



OneCare Vermont

Care Navigator User Guide

03/16/2020

Version 2.2

Welcome

Care Navigator™ (CN™) is secure, HIPAA compliant, web-based software being deployed by OneCare Vermont to support effective care coordination for our participating Providers and Collaborators. The CN™ tool works to streamline communication among care team members, patients, and their support systems. Claims data is uploaded into the system and provides key utilization metrics, diagnoses, and Accountable Care Organization (ACO)/Insurance information. The continuum of care providers enter information on current care coordination status, acuity level, care team member involvement, participation in community programs, as well as other pertinent patient information. The Shared Care Plan identifies goals and barriers that can be updated by all care team members.

Access to CN will be given to those organizations who hold a Participant or Collaborator Agreement with OneCare Vermont (OCV). These organizations include hospitals, medical practices, home health agencies, designated agencies, councils on aging and housing organizations.

This document will serve as a resource for learning and navigating through the Care Navigator™ system. You will find the following information which will be helpful as you begin using the tool for your patient assignments, workflows, and care management functions.

To report issues, or if you need assistance with troubleshooting, please contact the OneCare Operations Help Desk.

Email: HelpDesk@OneCareVT.org or call (802) 847-7220, Option 2

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Obtaining Access

1. **Access Requests:** For individuals who are requesting access, please contact our OneCare Vermont Operations Department via telephone at 802-847-7220, Option 2 or email at HelpDesk@OneCareVT.org
2. **Notification of Access:** Once your request is processed you will receive the email notification below from the following email address: no-reply@mycarenav.com.

*****This is an automated email. Please do not reply to this email. *****



OneCare Vermont

Dear < Care Coordinator's Name >,

Congratulations! Your account has been activated in Care Navigator™. The Care Navigator™ application will allow you access to patient information specific to your permissions identified through the user access assignment process.

Please use the information below to log into Care Navigator™.

Username: <username>

Password: <password>

To keep your account safe and prevent unauthorized access, you will be asked to change your password during initial Log in. Once changed, you will need to Log in using your newly created password.

Technical Support:

If you have any questions about the application, have trouble logging in, or experience any technical issue, please contact OneCare Vermont Operations Help Desk at HelpDesk@OneCareVT.org or 802-847-7220, Option 2 for assistance.

Thank you!

Care Navigator™ Support Team

Supported Browsers/Operating Systems

While any browser can be used for day-to-day Care Navigator activities, Internet Explorer is the preferred browser. The following are recommended minimum supported browsers and operating systems for Care Navigator:

Internet Explorer (preferred browser)

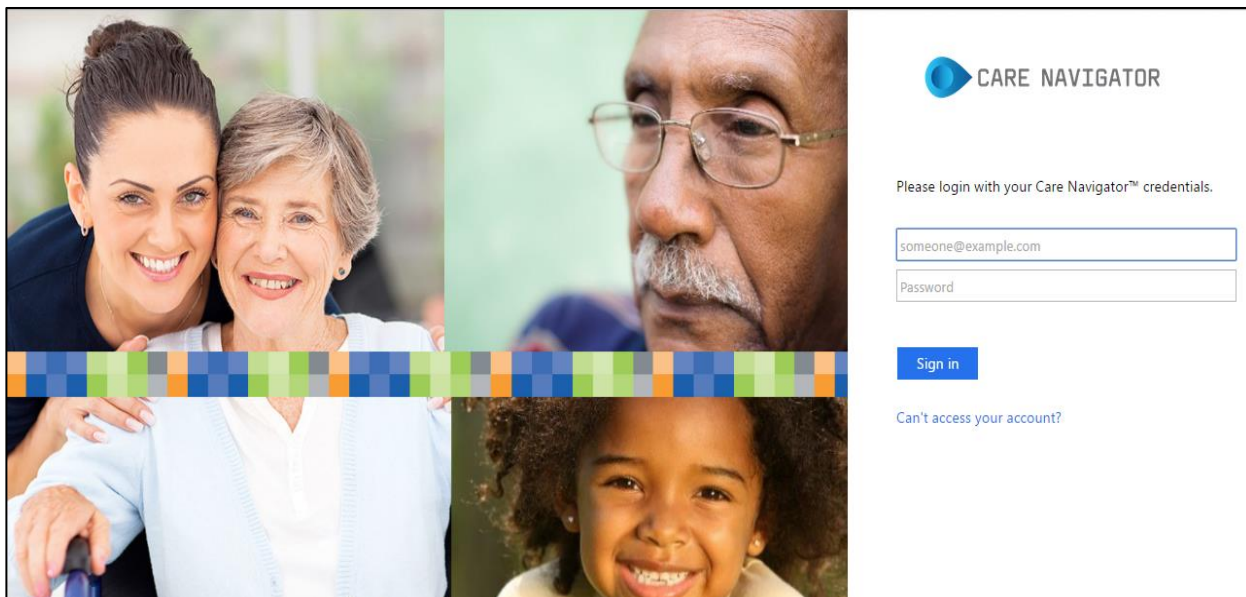
Google Chrome

Mozilla Firefox

Initial User Log-In

1. Go to the URL for CN Hub <https://onecare.mycarenav.com/>
2. Enter your username and password provided via email notification from the OneCare Vermont Help Desk and click on Sign In

3. This will prompt you to create a new password and then confirm the new password. **Please do not save your username and password to your browser as it interferes with the password reset process**
4. Enter your username and NEW password to access the system



1 Standard Log-in Screen

- A. Password Policy Guidelines
 - a. The password must be at least 8 characters
 - b. The password cannot be any of your previous 25 passwords
 - c. The password cannot contain your first or last name
 - d. The password cannot contain your username
 - e. The password must contain characters from three of the following categories:
 - i. Uppercase Letters, Lowercase Letters, Base 10 digits (0-9)
 - ii. Non-alphanumeric characters (special characters -!, \$, #, %)
- B. Once you have entered and confirmed your new password, please log in with your newly created password, click sign in.

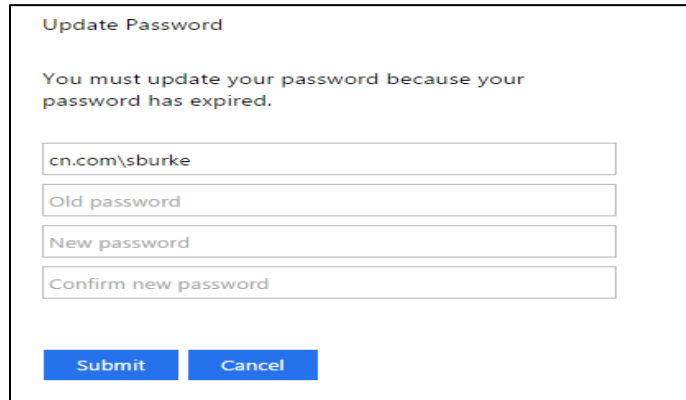
Please login with your Care Navigator™ credentials.

Sign in

[Can't access your account?](#)

Resetting an Expired Password:

- A. See above steps in the Password Policy Guidelines.



Update Password

You must update your password because your password has expired.

cn.com\sburke

Old password

New password

Confirm new password

Submit Cancel

User Roles

User Role Definitions:

User roles are determined by level of access to Patients' Protected Health Information (PHI) and are as follows:

1. **Level II:** Access to all patients' PHI in populations served within the user's organization. Person with full access to the functionality within a business unit. A person who assigns patients to specific care coordinators and oversees care coordination activities for an assigned business unit.
2. **OneCare Level of Access:** Access to all patients' PHI in the OneCare Network and functionality across all contracted Organizations. A person who assigns patients to specific care coordinators and oversees care coordination activities for OneCare business unit and/or HSA. This access is applicable only in certain situations and must be approved by OCV.

Levels of Access

Access to PHI varies within user roles based on HIPAA's minimum necessary rule. Access to PHI will be based on the minimum amount of patients' information needed to accomplish the coordination of care for a specific population and will be based on the factors below:

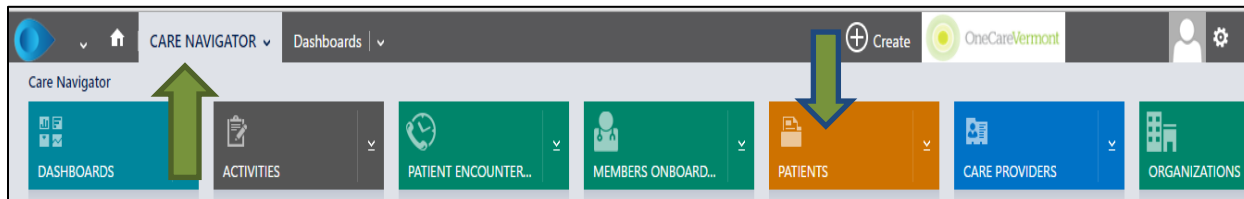
1. Age Group
2. Geographic Area
3. Hospital and Medical Practice
4. Insurance Plan

Level II Users

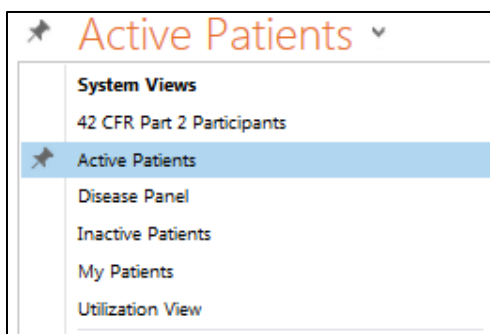
List of Active Patients:

Level II Users will have access to a list of patients who are attributed to their organization. To view the Active Patients list:

1. Hover over Care Navigator in the tool bar and choose 'Patients'
2. Click on 'Patients' and a list of active patients who you have access to will be displayed:



3. To see all patients: Check that the Active Patients option is chosen in the drop-down list:



4. To sort patients using data points click on the funnel to turn on filtering capabilities. Once the filter has been activated, the sorting capabilities below will be available:



Last Name	First Name	Date of Birth	Age	Member ID
Payer	Care Coordination Level	Revised Care Coordination Level	Care Coordination Status	Acuity Level
Lead CC	SCP Initiated	SCP Created	Attributed Health Service Area	Attributed TIN Name
Attributed Practice Name	Attributed Provider	Last Qualifying Visit	ED Visits past 12 months	Inpatient Admissions past 12 months
All Cause 30-day Readmissions	Office Visits	Home Health Visits past 12 months	Hospice Day past 12 months	Total Paid

Modified On				
-------------	--	--	--	--

5. Patient Search: patients are searchable by the following method:

- i. Complete all or a portion of the first name
- ii. *
- iii. Complete all or a portion of name

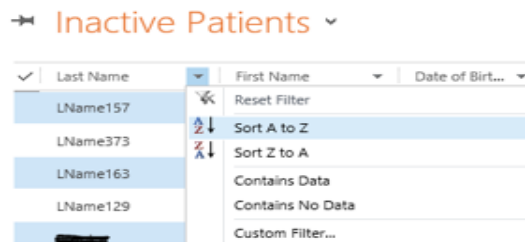
Searching for Inactive Patients:

- i. Change to Inactive Patients view at dropdown and turn on filter:

→ Inactive Patients

✓	Last Name	First Name	Date of Birth ↑	Member ID	Risk Category	Care Coordination Status	Lead CC	Acuity Level	Attributed Health Service Area	Attributed Tin Name	Attributed Practice Name	Attributed provider	In patient adm...
	LName157	FName157	5/8/1930			Moved	Abigail Tobias	3. Weekly contact					
	LName373	FName373	3/10/1991				Stacia Sirois						
	LName163	FName163	5/3/1991			Engaged	Alan Beams	1. Needs daily c...					
	LName129	FName129	10/25/1938				D.CC						

- ii. Click on the drop down next in the 'Last Name' column and select Custom Filter:



- iii. In the Select Operator drop down select 'Contains' and type in the person's last name and select OK:

Custom Filters

Show records where Last Name:

Contains

☒ AND ☐ OR

-- Select Operator --

- iv. This will bring forth any Inactive Patient with this last name in a 'Read only' status:


✈ Inactive Patients ▾

✓	Last Name	▼	First Name	▼	Date of Birt...	▼	Member ID...	▼	Risk Catego...	▼	Care Coordination Sta...	▼
	LName157		FName157		5/8/1930						Moved	

Care Coordinators

My Work

Care coordinators are assigned patients by Level II Users or **by someone with** OCV Level of Access, and will only have access to patients assigned to them. When the user logs in, they come to the My Work screen, which gives an overview of the following sections: User Inbox Unread, Event Notifications Unread, and My Patients, What's New, My Appointments, and My Tasks

1. **Home button:** Click on the home button  on the top left of the screen to come back to this page from any place in the system
2. **Panel Dashboard:** Click on drop down icon next to My Work and chose Panel Dashboard

My Work ▾

System Dashboards
Care Coordination Activities
Care Teams
Client Application Audit Reports
Event Notification
General Population
Login Reports
My Work
OCVT dashboard
Panel Dashboard
My Dashboards
elizabeth's view
Panel Dashboard

This dashboard contains information specific patients that you are on care teams for. You will be able to see those patients with No Care Plan, patients with an Initiated Care Plan and those with a Created Care Plan.

Panel Dashboard ▾

My Patients - No Care Plan ▾	My Patients - Initiated Care Plan ▾	My Patients - Created Care Plan ▾
Full Name ↑ Lead CC SCP Initiate... SCP	Full Name ↑ Lead CC SCP Initiate... SCP	Full Name ↑ Lead CC SCP Initiate... SCP

My Work

User Inbox Unread

Sent By	Sent On	Business Unit (Sent By)	Patient	Notification Type	Message
Elizabeth Roach	9/19/2018 7:5...	OneCare	FNAME104 L...	Notify	eco map uplo...
Elizabeth Roach	9/19/2018 7:4...	OneCare	FNAME104 L...	Notify	eco map has ...
Elizabeth Roach	9/19/2018 7:4...	OneCare	FName103 La...	Notify	eco map has ...
Kathleen Cam...	9/19/2018 3:5...	OneCare	FName102 LN...	Clinical	Client has ne...
Kathleen Cam...	9/19/2018 2:0...	OneCare	FNAME101 L...	Clinical	Client has ne...
Kathleen Cam...	9/19/2018 1:5...	OneCare	FNAME110 L...	Clinical	Client has ne...
Kathleen Cam...	9/19/2018 1:5...	OneCare	FNAME109 L...	Clinical	Client has ne...
Kathleen Cam...	9/19/2018 1:5...	OneCare	FNAME108 L...	Clinical	Client has ne...

1 - 8 of 533

Event Notifications Unread

No Event Notification records found.

3. User Inbox: This section contains notifications sent by members of the care team.

User Inbox Unread

Sent By	Sent On	Business Unit (Sent By)	Patient	Notification Type	Message
Kathleen Cam...	9/27/2018 1:5...	OneCare	FNAME112 L...	Notify	See Eco Map ...
Kathleen Cam...	9/27/2018 1:5...	OneCare	FName111 L...	Notify	See Eco Map ...
Kathleen Cam...	9/27/2018 1:5...	OneCare	FNAME110 L...	Notify	See Eco Map ...
Kathleen Cam...	9/27/2018 1:3...	OneCare	FNAME109 L...	Clinical	Client has ne...
Kathleen Cam...	9/27/2018 1:3...	OneCare	FNAME108 L...	Clinical	Client has ne...
Kathleen Cam...	9/27/2018 1:3...	OneCare	FNAME107 L...	Clinical	Client has ne...
Kathleen Cam...	9/27/2018 1:3...	OneCare	FNAME106 L...	Clinical	Client has ne...
Kathleen Cam...	9/27/2018 1:2...	OneCare	FNAME105 L...	Clinical	Client has ne...

1 - 8 of 603

Once you have viewed the Notification you have the option of marking the notification as read removing from the unread file. To complete this, open the message and hover over the 'Status' to view the dropdown menu and select 'Read'.

CARE TEAM NOTIFICATION STATUS : INFORMATION

New Care Team Notification Status

Notification Status

User Name: Dan CCS

Status: **Unread** (dropdown menu)

Care Team Notification: **Unread** (dropdown menu)

Patient: Gail Matthews

Notification Type: Very Important

Message: Crisis Plan has been uploaded to documents section. Please review.

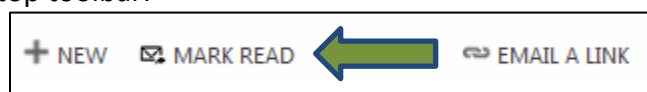
Sent On: 12/18/2017 1:43 PM

Sent By: Robyn Skiff

4. Event Notifications Unread: This section contains the admission, discharge, and transfer (ADT) alerts that have been received regarding patients whose care teams you are assigned to.

Event Notifications Unread				
Search for records				
Date/Time of Event	Patient	Facility	Facility	Event Type...
6/18/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Admission
6/18/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Transfer
6/18/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Admission
6/18/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Transfer
6/18/2018 12:00 AM	FName102 LName...	GMC		Admission
6/18/2018 12:00 AM	FName102 LName...	GMC		Transfer
6/13/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Admission
6/13/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Admission
6/13/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Transfer
6/13/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Admission
6/13/2018 12:00 AM	FName102 LName...	GMC	GIFFORD MEDICAL CE...	Transfer

Once you have reviewed the ADT alert you have the option of marking the notification read to remove it from the 'Unread' feed. To complete this, open the message and select the 'Mark Read' option from the top toolbar:



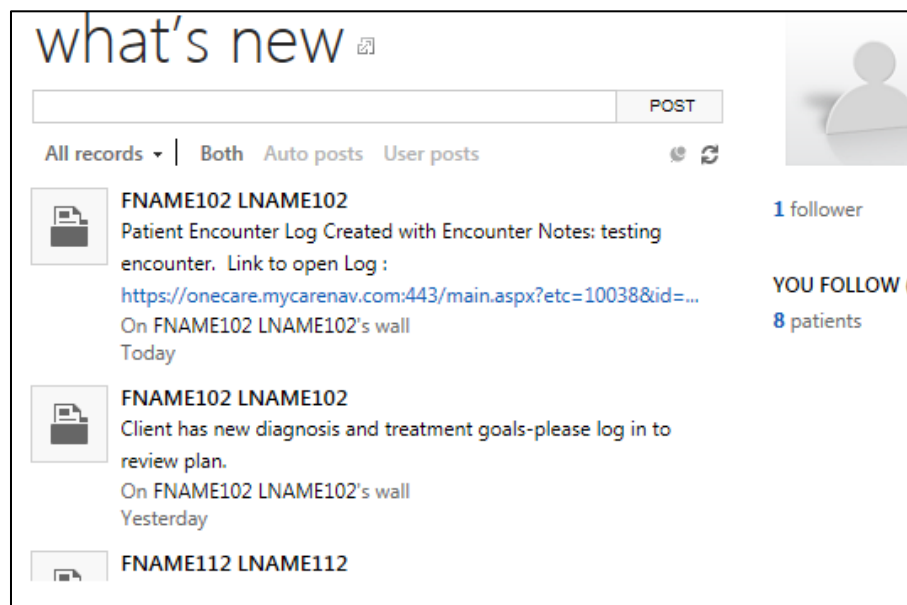
- 5. My Active Patients:** This section contains a list of patients whose care team you have been assigned to.

My Patients				
Search for records				
Last Name	First Name	Date of Birth	Member ID	Risk Category
Logan	Apple	10/9/1988	{062z3564Zx	
LName1	FName1	4/4/1942		
LName110	FName110	12/30/2006	{00564629124	
LName200	FName200	2/25/1932		
LName254	FName254	9/2/1931		
LName285	FName285	12/6/1931		
LName286	FName286	8/22/1938		
Lnamegv4	Fnamegv4	1/21/1958	{00283564Z4	

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Page 1

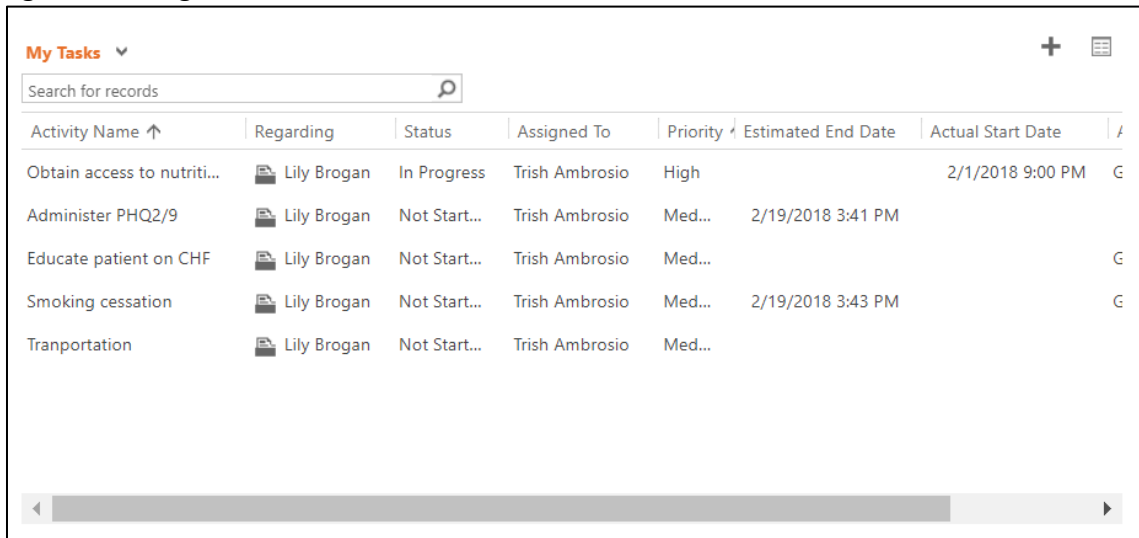
6. **What's New:** This section provides a feed of activity regarding patients the user is following including Encounters, Posts, and Care Team Notifications:



7. **My Appointments:** One-time or recurring appointments similar to an Outlook-type calendar can be recorded in this section.


My Appointments					
Search for records					
Start Date ↑	Patient	Activity Name	Priority	Care Provider	
9/29/2018 9:00 AM	Gail Matthews	Monthly Visit	Normal		
10/29/2018 9:00 AM	Gail Matthews	Monthly Visit	Normal		
11/29/2018 9:00 AM	Gail Matthews	Monthly Visit	Normal		
12/29/2018 9:00 AM	Gail Matthews	Monthly Visit	Normal		
1/29/2019 9:00 AM	Gail Matthews	Monthly Visit	Normal		
2/28/2019 9:00 AM	Gail Matthews	Monthly Visit	Normal		
3/29/2019 9:00 AM	Gail Matthews	Monthly Visit	Normal		
4/29/2019 9:00 AM	Gail Matthews	Monthly Visit	Normal		

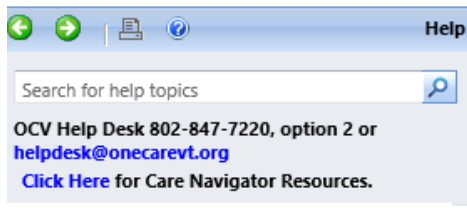
8. **My Tasks:** View assigned tasks or add tasks to any of the patients the user is assigned to by clicking on the + sign.



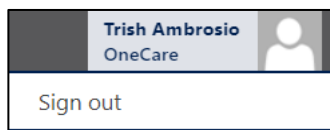
The screenshot shows a window titled "My Tasks" with a search bar and a table of tasks. The table has columns: Activity Name, Regarding, Status, Assigned To, Priority, Estimated End Date, and Actual Start Date. There are five tasks listed, all assigned to Trish Ambrosio and regarding Lily Brogan.

Activity Name ↑	Regarding	Status	Assigned To	Priority ↓	Estimated End Date	Actual Start Date	
Obtain access to nutriti...	Lily Brogan	In Progress	Trish Ambrosio	High		2/1/2018 9:00 PM	G
Administer PHQ2/9	Lily Brogan	Not Start...	Trish Ambrosio	Med...	2/19/2018 3:41 PM		
Educate patient on CHF	Lily Brogan	Not Start...	Trish Ambrosio	Med...			G
Smoking cessation	Lily Brogan	Not Start...	Trish Ambrosio	Med...	2/19/2018 3:43 PM		G
Tranportation	Lily Brogan	Not Start...	Trish Ambrosio	Med...			


9. **Help Button:** click on the? Icon  and this will display the Helpdesk contact information for you. As well as a link to the OneCare Website for additional resources.



10. **To Sign Out:** click on your name on the gray bar (see arrow above) and click on "Sign out"



Patient Dashboard



PATIENT : PATIENT DETAILS


Gail Matthews

DoB *	12/15/1938	Age	81	Lead CC	Amanda Aube	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landry, dtr	Primary Contact #	802-123-5689	Last Encounter	3/10/2020 4:52 PM	Eng. Reason	Utilization

42 CFR part 2 prohibits unauthorized disclosure of these records

The patient dashboard contains information that is either claims fed or entered by the care team members. The header contains information that gives a quick summary of patient information.

Beneath the dashboard, you will find a selection of menus to choose from based on your desired action. By default, each header is collapsed. Clicking on each header will expand to reveal further details within each category. For ease of viewing, close the header after you are done working within it.



CARE NAVIGATOR


Patients

Gail Matthews

Create

Kathleen Camisa
OneCare Staging

[UPLOAD DOCUMENT](#)
[SHARED CARE PLAN](#)
[ASSIGN CARE PROVIDER](#)
[SEND NOTIFICATION](#)
[FOLLOW](#)



PATIENT : PATIENT DETAILS

Gail Matthews

DoB *	12/15/1938	Age	81	Lead CC	Amanda Aube	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landry, dtr	Primary Contact #	802-123-5689	Last Encounter	3/10/2020 4:52 PM	Eng. Reason	Utilization

42 CFR part 2 prohibits unauthorized disclosure of these records

Patient Details

Care Team Notifications

Event Notifications

Encounter Log

Care Team Conference

Care Coordination

Care Plan

Key Utilization Metrics- past 12 months

Health Conditions

Community Programs

Documents

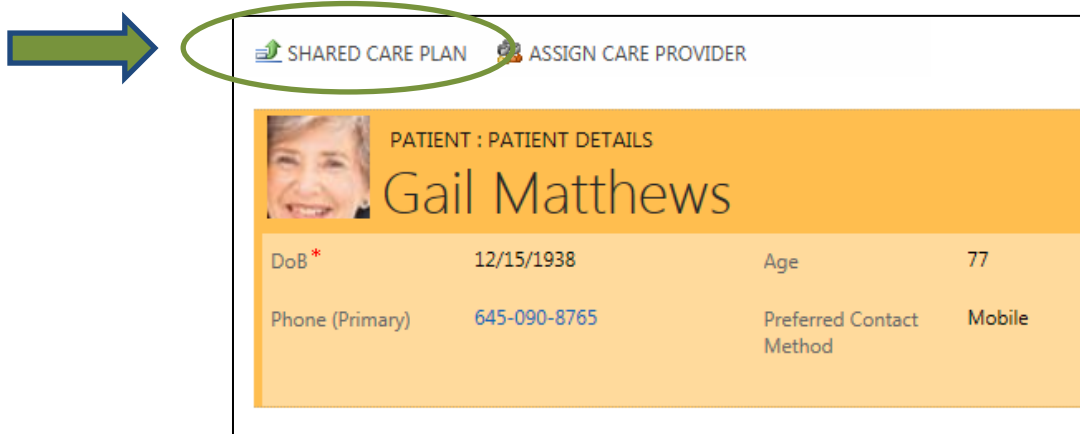
Resources

Shared Care Plan

The Patient's Shared Care Plan (SCP) is the plan of care that is a reflection of the collaborated effort among the patient's care team. The care coordinator will populate these fields within Care Navigator.

Viewing the Shared Care Plan

Shared Care Plan Document: To view the printable version of the Shared Care Plan, click on the icon above the patient name (**pictured below**)



To export this document to a PDF version as pictured below take the following steps:

1. Click on the disk icon in the top blue ribbon above the document
2. Choose the format you wish to convert the document into
3. Choose to Open or Save the document



Example of Completed Shared Care Plan:

Patient's Name : Gail Matthews (Test Patient)

DOB : 12/15/1938

Shared Care Plan

Patient Information					
Patient's Name: Gail Matthews (Test Patient)	Primary Phone#: (802) 847-3456	Type: Home		Email Address: GailMatthews@mycarenav.com	
Birthdate: 12/15/1938	Age: 81	Gender: Female	Identified Gender: female	Secondary Phone: (802) 999-3421	Type: Mobile
Address: (Street, City, State, Zip) 581 Ethan Allen Highway St. Albans Vermont 05478		Preferred Method of communication: Voice call		Communication Challenges: Hearing Impaired	
Legal Guardian: Anders Smith, Esq. 802-123-7896		Advanced Directive: No		AD Location: PCP office	
Primary Contact: Poppi Landrey, dtr			Primary Contact#: 802-123-5689		

Insurance Information		
Primary Insurance:	Current PCP: Dr. Sandra Jones	Attributed Provider:
Member ID:	Current PCP#: 802-123-4568	Attributed Practice:

Emergency Crisis Plan	
ED/Crisis Plan: Gail knows when she is short of breath and has gained 5+ pounds she needs to contact her cardiologist.	Crisis Plan Uploaded: Yes

About Me	
Preferred activities: I like to garden and love roses	Tips to avoid triggers/behaviors: Please be on time.
How I learn: I like to listen first and have written material for later	Physical Mobility: Limited Assistance uses a cane
Interaction tips: Spend some time talking with me before discussing my care	Mode of transportation: Transportation Agency
Communication style: I do best with slow communication. Repeating is also helpful.	Important Family information: I need a family member present when discussing future plans.

My Strengths	
I am resourceful and am good at solving problems	
I am a glass half full person with a positive outlook on life	

My Care Team						
Lead Care Coordinator: Robyn Skiff	Organization:	Phone#: 802-847-0606	Email: robyn.skiff@onecarevt.org			
Other Support: Johnson Smith, Neighbor, 802-987-1234		Other Support: Jim Matthews, Son, 123-4546-9875				
Name	Organization	Role	Participation Type			
Sandra KnowltonSoho	OneCare	Care Manager				
Kathleen Camisa	OneCare	Care Coordinator				
Elizabeth Roach	OneCare	Care Coordinator				
Robyn Skiff	OneCare	Care Coordinator	Care Team Member			
Community Programs						
Program		Date Of Enrollment	End Date			
SASH-Support and Services at Home		3/9/3017				
AAA-Area Agency on Aging/Council on Aging						
Self-Management Program (Diabetes, Chronic Conditions)		8/24/2018	9/5/2018			
Choices for Care- Home Health Agency						
My Goals						
PERSONAL						
GOAL	STEPS TO ACHIEVE MY GOAL	PRIORITY	STATUS	PERSON RESPONSIBLE	ACTUAL START DATE	DATE COMPLETED
Eat 5 serving of fruits and vegetables daily		Medium	Completed	Sarah Jemley	2/9/2018	2/25/2020
	Attend Healthy eating classes offered by SASH	Medium	Completed	Patient	2/1/2018	9/5/2018
I need help figuring out what to buy at the store that is good for me.		Medium	In Progress	Robyn Skiff	2/25/2020	
	Refer Gail to Nutritionist at the clinic.	Medium	Completed	Sandra KnowltonSoho	2/25/2020	2/25/2020
	Plan menu and create shopping list	Medium	In Progress	Robyn Skiff	2/25/2020	
I want to get out more and be with people. I		Medium	In Progress	Robyn Skiff	2/28/2020	
	Sign up for local gardening classes.	Medium	In Progress	Patient	2/25/2020	3/31/2020
	Ask Sarah if I can attend card games with her at the American Legion.	Medium	In Progress	Patient	3/2/2020	3/13/2020

TREATMENT						
GOAL	STEPS	PRIORITY	STATUS	PERSON RESPONSIBLE	ACTUAL START DATE	DATE COMPLETED
Take medications as prescribed		Medium	Completed	Sarah Jemley	1/30/2018	8/1/2018
	Arrange bubble packs	High	Completed	Sarah Jemley	1/29/2018	9/5/2018

FAMILY						
GOAL	STEPS TO ACHIEVE MY GOAL	PRIORITY	STATUS	PERSON RESPONSIBLE	ACTUAL START DATE	DATE COMPLETED

FUTURE						
GOAL	STEPS TO ACHIEVE MY GOAL	PRIORITY	STATUS	PERSON RESPONSIBLE	ACTUAL START DATE	DATE COMPLETED
Attend my grandson's birthday party this July		High	Completed	Robyn Skiff	7/12/2018	2/19/2020
	Do my balance exercises 3 times a week	Medium	Completed	Patient	1/30/2018	2/19/2020
	Walk 3 laps around main floor at least 3 times/wk	Medium	Completed	Patient	2/5/2018	2/19/2020
	Obtain a rolling walker	Medium	Completed	Robyn Skiff	5/1/2018	10/5/2018

Possible Challenges with Meeting My Goals		
CHALLENGE	TYPE	PLAN FOR HOW TO HANDLE THE CHALLENGE
Sometimes it is hard to remember all things I am working on.	Cognition	My care team will print an updated copy of my care plan and give it to me anytime changes are made to my care plan.

My Signature _____

Date: _____

Parent/ Legal Guardian Signature _____

Date: _____

Lead Care Coordinator's signature _____

Date: _____

Patient Details

This section gives general demographic information about the patient. Fields are fed from either claims data or input by care team members.

Patient Details

General

First Name	Gail	Gender *	Female
Middle Initial	--	Identified Gender	female
Last Name *	Matthews (Test Patient)	Race	--
Preferred Name	Poppy	Preferred Language other than English	English
Date of Birth *	12/15/1938	Communication Challenge	Visually Impaired
Marital Status	Divorced	COLST	No
Advance Directive	Yes	42 CFR Part 2	<input checked="" type="checkbox"/>
		42 CFR Part 2 Signed Date	10/15/2018
Advance Directive Location	PCP office		
Current PCP	Dr. Sandra Jones	Current PCP #	802-123-4568

Communication Details

Phone (Primary)	(802) 847-3456	Type (Primary)	Home
Phone (Secondary)	9802) 999-3421	Type (Secondary)	Mobile
Email	GailMatthews@mycarenav.com		
Preferred Contact Method	Voice call		
Primary Contact	Poppi Landrey, dtr	Primary Contact #	802-123-5689
Legal Guardian	Anders Smith, Esq. 802-123-7896	Legal Guardian #	802-456-7891
Physical Address	581 Ethan Allen Highway St. Albans 05478 Franklin	Mailing Address	Po Box 346 St Albans Vermont 05478 Franklin
Street	581 Ethan Allen Highway	Street	Po Box 346
City	St. Albans	City	St Albans
State	--	State	Vermont
ZIP	05478	ZIP	05478
County	Franklin	County	Franklin

42 CFR Part 2 Tracking

Patient records can be marked and tracked for 42CFR Part 2 re-disclosure notification compliance. When a patient has a 42CFR Part 2 consent completed and uploaded in the system, an alert can be turned on as displayed below:

PATIENT : PATIENT DETAILS ▾

Gail Matthews (Test Patient)

DoB *	12/15/1938	Age	79	Lead CC	Elizabeth Roach
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Visually Impaired
Primary Contact	Poppi Landrey, dtr	Primary Contact #	802-123-5689	Data last refreshed	

42 CFR part 2 prohibits unauthorized disclosure of these records

When a 42CFR Part 2 Consent is completed and uploaded, the following steps should be taken to record this in the patient record:

1. Upload 42 CFR Part 2 Consent into the Document section (see section on 'Documents' on the process to upload a document). The 42CFR consent will reside in the Document section

Documents			
Document Name	Document Type	Uploaded On ↓	Uploaded By
GMatthews 42CFR consent	42 CFR Part 2 Consent	5/7/2018	Robyn Skiff

2. In the 'Patient Details' section, check the box next to the '42 CFR Part 2' box and enter the date the patient signed the consent
3. The banner below will display in the patient header when the box is checked off to notify the care team the consent is on file

PATIENT : PATIENT DETAILS

Gail Matthews (Test Patient)

DoB *	12/15/1938	Age	79	Lead CC	Robyn Skiff	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Visually Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landrey, dtr	Primary Contact #	802-123-5689	Data last refreshed			

42 CFR part 2 prohibits unauthorized disclosure of these records

Patient Details

General

First Name	Gail	Gender *	Female
Middle Initial	--	Identified Gender	female
Last Name *	Matthews (Test Patient)	Race	--
Preferred Name	Poppy	Preferred Language other than English	English
Date of Birth *	12/15/1938	Communication Challenge	Visually Impaired
Marital Status	Divorced	COI/ST	No
Advance Directive	Yes	42 CFR Part 2	<input checked="" type="checkbox"/>
		42 CFR Part 2 Signed Date	10/15/2018

Activities and Notes

POSTS ACTIVITIES NOTES

All ▾ | Add Phone Call Add Task ...

A list of 42 CFR Part 2 participants can be seen as a system view under the 'My Patients' panel view, where the user can see the signed date, as well as the re-authorization date for each of those patients on the list.

42 CFR Part 2 Participants ▾					
Search for records 🔍					
Last Name	First Name	Date of Birth	42 CFR Part 2 Signed Date	42 CFR Part 2 Re-Auth Date	M
TestPatient01	TestMP	12/31/1974	4/27/2018	3/28/2019	
Brogan	Lily	12/31/1964	3/30/2018	2/28/2019	
LName8	FName8	5/15/1935	3/28/2018	2/26/2019	
LName68	FName68	6/18/1932	3/30/2018	2/28/2019	
LName104	FName104	12/10/1972	5/31/2018	5/1/2019	
LName134	fecf8275-0d6...	1/21/1930	4/5/2018	3/6/2019	
LName135	FName135	7/13/1932	3/11/2018	2/9/2019	
LName200	FName200	2/24/1932	3/28/2018	2/26/2019	

Entering a Note

A note can be entered under the 'Activities and Notes' section. Members of the patient's care team can view these notes. Enter the note and Click 'Done' when entry is completed.

Patient Details

General

First Name	Gail	Gender *	Female
Middle Initial	--	Identified Gender	female
Last Name *	Matthews (Test Patient)	Race	--
Preferred Name	Poppy	Preferred Language other than English	English
Date of Birth *	12/15/1938	Communication Challenge	Visually Impaired
Marital Status	Divorced	COLST	No
Advance Directive	Yes	42 CFR Part 2	<input checked="" type="checkbox"/>
Advance Directive Location	PCP office	42 CFR Part 2 Signed Date	10/15/2018
Current PCP	Dr. Sandra Jones	Current PCP #	802-123-4568

Activities and Notes

POSTS
ACTIVITIES
NOTES

Enter a note

Received information from Gail and Robyn to attend care conference next week, able to attend on Friday morning - looking forward to it! I will check in with Dr Smith on Wednesday to alert him and ask if he has any recommendations for discussion. Have a great week!

Sarah Jemley - 1/29/2018 4:33:34 PM

Gail moved in to Ashland Terrace independent living last week and is adjusting well. Care Conference scheduled with Choices for Care Case Manager and RN Coordinator from Dr. Smith's office and patient next Friday at 10am.

Robyn Skiff - 1/29/2018 4:17:13 PM

Entering a Post

Under 'Activities and Notes' click on 'Posts' and enter information that can be viewed by all Care Team Members. Use this when you want others on the care team to see an important but not urgent update in their What's New feed the next time you log in. Encounter log entries and Care Team Notifications will also flow into the 'Post' section.



Activities and Notes

POSTS ACTIVITIES NOTES

Both Auto posts User posts

Edwin Gonzalez (Test Patient)
test notification
On Edwin Gonzalez (Test Patient)'s wall
5/31/2018 7:05 AM

Edwin Gonzalez (Test Patient) LIKE | REPLY ✕
Lengthy home visit today - client made major changes to his care plan and agreed to PCP treatment goals. See my encounter

Event Notifications

Event Notifications are daily feeds coming from Patient Ping and VITL. Care team members are notified in real-time by email of any admissions, discharges and transfers (ADT feeds) when they are part of a patient's care team (see 'My Work' section). These feeds provide information about patients who have experienced changes in levels of care on a real-time basis. To see the details of the Event Notification, click on the record to open the message.

PATIENT : PATIENT DETAILS
Gail Matthews

DoB *	12/15/1938	Age	81	Lead CC	Amanda Aube	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landry, dtr	Primary Contact #	802-123-5689	Last Encounter	3/10/2020 4:52 PM	Eng. Reason	Utilization

42 CFR part 2 prohibits unauthorized disclosure of these records

Patient Details

Care Team Notifications

Event Notifications

Event Notifications Unread				
<input type="text" value="Search for records"/>				
Date/Time of Event...	Patient	Facility	Facility	Event Typ...
9/8/2018 12:00 AM	FNAME102 LNAME...	GMC		Admission
6/18/2018 12:00 ...	FNAME102 LNAME...	GMC	GIFFORD MEDICAL C...	Admission
6/18/2018 12:00 ...	FNAME102 LNAME...	GMC	GIFFORD MEDICAL C...	Transfer
6/18/2018 12:00 ...	FNAME102 LNAME...	GMC		Admission
6/18/2018 12:00 ...	FNAME102 LNAME...	GMC		Transfer
6/18/2018 12:00 ...	FNAME102 LNAME...	Bayada-BRATTLEBOR...		Admission
12/12/2017 12:00 ...	FNAME104 LNAME...			Admission

The details (including the patient's name and medical ID) will appear as shown below. After reviewing, the user can change the status of the notification to 'Mark Read':

[+ NEW](#)
[MARK READ](#)
[SHARE](#)
[EMAIL A LINK](#)
[RUN WORKFLOW](#)
[START DIALOG](#)
[RUN REPORT](#)

EVENT NOTIFICATION : INFORMATION

06s28350bX9

Event Notification

Patient		Details	
Patient *	Fname102 LNAME102	Facility Code	GMC
MemberID *	06s28350bX9	Facility	GIFFORD MEDICAL CENTER
		Date/Time of Event	6/18/2018 12:00 AM
		Event Type	Admission
		Notes Count	--

Notes

ACTIVITIES NOTES

Enter a note

No Notes found.

Care Team Notifications

The Care Team Notification feature allows members of a care team to alert other team members of key events or communications related to common patients. When the Notification message is completed and sent, recipients then receive an email alert with a link that prompts them to sign into Care Navigator. Upon signing in with their credentials, the user will be brought directly to the relevant patient's page to view the information. Notifications can also be viewed on the Care Navigator Homepage under 'My Unread Notifications'.

To Send a Care Team Notification:

1. Click on 'Send Notification' in top toolbar of the patient's dashboard to open the notification feature. The Notify Care Team Member(s) menu will open:

[UPLOAD DOCUMENT](#)
[SHARED CARE PLAN](#)
[ASSIGN CARE PROVIDER](#)
[SEND NOTIFICATION](#)
[UNFOLLOW](#)

PATIENT : PATIENT DETAILS

Gail Matthews (Test Patient)

DoB *	12/15/1938	Age	80	Lead CC	Robyn Skiff
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Visually Impaired
Primary Contact	Poppi Landrey, dtr	Primary Contact #	802-123-5689	Data last refreshed	

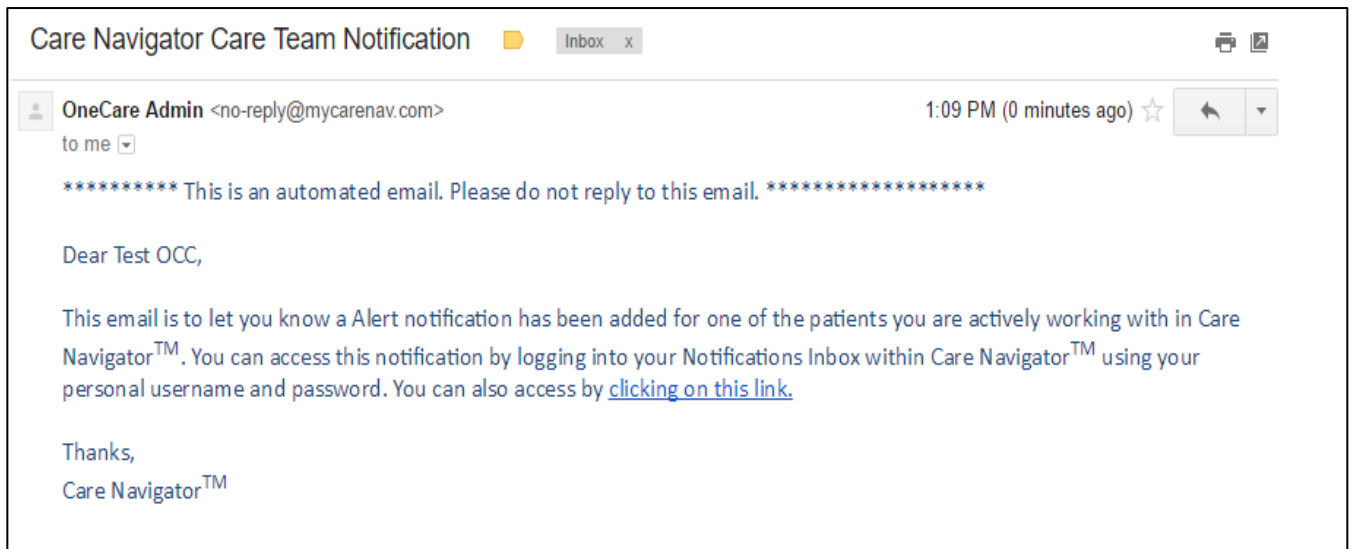
42 CFR part 2 prohibits unauthorized disclosure of these records

7. Select a Notification Type using the drop down on the right.
8. Enter a simple message with no protected health information. No more than 500 characters
9. A User can select either specific Care Team Members or all Care Team Members by choosing 'Select All' to send the notification to

10. Click the 'Send' button to send the notification

11. After the notification is sent a success message box will appear as shown below:

12. Notification Email: Recipients will receive an email to the address they have registered with when completing their User Agreement. Please contact the helpdesk@onecarevt.org if your email address has changed since initial registration.



Encounter Log

The Encounter Log is an area for a care coordinator to reflect meaningful interactions with the patient or the patient's care team.

Patient Encounter Log Entry:

1. Click on the 'Encounter Log' tab, then + sign to begin creating a new Encounter:

PATIENT: PATIENT DETAILS
Gail Matthews

DoB *	12/15/1938	Age	81	Lead CC	Amanda Auble	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landry, dtr	Primary Contact #	802-123-5689	Last Encounter	3/10/2020 4:52 PM	Eng. Reason	Utilization

42 CFR part 2 prohibits unauthorized disclosure of these records




Patient Details
Care Team Notifications
Event Notifications
Encounter Log





Date of Last Encounter: 3/10/2020 4:52 PM

Care Management Encounters +

Date ↑	Type of Contact...	Care Team Member	Duration	Encounter Purpose
3/5/2020 12:27 PM		Kathleen Camisa		Assessment/Physical, Assessment/Mental Health
2/21/2020 1:22 PM	Office Visit	Kathleen Camisa	1.5 hours	Assessment/Social, Disease Management, Support/...

2. A pop-up box will appear to record a new entry into the log. Enter the value for applicable fields below and click Save & Close:




  | New Patient Encoun... 

 SAVE  SAVE & CLOSE  NEW  FORM EDITOR


PATIENT ENCOUNTER LOG : INFORMATION

New Patient Encounter Log

Visit Summary

Visit Type*	 Care Management	Patient*	 Gail Matthews
		Start Date and Time	3/12/2020 2:28 PM
		Created By	 --

Care Management

General		Mileage	
Duration	--	Start Mileage	--
Care Team Member	Elizabeth Roach	End Mileage	--
Type of Contact	--	Actual Mileage	 --
Related Care Plan Goal	--		

Encounter Purpose		Encounter Notes	
Shared Care Plan Review/Update	<input checked="" type="checkbox"/>	Encounter Notes	--
Assessment/Physical	<input checked="" type="checkbox"/>		
Assessment/Mental Health	<input checked="" type="checkbox"/>		
Assessment/Social	<input type="checkbox"/>		
Goal Setting	<input type="checkbox"/>		
Condition Self-Management	<input type="checkbox"/>		
Palliative/Hospice Care Discussion	<input type="checkbox"/>		
Advance Directive Discussion	<input type="checkbox"/>		
Advance Directive Completed	<input type="checkbox"/>		
Crisis Plan Discussion	<input type="checkbox"/>		
Crisis Plan Completed	<input type="checkbox"/>		
Disease Management	<input type="checkbox"/>		
Med reconciliation	<input type="checkbox"/>		
Patient education	<input type="checkbox"/>		

General:

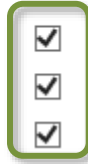
- The Patient Name will populate automatically
- The Start Date and Time will populate automatically
- Select the Duration of the encounter
- Select the Care Team Member of the patient
- Select the Type of Contact
- Select the Related Care Plan Goal

Encounter Purpose:

- The care coordinator can choose one or more reasons for seeing a patient under 'Encounter Purpose'.

Encounter Purpose

Shared Care Plan Review/Update
Assessment/Physical
Assessment/Mental Health



Encounter Notes:

- A brief note describing the care team member's interaction with the patient can be recorded in this section, and should include next steps or outcomes related to care coordination.

3. The Date of Last Encounter is displayed in both the patient header and above the box in the Encounter Log:

PATIENT : PATIENT DETAILS

Gail Matthews

DoB * 12/15/1938 Age 81 Lead CC [Erin Covey](#) CC Status Care Coordination Not Needed

Phone (Primary) Primary Contact Comm Challenge Hearing Impaired Acuity Level 3. Weekly contact

Last Encounter 3/10/2020 11:31 AM Eng. Reason Utilization

42 CFR part 2 prohibits unauthorized disclosure of these records

Encounter Log

Date of Last Encounter 3/10/2020 11:31 AM

Date of Last Encounter now appears here

Care Management Encounters

Date ↑	Type of Contact...	Care Team Member	Duration	Encounter Purpose
--------	--------------------	------------------	----------	-------------------

Care Team Conference

A Care Team Conference is a gathering of care team members who are providing an individual, family and care team members an opportunity to discuss the patients progress and ensure needs are being met.

1. Open the Care Team Conference tile and click on the plus sign

Care Team Conference

Care Team Conference

Care Team Conference Encounter...							
Created On	Created By	Status Reason	Patient/Family Invite...	Patient/Family Atten...	Reason Not Attending	Shared Care Plan Re...	SDoH Assessment
2/25/2020 1:23 PM	Dan CCS2	Completed	Yes	Yes		No	No
2/25/2020 12:52 PM	Robyn Skiff	Completed	Yes	Yes			
2/21/2020 1:29 PM	Kathleen Camisa	In Progress	Yes	Yes			
2/20/2020 7:36 PM	Dan Fanelli	Completed	Yes	No	Transportation		

1. Click + to add a Care Team Conference

2. When the next screen opens enter information in each area as below:

PATIENT ENCOUNTER LOG : INFORMATION

Gail Matthews's Care Team Conference

Visit Summary

Visit Type * ⓘ Care Team Conference

Patient * ⓘ Gail Matthews
 Created On ⓘ 2/27/2020 9:39 AM
 Created By ⓘ Elizabeth Roach
 Status Reason ⓘ In Progress

Care Team Conference

General

Patient/Family Invited * ⓘ No
 Patient/Family Attending * ⓘ No
 Reason Not Attending * ⓘ Transportation

Attendees

Care Team Member ⓘ

No Encounter Attendees records found.

Encounter Purpose

Shared Care Plan Review/Update ☒
 Assessment/Physical ☐
 Assessment/Mental Health ☐
 Assessment/Social ☐
 Goal Setting ☐

Encounter Notes

Encounter Notes * ⓘ met to discuss

2. Populate each section that has an *

4. Type your note, such as next steps and information the care team needs to know. Not for lengthy progress

3. Choose an Encounter Purpose. Multiple selections may be made.

<https://onecarestaging.mycarenav.com/main.aspx?etc=100618&ex>

New Patient Encoun...

SAVE SAVE & CLOSE + NEW FORM EDITOR

5. Click Save

3. Add Care Team Conference Attendees :

PATIENT ENCOUNTER LOG : INFORMATION

Gail Matthews's Care Team Conference

General

Patient/Family Invited* No
Patient/Family Attending* No
Reason Not Attending* Transportation

Attendees

Care Team Member

No Encounter Attendees records found.

6. Click on grid to add
Care Team Attendees

PATIENT ENCOUNTER LOG : INFORMATION

Gail Matthews's Care Team Conference

Encounter Attendees Associated...

ADD ATTENDEES + ADD NEW ENCOUNTER A... CHART PANE RUN REPORT EXPORT ENCC

Name

Created On

No Encounter Attendees records found.

7. Click Add Attendees to
add Care Team Attendees

Add Attendees

Select care team members that are attending the care team conference

☐ Select all

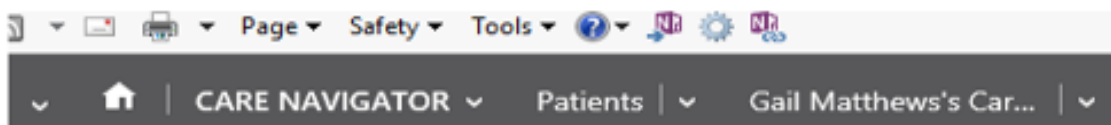
☐ Dan CCS2 (dan.wbpl.test+danccs2@gmail.com)
☐ Dan CCS9 (EMAIL NOT CONFIGURED)
☐ Danielle Palmer (Danielle.palmer@onecarevt.org)
☐ Elizabeth Roach (elizabeth.roach@onecarevt.org)
☐ Kathleen Camisa (kathleen.camisa@onecarevt.org)
☐ Robyn Skiff (robyn.skiff@onecarevt.org)
☐ Test TestCC (Danielle.Palmer@uvmhealth.org)

Submit

Cancel

9. Click submit

8. Choose Care Team Attendees that
attended Care Team Conference



11. Click on patient's name to go back to care team conference page

4. Return to main page, refresh your list, complete your Care Team Conference:

PATIENT ENCOUNTER LOG : INFORMATION

Gail Matthews's Care Team Conference

Visit Summary

Visit Type * Care Team Conference

Patient * Gail Matthews
Created On 2/27/2020 9:39 AM
Created By Elizabeth Roach
Status Reason In Progress

Care Team Conference

General

Patient/Family Invited * No
Patient/Family Attending * No
Reason Not Attending * Tra

Attendees

Care Team Member

Becky Bee
Dan CCS10
Dan CCS2

Status Reason Completed

_CreateFromType%3d1%

amisa
aging

12. Right click and refresh the list of Care Team Members who attended

13. Mark Status Completed

14. Click save button

15. Click the X in the top right hand corner to return to the main patient screen

Care Coordination

This section gives an overview of the patient's current and historical involvement with care coordination. The user can open the Care Coordination menu by single clicking on the tab, with the options below viewable upon opening:

UPLOAD DOCUMENT
 SHARED CARE PLAN
 ASSIGN CARE PROVIDER
 SEND NOTIFICATION
 FOLLOW

PATIENT : PATIENT DETAILS
Gail Matthews

DoB *	12/15/1938	Age	81	Lead CC	Amanda Aube	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landry, dtr	Primary Contact #	802-123-5689	Last Encounter	3/10/2020 4:52 PM	Eng. Reason	Utilization

42 CFR part 2 prohibits unauthorized disclosure of these records

Patient Details

Care Team Notifications

Event Notifications

Encounter Log

Care Team Conference

Care Coordination

Care Coordination Level	Level 1	Social Risk Score	4	Acuity Level	3. Weekly contact
Reason For Engagement	Utilization	Care Coordination Status	Engaged	Deceased Date	--

Care Coordination


Reason For Engagement	Created On ↑	Care Coordination Status	Created On ↑	Created On ↑	Acuity Level
Utilization	3/10/2020 8:14	Engaged	3/11/2020 8:38 AM	3/10/2020 8:14 AM	3. Weekly contact
Utilization	3/5/2020 1:51	Care Coordination Not Needed	3/10/2020 8:14 AM	3/5/2020 1:51 PM	3. Weekly contact
Utilization	3/5/2020 12:36	Care Coordination Not Needed	3/5/2020 1:51 PM	2/28/2020 2:11 PM	3. Weekly contact
SDoH - Internal Screening : Name of Tool : Vermont ...	2/28/2020 2:11	Care Coordination Not Needed	3/5/2020 12:36 PM	2/25/2020 1:18 PM	3. Weekly contact

- The user can open the Care Coordination menu by single clicking on the header, with the options below viewable upon opening. When a box turns gray when hovering on a field it indicates there is a list of options to choose from:
 - Care Coordination Level-a non-editable field fed from our data systems based on the Risk Category at the start of the year. This level will not change for the entire year.
 - Reason for Engagement-indicate the reason for engaging the patient
 - Social Risk Score-a non-editable field calculated from SDoH
 - Care Coordination Status-this field reflects the patient's level of engagement with care coordination.
 - Acuity Level-indicates the frequency of interaction needed either directly or indirectly with the patient.
 - Deceased Date-can be claims fed or input by care team member
 - About Me and Strengths
 - Care Team members
 - ACO/Insurance Information

About Me:

The 'About Me' section is based on your interactions with the patient. These important person centered fields help the team see the whole person.

These are free text fields, except for the Physical Mobility and Mode of Transportation, where the user must select from the drop-down menu to populate these fields. The ED/Crisis plan field is where information can be added regarding the Patient's preferences for how to handle a crisis. If a more detailed Crisis Plan is uploaded into the documents section then 'Crisis Plan Uploaded' box should be checked.



PATIENT: PATIENT DETAILS ▾
Gail Matthews (Test Patient)

DOB *	12/15/1938	Age	79	Lead CC	Elizabeth Roach	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Visually Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landrey, dtr	Primary Contact #	802-123-5689	Data last refreshed			

42 CFR part 2 prohibits unauthorized disclosure of these records

About Me

Preferred activities

I like to garden and love roses

How I learn

Please tell me new information and give me something written to take with me

Interaction Tips

Even if I have someone with me please talk to me about my situation

Communication Style

Please don't sugarcoat things I like to be told the truth

Tips to avoid triggers/behaviors

Please don't talk to me like I don't understand things; I am old but just as smart as you

Physical Mobility

Limited Assistance

Mode of Transportation

Transportation Agency

Important Family Information

I don't get along with my daughter but my son is a great help to me and always has been.

ED / Crisis Plan

Please alert my SASH Coordinator if I am in the ED. I prefer NOT to be admitted if possible. I get anxious when my blood sugar is high.

Crisis Plan Uploaded

☒

My Strengths

Strength ↑

Created On

I am a glass half full person with a positive outlook ...

8/24/2017 3:19 AM

I am resourceful and am good at solving problems


8/24/2017 3:18 AM

I work well with my team

1/29/2018 3:43 PM

My Strengths

My Strengths should be completed with the patient present to indicate the best interaction strategies:



PATIENT: PATIENT DETAILS ▾
Gail Matthews (Test Patient)

DOB *	12/15/1938	Age	79	Lead CC	Elizabeth Roach	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Visually Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landrey, dtr	Primary Contact #	802-123-5689	Data last refreshed			

42 CFR part 2 prohibits unauthorized disclosure of these records

About Me

Preferred activities

I like to garden and love roses

How I learn

Please tell me new information and give me something written to take with me

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Communication Style

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Tips to avoid triggers/behaviors

Please don't talk to me like I don't understand things; I am old but just as smart as you

Physical Mobility

Limited Assistance

Mode of Transportation

Transportation Agency

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☒

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Strength ↑

Created On

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8/24/2017 3:19 AM

I am resourceful and am good at solving problems


8/24/2017 3:18 AM

I work well with my team

1/29/2018 3:43 PM

Care Team Members:

The following section under the 'Care Coordination' submenu is the Care Team Members section. Here, a list of care team members and their role on the care team can be identified. Non-ACO members who are part of the care team can also be added. 'Other Support' fields have been added so a care team member can identify other individuals who are supporting the patient but not part of the care team. A box for 'Lead CC Change History' will allow you to view the Lead Care Coordinator changes and reasons over time:





PATIENT : PATIENT DETAILS
Gail Matthews

DoB *	12/15/1938	Age	81	Lead CC	Amanda Aube	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landry, dtr	Primary Contact #	802-123-5689	Last Encounter	3/10/2020 4:52 PM	Eng. Reason	Utilization

42 CFR part 2 prohibits unauthorized disclosure of these records

Care Team Members

Lead CC  [Amanda Aube](#)

Current PCP  [Dr. Sandra Jones](#)

Other Support 1 [Jonny Lavalee, neighbor 878-1234](#)

Other Support 2 [Sally Smith, DCF, 484-5432](#)

Other Support 3 --

Other Support 4 --

Other Support 5 --

Lead CC Change History

Created On	Changed By	Lead CC	Action	Reason for Change
3/11/2020 8:41 AM	Denise Macfarlane	Amanda Aube	Assigned	Patient/Family Request
3/11/2020 8:41 AM	Denise Macfarlane	Elizabeth Roach	Removed	Care provider removed as Lead CC but still on care t...
3/10/2020 3:33 PM	Elizabeth Roach	Elizabeth Roach	Assigned	Patient/Family Request
3/10/2020 3:33 PM	Elizabeth Roach	Erin Covey	Removed	Care provider removed as Lead CC but still on care t...
3/10/2020 11:35 AM	Elizabeth Roach	Erin Covey	Assigned	Patient/Family Request


1 - 5 of 40


Name	Role (To)	Lead CC	Participation Type	Licensure 1 (Name)	Licensure 2 (Name)	Description
Amanda Aube	Care Coordinator	Yes	Care Team Member			
Danielle Palmer	Care Coordinator	No	Care Team Member	RN		Age Well Care and Service Coordinator
Elizabeth Roach	Care Coordinator	No	Organizational Ad...			
Erin Covey	Care Manager	No	Care Team Member			

1 - 4 of 7

1. Click on the grid on the right hand side of the box to view the Active Connections for the patient. From this grid select 'Add Care Team Member' to bring a sub-menu up for care team additions:

Care Team Members

Lead CC  [Danielle Palmer](#)

Current PCP  [Dr. Sandra Jones](#)

Other Support 1 [Jonny Lavalee, neighbor 878-1234](#)

Other Support 2 [Sally Smith, DCF, 484-5432](#)

Other Support 3 --

Other Support 4 --

Other Support 5 --

Lead CC Change History

Created On	Changed By	Lead CC	Action	Reason for Change
2/28/2020 2:36 PM	Kathleen Camisa	Danielle Palmer	Assigned	Other: Initial Assignment
2/25/2020 10:51 AM	Test TestCC	Becky Bee	Assigned	Internal Staffing Change
2/25/2020 10:51 AM	Test TestCC	Danielle Palmer	Removed	Care provider removed as Lead CC but still on care t...
2/25/2020 9:51 AM	Kathleen Camisa	Danielle Palmer	Assigned	Patient/Family Request
2/25/2020 9:51 AM	Kathleen Camisa	Robyn Skiff	Removed	Care provider removed as Lead CC but still on care t...

1 - 5 of 28

2. Scroll down to locate the Care Team Members section

Name ↑	Role (To) ↑	Lead CC	Participation Type	Licensure 1 (Name)	Licensure 2 (Name)	Description
Danielle Palmer	Care Coordinator	Yes	Care Team Member	RN		Age Well Care and Service Coordinator
Elizabeth Roach	Care Coordinator	No	Organizational Ad...			
Erin Covey	Panel Coordinator	No	Care Team Member			
Kathleen Camisa	Care Coordinator	No				

1 - 4 of 7

Page 1

3. Click on the grid to begin the Care Team Member add

Active Connections for Patient

4. Click on Add Care Team Member

ADD CARE TEAM MEMBER

Search for records

✓ Name ↑	Legal Business Name (Name)	Role (To) ↑	Participation Type	Primary Phone (...	Email (Connected To)	Lead CC	Li
Danielle Palmer	Brattleboro Housing Authority - 030214667	Care Coordinator	Care Team Member			Yes	RN
Elizabeth Roach	OneCare	Care Coordinator	Organizational Ad...			No	
Erin Covey		Panel Coordinator	Care Team Member			No	

8. Click 'Save & Close' to complete the addition

5. Search for the Care Team Member you would like to add

6. Choose your role with the patient

7. Choose your Participation Type

Connection - Microsoft Dynamics CRM - Internet Explorer

https://staging.mycarenav.com/main.aspx?etc=3234&extraqs=%3fetc%3d3234&E2BD73-A94A-E611-80C7-0001

FILE CONNECTION CUSTOMIZE

Save Save & Close Chrome 38 Save Assign Copy a Link Follow Collaborate

Connection New Connection

Connections

Connected From Gail Ma...

Name* Erin Covey

Role* Panel Coordinator

Participation Type* Care Team Member

Lead CC ☐

Emergency Contact ☐

Description

Status Active

100%

Adding Non-ACO Participants: Non-ACO care team members can be added to the care team. These care team members won't have access to Care Navigator but should be noted as part of the care team:

PATIENT : PATIENT DETAILS
 **Gail Matthews**

DOB *	12/15/1938	Age	81	Lead CC	Amanda Aube	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Consent Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landry, dtr	Primary Contact #	802-123-5689	Last Encounter	3/10/2020 4:52 PM	Eng. Reason	Utilization

42 CFR part 2 prohibits unauthorized disclosure of these records

[Patient Details](#)
[Care Team Notifications](#)
[Event Notifications](#)
[Encounter Log](#)
[Care Team Conference](#)
[Care Coordination](#)

1. Click once on the Care Coordination option from the patient's page

Care Team Members

Lead CC	 Amanda Aube
Current PCP	 Dr. Sandra Jones
Other Support 1	Jonny Lavalley, neighbor
Other Support 2	Sally Smith, DCF, 484-5432
Other Support 3	--
Other Support 4	--
Other Support 5	--

Lead CC Change History

Created On	Changed By	Lead CC	Action	Reason for Change
3/11/2020 8:41 AM	Denise Macfarlane	Amanda Aube	Assigned	Patient/Family Request
3/11/2020 8:41 AM	Denise Macfarlane	Elizabeth Roach	Removed	Care provider removed as Lead CC but still on care t...
3/10/2020 3:33 PM	Elizabeth Roach	Elizabeth Roach	Assigned	Patient/Family Request
3/10/2020 3:33 PM	Elizabeth Roach	Erin Covey	Removed	Care provider removed as Lead CC but still on care t...
3/10/2020 3:33 PM	Elizabeth Roach	Erin Covey	Assigned	Patient/Family Request

Page 1

2. Scroll down to locate the Care Team Members section

Name	Role (To)	Lead CC	Participation Type	Licensure 1 (Name)	Licensure 2 (Name)	Description
Danielle Palmer	Care Coordinator	Yes	Care Team Member	RN		Age Well Care and Service Coordinator
Elizabeth Roach	Care Coordinator	No	Organizational Ad...			
Erin Covey	Panel Coordinator	No	Care Team Member			
Kathleen Camisa	Care Coordinator	No				

1 - 4 of 7

Page 1

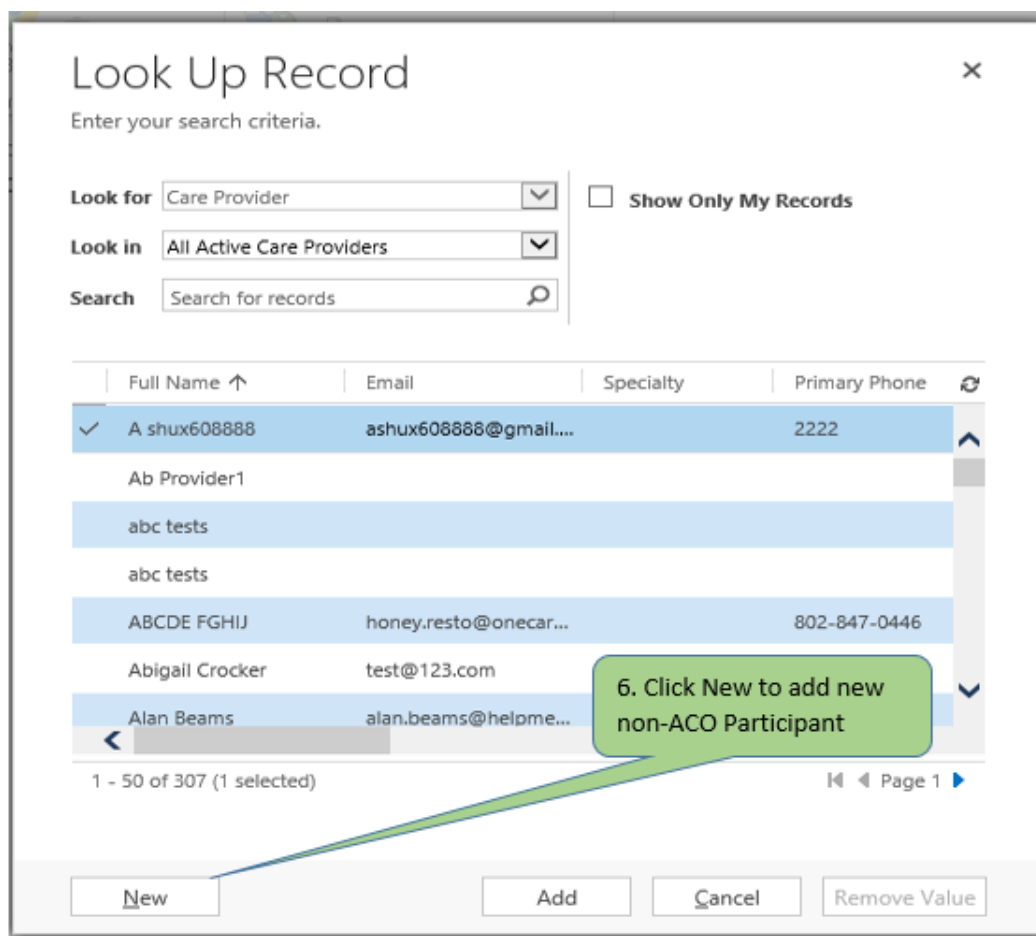
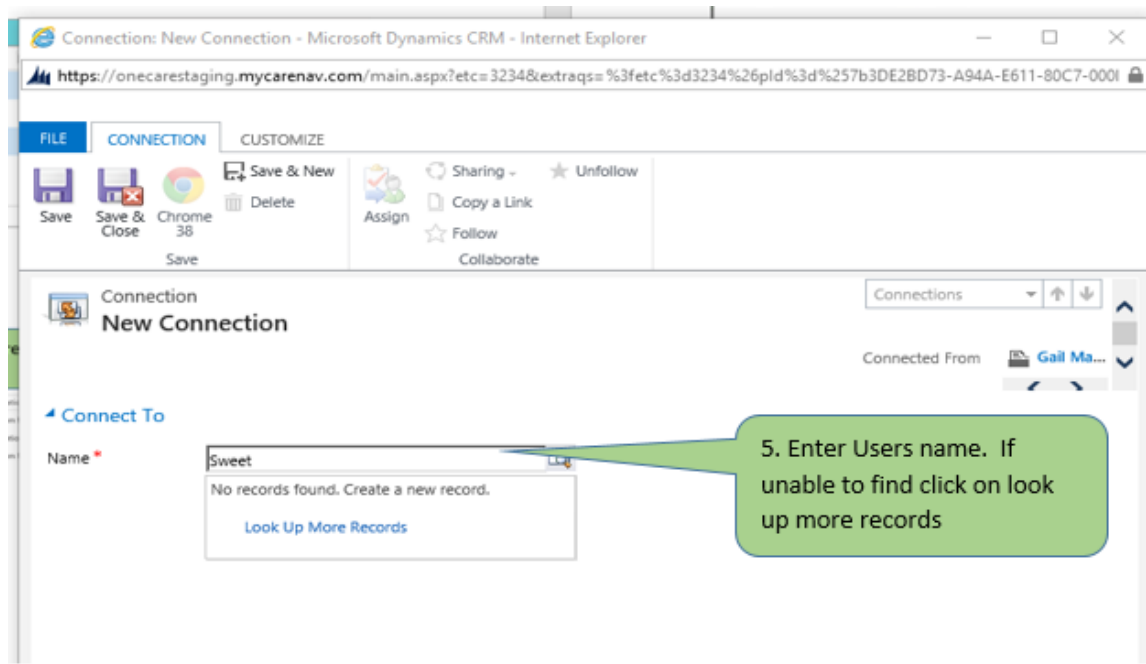
3. Click on the grid to begin the Care Team Member add

Active Connections for Patient

ADD CARE TEAM MEMBER

Name	Legal Business Name (Name)	Role (To)	Participation Type	Primary Phone (L...	Email (Connected To)	Lead CC	Link
Danielle Palmer	Brattleboro Housing Authority - 030214867	Care Coordinator	Care Team Member			Yes	RN
Elizabeth Roach	OneCare	Care Coordinator	Organizational Ad...			No	
Erin Covey		Panel Coordinator	Care Team Member			No	

4. Click on Add Care Team Member



CARE PROVIDER INFORMATION
Sally Smith

General

First Name *	Sally	Job Title	School Nurse	Business Unit	--
Middle Name	--	Legal Business Name	--		
Last Name *	Smith				
Non-ACO	<input checked="" type="checkbox"/>				
Description	School Nurse, ABC Elementary				

Additional Information

Specialty	--	Licensure 1	BN
TIN	--	Licensure 2	MDW
NPI	--		
Health Service Area	--		
TIN Name	--		

Contact Details

Email	sally.smith@abc.org	Ext	--
Home Phone Number	802-123-45678	Mobile Phone Number	--

7. Enter First Name & Last name, Job title & Description

8. If applicable add Licensure

9. Add contact details if you have them (optional)

10. Click Done

First Name * Elizabeth
Last Name * Smith
Done

Connection: New Connection - Microsoft Dynamics CRM - Mozilla Firefox

https://onecarestaging.mycarenav.com/main.aspx?etc=3234&extraqs=9

FILE CONNECTION CUSTOMIZE

Save Save & Close Chrome 38 Save Assign Follow Collaborate

13. Click Save & Close to return to the care team member grid

Connection
New Connection

Connect To

Name * Jody Smith

Role * Care Manager

Participation Type * Non-ACO

Emergency Contact ☐

Description ABC Designated Agency

Status Active

11. Add the Role

12. Add the non-ACO member's organization

Lead Care Coordinator Tracking Changes: When making changes to the LCC you will need to indicate a reason for the change. Locate the Care Team Member's table under the Care Coordination Tab:

Name ↑	Role (To) ↑	Lead CC	Participation Type	Licensure 1 (Name)	Licensure 2 (Name)	Description
Dan CCS10	Grandparent	No	Care Team Member			
Dan CCS9	Grandparent	No	Non-ACO			
Danielle Palmer	Care Coordinator	No	Care Team Member	RN		
Elizabeth Roach	Care Coordinator	No	Organizational Ad...			

1 - 4 of 8

1. Open team member you want to make LCC

Connection: Information - Microsoft Dynamics CRM - Internet Explorer

https://onecarestaging.mycarenav.com/main.aspx?etc=3234&extraqs=%3f_CreateFromId%3d%257b3DE2BD73-A94A-E611-80C7-000D3A1

FILE CONNECTION CUSTOMIZE

Save Save & Close Chrome 38 Delete Assign Sharing Copy a Link Follow Collaborate

Connection Information

Connect To

Name * Elizabeth R

Role * Care Coord

Participation Type * Organizational Admin

Lead CC ☒ Reason For Lead CC Change

Emergency Contact ☐

Description

Status Active

Message from webpage

The patient has already been assigned a Lead Care Coordinator, Do you want to change the Lead CC?

OK Cancel

3. Click ok

2. Click Lead CC box

https://onecarestaging.mycarenav.com/main.aspx?etc=3234&extraqs=%3f_CreateFromId%3d%257b3DE2BD73-A94A-E611-80C7-000D3A1

5. Click Save & Close

FILE CONNECTION CUSTOMIZE

Save Save & Close Chrome 38 Delete Assign Copy a Link Follow Collaborate

Connection Information

Connections

Connected From Gail Mat...

Connect To

Name * Elizabeth Roach

Role * Care Coordinator

Participation Type * Organizational Admin

Lead CC ☒

Emergency Contact ☐

Reason For Lead CC Change Patient/Family Request

4. Choose Reason for Lead CC Change

Lead CC Change History				
Created On ↑	Changed By	Lead CC	Action	Reason for Change
3/10/2020 11:35 AM	Elizabeth Roach	Erin Covey	Assigned	Patient/Family Request
3/10/2020 11:35 AM	Elizabeth Roach	Elizabeth Roach	Removed	Care provider removed as Lead CC but still on care t...
3/10/2020 8:15 AM	Elizabeth Roach	Elizabeth Roach	Assigned	Internal Staffing Change
3/10/2020 7:54 AM	Elizabeth Roach	Erin Covey	Assigned	Patient/Family Request
3/6/2020 1:38 PM	Robyn Skiff	Amanda Aube	Removed	Patient/Family Request

1 - 5 of 36

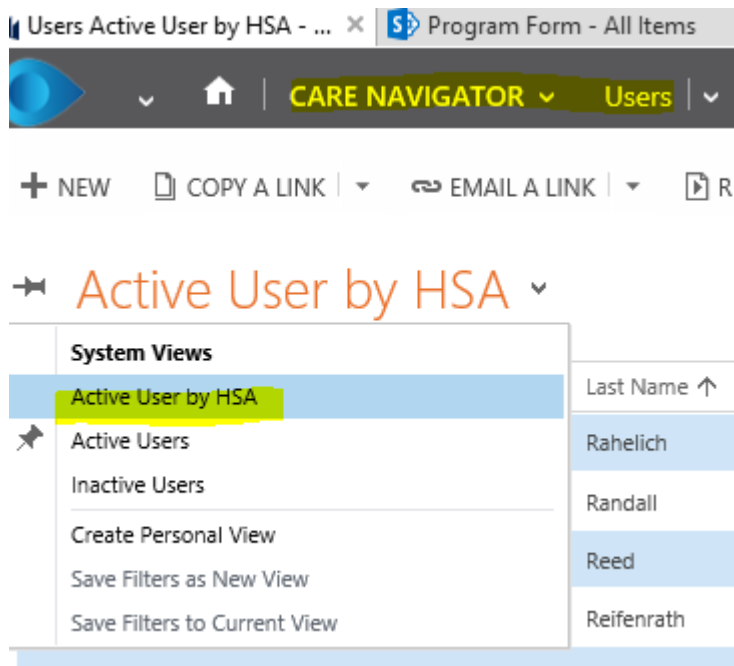
Page 1

Searching for other Care Navigator Users:

The following steps can be completed to identify other registered Care Navigator users:


- Hover on the Care Navigator Icon
- Choose the 'Users tile' (to find, arrow all the way to the right, the 'Users' tile will be the last tile)

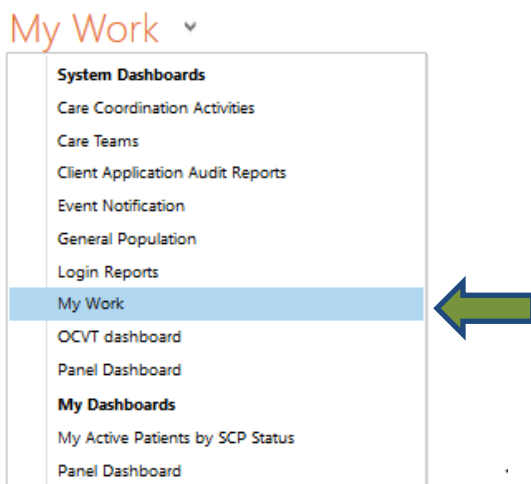




- iii. You can filter by HSA in this view and export to excel if desired.
- iv. Note when you click on a letter at the bottom that that will bring you to a user with the last name of the letter you click on. Example if you click on A that will give you all users with the last name that start with A.

How to Find Care Team Members on Care Teams:

1. From the Care Navigator home page click on the 'My Work' drop down arrow
2. Switch to the 'Care Teams' dashboard
3. Click on the associated view icon on the top right of the dashboard 
4. Change the selected view to 'All Active Care Team Members'
5. By turning on your filter and clicking on the drop down you will be able to sort by care team member



→ All Active Care Team Members (C... ▾

System Views
Active Connections
All Active Care Team Members
All Active Care Team Members (Current BU)
All Sales Team Members
All Stakeholders
Patients Assigned To Care Provider
Related Solutions

My Views
Active Care Team Members
Inactive Care Providers Active on Care Teams
Test - All Connection View for Grace
Create Personal View
Save Filters as New View
Save Filters to Current View

(Connected...	Lead CC (Conne...
N PRACTICES	
-WATERBURY	Dorothy Robins...
FAMILY MED...	Jamie Viens
Berlin	
TER	Penny Martin
Berlin	Kari Little
CARE, HEMA...	Mary Lacaillade
DICINE, PLLC	Kim Lague
ne	
CARE-BARRE	

Custom Filters

Show records where Name:

Contains

☒ AND ☐ OR

-- Select Operator --

OK

Cancel

→ All Active Care Team Members ▾

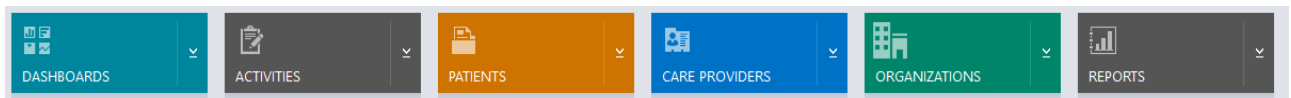
Search for records 🔍

Member ID ▾	Connected From ↑ ▾	Care Coordi... ▾	Care Coordi... ▾	Name ↑	Business Un... ▾	Created On... ▾	Payer (Con... ▾
	Edwin Gonzalez (Test ...	Engaged		Kathleen Camisa	OneCare	7/18/2019 3:32 P...	
07s28350cZ8	FNAME103 LNAME103			Kathleen Camisa	OneCare	8/8/2019 1:35 PM	
	FNAME104 LNAME104			Kathleen Camisa	OneCare	10/9/2018 9:51 A...	
	FNAME105 LNAME105			Kathleen Camisa	OneCare	2/27/2018 8:13 A...	
	FNAME106 LNAME106			Kathleen Camisa	OneCare	2/27/2018 8:16 A...	

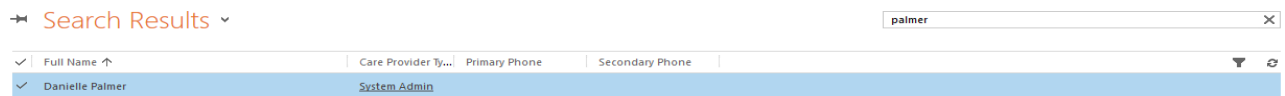
Bulk Deactivation of Care Team Members:

This functionality allows you to search for a care team member and deactivate them from one or multiple care teams. The care team member will receive an email indicating they have been deactivated from the team(s).

1. Hover over the Care Navigator Tile in the top black bar and select the 'Care Providers' tile



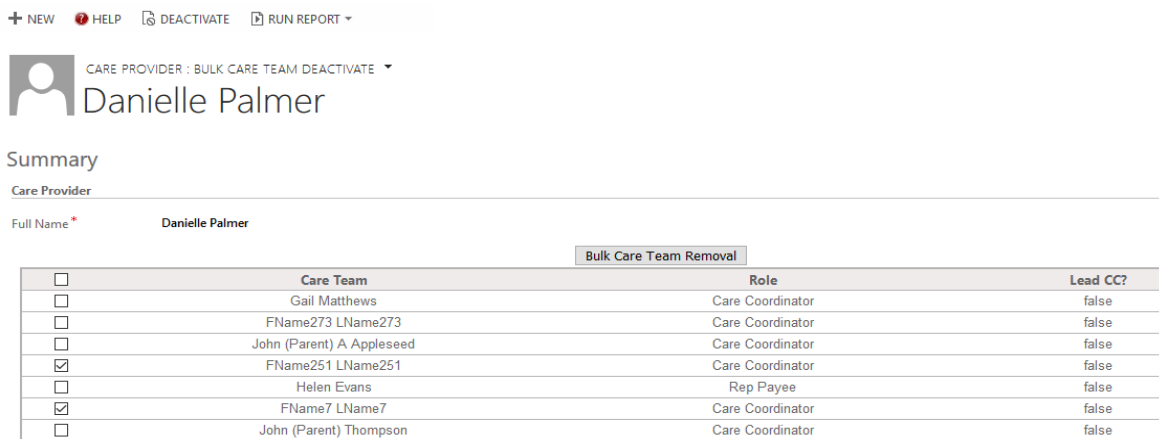
- Search for the Care Provider using the search bar and double click in-between the text on the blue line to open the record:



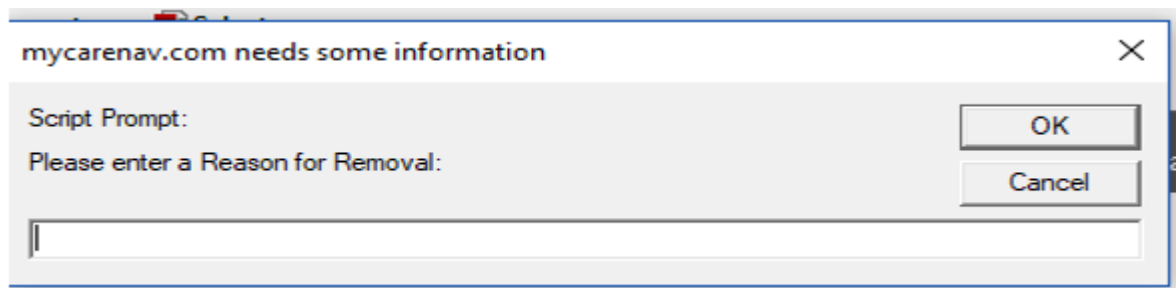
- A list of patients the Care Provider is assigned to will appear in a list view. To start the process ensure that the Care Provider field is set to 'Bulk Care Team Deactivate':



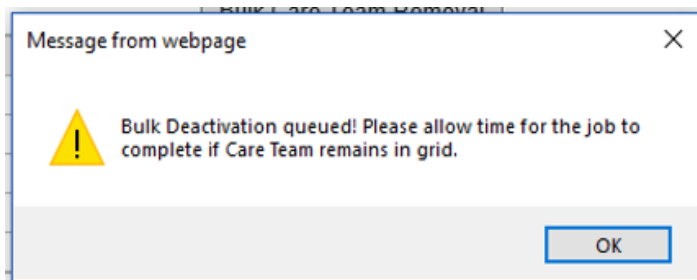
- Click in each box to place a check mark next to those patients you wish to deactivate the care provider from, and then click on the 'Bulk Care Team Removal' box:



- A dialogue box will appear asking you to enter a 'Reason for Removal'. Once entered click OK to start the deactivation process. The Care Provider will be notified by email that they have been deactivated from the Care Team(s).



6. Click 'OK' in the next box to indicating the Bulk Deactivation has been queued:



7. A Care Team Notification is sent upon removal from the care team(s).

ACO Insurance Information

The information populating this section is supplied by claims data feeds and is not able to be edited. This information indicates the connection the patient has to the Accountable Care Organization (ACO) as well as the Attribution History. Patients in care, who are no longer attributed, can continue in care coordination for the remainder of the calendar year, but claims data will not continue to update.

CARE NAVIGATOR

Patients

Gail Matthews

Create

Kathleen Camisa
OneCare Staging

UPLOAD DOCUMENT

SHARED CARE PLAN

ASSIGN CARE PROVIDER

SEND NOTIFICATION

FOLLOW

PATIENT : PATIENT DETAILS

Gail Matthews

DoB *

12/15/1938

Age

81

Lead CC

Amanda Aube

CC Status

Engaged

Phone (Primary)

(802) 847-3456

Contact Method

Voice call

Comm Challenge

Hearing Impaired

Acuity Level

3. Weekly contact

Primary Contact

Poppi Landry, dtr

Primary Contact #

802-123-5689

Last Encounter

3/10/2020 4:52 PM

Eng. Reason

Utilization

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ACO/Insurance Information

Attributed Health Service Area

St. Albans

Attributed ACO

Bennington ACO

Payer

BCBS

Member ID

654322343

Attributed TIN

University of Vermont Medical Center (UVM)

Attributed Provider

Mary Smith

Attributed Practice Name

AK Practice

Beneficiary Medicare Status

Aged without ESRD

Dual Status Description

Non-Medicaid

Attribution History

Date

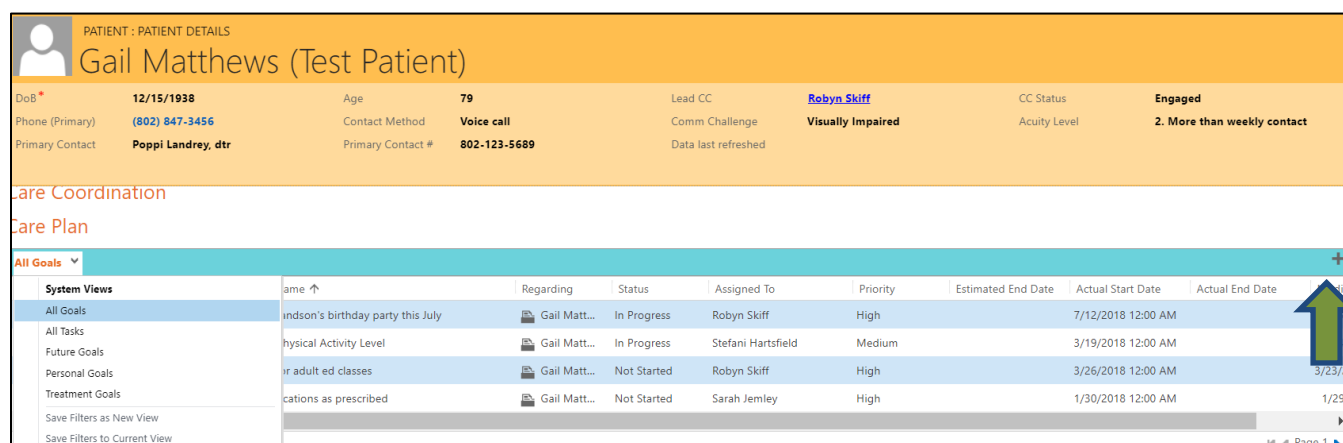
7/12/2016

Status

No

Care Plan-Adding Goals and Tasks

- a) **Patient's Care Plan:** The Shared Care Plan is created based on the work completed by the care team members associated with the patient.



PATIENT : PATIENT DETAILS
Gail Matthews (Test Patient)

DoB: 12/15/1938 Age: 79 Lead CC: Robyn Skiff CC Status: Engaged
 Phone (Primary): (802) 847-3456 Contact Method: Voice call Comm Challenge: Visually Impaired Acuity Level: 2. More than weekly contact
 Primary Contact: Poppi Landrey, dtr Primary Contact #: 802-123-5689 Data last refreshed

Care Coordination
 Care Plan

All Goals

System Views	Name ↑	Regarding	Status	Assigned To	Priority	Estimated End Date	Actual Start Date	Actual End Date
All Goals	Anderson's birthday party this July	Gail Matt...	In Progress	Robyn Skiff	High	7/12/2018 12:00 AM		
All Tasks	Physical Activity Level	Gail Matt...	In Progress	Stefani Hartsfield	Medium	3/19/2018 12:00 AM		
Future Goals	Adult ed classes	Gail Matt...	Not Started	Robyn Skiff	High	3/26/2018 12:00 AM		3/23/2018
Personal Goals	Medications as prescribed	Gail Matt...	Not Started	Sarah Jemley	High	1/30/2018 12:00 AM		1/29/2018
Treatment Goals								

Save Filters as New View
 Save Filters to Current View

Page 1

- Adding Goals to the Care Plan:** Under the 'Care Plan' section of the patient dashboard click on the '+' to open the menu to create a goal.
- Activity Level:** Choose 'Goals'
- Goal Category:** A list of categories taken from the Camden Domain Cards is provided to choose from, and is useful in categorizing patient goals.
- Goal Type:** Choose if the goal is 'Personal, Family, Treatment or Future'
- Activity Name:** Enter a brief description of the goal the patient wishes to achieve.
- Description:** More details can be written regarding the goal, but this information will not display in the Shared Care Plan (optional)
- Assigned to:** Hover over this area and a magnifying glass will appear with a list of current care team members. Choose the care team member or the patient who will be responsible for the completion of the goal.
- Add Priority:** This will automatically be defaulted to Medium, but can be changed as appropriate to Low or High.
- Add Dates:** Actual start date and estimated end date
- Click Save:** Once the goal has been saved a task can be associated with the goal.

Adding a Task to an Established Goal:

SAVE ✓ MARK COMPLETE SAVE & CLOSE PUSH NOTIFICATION ✕ CLOSE TASK ✕ DELETE ASSIGN ...

Eat 5 servings of fruits and vegetables daily

Activity Level *	Goals	Initiation Date	6/6/2019 2:13 PM
Goal Category *	Food and Nutrition	Estimated End Date	--
Goal Type *	Personal	Actual Start Date	--
Activity Name *	Eat 5 servings of fruits and vegetables daily	Actual End Date	--
Description	--		
Assigned To *	Patient		
Priority	Medium		
Status	Not Started		
Patient	Gail Matthews (Test Patient)		
Care Plan	Gail Matthews (Test Patient)'s Care Plan		

Tasks

Activity Name ↑	Regarding	Status	Assigned To	Priority	Estimated
No Task records found.					

1. Click on Plus (+) sign to the right of the 'Tasks' Header
2. **Activity Level:** Will default to 'Task'
3. **Goal Category:** Will default from the goal page
4. **Goal Type:** Will auto default from goal page
5. **Activity Name:** The clients brief description of the task
6. **Description:** More details can be provided regarding the task, but this information will not be displayed in the Shared Care Plan (optional)
7. **Assigned to:** Hover over this area and a magnifying glass will appear with a list of current care team members. Choose the care team member or the patient who will be responsible for the completion of the task
8. **Add Priority:** Medium is auto populated, you can choose from High, Medium, or Low
9. **Status:** Choose the status of the task
10. **Add dates:** Actual start/end date and estimated end date
11. Click **Save & Close** to save the Task, and then the '+' sign again to create another task.

- b) Dates the Shared Care Plan was Initiated and the Shared Care Plan was Created (the date when two goals with two tasks on each goal are on the patient's record) are system fed and are displayed as below:

SCP Initiated	1/29/2018	SCP Created	1/29/2018
---------------	-----------	-------------	-----------

- c) **Challenges and Barriers Categories:** The care coordinator can work with the patient to identify any challenges or barriers the patient may be experiencing preventing the patient from meeting their identified goals. This area can be used to reflect underlying social determinants of health the patient may be experiencing. Below are the 'Challenges and Barriers' domains:

Challenges/Barriers Categories	
Access	Language
Access to care	Legal Assistance
Addiction	Limited mobility and/ or ability to complete ADLs
Childcare	Literacy
Cognition	Medical diagnosis is unclear
Communication among providers	Mental Health
Diagnosis of Autism/Emotional Maturity	Physical Health
Eligibility	Single Parent
Financial	Symptoms are not well managed
Hearing deficit	Transportation
Housing	Visual Deficit

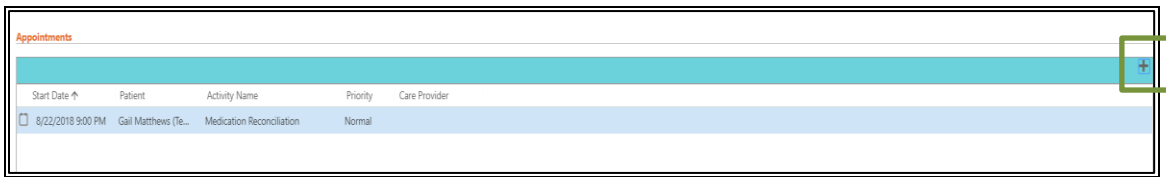
II. Adding A Challenge/Barrier:

- Go to the 'Challenges/Barriers' section of the Care Plan and click on the '+' sign.
- The 'New Barrier' Screen will be displayed
- Type of Barrier:** Double click on the magnifying glass to bring up the items to choose from, also listed above
- Barrier:** Type in a brief description of the barrier using the patient's words. This will populate on the shared care plan
- Action Plan:** A description of how the barrier can be addressed
- Click **Save & Close**

The screenshot shows the 'New Barrier' interface. At the top, there's a navigation bar with a home icon, the text 'New Barrier', and a user profile 'Kathleen Ca... OneCare'. Below this is a toolbar with icons for 'SAVE', 'SAVE & CLOSE', '+ NEW', and 'FORM EDITOR'. The main content area is titled 'BARRIER : INFORMATION' and 'New Barrier'. Under the 'General' tab, there are three main fields: 'Type of Barrier' with a dropdown arrow, 'Barrier' with a red asterisk, and 'Action Plan' with a blue plus icon. To the right of these fields, the 'Patient' is listed as 'Gail Matthews (Test Patient)'.

Appointments

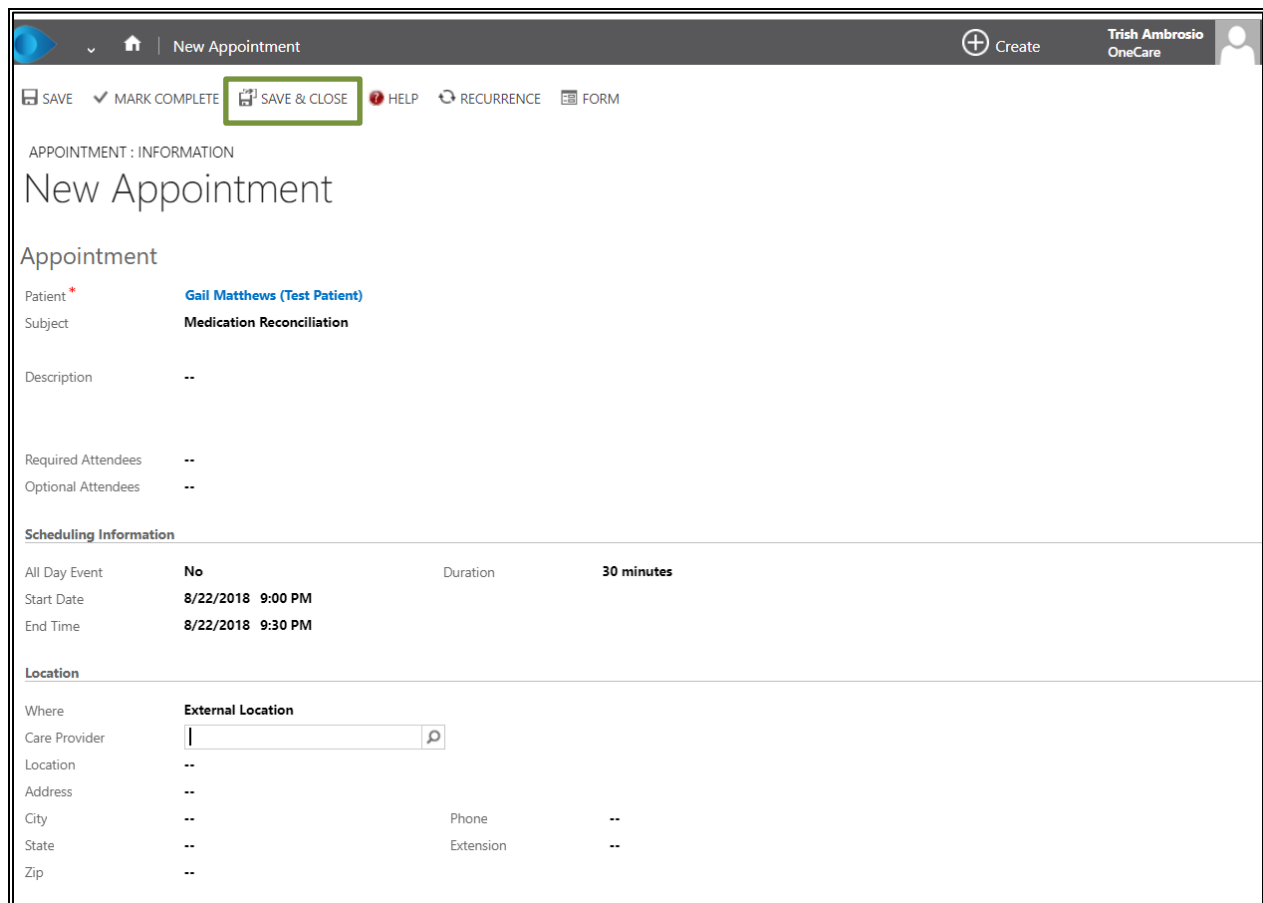
The user can enter any one-time or recurring appointments to track the patient in this section.



A screenshot of a web application showing a table titled "Appointments". The table has columns: Start Date, Patient, Activity Name, Priority, and Care Provider. One row is visible with the date 8/22/2018 9:00 PM, patient Gail Matthews (Te...), activity Medication Reconciliation, and priority Normal. A green box highlights a blue '+' button in the top right corner of the table area.

Start Date	Patient	Activity Name	Priority	Care Provider
8/22/2018 9:00 PM	Gail Matthews (Te...)	Medication Reconciliation	Normal	

To enter a new appointment, click on the '+' sign on the right-hand side of the page. Once the new window opens enter the details of the appointment. Appointments will be displayed on the Care Navigator home page. Click Save or Save & Close to save the appointment.



A screenshot of the "New Appointment" form in a web application. The form is titled "New Appointment" and includes sections for "Appointment : INFORMATION" and "Scheduling Information". The "Appointment : INFORMATION" section contains fields for Patient (Gail Matthews (Test Patient)), Subject (Medication Reconciliation), Description, Required Attendees, and Optional Attendees. The "Scheduling Information" section contains fields for All Day Event (No), Duration (30 minutes), Start Date (8/22/2018 9:00 PM), and End Time (8/22/2018 9:30 PM). The "Location" section contains fields for Where (External Location), Care Provider, Location, Address, City, State, Zip, Phone, and Extension. A green box highlights the "SAVE & CLOSE" button in the top left corner of the form.

Appointment : INFORMATION

New Appointment

Appointment

Patient * **Gail Matthews (Test Patient)**

Subject **Medication Reconciliation**

Description --

Required Attendees --

Optional Attendees --

Scheduling Information

All Day Event **No** Duration **30 minutes**

Start Date **8/22/2018 9:00 PM**

End Time **8/22/2018 9:30 PM**

Location

Where **External Location**

Care Provider

Location --

Address --


City -- Phone --

State -- Extension --

Zip --

Key Utilization Metrics - past 12 months

Information in this section is fed from claims data and gives a snapshot of utilization and risk scores that indicate the patient's current utilization and cost of health care services. It also displays detailed information specific to hospitalizations and emergency department encounters.



PATIENT : PATIENT DETAILS
Gail Matthews

DoB *	12/15/1938	Age	81	Lead CC	Amanda Aube	CC Status	Engaged
Phone (Primary)	(802) 847-3456	Contact Method	Voice call	Comm Challenge	Hearing Impaired	Acuity Level	3. Weekly contact
Primary Contact	Poppi Landry, dtr	Primary Contact #	802-123-5689	Last Encounter	3/10/2020 4:52 PM	Eng. Reason	Utilization

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Key Utilization Metrics- past 12 months

Cost Risk Score	9,000
Social Risk Score	4
Total Paid	--
Wellness and/or Disease Management Visit	--
In patient admissions past 12 months	1
All cause 30 day readmissions	--
ED Visits past 12 months	--
Skilled Nursing Facility Stays past 12 months	--
Hospice Days past 12 months	--
Home Health visits past 12 months	--

Hospitalizations		
Discharge Date ↑	Admission Date	Facility
7/15/2016	7/13/2016	
5/30/2016	5/26/2016	
5/13/2016	5/11/2016	

Social Risk Scores		
Created On ↑	Source	Social Risk Scor...
2/18/2020 12:06 PM	Data	4

ED Encounters		
Admission Date ↑	Facility	Reason
2/18/2020	Hospital ABC	Stroke sympt

Cost Risk Ratings		
Date ↑	Risk Category	Risk Score
4/22/2016	High	9,000

Risk Levels:

OneCare utilizes the John's Hopkins ACG (Adjusted Clinical Groups) risk score. This score predicts the complexity of care using the last 12 months of data to indicate the complexity of care needed for the subsequent 12 months. The average risk score is one and all scores above a one is considered higher than average. The following criteria is utilized to create a risk score:

- Age and gender
- Diagnosis (complex morbidity combinations)
- Procedures
- Pharmacy
- Utilization

Health Conditions

This section includes the Patient's Health Conditions extracted from claims and clinical data. The list includes conditions from a rolling 12 months, which are grouped into diagnostic categories. These categories are used to help create panels for selected conditions, which can be filtered on from the patient list.

Health Conditions	
Condition ↑	
Abdominal pain	

Community Programs

This area contains a list of care supports that a patient is utilizing to enhance their care. The patient or care team members may identify these programs.

Community Programs			
Program	Date of Enrollment ↑	End Date	End Date Reason
Area Agency on Aging			
SASH (Support and Services at H...	5/31/2016		

Add a Community Program

1. To add a program the patient is utilizing, click on the "+" symbol.
2. Click on the magnifying glass associated with 'Program' and choose from the menu of program options.
3. Dates can be added if you have the details of the start or end dates.
4. Click on 'Save & Close' to save the program.
5. The following is a list of Community Programs that can be selected:

SAVE SAVE & CLOSE + NEW FORM EDITOR

COMMUNITY PROGRAM : INFORMATION

New Community Program

Community Program

Program End Date --

Date of Enrollment -- End Date Reason --


Patient * Gail Matthews

1	AAA-Area Agency on Aging/Council on Aging
2	Adult Day Health
3	Alcohol/Substance Use Support Program
4	Choices for Care-Area Agency on Aging (AAA)
5	Choices for Care-Home Health
6	CIS-Children's Integrated Services
7	Community Action
8	CSHN- Children with Special Health Needs
9	DCF-Department of Children and Families
10	Diabetes Educator
11	Dietician
12	Domestic Violence Support Program
13	Financial Support
14	Food Access Support
15	Foster Care
16	Home Health- Aide
17	Home Health- Palliative
18	Home Health- PT/OT/ST
19	Home Health-Nursing
20	Hospice
21	Housing Case Management
22	Long-term Care Resident
23	Long-term Care Services
24	MAT- Medication Assisted Treatment
25	Meals on Wheels
26	Mental Health Case Management
27	Mental Health Case Management- CRT (Community Rehab & Treatment)
28	None - Patient would like to restart choices for care or see home health nurse
29	Northwestern Counseling & Support Services
30	Peer Support Program
31	Primary Care – Social Work Care Coordinator/Manager
32	Primary Care-RN Care Coordinator/Manager
33	Probation
34	Reach Up
35	SASH-Support and Services at Home
36	School-Based Support
37	Self-Management Class/Program (e.g. Tobacco Cessation, Diabetes)
38	Social Worker

39	Transitions of Care Nurse
40	Transportation Support (e.g. GMTA, SSTA)
41	Traumatic Brain Injury Program
42	VCCI – Vermont Chronic Care Initiative
43	VCIL – Vermont Center for Independent Living
44	Vermont Legal Aid
45	Vocational Rehab
46	WIC – Women, Infants and Children

Viewing Community Programs Assigned to a Patient

1. To view the list of Community Programs assigned to a patient, click on the grid symbol to the right of the plus sign (see arrow below):

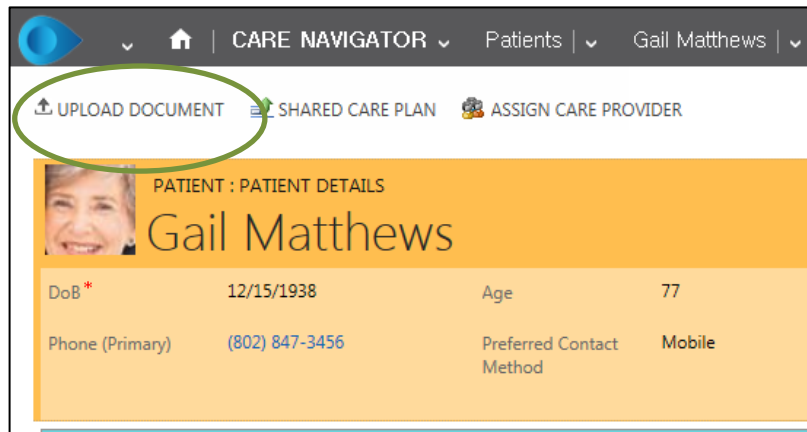


Program	Date of Enrollment ↑	End Date	End Date Reason
Mental Health Case Managemen...			
SASH-Support and Services at H...	6/14/2016		
Choices for Care-Home Health	10/23/2017		




Documents

This section centralizes all documents uploaded to the patient record when the 'Upload Document' function is utilized.

1. Click on 'Upload Document' at the top of the patients home page to start the upload process:



CARE NAVIGATOR Patients Gail Matthews

 UPLOAD DOCUMENT
  SHARED CARE PLAN
  ASSIGN CARE PROVIDER

PATIENT : PATIENT DETAILS

Gail Matthews

DoB * 12/15/1938 Age 77
 Phone (Primary) (802) 847-3456 Preferred Contact Method Mobile

2. A pop-up box will appear. Complete the requested fields and choose 'Upload File'. Note that only PDF files can be uploaded.

Upload Document

×

Use the form below to upload a file for the patient.

Only PDF files up to 5 MB in size are allowed to be

Document Type*

Crisis Plan

Document Title*

75 characters max

Description

250 Characters max

Source System

Medical Record

Created On*

Select File*

Browse...

No file selected.

Only PDF files up to 5 MB in size are allowed to be uploaded.

Cancel

Upload File

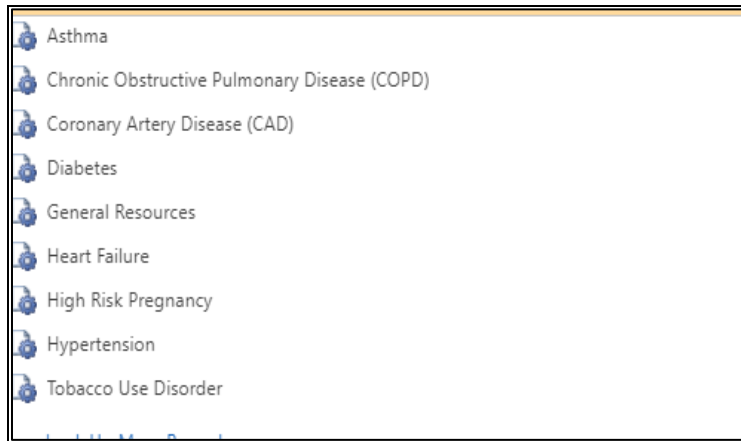
Resources

The resource library contains educational materials that can be assigned to a patient, based on a specific health condition. When a health condition is assigned to a patient's record, educational resources that can be applied specific to that condition, which will populate on the right-hand side in the 'Education Resource Master'.

Resources		Education Resource Master		
Health Conditions		Resource Type	Title	Description
Health Conditions ↑		Article	Learn About Asthma	If you or your child has asthma, y...
Asthma		Media File	Coronary Artery Disease (CAD)	Coronary Artery Disease (CAD)
Chronic Obstructive Pu...		Media File	Understand Warning Signs of an ...	Understand Warning Signs of an ...
Coronary Artery Diseas...		Media File	Learn about quitting smoking	Quitting smoking isn't easy. But i...
Diabetes				
1 - 4 of 7				

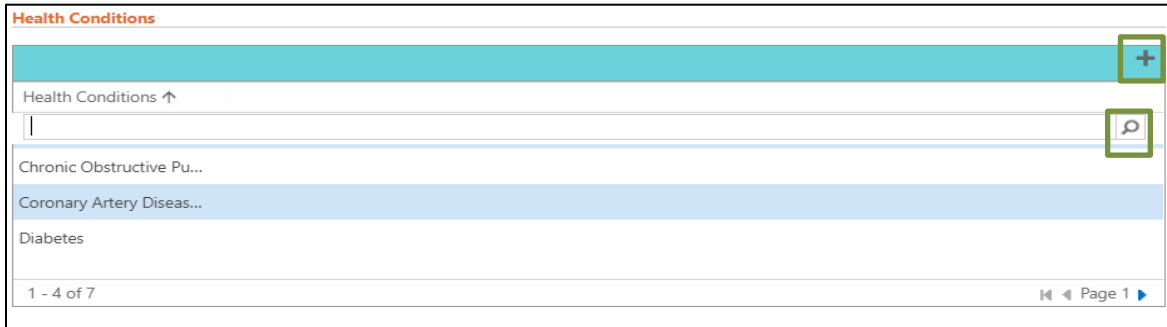
Health Conditions:

Currently, nine Disease Panels can be selected including:



To assign a Health Condition to a patient:

1. Click on the plus '+' sign on the upper right-hand side of the Health Conditions grid. A new line will appear.
2. Click on the magnifying glass on the right-hand side to choose from the list of possible health conditions.
3. Select applicable condition.



Education Resource Master

To add new education resources to the patient record:

1. Click on the plus sign in the right-hand corner of the Education Resource Master:

Education Resource Master		
Resource Type ↑	Title	Description
Article	Learn About Asthma	If you or your child has asthma, y...
Media File	Coronary Artery Disease (CAD)	Coronary Artery Disease (CAD)
Media File	Understand Warning Signs of an ...	Understand Warning Signs of an ...
Media File	Learn about quitting smoking	Quitting smoking isn't easy. But i...

2. A new window will open.
3. Under 'Look in' select the condition from the drop down list to begin a search of the articles mapped to that condition.
4. Place a check mark next to the article(s) to be assigned to the patient.
5. Click 'Select', then 'Add' to add the literature to the patient's record.

Look Up Records

Enter your search criteria.

Look for

Education Resource Master

Look in

Diabetes Resource Master

Search

Search for records

✓ Title

✓ Learn About Diabetes

High Blood Pressure

Quitting Smoking

Link Risk Assessment

1 - 31 of 31 (1 selected)

Selected records:

Learn About Diabetes

Select

Remove

New

Add

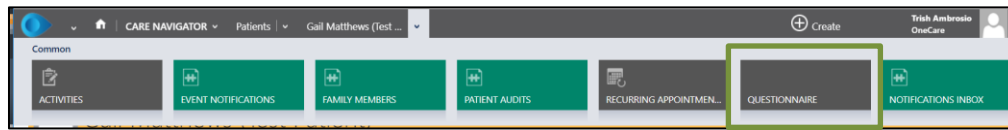
Cancel

Assessments/Questionnaires

Embedded Questionnaires

Care Navigator offers multiple questionnaires that can be accessed for the patient. Some of the assessments have branching logic that will lead to further assessments or follow-up tasks. Follow the steps below to access the questionnaire module for each patient:

1. Click on the down arrow to the right of the Patient Name.



2. Click on the “Questionnaire” box and you will see the screen below:

PATIENT : PATIENT DETAILS
Gail Matthews (Test Patient)

DoB * 12/15/1938 Age 79 Lead CC Robyn Skiff CC Status Engaged
 Phone (Primary) (802) 847-3456 Contact Method Voice call Comm Challenge Visually Impaired Acuity Level 2. More than weekly contact
 Primary Contact Poppi Landrey, dtr Primary Contact # 802-123-5689 Data last refreshed

Questionnaires NEW QUESTIONNAIRE

Questionnaire ↑	Number	Assigned On	Submitted On	Status
SF12v2	1	9/22/17 8:56 AM	09/22/17 8:58 AM	Submitted
SF12v2	2	10/24/17 8:58 AM		New
SF12v2	3	3/21/18 6:58 AM		New
Vermont Self-Sufficiency Outcome Matrix	1	9/22/17 7:05 AM	10/13/17 5:50 AM	Submitted
Vermont Self-Sufficiency Outcome Matrix	2	9/22/17 8:56 AM		New
Vermont Self-Sufficiency Outcome Matrix	3	10/27/17 7:03 AM		New
Vermont Self-Sufficiency Outcome Matrix	4	2/21/18 7:30 AM		New

3. A list of questionnaires taken by the patient will show in the next screen

- Number: The version of the questionnaire taken is indicated
- Assigned On: The date and time the questionnaire was initiated
- Submitted on: If the questionnaire was completed, the date and time of completion is listed
- Status: A questionnaire can be in new, draft, or submitted status

4. New Questionnaire: Click on “New Questionnaire” to show the list of questionnaires available for assignment to the patient. Click on the questionnaire to be completed with the patient.

New Questionnaires VIEW QUESTIONNAIRES

Questionnaire Masters

SF12v2
test_questionnaire
Vermont Self-Sufficiency Outcome Matrix

5. Administer the questionnaire. It can be cancelled, saved in draft form (for completion later), or completed and submitted

PATIENT : PATIENT DETAILS
Gail Matthews (Test Patient)

DoB * 12/15/1938 Age 79 Lead CC Robyn Skiff CC Status Engaged
 Phone (Primary) (802) 847-3456 Contact Method Voice call Comm Challenge Visually Impaired Acuity Level 2. More than weekly contact
 Primary Contact Poppi Landrey, dtr Primary Contact # 802-123-5689 Data last refreshed

☐ All of the time.
☐ Most of the time.
☒ Some of the time.
☐ A little of the time.
☐ None of the time.
 Reset

7 During the past 4 weeks, how much of the time has your physical health or emotional problems interfered with your social activities (like visiting with friends, relatives, etc.)?

☐ All of the time.
☒ Most of the time.
☐ Some of the time.
☐ A little of the time.
☐ None of the time.
 Reset

Thank you for completing these questions!

Cancel, Don't Save Changes Save and Resume Later I'm done! Submit

Trouble Shooting

This section outline types of errors a user may encounter, and how to report errors to the OneCare.

Business Process Errors

Users may occasionally see an error with the title 'Business Process Error'. In this case, the user should read the message carefully and if it is not clear what steps the user should take, contact the OneCare Vermont Operations Department via telephone: 802-847-7220, option 2 or email:

HelpDesk@OneCareVT.org

Access Errors

Users have permissions based on their role. If a user sees a permission error that is unexpected, contact the OneCare Vermont Operations Department via telephone: 802-847-7220, option 2 or email:

HelpDesk@OneCareVT.org

How to Report Errors - Telephone

Users should follow the instructions below when trying to report a system application error by phone:

1. Contact OneCare Operations Help Desk at (802) 847-7220, option 2
2. Provide help desk with your user name
3. Outline the steps taken that created the error and share all pertinent information
4. Operations Help Desk will log into the application to try and recreate the error and report directly to the Care Navigator Team
5. Follow up will occur within in 1 business day

How to Report Errors - Email

Users should follow the instructions below when trying to report a system application error by email:

1. Contact the Help Desk at HelpDesk@OneCareVT.org
2. Subject Line: Care Navigator System Application Error
3. Provide a synopsis of the error the end user is experiencing
4. Outline the steps taken that created the error
5. Share a screen shot of the error using the copy and paste functionality or your snipping tool
6. The Help Desk will work all email notifications within 1 business days