McKESSON
Empowering Healthcare

Business Performance Services

InteGreat Care Coordination
User Guide

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Chapter 1 - Introduction

This chapter introduces InteGreat Care Coordination as well as discusses how to sign in.

In this chapter

This chapter contains the following topics.

Topic	See page
Overview	2
Signing into InteGreat Care Coordination	3
Introducing the containers	4

Overview

McKesson is pleased to announce the release of InteGreat Care Coordination, v6.12. InteGreat Care Coordination provides an integrated platform to facilitate care and service coordination activities for children with special healthcare needs who are determined eligible for enrollment in Title XIX, Title XXI, Safety Net, and Early Steps lines of business (LOB).

InteGreat Care Coordination provides an integrated platform that allows healthcare professionals to document care coordination activities and produce performance reporting, clinic management using InteGreat Practice Management, and claims payments using the McKesson TPA system.

InteGreat Care Coordination provides role-based permissioned access to client data locally and state-wide. Healthcare professionals can use InteGreat Care Coordination to document the following types of care coordination activities: member identification, initial assessment, triage and program assignment, clinical assessment, task generation and task lists, individualized care plan development and review, care coordination intervention and education, disaster plan documentation, user security, and reporting. InteGreat Care Coordination can be used to document service coordination activities provided to enrolled clients, and to document allowable time and charges to the InteGreat Practice Management for targeted case management.

Signing into InteGreat Care Coordination

To sign into InteGreat Care Coordination:

1. Open Internet Explorer web browser and go to InteGreat Care Coordination web site. If you do not know the location of this web site, contact your network administrator. The Member Sign In screen appears.

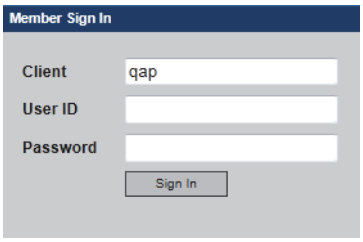


Figure 1. Member Sign In screen

2. In the **Client** text box, enter the name of the database to access. If you do not know the name of this database, contact your system administrator.
3. In the **User ID** text box, enter your user ID to log into InteGreat Care Coordination.
4. In the **Password** text box, enter your password to log into InteGreat Care Coordination.
5. Click the **Sign In** button.

Introducing the containers

Once successfully signed in, InteGreat Care Coordination's Dashboard, called My Dashboard, appears. The Dashboard is a digital display in a common screen of your assigned cases, an abbreviated schedule, and a filterable task list. This information is provided on the Dashboard through widgets. Widgets are drag-and-drop digital boxes which are placed onto the Dashboard.

InteGreat Care Coordination's functionality is largely accessed through "containers," accessible from the left side of the application. Containers are collections of similar information easily accessible from a button. Information displayed in containers is based on user permissions. This offers quick access to InteGreat Care Coordination's principle features.

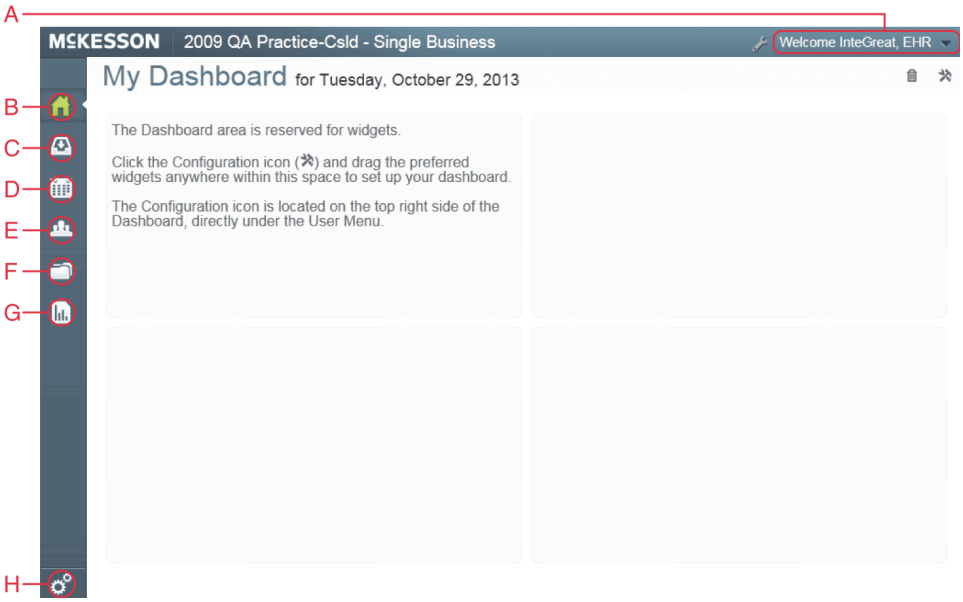


Figure 2. InteGreat Care Coordination (with call outs) when signed in for the first time

Refer to the table below to denote how tools, administrative functions, and containers are accessed in InteGreat Care Coordination (represented by call outs in ***Figure*** 2).

Call out	Description	See page
A	Tools and Administration	5
B	Dashboard container	9
C	Tasks container	21
D	Schedule container	23
E	Patients container	25
F	Cases container	129
G	Reports container	135
H	Settings	187

Chapter 2 - Tools and Administration

This chapter discusses InteGreat Care Coordination tools and administration.

In this chapter

This chapter contains the following topics.

Topic	See page
Tools	6
Print Blank Assessment	6
Add Task	6
Administration	7

Tools

This section contains the following topics:

Topic	See page
Print Blank Assessment	6
Add Task	6

Tool functions are available from the Tools icon ( ).

Print Blank Assessment

Use the Print Blank Assessment tool to print a blank initial assessment form to be filled out offline when an assessment cannot be performed online.

To print a blank assessment:

1. Select Tools > **Print Blank Assessment**. The blank initial assessment form appears as a PDF which may now be printed.

Add Task

Use the Add Task tool to create a new task which may or may not be associated with a member, or without accessing the Task container.

To add a new task:

1. Select Tools > **Add Task**. The New Task screen appears.
2. Enter information for the new task, then click the **OK** button.

   For more information how to add a new task, refer to InteGreat Practice Management documentation.

Administration

Administrative functions are available from the Administration icon ( ).

Function	Description
Help	Use the Help function to access InteGreat product documentation. To access InteGreat product documentation, select Administration > **Help**. A list of InteGreat product documentation appears.
About	Use the About function to display information about InteGreat, including product and build versions. To access InteGreat “about” information, select Administration > **About**. The About screen appears.
Announcements	Use the Announcements function to display announcements distributed by your practice manager. To access announcements, select Administration > **Announcements**. The Announcements screen appears.
Links	Use the Links function to display hyperlinks provided by Children’s Medical Services leadership. To access these hyperlinks, select Administration > **Links**. The Links screen appears.
Change password	Use the Change Password function to change your InteGreat password. For more information how to change this password, refer to InteGreat Practice Management documentation.
Logout	Use the Logout function to sign out from InteGreat. To sign out from InteGreat, select Administration > **Logout**.

Chapter 3 - Dashboard container

This chapter discusses how to use the Dashboard container.

In this chapter

This chapter contains the following topics.

Topic	See page
Introduction to Dashboard functionality	10
Interacting with widgets on the Dashboard	11
Placing widgets on the Dashboard	11
Deleting individual widgets from the Dashboard	11
Reseting the Dashboard	12
Cases widget	13
Information displayed in the Cases widget	13
Using the Cases widget	13
Schedule widget	15
Information displayed in the Schedule widget	15
Using the Schedule widget	15
Tasks widget	18
Information displayed in the Tasks widget	18
Using the Tasks widget	18

Introduction to Dashboard functionality

The Dashboard is a digital display in a common screen of your assigned cases, an abbreviated schedule, and a filterable task list. This information is provided on the Dashboard through widgets. Widgets are drag-and-drop digital boxes which are placed onto the Dashboard.

Below is a brief description of each widget type:

Widget	Description
Cases	The Cases widget displays cases which have been assigned to you either as a primary or secondary assignment. The Cases widget can be used in one of two sizes on the Dashboard: single and tall. The single-sized widget uses a quarter of the Dashboard space, while the tall-sized widget uses half of the Dashboard space.
Schedule	The Schedule widget displays scheduled patient appointments based on a selected calendar.
Tasks	The Tasks widget displays tasks assigned to a selected Care Coordination user.

Interacting with widgets on the Dashboard

This section contains the following topics:

Topic	See page
“Placing widgets on the Dashboard”	11
“Deleting individual widgets from the Dashboard”	11
“Reseting the Dashboard”	12

Placing widgets on the Dashboard

Up to two widgets may be placed on the Dashboard, and only one of each type. For example, two Cases widgets cannot be placed on the Dashboard at the same time. Furthermore, a widget may only be placed into an empty slot (not currently being occupied by a widget).

To place a widget on the Dashboard:

1. In the Dashboard container, click on the Configuration icon ( ) on the upper right of the Dashboard. A list of available widgets appears.

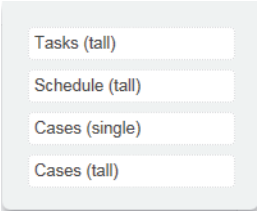


Figure 3. List of available widgets

2. While left-clicking the widget, drag the widget to the Dashboard slot the widget is to occupy. Upon releasing the mouse button, the widget appears. Once a widget has been placed on the Dashboard, that widget disappears from the list of available widgets.

Note: Only one Cases widget may be placed on the Dashboard, regardless of size. For example, once the “Cases (single)” widget has been placed on the Dashboard, the “Cases (tall)” widget cannot be used.

Deleting individual widgets from the Dashboard

To delete a widget from the Dashboard:

1. Click the Close button ( ) on the widget to be closed. The widget disappears from the Dashboard and reappears in the list of available widgets.

Reseting the Dashboard

Resetting the Dashboard removes all widgets, thereby allowing different widgets to be placed into slots.

To reset the Dashboard:

1. In the Dashboard container, click the Reset icon ( ) on the upper right of the Dashboard. All widgets placed on the Dashboard disappear.

Cases widget

This section contains the following topics:

Topic	See page
“Information displayed in the Cases widget”	13
“Using the Cases widget”	13

Information displayed in the Cases widget

The Cases widget displays cases which have been assigned to you either as a primary or secondary assignment. Unlike cases displayed in the Cases container, the Cases widget does not paginate cases; all cases display in a single page. The top of the Cases widget displays how many cases appear in the Cases widget.

The following information is displayed for each case in the Cases widget:

- the patient’s name
- the patient’s primary diagnosis
- the patient’s next review date
- the case type
- the case’s status

Figure 4. A case in the Cases widget

Using the Cases widget

Cases displayed in the Cases widget may be:

- sorted by member name.
- filtered by case type.
- sorted by the next review date.
- filtered by staff assignment.
- filtered by primary diagnosis.

Member demographics may also be accessed from the Cases widget.

For more information how to use cases displayed in the Cases widget, refer to “Chapter 7 - Cases container.”

To sort cases by member name:

1. From the **Sort/Filter by** drop-down list, select **Member Name**. Cases displayed in the Cases widget are sorted alphabetically by member last name.

To filter cases by case type:

1. From the **Sort/Filter by** drop-down list, select **Case Type**. A second drop-down list appears.

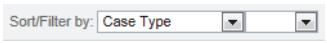


Figure 5. Sort/Filter by drop-down list with Case Type option selected

2. From the second drop-down list, select which case type to filter cases displayed in the Cases widget. Once selected, cases are filtered by case type.

To sort cases by the next review date:

1. From the **Sort/Filter by** drop-down list, select **Next Review Date**. Cases displayed in the Cases widget are sorted by the next review date.

To filter cases by staff assignment:

1. From the **Sort/Filter by** drop-down list, select **Staff Assignment**. A second drop-down list appears.

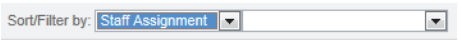


Figure 6. Sort/Filter by drop-down list with Staff Assignment option selected

2. Select one of these options:
   - Select **Primary staff assignment** to filter cases where you are the primary staff assigned.
   - Select **Secondary staff assignment** to filter cases where you are a secondary staff member assigned.

   Once selected, cases displayed in the Cases widget are filtered.

To filter by primary diagnosis:

1. From the **Sort/Filter by** drop-down list, select **Primary Diagnosis**. A second drop-down list appears.

Figure 7. Sort/Filter by drop-down list with Primary Diagnosis option selected

2. From the second drop-down list, select which primary diagnosis to filter cases displayed in the Cases widget. Once selected, cases are filtered by primary diagnosis.

To view member demographics for a case:

1. Click the member's name from the pertinent case to view member demographics in the Patients container. For more information about patient demographics, refer to "Patient Info tab" on page 29.

Schedule widget

This section contains the following topics:

Topic	See page
“Information displayed in the Schedule widget”	15
“Using the Schedule widget”	15

Information displayed in the Schedule widget

The Schedule widget displays scheduled patient appointments based on a selected calendar. Unlike the Schedule container, which displays patient appointments in time-slot formats for one or more selected calendars, the Schedule widget lists appointments for a selected date from one selected calendar. If there are no patient appointments for a specific date from a selected calendar, the Schedule widget displays no information.

Note: Patient appointments displayed in the Schedule widget do not automatically update if schedule calendars are revised from other locations. Information in the Schedule widget must be updated by clicking the **Refresh** button.

The following information is displayed for each patient appointment in the Schedule widget:

- status for the patient appointment (represented by a circle to the left of other appointment information)
- the time set for the patient appointment, colored to represent the visit type (refer to InteGreat Practice Management document for information regarding visit types)
- the member’s name
- the visit type
- the member’s telephone number

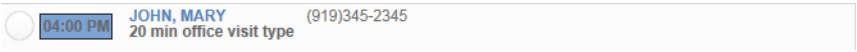


Figure 8. A patient appointment displayed in the Schedule widget

Using the Schedule widget

The Schedule widget can be used to:

- select a date to view patient appointments
- change the status of a patient appointment
- access member demographics associated with a patient appointment
- edit information regarding a patient appointment
- view payment information associated with a patient appointment
- view the history of a patient appointment
- print an encounter form for a patient appointment
- print encounter forms for all patient appointments currently in the Schedule widget
- refresh the Schedule widget

To select a date to view patient appointments:

1. From the **Calendar** drop-down list, select which calendar in which to view patient appointments.

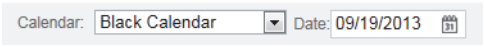


Figure 9. Calendar and Date from the Schedule widget

2. In the **Date** control, select the date in which to view patient appointments. The Schedule widget displays patient appointments for the selected date.

To change the status of a patient appointment:

1. Click the circle to the left of the patient appointment in which to change its status.

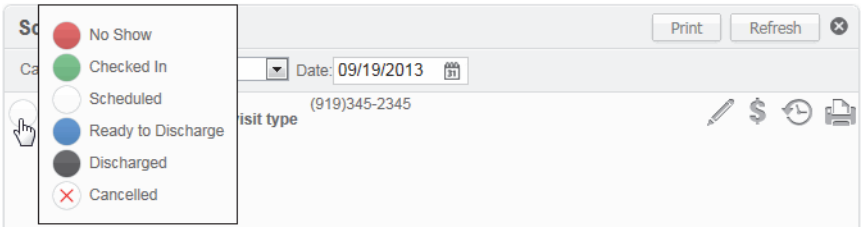


Figure 10. Changing the status of a patient appointment from the Schedule widget

2. Select the circle which represents the new status of the patient appointment.

To access member demographics associated with a patient appointment:

1. Click the member's name from the patient appointment to view member demographics in the Patients container. For more information about patient demographics, refer to "Patient Info tab" on page 29.

To edit information regarding the patient appointment:

1. Click the **Edit Visit** icon beside the patient appointment to be revised. For more information how to edit a patient appointment, refer to InteGreat Practice Management documentation.

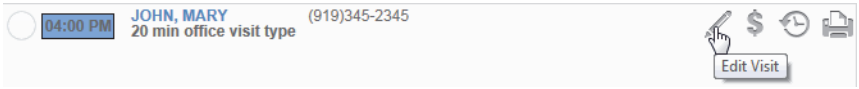


Figure 11. Edit a patient appointment from the Schedule widget

To view patient payment information associated with a patient appointment:

1. Click the **Patient Payment** icon beside the pertinent patient appointment. For more information how to access patient payment information, refer to InteGreat Practice Management documentation.

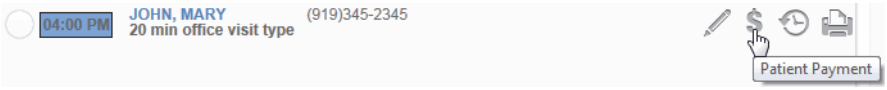


Figure 12. View patient payment information for a scheduled visit from the Schedule widget

To view the history of a patient appointment:

1. Click the **History** icon beside the pertinent patient appointment. For more information about the history for patient appointments, refer to InteGreat Practice Management documentation.

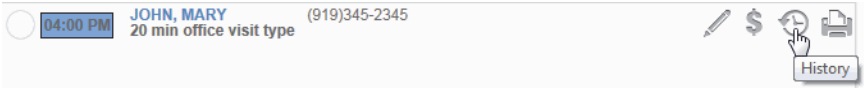


Figure 13. Viewing an appointment's history from the Schedule widget

To print an encounter form for a patient appointment:

1. Click the **Print Encounter Form** icon beside the pertinent patient appointment. The encounter form for that patient appears. For more information about encounter forms, refer to InteGreat Practice Management documentation.

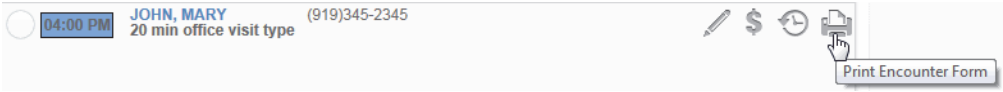


Figure 14. Printing an encounter form from the Schedule widget

To print encounter forms for all patient appointments currently in the Schedule widget:

1. Click the **Print** button in the Schedule widget. Encounter forms for all patient appointments appears. For more information about encounter forms, refer to InteGreat Practice Management documentation.

To refresh the Schedule widget:

1. Click the **Refresh** button in the Schedule widget.

Tasks widget

This section contains the following topics:

Topic	See page
“Information displayed in the Tasks widget”	18
“Using the Tasks widget”	18

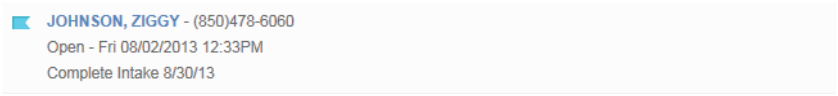
Information displayed in the Tasks widget

The Tasks widget displays tasks assigned to a selected Care Coordination user.

Note: Tasks displayed in the Tasks widget do not automatically update if tasks are revised or added from other locations. Information in the Tasks widget must be updated by clicking the **Refresh** button.

The following information may be displayed for a task in the Tasks widget:

- task priority
  - routine: Routine tasks are represented by the routine task icon ( ).
  - urgent: Urgent tasks are represented by the urgent task icon ( ).
  - as soon as possible (ASAP): ASAP tasks are represented by the ASAP task icon ( ).
- task category
- member name and telephone number (if applicable to the task)
- task status
- task due date
- reason for the task



Using the Tasks widget

Use the Tasks widget to:

- filter tasks displayed in the Tasks widget
- edit a task
- access member demographics associated with a task
- refresh the Tasks widget

To filter tasks displayed in the Tasks widget:

1. From the **User** drop-down list, select for whom to view tasks. Select **(all)** to view tasks from all users.
2. From the **List** drop-down list, select the task on which to filter the view. Select **(all)** to view tasks from all task lists.

To edit a task:

1. Click the **Edit Task** icon beside the task to be revised. For more information how to edit a task, refer to InteGreat Practice Management documentation.

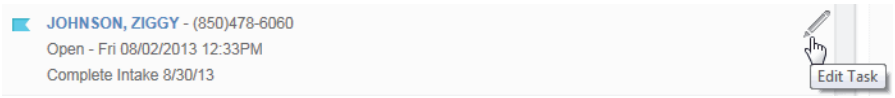


Figure 15. Editing a task from the Tasks widget

To view member demographics associated with a task:

1. Click the member's name from the task to view his or her demographics. For more information about member demographics, refer to "Patient Info tab" on page 29.

To refresh the Tasks widget:

1. Click the **Refresh** button in the Tasks widget.

Chapter 4 - Tasks container

The Tasks container displays tasks assigned to the signed on user. Functionality in the Tasks container is identical to InteGreat Practice Management. For more information about working with tasks, refer to InteGreat Practice Management documentation.

Chapter 5 - Schedule container

The Schedule container is used to manage member scheduling. Functionality in the Schedule container is identical to InteGreat Practice Management. For more information about working with schedules, refer to InteGreat Practice Management documentation.

Chapter 6 - Patients container

This chapter discusses how to use the Patients container.

In this chapter

This chapter contains the following topics.

Topic	See page
Introduction to the Patients container	27
Searching for members	28
Patient Info tab	29
Addl DMG. tab	29
DX tab	31
Create New Case action	31
Care Team action	33
Accessing the care team associated with a member	33
Adding a new provider for a member	35
Adding a new other provider for a member	37
Advanced provider search	38
Care Management tab	41
Introduction to the Care Management tab	41
Overview tab	41
Selecting a case when there is more than one case	42
Properties	42
Programs	46
Program history	55
Details tab	55
Notes	55
Assessments	77
Care plans	109
Services tab	121
Filtering which services display in the Service Tracker pane	122
Adding a new service tracker	123
Creating case-associated tasks	124

Topic	See page
Health Summary tab	126
Viewing treatment and equipment information from assessments	126
Accessing EHR	127

Introduction to the Patients container

The Patients container is used to:

- search for members
- access a member's demographics
- create tasks and appointments associated with a member
- access a member's billing profile
- access a member's care team
- access care management for a member, including staff assignments, assessments, programs, activities, care plans, and services
- access a member's health summary

The Patients container is composed of four areas as noted in the image below.

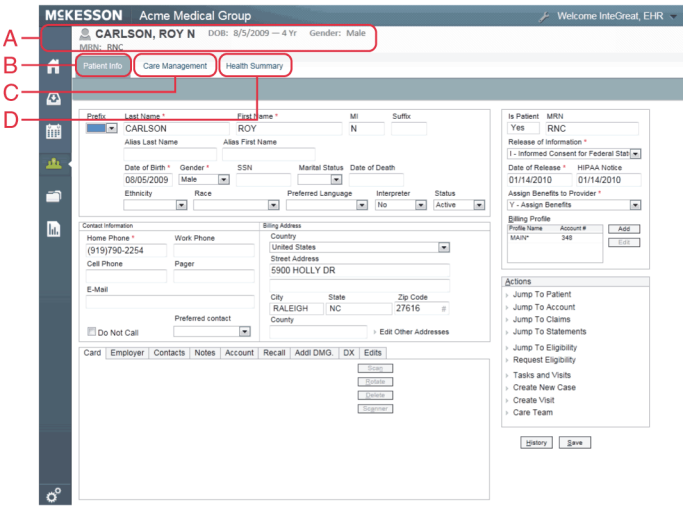


Figure 16. Patients container

Refer to the table below to denote areas of the Patients container (represented by call outs in ***Figure*** 16).

Call out	Description	See page
A	Patient banner	
B	Patient Info tab	29
C	Care Management tab	41
D	Health Summary tab	126

Searching for members

To search for members, do one of the following:

- Click on the Patients container. The Registration Search screen appears.
- If already in the Patients container, click on the Patients container icon. The Registration Search screen appears.

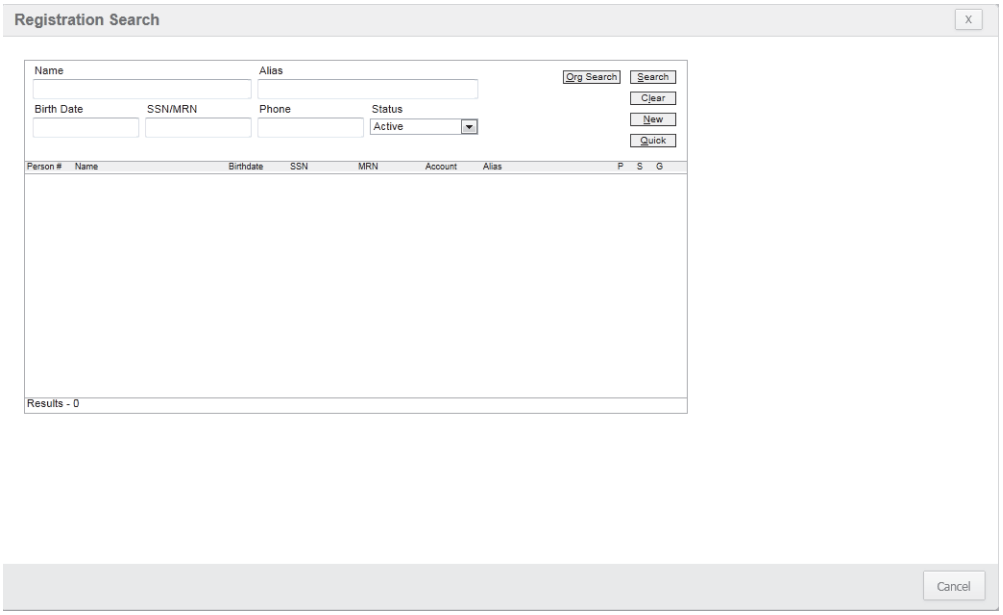


Figure 17. Registration Search screen

For more information about using the Registration Search screen, refer to InteGreat Practice Management documentation.

Patient Info tab

The Patient Info tab is used to access member demographics. If a member has been selected from another container, that member's demographics populate fields in the Patient Info tab; otherwise the fields are empty.

Information displayed in the Patient Info tab is identical to InteGreat Practice Management with the addition of new tabs and actions.

Refer to the following topics about these new tabs and actions:

Topic	See page
Addl DMG. tab	29
DX tab	31
Create New Case action	31
Care Team action	33

Addl DMG. tab

Use the Addl DMG. tab to enter additional demographics regarding the member.

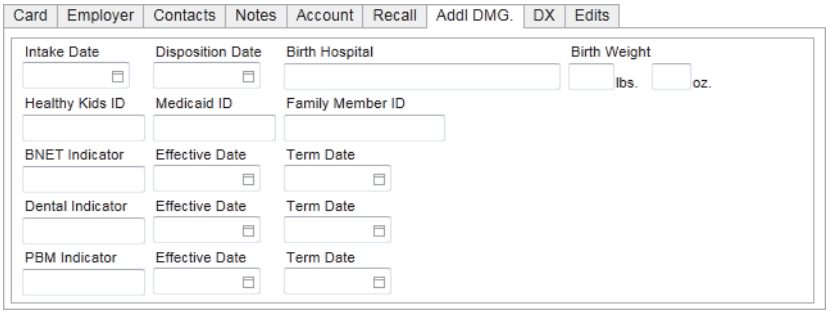


Figure 18. Addl DMG. tab

Enter the following demographics regarding the member (except those noted below, which are populated from the Eligibility Determination module of the TPA system).

Addl DMG. field descriptions

Field	Description
Intake Date	The **Intake Date** field displays the completion of intake processes to enter into the Children Medical Services Programs. This date is populated by the Eligibility Determination module of the TPA system.
Disposition Date	The **Disposition Date** field displays the ending date of service for the member. This date is populated by the Eligibility Determination module of the TPA system.
Birth Hospital	Use the **Birth Hospital** text box to specify the name of the hospital in which the member was born.

Addl DMG. field descriptions (continued)

Field	Description
Birth Weight	Use the **Birth Weight** text boxes to specify the member's birth weight in pounds and ounces.
Healthy Kids ID	The **Healthy Kids ID** field displays the member's Healthy Kids ID. This ID is populated by the Eligibility Determination module of the TPA system.
Medicaid ID	The **Medicaid ID** field displays the member's Medicaid ID. This ID is populated by the Eligibility Determination module of the TPA system.
Family Member ID	The **Family Member ID** field displays the member's Family Member ID. This ID is populated by the Eligibility Determination module of the TPA system. Family Member ID is used to help identify siblings within the Eligibility Determination database.
BNET Indicator	The **BNET Indicator** field indicates the member's enrollment in the BNET program. This information is populated by the Eligibility Determination module of the TPA system.
	The **Effective Date** field displays the member's date of enrollment.
	The **Term Date** field displays the termination date for BNET enrollment.
Dental Indicator	The **Dental Indicator** field indicates the member has dental coverage. This information is populated by the Eligibility Determination module of the TPA system.
	The **Effective Date** field displays the member's effective date for the current plan.
	The **Term Date** field displays the termination date for dental coverage for the current plan.
PBM Indicator	The **PBM Indicator** field indicates the member has pharmacy coverage for the current plan.
	The **Effective Date** field displays the member's effective date for pharmacy coverage through the PBM for the current plan.
	The **Term Date** field displays the termination date of pharmacy coverage through the PBM for the current plan.

DX tab

Use the DX tab to view the member's CMSN qualifying diagnoses. This information is populated by the Eligibility Determination module of the TPA system.

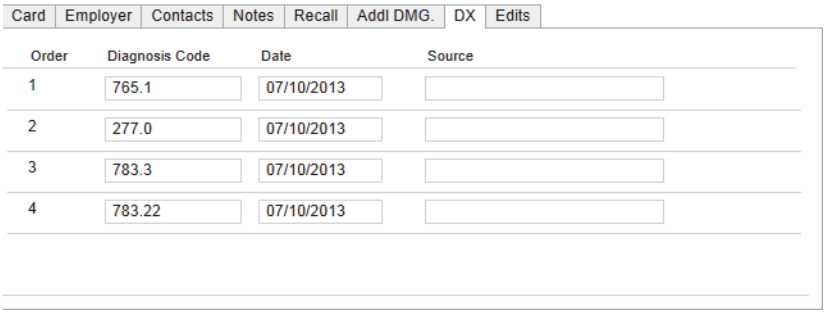


Figure 19. DX tab

Diagnoses are listed in order of primary, secondary, tertiary, and quaternary eligibility order. The DX tab displays:

- diagnosis code
- the date of diagnosis
- source of information

CMSN users do not have permission to remove, update, or change the content of the DX tab; this information is revised in the Eligibility Determination module of the TPA system.

Create New Case action

Use the Create New Case action to create a new case associated with the member.

To create a new case:

1. Click the **Create New Case** action from the Actions group.

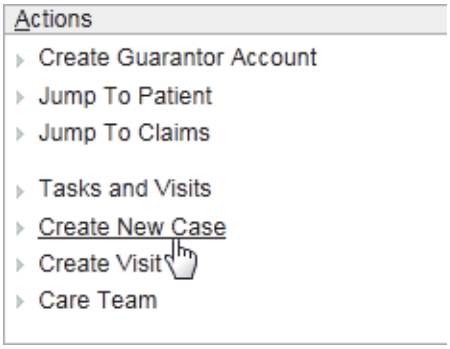


Figure 20. Selecting the Create New Case action

The Create Case screen appears.

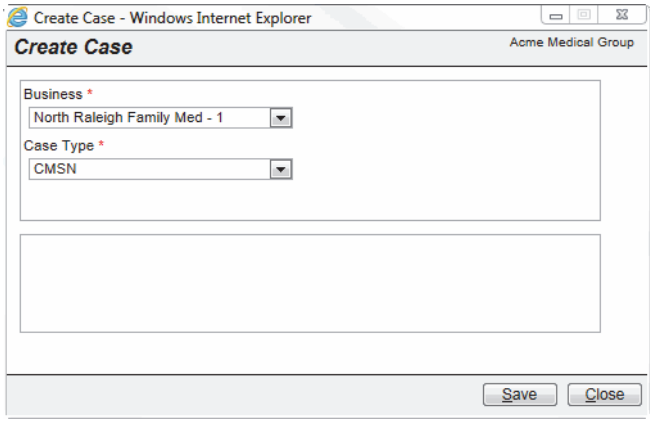


Figure 21. Create Case screen

2. From the **Business** drop-down list, select to which this member's case is to be associated.
3. From the **Case** type drop-down list, select either CMSN or ES as the case type.
4. Click the **Save** button once.
5. If there are no errors, click the **Close** button.

Note: If there is a match on an active case of this case type for the member, a new case cannot be created.

Care Team action

Use the Care Team action to access the care team associated with the member. This section contains the following topics:

Topic	See page
Accessing the care team associated with a member	33
Adding a new provider for a member	35
Adding a new other provider for a member	37
Advanced provider search	38

Accessing the care team associated with a member

To access the care team associated with a member:

1. Click the **Care Team** action from the Actions group.

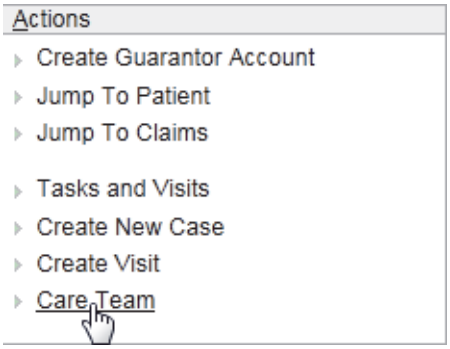


Figure 22. Selecting the Care Team action

The Care Team screen appears:

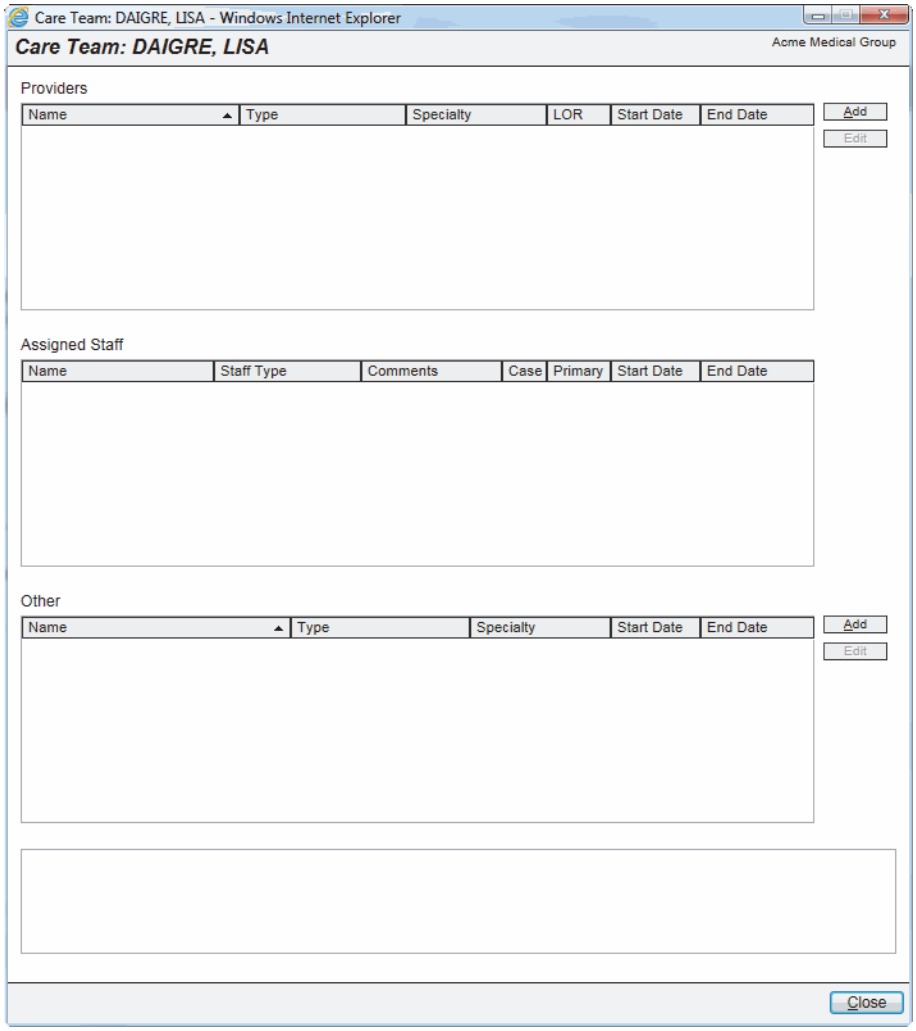


Figure 23. Care Team screen

The Care Team screen contains three groups:

- The **Providers** group contains a list of the member's providers. For more information how to add a member's provider, refer to "Adding a new provider for a member" on page 35. The information for a displayed provider can be revised by clicking the **Edit** button to the right of the Providers group.
- The **Assigned** Staff group contains a list of the member's assigned staff. This information is populated from the member's case. The information in the Assigned Staff group is read-only in the Care Team screen. For information how to assign staff, refer to "Assigning a new staff person in a case's properties" on page 45.
- The **Other** group contains a list of the member's other providers. For more information on how to add a member's other provider, refer to "Adding a new other provider for a member" on page 37. The information for a displayed other provider can be revised by clicking the **Edit** button to the right of the Other group.

2. Once information for the member's care team has been accessed, click the **Close** button.

Adding a new provider for a member

To add a new provider for a member:

1. Access the member's care team. For information how to do so, refer to "Accessing the care team associated with a member" on page 33.
2. To the right of the Providers group, click the **Add** button. The New Member Provider screen appears.

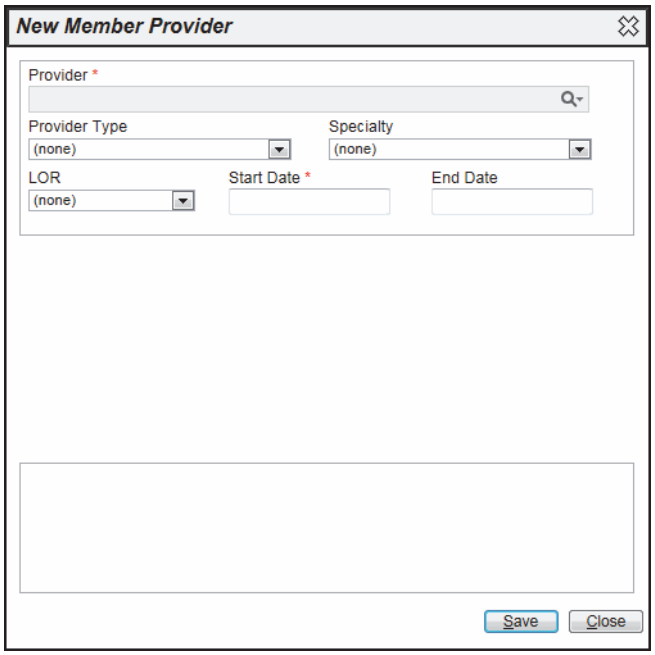


Figure 24. New Member Provider screen

3. Click inside the **Provider** field to specify the member's provider. Then either start typing the name of the provider in the field or click the **Advanced** button for more search options.

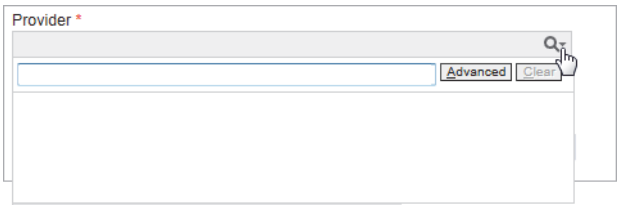


Figure 25. Searching for a member's provider

Note: To determine a provider's network affiliation, click the **Advanced** button. For more information on other search options, refer to "Advanced provider search" on page 38.

4. If the name of the member's provider displays in the drop-down list, select it as the member's provider. Names which are black font color are already linked to your practice. Names which are gray font color are not linked to your practice. Providers not currently linked to your practice during the search can be linked to your practice. This is a required field.

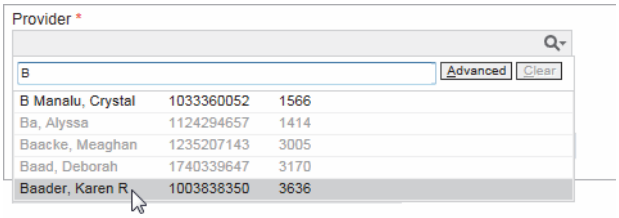


Figure 26. Selecting a member's provider

5. Specify the following information about this member's provider.

Fields in the New Member Provider screen

Field	Description
Provider Type	From the **Provider Type** drop-down list, select the provider type.
Specialty	From the **Specialty** drop-down list, select this provider's specialty.
LOR	From the **LOR** drop-down list, select this provider's Level of Reimbursement.
Start Date	From the **Start Date** text box, enter the date when this provider became part of this member's care team. Use the format ***mm*/*dd*/*yyyy***. This is a required field.
End Date	From the **End Date** text box, enter the date that this provider no longer is part of this member's care team. Use the format ***mm*/*dd*/*yyyy***.

6. Click the **Save** button once. If there are errors, they will display. Make corrections, then click the **Save** button again.
7. If there are no errors, click the **Close** button. The new provider is added to the Provider group in the Care Team screen.

Adding a new other provider for a member

To add a new other provider for a member:

1. Access the member's care team. For information how to do so, refer to "Accessing the care team associated with a member" on page 33.
2. To the right of the Other group, click the **Add** button. The New Member Other Provider screen appears.

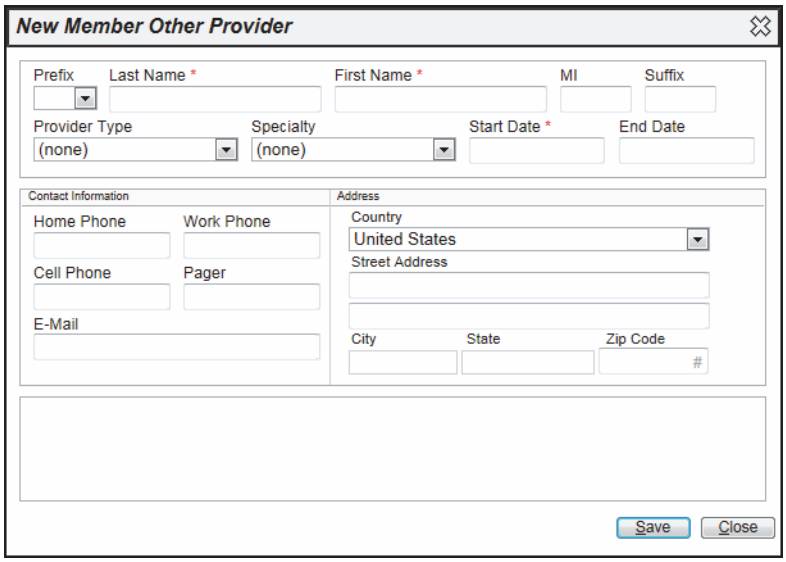


Figure 27. The New Member Other Provider screen

3. Specify the following information about this member's other provider.

Fields in the New Member Other Provider screen

Field	Description
Prefix	From the **Prefix** drop-down list, select a prefix for this other provider.
Last Name	In the **Last Name** text box, type this other provider's last name. This is a required field.
First Name	In the **First Name** text box, type this other provider's first name. This is a required field.
MI	In the **MI** text box, type this other provider's middle initial.
Suffix	In the **Suffix** text box, type this other provider's suffix.
Provider Type	From the **Provider Type** drop-down list, select which type this other provider is.
Specialty	From the **Specialty** drop-down list, select this other provider's specialty.
Start Date	In the **Start Date** text box, enter the date when this other provider became part of this member's care team. Use the format ***mm*/*dd*/*yyyy***. This is a required field.
End Date	In the **End Date** text box, enter the date that this other provider no longer is part of this member's care team. Use the format ***mm*/*dd*/*yyyy***.

Fields in the New Member Other Provider screen (continued)

Field	Description
Home Phone	In the **Home Phone** text box, enter this other provider's home telephone number.
Work Phone	In the **Work Phone** text box, enter this other provider's work telephone number.
Cell Phone	In the **Cell Phone** text box, enter this other provider's cell telephone number.
Pager	In the **Pager** text box, enter this other provider's pager number.
E-Mail	In the **E-Mail** text box, enter this other provider's e-mail address.
Country	From the **Country** drop-down list, specify from which country this other provider lives.
Street Address	In the **Street Address** text boxes, enter the street address for this other provider.
City	In the **City** text box, enter the name of the city of which this other provider practices.
State	In the **State** text box, enter the name of the state of which this other provider practices.
Zip Code	In the **Zip Code** text box, enter this other provider's zip code.

4. Click the **Save** button once. If there are errors, they will display. Make corrections, then click the **Save** button again.
5. If there are no errors, click the **Close** button. The new provider is added to the Other group in the Care Team screen.

Advanced provider search

The advanced provider search is used to find an external member provider who may not be found from the New Member Provider screen. The advanced provider search can be used to search against network affiliation. Furthermore, if the external provider cannot be found, a request can be submitted to add the external provider to the list of selectable providers.

Advanced provider search is accessed from the New Member Provider screen.

To perform an advanced provider search:

1. Click inside the **Provider** field to specify the member's provider, then click the **Advanced** button.

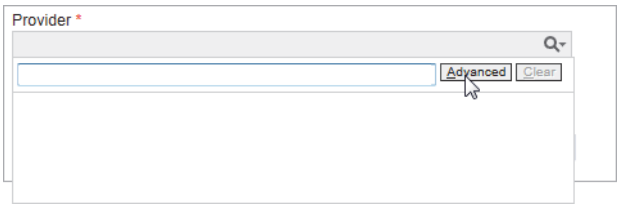


Figure 28. Selecting the Advanced button to perform an advanced member provider search

The External Provider Search screen appears.

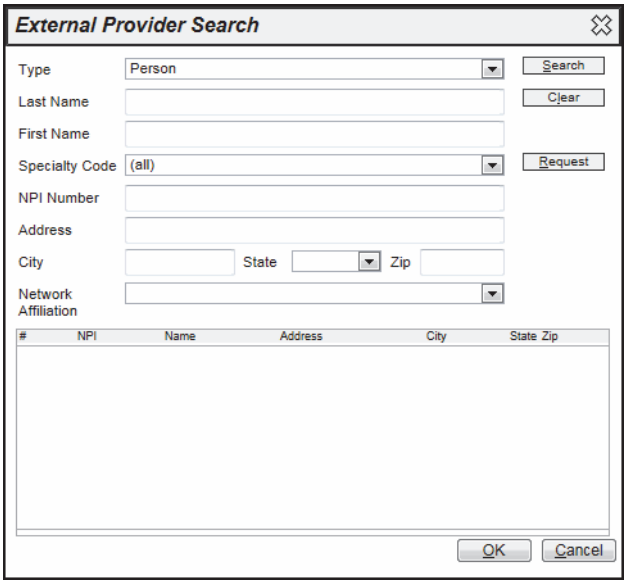


Figure 29. External Provider Search screen

2. Specify the following information about the external provider.

Fields in the External Provider Search screen

Field	Description
Type	From the **Type** drop-down list, select whether the external provider is a person or non-person. An example of a non-person is a facility.
Last Name	In the **Last Name** text box, enter the external provider's last name.
First Name	In the **First Name** text box, enter the external provider's first name.
Specialty Code	From the **Specialty Code** drop-down list, select the external provider's specialty.
NPI Number	In the **NPI Number** text box, enter the external provider's NPI number.
Address	In the **Address** text box, enter the external provider's street address.
City	In the **City** text box, enter the city associated with the external provider's address.
State	From the **State** drop-down list, select the state associated with the external provider's address.
Zip	In the **Zip** text box, enter the zip code associated with the external provider's address.
Network Affiliation	From the **Network Affiliation** drop-down list, specify whether the external provider's network affiliation is only with CMSN or with both CMSN and ES.

3. Click the **Search** button to determine if the external provider can be found. If the external provider is not found, revise your search parameters. If necessary, click the **Clear** button to clear all search parameters.

   If the external provider cannot be found, click the **Request** button to submit a request for the external provider to be added to the list of providers. For more information about entering a request for an additional external provider, refer to InteGreat Practice Management documentation.

4. If the external provider is found, select that provider, then click the **OK** button.

Care Management tab

This section contains the following topics:

Topic	See page
Introduction to the Care Management tab	41
Overview tab	41
Details tab	55
Services tab	121
Creating case-associated tasks	124

Introduction to the Care Management tab

Use the Care Management tab to access care management for a member on a case-by-case basis. The Care Management tab is used to:

- access case properties
- document program details
- view program history
- document case notes
- create assessments
- maintain the care plan
- track services

Information for a case (based on a member) may be accessed through the:

- Overview tab (described on page 41)
- Details tab (described on page 55)
- Services tab (described on page 121)

Overview tab

Use the Overview tab to:

- access case properties
- access information regarding programs associated with the case
- view the program history

This section contains the following topics:

Topic	See page
Selecting a case when there is more than one case	42
Properties	42
Programs	46
Children's Multidisciplinary Assessment Team (CMAT) and Pre-Admission Screening and Resident Review (PASRR) programs	47
Early Steps program	49

Topic	See page
Hug Me program	50
Medical Foster Care (MFC) program	51
Medical Home Project program	53
Partners in Care (PIC) program	53
Program history	55

Selecting a case when there is more than one case

A member may have both CMSN and ES cases. If the Care Management tab is selected from the Patient Info tab for a member who has both case types, the Member Cases screen appears. The Member Cases screen is used to select which case type for that member to access.

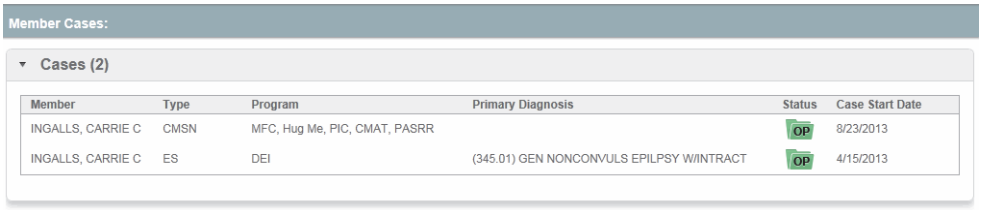


Figure 30. Member Cases screen

Properties

Properties display in the Properties pane. Use the Properties pane to get a snapshot of a member's care coordination basics such as:

- CMS start date
- staff members assigned to the case
- programs in which the member participates
- primary diagnosis

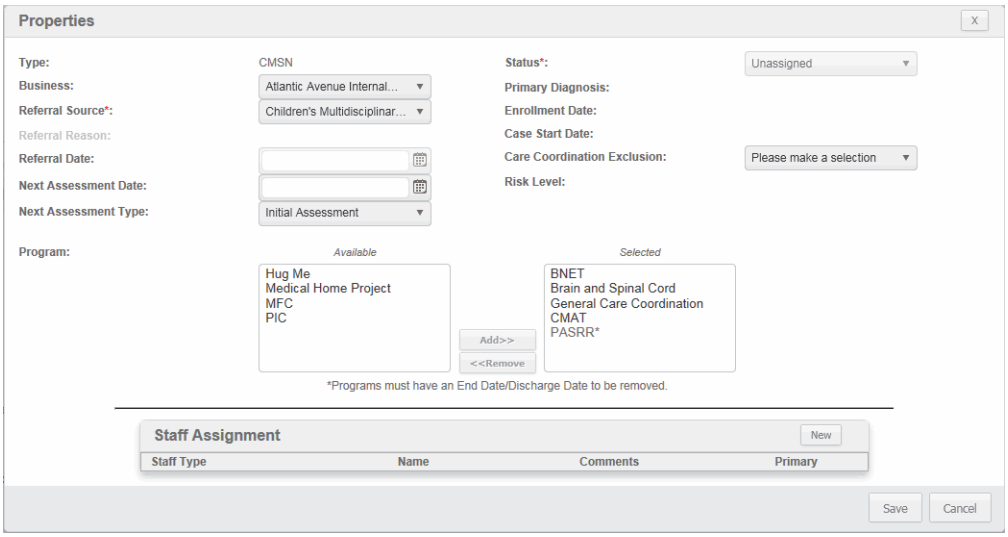


Figure 31. Properties pane

To access case properties:

1. Click the **Edit** button in the **Properties** pane. The Properties screen appears.
2. Specify case property information.

Case property descriptions

Field	Description
Type	The **Type** field displays the case type. This field is read-only.
Business	From the **Business** drop-down list, select which business to associate with the case.
Referral Date	In the **Referral Date** field, specify the date of the referral.
Status	The **Status** option represents the state of the case. From the Status drop-down list, select the status of this case: • Unassigned • New • Open • Readmit • Monitoring • Closed Not all statuses may appear in the current state of the case. The Status property is required.
Primary Diagnosis	The **Primary Diagnosis** field displays the member's primary diagnosis. This field is read-only. The primary diagnosis appears in this field from one of these sources: • CMSN: For CMSN, this information interfaces from the TPA system. • ES: For ES, this information is manually entered into the Early Steps pane. For information about this setting refer to "Early Steps program" on page 49.
Enrollment Date	The **Enrollment Date** field displays the member's enrollment date. This field is read-only.
Case Start Date	The **Case Start Date** field displays when the case was created. This field is read-only.
Program	The **Program** columns are used to specify in which programs the member participates. Available programs are listed in the **Available** column; programs in which the member participates are listed in the **Selected** column. For information how to select in which programs the member participates, refer to "Selecting which programs the member participates" on page 44.
Staff Assignment	The **Staff Assignment** group is used to specify staff assignments. One assigned staff must be the case's primary staff person. For information how to assign a new staff person, refer to "Assigning a new staff person in a case's properties" on page 45. To delete a staff person from the Staff Assignment property, hover over the staff person to be deleted, then click the **Delete** button ( ).
Referral Source	Unique to CMSN: From the **Referral Source** drop-down list, select the referral source. This is a required field.

Case property descriptions (continued)

Field	Description
Referral Reason	Unique to CMSN: The **Referral Reason** displays the reason for the referral. This field is read-only.
Next Assessment Date	Unique to CMSN: The **Next Assessment Date** field may automatically contain a date. If necessary, enter a different date for the next assessment.
Next Assessment Type	Unique to CMSN: From the **Next Assessment Type** drop-down list, select one of these assessment types to be performed: • Initial Assessment • Update Assessment • Redetermination Assessment • Readmit Assessment
Care Coordination Exclusion	Unique to CMSN: From the **Care Coordination Exclusion** drop-down list, select the Care Coordination exclusion: • Opt Out • Unable to Contact Client • Anticipatory Guidance • BSCIP • Clinic Services Only • Non CMS Client (CMAT) • Non CMS Primary Care • North Referral Center
Risk Level	Unique to CMSN: The **Risk Level** field displays the risk level. This field is read-only.

3. Click the **Save** button if any changes have been made to case properties.

To select which programs the member participates:

1. Access the case's properties in which to select which programs the member participates. For more information about accessing a case's properties, refer to "Properties" on page 42.
2. Select one or more programs in the Available column, then click the **Add>>** button to move it/them to the Selected column.
3. If necessary, select one or more programs in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

Note: A program must have an end (or discharge) date to be removed from the Selected column.

Note: ES case users do not need to select programs. The TPA system populates the programs for ES cases.

To assign a new staff person in a case's properties:

1. Access the case's properties in which to assign a new staff person. For more information about accessing a case's properties, refer to "Properties" on page 42.
2. Click the **New** button. The Add Staff Assignment screen displays.

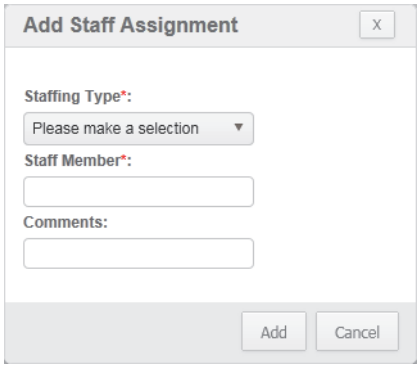


Figure 32. Add Staff Assignment screen

3. From the **Staffing Type** drop-down list, select the staffing type:
   - Nurse Care Coordinator
   - SSW Care Coordinator
   - CMAT RN
   - CMAT SSW
   - MFC SSW
   - Service Coordinator
   - Other

   This is a required field.
4. In the **Staff Member** text box, enter the staff person's name. Enter the staff person's last name, then first name. This is a required field.
5. In the **Comments** text box, enter any comments.
6. Click the **Add** button.

Once a new staff person has been added, the Properties screen reappears.

Programs

Eligible children with special needs can receive family–centered services. A member's participation in one or more of these programs is tracked within InteGreat Practice Management. Each program has its own pane.

Below is a representative image of program information.

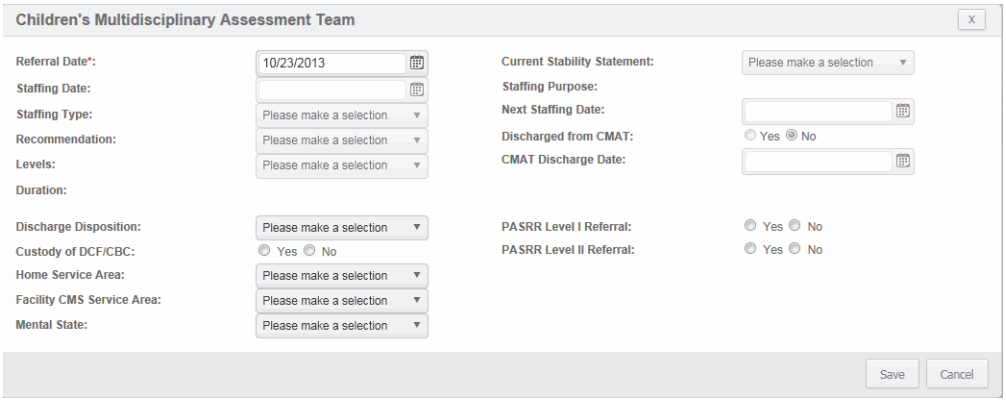


Figure 33. Program information (for CMAT and PASRR programs)

The following programs do not have topics discussing them, as they do not have options associated with them:

- BNET
- Brain and Spinal Cord
- General Care Coordination

Refer to the following topics about programs which have options associated with them:

Topic	See page
Children's Multidisciplinary Assessment Team (CMAT) and Pre-Admission Screening and Resident Review (PASRR) programs	47
Early Steps program	49
Hug Me program	50
Medical Foster Care (MFC) program	51
Medical Home Project program	53
Partners in Care (PIC) program	53

Children's Multidisciplinary Assessment Team (CMAT) and Pre-Admission Screening and Resident Review (PASRR) programs

CMAT and PASRR programs are grouped in the Children's Multidisciplinary Assessment Team pane.

To access CMAT and PASRR programs:

1. Click the **Edit** button in the **Children's Multidisciplinary Assessment Team** pane. The Children's Multidisciplinary Assessment Team screen appears.
2. Specify CMAT and PASRR program information.

CMAT and PASRR program fields

Field	Description
Referral Date	In the **Referral Date** field, specify the date the member was referred to this program. This is a required field.
Staffing Date	The **Staffing Date** field displays the date of a staffing meeting which has been documented in the CMAT Post Staffing Summary note. This field contains a date only after the CMAT Post Staffing Summary note associated with the case has been signed off.
Staffing Type	The **Staffing Type** field displays the type of staffing meeting to occur. This field contains information only after the CMAT Post Staffing Summary note associated with the case has been signed off.
Recommendation	The **Recommendation** field displays results of the staffing meeting. This field contains information only after the CMAT Post Staffing Summary note associated with the case has been signed off.
Levels	The **Levels** field displays the level of support for which the member qualifies. This field contains information only after the CMAT Post Staffing Summary note associated with the case has been signed off.
Duration	The **Duration** field displays the duration of the recommendation from the staffing. This field contains information only after the CMAT Post Staffing Summary note associated with the case has been signed off.
Discharge Disposition	From the **Discharge Disposition** drop-down list, select the discharge disposition: • Traditional Foster Care • Therapeutic Foster Care • Medical Foster Care • Therapeutic Group Home • Skilled Nursing Facility • Adult Skilled Nursing Facility • Home with other Relative Guardian • Home with Biological Parent(s) • Adoptive/pre-adoptive Family • Hospital • Rehabilitative Facility • ADP Home • Patient Expired • Aged Out • Client Moved Out of State • Other

CMAT and PASRR program fields (continued)

Field	Description
Discharge Disposition Reason	The **Discharge Disposition Reason** field appears only if the **Other** option is selected from the **Discharge Disposition** drop-down list. In the Discharge Disposition Reason text box, enter the other reason for the discharge disposition.
Custody of DCF/ CBC	In the **Custody of DCF/CBC** field, indicate using the **Yes** or **No** options whether or not the member is a participant of Florida's Department of Children and Families/Community-Based Care.
Home Service Area	From the **Home Service Area** drop-down list, select the member's home service area.
Facility CMS Service Area	From the **Facility CMS Service Area** drop-down list, select the facility CMS service area.
Mental State	From the **Mental State** drop-down list, select the member's mental state: • Mental Illness • Intellectual Disability • Mental Illness and Intellectual Disability • Neither Mental Illness nor Intellectual Disability • Not Applicable
Current Stability Statement	The **Current Stability Statement** field displays the reason why this member was recommended for the staffing. This field contains information only after the CMAT Post Staffing Summary note associated with the case has been signed off.
Staffing Purpose	The **Staffing Purpose** field displays the purpose of the staffing meeting. This field contains information only after the CMAT Post Staffing Summary note associated with the case has been signed off.
Next Staffing Date	In the **Next Staffing Date** field, specify the next staffing date.
Discharge from CMAT	In the **Discharge from CMAT** field, indicate using the **Yes** or **No** options whether the member is discharged from CMAT.
CMAT Discharge Date	In the **CMAT Discharge Date** field, specify the CMAT discharge date. This field is disabled if the **No** option is selected from the **Discharge from CMAT** field.
PASRR Level I Referral	In the **PASRR Level I Referral** field, indicate using the **Yes** or **No** options whether or not the member is referred for PASRR Level I.
Level I Referral Date	The **Level I Referral Date** field is not visible if the **No** option is selected from the **PASRR Level I Referral** field. In the Level I Referral Date field, specify the PASRR Level I referral date.
PASRR Level II Referral	In the **PASRR Level II Referral** field, indicate using the **Yes** or **No** options whether or not the member is referred for PASRR Level II.
Level II Referral Date	The **Level II Referral Date** field is not visible if the **No** option is selected from the **PASRR Level II Referral** field. In the Level II Referral Date field, specify the PASRR Level II referral date.

CMAT and PASRR program fields (continued)

Field	Description
Level II Completion Date	The **Level II Completion Date** field is not visible if the **No** option is selected from the **PASRR Level II Referral** field. In the Level II Completion Date field, specify the PASRR Level II completion date.
Agency	The **Agency** field is not visible if the **No** option is selected from the **PASRR Level II Referral** field. In the Agency drop-down list, specify whether the agency is APD or DCF.

3. Click the **Save** button if any changes have been made to CMAT or PASRR programs.

Early Steps program

To access Early Steps program:

1. Click the **Edit** button in the **Early Steps** pane. The Early Steps screen appears.
2. Specify Early Steps program information.

Early Steps program fields

Field	Description
Initial IFSP Date	The **Initial IFSP Date** field displays the date of completion of the initial Individual Family Support Plan. The date in this field comes from the TPA system.
Initial IFSP Due Date	The **Initial IFSP Due Date** field displays the due date of the initial Individual Family Support Plan. The date in this field comes from the TPA system.
1st Annual IFSP Date	The **1st Annual IFSP Date** field displays the date of completion of the first annual Individual Family Support Plan. The date in this field comes from the TPA system.
1st Annual IFSP Due Date	The **1st Annual IFSP Due Date** field displays the due date of the first annual Individual Family Support Plan. The date in this field comes from the TPA system.
2nd Annual IFSP Date	The **2nd Annual IFSP Date** field displays the date of completion of the second annual Individual Family Support Plan. The date in this field comes from the TPA system.
2nd Annual IFSP Due Date	The **2nd Annual IFSP Due Date** field displays the due date of the second annual Individual Family Support Plan. The date in this field comes from the TPA system.
Transition Conference Date	The T**ransition Conference Date** displays the date of the Transition Conference. The date in this field comes from the TPA system.
Transition Conference Due Date	The T**ransition Conference Due Date** field displays the due date of the Transition Conference. The date in this field comes from the TPA system.

Early Steps program fields (continued)

Field	Description
Authorization to Disclose	The **Authorization to Disclose** field is used to specify to whom information is authorized to be disclosed. Entities are listed in the **Available** column; entities allowed to receive information are listed in the **Selected** column. For information how to specify which entities are allowed to receive information, refer to "Specifying which entities are allowed to receive member information" on page 50.
Diagnosis	Use the **Diagnosis** fields to specify up to four member diagnoses. The diagnosis in the first Diagnosis field is the member's primary diagnosis.

3. Click the **Save** button if any changes have been made to Early Steps program.

To specify which entities are allowed to receive member information:

1. Access Early Steps program. For more information how to access Early Steps program, refer to "Early Steps program" on page 49.
2. Select one or more entities in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more entities in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

Hug Me program

To access Hug Me program:

1. Click the **Edit** button in the **Hug Me** pane. The Hug Me screen appears.
2. Specify Hug Me program information.

Hug Me program fields

Field	Description
Referral Date	In the **Referral Date** field, specify the date the member was referred to this program. This is a required field.
Start Date	In the **Start Date** field, specify the member's start date to this program.
End Date	In the **End Date** field, specify the member's end date from this program. This field is disabled if there is no start date.

3. Click the **Save** button if any changes have been made to Hug Me program.

Medical Foster Care (MFC) program

To access MFC program:

1. Click the **Edit** button in the **Medical Foster Care** pane. The Medical Foster Care screen appears.
2. Specify MFC program information.

MFC program fields

Field	Description
Referral Date	In the **Referral Date** field, specify the date the member was referred to this program. This is a required field.
Level of Reimbursement	From the **Level of Reimbursement** drop-down list, specify the level of reimbursement: • Level I • Level II • Level III This is a required field.
Was Client Placed	In the **Was Client Placed** field, indicate using the **Yes** or **No** options whether or not the member was placed. This is a required field.
Placement Reason	The **Placement Reason** field is visible if the **Yes** option is selected from the **Was Client Placed** field. From the Placement Reason drop-down list, select the placement reason: • Abandonment • Medical Condition • Medical Neglect • Neglect (non-medical) • Parent Inability to Care • Physical/Sexual Abuse • Other
Reason not Placed	The **Reason not Placed** field is visible if the **No** option is selected from the **Was Client Placed** field. From the Reason not Placed drop-down list, select the reason the member was not placed: • Death of client • Foster care placed other than MFC • MFC Nurse Care Coordinator caseload at capacity • MFC Program on administrative hold and closed to new admissions • No medical foster parent available • Not medically stable enough to be released from hospital • Transferred/moved out of area • Other

MFC program fields (continued)

Field	Description
Client Organization	From the **Client Organization** drop-down list, select the client organization: • Hospital • Adoption • Foster Care • Group Home • Nursing Facility • Parents • Relatives • Other
Admit Date	In the **Admit Date** field, specify the admission date. This field is disabled if the **No** option is selected from the **Was Client Placed** field. This is a required field if the member is admitted to MFC.
Discharge Date	In the **Discharge Date** field, specify the discharge date. This field is disabled if there is no admission date.
Discharge Destination	From the **Discharge Destination** drop-down list, select the member's discharge destination: • Adoption • Death • Foster Care • Group Home • Hospital • Nursing Facility • Parents • Relatives • Other
Discharge Level of Reimbursement	From the **Discharge Level of Reimbursement** drop-down list, select the discharge level of reimbursement: • Level 0 • Level I • Level II • Level III
Comments	In the **Comments** text box, enter any comments.

3. Click the **Save** button if any changes have been made to MFC program.

Medical Home Project program

To access Medical Home Project program:

1. Click the **Edit** button in the **Medical Home Project** pane. The Medical Home Project screen appears.
2. Specify Medical Home Project program information.

Medical Home Project program fields

Field	Description
Referral Date	In the **Referral Date** field, specify the date the member was referred to this program. This is a required field.
Start Date	In the **Start Date** field, specify the member's start date to this program.
End Date	In the **End Date** field, specify the member's end date from this program. This field is disabled if there is no start date.
Location	From the **Location** drop-down list, select a location.

3. Click the **Save** button if any changes have been made to Medical Home Project program.

Partners in Care (PIC) program

To access PIC program:

1. Click the **Edit** button in the **Partners in Care** pane. The Partners in Care screen appears.
2. Specify PIC program information.

PIC program fields

Field	Description
Referral Date	In the **Referral Date** field, specify the date the member was referred to this program. This is a required field.
PIC Enrollment Date	In the **PIC Enrollment Date** field, specify the PIC enrollment date.
Enrollment Status	From the **Enrollment Status** drop-down list, select the enrollment status: • Enrolled • Dis-enrolled • Re-enrolled • In process of recruiting • Unable to enroll • Discharge
Authorization Date from PCP	In the **Authorization Date from PCP** field, specify the authorization date from PCP.
Discharge Date	In the **Discharge Date** field, specify the discharge date.
Current Trajectory of Illness	From the **Current Trajectory of Illness** drop-down list, select the current trajectory of illness: • Newly Diagnosed Stage • Mid Stage • End of Life Stage

PIC program fields (continued)

Field	Description
Family Contact Date	In the **Family Contact Date** field, specify the family contact date.
Hospice Family Contact Date	In the **Hospice Family Contact Date** field, specify the date that Hospice contacted the family.
Discharge Reason	From the **Discharge Reason** drop-down list, select the discharge reason: • Closed to CMS • Lost Medicaid • Moved out of county • Moved to a long term care facility • Moved to full hospice • PCP did not reauthorize child • Family not contactable • Family not interested • Family not using services • Services no longer required • Family is receiving services elsewhere • Family wants services not offered/not available • Unhappy with services • Client expired • Other: If the **Other** option is selected, specify the reason. This field is disabled if there is no discharge date. This is a required field if there is a discharge date.

3. Click the **Save** button if any changes have been made to PIC program properties.

Program history

Use the Program History pane within the Overview tab to view the history of most programs associated with the case. The Program History pane always displays below program panes associated with the case. A number beside the Program History pane title represents how many programs are associated with the case.

To view the history of programs associated with a case:

1. In the Overview tab of a case, scroll below the program panes.
2. If there is a number greater than zero beside the program history pane title, click on the pane title to expand the pane. Programs associated with the case display. The Program History pane displays the following information about each program:

Column	Description
Program	The **Program** column displays the name of the program.
Referral Date	The **Referral Date** column displays the member's referral date to the program.
Start Date	The **Start Date** column displays the date the member started the program.
End Date	The **End Date** column displays the date the member left the program.

3. Click on a program to view a summary of that program's history with this case. Then click the **Close** button.

Details tab

Use the Details tab to:

- access notes associated with the case
- access assessments associated with the case
- access care plans associated with the case

This section contains the following topics:

Topic	See page
Notes	55
Assessments	77
Care plans	109

Notes

This section contains the following topics:

Topic	See page
Introduction to the Notes pane	56
Filtering which notes display in the Notes pane	58
The basics of creating a note	59

Topic	See page
Entering note information using Care Coordination, CMAT, CMAT Fair Hearing, Home Visit, Member Services, MFC, PBM, PIC, Social Services, or Transfer note type	62
Entering note information using the CMAT Post Staffing Summary note type	63
Entering note information using the Hospital Visit note type	69
Entering note information using the Case note type	70
Entering note information using Direct Services or Evaluation note type	72
Entering note information using the TCM note type	74
Printing note summaries	76

Introduction to the Notes pane

Formatted notes are designed for users to appropriately document on-going care coordination and service coordination activities. Time is reported via notes, where appropriate. Notes become a permanent part of the case in which they are associated; notes cannot be deleted or removed once they are created.

Depending upon user permissions, a user may have access to one or more of the following note types: Care Coordination, Case, CMAT, CMAT Fair Hearing, CMAT Post Staffing Summary, Direct Services, Evaluation, Home Visit, Hospital Visit, Member Services, MFC, PBM, PIC, Social Services, TCM, and Transfer.

Notes associated with the case are accessed from the Notes pane. A number beside the Notes pane title represents how many notes currently are in the pane. The Notes pane displays the following information about each note:

Description of columns within the Notes pane

Column	Description
Note	The **Note** column displays the note type and title of the note.
Activity	The **Activity** column displays the date of the activity that is being documented in the note.
Entered	The **Entered** column displays the date the note was entered into the member's record.
Time	The **Time** column displays the amount of time associated with the activity or activities being documented. This column only displays times for ES note types.
Signed	The **Signed** column displays by whom the note was signed.

Description of columns within the Notes pane (continued)

Column	Description
Status	The **Status** column displays the note's status. A note may be one of these statuses: • Draft: Draft status indicates the note has not been signed off. A note in draft status can be revised until it is signed-off. • Error: Error status indicates the note was entered in error on this member's record. A note in error status is non-editable. Notes with error status cannot be copied or amended. • Signed-off: Signed-off status indicates the note has been signed off. A note in signed-off status cannot be edited, but may be amended up to three times. The most recent signed-off version of the note is displayed in the Notes pane.

The Notes pane displays up to ten notes per page. Notes are displayed in reverse chronological order with the most recent notes displaying at the top. Use the following buttons to navigate pages within the Notes pane:

Description of navigation buttons within the Notes pane

Button	Description
First	The **First** button is used to display the first page.
Prev	The **Prev** button is used to display the previous page if there are multiple pages.
Next	The **Next** button is used to display the next page if there are multiple pages.
Last	The **Last** page is used to display the last page.

If there are fewer than ten notes for a case, the navigation buttons do not display.

Clicking on a note opens it. The structure and content of a note varies depending on which note type it is.

Filtering which notes display in the Notes pane

Notes can be filtered, thereby making it easier to locate specific notes.

To filter which notes display in the Notes pane:

1. Click the **Show Filters** button in the Notes pane.
2. Use any of the following filters:

Available filters within the Notes pane

Filter	Description
Type	Select a note type by which to filter notes: • All: The **All** option filters against all note types. • Care Coordination • CMAT • CMAT Fair Hearing • CMAT Post Staffing Summary • Home Visit • Hospital Visit • Member Services • MFC • PBM • PIC • Social Services • Transfer
Activity Date	Select a range of note activity dates by which to filter notes: • Enter only a date in the first field. • Enter only a date in the second field. • Enter dates in both fields.
Entered	Select a range of note entered dates by which to filter notes: • Enter only a date in the first field. • Enter only a date in the second field. • Enter dates in both fields.
Signed	From the **Signed** drop-down list, select a person by which to filter notes. The **All** option filters against all signed notes. Only individuals who have signed notes for this member display in this drop-down list.
Status	Select a note status by which to filter notes: • All: The **All** option filters against all note statuses. • Draft • Signed-off • Error

3. Click the **Apply** button. The Notes pane displays notes which meet the specified filter criteria. If one or more notes are found, the filters automatically hide.

   If no results are found the Notes pane displays “No results found,” instead of a list of notes. The filters remain displayed.

   If necessary, click the **Reset** button to reset filters to their default options.

The basics of creating a note

Despite the different structure and content between note types, all notes are created the same way. Furthermore, all notes display similarly.

To create a note:

1. Click the **New** button in the Notes pane. The Create Note screen appears.

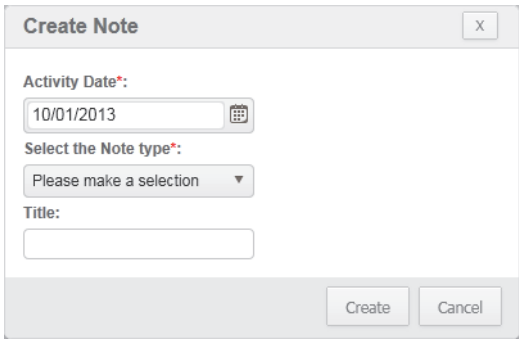


Figure 34. Create Note screen

2. The Activity Date field is used to enter the date a member activity is being documented. The Activity Date automatically displays the current date. If this is to be a different date, In the **Activity Date** field, specify the activity date. This is a required field.
3. From the **Select the Note type** drop-down list, select which note type to use for the note. The note types which display from this drop-down list are based on whether the case associated with the note is CMSN or ES; a CMSN case only displays CMSN-related note types, while an ES case type only displays ES-related note types. This is a required field.

   The following are CMSN note types:

   - Care Coordination
   - CMAT
   - CMAT Fair Hearing
   - CMAT Post Staffing Summary
   - Home Visit
   - Hospital Visit
   - MFC
   - Member Services
   - PBM
   - PIC
   - Transfer
   - Social Services

   The following are ES note types:

   - Case
   - Direct Services
   - Evaluation
   - TCM

4. In the **Title** text box, enter the title for the note.
5. Click the **Create** button to create the note. Once created, a note is permanently associated with the case and cannot be removed or deleted.

Once the note is created (or opened from the Notes pane), the note screen appears. Refer to the table below for a description of note screen elements.

Description of note screen elements

Element	Description
Print button	Use the Print button (), displayed on the top right of the note screen, to print a note. Upon clicking the Print button, a print preview of the note displays. For information how to print all case note summaries for a case, refer to "Printing note summaries" on page 76.
Navigation tab(s)	Navigation tabs, displayed to the left of the note screen, are used to navigate sections of a note: • Note: The Note navigation tab is where most note information is entered, though its content varies based on note type. For many note types, this is the only navigation tab. • Discussion: The Discussion tab is used to enter discussion information. This tab is only used in the CMAT Post Staffing Summary note type. • Task List: The Task List tab is used to select tasks associated with the member's activity the note documents. This tab is only used in the CMAT Post Staffing Summary note type. • Travel: The Travel tab is used to document travel time. This tab is used only for ES case types.
Action bar	The Action bar, displayed on the bottom of the note screen, shows the following: • when and by whom the note was created and last updated while the note is in draft status; • when and by whom the note is signed, when the note is signed off; • total minutes for billing associated with Case, Direct Services, Evaluation, and TCM note types; • the Action buttons.

Description of note screen elements (continued)

Element	Description
Action buttons	Action buttons display on the bottom right of the note screen: • Back: The Back button is used to navigate to a previous section of a multi-section note. If the note has only one tab (or is displaying the first tab), the Back button is disabled. • Next: The Next button is used to navigate to the next section of a multi-section note. If the note has only one tab (or is displaying the last section of a note), the Next button is disabled. • Sign-Off: The Sign-Off button is used to sign off a note which is in draft status. If a note is in Sign-Off status, this button reads Amend, and is used to amend a signed-off note. If a note is signed-off (or in error status), the Sign-Off button does not display. • Amend: The Amend button is used to update a signed-off note. When a note is amended, a copy of the signed-off note is created as the basis for the amended note. If a note is not signed-off (or in error status), the Amend button does not display. • Draft: The Draft button is used to save changes to a note which is in draft status. If the note is signed-off, the Draft button does not display. • Cancel: The Cancel button is used to ignore any changes made to the note. • Error: The Error button is used to change the note to error status. If a note is in error status, the Error button does not display.
View History	If a note has been amended, the View History link appears in the upper left of the note screen. If a note has not been signed-off, the View History link does not appear. Use the View History link to view the note's history as well as note iterations since it has been signed off. For information how to use the View History link, refer to "Viewing a note's history since sign-off" on page 76.

The structure and content of a note varies depending on which note type it is. For more information about note structure and content based on note type, refer to the following topics:

Topic	See page
Entering note information using Care Coordination, CMAT, CMAT Fair Hearing, Home Visit, Member Services, MFC, PBM, PIC, Social Services, or Transfer note type	62
Entering note information using the CMAT Post Staffing Summary note type	63
Entering note information using the Hospital Visit note type	69
Entering note information using the Case note type	70
Entering note information using Direct Services or Evaluation note type	72
Entering note information using the TCM note type	74

Entering note information using Care Coordination, CMAT, CMAT Fair Hearing, Home Visit, Member Services, MFC, PBM, PIC, Social Services, or Transfer note type

The following note types use the same note structure and content:

- Care Coordination
- CMAT
- CMAT Fair Hearing
- Home Visit
- Member Services
- MFC
- PBM
- PIC
- Social Services
- Transfer

This topic assumes that one of these note types have been selected during the note creation procedure. For information how to create a note, refer to "The basics of creating a note" on page 59.

To enter note information using Care Coordination, CMAT, CMAT Fair Hearing, Home Visit, Member Services, MFC, PBM, PIC, Social Services, or Transfer note type:

1. Enter information for the note as necessary:

   Description of note fields for Care Coordination, CMAT, CMAT Fair Hearing, Home Visit, Member Services, MFC, PBM, PIC, Social Services, or Transfer note type

Field	Description
Title	In the **Title** text box revise the title of the note.
Activity	In the **Activity** field, revise the date a member activity being documented occurred.

Description of note fields for Care Coordination, CMAT, CMAT Fair Hearing, Home Visit, Member Services, MFC, PBM, PIC, Social Services, or Transfer note type (continued)

Field	Description
Description	In the **Description** field, enter a description of the activity performed for the member, family, or guardian. Use any of the following text adjustments: • Use the **Bold** button to make selected text bold. • Use the **Italic** button to make selected text italic. • Use the **Underline** button to underline selected text. • From the **Font** drop-down list, change the font for selected text. • From the **Size** drop-down list, change the font size of selected text. • Use the **Align text left** button to left-align a selected paragraph. • Use the **Center text** button to center a selected paragraph. • Use the **Align text right** button to right-align a selected paragraph. • Use the **Justify** button to fully justify text for a selected paragraph. • Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list. • Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list. • Use the **Indent** button to indent a selected paragraph. • Use the **Outdent** button to remove the indent of a selected paragraph. • Use the **Format** button to use preset paragraph formatting to a selected paragraph.

2. Click one of the following buttons in the Action bar:
   - Click the **Sign-Off** button to sign off the note. The note changes to sign-off status.
   - Click the **Draft** button to keep the note in draft status. Clicking the Draft button saves and closes the note.
   - Click the **Cancel** button to ignore changes to the note since it was last opened. Clicking the Cancel button closes the note.
   - Click the **Error** button to change the note to error status. Clicking the Error button closes the note.

Entering note information using the CMAT Post Staffing Summary note type

This topic assumes that the CMAT Post Staffing Summary note type has been selected during the note creation procedure. For information how to create a note, refer to "The basics of creating a note" on page 59.

The CMAT Post Staffing Summary note type contains three tabs:

- Note: Use the Note tab to enter basic note information.
- Discussion: Use the Discussion tab to enter discussion notes.
- Task List: Use the Task List tab to select tasks.

To enter note information using the CMAT Post Staffing Summary note type:

1. Enter information within the Note tab as necessary:

Description of fields within the Note tab for the CMAT Post Staffing Summary note type

Field	Description
Title	In the **Title** text box revise the title of the note.

Description of fields within the Note tab for the CMAT Post Staffing Summary note type

Field	Description
Activity Date	In the **Activity Date** field, revise the date a member activity being documented occurred.
Staffing Date	In the **Staffing Date** field, specify the date for the staffing meeting. Once the note has been signed off, this date displays in the Children's Multidisciplinary Assessment Team pane.
Next Staffing Date	In the **Next Staffing Date** field, specify the date for the next staffing meeting.
Staffing Type	From the **Staffing Type** drop-down list, select the staffing type: • Initial • Follow-up • Reconsideration • Emergency • Continuity of Care • Discharge Once the note has been signed off, this selection displays in the Children's Multidisciplinary Assessment Team pane.
Staffing Purpose	From the **Staffing Purpose** drop-down list, select the staffing purpose: • Eligibility and LOC for SNF • Eligibility and LOR for MFC • Eligibility and LOC for Model Waiver • Dual Eligibility for SNF and MFC • Discharge • At request of Medicaid SA Nurse • Transition into Adulthood • Other Once the note has been signed off, this selection displays in the Children's Multidisciplinary Assessment Team pane.
Discharge from CMAT?	In the **Discharge from CMAT?** field, indicate using the **Yes** or **No** options whether or not the member was discharged from CMAT.

Description of fields within the Note tab for the CMAT Post Staffing Summary note type

Field	Description
Recommendation	From the **Recommendation** drop-down list, select the recommendation: • Discharge from CMAT • Insufficient Data for Recommendation • Medical Foster Care • Isn't Eligible for Services • Nursing Facility • Parent Declined Services • Parent Withdrew from Services • Prescribed Pediatric Extended Care (PPEC) • Private Duty Nursing • Services Denied • Model Waiver Once the note has been signed off, this selection displays in the Children's Multidisciplinary Assessment Team pane.

Description of fields within the Note tab for the CMAT Post Staffing Summary note type

Field	Description
Level	From the Level drop-down list, select the level: • Level I • Level II • Level III • Fragile • Skilled • Intermediate I • Intermediate II • Withhold LOC • Risk of Hospitalization • Does not Meet LOC Criteria • 1 Hour Daily • 2 Hours Daily • 3 Hours Daily • 4 Hours Daily • 5 Hours Daily • 6 Hours Daily • 7 Hours Daily • 8 Hours Daily • 9 Hours Daily • 10 Hours Daily • 11 Hours Daily • 12 Hours Daily • 13 Hours Daily • 14 Hours Daily • 15 Hours Daily • 16 Hours Daily • 17 Hours Daily • 18 Hours Daily • 19 Hours Daily • 20 Hours Daily • 21 Hours Daily • 22 Hours Daily • 23 Hours Daily • 24 Hours Daily Once the note has been signed off, this selection displays in the Children's Multidisciplinary Assessment Team pane.
Duration	In the **Duration** text box, enter the duration of the recommendation from staffing. Once the note has been signed off, this duration displays in the Children's Multidisciplinary Assessment Team pane.

Description of fields within the Note tab for the CMAT Post Staffing Summary note type

Field	Description
Current Stability Statement	From the **Current Stability Statement** drop-down list, select the reason why this member was recommended for the staffing: • The child is at risk for or is experiencing infrequent and predictable changes in medical needs. • The child is experiencing frequent and predictable or infrequent and unpredictable changes in medical needs. • The child is experiencing frequent and unpredictable changes in medical needs. • This factor does not appear to be an issue of concern for this child. • The child does not have a previous stability statement. Once the note has been signed off, this selection displays in the Children's Multidisciplinary Assessment Team pane.
Nursing Assessment Update	In the **Nursing Assessment Update** field, enter a nursing assessment update. Use any of the following text adjustments: • Use the **Bold** button to make selected text bold. • Use the **Italic** button to make selected text italic. • Use the **Underline** button to underline selected text. • From the **Font** drop-down list, change the font for selected text. • From the **Size** drop-down list, change the font size of selected text. • Use the **Align text left** button to left-align a selected paragraph. • Use the **Center text** button to center a selected paragraph. • Use the **Align text right** button to right-align a selected paragraph. • Use the **Justify** button to fully justify text for a selected paragraph. • Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list. • Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list. • Use the **Indent** button to indent a selected paragraph. • Use the **Outdent** button to remove the indent of a selected paragraph. • Use the **Format** button to use preset paragraph formatting to a selected paragraph.

Description of fields within the Note tab for the CMAT Post Staffing Summary note type

Field	Description
Psychosocial Assessment Update	In the **Psychosocial Assessment Update** field, enter a psychosocial assessment update. Use any of the following text adjustments: • Use the **Bold** button to make selected text bold. • Use the **Italic** button to make selected text italic. • Use the **Underline** button to underline selected text. • From the **Font** drop-down list, change the font for selected text. • From the **Size** drop-down list, change the font size of selected text. • Use the **Align text left** button to left-align a selected paragraph. • Use the **Center text** button to center a selected paragraph. • Use the **Align text right** button to right-align a selected paragraph. • Use the **Justify** button to fully justify text for a selected paragraph. • Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list. • Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list. • Use the **Indent** button to indent a selected paragraph. • Use the **Outdent** button to remove the indent of a selected paragraph. • Use the **Format** button to use preset paragraph formatting to a selected paragraph.

2. Click the Discussion tab (or the Next button), then enter discussion comments. Use any of the following text adjustments:
   - Use the **Bold** button to make selected text bold.
   - Use the **Italic** button to make selected text italic.
   - Use the **Underline** button to underline selected text.
   - From the **Font** drop-down list, change the font for selected text.
   - From the **Size** drop-down list, change the font size of selected text.
   - Use the **Align text left** button to left-align a selected paragraph.
   - Use the **Center text** button to center a selected paragraph.
   - Use the **Align text right** button to right-align a selected paragraph.
   - Use the **Justify** button to fully justify text for a selected paragraph.
   - Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list.
   - Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list.
   - Use the **Indent** button to indent a selected paragraph.
   - Use the **Outdent** button to remove the indent of a selected paragraph.
   - Use the **Format** button to use preset paragraph formatting to a selected paragraph.

3. Click the Task List tab (or the Next button), then select tasks associated with this member's staff. Potential tasks are listed in the **Available** column; assigned tasks are listed in the **Selected** column. To specify which tasks to assign:
   - Select one or more tasks in the Available column, then use the **Add>>** button to add it/them to the Selected column.
   - If necessary, select one or more tasks in the Selected, then use the **<<Remove** button to remove it/them from the Selected column.
4. Click one of the following buttons in the Action bar:
   - Click the **Sign-Off** button to sign off the note. The note changes to sign-off status.
   - Click the **Draft** button to keep the note in draft status. Clicking the Draft button saves and closes the note.
   - Click the **Cancel** button to ignore changes to the note since it was last opened. Clicking the Cancel button closes the note.
   - Click the **Error** button to change the note to error status. Clicking the Error button closes the note.

Entering note information using the Hospital Visit note type

This topic assumes that the Hospital Visit note type has been selected during the note creation procedure. For information how to create a note, refer to "The basics of creating a note" on page 59.

To enter note information using the Hospital Visit note type:

1. Enter information for the note as necessary:

Description of note fields for Hospital Visit note type

Field	Description
Title	In the **Title** text box revise the title of the note.
Activity	In the **Activity** field, revise the date a member activity being documented occurred.
Date of Admission	In the **Date of Admission** field, specify the date the member was admitted to the hospital.
Hospital	In the **Hospital** field, enter the name of the hospital into which the member was admitted.
Discharge Date	In the **Discharge Date** field, enter the date the member was discharged from the hospital (if applicable).

Description of note fields for Hospital Visit note type (continued)

Field	Description
Description	In the **Description** field, enter a description of the activity performed for the member, family, or guardian. Use any of the following text adjustments: • Use the **Bold** button to make selected text bold. • Use the **Italic** button to make selected text italic. • Use the **Underline** button to underline selected text. • From the **Font** drop-down list, change the font for selected text. • From the **Size** drop-down list, change the font size of selected text. • Use the **Align text left** button to left-align a selected paragraph. • Use the **Center text** button to center a selected paragraph. • Use the **Align text right** button to right-align a selected paragraph. • Use the **Justify** button to fully justify text for a selected paragraph. • Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list. • Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list. • Use the **Indent** button to indent a selected paragraph. • Use the **Outdent** button to remove the indent of a selected paragraph. • Use the **Format** button to use preset paragraph formatting to a selected paragraph.

2. Click one of the following buttons in the Action bar:
   - Click the **Sign-Off** button to sign off the note. The note changes to sign-off status.
   - Click the **Draft** button to keep the note in draft status. Clicking the Draft button saves and closes the note.
   - Click the **Cancel** button to ignore changes to the note since it was last opened. Clicking the Cancel button closes the note.
   - Click the **Error** button to change the note to error status. Clicking the Error button closes the note.

Entering note information using the Case note type

This topic assumes that the Case note type has been selected during the note creation procedure. For information how to create a note, refer to "The basics of creating a note" on page 59.

The Case note type contains two tabs:

- Note: Use the Note tab to enter basic note information.
- Travel: Use the Travel tab to enter travel times.

To enter note information using the Case note type:

1. Enter information within the Note tab as necessary:

Description of fields within the Note tab for the Case note type

Field	Description
Title	In the **Title** text box revise the title of the note.
Activity Date	In the **Activity Date** field, revise the date a member activity being documented occurred.

Description of fields within the Note tab for the Case note type (continued)

Field	Description
Time In	In the **Time In** field, specify the time the case activity started.
Time Out	In the **Time Out** field, specify the time the case activity ended.
Activity	The **Activity** list box contains a preset list of activities which may be clicked on to appear in the Description field below it. Click on specific activities which apply to the member's activity being documented.
Description	In the **Description** field, enter a description of the activity performed for the member, family, or guardian. Use any of the following text adjustments: • Use the **Bold** button to make selected text bold. • Use the **Italic** button to make selected text italic. • Use the **Underline** button to underline selected text. • From the **Font** drop-down list, change the font for selected text. • From the **Size** drop-down list, change the font size of selected text. • Use the **Align text left** button to left-align a selected paragraph. • Use the **Center text** button to center a selected paragraph. • Use the **Align text right** button to right-align a selected paragraph. • Use the **Justify** button to fully justify text for a selected paragraph. • Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list. • Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list. • Use the **Indent** button to indent a selected paragraph. • Use the **Outdent** button to remove the indent of a selected paragraph. • Use the **Format** button to use preset paragraph formatting to a selected paragraph.

2. Click the Travel tab (or the Next button), then enter the following information as necessary. There are two sets of time in/time out fields for travel time entry:

Description of fields within the Travel tab for the Case note type

Field	Description
Time In	In the **Time In** field, specify the time the case activity started.
Time Out	In the **Time Out** field, specify the time the case activity ended.

3. Click one of the following buttons in the Action bar:
   - Click the **Sign-Off** button to sign off the note. The note changes to sign-off status.
   - Click the **Draft** button to keep the note in draft status. Clicking the Draft button saves and closes the note.
   - Click the **Cancel** button to ignore changes to the note since it was last opened. Clicking the Cancel button closes the note.
   - Click the **Error** button to change the note to error status. Clicking the Error button closes the note.

Entering note information using Direct Services or Evaluation note type

The following note types use similar note structure and content:

- Direct Services
- Evaluation

This topic assumes that one of these note types have been selected during the note creation procedure. For information how to create a note, refer to "The basics of creating a note" on page 59.

The Direct Services and Evaluation note types contain two tabs:

- Note: Use the Note tab to enter basic note information.
- Travel: Use the Travel tab to enter travel times.

To enter note information using Direct Services or Evaluation note type:

1. Enter information within the Note tab as necessary:

Description of fields within the Note tab for Direct Services or Evaluation note type

Field	Description
Title	In the **Title** text box revise the title of the note.
Activity Date	In the **Activity Date** field, revise the date a member activity being documented occurred.
Service	In the **Service** field, enter the name of the service. To do so, type either the name of the service or its service code, then select that service from the drop-down list.
Diagnosis	From the **Diagnosis** drop-down list, select a diagnosis. If diagnoses have been entered for the member, they display when the Diagnosis drop-down list is clicked.
Time In	In the **Time In** field, specify the time the service started.
Time Out	In the **Time Out** field, specify the time the service ended.
Include for billing	Select the **Include for billing** check box if the time spent on this service is billable.

Description of fields within the Note tab for Direct Services or Evaluation note type (continued)

Field	Description
Description	In the **Description** field, enter a description of the activity performed for the member, family, or guardian. Use any of the following text adjustments: • Use the **Bold** button to make selected text bold. • Use the **Italic** button to make selected text italic. • Use the **Underline** button to underline selected text. • From the **Font** drop-down list, change the font for selected text. • From the **Size** drop-down list, change the font size of selected text. • Use the **Align text left** button to left-align a selected paragraph. • Use the **Center text** button to center a selected paragraph. • Use the **Align text right** button to right-align a selected paragraph. • Use the **Justify** button to fully justify text for a selected paragraph. • Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list. • Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list. • Use the **Indent** button to indent a selected paragraph. • Use the **Outdent** button to remove the indent of a selected paragraph. • Use the **Format** button to use preset paragraph formatting to a selected paragraph.

2. Click the Travel tab (or the Next button), then enter the following information as necessary. There are two sets of time in/time out fields for travel time entry:

Description of fields within the Travel tab for Direct Services or Evaluation note type

Field	Description
Time In	In the **Time In** field, specify the time the Direct Services or Evaluation activity started.
Time Out	In the **Time Out** field, specify the time the Direct Services or Evaluation activity ended.

3. Click one of the following buttons in the Action bar:
   - Click the **Sign-Off** button to sign off the note. The note changes to sign-off status.
   - Click the **Draft** button to keep the note in draft status. Clicking the Draft button saves and closes the note.
   - Click the **Cancel** button to ignore changes to the note since it was last opened. Clicking the Cancel button closes the note.
   - Click the **Error** button to change the note to error status. Clicking the Error button closes the note.

Entering note information using the TCM note type

This topic assumes that the TCM note type has been selected during the note creation procedure. For information how to create a note, refer to "The basics of creating a note" on page 59.

The TCM note type contains three tabs:

- Note: Use the Note tab to enter basic note information.
- Follow-up: Use the Follow-up tab to enter the expected follow-up plan.
- Travel: Use the Travel tab to enter travel times.

To enter note information using the TCM note type:

1. Enter information within the Note tab as necessary:

Description of fields within the Note tab for the TCM note type

Field	Description
Title	In the **Title** text box revise the title of the note.
Activity Date	In the **Activity Date** field, revise the date a member activity being documented occurred.
Location	From the **Location** drop-down list, select where the activity took place: 1 - Child's Home 2 - DEI Clinic 3 - Hospital 4 - School (public school site) 5 - Child Care Facility (2) 6 - Other Location 7 - Outpatient Clinic 8 - Residential Facility 0 - Early Intervention Classroom A - Community Agency B - Prescribed Pediatric Ext Care Facility (PPEC) C - County Public Health Unity D - CMS Clinic E - Family Day Care P - Public Place
Time In	In the **Time In** field, specify the time the case activity started.
Time Out	In the **Time Out** field, specify the time the case activity ended.
Diagnosis	From the **Diagnosis** drop-down list, select a diagnosis. If diagnoses have been entered for the member, they will display when the Diagnosis drop-down list is clicked.
Include for billing	Select the **Include for billing** check box if the time spent on this service is billable.
Activity	The **Activity** list box contains a preset list of activities which may be clicked on to appear in the Description field below it. Click on specific activities which apply to the member's activity being documented.

Description of fields within the Note tab for the TCM note type (continued)

Field	Description
Description	In the **Description** field, enter a description of the activity performed for the member, family, or guardian. Use any of the following text adjustments: • Use the **Bold** button to make selected text bold. • Use the **Italic** button to make selected text italic. • Use the **Underline** button to underline selected text. • From the **Font** drop-down list, change the font for selected text. • From the **Size** drop-down list, change the font size of selected text. • Use the **Align text left** button to left-align a selected paragraph. • Use the **Center text** button to center a selected paragraph. • Use the **Align text right** button to right-align a selected paragraph. • Use the **Justify** button to fully justify text for a selected paragraph. • Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list. • Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list. • Use the **Indent** button to indent a selected paragraph. • Use the **Outdent** button to remove the indent of a selected paragraph. • Use the **Format** button to use preset paragraph formatting to a selected paragraph.

2. Click the Follow-up tab (or the Next button), then enter a follow-up plan. Use any of the following text adjustments:
   - Use the **Bold** button to make selected text bold.
   - Use the **Italic** button to make selected text italic.
   - Use the **Underline** button to underline selected text.
   - From the **Font** drop-down list, change the font for selected text.
   - From the **Size** drop-down list, change the font size of selected text.
   - Use the **Align text left** button to left-align a selected paragraph.
   - Use the **Center text** button to center a selected paragraph.
   - Use the **Align text right** button to right-align a selected paragraph.
   - Use the **Justify** button to fully justify text for a selected paragraph.
   - Use the **Insert unordered list** button to set the selected paragraph as part of a bulleted list.
   - Use the **Insert ordered list** button to set the selected paragraph as part of a numbered list.
   - Use the **Indent** button to indent a selected paragraph.
   - Use the **Outdent** button to remove the indent of a selected paragraph.
   - Use the **Format** button to use preset paragraph formatting to a selected paragraph.
3. Click the Travel tab (or the Next button), then enter the following information as necessary. There are two sets of time in/time out fields for travel time entry:

Description of fields within the Travel tab for the TCM note type

Field	Description
Time In	In the **Time In** field, specify the time the TCM activity started.
Time Out	In the **Time Out** field, specify the time the TCM activity ended.

4. Click one of the following buttons in the Action bar:
   - Click the **Sign-Off** button to sign off the note. The note changes to sign-off status.
   - Click the **Draft** button to keep the note in draft status. Clicking the Draft button saves and closes the note.
   - Click the **Cancel** button to ignore changes to the note since it was last opened. Clicking the Cancel button closes the note.
   - Click the **Error** button to change the note to error status. Clicking the Error button closes the note.

Printing note summaries

Note summaries can be printed. In doing so, all notes which do not have “error” status can be selected for printing.

To print note summaries:

1. Click the **Summary** button in the Notes pane. The Note Summary Print Preview screen appears.

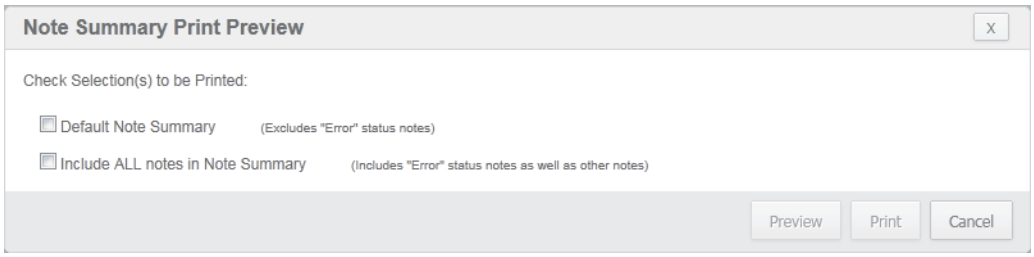


Figure 35. Note Summary Print Preview screen

2. Select one of these options:
   - **Default Note Summary:** Select this option to print notes which do not include the “error” status.
   - **Include ALL notes in Notes Summary:** Select this option to print all note summaries.

   One of these options must be selected before the Preview or Print buttons become enabled.
3. Click the **Preview** button to preview the note summaries.
4. Once the note summaries have compiled, click the **Print** button to print the note summaries.

To view a note’s history since sign-off:

1. While viewing a signed-off note, click the **View History** link. The Amendment History screen displays a list of all note iterations since sign-off. Oldest iterations display at the top of the list.

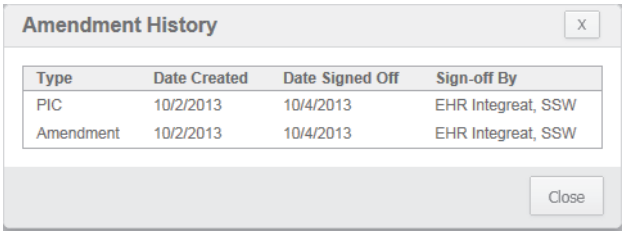


Figure 36. Amendment History screen

2. Click a note iteration from the list to view it. The note is read-only.
3. After viewing the note, click the **Close** button in the Action bar to close the note iteration. The Amendment History screen reappears.
4. Click the **Close** button to close the Amendment History screen.

Assessments

This section contains the following topics:

Topic	See page
Introduction to the Assessment pane	77
Filtering which assessments display in the Assessments pane	84
Creating a new assessment	85
Header tab assessment fields	85
Program Education tab assessment fields	87
Provider tab assessment fields	88
Medical/Dental History assessment fields	88
Review of Systems assessment fields	95
Psychosocial/Environmental tab assessment fields	100
CMAT tab assessment fields	105
Acuity Risk Tool tab assessment fields	106
Concerns tab assessment fields	107
Creating a copy of an assessment	108
Updating the next assessment date and type after sign-off	108

Introduction to the Assessment pane

Assessments display in the Assessments pane. Use assessments to document member health and abilities, including:

- medical and dental history
- activities of daily living (ADLs)
- psychosocial information

There are four types of assessments:

- initial assessment
- update assessment
- redetermination assessment
- readmit assessment

What distinguishes these assessment types is that they may be performed for a member at different times. The assessment form is identical for all assessment types.

By default, the number beside the Assessments pane title represents the total number of assessments for the member's case. If filtered, a number beside the Assessments pane title represents how many assessments currently are in the pane. The Assessments pane displays the following information about each assessment:

Description of columns within the Assessments pane

Column	Description
Type	The **Type** column displays the assessment's type.
Description	The **Description** column displays the title entered for the assessment.
Activity Date	The **Activity Date** column displays the date the assessment of the member took place.
Entered	The **Entered** column displays the date the assessment was entered into the member's record.
Signed	The **Signed** column displays who signed-off the assessment.
Status	The **Status** column displays the assessment's status. An assessment may be one of these statuses: • Draft: Draft status indicates the assessment has not been signed off. An assessment in draft status can be revised until it is signed-off. • Error: Error status indicates the assessment was entered in error on this member's record. An assessment in error status is non-editable. Assessments with error status cannot be copied or amended. • Signed-off: Signed-off status indicates the assessment has been signed off. An assessment in signed-off status cannot be edited, but may be amended. The most recent signed-off version of the assessment is displayed in the Assessments pane.

The Assessments pane displays up to ten assessments per page. Assessments are displayed in reverse chronological order with the most recent assessments displaying at the top. Use the following buttons to navigate pages within the Assessments pane:

Description of navigation buttons within the Assessments pane

Button	Description
First	The **First** button is used to display the first page.
Prev	The **Prev** button is used to display the previous page if there are multiple pages.
Next	The **Next** button is used to display the next page if there are multiple pages.
Last	The **Last** page is used to display the last page.

If there are fewer than ten assessments for a case, the navigation buttons do not display.

Clicking on an assessment opens it. Once an assessment is opened, the assessment screen appears. Refer to the table below for a description of assessment screen elements.

Description of assessment screen elements

Element	Description
Print button	Use the Print button (), displayed on the top right of the assessment screen, to print an assessment. For more information, refer to “Printing an assessment” on page 82.
New Concern button	Use the New Concern button (), displayed on the top right of the assessment screen, to document a new concern. A concern may be documented in draft status to be included with the assessment. A new concern may be entered at any time during the assessment from any assessment section. Upon completion of entering a new concern, the user is returned to the assessment section. For more information, refer to “Documenting a concern using the New Concern button” on page 83.

Description of assessment screen elements (continued)

Element	Description
Navigation tab(s)	Navigation tabs, displayed to the left of the assessment screen, are used to navigate sections of an assessment: • Header: The Header tab is used to enter contact information for the member, as well as how information for the assessment was collected. • Program Education: The Program Education tab is used to document whether or not the parent/guardian agreed to participate in Care Coordination. • Provider: The Provider tab is used to document which providers are interacting with the member. • Medical/Dental History: Medical/Dental History is used to document the member's medical and dental history. It contains the following sections: - Diagnosis - Allergies - Growth - Immunizations - Family History - Clinical History - Child Health Check-up - Dental Care - Medications - Nutrition - Development/ADL's - Treatment/Equipment • Review of Systems: Review of Systems is used to document the member's bodily systems. It contains the following sections: - Eye/Vision - Ear/Hearing - Nose/Throat - Oral/Dental - Respiratory - Cardiovascular - Gastrointestinal - Genitourinary - Endocrine - Dermatologic - Musculoskeletal - Hermatologic - Neurological • Psychosocial/Environmental: The Psychosocial/Environmental tab is used to document psychosocial and environmental factors affecting the member. • CMAT: The CMAT tab is used to document CMAT-related issues. • Acuity Risk Tool: The Acuity Risk Tool tab is used to document the member's acuity risk. • Concerns: The Concerns tab is used to document concerns.

Description of assessment screen elements (continued)

Element	Description
Action bar	The Action bar, displayed on the bottom of the assessment screen, shows the following: • when and by whom the assessment was created and last updated while the assessment is in draft status; • when and by whom the assessment is signed, when the assessment is signed off; • the Action buttons.
Action buttons	Action buttons display on the bottom right of the assessment screen: • Back: The Back button is used to navigate to a previous section of an assessment. If the assessment is displaying the first tab, the Back button is disabled. • Next: The Next button is used to navigate to the next section of an assessment. If the assessment is displaying the last tab, the Next button is disabled. • Draft: The Draft button is used to save changes to an assessment which is in draft status. If the assessment is signed-off, the Draft button does not display. • Copy: The Copy button is used to create a new assessment based on the contents of an existing one. For information how to copy an assessment, refer to “Creating a copy of an assessment” on page 108. • Sign-Off: The Sign-Off button is used to sign off an assessment which is in draft status. If an assessment is in Sign-Off status, this button reads Amend, and is used to amend a signed-off assessment. If a note is signed-off (or in error status), the Sign-Off button does not display. When an assessment is signed off, there is the opportunity to schedule the next member assessment and/or to create a member care plan. Refer to these topics for more information about each: - “Updating the next assessment date and type after sign-off” on page 108 - “Introduction to care plans” on page 109 • Amend: The Amend button is used to update a signed-off assessment. When an assessment is amended, a copy of the signed-off assessment is created as the basis for the amended assessment. If an assessment is not signed-off (or in error status), the Amend button does not display. • Cancel: The Cancel button is used to ignore any changes made to the assessment. • Error: The Error button is used to change the assessment to error status. If an assessment is in error status, the Error button does not display.

Description of assessment screen elements (continued)

Element	Description
Assessment Bookmark Indicator	The Assessment Bookmark Indicator ( ) is used to indicate the last tab displaying in the assessment before the Draft button was clicked or the InteGreat session timed out. The Assessment Bookmark Indicator displays on the pertinent tab when the assessment is reopened.
Clear Data button	The Clear Data button ( ), displayed on page contents for each tab, is used to clear all entered data from fields in the section.
View History	If an assessment has been amended, the View History link appears in the upper left of the assessment screen. If an assessment has not been signed-off, the View History link does not appear. Use the View History link to view the assessment's history as well as assessment iterations since it has been signed off. For information, refer to "Viewing an assessment's history since sign-off" on page 83.

To print an assessment:

1. Open the assessment to be printed, then click the **Print** button. The Assessment Print Preview screen appears.

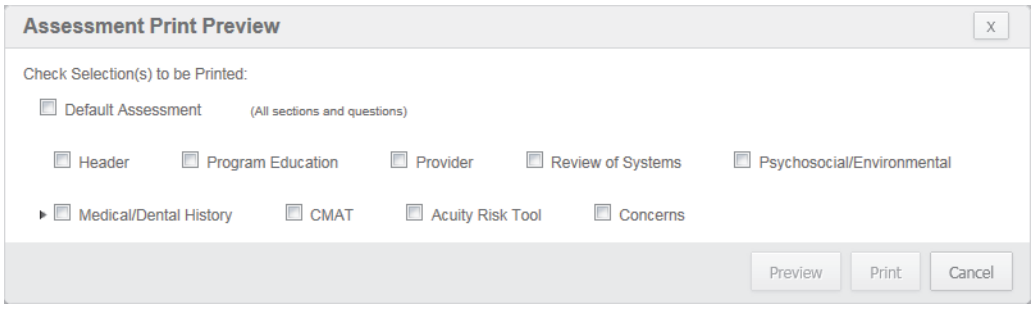


Figure 37. Assessment Print Preview screen

2. Select which part(s) of the assessment to print:
   - Default Assessment (which prints all tabs)
   - Header
   - Program Education
   - Provider
   - Review of Systems
   - Psychosocial/Environmental
   - Medical/Dental History
     - Allergies
     - Immunizations
     - Family History
     - Child Health Check-up
     - Dental Care
     - Nutrition
     - Development/ADL's
     - Treatment/Equipment
   - CMAT
   - Acuity Risk Tool
   - Concerns

3. Click the **Preview** button. A print preview of the assessment displays.
4. Click the **Print** button.

To document a concern using the New Concern button:

1. From an assessment in draft status, click the **New Concern** button ( ). The New Concern screen appears.

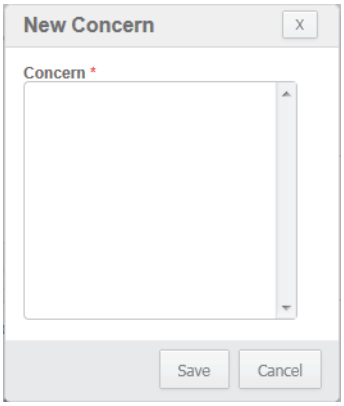


Figure 38. New Concern screen

2. In the **Concern** field, enter the concern.
3. Click the **Save** button.

Note: A concern is not saved with the assessment until saving a draft or signing off the assessment.

To view an assessment's history since sign-off:

1. While viewing a signed-off assessment, click the **View History** link. The Amendment History screen displays a list of all assessment iterations since sign-off. Older iterations display at the top of the list.

Figure 39. Amendment History screen

2. Click an assessment iteration from the list to view it. The assessment is read-only.
3. After viewing the assessment, click the **Close** button in the Action bar to close the assessment iteration. The Amendment History screen reappears.
4. Click the **Close** button to close the Amendment History screen.

Filtering which assessments display in the Assessments pane

Assessments can be filtered, thereby making it easier to locate specific assessments.

To filter which assessments display in the Assessments pane:

1. Click the **Show Filters** button in the Assessments pane.
2. Use any of the following filters:

Available filters within the Assessments pane

Filter	Description
Type	Select an assessment type by which to filter assessments: • All: The **All** option filters against all assessment types. • Initial Assessment • Update Assessment • Redetermination Assessment • Readmit Assessment
Activity Date	Select a range of assessment activity dates by which to filter assessments: • Enter only a date in the first field. • Enter only a date in the second field. • Enter dates in both fields.
Entered	Select a range of assessment entered dates by which to filter assessments: • Enter only a date in the first field. • Enter only a date in the second field. • Enter dates in both fields.
Signed	From the **Signed** drop-down list, select a person by which to filter assessments. The **All** option filters against all signed assessments for this member. Only individuals who have signed assessments for this member display in this drop-down list.
Status	Select an assessment status by which to filter assessments: • All: The **All** option filters against all assessment statuses. • Draft • Signed-off • Error

3. Click the **Apply** button. The Assessments pane displays assessments which meet the specified filter criteria. If one or more assessments are found, the filters automatically hide.

   If no results are found the Assessment pane displays “No results found,” instead of a list of assessments. The filters remain displayed.

   If necessary, click the **Reset** button to reset filters to their default options.

Creating a new assessment

An assessment may be created as a new assessment or from a copy of an existing assessment. For information how to create a copy of an existing assessment, refer to “Creating a copy of an assessment” on page 108.

To create a new assessment:

1. Click the **New** button in the Assessments pane. The New Assessment screen appears.

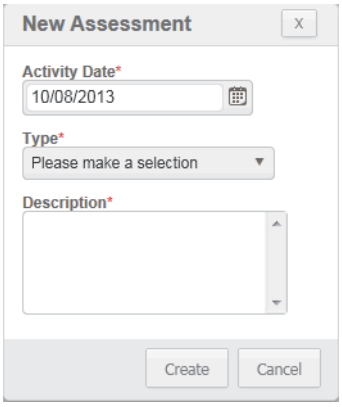


Figure 40. New Assessment screen

2. In the **Activity Date** field, specify the date the assessment of the member took place. This is a required field.
3. From the **Type** drop-down list select which type of assessment to create:
   - Initial Assessment
   - Update Assessment
   - Redetermination Assessment
   - Readmit Assessment

   This is a required field.
4. In the **Description** text box, enter a title or description for the new assessment. This is a required field.
5. Click the **Create** button. The assessment screen displays and is ready for information entry. Once created, an assessment is permanently associated with the case and cannot be removed or deleted.

   For more information about pane and field descriptions in an assessment, refer to “Header tab assessment fields”.

Header tab assessment fields

The Header tab is used to enter contact information for the member, as well as to document how information for the assessment was collected. Refer to the table below for descriptions of the Header tab assessment fields.

Description of Header tab assessment fields

Field	Description
Activity Date	The **Activity Date** field displays the date the assessment of the member took place. Revise the date a member activity being documented occurred if necessary.

Description of Header tab assessment fields (continued)

Field	Description
Description	The **Description** text box displays the title entered for the assessment. Revise the assessment's title if necessary.
Is the demographic information stated correct?	In the **Is the demographic information stated correct?** field, select whether the demographic information is correct or not: • Correct • Incorrect • Unknown This is a required field.
What is the best way to contact you?	In the **What is the best way to contact you?** field, select the best way(s) to contact the member. Contact methods are listed in the **Available** column; acceptable contact methods are moved to the **Selected** column. For information, refer to "Selecting which contact methods are available" on page 87. This is a required field.
What is your family's primary language/ child's primary language?	From the **What is your family's primary language/child's primary language?** drop-down list, select the member's primary language: • English • Spanish • Haitian Creole • Vietnamese • French • Other This is a required field.
Medical Foster Care Level of Reimbursement	From the **Medical Foster Care Level of Reimbursement** drop-down list, select the Medical Foster Care Level of Reimbursement: • Level 0 • Level I • Level II • Level III
Select method of collecting assessment information.	From the **Select method of collecting assessment information.** drop-down list, select how the assessment information was collected: • Face-to-Face • Telephonic • Medical Record This is a required field.
Select individual that provided assessment information.	From the **Select individual that provided assessment information.** drop-down list, select who provided the assessment information: • Client • Parent • PCP • Specialist This is a required field.

Description of Header tab assessment fields (continued)

Field	Description
Was a translator used?	In the **Was a translator used?** field, indicate using the **Yes** or **No** options whether or not a translator was used to collect assessment information. This is a required field.
Comments	In the **Comments** text box, enter any comments.

To select which contact methods are available:

1. Access the **Header** tab in the assessment.
2. Select one or more contact methods in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more contact methods in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

Note: This is a required field to complete an assessment.

Program Education tab assessment fields

The Program Education tab is used to document whether or not the parent/guardian agreed to participate in Care Coordination. Refer to the table below for descriptions of the Program Education tab assessment fields.

Description of Program Education tab assessment fields

Field	Description
Did the parent/ guardian or client agree to participate in Care Coordination?	In the **Did the parent/guardian or client agree to participate in Care Coordination?** field, indicate using the **Yes** or **No** options whether or not the member, or representative, agreed to participate in Care Coordination.
Comments	In the **Comments** text box, enter any comments.

Provider tab assessment fields

The Provider tab is used to document which providers are interacting with the member. Refer to the table below for descriptions of Provider tab assessment fields.

Description of Provider tab assessment fields

Field	Description
Do you need assistance with scheduling appointments or identifying providers?	In the **Do you need assistance with scheduling appointments or identifying providers?** field, indicate using the **Yes** or **No** options whether or not the member needs assistance to schedule appointments or to identify providers.
What other agencies are visiting your home?	In the **What other agencies are visiting your home?** field, select which agencies are visiting the member. Agencies are listed in the **Available** column; agencies that are visiting the member are moved to the **Selected** column. For more information, refer to "Selecting which agencies are visiting the member" on page 88.
Comments	In the **Comments** text box, enter any comments.

To select which agencies are visiting the member:

1. Access the **Provider** tab in the assessment.
2. Select one or more agencies in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more agencies in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

Medical/Dental History assessment fields

Medical/Dental History is used to document the member's medical and dental history. It contains the following sections:

- Diagnosis
- Allergies
- Growth
- Immunizations
- Family History
- Clinical History
- Child Health Check-up
- Dental Care
- Medications
- Nutrition
- Development/ADL's
- Treatment/Equipment

Refer to the table below for descriptions of Medical/Dental History assessment fields. The first column in the table specifies the section in the Medical/Dental History.

Description of Medical/Dental History assessment panes and fields

Section	Content	Description
Diagnosis	Qualifying Diagnosis	The **Qualifying Diagnosis** pane displays the member's qualifying diagnosis in tabular format: • The **Type** column displays the type of diagnosis. • The **Diagnosis** column displays the diagnosis code and description. • The **Date** column displays the date the diagnosis was determined. Information displayed in the Qualifying Diagnosis pane comes from the member's Addl DMG. tab (in the Patient Info tab). This information is read-only. For more information about the Addl DMG. tab, refer to "Addl DMG. tab" on page 29.
	Diagnosis	In the **Diagnosis** pane, select any of the following options that apply to the member's health summary regarding the qualifying diagnosis: • Diagnosis Verified • Diagnosis Not Verified • Updated in Health Summary • Unable to Validate or Confirm
	Comments	In the **Comments** text box, enter any comments.
Allergies	Allergies	In the **Allergies** pane, select any of the following options that apply to the member's health summary regarding allergies: • Allergies Verified • Allergies Not Verified • Updated in Health Summary • Unable to Validate or Confirm
	Comments	In the **Comments** text box, enter any comments.
Growth	Growth	In the **Growth** pane, select any of the following options that apply to the member's health summary regarding growth: • Growth Verified • Growth Not Verified • Updated in Health Summary • Unable to Validate or Confirm
	Comments	In the **Comments** text box, enter any comments.

Description of Medical/Dental History assessment panes and fields (continued)

Section	Content	Description
Immunizations	Immunizations	In the **Immunizations** pane, select any of the following options that apply to the member's health summary regarding immunizations: • Immunizations Verified • Immunizations Not Verified • Updated in Health Summary • Unable to Validate or Confirm
	Comments	In the **Comments** text box, enter any comments.
Family History	Family History	In the **Family History** pane, select any of the following options that apply to the member's health summary regarding family history: • Family History Verified • Family History Not Verified • Updated in Health Summary • Unable to Validate or Confirm
	Comments	In the **Comments** text box, enter any comments.
Clinical History	Clinical History	In the **Clinical History** pane, select any of the following options that apply to the member's health summary regarding clinical history: • Clinical History Verified • Clinical History Not Verified • Updated in Health Summary • Unable to Validate or Confirm
	Comments	In the **Comments** text box, enter any comments.

Description of Medical/Dental History assessment panes and fields (continued)

Section	Content	Description
Child Health Check-up	Enter date of child's last check up.	In the **Enter date of child's last check up.** pane, specify the date of the child's last check up.
	Do you need assistance with scheduling an appointment?	In the **Do you need assistance with scheduling an appointment?** field, indicate using the **Yes** or **No** options whether or not the member needs assistance to schedule an appointment.
	Has child been tested for lead poisoning? (Only applicable if child is between six (6) months and six (6) years of age.)	In the **Has child been tested for lead poisoning? (Only applicable if child is between six (6) months and six (6) years of age.)** field, select if the member has been tested for lead poisoning: • Yes • No • Don't Know • Not applicable
	Where does child receive healthcare?	In the **Where does child receive healthcare?** field, select which agencies the member receives healthcare. Agencies are listed in the **Available** column; agencies that the member receives healthcare are listed in the **Selected** column. For more information, refer to "Selecting from which agencies the member receives healthcare" on page 94.
	Has child been hospitalized in the past six (6) months?	In the **Has child been hospitalized in the past six (6) months?** field, indicate using the **Yes** or **No** options whether or not the member has been hospitalized in the past six months.
	Comments	In the **Comments** text box, enter any comments.
Dental Care	Is your child seeing a dentist?	In the **Is your child seeing a dentist?** field, indicate using the **Yes** or **No** options whether or not the member is seeing a dentist.
	Comments	In the **Comments** text box, enter any comments.

Description of Medical/Dental History assessment panes and fields (continued)

Section	Content	Description
Development/ ADL's	Does child require assistance with feeding?	In the **Does child require assistance with feeding?** field, select if the member needs assistance to feed: • Yes • No • Not age appropriate
	Does child require assistance with bathing?	In the **Does child require assistance with bathing?** field, select if the member needs assistance to bathe: • Yes • No • Not age appropriate
	Is child potty trained?	In the **Is child potty trained?** field, select if the member is potty trained: • Yes • No • Not age appropriate
	Does your child require assistance with toileting?	In the **Does child require assistance with toileting?** field, select if the member needs assistance toileting: • Yes • No • Not age appropriate
	Does child require assistance with dressing?	In the **Does child require assistance with dressing?** field, select if the member needs assistance dressing: • Yes • No • Not age appropriate
	Does child require assistance with mobility?	In the **Does child require assistance with mobility?** field, select if the member needs assistance with mobility: • Yes • No • Not age appropriate
	Does child sleep through the night?	In the **Does child sleep through the night?** field, select if the member sleeps through the night: • Yes • No • Not age appropriate
	Does child have any sleep habits?	In the **Does child have any sleep habits?** field, indicate using the **Yes** or **No** options whether or not the member has any sleep habits.

Description of Medical/Dental History assessment panes and fields (continued)

Section	Content	Description
Development/ ADL's (continued)	Does child communicate verbally?	In the **Does child communicate verbally?** field, select if the member communicates verbally: • Yes • No • Not age appropriate
	Does child have cognitive issues (ability to process information, emotions, perceptions, etc.)?	In the **Does child have cognitive issues (ability to process information, emotions, perceptions, etc.)?** field, select if the member has cognitive issues: • Yes • No • Not age appropriate
	Does child have social or emotional issues/concerns?	In the **Does child have social or emotional issues/ concerns?** field, select if the member has any social or emotional issues: • Yes • No • Not age appropriate
	Who are the child's primary caregivers?	In the **Who are the child's primary caregivers?** field, select all of the following options that apply as the member's primary caregiver(s): • Parents • Mother • Father • Maternal Grandparent(s) • Paternal Grandparent(s) • Foster Parent • Other
	Child-specific Safety Measures	In the **Child-specific Safety Measures** text box, enter any child-specific safety measures.
	Activities Permitted or Restricted	In the **Activities Permitted or Restricted** text box, enter any activities which are permitted or restricted.
	Method of Teaching Child, Family Members, or Other Caregivers	In the **Method of Teaching Child, Family Members, or Other Caregivers** text box, enter any methods of teaching the member, family members, or other caregivers.
	Comments	In the **Comments** text box, enter any comments.

Description of Medical/Dental History assessment panes and fields (continued)

Section	Content	Description
Treatment/ Equipment	Treatment	The **Treatment** pane is used to specify treatments for the member. For more information, refer to "Specifying a member treatment" on page 94.
	Equipment	The **Equipment** pane is used to specify equipment for the member. For more information, refer to "Specifying member equipment" on page 95.
	Comments	In the **Comments** text box, enter any comments.

To specify from which agencies the member receives healthcare:

1. Access the **Child Health Check-up** section in Medical/Dental History of the assessment.
2. Select one or more agencies in the Available column, then use the **Add>>** button to add it/ them to the Selected column.
3. If necessary, select one or more agencies in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify a member treatment:

1. Access the **Treatment/Equipment** section in Medical/Dental History of the assessment.
2. Click the **New** button in the Treatment pane. The Add Treatment screen appears.

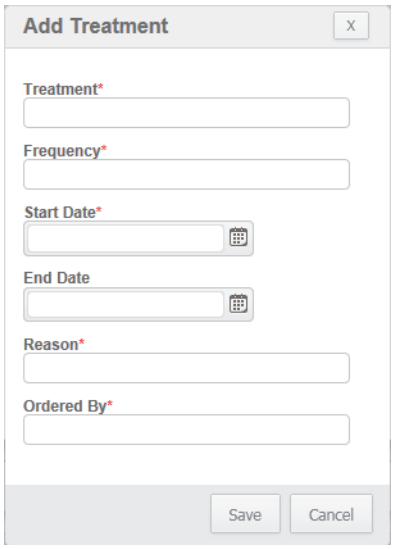


Figure 41. Add Treatment screen

3. In the **Treatment** text box, enter the name (or description) of the treatment. This is a required field.
4. In the **Frequency** text box, enter the frequency of the treatment. This is a required field.
5. In the **Start Date** field, enter the date in which the treatment should start. This is a required field.
6. In the **End Date** field, enter the date in which the treatment should end.
7. In the **Reason** text box, enter the reason for the treatment. This is a required field.
8. In the **Ordered By** text box, enter who ordered the treatment. This is a required field.
9. Click the **Save** button.

To specify member equipment:

1. Access the **Treatment/Equipment** section in Medical/Dental History of the assessment.
2. Click the **New** button in the Equipment pane. The Add Equipment screen appears.

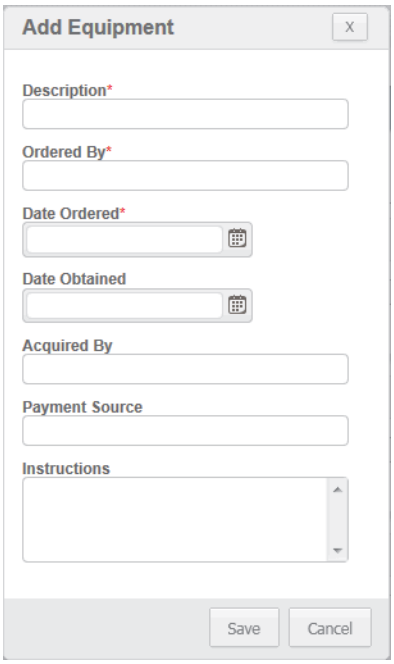


Figure 42. Add Equipment screen

3. In the **Description** text box, enter a description of the equipment. This is a required field.
4. In the **Ordered By** text box, enter who ordered the equipment. This is a required field.
5. In the **Date Ordered** field, enter the date in which the equipment was ordered. This is a required field.
6. In the **Date Obtained** field, enter the date in which the equipment was obtained.
7. In the **Acquired By** text box, enter who acquired the equipment.
8. In the **Payment Source** text box, enter the payment source.
9. In the **Instructions** text box, enter instructions how to use the equipment.
10. Click the **Save** button.

Review of Systems assessment fields

Review of Systems is used to document the member's bodily systems. It contains the following sections:

- Eye/Vision
- Ear/Hearing
- Nose/Throat
- Oral/Dental
- Respiratory
- Cardiovascular
- Gastrointestinal
- Genitourinary
- Endocrine
- Dermatologic
- Musculoskeletal

- Hermatologic
- Neurological

Refer to the table below for descriptions of Review of System assessment fields. The first column in the table specifies the section in Review of Systems.

Description of Review of Systems assessment panes and fields

Section	Content	Description
Eye/Vision	Does your child have any problems with vision?	In the **Does your child have any problems with vision?** field, indicate using the **Yes** or **No** options whether or not the member has any vision problems.
	Comments	In the **Comments** text box, enter any comments.
Ear/Hearing	Does your child have hearing problems?	In the **Does your child have hearing problems?** field, indicate using the **Yes** or **No** options whether or not the member has hearing problems.
	Comments	In the **Comments** text box, enter any comments.
Nose/Throat	Does your child experience issues with nose or throat, such as nose bleeds, etc.?	In the **Does your child experience issues with nose or throat, such as nose bleeds, etc.?** field, select which nose and/or throat issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which nose and/or throat symptoms the member has" on page 98.
	Comments	In the **Comments** text box, enter any comments.
Oral/Dental	Does your child have any dental issues or concerns?	In the **Does your child have any dental issues or concerns?** field, select which dental issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which dental symptoms the member has" on page 98.
	Comments	In the **Comments** text box, enter any comments.
Respiratory	Does your child have	In the **Does your child have** field, select which respiratory issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which respiratory symptoms the member has" on page 98.
	Comments	In the **Comments** text box, enter any comments.

Description of Review of Systems assessment panes and fields (continued)

Section	Content	Description
Cardiovascular	Does your child experience	In the **Does your child experience** field, select which cardiovascular issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which cardiovascular symptoms the member has" on page 99.
	Comments	In the **Comments** text box, enter any comments.
Gastrointestinal	Does your child experience	In the **Does your child experience** field, select which gastrointestinal issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which gastrointestinal symptoms the member has" on page 99.
	Comments	In the **Comments** text box, enter any comments.
Genitourinary	Does your child experience	In the **Does your child experience** field, select which genitourinary issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which genitourinary symptoms the member has" on page 99.
	Comments	In the **Comments** text box, enter any comments.
Endocrine	Does your child experience	In the **Does your child experience** field, select which endocrine issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which endocrine symptoms the member has" on page 99.
	Comments	In the **Comments** text box, enter any comments.
Dermatologic	Does your child experience	In the **Does your child experience** field, select which dermatologic issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which dermatologic symptoms the member has" on page 99.
	Comments	In the **Comments** text box, enter any comments.

Description of Review of Systems assessment panes and fields (continued)

Section	Content	Description
Musculoskeletal	Does your child experience	In the **Does your child experience** field, select which musculoskeletal issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which musculoskeletal symptoms the member has" on page 99.
	Comments	In the **Comments** text box, enter any comments.
Hematologic	Does your child experience	In the **Does your child experience** field, select which hematologic issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which hematologic symptoms the member has" on page 100.
	Comments	In the **Comments** text box, enter any comments.
Neurological	Does your child experience	In the **Does your child experience** field, select which neurological issues the member has. Symptoms are listed in the **Available** column; symptoms that the member has are listed in the **Selected** column. For more information, refer to "Specifying which neurological symptoms the member has" on page 100.
	Comments	In the **Comments** text box, enter any comments.

To specify which nose and/or throat symptoms the member has:

1. Access the **Nose/Throat** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which dental symptoms the member has:

1. Access the **Oral/Dental** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which respiratory symptoms the member has:

1. Access the **Respiratory** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which cardiovascular symptoms the member has:

1. Access the **Cardiovascular** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which gastrointestinal symptoms the member has:

1. Access the **Gastrointestinal** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which genitourinary symptoms the member has:

1. Access the **Genitourinary** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which endocrine symptoms the member has:

1. Access the **Endocrine** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which dermatologic symptoms the member has:

1. Access the **Dermatologic** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which musculoskeletal symptoms the member has:

1. Access the **Musculoskeletal** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which hematologic symptoms the member has:

1. Access the **Hematologic** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

To specify which neurological symptoms the member has:

1. Access the **Neurological** section in Review of Systems of the assessment.
2. Select one or more symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.

Psychosocial/Environmental tab assessment fields

The Psychosocial/Environmental tab is used to document psychosocial and environmental factors affecting the member. Refer to the table below for descriptions of Psychosocial/Environmental tab assessment fields.

Description of Psychosocial/Environmental tab assessment fields

Field	Description
Events affecting child and family	In the **Events affecting child and family** field, select which events are affecting the member and family. Events are listed in the **Available** column; events that are affecting the member and family are listed in the **Selected** column. For more information, refer to "Specifying which events are affecting the member and family" on page 102.
Emotional and behavioral health	In the **Emotional and behavioral health** field, select which events and symptoms apply to the member's emotional and behavioral health. Events and symptoms are listed in the **Available** column; events and/or symptoms that describe the member are listed in the **Selected** column. For more information, refer to "Specifying which events and symptoms apply to the member's emotional and behavioral health" on page 102.
Home environment	In the **Home environment** field, select which attributes apply to the member's home environment. Attributes are listed in the **Available** column; attributes apply to the member's home environment are listed in the **Selected** column. For more information, refer to "Specifying which attributes apply to the member's home environment" on page 102.
School and learning activities	In the **School and learning activities** field, select which school and learning activities apply to the member. Activities are listed in the **Available** column; school and learning activities are listed in the **Selected** column. For more information, refer to "Specifying which school and learning activities apply to the member" on page 102.
Cultural, ethnic, and spiritual factors	In the **Cultural, ethnic, and spiritual factors** field, select which cultural, ethnic and/or spiritual factors apply to the member. Factors are listed in the **Available** column; factors which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which cultural, ethnic and/or spiritual factors apply to the member" on page 103.

Description of Psychosocial/Environmental tab assessment fields (continued)

Field	Description
Substance abuse issues related to the child only	In the **Substance abuse issues related to the child only** field, select which substance abuse issues apply to the member. Issues are listed in the **Available** column; issues which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which substance abuse issues apply to the member" on page 103.
Legal issues	In the **Legal issues** field, select which legal issues apply to the member. Issues are listed in the **Available** column; issues which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which legal issues apply to the member" on page 103.
DCF Case Plan Goal	In the **DCF Case Plan Goal** field, select which DCF case plan goal issues apply to the member. Issues are listed in the **Available** column; issues which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which DCF case plan goal issues apply to the member" on page 103.
Community services, resources, and referrals	In the **Community services, resources, and referrals** field, select which community services, resources, and referral attributes apply to the member. Attributes are listed in the **Available** column; attributes which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which community services, resources, and referral attributes apply to the member" on page 103.
Disaster planning	In the **Disaster planning** field, select which disaster planning attributes apply to the member. Attributes are listed in the **Available** column; attributes which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which disaster planning attributes apply to the member" on page 103.
Transition planning	In the **Transition planning** field, select which transition planning attributes apply to the member. Attributes are listed in the **Available** column; attributes which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which transition planning attributes apply to the member" on page 104.
Transportation	In the **Disaster planning** field, select which transportation attributes apply to the member. Attributes are listed in the **Available** column; attributes which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which transportation attributes apply to the member" on page 104.
Family employment/ education/financial information	In the **Family employment/education/financial information** field, select which family employment, education, and financial attributes apply to the member. Attributes are listed in the **Available** column; attributes which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which family employment, education, and financial attributes apply to the member" on page 104.

Description of Psychosocial/Environmental tab assessment fields (continued)

Field	Description
Family support system	In the **Family support system** field, select which family support system attributes apply to the member. Attributes are listed in the **Available** column; attributes which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which family support system attributes apply to the member" on page 104.
Family strength, concerns, and goals	In the **Family strength, concerns, and goals** field, select which family strength, concerns, and goals apply to the member. Attributes are listed in the **Available** column; attributes which apply to the member are listed in the **Selected** column. For more information, refer to "Specifying which family strength, concerns, and goals apply to the member" on page 104.

To specify which events are affecting the member and family:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more events in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more events in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which events and symptoms apply to the member's emotional and behavioral health:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more events and/or symptoms in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more events/symptoms in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which attributes apply to the member's home environment:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more attributes in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more attributes in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which school and learning activities apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more activities in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more activities in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which cultural, ethnic and/or spiritual factors apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more factors in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more factors in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which substance abuse issues apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more issues in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more issues in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which legal issues apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more issues in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more issues in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which DCF case plan goal issues apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more issues in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more issues in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which community services, resources, and referral attributes apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more attributes in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more attributes in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which disaster planning attributes apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more attributes in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more attributes in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which transition planning attributes apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more attributes in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more attributes in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which transportation attributes apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more attributes in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more attributes in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which family employment, education, and financial attributes apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more attributes in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more attributes in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which family support system attributes apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more attributes in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more attributes in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

To specify which family strength, concerns, and goals apply to the member:

1. Access the **Psychosocial/Environmental** tab in the assessment.
2. Select one or more attributes in the Available column, then use the **Add>>** button to add it/them to the Selected column.
3. If necessary, select one or more attributes in the Selected column, then use the **<<Remove** button to remove it/them from the Selected column.
4. Enter additional comments if necessary.

CMAT tab assessment fields

The CMAT tab is used to document CMAT-related issues. Refer to the table below for descriptions of CMAT tab assessment fields.

Description of CMAT tab assessment fields

Field	Description
Staffing Date	In the **Staffing Date** field, specify the date for which CMAT staffing has been scheduled.
Staffing Type	From the **Staffing Type** drop-down list, select the staffing type: • Continuity of Care • Discharge • Emergency • Follow up • Initial • Reconsideration
Lead Case Manager	In the **Lead Case Manager** text box, enter the person who is the lead case manager.
Stability Statement	From the **Stability Statement** drop-down list, select the stability statement: • Not applicable • The child is at risk or is experiencing infrequent and predictable changes in medical need • The child is experiencing frequent and predictable or infrequent and unpredictable changes in medical need • The child is experiencing frequent and unpredictable changes in medical need • This factor does not appear to be an issue of current concern for this child • The child does not have a previous stability statement
Referral Date	In the **Referral Date** field, specify the date the member was referred to this program.

Description of CMAT tab assessment fields (continued)

Field	Description
Referral Source	From the **Referral Source** drop-down list, select the referral source: • Brain and Spinal Cord Program • Child Protection Team • Children's Multidisciplinary Assessment Team • CMS Care Coordinator • CMS Enrollment • Early Steps • Medical Foster Care • Medical Home Project • Newborn Screening • PIC Provider/Hospice • Agency for Persons with Disabilities • BSCIP Central Registry • Caregiver/Guardian • Client • Department of Children and Families/Community Based Care • Department of Juvenile Justice • Early Head Start • Healthy Start • Hospital Referral • Parent/Grandparent • Physician/Medical Referral • School/Daycare • Other
Medical History Summary	In the **Medical History Summary** text box, enter a medical history summary.
Agencies Involved in Child and Family Care	In the **Agencies Involved in Child and Family Care** text box, enter the agencies involved in member and family care.

Acuity Risk Tool tab assessment fields

The Acuity Risk Tool tab is used to document the member's acuity risk. Refer to the table below for descriptions of Acuity Risk Tool tab assessment fields.

Description of Acuity Risk Tool tab assessment fields

Field	Description
Score	In the **Score** text box, enter the member's acuity score based on the following guidelines: • A low acuity score is 1-2. • A medium acuity score is 3-4. • A high acuity score is 5-7.
Comments	In the **Comments** text box, enter any comments.

Concerns tab assessment fields

The Concerns tab documents entered concerns. Refer to the table below for descriptions of Concerns tab assessment fields.

Description of Concern pane in the Concerns tab

Field	Description
Concerns	The **Concerns** pane is used to document concerns to be included with the assessment. For more information, refer to these topics: • "Documenting a concern from the Concerns pane" on page 107 • "Removing a concern from the Concerns pane" on page 107

To document a concern from the Concerns pane:

1. Access the **Concerns** tab in the assessment.
2. Click the **New** button in the Concerns pane. The New Concern screen appears.

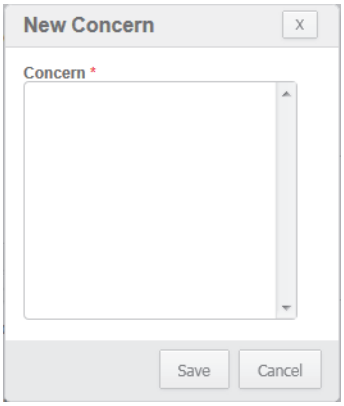


Figure 43. New Concern screen

3. In the **Concern** field, enter the concern.
4. Click the **Save** button.

Note: A concern is not saved with the assessment until saving a draft or signing off the assessment.

To remove a concern from the Concerns pane:

1. Access the **Concerns** tab in the assessment.
2. Click the **Removed** check box beside the concern to be removed.
3. Click the **Draft** or **Sign-Off** button to save the assessment.

Creating a copy of an assessment

A new assessment may be created based on the contents of an existing one, thereby transferring information into the new assessment.

To copy an assessment:

1. Open the assessment to be copied.
2. In the Action bar, click the **Copy** button. The Copy Assessment screen appears.

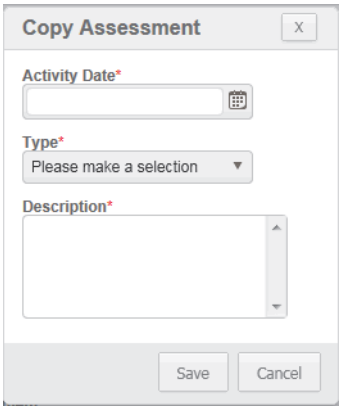


Figure 44. Copy Assessment screen

3. In the **Activity Date** field, specify the date the assessment of the member took place. This is a required field.
4. From the **Type** drop-down list select which type of assessment to create:
   - Initial Assessment
   - Update Assessment
   - Redetermination Assessment
   - Readmit Assessment

   This is a required field.
5. In the **Description** text box, enter a title or description for the new assessment. This is a required field.
6. Click the **Save** button. Once created, an assessment is permanently associated with the case and cannot be removed or deleted.

   For more information about pane and field descriptions in an assessment, refer to “Header tab assessment fields” on page 85.

Updating the next assessment date and type after sign-off

After an assessment has been signed off, the next member assessment, and its type, can be updated: the date and type of the next assessment can be specified.

As a guideline, these types of member assessments should be performed:

- An initial assessment should be performed within 30 days from induction into the program.
- A redetermination assessment should be performed every six months.
- An update assessment should be performed as needed.

To update the next assessment date and type:

1. Sign off a completed assessment. The Next Assessment screen appears.

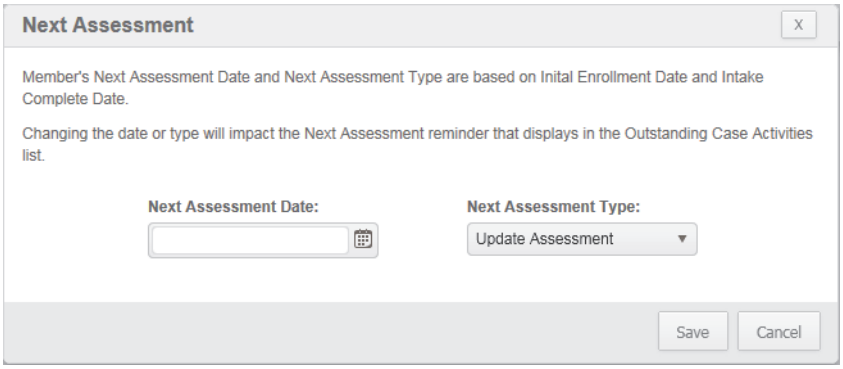


Figure 45. Next Assessment screen

2. In the **Next Assessment Date** field, specify the date for the next assessment.
3. From the **Next Assessment Type** drop-down list, select which assessment type to use for the next assessment:
   - Initial Assessment
   - Update Assessment
   - Redetermine Assessment
   - Readmit Assessment
4. Click the **Save** button.

Care plans

This section contains the following topics:

Topic	See page
Introduction to care plans	109
Properties tab	112
Concerns tab	113
Care Planning tab	116
Care Plan History tab	120

Introduction to care plans

Care plans display in the Care Plans pane. Use care plans to address the plan of action to achieve positive outcomes based on the identified concerns. Care plans may be created once any assessment, regardless of type, has been signed off.

A care plan is composed of goal sets. Each goal set contains:

- a goal: A goal is based on a documented concern regarding the member's health. Documented concerns may come either from the assessment associated with the care plan or those newly entered into the care plan. Once a goal is defined, interventions and goal outcomes are documented.
- an outcome: An outcome is the intended result of the goal set.
- one or more interventions: An intervention is a care plan task intended to meet the goal set's outcome.

Each case may only have one care plan open at one time. Once a care plan has been signed off, another care plan for that case may be created. Refer to the table below for information about care plan statuses.

When authoring care plans, consider the following:

- Document which concerns are affecting the member's health and care.
- Concerns can be rejected from the care plan.
- Interventions can be added to better meet outcomes.
- Based on each concern, create a goal set to address each concern.
- New concerns or goals may be added at any time.

The Care Plans pane only displays if there is at least one member care plan. A number beside the Care Plans pane title represents how many care plans currently are in the pane. The Care Plans pane displays the following information about each care plan:

Description of columns within the Care Plans pane

Column	Description
Date Initiated	The **Date Initiated** column displays the date the care plan was initiated.
Last Updated	The **Last Updated** column displays the date the care plan was last updated.
Next Review Date	The **Next Review Date** column displays the next date of review of the care plan.
End Date	The **End Date** column displays the date when the care plan ends.
Signed	The **Signed** column displays who signed-off the care plan.
Status	The **Status** column displays the care plan's status. A care plan may be one of these statuses: • Draft: Draft status indicate the care plan has been created but has not undergone any saved revisions. A care plan in draft status only represents the care plan is available. • Open: Open status indicate the care plan has been saved at least once. • Signed-off: Signed-off status indicate the care plan has been signed off. A care plan in signed-off status cannot be edited.

The Care Plans pane displays up to ten care plans per page. Care plans are displayed in reverse chronological order, based on initiation date, with the most recent care plans displaying at the top. Use the following buttons to navigate pages within the Care Plans pane:

Description of navigation buttons within the Care Plans pane

Button	Description
First	The **First** button is used to display the first page.
Prev	The **Prev** button is used to display the previous page if there are multiple pages.
Next	The **Next** button is used to display the next page if there are multiple pages.
Last	The **Last** page is used to display the last page.

If there are fewer than ten care plans for a case, the navigation buttons do not display.

Clicking on a care plan opens it. Once a care plan is opened, the care plan screen appears. Refer to the table below for a description of care plan screen elements.

Description of care plan screen elements

Element	Description
Print button	Use the Print button (), displayed on the top right of the care plan screen, to print the care plan. To print a care plan: 1. Click the **Print** button. The Care Plan Print Preview screen appears. 2. Select which part(s) of the care plan to print: - Default Care Plan (which prints all tabs) - Properties • Diagnoses • Participants • Signature Info - Concerns • New • Accepted • Met • Rejected - Care Planning - Care Plan History 3. Click the **Preview** button. A print preview of the care plan displays. 4. Click the **Print** button.
Navigation tab(s)	Navigation tabs, displayed to the left of the care plan screen, are used to navigate sections of a care plan: • Properties: The Properties tab is used to specify care plan participants and important dates related to the care plan. • Concerns: The Concerns tab is used to document concerns. • Care Planning: The Care Planning tab is used to document care planning goals. • Care Plan History: The Care Plan History tab displays the care plan's history. • Sign-off: The Sign-off tab displays by whom and when the care plan was signed off. The Sign-off tab only displays once the care plan is signed off.
Action bar	The Action bar, displayed on the bottom of the care plan screen, shows the following: • when and by whom the care plan was created and last updated; • the Action buttons.

Description of care plan screen elements (continued)

Element	Description
Action buttons	Action buttons display on the bottom right of the care plan screen: • Back: The Back button is used to navigate to a previous section of a care plan. If the care plan is displaying the first tab, the Back button is disabled. • Next: The Next button is used to navigate to the next section of a care plan. If the care plan is displaying the last tab, the Next button is disabled. • Save: The Save button is used to save changes to a care plan which is not ready for sign-off. If the care plan is signed-off, the Save button does not display. • Sign-Off: The Sign-Off button is used to sign off a care plan. If the care plan is signed-off, the Sign-Off button does not display. • Cancel: The Cancel button is used to ignore any changes made to the care plan (including newly entered concerns).

To create a new care plan:

1. Sign off a completed assessment. The Sign off Assessment screen appears.

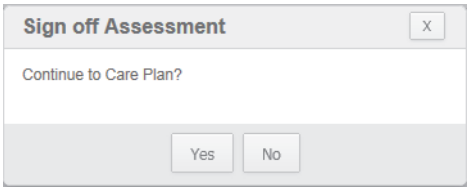


Figure 46. Sign off Assessment screen

2. Click the **Yes** button.

Note: If the **No** button is clicked, or if the InteGreat session times out, a new care plan is created which displays in the Care Plans pane. This care plan is in draft status and may be opened at a later time.

Properties tab

The Properties tab is used to specify care plan participants and important dates related to the care plan. Refer to the table below for descriptions of the Properties tab care plan fields.

Description of Properties tab care plan fields

Field	Description
Details	The Details pane displays the member's qualifying diagnosis in tabular format: • The **Type** column displays the type of diagnosis. • The **Diagnosis** column displays the diagnosis code and description. • The **Date** column displays the date the diagnosis was determined. The qualifying diagnostic information comes from the member's DX tab (in the Patient Info tab). This information is read-only.

Description of Properties tab care plan fields (continued)

Field	Description
Participants	In the **Participants** field, select the roles who are participating in the care plan: • Primary Care Coordinator • Client • Registered Nurse • Specialist • Primary Care Physician • Social Worker • Parent/Guardian • Other: If using the **Other** option, enter that participant.
Initiation Date	If the care plan is in draft status it has not been saved at least once. In this circumstance, the **Initiation Date** field does not contain a date. The Initiation Date field displays the date the care plan was saved for the first time. This field is read-only.
Review Date	If the care plan is in draft status it has not been saved at least once. In this circumstance, the **Review Date** field does not contain a date. The Review Date field displays the date the last time the care plan was saved. This field is read-only.
Next Review Date	The **Next Review Date** field displays the next date to review the care plan. By default, this field displays a date six months from when it was last saved. Specify a different date to review the care plan if necessary.
Physician Signature Obtained	In the **Physician Signature Obtained** field, select whether the physician's signature was obtained: • Yes • N/A
Physician Name	The **Physician Name** text box is enabled only if the Yes option is selected from the Physician Signature Obtained field. In the Physician Name text box, enter the physician's name.
Care Plan to Provider	In the **Care Plan to Provider** field, specify the date the care plan was sent to the provider.
Date Signature Obtained	In the **Date Signature Obtained** field, specify the date the physician's signature was obtained.

Concerns tab

The Concerns tab is used to document concerns and protocol sets. Below is a definition of each:

- A concern may be documented. Once a concern has been documented, a goal set may be created from it.
- A protocol set is a pre-defined goal set, each with a goal, interventions, and outcome. When using protocol sets, they are automatically added as care planning goal sets in the Care Planning tab, thereby streamlining the process of creating goal sets.

  For an introduction to goal sets, refer to "Introduction to care plans" on page 109.

The Concerns tab contains the Concerns pane, which is used to:

- display concerns, including those from the assessment associated with the care plan.
- create new concerns.
- add protocol sets which are to be used as goal sets for care planning.

A number beside the Concerns pane title represents how many concerns and/or protocol sets are currently displayed in the pane.

Concerns and protocol sets use the following statuses:

Description of concern and protocol set statuses

Status	Description
New	This status applies to any concern either entered into the care plan or the assessment associated with the care plan. The new status also applies to any protocol set which has been removed as a goal set from the Care Planning tab.
Accepted	This status applies to any concern which is used in a goal set. New protocol sets automatically have this status.
Met	This status applies to any concern which has been met. The concern is met when the goal plan's outcome associated with the concern is met.
Rejected	This status applies to any concern which has been rejected from use in the care plan.

The Concerns pane displays the following information about each concern and protocol set:

Description of columns within the Concerns pane

Column	Description
Description	The **Description** column displays the description of the concern or protocol set. The description for a concern may be changed by clicking its description.
Status	The **Status** column displays the status of the concern or protocol set. The status for concerns and protocol sets can be changed under these circumstances: • Any new-status concern may be changed to rejected status by clicking on the **New** status. Likewise, the rejected-status concern may be changed to new status by clicking on the **Rejected** status. • New protocol sets (which are created from the Concerns pane) automatically have accepted status. Protocol sets are also added as goal sets in the Care Planning tab. If a protocol set is removed from the Care Planning tab, then that protocol set is removed from the Concerns pane. **Note:** If the care plan is saved, the status for concerns associated with any goal sets cannot be changed.

The Concerns pane displays up to ten concerns/protocols per page. Concerns and protocols display in the following sort order:

- new
- accepted
- met
- rejected

Use the following buttons to navigate pages within the Concerns pane:

Description of navigation buttons within the Concerns pane

Button	Description
First	The **First** button is used to display the first page.
Prev	The **Prev** button is used to display the previous page if there are multiple pages.
Next	The **Next** button is used to display the next page if there are multiple pages.
Last	The **Last** page is used to display the last page.

To filter which concerns and/or protocol sets display in the Concerns tab:

1. Click the **Show Filters** button in the Concerns pane.
2. Use any of the following filters:

Available filters within the Concerns pane

Filter	Description
Status	Select a status by which to filter concerns and/or protocol sets: • All: The **All** option filters against all concern statuses. • New • Accepted • Met • Rejected
Description	In the **Description** text box, enter text by which to filter concerns and/or protocol sets.

3. The Concerns pane displays concerns and/or protocol sets which meet the specified filter criteria. If one or more concerns or protocol sets are found, the filters automatically hide.

   If no results are found the Concerns pane displays “No results found,” instead of a list of concerns/protocols. The filters remain displayed.

   If necessary, click the **Reset** button to reset filters to their default options.

To document a new concern in the care plan:

1. Click the **New** button in the Concerns pane. The New Concern screen appears.

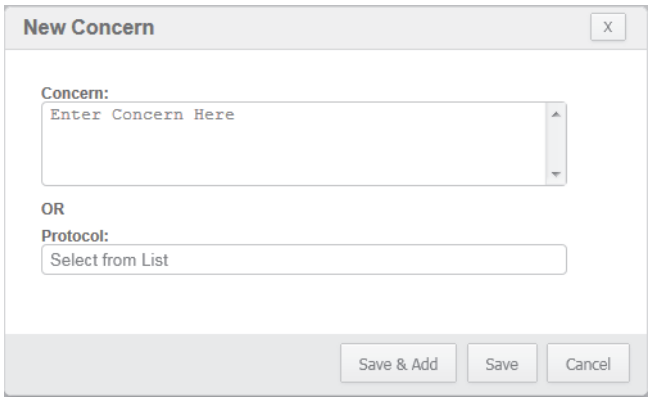


Figure 47. New Concern screen

2. Do one of the following:
   - In the **Concern** text box, enter the concern.
   - From the **Protocol** drop-down list, select a protocol set. To select a protocol set type into the Protocol field to search for a protocol set based on entered text. For information about each protocol definition, refer to "Protocol sets" on page 147.
3. Do one of the following:
   - Click the **Save & Add** button to save the entered concern/protocol set, then immediately enter a new concern/protocol set.
   - Click the **Save** button to save the concern, then return to the Concerns pane.

Note: New or revised concerns/protocol sets are saved to the care plan when the Save button is clicked in the Action bar at the bottom of the Care Plan page. Please be sure to click the Save button before navigating away from the Concerns pane, or leaving your computer, to ensure any changes made in the Concerns pane are retained.

Care Planning tab

The Care Planning tab is used to document goal sets. For an introduction to goal sets, refer to "Introduction to care plans" on page 109.

The Care Planning tab contains the Goals pane. The Goals pane displays goal sets within the care plan in which their outcomes have not been completed. If a goal set's outcome has been completed, then the care plan is saved, that goal set is moved from the Goals pane to the Care Plan History tab.

Refer to the table below for descriptions of what the Goals pane displays:

Description of columns within the Goals pane

Column	Description
Description	The **Description** column displays goal sets with the following information: • the concern for which the goal set is based • the goal defined for the goal set • all interventions • the intended outcome If a goal set was created from a concern (and not a protocol set in the Concerns tab), the goal set may be revised in the following ways: • Add a new intervention to the goal set by mouse-hovering over an intervention, then click on the **Add Intervention** button ( ). For information how to select an intervention, refer to "Care Planning tab" on page 116. • Remove an intervention from the goal set by mouse-hovering over the intervention to be removed, then clicking the **Remove** button ( ). • Change the goal set's outcome status by clicking on the outcome in the Description column. For more information how to do this, refer to "Changing the outcome for a goal set" on page 119. **Note:** If the care plan is saved, goal set interventions cannot be removed.

Description of columns within the Goals pane (continued)

Column	Description
Met	The **Met** column displays whether goal set interventions or their outcomes have been met. The Met column has the following functionality: • To denote that goal set's intervention has been met, mouse-hover over that intervention, then click the **Met** check box in the Met column. Once selected, that check box cannot be deselected. • If the status for the goal set's outcome is changed to Met, the Met check box for all interventions is checked. Once the care plan is saved, that goal set is moved from the Goals pane to the Care Plan History tab.
Type	The **Type** column displays whether the goal set is short-term or long-term. Goals sets can be sorted using the Type column.
Start Date	The **Start Date** column displays the start date for the goal set. Goal sets can be sorted using the Start Date column.
Due Date	The **Due Date** column displays the date the goal set's outcome should be met. If the due date passes, the due date turns red. Goal sets can be sorted using the Due Date column.
End Date	The **End Date** column displays the date when the goal set's outcome is to be met.

The Goals pane displays up to ten goal sets per page. Goal sets display in the order that they are added to the care plan. Use the following buttons to navigate pages within the Goals pane:

Description of navigation buttons within the Goals pane

Button	Description
First	The **First** button is used to display the first page.
Prev	The **Prev** button is used to display the previous page if there are multiple pages.
Next	The **Next** button is used to display the next page if there are multiple pages.
Last	The **Last** page is used to display the last page.

If there are fewer than ten goal sets for a care plan, the navigation buttons do not display.

To create a care plan goal:

1. Ensure there is at least one new-status concern in the care plan, which would be displayed in the Concerns pane in the Concerns tab. If there are no concerns, the New button is disabled. For more information about care plan concerns, refer to “Concerns tab” on page 113.
2. Click the **New** button in the Goals pane. The Goal Setting screen appears.

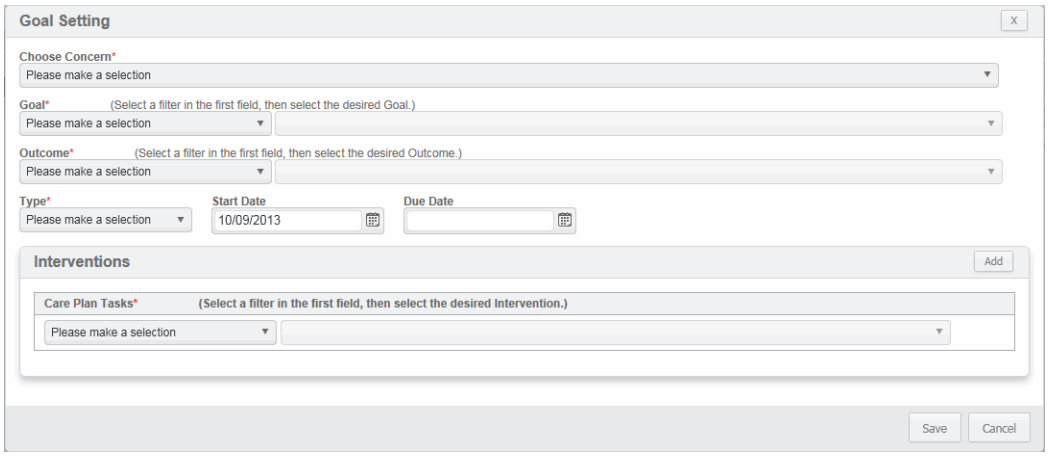


Figure 48. Goal Setting screen

3. From the **Choose Concern** drop-down list, select a concern by which to base the goal set. If there are no new-status concerns, there are no concerns from this drop-down list to select. Otherwise, this is a required field.
4. From the **Goal** drop-down list, select a filter category in which to select a goal from the field beside it:
   - Medical Issues
   - CMS Education Reqs
   - Psychosocial
   - MFC
   - PIC: TFK
   - Health Care Transition
   - Other

   This is a required field.
5. Based on the filter category selected from the **Goal** drop-down list, select a goal for the goal set. This is a required field.
6. From the **Outcome** drop-down list, select a filter category in which to select an outcome from the field beside it:
   - Medical Issues
   - CMS Education Reqs
   - Psychosocial
   - MFC
   - PIC: TFK
   - Health Care Transition
   - Other

   This is a required field.
7. Based on the filter category selected from the **Outcome** drop-down list, select an outcome for the goal set. This is a required field.

8. From the **Type** drop-down list, select whether this is a short-term or long-term goal set. This is a required field.
9. In the **Start Date** field, adjust the date when this goal set should begin. The Start Date field defaults to the date the goal set was created. Adjust this date if necessary.
10. In the **Due Date** field, adjust the date the outcome for this goal set should be met. By default this field displays the date three months into the future if defining a short-term goal set, or six months into the future if defining a long-term goal set.
11. From the **Care Plan Tasks** drop-down list in the Interventions pane, select a filter category by which to select an intervention from the field beside it:
    - CMS Education Reqs
    - Psychosocial
    - MFC
    - PIC: TFK
    - Health Care Transition
    - Other

    This is a required field.
12. Based on the filter category selected from the **Care Plan Tasks** drop-down list, select an intervention for the goal set. This is a required field.

    If an additional intervention is required for the goal set, click the **Add** button in the Interventions pane, then add a new intervention.
13. Once the goal set is complete, click the **Save** button.

Note: Upon adding a goal set, it appears in the Goals pane. Until the care plan is saved, a goal set may be removed from the Goals pane by clicking the **Remove Goal** button ( ). Once a care plan is saved, a goal set cannot be removed from the care plan.

To change the outcome status for a goal set:

1. Click on the outcome description to change its status. The Outcome Status screen appears.

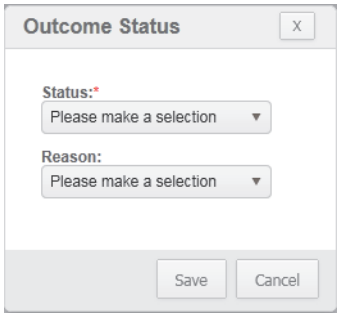


Figure 49. Outcome Status screen

2. From the **Status** drop-down list, select the outcome's new status:
    - Met
    - Not Met
    - Unachievable

    This is a required field.
3. If the Met option is selected from the Status drop-down list, the **Reason** drop-down list is disabled. If Not Met or Unachievable options are selected, select from the Reason drop-down list why the outcome's status is being changed:

- In Process
- Member Unavailable
- Comorbidity Exacerbation
- Reason Not Specified
- Non-compliant With Plan
- Unsuccessful Attempt
- Communication Barrier
- Services Not Available

4. Click the **Save** button. The goal set's outcome is changed in the Goals pane.

Note: If the goal set's outcome has been completed, then when the care plan is saved, the goal set is moved from the Goals pane to the Care Plan History tab.

Care Plan History tab

The Care Plan History tab displays goal sets in which their outcomes have been completed. The Care Plan History tab contains the Goals pane, which displays these goal sets in read-only tabular format.

The Goals pane displays the following information about each completed goal set:

Description of columns within the Goals pane

Column	Description
Description	The **Description** column displays completed goal sets with the following information: • the concern in which the goal set is based • the goal defined for the goal set • all interventions • the intended outcome
Met	The **Met** column displays whether goal set interventions or their outcomes have been met.
Type	The **Type** column displays whether the met goal set was short-term or long-term. Goals sets can be sorted using the Type column.
Start Date	The **Start Date** column displays when the met goal set started. Goal sets can be sorted using the Start Date column.
Due Date	The **Due Date** column displays when the goal set's outcome was set to be met. Goal sets can be sorted using the Due Date column.
End Date	The **End Date** column displays when an intervention or outcome was met. Goal sets can be sorted using the End Date column.

The Goals pane displays up to ten goal sets per page. Use the following buttons to navigate pages within the Goals pane:

Description of navigation buttons within the Care Plans pane

Button	Description
First	The **First** button is used to display the first page.
Prev	The **Prev** button is used to display the previous page if there are multiple pages.
Next	The **Next** button is used to display the next page if there are multiple pages.

Description of navigation buttons within the Care Plans pane (continued)

Button	Description
Last	The **Last** page is used to display the last page.

If there are fewer than ten goal sets for a care plan, the navigation buttons do not display.

Services tab

The Services tab, visible only for CMSN cases, is used to document the following types of services:

- inpatient visits
- emergency room visits
- acute rehabilitation
- skilled nursing facility services

The Services tab contains the Service Tracker pane, which is used to filter services. A number beside the Service Tracker pane title represents how many services currently are in the pane. The Service Track pane displays the following information about each service:

Description of columns within the Service Tracker pane

Column	Description
Type	The **Type** column displays the service's type.
Provider	The **Provider** column displays the service provider.
Admit Date	The **Admit Date** column displays the admission date for the service.
D/C Date	The **D/C Date** column displays the discharge date for the service.
Discharge Diagnosis	The **Discharge Diagnosis** column displays discharge diagnosis.
Service Reason	The **Service Reason** column displays the reason for the service.

The Service Tracker pane displays up to ten services per page. Services are displayed in reverse chronological order by service admission date with the most recent services displaying at the top. Use the following buttons to navigate pages within the Service Tracker pane:

Description of navigation buttons within the Service Tracker pane

Button	Description
First	The **First** button is used to display the first page.
Prev	The **Prev** button is used to display the previous page if there are multiple pages.
Next	The **Next** button is used to display the next page if there are multiple pages.
Last	The **Last** page is used to display the last page.

If there are fewer than ten services for a case, the navigation buttons do not display.

Clicking on a service opens it. For more information about services, refer to "Adding a new service tracker" on page 123.

This section contains the following topics:

Topic	See page
Filtering which services display in the Service Tracker pane	122
Adding a new service tracker	123

Filtering which services display in the Service Tracker pane

Services can be filtered, thereby making it easier to locate specific services.

To filter which services display in the Service Tracker pane:

1. Click the **Show Filters** button in the Service Tracker pane.
2. Use any of the following filters:

Available filters within the Service Tracker pane

Filter	Description
Type	Select a service type by which to filter services: • All: The **All** option filters against all service types. • Inpatient • Emergency Room Visit • Acute Rehab • Skilled Nursing
Provider	In the **Provider** text box, enter the provider name that provided service to the member.
Discharge Date	In the **Discharge Date** fields, select a range of discharge dates by which to filter services. Use the **Not Set** check box to filter when there is no discharge date set.
Admission Date	In the **Admission Date** fields, select a range of discharge dates by which to filter services.

3. Click the **Apply** button. The Service Tracker pane displays services which meet the specified filter criteria. If one or more services are found, the filters automatically hide.

   If no results are found the Service Tracker pane displays “No results found,” instead of a list of services. The filters remain displayed.

   If necessary, click the **Reset** button to reset filters to their default options.

Adding a new service tracker

To add a new service tracker:

1. Click the **New** button in the Service Tracker pane. The Add Service Tracker screen appears.

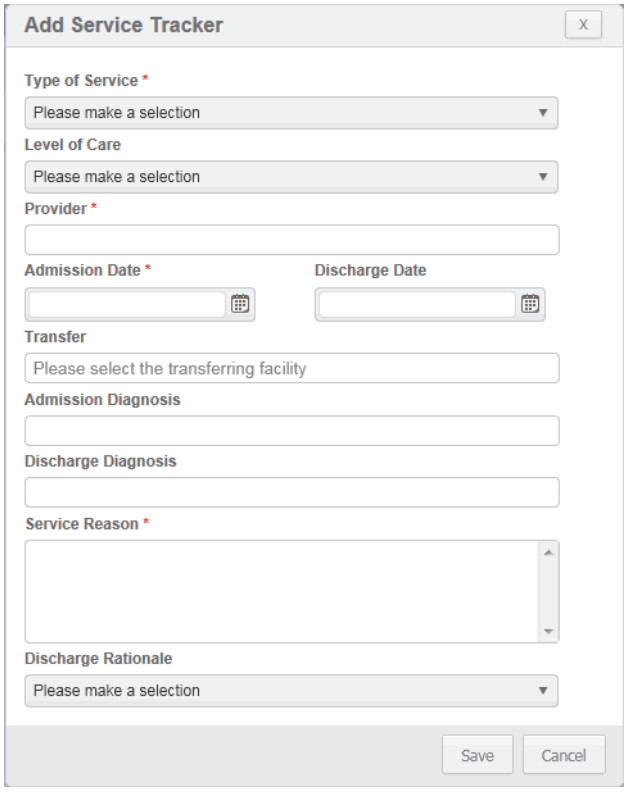


Figure 50. Add Service Tracker screen

2. From the **Type of Service** drop-down list, select which type of service to add:
   - Inpatient
   - Emergency Room Visit
   - Acute Rehab
   - Skilled Nursing

   This is a required field.

3. From the **Level of Care** drop-down list, select the level of care for the service:
   - Skilled
   - Fragile
   - Intermediate I
   - Intermediate II

4. In the **Provider** field, select the name of the service provider. To do so, type into the Provider field, then select the facility from the drop-down list. This is a required field.
5. In the **Admission Date** field, specify the date in which the member was admitted for services. This is a required field.
6. In the **Discharge Date** field, specify the discharge date.
7. In the **Transfer** field, select the transferring facility. To do so, type into the Transfer field, then select the facility from the drop-down list.
8. In the **Admission Diagnosis** field, enter the admission diagnosis.

9. In the **Discharge Diagnosis** field, enter the discharge diagnosis.
10. In the **Service Reason** field, enter the reason the service was rendered. This is a required field.
11. From the **Discharge Rationale** drop-down list, select a discharge rationale:
    - Aged out
    - Expired
    - Discharged
12. Click the **Save** button.

Creating case-associated tasks

A task can be created associated with a case. This can only occur from within the open case. This should not be confused with creating a task from the Tools menu. A case-associated task will display in the Tasks widget, the Tasks container, and in the Outstanding Activities screen in the Cases container. For information how to view outstanding activities, refer to "Viewing outstanding activities associated with a case" on page 133.

Note: If a task is not associated with a case, the due date set for task completion cannot be tracked from the Cases container where outstanding case activity associated with the task can be noted. For more information how to create a task which is not associated with a case, refer to "Add Task" on page 6.

To create a task associated with a case:

1. Click the **Add Task** button. The New Task screen appears. The current member automatically displays in the Patient field. The Patient field is disabled.

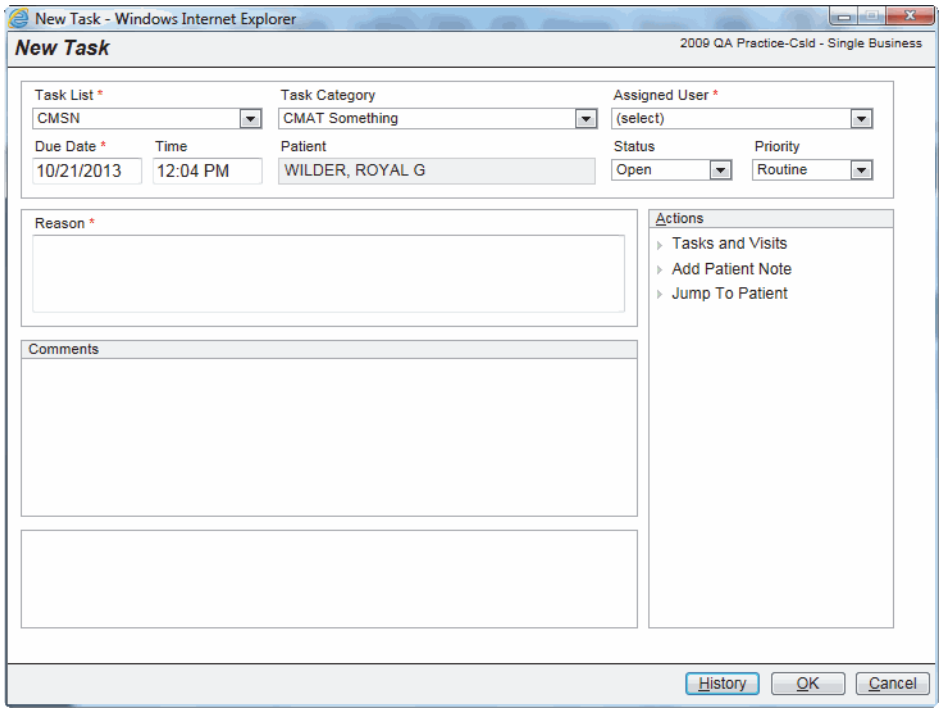


Figure 51. New Task screen

Refer to the table below for descriptions of fields in the New Task screen.

Description of fields in the New Task screen

Field	Description
Task List	From the **Task List** drop-down list, select a task list. Items available in this list have been configured for your Care Coordination environment. This is a required field.
Task Category	From the **Task Category** drop-down list, select a task category. Items in the Task Category drop-down list vary based on the item selected from the Task List drop-down list. Items available in this list have been configured for your Care Coordination environment. **Note:** To ensure that a description associated with the task displays in the Outstanding Activities screen, select from the **Task Category** drop-down list an option other than **(none)**.
Assigned User	From the **Assigned User** drop-down list, select the individual whom is assigned the task. This is a required field.
Due Date	In the **Due Date** field, enter the date the task is due for completion. By default, the date in this field is the current date. This is a required field.
Time	In the **Time** text box, enter the time associated with the date the task is due for completion.
Patient	The **Patient** field displays the member's name associated with the case from which the task is being created. Clicking on the member's name opens information for that member in a new window.
Status	From the **Status** drop-down list, select the status of the task: • Open • Unsuccessful • Pending • Completed • Cancelled
Priority	From the **Priority** drop-down list, select the priority for the task: • Routine • Urgent • ASAP
Reason	In the **Reason** field, enter the reason for the task. This is a required field.
Comments	In the **Comments** field, enter any additional comments.

2. Click the **OK** button.

For more information how to add a new task, refer to InteGreat Practice Management documentation.

Health Summary tab

This section contains the following topics:

Topic	See page
Viewing treatment and equipment information from assessments	126
Accessing EHR	127

Viewing treatment and equipment information from assessments

The Health Summary tab displays treatment and equipment information from signed-off assessments in read-only tabular format.

The Treatment pane displays the following treatment information from signed-off assessments:

Description of columns within the Treatment pane

Column	Description
Treatment	The **Treatment** column displays a description of the treatment.
Frequency	The **Frequency** column displays the frequency of the treatment.
Reason	The **Reason** column displays the reason for the treatment.
Ordered By	The **Ordered By** column displays who ordered the treatment.
Start Date	The **Start Date** column displays when the treatment should begin.
End Date	The **End Date** column displays when the treatment should end.

The Equipment pane displays the following equipment information from signed-off assessments:

Description of columns within the Equipment pane

Column	Description
Description	The **Description** column displays a description of the equipment.
Ordered By	The **Ordered By** column displays who ordered the treatment.
Date Ordered	The **Date Ordered** column displays when the equipment was ordered.
Acquired By	The **Acquired By** column displays who acquired the equipment.
Date Obtained	The **Date Obtained** column displays when the equipment was obtained.

For more information about assessments, refer to "Assessments" on page 77.

Accessing EHR

InteGreat Practice Management can link to InteGreat EHR using single sign on credentials. If InteGreat Practice Management is displaying a member's name in the Patient banner, that member's information is displayed when InteGreat EHR opens. However, there is no data sharing between the two applications.

For information about the Patient banner, refer to "Introduction to the Patients container" on page 27.

To access EHR:

1. From the Cases container, access a case pertaining to a member whose information is to be accessed in InteGreat EHR. For information how to access a case from the Cases container, refer to "Accessing information from the Cases container" on page 132.
2. Click the **Health Summary** tab.
3. Click the **Go to EHR** button. InteGreat EHR opens in a separate Web browser window.

Chapter 7 - Cases container

This chapter discusses how to use the Cases container.

In this chapter

This chapter contains the following topics.

Topic	See page
Introduction to the Cases container	130
Using the Cases container	131
Filtering which cases display in the Cases container	131
Information displayed in the Cases container	130
Accessing information from the Cases container	132

Introduction to the Cases container

The Cases container displays all cases to which the user's permissions provide access. To make it easier to locate specific cases, filter which cases display in the Cases container. Once a particular case is located:

- member demographics with the case may be accessed.
- the case details may be accessed.
- activities associated with the case may be viewed.
- the active care plan associated with the case may be viewed.

Information displayed in the Cases container

The Cases container displays the following information about each case:

- the member associated with the case
- the case type
- all programs associated with the case
- the primary diagnosis associated with the member
- the case status
- the due date for the case
- activity associated with the case

Using the Cases container

This section contains the following topics:

Topic	See page
"Filtering which cases display in the Cases container"	131
"Accessing information from the Cases container"	132

Filtering which cases display in the Cases container

To filter which cases display in the Cases container:

1. Click the **Show Filters** button.
2. Use any of the following filters:

Filter	Description
Status	Select a specific case status by which to filter cases: • All: The **All** option filters against all case statuses. • The **Unassigned** option filters against unassigned cases. • The **New** option filters against new cases. • The **Open** option filters against open cases. • The **Readmit** option filters against readmitted cases. • The **Monitoring** option filters against cases which are being monitored. • The **Closed** option filters against closed cases.
Staff Member	Enter the name of a staff member whom may be assigned cases. Enter the staff member's last name, then first name.
Type	Select a case type by which to filter cases: • All: The **All** option filters against all case types. • The **CMSN** option filters against CMSN case types. • The **ES** option filters against ES case types.
Due Date	Select a range of dates by which to filter cases.
Member	Enter the name of a member by which to filter cases. Enter the member's last name, then first name.
Business	Select which business by which to filter cases. The **All** option filters against all businesses.

Filter	Description
Program	Select which program by which to filter cases: • All: The **All** option filters against all programs. • The **None** option filters against no programs. • General Care Coordination • BNET • Brain and Spinal Cord • CMAT • PASRR • Hug Me • Medical Home Project • MFC • PIC • Part C • DEI
Activity	Select which activity by which to filter cases: • All: The **All** option filters against all activities. • Assessment • Care Plan • Intervention • IFSP • ES Note • Transition Conf • Task

3. Click the **Apply** button. The Cases container displays cases which meet the specified filter criteria. If one or more cases are found, the filters automatically hide.

   If no results are found the Case container displays “No results found,” instead of a list of cases. The filters remain displayed.

   If necessary, click the **Reset** button to reset filters to their default options.

Accessing information from the Cases container

To access member demographics associated with a case:

1. Click the member’s name. The Patient container displays the member’s demographics. For more information about member demographics, refer to “Patient Info tab” on page 29.

To access a case:

1. Click the **View Case** icon beside the pertinent case.

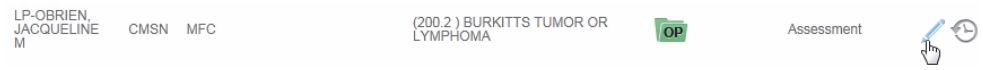


Figure 52. Viewing a case from the Cases container

The Patients container displays the **Care Management** tab. For more information about care management, refer to “Care Management tab” on page 41.

To view outstanding activities associated with a case:

1. Click the activity name beside the pertinent case. The Outstanding Case Activities screen appears.

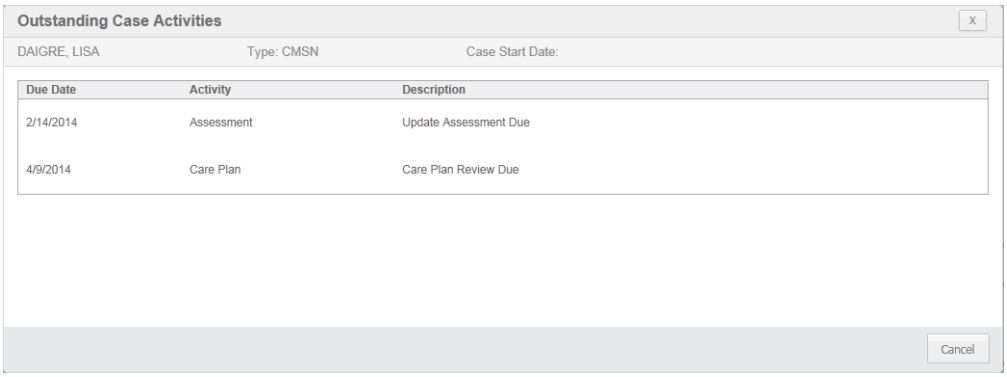


Figure 53. Outstanding Case Activities screen

The Outstanding Case Activities screen displays activities associated with a case which involve action(s) because their due dates have passed. Information is displayed in tabular format:

Column descriptions in the Outstanding Case Activities screen

Column	Description
Due Date	The **Due Date** column displays when the activity action was due.
Activity	The **Activity** column displays the name of the activity which requires action.
Description	The **Description** column displays a description of the action required.

2. Click the **View Case** icon beside the activity to open the case.

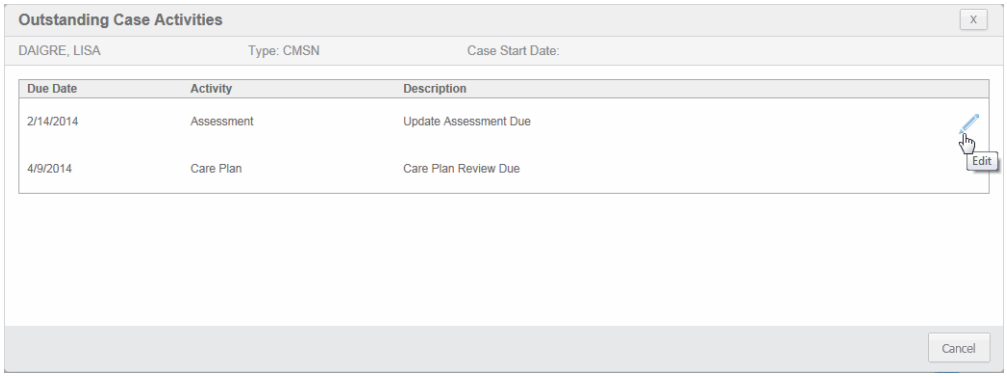


Figure 54. Viewing a case from the Outstanding Case Activities screen

The Patients container displays the **Care Management** tab. For more information about care management, refer to "Care Management tab" on page 41.

To view the active care plan associated with a case:

1. Click the **Review Active Care Plan** icon beside the pertinent case.

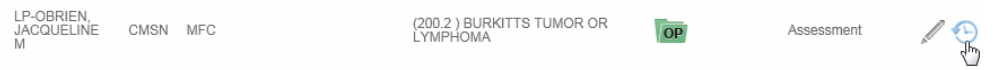


Figure 55. Reviewing an active care plan from the Cases container

The Active Care Plan screen appears.

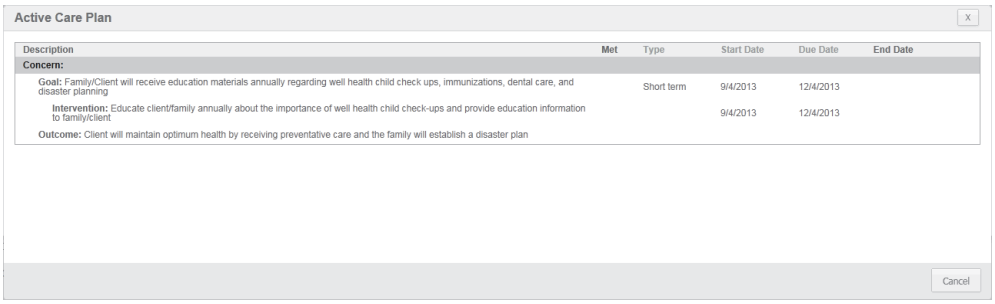


Figure 56. Active Care Plan screen

The Active Care Plan screen is read-only. For more information about adding or revising care planning information, refer to “Introduction to care plans” on page 109.

Chapter 8 - Reports container

This chapter discusses Care Coordination reports. Reports are generated from the Reports container.

In this chapter

This chapter contains the following topics.

Topic	See page
Introduction to the Reports container	136
Case List report	137
Case List Export report	139
CMAT Client List report	141
CMAT Clients Served report	143
Pre-Admission Screening and Resident Review (PASRR) report	145

Introduction to the Reports container

The Reports container is used to generate reports to help manage medical practices. The Reports container offers the same report categories and reports as those offered in InteGreat Practice Management. For information on how to use reports, refer to InteGreat Practice Management documentation.

InteGreat Care Coordination offers a new report category called Care Coordination. Below is a description of each report in the Care Coordination report category.

Report	Description
Case List	The Case List report generates a list of client cases by staff or program assignment. This is a formatted list not for exporting.
Case List Export	The Case List Export report exports a list of client cases by staff or program assignment. This report is generated specifically for exporting.
CMAT Client List	The CMAT Client List report generates a list of clients that have been staffed by CMAT within a date range. This report is generated specifically for exporting.
CMAT Clients Served	The CMAT Clients Served report generates a list of clients that have been staffed by CMAT within a date range. This report is generated specifically for exporting.
Pre-Admission Screening and Resident Review (PASRR)	The Pre-Admission Screening and Resident Review report generates a list of members who are enrolled in PASRR, their level of support, and funding. This report is generated specifically for exporting.

For parameter settings of these reports, refer to these topics:

Topic	See page
Case List report	137
Case List Export report	139
CMAT Client List report	141
CMAT Clients Served report	143
Pre-Admission Screening and Resident Review (PASRR) report	145

Case List report

This topic outlines Case List report parameters.

Required parameters for this report are not highlighted in gray. Additional parameters, highlighted in gray, are accessed by clicking the **Add Parameter** button. Non-required parameters which do not have settings can be removed by clicking the ⊗ button.

Note: When all additional parameters have been added to a report, the Add Parameter button becomes disabled.

Refer to the table below for Case List report parameter settings to generate a report.

Case List report parameter settings

Parameter	Qualifiers	Values
Business	is in the set	(all); or a subset of businesses
	is equal to	Select one business.
Case Created Date	is in the range	Enter a date range.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is before	Enter a date.
	is after	Enter a date.
Case Type	is equal to	(all)
		CMSN
		ES
Case Status	is equal to	(all); or select a status
	is in the set	(all); or select multiple statuses
Profile Class	is equal to	(all); or select a profile class
	is in the set	(all); or select multiple profile classes
Program	is equal to	(all); or select a program
	is in the set	(all); or select multiple programs
Staff Assignment	is equal to	(all)
		Primary
		Secondary
	is in the set	(all); or select multiple staff assignments

Case List report parameter settings (continued)

Parameter	Qualifiers	Values
Staff Assignment Type	is equal to	(all); or select a staff assignment type
	is in the set	(all); or select multiple staff assignment types
Sort By	is equal to	Assignment Date (Ascending)/Client Name
		Assignment Date (Descending)/Client Name
		Case Created Date (Ascending)/Client Name
		Case Created Date (Descending)/Client Name
Staff Assignment Date	is in the range	Specify a date range.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is before	Enter a date.
	is after	Enter a date.
Care Coordination Exclusion	is equal to	Select one exclusion.
	is in the set	Select one or more exclusions.
Staff Member	contains	Enter text that contains a staff member's name.
	starts with	Enter text that begins with a staff member's name.
	ends with	Enter text that ends with a staff member's name.
	is equal to	Enter a staff member's name.

Case List Export report

This topic outlines Case List Export report parameters.

Required parameters for this report are not highlighted in gray. Additional parameters, highlighted in gray, are accessed by clicking the **Add Parameter** button. Non-required parameters which do not have settings can be removed by clicking the ⊗ button.

Note: When all additional parameters have been added to a report, the Add Parameter button becomes disabled.

Refer to the table below for Case List Export report parameter settings to generate a report.

Case List Export report parameters

Parameter	Qualifier	Value(s)
Business	is in the set	(all); or a subset of businesses
	is equal to	Select one business.
Case Created Date	is in the range	Enter a date range.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is before	Enter a date.
	is after	Enter a date.
Case Status	is equal to	(all); or select a status
	is in the set	(all); or select multiple statuses
Profile Class	is equal to	(all); or select a profile class
	is in the set	(all); or select multiple profile classes
Program	is equal to	(all); or select a program
	is in the set	(all); or select multiple programs
Staff Assignment	is equal to	(all)
		Primary
		Secondary
	is in the set	(all); or select multiple staff assignments
Staff Assignment Type	is equal to	(all); or select a staff assignment type
	is in the set	(all); or select multiple staff assignment types

Case List Export report parameters (continued)

Parameter	Qualifier	Value(s)
Sort By	is equal to	Assignment Date (Ascending)/Client Name
		Assignment Date (Descending)/Client Name
		Case Created Date (Ascending)/Client Name
		Case Created Date (Descending)/Client Name
Staff Assignment Date	is in the range	Specify a date range.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is before	Enter a date.
	is after	Enter a date.
Care Coordination Exclusion	is equal to	Select one exclusion.
	is in the set	Select one or more exclusions.
Staff Member	contains	Enter text that contains a staff member's name.
	starts with	Enter text that begins with a staff member's name.
	ends with	Enter text that ends with a staff member's name.
	is equal to	Enter a staff member's name.

CMAT Client List report

This topic outlines CMAT Client List report parameters.

Refer to the table below for CMAT Client List report parameter settings to generate a report.

CMAT Client List report parameter settings

Parameter	Qualifier	Value(s)
Business	is in the set	(all); or a subset of businesses
	is equal to	Select one business.
CMAT Referral Date	is in the range	Enter a date range.
	is in the set ranges	Enter a set of date ranges.
	is equal to	Enter a date.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is in the year	this year
		last year
		(enter year)
	is on the fiscal day	current open
		last closed
	is in the fiscal year	this year
		last year
		(enter year)
	is within the last	Enter a number of days.
		Enter a number of months.
		Enter a number of years.

CMAT Client List report parameter settings (continued)

Parameter	Qualifier	Value(s)
CMAT Staffing Date	is in the range	Enter a date range.
	is in the set ranges	Enter a set of date ranges.
	is equal to	Enter a date.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is in the year	this year
		last year
		(enter year)
	is on the fiscal day	current open
		last closed
	is in the fiscal year	this year
		last year
		(enter year)
	is within the last	Enter a number of days.
		Enter a number of months.
		Enter a number of years.

CMAT Clients Served report

This topic outlines CMAT Clients Served report parameters.

Refer to the table below for CMAT Clients Served report parameter settings to generate a report.

CMAT Clients Served report paramter settings

Parameter	Qualifier	Value(s)
Business	is in the set	(all); or a subset of businesses
	is equal to	Select one business.
CMAT Referral Date	is in the range	Enter a date range.
	is in the set ranges	Enter a set of date ranges.
	is equal to	Enter a date.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is in the year	this year
		last year
		(enter year)
	is on the fiscal day	current open
		last closed
	is in the fiscal year	this year
		last year
		(enter year)
	is within the last	Enter a number of days.
		Enter a number of months.
		Enter a number of years.

CMAT Clients Served report paramter settings

Parameter	Qualifier	Value(s)
CMAT Staffing Date	is in the range	Enter a date range.
	is in the set ranges	Enter a set of date ranges.
	is equal to	Enter a date.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is in the year	this year
		last year
		(enter year)
	is on the fiscal day	current open
		last closed
	is in the fiscal year	this year
		last year
		(enter year)
	is within the last	Enter a number of days.
		Enter a number of months.
		Enter a number of years.

Pre-Admission Screening and Resident Review (PASRR) report

This topic outlines Pre-Admission Screening and Resident Review (PASRR) report parameters.

Required parameters for this report are not highlighted in gray. Additional parameters, highlighted in gray, are accessed by clicking the **Add Parameter** button. Non-required parameters which do not have settings can be removed by clicking the ⊗ button.

Note: When all additional parameters have been added to a report, the Add Parameter button becomes disabled.

Refer to the table below for Pre-Admission Screening and Resident Review (PASRR) report parameter settings to generate a report.

Pre-Admission Screening and Resident Review (PASRR) report parameter settings

Parameter	Qualifier	Value(s)
Business	is in the set	(all); or a subset of businesses
	is equal to	Select one business.
Admit Date	is in the range	Enter a date range.
	is on the day	today
		yesterday
		(enter day of year)
	is in the month	this month
		last month
		(enter month)
	is before	Enter a date.
	is after	Enter a date.
LOC	is equal to	(all); or select a LOC
	is in the set	(all); or select multiple LOCs
CMAT LOC	is equal to	(all); or select a CMAT LOC
	is in the set	(all); or select multiple CMAT LOCs
Profile Class	is equal to	(all); or select a profile class
	is in the set	(all); or select multiple profile classes
Sort By	is equal to	Client Name/Last Staffing Date
		Last Staffing Date/Client Name
		Provider/Client Name

Pre-Admission Screening and Resident Review (PASRR) report parameter settings (continued)

Parameter	Qualifier	Value(s)
Provider	contains	Enter text that contains a provider.
	starts with	Enter text that begins with a provider.
	ends with	Enter text that ends with a provider.
	is equal to	Enter a provider.

Appendix A - Protocol sets

This appendix defines all protocols sets available when authoring member care plans. A protocol set is a pre-defined goal set, each with a goal, interventions, and outcome. When using protocol sets, they are automatically added as care planning goal sets in the Care Planning tab, thereby streamlining the process of creating goal sets. For more information about care plans, refer to "Care plans" on page 109.

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Medical issues

The following protocol sets pertain to medical issues.

Alteration in self-concept related to chronic health condition

Protocol	Description
Goal	Client will be comfortable discussing fears and feelings about sickle cell disease.
Intervention	Care coordinator will refer client to a behavioral health counselor for any disturbance in body image and to address any drug seeking misconceptions relating to pain management.
Intervention	Encourage participation in support group activities and membership with the Sickle Cell Foundation.
Expected Outcome	Client will verbalize understanding of disease process and acceptance of lifelong condition.

Apnea Monitor

Protocol	Description
Goal	Client will maintain optimal health and receive prompt attention to assure their safety in the event of an apnea alarm.
Intervention	Care coordinator will educate caregiver/caregiver on the use and care of the apnea monitor.
Intervention	Care coordinator will educate the caregiver/caregiver with emergency #'s, (MD, vendor) in case of alarms, malfunction, etc.
Intervention	Care coordinator will assess client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Client will receive the appropriate assessment and interventions during the time the client is using an apnea monitor.

Caregiver/client is non-adherent to medical orders

Protocol	Description
Goal	Client will receive ordered services in the manner and frequency that they were ordered.
Intervention	Care coordinator will provide information and education to caregiver/client concerning the client's medical orders.
Intervention	Caregiver will inform the care coordinator if assistance or more information is needed.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Caregiver/client will receive education and information to provide or assist with care and make informed healthcare decisions.

Cleft Lip & Palate

Protocol	Description
Goal	Client will achieve optimal health and functioning with diagnosis of cleft lip/ cleft palate.
Intervention	Care coordinator will educate caregiver regarding client's nutritional needs per nutritionist recommendations.
Intervention	Care coordinator will provide education and access to resources related to diagnosis.
Intervention	Care coordinator will educate caregiver regarding importance of timely follow up, keeping all scheduled appointments, as well as the importance of dental/oral hygiene.
Intervention	Care coordinator will facilitate access to dental/orthodontic services.
Intervention	Care coordinator will assist with access to services to address psychosocial needs.
Intervention	Care coordinator will assist with referral and scheduling for surgical interventions as recommended by Cleft Team.
Expected Outcome	Caregiver/client will be knowledgeable and receive assistance with ensuring all medical and psychosocial needs are met.

Cognitive/Communication

Protocol	Description
Goal	Client will have restoration of function which can be restored or learn how to do things differently when function cannot be restored to the pre-injury level.
Intervention	Care coordinator will assist, as needed, with scheduling Neurological/ Psychological testing; (Evaluation) or Psychological/Educational evaluation through the school system.
Intervention	Care coordinator will assist, as needed, with scheduling evaluation and treatment utilizing a Speech/Language pathologist, and the Occupational Therapist as ordered.
Intervention	Care coordinator will refer client/student to homebound schooling, transition back to home school at appropriate time with a modifications and accommodations through the 504 plan or IEP.
Expected Outcome	Client will have improved cognition and communication skills that are consistent with his/her potential for recovery.

Communication barrier

Protocol	Description
Goal	Caregiver will receive comprehensible information concerning their client in order to be knowledgeable and meet the client's care needs.
Intervention	Care coordinator will arrange translation services based on caregiver preferences.
Intervention	Caregiver will inform the care coordinator of any assistance needed.
Expected Outcome	Caregiver will receive information to make informed healthcare decisions and translation services will be provided with the aid of professional translators regardless of the language barrier.

Congenital Heart Disease and other Cardiac Issues

Protocol	Description
Goal	Client will achieve optimal health status and exhibit age-appropriate growth and development.
Intervention	Caregiver will monitor vital signs, dietary intake, restrictions, and adhere to any prescribed orders as required.
Intervention	Care coordinator will educate caregiver on medications and potential side effects or adverse effects.
Intervention	Care coordinator will educate caregiver/client about the client's diagnosis, activity limitations and medical precautions.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Expected Outcome	Caregiver and client will be knowledgeable of his/her health condition and compliant with following medical orders.

Congenital Hydrocephalus with VP Shunt

Protocol	Description
Goal	Client will maintain optimal neurological function as evidenced by progressive growth and development.
Intervention	Care coordinator will educate caregiver and/or client on the importance of recognizing the signs and symptoms of shunt malfunction which include: headache, irritability, drowsiness, dizziness, lethargy, nausea/vomiting, increase in head circumference, bulging fontanels, pupils dilated and/or unequal.
Intervention	Care coordinator will assess the client's health and developmental milestones towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver and/or client will monitor and report changes in neurological status as evidenced by previously reviewed symptoms of malfunction. If any of these symptoms are noted, caregiver will seek medical assistance immediately.
Expected Outcome	Caregiver and/or client will understand the signs of shunt malfunction and will be knowledgeable about when to seek medical assistance.

Cranial Facial/Cleft Lip and Palate

Protocol	Description
Goal	Client will receive needed medical follow up, speech, dental, hearing services to promote optimal development.
Intervention	Care coordinator will provide information to caregiver/client on the importance of medical follow up, care of equipment and following the prescribed plan of care.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Caregiver will receive all necessary information to fully understand caring for a client with a Cranial Facial/Cleft Lip and Palate diagnosis.

Developmental Delay

Protocol	Description
Goal	Client will achieve their greatest potential of developmental milestones.
Intervention	Care coordinator will refer client to appropriate community agencies/ providers including Early Steps Client Find and/or Agency for Persons with Disabilities.
Intervention	Care coordinator will provide caregiver education on client development and appropriate developmental educational materials.
Intervention	Care coordinator will provide assessment, care coordination and follow up on client's developmental status and interventions.
Expected Outcome	Client will receive appropriate developmental interventions to address their developmental needs.

Diabetes Education

Protocol	Description
Goal	Client's blood glucose levels will be well controlled; Hgb A1C will be less than 7% to prevent future complications related to Diabetes and overall health status will be stable.
Intervention	Care coordinator will educate caregiver/client on importance of keeping scheduled appointments and ongoing communication with their healthcare team.
Intervention	Care coordinator will educate client/caregiver on the importance of medication administration, monitoring blood sugars, appropriate interventions, diet and exercise to best control Diabetes.
Intervention	Care coordinator will assess client's/caregiver's ability to perform medication administration and other interventions appropriately and safely.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Expected Outcome	Client/caregiver will be knowledgeable about maintaining blood glucose levels and the actions required for the client's stable overall health status.

Ear, Nose and Throat

Protocol	Description
Goal	Client will maintain optimal Ear, Nose and Throat function.
Intervention	Care coordinator will educate caregiver/client regarding current ENT diagnosis and when to seek medical assistance.
Intervention	Care coordinator will educate caregiver/client regarding the importance of attending medical and diagnostic appointments.
Intervention	Care coordinator will educate caregiver/client on the importance of following prescribed treatment plan.
Intervention	Care coordinator will coordinate client's needs towards the stated goal and educate caretaker/client and provide follow up and referrals as needed.
Expected Outcome	Client will remain free of infection and other complications associated with ENT diagnosis.

Education about Disease or Condition

Protocol	Description
Goal	Client will maintain optimal health status.
Intervention	Care coordinator will educate caregiver/client on signs and symptoms of distress and when to notify medical provider.
Intervention	Care coordinator will assess caregiver/client knowledge of the diagnosis and discuss and/or provide educational information based on their needs.
Intervention	Care coordinator will assess caregiver's ability to perform medication administration and other interventions appropriately and safely.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Expected Outcome	Caregiver and/or client will identify signs/symptoms of distress and will be knowledgeable about when to seek medical assistance. Caregiver and/or client will demonstrate and/or verbalize proficiency in medical interventions/tasks.

End Stage Renal Disease (ESRD)

Protocol	Description
Goal	Client will maintain optimal health and receive prompt attention to assure safety when signs of infection or excess fluid volume are noted.
Intervention	Care coordinator will educate all caregivers involved in client's care regarding the importance of the client receiving dialysis as ordered by the physician.
Intervention	Care coordinator will educate caregiver/client regarding the signs and symptoms of infection at the dialysis access site and client's risk for infection due to decreased immune system.
Intervention	Care coordinator will educate caregiver/client regarding the signs and symptoms of excess fluid volume and the importance of notifying the physician immediately.
Intervention	Care coordinator will educate caregiver/client regarding activity intolerance and interventions that can be used to assist client.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Client and caregiver will understand signs/symptoms of the disease process. Client will safely receive all medications, dialysis treatments, diagnostic tests, nutrition and therapies as ordered.

Failure to Thrive

Protocol	Description
Goal	Client will achieve and maintain adequate age appropriate growth.
Intervention	Care coordinator and caregiver will coordinate routine weight and height checks for ongoing monitoring of adequate growth and MD appointment attendance, as recommended.
Intervention	Care coordinator will educate the caregiver on tips for boosting calories in diet, appropriate to the client's age.
Intervention	Care coordinator will assess for organic and non-organic factors which may affect the client's feeding behaviors.
Intervention	Care coordinator will refer for feeding/speech therapy, nutritional and/or psychological evaluation, as indicated.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Client will obtain appropriate assessment, diagnosis and intervention to achieve age appropriate growth.

Gastrointestinal System

Protocol	Description
Goal	Client will achieve optimal health status with adequate dietary intake, appropriate weight maintenance and bowel elimination.
Intervention	Care coordinator will educate caregiver and client about the client's diagnosis, nutritional requirement and medical precautions.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will monitor client's dietary intake, bowel habits and provide appropriate medical interventions as prescribed.
Intervention	Caregiver will notify the client's physician of signs/symptoms of bowel obstruction, diarrhea, nausea/vomiting and/or decrease in eating habits.
Expected Outcome	Caregiver will be knowledgeable of the client's health condition the client will receive the appropriate assessment and interventions.

Gastrostomy

Protocol	Description
Goal	Client will maintain skin integrity; be free of infection and other complications associated with a gastrostomy tube.
Intervention	Care coordinator will instruct/educate caregiver to clean gastrostomy site with mild soap and water; reports any signs of infection and skin breakdown; how to position gastrostomy securely; monitor for leakage and report any problems to physician.
Intervention	Care coordinator will instruct/educate caregiver on gastrostomy feeding techniques, medication administration and proper positioning during feedings.
Intervention	Care coordinator will assess client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will provide gastrostomy feedings, medication administration and care as instructed.
Expected Outcome	Caregiver will be knowledgeable of gastrostomy tube care and client will receive appropriate care.

Genitourinary System

Protocol	Description
Goal	Client will achieve optimal health status with adequate fluid balance, free of infection and improved urinary elimination.
Intervention	Care coordinator will educate caregiver and client about the client's diagnosis, fluid requirement and medical precautions.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will monitor the client's fluid intake and urinary elimination patterns.
Intervention	Caregiver will notify the client's physician of any signs/symptoms of infection sign as painful urination, foul smelling urine and/or elevated temperature.
Expected Outcome	Caregiver will be knowledgeable of the client's health condition and the client will receive appropriate assessment and interventions.

Hearing Loss/Hearing Diagnosis

Protocol	Description
Goal	Client will achieve optimal hearing.
Intervention	Care coordinator will provide information to caregiver/client on the importance of medical follow up, care of equipment and following the prescribed plan of care.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Caregiver will receive information to make informed healthcare decisions and receive needed care, diagnostics and hearing aid from appropriate specialists.

HIV/AIDS

Protocol	Description
Goal	Client will maintain optimal health by receiving ordered medications and prompt medical and/or psychosocial attention as necessary.
Intervention	Care coordinator will educate all care givers involved in client's care regarding importance of administering medications as ordered and not missing doses.
Intervention	Care coordinator will educate caregivers regarding the importance of transporting client to all medical, diagnostic and therapy appointments.
Intervention	Care coordinator will protect client's right to privacy, by complying with HIPPA laws.
Intervention	Care coordinator will refer and educate caregivers on the importance of counseling for the client/caregiver when indicated i.e. social isolation, grief and anxiety.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will maintain confidentiality and provide care as instructed by medical providers.
Expected Outcome	Caregivers will understand signs/symptoms of disease process and provide care as prescribed. Client will receive appropriate emotional support, counseling, medications, diagnostic tests and therapies as ordered.

Infantile Cerebral Palsy

Protocol	Description
Goal	Client will receive appropriate evaluation and interventions to achieve optimal physical functioning.
Intervention	Care coordinator will educate caregiver on community resources available and refer for services as caregiver desires.
Intervention	Care coordinator will provide assessment, care coordination and follow up on client's developmental status and interventions.
Expected Outcome	Caregiver will receive information to make informed healthcare decisions for their client and will be knowledgeable of their client's progress towards the stated goal.

Medication Administration

Protocol	Description
Goal	Client will achieve optimal health as a result of receiving medication as prescribed by the client's physician.
Intervention	Care coordinator will educate MFC parents and all caregivers of the importance of having a physician order prior to giving any medication or treatment to client.
Intervention	Care coordinator will monitor in home records during home and office visits to ensure that medications and/or treatments are written out correctly on the flow sheets and that the flow sheets are being initialed each time that the medication is given.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	MFC parent will provide time sensitive medications at the ordered times each day and will document accordingly based on MFC standards.
Expected Outcome	Client will receive and have documented all ordered medications and treatments at the appropriate times and intervals.

Neonatal Abstinence Syndrome (NAS)

Protocol	Description
Goal	Client will display reduced periods of hyperactivity/irritability, free of seizure activity and recover from NAS without any adverse effects.
Intervention	Care coordinator will educate caregiver on signs and symptoms (ie: tremors, diarrhea, hiccups, poor feeding, irritability, excessive suck) of NAS.
Intervention	Caregiver will monitor withdrawal using an evaluative tool or a seizure withdrawal chart (ex. Neonatal Abstinence Score).
Intervention	Care coordinator will educate the caregiver on importance of prompt administration of prescribed medication of NAS symptoms.
Intervention	Care coordinator will educate the caregiver on normal growth and developmental milestones for motor, communication, cognitive and social skills for infant to 36 months of age.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Client will receive the appropriate assessment and interventions during the treatment period.

Pain Control

Protocol	Description
Goal	The client will report or indicate his/her pain is relieved or controlled. The non-verbal client will demonstrate pain relief/control as evidenced by decreased restlessness and irritability, age-appropriate pulse and respiratory rates, and participation in usual activities.
Intervention	Care coordinator will educate the caregiver on how to assess for pain and pain management techniques.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will routinely observe for pain and assess pain level using a client-friendly rating scale such as FLACC or Faces.
Intervention	Caregiver will identify and utilize all available methods of pain management including the administration of analgesics as prescribed by a physician and will assess the client's response to prescribed interventions and respond appropriately.
Expected Outcome	Caregiver will understand how to assess and manage the client's pain.

Physical Injury

Protocol	Description
Goal	Client will achieve optimal health and anticipated recovery from physical injury.
Intervention	Care coordinator will educate the caregiver on the appropriate care of the client's specific injuries.
Intervention	Care coordinator will educate the caregiver about signs and symptoms that could indicate secondary adverse effects as a result of the primary injuries.
Intervention	Care coordinator will educate the caregiver about the administration of medications for discomfort and treatments as ordered.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Client will receive the appropriate assessment and interventions during the time the client is recovering.

Respiratory Issues

Protocol	Description
Goal	Client will maintain optimum lung functioning as evidenced by clear & equal breath sounds.
Intervention	Care coordinator will educate the client/caregiver on the disease process and medication side effects or adverse effects.
Intervention	Care coordinator will educate on how to administer and assess response to nebulizer treatments or metered dose inhaler, including use of a spacer or aero chamber device.
Intervention	Care coordinator will educate the client/caregiver on how to identify triggers causing asthma attacks and monitor for signs and symptoms of respiratory distress and notify physician as needed.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will be able demonstrate competence in the care of the client and when to contact the physician for respiratory distress.
Expected Outcome	Caregiver/client will understand how to administer medications and provide treatments as prescribed.

Seizures and Seizure Observation

Protocol	Description
Goal	Client will maintain optimum neurologic function and will receive prompt correct attention to maximize their safety if seizure does occur.
Intervention	Care coordinator will educate the caregiver on any “aura” that has been identified which might alert them that a seizure is imminent and the steps to take if a seizure occurs.
Intervention	Care coordinator will educate the client/caregiver on seizure observations, recording seizure activity, seizure precautions, and notifying physician is prolonged seizures/seizures occur.
Intervention	Care coordinator will educate the caregiver and/or client on the correct, timely administration of medications and treatment as prescribed.
Intervention	Care coordinator will assess the client’s health and development milestones towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Caregiver will provide and understand the actions needed to care for the client when a seizure disorder exists.

Sickle Cell Anemia (Diagnosed)

Protocol	Description
Goal	Prevent potential impairment related to abnormal hemoglobin and sickled red blood cells.
Intervention	Care coordinator will educate caregiver and/or client on preventive measures, the importance of compliance with medication regime and the promotion of good health practices.
Intervention	Care coordinator will assess the client’s health status towards the stated goal and provide follow up and referral as appropriate.
Intervention	Caregiver will monitor for early signs of infection, encourage hydration, encourage balanced rest and exercise, avoid exposure to extreme cold and provide a healthy diet.
Expected Outcome	Caregiver and/or client will understand the importance of following the prescribed care plan and will be knowledgeable about when to seek medical assistance.

Sickle Cell Crisis (Potential)

Protocol	Description
Goal	Caregiver and client will be knowledgeable of lifelong blood disorder, treatment modalities, pain management, and learn ways to reduce and avoid a sickle cell crisis.
Intervention	Care coordinator will educate the caregiver/client on the importance of regular check-ups with the Hematologist. Fevers and any signs of infections must be report to the specialist immediately.
Intervention	Care coordinator will instruct the caregiver/client to avoid strenuous activities, contact sports, emotional stress and extreme temperatures. Encourage frequent rest periods and increased fluid intake every day.
Intervention	Caregiver will maintain up to date immunizations and appropriate flu shots as indicated.
Expected Outcome	Caregiver/client will identify signs/symptoms of infection and ways to reduce or avoid a sickle cell crisis. Caregiver/client will be knowledgeable about when to seek medical assistance. Caregiver/client will comply with pain management protocol and report any changes to Hematologist.

Skin Integrity/Range of Motion

Protocol	Description
Goal	Client will maintain optimal skin integrity and range of motion.
Intervention	Care coordinator will educate caregiver on need to turn and position frequently; maintain proper range of motion and report changes in function to physician.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will be educated about early signs and symptoms of skin breakdown, how to prevent and appropriate interventions.
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Caregiver will maintain optimal skin integrity and range of motion of the client.

Soft Cast/Spica

Protocol	Description
Goal	Client will achieve full recovery from injury.
Intervention	Care coordinator will educate the caregiver on cast care and neurovascular assessment.
Intervention	Care coordinator will educate the caregiver on the client's medical condition and when to notify the physician.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will provide care as order by the client's physician.
Expected Outcome	Caregiver will be knowledgeable of how to care for the client and identify adverse changes in the client's condition.

Spinal Cord Injury

Protocol	Description
Goal	Client will achieve optimal health and rehabilitation following traumatic brain injury.
Intervention	Care coordinator will assure access to and coordination of all medical and rehabilitation services.
Intervention	Care coordinator will educate client and caregiver about potential risks and challenges following SCI.
Intervention	Care coordinator will assess need for emotional support and arrange appropriate referrals.
Intervention	Care coordinator will assess need for and arrange necessary equipment, home and vehicle modifications.
Intervention	Care coordinator will assist in transition to adult services, education and vocational support.
Expected Outcome	Caregiver/client will be knowledgeable about impact of SCI, health and community resources, develop the skills necessary to support ongoing community reintegration, and will receive all services necessary to promote reintegration into community following spinal cord injury.

Tracheostomy

Protocol	Description
Goal	Client will maintain optimal respiratory function, skin integrity, free of infection and other complications associated with a tracheostomy.
Intervention	Care coordinator will assess caregiver/client knowledge of tracheostomy care.
Intervention	Care coordinator will provide/arrange for education of the caregiver/client on tracheostomy care, signs and symptoms of respiratory distress, how to manage tracheostomy emergencies, and when to notify a medical provider.
Intervention	Care coordinator will assess the client's health status towards the stated goal and provide follow up and referrals as appropriate.
Intervention	Caregiver will perform tracheostomy site care daily: change tube, collar and ties as directed, position tube, collar and ties securely; suction as needed; monitor skin integrity and report any signs of infection or skin breakdown; monitor for distress, respond appropriately and report any problems to physician.
Expected Outcome	Caregiver will understand tracheostomy care and will be knowledgeable about when to seek medical assistance and the client will receive competent care

Traumatic Brain Injury

Protocol	Description
Goal	Client will regain functional independence to his/her highest potential with implementation of individualized supportive measures.
Intervention	Care coordinator will educate client and caregiver about potential deficits and challenges following TBI.
Intervention	Care coordinator will educate or arrange for education of school personnel about teaching students with TBI.
Intervention	Care coordinator will arrange rehabilitation services as ordered, including medical care, therapies, supplies and equipment, home modifications and any other identified services.
Intervention	Care coordinator will arrange for appropriate evaluation of cognitive functioning.
Intervention	Care coordinator will assist in transition to adult services, education and vocational support.
Intervention	Care coordinator will assess and collaborate with caregiver's concerning the status/progress of the client and identifying any necessary changes to meet the goal of community reintegration.
Expected Outcome	Client and caregiver will be knowledgeable about impact of TBI, health and community resources and develop the skills necessary to support ongoing community reintegration.

Vision Loss Unspecified/Vision Diagnosis

Protocol	Description
Goal	Client will achieve optimal vision.
Intervention	Care coordinator will provide information to caregiver/client on the importance of medical follow up, care of equipment and following the prescribed plan of care
Intervention	Caregiver will provide care as instructed by medical providers.
Expected Outcome	Caregiver will receive information to make informed health care decisions and client will receive appropriate evaluations and interventions.

CMS education requirements

The following protocol sets pertain to CMS education requirements:

Disaster Planning

Protocol	Description
Goal	Client will have access to appropriate evacuation site to meet their special needs.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver regarding disaster planning and to address special evacuation needs and/or issues with registration for a special need's shelter or hospital.
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if client has appropriate disaster plan in place.
Intervention	Care coordinator will assist the caregiver to develop or update the CMS Disaster Plan annually or as needed.
Expected Outcome	Caregiver/client will receive education and establish an annual disaster plan.

Immunizations

Protocol	Description
Goal	Client will maintain current immunizations, following a catch-up immunization schedule, or have a valid immunization exemption.
Intervention	Care coordinator will provide information to caregiver/client on the required education issues.
Intervention	Caregiver will inform the care coordinator if assistance or more information is needed.
Intervention	Care coordinator will contact caregiver, PCP, or Florida SHOTS to verify dates of immunizations.
Expected Outcome	Caregiver/client will receive education and information to make informed health care decisions.

Nutrition and Physical Activity

Protocol	Description
Goal	Client will receive age/developmentally appropriate counseling/health education for nutrition and physical activity annually.
Intervention	Care coordinator will discuss current nutrition behaviors and will provide counseling/health education/anticipatory guidance for nutrition.
Intervention	Care coordinator will discuss growth, physical development, and the importance of an annual weight assessment.
Intervention	Care coordinator will provide referrals for additional screening and assessment for clients if appropriate.
Intervention	Care coordinator will discuss current physical activity behaviors and will provide counseling/health education/ anticipatory guidance for physical activity.
Intervention	Care coordinator will provide nutritional assistance program information if appropriate.
Expected Outcome	Caregiver/client will receive education and information to make informed health care decisions and client will receive appropriate screenings and interventions.

Oral Health

Protocol	Description
Goal	Client will have access to a dental provider for an annual dental visit.
Intervention	Care coordinator will provide information to caregiver/client on the required education issues.
Intervention	Care coordinator will provide a dental provider list or assist the caregiver to schedule the dental visit if needed.
Intervention	Care coordinator will contact caregiver to verify the client has a dental provider.
Expected Outcome	Caregiver/client will receive education and information to make informed health care decisions.

Well Client Checks

Protocol	Description
Goal	Client will receive annual well client check-ups.
Intervention	Care coordinator will provide information to caregiver/client on the required education issues.
Intervention	Caregiver will inform the care coordinator if additional assistance or information is needed.
Intervention	Care coordinator will contact caregiver or PCP to verify date of current well client check-up.
Expected Outcome	Caregiver/client will receive education and information to make informed healthcare decisions.

Psychosocial

The following protocol sets pertain to psychosocial issues.

Events Affecting Client and Caregiver

Protocol	Description
Goal	Client and caregiver will adapt to events affecting them.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver as related to the events affecting them and support their ability to access services.
Intervention	Care coordinator will provide supportive counseling via active listening and supportive communication skills including being empathic, showing concern, being respectful, and indicating confidence in the individual's ability to resolve the issue(s).
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine their adaptation to the events affecting them.
Expected Outcome	The client and caregiver will experience a reduction in stress and develop enhanced coping skills.

Emotional and Behavioral Health

Protocol	Description
Goal	Client and caregiver's emotional and behavioral needs will be met.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to the client/caregiver for appropriate counseling services and needed resources, and include the client in the assessment and care planning process if age 14 years or older.
Intervention	Care coordinator will provide supportive counseling via active listening and supportive communication skills including being empathic, showing concern, being respectful, and indicating confidence in the individual's ability to resolve the issue(s).
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to the client/caregiver to determine if client/caregiver has accessed services and to determine its effectiveness in improving emotional and behavioral health.
Expected Outcome	Client and caregiver will receive mental health counseling services to address emotional and behavioral health.

Home Environment

Protocol	Description
Goal	Client will have a safe home environment that meets their needs.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver regarding environmental safety, housing resources, and community resources to address household supports such as utilities, food, and home modifications.
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if they have accessed housing and/or environmental resources.
Expected Outcome	Client and caregiver will access needed housing and environmental resources.

School and Learning Activities

Protocol	Description
Goal	Client will receive a quality formal education appropriate for their medical needs and developmental abilities.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver regarding developmentally and medically-appropriate educational resources.
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if client has accessed educational resources.
Expected Outcome	Client will access needed educational resources.

Cultural, Ethnic and Spiritual Factors

Protocol	Description
Goal	Client will use appropriate resources to meet their specific cultural, ethnic and spiritual requirements.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver regarding meeting their cultural, ethnic and spiritual needs, such as special diets, need for translated material, interpreter services, religious resources and cultural events.
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if client/caregiver has accessed appropriate resources.
Expected Outcome	Client and caregiver will access needed cultural, ethnic and/or spiritual resources.

Substance Abuse Issues Related to the Client Only

Protocol	Description
Goal	Client will be free of substance abuse.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver regarding client's substance abuse and needed resources for treatment.
Intervention	Care coordinator will provide supportive counseling via active listening and supportive communication skills including being empathic, showing concern, being respectful, and indicating confidence in the individual's ability to resolve the issue(s).
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if client has accessed substance abuse resources and/or a treatment provider.
Expected Outcome	Client will access needed substance abuse resources.

Legal Issues

Protocol	Description
Goal	Client's legal needs will be met.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver regarding client's need for assistance and resources related to guardianship, consent, court orders and involvement in the juvenile justice system, criminal justice system, and/or client welfare system.
Intervention	Care coordinator will provide supportive counseling via active listening and supportive communication skills including being empathic, showing concern, being respectful, and indicating confidence in the individual's ability to resolve the issue(s).
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if client has accessed needed legal resources and/or agency assistance.
Expected Outcome	Client will access appropriate legal resources.

Community Services, Resources and Referrals

Protocol	Description
Goal	Client and caregiver will understand client's condition and care, utilize needed services, and will find those services satisfactory.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver regarding client's condition and care and how to access needed resources and services.
Intervention	Care coordinator will provide supportive counseling via active listening and supportive communication skills including being empathic, showing concern, being respectful, and indicating confidence in the individual's ability to resolve the issue(s).
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if client has accessed and is satisfied with community services and available resources.
Expected Outcome	Well informed client and caregiver will be able access appropriate and satisfactory community services and resources.

Transportation

Protocol	Description
Goal	Client will have safe transportation to meet their needs.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver regarding transportation resources and to address special transportation needs related to vehicle modification, access to appropriate car seats/booster seats, non-emergency medical transportation and ADA-compliant transportation to and from school or work.
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if client has accessed needed transportation resources and services.
Expected Outcome	Client will be able to access appropriate safe transportation.

Caregiver Employment, Educational and Financial

Protocol	Description
Goal	The client will have their needs met.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral for community resources to client/caregiver as related to their employment, educational and/or financial circumstances to address the client's needs related to their schedule and circumstances.
Intervention	Care coordinator will provide client/caregiver with information and assistance in applying for all available Social Security Income as needed.
Intervention	Care coordinator will provide supportive counseling via active listening and supportive communication skills including being empathic, showing concern, being respectful, and indicating confidence in the individual's ability to resolve the issue(s).
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if they have accessed needed resources and services to meet the client's needs.
Expected Outcome	Client and caregiver's employment, educational and/or financial circumstances will provide stability to and meet the needs of the client.

Caregiver Support System

Protocol	Description
Goal	The client will have their needs met.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver as related to their need for a support system to meet the client's needs.
Intervention	Care coordinator will provide supportive counseling via active listening and supportive communication skills including being empathic, showing concern, being respectful, and indicating confidence in the individual's ability to resolve the issue(s).
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if they have accessed needed resources and services to meet their need for a support system.
Expected Outcome	Client and caregiver will have an adequate support system to meet the client's needs.

Caregiver Strengths, Concerns and Goals

Protocol	Description
Goal	Agreed-upon goals for the client will be met.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver using their strengths to address their concerns and assist them in meeting agreed-upon goals for the client.
Intervention	Care coordinator will provide supportive counseling via active listening and supportive communication skills including being empathic, showing concern, being respectful, and indicating confidence in the individual's ability to resolve the issue(s).
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up and encouragement to client/ caregiver to determine progress towards goal achievement.
Expected Outcome	Client and caregiver will be empowered to overcome barriers to the short and long-term goals for the client.

MFC

The following protocol sets pertain to medical foster care.

Client is in a temporary Medical Foster Care setting

Protocol	Description
Goal	Client will obtain permanency.
Intervention	Encourage the MFC parent and Bio-parent to co-parent the client and communicate effectively. Bio-parent will contact the assigned social worker or social services coordinator when information about permanency plans is known.
Intervention	MFC care coordinator will collaborate and communicate with the client's foster care case worker regarding reunifications efforts and the client's case plan
Intervention	MFC care coordinator will attend the client's dependency court hearings as needed.
Expected Outcome	Client will be effectively co-parented while in MFC toward the goal of reunification and permanency.

Medical and Psychosocial client specific education and mentoring

Protocol	Description
Goal	Biological/Adoptive/Non-relative and Foster families will be able to care for their client's medical and psychosocial needs.
Intervention	MFC care coordinator will submit in writing what any caregiver needs to know to care for the client for inclusion in the client's case plan. This will include, but is not limited to client specific training, attendance at medical appointments and consistent communication with MFC care coordinator.
Intervention	MFC parent will provide ongoing client specific training to the biological/ adoptive caregiver and the MFC RN will provide verification of that training.
Intervention	MFC care coordinator and parent will monitor and document the biological/adoptive caregiver's ability to provide all special care needs through verbal communication and return demonstration of skills.
Expected Outcome	Biological/Adoptive/Non-relative and Foster families will be able to verbalize and demonstrate the skills necessary to meet the client's special care needs.

Trauma Informed Care

Protocol	Description
Goal	MFC parent will provide trauma informed care to meet the behavioral and emotional needs of the client.
Intervention	MFC care coordinator will provide the MFP with in-service training, education and resources on trauma informed care and appropriate behavioral interventions.
Intervention	MFC care coordinator will ensure that the MFP is supportive and involved with the MFC client's behavioral and emotional therapies and interventions.
Intervention	MFC care coordinator will monitor the home environment, parenting skills and any assigned home interventions to meet the client's psychosocial needs.
Expected Outcome	MFC parent will be able to meet the psychosocial needs of the client.

Temporary Transfers and Normalcy

Protocol	Description
Goal	Client will be incorporated as a caregiver member in the MFC home.
Intervention	MFC parent will minimize the frequency and duration of temporary transfer requests.
Intervention	MFC care coordinator and parent will attempt to use the same temporary caregiver as an extended caregiver member.
Intervention	MFC parent will request placement authority from the CBC case worker and MD approval from the MFC care coordinator for the temporary transfer.
Intervention	MFC care coordinator will assess the client upon the return to the client's MFC home for signs of complex trauma.
Intervention	If client show signs of complex trauma, future non-emergent transfers will be discouraged.
Expected Outcome	Client will not show evidence of emotional stress or trauma due to temporary transfers.

MFC client's adaption to a change in caregiver (admissions/ transfers/discharges)

Protocol	Description
Goal	The MFC client will adapt to a change in caregiver without any adverse effects to the client's health or behavior.
Intervention	MFC care coordinator will assess client for any changes in behavior, such as excessive crying, withdrawal or acting out and any adverse changes in eating, sleeping, bowel and bladder habits.
Intervention	MFC care coordinator will interview the caregiver(s) regarding the client's health status to assess for the presence of a stress-related opportunistic illness, such as a cold or deterioration in their chronic condition after the transfer.
Intervention	If the MFC client does not adapt well to the change in caregiver, the MFC SSW will refer the client for therapeutic services.
Intervention	The MFC care coordinator will arrange and provide appropriate client specific training and verification of skills necessary to care for the client.
Intervention	MFC care coordinator will provide home visits based on the MFC policy and as needed based on the needs of the client.
Intervention	If the MFC client is being discharged from the program a referral will be made to the CMS RN and SSW Care Coordinators as needed.
Expected Outcome	The client's medical and psychosocial status will be unaffected by the change in caregiver.

Interagency collaboration

Protocol	Description
Goal	MFC client will achieve optimum health status.
Intervention	MFC care coordinator will participate in interagency meetings concerning the MFC client.
Intervention	MFC care coordinator will share and receive written and verbal communication regarding the client's status with all involved agencies.
Intervention	MFC care coordinator will include the biological/adoptive/MFC caregiver in the interagency communications.
Expected Outcome	Client will receive continuity of care from collaboration and communication with other agency(s) involved in the client's case.

PIK: TFC

The following protocol set pertains to PIC: TFC.

Partners In Care: Together for Kids (PIC: TFK) Referral

Protocol	Description
Goal	Caregiver and/or client will be enrolled in PIC: TFK if eligible.
Intervention	Care coordinator will enroll or refer client for PIC: TFK services, if eligible.
Intervention	Care coordinator will educate client/caregiver about availability of Palliative Care Services, Children's Medical Services, and the Hospice with additional information as needed.
Intervention	Care coordinator will participate as a member of the multidisciplinary team lead by the PIC: TFK provider.
Intervention	Care coordinator will provide the initial and updated plan of care quarterly to the authorizing physician.
Intervention	Care coordinator will provide caregiver with additional information on their client's disease/condition, treatment, symptoms and services as needed.
Expected Outcome	Client/caregiver will receive PIC: TFK support services, treatments, and education as needed.

Health care transition

The following protocol sets pertain to health care transition.

Initiate Health Care Transition Planning Process at age 12

Protocol	Description
Goal	Client and caregiver will be aware of the CMS Health Care Transition Planning Process initiated at age 12.
Intervention	Care coordinator will provide developmentally-appropriate education and transition materials to the client and caregiver.
Intervention	Care coordinator will identify Agency for Persons with Disabilities (APD) eligibility and educational needs (Ages 12-14). Assist client and caregiver to determine eligibility.
Intervention	Care coordinator will discuss Helpline 2-1-1 Community Resources or the appropriate directory of community resources with the client and caregiver to promote self-reliance.
Intervention	Care coordinator will discuss and encourage self-management of health care with client and caregiver, provide mentoring, and will assist client and caregiver to develop a portable individualized Health Summary that is kept up to date.
Intervention	Care coordinator will educate client and caregiver to contact care coordinator about changes in health status, plan of care, and transitions from any health care setting (Hospitalizations, ER visits, PCP).
Expected Outcome	Client and caregiver will be able to verbalize understanding of Health Care Transition Planning Process and will contact care coordinator with transitions from any health care setting.

Health Care Transition Planning Process: Ages 13-14

Protocol	Description
Goal	Client and caregiver will be engaged in the Health Care Transition Planning Process when the client is age 13-14.
Intervention	Care coordinator will assess if the client has an Individualized Education Plan (IEP) starting at age 14, will help identify health-related activities to support the IEP, and will link client and caregiver to regional representatives for assistance with IEP.
Intervention	Care coordinator will identify Agency for Persons with Disabilities (APD) eligibility, educational needs (Ages 12-14), and will assist client and caregiver to determine eligibility if appropriate.
Intervention	Care coordinator will discuss and encourage self-management of health care with client and caregiver, provide mentoring, and will assist client and caregiver to develop a portable individualized Health Summary that is kept up to date.
Intervention	Care coordinator will educate client and caregiver and to contact care coordinator about changes in health status, plan of care, and transitions from any health care setting (Hospitalizations, ER visits, PCP).
Expected Outcome	Client and caregiver will be knowledgeable about available transition resources and will contact care coordinator with transitions from any health care setting.

Health Care Transition Process: Ages 15-17

Protocol	Description
Goal	Client and caregiver will establish a timeline for transfer to adult primary and subspecialty care.
Intervention	Care coordinator will identify client and caregiver decision-making needs.
Intervention	Care coordinator will discuss and encourage self-management of health care with client and caregiver, provide mentoring, and will assist client and caregiver to develop a portable individualized Health Summary that is kept up to date.
Intervention	Care coordinator will educate client and caregiver to contact care coordinator about changes in health status, plan of care, and transitions from any health care setting (Hospitalizations, ER visits, PCP).
Intervention	Care coordinator will complete the CMS Client/Young Adult Transition Checklist with the client and caregiver.
Intervention	Care coordinator will assist client and caregiver to complete the Transition Readiness Assessment Questionnaire (TRAQ) every 6 months beginning at age 16.
Intervention	Care coordinator will refer client and caregiver to Florida Legal Services for legal aid, if appropriate.
Intervention	Care coordinator will determine if the client is eligible for Division of Vocational Rehabilitation (VR) starting at age 15. If eligible, the care coordinator will obtain a referral for client.
Intervention	Care coordinator will assist and mentor client and caregiver with major issues before the 18th birthday (advance directives, levels of guardianship, voting).
Intervention	Care coordinator will refer client and caregiver to Florida Legal Services for legal aid, if appropriate.
Intervention	Care coordinator will refer client and caregiver to the local Center for Independent Living for assistance if appropriate.
Expected Outcome	Client and caregiver are completing transition activities including a timeline and planning for successful transfer to adult primary and subspecialty care.

Health Care Transition Process: Ages 18-21

Protocol	Description
Goal	Client and caregiver will transition to an adult health care provider.
Intervention	Care coordinator will discuss and encourage self-management of health care with client and caregiver and provide mentoring and will assist client and caregiver to update the portable individualized Health Summary.
Intervention	Care coordinator will educate client and caregiver to contact care coordinator about changes in health status, plan of care, and transitions from any health care setting (Hospitalizations, ER visits, PCP).
Intervention	Care coordinator will identify the client's/caregiver's insurance coverage and discuss SSI/private and public insurance options and will link the client and caregiver to local contacts.
Intervention	Care coordinator will assist the client and caregiver to find adult providers: Call physician's offices to discuss if they will accept the client and caregiver. Utilize the CMS Provider Relations Liaison (PRL) for assistance. Verify client/caregiver has contact information for adult provider.
Intervention	Care coordinator will assist the pediatric primary care provider and specialty providers in preparing the Transfer of Care Package which includes at a minimum: Transfer letter from pediatric PCP, Transition Checklist, portable individualized Healthy Summary, Transition Readiness Assessment Questionnaire, and Emergency/Disaster Plan.
Intervention	Care coordinator will assist client and caregiver to complete the Transition Readiness Assessment Questionnaire (TRAQ) every 6 months beginning at age 16.
Intervention	Care coordinator will assist the client and caregiver with transition to adult primary care and specialty providers and will initiate follow-up interaction to monitor successful transfer of care.
Intervention	Care coordinator will assess the client and caregiver to determine if they are receiving the services necessary to make a successful transition to adult life before closing the client and caregiver to CMS.
Expected Outcome	The client and caregiver will experience successful transition to an adult primary care and specialty care providers before closing to CMS.

Other

The following protocol set pertains to other issues.

Health Care Insurance Coverage

Protocol	Description
Goal	Client will have health care insurance coverage to meet their medical needs.
Intervention	Care coordinator will communicate with and provide appropriate education, care coordination and referral to client/caregiver as related to their health care insurance to cover the client's medical needs.
Intervention	Care coordinator will provide case consultation to the client's other assigned CMS care coordinator, physicians and agencies as needed.
Intervention	Care coordinator will provide follow-up to client/caregiver to determine if they have accessed needed resources and services to meet their need for health care insurance coverage.
Expected Outcome	Client will have access to appropriate health care coverage.

Appendix B - Settings

This appendix outlines settings unique to or required for InteGreat Care Coordination. For InteGreat Practice Management settings, refer to InteGreat Practice Management documentation.

In this appendix

This appendix includes the following topics.

Topic	See page
Selecting provider network affiliations	188
Selecting the network affiliation(s) for a new provider	188
Selecting the network affiliation(s) for an existing provider	192
Specifying service providers	194
Adding a new service provider	194
Revising settings for an existing service provider	195
Interface mapping	197

Selecting provider network affiliations

Each provider must have a network affiliation to work with either CMSN or ES. When a new provider is entered at Setup, network affiliation must be selected for that provider.

This section contains the following topics:

Topic	See page
Selecting the network affiliation(s) for a new provider	188
Selecting the network affiliation(s) for an existing provider	192

To select the network affiliation(s) for a new provider:

1. Click **Settings**.
2. Click **Providers**. A list of existing providers displays.

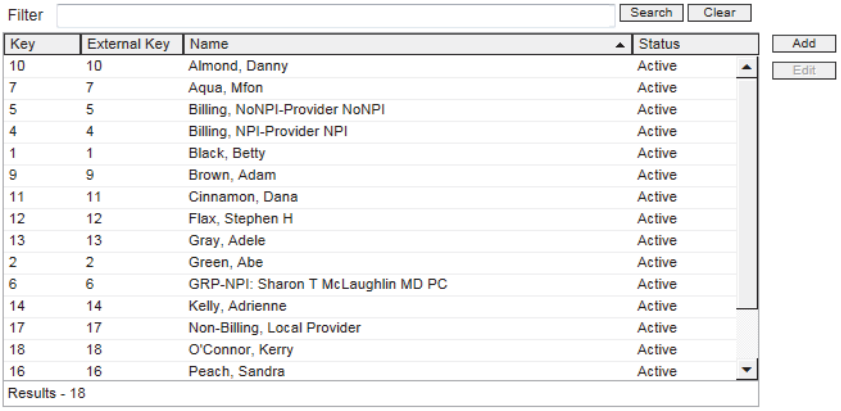

Figure 57. List of providers

3. Click the **Add** button. The New Provider screen appears.

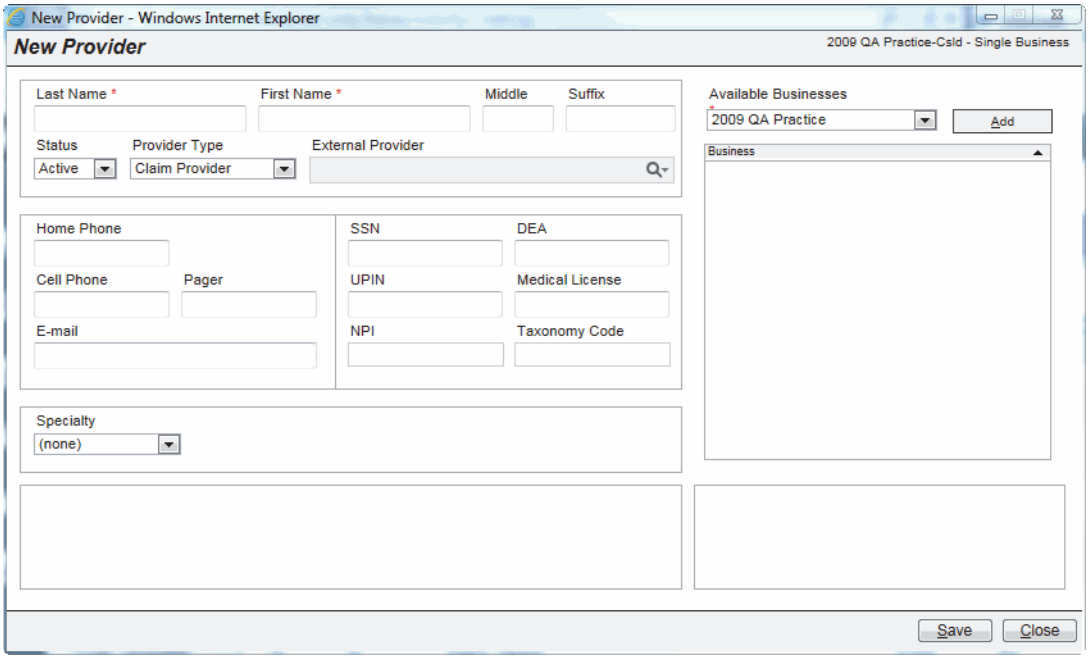

Figure 58. New Provider screen

4. Click inside the **External Provider** field, then click the **Advanced** button.

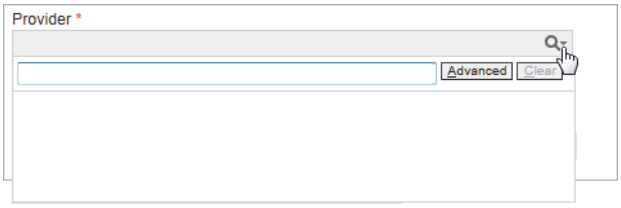

Figure 59. Clicking the External Provider field to display the Advanced button

The External Provider Search screen appears.

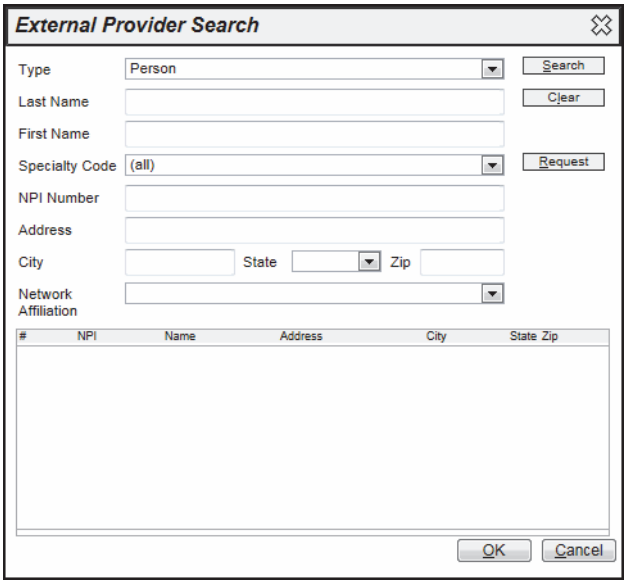

Figure 60. External Provider Search screen

5. Specify the following information about the external provider.

Fields in the External Provider Search screen

Field	Description
Type	From the **Type** drop-down list, select whether the external provider is a person or non-person. An example of a non-person is a facility.
Last Name	In the **Last Name** text box, enter the external provider's last name.
First Name	In the **First Name** text box, enter the external provider's first name.
Specialty Code	From the **Specialty Code** drop-down list, select the external provider's specialty.
NPI Number	In the **NPI Number** text box, enter the external provider's NPI number.
Address	In the **Address** text box, enter the external provider's street address.
City	In the **City** text box, enter the city associated with the external provider's address.
State	From the **State** drop-down list, select the state associated with the external provider's address.
Zip	In the **Zip** text box, enter the zip code associated with the external provider's address.
Network Affiliation	From the **Network Affiliation** drop-down list, specify whether the external provider's network affiliation is only with CMSN or with both CMSN and ES.

6. Click the **Search** button to determine if the external provider can be found. If the external provider is not found, revise your search parameters. If necessary, click the **Clear** button to clear all search parameters.

   If the external provider cannot be found, click the **Request** button to submit a request for the external provider to be added to the list of providers. For more information about entering a request for an additional external provider, refer to InteGreat Practice Management documentation.

7. If the external provider is found, select that provider, then click the **OK** button. The New Provider screen reappears with the specified external provider in the External Provider field.
8. Specify the following information about the new provider.

   Fields in the New Provider screen

Field	Description
Last Name	In the **Last Name** text box, type the provider's last name. This is a required field.
First Name	In the **First Name** text box, type the provider's first name. This is a required field.
Middle	In the **Middle** text box, type the provider's middle name.
Suffix	In the **Suffix** text box, type the provider's suffix.
Status	From the **Status** drop-down list, select whether the provider is active or inactive.
Provider Type	From the **Provider Type** drop-down list, select which type this provider is.
Home Phone	In the **Home Phone** text box, enter the provider's home telephone number.
Work Phone	In the **Work Phone** text box, enter the provider's work telephone number.
Cell Phone	In the **Cell Phone** text box, enter the provider's cell telephone number.
Pager	In the **Pager** text box, enter the provider's pager number.
E-Mail	In the **E-Mail** text box, enter the provider's e-mail address.
SSN	In the **SSN** text box, enter the provider's Social Security Number.
DEA	In the **DEA** text box, enter the provider's DEA number.
UPIN	In the **UPIN** text box, enter the provider's UPIN number.
Medical License	In the **Medical License** text box, enter the provider's medical license number.
NPI	In the **NPI** text box, enter the provider's NPI number.
Taxonomy Code	In the **Taxonomy Code** text box, enter the provider's taxonomy code.
Specialty	From the **Specialty** drop-down list, select the provider's specialty.

9. From the **Available Businesses** drop-down list, select which business(es) the provider is associated by clicking the **Add** button for each selected business. Businesses in which the provider is associated display in the Business list.

10. Click the **Save** button once. If there are errors, they will display. Make corrections, then click the **Save** button again.
11. If there are no errors, click the **Close** button. The new provider is added to the Providers setup category along with its network affiliation(s).

To select the network affiliation(s) for an existing provider:

1. Click **Settings**.
2. Click **Providers**. A list of existing providers displays.

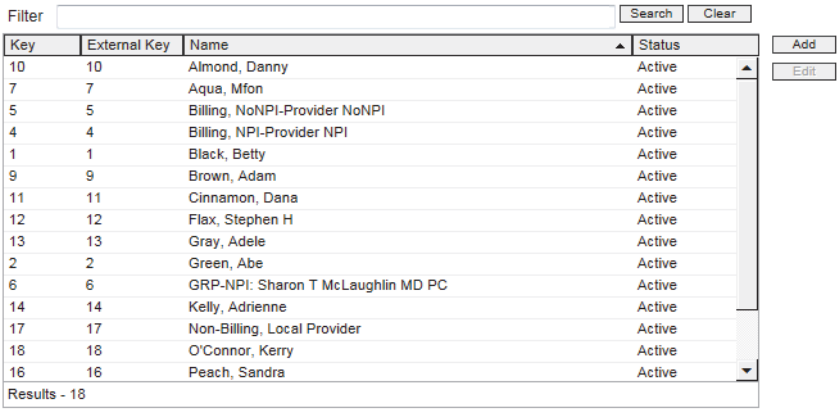

Figure 61. List of providers

3. Select a provider in which to select network affiliation(s), then click the **Edit** button. The New Provider screen appears.

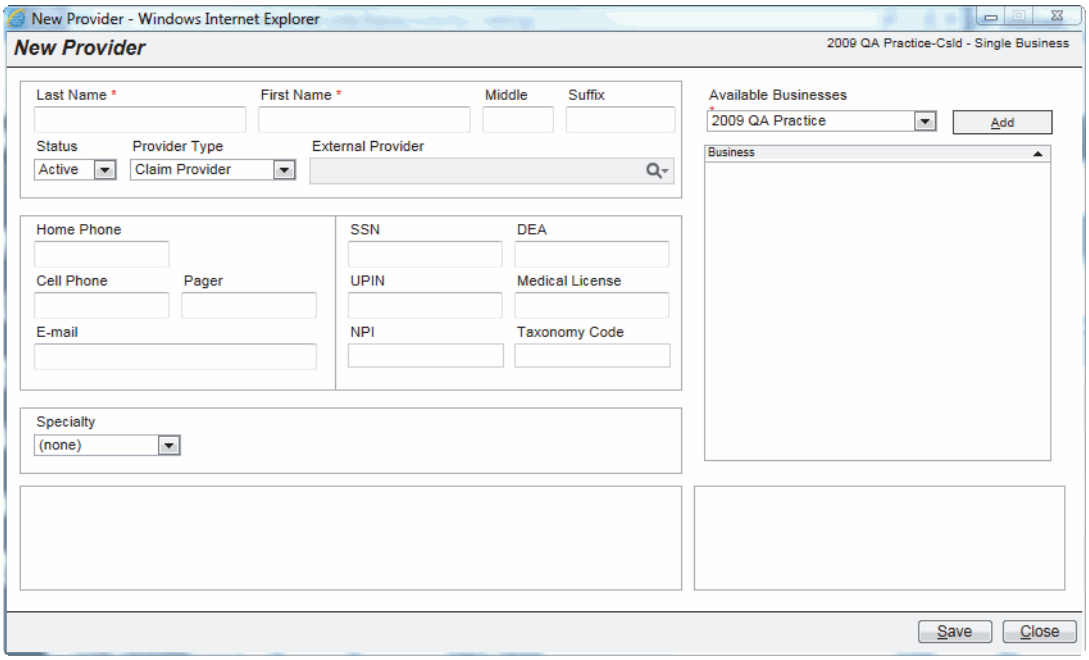

Figure 62. New Provider screen

4. Click inside the **External Provider** field, then click the **Advanced** button.

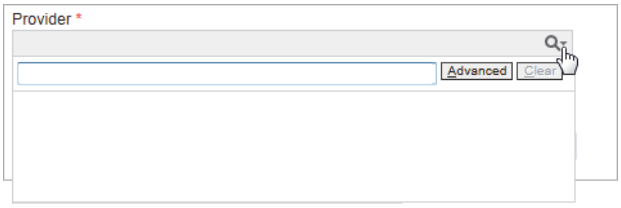

Figure 63. Clicking the External Provider field to display the Advanced button

The External Provider Search screen appears.

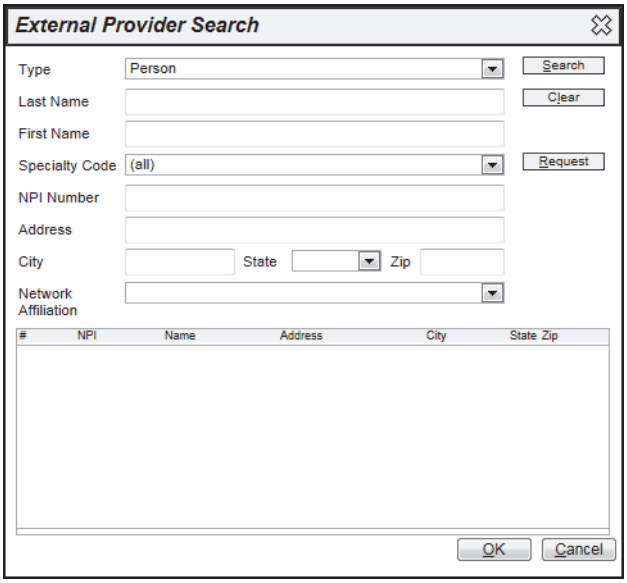

Figure 64. External Provider Search screen

5. From the **Network Affiliation** drop-down list, specify whether the external provider's network affiliation is only with CMSN or with both CMSN and ES.
6. Click the **OK** button. The New Provider screen reappears.
7. Click the **Save** button once. If there are errors, they will display. Make corrections, then click the **Save** button again.
8. If there are no errors, click the **Close** button. The provider's network affiliation(s) has been revised.

Specifying service providers

A service provider is a location of service a member uses or into which a member is being transferred. The Services in Setup displays a list of service providers available from the Service Tracker screen. For more information about the Service Tracker screen, refer to "Services tab" on page 121.

This section contains the following topics:

Topic	See page
Adding a new service provider	194
Revising settings for an existing service provider	195

To add a new service provider:

1. Click **Settings**.
2. Click **Services**. A list of service providers displays.
3. Click the **Add** button. The New Service screen appears.

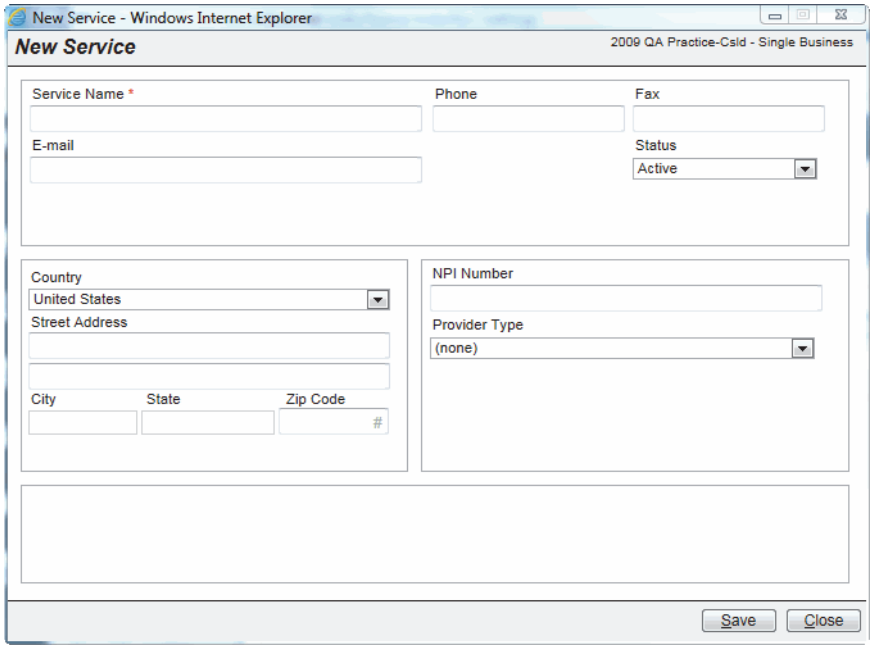

Figure 65. New Services screen

4. Specify the following information about the new service provider.

Fields in the New Service screen

Field	Description
Service Name	In the **Service Name** text box, enter the service provider's name. This is a required field.
Phone	In the **Phone** text box, enter the service provider's telephone number.
Fax	In the **Fax** text box, enter the service provider's fax number.

Fields in the New Service screen (continued)

Field	Description
E-Mail	In the **E-Mail** text box, enter the service provider's e-mail address.
Status	From the **Status** drop-down list, select whether the service provider is active or inactive.
Country	From the **Country** drop-down list, specify from which country the service provider lives.
Street Address	In the **Street Address** text boxes, enter the street address for the service provider.
City	In the **City** text box, enter the name of the city of which the service provider lives.
State	In the **State** text box, enter the name of the state of which the service provider lives.
Zip Code	In the **Zip Code** text box, enter the service provider's zip code.
NPI Number	In the **NPI Number** text box, enter the service provider's NPI number.
Provider Type	From the **Provider Type** drop-down list, select which type this service provider is.

5. Click the **Save** button once. If there are errors, they will display. Make corrections, then click the **Save** button again.
6. If there are no errors, click the **Close** button. The service provider has been added.

To revise settings for an existing service provider:

1. Click **Settings**.
2. Click **Services**. A list of service providers displays.

3. Select the service provider to revise its settings, then click the **Edit** button. The Edit Service screen appears.

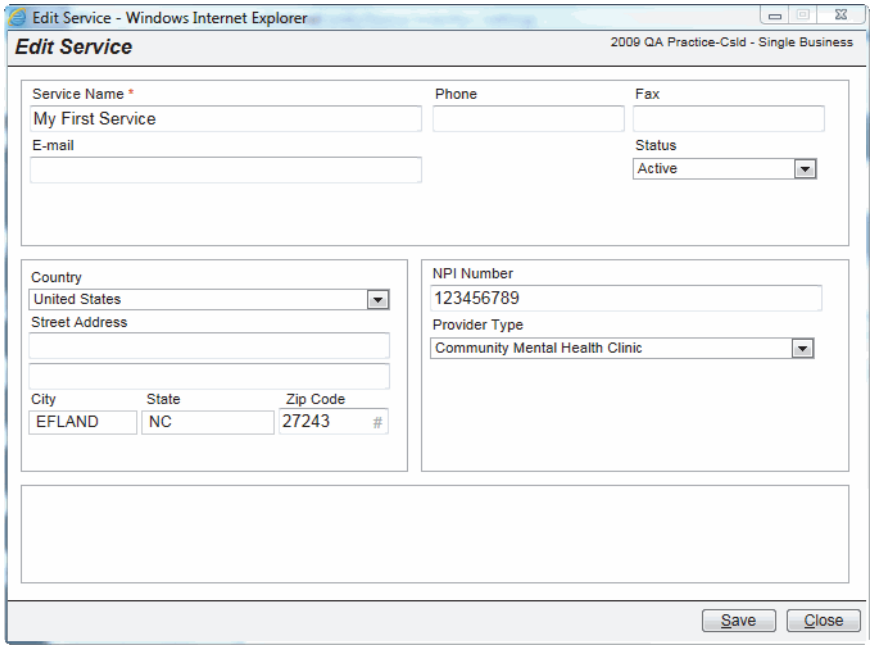

Figure 66. Edit Service screen

4. Revise the service provider settings. For a description of the service provider settings, refer to "Adding a new service provider" on page 194.
5. Click the **Save** button once. If there are errors, they will display. Make corrections, then click the **Save** button again.
6. If there are no errors, click the **Close** button. The service provider has been added.

Interface mapping

Interface mapping allows for directing of data that is being interfaced from ED/Facets via an HL7 interface into the correct table locations in the InteGreat application.

To receive assistance maintaining InteGreat interface mappings, please contact McKesson Customer Support.

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