Summary of Modifications to SMART in Version 13.4.3 (January 2012 Release)
Release Date February 29, 2012

This table summarizes the major changes for users in SMART Versions 13.4.3.

Several modules change in the new versions to provide greater functionality to the user, as summarized below.

Module Affected	Description
Activity List	Cancelling an intake and then clicking on the Client Profile or Activity List no longer results in a yellow screen.
Admission and Discharge (Treatment)	The fields on the tobacco screen in admission and discharge are required (light yellow) for state reporting. In addition, work has been done to remove the "unknown" values from the dropdown and to migrate all existing admissions to "unknown" use.
ATR Interview Data Report	When the ATR Interview Data Report is run by the ATR administrator, it no longer produces a yellow page.
Client Group Enrollment	On the benefit plan client group enrollments, if "self" is chosen as the relationship to the subscriber, the name, address and Medicaid ID will pre-fill from the client profile. If the plan type is Medicaid, Policy number becomes MCO # and Subscriber number is Medicaid #, which is limited to 11 characters.
Client Profile	A new menu item is added under "Client Profile" which allows the HealthChoice forms to be generated. When user selects HealthChoice, SMART will then allow the user to produce the HealthChoice Substance Abuse Notification Form, Ambulatory Concurrent Review Form, or the Discharge Form. Please see detailed attachments labeled "Health Choice Forms" for additional details.
Code Table Editor	The Gambling modality record and the related Gambling program category (i.e. program type on screen) record were both unexpired for future use.
Intake	An ATR intake may now not be created unless the client has at least one collateral contact.
Program Enrollment	- Updated error message when the patient has been discharged but a program enrollment was attempted. Message now states "For this Enrollment Type, start date cannot be after the discharge date." - A "date of last use" field has been added to the TEDS client program enrollment screen, directly below the primary, secondary and tertiary substances.
Treatment Plan	The following dropdowns have been widened in the base treatment plan, to better accommodate the length of the text in the dropdowns: Problem Profile> Problem Description; Goal Profile> Goal; Objectives > Dropdown

Treatment Plan Review	Treatment plan review: A new field "Is the client still using substances" has been added to the treatment plan review to support entry to the HealthChoice form.

Some changes affect only users at the MD Department of Juvenile Services, as summarized below.

Module Affected	Description
Needs Assessment & Reassessments	The "Summary Report" button has been removed from the DJS Needs Assessment Reassessments.

HealthChoice Forms

Substance Abuse Notification Form, Ambulatory Concurrent Review Form, and Discharge Summary Form

New Forms – Three forms: Substance Abuse Notification, Ambulatory Concurrent Review, and Discharge

- Each submenu item under Client Profile (HealthChoice) will be a form and will be prefilled with as much information as the clinician enters into the appropriate fields (listed below) in SMART.
- Each form will launch as a PDF.
- In all cases, if no data is found, leave the space on the form blank so that the clinician may complete it by hand.

HealthChoice Substance Abuse Notification form
Each field is numbered and described below.

1. Enter the Modality from the most recent Client TEDS program enrollment that is not closed.
    a. Modality type – TEDS code 7: Check Traditional Outpatient
    b. Modality type – TEDS code 6: Check Intensive Outpatient
    c. Modality type – TEDS code 12: Check Methadone Maintenance
    d. If there are no modalities of this type for the client, do not check any boxes
2. From the active client group enrollment where payor type – Medicaid (government contract)
    a. MCO Name – enter Group Name
    b. Date submitted to MCO –date printed
    c. Time time printed
3. Clients Last name, first name are from the client profile
4. Client DOB from client profile
5. Client gender from client profile
6. Client's MA Number is Subscriber # from the active client group enrollment where payor type – Medicaid.   This number will transfer from the Client Profile if Medicaid number is entered there. Otherwise, it may be entered directly on the client group enrollment.
7. Client's MCO Number is Policy # from the active client group enrollment where payor type – Medicaid
8. Other insurer group number: If client has another active client group enrollment where payor type is not Medicaid but is a Benefit plan, include the Subscriber #
9. Client's complete address: client's home address from client profile.
10. Client's phone number: List one phone number from client profile. First available.

11. From agency profile of the context agency: Treatment Facility name: Agency Name, Admin Office address, Office phone, fax phone
12. Medicaid ID from the Agency profile.

13. Facility Tax ID (use the Agency profile tax ID)
14. Primary Care Physician: If client has an active collateral contact where type – Primary Care Physician, display contact first and last name.
15. Treatment episode start date = start date of the client program enrollment used for this application
16. Requested Start date for MCO Authorization = same as #15
17. From active intake that is not an ATR intake. Due date from same intake if client is pregnant.   Prenatal care (yes/no) from intake screen.
18. Substance, date of last use, frequency and Method come from the client program enrollment used above. Severity will be added on the program enrollment for primary, secondary and tertiary substance. When it is added, then it will transfer to this field.
19. Prior treatment history:
    a. If there is a valid consent from another agency to the context agency, display:
        i. Name of other agency, modality from TEDS program enrollment with the most recent enrollment date
        ii. Start and end date of program
        iii. Successful vs. unsuccessful –use program disenrollment codes to judge this (of the program enrollment used in 19.a.i). Successful if completed or referred; all others are unsuccessful
20. Medications – pull all medications in the episode of care that do not have a discontinued date and/or reason
    a. List Medication, Dosage, Frequency. Adherence not filled in at this time.
21. Diagnosis: From admission, pull the principal diagnosis from each of Axis I-IV. Display the GAF score.
22. ASAM: From admission, display the level of risk indicated for each of dimensions I-VI.
23. Treatment: From the most recent active treatment plan, display the planned services:
    • Service Name, CPT code, planned sessions and frequency
24. Anticipated Discharge date: To be addressed at a later date. For now, the clinician will complete by hand.
25. Comments: Clinician comments/recommendations from the most recent active treatment plan
26. Treatment Clinician – This the primary care staff person (assigned to the treatment team, either on the admission or the treatment plan)
    a. Professional credentials, email and phone number from staff profile

HealthChoice Substance Abuse Ambulatory Concurrent Review form

Each field is numbered and is described below.

Bo**xes** 1-17 are identical to Notification Form; please see above.

18. From the treatment plan, the updated Diagnoses for AXIS I-V (principal diagnosis only on Axis I-IV
19. Medications – same as Notification form #19.
20. Response to treatment – Not completed in SMART at this time.
21. Alcohol/Drug screen results for last 6 tests:
    a. From drug test screen, display most recent 6 tests (include consented drug test records)
    b. Type, date of specimen, negative (check column if all drugs negative, positive – on each test, list all drugs for which client tested positive, including creatinine and methadone.
22. Is client currently using?
    a. Pull from the yes/no question being added to the treatment plan recommendations screen (from the most recent treatment plan review).
    b. If yes, list interventions from "need for further treatment" box on the most recent Treatment Review
23. Treatment: From the most recent active treatment plan, display the planned services:
    a. Service Name, CPT code, planned sessions and frequency, rate for the service for Medicaid plans
24. Anticipated Discharge date:
    a. To be added at a later date.
25. Aftercare Plan:
    a. Pull from comment box on the active treatment plan overview screen: "Transfer/discharge criteria"
26. Comments
    a. "Clinician's comments" on the active treatment plan
27. Treatment Clinician – this the primary care staff person (assigned on the treatment plan)
    a. Professional credentials from the staff profile
    b. Email and phone number from staff record (pick first phone number)

HealthChoice Discharge Summary form

Each field is numbered and described below.

Boxes 1-14 are the same as the SA Notification form

When the user chooses this form, display a dropdown list of the most recently closed qualifying client program enrollment, and the most recently opened qualifying client program enrollment.

15. Discharge Date from this facility
    a. end date of program enrollment that was used for this form
16. See question #17 on Notification form
17. From the discharge, the updated Diagnoses for AXIS I-V (principal diagnosis only on Axis I-V.)Display the GAF from admission and the GAF from discharge
18. See question #20 on Notification form
19. See question #21 on Concurrent Review form
20. Reason for discharge (disenrollment reason from the program enrollment used for this form)
21. See Question #25 on the Concurrent Review form
22. Notification to primary care physician – This will be addressed at a later date. For now, will be handwritten by clinician.
23. Treatment summary – In the initial January 2012 SMART Release, this is pulling from the Clinician's Comments in the Active Treatment Plan. This may be modified in subsequent versions.
24. Treatment Clinician – this the primary care staff person as assigned on the treatment plan.
    a. Professional credentials from staff profile
    b. Email and phone number from staff record

HealthChoice Substance Abuse Notification Form

ALL FIELDS ARE REQUIRED

Attach more pages if more space is needed

Please complete all sections. The information has been disclosed to you from records protected by Federal Confidentiality rules (CFR 42, Part 2). The Federal Ruled prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42, Part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1. [ ] Level I: Traditional Outpatient   [ ] Level II.1: Intensive Outpatient   [ ] OMT: Methadone Maintenance

2. MCO Name: Medicaid   **Date Submitted to MCO:** 02/29/2012   **Time:** 10:25AM

3. Client's Name: (Last) ChoiceClient   **, (First)** Health

4. Client's Date of Birth: 01/01/1980	**5. Client's Gender:** M _X_ F ___	**6. Client's MA Number:** 5554kk23432	**7. Client's MCO Number** (if different) : N/A

8. Other Insurer Group # (if applicable) :	**9. Client's Complete Address:** 77 Seventh Street Stevensivlle, MD 77777	**10. Client's Phone Number:** (301) 999-9999

11. Treatment Facility Name: MBC Treatment Center   **12. Facility MA # :**   **13. Facility Tax ID # :**

Address: 123 Main Street Columbia, MD 21046

Phone: Fax:

14. Primary Care Physician (if known) **:** N/A

15. Treatment Episode Start Date: 01/02/2011	**16. Requested Start Date for MCO Authorization:** 01/02/2011	**17. Client Pregnant?:** No If yes, Due Date (if known) : Scheduled to receive prenatal care? No

18. Substance Abuse	**Severity**	**Frequency**	**Method**	**Date of Last Use**
Crack		More than 3 times/day	Oral	12/31/2010
None		N/A	N/A	
None		N/A	N/A	

19. Prior Substance Abuse Treatment History - Last 3 Years   (if known)

Name of Treatment Facility	**Treatment Type** (e.g., OP, IOP, OMT)	**Dates of Service**	**Treatment Status**	
			Successful	Unsuccessful

20. List ALL Reported Current Medications (Including Medical, Psychiatric, & Sub. Abuse such as: Suboxone & Methadone) – Attach additional pages if necessary

Name of Medication	**Dosage**	**Frequency**	**Adherence** (e.g., Yes, No, Unknown)

21. Diagnosis/ DSM IV-R – Please complete all Axes

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V (GAF):

22. ASAM PPC (Circle one for each Level of Risk)				**Level of Risk**		
Dimension I: Withdrawal	0	1	2	3	4
Dimension II: Biomedical Conditions and Complications	0	1	2	3	4
Dimension III: Emotional/Behavioral Conditions and Complications	0	1	2	3	4
Dimension IV: Treatment Acceptance	0	1	2	3	4
Dimension V: Relapse/Continued Use Potential	0	1	2	3	4
Dimension VI: Recovery Environment	0	1	2	3	4

23. Treatment

	Code	# of Sessions (S) or Units (U) per week	Session/Unit conversion

24. Anticipated discharge date from this Level of Care:

25. Comments – optional   (please use additional pages if necessary)

26. Treatment Clinician's Name:

02/29/2012

Printed	Clinician Signature	Credentials	Date

Treatment Clinician's Email Address	Treatment Clinician's Phone Number

HealthChoice Substance Abuse
Ambulatory Concurrent Review Form

Please complete all sections. The information has been disclosed to you from records protected by Federal Confidentiality rules (CFR 42, Part 2). The Federal Ruled prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42, Part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1. [ ] Level I: Traditional Outpatient   [ ] Level II.1: Intensive Outpatient   [ ] OMT: Methadone Maintenance

2. MCO Name: Medicaid   **Date Submitted to MCO:** 02/29/2012   **Time:** 9:09AM

3. Client's Name: (Last) ChoiceClient   **, (First)** Health

4. Client's Date of Birth: 01/01/1980	**5. Client's Gender:** M _X_ F ___	**6. Client's MA Number:** 5554kk23432	**7. Client's MCO Number** (if different) : N/A

8. Other Insurer Group # (if applicable) :	**9. Client's Complete Address:** 77 Seventh Street Stevensivlle, MD 77777	**10. Client's Phone Number:** (301) 999-9999

11. Treatment Facility Name: Administrative Agency (MD-100100)	**12. Facility MA # :** 87365uu8yt4	**13. Facility Tax ID # :** 88-8888888

Address: 9658 Baltimore Ave College Park, MD 20742

Phone: (301) 397-2330   Fax: (666) 666-6666

14. Primary Care Physician (if known) : N/A

15. Treatment Episode Start Date: 02/22/2012	**16. Requested Start Date for MCO Authorization:** 02/22/2012	**17. Client Pregnant?:** No If yes, Due Date (if known) : Scheduled to receive prenatal care?

18. Updated Diagnosis Since Last Authorization Period (Please write again using DSMIV Codes even if there are no changes):

Axis I:	Hemorrhage, extradusal, traumatic
Axis II:	Alcohol Abuse
Axis III:	Fetal alcohol syndrome
Axis IV:	Adrenal cortical steroids
Axis V (GAF):	60

19. List ALL Reported Current Medications AND Current Medications prescribed by Substance Abuse treatment provider (such as Methadone or Suboxone). Attach additional pages if necessary.

Name of Medication	**Dosage**	**Frequency**	**Adherence** (e.g., Yes, No, Unknown)
Klonopin (clonazepam)	25 mg	prn	

20. Response to Treatment – Please ATTACH COMAR required treatment plan. This treatment plan should list specific gains made since initial treatment plan and all remaining symptoms with frequency and severity. The updated treatment plan should also provide justification for continuation of treatment.

21. Alcohol/Drug Screens/Breathalyzer Results Last 6 Tests – Include positive screen for medications not prescribed by the treatment program. Attach additional pages if necessary.

Specimen Type	Date of Specimen	Negative	Positive (if positive, what substances were positive and level present)
Urine Sample	02/22/2012		Creat, Methadone
Urine Sample	02/22/2012		Amphetamines, Barbiturates, Benzodiazephine
Urine Sample	02/22/2012		Hallucinogens, Heroin, Marijuana
Urine Sample	02/22/2012	X	

22. Is client currently abusing substances?
   If yes, list interventions to address usage (e.g., administrative detox, change in level of care):

23. Treatment

	Code	# of Sessions (S) or Units (U) per week	Session/Unit conversion
GROUP COUNSELING BY A CLINICIAN, Alcohol & Drug Services	H0005	[40] S weekly	

24. Anticipated Discharge Date from current level of care (if known):

25. After Care Plan:

disch criteria

26. Comments (anything not addressed in the treatment plan but supports request for continued level of care, e.g. employment, family, housing, health status, socialization, support system):
clinician comemnts

27. Treatment Clinician's Name:

Brown, David		LGSW 02/29/2012
Printed	Clinician Signature	Credentials Date
none@none.com	(333) 333-3333	
Treatment Clinician's Email Address	Treatment Clinician's Phone Number	

HealthChoice Substance Abuse
Discharge Summary

Please complete all sections. The information has been disclosed to you from records protected by Federal Confidentiality rules (CFR 42, Part 2). The Federal Ruled prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by CFR 42, Part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of this information to criminally investigate any alcohol or drug abuse patient.

1. [ ] Level I: Traditional Outpatient   [ ] Level II.1: Intensive Outpatient   [ ] OMT: Methadone Maintenance

2. MCO Name: Medicaid	Date Submitted to MCO: 02/29/2012	Time: 10:20AM

3. Client's Name: (Last) ChoiceClient   , **(First)** Health

4. Client's Date of Birth: 01/01/1980	5. Client's Gender: M _X_ F ___	6. Client's MA Number: 5554kk23432	7. Client's MCO Number (if different) : MCO Policy number entered

8. Other Insurer Group # (if applicable) :	9. Client's Complete Address: 77 Seventh Street Stevensivlle, MD 77777	10. Client's Phone Number: (301) 999-9999

11. Treatment Facility Name: Administrative Agency (MD-100100) Address: 9658 Baltimore Ave College Park, MD 20742	12. Facility MA # : 87365uu8yt4	13. Facility Tax ID # : 88-8888888

14. Primary Care Physician (if known) : N/A	15. Discharge Date from this Facility:	16. Client Pregnant?: No If yes, Due Date (if known) : Scheduled to receive prenatal care?

17. Updated Diagnosis Since Last Authorization Period (Please write again using DSMIV Codes even if there are no changes):

Axis I:

Axis II:

Axis III:

Axis IV:

Axis V (GAF):   Admission: 60   Discharge:

18. List ALL Medications at time of discharge prescribed by the substance abuse treatment provider (including Methadone/LAAM). Attach additional pages if necessary.

Name of Medication	Dosage	Frequency	Adherence (e.g., Yes, No, Unknown)
Klonopin (clonazepam)	25 mg	prn	

19. Alcohol/Drug Screens/Breathalyzer Results Last 6 Tests – Include positive screen for medications not prescribed by the treatment program. Attach additional pages if necessary.

Specimen Type	Date of Specimen	Negative	Positive (if positive, what substances were positive and level present)
Urine Sample	02/29/2012	X	
Urine Sample	02/28/2012	X	
Urine Sample	02/25/2012		Creat, Methadone
Urine Sample	02/22/2012		Creat, Methadone
Urine Sample	02/22/2012		Amphetamines, Barbiturates, Benzodiazephine
Urine Sample	02/22/2012		Hallucinogens, Heroin, Marijuana

20. Reason for Discharge

- Completed Treatment, No Substance Problem – No Substance Use_____
- Completed Treatment, No Substance Problem – Some Substance Use_____
- Completed Treatment Plan Referred___X____
- Did Not Complete Treatment Referred_____
- Non-Compliance – Administrative Discharge_____
- Client Left Before Completing_____
- Incarcerated_____
- Death_____
- Change in Service Within Episode_____

21. After Care Plan:

disch criteria

22. Notification to Primary Care Physician?   No _____   Yes_____   Date

23. Summary of Treatment (optional) :

clinician comemnts

24. Treatment Clinician's Name:

Brown, David		LGSW	02/29/2012
Printed	Clinician Signature	Credentials	Date
none@none.com	(333) 333-3333		
Treatment Clinician's Email Address	Treatment Clinician's Phone Number		