STRTP SmartCare Workflow

1. **Look Up Client to See if They Are in the System**
   - *Inquiries (My Office)*

   - Search for the client in the system. If the client is already in the system, create a new client inquiry for your program. If the client is NOT already in the system create a new client record.

   - Help Documents
     - How to Use the Client Search Window
     - How to Document a Client Inquiry
     - How to Create a New Client (if needed)

2. **Admit Client to Your Program**
   - *Client Programs (Client)*

   - Help Documents
     - How to Add the Client to Your Program

3. **Admission Statement**
   - Complete in *Services/Notes (My Office)*

   - Timeline: Completed within **five** calendar days of arrival to the STRTP

   - Content: The admission statement shall review the following:

     - The Child does not require inpatient care

     - The child has been assessed as requiring the level of services provided in an STRTP in order to maintain the safety and well-being of the child or others due to behaviors, including those resulting from traumas, that render the child or those around the child unsafe or at risk of harm, or that prevent the effective delivery of needed service and supports provided in the child's own home or in other family settings.

   - Help Documents:
     - How to Write a Progress Note for a Scheduled Service
     - How to Write a Progress Note for an Unscheduled Service

   - Downtime form: Optum Website > UCRM tab> *Service Note*

4. **Complete Consents**
   - Required Consents:
     - *Coordinated Care* Consent (Client)– required
     - *Consent for Telehealth (Client)*- required *
     - *Consent to Treat (Client)*- required*

- Providers may use their own program- specific Consent for Telehealth and Consent to Treat forms provided that all required elements outlined in regulations and BHINs are adhered to.

- The Coordinated Care Consent form is a legal document that allows a patient to give permission for different healthcare providers involved in their care to share relevant medical information with each other. (Ref. 42 CFR). How to Determine if the Client has Signed a Coordinated Care Consent.

- Providers should not use the Downtime forms (English or Spanish) on the CalMHSA website as these do not contain the County's required language – providers should only use the form on the Optum website created by San Diego County in MHP Documents - UCRM tab.

- Help Documents:
  - How to Complete a Coordinated Care Consent
  - How to Determine if the Client has Signed a Coordinated Care Consent
  - Coordinated Care Consent Explanation Sheet (pdf)
  - How to Complete a Consent for Telehealth

- Downtime form: Optum Website > UCRM tab> *Coordinated Care Consent*
- Downtime form: CalMHSA Website > Downtime Forms > *Consent to Treat*
- Downtime form: CalMHSA Website > Downtime Forms > *Consent for telehealth*

5. **Conduct Assessment**
   - Required Assessments:
     - *Mental Status Exam (Client)*
     - *CalAIM Assessment (Client)*

   - The MSE must be completed by a licensed/waivered/registered clinician. Can be completed within the CalAIM Assessment narrative box OR the standalone MSE document in SC.

   - Timeline: Completed within **five** calendar days of arrival to the STRTP

   - Help Documents:
     - CalAIM ASSESSMENT EXPLANATION SHEET INSTRUCTIONS (docx)
     - CalAIM Assessment
     - Mental Status Exam (MSE)

6. **Complete a Problem List**
   - *CalMHSA Client Clinical Problem List (Client)*

   - A Problem List must be completed for each client opened to your program. The Problem List can be entered through the CalMHSA assessment or the Service Note.

- If the program is accepting a problem list created by another program, they must write in the Service Note or Assessment that the problem list has been reviewed with the client and accepted.

- Help Documents:
  - How to Add a Problem to the Problem List
  - How to Remove a Problem That's Been Resolved

- Downtime form: CalMHSA Website > Downtime Forms > *CalAIM Assessment*
- Downtime form: CalMHSA Website > Downtime Forms > *Mental Status Exam*

7. **Establish Diagnosis**
   - *Diagnosis Document (Client)- required*

   - The Diagnosis Document in SmartCare is a program level document. This means that each diagnosis document is a "stand alone" document and each program must complete their own.

   - Help Documents:
     - How to Document a Diagnosis for a Client

   - Downtime form: Optum Website > UCRM tab> *Diagnosis Document*
     - **Please note-** If the downtime form is used, the program will still need to enter the Diagnosis Document into the SC system for the diagnosis to link to services for billing.

8. **Complete State Forms**
   - Required Forms:
     - *CSI Standalone Collection (Client)*- required
     - *California CANS (Client)* - required
     - *California Pediatric Symptom Checklist (Client)*- required

   - Help Documents:
     - How to Complete a CSI Demographic Record
     - Child and Adolescent Needs and Strengths (CANS) Tool
     - SmartCare CANS/ PSC
     - Pediatric Symptom Checklist (PSC)

   - Downtime form: CalMHSA Website > Downtime Forms > *CSI Standalone Collection*
   - Downtime form: CalMHSA Website > Downtime Forms > *California CANS*
   - Downtime form: CalMHSA Website > Downtime Forms > *California Pediatric Symptom Checklist*

9. **Care/ Treatment Plan**
   - Completed in a *Service Note* OR *Interdisciplinary Treatment Plan (Client)*

- Timeline: Completed within ten (10) calendar days of the child's arrival at the STRTP. The child's treatment plan shall be updated as the child's mental health treatment needs change, but at least every thirty (30) calendar days. The provider must document that the care plan was *reviewed and revised* or *reviewed without revision* in the care plan/next steps section of the service note every 30 days.

- Content:
    - Anticipated length of stay
    - Specific behavioral goals for the child and specific mental health treatment services the STRTP shall provide to assist the child in accomplishing these goals within a defined period of time.
    - One or more transition goals that support the rapid and successful transition of the child back to community based mental health care.
    - The child and authorized legal representative's participation and agreement, documented in the client record. If the child refuses to agree, the legal representative's participation and agreement shall be sufficient, but the child's refusal shall be documented in the Client Record.
    - Include participation of the child and family team, if applicable.
    - A trauma-informed perspective, which includes planned services to promote the child's healing from any history of trauma.

- Help Documents:
    - How to Complete the Interdisciplinary Treatment Plan
    - Care Plan Explanation Sheet

- Downtime form: Optum Website > UCRM tab> *Service Note*

10. **Identify Client as Special Population**
    - *Special Populations (Client)*
    - Special populations "Katie A ICC/IHBS" is used for any youth that would have been considered "subclass" under previous PWB criteria or used for any youth receiving ICC/IHBS services.
    - DHCS no longer requires the identification of class or subclass when determining eligibility for ICC/IHBS services, however, counties are recommended to continue tracking of those youth who would have been subclass.
    - Neither membership in the *Katie A.* class nor subclass is a prerequisite to consideration for receipt of ICC and IHBS, and therefore a child does not need to have an open child welfare services case to be considered for receipt of these

services. The state requires that these services be offered/provided by the MHP to all youth that meet criteria.

- The assessment should reflect that client was assessed for access criteria for ICC/IBHS services and that youth meets the access criteria for ICC/IBHS services.

- Help Documents
  - How To Identify a Client as Katie-A or Other Special Population - 2023 CalMHSA

11. **Transition Determination Plan**

- Completed in a *Service Note*

- A transition determination plan shall be developed, completed, and signed by a member of the STRTP mental health program staff prior to the date the child transitions out of the STRTP.

- A copy shall be provided prior to or at the time of the child's transition to the following as applicable: parent, guardian, conservator, or person identified by the court to participate in the decision to place the child in the STRTP.

- Content:
  - The reason for admission
  - The reason for transition- referencing the child's transition planning goals, or other reason for the child to be transferred to an alternate treatment setting
  - The course of treatment curing the child's admission, including mental health treatment services, medications, and the child's response
  - The child's diagnosis at the time of transition
  - The child's aftercare plan, which shall include the following:
    - The nature of the child's diagnosis and follow-up required.
    - Medications, including side effects and dosage schedules.
    - Goals and expected outcomes for any follow up treatment.
    - Recommendations regarding treatment that are relevant to the child's care.
    - Educational information, including grade level functioning and any special education needs.
    - Referrals to providers of medical and mental health services.

- Other relevant information

- Help Documents:
  - STRTP Transition Determination Plan Explanation Sheet

- Downtime form: Optum Website > MH Resources tab> *STRTP Transition Determination Plan*

12. **Daily Notes**

- Completed in the *Services/ Notes> Shift Summary* (Procedure)

- Timeline: There is a minimum of one (1) progress note per day.

- Content: The daily progress note shall document the following when applicable

  - The specific service(s) provided to the child.

  - A child's participation and response to each mental health treatment service directly provided to the child.

  - Observations of a child's behavior.

  - Possible side effects of medication (as applicable and within scope of practice)

  - Date and summaries of the child's contact with family, friends, natural supports, child and family team, existing mental health team, authorized legal representative, and public entities involved with the child.

  - Descriptions of the child's progress toward the goals identified in the treatment plan

- Downtime form: Optum Website > UCRM tab> *Day Treatment Service Note (Shift Summary)*

13. **Write a Note**

- New *Service Note (My Office)*

- All mental health progress notes shall be completed, signed, and dated (or electronic equivalent) within seventy-two (72) hours of the service provided.

- The mental health progress notes shall be maintained in the child's record

- If the child is a Medi-Cal beneficiary, the STRTP shall complete separate progress notes for each specialty mental health service provided.

- If a progress note for a specialty mental health service is provided, this replaces the requirement for the daily note.

- Downtime form: Optum Website > UCRM tab> *Service Note*

14. **Discharge Summary**

- *CalMHSA Discharge Summary (Client)*
- *CSI Update/Discharge (Client)*

- Help Documents:
  - How to Complete the Discharge Summary
  - How to Close a Client to a Program

- Downtime form: Optum Website > UCRM tab> *Discharge Summary*
- Downtime form: CalMHSA Website > Downtime Forms > *CSI Standalone Collection*

Other Topics in Treatment:

Billing Errors (as of 02/10/25)

- *Please note* that this information is always updating. Check the Optum Website> SmartCare tab> *SmartCare Information Notices* and your email for most up to date information.

- Clearing CoSD Service Error Report (My Office)
- 2025-01-24 BHS Contractor Memo-BH SmartCare Billing (pdf)
- SmartCare Services How to Guide 01.24.25 (pdf)

Scanning Documents

- Please note that no documents are required to be scanning into SmartCare (unless specified). However if you so choose, the following is a guide on how to upload documents to the client's chart: SmartCare Document Scanning (pdf)

SmartCare Service entry for services without a progress note

- This workflow shows the steps for service entry where a progress note will be completed outside of the SmartCare EHR. This process also works through the steps for billing for Add-On procedure codes: Administrative Service Entry (pdf)

Documenting and Billing for CFT Meetings in SmartCare

- Youth identified as being eligible for ICC and/or IHBS services are required to be provided CFT meetings at minimum of every 90 days.

- Providers should utilize **Procedure Code: CFT/MDT** when documenting a CFT meeting. This procedure code has been updated on the SmartCare Service Code Crosswalk.

There have been no changes to the documentation or claiming requirements for CFT meetings.

- 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.

- Providers should also ensure that youth receiving these services have been identified in the appropriate **Special Populations** category in SmartCare which will link the appropriate required modifier (HK) to the service for billing purposes as well allowing for tracking of these youth/services.

- Help Documents:
  - How to Document Treatment Team Meetings

- Medication Management Every quarter, all programs that prescribe medications review 1% of all charts for each prescriber where the client is receiving medication services.

- The Medication Monitoring forms are located on the Optum Website> *Forms* tab. Send the following forms via secure email to QIMatters.hhsa@sdcounty.ca.gov:

  - Medication Monitoring Report
  - Medication Monitoring Screening Tools
  - Medication Monitoring Feedback Loop (McFloop)

  Results of medication monitoring activities are reported quarterly to the QA unit by the 15th of each month following the end of each quarter (First quarter due October 15, second quarter due January 15, third quarter due April 15 and fourth quarter due July 15).

- For more details about the medication monitoring process, see the OPOH Section G.

Where to Find Help:

- CPT Crosswalk

  - Optum Website SmartCare tab>SOC Resources> *SmartCare Service Code Crosswalk*

  - This is your main guide for determining the appropriate codes to use in SmartCare. Contains a guide for which providers can bill for which services as well as a description of the code.

- CalMHSA Website (*Clinical Documentation* tab) – lots of step-by-step instructions for how to utilize the SmartCare platform.

- CalMHSA Website (*Downtime Forms* tab) – some of the necessary paper documents

STRTP SmartCare Workflow

- Optum Website (*SmartCare* tab)- County created guides, trainings, Townhalls and communications to the system of care.

- Optum Website (*UCRM* tab)- any of the necessary paper documents not found on the CalMHSA website, explanation sheets

- Optum Website (*MH Resources* > *STRTP* tab)- STRTP specific documents

- UTTMs- Emailed to all system of care monthly and on the Optum Website > *UTTM*

- Office Hours- Hosted by the QI team 1x/week, open session to ask questions

- QIP Meetings- Hosted monthly by the QI team to disseminate new information and answer questions

- QI Matters- Email the QI team with details. Please specify which of the above resources you have already tried so we can more easily figure out how to help!

- SmartCare System issues: i.e. glitches, functionality issues, pop up errors
    - Blue circle/Question mark in the bottom right hand corner of SmartCare EHR leads to the Live Chat

- SmartCare ARF submission and any access related issues or questions: BHS_EHRAccessRequest.HHSA@sdcounty.ca.gov

- SmartCare Support questions that cannot be addressed by the CalMHSA Support Desk: BHS_EHRSupport.HHSA@sdcounty.ca.gov