



Adirondack Health Institute

Lead • Empower • Innovate

Netsmart CareManager User Manual (Adult Health Home)

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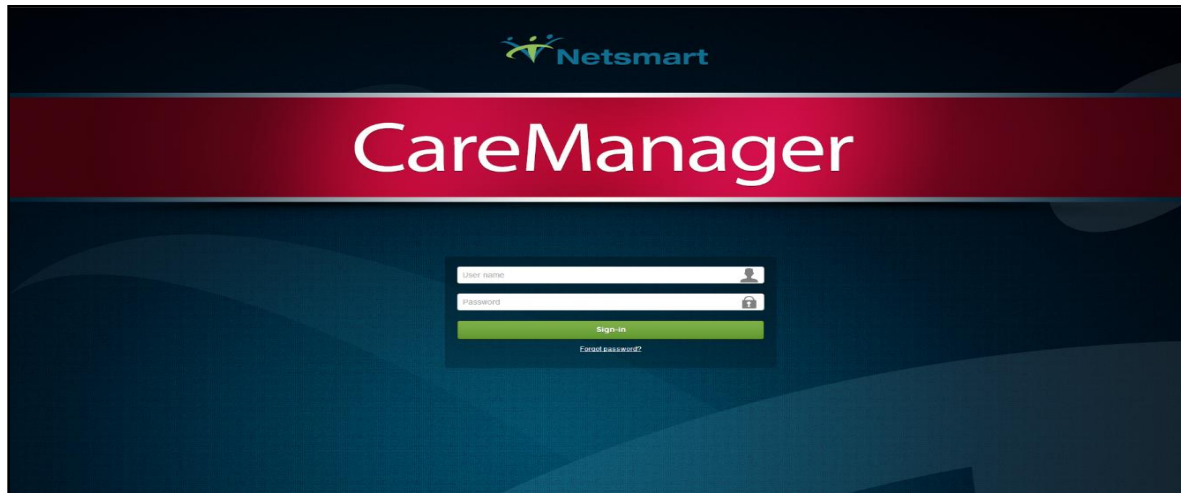
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Please note that this manual is subject to frequent change due to consistent system configurations to meet our Network's ever-changing workflow. If there are changes to workflow a new manual, or addendum, will be provided. If there are differences in drop downs, or system naming conventions, we may not issue a new manual as that may not impact the overall function of the system. If you see something in this manual that does not completely match, this may solely be due to us tweaking the system.

Accessing Netsmart CareManager

Go to <https://caremanager.netsmartcloud.com> using Internet Explorer (must be version 9 or higher), Firefox, Google Chrome, or Safari web browser. It is best practice to use Google Chrome.

Logging In



The Log-in Page is comprised of four elements:

User name- Your username is your email address (or an email address that is provided by the AHI if you are in CareManager for another Health Home)

Password- The initial (temporary) password will be given out by AHI. The password must then be changed to:

Minimum of 8 characters

1 capital letter

1 number

1 symbol

Sign-in Button

Forgot Password link

Password Reset

If you need a password reset, please contact the Health Home email healthhome@ahihealth.org.

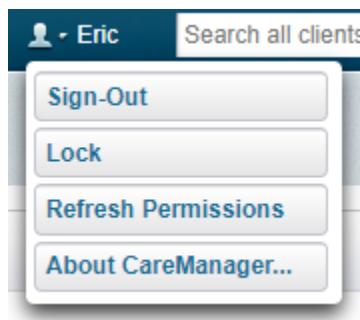
Locked Out of Your Account

If you are logging in and you use the wrong password too many times the system will inform you that your account has been locked for 5 minutes. Please note that the password reset will not work until those 5 minutes are up. If you need to gain access before those 5 minutes are up you can contact AHI.

Sign-Out/Lock Your Account

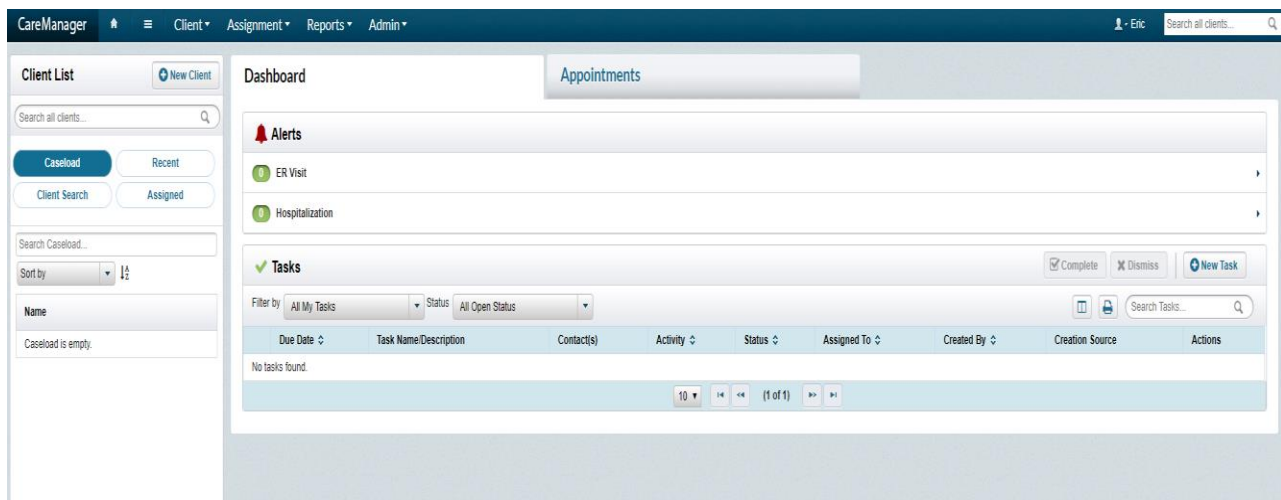
In order to protect your clients PHI you have the ability to either lock or sign out of CareManager. In the upper right-hand corner of the screen you will see your name, clicking on it will give you the following options:

- **Sign-Out**-This will log you out of the system and take you to the sign in screen where you enter your username and password
- **Lock**-This will lock the application allowing you to put in your password and pick up where you left off in the system
- **Refresh Permissions**-This will refresh your security settings if they have been updated by AHI
- **About CareManager...**-This will give you version information on CareManager

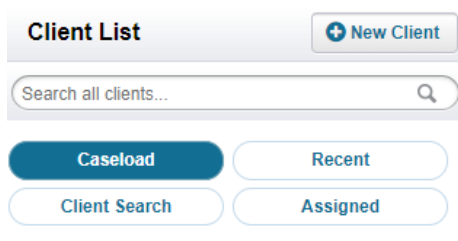


Dashboard

Once you sign into CareManager, you will land on your Dashboard page.



Dashboard Definitions



Client List is on the left side of the Dashboard

- **Caseload**-When Caseload is selected, you will see every client that is in your caseload.
- **Recent**-When Recent is selected, it will show all of the client's charts you have been in during your login session.
- **Client Search**-When Client Search is selected, it will show all of your client's that are currently in Search status. Client Search is synonymous with Outreach.
- **Assigned**-When Assigned is selected, it will show all clients are in assigned status. Assigned indicates a new referral assigned to you. This is someone who has not been outreached yet. Once a search Note is finalized for a client in Assigned status, he or she will be moved to Client Search status.

Under the client's name is their **Date of Birth (DOB)**, **Client ID**, **Chart** symbol and **Notes** button. You can click on the **Client's Name**, **Chart** symbol or **Notes** button to navigate your client's chart.

At the bottom of your client list there are navigation buttons where you can manually scroll through clients on your case list.

Another option will be to use the **Search Caseload** bar to avoid scrolling.

Alerts

The alerts function will let you know if a client has gone to the hospital or emergency room if a HIE consent is signed (HIXNY). These alerts will automatically show in the system with consent and will create a **Hallmark Event** within the system.

Tasks

Tasks are an optional feature and can be added as a reminder for you to track a task that needs to be completed. A task can be created from any tab in the member's chart, or on the **Dashboard**. All tasks can be reviewed:

On your homepage

View tasks per client in the Facesheet tab of the client's chart

By clicking on Tasks on the top of the screen when in a client's chart.

New Task

Task Name/Description*

Contact(s)*

Assigned To* Eric Nelson [Staff]

Created By Eric Nelson

Start Date* Due Date*

Activity

Status* New Priority Percent Complete %

Status Comments

Creating a Task

1. Click on **+New Task**
2. Add **Task Name/Description**
3. Add any **contacts** or **clients** that are involved with the task
4. If you are assigning this task to another individual type their name in the **Assigned To** field
5. Set a **Start Date** and a **Due Date**
6. Select **Activity** category
7. Select **Status** and **Priority**
8. Click **Save**

Tasks

Filter by All My Tasks Status All Open Status

	Due Date	Task Name/Description	Contact(s)	Activity	Status	Assigned To	Created By	Creation Source	Actions
<input type="checkbox"/>	04/30/2019	Create a training	Test		New	Eric Nelson	Eric Nelson	Tasks	Complete Dismiss Edit History

(1 of 1)

Ending a Task

1. Open the task you wish to end by selecting the **“gear”** icon associated with the task and select **Edit**
2. Change the **Status** to **“Completed”** or **“Dismissed”**
3. Click **Save**

Appointment Calendar

The appointment calendar feature in CareManager keeps track of your appointments with the client or appointments the clients may have solely within the system. From the dashboard:

Click on the **Appointments** tab

Click on any date on the calendar, or on the **+ Add Appointment** button

An **Appointment Details** window will open where you can enter the appointment information

Client Statuses in CareManager

Assigned- If a member has a status of “Assigned” this means the client has not been outreached to and has not had a **Client Search Note** completed.

Client Search- The client status will change from **Assigned** to **Client Search** when a *finalized Client Search Note* is entered into the system with a status of **Continue Search** or **Health Home Consent Pending**. Any member in Outreach and Engagement will have a status of “Client Search” until they either enroll into the program or come to the end of their 2 months of outreach (at which point they would be automatically opted out of the program).


Opt-Out/Withdraw- Any member who is closed from an outreach and engagement segment will have a status of “**Opt-out/Withdraw**.” These members can still enroll in the program and may be eligible for an additional outreach effort.

Enrolled- When a client moves from an outreach segment to an enrollment segment, you’ll see their status change from “**Client Search**” to “**Enrolled**”. If a client is directly enrolled into the program, their status will say “Enrolled” when they are initially assigned to your agency.

Discharged- When an enrolled client is no longer continuing in Health Home Services, the client must be **Discharged** from CareManager. It is important that the client be discharged accurately in order to reflect correctly in MAPP.

Demographics

The **Demographics** feature houses the **Personal**, **Contact**, **Health Home**, and **Demographic Survey** information for a client. Information includes name, address, health home assignment, marital status, religious affiliation, etc.

The small  in the top left-hand corner of the chart name will provide certain demographic information for quick access. This includes the Member's CIN, Date of Birth and Contact Information and any identifiers associated with the member.



Additional Client Information

Primary CIN: MP09811Z
 Date of Birth: 12/23/1987
 Email: me@aol.com
 Permanent Residence: 123 Main Street | Binghamton | NY | 13901
 Phone: 555-555-5555

Demographic Overview

- The Demographics feature is comprised of four sections
- Personal
- Health Home
- Contact
- Demographic Survey

Note: Fields with a **red asterisk *** indicate required fields. While other fields are not required, the more information entered for a client the better

Personal Information

The client's **Personal Information** is entered in this section. Information such as the Last Name, First Name and Medicaid Identified Gender will pull forward from the **Client Search** screen. In addition to the fields mentioned, the **Personal** information section also includes the following fields:

- Date of Birth
- Age
- Social Security Number (SSN)
- Identifier
- Alias History

Health Home Information



The client's **Health Home** section within Demographics houses the assignment information and other pertinent information for the Health Home. Information includes:

- Health Home Assignment
- Assignment Date
- Client Status
- **Source:** This field needs to be populated so that we can track where the referral came from.
- County of Fiscal Responsibility
- Advanced Directives – Medical
- Advanced Directives – Behavioral

Note: The Assignment Date will default to the current date when adding a client to CareManager for the first time. Once the client's Demographic information is saved, you are unable to edit the Health Home Assignment Date field.

Contact Information

The **Contact** section includes all information needed to contact a client (not the client's guardian, Case Manager, or similar). Information includes:

- Living Arrangements
- Email Addresses
- Addresses
- Phone Numbers

Demographic Survey Information

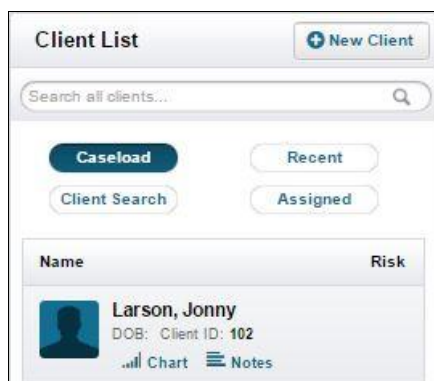
The **Demographic Survey** section contains more in-depth information about a client. Information includes:

- Primary Language
- Communication Preference
- Marital Status
- Education
- Religion
- Ethnicity
- Race
- Employment Status
- Preferred Gender
- US Veteran

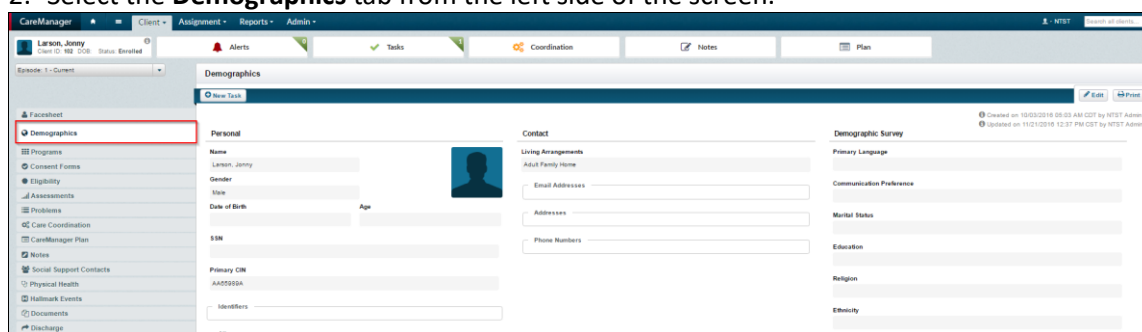
Navigating to Client Demographics

Demographics for a client already in the system can be accessed from the Home Screen.

1. From the **Dashboard**, select a client from the **Client List**.



2. Select the **Demographics** tab from the left side of the screen.

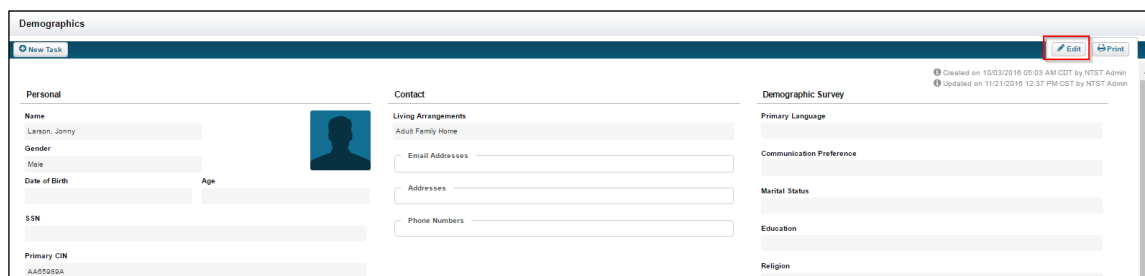


Note: Demographics can also be found by selecting the Client menu from the blue banner and selecting Client Chart and then Demographics from the list of features within the menu.

Editing Client Demographics

As information becomes available for a client, or information already gathered changes, the demographics information should be updated.

1. From the **Demographics** page, select the **Edit** from the top-right corner of the screen.



2. Once the demographics information has been updated, select the Save.

Programs

The **Program** page allows the user to associate a client to multiple Programs within an organization. Programs page will also display all Active Program(s) and Inactive Program(s). Programs will allow you to see different assessments and billing questionnaires depending on which ones you choose.

Program Overview

The Program page is comprised of three sections:

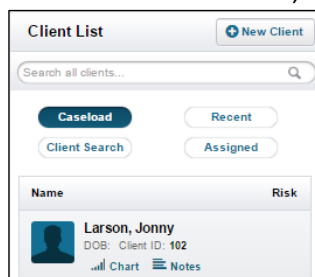
- Active Programs: The Program(s) the client is currently a member of.
- Inactive Programs: The Program(s) the client was previously a member of.
- Professional Network: Enrolled client's in the HH Program.

Programs						
New Program New Task						
Active Programs						
Name	Organization Name	Start Date	End Date	Current Episode	Record of Origin	Actions
HARP - Eligible	United Health Services	07/12/2017		✓	Direct Entry	View
Inactive Programs						
Name	Organization Name	Start Date	End Date	Current Episode	Record of Origin	
No Inactive Programs Entered						

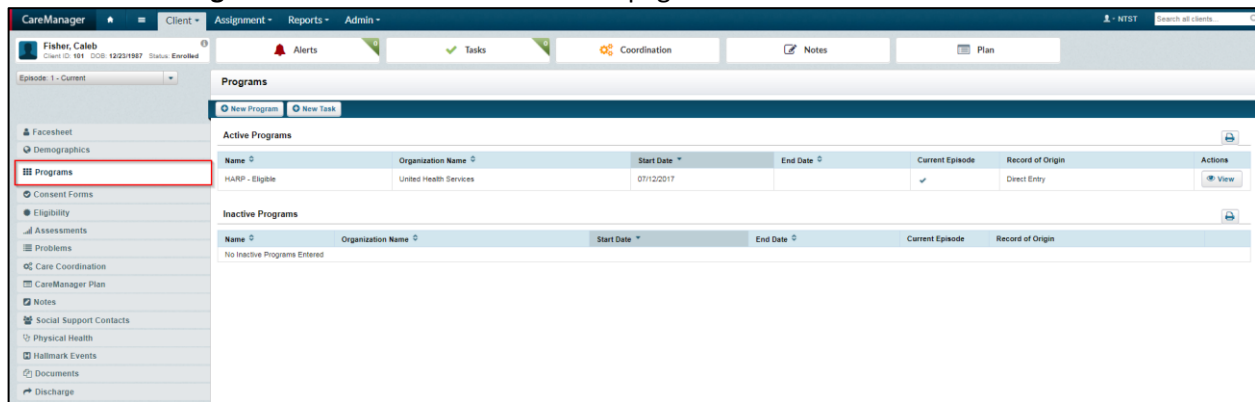
Navigating to Programs

Program information for a client already in CareManager can be accessed from the **Home Screen**.

1. From the **Dashboard**, select a client from the **Client List**.



2. Select the **Programs** tab from the left side of the page.



Adding New Program Information

New Program information can be added at any time from the Programs page.

1. Select the **+New Program** button.

The screenshot shows the 'Programs' page with a header bar containing '+ New Program' and '+ New Task' buttons. Below the header, there are two sections: 'Active Programs' and 'Inactive Programs'. The 'Active Programs' section contains a table with columns: Name, Organization Name, Start Date, End Date, Current Episode, Record of Origin, and Actions. A single row is visible with 'HARP - Eligible' as the Name, 'United Health Services' as the Organization Name, and '07/12/2017' as the Start Date. The 'Inactive Programs' section shows 'No Inactive Programs Entered'.

2. The **Programs** page will display. Select from the **Program** drop-down. Enter the **Start Date** for the program as well as the **End Date** if applicable.

The screenshot shows the 'Program Details' form. It has a 'Program' drop-down menu with 'HARP' selected. Below it, the 'Start Date' field is highlighted in red and contains '11/21/2016'. To the right, the 'End Date' field is also highlighted in red and is empty. The 'Organization' field is set to 'Capital Region Health Connections (CRHC)'. There is a '+ Program History' link at the bottom.

3. Select the **Save** or **Save & Close** button when once your selections have been made.
4. The green 'Save Successful' banner will show after you are brought back to the **Programs** page and you will now see the program under **Active Programs**.

The screenshot shows the 'Programs' page after saving. A green banner at the top says 'Save Successful'. Below it, the 'Active Programs' table now includes the new entry: 'HARP' with 'Capital Region Health Connections (CRHC)' as the Organization Name, '11/21/2016' as the Start Date, and a checkmark in the 'Current Episode' column. The 'Inactive Programs' section remains empty.

Editing Program Information

1. If a **Program** has been previously entered, select the **View** button to review the details.
2. You can select the **Edit** button to change the **Start Date** or **End Date**. You will also have a view of the **Program History**.

The screenshot shows the 'Program Details' form with the 'Program History' section expanded. The 'Program' field is 'HARP - Eligible' and the 'Organization' is 'United Health Services'. The 'Start Date' is '07/12/2017'. The 'Program History' table shows three entries for 'HARP - Eligible' with 'United Health Services' as the organization, all with a 'Start Date' of '07/12/2017' and 'Record of Origin' as 'Direct Entry'. The 'Last Updated' dates are '07/13/2017 02:10 PM CDT', '07/13/2017 03:25 PM CDT', and '07/13/2017 02:10 PM CDT'.

3. Select the **Save** or **Save & Close** button when finished.

Eligibility

The **Eligibility** page is where new Health Insurance (Medicaid) information can be entered and previously entered information modified. Medicaid information will be pulled down from MAPP initially, then it is up to your agency to maintain its accuracy. It is comprised of three sections:

- Active Health Plans
- Inactive Health Plans
- Health Plan History

The screenshot shows the 'Eligibility' page with two tabs: 'Eligibility' and 'New Task'. The 'Active Health Plans' section contains a table with columns: Start Date, End Date, Health Plan, Priority, Last Updated, Record Origin, and Actions. One row is visible with Start Date 11/21/2016, End Date, Health Plan United Health Care, Priority Primary, Last Updated 11/21/2016, Record Origin Client Eligibility, and a View button. Below this is the 'Inactive Health Plans' section with a similar table structure, currently showing 'No inactive health plans.' and a link to 'Health Plan History'.

When entering or editing Health Plan information the page is partitioned into three sections per plan.

- Eligibility Information
- Health Plan Information
- Subscriber Information

The screenshot shows the 'Eligibility' form with three main sections: 'Eligibility Information', 'Health Plan Information', and 'Subscriber Information'. The 'Eligibility Information' section includes fields for Assignment Date, Health Home, Social Security Number, Last Updated, Date of Birth, Medicare?, Medicare Status, and Record Origin. The 'Health Plan Information' section includes fields for Health Plan, Health Plan Code, Member ID, Priority, Start Date, End Date, and Active. The 'Subscriber Information' section includes fields for Relationship to Client, Gender, First Name, Middle Name, Last Name, Subscriber ID, Policy Group, and Date of Birth. Fields with a red asterisk indicate required fields.

Note: Fields with a **red asterisk *** indicate required fields. While other fields are not required, the more information entered for a client the better.

Adding New Eligibility Information

New Eligibility information/Health Plan information can be added at any time from the **Eligibility** page.

1. From the **Home Screen**, select a client from the **Client List**.

Client List + New Client

Search all clients...

Caseload Recent

Client Search Assigned

Name	Risk
Larson, Jonny DOB: Client ID: 102 Chart Notes	

2. Select the **Eligibility** tab from the left-hand column.

- Facesheet
- Demographics
- Programs
- Consent Forms
- Eligibility**
- Assessments
- Problems
- Care Coordination
- CareManager Plan
- Notes
- Social Support Contacts
- Physical Health
- Hallmark Events
- Documents
- Discharge

3. Select the **+Eligibility** button and then the **+Health Plan** button. This will bring you to the **Eligibility** screen.

Eligibility + New Task Save Save & Close Cancel

Eligibility Information

Assignment Date: 10/17/2016 Health Home: Capital Region Health Connections (CRHC) Social Security Number: Last Updated:

Date of Birth: Medicare?: Medicare Status: Record Origin:

Health Plan (New)

Health Plan Information

Health Plan*: Health Plan Code: Priority*: Active: Yes

Member ID: Start Date*: End Date:

Subscriber Information

Relationship to Client: Gender: First Name: Middle Name: Last Name: Subscriber ID: Policy Group: Date of Birth:

Note: Eligibility can also be found by selecting Client and then Eligibility from the CareManager toolbar.

Documenting Eligibility

This is where you will document eligibility information. The **Assignment Date** will auto-populate and cannot be modified.

1. The **Health Home**, **Date of Birth**, and **Social Security Number** fields will default to the information previously entered from the client's Demographics.

- From the drop-down enter the client's **Medicare?** and **Medicare Status** if applicable.

Eligibility Information			
Assignment Date 10/17/2016	Health Home Capital Region Health Connections (CRHC)	Social Security Number	Last Updated
Date of Birth	Medicare? Yes	Medicare Status Part B	Record Origin

Note: If the information entered into these fields are incorrect, the user should navigate back to the Demographics page and make the correct changes.

Note: Medicaid needs to be set as the primary insurance.

The **Last Updated** and **Record Origin** fields will auto-populate upon saving.

Health Plan (New)

- Select the **Health Plan** from the drop-down menu. The **Health Plan Code** will auto-populated based on the plan selected.
- The **Member ID** will auto-populate based from the client's previously entered information from the Demographics page.
- Select the appropriate **Priority** from the drop-down menu.
Note: Only one Health Plan can be identified as "Primary".
- Enter or select a **Start Date**.
Note: The "Start Date" should always be the date the client was referred.
- Enter or select an **End Date** if applicable.
- Choose if the plan is **Active** by selecting from the drop-down menu.

Health Plan Information	
Health Plan United Health Care	Health Plan Code
Member ID AA05080A	Priority* Primary
Start Date* 11/21/2016	End Date
Active Yes	
History	

Subscriber Information

- Select the subscriber's relationship to the client from the **Relationship to Client** drop-down.
- Select the appropriate **Gender** of the subscriber from the drop-down menu.
- Type in the **First Name**, **Middle Name**, and **Last Name** of the subscriber in the open text field.
- Enter in the subscriber ID in the **Subscriber ID** open text field.
- Enter the subscriber's policy group in the **Subscriber ID** open field.
- Select or enter the subscriber's date of birth in the **Date of Birth** field.

Subscriber Information

Relationship to Client
Self

Gender
Male

First Name
Jonny

Middle Name

Last Name
Larson

Subscriber ID
13241654

Policy Group
1321321

Date of Birth
11/28/2016

7. Once all the information has been entered, select the **Save** or **Save & Close** button.

Editing Eligibility Information

Eligibility information can be viewed and modified quickly and easily from the Eligibility page. If eligibility has changed, an end date is required to add a new Eligibility.

1. If Eligibility information has been previously entered, select the **View** button.

Eligibility						
Eligibility New Task						
Active Health Plans						
Start Date	End Date	Health Plan	Priority	Last Updated	Record Origin	Actions
11/21/2016		United Health Care	Primary	11/28/2016	Client Eligibility	View

2. Once viewing the **Eligibility Information** page, select the **Edit** button.

Eligibility

[Eligibility](#) [New Task](#) [Back](#) [Edit](#)

Eligibility Information

Created on 11/21/2016 11:37 AM CST by NTST Admin
Updated on 11/28/2016 04:39 PM CST by NTST Admin

Assignment Date
10/03/2016

Health Home
Capital Region Health Connections (CRHC)

Social Security Number

Last Updated
11/28/2016

Date of Birth

Medicare?

Medicare Status

Record Origin
Client Eligibility

Health Plan

Health Plan Information

Health Plan
United Health Care

Health Plan Code

Member ID
AA55986A

Priority
Primary

Start Date
11/21/2016

End Date

Active
Yes

History

Subscriber Information

Relationship to Client
Self

Gender
Male

First Name
Jonny

Middle Name

Last Name
Larson

Subscriber ID

Policy Group

Date of Birth

3. The modifiable fields are now enabled.

Once all the information has been updated, select the **Save** or **Save & Close** button.

Client Search (Outreach)

Once a client is processed and accepted through MAPP, the client will be assigned to a Care Management Agency for an Outreach segment (Client Search in CareManager). Outreach activities should begin once your agency accepts the assignment and the client appears in the system.

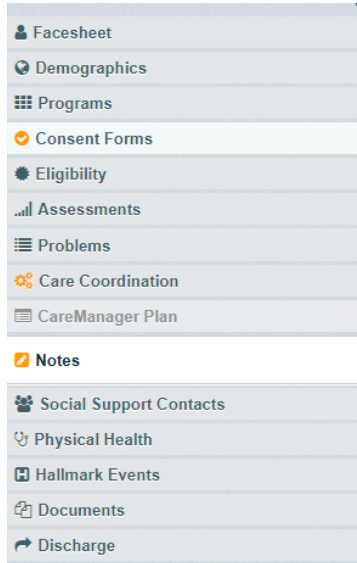
Note: All outreach efforts need to be documented regardless of whether or not an activity is billable. Please see the Outreach and Engagement Policy to see if an Outreach effort is completed that meets billing standards.



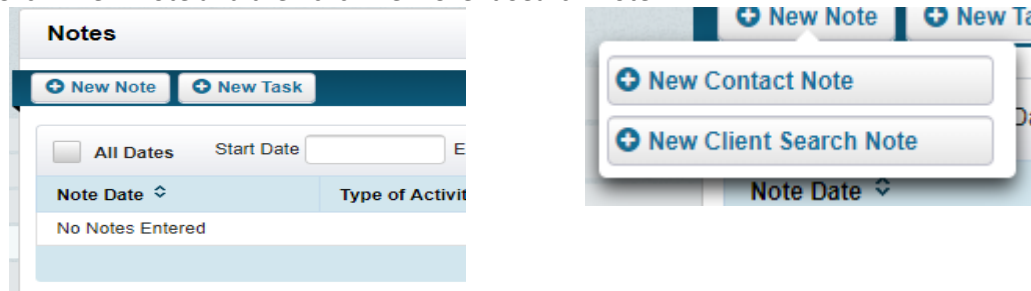
Billable Client Search Note Workflow

The **Client Search Note** is where you will track progress of your efforts to engage and enroll the client. To document billable outreach activities, you must complete **Client Search Note(s)**:

1. Click on the **Note** section of the client's chart.



2. Click +New Note and then click New Client Search Note



3. Complete the **Client Search Note** using the following fields:

Client Search Note Information

Note Detail

Note Type

Client Search Note

Note Date*

04/24/2019

Note Status*

Draft

Service Code*

1 - Outreach & Engagement

4 - No Bill Outreach

Note Detail

Note Type: Will automatically populate as Client Search Note to identify what note type you are in.

Note Date: The date you enter the note (will automatically default to current date when the note is finalized)

Note Status: Draft or Final. Finalized notes are used for billing purposes. Once the option of Final is saved the note is locked and it cannot be edited. Draft notes can be edited, but they will not support billing, and if you leave them in draft you cannot finalize any other notes or assessments.

Service Code: For all billable Outreach activities, use code **1 – Outreach & Engagement**.

Contact Detail

Client Search Date*

04/24/2019

Search Duration*

minutes

Search Type*

Location*

Contact Status*

Consent

No Consents found

New Consent

Contact Detail

Client Search Date: Date of the service

Search Duration: Amount of time spent during the service, can be any amount of time.

Search Type: Identifies how the contact or service was provided.

Location: Identifies where the service was performed.

Contact Status: Whether or not you were successful in contacting the target of the service.

Consent: The consent area will become available when you select “Client Enrolled” in the Client Search Status bar. This is where you will document the Health Home consent in your enrollment note.

Participants

☒ Tes, Holly

Assigned Team
None

Social Support Contacts
None

Referred Providers
None

Other Participants
Search...

Target*

Co-worker, Senior Care Manager, Supervisor
External Doctor/Provider
Family of Member
Member
Multidisciplinary Team
Other

Participants

This section will provide drop downs for the **Assigned Team**, **Social Support Contacts**, **Referred Providers**, and **Other Participants** once they have members on their care team. These drop downs are optional as the specifics about who was involved in the service will be captured in the note details.

Target: This field captures who the target of the encounter was as shown above.

Client Search Status *

☐ Continue Search ☐ Health Home Consent Pending ☐ Client Enrolled ☐ Client Opts-out of Health Home Services

Client Search Status

Continue Search: The client has not yet been found and the search continues.

Health Home Consent Pending: Contact with the client has been established yet no consent for services has been received.

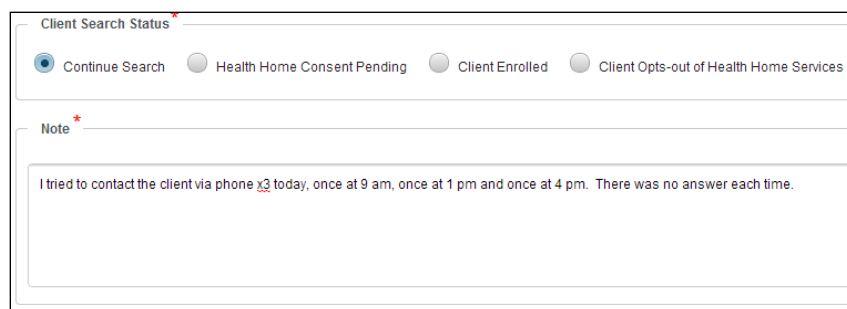
Client Enrolled: Contact with the client has been established and the client has agreed to services.

Client Opts-out of Health Home Services: Contact with the client has been made and the client declines services from a Health Home.

Continued Search – Client Search Status

If **Continue Search** is selected, the **+New Consent** button will remain disabled.

Enter information about the search activity in the **Note** field.



Client Search Status

☒ Continue Search
 ☐ Health Home Consent Pending
 ☐ Client Enrolled
 ☐ Client Opts-out of Health Home Services

Note

I tried to contact the client via phone x3 today, once at 9 am, once at 1 pm and once at 4 pm. There was no answer each time.

Once the form is completed, select the **Save** or **Save & Close** button.

Health Home Consent Pending – Client Search Status

If **Health Home Consent Pending** is selected, the **+New Consent** button and the **Follow-up Appointment** section will become enabled.

With the Follow-up Appointment section, you would be able to enter appointment information if you have it; the time for the appointment in the **Appointment Time** field and a location from the **Appointment Location** drop-down menu.

Enter information about the search activity in the **Note** field.



Client Search Status

☐ Continue Search
 ☒ Health Home Consent Pending
 ☐ Client Enrolled
 ☐ Client Opts-out of Health Home Services

Follow-up Appointment

Appointment Time: 01:00 PM
 Appointment Location: Other

Notes

Notes

If consent for services has been received, select the **New Consent** button in the **Contact Detail** section and fill out the applicable fields.

Once the form is completed, select the **Save** or **Save & Close** button.

Client Enrolled Option – Client Search Status

If **Client Enrolled** is selected, the **+New Consent** button and the **Follow-up Appointment** section will become enabled.

Enter information about the search activity in the **Note** field.

Client Search Status

☐ Continue Search
 ☐ Health Home Consent Pending
 ☒ Client Enrolled
 ☐ Client Opt-out of Health Home Services

Follow-up Appointment

Appointment Time: 10:00 AM

Appointment Location: Other

Notes

I visited with the client today and explained the services available. He agreed to services and consent to speak with him and his mother. Mrs. Smith were collected. We will be meeting again on Friday at 10 am to discuss in more detail his current circumstances.

Consent information needs be gathered at this time. Select the **New Consent** button in the **Contact Detail** section and fill out the applicable fields.

Once the form is completed, select the **Save** or **Save & Close** button.

Client Opt-outs of Health Home Services – Client Search Status

If the client does not want to participate or the client does not qualify for Health Home services, the **Client Opt-outs of Health Home Services** button should be selected.

The **Reason for Opt Out** field will then be enabled where you make a selection from the drop-down menu.

Enter information about the search activity in the **Note** field and upload the proper opt-out forms.

Client Search Status

☐ Continue Search
 ☐ Health Home Consent Pending
 ☐ Client Enrolled
 ☒ Client Opt-outs of Health Home Services

Reason For Opt-Out

Notes

Write update...

Note: When Opting Out the DOH 5059 Health Homes Opt-Out Form must be completed and added to Attachments.

Documenting a non-billable Client Search Note

Client Search Note Information

Note Detail

Note Type

Client Search Note

Note Date*

04/24/2019

Note Status*

Draft

Service Code*

1 - Outreach & Engagement

4 - No Bill Outreach

In order to document a non-billable Outreach efforts/activity, you must complete a **Client Search Note** using the steps listed above. To capture the fact this is a non-billable activity would be to select the **Service Code** of **No Bill Outreach**. All activities should be captured, so it is expected that note details will be completely filled out for both billable and non-billable notes.

Outreach Billing Questionnaire

For every month of active Outreach an Outreach Billing Questionnaire must be completed whether or not a billable service was done. If a billable service was done, a finalized questionnaire will trigger billing.

To access the Outreach Billing Questionnaire:

1. Select **Assessments** on the left-hand side of the client's face sheet.
2. Select **+New Assessment**.
3. From the drop down list select **+Outreach Billing Questionnaire**

Outreach Billing Questionnaire

Assessment Date	Entered By
04/01/2019	

Assessment Status*	Finalized By

— Outreach Billing Questionnaire

REMINDER: CHECK MEDICAID ELIGIBILITY IN EPACES EACH MONTH OF SERVICE

Was a core service provided to the member for the service month?

Is the member in Foster Care (under 21)?

Is the Member in AOT?

Assessment Date: This date will default to the first day of the month you are billing. Billing Questionnaires cannot be skipped, so if you forget to do one for the previous month you will need to finalize that one before moving onto the current month.

Entered By: This will populate with the name of the person completing the questionnaire.

Assessment Status: Draft or Final. Remember all questionnaires must be finalized in order to trigger billing.

Core Service: Select Yes if you completed a **Client Search Note** and intend to bill for the month. Select No if you do not intend to bill for the month.

Foster Care: Select Yes if your client is a minor and was in Foster Care that month. Select No if your client is a minor and NOT in Foster Care that month. Select N/A (over 21) if your client is not a minor.

AOT: Select Yes if your client is in AOT. Select No if your client is not in AOT.

- Complete the questionnaire as required. You must answer every question before you can finalize the questionnaire.

Note: A Client Search Note must be finalized for the month in order to save a finalized Outreach Billing Questionnaire in order to select Yes.

Enrolling the Client

Prior to enrolling the client utilizing the DOH 5055- Health Home Patient Information Sharing Consent, you must verify that they meet eligibility criteria which is detailed out in AHI's Qualifying Conditions Policy. The following is the process in CareManager in which we properly enroll a client into Health Home care management.

Eligibility Screening

Prior to enrolling we must ensure that the member is eligible for Health Home Care Management. Eligibility Screening will capture the Single Qualifying Condition or the Two Chronic Conditions that make someone eligible for this program. This screening will also capture the Risk Factors and functional deficits that the member has that is just as important as the diagnosis.

Eligibility Screening

Assessment Date*	Entered By
05/02/2019	

Eligibility Screening

1. Does the individual currently have 1 of the following conditions:

2. If no, does the individual currently have 2 of the following conditions:

Please Specify

3. Risk Factors: Check all that apply:*

4. Does the individual meet the Diagnostic eligibility and the Risk Factor eligibility criteria as defined by the state?*

Eligibility Screening History

Date	Assessment Score	Assessment Status
No previous Eligibility Screening assessments found.		

1. Does the individual currently have 1 of the following conditions:

▼

☐ HIV/AIDS (and the risk of developing another chronic condition)
☐ Serious Mental Illness

In this section you will choose the Single Qualifying Condition that makes the member eligible, if that is the reason they are coming into the program. Here you will either choose Serious Mental Illness (SMI), or HIV/AIDS.

2. If no, does the individual currently have 2 of the following conditions:

▼

☐ Asthma
☐ BMI > 25
☐ Diabetes
☐ Heart Disease
☐ Mental Health condition
☐ Other Chronic Conditions
☐ Substance Abuse Disorder

In this section you would choose “Other Chronic Conditions” if the member is eligible due to two or more chronic health conditions.

Please Specify

Specify what the condition (s) is/or depending on whether or not you answered question 1 or 2.

3. Risk Factors: Check all that apply:*

▼

☐ Deficits in activities of daily living such as dressing, eating, etc.
☐ Financial Needs
☐ Inappropriate ED use
☐ Lack of or inadequate connectivity with healthcare system
☐ Lack of or inadequate social/family/housing support
☐ Learning or cognition issues
☐ Non-adherence to treatments or medication(s) or difficulty managing
☐ Probable clinical risk for adverse event, e.g.: death, disability, inpatient
☐ Recent release from incarceration or psychiatric hospitalization
☐ Repeated recent hospitalization for preventable conditions either n

4. Does the individual meet the Diagnostic eligibility and the Risk Factor eligibility criteria as defined by the state?*

▼

Assessme

Question 3: Check all risk factors for the member.

Question 4: Answer Yes or No attesting to if they meet the Eligibility for the program.

Verifying Diagnosis and Uploading Documentation- Attachments

You must obtain verification of the qualifying diagnosis/es or eligibility determination. Scan and attach the documentation as follows:

The screenshot shows a web interface with two tabs at the top: 'Documents' and 'Attachments'. The 'Attachments' tab is selected. Below the tabs is a dark blue bar with a '+ New Attachment' button. Underneath is a table with the following headers: 'Creation Date', 'File', 'Description', and 'User'. The table body is empty, displaying 'No attachments.' At the bottom right of the table area, there are pagination controls showing '10', navigation arrows, and '(1 of 1)'.

1. Select the **Documents** tab in the client's Facesheet
2. Select the **Attachment** tab at the top of the screen
3. Select **+New Attachment**
4. Click **Select File to Attach** and search for the file
5. Select **Attach**

Refer to AHI's Attachment Description document for a list of required uploads when applicable to your members.

Entering Diagnosis/es in the Problem List

The **Problems** feature houses the **Problem Type, Chronicity, Onset, Severity, and Status** of the client's problems. Capturing the member's problems are crucial to many of CareManager's features such as documenting a **Care Plan** and **Referring to Providers**. The Primary Problem is the diagnosis that qualifies the client for care management services. If they have two chronic health conditions you will select one as primary, and one as secondary.

If any additional Problems need to be created, or edited/deleted please follow the below workflow:

Navigating to Problems

1. From the **Home Page**, select a client from the **Client List**.
2. Select **Problems** from the navigation list on the left.

Adding a New Problem

1. Select the **+New Problem** button. The **Problems Details** screen will appear.

Code System: The problems **Code System** consist of **SNOMED**, **DSM IV**, **DSM 5** and **ICD 10** searches. The SNOMED, DSM IV and DSM 5 may require a user to select the **ICD 10** code associated with the description or code chosen, if setup to do so.

Problem: The problem free text field will search for the problems entered based on the **Code System** selected.

Date Identified: This is the date a member was diagnosed with the problem. If this is unknown, use the date of the document that details out the diagnosis.

Date Recorded: This is the date the problem was added to CareManager.

Problem Type: This is the category the problem is associated with. This feature's functionality is tied to the **Care Plan**.

The **Care Plan's** functionality tied to the **Problem Type** is listed below. The **Care Plan** section dives into more detail.

- Adherence (Non-Problem Type Specific)
- Behavioral Health (Problem Type Specific)
- Physical Health (Problem Type Specific)
- Social Health (Problem Type Specific)
- Care Coordination Activities (Non-Problem Type Specific)

Chronicity: The **Chronicity** drop-down will have you select the frequency of the problem.

Onset: The **Onset** drop-down will have you select the time in the member's life that the problem started.

Severity: The **Severity** drop-down will have you select the harshness of the problem.

Status: The **Status** of the problem will allow you to select **Active** and **Non-Active** status's associated with the problem. This feature has functionality tied to the **Care Plan**. **Active** problems will be able to be pulled to a **Care Plan** and **Non-Active** problems will not be able to be pulled into the members **Care Plan**.

- Active
- Inactive
- Member chooses to not address
- Monitoring
- Resolved
- Unresolved

2. Select the **Code System** you would like to search.

3. Search for a problem in the **Problem** field by description.

4. The descriptions will appear below the search. Select the appropriate description.

Note: The first 'Problem' entered for a client will default as their **Primary** problem. Once more than one problem has been entered for a client, you can choose to change which 'Problem' should be **Primary**.

5. Enter the **Date Identified** and the **Date Recorded**

6. Select the **Problem Type** from the drop-down.

7. Select the **Chronicity** from the drop-down.
8. Select the **Onset** from the drop-down.
9. Select the **Severity** from the drop-down.
10. Select the **Status** from the drop-down.

Note: Depending on how your problem search is setup, you may be required to select the matching ICD 10 code associated with any non-ICD 10 problems added to the member's chart.

11. The **Record Origin** will auto-populate with **Direct Entry** when a user enters the problem.
12. Select the **Save** or **Save and Close** button to save the entered problem information.
13. The green '**Save Successful**' banner will present once you are brought back to the **Problems** page. You will also be able to view the added problem at that time.

Date of Verification	Problem	Problem Type	Onset	Status	Record Origin	Primary	Actions
11/01/2018	Mid recurrent major depression (disorder)	Behavioral Health	Child	Active	Direct Entry	true	View

Editing Problems

Problems can be viewed and modified within the problem feature. Depending in your permissions, options are available to **Delete** the problem, change the **ICD Code** associated with the problem and the **Problem Details**.

1. From the **Problems** page, select the **View** button for the **Problem** that needs to be modified.

Date Identified	Problem	Problem Type	Onset	Status	Record Origin	Primary	Actions
06/04/2018	Major depressive disorder, single episode, unspecified	Behavioral Health	Adult	Active	Direct Entry	No	View
06/01/2018	Bipolar disorder, current episode depression, mild or moderate severity, unspecified	Behavioral Health	Adolescent	Active	Direct Entry	No	View
05/01/2018	Encounter for administrative examinations, unspecified	Social Health	Unknown	Active	Problems Import	No	View
06/01/2008	Down syndrome, unspecified	Behavioral Health	Child	Active	Direct Entry	Yes	View

2. Select the **Edit** button. The editable fields will become enabled.

Problems

New Problem New Task Back Print **Edit** Delete

Created on 06/14/2018 10:24 AM CDT by NTST ADMIN
Updated on 06/14/2018 10:24 AM CDT by NTST ADMIN

Problem Details

Code System* ICD 10 Problem [F31.30] Bipolar disorder, crnt epsd depress, mild or mod sever, unsp Primary? ☐ Yes ☒ No

Date Identified* 06/01/2018 Date Recorded* 06/14/2018

Problem Type* Behavioral Health Chronicity* Acute Onset* Adolescent

Severity* Mild Status* Active Record Origin* Direct Entry

3. The previously entered information will display. This includes the **Problem, Diagnosis Information** and **Linked Referrals**.

Problems

New Problem New Task Save Save & Close Cancel

Created on 06/14/2018 10:24 AM CDT by NTST ADMIN
Updated on 06/14/2018 10:24 AM CDT by NTST ADMIN

Problem Details

Code System* ICD 10 Problem [F31.30] Bipolar disorder, crnt epsd depress, mild or mod sever, unsp Primary? ☐ Yes ☒ No

Date Identified* 06/01/2018 Date Recorded* 06/14/2018

Problem Type* Behavioral Health Chronicity* Acute Onset* Adolescent

Severity* Mild Status* Active Record Origin* Direct Entry

4. Once the **Problem** has been updated, select the **Save** or **Save and Close** button.

Deleting a Problem

1. Select the **View** button next to the problem you would like to delete.
2. In the upper right-hand corner select the **Delete** button.
3. A confirmation window will display. Select the **Yes** button.

Confirm

☒ Yes ☐ No

⚠ Are you sure you want to delete this problem?

Note: A problem cannot be deleted if it has already been added to a Care Plan.

Enrollment Note: Client Search Note

Once the **Eligibility Screen** and the **Problem(s)** (Diagnosis Information) is/are updated in the Problem List, a **Client Search Note** must be completed to move the client into an Enrolled status.

Consent
 No Consents found
[+ New Consent](#)

Client Search Status *

☐ Continue Search
☐ Health Home Consent Pending
☒ Client Enrolled
☐ Client Opt-out of Health Home Services

1. Select **Client Enrolled** in the Client Search Status bar to move the client into an enrolled status.
2. Enter note details regarding verifying eligibility and confirming criteria was met for enrollment into a health home and who has consented to Health Home services for the client

Health Home Consent Information
Updated on --/-- by

Consent Type
 Consent Type
 Health Home
 Consenter Type*

Consent Dates
 Start Date*
 04/25/2019
 End Date

 Expiration Date

Rescind Options
 Rescind Consent

 Rescind Date

Data Sharing Type
 Select a Health Home*
 AHI - Test

Client Opt-In/Out
 The client has consented to receive services from the listed Health Home for the coordination of their care.*

3. Add the **Health Home Consent (DOH 5055)**
 - a. Click on the **+New Consent** in the **Client Search Note**
 - b. Update the **Start Date** to the date the client's parent/guardian/legally authorized representative signed the consent (DOH 5055)
 - c. Click on the **Client Opt-in/Out** drop down and select **Client Opt-in**
 - d. Leave **End Date** and **Expiration Date** Blank
 - e. Enter any comments at the bottom of the consent and click the **Add Comment** button. If consent to enroll was provided by the member's parent/guardian/legally authorized representative, include that information in the comments field
 - f. Click **Save**
4. Mark the **Note Status** in the **Client Search Note** as **Final** and click **Save & Close**.

Consents

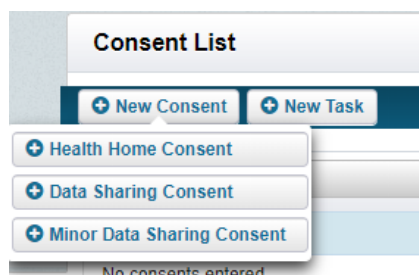
After the Health Home Consent to Enroll (DOH 5055) is signed and uploaded/added to CareManager there are other DOH consents that need to be obtained and uploaded.

Data Sharing Consent DOH 5055

1. From the **Home View**, select a client. The client **Facesheet** will display.



2. Select **Consent Forms** from the left side of the client chart. The **Consent List** will display. If there is previously entered consents, you will see them here.
3. Select the **+New Consent** button. A drop-down menu will appear allowing the user to select which consent form they want to complete, **Health Home Consent** or **Data Sharing Consent**.



4. Select the **+Data Sharing Consent** button. This will open the client's **Data Sharing Consent** form.

Data Sharing Consent Information

Created on --/--/-- by --
Updated on --/--/-- by --

Consent Type

Consent Type
Data Sharing

Consenter Type*

Consent Dates

Start Date*
05/02/2019

End Date

Expiration Date

Rescind Options

Rescind Consent

Rescind Date

Data Sharing Type

Data Sharing Type*

5055
Electronic HIE
Functional Assessment Consent
Health Home Release of Educational Records
HIE
Other
Provider
Support Network Contact

Client Opt-In/Out

The client has provided the following status of consent for the sharing of their information with the listed entity.*

	Share	Emergency
Sensitive Information		
HIV Status	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Medication List	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pregnancy Status	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Status	<input checked="" type="checkbox"/>	<input type="checkbox"/>

Complete the Data sharing Consent Information fields:

Start Date: Date the consent was signed.

End Date (if applicable): Date the consent was rescinded.

Expiration Date (if applicable): Use only if there is a time-limited consent.

Consenter Type*

Parent
Guardian
Legally Authorized Representative
Member/Self Individual is 18 years of age or older
Individual is under 18 years old, but is a parent, or is pregnant, or is married

Consenter Type: The name of the consenting individual.

Data Sharing Type: Please see below for the different data sharing types captured in this form.

Client Opt-In/Out: Only use the "Opt-In" feature. This is when it has been confirmed consent has been obtained.

Note: Depending on which Data Sharing Type is selected, there may be additional options to fill in.



5. Fill out the appropriate **Data Sharing Information** the client would like shared. All **Share** checkboxes will be selected by default. If the client would only like their information shared in case of an **Emergency**, select that option. You can only have **Share** or **Emergency** selected for **Client Care Information, Assessment Information, Documents, Sensitive Information** and **Care Coordination**.

Data Sharing Information		
Client Care Information	Share	Emergency
Appointment History	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Demographics Information	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Eligibility	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Health Home Discharge Information	<input checked="" type="checkbox"/>	<input type="checkbox"/>
History of Hospitalizations	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Physical Health	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Problem List	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Support Network: Contact List and Consent to Contact	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Assessment Information	Share	Emergency
FACT GP Assessment Results	<input checked="" type="checkbox"/>	<input type="checkbox"/>
General Assessment Results	<input checked="" type="checkbox"/>	<input type="checkbox"/>
PHQ-9 Assessment Results	<input checked="" type="checkbox"/>	<input type="checkbox"/>
SF12 Assessments Results	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sensitive Information	Share	Emergency
HIV Status	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Medication List	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Pregnancy Status	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Substance Abuse Status	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Care Coordination	Share	Emergency
CareManager Notes	<input checked="" type="checkbox"/>	<input type="checkbox"/>
CareManager Plan	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Client Search Notes	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Contact Notes	<input checked="" type="checkbox"/>	<input type="checkbox"/>
List of Referred Providers	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Documents	Share	Emergency
Attachments	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HAP	<input checked="" type="checkbox"/>	<input type="checkbox"/>

6. Write in your **Comments** at the bottom of the page. All comment history will show below the field if there have been previous comments for the client.

Comments

Comments

Add Comment

7. Select the **Save** or **Save & Close** button to finish the **Data Sharing Consent**. The green **“Save Successful”** banner will appear along with the consents.

Data Sharing Types

The **Data Sharing Type** are as follows:

Data Sharing Type

Data Sharing Type*

5055
Electronic HIE
Functional Assessment Consent
Health Home Release of Educational Records
HIE
Other
Provider
Support Network Contact

5055- Used to document the DOH 5055 when signed.

The screenshot shows a form titled 'Data Sharing Type'. It has a dropdown menu labeled 'Data Sharing Type*' with 'Electronic HIE' selected. Below it is another dropdown menu labeled 'Select an HIE*' with 'HIXNY' selected.

Electronic HIE- Select this type to document the receipt of a signed Health Information Exchange (HIXNY) consent

Functional Assessment Consent- Do not use. You do not need to document the receipt of the signed DOH-5230 in the consent forms tab.

Health Home Release of Educational Records – Do not use. You do not need to document the receipt of the signed DOH-5203 in the consent forms tab.

Other—Select this type if the consent you are documenting does not fit into any other category

The screenshot shows a form titled 'Data Sharing Type'. It has a dropdown menu labeled 'Data Sharing Type*' with 'Provider' selected. Below it is a search bar labeled 'Search for and select a Provider*' with the text 'Search for provider...' and a magnifying glass icon. There is also a link labeled 'Advanced Search'.

Provider – Select this type if you’re documenting a Provider that the client has given permission for you to share information with and is a member of the care team. Providers and Professional Networks will be gone over in greater detail later in the manual.

The screenshot shows a form titled 'Data Sharing Type'. It has a dropdown menu labeled 'Data Sharing Type*' with 'Support Network Contact' selected. Below it is a dropdown menu labeled 'Select a Social Support Contact*' with a search bar. To the right of this dropdown is a button labeled 'Or add a new Contact' and a button labeled 'New Contact'.

Support Network Contact – Select this type if you’re documenting a Social Support contact that the client has agreed to share information and is a member of the care team. You can select the social support name from the list of Social Supports documented in that tab. You can add a Contact from this screen as well.

Note: A scanned copy of all consents are required to be uploaded in the Attachments section of the chart.

Rescinding Consent

In the event a member/consenter no longer wants to share information with someone listed on the data sharing/minor data sharing consent the physical consent must be updated and re-scanned and uploaded into the member’s **Attachments** section of CareManager. Do **not** delete the previous version of the consent in the attachment’s areas.

In addition, if the person/entity removed from the consent was a member of the care team: you must also document this person/entity’s removal from the consent

1. Select **View** listed next to the party’s consent in the consent list

2. Select **Edit**
3. To rescind the consent, select the “**Rescind?**” check box. This will automatically input the end date to be the date “rescind” box is checked. If the person/entity was removed from the consent prior to you completing this step in the system, be sure to document this discrepancy in a contact note.
4. Do **NOT** switch the consent to **Opt-Out** in the Client Opt-in/out dropdown box. The system will automatically opt a client out of all consents when they are closed or discharged from the program.

If the person being removed from the consent was a member of the care team, be sure to end date their assignment on the care coordination page (in referred providers, professional network or social support contact section as applicable). Additionally, if the person was a social support, mark their contact status as “inactive.” Refer to the care team and social support sections for further details.

End-Dating Consent

You may need to “end-date” a consent if there is a consenter change for a client or if they no longer want to consent to be in the Health Home program.

By ending consent you must obtain new consents, including the consent to enroll, if they are to continue in the Health Home program. All previous steps to enter consent information must be followed and new consents must be scanned and uploaded into **Attachments** following the appropriate naming conventions. Previous versions of the consent should **not** be deleted from **Attachments**.

Contact Notes

Upon Enrollment all services will be documented in **New Contact Notes** until the client’s **Initial Care Plan** is finalized. Once the **Initial Care Plan** is finalized, all services and encounters can be documented as either New Contact Notes or New CareManager Notes, which will be gone over later in this manual.

Billable Contact Notes

1. Select the **Notes** tab of the client’s chart you are entering a note.
2. Select **+New Note** and then click **New Contact Note**
3. Complete the following fields:

Note Detail

Note Type
Contact Note

Note Date* 04/30/2019 Note Status* Draft

Service Code*

Type of Activity
None

CareManager Follow-Up Date

Entering a date will create a task in your tasklist for this note, when note is finalized.

Note Detail

Note Type: This will prepopulate to contain the type of note you are completing

Note Date: auto-populates to the date the note is finalized in the system

Note Status: Draft or Final. Ensure all information in the note is correct before you change the status to final.

Service Code: Non Billable or Comprehensive Care Management

Type of Activity: Select the core service provided in the activity/encounter being documented.

CareManager Follow-Up Date: Optional field for a Care Manager to enter a date for follow-up.

<p>Contact Detail</p> <p>Contact Date* 04/30/2019</p> <p>Contact Duration* minutes</p> <p>Contact Type*</p> <p>Location*</p> <p>Primary Reason for Contact*</p> <p>Other Reason for Contact*</p> <p>Contact Status*</p>	<p>Contact Detail</p> <p>Contact Date* 04/30/2019</p> <p>Contact Duration* minutes</p> <p>Contact Type*</p> <p>Location*</p> <p>Primary Reason for Contact*</p> <ul style="list-style-type: none"> AOT Summary Arrange / Confirm Transportation Confirm appointments Diligent Search Efforts Discuss member concerns Follow up with a member Other Request documentation Review of chart <p>Supervisory Review</p>
---	---

Contact Detail

Contact Date: The date that the service took place.

Contact Duration: Document the number of minutes the activity took you to perform

Contact Type: Select the way in which the contact was attempted or completed.

Location: The location where the Care Manager is at when the activity was performed

Primary Reason for Contact: Select the option that describes the activity/encounter being documented.

Please see above for the complete drop down.

Contact Status: Contact Achieved or Unable to Contact

Participants

☐ Tes, Holly

Assigned Team

None

Social Support Contacts

None

Referred Providers

None

Other Participants

Search...

Target*

- Co-worker, Senior Care Manager, Supervisor
- External Doctor/Provider
- Family of Member
- Member
- Multidisciplinary Team
- Other

Participants

Box next to client's name, Assigned Team, Social Support Contacts, Referred Providers, Other Participants will have a drop-down option once contacts and providers are entered. Your note detail section should include specifics about who was involved in the activity being documented as well.

Target: Who the target of the activity was.

Notes

Notes

Notes*

Write update...

Notes: This section is where you write the narrative of the contact, expanding on the information in the drop downs, and ensuring it was a billable service.

Documenting a Non-Billable Contact Note

Follow the instructions detailed above to document Contact Notes that capture **non-billable work**. Non-billable Contact Notes are used for keeping track of services that are not part of the Care Plan, or that do not meet the standard for core services. These notes are also used for changes of status:

Status Update

Statuses: This section is where you would move client's to **Diligent Search Efforts**, or into an **Excluded Setting**. You will also need to provide a reason for the change, and any additional comments that will clarify why there was a status change. To move them back into an Enrolled status you will need to enter another **Contact Note** and select the Status of Enrolled.

If you do not move the status back to Enrolled by the time allotted by the DOH (3 months for Diligent Search, 6 months for Excluded Setting) your client will automatically be Discharged.

HML (High, Medium, Low) Billing Questionnaire

Once a client is enrolled, a Billing Questionnaire must be completed monthly even if a billable service did not occur. For members with a billable service, the HML Billing Questionnaire serves as the attestation that a billable activity was completed. The HML Billing Questionnaire will be submitted to MAPP and/or to the payor for processing each month.

All questions will be prefilled from the previous month's questionnaire with the ability to edit the answers. You must complete one assessment for each month the client is enrolled. The system will not allow skip months.

1. Select the **Assessments** tab
2. Select **+HML Billing Questionnaire**

Assessments

New Assessment
New Task

HML Billing Questionnaire

Assessment Date

05/01/2019

Entered By

Assessment Status*

Finalized By

Primary Diagnosis

Diabetes mellitus (disorder)

Set Current Primary Diagnosis

HML Billing Questionnaire

REMINDER: HAVE YOU CHECKED EPACES TO CONFIRM MEMBER ELIGIBILITY?

1. Was a core service provided to the member for the service month?

Yes

1a. Date of core service provided*

2. Please select the conditions most applicable to the member. Selections should not exceed eight chronic conditions.

Diabetes

3. Is the member HIV positive?

No

Assessment Date: This date will automatically default to the first day of the month, starting the first month a member is enrolled.

Entered By: The name of the person completing the HML.

Assessment Status: Draft or Final. Only finalize the HML when you know that all billable activities have been entered for the month.

Finalized By: This will prepopulate with the name of the person finalizing the HML.

Primary Diagnosis: This should match the identified primary problem in the system. To verify the diagnosis is correct, click **Set Current Primary Diagnosis**. Remember that the Primary Diagnosis identified must be a qualifying condition for enrollment in the Health Home program.

- 1) **Was a core service provided to the member for the service month?** Yes or No answer. If you answer yes you will be asked for the date of core service.
- 2) **Please select the condition most applicable to the member.** Identify the qualifying chronic conditions that determined the member's eligibility for the Health Home. This should match the primary diagnosis.

4. Is the member homeless?

No

4a. Did the member meet the HUD 1 definition of homelessness within the past 6 months?*

No

5. Has the member been released from incarceration within the past year?

No

6. Has the member been discharged from an inpatient stay for a mental or physical illness within the last year?

The member was not discharged fr...

7. Has the member been discharged from an inpatient stay for substance abuse within the last year?

No

8. SUD Active Use/Functional Impairment?

No

9. Is the Member in AOT?

No

10. Is the Member in ACT?

No

11. Is the member an Adult Home Plus member?

No

12. Is the member in the expanded HH+ population?

No

13. Is the member in Foster Care (under 21)?

No

14. Did the member complete the UAS Complexity High Risk Assessment?

No

☐ I have reviewed all questions on this questionnaire for accuracy

Questions 4-14: If there is a Yes answer to these questions, additional questions will populate to capture the most information about the member.

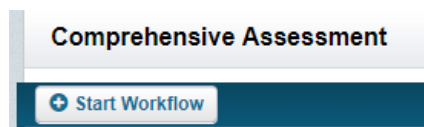
After all questions are answered you will need to attest that all of the responses are accurate.

Comprehensive Assessment



The Comprehensive Assessment is found at the bottom of the left-hand side of the client's chart under Additional Forms.

1. Select **Comprehensive Assessment**



2. Select **Start Workflow**
3. At the top of every section will be one, or two questions you must answer in order to progress through the Comprehensive Assessment.

Adult/Child*

Initial/Annual Assessment*

Adult/Child- Select if the Assessment is for an Adult or a Child client, this section will trigger questions that are unique to either of these populations.

Initial/Annual Assessment- The Initial Assessment option is for new assessments and will not pull any information over from any previous assessments (if applicable). The Annual Assessment option will pull information from the last assessment (if applicable).

4. Depending on the section the **Comprehensive Assessment** can push/pull information from the chart.

Add Current or New Problems

— Add Current or New Problems —

[+ Add Row](#)

- On select sections you are able to directly input **Problems** that will push to the **Problems** section of the chart.
- You will also be able to tie Providers to **Problems** in select locations as well.

Form Name	Validation Status	Actions
Demographics	Missing Required Fields	View Form
Social Determinants of Health	Missing Required Fields	View Form
Benefits	Missing Required Fields	View Form
Medical	Missing Required Fields	View Form
HIV/AIDS	Missing Required Fields	View Form
Trauma	Missing Required Fields	View Form
Mental Health Services	Missing Required Fields	View Form
Medications	Missing Required Fields	View Form
Substance Use Disorder	Missing Required Fields	View Form
Risk Behaviors and Factors	Missing Required Fields	View Form
Justice	Missing Required Fields	View Form
Activities of Daily Living	Missing Required Fields	View Form
Social Support	Missing Required Fields	View Form
Developmental Milestones	Missing Required Fields	View Form
School Academic Function	Missing Required Fields	View Form
Employment	Missing Required Fields	View Form
Priorities	Missing Required Fields	View Form

- When you complete the **Comprehensive Assessment** you will be presented with a screen where you can review all sections to see if you have missed questions, and you can instantly go back to the section and complete as needed.

Creating the Interdisciplinary Care Team in CareManager

The Care Team can consist of internal resources at your agency, external providers that the client/family reported during the assessments and social support contacts who play an active role in the member's care. Every care team member must be listed on the Care Coordination page of the client's chart.

Social Support Contacts

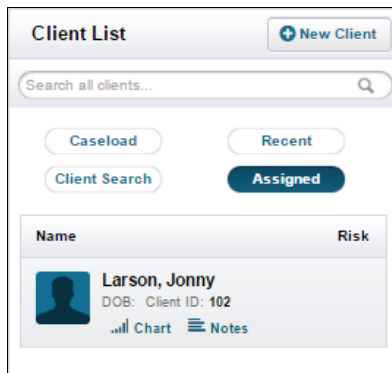
A client's **Social Support Network** can be a key factor in helping them stay engaged with their care. A Social Support Contact(s) can be defined as a client's mother, father, step-parent, sister, brother,



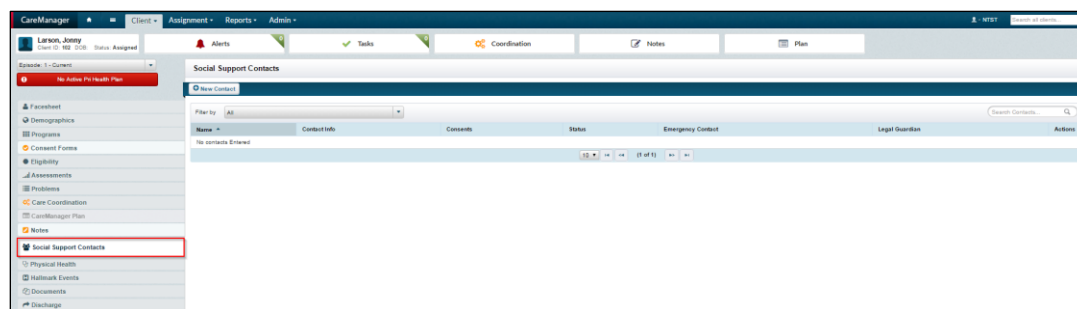
relative, spouse, sponsor, etc. Once the Social Support Contacts have been added into CareManager, those supports can be assigned as part of the client's Care Team, if appropriate. Social Support Contacts may also have a Data Sharing Consent on record if the client has provided permission for the Social Support Contact to have access to their care information.

Adding Social Support Contacts

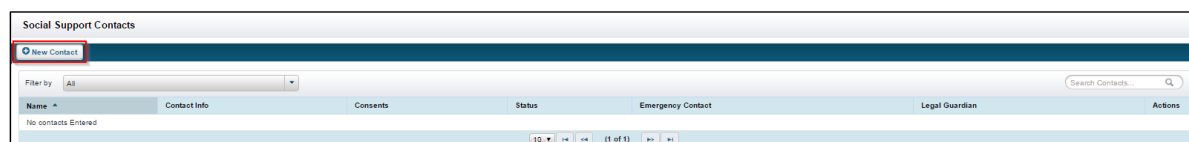
1. From the **Home View**, select a client from the **Client List**.



2. Select **Social Support Contacts** tab from the left side of the page.



3. From the **Social Support Contacts** tab, you will be able to see if any social supports have been added or not.
4. To add a new support contact select the **+New Contact** button from the top left corner of the page.



5. Once selected, the **Personal**, **Contact**, and **Comments** section becomes editable.
6. Fill in the **Last Name**, **First Name**, **Contact Status**, **Relationship to Client**, and if the support is a **Legal Guardian** and if the support is an **Emergency Contact**.

Personal

Last Name* Fisher **First Name*** Caleb

Contact Status Active

Relationship to Client Friend(s)

Legal Guardian to Client
☐ Yes ☒ No

Emergency Contact
☒ Yes ☐ No

7. Enter the **Email Address**, **Addresses**, and **Phone Numbers**, if applicable.

Contact

Email Address

Addresses

+ New Address

Phone Numbers

+ New Phone

Note: Only fields with a **red asterisk *** are required to be filled in. You are always able to edit and enter information as it comes in.

8. To enter an **Address**, select the **+New Address** button. You can add as many addresses as you would like by continuing to select the **New Address** button.

Addresses

Address

Type
Permanent Residence

Business Name

Street* 123 Main Street

Line 2

City* Overland Park

State* Kansas

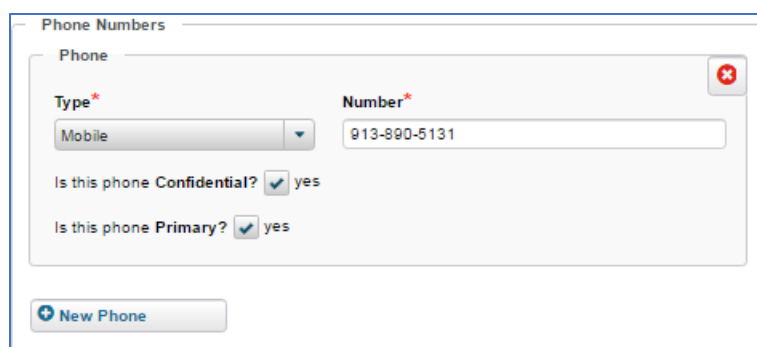
County

Zip / Postal Code* 66212

+ New Address

Note: You can select the **red 'X'** in the top right corner to remove the address if needed.

9. To add a **Phone Number**, select the **+New Phone** button. Select the **Type** from the drop-down menu and enter the **Number** in the open field. Select the checkboxes for **Confidential** and **Primary** if applicable.



Phone Numbers

Phone

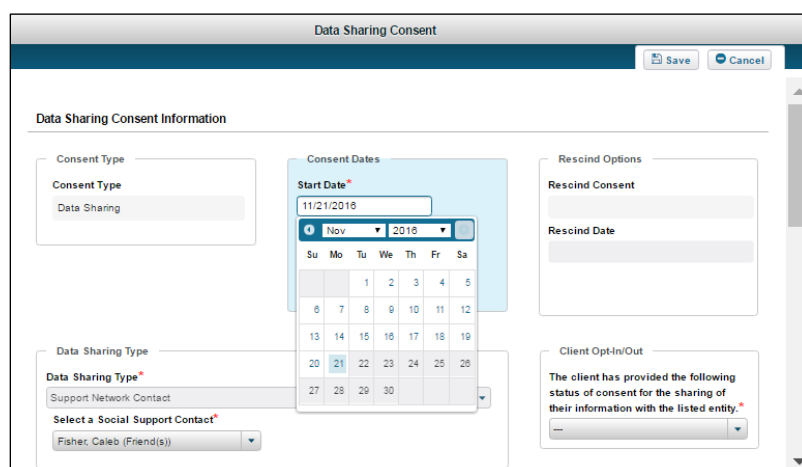
Type* Number*

Is this phone Confidential? ☒ yes

Is this phone Primary? ☒ yes

[+ New Phone](#)

10. If **Consent** has been given to the Support Contact, select the **+New Consent** button. The **Data Sharing Consent** modal will display.



Data Sharing Consent [Save](#) [Cancel](#)

Data Sharing Consent Information

Consent Type
Consent Type
Data Sharing

Data Sharing Type
Data Sharing Type*
Support Network Contact
Select a Social Support Contact*
Fisher, Caleb (Friend(s))

Consent Dates
Start Date*
11/21/2016
Nov 2016
Su Mo Tu We Th Fr Sa
1 2 3 4 5
6 7 8 9 10 11 12
13 14 15 16 17 18 19
20 21 22 23 24 25 26
27 28 29 30

Rescind Options
Rescind Consent
Rescind Date

Client Opt-In/Out
The client has provided the following status of consent for the sharing of their information with the listed entity.*
—

11. Enter the **Consent Dates**. The date will auto-populate with today's date.
12. From the Client Opt-in/Out drop-down, select Client Opt-in.
13. Make sure all applicable **Data Sharing Information** is checked correctly.
14. Enter any comments in the **Comments** section of the consent.
15. Select the **Save** button once all information is entered.
16. The green banner stating 'Save Successful' will show on the **Social Support Contacts** page.
17. Enter any **Comments** that are needed at the bottom of the **Social Support Contacts** page. You will also be able to see a history of any comments added to the social support.



COMMENTS

[Add Comment](#)

Comment History
11/21/2016, by NTST Admin
Caleb is Jonny's friend and helps with Jonny's goals. He sometimes will assist Jonny with transportation

18. Select the **Save** or **Save & Close** button to finish adding the **Social Support Contact**

Assigning a Social Support Contact



Once a Social Support Contact has been added to CareManager, the Support Contact needs to be assigned to the client's Care Team, if appropriate.

1. From the **Home Page**, select the client from the **Client List**.
2. Select the **Care Coordination** tab from the left of the screen. The **Care Coordination** screen will display as shown below.

The screenshot shows the CareManager interface with the 'Care Coordination' tab selected. The left sidebar lists various navigation options, with 'Care Coordination' highlighted. The main content area displays several sections: 'Coordinating Agency Assignment' with a table showing 'Alliance for Positive Health'; 'Team Assignment' with a table showing 'Care Manager' as the role; 'Social Support' with a message 'No Social Supports found'; 'Professional Network' with a message 'No professionals found'; and 'Provider Referrals' with a search bar and filters.

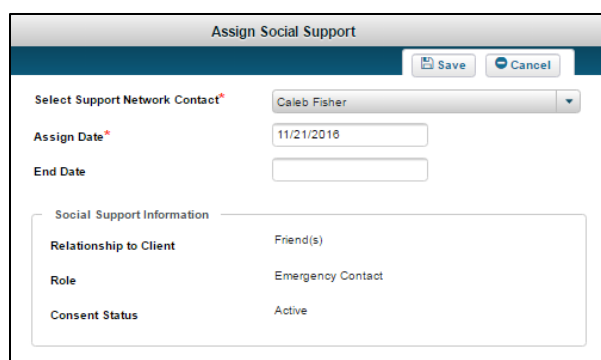
3. If there has not been a previously entered **Social Support** assigned in **Care Coordination**, a note stating 'No Social Supports found' will display.

The screenshot shows a 'Social Support' modal with a 'Date Assigned' field and a message 'No Social Supports found.'.

4. Select the **Assign Social Support** button. The **Assign Social Support** modal will display.

The screenshot shows the 'Assign Social Support' modal. It has a 'Save' button and a 'Cancel' button. The main content area includes a 'Select Support Network Contact' dropdown, 'Assign Date' and 'End Date' input fields, and a 'Social Support Information' section with fields for 'Relationship to Client', 'Role', and 'Consent Status'.

5. From the drop-down menu, select the correct **Support Network Contact**. The **Social Support Information** will auto populate from the **Social Support Contacts** information entered.
6. Enter the **Assign Date** field.



Assign Social Support

Save Cancel

Select Support Network Contact* Caleb Fisher

Assign Date* 11/21/2016

End Date

Social Support Information

Relationship to Client Friend(s)

Role Emergency Contact

Consent Status Active

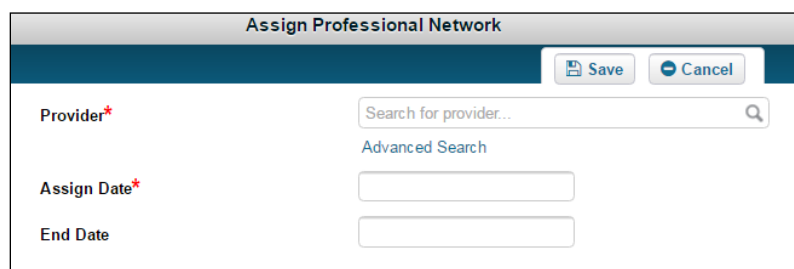
7. Enter an **End Date** if applicable.
8. Select the **Save** button when finished. Information selected will save and the social support is now assigned to the client.

Professional Network

The providers listed in the **Professional Network** are those who are already involved in the member's care as well as non-problem specific providers such as a pharmacy or preferred hospital.

Professional Network						Assign Provider
Dates Assigned	Name	Provider Role	Primary Role	Consent Status	Actions	
No professionals found.						
10 (1 of 1)						

1. Select **Assign Provider**
2. Search for and select the intended provider from the results.



Assign Professional Network

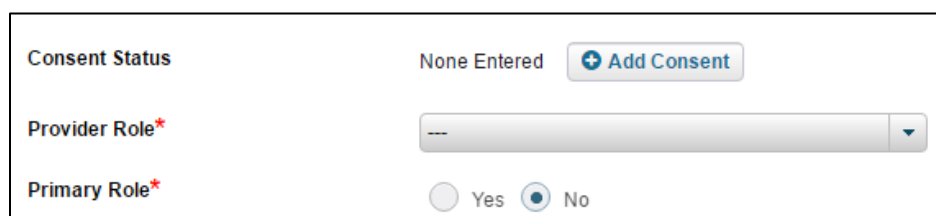
Save Cancel

Provider* Search for provider... Advanced Search

Assign Date*

End Date

3. The **+Add Consent** button, **Provider Role** dictionary and **Primary Role** radio buttons will present.



Consent Status None Entered + Add Consent

Provider Role*

Primary Role* Yes No

4. If appropriate, complete the **Provider Data Sharing Consent** by selecting the **+Add Consent** button.
5. Select the provider's role with the client from the **Provider Role** dictionary.

- Identify if this role is the primary role from the **Primary Role** radio buttons.
- Enter the date that the relationship between provider and client began in the **Assign Date** field.
- Click Save the **Save** button when finished.

Provider Referrals

Providers or organizations that are problem-specific and who need to be assigned to support the problems you have identified. These may be some of the same providers listed in the Professional Network.

Clients Problems can be referred to a provider. Multiple Problems can be referred to the same provider and Multiple Providers can be referred to one problem.

Refer Multiple Problems to a Provider

- From the right side of the **Provider Referrals** section of CareCoordination, select the **Refer Multiple Problems to Provider** button.

Problem	Problem Type	Problem Onset	Problem Status	Actions
Bipolar I disorder (disorder)	Behavioral Health	Adult	Active - Addressed in Care Plan	Actions
Diabetes insipidus (disorder)	Physical Health	Adolescent	Active - Addressed in Care Plan	Actions
Benign hypertensive heart AND renal disease	Physical Health	Birth	Active - Addressed in Care Plan	Actions

- The **Refer Problems to Provider** window will present.

Refer Problems to Provider

Referred Provider * [Search for provider...]

Organization []

Provider Consent Status []

Provider Referral Status * []

Referral Start Date * []

Referral End Date []

Services Provided

Description of Services Provided []

Frequency of Services Provided []

Duration of Services Provided []

Paid Service ☐ Yes ☒ No

Last Visit Date []

Problems to Refer

Problem	Status
<input type="checkbox"/> Bipolar I disorder (disorder)	Active - Addressed in Care Plan

3. Search for and select the intended provider from the **Referred Provider** field.

4. If appropriate, enter the **Organization** name where the member sees their provider.
5. If appropriate, complete the **Provider Data Sharing Consent** by selecting the **+Add Consent** button.

6. Identify the referral status in the **Provider Referral Status** dictionary.

7. Enter the date the service provider relationship began in the **Referral Start Date** field.


8. Select the check box next to each of the problems that should be referred to this provider from the **Problems to Refer** table.

Problem	Status
<input type="checkbox"/> Bipolar I disorder (disorder)	Active
<input checked="" type="checkbox"/> Benign hypertensive heart AND renal disease	Active
<input checked="" type="checkbox"/> Diabetes insipidus (disorder)	Active

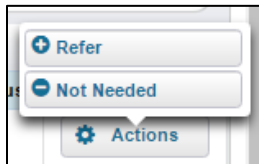
9. Select the **Save** button.

Referring Multiple Providers to One Problem

1. Select the **Actions** button from the **Actions** column of the problem row.

Referrals Needed				
Problem	Problem Type	Problem Onset	Problem Status	Actions
Bipolar I disorder (disorder)	Behavioral Health	Adult	Active	 Actions

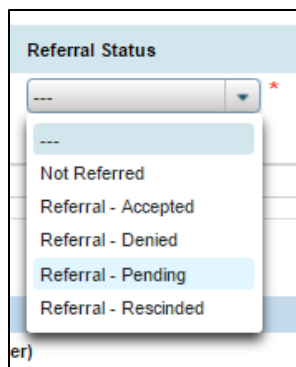
2. Select the **+Refer** button.



3. The **Refer to Provider** window will present. Note the **Problem Details** shown in the bottom of the window.
4. Search for and select the intended provider from the **Referred Provider** field.

5. If appropriate, complete the **Provider Data Sharing Consent** by selecting the **+Add Consent** button.

6. Identify the referral status in the **Provider Referral Status** dictionary.



Referral Status

Not Referred

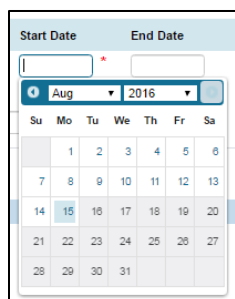
Referral - Accepted

Referral - Denied

Referral - Pending

Referral - Rescinded

7. Enter the date the service provider relationship began in the **Referral Start Date** field.



Start Date **End Date**

|

Aug 2016

Su	Mo	Tu	We	Th	Fr	Sa
	1	2	3	4	5	6
7	8	9	10	11	12	13
14	15	16	17	18	19	20
21	22	23	24	25	26	27
28	29	30	31			

8. If appropriate, enter the **Organization** name where the member sees their provider.

9. Enter comments into the free text **Comments** field.



Comments

10. If appropriate enter **Description of Services Provided** in the free text field.

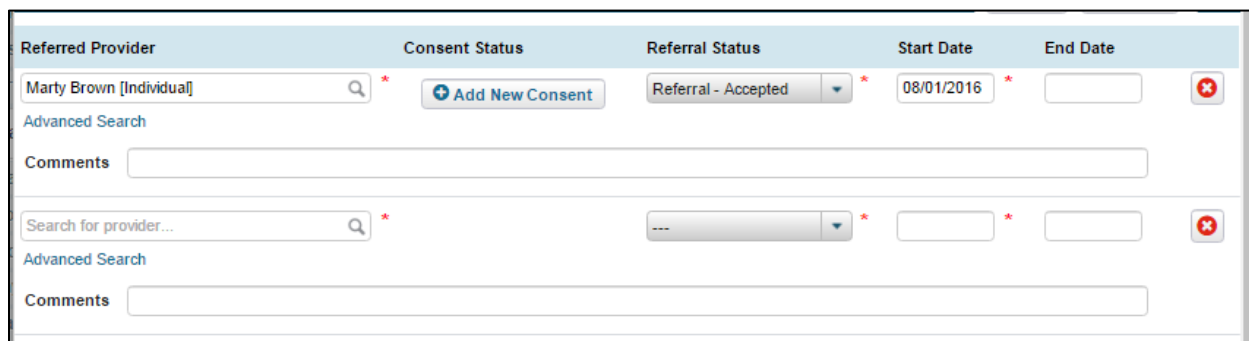
11. If appropriate enter **Frequency of Services Provided** in the free text field.

12. If appropriate enter the **Duration of Services Provided** in the free text field.

13. If appropriate select the correct radio button for **Paid Service**.

14. If appropriate enter the **Last Visit Date**.

15. Select the **+Add Referral** button. The referral fields will present beneath the previously completed fields.



Referred Provider	Consent Status	Referral Status	Start Date	End Date
Marty Brown [Individual] <input type="text"/>	<input type="button" value="+ Add New Consent"/>	Referral - Accepted <input type="text"/>	08/01/2016 <input type="text"/>	<input type="text"/>
Advanced Search Comments <input type="text"/>				
Search for provider... <input type="text"/>		--- <input type="text"/>	<input type="text"/>	<input type="text"/>
Advanced Search Comments <input type="text"/>				

16. Repeat steps 4 – 14 as appropriate.

17. Select the **Save** button when finished.

Adding a Custom Provider

When needing to access information about a **Provider** in CareManager, the user has an option to select a previously entered Provider from a Search List. If the Provider cannot be found, the **Add Custom Provider** feature allows the user to enter a new provider. The steps provided below shows adding a Custom Provider when referring problems on the Care Coordination page, but this same process is used in the Medications and Hallmark Event features as well.

1. Select **Care Coordination** from the left hand menu of the client chart.

The screenshot shows the CareManager interface for a client named Larson, Jonny. The 'Care Coordination' tab is selected in the top navigation bar. The left sidebar has 'Care Coordination' highlighted. The main content area shows three sections: 'Coordinating Agency Assignment', 'Team Assignment', and 'Social Support'. Each section has a table of assignments with columns for Date Assigned, Name, Role, Organization, and Actions. The 'Social Support' section shows a referral for 'Caito Fisher' with a status of 'Active'.

2. Select the **Refer Multiple Problems to Provider** button located next to the problem that needs to be referred. This is located within the **Provider Referrals** section.

The screenshot shows the 'Provider Referrals' section. It has a search bar and a table of problems. The table has columns for Problem, Problem Type, Problem Onset, Problem Status, and Actions. The first row shows 'Bipolar I disorder, most recent episode hypomanic (disorder)' with a status of 'Active' and a 'Refer' button.

3. The **Refer to Provider** pop-up window will display.

The screenshot shows the 'Refer Problems to Provider' pop-up window. It has a 'Save' button and a 'Cancel' button. The 'Referred Provider' field has a search bar. Below it are fields for 'Organization', 'Provider Consent Status', 'Provider Referral Status', 'Referral Start Date', and 'Referral End Date'. The 'Services Provided' section has fields for 'Description of Services Provided', 'Frequency of Services Provided', 'Duration of Services Provided', 'Paid Service' (Yes/No), and 'Last Visit Date'. The 'Problems to Refer' section has a table with columns for Problem and Status. The first row shows 'Diabetes insipidus (disorder)' with a status of 'Active - Addressed in Care Plan'.

- Enter the provider name in the **Referred Provider** field. The entered name will display with **[Add Custom]** following. Select the name that the user has entered.

Referred Provider*

Provider Consent Status

Provider Referral Status*

- The **Advanced Provider Search** pop-up window will display, as shown below

Advanced Provider Search

First, search for the provider. If not found, click the Add Custom Provider button above. Provider Name and Address or Phone Number is Required when adding a Custom Provider.

Provider Information

Provider Type* First Name Last Name Gender Organization*

Provider Licenses Health Plans

Specialties Roles Network Status Accepts New Patients Handicap Accessible

Provider Address

Street Address 1 Street Address 2

City State Zip County

Provider Contact

Phone Type Phone Number

Fax Fax Number

Email

- Complete the **Provider Information**, **Provider Address** and **Provider Contact** fields. Select the **Search** button.
- The search results will present at the bottom of the screen, as shown below.

No results found. Please click the 'Add Custom Provider' button above to enter a new custom provider into the system.

- Select the provider if applicable. If there are no providers in the search results, select the **Add Custom Provider** button.
- The **Confirm Provider Add** pop-up screen will display.

Confirm Provider Add

⚠ By continuing, you are adding a new provider record to the system. Please provide the most complete data for the provider as possible.

Click the Cancel button to update the provider information.
Click Add Custom Provider to continue.

- Select the **Add Custom Provider** button.

11. Enter the **Organization** name where the member sees the provider if known.
12. The **Refer to Provider** stand-alone form will display. Select the provider referral status from the **Provider Referral Status** drop-down menu.
13. Enter in the **Referral Start Date**.
14. Select the **Problems to Refer**.
15. Select the **Save** button. The information entered will save and the user will be returned to the **Care Coordination** page.
16. In the **Provider Referrals** section of the **Care Coordination** page, hover over and select the caption icon. The icon is located next to the **Referred To** field.
17. The **Provider Demographics** information will display.

Creating the Plan of Care

The CareManager Plan is the heart of the care coordination process and key to managing a client's care. The plan is supported by information obtained from the Comprehensive Assessment, and information obtained from providers, the member, and their family. The Initial Plan of Care is due within the first 60 days of enrollment.

- The **Initial Plan** is the first CareManager Plan created for a client.
- The **Plan Amendment** provides the flexibility to a Care Manager or Care Coordinator to make changes to the finalized plan when needed. As client care progresses, the plan may need to be updated quickly and easily.

Initial Plan

The screenshot shows the 'CareManager Plan' interface. On the left is a sidebar with a 'Facesheet' menu containing various options like 'Demographics', 'Consent Forms', 'Eligibility', 'Assessments', 'Problems', 'Care Coordination', 'CareManager Plan' (which is highlighted), 'Notes', 'Social Support Contacts', and 'Medications'. The main content area is titled 'CareManager Plan' and has a 'Care Coordination' button in the top right. Below the title are two tabs: '+ New Plan' and '+ New Task'. Under these tabs, there are filter options: a checked 'All Dates' checkbox, 'Start Date', and 'End Date' fields, followed by an 'Apply' button. Below the filters is a table with headers: 'Plan Date', 'Plan Type', 'Plan Status', and 'Client Signature'. The table body currently displays 'No Plans Entered'.

1. Select the **CareManager Plan** tab on the left-hand side of the Facesheet.
2. Select **+New Plan**.
3. Select **+Initial Plan**

Plan Type: This will default to Initial.

Plan Start Date: Date the care plan was finalized with the client.

Plan End Date: This field will be greyed out.

Plan Status: Leave the plan in Draft status until it is completed and reviewed with the client. To switch your Plan of Care to final, check the box that states “**Client reviewed Plan**”

Client Goal Statement: The goal statement should reflect what is the priority of the client concerning the work you will be doing together. It should be written from the perspective of the client.

Client Strengths and Client Barriers: These are determined through the assessment process and are what the client sees as strengths and barriers.

Participants: This section is not required but may help the client keep track of those who had input into the plan.

Objectives and Interventions

Objectives/interventions can be customized or selected from the library. **Objectives** are the goals of the client (Please see SMART guide for writing goals in the appendix) based off of the needs you will be working on. **Interventions** are the who/what/how: **Who** is responsible for a task to meet the objective, **What** will they be doing to meet the Objective, and **How** will they go about doing it.

The following categories are available for **Objectives and Interventions**:

Adherence: Use this section to document preventive quality measures including annual dental visits and well visits if they are not already naturally addressed within the physical health category and linked to the related physical health condition(s).

Behavioral Health: This is where you capture mental health **Objectives and Interventions** if they are in the **Problems** list.

Care Coordination Activities: This is where you would capture **Objectives and Interventions** that are associated with care management and care coordination activities. If the client needs help managing their care, this is the category that will address that need.

Physical Health: This is where you capture physical health **Objectives and Interventions** if they are in the **Problems** list.

Social Health: If any social health problems had been captured in any of the **Assessments** this is the category that would be captured.

The screenshot shows the 'Add Objectives and Interventions' window. At the top, there are buttons for 'Select from Library', 'Create Custom', 'Save', and 'Cancel'. Below these is a 'Filter by' dropdown set to 'Adherence' and a 'Search all...' search bar. The main content area is titled 'Objective and Intervention Selections' and 'Category'. It lists two objectives under the 'Adherence' category:

- Objective: Discuss medications and side effects with prescriber**
 - Interventions:**
 - ☐ Discuss all medication you are already taking with your doctor prior to starting a new medication.
 - ☐ Know what the most common side effects are.
 - Client Problems:** Select associated problems (dropdown menu)
- Objective: Take medications as prescribed**
 - ☐ Request refill reminders form pharmacy.
 - ☐ Review medications with Care Manager. (ask about medication reconciliation)

1. In the Objectives and Interventions section, find the appropriate category for the objective/intervention and select the **+Objectives/Interventions** button.
2. Select from the library of **Interventions** or click the **Create Custom** button.
3. Type in an objective in the **Objective** field.

The screenshot shows the 'Add Objectives and Interventions' window with the 'Create Objective and Intervention Selections' form. The form has a title bar that says 'Create Objective and Intervention Selections (* = Required)' and a 'Category' dropdown menu. The form fields are:

- Objective:** Enter Objective... (required field)
- Interventions:** Four text input fields for entering interventions. The first field is required. An 'Add' button is located to the right of the input fields.
- Client Problems:** Select associated problems (dropdown menu)
- Objective:** Enter Objective... (required field)
- Interventions:** Two text input fields for entering interventions.

4. Select the appropriate category from the **Category** drop-down menu.
5. Enter intervention(s) in the Intervention field(s). If there are more than four interventions, select the **+Add** button.
6. Select the appropriate problem(s) from the Associated **Client Problems** drop-down menu.
7. Continue adding **Objectives**, a **Category** and **Interventions** as needed.
8. Select the **Save** button. The entered items will now be listed in the CareManager Plan.

9. The **Status** of each new **Objective** is **New**.

The screenshot shows two sections of the CareManager interface. The top section is for 'Behavioral Health' with the objective 'Manage Depression'. It contains a table with three rows of interventions, each with a 'Status' dropdown set to 'New' and a 'Target Date' field. The bottom section is for 'Physical Health' with the objective 'Manage Diabetes'. It contains a table with three rows of interventions, each with a 'Status' dropdown set to 'New' and a 'Target Date' field. Both sections have 'Delete' and 'Add' buttons for each row.

Intervention	Status	Target Date
Learn new ways to verbalize emotions with family and friends.	New	
Identify 3 situations or things that make the client feel sad and discuss how not to feel sad	New	
	New	

Intervention	Status	Target Date
Discuss nutrition options with primary care physician.	New	
HAG: "I want to lose 15 pounds in the next 6 months".	New	
Explore options for exercise near home.	New	

10. The status of each newly entered **Intervention** is **New**.

11. **Enter a date in the Target Date field:** Target dates should accurately reflect when you hope to have the intervention completed by or the span of time it will cover.

This close-up shows the 'Status' and 'Target Date' columns of the intervention table. Each row has a 'Status' dropdown menu set to 'New' and a 'Target Date' text input field. The first two rows have the date '08/13/2013' entered, while the third row is empty.

Status	Target Date
New	08/13/2013
New	08/13/2013
New	

12. **Signature:** either capture the signature(s) electronically at the bottom of the care plan, or **Print** the finalized care plan and have the client/legal guardian sign. If signatures were captured manually upload a scanned copy of the signed care plan to the client's chart and keep the signed copy.

New Plan Amendment

Continue to update the **Care Plan** (by creating **+New Plan Amendments**) and print/sign minimally year or sooner if needed. If manual signature(s) obtained, be sure to scan and upload into attachments. When you create New Plan Amendments: All data from the most recently finalized plan will transfer onto the **New Plan Amendment**. However, any interventions you complete/resolve via your CareManager notes since the last finalized care plan will not show up on the amendment.

Note: Once the Initial Plan is completed and finalized in CareManager any subsequent care plans will be entered in as a New Plan Amendment.

Note: Anytime you leave a Care Plan in "draft" status, you are unable to document Care Manager notes until you have finalized the plan.

CareManager Notes

Once the initial Care Plan is finalized, all billable services and encounters can be documented as either New Contact Notes or New CareManager Notes as appropriate. To ensure that the plan is reviewed monthly, AHI will be looking for at least one CareManager note per month.

Documenting a Billable CareManager Note

The CareManager Note is used to track a client's progress on their current CareManager Plan. The note will contain all current **Objectives & Interventions** from the most recent finalized Care Plan, but you should only document on what was addressed during the activity you are logging. All billable services should be clearly documented in the CareManager Note.

1. Go to **Notes** tab
2. Select **+New Note**
3. Select **+New CareManager Note**

Note Detail

Note Type: This will auto-populate.

Note Date: This will default to the current date.

Note Status: Draft notes do not count in the system. You will be able to edit them but they will not support billing. Finalized notes are used for billing, tracking files and other reports but the note is locked permanently. Make sure all information in the note is correct before you change the status to final.

Service Code: **Non Billable** or **Comprehensive Care Management**

Type of Activity: Select the Core Service that was delivered.

Contact Detail

Contact Date*
04/30/2019

Contact Duration*
minutes

Contact Type*

Location*

Primary Reason for Contact*

Other Reason for Contact*

Contact Status*

Contact Detail

Contact Date: The date that the service took place.

Contact Duration: Document the number of minutes the activity took you to perform

Contact Type: Select the way in which the contact was attempted or completed.

Location: The location where the Care Manager is at when the activity was performed

Primary Reason for Contact: Select the option that describes the activity/encounter being documented.

Contact Status: **Contact Achieved** or **Unable to Contact**

Participants

☐ Tes, Holly

Assigned Team
None

Social Support Contacts
None

Referred Providers
None

Other Participants
Search...

Target*

Co-worker, Senior Care Manager, Supervisor
External Doctor/Provider
Family of Member
Member
Multidisciplinary Team
Other

Participants

The box next to client's name, **Assigned Team**, **Social Support Contacts**, **Referred Providers**, **Other Participants** will have a drop-down option once contacts and providers are entered. Your note detail section should include specifics about who was involved in the activity being documented as well.

Target: Who the target of the activity was.

- Enter **Goal Comments** into the goal comments open text field if needed.
- **Interventions:** Document the activities that took place during the encounter you are documenting under the appropriate **Intervention**. Any interventions that you did not address during the encounter can be left blank.
- **Status:** Status of the Intervention will switch to In Progress automatically and can be modified if needed. If you update the status of an intervention to **Complete** or **Discontinued** it will not show up in future notes and a care plan amendment will need to be done in order to put it back on the care plan. If you Complete or Discontinue every intervention under an objective, the objective is considered “completed” and will disappear from future notes and Care Plans.
- **Target:** Target date of the Intervention that was set during the last Plan or CareManager Note. This can be modified if needed.
- Adjust the slider according to the client's level of engagement between Not Engaged and Very Engaged for the “How engaged has the client been with this task?” Question.
- Enter detailed information in the **Intervention Updates** section: If you want to see their progress on the intervention you can click the blue word bubble to see the historical notes entered against that intervention. You can document updates on multiple Interventions within one note (so long as it occurred on that contact date)

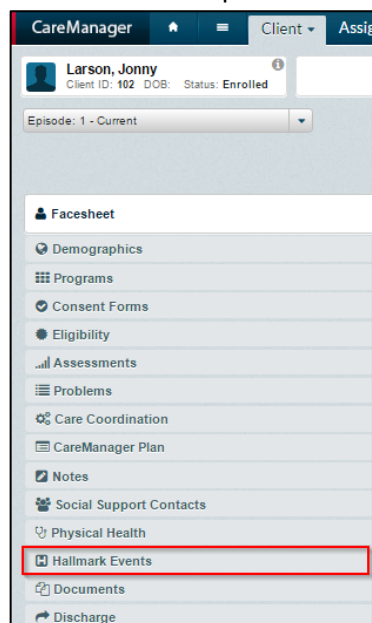
Discharge/Disenrollment

When you are ready to end services for an enrolled client a discharge must be completed. Completing the **Discharge** in the system is a function of a supervisor. Please ensure that all documentation is completed before Discharge and scan/upload any **Attachments**. Disenrollment forms and reason for discharge should be reviewed with your supervisor to ensure that a proper plan is in place for the client. You will then assign a **Task** to your supervisor to Discharge the client.

Other CareManager Fields and Functions

Hallmark Events

Documenting hospitalizations, inpatient stays, and ED visits as hallmark events are **required**. Due to our Hixny interface, a Hallmark Event will automatically populate when you receive an alert in the system. You can edit and update these Hallmark Events as you obtain more data about the cause of the alert.



Adding a New Hallmark Event

1. Select the **+New Hallmark Event** button. The **Hallmark Events** page will display.

 A screenshot of the 'Hallmark Event Information' form. The form is divided into two main sections. The left section, titled 'Hallmark Event Details', contains a 'Hallmark Event*' dropdown menu, a 'Notification Period' text field, a 'Last Updated' field with a timestamp, a 'Comments' text area, an 'Event Date*' field, a 'Record of Origin' dropdown, and a 'Direct Entry' checkbox. The right section, titled 'Participants', includes a 'Larson, Jonny' checkbox, an 'Assigned Team' dropdown, a 'Social Support Contacts' dropdown, a 'Referred Providers' dropdown, and an 'Other Participants' section with a search bar.

2. Select from the **Hallmark Event** drop-down. Certain sections will enable additional fields at the bottom of the form if applicable.

Note: The following fields will enable the *Hospitalization/Inpatient Details* section: *ED Visits, Hospitalizations-Alcohol and Other Drugs, Hospitalization - General, Hospitalization – Mental Health, Hospitalization – Physical Health, Residential Treatment Facilities, Residential/Rehabilitation Facilities and SA Inpatient Treatment.*

3. Select or enter the date in the **Event Date** field.
4. Enter the **Notification Period** in the open text field.
5. The **Record Origin** field will auto-populate.

6. Enter pertinent information about the Hallmark Event in the **Comments** field.

Hallmark Event Details

Hallmark Event*
Hospitalization - Mental Health

Event Date*
11/28/2016

Notification Period
Two Weeks

Last Updated
--/--/----

Record of Origin
Direct Entry

Comments
Client was suicidal and voluntarily entered the hospital.

7. In the **Participants** section, select the client checkbox, any **Assigned Team**, **Social Support Contacts**, and **Referred Providers** if applicable. If needed, search for **Other Participants** in the search field.

Participants

☒ Larson, Jonny

Assigned Team
NTST Admin

Social Support Contacts
Fisher, Caleb (Friend(s))

Referred Providers
Rodney Hiatt

Other Participants
Search...

Note: If a Hallmark Event Type other than those mentioned previously is selected, skip to step 13

8. If applicable, enter the information for the Hospitalization/Inpatient Details section including the **Hospital or Facility**, **Primary Care Physician**, **Record Origin**, **Admission Date**, **Admission Time**, **Admission Reason**, **Discharge Date** (if applicable), **Discharge Time**, **Attending Physicians(s)**, and **Consulting Physicians**.

Hospitalization / Inpatient Details

Hospital or Facility
Search for provider...
Advanced Search

Primary Care Physician
Search for provider...
Advanced Search

Record Origin
Direct Entry

Admission Date
Admission Time
Admission Reason

Discharge Date
Discharge Time

Attending Physician(s)
Search for provider...
Advanced Search
Attending Physician
No records found.

Consulting Physician(s)
Search for provider...
Advanced Search
Consulting Physician
Consult Description
No records found.

9. Enter a diagnosis in the **Admission Diagnosis** field. Information will dynamically display based on the search criteria entered.

Admission Diagnosis
296.20

[F32.9] Major depressive disorder, single episode, unspecified
[F32.9] Major depressive disorder, recurrent, unspecified
[F32.2] Major depressive disorder, single episode, severe without psychotic features
[F32.2] Major depressive disorder, recurrent severe without psychotic features
[F32.3] Major depressive disorder, single episode, severe with psychotic features
[F32.80] Other specified depressive episodes

10. If more than one diagnosis is needed, repeat step 9.

11. Select the Primary Diagnosis by selecting the box under the **Primary** column.

Primary	Diagnosis	Source
<input checked="" type="checkbox"/>	[F32.9] Major depressive disorder, single episode, unspecified	Direct Entry
<input type="checkbox"/>	[F41.1] Generalized anxiety disorder	Direct Entry

12. Enter information in the **History of Present Illness** field.

History of Present Illness*
Client has a long history of severe depression and anxiety. No suicide attempts have been made in the past year; but recently, the client's mother passed away causing depression and suicidal thoughts to worsen.

13. Once the Hallmark Event information has been updated, select the **Save** or **Save & Close** button.

Viewing and Editing Hallmark Event Information

Previously entered Hallmark Events can be viewed or edited if needed.

1. From the **Hallmark Events** page, select the **View** button next to the previous entry.
2. The previously entered information will display disabled.
3. To edit the information, select the **Edit** button from the top-right corner of the page. An example of updating a Hallmark Event would be if a client was discharged from the hospital.
4. The fields that can be modified will become enabled
5. Once the Hallmark Event information has been updated, select the **Save** or **Save & Close** button.

Note: HIXNY will be creating/updating some Hallmark Events automatically.

Physical Health

The Physical Health feature can be used to track if the member is not prescribed medications, as well as their allergies, vitals, immunizations and labs.

To access the Physical Health Features, you must select the **Physical Health** tab of your client's chart.

Medications	Allergies	Immunizations	Vitals	Labs																		
<div> <div>New Medication New Task</div> <div>Print View</div> </div> <div> <div>Filter by All</div> <div>Search Medications</div> </div> <table border="1"> <thead> <tr> <th>Medication</th> <th>Start Date</th> <th>End Date</th> <th>Frequency</th> <th>Days Supply</th> <th>Refill Date</th> <th>Record Origin</th> <th>Prescribing Physician</th> <th>Actions</th> </tr> </thead> <tbody> <tr> <td colspan="9">No medications entered</td> </tr> </tbody> </table> <div> <div>10</div> <div>1 of 1</div> </div>					Medication	Start Date	End Date	Frequency	Days Supply	Refill Date	Record Origin	Prescribing Physician	Actions	No medications entered								
Medication	Start Date	End Date	Frequency	Days Supply	Refill Date	Record Origin	Prescribing Physician	Actions														
No medications entered																						

Medications

During the assessment phase and ongoing you should obtain information about current medications. As prompted in the Comprehensive Assessment, you should obtain a current medication list and upload that medication list into the member's attachments area using the appropriate naming convention.

1. Click on the **Medications** tab
2. Click on **+New Medication**
3. Enter the required information:
 - a. In the **Medications** search bar, search for the medication
 - b. **Start Date:** As reported
 - c. **Frequency:** how often do they take the medication



- d. **Prescribing Physician:** select **Physician** from the list
- e. Add **Comments** as needed.
- f. Click **Save**

If there are several medications, you can upload medication list into the attachments area of the member's chart.

Allergies

Although this is not a mandatory field to be completed, you can capture the member's allergies here.

1. Click **+Add New Allergy**
2. Search for the correct Allergy updating: **Status**, **Type**, adding any **reactions** and **severity** of them.
3. Add any additional **comments** and click **Save & Close**

Immunizations

If you wish to document client immunizations you can utilize the Immunizations module to do so. Completion of the Immunizations tab is not mandatory.

1. Click on the **Immunizations** tab
2. Click on **+New Immunization**
3. **Immunization Date** will default to current day, change as needed 4.
Document **Immunization Details** including Status and Reactions, if any.
5. Enter **Comments** and then **Save & Close**

Vitals

If you wish to document client vitals you can do so in the Vitals. Vitals are not mandatory and **should only be documented by a qualified individual**.

1. Click on the Vitals tab
2. Click on **+New Vitals**
3. **Vitals Date & Vitals Time** will default to current day/time, change as needed
4. **Recorded By:** you can select another Team Member or yourself
5. Document **Vital Details**
6. Enter **Comments** and then **Save & Close**

Labs

If you wish to document client labs, you can utilize the Labs module to do so. Labs are not mandatory.

1. Click on the **Labs** tab
2. Click on **+New Lab**
3. **Lab Test Date** will default to current day, change as needed
4. Document **Lab Details** including **Lab Panel Type**, **Ordered By** and **Lab Location**
5. Enter **Results** as needed



6. Add **Comments** and then **Save & Close**



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Appendix

**Supervisory Roles and
Responsibilities in CareManager**

Attachment Descriptions

CareManager Case Note Desk Guide

Creating SMART Goals

DOH Forms for Adults

Creating Referrals in MAPP

Supervisory Functions

Assigning the Care Team

When a client is entered into the system, regardless of what status they are in, the client will need to be assigned a Care Manager and Care Manager Supervisor. Users with the “Care Manager Supervisor” security role will have access to assign clients to Care Management staff in order to start the Outreach or Enrollment processes in Netsmart CareManager.

Population Assignment	Care Coordinating Agency
<div>Select Coordinating Agency</div> <div>---</div>	

1. Go to **Assignment**
2. Click on **Care Coordinating Agencies** (only the agencies you have access to will appear)
3. Click on the Assign Care Team link

 Assign new team members by clicking Add Team Member then search for the team member.

 Add Team Member

4. Click on **+Add Team Member**

Team Member	Primary Organization	Roles	Assign Date	End Date
<div>Eric Nelson</div> <div>Assigned Caseload Count: 0</div> <div>Client Search Caseload Count: 1</div> <div>Enrolled Caseload Count: 14</div>	AHI Community Acc...	<div>1: ---</div> <div>2: ---</div>		

5. Enter the Team Member name (Caseload size will appear when selected)
6. Primary Organization will auto populate
7. Select the Role you are assigning this team member
8. Complete the **Assign Date**
9. To assign another team member to the client, just click on **+Add Team Member** and repeat steps 5-8
10. Click **Save**

Discharge/Disenrollment Process

1. Click on Discharge tab
2. Click on New Discharge



Discharge Date*	Discharge Time*
<input type="text" value="06/20/2019"/>	<input type="text" value="03:18 PM"/>
Discharged By*	Reason for Discharge*
<input type="text" value="Enter health home staff..."/>	<input type="text" value="---"/>

Comment

3. Enter **Discharge Date** (will auto-populate but is able to be changed)
4. Enter **Discharge Time** (will auto-populate but is able to be changed)
5. Select your name in the **Discharged By** box
6. Select the appropriate **Reason for Discharge**. The reasons are NYS defined End Codes
7. Depending on the reason you select, you may be asked to complete additional information (Member Deceased, Transferred to Another Health Home, etc.)
8. Add **Comments** regarding the discharge
9. Click **Save & Close**
 - To reenroll the individual, you must enter a referral through MAPP again and process accordingly. Contact AHI if the discharge was done in error.

Creating SMART Goals

SMART	Term Definition
Specific	Identifies a task to accomplish or a behavior to improve
Measurable	Provides clear measures that indicate how you will know that you have achieved your goal
Achievable	Offers both a challenge and a realistic target that is practical and achievable
Realistic	To be realistic, a goal must represent an objective toward which you are both <i>willing</i> and <i>able</i> to work.
Timely	Defines a timeframe for completion; either how often will you do a task or by when you will have completed it

By setting SMART goals you can increase a person's chance of turning their goal into reality and enjoying success.

SMART goals are developed with the input of the member; it makes sure the goal is specifically tailored to address the individual's needs.

Examples of SMART Goals are:

I will take my medication 3 times this week as prescribed.

I will ride the bus at least one time in the next 6 months.

I will earn a promotion to senior customer service representative by completing the required training modules in three months and applying for the role at the end of next quarter.

Attachment Descriptions

Document Type	What to Name It
Department of Health Forms	DOH [Number of the form] MM/DD/YYYY Example: DOH 5055 05/24/2019 (date that the form was signed)
HIXNY Consent	HIXNY Consent MM/DD/YYYY (date the consent was signed)
Comprehensive Assessment	Comprehensive Assessment MM/DD/YYYY (date that the form was completed)
Signed Plan of Care	Plan of Care MM/DD/YYYY (date that the plan was signed if not electronically signed)
Proof of Qualifying Condition(s)	Qualifying Condition(s) MM/DD/YYYY (date of the document)
Medications List	Medications List MM/DD/YYYY (date of the medications list)
HH + Documentation	HH+ Documentation MM/DD/YYYY (date of the documentation) Note: Documentation type varies depending on what HH+ population you are serving.
AOT Court Order	AOT Court Order MM/DD/YYYY (date of the court order)
Disenrollment Paperwork	Disenrollment Paperwork MM/DD/YYYY (date disenrollment paperwork was signed)
Hospital Discharge Paperwork	Hospital Discharge MM/DD/YYYY (date of hospital discharge)
HARP Plan of Care	HARP Plan of Care MM/DD/YYYY (date that the plan was signed)
Level of Service Request	LOSR MM/DD/YYYY (date Level of Service Request was approved)
Level of Service Determination	LOSD MM/DD/YYYY (date Level of Service Determination was approved)
UAS Eligibility Screening Results	UAS Eligibility Screening MM/DD/YYYY (date the Eligibility Screening was completed)
Non-DOH Consents	Consent Form [name of what the consent is for] MM/DD/YY (date the consent was signed)
Member's Rights and Responsibilities	Member's Rights and Responsibilities MM/DD/YYYY (date the form was signed)
Health Home Referral	Health Home Referral MM/DD/YYYY (date of the referral)

DOH Forms for Adults

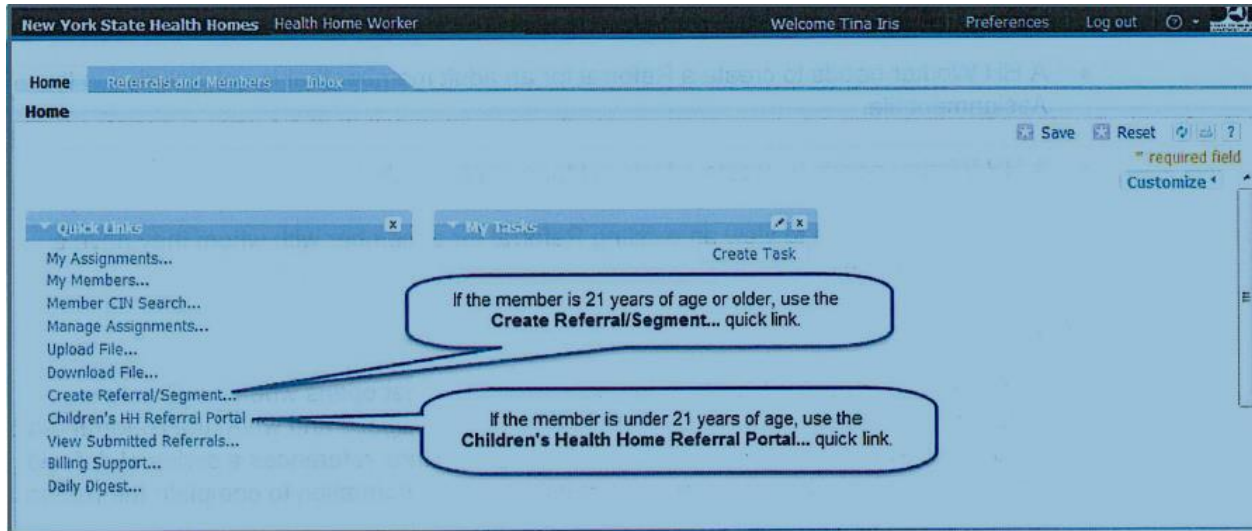
DOH Form to use During Outreach	Reason for form/when to complete
DOH 5236 Notice of Determination for Denial of Enrollment	The Notice of Determination for Denial of Enrollment form is to be used for individuals who are not yet members that were referred to you, that do not meet the Health Home eligibility requirements.
DOH 5059 Health Homes Opt- Out Form	This form is used by the Health Home care manager during outreach activities to document that the consentor (the child and/or their parent, guardian, or legally authorized representative) has been approached about enrolling in Health Home care management services, but declined to enroll in the Health Home program. The Health Homes Opt-Out Form (DOH 5059) is not used to withdraw consent. If the individual has signed a consent for Health Home enrollment (DOH-5055 or DOH-5200), then the appropriate form to withdraw consent (DOH-5202 or DOH-5058) must be used. The Health Homes Opt-Out Form (DOH 5059) is used only for individuals who choose not to enroll in the Health Home program and therefore would not have signed consent.
DOH Form to use During Enrollment	Reason for form/when to complete
DOH 5234 Notice of Determination for Enrollment	This form is to be completed and sent to the member in order to alert them of their enrollment into Health Home care management services. It is important to then upload this form into the member's record. It should not come as a surprise to a member that they have these services, and you as a care manager. By sending this form to the member you are showing that they are an active participant in the care they receive.
DOH 5055 Health Home Patient Information Sharing Consent	This form provides consent for enrollment in a Health Home and for the purpose of sharing health information for individuals who are 18 years of age or older or are under the age of 18 AND a parent, pregnant, or married. These members are legally able to consent for their own enrollment into a Health Home and consent to share their information.
DOH Form to use to Disenroll	Reason for form/when to complete
DOH 5058 Patient Information Sharing Withdrawal of Consent	The Health Home Patient Information Sharing Withdrawal of Consent (DOH 5058) rescinds the consent to enroll and the consent to release health information for children and adolescents that are over the age of 18 and children/adolescents under the age of 18 and who are parents, pregnant, or married. The Health Home Patient Information Sharing Withdrawal of Consent (DOH 5058) should be used for members who signed the Health Home Patient Information Sharing Consent (DOH 5055). These individuals can withdraw from the Health Home program at any time by using this form.
DOH 5235 Notice of Determination for Disenrollment	In the case of an unplanned discharge where you cannot meet with the client to sign the 5058, the care manager can sign this Notice of Determination for Disenrollment and send it to the last known address of the member. You will then upload a copy of this signed form into the member's record and create a note stating that you were unable to have a face to face meeting with the member for whatever reason.

CareManager Case Note Desk Guide

Member Status	Note Type	Service Code	Reason to Use
Outreach (Client Search)	Client Search Note	Outreach & Engagement	Used to document your billable Outreach services. This note is also used to move from Assigned status to Outreach (Client Search); from Outreach (Client Search) to Enrolled; and to Opt-out the Client.
		No Bill Outreach	Used to document attempted Outreach contacts, actions or encounters that are not billable.
Note: Contact Notes should not be used during Outreach (Client Search).			
Enrolled	Contact Note	Non Billable or Comprehensive Care Management	Used to document both billable and non-billable contacts, actions or encounters that are not directly tied to the members care plan. This note also moves people in and out of Diligent Search, and Excluded Settings.
	CareManager Note	Comprehensive Care Management	Used to document billable services each month and your care plan progression. This would also include collateral contacts, actions and encounters that support the members care plan. There should be at least one CareManager Note each month.
Note: Be sure all notes have been finalized.			

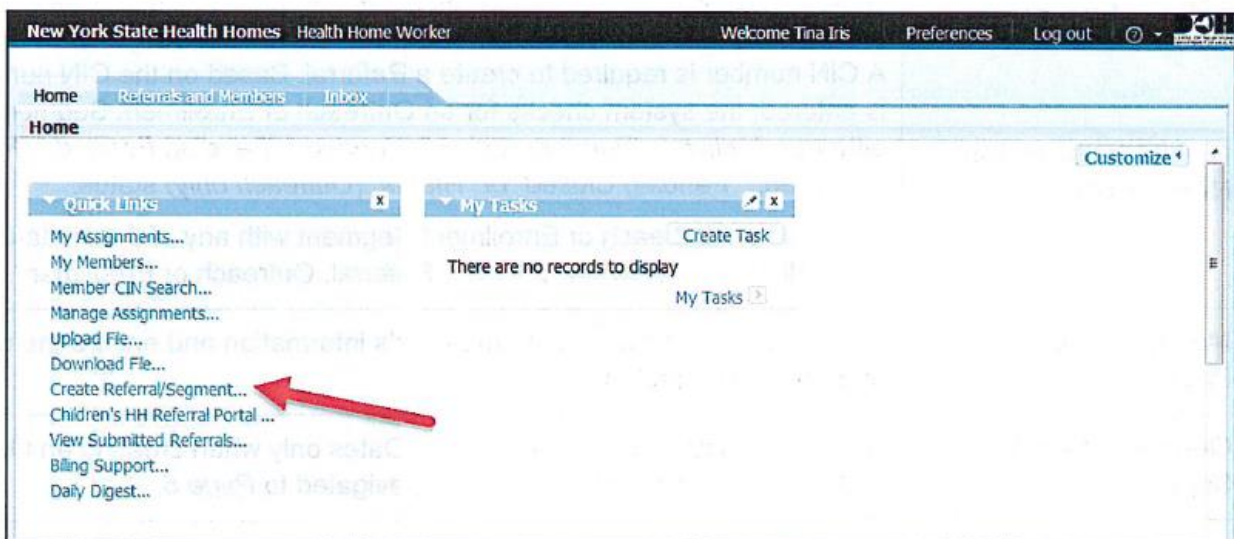
Creating Referrals in MAPP

The candidate's age determines which quick link is used when creating the Referral. The candidate is considered an "adult" or "child" strictly based on the candidate's age when creating a referral.



Creating a Referral in MAPP for Adults (age 21 and over)

1. Click the **Create Referral/Segment...** quick link within the Workspace to begin the Referral process.



2. Select the **Referral** radio button in the *Select Activity* pop-up.
3. Click the **Next** button.

New York State Department of Health MAPP

Select Activity

Activity *

☒ Referral

☐ Outreach Segment

☐ Enrollment Segment

Exit Next

4. Enter the "user-specific CIN" in the **CIN** field.
5. Click the **Next** button.
5. Click the **Next** button.

Client Identification Number (CIN)

CIN Entry

Enter Member's CIN Number

CIN IX10228X

Exit Back Next



Note: When entering a CIN in the CIN Search field, the "0" is a zero. If the CIN is entered incorrectly, the following error message will display:

Client Identification Number (CIN)

CIN Entry

Print

* CIN ix10229x does not exist

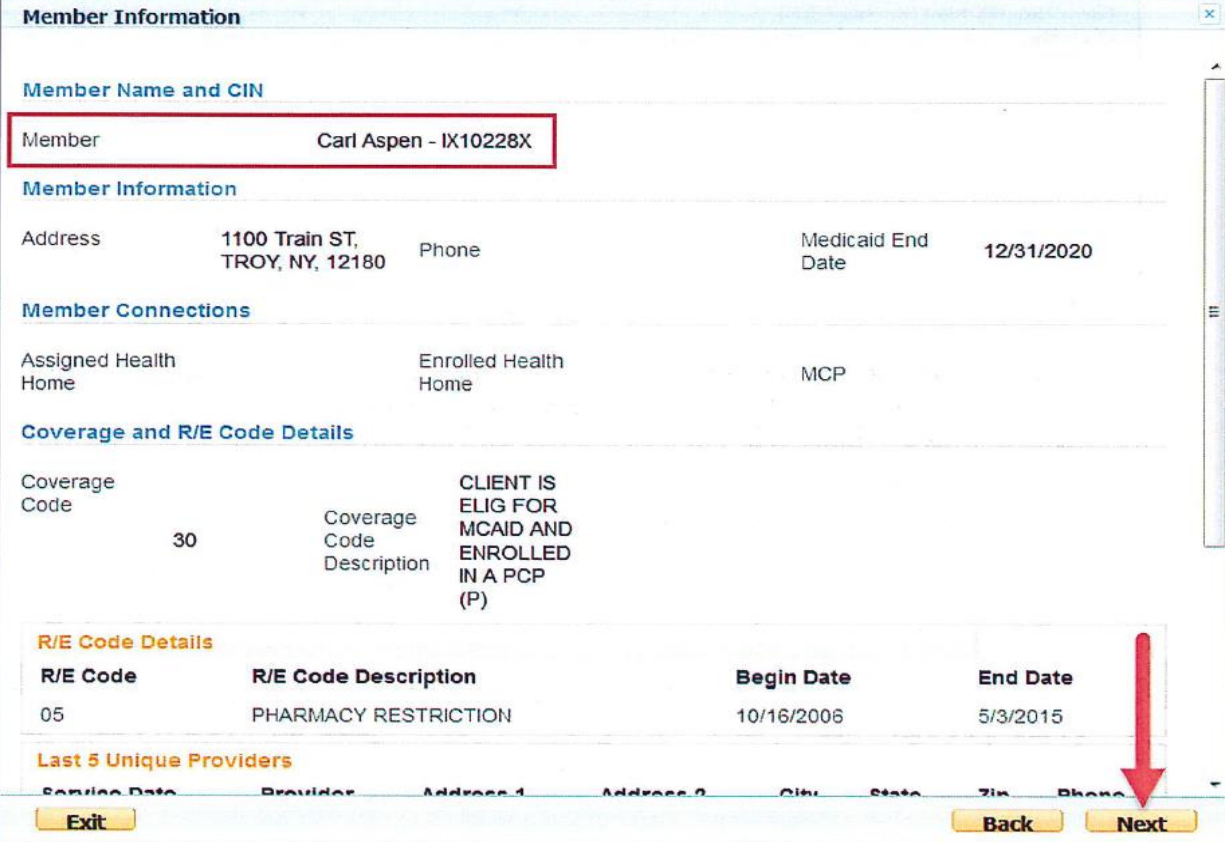
Enter Member's CIN Number

CIN ix10229x

Help

Exit Next

6. Verify the *Member Information* pop-up displays Carl Aspen's Medicaid History.
7. Click the **Next** button.



Member Information

Member Name and CIN

Member: Carl Aspen - IX10228X

Member Information

Address: 1100 Train ST, TROY, NY, 12180 Phone: Medicaid End Date: 12/31/2020

Member Connections

Assigned Health Home: Enrolled Health Home: MCP

Coverage and R/E Code Details

Coverage Code	Coverage Code Description
30	CLIENT IS ELIG FOR MCAID AND ENROLLED IN A PCP (P)

R/E Code Details

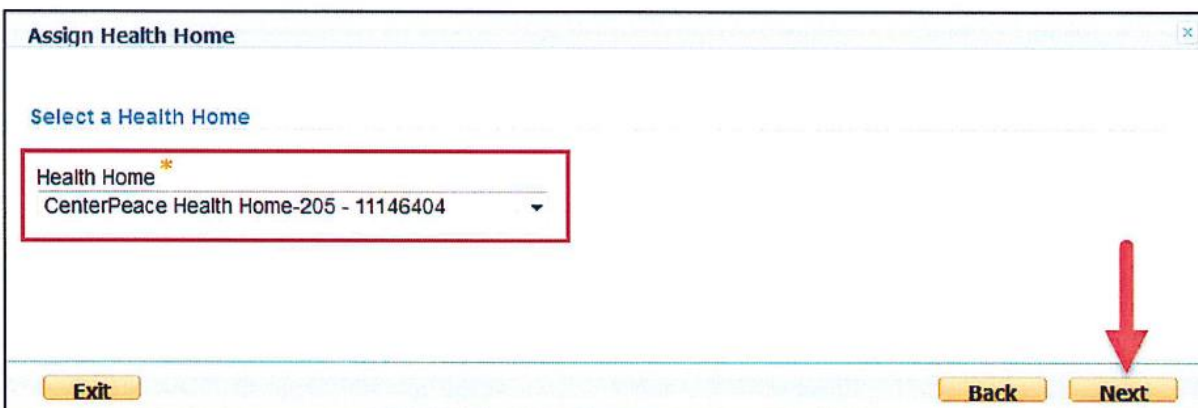
R/E Code	R/E Code Description	Begin Date	End Date
05	PHARMACY RESTRICTION	10/16/2006	5/3/2015

Last 5 Unique Providers

Service Date	Provider	Address 1	Address 2	City	State	Zip	Phone
--------------	----------	-----------	-----------	------	-------	-----	-------

Exit Back Next

8. Click the **Health Home** drop-down and select "CenterPeace Health Home-205" in the *Assign Health Home* pop-up.
9. Click the **Next** button.



Assign Health Home

Select a Health Home

Health Home *
CenterPeace Health Home-205 - 11146404

Exit Back Next

10. Verify the *Referral Summary* displays the correct information.

11. Click the **Next** button.

Referral Summary

Member Name and CIN

Member: Carl Aspen - IX10228X

Member Information

Address: 1100 Train ST, TROY, NY, 12180 Phone: Medicaid End Date: 12/31/2020

Member Connections

Assigned Health Home	CenterPeace Health Home-205 - 11146404	Enrolled Health Home	MCP
----------------------	--	----------------------	-----

Coverage and R/E Code Details

Coverage Code: 30 Coverage Code Description: CLIENT IS ELIG FOR MCAID AND ENROLLED IN A PCP (P)

R/E Code Details

R/E Code	R/E Code Description	Begin Date	End Date
05	PHARMACY RESTRICTION	10/16/2006	5/3/2015

Last 5 Unique Providers

Exit Back Next

12. Click the **Submit** button in the *Referral Confirmation* pop-up. This pop-up explains that a Referral will be submitted and a "Pending" Referral will be created for the corresponding Health Home.

Referral Confirmation

A referral will be submitted for Carl Aspen IX10228X once you click Submit. A pending referral will be created for CenterPeace Health Home-205 11146404.

Submit

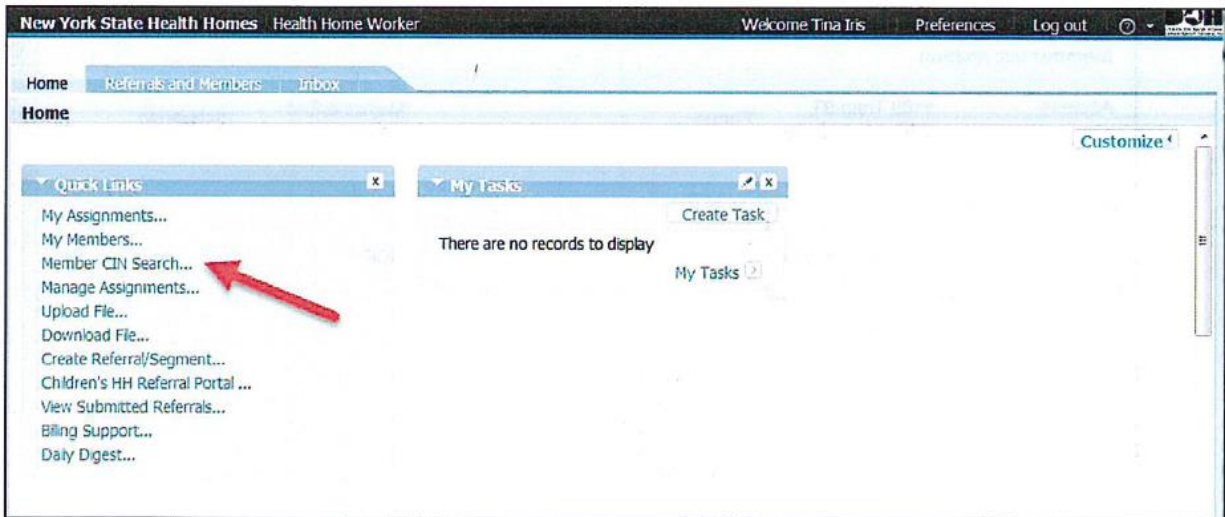
13. Click the **Close** button in the *Referral Success* pop-up.

Referral Success

Referral Success - A referral was successfully created for Carl Aspen IX10228X.

Close

14. Click the **Member CIN Search** quick link within the Workspace to verify Carl Aspen has a "Pending" Assignment with CenterPeace Health Home 205.



15. Enter the "user-specific" CIN in the **CIN #** field.
16. Click the **Search** button.
17. Verify Carl Aspen has a "Pending" Assignment with the CenterPeace Health Home-205 (the HH to which he was referred in the previous steps). You have completed this Exercise.

The screenshot shows the 'Member CIN Search' form. The 'CIN#' field contains 'IX10228X'. The 'Delimiter' dropdown is set to 'Comma Delimited'. The 'Download File Format' dropdown is set to 'Comma Separated Values (.csv)'. A red arrow points to the 'Search' button. Below the form, a table shows search results for Carl Aspen.

Member	DOB	Medicaid End Date	Coverage Code	Managed Care Plan	Health Home	Care Management Agency	HARP	Segment	Status	Start Date	End Date
Carl Aspen - IX10228X	3/3/1951	12/31/2020	30		CenterPeace Health Home-205 - 11146404		No	Assignment	Pending		