Adirondack Health Institute

Lead • Empower • Innovate

Netsmart CareManager User Manual (Children's Health Home)

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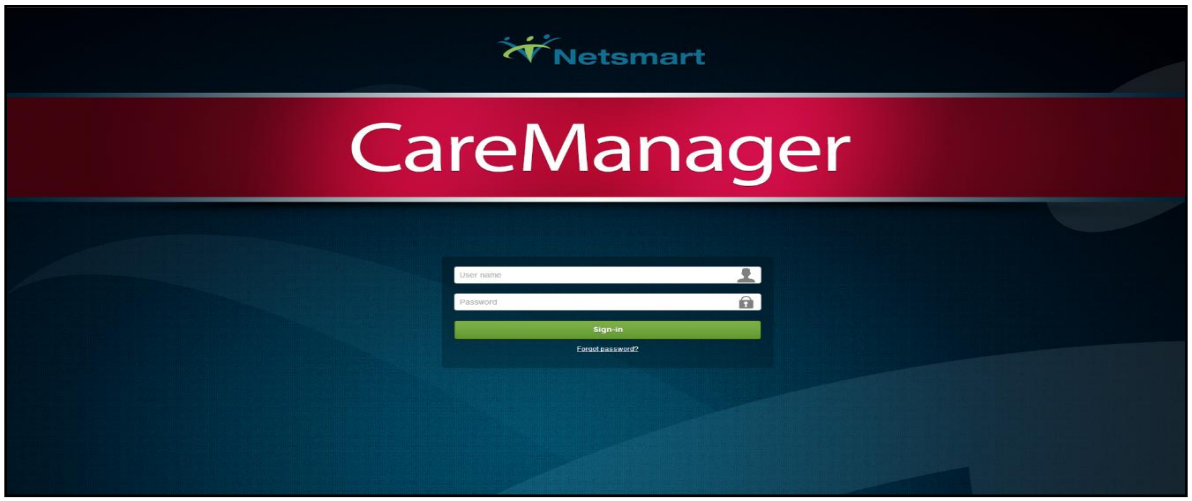
Please note that this manual is subject to frequent change due to consistent system configurations to meet our Network's ever-changing workflow. If there are changes to workflow a new manual, or addendum, will be provided. If there are differences in drop downs, or system naming conventions, we may not 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.

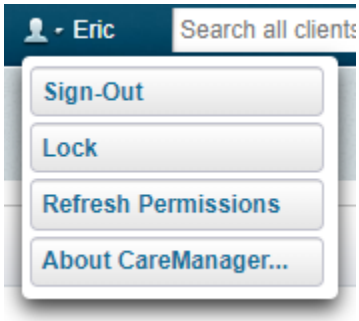
Locked Out of Your Account

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

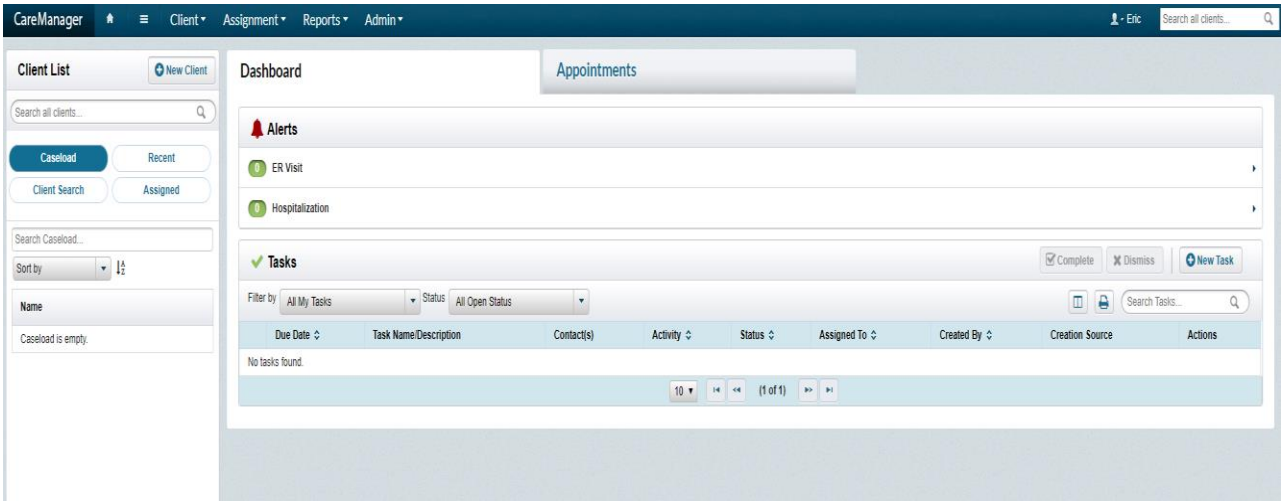
In order to protect your clients PHI you have the ability to either lock or sign out of CareManager. In the upper right-hand corner of the screen you will see your name, clicking on it will give you the following options:

- **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

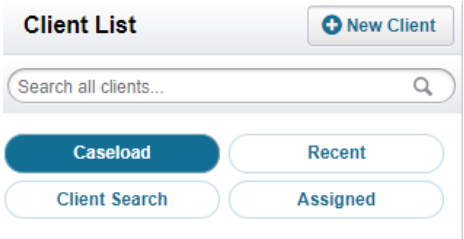


Dashboard

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.

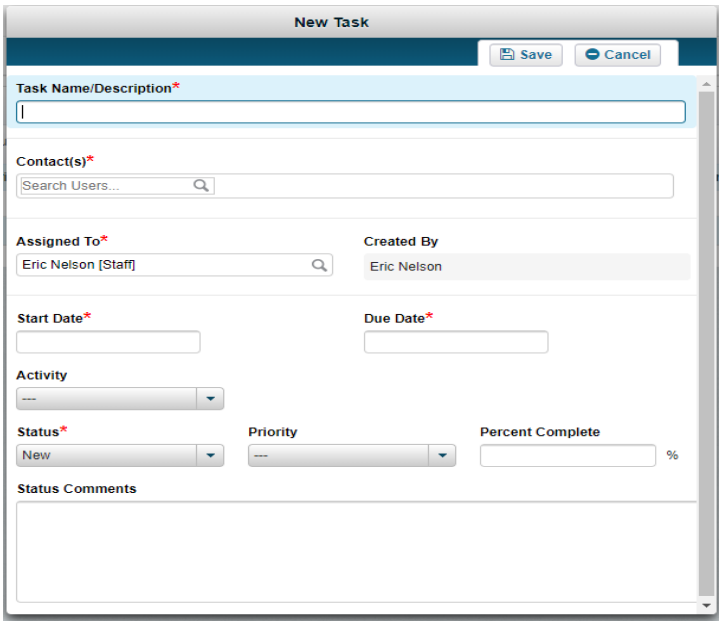
At the bottom of your client list there are navigation buttons where you can manually scroll through clients on your case list.
Another option will be to use the **Search Caseload** bar to avoid scrolling.

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.

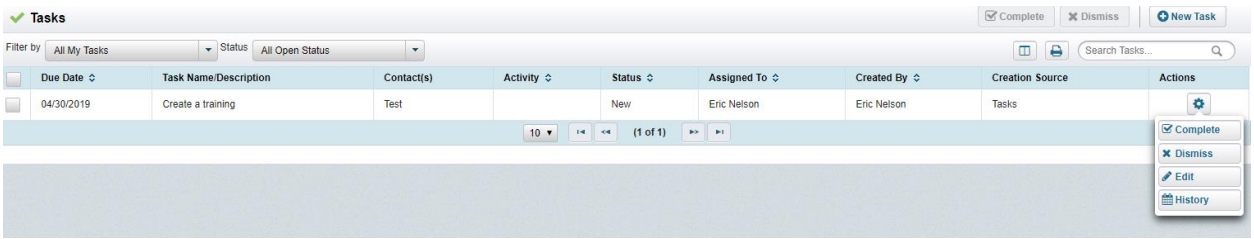
Tasks

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' 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.



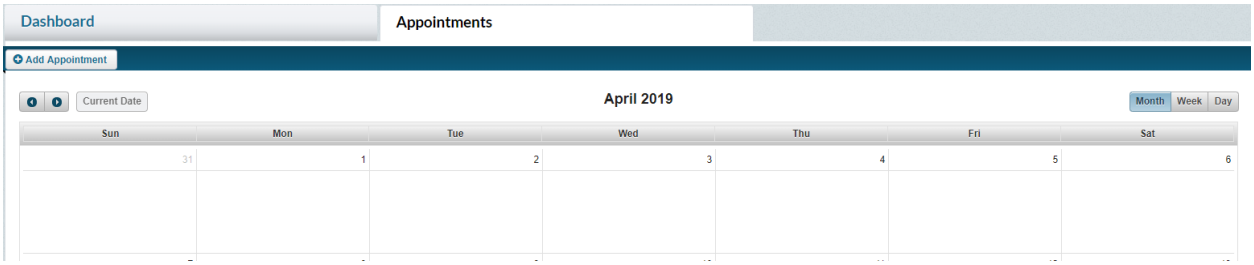
Creating a Task

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**



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.

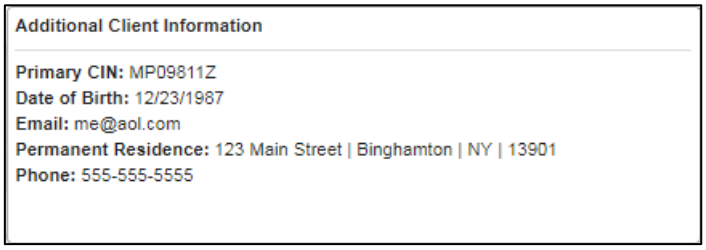
Enrolled- When a client moves from an outreach segment to an enrollment segment, you'll see their status change from "**Client Search**" to "**Enrolled**". If a client is directly enrolled into the program, their status will say "Enrolled" when they are initially assigned to your agency.

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

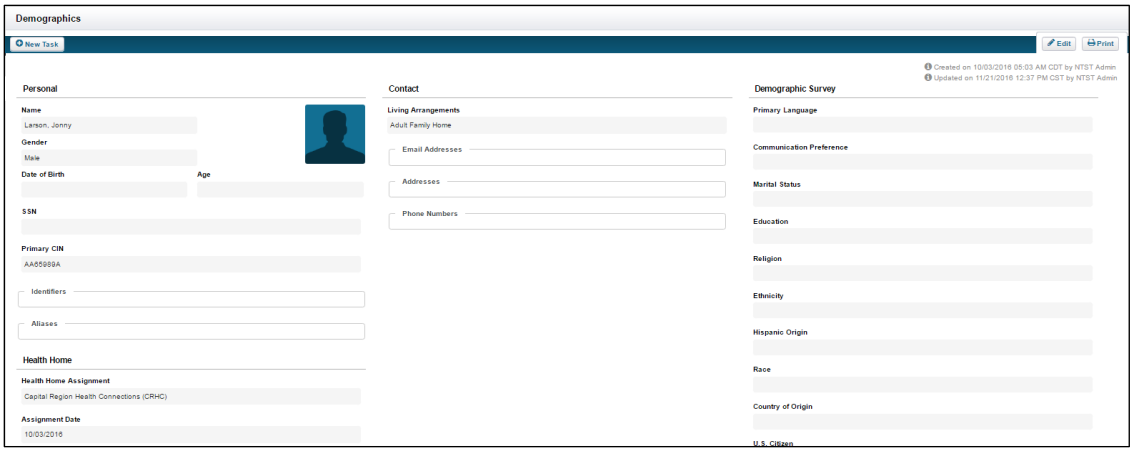
The **Demographics** feature houses the **Personal, Contact, Health Home**, and **Demographic Survey** information for a client. Information includes name, address, health home assignment, marital status, religious affiliation, etc.

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.



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 infomration 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

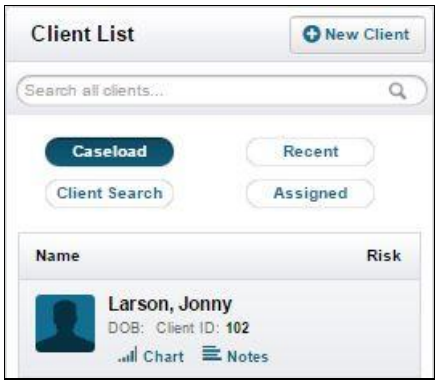
The **Demographic Survey** section contains more in-depth information about a client. Information includes:

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

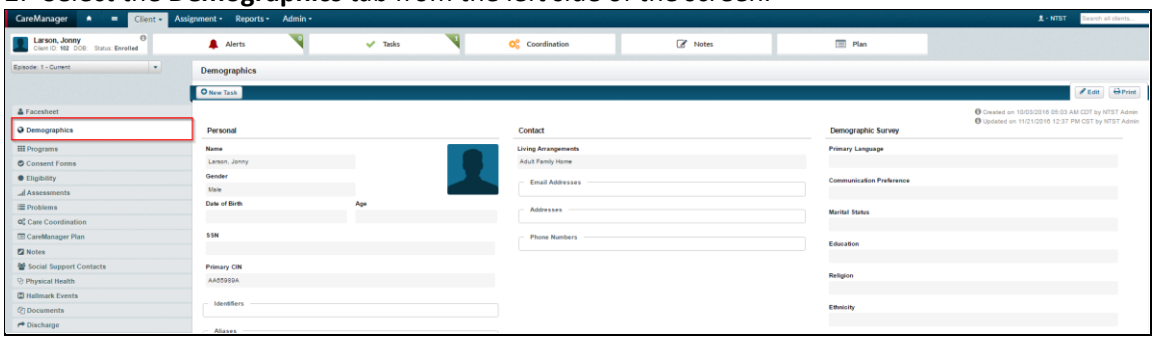
Navigating to Client Demographics

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.

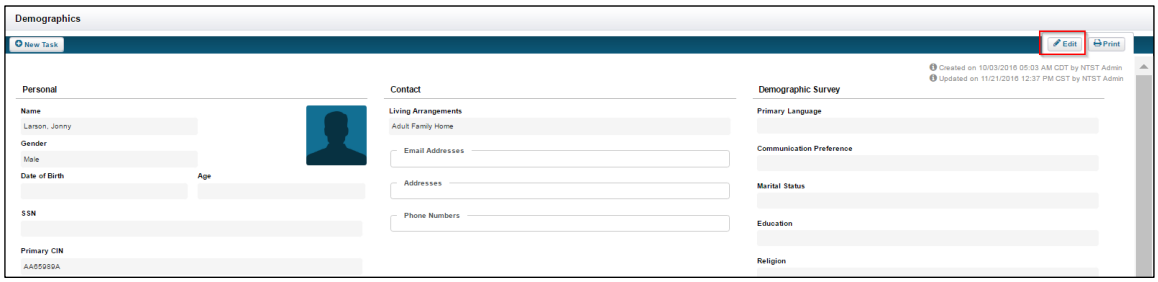


Note: Demographics can also be found by selecting the Client menu from the blue banner and selecting Client Chart and then Demographics from the list of features within the menu.

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.

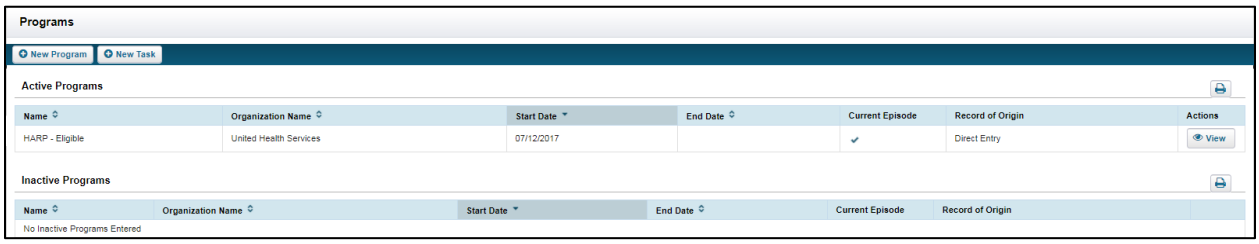
Programs

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. The program will automatically default to the Adult program if the client is over the age of 18. In order to serve them in the Children's program you will need to end the Adult program and add the Children's program.

Program Overview

The Program page is comprised of three sections:

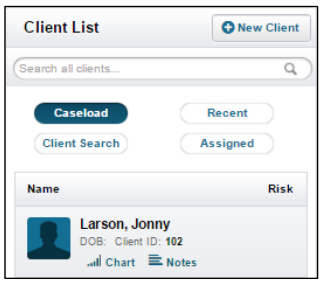
- Active Programs: The Program(s) the client is currently a member of.
- Inactive Programs: The Program(s) the client was previously a member of.
- Professional Network: Enrolled client's in the HH Program.



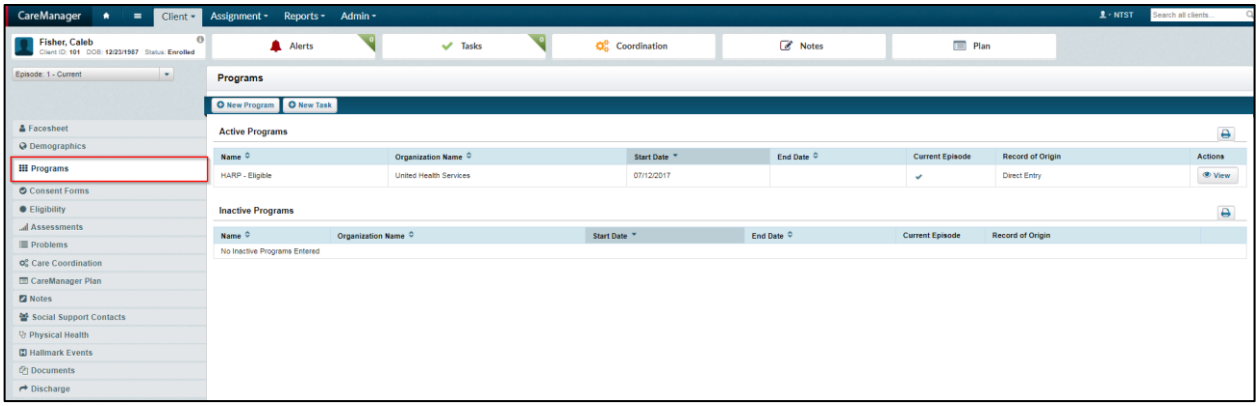
Navigating to Programs

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**.



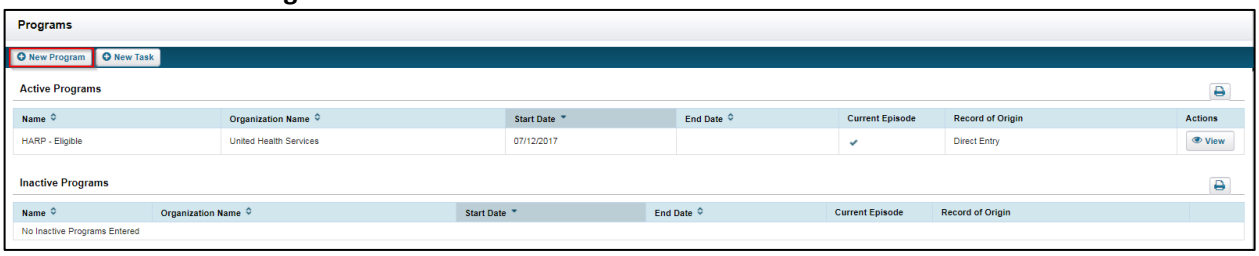
2. Select the **Programs** tab from the left side of the page.



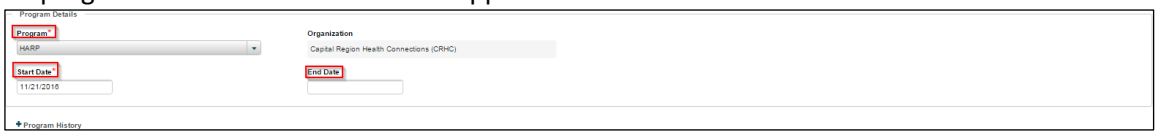
Adding New Program Information

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

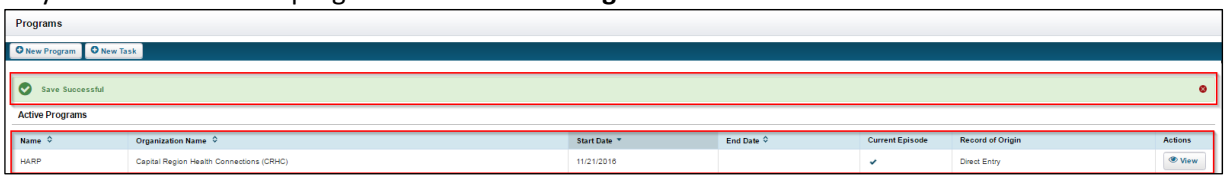
1. Select the **+New Program** button.



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.

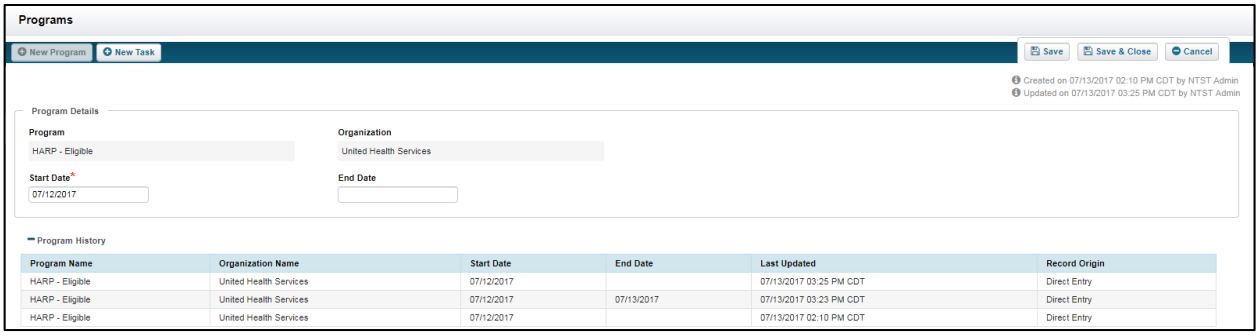


3. Select the **Save** or **Save & Close** button when once your selections have been made.
4. The green 'Save Successful' banner will show after you are brought back to the **Programs** page and you will now see the program under **Active Programs**.



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**.

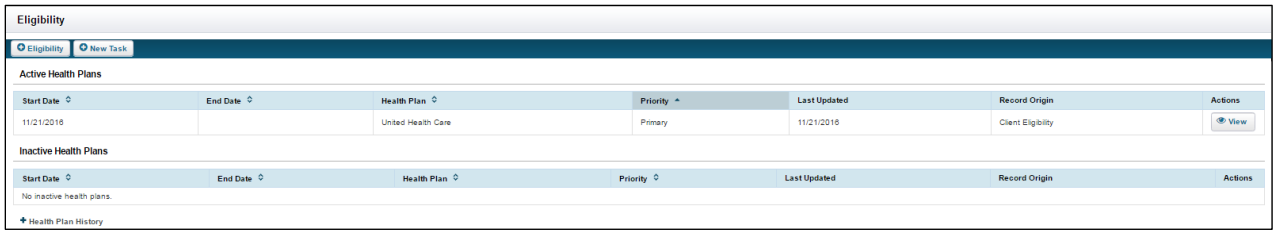


3. Select the Save or Save & Close button when finished.

Eligibility

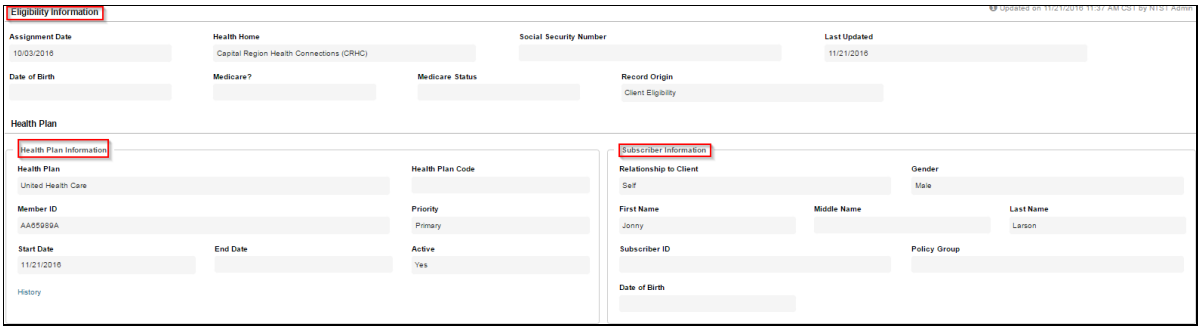
The **Eligibility** page is where new Health Insurance information can be entered and previously entered information modified. It is comprised of three sections:

- Active Health Plans
- Inactive Health Plans
- 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

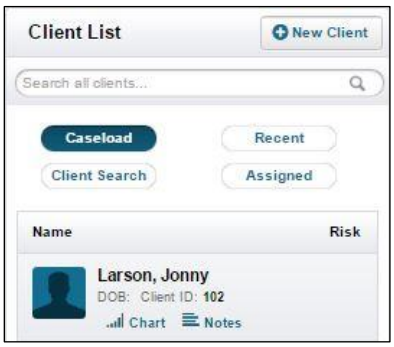


Note: Fields with a red asterisk * indicate required fields. While other fields are not required, the more information entered for a client the better.

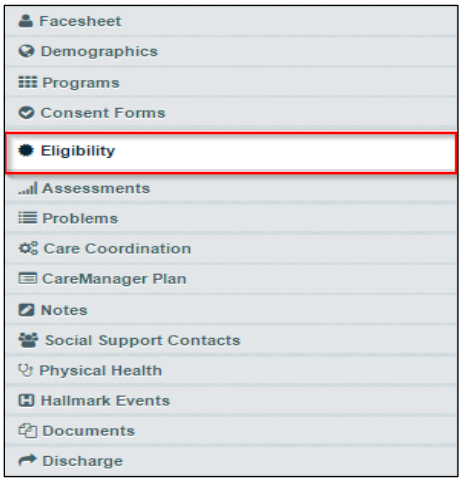
Adding New Eligibility Information

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

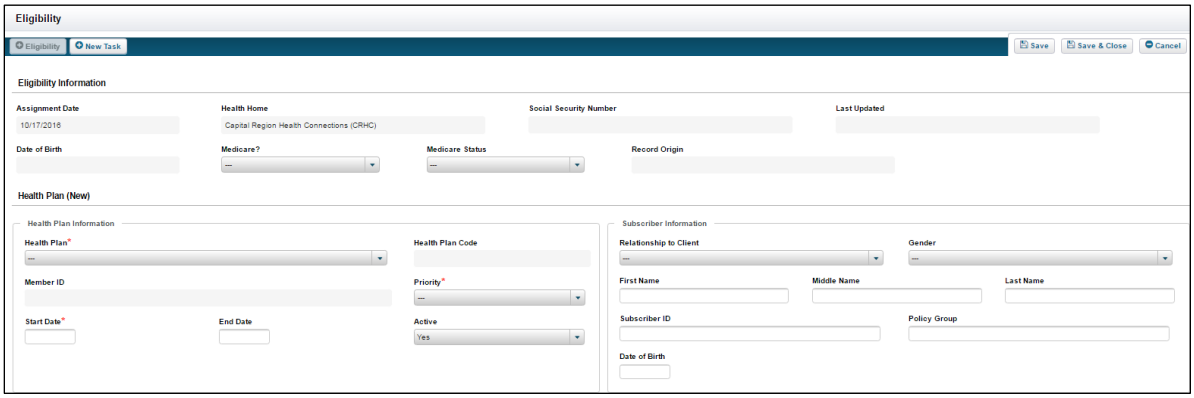
1. From the **Home Screen**, select a client from the **Client List**.



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



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



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

Documenting Eligibility

This is where a 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.
2. From the drop-down enter the client's **Medicare?** and **Medicare Status** if applicable.

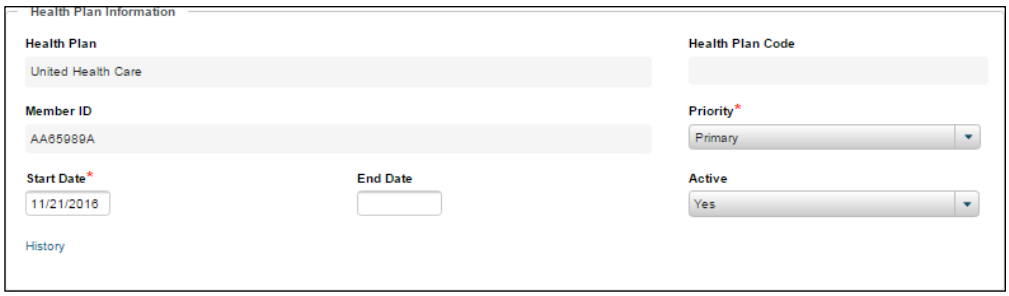
Note: If the information entered into these fields are incorrect, the user should navigate back to the Demographics page and make the correct changes.

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)

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



Subscriber Information

1. Select the subscriber's relationship to the client from the **Relationship to Client** drop-down.
2. Select the appropriate **Gender** of the subscriber from the drop-down menu.
3. Type in the **First Name, Middle Name,** and **Last Name** of the subscriber in the open text field.
4. Enter in the subscriber ID in the **Subscriber ID** open text field.
5. Enter the subscriber's policy group in the **Subscriber ID** open field.
6. 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

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

Eligibility Information

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: AA85989A
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.

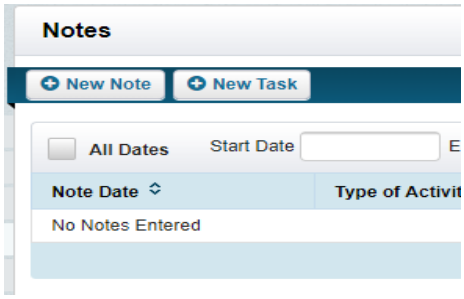
Note: All outreach efforts need to be documented regardless of whether or not an activity is billable. Please see the Outreach and Engagement Policy to see if an Outreach effort is completed that meets billing standards.

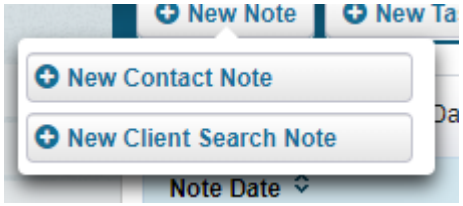
Billable Client Search Note Workflow

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)**:

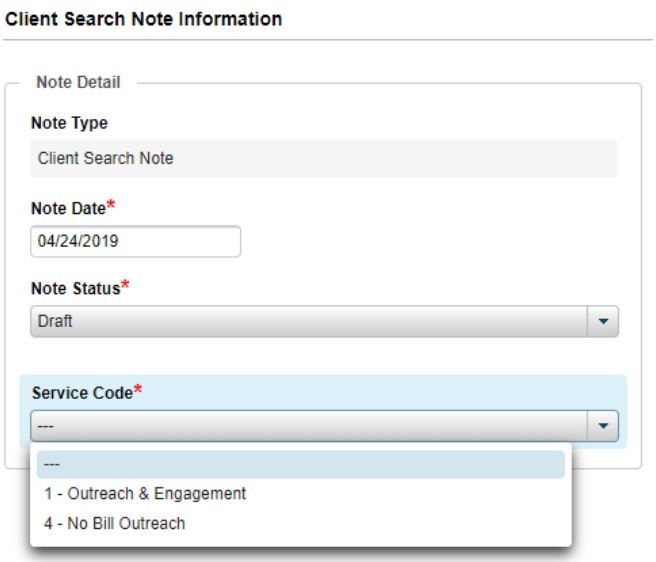
1. Click on the **Note** section of the client's chart.

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





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



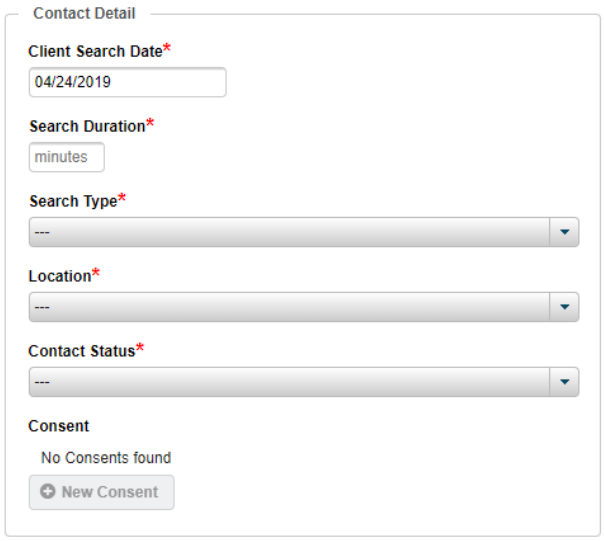
Note Detail

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.**

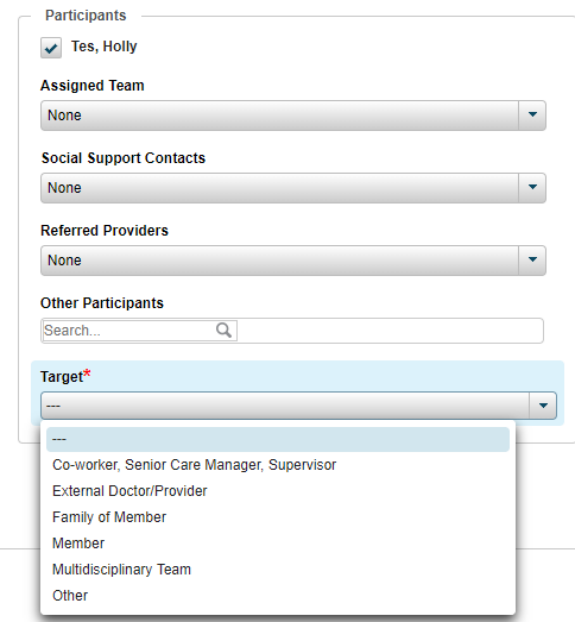


Contact Detail

Client Search Date: Date of the service

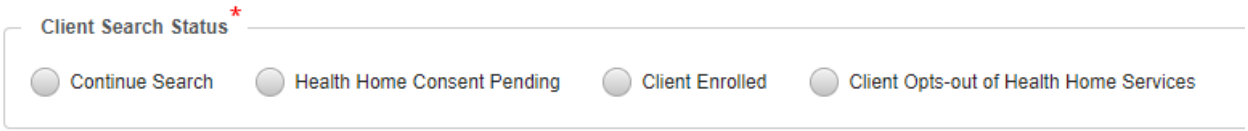
Search Duration: Amount of time spent during the service, can be any amount of time.

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
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.



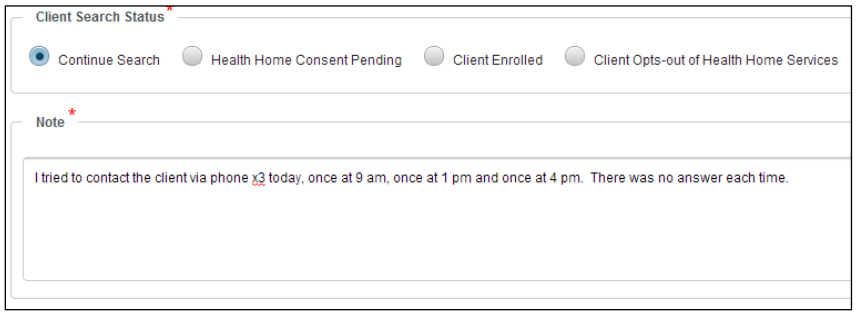
Client Search Status

Continue Search: 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.



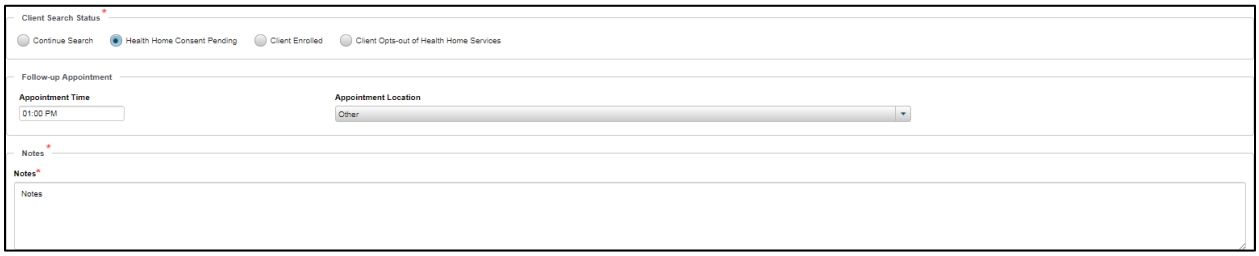
Once the form is completed, select the **Save** or **Save & Close** button.

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.



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 Opts-out of Health Home Services

Follow-up Appointment

Appointment Time: 10:00 AM

Appointment Location: Other

Notes *

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 Opts-out of Health Home Services – Client Search Status

If the client or the client's consenter does not want to participate or the client does not qualify for Health Home services, the **Client Opts-out 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 Opts-out of Health Home Services

Reason For Opt-Out *

Notes *

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

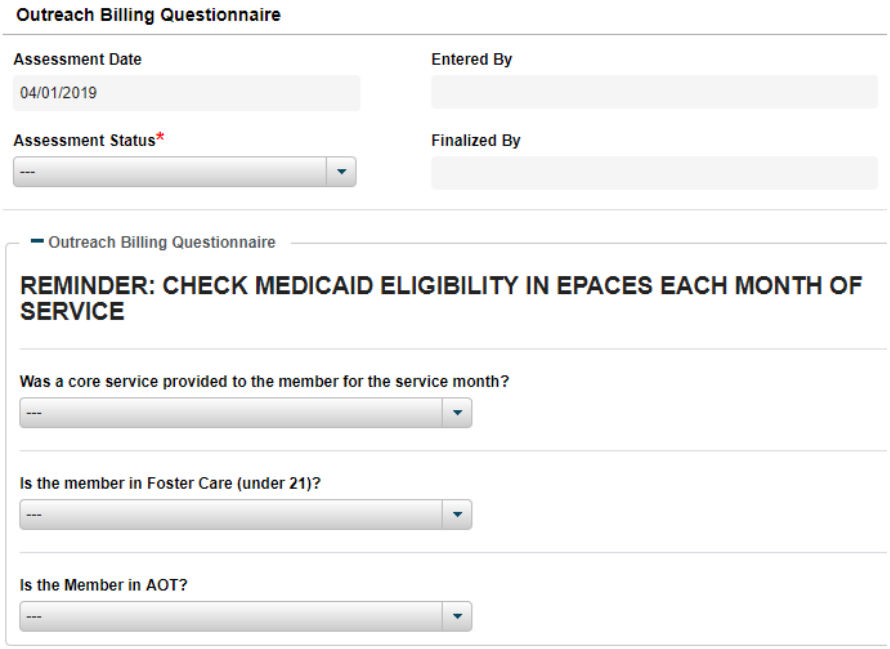
In order to document a non-billable Outreach efforts/activity, you must complete a **Client Search Note** using the steps listed above. To capture the fact this is a non-billable activity would be to select the **Service Code** of **No Bill Outreach**. All activities should be captured, so it is expected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



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.

Note: Any youth under the age of 21 who is in the HHSC that has an AOT order must be moved into the HHSA.

4. 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 5200- Health Home Consent to Enroll, 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.

Child Eligibility Screen

Prior to signing the DOH 5200 you must determine if the client meets all of the criteria issued by the Department of Health. If the member is entered directly into "enrollment" status from MAPP the eligibility screen and proof of diagnosis must be completed in the chart within the month of enrollment in the system.

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 **+Child Eligibility Screening**

Child Eligibility Screening

Assessment Date*
04/25/2019

Entered By

Assessment Status*

Finalized By

Eligibility Screening

1. Does the youth have active Medicaid?*

Yes No

Assessment Date: This is the date the eligibility screen is completed.

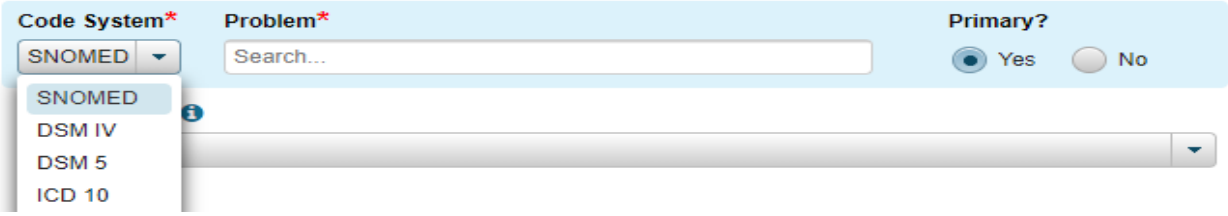
Assessment Status: Draft or Final.

1. Does the youth have active Medicaid?: The client must have active Medicaid in order to enroll. If this is answered "No" the rest of the screening will not populate. If you answer "Yes" you can proceed. Medicaid eligibility will be checked at the time of assigning the case by the Health Home, but it is up to you to continue to check Medicaid status for the duration of enrollment.

2. What is the youth's primary qualifying criteria? (Supporting documentation from a provider is required to be attached in the Documents area, please select one primary)

HIV/AIDS
SED
2+ Chronic Conditions
Complex Trauma
Youth does not meet the qualifying criteria
HCBS Only
HCBS and other conditions

Select the primary qualifying condition that is making the client eligible for Health Home services. Once the criteria is selected, additional field(s) will appear that prompt you to add the member's qualifying diagnosis/es. The first diagnosis entered onto this screening will be the member's Primary Problem. The Primary Problem for a member MUST be a qualifying condition that made the member eligible for the Health Home program. When entering a Primary Problem, the Care Manager will be required to select an ICD 10 code for the diagnosis being entered. This is because the Primary Problem is used for billing. To search for the diagnosis, you will need to search using a database listed in the Code System drop down box:



SNOMED: SNOMED is an acronym for Systematized Nomenclature of Medicine. If you select this code system to search for the primary diagnosis, you will still need to select the appropriate ICD Selection code from the dropdown box below the problem field.

DSM IV: Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition covers all mental health disorders for both children and adults. If you select this code system to search for the primary diagnosis, you will still need to select the appropriate ICD Selection code from the dropdown box below the problem field.

DSM 5: Diagnostic and Statistical Manual of Mental Disorders. If you select this code system to search for the primary diagnosis, you will still need to select the appropriate ICD Selection code from the dropdown box below the problem field.

ICD 10: International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list that contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.

Please select the youth's functional limitations pertaining to the SED diagnosis:*

- [ ] Ability to care for self (e.g. personal hygiene; obtaining and eating food; dressing; avoiding injuries); or
- [ ] Family life (e.g. capacity to live in a family or family like environment; relationships with parents or substitute parents siblings and other relatives; behavior in family setting); or
- [ ] Social relationships (e.g. establishing and maintaining friendships; interpersonal interactions with peers, neighbors, and other adults; social skills; compliance with social norms; play and appropriate use of leisure time); or
- [ ] Self-direction/self-control (e.g. ability to sustain focused attention for a long enough period of time to permit completion of age-appropriate tasks; behavioral self-control; appropriate judgment and value systems; decision-making ability); or
- [ ] Ability to learn (e.g. school achievement and attendance; receptive and expressive language; relationships with teachers; behavior in school).

Note: If SED is selected, you will need to answer additional questions about their functional limitation(s) pertaining to the SED diagnosis on the eligibility screen. The functional limitations should be indicated in the member's external eligibility documentation.

3. Please indicate the child's appropriateness criteria for receiving Health Home services:

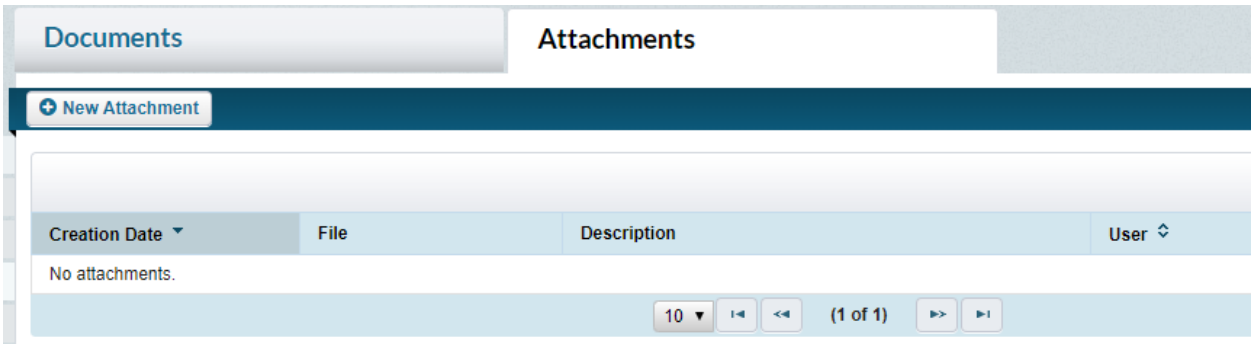
- [ ] At risk for an adverse event (e.g., death, disability, inpatient, out of home placement, mandated preventive services, etc.)
- [ ] Has inadequate social/family/housing support, or serious disruptions in family relationships
- [ ] Has inadequate connectivity with healthcare system
- [ ] Does not adhere to treatments or has difficulty managing medications
- [ ] Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
- [ ] Has deficits in activities of daily living, learning or cognition issues
- [ ] Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

Indicate the child's appropriateness criteria for Health Home services; at least one must be present.

Once the screening is completed, select the **Final** from **Assessment Status** then **Save & Close**.

Verifying Diagnosis and Uploading Documentation

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



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.

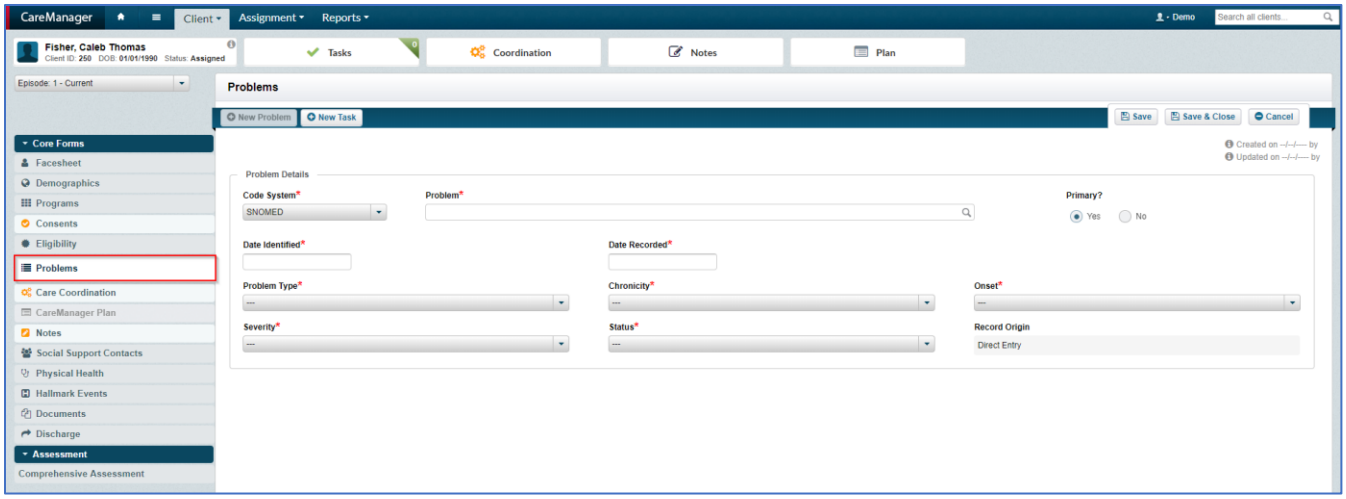
Entering Diagnosis/es in the Problem List

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**.

Upon completing the **Child Eligibility Screen** the **Primary Problem** (diagnosis) will be set in the system. You will still need to update this Problem with additional information detailed below. If any additional Problems need to be created, or edited/deleted please follow the below workflow:

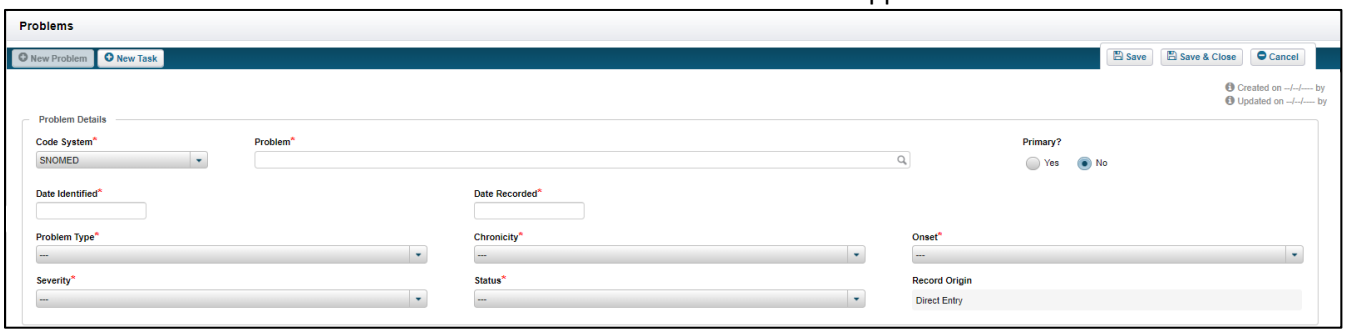
Navigating to Problems

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 Specific)

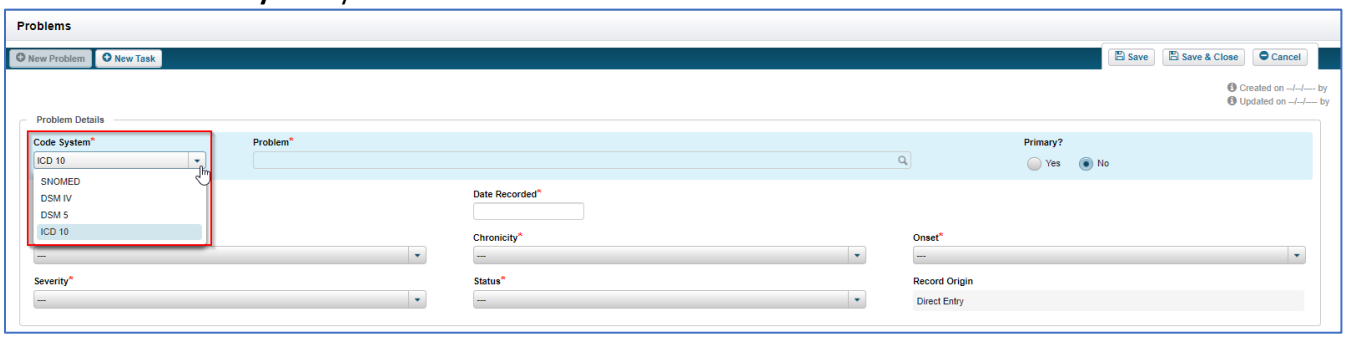
Chronicity: The **Chronicity** drop-down will have you select the frequency of the problem.
Onset: The **Onset** drop-down will have you select the time in the member's life that the problem started.
Severity: The **Severity** drop-down will have you select the harshness of the problem. The severity should reflect, when applicable, the CANS-NY ratings.

- **CANS score of 3 Dangerous/disabling:** Condition is life threatening or disabling; activities are severely impacted
- **CANS score of 2 Requires action/intervention:** Condition requires ongoing interventions; activities are moderately impacted
- **Require prevention or watchful waiting (CANS 1):** Condition may require some treatment, but the problem is not acute and not expected to have a duration of a year or more; mild limitations on activities
- **No action required at this time (CANS 0):** Child is healthy; no limitation in activities

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

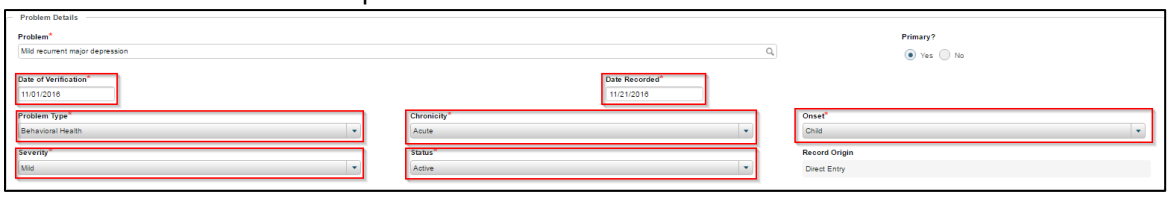
2. Select the **Code System** you would like to search.



3. Search for a problem in the **Problem** field by description.
4. The descriptions will appear below the search. Select the appropriate description.

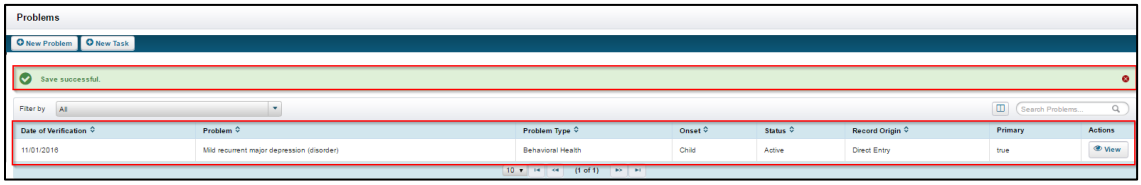
Note: The first 'Problem' entered for a client will default as their Primary problem. Once more than one problem has been entered for a client, you can choose to change which 'Problem' should be Primary.

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.

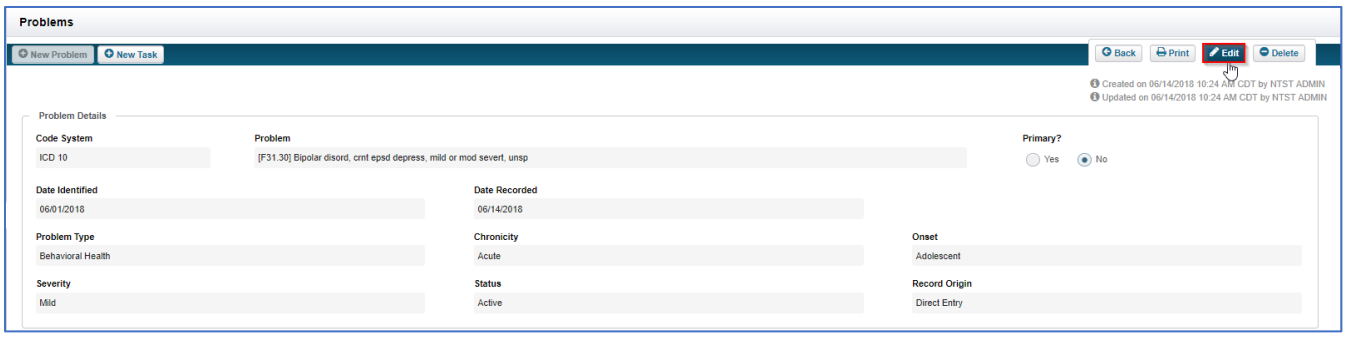


Editing Problems

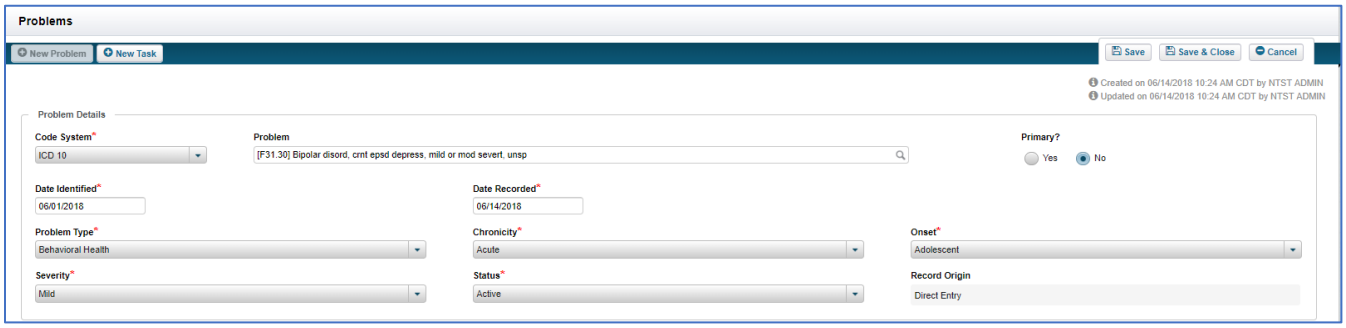
Problems can be viewed and modified within the problem feature. Depending in your permissions, options are available to **Delete** the problem, change the **ICD Code** associated with the problem and the **Problem Details**.

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

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



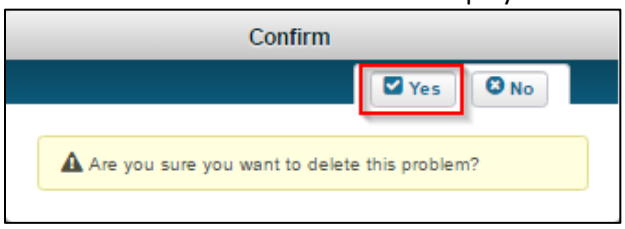
3. The previously entered information will display. This includes the **Problem, Diagnosis Information** and **Linked Referrals**.



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

Deleting a Problem

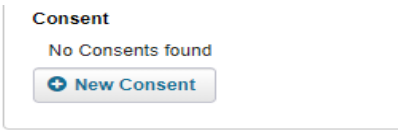
1. Select the **View** button next to the problem you would like to delete.
2. In the upper right-hand corner select the **Delete** button.
3. A confirmation window will display. Select the **Yes** button.

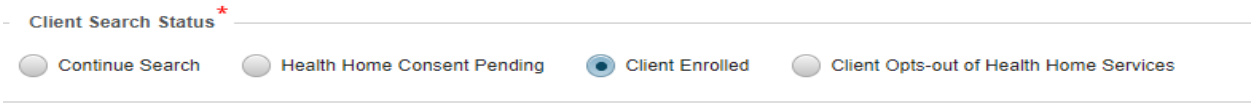


Note: A problem cannot be deleted if it has already been added to a Care Plan.

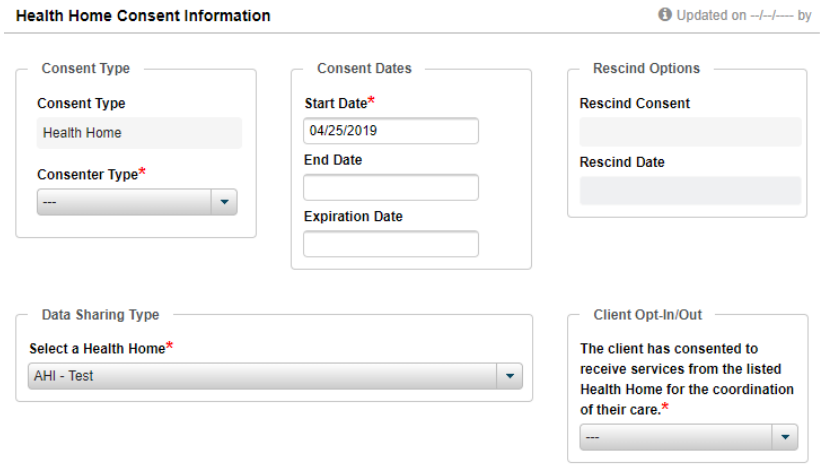
Enrollment Note: Client Search Note

Once the **Child 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.





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



3. Add the **Health Home Consent (DOH 5200)**
   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 5200)
   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.**

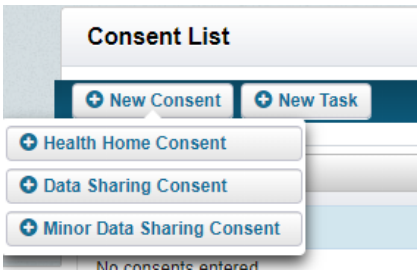
Note: If the child is over 18, or is a minor but is a parent, married, and/or pregnant; the child/youth does not sign the 5200 but the signed 5055 will suffice for both enrollment and data sharing.

Consents

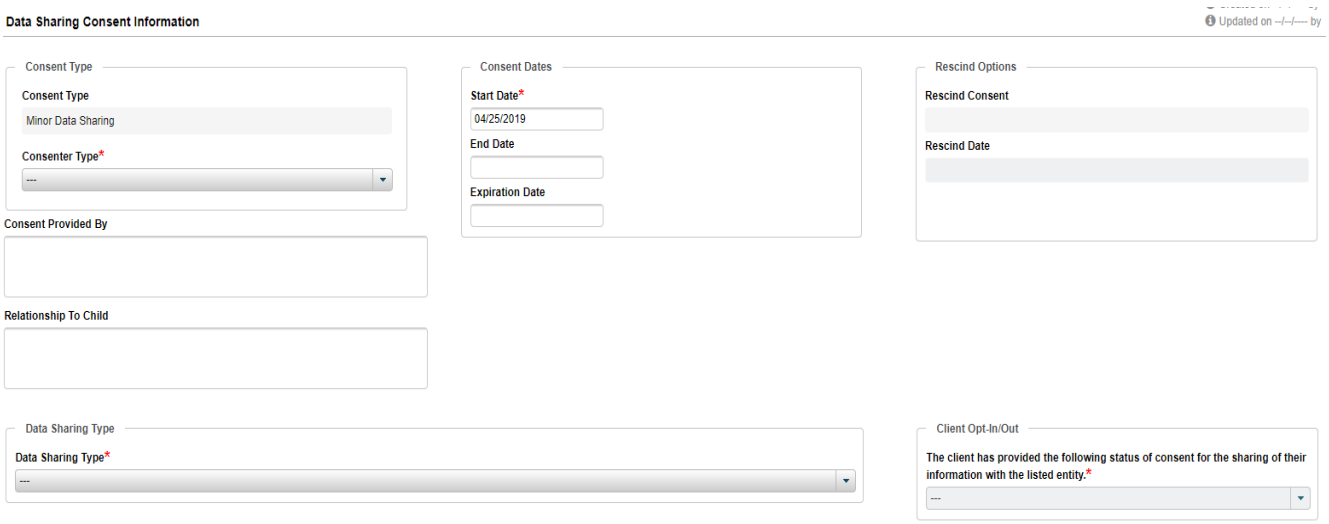
After the Health Home Consent to Enroll (DOH 5200) is signed and uploaded/added to CareManager there are other DOH consents that need to be obtained and uploaded.

Minor Data Sharing/Data Sharing Consent DOH 5201

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



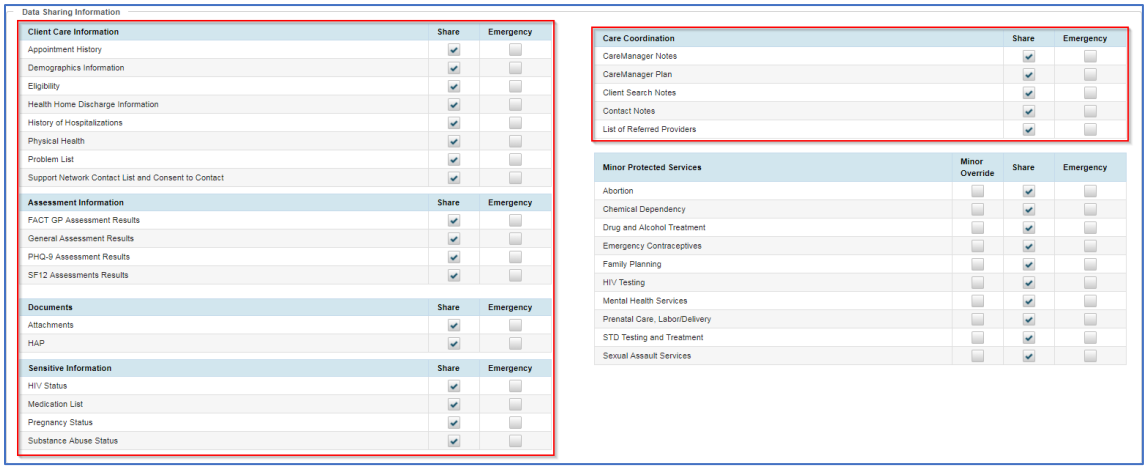
Complete the Data sharing Consent Information fields:

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.
Consent Provided By: The name of the consenting individual.
Relationship To Child: Relationship to the client.
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.
Consenter Type: Drop down that you can choose who the consenter is.

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

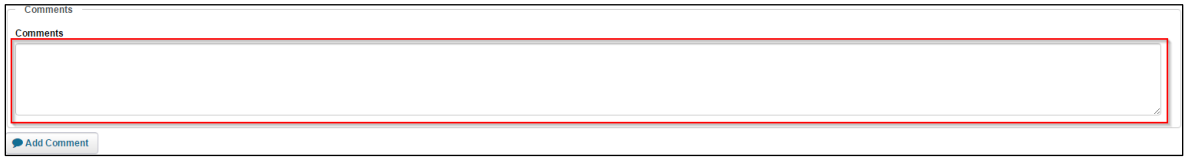
5. Fill out the appropriate **Data Sharing Information** the client would like shared. All **Share** checkboxes will be selected by default. If the client would only like their information shared in case of an **Emergency**, select that option. You can only have **Share** or **Emergency** selected **for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



6. Select the appropriate **Minor Protected Services** information in the **Data Sharing Information** section. This is where you will select the **Minor Protected Services Override** if any are applicable.

Minor Protected Services	Minor Override	Share	Emergency
Abortion	☐	☑	☐
Chemical Dependency	☐	☑	☐
Drug and Alcohol Treatment	☐	☑	☐
Emergency Contraceptives	☐	☑	☐
Family Planning	☐	☑	☐
HIV Testing	☐	☑	☐
Mental Health Services	☐	☑	☐
Prenatal Care, Labor/Delivery	☐	☑	☐
STD Testing and Treatment	☐	☑	☐
Sexual Assault Services	☐	☑	☐

7. 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.



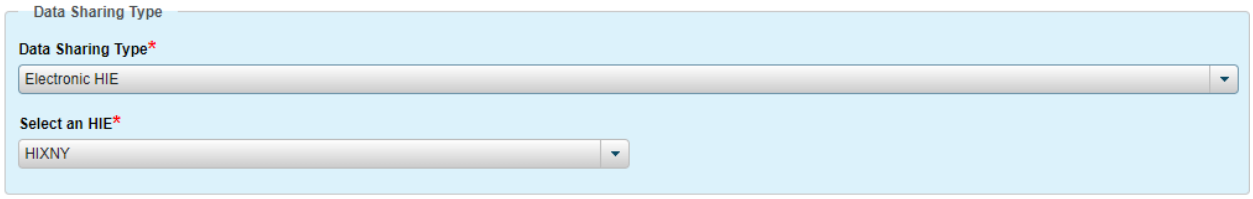
8. Select the **Save** or **Save & Close** button to finish the **Minor Data Sharing Consent**. The green **"Save Successful"** banner will appear along with the consents.

Data Sharing Types

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

5201
Electronic HIE
Functional Assessment Consent
Health Home Release of Educational Records
HIE
Other
Provider
Support Network Contact

5201- Used to document the DOH 5201 when signed.



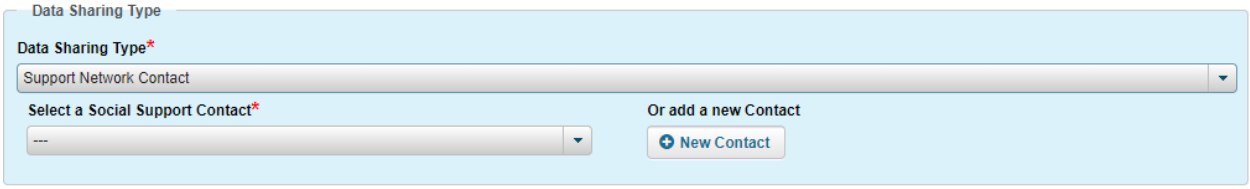
Electronic HIE- Select this type to document the receipt of a signed Health Information Exchange (HIXNY) consent

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 not fit into any other category

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.



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. See attachment descriptions conventions in the Appendix of this manual.

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 (client turns 18, becomes married, pregnant, or if there is a legal custody change).

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

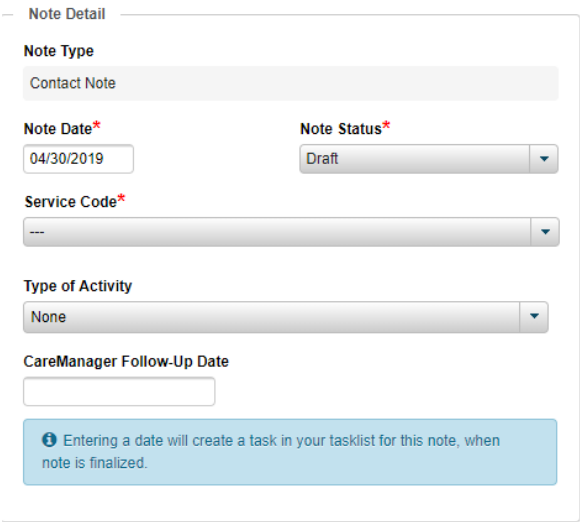
Upon Enrollment all services will be documented in **New Contact Notes** until the client's **Initial Care Plan** is finalized. Once the **Initial Care Plan** is finalized, all services and encounters can be documented as either New Contact Notes or New CareManager Notes, which will be gone over later 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: This will prepopulate to contain the type of note you are completing

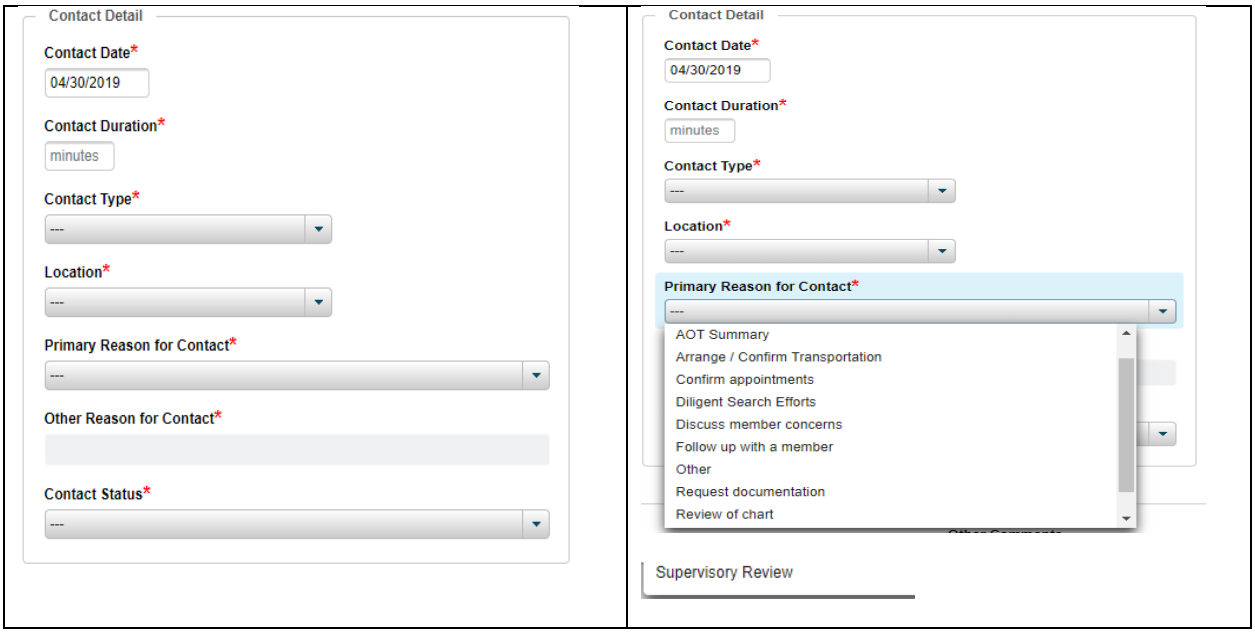
Note Date: Auto-populates to the date the note is finalized in the system

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.



Contact Detail

Contact Date: The date that the service took place.

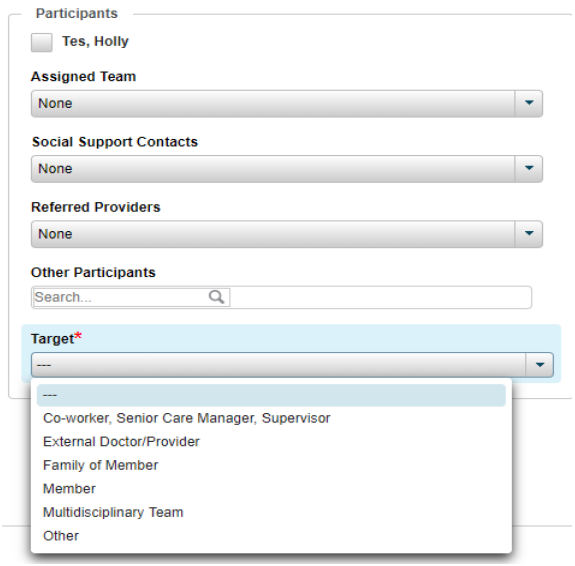
Contact Duration: Document the number of minutes the activity took you to perform

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

Location: The location of the Care Manager 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.**

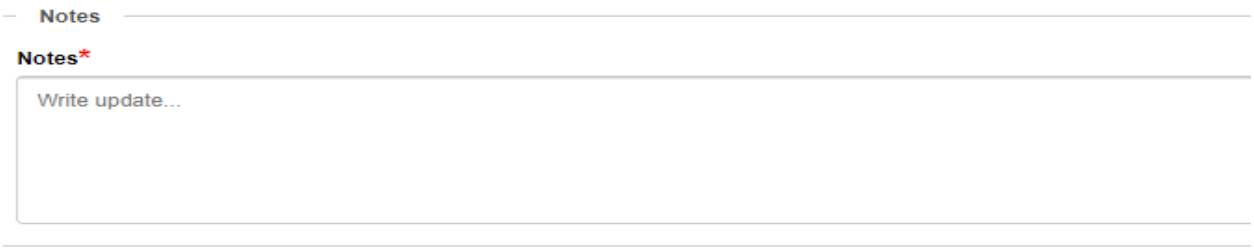
Contact Status: Contact Achieved or **Unable to Contact**



Participants

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 was the target of the activity.

Notes

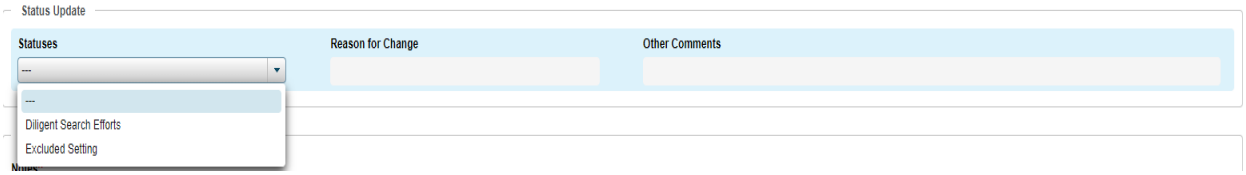


Notes: This section is where you write the narrative of the contact, expanding on the information in the drop downs, and ensuring it was a billable service.

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.

Children's Billing Questionnaire (CBQ)

Once a client is enrolled, a Billing Questionnaire must be completed monthly even if a billable service did not occur. The Children's Billing Questionnaire will confirm a billable activity was completed and the claim will be submitted to MAPP and to the payer for processing.

Children's Billing Questionnaire

Assessment Date: 04/01/2019

Entered By:

Assessment Status*: ---

Finalized By:

Primary Diagnosis:

Set Current Primary Diagnosis

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, and the date will not allow you to skip months.

1. Select the **Assessments** tab
2. Select +Children's Billing Questionnaire

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 CBQ.

Assessment Status: Draft or Final. Only finalize the CBQ 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 CBQ.

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.

Children's Billing Questionnaire

REMINDER: HAVE YOU CHECKED EPACES TO CONFIRM MEMBER ELIGIBILITY?

1.) Has the child been in Foster Care at any time this month? ---

2.) What is the date of the latest CANS-NY Assessment? ---

3.) What is the member's acuity level? ---

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

☐ I have reviewed and attest that information provided above is accurate and valid for the current month

1) **Has the child been in Foster Care at any time this month?** Yes or No answer.

2) **What is the date of the latest CANS-NY Assessment?** Enter when the last CANS-NY was completed. The system will then calculate 6 months from that date as your CANS Reassessment due date.
3) **What is the member's acuity level?** This question is for the month of service you're reporting; High Medium, or Low. This answer will dictate the amount of billable services needed to complete the CBQ.
4) **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.
5) Review and attest that the information provided is accurate and valid for the current month.

Assessments

Child and Adolescent Needs and Strengths NY (CANS-NY) – Completed in UAS

The CANS-NY is an assessment that is not completed in the CareManager platform, but in the State Universal Assessment System (UAS). The CANS-NY assessment is an integral tool in building the Care Plan and guiding services for the youth and family in conjunction with the Comprehensive Assessment. Even though the CANS-NY is completed in another system a summary of the report will need to be uploaded into CareManager to track the completion within the first 30 days or enrollment, and every 6 months thereafter. See attached

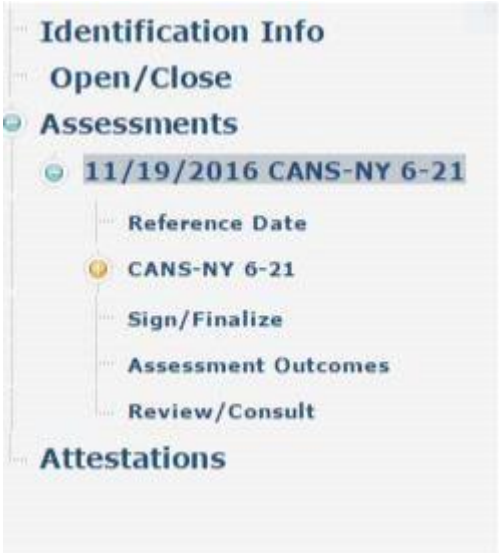
How to Print CANS Summary Reports from UAS

1. Search for your client in UAS-NY

2. Select your client and open case file

3. Note: You can only print summary reports after CANS has been finalized

4. On the left-hand side of the screen select "Assessments" and then select the CANS Assessment you would like to report on



5. Once this is highlighted go to the upper left hand corner of your screen and hover over the word "Reports"

6. You should see 3 options for reports:

7. Select the report you would like to run. **Download the PDF version to ensure you are able to upload it into the Netsmart CareManager system**.

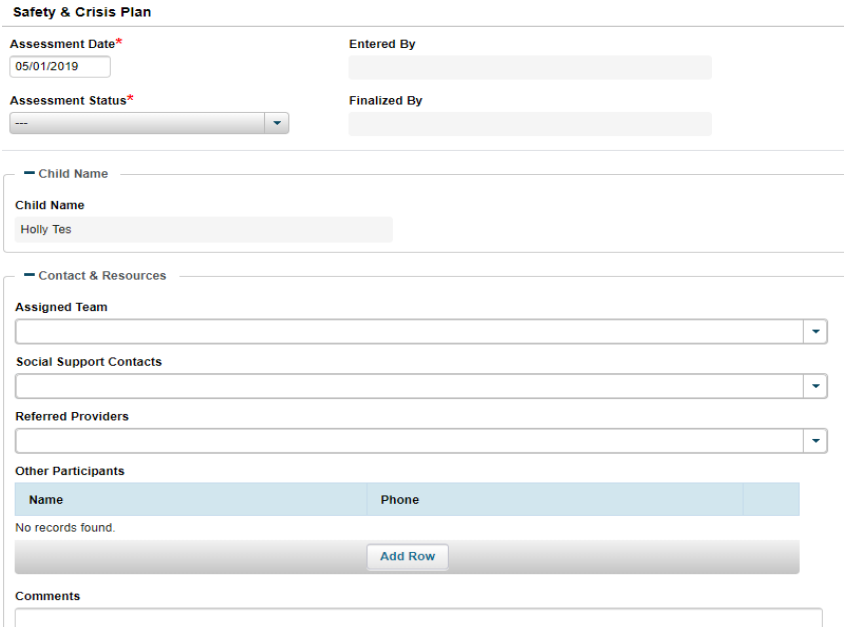
8. You are required to upload the **Assessment Results** and the **Plan of Care** Guidance report into the Netsmart CareManager system

For any questions about the UAS system, please contact their help desk:

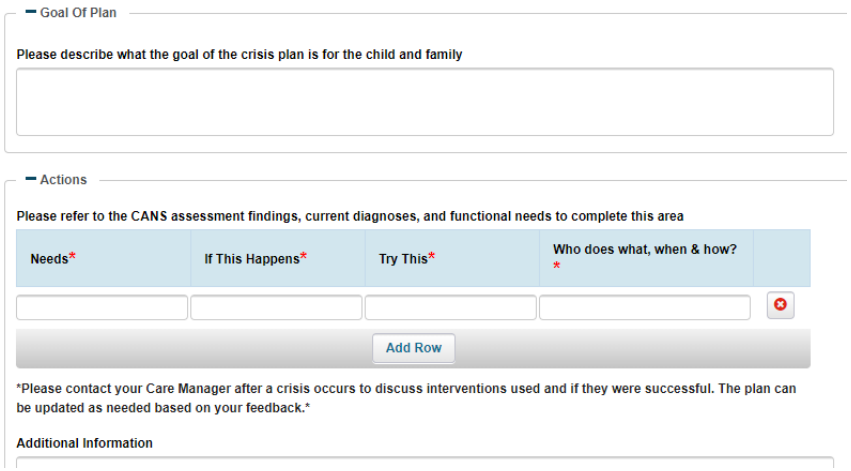
UAS-NY Support Desk
uasny@health.ny.gov
or
518-408-1021, option 1
Monday – Friday
8:30 AM – 12:00 PM
1:00 PM – 4:00 PM

Safety & Crisis Plan

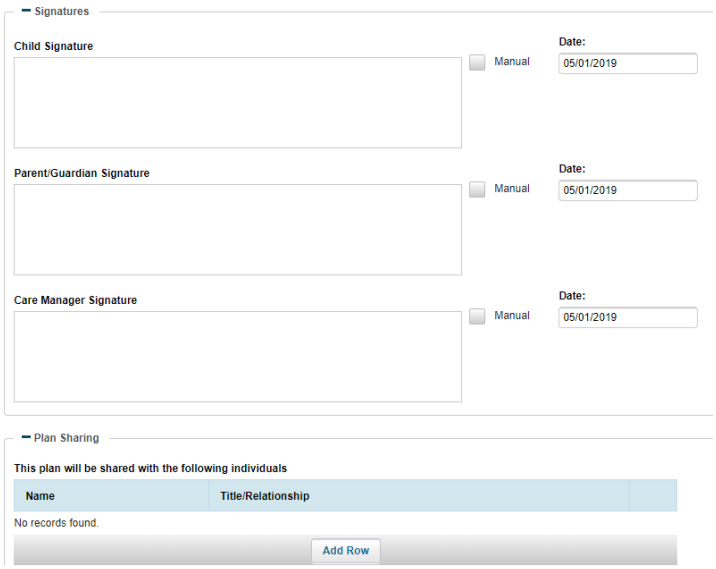
The Crisis Plan is a guide to give clients, providers and families' for preparedness and actions that are adaptable for any crisis a client may face. The Crisis Plan must be completed within 60 days of enrollment and reviewed every six months, or sooner if there has been a significant life change.



1. Select the **Assessments** tab
2. Select **+New Assessment**
3. Select **+Safety & Crisis Plan**
4. **Assessment Date**: The date the plan was finalized with the child and family.
5. **Assessment Status**: Keep in draft until child and family have finalized and approved, then mark as final.
6. **Entered by & Finalized by**: This will be pre-populated based on who enters and finalizes the assessment in CareManager.
7. **Child Name**: This will be pre-populated based on the member's chart you are completing.
8. **Contacts & Resources**: Identify all contacts/resources involved in the plan. The drop-down boxes will be populated with any social supports & providers that have been added to the client's chart as well as the assigned team members from your agency.



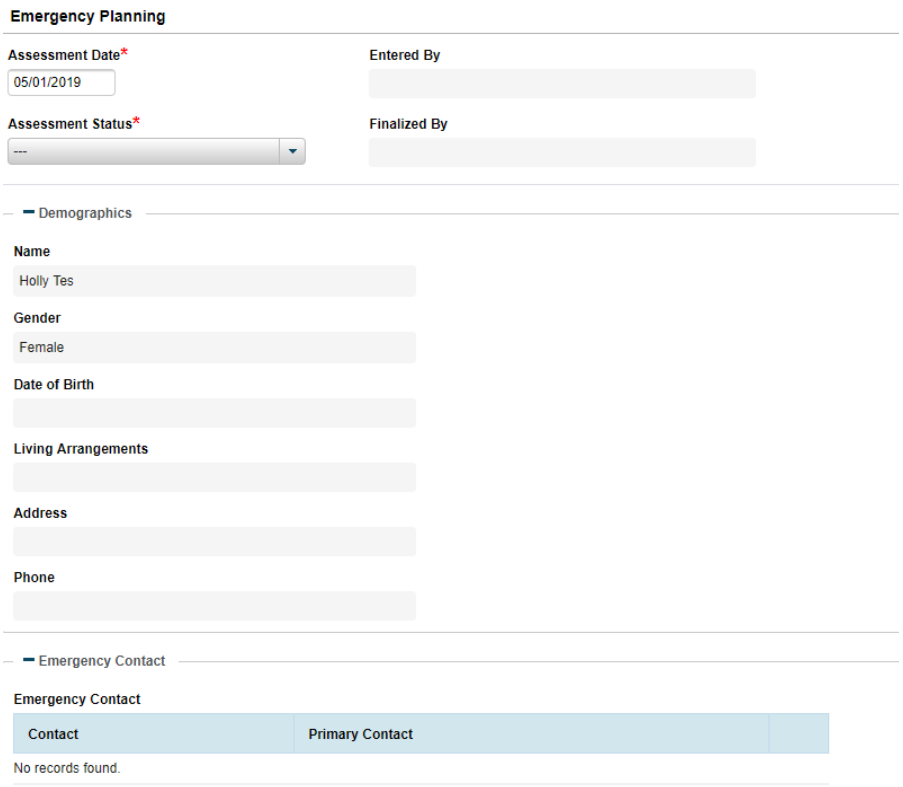
9. Complete the assessment as required. Do not leave any blanks within the assessment. Refer to the CANS findings, diagnoses and functional needs to complete the **Actions** area.



10. **Signatures:** Signatures from Care Manager and child/guardian can be captured manually or electronically. If they will be captured manually, be sure to scan and upload the plan into **Attachments**.
11. **Plan Sharing:** Enter the names of the individuals with whom this plan will be shared. It is expected that all assessments are shared with the care team.
12. Select **Save & Close:** This assessment can complete over multiple sessions with child/family if the Assessment Status is not changed to Final.

Emergency Planning Assessment

The Emergency Plan will utilize Demographic information and Social Support Contacts documented in the member's chart within the assessment. This plan should be completed within the first 60 days of enrollment and reviewed along with the care plan every six months, or sooner if needed.



1. Select the **Assessments** tab
2. Select +**New Assessment**
3. Select **+Emergency Planning**

Questions

What would your family do in an emergency or if you do not feel safe in your home or community?*

What is your exit plan if you had to leave your home immediately? (ex. In the event of a fire)*

In an emergency, where would your family meet up near your home? What would you do after that?*

In your house where do you keep your important papers? (Ex. Forms of identification, health/home/rental insurance)*

If you had to leave your home in an emergency, what would you need to have with you? (Ex. Medication, wallet, credit cards, clothes, important papers)*

4. Answer all questions. This section is free text, so it will be a conversation and discussion with the family.

Signature

Child Signature — Manual — Date 05/01/2019

Signature — Manual — Date 05/01/2019

Relationship to Child (Parent, Caregiver, Legal Guardian, etc.)

CareManager Signature — Manual — Date 05/01/2019

Plan Sharing

This plan will be shared with the following individuals

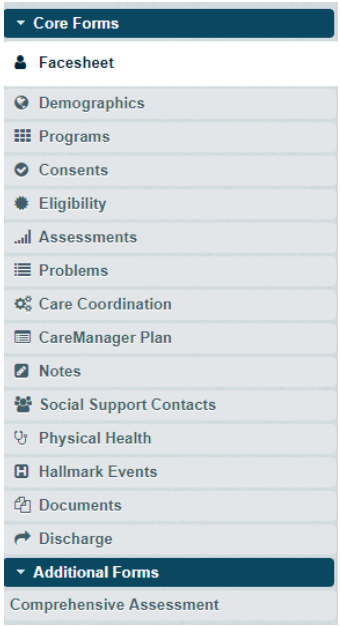
Name	Title/Relationship

No records found.

5. **Signatures:** Signatures from Care Manager and child/guardian can be captured manually or electronically. If they will be captured manually, be sure to scan and upload the plan into **Attachments.**
6. **Plan Sharing:** Enter the names of the individuals with whom this plan will be shared. It is expected that all assessments are shared with the care team.

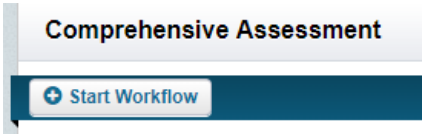
7. **Select Save & Close:** This assessment can complete over multiple sessions with child/family if the Assessment Status is not changed to Final.

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**

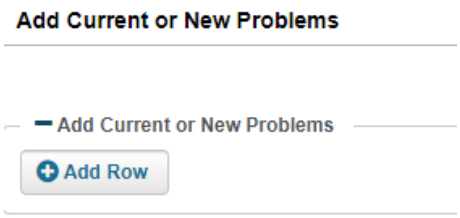


2. Select **Start Workflow**
3. At the top of every section will be one, or two questions you must answer in order to progress through the Comprehensive Assessment.

Adult/Child- 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.



5. On select sections you are able to directly input **Problems** that will push to the **Problems** section of the chart.
6. 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

7. 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

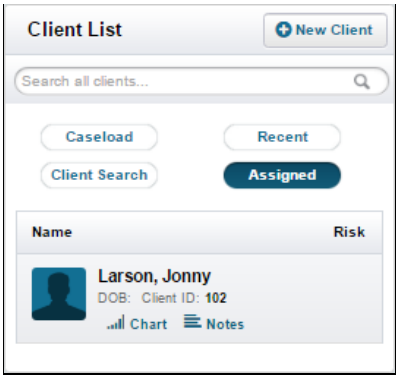
The Care Team can consist of internal resources at your agency, external providers that the client/family reported during the assessments and social support contacts who play an active role in the member's care. Every care team member must be listed on the Care Coordination page of the client's chart.

Social Support Contacts

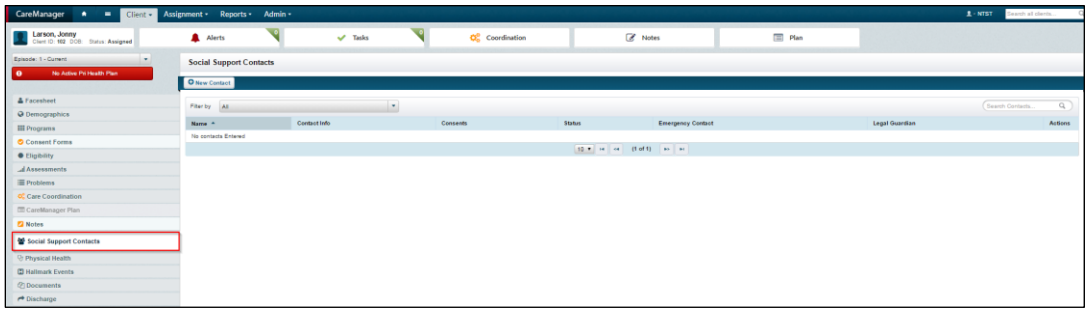
A client's **Social Support Network** can be a key factor in helping them stay engaged with their care. A Social Support Contact(s) can be defined as a client's mother, father, step-parent, sister, brother, relative, spouse, sponsor, etc. Once the Social Support Contacts have been added into CareManager, 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**.

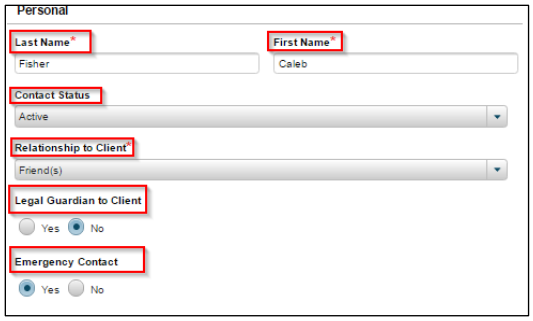


2. Select **Social Support Contacts** tab from the left side of the page.



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.

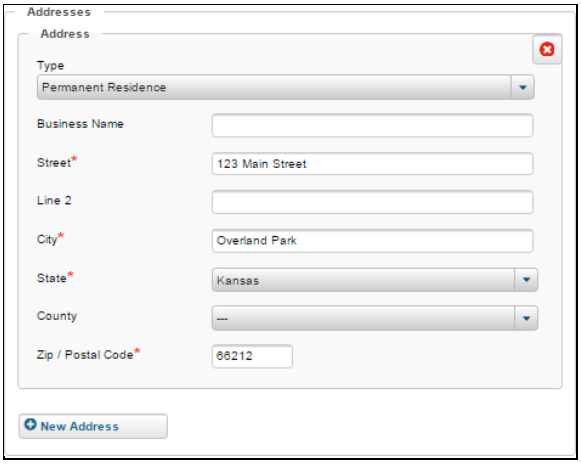
5. Once selected, the **Personal, Contact,** and **Comments** section becomes editable.
6. Fill in the **Last Name, First Name, Contact Status, Relationship to Client,** and if the support is a **Legal Guardian** and if the support is an **Emergency Contact**.



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

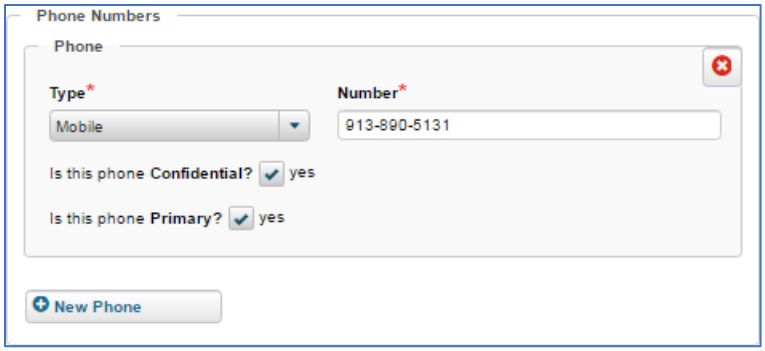
Note: Only fields with a red asterisk are required to be filled in. You are always able to edit and enter information as it comes in.

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.

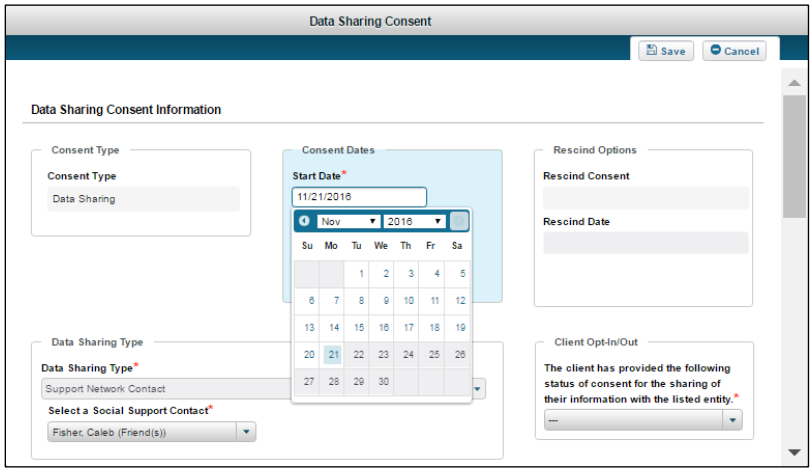


Note: You can select the red 'X' in the top right corner to remove the address if needed.

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.



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



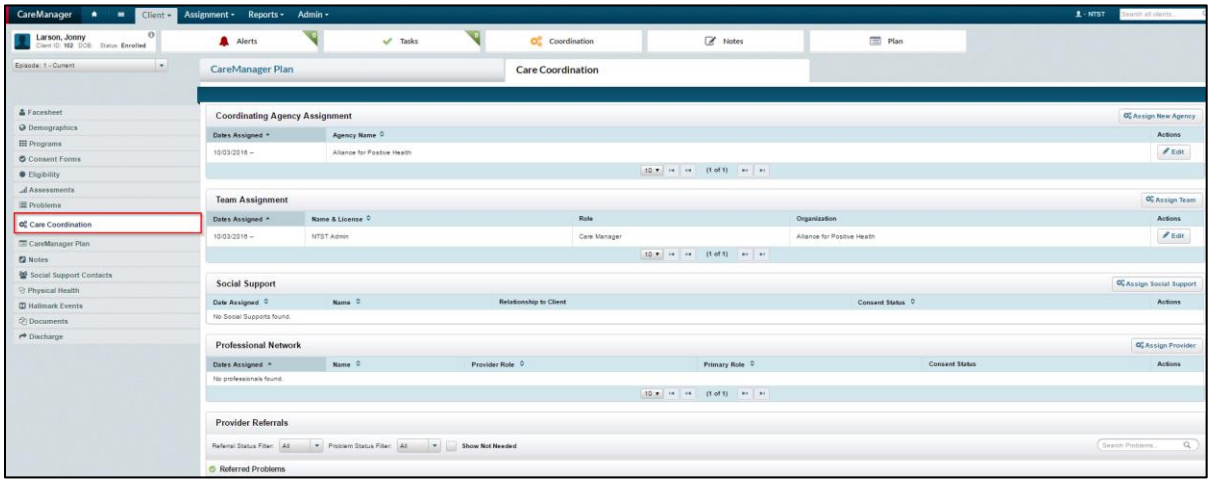
11. Enter the **Consent Dates**. The date will auto-populate with today's date.
12. From the Client Opt-in/Out drop-down, select Client Opt-in.
13. Make sure all applicable **Data Sharing Information** is checked correctly.
14. Enter any comments in the **Comments** section of the consent.
15. Select 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.

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

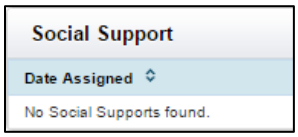
Assigning a Social Support Contact

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.

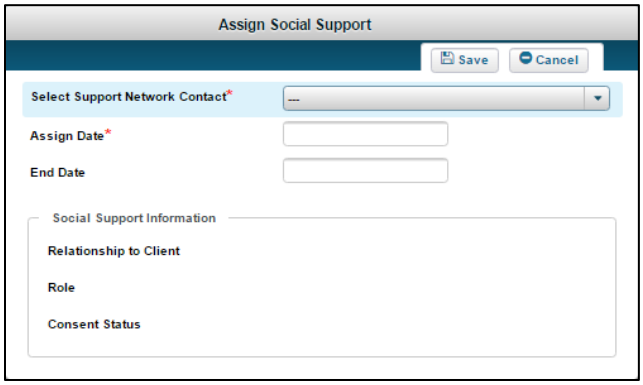
1. From the **Home Page**, select the client from the **Client List**.
2. Select the **Care Coordination** tab from the left of the screen. The **Care Coordination** screen will display as shown below.



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



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

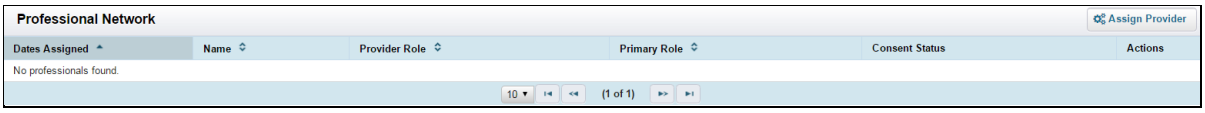


5. From the drop-down menu, select the correct **Support Network Contact**. The **Social Support Information** will auto populate from the **Social Support Contacts** information entered.
6. Enter the **Assign Date** field.

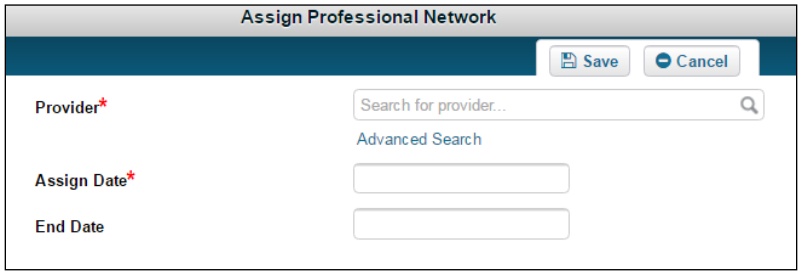
7. Enter an **End Date** if applicable.
8. Select the **Save** button when finished. Information selected will save and the social support is now assigned to the client.

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.



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



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

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.

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

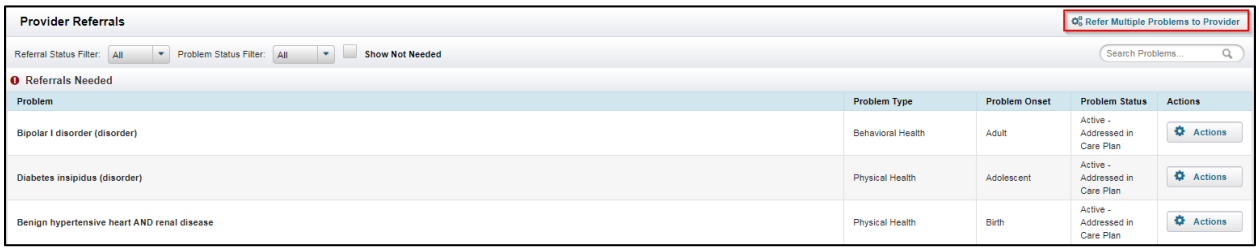
Provider Referrals

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.

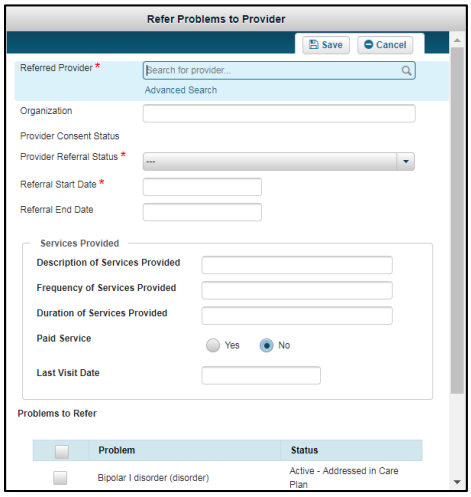
Clients Problems can be referred to a provider. Multiple Problems can be referred to the same provider and Multiple Proviers can be referred to one problem.

Refer Multiple Problems to a Provider

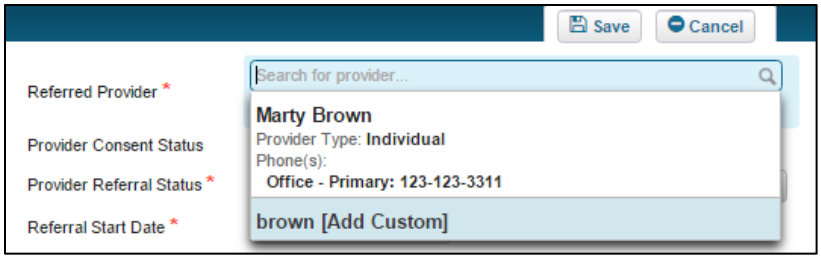
1. From the right side of the **Provider Referrals** section of CareCoordination, select the **Refer Multiple Problems to Provider** button.



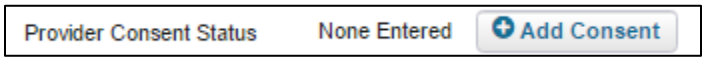
2. The **Refer Problems to Provider** window will present.



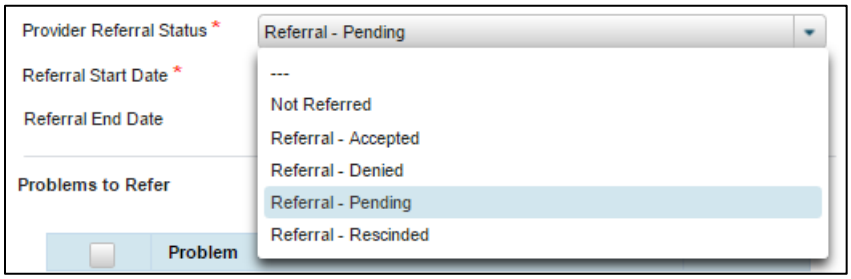
3. Search for and select the intended provider from the **Referred Provider** field.



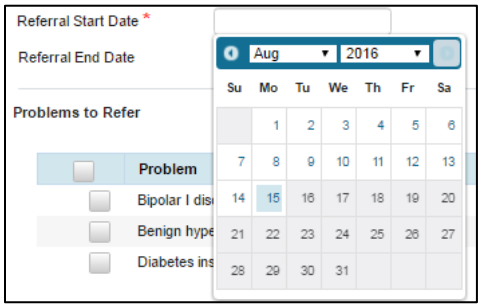
4. If appropriate, enter the **Organization** name where the member sees their provider.
5. If appropriate, complete the **Provider Data Sharing Consent** by selecting the **+Add Consent** button.



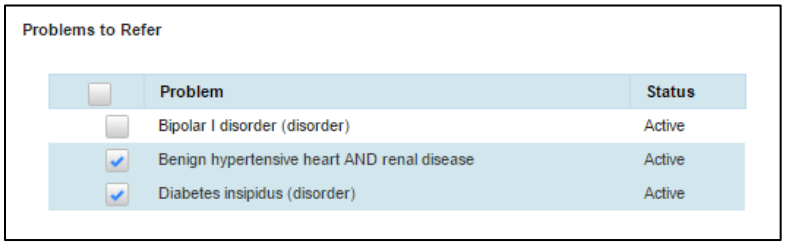
6. Identify the referral status in the **Provider Referral Status** dictionary.



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



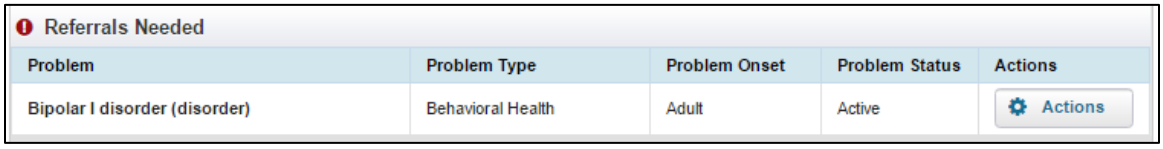
8. Select the check box next to each of the problems that should be referred to this provider from the **Problems to Refer** table.



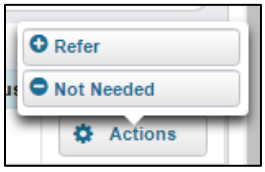
9. Select the **Save** button.

Referring Multiple Providers to One Problem

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

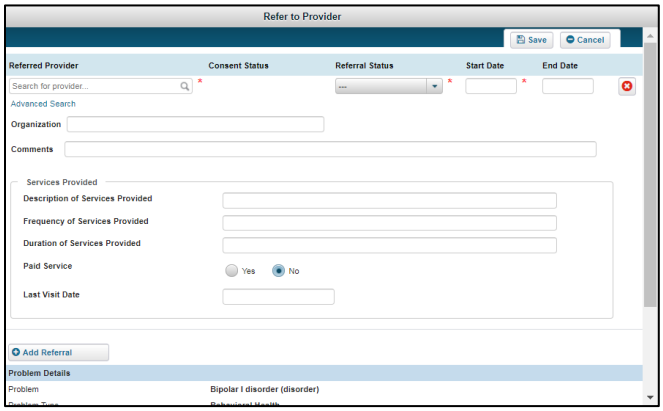


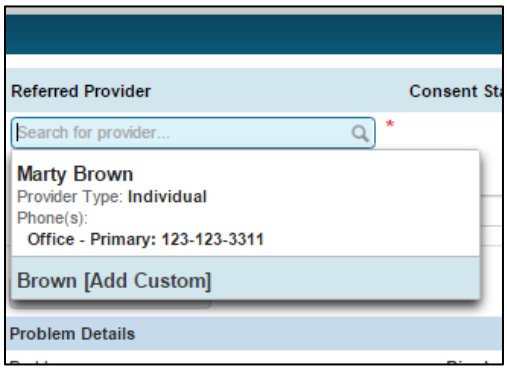
2. Select the **+Refer** button.



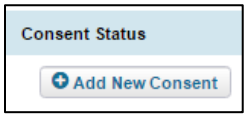
3. The **Refer to Provider** window will present. Note the **Problem Details** shown in the bottom of the window.

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

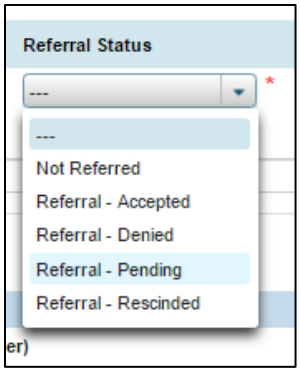




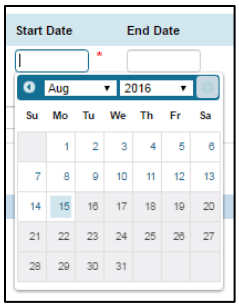
5. If appropriate, complete the **Provider Data Sharing Consent** by selecting the **+Add Consent** button.



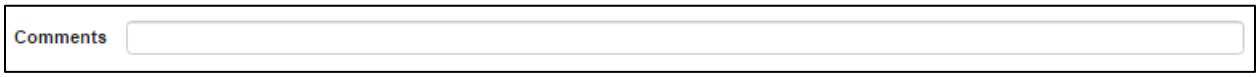
6. Identify the referral status in the **Provider Referral Status** dictionary.



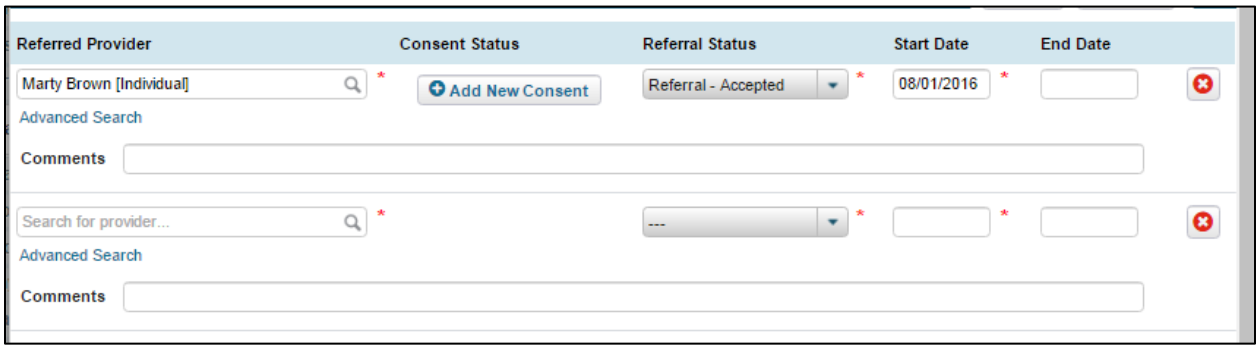
7. Enter the date the service provider relationship began in the **Referral Start Date** field.



8. If appropriate, enter the **Organization** name where the member sees their provider.
9. Enter comments into the free text **Comments** field.



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.



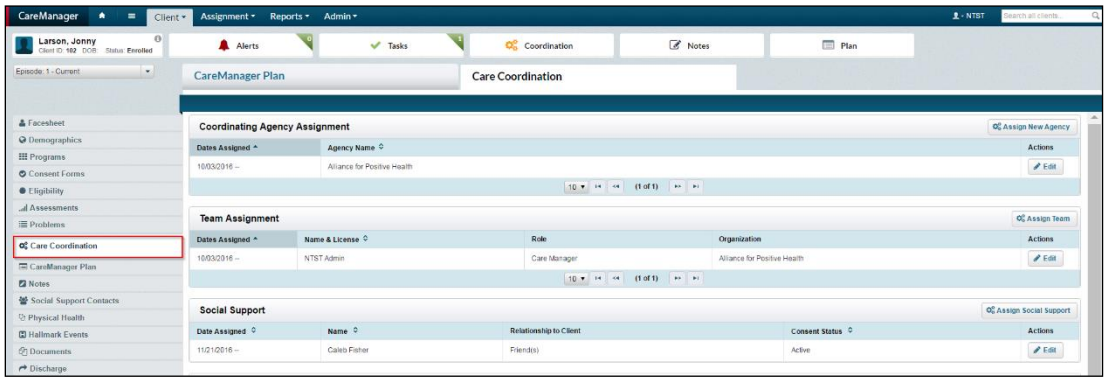
16. Repeat steps 4 – 14 as appropriate.

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

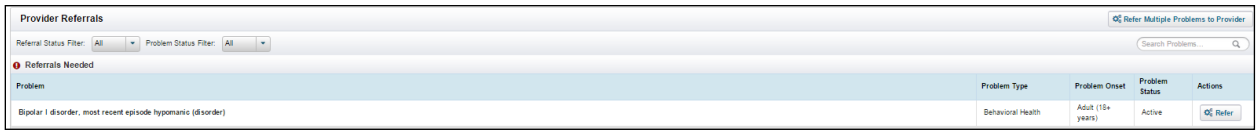
Adding a Custom Provider

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.

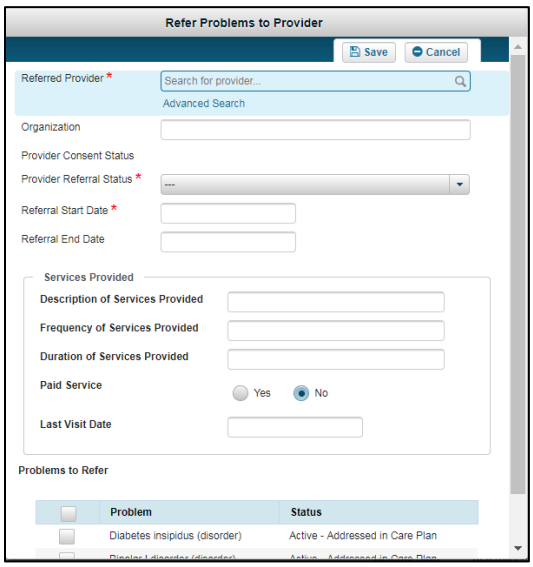
1. Select **Care Coordination** from the left hand menu of the client chart.



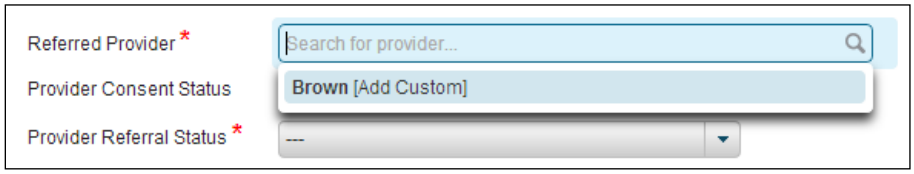
2. Select the **Refer Multiple Problems to Provider** button located next to the problem that needs to be referred. This is located within the **Provider Referrals** section.



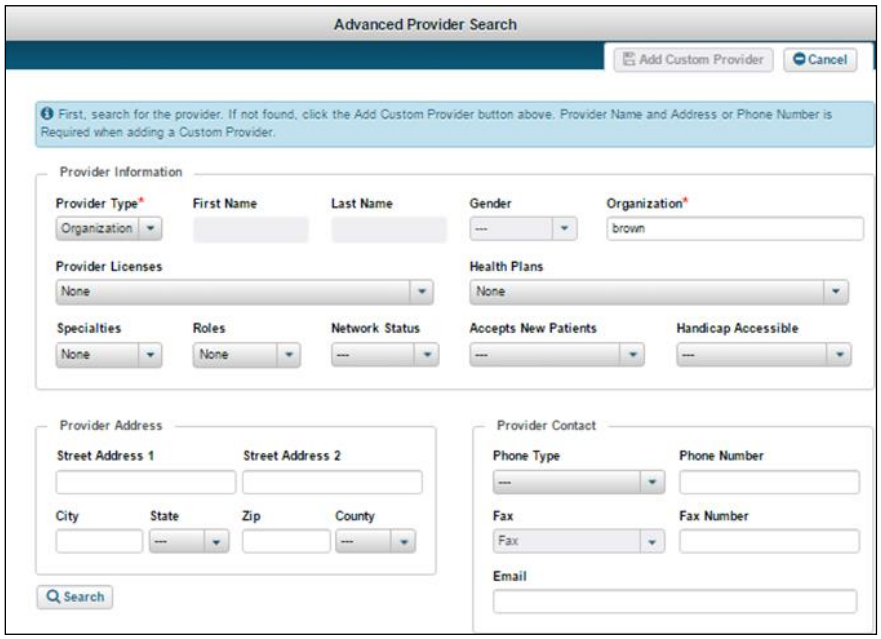
3. The **Refer to Provider** pop-up window will display.



4. 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.

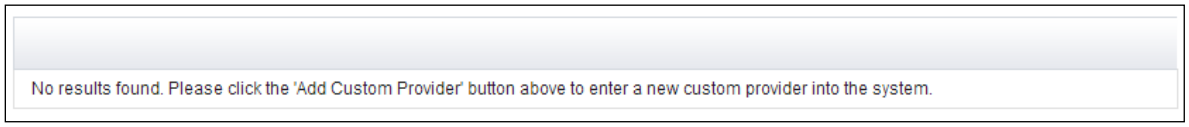


5. The **Advanced Provider Search** pop-up windown will display, as shown below



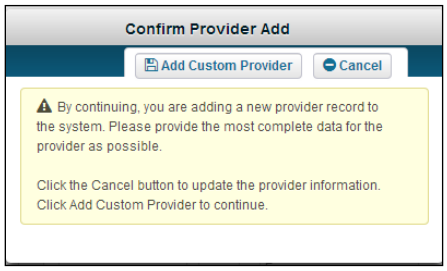
6. Complete the **Provider Information, Provider Address** and **Provider Contact** fields. Select the **Search** button.

7. The search results will present at the bottom of the screen, as shown below.



8. Select the provider if applicable. If there are no providers in the search results, select the **Add Custom Provider** button.

9. The **Confirm Provider Add** pop-up screen will display.



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

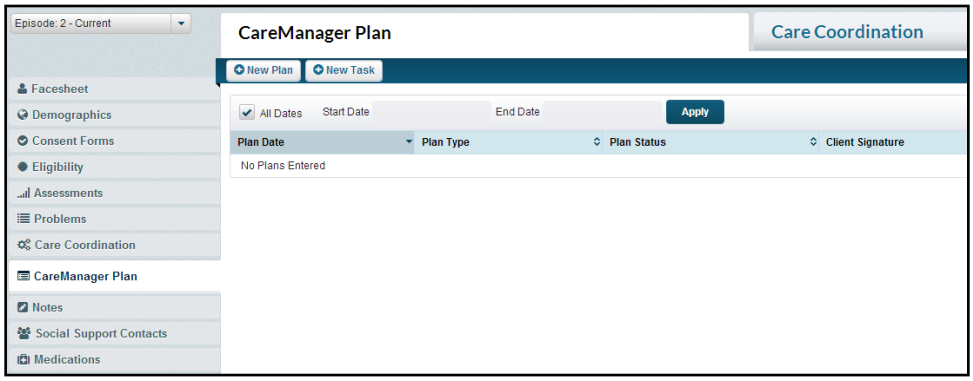
11. Enter the **Organization** name where the member sees the provider if known.
12. The **Refer to Provider** stand-alone form will display. Select the provider referral status from the **Provider Referral Status** drop-down menu.
13. Enter in the **Referral Start Date**.
14. Select the **Problems to 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 CANS-NY, Comprehensive Assessment, and information obtained from providers and the 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



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

Plan

Plan Type: Initial

Plan Start Date *: 07/12/2013

Plan End Date:

Plan Status: Client reviewed Plan

Draft

Client Goal Statement *

Rodney would like to improve his quality of life so he is not readmitted to the Emergency Department for his depression, diabetes and alcohol consumption.

Client Strengths

Rodney has s strong social support network and is open to receiving treatment from his Care Team.

Client Barriers

Rodney needs to learn how to advocate for himself among his support network and his peers. He has a history of erratically taking medications as prescribed.

Plan Type: This will default to Initial.

Plan Start Date: Date the care plan was finalized with the child and family.

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 and family concerning the work you will be doing together. It should be written from the clients perspective, in their own language.

Client Strengths and Client Barriers: These are determined through the assessment process (CANS-NY, and Comprehensive), and are what the client and family see as strengths and barriers.

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

Objectives and Interventions

Objectives/interventions can be customized or selected from the libraries created. **Objectives** are the goals of the client (Please see SMART guide for writing goals in the appendix) based off 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; **How** will they go about doing it?

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

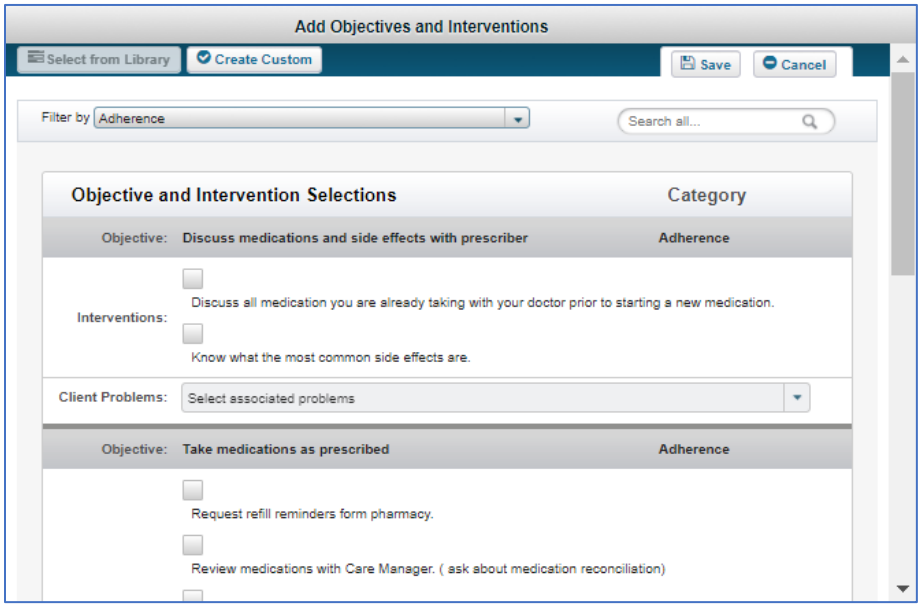
Adherence: Use this section to document preventive quality measures including annual dental visits and well child visits if they are not already naturally addressed within the physical health category and linked to the related physical health condition(s).

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

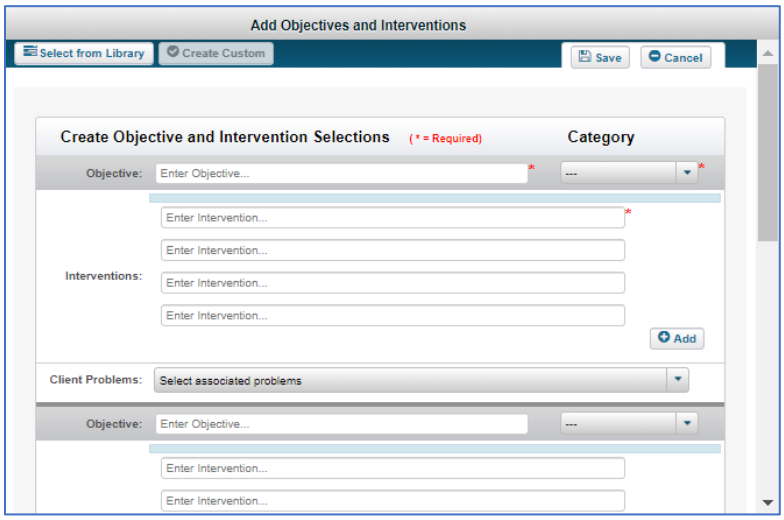
Care Coordination Activities: This is where you would capture **Objectives and Interventions** that are associated with care management and care coordination activities. If the client needs help managing their care, this is the category that will address that need.

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.

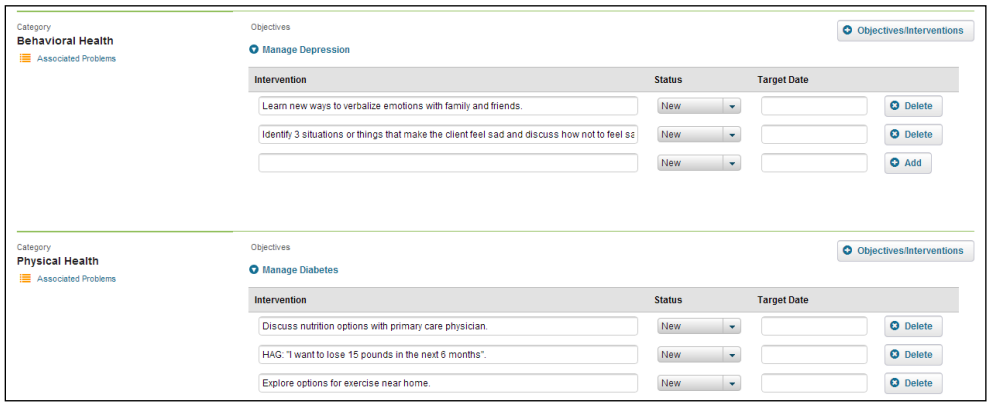


1. In the Objectives and Interventions section, find the appropriate category for the objective/intervention and select the **+Objectives/Interventions** button.
2. Select from the library of **Interventions** or click the **Create Custom** button.
3. Type in an objective in the **Objective** field.

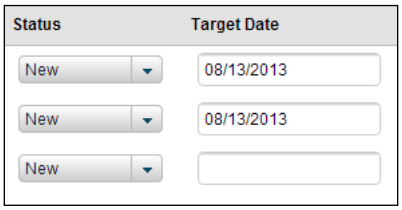


4. Select the appropriate category from the **Category** drop-down menu.
5. Enter intervention(s) in the Intervention field(s). If there are more than four interventions, select the **+Add** button.
6. Select the appropriate problem(s) from the Associated **Client Problems** drop-down menu.
7. Continue 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**.



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.



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 every six months, 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.

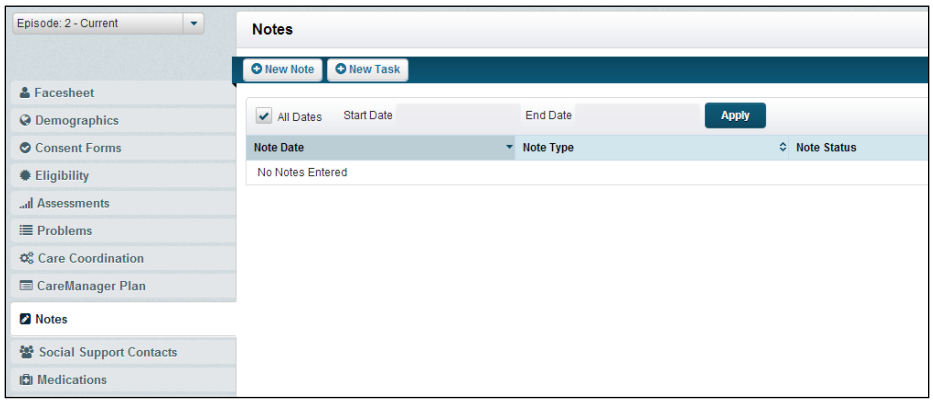
Note: Anytime you leave a Care Plan in "draft" status, you are unable to document Care Manager notes until you have finalized the plan.

CareManager Notes

Once the initial Care Plan is finalized, all services and encounters (whether billable or non-billable) can be documented as either New Contact Notes or New CareManager Notes as appropriate.

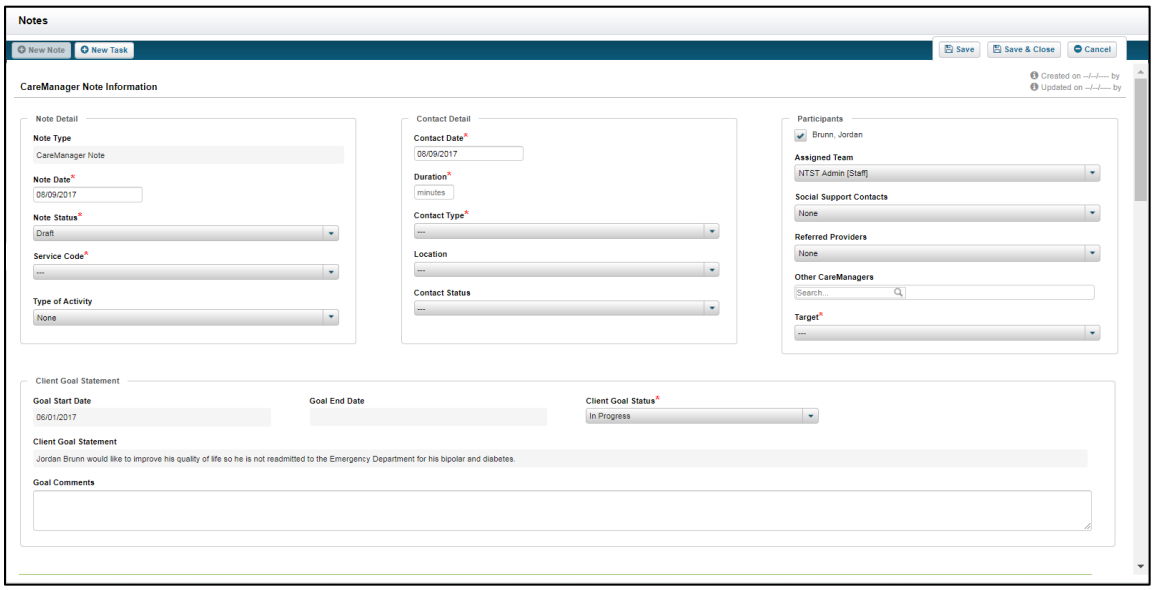
Documenting a Billable CareManager Note

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 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



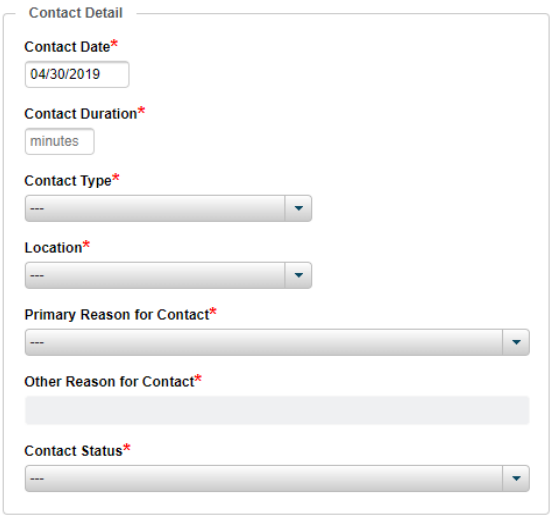
Note Type: This will auto-populate.

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: The date that the service took place.

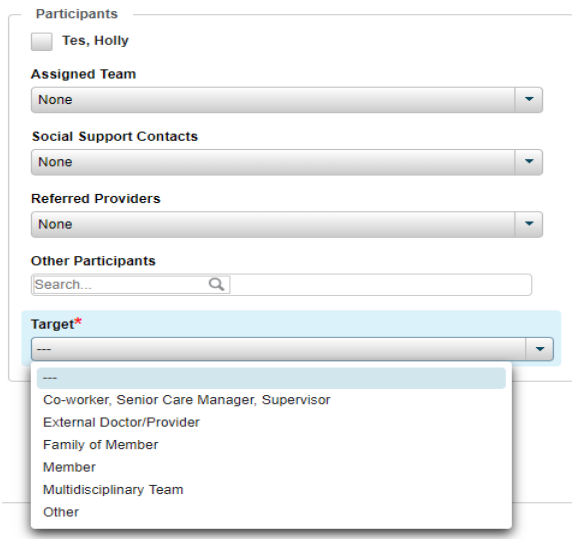
Contact Duration: Document the number of minutes the activity took you to perform

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

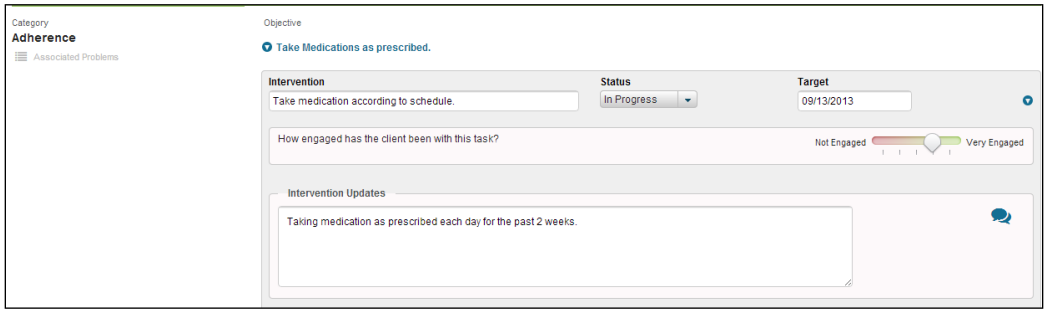
Primary Reason for Contact: Select the option that describes the activity/encounter being documented.

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



Participants

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 was target of the activity.



- 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)

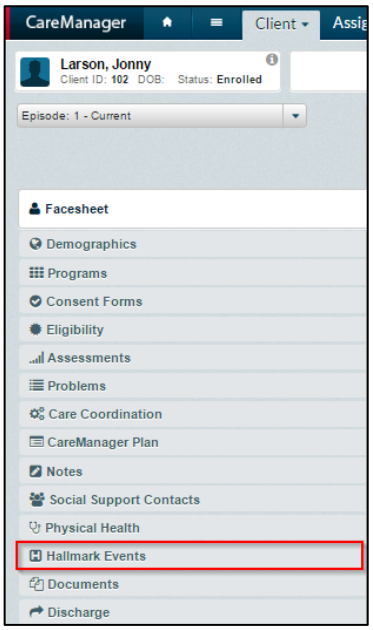
Discharge/Disenrollment

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.

Other CareManager Fields and Functions

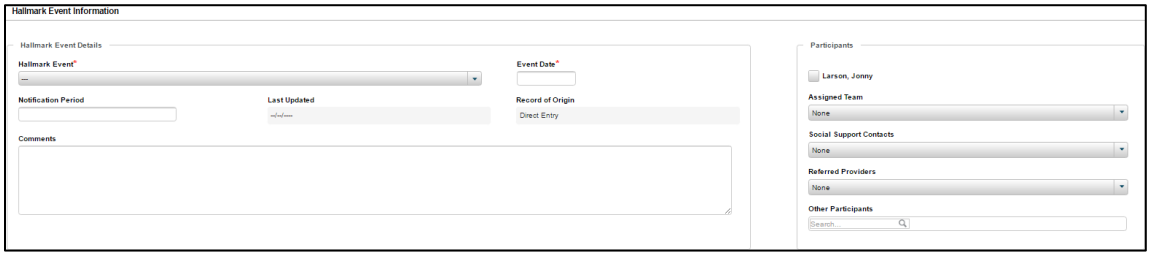
Hallmark Events

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.



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/Rehavilitation 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 Hiett

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

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	Source
No records found.	

Consulting Physician(s)

Search for provider... Advanced Search

Consulting Physician	Consult Description	Source
No records found.		

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

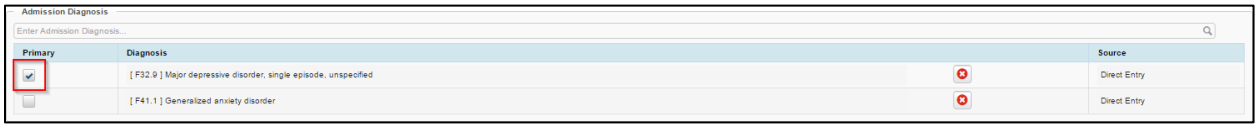
Admission Diagnosis

296.20

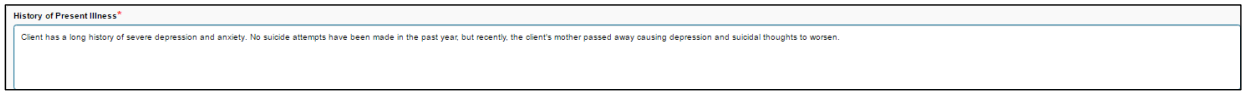
[F32.9] Major depressive disorder, single episode, unspecified
[F33.9] Major depressive disorder, recurrent, unspecified
[F32.2] Major depressive disorder, single episode, severe without psychotic features
[F33.2] Major depressive disorder, recurrent severe without psychotic features
[F32.3] Major depressive disorder, single episode, severe with psychotic features
[F32.89] Other specified depressive episodes

Source

10. If more than on diagnosis is needed, repeat step 9.
11. Select the Primary Diagnosis by selecting the box under the **Primary** column.



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



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.

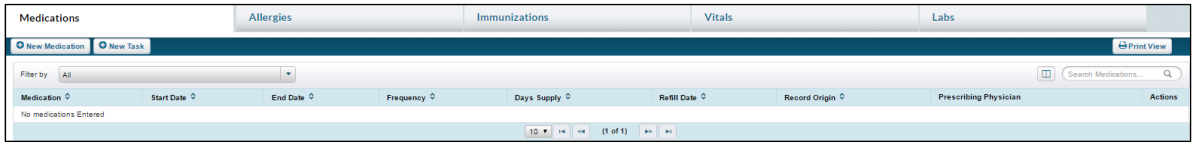
1. From the **Hallmark Events** page, select the **View** button next to the previous entry.
2. The previously entered information will display disabled.
3. To edit the information, select the **Edit** button from the top-right corner of the page. An example of updating a Hallmark Event would be if a 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.

1. Go to **Hallmark Events**
2. Select the **Hallmark Event** from the drop down
3. You can select **Other** and free text the event
   a. If you select an inpatient option, additional data fields will appear to capture the inpatient details
4. Enter details regarding the event including the **History of Present** Illness which gives the dialogue of what happened
5. Click **Save & Close**

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

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

In order to document client immunizations, you can utilize the Immunizations module to do so, or upload an Immunization list in the Attachments section.

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**

Adirondack Health Institute

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Appendix

Required Tracking for NYS Children's Health Home	**American Academy of Pediatrics Well-Child Care Visit Schedule**
Necessary Documentation in Chart	**Supervisory Roles and Responsibilities in CareManager**
Creating SMART Goals	**Attachment Descriptions**
DOH Forms for Children	**CareManager Case Note Desk Guide**
Creating Referrals in MAPP	

Required Tracking for NYS Children's Health Home

Measure	Netsmart Documentation
Annual Dental Visit	Must be addressed within an objective/intervention(s) on the member's care plan.
Preventive Pediatric Healthcare Visits (Ages 0-21)	Must be addressed within an objective/intervention(s) on the member's care plan.
Care Manager Follow-up After ED/Hospitalization for Psychiatric Reasons	Refer to AHI's Transitions of Care Policy
Care Manager Follow-up After ED/Hospitalization linked to qualifying chronic medical conditions	Refer to AHI's Transitions of Care Policy

American Academy of Pediatrics Well-Child Care Visit Schedule

2-5 days old
1 month old
2 months old
4 months old
6 months old
9 months old
12 months old
15 months old
18 months old
24 months old
30 months old
3 years old
4 years old
5 years old
6 years old
7 years old
8 years old
9 years old
10 years old
11 years old
12 years old
13 years old
14 years old
15 years old
16 years old
17 years old
18 years old
19 years old
20 years old
21 years old

Source: https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx

Necessary Documentation in Chart

NYS and AHI have a list of required documentation that is a part of the Health Home Program. They include but are not limited to:

- Signed DOH-5200 Health Home Consent for Enrollment (For Children Under 18 Years of Age)
- Signed DOH-5201 Health Home Consent Information Sharing (For Children Under 18 Years of Age)
- Signed DOH-5055 Health Home Consent Information Sharing (For Children Over 18 Years of Age)
- Signed DOH-5203 Health Home Consent Information Sharing Release of Educational Records
- Child Eligibility Screening Form
- Completion of a CANS-NY Assessment in the NYS UAS
- Safety & Crisis Plan
- Emergency Plan
- Initial/Amended Care Plans
- Interdisciplinary Care Team Members
- Monthly Children's Billing Questionnaire
- Outreach and Engagement Notes entered as Client Search Notes
- Enrolled Client Notes that tie to the Care Plan entered as CareManager Notes
- Signed Functional Assessment Consent
- Outreach Billing Questionnaire (if applicable)
- CANS-NY Assessment Results
- Proof of Health Home Eligibility
- Withdrawal Consents

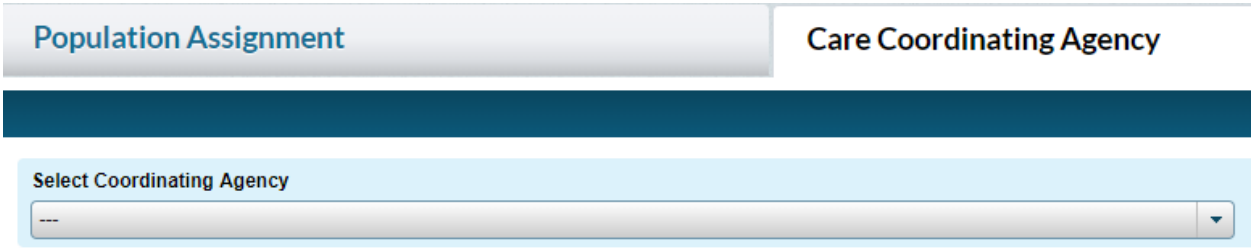
Health Home Care Manager's documentation must accurately and objectively reflect Health Home activities. Health Home Care Managers should consider all audiences when creating any documentation and assume that all involved in the Plan of Care, including the client, will have access to the materials in the client's care management record.

Documentation must show active and progressive movement towards enrollment and goal achievement and meet Medicaid billing requirements.

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 Management Supervisor. Users with the "Care Manager Supervisor" security role will have access to assign clients to Care Management staff to start the Outreach or Enrollment process in Netsmart CareManager.



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

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

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*
06/20/2019

Discharge Time*
03:18 PM

Discharged By*
Enter health home staff...

Reason for Discharge*

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 *willing* and *able* 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 5201 05/24/19 (date that the form was signed)
HIXNY Consent	HIXNY Consent MM/DD/YYYY (date the consent was signed)
Complex Trauma Exposure Assessment	Complex Trauma Exposure Assessment MM/DD/YYYY (date that the form was signed)
Complex Trauma Eligibility Determination	Complex Trauma Eligibility Determination Form MM/DD/YYYY (date that the form was signed)
CANS-NY Assessment Results	CANS-NY Assessment Results MM/DD/YYYY (date that the CANS was completed)
Comprehensive Assessment	Comprehensive Assessment MM/DD/YYYY (date that the form was completed)
Signed Safety & Crisis Plan	Safety & Crisis Plan MM/DD/YYYY (date that the form was signed if not electronically signed)
Signed Emergency Plan	Emergency Plan MM/DD/YYYY (date that the form was signed if not electronically signed)
Signed Plan of Care	Plan of Care MM/DD/YYYY (date that the form was signed if not electronically signed)
Proof of Qualifying Condition(s)	Qualifying Condition(s) MM/DD/YYYY (date of the document)
Growth Chart	Growth Chart MM/DD/YYYY (date when growth chart was obtained)
Medication List	Medication List MM/DD/YYYY (date when medication list was obtained)
504 Plan	504 Plan MM/DD/YYYY (date 504 was completed)
IEP	IEP MM/DD/YYYY (date IEP was completed)
Non-DOH Consents	Consent Form [name of what the consent is for] MM/DD/YYYY (date the consent was signed)
Disenrollment Paperwork	Disenrollment Paperwork MM/DD/YYYY (date disenrollment paperwork was signed)
Hospital Discharge Paperwork	Hospital Discharge MM/DD/YYYY (date of hospital discharge)
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 Children

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 consenter (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 5200 Children's Consent to Enroll	This consent must be completed and signed only by a parent, guardian, or legally authorized representative of a child or adolescent under the age of 18 for enrollment into the Health Home Serving Children's program. An individual with the right to provide consent, has the right to decline to enroll or opt out of Health Home prior to enrollment. An individual who has consented to enroll in the Children's Health Home Program has the right to withdraw that consent at any time.
DOH-5201 Children's Health Home Consent Information Sharing	Once the DOH-5200 is completed and signed, the DOH-5201 is completed for children/adolescents under age 18 who are not a parent, pregnant and/or married. This form outlines what, and with whom the child/adolescent's health information can be shared. The DOH-5201 has two sections.
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.

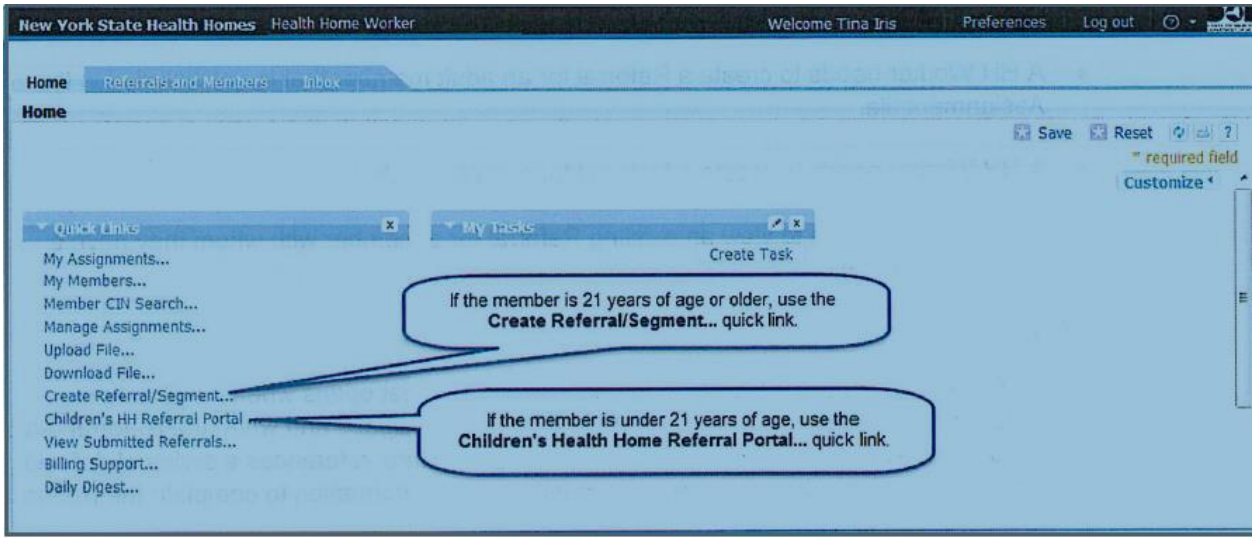
DOH 5230 Health Home Functional Assessment Consent Form	This consent form is used with all enrolled Health Home Serving Children members up to the age of 21 years old. Upon enrollment into a Children's Health Home, the care manager must obtain this consent to conduct the Child and Adolescent Needs and Strengths-New York (CANS-NY) assessment tool. This consent must be signed by a parent, guardian, or legally authorized representative if the child/adolescent is under the age of 18, or by the child/adolescent, if the child/adolescent is under the age of 18 and a parent, pregnant, and/or married. Individuals who are between 18 and 21 years of age can provide consent on their own behalf. The Health Home Functional Assessment Consent Form is needed to enter the members identifying information into the Uniform Assessment System-New York (UAS-NY) database. Without obtaining this consent, the Health Home care manager will not be able to complete a Child and Adolescent Needs and Strengths-New York (CANSNY) assessment in the Uniform Assessment System-New York (UAS-NY) system.
DOH 5203 Health Home Consent Information Sharing Release of Educational Records	The Health Home Consent Information Sharing Release of Educational Records (DOH 5203) is used to gain consent to release educational records to a Health Home for children and adolescents who have been enrolled in a Health Home. It includes information on what educational records can be shared and with whom. Consent for release of educational records for children and adolescents under age 18 must be provided by the parent as defined in Question 5 of the Health Home Consent Information Sharing Release of Educational Records (DOH 5203). Consent for release of educational records for those aged 18 and over must be provided by the individual.
DOH Form to use to Disenroll	**Reason for form/when to complete**
DOH 5202 Withdrawal of Health Home Enrollment and Information Sharing	The DOH 5202 must be used for children and adolescents less than 18 years of age who have been enrolled in a Health Home and completed Health Home Consent/Enrollment/For Use with Children Under 18 Years of Age form (DOH 5200) and Health Home Consent/Information Sharing/For Use with Children Under 18 Years of Age form (DOH 5201). The DOH 5202 is used to disenroll children/adolescents from the HH and take away consent to release health information. Withdrawal of consent for children under age 18 must be provided by the parent, guardian or legally authorized representative.
DOH 5204 Withdrawal of Release of Educational Records	The DOH 5204 is used to withdraw consent to release educational records (which includes Early Intervention Program records) for children and adolescents who have been enrolled in a HH. Withdrawal of consent for release of educational records for children under age 18 must be provided by the parent, guardian or legally authorized representative. Withdrawal of consent for release of educational records for those aged 18 and over must be provided by the individual.
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 you're 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 candidates 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.



1. Click the **Children's HH Referral Portal...** quick link within the Workspace.

2. Read the **Terms and Conditions** page.

New York State Department of Health MAPP

Terms And Conditions

Welcome to the Children's Health Home (HH) Referral and Assignment Portal (herein after "The Children's HH Referral Portal), which is housed in the New York State Medicaid Analytics Performance Portal (MAPP) Health Home Tracking System (HHTS). You have been provided access to the Children's HH Referral Portal to provide you the ability to refer a child, who is under the age of 21, enrolled in Medicaid, and that in your best informed judgement you believe meets the chronic condition eligibility and appropriateness criteria for Health Homes and would benefit from the comprehensive care management services provided by a Health Home. For information regarding the Health Home eligibility criteria please see:

http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/health_homes_and_children.htm

Please note that in order to proceed with referring a child for Health Home care management services through the Children's HH Referral Portal, you, the referring entity, will be required to:

1. Indicate you have obtained consent to make the referral. Consent must be obtained from the parent/guardian/legally authorized representative for individuals up until the age of 18. For individuals ages 18 to 21, or that are married, a parent, or pregnant may provide consent on their own behalf. Referrals cannot be made without an indication by the referring entity that consent has been obtained from the appropriate individual.

2. Provide a Medicaid Client Identification Number (CIN number). If a CIN number is unknown or the referred child is not enrolled in Medicaid, you will not be able to proceed with making a Health Home referral. To be eligible for Health Home Care management, a child must be enrolled in Medicaid. Health Home Care management services are not available to children who are not enrolled in Medicaid.

3. Indicate the Chronic Conditions for which, in your best informed judgment, you believe make the child you are referring eligible for Health Home services. Please check all that applies to the referred child. http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/09-23-2014_eligibility_criteria_hh_services.pdf

4. Indicate, in your best informed judgment, you believe the child meets the appropriateness criteria for Health Home care management.

5. As the referring entity, provide your contact information.

6. Provide contact information for the Parent/Guardian/Legally Authorized Representative or the individual (i.e., the individual was able to self-consent) that provided you the consent to make the referral

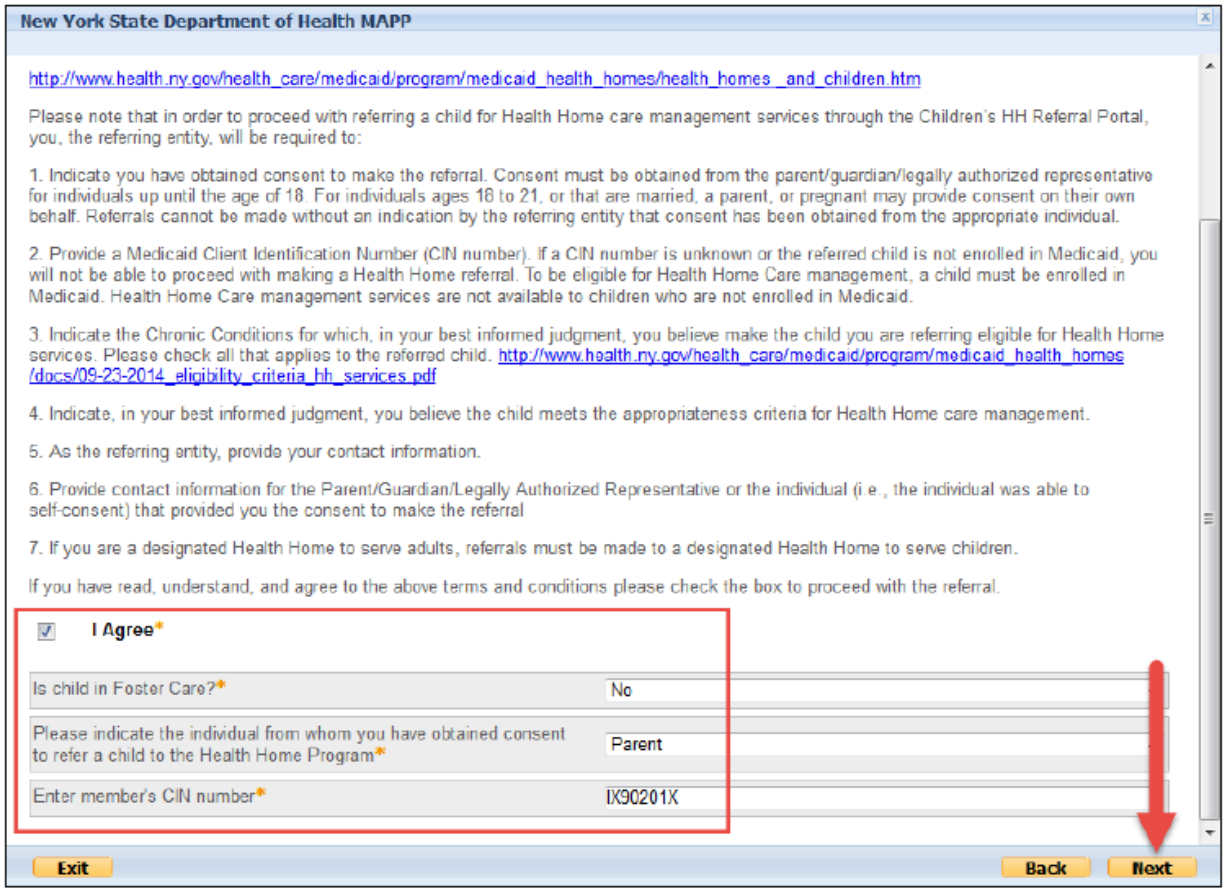
7. If you are a designated Health Home to serve adults, referrals must be made to a designated Health Home to serve children.

If you have read, understand, and agree to the above terms and conditions please check the box to proceed with the referral.

☐ **I Agree***

Exit | Back | Next

3. Select the ***I Agree*** check box.
4. Click the **Is child in Foster Care?** drop-down and select the *"No"* option.
5. Click the **Please indicate the individual from whom you have obtained consent to refer a child to the Health Home Program** drop-down and select the "*Parent*" option.
6. Enter the "user-specific CIN" in the **Enter member's CIN Number** field.
7. Click the **Next** button.

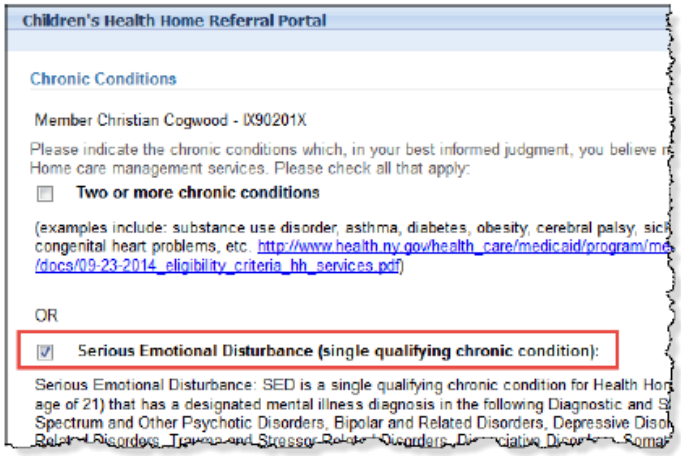


Note: After clicking the **Next** button, the MAPP HHTS checks the CIN to see if the member is currently assigned to a HH or CMA Organization. If the member is assigned, a Warning message appears. As a HH Worker, if you want to continue with the child Referral, a brief description is required (including your contact information) on why you want to proceed. In this scenario, the member does not exist in the MAPP HHTS.

- When answering the "Is child in Foster Care?" question:
  - If *"No"* is selected, you can proceed through the Referral pages.
  - If *"Yes"* is selected, a hard stop message appears stating to contact your local LDSS.

- If child is in Foster Care, please contact the local LDSS to refer the member to the Health Home program.

8. Select **Serious Emotional Disturbance (single qualifying chronic condition)** by placing a check mark next to this condition.



Note: There are four options to select in the **Chronic Conditions** Page. At least one of these options are required to proceed with the Referral:

- Two or more chronic conditions (Note: When this option is selected, the user must add a comment in the free text field.)
- Serious Emotional Disturbance (single qualifying chronic condition)
- Complex Trauma (single qualifying chronic condition)
- HIV/AIDS (single qualifying chronic condition)

In addition, the member needs to meet the Appropriateness Criteria, which is also required to proceed with the Referral.

9. Select the **Appropriateness Criteria** by placing a check mark next to this option.

10. Click the **Next** button.

AND

☑ **Appropriateness Criteria**

Individuals meeting the Health Home eligibility criteria must be appropriate for Health Home care management. Assessing whether an individual is appropriate for Health Homes includes determining if the person is:

- At risk for an adverse event (e.g., death, disability, inpatient or nursing home admission, mandated preventive services, or out of home placement)
- Has inadequate social/family/housing support, or serious disruptions in family relationships;
- Has inadequate connectivity with healthcare system;
- Does not adhere to treatments or has difficulty managing medications;
- Has recently been released from incarceration, placement, detention, or psychiatric hospitalization;
- Has deficits in activities of daily living, learning or cognition issues, or
- Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

Exit | Back | Next

11. Complete the **Consenter Contact Information** Page as indicated in the screen shot below.

Note:

- In the Phone Number field, do not use spaces or dashes.
- The Relationship field defaults to the option selected in *Step 5*.
- If desired, an email address, communication preferences and additional comments regarding the Consenter can be entered on the Consenter Contact Information Page.

Children's Health Home Referral Portal

Consenter Contact Information

Member Christian Cogwood - IX90201X

Please provide the following contact information from the person you received consent from to make this referral (e.g. the Parent/Guardian, individual (if self-consent provided) or legally authorized representative)

Title	Mrs.
First Name *	Mary
Last Name*	Cogwood
Relationship *	Parent

Address Details

Street 1	500 Learn Drive
Street 2	
City	Albany
State	New York
Zip	12208

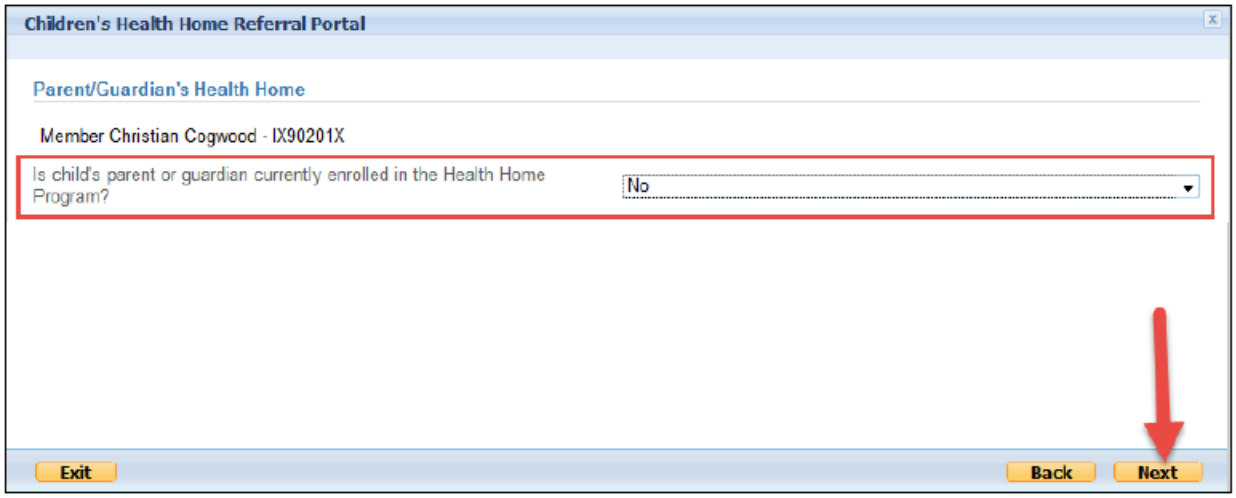
Phone Number Details

Area Code	555
Phone Number	5551100
Extension	
Phone Type	Home

Exit | Back | Next

12. Click the **Is child's parent or guardian currently enrolled in the Health Home Program** drop-down and select the *"No"* option.

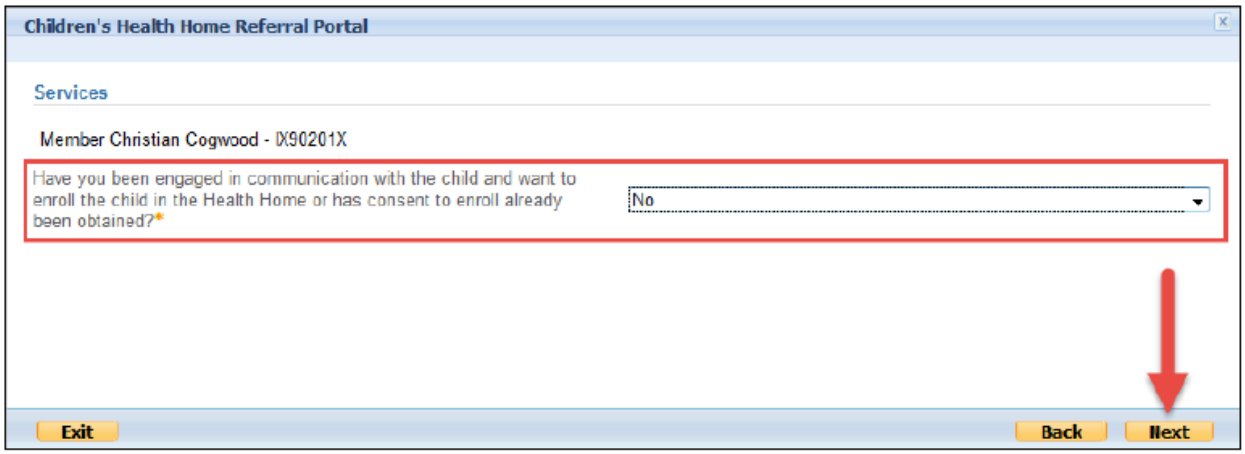
13. Click the **Next** button.



Note: If *"Yes"* is selected, the child's parent or guardian's CIN is required.

14. Click the **Have you been engaged in communication with the child and want to enroll the child in the Health Home or has consent to enroll already been obtained** drop-down and select the *"No"* option.

15. Click the **Next** button.



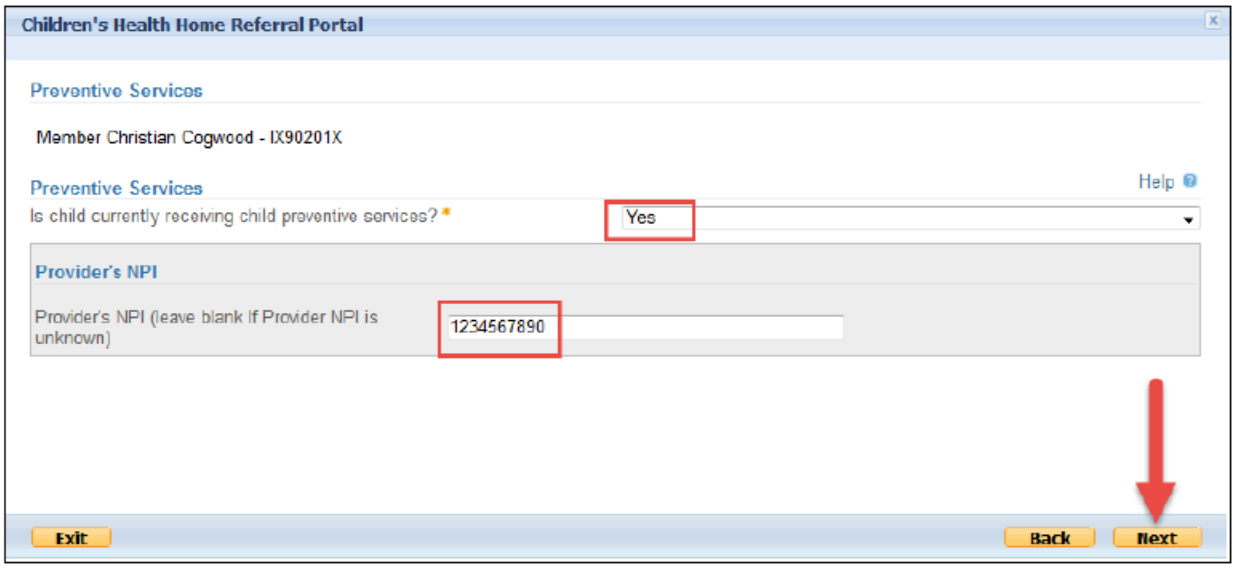
Note: If *"Yes"* is selected, the HH Worker is required to select either an Outreach or Enrollment Segment Type. For this scenario, a Segment is not created at this time. Additional information on Outreach and Enrollment Segments is provided in *Lesson 6*.

16. Click the **Is child currently receiving child preventive services?** drop-down and select the "*Yes*" option.

17. Enter "*1234567890*" in the **Provider's NPI** field.

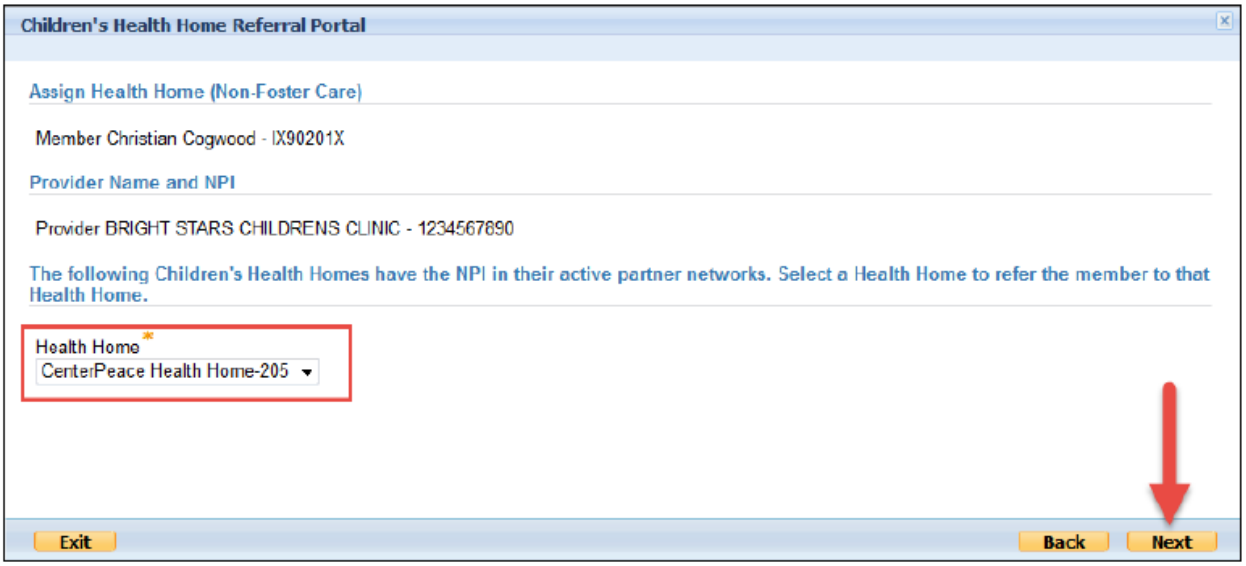
18. Click the **Next** button.

Note: When "Yes" is selected for this question, an additional field displays which allows the HH Worker to enter a Provider's Network Provider Identifier (NPI). This can be left blank if it's unknown.



19. Click the **Health Home** drop-down and select the *"CenterPeace Health Home-205"* option.

20. Click the **Next** button.



21. Verify the information is correct on the *Referral Summary* Page.

22. Click the **Next** button.

Children's Health Home Referral Portal

Children's Health Home Referral Summary

Member Christian Cogwood - IX90201X

Questions not answered in the Children's HH Referral portal are reflected in the Summary Screen as blank.

When returning to a previous page through an edit link, the system will return you to that page and require that you complete all remaining questions from that point forward before returning to the Summary Screen.

Terms And Conditions

I Agree	Is child in Foster Care?	Please indicate the individual for which you have obtained consent to refer a child to the Health Home Program	Action
Yes	No	Parent	Edit

Parent/Guardian CIN

Is child's parent or guardian currently enrolled in the Health Home Program?	Parent/Guardian Member	Action
No		Edit

Chronic Conditions

Two or more chronic conditions	Serious Emotional Disturbance	Complex Trauma	HIV/AIDS	Appropriateness Criteria	Action
No	Yes	No	No	Yes	Edit

Consenter Contact Information

Title	First Name	Last Name	Relationship	Action
	Mary	Cogwood	Parent	Edit

Address Details

Street 1	Street 2	City	State	Zip	Action
500 Learn Drive		Albany	New York	12208	Edit

Phone Number Details

Area Code	Phone Number	Extension	Phone Type	Email Address	Action
555	5551100		Home		Edit

Preferences

Preferred Time Of Day	Preferred Communication	Additional comments related to this referral	Action
No information entered			

Services

Have you been engaged in communication with the child and want to enroll the child in the Health Home or has consent to enroll already been obtained?	Segment Type	Action
No		Edit

Preventive Services

Is child currently receiving child preventive services?	Provider's NPI (leave blank if Provider NPI is unknown)	Provider	Action
Yes	1234567890	BRIGHT STARS CHILDRENS CLINIC - 1234567890	Edit

Assign Health Home (Non Foster Care)

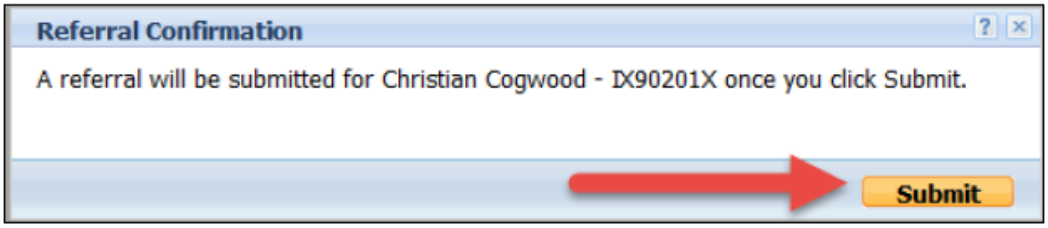
Provider NPI and Name	Health Home	Action
BRIGHT STARS CHILDRENS CLINIC - 1234567890	CenterPeace Health Home-205	Edit

Exit Next

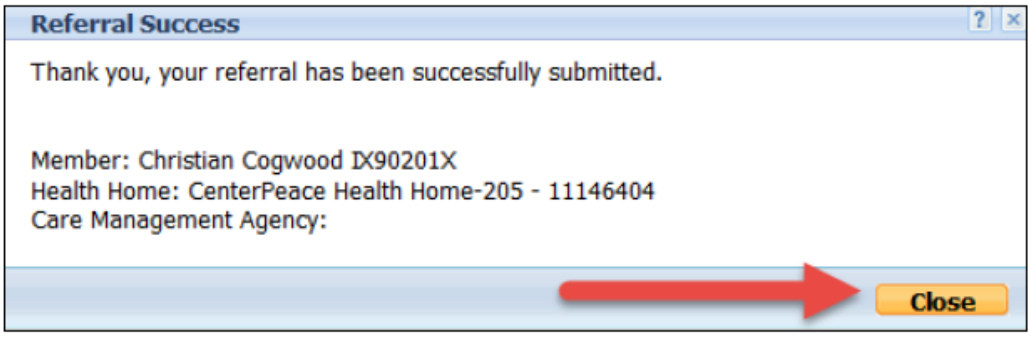
Important: Make sure to verify all information entered in the Referral Summary Page is correct before clicking the **Next** button. Once the Referral is submitted on the next page, a submitted Referral cannot be edited.

On the Referral Summary Page, use the **Edit** hyperlink in the Action column to edit the information within that section.

23. Click the **Submit** button in the *Referral Confirmation* pop-up.



24. Click the **Close** button in the *Referral Success* pop-up. You have completed this Exercise.



Note: The Health Home selected in *Step 18* is displayed in the *Referral Success Page*.

As a reminder for FFS members, if "No" was selected for *Step 15,* then the Health Home displayed in the Referral Success Page would be the DOH recommended Health Home assignment with a Referral record type. If there is no recommended Health Home, the MAPP HHTS randomly selects a Health Home based on the counties a Health Home serves and the member's County of Fiscal Responsibility.