ALAMEDA COUNTY

BEHAVIORAL HEALTH

Substance Use Services

SMARTCARE

SUD/CG MINI MANUAL

V6.1

ACBH - Billing and Benefits Support:

(800) 878-1313

ACBH - Information Systems

Help Desk Phone #: (510) 567-8181

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ACBH Provider's Website:

https://www.acbhcs.org/providers

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SUD End User Training Objectives

1. **SmartCare Overview and Basic Navigation**
   - SmartCare Navigation/Dashboards and Widgets/Toolbars/Quick links/Smart links
   - How to navigate through the SmartCare application and populate date fields based on State required guidelines

2. **Search for a Client & Create New Potential Client**
   - Client Search
     - Search for an existing client
   - Create a new potential client record
     - Client ID generation
   - Client Information Screen/Tabs
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3. **Substance Use Disorder (SUD)- Registration Document & Program Enrollment:**
   - Program Enrollment *(previously referred to as Opening an Episode)*
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ACBH Systems & Data Confidentiality, Security and Usage Agreement

ACBH SYSTEMS & DATA

Confidentiality, Security and Usage Agreement

Systems

SmartCare, Clinician's Gateway, Yellowfin, CANS/ANSA, MEDS, etc.

Purpose

The purpose of this agreement is to establish an environment of security for the electronic storing and usage of client confidential information and records including the usage of portable electronic devices for this purpose.

Background

Any person accessing Alameda County ACBH (Behavioral Health Care) data is required to protect confidential information relating to clients, patients, and residents on a daily basis, and have a duty to protect this information from loss, theft, or misuse whether the information is in paper or electronic form. Additionally, users are required to protect any electronic device assigned to them or in their possession used to gain access to ACBH systems.

Confidential Information

Confidential Information shall include all Alameda County ACBH systems, documents, data, and other materials. User agrees that the Confidential Information is to be considered confidential and shall hold the same in confidence, shall not use the Confidential Information other than for the purposes of its business with ACBH, and shall disclose it only to its authorized employees or other authorized users with a specific need to know. User will not disclose, publish or otherwise reveal any of the Confidential Information and must use secure email for any communications outside of Alameda County regarding confidential information. _____Initial

Secure and Private Work Environment

User is responsible for taking proper security and privacy precautions ensuring a secure and private work environment while utilizing portable devices in order to safeguard client information displayed. _____Initial

Security Agreement

User agrees to the stated required security criteria in order to access and utilize the ACBH systems.

I understand that sharing my account ID and password, client information or any breach of security is a HIPAA (Health Insurance Portability and Accountability Act) violation which may result in prison, fines up to $25,000 and/or revocation of my license. _____Initial

I attest that I have completed HIPAA security and privacy requirements training for protecting the confidentiality, integrity, and availability of protected health information under HIPAA within the past 12 months.

_____   _____   _____
User Signature   User Printed Name   Date

The supervisor agrees 1) to employee's usage of the system and 2) to provide information and direction for secure uses and practices while utilizing network resources.

The supervisor attests that the user has 1) signed an Oath of Confidentiality, 2) signed an Ethical Conduct Policy and 3) been trained in HIPAA security and privacy requirements

_____   _____   _____
Supervisor Signature   Supervisor Printed Name   Date

18 PHI Identifiers Under HIPAA

1. Names

2. Geographic subdivisions smaller than a state, Geocodes (e.g.-> zip, county, or city codes; street addr, etc.)

3. Dates. All elements of dates except year, unless individual is > 89 yrs. (e.g.-> birth date, admission date, etc.)

4. Telephone numbers

5. Fax numbers

6. Electronic mail addresses

7. Social security numbers

8. Medical record numbers

9. Health plan beneficiary numbers

10. Account numbers

11. Certificate/license numbers

12. Vehicle identifiers and serial numbers (including license plate numbers)

13. Device identifiers and serial numbers

14. Web Universal Resource Locator (URL)

15. Internet protocol (IP) address number

16. Biometric identifiers (including finger or voice prints)

17. Full face photographic images and any comparable images

18. Any other unique identifying number, characteristic, or code

What Is SmartCare:

SmartCare™ is a web-based software designed for Substances Use Disorder and Mental Healthcare organizations. Its primary purpose is to facilitate the coordination, reporting, and management of payment for all service delivery processes. With SmartCare, organizations can effectively maintain, protect, and organize health information pertaining to their clients. Furthermore, it serves as a central repository for collecting data used in eligibility determination and for generating local, state, and federal reports.

One of the key strengths of SmartCare is its commitment to being the most open and user-friendly application available in the market. It recognizes the dynamic nature of the health and human services industry and strives to remain adaptable to changing market conditions. SmartCare achieves this by employing an open-architecture framework that allows customers to easily update and expand the system to meet their evolving needs.

By adopting SmartCare, organizations gain access to a comprehensive software solution capable of mapping and incorporating their entire range of business processes into a single platform. This integration enables streamlined operations and improved efficiency. Moreover, SmartCare is designed to grow and evolve alongside the organization, ensuring it can effectively support future business requirements.

Chapter 1: Portal & SmartCare Log In

Logging onto the ACBH Web Portal

You must log in to the ACBH Web Portal to access SmartCare.

➢ ACBH Staff will use the URL to open SmartCare once you log on to the County Secure Network.

➢ CBO Agencies will use the ACBH Web Portal to access SmartCare.

If this is your first-time logging into the portal the system may prompt a Citrix Workspace installation message. Please follow the prompts, and download the Citrix Workspace as needed. If this is a company managed PC/Laptop, you will need your support team to install the software, as they have Administrative Credentials. If assistance is needed please contact the Help Desk for assistance.

1. The ACBH Web Portal address is: https://go.bhcsportal.org

2. Type your network Username, and press Tab.

3. Type your network password and press Return or click the Log On button. To protect password secrecy, the password is displayed on the screen as dots.
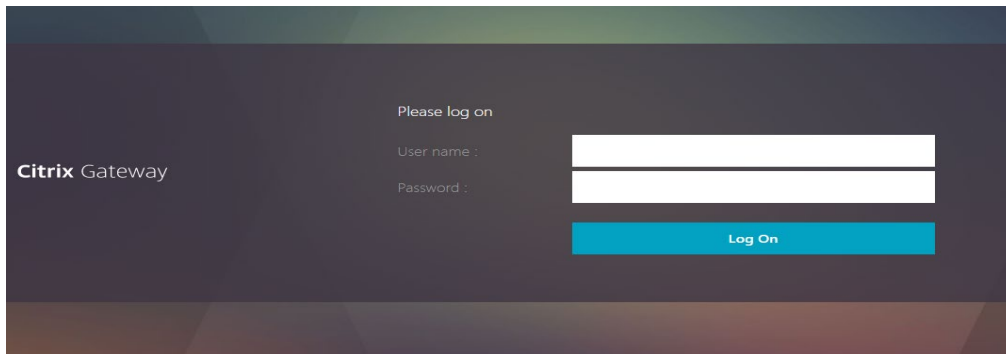
4. To log into SmartCare choose the Apps option and select the SmartCare Train Icon.
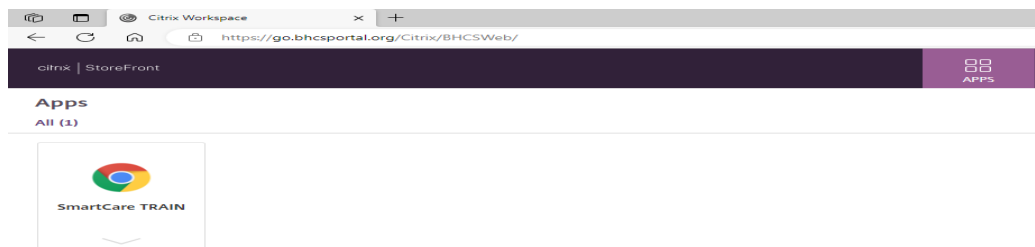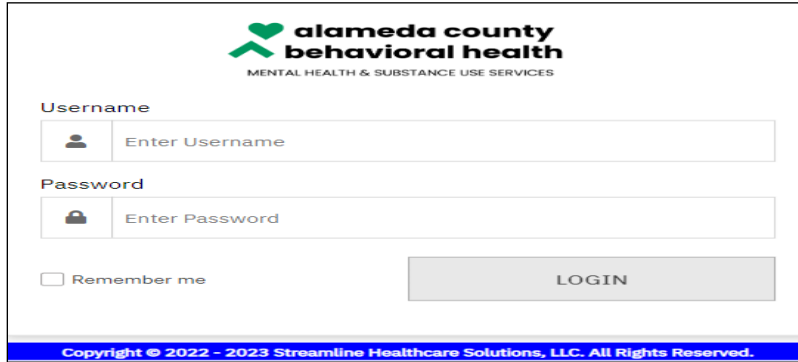

5. Click the SmartCare icon to prompt a new Chrome Window to open the SmartCare Log on Screen.
6. Click the SmartCare icon to prompt a new Microsoft Edge Window to open the SmartCare Log on Screen.

Logging into the SmartCare System

The first time you log in to the SmartCare system, follow these steps:

1. At the login page, you will be required to enter your Username and Password. After entering these two pieces of information, click "Remember Me" so that you will not have to repeatedly enter your password each time you open the application.

2. Click the LOGIN button.

After logging in for the first time, the system will now ask you to set security questions.


These questions are to ensure security for logged in users. The answers you enter are case sensitive.

If you have logged on previously, the logon will take you directly to one of the security questions you have selected. Supply the answer and select the "Remember Me" radio button, then click the Submit button.

What is CDAG

Clinical Data Access Groups (CDAG) ensure that staff only have access to see client chart information in SmartCare that is applicable to the service line (Mental Health or Substance Use services) that they serve. When you login into SmartCare you will need to choose between SUD and MHS organizations.

If you are only in one organization this should be seamless to you and you will not need to select anything. If a clinician provides both Mental Health and Substance Use services, the provider will be associated with both MH and Substance Use CDAG groups and will be prompted to select a CDAG group when logging into SmartCare.
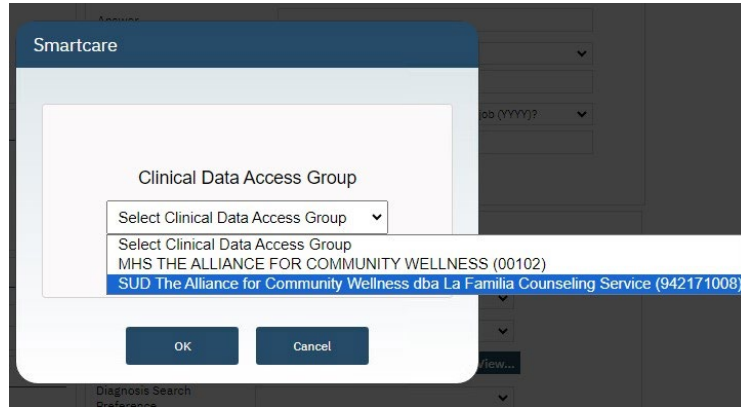
In the below example, Clinician A is logged in as a SUD staff person and therefore only sees the client's SUD services.

# Chapter 2: Basic Navigation & Overview of SC System

Users will experience SmartCare as a series of connected modules, accessible by using search functionalities, icon and action buttons, and QuickLink menu options. SmartCare was designed to enhance the user experience and to provide new system users with tools to navigate easily.

Overview

How a user navigates the SmartCare system can vary by preference. See the following section which list the various ways a user can access documents, screens, and reports using the applicable methods.

Title Bar

The title bar sits vertically across the home screen in SmartCare. Hover over the icons on the title bar to display the Icon name and action.
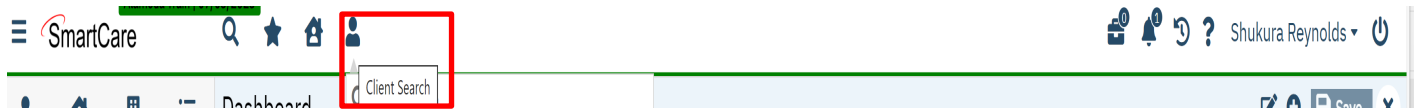
Common Toolbar Items

A tool bar appears on every page in the system. It is located to the right of the page's title. The tools displayed on this bar can vary by screen or by the list page you are currently looking at. See below example.


**TIP:** Hover over a specific tool to display its name.

Sometimes the Toolbars are too large for the size of your screen, so if you hover your arrow to the far right of the screen, other tools will appear.

NOTE: Some tools are permissioned, but denied tools will still be visible, but they will appear grayed out.

SC Navigation

Navigation filters above the Quick Links section allow you to sort by Client, Provider, Other or display All Quick Links.
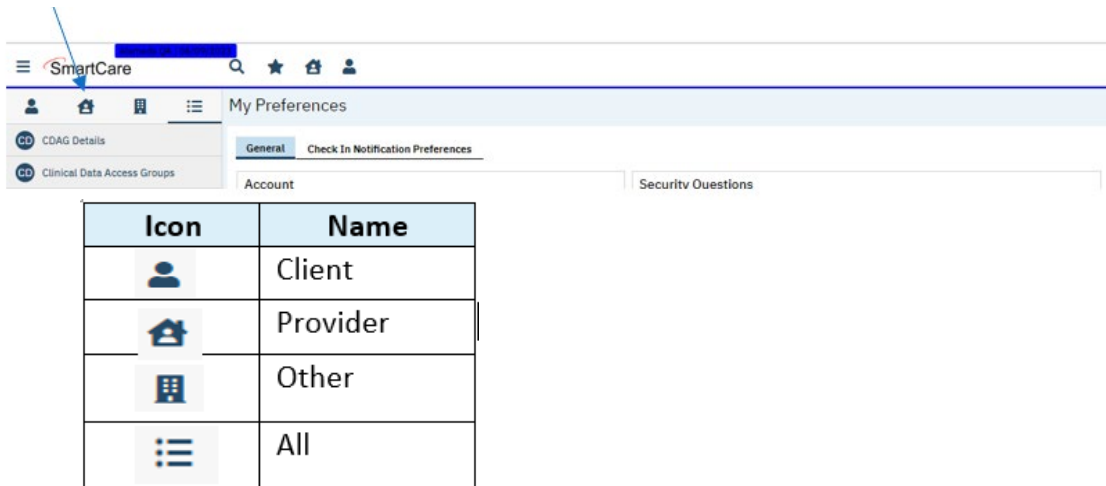
| Icon	Name
👤	Client
🏠	Provider
🏢	Other
☰	All

TIP: By clicking on SmartCare Icon you land back on your homepage.   SmartCare

When you log into SmartCare you will want to personalize it to meet your specific business needs. This can be done by personalizing:

1. Quick Links
2. My Preferences
3. Dashboards
4. Widgets
5. List Pages
6. Smart Links
7. Client Flags
8.

#1: Quick Links

Quick links are a quick way to navigate to specific screens and specific parts of SmartCare. These are meant to be at your fingertips and enable you to do your job. These can be found on the lefthand side of your screen:
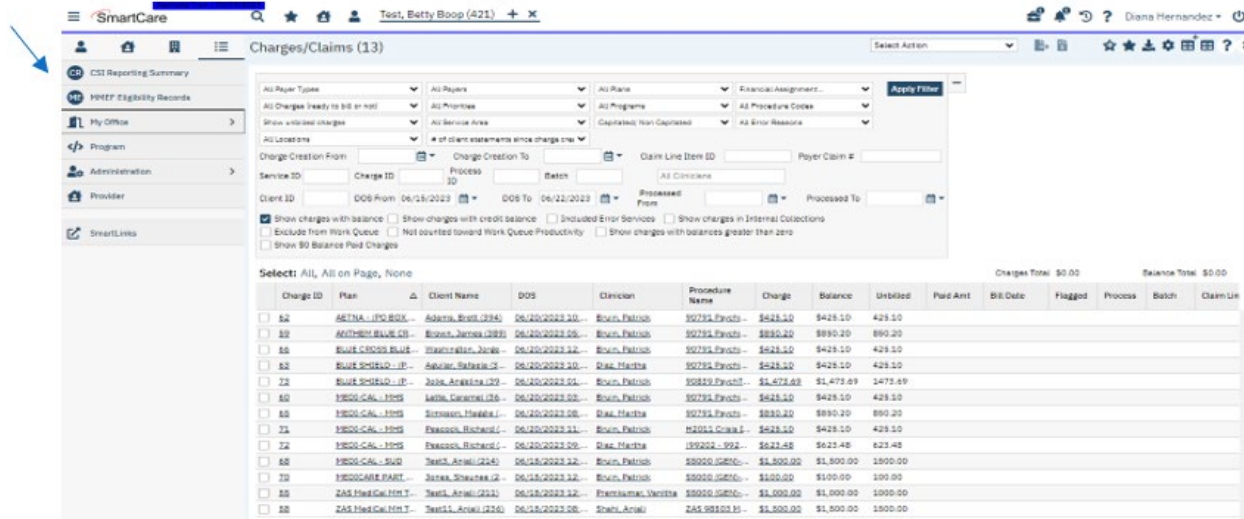
You can build and tailor these "Quick Links" to allow you to efficiently navigate between the different aspects of your job, without having to type in what you are looking for. To access and manage your "Manage QuickLinks" feature:

1. Locate the drop-down arrow next to your username in the upper right-hand corner of the screen.

2. Click on the drop-down arrow to open a menu of options.

3. Look for the "Manage QuickLinks" section and click on it.
4. Once inside the "Manage QuickLinks" section, you will have the ability to personalize the QuickLinks navigation according to your preferences.
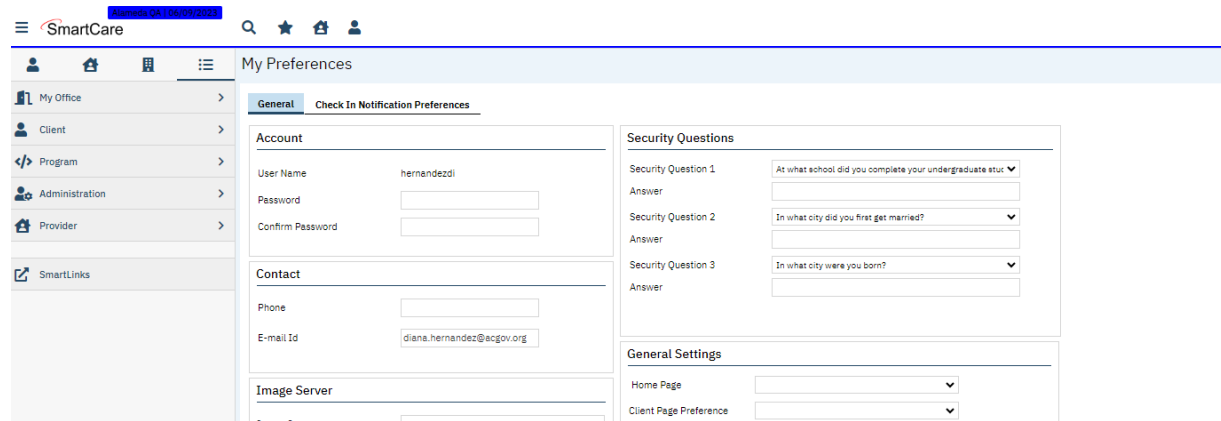
You can use this section to Reorder, Delete or Edit the Quick Links displayed names.
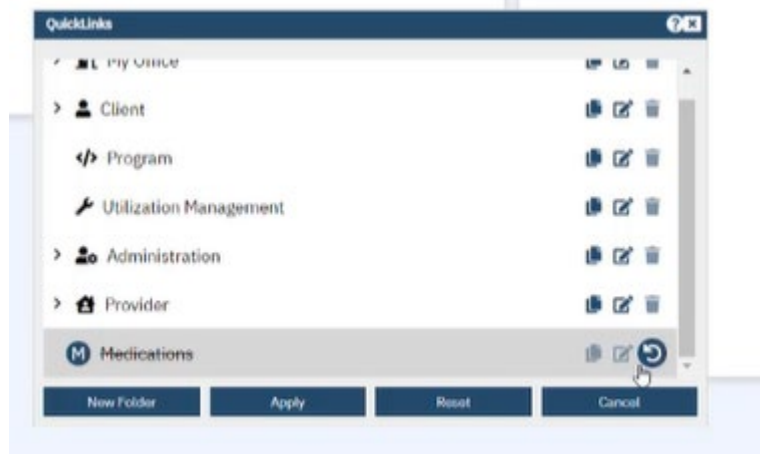

NOTE: Users may have core functions linked to specific screens, so please work with your organization to determine what the standards should be.

#2: My Preferences

Once you are logged into the system, the first screen you see may be My Preferences. On the General tab, sign-in to set up your default Preferences section for the various sections of the SmartCare system.
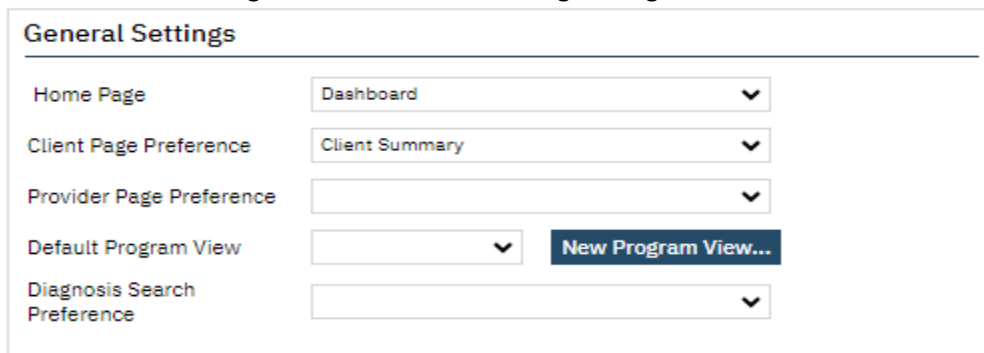

If this is not the first screen you see, navigate to the "My Preferences" screen by clicking the drop list arrow next to your name in the top right corner of the screen, and select "My Preferences" button.
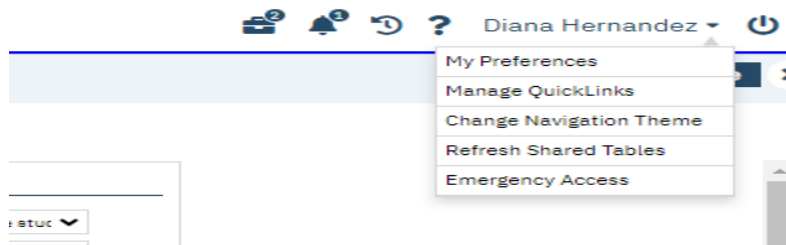
General Setting Section

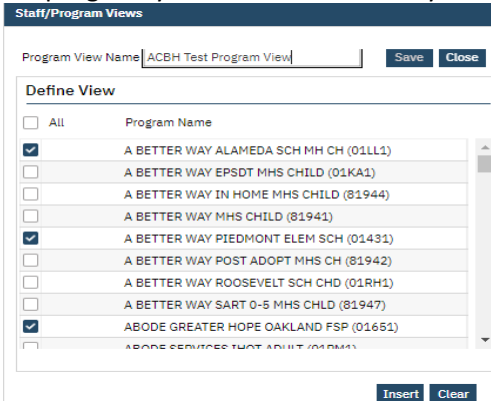In the General Settings section set the following settings:

1. **Home Page Dropdown:** Select the name of the Page/Dashboard that you want to open in the "My Office tab" when you login to the SmartCare system or when you click on the My Office tab when in the system. This will be the main page when you login every time.

Generally, this is set to view 'Dashboard' as shown in the screenshot above. After making your selection, click the ⊡ Save button located under your login name in the top right corner. (IMPORTANT: Be sure to perform a "Save" following any changes while logged into your account). **NOTE:** If a Home Page option is not selected, the system will default to the "My Preferences" screen when you log in.

2. **Client Page Preference Dropdown:** This is the <u>client record</u> that you want to first appear when you open a client page.
   NOTE: If the Client Page Preference is left empty, it will default to the the Client Summary screen which will display when opening a client when you perform a Search or select Open this Client.

3. **Provider Page Preference Dropdown:** This field identifies <u>the Screen</u> to which you are redirected upon selecting a provider in the system.

4. **Default Program View:** Setting a Program View lets you define the programs that you can filter for while using the Program Assignments page. The Program View you set up are displayed in the All Program Views dropdown list on the Filter portion of the Program Assignments page on the Program tab.

5. **Click the New Program View button**. The Program Views window is displayed.
   Type the name of the Program View you are creating in the Program View Name field.

   Select the checkbox next to each program you want to include in your Program View.

-or-

Select the **All** Programs checkbox to have all programs set up in SmartCare listed in the Program View.

Click the **Insert** button.

The Program View is displayed in the Programs Views area of the window.

To set up another Program View, repeat steps 2 through 5.

-or-

If you are finished setting up a Program View, click the Save button.
You will now be able to select your custom view from the Default Program View drop list.

NOTE: Diagnosis Search Preference Dropdown: This is an <u>obsolete</u> and should not be populated.

#3: Dashboards

The Dashboard is the central page of the SmartCare system. SmartCare main screens are either Dashboards or List Pages that display data and have links. From the Dashboard, you can quickly view pertinent information and access the detailed screens or list pages.

The Dashboard "My Office" is a central screen containing widgets, with real time data, as well as links to important screens for related workflows. Links and widgets can be clicked on to bring you to the displayed information.
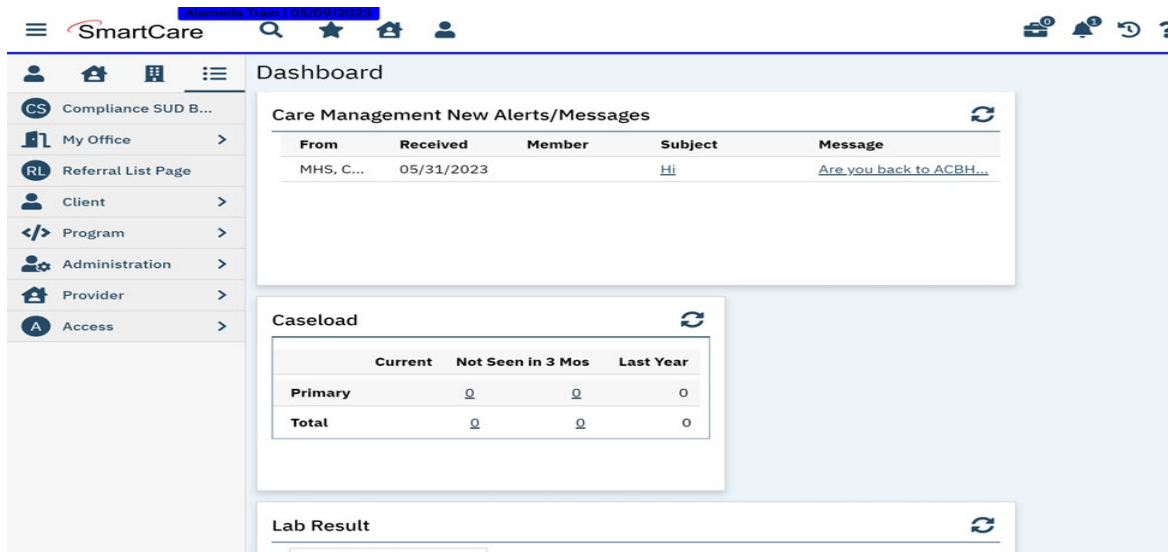
NOTE: Dashboards are hub pages, that can be customized and organized to meet your business needs.
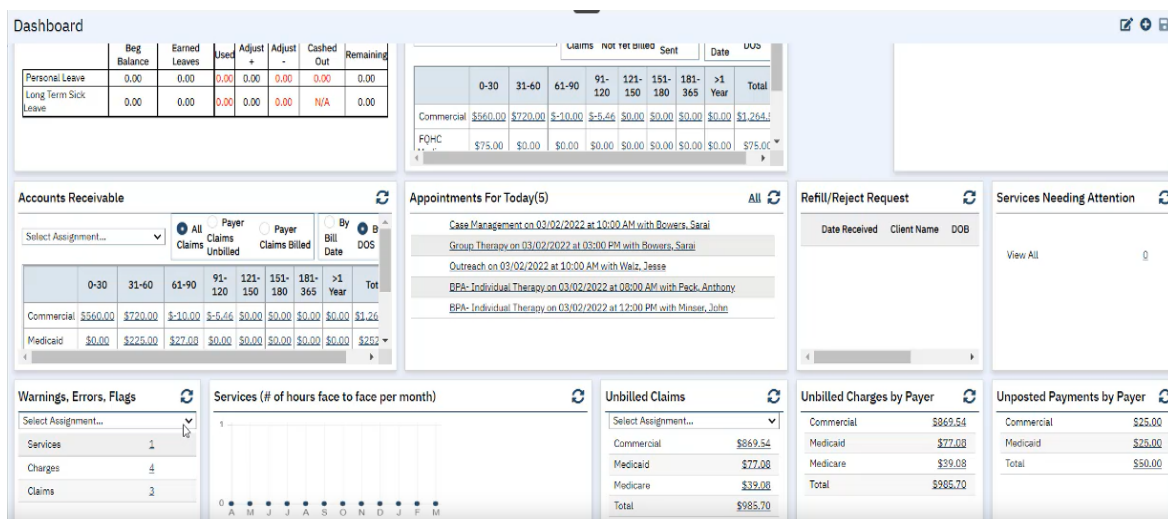
In addition, there are specialized Dashboards, e.g. Billing Dashboard, Provider Dashboard, etc. that can be updated with widgets specific to you. You can select which screen is displayed when you sign on and these dashboards can be tailored to meet your specific needs.

BEST PRACTICE: A good Dashboard should never require much scrolling.

#4: Widgets

Widgets gather information that the staff may need to act on, and provide a hyperlink to the page/screen where the staff can drill down or complete the items listed. Information is presented on the Dashboard in the form of widgets.

Each tile on the Dashboard is a widget, that you can resize and edit the display. Widgets are part of the core functionality of SmartCare, and are displayed on the staff's dashboard. You tailor the dashboard through the use of widgets.
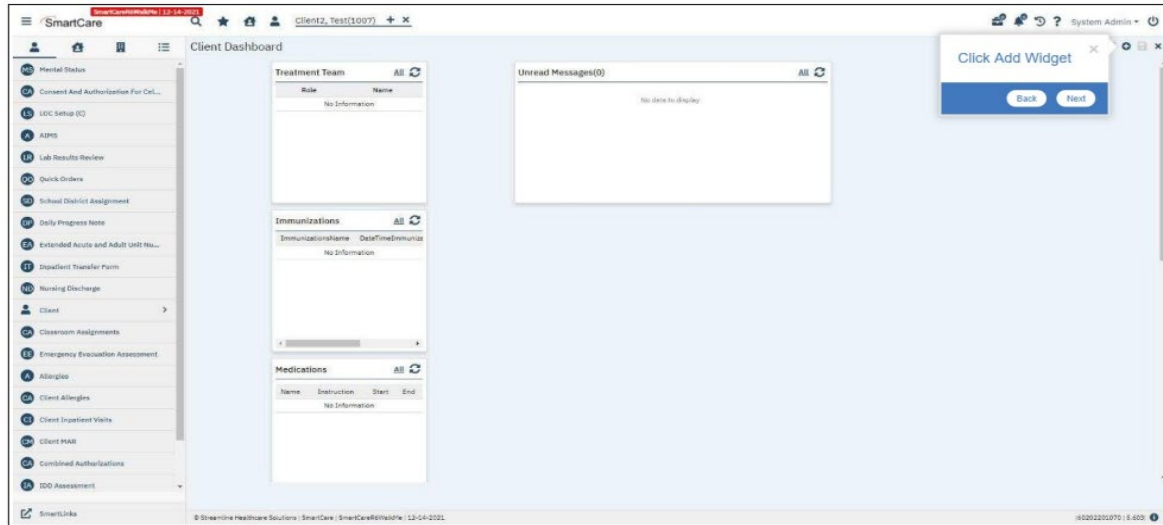
The great news is that you can customize these widgets by adding, removing or deleting a widget to meet your needs.

The order in which the widgets are displayed on the dashboard is determined by the default Order on the Widget Details screen. And widgets are permission based and they should be considered as part of your roles and permissions setup. Only the relevant widgets should be permissioned to each user.

NOTE: Click the reload icon (⟳) to refresh the widget. The data in the widget is refreshed/recalculated based upon the value set in the Auto Refresh Interval setting.

The "Warnings, Errors, Flags Widget" displays the total number of Services, Charges and Claims that have a system issue and need to be corrected. Like other Billing Widgets, the Warnings, Errors, Flags Widget can be filtered by financial assignments.

Warnings, Errors, Flags	⟳
Select Assignment....	⌄
Services	4512
Charges	11685
Claims	806

Many Widgets (depending on the kind of information they display) draw their information from and link to List Pages.

#5: List Pages

Selecting a page will typically take you to a list page where information is summarized. Key information in SmartCare is stored or displayed via List Pages, and entered via Detail Pages and Documents referenced by a specific List Page.

List Pages serve an important role in the management of information. Aside from being the location where information is stored and displayed, List Pages are also filterable to search and sort specific types of needed information.

Client Name ▽	DOS	Units	Charge (Rate Id)	Procedure	Status	Clinician	Program	Location	Comment	Failure to Complete Reason(s)	Add On Codes
Test, Christin...	04/13/2022...		50.00 (1)	Individual T...	Show	Buckley, Chri...	Main St - Ad...	Office			
Test, Christin...	04/14/2022...		50.00 (1)	Individual T...	Show	Buckley, Chri...	Main St - Ad...	Office			
Test, Beth (1...	04/11/2022...		50.00 (51)	BPA- Individ...	Schedul...	Scott, Beth	Maple Ave - ...	Office			
Test, Beth (1...	04/11/2022...			Case Manag...	Show	Scott, Beth	Main St - Cas...	Office			
Test, Beth (1...	04/12/2022...			Case Manag...	Schedul...	Scott, Beth	Main St - Cas...	Office			
Test, Beth (1...	04/10/2022...			Case Manag...	No Show	Scott, Beth	Main St - Cas...	Office			
Test, Beth (1...	04/14/2022...			Case Manag...	Schedul...	Scott, Be					
Test, Beth (1...	04/15/2022...			Case Manag...	Schedul...	Scott, Be					
Test, Beth (1...	04/16/2022...			Case Manag...	Schedul...	Scott, Be					
Test, Beth (1...	04/17/2022...			Case Manag...	Schedul...	Scott, Be					
Test, Beth (1...	04/11/2022...			Case Manag...	Cancel (...	Scott, Be					
Test, Beth (1...	04/28/2022...			Short Sessio...	Show	Scott, Be					

First   Previous   1   **2**   2 ⌄

> Data appears in the List. Most columns are sortable, and several fields give basic information on the entry. Click hyperlinks in the entries to navigate to detail pages related to that entry. (For example, clicking the date of service takes you to the Service Detail page, while clicking the Charge link takes you to a Charge Detail page.)

They are also able to be 'Favorited', which allows you to set commonly-used Filters and immediately apply them.

- ▪ The <u>My Office tab</u> contains list pages to help you organize your caseload and quickly access information.
- ▪ The <u>Client tab</u> contains list pages for list services, documents, disclosures and other information.

1. Use the Filters at the top of the List Pages to search for specific information in a list.

2. Click on the column headings to sort the list by the selected column.
   - Click the same column heading again to reverse the order of the list based on the selected column.

3. Lists with multiple pages will display page numbers on the bottom.
   - To navigate the pages, there are multiple options: You can select Page Number, Next/Last, or use the drop-down to navigate through the pages.

Filters

Column Headings

#6: SmartLinks

SmartLinks are displayed in the Left Navigation Menu for the staff. SmartLinks are system generated links located in the Navigation sidebar under the QuickLinks. The SmartCare system learns which screens you typically navigate to from the current screen and creates SmartLinks to enable you to navigate there directly.
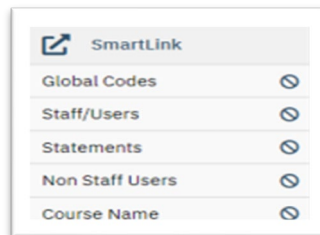
To help minimize the number of clicks required to get to the screens you frequently use, SmartCare creates SmartLinks to screens, reports, actions, or favorites that you visit regularly. The links in the SmartLinks section change over time depending on your system usage.

My Office Tab

My Office Tab contains overall information on all client's records assigned to you based on your security permissions; different roles may view different information.
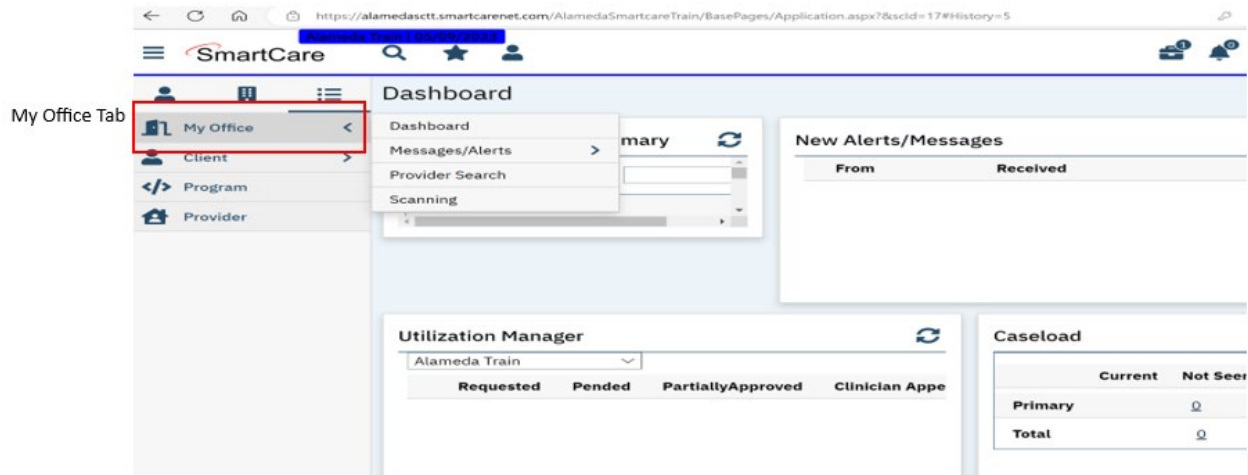
Client Tab

Client tab contains information in a client's individual record and only one client tab can be open at a time.

1. The clients name will display on the Client tab - last name, first name, followed by the client ID.
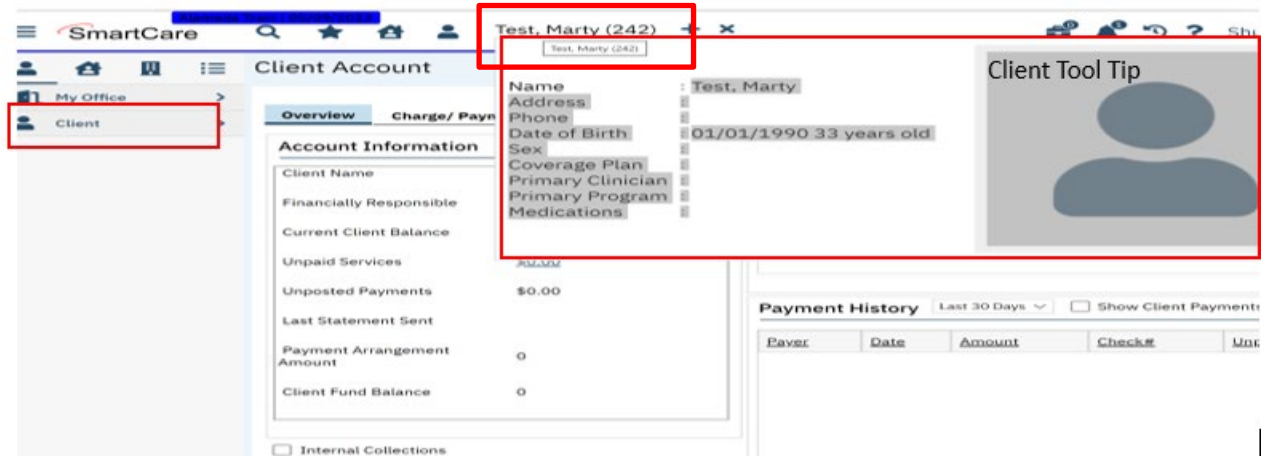
2. By hovering over client's name, while on Client tab, a Tool Tip will be displayed.
3. This Tool Tip will display information related to the client.
4. What is displayed can vary by role, depending on your security permissions.

System Quick Tips

1. Use the tab or mouse to move through pages, especially detail screens with multiple fields.
   a. Depending on the screen, pressing the tab may be faster and on other screens the mouse is sometimes faster.
2. Make sure that you select the Save button before moving off a screen.

Commonly Used SmartCare Tools & Icons

Icon	Name	Description
🗋	**New**	Will allow you to create a new entry based on the page that is displayed. For example, if the Authorizations page is displayed, clicking this icon displays the Client Search screen so you can create a new authorization for a client, or a new document or list page.
🖫 Save	**Save**	Will allow you to save what you are working on. Click this icon to save your work without closing the page. **NOTE:** Saving the form is different from signing, as saving does not require all validations to be fulfilled.
✖	**Close**	Will close the screen you are currently on and take you to the previous screen.
🗑	**Delete**	Displayed on certain pages, such as the Inpatient Activity Details page. Click this icon to delete the action displayed on the page. You will not able to retrieve what you delete.
ᴬᴮ✓	**Spell Check**	Displayed on any page throughout SmartCare where there is a free-form Comment field. Use to check the spelling of any text entered in free-form comment fields you completed on the page.
⬇	**Export**	Click this icon to export the data in the body of a list page into an Excel spreadsheet.
★	**Favorite(s)**	Click this icon to display a hyperlinked list of favorite pages and windows you marked as favorites. Click the link to display the page or window. Use the New Favorite icon to save a favorite page. ▪ Filters are specific to a user. ▪ Filters are not specific to clients. ▪ To create a filter, enter all filter parameters in the list page and click Apply Filter, click on New Favorite(s). This will save the filter that is currently displayed on the list page, enter a filter name, click OK button to complete.
ℹ	**Information**	Provides information about screen/document (who and when created and modified).
⎙	**Copy Service**	When selected this will open a calendar. Once date and time have been selected, Procedure and Location will copy from original service. ▪ This icon is meant to be used with services.
📅	**Schedule Follow-Up**	When selected will open calendar. Once date and time have been selected, Procedure and Location will copy from original service. ▪ This is meant to be used with services.

Icon	Name	Description
	Reschedule	When selected it will open a calendar. Once date and time have been selected New Entry Type pop-up will appear, unlike other times this will have a Reschedule option. Select Reschedule and enter cancel reason, then click OK. Service will then open with selected Date and time, Procedure and Location will copy from original service. ■ This can only be used with Scheduled services.
	Messaging	Allows you to send a message and automatically attach client document to message. ■ Utilized with Documents.
	Unsaved Changes Briefcase	This briefcase contains items that have not been saved. If you have left pages where you entered or changed data and did not save the page, SmartCare holds onto the changes for a certain amount of time. The information on these pages is held to give you an opportunity to save your work. 1. You can discard these changes by clicking "Discard All" or leave the changes unsaved by clicking the "Review Later" button or you may click "Cancel". 2. Unsaved changes should NOT be used to track items user needs to work on, widgets can accomplish this. 3. These changes only remain in your suitcase for 48 hours **BEST PRACTICE:** Try not to have many unsaved changes or keep a document under unsaved changes for too long as items can become corrupted and can no longer be accessed.
	Notification	The Bell icon lists active messages and notifications. Select each from the dropdown to read and resolve it.
	History	Allows you to quickly access the last screens or clients within a logged in session. Use to view all the pages you have accessed in this session in the sequence accessed. Click the tool to return to a specific page. 1. It will also list client records that have been opened within a logged in session. 2. When you log out of the session, your history will be erased. 3. The history window displays the last 13 QuickLinks and/or clients you have accessed in your current SmartCare session.
	Logout	Displayed on the Title bar. Click the icon when you are ready to sign off and close your session in SC.

Icon	Name	Description
?	**Help**	Displayed on all SC pages. Use this to display help on the specific SC module. **NOTE:** Not all Help sections contain current SC application information and currently does not contain ACBH work processes.
☑	**Validate**	After completing a section, you can hit the validate button and the system will specifically highlight what fields are required, that you might not have chosen or any issues that it is finding while it is validating. The validation button in SmartCare serves as a helpful tool to ensure that all necessary data is provided and that any errors or discrepancies are identified. **NOTE:** SmartCare currently does not indicate what fields are required with an asterisk (*). Until this is implemented, use this feature to identify required fields.

Based off of the R6 Navigation User Guide

Chapter 3: Use of Documents Within SmartCare

Documents

Information is not entered through dashboards or list pages, instead most information is entered into SmartCare by use of documents and detail pages. Documents are individual iterations of a template, and many List Pages are lists of Documents. When searching the SmartCare system for certain documents, list pages, or reports the system will automatically assign "S" for screen or "R" for report to identify which type of module you are working in. See below example.
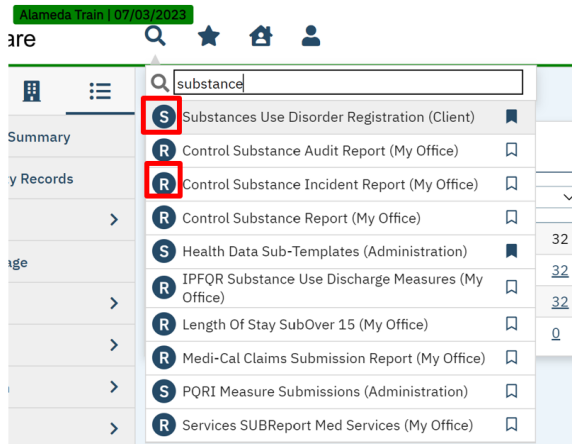
SmartCare Documents are screens that allow you enter data into specific fields, and you have the ability to save the overall document to its associated client or to a system record. Most Documents are informational – they record SUD Registration, Program Enrollment which is Admission, Discharge, and Annual data. You cannot bill Services from Documents alone, but a SUD Program Enrollment is required to complete Service Entry.
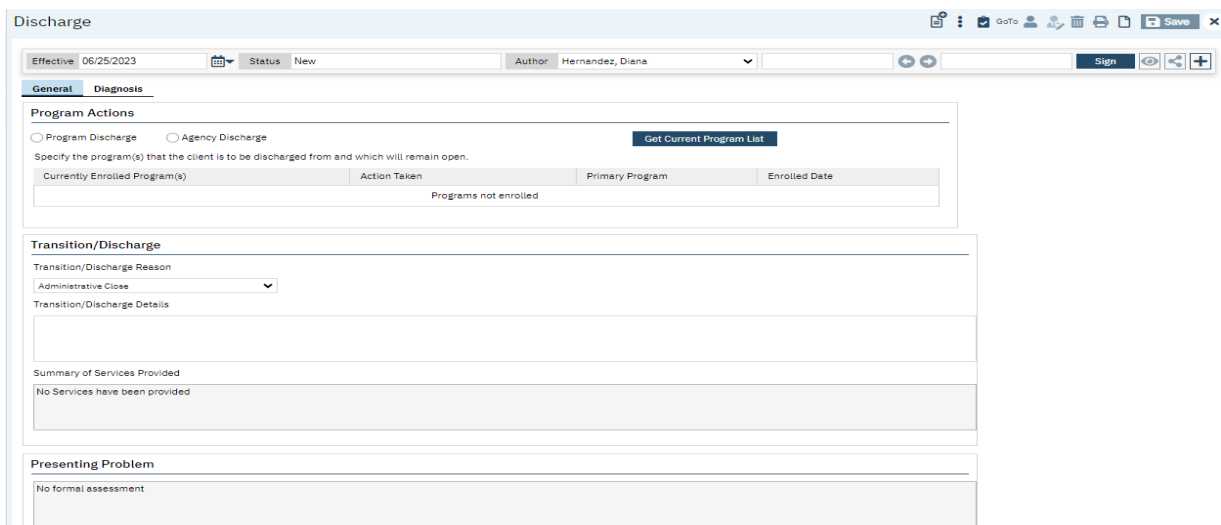
Document Status Bar

Each document will include a document status bar which list the documents *effective date*, *status*, and *author*.

The document status bar is also where a user will *sign* the SmartCare document to save and appropriately record the information and attach the document to the clients document history and record. See below example of a document status bar.
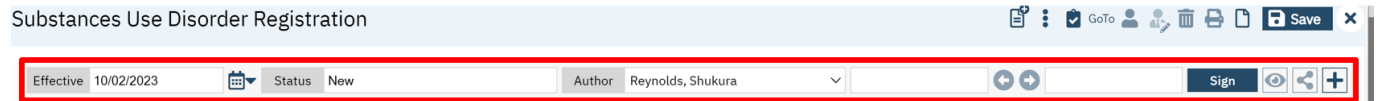
To see document details you can select the plus icon ⊞ to the far right of the status bar for "more details" this will cascade down the status bar. In the document details section the user can view previous and current document versions, previous and current authors and signers, and the clients program enrollment the document is linked too. See below example.
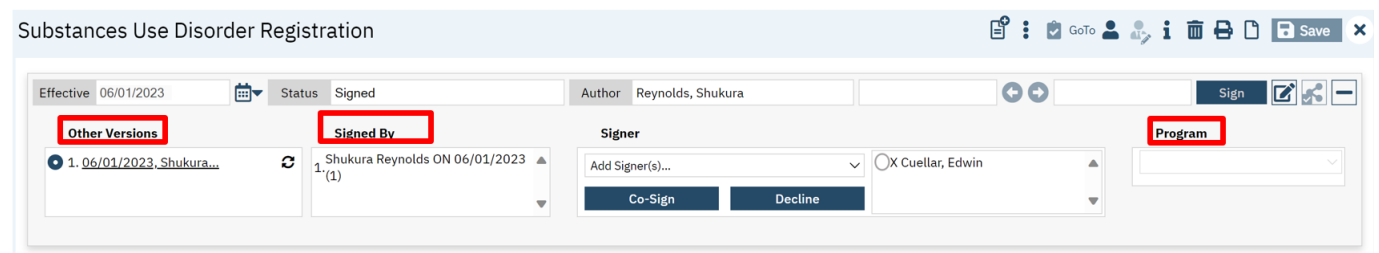
To cascade the document status bar up, you can select the minus icon ⊟ to the far right of the status bar for "less details" and the status bar will resume to its original layout.
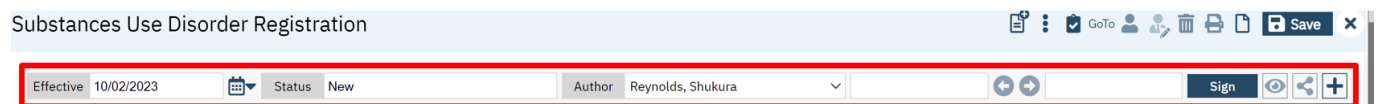
Editing Documents

A User can edit the document once it has been signed if there are necessary changes or corrections by using the pencil icon ✎ on the status bar.

To edit a signed document, follow the below process:

1.) Select the pencil icon ✎ to far right of the status bar
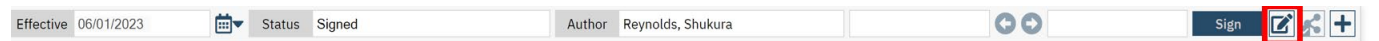
2.) The document will then prompt the user to create a new version of the document; select "OK"
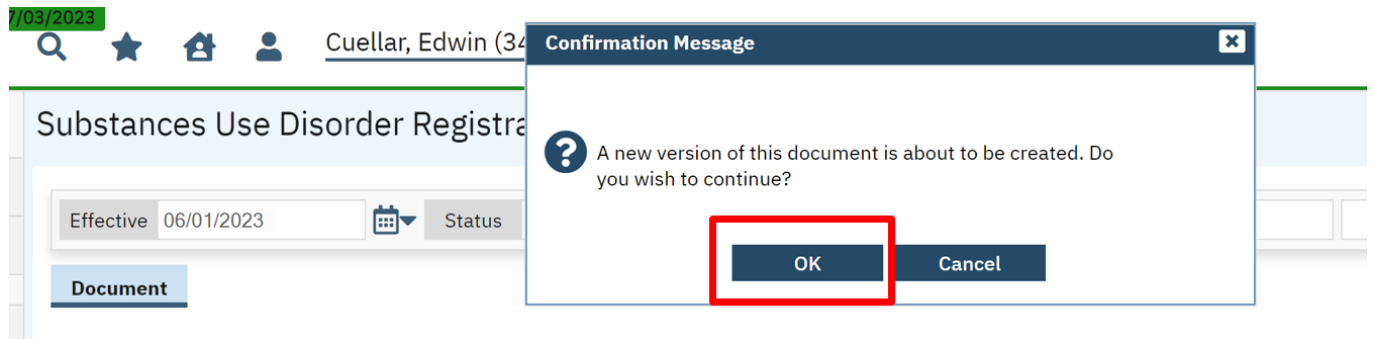
3.) The document will then convert back to a fillable screen from the signed PDF so that the user can select the applicable tab and/or required field to make the applicable edit.
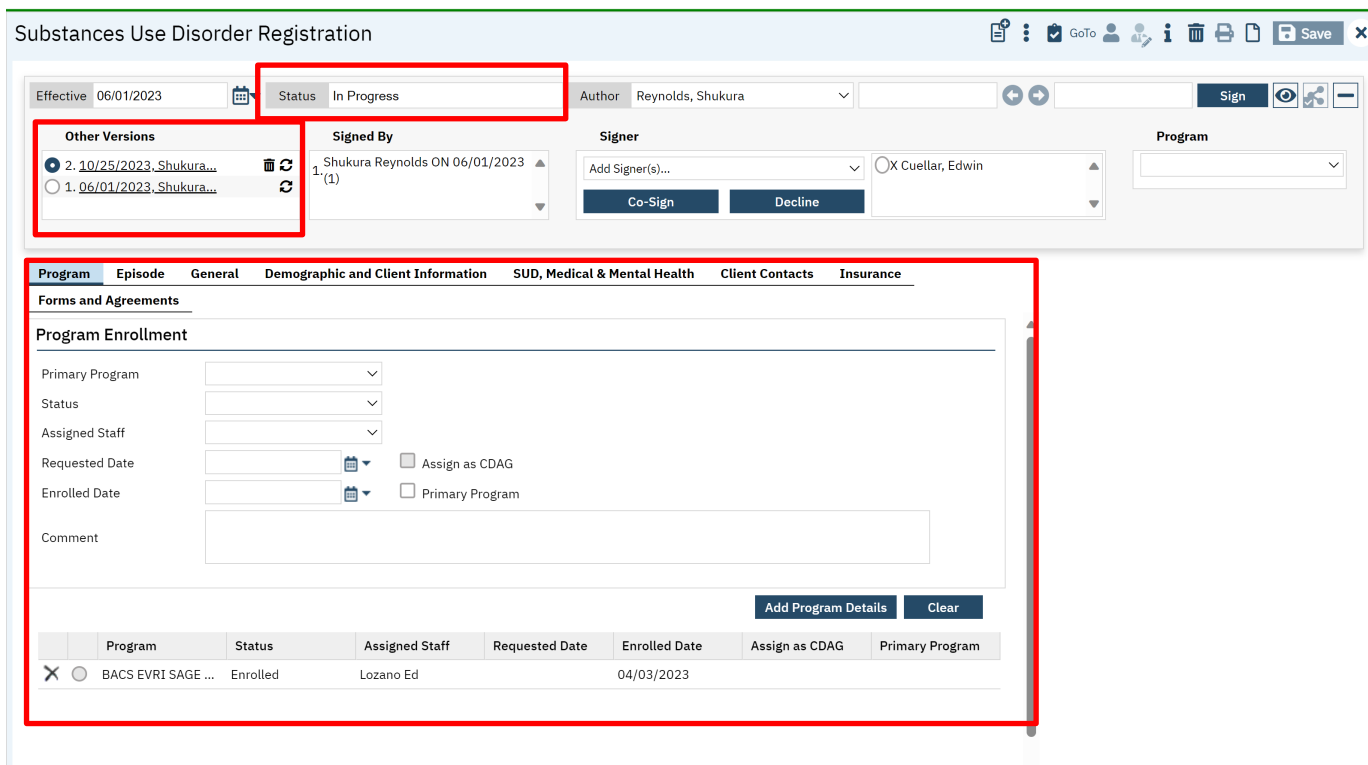
NOTE: Notice in the above example the new version has been added to the "other version" column under the status bar details. Also, the documents status has been updated to "In-progress" from "signed".

4.) Once all changes are made the user selects sign [Sign] to re-sign the document, this action will prompt the PDF completed and signed updated document to return to the screen.

To edit a document when the user is **not** the author, please follow the workflow below.

1.) The User will first need to update the Author on the document to their credentials by selecting their name as proxy from the top of the Author drop-down list.

2.) The User then will select the pencil icon to far right of the status bar to edit the document

3.) The document will then prompt the user to create a new version of the document; select "OK"
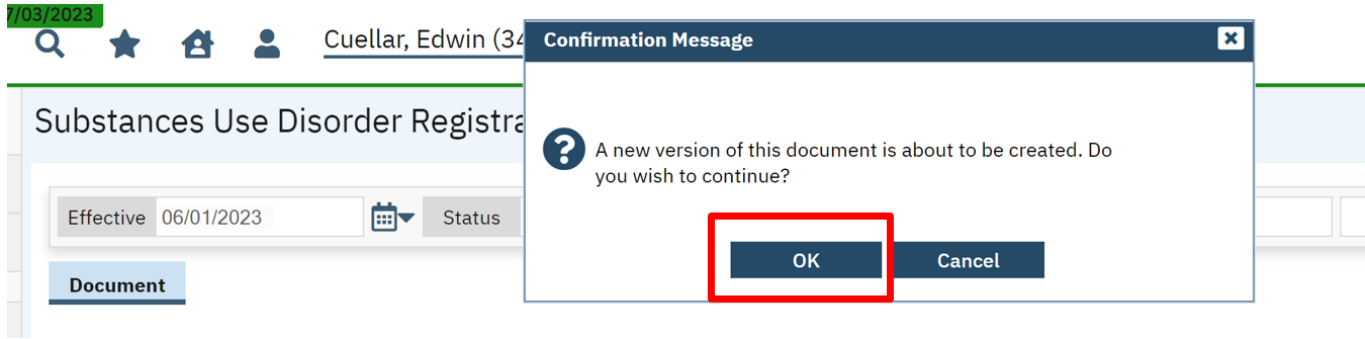
4.) The document will then convert back to a fillable screen from the signed PDF so that the user can select the applicable tab and/or required field to make the applicable edit.
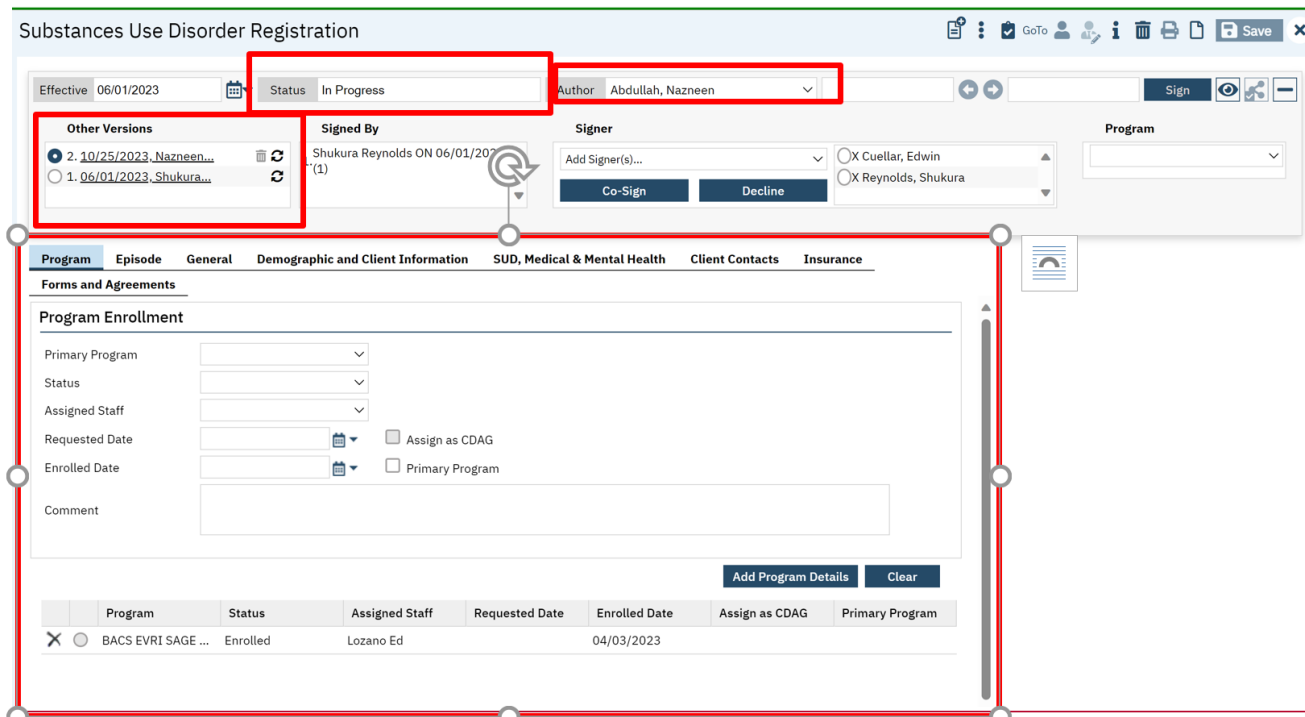
Note: Notice in the example the Author has changed to the proxy; the "other version" column is updated with the "new version" and the documents status has been updated from "signed" to "in-progress."

5.) Once all changes are made the user selects sign [Sign] to re-sign the document, this action will prompt the PDF completed and signed updated document to return to the screen.
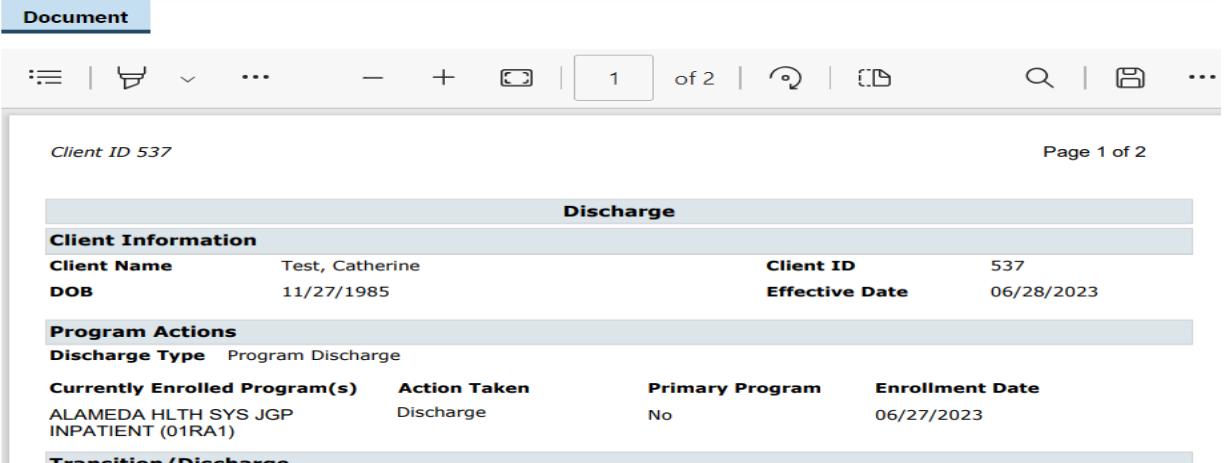
Use of documents allows information to be pulled for Reporting, State Reporting, etc. and used for initializations, or checked against validations. You have the ability to export these into a printable form, in a pdf., an example of this is a Discharge Document:

The completed Document is in a printable PDF form.

You can adjust a document view from fillable screen to a PDF document by selecting the icon on the status bar.

Document List Page

To view a list of documents which are "in-Progress" or are "Signed" on a client record select the documents list page, see the below example.

In the quick search menu type document; then select "Document (client)" from the drop-down list f
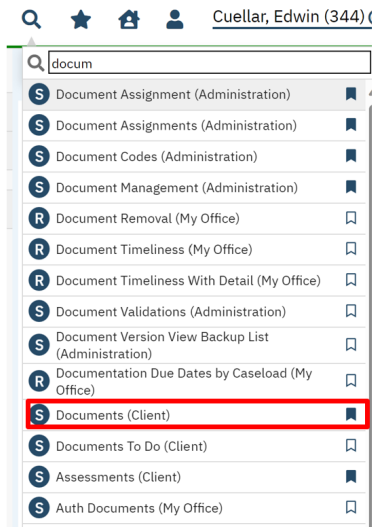
 2.) Once selected the documents list page by client will reflect.
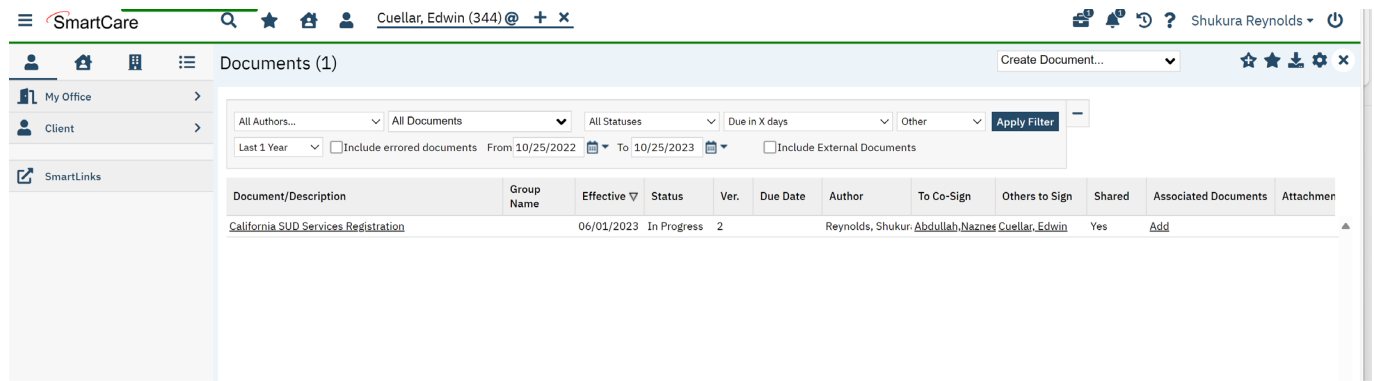
3.) Filter by any applicable information and select the **Apply Filter** icon to retrieve a list of applicable documents which are pertinent to the selected client record.
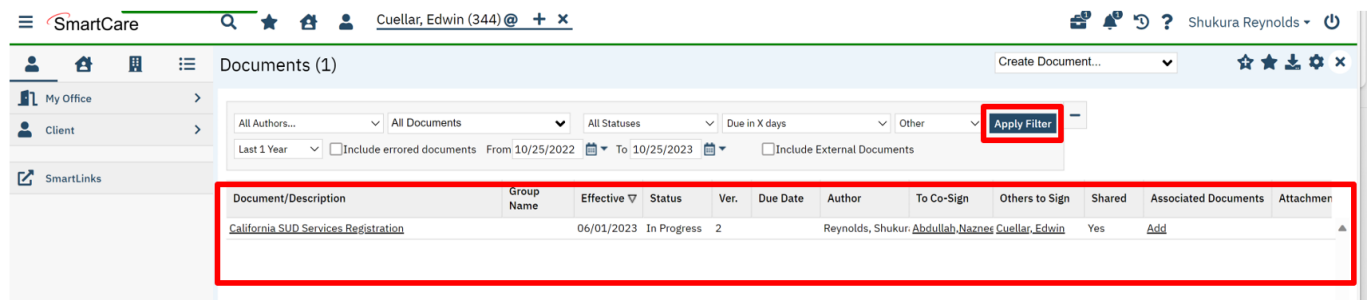
Select the hyperlink under the document to view the listed documents.

Detail Pages

Detail pages are specific to certain types of data entry, they are not typically signable and do not generate pdf. They contain a great deal of information about a specific action, event, or record. e.g., Service Entry
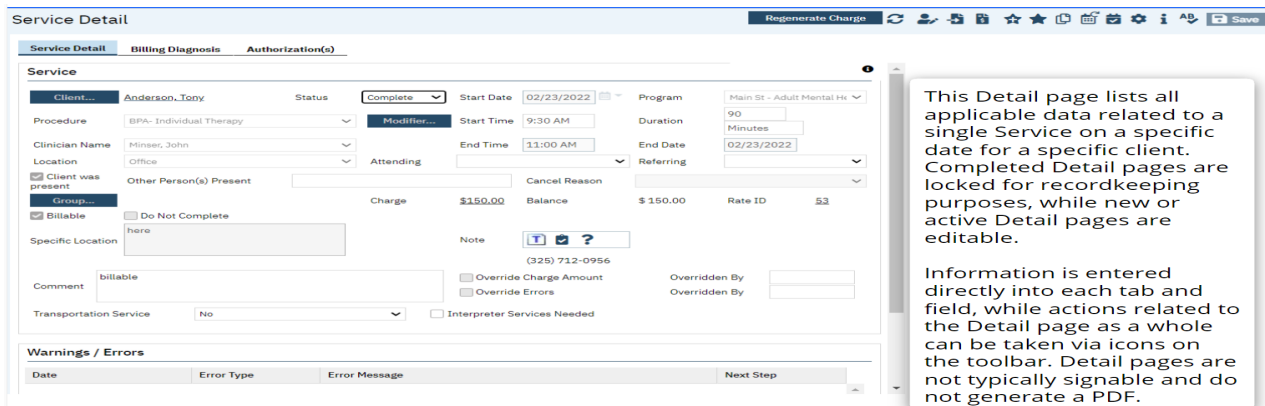
Completed documents and detail page entries will be accessible through the appropriate list page.

Client Records

The Client Record contains client information, entered into SmartCare concerning a client. The Client Search feature allows you to search from a pool of clients and select a client record or create a new record. Having a Client Record selected does a number of things in the system: it allows you to take actions that impacts registration, it allows you to run reports on the client, and it configures all client data-focused Widgets to display information on that Client via the Client Dashboard.

Scan and Upload Documents

SmartCare has the ability to scan and upload documents and it is currently under construction. This functionality will enable users to upload and scan various medical documents such as Medi-Cal cards, Authorization documentation, Driver's Licenses, and much more.

Chapter 4: Client Search

Before you can work with any client information in SmartCare, the client must have a SmartCare Client ID. If a client is new to your program, you must determine whether the client has a Client ID in SmartCare, by using the Client search screen, described below. If you cannot find an assigned Client ID, a new Client ID is needed, see Chapter 5 for instructions.

NOTE: It is possible that a client could have multiple last names, multiple first names and aliases, etc. To prevent creating a duplicate client and before registering a new client be sure you have tried all possible spellings of the client's name and aliases.

Preventing Duplicate Client Registration

- If there is a Social Security Number (SSN) in the system that is the same as the SSN you are searching for, the system displays an error message and does not let you continue.
    - You *__cannot__* override a Social Security Number match.
    - If you are sure that the SSN you entered is correct refer to your supervisor.
- If there is a client in the system with the same name and same birth date you are searching for, the system displays an error message and does not let you continue.
    - If two different clients have the exact same name and same birth date they may be duplicate clients refer to your supervisor.

To Begin a Client Quick Search:
1. Click on the Client Icon at the top of the tile bar to activate the client search option:
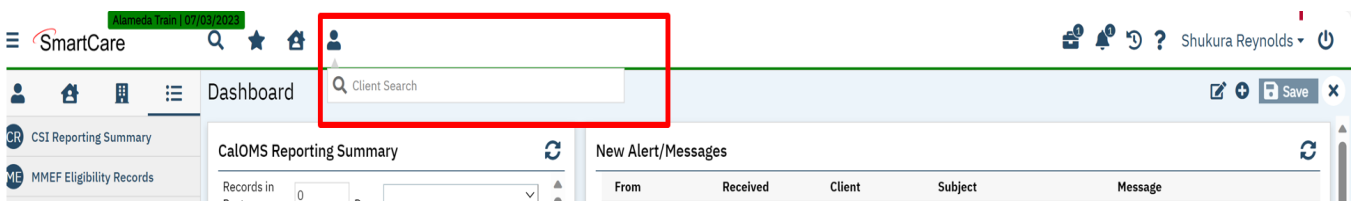
2. Click in the area that is labeled <Client Search> and begin typing either the clients "Last name, First Name" or the clients SmartCare ID number.

Last Name, first Name Example
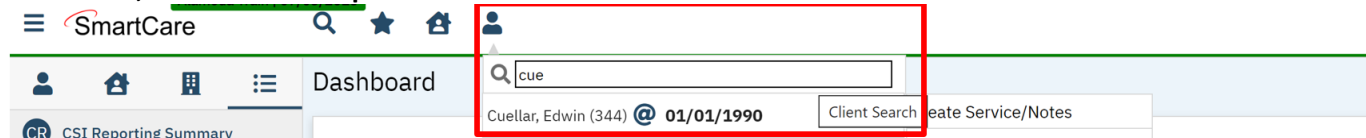
SmartCare ID # Example
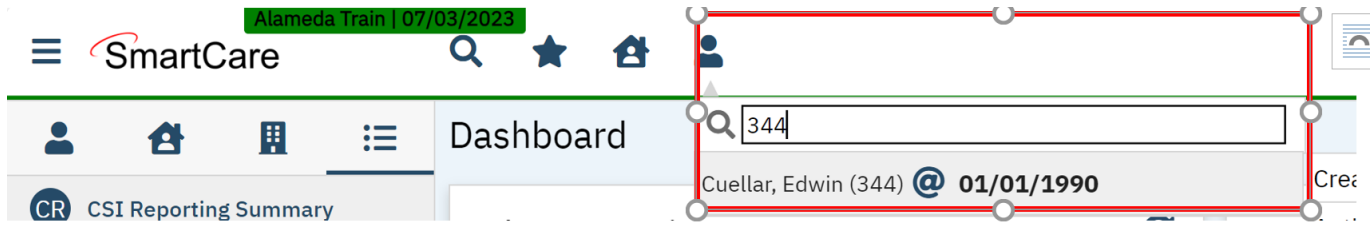
Note: If the client already exists in the SmartCare system select the client from the drop-down list. If your client is not reflecting in the drop-down list proceed to the Client Search screen.

To advance to the Client Search screen Click in the area that is labeled Client Search icon on the title bar.
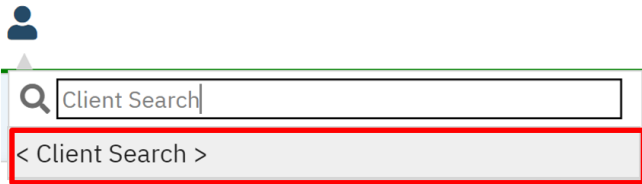
Click the area labeled <Client Search> to activate the Client Search screen as shown below:
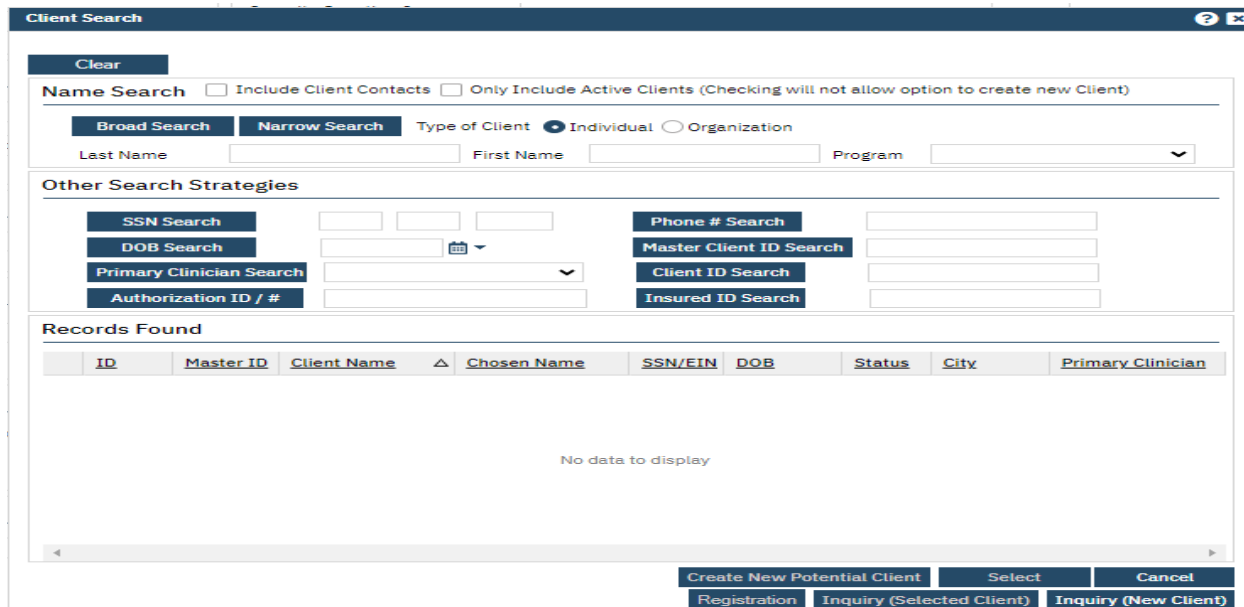
NOTE: SmartCare allows for multiple search options, as well as the Client Name from the Client Search screen:

Client Search Field Definitions

1. **Client Name: Required.** If unknown enter Jane or John Doe with DOB 1/1/1900.

2. **Social Security Number: Required.** The Social Security Number is the fastest way to find the client. If you have the client's SSN (not all 9's), enter the SSN in the SSN Search field, and click the SSN Search button.

3. **DOB: Required.** Enter date of birth, if unknown use 1/1/1900.

4. **Master Client ID Search:** Use this field to search by the clients SmartCare ID.

5. **Client ID Search:** Use this field to search by the clients SmartCare ID.

6. **Insured ID Search:** Use this field to search by the client's coverage plan # i.e. Medi-Cal ID, BIC #, CIN Etc.

NOTE: Searching by search criteria numbers 4-6 will not prompt the system to generate a new client ID, which is why these search criteria fields are **Not REQUIRED**. To generate a new potential client, follow the below workflow.

While still in the client search screen as exampled below please follow steps 1-5.

1. Enter the client's last name and first name and Click the "Broad Search" button (**NOTE:** There is a minimum of 3 characters required to search)

If the client's name search results in
2. Enter the client SSN. **NOTE: When SSN is unknown, enter all 9's.**

3. Enter the client's SSN and click the SSN Search button

If the client name search and the SSN search results in

Enter the client's DOB and click the DOB Search button

These three combinations will most likely provide results – the search results are found on the Records Found section of the Client Search screen:

	ID	Master ID	Client Name △	Chosen Name	SSN/EIN	DOB	Status	City	Primary Clinician
●	243	243	Testing, Zee		9999	01/01/19...	Active	Oakland	

4. Carefully review the Records Found results to determine if the client you are searching for is listed, once you find your client select your client using the radio button as shown above and click on the Select button

Create New Potential Client	Select	Cancel
Registration	Inquiry (Selected Client)	Inquiry (New Client)

5. Your client will now appear in the title bar next to the Client Icon by client name and client ID

☰ SmartCare   🔍 ★ 🏠 👤   Testing, Zee (243) ＋ ✕
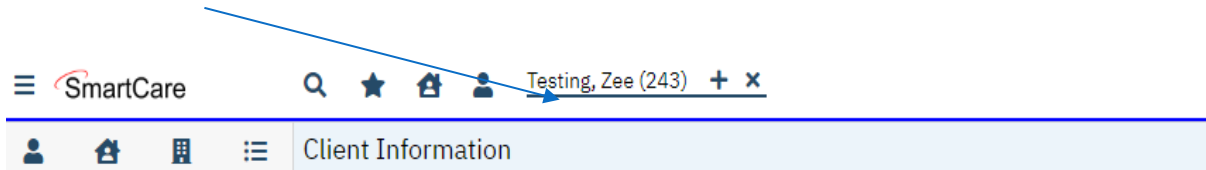
👤 🏠 🏢 ☰ | Client Information

🛑 **Next step requires moving to the Client Information Screen document to capture required data fields**

Chapter 5: Create a new Client ID

Before registering a new client, be **100**% sure you have tried all possible spellings of the client's name and client's alias names to prevent creating a duplicate Client ID. If you cannot find a client using the Client Search Screen, you must activate the ***Create New Potential Client*** option to generate a Client ID before you can start the Substance Use Disorder Services Registration document to Enroll/Admit the client to a Program before entering Services.

NOTE: Follow the ACBH Client Registration & Client Naming Convention Rules below to generate a new Client ID, the Rules can also be found in Appendix.

Client Registration Rules & How to Ask the Right Questions:

What is your name on your CA ID/ID or DL? (Field Name: **First Name**, **Middle name & Last name**.)
What is your preferred name? (Field Name: **Aliases - Preferred Name;** First, Middle & Last.)
What is your Gender Identity? (Field Name: **Gender Identity) NOTE:** Multiple selections will be available at a future date.
What is your sex of record on your Medi-Cal account (M/F/U)? (Field Name: **Sex,** one selection allowed of M/F/U. If client does not know-select U.)
What is your Sexual Orientation? (Field Name: **Sexual Orientation**, multiple selections allowed.)
What are your Pronouns? (Field Name: **Preferred Pronoun,** multiple selections allowed.)
*W*hat is your Date of Birth listed on *your CA ID/DL or on your birth certificate*? (Field Name: **Date of Birth**)
    NOTE: *If clients name and/or DOB are unknown or unable to obtain:*
all will be listed consistently as: Jane or John Doe with DOB 1/1/1900.
- *All other fields above are listed as unknown if client does not answer the questions.*

Client Naming Convention Rules

Because the information entered in the Client Registration screen establishes the client's identity, it is best to ask the client for a form of ID (CA ID, DL, SSN Card or other document) to be used for entering the client demographic data. Three critical pieces of information must be entered correctly: **client name, birth date, and Social Security Number.**

Client Last Name:
- Enter a last name as listed on the CA ID/ID, SSN Card or DL
  - Leave out apostrophes and blank spaces
    - "O'Connor" should be typed "OConnor"
    - "Torres-Smith" should be typed "Torres-Smith"
DO NOT enter Jr., Sr., etc. in the Last Name field, these are to be entered in the ***Suffix*** field
  - DO NOT enter spaces in front of name

Client First Name:
- Enter a first name as listed on the CA ID/ID, SSN Card or DL
  - Leave out apostrophes and blank spaces
  - DO NOT enter spaces in front of the name

Client Middle Name (optional):

- Enter a middle name as listed on the CA ID/ID, SSN Care or DL
    - Leave out apostrophes, dashes and blank spaces
    - DO NOT enter spaces in front of name
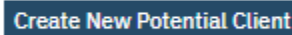
Client Suffix:
- Enter the client suffix title that is part of the client's name, such as Jr., Sr., or the Roman Numerals II, III, etc.

NOTE: SmartCare requires three (3) basic searches before the system will activate the *Create New Potential Client* option button to create a new Client ID.

- **Broad Search** Enter the client's last name and first name and Click the "Broad Search" button (**NOTE:** There is a minimum of 3 characters required to search)
- **SSN Search** the Social Security Number is the fastest way to find the client. **When SSN is unknown, enter all 9's**
- **DOB Search** if DOB is unknown use 1/1/1900

ENTER BASICALLY THE SAME INFORMATION AS USED FOR CLIENT SEARCH - MODIFY AS NEEDED

Create New Potential Client

Click Yes when asked to confirm you want to make a new Client.

Confirmation Message

? Are you sure you wish to create a new Client?

Yes   No
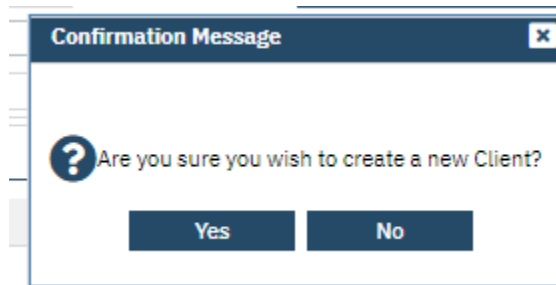
The new Client ID will appear on the Title bar next to the Client Icon

≡ SmartCare   Q ★ 🏠 👤   Testing, Zee (243) + ✕

👤 🏠 🏢 ☰ | Client Information
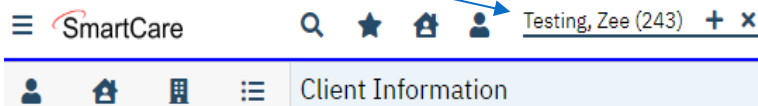
Once you have generated the Client ID, The SmartCare System will open the Client record via the Client Information screen.

Chapter 6. Client Information Screen and Updating Client Records

The *Client Information* screen is used to capture **General Client Information/demographics**. The client information screen holds the most recent client information, when the client information needs to be updated you will update the information using the tabs on the client information screen.

Client Information Screen Tabs

Tabs act like separate pages or sections on a document, typically containing different categories of information. The tabs required to complete the client information screen are noted in **red** font below, the other tabs are available but not required at this time:

> **#1: General Tab**
> **#2: Aliases Tab**
> **#3: Demographics Tab**
> **#4: Contacts Tab**
> #5 Primary care referral
> #6 Release of Information Log
> #7 Client Episodes
> #8 Family
> #9 Timeliness
> #10 Custom Fields

Client Information Screen:

To access the Client Information screen, follow the below steps.

Click on the Magnifying Glass and enter the search term "**Client Info**".

Select "Client Information (Client)" from the drop list.

This is the screen that you will see when you select Client Information Screen:

The workflow for completing the Client Information screen is as follows:

> 1. General Tab
> 2. Demographics Tab (Identifying information section Required; other sections are not required)
> 3. Aliases Tab
> 4. Client Contact

#1 General Tab

The general tab contains general information about the client such as name, e-mail address, phone number, address, etc. If an Inquiry was performed and/or Client Information was updated, some fields are already populated on this tab.

Data fields on the "General Tab" should be initialized from the client search screen, enter in the remaining required fields and click save.

General Information Section: Required.

1. Type of Client: **System Informational Field Only.**

2. Client ID: **This information will auto be populated.**

3. SSN: **This information will auto be populated.**

4. ~~Primary Clinician:~~ **Field not used at this time.**

5. ~~Primary Physician:~~ **Field not used at this time.**

6. Prefix: **Optional.**

7. First Name at Birth: **Required.**

8. Middle Name at Birth: **If Applicable.**

9. Last Name at Birth: **Required.**

10. Suffix at Birth: **If Applicable.**

11. Email: **Optional.**

12. Medi-Cal ID: **This information will auto be populated.**

13. Active: **System Informational Field Only.**

14. ~~Professional Suffix:~~ **Field not used at this time.**

15. Medical Beneficiary ID: **Not Required.**

16. ~~Patient Portal ID:~~ **Field not used at this time.**

17. Addresses: **Required.**

Phone Numbers Section

Collection of client phone numbers is **optional**. Should you collect a telephone number and want to input it into a client record select the phone number field applicable and enter the 10-digit phone number.

- o ~~DNC: Do not call~~ *Field not used at this time.*
- o ~~DNLM: Do not leave message~~ *Field not used at this time.*

Any of the Phone Number fields can be redefined to the values shown in the pop-up window below. Click the down arrow next to the field whose title you wish to change and select the new title from the pop-up list.

Addresses Section Required.

A client address is **required.** To enter a client address, complete the following.

1. Click the down arrow next to Home dropdown to add additional addresses.

2. Click the Details button and a data entry pop-up window will display the specific fields that need to be populated. Once complete select "OK".

TIP: The system is very finicky and 95% of the time if you enter information into the address box, it will give you an error message.

3. By clicking the OK button on the Address Details pop-up window, the address is inserted into the record and is displayed in the text box.

NOTE: If the client is Homeless enter the **Zip Code** for the **City Hall** of the city where the client indicates they most often sleep (in a shelter or on the street). Please see the SmartCare Global Code Tables on Page 58 for a list of the Cities and their zip codes.

Also, if you click on the "History" link, you will find a list of all the previous addresses that have been entered.

Comments Section: **Not Required.**
You may make any additional comments about client special needs or other items important to note in the textbox.

#2 Aliases Tab Optional.

Once you have entered client's general information, if the client has an alias use the Aliases Tab to enter the alias information.

The purpose of gathering alias information is to provide an additional means of searching for a person's name. By including aliases or alternate names that an individual may be known by, the search capabilities of the system are enhanced. This allows for a more comprehensive and accurate retrieval of information when conducting searches or generating reports.

In many cases, individuals may have multiple names they are known by, such as nicknames, maiden names, or previous legal names. By capturing and storing this alias information within SmartCare, the system can broaden its search parameters and increase the likelihood of finding relevant records associated with the client.

Enter this information when registering a client.

1. If the client has ever used an alias, enter them under the "Alias Tab". You may enter as many aliases as needed via the Client Information Screen.

2. Enter Alias information, e.g. First name, Last Name.

3. Assign "Alias Type" by selecting Dropdown Menu

4. "Allow Search" box is auto populated with a checkbox, which enables the search criteria.

5. If the Alias is what they would like to use as their primary name, please click the "Chosen Name" checkbox.

6. Select "Insert" and then "Save". If you don't save it, it will appear in your suitcase or can be lost.

7. Once an Alias is generated and inserted to a client record the Alias will appear on the "List of Alias" table and will appear in searches if you select the allow search box. F

The above shows a list of the aliases for this client.

#3: Demographics Tab: Required.

Some of the data on this tab will be initiated from the client search inquiry.

Identify Information Section: Required.

Complete the required fields.

1. Sex: **Required.**

2. Marital Status: **Required.**

3. Gender Identity: **Required.**

4. Sexual Orientation: **Required.**

5. Preferred Pronoun: **Required.**

6. Ethnicity: **Required; Multi-select field see drop down list of global codes.**

7. Race: **Required; Multi-select field see drop down list of global codes.**

8. ~~Deceased on and Cause of Death are completed by ACBH Staff.~~ **Do Not Complete these fields.**

9. ~~Client declined to provide:~~ **Field not used.**

Primary Care Physician Section: **Not Required.**
Financial Situation Section: **Not Required.**
Living Arrangement Section: **Not Required.**
Educational/Employment Section: **Not Required.**
Language Section: **Not Required.**
Transportation Information Section: **Not Required.**
Preferences Section: **Not Required.**
Picture Section: **Field not used.**

Contacts Tab: Optional.

Contacts Tab - Client Information Screen (This tab is optional, but if you choose to utilize it, there is required minimum information that is listed below).

This tab is used to add records indicating additional individuals that are important to the client's care. When you navigate to the tab the first time, the "List of Contacts" grid is empty if there are not already any contacts listed in the client's record.

Client Information Contacts Tab Required Fields:

- **Relation (Required):** Select the relationship the contact has with the client.
- **First Name (Required):** Enter the contact's first name.
- **Last Name (Required):** Enter the contact's last name.
- **Select whether the client relations are as following (Required):** Financially Responsible, Emergency Contact, Guardian, Household Member, Care Team Member, and/or Health Decision Maker

Client Information

General	Aliases	Demographics	Hospitalization	Primary care referral	Financial	Release of Information Log	Contacts

Client Episodes	SA Demographics	Referral	Special Rates	Family	External Referral	Timeliness	Reporting	Interfaces

Custom Fields

Contact Information

Relation	Next of Kin

Add to Frequent Contacts | Frequent Contact Search

Prefix | First Name: Love | Last Name: Big | Suffix

Date of Birth | Age | Sex | SSN | Insert...

List As: Big, Love | E-Mail | Assign Treatment Team Role

Credentials | Department | Professional Suffix

Organization | Mailing Name

☐ Financially Responsible ☐ Emergency Contact ☐ Guardian   Associated Client ID   ☑ Active

☐ Household Member ☐ Care Team Member ☐ Healthcare Decision Maker

Patient Portal ID   Create   Reset

Phone Numbers
☐ Same As Client Phones
Home
Business
Home 2
Business 2

Addresses
☐ Same As Client Address
Home
☐ Mailing
Details...   History

Comments

List of Contacts ☑ Show Only Active Contacts   Export List   Insert   Clear

Add a new contact or modify an existing contact by following the steps below.

1. Click the Add/Edit Contacts button. The Client Information screen opens to the Contacts tab.
2. Complete the required fields on the tab and click the Insert button.

	Contact	Relation	Phone	Organization	Guardian	Emergency	Financially Responsible	Household Member	Care Team Member	Active	Healthcare Decision Maker
✕ ●	Big, Think	Grandmother			No	No	No	No	No	Yes	No

Once complete click "save" to finish capturing all data.

Clinicians Gateway:

NOTE: Client Registration must be complete before the clinician can create a progress note in the Clinicians Gateway application.

- **Client Registration/ID information is transferred from the SmartCare system to the Clinicians Gateway application in 5-minute intervals.**

Chapter 7: Substances Use Disorder Registration Document

The Substance Use Disorder Registration document is used to capture required data fields for **Client Information/demographic** and opening an **Admission using the Program Enrollment**. The Registration document is where the User will complete program enrollment (previously referred to as opening an episode in INSYST). The registration document is also where the User will complete the CalOMS data collection at time of admission/intake. The following section will explain the SmartCare workflow which now combines both the Program enrollment process (historically opening an episode) and the CalOMS data collection.

Background Information: **What is a California Outcomes Measurement System (CalOMS)?**

To understand CalOMS Tx data collection, it is important to understand what an "outcome" is. An outcome is a comparison of information or data collected at two different points in-time (e.g. before treatment and after treatment). In CalOMS Tx, client information is collected **at admission** to treatment and **at discharge** from treatment. Then information from both points-in-time is compared. For clients in long-term treatment CalOMS Tx collects information **annually on the admission** anniversary date.

> To ensure continued funding from the federal government, states are required to report the status of client "**outcomes**" to the federal government as part of the SAPT Block Grant award. In turn, to receive funding from State Department of Health Care Service (DHCS), California counties and their contracted providers, along with state-contracted direct providers, are required to collect and submit CalOMS client data electronically to DHCS monthly.

> The data collected by counties and state-contracted direct providers is also used to understand client needs and improve service delivery. Gathering information about clients and the services they receive allows DHCS, counties, and state-contracted direct providers to better understand client needs and identify ways to improve treatment.

CalOMS: State Codes

State codes are now available as drop-down menu options. The User will select the below menu options from the drop-down where applicable. **Important note:** The state codes conditions still apply when selecting from the drop-down list. See the updated list below.

OLD INSYST State Codes	**NEW** SmartCare Drop-down list Menu Options
99900	Client Declined to State
99901	Unknown or Not Sure/Don't Know
99902	None or Not Applicable
99903	Other
99904	Client Unable to Answer
	(This value is reserved for **ONLY** developmentally disabled clients that are unable to answer the question and for clients undergoing detoxification services that have not stabilized.)

Substance Use Disorder Registration Document Tabs

Tabs act like separate pages or sections on a document, typically containing different categories of information. The tabs required to complete/sign the SUD Services Registration document are noted in **red** font below, the other tabs are available but not required at this time:

> **#1: Program Tab**
> **#2: Episode Tab**
> **#3: General Tab**
> **#4: Demographic and Client Information Tab**
>   **-Mental Health Information Section**
>   **-Medical Information Section**
> **#5: SUD, Medical and Mental Health Tab**
> ~~Diagnosis~~
> ~~Client Contacts~~
> ~~Insurance~~
> ~~Authorization Requests~~
> Forms and Agreements – the tab is available, but not being used at this time.

Substance Use Disorder Registration document:

To access this Registration document, follow the below steps.

Click on the Magnifying Glass and enter the search term "**Registration**".

Select "Substance Use Disorder Registration (Client)" from the drop list.

This is the screen that you will see when you select Substances Use Disorder Registration document:

The workflow for completing the SUD Registration Document is as follows:

1. Program Tab
2. Episode (only for now) Tab
3. General Tab
4. Demographic and Client Information Tab
5. SUD, Medical and Mental Health Tab

#1 Program Tab

A Program Enrollment is a period of treatment for a client at a Program. Before you can enter services for a client, there must be a Program Enrollment for the client in the Program providing the service.

NOTE: Program Enrollment data is also the method for collecting monthly California **Outcomes** Measurement System Treatment (CalOMS Tx). Additional background information on CalOMS can be found below.

Qualified Substance Use Disorder (SUD) Providers must follow the data collection protocols as detailed in the CalOMS Data Collection guide. Click the link or use the URL below for more CalOMS information:

> http://www.acbhcs.org/providers/caloms/CalOMS_Data_Collection_Guide.pdf
> http://www.acbhcs.org/providers/CalOMS/CalOMS.htm

Program Enrollment Section:

Program Enrollment/Admission is a period of treatment for a client at a Program. Before you can enter services for a client, there must be an open Program Enrollment/Admission for the client in the Program providing the service. **Enter the effective date on the status bar; the effective date should reflect the same date as the enrollment period.**

NOTE: The system is designed to only allow one Open Program Enrollment for the same Program. The following message appears when tempting to Add a new Program Enrollment when the Program is already Opened: ❌ Program already exists.

To Enroll/Admit the client to a Program complete the required fields in bold below:

1. **Primary Program: Required.** This will display a list of programs the user has permission to.

NOTE: If you do not see the Program needed to Enroll/Admit the client, please contact your manager or the Help Desk. You cannot proceed without this required information.

2. **Status**: **Required.** This is a dropdown list that allows you to Enroll in the program.

3. **Assigned Staff**: **Required**. Click on the drop-down list and select the active Clinician enrolling/admitting the client to the Program.

4. Requested Date**: Not Required.**

    TIP: Clicking the double angle brackets (<< or >>) in the calendar navigates you backward or forward by one year. Clicking the single angle bracket (< or >) navigates you 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.

5. **Enrolled Date**: **Required.** Enter the start date for the period of treatment/admission.

6. **Assign as CDAG**: **Required.** Select checkbox. This will assign a CDAG group.

7. **Primary Program: Not Required.**

8. **Comment: Optional.**

9. **Add Program Details**: **Required.** When you finish entering the data into the fields, click on the "Add Program Details" button.

NOTE: There could be multiple line items in the table. With each additional SUD Registration, the list will track each program enrollment overtime.

Click the **ADD Program Details** button and at the bottom of the screen you can see that the status is listed as "Enrolled".

		Program	Status	Assigned Staff	Requested Date	Enrolled Date	Assign as CDAG	Primary Program
✕	○	EDEN ADULT MED...	Enrolled	Abada, Louisa		06/01/2023	Y	Y
✕	○	A BETTER WAY AL...	Enrolled	Abada, Louisa	06/01/2023	06/01/2023	N	N

#2 Episode Tab

The Episode tab is where a client can be registered to begin an episode of care with the organization. When Episodes close, End Users may need to complete an SUD Update/Discharge Document if Required by their organization's process or policy.

Case Information Section: Required.

For this section, only the Registration date is required, if a registration date does not already exist. The *registration date will be the same date as the enrollment date*.

Example of when the registration date is required .

CalOMS Episode Information Section: Required.

CalOMS Episode Information

Transaction Type	Initial Admission ▾	CalOMS Program/FSN	▾
Request Date	📅 ▾	First Service Date	📅 ▾
Referral type	▾	Referral Sub-type	▾

How many days was the client on a waiting list before being admitted to this treatment program? ☐ Not sure / don't know ☐ Client unable to answer

What is the number of prior episodes in any alcohol or drug Treatment program in which the client has participated? ☐ Not sure / don't know ☐ Client unable to answer

Is there a consent form allowing future possible contact, signed by the client, on file within your agency? ▾

NOTE: This is the same data that we are currently completing for CalOMS in InSyst. Refer to CalOMS data dictionary for additional information.

1. **Transaction Type**: **Required.** Indicate the "Initial Admission".
   NOTE: Never use Transfer of Change in Service.

2. **IMPORTANT: After you enter the transaction type you must select** [Save] **to activate the program enrollments within the CalOMS Program/FSN field.**

CalOMS Episode Information

Transaction Type	Initial Admission ▾	CalOMS Program/FSN	AEGIS NTP CHICO (049950) ▾
Request Date	📅 ▾	First Service Date	📅 ▾
Referral type	Individual, including self-r ▾	Referral Sub-type	▾

How many days was the client on a waiting list before being admitted to this treatment program? 0 ☐ Not sure / don't know ☐ Client unable to answer

What is the number of prior episodes in any alcohol or drug Treatment program in which the client has participated? 2 ☐ Not sure / don't know ☐ Client unable to answer

Is there a consent form allowing future possible contact, signed by the client, on file within your agency? Yes ▾

3. **CalOMS Program/FSN: Required.** Select the Program you are currently enrolling in, using the drop-down list. This will then assign a FSN.
   i. *Definition of FSN: A FSN stand for "form serial number". This is the number that we submit on our submission file to the State to identify the enrollment activity. Please select one of these options: (Admission/ Annual/Discharge).*

3. **Request Date: Not Required.** Date which client requested Services.

4. **First Service Date**: **Not Required.** Date on which client first service is completed.

5. **Referral Type**: **Required**. How they were referred to the Program or what their source of referral is.

6. **Referral Subtype**: **Not Required.**

7. How many days was the client on a waiting list before being admitted to this treatment program? **Required.** Enter the number of days or use the checkboxes.

8. What is the number of prior episodes in any alcohol or drug treatment program in which the client has participated? **Required**. Enter the number of days or use the checkboxes.

9. Is there a consent form allowing future possible contact, signed by the client on file within your agency? Not **Required.** Select Yes or No from the drop list.

NOTE: **We will no longer be using the Z codes as was historically used in InSyst.**

#3: General Tab

The General tab contains general information about the client such as name, e-mail address, phone number, address, etc. If an Inquiry was performed and/or Client Information was updated, some fields are already populated on this tab.

Data fields on the "General Tab" should be initialized from the client information or a previous Substance Use Disorder Registration document. If not, then complete the following <u>required</u> fields:

General Information Section:

1. First Name at Birth: **Required.**

2. Middle Name at Birth: **If Applicable.**

3. Last Name at Birth: **Required.**

NOTE: You can check the "Same as current xxxxx" box, so you do not need to type the information again. e.g., ☐ Same as current first name

4. Suffix at Birth: **If Applicable.**

5. Is the client a Medi-Cal beneficiary: **Required**

NOTE: If you mark "yes", the Medi-Cal ID does not need to be completed. This information will be auto populated.

6. Phone Number: **If Available.**

7. Addresses: **Required.**

Phone Numbers Section

Any of the Phone Number fields can be redefined to the values shown in the pop-up window below. Click the down arrow next to the field whose title you wish to change and select the new title from the pop-up list.
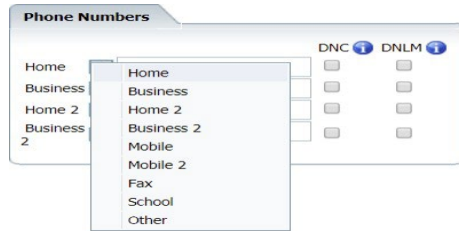
Addresses Section

1. Click the down arrow next to Home dropdown to add additional addresses.
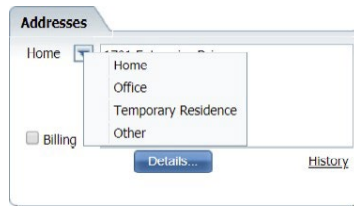
2. Click the Details button and a data entry pop-up window will display with the specific fields that need to be populated.
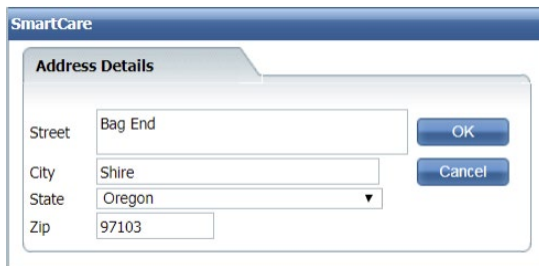
TIP: The system is very finicky and 95% of the time if you enter information into the address box, it will give you an error message.

3. By clicking the OK button on the Address Details pop-up window, the address is inserted into the record and is displayed in the text box.

NOTE: If they are Homeless enter the **Zip Code** for the **City Hall** of the city where the client indicates they most often sleep (in a shelter or on the street). Please see the appendix (Page 86) for a list of the Cities and their zip codes.

Also, if you click on the "History" link, you will find a list of all the previous addresses that have been entered.

Comments Section: **Optional.**
You may make any additional comments about client special needs or other items important to note in the textbox.

#4: Demographic and Client Information Tab:

Some of the data in this section will be initiated from the inquiry and registration document. Much of the information is used in other areas of the client record.

Identify Information Section: **Required.**

The Identify Information Section should initialize from the client information or a previous Substance Use Disorder Registration. As the client has more data, the more data will initialize more and more. If not complete the required fields.

10. Sex: **Required**

11. Marital Status: **Required**

12. Gender Identity: **Required**

13. Sexual Orientation: **Required**

14. Preferred Pronoun: **Required**

15. Ethnicity: **Required**

16. Race: **Required**

17. Deceased on and Cause of Death are completed by ACBH Staff. If these fields are available, please do not complete them.

18. Client declined to provide: **Not Applicable/Not Required**

Additional Identifying Information Section: **Required.**

1. **Place of Birth – Country: Required.** This displays the Birth Place Country of the client. If the client was not born in the United States, then the Birth State and Birth County are not required.
   o If born in the United State, then birth state is required.

2. **Place of Birth – State: Required.** This displays the birth place state of the client. If the client was not born in California, then the County is not required.
   o If they were born in California, then the birth place County is required.

3. **Place of Birth – County: Required.** This displays the birth County of the client.

4. **Special Population: Not Required**. This field should be disabled. If not disabled, please do not complete/

5. **Driver's License State: Required.**

NOTE: **Enter the Driver's License state first, prior to entering the Driver's License Number. When selecting either of the following drop-down options the SmartCare system will automictically enter the state code in the Driver's license number field.**

- o Client Declined to State - *99900*
- o Unknown or Not Sure/Don't Know - *99901*
- o None or Not Applicable - *99902*
- o Other - *99903*
- o Client Unable to Answer- *99904* (This value is reserved for **ONLY** developmentally disabled clients that are unable to answer the question and for clients undergoing detoxification services that have not stabilized.)

6. **Driver's License (DL) Number: Required.** Currently, when entering data into SC, the DL must have an "alpha" code and numbers.

Primary Care Physician Section: **Not Required.**

Financial Information Section: **Not Required.**

Family Information Section: **Required.** This section is related to CalOMS.

Family Information	
If the client is not male, is the client pregnant at the time of admission?	[dropdown]
What is the first name of the client's mother, or individual the client considers to be their mother	[field]
How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not?	☐ Client unable to answer
How many children does the client have age 5 or younger?	☐ Client unable to answer
How many of the client's children age 17 and under are living with someone else because of a child protection court order?	☐ Client unable to answer
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?	☐ Client unable to answer
How many days in the last 30 days has the client experiences family conflict?	○ Client declined to state ○ Client unable to answer

If the client is not male, is the client pregnant at the time of admission? **Required.** Select Yes or No from the drop list.

What is the first name of the client's Mother's: **Required.** Indicate the client's mother's name.
NOTE: If unknown, use *Mother or Mom*.

1.) How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not: **Required.** Indicate the number of dependents.

2.) How many children does the client have under the age of 5 or younger: **Required.** Indicate the number of dependents.

3.) How many of the client's children age 17 and under are living with someone else because of a child protection court order: **Required.** Indicate the number of dependents.

4.) 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? **Required.** Select Y/N

5.) How many days in the last 30 days has the client experienced family conflict? **Required.** Indicate the number of days.

NOTE: For this section there are two boxes on the right side of the question that you can choose from. You can select "Client declined to state", but if you choose to select "Client unable to answer", this box can only be used if they are in detox or disabled.   ○ Client declined to state   ○ Client unable to answer

Living Arrangement Section: **Required.** (refer to appendix for definitions).

Living Arrangement		
Living	House or apartment(includes trailers)	⌄
County of Residence	Alameda - CA ⬧ County of Financial Responsibility	Search here ⬧

NOTE: If they are "Homeless" please make sure that you indicate this in the "Living" field.

1. **Living: Required.** Select the environment in which the client is living from the dropdown list.

2. **County of Residence: Required.** Start typing the name of the CA County and then select the desired county from the drop-down list.

3. **County of Financial Responsibility: Required.** Enter the CA County who is financially responsible. (If you are unsure, use Alameda County).

Educational/Employment Section: **Required.**

Educational/Employment		
Educational Status	⌄ Military Status ⌄	Veteran Status ⌄
What is the client's highest school grade completed?	⌄ ○ Client declined to state	○ Client unable to answer
Employment Status	⌄	
Employment Information		

1. Educational Status: **Required.** Identify the highest grade level completed by the client.

2. Military Status: **Required.** Choose Y/N. Select "Yes" only if they are active.

3. Veteran Status: **Required.** There is a dropdown list to select from.

4. What it is the client's highest school grade completed? **Required.**

   NOTE: This is like the Education Status field, but this is required for CalOMS.

5. Employment Status: **Required.**

6. Employment Information: **Optional**

Note: *Refer to the appendix for additional information.*

Additional Employment and Educational Information Section: **Required.**

Additional Employment and Educational Information			
Is the client a CalWORKs recipient?	○ Yes ○ No ○ Not sure/Don't know		
Is the client receiving substance abuse treatment under the CalWORKs welfare-to-work plan?	☐ Yes ☐ No ☐ Not sure/Don't know		
How many days was the client paid for working in the past 30 days?	[ ] ☐ Client declined to state	☐ Client unable to answer	
Is the client currently enrolled in school?	○ Yes ○ No ○ Not sure/Don't know	○ Client unable to answer	
Is the client currently enrolled in a job training program?	○ Yes ○ No ○ Client declined to state	○ Client unable to answer	

1. Is the client a CalWorks recipient? **Required.**
   - If you select "Yes", please continue to the following questions.
   - If you select "No", the fields below are disabled and are not required.

2. Is the client substance abuse treatment under the CalWORKs welfare-to-work plan? **Required.**

3. How many days the clients paid for working in the past 30 days? **Required.**

4. Is the client enrolled in school? **Required.**

5. Is the client currently enrolled in a job training program? **Required.**

Language Section: **Required.**

Language			
Primary Language [▾] Preferred Language [▾] ☐ Client does not speak English Hispanic Origin [No ▾]			
☐ Interpreter Services Needed			

1. Primary Language: **Required.** Select the client's primary language in which to receive services.

2. Preferred Language: **Required.** Select the client's preferred language in which to receive services.

3. Client does not speak English check box: **Not Required.**

4. Hispanic Origin: **Required.** Select details about client's Hispanic origin.

5. Interpreter Services Needed: **Not Required.** Select this check box if applicable.

Legal Information Section: Required.

Transportation Information Section, Preferences Section, and Picture Sections: Not Required
Preferences Section: Not Required.
Picture Section: Not Required.

SUD, Medical & Mental Health Tab: All the below sections are Required.

Substance Use Information Section: Required.

Additional Substance Use Information Section: Required.

Additional Substance Use Information

How many days in the past 30 days has the client used alcohol?	☐ None or not applicable
How many days has the client used needles to inject drugs in the past 30 days?	☐ Client declined to state ☐ Client unable to answer
Has the client used needles to inject drugs in the past twelve months?	○ Yes ○ No ○ Client unable to answer
How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?	☐ Client declined to state ☐ Client unable to answer
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?	

Mental Health Information Section: Required.

Mental Health Information

Has the client ever been diagnosed with a mental illness?	○ Yes ○ No ○ Not sure/don't know
In the past 30 days, has the client taken prescribed medication for mental health needs?	○ Yes ○ No ○ Client unable to answer
How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs?	☐ Client is unable to answer
How many times in the past 30 days has the client received outpatient emergency services for mental health needs?	☐ Client is unable to answer

Medical Information Section: Required.

Medical Information

How many times has the client visited an emergency room in the past 30 days?	☐ Client unable to answer
How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems?	☐ Client unable to answer
How many days in the past 30 days has the client experienced physical health problems?	☐ Client unable to answer
What type of disability /disabilities does the client have, if any?	☐ None ☐ Visual ☐ Hearing ☐ Speech ☐ Mobility
What medication is prescribed as a part of treatment?	[dropdown]
Has the client been diagnosed with Tuberculosis?	○ Yes ○ No ○ Client declined to state ○ Client is unable to answer
Has the client been diagnosed with Hepatitis C?	○ Yes ○ No ○ Client declined to state ○ Client is unable to answer
Has the client been diagnosed with any sexually transmitted diseases?	○ Yes ○ No ○ Client declined to state ○ Client is unable to answer
Has the client been tested for HIV/AIDS?	○ Yes ○ No ○ Client declined to state ○ Client is unable to answer
Does the client have the results of the HIV/AIDS test?	○ Yes ○ No ○ Client declined to state ○ Client is unable to answer

Insurance Tab: Not Required.
Forms & Agreement Tab: Not Required.

Clinicians Gateway:

NOTE: Client Registration must be complete before the clinician can create a progress note in the Clinicians Gateway application.

- **Client Registration/ID information is transferred from the SmartCare system to the Clinicians Gateway application in 5-minute intervals.**

Creating Client Flags

Flags are icons used throughout the SC system to point out or mark important information about a client. Permissions can be set on a flag to allow or limit staff from viewing a client's flag(s). To use flags in SmartCare, you can access "Client Flags" in two ways:

Go to Client and choose the Client Flags Option.
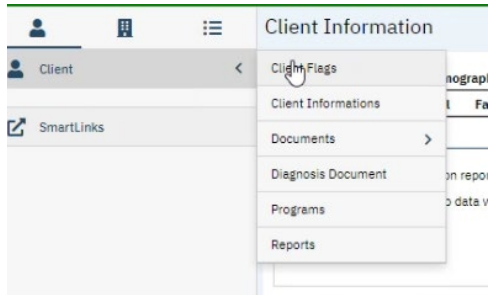
-or-

Complete a search, by typing in "flag":
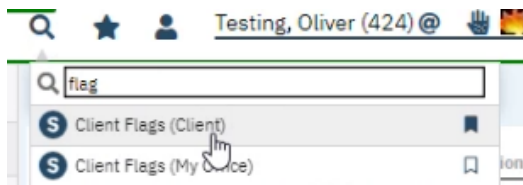
In SmartCare, an event is referred to as a "flag". Each flag will have a due date that can then be tracked and, as the due date nears, can be completed.

1. On the Client Flags tab click on new button to add a flag.
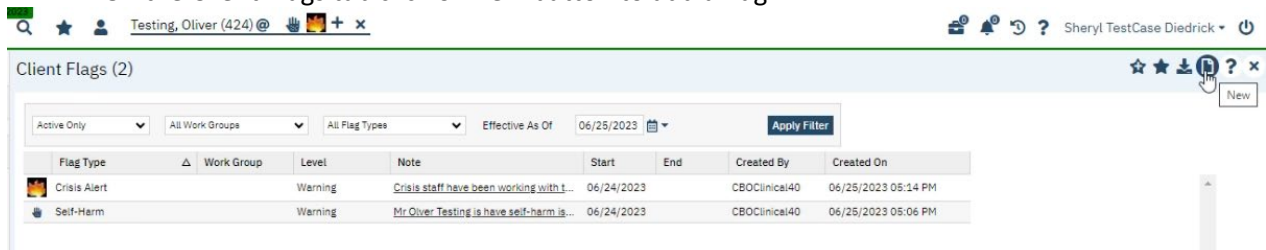
2. Select the "Type" field and a dropdown will appear.

1. Select the type of flag that you would like to add to the client's records.

2. Note: A comment needs to be entered. **Required.**

3. Click on Insert

4. Click on Save.

5. When you hover over the flag you can see the notes.

Testing, Oliver (424) @
Self-Harm : Mr Olver Testing is have self-harm issues - Please monitor him closely for the next 72 hours

ails
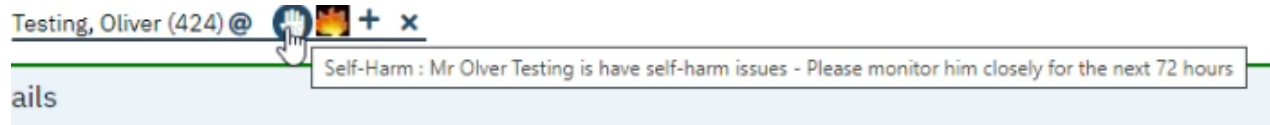
TIP: You can click on the add button to add additional flags.

Testing, Oliver (424) @

Chapter 8: Diagnosis Document

The *Diagnosis document* contains the client's diagnosis. If there is already a signed *Diagnosis document* for the client, that diagnosis will initiate when you open the *Diagnosis Document*. The *Diagnosis document* can be used to add, update, or remove diagnosis information.

IMPORTANT NOTE: Program enrollment must be completed, and the Program Status must be **Enrolled** before you can sign the diagnosis document, also the diagnosis document should be updated before any client is discharged, or you will not be able to return to complete that information.

1. To access the diagnosis document begin typing Diagnosis in the search bar and the Diagnosis Document will appear on the list.
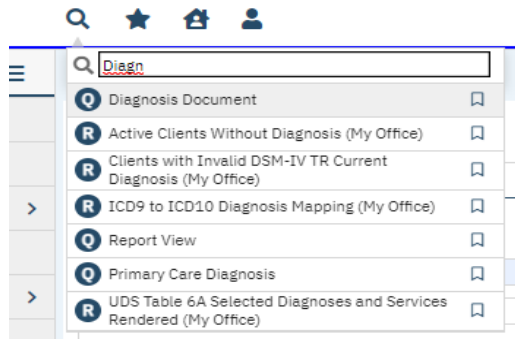
2. Select the Diagnosis Document:

3. Select Program in the CDAG Program Enrollment popup.
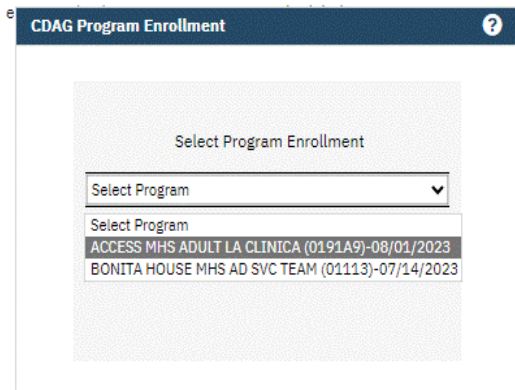
4. Diagnosis Document displayed.

To complete the Diagnosis Document:

1. Change the Effective date to the match the Program enrollment date.

2. In the "Code" field, begin typing the first letter of the code, e.g. "F" (the list contains ICD10/DSM 5 codes). Code F

3. Click on the Magnifying Glass (🔍 and enter the search term "Diagnosis".

4. Select a diagnosis from the dropdown list, below is an example of the drop down with ICD-10 codes:

NOTE: Use code without an * (* indicate DSM 5 description) for ICD-10 description

1. The Diagnosis Code and description fields will populate the diagnosis information. (2)
2. Select the code and press the "Insert" button.

TIP: Click on the favorite button if this is a diagnosis code that you use often. That way there is no need to go through all the codes.

Diagnosis Entry Section:

1. Type: **Required.** This is required for Primary diagnosis. It indicates the type of diagnosis; Primary, Additional, or Provisional.

2. Severity: **Not Required.**

3. Remission: **Not Required.**

4. Comments: **Not Required.**

5. Specifier: **Not Required.**

6. Source: **Not Required.**

7. Billable: **Required.** Select the appropriate radio button to show if this procedure is billable when applicable.

NOTE: In the "Order" column you can change the diagnosis order if they need to be updated.

Primary diagnosis needs to have **Order** set to 1.

You will need to reorder the diagnoses list if you need to add a new primary diagnosis.

1. Select the radio button to select the current primary in the Diagnosis list.
2. Change the order to the next number after the last Order number in the Diagnosis list.
3. Change the Type to Additional or Provisional
4. Select the **Modify** button to save the change.

5. Create new Primary diagnosis.
6. Set the Order to 1.
7. Select **Insert.**

8. Repeat Steps 1 – 4 to change the order of the Additional diagnosis.

Deleting diagnosis from the diagnosis list

Check on the delete icon next to the diagnosis to be deleted.

Confirm deletion.

NOTE: The Diagnosis list will contain diagnoses from previous program enrollments. Delete all diagnoses that do not apply to the current program enrollment.

Diagnosis List Section

If multiple diagnoses are listed in the Diagnosis List section, use the radio button (2) to select one if you wish to add notes in the "Screening Tools" or "Other General Medical Conditions" fields of the Diagnosis list section.

1. Select the Modify Button:

2. Screening Tools Used: **Not Required.** Enter screening tools utilized for data collection.

3. Other General Medical Conditions: **Not Required.** Enter other medical conditions here.

4. Click the insert button to create the entry on the diagnosis list. (1)

Edit Diagnosis document

Select edit icon.

Confirm edit.
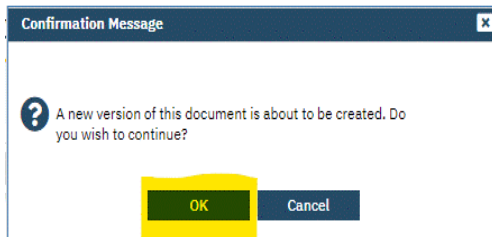
Edit Diagnosis document signed by the same author

1. <mark>Effective date must be the same as the program enrollment date</mark>.
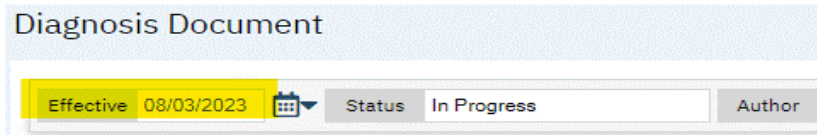
2. Make the updates.

3. Sign Diagnosis document.
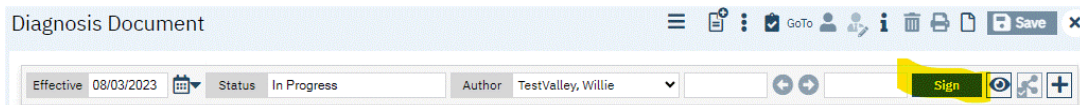
Edit Diagnosis document signed by a different author
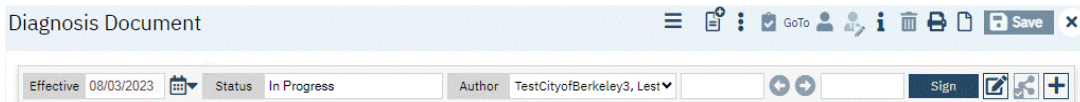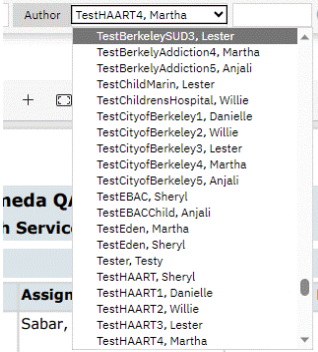
1. <mark>Effective date must be the same as the program enrollment date</mark>.

2. Change name of the author: Select **your** name from drop down.

3. Make update.
4. Sign the Diagnosis document.

Chapter 9: SUD Annual/Discharge Document

CalOMS Annual Update Data Collection-Program Enrollment Update

CalOMS Annual updates are required for those provider participants in treatment for twelve months or more, continuously in one provider and one service modality with no break in services exceeding 30 days.

- One example would be a participant in a narcotic treatment modality, such as methadone maintenance, for twelve months or longer. For such an individual, the provider must collect the CalOMS Tx data approximately one year from the day the individual was admitted to that specific provider and service modality.

Annual updates are required for all treatment program participants. New admissions entered on or after January 1, 2006 will require an annual update on the admission anniversary date in 2007 and each year thereafter that the client is in the same program and modality continuously. Annual updates are also required for admissions dated before January 1, 2006. For such admissions, the first and all subsequent annual updates should be collected no later than the anniversary date of the admission.

A matching admission for the individual for whom the annual update is being submitted must exist in the CalOMS Tx database.

SUD Annual/Discharge Document

The CalOMS Tx Annual Update data will be collected using the SUD Annual Discharge document in SmartCare.

1. To access the SUD Annual/Discharge document begin typing "SUD Annual/Discharge Document" in the search bar and the Document will appear on the drop-down list.
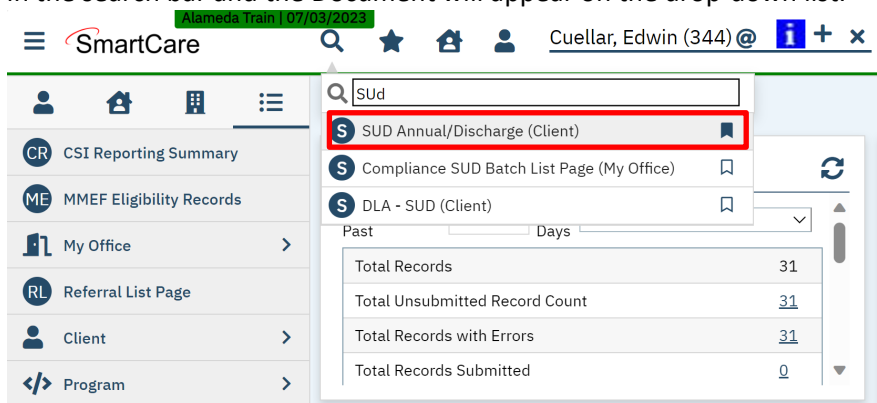
2. Select the SUD Annual/Discharge Document from the drop-down list.

3. Select Program in the CDAG Program Enrollment popup.
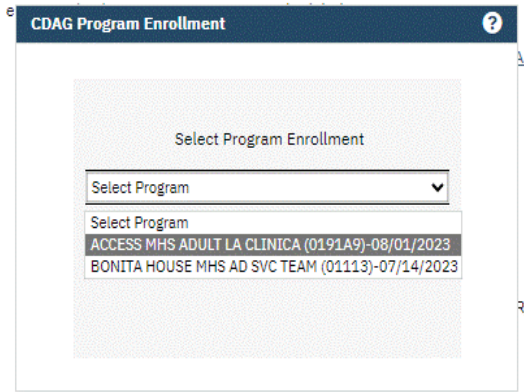
Once in the SUD Annual/Discharge Document date enter the document effective date on the document status bar. The effective date should be the date you enter the annual information.
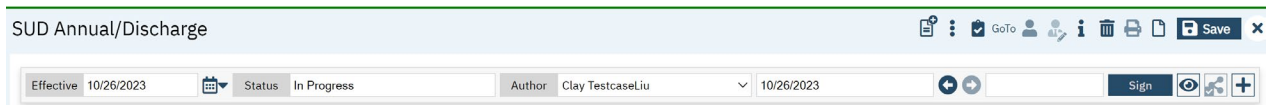
After entering the effective date complete the required fields on the general tab.

#1 General Tab:

CALOMS Episode Information
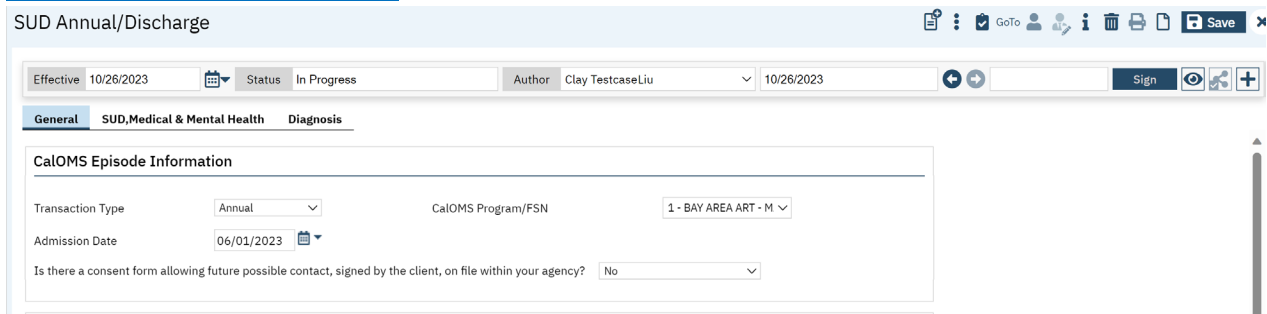
1. **Transaction Type:** Select "Annual" as the option.
2. **Admission Date:** This field auto-populates from the SUD Registration Document
3. **CalOMS Program/FSN:** Select the CalOMS Program FSN
4. Is there a consent form allowing future possible contact, signed by the client on file within your agency. **Required.** Select "Yes" or "No"

General Information and Additional Demographics Information Sections: **Not Required.**

These fields should have been initialized from the client information screen and SUD Registration Document. These sections do not have to be completed. *However, please review the information for accuracy.*

General Information

Current First Name	Edwin	First Name at Birth	Edwin	☐ Same as current first name
Last Name	Cuellar	Last Name at Birth	Cuellar	☐ Same as current last name
Middle Name		Suffix		Date of Birth 01/01/1990
SSN	333221111	Unable to Obtain SSN Reason		

Additional Demographic Information

Birth State: California — Birth County: Alameda — ☐ Other (born outside of California)

Driver's License Number: 77SEZ87 — ○ Client declined to state ○ None or not applicable ○ Client unable to answer

Mother's First Name: Cuellar — Driver's License State: California

You will be required to complete the below fields with the updated information for the client's annual Tx period. Referred to as the CALOMS Periodic Data Fields:

Family Information: **Required**

Family Information

If the client is not male, was the client pregnant at any time during treatment? If discharge or annual update, ask: Were you pregnant at any time during treatment?	No	# of Dependents 1
How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not?	1	☐ Client is Unable to Answer
How many children does the client have age 5 or younger?	0	☐ Client is Unable to Answer
How many of the client's children age 17 and under are living with someone else because of a child protection court order?	0	☐ Client is Unable to Answer
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	☐ Client is Unable to Answer
How many days in the past 30 days has the client had serious conflicts with members of their family?	0	○ Client declined to state ○ Client unable to answer

If this client is not male, was the client pregnant at any time during treatment? If discharged or annual update, ask: Were you pregnant at any time during treatment? **Required**. Even if the client sex is Male.

Employment/Income/Insurance: Required

Employment/Income/Insurance

What is the client's current employment status?   [Unemployed, acti ⌄]

How many days was the client paid for working in the past 30 days?   [0]   ○ Client declined to state ○ Client Unable to answer

Is the client currently enrolled in school?   ○ Yes ● No   ○ Client declined to state ○ Client Unable to answer

Is the client currently enrolled in a job training program?   ○ Yes ● No   ○ Client declined to state ○ Client Unable to answer

Additional Substance Use Information: Required

Additional Substance Use Information

How many days has the client used needles to inject drugs in the past 30 days?   [0]   ☐ Client declined to state ☐ Client unable to answer

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?   [0]

How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?   [30]   ☐ Client declined to state ☐ Client unable to answer

Legal Information: Required

Legal Information

How many times has the client been arrested in the past 30 days?   [0]   ☐ Client Unable to Answer

How many days has the client been in jail in the past 30 days?   [0]   ☐ Client Unable to Answer

How many days has the client been in prison in the past 30 days?   [0]   ☐ Client Unable to Answer

#2 SUD, Medical & Mental Health Tab: Required.

Substance Use Information: Required

Substance Use Information

Primary Drug Information   **Secondary Drug Information**

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

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

How many days in the past 30 days has the client used the primary drug? [0] ☐ None or Not Applicable

How many days in the past 30 days has the client used the secondary drug of abuse? [99902 - None or not applical ▾]

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

Additional Substance Use Information: Required

Additional Substance Use Information

How many days has the client used needles to inject drugs in the past 30 days? [0] ☐ Client declined to state ☐ Client unable to answer

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? [0]

How many days in the past 30 days has the client lived with someone who uses alcohol or drugs? [30] ☐ Client declined to state ☐ Client unable to answer

Mental Health Information: Required

Mental Health Information

Has the client ever been diagnosed with a mental illness? ○ Yes ● No ○ Not sure/don't know

In the past 30 days, has the client taken prescribed medication for mental health needs? ○ Yes ● No ○ Client unable to answer

How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? [0] ☐ Client is unable to answer

How many times in the past 30 days has the client received outpatient emergency services for mental health needs? [0] ☐ Client is unable to answer

Medical Information: Required

Once you have entered all the required information complete the document by selecting [Sign] on the document status bar.

Once the document has been signed the signed PDF file will generate.

Chapter 10: Client Discharge

To discharge the client from their CalOMS program enrollment. You will use the SUD Annual/Discharge document in SmartCare.

SUD Annual/Discharge Document

1. To access the SUD Annual/Discharge document begin typing "SUD Annual/Discharge Document" in the search bar and the Document will appear on the drop-down list.
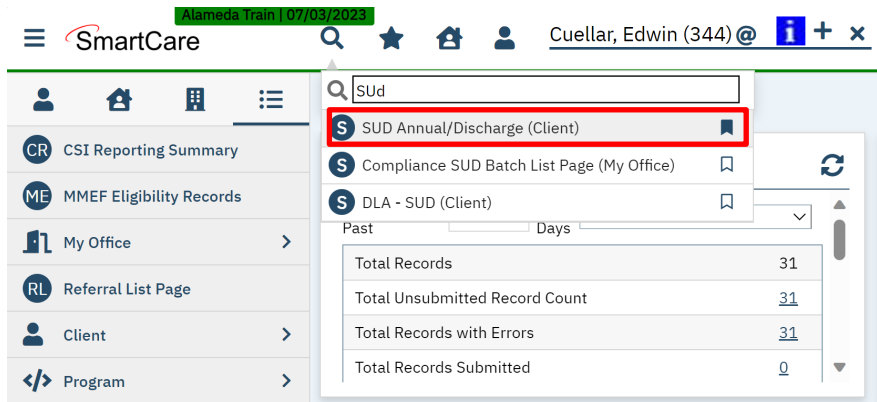
2. Select the SUD Annual/Discharge Document from the drop-down list.

3. Select Program in the CDAG Program Enrollment popup.
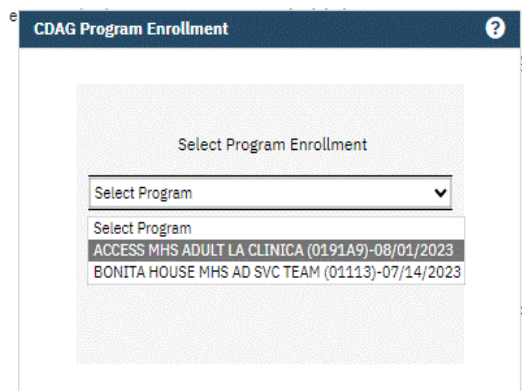
Once in the SUD Annual/Discharge Document, enter the document effective date on the document status bar. The effective date should be the date you are discharging the client information.

After entering the effective date complete the required fields on the general tab.

#1 General Tab:

CALOMS Episode Information

1. **Transaction Type:** Select "Discharge" as the option.
2. **Admission Date:** This field auto-populates from the SUD Registration Document
3. **CalOMS Program/FSN:** Select the CalOMS Program FSN
4. **Discharge Date:** Enter the date of discharge for the client
5. **Discharge reason:** Select the discharge reason.
6. Is there a consent form allowing future possible contact, signed by the client on file within your agency. **Required.** Select "Yes" or "No"

General Information and Additional Demographics Information Sections: Not Required.

These fields should have been initialized from the client information screen and SUD Registration Document. These sections do not have to be completed. ***However, please review the information for accuracy.***

You will be required to complete the below fields with the updated information for the client at time of discharge. Referred to as the CALOMS Periodic Data Fields:

Family Information: Required

Family Information

If the client is not male, was the client pregnant at any time during treatment? If discharge or annual update, ask: Were you pregnant at any time during treatment?	No ▼	# of Dependents	1
How many children does the client have aged 17 or less (birth or adopted), whether they live with the client or not?	1	☐ Client is Unable to Answer	
How many children does the client have age 5 or younger?	0	☐ Client is Unable to Answer	
How many of the client's children age 17 and under are living with someone else because of a child protection court order?	0	☐ Client is Unable to Answer	
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	☐ Client is Unable to Answer	
How many days in the past 30 days has the client had serious conflicts with members of their family?	0	○ Client declined to state	○ Client unable to answer

If this client is not male, was the client pregnant at any time during treatment? If discharged or annual update, ask: Were you pregnant at any time during treatment? **Required**. Even if the client sex is Male.

Employment/Income/Insurance: Required

Employment/Income/Insurance

What is the client's current employment status?	Unemployed, acti ▼		
How many days was the client paid for working in the past 30 days?	0	○ Client declined to state	○ Client Unable to answer
Is the client currently enrolled in school?	○ Yes ● No	○ Client declined to state	○ Client Unable to answer
Is the client currently enrolled in a job training program?	○ Yes ● No	○ Client declined to state	○ Client Unable to answer

Additional Substance Use Information: Required

Additional Substance Use Information

How many days has the client used needles to inject drugs in the past 30 days?	0	☐ Client declined to state ☐ Client unable to answer
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?	0	
How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?	30	☐ Client declined to state ☐ Client unable to answer

[Legal Information:](#) Required

Legal Information

How many times has the client been arrested in the past 30 days?   0   ☐ Client Unable to Answer

How many days has the client been in jail in the past 30 days?   0   ☐ Client Unable to Answer

How many days has the client been in prison in the past 30 days?   0   ☐ Client Unable to Answer

[#2 SUD, Medical & Mental Health Tab:](#) Required.

[Substance Use Information:](#) Required

Substance Use Information

Primary Drug Information		**Secondary Drug Information**	
What is the client's primary alcohol or drug problem?	Alcohol ⌄	What is the client's secondary alcohol or drug problem?	Heroin ⌄
How many days in the past 30 days has the client used the primary drug?	2 ☐ None or Not Applicable	How many days in the past 30 days has the client used the secondary drug of abuse?	2 ⌄
What is the client's usual route of administration they use most often for their primary drug of abuse?	Oral ⌄	What is the client's usual route of administration they use most often for the secondary drug of abuse?	Inhalation ⌄

[Additional Substance Use Information:](#) Required

Additional Substance Use Information

How many days has the client used needles to inject drugs in the past 30 days?   2   ☐ Client declined to state ☐ Client unable to answer

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?   2

How many days in the past 30 days has the client lived with someone who uses alcohol or drugs?   2   ☐ Client declined to state ☐ Client unable to answer

Mental Health Information: Required

Mental Health Information

Has the client ever been diagnosed with a mental illness? ○ Yes ● No ○ Not sure/don't know

In the past 30 days, has the client taken prescribed medication for mental health needs? ○ Yes ● No ○ Client unable to answer

How many days in the past 30 days has the client stayed for more than 24 hours in a hospital or psychiatric facility for mental health needs? [2] ☐ Client is unable to answer

How many times in the past 30 days has the client received outpatient emergency services for mental health needs? [2] ☐ Client is unable to answer

Medical Information: Required

Medical Information

How many times has the client visited an emergency room in the past 30 days? [2] ☐ Client is unable to answer

How many days has the client stayed overnight in a hospital in the last 30 days for physical health problems? [2] ☐ Client is unable to answer

How many days in the past 30 days has the client experienced physical health problems? [2] ☐ Client is unable to answer

What type of disability /disabilities does the client have, if any? [None ▼]

Has the client been tested for HIV/AIDS? ○ Yes ● No

○ Client declined to state ○ Client Unable to answer

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

○ Client declined to state ○ Client Unable to answer

Once you have entered all the required information complete the document by selecting [Sign] on the document status bar.

SUD Annual/Discharge

Effective 10/26/2023   Status Signed   Author TestcaseChu, Dena   10/26/2023   [Sign]

Once the document has been signed the signed PDF file will generate.

Alameda Train | 07/03/2023			
CalOMS Update/Discharge			
General			
CalOMS Episode Information			
County of Submission Alameda	**Transaction Type** Discharge	**CalOMS Program/FSN**	Q0100000 - AEGIS NTP CHICO (049950)
Admission Date 10/26/2023	**Discharge Date** 10/26/2023	**Discharge Status**	Completed Treatment Plan & Goals / Referred /Standard (all questions)
Is there a consent form allowing future possible contact, signed by the client, on file within your agency?			Yes
General Information			
Current First Name Bobby	**First Name at Birth** Bobby	☑	Same as current

Administrative Discharge

To process an ***administrative discharge,*** the User will need to select one of the following from the "Discharge Status" drop-down list:

Discharge Status | Left Before Comp ⌄ |

Completed Treatment Plan & Goals / Referred /Standard (all questions)
Completed Treatment Plan & Goals / Not Referred / Standard (all questions)
Left Before Completion w / Satisfactory Progress / Standard (all questions)
Left Before Completion w / Satisfactory Progress / Administrative (minimum questions)
Left Before Completion w / Unsatisfactory Progress / Standard (all questions)
Left Before Completion w / Unsatisfactory Progress / Administrative (minimum questions)
Death
Incarceration

Once the User has selected one of the administrative options, the SUD Annual/Discharge form will update the CalOMS period data fields to the administrative discharge format.

Complete the required fields as informed below.

#1 General Tab:

CALOMS Episode Information

1. **Transaction Type:** Select "Discharge" as the option.
2. **Admission Date:** This field auto-populates from the SUD Registration Document
3. **CalOMS Program/FSN:** Select the CalOMS Program FSN
4. **Discharge Date:** Enter the date of discharge for the client
5. **Discharge reason:** Select the discharge reason.
6. Is there a consent form allowing future possible contact, signed by the client on file within your agency. **Required.** Select "Yes" or "No"

General Information and Additional Demographics Information Sections: Not Required.

These fields should have been initialized from the client information screen and SUD Registration Document. These sections do not have to be completed. *However, please review the information for accuracy.*

You will be required to complete the below fields with the updated information for the client at time of discharge. Referred to as the CALOMS Periodic Data Fields:

Family Information: Required

Family Information

If the client is not male, was the client pregnant at any time during treatment? If discharge or annual update, ask: Were you pregnant at any time during treatment?   No

#2 SUD, Medical & Mental Health Tab: Required.

Substance Use Information: Required

Substance Use Information

Primary Drug Information

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

Once you have entered all the required information complete the document by selecting **Sign** on the document status bar.

SUD Annual/Discharge

Effective 10/26/2023   Status Signed   Author TestcaseChu, Dena   10/26/2023   Sign

Once the document has been signed the signed PDF file will generate.

SUD Annual/Discharge

Effective 10/26/2023   Status Signed   Author Reynolds, Shukura   10/26/2023   10/27/2023   Sign

Draw   Read aloud   1   of 3

Client ID: 972   Page 1 of 3

Alameda Train | 07/03/2023

CalOMS Annual/Discharge

General

CalOMS Episode Information

| County of Submission | Alameda | Transaction Type | Discharge | CalOMS Program/FSN | Q0100000 – AEGIS NTP CHICO (049950) |
| Admission Date | 10/26/2023 | Discharge Date | 10/26/2023 | Discharge Status | Left Before Completion w / Unsatisfactory Progress / Administrative (minimum questions) |

Is there a consent form allowing future possible contact, signed by the client, on file within your agency?

Chapter 11: Reports

SmartCare comes equipped with a suite of standard reports, which cover a wide variety of organizational needs. Each user can find the reports that they are permissioned to see by looking at "My Reports Screen".
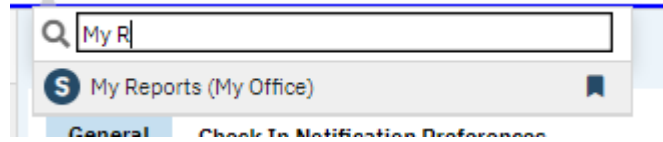
In addition, reports are easily permissioned, and administrators can ensure that the right staff can access the reports they need without cluttering their accounts with unnecessary options. You can search by folder or by entering text into the search box to find your report.

These are some example of standard out of the box reports from SmartCare:

Report Name	Description	Folder
1099 Report	Print 1099 for specific insurers/provi...	
2022 NOMS SPARS Report	2022 NOMS SPARS Report	
Access to Services Reporting	Access to Services Reporting	
Account Selection Reason	General Ledger Account Selection Reaso...	General Ledger
Active Clients With No Primary...		CoreStandardReports
Active Clients With No Primary...		CoreStandardReports
Active Clients Without Diagnos...		CoreStandardReports
Active Pharmacy List		CoreStandardReports
Active Pharmacy List-In Progre...		Standard Reports
Adjudication Summary Report		Standard Reports
Alameda County Behavioral Heal...	Alameda County Behavioral Health Care...	
AR - Aging Summary		Standard Reports
Attendance Report		
Authorization Code to Procedur...		CoreStandardReports
Authorization Report - Expiry,...	Authorization Report - Expiry, Exhaust...	
Auths Missing Coverage Plans		CoreStandardReports
Billable Clinicians By Coverag...		CoreStandardReports
California PEI Client Report	California PEI Client Report	
CCDAs Created and Sent Report	CCDAs Created and Sent Report	
CCDAs Received and Reconciled...	CCDAs Received and Reconciled Report	
Claim From Services Report	Claim From Services Report	
ClaimLine Charge Amount Update		Standard Reports
Client Assessment List With DL...		CoreStandardReports
Client Contacts Address Histor...		Standard Reports
Client Demographic Breakdown		CoreStandardReports
Client Insurance & Date Span R...		

Administrators can even permission selected reports into Quick Links. Nearly every report has filtering and export into excel capabilities.

My Reports

Medications for Clients in the Main St - Adult Mental Health Program as of 4/11/2023

Bowers, Pacifica (1007)	Rx Start	Rx End	Ordered Date	Date Created	Prescribed By	Entered By
Strattera						
10mg, cap, Oral 1.00 each 5 Times per Day						
Test, Kim (1009)	Rx Start	Rx End	Ordered Date	Date Created	Prescribed By	Entered By
Abilify			11/8/2022	11/8/2022	Buckley, Christine M.D.	Buckley, Christine
2mg, Tab, Oral 1.00 each 5 Times per Day	11/8/2022	5/6/2023				
Azithromycin			11/8/2022	11/8/2022	Buckley, Christine M.D.	Buckley, Christine
250mg, Tab, Oral 1.00 each Three times a day	11/8/2022	11/17/2022				
Synthroid			11/8/2022	11/8/2022	Buckley, Christine M.D.	Buckley, Christine
88mcg, Tab, Oral 1.00 each 5 Times per Day	11/8/2022	11/2/2023				
Tylenol			11/8/2022	11/8/2022	Buckley, Christine	Buckley, Christine
325mg, Tab, Oral 1.00 each Every 4 Hours (as needed)	11/8/2022	12/7/2022				
Lisinopril			11/7/2022	11/7/2022	Buckley, Christine M.D.	Buckley, Christine
10mg, Tab, Oral 1.00 each Daily	11/7/2022	11/1/2023				
10mg, Tab, Oral 1.00 each 5 Times per Day	9/14/2022	10/13/2022				
Vitamin D3						
10 mcg(400 unit), cap, oral 1.00 each 5 Times per Day						
Testa, Beth (1010)	Rx Start	Rx End	Ordered Date	Date Created	Prescribed By	Entered By
Ativan			8/5/2022	8/5/2022	Scott, Beth M.D.	Scott, Beth
1mg, Tab, Oral 1.00 each Daily	8/5/2022	9/3/2022				

Nearly every report has filtering parameters. Select your parameters at the top, then click View Report.

The report will populate for the desired parameters. You can save or print the report using icons in the toolbar, or re-run it with new parameters. If the report has multiple pages, use the blue arrows to go to forward or backward.

ACBH Standard Reports will be forthcoming in the coming weeks.

Chapter 12: Services

In November 2023, we will be providing SmartCare Training on Services and the different ways to record services provided by programs directly to clients. Additional Information will be coming soon.

Chapter 13: Client Maintenance

Alias

Aliases cannot be changed, but any user can add new aliases or can delete an alias by updating the Alias Tab.

Entering a New Client Address

Any authorized user can enter a new address for a client with an open program. The SmartCare system directs the User to this screen when registering a new client.

To enter a new address:

1. Choose ADDRESS from the Client Maintenance Menu to display the Address Maintenance Selection Screen, as described above.
2. Enter data in the following fields:
    - **Client Number:** Enter the number for the client whose address you want to enter. If you are already viewing a list of the client's addresses when you press Num Lock (Gold)-I, the Client Number is entered automatically.
    - **Reporting Unit:** Enter the Reporting Unit Number for the program that has an open episode for the client. The Effective Date of the address you are entering must fall within this episode.
    - **Effective Date:** By default, the Effective Date is today's date. Only Supervisors can alter it.
    - **Street Number:** Enter a street number with up to five (6) digits.
    - **Street Direction:** If the address has one, enter a street direction, such as "N", "NE", "E", "SE", "S", "SW", "W", "and NW".
    - **Street Name:** Enter a street name with up to twenty characters. (Do not enter "Street", "Road", or other street type here.)   Enter "**Homeless"** as a street name if the client is homeless.
    - **Street Type:** Enter an abbreviation for the street type, such as "ST", "BL", "RD", and "AV".
    - **Apartment/Unit/Space #:** Enter up to four characters. Do not enter the symbol "#", and do not enter a period at the end.
    - **City:** Enter a city name with up to twenty characters. Enter a city name even if the client is **Homeless**. Enter the **Zip Code** for the **City Hall** of the city where the client indicates they most often sleep (in a shelter or on the street).
    - **State:** Enter the two letter abbreviation for the state name.
    - **Zip Code:** Enter the Zip Code, and the cursor moves to the plus-four digits, which you can enter if available.

NOTE: The Zip Codes can be found on the USPS website:

https://tools.usps.com/go/ZipLookupAction!input.action

Enter the address on the first screen and click submit.

Address is displayed with Zip Code on the second screen. Note: <u>You no longer need the +4.</u>

Client Address Update

- If you have a change of address create a new address for the client.
- Only use the update function if there is a correction in the current address.

You can change most of its data. However, you cannot change the Client Number, the Program, the Effective Date. Because you cannot change the Program Unit, if the wrong program has been entered for an address, you must delete the record and enter a new one.

The **CITY, STATE AND ZIP CODE** MUST match or the system will NOT ALLOW ENTRY. Another requirement is that ZIP MUST be entered in the ZIP CODE for billing purposes. In order to successfully claim to Medi-

Cal, as per the State regulations a complete and accurate address including the zip in SmartCare is required. ALL REJECTED SERVICE CLAIMS WILL BE SENT BACK TO THE PROGRAM FOR CORRECTIONS.

The **CITY, STATE AND ZIP CODE** MUST be valid or the system will NOT ALLOW ENTRY. Always enter the ZIP in the ZIP CODE field. This is a requirement of the Medi-Cal billing program.

- **City** names MUST be spelled correctly or the system will give an error message
- **State** abbreviation must be same as the state which the city is located
- **Zip Code** must be the valid zip code (for the city and state) for the address entered.

Homeless:

Enter the **Zip Code** for the **City Hall** of the city where the client indicates they most often sleep (in a shelter or on the street).

City Hall Codes use for Homeless Client Address			
Alameda	94501	Newark	94560
Albany	94706	Oakland	94612
Berkeley	94704	Piedmont	94611
Castro Valley	94546	Pleasanton	94566
Dublin	94568	San Leandro	94577
Emeryville	94608	San Lorenzo	94580
Fremont	94538	Sunol	94586
Hayward	94541	Union City	94587
Livermore	94550		

NOTE: SmartCare does not capture +4 zip codes.

CalOMS fields are identified in the field title.

Sex – CalOMS

F=Female	M=Male	U=Unknown

Physical Disability - CalOMS

Section 503 of the Federal Rehabilitation Act of 1973 defines "disability" as a physical or mental impairment that substantially limits one or more of the major life activities of the individual, a record of such an impairment, or being regarded as having such an impairment.

Circle and add the number codes to create the sum of all of the client's physical disabilities, as stated by the client, and enter the total in this field.

None	Physical Impairment/ Mobility	Client Declined to State
Severe Visual Impairment	Developmentally Disabled	Client Unable to Answer
Severe Hearing Impairment	Other Physical Impairment	
Speech Impairment	Mental	

Language/Preferred language

Enter the code which best represents the client's preferred language, that is, the language the client would prefer to speak, as reported by the client.

English	Vietnamese
Spanish	Laotian
Chinese Dialect	Cambodian
Japanese	Sign ASL
Filipino Dialect	Other

Race – CalOMS

A	White	G	Laotian	L	Other	U	Guamanian
B	Black	H	Cambodian	M	Unknown	T	Hawaiian
C	Native American	I	Japanese	X	Mixed Race	Q	Korean
E	Chinese	J	Filipino	O	Alaskan Native	R	Samoan
F	Vietnamese	K	Other Asian	S	Asian Indian	N	Other South East Asian

Ethnicity – CalOMS

Enter the appropriate number from the Hispanic origin **codes** listed below to indicate the client's Hispanic background as identified by the client.

1	Non-Hispanic	4	Puerto Rican
2	Mexican/ Mexican American	5	Other Latino
3	Cuban	6	Other Hispanic

Marital Status

Never Married is used for a single person who does not live with girlfriend/boyfriend and has never been married.

Never Married	Widowed	Separated
Married/ Live Together	Divorced/ Dissolved	Unknown

Client Birth Name - CalOMS

Enter the name given at birth

Birth Place - CalOMS

Enter the County / State of birth. Refer to County/State tables or the CalOMS Data Collection guide.

Appendix A:
SmartCare Global Codes

This document lists SmartCare Global codes for: Substance Use Disorder Registration, which includes Client General/Demographic Information, Program Enrollment, Service Entry, and Substance Use Disorder Update/Discharge.

County Codes - CalOMS

Alameda	Placer
Alpine	Plumas
Amador	Riverside
Butte	Sacramento
Calaveras	San Benito
Colusa	San Bernardino
Contra Costa	San Diego
Del Norte	San Francisco
El Dorado	San Joaquin
Fresno	San Luis Obispo
Glenn	San Mateo
Humboldt	Santa Barbara
Imperial	Santa Clara
Inyo	Santa Cruz
Kern	Shasta
Kings	Sierra
Lake	Siskiyou
Lassen	Solano
Los Angeles	Sonoma
Madera	Stanislaus
Marin	Sutter
Mariposa	Tehama
Mendocino	Trinity
Merced	Tulare
Modoc	Tuolumne
Mono	Ventura

Monterey	Yolo
Napa	Yuba
Nevada	Unknown California County
Orange	Not California County

State Code - CalOMS

Alabama	Nebraska
Alaska	Nevada
Arizona	New Hampshire
Arkansas	New Jersey
California	New Mexico
Colorado	New York
Connecticut	North Carolina
Delaware	North Dakota
District of Columbia	Ohio
Florida	Oklahoma
Georgia	Oregon
Hawaii	Pennsylvania
Idaho	Rhode Island
Illinois	South Carolina
Indiana	South Dakota
Iowa	Tennessee
Kansas	Texas
Kentucky	Utah
Louisiana	Vermont
Maine	Virginia
Maryland	Washington
Massachusetts	West Virginia
Michigan	Wisconsin
Minnesota	Wyoming

Mississippi			
Missouri		Unknown State	
Montana		Not US State	

Mother's First Name - CalOMS

Enter Mother's first name. If the mother first name is unknown enter "Mother".

Driver's License (DL) – CalOMS

Enter Driver's License and the State that issued the license.

Prop47

Any client that has been arrested. NOTE: This functionality does not exist currently in SmartCare and will be forthcoming.

Y=YES	N=NO

Homeless Address - CalOMS

Enter the client's home address with Zip Code. If the client is homeless, enter Homeless as the street name and enter the Zip Code for the City Hall of the city where the client indicates they most often sleep (in shelter or on the street).

City Hall: Codes use for Homeless Client Address			
Alameda	94501	Newark	94560
Albany	94706	Oakland	94612
Berkeley	94704	Piedmont	94611
Castro Valley	94546	Pleasanton	94566
Dublin	94568	San Leandro	94577
Emeryville	94608	San Lorenzo	94580
Fremont	94538	Sunol	94586
Hayward	94541	Union City	94587
Livermore	94550		

Relation

The relationships currently defined are:

Father	Husband	Relative	Friend	Therapist	Prob Ofr (Probation Officer)
Mother	Wife	Guardian	Partner	Physician (MD / Physician)	Parole Ofr (Parole Officer)
Son	Brother	Conservatr (Conservator)	Employer	Board Care	Other
Daughter	Sister	Attorney	Minister	Psych MD	Advocate
Aunt	Court	Foster Mother	Foster Father	Foster Daughter	Foster Son

Program Enrollment

Client Unable to Answer code is only allowable for certain questions and ONLY when the client is coded in the Client Registration screen as having a Physical Disability of "Developmentally Disabled" or enrolled in a detoxification program.

The following definitions should be under Demographic and Client Information Tab.

Living Arrangement

In the Living Arrangement Section please choose one of the following options:

Parent	Granddaughter	Step Sibling	Primary Care Physician
Spouse	Grandfather	Step Daughter	Primary Physician
Stepfather	Grandmother	Step Son	None
Stepmother	Grandparents	Law Enforcement Official	Unknown
Uncle	Grandson	Next of Kin	

1	*Homeless*	Individuals should be considered homeless if their primary place of residence over the past week and at the day of intake/exit could be described as a: 1) Place not meant for human habitation (e.g., a vehicle, an abandoned building, bus-train/subway station/airport or anywhere outside); 2) Emergency shelter; 3) Persons fleeing domestic violence; 4) Eviction within 14 days from a private dwelling unit and no subsequent residence has been identified and the person lacks the resources and support networks needed to obtain housing; 5) Institution or treatment facility (<u>for less than</u> <u>90 days, on the streets or in a shelter prior to that, and he/she</u> <u>lacks the resources and support</u> <u>networks needed to obtain</u> <u>housing</u>); 6) Fleeing a domestic violence situation; 7) Living in someone else's housing without the resources to obtain other housing AND have been notified that the arrangement is short-term (less than 14 days); 8) Unaccompanied youth or families with children/youth who have moved at least twice in the past 60 days and remain unstably housed.
2	*Dependent living*	Individuals who are housed but are not contributing to the cost of where they are living in any way. This category could include individuals currently staying in residential or treatment programs, living with relatives, incarcerated, hospitalized, or in other situations where they are not paying for room and board.
3	*Independent living*	Individuals who are housed and pay rent or otherwise contribute financially to the cost of the home/apartment, e.g., own their home, rent and live alone, living with roommates, some sober living, etc.

Rev(03/2017)

If you have questions about how to categorize a client's current living situation, please contact the Housing Services Office at (510) 777-2112; E-mail: everyonehome@acbhcs.org

Referral Type - CalOMS

1	Court/Criminal Justice
2	Individual - Including Self-Referral
3	Employer/EAP
4	School /Educational
5	Other Community Referral
6	Other – Health Care Provider
7	12 Step Mutual Aid
8	Probation/ Parole
9	Post Release Community/Supervision (AB-109)
10	DUI/ DWI

11	Adult Felon Drug Court
12	Dependency Drug Court
13	Dependency Court
14	Child Protection Services

Admission Status

1	Substance Abuser	4	Minor Child of Substance Abuser
2	Spouse of Substance Abuser	5	Parent of Substance Abuser
3	Adult Child of Substance Abuser	6	Other Co-Dependent of Substance Abuser

Admission Legal Status – CalOMS

1	Not Applicable	5	Admitted under diversion from any court
2	Under Parole Supervision by CDC	6	Incarcerated
3	Under Parole from any other jurisdiction	7	Awaiting Trail
4	Post Release community Service AB109 or on Parole from any federal, state or legal jurisdiction can be used with Referral Code 22	99904	Unable to Answer

Client Homeless at Admission - CalOMS

1 = Homeless	2 = Dependent Living	3 = Independent Living

CDC (California Departments of Corrections and Rehabilitation) CDCR - CalOMS

No criminal justice involvement
Under parole supervision by California Department of Corrections and Rehabilitation (CDCR)
On parole from other jurisdiction
Post-release community supervision (AB109) or on probation from any federal, state, or local jurisdiction
Admitted under other diversion from any court under California Penal Code, Section 1000
Incarcerated
Not Applicable
Client unable to answer (If this code is used type of service must be detoxification)

Medication Prescribe (as part of the treatment) - CalOMS

1	None	4	Buprenorphine (Subutex)
2	Methadone	5	Buprenorphine (Suboxone)
3	LAAM	99903	Other (only for medications prescribed for SUD treatment; e.g. Antabuse)

Substance Problem – Primary & Secondary - CalOMS

Heroin	Other Tranquilizers
Alcohol	Non-Prescription Methadone
Barbiturates	Other Opiates and Synthetics
Other Seeds/Hypnotics	Inhalants
Methamphetamines	Over the Counter
Other Amphetamines	OxyCodone/OxyContin
Other Stimulants	Ecstasy
Cocaine/Crack	Other Club Drugs
Marijuana/Hashish	Unknown
PCP	Other (specify)
Other Hallucinogens	None (Secondary Only)
Benzodiazepine	

Usual Route of Administration – Primary and Secondary – CalOMS

Oral	Inhalant	None or not applicable
Smoking	Injection(IV or intramuscular)	Other

Treatment Location Service Codes- as of 6/22/2018

1	Office	20	Telehealth
2	Field	22	IP PsyFacility
3	Phone	23	SkilledNurseFacility
4	Home	24	CustodialFacility
5	School	25	PsyFac-PartHsp
9	Inpatient	26	CommMHFacility
10	Emerg. Shelter	27	IntermedCareFacility
12	Primary Care	28	PublicHealthCl
19	Residential Treatment		

Referred to - CalOMS

1	Fed/ State Criminal Justice
2	Local/ County Criminal Justice

3	Self
4	Family/ Friend
5	Employer
6	School /College
7	Medical: hospital/ clinic/ physician/ nurse
8	Social Services
9	Community Agency
10	Mental Health
11	Public Guardian
12	Public Health/Public Health Nursing
13	Residential Care Facility
14	Drug Residential
15	Drug Outpatient
16	Alcohol Residential/ Outpatient
17	Telephone Directory
18	Brochure/ Flyer/ Newspaper/ Newsletter
19	Other
20	12 Step Program
21	SACPA/ Prop36/ OTP/ Probation/ Parole
22	AB 109 Post Release Community/Supervision
23	DUI/ DWI
24	State Drug Partnership(DCP)Adult Felon Drug Court
25	Comprehensive Drug Court Implementation(CDCI)/ Dependency Drug Court
26	Dependency Court/Child Protective Services(CPS)

ACBH-QA Guidelines to meet the CalOMS requirements

Discharge Codes and Definitions

Per the CA Department of Behavioral Health Care Services (DHCS) California Outcome Measurements
 (CalOMS) discharge information must be collected for all service recipients regardless of the discharge status. Please refer to the ACBH Quality Assurance Department memo dated November 20,2017 RE: Discharge Codes - California Outcome Measurements (CalOMS).

Alameda County Behavioral Health Care Services (ACBH) provides the following guidance on the application of types of discharge codes and criteria to ensure and support consistent determinations on discharge status for SUD clients.

OVERVIEW:

A standard discharge shall be reported when the client is available to be interviewed for the CalOMS treatment discharge either via phone or in person. The client may have:
Completed their treatment
Attended a single treatment service
Made satisfactory or unsatisfactory progress in treatment and will be referred to another program.

Providers shall use Standard Discharge Codes Table A and B to select the discharge code based on the ratio of achieved goals to the client's total goals. For Table A: 1, 2, 3, and 5; and for Table B. 4, 6, 7, and 8.

In deciding which Discharge Status Code to use, providers must consider the client's sense of success or failure, and also evaluate the client's progress based on a comprehensive review of the performance for all treatment plan goals associated with the episode of service. This review includes any objectives and action steps associated with the treatment plan goals. If a goal is composed of multiple objectives or action steps, the goal shall be considered "achieved" if at least 50% of the objectives and/or action steps associated with the goal were completed. Deferred treatment plan goals are not included when considering the ratio of total treatment plan goals to the number of achieved goals.

EXAMPLE: During the course of treatment, three treatment plans were written up. Within the three treatment plans the client had a total of: 3 deferred goals; 9 active treatment goals with 18 objectives and action steps.

SCENARIO 1: Of the 9 goals the client completed 4 goals consisting of 9 objectives and action steps.

ANSWER 1: 4/9 = 44%. Use "5. Left Before Completion with Unsatisfactory Progress-- Referred" -or- "6. Left Before Completion with Unsatisfactory Progress-Not Referred"

SCENARIO 2: Of the 9 goals, the client partially completed 3 goals (achieved 50% of the six objectives associated with those 3 goals) and fully completed 6.

ANSWER 2: 9/9 = 100%. Use "1. Completed Treatment/Recovery Plan Goals- Referred" -or- "2. Completed Treatment/Recovery Plan Goals- Not Referred"

SCENARIO 3: Of the 9 goals, client has 3 incomplete goals (achieved less than 50% of the 7 objectives associated with those three goals), and 6 completed goals.
ANSWER 3: 6/9 = 66%. Use "3. Left Before Completion with Satisfactory Progress- Referred" -or- "4. Left Before Completion with Satisfactory Progress - Not Referred

Standard Discharge Codes - Table A

Percent(%) of Tx Plan Goals Achieved	Discharge Status Code and Description
100-75%	**1**. Completed Tx/Recovery Plan Goals- Referred (Standard all questions)
100-75%	**2**. Completed Treatment/Recovery Plan Goals- Not Referred (Standard all questions)
75-50%	**3**. Left Before Completion with Satisfactory Progress – Referred (Standard all questions)
<50%	**5**. Left Before Completion with Unsatisfactory Progress – Referred (Standard all questions)

Administrative Discharge Codes – Table B

Proposed % of Tx Plan Goals Achieved	Discharge Status Code

Discharge Employment status – CalOMS

1	Full time (35 hours or more per week)	04	Unemployed not in the labor force (not seeking work)
02	Part time (less than 35 hours per week)	05	Not in the labor force (not seeking work)
03	Unemployed looking for work		

Discharge Children in Household

Enter the number of children living with the client at discharge.

Client Homeless at discharge – CalOMS

1	Homeless	2	Dependent Living	3	Independent Living