



OneCare Vermont

## Care Navigator User Guide

07/9/2020

Version 2.3

# 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](mailto: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](mailto:HelpDesk@OneCareVT.org)

- 4.2. **Notification of Access:** Once your request is processed you will receive the email notification below from the following email address: [no-reply@mycarenav.com](mailto: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](mailto: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)

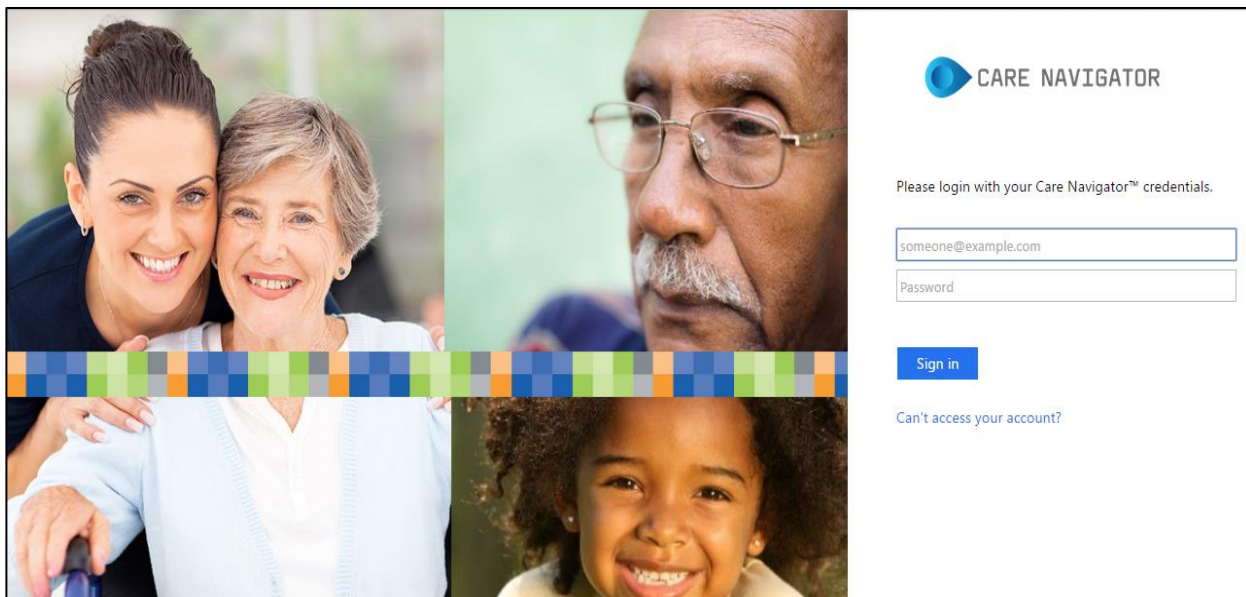
**Google Chrome**

**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.

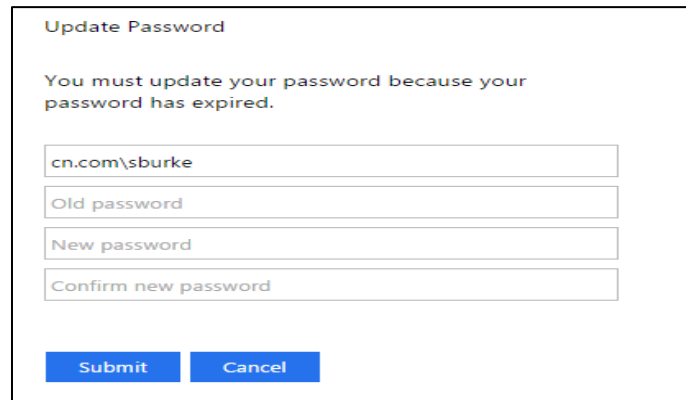
Please login with your Care Navigator™ credentials.

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:

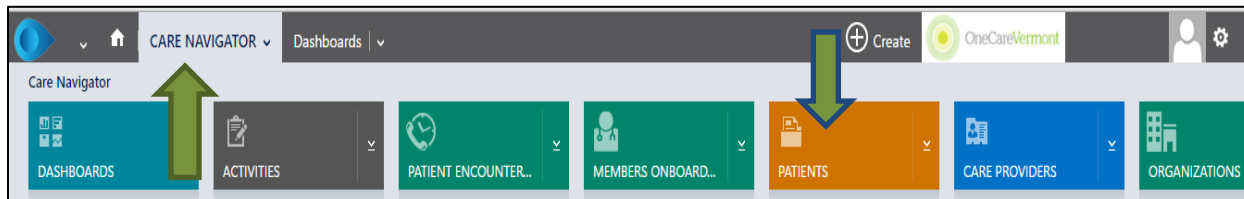
1. Age Group
2. Geographic Area
3. Hospital and Medical Practice
4. Insurance Plan

## Level II Users

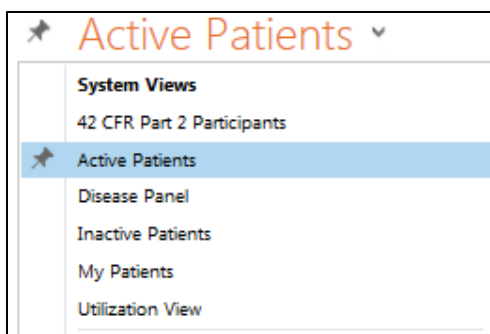
### List of Active Patients:

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

gail\*matthew

**6. Searching for Inactive Patients:**

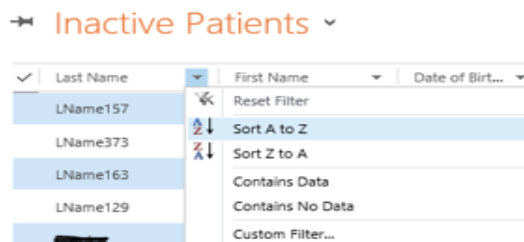
- i. Change to Inactive Patients view at dropdown and turn on filter:

→ Inactive Patients

Search for records

| ✓ | 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   | 3/10/1931       |           |               |                          | Stacia Sirois  |                     |                                |                     |                          |                     |                   |
|   | LName163  | FName163   | 5/3/1931        |           |               | 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 LName157

AND OR

-- Select Operator --

OK Cancel

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


→ Inactive Patients

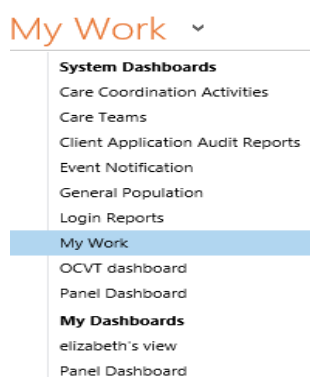
| ✓ | Last Name | First Name | Date of Birt... | Member ID... | Risk Catego... | Care Coordination Sta... |
|---|-----------|------------|-----------------|--------------|----------------|--------------------------|
|   | LName157  | FName157   | 5/8/1930        |              |                | Moved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

# Care Coordinators

## My Work

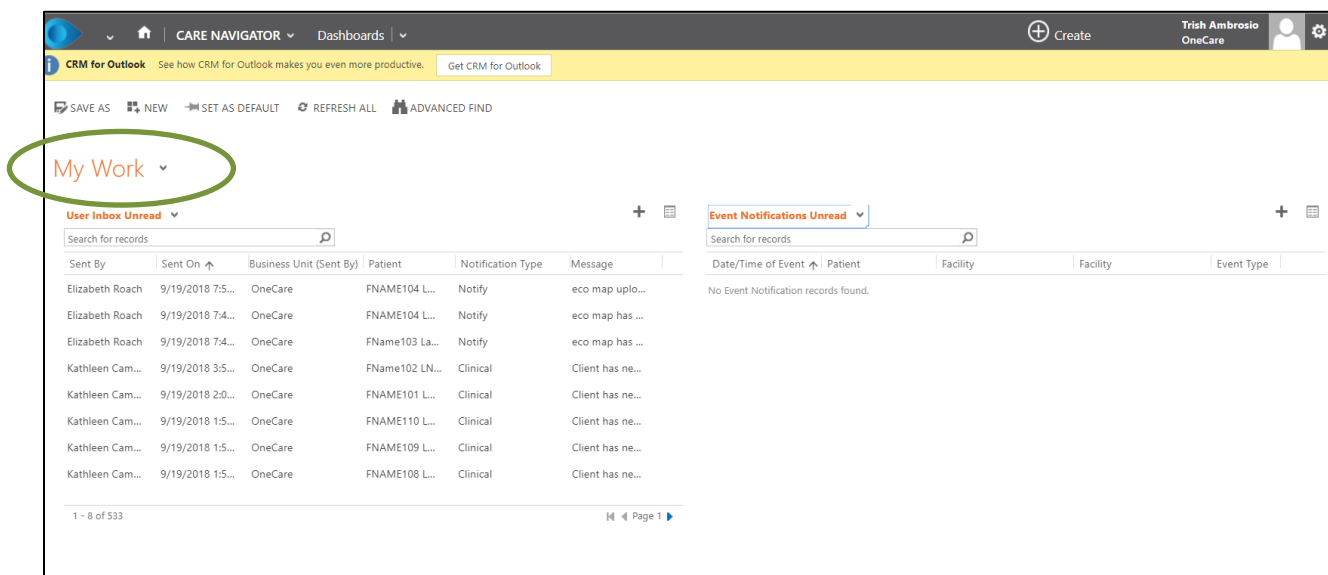
Care coordinators are assigned patients by Level II Users or **by someone with** OCV Level of Access, and will only have access to patients assigned to them. When the user logs in, they come to the My Work screen, which gives an overview of the following sections: User Inbox Unread, Event Notifications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



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



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

**User Inbox Unread** + ☰

Search for records 🔍

| 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 Page 1

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: **Read** ⌵

Care Team Notific: **Read**


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** ☰

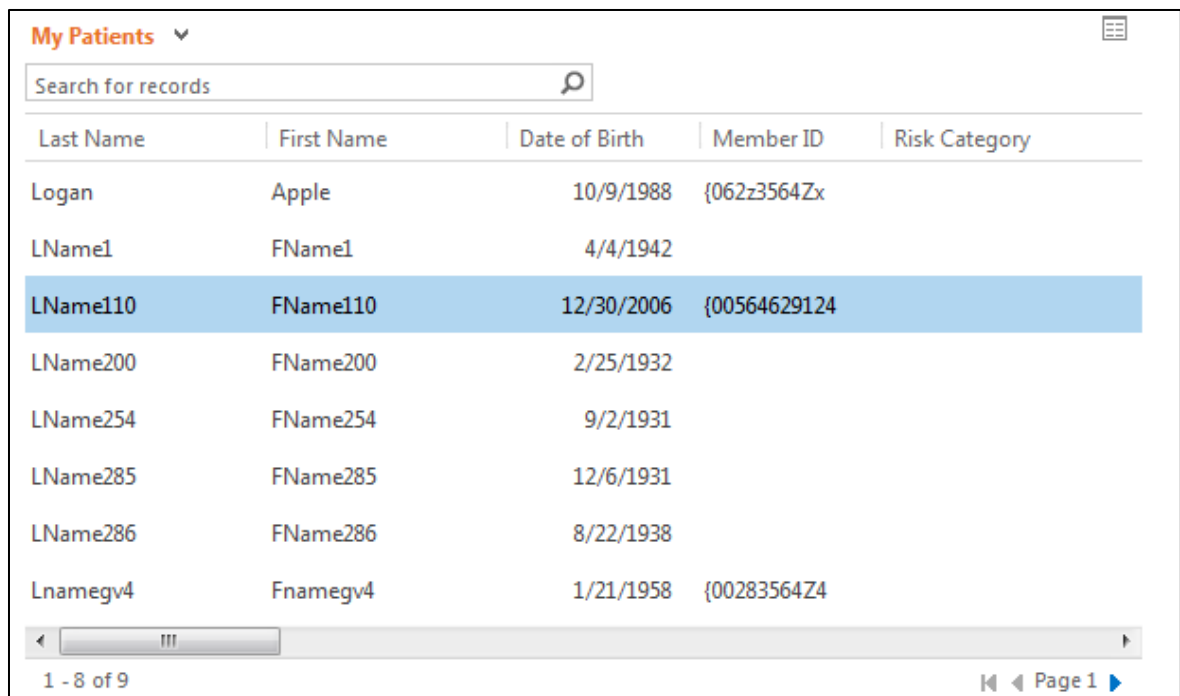
Search for records 🔍

| 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:

+ NEW ✉ MARK READ ⬅ 📧 EMAIL A LINK

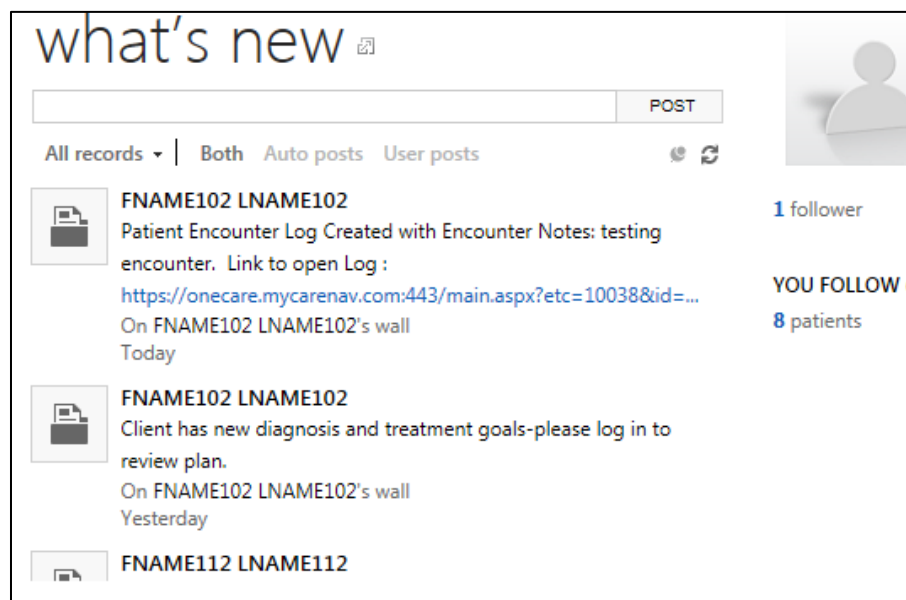
5. **My Active Patients:** This section contains a list of patients whose care team you have been assigned to.



The screenshot shows the 'My Patients' section of a software interface. At the top, there is a search bar labeled 'Search for records' with a magnifying glass icon. Below the search bar is a table with five columns: 'Last Name', 'First Name', 'Date of Birth', 'Member ID', and 'Risk Category'. The table contains several rows of patient data. The row with 'LName110' and 'FName110' is highlighted in blue. At the bottom of the table, there is a pagination bar showing '1 - 8 of 9' and a 'Page 1' indicator with navigation arrows.

| 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  |               |

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



The screenshot shows the 'what's new' feed interface. At the top, there is a search bar and a 'POST' button. Below the search bar, there are tabs for 'All records', 'Both', 'Auto posts', and 'User posts'. The feed displays several posts from patients. The first post is from 'FNAME102 LNAME102' and mentions a 'Patient Encounter Log Created with Encounter Notes: testing encounter'. The second post is also from 'FNAME102 LNAME102' and mentions 'Client has new diagnosis and treatment goals-please log in to review plan.' The third post is from 'FNAME112 LNAME112'. On the right side of the feed, there is a profile picture placeholder and text indicating '1 follower' and 'YOU FOLLOW (8 patients)'.

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

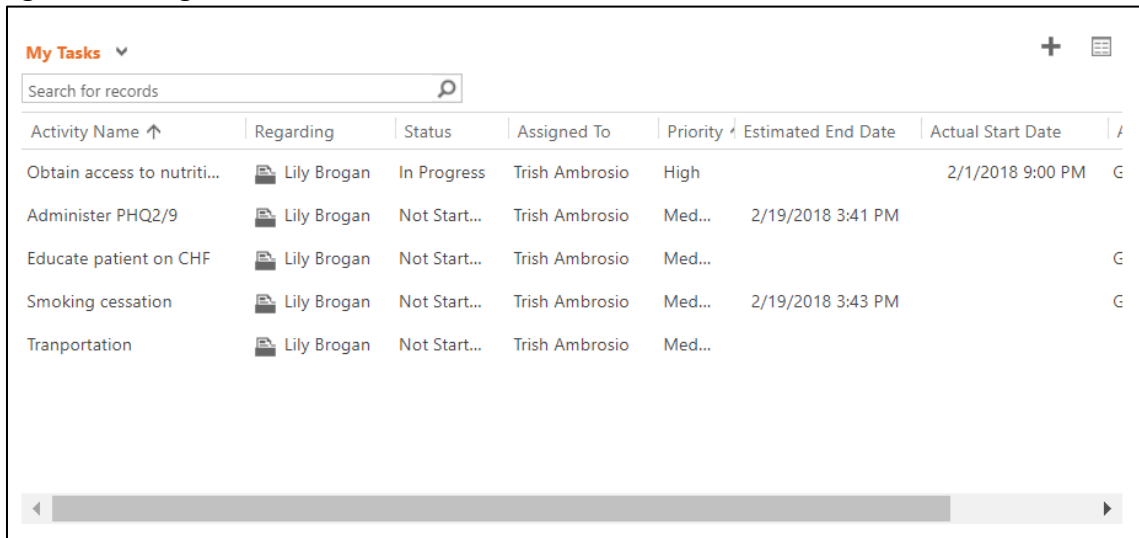
My Appointments

+

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.



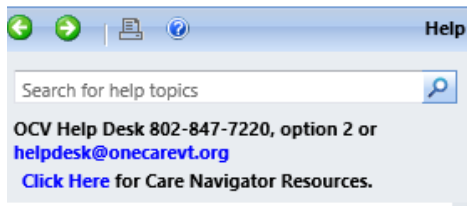
**My Tasks** + [Menu Icon]

Search for records [Search Icon]

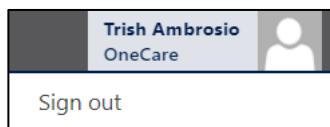
| Activity Name ↑             | Regarding   | Status       | Assigned To    | Priority ↓ | Estimated End Date | Actual Start Date |   |
|-----------------------------|-------------|--------------|----------------|------------|--------------------|-------------------|---|
| Obtain access to nutriti... | 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...     |                    |                   |   |

[Scroll Bar]



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 ▾<br> Gail Matthews |                   |                   |  |                |                              |              |                    |
| DoB *  | 12/15/1938        | Age               | 81   | Lead CC        | <a href="#">Jim5 Burris5</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM            | Eng. Reason  | Medical Complexity |

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 Danielle Palmer OneCare Staging   

 UPLOAD DOCUMENT  SHARED CARE PLAN  ASSIGN CARE PROVIDER  SEND NOTIFICATION  FOLLOW

|  |                   |                   |   |                |                              |              |                    |
|--|-------------------|-------------------|---|----------------|------------------------------|--------------|--------------------|
| PATIENT : PATIENT DETAILS ▾<br> Gail Matthews |                   |                   |   |                |                              |              |                    |
| DoB *  | 12/15/1938        | Age               | 81  | Lead CC        | <a href="#">Jim5 Burris5</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM            | Eng. Reason  | Medical Complexity |

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

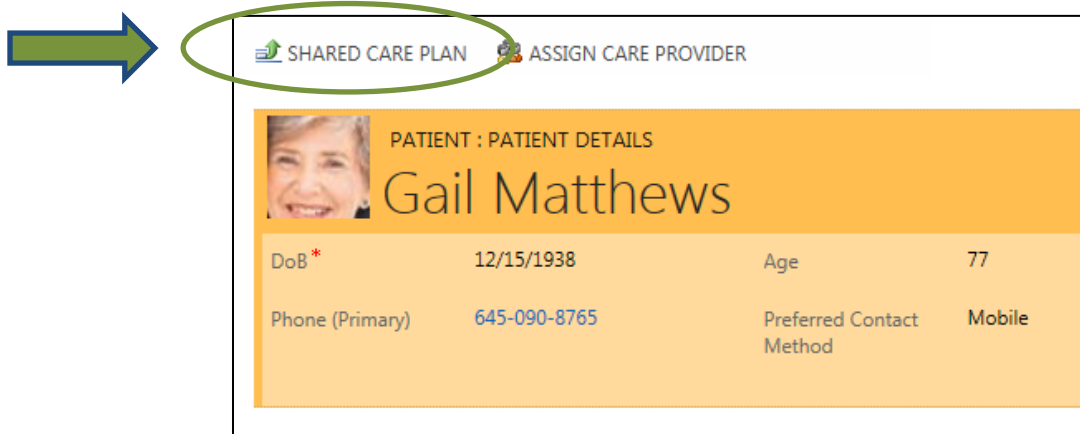
Resources

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

| Insurance Information |                                  |                      |
|-----------------------|----------------------------------|----------------------|
| Primary Insurance:    | Current PCP:<br>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<br>breath and has gained 5+ pounds she needs to<br>contact her cardiologist. | Crisis Plan Uploaded: Yes |

| About Me  |   |
|---|---|
| Preferred activities: I like to garden and love<br>roses                              | Tips to avoid triggers/behaviors: Please be on time.  |
| How I learn: I like to listen first and have written<br>material for later            | Physical Mobility: Limited Assistance uses a cane   |
| Interaction tips: Spend some time talking with<br>me before discussing my care        | Mode of transportation: Transportation Agency   |
| Communication style: I do best with slow<br>communication. Repeating is also helpful. | Important Family information: I need a family member present<br>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:<br>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         | Race                                  | --               |
| Preferred Name    | Poppy            | Preferred Language other than English | English          |
| Date of Birth*    | 12/15/1938       | Communication Challenge               | Hearing Impaired |
| Marital Status    | Married          | COLST                                 | Yes              |
| Current PCP       | Dr. Sandra Jones |                                       |                  |
| Advance Directive | No               |                                       |                  |

#### 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<br>St. Albans<br><br>05478<br>Franklin | Mailing Address   | Po Box 346<br>St Albans<br>Vermont<br>05478<br>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 found in the Care Coordination section of the patient record, as displayed below:

PATIENT : PATIENT DETAILS ▾  
 **Gail Matthews**

|                 |                   |                   |              |                |                              |              |                    |
|-----------------|-------------------|-------------------|--------------|----------------|------------------------------|--------------|--------------------|
| DoB *           | 12/15/1938        | Age               | 81           | Lead CC        | <a href="#">Jim5 Burris5</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM            | Eng. Reason  | Medical Complexity |

### Care Coordination

42 CFR Part 2 ☒  
 42 CFR Part 2 Signed Date 2/21/2020


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

PATIENT : PATIENT DETAILS ▾  
 **Gail Matthews**

|                 |                   |                   |              |                |                              |              |                    |
|-----------------|-------------------|-------------------|--------------|----------------|------------------------------|--------------|--------------------|
| DoB *           | 12/15/1938        | Age               | 81           | Lead CC        | <a href="#">Jim5 Burris5</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM            | Eng. Reason  | Medical Complexity |

### Care Coordination

42 CFR Part 2 ☒  
 42 CFR Part 2 Signed Date 2/21/2020

42 CFR part 2 prohibits unauthorized disclosure of these records

## Entering a Note

### Patient Details

#### General

|                   |                  |                                       |                  |
|-------------------|------------------|---------------------------------------|------------------|
| First Name        | Gail             | Gender *                              | Female           |
| Middle Initial    | --               | Identified Gender                     | Female           |
| Last Name *       | Matthews         | Race                                  | --               |
| Preferred Name    | Poppy            | Preferred Language other than English | English          |
| Date of Birth *   | 12/15/1938       | Communication Challenge               | Hearing Impaired |
| Marital Status    | Married          | COLST                                 | Yes              |
| Current PCP       | Dr. Sandra Jones |                                       |                  |
| Advance Directive | No               |                                       |                  |


Activities and Notes

| POSTS  | NOTES |
|--|-------|
| Enter a note   |       |
| Received information from Gail and Robyn to attend care conference next week. To attend on Friday morning-looking forward to it.<br>Dan Fanelli - Thursday, June 24, 2020 7:27:40 PM |       |

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.





**Activities and Notes**

POSTS ACTIVITIES NOTES

Enter post here POST

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 X  
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 ▾<br><b>Gail Matthews</b> |                   |                   |              |                |                            |              |                    |
| DoB *  | 12/15/1938        | Age               | 81           | Lead CC        | <a href="#">Jims Burns</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM          | Eng. Reason  | Medical Complexity |

Patient Details

Care Team Notifications

Event Notifications

| Event Notifications Unread ▾ |                   |                      |                      |              |  |
|------------------------------|-------------------|----------------------|----------------------|--------------|--|
| 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':

## 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'.

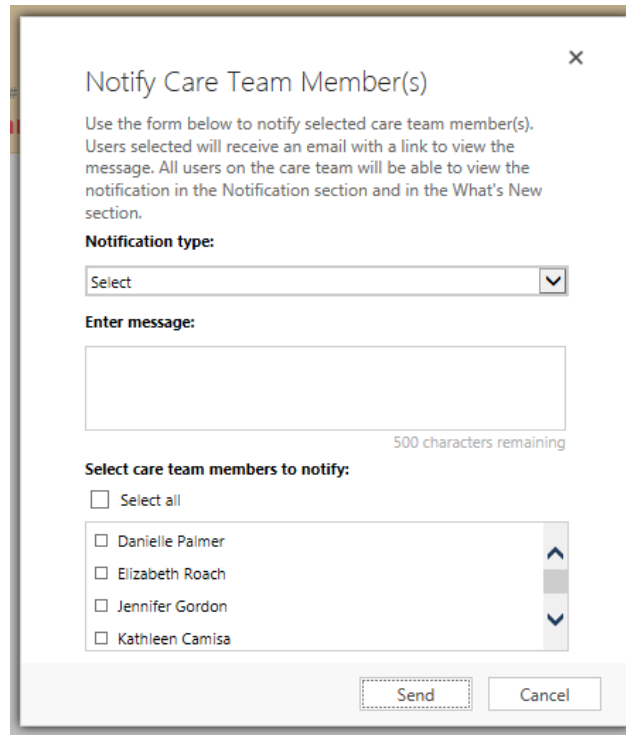
To Send a Care Team Notification:

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:

| PATIENT : PATIENT DETAILS ▾ |                   |                   |              |                |                              |              |                    |
|-----------------------------|-------------------|-------------------|--------------|----------------|------------------------------|--------------|--------------------|
| DoB *                       | 12/15/1938        | Age               | 81           | Lead CC        | <a href="#">Jim S. Burns</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM            | Eng. Reason  | Medical Complexity |

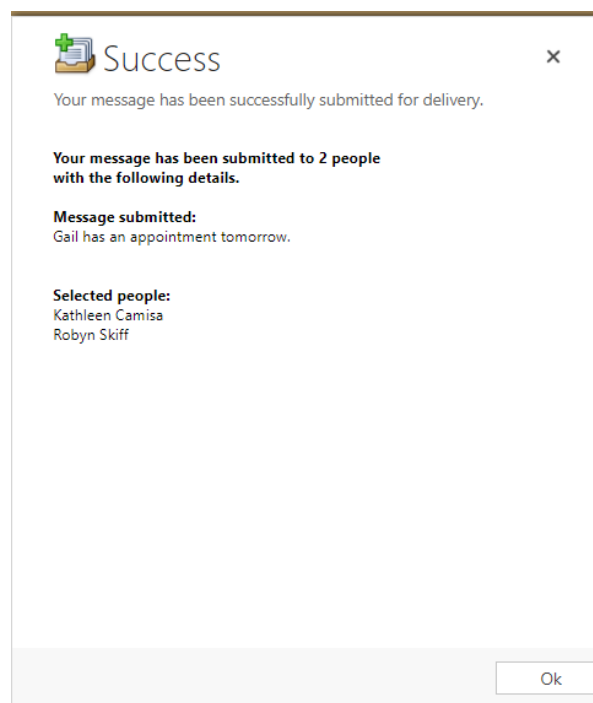
7. Select a Notification Type using the drop down on the right.
8. Enter a simple message with no protected health information. No more than 500 characters
9. A User can select either specific Care Team Members or all Care Team Members by choosing 'Select All' to send the notification to

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



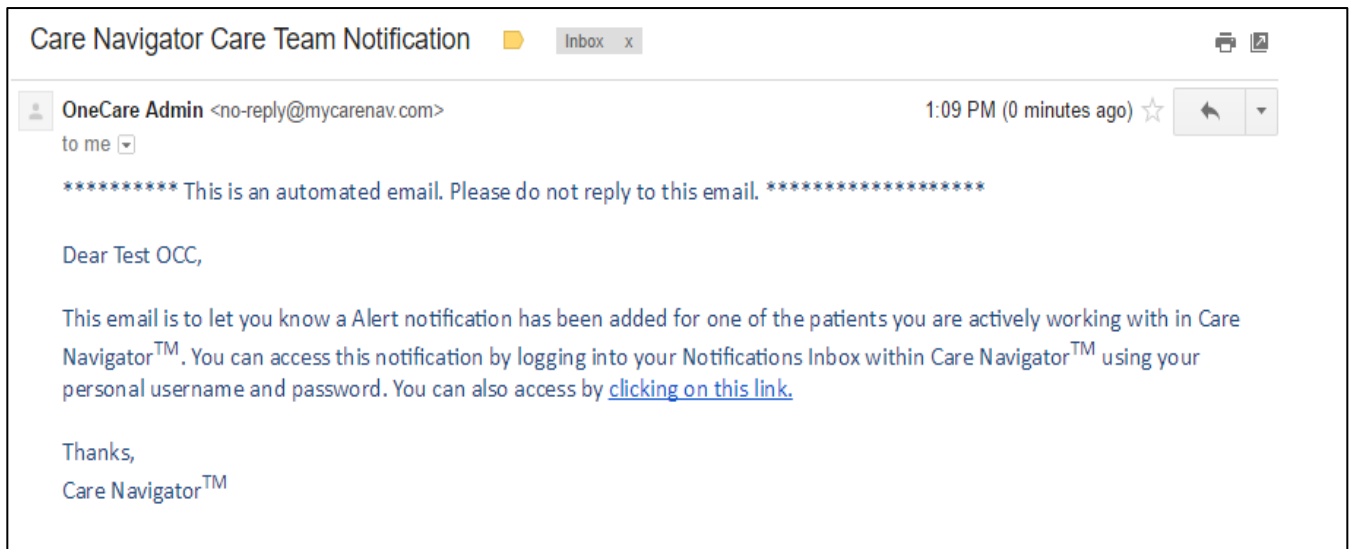
The dialog box is titled "Notify Care Team Member(s)" and includes a close button (X) in the top right corner. Below the title is a paragraph of instructions: "Use the form below to notify selected care team member(s). Users selected will receive an email with a link to view the message. All users on the care team will be able to view the notification in the Notification section and in the What's New section." The form contains three main sections: 1. "Notification type:" with a dropdown menu currently set to "Select". 2. "Enter message:" with a large text input field and a "500 characters remaining" indicator at the bottom right. 3. "Select care team members to notify:" which includes a "Select all" checkbox and a list of four names with checkboxes: Danielle Palmer, Elizabeth Roach, Jennifer Gordon, and Kathleen Camisa. At the bottom of the dialog are "Send" and "Cancel" buttons.

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



The success message box is titled "Success" with a green plus icon and a close button (X) in the top right corner. The text inside reads: "Your message has been successfully submitted for delivery." Below this is a bolded line: "Your message has been submitted to 2 people with the following details." This is followed by two sections: "Message submitted:" with the text "Gail has an appointment tomorrow." and "Selected people:" with the names "Kathleen Camisa" and "Robyn Skiff". An "Ok" button is located at the bottom right of the box. A blue arrow points from the right side of the box towards the left.

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](mailto: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        | <a href="#">Jms Burns</a> | CC Status    | In-outreach        |
| Phone (Primary) | (802) 647-3456    | 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 | 6/24/2020 9:28 AM         | Eng. Reason  | Medical Complexity |

Patient Details  
Care Team Notifications  
Event Notifications  
**Encounter Log**

Date of Last Encounter: 6/24/2020 9:28 AM

| Care Management Encounters ▾ |                    |                  |            |  |
|------------------------------|--------------------|------------------|------------|--|
| Date ↑                       | Type of Contact... | Care Team Member | Duration   | Encounter Purpose                                  |
| 6/24/2020 9:22 AM            | Home Visit         | Kathleen Camisa  | 15 minutes | Disease Management                                 |
| 3/5/2020 12:27 PM            |                    | Kathleen Camisa  | 15 minutes | Assessment/Physical                                |
| 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:

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

Duration --  
 Care Team Member [Elizabeth Roach](#)  
 Type of Contact --  
 Related Care Plan Goal --

### Mileage

Start Mileage --  
 End Mileage --  
 Actual Mileage 🔒 --

### Encounter Purpose

|                                    |                                     |
|------------------------------------|-------------------------------------|
| Shared Care Plan Review/Update     | <input checked="" type="checkbox"/> |
| 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"/>            |

### Encounter Notes

Encounter Notes --

### General:

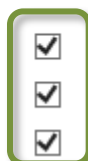
- The Patient Name will populate automatically
- The Start Date and Time will populate automatically
- Select the Duration of the encounter
- Select the Care Team Member of the patient
- Select the Type of Contact
- Select the Related Care Plan Goal

### 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        | <a href="#">Jim S. Burris</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM             | Eng. Reason  | Medical Complexity |

### 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 Encount... |                 |               |                          |                         |                      |                        |                 | + |  |
|---------------------------------|-----------------|---------------|--------------------------|-------------------------|----------------------|------------------------|-----------------|---|--|
| 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**

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>

SAVE SAVE & CLOSE + NEW FORM EDITOR

5. Click Save

3. Add Care Team Conference Attendees :

## 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

## 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

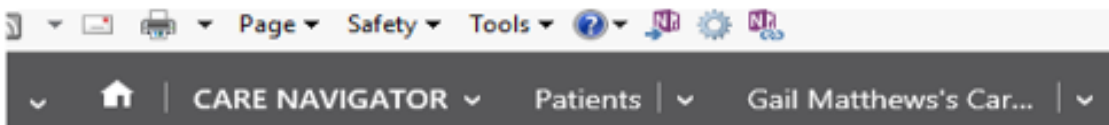
- ☐ Dan CCS2 (dan.wbpl.test+dancs2@gmail.com)
- ☐ Dan CCS9 (EMAIL NOT CONFIGURED)
- ☐ Danielle Palmer (danielle.palmer@onecarevt.org)
- ☐ Elizabeth Roach (elizabeth.roach@onecarevt.org)
- ☐ Kathleen Camisa (kathleen.camisa@onecarevt.org)
- ☐ Robyn Skiff (robyn.skiff@onecarevt.org)
- ☐ Test TestCC (Danielle.Palmer@uvmhealth.org)

8. Choose Care Team Attendees that  
attended Care Team Conference

9. Click submit

Submit

Cancel



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

|  |                   |                   |              |                |                               |              |                    |
|--|-------------------|-------------------|--------------|----------------|-------------------------------|--------------|--------------------|
| <b>PATIENT : PATIENT DETAILS ▾</b><br><b>Gail Matthews</b> |                   |                   |              |                |                               |              |                    |
| DoB  | 12/15/1938        | Age               | 81           | Lead CC        | <a href="#">Jim S. Burris</a> | CC Status    | In-outreach        |
| 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 # | 802-123-5699 | Last Encounter | 6/24/2020 9:28 AM             | Eng. Reason  | Medical Complexity |

Patient Details

Care Team Notifications

Event Notifications

Encounter Log

Care Team Conference

Care Coordination

42 CFR part 2 prohibits unauthorized disclosure of these records

42 CFR Part 2 ☒  
 42 CFR Part 2 Signed Date 2/21/2020

|                         |                    |                          |             |               |                   |
|-------------------------|--------------------|--------------------------|-------------|---------------|-------------------|
| Care Coordination Level | Medium Risk        | Social Risk Score        | 4           | Acuity Level  | 3. Weekly contact |
| Reason For Engagement   | Medical Complexity | Care Coordination Status | In-outreach | Deceased Date | --                |

### Care Coordination

| Reason For Engagement  | Created On | Care Coordination Status     | Created On        | Created On        | Acuity Level      |
|------------------------|------------|------------------------------|-------------------|-------------------|-------------------|
| Medical Complexity     | 6/2        | In-outreach                  | 6/23/2020 2:21 PM | 3/10/2020 8:14 AM | 3. Weekly contact |
| Medical Complexity     | 6/2        | Engaged                      | 3/11/2020 8:38 AM | 3/5/2020 1:51 PM  | 3. Weekly contact |
| SDoH-Social Risk Score | 6/2        | Care Coordination Not Needed | 3/10/2020 8:14 AM | 2/28/2020 2:11 PM | 3. Weekly contact |
| SDoH - Patient Report  | 6/2        | Care Coordination Not Needed | 3/5/2020 1:51 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:
  - 42 CFR Part 2- Place a check mark in the box next to the '42 CFR Part 2' if the patient has a 42 CFR Part 2 consent form uploaded to the record.
  - 42 CFR Part 2 Signed Date- Enter the date the patient signed the consent.
  - 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

- f) Care Coordination Status-this field reflects the patient's level of engagement with care coordination.
- g) Acuity Level-indicates the frequency of interaction needed either directly or indirectly with the patient.
- h) Deceased Date-can be claims fed or input by care team member
- i) About Me and Strengths
- j) Care Team members
- k) 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**

|                 |                   |                   |              |                |                              |              |                    |
|-----------------|-------------------|-------------------|--------------|----------------|------------------------------|--------------|--------------------|
| DOB             | 12/15/1938        | Age               | 81           | Lead CC        | <a href="#">Jim S Burris</a> | CC Status    | In-reach           |
| 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 | 6/24/2020 9:28 AM            | Eng. Reason  | Medical Complexity |

### About Me

Preferred activities  
 How I learn  
 Interaction Tips  
 Communication Style  
 Tips to avoid triggers/behaviors  
 Physical Mobility  
 Mode of Transportation  
 Important Family Information  
 ED / Crisis Plan  
 Crisis Plan Uploaded

I like to garden and love roses.  
 I like to listen first and have written material for later  
 Spend some time talking with me before discussing my care.  
 I do best with slow communication. repeating is also helpful.  
 Please be on time.  
 Limited Assistance uses a cane  
 Transportation Agency  
 I need a family member present when discussing future plans.  
 Gail knows that when she is short of breath and has gained 5+ pounds  
☒

| Strength ↑   | Created On        | Owner       |
|--|-------------------|-------------|
| I am a glass half full person with a positive outlook. | 2/25/2020 1:17 PM | Robyn Skiff |
| I am resourceful and good at solving problems.         | 2/25/2020 1:17 PM | Robyn Skiff |

### a. My Strengths

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



PATIENT : PATIENT DETAILS ▾

Gail Matthews

|                 |                   |                   |              |                |                               |              |                    |
|-----------------|-------------------|-------------------|--------------|----------------|-------------------------------|--------------|--------------------|
| DOB             | 12/15/1938        | Age               | 81           | Lead CC        | <a href="#">Jim S. Burris</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM             | Eng. Reason  | Medical Complexity |


## About Me

|                                  |  |
|----------------------------------|--|
| Preferred activities             | I like to garden and love roses.                                     |
| How I learn                      | I like to listen first and have written material for later           |
| Interaction Tips                 | Spend some time talking with me before discussing my care.           |
| Communication Style              | I do best with slow communication. repeating is also helpful.        |
| Tips to avoid triggers/behaviors | Please be on time.   |
| Physical Mobility                | Limited Assistance uses a cane                                       |
| Mode of Transportation           | Transportation Agency  |
| Important Family Information     | I need a family member present when discussing future plans.         |
| ED / Crisis Plan                 | Gail knows that when she is short of breath and has gained 5+ pounds |
| Crisis Plan Uploaded             | <input checked="" type="checkbox"/>                                  |

| Strength ↑   | Created On        | Owner       |
|--|-------------------|-------------|
| I am a glass half full person with a positive outlook. | 2/25/2020 1:17 PM | Robyn Skiff |
| I am resourceful and good at solving problems.         | 2/25/2020 1:17 PM | Robyn Skiff |

## 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        | <a href="#">Jim5 Burris5</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM            | Eng. Reason  | Medical Complexity |

ED / Crisis Plan ☐ Gail knows that when she is short of breath and has gained 5+ pounds she needs to con :  
 Crisis Plan Uploaded ☒

**Care Team Members**

Lead CC  [Jim5 Burris5](#)  
 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                                      |
|-------------------|--------------------|--------------|----------|--|
| 6/1/2020 10:06 PM | OneCare MobileA... | Jim5 Burris5 | Assigned | Other: This is a test of the Other feature             |
| 6/1/2020 10:05 PM | OneCare MobileA... | Jim5 Burris5 | Removed  | Patient/Family Request                                 |
| 6/1/2020 7:15 PM  | OneCare MobileA... | Jim5 Burris5 | Assigned | Other:   |
| 6/1/2020 7:13 PM  | OneCare MobileA... | Jim5 Burris5 | Removed  | Care provider removed as Lead CC but still on care ... |
| 6/1/2020 7:10 PM  | OneCare MobileA... | Jim5 Burris5 | Assigned | Care provider promoted to Lead CC from care team       |

| Name             | Role (to)        | Lead CC | Participation Type | Licensure 1 (Name) | Licensure 2 (Name) | Description                           |
|------------------|------------------|---------|--------------------|--------------------|--------------------|---------------------------------------|
| Betty Jones, RN  | Care Coordinator | No      | Care Team Member   |                    |                    | Testing                               |
| Danielle Palmer  | Care Coordinator | No      | Care Team Member   | RN                 |                    | Age Well Care and Service Coordinator |
| Elizabeth Rooney | Care Coordinator | No      | Non-ACO            | RN                 |                    |                                       |
| Elizabeth Smith  | Care Coordinator | No      | Non-ACO            | RN                 |                    | Area on Aging                         |

- 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... |

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

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 (L...) | Email (Connected To) | Lead CC | Lin ▼ |
|-----------------|--|-------------------|----------------------|----------------------|----------------------|---------|-------|
| Danielle Palmer | Battleboro 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

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

FILE CONNECTION CUSTOMIZE

Save Save & Close Chrome 36 Save

Assign Copy a Link Follow Collaborate

Connections

Connected From Gail Ma...

Name\* Erin Covey

Role\* Panel Coordinator

Participation Type\* Care Team Member

Lead CC ☐

Emergency Contact ☐

Description

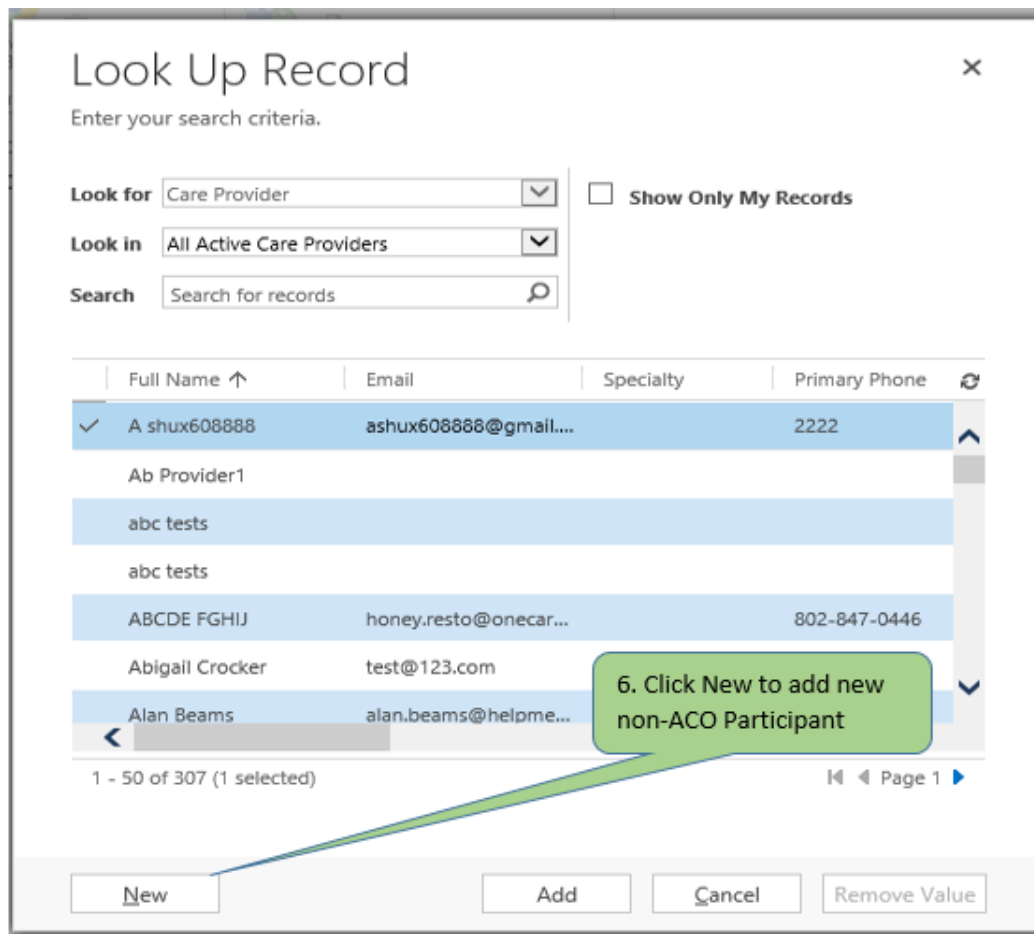
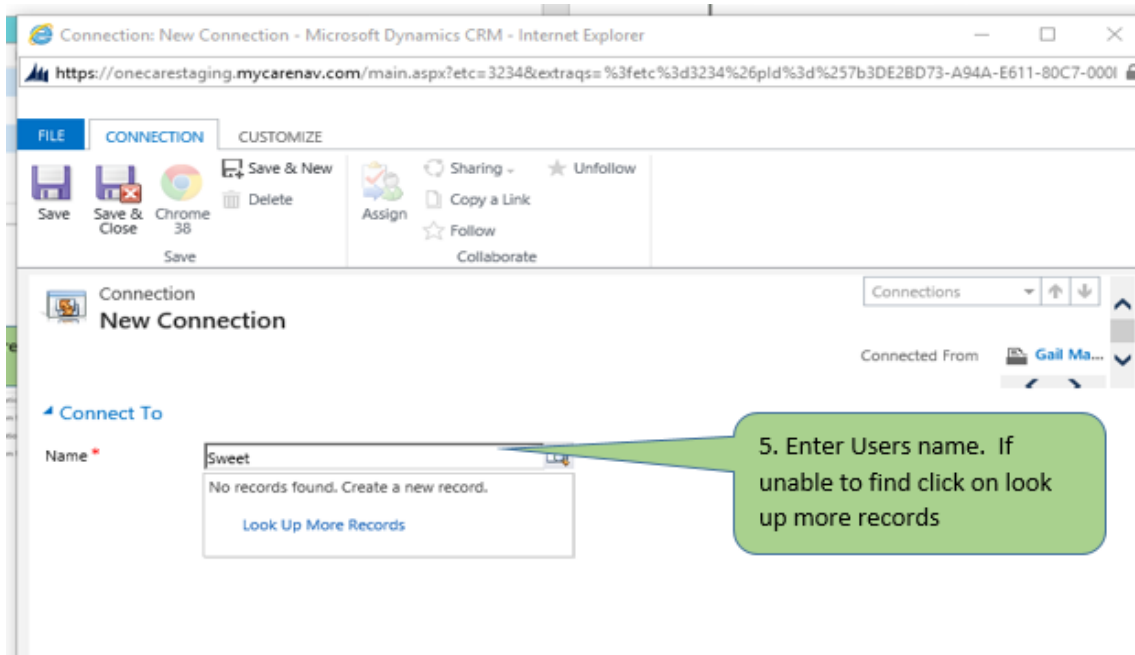
Status Active

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

6. Choose your role with the patient

7. Choose your Participation Type





### General

First Name \* Sally  
Middle Name --  
Last Name \* Smith  
Non-ACO ☒  
Description School Nurse, ABC Elementary

Job Title School Nurse  
Legal Business Name --  
Business Unit --

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

8. If applicable add Licensure

### Additional Information

Specialty --  
TIN --  
NPI --  
Health Service Area --  
TIN Name --

Licensure 1 RN  
Licensure 2 MDW

### Contact Details

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

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

First Name \* Elizabeth  
Last Name \* Smith  
Done

10. Click 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 Assign Follow Collaborate

Connection  
New Connection

Connect To  
Name \* Jody Smith  
Role \* Care Manager  
Participation Type \* Non-ACO  
Emergency Contact ☐  
Description ABC Designated Agency  
Status Active

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

11. Add the Role

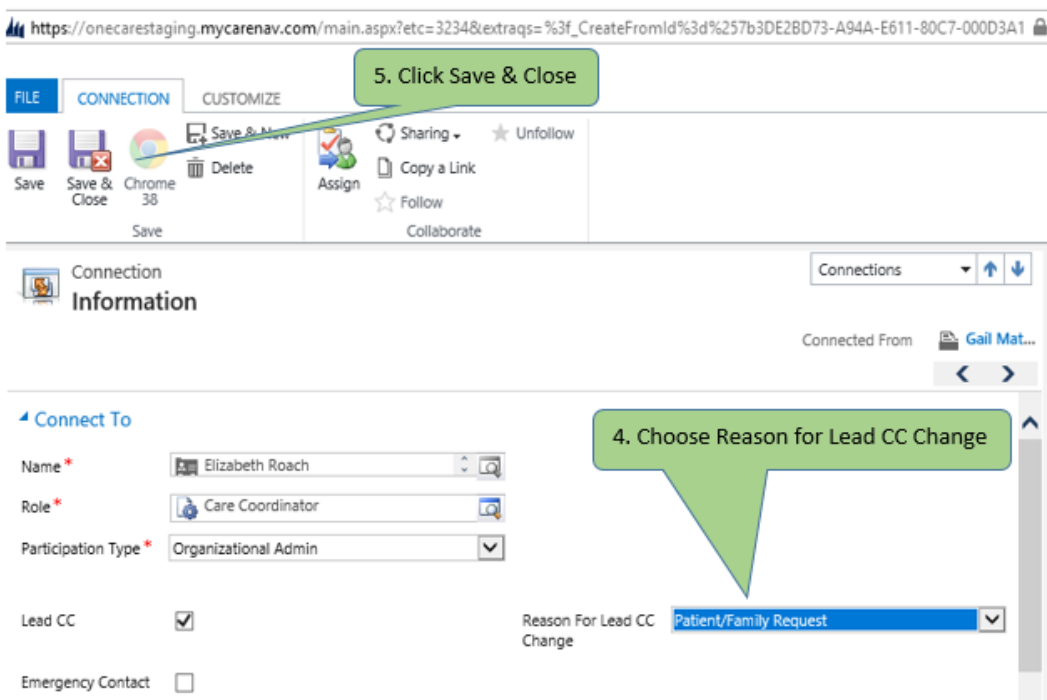
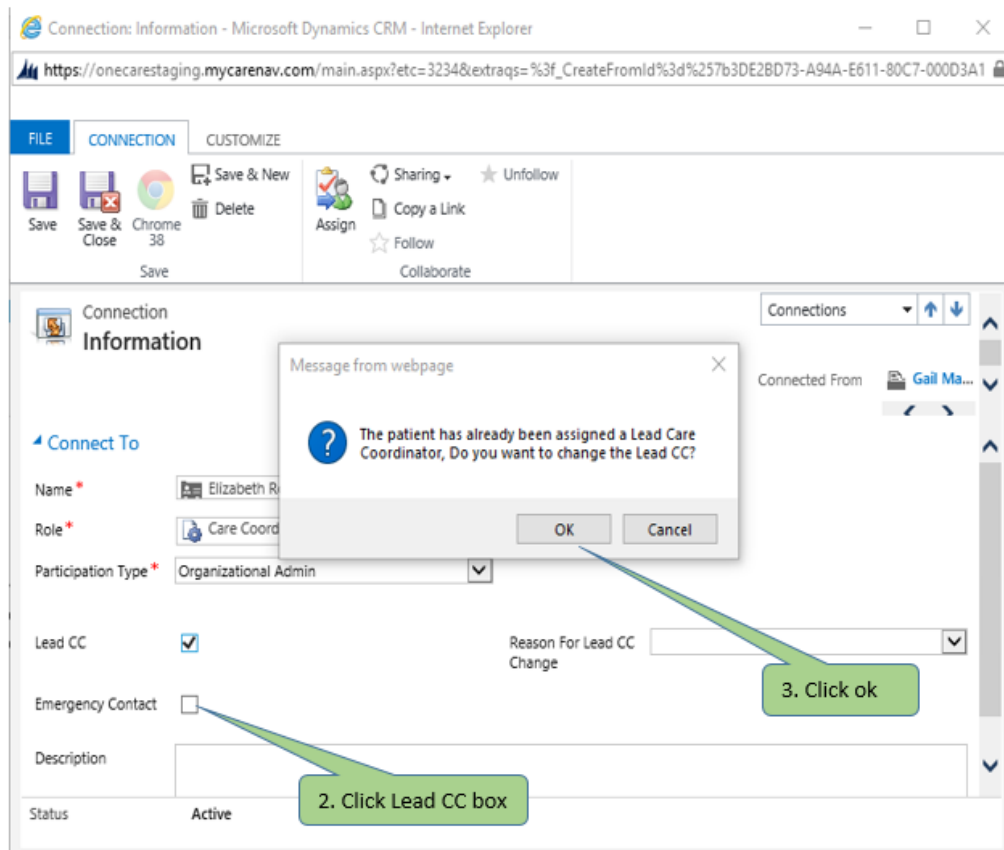
12. Add the non-ACO member's organization

**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



| 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)

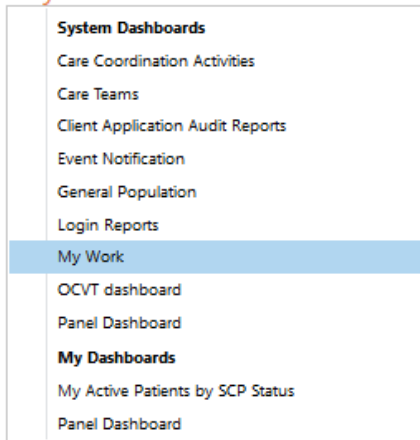
The screenshot shows the Care Navigator interface. At the top, there are two tiles: 'NEXT OF KIN' and 'USERS'. A green arrow points to the 'USERS' tile. Below the tiles, the 'Users Active User by HSA - ...' tab is selected. The 'CARE NAVIGATOR' dropdown menu is open, and the 'Users' option is selected. Below the navigation bar, the 'Active User by HSA' view is displayed. It shows a list of users with their last names: Rahelich, Randall, Reed, and Reifenrath. The 'Active User by HSA' view is highlighted in orange.

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

## My Work ▾



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



## Custom Filters ×

Show records where Name:

Contains ▼ camisa

☒ AND ☐ OR

-- Select Operator -- ▼

OK

Cancel

### ➔ All Active Care Team Members ▼

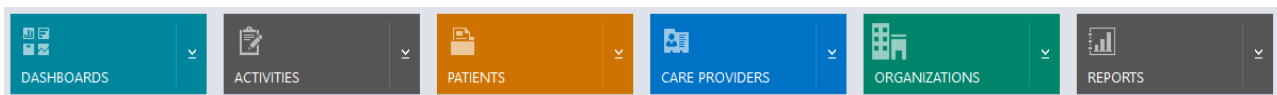
Search for records 🔍

| Member ID <span>▼</span> | Connected From <span>↑</span> | Care Coordi... <span>▼</span> | Care Coordi... <span>▼</span> | Name <span>↑</span> | Business Un... <span>▼</span> | Created On... <span>▼</span> | Payer (Con... <span>▼</span> |
|--------------------------|-------------------------------|-------------------------------|-------------------------------|---------------------|-------------------------------|------------------------------|------------------------------|
|                          | 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



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

➔ Search Results ▼

palmer ×

| Full Name <span>↑</span> | Care Provider Ty... | Primary Phone | Secondary Phone |
|--------------------------|---------------------|---------------|-----------------|
| Danielle Palmer          | System Admin        |               |                 |

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':

CARE PROVIDER : BULK CARE TEAM DEACTIVATE ▼



Danielle Palmer

Owner\*  
Marvin Sugirin

#### Summary

Care Provider

Full Name \* Danielle Palmer

Bulk Care Team Removal

| <input type="checkbox"/> | Care Team                 | Role             | Lead CC? |
|--------------------------|---------------------------|------------------|----------|
| <input type="checkbox"/> | Gail Matthews             | Care Coordinator | false    |
| <input type="checkbox"/> | FName273 LName273         | Care Coordinator | false    |
| <input type="checkbox"/> | John (Parent) A Appleseed | Care Coordinator | false    |
| <input type="checkbox"/> | FName251 LName251         | Care Coordinator | false    |
| <input type="checkbox"/> | Helen Evans               | Rep Payee        | false    |
| <input type="checkbox"/> | FName7 LName7             | Care Coordinator | false    |
| <input type="checkbox"/> | John (Parent) Thompson    | Care Coordinator | false    |

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:

+ NEW HELP DEACTIVATE RUN REPORT

CARE PROVIDER : BULK CARE TEAM DEACTIVATE  
Danielle Palmer

#### Summary

Care Provider

Full Name \* Danielle Palmer

| Bulk Care Team Removal              |                           |                  |          |
|-------------------------------------|---------------------------|------------------|----------|
| <input type="checkbox"/>            | Care Team                 | Role             | Lead CC? |
| <input type="checkbox"/>            | Gail Matthews             | Care Coordinator | false    |
| <input type="checkbox"/>            | FName273 LName273         | Care Coordinator | false    |
| <input type="checkbox"/>            | John (Parent) A Appleseed | Care Coordinator | false    |
| <input checked="" type="checkbox"/> | FName251 LName251         | Care Coordinator | false    |
| <input type="checkbox"/>            | Helen Evans               | Rep Payee        | false    |
| <input checked="" type="checkbox"/> | FName7 LName7             | Care Coordinator | false    |
| <input type="checkbox"/>            | John (Parent) Thompson    | Care Coordinator | false    |

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).


mycarenav.com needs some information

Script Prompt:  
Please enter a Reason for Removal:

OK  
Cancel

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

Message from webpage

 Bulk Deactivation queued! Please allow time for the job to complete if Care Team remains in grid.

OK

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.



PATIENT : PATIENT DETAILS ▾

**Gail Matthews**

|                 |                   |                   |              |                |                              |              |                    |
|-----------------|-------------------|-------------------|--------------|----------------|------------------------------|--------------|--------------------|
| DoB             | 12/15/1938        | Age               | 81           | Lead CC        | <a href="#">Jim S Burris</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM            | Eng. Reason  | Medical Complexity |

**ACO/Insurance Information**

|                                |                                |                             |   |
|--------------------------------|--------------------------------|-----------------------------|---|
| Attributed Health Service Area | <a href="#">Burlington</a>     | Attributed TIN              | <a href="#">University of Vermont Medical Center Inc.</a> |
| Attributed ACO                 | <a href="#">Bennington ACO</a> | Attributed Provider         | <a href="#">Mary Smith</a>                                |
| Payer                          | <a href="#">Medicaid</a>       | Attributed Practice Name    | <a href="#">AK Practice</a>                               |
| Member ID                      | 654322343                      | Beneficiary Medicare Status | Aged without ESRD   |
|                                |                                | Dual Status Description     | Non-Medicaid  |

| Attribution History |        |  |  |
|---------------------|--------|--|--|
| Date ↕              | Status |  |  |
| 7/12/2016           | 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    | or adult ed classes                 | Gail Matt... | Not Started | Robyn Skiff        | High     | 3/26/2018 12:00 AM |                   | 3/23/2018       |
| Personal Goals  | ications 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**

SAVE SAVE & CLOSE + NEW FORM EDITOR

BARRIER : INFORMATION

## New Barrier

General

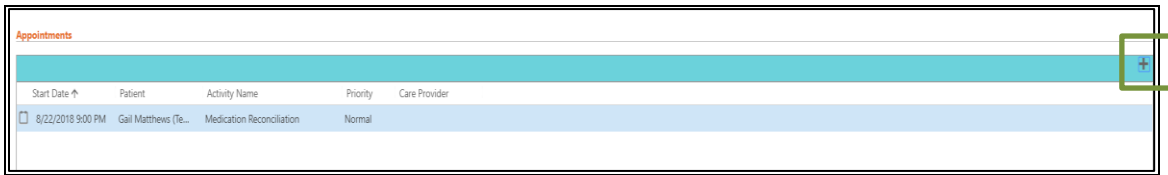
Type of Barrier -- Patient <sup>\*</sup> [Gail Matthews \(Test Patient\)](#)

Barrier <sup>\*</sup> --

Action Plan <sup>+</sup>

## Appointments

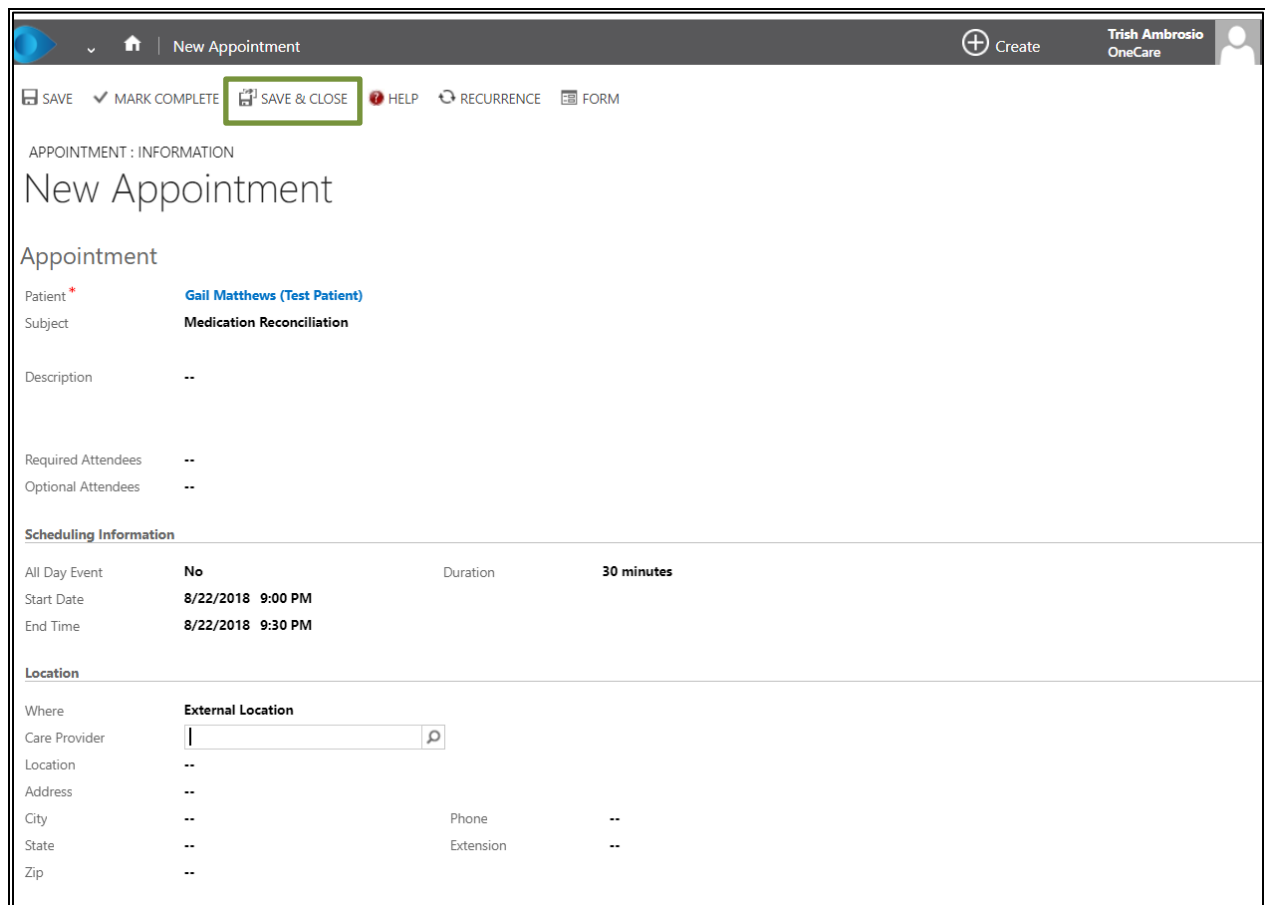
The user can enter any one-time or recurring appointments to track the patient in this section.



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 '+' 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 includes fields for Patient (Gail Matthews (Test Patient)), Subject (Medication Reconciliation), Description, Required Attendees, and Optional Attendees. The 'Scheduling Information' section includes 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 includes 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        | <a href="#">Jim S. Burris</a> | CC Status    | In-outreach        |
| 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 | 6/24/2020 9:28 AM             | Eng. Reason  | Medical Complexity |

### 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      |          |

**ED Encounters**

| Admission Date | Facility     | Reason         |
|----------------|--------------|----------------|
| 2/18/2020      | Hospital ABC | Stroke symptom |

**Social Risk Scores**

| Created On         | Source | Social Risk Score |
|--------------------|--------|-------------------|
| 6/22/2020 8:31 PM  | Data   | 4                 |
| 6/22/2020 6:17 PM  | Data   | 4                 |
| 2/18/2020 12:06 PM | Data   | 4                 |

**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):

Community Programs

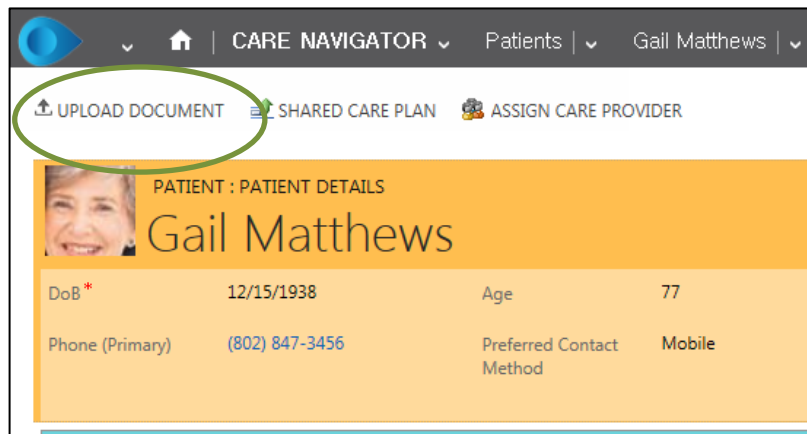


| Program                           | Date of Enrollment ↑ | End Date | End Date Reason |
|-----------------------------------|----------------------|----------|-----------------|
| Mental Health Case Managemen...   |                      |          |                 |
| SASH-Support and Services at 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

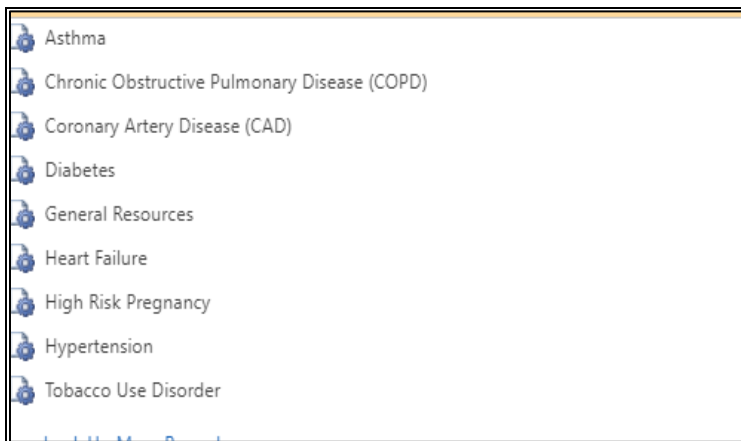
## Resources

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                |  |                           |                                    |                                       |

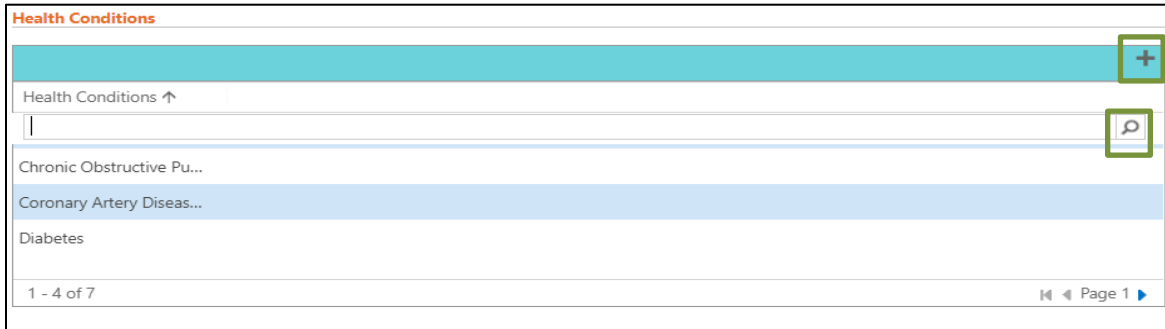
## Health Conditions:

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)

Page 1

Selected records:

Learn About Diabetes

Select

Remove

New

Add

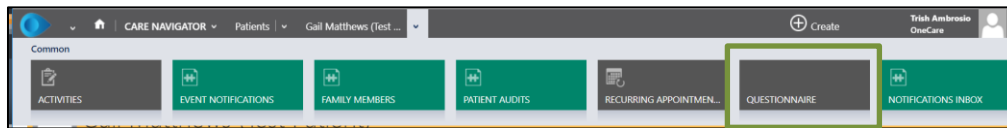
Cancel

## 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](mailto: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](mailto: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](mailto: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