



Children's Health Home of Upstate New York
Family Driven Care Management Services

www.ChildrensHealthHome.com

Netsmart CareManager User Manual

Last Updated: June, 2020

*Please check the CHHUNY Portal for the most updated copy



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ACCOUNT

New User Accounts

Please submit an add new user request to CHHUNY Helpdesk at: <https://chhuny.giva.net/>

Initial Temporary Password

1. You will receive an encrypted email which you will need to access to get your initial temporary password.
2. When you receive this encrypted email you will open the attachment and click on the 2nd link "Don't want to sign in? Get a one-time passcode to view the message".
 - a. This will take you to a webpage that asks for a passcode and sends you an email with that passcode. You can copy and paste it into the window.
3. Once you have gained access to the email you will find your temporary password. Navigate to Netsmart CareManager and use this along with your email address to login.
4. This password is also used to log into the help desk. Navigate to the help desk <https://chhuny.giva.net/> and use your email address and this password to get in.
 - a. Once you have logged into the help desk, click on the "Personalize" link in the upper right-hand corner to change your password.

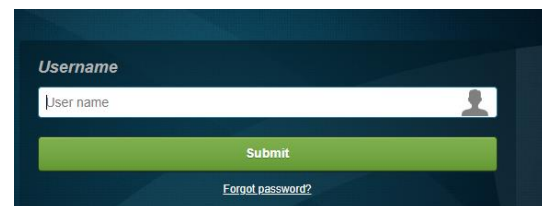
To view your message, sign in using the following email address:
c. [REDACTED].com

[SIGN IN AND VIEW YOUR ENCRYPTED MESSAGE](#)

[Don't want to sign in? Get a one-time passcode to view the message.](#)

Logging In

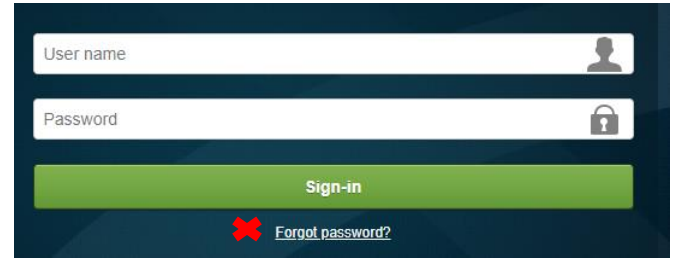
1. Open your preferred browser and navigate to <https://caremanager.netsmartcloud.com>
 - a. CHHUNY recommends using Google Chrome or Mozilla Firefox as your browser when navigating CareManager
2. Enter your username
 - a. Your username will be work your email.
3. Click **Submit**
4. Then, you will be prompted to enter your password
5. Click **Sign-in**
6. You must reset your password upon first login
 - a. Password Requirements
 - Minimum 8 Characters
 - 1 Capital Letter
 - 1 Number
 - 1 Symbol
7. When you log in for the second time you will be required to setup 3 security questions
8. You will set up Okta Multi-Factor Authentication.
9. Do not save your password into your browser



The screenshot shows a login form with a dark blue background. At the top, it says "Username". Below that is a white input field with "User name" written inside. To the right of the input field is a small grey person icon. Below the input field is a green "Submit" button. At the bottom of the form, there is a link that says "Forgot password?".

Password Reset

Care Managers will utilize the Okta account system to reset their passwords. Instructions are on page 12 of this manual.



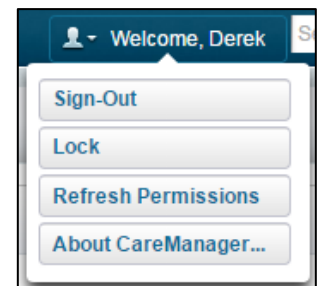
Account Locked

If you are logging in and you use the wrong password too many times the system will inform you that your account has been locked for 5 minutes. If you need to gain access before those 5 minutes are up you can contact the [help desk](#).

Sign-Out/Lock Your Account

It is important to protect your clients' Protected Health Information (PHI) so you need to practice locking the program or signing out of the program when you walk away. In the upper right-hand corner of the screen you will see "Welcome, *your name*". When you click on it you will see 4 buttons.

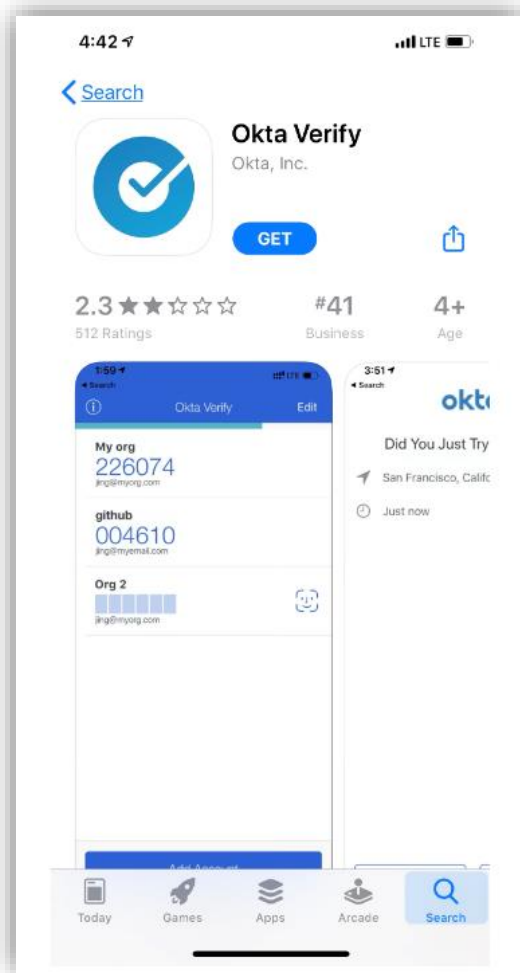
- **Sign-Out**
 - This will take you to the sign in screen where you enter your username and password
- **Lock**
 - This will lock the application allowing you to put in your password and pick up where you left off
- **Refresh Permissions**
 - This will refresh your security settings if they are updated in the background
- **About CareManager...**
 - This will give you version information on CareManager



Multi-Factor Authentication

User Guide

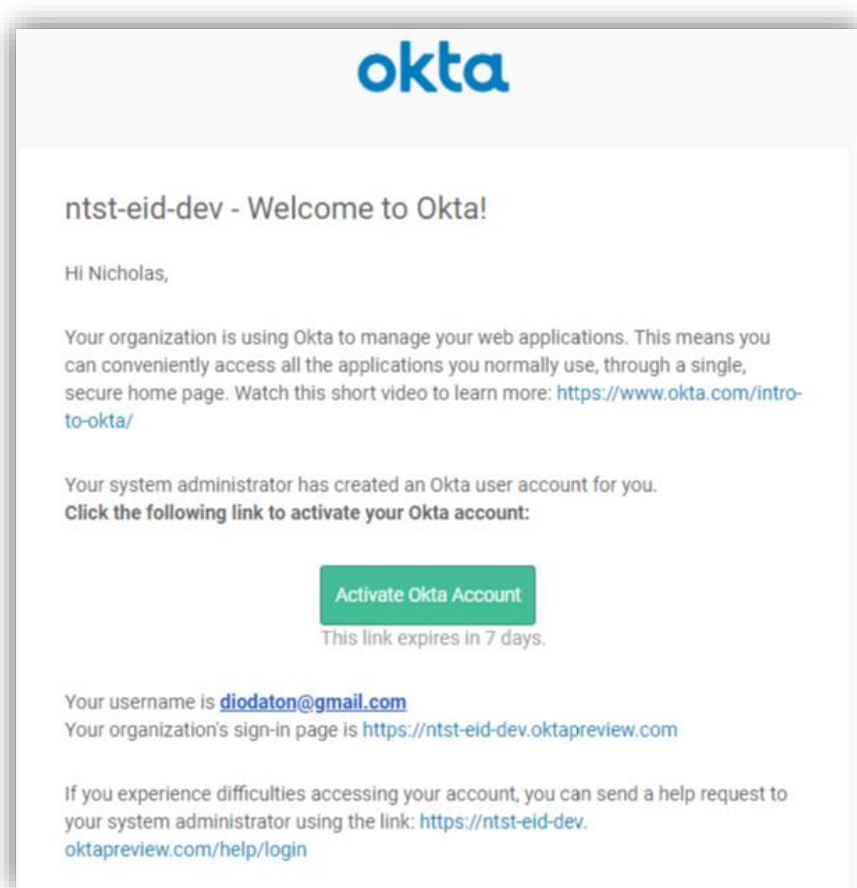
For the multi-factor authentication process in CareManager, users will be able to choose from using entering a code received in a text message sent to their mobile phone or a generated code in the **Okta Verify** mobile app. If users choose to use the **Okta Verify** mobile app, they will need to download the app to their smartphone from **Google Play** or the **Apple Store** prior to starting the Okta Account Setup process. Below is a screenshot of the app that needs to be downloaded.



Okta Account Setup

When Netsmart releases the MFA solution to Production on **April 6th 2020**, all users will receive the following email to provision their account in **Okta**. Emails will be sent to the confirmed email address provided by Health Homes. Users will only have **ONE** user account across all health home organizations in which they are associated and the new login process after account setup will allow for the user to select the health home that they want to log into.


1. Users will click the **'Activate Okta Account'** button on the email to start the account setup.



Users will be prompted to enter a new password at this time. They will also need to set up a security question and answer that can be used when resetting their password. They will then select a picture to choose as a security image. This will be displayed on the login screen after the initial setup the first time the user logs into CareManager.


2. Users will click on the **'Create My Account'** button at the bottom of the page to complete the account setup.

Welcome to ntst-eid-dev, Nicholas!
Create your ntst-eid-dev account

 Enter new password


Password requirements: at least 8 characters, a lowercase letter, an uppercase letter, a number, no parts of your username. Your password cannot be any of your last 4 passwords.

Repeat new password













 Choose a forgot password question

What is the food you least liked as a child? ▾

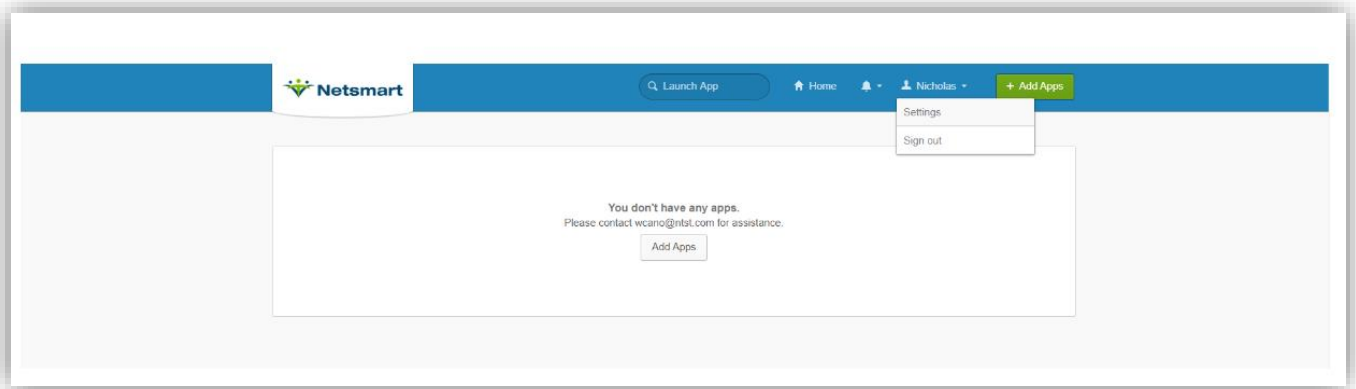
Answer

 Click a picture to choose a security image

Your security image gives you additional assurance that you are logging into Okta, and not a fraudulent website.

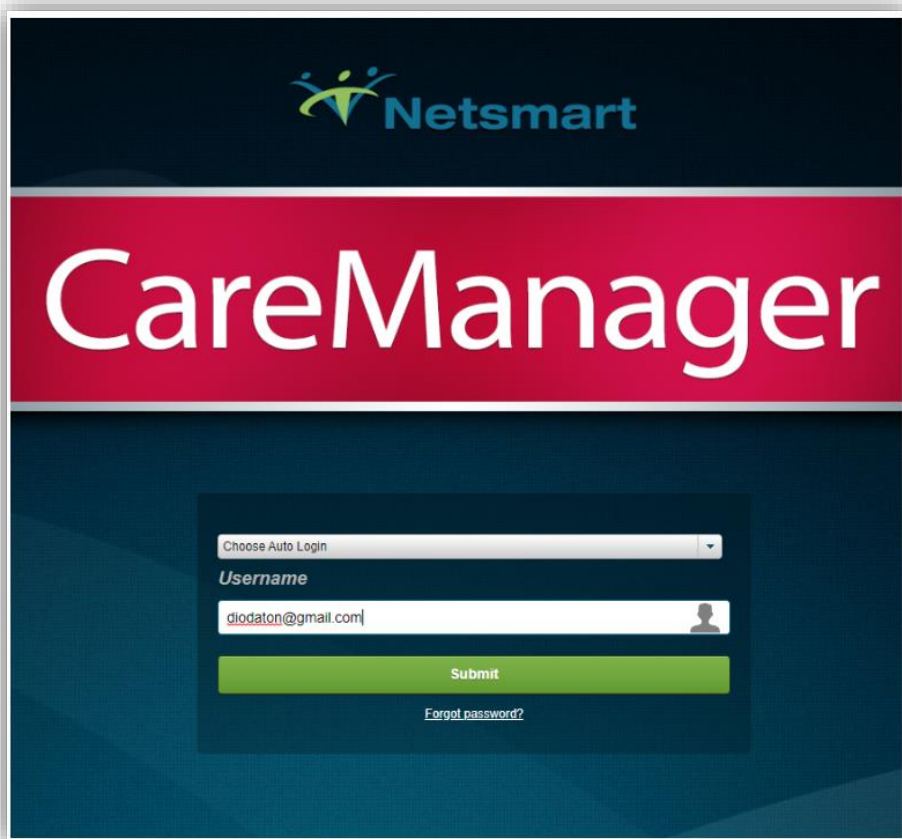
3. Once the process has completed, the following screen will be displayed. The user will then select the **'Sign Out'** option under the user menu. Now, the user will be able to log into CareManager using Multi-Factor Authentication.



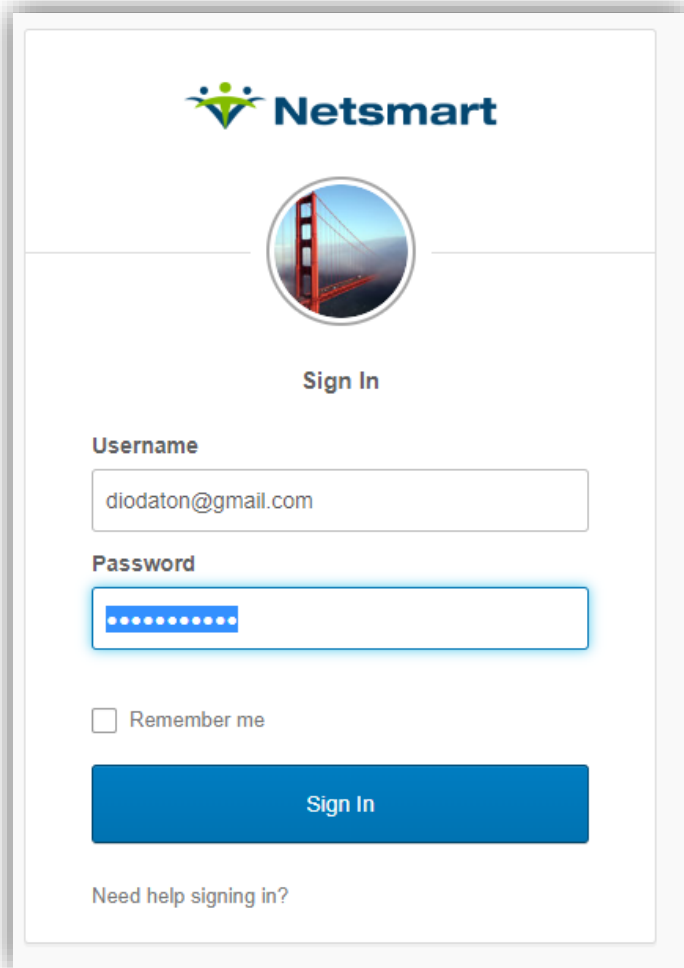
CareManager Account Login

Once the user account is set up in CareManager, users can now log into CareManager using their new user login. The multi-tenant capability will also be available.

1. On the CareManager Login page, users will enter their username and select **'Submit'**.



2. The new **Okta** login screen will be displayed. Users will enter their password and select **'Sign In'**. After logging into CareManager successfully for the first time using the **Okta** login screen, users will begin seeing their security image on the Sign In page as shown in the screenshot below.



Netsmart

Sign In

Username
diodaton@gmail.com

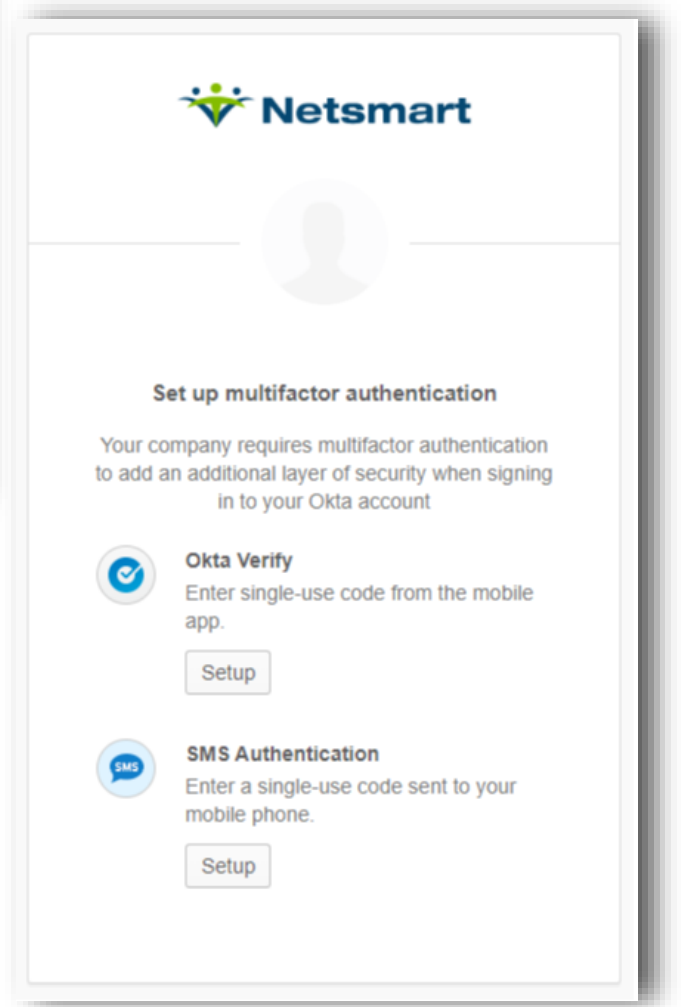
Password
[Masked]

Remember me

Sign In

Need help signing in?

3. Users will then be required to configure multi-factor authentication option they want to use going forward. They will choose between the **Okta Verify** app or **SMS Authentication**. This is a one-time setup process and once an option is selected, the user will be required to use that option for all subsequent logins.



Netsmart

Set up multifactor authentication

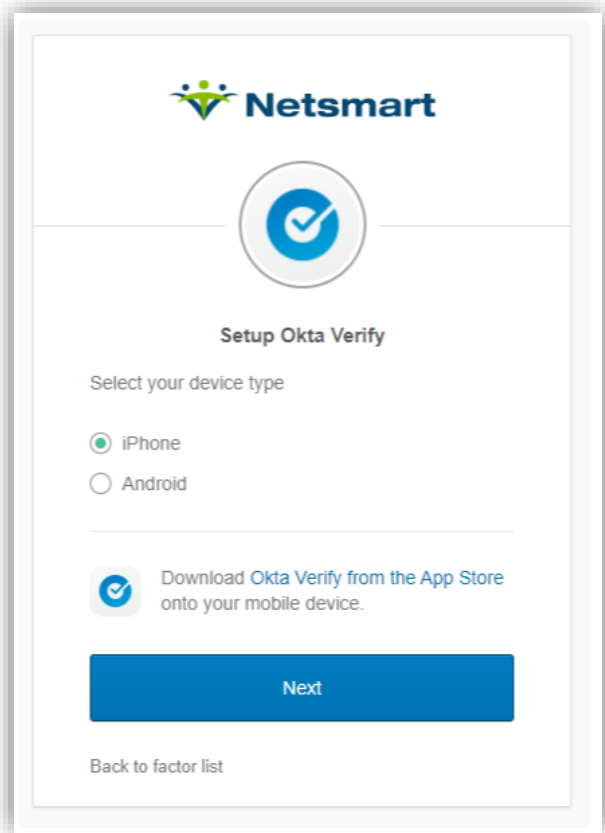
Your company requires multifactor authentication to add an additional layer of security when signing in to your Okta account

Okta Verify
Enter single-use code from the mobile app.
Setup

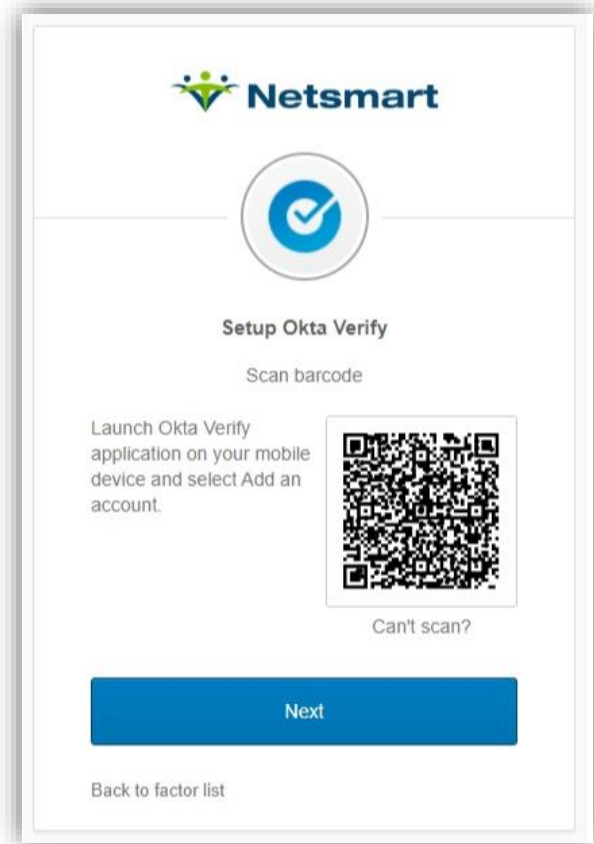
SMS Authentication
Enter a single-use code sent to your mobile phone.
Setup

Okta Verify App

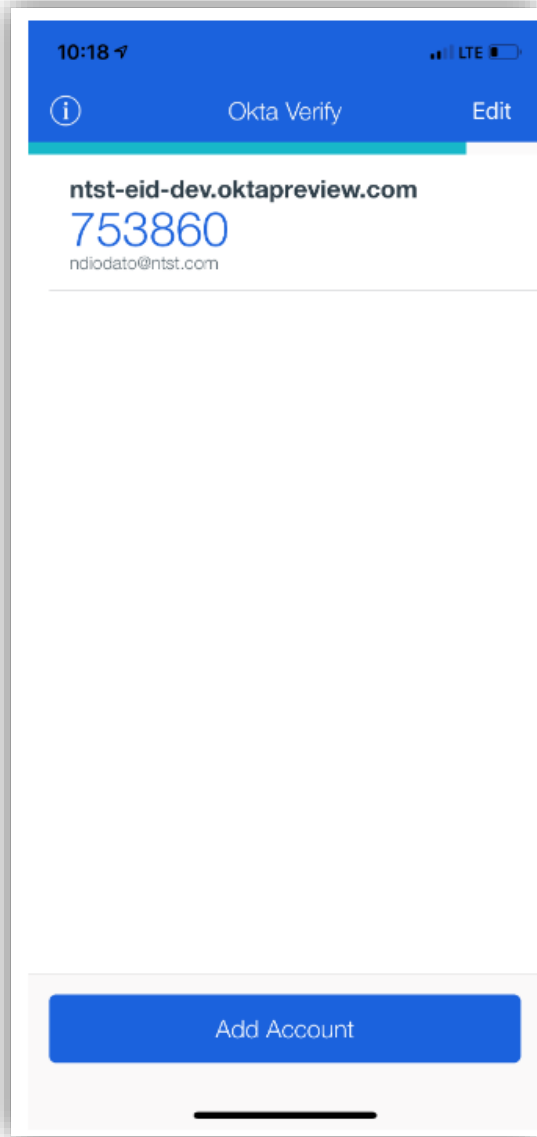
1. If the user wants to use the **Okta Verify** mobile app, they will click on the **'Setup'** button under **Okta Verify**. This will prompt the user to select the device type. After selecting the applicable device type for their mobile phone, they will click the **'Next'** button.



2. A barcode will then be displayed for the user as shown below.

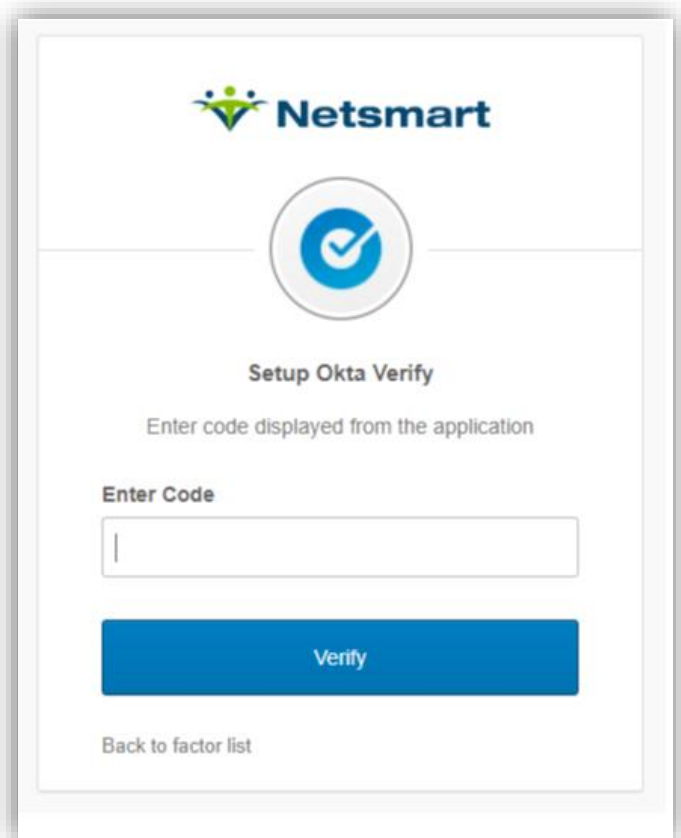


- The user will then launch the **Okta Verify** app on their mobile phone and select '**Add Account**' as shown below. Selecting '**Add Account**', the camera on the user's mobile phone will open automatically to bar scanning mode. The user will use their phone to scan the barcode on their screen.



- After scanning the barcode in the **Okta Verify** mobile app, users will be presented with a code in the app as shown in the screenshot on the left. This code will be used to complete the login process for CareManager. Please note that the code changes every 30 seconds.

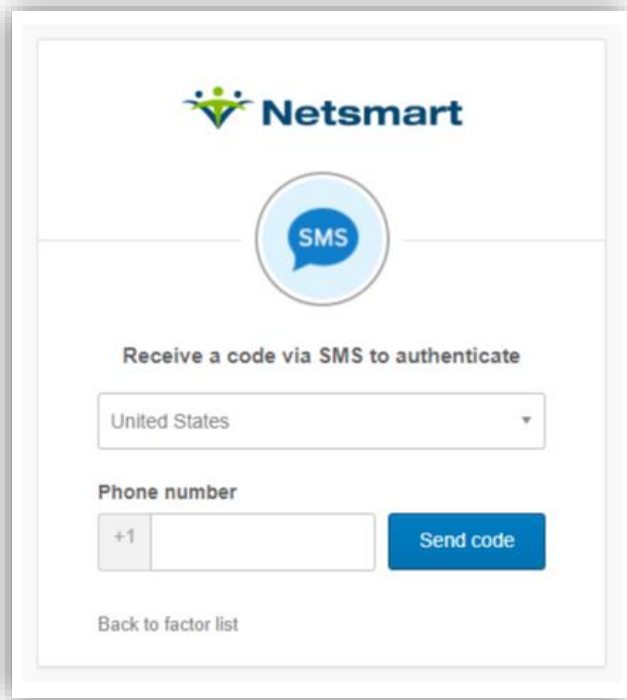
Users will enter the code in the '**Enter Code**' field and then select the '**Verify**' button. If the authentication process is successful, CareManager will be launched.



Note: Each time the user logs into CareManager going forward, they will be prompted to enter a code from the Okta Verify app as shown in the screen shots above.

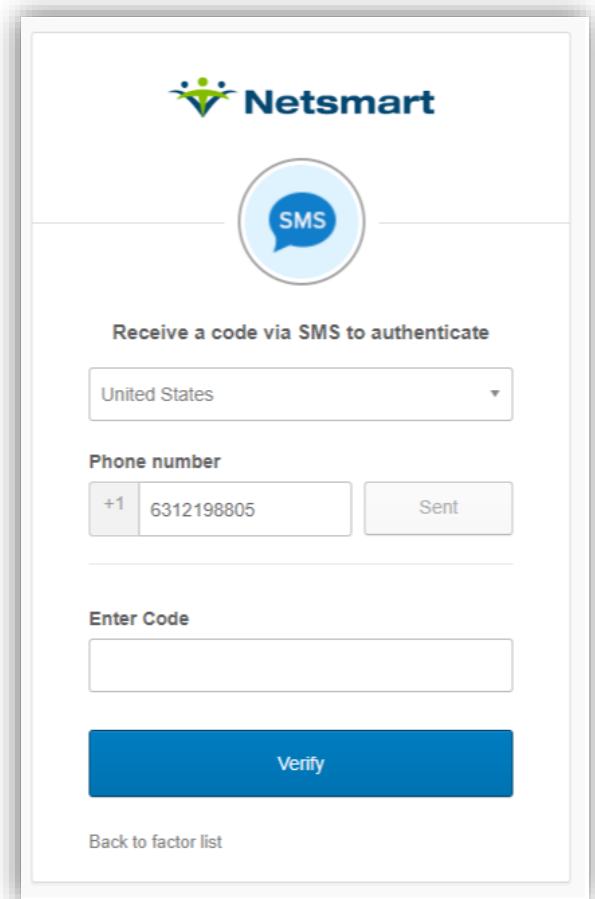
SMS Authentication

1. If the user wants to use the **SMS Authentication** process, they will click on the **'Setup'** button under **SMS Authentication**. This will prompt the user to enter their mobile phone number. After entering their mobile phone number, they will click the **'Send Code'** button.



2. An authentication code will be sent to the user's mobile phone.

3. Users will enter the code in the **'Enter Code'** field and then select the **'Verify'** button. If the authentication process is successful, CareManager will be launched.

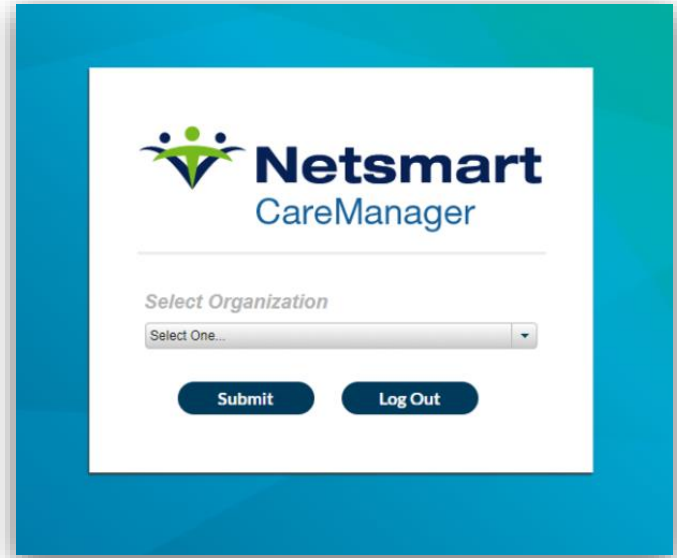


Note: Each time the user logs into CareManager going forward, they will be prompted to enter a code received via text message as shown in the screen shots above.

CareManager Multi-Tenant Login

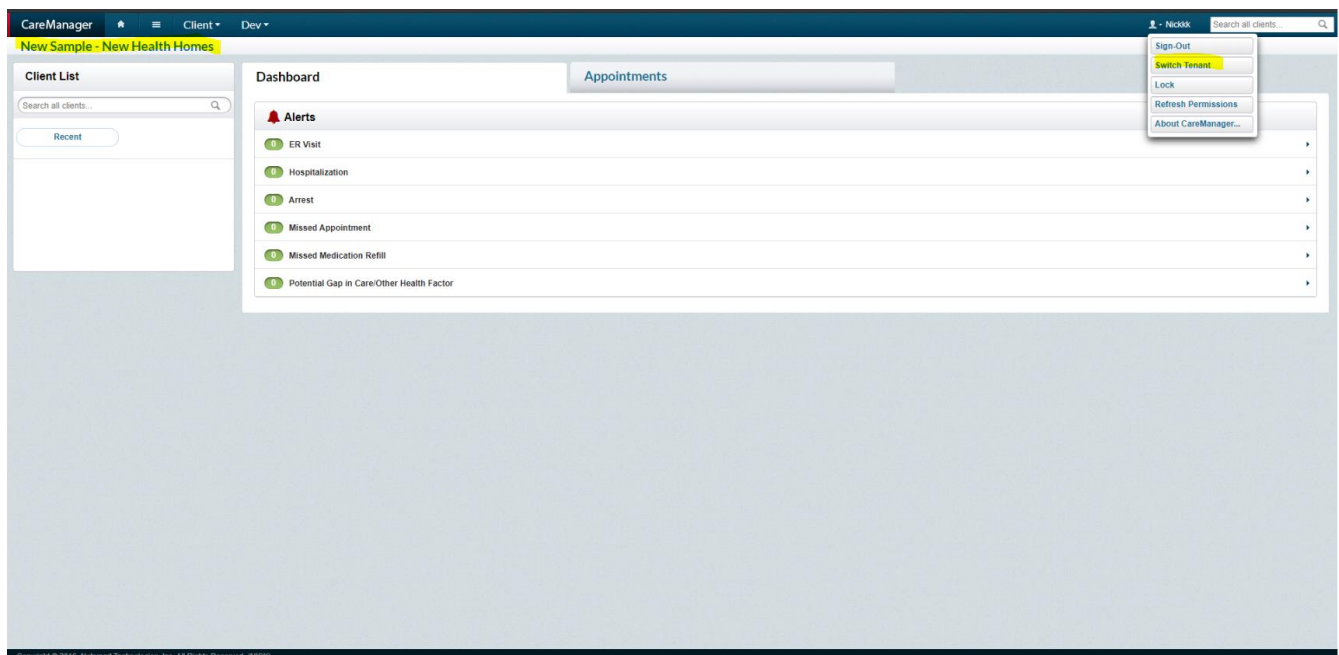
Once the user completes the multi-factor authentication process, CareManager will be launched. For users who are associated with multiple health homes, they will be prompted to select the health home they want to log into.

Users will select the **'Organization'** and then select the **'Submit'** button. This will launch CareManager for the selected health home.



When users associated with multiple organizations are logged into CareManager, they will see the Organization they just logged into in the banner in the top left of the screen.

Users be able easily switch between health homes using the **'Switch Tenant'** option under the user menu.



Password Resets

1. If a user needs to reset their password after their Okta login has been activated, they will do this by selecting the **'Need help signing in?'** link on the Okta login screen.

Netsmart

Sign In

Username
diodaton@gmail.com

Password

! Please enter a password

Remember me

Sign In

Need help signing in?
Forgot password?
Help

2. Clicking the link will display the following screen. The user will enter their email address and click the **'Reset via Email'** button.

Netsmart

Reset Password

Email or Username

Reset via Email

Back to Sign In

3. The user will be notified that an email has been sent.

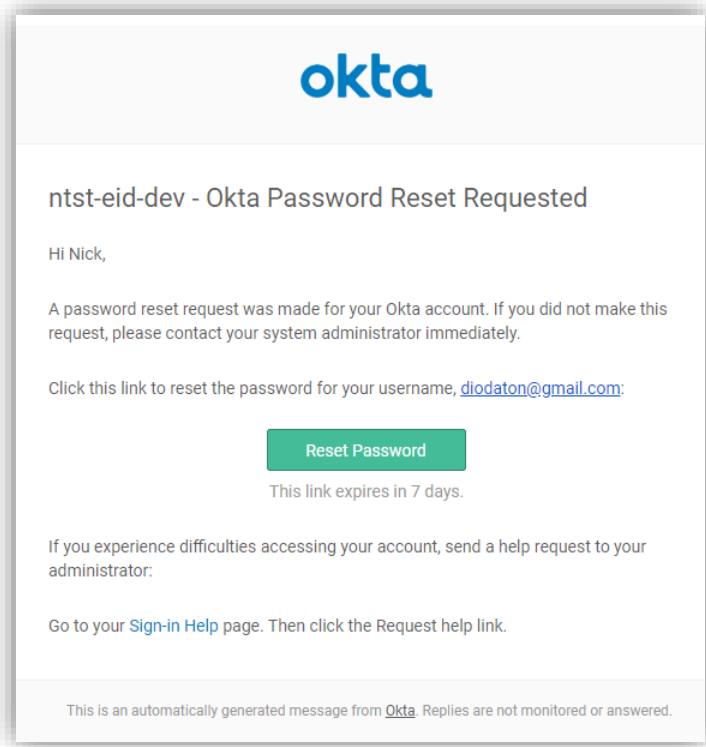
Netsmart

Email sent!

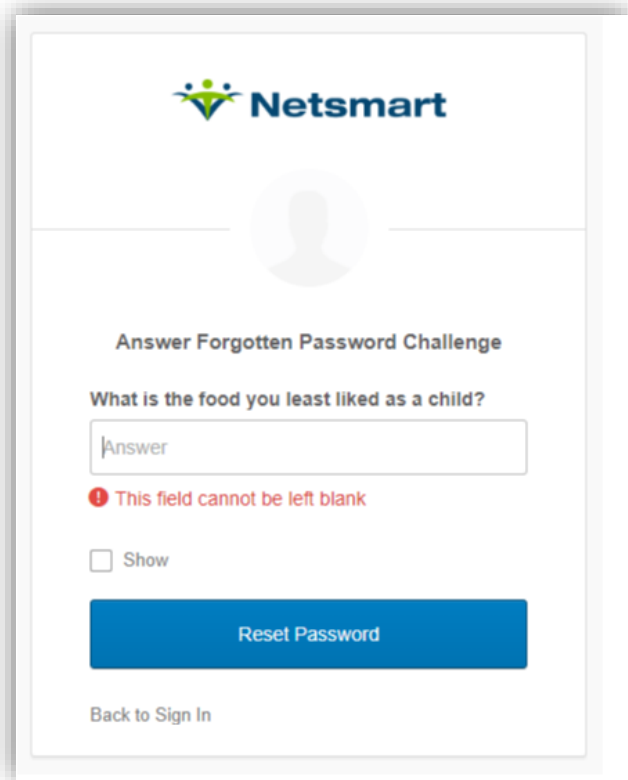
Email has been sent to diodaton@gmail.com with instructions on resetting your password.

Back to Sign In

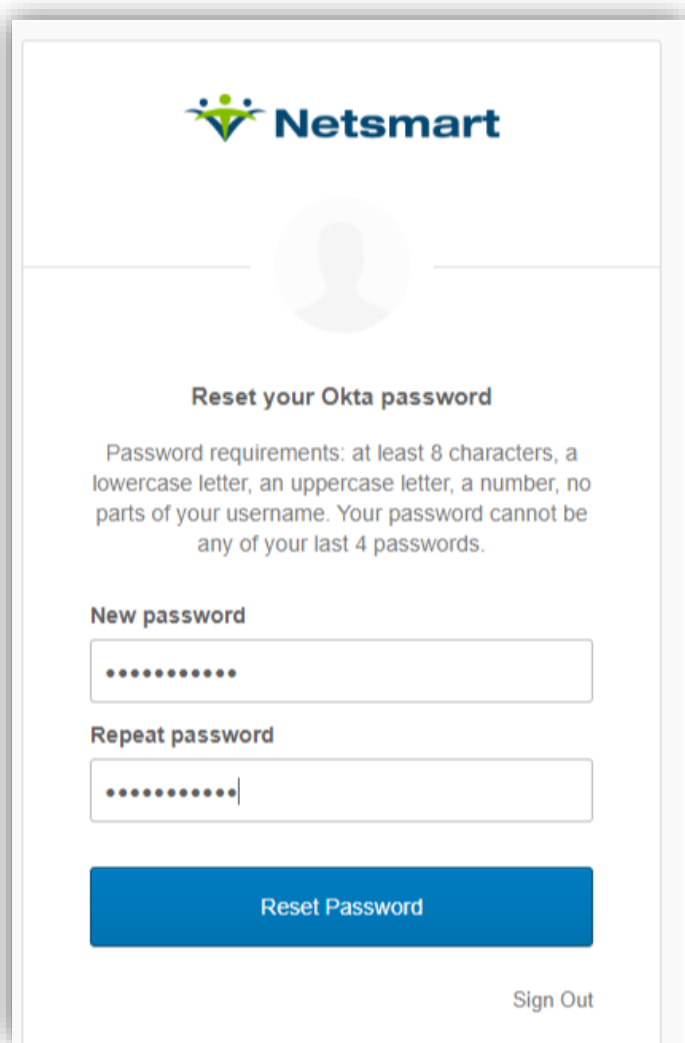
- When the user receives the Okta email, they will click on the **'Reset Password'** button.



- The user will be prompted to enter the answer to their security question. Once entered, they will select the **'Reset Password'** button.



- The user will then be prompted to enter a new password. Once entered, they will select the **'Reset Password'** button. The user will then be returned to the **Okta** profile page. The user will be required to navigate back to CareManager and start the login process again using the new password.



The screenshot shows a web form for resetting a password. At the top left is the Netsmart logo, which consists of a stylized green and blue icon followed by the word "Netsmart" in blue. Below the logo is a circular placeholder for a user profile picture. The main heading is "Reset your Okta password". Below this is a paragraph of password requirements: "Password requirements: at least 8 characters, a lowercase letter, an uppercase letter, a number, no parts of your username. Your password cannot be any of your last 4 passwords." There are two input fields: "New password" and "Repeat password", both containing masked characters (dots). Below the input fields is a large blue button labeled "Reset Password". At the bottom right of the form is a link labeled "Sign Out".

DASHBOARD

Once you sign into the system, you will land on your Dashboard page.

Client List

Search all clients...

Caseload **Recent**
Client Search **Assigned**

Name	Risk
Knapp, Jerome DOB: 05/05/1966 Client ID: 25931 Chart Notes	
OttOne, Wayne DOB: 04/20/1985 Client ID: 26070 Chart Notes	
Pare, Richard DOB: 04/19/1985 Client ID: 25999 Chart Notes	
TaylorFour, Andrew DOB: 04/23/1985 Client ID: 25891 Chart Notes	

Dashboard **Appointments**

Alerts

- 0 ER Visits
- 0 Hospitalization
- 0 Missed Medication Refills
- 0 Arrests
- 0 Missed Appointments
- 0 Potential Gaps In care/Other Health Factors

Tasks **New Task** **Print View**

Filter by All My Tasks Show Dismissed Search Tasks...

Due Date	Task	Contact(s)	Activity	Status	Assigned To	Created By	Creation Source	Actions
02/03/2016	Complete Care Manager Plan	Jerome Knapp (25931)	CareManager Plan	New	Kristy Talbot	Kristy Talbot	Direct Entry	

Client List

1. Once you sign into the system, you will see your **Client List** on the left side of the screen
2. **Caseload** will show your enrolled clients
3. **Recent** will show the clients you have recently viewed
4. **Client Search** will show your clients in Outreach
5. **Assigned** will show your clients without an initial Client Search Note entered
6. Under the client's name is their Date of Birth (**DOB**), **Client ID**, **Chart** button and **Notes** button
 - o You can click on the **Client's Name**, **Chart** button or **Notes** button to navigate to their chart.
7. At the bottom of your client list you will see page navigation buttons to help you scroll through the different clients on your list

Client List

Search all clients...

Caseload **Recent**
Client Search **Assigned**

Search Caseload...

Name	Risk
AprilFive, Lashonda DOB: 08/19/2002 Client ID: 1670 Chart Notes	
CareyFive, Lashonda DOB: 08/19/2002 Client ID: 1217 Chart Notes	
ClarkeFive, Lashonda DOB: 08/19/2002 Client ID: 1639 Chart Notes	
DavisFive, Lashonda DOB: 08/19/2002 Client ID: 683 Chart Notes	
DiamondFive	

30 (1 of 1)

Alerts

The alerts, **when active**, will let you know if a client has gone to the hospital or emergency room if you have proper consent on file. Alerts will create a **Hallmark Event** within the system. Alerts will not be active for Children’s Health Home until HIE connections are able to release minor data.

Dashboard

Alerts
0 ER Visits
0 Hospitalization
0 Missed Medication Refills
0 Arrests
0 Missed Appointments
0 Potential Gaps In care/Other Health Factors

Tasks

Tasks will allow you to keep track of all the things you need to do for a client. More information available in the Task section.

1. Different pages within your client’s chart will show a “**New Task**” button
2. Depending on where you are at in the client’s chart the system will automatically fill in some of the fields.
3. Update the fields as necessary to make sense for what you need to do and click the “**Save**” button.

New Task

Task Name/Description*

Contact(s)
Search Users...

Assigned To* Derek Ross Created By Derek Ross

Start Date* Due Date*

Activity

Status* New Priority Percent Complete %

Status Comments

Appointment Calendar

This is an appointment calendar feature you can use to keep track of your appointments with the client or appointments the clients may have with providers for tracking purposes. From the dashboard, click on the “**Appointments**” tab. You can click on any date on the calendar, or on the **+ Add Appointment** button and an Appointment Details window will open.

You can fill out all the fields like any other calendar software and include recurrences, appointment date and times, add locations and addresses.

CareManager Client Assignment Admin Chelsea Search all clients

Client List Dashboard **Appointments**

Add Appointment

April 2018

Sun	Mon	Tue	Wed	Thu	Fri	Sat
1	2	3	4	5	6	7
8	9	10	11	12	13	14
15	16	17	18	19	20	21
22	23	24	25	26	27	28
29	30	1	2	3	4	5
6	7	8	9	10	11	12

Appointment Details

From* 06/10/2015 01:00 AM All Day

To* 06/10/2015 01:30 AM

Appt Type*

Description* New Appointment

Recurrence View/Change None

Participants* Derek Ross [User] Search for participants...

Location Type

Address

Comments

CLIENT STATUS



Assigned

If a member has a status of “Assigned”, this means the client is ready for outreach and has not yet had a **Client Search Note** completed.

Client Search

The client status will change from **Assigned** to **Client Search** when a *finalized* **Client Search Note** is entered into the system with a status of **Continue Search** or **Health Home Consent Pending**. Any member in Outreach and Engagement will have a status of “Client Search” until they either enroll into the program or come to the end of their outreach period and have not enrolled (at which point they would be automatically opted out of the program).

Opt-Out/Withdraw

Any member who is closed from an outreach and engagement segment (because they either opt-out from the program or enrollment didn’t occur) will have a status of “**Opt-out/Withdraw**”. These members may be eligible for an additional period of time for outreach. Please contact CHHUNY Referral team for more information.

Enrolled

When a client moves from an outreach segment to an enrollment segment you’ll see their status change from “Client Search” to “**Enrolled**”. If a client is directly enrolled into the program, their status will say “Enrolled” when they are initially assigned to your agency. Please review the Enrollment Process for more information.

Discharge

When an enrolled client, for whatever reason, is no longer going to continue in Health Home Services, the client is **Discharged** from CareManager. It is important that the client be discharged within the appropriate timeframe so it accurately reflects in the MAPP System.

Diligent Search Efforts

If a member is determined to be disengaged from Health Home (HH) services, the Care Manager (CM) will follow the Continuity of Care policy and place the member into the Diligent Search “sub-status via a contact note. The member will stay in “Diligent Search” until the member is re-engaged and the CM will put them back into an “Enrolled” status. If the member does not resume active care management and the Diligent Search period ends, the member will automatically be discharged from the system. For more detailed instruction, please review CHHUNY’s Sub-status Instructions on page 83 of this manual.

Excluded Settings

If a member enters an excluded setting while they’re enrolled in the health home program, and it’s anticipated they will be in that setting for less than six months, the CM will place the member into the Excluded Setting sub-status via a Contact note. The client will remain in this status until either they resume active care management and are placed back in “enrolled” status, or they will be automatically discharged if they remain in the excluded settings status for 6 months. For more detailed instruction, please review CHHUNY’s Sub-status Instructions on page 83 of this manual.

DOCUMENTATION

Documentation is the key to not only receive credit for what you do but also to ensure that your agency can bill for the services you provide. NYS and CHHUNY have a list of required documentation that is a part of the Health Home Program. They include but are not limited to:

- Signed DOH-5200 Health Home Consent for Enrollment (For Children Under 18 Years of Age)
- Signed DOH-5201 Health Home Consent Information Sharing (For Children Under 18 Years of Age)
- Signed DOH-5055 Health Home Consent Information Sharing (For Children Over 18 Years of Age)
- Signed DOH-5203 Health Home Consent Information Sharing Release of Educational Records
- Child Eligibility Screening Form
- Completion of a CANS-NY Assessment in the NYS UAS
- Safety & Crisis Plan
- Emergency Plan
- Initial/Amended Care Plans
- Interdisciplinary Care Team Members
- Monthly Children's Billing Questionnaire
- Outreach and Engagement Notes entered as Client Search Notes
- Enrolled Client Notes that tie to the Care Plan entered as CareManager Notes
- Signed Functional Assessment Consent
- Outreach Billing Questionnaire (if applicable)
- CANS-NY Strengths and Needs
- CANS-NY Assessment Results
- Proof of Health Home Eligibility
- CHHUNY Enrollment Manual

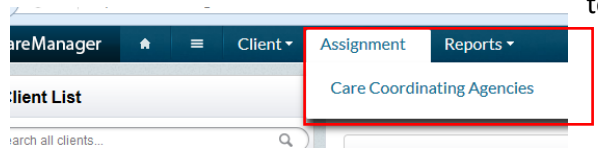
Health Home Care Manager's documentation must accurately and objectively reflect Health Home activities. Health Home Care Managers should consider all audiences when creating any documentation and assume that all involved in the Plan of Care, including the client, will have access to the materials in the client's care management record.

Documentation must show active and progressive movement towards enrollment and goal achievement and meet Medicaid billing requirements.

(Refer to specific CHHUNY policies for further guidance about Health Home Documentation)

ASSIGN CLIENTS TO CARE MANAGER- CARE MANAGER SUPERVISOR SECURITY ROLE ONLY

When a client is imported into the system via MAPP, regardless of what status they are in, the client will need to be assigned a Care Manager *and* Care Manager Supervisor. Users with the “Care Manager Supervisor” security role will have access to assign clients to Care Management staff in order to start the Outreach or Enrollment documentation process in Netsmart CareManager.



1. Go to **Assignment**
2. Click on **Care Coordinating Agencies** (only the agencies you have access to will appear)
3. Click on the **Assign Care Team** link

Client	Date of Birth	County	Assigned Agency	Assignment Dates	Agency Care Team
Chhuny, Five (112) ID: 112 Episode: 1 Status: Assigned	09/13/2012		Abbott House	09/27/2016 --	Assign Care Team

4. Click on **+Add Team Member**
5. Enter the **Team Member** name (Caseload size will appear when selected)
6. **Primary Organization** will auto populate
7. Select the **Role** you are assigning this team member
8. Complete the **Assign Date**
9. To assign another team member to the client, just click on **+Add Team Member** and repeat steps 5-8.
10. Click **Save**

Assign new team members by clicking Add Team Member then search for the team member.

Team Member	Primary Organization	Roles	Assign Date	End Date
Enter team member... *	---	1: --- *	---	---
		2: ---		

[Add Team Member](#)

OUTREACH AND ENGAGEMENT

Once a client assignment is processed and accepted through the MAPP system, the client will be assigned to a Care Management Agency for Outreach and Engagement. Outreach and Engagement should begin once your agency accepts the assignment and the client appears in Netsmart. Please refer to CHHUNY’s Referral and Assignment Policy for more information.

- There are instances where a member will be entered into Netsmart in an “Enrolled” status (for example: if a member transfers to your agency from another agency/HH, or if the member already signed their Health Home Consent (DOH 5200 or DOH 5055). Please Review the Enrollment Date section of this manual for more details on how to proceed with these members.

Once an Outreach and Engagement effort is completed, the encounter/effort should be documented in the CareManager system as a **Client Search Note**. **Regardless of whether an activity is billable or not, all outreach efforts need to be documented.**

- If an Outreach and Engagement effort is completed that meets billing standards, the activity should be documented in the CareManager system in a **Client Search Note** and select the Service Code: **“Non-billable”**

Document a Client Search Note (This process is optional as of 7/1/2020 if direct enrolling through MAPP)

The client search note allows you to track progress of your outreach and engagement efforts with a client/their consentor and documenting the consent status to enroll in Health Home Services. To document outreach activities, you must complete **Client Search Note(s)**:

1. Navigate to the note section of the client's chart you wish to enter a note for.
2. Click **+New Note** and then click **New Client Search Note**
3. Complete the following fields:

a. Note Detail

- i. **Note Type**: this field will automatically populate for you in the system
- ii. **Note Date**: the date you enter the note (will automatically default to current date when the note is finalized)
- iii. **Status**: Draft notes do not "count" in the system. You will be able to edit them but they will not support billing . Finalized notes are used for billing, tracking files and other reports but the note is locked permanently. It cannot be edited or changed back to draft. Make sure all information in the note is correct before you change the note status to **final**
- iv. **Type of Activity**: This field indicates which Core Service was provided for the activity you are documenting. Select **Care Management** when documenting a billable outreach activity
- v. **Service Code**: For all billable Outreach activities, use code **Non-Billable Core Service**

The screenshot shows the 'Note Detail' form with the following fields and values:

- Note Type**: Client Search Note
- Note Date***: 03/22/2019
- Note Status***: Draft
- Type of Activity***: Care Management
- Service Code***: 800 - Billable Core Service

b. Contact Detail

- i. **Client Search Date**: the actual date of the activity or encounter that you are documenting took place. Activities on different days must be documented in separate notes.
- ii. **Search Duration**: Document the number of minutes the activity/encounter you are logging took place
- iii. **Search Type**: Select the type that best describes the activity being documented. For example:

The screenshot shows the 'Contact Detail' form with the following fields and values:

- Client Search Date***: 03/22/2019
- Search Duration***: minutes
- Search Type***: ---
- Location***: ---
- Contact Status***: ---
- Consent**: No Consents found
- New Consent**: + New Consent

- “Client-In Person” would be selected if the activity being documented involved a face to face with the client
 - “Collateral – In Person” would be selected if the activity being documented involved a face to face with someone other than the client (family, support, provider)
 - If the client was involved/present in the activity being documented, ensure that’s reflected in the search type you select (even if other individuals were involved in the activity)
 - **The “Other” option should not be used when documenting Client Search notes.**
- iv. **Location:** The location the Care Manager is at when the activity was performed/encounter occurred
- v. **Contact Status:** This refers to whether a dialogue was achieved with the **target** of your activity or not (see Participants section for information about target). If you achieved dialogue with your identified target, you would select **Contact Achieved**. **Regardless of whether or not contact was achieved, all outreach efforts need to be documented.**
- vi. **Consent:** The consent area will become available when you select “Client Enrolled” in the **Client Search Status** bar. This is where you will document the Health Home consent in your enrollment note (See Enrollment Process section)

c. Participants

Box next to client’s name, Assigned Team, Social Support Contacts, Referred Providers, Other Participants can all be left **blank**. Your note detail section (where you provide a narrative about what occurred) should include specifics about who was involved in the activity being documented

Target: This field captures who the target of the activity is. The list includes the member, Supervisor providing direction on the case, Providers, family and members of the interdisciplinary team. Select the option that best reflects the activity/effort being documented and should be in alignment with the selection in the “client search” field. “Other” should only be selected if the target is not captured in the options provided in the list

d. Client Search Status:

You will need to select the appropriate “status” of your activity being documented

Client Search Status *

Continue Search
 Health Home Consent Pending
 Client Enrolled
 Client Opts-out of Health Home Services

- i. **Continue Search** – You have not connected with the client/consenter and will continue to perform additional Outreach activities in the future (only select this status if client was assigned to your agency and you did not have contact with the client prior to assignment)
- ii. **Health Home Consent Pending** – You have connected with the client/consenter, but they have not yet agreed to participate in the Health Home or you have not yet verified Health Home eligibility status, so you have not enrolled the client
 - a. If this radial is selected, the follow up appointment section opens where you can create a future appointment with them if desired. The appointment will populate on the calendar on your dashboard.
- iii. **Client Enrolled*** – The client/consenter has agreed to receive health home services AND meets eligibility requirements as indicated by the completed **Eligibility Screening (this must be completed first)**.

***SEE “ENROLLMENT PROCESS” SECTION BELOW AND FOLLOW INSTRUCTIONS PRIOR TO SELECTING THIS OPTION. THIS WILL ENROLL THE CLIENT AND ONCE SAVED, YOU CANNOT REVERSE IT WITHOUT DISCHARGING.**

- iv. **Client Opt-Out of Health Home Services** – Client/client’s consenter does not want to participate or does not qualify for Health Home services
 1. The **Reason for Opt-Out** drop down will appear. Select the appropriate reason for why the client will not be receiving Health Home services.
 2. Only select “**End Assignment, No Outreach- Non-bill**” if you have not documented any outreach efforts and do not intend to outreach the member

e. Note

- i. Enter a detailed note of the activities that took place on the **client search date** indicated on the note.

The image shows a screenshot of a software interface for entering notes. At the top, the word "Notes" is displayed in a bold, dark font, followed by a small red asterisk. Below this is a large, empty rectangular text box with a thin border. Inside the text box, the placeholder text "Write update..." is visible in a light gray font. The entire form is set against a white background.

b. Save Note

- i. Save a Draft by Clicking **Save / Save & Close** in the top right corner
- ii. Save as final by selecting **Final** in **Note Status** and clicking **Save & Close**.
 1. Notes will not appear as a billable core service activity for the month unless they are finalized.

Please review Appendix D Note Grid training for additional guidance

ENROLLMENT PROCESS

If the consentor agrees to enroll the child/youth in the Health Home, you must first verify state issued eligibility criteria and have the legal guardian sign the DOH 5200- Health Home Consent to Enroll.

If the child/youth can self-consent, then the child/youth would sign the DOH-5055 to enroll in the health home program.

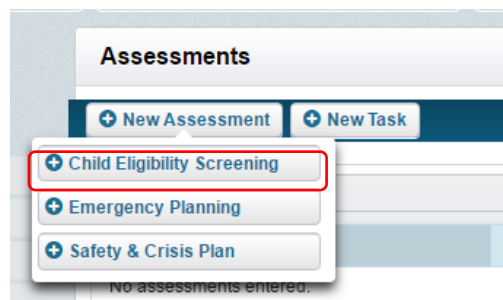
Please see the Enrollment Manual for Non Self-Consenter and for Self-Consenter's

(See **CHHUNY Access to and Sharing of PHI and Use of Health Home Consents Policy, CHHUNY Eligibility Policy for further guidance about Eligibility Requirements and Consents**)

Step 1: Child Eligibility Screen

When a child/youth/their consentor indicates interest in enrolling in the Health Home program, an eligibility screen must be completed **PRIOR TO ENROLLMENT** to determine if they meet the criteria issued by the Department of Health. CHHUNY also requires that documentation verifying the primary diagnosis/es for enrollment be obtained and documented in the system. If the member is entered into Netsmart directly into "enrollment" status, the eligibility screen and proof of diagnosis must be completed in the chart within the month of enrollment in the system.

1. Go to **Assessment** tab
2. Click on **+New Assessment**
3. Click on **+Child Eligibility Screening**



4. Complete the following fields:

- a. **Assessment Date:** the date the eligibility screen is completed
- b. **Assessment Status:** you can leave in draft until you've verified everything is correct. Then mark as final.
- c. **Question 1:** The client must have active, qualifying Medicaid in order to enroll. Select "Yes" if this has been verified

— Eligibility Screening

1. Does the youth have active Medicaid?*

Yes No

- d. **Question 2:** Indicate the primary qualifying criteria

2. What is the youth's primary qualifying criteria? (Supporting documentation from a provider is required to be attached in the Documents area, please select one primary)

- HIV/AIDS
- SED
- 2+ Chronic Conditions
- Complex Trauma
- Youth does not meet the qualifying criteria
- HCBS Only
- HCBS and other conditions

Select the criteria the member has that makes them eligible for services.

- Please note that you would select “**HCBS and other conditions**” if the member is eligible for HCBS and you have also confirmed they meet mainstream HH eligibility criteria (having 2 or more chronic conditions, SED determination, HIV/AIDS, complex trauma, appropriateness)
- Please note you would select “**HCBS Only**” if the member is deemed eligible for HH because they are eligible for HCBS but you have not confirmed they meet mainstream HH eligibility criteria

Once the criteria is selected, additional field(s) will appear that prompt you to add the member’s qualifying condition(s). The first condition entered onto this screening will be the member’s **Primary Problem**. The Primary Problem for a member **MUST** be a qualifying condition that made the member eligible for the Health Home program. When entering a Primary Problem, the Care Manager will be required to select an ICD 10 code for the condition being entered – the CM must ensure the correct code is selected and is supported by supporting documentation . This is because the Primary Problem is used for billing. To search for a diagnosis, you will need to search using either the DSM IV, DSM 5 or ICD10 code databases listed in the **Code System** drop down box:

Code System* Problem* Primary?

ICD 10 Yes No

- **DSM IV:** Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition covers all mental health disorders for both children and adults. *If you select this code system to search for the primary diagnosis, you will still need to select the appropriate ICD Selection code from the dropdown box below the problem field.*
- **DSM 5:** update to the Diagnostic and Statistical Manual of Mental Disorders. *If you select this code system to search for the primary diagnosis, you will still need to select the appropriate ICD Selection code from the dropdown box below the problem field*
- **ICD 10:** International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list that contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
- **SNOMED:** SNOMED is an acronym for Systematized Nomenclature of Medicine. It is recognized throughout the US and internationally. SNOMED codes are considered a universal language and not a diagnosis or diagnostic code – it is a collection of medical terms providing codes, terms, synonyms and definitions used in clinical documentation and reporting. **Do not use this code system to search for a diagnosis!**

For members that enroll under a Complex Trauma determination, search for a primary problem that is supported by the findings on the complex trauma eligibility determination form completed by the licensed professional.

Refer to CHHUNY’s Health Home Eligibility policy for more information about qualifying conditions and appropriateness criteria

- e. **Question 3:** Indicate the child’s appropriateness criteria for Health Home services (you can select multiple, but at least one must be present and selected):

3. Please indicate the child's appropriateness criteria for receiving Health Home services:

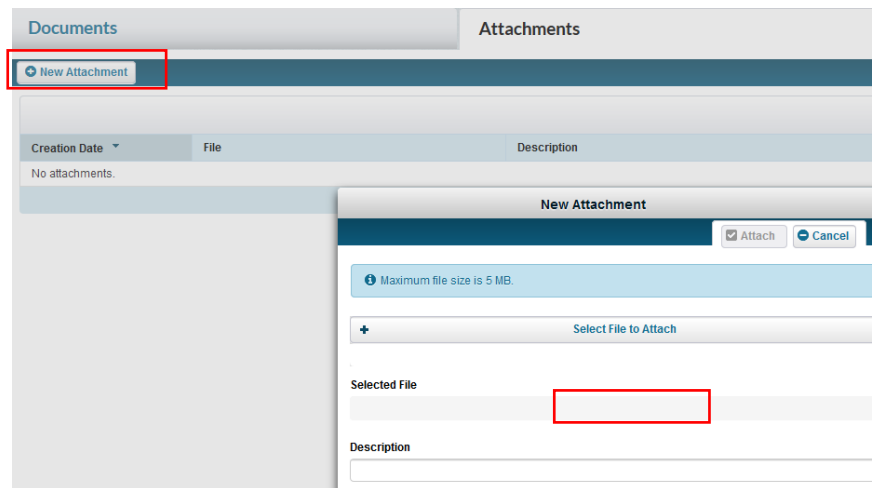
- At risk for an adverse event (e.g., death, disability, inpatient, out of home placement, mandated preventive services, etc.)
- Has inadequate social/family/housing support, or serious disruptions in family relationships
- Has inadequate connectivity with healthcare system
- Does not adhere to treatments or has difficulty managing medications
- Has recently been released from incarceration, placement, detention, or psychiatric hospitalization
- Has deficits in activities of daily living, learning or cognition issues
- Is concurrently eligible or enrolled, along with either their child or caregiver, in a Health Home

f. Be sure the assessment status says "final" and then **Save & Close**. All problems you enter on this screening will feed into the member's Problem List.

Step 2: Attach Qualifying Condition verification documentation

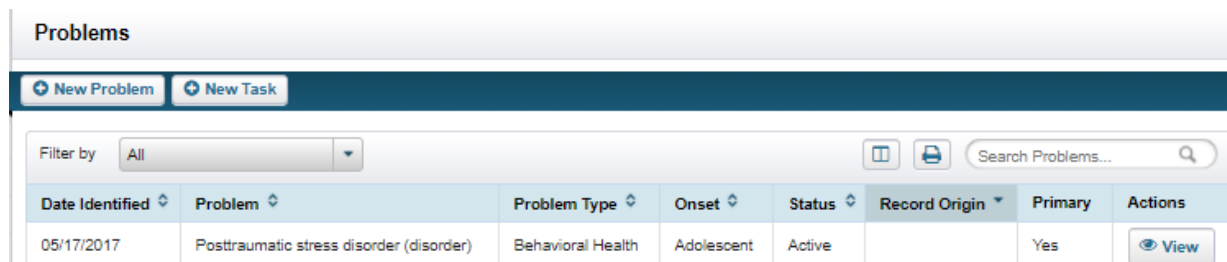
You must obtain verification of the qualifying diagnosis/es or eligibility determination made by Medicaid qualified providers that are licensed practitioners acting within their scope of practice. Please review CHHUNY's Eligibility Policy for examples of acceptable documentation. Scan and attach the documentation as follow:

1. Go to **Documents**
 - a. Click on the Attachments tab
2. Click on **+New Attachment**
3. Select the file to attach
4. Enter the description for Qualifying Conditions listed on CHHUNY's "Attachment Description" document
5. Click **Attach**



Step 3: Review/Update the Qualifying Conditions in the Problem list

1. Go to **Problems** tab in the member's chart
 - a. The qualifying condition(s) will be present in the Problems List if the Child Eligibility Screening was finalized. There is additional information that is needed per problem which you can complete by clicking on the view button for problems already listed. Be sure a qualifying condition is flagged as the **Primary** Problem.



b. Fill in the following fields:

Date Identified*	Date Recorded*	
<input type="text"/>	<input type="text"/>	
Problem Type*	Chronicity*	Onset*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Severity*	Status*	Record Origin
<input type="text"/>	<input type="text"/>	Direct Entry

- i. **Date Identified:** date they were diagnosed (if unknown, you can enter an approximate date and update later once confirmed)
- ii. **Date Recorded:** date you entered it into the system
- iii. **Problem Type:** select category of your problem (ties to where it will be categorized on the Care Plan). If the Problem is a Medical Diagnosis or condition, select Physical Health. If it is a Mental Health or Substance Use diagnosis or condition, select Behavioral Health. If the problem is a social health problem (like housing or school), select Social Health.
- iv. **Chronicity:**
 - **Chronic:** Diagnosis or symptom is ongoing and long developing (chronic)
 - **Acute:** Diagnosis or symptom is temporary and sudden (acute)
 - **Undetermined:** If this has not yet been determined select undetermined. Symptoms rather than a diagnosis may be more likely to be undetermined
- v. **Onset:** What time of life did this start for the member
 - **Child:** Less than 12 years old
 - **Adolescent:** 12-21 years old
 - **Adult:** greater than 21 years old
- vi. **Severity:** How severe is this issue. The severity should reflect, when applicable, the CANS-NY ratings.
 - **Dangerous/disabling (CANS 3):** Condition is life threatening or disabling; activities are severely impacted
 - **Requires action/intervention (CANS 2):** Condition requires ongoing interventions; activities are moderately impacted
 - **Require prevention or watchful waiting (CANS 1):** Condition may require some treatment, but the problem is not acute and not expected to have a duration of a year or more; mild limitations on activities
 - **No action required at this time (CANS 0):** Child is healthy; no limitation in activities
- vii. **Status:** Identify the current level of needs for the identified diagnosis/symptom/condition. The CANS ratings in parenthesis can be used as a guide. **Note** that qualifying condition(s) must be addressed on a plan of care and therefore must have statuses indicating the member requests assistance.
 - **CM assistance not needed:** Select if the Child/ Youth/ Family does not need assistance from Care Manager or Care Team to address the condition because it is low severity (CANS 0 or 1). Problems with this status will not be addressed on a plan of care.

- **Requests CM Assistance:** Select if the Child/ Youth/ Family requests assistance from Care Manager or Care Team regardless of severity. Problems with this status will be pulled to the plan of care to be addressed.
- **Declines CM Assistance:** Select if the Child/ Youth/ Family does not want assistance from Care Manager or Care Team even though the condition is high severity (CANS 2 or 3). Problems with this status will not be addressed on a plan of care.
- **Deferred:** Select if the member chooses to postpone addressing the diagnosis/symptom/ condition on their plan of care until a later date. Problems with this status will not be addressed on a plan of care.

viii. **Record Origin:** auto-populates for you

Step 4: Client Search Note

Once the **Eligibility Screening** and the Qualifying Condition **Problem(s)** are updated in the Problem List, complete a **Client Search Note** (refer to previous Client Search Note section for instructions) and:

1. Select **Client Enrolled** in the **Client Search Status** bar to move the client into an enrolled status.
2. Enter **note details** about the encounter, confirming eligibility criteria was met for enrollment into a health home and who signed the appropriate consent(s) allowing for enrollment, data sharing, etc. in the Health Home program
3. Add the **Health Home Consent** at this point (Health Home consent is either the signed DOH-5200 or the signed DOH-5055 depending on consentor status of the member! Please refer to CHHUNY's Consent Policy for more information). If this step is missed in the enrollment note, you can still document the Health Home consent in the consent forms tab (review Consent section for more detail).
 - a. Click on the **+New Consent** in the Client Search Note

The screenshot shows a 'Client Search Status' bar with three radio button options: 'Continue Search', 'Health Home Consent Pending', and 'Client Enrolled'. The 'Client Enrolled' option is selected and highlighted with a red box. Above the bar, there is a 'Service Code*' dropdown menu and a 'Consent' section with a '+New Consent' button, also highlighted with a red box.

The screenshot shows the 'Health Home Consent Information' form. It contains several sections:

- Consent Type:** A dropdown menu with 'Health Home' selected.
- Consent Dates:** Fields for 'Start Date*' (populated with '06/17/2015'), 'End Date', and 'Expiration Date'.
- Rescind Options:** Fields for 'Rescind Consent' and 'Rescind Date'.
- Data Sharing Type:** A dropdown menu with 'Select a Health Home*' and 'HHUNY Central' selected.
- Client Opt-In/Out:** A dropdown menu with a message: 'The client has consented to receive services from the listed Health Home for the coordination of their care.*'

- b. **Consent Type** automatically populates
 - c. Update the **Start Date** to the date the client's parent/guardian/legally authorized representative signed the HH consent (5200); or the date the client signed the HH consent (5055)
 - d. Click on the **Client Opt-in/Out** drop down and select **Client Opt-in**
 - e. Leave **End Date** and **Expiration Date** Blank
 - f. Enter any comments at the bottom of the consent and click the **Add Comment** button
 - i. If consent to enroll was provided by the member's parent/guardian/legally authorized representative, include that information in the comments field
 - g. Click **Save**
4. Mark the **Note Status** in the Client Search Note as Final once you've reviewed the note for accuracy and then click on **Save & Close**

CONTACT NOTES

Once a client is enrolled in the Health Home program, all services, efforts and encounters (whether billable or non-billable) will be documented in either billable or non-billable (as appropriate) **Contact Notes** until the member's Initial Care Plan is finalized. Once the initial Care Plan is finalized, all services and encounters (whether billable or non-billable) can be documented as either Contact Notes or CareManager Notes as appropriate. CareManager notes aren't available until the Care Plan is finalized, these notes are reviewed later in the manual.

Contact Notes capture any work completed in relation to the following: Assessments and Plan of Care, Case Reviews, Diligent Search Efforts, Error Resolution, Minor protected services, Immediate Needs/Crisis Intervention and Transitions of Care.

To review how to document an error resolution Contact Note: please review the “**Documenting a Non-Billable Chart Error Resolution Note**” in the Additional Features section of this manual

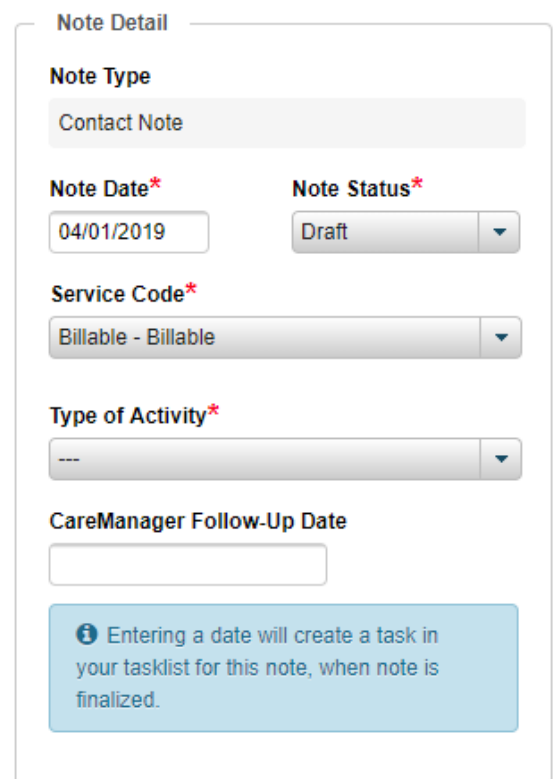
Please review Appendix D: Note Grid training document for additional guidance

Documenting a Billable Contact Note:

1. Navigate to the note section of the client's chart you wish to enter a note for.
2. Click **+New Note** and then click **New Contact Note**
3. Complete the following fields:

a. Note Detail

- i. **Note Type:** This will prepopulate to contain the type of note you are completing
- ii. **Note Date:** auto-populates to the date the note is finalized in the system
- iii. **Note Status:** Draft notes do not count in the system. You will be able to edit them but they will not support billing (the CBQ won't recognize billable notes left in draft). Finalized notes are used for billing, tracking files and other reports but the note is locked permanently. It cannot be edited or changed back to draft. Make sure all information in the note is correct before you change the status to **final**.
- iv. **Service Code:** Select **Billable**
- v. **Type of Activity:** Select the core service provided in the activity/encounter being documented. (Please reference Core Services Policy on the CHHUNY website). You must identify a core service that was provided if you are documenting billable work that was done.
- vi. **CareManager Follow-Up Date:** Optional field for a Care Manager to enter a date for follow-up



Note Detail

Note Type
Contact Note

Note Date* 04/01/2019 **Note Status*** Draft

Service Code* Billable - Billable

Type of Activity* ---

CareManager Follow-Up Date

Entering a date will create a task in your tasklist for this note, when note is finalized.

b. **Contact Detail**

- i. **Contact Date:** The date that the activity/effort that you are documenting took place. Activities on different days must be documented in separate notes.
- ii. **Contact Duration:** Document the number of minutes the activity/encounter took you to perform
- a. **Contact Type:** Select the type that best describes the activity you performed/attempted. For example:
 - “Client-In Person” would be selected if the activity being documented involved a face to face with the client
 - “Collateral – In Person” would be selected if the activity being documented involved a face to face with someone other than the client (family, support, provider)
 - If the client was involved/present in the activity being documented, ensure that’s reflected in the search type you select (even if other individuals were involved in the activity)
 - Do not use “other” unless you’re documenting an error resolution contact note (refer to the additional features section for more instruction on this type of note)
- iii. **Location:** The location where the Care Manager is when the activity was performed/attempted
- iv. **Primary Reason for Contact:** Select the option that describes the activity/effort being documented. **Please review the document “Primary Reason for Contact Grid” for further clarification.**

The screenshot shows a form titled "Contact Detail" with the following fields:

- Contact Date***: A date input field containing "12/28/2017".
- Contact Duration***: A text input field containing "minutes".
- Contact Type***: A dropdown menu with a downward arrow.
- Location***: A dropdown menu with a downward arrow.
- Primary Reason for Contact***: A dropdown menu with a downward arrow.
- Other Reason for Contact**: A text input field.
- Contact Status**: A dropdown menu with a downward arrow.

- 1. **Assessments and Plan of Care:** Working on and completing assessments, working on and completing plan of care amendments, etc.
- 2. **Case Reviews:** Efforts to schedule and conduct a case review, results/findings from a case review and sharing with members from care team
- 3. **Diligent Search Efforts:** Efforts to relocate and reengage a member/family which include, but aren’t limited to: attempting face-to-face visit at the last known address, successful phone contact with care and service providers, etc. Please review CHHUNY’s Continuity of Care Policy for more information.
- 4. **Error Resolution:** Documentation of chart errors (non-billable notes only) * please refer to “Documenting a Non-Billable Chart Error Resolution Note” in the Additional Features section to review how to document these
- 5. **Excluded Settings:** use when you’re entering a member into the “Excluded Settings” sub-status
- 6. **Immediate Needs/Crisis Intervention:** Connecting member with a food cupboard, using the member's safety & crisis plan in the event of a crisis, etc.
- 7. **Minor Protected Services:** select if you’re documenting work that is done towards the completion of the minor/adolescent plan of care form(s); work done towards objectives/interventions identified on the minor/adolescent plan of care form
- 8. **Transitions of Care:** Conducting discharge planning activities like engaging with member/family to assess understanding of discharge plan, confirming follow up

The screenshot shows a dropdown menu titled "Primary Reason for Contact*" with the following options:

-
- Assessments and Plan of Care
- Case Review
- Diligent Search Efforts
- Disenrollment
- Error Resolution
- Excluded Setting
- Immediate Needs/Crisis Intervention
- Minor Protected Services
- Other

appointments have been scheduled), etc. Please refer to CHHUNY’s Transitions of Care Policy for more information.

- 9. **Other:** should only be used if prompted by CHHUNY or for documenting outreach efforts for a member that moved directly into Enrollment and never had an Outreach segment. If you select this option, you must include what the Other Reason for Contact in the box below.
- v. **Contact Status:** This refers to whether or not a dialogue was achieved with the target of your encounter (see participants section)

c. **Participants**

Box next to client’s name, Assigned Team, Social Support Contacts, Referred Providers, Other Participants can all be left blank. Your note detail section (where you provide a narrative about what occurred) should include specifics about who was involved in the activity being documented

Target: This field captures who the target of the activity is. The list includes the member, Supervisor providing direction on the case, Providers, family and members of the interdisciplinary team. Select the option that best reflects the activity/effort being documented and should be in alignment with the selection in the “contact type” field. “Other” should only be selected if the target is not captured in the options provided in the list

Participants

Alexander, Lashonda

Assigned Team
None

Social Support Contacts
None

Referred Providers
None

Other Participants
Search...

Target*

- d. **Status Update:** Leave Statuses dropdown blank unless you are either entering a member into Diligent Search Status sub-status, Excluded Setting sub-status, or are putting a member back into enrolled status from either Diligent Search or Excluded Settings sub-statuses. Using this feature is covered extensively in the **Sub-Status User Manual** on the CHHUNY website. Please refer to that manual for guidance on this process and documentation expectations.
- e. **Notes:** provide narrative detail about the activity/encounter/effort

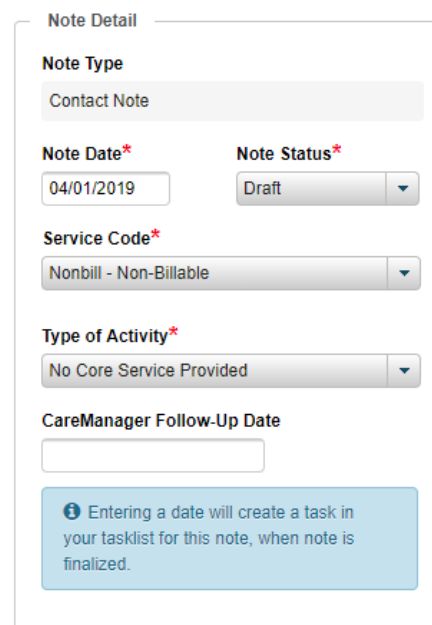
Documenting a Non-Billable Contact Note

Follow the instructions below to document Contact Notes that capture **non-billable work** completed in relation to the following: Assessments and Plan of Care, Case Reviews, Diligent Search Efforts, Immediate Needs/Crisis Intervention and Transitions of Care. To document a non-billable contact note for chart error resolution, please review “**Documenting a Non-Billable Chart Error Resolution Note**” in the Additional Features section.

1. Navigate to the note section of the client’s chart you wish to enter a note for.
2. Click **+New Note** and then click **New Contact Note**
3. Complete the following fields:

a. Note Detail

- i. **Note Type:** This will prepopulate to contain the type of note you are completing
- ii. **Note Date:** auto-populates to the date the note is finalized in the system
- iii. **Note Status:** Draft notes do not count in the system. You will be able to edit them but they will not support billing. Finalized notes are used for billing, tracking files and other reports but the note is locked permanently. It cannot be edited or changed back to draft. Make sure all information in the note is correct before you change the status to final.
- iv. **Service Code:** Select **Non-Billable**
- v. **Type of Activity:** Select **No Core Service Provided**
- vi. **CareManager Follow-Up Date:** Optional field for a Care Manager to enter a date for follow-up



Note Detail

Note Type
Contact Note

Note Date* 04/01/2019 Note Status* Draft

Service Code* Nonbill - Non-Billable

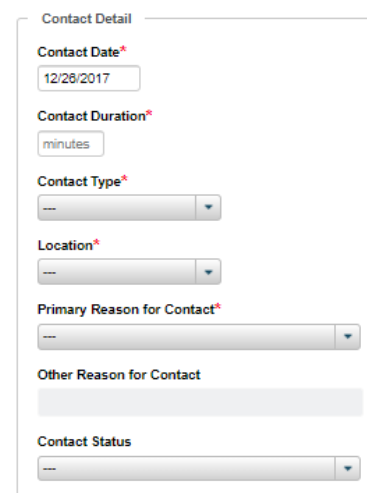
Type of Activity* No Core Service Provided

CareManager Follow-Up Date

Entering a date will create a task in your tasklist for this note, when note is finalized.

b. Contact Detail

- i. **Contact Date:** The date that the activity/encounter that you are logging took place. Activities on different days must be documented in separate notes.
- ii. **Contact Duration:** Document the number of minutes the activity/effort took you to perform
- iii. **Contact Type:** Select the type that best describes the activity you performed or was attempted. For example:
 - “Client-In Person” would be selected if the activity being documented involved a face to face with the client or was attempted
 - “Collateral – In Person” would be selected if the activity being documented involved a face to face with someone other than the client (family, support, provider) or was attempted
 - If the client was involved/present in the activity being documented, ensure that’s reflected in the search type you select (even if other individuals were involved in the activity)
 - Do not use “other” unless you’re documenting an error resolution contact note (refer to the additional features section for more instruction on this type of notes)
- iv. **Location:** The location where the Care Manager is when the activity/effort was performed
- v. **Primary Reason for Contact:** Select the option that describes the activity/encounter being documented. **Please review the document “Primary Reason for Contact Grid” for further clarification.**
 1. **Assessments and Plan of Care:** Working on and completing assessments, working on and completing plan of care amendments, etc.
 2. **Case Reviews:** Efforts to schedule and conduct a case review, results/findings from a case review and sharing with members from care team
 3. **Diligent Search Efforts:** Efforts to relocate and reengage a member which include, but aren’t limited to: attempting face-to-face visit at the last known address, successful



Contact Detail

Contact Date* 12/26/2017

Contact Duration* minutes

Contact Type*

Location*

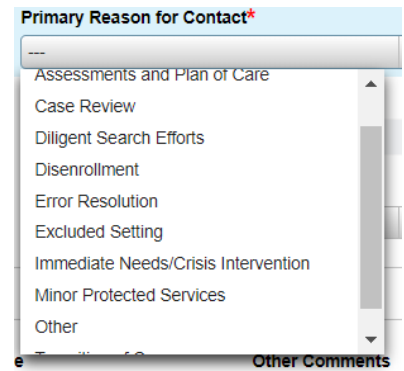
Primary Reason for Contact*

Other Reason for Contact

Contact Status

phone contact with care and service providers, etc. Please review CHHUNY's Continuity of Care Policy for more information.

4. **Error Resolution:** Documentation on chart errors (non-billable) * please refer to "Documenting a Non-Billable Chart Error Resolution Note" in the Additional Features section to review how to document these
5. **Excluded Settings:** use when you're entering a member into the "Excluded Settings" sub-status
6. **Immediate Needs/Crisis Intervention:** Connecting member with a food cupboard, using the member's safety & crisis plan in the event of a crisis, etc.
7. **Minor Protected Services:** select if you're documenting work that is done towards the completion of the minor/adolescent plan of care form(s); work done towards objectives/interventions identified on the minor/adolescent plan of care form
8. **Transitions of Care:** Conducting discharge planning activities like engaging with member (and family when appropriate) to assess understanding of discharge plan, confirming follow up appointments have been scheduled), etc. Please refer to CHHUNY's Transitions of Care Policy for more information.
9. **Other:** should only be used if prompted by CHHUNY or for documenting outreach efforts for a member that moved directly into Enrollment and never had an Outreach segment. If you select this option, you must include what the Other Reason for Contact in the box below.
 - v. **Contact Status:** This refers to whether or not a dialogue was achieved with the target of your encounter (see participants section)



c. Participants

Box next to client's name, Assigned Team, Social Support Contacts, Referred Providers, Other Participants can all be left **blank**. Your note detail section (where you provide a narrative about what occurred) should include specifics about who was involved in the activity being documented

Target: This field captures who the target of the activity is. The list includes the member, Supervisor providing direction on the case, Providers, family and members of the interdisciplinary team. Select the option that best reflects the activity/effort being documented and should be in alignment with the selection in the "contact type" field. "Other" should only be selected if the target is not captured in the options provided in the list

d. **Status Update:** Leave Statuses dropdown blank unless you are either entering a member into Diligent Search Status sub-status, Excluded Setting sub-status, or are putting a member back into enrolled status from either Diligent Search or Excluded Settings sub-statuses. Using this feature is covered extensively in the **Sub-Status** Section of this manual. Please refer to that manual for guidance on this process and documentation expectations.

e. **Notes:** provide narrative detail about the activity/encounter

CHILDREN'S BILLING QUESTIONNAIRE (CBQ)

Once a client is enrolled, a Billing Questionnaire must be completed monthly (**regardless of whether or not billable service(s) were completed for the client**). These should be finalized **at the end of the month** to ensure it accurately reflects the member's status for that month. The CBQ will confirm that billable activity was completed and it will be submitted to MAPP and to the payer for processing.

All questions will be prefilled from the previous month's questionnaire with the ability to edit the answers. You must complete one assessment for each month the client is enrolled – the system will not allow you to skip months.

To access a CBQ:

1. Click on **Assessments** Tab
2. Click on **+New Assessment** and then **+Children's Billing Questionnaire**

The CBQ is covered in detail in Appendix B of this manual.

ASSESSMENT PROCESS

Once the client is enrolled, you are ready to begin completing the assessment process. Be sure to document the efforts to complete the assessments in Contact Note(s).

Please refer to CHHUNY's CANS-NY Policy for timeframes surrounding the completion of the CANS-NY (including situations when members transfer from one CHHUNY CMA to another)

A Care Manager has 60 days from enrollment to complete the **Emergency Planning Assessment, Safety & Crisis Plan, Comprehensive Assessment** and the **Initial Plan of Care**. The Care Manager will collaborate with the **Interdisciplinary Care Team** and obtain information about **Problems, Medications, Providers, Social Supports** and **Demographic Information** for the member.

(See CHHUNY Comprehensive Assessment policy and Plan of Care policy for further guidance about the assessment process and interdisciplinary team meetings (case reviews))

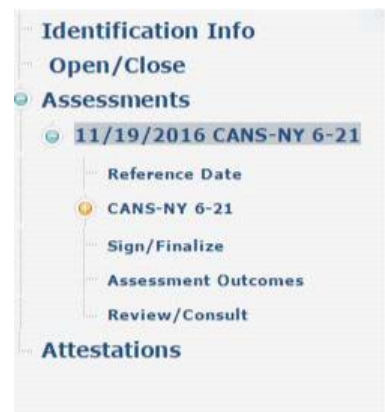
Assessments

Child and Adolescent Needs and Strengths NY (CANS-NY) - to be completed in NYS UAS

When completing the CANS-NY, you should be transferring the information regarding Problems, Medications, Providers, and Social Supports into Netsmart to begin building the client chart. When a CANS-NY assessment is completed, the **Assessment Results** report and the **Strengths and Needs** report must be uploaded into the client chart. Please follow the CHHUNY issued naming convention when uploading documents into your client's chart. Some of the data will be required to be documented prior to entering other assessments as described below.

How to Print CANS Summary Reports from UAS-NY

1. Search for your client in UAS-NY
2. Select your client and open case file
3. **IMPORTANT:** you can only print summary reports after CANS has been finalized
4. On the left hand side of the screen select "Assessments" and then select the CANS Assessment you would like to report on



5. Once this is highlighted go to the upper left-hand corner of your screen and hover over the word "Reports". You should see several options for reports to download.

6. Select the report you would like to run. **Download the PDF version to ensure you are able to upload it into the Netsmart CareManager system.**

7. You are required to upload the **Assessment Results** and the **Strengths and Needs** report into the Netsmart CareManager system

For any questions about the UAS system, please contact their help desk:

For guidance on how to fix errors on CANS (i.e. associating incorrect Health Home on the CANS), please refer to CHHUNY CANS-NY Policy

Ensure your document the work that is done to complete the CANS-NY in note(s). Review "**contact notes**" section for more details.

UAS-NY Support Desk
uasny@health.ny.gov
or
518-408-1021, option 1
Monday – Friday
8:30 AM – 12:00 PM
1:00 PM – 4:00 PM

Safety, Crisis & Emergency Plan Form

The Safety, Crisis & Emergency Plan is a form to give members, families' and providers to help them prepare and guide actions for any crisis situation a member may face. The Safety, Crisis & Emergency Plan must be completed within 60 days of enrollment and reviewed every six months, or sooner if there has been a significant life change. If, upon review, there are no changes to make to the existing plan, you must still document a new Safety, Crisis & Emergency Plan in the form section. It is required per DOH to be included in the 10 elements of a Plan of Care. The Safety, Crisis & Emergency Plan interacts with the Demographic , Social Support and Professional Network areas to help Care Managers complete the Safety, Crisis, & Emergency Plan more effectively. Be sure to document the work that is done to complete the Safety, Crisis & Emergency plan in note(s).

On the Plan of Care, be sure to click this box to verify that you have complete a Safety, Crisis & Emergency Plan.

Emergency Planning Assessment completed with child and family

1. Scroll down to the Forms areas in the Navigation Pane in Netsmart CareManager
2. Click the the **Safety, Crisis & Emergency Plan** tab
3. Click **+New Safety, Crisis & Emergency Plan**
4. Complete the entire assessment, mark **Status** as **Final** once child/youth/family have agreed to the plan
5. Review **Signature** section for details on capturing electronic signatures or manual signatures
6. Click **Save & Close**

Additional Forms

- COVID 19 Screening
- Children's Assessment Update Form
- Safety, Crisis & Emergency Plan
- Comprehensive Assessment and Reassessment

Safety, Crisis & Emergency Plan

+ New Safety, Crisis & Emergency Plan

+ New Task

Created By

Created On

No Safety, Crisis & Emergency Plan entries.

*** Do Not Use the Referred Providers Area within the Safety, Crisis and Emergency Plan. This area is not longer active in Netsmart CareManager**

Comprehensive Assessment & Reassessment

The Comprehensive Assessment and Reassessment Forms are built into Netsmart CareManager and are live as of June 2021. Ensure you document the work that is done to complete the Comprehensive Assessment/Reassessment in note(s). h

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Hallmark Events
Documents
Discharge
Additional Forms
COVID 19 Screening
Children's Assessment Update Form
Safety, Crisis & Emergency Plan
Comprehensive Assessment and Reassessment

Go to the Forms area on the bottom left of the navigation page in Netsmart CareManager

Click on [Comprehensive Assessment and Reassessment](#)

Click on 'New Comprehensive Assessment and Reassessment'

Select 'Initial' or 'Reassessment' depending on Assessment has been completed previously.

If an update needs to be complete, Care Managers will utilize the 'Reassessment' Form. If an archived Initial, or Reassessment Comprehensive Assessment (paper form) has already been completed, you will use the Reassessment

Complete the Comprehensive Assessment or Reassessment as indicated.

The Comprehensive Assessment and Reassessment form interacts with multiple areas within the members' chart. If the Comprehensive Assessment is not allowing you to move from 'Draft' to 'Final' status, please review the assessment to ensure ALL required fields have been answered.

Please see the Comprehensive Assessment and Reassessment Manual for guidance in completing the Comprehensive Assessment.

We suggest that ALL work in the Navigation Pane, including the Care Coordination Area, is completed prior to beginning a Comprehensive Assessment to avoid any difficulties in completing the assessment.

Comprehensive Assessment and Reassessment

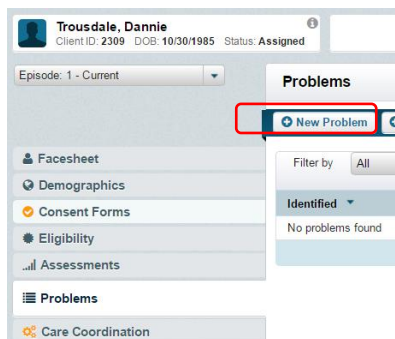
[+ New Comprehensive Assessment and Reassessment](#)

The paper version of the Comprehensive Assessment has been archived as of June 2021. There is a paper reference guide on the CHHUNY portal to utilize when facing technology issues. This paper version SHOULD NOT be uploaded in the chart but is used as a guide to complete the Comprehensive Assessment that is built into Netsmart CareManager

Documenting Problems

During the assessment process, problems should be identified that you will be working on with the client/family to resolve or improve. You will identify the PRIMARY Problem through the [Children's Eligibility Screen](#). Additional problems can include medical and behavioral health diagnoses or symptoms as well as social health problems (such as homelessness or family issues). It is important to keep a running problems list in the member's chart so that you can create objectives and interventions on the care plan which will address them. **Note** that qualifying condition(s) must be addressed on a plan of care and therefore must have statuses indicating the member requests assistance

1. Go to **Problems**
2. Click on **+New Problem**



3. **Problem Details:** Select which Code System to search and then search the Problem list and add the identified problem.

Problem Details

Code System* Problem* Primary? Yes No

4. Select the **Code System** in which you will search for the problem you are entering:
 - a. **DSM IV:** Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition covers all mental health disorders for both children and adults. *If you select this code system to search for the condition you will mark as primary, you will still need to select the appropriate ICD Selection code from the dropdown box below the problem field.*
 - b. **DSM 5:** update to the Diagnostic and Statistical Manual of Mental Disorders. *If you select this code system to search for the condition you will mark as primary, you will still need to select the appropriate ICD Selection code from the dropdown box below the problem field*
 - c. **ICD 10:** International Statistical Classification of Diseases and Related Health Problems (ICD), a medical classification list that contains codes for diseases, signs and symptoms, abnormal findings, complaints, social circumstances, and external causes of injury or diseases.
 - d. **SNOMED:** SNOMED is an acronym for Systematized Nomenclature of Medicine. It is recognized throughout the US and internationally. SNOMED codes are considered a universal language and not a diagnosis or diagnostic code – it is a collection of medical terms providing codes, terms, synonyms and definitions used in clinical documentation and reporting. **Do not use this code system to search for a diagnosis!**
5. Indicate if it is the **Primary Diagnosis** by selecting “Yes” (note a qualifying condition should always be marked as the Primary from the [Eligibility Screening](#) unless you need to change in the future to another qualifying diagnosis). You can have only one primary problem identified in the system (although the member may have more than one qualifying criteria!)

6. Fill in the following fields

Date Identified*	Date Recorded*	
<input type="text"/>	<input type="text"/>	
Problem Type*	Chronicity*	Onset*
<input type="text"/>	<input type="text"/>	<input type="text"/>
Severity*	Status*	Record Origin
<input type="text"/>	<input type="text"/>	Direct Entry

- a. **Date Identified:** date they were diagnosed (if unknown, you can enter an approximate date and update later once confirmed)
- b. **Date Recorded:** date you entered it into the system
- c. **Problem Type:** select category of your problem (ties to Care Plan). If the Problem is a Medical Diagnosis/symptom/condition, select Physical Health. If it is a Mental Health or Substance Use diagnosis/symptom/condition, select Behavioral Health. If the problem is a social health problem (like housing or education), select Social Health.
- d. **Chronicity:**
 - i. **Chronic:** Diagnosis or symptom is ongoing and long developing (chronic)
 - ii. **Acute:** Diagnosis or symptom is temporary and sudden (acute)
 - iii. **Undetermined:** If this has not yet been determined select undetermined. Symptoms rather than a diagnosis may be more likely to be undetermined
- e. **Onset:** What time of life did this start for the member
 - i. **Child:** Less than 12 years old
 - ii. **Adolescent:** 12-21 years old
 - iii. **Adult:** greater than 21 years old
- f. **Severity:** How severe is this issue. The severity should reflect, when applicable, the CANS-NY ratings.
 - i. **Dangerous/disabling (CANS 3):** Condition is life threatening or disabling; activities are severely impacted
 - ii. **Requires action/intervention (CANS 2):** Condition requires ongoing interventions; activities are moderately impacted
 - iii. **Require prevention or watchful waiting (CANS 1):** Condition may require some treatment, but the problem is not acute and not expected to have a duration of a year or more; mild limitations on activities
 - iv. **No action required at this time (CANS 0):** Child is healthy; no limitation in activities
- g. **Status:** Identify the current level of needs for the identified diagnosis/symptom/condition. The CANS ratings in parenthesis can be used as a guide
 - i. **CM assistance not needed:** Select if the Child/ Youth/ Family does not need assistance from Care Manager or Care Team to address the condition because it is low severity (CANS 0 or 1). Problems with this status will not be pulled to the plan of care to be addressed.
 - ii. **Requests CM Assistance:** Select if the Child/ Youth/ Family requests assistance from Care Manager or Care Team regardless of severity. Problems with this status will be pulled to the plan of care to be addressed.
 - iii. **Declines CM Assistance:** Select if the Child/ Youth/ Family does not want assistance from Care Manager or Care Team even though the condition is high severity (CANS 2 or 3). Problems with this status will not be pulled to the plan of care to be addressed.

Please reference Appendix C additional information

Updating the problem status

Please refer to **Appendix C** which walks you through the steps to take when updating statuses of problems (steps can vary depending on whether or not the problem is linked to the plan of care, etc.)

Updating a primary problem

A problem flagged as “primary” in Netsmart CareManager must be a condition the member has that meets Health Home (HH) eligibility criteria. In the event a problem flagged as primary is incorrect (either the diagnostic code is incorrect, or the diagnosis changes per a licensed professional for example), the CMA will need to update the member’s chart to reflect the correct primary problem. Please refer to **Appendix C** for instructions on how to complete this in the member’s chart.

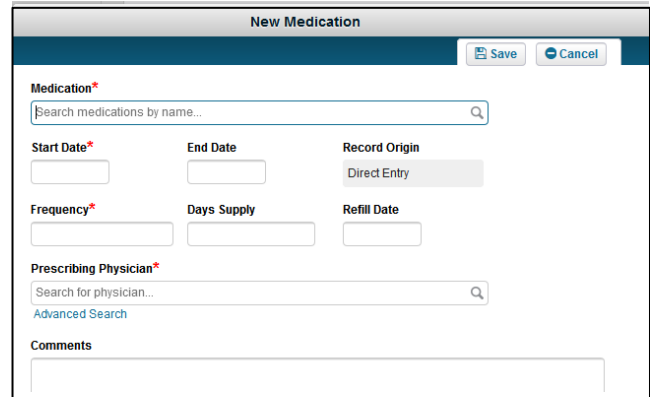
Physical Health

The Physical Health feature can be used to track if the member is not prescribed medications, as well as their allergies, vitals, immunizations and labs.

To access the Physical Health Features, you must select the **Physical Health** tab of your client's chart.

Medications

During the assessment phase and ongoing you should obtain information about current medications. As prompted in the Comprehensive Assessment, you should obtain a current medication list and upload that medication list into the member's attachments area using the appropriate naming convention. If the member is **NOT** prescribed any medications, then you are required to document this in the Medications tab:



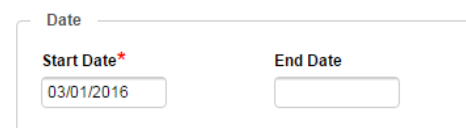
1. Click on the **Medications tab**
2. Click on **+New Medication**
3. Enter the required information:
 - a. In the **Medications** search bar, search for the term **"No Known Medications"**
 - b. **Start Date:** As reported
 - c. **Frequency:** type **"n/a"**
 - d. **Prescribing Physician:** select **Unknown Physician** from the list
 - e. Add **Comments** as needed.
 - f. Click **Save**

Medication	Start Date	End Date	Frequency	Days Supply	Refill Date	Record Origin	Prescribing Physician	Actions
No Known Medications	04/01/2019		n/a			Direct Entry	Unknown Physician	View

Filter by: All [dropdown] [grid icon] [print icon] Search Medications... [search icon]

10 [dropdown] [left arrow] [right arrow] (1 of 1) [left arrow] [right arrow]

4. If at some point afterwards the member is now prescribed medication(s):
 - a. End the current "No Known Medications" entry by:
 - Clicking on **View** in the Medication list
 - Click on the **Edit** button
 - Provide the **End Date** to indicate that dosage has ended
 - Add a **Comment** about this change in the entry
 - Upload medication list into the attachments area of the member's chart



Allergies

Although this is not a mandatory field to be completed, you can capture the member's allergies in the Allergies tab within the Physical health section.

1. Click **+Add New Allergy**
2. Search for the correct Allergy updating: **Status**, **Type**, adding any **reactions** and **severity** of them.
3. Add any additional **comments** and click **Save & Close**

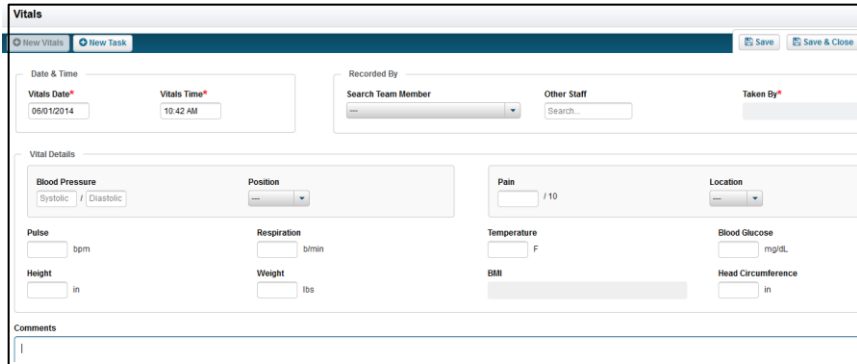
Immunizations

If you wish to document client immunizations (past and upcoming), you can utilize the Immunizations module to do so. Completion of the Immunizations tab is not mandatory.

1. Click on the **Immunizations** tab
2. Click on **+New Immunization**
3. **Immunization Date** will default to current day, change as needed
4. Document **Immunization Details** including Status and Reactions, if any.
5. Enter **Comments** and then **Save & Close**

Vitals

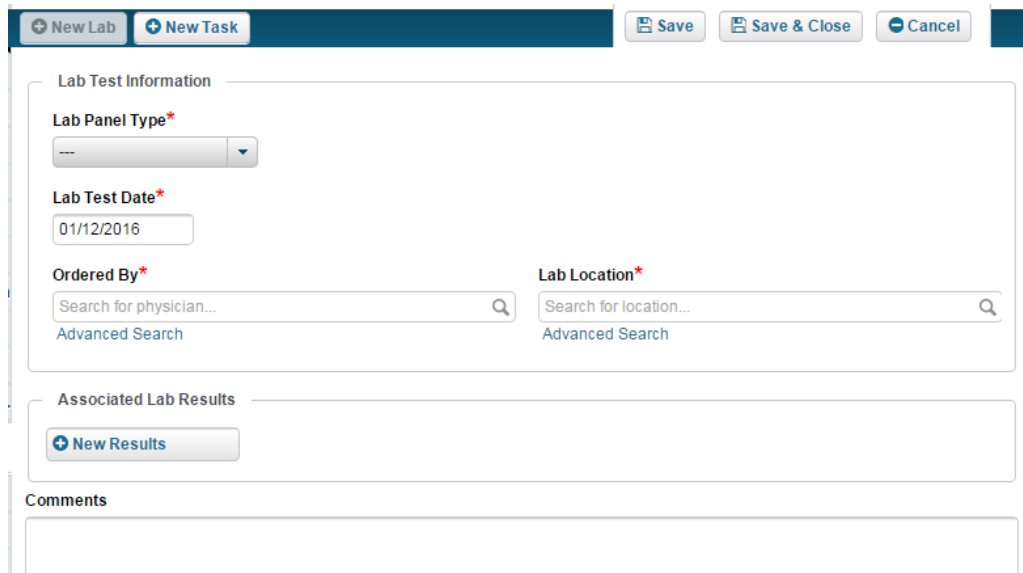
If you wish to document client vitals and BMI, you can utilize the Vitals tab to do so. Vitals are not mandatory and **should only be documented by a qualified individual**.



1. Click on the **Vitals** tab
2. Click on **+New Vitals**
3. **Vitals Date & Vitals Time** will default to current day/time, change as needed
4. **Recorded By**: you can select another Team Member or yourself
5. Document **Vital Details**
6. Enter **Comments** and then **Save & Close**

Labs

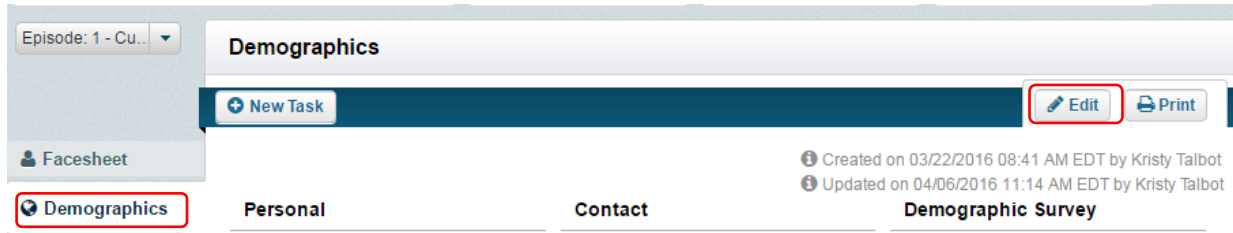
If you wish to document client labs, you can utilize the Labs module to do so. Labs are not mandatory.



1. Click on the **Labs** tab
2. Click on **+New Lab**
3. **Lab Test Date** will default to current day, change as needed
4. Document **Lab Details** including **Lab Panel Type**, **Ordered By** and **Lab Location**
5. Enter **Results** as needed
6. Add **Comments** and then **Save & Close**

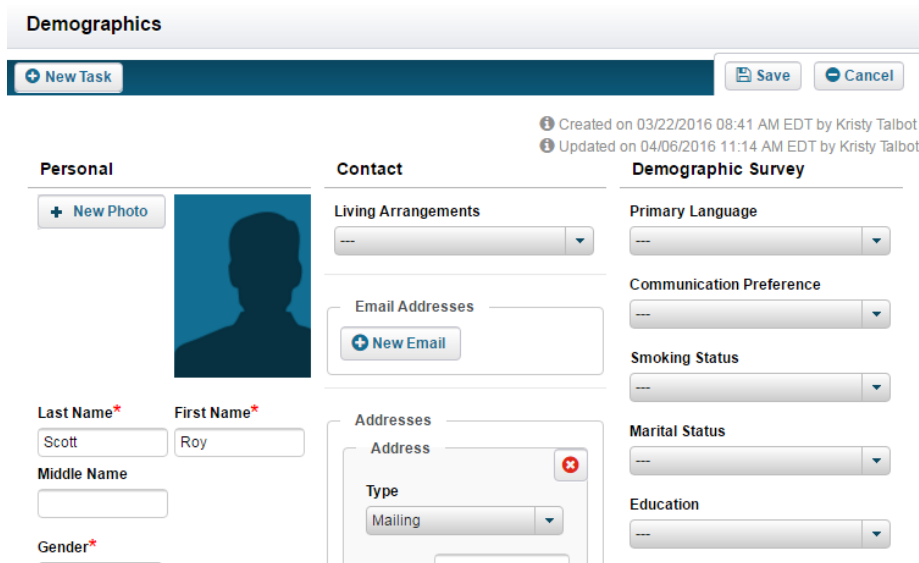
Demographics

The demographics page is where you can add and update any of the client's personal information (child/youth/enrollee demographic information is to be listed, not parent/legal guardian's demographics). The initial information in this tab comes from MAPP and will not update unless the CMA edits this page. Updates should be made as you become aware of changes. To update any of the demographics:



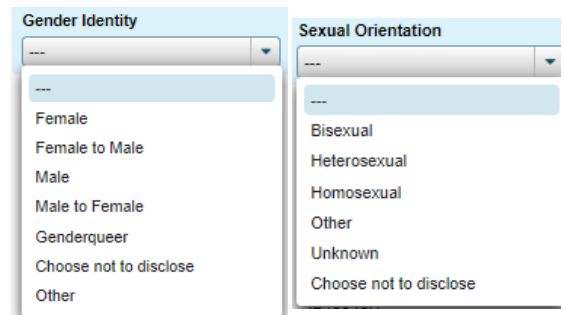
The screenshot shows the top of the Demographics page. It includes a dropdown menu for 'Episode: 1 - Cu...', a 'New Task' button, and 'Edit' and 'Print' buttons. Below the header are three tabs: 'Demographics' (highlighted with a red box), 'Personal', and 'Contact'. On the right, there is a 'Demographic Survey' tab. Metadata text indicates the page was created on 03/22/2016 and updated on 04/06/2016.

1. Click on **Demographics** tab
2. Click on the **Edit** button in the right



The screenshot shows the main form area of the Demographics page. It is divided into three columns: 'Personal', 'Contact', and 'Demographic Survey'. The 'Personal' column contains a 'New Photo' button, a photo placeholder, and text input fields for 'Last Name*' (Scott), 'First Name*' (Roy), 'Middle Name', and 'Gender*'. The 'Contact' column contains a 'Living Arrangements' dropdown, an 'Email Addresses' section with a 'New Email' button, and an 'Addresses' section with a 'Type' dropdown (Mailing). The 'Demographic Survey' column contains dropdown menus for 'Primary Language', 'Communication Preference', 'Smoking Status', 'Marital Status', and 'Education'. Metadata text is visible at the top right of the form area.

- a. **Personal:** contains all of the client's personal information including name, DOB and SSN (not required).
 - Make sure that you contact CHHUNY before you update the client's name, gender, DOB (Medicaid must have the same information on file otherwise errors can occur) or the source fields
 - If a member's Medicaid CIN changes, please contact the CHHUNY help desk who can assist with updating this field
 - Note that there are dropdowns in this section to identify the member's **Gender Identity** and **Sexual Orientation**. These must be filled out to reflect the member's response (during the assessment process)
- b. **Health Home:** contains information about the Health Home they are associated with and gives a little bit of information for when and how they were assigned. You are not able to edit this information.
- c. **Contact:** add contact information for client by clicking on the **+New** icons
 - You must ensure that at least one address is marked as "Billing Address"
- d. **Demographic Survey:** must be completed during the assessment phase. On an ongoing basis, update as needed



The image shows two dropdown menus. The 'Gender Identity' dropdown is open, showing options: Female, Female to Male, Male, Male to Female, Genderqueer, Choose not to disclose, and Other. The 'Sexual Orientation' dropdown is also open, showing options: Bisexual, Heterosexual, Homosexual, Other, Unknown, and Choose not to disclose.

1. While in the **Demographics** tab, click the **Edit** button in the right corner
2. Complete the **Demographic Survey** by selecting the most appropriate answer in the drop down
3. Click **Save**

Social Support Contacts

Social Supports can be friends, family members, neighbors, that the member/their consenter identifies they can turn to and rely on in times of need. Add Social Support Contacts as reported throughout the assessment phase and ongoing throughout the member's enrollment in the health home program. What you can share with these supports depends on what consent these individuals are on as requested by member/consenter. For example, some social supports may be on the DOH-5201/5055 and can have access to the member's health information, while others may be better suited on a more restricted agency consent. Some supports may not be on any consent but can still be identified in this area as a support. Discuss these options with the member/consenter.

The names within the Social Support Contacts can then be selected in the Safety & Crisis Plan and Emergency Plan when applicable.

To add the contact to the **Social Support Contacts** section of the Chart:

1. Navigate to **Social Support Contacts** tab
2. Click on the **+New Contact** button
3. Document the necessary information including name and contact information.
 - a. Indicate this is an Active contact; select the relationship to the client; identify if this is a legal guardian and/or emergency contact
4. If the client agreed to share information with the contact (therefore adding them to the DOH 5201/DOH 5055(as applicable) or an agency consent, AND if this person will be a member of the care team, you can add a Minor Data Sharing / Data Sharing consent from this screen

- a. Click the **Consent** button
- b. The Contact's name will auto-populate the Consent
- c. Select the **Start Date** of the consent which is the date the contact was added to the DOH 5201 (or 5055 when applicable)
- d. **Data Sharing Type** and **Select a Social Support Contact** are pre-filled since the system knows you're documenting consent for the social support 's entry you're in
- e. Select **Opt-in** in the **Client Opt-In/Out** box
- f. If there are any restrictions on what you can share with this contact, indicate as such in the **Data Sharing Information** section:

- i. For example, a 15 year old member indicates in section 2 of the DOH 5201 that information about drug and alcohol treatment services cannot be shared with their parent, you would indicate as such when you document their parent's consent: in the minor protected services section, click the box under "minor override" in the Drug and Alcohol Treatment services row
- ii. If the member indicated on the consent that information about their drug and alcohol treatment services could be shared with their parent in the event of an emergency, you would check the emergency box in the drug and alcohol treatment row
- iii. Per DOH: if a member is of age to complete section 2 of the DOH 5201 but it is not completed, the HHCM must be cognizant of restrictions posed and act accordingly as the providers listed on section 2 of the 5201 will not be able to share information relating to these health services. Consent entries should reflect as such if applicable.

Minor Protected Services	Minor Override	Share	Emergency
Abortion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Drug and Alcohol Treatment	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emergency Contraceptives	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family Planning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HIV Testing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental Health Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prenatal Care, Labor/Delivery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
STD Testing and	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

- g. Add a **comment** as needed
 - h. Click **Save** to add the consent
 - i. Click **Save** to add the contact
5. If someone is no longer an identified social support for the member, you will want to mark the **contact status** as inactive:
 - a. **Social Support Contacts** tab
 - b. Click **View** next the contact's name
 - c. Click **Edit**
 - d. Update **Contact Status** to **Inactive**

If the contact was removed from the DOH 5201 (or 5055) or an agency consent, refer to **Rescinding Consent** section in the manual

If this contact will no longer be part of the care team, refer to **"removing a care team member"** section

6. **If the member has no social supports, you must document this by adding a social support entry with the name "None Known"**
 - a. Mark the Contact status as active; Relationship to client should be "other"; legal guardian and emergency contact marked as "no"
 - b. If the member later identifies a social support(s), follow the steps in step 5 for marking this entry as "inactive"

Care Coordination (Building the Interdisciplinary Care Team)

The Care Team can consist of internal resources at your agency, external providers that the client/family reported during the assessments and social support contacts who play an active role in the member's care. Every care team member must be listed on the Care Coordination page of the member's chart and have an active consent status.

Coordinating Agency Assignment

The Coordinating Agency Assignment section will show that your agency is assigned to the client's chart and is updated and maintained by CHHUNY Staff.

Coordinating Agency Assignment	
Dates Assigned ▲	Agency Name ⇅
02/01/2018 --	Cayuga Centers

Team Assignment

This Team Assignment section will show you who from your agency is assigned to the client's chart. This is the area that the Care Manager Supervisor will be able to change or reassign a care manager to the chart. CHHUNY requires that both a Primary **Care Manager** and a **Care Manager Supervisor** be assigned to a client to monitor supervisor to staff ratios.

Team Assignment		
Dates Assigned ▲	Name & License ⇅	Role
08/07/2018 --	Chelsea Graham	Care Manager (Primary Role)
08/07/2018 --	Kristy Talbot	Care Manager Supervisor (Primary Role)

10 ▼ ⏪ ⏩ (1 of 1) ⏪ ⏩

Social Supports

Social Supports can be friends, family members, neighbors, etc. that the member/their consentor identifies they can turn to and rely on in times of need. Once you add all social support contacts to the Social Support Contacts page, you can identify any supports that are also part of the client's Care Team on the Care Coordination Page.

To add social supports to the Care Team you must:

1. Navigate to the **Care Coordination** tab of the client's chart
2. Click on the **Assign Social Support** button

Social Support				
Date Assigned ⇅	Name ⇅	Relationship to Client	Consent Status ⇅	Actions
No Social Supports found.				

3. Select the contact you wish to add to the care team from the drop down
4. Fill out the **Assign Date** (the date the support became a member of the care team – i.e. the date they were added to the consent)
5. Click **Save**

Assign Social Support

Select Support Network Contact*
Dad Johnson

Assign Date*
End Date

Social Support Information

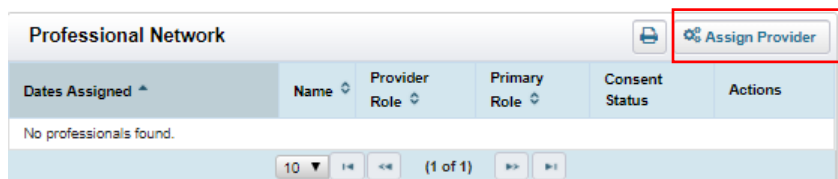
Relationship to Client
Role
Consent Status

Professional Network

Not all of a client's providers are directly related to providing care and treatment to a problem documented in the member's chart. For example: a member's MCO is a good resource for care team members and the family but may not be directly involved in the treatment or care of member's condition; a dental care provider is someone the member receives services from but the member doesn't have a dental health problem; a guidance counselor that is a mentor and support but there isn't a school problem). In the Professional Network, a Care Manager can add a provider or support to the Care Team without having to associate them to a specific problem.

To add an individual/entity to the Professional Network, you must:

1. Open the **Care Coordination** tab
2. Navigate to the Professional Network section and click the "Assign Provider" button
3. **Provider:** Search for the provider in the next window by typing a hyphen and the last name or organization name (ex. -CHHUNY, -Sullivan, -Bryl).
 - a. If the provider is not in the list, you can click "**Advanced Search**" and add a custom provider entry. If you add a provider this way, it will be available to **all** CHHUNY Netsmart users when they search for a provider in the professional network.
 - i. Indicate if you're adding an organization or an individual
 1. As you're able, be as specific as possible about who is the actual member of the care team. For example, if you're adding the guidance counselor you'd document an individual entry for Sally -Johnson, not an organization entry for -ABC High School.
 2. Please be sure to add a hyphen before the LAST NAME of an individual and before the ORGANIZATION NAME.
 - a. -CHHUNY, Cory -Sullivan, Nicole -Bryl
 - b. This will allow for differentiation between outdated entries in the professional network area with limited role selections and new entries that allow for accurate recording of the individual/organizations role
 - c. Add the provider/entity's information including address and phone number.
 - ii. Select **All of the Roles** from the "**Roles**" drop down box
 - iii. Click **Search** to ensure another entry matching the description hasn't already been entered
 - iv. Select **Add Custom Provider** when complete
4. **Consent Status:** This is an optional component within the professional network area. Please ensure that all entries within the Care Coordination Tab are identified on the paper version of the DOH 5201/5055 prior to entering them in the Care Coordination Area.
5. **Provider Role:** Select the appropriate role from the selection. Please be sure to search using the hyphen prior to the individual's last name or organization's name. If there is no option including the hyphen, please create a custom entry for the provider that includes the hyphen and selection of all the roles that appear.
6. **Primary Role:** select "No"
7. **Assign Date:** date the provider was added to the care team
8. **End Date:** Fill this area in if in the future they are no longer part of the care team (refer to "**removing a care team member**" section)
9. Click **Save**



Referred Providers

This area within Netsmart CareManager has been archived as of June 2021. Please document individuals in the Professional Network area following the current guidance.

Removing a Care Team Member

There may be times when a care team member is removed from the care team. If this happens, ensure the following steps are done:

- a. Ensure the consent is updated by the member/consenter (review CHHUNY Access to and Sharing of PHI and Use of Health Home Consents Policy for instructions). Ensure updated consent is scanned and uploaded into the Attachments area. Do not delete the previous version of the consent
- b. Rescind the individual's consent in the consent forms tab (refer to "Rescinding a Consent" section in the manual)
- c. If the individual is a referred provider for a problem in the system:

- i. Navigate to the care coordination page, scroll down to the referred providers section, and click "view" and "edit referral" next to the problem the provider is referred to

- ii. In the window, update the Referral Status to "Referral Rescinded". Associate the end date to reflect the date the individual was no longer part of the care team (date they were removed from the consent).

- iii. Click save

- d. If the individual was in the professional network section:

- i. Scroll to their entry on the care coordination page in the professional network section and click "edit"
- ii. Update the "end date" to reflect the date the individual was no longer part of the care team (date they were removed from the consent).

- iii. Click save

- e. If the individual was in the social support section:

- i. Scroll to their entry on the care coordination page in the social support section and click "edit"
- ii. Update the "end date" to reflect the date the individual was no longer part of the care team (date they were removed from the consent).

- iii. Click Save

Edit Referral

Save Cancel

Referred Provider* Kym Jones

Organization Rochester Health Center

Consent Status Rescinded

Referral Status* Referral - Rescinded

Start Date* 04/06/2012

End Date* 04/22/2019

Comments

Assign Professional Network

Save Cancel

Provider* John Carter

Consent Status Rescinded

Provider Role* Care Team Member

Primary Role* Yes No

Assign Date* 04/02/2019

End Date 04/22/2019

Assign Social Support

Save

Select Support Network Contact* Belinda Barnes

Assign Date* 04/02/2019

End Date 04/22/2019

Social Support Information

Relationship to Client Grandmother

CONSENTS

Documenting a Health Home Consent

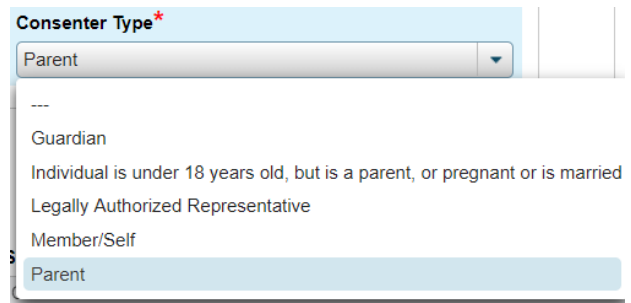
In the system the Health Home Consent is the way you document that a DOH 5200 Health Home Consent to Enroll was signed by the client's legal guardian and agreed for the child/youth to enroll in Health Home Services.

If the child 18 or over, or is a minor but is a parent, married, and/or pregnant; the child/youth does not sign the 5200 but the signed 5055 will suffice for both enrollment and data sharing.

Follow these instructions to document the Health Home Consent if it was not documented in the enrollment note (for example: the member's chart was imported into Netsmart in "enrolled" status so the enrollment note wasn't completed in the system)



1. Click the **Consent Forms** tab
2. Click on **+New Consent** and then **Health Home Consent**
 - a. Identify **Consenter type** in the drop down box:
 - i. **Selecting the correct consenter type is important!** If the member signed the DOH 5055, you'll either select "member/self" or "Individual is under 18 years old, but is a parent or pregnant or is married" as applicable. If the DOH 5200 was signed by the member's consenter, select either "guardian", "Legally authorized representative" or "parent" as applicable
 - ii. **What you select here impacts future entries in the consent forms tab**
 - b. Update the **Start Date** to the date the consent was signed
 - c. Click on the **Client Opt-in/Out** drop down and select **Client Opt-in**
 - d. Leave **End Date** and **Expiration Date** Blank
 - e. If applicable, enter the name of the consenting individual and the relationship to the client in the comments at the bottom of the consent and click the **Add Comment** button
3. Click **Save** or **Save & Close**
4. Scan a copy of the signed DOH 5200 or DOH 5055 and upload to the **Attachment** section of the chart using the appropriate naming convention



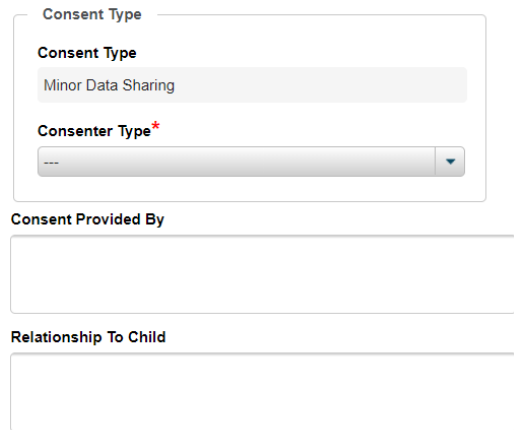
Documenting Minor Data Sharing / Data Sharing Consent

During the [Enrollment Process](#), you recorded the fact that they agreed to Health Home services by documenting the Health Home Consent (refer to enrollment process or Health Home consent section above). Next, ensure that the receipt of the signed DOH 5201 is documented in the consent forms tab (if applicable).

- **Please note that if the member signed the DOH 5055 to enroll, and you've indicated in the Health Home consent entry that consent was provided by the member/individual, the receipt of the DOH 5055 will be documented in the consent forms tab automatically in the system.**
- **Please note you do not need to document receipt of the Functional Assessment Consent or the Health Home Release of Educational Records. However, they must be scanned and uploaded into the Attachments area of the chart.**

Documenting receipt of the completed Minor Data Sharing Consent (DOH 5201)

1. Click the **Consent Forms** tab
2. Click on **+New Consent** and then **+Minor Data Sharing Consent**
3. Identify who the consenter is in the **Consenter type** drop down box, and who provided consent and their relationship to the child in the subsequent boxes underneath
4. Input Consent Start Date
 - **Start Date:** the date the consent was signed/individual was added to the consent
 - **End Date:** Leave blank.
 - **Expiration Date:** Leave Blank
5. Select the **Data Sharing Type** drop down and select **5201**



Consent Type

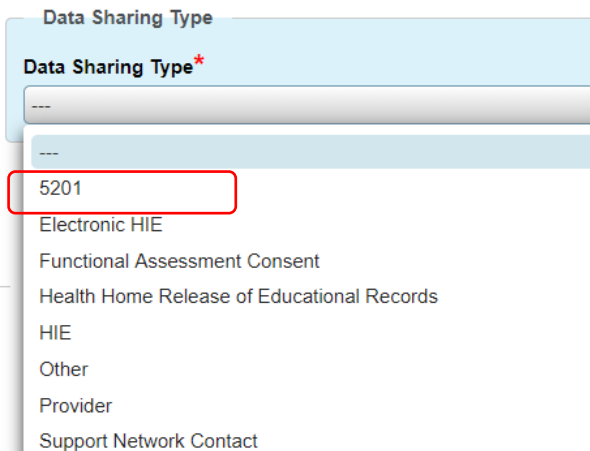
Consent Type

Minor Data Sharing

Consenter Type*

Consent Provided By

Relationship To Child



Data Sharing Type

Data Sharing Type*

5201

Electronic HIE

Functional Assessment Consent

Health Home Release of Educational Records

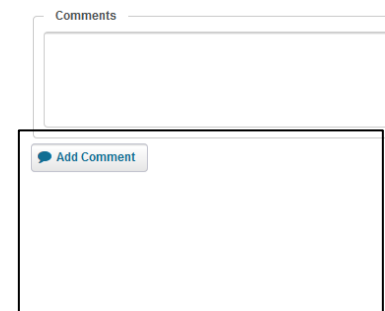
HIE

Other

Provider

Support Network Contact

6. Client Opt-In/Out
 - a. **Opt-in** – select when consent is given
 - b. **Opt-Out**- should **not** be selected; the system will automatically opt a client out of all consents when they are closed or discharged from the program
7. Data Sharing Information
 - Since you're documenting the receipt of the DOH 5201 (you're not documenting those who are on the consent and any restrictions they may have), leave everything checked as "share"
8. Comments
 - a. Add any comments you wish to document in the consent
 - b. You must click **Add Comment** prior to saving the consent or the comments will not be saved.
9. Once completed, click **Save** or **Save & Close**
10. Ensure a copy of the entire DOH 5201 (sections 1 and 2) is scanned and uploaded into the Attachments area of the chart.



Comments

Add Comment

Documenting receipt of the Data Sharing Consent (DOH 5055):

- A DOH 5055 consent form entry will populate on its own (either automatically by Netsmart or via import from CHHUNY) if you documented in your Health Home consent that consent was provided by member/self" or "Individual is under 18 years old, but is a parent or pregnant or is married (because the Health Home consent and data sharing consent are the same document in this case).
- Ensure the entire DOH 5055 consent is scanned and uploaded into the Attachments area of the chart using the appropriate naming convention

Documenting receipt of a completed HIE Consent:

You will want to document the receipt of a signed Health Information Exchange consent which will be used when RHIO connections are made (which will allow for alerts to populate when members go to the ER, etc.). To complete:

1. Click the **Consent Forms** tab
2. Click on **+New Consent** and then **+Minor Data Sharing Consent** or **+Data Sharing Consent** as applicable
3. Input Consent Start Date
 - a. **Start Date:** the date the consent was signed/individual was added to the consent
 - b. **End Date:** Leave blank.
 - c. **Expiration Date:** Leave Blank
4. Click the **Data Sharing Type** drop down and select **either HIE or electronic HIE** as applicable
5. Client Opt-In/Out
 - a. **Opt-in** – select when consent is given
 - b. **Opt-Out**- should not be selected; the system will automatically opt a client out of all consents when they are closed or discharged from the program
6. Data Sharing Information
 - a. Since you're documenting the receipt of the HIE, leave everything checked as "share"
7. Comments
 - a. Add any comments you wish to document in the consent
 - b. You must click **Add Comment** prior to saving the consent or the comments will not be saved.
8. Once completed, click **Save** or **Save & Close**
 - a. Scan and upload completed consent into the Attachments area of the member's chart using the appropriate naming convention

Documenting receipt of Hixny Consent:

When a member is consented in Netsmart for Hixny, Hixny will start sending any alerts for member's consented, regardless of where the data originated. If the member is from a different region, Hixny will query the SHIN-NY information for other RHIO's data to bring alerts into our system. Signed forms should be stored in the Netsmart chart once received. Document Hixny consent as Electronic HIE consent in Netsmart.

Follow same documentation process as outlined above for HIE Consent, except:

- Click the **Data Sharing Type** drop down and select electronic HIE

Documenting the consent on file for a care team member

It is a requirement that you document that you have active consent on file for Care team members in the Consent Forms tab. Care team members must be identified on the care coordination page (which section they are in depends on their role in the member's care). It is strongly recommended that you document care team member's consents when you are entering them in as social supports, professional network entries or referred providers on the care coordination page. When you document their consent at this time, their consent will automatically populate on the consent forms tab. Please refer to **the Care Coordination (how to build an interdisciplinary team)** section for instructions.

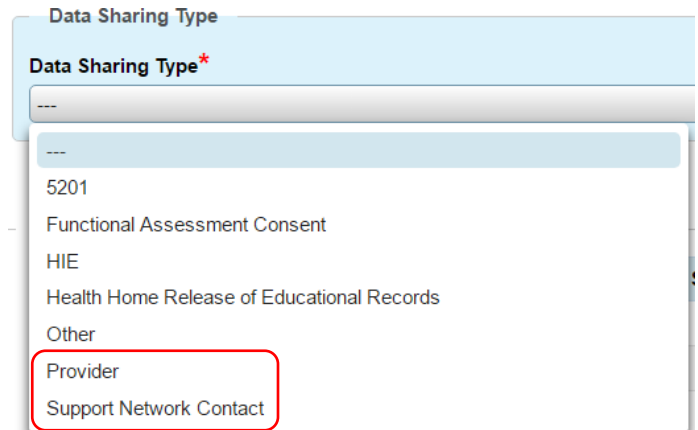
However, you can document their consent in the consent forms tab as well. To do so:

1. Click the **Consent Forms** tab
2. Click on **+New Consent** and then **Minor Data Sharing Consent** or **Data Sharing Consent** (depending on consent type)
 - a. If Minor Data Sharing consent is selected, you will need to indicate the **Consenter type**, and provide information about who provided consent and their relationship to the child
3. Input Consent Start Date
 - **Start Date:** the date the consent was signed/individual was added to the consent

- **End Date:** This will populate automatically when the “Rescind” button is selected. Please review “Rescind Consent” and “End Date Consent Option” sections
- **Expiration Date:** Leave Blank

5. Select the **Data Sharing Type**

- **Provider** – Select this type if you’re documenting a Provider that the client has given permission for you to share information with AND is a member of the care team. This will bring up a search screen for you to find any providers that we have in the system. You can add custom if you are unable to find the provider you’re looking for. Please refer to the Care Coordination section for full instructions for how you would add a custom provider entry.
- **Support Network Contact** Select this type if you’re documenting a Social Support contact that the client has agreed to share information AND is a member of the care team. You can select the social support name from the list of Social Supports documented in that tab. You can add a Contact from this screen as well. If you select this option, you will have the option to select a social support contact that has already been documented in the chart, or add a new social support contact directly from this screen. For instructions on adding social support contacts, please refer to the **Social Supports Contacts** section.



4. Client Opt-In/Out

- Opt-in** – select when consent is given
- Opt-Out**- should not be selected; the system will automatically opt a client out of all consents when they are closed or discharged from the program

5. Data Sharing Information

If there are any restrictions on what information can be shared with this support/provider, indicate as such below. Everything is automatically checked to indicate it can be “shared”:

- A check mark in Share means that you can share that type of information
- A check mark in emergency means the person on the consent has access to that type of information in the event of an emergency only
- Leaving the share or emergency boxes unchecked signals that this information should never be shared
- A check mark in Minor Override means the minor specifically determined they did not want to share information about the applicable minor protected service(s) with the particular provider/social support
- If there is a box flagged as Minor Override, Emergency, or if no boxes are checked, the consent will show a red exclamation point next to it in the consent forms list to indicate there are restrictions. It is guidance that Care Managers are checking to ensure they’re not sharing information they shouldn’t be prior to engaging with providers, supports, etc. For example, Courtney April is a member’s cousin who is a member of their support system and is on their care team. However, there is a restriction present about information that can be shared with Courtney as indicated by the red exclamation point when viewing Courtney’s consent entry in the Consent Forms tab. You’d click on View to learn more about restriction(s) present. You can also review the applicable consent that has been scanned and uploaded into attachments for more information.

Minor Protected Services	Minor Override	Share	Emergency
Abortion	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Chemical Dependency	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Drug and Alcohol Treatment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Emergency Contraceptives	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Family Planning	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
HIV Testing	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Mental Health Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Prenatal Care, Labor/Delivery	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
STD Testing and Treatment	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>
Sexual Assault Services	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>

02/19/2019 -

Chelsea
Graham

Minor Data
Sharing

Support Network
Contact

April, Courtney
(Cousin)

 View

6. Comments

- a. Add any comments you wish to the consent entry
- b. You must click **Add Comment** prior to saving the consent or the comments will not be saved.

7. Once Finalized, click **Save** or **Save & Close**

8. Ensure a copy of the applicable consent is scanned and uploaded into the chart using the appropriate naming convention.

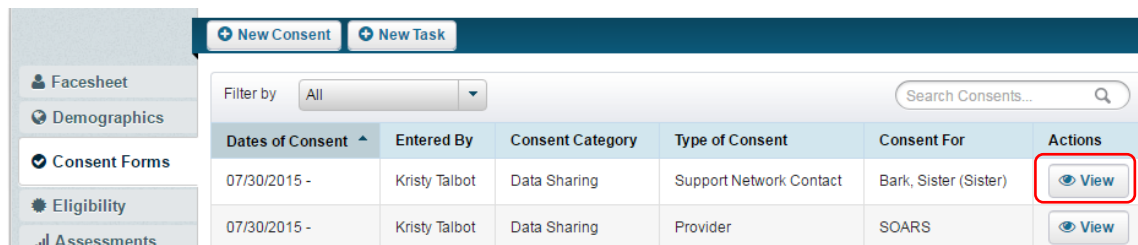
Not every individual or every entity listed on a consent needs to have their consent documented in the consent forms tab. Only care team members' consents need to be reflected here.



Rescinding Consent Option

You may need to use the "Rescind" feature in the event a member/consenter says they no longer want you to share information with a party listed on a data sharing/minor data sharing consent anymore. If this occurs, the consent must be updated per CHHUNY policy and re-scanned and uploaded into the member's attachments area. Do **not** delete the previous version of the consent in the attachments areas. Please refer to CHHUNY's Access to and Sharing of PHI (Consent) Policy for more information.

If the person/entity removed from the consent was a member of the care team: you must also document this person/entity's removal from the consent in the consent forms tab in Netsmart

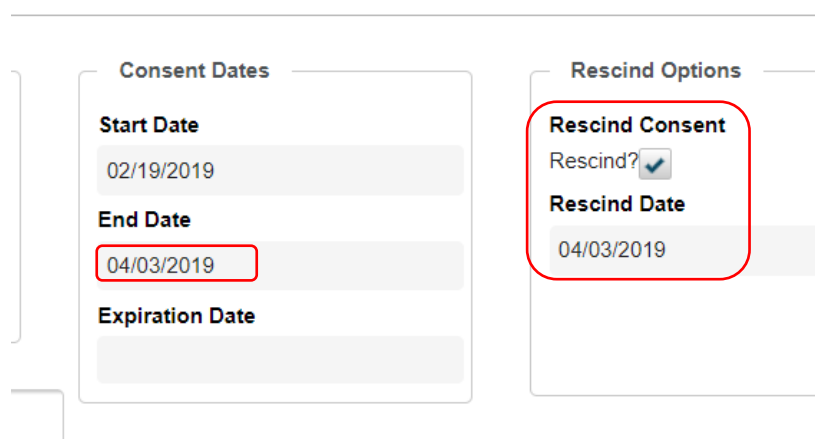
1. Navigate to the Consent Forms tab and click on the **View** button listed next to the party's consent in the consent list



Dates of Consent	Entered By	Consent Category	Type of Consent	Consent For	Actions
07/30/2015 -	Kristy Talbot	Data Sharing	Support Network Contact	Bark, Sister (Sister)	 View
07/30/2015 -	Kristy Talbot	Data Sharing	Provider	SOARS	 View

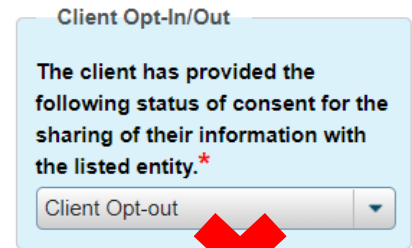
2. Click on the **Edit** button

3. To rescind the consent, select the **"Rescind?"** check box. This will automatically input the **end date** and **Rescind date** to be the date "rescind" box is checked. If the person/entity was removed from the consent *prior* to you completing this step in the system, be sure to document this date discrepancy in an error resolution contact note (please review instructions in the Additional Features section)



Consent Dates	Rescind Options
Start Date 02/19/2019	Rescind Consent Rescind? <input checked="" type="checkbox"/>
End Date 04/03/2019	Rescind Date 04/03/2019
Expiration Date	

- Do **NOT** switch the consent to **Opt-Out** in the Client Opt-in/out dropdown box. The system will automatically opt a client out of all consents when they are closed or discharged from the program. If the person being removed from the consent was a member of the care team, be sure to end date their assignment on the care coordination page (in referred providers, professional network or social support contact section as applicable). Additionally, if the person was a social support, mark their contact status as “inactive”. Refer to the “removing a care team member” section for further details.



End-Dating Consent Option (when consentor changes)

You may need to “end-date” a consent in the event there is a consentor status change for a member.

For example: upon enrollment a member’s parent enrolls the member into the program by signing the appropriate consents (DOH-5200, DOH-5201, etc.). While the member is enrolled, they turn 18 and can now consent for themselves. Once the member turns 18, the Care Manager is responsible for obtaining all new consents that are signed by the member (i.e. DOH-5055, DOH-5230, etc.) per policy guidelines. All of the change of consent work should be completed within the same day to avoid MAPP errors.

Once new consents are signed:

- Ensure they are scanned and uploaded into the attachments area of the chart. Do not delete the previous version(s) of the consents!
- Next, navigate to the consent forms tab. Find the active “Health Home” consent entry (that reflects the consent provided by the previous consentor). Click “view” and then “edit”
- Associate an end date. The end date must be **one day before** the new Health Home consent was signed by the new consentor
 - For example, if the new HH consent was signed by the new consentor on 4.22.19, the health home consent entry that was entered previously would be end dated for 4.21.19
 - This is an important step to ensure there isn’t a gap in enrollment segment which can cause the member to become disenrolled in MAPP and subsequent issues. If this happens, contact the CHHUNY Help desk.
- Do NOT select “client opt-out” from the client opt-in/out box. Leave as “client opt-in”
- Click save
- The previous HH consent entry should now look like this on the consent forms tab:

03/06/2019 - 04/21/2019	Chelsea Graham	Health Home	Health Home	CHHUNY	View
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- Follow the same steps for end-dating the previous entry for the receipt of the DOH 5201
- Next, document the new Health Home consent, ensuring the start date reflects the date the consent was signed
 - Refer to **documenting a Health Home consent** section. Ensure the start date reflects the date the new consent was signed!
- Follow the steps for documenting receipt of a new minor data sharing (or data sharing) consent (refer to documenting data sharing consent section
 - Ensure the start date reflects the date the new consent was signed!
- If any changes to care team members occur (either care team member(s) are removed or added), please refer to “**care coordination (building an interdisciplinary care team)**” section and “**removing a care team member**” section as applicable

(See **CHHUNY Access to and Sharing of PHI and Use of Health Home Consents Policy** for further guidance about the Consent process)

INITIAL PLAN OF CARE

The Plan of Care is supported by information obtained from the CANS-NY assessment domains and findings from the Comprehensive Assessment. The Initial Plan of Care is due within the first 60 days of enrollment.

(See CHHUNY's CANS-NY Policy, Comprehensive Assessment policy, Plan of Care Policy, and Comprehensive Assessment manual for further guidance on Assessment and Care Plan documentation)

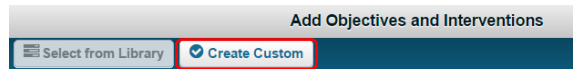
To complete the first Plan of Care within CareManager for your member, you will enter it as the **Initial Plan**. Any subsequent care plan amendments will be entered in as a **New Plan Amendment** (refer to **New Plan Amendment** section for more detail)

Documenting the Initial Plan

To complete the first Plan of Care within CareManager for your member, you will enter it as the Initial Plan.

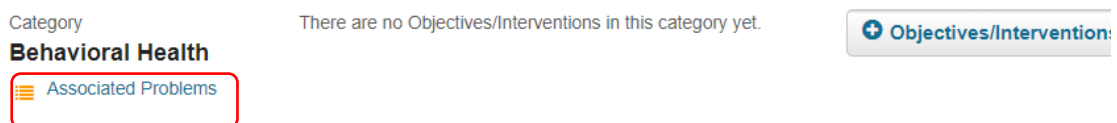
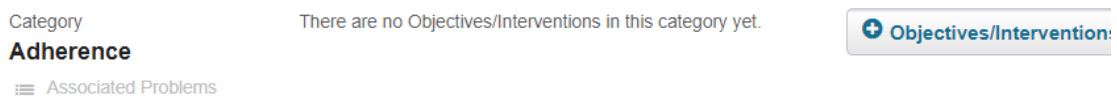
1. Go to **CareManager Plan** tab
2. Click on **+Initial Plan**
3. Fill in the required fields:
 - a. **Plan Type**: This will automatically be filled for you
 - b. The **Plan Start Date** should reflect the date the care plan was finalized with the child/youth/family
 - c. **Plan End Date**: This should always be left blank. The plan will remain the "active" plan until a New Plan Amendment is created and finalized
 - d. **Plan Status**: Leave the plan in Draft status until it is completed, reviewed with the client/family and you have obtained the client/consenter signature. If you are unable to get the plan signed on the date of completion, then you can finalize the plan without a signature as long as you have notes in the system that support a plan to get the signature(s) within the next 30 days. To switch your Plan of Care to final, check the box that states "**Client reviewed Plan**"
 - e. Indicate the **Emergency Planning** Assessment was completed (remember this is considered part of the plan of care per policy but has been built as its own assessment. Ensure it has been completed with the family and documented in the Assessment tab. Review the Assessment section for more detail).
 - f. Update **Client Goal Statement**: the goal statement should reflect what is important and of priority to the child/youth and family. It should be written in a manner that is understandable to the individual and his or her parent/legal guardian
 - g. Add **Strengths, Barriers, History and Risk Factors** as determined through the assessment process, as related to services and treatment, well-being and recovery.
4. **Participants**: leave this section blank
5. Add client specific **Objectives** and **Interventions**
 - a. Locate the category where you want to write an Objective and Intervention
 - i. The first category you'll see is the **Adherence Category**: You may use this section to document work being done specific to preventive measures and screenings to include: **annual dental visits** and **well child visits** . Care Managers can address these quality measures in the physical health section if they're linked to a documented problem (for example there is a dental health problem the member wants assistance with). If not, the adherence category is the perfect place to do so. If these will not be addressed on the plan of care, ensure the documentation in the chart supports this.
 1. To document objective/interventions in this section, click the **+ Objectives & Interventions** button in the Adherence category section.

- Click the **Create Custom** button.



- Select the appropriate **Category** (Adherence) and then type in your **Objectives & Interventions**.
 - Create objectives and interventions to capture your work/efforts with these measures. They should be specific to the child/youth/family. Examples of objectives you could use for members who attend their dental visits and well-child visits regularly:
 - Within the next six months, Lashonda will maintain her oral health as evidenced by having no cavities
 - Lashonda will continue to thrive and reach her developmental milestones over the next 12 months
- You can add additional lines for Interventions by clicking the **+Add** button
- You must identify which problem(s) the objective/intervention(s) are addressing by selecting them from the **Client Problems** drop down box. In the Adherence category, select the member's qualifying condition(s). Click save when complete.

- Each category on the plan with problems that the child/youth/family identify they want assistance with will be highlighted: you'll see **"Associated Problems"** in blue underneath the category title. See screen shot below. If you hover your mouse over the "associated problems" in blue, you'll see the problems that have been entered into the problem list, linked to that category, and have a status that reflects the member requests assistance. Click the **+Objectives/Interventions** button in that category.
 - Please refer to **Appendix C** which walks you through the steps to take when updating statuses of problems (ex: if you need to update a status from assistance requested to not requested)



- c. Follow the instructions 1-5 listed above to document objective(s) and intervention(s) for each category with associated problems the member requests assistance with
- d. If you want to make a change to the wording of an objective or intervention that you just added, you can do so directly in the appropriate boxes once it's been populated onto the draft plan (ex: in the picture below, you can update the wording for "test objective 1" as well as the wording for the test interventions.
 - i. If you click on the small blue arrow to the left of "custom objective" it will collapse the associated text boxes for that objective to minimize the scrolling you may need to do to get through the entire plan. You can click the arrow button again to display the boxes again.

The screenshot shows the 'Objectives' section of a care plan. On the left, the 'Category' is 'Behavioral Health' and there is an 'Associated Problems' link. The main area is titled 'Objectives' and contains a 'Custom Objective' field with the text 'Test objective 1'. Below this is a table with three columns: 'Intervention*', 'Status*', and 'Target Date*'. The table has two rows of data and an 'Add' button at the bottom right. Each row has a 'Delete' button to its right.

Intervention*	Status*	Target Date*	
test intervention 1	New	04/27/2019	Delete
test intervention 2	New	08/07/2019	Delete
	New		Add

- 6. Intervention **Status**: leave as "new"
- 7. Next, you'll need to add **Target Dates** within the care plan for each Intervention. Target dates should NOT all be set out for six months (when you intend to complete the next care plan review), but instead be an accurate reflection of when the family/care team member intends to have the intervention completed by or the span of time it will cover.
- 8. From this view, you can also add more interventions if desired. Click the **+Add** button and the row will activate allowing you to enter another intervention with target date
 - a. You can also delete an intervention you just created by clicking the **xDelete** button to the right of the intervention

- 9. Review the Care Plan with the client/legal guardian
- 10. Mark the care plan as **Client Reviewed** once it has been reviewed and approved by child/youth/family
- 11. **Signature**: either capture the signature(s) electronically at the bottom of the care plan after you've selected "client reviewed plan". The electronic signatures can be captured via mouse or topaz (please contact the CHHUNY help desk if you have questions about using the topaz feature after you confirm it's been installed in your computer). Ensure you indicate the name of the individual who signed in the text box below (if a client's consentor signed instead of the client when applicable, indicate the consentor's name in the client name box). If electronic signature is not possible, you may **Print** the finalized care plan and have the client/legal guardian sign. If you are unable to get the plan signed on the date of completion, then you can finalize the plan without a signature as long as you have notes in the system that support a plan to get the signature(s) within the next 30 days.

The screenshot shows the 'Plan Status' dropdown menu. The 'Draft' option is selected, and the 'Client reviewed Plan' option is highlighted with a red box.

- a. If signatures were captured manually: Upload a scanned copy of the signed care plan to the client's chart and keep the signed copy filed at your office
(See [File Attachment](#) section for more detail on how to upload a document)

12. Continue to update the **Care Plan** (by creating **+New Plan Amendments**) and print/sign minimally every six months, or sooner if required (review the **New Plan Amendment** section for more detail)
13. **Important to note:** Anytime you leave a Care Plan in “draft” status, you are unable to document Care Manager notes until you have finalized the plan. Note that care plans not updated/finalized within required timeframes can impact your ability to bill. Refer to CHHUNY Billing and Claims Payment policy)

Please refer to CHHUNY’s Plan of Care Policy for elements to include on a Plan of Care. Refer to CHHUNY’s Plan of Care Tips and Tricks for more information about writing a care plan

Minor Protected Services on a Plan of Care:

In the event a member requests assistance with minor protected services that they’ve indicated cannot be shared with a parent/legal guardian/legally authorized representative/provider, the Care Manager will document this work on the Minor/Adolescent Plan of Care Form. Please refer to the form and corresponding guidance document on the Training page of the CHHUNY website for more details on how to document the form, upload it into the chart, and document the work that is done to achieve the identified objectives/interventions.

Please refer to CHHUNY’s Plan of Care Policy for elements to include on a Plan of Care. Refer to CHHUNY’s Plan of Care Tips and Tricks for more information about writing a care plan

CAREMANAGER NOTES: AVAILABLE ONCE THE INITIAL PLAN IS FINALIZED

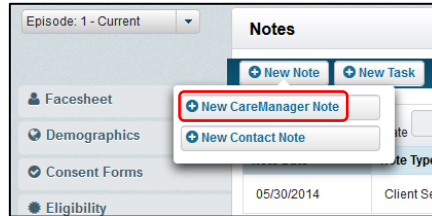
Once the initial Care Plan is finalized, all services and encounters (whether billable or non-billable) can be documented as either New Contact Notes or New CareManager Notes as appropriate. If you have enrolled the member and finished the initial plan, but CAN’T document a CareManager note, double check to ensure you’ve marked the Care Plan as “FINAL”. **Leaving a Care Plan in draft will prohibit you from documenting CareManager notes. Conversely, leaving a Care Manager note in draft will prohibit you from documenting other CareManager notes or a Care Plan!**

- Contact Notes capture any work completed in relation to the following: Assessments and Plan of Care, Case Reviews, Diligent Search Efforts, Error Resolution, Immediate Needs/Crisis Intervention and Transitions of Care. Please review the “**DOCUMENTATION FOR ENROLLED CLIENTS BEFORE INITIAL PLAN COMPLETION**” section for more details on Contact Notes.
- CareManager notes are used to document the work done on the interventions to help the member achieve their desired objective(s) and goal identified on the plan of care
 - Example: there is an intervention about a primary care office providing a referral to a nutritionist for member Jane. The Care Manager speaks with the doctor’s office to confirm which nutritionist the client has been referred to, and assists with scheduling an introductory appointment with the member and their family. This work would be documented in a CareManager note with the detail underneath the appropriate intervention.
- Please review the Note Grid training document on the Training page of the website and in the appendix section for additional guidance

Documenting a Billable CareManager Note

The CareManager Note allows you to track a client’s progress on their current CareManager Plan. The note will contain all current **Objectives & Interventions** from the most recent finalized Care Plan, but you should only document on what was addressed during the activity you are logging. Please refer to the Initial Plan of Care and Care Plan Amendment sections for more details

1. Go to **Notes** tab
2. Click on **+New Note**
3. Click on **+New CareManager Note**
4. Complete the following fields:



a. Note Detail

- i. **Note Type:** This will prepopulate to contain the type of note you are completing
- ii. **Note Date:** auto-populates to the date the note is finalized in the system
- iii. **Note Status:** Draft notes do not count in the system. You will be able to edit them but they will not support billing (the CBQ won't recognize billable notes left in draft). Finalized notes are used for billing, tracking files and other reports but the note is locked permanently (. It cannot be edited or changed back to draft. Make sure all information in the note is correct before you change the status to **final**. *If you leave a CM note in draft, you're unable to write other CM notes or create a care plan amendment!*
- iv. **Service Code:** Select **Billable**
- v. **Type of Activity:** Select the Core Service that was delivered (Please refer to CHHUNY's Core Services policy for more information). You must identify a core service if you are documenting billable work that was done.

Note Detail

Note Type
CareManager Note

Note Date*
04/22/2019

Note Status*
Draft

Service Code*
Billable - Billable

Type of Activity*

b. Contact Detail

- i. **Contact Date:** The actual date of the activity or encounter you are logging. Activities on separate days need to be in separate notes
- ii. **Duration:** Document the number of minutes the activity/encounter took you to perform
- c. **Contact Type:** Select the type that best describes the activity you performed. For example:
 - "Client-In Person" would be selected if the activity being documented involved a face to face with the client
 - "Collateral – In Person" would be selected if the activity being documented involved a face to face with someone other than the client (family, support, provider)
 - If the client was involved/present in the activity being documented, ensure that's reflected in the search type you select (even if other individuals were involved in the activity)
 - Do not use other unless you're documenting an error resolution contact note (refer to the additional features section for more instruction on this type of note)
- iii. **Location:** The location where the Care Manager is at when performing the activity

Contact Detail

Contact Date*
04/22/2019

Duration*
minutes

Contact Type*

Location

Contact Status*

- iv. **Contact Status:** This refers to whether or not a dialogue was achieved with the identified **target** (see Participants section below)

c. Participants

Box next to client’s name, Assigned Team, Social Support Contacts, Referred Providers, Other Participants can all be left **blank**. Your note detail section (where you provide a narrative about what occurred) should include specifics about who was involved in the activity being documented

Target: This field captures who the target of the activity is. The list includes the member, Supervisor providing direction on the case, Providers, family and members of the interdisciplinary team. Select the option that best reflects the activity/effort being documented and should be in alignment with the selection in the “contact type” field. “Other” should only be selected if the target is not captured in the options provided in the list

The screenshot shows a form titled "Participants" with the following fields:

- Alexander, Lashonda
- Assigned Team: None (dropdown)
- Social Support Contacts: None (dropdown)
- Referred Providers: None (dropdown)
- Other Participants: Search... (text input with search icon)
- Target*: --- (dropdown)

d. Client Goal Statement:

- i. The **Goal State Date** will reflect the start date of the most recently finalized plan of care
- ii. **Client Goal Status:** leave as “in progress”. If you mark it as “complete” or “discontinue”, the goal statement will be removed from the next care plan amendment. You should only select those options if you’re preparing to update and amend the plan of care. Please refer to the **New Plan Amendment** section for more details.

e. Document the activities that took place during the encounter you are documenting under the appropriate **Intervention. The Intervention Updates box for any interventions that you did not address during the encounter can be left blank.**

- i. Update **Status** of Intervention or update the **Target** date if appropriate
 - 1. If you update the status of an intervention to **Complete** or **Discontinued** it will not show up in future notes and a care plan amendment will need to be done in order to put it back on the care plan. If you Complete or Discontinue every intervention under an objective, the objective is considered “completed” and will disappear from future CM notes/Care Plans. Review “**New Plan Amendment section**” for more details.
- ii. If desired, use the rating bar to indicate how **Engaged** the client is with this Intervention
- iii. Give detailed information on your activities in the **Intervention Updates** section

The screenshot shows an "Intervention" form with the following elements:

- Intervention***: Care Manager will provide referral to :
- Status***: In Progress (dropdown)
- Target Date***: 07/10/2019
- Engagement: How engaged has the client been with this task? (Rating bar from Not Engaged to Very Engaged)
- Intervention Updates**: Write update... (text area)

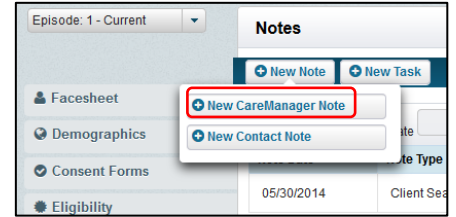
- iv. If you want to see their progress on the intervention you can click the blue word bubble to see the historical notes entered against that intervention. You can document updates on multiple Interventions within one note (so long as it occurred on that contact date)



Documenting a Non-Billable CareManager Note

If you made efforts to work on a specific intervention, but the activity doesn't meet billing standards, this information should still be documented underneath that intervention in a non-billable CareManager note.

1. Go to **Notes** tab
2. Click on **+New Note**
3. Click on **+New CareManager Note**
4. Complete the following fields:



a. Note Detail

- i. **Note Type:** This will prepopulate to contain the type of note you are completing
- ii. **Note Date:** The date the note is finalized in the system
- iii. **Note Status:** Leave the note in draft until you've reviewed the note details for accuracy. Once the note is marked as final, it cannot be edited or changed back to draft. If you leave a CM note in draft, you're unable to write other CM notes or create a care plan amendment!
- iv. **Service Code:** Select **Non-Billable**
- v. **Type of Activity:** Select **"No Core Serviced Provided"**

Note Detail

Note Type
CareManager Note

Note Date*
04/22/2019

Note Status*
Draft

Service Code*
Nonbill - Non-Billable

Type of Activity*
No Core Service Provided

b. Contact Detail

- i. **Contact Date:** The actual date of the activity or encounter you are logging. Activities on separate days need to be in separate notes
- ii. **Duration:** Document the number of minutes the activity/encounter took you to perform
- d. **Contact Type:** Select the type that best describes the activity you performed or was attempted. For example:
 - "Client-In Person" would be selected if the activity being documented involved a face to face with the client or was attempted
 - "Collateral – In Person" would be selected if the activity being documented involved a face to face with someone other than the client (family, support, provider) or was attempted
 - If the client was involved/present in the activity being documented, ensure that's reflected in the search type you select (even if other individuals were involved in the activity)
 - Do not use other unless you're documenting an error resolution contact note (refer to the additional features section for more instruction on this type of note)

Contact Detail

Contact Date*
04/22/2019

Duration*
minutes

Contact Type*

Location

Contact Status*


- iii. **Location:** The location where the Care Manager is at when performing the activity
- iv. **Contact Status:** This refers to whether or not a dialogue was achieved with the **target** of your activity (see Participants section)

c. **Participants**

Box next to client’s name, Assigned Team, Social Support Contacts, Referred Providers, Other Participants can all be left **blank**. Your note detail section (where you provide a narrative about what occurred) should include specifics about who was involved in the activity being documented

Target: This field captures who the target of the activity is. The list includes the member, Supervisor providing direction on the case, Providers, family and members of the interdisciplinary team. Select the option that best reflects the activity/effort being documented and should be in alignment with the selection in the “contact type” field. “Other” should only be selected if the target is not captured in the options provided in the list

- d. Document the activities that took place during the encounter/effort you are documenting under the appropriate **Intervention**. The Intervention Updates box for any interventions that you did not address during the encounter can be left blank.
 - v. Update **Status** of Intervention or update the **Target** date
 - 1. If you update the status of an intervention to **Complete** or **Discontinued** it will not show up in future notes/care plan amendment (a care plan amendment will need to be done in order to put it back on the care plan). If you Complete or Discontinue every intervention under an objective, the objective is considered “completed” and will disappear from future CM notes/Care Plans. Review “**New Plan Amendment section**” for more details.
 - vi. If desired, indicate how **Engaged** the client is with this Intervention if appropriate
 - vii. Give detailed information on your activities in the **Intervention Updates** section

- b. If you want to see their progress on the intervention you can click the blue word bubble  to see the historical notes entered against that intervention. You can document updates on multiple Interventions within one note (so long as it occurred on that contact date)

NEW PLAN AMENDMENT

Care Plans need to be reviewed and amended every six months (if not sooner per policy). As you prepare to amend a care plan, it's important to note that any objectives/interventions that have not been completed/discontinued in CareManager notes since the previous plan was finalized will carry over to the next plan amendment. If objective(s)/intervention(s) need to be removed from a care plan before the next care plan amendment, this work must be done in a CareManager note (you cannot close out interventions/objectives in a new plan amendment!).

Closing out objective(s)/intervention(s) prior to the new plan amendment

To do this: document a billable or non-billable CareManager note (as applicable) and update the status of the goal statement (if applicable) and each applicable intervention to either completed or discontinued as appropriate. Review the “**documenting a billable/non-billable caremanager note**” sections for instructions on documenting these notes.

Documenting the New Plan Amendment

1. Go to **CareManager Plan** tab
2. Click on **+New Plan Amendment**

All the data from the last finalized plan will carry over to the New Plan Amendment (except for any objective(s)/intervention(s) that have been closed out via CareManager notes since the last plan was finalized). Proceed with updating the goal statement, strengths, barriers, history and risk factors as applicable (as supported by assessment/reassessment/assessment update process). Review the **Initial Plan of Care** section for instructions for how to complete each part of the plan (adding objectives/interventions/capturing signatures/finalizing the plan).

ENDING SERVICES

Ending Outreach and Engagement

To end services during Outreach and Engagement, you must complete a **Client Search Note** and Opt the client out of the Health Home program

1. Navigate to the note section of the client's chart you wish to enter a note for.
2. Click **+New Note** and then click **New Client Search Note**
3. Document all required fields (refer to **Documenting Billable/Non-billable Client Search Note** section)
4. In the Client Search Status Bar select **Client Opts out of Health Home Services**
 - a. **Reason for Opt-Out** drop down will appear. Select the appropriate reason for why the client will not be receiving Health Home services.
 - b. **Only select “End Assignment, No Outreach- Non-Billable” if your client is in Assigned status and you have not provided and don't intend to provide any billable services during the current outreach segment. This is ONLY used if this if your first and only note for the current segment. If you select this option you do not need to complete an Outreach Billing Questionnaire.**

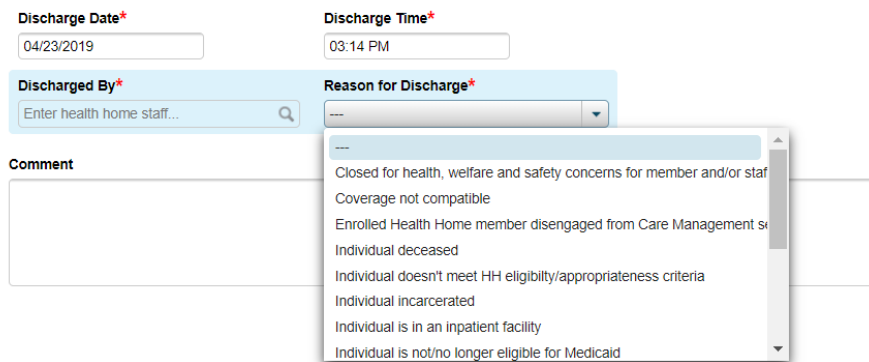
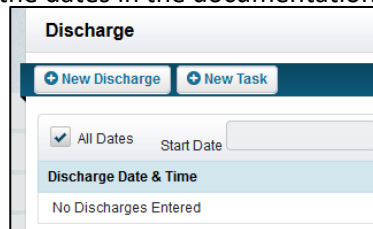
The screenshot shows the 'Client Search Status' section of a software interface. It features four radio buttons: 'Continue Search', 'Health Home Consent Pending', 'Client Enrolled', and 'Client Opts-out of Health Home Services'. The 'Client Opts-out of Health Home Services' option is selected and highlighted with a red box. Below this is a 'Reason For Opt-Out' dropdown menu, which is currently open, displaying a list of reasons including 'Client moved out of state', 'End Assignment, No Outreach- Non-Billable', 'Hiatus to Closed', 'Inability to contact/locate member', 'Member Deceased', 'Member Dissatisfied with Services', 'Member Incarcerated', and 'Member Opted-Out (Pre-Consent)'. The 'End Assignment, No Outreach- Non-Billable' option is highlighted in yellow in the original image.

Ending Enrollment

When you are ready to end services for an enrolled client a discharge must be completed. **If you are transferring the client to another Care Management Agency or Health Home, you MUST first contact CHHUNY before completing a discharge in the CareManager system.** Refer to CHHUNY's Member Transfer Policy for additional information.

There are documentation requirements that need to be completed prior to discharging a member from Netsmart CareManager. Ensure you review the **Member Disenrollment Policy** to ensure all documentation is complete prior to discharging the member. Be sure the dates in the documentation fall on or before the discharge date.

1. Click on **Discharge** tab
2. Click on **+New Discharge**



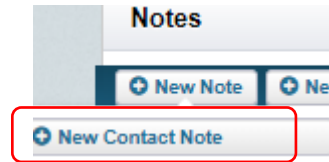
3. Enter **Discharge Date** (will auto-populate but is able to be changed)
4. Enter **Discharge Time** (will auto-populate but is able to be changed)
5. Select the name of the staff member completing the discharge in the **Discharged By** box
6. Select the appropriate **Reason for Discharge**. The reasons are NYS defined End Codes
7. Depending on the reason you select, you may be asked to complete additional information (Member Deceased, Transferred to Another Health Home, etc.)
8. Add **Comments** regarding the discharge
9. Click **Save & Close**
 - Once you have saved, the client's chart will be locked and you will not be able to edit any information.
 - To re-enroll the individual, you must enter a referral through MAPP again and process accordingly.
 - Contact CHHUNY Help Desk if the discharge was done in error.

ADDITIONAL FEATURES

How to Document a Chart Error Resolution Contact Note

If something is documented in error within a member's chart (for example: notes/questionnaires that need to be voided), the Care Manager must document a non-billable chart error resolution note that includes all pertinent details about the error:

1. Go to **Notes** tab
2. Click on **+New Note**
3. Click on **+New Contact Note**
4. Complete the following fields:



a. Note Detail

- i. **Note Type:** This will prepopulate to contain the type of note you are completing
- ii. **Note Date:** Will reflect the date the note is finalized in the system
- iii. **Note Status:** Draft notes do not count in the system. You will be able to edit the note while in draft, but switch the status to final once you've confirmed all details are accurate.
- iv. **Service Code:** Select **Non-Billable**
- v. **Type of Activity:** Select **No Core Service Provided**

b. Contact Detail

- i. **Contact Date:** The date of the error you're documenting the note about
- ii. **Duration:** Document the number of minutes the activity/note took you to document
- iii. **Contact Type:** Select **"Other"**
- iv. **Location:** Select **"Other"**
- v. **Primary Reason for Contact:** select **Error Resolution**
- vi. **Contact Status:** Select **"Contact Not Achieved"**

c. Participants

- i. **Box next to client's name, Assigned Team, Social Support Contacts, Referred Providers, Other Participants** can all be left **blank**. Your note detail section (where you provide a narrative about what occurred) should include specifics about who was involved in the activity being documented.
- ii. **Target:** select **Other**

The screenshot shows three panels in a software interface:

- Note Detail:** Includes fields for Note Type (Contact Note), Note Date (04/02/2018), Note Status (Draft), Service Code (900 - Non-billable), Program (---), Type of Activity (No Core Service Provided), and CareManager Follow-Up Date.
- Contact Detail:** Includes fields for Contact Date (04/02/2018), Contact Duration (minutes), Contact Type (Other), Location (Other), Primary Reason for Contact (Error Resolution), Other Reason for Contact, and Contact Status (Contact Not Achieved).
- Participants:** Includes a checkbox for Burton, David, Assigned Team (None), Social Support Contacts (None), Referred Providers (None), Other Participants (Search...), and Target (Other).

A blue tooltip at the bottom left of the Note Detail panel states: "Entering a date will create a task in your tasklist for this note, when note is finalized."

d. **Status Update**

- i. Leave blank. Please refer to the Sub Status user manual on when/how you use this drop down

e. **Notes**

- i. Provide detail about what occurred

Medicaid Eligibility

The eligibility tab contains the client’s insurance information. You can view their current eligibility status and add new insurances as needed. You have the ability to update the insurance information, **contact CHHUNY before you do so.**

1. Click on **Eligibility** tab
2. Click on **+Eligibility** to add a new insurance
3. Fill out all required fields ensuring all the information is accurate
4. Click **Save & Close**

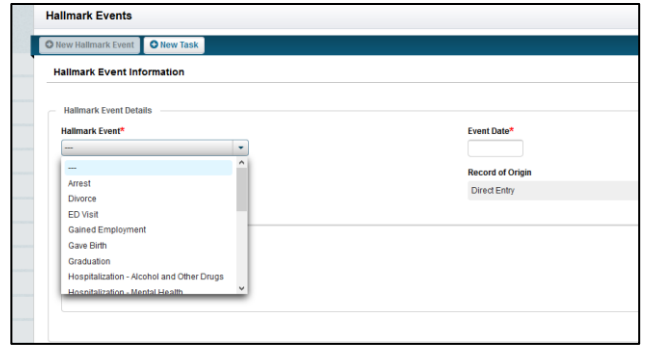
The screenshot shows two panels in a software interface:

- Eligibility Info:** Includes fields for Effective Date (04/01/2014), Start Date (04/01/2014), End Date, and Medicaid ID (A11111AA).
- Health Plan Info:** Includes a Health Plan dropdown, Health Plan Code, Member Plan ID, and a + New Plan button.

Hallmark Events

Documenting hospitalizations, inpatient stays, and ED visits as hallmark events are **required**. Other pertinent events impacting the client and family should also be documented as hallmark events. Other non-clinical, positive and negative events that may impact the progress of the Care Plan may also be documented as hallmark events. When the connection with the RHIO/HIE is made through Netsmart CareManager, a Hallmark Event will automatically populate when you receive an alert in the system. You can edit and update these Hallmark Events as you obtain more data about the cause of the alert.

1. Go to **Hallmark Events**
2. Select the **Hallmark Event** from the drop down
3. You can select **Other** and free text the event
 - a. If you select an inpatient option, additional data fields will appear to capture the inpatient details
4. Enter details regarding the event including the **History of Present Illness** which gives the dialogue of what happened
5. Click **Save & Close**

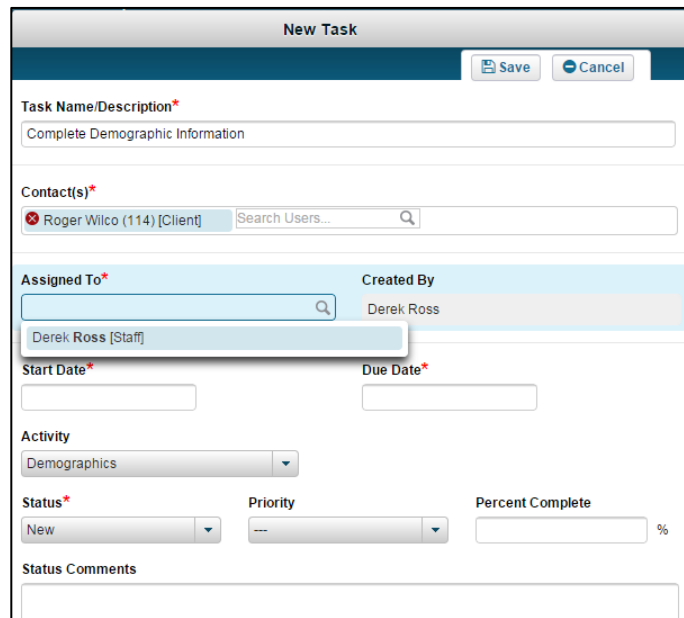


Tasks

Tasks are an optional feature and can be added as a reminder for you to track a task that needs to be completed. You can create a task from any tab in the member' chart. You can view all tasks on your homepage, or view tasks per client in the Facesheet tab of the client's chart or by clicking on Tasks on the top of the screen when in a client's chart.

Creating a Task

1. Click on **Facesheet** tab
2. Click on **+New Task**
3. Add **Task Name/Description**
4. Add any **contacts** or **clients** that are involved with the task
5. If you are assigning this task to another individual type their name in the **Assigned To** field
6. Set a **Start Date** and a **Due Date**
7. Select **Activity** category
8. Select **Status** and **Priority**
9. Click **Save**



Ending a Task

1. Open the task you wish to end by selecting the **“gear”** icon associated with the task and select **Edit**

Due Date	Task	Contact(s)	Activity	Status	Assigned To	Created By	Creation Source	Actions
07/30/2015	test	Eun Barksdale (2669), Derek Ross	Appointments	New	Derek Ross	Kristy Talbot	Direct Entry	
07/31/2015	hgkjh	Eun Barksdale (2669)		New	Kristy Talbot	Kristy Talbot	Direct Entry	

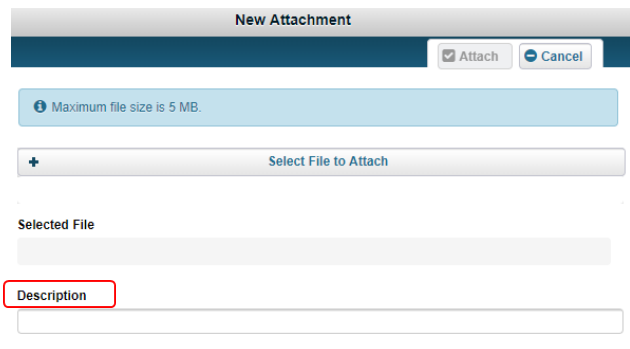
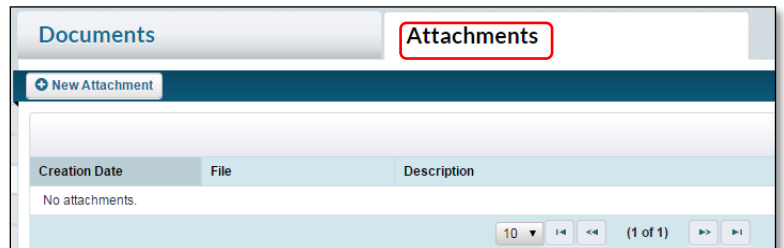
2. Change the **Status** to **“Completed”** or **“Dismissed”**
3. Click **Save**

File Attachment

You will need to attach files to a client's chart under the documents tab. Please keep in mind that anything added to this area is a part of the chart and should be treated as such. You should never delete an attachment unless there is a PHI issue (for example: a member's consent was uploaded into another member's chart). In the event you ever delete an attachment you must document an error resolution contact note explaining the deletion.

Files that you are required to attach include but are not limited to: signed Care Plans, all Consents and diagnosis verification documentation. Refer to CHHUNY's Attachment Description document for a list of required uploads when applicable to your members.

1. Navigate to the **Documents** tab in the member's chart
2. Click on the **Attachment** tab at the top of the screen
3. Click **+New Attachment**
4. Click **Select File to Attach** and search for the appropriate file
5. Please refer to the **Attachment Description** guidance document for instruction on what **Description** to use
6. Click **Attach**



You can click the **“view”** button next to an upload to view that document on your computer. Note that the document will download on your computer and should be treated as PHI

Sub-status in Netsmart

Updating Status to Diligent Search or Excluded Setting Sub-status

At any time during a member's enrollment segment they may go into an excluded setting or have a disruption in their continuity of care leading to the member being placed into diligent search efforts. When members become disengaged and are either lost to service or are in an excluded setting, the Care Manager should be following policy and placing the member into either the Diligent Search or Excluded Setting sub-statuses. This is done by updating the Status section of a contact note. Either instance results in a member having to enter into a sub-status in Netsmart CareManager. In some instances, the member may also be automatically placed into a pended status in the Medicaid Analytics Performance Portal (MAPP). A CMA is able to bill for a member in pended status when it is due to being in DSE.

Continuity of Care: Diligent Search Efforts

If a Care Manager loses contact with a member during active enrollment, they are considered to have a disruption in the continuity of their care and the Care Manager must start Diligent Search Efforts (DSE) by placing the member into the DSE sub-status. CHHUNY recommends that you wait until the first day of the month following when a member is determined to have a disruption in continuity of care to place the member into DSE.

For example, if a member is determined to be eligible for DSE on 3/19/18, the Care Management Agency should put them into DSE on 4/1/18 in case the member is found during the remainder of the month of March.

During DSE, the Care Manager must follow policy regarding time frames for DSE and level of effort required to reengage the member into services.

The Care Manager must place the member into a Diligent Search status in Netsmart CareManager by completing a Contact Note and selecting the Diligent Search Status. The member may remain in DSE for up to 3 months. At any time during the 3-month period allotted for DSE, the CMA may disenroll the member if attempts to locate are likely to be unsuccessful by following the Disenrollment policy. If the member remains in DSE for the full 3 months, they will **automatically be disenrolled from the Netsmart CareManager and in MAPP at the end of the 3 month period**. Even in instances when a member is automatically disenrolled from Netsmart CareManager, the CMA is responsible for following all requirements outlined in the Disenrollment policy.

Process

1. Member is identified as having a gap in their continuity of care (lost to services)
2. CMA will follow “[Updating a Member’s Status](#)” guidance by completing a contact note and placing the member into the Diligent Search status. The member will show as being pended in MAPP while in DSE.
3. CMA will follow Continuity of Care Policy
4. CMA will complete an HML or CBQ for each month of DSE
 - a. Select “Yes” to Core Service if CMA met the level of effort requirements for DSE per Continuity of Care Policy

If member is found in an Excluded Setting during DSE follow Excluded Setting Rules below

If member is found during DSE and is ready and eligible to re-engage in active care management services:

- CMA will follow “[Updating a Member’s Status](#)” guidance by completing a contact note and placing the member into the Enrolled status
- CMA will follow “[Resuming Active Care Management](#)” guidance

If member is not found after the allotted time frame for DSE:

- The member will automatically be **disenrolled from Netsmart CareManager and MAPP**

Continuity of Care: Continued Search

When the allotted time period according to policy for Diligent Search Efforts has passed and the member is not located, they will automatically be disenrolled from the Health Home program. Continued Search process has ceased as of March 4, 2019.

Excluded Setting

There may be times during a member's enrollment period when they enter into an excluded setting. A member may be found to be in an excluded setting while:

1. In active enrollment, meaning the Care Manager is actively working with the member when they are identified as needing to enter into an excluded setting
OR
2. In diligent search efforts, meaning the Care Manager was conducting efforts to locate a member which resulted in finding the member in an excluded setting

In both instances, if a Care Manager is informed that the member will be in the excluded setting for *less than six months*, the Care Manager must place the member into an Excluded Setting sub-status in Netsmart CareManager by completing a Contact Note and selecting the Excluded Settings status. *Putting a member into an Excluded Setting sub-status will pend the member in MAPP and billing will not be allowed.*

An Excluded Setting is defined as a facility or placement where:

- Care coordination/management is part of the responsibility of the setting and therefore Health Home Care Management would be a duplication of services
- Medicaid funding is utilized in the setting for specific coordination of and/or linking the member to services
- The setting can be a long-term facility, placements, hospitals, institutions, etc. therefore are not aligned with Health Home Care Management which is community based

Process

If member is found to be in an Excluded Setting and will be discharged or released within 6 months:

- CMA will follow the Continuity of Care or Disenrollment Policy
- CMA will complete an CBQ/HML for any months identified as billable in accordance with policy
- CMA will follow "[Updating a Member's Status](#)" guidance by completing a contact note and placing the member into the Excluded Setting status during the first month they are unable to bill
- Member will automatically be pended in MAPP
- During the month of discharge from a facility (or 30 days prior is the CMA intends to assist with release/discharge planning from a facility other than incarceration) the CMA will follow "[Updating a Member's Status](#)" guidance by completing a contact note and placing a member into the Enrolled status before documenting efforts or the CMA will be unable to bill. This will automatically end the member's pended status in MAPP.

If member is found to be in an Excluded Setting and will NOT be discharged or released within 6 months:

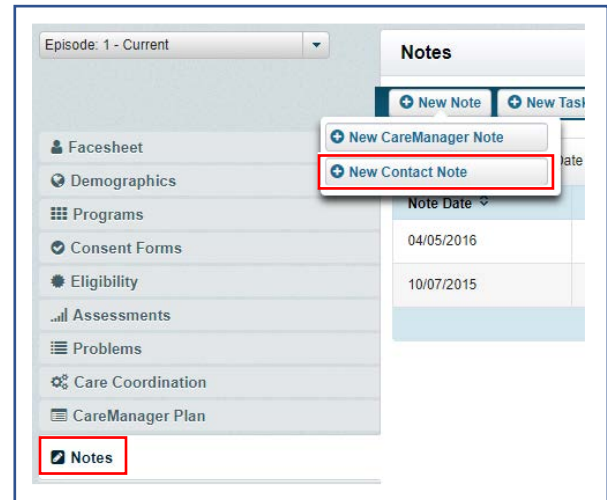
- CMA will follow the Continuity of Care and/or Disenrollment Policy

If member is being discharged from Excluded Setting and will be ready and eligible to re-engage in active care management services:

- CMA will follow "[Updating a Member's Status](#)" guidance by completing a contact note and placing the member into the Enrolled status during the month of discharge or no more than 30 days prior to their discharge date if the member is in an excluded setting other than incarceration and intends to assist with discharge planning
- CMA will follow "[Resuming Active Care Management](#)" guidance

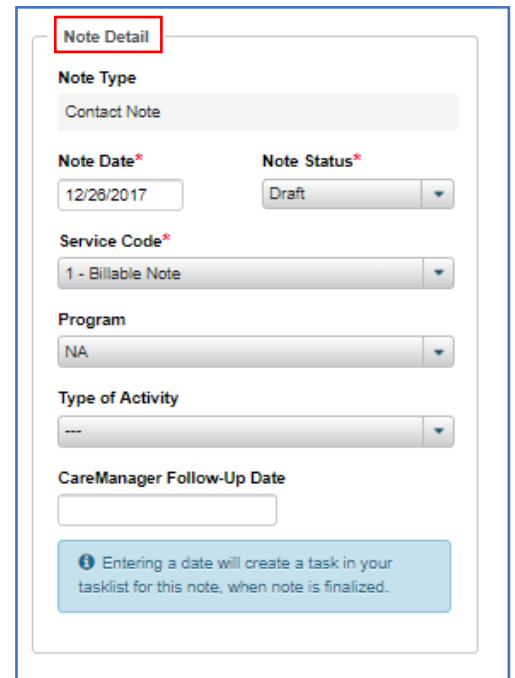
Updating a Member's Status

1. Navigate to the note section of the client's chart
2. Click **+New Note** and then click **New Contact Note**
This will open up your Contact Note template
3. Complete the following fields:



Note Detail

- a) **Note Type:** This will prepopulate to contain the type of note you are completing
- b) **Note Date:** auto-populates to the date the note is finalized in the system
- c) **Note Status:** Keep your note as draft until you have completed all sections. Once you review your note, mark as final.
- d) **Service Code:** Select either **Billable or Non-Billable Note** dependent upon if you provided active and progressive care management services. If you are placing the member into an excluded setting via this note, you will be UNABLE to bill for the month even if you select Billable. When placing a member into an excluded setting, do so during the first month you are unable to or do not intend to bill.
- e) **Program:** This field is no longer required. You should select **NA**
- f) **Type of Activity:** Select the core service provided in the activity/encounter being documented. If you are completing a **Non-Billable** note, select "No Core Service Provided". If you are completing a **Billable** note, select the core services that best captures the work documented.
- g) **CareManager Follow-Up Date:** Optional field for a Care Manager to enter a date for follow-up

A screenshot of the 'Note Detail' form. The 'Note Type' is 'Contact Note'. The 'Note Date' is 12/26/2017 and the 'Note Status' is Draft. The 'Service Code' is 1 - Billable Note, the 'Program' is NA, and the 'Type of Activity' is ---. There is a 'CareManager Follow-Up Date' field. A blue box at the bottom contains a message: 'Entering a date will create a task in your tasklist for this note, when note is finalized.'

Contact Detail

1. **Contact Date:** The date that the member’s sub-status started should start. If you are placing the member into an excluded setting via this note, you will be UNABLE to bill for the month the Contact Date falls in. When placing a member into an excluded setting, do so during the first month you are unable to or do not intend to bill.
2. **Contact Duration:** Document the number of minutes the activity/encounter took you to perform.
3. **Contact Type:** Select the type that best described the activity performed. You can distinguish between activities that occur with the client or with the collateral. Select “Other” if you are documenting a non-billable note that is only intended to enter a member into a status
4. **Location:** The location where the Care Manager is at when the activity was performed. Select “Other” if you are documenting a non-billable note that is only intended to enter a member into a status
5. **Primary Reason for Contact:**
Select “Excluded Setting” if you are updating the member’s status after being found in or admitted into an Excluded Setting.

The screenshot shows a form titled "Contact Detail" with the following fields:

- Contact Date***: 12/28/2017
- Contact Duration***: minutes
- Contact Type***: ---
- Location***: ---
- Primary Reason for Contact***: ---
- Other Reason for Contact**: (empty text box)
- Contact Status**: ---

Primary Reason for Contact*

Excluded Setting

Select “Diligent Search Efforts” if the member is entering into a Pended status after becoming lost to care and the Care Manager will be starting diligent search efforts to reengage the member.

Primary Reason for Contact*

Diligent Search Efforts

Select “Assessment and Plan of Care” if the member is resuming active care management after being in a DSE or Excluded Setting status

Primary Reason for Contact*

Assessments and Plan of ...

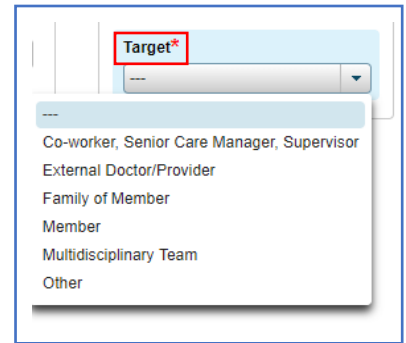
6. **Contact Status:** This refers to whether or not a dialogue was achieved with the **Target** of your encounter. Select Contact Achieve if you were able to dialogue with your target and select no if you were unable to dialogue with your target.

4. Participants

- a) You are not required to fill out the participants section.

5. Target

- a) The individual you intended to dialogue with during the encounter is considered your Target.

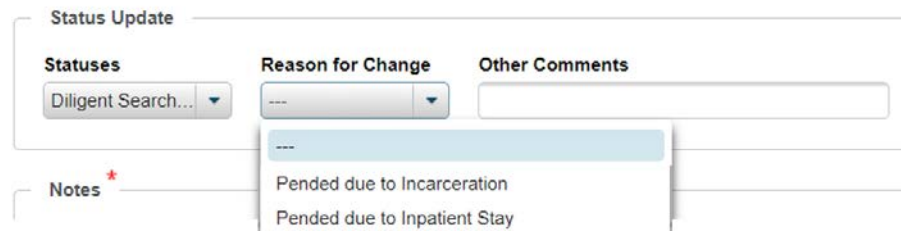


6. Status Update

The status of a member will change based on which status you select under “Statuses”

If the note being entered into the system is not being utilized to update a status change, then leave the Status Update field blank.

To select a status change:

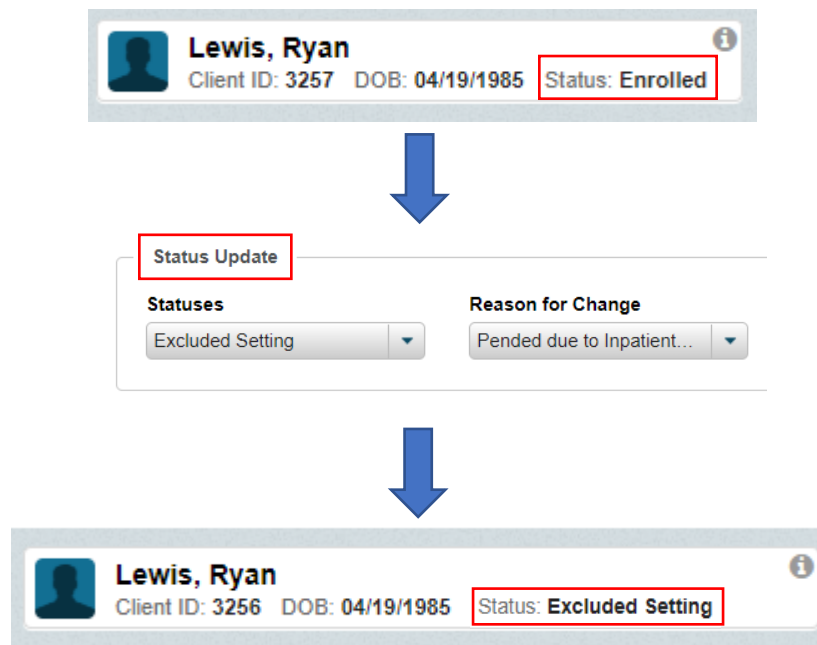


- a) **Statuses:** Select the status option that reflects the reason the member is going into the selected status
 - a. **Diligent Search Efforts:** Select if the member has been deemed lost to services and will be entering into DSE
 - b. **Excluded Setting:** Select if the member is going into an Excluded Setting regardless of if it was from DSE or active care management
 - c. **Enrolled:** Select if the member is going back into active care management. You will only see this option if the member has a current status of Excluded Setting or Diligent Search Efforts
- b) **Reason for Change:**
 - a. **Pended due to Incarceration:** Select if the member is entering into the status Excluded Setting because they have been incarcerated for 6 months or less
 - b. **Pended due to Excluded Setting:** Select if the member is entering into the status Excluded Setting because they are inpatient for 6 months or less
 - c. **DSE:** Select if the member is entering into the status Diligent Search Efforts
 - d. **Enrolled:** Select if the member is entering into the status Enrolled and is resuming active care management

7. Notes

Document the note that identifies what occurred during the encounter or why the note is being completed. Billable notes must contain enough detail to support that the encounter was active, progressive and met a core service.

Upon completion of your note, you must mark it as **Final** then **Save and Close**. You will see the member's status change to the status you selected within your note.



*A change in the member's **Status** in Netsmart CareManager will automatically create a record of the change that will be sent to MAPP within 24 hours of the status change.*

Resuming Active Care Management

When a member is placed back into enrolled status and resumes active care management, the Care Management Agency is responsible and expected to complete the following within 30 days of resuming active care management unless otherwise stated:

Consents

1. Ensure all Consents are up to date and completed correctly
 - a. Add or remove care team members and supports as needed
 - b. Ensure that the consentor (person who signed the consent) is still accurate if the individual is a minor
 - c. Complete new consents as necessary

Eligibility Criteria

1. Review eligibility criteria and ensure that it is still applicable to the member and confirms their continued eligibility
 - a. If the member is no longer eligible for or willing to engage in the Health Home program, they should not have been placed back into an Enrolled status but they should instead be disenrolled from the program. If you accidentally enrolled a member who is no longer eligible or willing to engage in the program, contact the CHHUNY Helpdesk for direction on next steps
 - b. CHHUNY: complete an eligibility review contact note
 - c. If eligibility has changed, document the change in a contact note and recomplete an eligibility screening as required

Comprehensive Assessment

1. If the most recent comprehensive assessment for the member was completed within the last year:
 - a. Ensure the most recent comprehensive assessment or reassessment is available in the chart
 - b. Complete an assessment update form within 5 business days of resuming active care management to capture any change(s) that caused or occurred during the pended status
2. If the most recent comprehensive assessment or reassessment for the member was NOT completed within the last year:
 - a. Complete a new assessment within the first 60 days of resuming active care management

Crisis Plan, Safety and Crisis Plan and/or Emergency Plan

1. If the most recent Crisis Plan, Safety and Crisis Plan and/or Emergency Plan for the member was completed within the last six months:
 - a. Review the plan(s) with the member and/or consentor
 - b. If there are any changes that need to be made, complete a new plan(s) in the system.
 - c. If there are NOT any changes necessary, ensure a note is completed that supports that you reviewed the plan with the member and/or consentor
 - d. Complete plan(s) in the system with the member and/or consentor at their 6-month due date (calculate from the previous plan)
2. If the most recent Crisis Plan, Safety and Crisis and/or Emergency Plan for the member was NOT completed within the last six months:
 - a. Complete a new plan(s) in the system

CANS-NY

You must complete a CANS-NY reassessment within 30 days of resuming active care management if any of the following situations are true for your member regardless of when the previous CANS-NY was completed:

1. Significant change in child's functioning (includes increase or decrease of symptoms or new diagnosis)
2. Service plan or treatment goals were achieved
3. Child admitted, discharged or transferred from hospital/detox, residential placement, or foster care
4. Child has been seriously injured or in a serious accident
5. Child's (primary or identified) caregiver is different than on the previous CANS
6. Significant change in caregiver's capacity/situation
7. Court request

If none of the above reasons for completion of a CANS-NY reassessment apply:

1. If the CANS-NY is over 6 months old
 - a. Complete a CANS-NY and select "CANS-NY Reassessment at 6 months" option within 30 days of resuming active care management
2. If the CANS-NY is less than 6 months old
 - a. Ensure the most recent CANS-NY assessment uploads are available in the chart
 - i. Plan of Care Guidance Report
 - ii. CANS Assessment Results
3. If a CANS-NY has never been completed
 - a. Complete a CANS-NY assessment within 30 days of resuming active care management

Care Coordination

1. Update existing problems in the system including status and severity. Add any new problems the members needs assistance with that have developed since the member was last actively engaged in Care Management. New problems should be supported by the assessment update form or newly completed assessment.
2. Review the data sharing consent with the member and/or consentor, update as necessary and upload into the member's chart
3. Add new providers and supports into the system on your Care Coordination Page as required

Care Plan

1. Create a new plan of care based off the more recent assessment, and assessment update form if applicable, and previous plan of care within 60 days of resuming active care management

Other

1. Update Demographics Page including Demographic Survey
2. Update Program Types for any programs the member is CURRENTLY in (HARP Enrolled, HARP Eligible, HH+)
3. Update Social Supports
4. Resume completion of HML/CBQ monthly
5. Complete a Hallmark Event related to the event that caused a gap in their enrollment as applicable

Programs

There may be a time when you'll need to add a program type for a member. Currently, the only program type should be applied to children/youth who transferred to Health Home Care Management as a result of the 1915c waiver transition. This program type is applied as a way to identify those records as their charts will look different than other members' charts as a result of the transition.

To add a program type:

1. Click on the **programs** tab
2. click on **+New Program**
3. Select the **Program** type from the drop-down box
4. **Start date** should reflect the date this program became effective for this member
5. **End date** should be entered once this program is no longer in effect for this member

Program Details

Program*	Organization
<input type="text" value="---"/>	<input type="text" value="CHHUNY"/>
Start Date*	End Date
<input type="text"/>	<input type="text"/>

+ Program History

Editing Notes

Users with Supervisor security role access are able to edit the following fields in a finalized Client Search, Contact or CareManager note:

Contact Duration, Contact Status, Contact Type, Program, Service Code, Type of Activity

Selections made in all fields of the note are to be supported by the narrative in the note detail section.

If you need to void a note, you must submit a ticket to the CHHUNY help desk.

Please see the CHHUNY Helpdesk Manual for more guidance.

APPENDIX A—REQUIRED TRACKING FOR NYS CHILDREN’S HEALTH HOME: QUALITY MEASURES

Measure	Netsmart Documentation
Annual Dental Visit	Must be addressed within an objective/intervention(s) on the member’s care plan.
Preventive Pediatric Healthcare Visits (Ages 0-21)	Must be addressed within an objective/intervention(s) on the member’s care plan.
Care Manager Follow-up After ED/Hospitalization for Psychiatric Reasons	Refer to CHHUNY’s Transitions of Care Policy for further guidance on documentation requirements
Care Manager Follow-up After ED/Hospitalization linked to qualifying chronic medical conditions	Refer to CHHUNY’s Transitions of Care Policy for further guidance on documentation requirements

American Academy of Pediatrics Well-Child Care Visit Schedule

2-5 days old
1 month old
2 months old
4 months old
6 months old
9 months old
12 months old
15 months old
18 months old
24 months old
30 months old
3 years old
4 years old
5 years old
6 years old
7 years old
8 years old
9 years old
10 years old
11 years old
12 years old
13 years old
14 years old
15 years old
16 years old
17 years old
18 years old
19 years old
20 years old
21 years old

Source: <https://www.healthychildren.org/English/family-life/health-management/Pages/Well-Child-Care-A-Check-Up-for-Success.aspx>

APPENDIX B – CHILDREN’S BILLING QUESTIONNAIRE

Children’s Billing Questionnaire: Once a client is enrolled, a Children’s Billing Questionnaire (CBQ) must be completed on a monthly basis whether or not a billable service is completed for the client. If the member is discharged during the month, you should still be completing the CBQ for the month. The selections made on the previous month’s CBQ will carry over to the next month’s CBQ – ensure you update as appropriate for the month you’re reporting. These should be finalized at the end of the month to ensure it accurately reflects the member’s status for that month.

- **Assessment Date-** the date will prepopulate by Netsmart starting with the first month of enrollment. In order to reduce the number of errors or missed months, Netsmart will not allow you to change the date or skips months during the enrollment segment. Once a CBQ is completed for a month, as long as the member is still enrolled (or was enrolled at any time during a month), Netsmart will allow you to generate another CBQ and the date will populate with the subsequent month ongoing.
- **Entered by & Finalized by** – will prepopulate based on who enters and finalizes the CBQ in the system
- **Assessment Status** – leave in draft until you ensure the questionnaire is accurately completed. Once you mark the status as final, you will be unable to edit the questionnaire. Please contact the CHHUNY help desk if a questionnaire was finalized but contains error(s).
- **Primary Diagnosis-** auto-populates from the Problem flagged as “primary” in the problem list. You can click on the “Set Current Primary Diagnosis” button to confirm you have the most up to date primary diagnosis listed if you changed for some reason.
- **“Reminder: HAVE YOU CHECKED EPACES TO CONFIRM MEMBER ELIGIBILITY?”** This is just a friendly reminder to consistently check for Medicaid Eligibility. If we submit a billing instance through MAPP, they will deny the claim until Medicaid is reinstated (if Medicaid is inactive). Please refer to CHHUNY Eligibility Policy and Member Medicaid Eligibility & Status guidance document
- **Question #1:** Indicate if the child has been in Foster Care at any time during the month of service in which you are documenting a billing instance for
- **Question #2:** Indicate the date of the most recent completed CANS-NY for this member. If you haven’t completed the CANS-NY yet, you can select “Not yet completed” – you can bill at Low acuity the first two months of enrollment without a CANS-NY being completed. Please refer to CHHUNY’s CANS-NY policy for more detail.
 - If the CANS-NY is complete, select completed and enter the most recent completed date. The document will automatically set the reassessment date to the last day the CMA can bill off the current CANS-NY without completing a reassessment. For example, a CANS-NY is completed 4/24. April is considered month 1, and the Reassessment at six months is due by 9/30/19.
 - This field does not need to be updated on subsequent CBQs until a new CANS-NY is completed (the data will feed to the next month and so on).
- **Question #3:** Identify the member’s acuity level. If during the initial enrollment phase (first two months of enrollment), you do not have a CANS-NY completed, select Low
 - Once a CANS-NY is completed, indicate the current acuity level based on the CANS-NY output (you can find this in MAPP)
 - You only need to update this field if you have completed an updated CANS-NY that month and the acuity level has changed

- If you select **Low** and indicate Yes to question 3a.- the system will confirm a billable Contact Note or billable CareManager Note is finalized with a contact date for that month of service. If this has not been documented, it will not allow you to finalize the CBQ
- If you select **Medium or High** and indicate Yes to question 3a.- you must ensure that you have documented two billable Contact/ CareManager Notes which are:
 - Marked as final
 - Contact dates fall within the month of service
 - At least one note identifies Contact Type as “Client In-Person” and Contact Status is “Contact Achieved”.
- If you did not provide the necessary core services that month per acuity, select NO to question 3a. And the month will be considered non-billable.
- **If a CANS-NY indicates a Child/Youth as being a Medium or High Acuity, but you do not meet the requirements listed above for billing for Medium or High, you MUST SELECT NO TO QUESTION 3a. You cannot bill at “LOW” acuity if you don’t meet Med/high acuity standards!**
- If the member has a plan of care over 365 days old, you cannot bill and must indicate “no” to core service provided until the plan of care is updated in the system. Please review Plan of Care Policy for more details.
- **Question #4:** Identify the qualifying chronic conditions- you can select more than one option and this only needs to be completed on the first CBQ you submit for the member’s enrollment segment. No need to update on subsequent CBQs unless there is a change in the member’s qualifying conditions as indicated on an eligibility screen.
 - “Children’s HCBS Only” is selected for children determined eligible for HH because they are deemed eligible for HCBS. “HCBS and Other Conditions” is for those you’ve confirmed meet HH criteria and eligibility for HCBS
 - If you select “HCBS and Other Conditions” or “One or more DD conditions” you will also indicate another condition(s) the member has that meets eligibility criteria in the dropdown box
 - SMI/SED should only be selected if the member meets the Health Home single qualifying condition of SED for the children’s program (SMI is used in the adult health home program). Ensure you review CHHUNY’s Eligibility policy for more guidance on this criterion.
 - Mental Health should only be selected when the member does not meet the Health Home single qualifying condition of SED, however the member is Health Home eligible by meeting two (2) chronic conditions of one or more mental health diagnoses or other eligible chronic conditions.
 - If you select “Other” a text box will appear for you to indicate the condition that doesn’t fall under the other categories
- You must check the final box indicating you have reviewed the information and attest it is accurate for that month of service
- Finalize, Save & Close → A Billing Instance will be generated on the Billing Support Upload File for HHUNY to Submit to MAPP

APPENDIX C – UPDATING A PRIMARY PROBLEM

A problem flagged as “**primary**” in Netsmart CareManager must be a condition the member has that meets Health Home (HH) eligibility criteria. In the event a problem flagged as primary is incorrect (either the diagnostic code is incorrect, or the diagnosis changes per a licensed professional for example), the CMA will need to update the member’s chart to reflect the correct primary problem. This guidance document will walk you through how to complete this in Netsmart CareManager. Note that this guidance can be used to update statuses for non-primary problems as well.

Step 1: Identify if the primary problem is linked to an objective on the care plan.

You can do this by reviewing the most recently finalized plan of care and/or reviewing “linked objectives” in the problem entry

- If the problem **is** linked to a/n objective(s) on the current care plan, discontinue the objectives and interventions. To do this:
 - a. Navigate to the Notes tab and select **+New CareManager note**
 - b. Within the note, change the **status** of each intervention under the applicable objective(s) to completed or discontinued as appropriate and indicate a reason in the intervention update box. For additional instructions on completing notes, please refer to the Netsmart CareManager user manual.

The screenshot shows a user interface for an objective. At the top, it says 'Objective' and 'objective 1'. Below that, there are three main fields: 'Intervention*' with the value 'intervention 1', 'Status*' with a dropdown menu currently showing 'Discontinued', and 'Target Date*' with the value '03/28/2019'. Below these fields is a progress indicator for 'How engaged has the client been with this task?' ranging from 'Not Engaged' to 'Very Engaged'. At the bottom, there is a section titled 'Intervention Updates' which contains a large text input area with the placeholder text 'Write update...'. A red box highlights the 'Status' dropdown and the 'Intervention Updates' text area.

- If the problem **is not** linked to a/n objective(s) on the current care plan, continue to Step 2

Step 2: Update the problem status

In the problems tab, update the **status** of the appropriate problem to indicate:

- “CM Assistance not needed”

The screenshot shows a dropdown menu for the 'Status*' field. The current selected status is 'CM assistance not needed'. The dropdown list includes the following options: '---', 'CM assistance not needed' (highlighted with a red box), 'Requests CM Assistance', 'Declines CM Assistance', and 'Deferred'.

If this problem entry already reflects this status, continue to step 3

Step 3: End active referrals to that problem

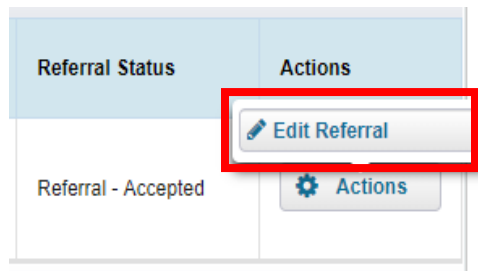
You can see if the problem has an active referral by opening up the problem entry and reviewing the information found under “linked referrals”. You can also navigate to the Care Coordination page, scroll down to the Referred Problems section and review if the problem has an active referral to a provider.

- An active referral is when there is a referral start date but no end date.

Referred Problems		
● Referred To: Kim Jones Consent Status: Active		
Problem	Referral Start Date	Referral End Date
Bipolar disorder, unspecified	02/15/2019	

If there is not an active referral to the problem, continue to step 4

- To end a referral: click on the **Actions** button and select **Edit Referral**



- Change the **Referral Status** to “Referral-Rescinded”

Referred Provider*	Kim Jones
Organization	Therapeutic Times
Consent Status	Active
Referral Status*	Referral - Rescinded
Start Date*	---
End Date*	Not Referred
Comments	Referral - Accepted
	Referral - Denied
	Referral - Pending
	Referral - Rescinded

- Select an **End Date**, then click **Save**

Referral Status* Referral - Rescinded

Start Date* 02/15/2019

End Date*

Comments

Services Provided

Description of Service

Frequency of Service

Duration of Services Provided 45 minutes

Step 4: Add a new primary problem entry in the problem list

If you do not need to add a new problem in the problem list, proceed to step 5.

- Navigate to the problems tab, click on **+New problem**
- Fill in every required field. For more details on how to enter in a problem, please refer to the “entering problems” manual or the Netsmart CareManager user manual.

Please note: When entering a Primary Problem or updating a current problem to be the Primary Problem, the Care Manager will be required to select an ICD 10 code that relates to the diagnosis being entered. Search for the diagnosis using the DSM or ICD code system options (as applicable). Problem status should reflect care team assistance is requested. For additional information on how to add problems into Netsmart please refer to the APPENDIX C.

Updated on --/-- by

Problem Details

Code System* ICD 10

Problem*

Primary? Yes No

Date Recorded*

Chronicity

Onset

Severity*

Status*

Record Origin Direct Entry

- To indicate this diagnosis is the primary problem, select the “Yes” radial under the “Primary?” heading. Confirm you are choosing to set this diagnosis as the primary problem in the system.

Problem
[F41.9] Anxiety disorder, unspecified

Date Recorded*
02/19/2019

Primary?
 Yes No

Onset
3- Adult

Record Origin
Direct Entry

Confirm Primary Problem

Yes No

⚠ Another problem is already set as the primary problem, do you wish to proceed with making this problem primary?

- If not already in the chart, scan the supporting documentation for the primary problem into the attachments section of the member’s chart by navigating to Attachments, selecting **+New Attachment** and uploading the qualifying proof. Follow the issued attachment description naming convention

Documents Attachments

[+ New Attachment](#)

✓ Attachment 'Supporting Docs.docx' added.

Creation Date	File	Description
02/19/2019 11:06 AM EST	Supporting Docs.docx	Qualifying Conditions

Step 5: Flag another problem entry as “primary”

If this was already done during step 4, continue to step 6.

- Navigate to the problems tab, select the “View” button next to the entry you wish to flag as “primary”

Filter by All

Search Problems...

Date Identified	Problem	Problem Type	Onset	Status	Record Origin	Primary	Actions
03/12/2019	Bipolar I disorder, current or most recent episode manic, with psychotic features	Behavioral Health	3- Adult	Controlled or Resolved; No assistance needed	Direct Entry	Yes	View
03/09/2017	Unspecified anxiety disorder	Behavioral Health	3- Adult	Uncontrolled; requests Care Team assistance	Direct Entry	No	View

- Select Edit, and then select the “Yes” radial under the “Primary?” heading. Confirm you are choosing to set this diagnosis as the primary problem in the system

Created on 02/19/2019 10:42 AM
Updated on 02/19/2019 10:56 AM

Problem
[F41.9] Anxiety disorder, unspecified

Date Recorded*
02/19/2019

Primary?
 Yes No

Onset
3- Adult

Record Origin
Direct Entry

Confirm Primary Problem

Yes No

⚠ Another problem is already set as the primary problem, do you wish to proceed with making this problem primary?

Step 6: Complete a new Eligibility Screen (if applicable)

Complete a new Eligibility Screen if the new primary problem is not reflected in the current eligibility screen. If a new eligibility screen is not required, proceed to step 7.

- For example: a member's eligibility screen correctly identifies their qualifying conditions are asthma and type 2 diabetes. When the diabetes diagnosis was entered in as the primary problem, it was incorrectly entered in as gestational diabetes mellitus. Care Manager goes through the process for updating the primary problem to the type 2 diabetes diagnosis. A new eligibility screen is **not** required. If the member's diagnosis changed from type 2 diabetes to another diagnosis, then you would need to complete a new eligibility screen in addition to the steps outlined in this document.

Step 7: Complete an error resolution contact note

Create an error resolution contact note to explain the change made to the primary problem.

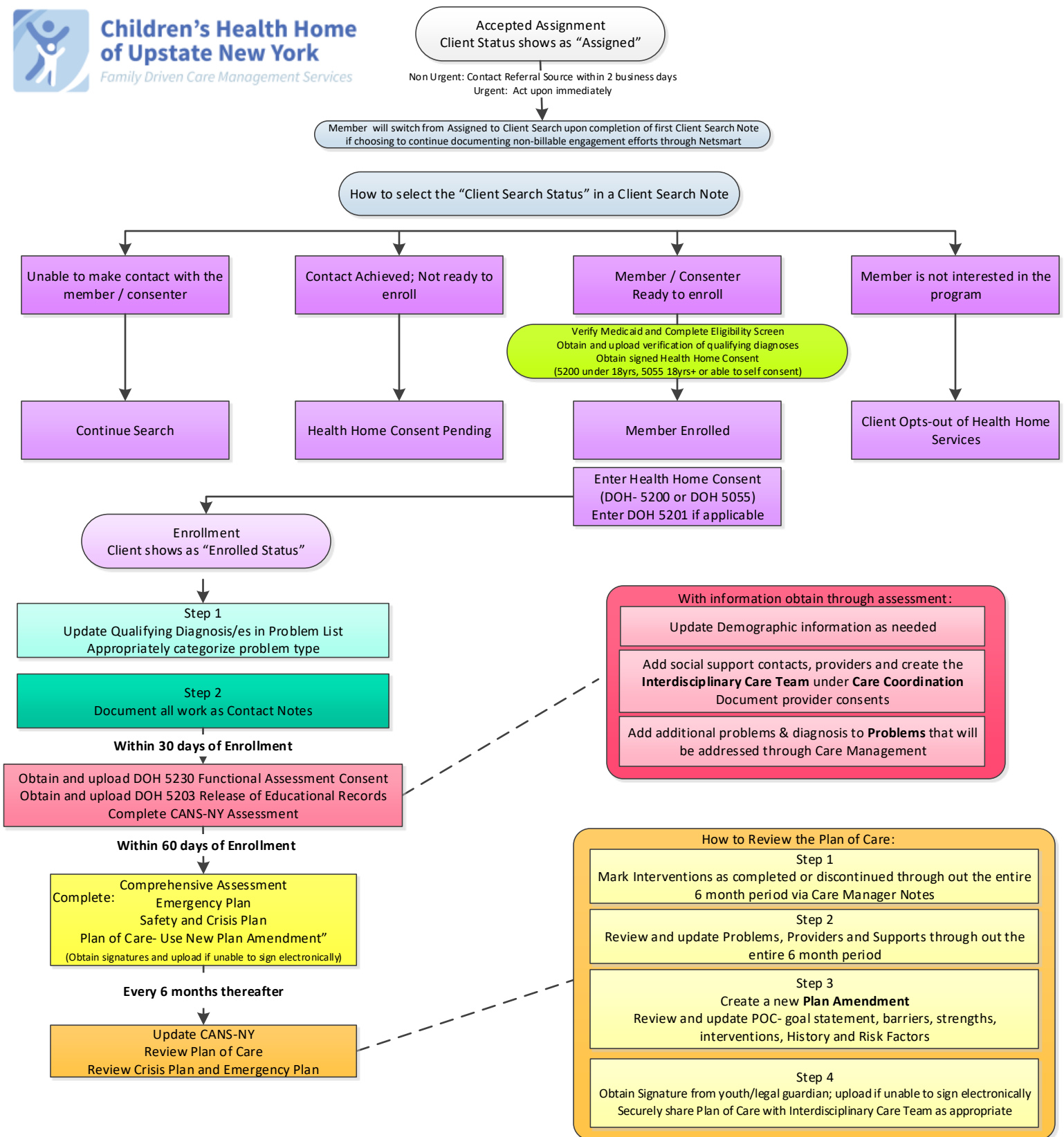
- Navigate to the notes tab and select **+New contact note** containing details about the change in primary problem. For additional support on completing an error resolution note please refer to the Netsmart CareManager User Manual

Additional Items to Review:

- On future Billing Questionnaires ("HML" for AHH , "CBQ" for CHH), ensure you have the current primary problem indicated prior to finalizing the questionnaire. Click on the **"Set Current Primary Diagnosis"** button on the questionnaire to refresh
- Refer provider(s) to the updated primary problem on the Care Coordination page
- Amend the plan of care to address the condition per member/family's preferences
- If you have any questions about your previous billing, please reach out to the billing team.

APPENDIX D: NOTE GRID

Note Type			
	CLIENT SEARCH NOTE	CAREMANAGER NOTE	CONTACT NOTE
OUTREACH	All outreach efforts should be documented as a Client Search Note	N/A	Only use for Error Resolution
ENROLLMENT Prior to Completion of Plan of Care	N/A Note no longer available during enrollment	N/A	All documentation will be captured in contact notes until a plan of care is created (first 60 days following enrollment) If a member went directly into enrollment, document the outreach efforts as a Contact Note (select "Non-Billable" as Service Code and "Other" as Primary Reason for Contact)
ENROLLMENT After Completion of Plan of Care	N/A Note no longer available during enrollment	Any service aligning with an intervention, whether it is billable or non-billable, needs to be documented under that specific intervention	<p>Only use for the following reasons:</p> <ul style="list-style-type: none"> Assessment and Plan of Care (ex: working on and completing assessments, working on and completing plan of care amendments) Transitions of Care (ex: conducting discharge planning activities like engaging with member (and family when appropriate) to assess understanding of discharge plan, confirming follow up appointments have been scheduled) Diligent Search Efforts (ex: attempting face-to-face visit at the last known address, successful phone contact with care and service providers, etc.) Case Review (ex: efforts to schedule and conduct a case review, results/findings from a case review and sharing with members from care team) Immediate Needs/Crisis Intervention (ex: connecting member with a food cupboard, using the member's safety & crisis plan in the event of a crisis) Error Resolution (chart errors)=Non-billable Minor Protected Services = work that is done towards the completion of the minor/adolescent plan of care form; work that is done related to the objective(s) and intervention(s) identified on the minor/adolescent plan of care form Disenrollment: used to summarize/document disenrollment efforts Excluded Settings - use when you're entering a member into Excluded Setting sub-status Other- should only be used if prompted by HHUNY or for documenting outreach efforts for a member that moved directly into Enrollment and never had an Outreach segment
<p>SEGMENT</p> <p>Additional Guidance for Enrollment Post-Plan of Care Note selection:</p> <ul style="list-style-type: none"> If you are addressing an immediate need and/or crisis intervention during another service that applies to an active intervention, you do not need to document two notes, you can just document in the CareManager Note. Remember that the activities would need to occur on the same day in order to be in the same note! If not, document multiple notes. If you are completing work on an assessment or plan of care during another service that applies to an active intervention, you do not need to document two notes, you can just document in the CareManager Note. Remember that the activities would need to occur on the same day in order to be in the same note! If not, document multiple notes. If a Transitions of Care applies to an active intervention and you want to document the work under that intervention, you do not need to also document a Contact Note but in the CareManager note in which you are addressing the Transition of Care under an intervention, you must select "Type of Activity= Transition of Care" on that CareManager Note. If you are documenting a case review and work on an assessment/plan of care that occurred on the same day, use case review as the primary reason of contact Diligent Search Efforts, and Case Review details all must be documented as Contact Notes only. 			



REMINDERS

- Complete a **Note** for every Core Service that is provided during the month once enrolled.
- Complete the **Children's Billing Questionnaire (CBQ)** for every **Enrolled** client with or without a billable service
- Add in **Hallmark Events** as required
- After the client/legal guardian manually sign any documents, scan and attach to the system initially and any time there are any changes; do not delete old versions
- Complete quarterly **Eligibility Review**
- Complete **Assessment Update Form** for significant events as required

APPENDIX F: HCBS/LOC Documentation CHHUNY Guidance Document:

HCBS/LOC Documentation in Netsmart CareManager

Background

Children served by CHHUNY are to be appropriately identified and assessed for Home and Community Based Services (HCBS) which will offer support and services to children in non-institutionalized settings that enable them to remain at home and in the community. The eligibility assessment for HCBS is completed in the Uniform Assessment System (UAS), however there are requirements to be completed in Netsmart CareManager to indicate its completion and the child/youth's status of receiving HCBS.

Purpose

This document was created to provide guidance on how and when to use the following features in Netsmart CareManager:

- General Assessment
- Program Types*: Children's Waiver/HCBS & Children's Waiver/Waitlist
- HCBS/LOC Documentation Primary Reason for Contact in Contact Notes

Every HCBS LOC Determination/Redetermination Assessment completed in UAS will need to be documented in the General Assessment area in order to develop annual due date reports for CMs to utilize. The program types will indicate the length in which a child is placed on the DOH Waiver waitlist and/or actively participating in the Waiver program by documenting begin and end dates.

*Note: for children who transitioned from waiver to HH January-April 2019, you will need to ensure you have the "1915c Waiver Transfer" program type documented in those member's charts in addition to the Children's Waiver/HCBS. The 1915c Waiver Transfer program will never be ended in the chart.

General Assessment

The General Assessment is used to track the completion of the HCBS/LOC Determination and Redetermination outcomes so we can develop reports. Every LOC assessment completed needs to be documented in the GA section of the chart.

1. Click on the **Assessments** tab in the member's chart
2. Click on **+New Assessment**
3. Click on **+General Assessment**
4. **Assessment Date:** indicate the date the HCBS Eligibility/LOC was finalized. This date will be used for reporting in Tableau to indicate when the next assessment is due annually. This date needs to align with the UAS LOC finalization date.
5. **Assessment Type:** select the appropriate outcome from the assessment:
 - a. HCBS LOC Eligible – Accepted Services
 - b. HCBS LOC Eligible – Declined Services
 - c. HCBS LOC – Ineligible
 - d. HCBS LOC Redetermination- Eligible & Continuing Services
 - e. HCBS LOC Redetermination- Eligible but Discontinuing Services
 - f. HCBS LOC Redetermination- Ineligible
6. **Score:** there is no "score" on the assessment, but this is a required field so please enter a placeholder of "N/A"

CHHUNY Guidance Document:

HCBS/LOC Documentation in Netsmart CareManager

- Comments:** complete any comment if desired

Program Type: Children's Waiver/HCBS

This program type is to be used when a child is active in a waiver program, even if not yet receiving HCBS due to capacity issues.

- Click on the Programs tab in the member's chart
- Click on **+New Program**
- Select "**Children's Waiver/HCBS**" from the program drop down box
- Organization will automatically populate
- Start date:** should reflect the date the child/youth was approved for HCBS by DOH Capacity Management.
- End date:** leave blank. You would populate an end date if the member is no longer participating in the Children's Waiver and receiving HCBS.

Program Type: Children's Waiver/Waitlist

This program type is to be used when a child has been determined eligible for Waiver/HCBS but has been placed on the DOH Waitlist to receive Waiver services. DOH Capacity Management will notify the CM that the child has been placed on the waitlist after the LOC is finalized if there are no available slots remaining.

- Click on the Programs tab in the member's chart
- Click on **+New Program**
- Select "**Children's Waiver/Waitlist**" from the program drop down box
- Organization will automatically populate

CHHUNY Guidance Document:

HCBS/LOC Documentation in Netsmart CareManager

5. **Start date:** should reflect the date the child/youth was put on the waitlist by DOH Capacity Management.
6. **End date:** leave blank. You would populate an end date once the member is no longer on the DOH Waiver Waitlist.

– Program Details

Program* Children's Waiver/Waitlist	Organization CHHUNY
Start Date* <input type="text"/>	End Date <input type="text"/>

+ Program History

- a. If the child is being removed from the waitlist due to an available slot, the Children's Waiver/HCBS Program type should be added to the chart following the instructions above.

If a member declines a LOC assessment/reassessment for HCBS

This should be documented within note(s) in the member's chart. If declining the reassessment leads to them no longer receiving HCBS or no longer being on the waitlist, follow the steps above for ending any applicable program types.

Documenting the work being done related to HCBS/LOC process

There are a few ways to document the work being done related to HCBS/LOC process:

- Any time a CM needs to document something related to the HCBS/LOC process in the Netsmart chart, contact note(s) can be document with the primary reason for contact being "HCBS/LOC Documentation".
- If the HH Plan of Care already has HCBS identified and the note would be more appropriate to be documented under HCBS objective/intervention, the work can be documented in a CareManager note with the activity documented under the appropriate intervention(s)

Primary Reason for Contact*

HCBS/LOC Documentation