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# General Introduction to AGP Platform

This manual is a guide on how to access and use the following web-based Amerigroup (AGP) system applications for Blue Plus SecureBlue (MSHO) and MSC+ members:

- CareCompass
- Member360

Each system will be reviewed in more detail throughout the manual. CareCompass and Member360 will require the user to be logged onto the Citrix Receiver. These systems will be used to: track and enter assessments, document contact notes, make referrals and reminders through queues and tasks, view assignments, enter and view service agreements, view and update member demographic information and more. As a reminder, Care Coordination Delegates should continue to refer to the Care Coordination Guidelines for Care Coordination responsibilities and timeline requirements.
AGP General Access information:
Each Delegate will be responsible for providing Blue Plus a monthly update of active system users at their agency (process will be included on AGP’s IT job aid coming soon). Active users must access the systems at least once in a 90-day period to avoid being deactivated. It is our expectation that each user will log onto Citrix to access CareCompass and Member360 daily to check for member notifications. Note that in CareCompass individual landing home pages will appear different depending on one’s access level. For example; managers and designated support staff will be able to view delegate queues (i.e. BCBS - Delegate Reassignment Queue) and the full delegate membership. Care Coordinators will only have access to their individual queues and assigned members.

Access Request:
Each user that requires access to any of the AGP system(s) must have their own unique US Domain ID/Username. The Care Coordination Delegate Manager/Supervisor must complete and return the AGP User Access form to request a US Domain ID/Username for each individual in their agency that requires access to the AGP platform.

Exception: Access request for existing users during the initial implementation of the AGP platform will be obtained from BCBS and Bridgeview. No action is necessary for users that currently have access to Bridgeview.

Access Termination:
When an individual user no longer requires access to the AGP system platform, it is important that the Delegate Agency report this information to AGP immediately (process will be included on AGP’s IT job aid coming soon). The Delegate Agency must complete and return the AGP User Access Form identifying the individual user and the access termination effective date AGP access is to be terminated.

AGP Systems Introduction:
The AGP platform consists of multiple systems; Care Coordination delegates will use the following 3 web-based systems to complete their work:

**CareCompass:** System that houses member demographics, resources and multiple data entry points (i.e. Health Risk Assessment, Plan of Care, Case Notes, managing enrollment and assigning Care Coordinators, etc.). CareCompass provides notifications for service agreement(s) and prior authorization(s) that have been updated, changed and completed.

**Member360:** A separate, linked system. This system is an easy to use, read only system. It allows the user to efficiently access a variety of individual health information and authorization(s). This system updates on a nightly basis.
Interactive Care Reviewer (ICR): An interactive web-based program accessed through Availity. This system requires a separate sign on and username/user ID and password. Delegates will decide how they would like to access this system as an agency. This system will be used to enter service agreement(s) and authorization(s). Providers will access this portal to obtain authorizations. Refer to the ICR Training Materials.

Acronyms and Definitions

AGP: Amerigroup

FACETS: Claims system (This system will not be accessed by CC)

MACESS: Document repository (This system will not be accessed by CC)

Learning Management System: Online training module for CareCompass and Member 360

Member in Focus: A member’s record pulled up to view in CareCompass.

Queue: A method in CareCompass that is used for communication between the Care Coordinator/Delegate and AGP and from AGP to the Care Coordinator/Delegate. (I.e. used as a to do list/referral system)

Logging into Citrix

Instruction on how to log into Citrix is posted on the Care Coordination portal under the Amerigroup tab.

CareCompass

Logging in to CareCompass

1. You will first log into the Anthem Citrix Receiver using your Username (which is your Amerigroup AF number), password and pin+RSA token code.
2. Then click on the CareCompass Icon to enter the CareCompass application.

3. Users can use Google Chrome or Internet Explorer to open CareCompass.

4. You will see Clinical CareAdvance, but you are in the CareCompass application.

Logging out of CareCompass

Always close CareCompass using the Logout button in the upper right-hand corner. This method will prompt you to release any unlocked cases you worked on.
Navigational Tips

Tooltips
If you hover your mouse over an icon, the name of that icon will appear

Filters
Search filters are available in many areas of CareCompass to help you find members, cases, or assessments. Depending on the area, you can add or remove your columns, search by a specific category, or change the order of the results. The image below shows different filter options.

Filters:
1. Type the search criteria into the appropriate field
2. Click the filter icon to the right of the field
3. Choose the search parameter (contains, equal to, not equal to)
4. The search results will display

NOTES:
- Click CLEAR FILTERS after each search. User errors (inability to locate information, etc.) often result from a failure to clear filters.
- Click on a column header to sort the data by ascending or descending order
Home Page of CareCompass

When you first sign on to CareCompass, no member will be in focus. Some of the options available under Menu will be grayed out until you have a member in focus.

**Assignments and Tasks**: This contains hyperlinks to Patients, CM, Tasks, Q-UM, Q-tasks. Please see Assignments and Tasks section below for more information.

**Communications**: Care Coordinators will not use this area.

**Today**: Care Coordinators will not use this area

**New Messages**: This table should be viewed daily. Communications from Blue Plus internal teams such as Utilization Management and Case Management will be located here. The messages will include all recent notifications, hospitalizations, authorizations completed. To view them fully you can look in Member 360 under Communication.
**Menu**: Includes My Work Assignments and Standard tools. At any time after you have pulled a member into focus and you want to go back to the home page you can do so by clicking on the Home Key in the upper right-hand corner (shown below).

![Home Key](image)

**Notifications from Blue Cross**

Notifications will be displayed in the New Messages area. The messages will include all recent notifications, hospitalizations, authorizations completed. To view them fully you can look in Member 360 under Communication.

![Notification Example](image)

- When you click on a New Message, more details will be displayed. See example below.

![Notification Example](image)
Bringing a member into focus

To view or work on a member’s file in CareCompass, you must bring a member into focus.

- After logging into CareCompass this window will appear:

![Window with My Work Assignments and Patients sections circled]

The two areas circled above are ways to bring your member into focus:

- Click on My Work Assignments
- Then click on the member you want to bring into focus

OR

- Click on Patients under Assignments and Tasks
- Then click on the member you want to bring into focus

When you bring a member into focus, their information will display in the ribbon at the top of the screen and will include basic member demographics and eligibility information.
Verifying Enrollment
All members must be actively enrolled with Blue Plus before a Care Coordinator can authorize services and provide care coordination.

- Once the member is in focus, view the ribbon to locate the enrollment date.
- The second row in the ribbon (circled area in screenshot below) displays whether a member is enrolled and active.

In the example below, the member is active with no specific term date (the date 12/31/2199 signifies open ended enrollment.) If a member is termed or has a future term date, it will display in this section with the specific term date.

Member Dashboard
The member dashboard is a summary of the member’s record and is where member’s information can be verified.

The most effective way to use the dashboard is to open it in a separate window, which aids navigation and use. To open the floating dashboard, click on the icon to the right of the member’s name (in the summary banner at the top of the window)

Some of the categories found in the Member Dashboard area include:

- **Demographics**: Basic member information
- **Summary**: A snapshot of all the categories and how much information is available for view within each category
- **Additional Information**: Health Plan information, date of last assessment, eligibility
- **Active Coverages**: Health Plan information
- **Medications**: Care Coordinators may view the member’s medications here
- **Conditions**: A list of conditions that are reported through claims
- **Recent Assessments**: A list of assessments completed with the member
- **Assignments**: View history of care coordinators or other Blue Plus case managers (disease management, behavioral health)
- **Personal Contacts**: List of important contacts, this must be manually entered by the Care Coordinator
**Treating Providers:** Member’s PCP can be found here

![Member Dashboard](image)

**Address Book**
You will frequently view and use the Address Book in CareCompass. The address book will automatically populate member information that is provided from the enrollment files from DHS. The Care Coordinator can only update the address field by sending in updates to AGP using the Demographic Change Template. The Care Coordinator cannot edit a member’s address directly in the CareCompass system.

To access the address book:

1. Bring a member into focus
2. Click the Member Information (Under Standard Tools)
3. Select Address Book from the menu options
Adding a Contact in the Address Book

Delegates will need to add a new contact to the Address Book for the following reasons:

- When receiving a new member- Adding the Care Coordinator contact:
  - Care Coordinators will need to add their name and phone number in the address book under “Other” contact. This allows internal teams to reach out to the assigned Care Coordinator. (Include “CC” or “Care Coordinator” in the name as best practice.) See receiving a new case in CareCompass

AND

- When a member is not the primary contact, you will add a new contact for the member’s guardian or caregiver.

To add a Contact in the Address Book:

1. Click Create New Contact
2. Fill in appropriate information following the prompts below.
3. Choose Other from the drop-down list
4. Enter details and hit **Save**

![Contact Details](image)

**NOTE**: It is also possible to edit or delete an existing contact.

**Changing Member Demographics (this section coming soon)**

**Member Cases & Tasks**

You should check the Member Cases & Tasks area daily for requests or reminders regarding member cases. Access this area from the Home Page or Frequently Used Tools menu.

**Frequently Used Tools tasks menu view:**
Assignments and Tasks view:

Displayed here is the view after logging into CareCompass from your Home Page. You can click on “Tasks” and go directly to a full list of your assigned tasks.

Shown here is a list of all tasks assigned to a member. Completed tasks or tasks not due yet will display as black. When an assigned task is past due, it will show as red. You can filter the tasks to show those which are incomplete only for a clean view.

You have the option to create a reminder “task” within CareCompass. Reminders can be created for various follow-up tasks related to a member’s care such as:

1. Re-assessments
2. Semi-annual contact
3. Follow up post-hospitalization
4. Needs identified during member contact (scheduling of appointments, rides, obtaining medical equipment or supplies, completion of a Health Care Directive, care conference reminders, etc.)

Add a reminder related to a member in Member Cases & Tasks. Begin this procedure with a member in focus:

1. Click Member Cases & Tasks
2. Click the Tasks tab
3. Click Add Task
4. Complete the fields in the Add Task area.
5. Click Save

NOTE: To add a reminder unrelated to a member, begin this procedure without a member in focus. To return to the homepage, users must click the house icon in the upper right-hand corner.

Add a Task during your Assessment

During an Assessment, you can add a Task related to the member. Examples of a task could be:

- a reminder to obtain requested supplies and equipment
- follow up on a bill the member showed you during the visit
- reminder to assist with scheduling of an appointment

You can assign yourself a task about anything you may need to be reminded about during your assessment with the member.

The task will automatically be associated with the member if the member is in focus.

1. Click on Add Task
2. Enter the information

Add Task

3. Select the number of days or a day and time when you want to be alerted of the task.
4. Assign the Task to yourself or another User
5. Tasks can be shared among any CareCompass user
6. Select the Urgency Level: urgent, high, medium or low
7. Add a note if desired
8. Click Save

Marking a Task Complete

9. Click on the relevant task in the list. The selected item will become highlighted
10. Choose Mark Complete

Result: the task will disappear from your list by selecting the applicable filters. It is recommended to keep the “incomplete” filter applied to show only tasks due.
Managing my work assignments

“My Work Assignments” are members assigned to you as a Care Coordinator.

Start each day by checking My Work Assignments for newly-assigned members and to review existing cases.

1. Click My Work Assignments (Under Frequently Used Tools)

2. The Patients tab provides a list of all members assigned to you.

3. Members highlighted in bold are newly assigned members to you.
4. Members not bolded are members you have been following ongoing.

Managing Delegate and Care Coordinator Assignments

Care Coordinator Assignment (Managers only)
Managers and/or supervisors at each Delegate agency have the ability to assign members to Care Coordinators within their agency.

Each member can only have one primary case manager (Care Coordinator) in CareCompass. Delegates are required to assign all members to a Care Coordinator.
After logging into CareCompass:

1. Click on My Work Assignments (Frequently Used Tools menu)
2. Click Manage Queue Assignments and the delegate assignment queue will display on the left-hand side of the screen
3. Select the queue to make assignments from.
4. If the queue is not visible, under Select Any User/Queue, search for the desired queue.

**NOTE**: Each Delegate Agency will have their own assigned queue by name of the Agency
5. A list of members assigned to the Delegate agency will appear as shown here:
6. Click on the member to bring the member into focus.
7. Click on Care Management (under Standard Tools) and choose **Assignments**

8. At the top of the Assignments area, click **Add**

9. Enter your name making sure the ‘Users’ box is checked
10. Click the **Search** button
11. Select the Care Coordinator’s name from the Search Result dialog box

![Search Result Dialog Box](image1.png)

12. Click the **ROLE** button

13. Choose ‘Case Manager’.

![Select Role Dialog Box](image2.png)

14. Choose ‘Set as Primary’.

![Add Assignment Dialog Box](image3.png)

15. Click the **SELECT** button, followed by **SAVE**.
Deleting Members from the Delegate queue (Managers only)

1. After assigning a member to a Care Coordinator, you must delete the member from your Delegate enrollment queue:
2. Click on Manage Queue Assignments from the Assignments and Tasks Window
3. Click on the Patients tab
4. Click in the member to bring the member to be deleted out of the queue in focus
5. Click on Care Management and then click on Assignments
6. Select the queue you want the member to be deleted from. Then click the Delete button

Reporting Enrollment Discrepancies

If a member has been determined by the Delegate to be assigned to them incorrectly, the member can be re-routed to the Blue Plus enrollment team for review and re-assignment through the BCBS-Delegate ReAssignment Queue.

If a member has been determined by the Delegate to be assigned to them incorrectly, the member can be re-routed to the Blue Plus enrollment team for review and re-assignment through the BCBS-Delegate ReAssignment Queue.

1. Go to My Work Assignments (under Frequently Used Tools) and then select the member name you want to reassign to bring that member info focus.
2. Once in focus, choose Member Cases and Tasks then choose the Tasks tab and choose to Add Task.
When in the task entry box, user should:

3. In the subject field, type “Delegate Misassignment”
4. Choose In “1 days”
5. Select “Urgent”
6. There is currently no template to select.
7. In the notes, please provide one of the following reasons:
   - Incorrect PCC
   - Incorrect Address/County of Residence (COR)
   - Incorrect Living Arrangement
   - Termed but should be active
   - Transfer Issue
   - Other reason
   - Termed
   - Member deceased
   - Termed in MN-ITS
   - Changed health plans
   - Moved out of service area/state
8. Explain the enrollment issue (similar to the information you would have previously sent the secureblue.enrollment@bluecrossmn.com email box in the past.
9. Select User and click the search icon.
A SEARCH FOR USER OR QUEUE box will appear as shown below:

10. Enter BCBS in the Search For Name field
11. Check only the Queues box
12. Select BCBS – Delegate ReAssignment Queue and click Continue
13. Click Save in the Add Task box to finalize and send the task to the enrollment team.

NOTE: All discrepancies and errors need to be reported by the 15th of the month or the assigned Delegate is responsible to complete all care coordination tasks prior to transferring to the correct Delegate the 1st of the following month, unless previously discussed. See the Care Coordination Guidelines on the Care Coordination website for complete details.

IMPORTANT: After sending the notification through the Delegate ReAssignment Queue process, the new Care Coordinator must assign themselves as the ‘primary’ Case Manager (Care Coordinator) and leave the previous Care Coordinator assigned as “secondary” which will happen automatically. This will allow the previous Care Coordinator access to the member’s case to complete any unfinished tasks up to 60 days after the transfer.

Reports (this section coming soon)
Opening a Newly Enrolled Member to Care Coordination

Care Coordinators must “Open a Case” for all newly enrolled members.

1. Find the member in CareCompass and “bring into focus”.
2. Click on suitcase icon or Cases in the top toolbar (either one)

3. Click on **New Case** and select Care Management in the dropdown.

4. A new Screen will Pop Up

5. Enter values into the following fields:
   - Case Name: must be BCBS Care Coordination
   - Reason: Non-triage
   - Case Acuity: Low
   - Case Phase: “Active” for an enrolled member

6. Click **Continue**
7. Click **Save**
Transfers in Care Coordination Delegation

See Care Coordination Guidelines for details, policies, and tasks associated with transfers in Care Coordination.

Once the Delegate has confirmed a transfer in Care Coordination is appropriate, the Delegate will need to:

- Follow all processes indicated in the Transfers section of both community and nursing home Care Coordination Guidelines posted on the Care Coordination website.
- Initiate the Member Demographic Change form process as outlined in the Care Coordination guidelines.
- Complete the BCBSMN Transfer Notes progress note template (as shown below). This is replacing the 6.08 Transfer in Care Coordination Delegation form.
- See Creating a Progress Note section of this manual if needed.
Example of the BCBSMN Transfer Notes progress note template:

Closing a Case
When a member terms from Blue Plus the Care Coordinator should follow the process below to close the case in CareCompass.

1. Bring the member into focus in CareCompass.
2. Click Cases (under Frequently Used Tools), and then select the appropriate case from the resulting list.
3. Click the Case Options drop-down list and select Edit (if not already in edit mode).
4. Click the Case and Description tab under Case Properties.
5. Click the Close Case button at the bottom of the Case Properties area.
6. Complete the Change Case Status sub-menu:
   - Select a Case Closure Reason from the Reason drop-down list. For example, select Disenrolled or Death.
   - Leave the Notes field blank.
   - Select the checkbox next to the question Do you want to remove the assignment for this member?
   - Do NOT select the checkbox next to the question Do you want to create a follow up task?
   - Do NOT select the option to create a Satisfactory Survey Assessment.
7. Click **Confirm**

8. If the member has any open service agreements/authorizations, refer to the ICR Training materials regarding closing service agreements or authorizations.

**Assessments and Plans of Care**

**NOTE:** The care plans (MN Collaborative Plan of Care, MN My Care Plan-telephonic, and MN My ICF-DD and HCBS Waiver Care Plan) are also listed with the other assessments in the Assessment area of CareCompass

The following, step-by-step directions, will show you how to complete an assessment and care plan. Before you start an assessment or care plan, make sure the member is in focus.

1. Click the Assessments icon on the Quick Tools bar or Care Management, then click **Assessment**
2. Use the filters to find the assessment you want to perform. Assessment can be searched by the STATUS (In Progress, Complete, or Never Taken) or by NAME.

### Assessments

<table>
<thead>
<tr>
<th>STATUS</th>
<th>CATEGORY</th>
<th>NAME</th>
</tr>
</thead>
<tbody>
<tr>
<td>In Progress</td>
<td></td>
<td>MN</td>
</tr>
</tbody>
</table>

3. Search for the Minnesota specific assessments and care plans by entering MN in the Name column and under the drop down select **Contains**.

The MN Assessments and care plans are:

- AGP MN My Health Risk Assessment Care Plan
- MN Collaborative Plan of Care
- MN LTCC Services Assessment
- MN ICFDD and HCBS Waiver HRA and Care Plan Supplement
- MN PCA Assessment Service Plan (3244)
- MN NH Member Annual Assessment
- MN Transitional Health Risk Assessment
- MN Supplemental Waiver PCA Assessment Service Plan (3428D)

4. Click the row that contains the name of the assessment/care plan you want to use. The area at the bottom of the window populates with the questions in that assessment.
5. Scroll through the questions if you are not certain that the assessment you selected is the one you want to use
6. Click the Take Assessment button
7. Document the member’s responses and click the Continue button at the end of each section of an assessment
8. If errors are identified during the completion of the assessment, an error message will appear before the user can continue.

![Message from webpage]

CareCompass will notify the user how far along they are in completing the assessment. Be sure that the assessment is 100% completed before finishing the assessment.

![5% Completed]

9. When you come to the end of the assessment, hit Continue.
10. For assessments only, complete a BCBSMN Assessment Complete Contact Note.
11. Print the care plan for member signature. Once signed, upload a copy of the signature page to a BCBSMN Contact Note. Be sure to change your subject line to “CCP Signature Page”.
12. If you later noted that you did not complete every field or noted an error, you may use the Retake function to update the current assessment or care plan.

**NOTE:** While conducting an assessment, you may view other sections of CareCompass, such as the Conditions List, Procedures List, Allergy List, Medication List, or the Address Book. Add the item to the list, if applicable (e.g. a new medication, a specialist’s contact information), and click Continue Assessment. In Medication List you may enter medications the member is taking in the Medication List. You can also change the filters to add or remove specific information being stored on the medication list. Or, if you prefer, you can upload a list of medications in the Assessment Complete Contact Note template.
• You can also add a task for yourself or a progress note while administering the assessment.

![AGP MN My Health Risk Assessment Care Pan](image)

• The buttons are at the top of each assessment area. After you finish a task or note, click the Continue Assessment button to return to the health assessment.

• Assessments and the Plan of Care are saved automatically when the user leaves CareCompass or moved to another section of CareCompass.

• To resume, the user should select the assessment, per the instructions above. Click **Resume**. Clicking resume will start the assessment on the page that the user left the assessment.

• Clicking **Restart** will also resume the assessment but will start the assessment from the beginning.

![Resume Restart](image)

Transitional Health Risk Assessments (Community and Nursing Facility)

**Community**

For members who have had a Health Risk Assessment (includes LTCC, MnCHOICES, 3428H) completed within 365 days of enrollment the Care Coordinator should complete a Transitional HRA. This includes product changes.

1. Following the steps 1 through 9 outlined above with the member in focus, choose and complete MN Transitional Health Risk Assessment
2. Enter a BCBSMN – Assessment Complete Contact Note. In the drop-down option select Transitional HRA.
3. Upload a copy of the previous assessment and care plan into this note, if assessment and care plan is not already entered into CareCompass.
4. Review Care Coordination guidelines section Transitional Health Risk Assessment for all requirements to be completed in the transitional HRA process.
**Nursing Facility**

Follow this process for a nursing facility member who has a product change.

1. With the member in focus select the most recent NH Member Assessment.
2. Click on Re-take and complete the Transitional Health Risk Assessment portion of the NH assessment.
3. To finish the assessment, and have it stored as a completed assessment, the user must select Complete.
4. Enter a BCBSMN – Assessment Complete Contact Note. In the drop-down option select Transitional HRA.

**Finding a question in the assessment or care plan**

1. Click the Double arrows on Find a Question on the left side of the assessment area
2. Type the keywords of a question in the Find a Question field. As you type, questions containing that keyword will display.
3. Choose the question you wish to answer. The question and answer choices will display in the dialog box.
4. Choose the answer
5. Click **Save**

Search for another question or click the double arrow to close the dialog box and return to the main assessment screen. When you reach the question you answered in the main assessment screen, the answer you choose will display.
Skip to a page in an Assessment or Care Plan

CareCompass allows users to skip to different pages of the assessment or Care Plan to make changes and edits during the assessment.

**NOTE:** When the skip function is used and the page is complete, the system will take the user back to the area where they were last located.

1. Scroll through the list of categories to find the questions you want to answer.
2. Click to display and answer the questions in that category
3. Click continue. You will return to the last question you were on before you skipped.

**NOTE:** you must click **Continue** after you complete all the questions on a page. Do not skip to another page until after you return to the last question you answered before you skipped. Otherwise, you may miss a mandatory question.

Plan of Care Updates

Required goal progress and outcome documentation and any updates to the plan of care can be entered anytime throughout the year using the Re-take function.

1. With the member in focus select the most recent care plan.
2. Click on **Re-take** and enter your updates to the care plan including goal progress and outcome notes.
3. To finish the care plan, and have it stored as a completed care plan, the user must select Complete.

Annual Assessments, Re-Assessments, Annual Plans of Care

Once an assessment or plan of care is complete, it can be re-taken with all fields populated with the answers from the previous year. All answers are editable, so that the new assessment, or plan of care, can be completed. To complete an annual assessment or annual plan of care, you must select the assessment or plan of care and select **Retake Assessment**.

All assessments and care plans must be completed in order to be printed and provided to the member.
Signatures on Assessments and Care Plans

**Care Coordinator signatures on Assessments**

The Care Coordinator can sign the assessment by typing their name and UMPI number.

**Member and Care Coordinator signature on Care Plan**

After the member and care coordinator signs, a copy of the signature page must be uploaded to a Contact Note. Be sure to change the subject line to “CCP Signature Page”.

**Provider Signature Requirements**

**Optional**: Copies of the provider signature letters may be uploaded to a BCBSMN Contact Note. Be sure to change the subject line to: Provider Signatures. Keep copies of the letter in the member file if you choose not to upload them to CareCompass.

For the entire process refer to the process outlined in the Care Coordination guidelines for Community members and Instructions for the Collaborative Care Plan.

**Accessing Past Assessments & Care Plans**

The steps below provide direction to access a member’s completed health risk assessment or Care Plan

1. Click the Assessment icon on the Quick Tools Bar
2. Use the filters to find and select the assessment you may want to review.
3. Click the View History button. You can’t see this button unless you highlight an assessment that is in progress or has been completed.
4. Click View Comparison Data to review all the results at once and compare them, if the assessment has been taken more than once.

**NOTE:** Remember to click CLEAR FILTERS after you finish your search.

**Progress Notes**

In Progress Notes you will be able to document contact notes and complete/print some forms using built-in templates. Below is a list of templates that are built into the system.

- BCBSMN – Assessment Complete Contact Note
- BCBSMN – Contact Note
- BCBSMN – Historical Assessment Contact Note
- BCBSMN – Refusal of Assessment Contact Note
- BCBSMN – Unable to Reach Assessment Contact Note
- BCBSMN Semi-annual Visit Contact Note
- BCBSMN Transfer Notes
- MN Notification of Care Transition
- MN Transitions of Care Log

**NOTE:** You must use the correct note template for a particular activity. Below we will discuss when to use each template.

Contact notes include an optional field to record the time required to complete the activity in 15-minute increments. Each delegate can determine if they want to use this feature to track their care coordination time.

**BCBSMN Assessment Complete Contact Note (Required)**

The Assessment Complete Contact note must be completed when the member’s initial and annual reassessment is completed. This template is required because it contains reportable information. Information from this template will replace the HRA data that you previously entered into Bridgeview.
BCBSMN Contact Note (Optional)

This optional freeform contact note template is available to document your contacts. You can track your time spent in the template in 15-minute increments. You may change the Subject Line if needed before saving. Never use this general free form contact note for activities associated with the required templated contact notes on this list.

<table>
<thead>
<tr>
<th>BCBSMN Contact Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Date:</td>
</tr>
<tr>
<td>* Notes:</td>
</tr>
<tr>
<td>* Time required to complete the activity (in 15 minute increments)</td>
</tr>
</tbody>
</table>

BCBSMN – Historical Assessment Contact Note

This is an area where the previous 3 years of HRA dates were imported from Bridgeview. This is for historical use only and users should not use this template.

BCBSMN Refusal of Assessment Contact note (Required)

The Refusal of Assessment Contact note is used to document when the member refuses to complete an initial or annual re-assessment. This template is required because it contains reportable information. Information from this template will replace the HRA data that you previously entered into Bridgeview.

<table>
<thead>
<tr>
<th>BCBSMN Refusal of Assessment Contact Note</th>
</tr>
</thead>
<tbody>
<tr>
<td>* Date Assessment was Refused: 7/15/2018</td>
</tr>
<tr>
<td>* Assessment Type: Initial Health Risk Assessment</td>
</tr>
<tr>
<td>Notes: XXXX</td>
</tr>
<tr>
<td>Time Required to complete the Activity: 15</td>
</tr>
</tbody>
</table>

BCBSMN – Unable to Reach Assessment Note (Required)

The Unable to Reach Assessment note is used to document the required three attempts to contact the member for assessment. It is completed during the final attempt to contact and at the time the unable-to-contact letter is sent. This template is required because it contains reportable information. Information from this template will replace the unable to reach information that you previously entered into Bridgeview.
**NOTE:** Each Delegate can determine how to enter the time spent completing the unable-to-reach activities. A general contact note template can be used to document each individual outreach attempt. However, each Delegate must assure that they do not duplicate billing if you are tracking your time spent. For example, they may enter the total amount of time on this template. Or, enter it on each of the general contact notes on the date of each contact attempt. Just be sure not to duplicate billing.

**BCBSMN Semi-Annual Visit Contact Note (Optional)**

Care Coordinators can document their semi-annual contact using this optional template.
BCBSMN Transfer Notes

Once the Delegate has confirmed a transfer in Care Coordination is appropriate, the Delegate will need to complete this template. This information will be visible for the next Care Coordinator to review.

MN Notification of Care Transitions

Complete and print this optional fax form to notify the physician of a transition of care.

MN Transitions of Care Log

Optional form to document transitions of care.

NOTE: You can only do one transition per log with this template. You may document each transition separately as you are notified of transitions. Or, you may wait to complete this template when member returns to the usual care setting and then document all the activities at one time. Or, continue to use the 6.22 Transitions of Care Log Word document located on the care coordination portal and upload it into a Contact Note in CareCompass or save in their delegate member record.

Procedure

The following describes the general procedure for starting a contact note template and/or completing one of the available forms.

NOTE: You must bring a member into focus to start this procedure. See Bringing a member into focus.

1. Bring a member into focus
2. Click on the Progress Notes icon in the Quick Tools area (Menu tab)

3. Click Add Progress Note. A new blank Progress Note displays

4. Click the magnifying glass icon beside the Select Template field

5. The Select Template dialog box appears

6. Select the appropriate template from one of the sub-menus. The sub-menu AGP LTSS MN Forms has the templates/forms used in Minnesota

7. Complete the required fields on the template

8. Click Save.

**NOTE:** You cannot edit a note/template once saved.

You may print forms/contact notes within CareCompass. You cannot print just one contact note. You can do an advanced filter or filter to one day. Then you can print that day.

1. Click on All Entries at the bottom of the page.
2. Select Advanced Filter.
3. Enter the dates span you wish to print and click on **Apply**.

4. Under More Options select **Print**
5. Click Open

6. A PDF of your notes will appear and then you can print.

Making a Referral to Case Management

If a member requires Complex Case Management for complex medical conditions, the member can be referred through the BCBS – Referral to Complex Case Mgt queue (previously known as making a Medical Management Referral). For detailed information regarding the referral process, refer to the Care Coordination Guidelines.

1. Click My Work Assignments (under Frequently Used Tools), and then select the name of the member you want to refer. This will bring the member into focus.

2. While the member is in focus (member’s name and eligibility banner will appear at the top of your screen), you will select the Tasks tab:

3. Click Add Task. A new blank task note displays.
4. In the subject line, the user should indicate the reason for the task: Referral to CM
5. If the member is in focus, the box “Associate with member: XXXX” will be automatically checked.
6. Select In ___ Days (Enter the number of days this task is due)

7. Select “User”, leave the text field blank and select the search icon:

8. In the Search For Name field, type BCBS:

9. In Search in Option Deselect the check box for Users (only the Queues box should be checked):
10. Then select **SEARCH**:

![SEARCH FOR USER OR QUEUE](image1)

11. Click on the BCBS- Referral to Complex Case Mgt Queue and select **Continue**:

![SEARCH FOR USER OR QUEUE](image2)

12. Select the appropriate urgency level for referral:

![Urgency Levels](image3)
13. Select Template (This is the only template that you will use a form under AGP)
14. Select Header: AGP CM/DM Forms
15. Select CM Referral/Transition Note
16. Complete the CM Referral/Transition NOTE:
17. *Date: Select today's date
18. *Referral Direction: Select Referred to CM
19. Member Name: will auto populate with the member that you have pulled into focus
20. Member ID: will auto populate with the member that you have pulled into focus
21. Updated Contact #
22. Identify if the member has been notified of the referral
23. *Referral from/Transition to: Select Disease Management
24. In the Referral/Transition Reason text field: identify the reason(s) for the referral to Complex Case Mgt and include any pertinent notes that may be helpful.

<table>
<thead>
<tr>
<th>Referral/Transition Reason:</th>
</tr>
</thead>
<tbody>
<tr>
<td>ERx5 in last month</td>
</tr>
<tr>
<td>Family overwhelmed</td>
</tr>
<tr>
<td>Daughter Jane Doe is auth rep</td>
</tr>
<tr>
<td>Her number is 651-123-2235</td>
</tr>
<tr>
<td>Call after 10 AM, she works nights</td>
</tr>
</tbody>
</table>

25. Select Save.

NOTE: If a member is currently assigned to a Care Coordinator and is referred and opened to Complex Case Mgt, they will appear as the secondary CM. The Primary CM (BP Care Coordinator) assignment will not be affected by this process.

Requesting Case Mix Exceptions and EW Conversions

If a member requires a Case Mix Exception or EW Conversion, the user should send the request through the BCBS – Case Mix Exception and EW Conversion Request. For detailed information regarding the request to exceed case mix cap and conversion process, refer to the Care Coordination Guidelines.

1. Click My Work Assignments (under Frequently Used Tools), and then select the name of the member you want to refer. This will bring the member into focus.
2. While the member is in focus (member's name and eligibility banner will appear at the top of your screen), you will select the Tasks tab. A new blank task note displays.

3. In the subject line, the user should indicate the reason for the task: "Request to Exceed Case Mix Cap" or "EW Conversion"
4. If the member is in focus, the box “Associate with member: XXXX” will be automatically checked.
5. Specify when this task is due: Enter 1 in the text field indicating this task is due in 1 day.
6. Select “User”, leave the text field blank and select the search icon:

7. In the Search For Name field, type BCBS:

8. In Search in Option deselect the check box for Users (only Queues box should be checked):

9. Select SEARCH
10. Click on the BCBS- Case Mix Exception and EW Conversion and select **Continue**:
11. Select the appropriate urgency level for task:

- Urgent
- High
- Medium
- Low

12. Skip Select Template

13. In the Notes section: identify the reason(s) for Requesting to Exceed Case Mix Cap Conversion and include any pertinent notes that may be helpful.

Returning to community post LT- SNF placement x 5 years. Need conversion rate. See documents attached to contact note.

14. Select Save
Clinical and Wellness Tools

- The Tools menu is located under the Standard Tools header on the left-side Menu.
- Clinical and Wellness Tools are optional tools for the Care Coordinator to document member health information.

Healthwise Knowledge Base

Healthwise Knowledge Base is a database that has a wide range of health information. This information can help you or a member understand their condition or how to manage their health.

**NOTE:** Information should not be printed to be given to members or caregivers.

The Care Coordinator can review different resources including information on specific Conditions, Wellness and Prevention topics, Life Stages, and more.

Each area (Conditions, Wellness and Prevention, Life Stages and Explore More) has a “Topics” and “Tools” tab to further narrow your search as applicable. See screenshot below for an example of the Tools and Tabs under the Wellness and Prevention section.
Member360

Introduction
Member360 is a separate, linked system. This system is an easy to use read only module which allows you to rapidly access many types of health, authorization, and claims information for a member.

Information displayed in Member360 originates from many other separate databases including:

- Facets (claims and authorization information);
- CareCompass (enrollment, health information, case properties, assessments, care plans, case notes, etc.)
- MACESS (correspondence sent out from the health plan such as DTRs and authorization letters).

**NOTE:** Member 360 Data is refreshed every evening with information from the above systems.

Member Search

1. Click on Google Chrome M360 or Internet Explorer M360
2. You will be taken to this screen

3. Click **Search**.
4. A member’s list displays with applicable line items
• The Member Care Summary page is the landing page when you access Member360. The top of the screen displays the member’s demographic information. Below that is a banner with different tabs where you can access specific types of information:

<table>
<thead>
<tr>
<th>Tab</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Member Care Summary</td>
<td>Displays the member’s demographics.</td>
</tr>
<tr>
<td>Eligibility</td>
<td>Displays the member’s benefits and eligibility information.</td>
</tr>
<tr>
<td>Claims</td>
<td>Provides a list of claims data.</td>
</tr>
<tr>
<td>Utilization</td>
<td>Provides a list of active and inactive service authorizations.</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>Provides a list of prescription medications that has been dispensed.</td>
</tr>
<tr>
<td>Labs</td>
<td>Displays the member’s lab reports.</td>
</tr>
<tr>
<td>Care Management</td>
<td>Displays the Care Management Summary which includes the Case Management (CM) cases, health assessments, and care plans.</td>
</tr>
<tr>
<td>Episodic Viewer</td>
<td>Provides a chronological analysis of clinical event.</td>
</tr>
<tr>
<td>----------------</td>
<td>-----------------------------------------------------</td>
</tr>
<tr>
<td>Communication</td>
<td>Provides a list of written or faxed correspondence from MACESS. This will also show authorizations or appeals.</td>
</tr>
<tr>
<td>Documents</td>
<td>Provides a list of reports. Information such as letters sent to the member including care plans, HRA’s contact notes.</td>
</tr>
<tr>
<td>Lab Reports</td>
<td>Displays the member’s lab reports</td>
</tr>
</tbody>
</table>

**Navigation Features**

There are navigation icons to help you move through Member360. See the sections below for more information.

**Icons**

- The Reload/Refresh icon is used to reload the original search information
- The Expand icon is used to show more data within that box
- The Search icon is used to customize your search in that box
- The Print icon is used to request a print of the data

**Links**

- There is a Links tab at the top right of each page of Member360
- Hover over Links and move your mouse to Common Links to display the available links
  - Member360 FAQ to view information that will help you with trouble shooting common issues.
  - Click What’s New to find out about new features or recent updates to Member360

**Additional Features**

Member360 offers multiple features to promote efficient access to health information

**Banner**

This feature is located at the top of the Member Care Summary page. The banner area provides demographics and other commonly referenced information.
You can collapse or expand the banner by clicking on the arrow beside the member’s name (top left corner of the banner)

**Member Care Summary**

This tab allows you to simultaneously view a cross section of all data types. This is the default tab that displays below the banner.

The active alerts section includes care gap alerts and HIPAA privacy indicators, if any.

**Detailed Entries**

In most areas of Member360, you can access a detailed data entry by clicking on a row of data. The detailed information will appear in the right half of the Member360 window.

**Tooltips**

When your cursor hovers over many data elements, additional information is available through a tooltip.

If you click on the data element, the tooltip will remain until you click on the data element again. For example, additional primary care provider (PCP) information is available in the banner area via a tooltip. Just hover over the PCP’s name.

**Flexible Date Ranges**

Data can be viewed using default date ranges or custom dates.