



OneCare Vermont

Care Navigator User Guide

10/15/2020 Version 2.4

Welcome

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

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

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

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

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

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Obtaining Access

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

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



OneCare Vermont

Dear < Care Coordinator's Name > ,

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

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

Username: <username>

Password: <password>

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

Technical Support:

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

Thank you!

Care Navigator™ Support Team

Supported Browsers/Operating Systems

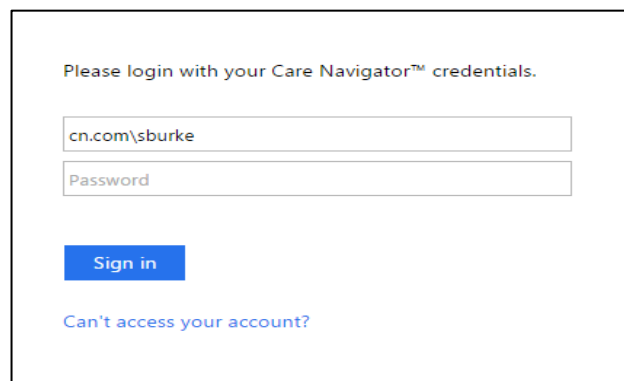
1. While any browser can be used for day-to-day Care Navigator activities, Internet Explorer is the preferred browser. The following are recommended minimum supported browsers:
 - **Internet Explorer** (preferred browser)
 - **Google Chrome**
 - **Mozilla Firefox**

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 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

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.

cn.com\sburke

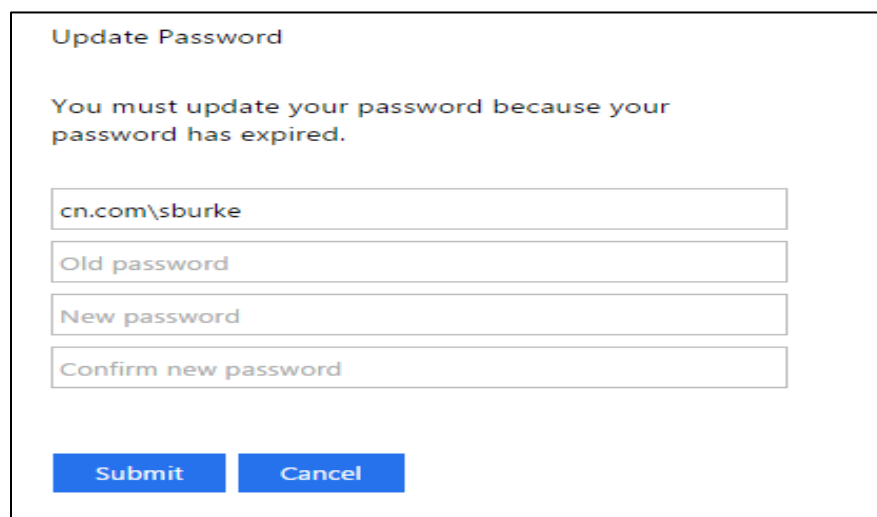
Password

Sign in

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

Resetting an Expired Password:

1. 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):

Access Level Term	Definition
Level 1 Care Coordinator	View/edit information and provide care coordination for patients assigned to within a business unit (aka practice or organizational unit such as a hospital); unable to see any patients unless added to the care team
Level II Care Coordinator Supervisor	View/edit information for all patients attributed to a business unit (aka practice, or hospital); ability to assign patients to specific care coordinators
Attribute Based Access	The ability to provision access to users based upon multiple factors. The attributes include: HSA, Payer, TIN, Practice
Collaborator Based Access	There are two roles: "Panel Role" and "Level 1 Care Coordinator" access. The Panel role provides access to the CN user to a specific panel of patients created by OneCare. The Level 1 Care Coordinator role follows the business rules outlined above.
Administrative Access (OneCare Only)	Full access to all OneCare Patients and Care Navigator Users. Permissioning and testing abilities.

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:

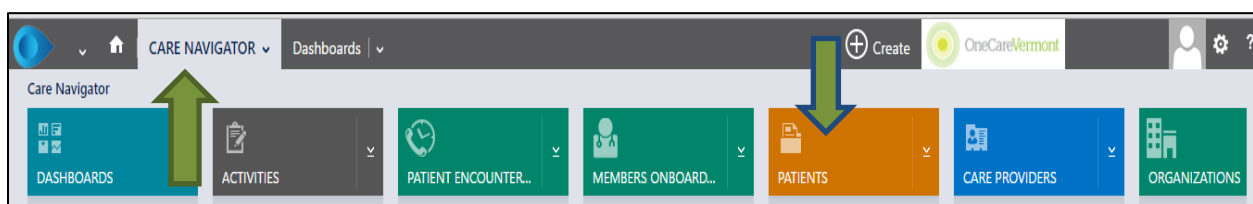
1. Age Group
2. Geographic Area
3. Hospital and Medical Practice
4. Insurance Plan

Level II Users

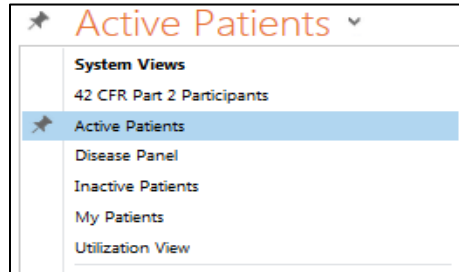
List of Active Patients:

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:



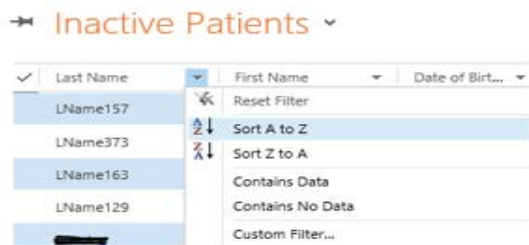
5. **Patient Search:** patients are searchable by the following method:

- Complete all or a portion of the first name
- * (an asterisk can be used for partial name if spelling, etc. is not known (ex. gai*mat)
- Complete all or a portion of name

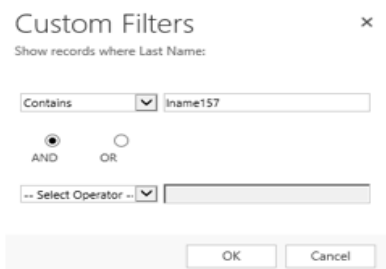
gail*matthew

6. **Searching for Inactive Patients:**

- Change to Inactive Patients view at dropdown and turn on filter:
- Click on the drop down next in the 'Last Name' column and select Custom Filter:



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




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

Care Coordinators

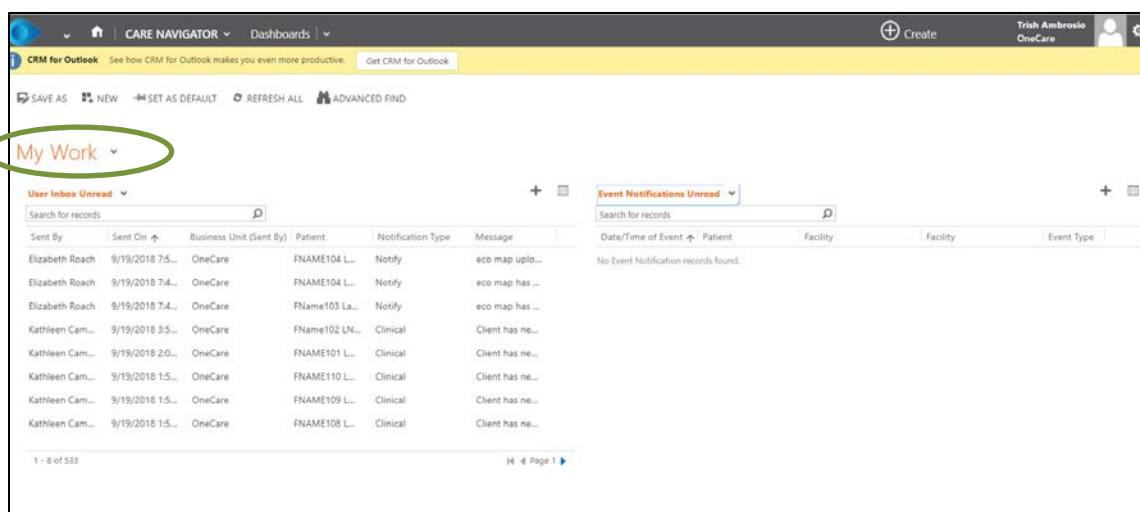
My Work

Care coordinators are assigned patients by their Organizations Attribution, Collaborator Agreement, Health Service Area or based on their Patient Panel (in some instances). 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 ▾

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

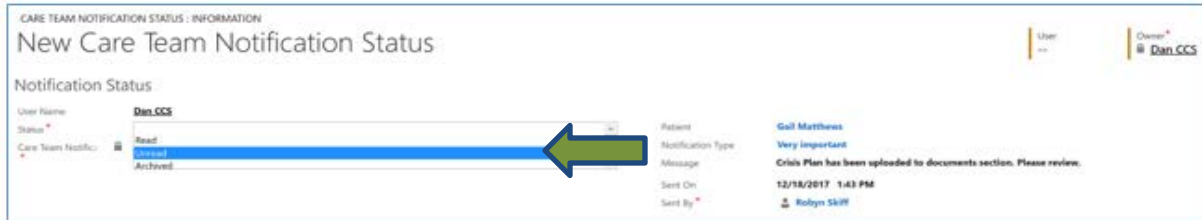


Sent By	Sent On	Business Unit (Sent By)	Patient	Notification Type	Message
Elizabeth Roach	9/19/2018 7:5...	OneCare	FNAME104 L...	Notify	eco map uplo...
Elizabeth Roach	9/19/2018 7:4...	OneCare	FNAME104 L...	Notify	eco map has ...
Elizabeth Roach	9/19/2018 7:4...	OneCare	FName103 La...	Notify	eco map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

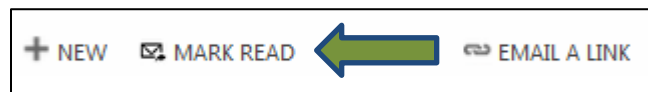
3. **User Inbox:** This section contains notifications sent by members of the care team.

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					

4. After viewing the Notification there is the option of marking the notification as read. To do this, open the message and hover over the 'Status' to view the dropdown menu and select 'Read'.



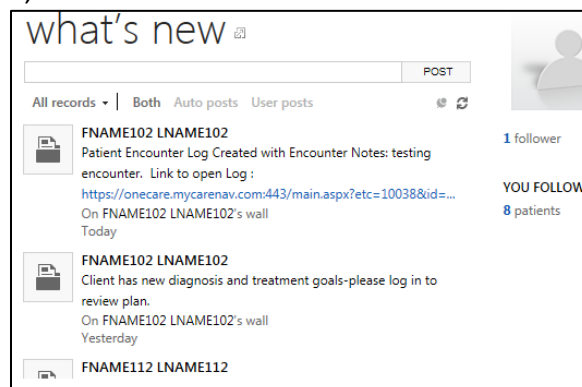
5. **Event Notifications Unread:** This section contains the admission, discharge, and transfer (ADT) alerts that have been received regarding patients whose care teams you are assigned to. Once you have reviewed the ADT alert you have the option of marking the notification read to remove it from the 'Unread' feed. To complete this, open the message and select the 'Mark Read' option from the top toolbar:



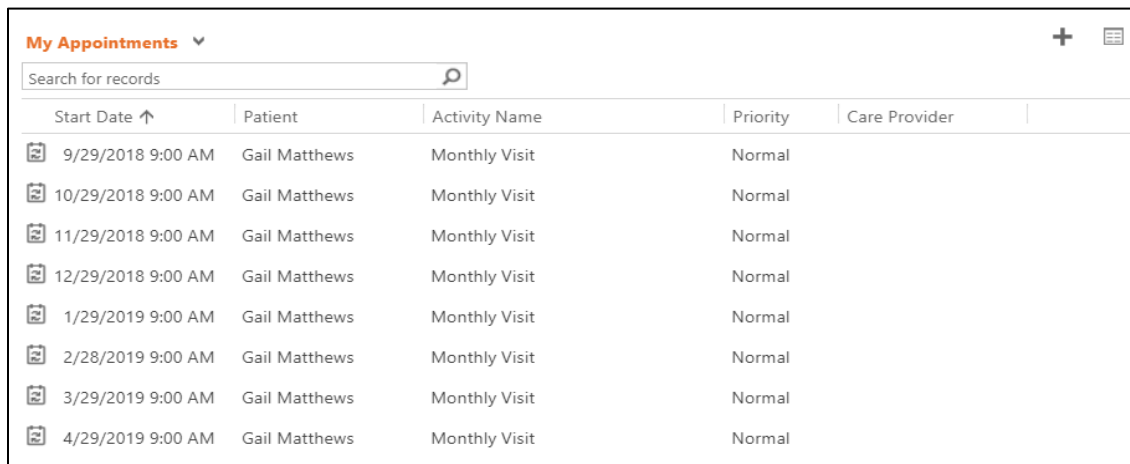
6. **My Active Patients:** This section is a list of patients whose care team you have been assigned to.

My Patients				
Search for records				
Last Name	First Name	Date of Birth	Member ID	Risk Category
Logan	Apple	10/9/1988	{062z3564Zx	
LName1	FName1	4/4/1942		
LName110	FName110	12/30/2006	{00564629124	
LName200	FName200	2/25/1932		
LName254	FName254	9/2/1931		
LName285	FName285	12/6/1931		
LName286	FName286	8/22/1938		
LNamegv4	FNamegv4	1/21/1958	{00283564Z4	

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

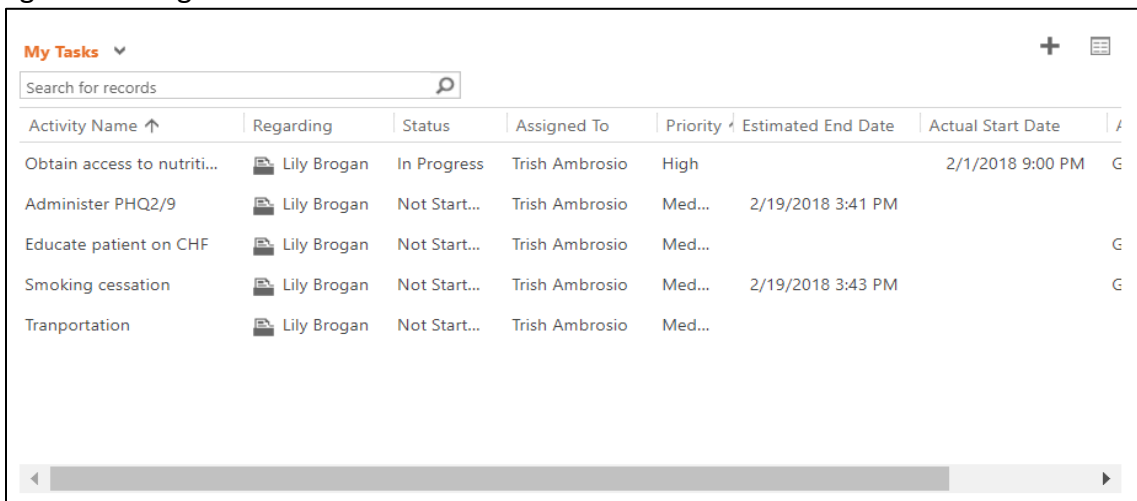


- 8. My Appointments:** One-time or recurring appointments similar to an Outlook-type calendar can be recorded in this section.



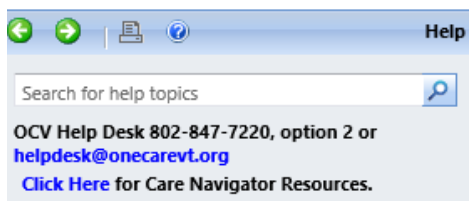
Start Date ↑	Patient	Activity Name	Priority	Care Provider
9/29/2018 9:00 AM	Gail Matthews	Monthly Visit	Normal	
10/29/2018 9:00 AM	Gail Matthews	Monthly Visit	Normal	
11/29/2018 9:00 AM	Gail Matthews	Monthly Visit	Normal	
12/29/2018 9:00 AM	Gail Matthews	Monthly Visit	Normal	
1/29/2019 9:00 AM	Gail Matthews	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	

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

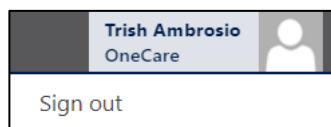


Activity Name ↑	Regarding	Status	Assigned To	Priority	Estimated End Date	Actual Start Date
Obtain access to nutriti...	Lily Brogan	In Progress	Trish Ambrosio	High		2/1/2018 9:00 PM
Administer PHQ2/9	Lily Brogan	Not Start...	Trish Ambrosio	Med...	2/19/2018 3:41 PM	
Educate patient on CHF	Lily Brogan	Not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



- 10. 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.




- 11. To Sign Out:** click on your name on the gray bar (see arrow above) and click on “Sign out”









Patient Dashboard



 <div> PATIENT : PATIENT DETAILS ▾ Gail Matthews </div>							
DoB *	12/15/1938	Age	81	Lead CC	Jim5 Burris5	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

1. 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.
2. 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. 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

 <div> PATIENT : PATIENT DETAILS ▾ Gail Matthews </div>							
DoB *	12/15/1938	Age	81	Lead CC	Jim5 Burris5	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

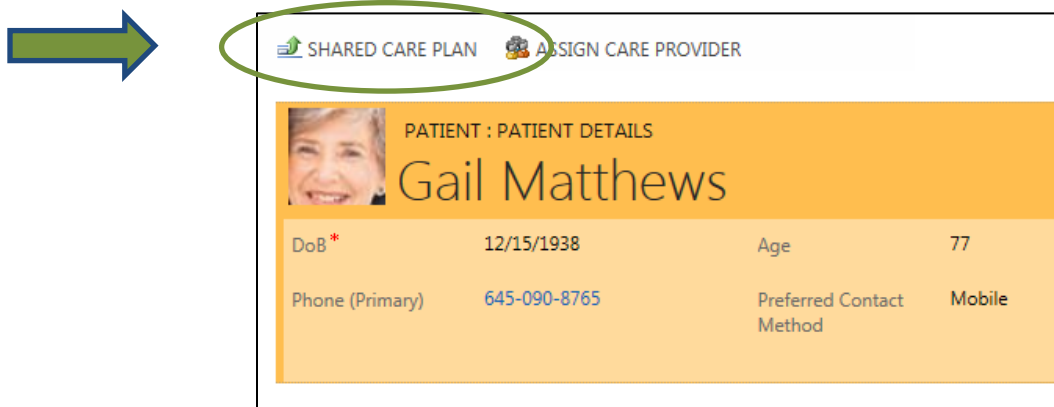
Resources

Shared Care Plan

1. 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.

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 Page 1 of Completed Shared Care Plan:

Patient's Name : Gail Matthews (Test Patient)

DOB : 12/15/1938

Shared Care Plan

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

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

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

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

Patient Details

1. 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 St. Albans 05478 Franklin	Mailing Address	Po Box 346 St Albans Vermont 05478 Franklin
Street	581 Ethan Allen Highway	Street	Po Box 346
City	St. Albans	City	St Albans
State	--	State	Vermont
ZIP	05478	ZIP	05478
County	Franklin	County	Franklin

42 CFR Part 2 Tracking

1. 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	Jim5 Burris5	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

2. When a 42CFR Part 2 Consent is completed and uploaded, the following steps should be taken to record this in the patient record:
 - a. 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
 - b. In the 'Care Coordination' section, check the box next to the '42 CFR Part 2' and enter the date the patient signed the consent
 - c. 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	Jim S. Burris	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	<input checked="" type="checkbox"/>
42 CFR Part 2 Signed Date	2/21/2020

42 CFR part 2 prohibits unauthorized disclosure of these records

Entering a Note

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

Patient Details

General

First Name	Gail	Gender *	Female
Middle Initial	--	Identified Gender	Female
Last Name *	Matthews	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 invitation from Gail and Robyn to attend care conference next week, able to attend on Friday morning-looking forward to.
 Dan Fanelli - Saturday, June 20, 2020 7:27:40 PM

Entering a Post

1. 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. 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

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



PATIENT - PATIENT DETAILS

Gail Matthews

DoB *	12/15/1938	Age	81	Lead CC	Jim's Burns	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

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

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

NEW

MARK READ

SHARE

EMAIL A LINK

RUN WORKFLOW

START DIALOG

RUN REPORT

EVENT NOTIFICATION : INFORMATION

06s28350bX9

Event Notification

Patient

Patient *

Fname102 LNAME102

MemberID *

06s28350bX9

Details

Facility Code

GMC

Facility

[GIFFORD MEDICAL CENTER](#)

Date/Time of Event

6/18/2018 12:00 AM

Event Type

Admission

Notes Count

--

Notes

ACTIVITIES

NOTES

Enter a note

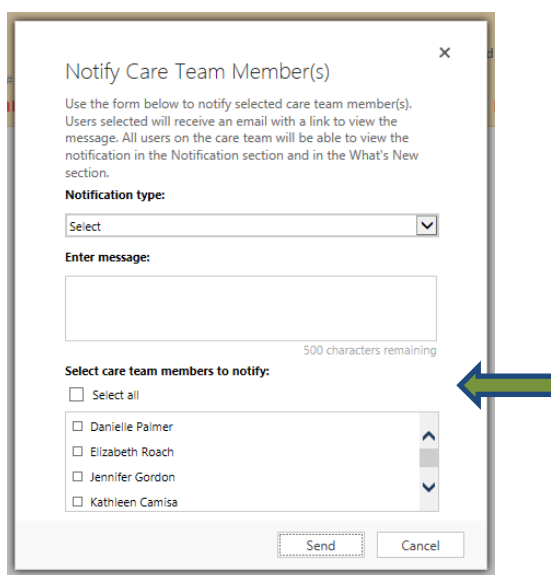
No Notes found.

Care Team Notifications

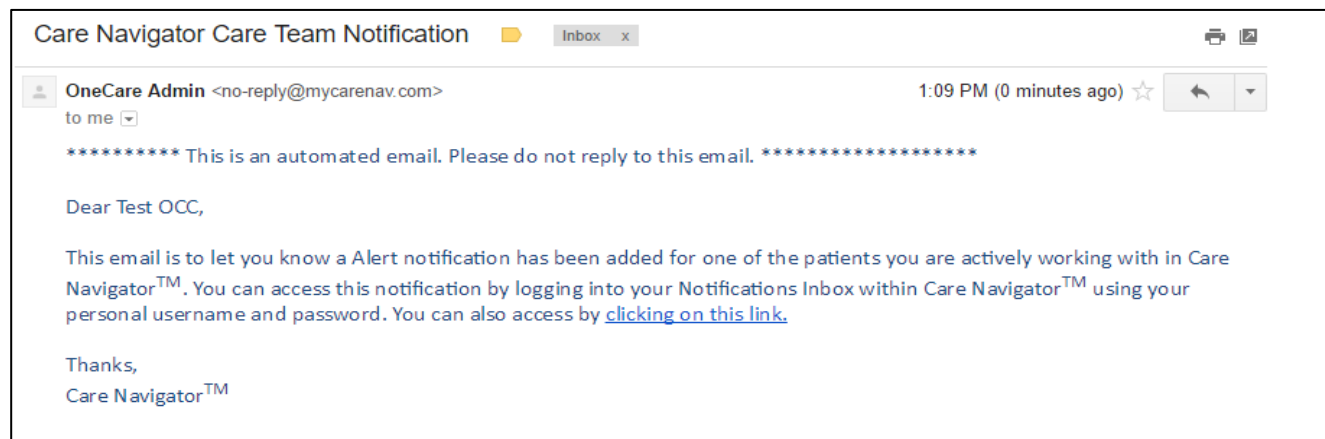
1. The Care Team Notification feature allows members of a care team to alert other team members of key events or communications related to common patients. When the Notification message is completed and sent, recipients then receive an email alert with a link that prompts them to sign into Care Navigator. 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.
2. Select a Notification Type using the drop down on the right.
3. Enter a simple message with no protected health information. No more than 500 character.
4. A User can select either specific Care Team Members or all Care Team Members by choosing 'Select All' to send the notification



5. After the notification is sent a success message box will appear as shown below
6. Notification Email: Recipients will receive an email to the address they supplied on their User Agreement. Please contact helpdesk@onecarevt.org if your email address has changed.



Encounter Log

1. 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: Jim's Burns 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, dr 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:

SAVE SAVE & CLOSE NEW FORM EDITOR Create

PATIENT ENCOUNTER LOG : INFORMATION

New Patient Encounter Log

Visit Summary

Visit Type: Care Management

Patient: Gail Matthews (Test Patient)
Start Date and Time: 9/16/2020 11:54 AM
Created By: --

Care Management

General

Duration: --
Care Team Member: Erin Covey
Type of Contact: --
Related Care Plan Goal: --

Mileage

Start Mileage: --
End Mileage: --
Actual Mileage: --

Encounter Purpose

Shared Care Plan Review/Update ☐
Assessment/Physical ☐
Assessment/Mental Health ☐
Assessment/Social ☐
Goal Setting ☐
Condition Self-Management ☐
Palliative/Hospice Care Discussion ☐
Advance Directive Discussion ☐
Advance Directive Completed ☐
Crisis Plan Discussion ☐
Crisis Plan Completed ☐
Disease Management ☐
Med reconciliation ☐
Patient education ☐
Support/Counseling ☐

Encounter Notes

Encounter Notes: --

3. Encounter Purpose:

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

4. Encounter Notes:

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

Encounter Log

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

Care Management Encounters ▼

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



Care Team Conference

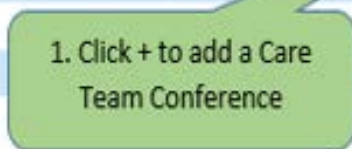
1. A Care Team Conference is a gathering of care team members who are providing an individual, family and care team members an opportunity to discuss the patients progress and ensure needs are being met.
2. Open the Care Team Conference tile and click on the plus sign

Care Team Conference

Care Team Conference

Care Team Conference Encount... ▼

Created On ↑	Created By	Status Reason	Patient/Family Invt...	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		



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

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=10061&ex>

New Patient Encoun...

SAVE SAVE & CLOSE NEW FORM EDITOR

5. Click Save

4. Add Care Team Conference Attendees :

PATIENT ENCOUNTER LOG : INFORMATION

Gail Matthews's Care Team Conference

General

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

Attendees

Care Team Member ↕

No Encounter Attendees records found.

6. Click on grid to add
Care Team Attendees

PATIENT ENCOUNTER LOG : INFORMATION

Gail Matthews's Care Team Conference

Encounter Attendees Associated... ▾

ADD ATTENDEES

+ ADD NEW ENCOUNTER A...

CHART PANE ▾

RUN REPORT ▾

EXPORT ENCC

Name ↑

Created On

No Encounter Attendees records found.

7. Click Add Attendees to
add Care Team Attendees

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

PATIENT ENCOUNTER LOG : INFORMATION

Gail Matthews's Care Team Conference

Visit Summary

Visit Type * Care Team Conference

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

Care Team Conference

General

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

Attendees

Care Team Member

Becky Bee
Dan CCS10
Dan CCS2

Status Reason Completed

_CreateFromType%3d1%

amisa

aging

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

13. Mark Status Completed

14. Click save button

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

Care Coordination

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

UPLOAD DOCUMENT
 SHARED CARE PLAN
 ASSIGN CARE PROVIDER
 SEND NOTIFICATION
 FOLLOW

PATIENT : PATIENT DETAILS ▾							
	Gail Matthews						
DOB	12/15/1938	Age	81	Lead CC	JimS.BurrisS	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

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
 - 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:

1. The 'About Me' section is based on your interactions with the patient. These important person centered fields help the team see the whole person.
2. 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	Jim S. Burris	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: ☒


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

My Strengths

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

Care Team Members:

1. 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	Jim S Burris	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

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  [Jim S Burris](#)

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...	Jim S Burris	Assigned	Other: This is a test of the Other feature
6/1/2020 10:05 PM	OneCare MobileA...	Jim S Burris	Removed	Patient/Family Request
6/1/2020 7:15 PM	OneCare MobileA...	Jim S Burris	Assigned	Other:
6/1/2020 7:13 PM	OneCare MobileA...	Jim S Burris	Removed	Care provider removed as Lead CC but still on care ...
6/1/2020 7:10 PM	OneCare MobileA...	Jim S Burris	Assigned	Care provider promoted to Lead CC from care team

1 - 5 of 55

Page 1

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

1 - 4 of 9

Page 1

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

Care Team Members

Lead CC  [Danielle Palmer](#)

Current PCP  Dr. Sandra Jones

Other Support 1 Jonny Lavalee, neighbor 878-1234

Other Support 2 Sally Smith, DCF, 484-5432

Other Support 3 --

Other Support 4 --

Other Support 5 --

Lead CC Change History

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

1 - 5 of 28

Page 1

2. Scroll down to locate the Care Team Members section

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

1 - 4 of 7

Page 1

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

Active Connections for Patient

ADD CARE TEAM MEMBER

4. Click on Add Care Team Member

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

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

Connection - Microsoft Dynamics CRM - Internet Explorer

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

FILE CONNECTION CUSTOMIZE

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

Connection

New Connection

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

Adding Non-ACO Participants:

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

PATIENT: PATIENT DETAILS

Gail Matthews

DOB	12/15/1938	Age	81	Lead CC	Jim S Burris	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	Enq. Reason	Medical Complexity

Care Team Members

Lead CC	Jim S Burris
Current PCP	Dr. Sandra Jones
Other Support 1	Jonny Lavalley, 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...	Jim S Burris	Assigned	Other: This is a test of the Other feature
6/1/2020 10:05 PM	OneCare MobileA...	Jim S Burris	Removed	Patient/Family Request
6/1/2020 7:15 PM	OneCare MobileA...	Jim S Burris	Assigned	Other:
6/1/2020 7:13 PM	OneCare MobileA...	Jim S Burris	Removed	Care provider removed as Lead CC but still on care ...
6/1/2020 7:10 PM	OneCare MobileA...	Jim S Burris	Assigned	Care provider promoted to Lead CC from care team

1 - 5 of 55 Page 1

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

1 - 4 of 7 Page 1

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

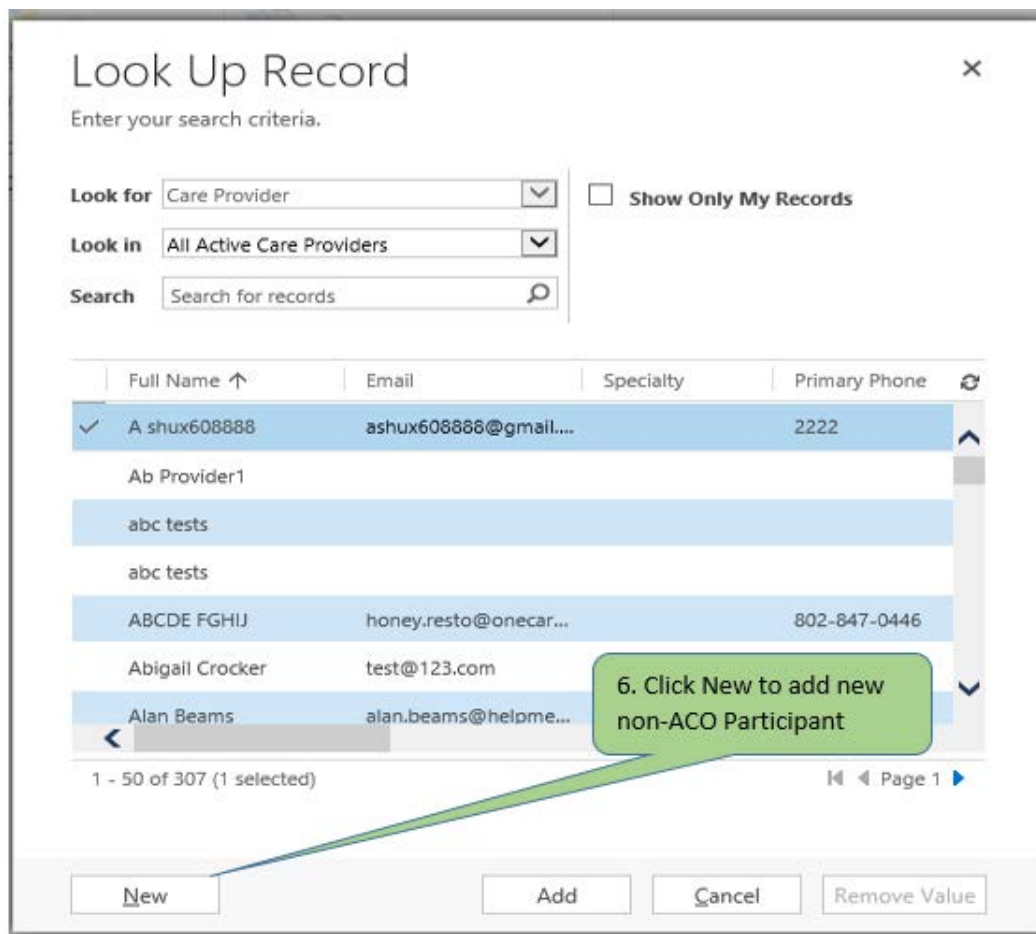
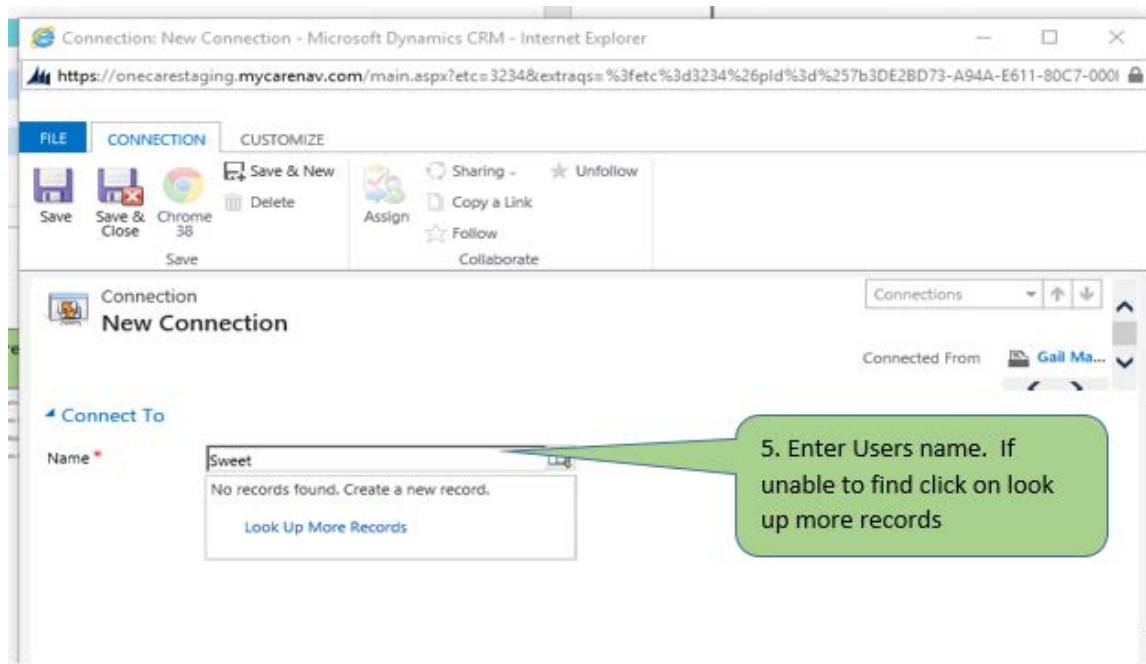
Active Connections for Patient

ADD CARE TEAM MEMBER

Search for records

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

4. Click on Add Care Team Member



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 BN
Licensure 2 MD

Contact Details

Email sally.smith@abc.org
Home Phone Number 802-123-4567

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

Connections

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 Changes: When making changes to the LCC you will need to indicate a reason for the change.

Locate the Care Team Member's table under the Care Coordination Tab:

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

1 - 4 of 8

1. Open team member you want to make LCC

Connection: Information - Microsoft Dynamics CRM - Internet Explorer

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

FILE CONNECTION CUSTOMIZE

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

Connection Information

Connect To

Name * Elizabeth Roach

Role * Care Coordinator

Participation Type * Organizational Admin

Lead CC ☒

Emergency Contact ☐

Description

Status Active

Reason For Lead CC Change

Message from webpage

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

OK Cancel

2. Click Lead CC box

3. Click ok

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

FILE CONNECTION CUSTOMIZE

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

Connection Information

Connect To

Name * Elizabeth Roach

Role * Care Coordinator

Participation Type * Organizational Admin

Lead CC ☒

Emergency Contact ☐

Reason For Lead CC Change Patient/Family Request

4. Choose Reason for Lead CC Change

5. Click Save & Close

One you click Save & Close you will return to the Care Coordination section. Here you will see the update you have made under the 'Lead CC Change History' grid:

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				

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)



- 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:

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

My Work ▾

- System Dashboards**
- Care Coordination Activities
- Care Teams
- Client Application Audit Reports
- Event Notification
- General Population
- Login Reports
- My Work**
- OCVT dashboard
- Panel Dashboard
- My Dashboards**
- My Active Patients by SCP Status
- Panel Dashboard



✈ All Active Care Team Members ▾

System Views	Name (Connected From)
Active Connections	
All Active Care Team Members	Middlebury
All Active Care Team Members (Current BU)	Middlebury
All Sales Team Members	Middlebury
All Stakeholders	Middlebury
Patients Assigned To Care Provider	Middlebury
Related Solutions	Vergennes
Create Personal View	Middlebury
Save Filters as New View	
Save Filters to Current View	Bristol

✈ All Active Care Team Members ▾

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

Custom Filters ×

Show records where Name:

Contains ▾ camisa

☒ AND ☐ OR

-- Select Operator -- ▾

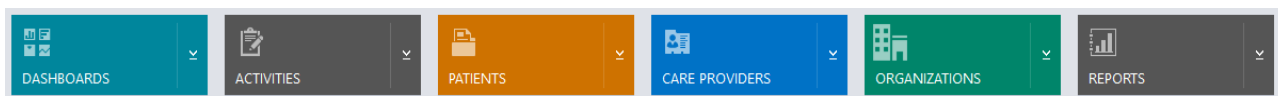
OK

Cancel

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 the change.

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



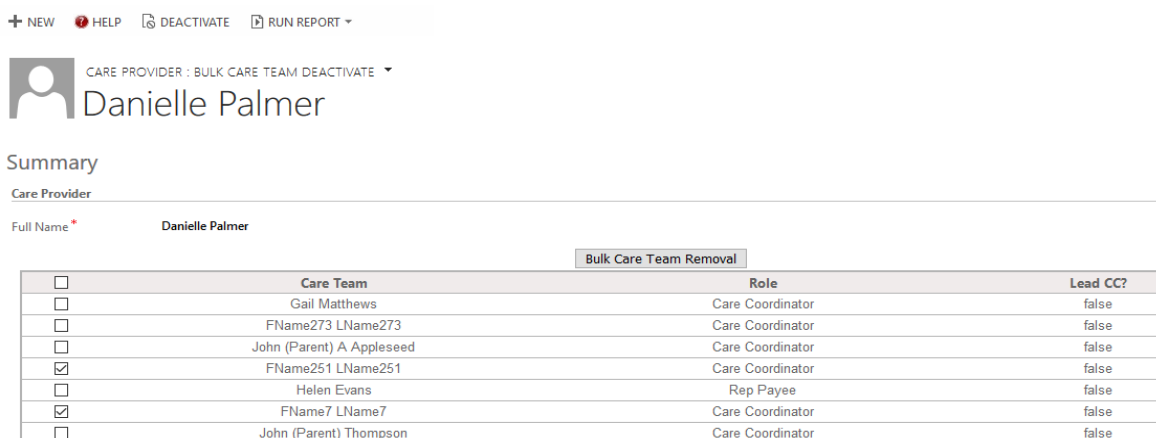
2. Search for the Care Provider using the search bar and double click in-between the text on the blue line to open the record:



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

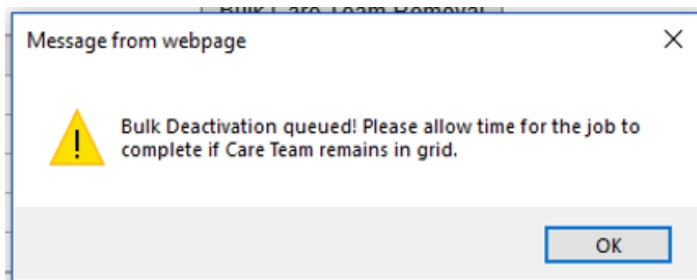


4. Click in each box to place a check mark next to those patients you wish to deactivate the care provider from, and then click on the 'Bulk Care Team Removal' box:



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

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



- 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. This information indicates the connection the patient has to the 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	Jim S. Burris	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 #	002-123-5689	Last Encounter	6/24/2020 9:22 AM	Eng. Reason		Medical Complexity	

ACO/Insurance Information

Attributed Health Service Area	Burlington	Attributed TIN	University of Vermont Medical Center Inc.
Attributed ACO	Bennington ACO	Attributed Provider	Mary Smith
Payer	Medicaid	Attributed Practice Name	AK Practice
Program Information	Traditional	Dual Status Description	Non-Medicaid
Medicaid Expanded Category	--		
Member ID	654322343		

Attribution History

Date	Status
7/12/2016	No

Care Plan-Adding Goals and Tasks

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

8. **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.
9. **Add Priority:** This will automatically be defaulted to Medium, but can be changed as appropriate to Low or High.
10. **Add Dates:** Actual start date and estimated end date
11. **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

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.
 - a) **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:

- b) **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 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**

Appointments

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




Appointments				
Start Date	Patient	Activity Name	Priority	Care Provider
8/22/2018 9:00 PM	Gail Matthews (J...	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.

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	Jim S. Burris	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	Enq. 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	

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

ED Encounters

Admission Date ↑	Facility	Reason
2/18/2020	Hospital ABC	Stroke symptoms

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 and Utilization.

Health Conditions

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

Community Programs

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

Add a Community Program

1. To add a program the patient is utilizing, click on the "+" symbol.

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

Viewing Community Programs Assigned to a Patient

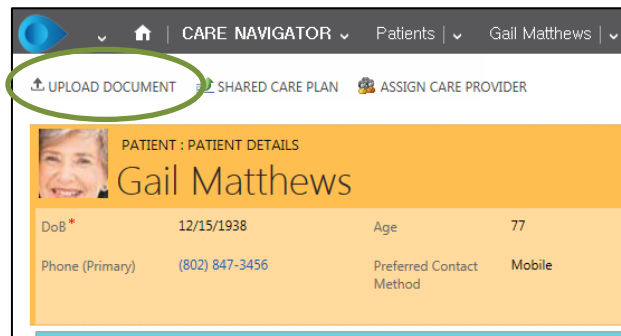
1. To view the list of Community Programs assigned to a patient, click on the grid symbol to the right of the plus sign (see arrow below):

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

Documents

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

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



2. A pop-up box will appear. Complete the requested fields and choose 'Upload File'. (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* 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'.

Health Conditions:

Currently, nine Disease Panels can be selected including: Asthma, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), Diabetes, General Resources, Heart Failure, High Risk Pregnancy, Hypertension and Tobacco Use Disorder.

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 health conditions.
3. Select applicable condition.

Education Resource Master

To add new education resources to the patient record:

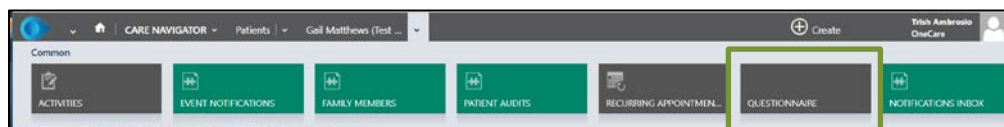
1. Click on the plus sign in the right-hand corner of the Education Resource Master
2. A new window will open.
3. Under 'Look in' select the condition from the drop down list to begin a search of the articles mapped to that condition.
4. Place a check mark next to the article(s) to be assigned to the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

Assessments/Questionnaires

Embedded Questionnaires

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

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



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

PATIENT : PATIENT DETAILS
Gail Matthews (Test Patient)

DOB: 12/15/1938 Age: 79 Lead CC: [Rebryn 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 3:50 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
 - a. Number: The version of the questionnaire taken is indicated
 - b. Assigned On: The date and time the questionnaire was initiated
 - c. Submitted on: If a questionnaire is complete, the date and time of completion is listed
 - d. Status: A questionnaire can be in new, draft, or submitted status
4. New Questionnaire: Click on “New Questionnaire” to show the list of questionnaires available for assignment to the patient. Click on the questionnaire to be completed with the patient.
5. Administer the questionnaire. It can be cancelled, saved in draft form, or completed.

PATIENT : PATIENT DETAILS
Gail Matthews (Test Patient)

DOB: 12/15/1938 Age: 79 Lead CC: [Rebryn 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](#)

Troubleshooting

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

Business Process Errors

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

HelpDesk@OneCareVT.org

Access Errors

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

HelpDesk@OneCareVT.org

How to Report Errors - Telephone

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

1. Contact OneCare Operations Help Desk at (802) 847-7220, option 2
2. Provide help desk with your user name
3. Outline the steps taken that created the error and share all pertinent information
4. Operations Help Desk will log into the application to try and recreate the error and report directly to the Care Navigator Team
5. Follow up will occur within in 24-36 business hours

How to Report Errors - Email

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

1. Contact the Help Desk at HelpDesk@OneCareVT.org
2. Subject Line: Care Navigator System Application Error
3. Provide a synopsis of the error the end user is experiencing
4. Outline the steps taken that created the error
5. Share a screen shot of the error using the copy and paste functionality or your snipping tool
6. The Help Desk will work all email notifications within 24-36 business hours