CareCompass-Member360 Manual

This manual is a guide for Care Coordinators and support staff to access and use CareCompass and Member360 (Amerigroup system applications) for Blue Plus MSHO and MSC+ members.

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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.

Contacting AGP IT Support

1-888-268-4368

When calling AGP IT Service Desk. Be sure to identify yourself as the MN Alliance. The representative will ask for your US Domain ID (AF or AG#) and your User PIN (Employee PIN). This is the same number that you find in your **My IT Profile** on the Security questions screen (see below).
AGP General Access information:
It is our expectation that each user will log onto Citrix to access CareCompass and Member360 daily to check for member notifications in the New Messages area.

Active users must access the systems at least once in a 90-day period to avoid being deactivated. If deactivated the user must call into AGP IT.

Your Partner Relations Consultant will be providing you with a monthly list of users for each Delegate to verify if access continues to be needed.

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 email the Partner Relations email box to request a US Domain ID/Username for each individual in their agency that requires access to CareCompass and Member360.

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 the Partner Relations at Partner.Relations@bluecrossmn.com immediately. The Delegate Agency must include the individual user and the CareCompass/Member360 access termination effective date.

New User Access:
1.) First time log in email will be sent to user from an Anthem email box within one week of request submission:

   First Time Log In

   This email contains CONFIDENTIAL user ID and password information. Please safeguard this information by disclosing it to appropriate parties only.

   User Id/US Domain: XXXX
   Temporary Password: XXXx (CASE Sensitive)
   Temporary Pin: XXXX

2.) Follow instructions provided on your First Time Logon email
3.) Work with delegate IT to download necessary software to device
4.) Contact 888-ANTHEM8 for log-in issues or concerns
   a. Press #2 for password reset or account unlock
   b. Press #5 for all other issues
      When speaking with the anthem IT person, identify yourself as being with the “Minnesota Alliance”
5.) Upon successful log in onto the Citrix Receiver, new users must set up their security questions.

**Set up Security Questions:**
1. Go to Citrix Logon home page [https://extcitrix.antheminc.com](https://extcitrix.antheminc.com)
2. Select My IT Profile link

![Citrix Logon](image)

3. Enter your US Domain ID (AF or AG number):

   **My IT Profile: Login**

   ![My IT Profile: Login](image)

4. Select the authentication method PIN & Token Authentication

   **My IT Profile: Login**

   ![My IT Profile: Login](image)

5. Enter your 4-digit PIN you created and generated RSA token code
6. Select Update Security Questions link and complete security questions and click on Update. You may also change your User PIN (Temporary PIN assigned to you in your First Time Log in email for calling into AGP IT Enterprise) on this page. *You answer will always show as 4 dots.
Resetting your Password (Existing Users):

2. Enter your US Domain ID (Example: AF12345 or AG12345)
3. Click on PIN & Token authentication and enter your PIN and Token # and click Continue
4. Authenticate by choosing to either enter your password or answer security questions
5. After that you will come to this screen. Here you can change your password.
6. Click on Change passwords and follow the directions to choose a new password.
7. Passwords must be reset every 30 days to avoid being locked out of Citrix.

**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)
- **US Domain I.D./User Name:** a seven-digit code that begins with AF or AG assigned to each user (i.e., AF99999)
**User PIN:** (Might also be referred to as an **Employee PIN**). This number should be used to identify yourself when calling AGP IT Service Desk. This is the same number that you find in your **My IT Profile** on the Security questions screen (see below). We recommend that you change the pin listed here to match your RSA token pin (Your RSA token pin is the 4-8 digit pin you created to go with your RSA token—we recommend a 4 digit numeric pin)

![User PIN Image]

**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 or AG number), password and pin+RSA token code.

![CareCompass Image]

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
**Toolips**
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.

![Filter Options](image)

**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).
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 Member360 under Communication.

Click on each New Message to view details. You can also go to Member360 under Communication to view the complete message.

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

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

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**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**

Complete the Demographic Change Form to change the member’s phone number, residential address, mailing address, COR, EW Date Span, changes to living arrangement, and PCC, in CareCompass. Send the form securely to:

SecureBlue MSHO:  **mnmmp@anthem.com**
Any demographic changes can be verified in Member360 within 72 hours of the request. The demographic changes will only display for up to 90 days; Care Coordinators must still notify the member’s county financial worker via DHS 5181 for the changes to get inputted into the enrollment files.

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: If you need to change a Task after it has been saved, you must mark the saved task as complete and enter a new Task. The edit task function does not allow for consequential changes. (i.e.: date change, note changes)

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**

- **Save**
- **Cancel**

**Task Fields**

- **Subject:**
  - Assist with scheduling primary care appt.
  - Associate with member: Train28 MN28
  - Consultation
- **In:**
  - Days
  - **Due:** 12/12/2019
  - **Time:** None
  - **User:**
- **Urgent**
  - High
  - Medium
  - Low

**Select Template:**

**Notes:**

Member is due for her annual MD appt. with Dr. John Doe at Rainy Clinic on 1/12/19. Reminder to assist with scheduling of appointment and transportation.

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
Anyone at a Delegate agency has the ability to assign members to Care Coordinators within their agency. Delegate managers/supervisors should determine their own process for completing care coordination assignment.
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.
   Click on the plus sign to the left of the queue name to open the queue.
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 for User or Queue]

12. Click the ROLE button
13. Choose 'Case Manager'.

![Select Role]

14. Choose 'Set as Primary'.

![Add Assignment]

15. Click the SELECT button, followed by SAVE.
Mass Re-Assignment of Members
These steps can be taken when needing to move members from one Care Coordinator to another Care Coordinator in the event of employment changes or leaves of absence.

1. Log into Care compass
2. Click on “My Work Assignments”.
3. Click on “Manage Queue Assignments”.

4. Click on “Patients” tab
5. Next to manager name, expand (+) list of Care Coordinators under the manager

6. Under “Selected User” click select box (circled below). This will highlight all the members in the Care Coordinator’s queue.

7. Choose “Assign selected”

8. Follow step above for Care Coordinator Assignment.
**Reporting Enrollment Discrepancies**

If a member has been determined by the Delegate to be assigned to them incorrectly, the Delegate should report the discrepancy through the secureblue.enrollment@bluecrossmn.com email box.

**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.

**Reports (additional reports coming soon)**

**Care Coordination Delegate Management Reports**

Care Coordination Delegates have access to generate the following reports from CareCompass:

1. MSHO MOC Dashboard Report (aka MSHO Assessment Completion Report)
2. MSC+ Assessment Completion Report
3. Assessments Due Report
4. Enrollment Reports

See below for details on each report. Delegates are responsible to pull their own reports from CareCompass. Blue Plus will not be sending out notifications that reports are ready or copies of these reports directly to Delegates.

<table>
<thead>
<tr>
<th>Report Name</th>
<th>Description/Purpose of Report</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>MSHO MOC Dashboard Report</td>
<td>MSHO assessments completed. Use this report to track timely assessment completion.</td>
<td>Monthly</td>
</tr>
<tr>
<td>MSC+ Assessment Completion Report</td>
<td>MSC+ assessments completed. Use this report to track timely assessment completion.</td>
<td>Monthly</td>
</tr>
<tr>
<td>Assessments Due Report</td>
<td>MSHO and MSC+ assessments coming up due- 30, 60 &amp; 90 day interval</td>
<td>Monthly</td>
</tr>
<tr>
<td>Enrollment Reports</td>
<td>Report of newly enrolled members, termed members, and current roster of all currently enrolled members via delegate agency assignment</td>
<td>Monthly</td>
</tr>
</tbody>
</table>

Generating a report from CareCompass:

1. Hover over **Tools** in the Standard Tools menu
2. Select **External Links**
3. Select **Reporting Server**

4. Select **Health Plans**

5. Select **Minnesota Reports**
6. Select the report you would like to generate.

**Printing Assessments and Plans of Care (additional detail coming soon)**

1. Hover over **Tools** in the Standard Tools menu
2. Select **External Links**
3. Select **Reporting Server**
4. Select **Health Plans**
5. Select **Minnesota Reports**
6. Select the report you would like to generate (i.e. assessment or care plan)
7. Enter the Subscriber ID number and select assessment date
8. Select View Report

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**Opening a Case for a Member for the first time**

Care Coordinators must “Open a Case” for all members who have not been opened to case management in CareCompass. The case remains open as long as they are enrolled with BluePlus.

- If a member disenrolls and then re-enrolls, you must open a new case
- You do not need to open a new case for Product Changes
- You do not need to open a case for transfers

To Open a Case:

1. Find the member in CareCompass and “bring into focus”.
2. Click on suitcase icon or Member Cases and Tasks frequently used tools (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
   - Open Reason: Non-triage
   - Case Acuity: Low
   - Case Phase: “Open/Active” for an enrolled member

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

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

Initiating a Transfer

NOTE: the transferring Care Coordinator must have all HRA data entered into CareCompass prior to the transfer effective date. Once the member is re-assigned to the receiving Delegate in CareCompass, the transferring Care Coordinator will no longer have access to the member’s record.

To initiate a transfer in Care Coordination, the Delegate will need to:

1. Complete the BCBSMN Transfer Notes progress note template (as shown below). This is replacing the 6.08 Transfer in Care Coordination Delegation form.
   a. See Creating a Progress Note section of this manual if needed.
2. Initiate the Member Demographic Change form process as outlined in the Care Coordination guidelines.

Example of the BCBSMN Transfer Notes progress note template:
Enter the Transferring Delegate in the Notes section of the template.

**Receiving a Transfer**

To determine if a new member in your Delegate queue is a *transfer* and not a *new* enrollee, the receiving Delegate will need to verify the member’s enrollment dates in the member’s ribbon after bringing the member into focus as shown here:

![Image of member's ribbon with enrollment dates]

If the enrollment date is the same as the current month, the member is not a transfer and is a *new* enrollee.

If the enrollment date is a historical date prior to the current month, the member is a *transfer*.

1. If a transfer, review the member’s progress notes and verify if there is a completed ‘BCBS Transfer Notes’.
2. If there is no ‘BCBS Transfer Notes’ in the member’s record, follow the process *Reporting Enrollment Discrepancies* in this manual for Blue Plus enrollment to research and respond.
3. Assign the new Care Coordinator following the process outlined in *Care Coordinator Assignment* section.
4. Update the member address book with the new Care Coordinator’s contact information following process outlined in *Address Book* section.
5. Refer to Care Coordination guidelines for complete list of all requirements related to the transfer process.
Transfers within your Agency (reassigning members to a new Care Coordinator)

When transferring a member to a different Care Coordinator in your agency, follow the steps below to assign the new Care Coordinator.

1. Bring the member into focus
2. Click on Care Management from the Tools Menu on the left side
3. Click on Assignments

4. Click on Add to add the new Care Coordinator. Select the new Care Coordinator from the Queue/User. Select Case Manager as the Role type. Mark Set as Primary and hit Save.
5. Click on the previous Care Coordinator and hit Delete.

Closing a Case

When a member terms from Blue Plus AND you have completed all your work in CareCompass, 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.

Once the case has been closed, you will not be able to access it. If you have additional work to complete on the case and you have already closed it, please contact your Partner Relations Consultant.

**Assessments and Plans of Care (Effective 3/1/19)**
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

   NAME
   MN

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:
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.

![Error Message](image)

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.

![Progress Bar](image)

9. If the document requires the Care Coordinator signature only, the Care Coordinator can sign by typing the following in the signature fields: 
   `/s/First Name and Last Name`
10. When you come to the end of the assessment, hit Continue.
11. For assessments only, complete a BCBSMN Assessment Complete Contact Note.
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) (Effective 3/1/19)**

**Community**

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

**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 (Effective 3/1/19)**
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**.

```
Retake Assessment

Assessment Details
Name: MN Transitional Health Risk Assessment
Status: Completed
```

All assessments and care plans must be completed in order to be printed and provided to the member.

**Printing Assessments and Care Plans (additional detail coming soon)**
Refer to Accessing Past Assessments & Care Plans (pg 45) for instruction on how to print a completed assessment or care plan (this method is not recommended for printing documents to give to members).

Completed Assessments and Care Plans can also be printed following the process found in the **Reports** section (pg 30) above. (use this method for printing member documents).
Signatures on Assessments and Care Plans (Effective 3/1/19)

Care Coordinator signatures on Assessments
If the document requires the Care Coordinator signature only, the Care Coordinator can sign by typing the following in the signature fields: /s/First Name and Last Name.

Collaborative Care Plan Signature Page—Uploading a copy (Effective 3/1/19)
Once the care plan is signed by the member, you must upload a copy of the signature page to a contact note
1. In progress Notes click on Add Progress Note
2. Do not select a template
3. In the Subject Line enter: Collaborative Care Plan Signature Page
4. Click on “Browse” to search for your saved document and upload
5. Once the signature page is uploaded click on Save.
PCA Assessments Signature Page—uploading a copy (Effective 3/1/19)

The Care Coordinator must obtain the member, responsible party and interpreter signatures, as applicable using the signature page of the DHS PCA assessment forms (DHS-3244 and DHS-3428D) and then upload a copy to a contact note.

1. In progress Notes click on Add Progress Note

2. Do not select a template
3. In the Subject Line enter: PCA Assessment Signature Page
4. Click on “Browse” to search for your saved document and upload
5. Once the signature page is uploaded click on Save.
Provider Signature Requirements (Effective 3/1/19)

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.

1. In progress Notes click on Add Progress Note

2. Do not select a template
3. In the Subject Line enter: Provider Signature Letters
4. Click on “Browse” to search for your saved document and upload
5. Once the signature page is uploaded click on Save.

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. To download a copy of the assessment, select Download (Excel, Word or PDF). Assessments/Plans of Care can be printed, however, it is not recommended to use this printing method for documents to be given to members. See Reports section on Pg 29 for printing member documents.

5. 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 (Effective 1/1/19)**
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 (required)
- BCBSMN – Contact Note (optional)
- BCBSMN – Historical Assessment Contact Note
- BCBSMN – Refusal of Assessment Contact Note (required)
- BCBSMN – Unable to Reach Assessment Contact Note (required)
- BCBSMN Semi-annual Visit Contact Note (optional)
- BCBSMN Transfer Notes (required)
- 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 templates 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.

**Procedure to enter a Progress Note**
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.

```
AGP LTSS MN Forms

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

7. Complete the required fields on the template.
8. Click **Save**.

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

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

The Assessment Complete Contact Note must be completed when the member’s initial and annual reassessment is completed. The Assessment Complete Contact Note is also used for documenting transitional needs.

For members on EW, you must add the Waiver Case Mix letter and Waiver span start and end dates.

This template is required because it contains reportable information. Information from this template will replace the HRA data that you previously entered into Bridgeview.
Assessment Complete Contact Note for Transitional HRA:

See below for an example of how to complete an Assessment Complete Contact Note for a Transitional HRA (for a community or nursing home member).

- Select Transitional HRA (not initial or reassessment) for the Assessment Type
- Fill in the date of previous full assessment that was reviewed with the Transitional HRA (this field is required for Transitional HRAs)
- Complete the waiver case mix and span if applicable
- Enter the Living Status

**Progress Notes**

<table>
<thead>
<tr>
<th>Open Entry</th>
<th>Back to Progress Notes</th>
<th>More Information</th>
<th>Full Text View</th>
<th>More Options</th>
</tr>
</thead>
</table>

**BCBSMN - Assessment Complete Contact Note**

- * Date Assessment was completed: 03/2019
- * Assessment Type: Transitional Assessment

For transitional assessments completed; what is the date of the previous face to face:

- Waiver Case Mix Letter: A
- Waiver Span Start Date: 01/1/2019
- Waiver Span End Date: 03/30/2019
- * Living Status: Community
- Assessment Notes:

**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.

**BCBSMN Contact Note**

- * Date:

- * Notes:

- * Time required to complete the activity (in 15 minute increments)
**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.

![BCBSMN Refusal of Assessment Contact Note](image)

**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.

![BCBSMN - Unable to Reach Assessment Note](image)

**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 (Required)**

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.

Printing Progress Notes
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.

![Image of My Work Assignments menu]

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:

![Image of My Work Assignments with Tasks tab selected]

3. Click Add Task. A new blank task note displays.

![Image of My Work Assignments with Add Task highlighted]

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

12. Select the appropriate urgency level for referral:

- ☐ *Urgent*
- ☐ *High*
- ☐ *Medium*
- ☐ *Low*
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.
Referral/Transition Reason:

- BRx5 in last month
- Family overwhelmed
- Daughter Jane Doe is auth rep
- Her number is 651-123-2235
- Call after 10 AM, she works nights

25. Select **Save**.

**Add Task**

[Save] [Cancel]

**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.

**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.

- External Links (note that External Links only work when you are in a member record)
- One of the external links is Member360

**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:** Member360 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

<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>
</tbody>
</table>
**Labs**
Displays the member’s lab reports.

**Care Management**
Displays the Care Management Summary which includes the Case Management (CM) cases, health assessments, and care plans.

**Episodic Viewer**
Provides a chronological analysis of clinical event.

**Communication**
Provides a list of written or faxed correspondence from MACESS. This will also show authorizations or appeals.

**Documents**
Provides a list of reports. Information such as letters sent to the member including care plans, HRA’s contact notes.

**Lab Reports**
Displays the member’s lab reports

---

**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