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

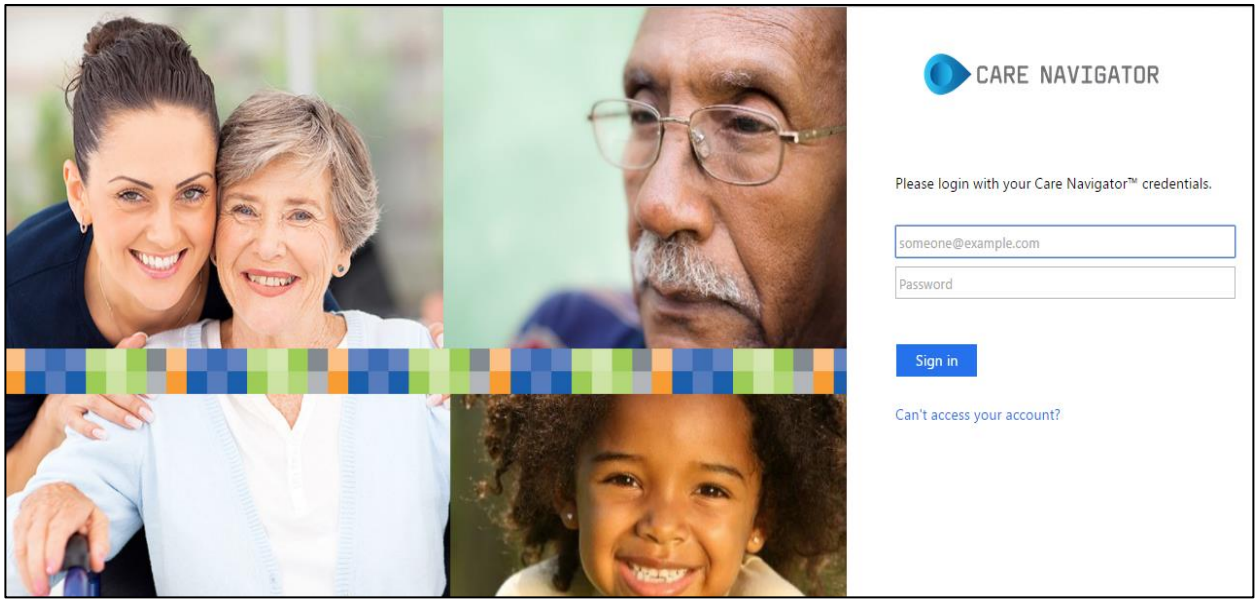
While any browser can be used for day-to-day Care Navigator activities, Internet Explorer is the preferred browser. The following are recommended minimum supported browsers and operating systems for Care Navigator:

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

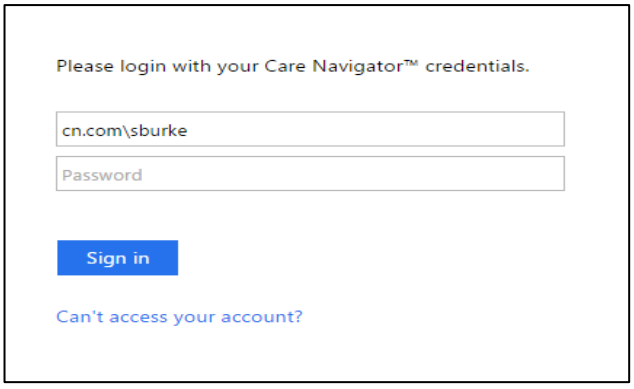
3. This will prompt you to create a new password and then confirm the new password. Please do not save your username and password to your browser as it interferes with the password reset process
4. Enter your username and NEW password to access the system



1 Standard Log-in Screen

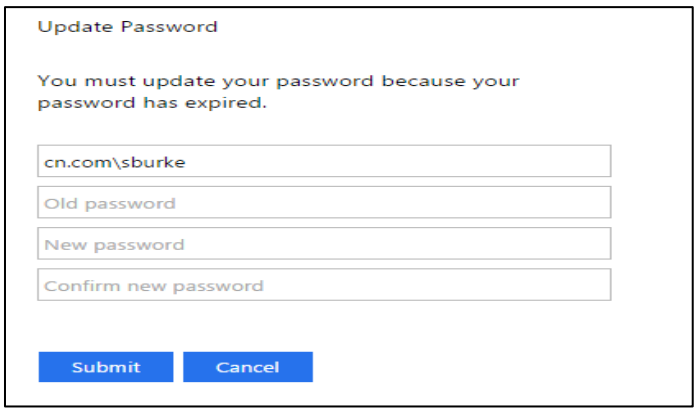
A. Password Policy Guidelines
- **a.** The password must be at least 8 characters
- **b.** The password cannot be any of your previous 25 passwords
- **c.** The password cannot contain your first or last name
- **d.** The password cannot contain your username
- **e.** The password must contain characters 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.



Resetting an Expired Password:

A. See above steps in the Password Policy Guidelines.



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:

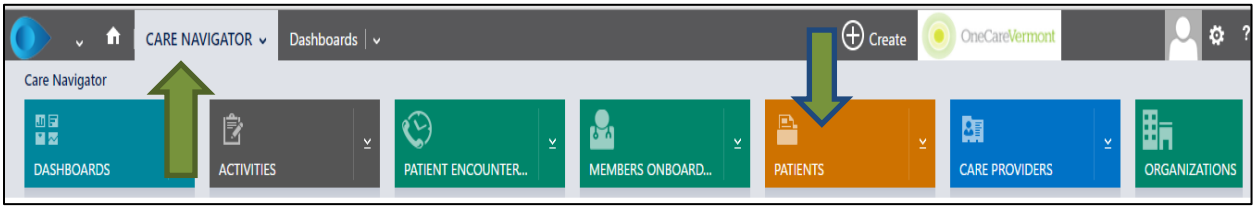
1. Age Group
2. Geographic Area
3. Hospital and Medical Practice
4. Insurance Plan

Level II Users

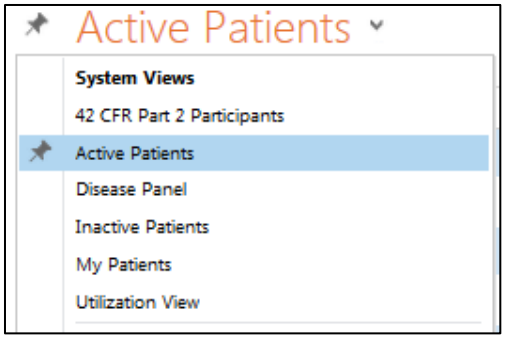
List of Active Patients:

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:

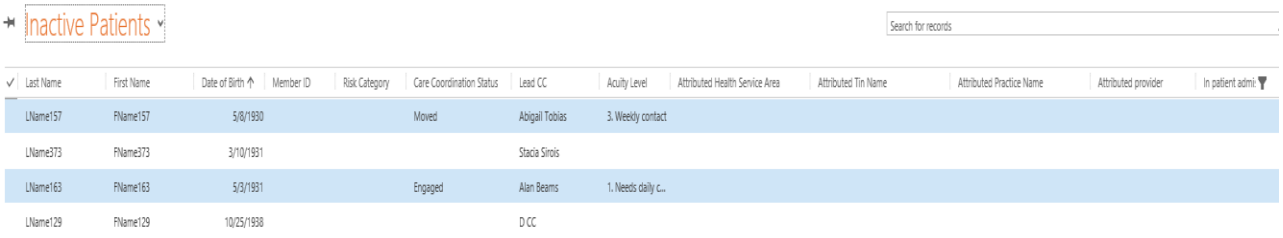
Last Name	First Name	Date of Birth	Age	Member ID
Payer	Care Coordination Level	Revised Care Coordination Level	Care Coordination Status	Acuity Level
Lead CC	SCP Initiated	SCP Created	Attributed Health Service Area	Attributed TIN Name
Attributed Practice Name	Attributed Provider	Last Qualifying Visit	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				

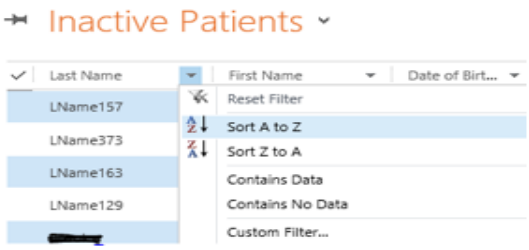
5. **Patient Search:** patients are searchable by the following method:
   i. Complete all or a portion of the first name
   ii. *
   iii. Complete all or a portion of name

Searching for Inactive Patients:

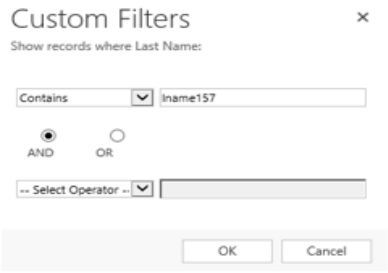
i. Change to Inactive Patients view at dropdown and turn on filter:



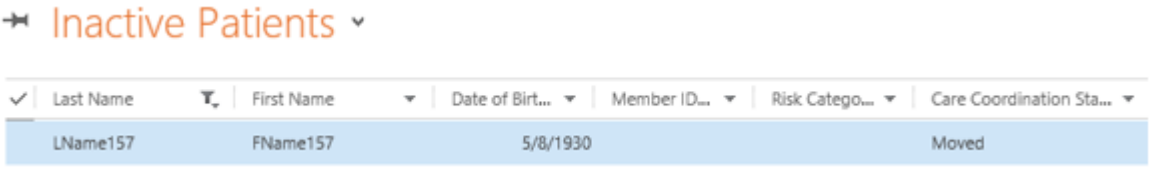
ii. Click on the drop down next in the 'Last Name' column and select Custom Filter:



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



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

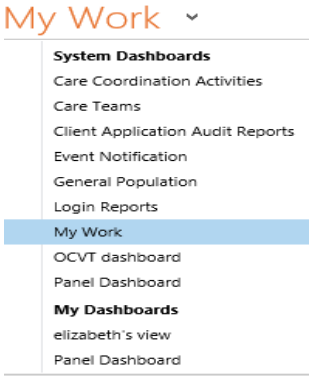


Care Coordinators

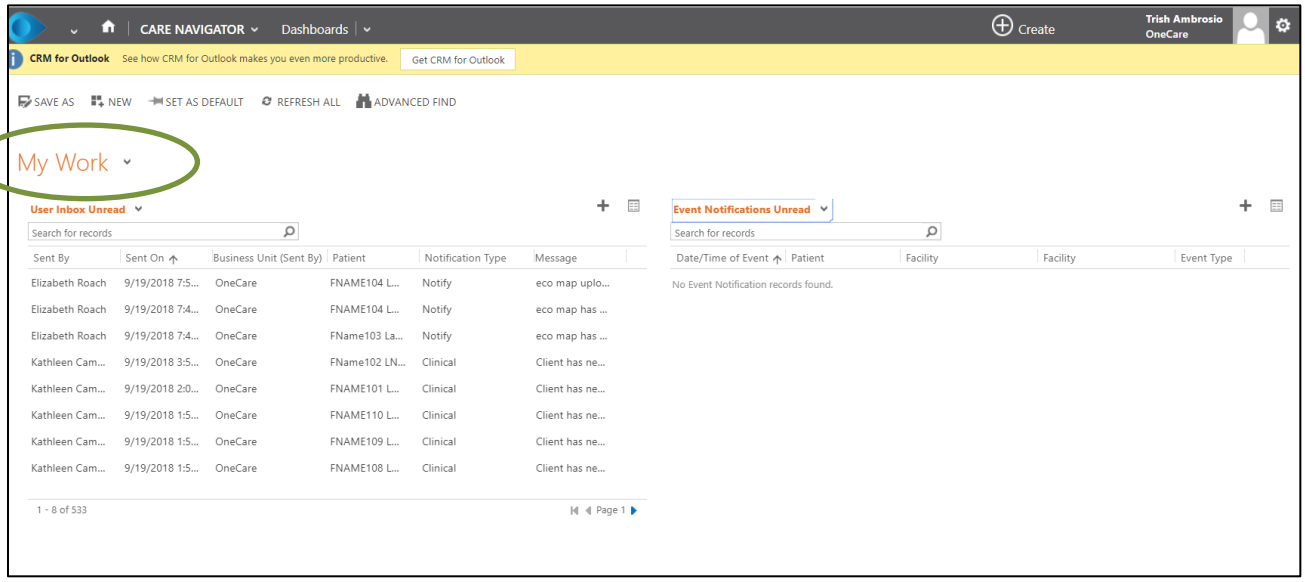
My Work

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

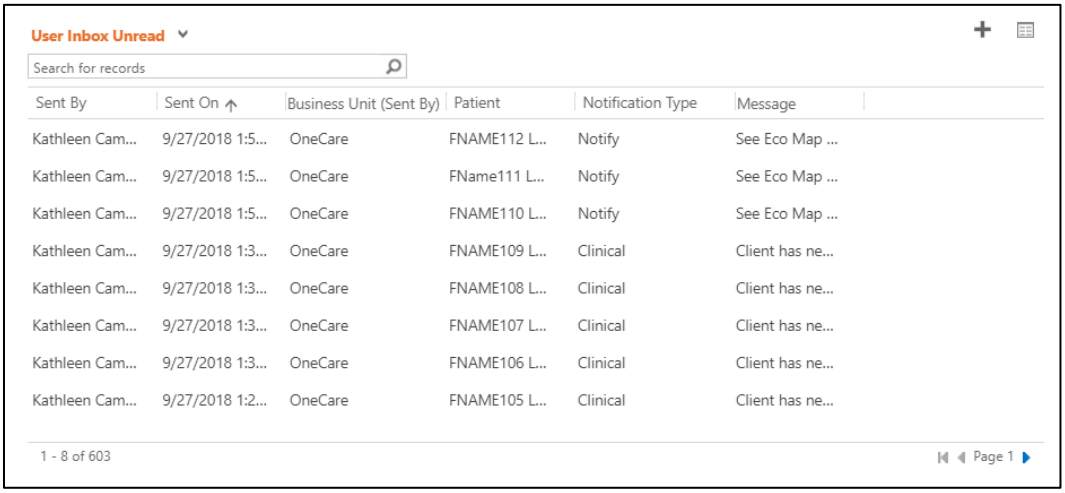
1. **Home button**: Click on the home button  on the top left of the screen to come back to this page from any place in the system
2. **Panel Dashboard**: Click on drop down icon next to My Work and chose Panel Dashboard



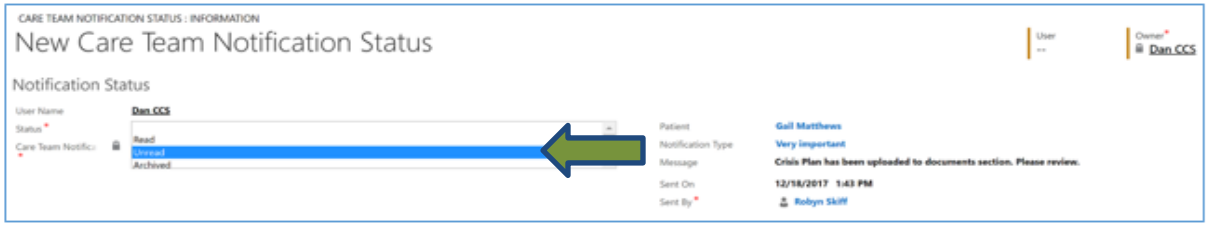
This dashboard contains information specific patients that you are on care teams for. You will be able to see those patients with No Care Plan, patients with an Initiated Care Plan and those with a Created Care Plan.



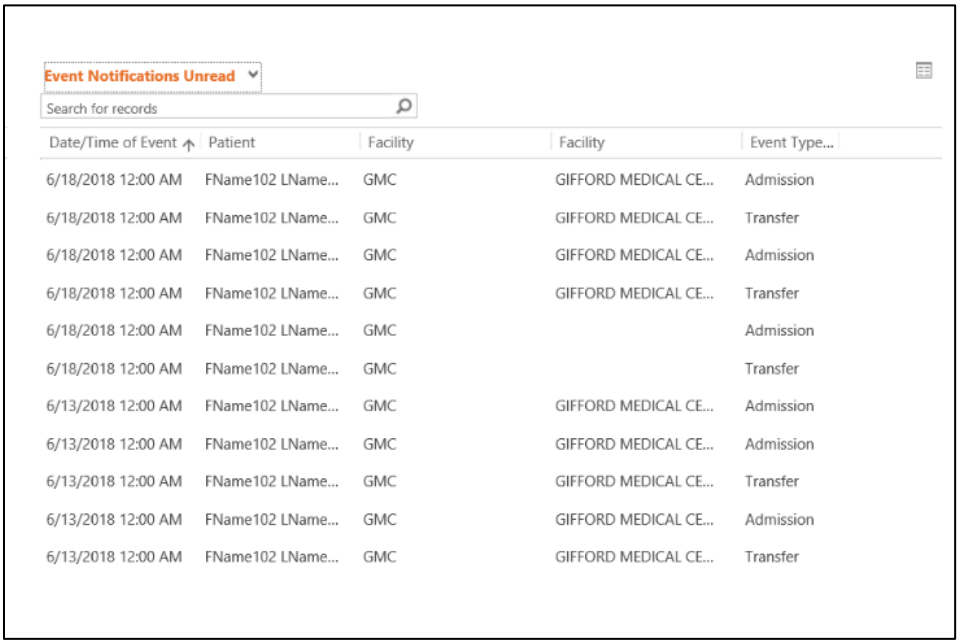
3. **User Inbox:** This section contains notifications sent by members of the care team.



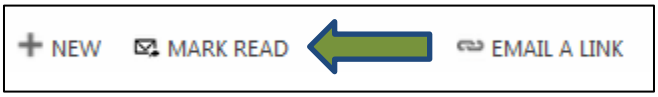
Once you have viewed the Notification you have the option of marking the notification as read removing from the unread file. To complete this, open the message and hover over the 'Status' to view the dropdown menu and select 'Read'.



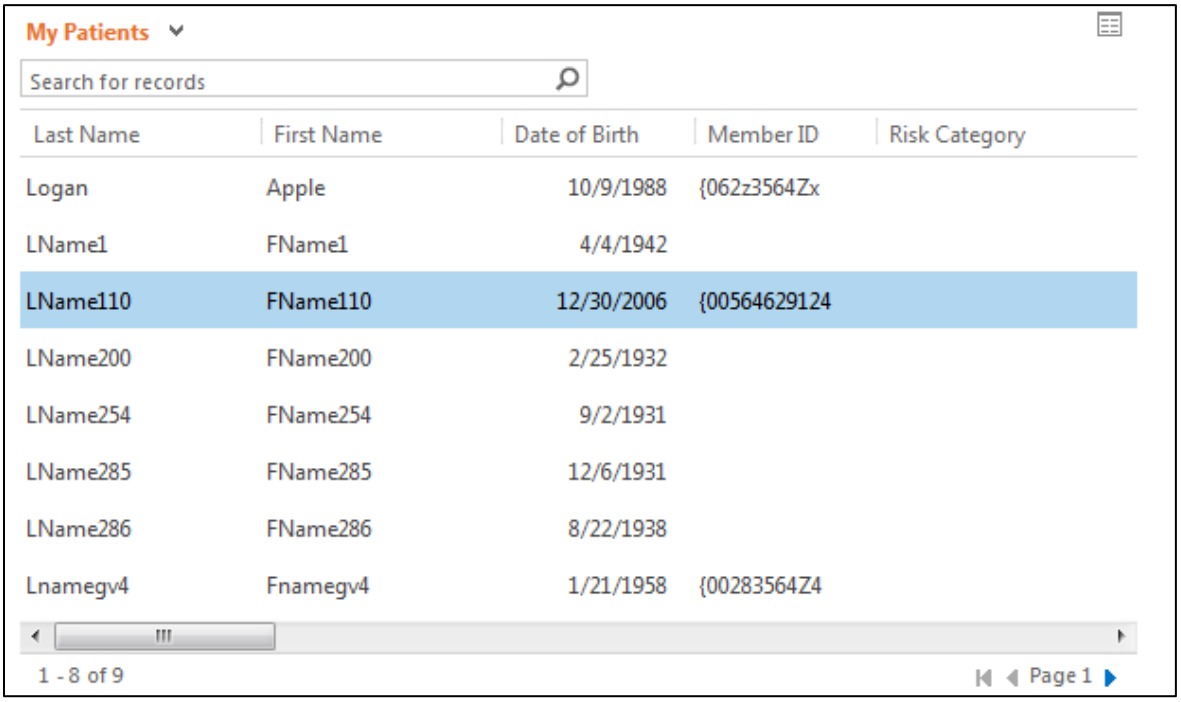
4. **Event Notifications Unread:** This section contains the admission, discharge, and transfer (ADT) alerts that have been received regarding patients whose care teams you are assigned to.



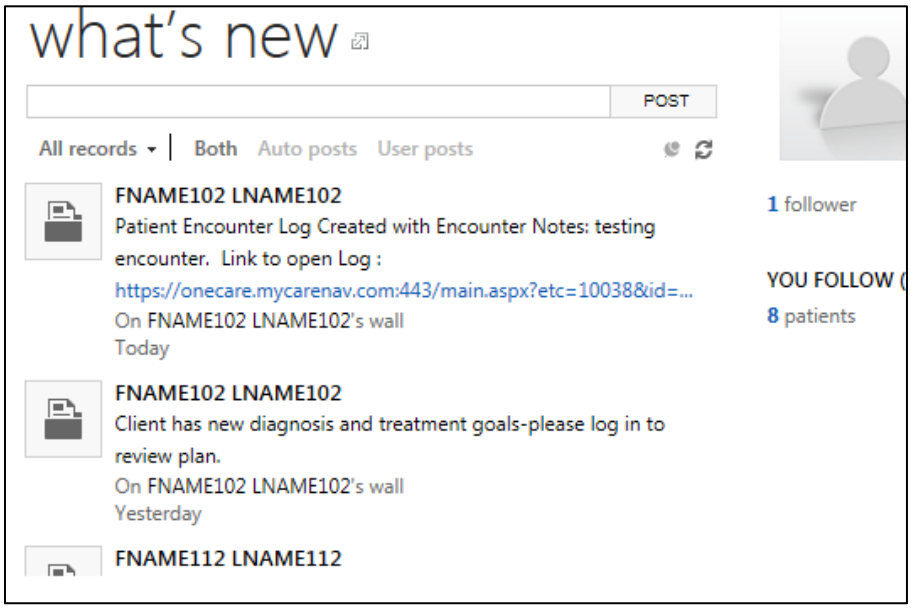
Once you have reviewed the ADT alert you have the option of marking the notification read to remove it from the 'Unread' feed. To complete this, open the message and select the 'Mark Read' option from the top toolbar:



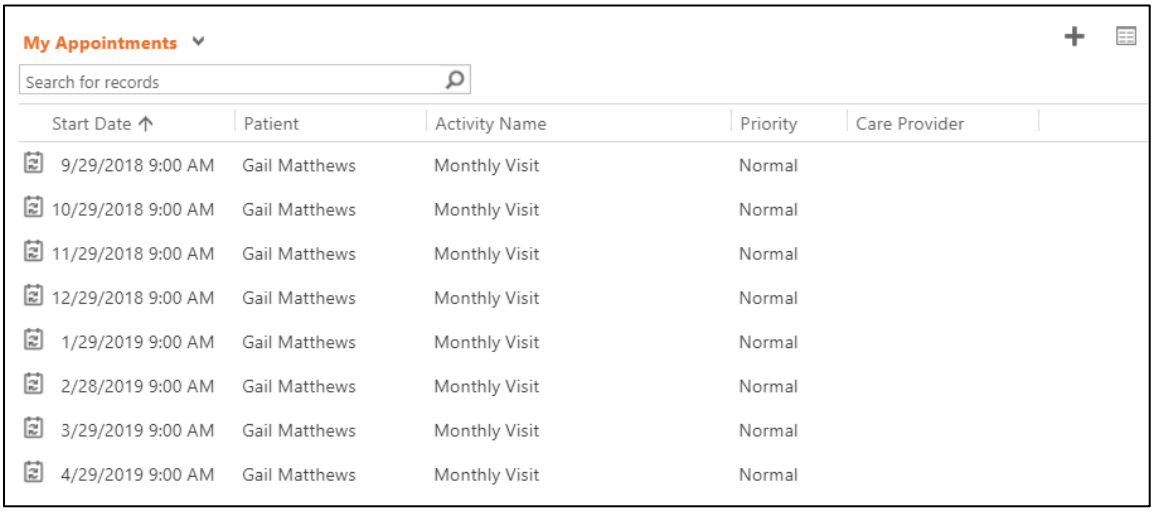
5. **My Active Patients:** This section contains a list of patients whose care team you have been assigned to.



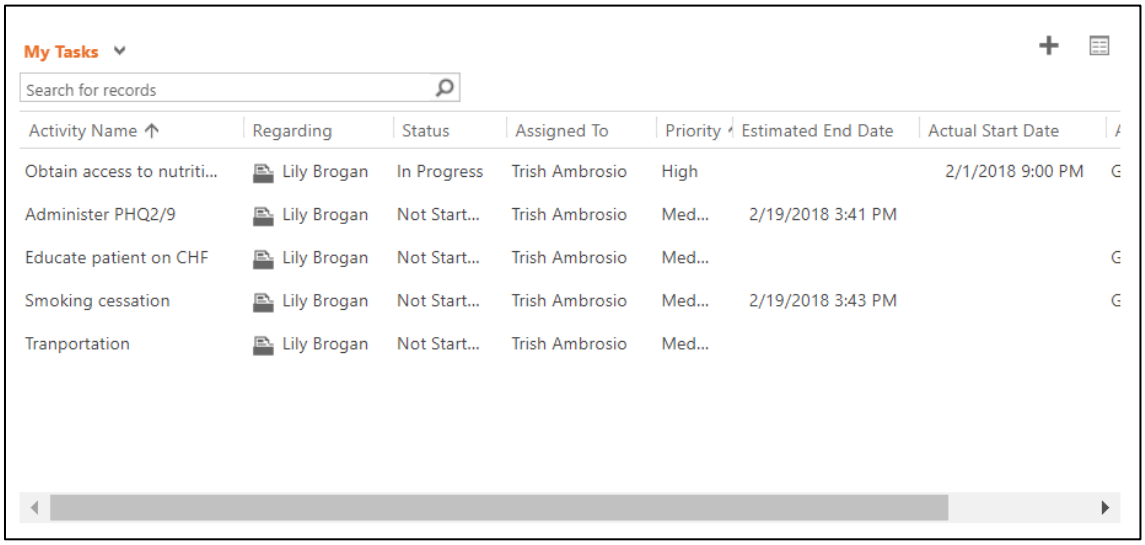
6. **What's New:** This section provides a feed of activity regarding patients the user is following including Encounters, Posts, and Care Team Notifications:



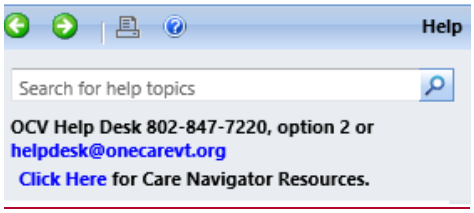
7. My Appointments: One-time or recurring appointments similar to an Outlook-type calendar can be recorded in this section.



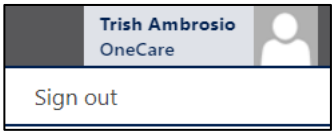
8. **My Tasks**: View assigned tasks or add tasks to any of the patients the user is assigned to by clicking on the + sign.



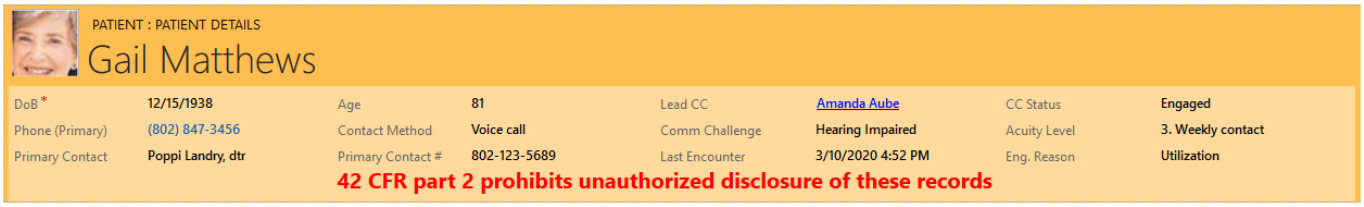
9. **Help Button**: click on the? Icon ? and this will display the Helpdesk contact information for you. As well as a link to the OneCare Website for additional resources.



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

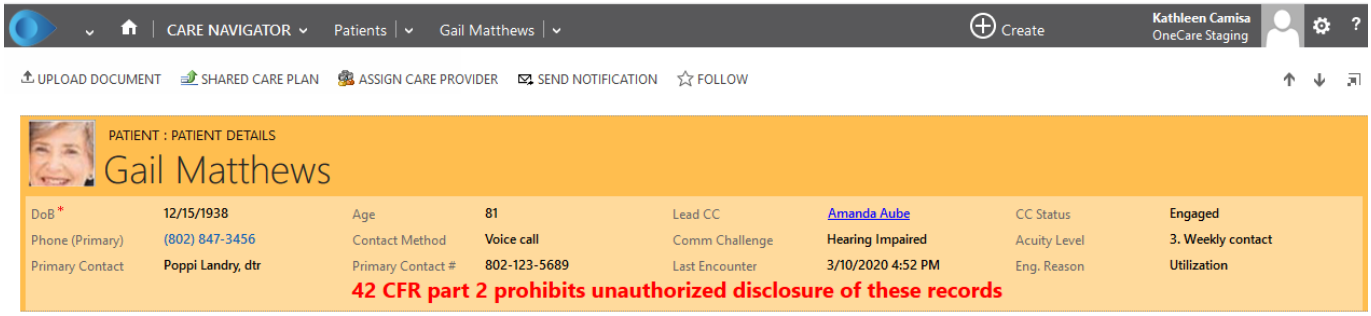


Patient Dashboard



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.



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 posiitive 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.

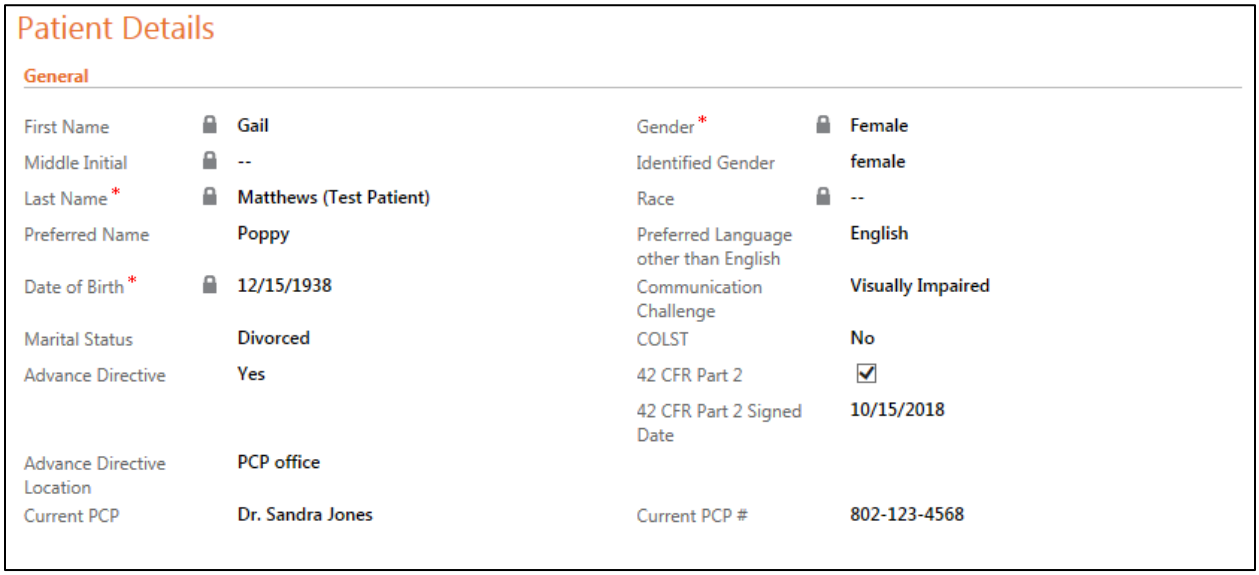
My Signature _____ Date: _____

Parent/ Legal Guardian Signature _____ Date: _____

Lead Care Coordinator's signature _____ Date: _____

Patient Details

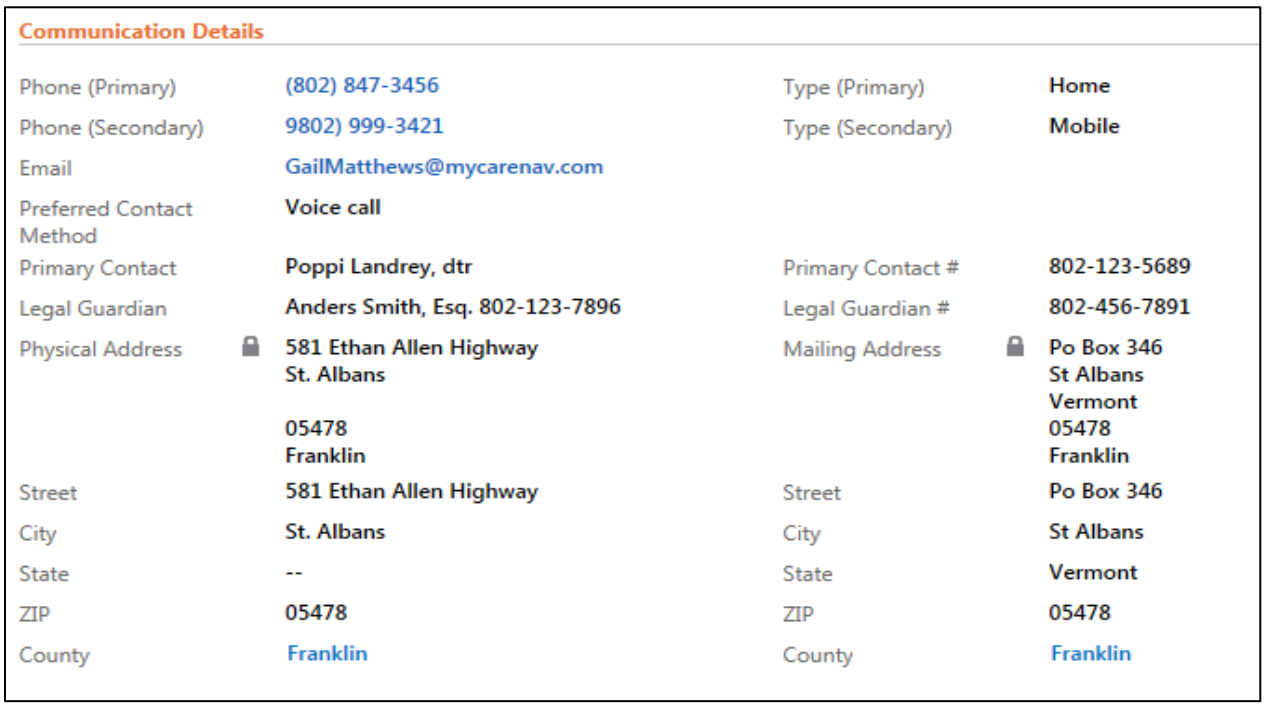
This section gives general demographic information about the patient. Fields are fed from either claims data or input by care team members.



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	☑
		42 CFR Part 2 Signed Date	10/15/2018
Advance Directive Location	PCP office		
Current PCP	Dr. Sandra Jones	Current PCP #	802-123-4568

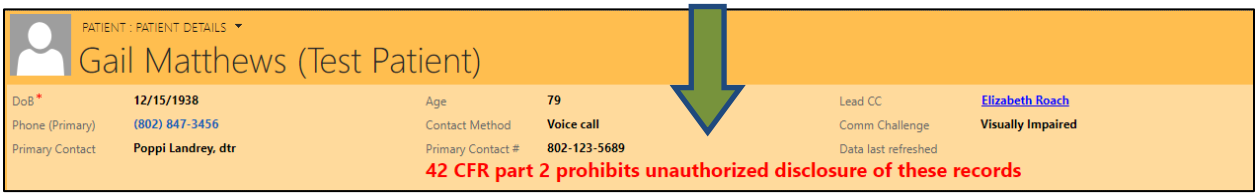


Communication Details

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

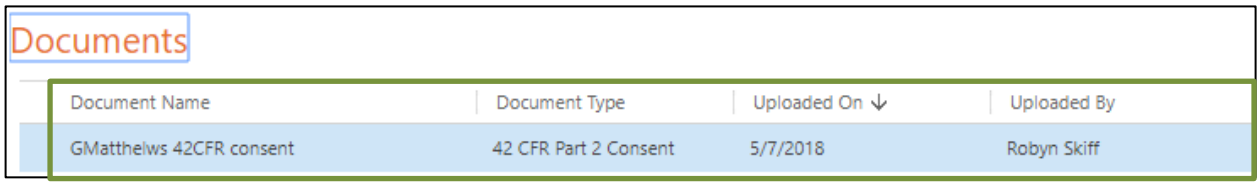
42 CFR Part 2 Tracking

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:

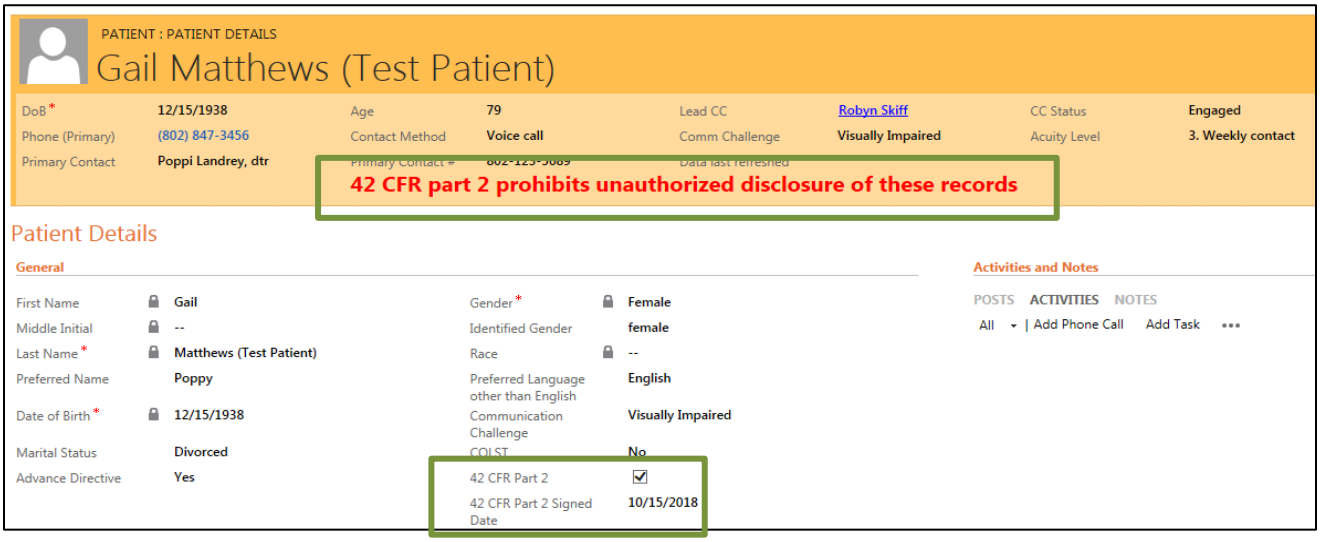


When a 42CFR Part 2 Consent is completed and uploaded, the following steps should be taken to record this in the patient record:

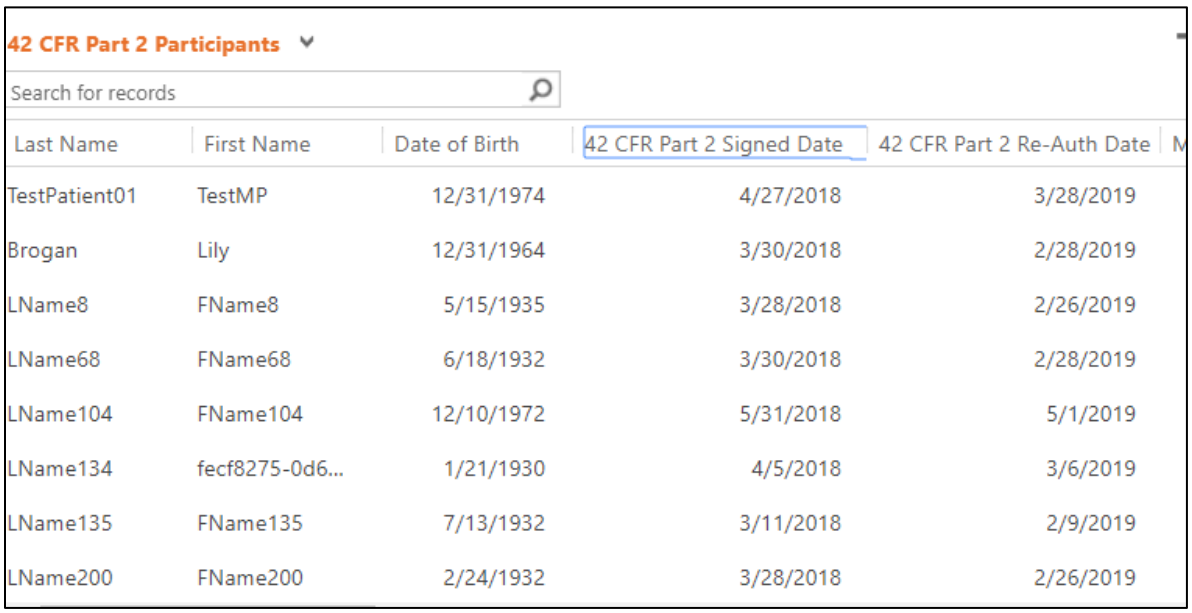
1. Upload 42 CFR Part 2 Consent into the Document section (see section on 'Documents' on the process to upload a document). The 42CFR consent will reside in the Document section



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



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.



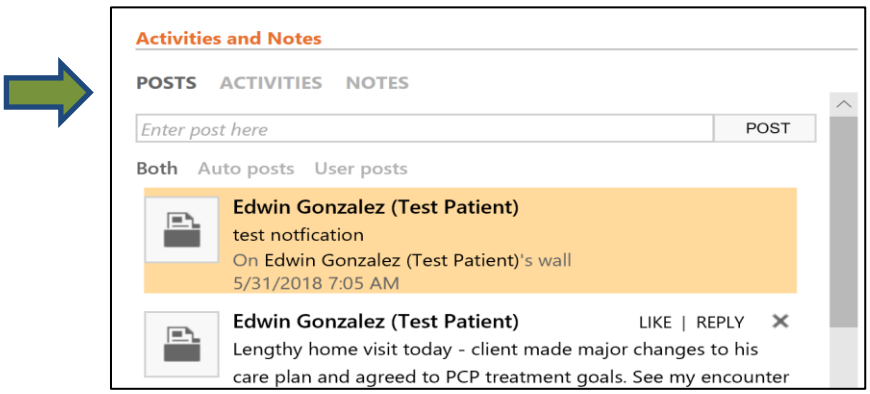
Last Name	First Name	Date of Birth	42 CFR Part 2 Signed Date	42 CFR Part 2 Re-Auth Date
TestPatient01	TestMP	12/31/1974	4/27/2018	3/28/2019
Brogan	Lily	12/31/1964	3/30/2018	2/28/2019
LName8	FName8	5/15/1935	3/28/2018	2/26/2019
LName68	FName68	6/18/1932	3/30/2018	2/28/2019
LName104	FName104	12/10/1972	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.

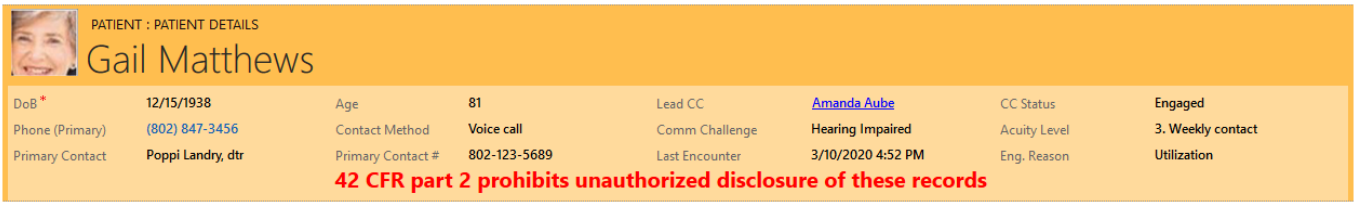
Entering a Post

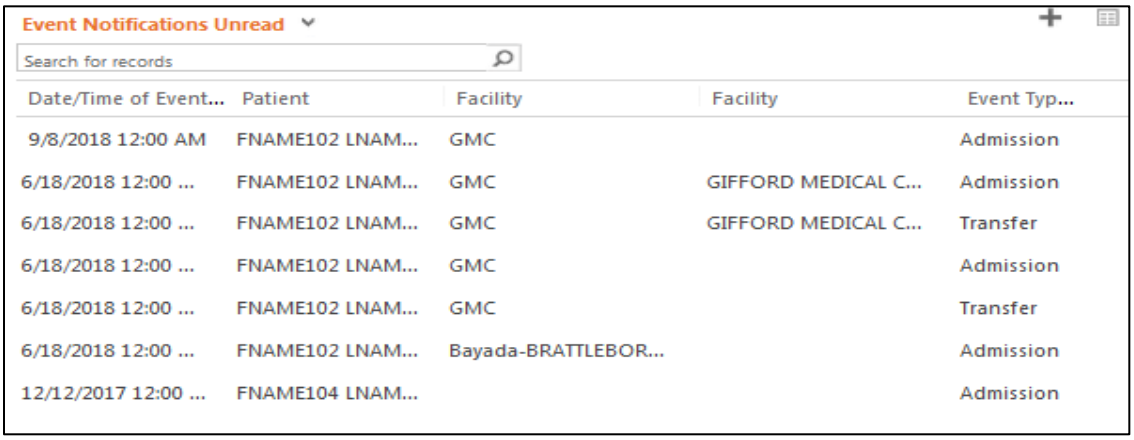
Under 'Activities and Notes' click on 'Posts' and enter information that can be viewed by all Care Team Members. Use this when you want others on the care team to see an important but not urgent update in their What's New feed the next time you log in. Encounter log entries and Care Team Notifications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



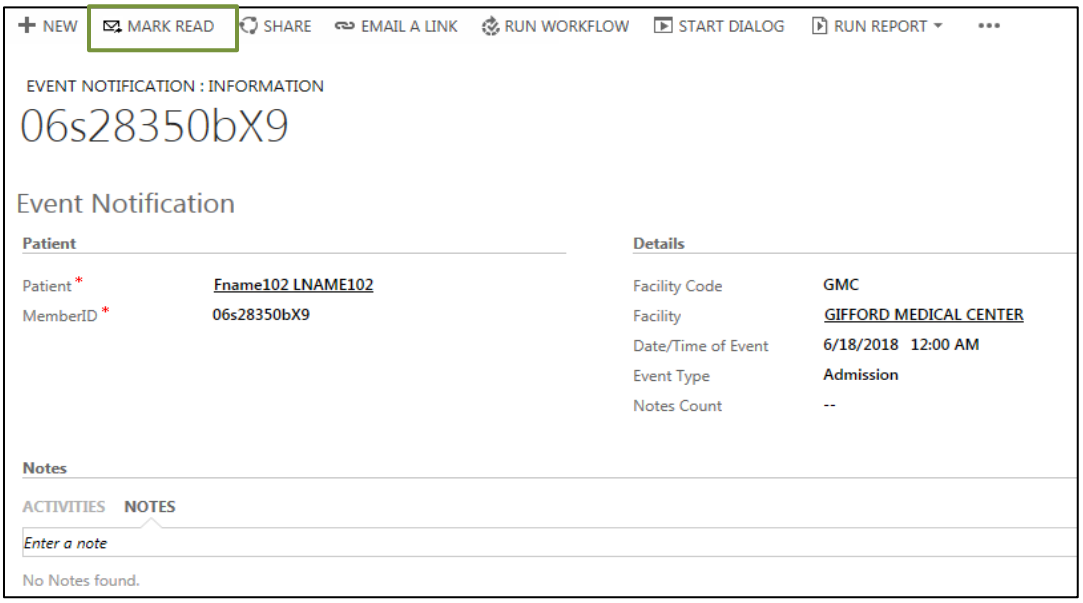
Event Notifications

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.





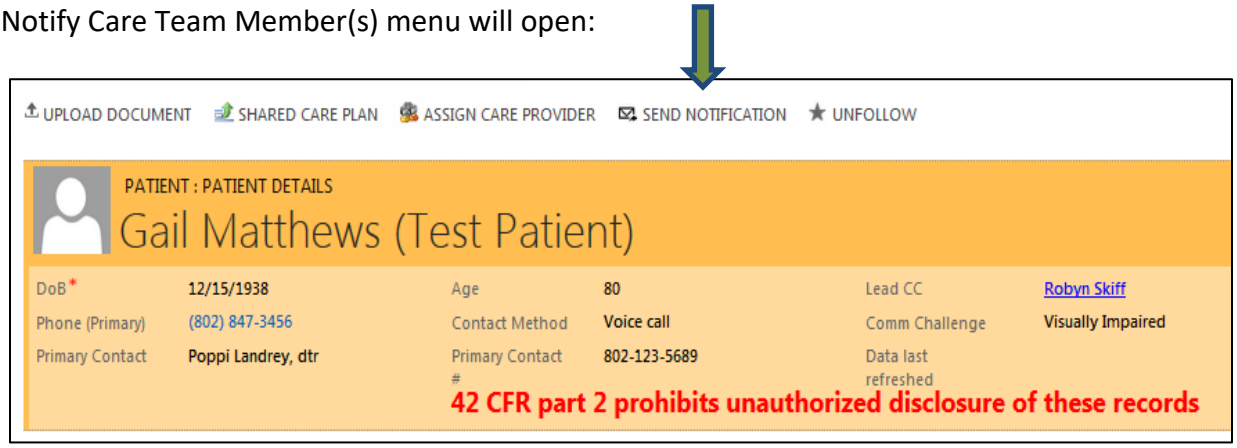
The details (including the patient's name and medical ID) will appear as shown below. After reviewing, the user can change the status of the notification to 'Mark Read':



Care Team Notifications

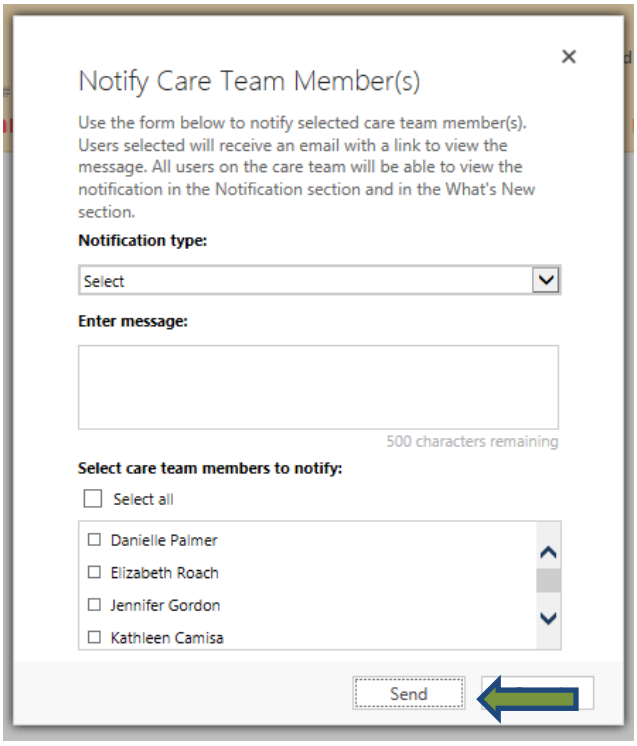
The Care Team Notification feature allows members of a care team to alert other team members of key events or communications related to common patients. When the Notification message is completed and sent, recipients then receive an email alert with a link that prompts them to sign into Care Navigator. 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:

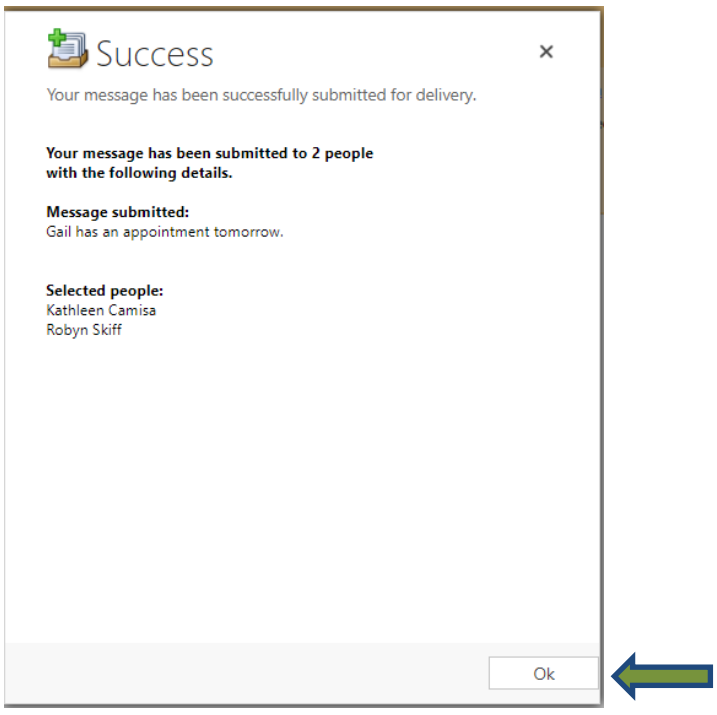


7. Select a Notification Type using the drop down on the right.
8. Enter a simple message with no protected health information. No more than 500 characters
9. A User can select either specific Care Team Members or all Care Team Members by choosing 'Select All' to send the notification to

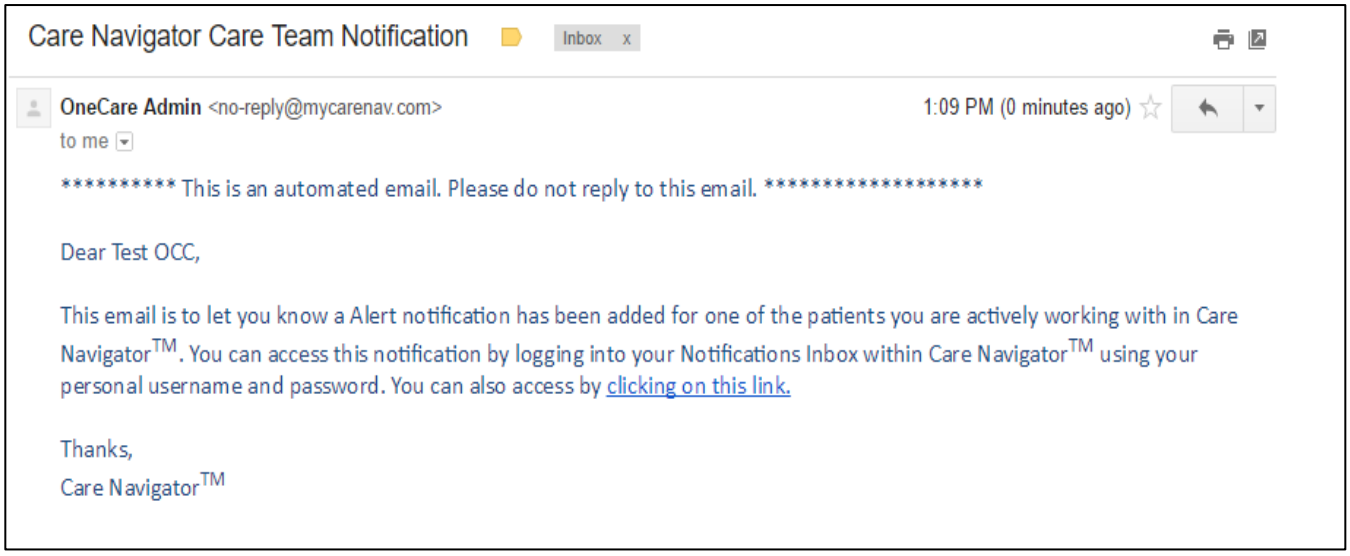
10. Click the 'Send' button to send the notification



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.

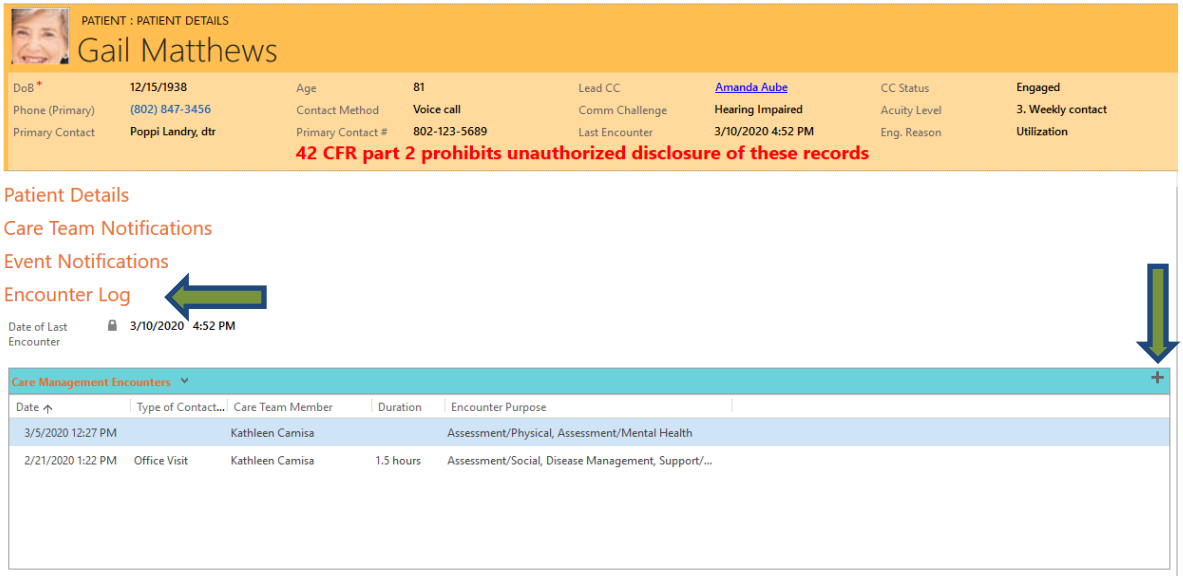


Encounter Log

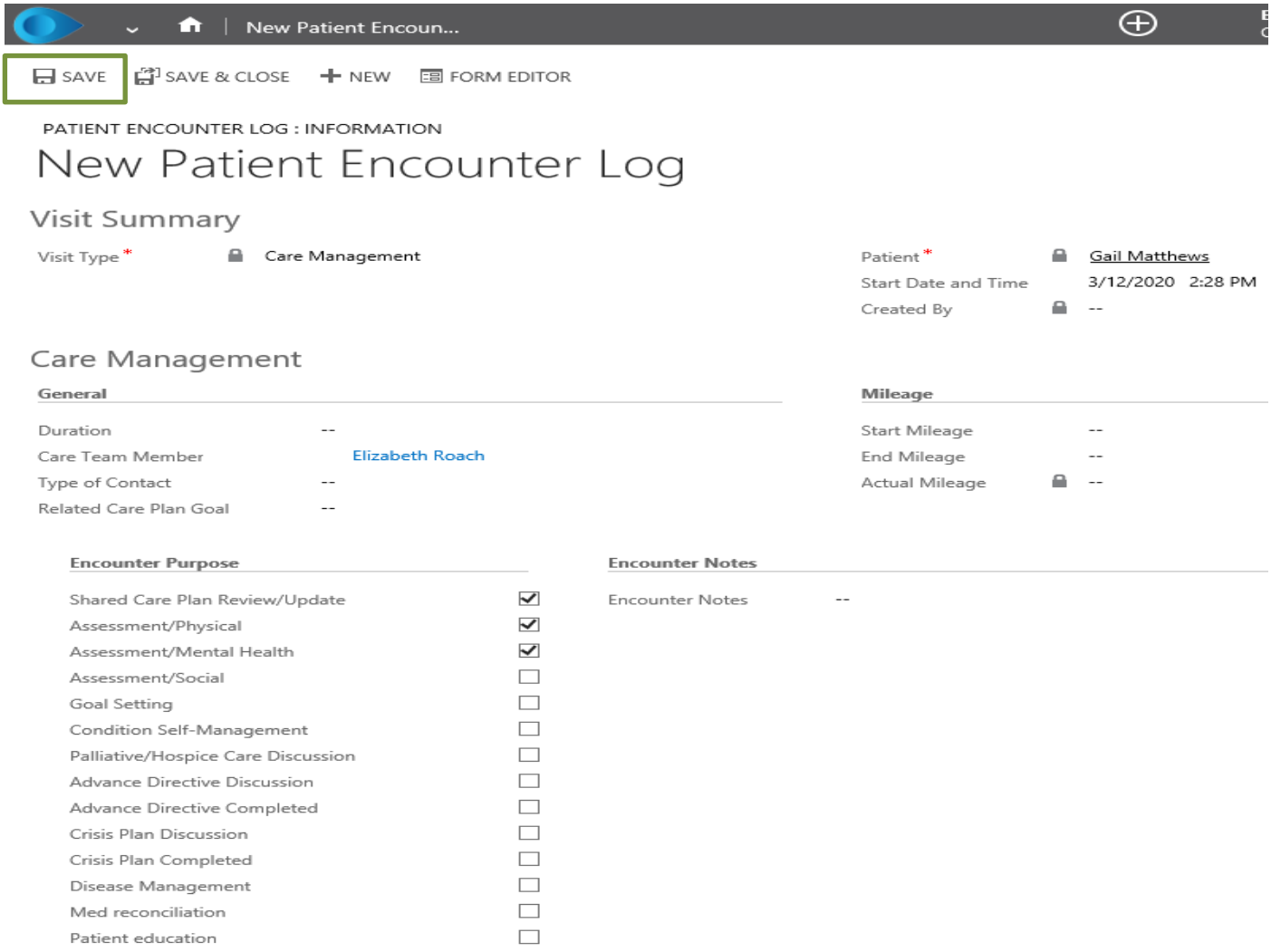
The Encounter Log is an area for a care coordinator to reflect meaningful interactions with the patient or the patient's care team.

Patient Encounter Log Entry:

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



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:

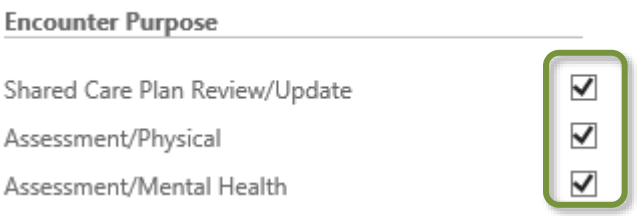


General:

- 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:

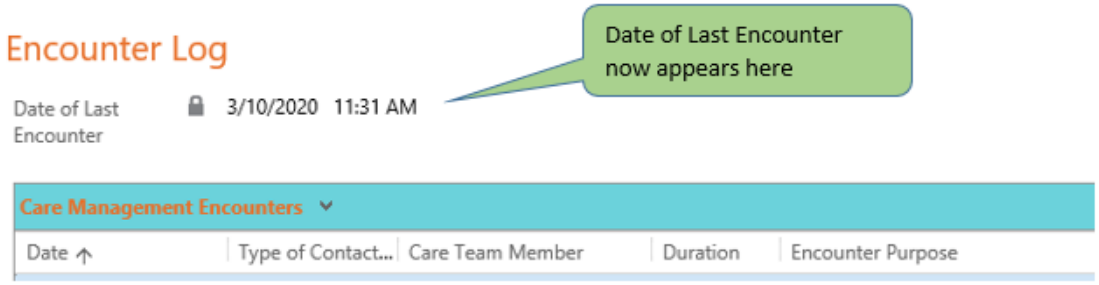
- The care coordinator can choose one or more reasons for seeing a patient under 'Encounter Purpose'.



Encounter 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.

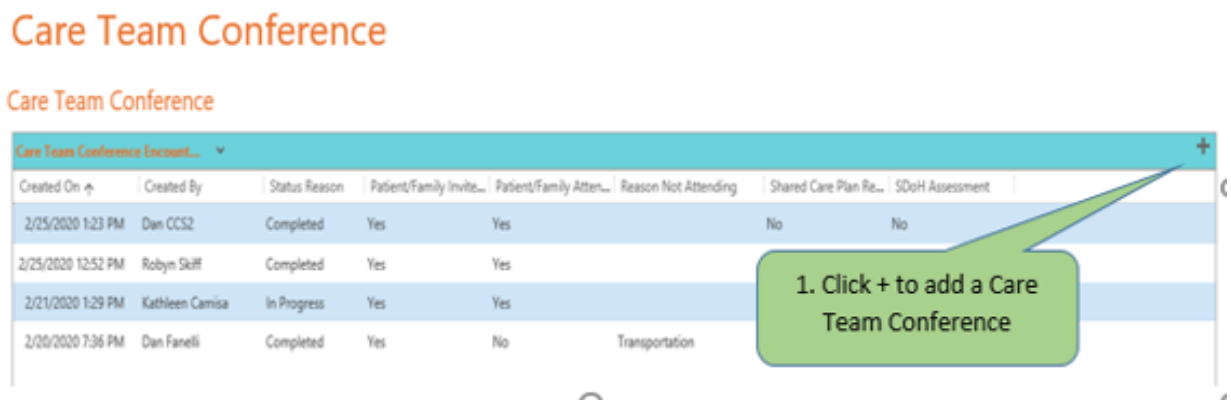
3. The Date of Last Encounter is displayed in both the patient header and above the box in the Encounter Log:



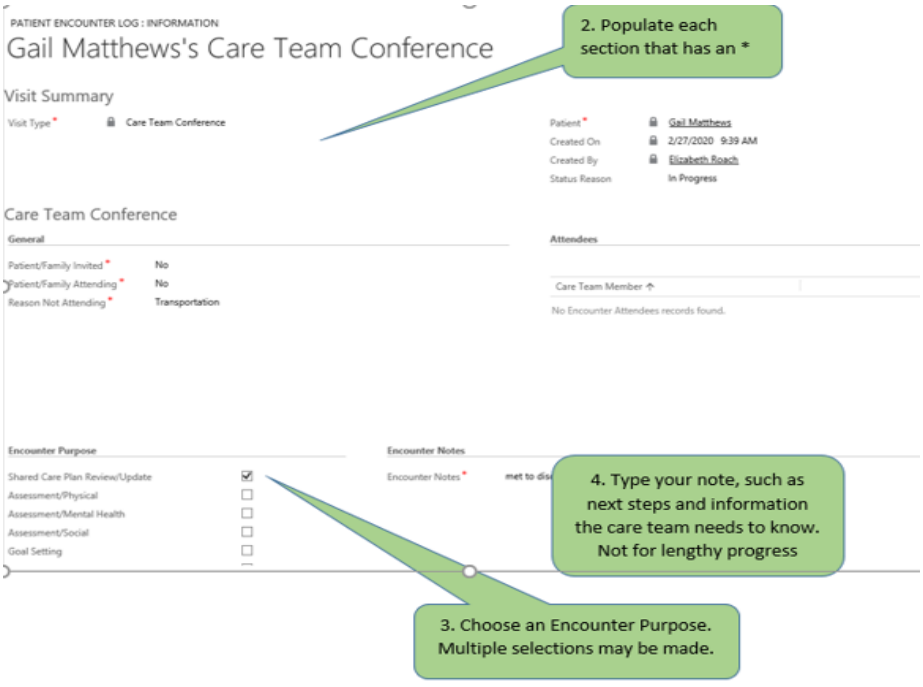
Care Team Conference

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.

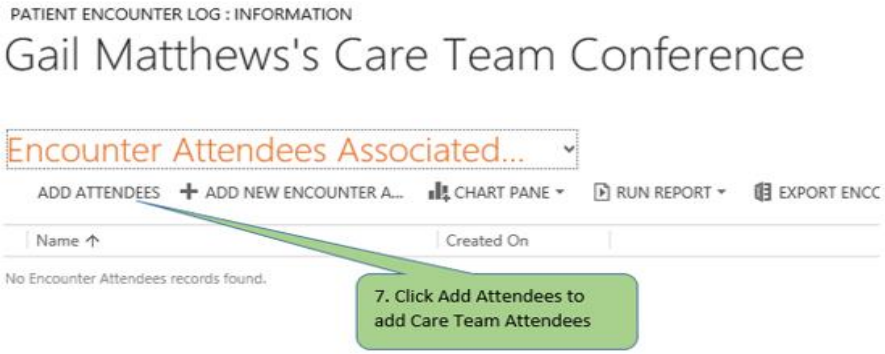
1. Open the Care Team Conference tile and click on the plus sign

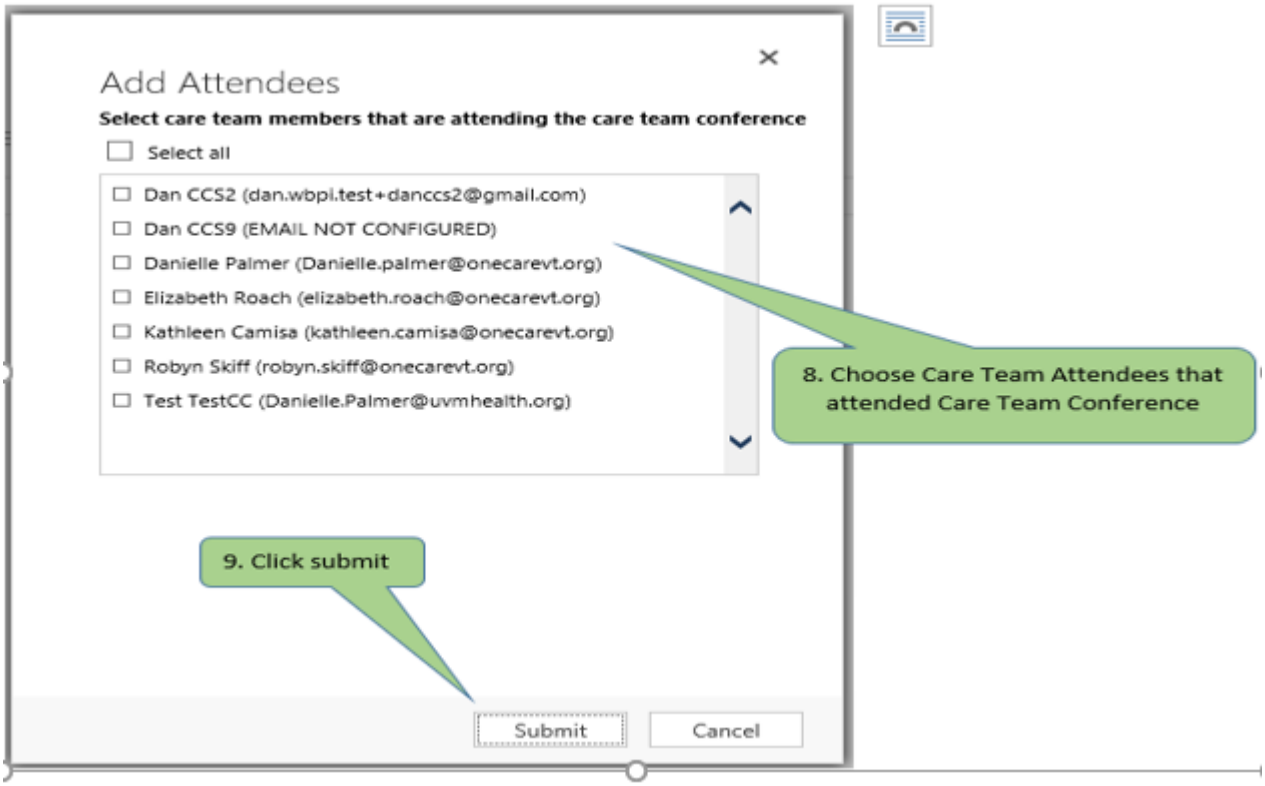


2. When the next screen opens enter information in each area as below:

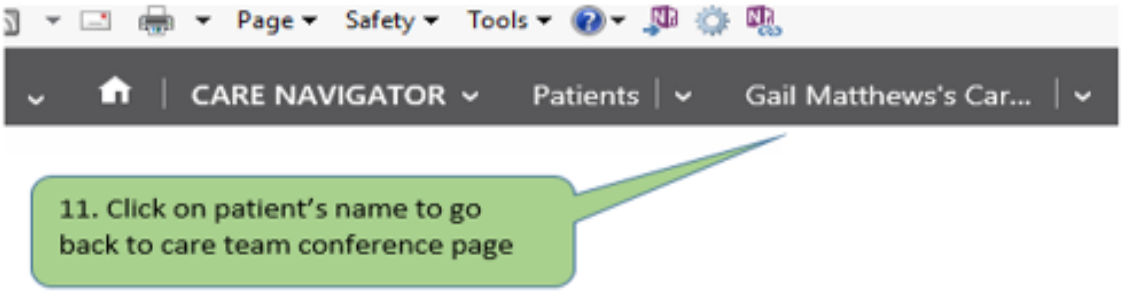


3. Add Care Team Conference Attendees :

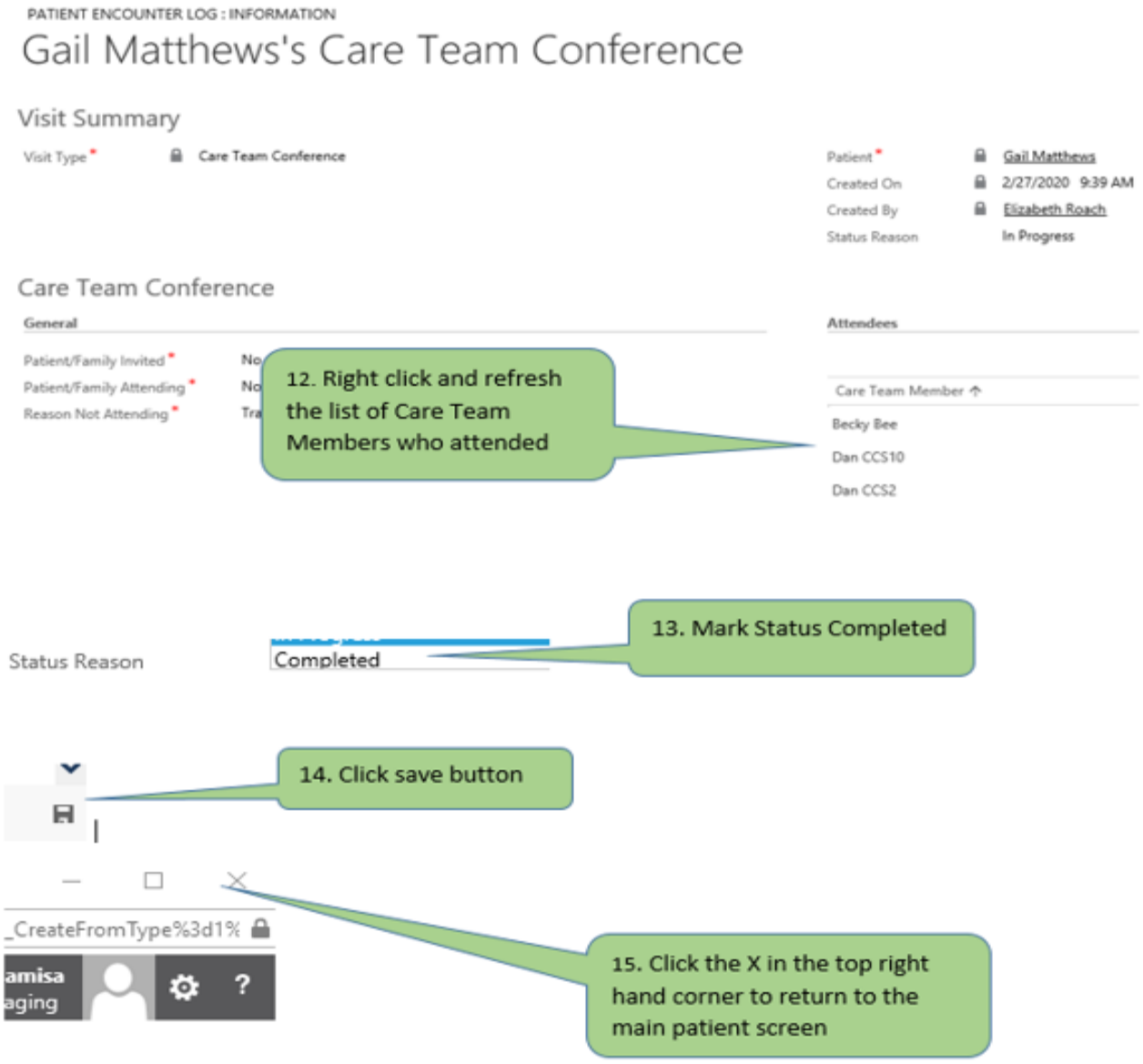





Success
Added 2 encounter attendees
Selected people:
Becky Bee
Dan CCS10
10. Click ok to close
Ok

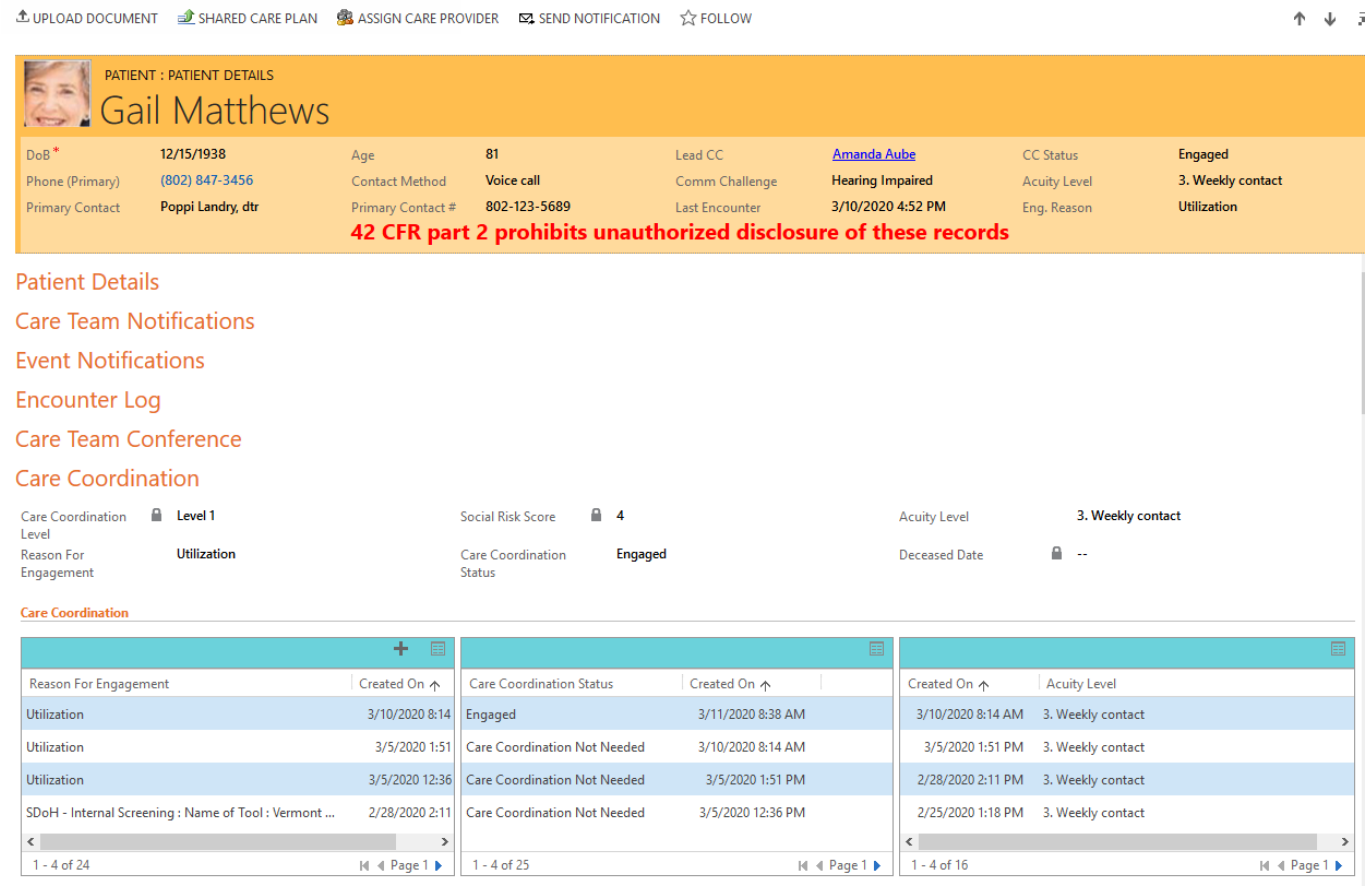

Page
Safety
Tools
CARE NAVIGATOR
Patients
Gail Matthews's Car...
11. Click on patient's name to go back to care team conference page

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



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:



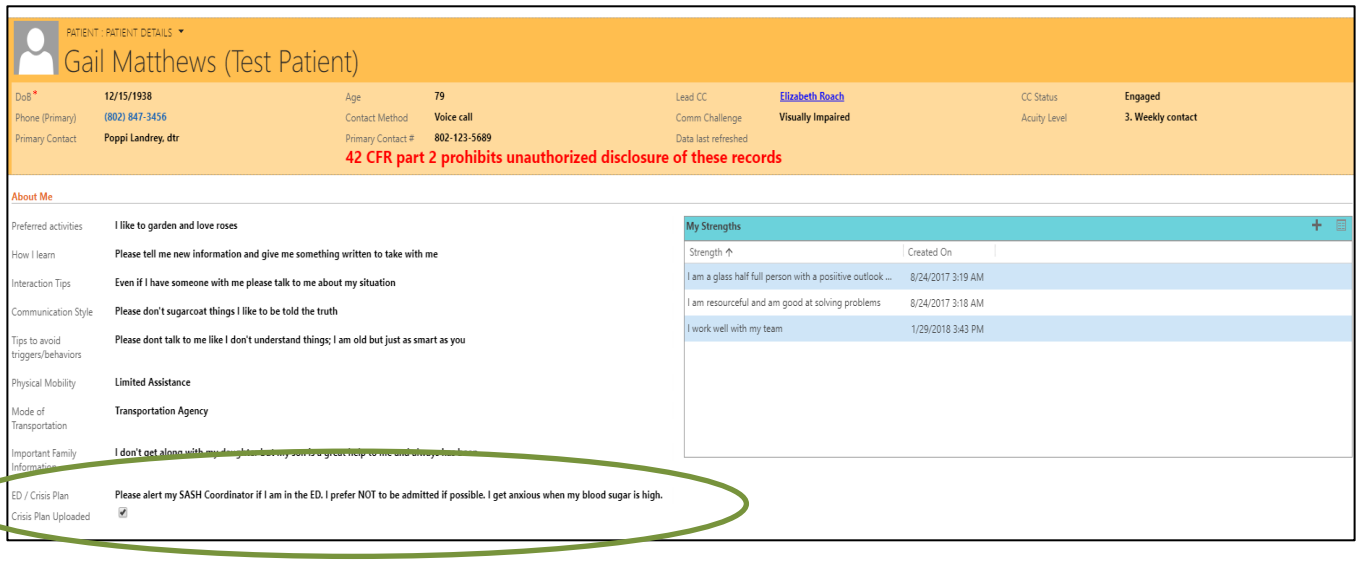
- The user can open the Care Coordination menu by single clicking on the header, with the options below viewable upon opening. When a box turns gray when hovering on a field it indicates there is a list of options to choose from:

  a) 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.
  b) Reason for Engagement-indicate the reason for engaging the patient
  c) Social Risk Score-a non-editable field calculated from SDoH
  d) Care Coordination Status-this field reflects the patient's level of engagement with care coordination.
  e) Acuity Level-**i**ndicates the frequency of interaction needed either directly or indirectly with the patient.
  f) Deceased Date-can be claims fed or input by care team member
  g) About Me and Strengths
  h) Care Team members
  i) ACO/Insurance Information

About Me:

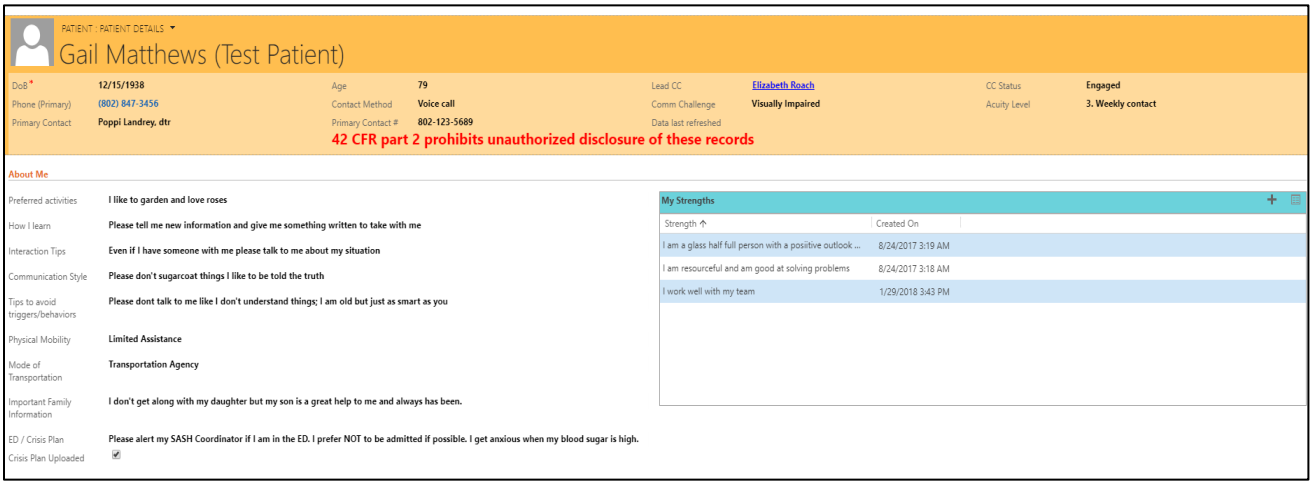
The 'About Me' section is based on your interactions with the patient. These important person centered fields help the team see the whole person.

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.



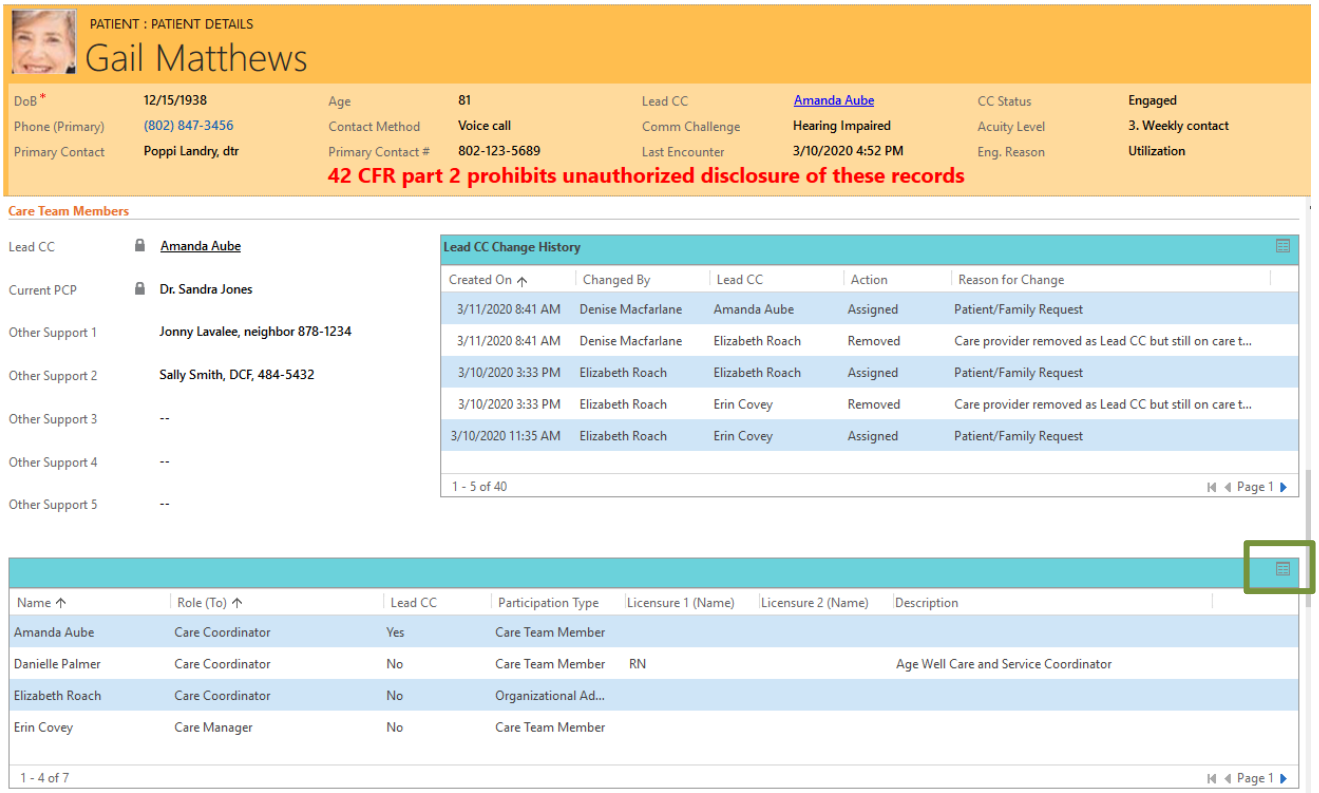
My Strengths

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

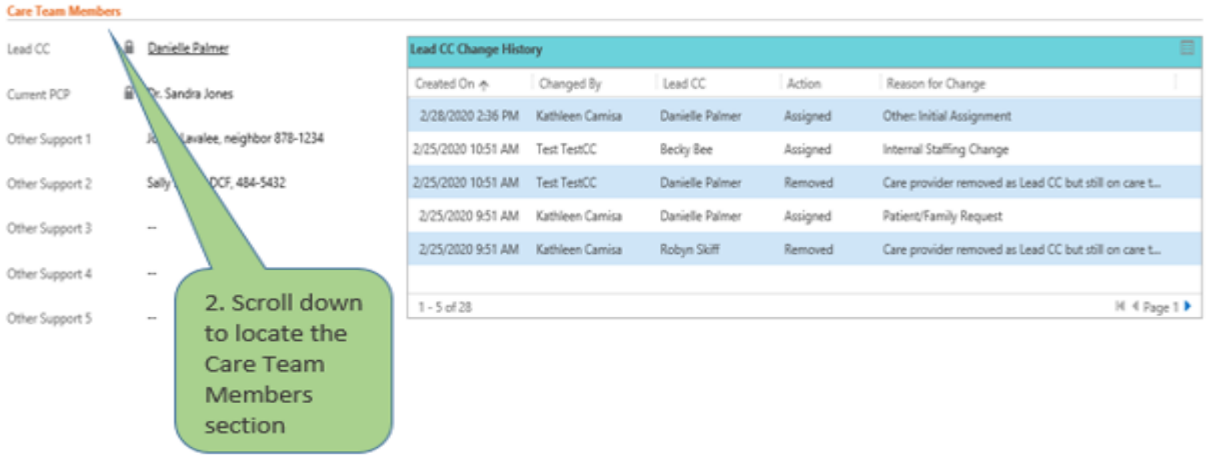


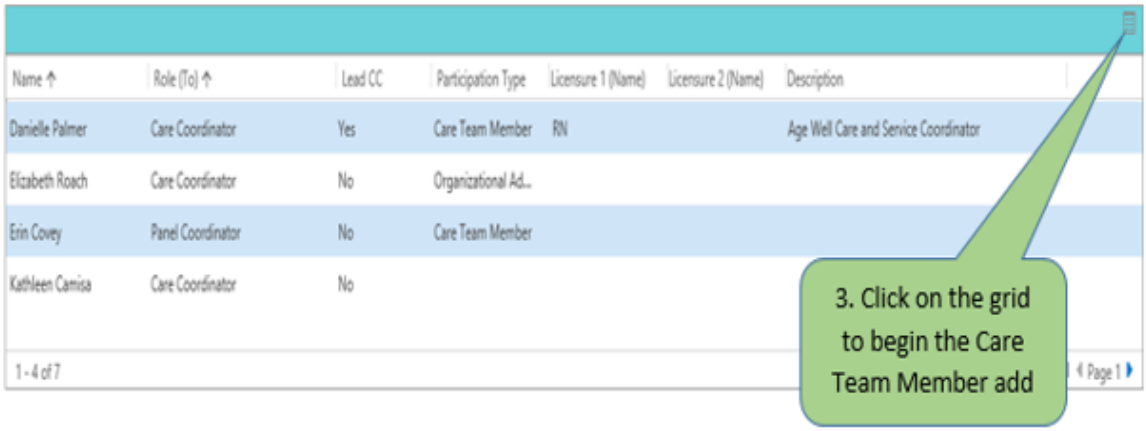
Care Team Members:

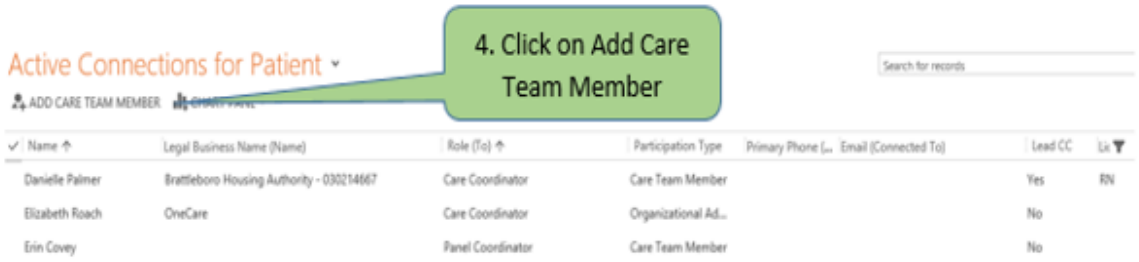
The following section under the 'Care Coordination' submenu is the Care Team Members section. Here, a list of care team members and their role on the care team can be identified. Non-ACO members who are part of the care team can also be added. 'Other Support' fields have been added so a care team member 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:

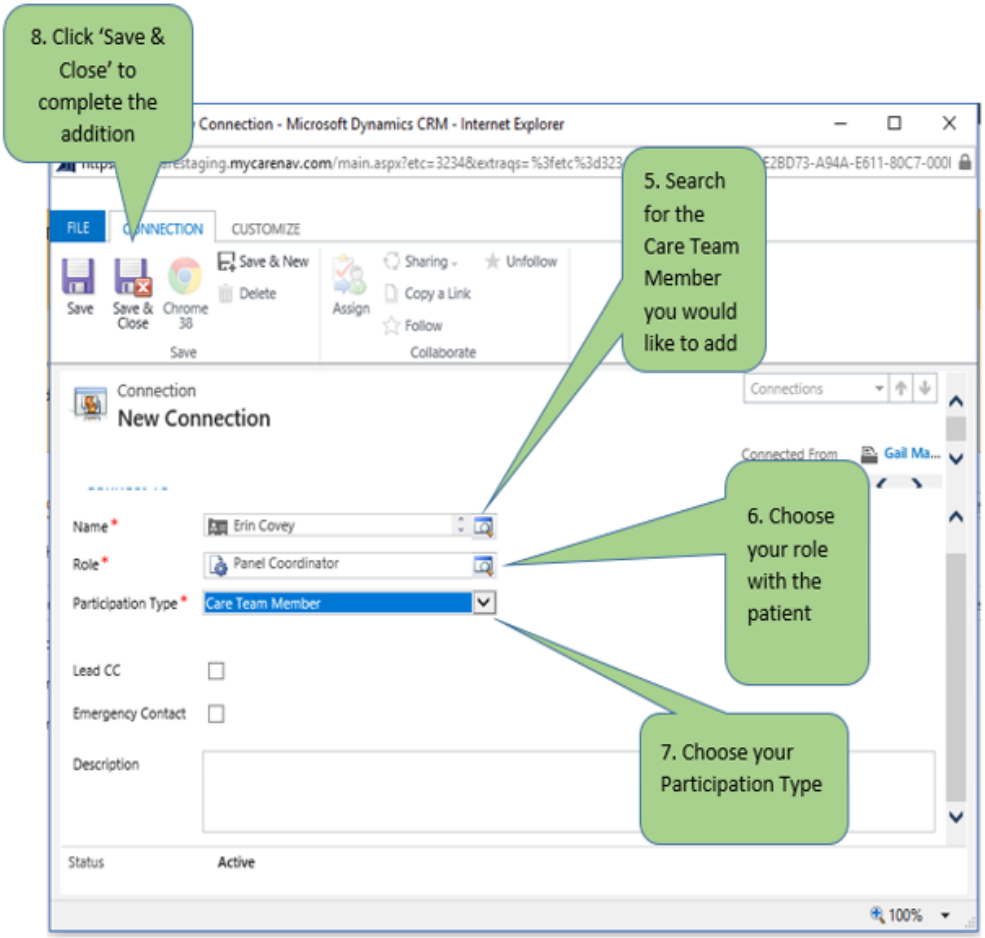


1. Click on the grid on the right hand side of the box to view the Active Connections for the patient. From this grid select 'Add Care Team Member' to bring a sub-menu up for care team additions:

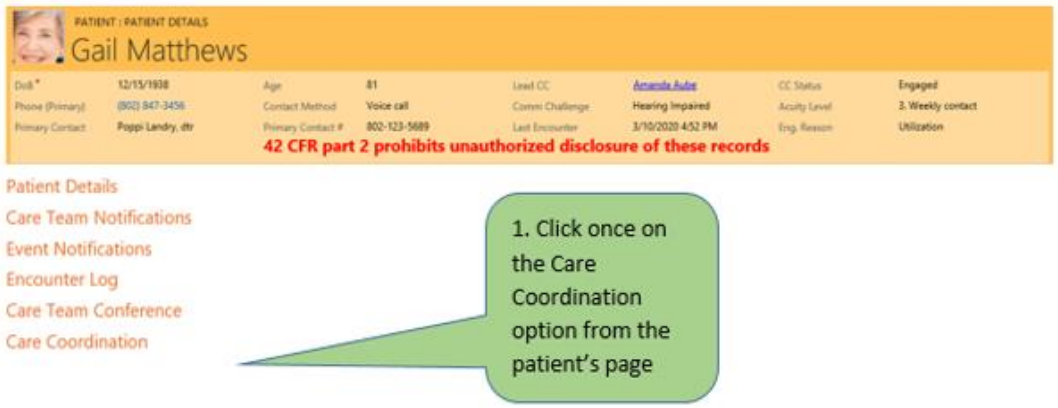


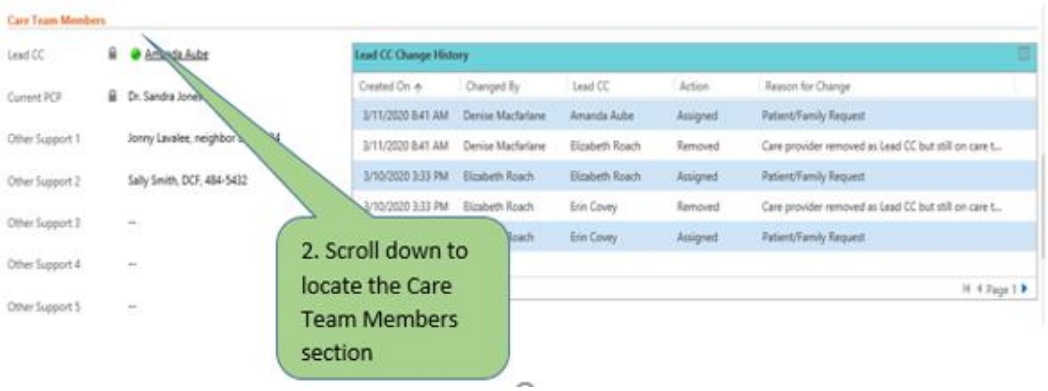

Name
Role (To)
Lead CC
Participation Type
Licensure 1 (Name)
Licensure 2 (Name)
Description
Danielle Palmer
Care Coordinator
Yes
Care Team Member
RN
Age Well Care and Service Coordinator
Elizabeth Roach
Care Coordinator
No
Organizational Ad...
Erin Covey
Panel Coordinator
No
Care Team Member
Kathleen Camisa
Care Coordinator
No
1 - 4 of 7
Page 1
3. Click on the grid to begin the Care Team Member add

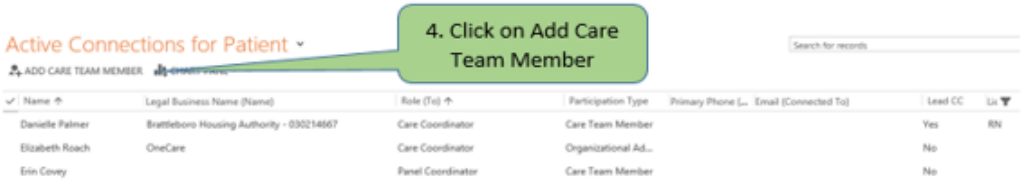

Active Connections for Patient
ADD CARE TEAM MEMBER
4. Click on Add Care Team Member
Search for records
Name
Legal Business Name (Name)
Role (To)
Participation Type
Primary Phone (...
Email (Connected To)
Lead CC
Danielle Palmer
Brattleboro Housing Authority - 030214667
Care Coordinator
Care Team Member
Yes
RN
Elizabeth Roach
OneCare
Care Coordinator
Organizational Ad...
No
Erin Covey
Panel Coordinator
Care Team Member
No

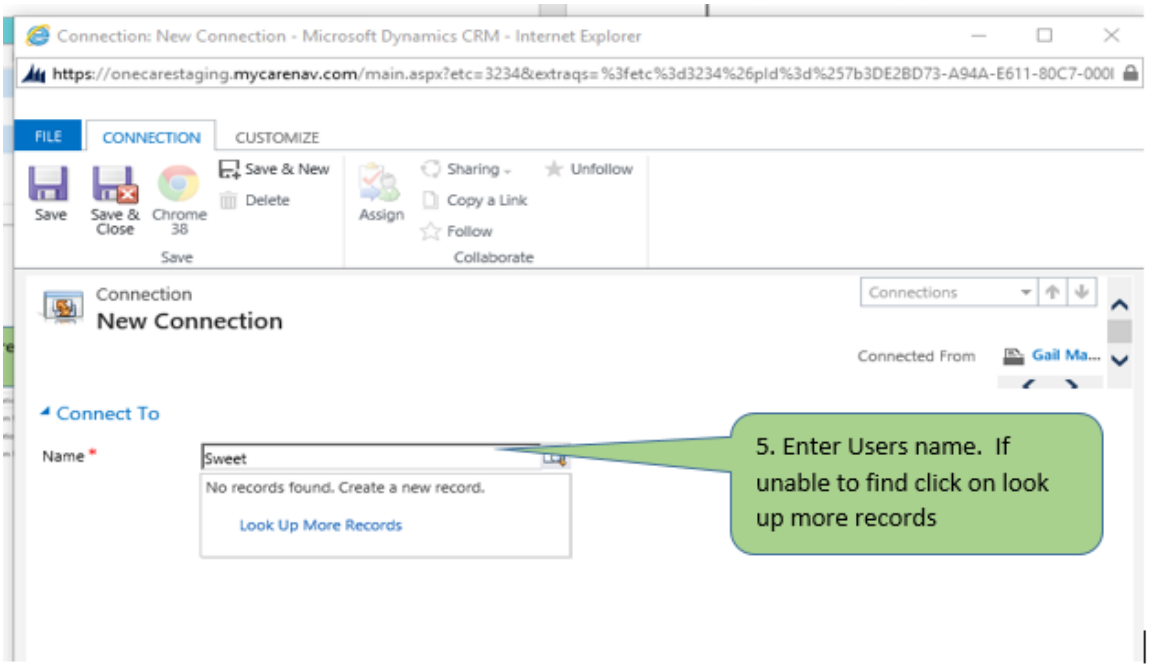

8. Click 'Save & Close' to complete the addition
Connection - Microsoft Dynamics CRM - Internet Explorer
FILE
CONNECTION
CUSTOMIZE
Save
Save & Close
Chrome 38
Save & New
Delete
Assign
Sharing
Unfollow
Copy a Link
Follow
Save
Collaborate
5. Search for the Care Team Member you would like to add
Connection
New Connection
Connections
Connected From
Gail Ma...
Name *
Erin Covey
Role *
Panel Coordinator
Participation Type *
Care Team Member
6. Choose your role with the patient
Lead CC
Emergency Contact
Description
7. Choose your Participation Type
Status
Active
100%

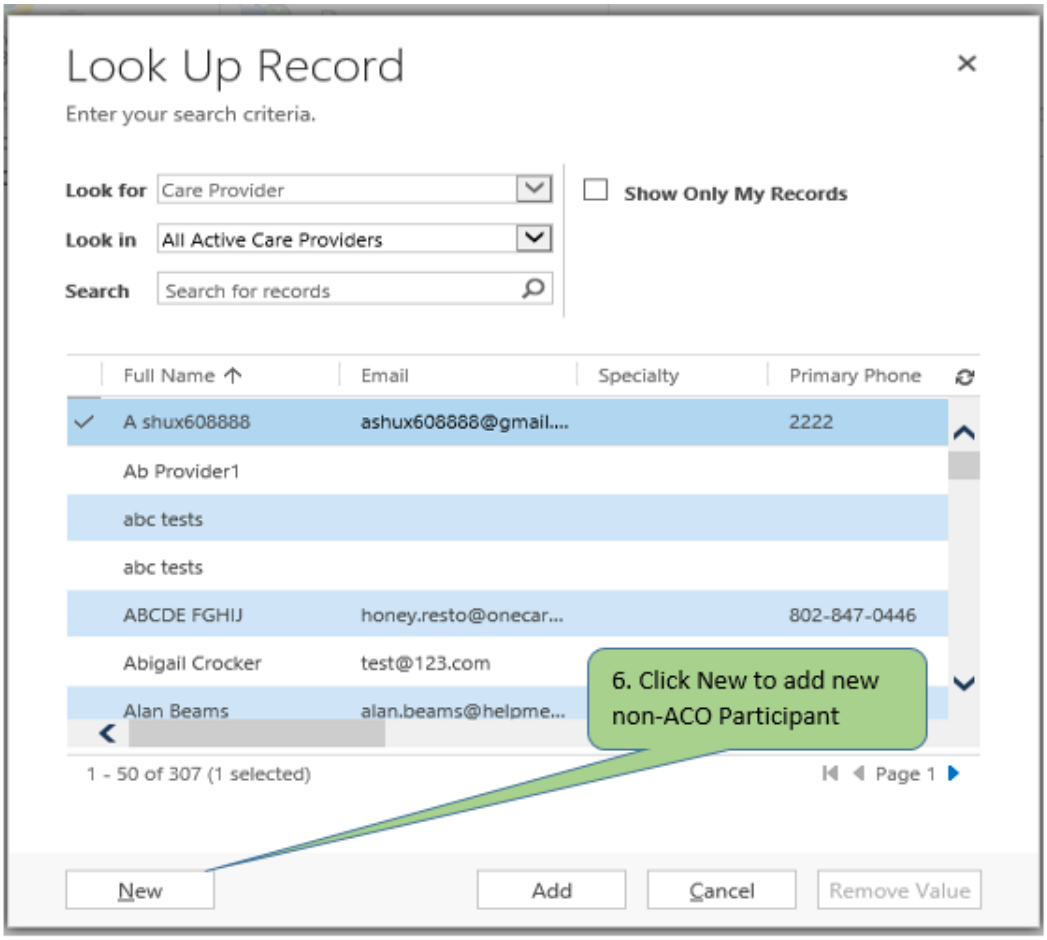
Adding Non-ACO Participants: Non-ACO care team members can be added to the care team. These care team members won't have access to Care Navigator but should be noted as part of the care team:

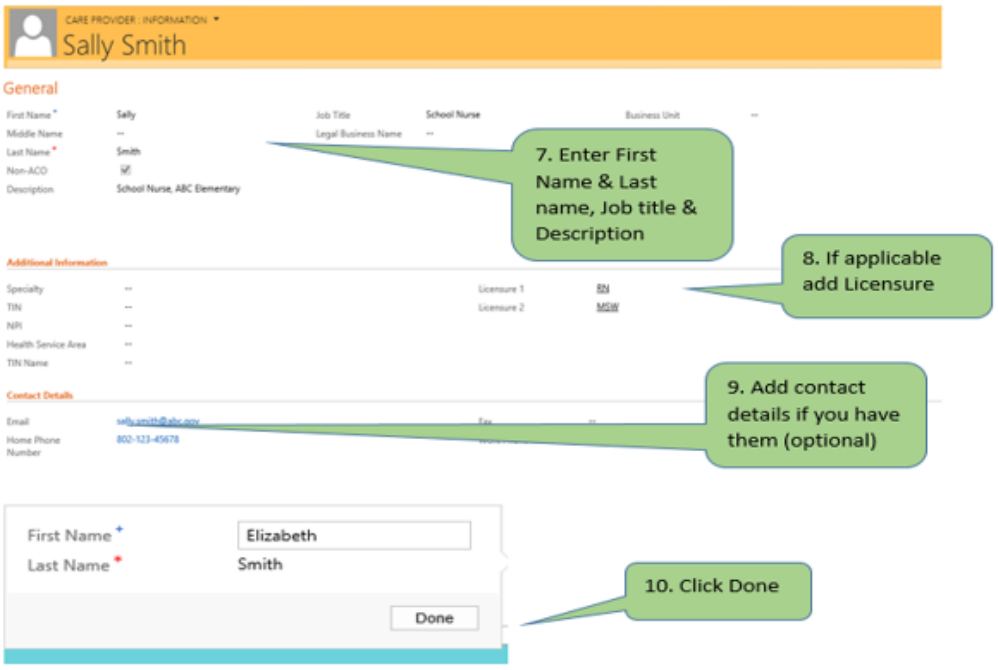


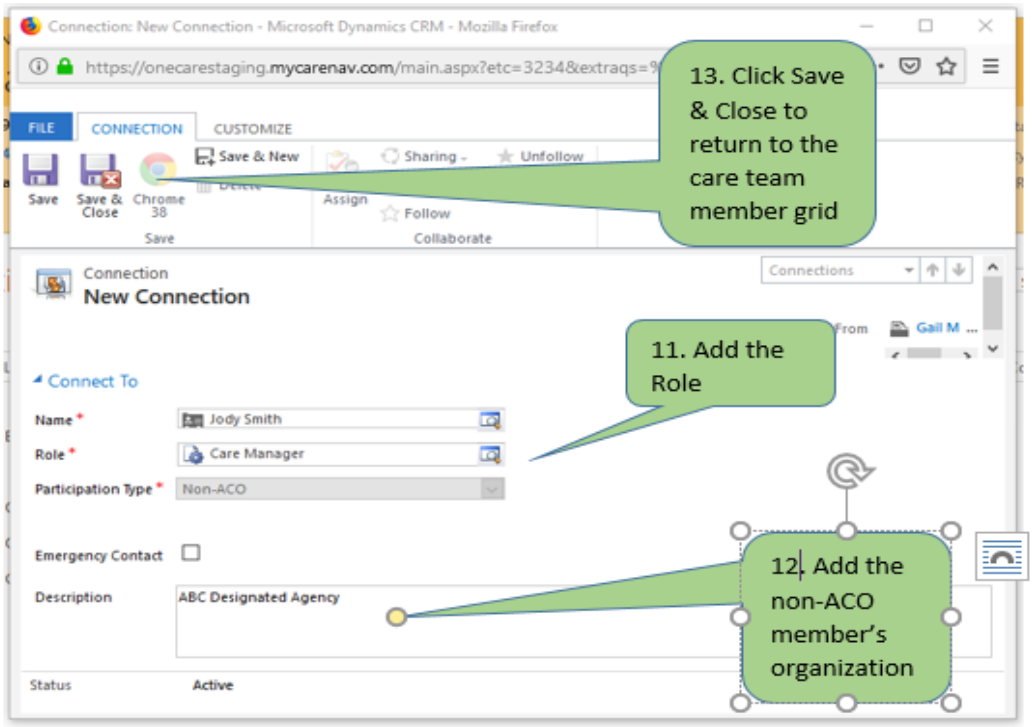




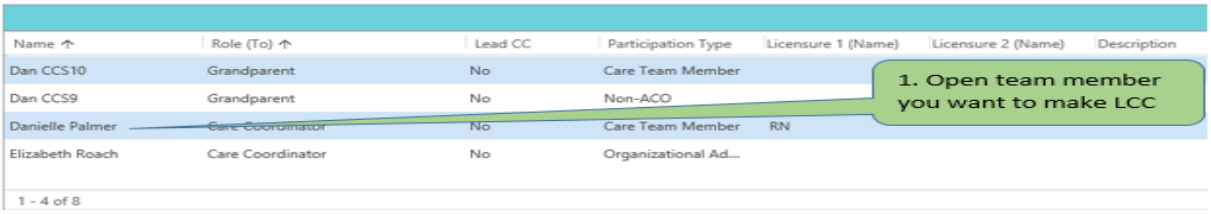

Connection: New Connection - Microsoft Dynamics CRM - Internet Explorer
https://onecarestaging.mycarenav.com/main.aspx?etc=3234&extraqs=%3fetc%3d3234%26pId%3d%257b3DE2BD73-A94A-E611-80C7-000I
FILE
CONNECTION
CUSTOMIZE
Save
Save & Close
Chrome 38
Save & New
Delete
Save
Assign
Sharing
Unfollow
Copy a Link
Follow
Collaborate
Connection
New Connection
Connections
Connected From
Gail Ma...
Connect To
Name *
Sweet
No records found. Create a new record.
Look Up More Records
5. Enter Users name. If unable to find click on look up more records

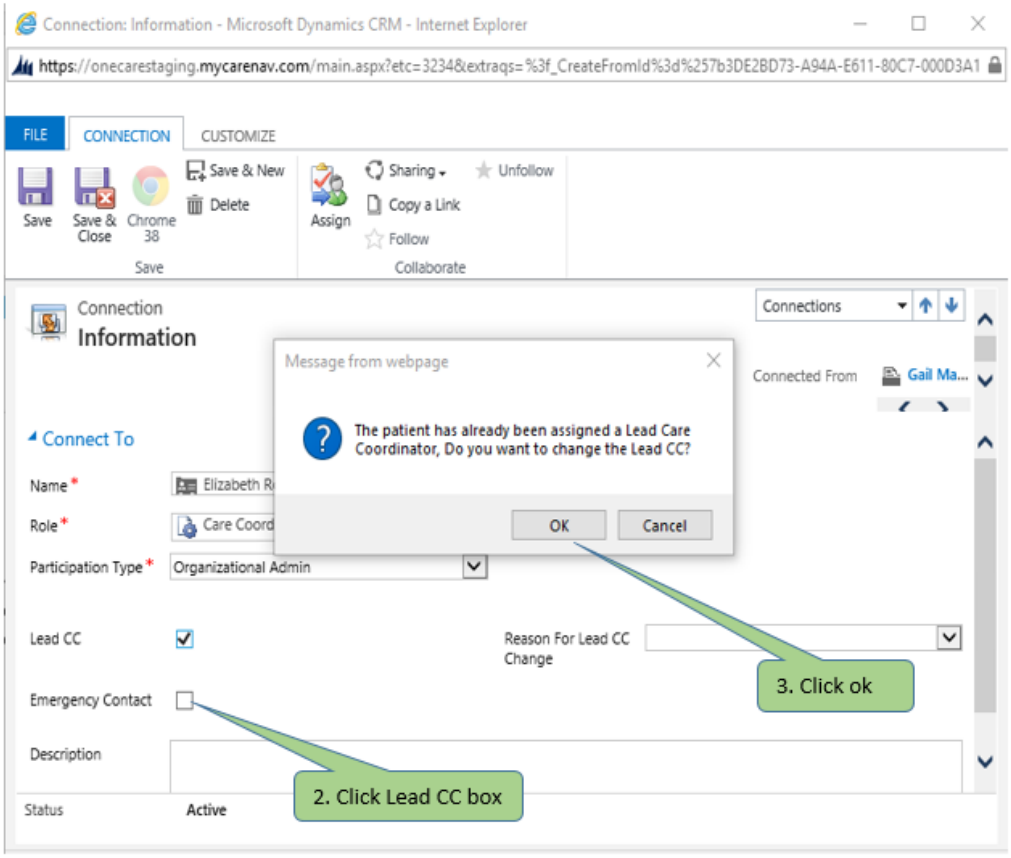

Look Up Record
Enter your search criteria.
Look for
Care Provider
Show Only My Records
Look in
All Active Care Providers
Search
Search for records
Full Name
Email
Specialty
Primary Phone
A shux608888
ashux608888@gmail....
2222
Ab Provider1
abc tests
abc tests
ABCDE FGHIJ
honey.resto@onecar...
802-847-0446
Abigail Crocker
test@123.com
Alan Beams
alan.beams@helpme...
1 - 50 of 307 (1 selected)
Page 1
6. Click New to add new non-ACO Participant
New
Add
Cancel
Remove Value

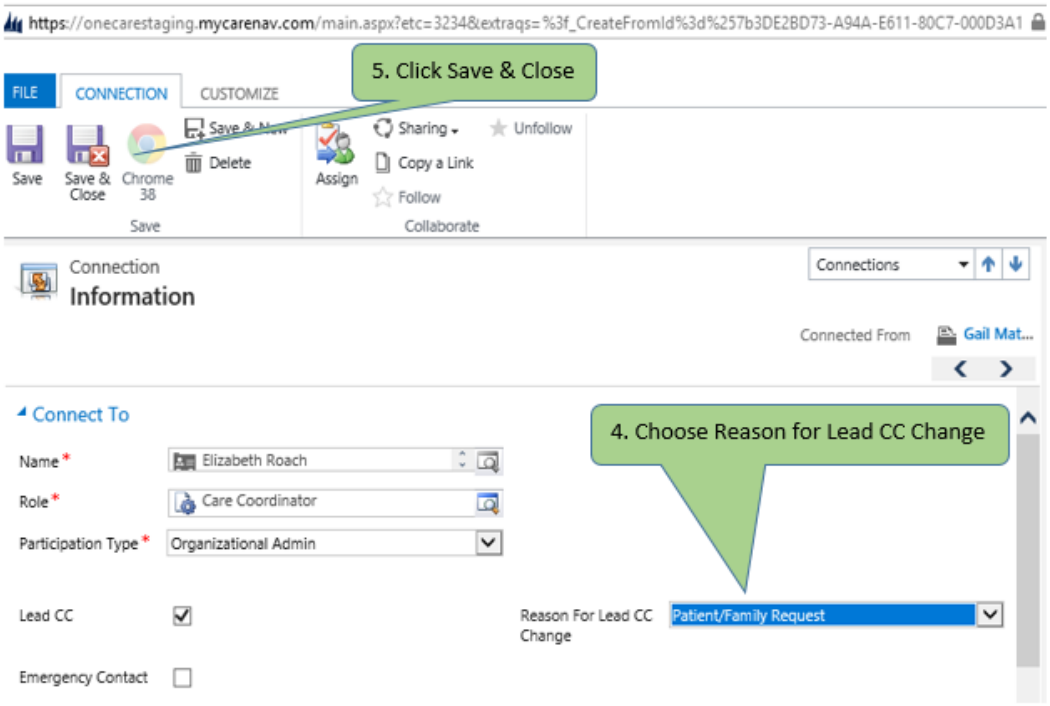


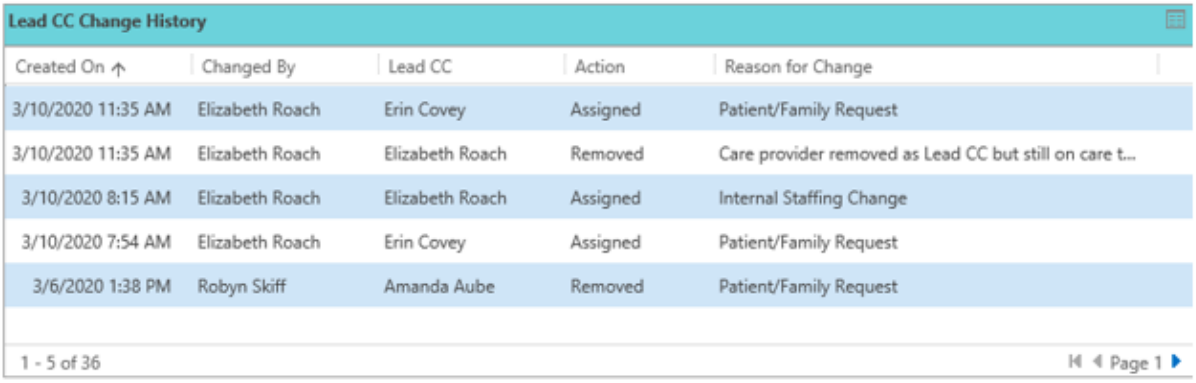


Lead Care Coordinator Tracking Changes: When making changes to the LCC you will need to indicate a reason for the change. Locate the Care Team Member's table under the Care Coordination Tab:


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
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
Save & New
Delete
Save
Assign
Sharing
Copy a Link
Follow
Unfollow
Collaborate
Connection
Information
Connections
Connected From
Gail Ma...
Message from webpage
The patient has already been assigned a Lead Care Coordinator, Do you want to change the Lead CC?
OK
Cancel
Connect To
Name *
Role *
Participation Type *
Organizational Admin
Lead CC
Reason For Lead CC Change
Emergency Contact
Description
Status
Active
3. Click ok
2. Click Lead CC box





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

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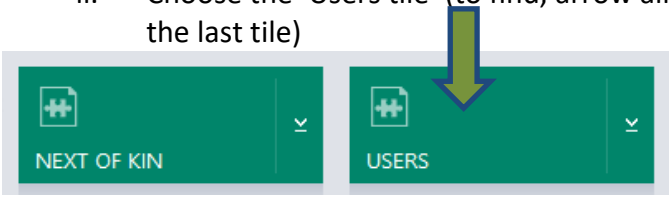
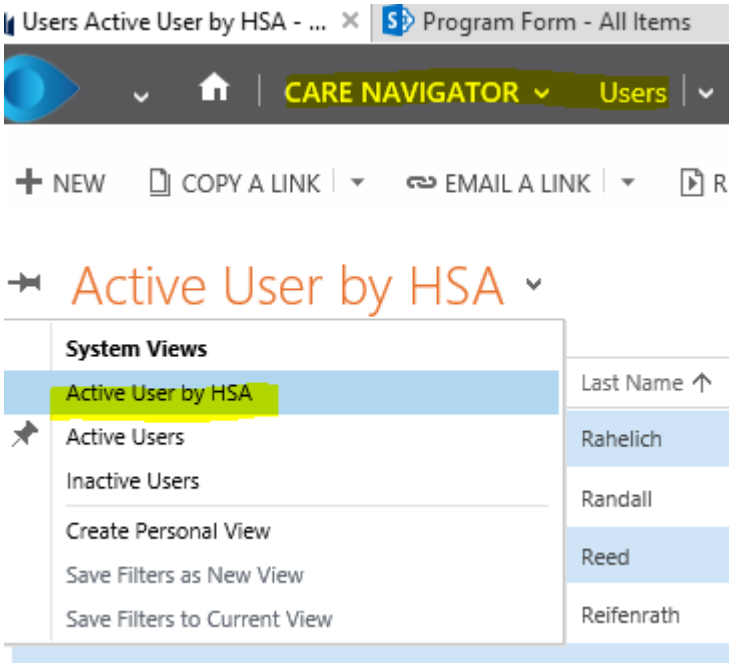
Searching for other Care Navigator Users:

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

i. Hover on the Care Navigator Icon

ii. Choose the 'Users tile' (to find, arrow all the way to the right, the 'Users' tile will be the last tile)



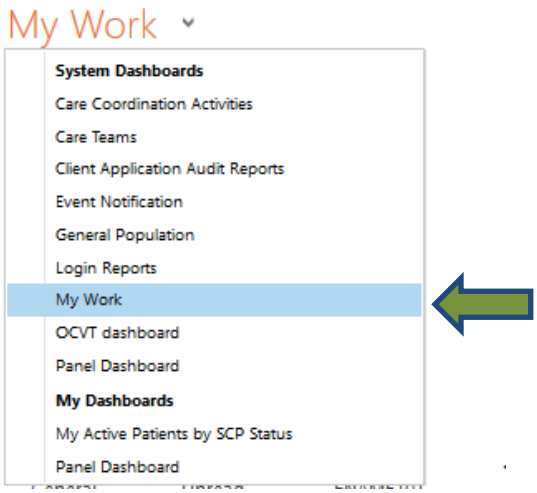


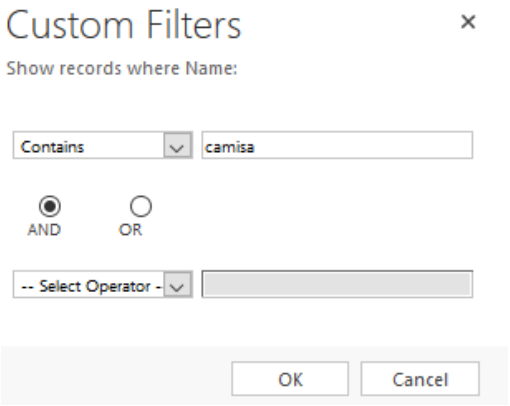
iii. You can filter by HSA in this view and export to excel if desired.

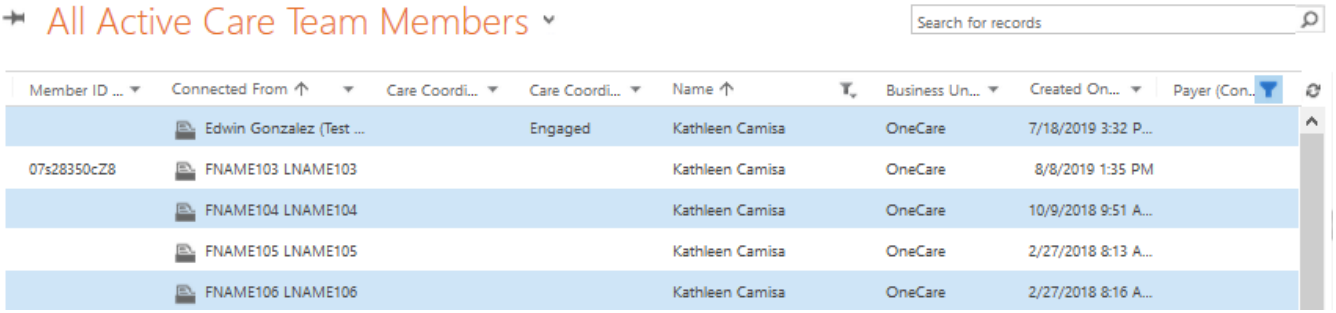
iv. Note when you click on a letter at the bottom that that will bring you to a user with the last name of the letter you click on. Example if you click on A that will give you all users with the last name that start with A.

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





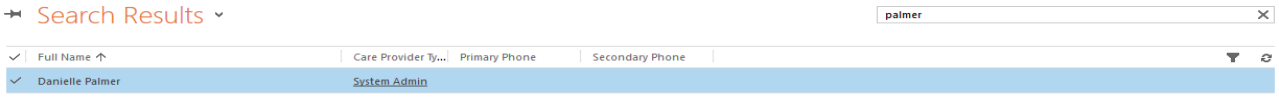


Bulk Deactivation of Care Team Members:

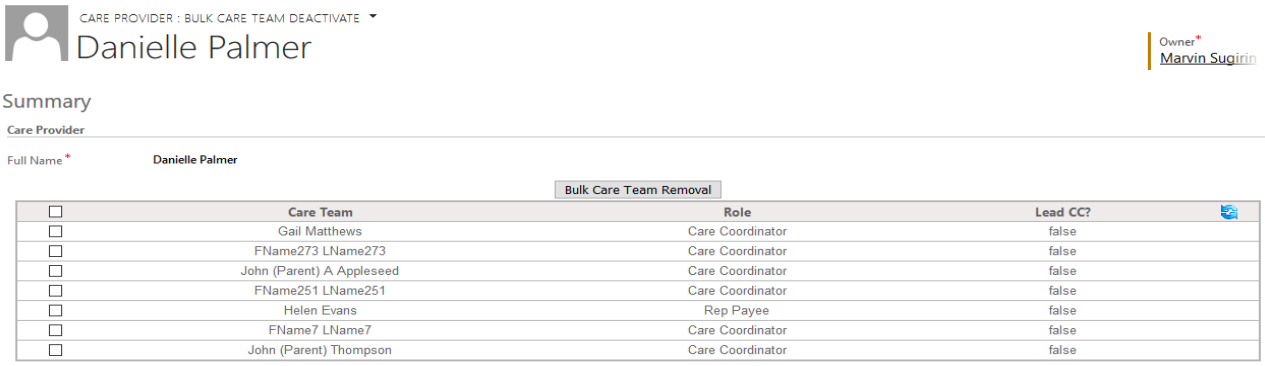
This functionality allows you to search for a care team member and deactivate them from one or multiple care teams. The care team member will receive an email indicating they have been deactivated from the team(s).

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

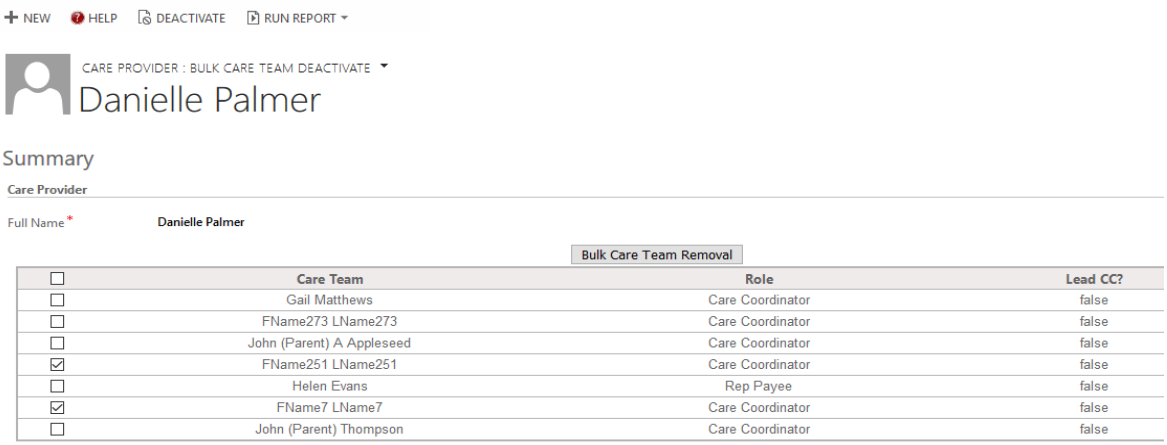
2. Search for the Care Provider using the search bar and double clink in-between the text on the blue line to open the record:



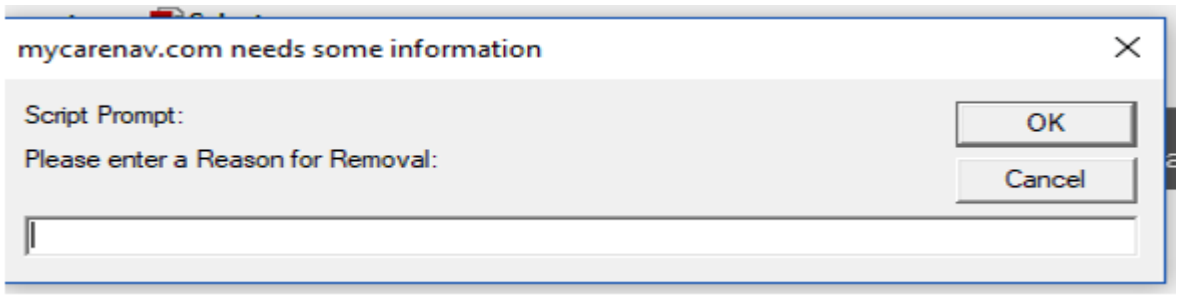
3. A list of patients the Care Provider is assigned to will appear in a list view. To start the process ensure that the Care Provider field is set to 'Bulk Care Team Deactivate':



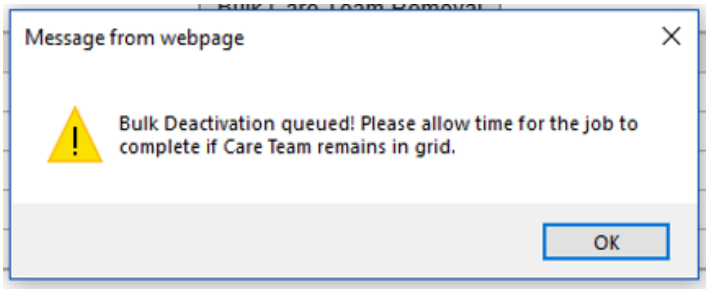
4. Click in each box to place a check mark next to those patients you wish to deactivate the care provider from, and then click on the 'Bulk Care Team Removal' box:



5. 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).



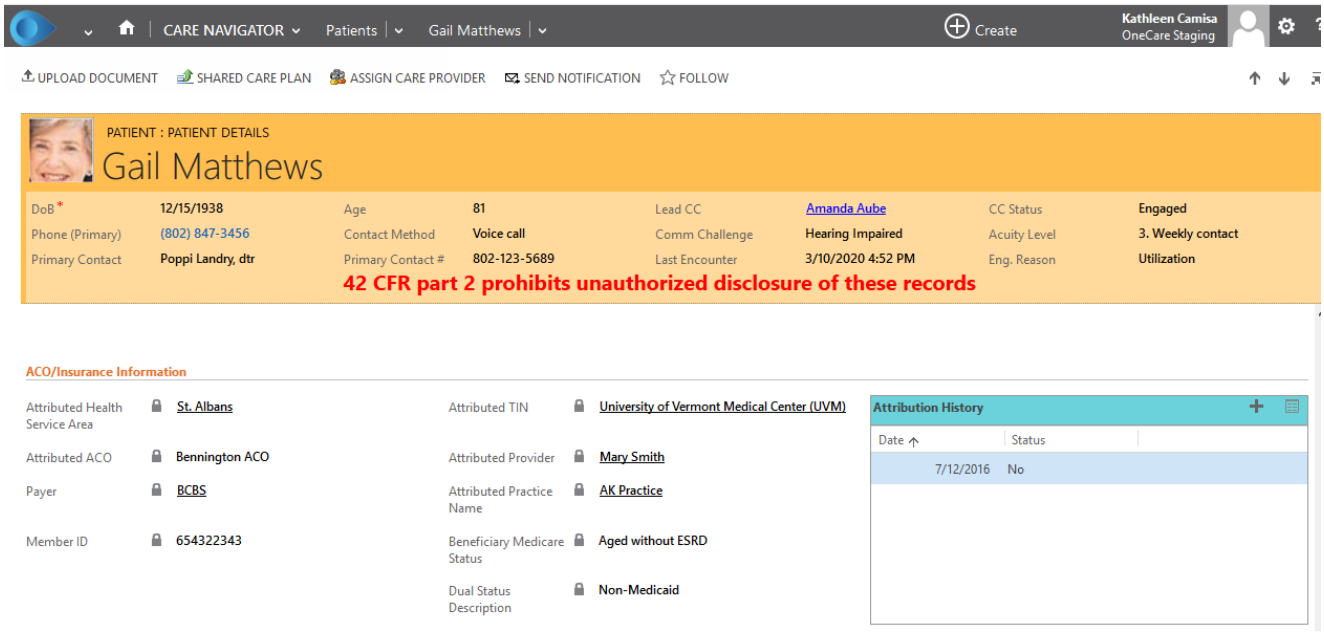
6. Click ‘OK’ in the next box to indicating the Bulk Deactivation has been queued:



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

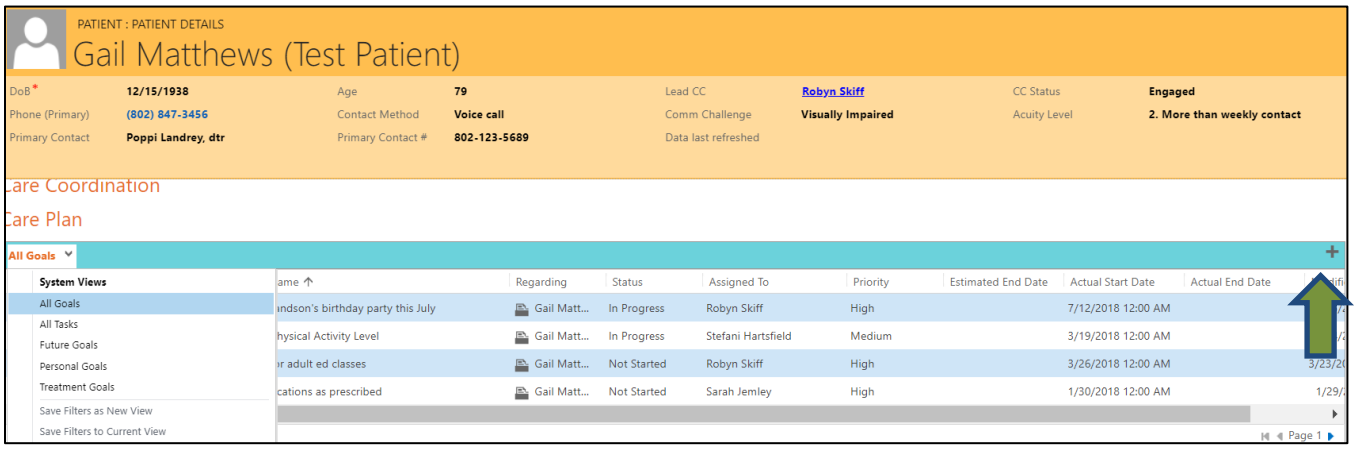
ACO Insurance Information

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.



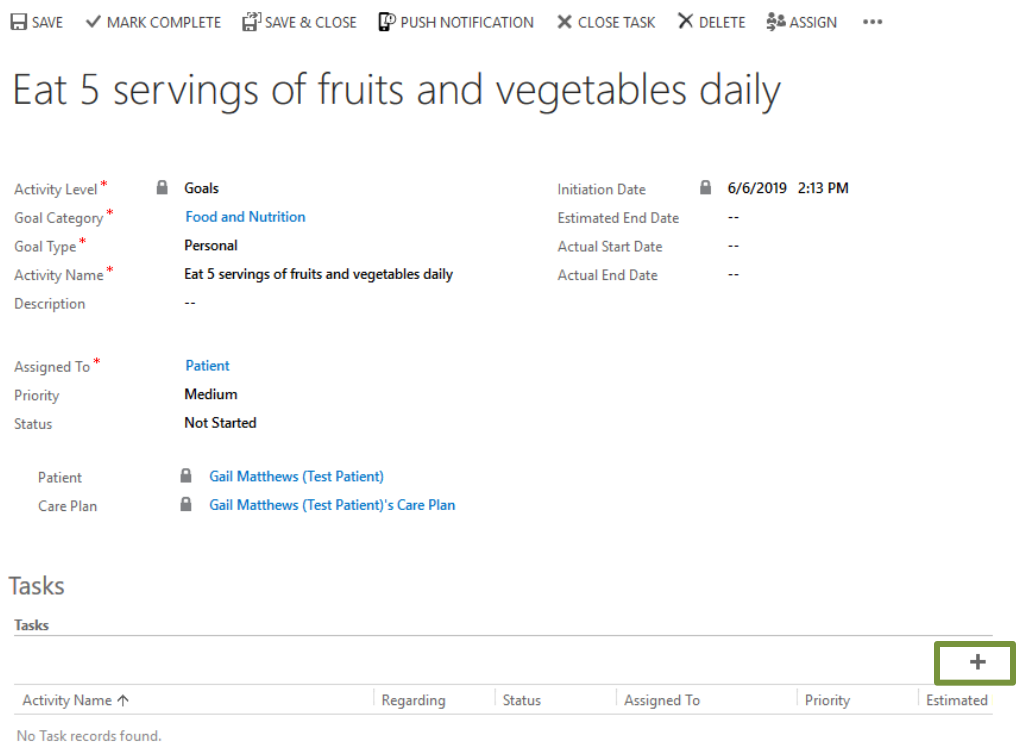
Care Plan-Adding Goals and Tasks

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.



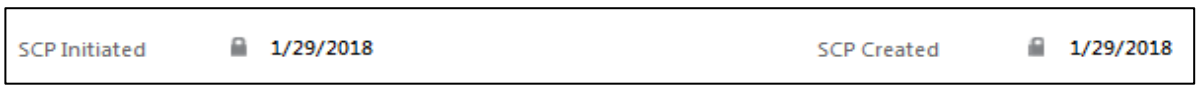
1. **Adding Goals to the Care Plan:** Under the 'Care Plan' section of the patient dashboard click on the '+' to open the menu to create a goal.
2. **Activity Level:** Choose 'Goals'
3. **Goal Category:** A list of categories taken from the Camden Domain Cards is provided to choose from, and is useful in categorizing patient goals.
4. **Goal Type:** Choose if the goal is 'Personal, Family, Treatment or Future'
5. **Activity Name:** Enter a brief description of the goal the patient wishes to achieve.
6. **Description:** More details can be written regarding the goal, but this information will not display 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 goal.
8. **Add Priority:** This will automatically be defaulted to Medium, but can be changed as appropriate to Low or High.
9. **Add Dates:** Actual start date and estimated end date
10. **Click Save:** Once the goal has been saved a task can be associated with the goal.

Adding a Task to an Established Goal:



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:



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:

a) Go the 'Challenges/Barriers' section of the Care Plan and click on the '+' sign.

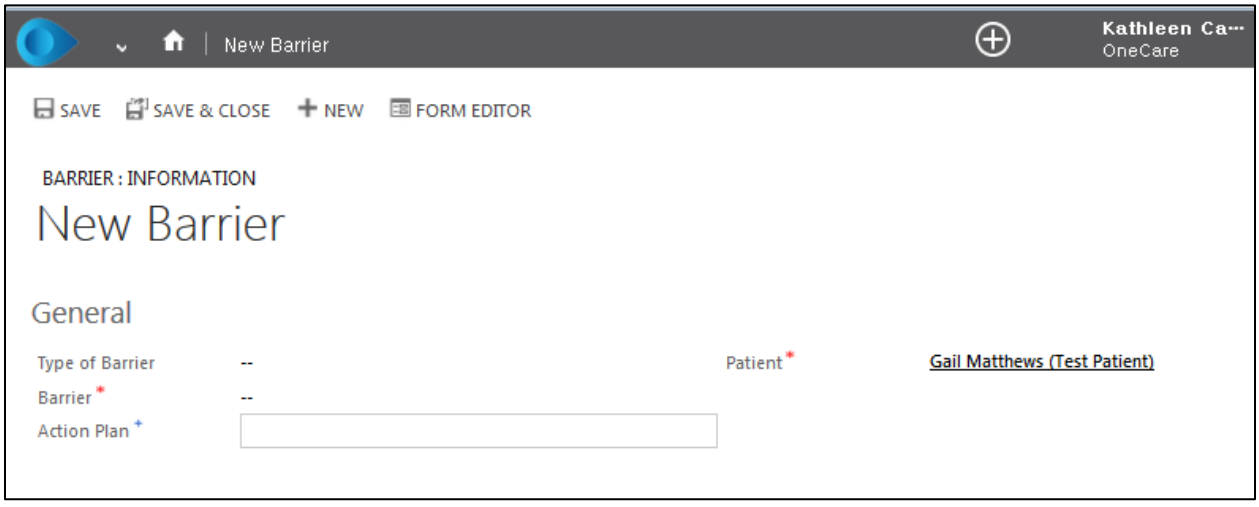
b) The 'New Barrier' Screen will be displayed

c) **Type of Barrier:** Double click on the magnifying glass to bring up the items to choose from, also listed above

d) **Barrier:** Type in a brief description of the barrier using the patient's words. This will populate on the shared care plan

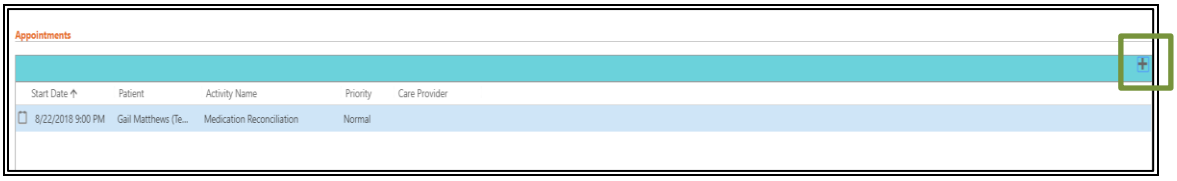
e) **Action Plan:** A description of how the barrier can be addressed

f) Click **Save & Close**

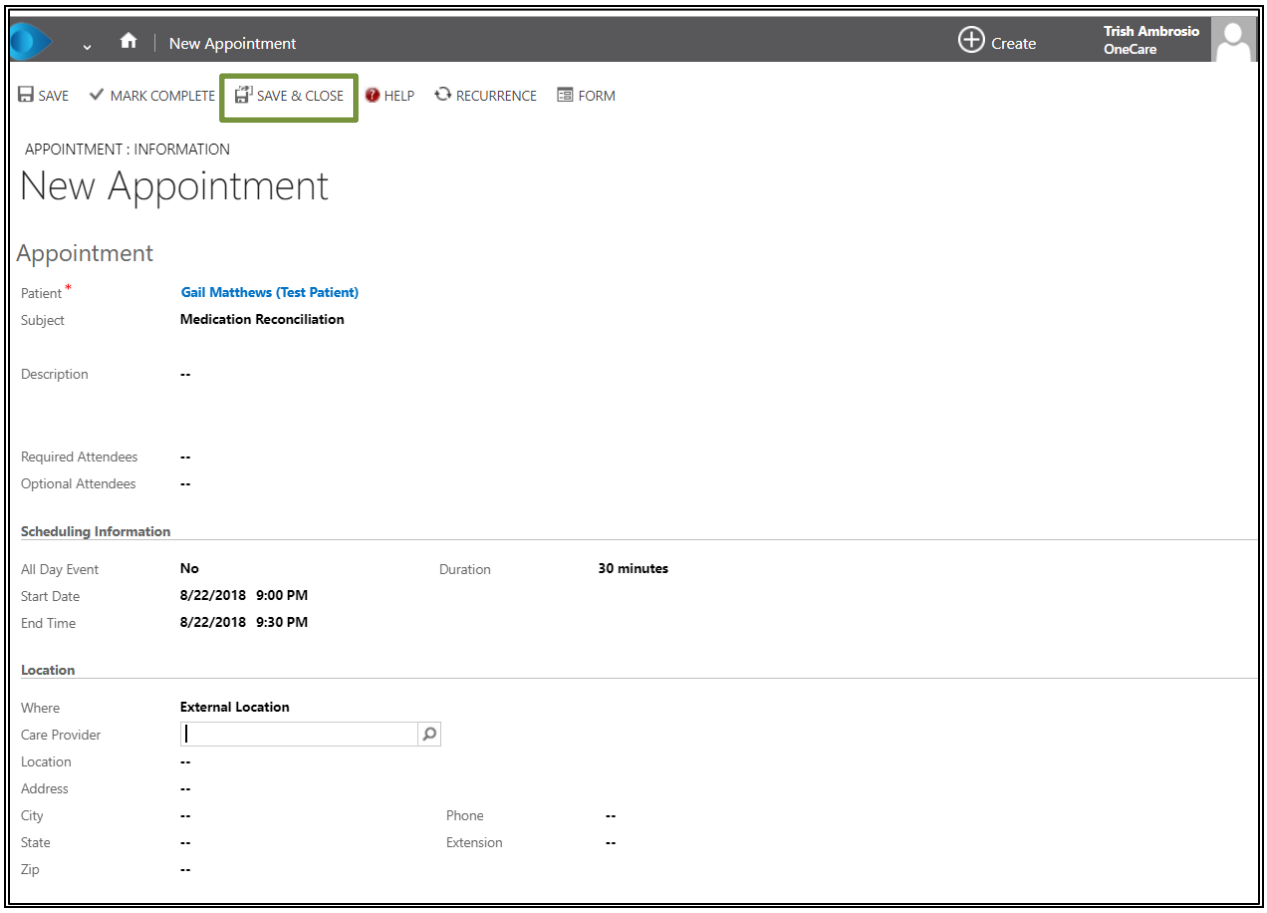


Appointments

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

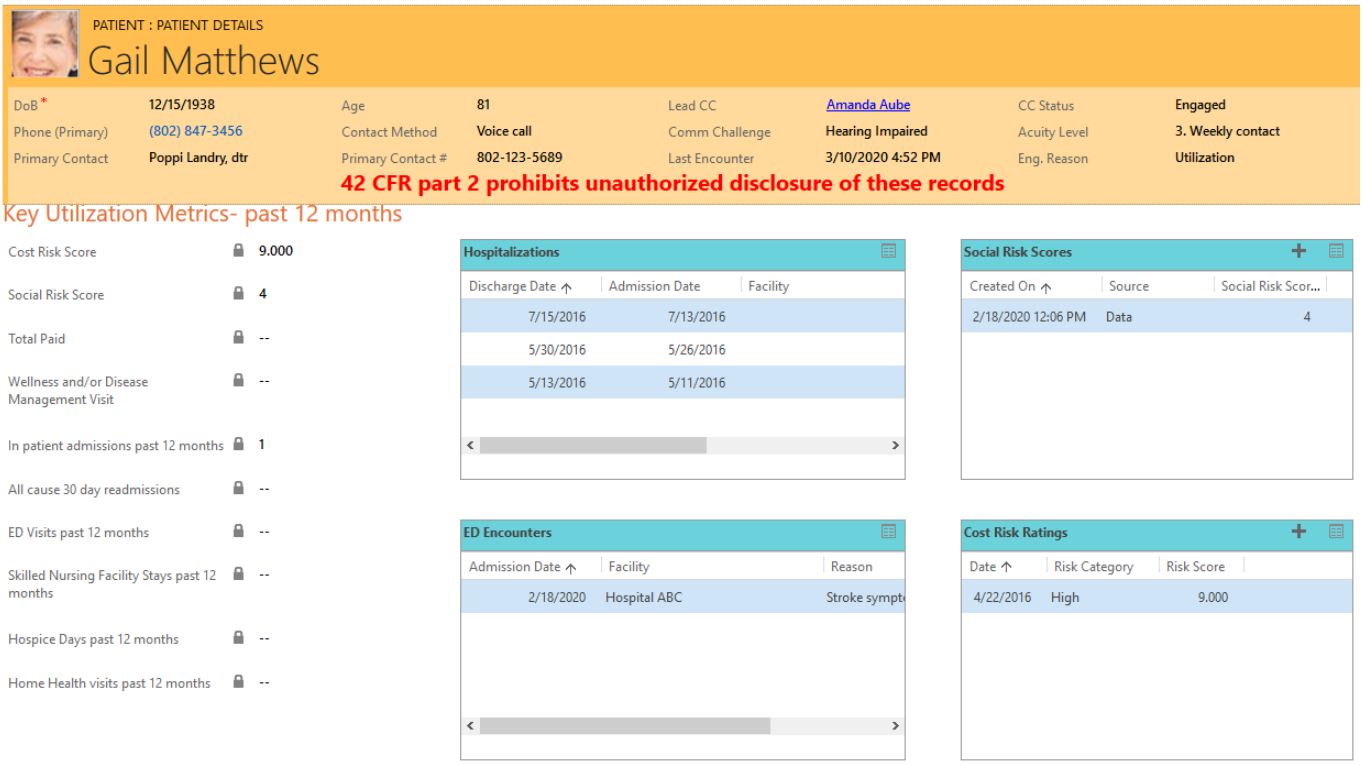


To enter a new appointment, click on the '+' sign on the right-hand side of the page. Once the new window opens enter the details of the appointment. Appointments will be displayed on the Care Navigator home page. Click Save or Save & Close to save the appointment.



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.



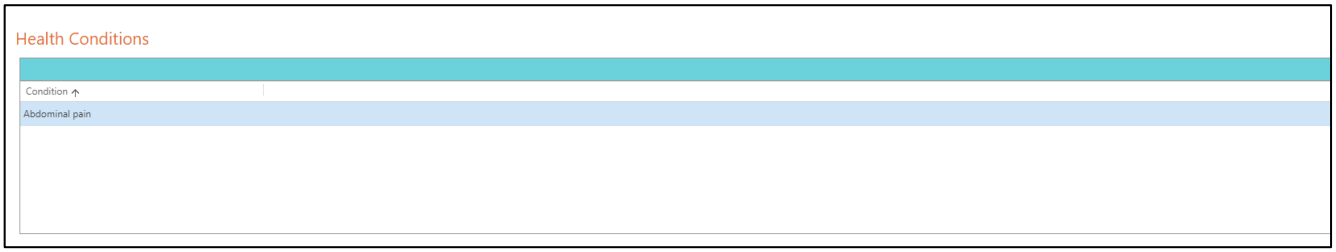
Risk Levels:

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:

a) Age and gender
b) Diagnosis (complex morbidity combinations)
c) Procedures
d) Pharmacy
e) Utilization

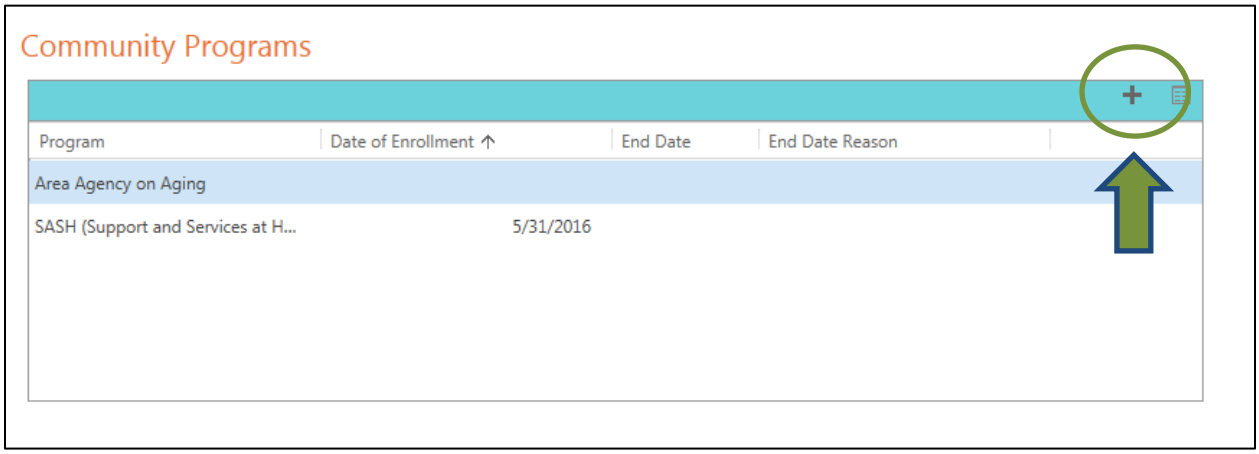
Health Conditions

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.



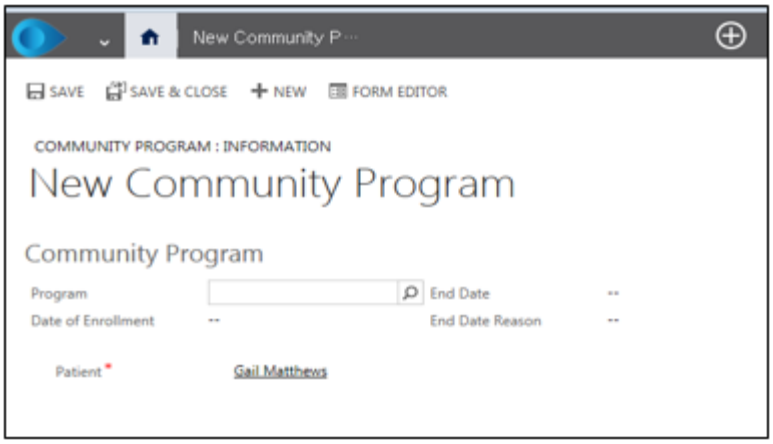
Community Programs

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.



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:

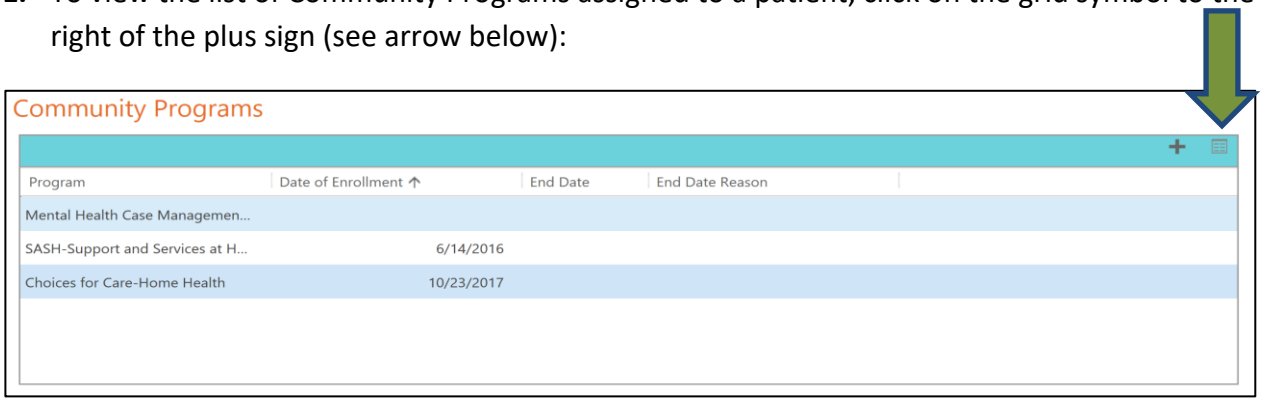


1	AAA-Area Agency on Aging/Council on Aging
2	Adult Day Health
3	Alcohol/Substance Use Support Program
4	Choices for Care-Area Agency on Aging (AAA)
5	Choices for Care-Home Health
6	CIS-Children's Integrated Services
7	Community Action
8	CSHN- Children with Special Health Needs
9	DCF-Department of Children 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

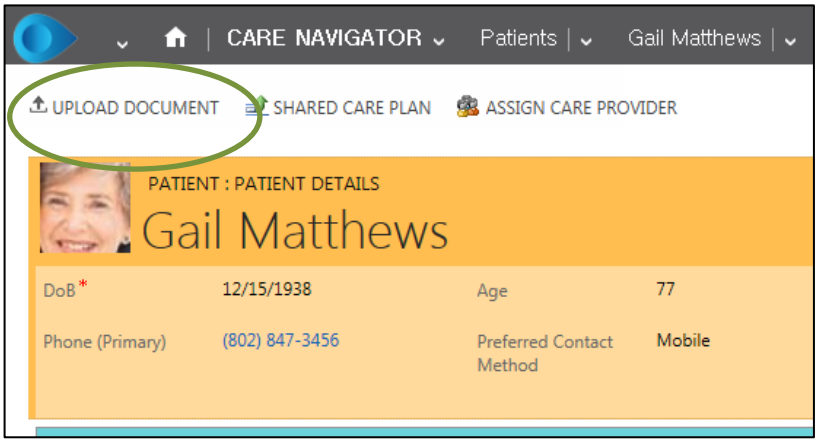
1. To view the list of Community Programs assigned to a patient, click on the grid symbol to the right of the plus sign (see arrow below):



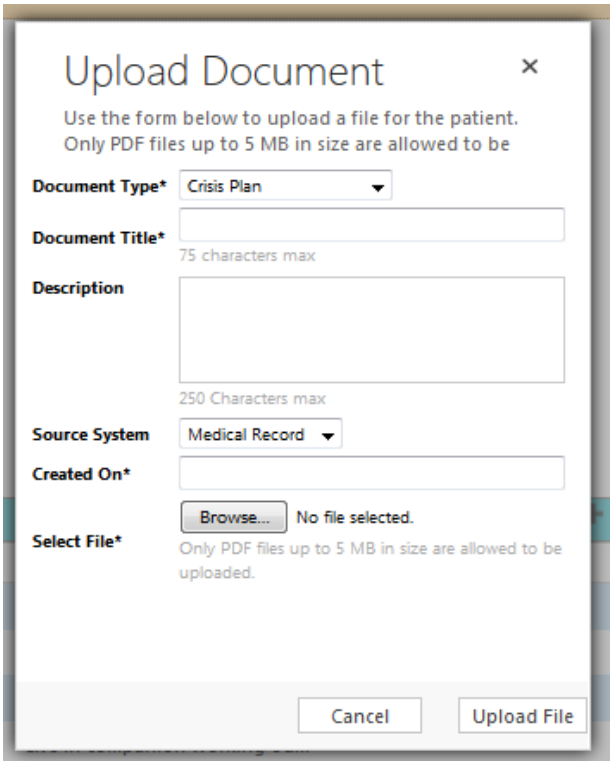
Documents

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:

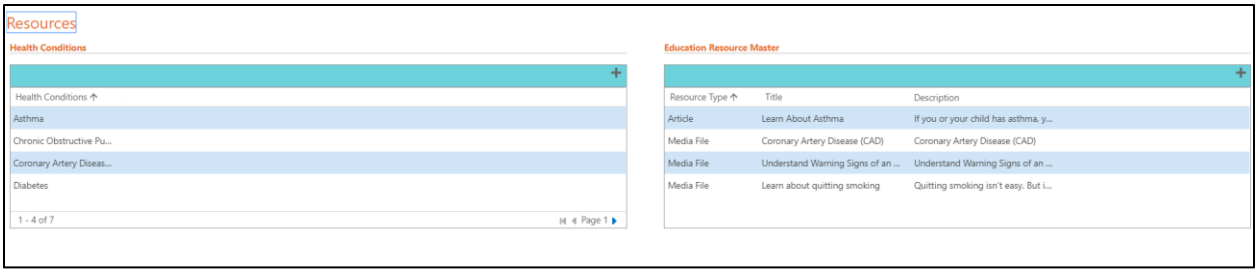


2. A pop-up box will appear. Complete the requested fields and choose 'Upload File'. Note that only PDF files can be uploaded.



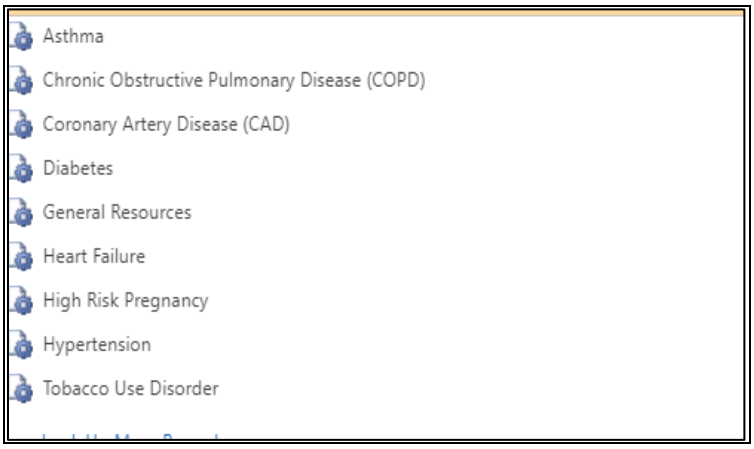
Resources

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'.



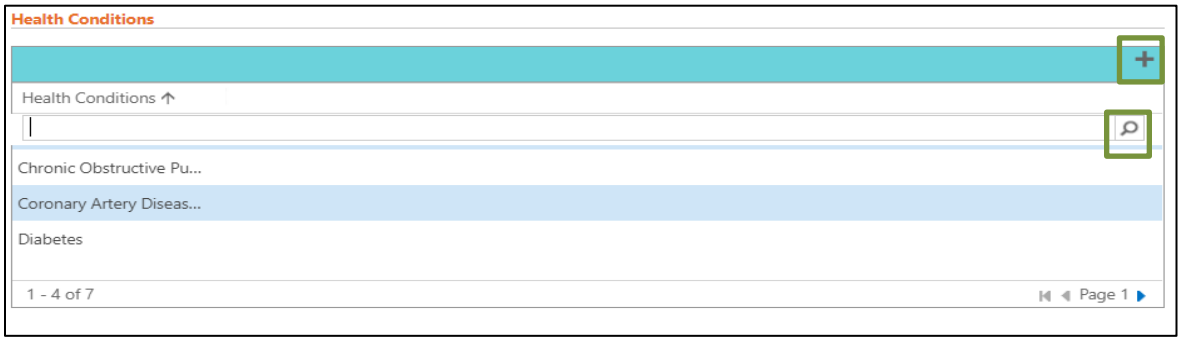
Health Conditions:

Currently, nine Disease Panels can be selected including:



To assign a Health Condition to a patient:

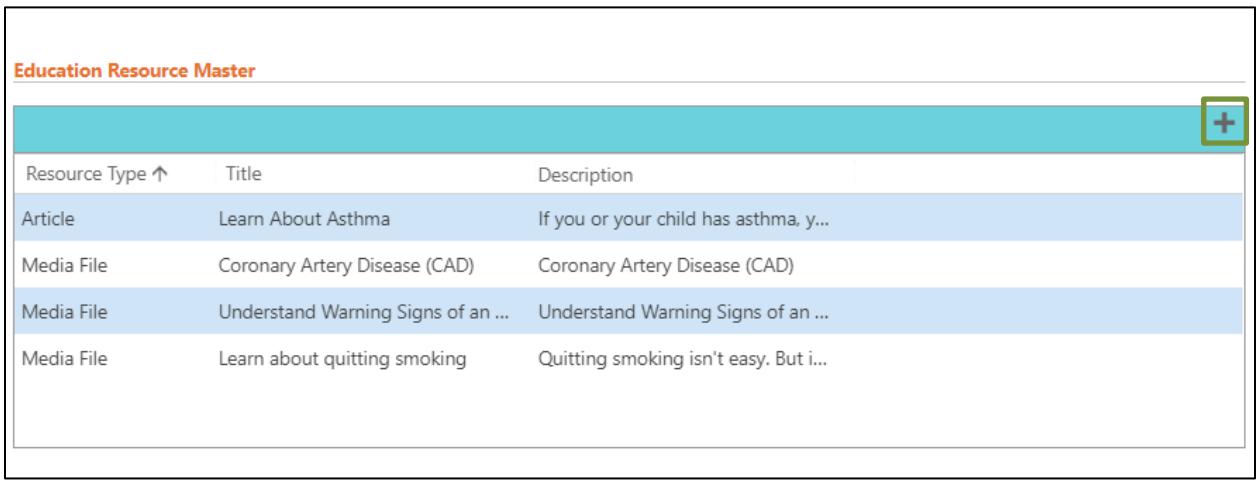
1. Click on the plus '+' sign on the upper right-hand side of the Health Conditions grid. A new line will appear.
2. Click on the magnifying glass on the right-hand side to choose from the list of possible health conditions.
3. Select applicable condition.



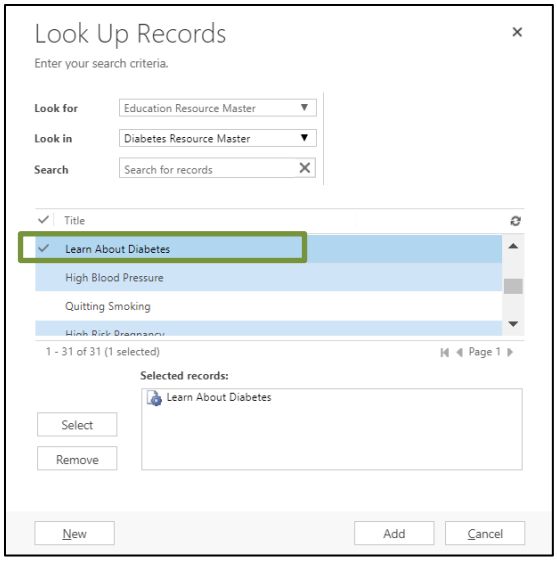
Education Resource Master

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:



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.

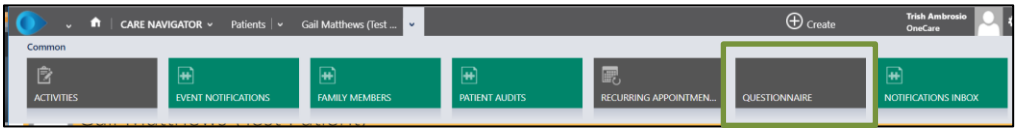


Assessments/Questionnaires

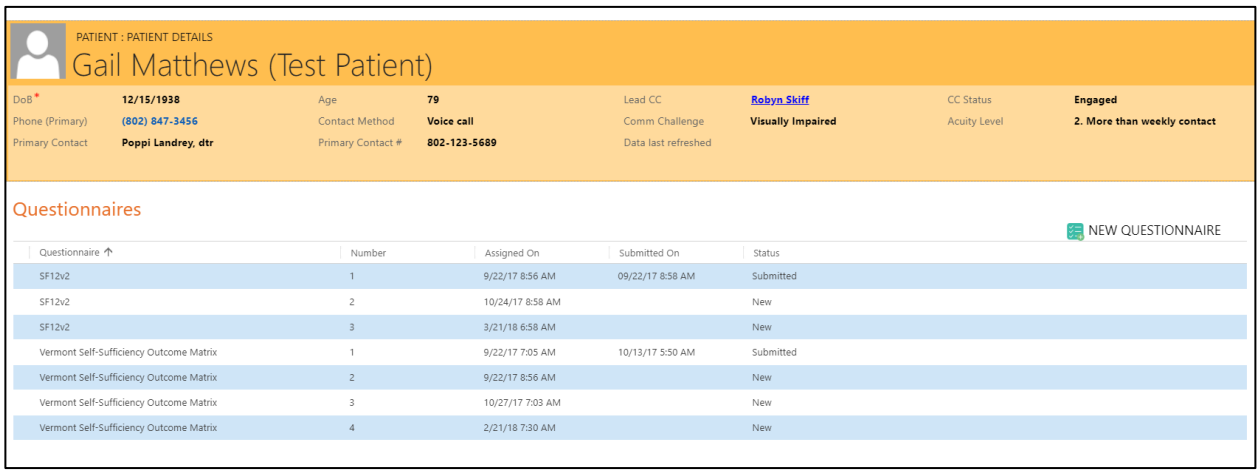
Embedded Questionnaires

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:

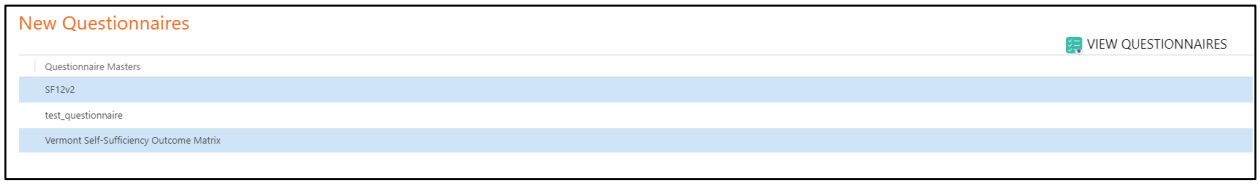
1. Click on the down arrow to the right of the Patient Name.



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



3. A list of questionnaires taken by the patient will show in the next screen
   a. Number: The version of the questionnaire taken is indicated
   b. Assigned On: The date and time the questionnaire was initiated
   c. Submitted on: If the questionnaire was completed, the date and time of completion is listed
   d. 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.



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

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