

# AccuCare Workflow Guide

This is a general guide to the AccuCare clinical workflow. All workflows may vary. Use for reference and training only.

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## MAIN MENU: NAVIGATION

### Main Menu:

- Navigate to any of the main modules in AccuCare by selecting the associated Icon
- Jump navigation pane allows user to access any module within AccuCare without having to exit back to the main menu
- Top Ribbon can be personalized by the user to display Icons of module they use most often.

**Ribbon**

**Jump Navigation**

# CLIENT INTAKE

## Adding New Client: Client Intake



- You can use **[Search]** or **[Display All]** to see if the client is already in AccuCare, or create a new one by entering in the most basic information Assign initial case manager and agency
- On **Demographics Tab** - Click the **[Add New Client]** button to add new client to the database and enter their demographic information.

Client Intake

Search by:  Last Name  Date Of Birth  Phone  SSN  Client Reference #  Billing Reference #

Begins with or matches:

Client Name:   
 Level of Care:   
 Location:

Name	DOB	Phone	SSN	Client Ref #	Billing Ref #

Demographics
Case Management
Billing
Payers
Fee Schedule
Referrals
AI/AN
Custom Forms
Multi-Dimensional Assessment
Comments

**Main**

Client Name:	First Encounter Date:
Nickname:	Marital Status:
Date of Birth:	Work Status:
Gender:	Race:
Social Security #:	Religion:
Client Reference #:	Ethnic Group:

**Contact Information**

Address:	Phone 1:
	Phone 2:
	Phone 3:
Email:	Phone:
Emergency Contact:	

**Legal Status**

Involved with Child Protective Services:

Current Probation Status:

Current Parole Status:

Family in Criminal Justice System:

**Military**

Military Status:	Family Members with Military Background:
Military Branch:	Number of Family Members in Military:

**Additional**

Privacy Agreement Signed:

Archived:

- Fill out the fields in **Main**, **Contact Information**, **Legal Status**, **Military** and **Additional** of the demographic dialog box
- Not all fields are required.
- **Recommend discussing as group to gain consensus on what field should be filled out**

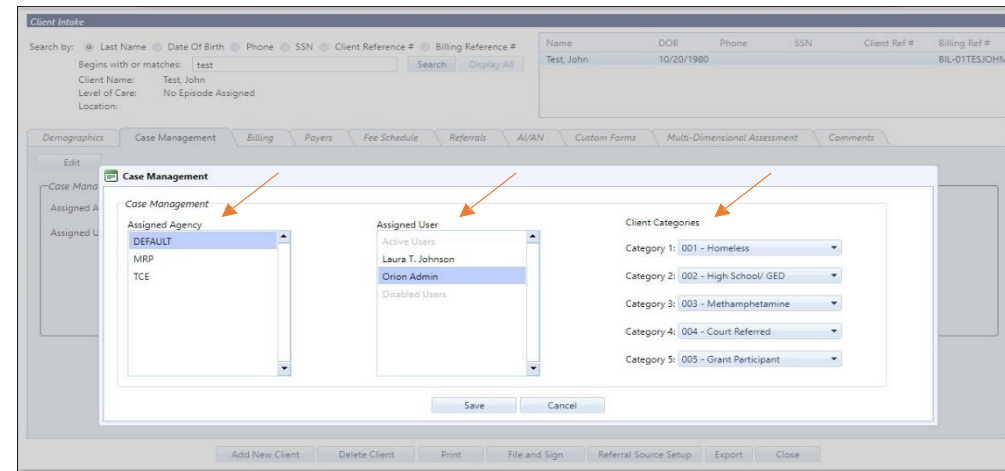
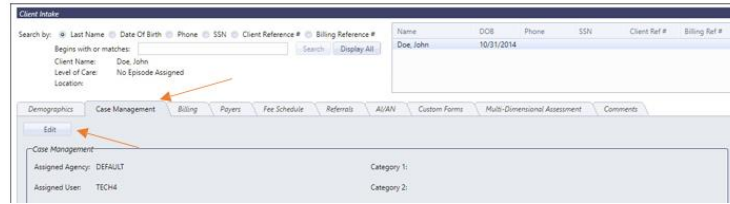
The screenshot shows the 'Client Intake' form with the following sections and fields:

- Search by:** Last Name, Date Of Birth, Phone, SSN, Client Reference #, Billing Reference #
- Table:**

Name	DOB	Phone	SSN	Client Ref #	Billing Ref #
Abbey, Janet	10/19/1980		232-32-2222	987979797	987979797
Abbey, Julia	03/07/1975	(555) 555-4524	789-78-7977	987979797	987979797
- Demographics**
  - Main:** Title (Miss), First Name (Julia), Middle Name (Abbey), Date of Birth (03/07/1975), Gender (F), Social Security (789-78-7977), Last Name at Birth, Client Reference (987979797), Nickname.
  - First Encounter Date (03/15/2016), Marital Status (Married), Work Status (Part-time (regular hon)), Religion (Catholic), Race (American Indian), Ethnic Group.
- Contact Information:** Address 1 (1512 South St), Address 2, City (Omaha), State (NE), Zip Code (68130-), Phone 1 ((555) 555-4524), Phone 2, Phone 3, Email.
- Emergency Contact Information: Full Name (Janet Test), Relation (sister), Phone ((402) 454-5444).

- Legal Status:** Currently Involved with Child Protective Services (Yes), State (ND), State Other, Current Probation Status (Juvenile), Program (Tribal Probatic), Program Other, Current Parole Status (Juvenile), State (ND), State Other, Do you have any family involved in the criminal justice system?
- Military:** Military Status (Retired), Military Branch (Air Force), Client has family with Military Background (Don't know), Number of family members in Military (0, 1, 2, 3, 4, 5, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18, 19, 20, Don't know, Refused).
- Additional:** Privacy Agreement Signed (checked), Archived.

- Click the **Case Management** Tab
- Click the [Edit] button to open this dialog box
- **Assigned Agency** will show you which agency and group of clinicians the client is assigned to.
- **Assigned User** is usually the person who added the client to the database as new client.
- **Client Categories** allows you assign up to 5 tags per client from a picklist created in Setup > Client Categories.



## Referral Tab

- Click the Referrals Tab if you want to record a referral record for the client, either incoming or outgoing.
- Click the [Add] button to add a referral to your client records.

**Client Intake**

Search by:  Last Name  Date Of Birth  Phone  SSN  Client Reference #  Billing Reference #

Begins with or matches:

Client Name: Test, John  
Level of Care: No Episode Assigned  
Location:

Name	DOB	Phone	SSN	Client Ref #	Billing Ref #
Test, John	10/20/1980	(402) 999-9999	121-21-2121		BIL-01TESJOHM

Demographics Case Management Billing Payers Fee Schedule **Referrals** AI/AN Custom Forms Multi-Dimensional Assessment Comments

Date of Referral	Name	Agency	Contact	Type	Results	Edit	Delete	Print	File & Sign	Signed
No records to display.										

- Choose the radio button for type of referral you are creating
- You can select an existing **Referral Source** from the drop down list or create a new one to be added to the list by clicking on the **Add New** link
- Under **Referral Details** you can tag more details to the referral record.
- You can customize each picklist
- Type in any comments in the **Referral Comment** dialog box

The screenshot shows the 'Add/Edit Referral Record' form. At the top, there are search filters for 'Last Name', 'Date Of Birth', 'Phone', 'SSN', 'Client Reference #', and 'Billing Reference #'. The client information for 'Able, Tom' is displayed. The 'Referral Date' is set to 01/19/2018. The 'Referral Source' section has a search bar and a dropdown menu showing 'Canku Teca - Lake Andes, Canku Teca, S'. The 'Referral Details' section includes a 'Level of Care' dropdown set to 'No Episode Assigned' and several other dropdown menus for 'Type of Contact', 'Previous Services', 'Service Requested', 'Funding Source', 'Referral Reason', 'Result', 'Category', 'Other 1', and 'Other 2'. The 'Referral Comments' section is a large text area at the bottom. Red circles and arrows highlight the 'Referral Source' and 'Referral Details' sections, and the 'Referral Comments' text area.

## Custom Forms Tab:

- Click on the Custom Forms Tab
- Click the **[Add]** button open the create New Form dialog box
- Click the drop down arrow to see published assigned custom forms.
- Once you have selected the form click the **[Create New Form]** button

The screenshot displays the 'Client Intake' interface. At the top, there is a search bar with options for 'Last Name', 'Date Of Birth', 'Phone', 'SSN', 'Client Reference #', and 'Billing Reference #'. Below this, the client information for 'Test, Joe' is shown, including 'Level of Care: No Episode Assigned'. The main navigation bar includes tabs for 'Demographics', 'Case Management', 'Billing', 'Payers', 'Fee Schedule', 'Referrals', 'AI/AN', 'Custom Forms', 'Multi-Dimensional Assessment', and 'Comments'. The 'Custom Forms' tab is selected, and an 'Add' button is visible. A 'Create New Form' dialog box is open, showing a dropdown menu for 'Form Type' with 'Confidential Health and Intake Questionnaire' selected. The dialog box has 'Create New Form' and 'Cancel' buttons. Red arrows point to the 'Add' button, the 'Custom Forms' tab, the dropdown arrow, and the 'Create New Form' button.



- Here is an example the of a published forms
- Select a Level of Care from picklist if available
- Collect information from client to fill out form
- Save when done to add to you client's record

Client Intake

Search by: Last Name Date Of Birth Phone SSN Client Reference # Billing Reference # Name DOB Phone SSN Client Ref # Billing Ref #

Begins with or matches: |test| Search Display All

Client Name: Test, Joe

Client Intake Custom Forms

Form Date: 01/22/2018 Level of Care: No Episode Assigned

**FAMILY RECOVERY SERVICES**  
CONFIDENTIAL HEALTH AND INTAKE QUESTIONNAIRE

Golden City  Silver Stone

**GENERAL INFORMATION**

Name: Joe Test Intake Date: Age: Date of Birth:

Place of Birth:

Address: Phone:

NAME OF EMERGENCY CONTACT: Address:

Phone:

Previous Substance abuse treatment?  Yes  No  Not Answered Dates:

Most Recent Program: Date:

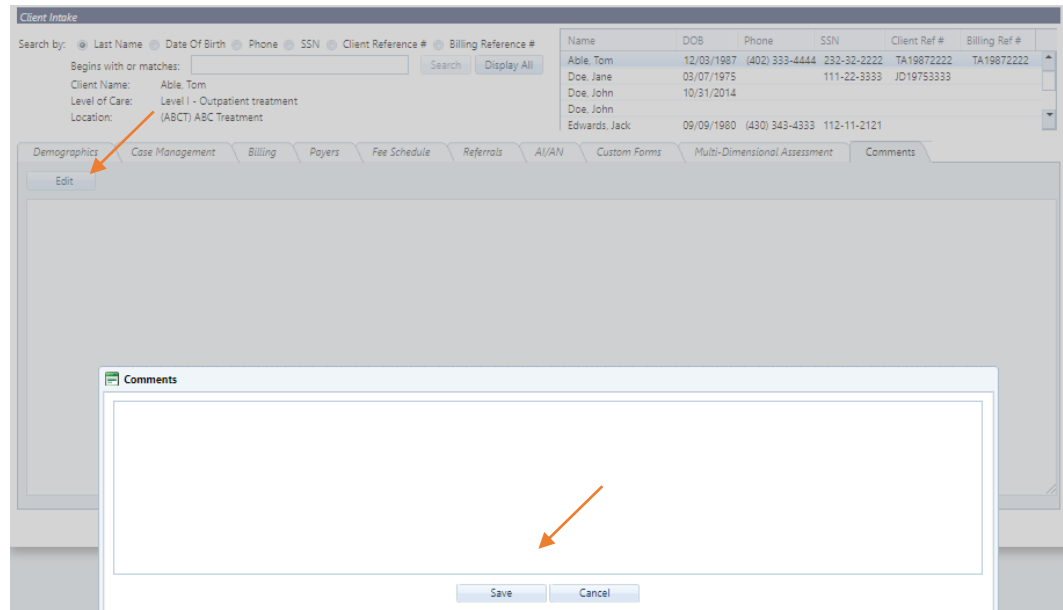
Detox:  Residential:

Who referred you to Ujjima?:

Save Cancel

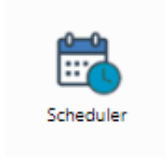
## Comments Tab

- Click the Comments Tab
- To add other comments click the [Edit] button
- This dialog box can be used for general comments and notes



## SCHEDULER: APPOINTMENTS AND CHECK-INS

### Add New Appointment:



- Schedule Pre-Screen (or any) appointment from the scheduler
- Use templates to assist with auto-filling the appointment details
- Select Transfer to Billing and/or Transfer to Progress Notes to track for check-ins and quality assurance

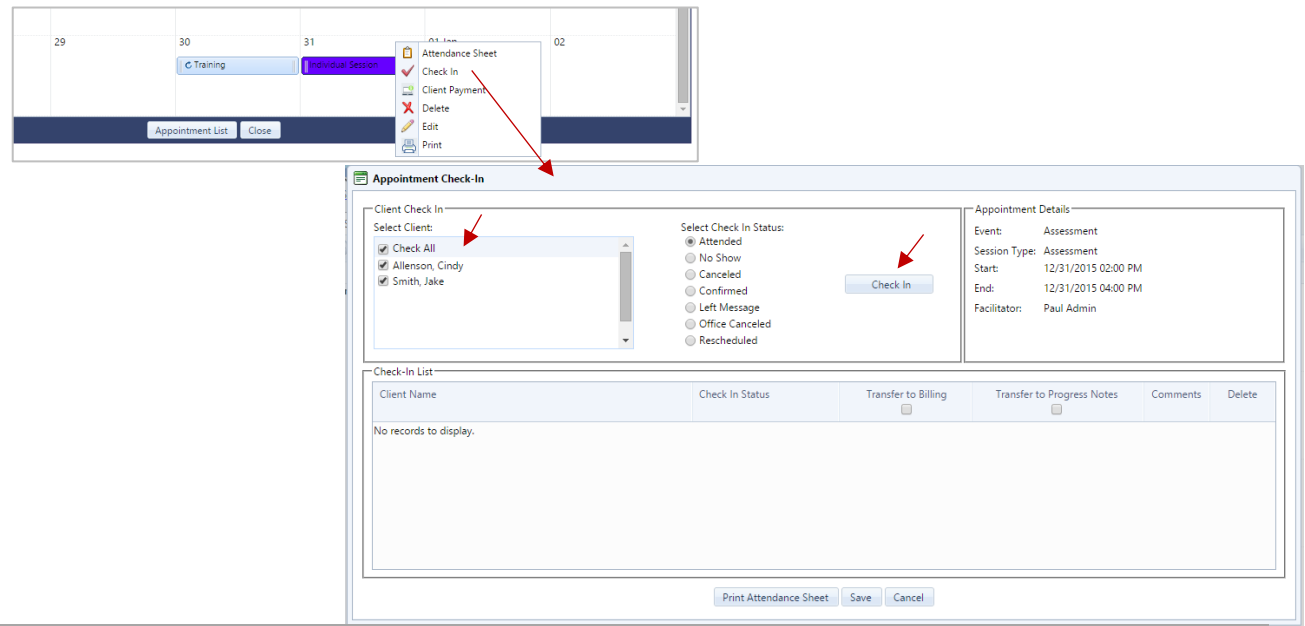
The screenshot displays the 'Scheduler' application interface. At the top, there are navigation tabs for Staff, Calendar, Clients, and Reports. A search bar and a date selector for September 2015 are also present. The 'Add/New' button is highlighted with a red arrow. Below this, the 'New Appointment' dialog box is open, showing the following details:

- Staff: John Training
- Facilitator: John Training
- Client: Adams, Leo M.
- Template: Individual Session
- Session Type: Individual Session
- Event: Individual Session
- Start Time: 12/31/2015, 1:00 PM
- End Time: 12/31/2015, 2:00 PM
- Color: Blue

The 'Transfer' section includes checkboxes for 'Transfer To Billing' (checked) and 'Transfer To Progress Notes'. The 'Recurrence' section is set to 'Weekly' on 'Saturday' with a recurrence of every 1 week. The background calendar shows a grid for September 2015 with various appointment slots such as 'Assessment', 'Ind Session - to test Archwin', 'Anger Management', and 'Discharge'.

### **Check-in Appointments:**

- After the appointment is complete, you can check in the client by right clicking on the appointment and selecting the “Check In” icon.
- This allows user to “check in” clients from the appointment and assign the appropriate check in status.
- By checking in the client, this will allow users to track the status and carry the appointment information into billing and progress notes actions



## EPISODES OF CARE: ADMISSION, TRANSFER AND LEVELS OF CARE

### Create Episodes and Assign Level of Care:



•The client can be assigned a level of care based on where they are at in the clinical process.

- To assign a new episode/LOC, select Episodes of Care icon from the main menu.
- Select Add Episode for a new episode and initial LOC

***\*You can at any point, add levels of care, manage episodes and administer a custom form***

Episodes Of Care

Select a Client: Abracadabra, John      Default Level of Care for New Records: No Episode Assigned [Change](#)

[+ Add Episode](#)

Case Summary: Client Reference #: Age at Admission: Episode Dates:

[Add Level of Care](#) [Manage Episode](#) [Custom Forms](#)  Include Discharged

Level of Care	Status	Location of Service	Admit Date	Discharge Date	Transfer	Discharge	Edit	Chart	Report
There are no active Levels of Care to display. Check Include Discharged to display the history.									

[Export](#) [Census Report](#) [Current Admissions Report](#) [Close](#)

### **Admit Client and Assign Level of Care:**

- Select the appropriate information from the drop down lists
- If Default Level of Care is selected, this will automatically attach this level of care to records created (can be modified at any time or will change based on current LOC)
- Assign staff by typing in first name and selection list will appear or click on icon for advanced search
- Select diagnosis when applicable

**Begin Client Episode 1**

Admission Details

Episode: 1      Age at Admission: 28

Date of Admission: 01/04/2016      Time (Optional)

Selected Analysis: No Placement Analysis Available

Population Type: Adult

Selected Level of Care: First Contact

Location of Services: (GVC) Grass Valley

Default Level of Care:

Care Team

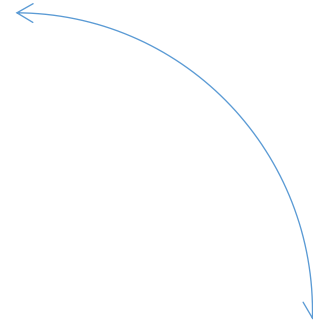
Staff: Paul Clinician

Case Manager: Paul Clinician

Diagnosis

Comments

Admit    Cancel



Episodes Of Care

Select a Client: Aardvark, Alan      Default Level of Care for New Records: First Contact - (GVC) Grass Valley [Change](#)

Episode 1 - Admitted 01/11/2016      Add Episode

Case Summary: Aardvark, Alan      Client Reference #: EU779TTH      Age at Admission: 34      Episode Dates: 01/11/2016 - Current

Add Level of Care      Manage Episode

Level of Care	Status	Location of Service	Admit Date	Discharge Date	Transfer	Discharge
Treatment from: 01/11/2016 onward						
First Contact	Active	(GVC) Grass Valley	01/11/2016			

### Transfer Level of Care:

- To assign (or transfer to) a new episode/LOC, select Episodes of Care icon from the main menu.
- Select the Transfer icon to discharge client from existing LOC and re-assign or transfer to a new LOC
- Fill in information from Transfer screen (reason, level, location) and select Transfer button to complete

The screenshot displays the AccuCare software interface. At the top, the 'Episodes Of Care' section shows a table with columns: Level of Care, Status, Location of Service, Admit Date, Discharge Date, Transfer, and Discharge. A red arrow points from the 'Transfer' button in the table to the 'Transfer Client' dialog box.

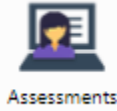
The 'Transfer Client - Smith, Jake' dialog box contains the following fields:

- Client Episode Data: Episode: 1, Population Type: Adult, Date of Admission: 01/04/2016, Age at Admission: 28, Level of Care: First Contact, Location of Service: (GVI) Grass Valley.
- End Date of Setting: 01/04/2016, Date of Transfer: 01/04/2016, Age at Transfer: 28.
- Reason for Transfer: Treatment completed successfully.
- Level of Care/Location of Service: Population Type: Adult, Selected Level of Care: Pre-Screening, Location of Service: (GVI) Grass Valley, Default Level of Care: .
- Discharge Summary Section: Goals Attempted During Treatment, Goals Met During Treatment, Summary.

Buttons at the bottom of the dialog box include 'Transfer' and 'Cancel'.

# ASSESSMENTS, SCREENING, CUSTOM FORMS

## Clinical Assessments (ASI):



- Select New Assessment to begin the biopsychosocial evaluation
- Once complete, a full narrative can be printed out by selecting Reports button
- You can also electronically file and sign the assessment to the clients chart

**\*Assessments are based on the Addiction Severity Index (ASI)**



## Screening/Supplements



Screening

- Screening and Supplements can be administered from the main menu
- Over 16 clinical tools are available to be administered for the client

File > Screening Tools / Supplements

Search by:  Last Name  SSN  Client Ref. #

Name: Adams, Leo    SSN: 405-25-9965    Client Ref. #

Begins with or matches:

Retain Filters

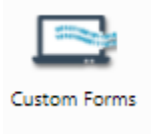
Supplement Selection	Creation Date Date Range Filter	Created By	Supplement Type
<input checked="" type="radio"/>	08/31/2015	Ima N. Training	Health Questionnaire
<input type="radio"/>	08/06/2015	Orion Clinician	Health Questionnaire
<input type="radio"/>	08/06/2015	Orion Clinician	YOS Counseling File Review - Dischar
<input type="radio"/>	06/26/2015	Ima N. Training	American Indian/Alaskan Native Sup
<input type="radio"/>	06/10/2015	Ima N. Training	Intimate Partner Violence Screening
<input type="radio"/>	06/10/2015	Ima N. Training	Domestic Violence Screening
<input type="radio"/>	03/19/2015	Ima N. Training	DARTS Admission Supplement
<input type="radio"/>	02/11/2015	Ima N. Training	American Indian/Alaskan Native Sup
<input type="radio"/>	06/19/2014	Ima N. Training	Depression Screening (CES-D Scale)
<input type="radio"/>	06/19/2014	Ima N. Training	Fagerstrom Tolerance Scale

**Create New Supplement**

Select Supplement or Screening

- Fagerstrom Tolerance Scale
- Addiction**
- Fagerstrom Tolerance Scale**
- Simple Screening Instrument for Substance Abuse
- South Oaks Gambling Screen (SOGS)
- Substance Abuse Diagnostic
- Mental Health**
- Depression Screening (CES-D Scale)
- Domestic Violence Screening
- Intimate Partner Violence Screening
- Mental Health Screening Form-III (MHSEF-III)
- Mental Health Status Exam
- Modified Mini Screen (MMS)
- Pediatric Symptom Checklist - Youth Report (Y-PSC)
- Pediatric Symptom Checklist (PSC)
- PTSD Checklist (PCL)
- RPMS Suicide Reporting Form
- Social Interaction Anxiety Scale (SIAS)
- Strengths, Needs, Abilities, Preferences (SNAP)
- Medical**
- Health Questionnaire

## Custom Forms



- You can create your own Custom Forms to collect data specific to your clinical needs
- Select “Add” to administer a custom form
- Data collected from forms can also be exported to excel for additional analysis

File > Custom Forms

Search by: Last Name

Begins with or matches:

Search Display All

Name	SSN	Client Reference #
Smith, Jennifer		
Smith, Joey		
Smith, John J.		

Date	Form Name	Select
No records to display.		

Create New Form

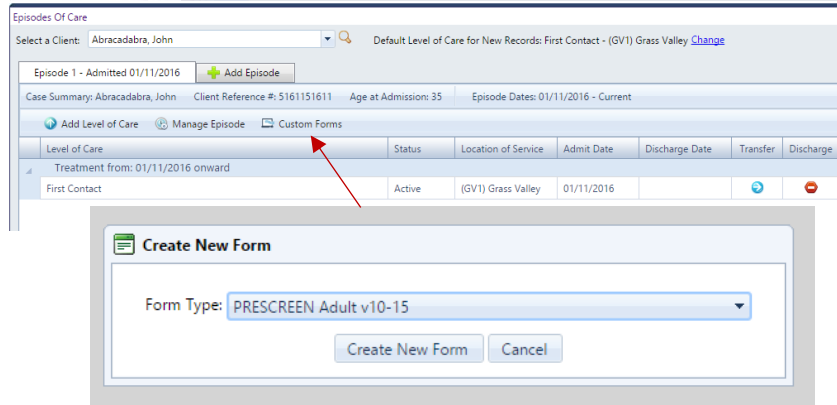
Form Type: Adolescent Supplement - Developmental History v11-19-15

- Adolescent Supplement - Developmental History v11-19-15
- Initial Contact Form
- PRESCREENING Adolescent v10-15
- PRESCREENING Adult v10-15
- PRESCREENING Residential v10-15

Add Edit Delete Preview Print File and Sign Export to Excel Close

**Administer Custom Form:**

- For workflow efficiency, Custom Forms can be accessed from multiple modules including:
  - Main Menu
  - Client Intake
  - Episodes of Care
  - Medication Management
  - Assessments
  - Screening/Supplements



# CLIENT DIAGNOSIS

## Client Diagnosis



Diagnosis

- Add, modify or delete and set diagnosis as active or inactive
- Set primary and admitting for billing

purposes

- Includes **ICD-9, ICD-10, DSM-IV and DSM-5 for ICD-9 and ICD-10**
- Attach diagnosis to client progress notes and during episode/level of care management

Client Diagnosis

Select a Client: Lawrence, Tara Client Reference #: wwer34 SSN:

Diagnosis List  Show Active Only

Select	Code	Description	Axis	Set	Admitting	Primary	Diagnosis Date(s)	Diagnosed By	Status	View History
<input type="checkbox"/>	F06.34	Depressive disorder due to another medical condition, With mixed features		DSM-5 (ICD-10)		<input checked="" type="checkbox"/>	11/11/2015 - current	Sandra Jones	Active	
<input type="checkbox"/>	F10.180	Alcohol-induced anxiety disorder, With mild use disorder		DSM-5 (ICD-10)		<input type="checkbox"/>	11/11/2015 - current	Sandra Jones	Active	

Add Edit Update Status Delete Reporting Close

### Add/Edit Diagnosis

Coding System: ICD-10

Axis: ICD-9  
ICD-10  
DSM-IV  
DSM-5 (ICD-9)  
DSM-5 (ICD-10)

Diagnosis Date: 11/15/2015

Diagnosed by: Paul Admin

Primary

Admitting

Archived

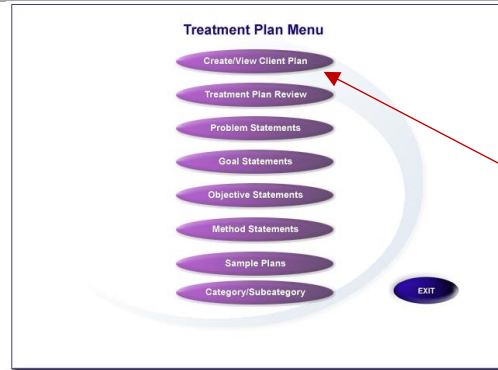
OK Cancel

# TREATMENT PLANNING

## Create a Treatment Plan:



- Select Create/View Client Plan
- Treatment Plan Review
- Problem, Goal, Objective, Method, Statements
- Sample Plans
- Category/Subcategory



**File > Open Treatment Plan**

Select Treatment Plan Type: **Adult**

Search by:  Name  SSN  Client Ref. #

Begins with or matches:

Name	SSN	Client Reference #
Adams, Leo	405-25-8965	
Adult, Emily	555-44-6666	EAA041185
baw, Eric	557-65-9867	BAB120679
bloggs, joe	111-11-1236	
Brown, Jose	228-94-2052	
Brown, Tyzone	210-22-2010	999234
Burke, Timothy	456-45-4785	124578
Bush, Rose	503-89-0333	
Butler, Charles	987-20-1367	100500
burley, kristen	555-91-7814	7146

Name: First **Leo**  
Middle **M**  
Last **Adams**  
SSN: **405-25-8965**  
Date of Birth: **08/01/1973**  
Client Reference #:

**Treatment Plans:**

#	Date	Treatment Plan Type	File/Sign Status
1	12/07/2012	Addiction	--
2	12/07/2012	Addiction	--
3	03/07/2013	Addiction	--

**Use Sample Plans and Statements:**

- Create treatment plans with sample statements and sample plans or directly enter data into fields.

File > Treatment Plan > Create / View Treatment Plan > For: Leo Adams

Name: Leo Adams Plan Type: Addition Voice: First Person

SSN: 405-25-8965 Client Reference #:

Plan Date: 01/12/2016 Staff Responsible: JTC Plan Number: 21

Level of Care: No Episode Assigned

Title:

Diagnosis:

Problem:

Goal:

Objective 1:

Method 1.1:

Method 1.2:

Method 1.3:

File > Treatment Plans > Problem Statements

Questionnaire Type: Adult

Plan Type:  Addiction  Mental Health  Co-Occuring

Category: Interpersonal Relationships

Sub Category:

1. I have a limited support system, which may cause relapse while waiting for my inpatient bed date.

2. My drug use has impaired my ability to communicate with my family as well as impacted my ability to work.

3. My inability to express emotion triggers my belief that chemical use is the only way to relieve my pain.

4. My low trust level of others is blocking my ability to develop a support system for recovery.

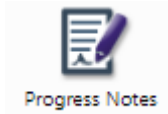
5. I have allowed my drugs and alcohol to become more important than my education.

I have a limited support system, which may cause relapse while waiting for my inpatient bed date.

Close Use Print Assign to Category

# PROGRESS NOTES

## Creating Progress Notes



- Create individual or group notes
- Individualize each client's note within the group note

File > Progress Notes

Select by: # Client Group

Search by: Last Name

Begins with or matches: Search Display All

Name	SSN	Client Reference #
Carmona, Alejandra	607018856	
Catts N, Sam E.	333739999	666666
Ch, Ceira K.	323790990	679999
Chenavagh, Debra G.	121212121	5123
Chooze, Robyn A.	380202023	
Cherry, Hysol J.		-139

Retain Filters

Note Selection	Session Date	Code	Description	File/Sign Status	Print/File Selection
Enter Date	Enter Date			Apply Filters	

No records to display.

Buttons: Add Group Note, Add Individual Note, Add From Schedule, View Note, Delete Note, Print, File and Sign, Close

File > Progress Notes > Group Notes

Choose a Group: Anger Management Group Setup

Client Name	SSN	Client Reference #	Select All
Adams, Leo M.	405289855		<input checked="" type="checkbox"/>
Espinosa, Daniel S.	111115079		<input checked="" type="checkbox"/>
Falson, David A.	565789983	95	<input checked="" type="checkbox"/>
Malone, Richard			<input checked="" type="checkbox"/>
Mich, Luddy K.			<input checked="" type="checkbox"/>

File > Progress Notes > Add Note

Note Info

Group: Anger Management Co-Facilitator: [Dropdown]

Clinician: John Training

Session Type: [Dropdown] Sort by Description

Session Date: Enter Date Time: Start: [Dropdown] to End: [Dropdown] Duration: [Dropdown]

Group Note:

Enter Individual Note for Group Members:

Adams, Leo M.

Level of Care: No Episode Assigned

Diagnosis: [Text Area]

Espinosa, Daniel S.

Level of Care: No Episode Assigned

Diagnosis: [Text Area]

Buttons: Back, Statements, Save, Cancel

## Using Statement Templates:

- Create statements to assist with commonly used phrases and templates

File > Progress Notes > Add Note

Note Info

Client: Caste N, Sam E. Level of Care: No Episode Assigned

Clinician: John Training Co-Facilitator:

Session Type: Sort by Description

Session Dates: Enter Date [ ] Time: Start: [ ] to End: [ ] Duration: [ ]

Diagnosis: [ ] Diagnose View To Print

Note:

Statements Save Cancel

File > Progress Notes > Statements

Statement Type:  Individual  Group

Available Statements:

Current issues treatment goals status update 1, 2, 3

D A P

E/M Statement

Exercise: S: O: all clients participated in the scheduled exercise session. A: All clients enjoyed the session. Focus Intervention Response Plan

Go to a Survivor's meeting tonight and meet with his survivor sponsor. There is much more that client is not Group members expressed their emotional stage. Participants were encourage to give feedback to each other I met with client to determine completion of assignment and he was not able to complete assignment. Client S: O: A: P: F10.00 severe alcohol dependence

S: O: A: P: F10.00 severe alcohol dependence

Use Add Edit Delete Print Exit



## Progress Notes – add from Scheduler

- Create progress notes from scheduler appointments.
- Clients that have been “checked-in” via scheduler will appear in the appointment transfer window.
- Information from the appointment will automatically fill data for the note

The image shows two overlapping software windows. The left window is titled 'File > Progress Notes' and contains a search interface with fields for 'Name', 'SSN', and 'Client Reference #'. Below the search fields is a table with columns for 'Note Selection', 'Session Date', 'Code', and 'Description'. At the bottom of this window is a toolbar with buttons: 'Add Group Note', 'Add Individual Note', 'Add From Scheduler', 'View Note', and 'Delete No'. A red arrow points from the 'Add From Scheduler' button to the right window.

The right window is titled 'File > Progress Notes > Appointment Transfer' and contains an 'Appointment Filters' section with 'Set Filters' and 'Clear Filters' buttons. Below this is a 'Select Check-Ins (Click headers to sort)' section with a table:

	Client Name	SSN	Client Reference #	Note Created	
▲	Date: 09/17/2015, 11:00 AM	Session Type: Anger Management	Subject: Anger Management		<input checked="" type="checkbox"/>
▲	Status: Attended				<input checked="" type="checkbox"/>
	Able, Jacob		JA19804344	No	<input checked="" type="checkbox"/>
	Adams, Leo M.			No	<input checked="" type="checkbox"/>
▲	Date: 09/17/2015, 9:00 AM	Session Type: Adult OP Admission	Subject: Adult OP Admission		<input type="checkbox"/>
▲	Status: Attended				<input type="checkbox"/>
	Abalone, John A.		54646464646	No	<input type="checkbox"/>
	Abernacky, Paul		gh46544565	No	<input type="checkbox"/>

# MEDICATION MANAGEMENT

## Medication Management:



- Manage client medications, problems, allergies as well as place orders through E-Prescribe functionality

Medication Management

Client  Prescription Notifications: 6 Pending

**Medications**

Medication  
No Medications Recorded.

**Allergies**

Allergy	Reaction	Onset Date
No Allergies Recorded.		

**Problems**

ICD9 Code	Description	Onset Date
No Problems Recorded.		

Reports Close

## CLIENT CHART (CHART MANAGEMENT)

### Chart Management



• File and sign records directly from modules in AccuCare to the client's chart

- Upload external documents and sign
- Manage Chart Documents allow you to assign (or re-assign) documents to episodes/levels of care for tracking
- Add From Library allows you to store forms that can be used to file and sign only but not require data entry fields (i.e. Release Forms)

Chart Management Total Space Remaining: 9.98GB

Select a Client: Adams, Leo 🔍

---

Filters

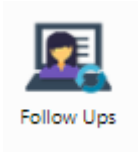
Filter(s): Select a filter Episode(s): Select Episode(s) Dates:  All Dates  Date Range Enter a Start Date to Enter an End Date Apply Filters Clear Filters

Select	Date	Episode	Description	Level of Care	Location	Created By	Document Type	Chart Category	Initial Signature	Date Signed	# Signatures
<input checked="" type="checkbox"/>	11/17/2015	--	<a href="#">Progress Not</a>	--	--	John Training	Progress note	Outpatient Progr	Ima N. Training	11/17/2015	1
<input type="checkbox"/>	11/17/2015	--	<a href="#">Assessment</a>	--	--	John Training	Evaluations	Unassigned	Ima N. Training	11/17/2015	1
<input type="checkbox"/>	03/19/2015	--	<a href="#">Consumer Rights and Respu</a>	--	--	John Training	Unassigned	Unassigned	John Training	12/31/2015	1
<input type="checkbox"/>	09/04/2014	--	<a href="#">rights and responsibilities</a>	--	--	John Training	Intake Docs	Substance Abuse	--	--	0
<input type="checkbox"/>	09/04/2014	--	<a href="#">cojac</a>	--	--	John Training	Evaluations	Intake	--	--	0
<input type="checkbox"/>	06/19/2014	--	<a href="#">client rights</a>	--	--	John Training	Consent Forms	Intake	--	--	0
<input type="checkbox"/>	06/19/2014	--	<a href="#">FACE SHEET</a>	--	--	John Training	Face Sheet	Intake	Ima N. Training	06/19/2014	1
<input type="checkbox"/>	01/28/2014	--	<a href="#">Detox Treatment Plan</a>	--	--	John Training	Treatment Suppo	RT Note	--	--	0
<input type="checkbox"/>	01/28/2014	--	<a href="#">Medical Evaluation</a>	--	--	John Training	Medication Mana	RT Note	--	--	0
<input type="checkbox"/>	12/10/2013	--	<a href="#">Sandy's note</a>	--	--	John Training	Progress note	Substance Abuse	--	--	0
<input type="checkbox"/>	12/10/2013	--	<a href="#">Sandy-P.N.</a>	--	--	John Training	Progress note	Outpatient Progr	--	--	0
<input type="checkbox"/>	12/10/2013	--	<a href="#">Leo's</a>	--	--	John Training	Recovery Suppor	Pictures	Ima N. Training	12/10/2013	1
<input type="checkbox"/>	10/02/2012	--	<a href="#">Discharge Note</a>	--	--	John Training	Unassigned	Unassigned	--	--	0

Upload File
Add From Library
Manage Chart Documents
View/Sign Off
Print
Delete
Close

# FOLLOW-UPS

## Follow ups



- Follow ups are directly integrated with the assessments
- Follow ups completed will calculate a composite score to compare to the baseline (captured in the biopsychosocial assessment)
- Follow ups can be done at any time after the assessment is complete

File > Open Follow Up

Search by:  Last Name  SSN  Client Reference #

Begins with or matches:

Name	SSN	Client Reference #
Adams, Leo	405-25-8965	

Select Questionnaire Type:

**Assessments:**

Date	Interviewer	Questionnaire	Select
09/24/2013	TRN	Adult	<input checked="" type="checkbox"/>
09/24/2013	TRN	Adult	<input type="checkbox"/>
09/24/2013	TRN	Adult	<input type="checkbox"/>
09/24/2013	TRN	Adult	<input type="checkbox"/>

**Follow Ups:**

Date	Interviewer	Questionnaire	Select
12/08/2015	TRN	Adult	<input checked="" type="checkbox"/>

# DISCHARGE/TRANSFER

## Discharge/Transfer:



- Transfer or Discharge client from any level of care through the Episodes of Care module
- Fill out appropriate information
- You can also close out the episode

The screenshot shows the AccuCare software interface for managing client episodes. The top window, titled 'Episodes Of Care', displays a table with columns for Level of Care, Status, Location of Service, Admit Date, Discharge Date, Transfer, and Discharge. A table row shows a client named John Abbracadabra with a status of 'Active' and a location of service of '(GVI) Grass Valley'. Red arrows point to the 'Transfer' and 'Discharge' buttons in this table.

The bottom window, titled 'Transfer Client - Smith, Jake', is a form for entering transfer information. It includes sections for Client Episode Data (Episode 1, Population Type: Adult, Date of Admission: 01/04/2016, Age at Admission: 28), Care Team (Staff: Paul Clinician, Case Manager: Paul Clinician), Discharge Summary Section (Goals Attempted During Treatment, Goals Met During Treatment), and a Summary section. Red arrows point to the 'Transfer' and 'Cancel' buttons at the bottom of this form.

# REPORTS: MANAGER REPORTS, DATA ANALYSIS, DATA QUERY

## Reports:

- **Manager reports** can provide clinical summaries for client, provider and agency
- **Data Query** provides a filtered export on a majority of data collected in AccuCare
- **Data Analysis** reports provide numerical and graphical reports based on a variety of national measures

