SmartCare CSU Guide

Contents

Client Search/Inquiry/New Client

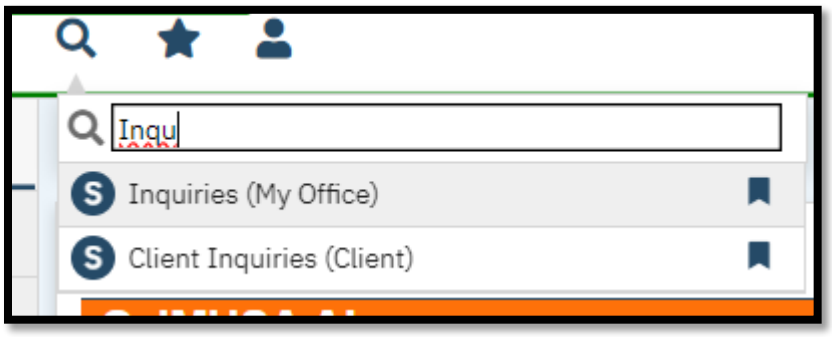
In SmartCare the proper sequence when receiving a new client is to:

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

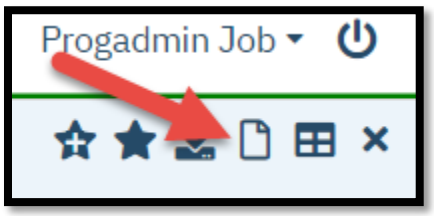
Open Inquiry

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

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

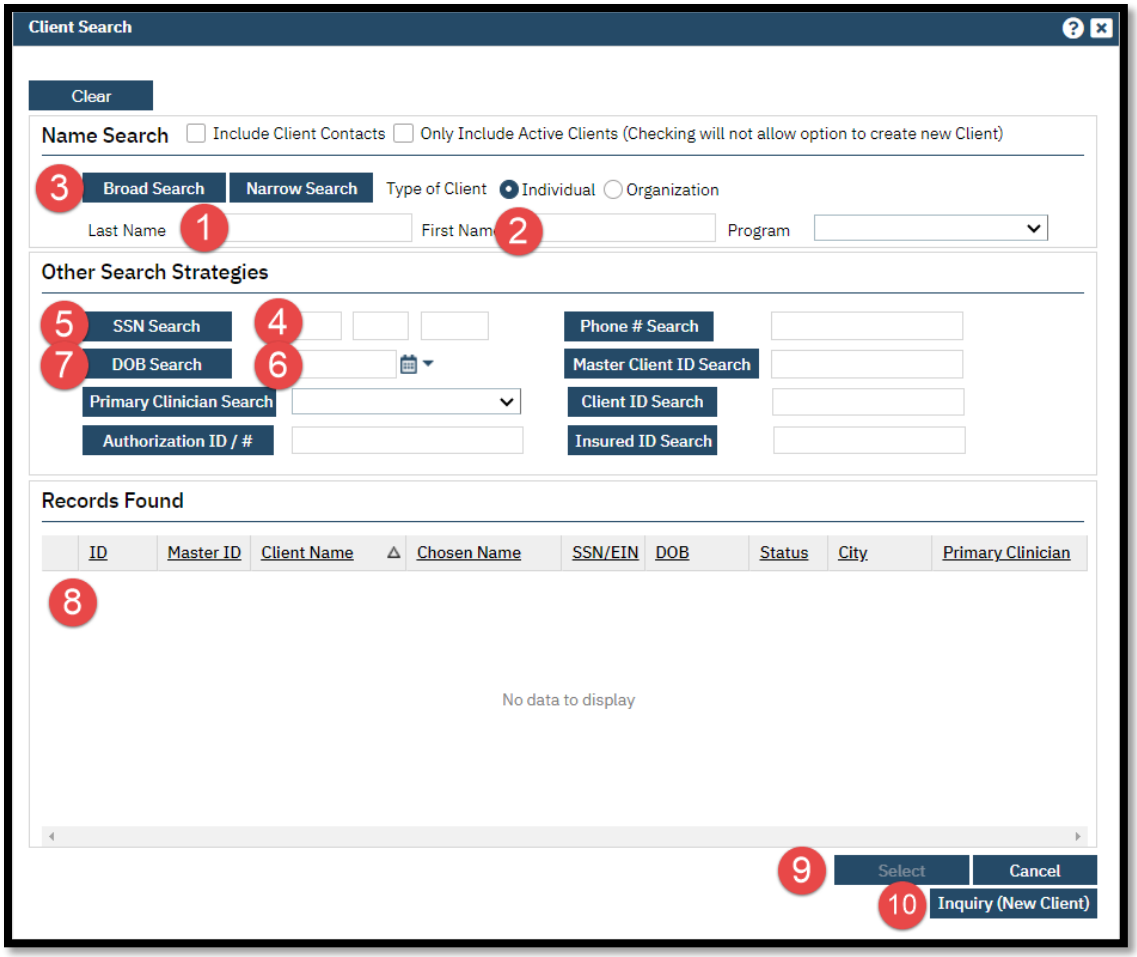


2. Click the New Icon



Client Search

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

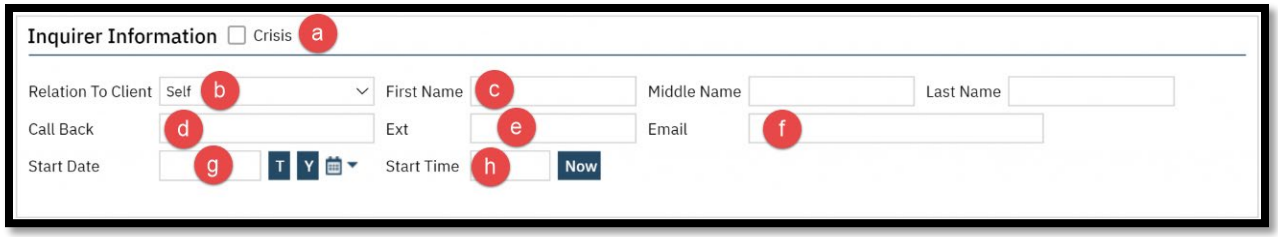


1. Enter a Last Name
2. Enter a First Name
3. Click Broad Search
4. Enter Social Security Number
5. Click SSN Search
6. Enter Date of Birth
7. Click DOB Search

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

Complete Inquiry

Initial Tab



1. **Field Definitions: Inquirer Information**

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

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

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

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

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

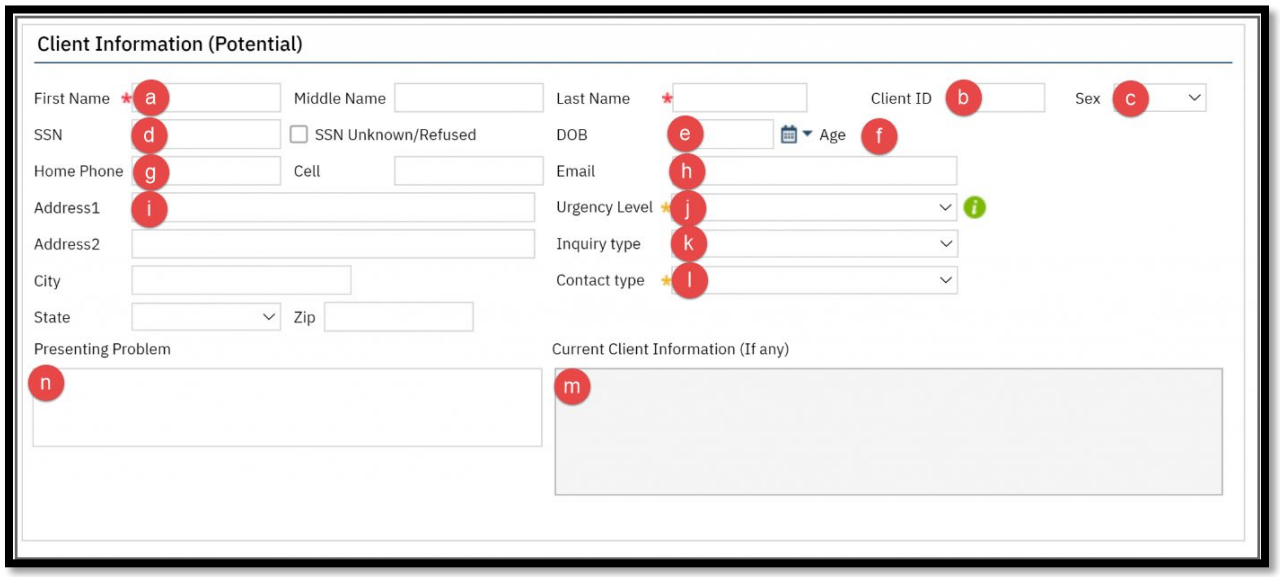
    f. **Email:** Enter an email address for the inquirer. If Relation to Client = Self, this information will also pull into the Email field in the Client Information (Potential) section of the Initial tab.

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

        - This field also has paired buttons, T and Y, for today and yesterday, respectively. Click the T button to set the date to today. Click the Y button to set the date to yesterday.
        - Enter the date in the mm/dd/yyyy format or click the calendar icon to select the date.

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

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



2. Field Definitions: Client Information (Potential)

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

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

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

selected from the dropdown. This pertains to the legal gender for billing insurance.

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

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

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

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

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

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

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

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

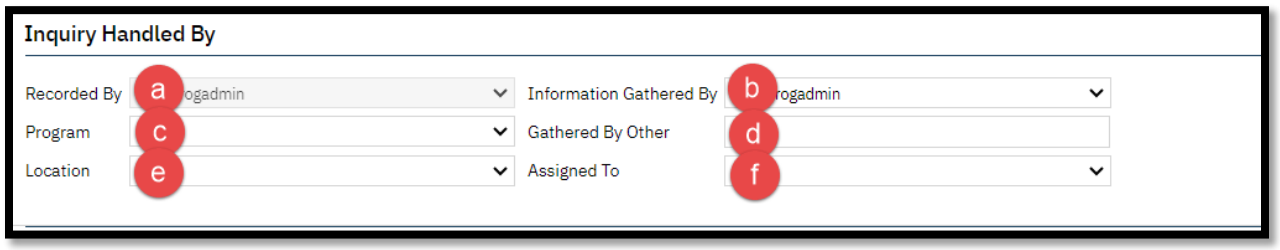
l. **Contact Type (Required):** Select a value to describe the mode of contact used by the client.

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

    - Client ID
    - Last Inquiry Date
    - Coverage History
    - Episode Number from Episodes tab of client information
    - Registration Date from Episodes tab of client information

- Discharge Date from Episodes tab of client information

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



1. **Field Definitions: Inquiry Handled By**

   a. **Recorded:** Defaults to the logged in user and cannot be edited.

   b. **Information Gathered By:** Select which staff member gathered the information from the client. This is usually the same as Recorded By. However, if an Inquiry is received by one person and logged by another, this field is available.

   c. **Program:** Select which program information or services were being inquired about or by which program the Inquiry was handled.

   d. **Gathered By Other:** Enter text to note if the Inquiry was gathered by someone other than a staff member, such as a community partner.

   e. **Location:** Select where the client was calling from.

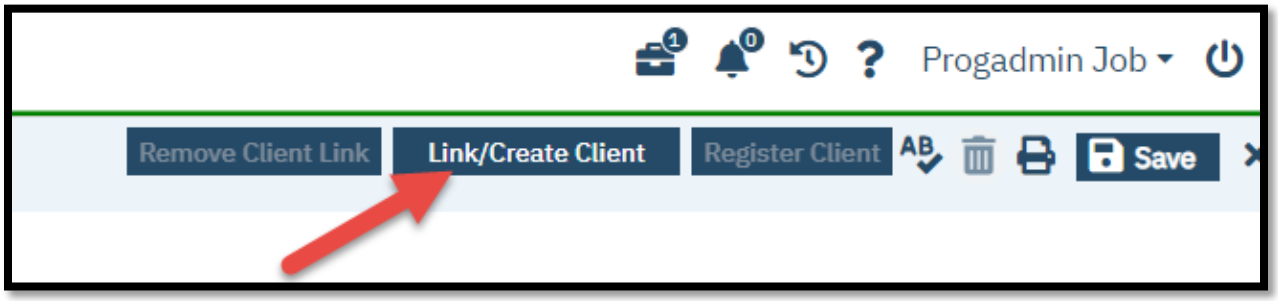
   f. **Assigned to**: Select to whom the Inquiry is assigned.

4. When finished entering information, click the Save button in the top right corner

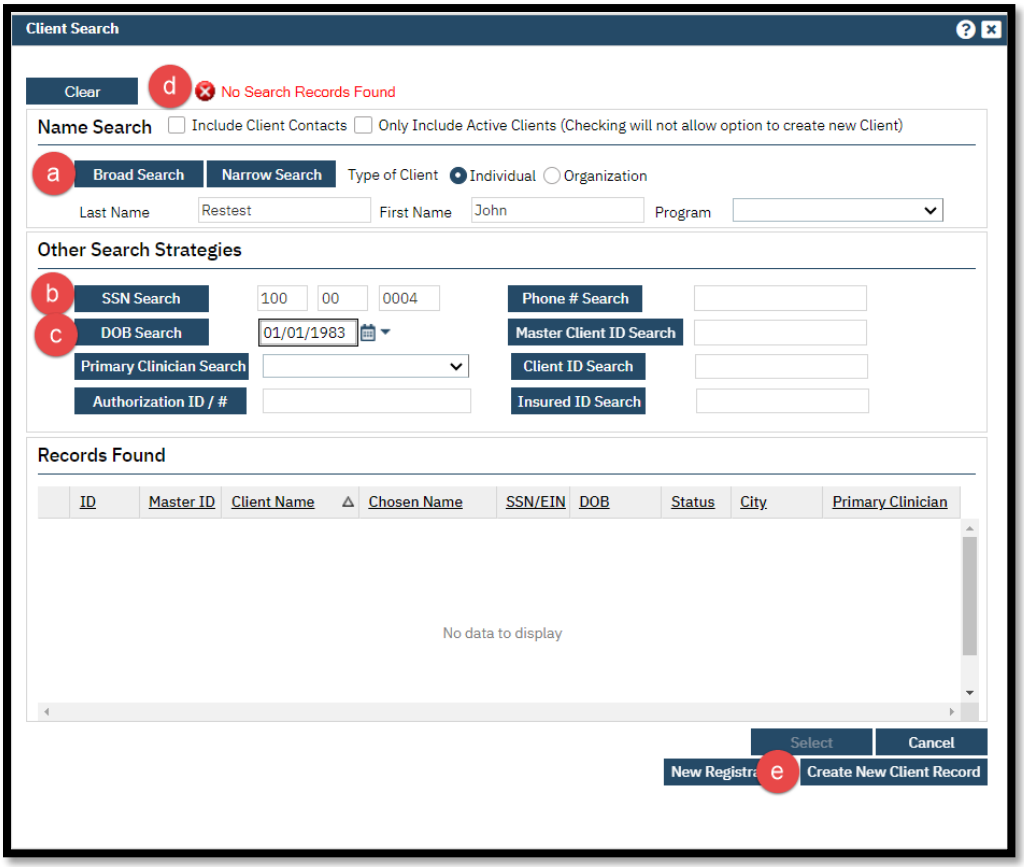
Create New Client If Needed

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

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



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



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

The client will now need to be added to your program to continue documentation.

Bedboard

Bedboard is a list page used by programs to manage beds. The Bedboard list page shows all beds and identifies whether the bed is in use or not. You can use Bedboard to manage

new admissions and discharges, clients' attendance, and change beds. Admitting a client using this Bedboard will automatically enroll the client in the designated Program.

How to Open the Bedboard (My Office) List Page

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

How to Admit a Client to a Bed

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

1. Locate an empty bed in your facility on the Bedboard (My Office) List Page.
2. Click the down arrow in the Status column in the row for the target bed.
3. Choose the Admit link.
4. The Census Management – Admit screen will open.
    a. Verify the Admit Date and Time is correct.
    b. Verify the correct Program is selected
    c. Choose the correct Client Type
    d. Choose the correct Admission Type
5. Click the Save Icon. An enrollment to the Program associated with the bed will be created automatically.

Safety Check Order

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

1. Click the Search icon
2. Type Client Orders in the search bar
3. Click to select Client Orders (Client)
4. Click the New icon in the top right corner
5. If there are no other active Orders, the CDAG Program Enrollment window will popup. Select the appropriate program with the correct enrollment date and click OK.
6.
7. The Client Order screen will open
    a. Order Entry Details

1. Entered by should be the Staff entering the order
2. Order Mode: Electronic
3. Order Status: Active
4. Ordering Physician: for this order it can be the
5. Onsite Specimen Collection N/A
6. Read back and verified N/A

b. Order

1. Type Safety in the search bar
2. Select one of the Safety Check orders with the appropriate frequency
3. Preference: N/A
4. Discontinued: N/A
5. Priority: Now
6. Start: Other
7. Start Date enter date the order should start on
8. Start Time enter time the order should start
9. Enter an end date and time if applicable (leave blank if order should continue until discontinued)
10. Program: will prepopulate with the residential program
11. Comments: if needed

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

Legal Status Order

How to Place a Legal Status Order in Client Orders

Intake

CSI Standalone Collection

How to Complete a CSI Demographic Record

Documentation

NOTE: None of the Services/Notes mentioned in the Documentation section will generate any charges for the CSU Stay. To enter this service see: Service Entry

LPHA/Non-LPHA

1. Diagnosis Document (LPHA)
   How to Add a Diagnosis
   How to Delete a Diagnosis
   How to Modify and/or Re-Order a Diagnosis
   How to Modify a Diagnosis After the Document is Generated
   How to Save a Favorite Diagnosis
   How to Pull a Diagnosis Forward from Another Program
   Reordering Diagnoses List
2. Problem List
   How to Add a Problem to the Problem List
   How to Remove a Problem That's Been Resolved
   How to Add Favorites to the Problem List Screen
   How to Filter/Sort a Client's Problem List
3. Crisis Assessment
   If you complete the Crisis Assessment in SmartCare, follow these instructions.
   a. With the client open, click the Search icon.
   b. Type "Crisis Assessment" in the search bar.
   c. Select "Crisis Assessment (Client)" from the search results.
   d. The CDAG Program Enrollment window will popup. Select your program.
   e. Click OK.
   f. This will bring you to the Crisis Assessment document screen.
      i. If you are completing the assessment after the fact, or are entering in the answers from a paper version, make sure your effective date is the date the assessment actually took place.
   g. When you are finished with the document, click Sign. If you have missed any fields, the system will alert you to what needs to be completed.
   h. This will bring you to the PDF. You may now click the Close icon.
4. MSE
   Mental Status Exam (MSE)
5. Safety
   a. Risk Assessment (if applicable)
      i. With the client open, click the Search icon
      ii. Type "Risk Assessment (client)" in the search bar
      iii. Select "Risk Assessment (client)" from the search results

iv. The CDAG Program Enrollment window will popup. Select the appropriate program with the enrollment date that matches the dispatch date.
v. Click OK.
vi. This will bring you to the Risk Assessment document screen. Complete the entire document.
vii. If you are completing the Risk Assessment after the fact or are entering in the answers from a paper version, make sure your effective date is the date the assessment actually took place.
viii. When you are finished with the document, click Sign.
ix. This will bring you to the PDF. You may now click the Close icon.

b. Safety/Crisis Plan (if applicable)
How to Complete the Safety Plan

6. Valuables and Belongings
How to Complete the Personal Effects Inventory (PEI)
7. Safety Checks (Whiteboard)
    a. Click the Search icon
    b. Type Whiteboard in the search bar
    c. Click to select Whiteboard (My Office)
    d. Click the time link to the next Safety Check in the Next Check column
    e. The Flowsheet Detail Popup screen will open
        i. Date/Time
            1. Ensure the correct Date/Time is entered
        ii. Safety Check
            1. Select Status Complete
            2. If the Check was performed by another Staff, change the Completed by to the correct name
            3. Enter a comment if applicable
        iii. Current Behavior / Client Status
            1. Select Status
            2. Select Activity
            3. Select Location
            4. Other/Comments free text as applicable
    f. Click Save & Close when finished
    g. Cancel without saving if needed
    h. Safety Checks can be reviewed in the Flow Sheet
8. Services/Notes – Procedure: Shift Summary
How to Document an End of Shift Summary

9. Care Plan
10. 72 Hour Follow Up Call

    How to Write a Progress Note for an Unscheduled Service

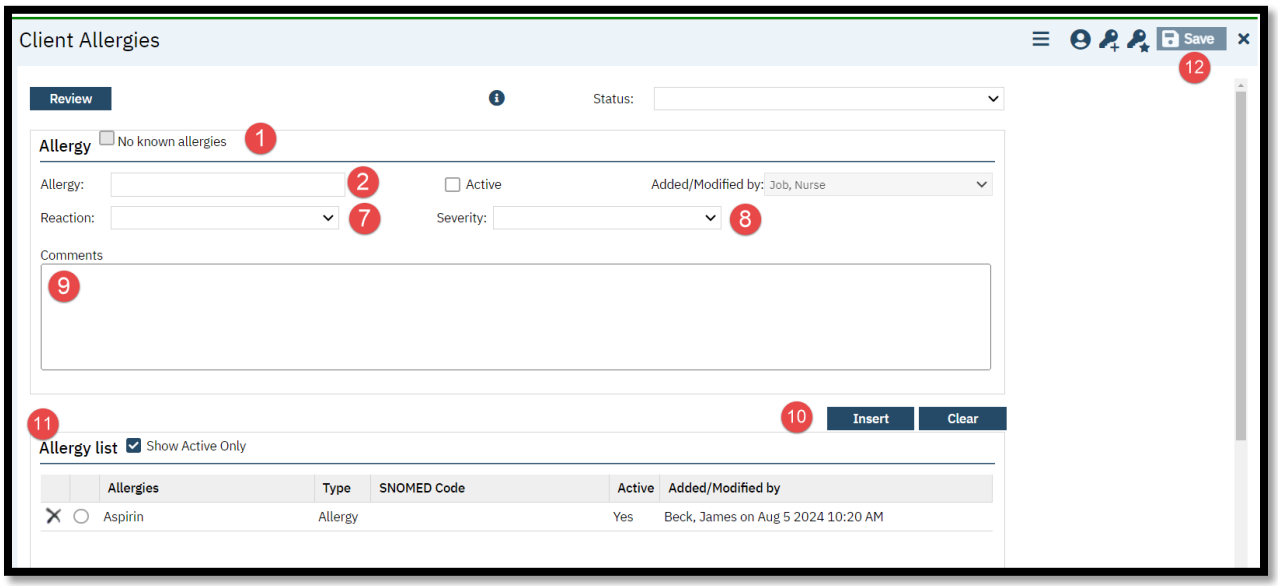
    Procedure: Brief Contact Note

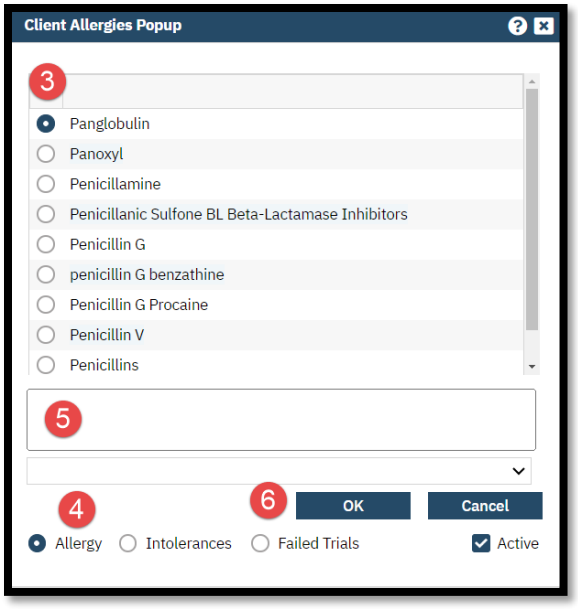
Nursing

1. Home medications

   Dr First training separate
2. Allergies
   a. To view Allergies

      Allergies (Client) List Page
   b. To enter Allergies
      i. Click on the Search icon, with the client open
      ii. Type “Client Allergies (Client)” in the search bar
      iii. Select “Client Allergies (Client)” from the search results
      iv. This will bring up the Client Allergies Screen





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

3. History and Physical form does not share documentation with other notes/assessments
   History and Physical Standalone Form
4. Vitals
   How to Document Vitals
5. AIMS
   How to Complete the AIMS Assessment
6. Review MAR/Chart medications - Dr First training separate
7. Services/Notes – Procedure: Nursing Assessment
   Psych/Medical Note Training

How to Complete the Psych/Medical Note

8. Other Services/Notes
   How to Write a Progress Note for an Unscheduled Service
   a. Procedure: Nurse Progress Note – Incident Documentation
   b. Procedure: Shift Summary – End of shift documentation if program requires

Prescriber

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

Service Entry

Bed Day

Manual entry of the Bed Day Type is completed by creating a Service for the day. A service can be created in various ways. This is the only Service entry which will generate a charge for the CSU stay.

1. With an active client selected, Click the Search icon.
2. Type 'Services' into the search bar.
3. Click to select Services (Client). The Services list page will open.
4. Select the New icon from the tool bar. A new Service Detail page opens.
5. Change the status to Show.
6. Select the Prescriber for your facility for that day from the dropdown.
7. Select the Program from the dropdown.
8. Select the Procedure from the dropdown.

    a. The Procedure will determine the Bed Day type.
        1. Crisis Stabilization – Emergency Room Services
        2. Crisis Stabilization Unit
9. Select the Location from the dropdown.
10. Complete the start time and date.
11. Enter Face to Face time.
    a. Note, the field is face to face but is the total of the entry type. For example: if the procedure is set up as hours it would be the total hours.
12. Enter the attending. This is required for institutional claims.
13. Click the Save and Close buttons.
14. The service is now created and billing jobs will complete the service.

Discharge

Update CSI

How to Complete a CSI Demographic Record

CalMHSA Discharge Summary

How to Complete the Discharge Summary

Discharge

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