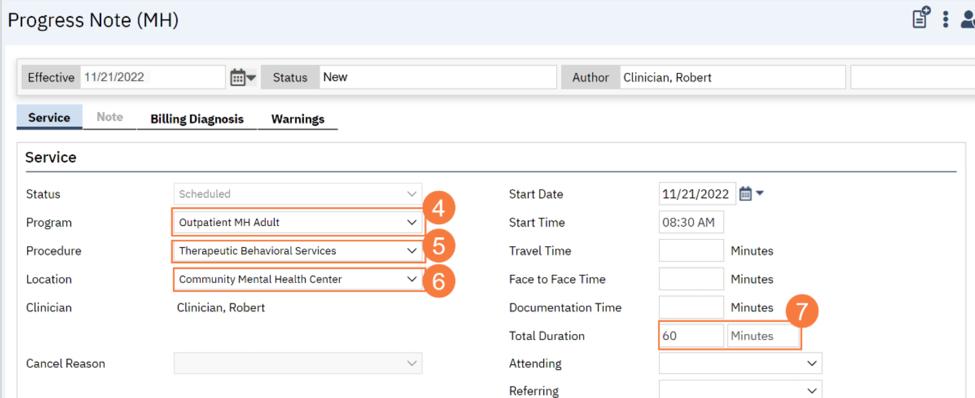
1. From the Staff Calendar screen, **click and drag your mouse on the calendar timeslot** you want to book.



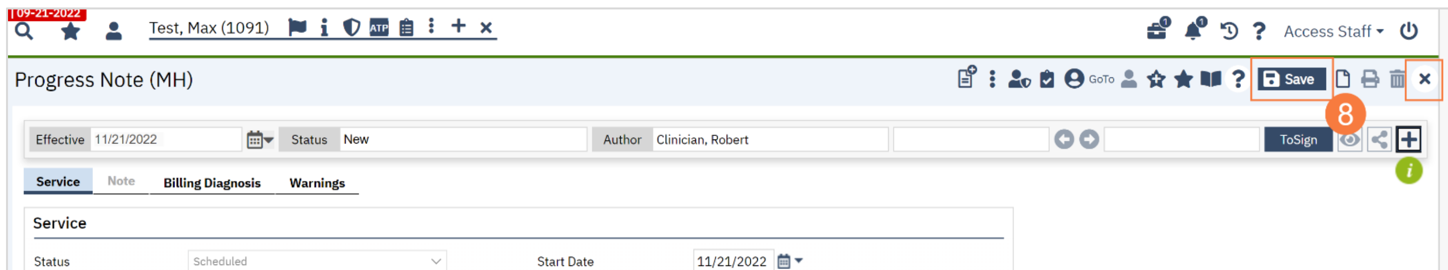
2. In the New Entry Type pop-up, **select the New Service Entry radio button.**
3. **Click OK**.



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.**

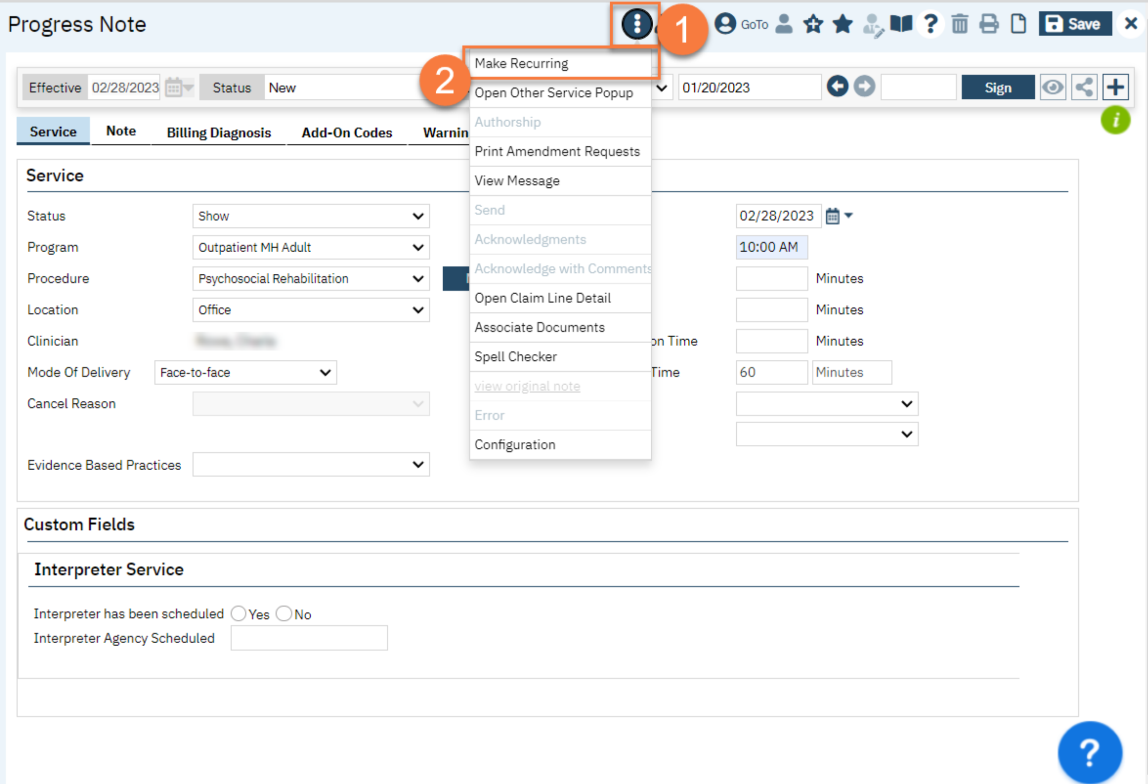


8. **Click the Save icon**. **Click the X icon** to close the screen.

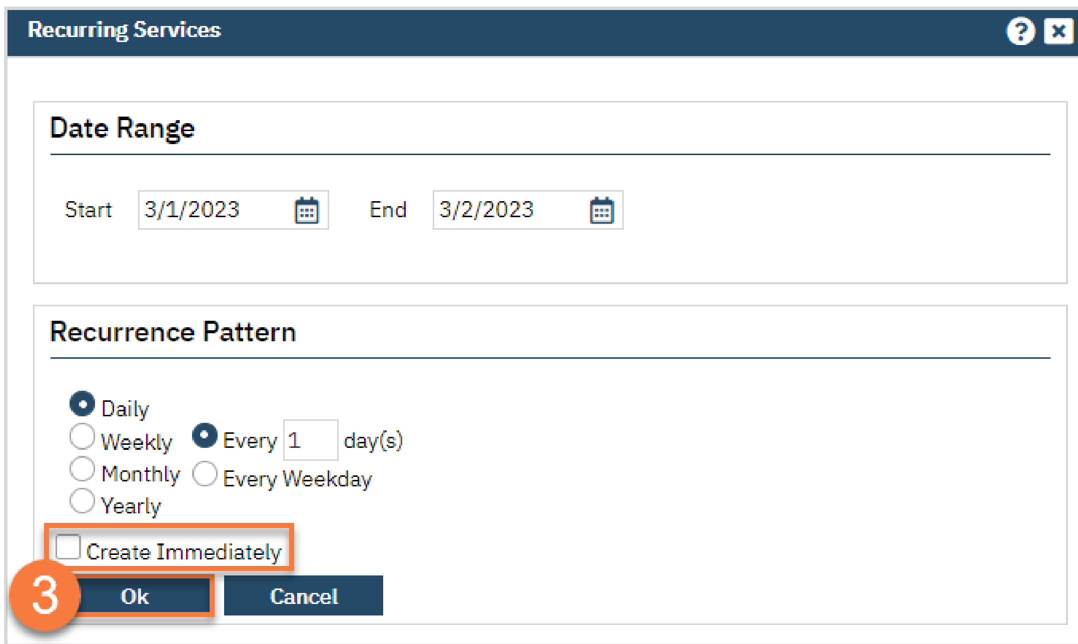


How to Create a Recurring Individual Service Appointment

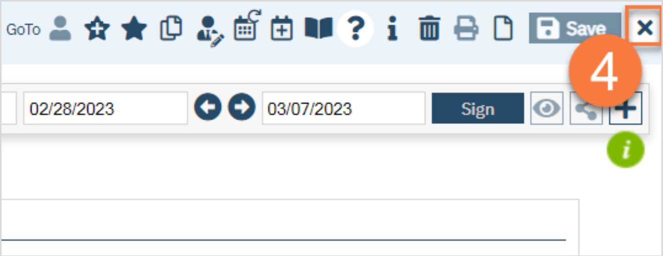
1. Follow the steps laid out in How to Create an Appointment from Your Calendar. Once you've saved (step 8), **click the triple vertical dot icon** in the upper right.
2. **Select "Make Recurring"** from the dropdown menu.



3. This brings up the Recurring Services pop-up screen. **Complete the information and click OK**. We recommend you **check "Create Immediately"**, as this automatically adds these appointments to your calendar with all the information. Not checking this box results in an appointment that says "Service Exists" with no other information.



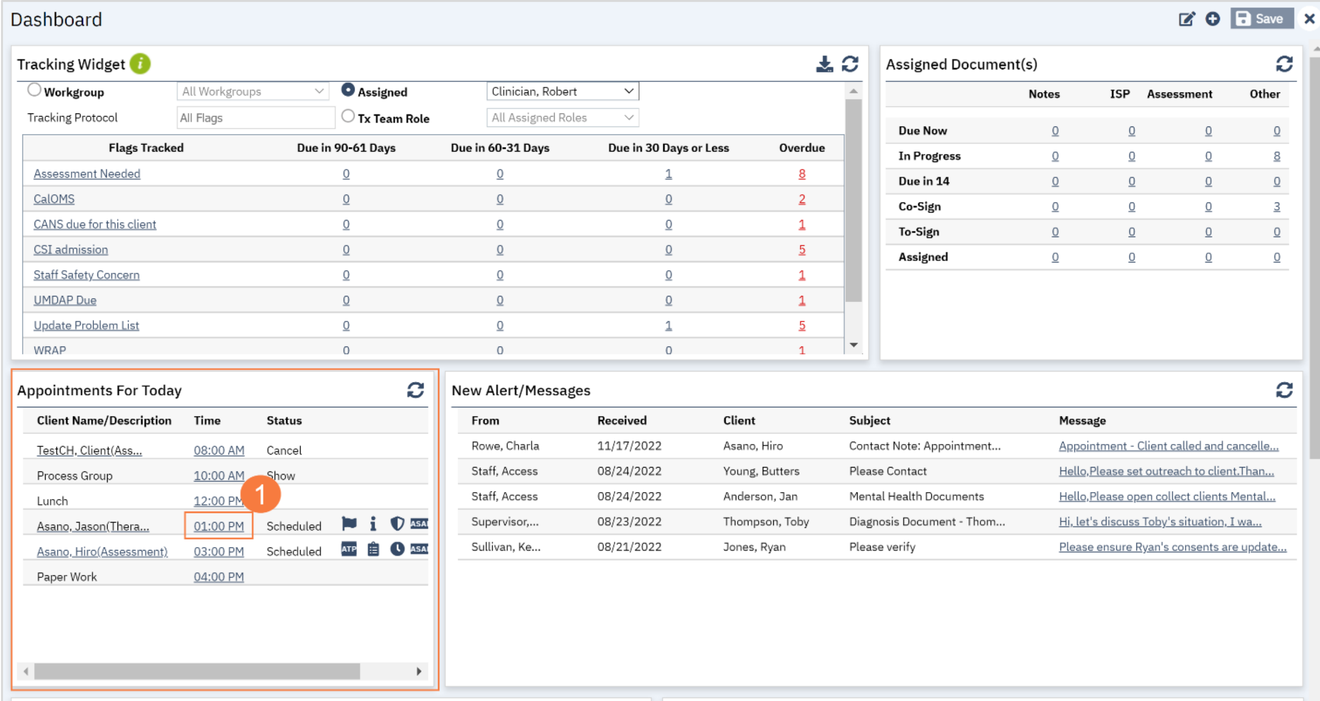
4. Clicking OK on the pop-up dismisses the pop-up and takes you back to the service note screen. You can now close the service note screen by clicking the X icon in the top right corner.



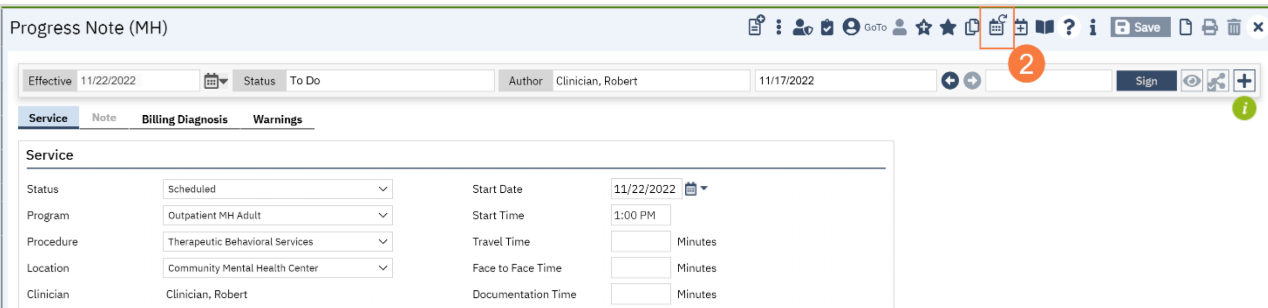
How to Reschedule a Client's Appointment

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

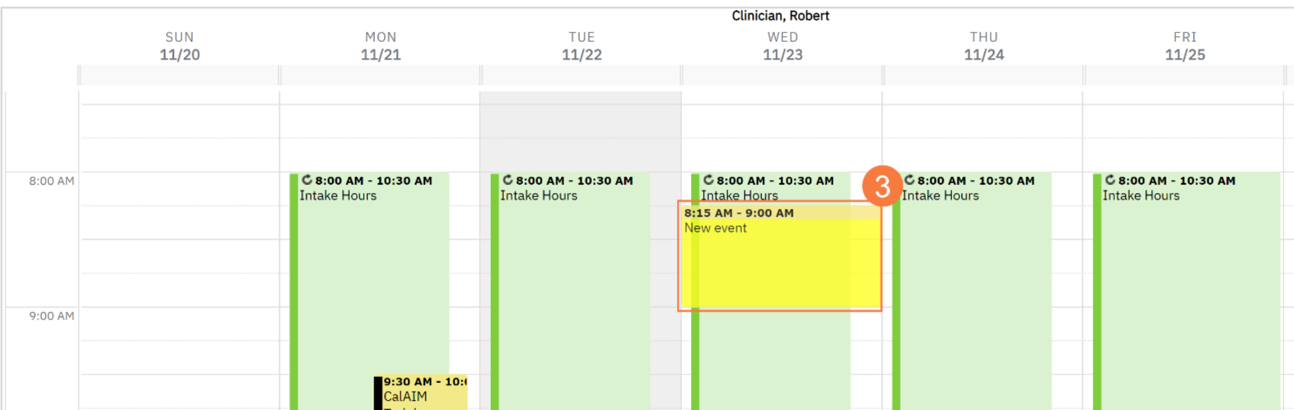
1. From your SmartCare home page, locate the Appointments for Today widget. **Click the appointment time** to the right of the patient you need to reschedule.



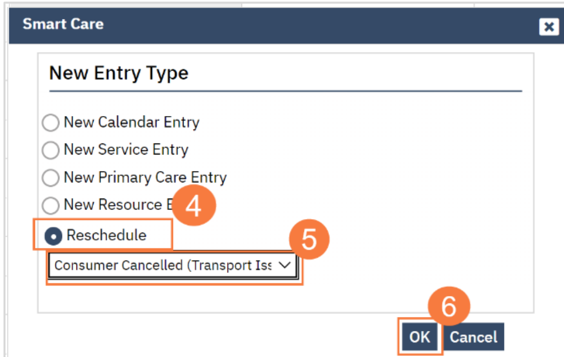
2. In the Progress Note screen, **click the Reschedule icon**.



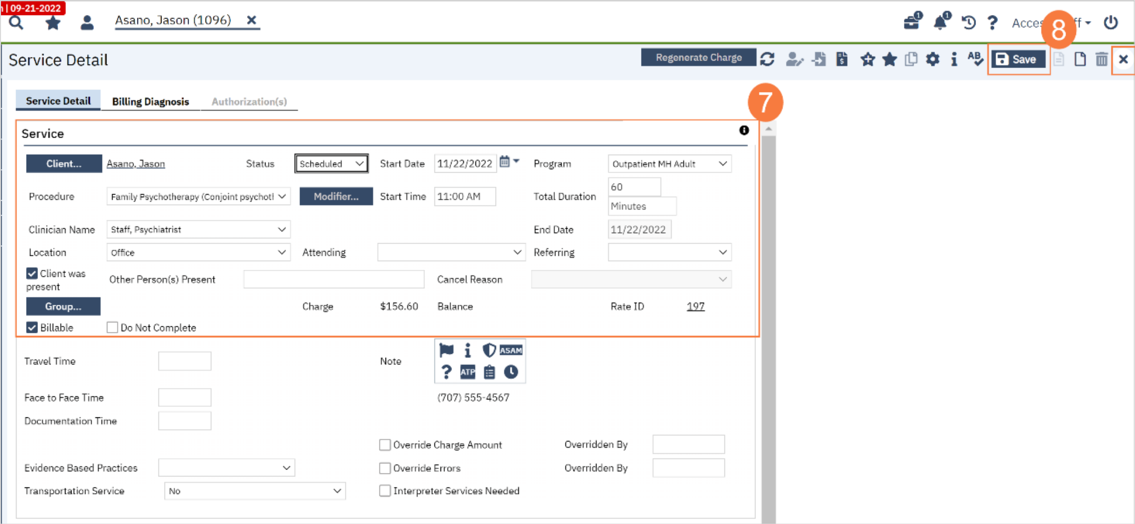
3. Your Staff Calendar screen will open, **click and drag your mouse on the calendar timeslot** you want to book.



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.



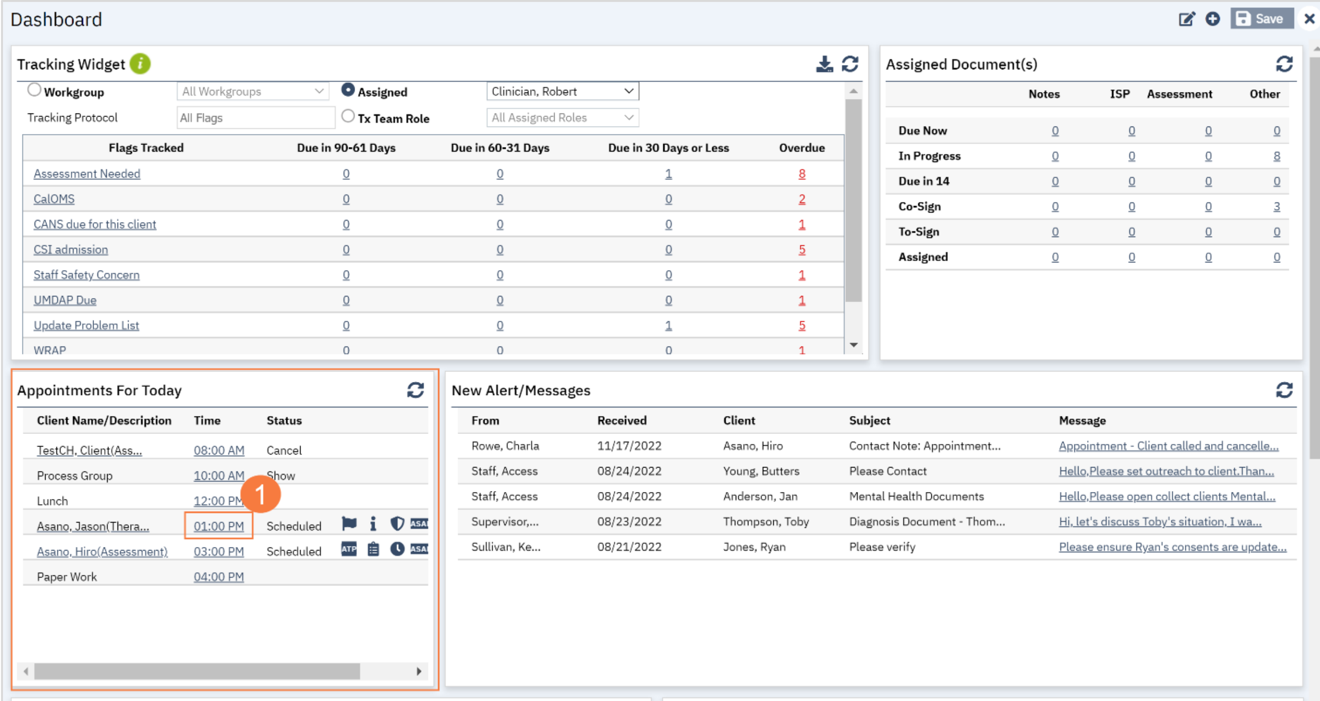
7. The Service Entry window will open, ensure all the information in correct
8. **Click Save** to reschedule the appointment. **Click the X** to close.



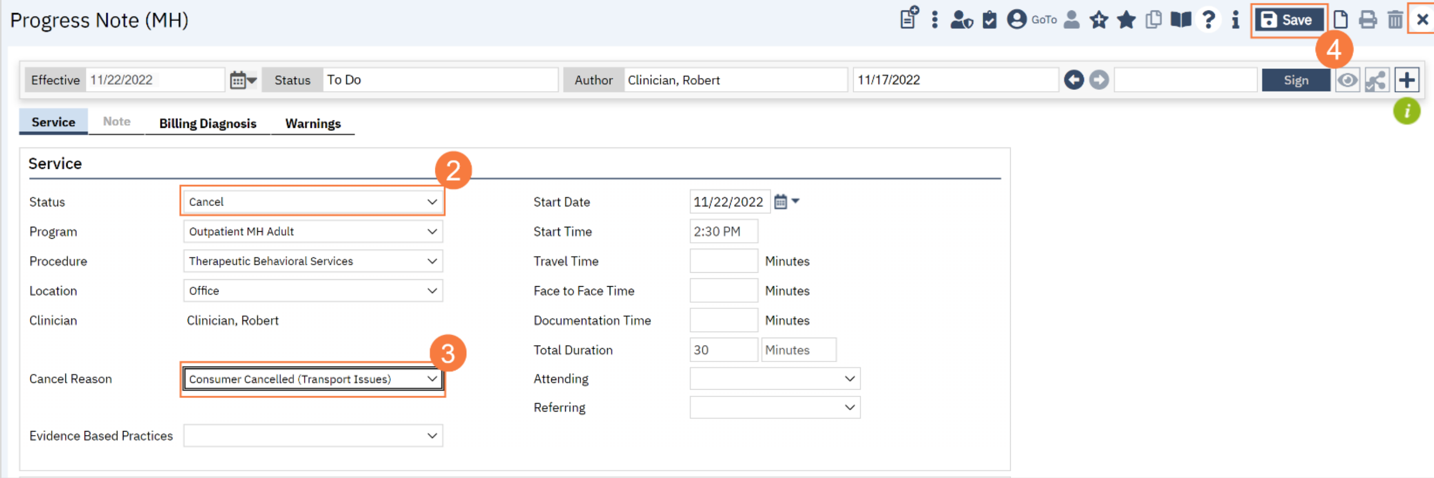
How to Cancel a Client's Appointment

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.



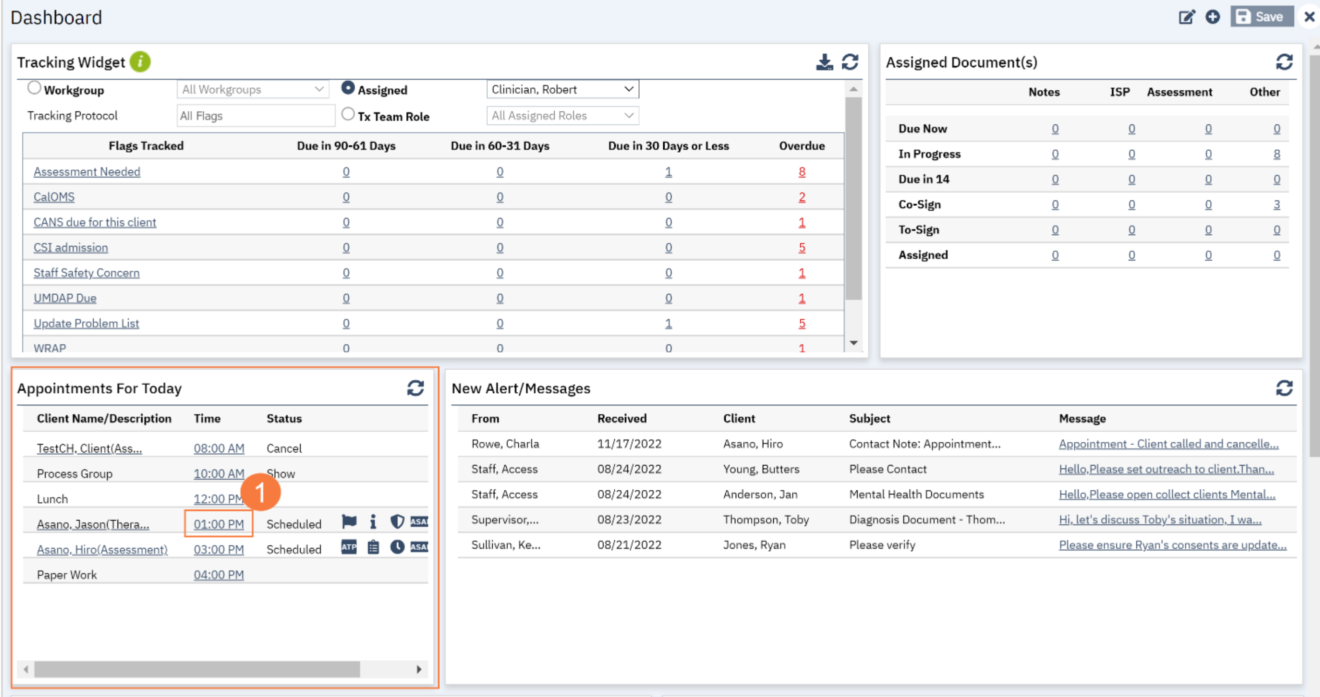
2. The Progress Note screen will open, **click the drop-down menu in the Status field** and **select Cancel.**
3. **Click the drop-down menu in the Cancel Reason field** and **select the appropriate reason.**
4. **Click Save** to cancel the appointment. **Click the X** to close.



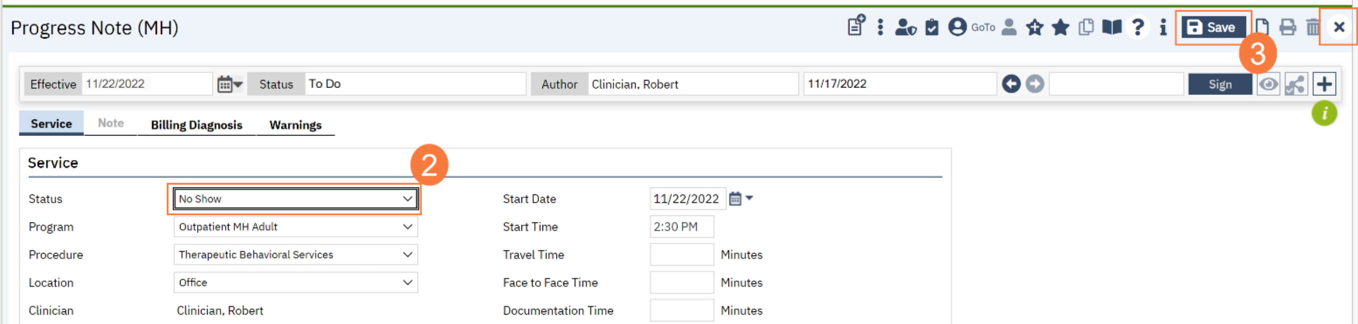
How to Document a No-Show Appointment

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 Document Additional Information for a Scheduled Appointment that Results in a No-Show

Sometimes you review the client's chart, discuss the case with your treatment team, or otherwise prepare for an upcoming service. Sometimes, when the client doesn't show, you take the time to do something else related to the client's case. Sometimes, you drive out to meet the client and the client isn't present at the appointed meeting place. Regardless, you need to mark the scheduled appointment as a no-show.

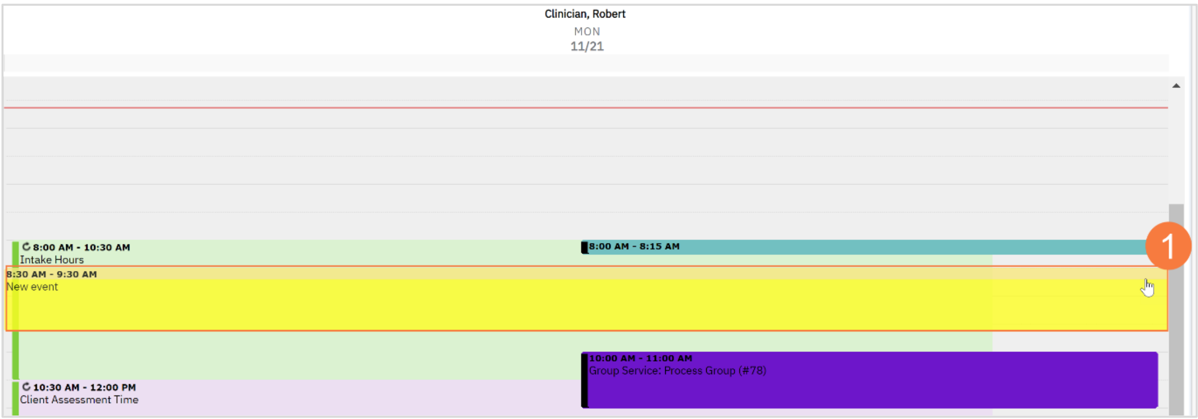
CalMHSA is working to add a method of entering informational notes directly attached to the no-show or cancelled service. This is currently in development.

If you provide a billable service during the time you would have spent with the client, you would need to mark the scheduled appointment as a no-show and create a new, unscheduled service to document the service you ended up providing. Talk to your supervisor if you have questions about whether the tasks you provided were billable or simply informational.

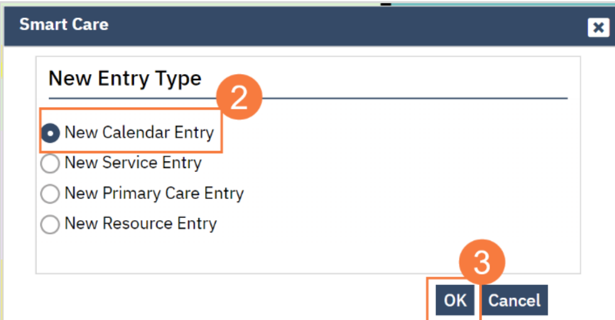
How to Schedule Non-Client Time on Your Calendar

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

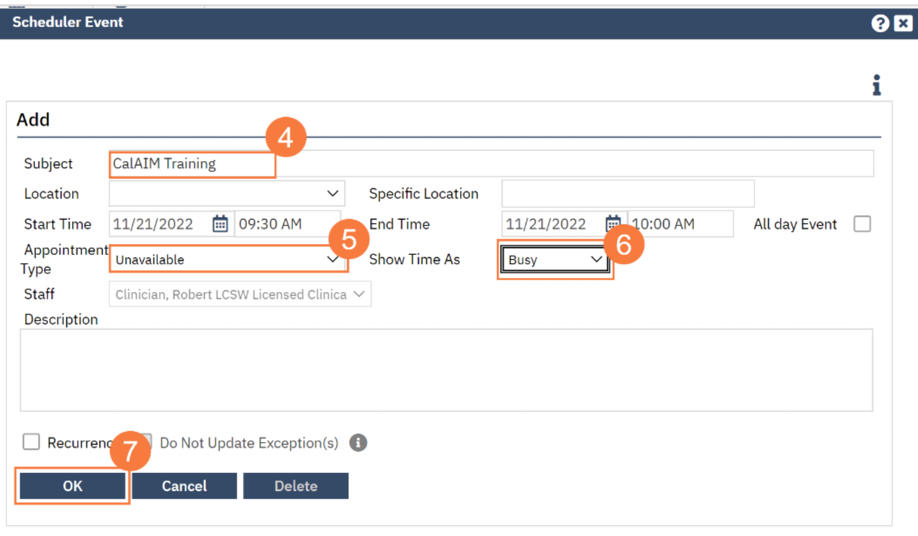
1. From the Staff Calendar screen, **click and drag your mouse on the calendar timeslot** you want to book.



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**.

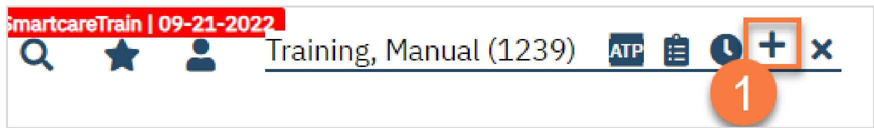


Other Functionality

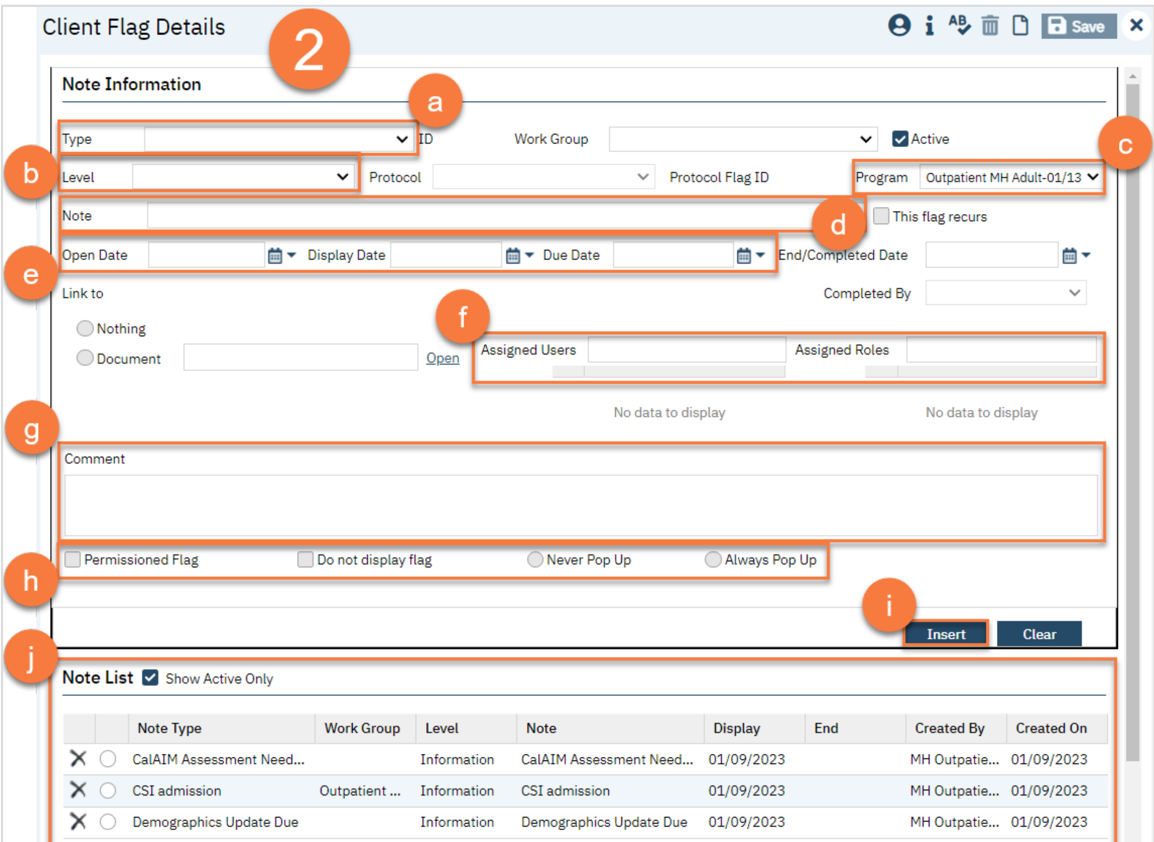
Introduction?

How to Create a Flag to Alert Treatment Team Members to Important Client Information

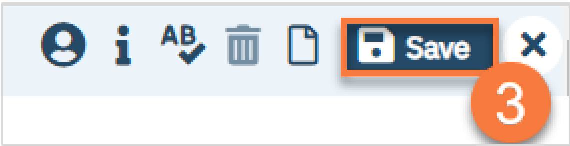
1. Make sure you have the client open. Click the plus icon next to the client's name.



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.

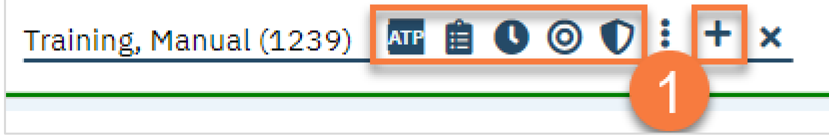


3. Once you've added all flags, **click Save**. You are now finished and may close this screen.

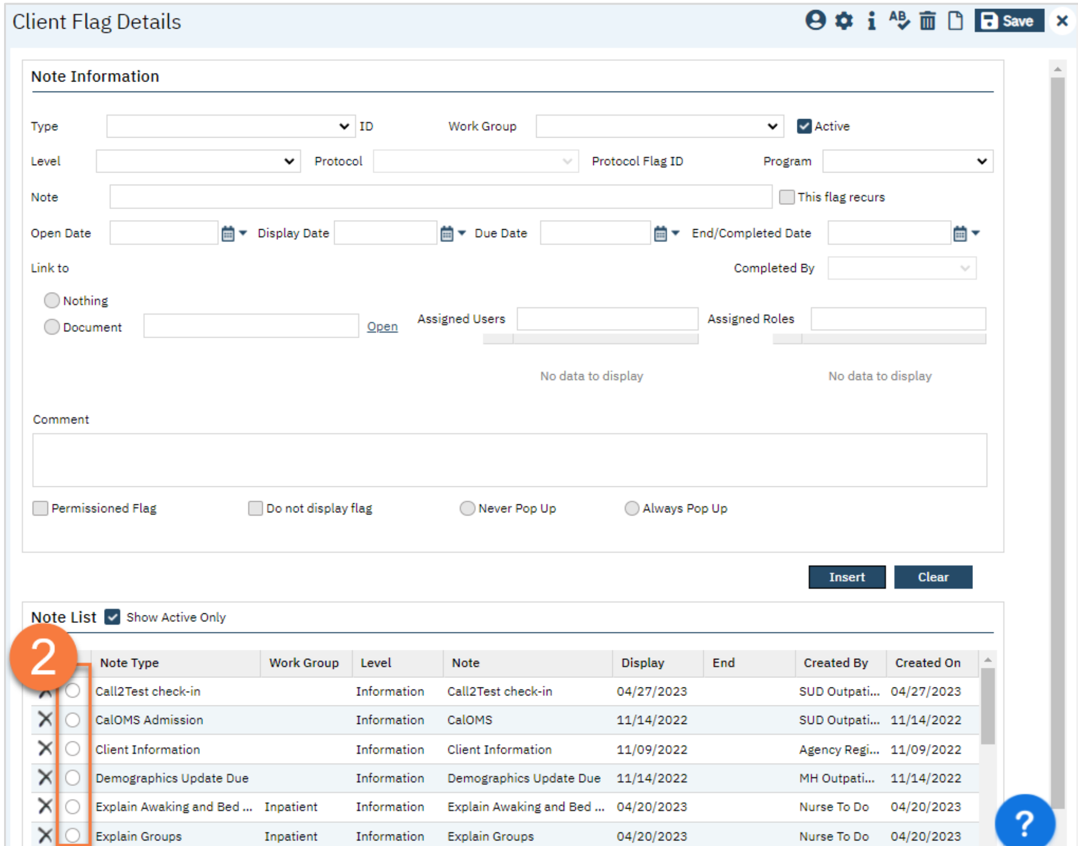


How to Modify an Existing Flag

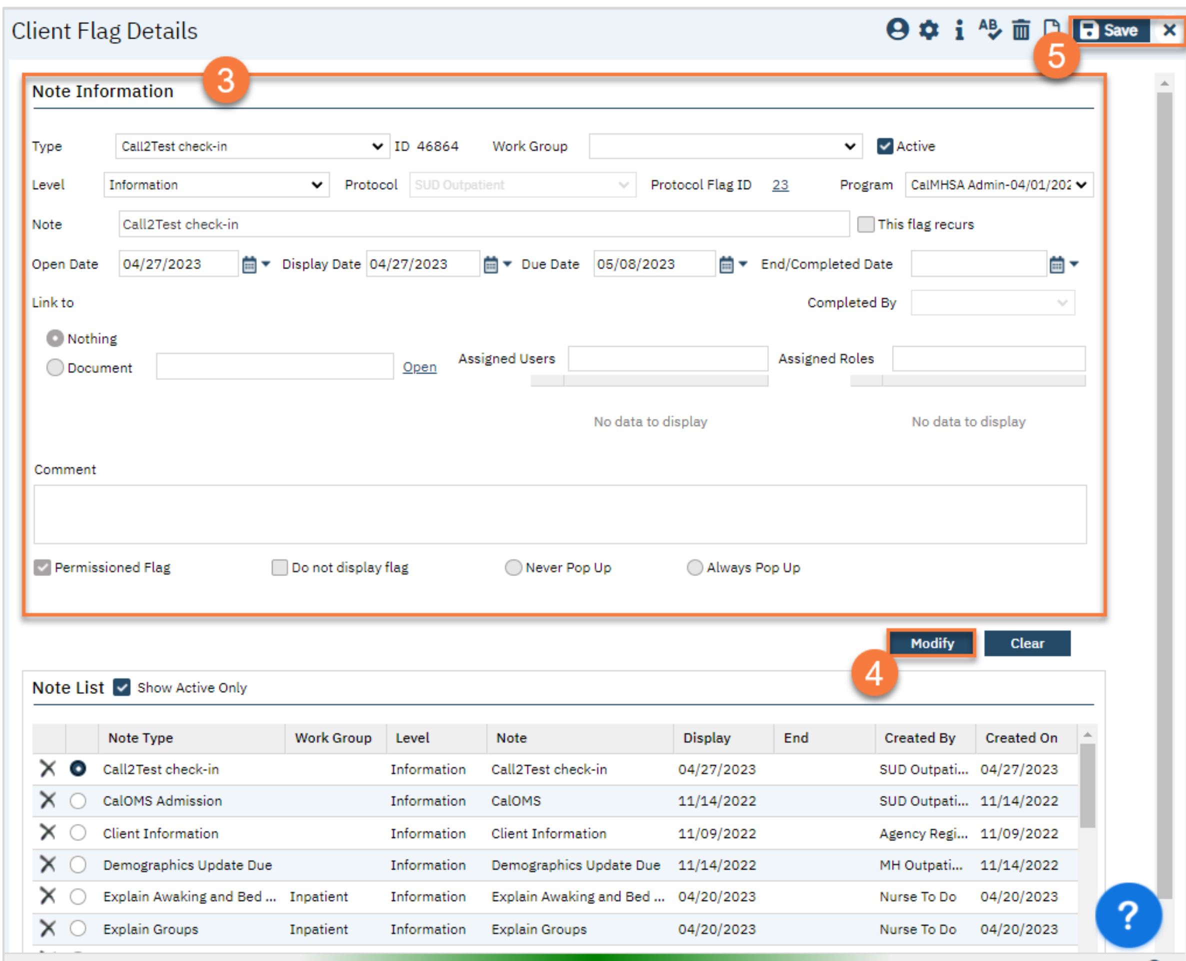
1. With the Client open, click on the icon related to the flag you're trying to update. If you don't see it, click on the Plus icon.



2. This takes you to the Client Flag Details screen. Select the flag you want to modify.

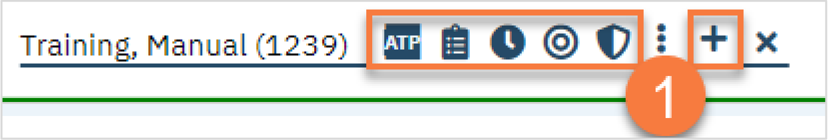


3. This brings the information to the top half of the screen. Make the edits in this section.
4. Click “Modify”. This updates the flag.
5. Click Save and close.

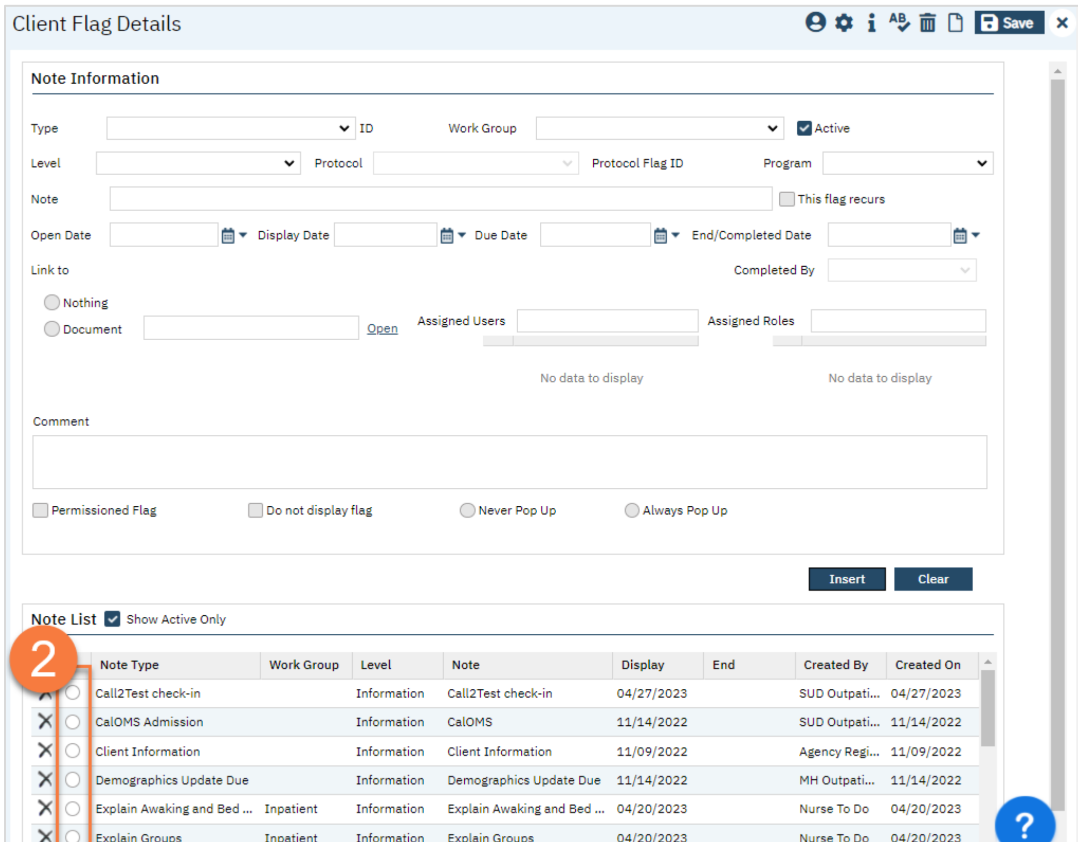


How to Mark a Flag as Complete

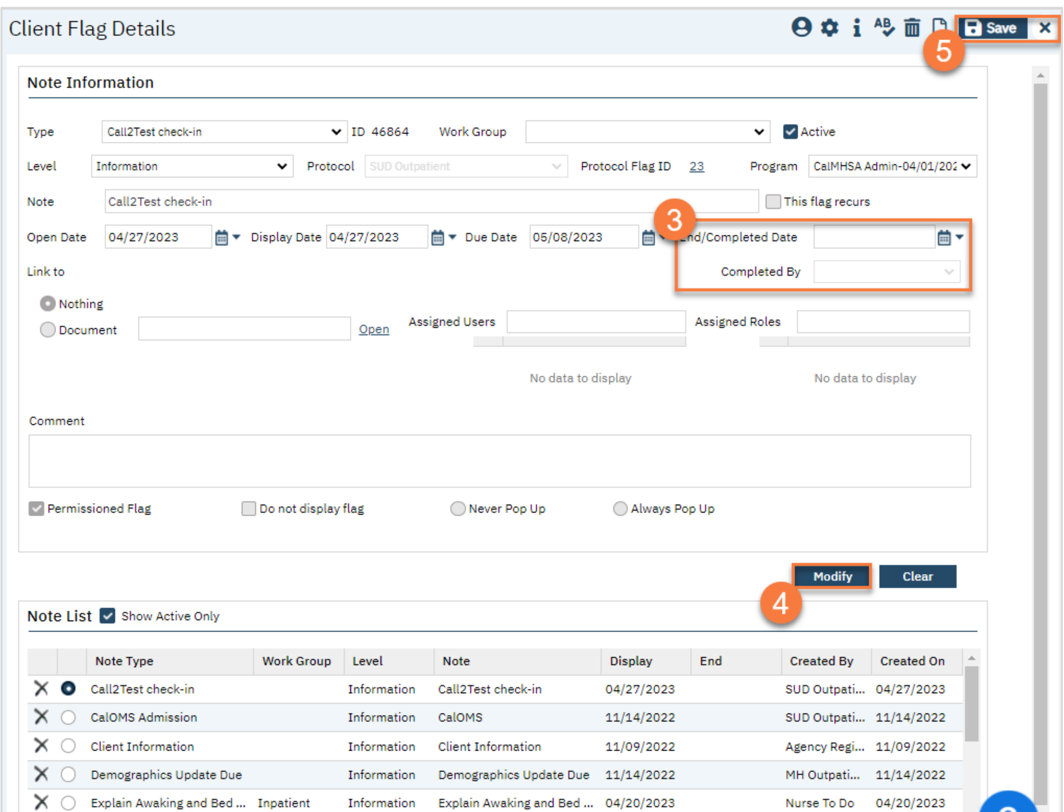
1. With the Client open, click on the icon related to the flag you're trying to update. If you don't see it, click on the Plus icon.



2. This takes you to the Client Flag Details screen. Select the flag you want to complete.



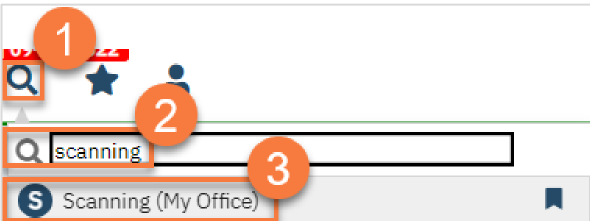
3. This brings the information to the top half of the screen. Enter the “End/Completed Date” and the “Completed By” fields.
4. Click “Modify”. This marks the flag as complete.
5. Click Save and close.



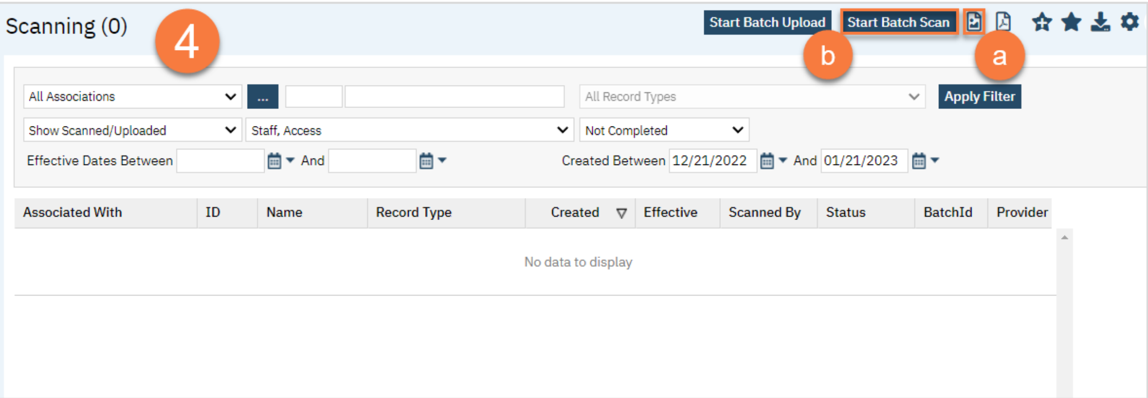
How to Scan a Document into the Client's Record

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.

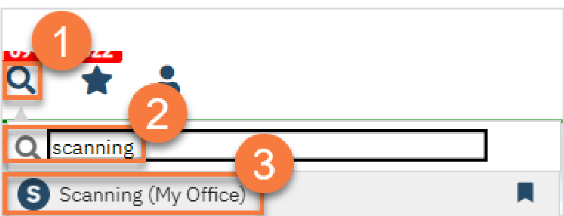


4. To scan, you need a scanner attached to your workstation. Scanning will use your scanner's software but save it in SmartCare.
   a. To scan a single document, click the "Scan New Images" icon.
   b. To scan multiple documents in a batch, click the "Start Scan Upload" button.

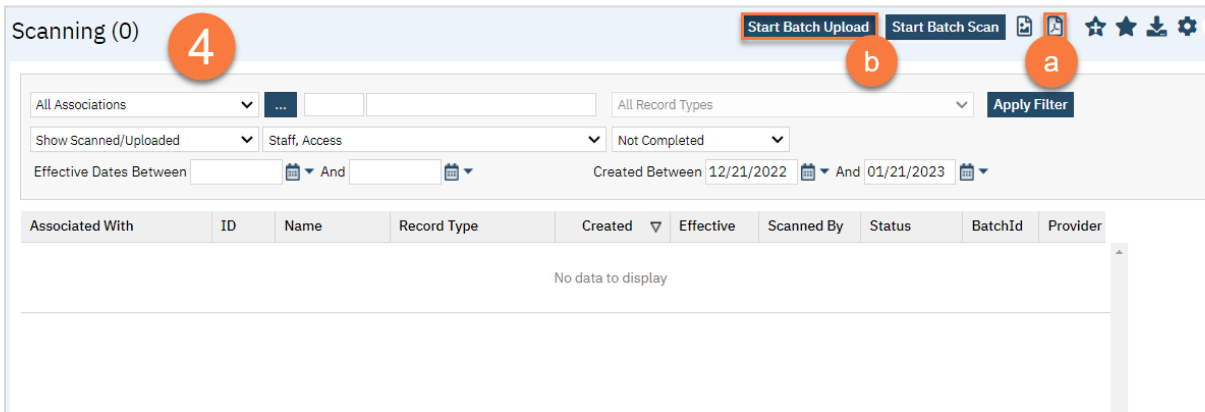


How to Upload a Document into the Client's Record Without a Scanner

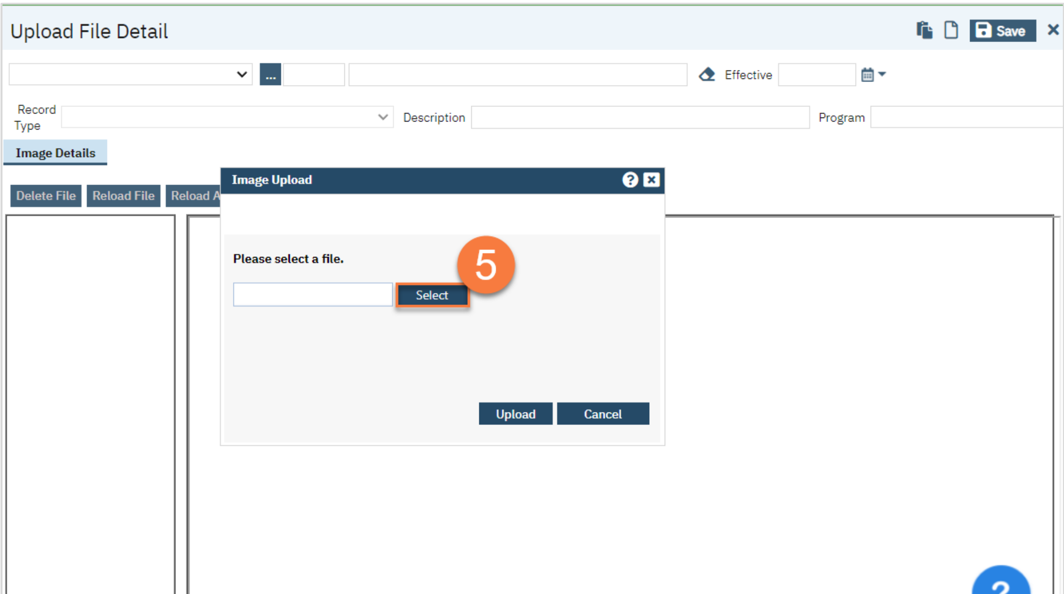
1. **Click the Search icon**.
2. **Type "Scanning"** in the search bar.
3. **Select "Scanning (My Office)"** from the search results.



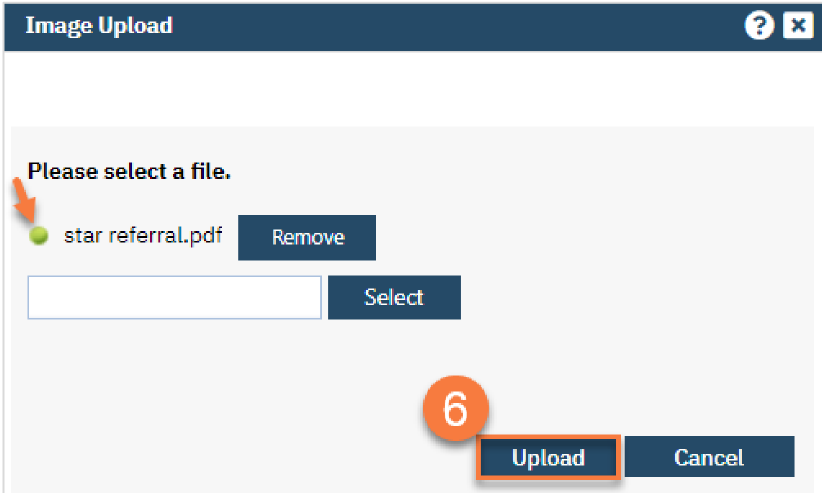
4. You can upload documents one at a time or as a batch.
   a. To upload a single document, click the "Upload New Images" icon.
   b. To upload multiple documents in a batch, click the "Start Batch Upload" button.



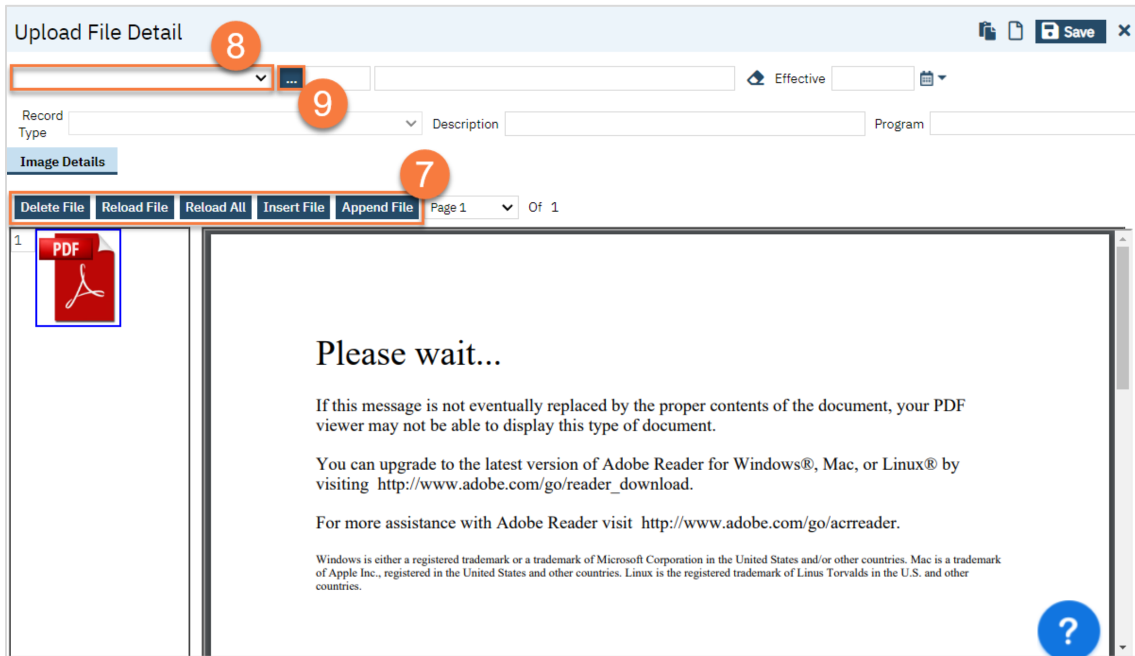
5. Choosing upload will open the Upload File Detail screen. This will include a pop-up. **Click Select** to find the file on your computer.



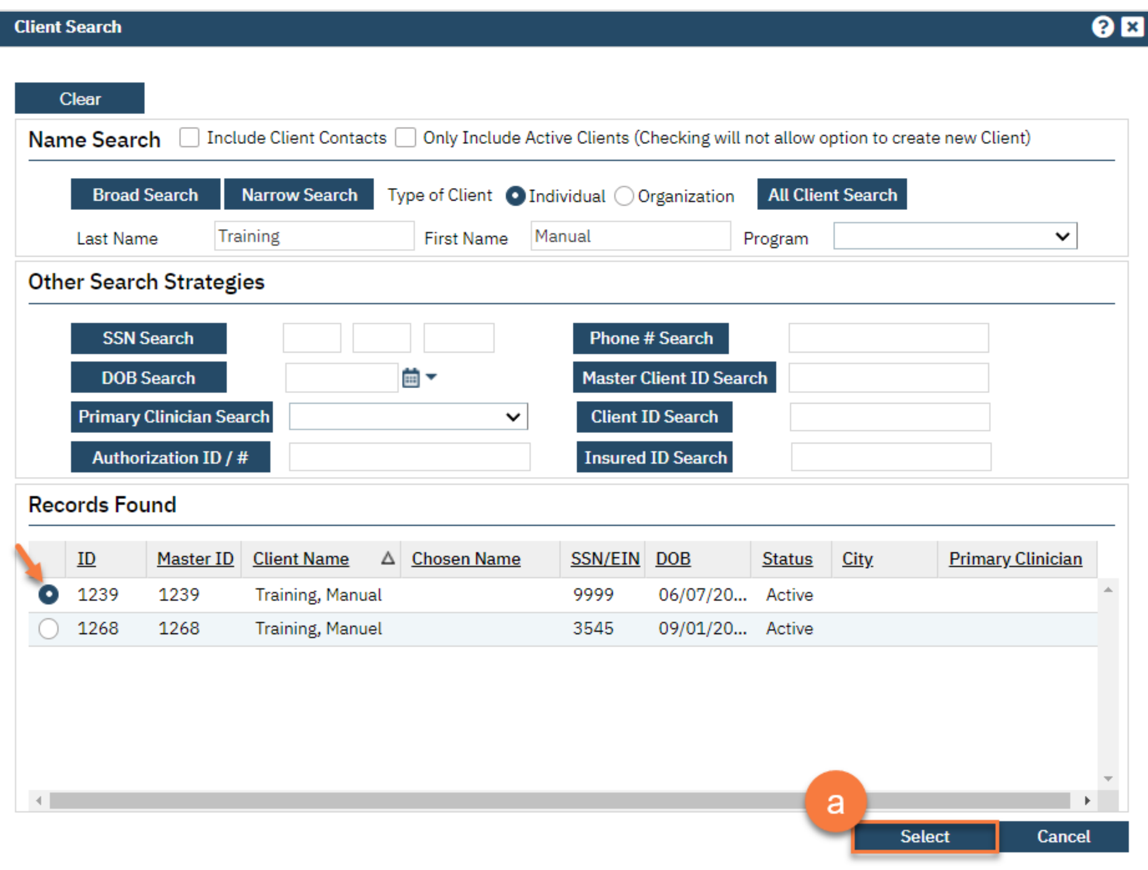
6. Once it's ready, a little green circle will appear next to it. **Click Upload**.



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.

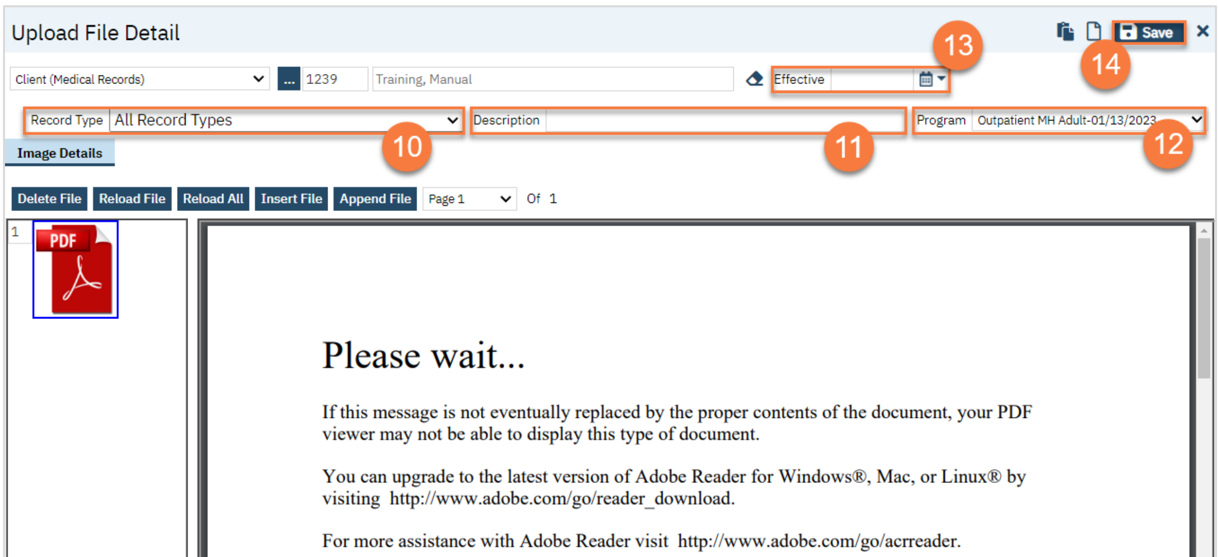


a. This will bring up the client search. Use the client search to find the client. Click Select when you've located the client.



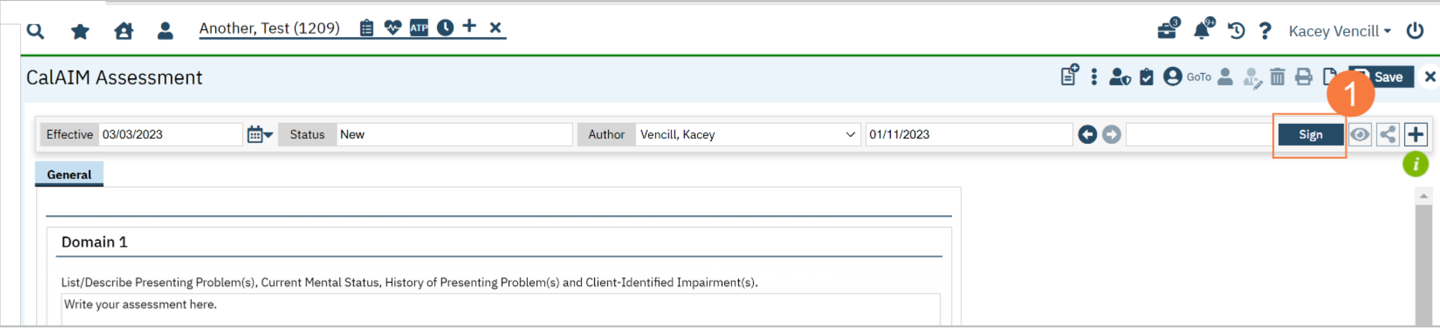
10. **Select the Record Type**.
11. **Enter the description** of the document.
12. **Enter the program** the document is associated with.

13. **Enter the Effective date** of the document.
14. **Click Save.**

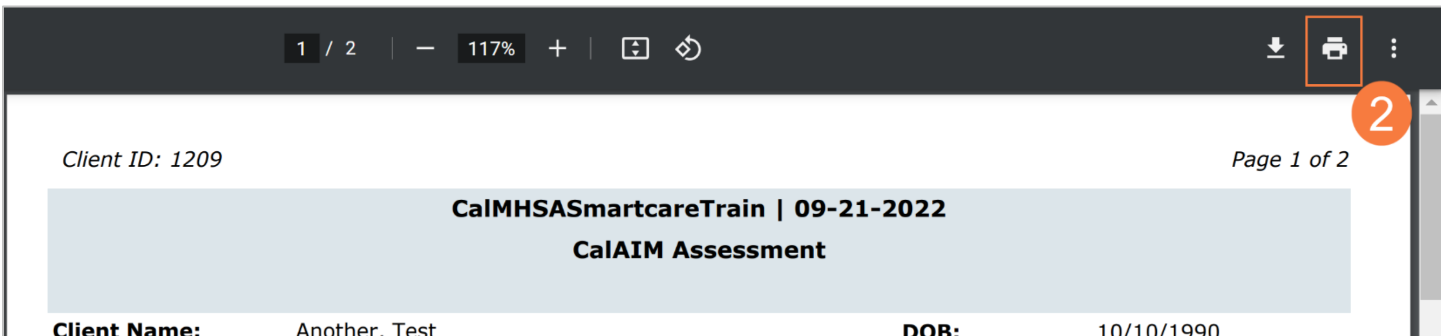


How to Print a Document to Get a Client's Signature

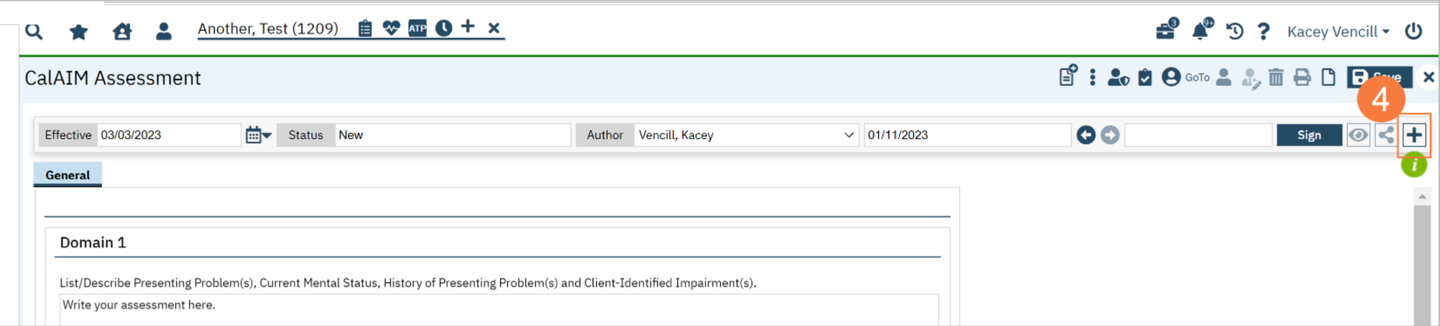
1. After you have completed the form, **click Sign** to create the PDF document.



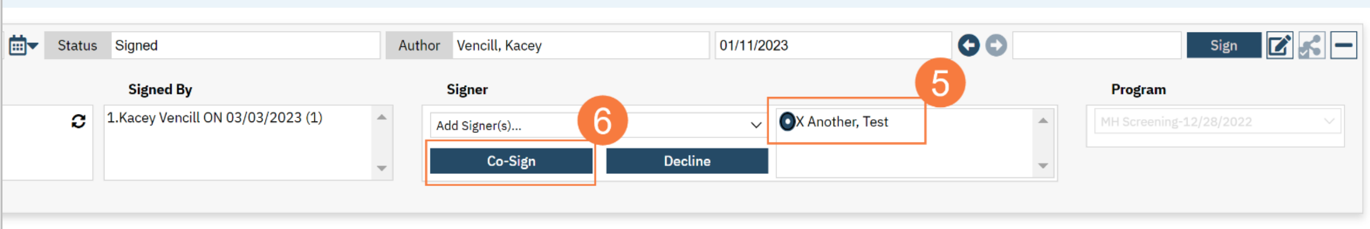
2. **Click the Print icon** once the document has generated.



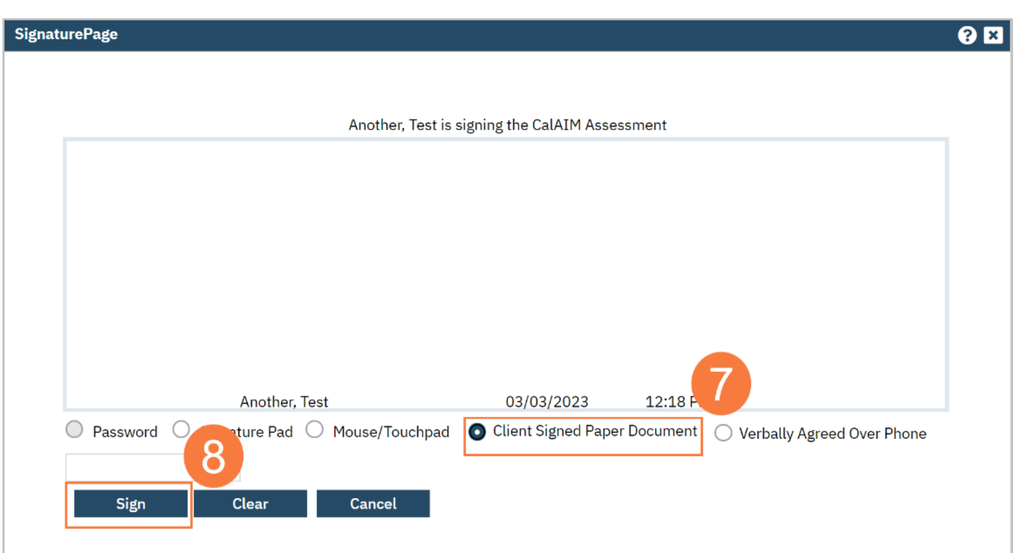
3. Have the client sign the paper document and scan the document back into SmartCare. (See *How do I scan a document into the client's record?*)
4. Navigate back to the form in SmartCare and click the Plus Sign icon.



5. **Click the radio button to** select the client's name.
6. **Click the Co-Sign button**.



7. In the Signature Page pop-up, **click to select the radio button** for Client Signed Paper Document.
8. **Click Sign.**

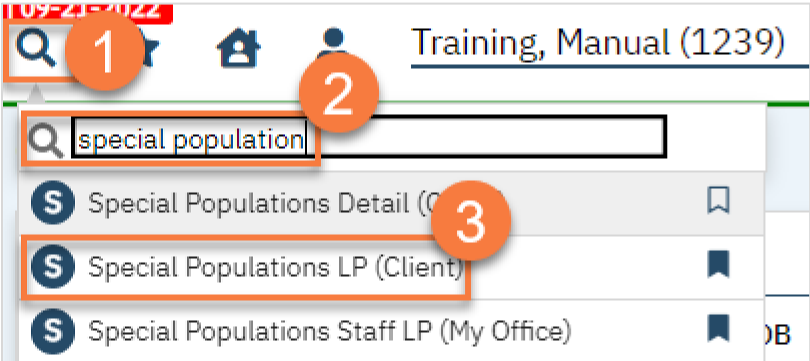


9. The document will now display the client 's signature was obtained on paper.

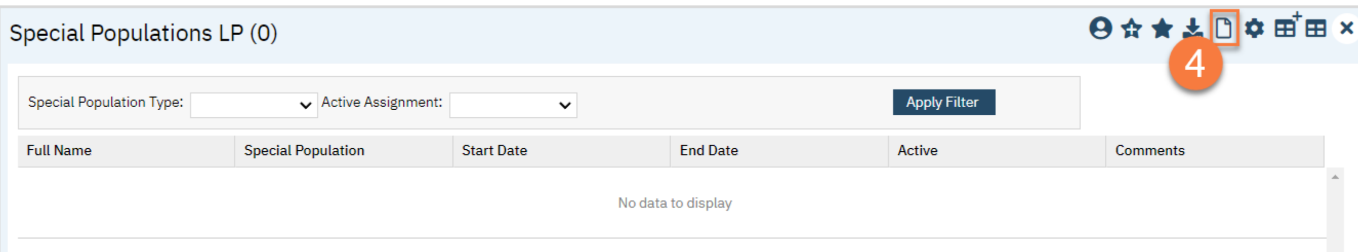
Client: Another, Test (Signed Paper Copy) **Signature Date:** See Paper Copy

How To Identify a Client as Katie-A or Other Special Population

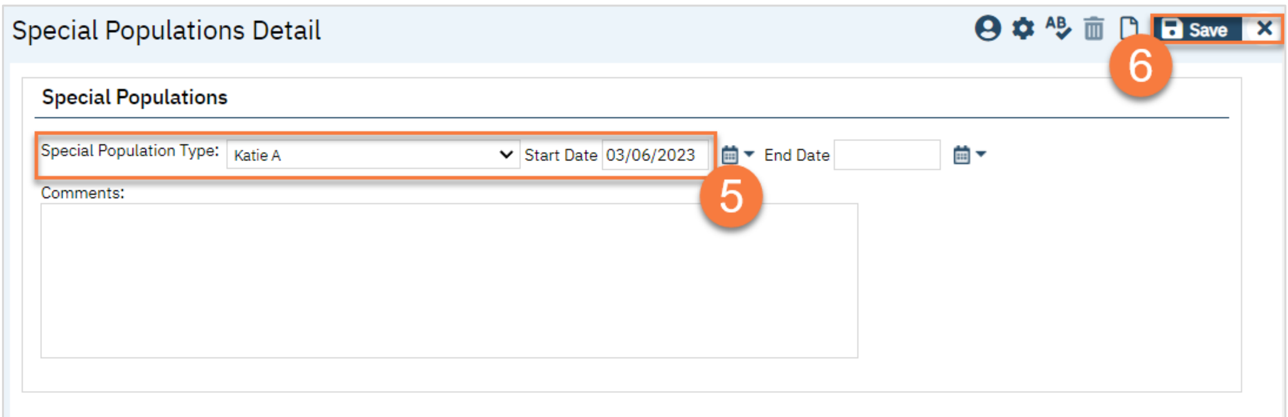
1. With a client selected in the header, **click the Search icon**.
2. **Type Special Populations** in the search bar.
3. **Click to select Special Populations LP (Client).**



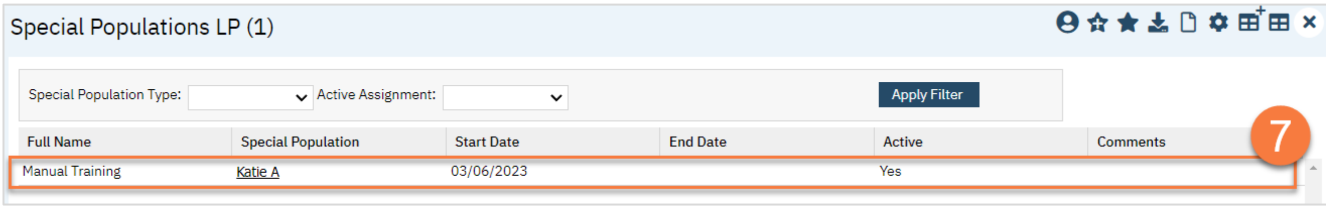
4. This takes you to the Special Populations list page. This will show you any special populations that the client is already associated with. To add a special population, click on the New icon.



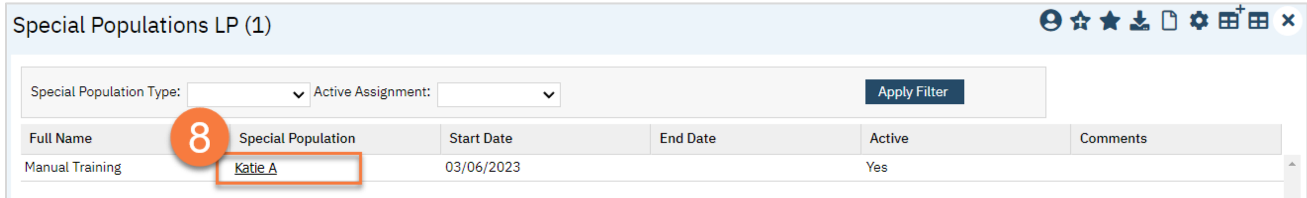
5. **Select the special population and enter the start date.**
6. **Click Save and then close.**



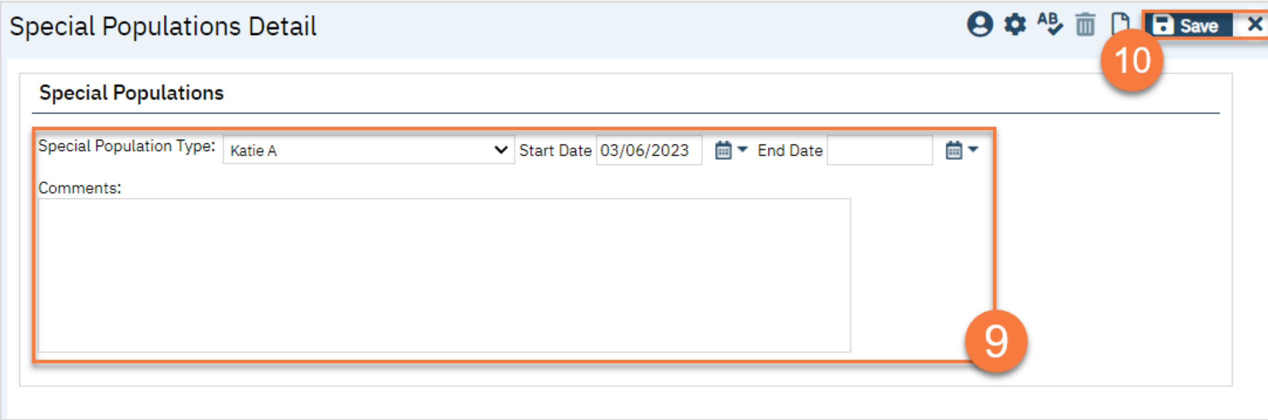
7. This takes you back to the list page, where you can confirm the entry.



8. To edit a special population identifier, **click on the link in the special population column**.



9. This takes you back to the Special Populations Detail screen. **Make the edits**, for example, adding an end date.
10. Once you've finished with your edits, **click Save and close**.

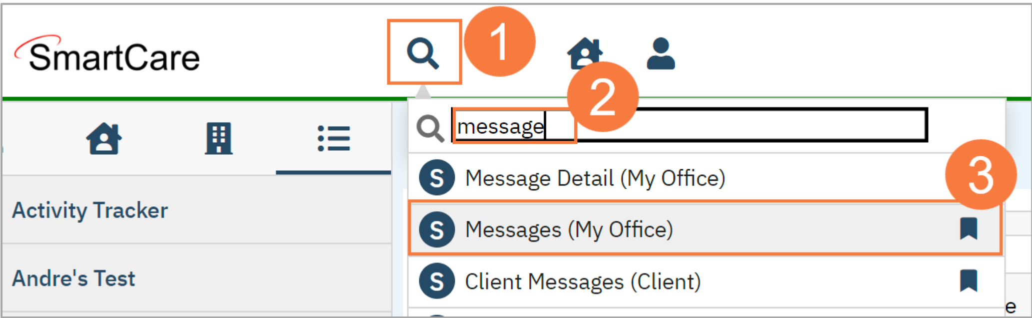


Messaging in SmartCare

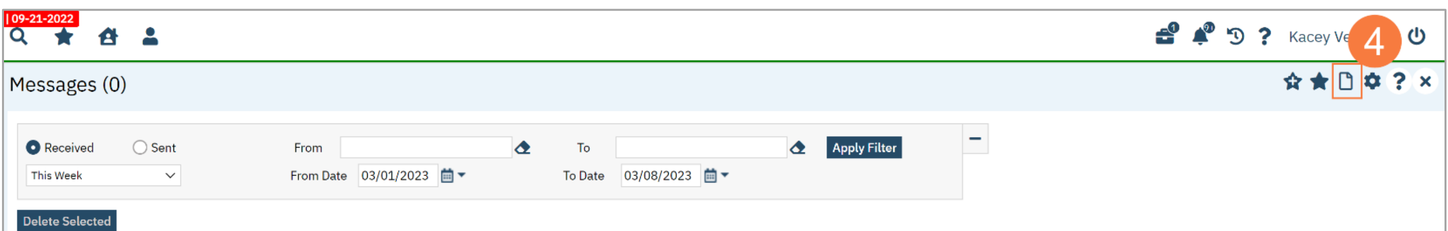
In this section you will learn how to send and receive messages in SmartCare.

How to Send a Message

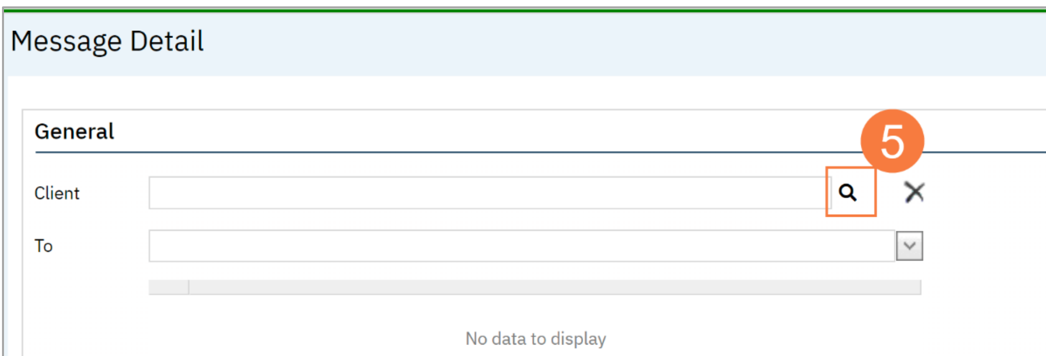
1. Click the Search icon.
2. Type Messages in the search bar.
3. Click to select Messages (My Office).



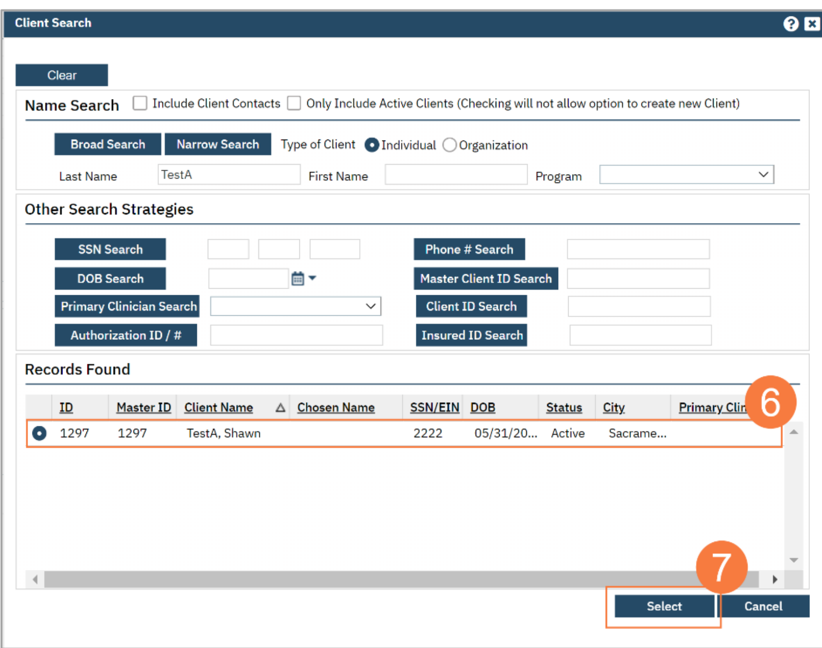
4. Click the New icon to create a new message.



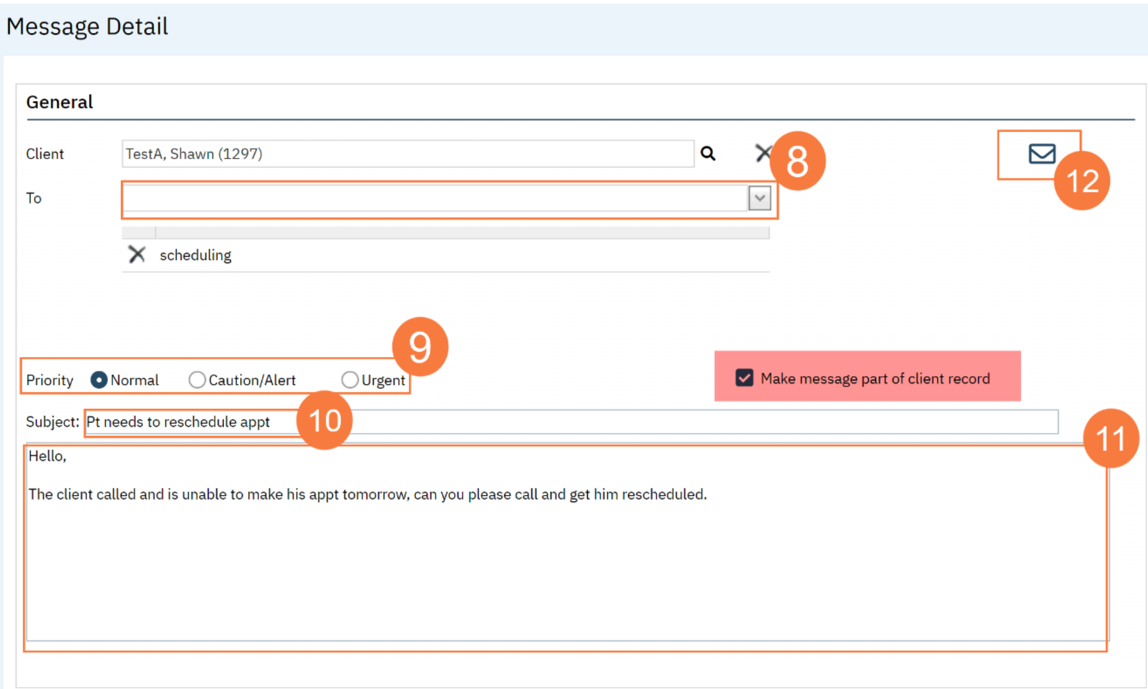
5. Click the Magnifying glass icon next to the Client field and search for the client (if applicable).



6. **Enter the search criteria** and **click the radio button** to select the patient.
7. **Click Select**.

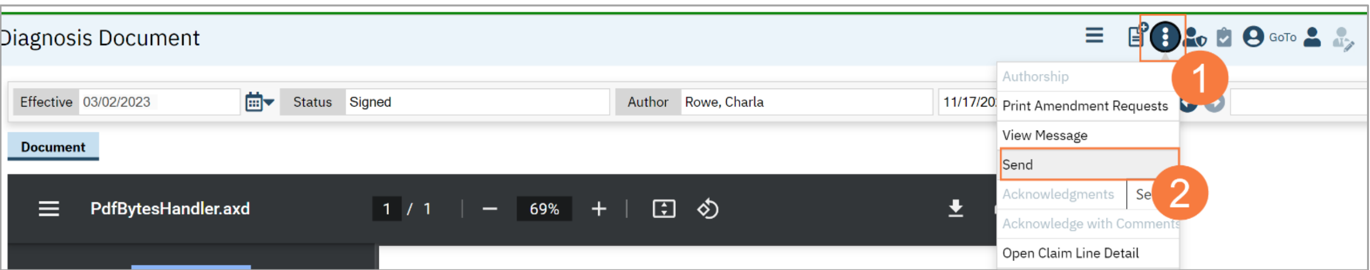


8. **Click in the To box and begin to type the staff member's name.**
   a. **To save this person as a favorite click the Star icon.**
9. **Click the radio button** to change the priority from Normal if it applies.
   a. Note: By default the Make message apart if clients record will be checked. This may have legal ramifications for a client requesting their records in the future. If this box is checked, any replies to this message will automatically have this box checked and be unable to uncheck this box.
10. **Click in the Subject field** and **type an appropriate subject.**
11. **Click in the empty box below** and **type the message.**
12. **Click the mail icon** to send the message.

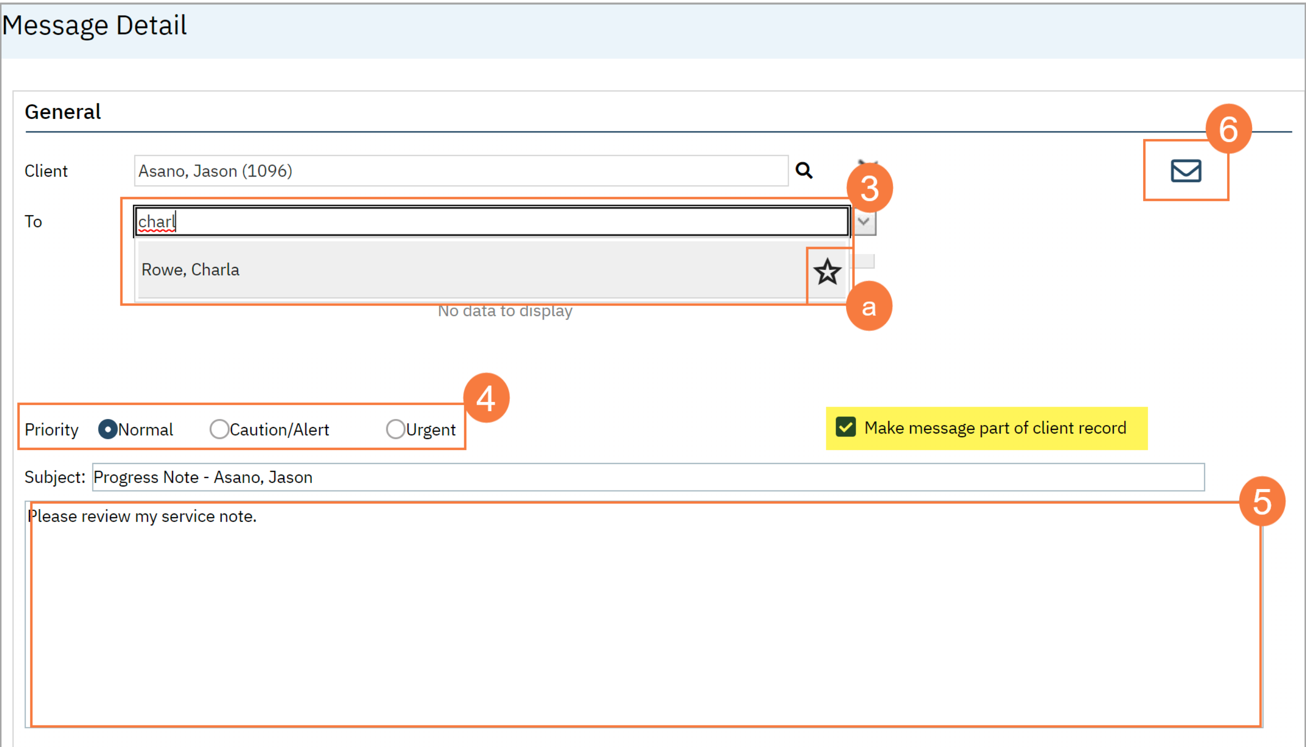


How to Send a Document in a Message

1. Open the document you want to send. **Click on the three dots icon** in the upper right side.
2. **Click Send** from the menu.



3. **Click in the To box and begin to type the staff member's name.**
   a. To save this person as a favorite **click the Star icon**.
4. **Click the radio button** to change the priority from Normal if it applies.
   a. Note: By default the Make message apart if clients record will be checked. This may have legal ramifications for a client requesting their records in the future. If this box is checked, any replies to this message will automatically have this box checked and be unable to uncheck this box.
5. **Click in the empty box below** and **type the message.**
6. **Click the mail icon** to send the message.



Error Correction Processes

To err is human" – Alexander Pope. This section addresses common mistakes and the processes for correcting them. Keep in mind that sometimes errors are fixable by the direct service provider *up until a certain point in time*. Once the billing process is started, many errors are no longer fixable by the provider and must be addressed by someone with additional SmartCare permissions. There is a method in SmartCare with which to request these changes.

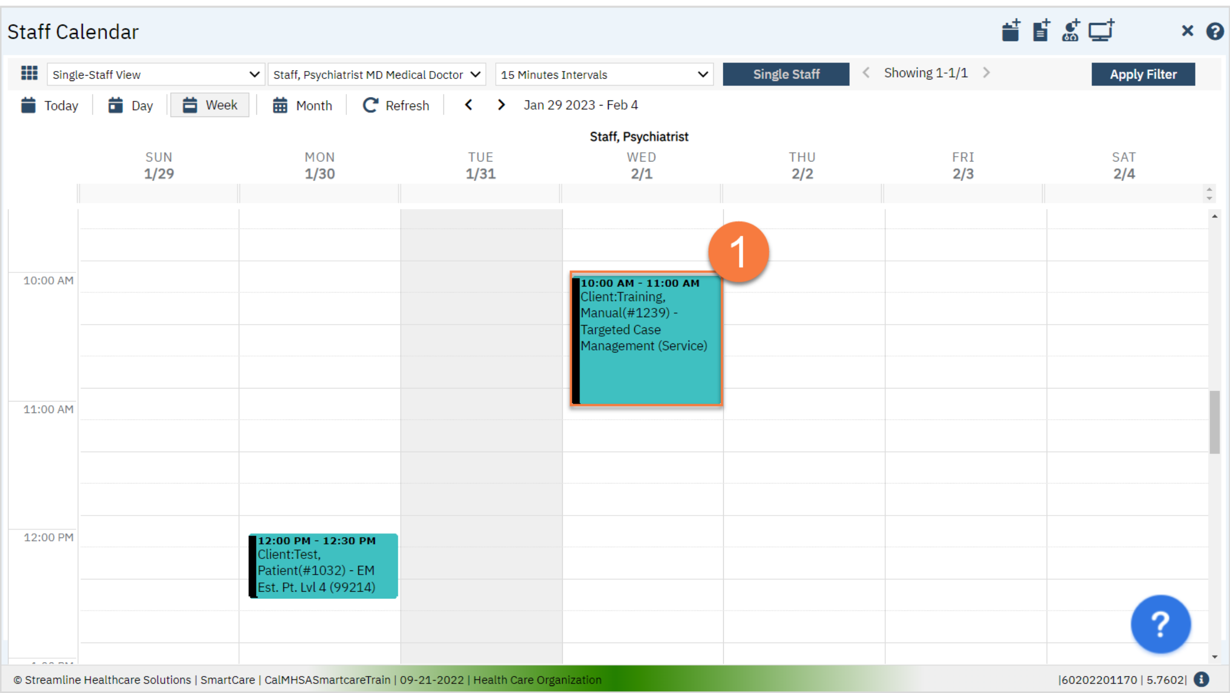
Service Note Errors

If a service note error occurs, but the status of the service is "Show", the end user can make edits as necessary. Once the status of the service changes to "Complete", this means billing for the claim has started and the provider will have to request the changes to be made by another user, such as System Administrator, Biller, or Medical Records/Quality Assurance.

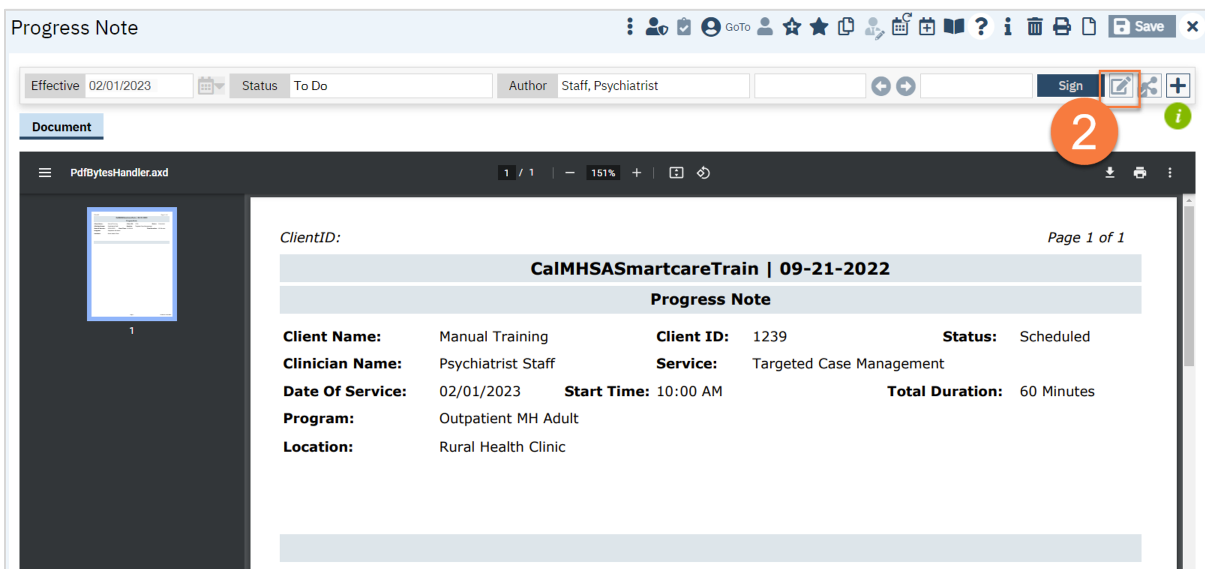
How to Fix an Error on the Service Note if You Have Signed It Already

As long as the service status does not show as "error" or "complete", the provider of the service can make changes to the service. If you're unable to edit the service note due to the service status, you'll need to report the error to your System Administrator to have them make the correction. CalMHSA is working to develop an error reporting process in SmartCare.

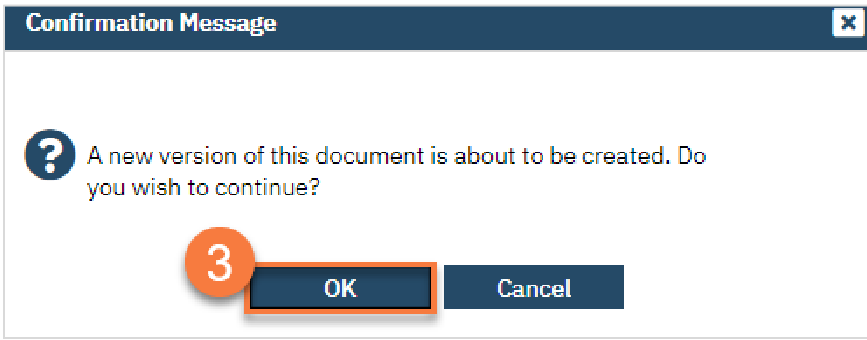
1. From the Staff Calendar, **click on the appointment** you want to edit.



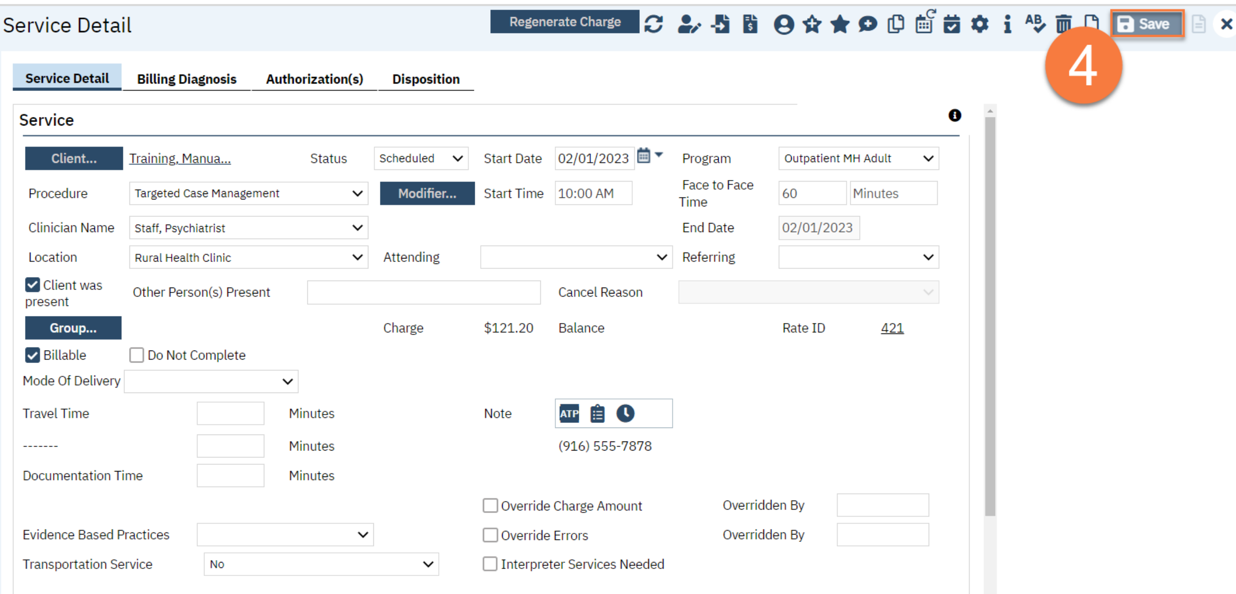
2. This will take you to the service note, which will show as a pdf. **Click the Edit icon** in the upper right corner.



3. This will initiate a pop-up window indicating this will make a new version of the note. **Click OK**.



4. Make your changes to the service and/or the note and **click Save.** You can make changes to the progress note itself, as the old version of the progress note has been saved.



I wrote a duplicate service note. How can I delete it?

If the status of the service is not “complete”, you can likely edit it. To fully delete the service note, you’ll need to report the error to your System Administrator to have them make the correction. CalMHSA is working to develop an error reporting process in SmartCare.

I wrote a service note under the wrong client. How do I move it to the correct client?

You’ll need to report the error to your System Administrator to have them make the correction. CalMHSA is working to develop an error reporting process in SmartCare.

I wrote a group service note but I forgot to update the participant/facilitator list. How do I fix it?

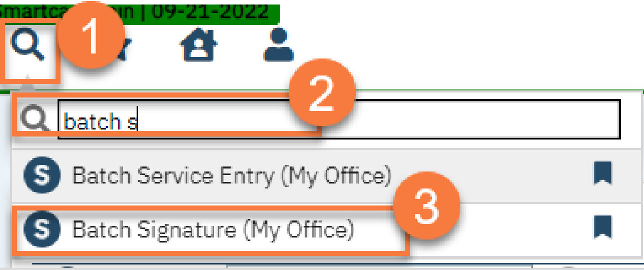
If the status of the service is not “complete”, you can likely edit it. If the service is marked as “complete”, you’ll need to report the error to your System Administrator to have them make the correction. CalMHSA is working to develop an error reporting process in SmartCare.

Supervisor Workflows

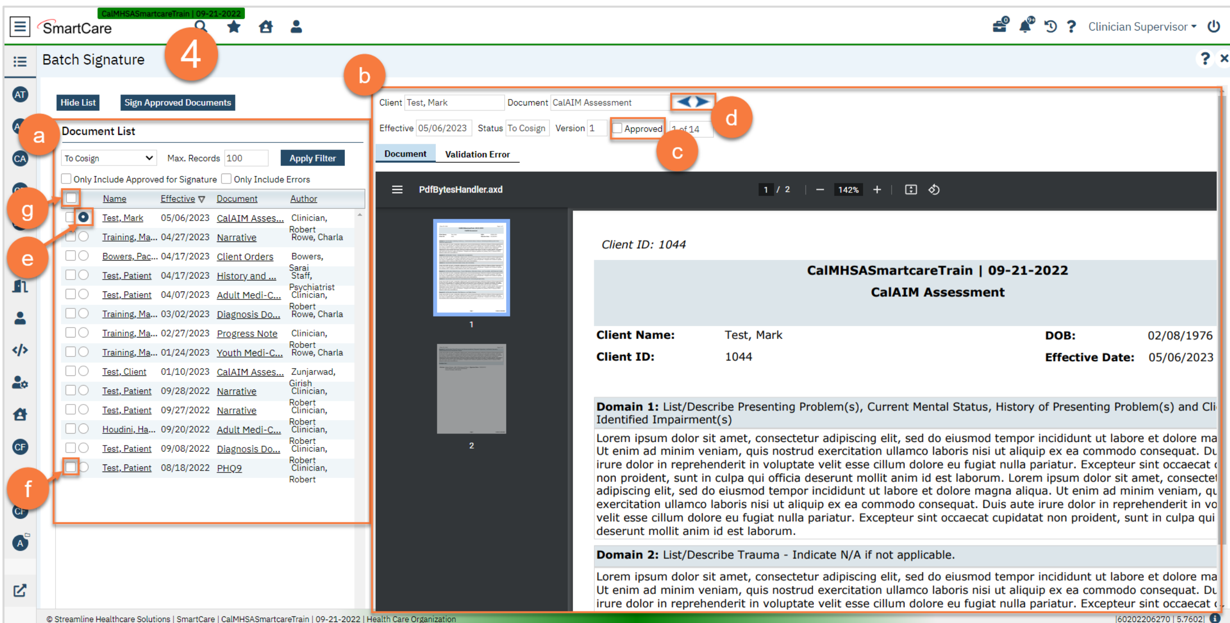
This section will cover workflows specific to Supervisors.

How to Sign Documents in a Batch

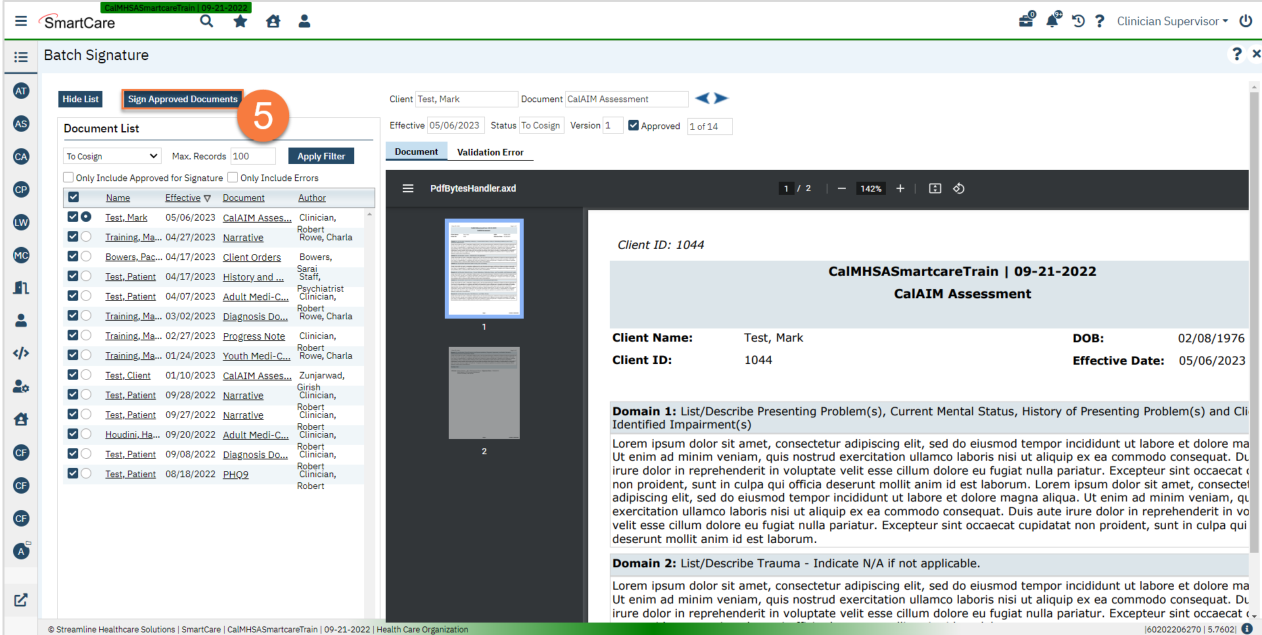
1. Click on the Search icon.
2. Type in "Batch Signature" in the search bar.
3. Select "Batch Signature (My Office)" from the search results.



4. This brings you to the Batch Signature screen.
   a. **The document list will show you which documents need to be signed, co-signed, or approved**. If you don't see any documents on the list, change the filter.
   b. The document you have selected in the document list will show in the document viewer section. Here you can **review the document** before signing it.
   c. After reviewing the document, **check "Approved"** at the top of the document viewer. This will mark the document approved for signature.
   d. You can **use the arrow icons** in the document viewer section to easily move to the next document on the list.
   e. You can also **select documents to view by clicking on the radio button** next to them in the document list.
   f. If you've already reviewed the documents but didn't mark "approved" in the document viewer, you can **mark the documents as approved by clicking on the checkbox next to the document in the document list**.
   g. To approve all documents, **click on the checkbox in the header row of the document list section**.

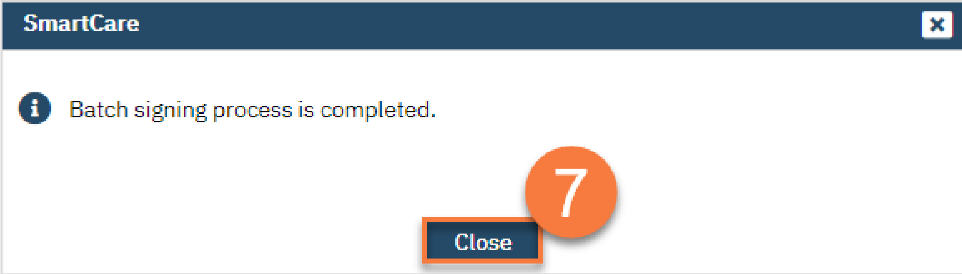


5. Once you're ready to sign your batch, **click Sign Approved Documents**.



6. This will initiate the batch signature process. You'll see a pop-up with the status of the process. If you need to interrupt the process, you can click Stop.

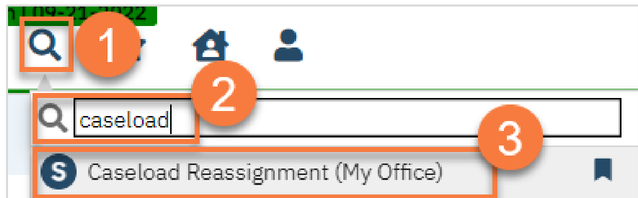
7. When completed, you'll see a pop-up indicating the signature process has been completed. **Click Close**. You are finished and can now navigate away from this screen.



How to Change the Author of a Document

Sometimes a staff member may be out on leave or may cease employment with the county before completing all of their documentation. Any document they've started will show as "in progress" and cannot be edited by another user. A supervisor can change the author of a document using Caseload Reassignment.

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



4. This takes you to the Caseload Reassignment list page. **Enter the staff member’s name (last, first) in the Staff search bar**.
5. **Click Apply Filter**.
6. This will show any assignments that are associated with that staff member, including flags. You can use the filters to further define what you’re looking for. **Select the documents you want to reassign by clicking on the corresponding checkbox**. You can select multiple documents at a time. You can also select a group of documents by clicking on the appropriate link.
7. Once you’ve selected the documents you want to reassign, **click on the Reassignment icon**.

SmartCare
CalMHSASmartcareTrain | 09-21-2022
Clinician Supervisor

Caseload Reassignment (23)

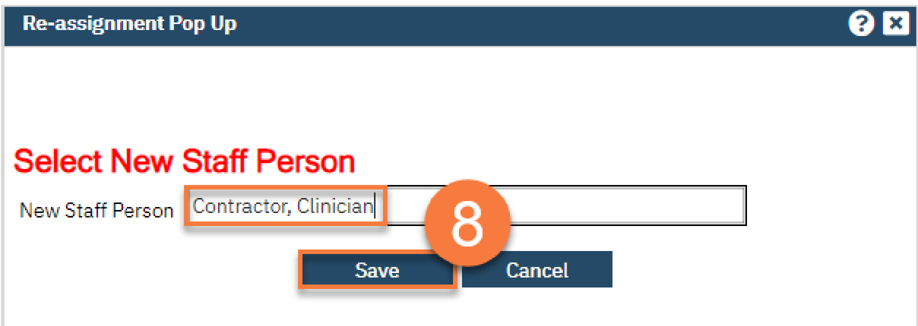
7

Assignment Type: Documents – In Progress
Assignment Sub-Type:
Staff: Clinician, Robert
4
Client...
Apply Filter
5

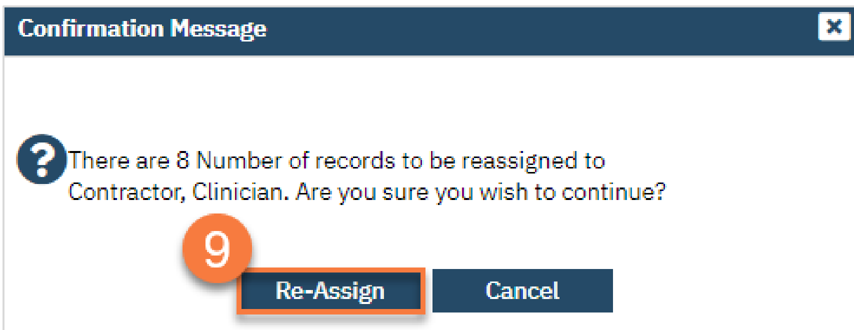
Select: All, All on Page, None
6

	Client	Staff	Assignment Type	Assignment Sub-Type	Description
☑	Schrute, Dwight	Clinician, Robert	Documents – In P...	Adult Medi-Cal Sc...	Document: Adult Medi-Cal Screening Tool - ...
☐	Test, Patient	Clinician, Robert	Documents – In P...	Adult Medi-Cal Sc...	Document: Adult Medi-Cal Screening Tool - ...
☐	Test, Ryan	Clinician, Robert	Documents – In P...	CalAIM Assessm...	Document: CalAIM Assessment - 04/10/20...
☐	Test, Ryan	Clinician, Robert	Documents – In P...	California CANS	Document: California CANS - 04/11/2023 - ...
☐	Smith, April	Clinician, Robert	Documents – In P...	Adult Screening T...	Document: Adult Screening Tool - 08/19/20...
☑	Gibbons, Greg	Clinician, Robert	Documents – In P...	Assessment	Document: Assessment - 09/24/2022 - In P...
☑	Houdini, Harry	Clinician, Robert	Documents – In P...	Agency/Program ...	Document: Agency/Program Discharge - 09/...
☑	Jones, Jill	Clinician, Robert	Documents – In P...	CALOCUS	Document: CALOCUS - 02/07/2023 - In Pro...
☑	Tommy, Max	Clinician, Robert	Documents – In P...	Diagnosis Docum...	Document: Diagnosis Document - 11/16/20...
☐	Asano, Jason	Clinician, Robert	Documents – In P...	Referral Document	Document: Referral Document - 11/21/202...
☐	Asano, Jason	Clinician, Robert	Documents – In P...	CSI Standalone C...	Document: CSI Standalone Collection - 01/0...
☐	Asano, Hiro	Clinician, Robert	Documents – In P...	Coordinated Care ...	Document: Coordinated Care Consent - 12/...
☑	Tim, ClintonR	Clinician, Robert	Documents – In P...	California CANS	Document: California CANS - 12/05/2022 - ...
☐	CalMHSA, Testing	Clinician, Robert	Documents – In P...	Registration Docu...	Document: Registration Document - 12/19/...
☐	CalMHSA, Testing	Clinician, Robert	Documents – In P...	CA ASAM	Document: CA ASAM - 12/19/2022 - In Prog...
☐	Smits, Jonny	Clinician, Robert	Documents – In P...	CalAIM Assessm...	Document: CalAIM Assessment - 12/23/20...
☑	Test, George	Clinician, Robert	Documents – In P...	CSI Standalone C...	Document: CSI Standalone Collection - 01/0...
☐	Another, Test	Clinician, Robert	Documents – In P...	CSI Standalone C...	Document: CSI Standalone Collection - 01/0...
☐	Another, Test	Clinician, Robert	Documents – In P...	CSI Standalone C...	Document: CSI Standalone Collection - 01/0...
☐	Another, Test	Clinician, Robert	Documents – In P...	CSI Standalone C...	Document: CSI Standalone Collection - 01/0...

8. This will bring up the Re-assignment Pop Up window. **Enter the name of the staff member you're reassigning these documents/tasks to and click Save**.



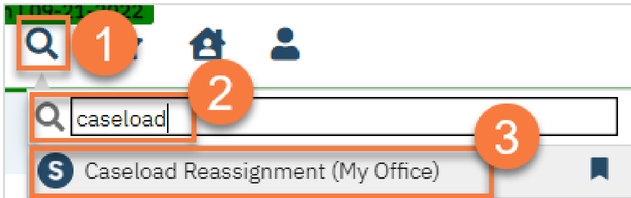
9. This will bring up a confirmation popup window alerting you to the number of items you're about to reassign. **Click Re-Assign** to complete the process. Click Cancel if you want to cancel the reassignment process.



How to Reassign Cases in a Batch

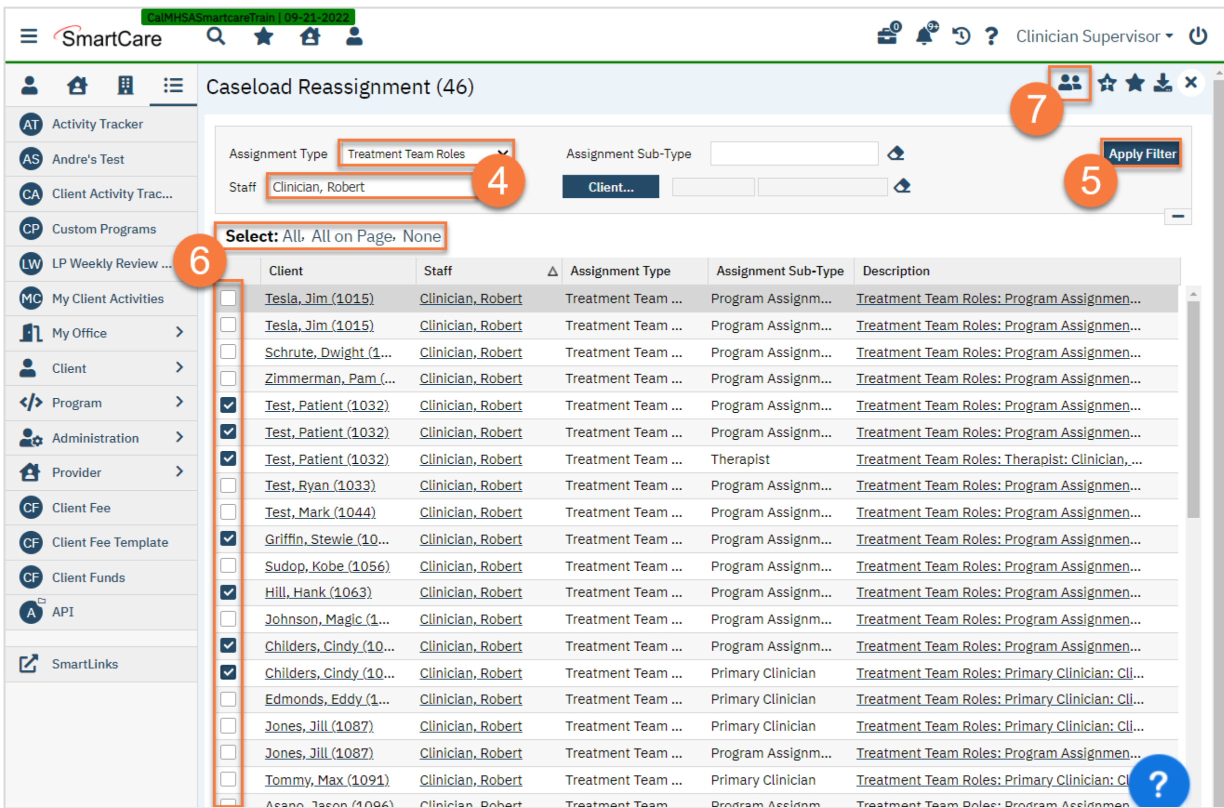
Sometimes a staff member may be out on leave or may cease employment with the county. A supervisor can move multiple clients from one staff member to another using Caseload Reassignment.

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

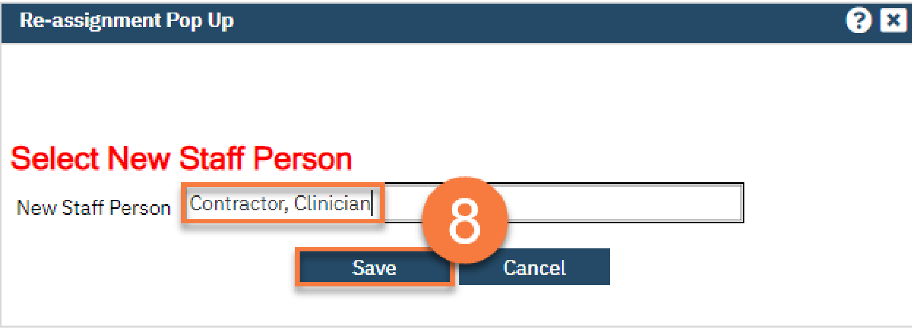


4. This takes you to the Caseload Reassignment list page. **Enter the staff member's name (last, first) in the Staff search bar**. **Choose the Assignment Type "Treatment Team Roles"**.
5. **Click Apply Filter**.
6. **Select the assignments you want to reassign by clicking on the corresponding checkbox**. Each treatment team role will show. If the client is open to multiple programs, the same staff may be listed as the primary program clinician for multiple programs. Make sure to select all the assignments you're wanting to transfer. You can also select a group of assignments by clicking on the appropriate link.

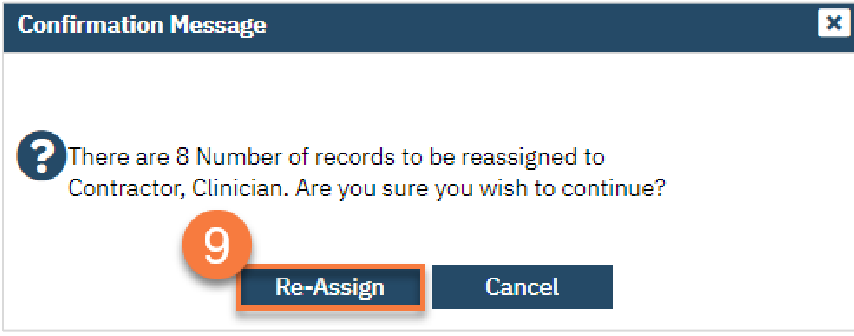
7. Once you've selected the assignments you want to reassign, **click on the Reassignment icon**.



8. This will bring up the Re-assignment Pop Up window. **Enter the name of the staff member you're reassigning these assignments to and click Save**.



9. This will bring up a confirmation popup window alerting you to the number of items you're about to reassign. **Click Re-Assign** to complete the process. Click Cancel if you want to cancel the reassignment process.


Confirmation Message
There are 8 Number of records to be reassigned to Contractor, Clinician. Are you sure you wish to continue?
9
Re-Assign
Cancel

Revision Tracking

Section	*Update*	*Date*
Coordinated Care Consent and Authorizations to Disclose Confidential Information	Added note regarding not using the “verbal only” option for CCC and ROI.	3/2/2023
Life Cycle of the Client: Services How do I add the client to my program?	Added note regarding needing a diagnosis document when opening to a new program.	3/23/2023
Error Correction Processes	Added section	3/23/2023
Screens vs. Documents	Added screenshots and expanded section	5/8/2023
Client Search	Added section	5/8/2023
Login Help	Added section	5/8/2023
Logging in to SmartCare	Expanded section	5/8/2023
Changing Your Password	Added section	5/8/2023
Multiple	Changed headers to not be questions	5/8/2023
Supervisor Workflows: How to Sign Documents in a Batch	Completed section	5/8/2023
Supervisor Workflows: How to Change the Author of a Document	Added section	5/8/2023
Supervisor Workflows: How to Reassign Cases in a Batch	Added section	5/8/2023