Diagnosing PAD using QuantaFlo

QuantaFlo produces a blood volume waveform from the anterior and posterior tibial artery distributions.





(Master RC, 2018)

Documenting Peripheral Vascular Disease: Put the Puzzle Together

Is there a history of..?

- Arteriosclerosis
- Erectile dysfunction
- HTN
- Smoking hx
- Stents or vascular surgeries
- DM, MI, stroke, hyperlipidemia
- Family history of PAD

Is the member prescribed...?

- Antiplatelet medications
  - Clopidogrel (Plavix)
  - Cilostazol (Pletal)
- Aspirin
- Anticoagulants
  - Warfarin
  - Dabigatran (Pradaxa)
  - Rivaroxaban (Xarelto)
  - Apixaban (Eliquis)

Does the Member report?

- Claudication
- Non-healing LE ulcers
- Cramping pain in legs with or without activity
- Difficulty walking
- Other non-typical LE pain

Physical Exam

- Abnormal QuantaFlo results
- Skin changes
  - Redness, pallor, cyanosis
  - Thin and shiny
  - Loss of hair
  - Cool to touch
- Diminished or absent pulses
- Brittle, hypertrophic or ridged nails

Arterial Disease vs. Venous Disease

When documenting arterial disease, use PVD or Atherosclerosis diagnoses

When documenting venous disease, diagnose the specific venous condition

Examples of Arterial Disease Diagnoses

Peripheral vascular disease, unspecified

Atherosclerosis diagnoses

Atherosclerosis of native arteries of extremities, with intermittent claudication
Other atherosclerosis of native arteries, bilateral legs
Unspecified arthrosclerosis of native arteries of extremities, bilateral legs

Examples of Venous Disease Diagnoses

Venous insufficiency (chronic, peripheral)

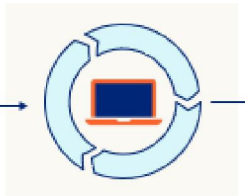
Impaired venous return in the legs, causing edema, skin changes, and lower extremity discomfort.

Asymptomatic varicose veins of bilateral lower extremities

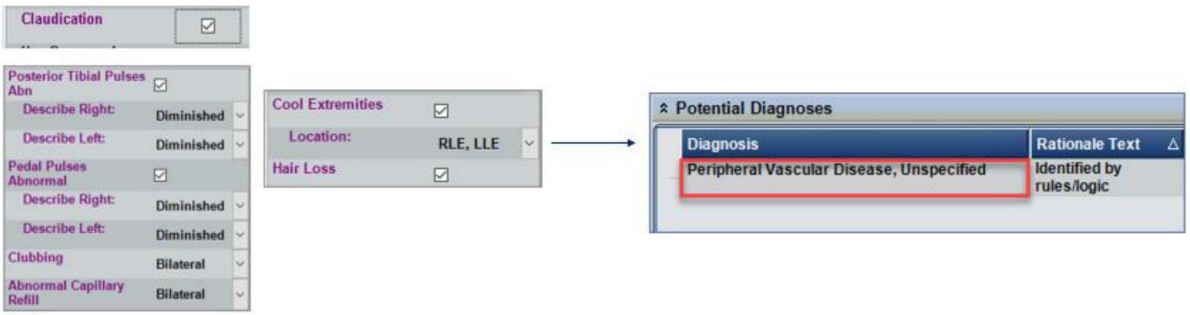
Dilated, elongated, and tortuous networks in the subcutaneous venous system resulting from valvular incompetence.

Smart Logic Rule: Peripheral Vascular Disease

- Documentation of QuantaFlo results <0.90 OR claudication documented OR
- Any 4 of the following: absent or diminished foot pulses, clubbing, hair loss, cool extremities, abnormal capillary refill



Peripheral Vascular Disease will populate within the Diagnosis Cart/ DCP/ Page 3



Cancers

Active Cancer

A primary cancer diagnosis is active in **ANY** of the following scenarios:

- Member is currently receiving treatment
- Includes surgery, chemotherapy, hormonal therapy, radiation therapy or anti-cancer medications
- Radioactive seed implants for prostate cancer remain active within 1 year of implantation
- Member is awaiting a treatment plan
- Newly diagnosed cancer
- Receiving consults to plan treatment after cancer has been confirmed
- Member has not received treatment for the cancer and therefore it is still present
- Member declines treatment
- Member not a candidate for treatment
- Watchful waiting/ observation only approach

Routine surveillance for recurrence is not sufficient to document cancer as active.

History of Cancer

Personal history of cancer diagnoses are equivalent to 'history of'. It indicates that treatment of the cancer is complete, and the cancer is resolved. This diagnosis is used for primary malignancies only

Personal history of cancer diagnosis is appropriate when **all** the following criteria have been met:

- Member has completed treatment for primary cancer at its site AND
- There is no further treatment planned to the primary site AND
- There is no evidence of any existing primary malignancy at the site

If ALL criteria are met, add the *Personal history of* cancer diagnosis. This diagnosis will remain because it refers to a person's history.

Documenting Cancer: Active and History of Cancer

Personal History of Cancer example: →

Diagnosis	Rationale Text	Active	Resolved	Remove	Assessment	Plan	Note
Personal history of malignant carcinoid tumor of bronchus and lung		☑	☐	☐	☑ Stable ☐ Unstable ☐ Suboptimally Co	☑ Continue Therapy ☐ Patient education ☐ FU with PCP ☐ FU with Specialist ☐ Send to ER or Urge	

Active Cancer example: →

Diagnosis	Rationale Text	Active	Resolved	Remove	Assessment	Plan	Note
Cancer - Lung		☑	☐	☐	☑ Stable ☐ Unstable ☐ Suboptimally Co	☑ Continue Therapy ☐ Patient education ☐ FU with PCP ☐ FU with Specialist ☐ Send to ER or Urge	Receiving radiation therapy daily x 3 weeks

Provide supportive evidence in notes column, as needed

Documenting Blood Cancers

The blood cancers are:

- Leukemia
- Multiple Myeloma
- Hodgkin's Lymphoma (HL)
- Non-Hodgkin's Lymphoma

A common treatment goal for blood cancers is to achieve remission, not necessarily cure

When documenting these cancers, indicate whether the blood cancer is:

- …In remission
- …Not in remission
- …In relapse
- Personal history of…

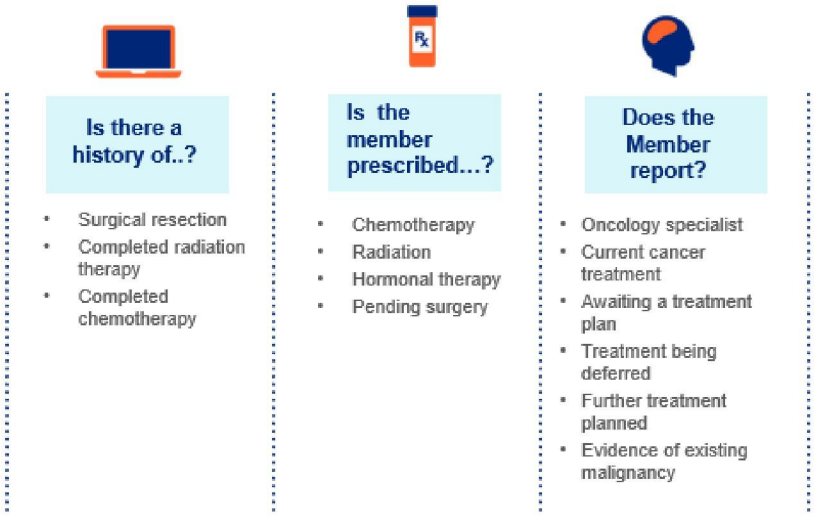
Helpful Tips to Determine Cancer Status

Ask the member probing questions to determine if it is an active cancer, personal history, in remission, in relapse or not in remission, such as:

- "Did they find any cancer after you completed treatment?"
- "How long ago was your cancer diagnosed?
- "How long ago was your last cancer treatment therapy?"
- "Do you have treatment planned in the future?"
- "Is there still evidence of active cancer in your body?"

Document additional information that the member tells you in the *Notes* column to support the documented cancer diagnosis.

Active Cancer or History of Cancer: Put the Puzzle Together



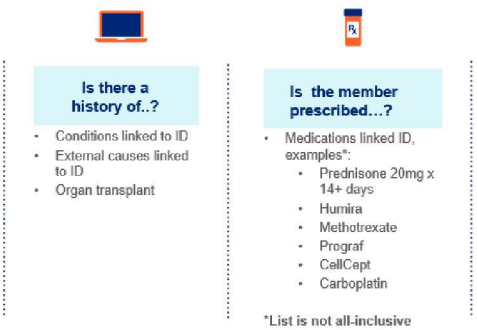
Secondary Immunodeficiency

Definition: Decreased ability to fight infection or cancer due to underlying conditions, drugs or external causes:

Conditions	Drugs	External Causes
Uncontrolled diabetes (hyperglycemia with A1C ≥ 8)	Steroids: ≥ 20 mg/day of prednisone (or equivalent) for >14 days	Radiation therapy
COPD	Disease-modifying anti-rheumatic drugs (DMARDs), member actively taking	Dialysis
Autoimmune diseases • Rheumatoid arthritis-Active state • Lupus (SLE)	Biologic response modifiers (biologics)	
Malignancies	Immune system suppressants s/p transplant	
Sickle cell disease	Chemotherapeutic agents	
Ulcerative colitis, Crohn's disease		
Alcoholic Liver Disease		
Moderate and Severe Malnutrition		
Asplenia		

Please Note: These are examples and not an exhaustive list

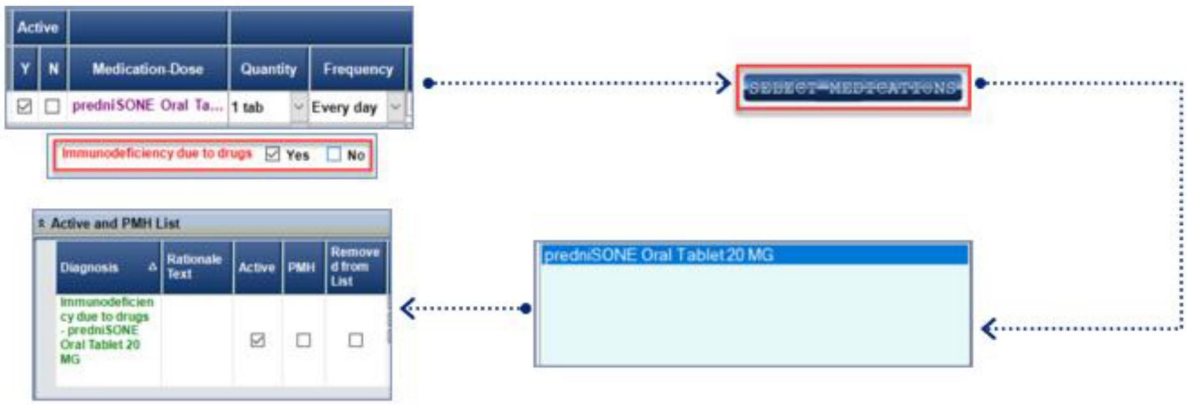
Documenting Secondary Immunodeficiency: Put the Puzzle Together



Smart Logic Rule: Secondary Immunodeficiency due to Drugs

Documentation of active medication with potential to cause immunodeficiency





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DIAGNOSING DURING THE VISIT: PUTTING THE PUZZLE TOGETHER – PART 2

Genitourinary System

Chronic Kidney Disease

Definition: Abnormalities of kidney structure or function, present for >3 months with implications for health.

Chronic Kidney Disease Staging

Stages of CKD	Description	eGFR (mL/min) (lab test)
Stage 1	• 2 results of proteinuria 90+ days apart • Signs of mild kidney disease but with normal GFR	≥ 90
Stage 2	• 2 results of proteinuria 90+ days apart • Signs of mild kidney disease with reduced GFR	60-90
Stage 3a Moderate		2 results 90+ days apart: **45-59**
Stage 3b Severe		2 results 90+ days apart: **30-44**
Stage 4 Severe		2 results 90+ days apart **15-29**
Stage 5 End Stage		2 results 90+ days apart **< 15**

Note: Need two eGFRs ≥ 90 days apart

CKD prognosis including reversibility and improvement

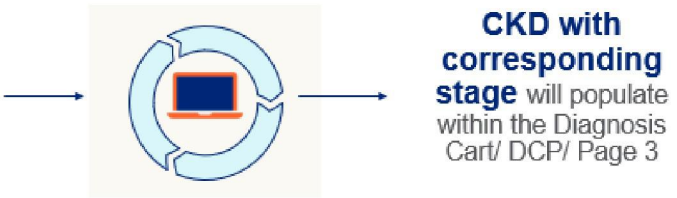
- **Clinical course can be highly variable**
- **Unfortunately, typically causes are chronic (e.g., diabetes mellitus, HTN)**
- **Though progression is common, intervention can slow deterioration or even lead to improvement. Examples:**
  - Appropriate management of diabetes mellitus and of hypertension
  - Discontinuation of nephrotoxic meds (e.g., NSAIDs)
  - Appropriate hemodynamic management (e.g., in the case of heart failure)
  - Immunosuppressive treatment of autoimmune conditions as applicable
  - And in some cases, spontaneous structural regeneration can take place (e.g., with interstitial nephritis)

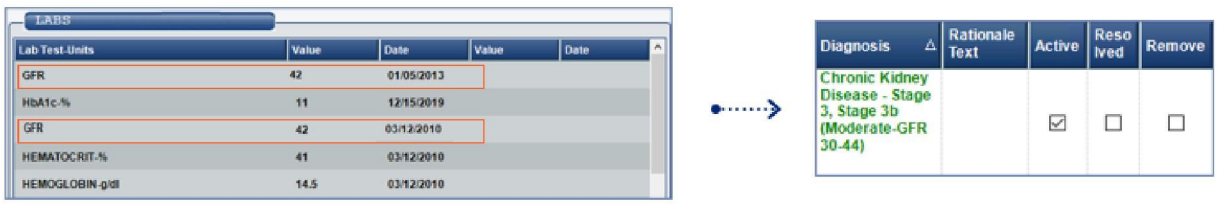
Documenting CKD: Put the Puzzle Together



Smart Logic Rule: CKD

- **Presence of two or more prepopulated GFRs ≥ 90 days apart**





Neurological System

Dementia

Definition: The development of multiple cognitive deficits manifested by both memory impairment and cognitive impairment.

Memory impairment:
Impaired ability to learn new information or to recall previously learned information

Cognitive impairment (one or more of the following):

- Aphasia (language disturbance)
- Apraxia (impaired ability to carry out motor activities despite intact motor function)
- Agnosia (failure to recognize or identify objects despite intact sensory function)
- Disturbance in executive functioning (i.e., planning, organizing, sequencing, abstracting)
- 47 million people are living with dementia worldwide that number will increase to over 75 million by 2030 and 135 million by 2050

- Dementia prevalence increases with age
- Dementia is the most important contributor to disability in the elderly
- The total monetary cost of dementia in 2010 was between 157 billion - $215 billion
- 47 million people are living with dementia worldwide that number will increase to over 75 million by 2030 and 135 million by 2050
- Dementia prevalence increases with age
- Dementia is the most important contributor to disability in the elderly
- The total monetary cost of dementia in 2010 was between 157 billion - $215 billion

Risk Factors for Dementia

Apart from the rare cases of dementia caused by genetic mutations, experts believe that dementia, like other common chronic diseases, develops as a result of multiple factors rather than a single cause. Factors include:

- Age
- Family History/Genetic Factors
- Mild Cognitive Impairment (MCI)
- Cardiovascular Disease Risk Factors
- Education
- Social and Cognitive Engagement

Rationale for screening

- About 50% of patients who meet the criteria for dementia remain undiagnosed
- Cognitive assessment is required by CMS during the annual wellness visit
- A brief structured cognitive assessment tool more accurately classifies patients with cognitive impairment than spontaneous detection by the patient's own PCP

Screening targets multiple outcomes

- Provides opportunity for early intervention
- Improves functional autonomy
- Delays institutionalization
- Lowers caregiver stress
- Provides an opportunity for Advanced Care Planning

Mini-Cog

Mini-Cog tool can help identify cognitive impairment but cannot diagnose Dementia.

2 component Test

Three Word Recall

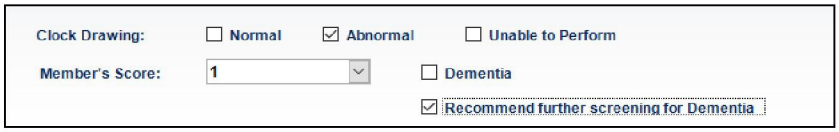
- Test recall
  - Ask the patient to recall three unrelated words & Do not give any hints of cues

Clock Drawing Test (CDT)

- Tests executive function
  - Give the patient a piece of paper with a circle drawn on it
  - Ask the patient to "place the numbers so they look like the face of a clock."
  - After the patient has completed placing the numbers ask them to **"Draw the hands of the clock so that it reads ten after eleven."**

Abnormal Mini-Cog

- When the Mini-Cog tool is abnormal a recommendation for Dementia screening should be selected, only if this is a new finding for the member.





Polyneuropathy

Neuropathy Terminology

Mononeuropathy	One nerve affected by a process of entrapment, compression, or trauma (carpal tunnel/cubital tunnel)
Polyneuropathy	Multiple nerves affected by a process. Most often presented in the peripheral nerves (pre-diabetes, diabetes, deficiencies, medications, other underlying conditions)
Radiculopathy	Nerve root dysfunction
Myelopathy	Spinal cord dysfunction

Wide variety of Causes

- Diabetes mellitus/Pre-diabetes
- Alcohol abuse
- Charcot-Marie-Tooth (CMT)
- Hypothyroidism
- Drugs
- Infections
- Inflammatory conditions/autoimmune diseases
- Hereditary diseases
- Vitamin deficiencies
- Environmental exposure

It also often occurs as a side effect of medication or as a manifestation of systemic disease. Polyneuropathies may in fact have several contributing etiologies.

Documenting Polyneuropathy: Signs and Symptoms

Sensory

- Numbness
- Paresthesia
- Allodynia; tingling
- Burning pain
- Reduced sensitivity to pain and temperature
- Reduced proprioception;
- Decreased coordination and balance
- Decreased vibration sense
- Decreased ability to feel the monofilament

Motor

- Muscle weakness
- Muscle wasting
- Muscle cramps
- Fasciculation
- Impaired balance
- Impaired coordination

Other Signs

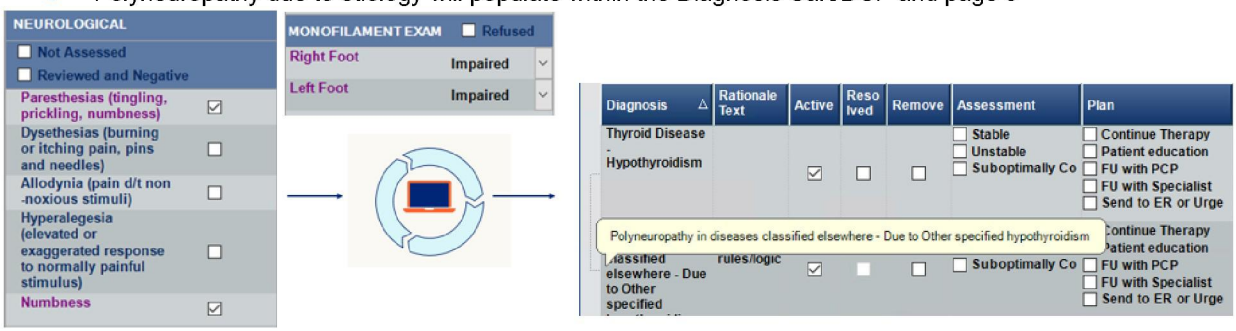
- Diminished/ absent deep tendon reflexes, Diminished/ absent Achilles reflex.

Smart Logic Rule: Polyneuropathy

- Documentation of signs or symptoms of polyneuropathy in the ROS and/or the Physical Exam will trigger a diagnosis of Polyneuropathy

AND

- Documentation of an active diagnosis with the potential to cause Polyneuropathy
- Polyneuropathy due to etiology will populate within the Diagnosis Cart/DCP and page 3



Diabetes Mellitus and Complications

Diabetes Type 2 and complications:

Diabetes is the #1 cause for:

- Renal failure
- Non traumatic lower limb amputations
- Non congenital blindness
- Diabetes is a major contributor to heart attack and stroke

ADA diabetes management: A1C goals:

General Approach:

Management goals should be individualized for each patient and determined by the treating clinician. The following A1C goals have been proposed by the ADA:

- <7.0% may be a reasonable goal for a non-pregnant adult
- A1C <8% may be appropriate for those with a history of severe hypoglycemia, limited life expectancy, extensive comorbid conditions, advanced microvascular or macrovascular complications

Older Adults:

Less stringent A1C goals have been recommended for older adult populations.
The following A1C goals have been proposed by the ADA:

- <7.0-7.5% in healthier older adults
- <8.0-8.5% for those with multiple coexisting chronic illnesses, cognitive impairment, or functional dependence

Assess Diabetic Control

- Ask about HgbA1C – last date?
- What are the most recent blood sugar readings in their glucometer or log?
- Type and dose of medications?
- Other complications present?

Whether a member's diabetes is controlled impacts Star, HEDIS, and other quality measures

ADA definitions: Diabetes with hyperglycemia

- Refers to diabetes that is above a patient's target glycemic goal or is poorly controlled.
- Glycemic goal: A1C less than 7% for many adults is appropriate.
- Target glucose range generally considered 70-180 mg/dL; therefore, blood glucose levels averaging above this range indicate poor glycemic control.
- The diagnosis of hyperglycemia is a clinical judgement considering the patient's overall health status and individualized glycemic goal.

Diabetic Complications

Complication	
Nephropathy/CKD	*Proteinuria or presence of nephropathy are considered proof of diabetic contribution*
Retinopathy	*Check ophthalmology history*
Vascular Disease	*Atherosclerosis (macrovascular manifestations) almost always affected by longstanding diabetes*
Polyneuropathy	*Review ROS and monofilament and vibratory sensation testing*
Ulcers and other specified manifestations	*Document any ulcers in the skin grid*
Hyperlipidemia	*Assumed relationship with diabetes*
Hyperglycemia	*Assess glycemic control and goals*

Diabetes Type 2 and Complications

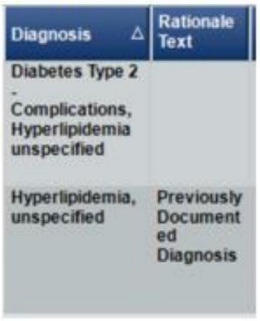
In ICD-10, the diagnoses of Diabetes and the complication are linked together. When selecting the complication, it is not appropriate to also code the complication separately unless this provides additional specificity.

One exception is with Chronic Insulin Therapy where it is also coded separately.

Examples:

- If a member with a diagnosis of diabetes with the complication of peripheral neuropathy, the combo code will cover both diabetes and peripheral neuropathy. The active diagnosis of peripheral neuropathy by itself would be a duplicate diagnosis.
- If a member with a diagnosis of hyperlipidemia, on a statin and diabetes, the diagnosis of DM with complication hyperlipidemia will cover both conditions. A separate diagnosis of hyperlipidemia would be a duplicate diagnosis.

Remove *Hyperlipidemia*- it is a duplicate



- Diabetes with chronic kidney disease: Keep both the Diabetes with Chronic Kidney Disease and the Chronic Kidney Disease with staging diagnosis because the staging adds specificity

Keep *Chronic Kidney Disease Stage 4...*
diagnosis because it brings higher specificity

Diagnosis	Rationale Text	Active
Chronic Kidney Disease - Stage 4 (Severe-GFR 15-29)		☑
Diabetes Type 2 - Complications, Chronic Kidney Disease		☑

REMEMBER: CODE THE DISEASE AND MANIFESTATION OF DIABETES

Documenting Diabetes and Complications: Putting the Puzzle Together



Pulmonary System

Chronic Obstructive Pulmonary Disease (COPD)

Definition: Slowly progressive disease involving the airways or pulmonary parenchyma (or both) that results in airflow obstruction (American Thoracic Society)

COPD: Making a diagnosis

Common symptoms and risk factors (not an all-inclusive list):

- Dyspnea / cough / sputum production
- Tobacco smoking
- Secondhand smoke
- Biomass fuel exposure
- Air pollution
- Age
- Genetic abnormalities
- Abnormal lung development
- Concomitant chronic diseases
- Occupation
- History of recurrent respiratory infections

Diagnosing COPD:

- Spirometry is required to make a NEW diagnosis.
- When documenting an already established diagnosis it is important to document the findings that support COPD:
- Relevant history
- Exposure to risk factors
- Symptoms
- Physical exam



Chronic Respiratory Failure

Definition: Condition that results in the respiratory system's inability to effectively maintain gas exchange and induces chronically low oxygen levels or chronically high carbon dioxide levels.

Etiologies which may cause or contribute to chronic respiratory failure (not all-inclusive):

Structural defects of chest wall	Muscle disease paralyzing respiratory muscles	Conditions that depress the respiratory center	Lung conditions
• Kyphoscoliosis • Severe injury	• Myasthenia gravis • Muscular dystrophy • Spinal cord injury	• Sleep apnea • Extreme obesity	• Emphysema • Asthma • Cystic fibrosis • Chronic Bronchitis • COPD

(Feiler-Kopman DJ, 2022)

Documenting Chronic Respiratory Failure: Put the Puzzle Together



Is there a history of..?

- COPD
- Pulmonary emboli
- Asthma
- Sleep Apnea
- Pulmonary HTN
- Cor Pulmonale
- Any condition causing hypoxemia and/or hypercapnia



Is the member prescribed…?

- Oxygen use
  - Intermediate
  - Continuous

Psychological System

Major Depressive Disorder

Depression Statistics

- It is the most common psychiatric disorder in the general population
- An estimated 1 in 4 adults with a chronic medical condition also have MDD as a comorbidity
- 50-75% of older adults who commit suicide saw their medical doctor during the prior month for general medical care and 39% saw their doctor during the week prior to their death

Major Depressive Disorder DSM-V Criteria

Five (or more) symptoms have been present during the same two-week period and represent a change from previous functioning.
At least **one** of the symptoms is either

- Depressed mood
- Loss of interest or pleasure

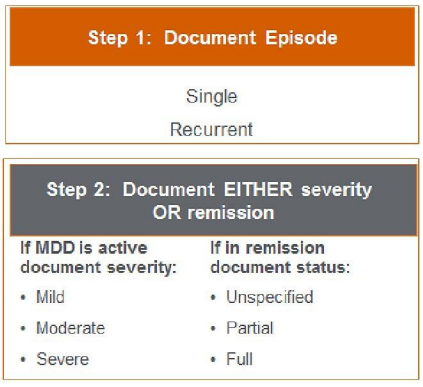
The symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
The episode is not attributable to the direct physiological effects of a substance or to another medical condition.

MDD

- 5 or more of the following symptoms:
  - Depressed mood
  - Anhedonia (inability to experience pleasure)
- Must have one of the 2 above within the 5
  - Insomnia or hypersomnia
  - Change in appetite or weight
  - Psychomotor retardation or agitation
  - Low energy
  - Poor concentration
  - Thoughts of worthlessness or guilt
  - Recurrent thoughts of death or suicide
- PHQ-2 is within your ROS section
- PHQ-9 is in the PSY tool and its completion may be required based on computer logic

Different Types of MDD

When there is a diagnosis of MDD, the episode of either Single or Recurrent must be included, and then documented in either the Severity OR Remission status, you cannot have both Severity AND Remission selected.
MDD is either in remission or active. If it is active, you will then need to specify the Severity.

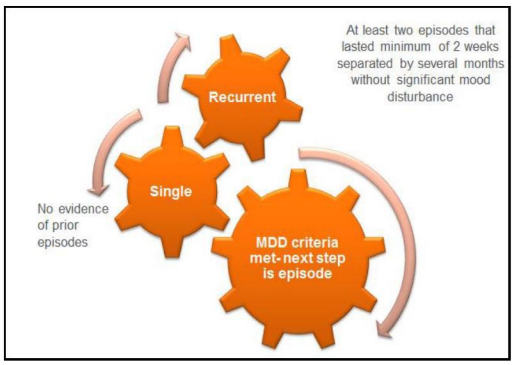


Single Verses Recurrent

Below is an example where the MDD criteria has been met within the largest gear in the image. To help differentiate Single verses Recurrent, you need to ask a few probing questions about the member's depression:

- Have they had depression before?
  - If so, when, and how long did it last?

A member with no prior episodes will have MDD single episode, whereas a member with at least 2 prior episodes that lasted a minimum of 2 weeks separated by several months without significant mood disturbance would have MDD recurrent.



Severity of MDD

You have identified that the member has MDD with either Single or Recurrent episodes, now the question becomes:

- Do they still have symptoms or are they in Remission?

If they have ongoing symptoms, then whether it is Mild, Moderate, or Severe will be decided by you. You can see the three different levels and criteria on the slide.
This section and criteria are built into the PSY tool and tablet logic. As you complete the PHQ 9 questions with the member, the group of diagnoses applicable to the answers will be highlighted. You will use your clinical judgment to make the appropriate diagnosis.

DSM-5 Criteria and PHQ-9 for MDD

Five (or more) of the following symptoms present most of the day, nearly every day during the same 2-week period; at least one of the symptoms is either depressed mood or anhedonia.

1. Depressed mood
2. Anhedonia
3. Significant weight loss or gain, or change in appetite
4. Insomnia or hypersomnia
5. Psychomotor agitation or retardation
6. Fatigue or loss of energy
7. Feelings of worthlessness or excessive or inappropriate guilt
8. Diminished ability to think or concentrate, or indecisiveness
9. Recurrent thoughts of death and suicide

Additional DSM-5 criteria

- Symptoms must cause clinically significant distress or impairment
- Not attributable to a substance or another medical condition
- Not better explained by the presence of another psychiatric condition
- No previous manic (bipolar disorder) or hypomanic episodes

Note: MDD may be diagnosed in members experiencing a significant loss if DSM-5 criteria for MDD are met. *Examples include bereavement, financial loss or loss due to a natural disaster, serious medical illness or disability*

PHQ-9

The PHQ-9 is a tool designed to screen, diagnose, assess severity and monitor a patient's response to treatment.

Consider MDD if there are at least 5 questions with a response of ***"more than half the day"*** or ***"nearly every day"*** (one of which must be question #1 or #2).

Severity Score Interpretation
1-4= Minimal
5-9= Mild
10-14= Moderate
15-19= Moderate severe
20-27= Severe

Note: ICD-10 does not have a code for 'moderate severe'. Allocating the appropriate code is dependent on clinical judgement.

American Psychological Association. Diagnostic and Statistical Manual of Mental Disorders : DSM-5. American Psychiatric Publishing; 2013.

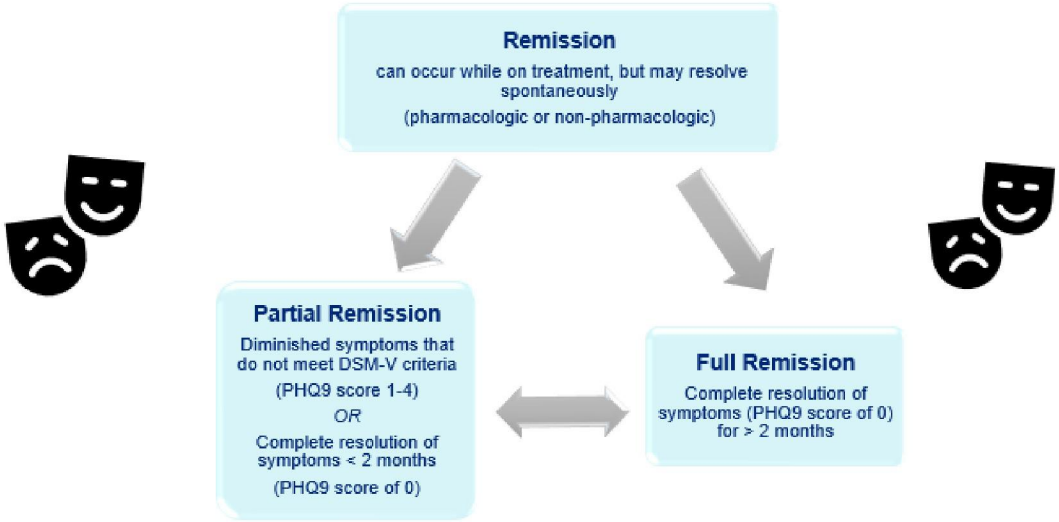
Remission Status of MDD

If severity can't be decided because symptoms are resolved, you can identify MDD single or recurrent with remission status.
Remission can occur while on treatment, buy may resolve spontaneously (pharmacologic or non-pharmacologic).
These patients are those with MDD who are under treatment of some kind, thus their PHQ2/9 is not positive.

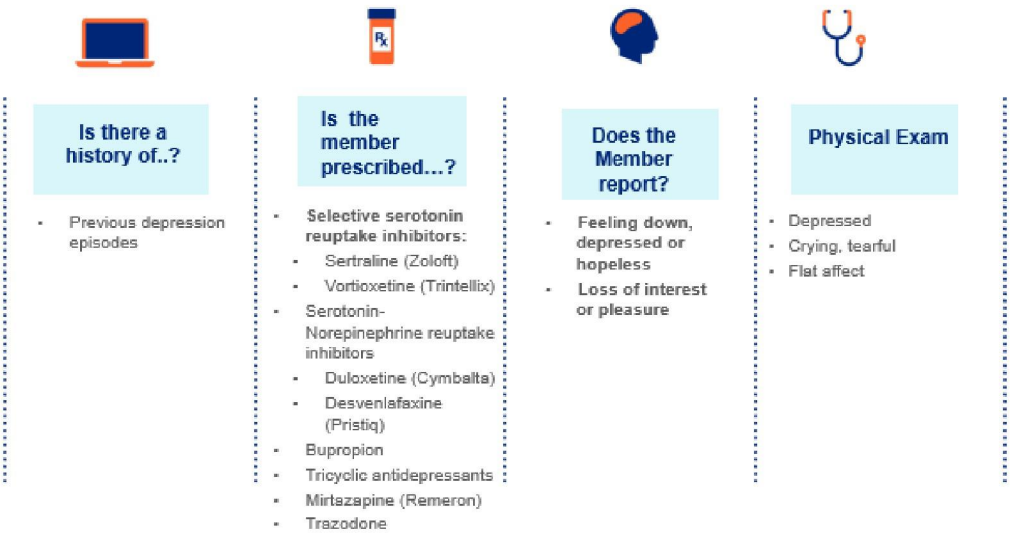
- Full remission is defined as complete symptom resolution for > 2 months.
- Partial remission is defined as diminished symptoms such as didn't meet the DSM V criteria (PHQ2/9 questions) OR complete resolution of symptoms < 2 months.

You can use some probing questions to help you decide that include:

- "I see you are on Celexa, was that for depression?"
- "How long have you been on this medication?"
- "Have your depression/symptoms resolved since being on the medication? If so, how long have those symptoms been gone?"



Documenting Major Depressive Disorder: Put the Puzzle Together



Piece it Together

Case Study: John Doe

- PMH: Shingles in 2016, bilateral cataract extraction, atrial fib, heart failure, HTN, PVD, hyperlipidemia, CABG w/stents, Type 2 Diabetes, hx thyroidectomy in 1998 r/t cancer, left lung transplant, depression in the past 2 years and at age 40, hospitalized for pneumonia 3 months ago, sober from alcohol x 31 years, Lupus
- Medications: Claritin, ASA, Plavix, Lasix, 2L Oxygen, metoprolol, Prilosec, simvastatin, Lantus, Empagliflozin, vitamin B12, levothyroxine, CellCept, amiodarone, amitriptyline
- ROS: Cough, SOB with moderate activity, 2L of O2 continuous, leg pain with walking relieved with rest, PHQ9 score of 3 (PHQ2 score 0), CPap
- PE: BP 147/94, HR 58, BMI 36.7, impaired monofilament, dependent edema, left chest pacemaker
- Labs: GFR 42 in 2020; GFR 46 in 2019; 2+ glucosuria; hba1c 6.7%; QuantaFlo: Rt 0.82, Lt. 0.94

Questions:

- What are the PMH (resolved) conditions?
- What are potential Causes of Polyneuropathy?
- What are potential causes of Immunodeficiency?
- What are the diabetic complications?
- What are the active diagnoses for the Cardiovascular system?
- What are the active diagnoses related to Psych/ Mental Health?
- What are the remaining active diagnoses?

BEST PRACTICES & RESOLUTIONS TO COMMON ISSUES

Overview

We strive to provide you with the tools to address both clinical and technological issues, and the resources to help you when in need.

- Review best practices for successful day to day operations
- Common pitfalls and their resolutions

Technology Trends & Resolutions

Common Issues & Points of Contact

- Malfunctions requiring contact to the Clinical Support Center (CSC)
  - **VPN Issue(s)**: Unable to connect or secure a connection to Auto VPN
  - **MS Password**: Reset and/or Locked out
- Malfunctions requiring contact to your CTM & CSC (+ Vendor if applicable)
  - **Outlook email (cell phone)**: Password reset and/or any additional app malfunction
  - **Cell Phone** malfunctions
  - **Tablet** malfunctions
  - **eHouseCalls**: Unable to log-in for a prolonged amount of time
- Malfunctions requiring contact to your CTM, Police, & CSC (+ Vendor if applicable)
  - **Cell Phone**: Lost and/or Stolen
  - **Tablet**: Lost and/or Stolen

Equipment Issues

If you experience any issues with the following, please contact our Equipment team by email optum_equipment_team_DL@ds.uhc.com.

- Broken Cell Phone
- Broken or Lost Stylus Pen(s)
- Tablet Charger Cords (Car and Wall)

eHC Loading Malfunction: Error Possibilities

Loading Malfunction: Error Possibilities

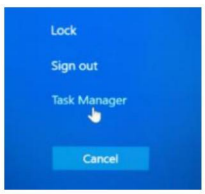
- eHouseCalls is stuck in a "eHouseCalls starting…" status and the program won't open
- eHC locked out because you have entered the incorrect password in too many times, and it triggers a Timed Lock Out



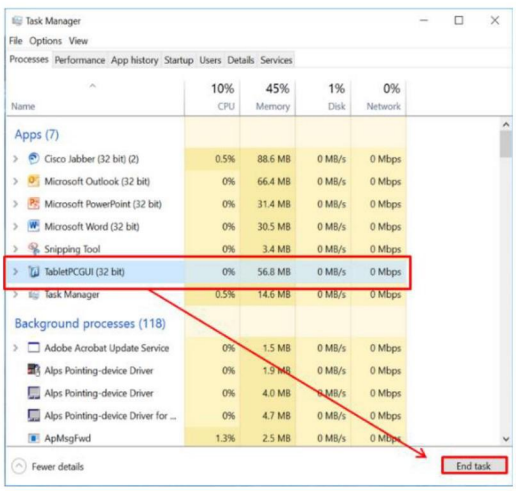


Loading Malfunction: Resolution

1. **CTRL + ALT + DEL**
2. Select **Task Manager**



Scroll down and select **TabletPCGUI**



4. Select **End Task**
5. Launch **eHouseCalls** and **Login** again

All Platforms | Salaried Only | Optum Employees Only | Vendor Only

Paper Assessments

Policy

- Notify both your CTM and the CSC (+Vendor if applicable) if your tablet is malfunctioning
- Complete visits on paper
- Transcribe assessments within 24 hours into your tablet if your tablet is repaired
- Use standard correction
  - If there are errors in the assessment, cross out the error with one line, and then initial and date each change **legibly**
- Shred all papers after the assessment is transcribed
- Request a UPS label to return paper charts
  - Supply Fulfillment Operations: mailingdistributiongroup@xlhealth.com
  - On the e-mail request, copy your CTM; they will monitor the paper assessment process to ensure the assessment is received and processed timely
  - Supply Fulfillment Operations will provide you with a UPS label and cover sheet template within 24 hours of receiving the e-mail request

Lab Tests

- iFOBT: Using a Paper Assessment
  - Do not provide the kit
  - Recommend Follow-Up
- A1C: Using a Paper Assessment
  - Perform the test
  - Remember the Criteria
- Hep C: Using a Paper Assessment
  - Cannot Perform test
- Lipid Panel
  - Perform test on flagged members only

Securing & Handling

- All paper assessments that cannot be transcribed to the tablet should be returned to Fulfillment within **48 hours**
- Each assessment should include the following identifiers
  - **Page 1:**
    - Member's first and last name
    - Member ID number
    - Member's date of birth
    - Member's address and phone number
    - Date of Visit
    - Practitioner's ID and name
    - Practitioner Signature & Credentials
  - **Page 2**:
    - Include 3 **member identifiers**

Reminders and Tips

When or if your tablet malfunctions, you will:

- Continue to document the assessment on paper
- Remember: iFOBT and Hep C tests cannot be offered to the member
  - If the member was flagged for a FOBT or Hep C test, you will not be able to offer this test for the member because you cannot enter a barcode into the tablet
- Completed paper assessments should be documented in the portal as Paper Assessment by selecting the checkbox
- If the member is a Special Needs Plan Member, the HRA tool should also be completed
- Contact both your CTM & the CSC (+Vendor if applicable)
- Blue or Black ink ONLY
- Write Legibly
- 3 member identifiers
- Date of the actual visit
- Ensure you provide your signature AND credentials
- Someone 21 or older must sign when or if a paper assessment is returned

Protecting Member Data

Part of quality is ensuring we protect our member's information.

- Only Necessary Information- as minimal as possible
  - HIPAA requires that we use and disclose only the minimum amount of PHI necessary to accomplish the task at hand
- Be aware: Carrying paper PHI with you on visits puts our members' information and our company at risk
  - This can lead to identify theft and embarrassment for the member, and loss of confidence in Optum
  - For Optum, an inappropriate disclosure of member information can lead to media attention, assessment of monetary penalties, and litigation
- Always keep PHI in your possession – do not leave it unattended
  - Do not leave PHI in your car or at a member's residence
  - Prevent inappropriate viewing:

    Ensure that paper PHI in your possession is not visible to members or the public
    Keep paper PHI in a manila or sealing envelope, inside a bag
- Incident Reporting
  - Lost PHI? You must immediately report the loss to Optum Privacy (privacy@optum.com)

QuantaFlo

These are best practices to avoid issues with QuantaFlo:

- The sensor should be applied to each digit as prompted on the Launched QuantaFlo screen, working in sequential order.
- Make sure the toes are warmed for 5 minutes
- Remind the member to be still
- If USB becomes disconnected, unplug and then plug in again, and/or try another USB port
- Contact UHG Clinical Support Center at: 1-855-247-8474, Option #4 for additional assistance with application functionality or sensor issues
- If you require a replacement QuantaFlo sensor at any time, do not discard your defective sensor. Sensor must be returned per CSC instructions.
- Contact Clinical Helpdesk 1-855-247-8474 for providers who request results of QuantaFlo, Option # 2 or email the helpdesk: HouseCallsClinicalHelpDesk_DL@ds.uhg.com
- For additional detailed QuantaFlo information refer to the QuantaFlo topic on the CEC
- For any issues completing the Simulator Training: Refer to your Simulation Invite which will contain specific instructions and email links

Lab Issues

- Reminders:
  - The lab tool doesn't have to be RED to perform a test if the member meets criteria (iFOBT and A1C only)
  - There are four flagged tests: iFOBT, A1C Now, Lipid Panel, Hep C

Lab Consent

Check **VERIFIED**. You must check the Verify box first before proceeding with the remainder of the tool.



Error Codes

When performing labs in the home, you may receive an error code from time to time. Become familiar with the error codes to understand better how you can prevent further error codes in the future. There are several error codes which can occur. Some error codes are similar as to why they occur. **There is a pamphlet within the A1CNow kit that provides you with the list of error codes**. Be sure to place the monitor on a flat surface and know that if the hemoglobin is high in that member, you will not have incorrect results.

Non-Error Codes

- 09TL
  - The monitors count down the number of tests performed and will only perform 20 tests. The monitor shows how many tests are left by displaying the number left before "**TL**".
  - Example: **09TL** = 9 tests are left

- QCOK
  - When the display finishes counting down, there is a cycle that will appear on the monitor "{QCOK", the test result (%A1c) and the number of tests left (09TL). These screens will cycle through for 10 minutes after the test result is reported, or until the next Test Cartridge is inserted.

THE ERROR AND NON-ERROR CODES JOB AID IS LOCATED ON THE CEC.

Complaints & Grievances

- Required to report all complaints
- OptumCare receives, investigates, & manages all complaints:
  - HouseCalls Visit
  - Insurance Benefit/Plan
  - Other stakeholders
- Complaint: Dissatisfaction expressed by a member
  - APC late arrival to the HouseCalls visit
  - Expression of plan dissatisfaction
  - Any grievance expressed during the visit

Reporting Complaints and Grievances

If the Member verbalizes dissatisfaction during a HouseCalls visit

1. Notify the Helpdesk- **Option 0**
2. Once a Helpdesk agent is available, explain the member's situation
3. The agent will then speak with the member
4. A report will be submitted

The APC may speak on behalf of member. The following should be provided to agent:

- Member name
- Members full address; including city, state, & zip
- Member's date of birth
- Complaint details

THE COMPLAINT MANAGEMENT POLICY IS AVAILABLE TO BE REVIEWED ON THE CEC (CLINICAL EDUCATION CENTER) UNDER THE POLICIES SECTION.

Resources During Visits

Practitioner Help Desk

The Practitioner Help Desk is a useful resource for different problems that might be encountered. The "Where do I go for help?" document provides a listing of the resources available through the Practitioner Help Desk phone number 1-855-247-8474. The Practitioner Help Desk has a recording with automated options for each department. Exercise caution when listening to the prompts to ensure that the correct option is selected so the call is routed to the appropriate team for your need.

Language Line

The Language Line is a resource that is available to you in the home when you are visiting a member who speaks a different language. There is a Job Aid available for the language line that you can access on the CEC. You can also access the Language Line Job Aid from within eHouseCalls by clicking on the Reference Documents Dashboard button or icon.

Important information about the use of the Language Line includes:

- You can the identify the need for an interpreter need in eHouseCalls, Practitioner Portal, or at the door and then place the call to the Language Line
- If asked for Client ID Number, provide number 686165. This code is only for use while working in this role
- Follow the prompts to select the appropriate language and select Prompt 0 if you do not know the member's language
- Once an interpreter is one the line, ask and document in eHC the interpreters name and ID
- Briefly explain to the interpreter the purpose of the HouseCalls visit and then start the visit allow the interpreter to provide translation services

Clinical Profile

The Clinical Profile is a dashboard that allows practitioners the ability to review member information prior to their HouseCalls Visit. The website address is: https://clinicalprofile.optum.com/#/dashboard/. All members who receive a HouseCalls visit will have a profile on the website including UHC Medicare & Retirement, Community & State and Special Needs Plans. The member is always the primary source of information for the HouseCalls visit. However, this website conveniently provides snapshot information to supplement the visit, such as:

- Summaries of previous HouseCalls visits
- Utilization of services by the member
- STAR clinical gaps
- Medications
- Current program enrollments

Suggestions for use of the Clinical Profile site:

- Preparation for a HouseCalls visit with a new member who has no previous visit information
- or for members who cannot provide their medical history (ex. Members with dementia)
- Review information to focus the HouseCalls visit in coordination with information in eHouseCalls
- Review post-HouseCalls visit to confirm/ verify information
- Review of available lab data to substantiate diagnoses
- Confirmation of PCP information, PMH, hospitalizations and emergency room visits

Remember that you will use the Member Client ID located in Practitioner Portal to search for the member on the Clinical Profile site. There is a Job Aid available for the Clinical Profile site that can be located on the CEC.

CEC and APC Connection Sites

Clinical Education Center (CEC)

The CEC website is available to you if you find that before, during, or after a visit you need more information about a particular condition, process, lab, or referral. On the CEC you can look up Job Aids, view documents related to the clinical initiatives, view information for the special non-UHC health plans, and view information such as Clinical Presentations. You will receive an email invitation to access the site. If you have issues with accessing the site, from the log in page you can first select **Forgot Password** and if the issue continues you can email: **clientlearning@optum.com** for assistance.

The web address for the site if you need to request new password after initial log in is: https://learn.optum.com/

After review of the site, if you remain unable to locate any information you need, or if you still have questions, then you can feel free to reach out to CTM for assistance. We want you to feel comfortable in knowing that you are supported in your role.

APC Connection

The APC Connection website is another resource available to you. The website address is: https://uhgazure.sharepoint.com/teams/APCHC

This site houses the weekly agendas and provides links to other frequently used sites like the CEC, Clinical Profile, GSS, and Practitioner Portal. You may need to request access the first time you visit the site, so you may see a pop up on your first visit to the site where you will proceed by clicking the link to request site access. Your access should be approved within a few days.

Wrap-Up

We want you to remember that as an APC, the technology you have may experience an issue at some point. However, it is most important that you remember to remain confident, don't get discouraged, and be honest with your members. If you express your frustration about your equipment in front of the member, that could cause the member to lose trust in their health plan. Always remain true to yourself and your abilities, and you will be successful!

- Technology issues: always remember to reach out to the CSC: 855.247.8474, Option 4
  - Refer to the technical troubleshooting guide located on the CEC under the Technology tab for instances when you need to email the equipment team for resolution
- When you are seeing members and your computer malfunctions, continue the assessment on paper, and review the paper assessment policy. Contact your CTM (+Vendor if applicable) if you have further questions.
- Remember, any mishandling of PHI can result in placing Optum and the member at risk of exposed information
- QuantaFlo issues: follow the tips provided above
- Labs: if you encounter error codes, review, and remember these tips are provided in the A1C kits
- Always take the members seriously regarding their complaints and grievances; all must be reported to the Helpdesk

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Optum Coding and Documentation materials are based on current guidelines, are to be used for reference only, and are not intended to replace the authoritative references identified below.
·Clinical and coding decisions are to be made based on the independent judgment of the treating physician or qualified health care practitioner and the best interests of the patient.
·ICD-10-CM, CPT and HCPCS are the authoritative references for purposes of assigning diagnoses and procedure codes to be reported.
·It is the responsibility of the physician and/or coding staff to determine and submit accurate codes, charges, and modifiers for services rendered.

Substance Use Disorders (SUD)

Fast Facts:

- Only 18.5% of the 22.5 million people (8.5 % of the U.S. population) received the needed treatment for a drug or alcohol use problem in 2014. Seven to 15.3% of the population needed substance abuse treatment in 2018. Only 0.6-1.6% received treatment in 2018 (USDHHS, SAMHSA, 2019)
- The National Survey on Drug Use and Health reported 20.4 million Americans had SUD in 2019
- An estimated 95,000 people die from alcohol-related causes annually, making alcohol the third leading preventable cause of death in the United States (CDC, 2020)
- US standard drink is 14.0 g of pure alcohol can be found represented by the following: 12 oz. beer, 8 ounces of malt liquor, 5 ounces of wine, and 1.5 ounces of 80 proof distilled spirits or liquor

Definitions:

- **Physical dependence** is a state of adaptation that is manifested by tolerance or withdrawal
- **Tolerance** is a state of adaptation in which exposure to a drug induces changes that result in a diminution of one or more of the drug's effects over time
- **Withdrawal** is a drug class specific syndrome that can be produced by abrupt cessation, rapid dose reduction, decreasing blood level of the drug, and/or administration of an antagonist
- **Psychological dependence** is a substance use disorder with a problematic pattern, leading to clinically significant impairment or distress and is diagnosed by meeting DSM-5 criteria
- **Drug dependence in remission**:
  - Is defined by DSM-5 as none of the criteria having been met for at least 3 months except craving or a strong desire to use the drug
  - Should be documented for a patient whose past medical history is significant for drug dependence
  - The term "history of" should be avoided. There is NO code in ICD-10 for history of dependence

Screening:

- There are many drug and alcohol screening tools available such as CAGE or DAST-10 (Drug Abuse Screen Test)
- Screening is used to identify people who are *likely* to have a disorder

CAGE Questionnaire

The CAGE questions were developed by Dr. John Ewing in 1970 and have been found to be an effective assessment tool for identifying alcoholics. The CAGE is located in the Social History section on page 7 of eHouseCalls.

Questions include:

1. Have you ever felt you should cut down on your drinking?
2. Have people annoyed you by criticizing your drinking?
3. Have you ever felt bad or guilty about your drinking?
4. Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?

Scoring: Item responses are scored "0" or "1" with the highest score as an indication of alcohol issues



Alcohol				
	☑ Current ☐ Former ☐ Never	☐ Interested in quitting ☐ Counseled to quit	Drinks per week:	
			Drinks per occasion:	
	CAGE Screening		☐ Refused	
	Have you felt you should cut down on your drinking?		☐ Yes	☐ No
	Have others annoyed you by criticizing your drinking?		☐ Yes	☐ No
	Have you ever felt guilty about your drinking?		☐ Yes	☐ No
	Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover?		☐ Yes	☐ No

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- **Note: If member responds to positive alcohol use then the CAGE questionnaire in eHouseCalls on page 7 should be completed.**

Clinical Clues:

- Past Medical History positive for substance use or treatment of SUD
- ROS positive for symptoms of withdrawal such as insomnia, dry mouth, drug cravings, clouded mental function
- Medications consist of chronic or high dose opioids or sedatives, especially if take together
- Medication misuse, early refills, taking via a route different than that prescribed
- Social History positive for recreational drugs

Making the Diagnosis:

- There are two clinical diagnosis that fall into the same code of SUD
  - Physical dependence- independent of DSM-5 criteria
  - Psychological dependence- must meet DSM-5 criteria
- The clinical determination of physical dependence, along with documentation of an assessment/ plan, is enough to make a substance use disorder diagnosis of dependence
- A psychological dependence diagnosis is made by confirming at least two of the DSM-5 substance use disorder diagnostic criteria, within a 12-month period

DSM-5 Diagnostic criteria for SUD (Substance use disorder requires at least two of the following be met within a 12 month period)	Criteria Met Yes = 1
1. Consuming substance in larger amounts for a longer period than was intended	
2. Persistent desire or unsuccessful efforts to cut down or control use	
3. Significant time spent on activities to obtain, use, or recover from its effects	
4. Craving or urge to use substance	
5. Recurrent use resulting in a failure to fulfill major role obligations at home, work or school	
6. Continued use despite social/interpersonal problem	
7. Important social, occupational or recreational activities are given up or reduced because of use	
8. Recurrent use in situations in which it is physically hazardous	
9. Continued use despite knowledge of a known physical or psychological problem, likely to have been caused or exacerbated by the substance	
10. Tolerance, as defined by either of the following: a) A need for markedly increased amounts to achieve intoxication or desired effect b) A markedly diminished effect with continued use of the same amount	
11. Withdrawal as manifested by either of the following: a) The characteristic withdrawal syndrome b) Is taken to relieve or avoid withdrawal symptoms	
Total	
Final DSM-5 Criteria recommends three diagnostic categories: mild (2-3), moderate (4-5) and severe 6+ positive criteria	

- **The DSM-5 criteria used to diagnose psychological dependence does not apply when the dependence is exclusively a physical dependence.**

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- **A person may have a physical dependence on a substance without having a psychological dependence or addiction.**

Severity of use:

- The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) updated the terminology from substance **abuse** and substance **dependence** to **substance use disorders** measured on a continuum from mild to severe
  - **Substance Abuse** is equivalent to Substance Use Disorder, Mild
  - **Substance dependence** is equivalent to Substance Use Disorder, Moderate or Severe

Comprehensive assessment includes:

- Determining the type and severity of a patient's substance use
- Diagnosing SUD or other conditions if present
- The identification of psychiatric and medical conditions

Consider message to PCP in non-urgent communication section on page 16 and make a behavioral health referral, if member consents, to assist with:

- Understanding the patient's perception of their condition and ability to change
- Identifying barriers and facilitators to reducing the use
- Development of a treatment plan, if needed

Substance catagories:

- Alcohol, Opioids, Cannabis, Sedatives (includes hypnotics or anxiolytics), Cocaine, Amphetamines (includes other stimulants), Hallucinogens, Inhalants, or Other psychoactive substances

Diagnoses in eHouseCalls:

The APC will perform a search for the category of substance use in the tablet. When performing a search, the APC can access the Constitutional section of the Diagnosis search category for a quick find on alcohol abuse types and substance abuse. It is important to document the substance of use if known (Figure I). The APC can also search in the browser in the diagnosis cart by typing in **"sub"** and a large selection of types of substance uses will be available for selection (Figure II). Opioid abuse and dependence are found in the following (Figure III).

Figure I

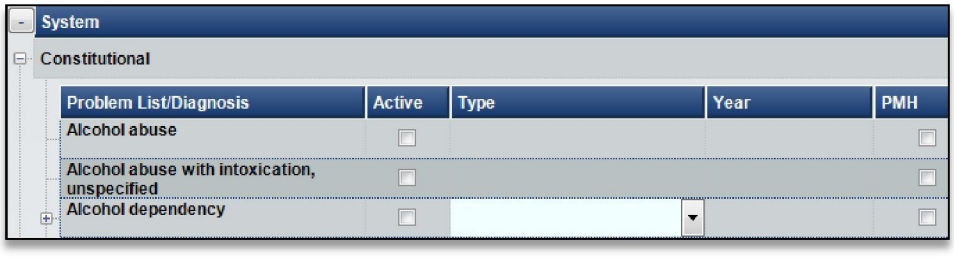

Figure II

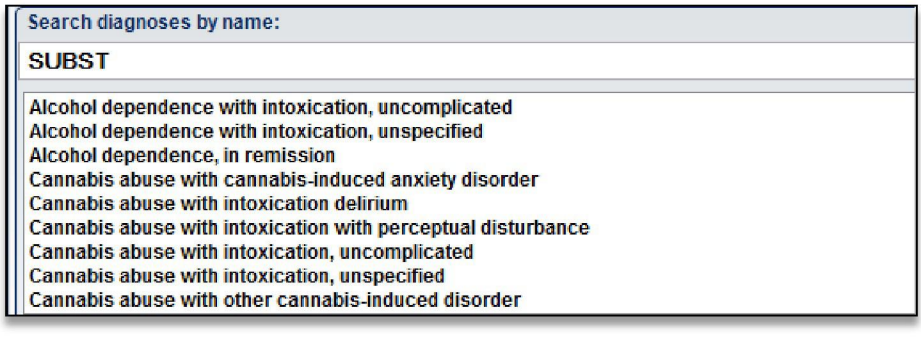

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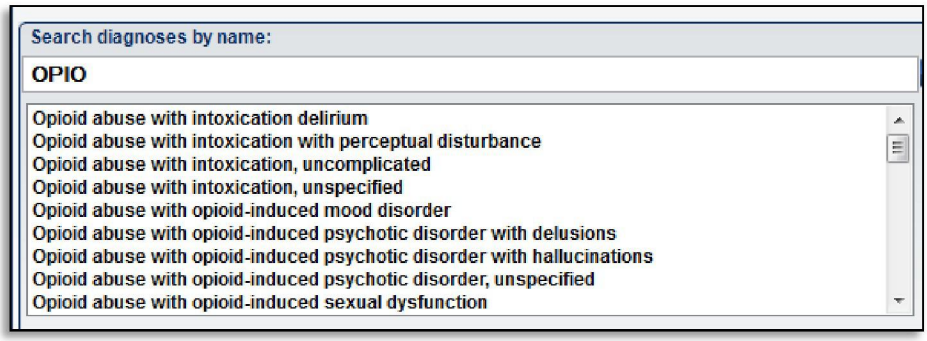
Figure III



Smart Logic:

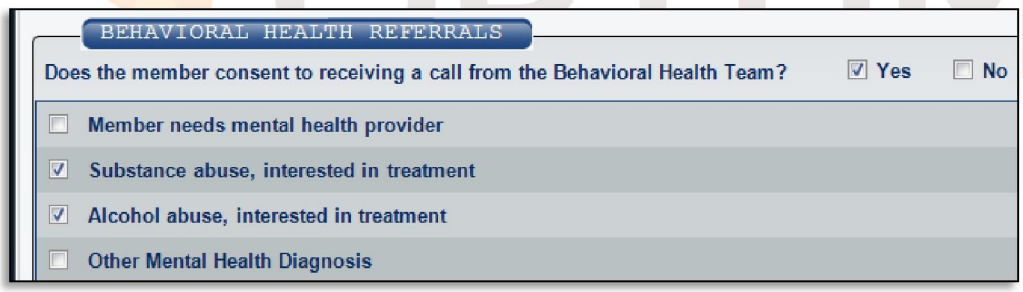
Smart logic is a feature that is based on the clinical findings documented in the encounter and is populated on page 15 for review and confirmation. If 'drug use' is selected in the social history section, *'substance abuse' d*iagnosis will be auto populated on the diagnosis confirmation page. Evaluate if this diagnosis is appropriate for the member on page 15. You need to provide free text documentation to support a diagnosis based on DSM-5 criteria.

- **Select the most specific diagnosis in the tablet based on your assessment findings and remove the diagnosis of 'Substance abuse' if prepopulated by tablet logic and select the associated substance if known.**

Referrals

Behavioral Health

Ask the member if our behavioral health team can contact them to discuss their substance use.



PCP

A referral to the member's PCP may be indicated if the member declines a behavioral health referral. The APC will document relevant findings in the Communication Details' section of the CRD tool.

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CASE STUDIES

Example of Substance Abuse Disorder:

HPI: 68-year-old male member who is seen for HouseCalls visit. Member states he has 6 beers at night and 4-6 oz. of scotch nightly. He has tried to cut down but has been unsuccessful. He says it calms him and he feels he can deal with life events better despite encouragement from his partner to stop drinking. Member denies any history of mental health hospitalization or treatment. He continues to work night shift as a forklift operator and admits to drinking before work. He is currently on suspension at work due to his drinking.

MEDS: Lisinopril 20 mg daily; Omega 3 vitamin daily; Xanax 0.25 mg PRN

CAGE question responses:

- Have you ever felt you should cut down on your drinking? **N**
- Have people annoyed you by criticizing your drinking? **Y**
- Have you ever felt bad or guilty about your drinking? **N**
- Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover? **Y**

  Scoring: Items responses are scored "0" or "1" with the highest score is an indication of alcohol issues

EXAM: Alert and disheveled, avoids eye contact with examiner. VSS. CV: S1, S2 RRR, no murmur; Lungs: CTA; Abdomen soft and non-tender; full ROM. Steady gait.

LABS: None available; on the DSM-5 criteria member scores in the moderate range (5)

ASSESSMENT:

Description with Plan:	Alcohol Dependence Hypertension Plan: Consider a message to PCP in non-urgent communication section on page 16 and make a behavioral health referral if member consents.

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Example of Substance Use Disorder:

HPI: 65-year-old female who is seen for a HouseCalls visit. Member states she has chronic pain from trigeminal neuralgia. On continuous opioids for the last year without the ability to wean off due to pain, is well controlled at this time. Tolerating dose well, no psychological dependence noted. She recently forgot her medication over a weekend trip and found herself sweaty and nauseated, that resolved once she resumed her medication.

MEDS: Oxycodone 5mg by mouth TID

ROS & EXAM: normal

DSM-5 criteria: member scores 0

ASSESSMENT:

Description with Plan:	Opioid dependence, uncomplicated Chronic Pain Trigeminal Neuralgia Plan: F/u with PCP to discuss plan to wean off Oxycodone.

Example of Opioid drug dependence in remission:

HPI: 60-year-old male member who is seen for HouseCalls visit. During the visit you realize that he is no longer taking his Vicodin medication for pain like he was last year. Upon further investigation he reports that while it was difficult, he was able with the help of his physician to wean off the medication. He proudly reports that it has been 4 months since he had one and he is using other nonpharmacological therapy to control his pain associated with his back pain. He also reports his blood pressure and acid reflex are controlled

MEDS: Metoprolol 50mg daily; Pepcid 40mg daily

EXAM: VSS. CV: S1, S2 RRR, no murmur; Lungs: CTA; Abdomen soft and non-tender; full ROM. Steady gait.

ASSESSMENT:

Description with Plan:	Opioid drug Dependence, in remission Hypertension GERD without esophagitis Intervertebral disc disorders with radiculopathy, lumbar region Plan: Stable, f/u with PCP PRN

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Optum

eHouseCalls Training Manual

Software Version 2.55.0.0
2023

Optum

TABLE OF CONTENTS

HouseCalls Overview 9

Training Expectations 9

Launching and Logging into eHouseCalls 10

Moving the Taskbar 11

Startup and Sync Procedures 13

Step 1: Tablet Login 13

Step 2: Auto-Connect to Internet & VPN 14

Connect to the internet 14

Auto VPN 15

Step 3: Login to eHouseCalls 15

Step 4: Synchronization Status 16

Step 5: Synchronize Data 16

Other Settings & Processes 17

Adjust the Screen Timeout Feature 17

Switch to Landscape (laptop view) 18

Switch to Portrait (tablet view) 18

Logout Process 18

The Dashboard 19

Synchronization Status 20

Verifying Connectivity 20

Synchronize Data 21

Application Details 21

Upgrade the eHouseCalls Application 21

Scheduled Appointments 22

Member Details 24

Open an Assessment 25

Status of the Member Visit 26

Alternate Location Appointments 27

Assessments in Progress 27

Past Appointments 27

Blank Assessment 27

eHouseCalls Assessment Overview 29

Virtual Keyboard (Tablet Mode) 30

Red Text 30

Data Grids 30

Data Entry Overview 31
Numeric Values 31
Dates/Calendars 32
Add Row/Delete Row 32
Drop-Downs & Checkboxes 33
Diagnostic Toolbar 33
Navigation Buttons 33
Documenting Assessment Page 1 35
HIPAA Privacy Notice Documentation 35
Member Demographics 37
Mailing Address 37
Race 37
Ethnicity 37
Email/Text Consent 38
Reason for the Visit 39
Member Properties 40
Assessment Location 40
Non-Member Contact 42
Caregiver Help and Support 42
Member Identified Topics 42
PCP Information 43
Search PCP Tool 43
Documenting Assessment Page 2 46
Specialist Information 47
Editing Pre-populated Data 47
Surgery Details 47
Admissions 48
Emergency Room Visits 48
The Diagnosis Cart 49
Diagnosis Rationale Icons 49
Adding Diagnoses 49
Quick Pick 50
Add Diagnosis 50
Documenting Assessment Page 3 51
Clinical Review 51
Additional Options 51
Change Diagnosis Order 51
Social/Family History 52
Add Diagnosis 52

Multi-Level Diagnosing 52
Documenting Assessment Page 4 56
A Comprehensive Medication Review 57
Post Discharge Visit (PDV) 57
Medications/Supplements Grid 58
Duplicate Medications 63
Statin Days Supply 63
Prescription Home Delivery 64
Member In Scope 64
Member Not In Scope 65
Medical Devices 65
Pharmacy Adherence 65
Barriers to Adherence 66
Show Cart Button 66
Documenting Assessment Page 5 67
Allergies 68
Labs 68
Screenings 68
Vaccination History 68
Received Vaccinations 68
Not Received Vaccinations 68
Incomplete Grid 69
Documenting Assessment Page 6 70
Preventative Screenings 70
Colorectal Cancer Screening 71
Bone Density Screening 71
Diabetic Retinal Screening 71
Documenting Assessment Page 7 73
Social History/Risk Factors 74
Family History 76
Documenting Assessment Pages 8-10 77
Review of Systems (ROS) 78
Page 9 78
Page 10 79
Documenting Assessment pages 11-14 81
Physical Exam (PE) Overview 82
ROS Highlighted Sections 82
Page 11 82

Page 13 83
Page 14 85
Optional Components of an Assessment 87
Addressing the Diagnostic Toolbar 88
Show Desktop 88
Summary of Last Annual Visit 88
Display Previous Assessment 88
Post Discharge Visit Form 89
Outreach Information 89
Hospitalization Information 90
PCP Information 91
Specialist Information 91
Mandatory Message for Post Discharge Form 92
Alert Message: Closing Post Discharge Visit Form 93
STARS - Star Gap Measures 93
ADL - Barthel Index of Activities of Daily Living 95
MNA - Mini Nutritional Assessment 96
PA - Pain Assessment 97
COG - Mini-Cognitive Assessment 98
FRA - Fall Risk Assessment 99
PSY - Depression Screening Tool 100
SDOH - Social Determinants of Health 102
HRA - Health Risk Assessment 103
CRD - Comprehensive Referral Display 105
Expansion and Collapse of Referral Sections 105
OAH Question Configuration 105
Referral Types 106
WellMed Care Advocate Team 107
Landmark Longitudinal Care Management 109
Alert messages 116
Care Manager Referrals 117
Clinically Significant Referrals 118
A1C Referral 119
Social Work Referral 120
Pharmacy Clinical Referral 121
SDOH/Social Needs 122
Referral Restrictions 124
FVIS - Flu Vaccination Information Sheet 124
SOF - Summary of Findings 125

LAB – A1C+NOW (Blood), FOBT Let's Get Checked (LGC) Testing 126
MTM – Medication Therapy Management 129
Assessment Notes 129
More Tab 130
Documenting Assessment Page 15 131
Diagnosis Confirmation - Assessment & Plan 131
Active Diagnoses List 132
Previously Diagnosed 132
Potential Diagnoses 132
Removed 132
Add Diagnosis 133
Additional Diagnosis/Notes Section 133
Documenting Active Diagnoses 133
Chronic Conditions 133
Checkbox - Member has Diabetes Diagnosis 134
Documenting Assessment Page 16 135
Member Education 136
Delivery Method 136
Required Education 136
General Education 137
Client and Referral Education 138
Body System Education 139
Other Education 140
Listening Checkpoint 141
Mandatory Messages and Hard Stop 141
Recommendations 142
Non-Urgent Communications 142
Documenting Assessment Page 17 143
Ask Your PCP Letter 144
Documenting Assessment Page 18 145
Social Needs HouseCalls Care Connector Assistance 145
HouseCalls Care Connector Assistance - Vaccine 147
Documenting Assessment Page 19 148
Assessment Notes 149
Support Services 149
Special Circumstances 150
Advocate4Me 150
Prescription Home Delivery 150

Member In Scope 151
Member is Not In Scope 151
Member is Not Eligible 152
Mandatory Messages 152
Personal Protective Equipment Documentation 152
Clear Transparent Face Masks 153
Sensitive Diagnosis Consent 153
Member Signature 153
Documenting Assessment Page 20 154
Status 155
Signature 155
Practitioner Accompaniment 155
Save 155
After the Visit 156
Verifying a Successful Finalization & Sync Tablet 156
Interpreter/Translator Member Visit 157
Virtual Visits 157
Accessing Member Visit 157
Time Slots 157
Member Authentication 158
Page 1 158
HIPAA Privacy Notice Documentation 158
Medication Page 160
Preventative Screenings 160
Unable to Perform Details 160
Review of Systems (ROS) 161
Physical Exam (PE) 161
Vital Signs & Constitutional 161
HEENT - Eyes 162
HEENT - Ears 163
HEENT - Neck 163
Respiratory 163
Cardiovascular 164
Gastrointestinal 164
Genitourinary 165
PVD Screening 165
Musculoskeletal 166
Neurological 167
Skin Section 167

Diagnostic Tools 168
Mini Cog 168
MNA 168
CRD 168
Member Education 168
Labs 168
Page 19 169
Mandatory Messages: Deselecting Auto-Selections 169
Removal of Mandatory Messages 169
Visit Consent: Video Virtual visit 170
Review Visit Consent 170
Member Signature 170

HOUSECALLS OVERVIEW

HouseCalls combines the human touch of an in-home medical examination with sophisticated technology and targeted health education to improve the health and quality of life for our members. Our network of health care practitioners' visits members in their home to collect critical insight unavailable outside the HouseCalls program. With this combination of unique information and hands-on care, we can build a strong foundation of trust, create stronger adherence to physician's orders and medication, and craft a plan of customized care for each member that can be shared electronically with their care providers.

You will use the eHouseCalls software to document member data from your visit. This software was created in-house, by incorporating feedback from practitioners to design an assessment that is easy to use and enables you to document all issues while visiting with the member. When you finalize an assessment, it is transmitted to our server. The information collected during visits is extremely valuable and will be incorporated into existing clinical services operated by Optum and its business partners to support ongoing member care management efforts.

We want to thank you for enabling us to bring this valuable service to our members. Welcome!

Training Expectations

Through training we will focus on documenting house calls visits in eHouseCalls. By the end of training, you will be expected to know how to:

- Login to your tablet
- Connect your tablet to the Internet and VPN (Cisco AnyConnect)
- Log into eHouseCalls and sync data
- Verify scheduled member appointments
- Status visits you are not able to start
- Navigate and document the eHouseCalls Assessment using a Practice Assessment
- Finalize the Assessment

eHouseCalls is the name of the EMR used to document member visits with the HouseCalls Program. It is an application built and maintained by an in-house software development team. What makes the EMR unique is the ability to document assessments during the member visit without Internet access.

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LAUNCHING AND LOGGING INTO EHOUSECALLS

The eHouseCalls software can be opened by finding and clicking the appropriate icon on the desktop (background) screen of the company-issued laptop/tablet.



1. From the Desktop, double-click the eHouseCalls icon to launch eHouseCalls. The initial login window displays.

ANY TIME YOU LAUNCH THE EHOUSECALLS APPLICATION, THE TABLET SCREEN WILL TURN SIDEWAYS (PORTRAIT ORIENTATION). THE SCREEN CAN BE REORIENTED AFTER COMPLETING A SUCCESSFUL LOGIN.

2. Once the login window appears, confirm the Login Name matches your MS User ID, then enter your MS Password in the box provided.
3. Click the **LOGIN** button. An error message will display if the login credentials are incorrect.



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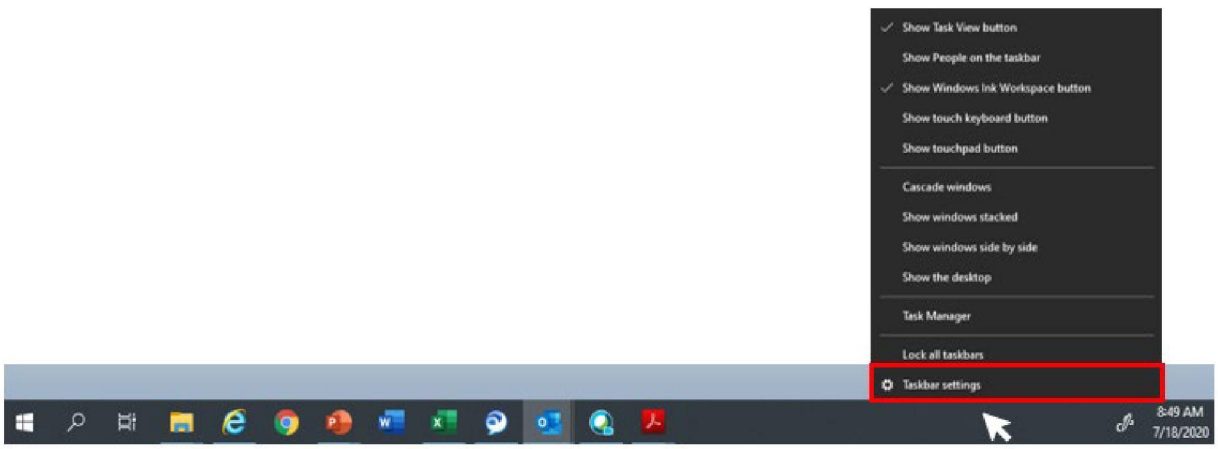
4. After completing a successful login, click the **SWITCH TO LANDSCAPE** button- found near the large HouseCalls logo. Your screen orientation will rotate back to the normal view.



Moving the Taskbar

The black bar located at the bottom of the computer screen is call the **Taskbar**. It displays settings on the right side, as well at the date and time. The left side displays the Start button/menu and a series of icons representing open applications that can clicked on to select and arrange multiple application on the screen.
In order to see the entire eHouseCalls assessment page, the Taskbar will need to be moved away from the bottom of the screen.

1. **Right click** on an open area of the Taskbar- somewhere not occupied by an icon.



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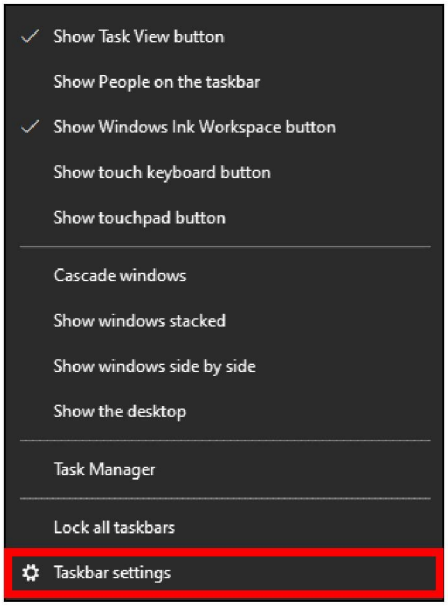
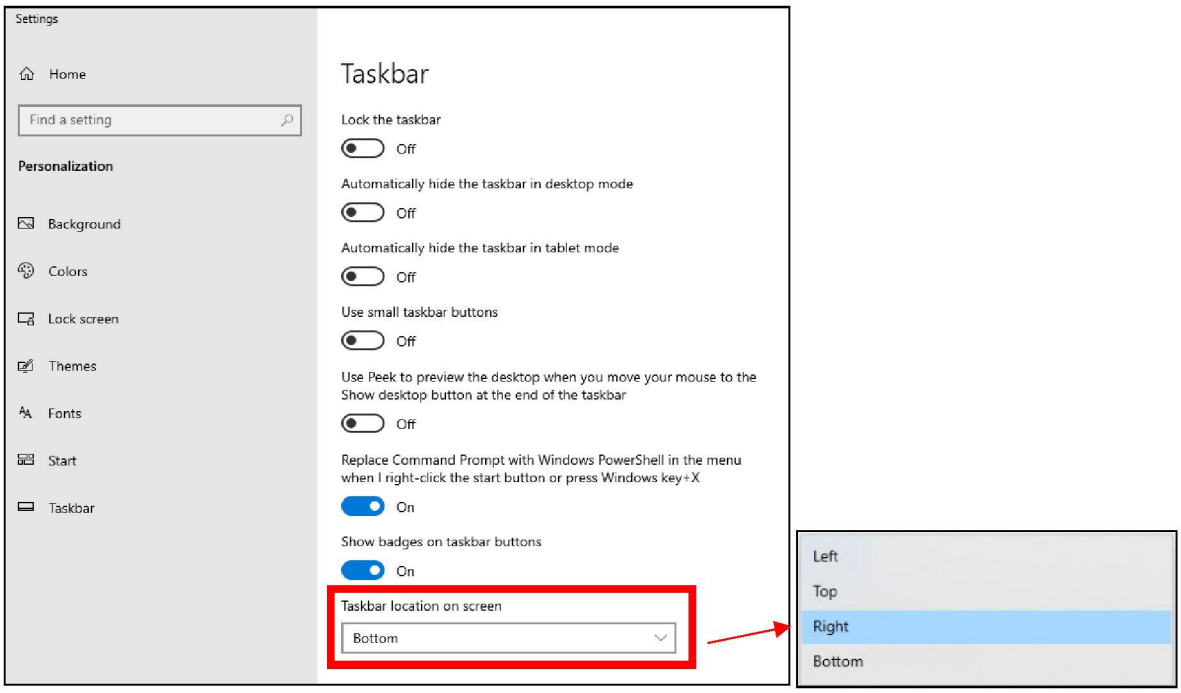
2. A pop-up menu will appear. Select the option at the bottom of the list: **Taskbar Settings**



3. A Taskbar setting window will appear. Find the drop-box setting for **Taskbar Location on Screen** and change the option to ***Left*** or ***Right***.



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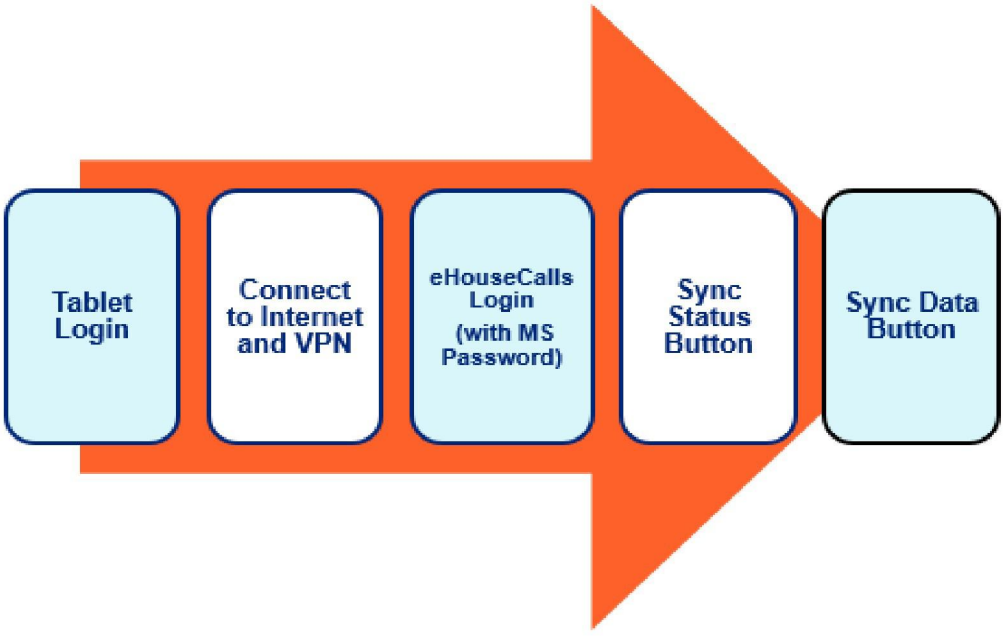
STARTUP AND SYNC PROCEDURES

The start of a typical workday begins with powering on your tablet, logging in, and completing a synchronization. Much of our data needs to be protected from malicious use or theft, so this process will give you secure access to copy and save all the member data needed for your scheduled visits to the internal memory of your tablet.

Tablet synchronization can be summarized in the following steps:



Step 1: Tablet Login

Before logging in, you will need to power on the device and let it complete the startup process.

1. Turn on your laptop by pushing the power button and the boot up process will begin.

2. Once the boot up process begins, **DO NOT** press any other button on the laptop until you see the blue screen, signifying the boot up process has complete



3. When the blue screen appears, press **Enter** on your keyboard.
4. When the **Legal Notice** appears, click **OK**.
5. From the login screen press your registered **fingerprint** on the reader of your device **or** input your Windows Hello **PIN** in the password field. When entering the PIN, press the **Return/Enter** key.

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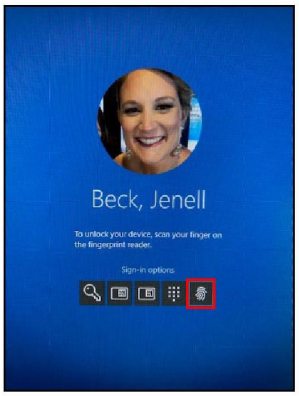
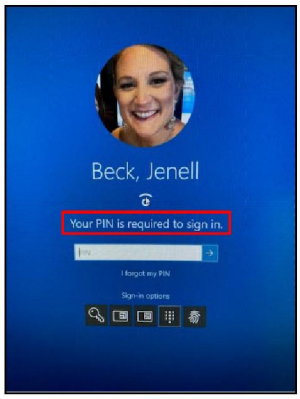
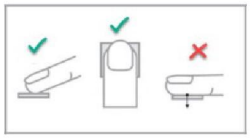




OR



FOR A TOUCH FINGERPRINT READER, YOU DO NOT NEED TO CENTER YOUR FINGER ON THE READER. THE MOST EFFECTIVE WAY IS THE FRONT OF YOUR FINGER WITH A 45-DEGREE ANGLE, LIKE YOU ARE PRESSING A BUTTON.



Step 2: Auto-Connect to Internet & VPN

An Internet connection allows the tablet to download data wirelessly. However, member data (and other private data) is stored in a protected area. To access this information, a VPN connection is used- this creates a secured Internet connection to safely download member data.

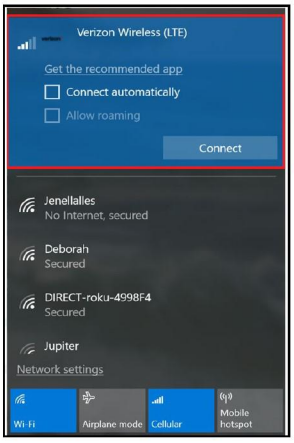
Connect to the internet

1. Navigate to the desktop system tray and click the WIFI icon (if you see either of the two icons below) to set up an Internet connection. The WIFI Connections window displays.





2. From the WIFI Connections window and from the Broadband Connection list, select "**Verizon Wireless (LTE) or** your preferred **Wi-Fi** connection, and then click **Connect**. Some Wi-Fi connections will require a password.



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3. Wait one minute and then verify internet connectivity, by ensuring the icon is shown in the desktop taskbar.



A HOME WI-FI CONNECTION IS THE EASIEST AND MOST RELIABLE INTERNET CONNECTION TO USE AND CHOOSE TO CONNECT TO IT. ONCE AN INTERNET OPTION IS SET UP, THE TABLET WILL AUTO-CONNECT IN THE FUTURE.

Auto VPN

Once you've successfully logged in and confirmed an Internet connection, your tablet will attempt to auto-connect with the VPN. The VPN secures your Internet connection and enables you to send and receive data from your tablet to our secure server.

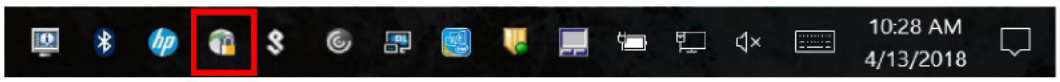
A VPN connection is needed at least twice a day when you use the tablet; before you see members for the day, and at the conclusion of your workday. The connection is automated, assuming you sustain an internet connection.

IF A MEMBER IS ADDED OR REMOVED FROM YOUR SCHEDULE, YOU WILL NEED TO CONNECT TO THE VPN IN ORDER TO SEE THE DATA CHANGES REFLECTED IN YOUR TABLET.

A VPN connection is confirmed by the gold lock appearing on the Cisco AnyConnect icon, which is found on the Windows taskbar.



Not Connected to VPN *Connected to VPN*



YOU DO NOT NEED A VPN CONNECTION TO CONDUCT EHOUSECALLS ASSESSMENTS THROUGHOUT YOUR DAY. FOR ALL VPN ISSUES, CONTACT THE CLINICAL SUPPORT CENTER (CSC) AT [redacted], OPTION #4.

Step 3: Login to eHouseCalls

1. From the Desktop, double-click the eHouseCalls icon to launch eHouseCalls, (shown below). The initial login window displays.
2. Once the eHouseCalls initial login window displays, ensure that your Login Name matches your MS Username and then enter your MS Password in the textbox provided.
3. Click the **LOGIN** button. The Dashboard will display.

THE EHOUSECALLS APPLICATION LOGIN WILL ALLOW A MAXIMUM OF 3 LOGIN ATTEMPTS AND THEN YOU WILL BE LOCKED OUT FOR 10 MINUTES. AFTER 10 MINUTES, YOU CAN TRY TO LOG IN AGAIN OR YOU CAN RESTART YOUR TABLET TO LOG IN IMMEDIATELY.

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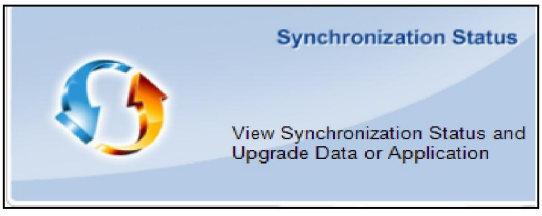
Step 4: Synchronization Status

Once you have logged into eHouseCalls, it is important to verify your connectivity status to the internet and VPN, synchronize your data, and upgrade the application (if needed). To access the *Synchronization Status* screen, click the **Synchronization Status** button on the Dashboard to perform these functions.



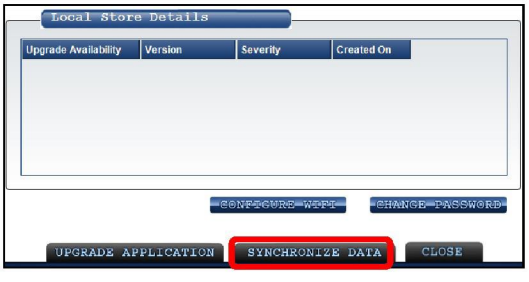
Step 5: Synchronize Data

1. When connected to both internet and VPN, **Yes Yes** should display at the top of the window.



- If either of these connections indicate No:
  - Reboot the computer, complete the login process, successfully reestablish an internet and VPN connection, and then try to synchronize once again
  - Contact **HouseCalls IT Support** if you are still unable to connect

2. Once connected successfully, click the **SYNCHRONIZE DATA** button. A "Data synchronized successfully" pop-up will display confirming completion.



MAKE SURE THE DATES AND TIMES FOR DATA LAST UPDATED FROM SERVER AND DATA LAST UPDATED TO SERVER ARE UPDATING EVERY WORKDAY WHEN YOU ARE IN LIVE MODE. IN A PRACTICE MODE, ONLY THE DATA LAST UPDATED TO SERVER WILL UPDATE AS YOU FINALIZE PRACTICE ASSESSMENTS AND SYNCHRONIZE DATA.

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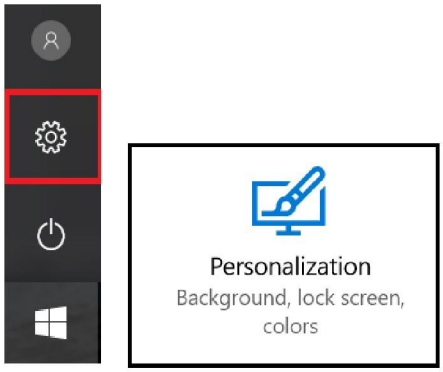
Other Settings & Processes

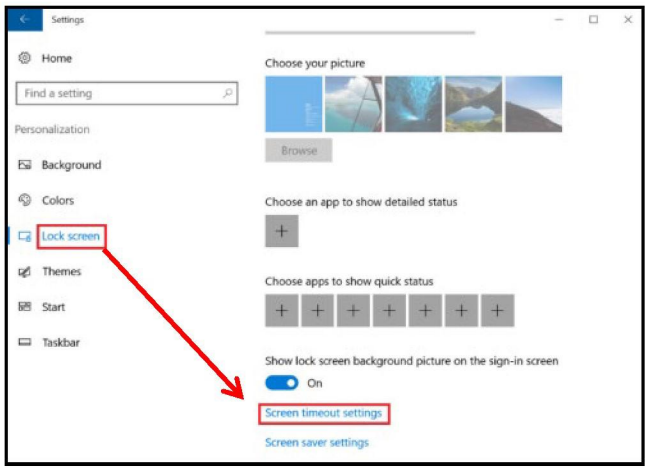
Adjust the Screen Timeout Feature

When starting to work within your device, you may find that the display screen "times out" or goes dark quickly. In order to adjust the timer:

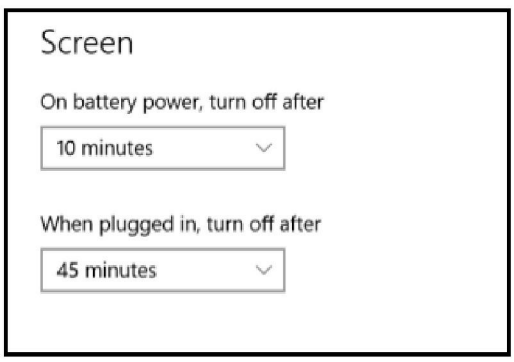
1. Find the black **Task Bar** located at the bottom of the tablet screen. Click the Windows Start button in the lower left corner and select the **Settings menu** (the cog icon).
2. Select **Personalization**.



3. Scroll down and select **Lock Screen**, and then **Screen timeout settings**.



4. Scroll down to select your preferences of time for the screen display. **Recommended: 45 minutes**



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Switch to Landscape (laptop view)

To document the assessment in laptop (landscape) view, click the **Switch to Landscape** button to rotate the screen orientation. The eHouseCalls assessment will display on half the screen and is unable to be maximized beyond that. Scroll bars will be used to see parts of the page that fall off the screen.



Switch to Portrait (tablet view)

If you wish to document in tablet (portrait) mode, the eHouseCalls application will auto-default to that display any time the software is launched. Once the screen has rotated to portrait mode, detach the keyboard, and physically rotate the tablet.

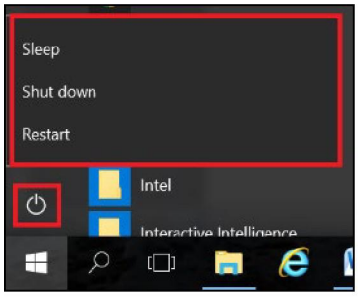
Logout Process

At the end of each day, you must log out of eHouseCalls and properly shutdown your tablet.

1. Return to the **Dashboard** of eHouseCalls and click the **LOGOUT** button.



2. Click the Windows Start button in the Task Bar and select **Shut Down**.



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THE DASHBOARD

After a successful login, the Dashboard displays. This is where you will access scheduled members and their assessments. The large buttons are used to help manage assessments, synchronize member data, access additional APC resources, and locate both a blank assessment and a practice member assessment.
At the top of the dashboard screen, below the HouseCalls banner, you will find a button that offers the option to switch the screen orientation from portrait to landscape mode, and back if desired. Please note, if you would like to change your screen orientation after navigating away from your eHouseCalls dashboard, you can fold back your screen (like a notebook) or forward to return back to a laptop setup. Also, if there is an application upgrade available, you will find a flashing message at the top of the page alerting you to upgrade your application.
If we navigate to the bottom of the dashboard, **Flash News** alerts are available. This feature helps communicate information to all HouseCalls APCs in the field and can also be found in the Practitioner Portal.



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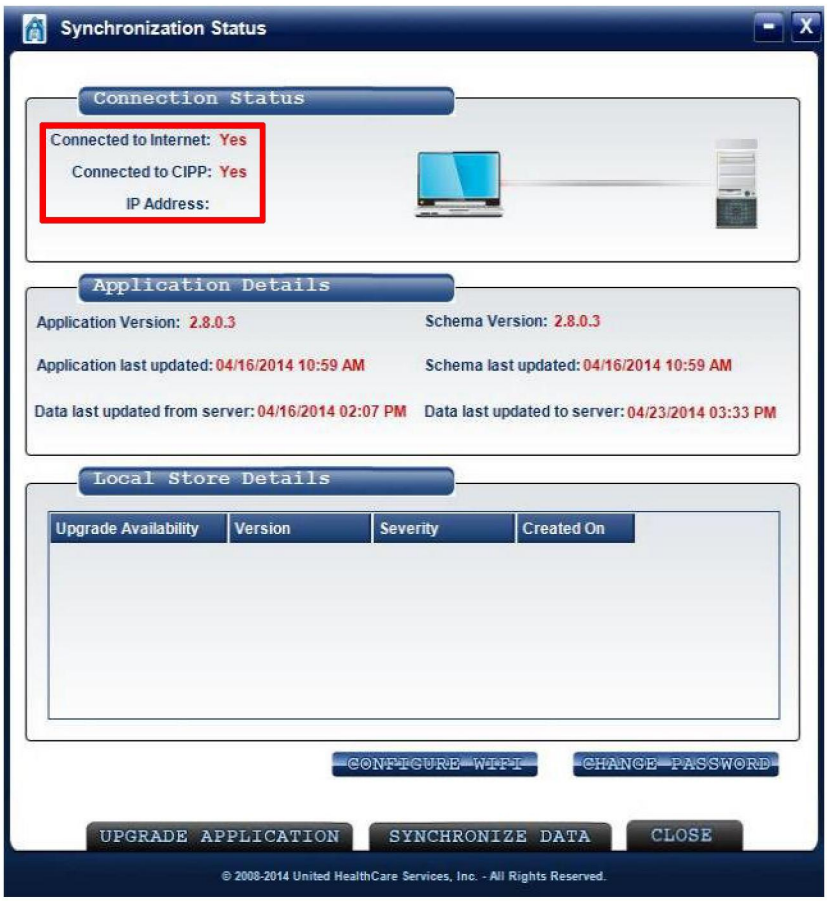
Synchronization Status

This button has two primary functions: Synchronizing data and upgrading the software (if needed). Both tasks depend on a connection to the Internet and VPN, which can also be confirmed here.



Verifying Connectivity

Once you have selected the Synchronization Status button from the dashboard, a new window will appear. ***** WAIT UNTIL THE NEW WINDOW APPEARS BEFORE CONTINUING*****
At the top of the new window, you will see a connection status section. When attempting to successfully synchronize your eHouseCalls application or upgrade the application, you should see a **Yes Yes** status displaying. You must have **Yes** indicated for both connections to sync and upgrade successfully. This also allows scheduling data to be sent to and from your tablet, which would include things such as your finalized assessments and your updated member schedule.



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Synchronize Data

Syncing (the act of receiving and sending data) can be completed as often as you like, but should be done at least twice a day when you are scheduled for member visits:

- Before leaving to complete visits, so that you have the most updated schedule, accounting for any rescheduled appointments that day
  AND
- After returning home and have finalized the assessments for the completed visits that day

The process for synchronizing eHouseCalls is:

2. Confirm that you have successfully connected to the internet and VPN, indicated by the **Yes Yes**.
3. Click the **Synchronize Data** button at the bottom of the window. Once completed, you will receive a pop-up, alerting you that you have successfully synchronized.

If there is data to send to or receive from the servers, the dates will change and display the current date and time it was successfully synchronized.



NOTE: MAKE SURE THE DATES AND TIMES IN THE *APPLICATION DETAILS* SECTION ARE UPDATING EVERY DAY AFTER YOU ARE IN LIVE MODE. IN PRACTICE MODE, ONLY THE *DATA LAST UPDATED TO SERVER* FIELD WILL UPDATE AS YOU SYNCHRONIZE.

Application Details

The application details section will have 3-line items that will display:

- **Application & Schema Versions**: Which is the current application version you're working in
- **Application Last Updated**: The time and date you last successfully upgraded your eHouseCalls application when there was an upgrade pushed
- AND
- **Data Last Updated To and From the Server**: The date and time you last successfully synchronized your eHC application, and/or sent or received data from the servers

Upgrade the eHouseCalls Application

When a new version of the eHouseCalls application is made available you will receive a notification, documentation detailing the software changes, (referred to as **Release Notes**) and a schedule for live WebEx training sessions to review the updates, if needed.

To upgrade, confirm your YES YES connectivity status, and then:

- Click **Synchronize Data**
- Click the Upgrade Application button
- Log back into eHouseCalls when prompted
- Repeat the process (as necessary).

MAKE SURE YOU FINALIZE ANY OUTSTANDING MEMBER ASSESSMENTS BEFORE STARTING AN UPGRADE.

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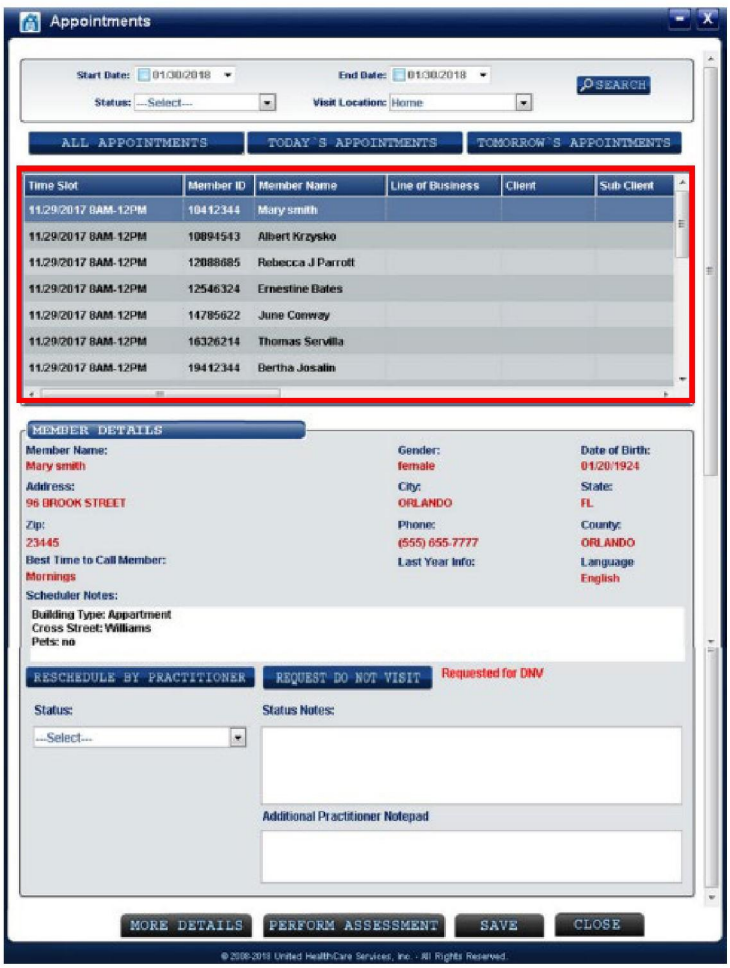
Scheduled Appointments

Clicking the **Scheduled Appointments** button produces a large pop-up window. This window shows all appointments for the current day and the next 4-5 business days. This option is used to open a member's scheduled appointment and prepopulated assessment. This is the button you will select when you are in a member's home and ready to begin the visit.
At the top of the window, search fields can be used to filter member assessments using date range, current status, and visit location dropdowns. If you wish to select an option from the Visit Location drop-down, the system will populate alternate location appointments that have been previously locked/visited by the Practitioner.

In addition, three filter buttons are available: **All Appointments, Today's Appointments,** or **Tomorrow's Appointments.** After applying filters, a grid below the filter area displays the results of the search. Each row represents a member assessment.





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The table below reviews the information found in the columns that populate the grid.

Field	Description
Time Slot	Indicates the block of time and date of a scheduled appointment.
Member ID	Unique HouseCalls Member ID number assigned to the member.
Member Name	Indicates the name of the member you will be performing the visit with.
Line of Business	Indicates the member's health plan business segment.
Client	Indicates different clients for the member and differentiates Individual vs. Duals
Sub Client	Indicates the member's health plan.
CDO	Care Delivery Organization
Phone	Indicates the phone number we have on file for the member. Note that this may not be the same phone number you use to contact the member regarding their HouseCalls visit.
Status	Indicates the current status of the assessment.

Status	Description
Scheduled	Indicates a member has been scheduled, but the assessment has not been started.
In Progress	Indicates the assessment was started but not completed, finalized, or noted as could not complete the visit.
Completed	Indicates a completed visit with the member. This is not the same as finalizing. Checking the *Completed Visit* box schedules the follow-up survey
Documentation Finalized	Indicates the documentation has been finalized. Optum will QA finalized assessments that are sent. You cannot make edits to assessments once they have been finalized, but you may view them in read-only mode.
Could Not Be Completed	Indicates that you started the assessment but were unable to complete it. When you select this status, the assessment is locked and disabled. You will need to document a Reason why the assessment wasn't completed. You cannot make changes to an assessment in this status

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Visit Type	**Provides additional details including; if the member needs an interpreter, requires a PVD Screening, LAB tests such as FOBT, A1C, DRE (Diabetic Retinal Exam) and OMW (Osteoporosis Management in Woman) Members identified as a Post Discharge Visit (PDV) are also noted. NOTE: DRE and OMW will only appear if the member is eligible and if you are trained to perform the test.**
City	**Indicates the city where the member resides.**
Zip Code	**Indicates the zip code where the member resides.**
Reschedule Date	**Indicates if the member visit was rescheduled or will be rescheduled.**

Member Details

The Member Details section displays the demographic information for the name selected in the grid at the top of the window. This is your second visual cue that you have successfully selected the right member's name/assessment. This section will include details like the member's address, phone number, last visit date (if they've had a previous HouseCalls visit), and a small subset of scheduler notes. There will be a larger, more detailed list of scheduler notes available to you in the Practitioner Portal.

NOTE: IF A MESSAGE STATING, "LOCKED FOR DATA ENTRY" APPEARS, THE ASSESSMENT IS CURRENTLY OPEN BY SOMEONE ELSE FOR UPDATES. ONCE THE OTHER USER HAS COMPLETED THE UPDATES, THE MESSAGE WILL CHANGE TO "DATA ENTRY DONE" AFTER RE-SYNCING THE TABLET.

When a Pre-visit user captures data in all pre-visit sections:

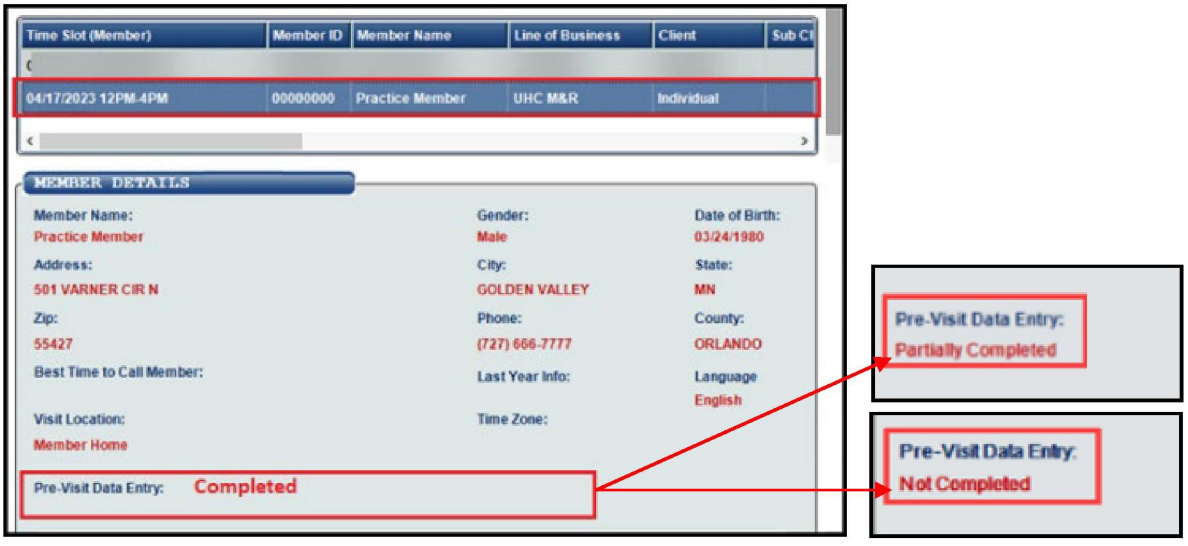
- For ***Pre-visit Data Entry*** field under Member details section, ***Status*** will be populated as ***Completed.***

When a Pre-visit user captures data partially in any of the pages of the application, then:

- For ***Pre-visit Data Entry*** field under Member details section, ***Status*** will be populated as ***Partially Completed.***

When no data is documented by a pre-visit user on the eHC assessment, then:

- For ***Pre-visit Data Entry*** field under Member details section, ***Status*** will be populated as ***Not Completed.***



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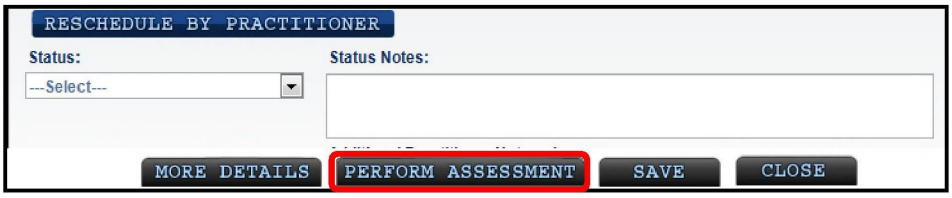
Open an Assessment

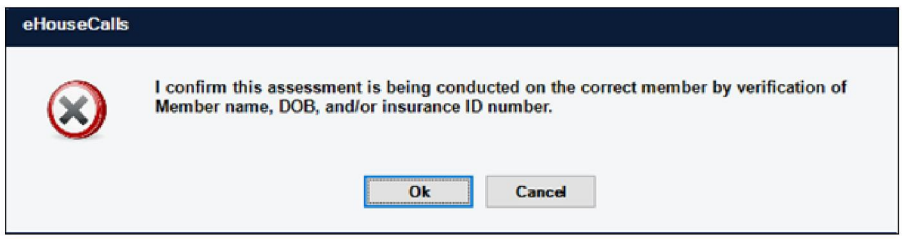
1. From the Dashboard, click **Scheduled Appointments**.
2. From the displayed grid, select the member assessment you want to open and click the **PERFORM ASSESSMENT** button at the bottom of the screen.





Member Verification Pop Up Alert

A verification pop-up appears after clicking on the **Perform Assessment** button. It is your responsibility to confirm the Member name, Member's DOB and/ or Insurance Number, and then click **OK** to proceed.



The **Member Details** popup window will appear. Click the **PERFORM (WITH MEMBER/UPDATE)** button to open the first page of the assessment.



IF YOU RESCHEDULE THE APPOINTMENT FROM THE TABLET AND TRY AGAIN TO OPEN THE SAME ASSESSMENT, THE FOLLOWING MESSAGE APPEAR:

"YOU HAVE RESCHEDULED THE APPOINTMENT IN THE PORTAL. DO YOU WANT TO PERFORM THE ASSESSMENT NOW?"

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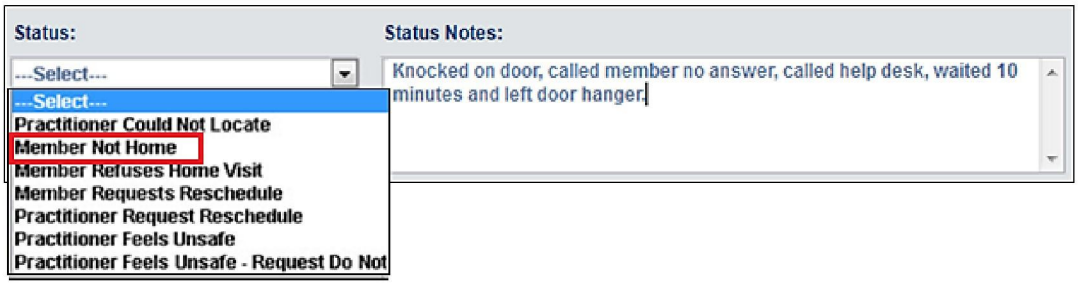
Status of the Member Visit

At the bottom of the **Scheduled Appointments** window is an area used to address circumstances that prevent you from beginning the visit/assessment.



If you cannot start the visit, the assessment is not opened. Instead, the **Status** drop-box and **Status Notes** field are used. The drop box provides reasons, such as **Member Not Home** or **Could Not Locate** the member. In those two scenarios, contact the Practitioner Helpdesk for help- they will attempt to reach the member before you move on with your day. You must also note that you contacted the Helpdesk in the notes section.

Reschedule by Practitioner

Located at the bottom of the Scheduled Appointments window is a blue **Reschedule by Practitioner** button, used to reschedule a visit by member request. The button links to the **Practitioner Portal** to complete the process, so you must be connected to the VPN and have an available slot that coincides with the desired reschedule date. Refer to the Practitioner Portal guide for steps to reschedule.

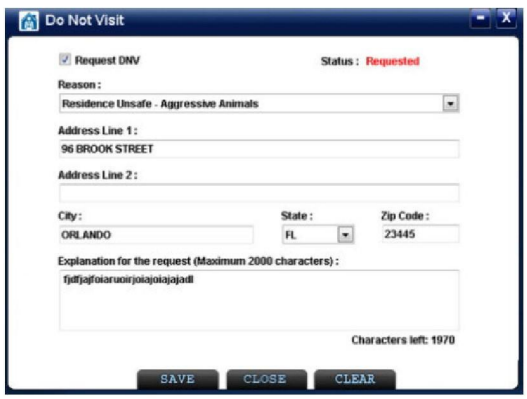


IF YOU CANNOT CONNECT TO THE VPN, CALL PROVIDER RELATIONS AT 855-247-8474, OPTION #1 TO RESCHEDULE THE VISIT OR WAIT UNTIL 8PM EST FOR THE "RESCHEDULE" OPTION TO BECOME AVAILABLE IN THE PRACTITIONER PORTAL.

Request Do Not Visit

The **Request Do Not Visit** button can be used for **Scheduled** or **In Progress** assessments if you feel unsafe or uncomfortable and do not wish to be rescheduled with that member. If a Do Not Visit request was previously selected, the "Requested for DNV" text will be displayed in red next to the button.
When you select the "**Practitioner Feels Unsafe – Request Do Not Visit"** option from the Status drop-down list, a **Do Not Visit** pop-up window will open. All fields in the Do Not Visit window are mandatory except Address Line 2. If any field is not entered, an alert message will display.

1. Click the **Request DNV** checkbox. The fields will become enabled.
2. Select a **Reason** from the drop-box
3. Input the full address
4. Enter an explanation for the request.
5. Select **Save** to submit the request. The Status in the top-right corner will update.
6. Click **Close** from the Do Not Visit pop-up window.



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Alternate Location Appointments

This feature is only used by a specially trained group of providers conducting visits at a location other than the members' home. Additional documentation and training will be provided if you are asked to do these visits.



Assessments in Progress

Shows all assessments which have been started, but not finalized. Any assessments that need to be finalized can be accessed from this option. Statuses included: **Completed** and **In Progress**. The number on this bucket represents assessments that require action by the practitioner within 24-48 hours.



Past Appointments

Shows the last 15 days of finalized assessments. These assessments are read only and non-editable



Blank Assessment

This is also where you can open a Practice Assessment.



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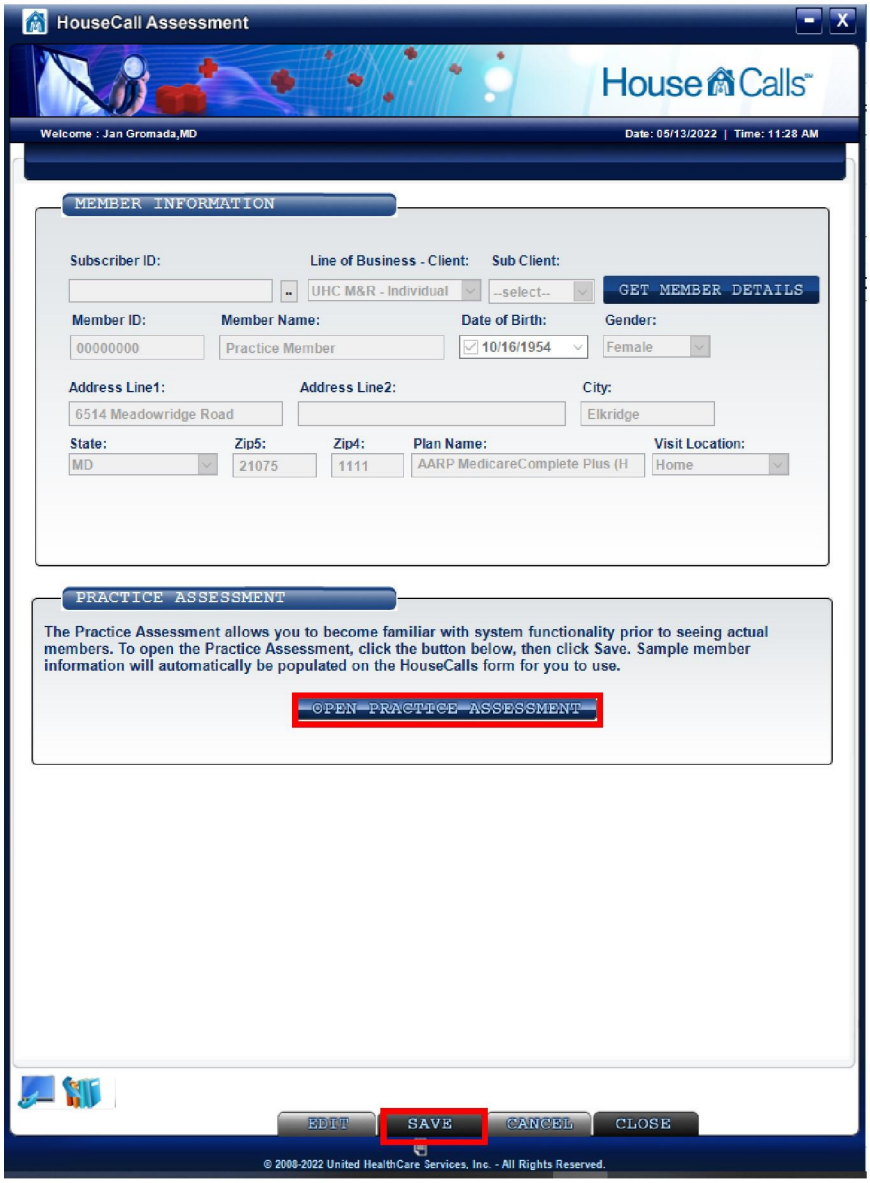
Practice Assessment

The **Blank Assessment** window also provides the option to **OPEN A PRACTICE ASSESSMENT.** This feature opens an assessment filled with simulated member information. This tool can be used to mimic and experiment with an assessment without touching a real document.

1. Login to eHouseCalls and select **Blank Assessment** from the Dashboard.
2. Click the **Open Practice Assessment** button from the middle of the screen.
3. Click the **Save** button at the bottom of the screen.



ALL OTHER PRACTICE ASSESSMENTS USED FOR NEW HIRE POST-TRAINING WILL BE IN THE SCHEDULED APPOINTMENTS BUTTON OF THE DASHBOARD.

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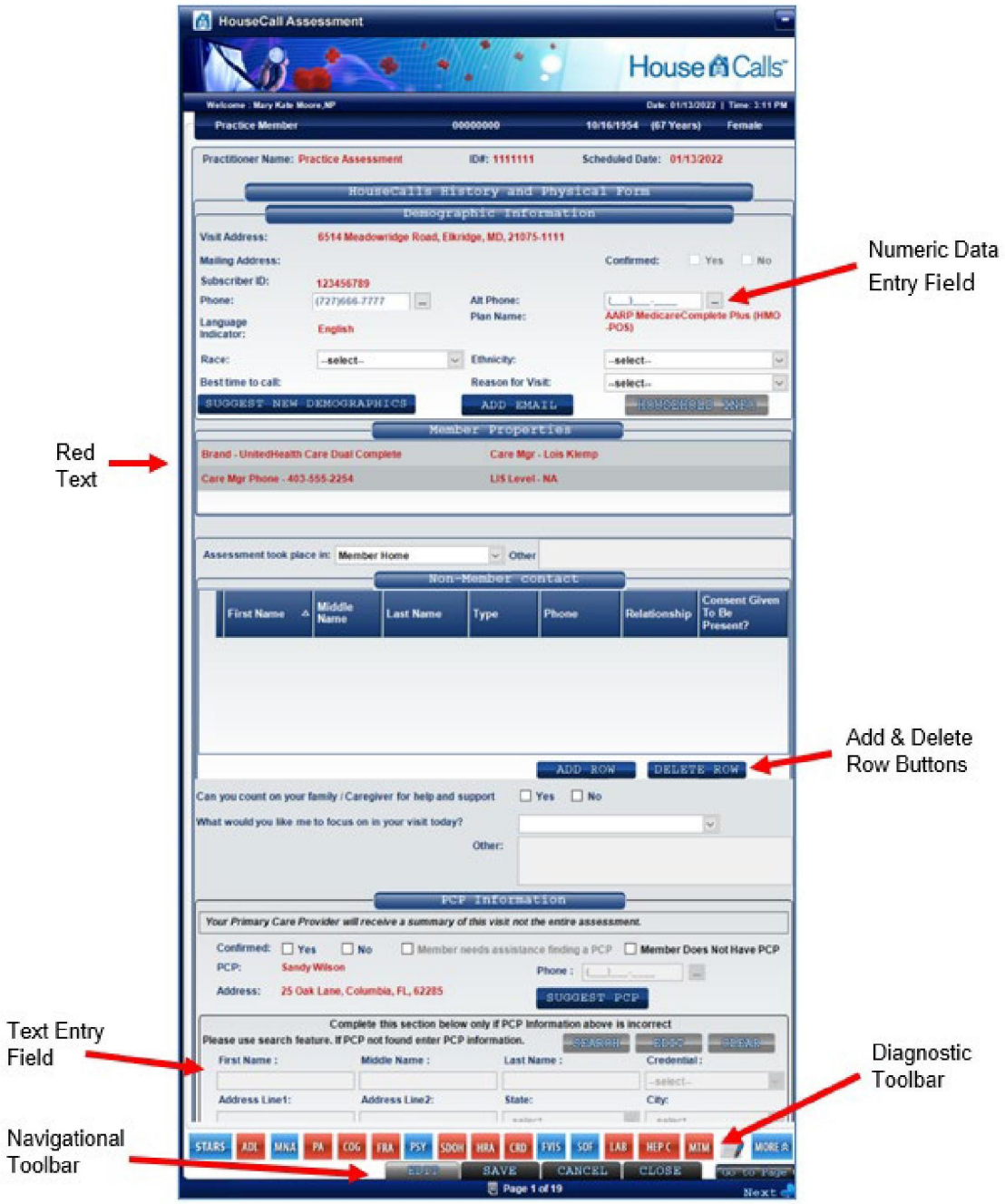
eHouseCalls Assessment Overview

All assessments are formatted in a similar fashion. The top of every page is prepopulated with your name, today's date, current time, the member's name, member ID, member DOB, and age.

Each page will have data entry fields, and at the bottom of the page, a series of color-coded diagnostic tools and navigational buttons.



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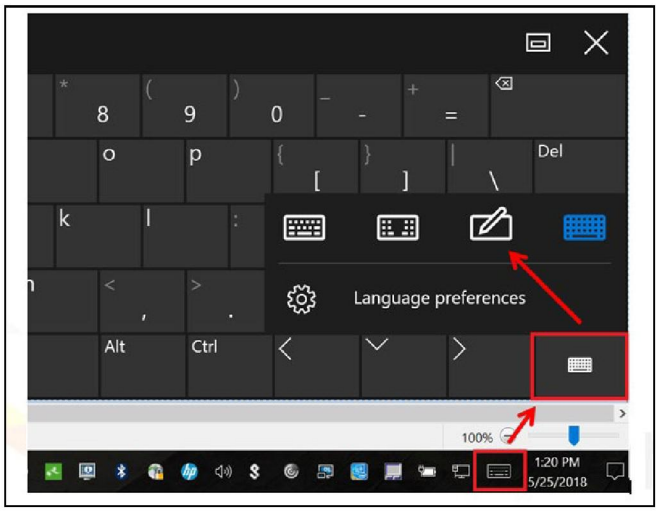
Virtual Keyboard (Tablet Mode)

If you are documenting in tablet mode, a virtual keyboard may be needed for data entry. To open the virtual keyboard, use your stylus to click the keyboard icon- located on the bottom right portion of your taskbar. Once the icon has been selected, you will have 4 options to document in addition to language preferences within the tool; English is the defaulted language.



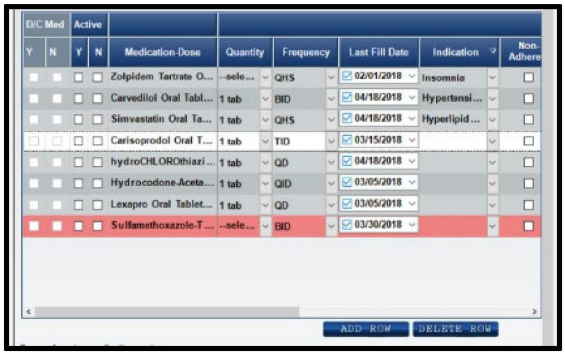
IT IS IMPORTANT TO BE VERY CAREFUL YOU ARE DOCUMENTING INFORMATION IN THE CORRECT ASSESSMENT. THERE IS NO WAY TO MOVE THE INFORMATION AND ADD IT TO THE PROPER ASSESSMENT IF THE WRONG ONE WAS DOCUMENTED.

Red Text

Text in a red font indicates prepopulated, un-editable fields and/or mandatory fields that are required to be addressed in the assessment.

Data Grids

Much of the member's assessment information is organized into a grid-type format for easy review. The **Scheduled Appointments** window in the Dashboard was the first example of how information is structured into rows and columns. This format is used throughout the assessment to document medications, surgeries, and more.



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The data grids dispersed through the assessment offer several unique features:

- Column widths can be adjusted by clicking and dragging the border of a column header
- Rows of data can be sorted or reordered by clicking on a column header
- For some larger grids, columns can be collapsed. Additional scroll bars have been added to show or hide additional columns of data
- **The Hover feature**- Moving the pointer/cursor and resting it over a column head will provide a small pop-up that offers additional tips or information.

Data Entry Overview

There are several ways to input member data to an assessment. In general, most information can be added using your stylus and touch screen, which allows you to work with your device as a stand-alone tablet.

Numeric Values

For Numeric fields, such as Phone Numbers, a keypad is available.

1. Click on the gray ellipses button to the right of the data entry field.



2. Use your stylus to input the appropriate numbers.
3. Press the SELECT button when finished and the number populates into the field.
4. Click the CLEAR button to clear the data in the field and start again, or the CANCEL button to cancel the request and close the pop-up box.

IF YOU ARE USING YOUR KEYBOARD INSTEAD OF A STYLUS, THE *BACKSPACE* BUTTON WILL ERASE TEXT TO THE LEFT OF YOUR CURSOR AND THE *DELETE* BUTTON WILL ERASE TEXT TO THE RIGHT OF YOUR CURSOR. *START* WILL MOVE YOUR CURSOR TO THE START OF THE FIELD AND *END* WILL MOVE YOUR CURSOR TO THE END OF THE TEXT.

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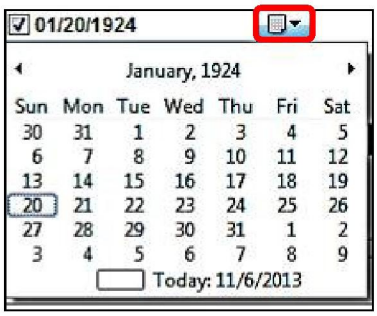
Dates/Calendars

Dates are entered using the calendar feature; you cannot type a date directly into the data-entry field.

1. Select the drop-down arrow next to the date field.



2. Click on the header value (i.e., February 1936) and continue to click until the you backed out far enough to see and select the decade/year desired
3. Click on specific year, month, and day as the calendar "zooms in" based on your selections.

Add Row/Delete Row

Rows of information can often be pre-populated, but as you conduct a visit, you may have to add additional rows of data. The **ADD ROW** and **DELETE ROW** buttons are used for this purpose.

1. To add a row of information, click the **ADD ROW** button.
2. Work left to right, adding the requested information to each column of the newly added row.
3. If a row was added in error, highlight the desired row, and click the **DELETE ROW** button. If a pop-up window displays, you will need to close it first.



YOU ARE ONLY ABLE TO DELETE ROWS YOU ADDED; PREPOPULATED ROWS CANNOT BE DELETED.

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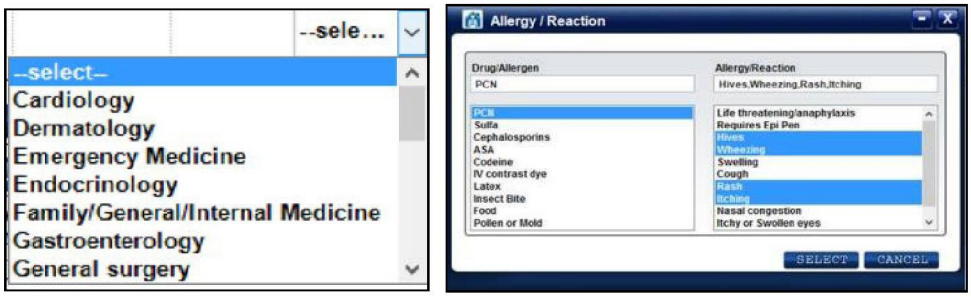
Drop-Downs & Checkboxes

Throughout the assessment, drop-down menus and checkboxes are available to help make documentation easier. Your stylus can be used on the touch screen of your device to mark selections.



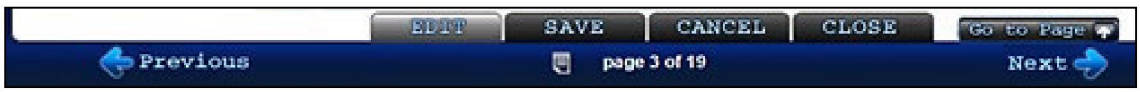
Diagnostic Toolbar

At the bottom of every assessment page is the **Diagnostic Toolbar**. It houses a series of color-coded tools that will be addressed later in this chapter.



Navigation Buttons

The Navigation buttons are located at the bottom of each page. These buttons allow you to easily move from page to page through the assessment. The table below explains each function:



Tool	Button	Description
Edit		**This button controls your ability to document the assessment, If the EDIT button is gray, you can document the assessment. However, if the EDIT button is black, the assessment is READ-ONLY.** **An assessment automatically opens in Edit mode, but if you close the assessment and reopen it later, it opens in READ-ONLY mode. Click the EDIT button to turn it gray in order to continue documentation.**
Save		**The SAVE button saves your work, but also turns the EDIT button black, putting the assessment in READ-ONLY mode** **You do not need to save each page as you work- changing pages will do that for you. This button is only used at the end of the assessment or to close the assessment and come back to it later.** **All other SAVE buttons found in pop-up boxes and other area should be used.**

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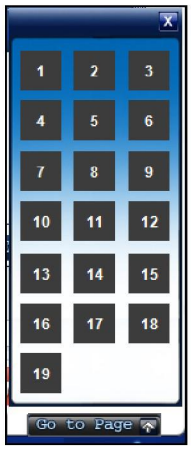
Go to Page		**Click this button to opens small window used to skip to any page in the assessment. As you hover your stylus over the page numbers, a pop-up will list what is on each page.** **Choosing a page also saves your work automatically.** **NOTE: The Go To Page button is a good example of an area that works with the *HOVER* feature.** **Moving the pointer/cursor and resting it over one of the numbers on the page menu will provide a small pop-up that offers additional tips or information.** **The assessment has many areas where the hover feature may be helpful.**
Next/Previous		**Clicking Next or Previous advances you to the next consecutive page or brings you back to the previous page. In addition, changing pages saves your work automatically.**
Page Number		**Displays the current page number at the bottom of the window (i.e., page 3 of 19).**

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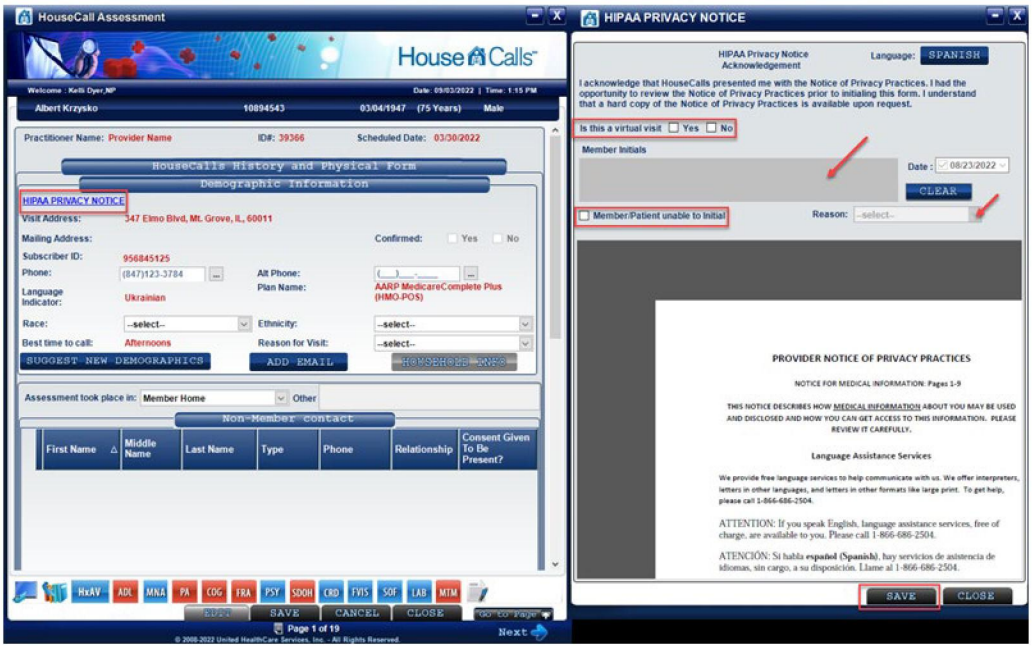
DOCUMENTING ASSESSMENT PAGE 1

HIPAA Privacy Notice Documentation

HIPAA Privacy Notice Documentation is required for all new members or if the documentation was not previously completed. It is also required in the Practice Member on initial start, and any time the data is cleared for a new practice. This form will automatically load after selecting SAVE to enter the assessment when the form has not previously been completed.

The form is completed by selecting the Yes/No checkbox for "Is this a virtual visit", and then obtaining the member's initials in the member initial field. If you are unable to obtain the initials for any reason, there are drop-down options available to select indicating the reason you are unable to do so. Allow the member the opportunity to review the Privacy Notice if they request, as the Notice is available in English and Spanish in the popup window. Only leave a paper copy of the Privacy Notice if the member requests. You will then Select SAVE to complete the documentation and continue with page 1.

THE PRIVACY NOTICE CAN BE ACCESSED THROUGH A LINK ON PAGE 1 AT THE TOP OF DEMOGRAPHIC INFORMATION SECTION.



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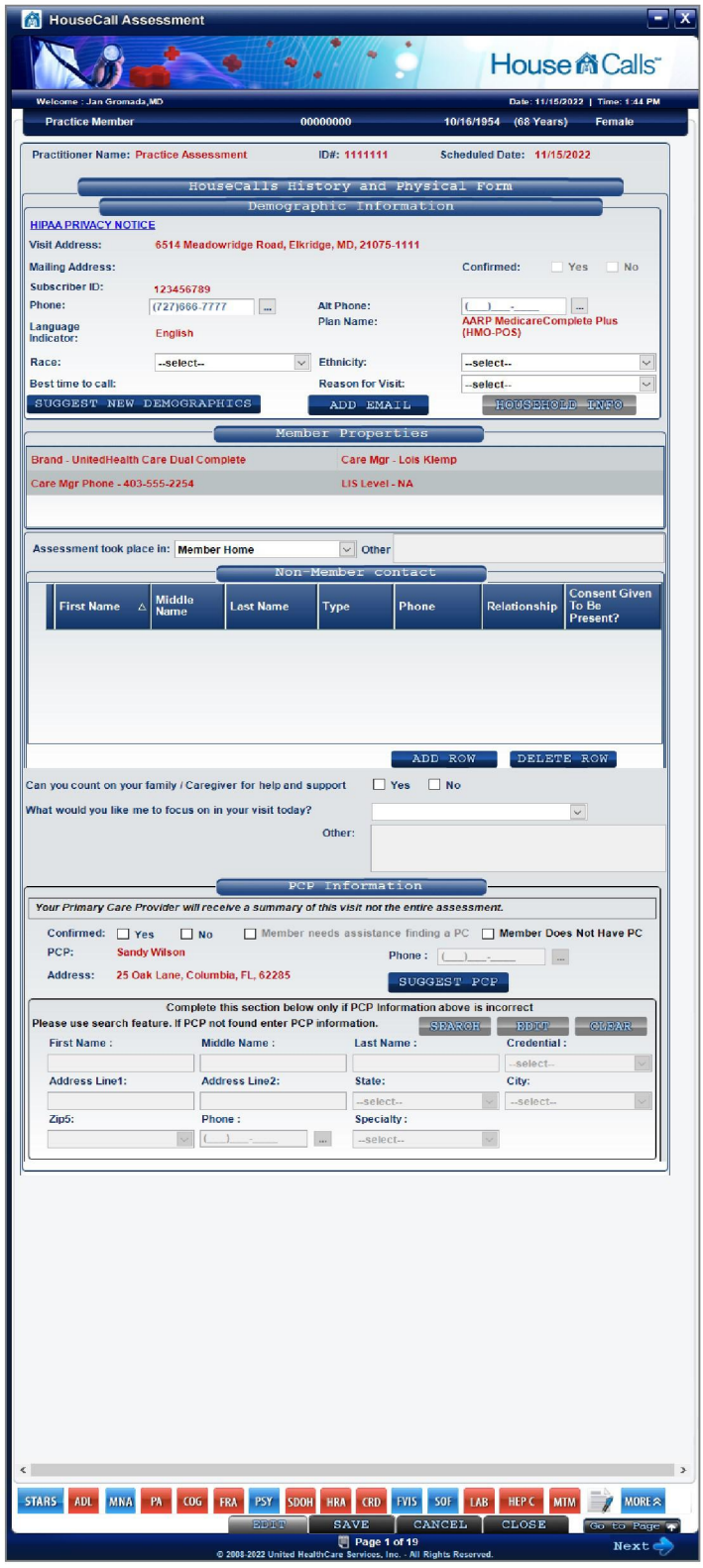
On page 1 of the assessment, you will document Member Demographics, Reason for Visit, Member Properties, Non-Member Contacts, and Primary Care Provider (PCP) Information.

This page has several areas to review, most of them designated with a blue, bubble shaped title bar. Each area is reviewed separately, starting at the top of page 1, and working down.



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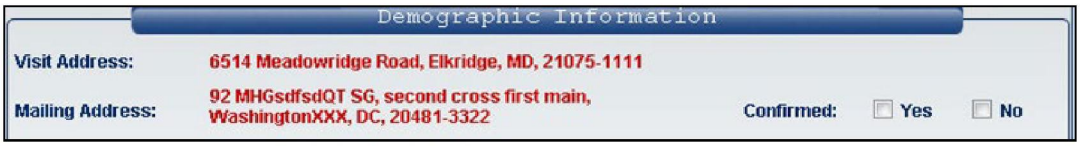
Member Demographics

The **Demographic Information** section displays personal member information such as their physical and mailing addresses, subscriber ID, phone number, and Care Level Plan (or Disease Management Plan). This section is **prepopulated and not editable**.

Mailing Address

To start, confirm the member's physical mailing address in order to ensure that communications are being sent to the member's preferred location. If a mailing address is prefilled on the assessment, confirm if the information is correct by selecting the appropriate **Yes** or **No** checkbox in the Demographics grid.



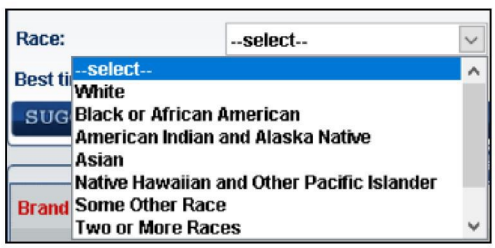
If there is no mailing address listed for the member (see the practice assessment for an example), the **Confirmed: Yes/No** will be disabled. In these instances, a mailing address can be added.

If the mailing address or any additional demographic information needs to be changed, click the **SUGGEST NEW DEMOGRAPHICS** button to open a popup used to record updates to the demographic section. The button should only be used if the information from the member differs from what we have on record.

IF YOU UPDATE THE SUGGEST NEW DEMOGRAPHICS POP-UP WINDOW, YOU WILL NOT SEE THE CHANGES ON PAGE 1 AFTER SAVING. THIS AREA GETS UPDATED ONLY AFTER YOU FINALIZE THE ASSESSMENT AND THE NEW INFORMATION CAN BE VALIDATED.

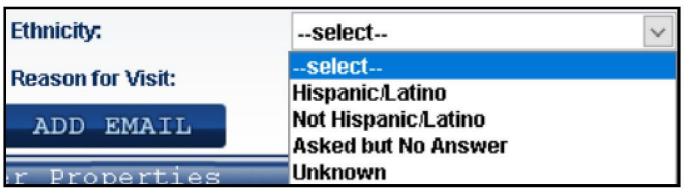
Race

The **Race** field is mandatory and requires that a selection is made from the dropdown menu of the members stated race. A page alert will be generated if a **Race** dropdown selection is not made.



Ethnicity

The **Ethnicity** field is mandatory and requires that a selection is made from the dropdown menu of the members stated ethnicity. A page alert will be generated if an **Ethnicity** dropdown selection is not made.



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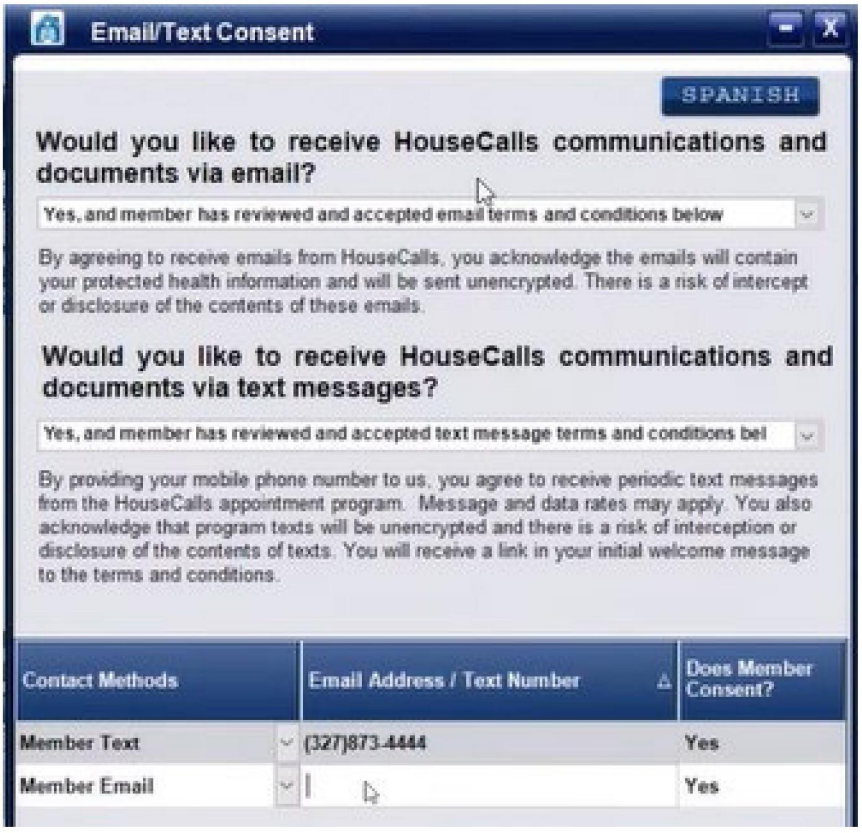
Email/Text Consent

The **Email/Text Consent** button allows you to add email and text information for the member. If the member is not eligible, it will be disabled (greyed out). Clicking on the button will open a pop-up box to document member consent for HouseCalls Communications via email and/ or text.



In the popup box, the consent is viewable. The questions **"Would like to receive HouseCalls communications and documents via email?"** and **"Would you like to receive HouseCalls communications and documents via text messages?"** will appear and it is mandatory to select a dropdown option.

Once the member has stated a preference for communications, complete the member contact grid including selections for **Contact Methods** and **Email Address/Text Number**. Character validation is present within the contact fields to ensure that phone numbers and email addresses are entered appropriately. Documented member preferences will display on page 16 as the Delivery Method for documents.

Use **Add Row** to add additional member contacts. The **"Does Member Consent"** column will be auto populated and will match the answers to the above consent questions.

The consent language can be changed to Spanish by selecting the Spanish button.

There is a **Reviewed, no change** checkbox available at the bottom of the popup window, that will be enabled if prefilled information is present.

If the member is eligible and you do not complete the Email/Text Consent, a page alert will occur.

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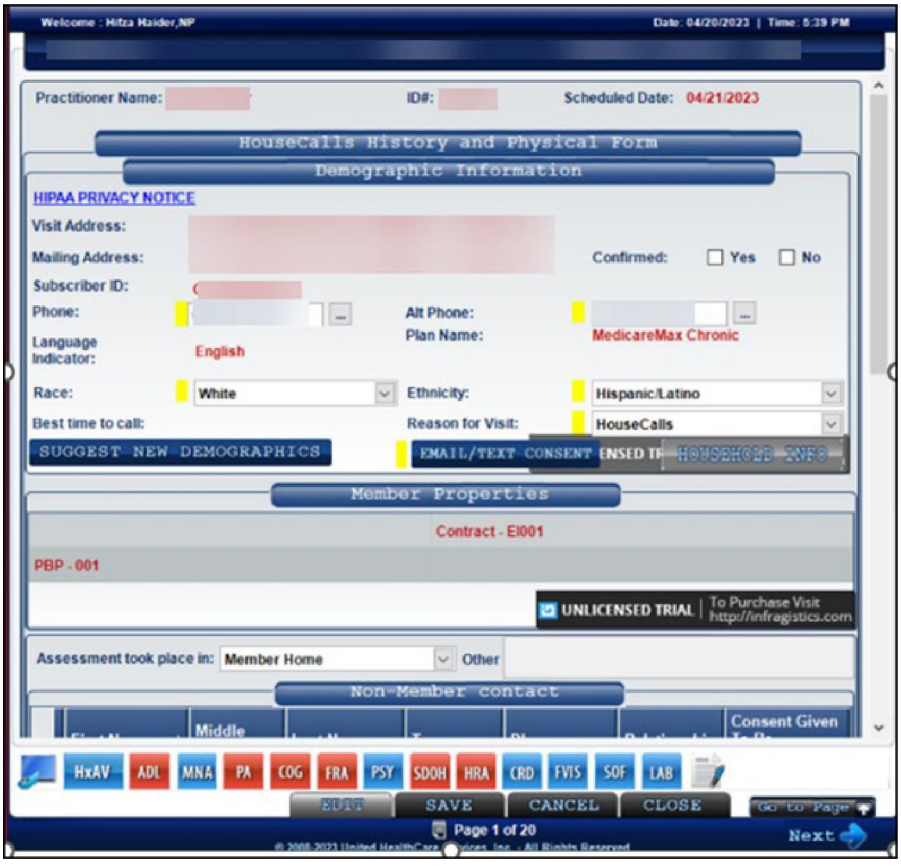
If a **digital consent** and **email/text** information is provided during the pre-visit call:

Review the items previously completed these will be noted by yellow color coding which is already available in eHC.



Reason for the Visit

The Reason for Visit field is mandatory and requires that a selection is made from the dropdown menu. The options of 360 or HouseCalls are available. HouseCalls should always be selected with the only exception being when the visit is performed with a Cigna member in the state of AZ



ALWAYS SELECT "HOUSECALLS" AS THE REASON FOR VISIT, EXCEPT WHEN PERFORMING A VISIT WITH A CIGNA MEMBER IN THE STATE OF AZ.

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The following alert displays if HouseCalls is selected for Cigna member and you select Save, Next, or Go to:



The following alert displays if 360 is selected for non-Cigna member and you select Save, Next, or Go to for a non-Cigna member:



A mandatory message is displayed on Page 18 if you save the assessment without selecting Reason for Visit.

Member Properties

This area contains prepopulated information specific to the member, including information regarding Healthy Visits, and/or Optum Program Eligibility such as CCM DNSP Optum at Home program or Dispatch Health.

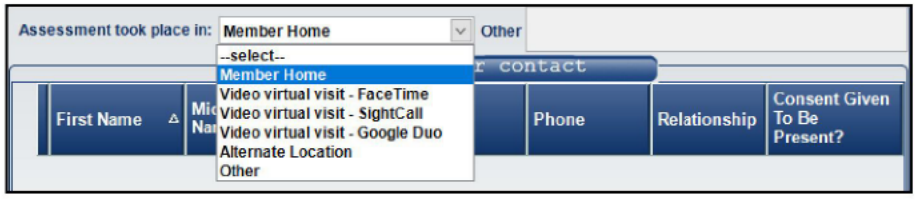
For M&R plan types, the **Advocate4Me** member services number and hours of operation will be displayed.



Assessment Location

Review this area to record where the visit took place, using the provided drop down. This field may be pre-populated. If OTHER is selected, add the visit location in the ***Other*** box provided. (i.e., daughter's home). Drop down options include:

- Member Home
- Video Virtual Visit (FaceTime, SightCall, Google Duo)
- Alternate Location
- Other



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In-Office Visit Modality

Should a member be scheduled for the in-office location it will be displayed in **Other** text box next to Assessment took place in drop-down.

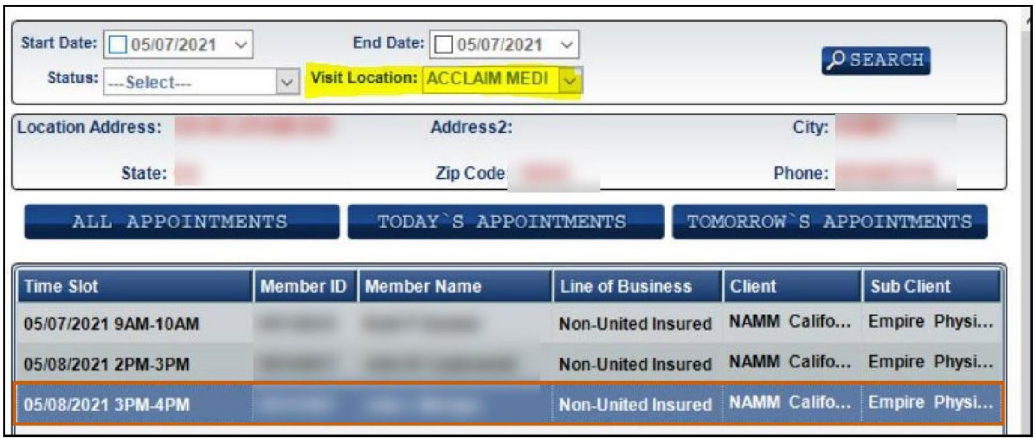


While conducting an In-Office modality type, Practitioner will be able to view:

- Standard assessment
- Access available data

When Practitioner views **Scheduled Appointments/Assessment In progress/Past Appointments**, then the **In-Office** modality is displayed in Assessment took place in dropdown and on select and search respective members gets loaded.





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Non-Member Contact

The **Non-Member Contact(s)** section lists alternate contact persons for the member. This section may be prepopulated. You will be able to edit/delete those contacts, add additional ones, and document anyone present during the visit with the member.



To add non-member contacts, click the **Add Row** button and fill in each column, working left to right.

- The **First Name** and **Last Name** fields are typed in. The **Middle Name** field is optional.
- The **Type** drop box offers options such as Relative or Emergency Contact
- The **Phone** field has its own **ADD** button. Clicking it will create a sub-row for the phone number below the main line. The button can be pressed multiple times, in case there is more than one number.
- The **Relationship** column is a drop box with options such as relative or friend
- The last column is a **check box- selected if/when the member gives permission to let the contact stay during the visit**.

Caregiver Help and Support

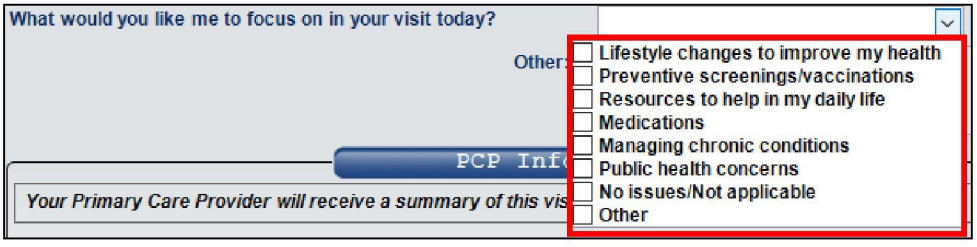
Below the Non-Member Contact section is a small line item inquiring if the member can count on their family/Caregiver for help and support. You must ask every member that question, even if you did not put anything the section above. If you do not select either Yes or No, you will receive an alert.



Member Identified Topics

The question, **What would you like me to focus on in your visit today?** Should be answered by selecting one or more of the options provided in the relate drop box. Options include:

- Lifestyle changes to improve my health
- Preventive screenings/vaccinations
- Resources to help in my daily life
- Medications
- Managing chronic conditions
- Public health concerns
- No issues/Not applicable
- Other – Free text box



An error message will appear if you do not select any option for the question, “What would you like me to focus on in your visit today?”

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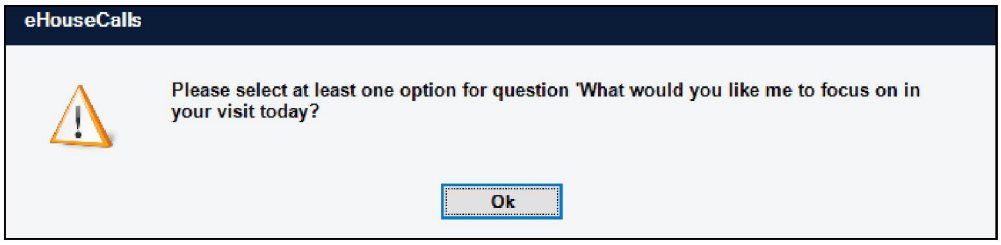
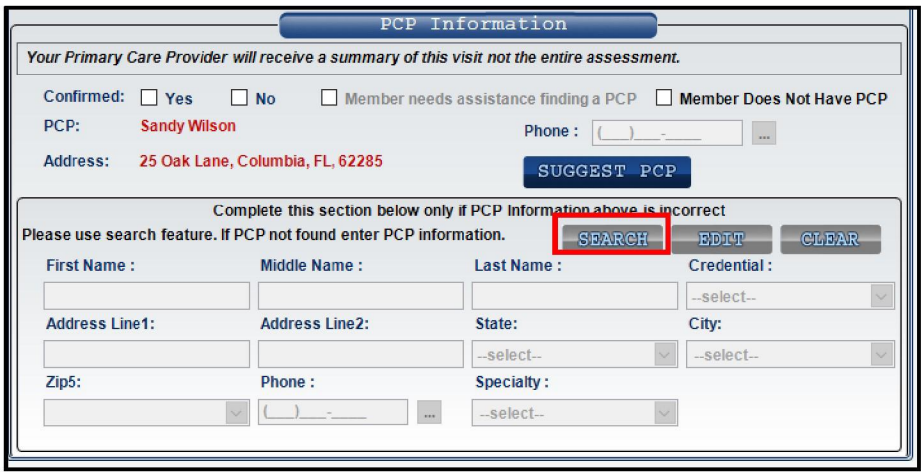


PCP Information

After completing the visit and submitting your finalized assessment, a Post Assessment Letter (PAL) is sent to the member's PCP. The last section of page 1 is used to either confirm the PCP's name, address, and phone number; or update that information to ensure the PAL is sent to the proper destination.

Most PCP scenarios can be easily documented using one of the provided check marks.



- **Confirmed: YES** - Use this check box when the PCP information is prefilled (in red font) and you can confirm it is up to date and accurate
- **Confirmed: NO** - If the prefilled PCP information is incorrect, check this box. Updated information will need to be added (see next section)
- **Member Needs Assistance Finding a PCP**- If the member does not have a PCP but would like help finding one, check this box. This prompts a pop-up message informing the member to call the number on the back of their card. If the member participates in Support Services and is identified as "Needs PCP", the '*Member needs assistance finding PCP*' will be disabled or grayed out. When hovering over the disabled option, the text will display:
  - "Call Support Services to get help for member. Please document in Support Services section on page 18."
- **Member Does Not Have a PCP**- The check box indicates the member does not have a PCP, but also does not want one.

If PCP demographics need to be added or updated, click the **SEARCH** button. If the assessment has prepopulated information in red font, the **Confirmed-NO** box will need to be selected first.

Search PCP Tool

eHouseCalls has a built-in database of PCP demographics that can be searched and auto filled with minimal information. If you are not connected to the VPN, search results will display 50 results from that built-in database. If you ARE connected to the VPN, the system will search the entire database.

1. A pop-up window will appear after clicking the SEARCH button.
2. Enter the PCPs name and state and click the SEARCH button found in the new window.

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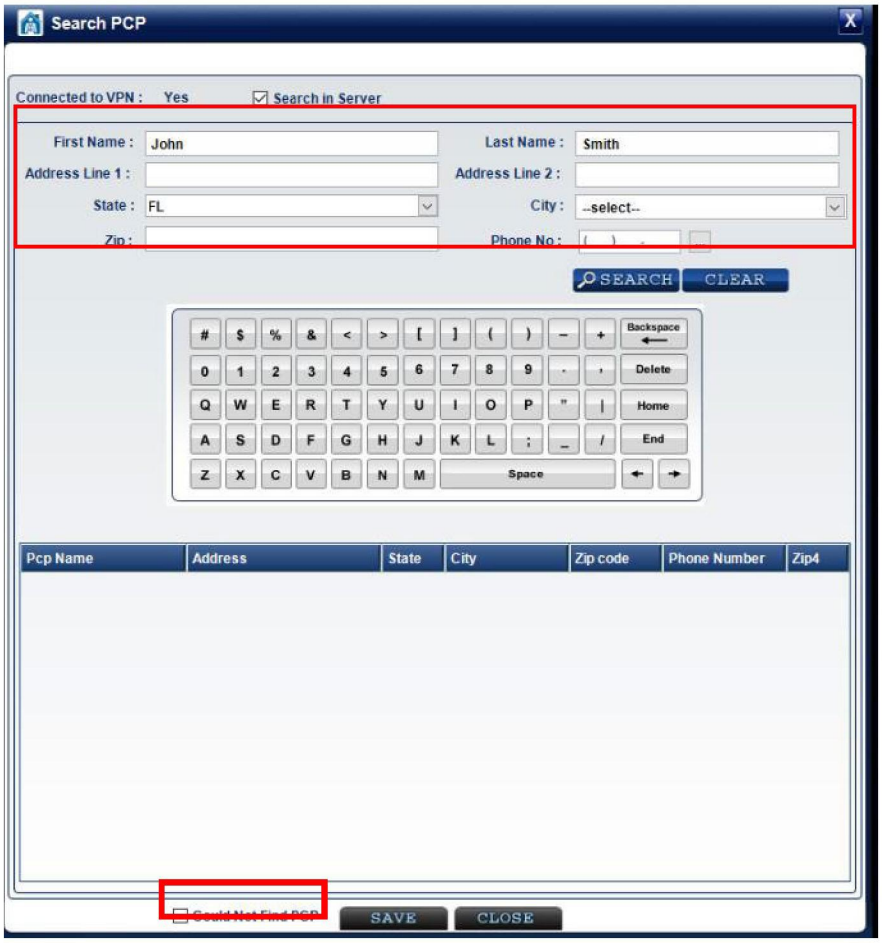
3. Select the correct row of PCP demographics from the list of results that appears at the bottom of the window and click SAVE.
4. Click the NEXT button at the bottom of page 1 to move to the next page. This will also save your updates.



IF THE SEARCH FEATURE DOES NOT PROVIDE THE ANY CORRECT INFORMATION, SELECT THE CHECK BOX, "COULD NOT FIND PCP" AND CLICK THE SAVE BUTTON. THIS WILL CANCEL THE SEARCH AND TAKE YOU BACK TO THE BOTTOM OF PAGE 1- WHERE YOU CAN TYPE IN THE PCP INFORMATION.

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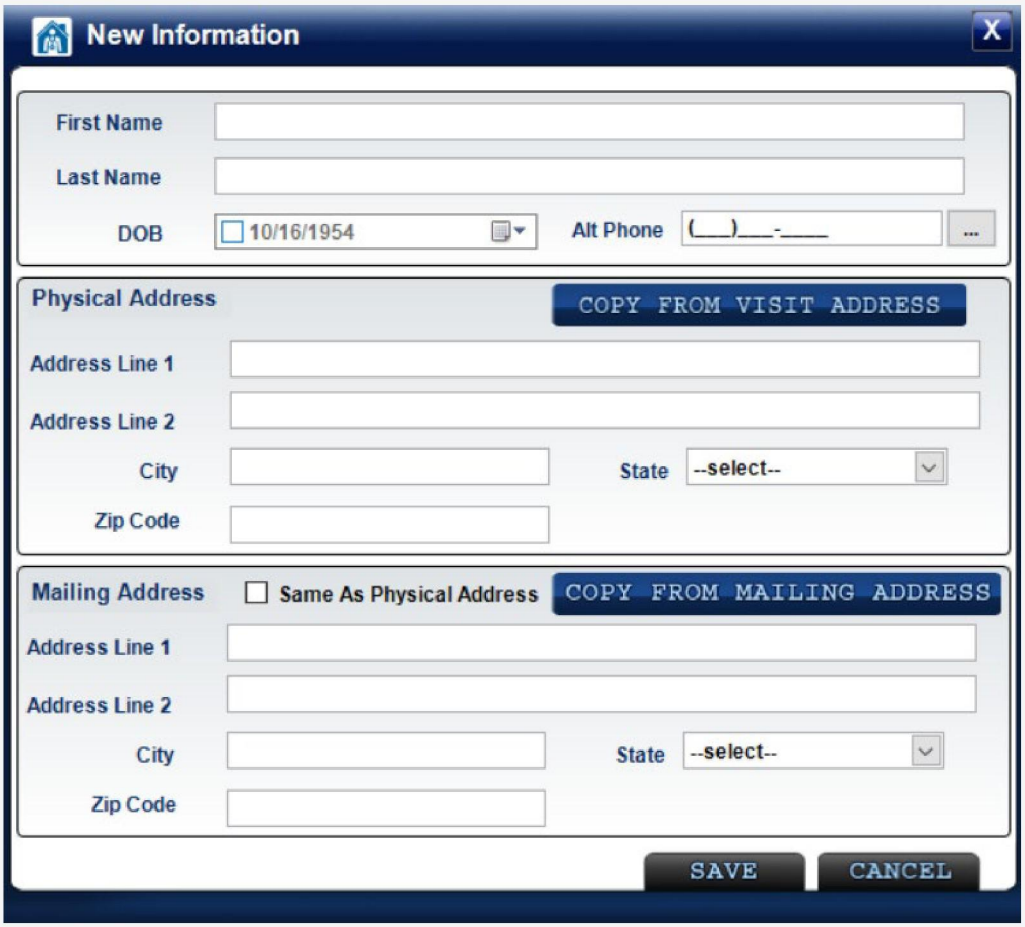
Practice Exercise: Entering and Editing Member Information

Use the instructions provided, update the member's demographic information.

- On page 1, Click the **Suggest New Demographics** button to open a pop-up box.



- Using the laptop keyboard, update the member's first and last name to **John Doe**.
- Update the Date of Birth to **Oct 14, 1955**. This can be typed in with the keyboard or manipulated with the calendar icon using a stylus with the touch screen feature.
- Click the button with 3 dots to open a number pad. Use the stylus to enter a new phone number for the member. The laptop keyboard can also be used, if preferred.
  - **Alt Phone:** (330) 555-1234
- The Physical Address can be left blank.
- The Mailing Address needs to be added:
  - **Address Line 1:** 1234 Sesame St
  - **Address Line 2:** Leave blank
  - **City:** Baltimore
  - **State:** MD (click the drop box to open and select the state)
  - **Zip Code:** 21236
- Click the **SAVE** button. A pop-up message will confirm the data was saved successfully.

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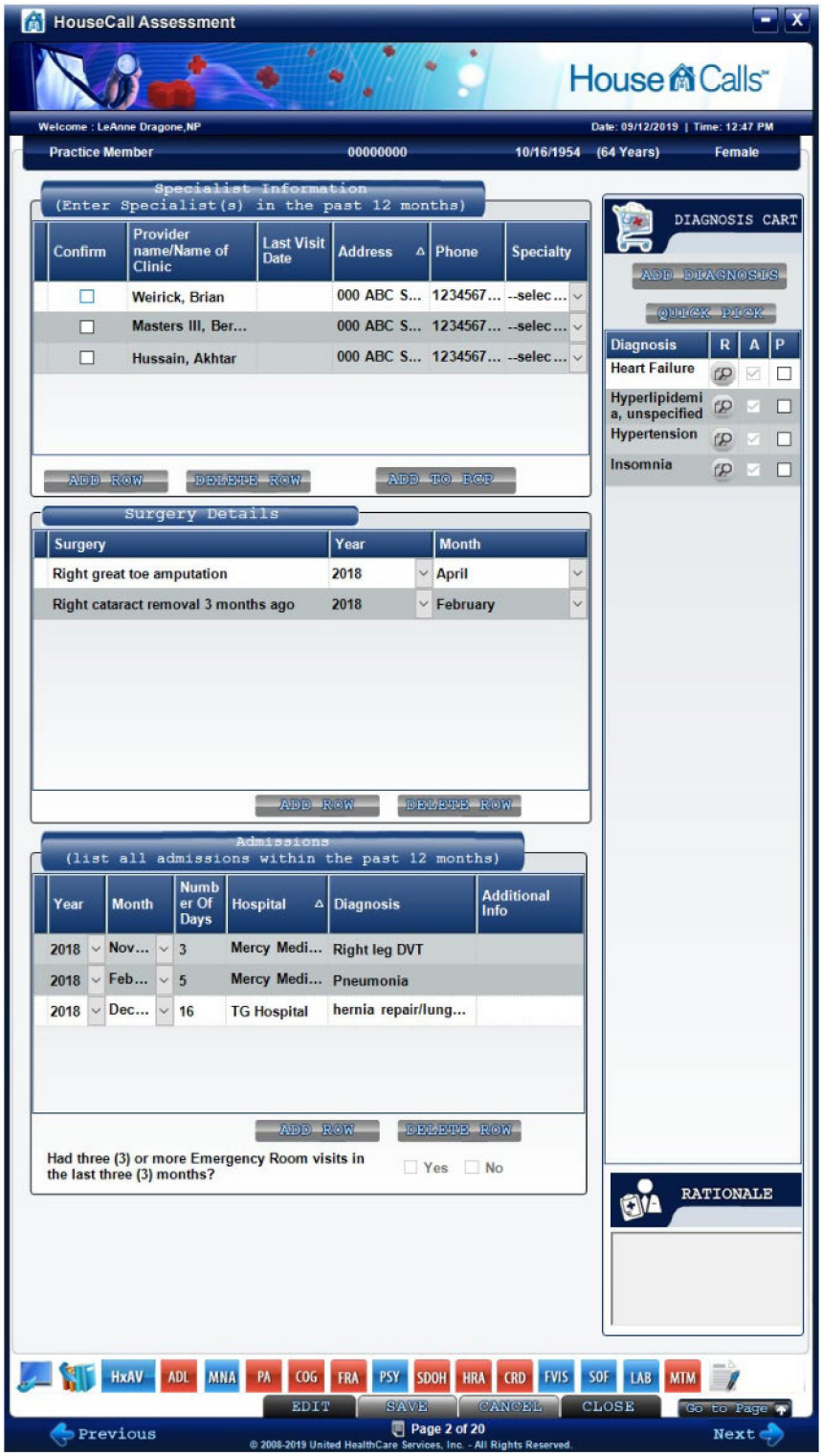
DOCUMENTING ASSESSMENT PAGE 2

On page 2 of the assessment, you document member Specialist Information, Surgery Details, Admissions, Emergency Room Visits, and the Diagnosis Cart.



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Specialist Information

The **Specialist Information** section displays a grid prepopulated with specialists the member has seen in the past. Review this list with the member and check the box in the **CONFIRM** column if the specialist has been seen within the past 12 months (see the time-based guideline in the title bar). For every specialist confirmed, add the **Last Visit Date** in the designated column, and add the **Specialty**, if possible.

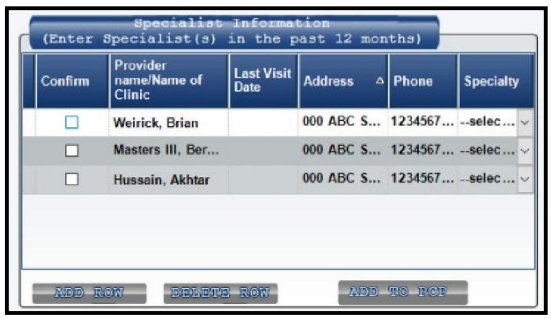
In addition, use **ADD ROW** to add any new Specialists if they are not already on the prepopulated list. Once a row is added, fill in the columns- Name, Last Visit Date (approximate is fine), and Specialty.

Editing Pre-populated Data

In **Specialist Information** editing or deleting pre-populated specialist data is enabled, but you will only be able to edit the following pre-populated fields:

- Last Visit Date
- Address
- Phone

Once you edit any information, the information flows back to the Portal, so the updates show in next year's assessment.



YOU WILL NOT HAVE THE OPTION TO EDIT THE PRE-POPULATED *PROVIDER NAME/NAME OF CLINIC* FIELD.

Surgery Details

This section is used to document relevant surgeries. Some surgeries may be pre-populated from claims information or previous HouseCalls.

- Clicking the **ADD ROW** button opens a pop-up box with an alphabetical list of surgeries to choose from.



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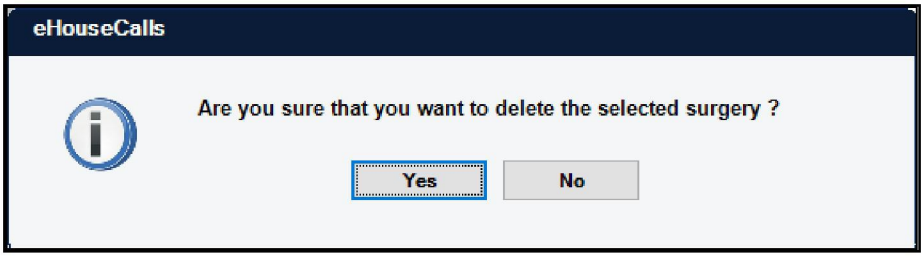
- Select from the multi-select drop-down list or click the top button to Type in Surgery Details and free text the name of the surgery (if it's not available in the list). Smart logic will enable conditions to be added to your diagnosis confirmation page based on surgeries documented.
- Click the **SELECT** button to add the surgery to the new row created on page 2
- For the rest of the added row, enter the month for each surgery to the best of your ability- unless the surgery was within the last year- then you must indicate both month and the year.
- If the member cannot remember the month, you can select **January as the default month**. If the member is unable to recall when the surgery occurred in general, under the Year column it provides an option to select Unknown.
- If **TOTAL COLLECTOMY** and/or **BILATERAL MASTECTOMY** are selected, you will receive a notification that the diagnosis will be transferred to the preventative screenings grid on page 6. The date will not transfer.
- Be mindful of gender appropriateness when documenting new surgeries; otherwise, you will be prompted with an error message.

If you try to delete a pre-populated surgery an alert appears. Click YES, to confirm the pre-populated surgery for deletion



Admissions

The Hospital Admissions grid is used to document any hospital admissions (24 hours or more) within the last 12 months. Some hospital admissions are prepopulated, but you may also need to add admissions to the grid. The prepopulated admissions are non-editable.

The **ADD ROW** and **DELETE ROW** buttons are also available on this grid to update information, if needed.

You will potentially see a blue hyperlink display in the **Additional Info** column if a discharge note from the hospital is available for review.

Emergency Room Visits

At the very bottom of Page 2, you will see the question asking if the member has had 3 or more ER visits within the last 3 months. You must ask every member that question, even if nothing is listed in the above Admissions grid.

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THE DIAGNOSIS CART

The **Diagnosis Cart** is a tool to store diagnoses while working through the assessment. It is available on multiple pages of the assessment and appears for the first time on page 2.

Some diagnoses will appear automatically, based on system logic, or claim information, but these are not final determinations of the member's condition.

The **Diagnosis Cart** occupies a limited amount of space to the side of the screen, so some text is abbreviated. The columns in the cart display the following information:

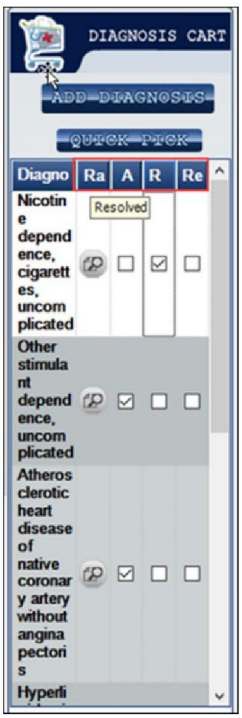
Diagnosis- This column lists the diagnosis name

- **Ra** - Rationale or how the diagnosis was added to the cart. Each diagnosis will have an associated icon in that column.
  - Click on the icon and the Rationale box at the bottom of the cart will list how the diagnoses were added, (see the table below)
- **A** - Active
- **R** - Resolved
- **Re** - Removed

Diagnosis Rationale Icons

The table below defines the Rationale Icons. Clicking on an icon will display the associated description in the Rationale box.

Rationale Icon	Description
	**Manually Added by Practitioner**
	**Added by Rules or Added by Logic**
	**Diagnosis added from Indication Drop-Down List in the *Medications* Grid**
	**Diagnosis added from *Past Medical History* Grid**
	**Previously documented diagnosis**
	**Added based on documented Surgery in the Surgery Details Grid.**



Adding Diagnoses

There are two methods to add your own diagnoses to the Cart. You can choose to click the button labeled **Add Diagnosis** or **Quick Pick.**

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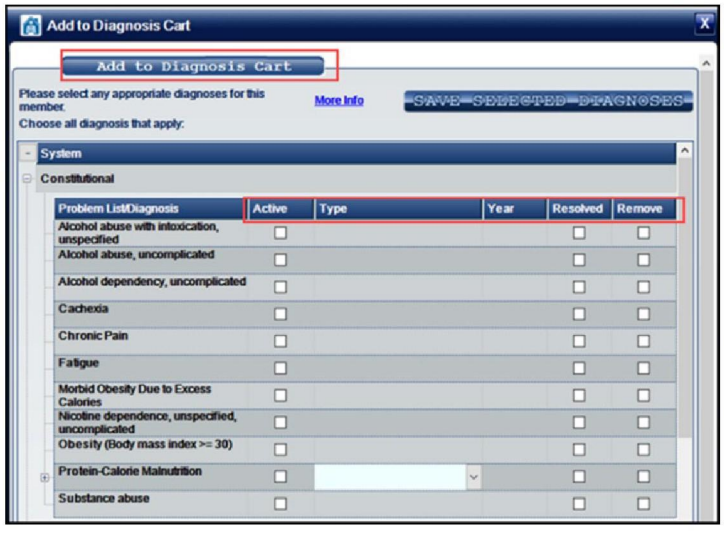
Quick Pick

If the **Quick Pick** button is selected, a limited list of common diagnoses will fill the grid in the Diagnosis Cart. After finding the diagnosis on the list, choose the appropriate check box, (Active, Resolved, and Removed) then click the Add to Cart button at the bottom of the screen to complete the action.
If you cannot find the diagnosis in the limited list available, it can be found with the **Add Diagnosis** button.

Add Diagnosis

The **Add Diagnosis** button holds the higher specific diagnoses not available in the **Quick Pick** option. Clicking the button opens a large pop-up window with drop-down boxes arranged by system, or (if you prefer) an option to find the diagnosis with the search feature at the bottom of the window.
Whenever you are adding a diagnosis, select the most specific diagnoses as it pertains to the member.



Adding Diagnoses with Drop-Down Boxes

1. Click the **ADD DIAGNOSIS** button. The ***Add to Diagnosis Cart*** window will open with a list of conditions categorized by system.
2. Click the **+** symbol next to the desired system.
3. Select the **Active**, **Resolved, or Removed** checkbox to select a diagnosis.
4. Make any additional applicable selections from the **Type** drop-down box and/or by selecting a date in the year field (if enabled).
5. Click the **Save Selected Diagnosis** button at the top or bottom of the screen. The diagnoses will be added to the cart as Active.

Adding Diagnoses with the Search Function

1. Click the **ADD DIAGNOSIS** button at the top of the cart. The ***Add to Diagnosis Cart*** window will open with a search box at the bottom of the page.
2. Type the diagnosis name in the **Search diagnoses by name** field. A list of diagnoses will display in the list.
3. Highlight the correct diagnosis and press the **SELECT** button.
4. When all selections have been made, click the **SAVE SELECTED DIAGNOSIS** button. The diagnoses will be added to the cart as Active.

SOME CONDITIONS MAY REQUIRE "MULTI-LEVEL DIAGNOSING". THIS CONCEPT IS ADDRESSED LATER IN THIS GUIDE.

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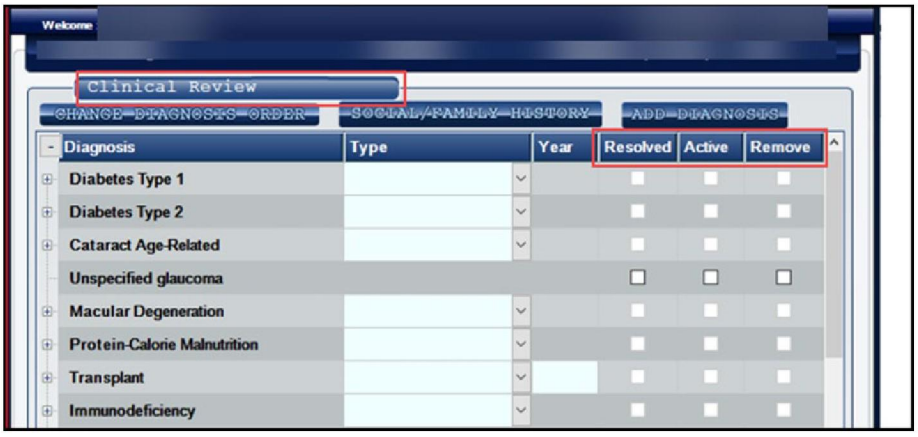
DOCUMENTING ASSESSMENT PAGE 3

On page 3 of the assessment, you will discuss and document the member's **Past Medical History** and **Social/Family History.**



Clinical Review

A systems approach should be used to complete the member's comprehensive Clinical Review. Accurate diagnosis capture and substantiation to the highest specificity is important for our members. This page contains a static list of diagnoses that allows for customization of diagnoses, documentation of family medical history, and the ability to add diagnoses to the list.
At times, there may be prepopulated diagnoses that appear on this page appearing in red font. These diagnoses come from past claims and/or a prior HouseCalls visit. It is expected that these are reviewed with the member during your visit.



Additional Options

At the top of the page, three buttons offer other options. You can choose to change the diagnosis order, document the social/family history, and/or add a diagnosis to the existing list on the page.



Change Diagnosis Order

The order of diagnoses found on page 3 can be customized. Clicking **Change Diagnosis Order** opens a window with the diagnosis list. The left button at the top will arrange the list in **Alphabetical Order: A-Z.** (Click the button a second time for Z-A) The right button will **Restore Default** list order.

A fully customized order can be created by using the up and down arrows on the right side of the window to arrange the list as you like. Click the **SAVE** button and the new list will be the default for future assessments.

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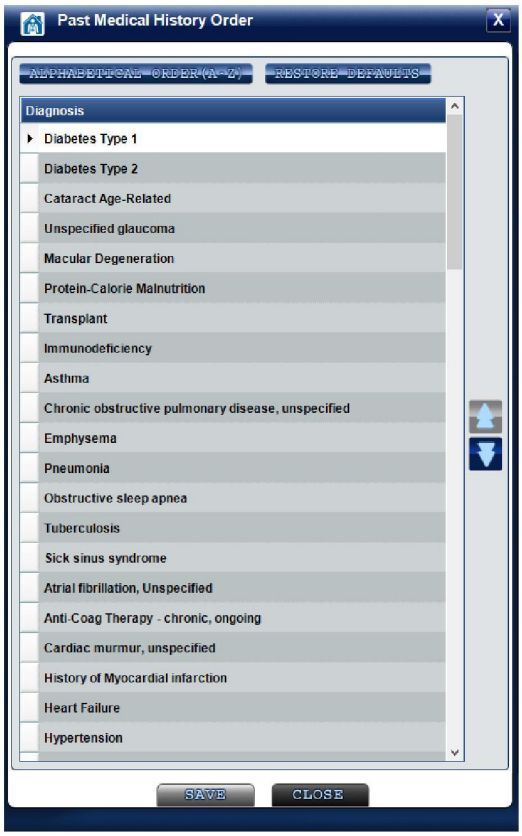

ANY CUSTOMIZED ORDER WILL RESET BACK TO THE DEFAULT ORDER WHEN YOU ARE UPDATED FROM THE TRAINING SOFTWARE TO THE PRODUCTION VERSION.

Social/Family History

As a convenience, the **Social/Family History** button at the top of the Past Medical History page allows you to document the member's first-degree relatives (mother, father, daughter, son, sister, or brother), while working on a member's PMH.

This button works as a short cut- it skips ahead to page 7 of the assessment. Instructions to document the **Social/Family History** will be reviewed in that section of the guide.

Add Diagnosis

The Add Diagnosis button holds the higher specific diagnoses not available in the Clinical Review. This button will allow you to select a diagnosis to add using the same menu and method as the Diagnosis Cart. Remember to select the most specific diagnoses as it pertains to the member.

Clinical Review Additions

Any diagnoses that are added using the Diagnosis Cart will be located on page 15.

Multi-Level Diagnosing

Multi-Level Diagnosing refers to identifying a **Disease Category**, then specifying the **Type** appropriate for that diagnosis. In many cases, a member can have one or more types of a disease process, such as Diabetes with Complications, and additional levels of specificity may be required.

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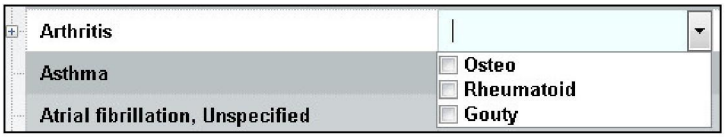
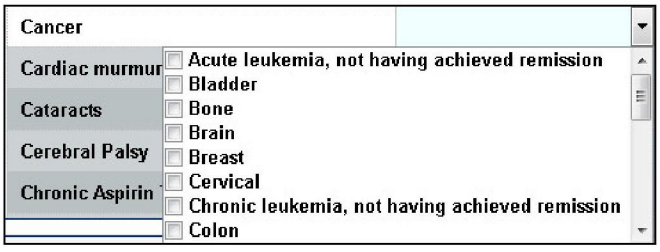
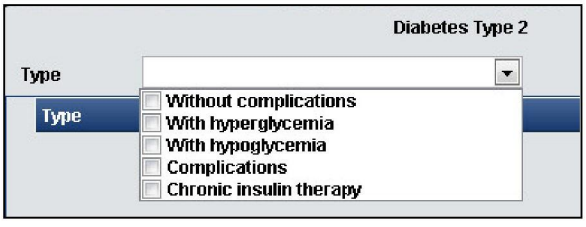
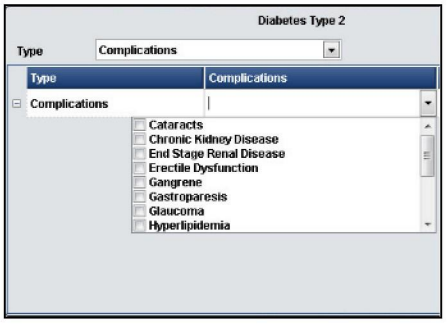
For example, Diabetes Type II Complications with Ulcer (location, severity, and laterally). In addition, the etiology of a disease is essential to diagnose a condition correctly.

<table>
<tr><th>Diagnoses</th><th colspan="2">Multi-Level Selections</th></tr>
<tr><td>Arthritis</td><td colspan="2">
</td></tr>
<tr><td>Cancer</td><td colspan="2">
</td></tr>
<tr><td rowspan="5">Diabetes Type I & II</td><td colspan="2">
</td></tr>
<tr><td>Without complications</td><td>Select the applicable Active and Resolved checkboxes</td></tr>
<tr><td>With Hyperglycemia</td><td>Select the applicable Active and Resolved checkboxes</td></tr>
<tr><td>With Hypoglycemia</td><td>Select the applicable Active and Resolved checkboxes</td></tr>
<tr><td>Complications</td><td>Select the applicable Complications (multi-select) and the Active and Resolved checkboxes:

</td></tr>
<tr><td>Complications w/Ulcers</td><td>If Ulcers is selected as a Complication for a member with Diabetes Type II, the Location, Severity/Stage, and the Active and Resolved checkboxes must be selected.</td></tr>
</table>

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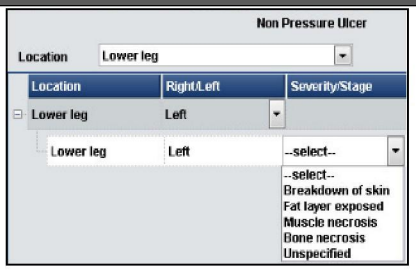
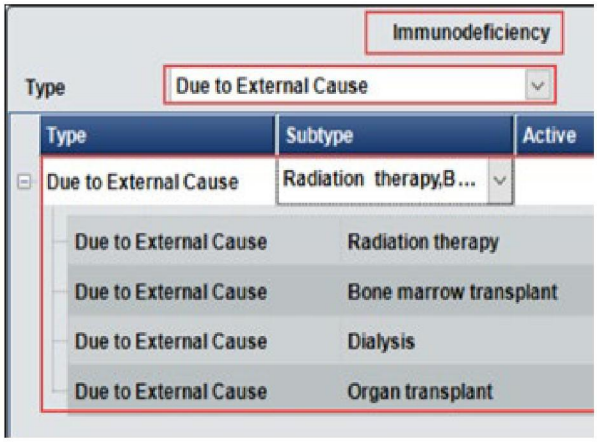
<table>
<tr><th>Diagnoses</th><th colspan="2">Multi-Level Selections</th></tr>
<tr><td rowspan="3"></td><td></td><td>
</td></tr>
<tr><td>Chronic insulin therapy</td><td>Select the applicable Active and Resolved checkboxes. Note that Chornic Insulin must be linked to DM and status.</td></tr>
<tr><td colspan="2">On the Diagnosis Confirmation page, if Diabetes Type 1 & Diabetes Type 2 - with Hyperglycemia and Immunodeficiency due to condition have been selected without documentation of manifestation details for Immunodeficiency due to condition, then a mandatory message will appear</td></tr>
<tr><td></td><td colspan="2">NOTE: If you select With Complications or Diabetes Type II, you will need to address all the complications for that diabetic member. Chronic Insulin Therapy is also a condition that should be linked to DM1 and DM2 as noted.</td></tr>
<tr><td>Immunodeficiency due External Cause</td><td colspan="2">When selecting the Immunodeficiency Diagnoses, a popup appears to allow drop-down selection of Type, Subtype and Conditions, as follows:
Type: Immunodeficiency- Due to External Cause:
Subtypes for External Cause (Options are multi select)
○ Radiation therapy
○ Bone marrow transplant (Subtype level)
○ Dialysis
○ Organ transplant

</td></tr>
<tr><td>Immunodeficiency due to Condition</td><td colspan="2">Subtype for Condition (Options are multi select)
○ Lupus
○ Rheumatoid - Arthritis
○ Cirrhosis</td></tr>
</table>

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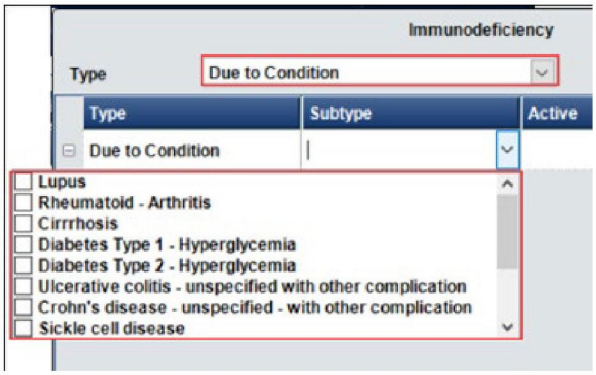
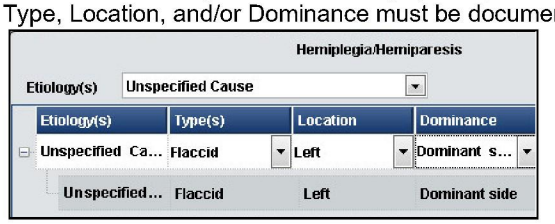
Diagnoses	Multi-Level Selections
	○ Diabetes Type 1 - Hyperglycemia (Mutual exclusive with Diabetes Type 2) ○ Diabetes Type 2 - Hyperglycemia (Mutual exclusive with Diabetes Type 1) ○ Ulcerative colitis - unspecified with other complication (Mutual Exclusive with Crohn's disease, unspecified, with other complication) ○ Crohn's disease- unspecified-with other complication (Mutual Exclusive with Ulcerative colitis, unspecified with other complication) ○ Sickle cell disease ○ Acute leukemia- not having achieved remission ○ Chronic leukemia- not having achieved remission ○ Lymphoma ○ Multiple Myeloma ○ Acquired absence of spleen 
Hemiplegia/Hemiparesis	Once an etiology is selected, including: Due to Head Injury, Unspecified Cause, Late effect of CVA, the Type, Location, and/or Dominance must be documented. 
Transplant	This is the only diagnoses from the Clinical Review page that requires a Year to be documented.

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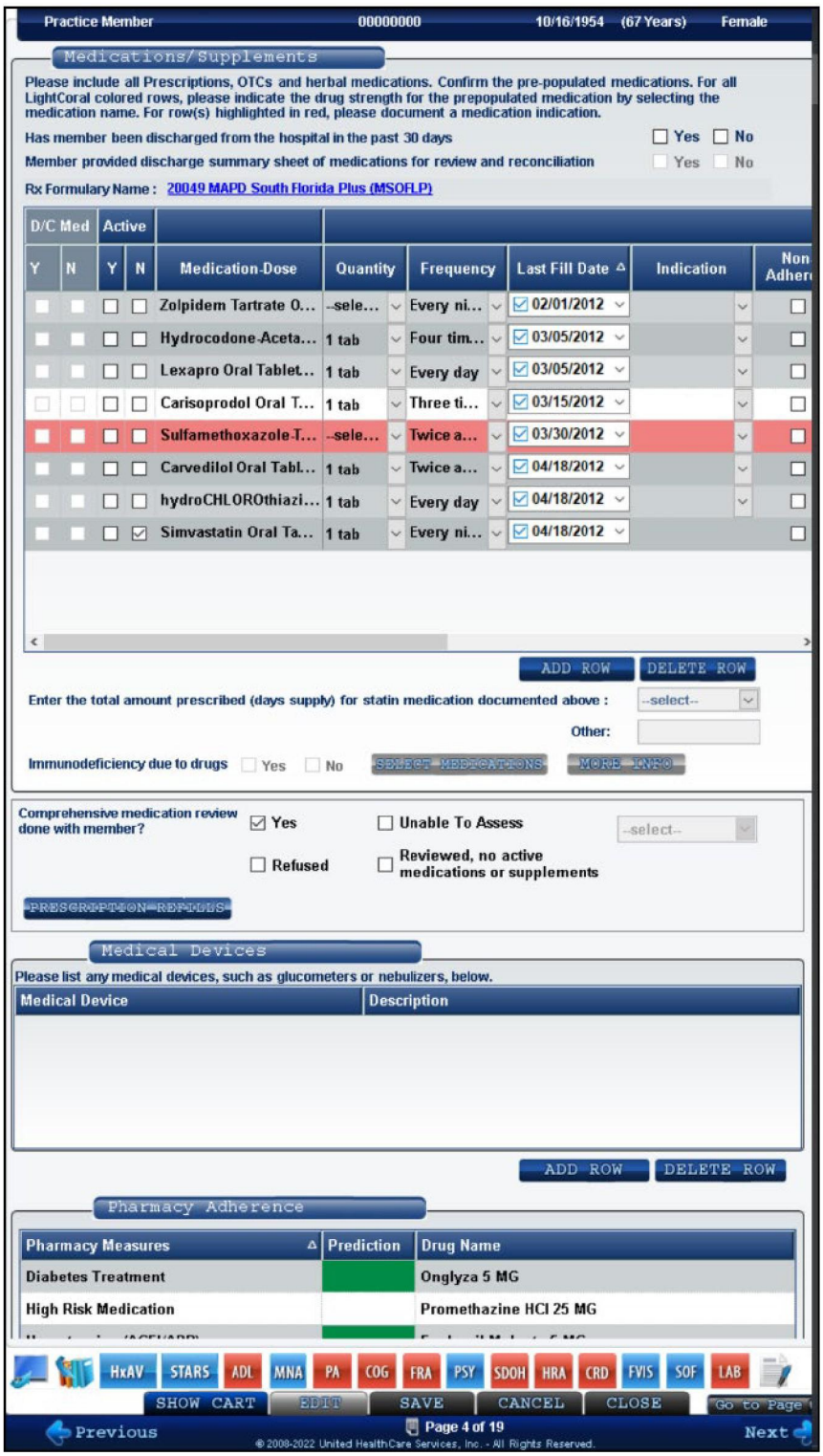
DOCUMENTING ASSESSMENT PAGE 4

On page 4 of the assessment, you will discuss and document member Medications, Additional Supplements, Pharmacy Adherence, and Barriers to Adherence.



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A Comprehensive Medication Review

The medication review is an important part of the assessment, and its proper documentation is unique. On this page you will be documenting and reviewing all prescriptions, over the counter medications, herbal medications, and any applicable supplements. You will be documenting all medications the member is taking, even if not prescribed to them.

The Medication Grid at the top of page 4 is documented **ONLY IF** you can complete a **Comprehensive Medication Review.** Review the four check boxes in the middle of the page to confirm.



- **Yes**- Checking this box means you can complete the review. The **Medication Grid** will need to be documented.

If you select one of the other checkboxes, a pop-up alert will appear, advising all changes made to the grid will be deleted.

- **Refused**- The member refuses to review medications with you. Skip the Medication Grid and continue with the assessment
- **Reviewed, no active medications or supplements-** The member states he/she has no medications. The is nothing to document on the Medications Grid
- **Unable to Assess**- You cannot complete the review. In this situation, a reason must be selected from the nearby drop-box. The Medication Grid cannot be documented. Reasons listed in the drop-box include:
  - **Member has Dementia/Alzheimer's**
  - **Medications not present**
  - **Caregiver not present**
  - **No original containers**

Post Discharge Visit (PDV)

After the description and listed expectations located at the top of the page, a line item reads, **"Member provided discharge summary sheet of medications for review and reconciliation**." The only time that question will be enabled is if this is a **Post Discharge Visit**. This is also the only place a PDV status impacts the assessment.
You will be required to either select YES or NO. If Yes is selected, you will need to address every medication listed or added and identify if it was a discharge medication. (D/C Med)
You will be asked whether the member has been discharged from the hospital in the last 30 days



1. If **Yes** is selected for the discharge question, the "*Member provided discharge summary sheet of medications for review and reconciliation*" question and the **D/C Med** column of the Medication grid will be unlocked. (The unlocked fields will be mandatory and will generate a Mandatory Message if not completed)
2. If **No** is selected for the discharge question, the "*Member provided discharge summary sheet of medications for review and reconciliation*" question and the **D/C Med** column of the Medication grid will be disabled.
3. If the new discharge question is not answered, a Mandatory Message will appear on page 18:



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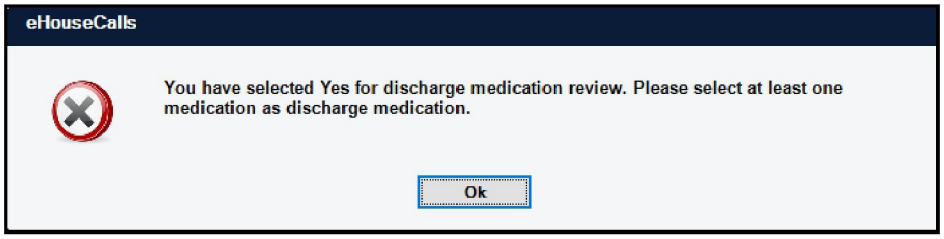
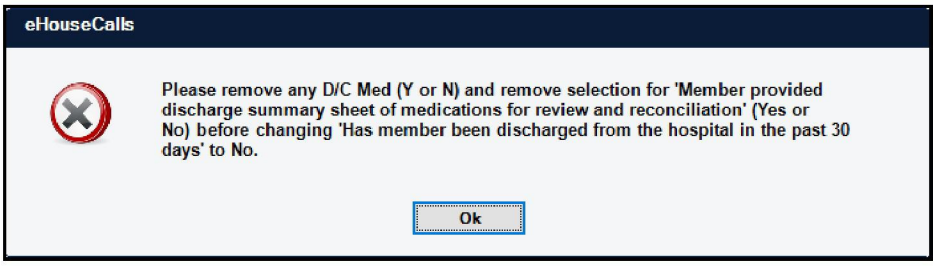
- If the member is flagged for a discharge visit "Member provided discharge summary sheet of medications for review and reconciliation" is **disabled**.
- If **Yes** is selected for both the discharge questions above the medication grid without marking at least one medication as D/C med, a pop-up alert will appear:



- If **Yes** is selected for both the discharge questions above the medication grid AND marks at least one medication as D/C med, then changes the response of "*Member provided discharge summary sheet of medications for review and reconciliation"* to **No,** then a page alert will appear as below.
  - In the alert, upon selecting **No**, the alert will close.



Medications/Supplements Grid

The **Medications/Supplements** grid is where you document all medications the member is taking or should be taking. This includes prescription drugs, OTC, and any herbal supplements. You should also record if the member is taking both the brand name and generic version of the same medication. It is imperative that you are looking at the member's medication bottles when completing this page.

MEDICATIONS IN THE GRID MAY BE PREPOPULATED BASED ON THE MEMBER'S PRESCRIPTION FILL HISTORY. YOU CAN ALSO ADD ADDITIONAL MEDICATIONS.

The text at the top of the page explains documentation requirements for the **Medication Grid**, including color-coded errors.

- **Light Coral (Pink) Rows** are missing the drug strength for the pre-populated medication.
- **Red Rows** require a medication indication

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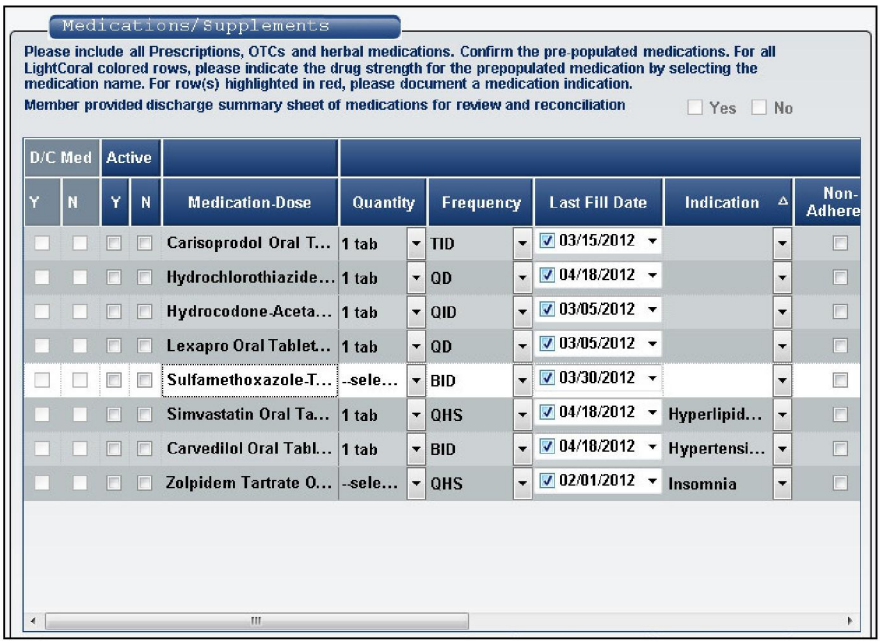
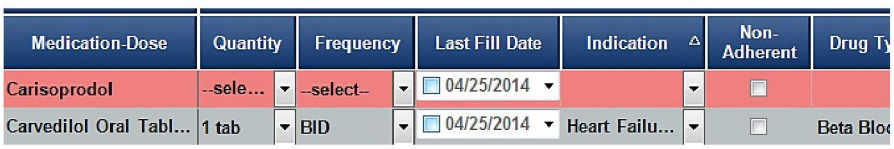


The table below reviews the columns of the Medication Grid and details the documentation criteria.

Column Name	Description
D/C Med	**The D/C Med (*Discharge Medication*) column will ONLY be enabled for members identified as PDV. For each medication, you must indicate if it is active by selecting the Y or N checkbox.** **When a medication is marked as Active – Yes, the system will automatically document that you have completed a post discharge medication reconciliation.** **THIS SECTION IS REFERRING TO THE DISCHARGED MEDICATIONS, NOT DISCONTINUED MEDICATIONS.**
Active Y/N	**For each medication, select Y if it is Active (The member is or should be currently taking the medication). Select N if the member is no longer taking the medication.** **When a medication is marked as Active – Yes, the system will automatically document that you have completed a comprehensive medication review.**
Medication-Dose	**This field lists the medication name and strength. Prefilled medication rows that appear in Light Coral indicate the med strength is missing. Click the medication name to open a pop-up window and select a strength. Once updated, the row will change color to match the rest of the grid.**  **eHouseCalls does not allow duplicate medications to be added to the grid, with two exceptions:** ○ Certain maintenance drugs such as Insulin, Coumadin, Lasix, Metformin, Glyburide and Glucophage can be added more than once ○ You can add both the generic and brand name for the same medication so we can ensure the member is not over/under dosing

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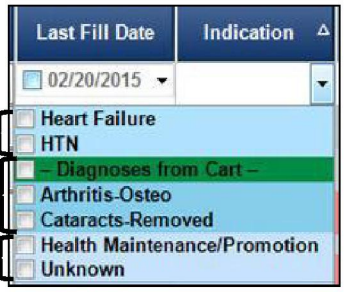
Quantity	**Indicate the prescribed medication quantity by selecting from the drop-down list. Select *As Directed* ONLY if the option is not listed. Add additional notes in the far-right Notes column.**
Frequency	**Indicate medication frequency by selecting from the drop-down list. Select *As Directed* ONLY if the frequency option is not listed. Add additional notes in the far-right Notes column.**
Last Fill Date	**A last fill date should be documented for all prescription medications. It is auto filled for prepopulated medications based on claims information and is generally accurate.** ○ For OTC medications the Last Fill Date checkbox does not need to be checked. ○ If you accidentally typed in a wrong date for an OTC med and need to remove it, uncheck the box next to the date, enter the correct date and re-check the box. □
Indication	**The Indication column is used to associate indications (diagnoses) with the medications. The multi-select drop-down list may be prepopulated with common uses for the medication, active diagnoses added to the diagnosis cart, Health Maintenance, and/or Unknown.**

Common uses for the med

Active diagnoses that have been added to the diagnosis cart

Other



- ○ The indication is mandatory for every ***Active*** *medication*. If the appropriate indication is not listed, add the diagnoses to the Diagnosis Cart or mark it *Active* if it is in the cart as inactive.
- ○ A medication can have more than one indication such as medications for diabetes or cardiac conditions
- ○ A medication will turn **RED** if an Indication is not selected for an Active Medication

Non-Adherent	**If the member is taking a medication less than 80% as it is prescribed, check the box to document they are non-adherent. You are required to indicate the reason for non-adherence at the bottom of the page.**
Drug Type	**This column shows the MKI (medication key indicator) for the drug. MKI is similar to Drug Class but it is an in-house classification. The MKI will automatically prepopulate for all prepopulated and manually added medications.**

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Prescriber	**THIS FIELD IS ONLY MANDATORY FOR MEDICATION THERAPY MANAGEMENT (MTM) MEMBERS, IDENTIFIED WHEN THE MTM TOOL IS HIGHLIGHTED IN RED. ALL OTHERS DO NOT NEED A PRESCRIBER- THE FIELD WILL BE GRAYED OUT. IF AN MTM MEMBER IS MISSING A PRESCRIBER FOR AN ACTIVE MEDICATIONS, YOU WILL RECEIVE A MANDATORY MESSAGE.** **Add or edit Prescriber names by using a text field or selecting from a prepopulated list. This list of names includes the prescriber names already listed in the medication grid, the documented PCP on page 1, and all confirmed specialists.** **elect *Self-Prescribed* which for OTC and supplements that the member initiated. If the PCP recommended an OTC medication or supplement, document the name in the *Prescriber* column.**
S/V/P/M	**Only use this drop-down list if the member is NOT using their prescription benefit . This tracks inconsistencies in prescription fill history. A full description of the list displays when you hover your cursor over the column.** **The column is a single select drop-down list with the following options:** ○ **S**= Samples – e.g. received at a PCP Office ○ **V**= VA Supply – from Veterans Administration ○ **P**= Pharmacy Program – e.g. for free or low-cost medications obtained through a program with a pharmaceutical company ○ **M**= Member Initiated - e.g. Member decided to start taking Aspirin, or Vitamins
Note	**Use this area to document any pertinent notes related to the medication. For example, if *As Directed* is selected from the Quantity or Frequency columns, indicate what is as directed in the Notes column.**

Medication/Supplements Popup

Although the list of medications available in the drop down is comprehensive, it can be difficult at times to locate a specific medication or supplement. To avoid manual errors (misspelling), attempt to find the drug in the search bar. If still unable to locate what you need, there is an option to search and select or check the box labeled, **Could not find medication/supplement** (snapshot below). If you select this checkbox, you can manually type information after adding a row. Select either 'medication' or 'supplement' followed by free texting the medication/supplement form (dose) in the below area.

IF IMMUNODEFICIENCY MEDICATIONS ARE ADDED, THE MEDICATION WILL DISPLAY IN PURPLE FONT AND THE IMMUNODEFICIENCY DUE TO DRUGS QUESTION WILL BE ENABLED.

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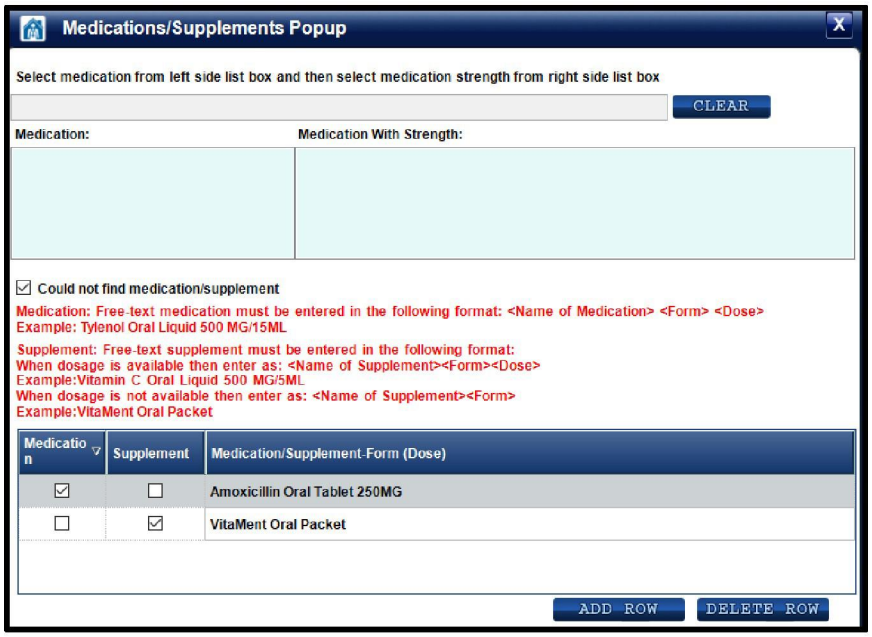


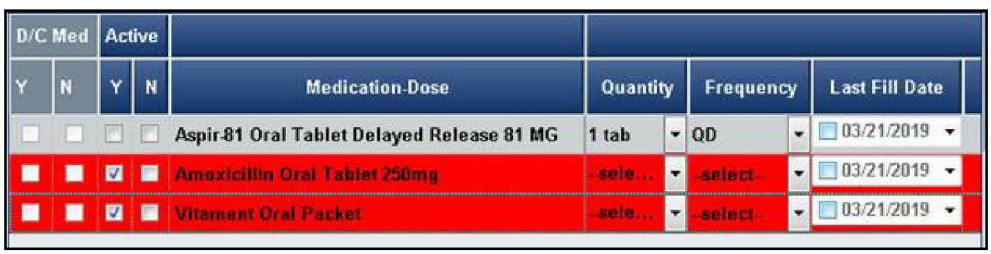
Formatting

If you are manually entering a medication or supplement, the format provided below must be used.

Condition	Format	Example
When dosage is available	**<Name of Medication><Form><Dose>**	**Tylenol Oral Liquid 500 MG/15 ML**
When dosage is NOT available	**<Name of Supplement><Form>**	**Vitamin Oral Packet**

IF YOU MISSPELL THE DRUG NAME OR DIRECTIONS, THIS WILL RESULT IN A FAILED AUDIT. AN ACCURATE & COMPLETED FORMAT OF MEDICATIONS AS IDENTIFIED ABOVE IS CRITICAL.

After hitting select on the pop-up box any free texted medication will then populate to the medication grid for final completion of the remaining fields as illustrated below:



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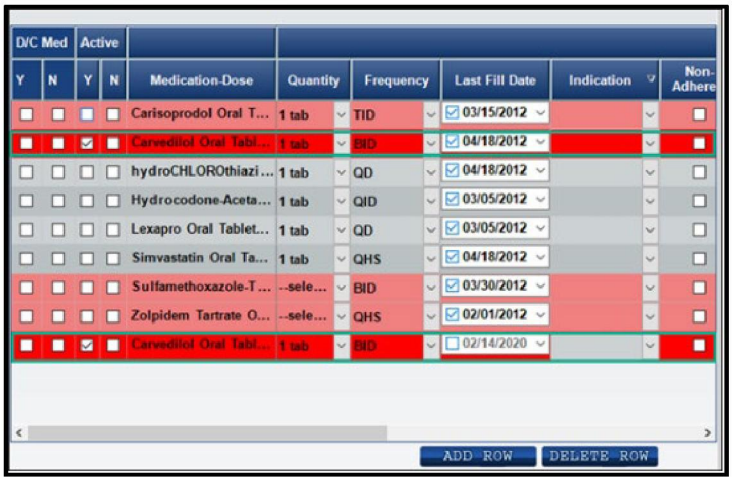
Duplicate Medications

If you enter duplicate medications or add a duplicate medication from the preloaded list including the same frequency, dose, and quantity, then the following pop up will be displayed when you try to save or leave page 4.

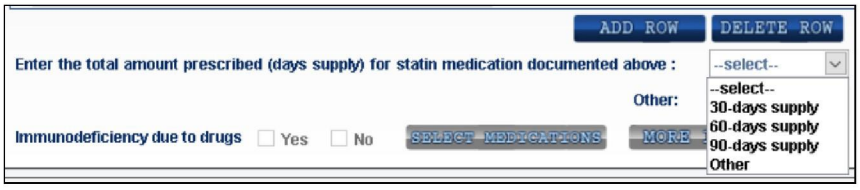




Once you select "OK" from the popup, the popup will close, and you will need to either delete the duplicate medication or make an update to the medication.

Statin Days Supply

There is a statement listed for the total amount of prescribed days supply for statin medications that the member is prescribed. A dropdown menu is used to enter if the medication was filled as a 30, 60, 90, or other amount of days supply. This area becomes enabled when a Statin medication is populated in the medication grid. When the member is taking an Active Statin medication, the directions on the medication label and the quantity listed on the bottle will need to be reviewed to determine the days supply of medication. If the member has a Statin medication populated that is no longer active, the days supply question will be present with the dropdown options disabled.



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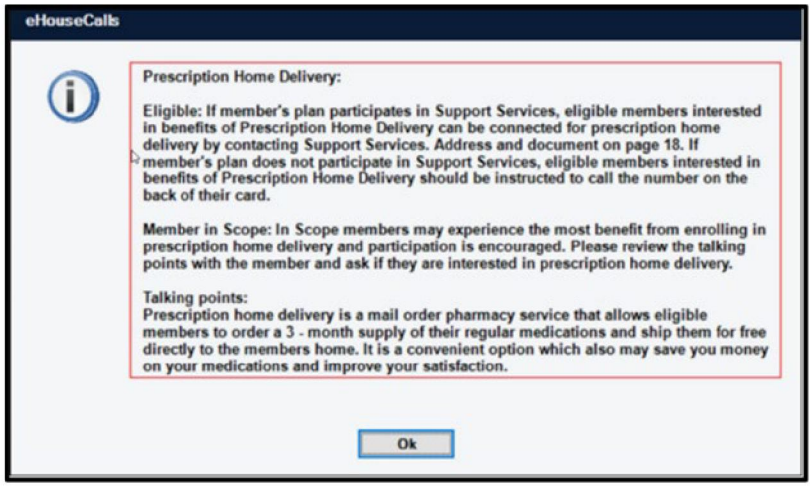
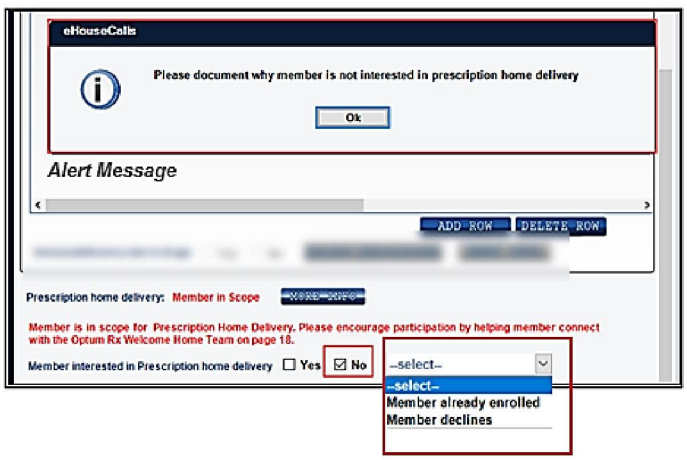
Prescription Home Delivery

This section will be present for members who are eligible for Optum Rx Prescription Home Delivery. Optum Rx is a Home Delivery Pharmacy providing mail order prescriptions where members are able to receive a 90-day supply of medication shipped to their home. Eligible members may be designated as either In Scope or Not In Scope. The More Info button is present and will open a pop-up box that explains Eligible and Member in Scope as well as talking points to guide the conversation with the member.



Member In Scope

Prescription home delivery is available for the member when **Presription home delivery** with **Member in Scope** is present in red font below the medication grid. Members with this designation have been pre-determined to receive the maximum benefit from enrollment. Instructional text will also be present in Red font that states, ***"Member is in scope for Prescription Home Delivery. Please encourage participation by helping member connect with the Optum Rx Welcome Home team on page 18."*** **Member interested in Prescription Home Delivery** will be indicated by using the **Yes** and **No** checkboxes. A page alert will occur when attempting to save or navigate away from the page when the **Yes** or **No** checkbox is not selected. If **Yes** is selected, additional documentation will be required on page 18 in the Prescription Home Delivery Section. If **No** is selected, you are required to enter a selection in the corresponding dropdown menu with the options of either **Member already enrolled** or **Member declines**. A page alert will occur when attempting to save or navigate away from the page if **No** is selected and a reason is not selected from the corresponding dropdown menu. A Mandatory Message will be generated on page 18 if this section is not completed when the member is In Scope.



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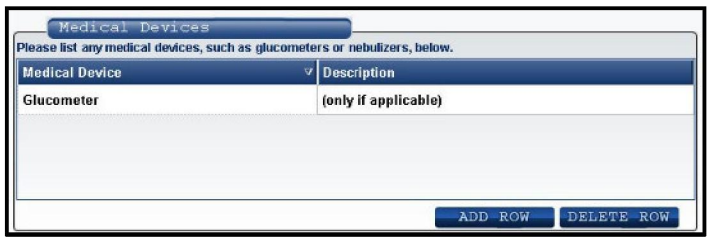
Member Not In Scope

Prescription home delivery remains available for the member when **Prescription home delivery**: **Eligible** is present in blue font below the medication grid. Instructional text will also be present in blue font that states, ***"Member is not in scope. If member is interested in Prescription home delivery, please document in Support Services on page 18."*** In Scope and the Member Interested statement will be disabled for selection in gray font. If the Not In Scope member wishes to enroll in Prescription Home Delivery, additional documentation will be required on page 18 in the Support Services Section.



Medical Devices

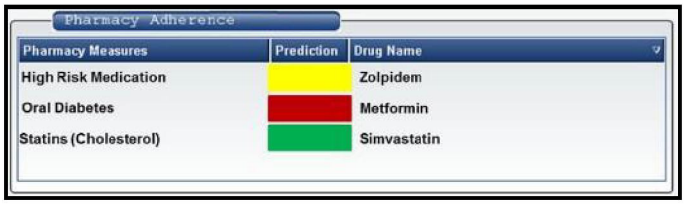
This section is used to document Medical Devices and any medical device descriptors. To add a Medical Device, click the **Add Row** button and free text the Medical Device and a Description (if applicable). The description of the device could include Brand Name or physical appearance of the device, although this field is optional.



Pharmacy Adherence

The Pharmacy Adherence grid contains prepopulated data with Pharmacy Measures, Prediction and Drug Name. This section alerts you to potential medication adherence issues identified by pharmacy and should help to guide your conversation with the member on medication education. The prepopulated information in this section is not based on any data entry you perform, but on a member's prescription fill history. There are 3 colors of Prediction indicators:

- **Green**- Indicates the member is on track for adherence.
- **Yellow**- Indicates a moderate risk for non-adherence. Diabetes Treatment will only display in yellow.
- **Red**- Indicates a high risk for non-adherence



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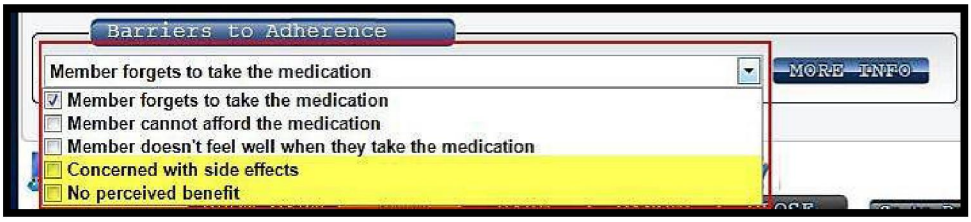
Barriers to Adherence

The Barriers to Adherence grid allows you to select reasons for a member's medication non-adherence if non-adherent was selected from the Medications grid. In order to select a barrier to adherence, click the drop-down arrow and select one or more barriers from the multi-select options list. Click the **More Info** button to display an explanation of the Pharmacy Adherence section.



AT LEAST ONE SELECTION UNDER BARRIERS TO ADHERENCE IS MANDATORY IF NON-ADHERENT IS SELECTED FOR ANY MEDICATIONS IN THE MEDICATIONS GRID.

Show Cart Button

A **Show Cart** button is provided at the bottom of the page. It is used to display the **Diagnosis Cart** for your convenience. Because all active medications require an indication, the system has provided you the opportunity to add diagnoses if you'd like. However, the cart takes up a lot of real estate on the page, so when not in use, you will want to **Hide** the **Cart**.

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DOCUMENTING ASSESSMENT PAGE 5

On page 5 of the assessment, you will discuss and document member Allergies, review prepopulated member labs, and document the member's Vaccination History.



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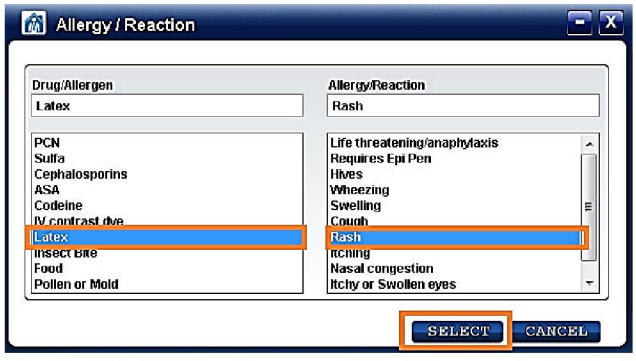
Allergies

Use the **Allergies** grid to document all allergies and reactions. DO NOT use abbreviations.

- Select the **YES** check box if allergies are present
- Click **ADD ROW** open the ***Allergy/Reaction*** window, where two lists can be addressed at once- Drug/Allergen and Allergy/Reaction.



Labs

The **Labs** grid is prepopulated with the two most recent rounds of lab test values on record. This is informational only and provided to give a more complete clinical picture of the member. Data will only populate if the member gets labs from either LabCorp or Quest Diagnostics.

The member may have lab values on paper to show you, but you are not expected to document all those values in the assessment. Use the scroll bar on the right to view lab tests and their values.

Screenings

The Screenings section will include any screening tests that the member had performed during previous HouseCalls Visits. These may include previous PVD screening (QuantaFlo) results, FOBT, diabetic retinal screening and/or bone density testing.

Vaccination History

In the **Vaccination History** section document when the member last received vaccines for Influenza, Pneumovax, Herpes Zoster, Tdap/Td, Prevnar 13, Prevnar 15, Prevnar 20, and COVID Vaccination (Dose 1 or Dose 2). If the grid is pre-populated from a previous visit, select Reviewed, no change only after reviewing and verifying the information with the member or update the vaccinations as needed.

Received Vaccinations

Complete the Status column with a selection from the dropdown menu when appropriate and enter the Month and Year each Vaccination was received. For Vaccines requiring a Month's entry, January will be the default if the month is unknown.

Not Received Vaccinations

If a Vaccination has not been received, a selection is required from the Reason for not receiving vaccine dropdown menu. COVID-19 Dose 1, and COVID-19 Dose 2 require the selection of both Status Not Received and a selection from the Reason for not receiving vaccine dropdown menu. If an additional Booster dose of COVID-19 vaccine has been received, this information will be documented in the Assessment Notes.

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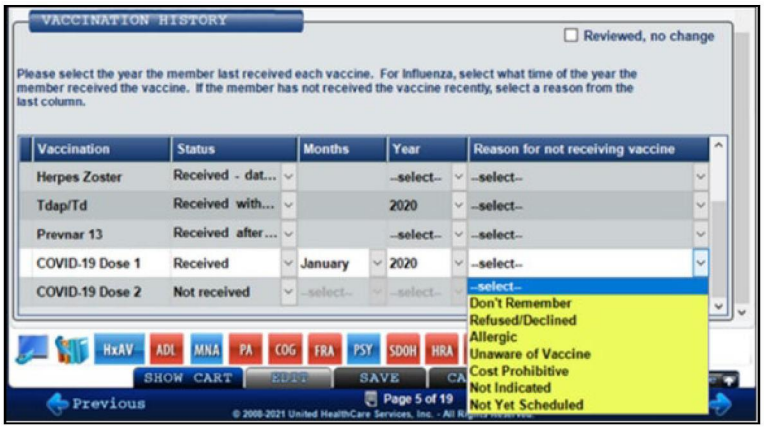
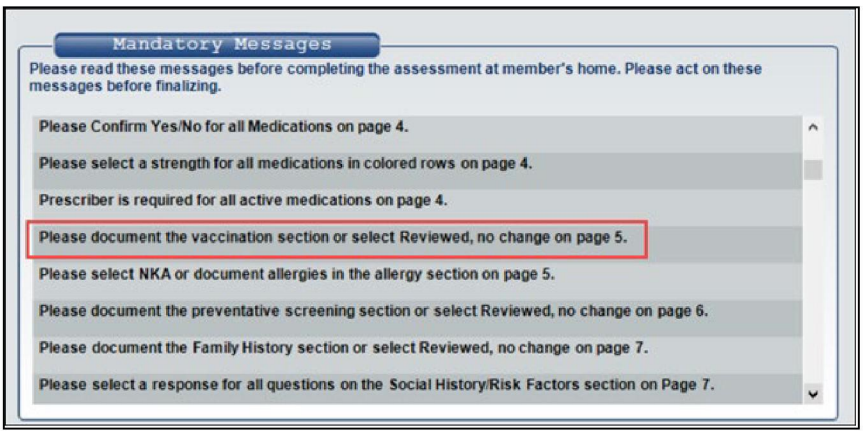


Incomplete Grid

If the Vaccination History grid is not completed correctly, a Mandatory Message will be generated on page 18.



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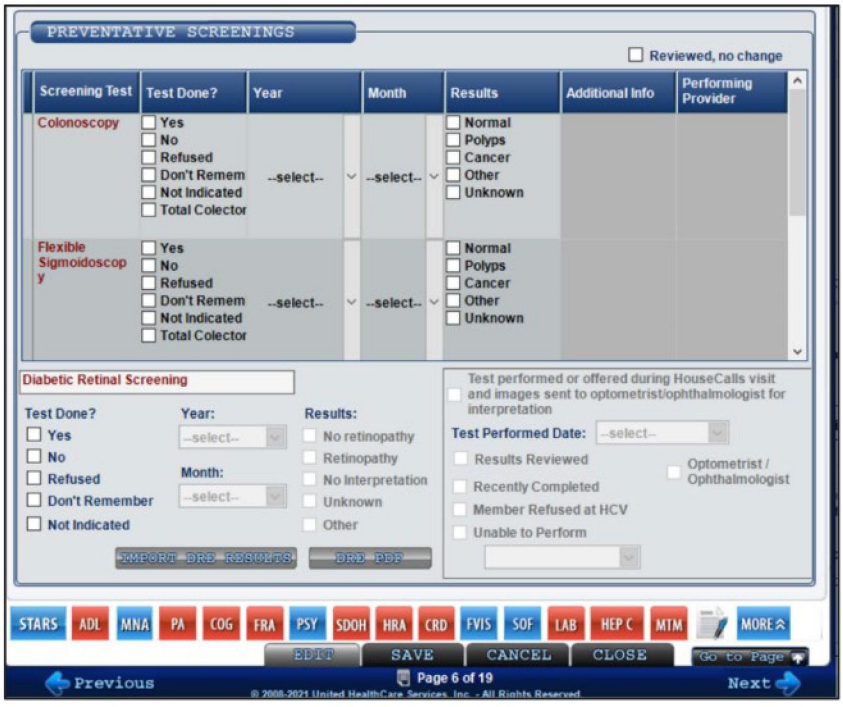
DOCUMENTING ASSESSMENT PAGE 6

On page 6 of the assessment, you will discuss and document **Preventative Screenings.**



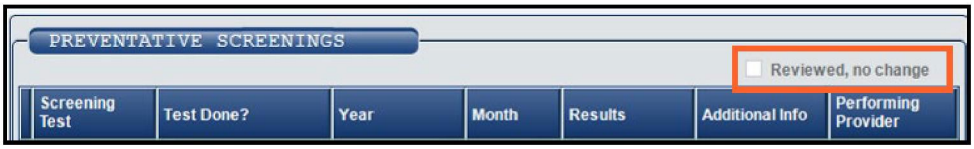
Preventative Screenings

Page 6 documents **Preventative Screenings**. The grid is a mandatory element of the HouseCalls Visit- it must be reviewed thoroughly and updated. This is also a chance to teach the member about the Preventative Screenings/Vaccination form and when these tests should be received.
If the member is identified as having a gap for a screening, the **Screening Test** column head will appear in maroon text. Each screening requires the following information:

- **Test Done?** - Check boxes are listed to record if the test has been done. In addition to *YES* and *NO*, other options are provided for more specific scenarios. For example, a Mammogram may not be needed for a male, so *Not Indicated* would be the proper selection (instead of *NO*)
- **Year** - Use the drop box to document the year the test was completed
- **Month** - Use the drop box to document the month the test was completed. January can be used as a default entry if the month cannot be accurately determined or if the member cannot remember
- **Results** - Check boxes provide options to record the results of the test
- **Additional Info** – Some tests may require some additional information about the results.
- **Performing Provider** – Some tests may require information about who administered the test

ONCE THE PREVENTATIVE SCREENINGS GRID IS STARTED YOU WILL NOT BE ABLE TO NAVIGATE TO ANOTHER PAGE UNTIL IT IS COMPLETE.

If the Preventative Screenings grid is pre-populated, the "**Reviewed, no change**" checkbox may be selected only after the pre-populated information has been verified with the member. Pre-populated information in the grid may be edited if necessary.



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Colorectal Cancer Screening

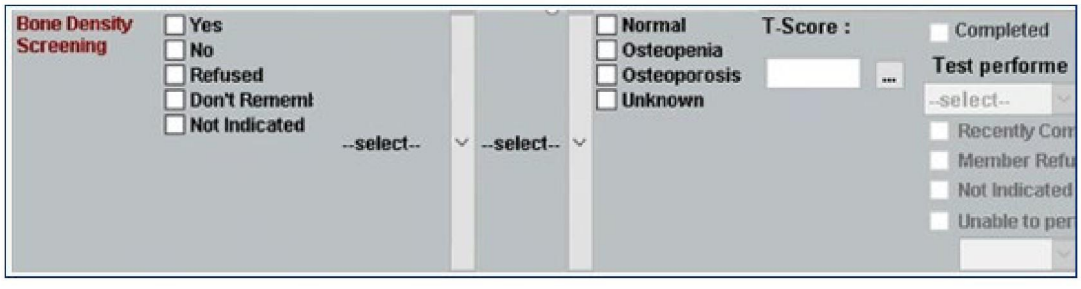
The gap for colorectal screening encompasses Colonoscopy, Flexible Sig, FIT-DNA, or FOBT testing. Last Colorectal screening information should be collected from the member including if the test was performed, **Year**, **Month**, and **Results**. The **Additional Info** column in this section is only required for FIT-DNA and FOBT testing.

> **FOBT TESTS PERFORMED IN AN OFFICE SETTING OR PERFORMED ON A SAMPLE COLLECTED VIA DIGITAL RECTAL EXAMS (DRE) ARE UNACCEPTABLE COLORECTAL CANCER TEST.**

Last Mammogram information should be collected from the member including if the test was performed, **Year**, **Month**, and **Results**. If a Mammogram is not an appropriate screening for the member (due to gender, for example) select **Not Indicated** in the ***Test Done*** column.

Bone Density Screening

Last Bone Density Screening information should be collected from the member including if the test was performed, and when the test was performed, the **Year**, **Month**, and **Results**.
The **T-Score** (in the ***Additional Info*** column**)** and the information in the **Performing Provider** column are only documented if you are performing the test in the home. Otherwise, these columns are left blank.
If the member is flagged for the OMW screening in the home and the APC is trained to perform the screening, the **Month** and **Year** will not be entered, and the **Additional Info** and **Performing Provider** columns will be enabled for completion. **Completed** will be selected in the **Performing Provider** column which will then enable the entry of the **Test Performed** dropdown date and the **T-Score** that will allow for documentation of a completed screening. The options of **Recently Completed, Member Refused**, **Not Indicated**, and **Unable to Perform** (requires selection from Unable to Perform dropdown menu) are available for selection if the test is not able to be completed. When any of these options are selected, the **Month** and **Year** column will become enabled to allow for the complete documentation of the members previous Bone Density Screening.



Diabetic Retinal Screening

Last Diabetic Retinal Screening information should be collected from the member including if the test was performed and when performed, the **Year**, **Month**, **Results,** and that the test was performed by an **Optometrist/Ophthalmologist**.
If a member is not a diabetic, select **Not indicated** and no further documentation in this section is needed. For our diabetic members, this section is mandatory.
If the member is flagged for the Diabetic Retinal Exam in the home, and the APC is trained to perform the screening, **Yes** will be selected for **Test Done**. The **Month**, **Year,** and **Results** will not be entered and the **Test Performed** area will be enabled for completion. Selecting the checkbox **Test performed or offered during HouseCalls visit and images sent to optometrist/ophthalmologist for interpretation** will enable the **Test Performed Date** dropdown menu and auto select the **Optometrist/Ophthalmologist** checkbox. No other entries should be made in the Diabetic Retinal Screening area and the chart may be Statused as Completed until the DRE results are available for Import.

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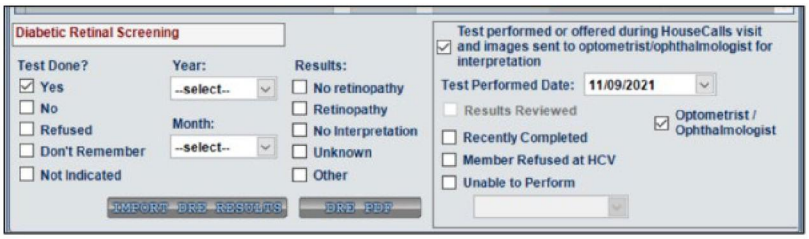
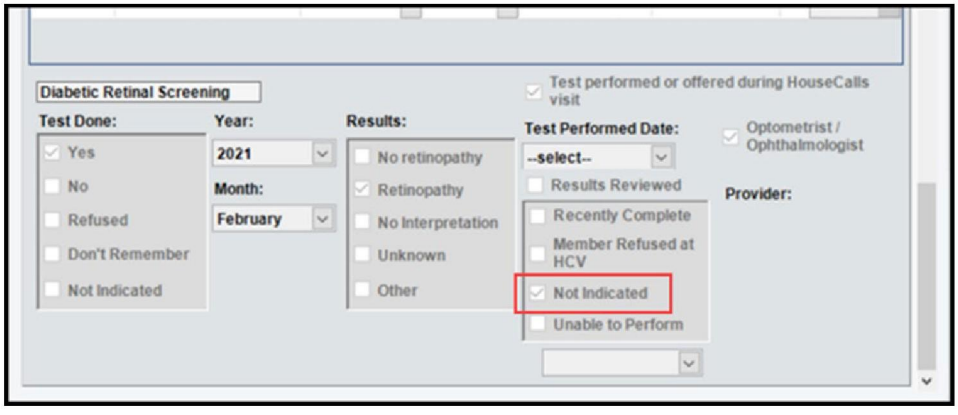


A banner alert will be displayed on the eHC Dashboard when the DRE results are available for Import. Upon re-entering the assessment with available DRE results**, Import DRE Results** is selected followed by selecting **DRE PDF** which will allow the APC to review the DRE report. Auto-selection will then occur of **Results** and **Results Reviewed** and an auto-population of the name of the performing provider will occur. Any diagnosis noted on the DRE report will auto-populate in the Active diagnosis list on page 15. The options of **Recently Completed**, **Member Refused at HCV**, **Not Indicated**, and **Unable to Perform** (requires selection from Unable to Perform dropdown menu) are available for selection if the test is not able to be completed. When any of these options are selected, the **Month**, **Year,** and **Results** columns will become enabled to allow for the complete documentation of the members previous Diabetic Retinal Screening.



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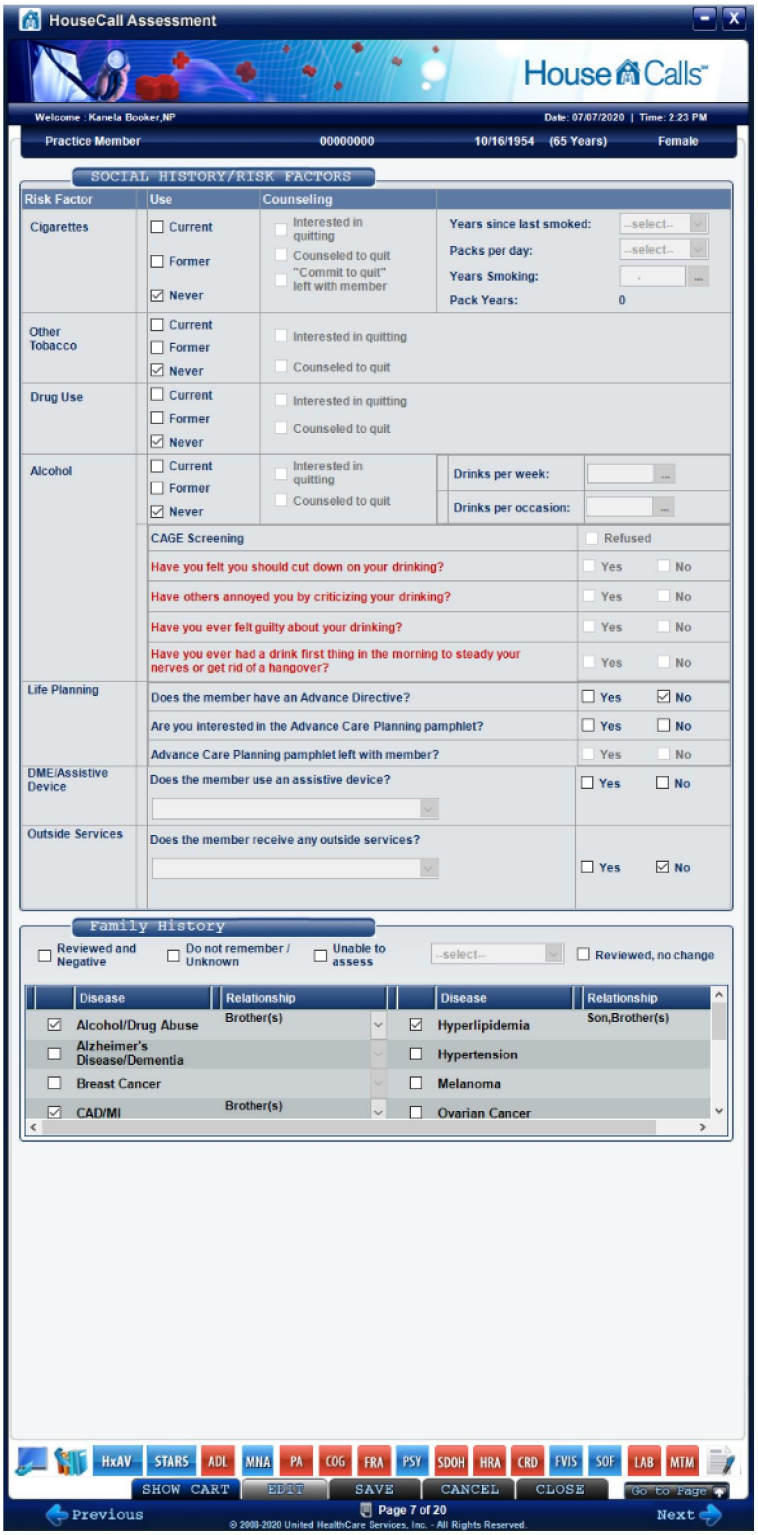
DOCUMENTING ASSESSMENT PAGE 7

On page 7 of the assessment, you will discuss and document member Social History/Risk Factors and Family History.



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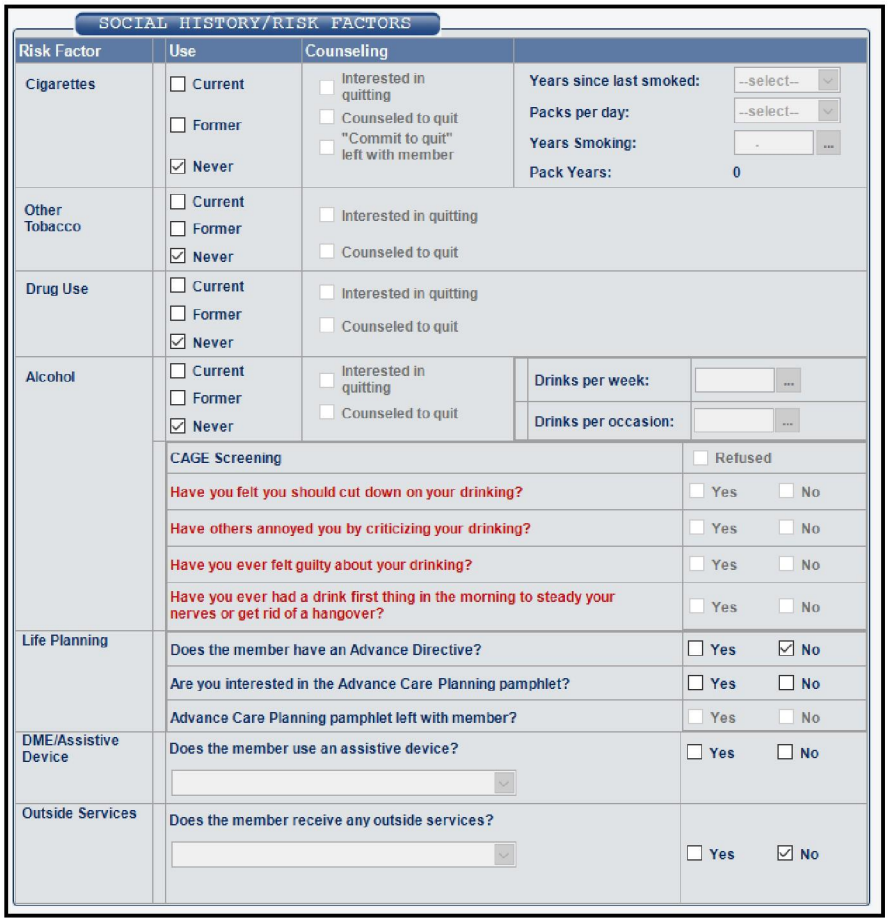
Social History/Risk Factors

The **Social History/Risk Factors** page, also available from the ***Past Medical History*** page addresses the member's tobacco, alcohol, and drug use. This is also where you document advanced directive, assistive devices, and outside services the member is receiving.



The following table reviews the **Social History/Risk Factors** sections in further detail.

Section	Description
Cigarettes	• If the member is a **current** smoker, indicate the packs per day and the number of years they have smoked ○ The system will automatically calculate the number of packs per year • If the member is a **former** smoker or **never** smoked, select the appropriate checkbox. Document years since last smoked, packs per day, and years smoking. • Indicate if the member is interested in quitting. If a current user and not interested in quitting, the member should be counseled to quit and a *Commit to* Quit letter should be left with them
Other Tobacco	• Indicate if the member is a current, former or never used other tobacco such as chew, snuff, cigars, pipes, dip, e – cigarettes, etc. • Indicate if the member is interested in quitting. If a current user and not interested in quitting, the member should be counseled to quit and a *Commit to* Quit letter should be left with them

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Drug Use	• Indicate any illicit drug use including marijuana that the member does not have a prescription for • Indicate if the member is interested in quitting. If a current user and not interested in quitting, the member should be counseled to quit
Alcohol	• Indicate the member's intake of alcohol. If **current**, document the drinks per week or the drinks per occasion, (You cannot complete both) • Indicate if the member is interested in quitting and if a current user and not interested in quitting, the member should be counseled to quit • When **current** is selected, the CAGE screening is mandatory and each question will require a yes/no checkbox selection. The member has the option to refuse the CAGE screening.
Life Planning	• Indicate if the member has an Advance Directive • If the member does not have an Advance Directive indicate if they are interested in receiving the pamphlet • If the member is not interested in an Advance Care Planning Pamphlet select **No** • If the member is interested in the Advanced Care Planning Pamphlet, select **Yes** and then indicate if the Advanced Care Planning Pamphlet was left with the member using the Yes/No checkboxes. If you do not have the pamphlet on hand to give to the member, select **No** and a copy will be automatically mailed to the member. □
	WHEN THE "ARE YOU INTERESTED IN THE ADVANCE CARE PLANNING PAMPHLET?" QUESTION IS ANSWERED WITH YES, AUTO-SELECTIONS WILL OCCUR IN THE MEMBER EDUCATION AREA ON PAGE 16 WHERE ADVANCED CARE PLANNING WILL BE SELECTED AND ON THE AYPCP ON PAGE 18 ADVANCE DIRECTIVE WILL BE SELECTED.
DME/Assistive Devices	• Document if the member uses an Assistive Device and select the type (select from the multi-select drop-down list).
Outside Services	• Indicate if the member is currently receiving any outside services and the type (Select from the multi-select drop-down list). • Hospice members are not eligible for referrals. Selecting Hospice will disable the CRD tool turning it gray. See section on CRD tool for more information

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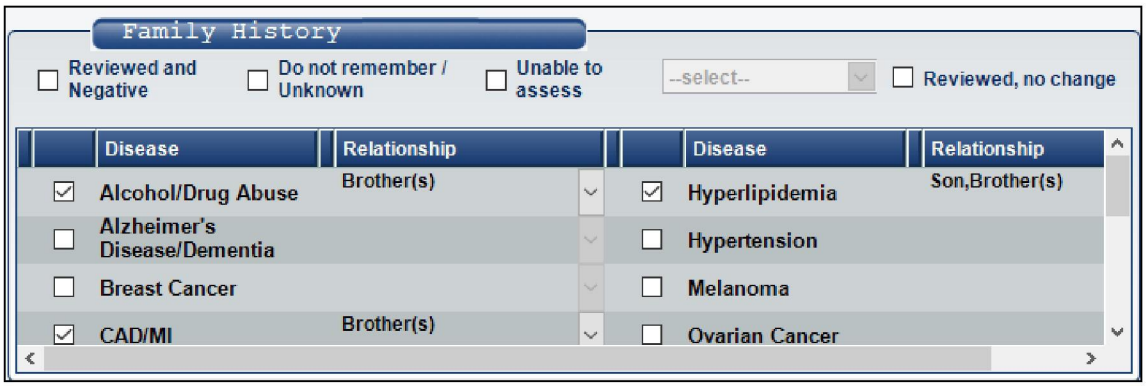
Family History

The Family History section **only** reviews the diagnoses listed in the tablet for first degree relatives (i.e., Mother, Father, Son, Daughter, Sister(s), Brother(s), or Don't Remember/Unknown). The familial relationship for each disease is selected by checking the appropriate relative checkboxes from the dropdown menu for each disease.

If there is information pre-populated from a previous HouseCalls visit, this information will need to be reviewed and verified with the member. If the pre-populated information does not require any edits, then the **Reviewed, no change** checkbox may be selected. If changes are required to the pre-populated information, the information within the grid can be adjusted. you will need to check the **Reviewed, no change** checkbox, or adjust the information within the grid.



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DOCUMENTING ASSESSMENT PAGES 8-10

The **Review of Systems** (ROS) is made up of three pages in the assessment. This is where you will document symptoms the member has experienced, from their perspective, within the last 4 weeks.



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Review of Systems (ROS)

The **ROS** pages are grouped by system, separated by blue title bars- each with their own set of check boxes. For most systems, you will have the option to select **Not Assessed** or **Reviewed and Negative.**

- **Not Assessed** - Select if unable to assess the system due to member limitations or refusal.
- **Reviewed and Negative** - Select if the finding for a system is negative. The inclusion of 'reviewed and negative' is visible using the hover feature in each system.
- If the member has **positive findings**, select the appropriate checkboxes under the system. You may find additional checkboxes, drop-down options, or free textboxes used to describe additional details of the symptom.



A **"Global" Reviewed and Negative** check box, located at the top of the page, will auto select the Reviewed and Negative option for all systems if it is checked. Please be mindful that if selected, it will tell the system that you have addressed every single section of the review of systems, and there was nothing to report.

The **Additional Notes** button allows you to enter any notes specific to the ROS. These notes can be found collated at the bottom of page 10. Any notes taken utilizing this notepad will live in the review of systems and will not be included in your general assessment note pad from your diagnostic tool bar.



You will also the see diagnosis cart is available on every page of the Review of Systems, and it cannot be collapsed.

Page 9

Integumentary Grid

If you select any type of Integumentary option (i.e., Rash, Atypical Skin Lesions, Pressure, Stasis, and Foot Ulcers) you must record the details in the **Skin Abnormality Grid** on page 14 in the Examination pages. If you fail to record the wound details, you will be prompted with an error (a Mandatory Message- see page 18) and will not be able to finalize the assessment. It is also important that you use the same terminology in both sections.



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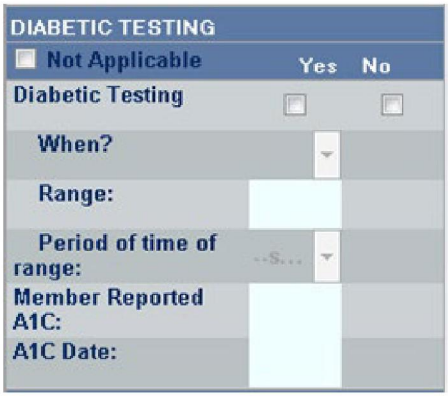
Diabetic Testing Grid

The **Diabetic Testing** section is MANDATORY for all members and will remain unaffected even if the ***Global Reviewed and Negative*** checkbox is selected. System Options and their functionality are described below

THE *NOT APPLICABLE* BOX SHOULD ONLY BE CHECKED IF THE MEMBER DOES NOT HAVE A DIAGNOSIS OF DIABETES.

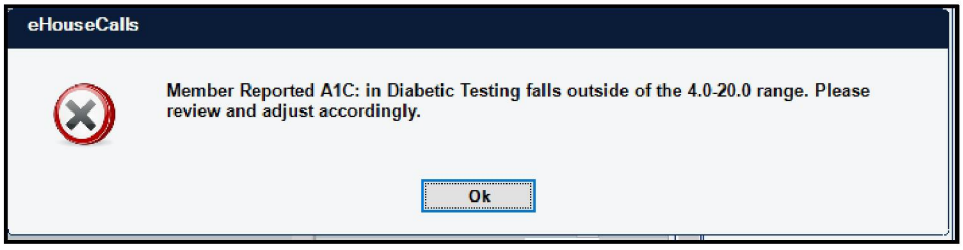


System Options and their functionality are described below:

- **Diabetic Testing** - Yes or No checkbox:
  - Choose **No** if the member has diabetes and reports they do not check their blood sugar.
  - Choose **Yes** for ***Checking Blood Sugar***, and three fields are mandatory: *When? Range, and Period of time of range.*
- **When?** - Multi-select drop-down list with options: Fasting/Before Meals/After Meals/Random/Occasional/Daily/Twice Daily/Other
- **Range** - Has a numeric keypad and allows either 2 or 3 numbers for each field with a format of xxx-xxx.
- **Period of time of range** - Single select drop-down with options: Within last week/Within last month/Within last 3 months.
- **Member Reported A1C** - Optional numeric keypad and accepts a formatted entry of (xxxx).
- **A1C Date**- Optional textbox field to enter the month and year.

YOU DO NOT NEED TO TYPE IN THE DECIMAL POINT. THIS FIELD BE DOCUMENTED EVEN WHEN DIABETIC TESTING IS DOCUMENTED AS NO

There is an A1C pop up alert if you enter a value outside of the given range (4.0-20.0) and then attempt to navigate to another page. You must correct the value before you can move to another page.



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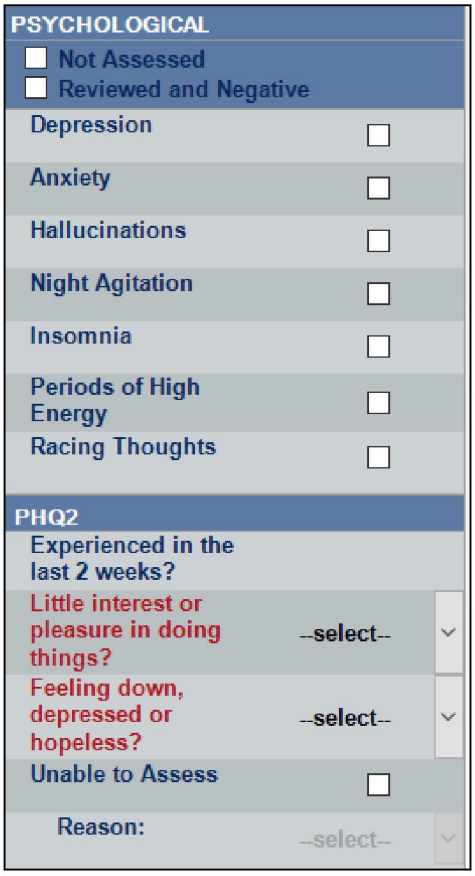
Psychological Grid

The **Psychological grid** consists of two parts: the psychological ROS questions and the PHQ2 questions. If **Not Assessed** or **Reviewed and Negative** is selected for the psychological questions, the PHQ2 questions highlighted in red are mandatory, and will remain enabled to be addressed for all members.

> **THE DEPRESSION TOOL WILL REMAIN ENABLED EVEN IF THE *GLOBAL REVIEWED AND NEGATIVE* CHECKBOX IS SELECTED IN THE ASSESSMENT.**

The **Depression Tool** questions relate to symptoms of depression within the last 2 weeks. Both questions must be answered, and if the member responds positively to either of the questions, the *PSY* Diagnostic tool becomes mandatory. If you are unable to assess the member with these two questions, select *Unable to Assess* and indicate the *Reason* from the drop-down list.



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DOCUMENTING ASSESSMENT PAGES 11-14

On pages 11-14 of the assessment, you will document the member's Examination. On each page of the Examination, there is an Additional Notes function, as well as the Diagnosis Cart.



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Physical Exam (PE) Overview

The **Physical Examination (PE)** pages are comprised of four assessment pages broken down by system, similar to the **Review of System** pages. The PE pages are grouped by system. To document, select one of the options listed in the table below:

Options	Description
WNL Checkbox	**Select if the member falls within normal limits. When you hover your stylus over WNL, a pop-up will appear to show you what criteria fall within the normal limits threshold.**
Abnormal Checkbox	**Select if there is a positive finding within this section by selecting the Abnormal checkbox. Indicate which findings were abnormal, or positive. There are additional checkboxes that should be marked, drop-down options to choose from, and/or free textboxes to describe additional details.**
Unable to assess/perform	**Select if the area/ body system could not be assessed. Choose an option from the drop down to indicate the reason the area was not assessed.**

An **Additional Notes** button is available at the top of each page. Use it to open a pop-up window and add details that were not included in the checkboxes and drop-down lists. These notes are specific to the PE pages only and can be found at the bottom of page 14.



Just like the Review of Systems, you will have the diagnosis cart available to you on every page of the examination, and it cannot be collapsed.

ROS Highlighted Sections

Page 11

Constitutional Exam

On page 11 you will document the member's current **Constitutional** condition based on your clinical judgment. This section is all vital signs obtained at the time of the visit. **Parameters surrounding vital signs include:**

- **Height** - This may be prepopulated, but should be remeasured during the visit by using the folding ruler and entering between the ranges of 4 ft. to 7 ft.
- **Weight** - The value entered must be between 70 lbs. to 350 lbs. or an alert message will be generated
- **BMI**
- **Blood Pressure (BP)** - An entry less than 140/90 closes the measure. If the initial BP is 140/90 or higher, the reading is required to be repeated and recorded
- **Respiratory Rate (R)** - The value entered must be between 14 to 26 breaths or an alert message will be generated
- **Heart Rate (HR)** - The value entered must be between 50 to 110 beats per minute or an alert message will be generated
- **Wearing Oxygen** - check the box if the member is wearing oxygen
- **Temp** - This field is used to document the temperature reading obtained at the beginning of the visit

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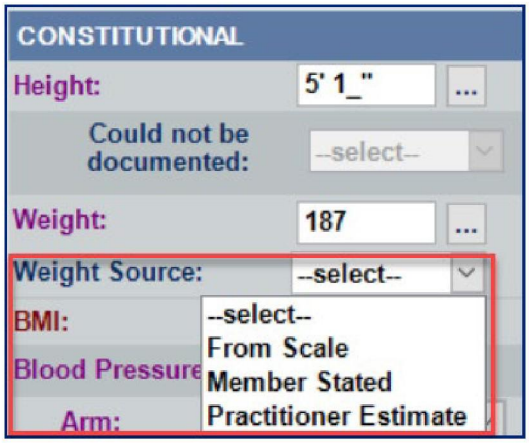
If data is entered outside of these parameters, an alert will appear. The value can remain but is a reminder to check your entry. If unable to perform BP, RR or HR, select unable to perform and choose the appropriate option from the drop-down list.

It is mandatory to document the height and weight at each visit. It is best practice to use the company provided equipment to obtain the height and weight. The **Weight Source** dropdown menu must be used to accurately document how the weight was obtained.



IF THE MEMBER IS IDENTIFIED AS HAVING A GAP FOR BMI, THE CALCULATED BMI FIELD WILL DISPLAY IN MAROON TEXT UNTIL A WEIGHT SOURCE SELECTION IS MADE. TO CLOSE THE GAP, IT IS MANDATORY TO SET THE WEIGHT SOURCE TO "FROM SCALE". ONCE CLOSED, THE BMI FIELD WILL CHANGE TO THE DEFAULT TEXT COLOR (BLACK).

Page 13

Peripheral Disease Screening

Using QuantaFlo

The **Peripheral Vascular Disease (PVD) Screening** section is only **MANDATORY** for members seen by providers with the proper training and equipment for the **QuantaFlo** software.

If the member is flagged, the PVD Screening section header will be notated in **Red** text with the **QuantaFlo** button enabled. At least one selection must be made from the grid, or an error will appear (see Mandatory Messages on assessment page 18). System Options and functionality are described below:

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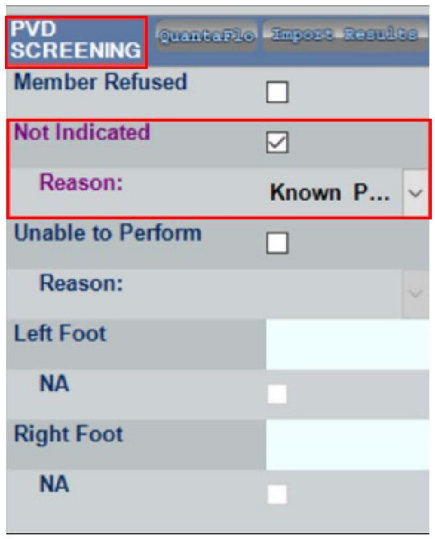
- **QuantaFlo Button**- When clicked, the QuantaFlo application will launch and the following fields will auto-populate within the QuantaFlo application: Member ID, Last Name, First Name, Gender, & Date of Birth
- **Import Results Button**- Once a QuantaFlo test is performed and results are finalized, click this button. The results of the test are saved and displayed within PVD screening section
- **Member Refused**- Select this checkbox if the member refuses to participate in the PVD Screening



- **Not Indicated**- The Reason, drop-down is disabled until you select the check-box, turning the **Not Indicated** purple and enabling the drop-down options:
  - Recently Completed
  - Know PVE
  - Known Amputation due to PVD

  Once you have selected the Not Indicated->Reason from the above list, the PVD screening heading will turn white indicating the PVE Screening is completed
- **Unable to Perform**- Select this checkbox if, for any reason, you are not able to perform the PVD Screening on the member. It is mandatory to select a reason if the checkbox is selected. Multi-select options include: *Ambient light, Physical malformation, Involuntary movement, Inconclusive results, and Video Virtual Visit, Sensor not available*



- **Left Foot**- This value is auto-populated when the Import Results button is selected. If the limb is unavailable for testing, select the NA checkbox
- **Right Foot**- This value is auto-populated when the Import Results button is selected. If the limb is unavailable for testing, select the NA checkbox

Documentation for referrals is included in the QuantaFlo Job Aid and discussed in the CRD tool. (See **Diagnostic Tools**)

IMPORTED RESULTS CANNOT BE EDITED, BUT THERE IS AN OPTION TO RE-LAUNCH THE QUANTAFLO APPLICATION AND REPEAT THE TEST.

The **QuantaFlo** and **Import Results** button will be disabled if "Member Refused" or "Unable to perform" are selected.

If the **Import Results** button is clicked before selecting the **QuantaFlo** button, an error message will appear.

DOCUMENTATION OF ABNORMAL PVD RESULTS (<0.90) FOR THE LEFT OR RIGHT FOOT ON PAGE 13 WILL AUTO-POPULATE WITHIN THE CARE MANAGER REFERRAL SECTION OF THE CRD TOOL.

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Monofilament, Vibratory, and/or Achilles Reflex Testing

It is vital to perform a complete foot exam on all members, which includes a Monofilament Exam- this is required for all members. If a member has diabetes, signs or symptoms of polyneuropathy, or abnormal Monofilament Exam, then the Vibratory Testing should also be performed. Achilles Reflex Testing is optional for all members but may be completed if clinically indicated.



Skin Abnormalities

The **Skin** grid is where you document the details of any skin issues you identified in the ***Review of Systems***, or if issues were identified during your examination.

SELECTIONS MADE FROM THE INTEGUMENTARY GRID IN THE REVIEW OF SYSTEMS SHOULD BE CONSISTENTLY DOCUMENTED IN THE SKIN GRID, OTHERWISE AN ERROR (SEE MANDATORY MESSAGE- ASSESSMENT PAGE 18) WILL APPEAR.



Documenting a wound or skin abnormality

1. On the Skin grid, click the **Abnormal** checkbox and **ADD a ROW**.
2. Select the Abnormality Type from the drop-down list and record the location.
3. If the wound of an Ulcer is indicated, select the Location and the Stage from the drop-down lists.

A LEGEND IS PROVIDED BELOW THE SKIN GRID. IT CAN BE USED FOR REFERENCE WHEN IDENTIFYING AN ULCER STAGE.

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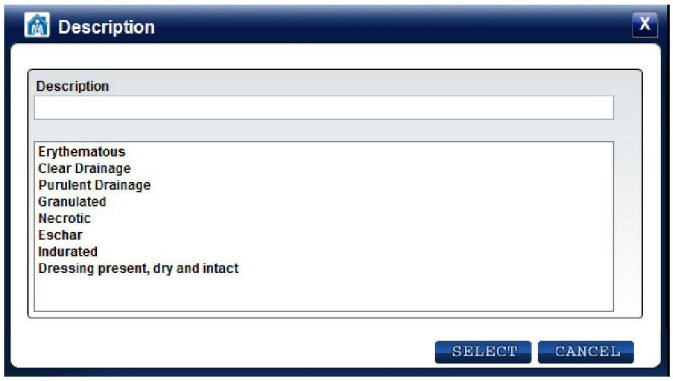
4. The Size field will generate a pop-up box. Enter the wound size in three dimensions (LxWxD/H) using millimeters and click SELECT. If you do not enter a value for any of the three positions of the wound, a 000 will be inserted when you save.



5. The **Description** field also generates a pop-up window. Select a prepopulated wound description or type in a custom description using the on-screen keyboard.



6. In the last three columns, select checkboxes to state the wound or ulcer is ***Under Treatment*** or a ***New Wound***. If you are unable to view the wound or ulcer enough to document specifics, select ***Unable to Assess***.

WOUND SIZE AND DESCRIPTION ARE REQUIRED FOR ALL ABNORMALITY TYPES EXCEPT FOR RASHES, WOUNDS THAT ARE DRESSED, AND/OR IF YOU ARE UNABLE TO VISUALIZE OR MEASURE THE WOUND. YOU WILL NOT DO ANY WOUND CARE OR REMOVE DRESSINGS.

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Optional Components of an Assessment

Use your clinical judgement to determine if an optional component of the assessment should be addressed. This will ultimately create a more individualized and member focused visit.

Specialist	Review of Systems	Physical Exam
• Name - Mandatory • Speciality - Mandatory • Address - Optional • Phone Number - Optional • Last Visit Date - Mandatory (Approx. ate acceptable)	The following sections are optional. Mark **NA** or **Unable to Assess** if not addressed with the member. • Eyes • Ears • Nose &Throat • GI	The following sections are optional. Mark **NA** or **Unable to Assess** if not addressed with the member. • Respiratory Rate • Eyes • Ears • Nose/Mouth/Throat • Neck • GI • GU • Achille's Reflex (optional for all members)

IF THE MEMBER HAS A CONCERN OR COMPLAINT ABOUT ANY OF THE EXAM COMPONENTS LISTED, ASK THE ASSOCIATED ROS QUESTIONS AND PERFORM THE EXAM.

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ADDRESSING THE DIAGNOSTIC TOOLBAR

The **Diagnostic Toolbar** is located at the bottom of every assessment page and contains necessary tools for fully assessing and evaluating the member. Some are mandatory and others become mandatory based documentation of the assessment. Icons appear in **blue**, **red,** or **green.** A **blue** icon indicates the tool is optional, a **red** icon is mandatory. If you record certain findings within the assessment, blue tools can turn red, making the tool mandatory. Once the documentation requirements have been met, **red** icons will turn **green**.

THE ASSESSMENT CANNOT BE FINALIZED UNTIL ALL MANDATORY TOOLS HAVE BEEN COMPLETED.



Show Desktop



Minimizes the eHouseCalls application and takes you to the Windows desktop without closing the assessment. To return to the form, click on the eHouseCalls icon on the taskbar at the bottom of the screen.

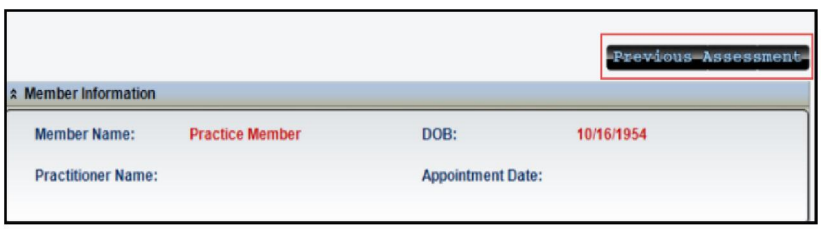
Summary of Last Annual Visit



If the member had a visit within the last year, a summary of that visit is available to you. This tool provides a past clinical picture that can be discussed with the member, but it will only display the data from the previous HC Visit, not all member visits.

Display Previous Assessment

To display the previous year's assessment, click the button: **Previous Assessment**.



After clicking the button, a window opens displaying the previous assessment in PDF.

- Other pages of the PDF assessment can be viewed.
- The PDF page will have a Close button, used to continue with assessment.

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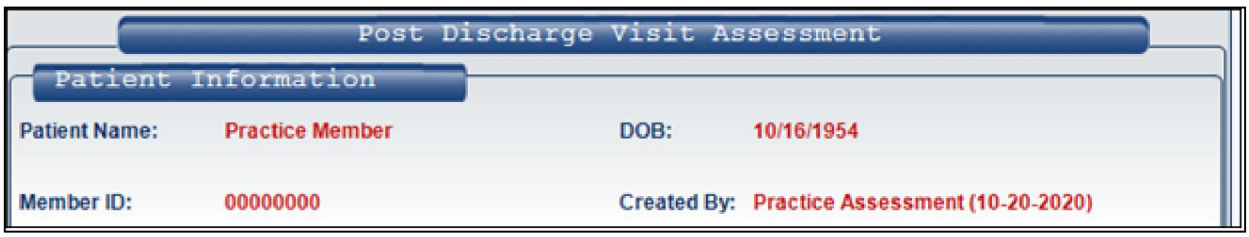
Post Discharge Visit Form

This tool will be available if the member is scheduled or is eligible for a post discharge visit. When the APC clicks on this tab the Post Discharge Visit Assessment will open where the following fields will be populated under Patient Information:

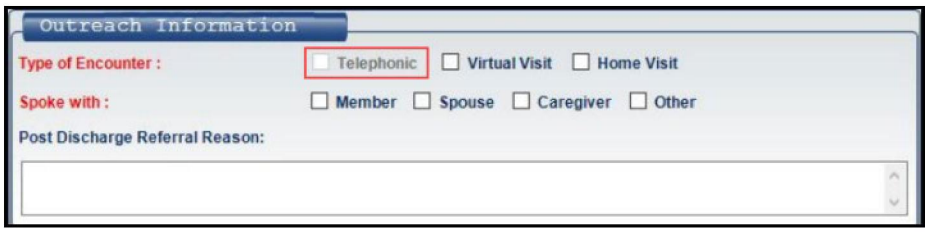
- Patient Name
- DOB
- Member ID
- Created By



Outreach Information

The following check boxes will appear under **Outreach Information** in the ***Post Discharge Assessment:***

1. **Type of Encounter**- An option **MUST** be selected
   - Telephonic (Currently disabled)
   - Virtual Visit
   - Home Visit
2. **Spoke with-** An option **MUST** be selected; Multi-select is available
   - Member
   - Spouse
   - Caregiver
   - Other
3. Post Discharge Referral Reason (200-character max)



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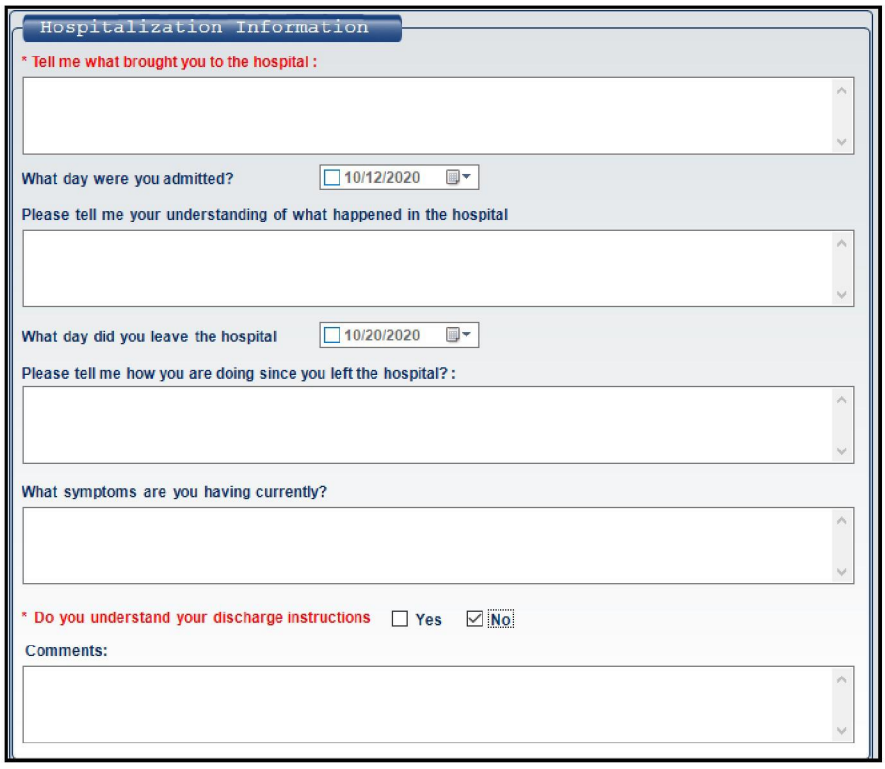
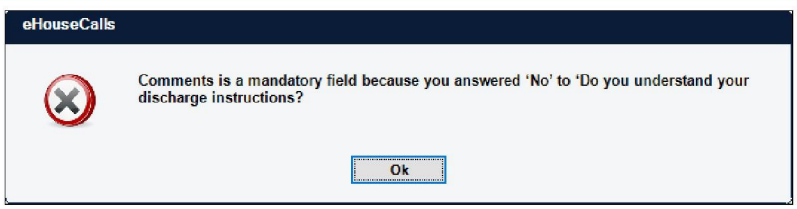
Hospitalization Information

The following fields will appear under **Hospitalization Information** in the ***Post Discharge Assessment:***



1. **Tell me what brought you to the hospital** (Mandatory)- Examples: acute symptoms, worsening of chronic health conditions, medication, transportation, or care giver issues, referred by PCP/specialist, scheduled admission, etc.…
2. What day were you admitted? – Calendar Feature available
3. **Please tell me your understanding of what happened in the hospital**- Examples: surgeries, treatments, x-ray, CT scans, lab work, diagnoses.
4. What day did you leave the hospital? – Calendar Feature available
5. Please tell me how you are doing since you left the hospital?
6. What symptoms are you having currently?
7. Do you understand your discharge instructions? (Yes/No)
8. **Comments** (Comments are mandatory if NO is selected for previous question)

AN ALERT MESSAGE WILL DISPLAY IF NO IS SELECTED AND COMMENTS ARE NOT ADDED.



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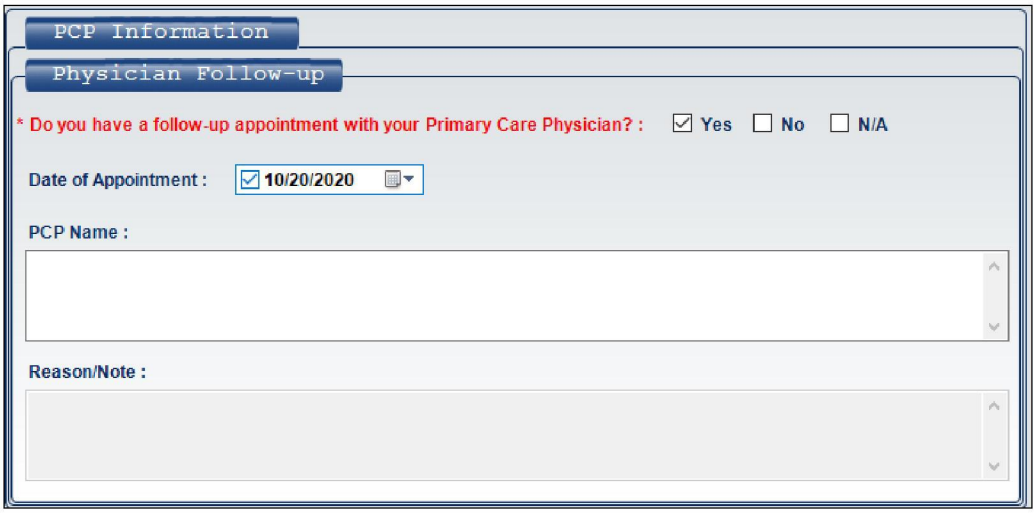
PCP Information

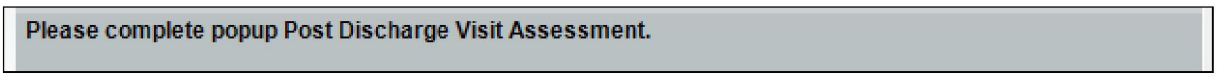
The following fields will appear under **PCP Information- Physician Follow-up** in the **Post Discharge Assessment:**

1. Do you have a follow-up appointment with your Primary Care Physician? (Yes/No/NA)
2. Date of Appointment
3. PCP Name
4. Reason/Note



Mandatory Message

If the Post Discharge Visit form is saved without answering -***Do you have a follow-up appointment with your Primary Care Physician?*** - a Mandatory Message will appear at the end of the Assessment:



Specialist Information

The following fields will appear under **Specialist Information** in the ***Post Discharge Assessment:***

1. Is there a specialist you need to follow-up with? (Yes/No/NA)
2. Specialty/Specialist Name/Date of Appointment
   - Specialty
   - Specialist Name
   - Date of Appointment
3. Comments
4. Discuss the importance of having and maintaining a Personal Health Record that is portable and can be taken to all medical appointments. Person Health Record Discussed:
   - Yes
   - Declined

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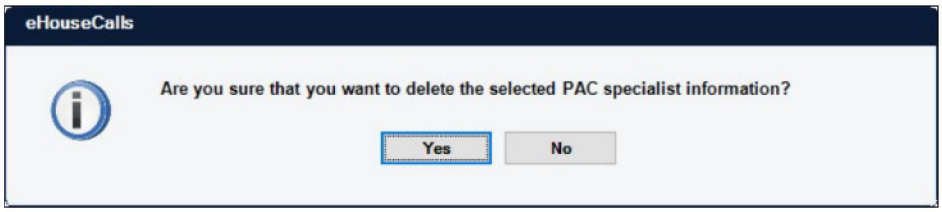
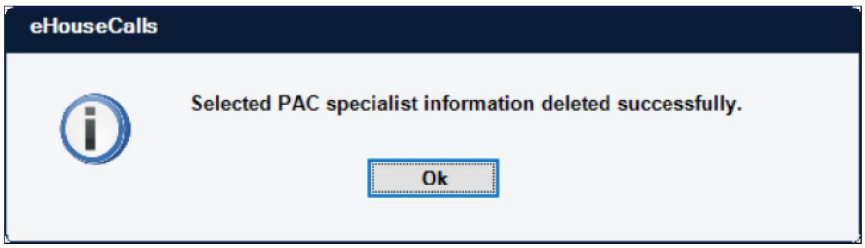
If the **DELETE ROW** button is selected, a pop-up will appear:



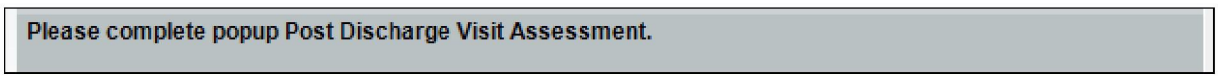
If **Yes** is selected, the Specialist information will be deleted, and a confirmation message will display.



Mandatory Message for Post Discharge Form

If the Post Discharge Visit form is saved without answering any of the following questions, a Mandatory Message will appear at the end of the Assessment:

1. Outreach Information
2. Type of Encounter
3. Spoke with
4. Hospitalization Information
5. Tell me what brought you to the hospital
6. Do you understand your discharge instructions?



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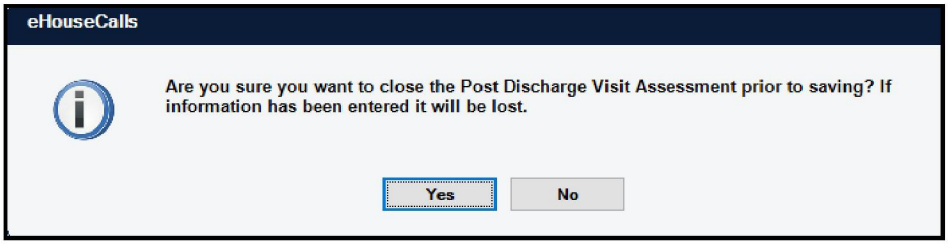
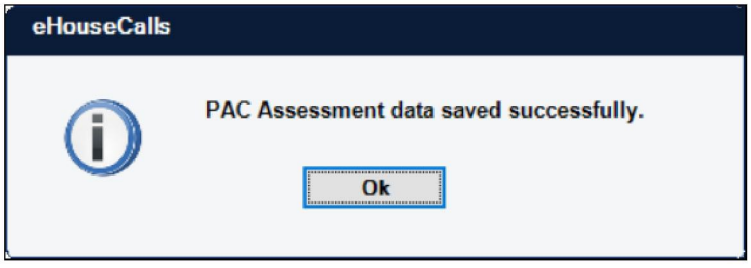
Alert Message: Closing Post Discharge Visit Form

If the Post Discharge Visit form is closed without saving, an alert will appear:

"Are you sure you want to close the Post Discharge Visit Assessment prior to saving? If information has been entered it will be lost."



Upon clicking **No**, the assessment will be saved, and a confirmation message is displayed



STARS - Star Gap Measures

STARS The **STAR Measure Summary Tool** will only appear if the system identifies gap(s) for the Member. You will be able to review the ***Measure Name, Measure Description,*** and ***Status*** of the gap displayed in **red** text to review and update.

IT IS RECOMMENDED THAT YOU REVIEW ANY MEMBER TAILORED OPEN GAPS TO DETERMINE IF THE STAR MEASURES FOR THE MEMBER CAN BE CLOSED AND ARE APPLICABLE.

In order to close a gap, the system provides the ability to click individual line items to navigate to the appropriate assessment page. Once a Star Measure Gap has been addressed or closed, the status is changed to Closed, and the font of the STAR gap reverts to the default color (**black**).

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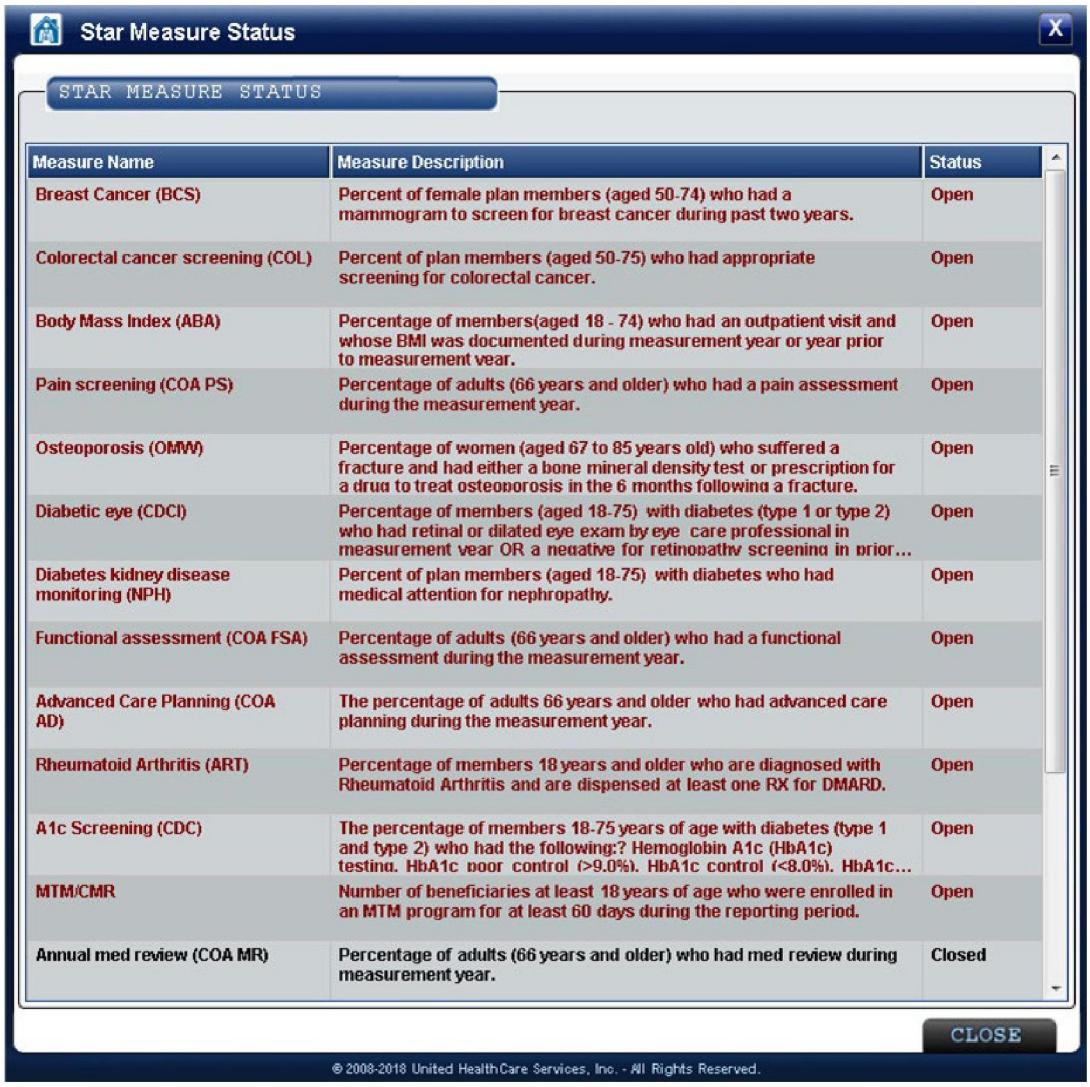

ONLY ONE GAP CAN BE ADDRESSED AT A TIME; ONCE YOU TAKE AN ACTION TO CLOSE A GAP, USERS WILL NEED TO CLICK THE "STARS" DIAGNOSTIC TOOL AGAIN TO SEE THE REMAINING GAPS. IF ANY OF THE GAPS ARE UNABLE TO BE ADDRESSED, IT WILL NOT PREVENT YOU FROM FINALIZING THE ASSESSMENT.

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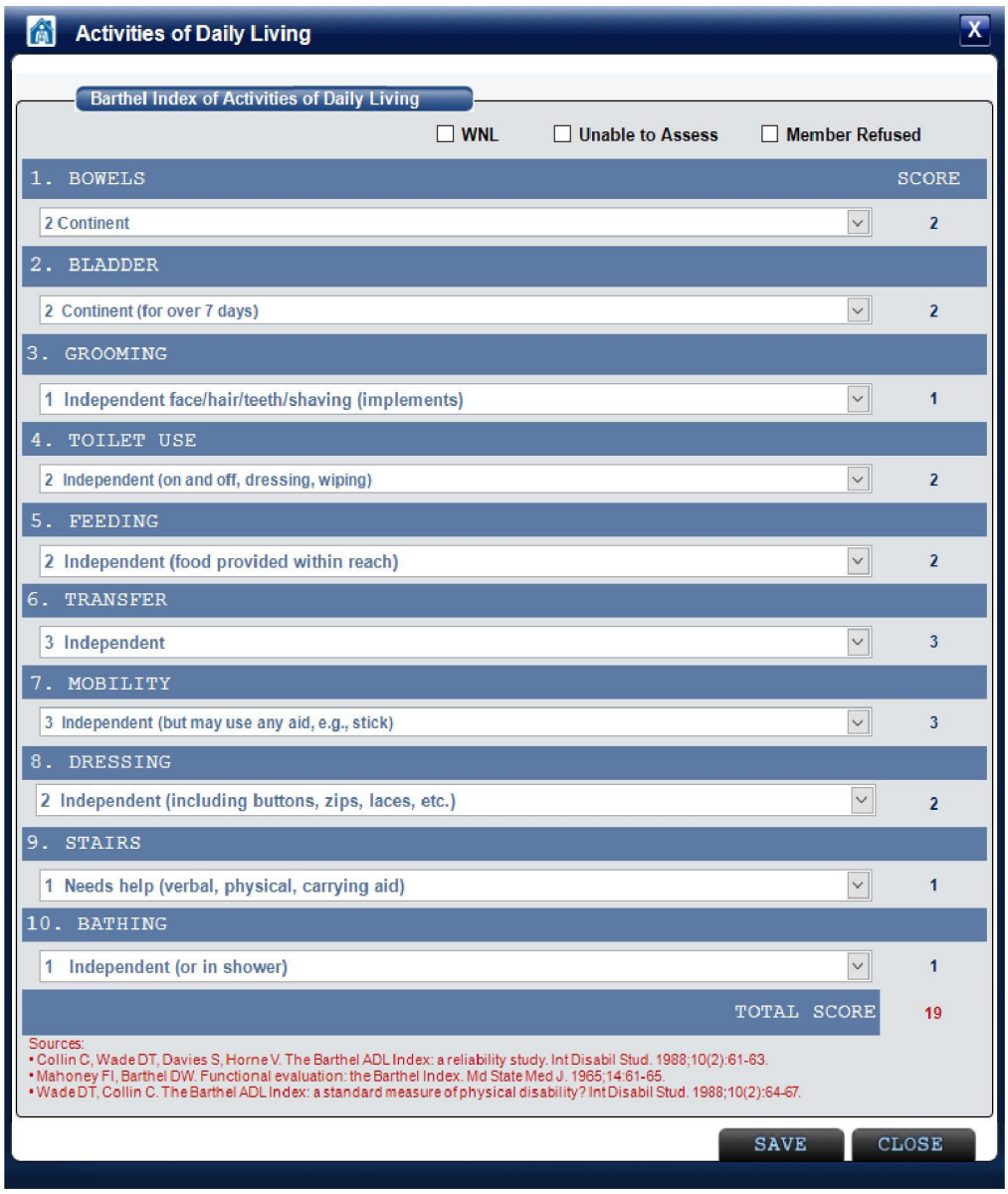
ADL - Barthel Index of Activities of Daily Living

ADL **The Barthel Index of Activities of Daily Living (ADL)** must be completed for all members seen during the HouseCalls visit. It will be used to assess the member's ability to independently care for themselves. You will evaluate the member's ability to control bowel and bladder movements, as well as independently groom, feed, transfer, dress, and bathe. You will also discuss the ability for mobility and stair navigation.

Discuss each aspect, and when the member is unable to do so independently use the drop-down menu to address what they state. Questions 1 -10 must be addressed before the tool can be closed and completed.



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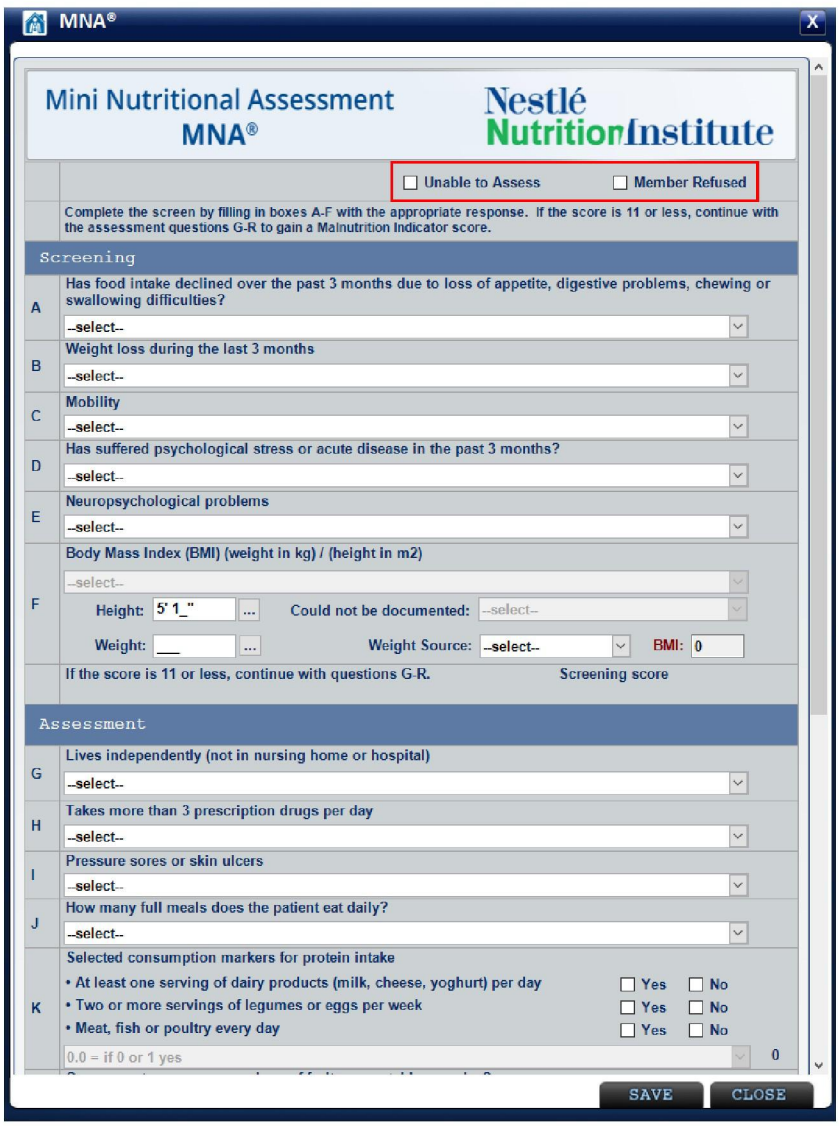
MNA - Mini Nutritional Assessment

The Mini Nutritional Assessment (MNA) is used to assess the member's nutritional status. It is mandatory for any member when there is documentation in the ROS that the member experienced unintentional weight loss of greater than 10% in the last 6 months and/or has a calculated BMI less than 19 on the PE of the assessment, or for any member the APC identifies as having a diagnosis of any type of malnutrition.

The **Unable to Assess** and **Member Refused** checkboxes at the top are not mandatory, but if either option is selected the remaining questions become Inactive. Select **Unable to Assess** if the member has dementia, language barrier or other conditions that would not allow the use of the MNA tool.
If the member is identified as having a gap for BMI, the calculated BMI field will display in maroon text.
(add new screen shot)

PLEASE BE SURE TO RECORD THE MEMBER'S ARM AND CALF CIRCUMFERENCE. THIS IS ONLY REQUIRED IF YOU HAVE TO COMPLETE THE BOTTOM OF THE TOOL, AND IF THE MEMBER'S SCORE IS 11 OR LESS.



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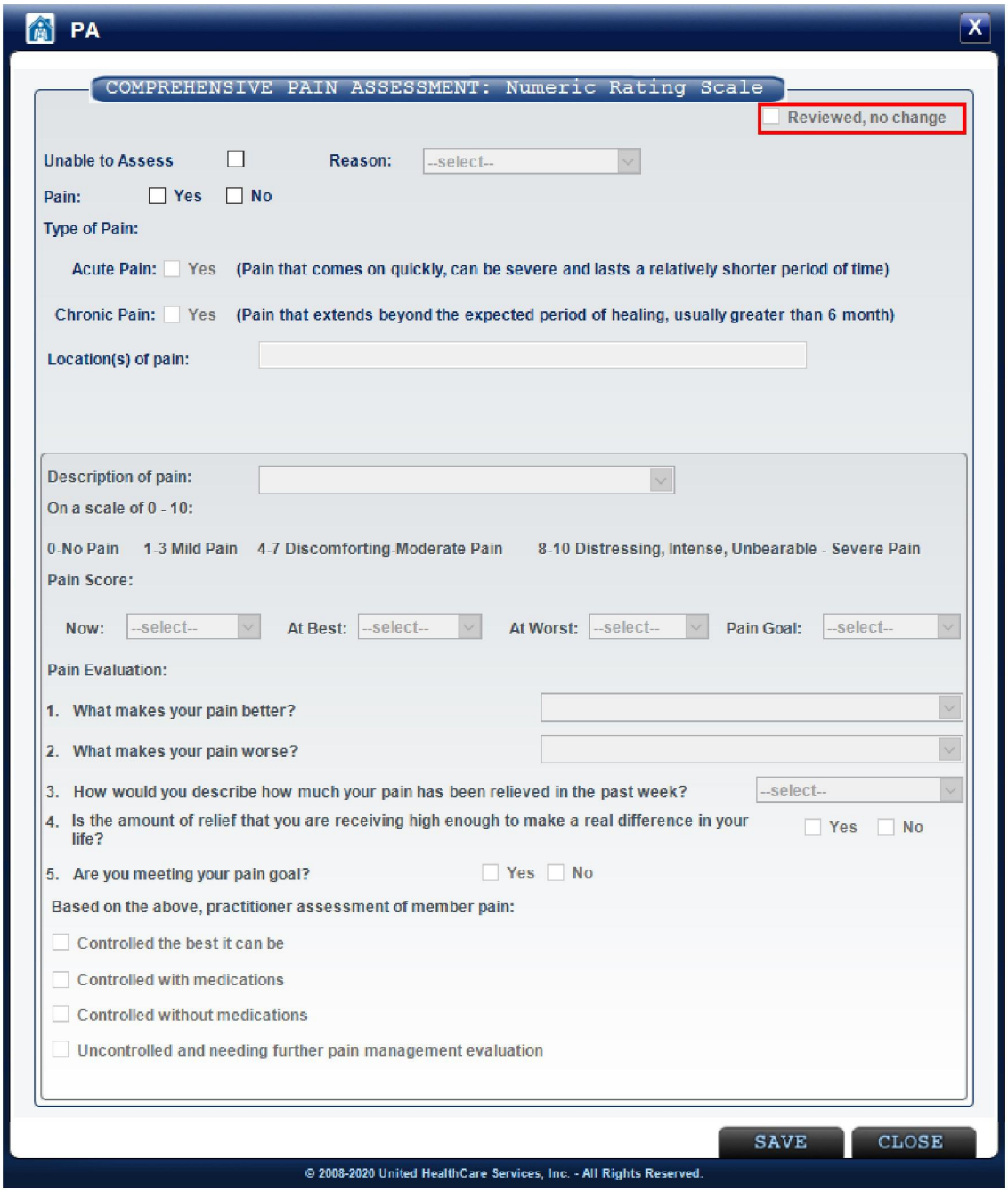
PA - Pain Assessment



The **Pain Assessment** is mandatory for all HouseCalls members. Use the tool to assess the levels of pain the member experiences and how their pain is being managed. If the member has a diagnosis of pain, then the pain assessment must be documented. If the member has indicated any acute or chronic pain documented during the ROS, then the **Pain** checkbox is auto-selected ***Yes,*** and the location of pain will auto populate in the **Pain Assessment** tool.

A **Reviewed**, **No Change** checkbox is provided at the top of the page to confirm prefilled information is up to date. The checkbox only works if the PA Tool is prefilled. Selecting it will disable all other fields.



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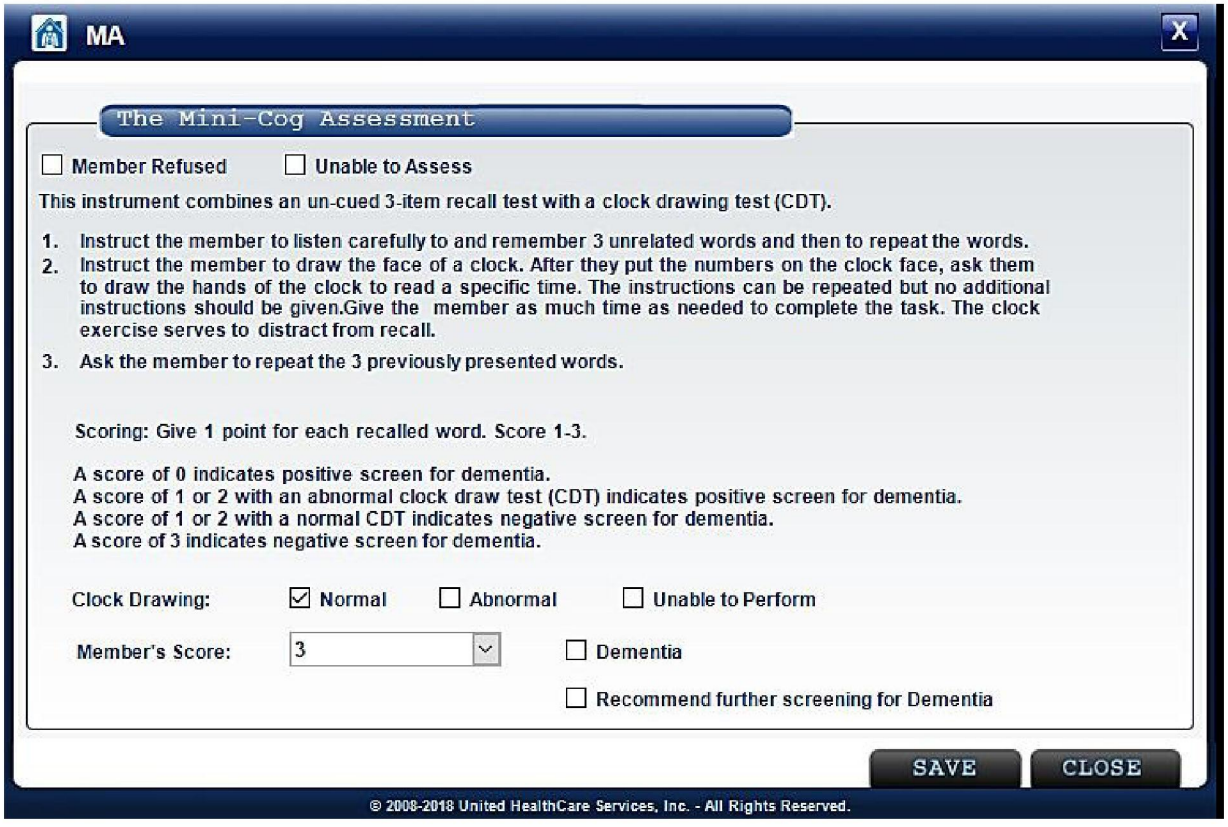
COG - Mini-Cognitive Assessment

COG The **Mini-Cognitive Assessment (Mini-Cog)** is required for all members to screen for signs/symptoms of cognitive impairments and/or Dementia. The instructions for the test are provided in the pop-up window of the tool. The assessment consists of a clock drawing test and a 3-word recall exercise. Provide the member with pen and paper to draw the clock- the tablet is not designed to capture the member's clock drawing. If the member is unable to complete the task, select the appropriate checkbox. If **Dementia** or **Recommend further screening for Dementia** is checked, the ***"Mini Cog Test Abnormal"*** setting in the **CRD tool** is auto selected.

- **ANY DRAWING DONE BY THE MEMBER ON PAPER DO NOT NEED TO BE SENT INTO THE CLINICAL HELP DESK.**
- **THERE IS AN AREA DESIGNATED ON THE BACK OF THE ASK YOUR PCP FORM TO COMPLETE THE CLOCK DRAWING.**



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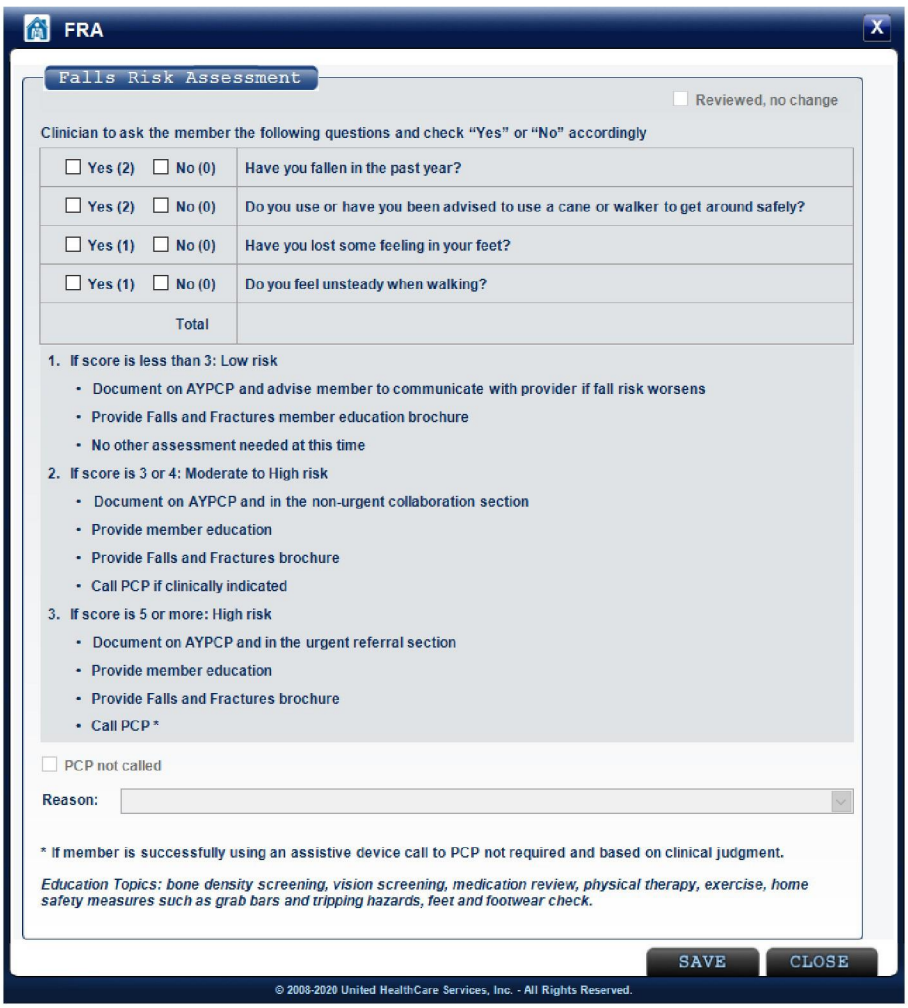
FRA - Fall Risk Assessment

FRA The Fall Risk Assessment (FRA) screens for member mobility and risk for falls. Auto selections may appear within the FRA tool if information was documented in other areas of the assessment. After documenting responses to questions, a score will appear. Based on the score, perform the necessary action as indicated within the tool.

If the FRA score is 3 or 4, documentation is needed on page 17 in the non-urgent communication details box. If the FRA score is 5 or 6, this score will auto populate in the CRD Tool under High Fall Risk. Document and use your clinical judgement to determine if the PCP is needs to be called. If the PCP is already aware of the members high falls risk and you determine that the PCP does not need to be called, select the box, PCP not called and choose the appropriate reason the PCP was not called. When the PCP not called box is selected, auto selection within the CRD tool will be removed.
A **Reviewed**, **No Change** checkbox is provided at the top of the page to confirm prefilled information is up to date. The checkbox only works if the tool is prefilled. Selecting it will disable all other fields.

IF A MEMBER IS UNABLE TO COMPLETE THE TOOL, YOU WILL BE REQUIRED TO ANSWER THE QUESTIONS WITH "NO" RESPONSES, AND THEN PROVIDE A NOTE IN THE ASSESSMENT NOTEPAD SECTION.



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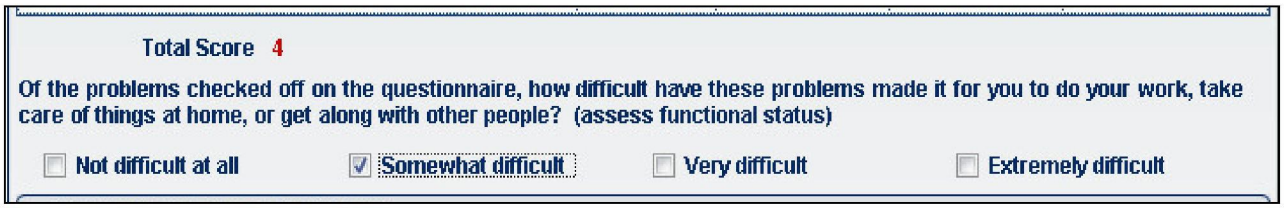
PSY - Depression Screening Tool



The **Depression Screening Tool (PSY)**, which includes the **PHQ9**, becomes a mandatory tool and turns red if there is an active anti-depressant, active PSY related diagnosis, PSY med is documented, and/or all WellMed members.

The first two questions are from the ***ROS*** (PHQ-2) on page 9. The answers auto populate so if they were checked off in error, return to the ROS and edit the answers. If the member responds yes to either of the items, continue with the screening by selecting response for each of the questions in the top list. If the tool is mandatory, complete the remaining questions from the PHQ9.
The member's score is calculated automatically, and the corresponding level of depression will be highlighted in blue. If you disagree, based on your clinical judgment, notate that with the **Assessment Notes** feature (discussed later in this section). If the member has any other mental health diagnoses, select those from the section below the depression scoring, or add them to the ***Diagnosis Cart***.
Applicable diagnosis will be highlighted in blue for clinical evaluation.
For the documentation of a depression diagnosis, two or more active depression disorders generate a pop-up alert. This will occur whether it was manually added or a prepopulated Major Depression Diagnosis.
For WellMed members and members with or without specified UHC health care plans, the **PSY Tool** is **mandatory** to complete regardless of the PHQ2 in the ROS grid. If the **PSY Tool** is not completed for WellMed members, the icon will appear in **red,** and you will be prompted with a message to complete it.

- **THE DIAGNOSIS SELECTED BY THE PSY TOOL SHOULD BE THE MOST SPECIFIC DIAGNOSIS SELECTED BY THE APC. THIS DIAGNOSIS SHOULD BE SELECTED AS ACTIVE ON THE DIAGNOSIS CONFIRMATION PAGE (PAGE 15). DUPLICATE DIAGNOSES SHOULD BE REMOVED FROM THE LIST.**
- **THE FUNCTIONALITY QUESTION ON THE PSY TOOL MUST BE ADDRESSED IN ORDER TO COMPLETE THE SCREENING COMPLETELY AND CORRECTLY.**



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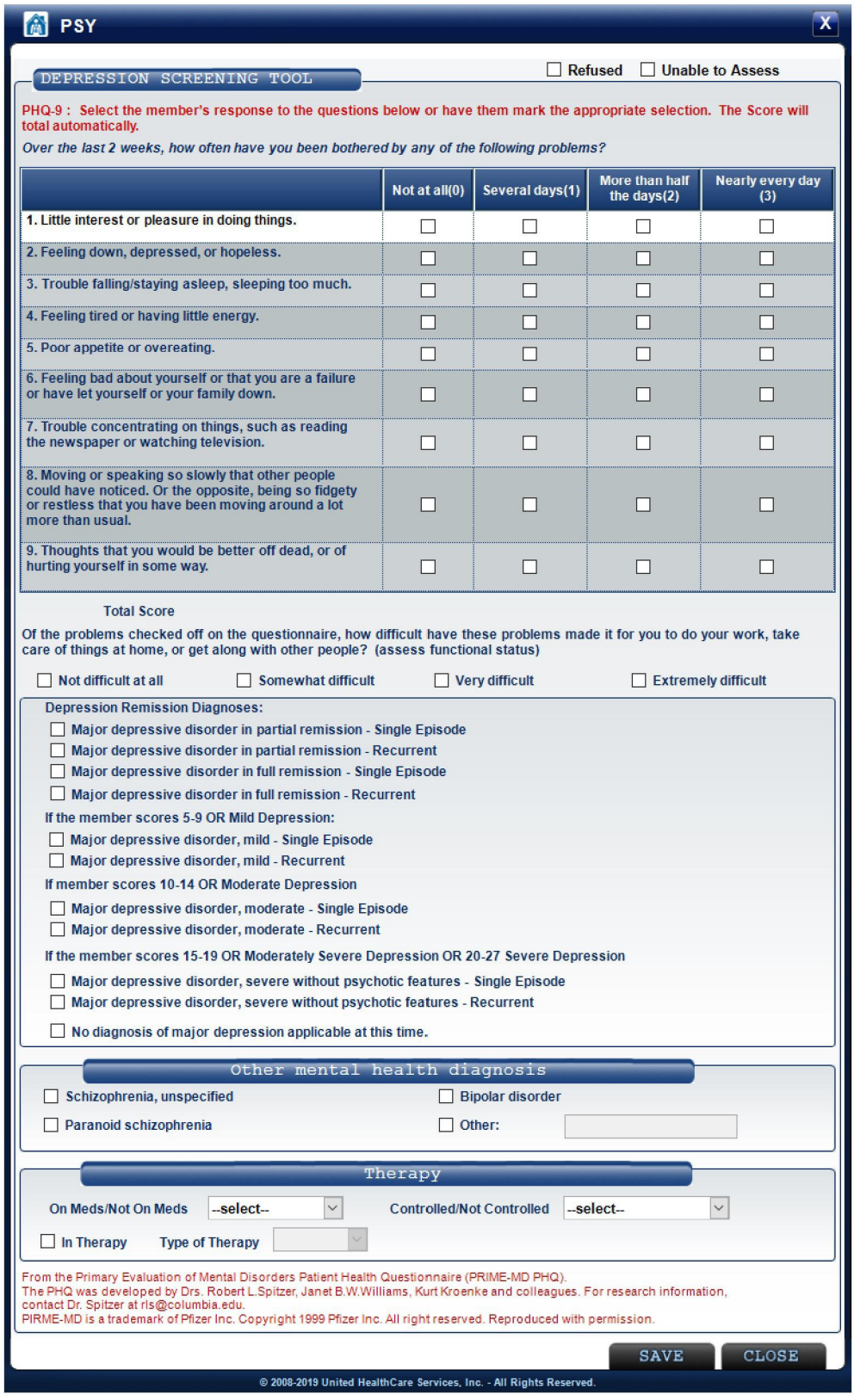

PSY

DEPRESSION SCREENING TOOL

☐ Refused ☐ Unable to Assess

PHQ-9 : Select the member's response to the questions below or have them mark the appropriate selection. The Score will total automatically.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all(0)	Several days(1)	More than half the days(2)	Nearly every day (3)
1. Little interest or pleasure in doing things.	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless.	☐	☐	☐	☐
3. Trouble falling/staying asleep, sleeping too much.	☐	☐	☐	☐
4. Feeling tired or having little energy.	☐	☐	☐	☐
5. Poor appetite or overeating.	☐	☐	☐	☐
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	☐	☐	☐
8. Moving or speaking so slowly that other people could have noticed. Or the opposite, being so fidgety or restless that you have been moving around a lot more than usual.	☐	☐	☐	☐
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	☐	☐	☐	☐

Total Score

Of the problems checked off on the questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? (assess functional status)

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Depression Remission Diagnoses:

- ☐ Major depressive disorder in partial remission - Single Episode
- ☐ Major depressive disorder in partial remission - Recurrent
- ☐ Major depressive disorder in full remission - Single Episode
- ☐ Major depressive disorder in full remission - Recurrent

If the member scores 5-9 OR Mild Depression:

- ☐ Major depressive disorder, mild - Single Episode
- ☐ Major depressive disorder, mild - Recurrent

If member scores 10-14 OR Moderate Depression

- ☐ Major depressive disorder, moderate - Single Episode
- ☐ Major depressive disorder, moderate - Recurrent

If the member scores 15-19 OR Moderately Severe Depression OR 20-27 Severe Depression

- ☐ Major depressive disorder, severe without psychotic features - Single Episode
- ☐ Major depressive disorder, severe without psychotic features - Recurrent

☐ No diagnosis of major depression applicable at this time.

Other mental health diagnosis

☐ Schizophrenia, unspecified ☐ Bipolar disorder

☐ Paranoid schizophrenia ☐ Other:

Therapy

On Meds/Not On Meds --select-- Controlled/Not Controlled --select--

☐ In Therapy Type of Therapy

From the Primary Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD PHQ).
The PHQ was developed by Drs. Robert L.Spitzer, Janet B.W.Williams, Kurt Kroenke and colleagues. For research information, contact Dr. Spitzer at rls@columbia.edu.
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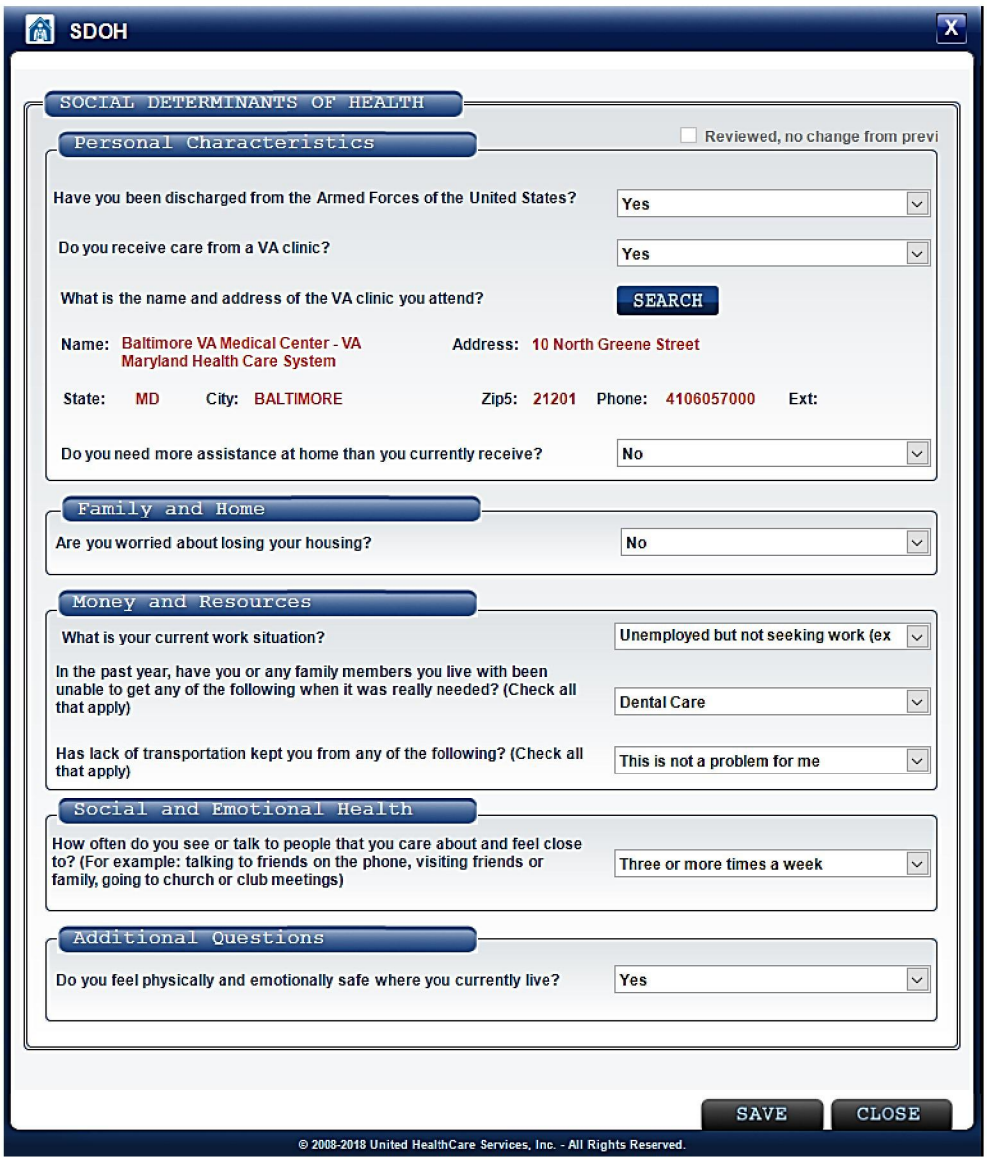
SDOH - Social Determinants of Health

SDOH The **Social Determinants of Health** tool is mandatory for all members- including Blank Assessments. If the member had a previous visit, the data will be pre-populated and you may select the *Reviewed, no change from previous visit* checkbox if there are no changes. Automatic SDOH referrals are created based on information documented.

- **THE *SOCIAL DETERMINANTS OF HEALTH/SOCIAL NEEDS* AREA WILL PRE-POPULATE IN THE CRD TOOL WHEN NOTED IN THE SDOH. THESE WILL GENERATE A SOCIAL REFERRAL BY CASE MANAGEMENT. YOU MUST ALSO DOCUMENT IF THE MEMBER ACCEPTS THE SOCIAL REFERRAL BY CHECKING "YES" OR "NO".**
- **IT IS IMPORTANT TO REVIEW PRE-POPULATED INFORMATION FOR ALL ASSESSMENTS. IF MEMBER WAS SEEN PREVIOUSLY, APC IS TO REVIEW TO ENSURE SITUATION HAS IMPROVED OR EXACERBATED.**



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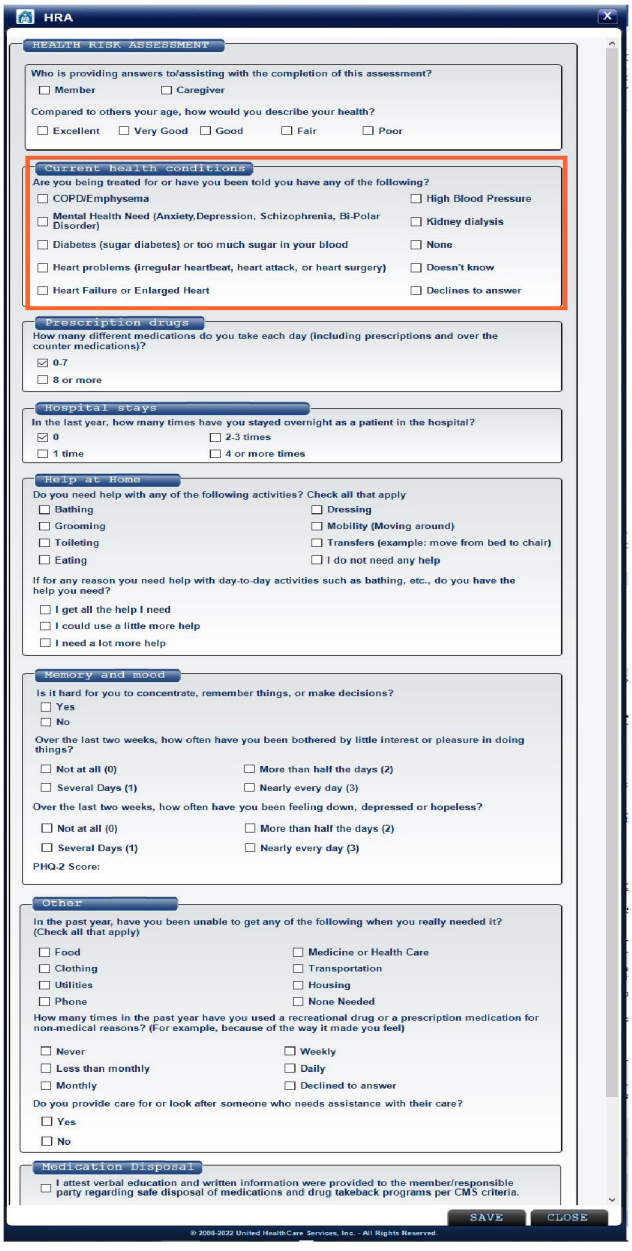
HRA - Health Risk Assessment

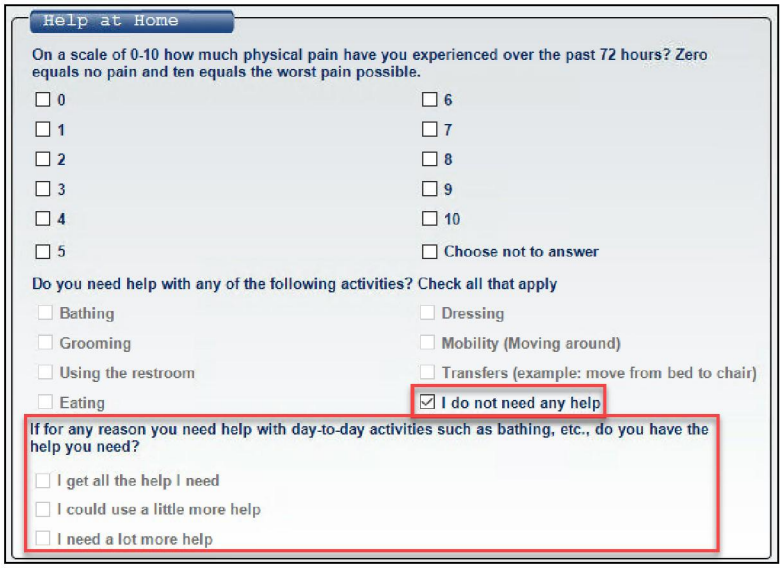
HRA The **Health Risk Assessment** tool will only be visible and mandatory to be completed for **Special Needs Plans (SNP)** and **CCM DSNP** members only. Eligible members will have DSNP information noted in the member properties section. Based on the information documented within the assessment and previous visit documentation, corresponding answers will be triggered and auto populated within the HRA tool. If any prepopulated data is changed within the HRA Tool, a mandatory message will prompt to confirm said changes are intended.

It is recommended to complete this tool later in the visit so information will prepopulate.

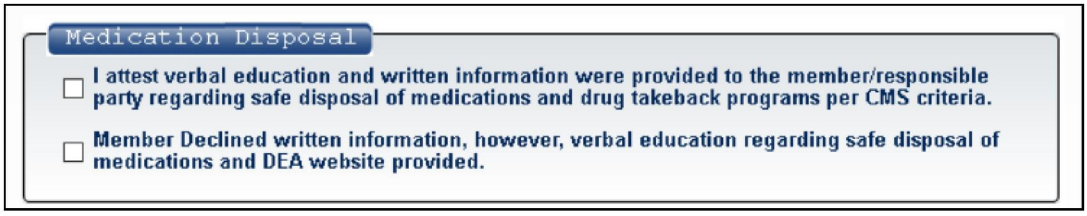
IF ONE YOU SELECT NONE, DOESN'T KNOW, OR DECLINES TO ANSWER FOR THE QUESTION "ARE YOU BEING TREATED FOR OR HAVE YOU BEEN TOLD YOU HAVE ANY OF THE FOLLOWING" THE QUESTION WILL BE DISABLED.



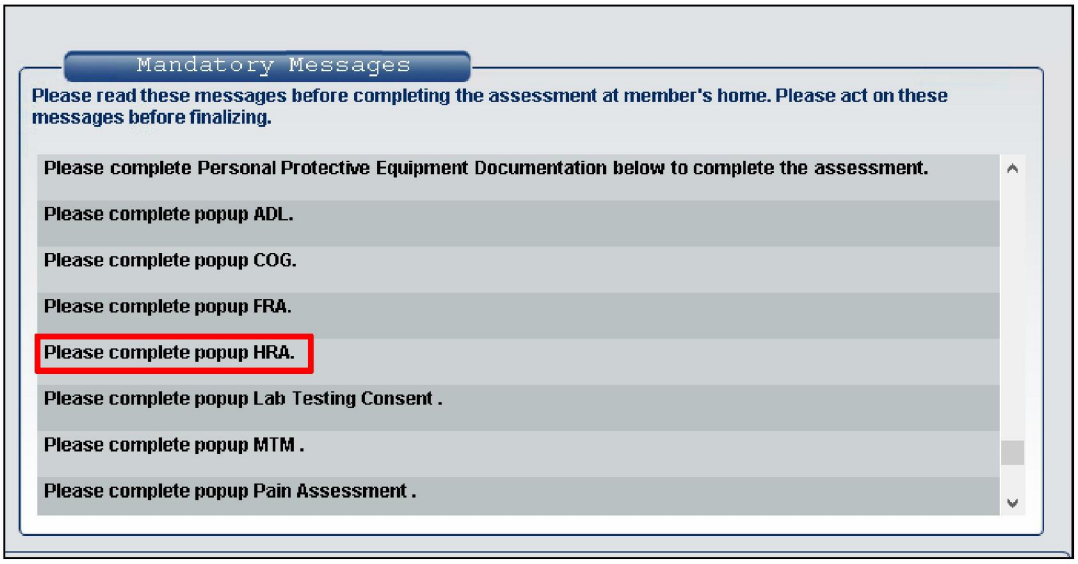
In the Help at Home section of the HRA tool, under the question, “If for any reason you need help with day-to-day activities such as bathing, etc., do you have the help you need?”, the checkboxes will be disabled if the selection "I do not need any help" is selected. If “I do not need any help” is not selected, all checkboxes will be enabled.



In the Medication Disposal section, a selection is mandatory to attest the medication disposal information and education provided to the member.



If the area is not fully completed, you will see a mandatory message on page 18.



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CRD - Comprehensive Referral Display



The **CRD tool** holds referrals to the care managers, social workers, and pharmacy staff. Both care manager and social worker referrals are considered urgent while the pharmacy referrals are considered non-urgent.

The tool may be **BLUE** (optional) or **RED** (mandatory) depending on documentation within the assessment. If a section in the CRD tool is flagged and was auto populated from other areas of the assessment, you must address that section. Document in the tool as needed, however, additional referrals can be generated based on your clinical judgement.

It is recommended to complete the **CRD tool** toward the end of the visit so items will auto populate from the ROS, PE, and other portions of the assessment.

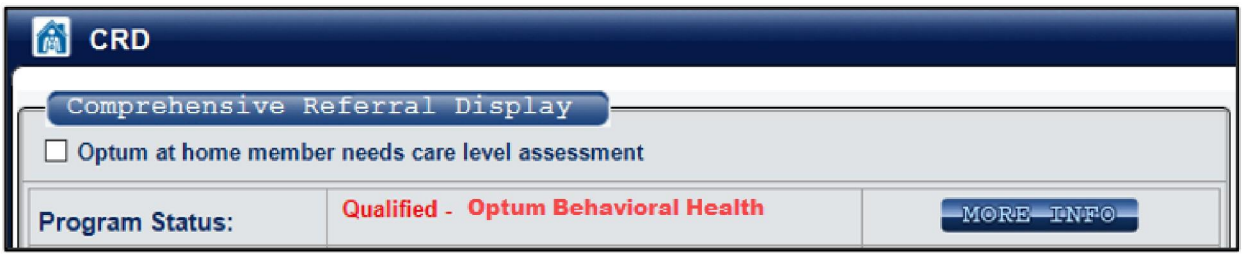
Each section of the referral cart has a **MORE INFO** button that will elaborate on that referral section.

Expansion and Collapse of Referral Sections

The CRD Tool opens all options under a referral section in an expanded view when a referral is triggered by a rule. If a user expands a referral section, then all the respective referrals and options under the referrals are displayed in expanded view, if not already triggered by a rule.

OAH Question Configuration

In the CRD tool, the Optum at Home question has been configured to only display as active for eligible members. The Optum At Home question is only enabled if the CDO is CCM DSNP. It will be disabled for all other clients.



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Referral Types

Type	Explanation
Optum at Home	This referral is only for Optum at Home CCM DSNP members within eligible states. Only providers in eligible states can use this feature.
WellMed Care Advocate Team	This area is flagged if a member is noted as qualified and/or qualified/enrolled. Referral into the program cannot be provider generated.
Landmark Longitudinal Care Management	This area is flagged if a member is noted as qualified and/or qualified/enrolled. Referral into the program cannot be provider generated.
Care Manager (URGENT)	Care managers will follow up with members based on information triggered in this section. Follow up will occur within several days of receiving the referral. Members can refuse a referral and if this occurs, it will not be processed.
Social worker (URGENT)	Members will receive social work follow up based on aspects identified in the tool.
Emergent & Urgent Behavioral Health	This referral can be selected by APC an/or auto referred based on system logic. All members seen are eligible for emergent and urgent referrals.
Moderate Behavioral Health	Only for eligible members. Criteria is based on members health plans participation in BHP referrals. If the member is not eligible the referral will be disabled.
Behavioral Health Therapy Program	Only for eligible members. Criteria is based on members health plans participation in BHP referrals. If the member is not eligible the referral will be disabled. Referral will be auto-selected based on assessment documentation and cannot be provider generated.
Pharmacy	These non-urgent referrals can be selected so pharmacists can discuss the member medications if they have questions.
SDOH/Social Needs	Depending on documentation in the SDOH tool. These will generate a social referral by case management. You must also document if the member accepts the Social Referral by checking “Yes” or “No”.

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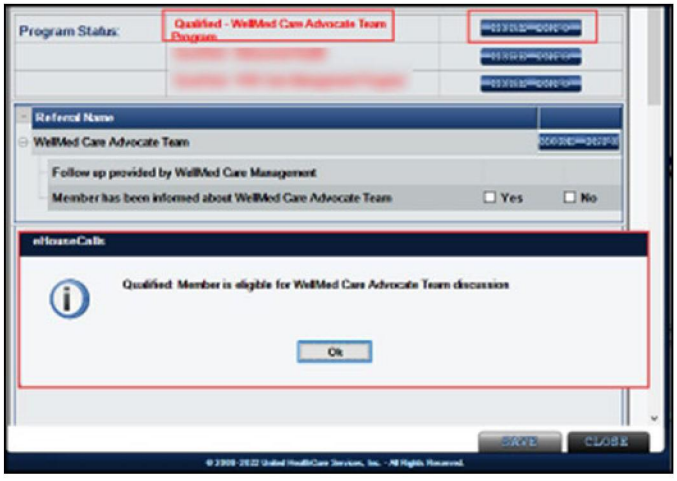
WellMed Care Advocate Team

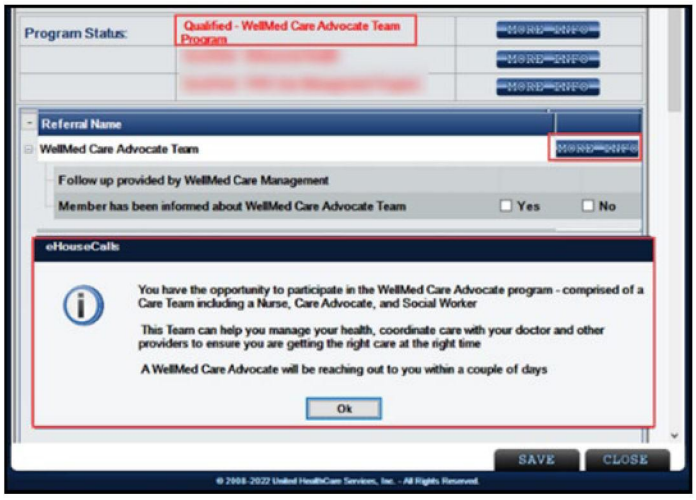
In the CRD tool, the WellMed Care Advocate Team referral will only display for eligible members in Program Status.



Program Status More Info button is available.



The referral displays for documentation under Referral Name. The **More Info** button is available and provides a description of the referral and talking points.



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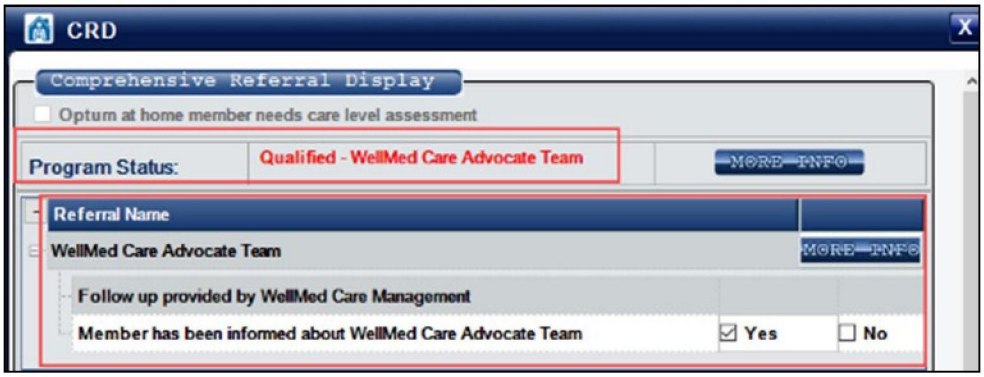
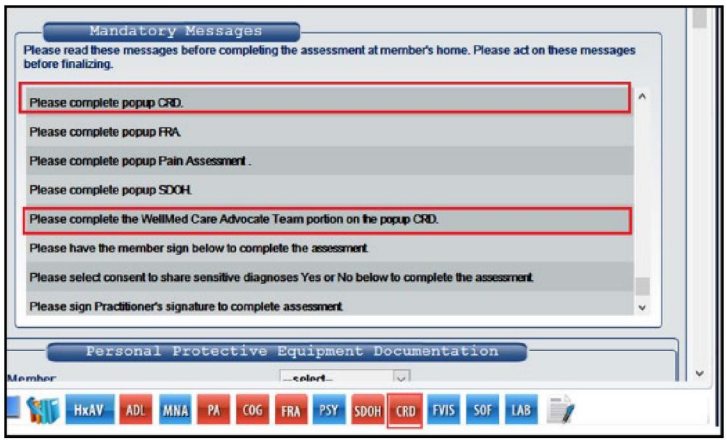
When the referral is present, it is the APC's responsibility to educate the member about the referral and ask the member if accept the referral. **Member accepts program referral** is documented with **Yes** and **No** checkboxes.



Mandatory Message

If the WellMed Care Advocate Team referral is not addressed in its entirety, a Mandatory Message will be triggered. The CRD Tool will remain **RED** until documentation of WellMed Care Advocate Team referral is completed. The tool will turn **Green** when documentation is completed.



THE WELLMED CARE ADVOCATE TEAM REFERRAL FUNCTIONALITY TOOL IS NOT AVAILABLE FOR VIRTUAL VISIT USERS.

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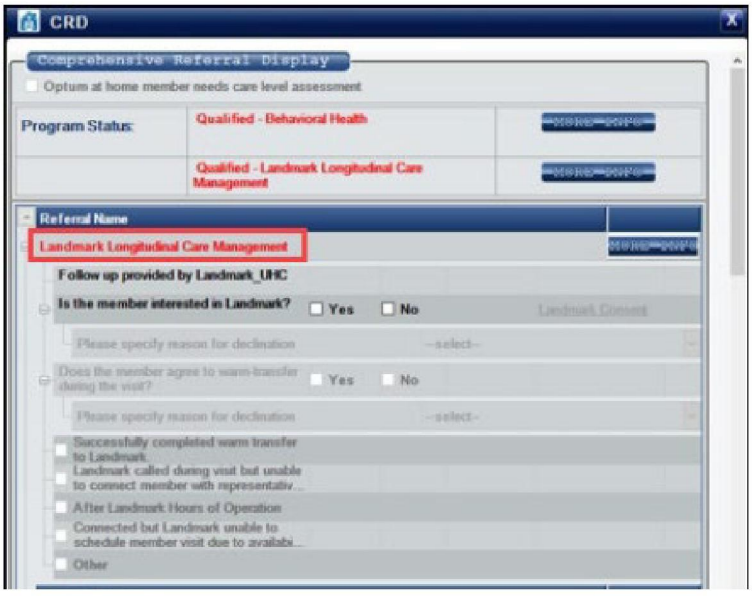
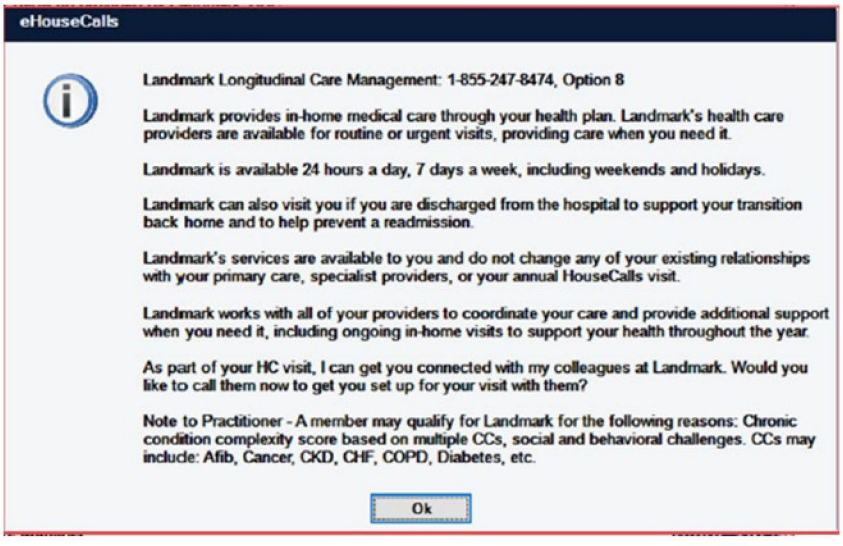
Landmark Longitudinal Care Management

In the CRD tool, the Landmark Longitudinal Care Management referral will only display for eligible members in Program Status.



The referral displays for documentation under Referral Name. The **More Info** button is available and provides a description of the referral and talking points.



When the referral is present and the member is eligible, it is the APC's responsibility to educate the member about the referral and ask if they accept the referral. **Is the member interested in Landmark?** is documented with **Yes** and **No** checkboxes.

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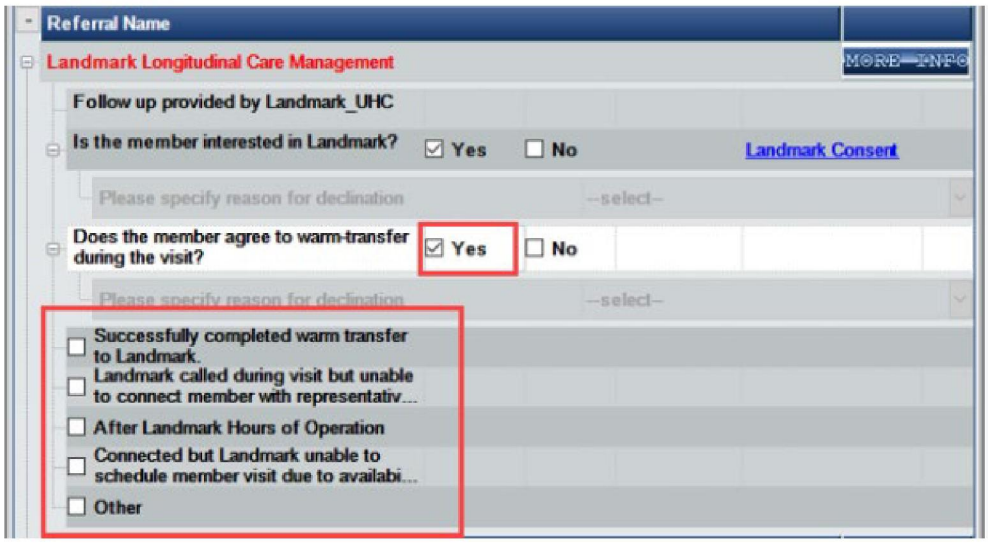
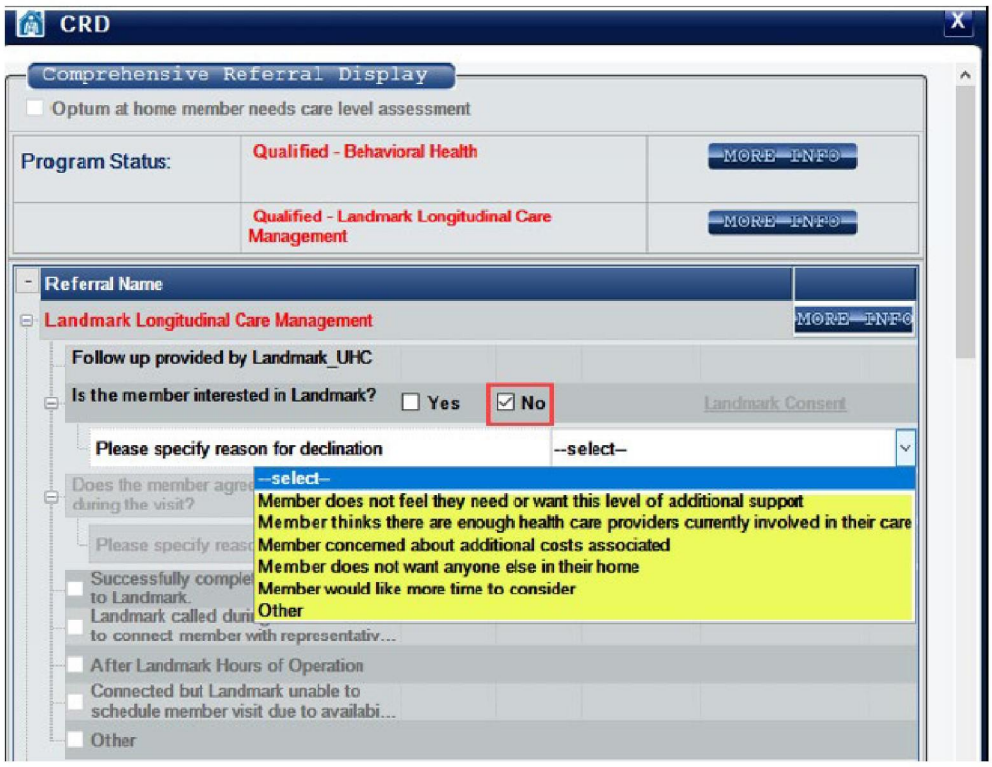
Member Interested in Landmark Longitudinal Care Management Referral

If the member accepts the referral, **Yes** will be selected which enables the selections for documentation of the required warm transfer to Landmark process. Warm transfer selections include:

- Successfully completed warm transfer to Landmark
- Landmark called during visit but unable to connect member with representative
- After Landmark Hours of Operation
- Connected but Landmark unable to schedule member visit due to availability
- Other



If the member declines the referral, **No** will be selected which enables the **Please specify reason for declination** drop down menu. A selection from the dropdown identifying the reason the member declined the referral is required.



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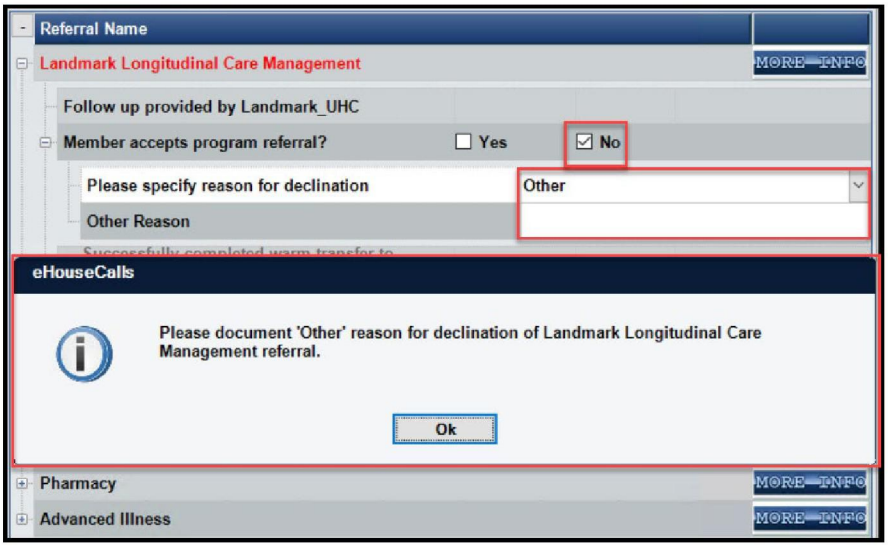
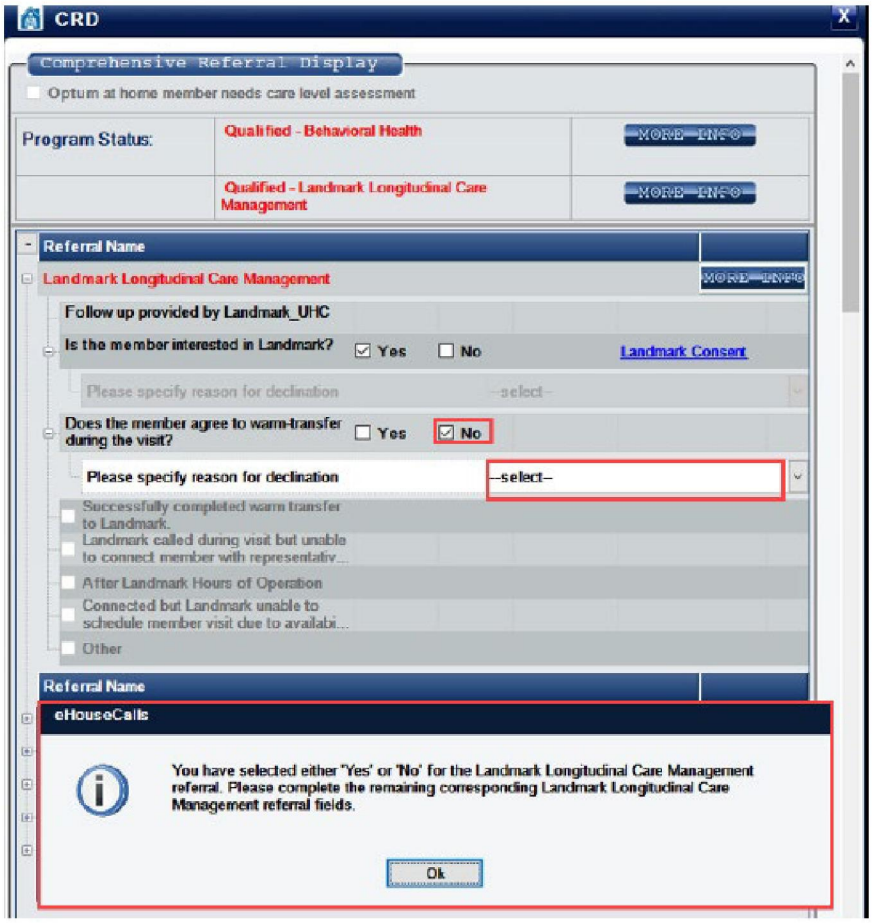
If **Other** is selected from the dropdown list, a text entry is required in the **Other Reason** text box. If an entry is not added to the Other Reason text box, a pop-up alert will be generated to indicate an entry is required.



If the member declines a warm transfer, **No** will be selected which enables the **Please specify reason for declination** drop down menu. A selection from the dropdown identifying the reason the member declined the referral is required. If a reason is not selected, an alert message is displayed.



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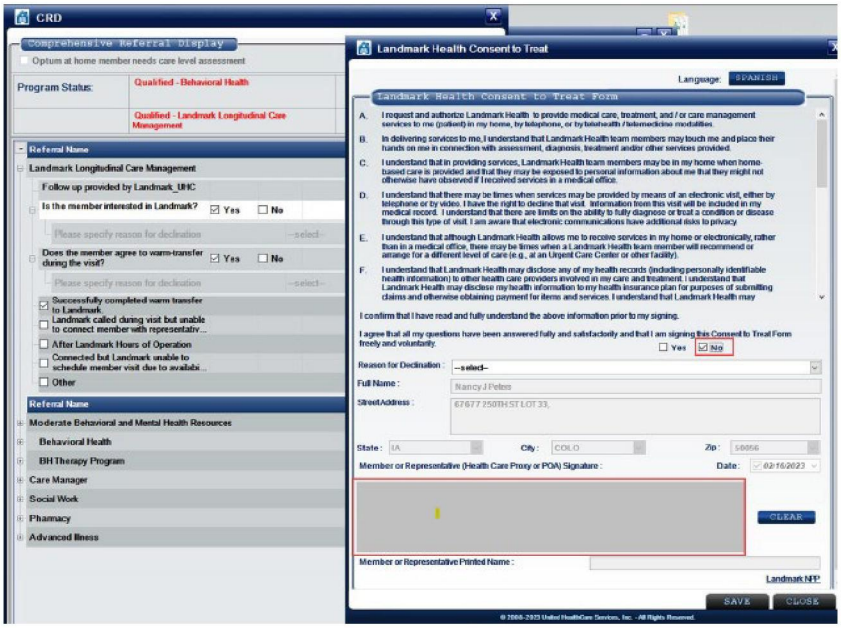
A Landmark Consent blue hyperlink will become enabled when **Yes** is selected for the question **Is the member interested in Landmark**? The **Landmark Consent to Treat** pop-up will open when member has shown interest in Landmark.



If the member does not agree to sign the Landmark Consent to Treat Form and selects the **No** option, the Reason for Declination field will become enabled with an option required for selection. The signature field will be disabled if the response to the consent question is **No**.



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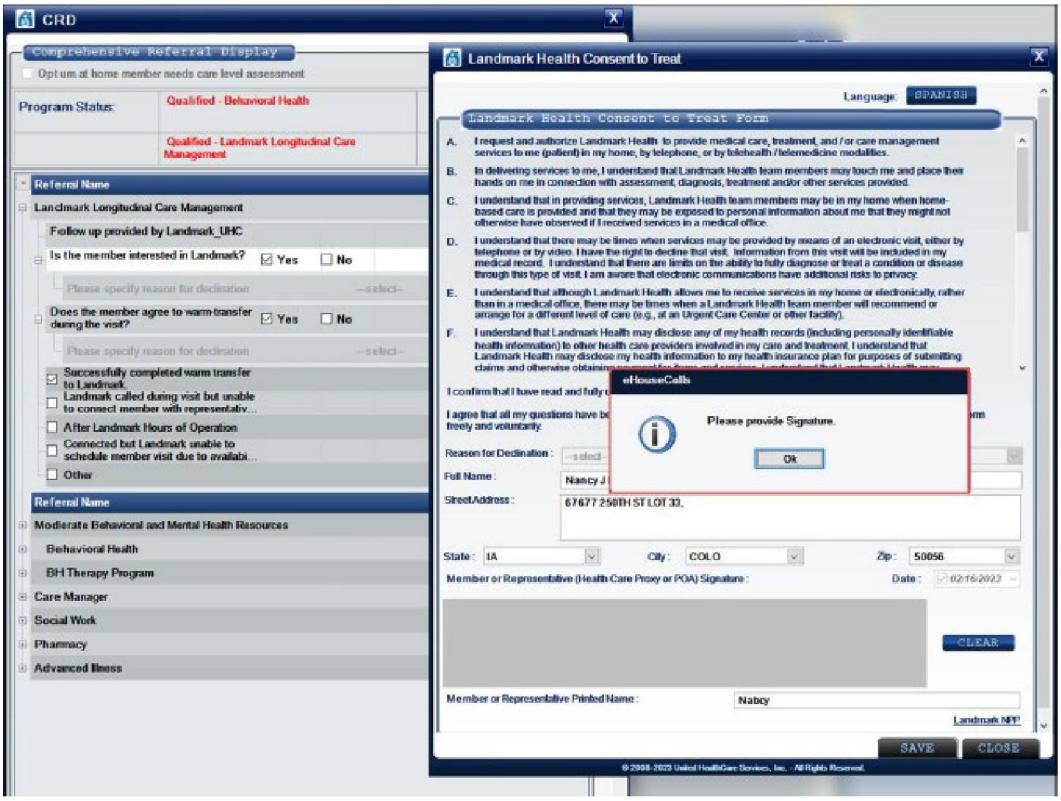
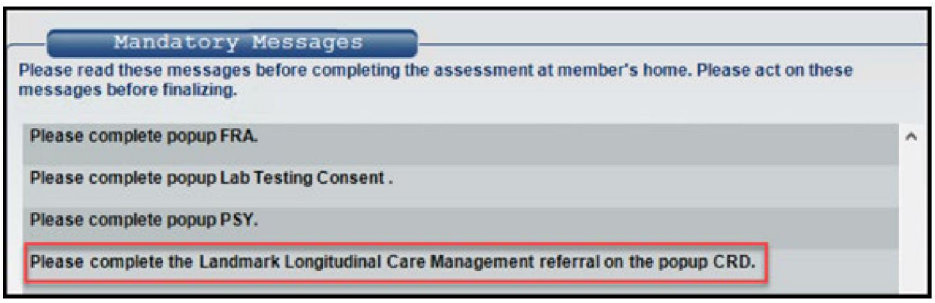
Documentation of Full Name, Address, State, City, Zip Code, and signature field is required if the response to the consent question is **Yes**. An alert message will be displayed if the practitioner tries to save the page without collecting this information.



Mandatory Message

A Mandatory Message will be generated on page 18 if the Landmark Longitudinal Care Management referral documentation is not completed when the referral is enabled.



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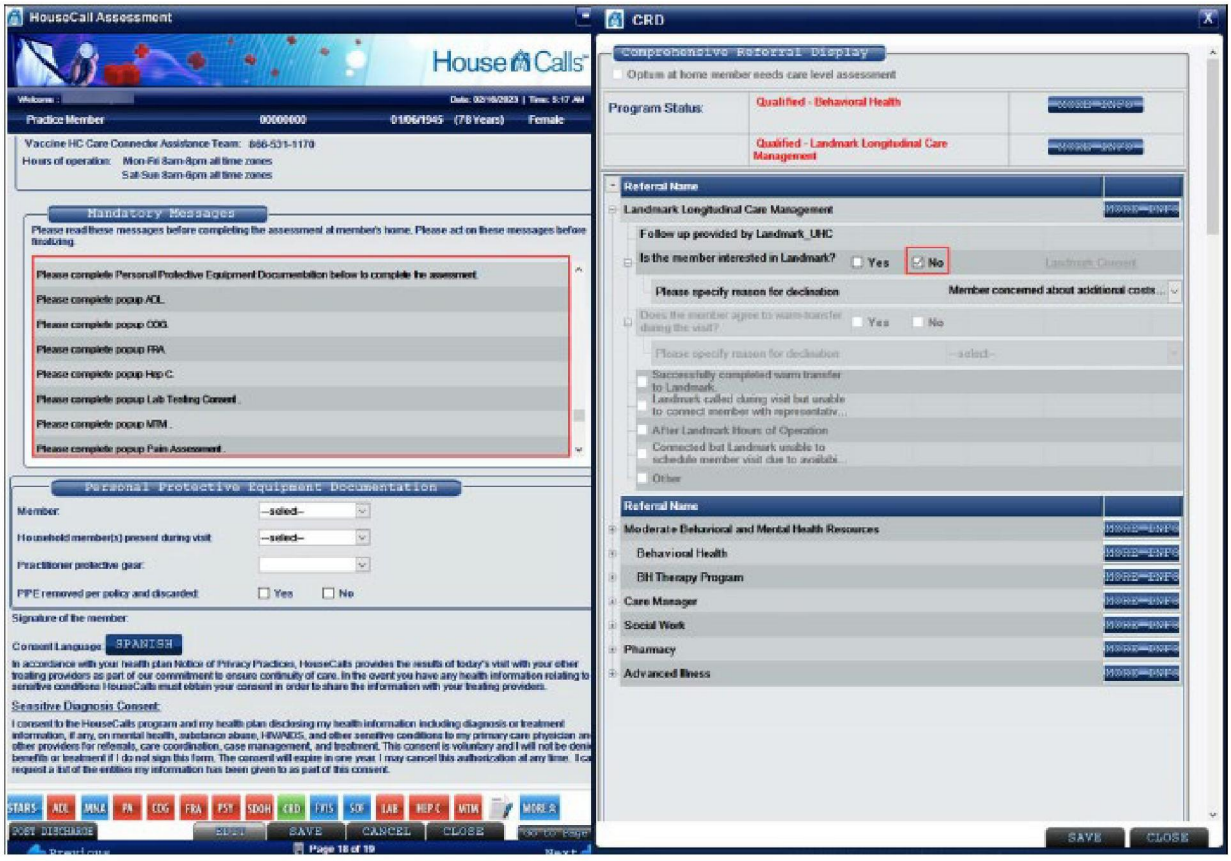
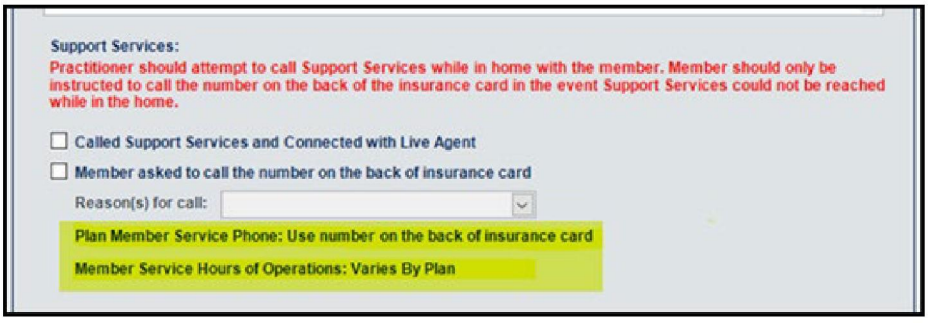
A Mandatory Message will NOT be generated on page 18 for members who have not shown interested in Landmark by selecting the **No** option for the question **Is the member interested in Landmark**? or if the member is ineligible for Landmark referral.



Support Services

It is important for the APC to assist the member with outreach while in the home if support services are needed. If the APC performs a warm transfer for the member, please document “Called Support Services and connected with Live Agent”.



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Moderate Behavioral and Mental Health Resources - Enabled

Qualified or Enrolled in Optum Behavioral Health or Behavioral Health will display when a member is eligible for Moderate Behavioral and Mental Health Resources. Referrals will be enabled for Behavioral Health and BH Therapy Program. All documentation related to psych conditions and social history should be completed while in the home to ensure that Moderate Behavioral Health referrals are selected appropriately.

Behavioral Health

- **APC WILL DOCUMENT MEMBER ACCEPTS BEHAVIORAL HEALTH REFERRAL WITH YES AND NO CHECKBOX OPTIONS**
- **BENEFITS OF FOLLOW UP CALL REVIEWED WITH THE MEMBER, BECOMES ENABLES WHEN MEMBER ACCEPTS BEHAVIORAL HEALTH REFERRAL IS ANSWERED WITH NO**

If "*Interested in treatment for alcohol use*" or "*Interested in treatment for substance use*" **is populated** into the Behavioral health section **and user declines Behavioral Health Referrals by selecting** No **option, BH Therapy section is enabled**



Moderate Behavioral and Mental Health Resources - Disabled

If the member is not eligible for Behavioral health referrals, then the Moderate Behavioral and Mental Health Resources section will be **disabled**.

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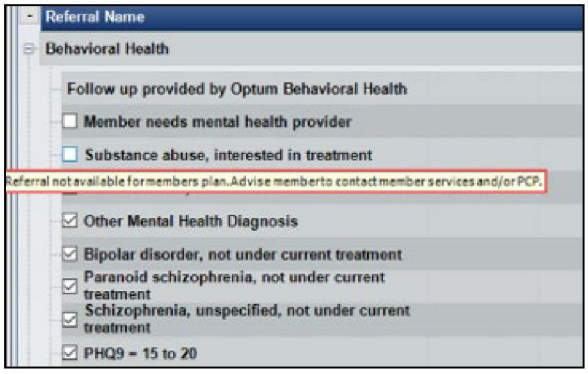
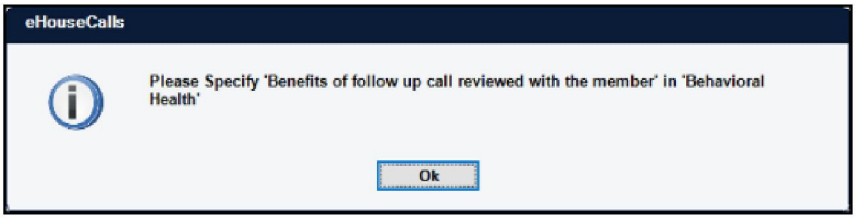
Hover text

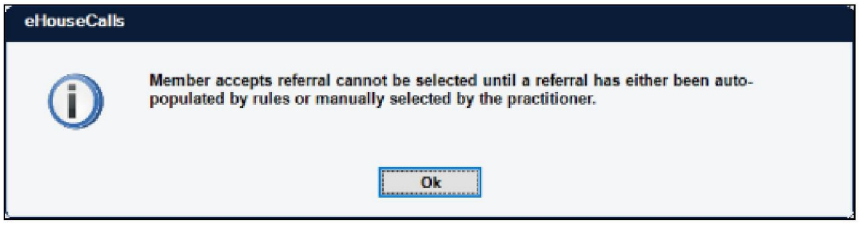
If the member's health plan does not participate in a Behavioral Health referral, then in the CRD Tool the Behavioral Health referral will displayed as disabled and the text when hovering over the referral condition will display:

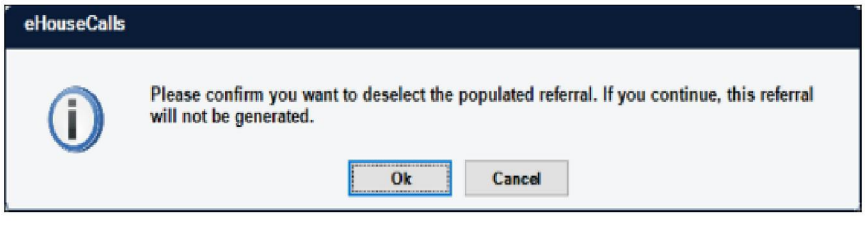
- "Referral not available for members plan. Advise member to contact member services and/or PCP."



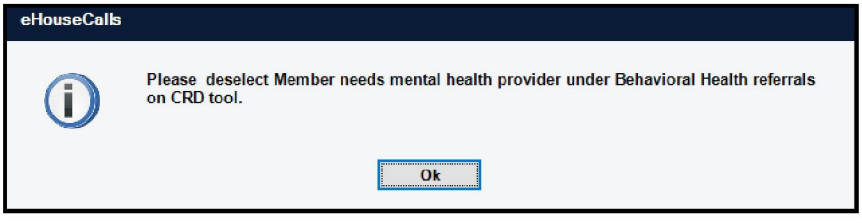
Alert messages







- Deselection of "Member Needs Mental Health Provider"
  - If the APC selects "Member needs mental health provider", the member has accepted the Behavioral health referral in the CRD tool, **AND** they select either Connected with a live agent or Needs Behavioral Health Provider on Page 18.



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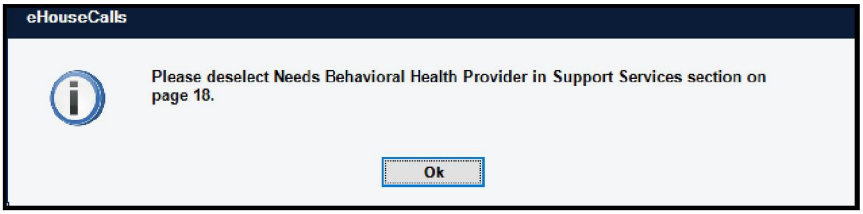
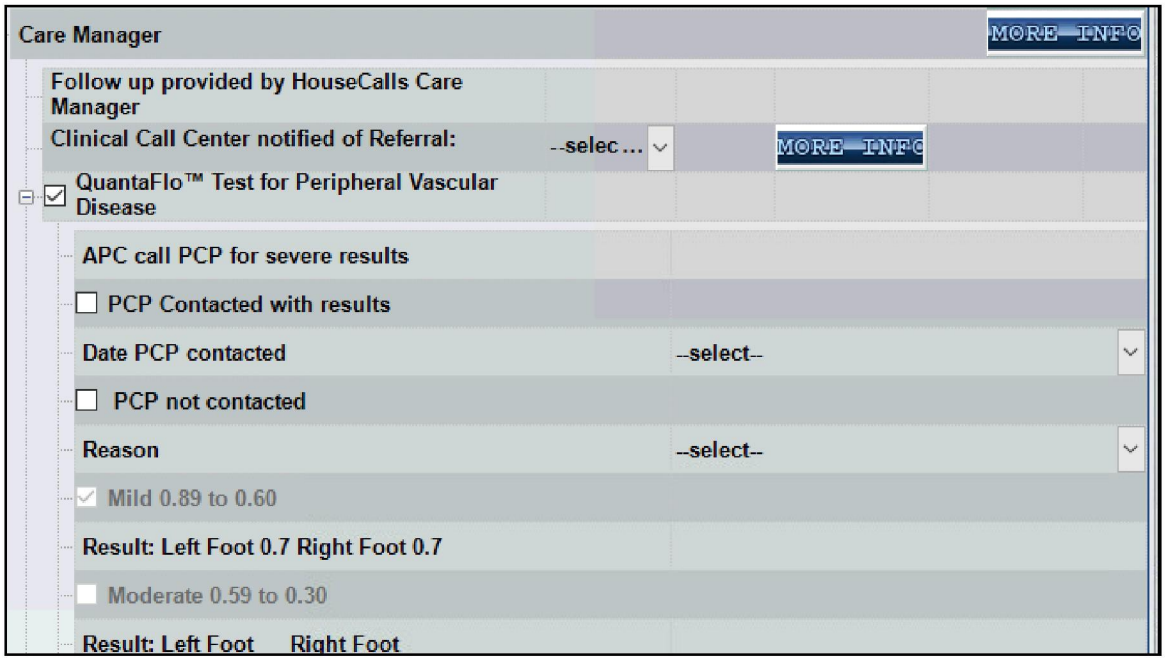
- Deselection Needs BH Provider in Support Services Section
  - If the APC selects member accepts Behavioral health referral, they select either Connected with a live agent or Needs Behavioral Health Provider Connected with a live agent, and then attempts to select “Member needs mental health provider” in the CRD Tool, an alert message will display.



Care Manager Referrals

- Care Manager Referrals will be auto populated based on documentation in the assessment:
- QuantaFlo Test for PVD is auto populated if the PVD Screening (QuantaFlo) results from Page 13 fall within the range, Mild 0.89 to 0.60, Moderate 0.59 to 0.30, or Severe 0.29 to 0.00
- If a member has different levels of results, it will populate accordingly
- The following questions will be enabled for selection under “APC call PCP for severe results”
  - APC will call PCP with Severe Results and will enable drop down menu - PCP Contacted with results and Date PCP contacted
  - If contacting PCP is not indicated, APC will select Contacting PCP not indicated and select Reason from the drop-down options: PCP contacted previously, Scheduled to see PCP, or Member has no PCP at present time.



Mandatory Message

If the member is eligible for QuantaFlo/PAD Screening and the APC has documented severe QuantaFlo/PAD Screening results for the member, but they have not made any selections for contacting the PCP regarding the QuantaFlo/PVD results, a mandatory message will be displayed on page 18.

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Contacting PCP Not Contacted Reason

If the member is eligible for QuantaFlo/PAD Screening, the Digital ABI test for PVD referral is active, and the APC has selected the checkbox "**PCP not contacted**" but has not selected a reason, then an alert message will display.



- Ultrasound Wrist Scan for Bone Density is auto selected if the T-score results in pg 6 falls between -2.5 to -5
  - This would only be applicable for APCs conducting the mini-OMNI testing in the home
- Mini Cog Test Abnormal is auto selected if the dementia or 'recommend further screening for dementia' is selected by in mini cog tool.
- High Fall Risk is auto selected if the score is 5 or greater in FRA tool.
- Diabetic Retinal Screening is only used by practitioners doing testing in the home
- Clinically Significant Findings will be added based on your clinical judgement

- **RETINAL EYE EXAM ABNORMAL REFERRAL SHOULD ONLY BE COMPLETED IN THE CRD TOOL WHEN THE DRE IS PERFORMED IN THE HOME.**
- **IF RETINOPATHY IS DOCUMENTED AS A PREVIOUS DIABETIC RETINAL SCREENING RESULT ON PAGE 6, AUTO-SELECTION OF RETINAL EYE EXAM ABNORMAL WILL OCCUR IN THE CRD TOOL - DESELECT THIS REFERRAL. DOCUMENT IN THE COMMUNICATION DETAILS SECTION THAT A DRE WAS NOT PERFORMED IN THE HOME.**
- **YOU SHOULD UNSELECT MINI COG IF PCP IS AWARE AND/OR THE CONDITION IS BEING ADDRESSED. DETAILED DOCUMENTATION OF WHY THE REFERRAL WAS DESELECTED SHOULD BE NOTED IN THE ASSESSMENT NOTE AND/OR THE NON-URGENT COMMUNICATION SECTION ON PAGE 16.**

Once a referral is auto populated, four mandatory portions must be completed that include: notification of the clinical call center, if member accepts the referral, contact details and communication details. Failure to complete the mandatory sections will trigger an alert message.

Clinical Call Center notified of the referral options are either By Phone or By Tablet, **tablet is the preferred method.** If the By Phone option is selected, then a Referral is not generated. If By Phone is selected, then Referral must be called into the Clinical Help Desk by phone on the same day as the visit.

The box labeled, "**Member accepts HouseCalls Referral"** – must be addressed with the member and checked ***Yes*** if they agree. If a member does not agree, it will not be generated, and the benefits of the referral should be explained to the member.

Clinically Significant Referrals

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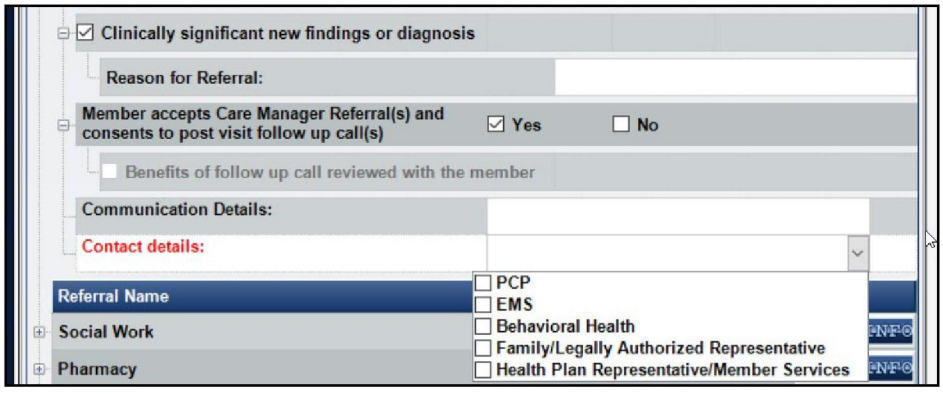
Anything identified clinically significant should be included in this section. Examples include worsening angina, new PVD, worsening or exacerbated situations, and/or new skin breakdowns/wounds.

Clinically significant new findings or diagnosis question has two required areas of documentation:

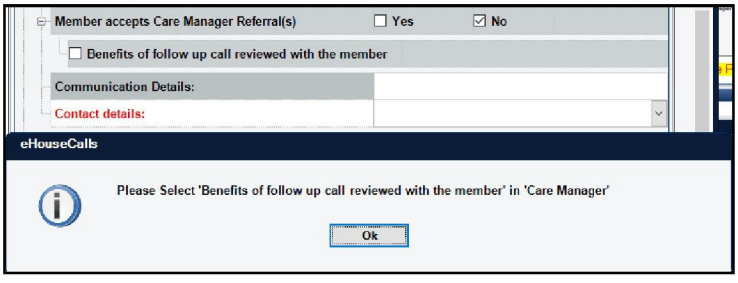
- Reason for Referral – A free text box
- Contact Details – drop-down with options (PCP, EMS, Behavioral Health, Family/Legally Authorized Representative, Health Plan Representative/Member Services). It will turn red whenever clinically significant findings are selected.

You should call the PCP and document the communication based on established protocols or clinical decision making. Examples include: QuantaFlo results or falls

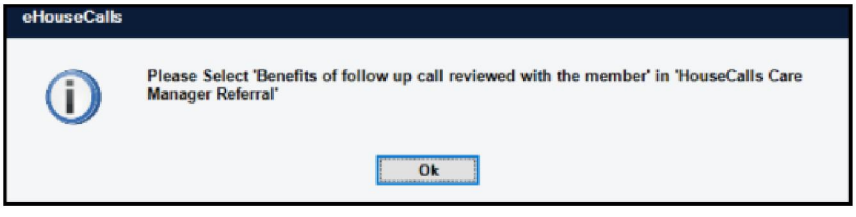


The following alert is displayed if the question **Member accepts HouseCalls Care Manager Referral** has not been answered. If you check YES for this section, please DO NOT tell the member to expect a call within 2 business days. APC will simply tell member that someone will call them to review this information with them.

You must select an option from the Contact details drop down section.



The following alert is displayed if the **No** option is selected for **Member accepts HouseCalls Care Manager Referral Yes/No and Benefits of follow up call reviewed with the member** checkbox is not selected with any of the options selected in HouseCalls Care Manager Referral section.



A1C Referral

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In the CRD tool, under Care Manager referral, placed below High Fall Risk. you will see the following section to document A1C prediabetic or diabetic levels for Universal A1C testing:

- Non-Diabetic A1C Results
  5.7 to 6.4
  Result: ___
  6.5 or greater
  Result: ___

DOCUMENTATION OF PCP CALLED FOR RESULTS > 6.5 IS ESSENTIAL TO CLOSE THE CRD TOOL.

If the member is a known Diabetic and has an elevated level > 13, it will be auto populated into the CRD.

- Diabetic A1C Results
  Result > 13

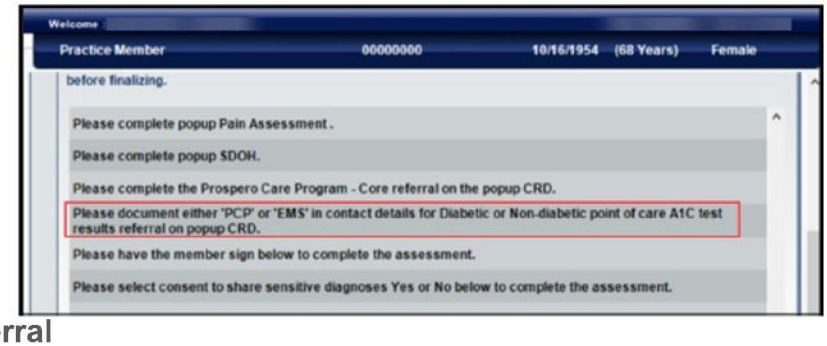


DOCUMENTATION OF PCP CALLED FOR RESULTS > 13 IS ESSENTIAL TO CLOSE THE CRD TOOL.

If you hover on Non-diabetic A1c results referral you will see an alert stating,
"Referral generated based on A1c results documented on Lab tool."

There is a similar alert for Diabetic A1C Results stating, **"Referral generated based on A1C results documented on Lab tool."**

A mandatory message will display when the CRD tool is saved without documenting Contact Details or without selecting PCP or EMS as Contact Details.



Social Work Referral

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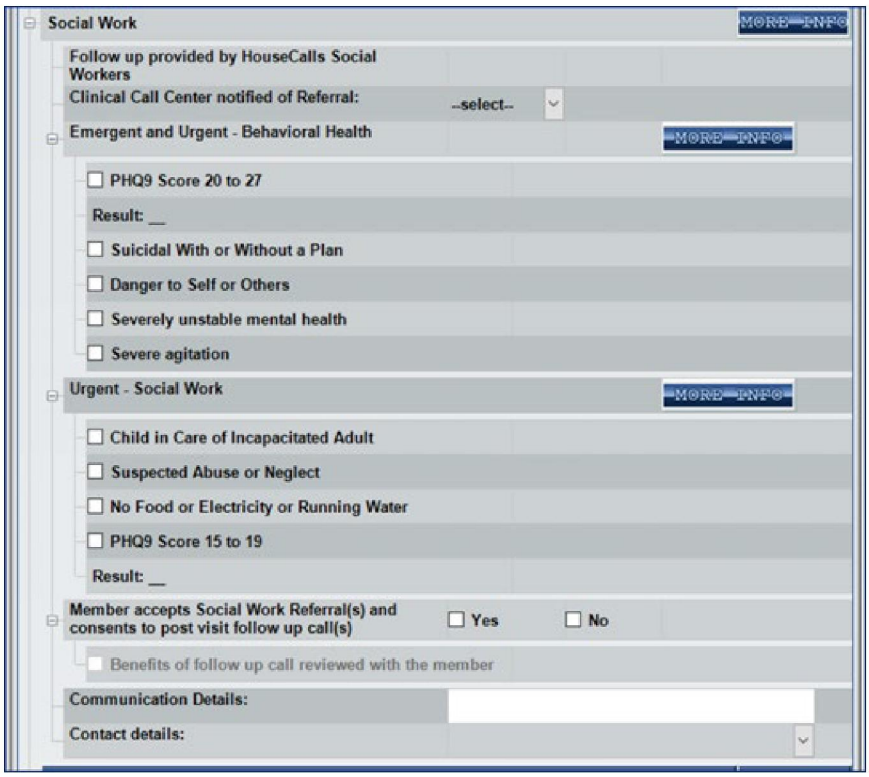
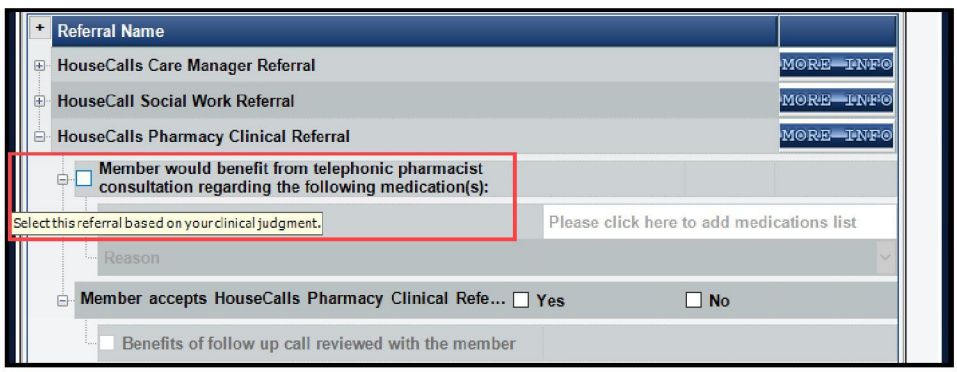
The HouseCalls Social Work Referral section in the CRD tool contains Social Work and Behavioral Health referrals.

Once a referral is selected, you will be required to document if a referral is made by phone or tablet, if the member agrees to referral, and communication details. Failure to complete the required sections will result in pop-up messages alerting you to missing documentation.



Pharmacy Clinical Referral

A **Pharmacy Clinical Referral** is based on your clinical judgement and the member's needs. "**Member would benefit from telephonic pharmacist consultation regarding the following medications"** is the option that may be selected for referral. The member must agree to the referral; if the member does not agree, then a referral will not be generated.



There are two fields that will be documented into the tool.

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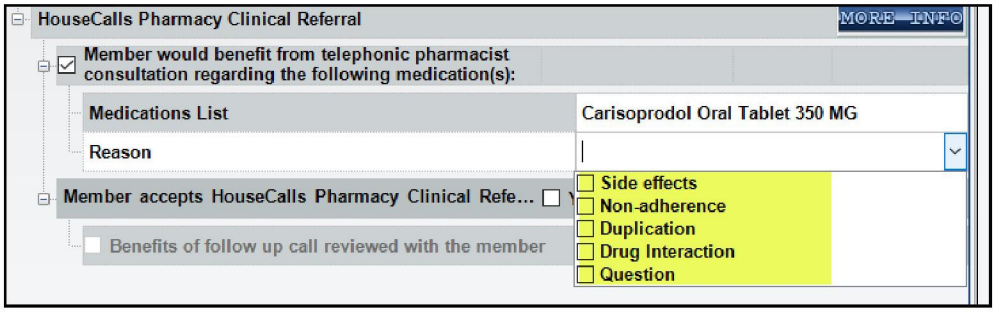
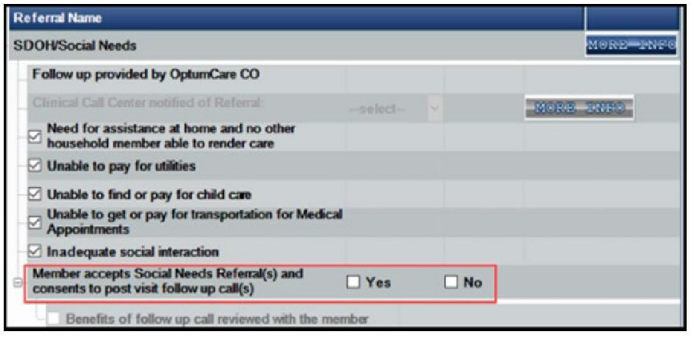
- **Medications List**- Displays the Medication popup to document Medications.
- **Reason**- Contains multi-select options:
  - Side effects
  - Non-adherence
  - Duplication
  - Drug Interaction
  - Question



SDOH/Social Needs

The SDOH tool auto selects referrals into the CRD tool when there are documented social needs:

- Lack of food and clothing
- Unable to pay for utilities, childcare, prescriptions
- Unable to get transportation to work or medical appointments, etc.



Referrals are visible in the CRD based on information entered into the SDOH tool. It is advisable to review with the Member; you will have the ability to de-select the referrals generated, if you think referrals are not needed. To complete SDOH/Social Needs referral:

- Select if the “Member accepts social needs referral”
- Selection for “Clinical Call Center notified of Referral” is disabled

SDOH Referrals – More Info

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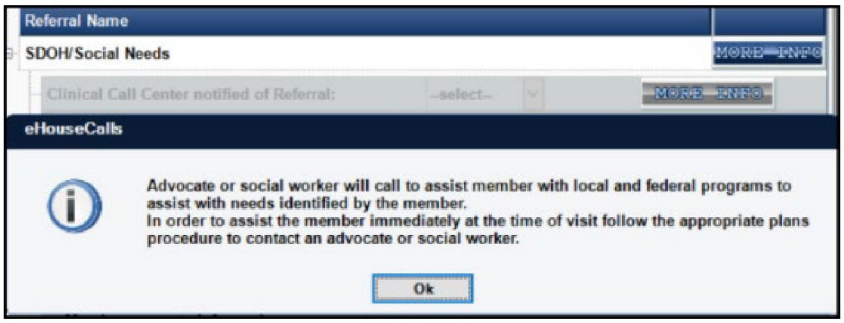
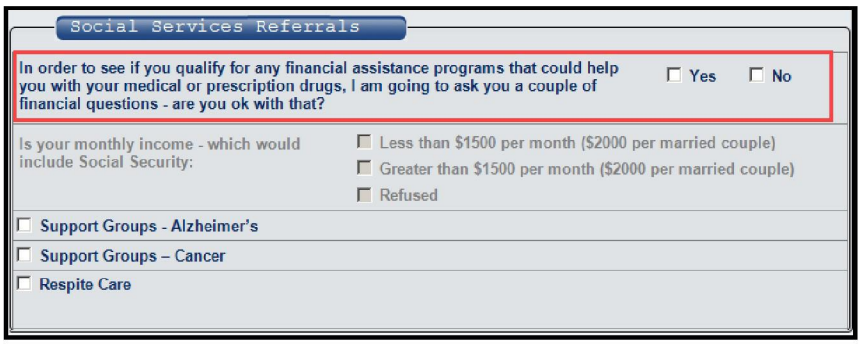
In the SDOH tool, clicking the **More Info** button will generate the following pop-up:



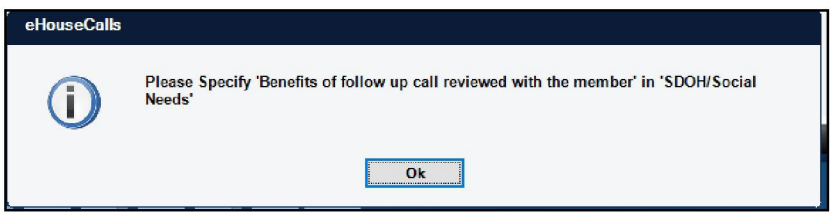
Social Services referrals look at the availability of financial support and assistance for medical and/or prescription drugs for the member. This question is required for all members, unless it is grayed out which indicates that the member is already receiving financial assistance [LIS]).



If you deselect an option, it will send you alert for you to confirm for agreement.



If a reason for declination is not selected, you will receive an alert



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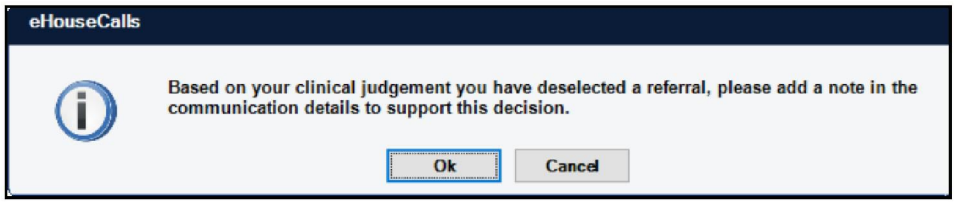
Referral Restrictions

The CRD tool does not allow manual selection of logic-generated referrals.

Deselecting Alerts

An alert will appear if any referral is selected by logic and the APC tries to deselect the referral. The tool cannot be saved until communication details are added.



Referrals for Hospice Members

Referrals are not indicated for members on hospice. For members who are on hospice, if documentation was present within the CRD tool, a pop-up alert will appear indicating that no referrals will be generated. After acknowledging the pop-up, all documentation within the CRD tool will be deleted and the tool will be disabled.

THE CRD TOOL WILL BE DISABLED FOR MEMBERS WHO ARE DOCUMENTED AS RECEIVING HOSPICE OUTSIDE SERVICES WITHIN THE SOCIAL HISTORY ON PAGE 7

FVIS - Flu Vaccination Information Sheet

HOUSECALLS IS NOT ADMINISTERING FLU VACCINATIONS TO MEMBERS.

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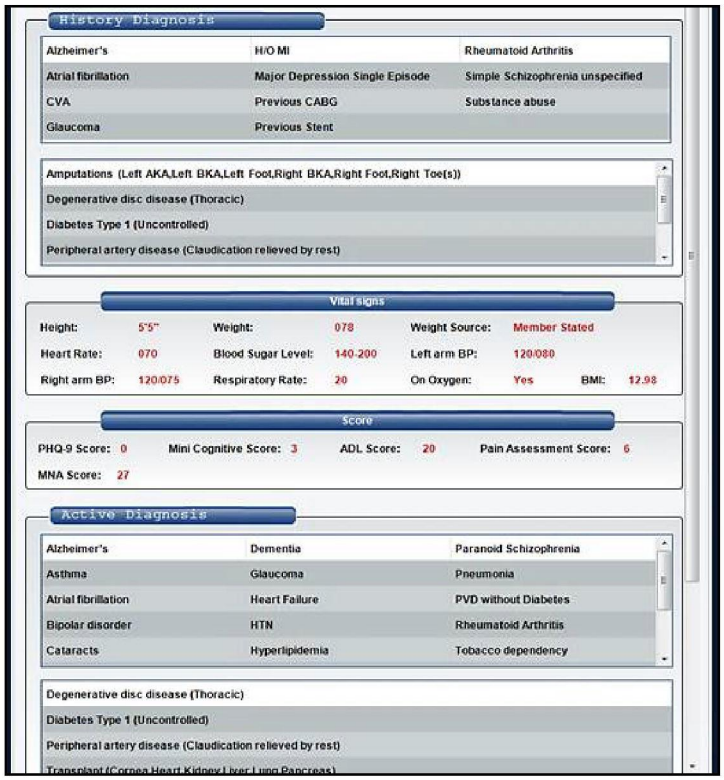
SOF - Summary of Findings



The **Summary Page** tool will display a summary of the current year's documented HouseCalls visit (if applicable). This tool is used for informational purposes.

The Summary Page Tool data includes:

- Member Information (Member Name, DOB, Practitioner Name, and Appointment Date)
- History Diagnosis (Diagnoses with types, if applicable)
- Vital Signs (Height, weight, heart rate, etc.)
- Score (PHQ-9 Score, Mini Cognitive Score, ADL Score, Pain Assessment and MNA Score)
- Active Diagnosis (Active diagnoses with types, if applicable)
- Collaboration (Collaboration information, such as if PCP was contacted and reason)



THE SUMMARY PAGE HAS BEEN UPDATED AND HOUSECALLS ASSESSMENTS FINALIZED WITH AN OLDER VERSION OF THE EHOUSECALLS ASSESSMENT SOFTWARE WILL DISPLAY LESS INFORMATION.

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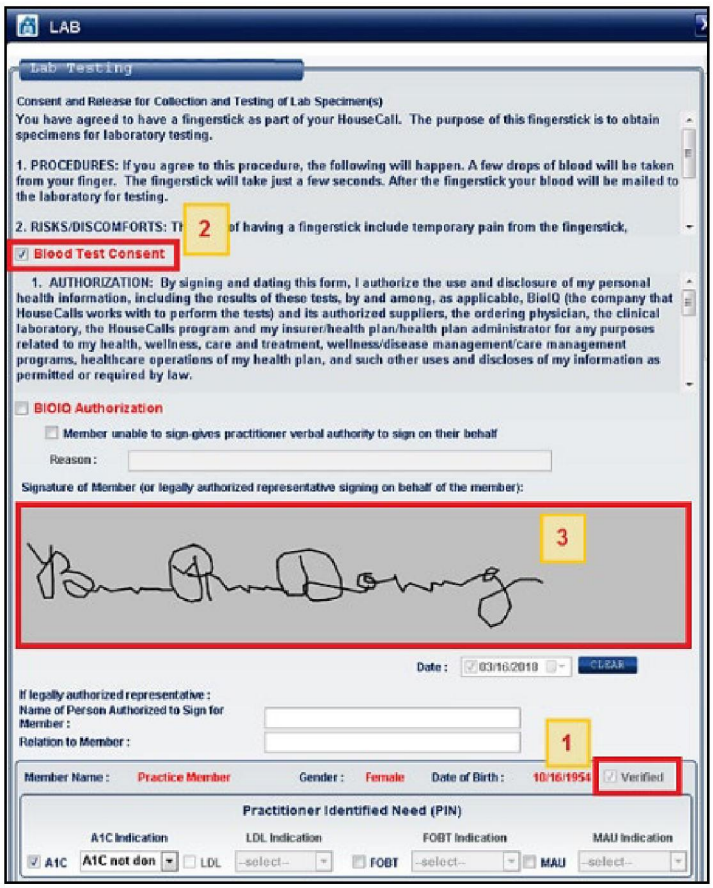
LAB – A1C+NOW (Blood), FOBT Let's Get Checked (LGC) Testing

LAB The LAB Tool is used to document A1C+NOW blood home testing for Diabetics and Non-Diabetics and FOBTLGC testing for colorectal cancer testing. The LAB tool can be system identified (Point of Care-POC) which is flagging the lab tool for the APC to complete, or it can be initiated by the APC should there be a gap in care. The Practitioner Identified Needs (PIN) section allows you to request labs. It should be noted that the Lab tool will not be visible if the Member's health plan does not participate.

THE MAU AND LDL SECTIONS ARE DISABLED - WE DO NOT CONDUCT THESE LABS AT THIS TIME. IF ENABLED IN THE ASSESSMENT SELECT UNABLE TO COLLECT TO CLOSE LAB TOOL.

Documenting A1C Test Results

1. **Verify** the member's name and DOB and then click the Verified checkbox
2. Select the **Blood Test Consent** checkbox
3. Capture the **member signature** in the gray signature text field



IF THE MEMBER CANNOT SIGN, SELECT "UNABLE TO SIGN – GIVES PRACTITIONER VERBAL AUTHORITY TO SIGN ON THEIR BEHALF" AND FILL IN THE REASON TEXT FIELD (I.E. CAST ON WRIST). THEN SIGN MEMBER'S NAME BY PRACTITIONER NAME IN THE SIGNATURE BOX. IF A LEGALLY AUTHORIZED REPRESENTATIVE IS SIGNING FOR THE MEMBER, ENTER THE NAME OF THE REPRESENTATIVE AND RELATIONSHIP TO THE MEMBER IN THE APPROPRIATE FIELDS.

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4. For Practitioner Identified Need (PIN) A1C Testing ONLY, select the A1C checkbox and select the appropriate option from the drop-down list.



BARCODES ARE NOT USED FOR A1C TESTING.

5. In the middle of the page, located under the Point of Care header, enter Collection Date, Collection Time, and Results.



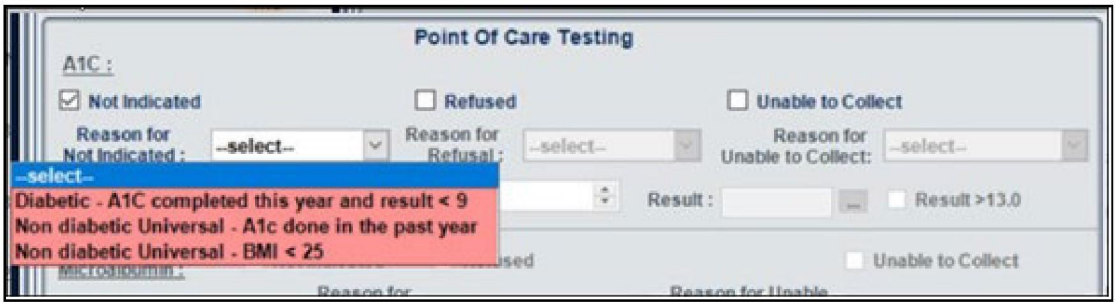
IF THE A1C LAB IS NOT COLLECTED AND YOU SELECT "REFUSED" OR "UNABLE TO COLLECT", YOU MUST SELECT A *REASON FOR REFUSAL* FROM THE APPROPRIATE DROP-DOWN LIST.

IF MEMBER STATES THAT THEY RECENTLY HAD AN A1C DONE – PLEASE DOCUMENT RESULTS IN ROS PAGE 10 OF EHC APPLICATION

Not Indicated Reason for A1C

Drop-down **Reason for Not Indicated** added to A1C Test with the following options:

- Diabetic – A1C completed this year and result < 9
- Non-diabetic Universal – A1C done in the past year
- Non-diabetic Universal – BMI < 25



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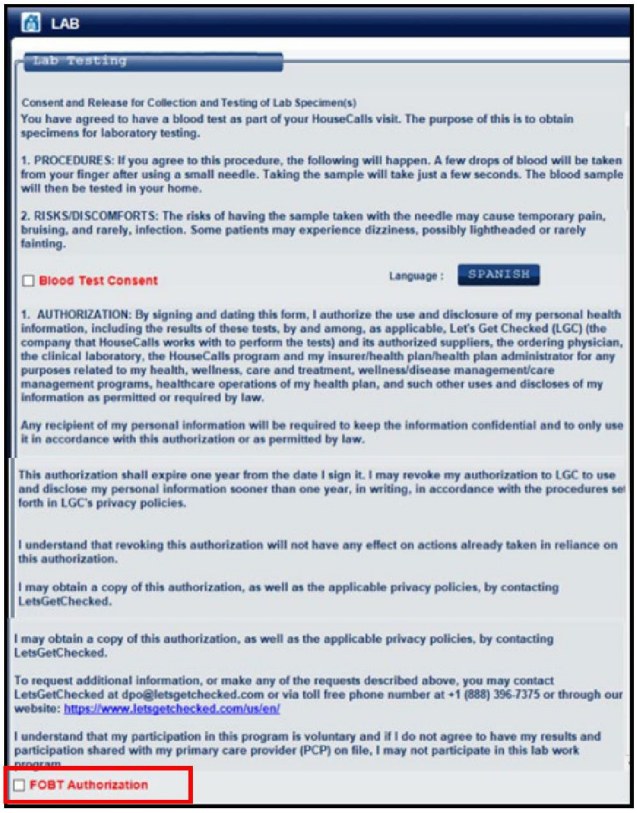
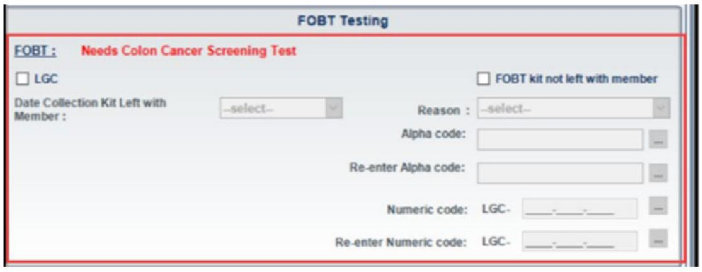
Documenting FOBT LGC Test Results

1. Verify the member's name and DOB and then click the **Verified** checkbox
2. Select the **FOBT Authorization** checkbox
3. Capture the **member signature** in the gray signature text field.



> **IF THE MEMBER CANNOT SIGN, SELECT "UNABLE TO SIGN – GIVES PRACTITIONER VERBAL AUTHORITY TO SIGN ON THEIR BEHALF" AND FILL IN THE REASON TEXT FIELD (I.E. CAST ON WRIST). THEN SIGN MEMBER'S NAME BY PRACTITIONER NAME IN THE SIGNATURE BOX. IF A LEGALLY AUTHORIZED REPRESENTATIVE IS SIGNING ON BEHALF OF THE MEMBER, ENTER THE NAME OF THE REPRESENTATIVE AND RELATIONSHIP TO THE MEMBER IN THE APPROPRIATE FIELDS.**

4. Enter the date you left the kit with member, and then input the barcode twice in the appropriate fields.



> **IF THE FOBT KIT WAS NOT LEFT WITH THE MEMBER, SELECT THE CHECKBOX AND THE APPLICABLE REASON THE KIT WAS NOT LEFT WITH THE MEMBER FROM DROP-DOWN LIST.**

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MTM – Medication Therapy Management



The **MTM (Medication Therapy Management) Tool** only appears and is mandatory for members who:

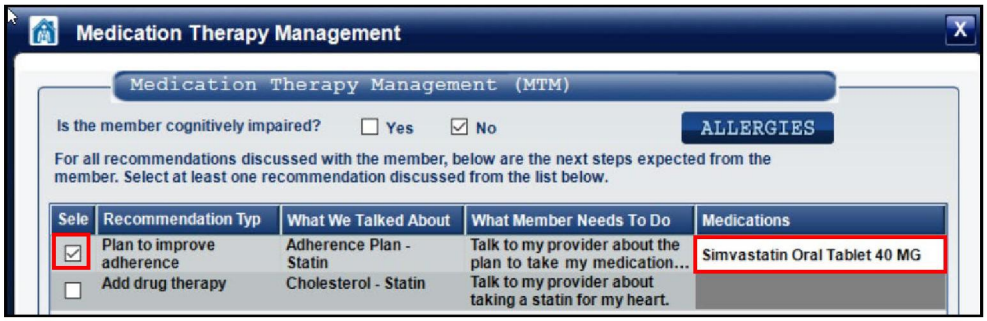
- Have three to five chronic illnesses
- Have 8 or more medications
- Have expected costs for medications over a certain threshold

MTM members are eligible to receive additional support such as outreach calls, printed materials, and follow-up letters. The goal of the MTM program is to help our members understand their medications and to use them safely.

A recommendation selection must be discussed with the member and documented from the prepopulated list. Depending on the active diagnoses and medication classes, the MTM tool will identify potential drug therapy problems (DTPS). Non adherent drugs: high risk medications (HRM) can also be selected to be discussed with the Member. A mandatory message will appear on page 18 if the MTM tool is not addressed completely. Members should be able to verbalize comprehension and understanding of the recommendation.

- **Drug Therapy Problems (DTPs)** – the MTM tool will identify potential drug therapy problems (DTPS) when a member has a chronic condition and/or a high-risk medication utilization is indicated. Feature is enabled for all listed DTPs so that you will only see the meds or drug classes which pertain to the identified problem
- **Plan to Improve Adherence** –. Feature for 'plan to improve adherence' is noted when member is non adherent and further education can be conducted
- **Inappropriate Therapy** – This is enabled when a medication is not correctly indicated for a condition
- **High Risk Medication** - any High-risk medications (HRM) that the member takes will appear as 'inappropriate therapy' for you to address with the member.

When addressing the MTM tool, the Medications column must be populated if the row is checked off as shown below.



Members are encouraged to speak to PCP about a recommendation that was discussed. All MTM members receive a Personalized Medication List and Medication Action Plan letter that should be used to assist them at their medical appointments. The MTM letter that members receive will reflect the DTPs that you addressed during the HCV. Remember, you are required to address a minimum of 1 DTP.

Assessment Notes



Enables you to enter notes regarding your visit. This section might be used to enter personal information/indicators, such as housing conditions. These notes are also visible and accessible for documentation on page 18.

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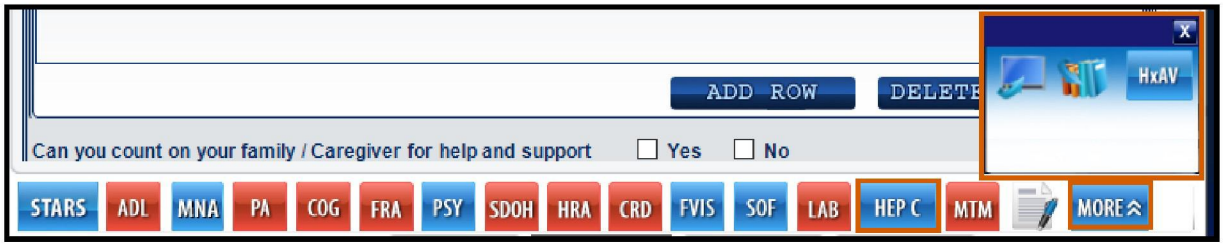
More Tab



The More tab is displayed on the diagnostic tool bar when the list of tool icons exceeds the panel length. When the More is selected, a window will open with additional tool buttons.



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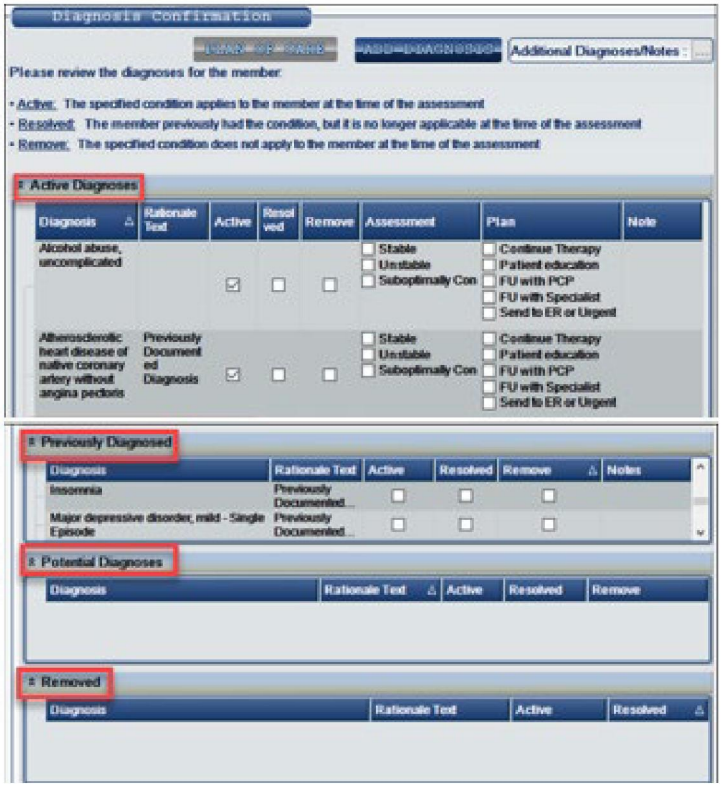
DOCUMENTING ASSESSMENT PAGE 15

Diagnosis Confirmation - Assessment & Plan

On page 15 of the assessment, you will discuss and document Member Diagnosis Confirmation, Assessment, and Plan of Action. Diagnoses can be present in 1 of 4 expandable/collapsible lists: **Active Diagnoses, Previously Diagnosed, Potential Diagnoses,** or **Removed.** This page provides diagnoses that are added either by system logic, from a previous HouseCalls visit or claims information, or diagnoses the APC has added during the visit.



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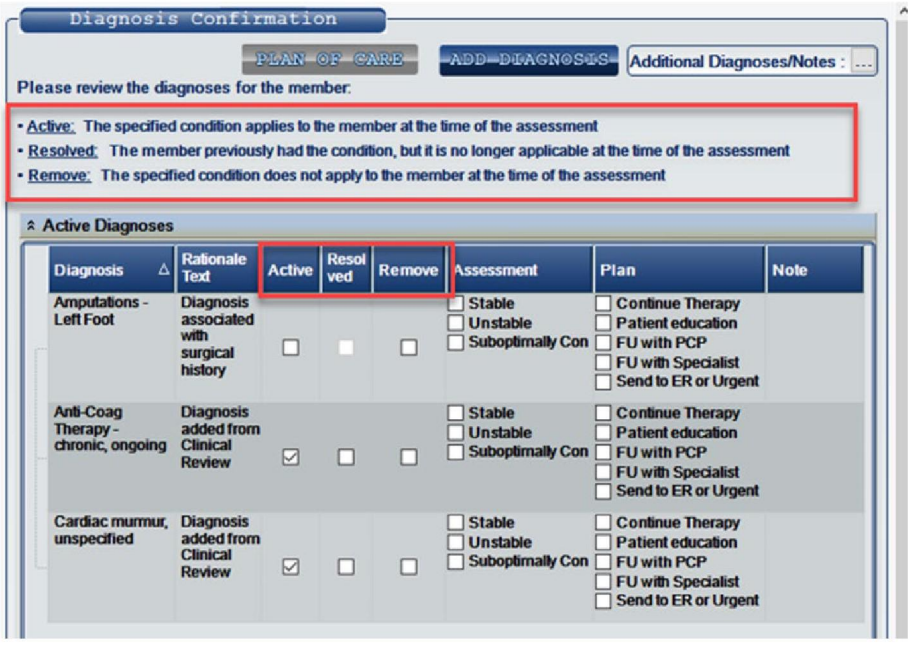
Active Diagnoses List

On the diagnosis confirmation page, there will be three options to status the diagnoses: Active, Resolved and Remove. Only one of these options can be selected for each diagnosis. To make a diagnosis active, manually check Active after considering all evidence from PMH, medications, review of systems and physical exam. Each diagnosis in this section must be addressed and have the appropriate status selected. The definition of the status will be provided at the top of the page.



Previously Diagnosed

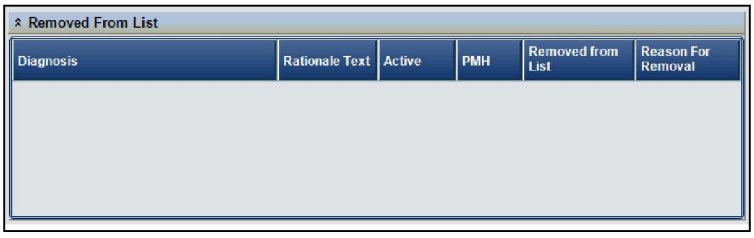
The diagnoses in Previously Diagnosed list are in a designated area below the Active Diagnoses list. These diagnoses display with the Rationale Text Previously Documented Diagnosis. Carefully review each diagnosis with the member in consideration of the entire clinical picture and then select the appropriate status. Diagnoses that have the status of Active or Remove selected will move to the appropriate list. The only diagnoses that should remain in this section are the past medical history diagnoses which are designated using the Resolved checkbox.

Potential Diagnoses

This list contains prepopulated conditions based on clinical data and diagnoses that are suggested by smart logic and/or tablet rules or identified by clinical logic prior to the visit. Resolved will be disabled (greyed out) for these diagnoses.

Removed

If a diagnosis needs to be removed, select the **Removed** checkbox and the diagnosis will be moved to the Removed section.



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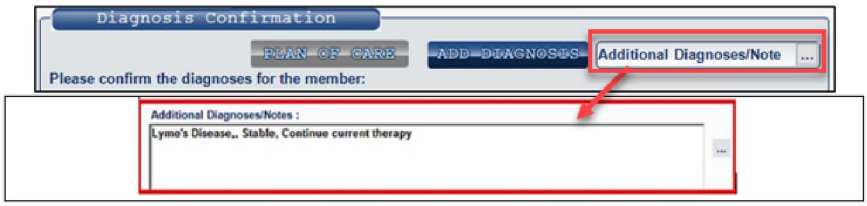
Add Diagnosis

This tab can be used to add conditions to the Diagnosis Confirmation page. Use the tab to search the Diagnosis Cart database before moving to the Additional Diagnosis free text box.



Additional Diagnosis/Notes Section

If a diagnosis needs to be added based on your clinical judgment, use the **Add Diagnosis** button- a page will appear listing diagnoses by system, and free texting ability at the bottom. Any unavailable diagnosis needs to be documented in the **Additional Diagnoses/Notes** textbox and must include an assessment and plan.



To assist with sorting/filtering columns on the **Diagnosis Confirmation** page, click the applicable blue column header you wish to filter.

Documenting Active Diagnoses

1. Identify if the Diagnosis is Active
2. Select the member's condition from the **Assessment** column.

STABLE (CONDITION IS STABLE), UNSTABLE (REQUIRES AN URGENT REFERRAL) OR SUB OPTIMALLY CONTROLLED (CONDITION IS NOT CONTROLLED).

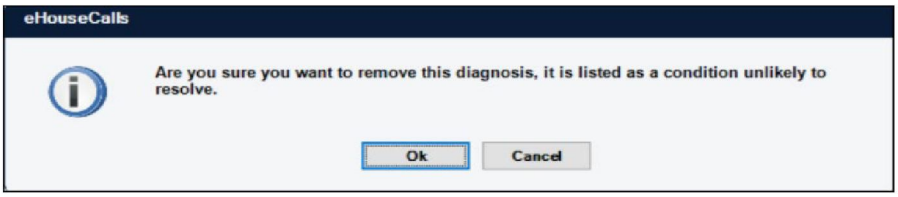
3. Next, select a suggested plan of treatment from the multi-select **Plan** column.
4. Use the **Notes** column to enter any additional information about the diagnosis, assessment, or plan.

Diagnoses Requiring Additional Documentation

Certain diagnoses will display with dropdown menus that require selection of the supporting information for the diagnosis. A Mandatory Message will be generated if a dropdown menu option is not selected. The dropdown menu selection must correlate with documentation in other areas of the assessment, or a Mandatory Message will be generated.

Chronic Conditions

An assessment alert will appear if you attempt to remove a chronic condition identified as 'unlikely to resolve' according to the scenarios below:



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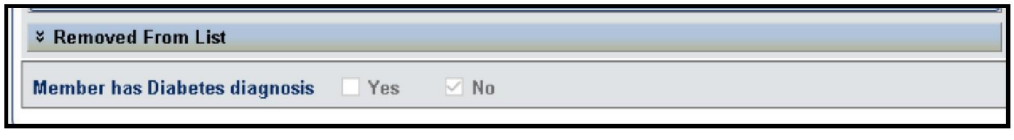
Below are chronic conditions related to the above alert.

- CHF/heart failure
- All COPD codes
- Chronic Hepatitis B
- Atherosclerosis of aorta
- Atherosclerosis of the extremities
- Many psychiatric codes, even single episode (use remission identifier)
- All alcohol and drug dependency (even in remission)
- Diabetes with complications such as neuropathy, retinopathy, or CKD
- Diabetes
- Parkinson's Disease
- Lupus
- Multiple Sclerosis
- Rheumatoid arthritis
- Status amputation (below the waist; AKS, BKA or foot/partial foot amputations)
- All functional artificial openings
- HIV/AIDS
- Ankylosing spondylitis
- Status transplant for the following:
  - Heart
  - Bone Marrow
  - Stem cell
  - Liver
  - Lung
  - Pancreas
  - Kidney
- Dementia

Checkbox - Member has Diabetes Diagnosis

Member has Diabetes Diagnosis statement appears with Yes and No checkboxes at the bottom of the Diagnosis Confirmation Page. The auto-selection of Yes and No occurs based the presence of any diabetes diagnosis in the Active and PMH list or PMH list. When a diabetes diagnosis is present in the Active and PMH list or in the PMH list an auto-selection of Yes will occur. When there is not a diabetes diagnosis present in the Active and PMH list or PMH list or when diabetes diagnoses present in these lists are removed from the list, an auto-selection of No will occur. The Yes and No checkboxes are disabled for selection by the APC.



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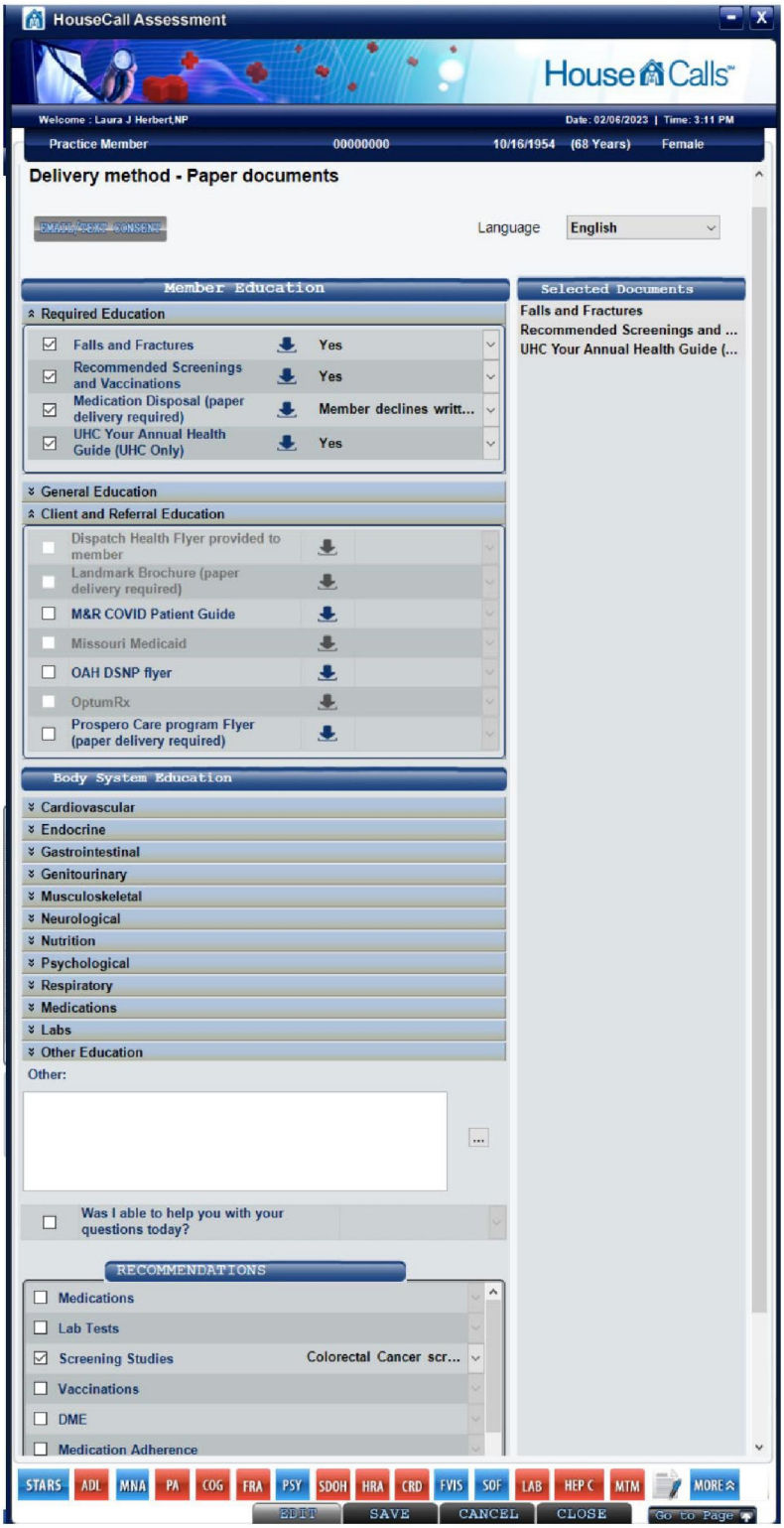
DOCUMENTING ASSESSMENT PAGE 16

On page 16 of the assessment, you will discuss and document **Member Education** and **method of delivery.**



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Member Education

The **Member Education** section has four section headers: Required Education, General Education, Client and Referral Education, and Body Systems.

Delivery Method

At the top of the page Delivery method -will be indicated as Digital documents, or Paper documents. Document delivery preference can be changed, if needed, on page 16 by selecting the Email/Text consent button and updating the members selections. A selection can be made to send documents to the member in English or Spanish.



Once each necessary item is selected, the arrow pointing down can be selected to view the educational material in PDF form. Selected Documents will be listed at the right, under **Selected Documents**.

Required Education

When expanded this section contains education documents that are required to be provided to the member. In the Required Education it is necessary to open the dropdown arrow on the far right and then select Yes or No indicating material was selected for member.

Selected Documents will be listed at the right, under Selected Documents. If you do not select all the required education materials, a popup alert will appear.



Medication Disposal

A selection of a Medication Disposal option is mandatory to attest to the Medication Disposal information and education that was provided to the member. If the member has an HRA tool present, then the Medication Disposal attestation will be completed in the HRA tool, and the attestation statements should match in the Member Education section. When Safe Medication Disposal is selected you will see an additional pop-up generate for you to document the attestation of this information. If you then select that

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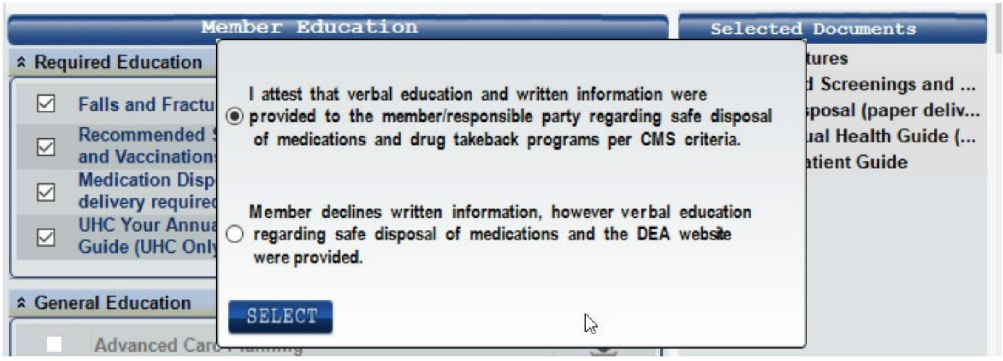
written information was left with the member, a secondary pop-up alert reminding you to leave the paper document will appear.



General Education

When expanded this section contains broad educational material available for the member. Once each desired item is selected, the arrow pointing down can be selected to view the educational material in PDF form. **Selected Documents** will be listed at the right, under **Selected Documents**.

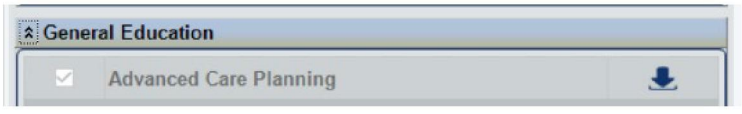


Auto Selected Education Documents

Some educational items can be auto populated based on documentation from other pages of the assessment.

When **"Commit to Quit" Left with Member** checkbox is selected on page 7, an auto selection of **Tobacco Cessation** will occur on page 16 under General Education.

In the Life Planning section on page 7, if **"Advanced Care Planning pamphlet left with member"** checkbox selection is **Yes**, then an auto selection of the **Advanced Care Planning** checkbox under General Education will occur on page 16. The selection will automatically filter under Selected Documents. If changes to this material selection are necessary, it is required to update the **Advanced Care Planning** section on page 7.



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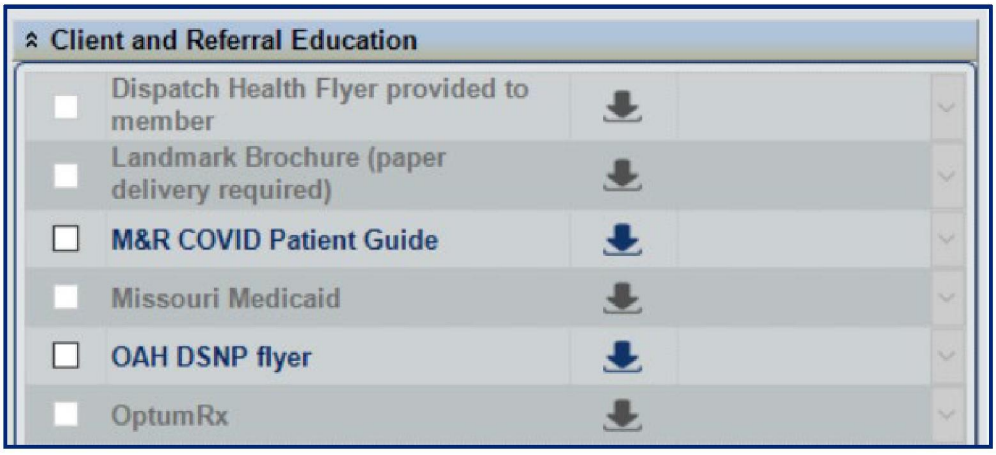
Client and Referral Education

In the Client and Referral Education section, it is necessary to open the dropdown arrow on the far right and then select Yes or No indicating material was selected for member. Client and Referral Education materials will only be available for selection if the member is eligible for the particular program. Otherwise, these selections will be disabled.



DSNP Educational Materials

Each year the Centers for Medicare and Medicaid Services puts together what is called 'final rule' regulations. Any time a practitioner refers a DSNP member to contact member services about an issue, such as needing a PCP, questions about the plan, etc. documentation must occur within the record. If you assist or instruct the Special Needs Plan members to contact member services for their questions or needs, please document this on page 16, in the free text box. The **Yes** or **No** dropdown selection will indicate if the printed leave behind materials were provided to the member. The selection of **OAH DSNP flyer** is mandatory when the member is flagged as OAH DSNP. A Mandatory Message will be generated if the documentation is incomplete. The selection is disabled for non-eligible members.

Landmark Longitudinal Care Management

The selection of **Landmark Longitudinal Care Management** materials left with member is mandatory when the member is flagged in the CRD tool for the Landmark Longitudinal Care Management referral. The **Yes** or **No** dropdown selection will indicate if the printed leave behind materials were provided to the member. A Mandatory Message will be generated if the documentation is incomplete. The selection is disabled for non-eligible members.

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Body System Education

The Body System Education section allows you to expand each system to view documents for selection by clicking on the down arrow. Preselection of the education material checkbox is not required in order to see the document as in the section above. This provides you with the opportunity to view the educational material before sending it to or leaving it with the member. Once each necessary item is selected, the arrow pointing down can be selected to view the educational material in PDF form. Selected Documents will be listed at the right, under Selected Documents.



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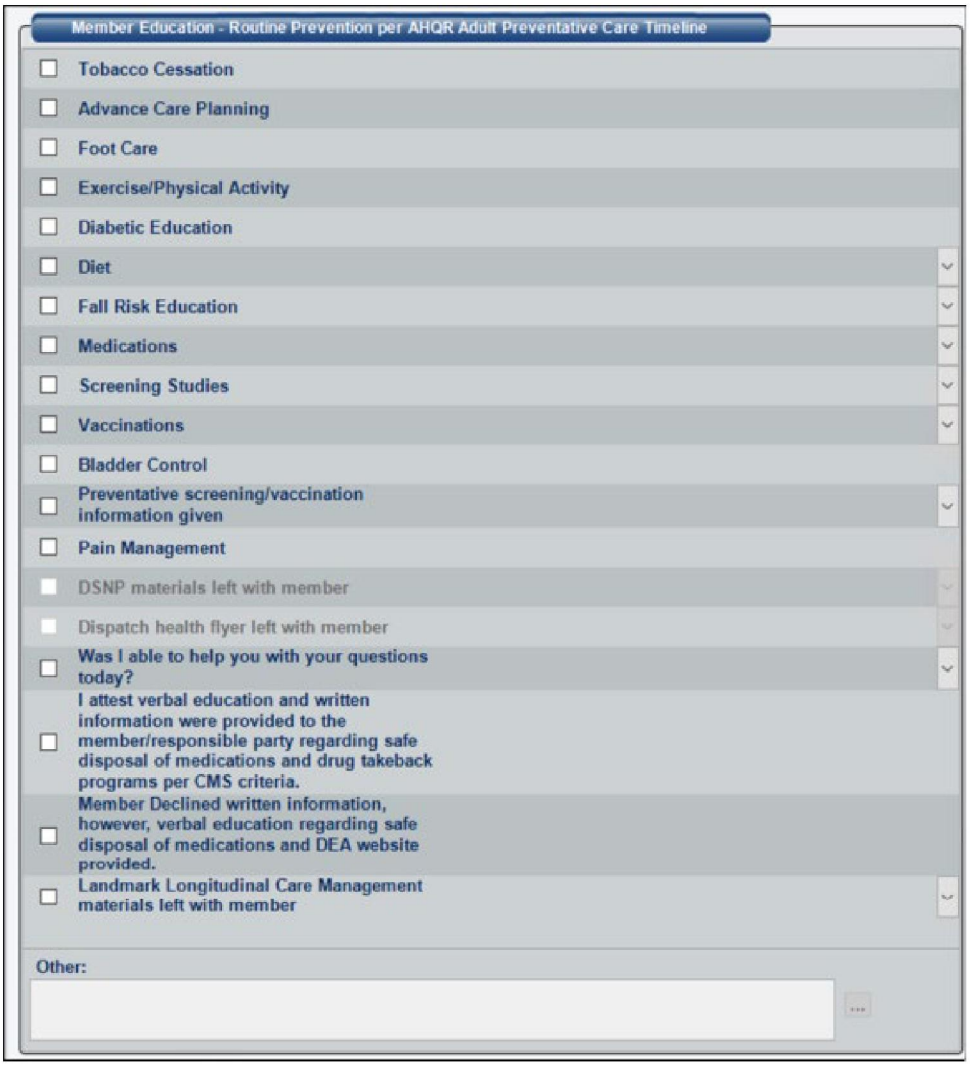

Other Education

The **Other Education** section contains selections should be reviewed for potential auto selections that have populated based on documentation in other areas of the assessment. Manual selections and deselections can occur as appropriate.

The **Other:** free text section is available to document education provided that does not have leave behind materials.



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Listening Checkpoint

"Was I able to help you with your questions today?" is mandatory for completion and documentation.

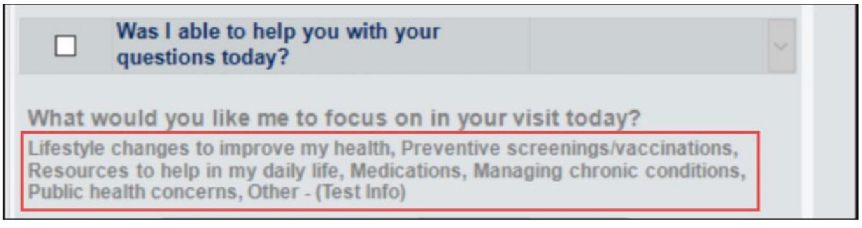
- Yes
- No
- No issues/Not applicable

All items selected from the page 1 question, ***What would you like me to focus on in your visit today***, will pre-populate to page 16 and the same value will be auto selected for the question ***Was I able to help you with your questions today?***. See example below:

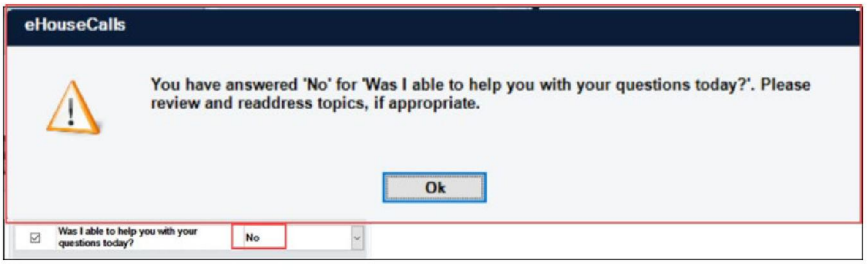
When you select **No issues/Not applicable** for the question, What would you like me to focus on in your visit today" on page 1, then on page 16 **No issues/Not applicable** will be auto selected for the question, Was I able to help you with your questions today?.



When you select **Other** and enter the member's response in the enabled text box for the question, What would you like me to focus on in your visit today? on page 1, then on page 16 the same response will be pre-populated to the question Was I able to help you with your questions today?.



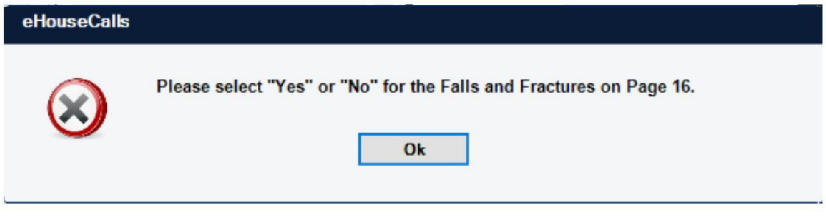
An alert message will display if the captured response from the page 1 question, What would you like me to focus on in your visit today?(**Excluding No issues/Not applicable**) disagrees with the selected answer on page 16. See example below: Alert Message, with No selected



Mandatory Messages and Hard Stop

Hard Stop

If page 16 is opened and the Required Education Yes/No dropdown selections are not completed, corresponding pop-up alerts will appear and act as a hard stop preventing navigation away from page 16 until the documentation is completed.



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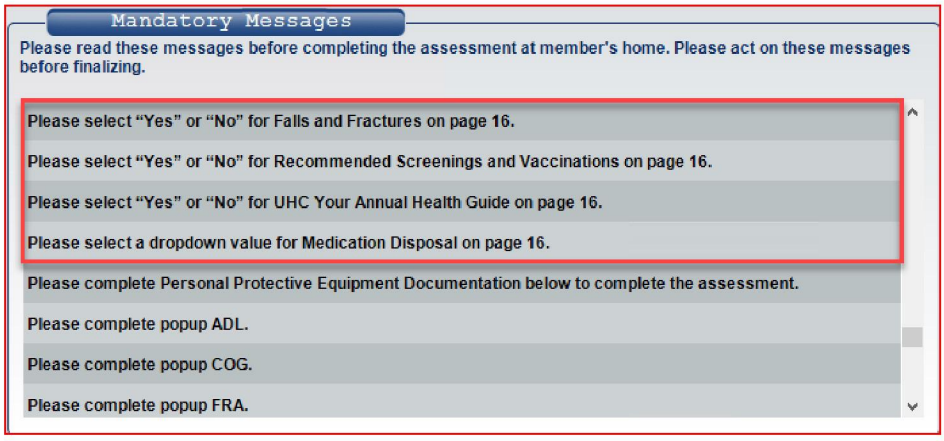
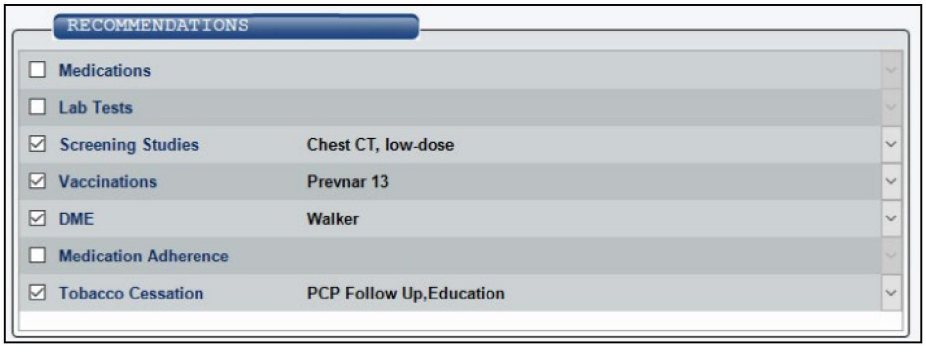
Mandatory Messages

If page 16 is not opened resulting in the Required Education documents Yes/No dropdowns not being addressed Mandatory Messages will be displayed on page 18.



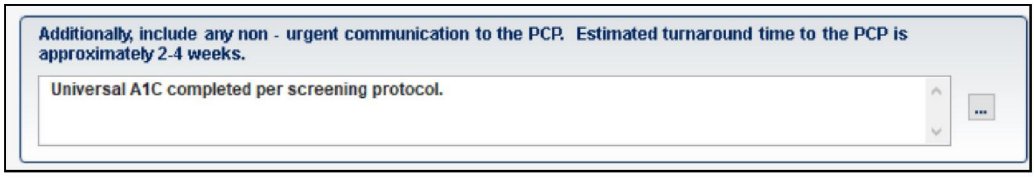
Recommendations

The **Recommendations** grid allows you to identify specific recommendations through multi-select drop-down lists. Always review the pre-selected items, before documenting this section as some of the recommendations will be auto selected based on your information already entered the tablet. You must select a recommendation box by checking the box to enable the drop-down option choices.



Non-Urgent Communications

The **Additional Collaboration** text field (below) allows you to document any additional non-urgent communications to the PCP. It is not a request for follow-up or assistance. This is also where you would document any information you would like included in the letter that is sent to the PCP



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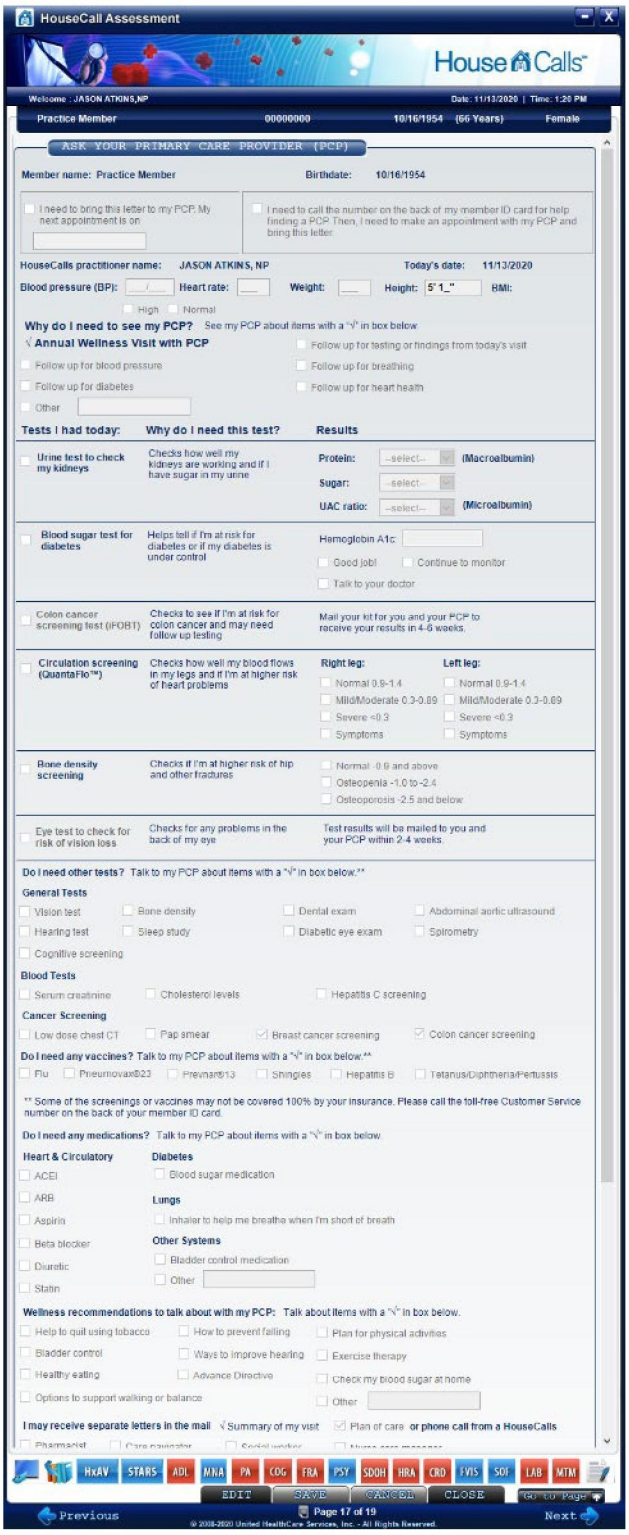
DOCUMENTING ASSESSMENT PAGE 17

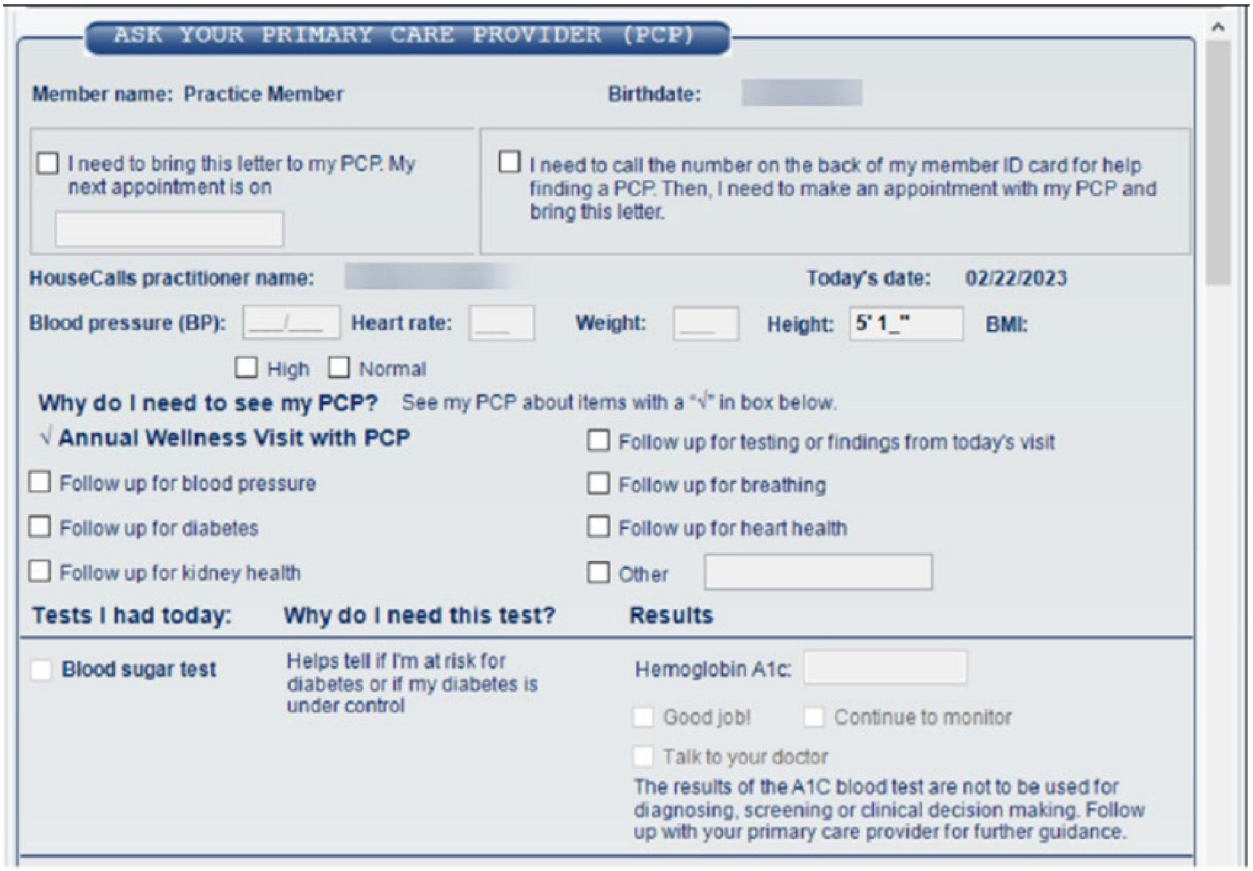
On page 17 of the assessment, you will discuss and document the **Ask Your PCP Letter.**



Ask Your PCP Letter

The **Ask Your PCP (AYPCP) Letter** page on the tablet is an electronic duplicate of the paper AYPCP letter, which is left with the member after the visit. This letter is not sent to the member's PCP, so be sure to document the same items on both, the paper and electronic AYPCP forms.

You should ensure that completed screenings and/or recommendations should be noted on the AYPCP Form.



IF YOU MAKE ANY CHANGES TO ANY OF THE SCREENINGS WITHIN THE APPLICATION, THE CHANGES WILL BE REFLECTED ON THE AYPCP PAGE. YOU WILL BE RESTRICTED FROM DESELECTING THE TRIGGERED RULE OR SELECTED OPTION IF NOT CORRECTED PRIOR TO PAGE 17. YOU WILL ALSO SEE ALERTS ASKING IF YOU ARE SURE YOU WANT TO DESELECT

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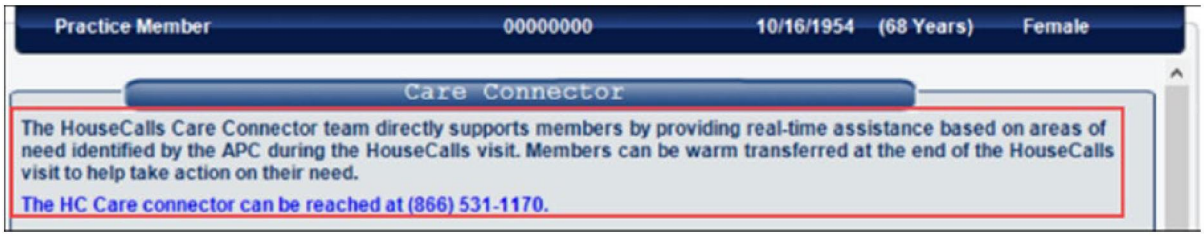
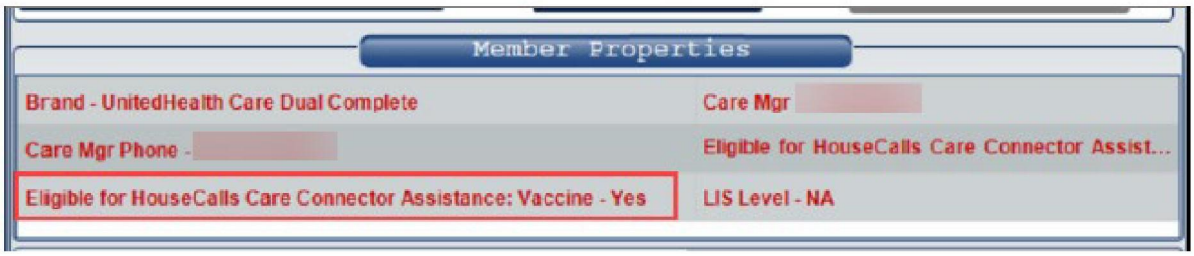
DOCUMENTING ASSESSMENT PAGE 18

On Page 18 of the assessment you will document **HouseCalls Care Connector referrals** for eligible members. You will document HouseCalls Care connector Assistance for SDOH and Vaccines. If members are not eligible for HouseCalls Care Connector Assistance, the page will be disabled.



HouseCalls Care Connector Assistance

Eligible members will have the HouseCalls Care Connector Assistance section enabled for documentation. Eligibility can be viewed in Member Properties on page 1.



Social Needs HouseCalls Care Connector Assistance

The Care Connector Program utilizes a HouseCalls team dedicated to providing members with assistance for identified needs. When the member has a social need identified, the following process will be used to complete the referral:

1. Confirm member eligibility on page 1
2. Complete SDOH and CRD tool documentation in eHouseCalls
3. Obtain the members acceptance of the SDOH/Social Needs referral in the CRD tool in eHouseCalls
4. If member declines SDOH/Social Needs referral, section on page 18 will disable
5. If Member agrees to SDOH/Social Needs referral in CRD tool, deselect any social needs member does not want addressed if applicable. Select **Yes** to **Member agrees to post-visit follow-up call(s)**
6. Select member's **Yes/No** response for **Would you like to speak with someone who can assist you with your social needs**
7. Complete warm transfer process using the member's phone (with their permission)
   - If member declines the warm transfer, document **No** in the HC Care Connector Assistance section to **Member accepts warm transfer** and select a reason from the **Please Specify Reason(s) for Declination** dropdown menu. Referral will then be sent electronically through the CRD tool to a UHC support team for a follow-up phone call

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When a member accepts the warm transfer, a selection is required for either Successfully completed warm transfer to HC Care Connector or Attempted warm transfer, but unable to connect with HC Care Connector

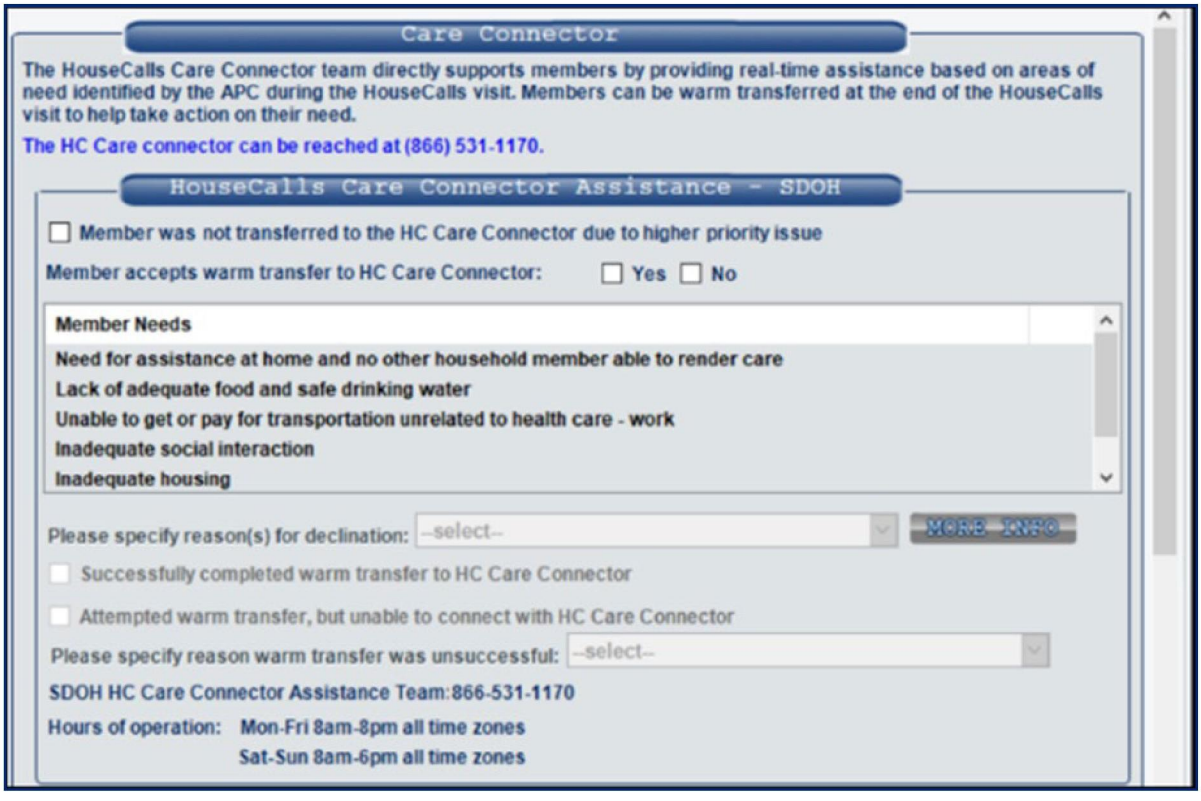
Check box **Member was not transferred to the HC Care Connector due to higher priority issue** will be enabled and auto selected, if member has any of the below urgent SW referral reasons documented or referral to Landmark or Prospero and member has accepted the referral:

- Danger to self or others
- Severe agitation
- Severely unstable mental health
- Suicidal with or without a plan
- Suspected abuse or neglect
- PHQ9 score 15 to19
- PHQ9 score 20 to 27
- Child in care of incapacitated adult

This will disable the rest of the section.

HC Care Connector Phone Numbers

For an ***eligible*** member, phone number of Care Connector on page 18 is displayed.
For an ***ineligible*** member, phone number of Care Connector on page 18 will be hidden.



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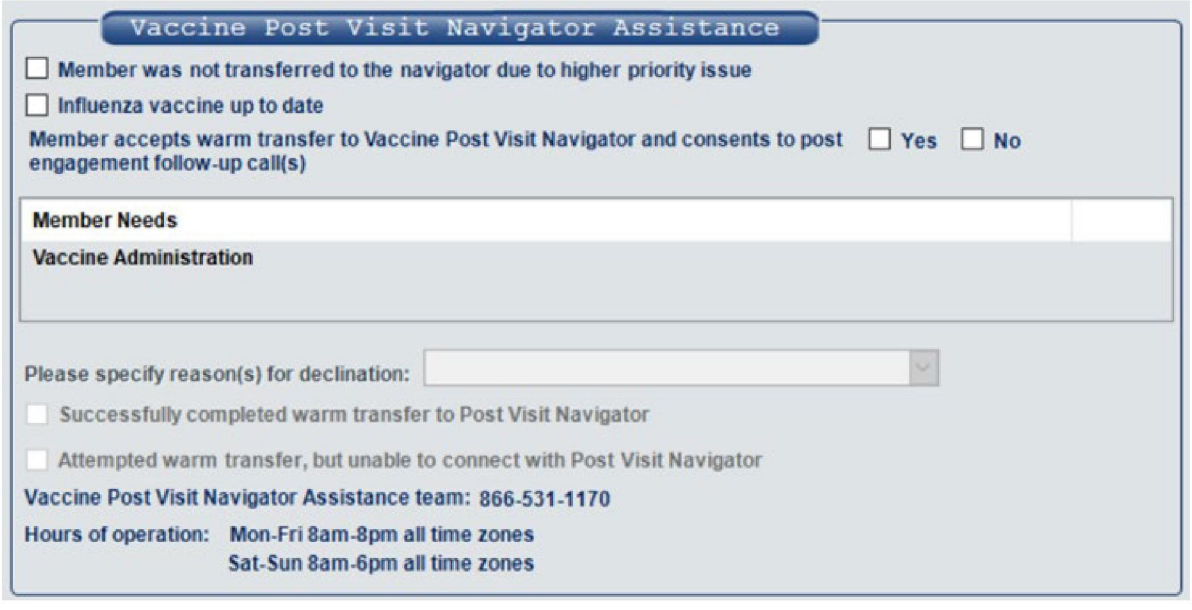
HouseCalls Care Connector Assistance - Vaccine

This section is enabled when an eligible member is due for an influenza vaccine. The following steps are used to document the section:

1. Confirm member eligibility on page 1
2. Complete page 5 Vaccination documentation to determine if member is up to date on influenza vaccination.
3. If member is up to date on influenza vaccine, on page 18 within the Vaccine Post Visit Navigator section, select the checkbox **Influenza vaccine up to date**. The section will disable, and no further action is needed.
4. If the member is not up to date on the influenza vaccination, ask member **Would you like to speak with someone who can assist you with obtaining a flu vaccine?**
5. Complete warm transfer process using the member's phone (with their permission).



When a member accepts the warm transfer, a selection is required for either **Successfully completed warm transfer to HC Care Connector**, **Attempted warm transfer, but unable to connect with HC Care Connector.**

If a warm transfer is not completed, a reason will need to be selected from the **Please Specify Reason(s) for Declination** dropdown menu.

Check box **Member was not transferred to the navigator due to higher priority issue** will be enabled and auto selected, if member has any of the below urgent SW referral reasons documented or referral to Landmark or Prospero and member has accepted the referral:

- Danger to self or others
- Severe agitation
- Severely unstable mental health
- Suicidal with or without a plan
- Suspected abuse or neglect
- PHQ9 score 15 to19
- PHQ9 score 20 to 27
- Child in care of incapacitated adult

This will disable the rest of the section. The checkbox can be manually selected the checkbox if there is another urgent, higher priority issue, such as an urgent medical issue. The checkbox can only be de-selected if it was manually selected.

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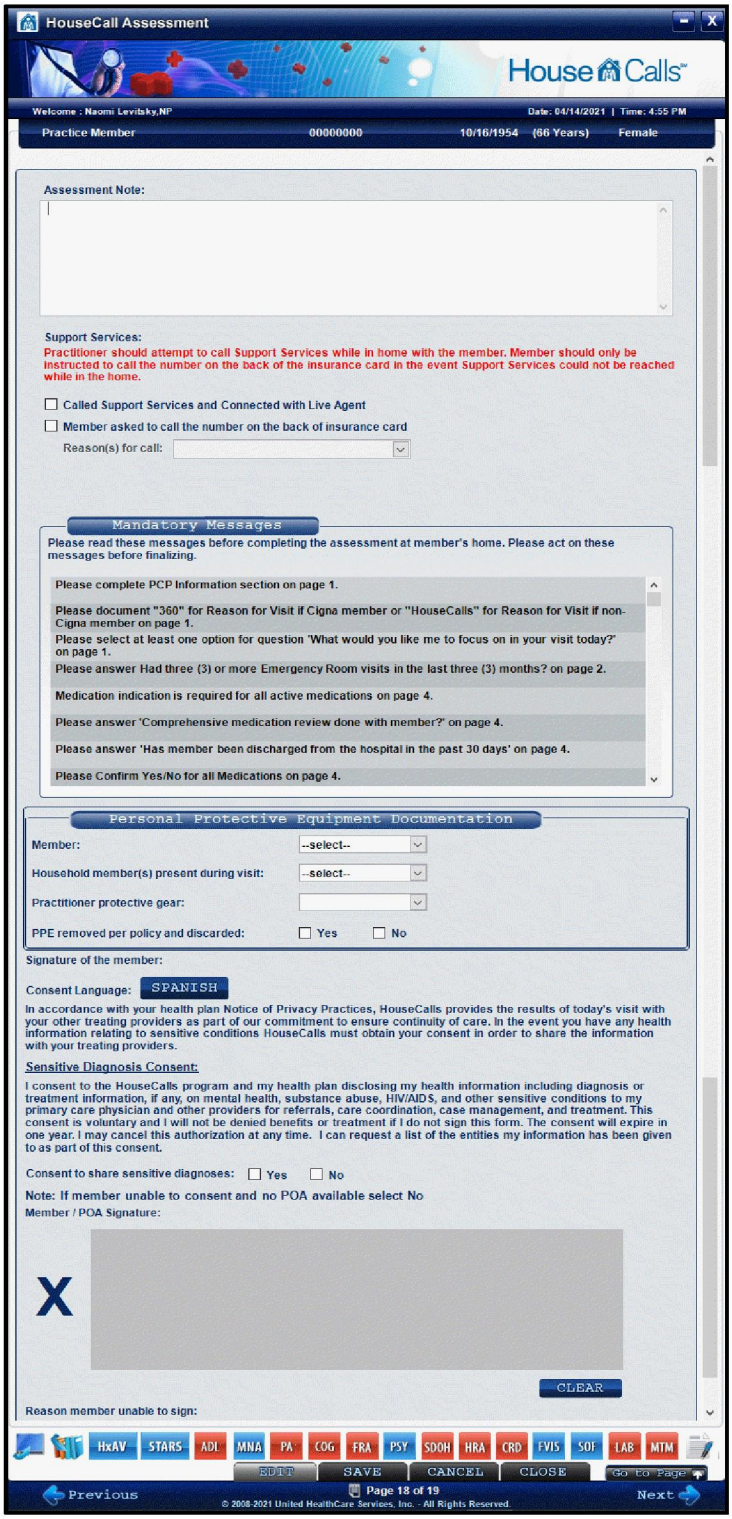
DOCUMENTING ASSESSMENT PAGE 19

On page 19 of the assessment, you will document any additional **Assessment Notes**, address **Support Services** (if applicable), resolve **Mandatory Messages**, document **Personal Protective Equipment** use, discuss **Sensitive Diagnosis Consent**, and obtain the **Member's Signature.**



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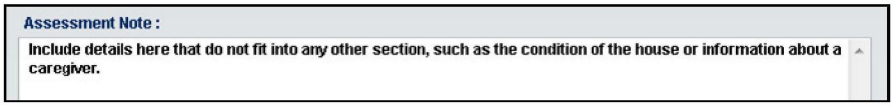
Assessment Notes

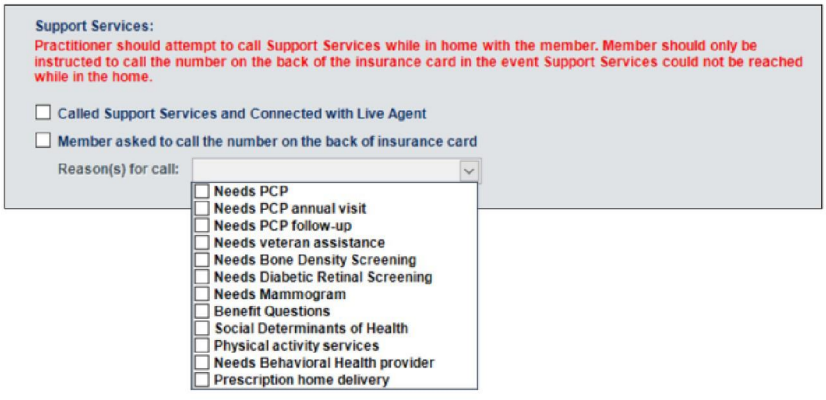
The **Assessment Notes** textbox enables you to input additional notes, details, or information that you were unable to document elsewhere in the assessment during the visit.

THE ASSESSMENT NOTES TEXTBOX CAN BE ACCESSED FROM ANY PAGE IN THE ASSESSMENT BY CLICKING ON THE ASSESSMENT NOTES ICON LOCATED ON THE DIAGNOSTIC TOOLBAR AT THE BOTTOM OF EACH ASSESSMENT PAGE.

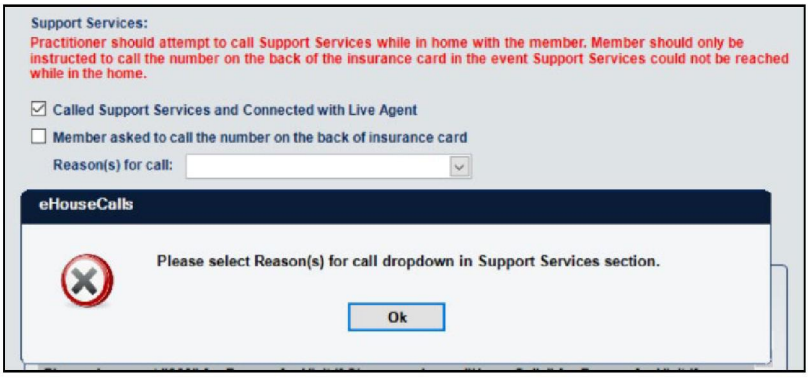


Support Services

The **Support Services** section allows for documentation if you call Support Services and Connect with a Live Agent during the visit or is you instruct the member to call the back of their card for assistance. The **Reason(s) for call dropdown** menu will become enabled and will be used to select the reason for the call to either Support Services or the number listed on the back of the insurance card. The Reason(s) for call dropdown list is multiselect and all reasons for the call should be selected. The options will be visible based on the line of business. Auto-selections may occur in the Support Services area based on documentation in the assessment. There may also be text visible displaying the phone number and/or hours of operation for Support Services that will be based on the member's plan.



A pop-up alert will occur when the checkbox for either **Called Support Services and Connected with Live Agent** or **Member asked to call the number on the back of insurance** is selected and a reason is not selected from the **Reason(s) for call** dropdown menu.



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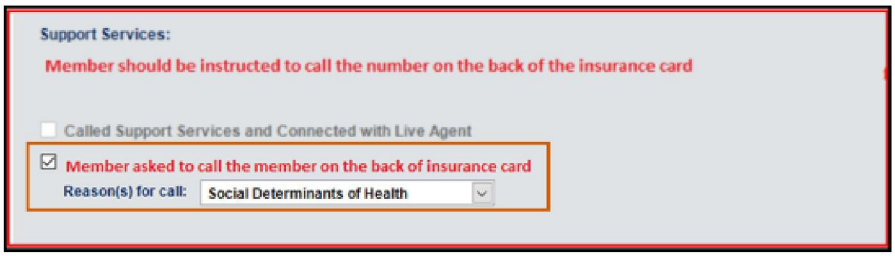
Special Circumstances

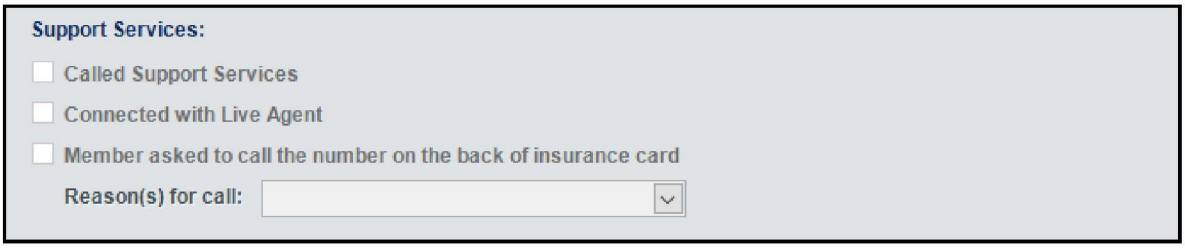
Based upon the member's health plan, the Support Services section may display differently. In some plans, the member may not be eligible for Support Services and other established processes may be used. It is important to always review the Job Aid for any Non-UHC plans to familiarize yourself with the Support Services process for any particular plan.

You may see instructional text in the section, auto-populations from the SDOH tool, or plan related information displayed including plan contact information, phone number, and/or hours of operation.



A pop-up alert will occur if an attempt is made to deselect any auto-selected checkboxes in Support Services that have been generated based on documentation in the assessment.

If the member is enrolled in a plan type that has chosen not to activate support services, then all the Support Services fields will be disabled and grayed out. You should refer the member to the number on the back of their insurance card for assistance. Additionally, the Services Contact Number and hours of operation may display in the Member Properties section of the assessment.



Advocate4Me

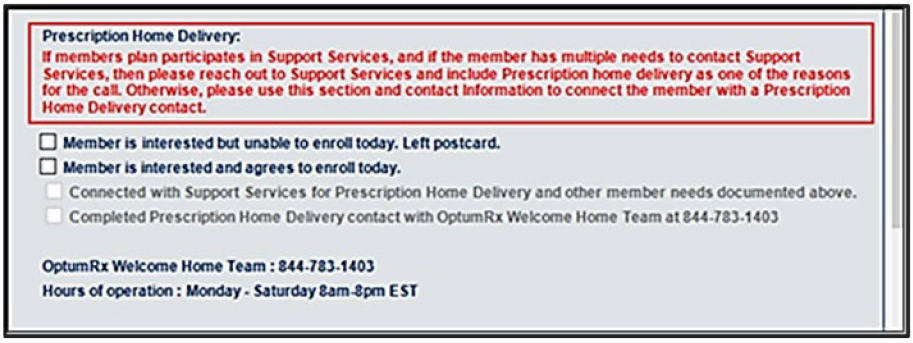
For any UHC M&R member (Individual, Group), in the support services section you will see the following:

- M&R Support Services – **866-221-6030**
- M&R Hours of Operation – **Monday through Friday 7am to 5pm CST**

Similar, customized contact information will appear for UHC C&S members.

Prescription Home Delivery

The Prescription Home Delivery Section is enabled for documentation.



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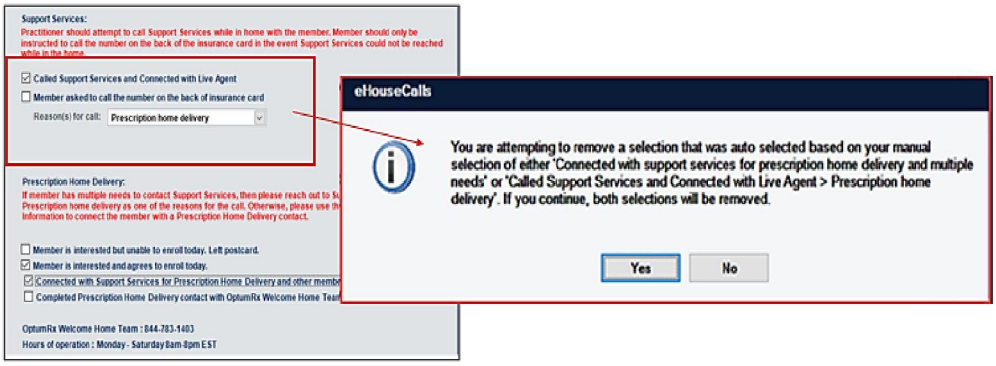
Member In Scope

When the member is In Scope for Prescription Home Delivery and is interested in enrolling, the following options are available for selection.

- Member is interested but unable to enroll today
- Member is interested and agrees to enroll today

If **Member is interested and agrees to enroll today** is selected, the following options will become enabled and will require a selection. Options available for selection include:

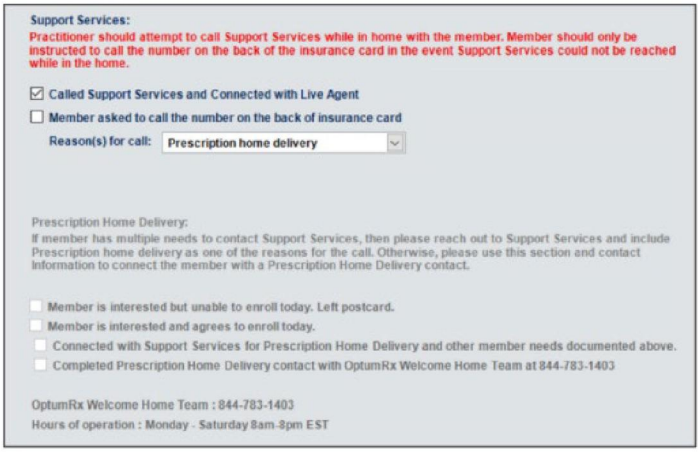
- Connected with Support Services for Prescription Home Delivery and other member needs documented above.
  - This option should be selected when the member desires to enroll in Prescription Home Delivery and also has additional Support Services needs.
  - If this option is selected, an auto-selection in Support Services will occur of **Called Support Services and Connected with Live Agent** and **Reason(s) for call** dropdown of **Prescription Home Delivery**. A warm transfer to Support Services should then be completed to facilitate the member's enrollment in Prescription Home Delivery and the addressing of the member's additional Support Services needs. A pop-up alert will occur if attempting to deselect the auto-selections.



- Completed Prescription Home Delivery contact with OptumRx Welcome Home Team at 844-783-1403
  - If this option is selected, a warm transfer to OptumRx should be completed to facilitate the member's enrollment in Prescription Home Delivery

Member is Not In Scope

The Prescription Home Delivery Section will be present but disabled in gray font when the member is Eligible for Prescription Home Delivery and is not In-Scope. If the Prescription Home Delivery Section is disabled, and the member desires to enroll in Prescription Home Delivery, the Support Services section will be used to document the contact to Support Services for Prescription Home Delivery.



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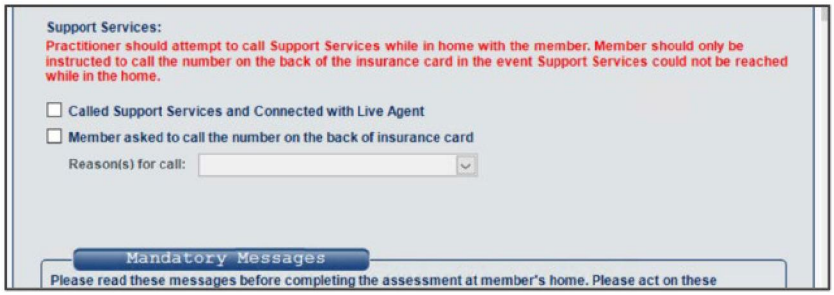
Member is Not Eligible

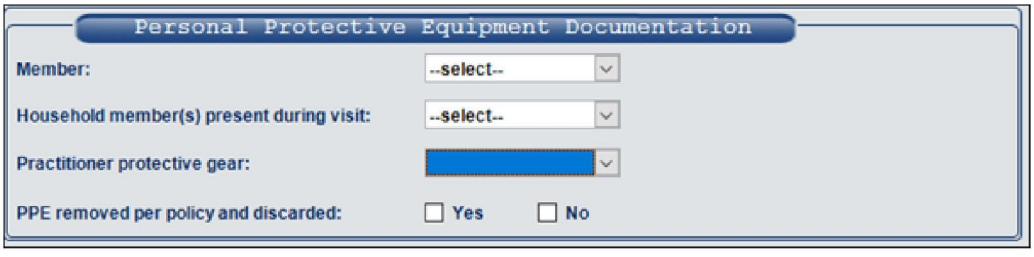
If the member is not eligible for Prescription Home Delivery, then the Prescription Home Delivery section will not be present.



Mandatory Messages

The **Mandatory Message** grid lists all the items that need to be addressed before you leave the member's home. This will also flag areas within the assessment that may not have initially required a hard-stop, but still need to be addressed You will not be able to finalize the assessment unless all Mandatory Messages are addressed.

Personal Protective Equipment Documentation



There are dropdowns selections here to document the PPE worn by the member, household member, and the APC. On the Member dropdown there are selection options to document whether the member wore mask or declined to wear mask. There is also a dropdown for Household member-where you will document if the household member was present and if they wore a mask. The next dropdown is for PPE worn by the APC and has multi-select options to document the PPE you wore during the visit. None worn is also available, but it is mutually exclusive to the other options, so if you select none worn you will not be able to make any other selections.

You will also see the question PPE removed per policy and discarded with yes and no checkboxes.



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Clear Transparent Face Masks

Clear transparent face masks are required to be worn when performing visits with deaf or hearing-impaired members. These masks are available for order on the Practitioner Portal.

KEEP UP TO DATE WITH LEADERSHIP COMMUNICATION CONCERNING PPE UTILIZATION AND DOCUMENTATION REQUIREMENTS FOR PPE UTILIZATION.

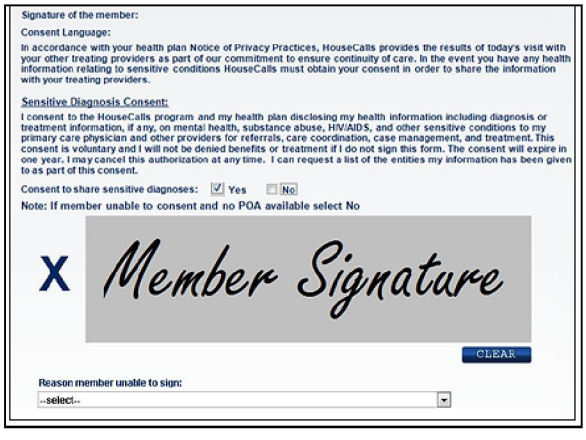
Sensitive Diagnosis Consent

In order to comply with Federal and State privacy laws, there are diagnoses that have been identified by our company's legal and clinical teams as "sensitive diagnoses". Examples of these are include STDs, HIV, substance abuse disorders, gender identity, intellectual disabilities, assault, and self-harm. The member has the choice as to whether sensitive diagnoses are included in the Visit Summary sent to the PCP. The question whether the member agrees to the release of sensitive diagnoses is **required to be asked and documented for every member**. A "No" response does not negate the HouseCalls visit or affect any insurance benefits or coverage.

The eHouseCalls assessment also provides an option to switch the consent language from English to Spanish.

Member Signature

The **Member Signature** grid of the assessment is where the member should sign when the visit is completed. If the member is unable to sign, a reason is required to be selected from the Reason drop-down box.
If a paper assessment was used and the information must be transcribed back into the tablet, select the reason, "Assessment completed later, thus no member signature".
The member signature can be acquired at any time during the visit- it is confirming you started the visit with the member in their home.



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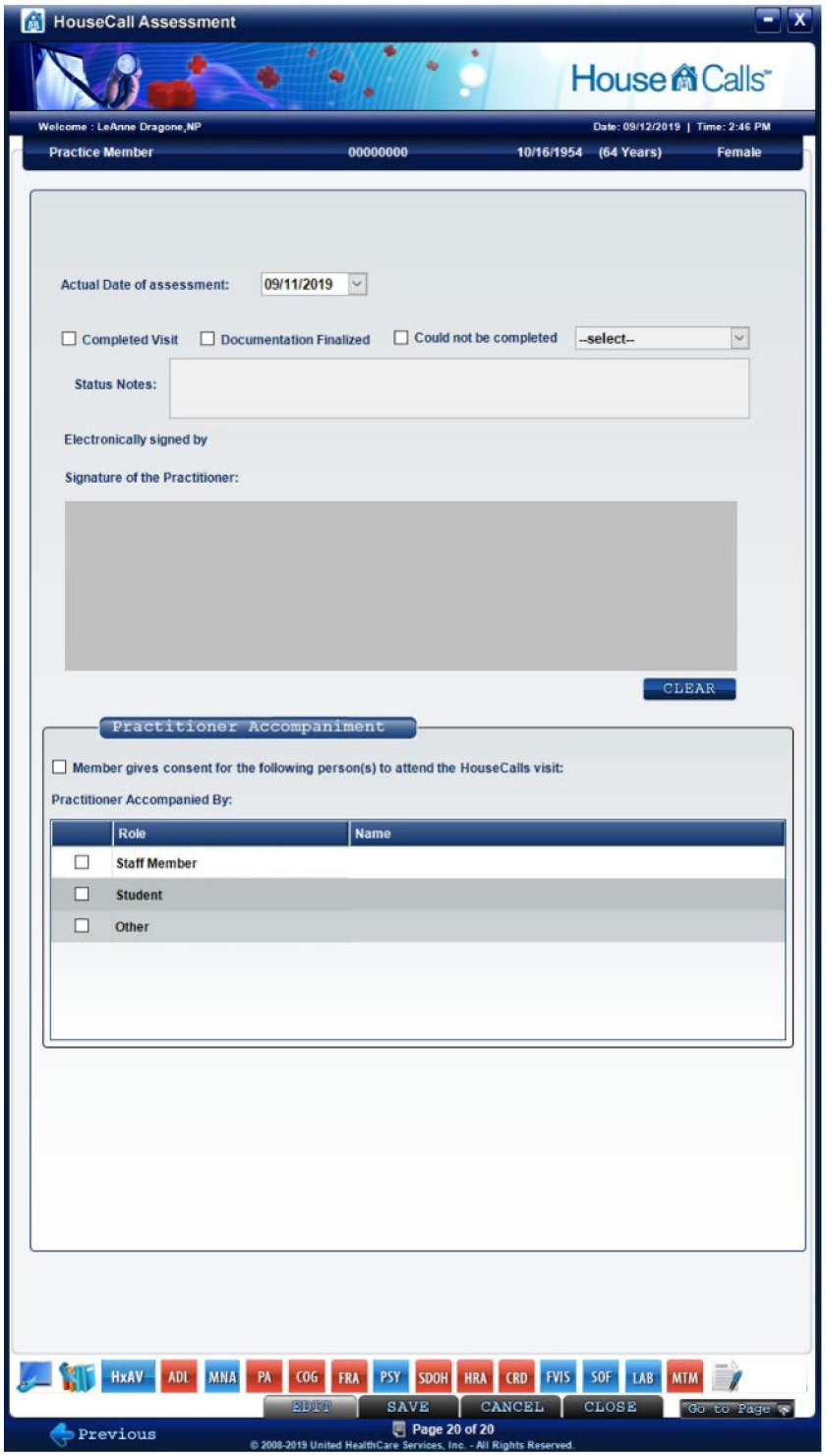
DOCUMENTING ASSESSMENT PAGE 20

On page 20 of the assessment, you will select the date of the assessment, whether the visit was Completed, Finalized, or Could Not Be completed, document any Practitioner Accompaniment, and input your personal electronic signature. ***Always remember to Sign, Finalize, and then Save.***



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Status

Selecting one of the check boxes at the top of the page assigns a status to the assessment:

- **Completed Visit** - A status indicating you have completed the visit and reached the end of the assessment but may want to add or edit before submitting as Documentation Finalized.
- **Documentation Finalized** - When you are satisfied that all information has been collected completely and accurately, you need to finalize the assessment. Finalizing the assessment notifies us that the assessment is fully complete and ready to be uploaded to all our internal systems. The expectation is that all assessments will be finalized within 24-48 hours after the visit.

AFTER FINALIZING, A SYNCHRONIZATION NEEDS TO BE COMPLETED IN ORDER TO SEND/SUBMIT THE ASSESSMENT.

- **Could Not Be Completed**- This checkbox should only be selected in instances where you **start** a HouseCalls Visit with a member but could not complete or finish documenting the assessment.

Available options include:

- Called 911
- Member ill and requested to stop the visit
- Household Emergency
- Member refuses to continue with the visit
- Practitioner feels unsafe
- Practitioner Emergency
- Weather Emergency
- Practitioner Feels Unsafe – Request Do Not Visit

Signature

Your signature should match your name as it appears in the assessment. For example- if Florence Nightingale, NP is listed on the assessment, you would sign your assessment the exact same way.

Practitioner Accompaniment

If Optum approves accompaniment for the HouseCalls visit, the **Practitioner Accompaniment** grid must be documented. **Only Optum/HouseCalls approved accompaniment is permitted.** If a third party is present during the visit, such as a CTM ride-along, the member must give consent. Document consent by checking the appropriate box in the **Practitioner Accompaniment** section.



Save

The **Save** button at the bottom of the page will add you work to the document and update the status you chose at the top of the page. It is the very last step to complete or finalize the assessment and end the visit with the member.

Remember : Sign → Finalize → Save

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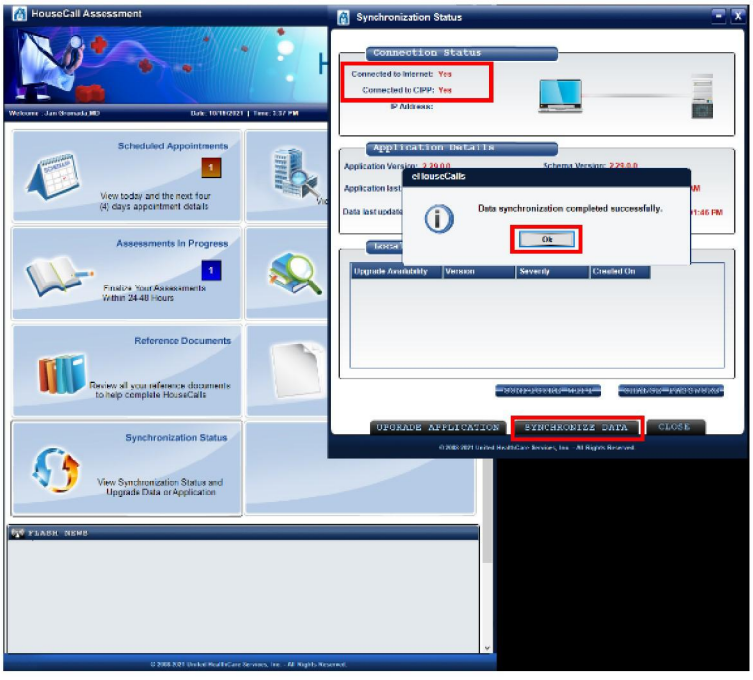
AFTER THE VISIT

Verifying a Successful Finalization & Sync Tablet

1. Click the **Scheduled Appointments** bucket from the Dashboard.
2. From the **Appointments** window (use the left to right scroll bar) and locate the **Status** column, the verbiage should show: **Documentation finalized**.



3. To send a finalized assessment to the Optum server to be QA'd, navigate back to the Dashboard, and click the **Synchronization Status** bucket.
4. Verify the red **Yes, Yes** at the top of the screen and then click **Synchronize Data** from the bottom of the window, and then **Ok** when it has been completed successfully.



CONNECTED TO INTERNET: YES (INDICATES SUCCESSFUL INTERNET CONNECTION) AND CONNECTED TO CIPP: YES (INDICATES SUCCESSFUL CONNECTION TO THE VPN). IF EITHER STATE NO, EITHER RECONNECT TO INTERNET OR AUTO VPN

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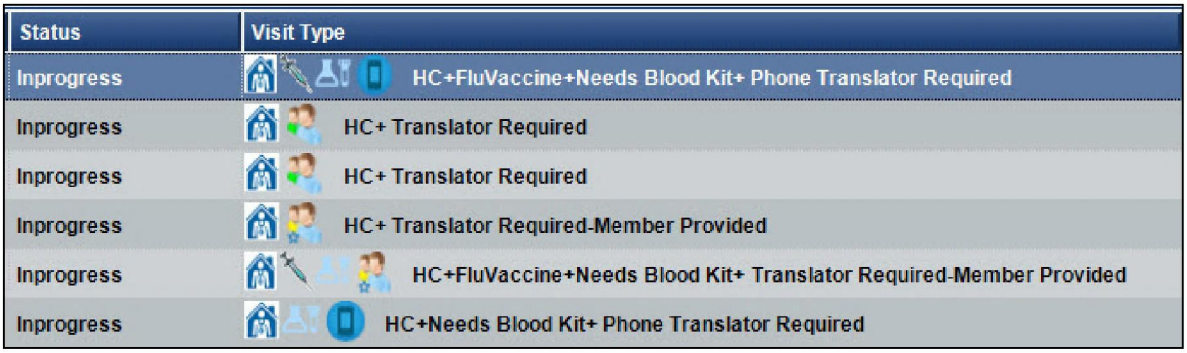
INTERPRETER/TRANSLATOR MEMBER VISIT

In the **Scheduled Appointments** bucket on the dashboard, the ***Visit Type*** column provides additional important details about the visit. Visit Type information includes details on whether a member will provide a sign language interpreter for the visit, whether HouseCalls will need to provide the interpreter for the member, or if language translator will need to be dialed from your work cell phone. This column will also identify if a member is scheduled to receive PVD screening, Blood Kit, or FOBT LGC Kit.



Status	Visit Type
Inprogress	HC+FluVaccine+Needs Blood Kit+ Phone Translator Required
Inprogress	HC+ Translator Required
Inprogress	HC+ Translator Required
Inprogress	HC+ Translator Required-Member Provided
Inprogress	HC+FluVaccine+Needs Blood Kit+ Translator Required-Member Provided
Inprogress	HC+Needs Blood Kit+ Phone Translator Required

Virtual Visits

Clinicians who are trained to complete Virtual Visits via FaceTime, Google Duo, and/or Sight Call will document member information with some unique documentation requirements. Alternate methods of documentation and custom drop-down options are needed to complete the assessment because you are not physically present with the member.

Accessing Member Visit

Virtual Health (with a location) will be visible in two areas- In the **Member Details** and the **Location Address**. All virtual visit members are scheduled directly to you and will appear in the **Scheduled Appointment** location.

1. Open the **Scheduled Appointments** bucket from the Dashboard
2. Select **Virtual Health** from the Visit Location drop box
3. Select a **start** and **end date** for the search
4. Click **Search**

Time Slots

In Scheduled Appointments, the Member Time Slot column and the Practitioner Time Slot column will display when the member and APC are in different time zones.

By viewing the Practitioner Time Slot column, the APC will be able to accurately view the schedule of visits even when the scheduled members live in different time zones. Visits impacted by different time zones will be highlighted. This should prevent overlap of appointments due to time zone differences.

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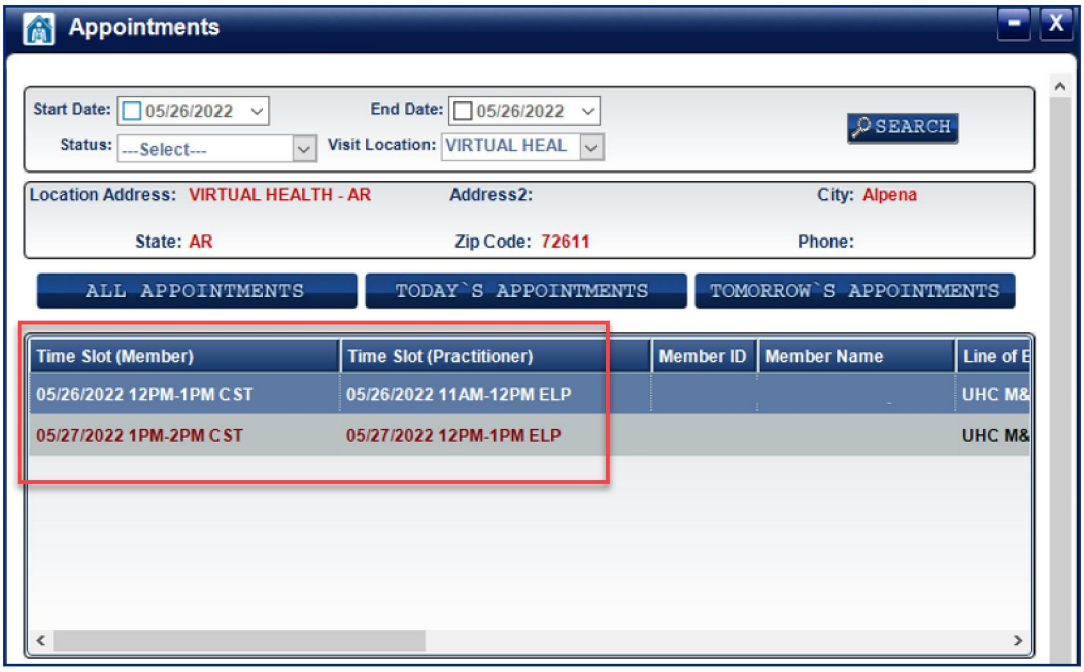
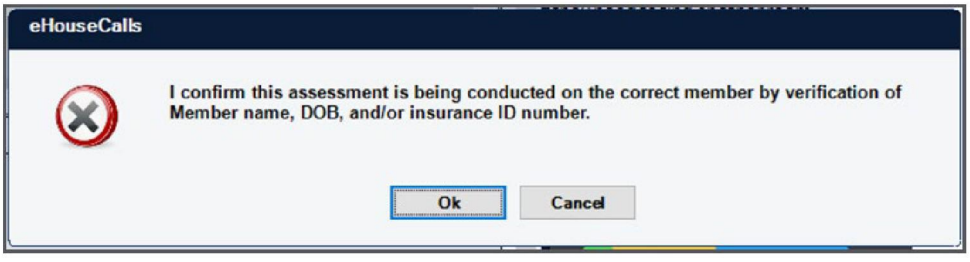


Member Authentication

At the start of the visit, verify members by asking their name, DOB and/or insurance ID number in the same manner as F2F visit because HIPAA rules still apply. If members are not in a private room, advise them you will ask personal questions related to their health and ask if they need to relocate to another room.



Page 1

HIPAA Privacy Notice Documentation

The form is completed by selecting the Yes checkbox for "Is this a virtual visit." The Member/Patient unable to initial and Reason field will then generate auto-selections. The member will be directed to the HIPPA Privacy Notice online website as indicated in the form. The member will also be offered a paper copy of the HIPPA Privacy Notice. You will then select the Yes checkbox that the member has been advised of the website and of the opportunity to have a paper copy mailed upon their request. You will then Select SAVE to complete the documentation and continue with page 1.

THE PRIVACY NOTICE CAN BE ACCESSED THROUGH A LINK ON PAGE 1 AT THE TOP OF DEMOGRAPHIC INFORMATION SECTION.

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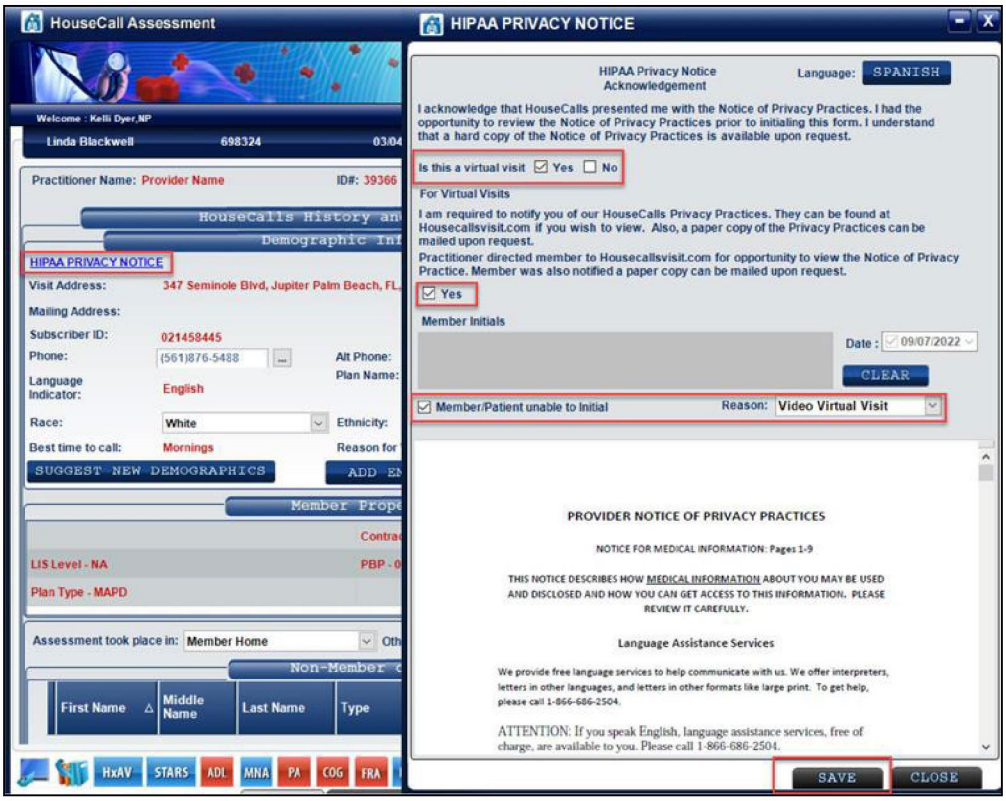
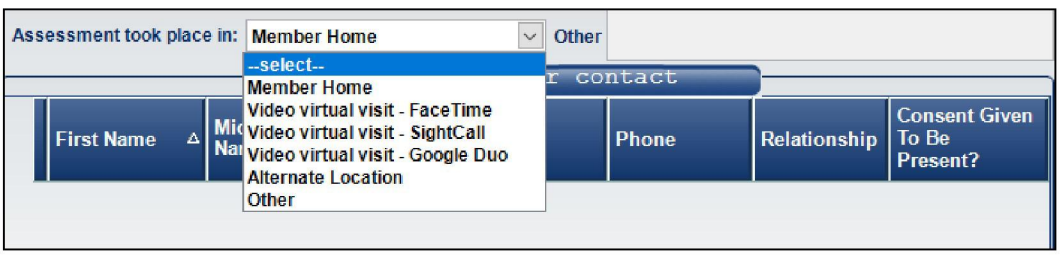


Assessment took place in field provides several options for the location of the visit:

- Member Home
- Video Virtual Visit – Facetime
- Video Virtual Visit – Google Duo
- Video Virtual Visit – Sight Call
- Alternate Location
- Other

The **Visit Type** field may be pre-populated, but you will have the option to update it, if needed.



When the location is changed from in person to virtual visit, an alert will appear stating:
You are trying to change 'Assessment took place In' from Member Home to Video virtual visit-Facetime. Changing 'Assessment took place in' to Virtual visit will delete any previously entered data". An alert will also populate if you change Virtual platform to in person.

YOU MAY FIND VERBIAGE REFLECTING REFERENCE TO POST-ACUTE STATUS, BUT THIS WOULD ONLY BE FOR A POST DISCHARGE VISIT.

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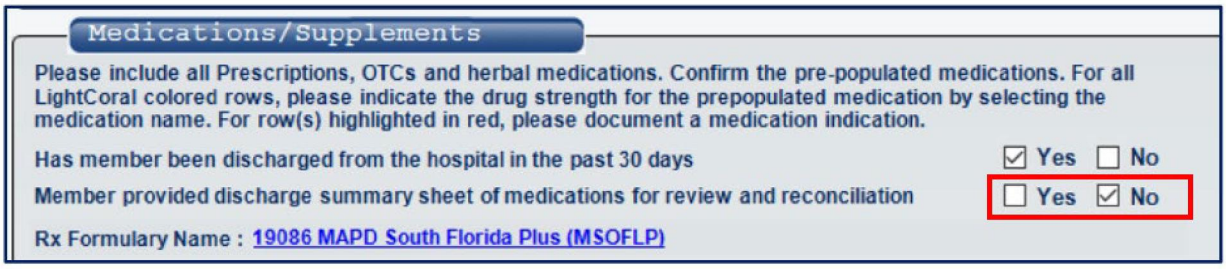
Medication Page

If the member is flagged as a PDV visit (Post Discharge), select **NO** for **"Member provided discharge summary sheet of medications for review and reconciliation".**



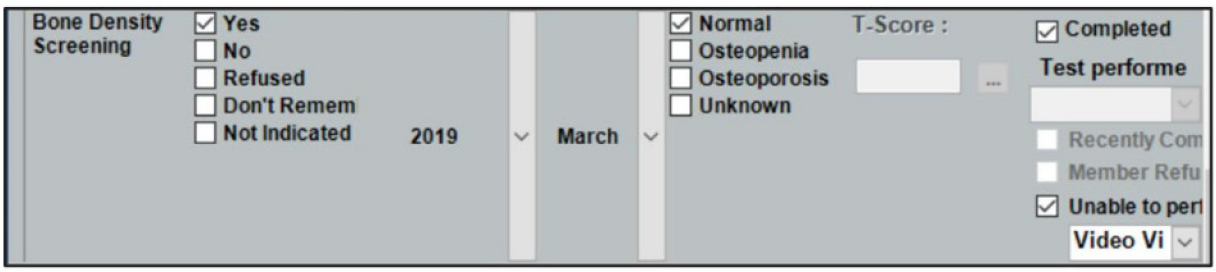
Preventative Screenings

Information for Preventative Screenings will be collected and documented with the exception of documentation for OMW, and DRE screenings flagged to be completed in the home. When a Virtual Visit modality is selected from the **Assessment took place in** dropdown menu on page 1, auto-selections will occur in the Preventative Screenings grid for members flagged for OMW or DRE.

Unable to Perform Details

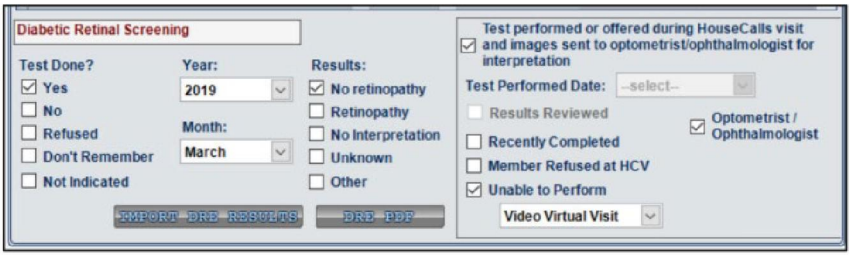
When a Virtual Visit modality is selected for a member flagged for OMW testing, auto-selection of **Completed** and **Unable to perform-Video Virtual Visit** will occur. Any previous Bone Density Screening information that the member can provide should be documented.

Bone Density Screening



Diabetic Retinal Screening

When a Virtual Visit modality is selected for a member flagged for DRE testing, auto-selection of **Completed** and **Unable to perform-Video Virtual Visit** will occur. Any previous Diabetic Retinal Screening information that the member can provide should be documented.



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- **UNDER BONE DENSITY, DO NOT DOCUMENT ANYTHING UNDER THE ADDITIONAL INFO OR PROVIDER COLUMNS.**
- **FOR DIABETIC RETINAL EXAM, DO NOT ENTER ANYTHING UNDER THE PROVIDER INFO SECTION. HOWEVER, YOU MUST STILL DOCUMENT THE OPTOMETRIST/OPHTHALMOLOGIST FIELD IF THE MEMBER HAD AN EXAM.**

Review of Systems (ROS)

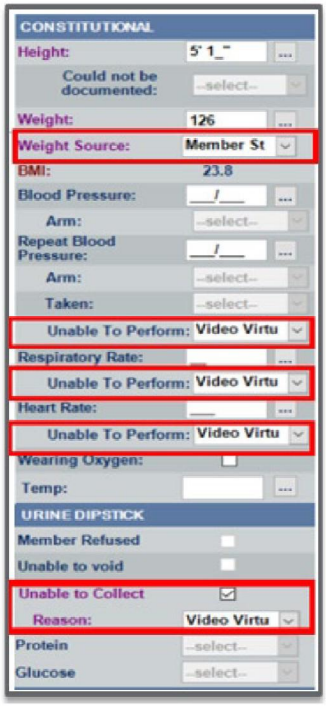
- Conduct a robust ROS – Identify member needs and educate
- Type member reported values (BP or blood sugar results) in the ROS notes as needed

Physical Exam (PE)

For any system documented a drop-down list for the **Unable to Perform** selection provides reasons for the selection, including **Video Virtual Visit**.

Vital Signs & Constitutional

- For General Appearance, document what you see via the video
- For Blood Pressure, Respiratory Rate and Heart Rate- Video Virtual Visit will pre-populate. The NCQA allows blood pressure readings from digital cuffs when taken by the member and reported during a virtual or telephonic visit. If a blood pressure is obtained in this manner by the member during the Video Virtual Visit should be recorded in the Blood Pressure field and in the Repeat Blood Pressure field if repeated. When recording a blood pressure obtained by the member during the Video Virtual Visit, the Assessment Notes may be used to indicate that the blood pressure was obtained by the member. The Member weight source should be documented as "member stated."



- For elements that cannot be completed, Unable to Assess will prepopulate (i.e., *Monofilament, Vibratory* and/or *Achilles Reflex*)
- When documenting in the Notes section do not use abbreviations

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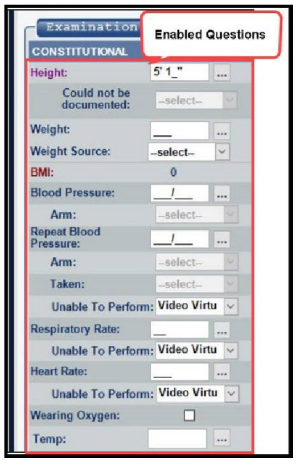
When the visit type is set to **Video Virtual visit**, the following fields will be enabled under the Constitutional section on page 11.

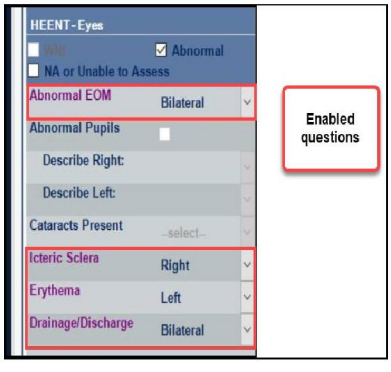
- Height
- Weight
- Weight Source
- BMI
- Blood Pressure (May be documented when obtained by the member using a digital cuff)
- Blood Pressure – Arm
- Repeat Blood Pressure - Unable to Perform (May be documented when obtained by the member using a digital cuff)
- Respiratory Rate - Unable to Perform
- Heart Rate - Unable to Perform
- Wearing Oxygen
- Temperature



HEENT - Eyes

The following questions are disabled in the Examination HEENT-EYES:

- Checkbox for "WNL"
- Abnormal Pupils
- Describe Right: Unequal, Dilated, Pinpoint
- Describe Left: Unequal, Dilated, Pinpoint
- Cataracts Present: Left, Right, Bilateral



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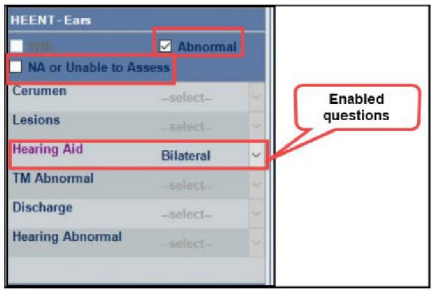
HEENT - Ears

The following are disabled in the Examination HEENT-EARS on Page 11:

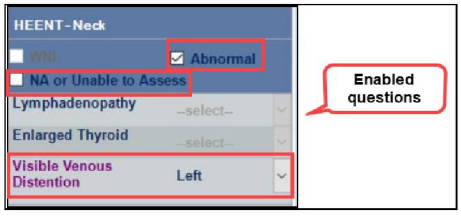
- Checkbox for "WNL"
- Cerumen: Left, Right, Bilateral
- Lesions: Left, Right, Bilateral
- TM Abnormal: Left, Right, Bilateral
- Discharge: Left, Right, Bilateral
- Hearing Abnormal: Left, Right, Bilateral



HEENT - Neck

The following questions are disabled in the Examination HEENT-NECK on Page 11:

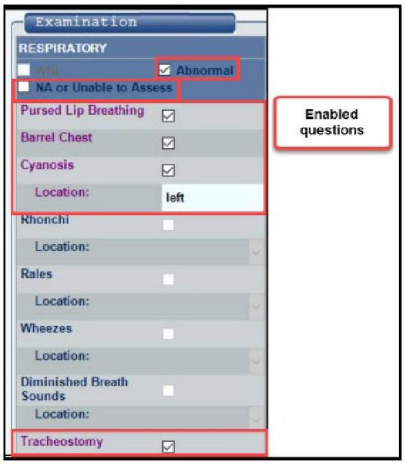
- Checkbox for "WNL"
- Lymphadenopathy: Left, Right, Bilateral
- Enlarged Thyroid: Left, Right, Bilateral



Respiratory

The following are disabled in the Examination Respiratory on Page 12:

- Checkbox for "WNL"
- Rhonchi and Location: RUL, RML, RLL, LUL, LLL
- Rales and location: RUL, RML, RLL, LUL, LLL
- Wheezes and location: RUL, RML, RLL, LUL, LLL
- Diminished Breath Sounds and Location: RUL, RML, RLL, LUL, LLL



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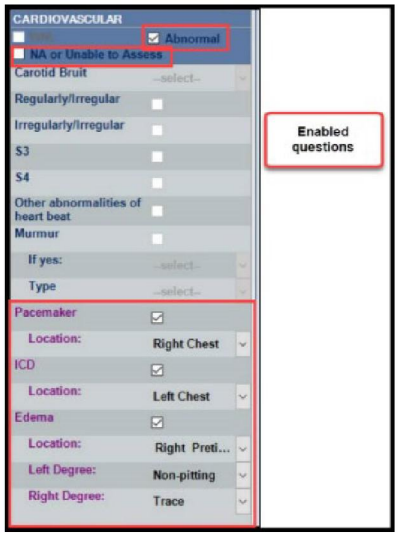
Cardiovascular

The following are disabled in the Examination Cardiovascular on Page 12:

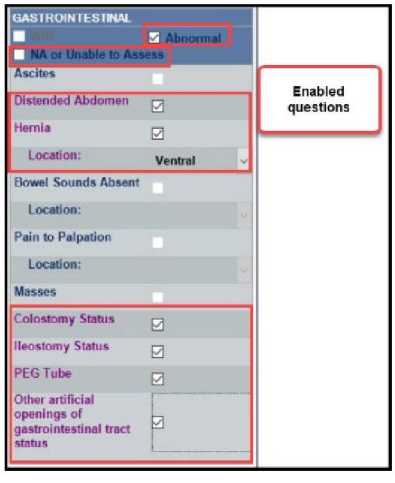
- Checkbox for "WNL"
- Carotid bruit: Left, Right, Bilateral
- Regularly/Irregular
- Irregularly/Irregular
- S3
- S4
- Other Abnormalities of heartbeat
- Murmur
  - If yes: Systolic, Diastolic, undetermined
  - Type: Known, Unknown



Gastrointestinal

The following questions are disabled in the Examination Gastrointestinal on Page 12:

- Checkbox for "WNL"
- Ascites
- Bowel Sounds Absent
  - Right Upper Quadrant, Left Upper Quadrant, Right Lower Quadrant, Left Lower Quadrant
- Pain to Palpation section
  - Right Upper Quadrant, Left Upper Quadrant, Right Lower Quadrant, Left Lower Quadrant
- Masses



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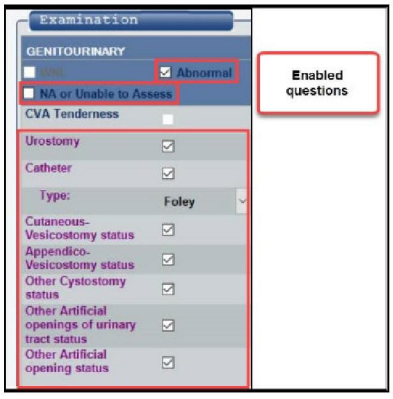
Genitourinary

The following are disabled in the Examination Genitourinary on Page 13:

- Checkbox for "WNL"
- CVA TENDERNESS



PVD Screening

Unable to perform checkbox and Reason Video Virtual Visit will pre-populate when member is flagged for QuantaFlo testing. The following are disabled in the Examination PVD Screening on Page 13:

- QuantaFlo button
- Import Results button
- Member Refused
- Recently Completed
- Left Foot
- Right Foot



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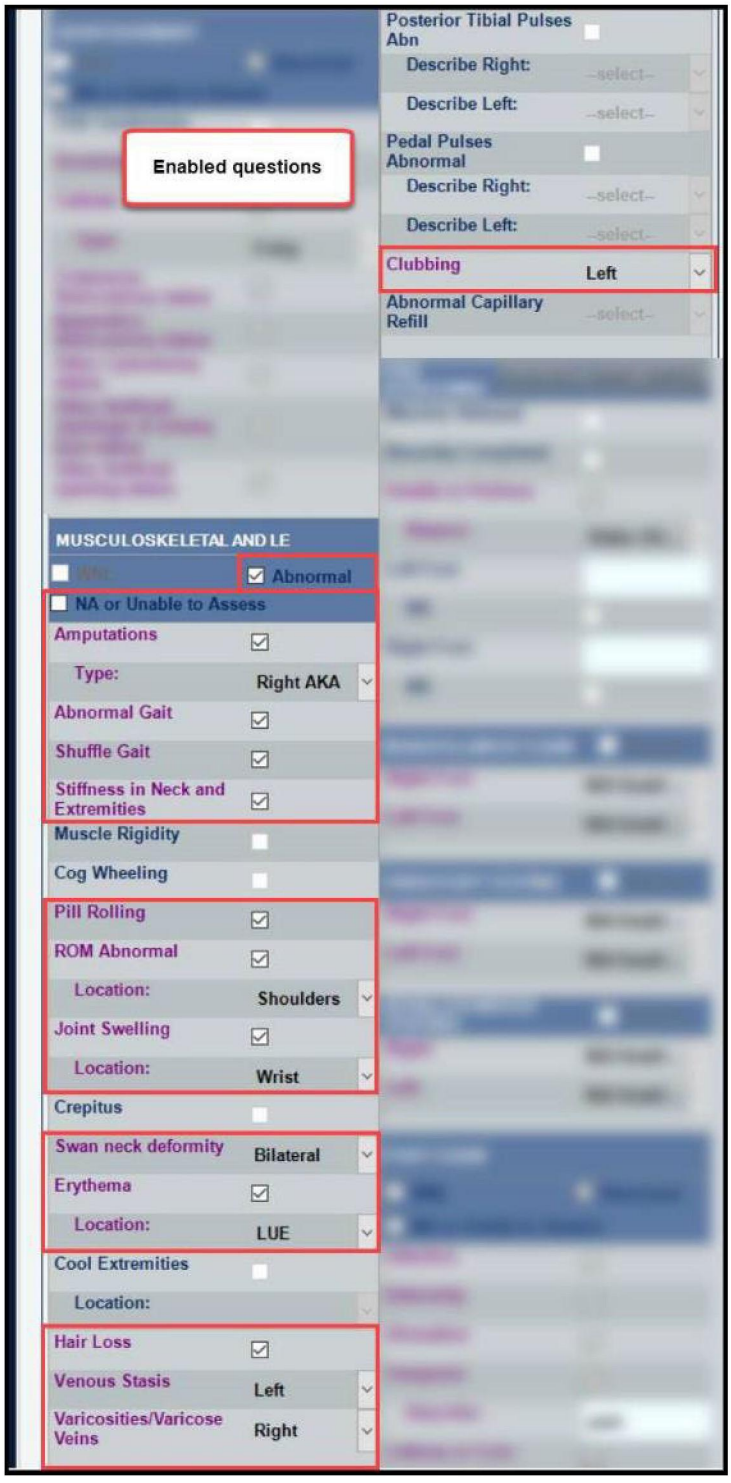
Musculoskeletal

The following questions are disabled in the Examination Musculoskeletal and LE on Page 13:

- Checkbox for "WNL"
- Muscle Rigidity
- Cog Wheeling
- Crepitus
- Cool Extremities and Location: RUE, LUE, RLE, LLE
- Posterior Tibial Pulses Abnormal
  - Describe Right: Normal, Diminished, Absent
  - Describe Left: Normal, Diminished, Absent
- Pedal Pulses Abnormal
  - Describe Right: Normal, Diminished, Absent
  - Describe Left: Normal, Diminished, Absent
- Abnormal Capillary Refill: Left, Right, Bilateral



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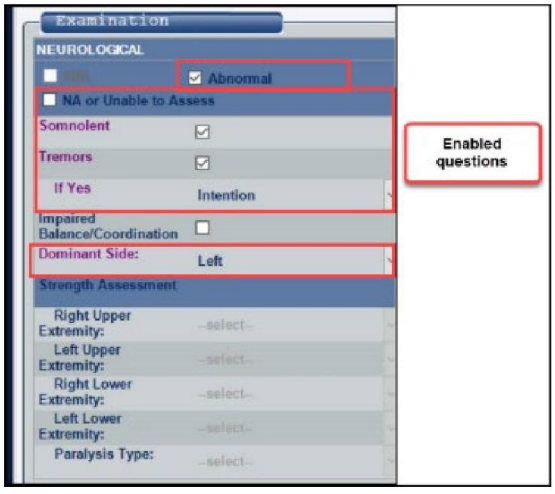
Neurological

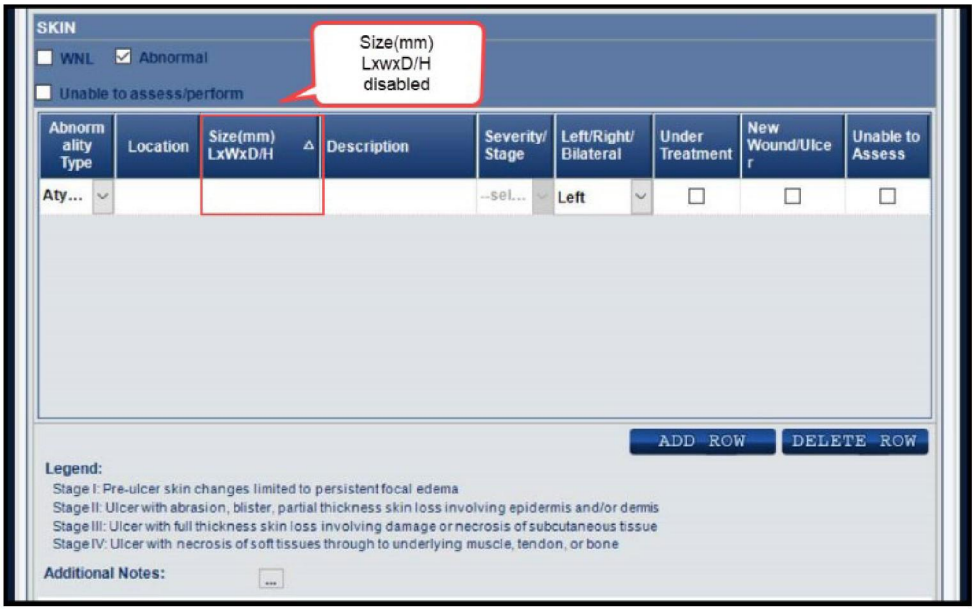
The following are disabled in the Examination Neurological on Page 14:

- Checkbox for "WNL"
- Right Upper Extremity: Normal, Weak, Paralyzed, Amputee
- Left Upper Extremity: Normal, Weak, Paralyzed, Amputee
- Right Lower Extremity: Normal, Weak, Paralyzed, Amputee
- Left Lower Extremity: Normal, Weak, Paralyzed, Amputee
- Paralysis Type: Spastic, Flaccid, Unspecified
- Given questions are enabled in the Examination Neurological on Page 14:
- Somnolent
- Tremors
  - If yes: At Rest, Intentional
- Impaired Balance/Coordination
- Dominant Side: Left, Right



Skin Section

In Skin Section of the Assessment – "Size (mm) LxWxD/H" is disabled.



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Diagnostic Tools

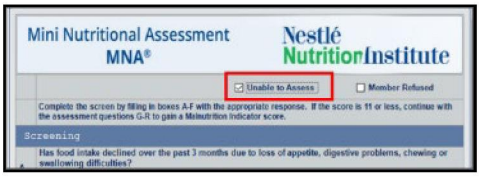
Mini Cog

Complete test as normally directed. Have the member hold the completed clock draw up to the camera for evaluation and then have the member recall the three words.

MNA

For the MNA assessment, whether Mandatory or Provider initiated, complete screening sections (A-F)

- If the Screening score is <11, the tool is unable to be completed virtually, select "Unable to Assess"
- If member has score <11, discuss nutrition status with member
- Document in SDOH tool or CRD tool for referral if indicated

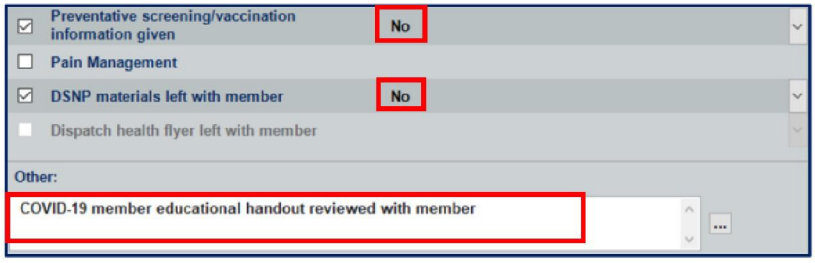


CRD

- Continue to complete the CRD Tool for Referrals as you would a F2F
- Remember, referrals feed into this tool from different parts of the assessment, so complete this part of the assessment towards the end of your visit
- If something is clinically significant, document and call the PCP- as you currently do with in-home visits

Member Education

- For the Recommended Health Screening and Vaccination, check "No"
- Review with the member any other pertinent Member Education materials and document in the 'Other' section
- For a DSNP flyer, if enabled, select 'No'



Labs

A1C Point of Care Testing – Unable to Collect

A1C will pre-populate with Unable to Collect selected and Reason for Unable to Collect dropdown menu pre-populated with Video Virtual Visit.



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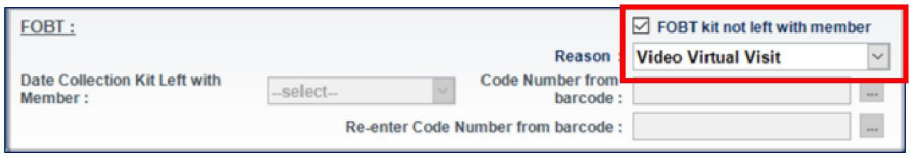
Blood Testing – FOBT LGC – Reason

FOBT will prepopulate with FOBT kit not left with member selected and with the Reason dropdown prepopulated Video Virtual Visit.

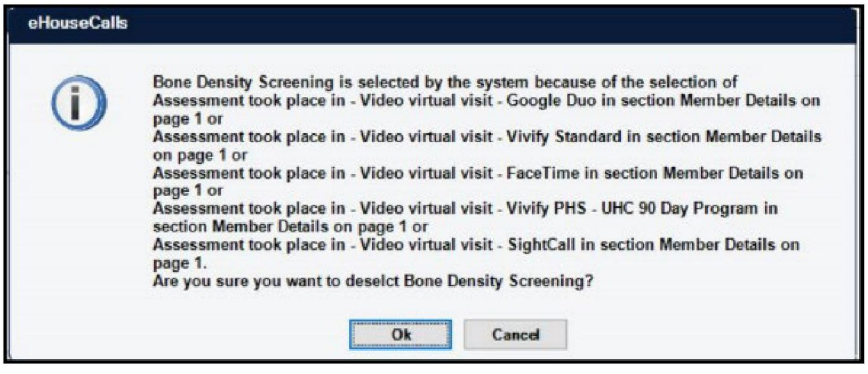


Page 19

Mandatory Messages: Deselecting Auto-Selections

If an auto-selection is changed, alert messages are displayed.

- Example: Alerts for Bone Density Screening



Removal of Mandatory Messages

The following sections have mandatory messages regarding completion removed when unable to perform based on the **Video Virtual visit** selection:

- Strength Assessment
- Advance Care planning
- Bone Density Screenings – OMW
- Diabetic Retinal Screenings
- Member Education/DSNP Materials

For Virtual Visits, Personal Protective Equipment Documentation on page 18 is disabled



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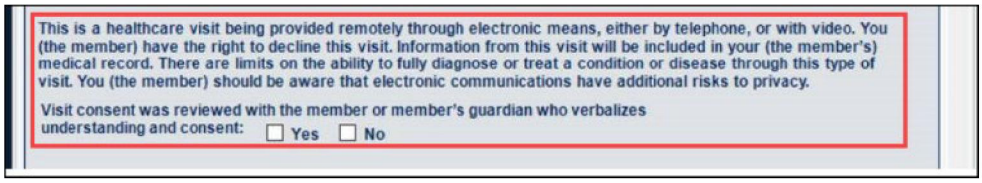
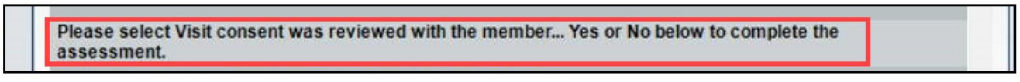
Visit Consent: Video Virtual visit

On page 18, the following text has been added to the current general consent section.



Review Visit Consent

If "Visit consent was reviewed with the member or member's guardian who verbalizes understanding and consent" is not selected, the following mandatory message will be displayed:

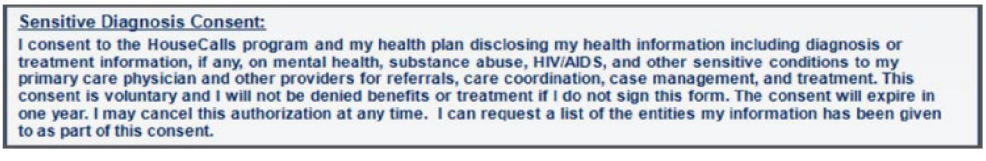


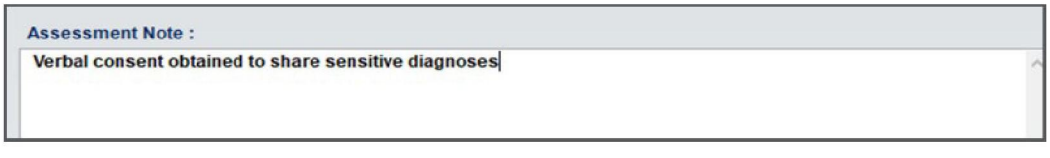
Member Signature

The reason for a member to be unable to sign will be auto selected with Video Virtual visit. The drop-down is editable if necessary.



- Video Virtual Visit should be selected from the drop down since member signature will not be obtained
- To obtain Sensitive Diagnosis Consent - Read the consent from eHC and document the member's verbal consent in the assessment notes, and then check the appropriate box (Yes/No)





For any other type of visit, the following alert will be displayed when finalizing the assessment.

- "Are you sure that documentation of the assessment is completed?"

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Optum Coding and Documentation materials are based on current guidelines, are to be used for reference only, and are not intended to replace the authoritative references identified below.
·Clinical and coding decisions are to be made based on the independent judgment of the treating physician or qualified health care practitioner and the best interests of the patient.
·ICD-10-CM, CPT and HCPCS are the authoritative references for purposes of assigning diagnoses and procedure codes to be reported.
·It is the responsibility of the physician and/or coding staff to determine and submit accurate codes, charges, and modifiers for services rendered.

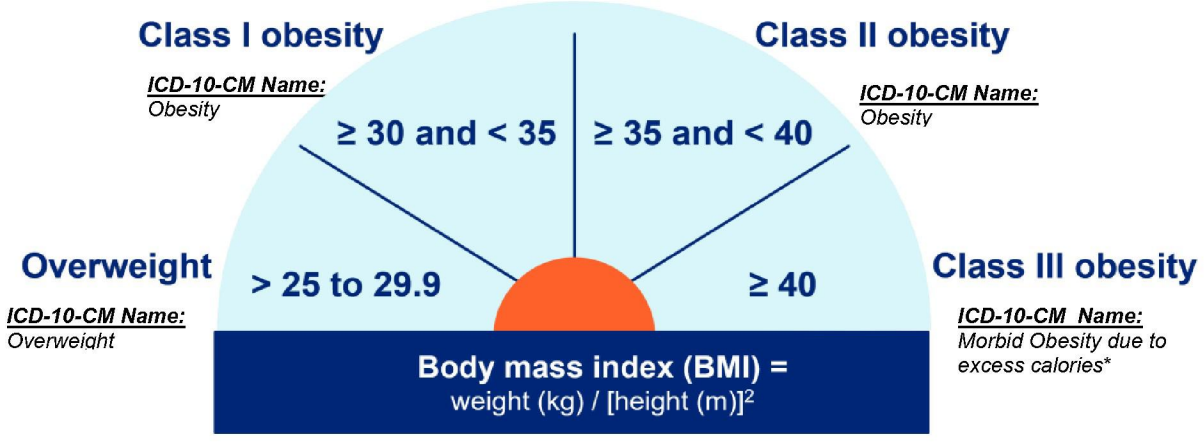
HouseCalls: Morbid obesity

Overview

- According to 2017-2018 data from the National Health and Nutrition Examination Survey (NHANES), more than 2 in 5 U.S. adults have obesity[1].
- **There is no "master list" of comorbid conditions, as more than 230 comorbid conditions have been observed with obesity[2].** Obesity may increase the mortality risk and morbidity associated with the following* (not all-inclusive):

  - Diabetes mellitus type 2
  - Obstructive sleep apnea
  - Arthritis of load-bearing joints
  - Past medical history of myocardial infarction
  - Hypertension
  - Heart failure
  - Atrial fibrillation
  - Dyslipidemia

These are merely examples, and the treating clinician is advised to defer to their clinical judgment and see references for more information.



The National Heart, Lung, and Blood Institute, part of the National Institutes of Health, points out that, clinically, we should be using the phrases Class I, Class II, and Class III to describe levels of obesity in our patients. This terminology replaces the term "morbid obesity". Because this term has derogatory connotations, the panel recommends that health care practitioners avoid using it. However, it is still reflected in the ICD-10-CM as the following.

Diagnosing morbid (severe) obesity

To diagnose morbid (severe) obesity, a member must have **either**:

- BMI of ≥ 40
- BMI between 35-39.9 plus at least one comorbid condition as listed above. List is not all-inclusive, and the clinician is encouraged to ~~defer to~~ utilize their clinical judgement.

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Documenting obesity in eHouseCalls

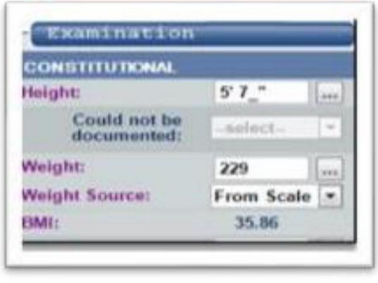
1. Review the member's current information for:
    - Active diabetes, arteriosclerotic disease, hypertension, obstructive sleep apnea, etc.
    - BMI (Note: To obtain an accurate height and weight, use a company scale and folding ruler).
2. Document diagnoses on page 15; include status of condition and plan.

Prepopulated Diagnosis

- Prepopulated diagnosis Morbid Obesity may be presented in the previously diagnosed section if it has been documented in the past. It is the clinician's responsibility to either accept, resolve, or remove the diagnoses prepopulated on page 15 and provide supportive documentation such as BMI and pertinent chronic comorbid conditions for the accepted diagnoses.
- If the patient has a diagnosis that is not prepopulated, the clinician will need to ~~manually~~ use the "Add Diagnosis" button to document the appropriate diagnosis with relevant supporting evidence

Smart Logic

- Smart Logic is a feature in eHouseCalls that suggests potential diagnoses based on the clinical findings documented in the encounter. It is the clinician's responsibility to either accept or remove the diagnoses auto-populated by Smart Logic on page 15 and provide supportive documentation for the accepted diagnoses.
- If the patient has a diagnosis that is not populated by Smart Logic, the clinician will need to use the "Add Diagnosis" button to document the appropriate diagnosis with relevant supporting evidence
- The diagnosis of "Morbid Obesity Due to Excess Calories" populates if the clinician enters a BMI 35-39.9 under the Physical Examination section and the member has an appropriate comorbid condition.



Morbid Obesity Due to Excess Calories	Selected by Rules	☑	☐	☐	☐ Stable ☐ Unstable ☑ Suboptimally Co	☐ Continue Therapy ☑ Patient education ☑ FU with PCP ☐ FU with Specialist ☐ Send to ER or Urge

Sample case study

Example: Morbid obesity due to excess calories*
HPI: 67-year-old female with arteriosclerotic heart disease, HTN, Type 2 DM. Pt is concerned about weight.
PMH: CAD, HTN, Type 2 DM, PVD
MEDS: Lisinopril 20 mg daily; metformin 500 mg PO BID; ASA 81 mg daily
EXAM: VS: 128/70, 68, 20; Weight 229 Height: 5'7" BMI: 35.86. Extremities with 1+ pulses bilaterally. QuantaFlo 0.70 R leg, 0.80 L leg.
ASSESSMENT:

- Morbid obesity due to excess calories - behavior/lifestyle interventions (e.g., 30-minute exercise 5-7 days/week). Track intake and weights on mobile app. Attempt DASH diet.
- Hypertension, essential (primary) - stable, follow up with PCP
- Type 2 diabetes mellitus with diabetic peripheral angiopathy without gangrene- continue ASA, follow up with PCP
- Atherosclerotic heart disease of native coronary artery without angina – stable, follow up with PCP
- Peripheral Vascular Disease, Unspecified- Suboptimal Controlled, Follow up with PCP, Care Management Referral

**This information is fictional and not based on a real patient. Example documentation is not for management purposes.*

1. Centers for Disease Control and Prevention (CDC). Adult Obesity Facts. https://www.cdc.gov/obesity/data/adult.html. Updated May 17, 2022 . Accessed August 16, 2022.
2. Perreault L. Obesity in adults: Prevalence, screening, and evaluation. In: Post TW, ed. *UpToDate*. Waltham, MA: UpToDate Inc. https://www.uptodate.com/contents/obesity-in-adults-prevalence-screening-and-evaluation. Accessed August 16, 2022.

For additional coding information, please refer to the current ICD-10-CM Browser Tool: https://icd10cmtool.cdc.gov/
The information is not all-inclusive and is intended solely as a communication tool. All clinical decisions are to be made at the sole discretion of the clinician and clinical care team.

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Ride Along Expectations: Practitioners Job Aid

Ride Along Purpose:

The purpose of the Ride Along is to assure all members are receiving a complete and consistent HouseCalls visit (HCV) that follows HouseCalls identified standards. It is an opportunity to address knowledge gaps and ask questions regarding the HouseCalls visit and documentation. Any education needs will be communicated upon completion of the Ride Along review. The post ride along review will be conducted via TEAMs by the Clinical Team Manager (CTM) or Clinical Advisor (CA). Assessments may be returned to the portal as discrepancies for any necessary documentation corrections.

Categories to be Addressed:

- Listening Checkpoints performed throughout the HCV
- Beginning of Visit
- History, Physical Review and Diagnoses
- Preventative Screenings
- Diagnosis Confirmation
- Review of Systems
- Physical Exam
- QuantaFlo evaluation and Tools
- Referrals and Member Value
- Education Compliance

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Sections will be evaluated by the CTM or CA as the APC performs the visit:

Beginning of Visit:

Beginning of Visit
Introduces self, explains purpose of visit, reviews and documents member list of goals for visit
Member consent obtained
Video Modality (FaceTime, Google Duo, Vivify, Other)
For Video Visit: Able to connect/troubleshoot
Atmosphere: private location, no background noise
Professionally dressed per departmental dress code and wearing company ID badge
Proper use and documentation of appropriate PPE for Face-to-Face (Documentation only for Virtual or Video Visit)
Covid Survey Completed
Optum Secure Visits (OSV+) Device (Salaried Employees Only)
Member confirmation - Insurance card/DOB
Confirmed emergency contact
Confirmed PCP name and address
Confirmed specialists seen at least annually

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Important reminders:

- Temperature check performed at door and documented during physical exam
- Member consent specific to VVV read to member and documented on page 18

Note: Specialist information must also include last visit date

History, Physical Review and Diagnosis:

History, Physical Review, and Diagnoses
Admissions/Emergency Room Visits
Past Medical History
Past Surgical History
Comprehensive Medication Review
Allergies/Vaccination History Assessed, Documented and Recommended/Member Education
Allergies addressed and documented
Influenza
Pneumovax
Prevnar 13
Tdap
Herpes Zoster
COVID-19 1 & 2

Important Reminders:

- Past Medical History should be reviewed with the member and is not to be skipped during the assessment
- Document current member medications including dosage, frequency, route, last fill date, and prescriber. Additional supplements, pharmacy adherence, barriers to adherence.
- If a member is PDV, (post discharge visit), must complete the post discharge medication reconciliation with the member.
- Allergies and vaccinations: APC should assess and document in the vaccination section, recommendation section, and member value and education section.

Preventative Screenings: the APC will be evaluated on and the comments for each section are noted in the column on the right:

- Urine Dipstick will not be performed, leave section blank

Preventive Screenings
Functional Assessment (See comment)
Body Mass Index (See comment)
Rheumatoid Arthritis (See comment)
Breast Cancer (See comment)
Comprehensive Diabetes Care - Medical Attention for Nephropathy (See comment)
Comprehensive Diabetes Care - Retinal Eye Exam (See comment)
Comprehensive Diabetes Care - A1C and Universal (See comment)
Advanced Care Planning (See comment)
Pain Screening (See comment)
Colorectal Cancer Screening (See comment)
Osteporosis (See comment)
Statin Treatment (See comment)

Functional Assessment: Complete Barthel Index of ADLs
Body Mass Index: Height from measuring tape, weight from scale, MNA done when BMI < 19
Rheumatoid Arthritis: Ensure f/u with Rheumatologist and DMARD prescribed
Breast Cancer: Recommend Mammogram if between 50-74 and not had in TWO years
Comp Diabetes Care-Medical Nephropathy: Requests for a urine dipstick to check for protein and glucose
Comp Diabetes Care-A1C: Recommend/perform 18-75 based on criteria: not completed in current year, member doesn't recall, or A1C was > 9% over 3 months
Comp Diabetes Retinal Eye Exam: Recommend annual dilated eye exam for diabetic member
Advanced Care Planning: Leave pamphlet with member if applies
Annual Med Review: Document active medications to include dosage, route and frequency, last fill date and prescriber, additional supplements, barriers to adherence. Specific type of medication (i.e: "tablet" versus "capsule" should be specific in med grid. If PDV (Post discharge visit) the APC must complete the post discharge med reconciliation
Pain Screening: Completed pain screening
Colorectal Cancer Screening: Recommended if member has not had a colonoscopy in 10 years or other criteria not met: Not completed FOBT in past year or doesn't remember or hasn't had a Cologuard (FIT-DNA) in past 3 years.
Osteoporosis: Recommend BDT for women 65 and older and recommend treatment if they have osteoporosis
Statin: Recommend to continue treatment or recommend if not on statin and have diabetes or CVD

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Review of Systems:

Review of Systems/ROS: At least one dx related question per system
Constitutional
Head
EENT - Eyes (Optional)
EENT - Ears (Optional)
EENT - Nose/Throat (Optional)
Respiratory
CV
GI (Optional)
GU
Integumentary
Neurological
Musculoskeletal
Endocrine
Diabetic testing
Psychological

Diagnosis Confirmation:

Diagnosis Confirmation (See comment)
COPD
Diabetes
Vascular Disease
Cardiac Arrythmia
Major Depressive Disorder
Morbid Obesity
Neuropathy
Heart Failure
Minor Diagnoses Missed (5% Deduction for First 4)
Review of Active Diagnoses - Up to Date (See comment)
PMHx (on bottom of Diagnosis Confirmation Page) addressed and resolved

NOTE: If the member has a concern or complaint regarding the exam components listed, ask the associated ROS questions and perform the exam

Only obvious diagnosis with evidence will be reviewed with the APC if not identified during visit

Physical Exam Sections to be completed:

Physical Exam
Height/Weight (See comment)
Blood Pressure
Pulse/Respiration (Respiration rate optional)
Temp taken prior to entering home or before F2F
General Appearance
HEENT - Eyes (Opthalmoscope/Pupils) (Optional, See comment)
HEENT - Ears (Otoscope) (Optional, See comment)
HEENT - Nose/Throat (Optional, See comment)
HEENT - Neck (Thyroid) (Optional, See comment)
Respiratory - Anterior and Posterior (See comment)
CV - Carotids, Auscultate All 4 Valves (Stethoscope to Skin) (See comment)
GI - Abdominal Exam (Stethoscope to Skin) (Optional, See comment)
GU - Assess for CVA tenderness, urostomy or catheter (Optional)
Musculoskeletal - Strength of All 4 Extremities (See comment)
Monofilament - Proper Technique (See comment)
Neurological - Vibratory/Achilles Reflex (Achilles optional, See comment)
Psychological - Affect (See comment)
Skin - Measurement of Assessable Wounds (See comment)

Sections with expectations described below:

Ht/Wt:	Measure ht with measuring tape and weight with company scale or document if unable on all members.
Blood Pressure	Use of appropriate size cuff
Pulse: (radial & pedal)	Performed on all members
Respiratory	Assess all lobes of the lungs using stethoscope to skin (where applicable) listening for diminished breath sounds, wheezes, rhonchi, cyanosis, pursed breathing and assess for trachea
*HEENT	The APC uses otoscope/ophthalmoscope to examine EOM, pupillary reaction, cataracts, erythema, d/c. Ears-cerumen impaction, infection, perforation, d/c & hearing aids. Nose Neck &Throat for lesions, lymphadenopathy, dentures, erythema, and mucosal abnormalities.
Cardiovascular	Assess all chambers using stethoscope to skin (where applicable) Assess rhythm, murmur, rub, bruit, pacemaker, and carotid bruits

***Some components of the Physical Exam may be optional to perform. Mark NA or Unable to assess**

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Physical Exam Sections continued:

***GI:**	Auscultate bowel sounds. Palpate all 4 quadrants, assessing for ascites, hernia, distention, pain, colostomy and ileostomy, PEG where applicable
MS:	Assess for amputations, gait, stiffness, rigidity, cogwheeling, ROM, crepitus, swan nek deformity, erythea, cool extremities, hair loss, venous stasis, varicosities, pedal pulses
Monofilament	Assess 5 spots on feet bilaterally as shown on the monofilament supplied by HouseCalls supply department
Neurological	Test vibratory on all diabetics and anyone with abnormal monofilament or polyneuropathy history. ***Achilles Reflex** is optional on all members.
Psych	Assess for flat affect, depressed mood, mania, disorientation, agitation, confusion, and hostility
Skin	Assess for any open wounds, lesions and rashes. Describe using size, color, location, discharge and if under treatment. Document consistent findings.

Urine Dipstick will not need to be performed and will be left blank

QuantaFlo Evaluation and Tools:

Quantaflo: Observed, Technique appropriate, Accurate Waveforms
Tools
MiniCog
Nutritional Screening
PHQ-9
SDOH
Falls Risk
MTM Grid Completed Successfully
Health Risk Assessment (HRA)

MNA required if BMI < 19

Labs

Lab
FOBT left/not left per criteria
A1C
Hepatitis C
PIN Labs
MTM Grid Completed Successfully

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Referrals

Referrals (CRD)
Urgent Referrals, including documentation of appropriately notifying PCP and HelpDesk on CRD
Urgent/Emergent Clinical Referrals per HouseCalls guidelines
APS notified per protocol (utilities disconnected, threat of eviction, no food, no running water)
Optum Behavioral Health (See comment)
Suicidal with or without a plan/Danger to self or others
Non-urgent Referrals, including documentation of appropriately notifying correct department on CRD
Optum Behavioral Health (See comment)
Other non-urgent referral/communication
Member Resources
Nurse Line (See comment)
COVID Support Line (See comment)
Member Services (See comment)
Optum RX Customer Service (See comment)
Dispatch Health (See comment)
Advocate4Me (See comment)
Local Agencies (See comment)
Optum Health Help Line (See comment)
Prescription Refill Documentation (See comment)

Member Value & Education Compliance

Member Value & Education Compliance
Engages member in visit - documented recommendations and responses to member visit goals
Uses infection control technique (washes hands, cleans equipment)
Documents CTM presence
Education correlates with health conditions - discussion with member
Education given at appropriate health literacy level (and answers member's questions)
Education given in appropriate language and interpreter service used as needed
Manager discretion (used for those aberrant instances that are not defined on the RAL tool)
APC arrived for RAL visit on time
APC communicated with CTM 24 hrs prior with address, name of member, and time of first visit
APC waited for CTM prior to starting HCV visit
HCV completed in one hour or less without missing components of HCV
APC respectful of members home/property (i.e. member requested to remove shoes, move vehicle, furniture, etc.)
Correct supplies utilized for member (BP cuff size, light shield for QF, monofilament etc.)
Missed opportunity (add detail in comments)
Educational Materials provided and reviewed with member
Ask your PCP (AYP)
Recommended Screenings/Vaccinations
COVID Leave Behind
Falls and Fractures
Your Annual Health Guide
Safe Drug Disposal Leave Behind
Thanks member for plan
Leaves gift (when appropriate)

At each member visit, leave the Safe Drug Disposal Leave Behind, discuss briefly and document member education in eHC.

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HouseCalls Orientation Guide

Per Assessment Practitioner Hire
Document Version 6.3
HP Elitebook
April 2021 Binder

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Table of Contents

TABLE OF CONTENTS **2**

WELCOME TO HOUSECALLS! **8**

HouseCalls Training Program 8
Purpose of Training *8*
HouseCalls Organizational Structure: Field Operations *8*
The HouseCalls Team *8*

THE HOUSECALLS MODEL **9**

Objectives 9
The HouseCalls Story 9
Company Divisions 9
Goals of HouseCalls Visits 9
HouseCalls Model 10
HouseCalls Data *10*
What is the Model of Care? *15*

EHOUSECALLS TABLET TECHNOLOGY **15**

Tablet Technology 15
Data Collection *16*
Tablet Functionality *16*
Tablet Care and Maintenance *16*
Smart Cards *17*
Equipment and Accessories *17*
Tablet Security *18*

LOGIN PROCESS & SYNCHRONIZATION **19**

Login Process 19
Powering on the Tablet *19*
Step 1: Windows & Smart Card *20*
Step 2: Internet & Auto VPN *21*
Step 3: eHouseCalls *22*
Step 4: Synchronization Status *23*
Step 5: Synchronize Data *23*

MOVING THE TASKBAR **24**

eHC Landscape Orientation 24

OUTLOOK **26**

Outlook Email 26

CONDUCTING A HOUSECALLS VISIT **26**

Objectives 26
Visit Focus 26
Prior to Visit 27

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The Day Before the Visit 27
Supplies 27
Introductory Call with Member 28
Non-UHC Member HouseCalls Visit Talking Points 28
Introductory Call: Leaving a Message 29
Introductory Call: Be prepared to answer questions 29
Gift Card Program 29
COVID-19 PROTOCOLS 29
Self-Monitoring 30
Screening Members Prior to the Visit 30
Documenting Pre-Screening Questions 30
COVID Prescreening Questions (Based on CDC Guidelines) 31
Member Talking and Educational Points 31
Check Member Temperature at the Door 32
What happens if family member comes to door? 32
Prescreening: HCV Determination 32
If Visit is Deferred 33
Survey for HouseCalls APC 33
How to Stay Healthy- Personal Protection Equipment (PPE) 33
Required: Cleaning Equipment 33
PPE Disposal 33
Personal Protective Equipment Documentation: 34
COVID-19 Exposure Actions 34
Returning to See Members 35
DAY OF VISIT 35
The Visit Day: Preparation 35
No Matter Which Door You Enter 35
At Member's Door 35
Member Not at Home 36
THE HOUSECALLS VISIT 36
Beginning the HouseCalls Visit 36
Documentation – Verify and Collect Visit Data 37
Medication Therapy Management 38
Assessment Highlights 38
Review of Systems 39
Physical Exam 39

SCREENING TOOLS 41

FALLS RISK ASSESSMENT (FRA) 41
Sensory Systems 42
Musculoskeletal 42
Cardiovascular 42
Intrinsic Factors 42
PCP Recommendations for fall prevention 43
Member Recommendations 43
Education & Prevention 44
Best Practices for Members to Avoid Falls 44
FINISHING THE VISIT 44

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Educate Members about COVID-19 44
Listening Checkpoint #4 45
PCP Outreach 45
Assisting Members with Connecting to Services 45
Give EVERY Member 46
Member Education Materials 46
The Ask Your PCP Handout 46
Reviewing Your Assessment 46
Peer Suggestions 46
DIAGNOSIS CONFIRMATION PAGE 47
Diagnosis Expectations 47
Diagnosis Confirmation Page Lists 48
Active & PMH List 48
Write-in Diagnoses and Notes 48
Smart logic 48
Conditions Unlikely to Resolve 49
Conditions Likely to Resolve 49
Diagnoses to Remain Active 50
PMH List 50
Removing an Unsupported Diagnosis from the List 51
Removing Duplicate Diagnoses from the List 51
HOUSECALLS LAB PROGRAM 52
Objectives 52
Current Tests 52
Lab Collection Criteria 52
Lab Scheduled: Tablet and Portal Views 53
Lab Program: Special Situations 53
Exceptions to the HouseCalls Lab Program 53
Consent for Labs 54
Lab Educational Materials 54
A1cNOW+ Point of Care Test 55
Materials Needed for Testing 55
Procedure 55
Documenting A1C Now+ Results 56
iFOBT: Immunochemical Fecal Occult Blood Test 57
iFOBT Test 57
iFOBT Procedure 57
iFOBT Kit 58
iFOBT Kit Mailing Instructions 58
iFOBT Reminders 58
iFOBT: Key Points 59
iFOBT Results 59
Obtaining Informed Consent and Authorization 60
Documentation of Labs 60
Signing on Behalf of the Member 61
HgbA1C Tablet Documentation Requirements 61

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Documenting A1C Now+ Results 62
iFOBT Tablet Documentation Requirements 62
iFOBT Reason for Refusal 63
MANAGING YOUR LAB SUPPLIES 64
Supply Replenishment/Kit Storage 64
Disposal 64
Traveling with Sharps Containers (If Applicable) 64
Materials of Trade 65
Infection Control 65
ADDRESSING HOUSECALLS REFERRALS 65
COMPREHENSIVE REFERRAL DISPLAY (CRD) TOOL 65
System Identified Referrals 65
Urgent APC Identified 65
Member Needs Referrals 66
PHS Care Management Program 66
Member Identification 66
Palliative Care Program 67
Palliative Care Program Referral-Member Identification 67
Member Identification 68
HouseCalls Care Manager Referrals 68
Clinically Significant New Findings or Diagnoses 69
Clinical Center Notification 70
CRD Tool Documentation for Digital ABI results 70
Social Work Referrals 71
Emergent & Urgent Behavioral Health Issues 72
Important Behavioral Health Referrals 73
Documenting Important Behavioral Health Referrals 74
Pharmacy Clinical Referral 75
Advanced Illness Referral 75
SDOH/ Social Needs Referral 76
Referral follow up 77
Documenting Non-Urgent Communication 77
SOCIAL DETERMINANTS OF HEALTH: REFERRALS FOR IDENTIFIED ISSUES 78
Navigate4Me (COVID Support Line) 78
Urgent Social Work 78
Nurse Line 78
Eldercare Locator 78
Anxiety/Emotional Support Helpdesk 78
Local DOH Agency 78
ADVOCATE4ME 78
Purpose 78
Process 79
UHC Membership Support 79
Best Practices for Documentation of Support Services 80
Member Resources & Helpful Reminders 83
Refusal of Advice 84
PCP: After Hours and Weekends 84

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Reminders *84*

QUALITY DOCUMENTATION AND CLINICAL PEER REVIEW 84

PURPOSE 84
GOALS OF THE CLINICAL PEER REVIEW TEAM (CLPR) 84
Chart Reviewers *85*
CLINICAL PEER REVIEWS 85
Key Components of Documentation *85*
Clinical Peer Review Documentation Requirements *90*
EXAMPLES: DIAGNOSES CAPTURED 91
Examples of Documentation for Urgent Medical and Social Referrals *93*
SCREENING TOOLS 94
Mandatory Tools *94*
Non-Mandatory Tools *95*
Exception Tools *96*
ADDITIONAL ELEMENTS OF THE EVALUATION OF THE ASSESSMENT 97
Appropriate plan documented *97*
Screening and Immunizations *97*
Member Weight & Height *97*
DOCUMENTATION DISCREPANCIES (CLINICAL PEER REVIEWS/CHART REVIEWS) 97
Process for chart returns *97*
Tips for Writing Professional Amendments *100*
CODING REVIEWS 100
Coding Query Communication *100*
ADDENDUM REVIEWS: HIGH FREQUENCY CHART RETURNS 102
Practitioner Post Visit Review Process *107*
HouseCalls Clinical Education Team *109*
Resources *110*
CHART RETURNS FOR CONSISTENCY 110
Change View of PDFs *110*

BEST PRACTICES & RESOLUTIONS TO COMMON ISSUES 111

OVERVIEW 111
TECHNOLOGY TRENDS & RESOLUTIONS 111
Equipment Issues *111*
EHC LOADING MALFUNCTION: ERROR POSSIBILITIES 112
Loading Malfunction: Error Possibilities *112*
Loading Malfunction: Resolution *112*
PAPER ASSESSMENTS 113
Paper Assessment Policy *113*
Securing & Handling Paper Assessment *114*
Paper Assessment Reminders and Tips *114*
PROTECTING MEMBER DATA 114
LAB ISSUES 115
Lab Consent *115*
Error Codes *116*
COMPLAINTS & GRIEVANCES 116
Reporting Complaints and Grievances *117*

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WRAP-UP 117

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Welcome to HouseCalls!

HouseCalls Training Program

Purpose of Training

Provide a comprehensive education to include program overview, technology, job responsibilities, and expectations. Our goal is for all clinicians to be successful in conducting a HouseCalls visit that is consistent and meaningful to our members. We hope at the end of this training you will share the same passion to care for our members.

HouseCalls Organizational Structure: Field Operations

It is important for all of us to build connectedness with all HouseCalls Practitioners. Through our program, we build a relationship with all HouseCalls Practitioners, as we recognize you are working from a remote location. Our Network includes an all-encompassing clinical management structure to support the HouseCalls mission.

- HouseCalls Clinical President & Sr. Vice President
  - Kristy Duffey, MS, APRN-BC, FAAN, Chief Clinical Officer, Clinical Operations, Care Service President
  - Hope Miller, MS, GNP-BC, Senior Vice President, HouseCalls Clinical Field Operations
- Clinical Vice President
  - 3 Vice Presidents
  - Divided by Region: Southeast, Northeast, and West
- Director of Clinical Operations
  - 9 Directors
  - Divided by Clinical VP's Regions
- Lead Clinical Team Managers
  - Supervises all CTMs in their region
- Clinical Team Managers (CTMs)
  - Your direct manager

The HouseCalls Team

The HouseCalls program **requires a true team effort,** and has many teams supporting the HouseCalls missions and program. This support translates into a stronger overall **TEAM** and better experience for **OUR** Members. HouseCalls Teams include:

- HouseCalls Practitioners
- HouseCalls Practitioner Training Team
- Team Care (TC) Call Center: Call center representatives that work to schedule all members
- Practitioner Help Desk: Subset of TC who work with the NP to contact the member
- HouseCalls Clinical Team: Anyone who impacts members on a clinical level
- HouseCalls IT Support: Also referred to Clinical Support Center (CSC)
- Supply Fulfillment: Manages practitioner supplies, inventory, and replenishment
- HouseCalls Network Management Team

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  - Onboarding: Pre-Going Live Team, working with you to ensure a timely Go Live process
  - Provider Relations: Post-Going Live Team, working directly with you and your CTM regarding all logistical coordination
- Clinical Peer Review Team
- Additional Departments
  - Care Management
  - Medical Management
  - Pharmacy

The HouseCalls Model

Objectives

- Discuss the HouseCalls Model
- Traditional Medicare and Medicare Advantage
- Discuss HEDIS, Stars, and Risk Adjustment
- Explore Special Needs Plans (SNP)
- The impact on Members, PCPs, and Health Plans

The HouseCalls Story

- Started as an independent disease-management company and Medicare Advantage plan in 2007
- Joined with UnitedHealthcare in 2012
- Now part of the Optum division of UnitedHealth Group
- Has grown *substantially* since 2012
- The HouseCalls home-based clinical program supports aging in place, promotes physician office visits, and preempts costly institutional care for all members that will include Special Needs Plan members, whom participated in the HouseCalls program.

Company Divisions

UnitedHealth Group is broken up into two major divisions: UnitedHealthcare and Optum. Under UnitedHealthcare, there are many insurance divisions, but the ones that HouseCalls services the most are:

- Medicare & Retirement (M&R)
- Employer & Individual (E&I)
- Community & State (C&S)

Under the Optum banner, there are many divisions but two that are relevant are Complex Care and HouseCalls. The two levels, while operating independently, both use Advanced Practice Clinicians (APCs) to perform assessments and/or provide care in the community.

Goals of HouseCalls Visits

- Collect vital health information for the member, PCP, and the health plan

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- Supports UHG's mission of "Helping people live healthier lives and making the healthcare system work better for everyone"
- Encourages members to be active participants in their own health care
- Provides education regarding preventative and management of chronic illnesses
- Supports our insurance plan partners in achieving excellence in plan ratings

HouseCalls Model

HouseCalls Visits are face-to-face visits done usually in a member's home that last approximately one hour. At times, alternate locations for visits could occur and include mobile clinics, urgent care centers, and provider offices. These visits, or any testing done during the visit, are of no charge to the members. Members are contacted to schedule a voluntary visit based on eligible plans.

Information is collected using our EMR software designed by HouseCalls and it includes, but is not limited to, these aspects:

- Verifying demographic information, confirming PCP and specialist information, PMH, social history, functional assessments, medication review, reviewing preventative screenings (which also includes education on PS), and mental and physical health

At the completion of the visit:

- The information is shared with their PCP and health plan
- The member receives a brief summary of information collected
- Referral programs may also receive information about the member if identified to improve their benefits and care

Your role as the APC in the field is to:

- Identify areas of knowledge-deficits regarding preventative care and maintenance of current conditions
- Educate the member about their conditions and ways to improve their health
- Generate referrals to programs that can assist the member with improving or maintaining their health

All of these aspects discussed create a stronger link with their PCP and health plan.

HouseCalls Data

Data that is collected during a HC visit is used by many people to help improve a person's overall health.

The PCP

- Via the Ask Your PCP (AYPCP) form given to the member at the time of the HC and encouraged to take to their next visit
- Contact via phone for Urgent Issues
- Sent a Post Visit Summary letter

Med Assist

- Examines the gaps in Care
- Reviews diagnosis data

Star Gazers

- Monitor for gaps in care
- Compares information to diagnosis data

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Referrals

- Behavioral Health partners
- Pharmacy team for medication consultation
- My Advocate for income subsidy referral
- Care Management for urgent and non-urgent issues

Member Education

Member education is a major part of the HouseCalls program. You will be provided with member education materials and the expectation is that you provide disease-specific documents to members at the time of the visit. Major chronic diseases are especially important. You can only use approved material provided by the company. Examples include, but are not limited to:

Diabetes

- Take Charge of you Diabetes
- Managing Diabetes: The A1C Test
- What is Diabetic Retinopathy?
- Keeping Feet Healthy
- Meal Planning

Chronic Kidney Disease

- DASH diet
- What is High Blood Pressure?

COPD

- Take Charge of your COPD
- Treatment for COPD
- Using Inhalers

Heart Disease

- Symptoms of a Heart Attack
- What is Atrial Flutter/Atrial Fibrillation?

How Health Plans are Rated

HEDIS (Healthcare Effectiveness Data & Information Set) and is a tool to measure performance of health plans & is used by 90% of healthcare plans in the US. Aspects of HEDIS include:

- HEDIS contains 90 measures across 6 domains of care
- HEDIS assists beneficiaries with making the best decisions for their healthcare annually

Star Measures are benchmarks for the delivery of care, and some Star weights are linked back to HEDIS measures. The Medicare Star Rating System measures how well Medicare Advantage and Part D plans perform. It is important to identify the aspects of the Star rating system, as described below:

- Overall Plan ratings range from 1 Star to 5 Stars while individual categories also receive a Star rating
- Medicare reviews plan performances each year and awards the Star rating per plan each fall; then publishes them on their website
- Plans that receive only one or two stars for three years in a row are determined to be low-performing plans, and members must call the plan to enroll rather than through the Medicare website.

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- Plans rated 1-2 stars are low performing plans, members can dis-enroll from plan at any time, and no bonus payments are given.
  - Bonus plans are only given to higher performing plans to use specifically for member benefits
- STAR ratings reflect each plan's clinical quality, their operational system and attest to their member's satisfaction with the plan
- The STAR ratings are based on very specific criteria that is set up by CMS and is measured annual
- The overall goal of the STAR rating system is to promote ongoing quality improvement

Specific Examples of Star and HEDIS Measures assessed during a HC visit

Based on the HouseCalls assessment you will be able to capture Star and HEDIS measures per CMS standards as described below.

Diabetic Kidney Disease

- Measure:
  - Diabetic members (18-75 y/o) have a kidney function test or evidence of nephropathy
- Measured at HC visit by:
  - testing urine during a HC visit
  - documentation of ACE or ARB
  - documenting ESRD, renal transplant, dialysis, nephrologist

Annual Medication Review

- Measured by a comprehensive medication review at every HC visit

Pain Screening

- Measured by Pain Assessment at every HC visit

Functional Assessment

- Measured by completion of a functional assessment (Barthel ADL Index) at every HC visit

Body Mass Index (BMI)

- Measured by a BMI documented by a weight obtained from a scale
- Measured utilizing tape measure to obtain member's actual height

Breast Cancer Screening

- Female members (aged 50-74) who had a mammogram during the past two years
- Documentation of member reported mammogram; document mastectomies

Colorectal Screening

- Members 50-75 who: colonoscopy < 10 years ago or sigmoidoscopy < 5 years ago or fecal occult blood / guaiac testing
- iFOBT kit left with member with instructions to return document colorectal screenings or colon surgeries

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Osteoporosis Management

- Women (aged > 67) with a fracture and had a BMD test or Rx to treat /prevent osteoporosis in the 6 months following
- Documentation of reported DEXA scan with date
- Documentation of Rx to treat osteoporosis within 6 months post fracture

Indirect Measures

You can make a difference and impact the STAR rating by ensuring that the direct and indirect measures are addressed during your HouseCalls visit. Examples of Indirect Measures include:

- Medication Adherence & High-Risk Medication
- Controlling Blood Pressure
- Annual Flu Vaccine
- Diabetes Treatment
- Improving or Maintaining Mental Health
- Monitor, Improve or Maintain Physical Health
- Improving Bladder Control
- Reducing the Risk of Falling
- Plan All-Cause Readmissions
- STAR and HEDIS ratings reflect the ability of MA plans to achieve quality initiatives and member satisfaction
- CMS also funds MA plans based on the health status of its members through risk adjustment

Financial Risk

- CMS remits payment to Medicare Advantage (MA) plans in order to provide health care services to their enrolled members
- MA plan assumes financial risk for covering members' healthcare costs, even if the member's care exceeds the allocated funds
- MA plans ensure sufficient funds are available to pay the healthcare costs of their membership by calculating the degree of financial risk they are assuming for enrolled members
- This calculation is called the Risk Adjustment Factor (RAF)

Risk Adjustment Factor

- Used to estimate health care costs for a member based on their predicted health status
- Determined by calculating the sum of fixed factors and reported factors which impact a members' health

Impact of HouseCalls Program on RAF

Once we complete our documentation and finalize the assessment, the coding team translates identified diagnoses into their corresponding ICD 10 codes. ICD 10 codes are then ranked within Hierarchal Category Codes (HCCs) to group diagnoses that have similar cost patterns. These HCCs are tallied to provide the reported risk score which is then added to the fixed criteria to get the Risk Adjustment Factor.

- CMS' risk adjustment model is predictive and prospective
  - MA plans receive payment the following year based off what is reported in a "base" year

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- Reported diagnoses do not rollover from year-to-year, thus, chronic medical conditions must be recaptured and reported to CMS every calendar year
- Allocation of funds cannot be obtained for unreported diagnoses
- Accurate documentation and specific diagnosing during the HouseCalls visit are the keys to ensuring that the health plan receives adequate compensation to provide health care services to its members

- Clinical documentation should be an accurate depiction of the members' health status

Medicare and Medicare Advantage Plans

Medicare Advantage Plans (MAP) administers Medicare benefits to enrollees who voluntarily choose a MAP plan and continue to pay Part B premiums to Medicare. The payment structure for MAP involves quality initiatives and member satisfaction, and risk adjustment scores, which Medicare in turns pays the Medicare Advantage Plans for the members using a complicated payment structure. Health plans with high performance (Star ratings), rebates, and bonus payments are returned to the health plans to use for additional member benefits.

As the APC seeing MAP members, it is important to:

- Correctly identify and document diagnoses to ensure the member gets the best service their plan offers
- Identify chronic diseases like CKD or diabetes with best practices of documentation, which will assist in connecting the member to programs best assisting in managing their illnesses

Special Need Plans (SNP)

SNP(s) are a type of Medicare Advantage Plan, (such as an HMO or PPO) that were established by the Medicare Modernization Act of 2003.

- They are designed to provide targeted care, such as improved coordination and continuity of care, to beneficiaries with special needs
- CMS defines those providing services for SNP beneficiaries as anyone associated with their care, such as marketing, enrollment, clinical, network, communication and sales.

Each Medicare Advantage SNP limits its membership to people in one of these groups:

- Live Independently
  - Dual SNPs (DSNP): health plans for individuals eligible for Medicare and Medicaid
  - Chronic SNPs (CSNP): health plans for individuals with one or more identified chronic condition (e.g., diabetes, congestive heart failure)
- Live in a Facility
  - Institutional SNPs (ISNP): health plans for individuals residing in nursing homes or equivalent settings (e.g., assisted living facilities) for 90 days or longer

At HouseCalls, we see Dual SNP members and Chronic SNP members as a small part of our membership group.

CMS mandates that all Special Need Plan (SNPs) design and implement an evidence-based Model of Care (MOC) to support beneficiaries individualized health care needs.

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What is the Model of Care?

The Model of Care is the playbook about how we will implement, deliver, and evaluate the care we provide to our members and is then submitted to CMS for approval. CMS mandates that all Special Need Plan (SNPs) design and implement an evidence-based Model of Care (MOC) to support beneficiaries, and individualized health care needs.

- Vital quality improvement component
- Specific needs met for identified beneficiaries
- Framework to promote quality care management and coordination of care for special needs members

CMS goals are not to be overly prescriptive for SNP, but there are certain elements that are required and CMS conducts audits from time-to-time to determine if the Model is being followed.

In order to meet CMS guidelines for individualizing care for SNP member, CMS requires that a Health Risk Assessment be completed annually on every member. This is a questionnaire (tool) that you will complete during the HouseCalls visit. If the need arises to use a paper assessment form, the form is included in the paper assessment packet but only has to be completed when the member you are seeing is a SNP member. Please inform members they will be receiving a copy of their Plan of Care based on the SMART goals in the mail. As practitioners, we need to be aware of these requirements for SNP members and assist our health plan partners meet the CMS requirements.

Other SNP Documentation Requirement
If you refer a SNP member to Member Services, (the number on the back of their Insurance Card) this needs to be documented in the assessment. This referral will be free typed into the Member Education text box in the electronic assessment.

More to come . . .

CMS changes its rules frequently, so you will need to keep up to date with changes in the software as they are rolled out.

eHouseCalls Tablet Technology

Tablet Technology

The laptop you will utilize to document HouseCalls visits is an HP Elitebook laptop. Because your laptop is dual purpose, you have the capability to switch back and forth from laptop to tablet mode throughout your workday by folding the keyboard in different positions.



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Data Collection

- We use the HP tablet, Stylus pen (USB Charged), and our proprietary software eHouseCalls for the collection and submission of member information
- Touchscreen Capability Enabled; track pad, finger, stylus, and wired & wireless mouse
- The assessment can be documented 1 of 2 ways:
  - Portrait Orientation (Vertical): Laptop Folded
  - Landscape Orientation (Horizontal): Traditional Laptop Mode
- To remain HouseCalls compliant, it is imperative that you **DO NOT modify the resolution settings**; doing so impacts the ability to fully see and complete the assessment

Tablet Functionality

When the eHouseCalls application loads, the orientation of the screen will display in portrait orientation. You are able to rotate the orientation by folding and unfolding the laptop. The battery life of the tablet is somewhere between 4.5-5 hours. To conserve the battery life of the tablet, it is expected that it will be charged in the field by utilizing the car tablet charger, and after work/overnight with the wall charger.





Tablet Care and Maintenance

- **Do not** charge tablet at member's home/connect to their WiFi
  - **Free & Voluntary visit**: No cost should be incurred for member
- **Do not** change the computer resolution
  - It will **blow out the assessment**, cutting off functional buttons (EMR Built)
- Keep liquids away from the tablet
- Only use tablet/email for **business purposes**
- Do not print from the tablet: **PHI Compliance**
- Carry a supply of **paper assessments**
  - If your tablet malfunctions in the field
- Keep **tablet on** in between visits
- **Shutdown** & **Charge** tablet overnight: **Remove the Smart Card** when shutting down
- **Do not** leave tablet unattended; **especially** in the car
  - **Theft**
  - **Overheat**: Fry the hardware
  - **Freeze**: Decreases the life span of battery

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Smart Cards

Your Smart Card is designed to be an enhanced level of security when utilizing your issued company tablet, in order to communicate with our servers. You will utilize your Smart Card by inserting it into your tablet when initially logging in, after powering on the device. The Smart Card will remain in your computer as long as your device is ON. Once powering your device down at the end of the day, remove the Smart Card and store it safely in your badge holder for next use.



Equipment and Accessories

Equipment	Graphic	Description
HP Elitebook Laptop/Tablet		The laptop you received is a foldable combination laptop/tablet. This piece of equipment is used to open the electronic assessment and collect member data during a HouseCalls visit, as well as to attend WebEx training sessions and access other business systems.
Stylus Pen	 	The stylus pen is used to input data into the tablet, mainly during member visits. When you are not using the stylus, place it on the side of your keyboard; it will attach by magnet. Should your stylus run low on charge, be sure to utilize the charging cord; one end being inserted into the USB port on your keyboard, and the other inserted into the pen as shown.

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Car Charger		The Car charger consists of an adapter with one male end which is inserted into the car adapter outlet, and the other end that will be inserted into the side of your tablet keyboard. It is the USB-C port on the right side of your keyboard.
Wall Tablet Charger		The wall charger is used to charge your tablet in the home. It is optional to take it with you while on the road but should never be utilized in a member's home. As a reminder, you are asked to charge your laptop in the car, after your visits each day, and until you begin your next workday to ensure your laptop is always fully charged.

Tablet Security

HIPAA

- **Protect Member Data**
  - –Never leave tablet unattended
  - –Adhere to paper assessment policies
- **PHI Compliance**
  - –Printing from the company tablet has been disabled
- **VPN Connection**
  - –Auto VPN: Secure encrypted channel communicating with our servers

Password Security

- **Passwords expire**
  - –**MS** (every 90 days), system will prompt for change and will sync all systems concurrently
  - –**Smart Card** will expire annually
- **eHC Synchronization Process**

Equipment Lost/Stolen?

- **If tablet is lost or stolen:**
  1. File a police report
  2. Contact the CSC 1-855-247-8474, Option #4
  3. Notify your CTM
- **If Smart Card is Lost, Stolen, or Defective:**
  1. Contact the CSC 1-855-247-8474, Option #4
  2. Notify your CTM

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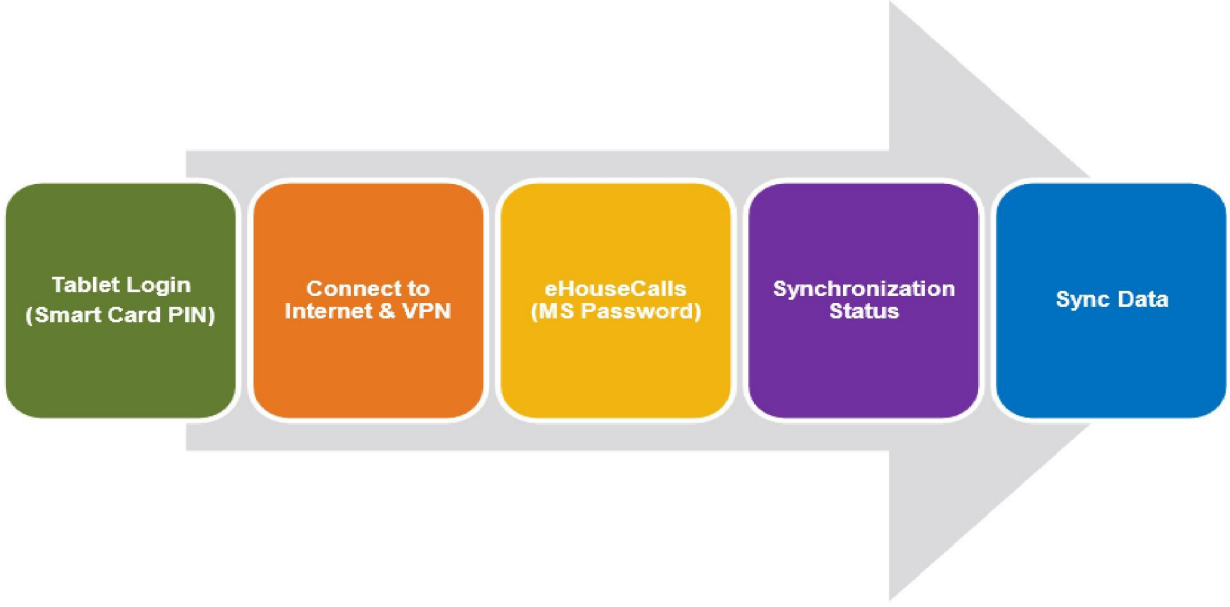
Login Process & Synchronization

Login Process

In order to protect member information, launch the eHouseCalls (eHC) application, and send & receive the most updated member information, you will be required to follow the steps below **2 times a day**. After powering on the tablet, the steps include: Turning on your computer (login with Smart Card Password), ensuring connection to Internet & (Auto) VPN, logging into eHouseCalls (MS Password), selecting Synchronization Status, and clicking Synchronize Data.



Powering on the Tablet

To power on the tablet

1. To turn on your laptop by pushing the power button on the top left-hand corner of your keyboard. The boot up process will begin.



2. Once the boot up process begins, **DO NOT** press any other button on the laptop until you see the **CTRL+ALT+DEL** to unlock screen, signifying the boot up process has completed.

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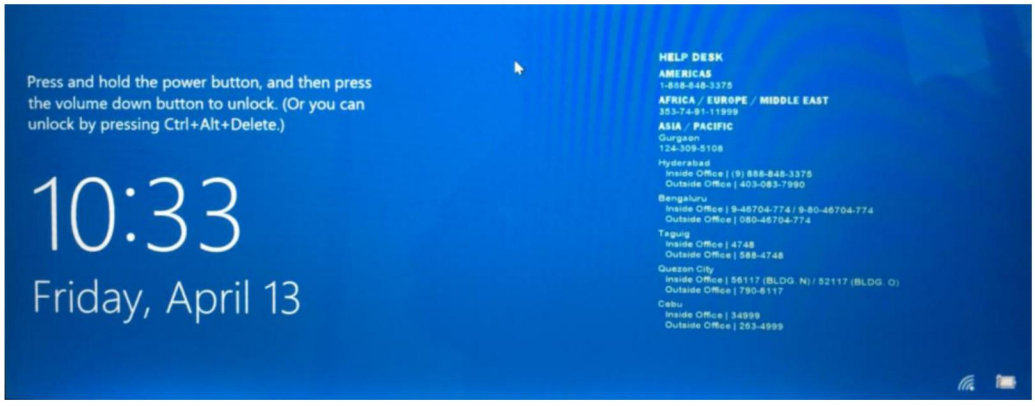
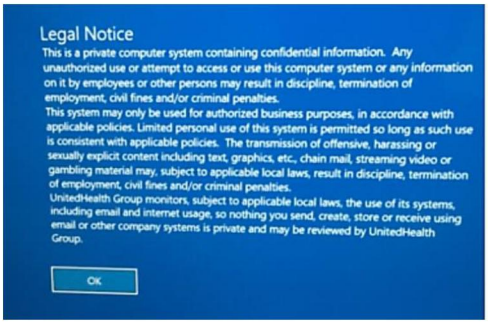


Step 1: Windows & Smart Card

To log in to Windows

1. From the CTRL+ALT+DEL screen, perform the command by pressing the **CTRL+ALT+DEL** buttons simultaneously on your keyboard. The Legal Notice policy screen displays.
2. From the Legal Notice screen, click the **OK** button. The login screen displays.



3. From the login screen, **insert your Smart Card**, and then input your **Smart Card Password** in the password field. Press the **Return/Enter** key. The desktop displays.



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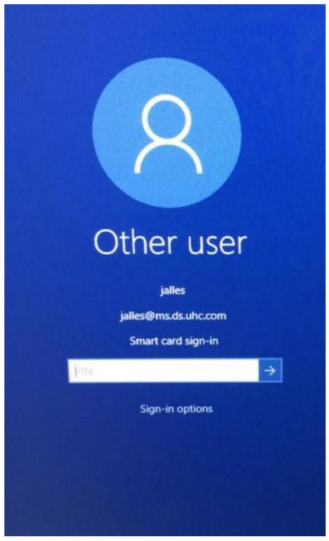
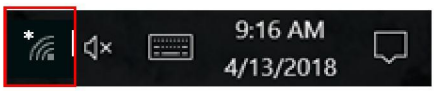


Step 2: Internet & Auto VPN

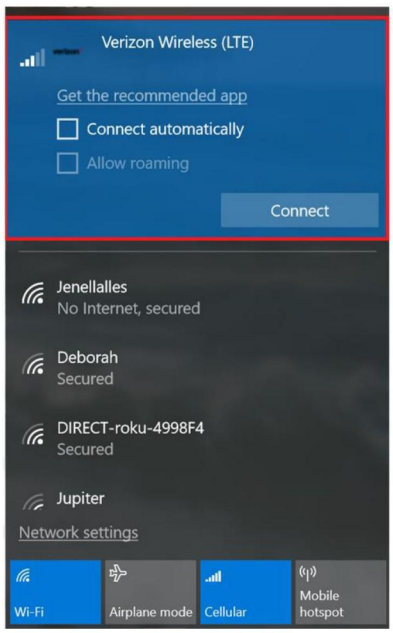
Connect to the internet

1. Navigate to the desktop system tray and click the WIFI icon (if you see either of the two icons below) to set up an Internet connection. The WIFI Connections window displays.





2. From the WIFI Connections window and from the Broadband Connection list, select "**Verizon**" or your preferred **WiFi** connection, and then select the **Connect** button. Some WiFi connections will require a password.



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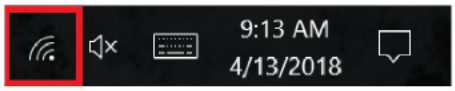
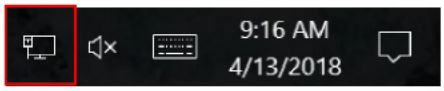
3. Wait one minute and then verify internet connectivity, by ensuring the icon is shown in the desktop system tray.





NOTE: A home WiFi connection is the easiest and most reliable Internet connection to use, if you have one. Once an Internet option is set up, the tablet will auto-connect in the future.

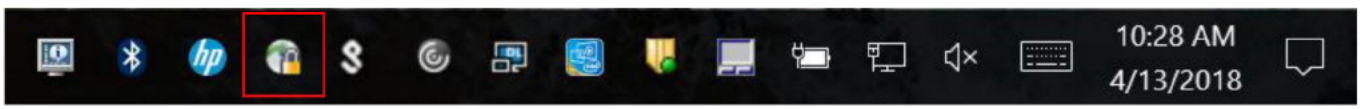
Auto VPN

Once you've successfully logged in and confirmed an Internet connection, the Smart Card in your tablet will attempt to auto-connect with the VPN after a few minutes. The VPN secures your Internet connection and enables you to send and receive data from your tablet to our secure server.

A VPN connection is needed at least twice a day when you use the tablet; before you see members for the day, and at the conclusion of your workday. The connection is automated, assuming you have an Internet connection and your Smart Card is inserted in the tablet.

NOTE: If a member is added or removed from your schedule, you would need to connect to the VPN in order to see the data changes reflected on your tablet.

A VPN connection is confirmed by the gold lock appearing on the Cisco AnyConnect icon, which is found in the Windows taskbar.



NOTE: You do not need a VPN connection to conduct eHouseCalls assessments throughout your day. For all VPN issues, contact the Clinical Support Center (CSC) at [redacted] Option #4.

When you are successfully connected, your Cisco AnyConnect icon will appear with a gold padlock.



Not Connected to VPN



Connected to VPN

Step 3: eHouseCalls

The next step will be to log into eHouseCalls.

1. From the Desktop, double-click the eHouseCalls icon to launch eHouseCalls, shown below. The initial login window displays.
2. Once the eHouseCalls initial login window displays, ensure that your Login Name matches your MS Username and then enter your MS Password in the textbox provided.
3. Click the **LOGIN** button. The Dashboard displays.

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NOTE: The eHouseCalls application login will allow a maximum of 3 login attempts and then you will be locked out for 10 minutes. After 10 minutes, you can try to log in again or you can restart your tablet to log in immediately.





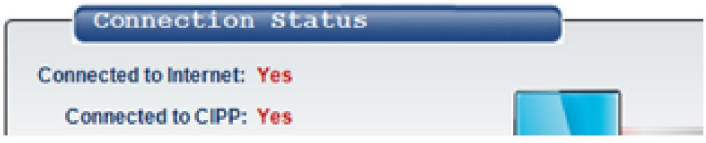
Step 4: Synchronization Status

Once you have logged into eHouseCalls, it is important to verify your connectivity status to the internet and VPN, synchronize your data, and upgrade the application (if needed). To access the *Synchronization Status* screen, click the **Synchronization Status** button on the Dashboard to perform these functions.



Step 5: Synchronize Data

1. When connected, **Yes Yes** should display at the top of the window.



2. If either of these connections indicate **No**:
   - Reboot the computer, complete the login process, successfully reestablish an internet and VPN connection, and then try to synchronize once again
   - Contact HouseCalls IT Support, if you are still unable to connect
3. Once connected successfully, click the **SYNCHRONIZE DATA** button. A "Data synchronized successfully" pop-up will display confirming completion.

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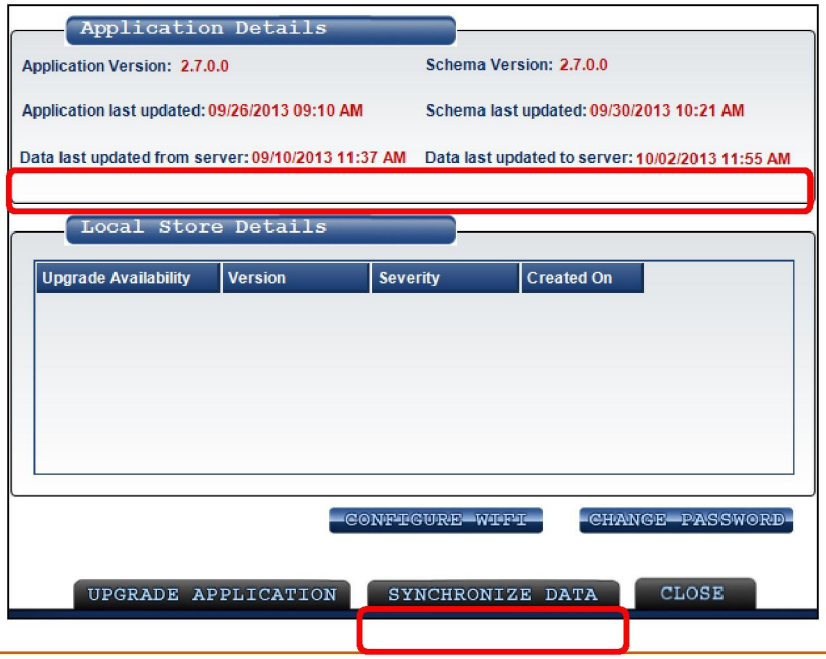


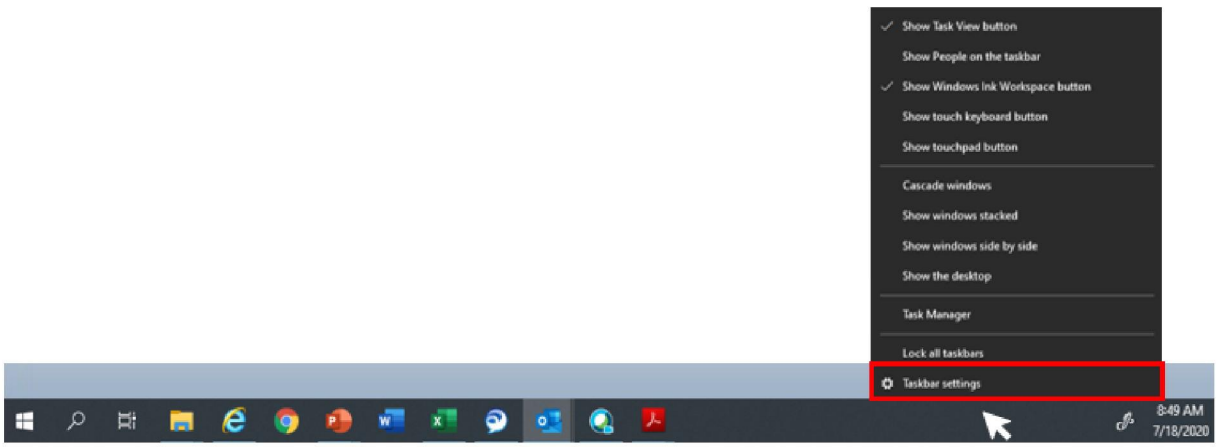
NOTE: Make sure the dates and times for Data last updated from server and Data last updated to server are updating every day you work for HouseCalls.

Moving the Taskbar

eHC Landscape Orientation

While in a landscape (laptop) mode, you will need to move your taskbar to either the left or the right side of the screen to ensure your assessment's features are not obstructed.

1. **Right click** on a blank portion of the taskbar where there are **no** icons to open the options menu



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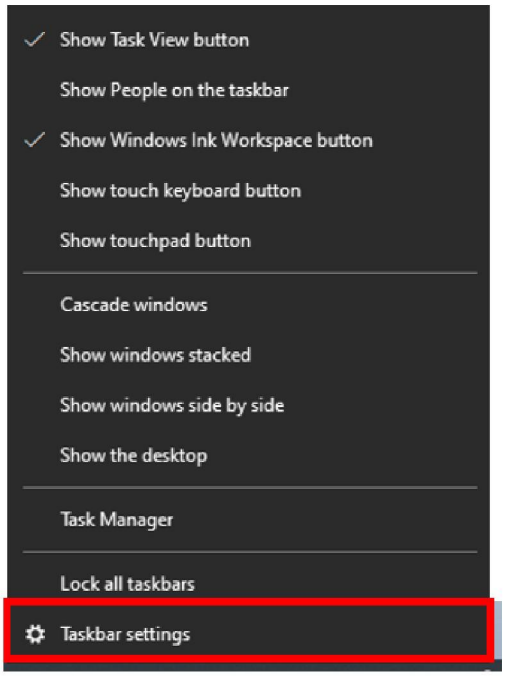
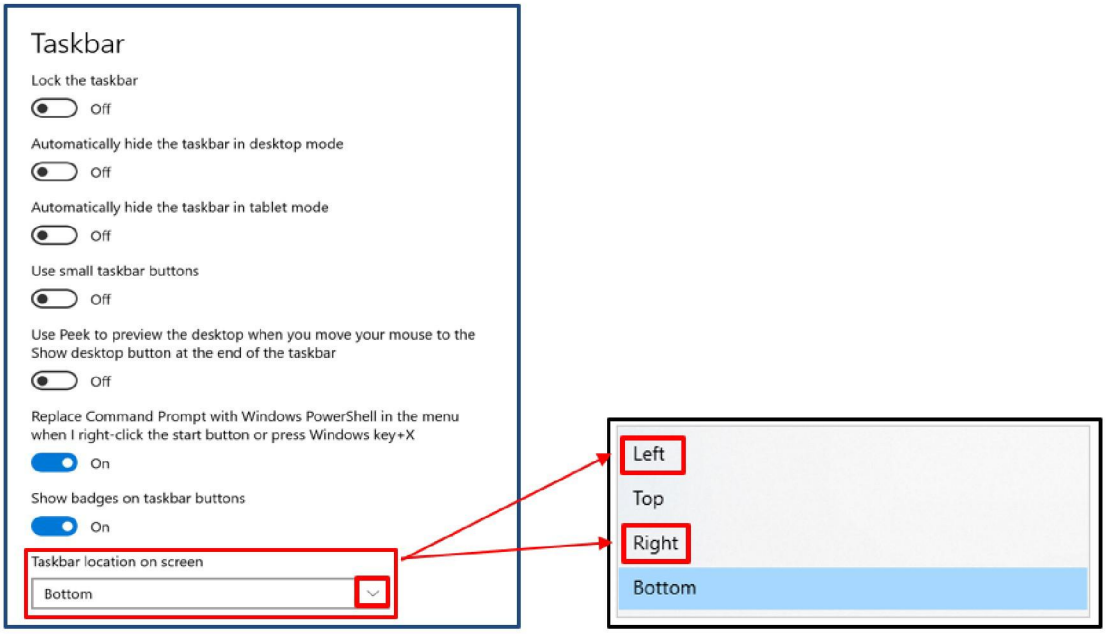
2. Select **Taskbar Settings**



3. When the Taskbar Settings menu appears, navigate down the to the **Taskbar Location on Screen** drop-down, and change the selection from **Bottom** to **Left** or **Right**.



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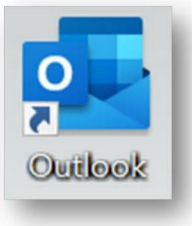
Outlook

Outlook Email

Optum utilizes **Outlook 365** for our company email and the Outlook icon will be located on your desktop.

- As a reminder, you will need **Internet and VPN** connection to effectively send and receive emails.



Once launched, you will be looking for the bottom bar of the Outlook window to say **Connected to: Microsoft Exchange**. If you have both secured connections (internet & VPN) and you still see "trying to connect" at the bottom of your Outlook window, please close out of the application and relaunch it.



Conducting a HouseCalls Visit

Objectives

- Discuss the process for conducting a HouseCalls visit
  - Prior, during and finishing the visit
- Review the delivery, use and care of equipment and supplies
- Discuss the process for completing a HouseCalls visit
- Review expectations for daily self-check, member assistance and submitting the assessment

Visit Focus

A HouseCalls visit allows the practitioner to interact on a limited basis and does not establish an ongoing therapeutic relationship with the member. There is no responsibility to write orders, renew, discontinue RX or OTC medications, or initiate therapies. Your role is to assess, document, perform labs, collaborate, refer, and educate our members.

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Prior to Visit

The Day Before the Visit

Your assessment begins the **day before** the visit, even prior to entering their home. You will review member information, prepare your supplies, make an introductory call, and map your route. You are expected to arrive on time to your first visit.

If the member has had a HouseCalls visit before, you will be able to review the same information in the HxAV (History of Annual Visit) tool in eHC and a pdf of the prior visit in the Practitioner Portal. You can also view the Clinical Profile of the member. Refer to the Clinical Profile Job aid for more information and the link.

Supplies

You will receive all the supplies you need to conduct your HouseCalls visits except for a stethoscope, which you are expected to provide. These supplies will be in multiple boxes delivered via UPS. Prior to delivery, you will receive an email to your Optum email account with the estimated delivery date. After receiving your initial supply order, it is your responsibility to keep at least 2 weeks of supplies on hand at all times. Reorders are done through the Practitioner Portal which will be discussed later in your training.

Items received in the initial shipment include:

- Lab coats and scrubs
- Rolling backpack or Shoulder bag
- Scale
- Blood pressure cuffs
- Ophthalmoscope, Otoscope and ear speculums
- Monofilament test
- Urine dipsticks and cups
- Alcohol pads and Paws disinfectant wipes
- Clip board
- Diagnosis specific educational materials
- PPE equipment



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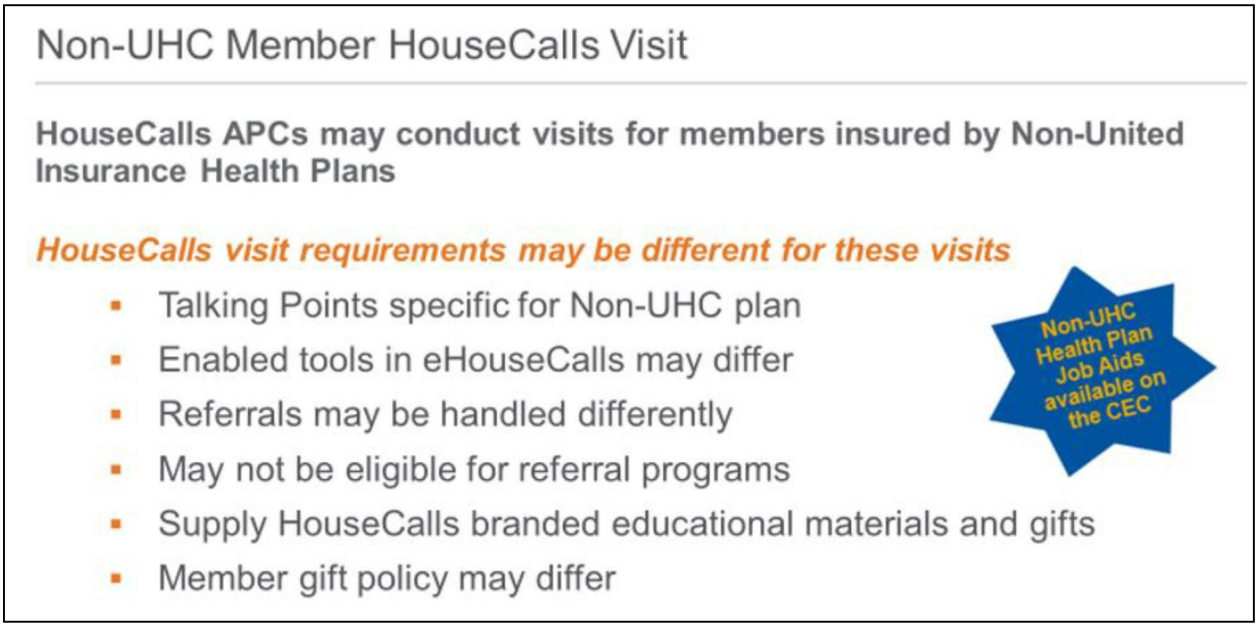
Introductory Call with Member

Introductory Calls should be made prior to 8:00 PM the day before the visit. Here are talking points to address with the member to help you both have a successful visit.

- The provider makes the call as an introduction
- Arrival block of time, location of visit
- "Easy access" clothing and shoes
- Insurance card available
- Medications in original bottles
- Appointment cards
- Glucometer and logbook if applicable
- List of PMH, vaccines, screening tests
- Need for urine specimen
- COVID screening questions
- Review member plan to able to prepare for talking points to specific plans
- If member is a Non-UHC member, the APC should not use any language or reference to UHC or Optum in the conversation.

Non-UHC Member HouseCalls Visit Talking Points



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Listening Checkpoint # 1: Introductory Call

Listening Checkpoints ensure that the member experiences the benefits of receiving a HouseCalls visit. By reassuring members that we are listening and are committed to helping them, we support the value of the HouseCalls visit to the member and increase their satisfaction



Add these suggested phrases to your introductory call:

- " I will be coming to do your HouseCalls visit tomorrow. As part of that visit, **I will listen to your questions and concerns,** so please think about what you wish to discuss. **If it's helpful, you can make a list."**
- "**HouseCalls visits are all about you. I have time for you to ask questions** and get answers about the things that matter most to you about your health."
- "**I am here to listen to your concerns** and also complete the requirements of this visit."

Introductory Call: Leaving a Message

- "Hi, this is Sally Jones, the Practitioner/Provider with your health insurance company. I am calling to remind you I will be coming for your HouseCalls visit tomorrow.

  I plan to be at your home between 9:00 AM &11:00 AM. Please call back to discuss the visit, if you have any questions or are not going to be home at that time. I look forward to seeing you! My number is (888)555-5555. Thank You."
- **Alternate #:** 1-866-686-2504 HouseCalls Member Line
- You are still expected to go to the visit as scheduled, even if you cannot reach the member during the Introductory call. If unable to ask the COVID screening questions on the day before call, ask at the doorway maintaining distance.

Introductory Call: Be prepared to answer questions

- Refer to Introductory call script from your reference material
- Note: **Only you** can make the introductory calls – these cannot be delegated to others

Gift Card Program

- Gift Card Program should ONLY be discussed if the Member brings up
- Eligible members will be mailed a gift card incentive as a result of completing a HouseCalls visit
- If the member has questions, advise the member to call HouseCalls Member Line 1-866-686-2504 with questions about their eligibility and other details about the card
- The member's HouseCalls Visit must be completed in order to receive the incentive
- Cards are sent 4-6 weeks following the visit to eligible members only

COVID-19 Protocols

- COVID-19 is the infection caused by the novel coronavirus that spread person-to-person most frequently during close exposure to a person infected. Person-to-person spread appears to occur similar to other respiratory viruses, mainly via respiratory droplets produced when an infected person speaks, coughs, or sneezes.

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- Although not likely to be the predominant mode of transmission, it is not clear the extent to which touching a surface contaminated with the virus and then touching the mouth, nose, or eyes contributes to transmission.
- People with COVID-19 have had a wide range of symptoms reported – ranging from mild symptoms to severe illness. These symptoms may appear 2-14 days after exposure to the virus. People with these symptoms or combinations of symptoms may have COVID-19: fever (temperature ≥ 100.0 F) or chills; new or worsening cough; shortness of breath or difficulty breathing; new loss of taste or smell; nausea or vomiting; diarrhea; fatigue; muscle or body aches; headache, sore throat; congestion or runny nose; or other symptoms as defined by the CDC.

Self-Monitoring

Self-monitoring is an important factor in safety. Daily Self-Monitoring is required on days you are working for HouseCalls. Currently, you will answer monitoring questions via a daily Optum1Click survey questionnaire sent to your Optum email address.

Symptoms currently required to be reported include:

- Temperature, watch for fever (100 or higher) or chills (*Thermometer will be provided)*
- New cough or worsening cough
- Shortness of breath or difficulty breathing
- Nausea or vomiting
- Muscle pain or body aches
- Sore throat
- New loss of taste or smell
- Headache
- Congestion or runny nose
- Other symptoms as defined by CDC (COVID toes)

Any positive results must be reported to your CTM immediately. If removed from the field, contact your HR department, the Enterprise Occupational Health Service and self-isolate. Your PCP should be contacted for a request for COVID testing and you should remain in self-isolation until test results are returned.

Screening Members Prior to the Visit

- Review available member history to identify any potential active respiratory or other disease requiring isolation
- Conduct a telephonic pre-visit assessment with the member to assess symptoms of potential active respiratory-transmissible diseases (on your day before call)
- If unable to reach the member telephonically, complete the assessment at the door before entering the member's home, maintaining a distance of at least 6 feet

Documenting Pre-Screening Questions

The pre-screening questions and the member's answers are to be entered into the COVID19 Survey. The link is on the Practitioner Portal and will be covered in another section of your training.

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COVID Prescreening Questions (Based on CDC Guidelines)

1. In the past 14 days, have you or a member of your household experience any one of the following symptoms: fever (temperature > 100.0 F) or chills; new or worsening cough; shortness of breath or difficulty breathing; new loss of taste or smell; nausea or vomiting; diarrhea?
    - If yes: defer the visit following the guidelines in section 3 of the Screening Tool
2. In the past 14 days, have you or a member of your household experienced two or more of the following symptoms: fatigue, muscle pain/body aches, headache, sore throat, congestion/runny nose?
    - If yes: defer the visit following the guidelines in section 3 of the Screening Tool
3. In the past 14 days, have you or a member of your household experienced any one of the following symptoms: fatigue, muscle pain/body aches, headache, sore throat, congestion/runny nose?
    - If yes: Will you be able to wear a mask during the visit?
    - If no: defer the visit following the guidelines in section 3 of the Screening Tool
4. Do you use a nebulizer for breathing treatments?
    - If yes: Are you safely able to go without a treatment for 4 hours prior to and during my visit?
    - If no: defer the visit following the guidelines in section 3 of the Screening Tool
5. In the last 14 days, have you or anyone in your household been diagnosed with COVID-19?
    - If yes: defer the visit following the guidelines in section 3 of the Screening Tool
6. In the last 14 days, have you or a member of your household been in the same indoor environment as a person who has been diagnosed with, or is suspected of having, COVID-19?
    - If yes: defer the visit following the guidelines in section 3 of the Screening Tool
7. In the past 30 days, have you or a member of your household been hospitalized for COVID-19?
    - If yes: defer the visit following the guidelines in section 3 of the Screening Tool
8. If proceeding with the visit and not already addressed during question #3: During the visit, I will be wearing a mask for your safety and will have one for you that I encourage you to wear if you wish to do so
    - If member is unable or declines to wear a mask during the visit, proceed with the visit unless per your judgement there is a clinical indication not to do so; in that instance, defer the visit following the guidelines in section 3 of the Screening Tool.

Member Talking and Educational Points

During the pre-visit screen on the day before call, discuss with the member how you are prepared to provide a safe environment. Here is the content you should be sharing with your members:

- "Your safety is important to us and during this visit I will be wearing a mask, face shield and gloves. I am able to provide you with a mask for use during the visit. You are required to wear one to keep everyone safe and healthy."
- 'I will follow CDC guidelines for cleaning my equipment before entering your home and during the visit to help you stay safe."

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- "As part of keeping you safe, I will be constantly monitoring my health and if I experience any symptoms or believe I have been exposed to COVID-19, I will not perform the visit and will self-isolate."

If the member or a household member is **symptomatic but not acutely short of breath**, counsel the member on self-isolation, symptom monitoring and maintaining isolation at home for 14 days, washing their hands frequently and seeking medical care if symptoms worsen such as shortness of breath.

Your actions should be to reschedule the member for another visit at least 2 weeks into the future and notify your CTM per HouseCalls protocol. Provide to the member resource numbers for the Nurse Line 877-365-7949 and the COVID-19 Support line 844-205-7182. Suggest they utilize these numbers and contact their PCP if any additional assistance is needed.

If the member has an **acute presentation with shortness of breath**, take precautions and use your clinical judgement but consider contacting EMS. You will need to contact the PCP regarding your disposition and your CTM. Remember to document your actions in the eHC assessment.

Check Member Temperature at the Door

- Ask the COVID-19 Screening questions if unable to ask via phone in the day before Intro call
- Check the member's temperature with the provided no-touch thermometer before entering the home
- If the member has a temperature of 100º or greater:
- Advise the member the visit will be rescheduled
- Direct them to follow-up with their PCP and/or seek testing for COVID
- Status the member for reschedule per current protocol
- Document temperature in the member COVID survey in the Portal

What happens if family member comes to door?

- APC will assess the family member who answers the door by asking COVID screening questions
- APC will assess family member's temperature at door
- If any of the COVID questions are positive for **symptoms**, the visit will need reschedule
- IF family member displays no symptoms and temperature normal, proceed into the home and assess the member also with COVID questions and no-touch thermometer
- If member has any positive findings, the APC will terminate the visit and status to reschedule the member 2 weeks from date of visit
- Review exposure guidelines as mentioned in this manual and refer to our policy

APC should always maintain gloves and mask during entire visit

Prescreening: HCV Determination

If the member/household contacts are asymptomatic and community risk is estimated to be low, proceed with the visit with these pointers in mind:

- Conduct the visit in an open, well-ventilated area if possible
- Use Standard Precautions
- Use Personal Protection Equipment (PPE) as appropriate
- Follow hand hygiene recommendations

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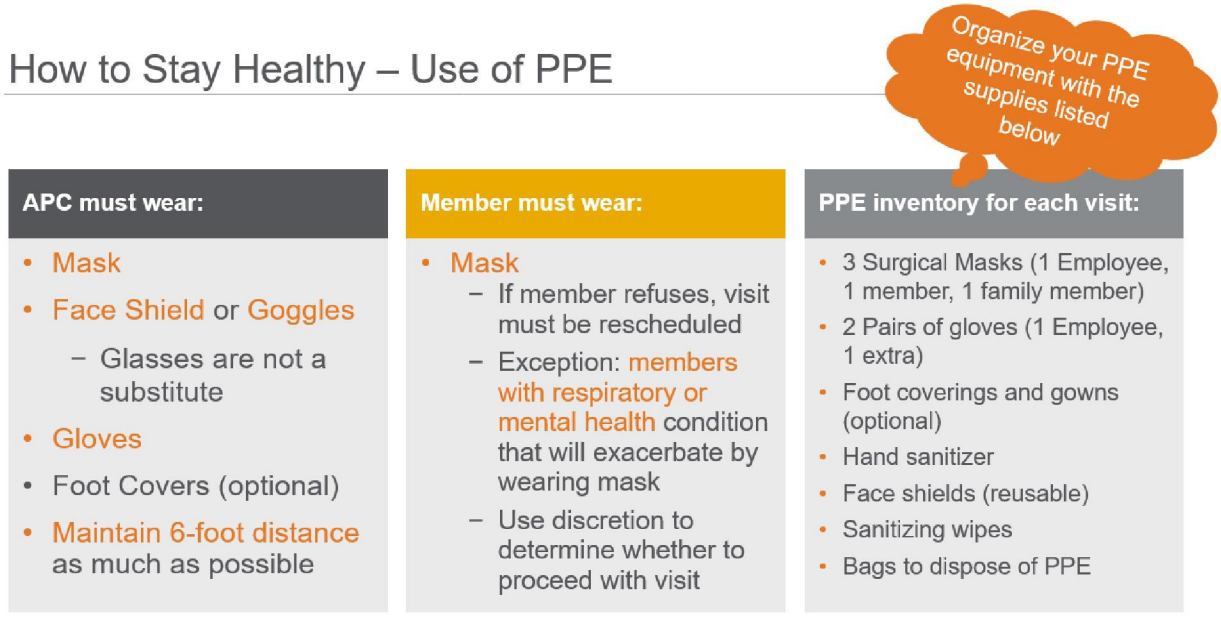
If Visit is Deferred

- Follow the HouseCalls protocol – offer member the option of a virtual visit in place of an in-person visit. If member declines, engage procedure to reschedule the visit for a later date at least two weeks out. If unable to reschedule due to full schedules, status assessment as "member requests reschedule" and add note that says "reschedules at least two weeks out"
- For any member that indicates having symptoms identified during the screening questions, offer the COVID-19 support line (844-205-7182)
- Instruct members who have any other health concerns or issues to contact their health care provider and provide nurse line number (877-365-7949, Available 24/7)
- Send documentation to your CTM to notify the visit has been deferred

Survey for HouseCalls APC

The APC will complete a survey prior to HouseCalls visit. The APC will receive survey via Outlook email.

How to Stay Healthy- Personal Protection Equipment (PPE)



Required: Cleaning Equipment

While still wearing PPE, clean the member's surfaces touched during visit. Always clean and disinfect equipment with appropriate EPA- registered disinfectant after use on patient and prior to use on another patient. If possible, consider using disposable items and equipment that can be discarded after use For best practices, only take into the home what is needed for the visit. Use the provided drape. This should be done while wearing your PPE equipment. This includes but not limited to:

- BP cuff – Stethoscope- Tuning fork - Reflex hammer - Scale

If gloves become torn, perform hand hygiene. Bags should be cleaned and disinfected weekly with Sani-wipes. This is a standard that will be evaluated during member visits by your CTM.

PPE Disposal

Your PPE equipment should be bagged in the provided trash bags and disposed in a member's external trash can as you leave the home if possible. If there is absolutely no option for disposal of PPE outside the member's home, double bag your trash for transport and dispose of elsewhere. Remove PPE in the

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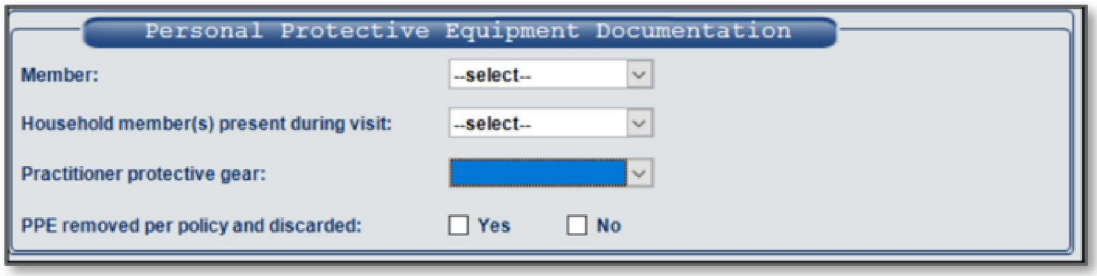
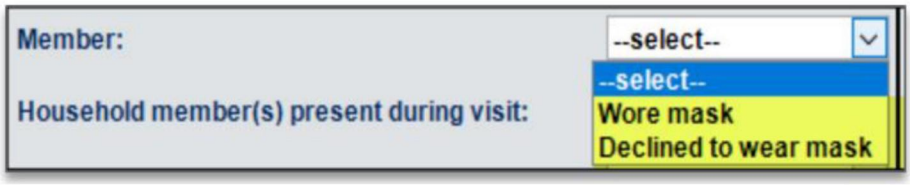
following sequence: Gloves then mask, wash hands or use an alcohol-based sanitizer immediately after removing PPE.

Personal Protective Equipment Documentation:

The APC should document personal protective equipment PPE) utilization on page 18 of eHC. It is also important to document member usage of PPE and PPE removal. In addition, the household member should be documented if present. If the APC performs a virtual visit, this section on page 18 will be disabled.







COVID-19 Exposure Actions

Contact your CTM of potential exposure. For salaried employees, HRdirect will notify Enterprise Occupational Health and Safety (EOHS).

For faster response:

- From 8am to 5pm Monday to Friday (CST), contact EOHS directly at 1-800-742-5120
- Do NOT contact Workers' Compensation (Sedgwick) to report and exposure. An exposure or potential exposure does not qualify for a worker's compensation claim
- EOHS will assess the situation and provide guidance to the employee and/or CTM
- Notify your Clinical Team Manager or Regional Director
- Contact the Clinical Help Desk at 888-591-1511 or HouseCallsClinicalHelpDesk-DL@ds.uhc.com for support to escalate any clinical issues or concerns.

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Returning to See Members

APCs with symptoms who tested positive for COVID may return to work

- At least 10 days from onset of symptoms **AND**
- Improvement in any respiratory symptoms **AND**
- 72 hours afebrile without the use of antipyretics

APCs without symptoms who tested positive for COVID, and who remain asymptomatic, may return to work:

- 10 days after the last positive test

Note: Should symptoms develop, APC must follow the symptomatic return guidance

APCs with symptoms who tested negative for COVID:

- If experience symptoms for **more** than 72 hours, see PCP for clearance to return to work
- If experience symptoms or l**ess** than 72 hours and the symptoms are considered resolved, clear to return to work

Day of Visit

The Visit Day: Preparation

You are expected to dress professionally in HouseCalls issued clothing and/or lab coat with your Optum identification badge. There is a dress code policy on the HouseCalls Clinical Education Center (CEC) that you are expected to review.

Additional important aspects to the visit include:

- Personal Safety – Safety Equipment: this safety kit will be shipped with your initial supplies and includes items if your vehicle were to break down on the side of the road
- Company issued cell phone has been issued and should be used for company business
- Weapons – per policy, no weapons are allowed
- Pet safety – you are permitted to ask a member to secure their pet
- Only approved accompaniment is allowed during a visit; **no visitors, scribes, or assistants**
- If you feel unsafe in a home, please leave in a calm and professional manner

No Matter Which Door You Enter

You are a guest in the member's home and each member's home is to be treated with respect and patience while focusing on completing the visit.

At Member's Door

- Arrive wearing your PPE: mask, face shield or goggles and gloves
- Ask the COVID-19 Screening questions if unable to ask via phone in the day before Intro call
- Check the member's temperature with the provided no-touch thermometer before entering the home
- If a family member answers the door, ask the family member the pre-screening questions and check their temperature. Then, ask the member and check their temperature

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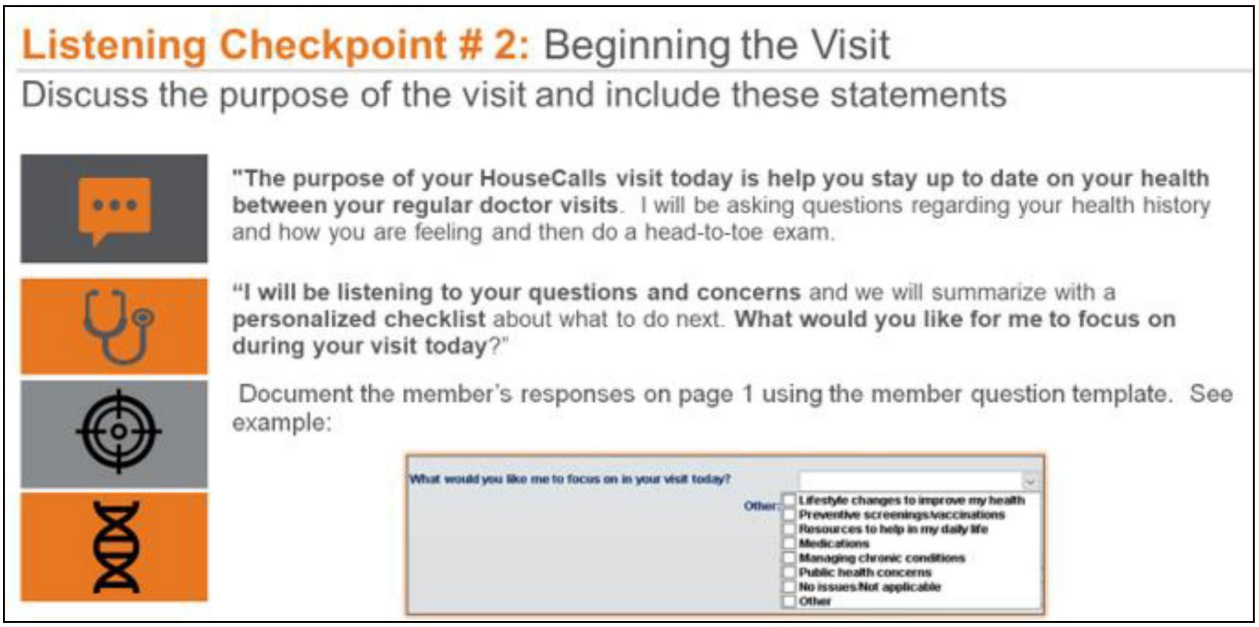
- If the member or family member has a temperature of 100º or greater:
  - Advise the member the visit will be rescheduled
  - Direct them to follow-up with their PCP and/or seek testing for COVID
  - Status the member for reschedule per current protocol



Member Not at Home

Arrive to the home at the designated time. If the member does not answer the door, please follow these steps:

1. Call the member
2. Call the Helpdesk so they can call the member
3. If the Helpdesk cannot reach them, wait a minimum of 10 mins and then leave a door hanger
4. Document details in eHouseCalls under **Scheduled Appointments**



The HouseCalls Visit

Beginning the HouseCalls Visit

Observations in the Home

Home safety is a vital component to the member's well-being, so during the visit assess for safety inside and outside the home.

- Outside the home
  - State of repair
  - Clutter around building

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- Inside the home
  - Lighting, odors, obstacles, floors, reminder notes
  - Observe the member as they move and ambulate in their home

As you begin the HouseCalls assessment, you will use the eHC software as your guide. All pages and tools of the assessment will be reviewed in order.

- Tablet use – hold like paper (using stylus or finger) or connected to the magnetic keyboard
- Establish a personal connection
  - Introduce yourself and explain the purpose of the visit
- Maintain eye contact while using tablet/interviewing
- Exhibit good listening skills
- Balance patience with the ability to redirect conversation
- You may NOT disclose PHI *except*
  - Suspected abuse or neglect
  - Disease affecting safety of the general public
- Do not discuss other members you are scheduled to visit

Documentation – Verify and Collect Visit Data

This section discusses all the elements of the assessment. The eHouseCalls manual provides additional details with screenshots to assist you with documentation.

- Member information verification: Insurance ID card or verify DOB
- Emergency Contacts or Caregivers
  - Anyone else present during the visit
  - Ask permission of member if household members are in room and document that consent was obtained
  - You may NOT disclose PHI except:
    - Suspected abuse or neglect
    - Disease affecting safety of the general public
- Verify PCP name and address
- Identify any specialists
- Major surgical history
- Admissions within the last 12 months
- ER visits in past 3 months
- Medications - member knowledge & adherence
  - Post Discharge Visit (PDV) - All members that have been discharged from the hospital within 30 days of their HCV will be flagged as a post discharge visit (PDV) and a reconciliation of all their medications will be required.
  - Medication Therapy Management members (MTM) are identified as having three of five chronic illnesses, have 8 or more medications, and expected costs for medication over a certain threshold.
- Allergies & reactions

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- Vaccines/Immunizations
- Preventive Screenings
- Pertinent Family History

Medication Therapy Management

- Mandate by CMS that provide Part D plans and members are assigned into this program. The goal of the program is to assist our members to understand their medications and to use them safely. To quality, they are identified as having:
- Three or more chronic illnesses
- Prescribed 8 or more medications
- Spend $3000 or more cost per year
- All MTM members receive a Personalized Medication List and Medication Action Plan letter after the visit. Please inform the member they will be receiving a letter after the visit.

Comprehensive Medication Review

- Consultation by practitioner assessing safety and efficiency
- Practitioner accurately documents for each medication and without misspelling:
  - Drug name, form, dosage, frequency, last fill date, indication, and prescriber name
  - Prescriber name must appear for each prescription medication listed as actively being taken by the member. For over the counter (OTC) and herbal supplements, may choose a provider name or input Self-Prescribed.
  - Drug name must be accurate. Choose from tablet drug name choices first or type exactly as it appears on medication label if not available in the data base. A misspelled drug name will fail the audit process, this includes the allergy section.
- Formulation of the drug needs to match formulation in the directions.
  - For example, Metformin 500mg tablet should have corresponding 'tablet' in directions such as 1 tablet PO in morning and evening.
  - If 1 capsule PO in morning and evening is chosen, this would fail audit.
  - For Albuterol solution for nebulizer, the medication is 'inhaled'. If directions are written 1 vial PO every 4 to 6 hours as needed, this would read as 'swallowed' and fails audit.

Do not use 'Unknown' or 'N/A' in the medication grid. An incorrect provider field results in a failed audit and generates the need to perform the medication review again with that member.

Include listening checkpoints (#3) such as "Were there any (other) questions you had regarding your medications today? I have time."

Assessment Highlights

- Allergies & reactions
- Vaccines/Immunizations
- Preventive Screenings
- Pertinent Family History
- Social History
  - Tobacco, Alcohol and Drug use, Life planning (Advance Care Planning Brochure), Assistive devices and Outside services

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Review of Systems

- Review each body system
- Elaborate/specify as needed if there is a positive finding
- Timely: Present & within the last Month
  - May have to clarify or re-direct

Physical Exam

During HouseCalls visits, the member is generally seated and remains dressed. Vital Signs are essential and are to be taken and recorded during the visit. We do not record or use pulse oximetry readings during the visit. Even if you have your own device, do not use these during visits.

- BP and recheck if high or low
  - A BP of less than 140/90 closes the measure; if the initial BP is 140/90 or higher, the reading needs to be repeated and recorded
- Pulse & Respirations
- Height as measured utilizing provided measuring tape
- Weight: Use the Scale
  - BMI will be automatically calculated
  - Must use scale on hard surface
    - Max 400 lbs
    - If unable to use the scale for these reasons, you must document reason in the PE notes section

Physical Exam Highlights

- Constitutional: Overall Appearance
- HEENT: These areas are currently being deferred – mark as "unable to assess"
  - Eyes: EOMs, pupillary response to light and accommodation, red reflex for cataracts and funduscopic exam
  - Ears: Observe for skin lesions
  - Otoscope exam of each ear for patency and cerumen
  - Gross hearing evaluation
  - Oral cavity: Dentition, denture fit, lesions
  - Neck**:** Auscultate for carotid bruits, palpate nodes & thyroid
- Cardiac & Respiratory: Auscultate on skin, <u>not through clothes</u>
- Abdomen can be auscultated and light palpation over clothing
- Wounds: Do not remove dressings; document what you see
- Feet: Monofilament testing on **<u>everyone</u>**
  - Additionally, Achilles reflex & vibratory sense is **required if**:
    - Monofilament abnormal or
    - Positive neuropathy in ROS or
    - Member is diabetic

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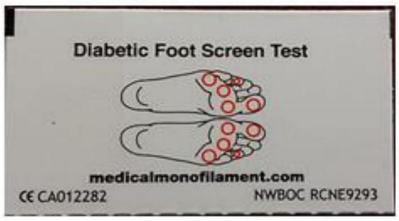
Monofilament Usage





This test is to be completed on **all members every visit** to assess for sensation. If you are unfamiliar with how to administer this test, please review these key points:

1. Demonstrate sensation on member's arm first
2. Member to close eyes, turn head
3. Instruct to say "yes" when they feel the monofilament
4. Touch the monofilament to the designated places on the foot for 1 – 1.5 seconds
5. The monofilament should bend to a "C" shape, may repeat x 2 if not felt
6. Ascertain if felt
7. Avoid callus areas
8. Document as normal or impaired on tablet

Vibratory Sensation Testing

This additional test will assist you in identifying any neuropathy or sensory issues for our members. Below, are key elements related to completing the test.

Use 128 Hz Tuning Fork:

1. Demonstrate sensation on member's upper extremity
   - Strike fork against something firm
   - Gently place on boney prominence on upper extremity
2. Instruct member to say "now" when they feel sensation and when sensation stops
3. Vibrate, touch bony area on lower extremity
4. Ascertain sensation
5. Manually stop vibration
6. Ascertain absence of sensation

Achilles Reflex Testing

This test must be completed on all diabetics and anyone with a positive finding in the ROS. Please review the procedural steps below for assistance.

- With member sitting, ask the member to relax their leg then dorsiflex the foot while supporting leg
- Using reflex hammer, strike the Achilles tendon and monitor for visual and/or felt forward flexion of the foot
- When the reflexes are absent try eliciting it after re-enforcing (Jendrassik maneuver), by asking the patient to interlock and pull flexed fingers.
- Grade deep tendon reflexes:
  - 0 = absent despite reinforcement
    1 = present only with reinforcement
    2 = normal

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3 = increased but normal
4 = markedly hyperactive, with clonus

Urine Dipstick Screening

Each member is requested to provide a small urine specimen for a spot evaluation for the presence of glucose and protein.

1. Dip and tap
    - Dip strip into urine
    - Tap to remove excess
    - Read at exactly 60 seconds
2. Record Protein and Glucose results as Neg, Tr, 1+, 2+, 3+, or +4
3. Maintain strips in bottle until use
4. Needs to be maintained at 35-85 degrees
5. Avoid high humidity
6. Never leave in hot/cold car
7. Bring bottle into residence nightly

Screening Tools

Screening tools can be mandatory or optional based on tablet logic. Keep in mind that any "Optional" screening tool may become mandatory if triggered by entered assessment data.

- Mandatory screening tools
    - ADLs – Barthel Index
    - Comprehensive Pain Assessment
    - Mini-Cog
    - Fall Risk Assessment
    - Health Risk Assessment
    - Social Determinants of Health
- Optional screening tools.
    - Mini Nutritional Assessment (MNA)
    - Depression – PSY/PHQ-9

Falls Risk Assessment (FRA)

Falls are the second leading cause of accidental or unintentional injury worldwide with adults over the age of 65 suffering the greatest number of fatal falls. The tool is used to identify if the member is at risk for falls based on the following scoring system:

- Score < 3 = Low risk
- Score 3-4 = Mod-High Risk
- Score ≥ 5 = High Risk

There are many contributing factors related to falls that include:

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Sensory Systems

- Decreased visual acuity, depth perception, contrast sensitivity
- Decreased proprioception
- Vestibular system: loss of labyrinthine hair cells and nerve fibers

Musculoskeletal

- Decreased strength, bone and muscle mass
- Degenerative joint disease
- Osteoporosis/osteopenia

Cardiovascular

- Decreased ability to adapt to postural changes
- Decreased vascular compliance
- Age related changes in total body water

Intrinsic Factors

- History of falls
- Gait or balance disturbance
- Lower extremity weakness
- Fear of falling
- Age related changes
- Age over 80
- Dizziness
- Incontinence
- Female gender
- Orthostatic hypotension
- Depression
- Visual, hearing, cognitive, or functional impairment
- Parkinson's, arthritis, neuropathy, anemia
- Vitamin D deficiency

Extrinsic Factors

- Ill fitting, improper, or worn footwear
- Lack of or improper use of assistive device
- Clutter, rugs, stairs
- Poor lighting
- Wet, uneven, or shiny floor surfaces
- Unfamiliar environments
- Multiple pharmacies
- Recent change in medications (addition or dose change)

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Medication and Falls

- Medications is one of the MOST modifiable risk factors
- Certain classes of medications have higher impact on falls (check next slide)
- Multiple medications
- Recent dose changes
- Poor adherence to medications

Fall Risk Increasing Medications

- Psychotropic (antipsychotics, benzodiazepines, sedatives, antidepressants)
- Narcotics
- Anticonvulsants and Parkinson's medications
- Antihypertensive
- Sleeping agents
- Diuretics

In order to properly evaluate fall risk in the home, the HRA tool is completed on all members. As the APC it is responsibility to educate and make recommendations to the PCP.

PCP Recommendations for fall prevention

Diagnostic testing based on H&P

- CBC, CMP, drug or vitamin D levels
- EKG, echo
- X-ray for ortho issues
- Neuro imaging (CT, MRI) of head and/or spine if indicated
- Holter monitoring

Member Recommendations

- Vision
  - Routine vision and eye screening is recommended to prevent falls
  - Multifocal lenses contribute to an increased risk of falls
- Exercise
  - Exercise programs should be regularly assessed
  - Exercise programs should include activities that increase and improve
    - Balance
    - Gait
    - Strength training
    - Flexibility
    - Cardio/fitness/endurance

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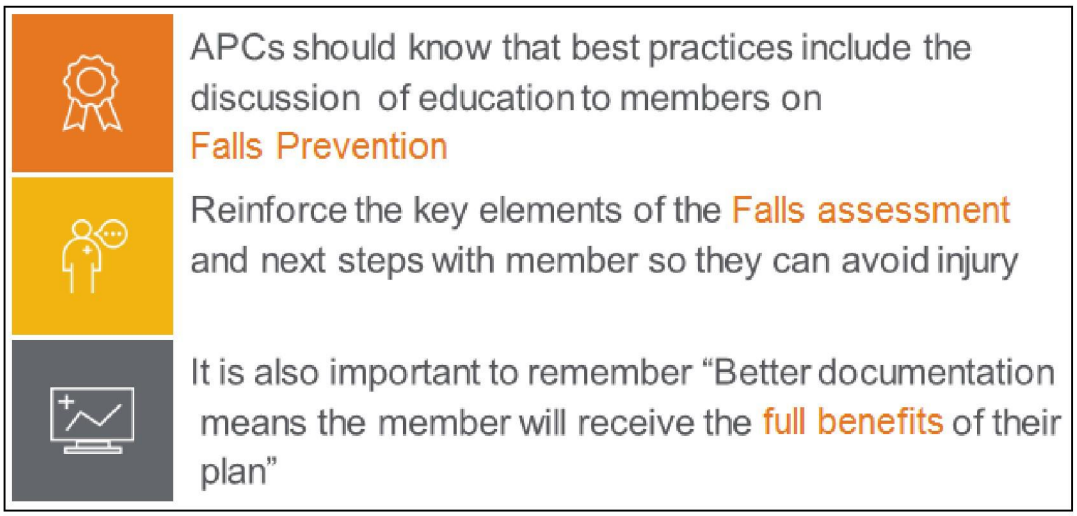
Education & Prevention

- Fall Risk Brochure
  - Falls Risk Brochure should be handed out to everyone regardless of risk; If there is or low fall risk and none of the drop-down options on page 16 Falls Risk Education clinically apply to that member (Med Review, DME, Vision, Balance), we should select Balance
- Monitor and manage hypotension and postural hypotension
  - Ensure adequate hydration
  - Consider salt intake
  - Elastic stockings
- Manage and prevent hypoglycemia
- Consider minimizing/adjusting medications
- Common cardiovascular disorders that contribute to falls
  - Carotid sinus hypersensitivity
  - Vasovagal syndrome
  - Brady arrhythmias
  - Tachyarrhythmias
- Orthopedic and pain issues
- Parkinson's disease

Best Practices for Members to Avoid Falls



NOTE: If you have a member who is unable to complete the tool, you will be required to answer the questions with "No" responses, and then provide a note in the assessment notepad section

Finishing the Visit

Educate Members about COVID-19

Discussion focus aims to:

- Provide information about COVID-19 (using the member guide)

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- Reinforce ways to stay healthy and safe
- Educate members who inquire about "what should I do if I think I have Coronavirus?"
  - Symptoms of infection (cough, body aches, runny nose, sore throat, fever, GI symptoms)
  - Achieving social distance within the home (clean surfaces, wear a mask, wash hands)
  - When to call PCP if symptoms worsen (i.e. fever, dyspnea, chest pain)
  - Keeping others safe when seeking medical care

Listening Checkpoint #4

As part of the 4th listening checkpoint, we want to provide the member a summary of the visit. In reference to the Ask Your PCP form, use the term "personalized checklist" which is consistent with other communications the member receives from HouseCalls. It is also important for members to know what happens after the visit and what to do if they have follow up questions. By using the statement above, we communicate to members to take the personalized checklist to their next PCP appointment and we will mail them and their PCP a comprehensive summary of the visit, including all of their next steps for the screenings and recommendations we reviewed. If the member has questions, they can follow-up with their PCP and/or call the HouseCalls member line number on the back of the AYPCP form.

PCP Outreach

It is important that members keep in contact with their PCP, especially during periods of uncertainty like during the COVID outbreak. Educate on the importance of continuing with primary care and outreaching to PCP with any urgent needs, warm transfer to dedicated members services team to assist with scheduling appointment(s) or finding a PCP (if needed). Examples of questions to discuss with the member include:

- "Are you able to access your PCP when/if needed including virtual or telephonic visits?
- "Is there anything you want me to call your primary care provider to talk about for you?"
  - If yes, document to give the info to PCP
- "Based on my assessment of your conditions, I would like to contact your provider to discuss the following:
  - List condition and issue (example, needs a med refill, needs a med adjustment, etc.)
- "I will ask the provider to reach out to you to discuss this further. If you don't hear back from the **<insert provider's name>,** I encourage you to give their office a call."

Assisting Members with Connecting to Services

There are many resources that you can provide the member during the visit and you are expected to assist them in connecting to these services. Help for a variety of issues is just a telephone call away. Using the member's phone, help them connect before you leave the home. Below are a few examples of these services with more detail available on a Job Aid and will be discussed further in the Referrals presentation.

- COVID Support Line: Outreach x 2 weeks to members needing assistance with medical and non-medical needs
- Advocate4Me: Assist with obtaining appts. for preventative screenings, social needs
- Nurse Line: Assistance with clinical/medical questions and issues
- Behavioral Health: Three programs to assist members

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Give EVERY Member

- Ask Your PCP handout
- Age Page Falls & Fractures brochure
- Your Annual Health Guide handout
- Recommended Screening/Vaccination handout
- Member Visit Magnet
- Member gift and a Thank you!

Member Education Materials

- Tobacco Users – "Commit to Quit
- Diagnoses specific – approved handouts
- Provide special flyers as pertinent to member eligibility:
  - Dispatch Health: (OAH or National Flyer)
  - Optum at Home or DSNP members (DC, DE, GA, IA, & PA)

The Ask Your PCP Handout

The Ask Your PCP handout is a form the practitioner completes during every HCV and leaves with the member at the close of the visit. It is designed for the member to ask questions about their health from their perspective at their next PCP visit. Encourage them to take it with them to their next PCP appointment.

- Date of the visit
- Member's vital signs
- HCP's name
- Preventive Care Suggestions
- Additional Recommendations
- DME Suggestions

The information documented on the electronic and paper forms of the AYPCP letter should be identical.

Reviewing Your Assessment

- Review your assessment paying attention to the PMH and Active diagnoses
- Complete any referrals as warranted or indicated
- Finalize assessment and save
- Sync your assessment within 48 hours
- If need to make an amendment, assessment is available for up to 48 hours on the Practitioner Portal

Peer Suggestions

- Prior to the visit- get prepared
- Keep the member's "Ask Your PCP" letter next to you and complete as you go along and use to reinforce teaching
- Hand out the Recommended Screening/Vaccine form as you review the section in the assessment
- Complete your documentation during your visit, or before going to the next home

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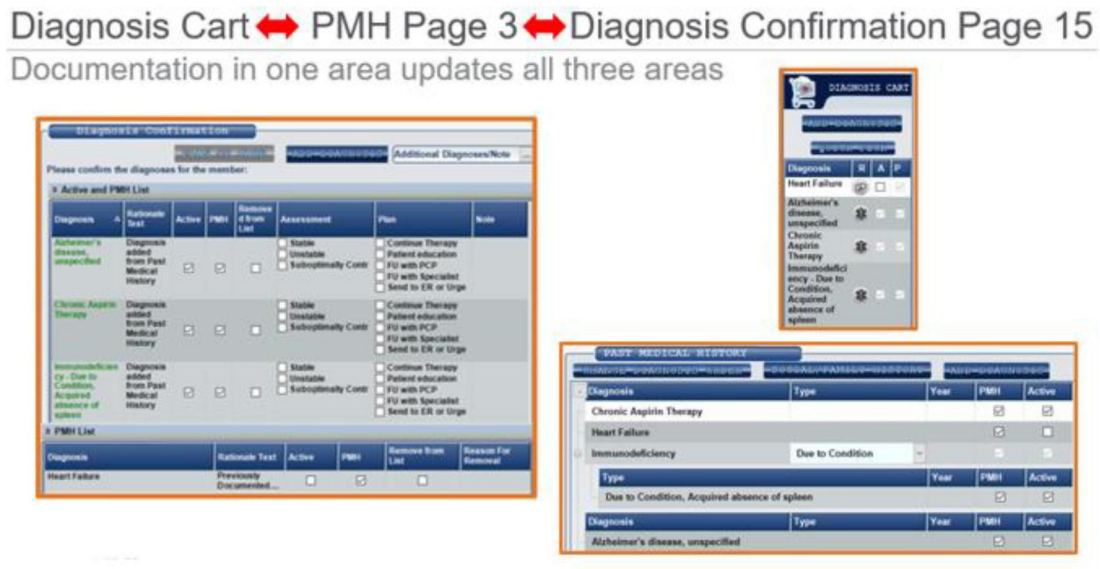
- Take time to review your work either at the time of the visit or later but before you finalize and sync
- Address all areas of the assessment and provide member education
- Document all urgent collaborations and referrals
- Closing the visit - Leave educational materials, gift, Screenings and Vaccination and AYPCP form
- Trust your gut and follow your instincts
- When in doubt - call!
  - The Helpdesk
  - The Clinical Helpdesk/Hotline
  - Clinical Team Manager
  - Member's PCP

Diagnosis Confirmation Page

Diagnosis Expectations

It is expected that you identify diagnoses during HouseCalls Visit to the highest level of specificity based on:

- Medication Review
- Review of Systems
- Physical examination findings
- Notes
- Diagnoses that are prepopulated in the diagnosis cart (PHM dx) should be considered when making or confirming diagnoses
- Professional judgment, expertise, and experience



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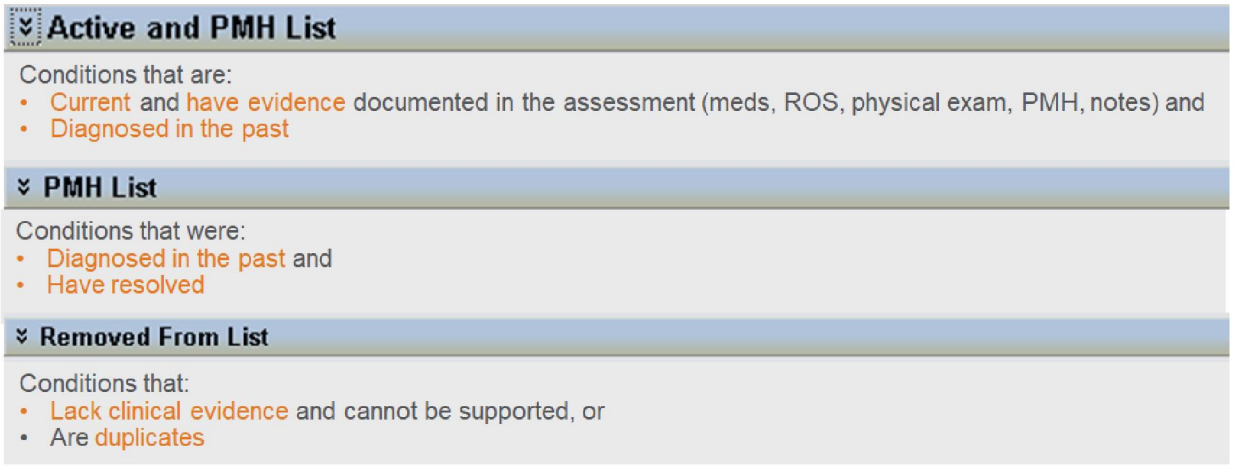
Diagnosis Confirmation Page Lists



Active & PMH List

Components of Diagnosis Documentation

ACTIVE status	PMH status	Remove from list	Assessment	Plan
Diagnoses that are current and have evidence documented in the assessment: • Medications • ROS • Physical exam • PMH • APC notes *GREEN font	Conditions that were diagnosed in the past which may be: • Resolved and no longer current (PMH only) or • Current & active (Active & PMH)	Diagnoses that: • Lack evidence and cannot be supported, or • Are duplicates	• Stable • Unstable • Suboptimally controlled	• Continue therapy • F/U PCP and/or specialist • Patient Education • Send to urgent care or ED

Write-in Diagnoses and Notes

For diagnoses that cannot be located under **ADD DIAGNOSIS**, type them in the **Additional Diagnoses/Note** notepad with all corresponding components (active, PMH, etc.). Use the **Note** column to document additional substantiating information regarding a diagnosis.

Smart logic

Some diagnoses are populated by computer logic or Smart logic. Based on what is documented in the assessment, diagnoses are suggested, and the APC must confirm or remove from the diagnosis confirmation page. Examples are listed below:

- BMI 35-39.99 with comorbid conditions → Severe/Morbid obesity due to excessive calories
- Former Cigarettes/Tobacco → Personal history of nicotine dependence
- Current Cigarettes/Tobacco → Nicotine dependence, cigarettes, uncomplicated
- Abnormal monofilament or symptoms of paresthesia → Polyneuropathy

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Conditions Unlikely to Resolve

"Conditions Unlikely to Resolve" refers to chronic conditions that will remain with the member/patient for the rest of their life.

These conditions never truly resolve but may:

- Compensate with treatment
- Transition into remission status

Documentation should indicate the clinical significance of the diagnosis even when it may not be readily apparent on examination. These conditions should remain active on the diagnosis confirmation page. The following are generally considered to be **conditions unlikely to resolve**:

- CHF/heart failure
- All COPD codes
- Chronic hepatitis B
- Atherosclerosis of aorta
- Atherosclerosis of the extremities
- All psychiatric codes, even single episode (use remission identifier)
- All alcohol and drug dependency (even in remission)
- Diabetes
- Parkinson's disease
- Lupus (SLE)
- Multiple Sclerosis (MS)
- Rheumatoid arthritis (RA)
- Status amputation (below the waist; AKA, BKA or foot/partial foot amputations)
- All functional artificial openings
- HIV/AIDS
- Status transplantation for the following:
  - Heart
  - Bone marrow
  - Stem cell
  - Liver
  - Lung
  - Pancreas
  - Kidney

Conditions Likely to Resolve

When might a condition which is statused "Condition unlikely to resolve", resolve?

- When an artificial opening is reversed, closed, or no longer functional

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- A chronic condition resolves when there is an:
  - Organ transplant and there is no evidence of the active disease that necessitated the transplant.
- Examples:
  - Diabetes without complications status-post pancreas transplant
  - Cirrhosis/end-stage liver disease/hepatitis status-post liver transplant
  - COPD/emphysema status-post lung transplant
  - CHF/cardiomyopathy status-post heart transplant

Diagnoses to Remain Active

These conditions, while an intervention might have occurred, did not completely resolve the condition thus should be maintained as active in the assessment on the diagnosis confirmation page (15).

- Amputations- specified
- Cataracts- removed
- Chronic deep venous thrombosis
- Chronic pulmonary embolism
- Colostomy, ileostomy, tracheostomy, gastrostomy, PEG tube
- All "(Personal) History of" diagnoses
- History of MI
- Previous angioplasty
- Previous CABG
- Transplants (any type)
- Mastectomy (unilateral and Bilateral)
- Lymphoma, leukemia, multiple myeloma

PMH List

Diagnoses present within the PMH list indicate that:

- The APC agrees that the member had this condition in the past
- The condition has resolved and is not active

Prepopulated diagnoses will appear in the PMH list, they are auto checked as PMH, and the rationale is **previously documented diagnosis**. These diagnoses are obtained from previous claims, medical charts, or previous HC visits. Diagnoses may be current, outdated, resolved, ruled out, or duplicated.

The practitioner's responsibility is to:

- Review prepopulated diagnoses
- Use the information to guide interview and assessment of the member
- Determine if diagnoses can be confirmed
- Remove any unsubstantiated diagnoses

Open the PMH list before finalizing to ensure you have addressed all previously documented diagnoses with the member. For chronic conditions that are unlikely to resolve, assess if they are present, resolved, or if the member ever had that condition. Based on evaluation of the member, if no evidence is found for

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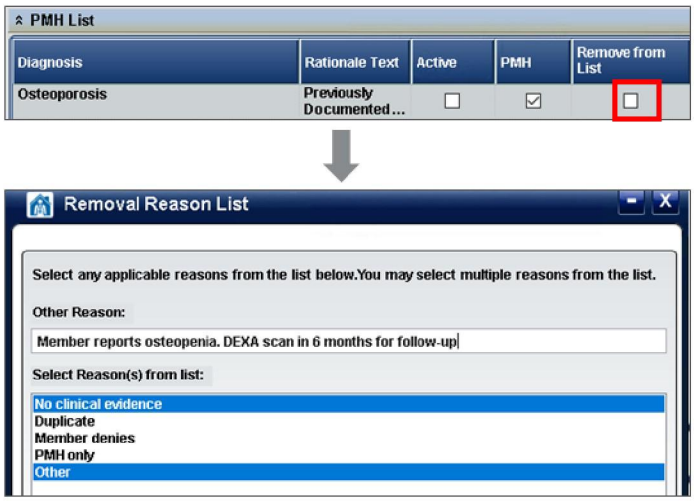
a condition and it is believed that the member never had the diagnoses, remove the diagnosis from the list. Select the **remove from list** checkbox, enter the reason for removal, and click **Save**.

Removing an Unsupported Diagnosis from the List

Example:

- PMH List shows Osteoporosis
- Last bone density test showed osteopenia. Has f/u scan in 6 months
- Began exercising and increasing dietary calcium
- Member does not take bisphosphonates. Takes calcium + Vitamin D
- APC removes Osteoporosis from the list due to **No clinical evidence**



Removing Duplicate Diagnoses from the List

If multiple diagnoses are populated for the same condition, choose the most specific diagnosis that can be supported by evidence found within the assessment. Use clinical judgment to determine best and most accurate diagnosis. Use the unspecified diagnosis if a more specific diagnosis cannot be confirmed. Ensure ALL diagnoses have documented clinical support in the assessment. Incorrect/unsubstantiated diagnoses should be removed from the *Active & PMH* list.

Chronic diastolic (congestive) heart failure	☑	☑	☑ Stable ☐ Unstable ☐ Suboptimally Controlled	☑ Continue Therapy ☐ Patient education ☐ FU with PCP ☐ FU with Specialist ☐ Send to ER or Urgent Care
Chronic systolic (congestive) heart failure	☑	☑	☑ Stable ☐ Unstable ☐ Suboptimally Controlled	☑ Continue Therapy ☐ Patient education ☐ FU with PCP ☐ FU with Specialist ☐ Send to ER or Urgent Care
Heart Failure	☑	☑	☑ Stable ☐ Unstable ☐ Suboptimally Controlled	☑ Continue Therapy ☐ Patient education ☐ FU with PCP ☐ FU with Specialist ☐ Send to ER or Urgent Care

PDF Example of multiple Heart Failure diagnoses documented as active

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Keep the diagnosis that can be confirmed based on your clinical judgment and remove the rest from the Active & PMH list.

HouseCalls Lab Program

Objectives

- State the two types of lab tests that may be collected by HouseCalls practitioners
- Identify how labs are flagged for collection in the tablet and Portal
- Discuss lab supplies distribution, storage and use

Current Tests

There are two types of instances when a lab will be conducted by tablet if provider identified. If it is tablet identified, it will be based on information we have received from claims or previous visits based on our criteria. As the practitioner in the home, if a member meets the criteria and is not flagged, you can conduct either one of our two labs (HbA1c or FOBT).

Tests included as part of the HouseCalls Lab program at this time:

- Hemoglobin A1c
  - Performed via finger stick during the visit with the A1CNow+ kit. Results are available in 5 minutes and performed only on known diabetic members who meet specified criteria
- Immunochemical fecal occult blood test (iFOBT)
  - "Lab in an envelope" kit that you will give the member to collect the specimen and mail in the envelope. This requires that the bar code from the lab kit be entered into the tablet

NOTE: No dietary modifications are required prior to collection of either test

Lab Collection Criteria

The criteria below shows eligibility for the tablet and PIN identified lab capture.

iFOBT	A1C
Ages: Eligible if aged 50-75 and the member has not had: • A colonoscopy within the past 10 years *or* • A Flex Sig within the past 5 years *or* • A Cologuard within the past 3 years (FIT-DNA) *or* • A fecal occult blood test within the current calendar year • Or if they cannot recall their last colorectal screening test or deny any colorectal screening	**Ages: Eligible if aged 18-75 with a known diagnosis of Diabetes and the member:** • Has not had an A1C performed in the current calendar year • No recall of when last A1C was performed • Had an A1C more than 3 months ago and result was greater than 9%

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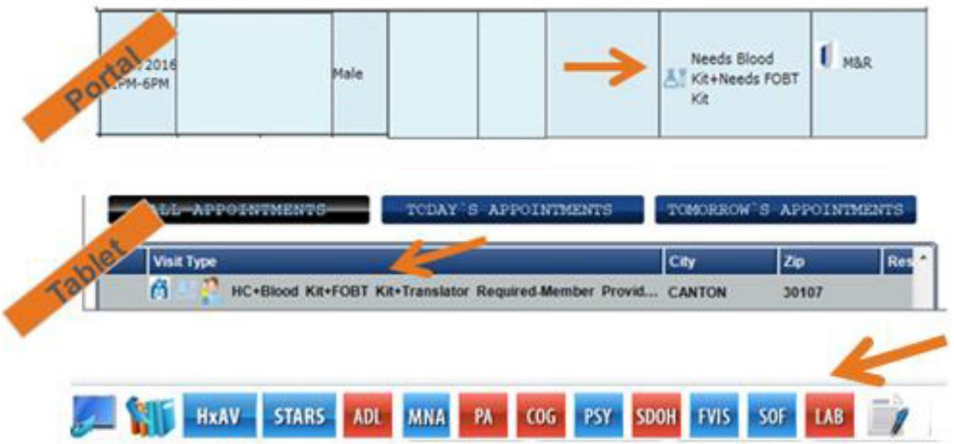
Lab Scheduled: Tablet and Portal Views

Members identified as needing labs are highlighted in the:

- **Practitioner Portal** on Appointment screen
- **eHC Assessment appointment** list under "Visit type"
- **Lab tool** on the member's assessment will be **Red**

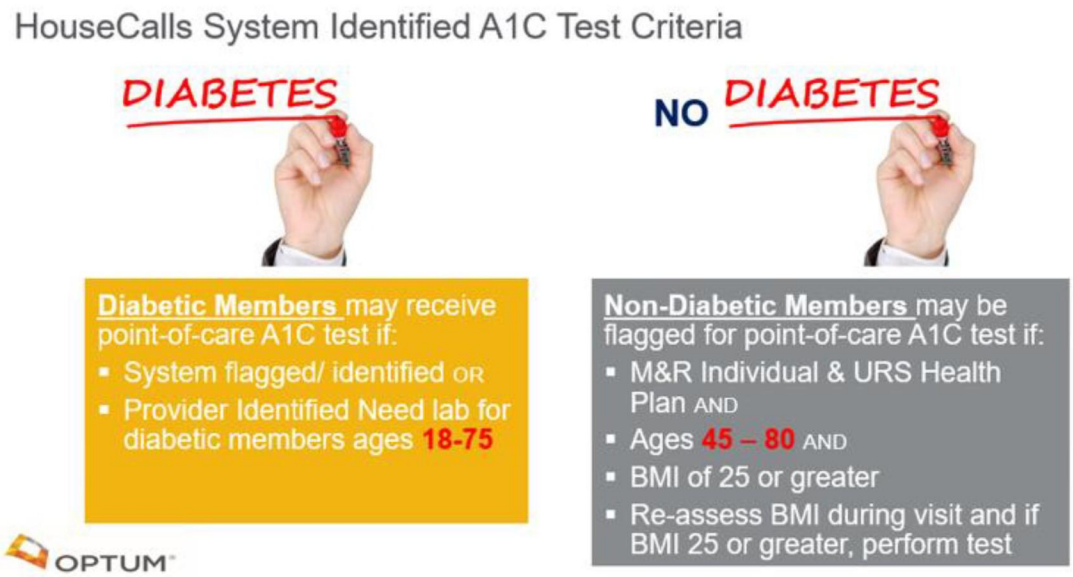


Another area you will be able to identify if a lab is required will be on the Tool Bar as pictured above; the LAB tool will be red. It will turn Green if initially Red OR Blue and you will be required to finalize the eHouseCalls assessments.

Lab Program: Special Situations

Exceptions to the HouseCalls Lab Program

HgbA1C testing is provided to M&R Individual and URS Group Retiree health plans, ages 45-80 with a BMI of 25 or greater in all states.



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The tablet should flag these members based on last year's BMI. If the member no longer meets th criteria, the test should not be performed.

There are Job Aids to assist you with these member groups on the HouseCalls Clinical Education Center (CEC) in addition to a LearnSource that is to be completed before you start seeing members. For additional questions, contact your CTM.

Consent for Labs

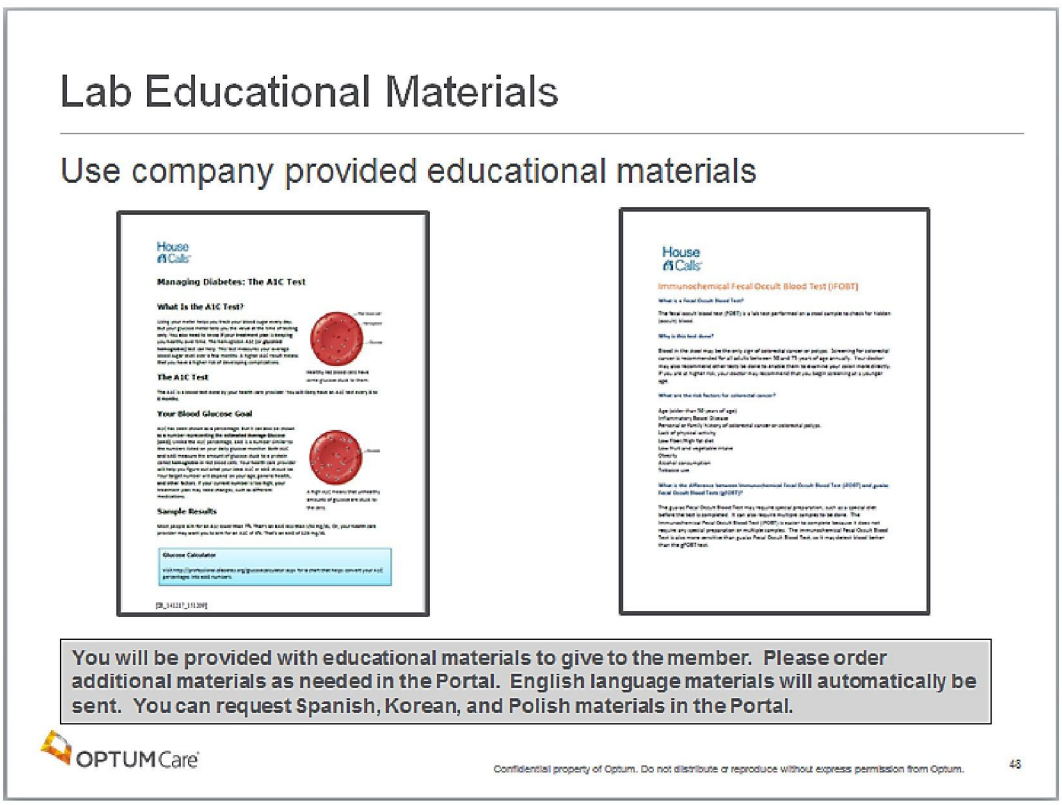
Obtain informed consent for lab sample collection and authorization for release of information to vendor.

- All practitioners who collect lab samples should educate every member about their screening and the risks or discomforts before collecting the sample.
- Educate the member on test(s) using company-provided educational materials and explain procedure for lab collections.
- Instruct the member to report any severe or unusual reactions to their PCP.
  - If the member does not have a PCP, click on "Member needs assistance finding a PCP" and have the member contact Member Services at 1-866-686-2504.

- **NOTE: You will be provided with educational materials to give to the member. Please order additional materials as needed in the Portal. English language materials will automatically be sent. You can request Spanish, Korean, and Polish materials in the Portal.**

Lab Educational Materials

This education material pertaining to the labs can be provided to the member because it is a company approved document. These materials can also be ordered on the Practitioner Portal.



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A1cNOW+ Point of Care Test

Hemoglobin A1c Test: Point-of-Care (POC)-A1cNOW+®

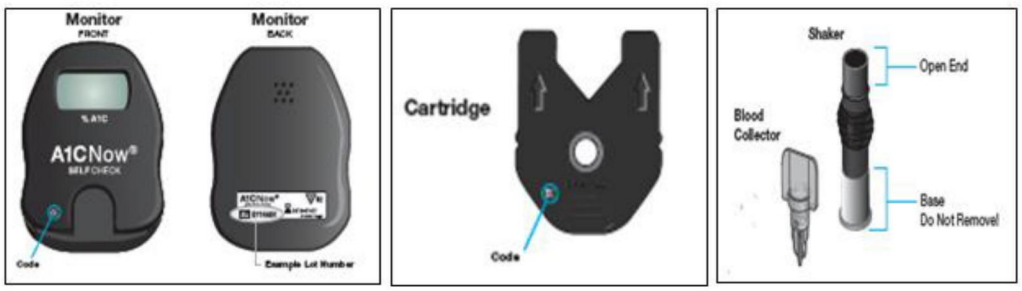
The A1cNOW POC test will provide results in the home in about 5 minutes. The immediate result will provide a good educational opportunity to our diabetic members not only about the A1c test and its function, but other diabetic education (i.e. diet, neuropathy, nephropathy, general diabetic information).

- Performed in the home with results in 5 minutes
- Uses a finger stick collection
- Provides results to members immediately
- Provides results to PCP by documenting result in the HouseCalls assessment for inclusion in the Post Assessment letter
- Also document on the AYPCP letter for member and PCP reference that a lab was done and the results
- Instructions on how to use the kit are included in the kits

Materials Needed for Testing

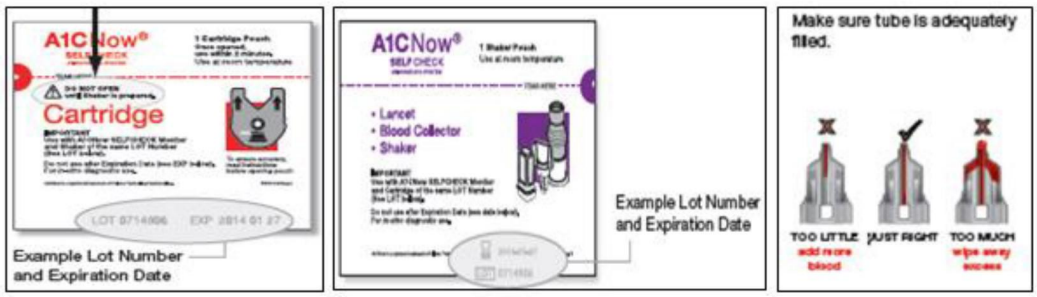
Kit Contents

- Monitor
- Collector packet (#1 purple packet)
  containing blood collector and shaker
- Cartridge (#2 red packet)



Procedure

1. Check that cartridges and blood collector have the same lot number
2. Perform finger stick - Requires one large drop of blood (5 microliters). Collect the blood using the blood collector.



3. Insert blood collector into sampler body (shaker). Make sure the collector is fully inserted into the shaker. There should be no gap.

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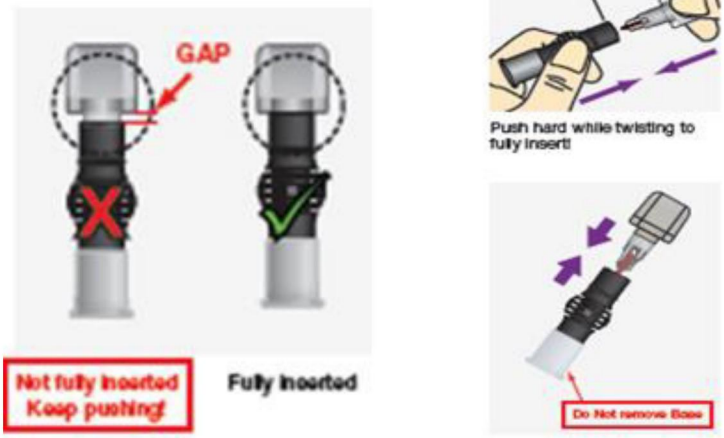
4. Shake well 6-8 times and stand sampler on table while preparing cartridge.



5. Insert cartridge into monitor and wait for **SMPL** to display on the monitor
6. Remove base of sampler and insert into cartridge on monitor.
7. Push down completely to dispense diluted sample and remove quickly when the monitor reads **RUN**.
8. Wait 5 minutes for result to read. The display will count down the time.



Documenting A1C Now+ Results

- If the member states they had the test recently, document their reported results in the eHouseCalls assessment on Page 10 of the assessment under “Diabetic Testing” and mark the test as “Refused-Recently Completed”
- If the member refuses or you are unable to collect, select the appropriate reason from the drop-down box.
- If the A1C result is higher than 13%, you will receive a pop-up box asking you to confirm it is a number higher than 13%. The pop-up instructs you to enter 13% in the results field and check the box to the right confirming the elevated reading.

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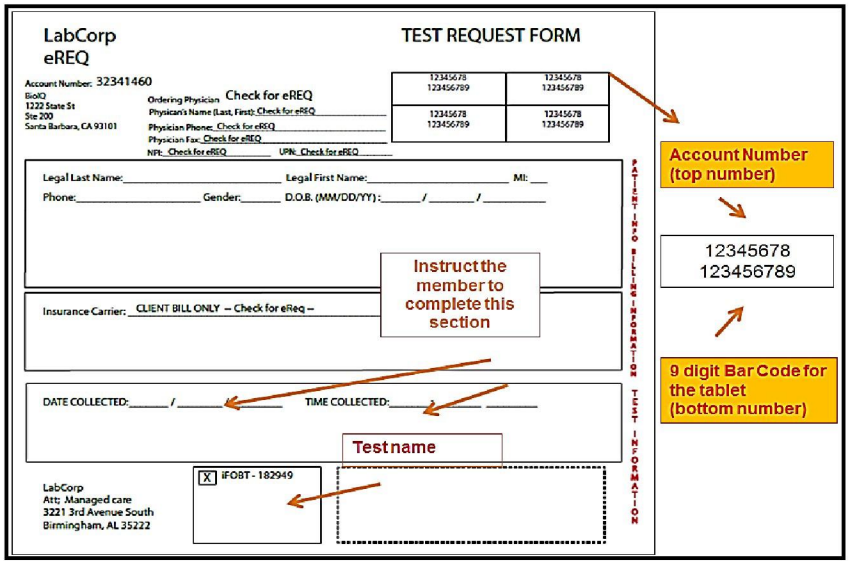
iFOBT: Immunochemical Fecal Occult Blood Test

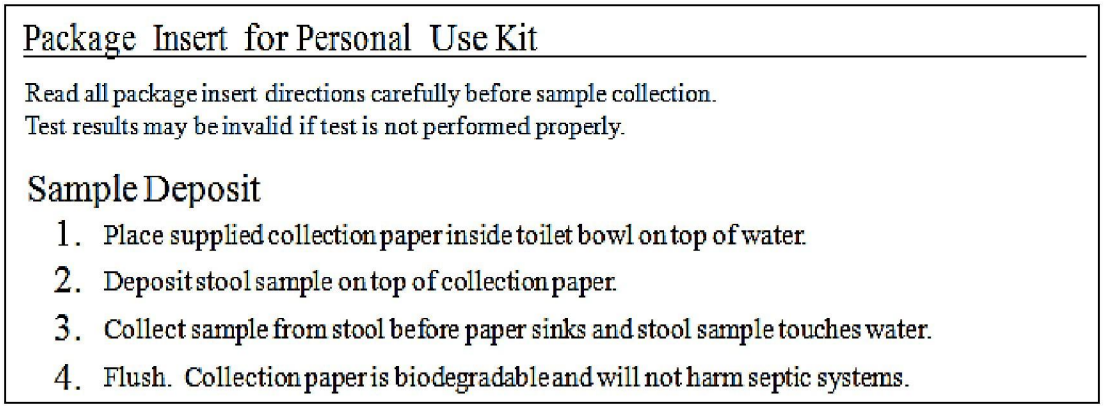
iFOBT Test

- Everything needed for the collection and mailing the test is included in the envelope.
- The practitioner is expected to open the kit and instruct the member on how to collect the specimen and return the envelope *along* with the test request form.
- The practitioner should complete the member's name and DOB, while the member will complete the date and time of collection prior to mailing.
- There is a 9-digit bar code that is required to be entered into the eHouseCalls assessment for the test to be processed.



iFOBT Procedure

Explain instructions for iFOBT collection kit to the member.



Package Insert for Personal Use Kit

Read all package insert directions carefully before sample collection.
Test results may be invalid if test is not performed properly.

Sample Deposit

1. Place supplied collection paper inside toilet bowl on top of water.
2. Deposit stool sample on top of collection paper.
3. Collect sample from stool before paper sinks and stool sample touches water.
4. Flush. Collection paper is biodegradable and will not harm septic systems.

- Write member name and DOB on iFOBT sampling bottle and the test request form. Do NOT enter date/time collected.
- Leave kit and instructions with the member – ask them to collect and return as soon as possible. As a reminder they can place it near their toilet.
- Be sure to review the instructions with them. The instructions are available in English and Spanish.

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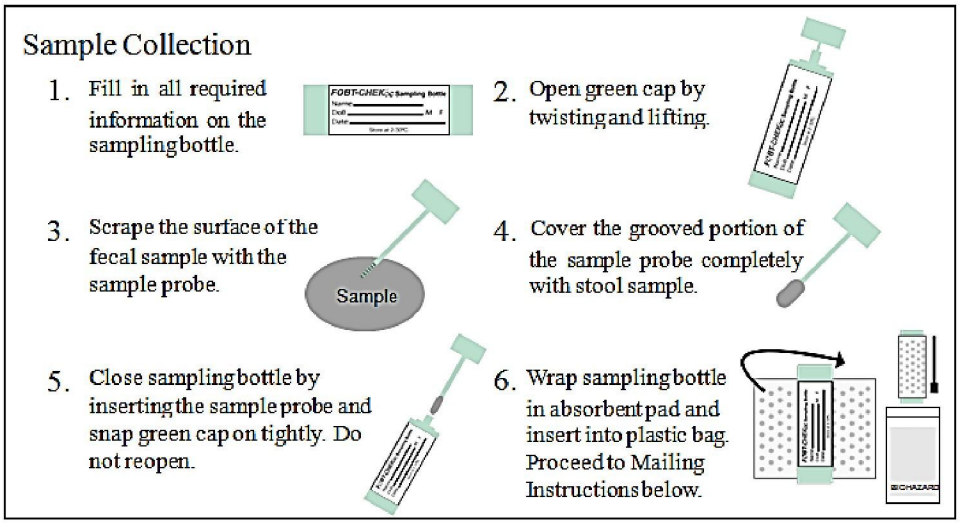
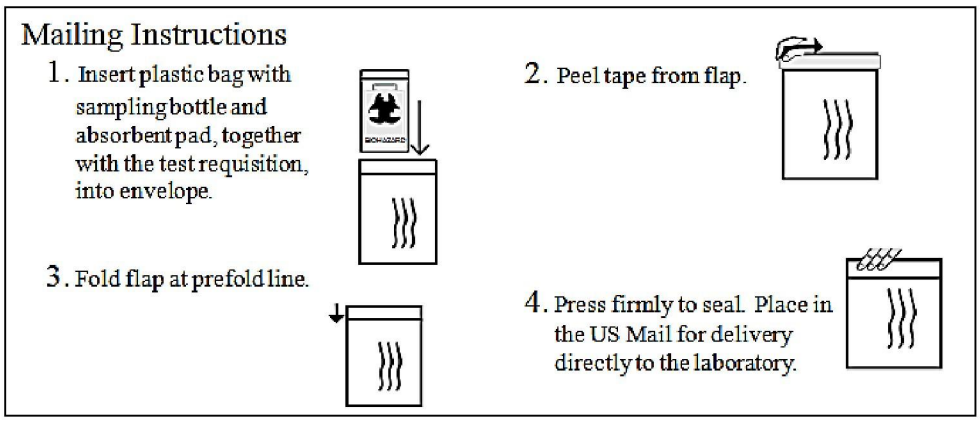
iFOBT Kit



iFOBT Kit Mailing Instructions



NOTE: Please remember to remind the member to write the date and time collected on the eRequisition form, and to mail the sample to the lab as soon as possible.

iFOBT Reminders

- The 9 Digit barcode sticker from the Test Request Form (TRF) will be placed on the specimen tube
- Write member name and DOB on iFOBT sampling bottle and the test request form. Do NOT enter date/time collected.
- Leave kit and instructions with the member –As a reminder they can place it near their bathroom
- Encourage the member to mail in the iFOBT test as soon as possible after collection
- Be sure to review the instructions with them

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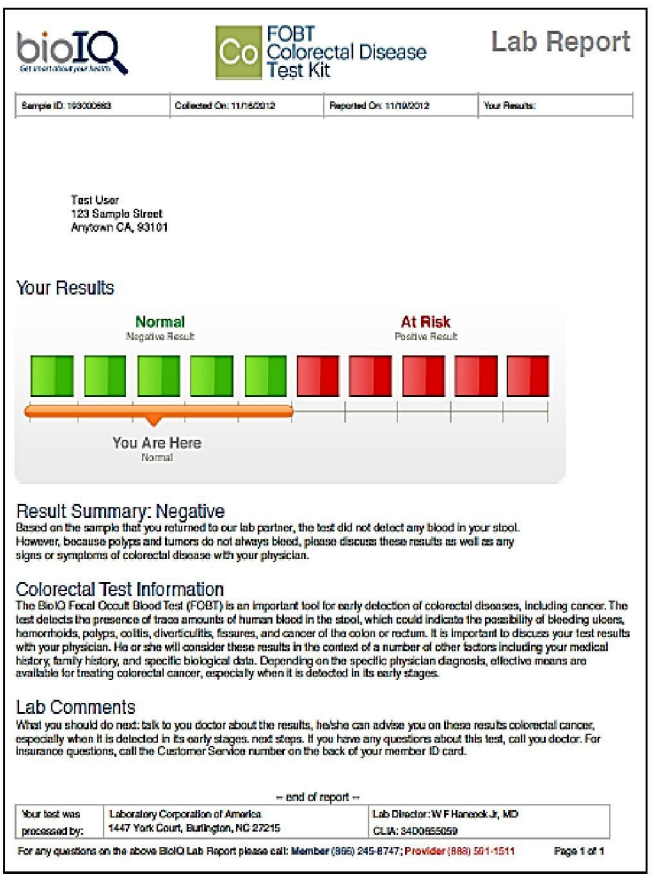
iFOBT: Key Points

- Do NOT leave an iFOBT kit if you are completing a paper assessment. The specimen cannot be processed when there is no recording of the bar code

- If during the visit, if a member reports a current colorectal screening, do not leave a kit
  - Mark the appropriate box in the lab tool and in the Preventative Screening Section to close the gap
- Sync your tablet every evening so that the bar code information can be sent to the lab
  - This allows the specimen to be processed as soon as it arrives at the lab
- The latest iFOBT test request forms are now asking for the following:
  - Insurance number
    - For all HouseCalls APCs, the insurance information can be ignored. Please write "N/A" over this area. The member demographics are still needed.
  - Group number
  - Member address

iFOBT Results

This is an example of the report that members receive in the mail from BioIQ with their iFOBT results. Their PCP will also receive a copy of the results.



bioIQ

FOBT Colorectal Disease Test Kit

Lab Report

Sample ID: 193000883	Collected On: 11/16/2012	Reported On: 11/19/2012	Your Results:

Test User
123 Sample Street
Anytown CA, 93101

Your Results

Normal
Negative Result

At Risk
Positive Result

You Are Here
Normal

Result Summary: Negative

Based on the sample that you returned to our lab partner, the test did not detect any blood in your stool. However, because polyps and tumors do not always bleed, please discuss these results as well as any signs or symptoms of colorectal disease with your physician.

Colorectal Test Information

The BioIQ Fecal Occult Blood Test (FOBT) is an important tool for early detection of colorectal diseases, including cancer. The test detects the presence of trace amounts of human blood in the stool, which could indicate the possibility of bleeding ulcers, hemorrhoids, polyps, colitis, diverticulitis, fissures, and cancer of the colon or rectum. It is important to discuss your test results with your physician. He or she will consider these results in the context of a number of other factors including your medical history, family history, and specific biological data. Depending on the specific physician diagnosis, effective means are available for treating colorectal cancer, especially when it is detected in its early stages.

Lab Comments

What you should do next: talk to you doctor about the results, he/she can advise you on these results colorectal cancer, especially when it is detected in its early stages. next steps. If you have any questions about this test, call you doctor. For insurance questions, call the Customer Service number on the back of your member ID card.

-- end of report --

Your test was processed by:	Laboratory Corporation of America 1447 York Court, Burlington, NC 27215	Lab Director: W F Hancock Jr, MD CLIA: 34D0655059

For any questions on the above BioIQ Lab Report please call: Member (866) 245-8747; Provider (888) 561-1511 Page 1 of 1

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Obtaining Informed Consent and Authorization

- The consent form is electronic and is attached to the assessment in the Lab Tool
- If your tablet is not functioning for any reason, DO NOT leave an iFOBT kit
- You MAY collect and perform an A1C point-of–care tests if your tablet is not working or you are using a paper assessment
- Be sure to verify the member information again on this document



- Complete the questions on the lab tool in the tablet. The member, representative, or practitioner reads the consent & authorization and checks boxes:
  - Check box for obtaining consent to lab specimen collection (if obtaining a blood test)
  - Check box for obtaining authorization to release information to lab vendor for **iFOBT test**
- The member or representative signs the consent/authorization form on the tablet
- If the member refuses to consent for authorization of testing, the testing cannot be done
- If the member refuses to consent to the authorization for release of information, we cannot do the iFOBT

Documentation of Labs

Documentation in the lab tool can sometimes be tricky. You should start in the middle with verification of the member's name and DOB; this will enable the signature pad for the member to sign. From there, you must check the box for either or both blood test consent/ BIOIQ. The A1C requires both boxes, and the iFOBT only requires the BIOIQ Authorization.



Start in the middle of the page with verification of the member's name and DOB. This will enable the signature pad for the member to sign.

For the iFOBT test, the BIOIQ Authorization box must be checked after explanation.

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Signing on Behalf of the Member

A checkbox with the message “member unable to sign” gives the practitioner verbal authority to sign on behalf of the member. There is a “reason” box available where the APC may free text the rationale for signing on the member’s behalf.

In such a case, the Practitioner selects the checkbox under the BIOIQ authorization and enters the reason for signing on the member’s behalf in the **Reason** text box. The practitioner should sign the member’s name and the APC’s name and title in the text box.

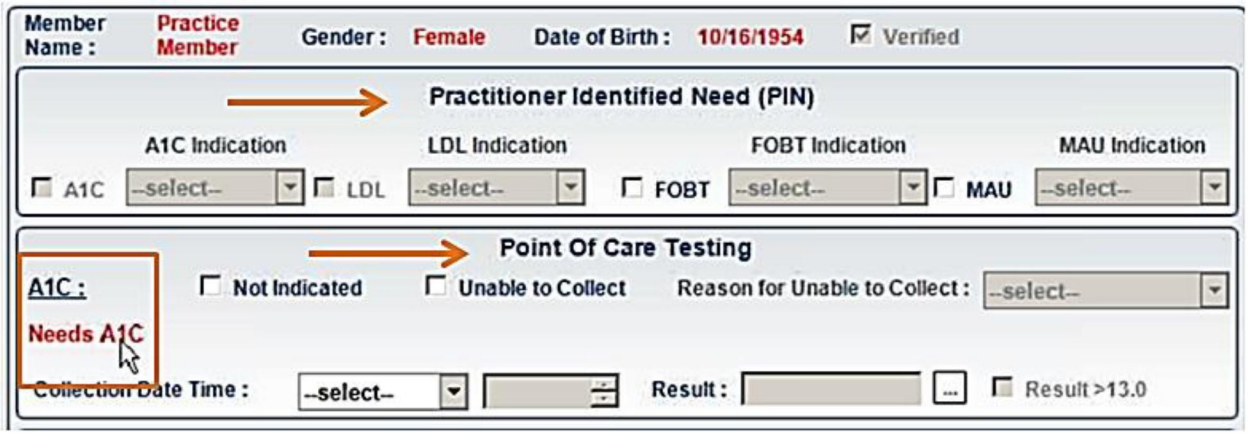
If the checkbox is selected, the mandatory text-box **Reason** will be enabled, and text boxes **Name of Person Authorized to Sign for Member** and **Relation to Member** will be disabled.



HgbA1C Tablet Documentation Requirements

There are two sections for entering the A1C test results. If it is a PIN lab, enter the reason the member meets the criteria and then the results below. If it is a pre-identified lab, then select the correct box in the Point of Care (POC) section and enter the results in that section.

A test that is indicated in **BOLD RED** font is to be collected or the reason not collected must be documented.



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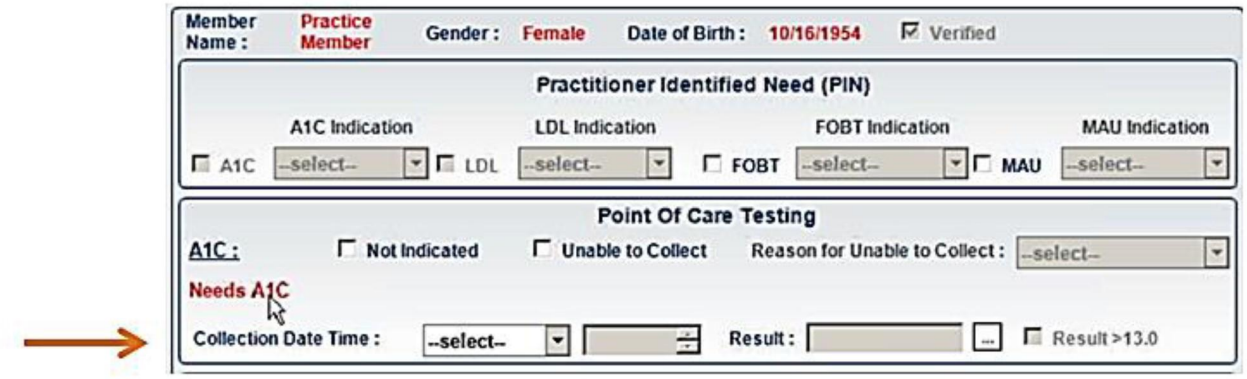
Documenting A1C Now+ Results

After the test is performed, fill in the date and time of collection and the results. *MAU listed under Point of Care should not have any information entered at this time.*

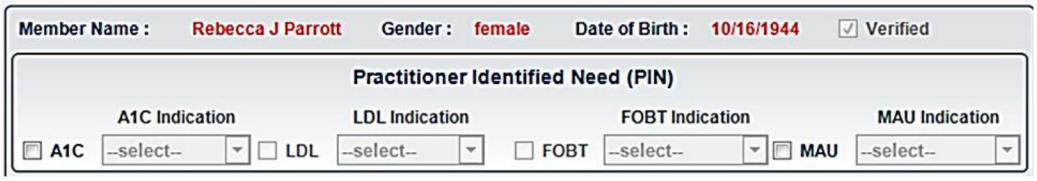


- If the member states they had the test recently, document their reported results in the eHouseCalls assessment on Page 10 of the assessment under "Diabetic Testing", and mark the test as "Refused- Recently Completed"
- If the member refuses or you are unable to collect, select the appropriate reason from the drop-down box.
- If the A1C result is higher than 13%, you will receive a pop-up box asking you to confirm it is a number higher than 13%. The pop-up instructs you to enter 13% in the results field and check the box to the right confirming the elevated reading.



iFOBT Tablet Documentation Requirements

Tests indicated in **BOLD RED** font should be collected as identified gaps. For the iFOBT, this means explaining the kit to the member and leaving it for them to collect the sample and mail it to the lab.





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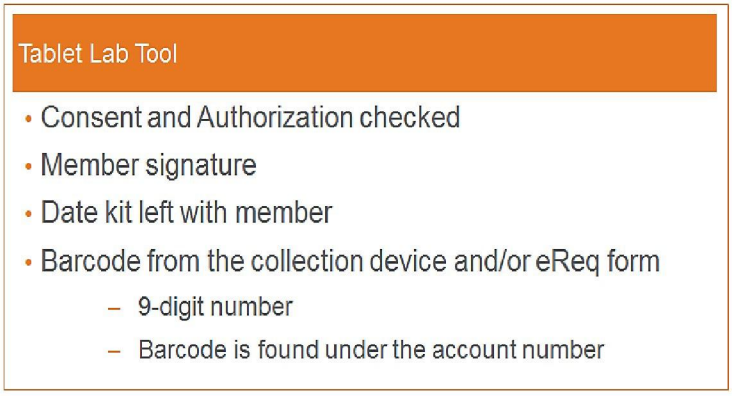
Indicate the date the iFOBT kit was left with the member and then enter the **bar code** from the Test Request Form into the assessment twice. They are nine-digit numbers and they must match to complete the Lab Tool. Please double check these numbers when entering them into the tablet. The results won't be able to be reported without a correct barcode.

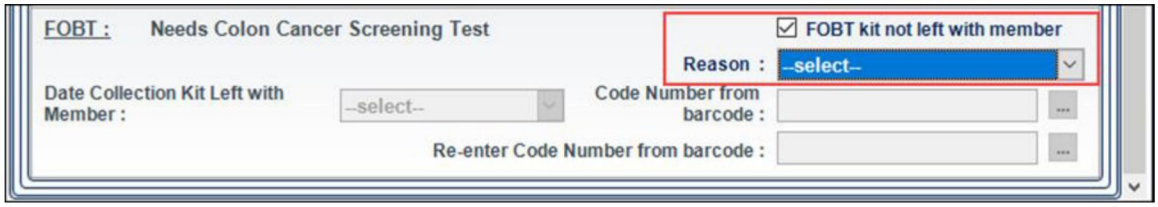
- IMPORTANT: The lab cannot process iFOBT samples received without the following information:

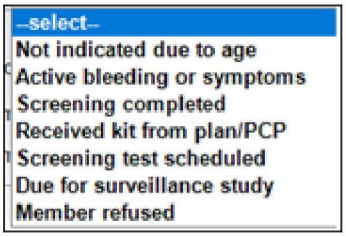


iFOBT Reason for Refusal

If the kit is not left with the member, you should select checkbox **FOBT kit not left with member**, **Reason** drop-down gets enabled and contains below options:

- Not indicated due to age
- Active bleeding or symptoms
- Screening completed
- Received kit from plan/PCP
- Screening test scheduled
- Due to surveillance study
- Member refused





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Managing your Lab Supplies

Practitioners who obtain labs directly from members will have the following available at the time of visit:

- iFOBT sample kit, appropriate mailing packaging and needed instructions for member
- A1cNOW+ kit, lancets, alcohol prep pads, gauze, band-aids, and professional towels for hemoglobin A1c testing.
- Sharps container- applicable ***only*** if you do visits in Massachusetts, Oregon, Wisconsin, or in King County
- Printed educational materials for each test
  - Be sure to provide applicable, available educational materials to the member.

Supply Replenishment/Kit Storage

Replenishment lab supplies are ordered by the Practitioner in the Practitioner Portal.

APCs are required to follow all procedures in maintaining the integrity of the lab kits.

- Home storage- keep them at room temperature
  - Do not expose to direct sunlight
- While out on visits- keep the kits with you in your bag
  - Do not leave in your car

NOTE: Before your visits, please check that none of your kits have expired.

Disposal

- In order to perform the blood tests, we will be utilizing self-retracting lancets included along with your lab supplies.
- Most states allow used lancets to be thrown into the regular trash for disposal, but some do not.
- Reminder: If you perform visits in: Massachusetts, Oregon, Wisconsin, or in King County, Washington- you MUST UTILIZE a sharps container to dispose of the used lancets
- For all other counties and states, lancets can be disposed of in the regular trash.

Traveling with Sharps Containers (If Applicable)

If you perform visits in Massachusetts, Oregon, Wisconsin, or in King County, WA you will be provided with a Sharps container.

- Packages must be securely closed, secured against movement, and protected against damage
- The Department of Transportation has regulations regarding the transport of hazardous materials. Therefore, we travel with the sharps container fully secured, closed, and within another box
- Practitioners will use the white shipping box that the sharps container ships in for this purpose
  - Please maintain the integrity of this box as it will be re-used for shipping the full sharps container back for disposal

NOTE: A sharps container that is ¾ full is considered full. Order a new sharps container when the container is half full.

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Materials of Trade

This document from the U.S. Department of Transportation outlines transportation of hazardous substances. This document is available in the HouseCalls Clinical Education Center.

Infection Control

HouseCalls follows the standard CDC guidelines for infection control:

- Hand Hygiene
  - Single, most effective disease prevention activity
  - Hands should be washed with soap and water
  - If soap and water is not available, cleanse with an alcohol-based antiseptic

NOTE: Always wear gloves during specimen collection and handling.

- You will be assigned a LearnSource course called Bloodborne Pathogens and Infection Prevention & Control. Please complete this course as soon as possible.
- The Bloodborne course discusses protocols for needle sticks. Forms to report incidents will be sent with the lab supplies.
- You will also be receiving additional self-care supplies, as mentioned in the Bloodborne Pathogens LearnSource.
  - Example: Eye wash bottles and foam hand sanitizer

Addressing HouseCalls Referrals

Comprehensive Referral Display (CRD) Tool

HouseCalls referrals are generated and documented in the CRD tool. There are several referrals systems in place to help you help your member. HouseCalls has System Identified Referrals, Urgent APC Referrals and Member Needs Referral actions that you the APC can help the member with based on what is identified.

System Identified Referrals

- Referrals identified in eHC by the system
- Members are pre-qualified
- APC asks if member wishes to be enrolled:
  - PHS Care Management Program
  - Palliative Care
  - Optum-At-Home

Urgent APC Identified

- APC generates for clinically significant findings and/or system suggests based on smart logic
- Always requires PCP contact, at minimum
  - Urgent Medical referrals

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- Urgent Social Work referrals
- Emergent & Urgent Behavioral Health referrals

Member Needs Referrals

- APC identified member needs
- APC connects member with resources at the visit, if applicable:
  - Important Behavioral Health Referral
  - Pharmacy
  - SDOH
  - Advocate4Me
  - DispatchHealth
  - AbleTo
  - COVID Support Line
  - Nurses Line

Please note that OAH is in the states of **GA, PA, DE, IA, DC, and MO.**

It is recommended that the APCs complete the CRD tool toward the end of the visit so items will prepopulate to this tool.

PHS Care Management Program

The PHS Care Management program is an ongoing program offered by UnitedHealthcare which allows members with selected conditions to manage their health. The program uses condition-appropriate technology and pathways to support members. The member may receive interactive technology, and some will have active monitoring by a care manager. Pathways consist of educational health tips/videos, biometric questions and other health questions to track member's condition(s) and overall health. A care manager may review the information for trends that may indicate a change in the member's health. Members who participate may receive:

- A tablet with interactive questions targeted at a particular condition, based on the program they are eligible for
- Access to a registered nurse who will review the member's information and provide outreach as needed.
- Education provided through the pathways can help members better understand their conditions.
- Members have multiple ways to participate including their own smart phone.

Member Identification

- Eligible members will be flagged in eHouseCalls in the Comprehensive Referral Display (CRD) tool



Program status

- Qualified - member meets eligibility criteria for PHS Care Management program
- Enrolled - member is already enrolled in PHS Care Management program

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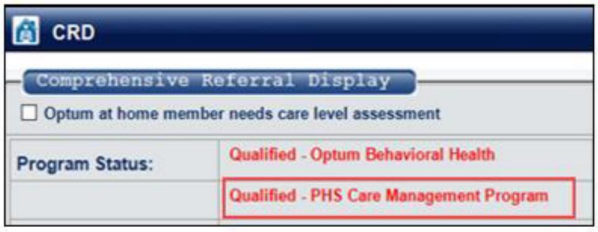
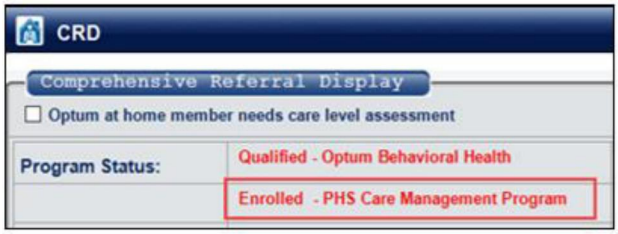
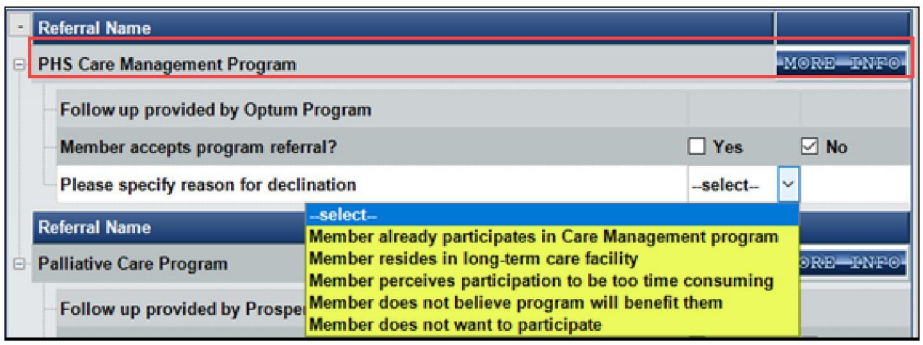




1. Document if member wishes to enroll in the PHS Care Management program in the CRD tool
2. A referral is submitted electronically



Palliative Care Program

Prospero offers home-based supportive care for people facing serious illness. The care team will include a physician, social worker, and nurses to deliver care in the home, via telehealth, or over the phone.

Eligible members may include people with serious illness including:

- Advanced dementia
- COPD
- Heart failure
- Advanced cancer
- Multiple chronic conditions that have a pattern of avoidable hospital admissions for treatment of symptoms or outpatient conditions (e.g. UTI, dehydration)

Palliative Care Program Referral-Member Identification

Eligible members will be flagged in eHouseCalls in the Comprehensive Referral Display (CRD) tool.



Program status:

- Qualified - member meets eligibility criteria for program



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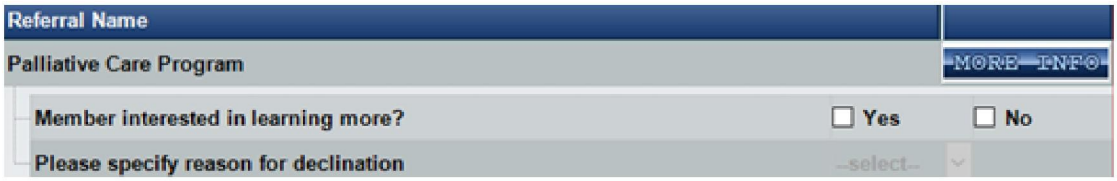
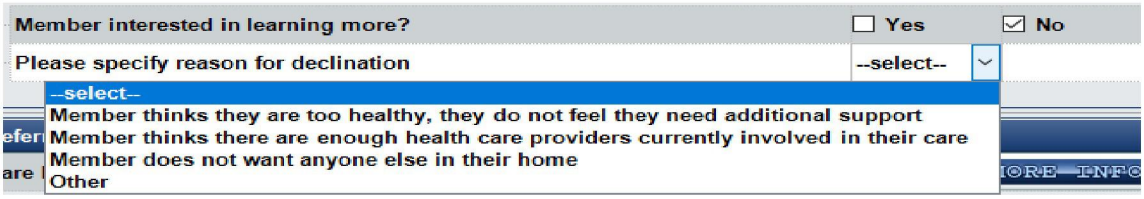
Member Identification

1. Document if member wishes to enroll in the Palliative Care Program in the CRD tool
2. A referral is submitted electronically to Case Management



If member declines, document reason for declination.



HouseCalls Care Manager Referrals

The HouseCalls Care Manager Referrals included in the CRD tool are:

- Digital ABI Test for PVD
- Ultrasound Wrist Scan for Bone Density *
- Retinal Eye Exam Abnormal *
- Urine Microalbumin (not used at this time) *
- Mini Cog Test Abnormal
- High Fall Risk
- Clinically Significant Findings

*** Indicates only completed in specific areas or not.**

Care Manager Referrals

- An urgent medical referral will only be generated if an issue/condition is identified in the CRD tool or the APC considers it as clinically significant or a new diagnosis
- **PCP** should always be notified **first** unless this would cause a life-threatening delay
- Activate EMS if instructed by the PCP or if warranted by the urgency of the member's condition
- APC makes referral by tablet or phone **(tablet is the preferred method for clinical call center notification)**
- If phone option is selected the tablet will not generate a referral
- When referral is made the APC must notify member that they will receive a call from a nurse care manager to address:
  - Any medical concerns identified during the visit
  - Provide education on disease processes
  - Sign and symptoms to be aware of or red flags
- The nurse care manager may connect with the PCP to ensure PCP is aware of current symptoms or appropriate follow up is scheduled

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- If the member is flagged as being in hospice, then a referral will not be generated

Auto-populated Care Manager Referrals

HouseCalls Care Manager Referrals will be auto populated based on the results documented in sections of the eHouseCalls application.

- **Digital ABI Test for PVD** is auto selected if the PAD Screening (QuantaFlo) results from Page 13 fall within the range:
  - Moderate 0.89 to 0.60
  - Significant 0.59 to 0.30
  - Severe 0.29 to 0.00
- **Mini Cog Test Abnormal** is auto selected if dementia or recommend further screening for dementia is selected in mini cog tool
- **High Fall Risk** is auto selected if the score is 5 or greater in the FRA tool

Clinically Significant New Findings or Diagnoses

APC may identify a clinically significant new finding or diagnosis during the HouseCalls visit.

Examples, not limited to:

- QuantaFlo results
- Worsening angina
- Signs of hypoxia, respiratory distress
- Acute change of consciousness
- Severe hypotension
- Symptomatic Hypoglycemia

The APC will use their professional judgment in determining what is clinically significant.

Documenting Clinically Significant New Findings

- Select Clinically significant new findings diagnosis
- Select the reason for the referral and document in chat box (Ex: worsening angina, high falls risk or new diagnosis of PAD)
- Select contact details (example, PCP)
- Member accepts Care Manager Referral – must be addressed with the member and checked Yes if they agree, if No is selected no referral will be generated
- It is the expectation that the benefits of the referral are explained to the member



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Document Communication Details

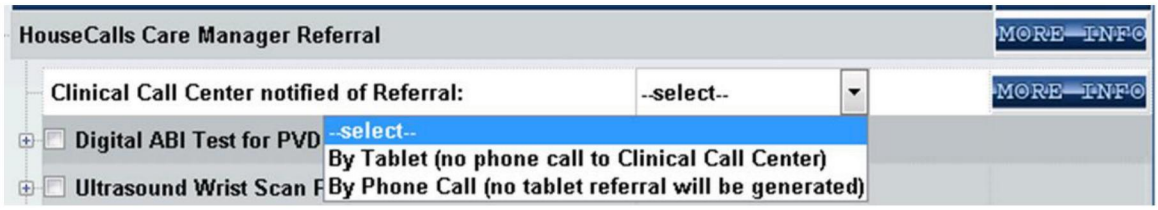
- "Spoke with Jane in Dr. Smith's office. Reported member's +4 glucose in urine. Same day appointment made with PCP."
- Select **Contact details**



- The APC should call the PCP and document the communication based on established protocols or clinical decision-making

Clinical Center Notification

- Select Clinical Call Center notified of referral by tablet or phone



CRD Tool Documentation for Digital ABI results

QuantaFlo results- MODERATE (0.89-0.60):

- Results will auto populate
- Check referral to Clinical Call Center- check **Notify by Tablet**
- If new diagnosis of PAD, contact PCP and document diagnoses findings in clinically significant- reason for referral
- Contact details
- Member accepts referral and communication details' section
- If PAD is an existing diagnosis, ensure that it is listed on page 3 – PMH

QuantaFlo results- SIGNIFICANT (0.59- 0.30):

- Results will auto populate
- Check referral to Clinical Call Center- check notify by tablet
- ADD diagnosis of PAD under **clinically significant**
- Contact PCP (only if NEW diagnosis)
- Document contact details and communication details (if appropriate i.e. NEW, member accepts referral
- If PAD is an existing diagnosis, ensure that it is listed on page 3 – PMH

QuantaFlo results- SEVERE (0.29-0.00):

- Results will auto populate

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- Check referral to Clinical Call Center- check notify by tablet
- Contact PCP and document diagnoses findings in clinically significant- reason for referral
- Contact details
- Member accepts referral and 'communication details' section.
- If PAD is an existing diagnosis, ensure that it is listed on page 3 – PMH.

Social Work Referrals

APC can select one of these referrals based on clinical judgment

- No food or Electricity or Running Water
- Danger to Self or Others
- Suspected Abuse or neglect
- Child in Care of Incapacitated Adult

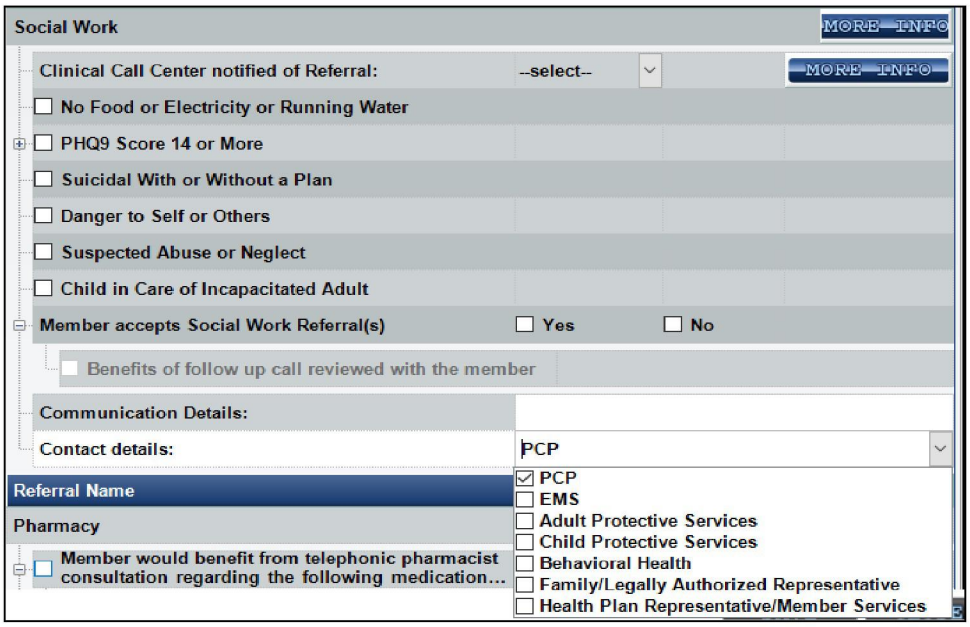
Auto-populated Social Work Referrals

The following HouseCalls Social Work Referrals will be auto-populated based on the results of related sections of eHouseCalls application:

- **PHQ9 Score 14 or More'** is auto selected, when PHQ9 result is 14 or more in PSY tool
- **Suicidal With or Without a Plan** is auto selected, when result of Question 9 on PSY tool is greater than 0

Documenting Social Work Referral in CRD Tool

1. Select the reason for the referral
2. Select Clinical Call Center notified by tablet or phone
3. Member accepts HouseCalls Social Work Referral? - Must be addressed with the member and checked Yes if they agree
4. If No is selected no referral will be generated and it is the expectation that the benefits of the referral are explained to the member
5. Document Communication detail
6. Document contact details



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Social Work Referral generated in the CRD Tool

When a social work referral is generated in the CRD tool

- APC must make referral by tablet or phone to the Clinical Call Center **(tablet is the preferred method for clinical call center notification)**
- If phone option is selected the tablet **will not** generate a referral
- When referral is made, the APC must notify member that they will receive a call from the social work department
- The social worker will review any concerns identified during the visit and attempt to connect the member with community resources or organizations in their area that provide assistance

Emergent & Urgent Behavioral Health Issues

Emergent Behavioral Health Referrals

- Emergent Criteria
  - Suicidal with a plan
  - Severe, unstable mental health
  - Severe agitation, danger to self or others
- APC action:
  - Call 911 for an emergency
  - Call Mental Health Provider first. If unable to reach MHP, call PCP
  - Notify Clinical Call Center by tablet
  - If eligible, call Optum Behavioral Health Services[redacted]n the menu. Identify yourself as a HouseCalls APC
  - Optional to call National Suicide Hotline: 1-800-784-2433
  - Educate member on Social Work referral from More Info button
  - Ask if member accepts referral
  - In CRD tool: Social Work, document ember responses, communication details and notify CCC by tablet

Urgent Behavioral Health Referrals

- Urgent Criteria
  - Suicidal without a plan
  - PHQ-9 score of 20 or greater
- APC Action:
  - Call mental health provider (MHP) FIRST. If member does not have MHP or if unable to reach, call PCP
  - If eligible and member needs immediate assistance, call Optum Behavioral Health 1-800-741-6473
  - In CRD tool: Social Work, document communication details and notify CCC by tablet
  - Educate member on Social Work referral from More Info button
  - Ask if member accepts referral
  - In CRD tool: Social Work, document member response, communication details and notify CCC by tablet

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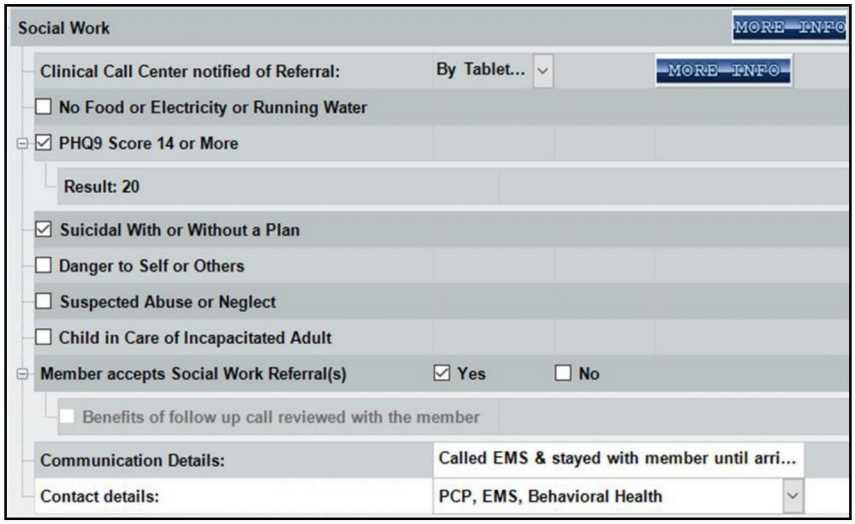
Documentation in CRD Tool

- Submitting referral 'By Tablet'
- "Called EMS, PCP, Optum Behavioral Health, NSH and MHP. Spoke with Jane, LPN. Reported member PHQ9 score of 20 & suicidal with a plan. Stayed with member until EMS arrived."
- Educated member on referral from More Info button
- Member accepted Social Work referral



Important Behavioral Health Referrals

Important Behavioral Health (BH) Referrals are for members whose health plan participates in BH referrals. IF the members health plan does not participate in Important BH referrals, the section will be disabled, and you will see a hover text that will display stating that the referral is not available for the member's plan.

Eligibility for the member will be indicated under Program Status.

Program Status	Significance
Program Status: Qualified - Optum Behavioral Health	Member is in a health plan that offers Optum Behavioral Health
Program Status: Enrolled - Optum Behavioral Health	Member is already enrolled in Optum Behavioral Health (OBH). Enrolled members do not need a new OBH referral
Program Status: Qualified - Behavioral Health	Member is in a health plan that follows up on Behavioral Health referrals and no OBH
No Program Status regarding Behavioral Health	Referral not available for members plan. Advise member to contact member services and/or PCP

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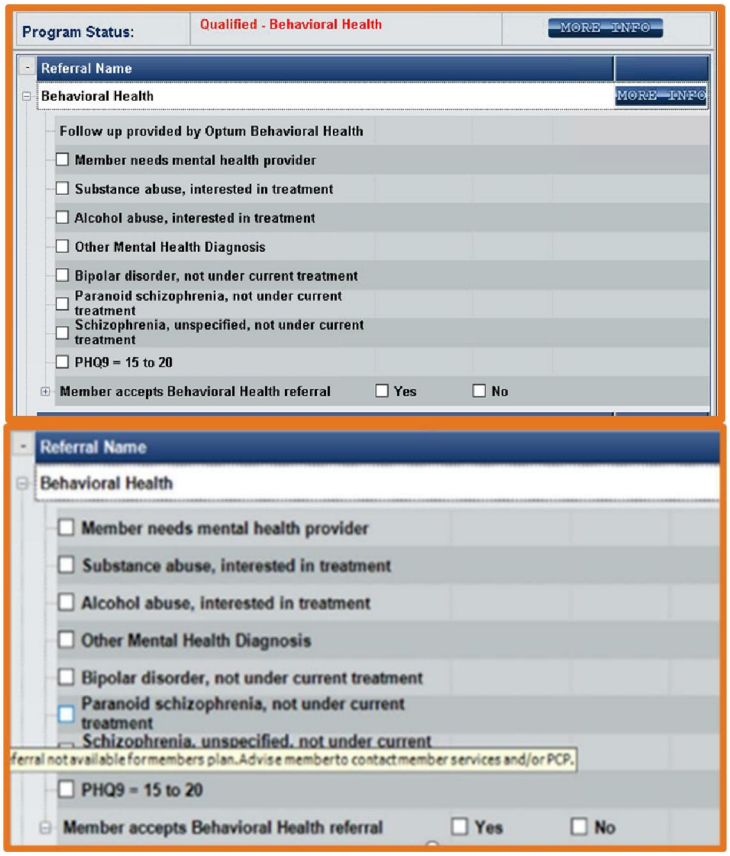

Documenting Important Behavioral Health Referrals

It is important for you to do the following:

- Identify member eligibility for an Important behavioral health referral and if follow-up is provided by Optum Behavioral Health (OBH) or member's health plan
- Select the identified behavioral health issues from the options available
- For members who need a mental health provider and are eligible for OBH, it is preferred to call the Advocate4Me support line to assist the member immediately at the end of the visit
- If member was connected successfully to an Advocate4Me agent
- Un-check the option "member needs mental health provider" in the behavioral health referrals section of the CRD tool to prevent a duplicate referral.
- In the Support Services section on page 18, select the reason "Needs Behavioral Health Provider" from the drop-down options
- Select the Behavioral Health 'More Info' button and educate member on this referral.

Appropriate CRD Documentation

- Document if the member accepts by selecting "Yes" or "No"
- If member consents, state the following 3 talking points:
- "We will include a referral for Behavioral health Services"
- "However, depending on your health plan, you may or may not receive a call"
- "In addition, please contact your primary care provider for assistance"
- If member declines, discuss the benefit of follow-up call with the member and recommend they follow-up with their PCP. Document this in the 'non-urgent communication' text box on page 16

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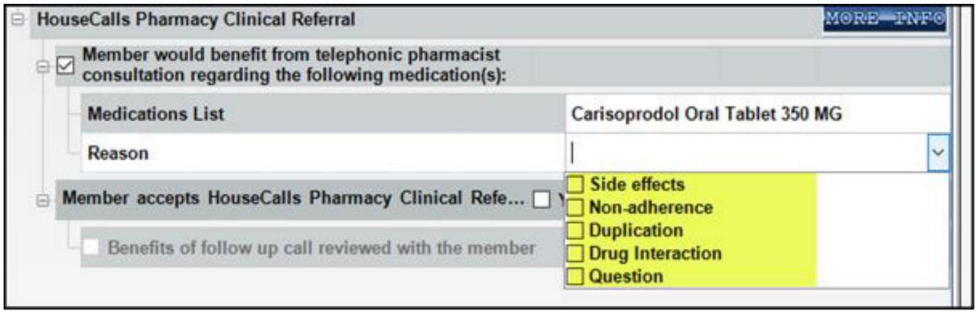
Pharmacy Clinical Referral

Document in the CRD if:

- In APC's clinical judgement member would benefit from telephonic pharmacist consultation regarding specific medications
- If member agrees to consult the APC will inform the member:
  - You will receive a call for one of our pharmacists
  - The pharmacist will address any medication concerns from today's visit
  - The pharmacist will also provide education related to your prescribed medications and answer any questions related to your prescribed medications

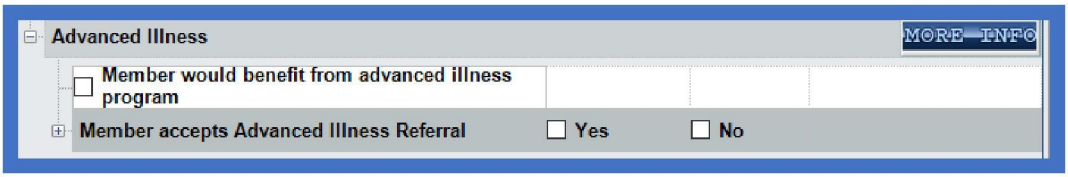
Documenting Pharmacy Referral in CRD Tool

1. Select member would benefit from telephonic pharmacist consultation regarding the following medications
2. Select medication/s from the list
3. Select reason- (all that apply) side effects, non-adherence duplication drug interaction question
4. Select member accepts HouseCalls Pharmacy Clinical Referral Yes/No

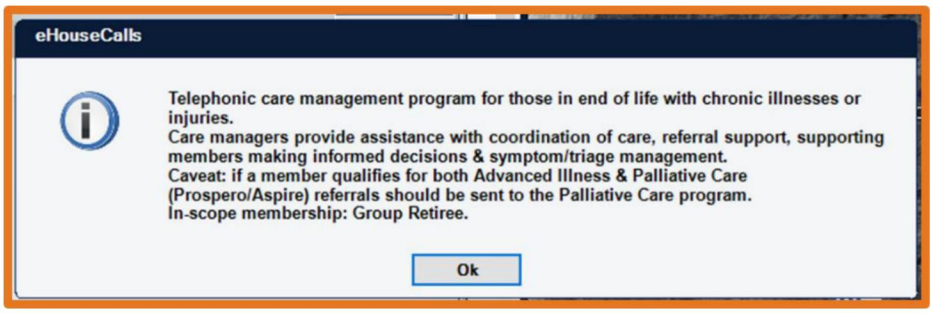


Advanced Illness Referral

If a member would benefit for an Advanced Illness program, select the check box that they would benefit. It should be noted selecting this means that you expect the member to have a life expectancy of less than one year.



There is a More Info button that provides eligibility and referral information that can be used as reference and communication with the member.



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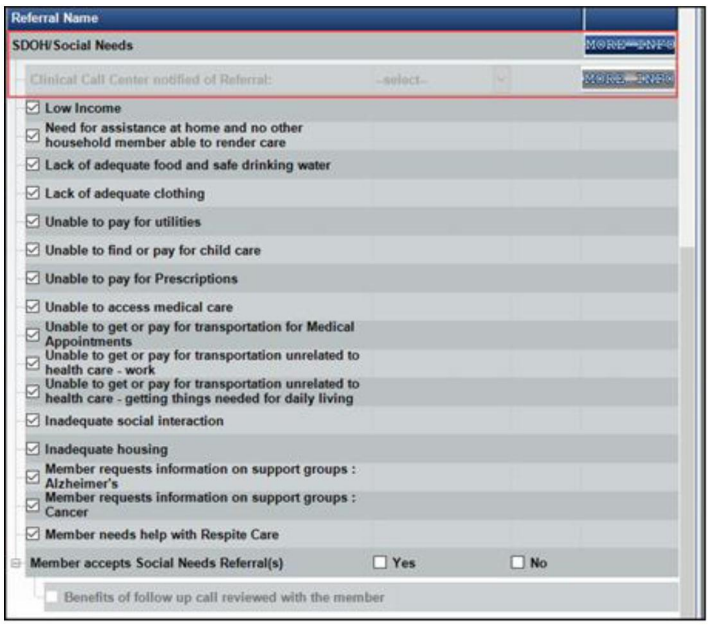
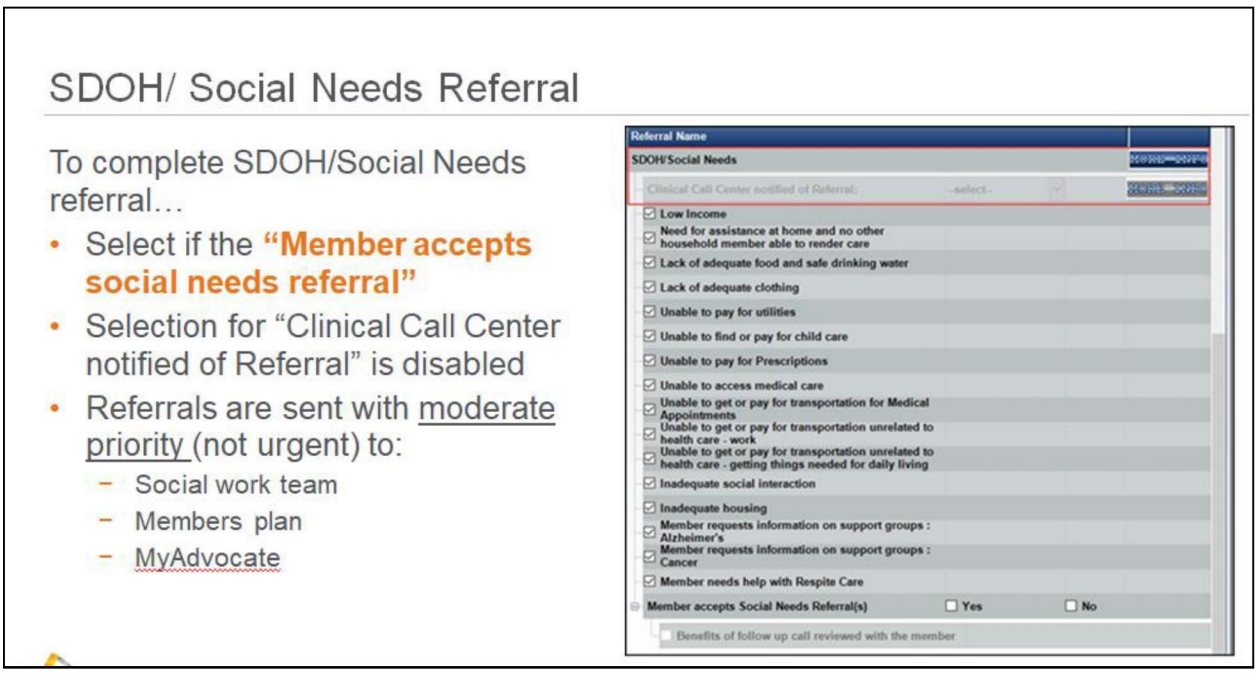
SDOH/ Social Needs Referral

The SDOH tool auto-selects referrals into the CRD tool when there are documented social needs, such as:

- Lack of food and clothing
- Unable to pay for utilities, childcare, prescriptions
- Unable to get transportation to work or medical appointments, etc.

Referrals are visible in the CRD tool under **SDOH/Social Needs**





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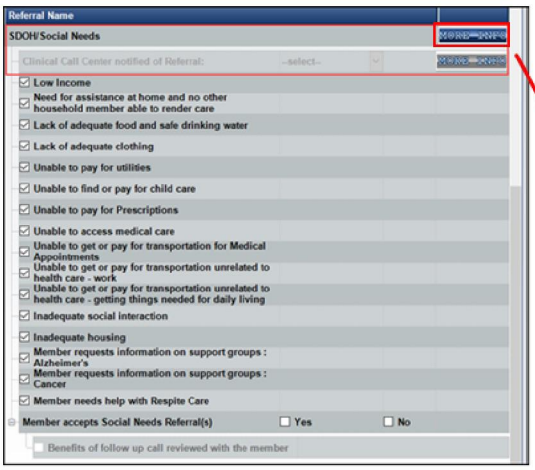
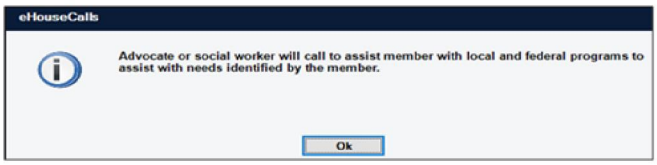
SDOH/ Social Needs Referral



When selecting "More Info," the following alert will display:

"Advocate or social worker will call to assist member with local and federal programs to assist with needs identified by the member"



NOTE: The SDOH Tool may not be present in the tools if the member is within the United Healthcare Employee & Individual (E & I) plan.

Referral follow up

HouseCalls Care Manager Referral

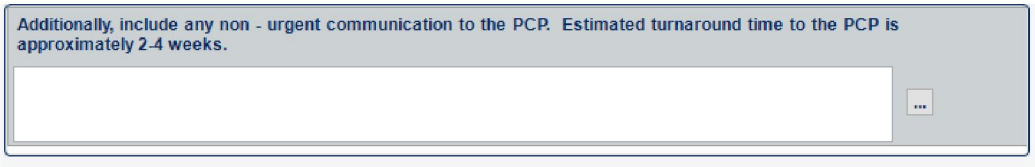
- Once the practitioner finalizes the assessment, HouseCalls Care Manager Referrals selected in the CRD tool are generated in the CRD tool and sent for referral

Social Work Referral – Group Retiree

- If the practitioner documents a Social work referral for a group retiree member, once the assessment is finalized a referral will be generated and sent to My Advocate

Documenting Non-Urgent Communication

- Non-urgent communication can be documented on page 16 of the assessment
- The Additional Collaboration text field (below), allows you to document any additional non-urgent communications to the PCP
- This is also where you would document any information you would like included in the letter that is sent to the PCP
- It is **not** a request for follow-up or assistance



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Social Determinants of Health: Referrals for Identified Issues

Navigate4Me (COVID Support Line)

- Enrolls the member in a 2-week follow-up and helps with ongoing issues
- M&R and URS- Group Retiree plans **Only**
  - Ask for the COVID Support Line: (**844) 205-7182**
  - If not eligible, refer member to member services number on the back of their insurance card

Urgent Social Work

- Utility services concerns
- Food, Water, Meal delivery
- Transportation
- Member does not feel safe, suspected abuse, neglect, or urgent behavioral health issues
  - Call member's PCP **&** APS (Adult Protective Services)

Nurse Line

For non-urgent health concerns:

- M&R Individual URS members: Call **(877) 365-7949**
- Other Plans: Call the number on the back of member's insurance card

Eldercare Locator

- Local agencies on aging
- Senior support services
- Housing
- Transportation
- **https://eldercare.acl.gov/Public/Index.aspx**

Anxiety/Emotional Support Helpdesk

- Provided through Optum Behavioral Health
  - Anxiety Helpline: **(866) 342-6892**

Local DOH Agency

- For guidance on local testing and treatment availability

Advocate4Me

Purpose

- Advocate4Me (A4Me) provides outreach to UHC Medicare & Retirement Individual plan members only
- Provides free assistance into programs for eligible members with identified GAPS

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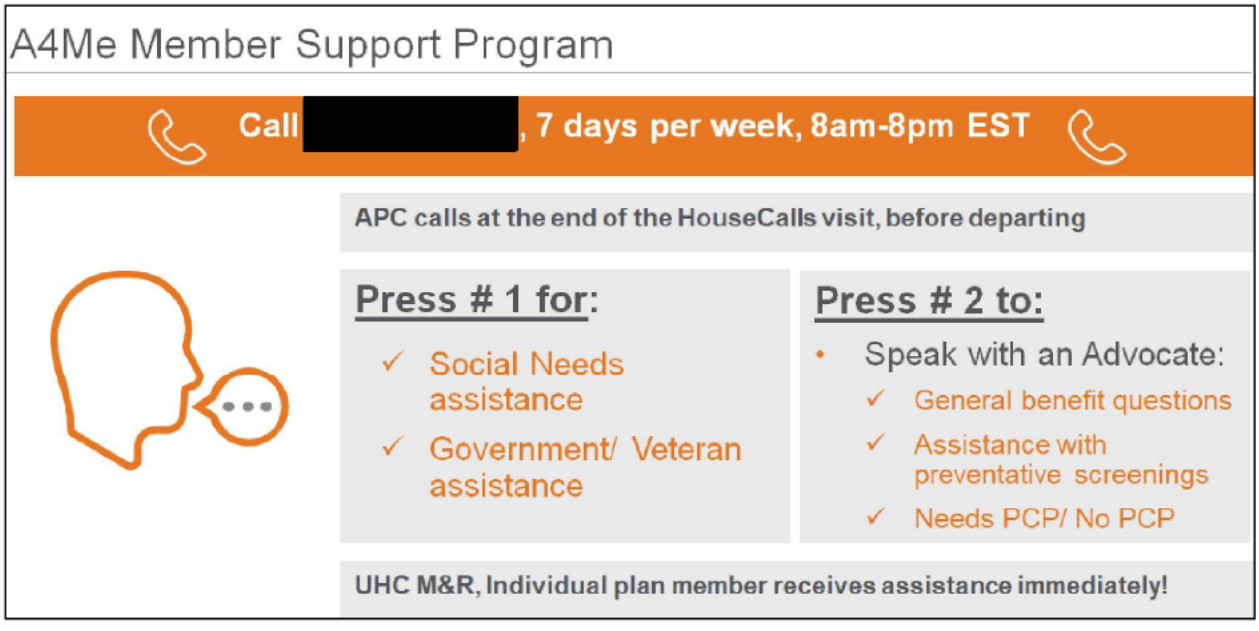
Reasons for Calling:

- No PCP
- Needs PCP or annual wellness visit appointment
- Needs Mental Health provider
- General benefits questions
- Bone density test
- Dilated retinal exam
- Mammogram

Process

- Complete HouseCalls visit
- Discuss Advocate4Me (A4Me) with member:
  - Not mandatory, but recommended
  - Focuses on individual health care needs
  - Assistance with preventative care screenings
  - A live A4Me agent will work with member in real time
- Call A4Me from member's phone, with member's permission. Explain you will leave once they get on the phone with the agent
- Listen to the prompts and chose the appropriate option. Provide info the agent requests and state *"I would like to speak with an Advocate."*
- Give the phone to the member and depart members' home



UHC Membership Support

If the member has an issue and is not part of the UHC plan, direct the member to call member services on the back of their insurance card.

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UHC Plans

- United Healthcare M & R (Medicare and Retirement Individual)
- United Healthcare C & S (Community and State)
- United Healthcare Group Retiree (URS)

Services Available

- Assistance for social determinants of health or social issues
- Assistance with veterans
- Assistance with members who don't have PCP
- Assistance with annual wellness visits
- Benefit questions
- Preventative screenings
  - Mammogram
  - Dilated Retinal Exam
  - Bone density screening
- Behavioral Health needs

Best Practices for Documentation of Support Services

Issues identified

- Member needs bone density screening
- Member needs mental health provider
- Member has benefit questions

Inform Member

- Resources are available through A4Me
- APC will inform member with their permission, they will contact member services

Next Steps: (UHC M & R, C & S & Group Retiree Plans)

- Call A4Me support services **1-888-867-5582** while in the home and speak with live agent
- Dial Option #1: Social, government or veteran's assistance
- Dial Option #2: General benefit, preventative screenings, PCP, behavioral health
- Documentation of Member Support Services

Support Services Checkbox Enabled

If Support Services are enabled and available on page 19, document your outreach.

- Select 'Called support services'
- Select with 'Connected with live agent'
- Document reason for call
- The APC should ONLY utilize the **Member asked to call the number on the back of their insurance card** if they are not in a plan supported by A4Me

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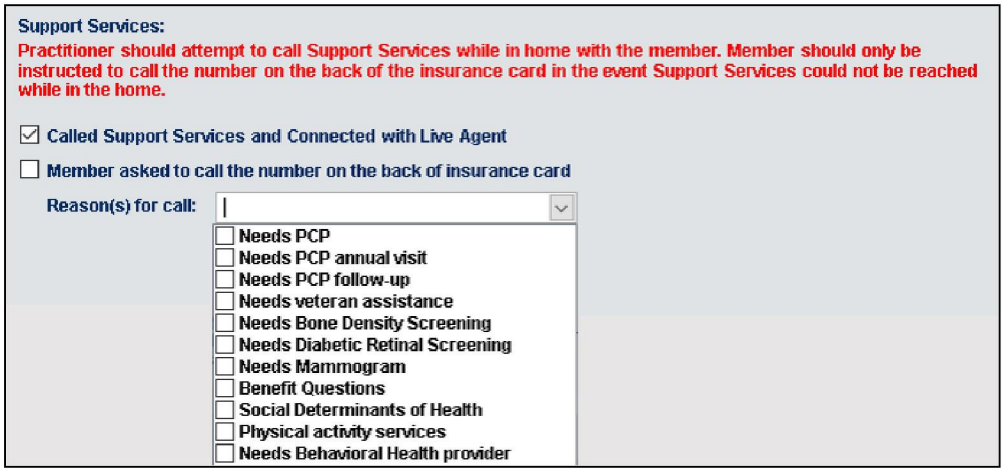

Dispatch Health Services

1-833-901-3127; 7 days a week, 6AM-12AM EST

Dispatch Health Services are for members enrolled in M&R and Optum at Home (OAH) who are in M&R (Medicare & Retirement), C&S (Community & State) and E&I (Employer & Individual) plans to:

- Help in reducing ED visits
- Improve overall healthcare by offering on-demand care in the member's home
  - Medical teams will treat in the member's home

Members must live in the select locations and hours of operation are based by region.

The following locations are available for DispatchHealth:

- Arizona, Phoenix
- Arizona, Tucson
- Colorado, Colorado Springs
- Colorado, Denver
- Connecticut, Hartford
- Florida, Fort Lauderdale
- Florida, Miami
- Florida, Tampa
- Georgia, Atlanta
- Idaho, Boise
- Indianapolis, Indiana
- Massachusetts, Springfield
- Nevada, Las Vegas
- Nevada, Reno
- New Jersey, Morristown
- New Jersey, Ridgewood
- North Carolina, Raleigh-Durham
- Ohio, Cleveland/Akron

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- Oklahoma, Oklahoma City
- Oregon, Portland
- Tennessee, Knoxville
- Tennessee, Nashville
- Texas, Dallas
- Texas, Fort Worth
- Texas, Houston
- Texas, San Antonio
- Virginia, Richmond
- Washington, Olympia
- Washington, Seattle
- Washington, Spokane
- Washington, Tacoma

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Member Resources & Helpful Reminders

Resource	Service to Member	Phone Number & Hours	Member Facing Number	Plan in Scope	Related Job Aid
COVID Support Line	Medical and non-medical help with meds, transportation, etc. enrollment in 2-week program with 4 calls to check in with member	844-205-7182	844-205-7182 Give number to member or warm transfer	M&R Individual and URS	Pre-Visit member screening tool
NurseLine	Assistance with clinical/medical questions and issues	877-365-7949 24/7 Availability	877-365-7949 24/7 Availability	M&R Individual and URS	Member Self-Isolation Service V3
A4Me with options for SDOH assistance for veterans and non-veterans	Assists with gaps in care, PCP, SDOH, veteran's services, and for behavioral health	888-867-5582 7 days a week 8AM-8PM EST	APC calls number and warm transfers or use member's phone if in home	All UHC Lines of Business: M&R Individual, C&S, and Group Retirees	Advocate4Me Member Support Line Job Aid
Optum Behavioral Health	Urgent behavioral health issue	800-741-6473	N/A	Eligibility indicated in eHouseCalls. Utilized for all emergent issues	Behavioral Health Referral Job Aid
Optum Health Help Line	Provides emotional support	866-342-6892	866-342-6892	Free of charge and open to anyone	Talking points for providers to patients
AbleTo	AbleTo is a behavioral health program that will be utilized to address stable members with mental and behavioral health needs. The overall goals are to reduce stigma and increase services to our members.	Referral process is completed by a back-end algorithm after HCV assessments are finalized. APC should not guarantee automatic qualification into the program when discussing AbleTo program with member. Inform the member that should they qualify, they will receive a call from the program.	AbleTo will reach out to the member	M&R Group Retirees (URS)	AbleTo & HouseCalls Job Aid

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Refusal of Advice

- You may need to call despite refusal
- Educate member of possible negative consequences
- Encourage member to contact their PCP for follow up
- Document advice, interaction, and member action/inaction in the text box under the Collaboration section

PCP: After Hours and Weekends

- Leave a message, if possible
- If not possible to leave a message, call the on-call practitioner for that PCP
- If unable to reach PCP, try the following business day
- If situation is Urgent instruct the member to go to the nearest urgent care center, emergency department or call 911

Reminders

All urgent communications/collaborations require a phone call to the Primary Care.

- When to Contact the Clinical Call Center
  - For all urgent social service issue
  - For all urgent medical issues
  - After calling the PCP for collaboration
  - After calling Behavioral Health
  - After calling APS
  - After calling EMS

It is about connecting with people that helps create true understanding.

Quality Documentation and Clinical Peer Review

Purpose

The purpose of the clinical peer review process is to ensure there is consistency and accurate documentation to the highest level of specificity. There are three types of chart return reviews that will be discussed in this section.

Goals of the Clinical Peer Review Team (CLPR)

Check to see that all active diagnoses are captured by:

- Confirming that all diagnoses are supported in the assessment to highest level of specificity
- Ensuring that urgent issues receive proper collaboration, referral and follow-up
- Educating new and seasoned APCs in HouseCalls documentation guidelines

All the critical quality components help us to provide better care of the member because conditions are identified and managed by their plan.

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Chart Reviewers

Charts can be reviewed after completion by different members of the HouseCalls team as listed below:

- Clinical Peer Reviewers- highly skilled group of your colleagues: Clinical Team Managers & APCs who are highly skilled and, on a team, to do a comprehensive review periodically
- Clinical Leadership- direct supervisor
- Coding Team- Certified Coding Specialist
- Collaborating physicians based on state requirements and identified in the Practitioner Portal
- NPs/PAs/MDs – self review can be conducted in the Portal as a post visit assessment

Clinical Peer Reviews

Charts are reviewed by your peers, Advanced Practice Clinicians. The process is designed to help and support your documentation. The primary goal of the clnical peer review is to identify potential opportunites for documentation improvement and provide feedback using a peer to peer collaborative model. A sample of your charts will be reviewed on an ongoing basis. The results will be shared with your Clinical Team Manager by email or conference call.

The APC may request to meet with the CLPR if desired. If additional clarification is needed to support the documentation, the CLPR may return the chart to the Portal. The APC can also request an amendment if desired by contacting the education team by calling 1-855-247-8474 option #3 and provide provider ID information and member ID so the educator can expedite the request without delay.

The focused peer review charts are specific chart reviews conducted by Clinical Team Manager. These are specific diagnoses in review such as PVD. These are charts where the diagnosis was not documented at a higher specificity.

Ongoing documentation also includes documentation discrepancies which include charts returned from coders who also review charts monthly for clarity on diagnoses. Also, the APC may request a chart for return to make addendums in a self review. These charts are returned to the documentation discrepancy section of the portal. In addition, charts can be returned based on a computer analysis and this occurs on a monthly basis. These charts are high frequency chart returns and are returned to the documentation discrepancy section of the portal.

Key Components of Documentation

- Document all clinically relevant conditions
- Ensure documentation supports all diagnoses
- Document PCP recommendations and referrals as indicated
- Address any open gaps in care (STARS and HEDIS)
- Clear and specific documentation results and better health outcomes for our members

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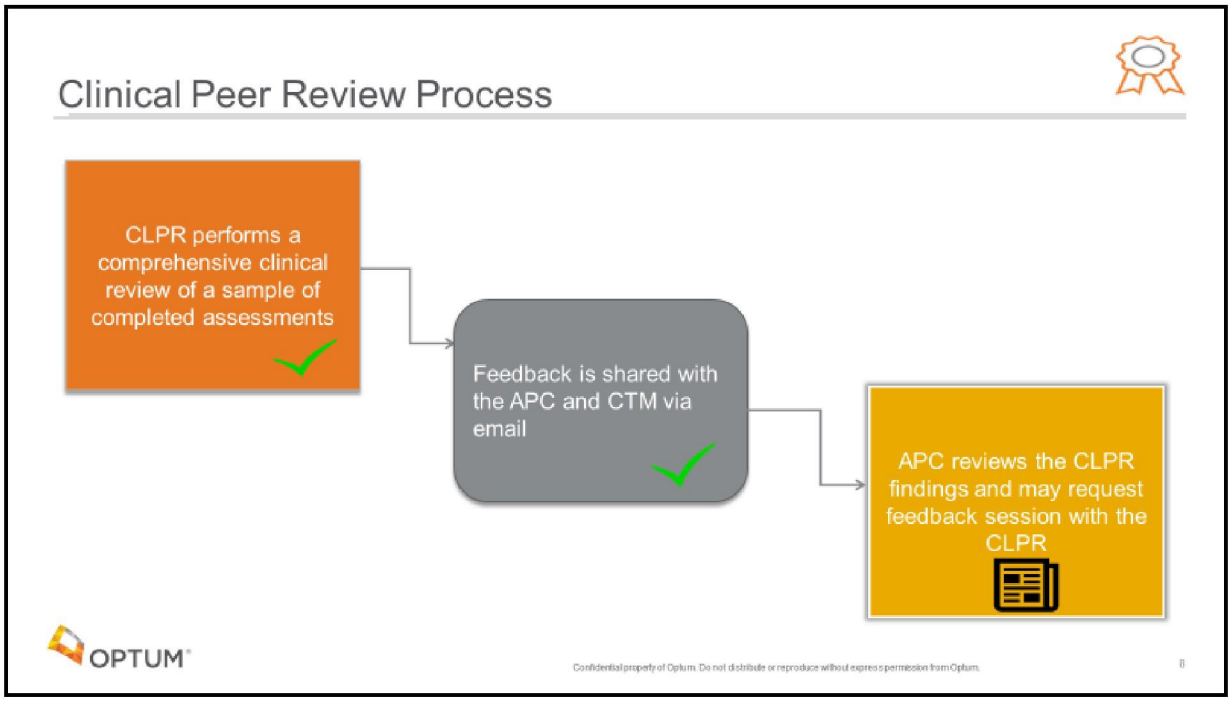

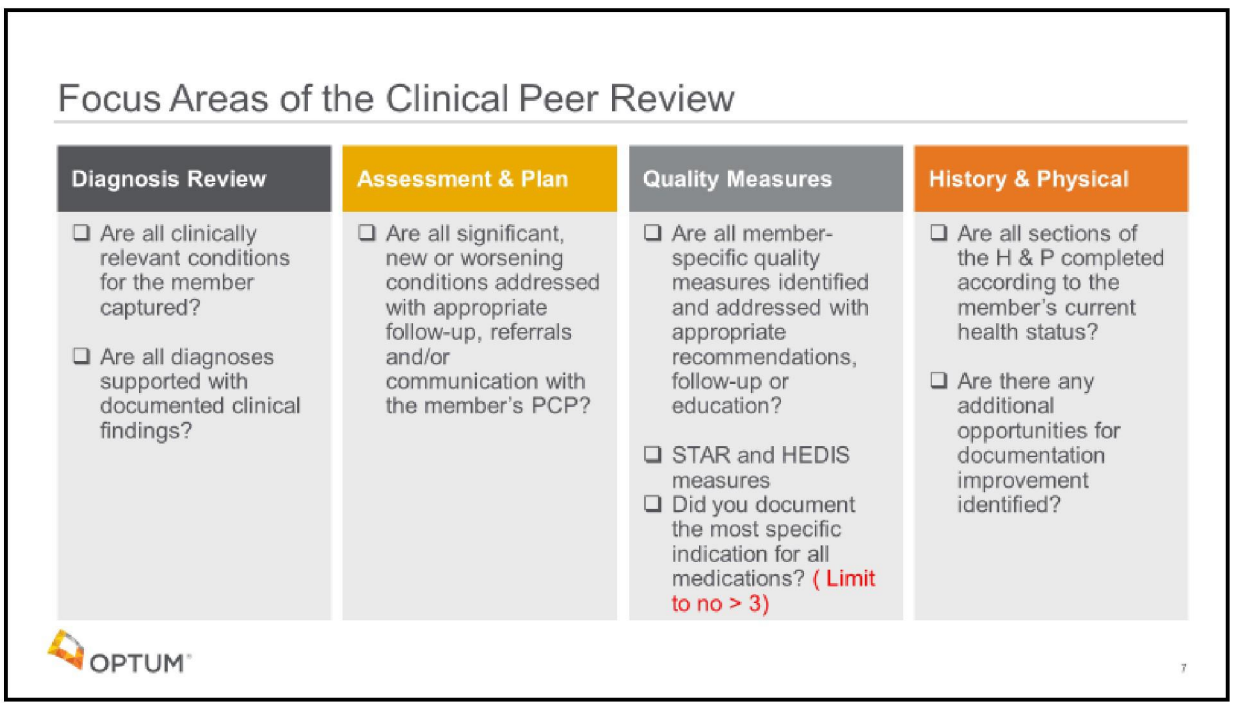

It is important to capture all active diagnoses. When capturing the diagnosis, it is important to review page 15 carefully. Evaluate each diagnosis in relationship to its active status and past medical history status. Some diagnoses may be active and others active and past medical history. Please utilize your best clinical judgment and select the appropriate checkmark boxes. All active diagnoses must include an assessment and plan. Consider the stability of each dx- is it stable and well controlled? Unstable? Or sub optimally controlled? In the Plan section, you are able to determine follow up care which may include

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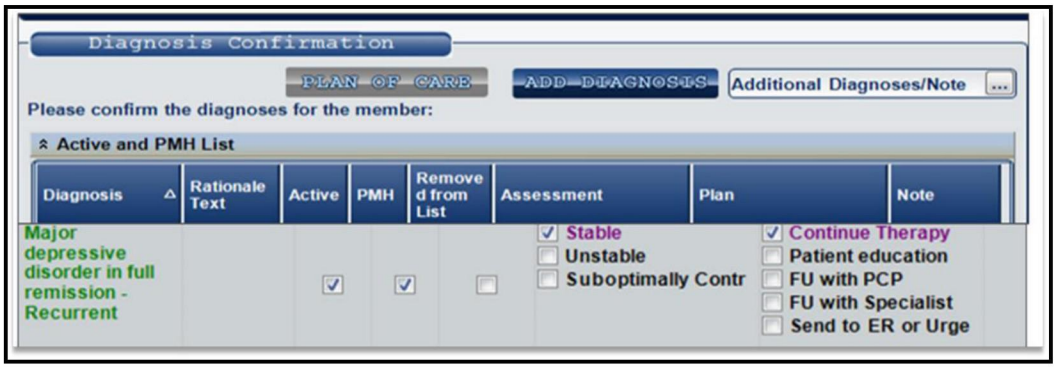
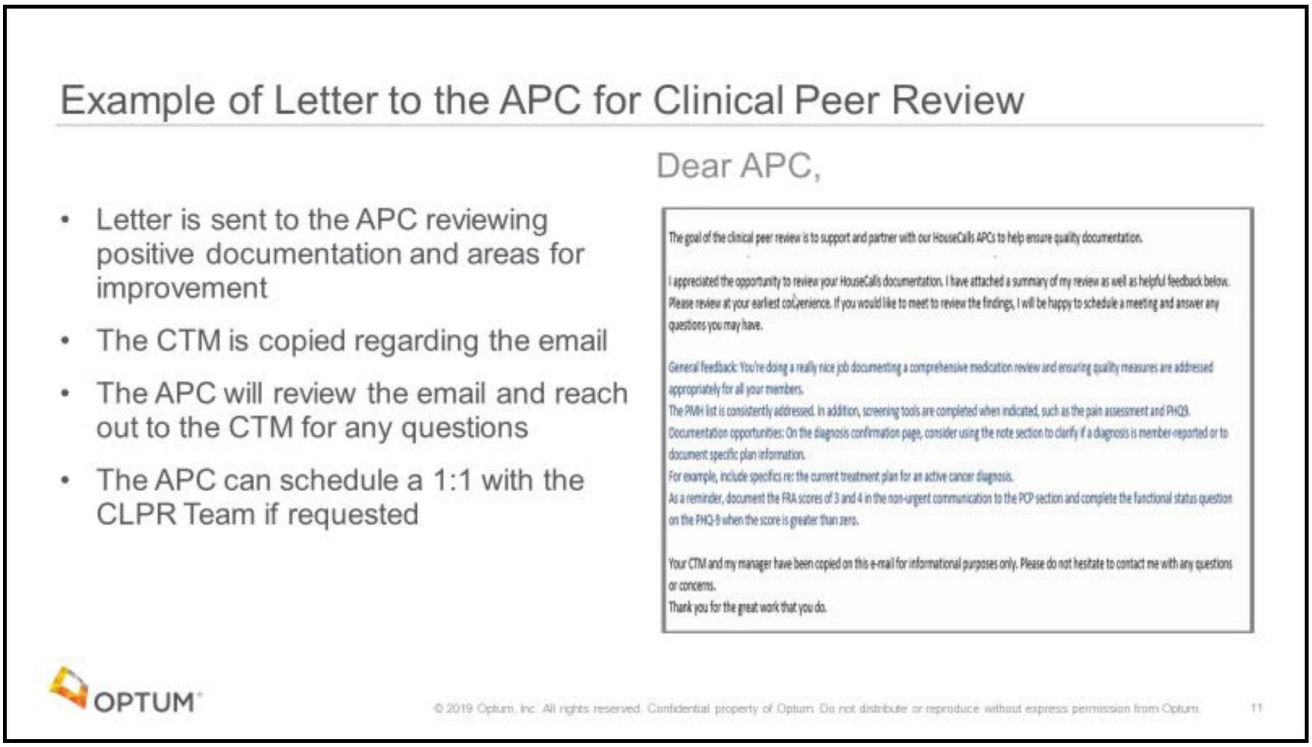
continue therapy, education, F/U with PCP or specialist. In the case of an unstable condition, the APC may send the member to ER or urgent care.

It is important to ensure that the diagnosis you have selected best represents the member's current health status. For example, in the screenshot below, MDD in full remission is selected. Ensure that the PHQ9 is consistent with regards to severity level or remission status. Also be sure to evaluate the PMH section on page 15 for any diagnoses that may need to be made active.





Focused Peer Reviews

- CTM driven approach in reviewing charts for specific diagnosis
- CTM will send email to the practitioner
- Charts will be returned to the "Peer Review" section of the Completed Assessments section in the portal

Practitioner Portal

Completed Appointments	
Received	576
Not Received	0
Post Visit Amendment	0
Peer Review	2
Total	576

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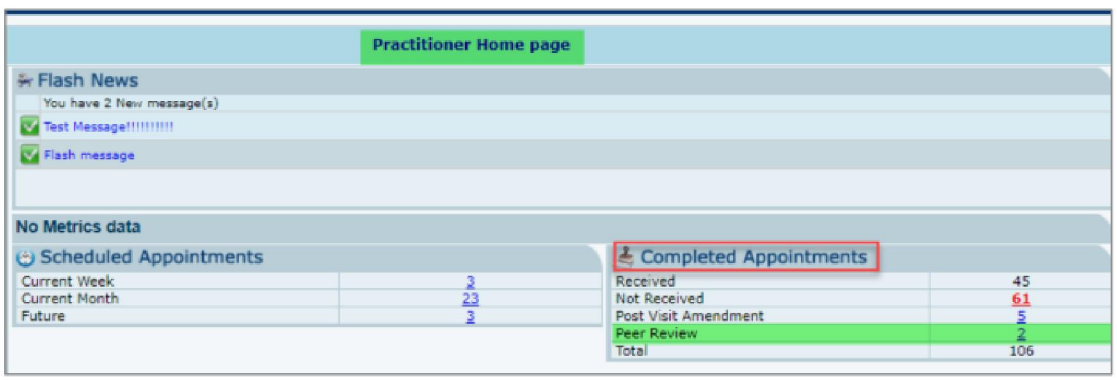
Access to Focused Peer Review Charts

In the Practitioner Portal, select from the blue hyperlink in the second column of the Peer Review section within the Completed Appointments category to access the charts



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The APC will locate the charts for review under the Completed appointments category in the portal. The Peer review section will house the charts for the APC to access for review. There will be a blue hyperlink with the number of charts and the APC will select the blue hyperlink to open the window. Also, numeric hyperlink may be red if the APC doesn't access the charts within 48 hours of charts being located to this section. Please access and review these charts as soon as you can.

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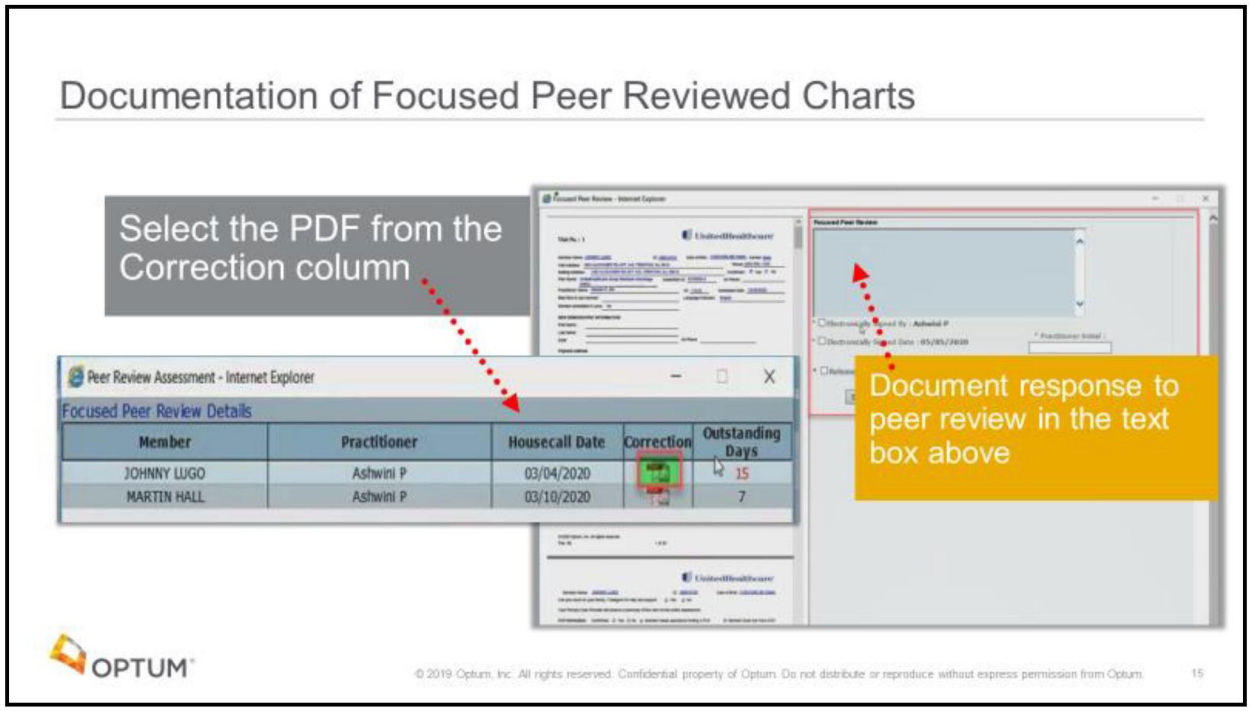
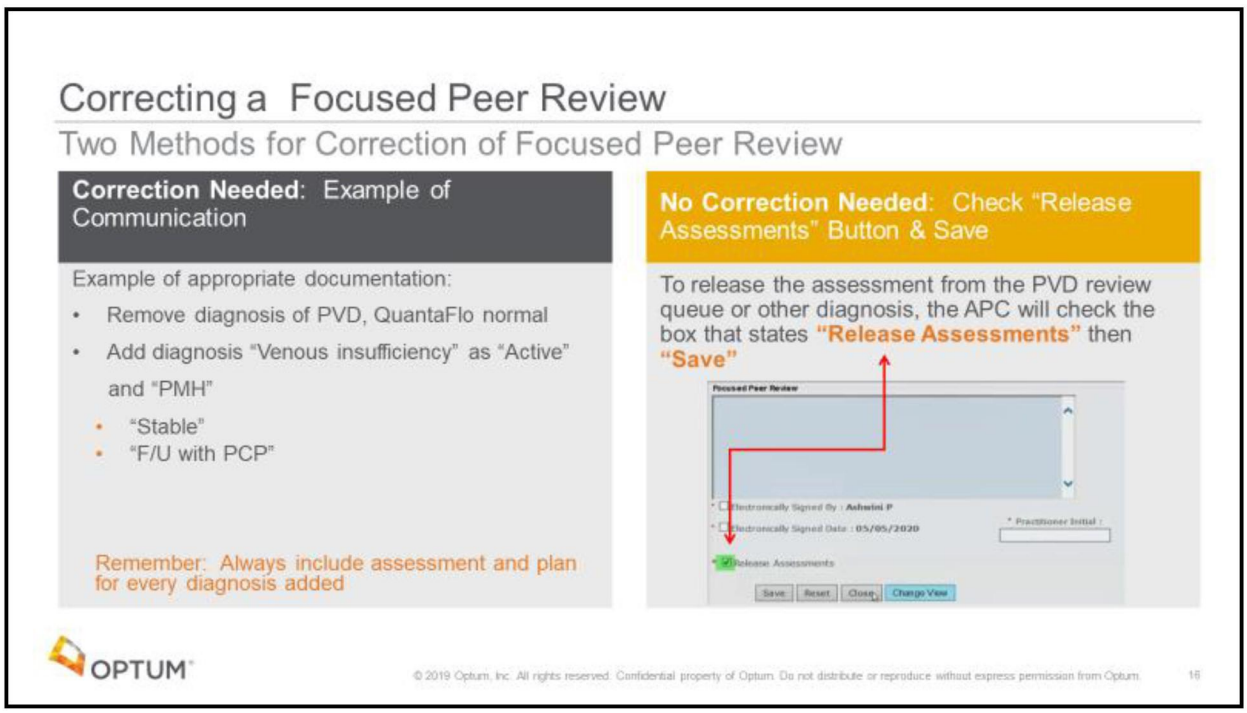
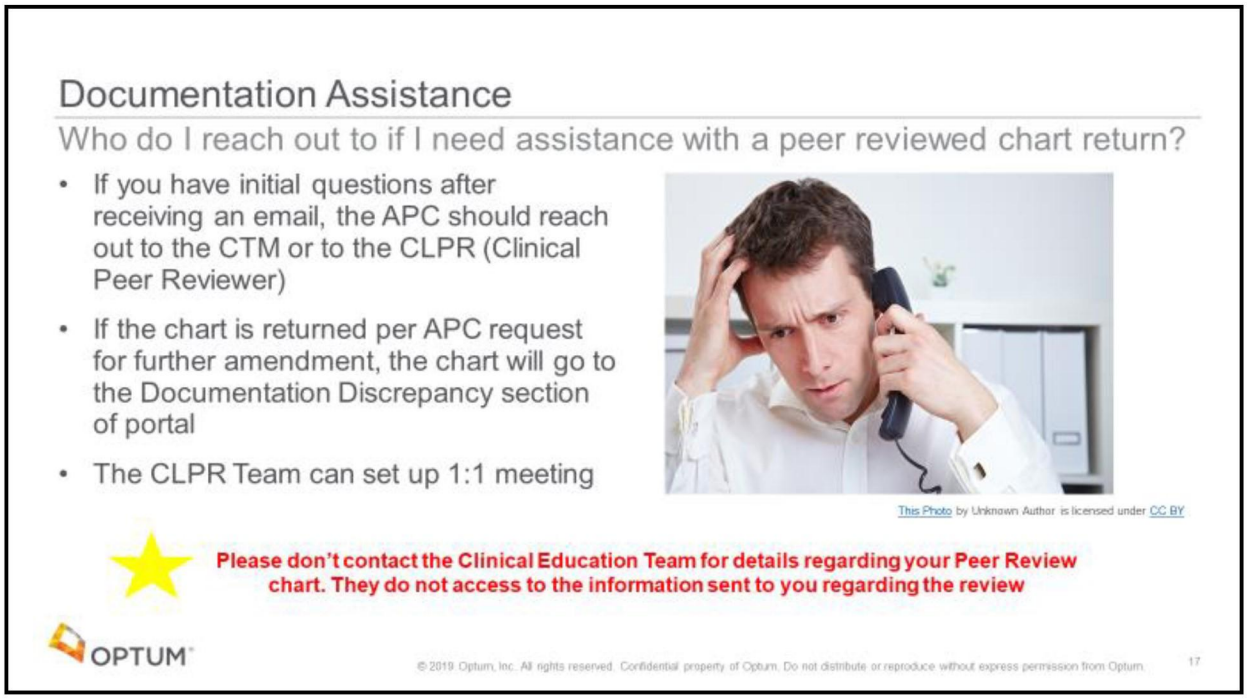


The location of these focused peer review charts will be returned to the "Peer Review" section under Completed Assessments section of the Portal.



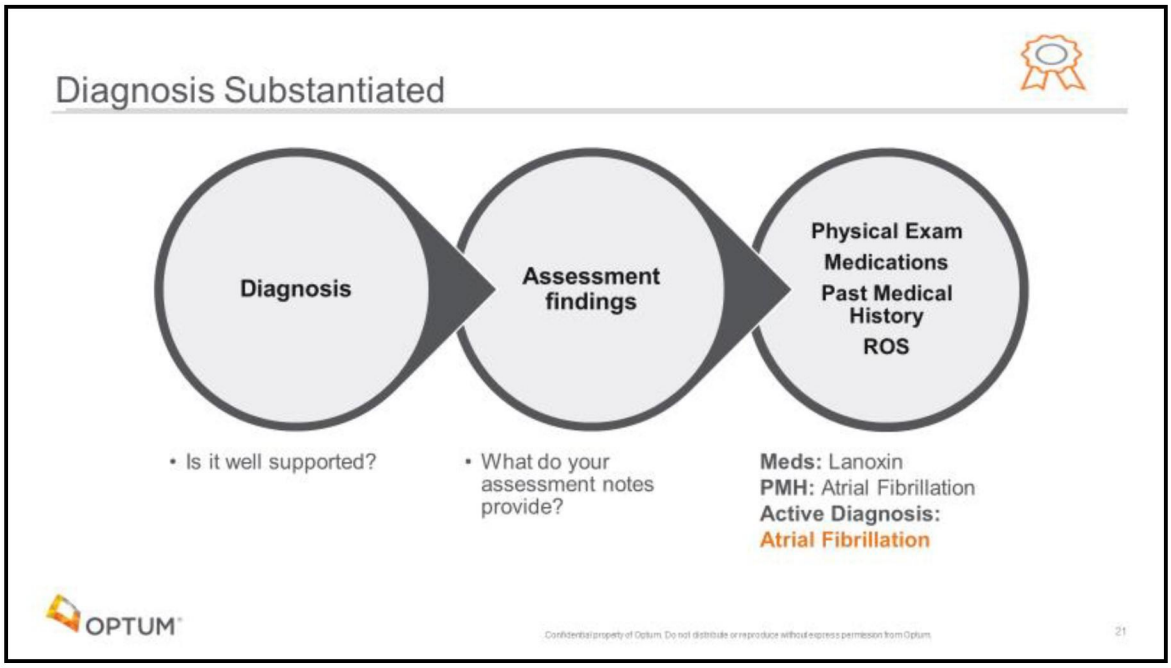


Clinical Peer Review Documentation Requirements

Diagnosis Substantiated

Each diagnosis should have active supporting evidence in the assessment. Diagnoses can be supported in one or more of the following sections: PMH, Surgery details, Medications, Social history, ROS, Physical Exam, Labs, Screening tools and/or Assessment notes. Please ensure that the most clinically accurate and specific diagnosis is chosen based on your assessment findings. Please remove any diagnoses that are conflicting.

For example is the diagnosis well supported by the documentation? What do your assessment notes provide in relation to the diagnosis. Below, we have a member who is on Simvastatin and in the prior history they had hyperlipidemia. The APC should be able to confirm the diagnosis as an ACTIVE Hyperlipidemia diagnosis on page 15.



It is important to substantiate the diagnosis. Demonstrate support by documenting items in the past medical history, medications, surgery history, social, screening tools, PE, Labs and Notes. This example demonstrates an example of the member having a history of atrial fib and active medications for atrial fibrillation. Should you consider "Atrial Fibrillation" as Active? "Yes".

Examples: Diagnoses Captured

Listed below are some examples of items that should be considered in the diagnosis captured section of the QA review. It is important to remember to associate any diagnosis related to Diabetes. If a member is on a statin, we should consider: Diabetes with complications- hyperlipidemia. If a member is obese with BMI: 35- 39.99 and has history of diabetes, OSA or PAD, we should consider Morbid/Severe Obesity with excess calories. If the member has either heart failure or cirrhosis and is on a medication like spironolactone or loop diuretic, the APC should consider "Secondary Hyperaldosteronism" as an active diagnosis. This condition doesn't require any labs.

Diabetes with complications hyperlipidemia	• Meds: Statin, Metformin • PMH: Hyperlipidemia, Diabetes
Severe/Morbid Obesity due to excess calories	• PE: BMI 35 – 39.99 • PMH: Co-morbid conditions w/ Diabetes; PAD, HTN, or Heart failure
Secondary Hyperaldosteronism	• PMH: Heart Failure or cirrhosis • Meds: Spironolactone, loop diuretics

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Referrals

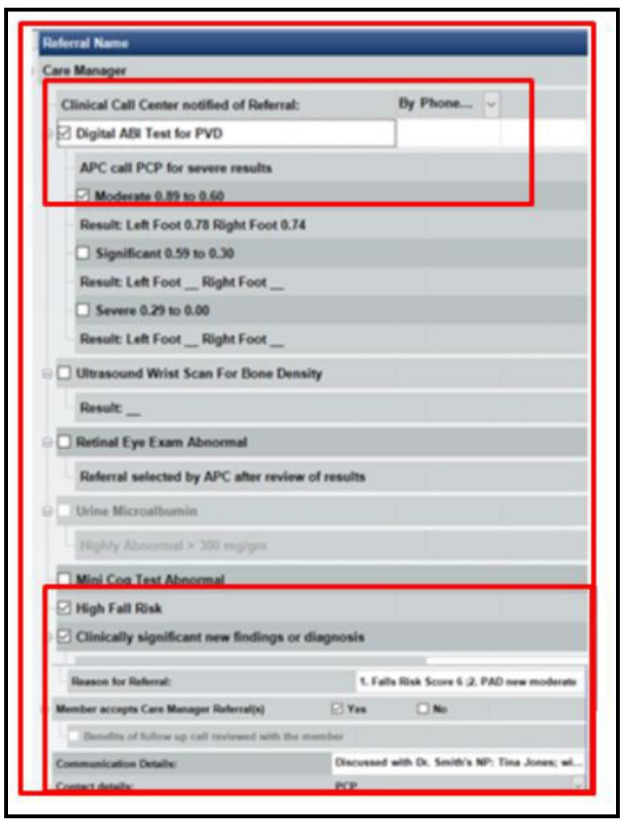
It is important to document referrals in the CRD Tool. If there are any missing elements of documentation related to a referral for urgent medical or urgent behavioral health issues or pharmacy referrals. As per protocol, the appropriate resource should be contacted for the member.

Emergent/Urgent:

For urgent referrals, the APC should document any urgent referral within the CRD (Comprehensive Referral Display) tool. Conditions that might be considered for urgent referrals could be several scenarios; however, to provide some examples it is important to consider the following:

Uncontrolled pain > 8, High fall risk of > 5, new diagnosis of PAD based on findings from QuantaFlo such as "severe" findings, unstable behavioral issues or uncontrolled diabetes.

The APC is required to document contact to the Clinical Call Center by checking the "by tablet" from the dropdown. The APC should call PCP and provide communication in the communication box in the CRD tool. The APC should also document the member accepted the referral in the referral section of the CRD. For medical referrals, the APC should use the "Care Manager" section of the CRD Tool to document all communication. (see figure I below) For social issues that are urgent, the APC will also document these in the CRD tool under the "Social Work" section of the CRD tool and include documenting the Clinical Call Center has been notified by tablet from the dropdown. Also, the member accepts social work referral should be addressed with "yes" or "no". Communication details should be provided on the issues and should include conversation with a licensed personnel and directive provided in the communication details as shown below:



Documentation of Urgent Referrals

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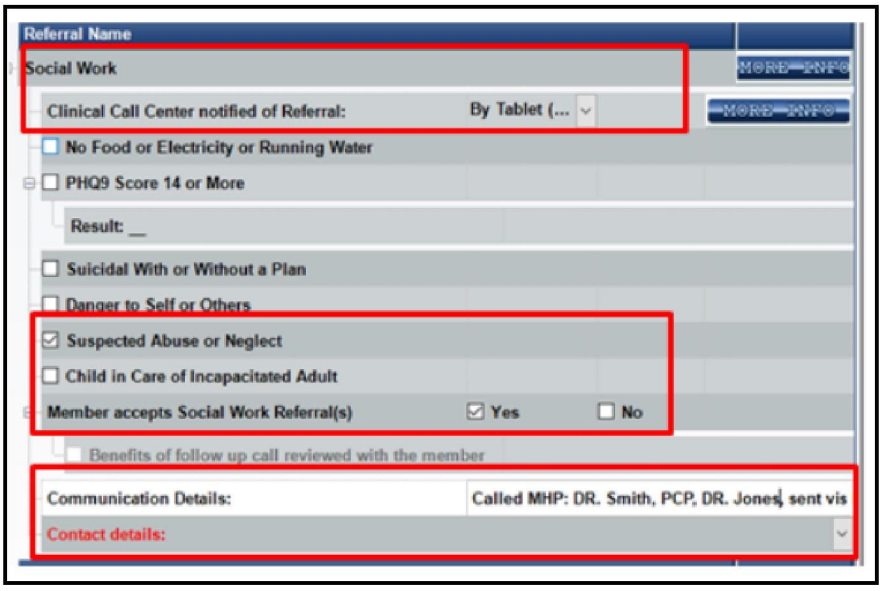


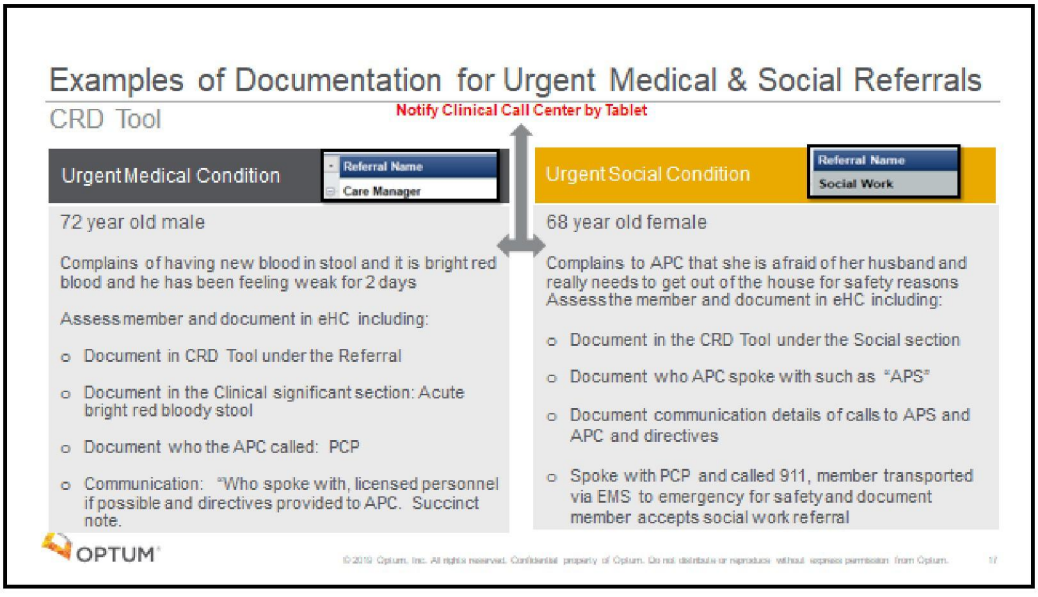
Social Work Referral Section of the CRD Tool

Non-Urgent referrals:
These are identified issues that can be addressed within 48 hrs. Use your clinical judgment on medical issues identified that need addressed. Documentation of these issues is on page 17 of the assessment in the free text non-urgent box. This non-urgent box doesn't generate any referrals.

Behavioral health can be documented on page 17 of the eHouseCalls assessment and this will generate a referral automatically. Advanced Illness should not be utilized at this time for selection. The APC may also use the non-urgent collaboration text box on page 17 for further documentation of a non-urgent issue.

NOTE: Completion of all sections and tools of the assessment will improve overall quality for the member's needs and better management of their care.

Examples of Documentation for Urgent Medical and Social Referrals



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Screening Tools



Mandatory Tools

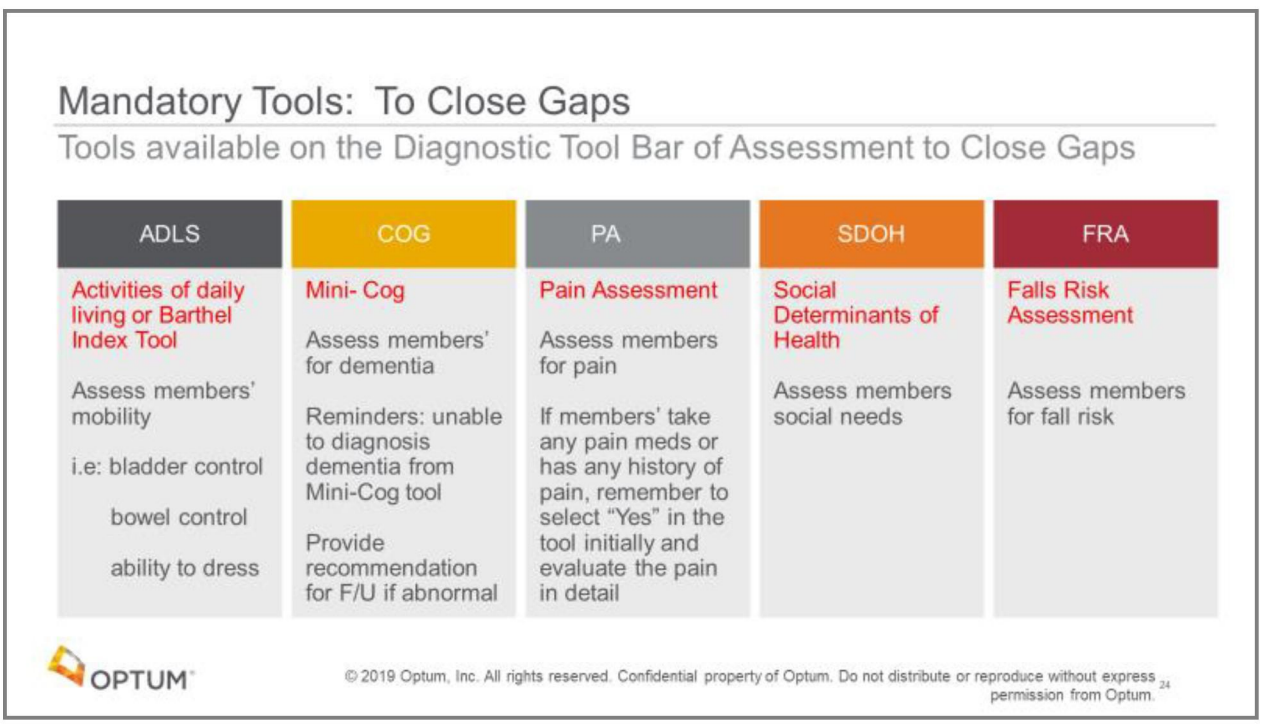
There are mandatory tools that you as the APC will need to assess the member for. These mandatory tools are displayed in the following picture. These tools are to assist in closing gaps for members. The tools are described in the following.

Please complete the full PHQ9 when:

- The member is on a medication for depression or other mental health diagnosis
- The member reports depression in the ROS
- The PHQ2 has a score greater than zero

Be sure to complete all of the mandatory tools which include: Activities of Daily Living (ADL), Mini-Cog testing (COG), Pain Assessment (PA), Social Determinants of Health (SDOH), and the Fall Risk Assessment (FRA) on all members. Also understand the monofilament testing and PHQ-2 questions are both mandatory in the assessment. If you do not complete these items, the tablet will send you an alert message.

The Comprehensive Pain Assessment must be completed on all members. If a member has acute or chronic pain, 'Yes' should be selected and all sections of the pain assessment should be completed.



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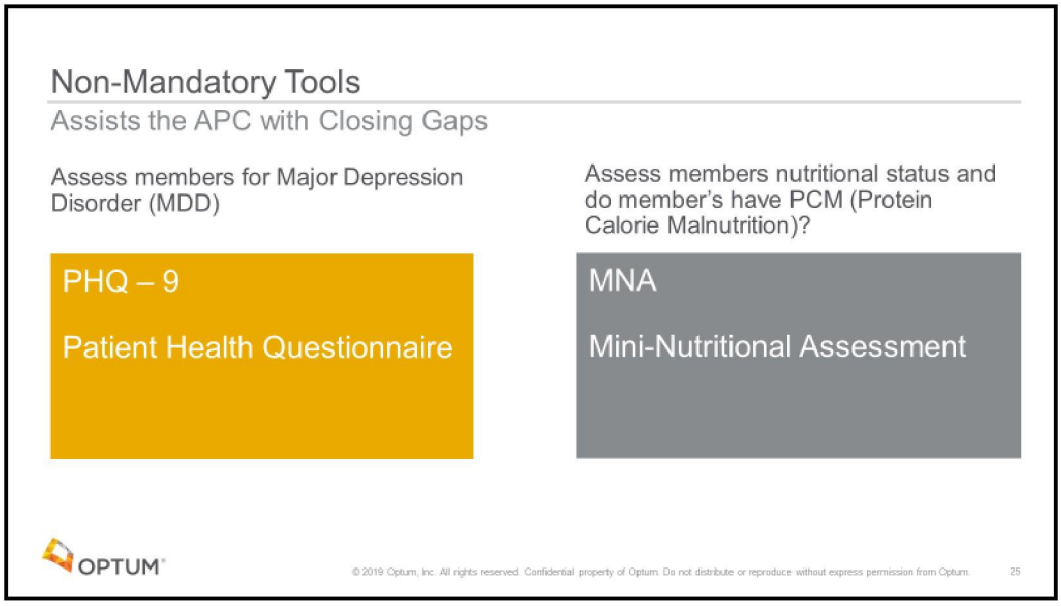
Non-Mandatory Tools

There are non-mandatory tools that are also available to the APC to assist with gap closure on mental health and nutritional status as shown below in the picture. These tools can become mandatory for the APC to complete when certain criteria are met. For the PHQ-9 if the member has any medications for depression or the APC documents depression in the assessment, the PHQ-9 tool will turn RED. The MNA or mini-nutritional tool can also become mandatory if the APC documents the member has BMI < 19 and an unintentional weight loss of > 10% over the past 6 months. This tool will turn RED if this is documented in the assessment as a flag to the APC to complete.



There are also tools to assist the APC in assessing members for depressive disorder. These tools on this slide are considered non-mandatory but may become mandatory depending on the history and documentation on behalf of the member. So, if the member is on an anti-depressive, the APC is required to further assess the member. Or if the member has any history of depression, it is important to reassess the member for that history and consider is it in remission or active. It is recommended that the APC utilize the PHQ 9 tool to further assess and better define MDD. Also, it is important to consider using the MNA tool to assess the member's nutritional status. If the member has a BM*I < 19 or unintentional weight loss of > 10% over the past 6 months, the MNA tool will go from "blue" to "red" requiring the APC to further assess the member for malnutrition and specifically protein calorie malnutrition*

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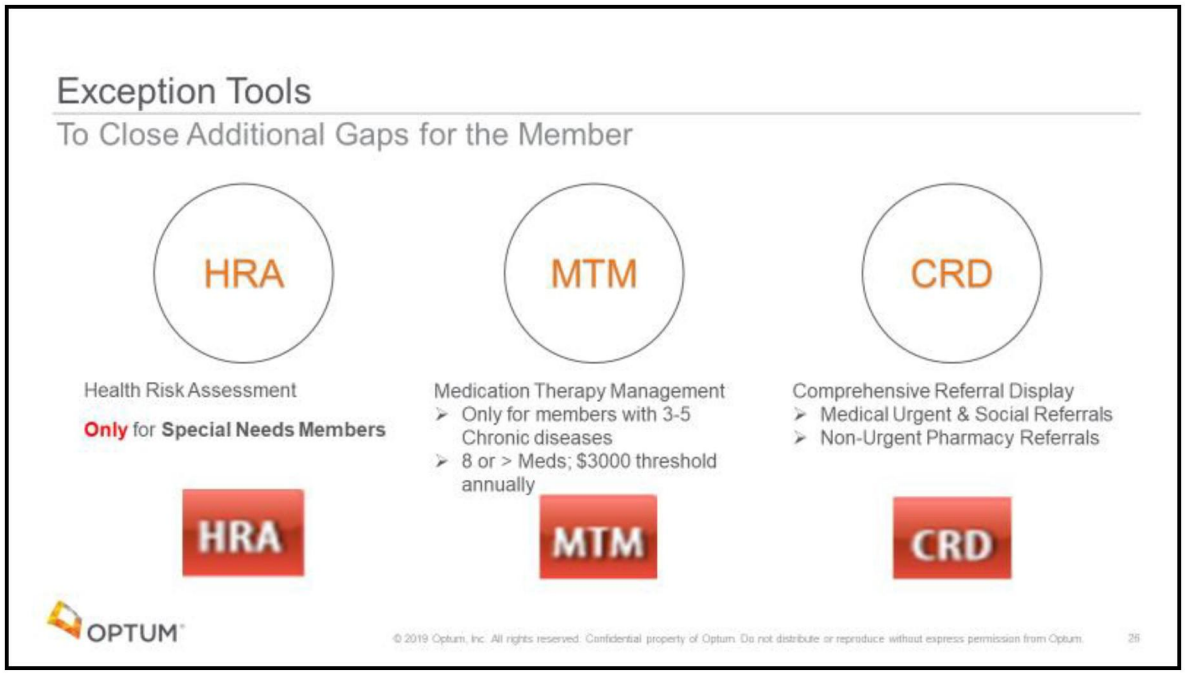
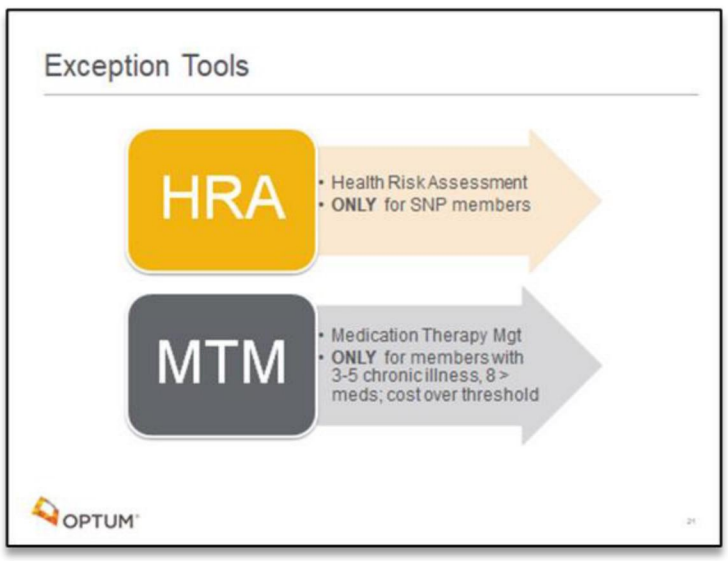


Exception Tools

The exception tools include the HRA or Health Risk Assessment and MTM or medication therapy management tools. See below for their individual descriptions as to when they will be available in the assessment for the APC to complete.



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CRD Tool: Comprehensive Referral Display Tool

The CRD Tool is the comprehensive referral display tool that holds referrals to the care managers, social workers, and pharmacy staff. Both care manager and social worker are considered urgent while the pharmacy referral section is non-urgent. This tool may be blue or red depending on the documentation of the APC. If the tool is red, the APC must document in this section.



Additional Elements of the Evaluation of the Assessment

Appropriate plan documented

All diagnoses should have an appropriate assessment and plan of care. The APC should identify if the condition is stable, unstable or sub-optimally controlled. If the condition is unstable a call should be made to the PCP. The APC should consider for example the member who uses cigarettes and is diagnosed with "nicotine, cigarettes, uncomplicated". This condition should direct the APC to consider "sub optimally controlled" for the member who is still actively smoking. The APC would also document the member is NOT to "continue therapy" however the APC should document, "the member is educated on smoking cessation" and will follow-up with the PCP for further care.

Screening and Immunizations

Ensure that preventative screenings and immunizations are recommended based on national guidelines for age, gender and diagnosis. HouseCalls recommendations are in accordance with the U.S. Preventative Services Task Force. For specific guidelines, refer to the member handout 'Recommended Screenings/Vaccinations for Members' in the Reference Documents section on the Portal. The month and year must be documented. If the member doesn't recall the month, select January as this is the default month.

Member Weight & Height

If a member is not weighed on the scale or documentation is not present as to why unable to weigh; points will be adjusted. Please remember to measure the member with the disposable measuring tape.

Documentation Discrepancies (Clinical Peer Reviews/Chart Reviews)

The Clinical Peer reviews are sent back to the APC via Practitioner Portal under the 'Received assessments". From the home page of the HouseCalls Practitioner portal, click on the highlighted number next to "Documentation Discrepancy". There will be a blue hyperlink. It is the expectation that all documentation discrepancy be returned in 7 business days however this will alert you after 48 hrs.

If your hyperlink is **RED,** there are charts that have been in this section for > 48hrs. Access the documentation discrepancy by following the steps below. Also, if you request for a chart to be returned for additional notes for an assessment you have already finalized, the chart may be requested, and it will be sent to this section in the portal.

Process for chart returns

The Documentation Discrepancy section of the portal will allow some coding queries to be received under Received Assessments for review if diagnoses were not captured or substantiated.

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Other chart reviews will be performed by CLPR Team and their review is sent to the CTMs for process and discussion with the APC. There will be an email that will be sent to the APC and the APC should reach out to their CTM for further discussion of the chart review.

Always check the Post Visit Amendment for any charts that you have finalized within the last 48 hours and request any charts beyond 48 hours from the training team. Click on the Documentation Discrepancy section and double click on the blue hyperlink in the second column which displays the charts that you requested or your CTM requested for review.

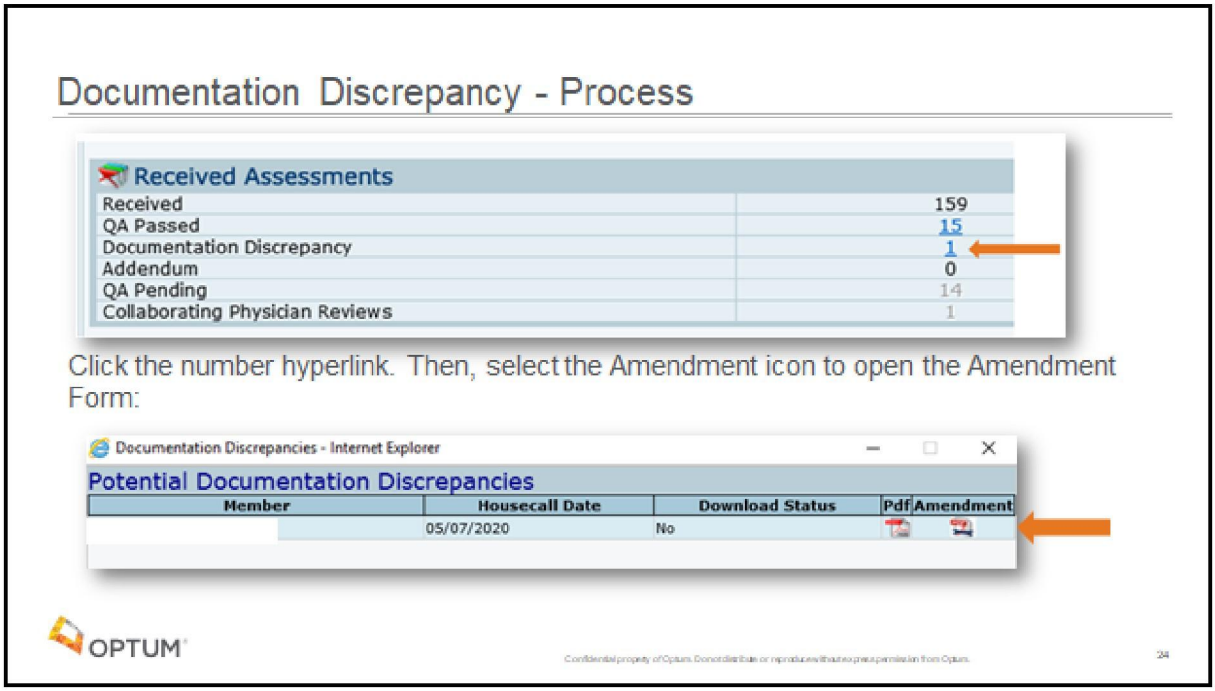
It is important to remember the charts are initially returned for your review and the display of those charts will be initially highlighted in blue for the first 48 hours. Then, if the charts are not accessed and reviewed and returned to the server within 48 hours, the number of charts in this section will then turn red to alert the APC the charts need attention

Please reach out to training team via email: **HouseCallsPractitionerTraining@optum.com**

Provide the following information: Name, Provider ID #, Date of visit and Member ID #.

Once the APC clicks on the number of charts in the documentation discrepancy section, there will be a page that displays both the member's name and date of the visit and will also house the PDF of the assessment. Click on the Amendment Icon, this will open a window which explains the chart to review the amendment coversheet.

Click on the Amendment PDF icon as shown below in the second screenshot



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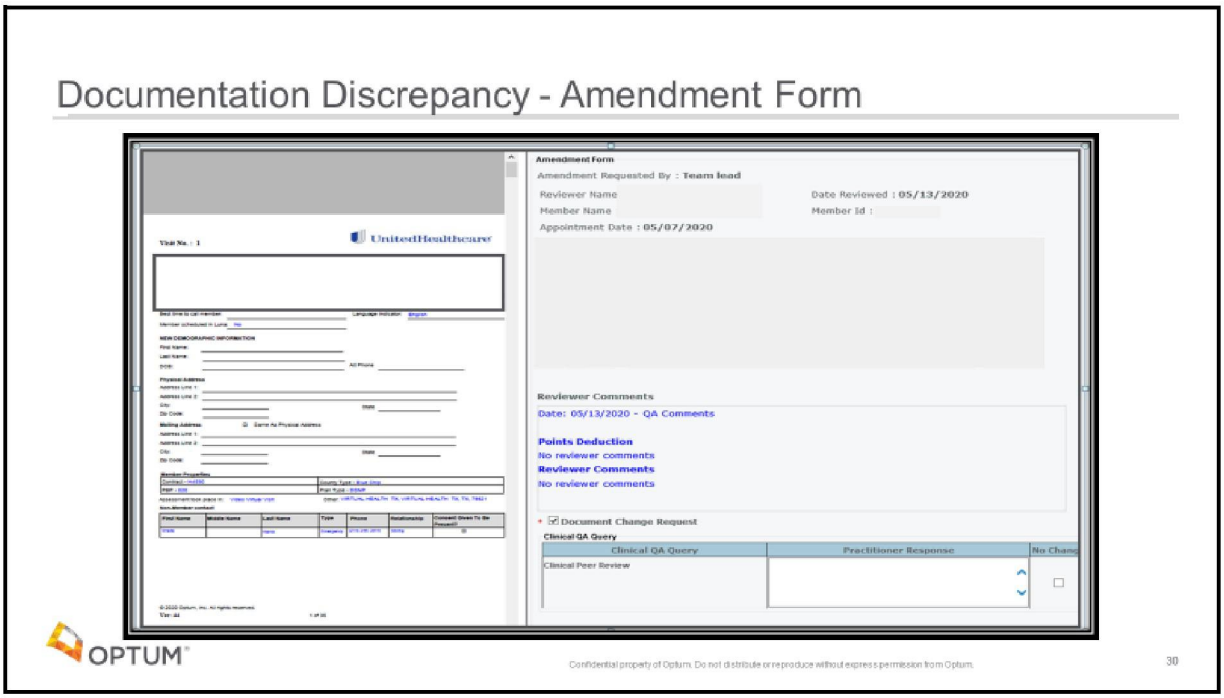
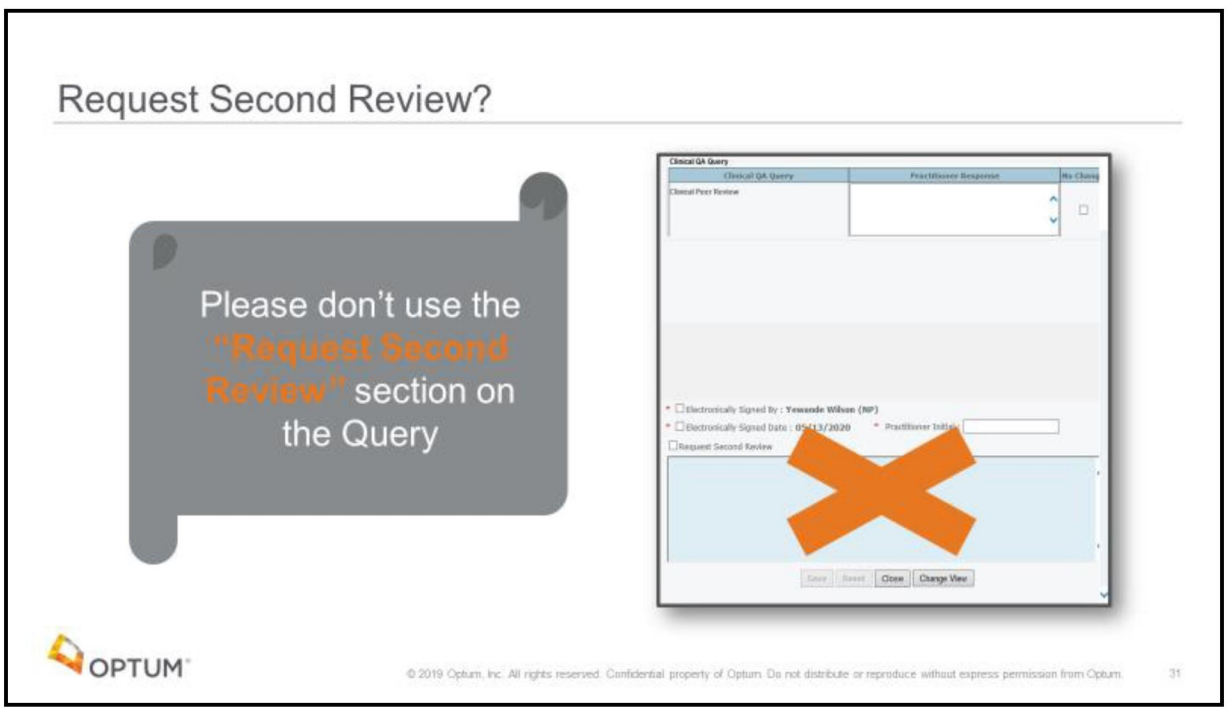
The Assessment PDF is displayed on the left and the amendment for is on the right:





Please refer to the email you received from the CLPR team member.

- Review the assessment to determine if any changes are warranted using your clinical judgment and assessment findings.
- If based on your clinical judgment you would like to make an amendment, enter your changes in the Practitioner response column. Remember that anything entered in this space becomes a permanent part of the member's record word for word.

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Tips for Writing Professional Amendments

Everything written in the Practitioner Response box is included in the Amendment and becomes a part of the member's permanent medical record. Therefore, please do not include communication to the CLPR or Coding team.

- Full sentences with correct spelling
- The amendment must be clear, concise, and specific
- Include details such as page number(s) and be specific as to which diagnosis is being added or removed
- Do not use abbreviations

Coding Reviews

Coding Reviews are reviews generated after a coder evaluates the chart for consistency with documentation. Coding Reviews are returned via Practitioner Portal under Received Assessments →"Addendums" and are ICD-10 codes related to documentation. Any questions related to addendums should be addressed with your CTM or email the coder directly. These charts are to be returned within 7 business days.

Once you have clicked on the hyperlink you will open the amendment form to review the information being communicated back to the APC by the coder. The APC will also review the PDF of the submitted chart in order to make your clinical decision.



Coding Query Communication

The coding query communication looks slightly different than the other returned assessment communications. The communication includes member demographics, identification of the coder, practitioner information and date of service in the top portion. In the lower portion the left text box will be the coder query communication and, on the right will be for the practitioner to type in a response.

In the lower portion the left text box will be the coder query communication and, on the right will be for the practitioner to type in a response.

When you finish adding your response to the Practitioner Response field, you will electronically sign, input your initials, and click save. The Coder will receive the response and then the Coder will make the **applicable** change(s) to the chart.

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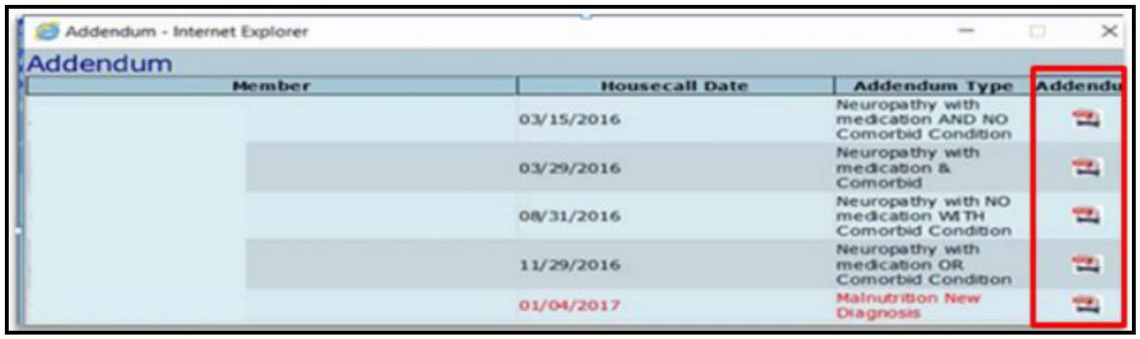
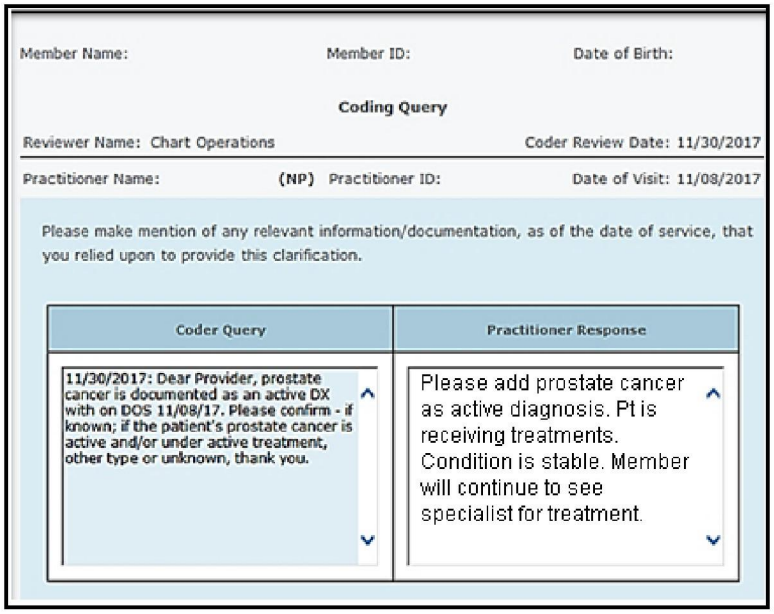
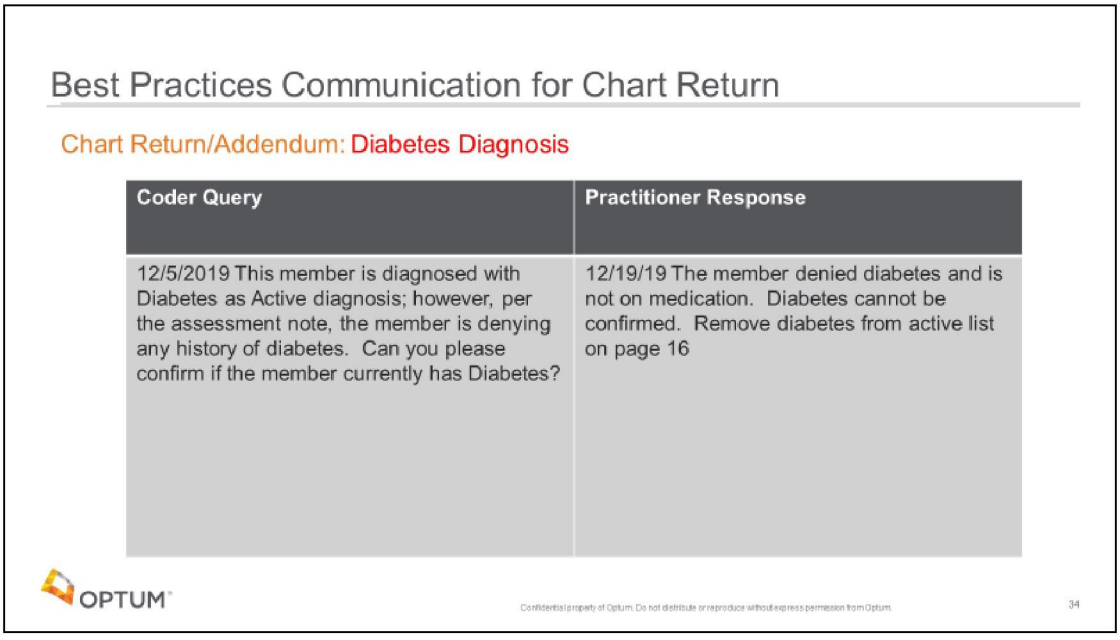




Below is a communication example from a Certified Coder:

The following example includes a coding query from an actual chart and the APC's response to the query. This is how the response should be completed to be compliant with best practices.



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Addendum Reviews: High Frequency Chart Returns

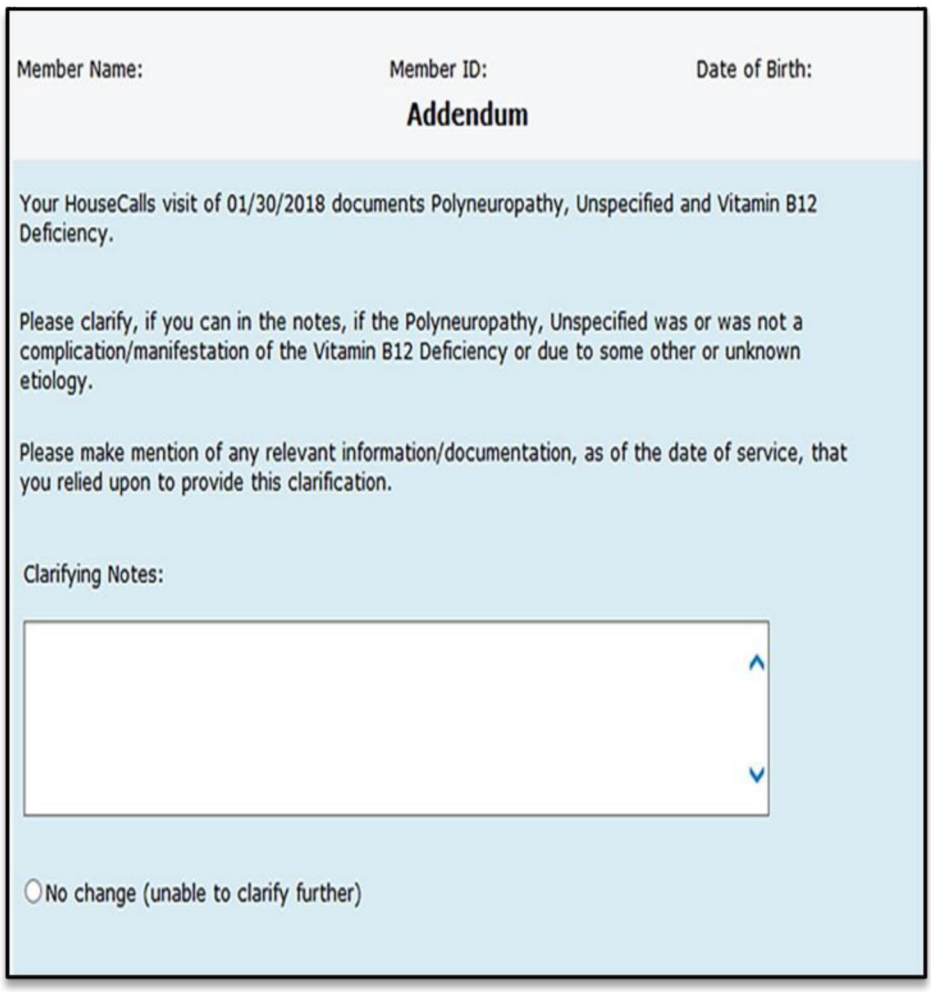
Addendum reviews are charts that are generated by an analysis process and are computer generated. These charts will consist of diagnoses that are not identified at a higher specificity. These are also known as high frequency chart returns. Diagnoses queried include Major depressive disorders, polyneuropathy, CKD, protein calorie malnutrition, obesity, and chronic kidney disease. In the chart below you can see the diagnosis on the left and supportive data on the right to help with substantiation.

Common Missed Diagnoses

Major Depression Disorder	Utilize PHQ-9
Protein Calorie Malnutrition	BMI < 19; Weight Loss > 10% in 6 months
Polyneuropathy	Etiology Specific

These charts are sent every first of the month via portal in the addendum section of the received assessments section. It is the expectation that these charts are returned within 7 business days.

Examples of Chart Return Coversheets are included below:



Member Name: Member ID: Date of Birth:

Addendum

Your HouseCalls visit of 01/30/2018 documents Polyneuropathy, Unspecified and Vitamin B12 Deficiency.

Please clarify, if you can in the notes, if the Polyneuropathy, Unspecified was or was not a complication/manifestation of the Vitamin B12 Deficiency or due to some other or unknown etiology.

Please make mention of any relevant information/documentation, as of the date of service, that you relied upon to provide this clarification.

Clarifying Notes:

○ No change (unable to clarify further)

Polyneuropathy Coversheet

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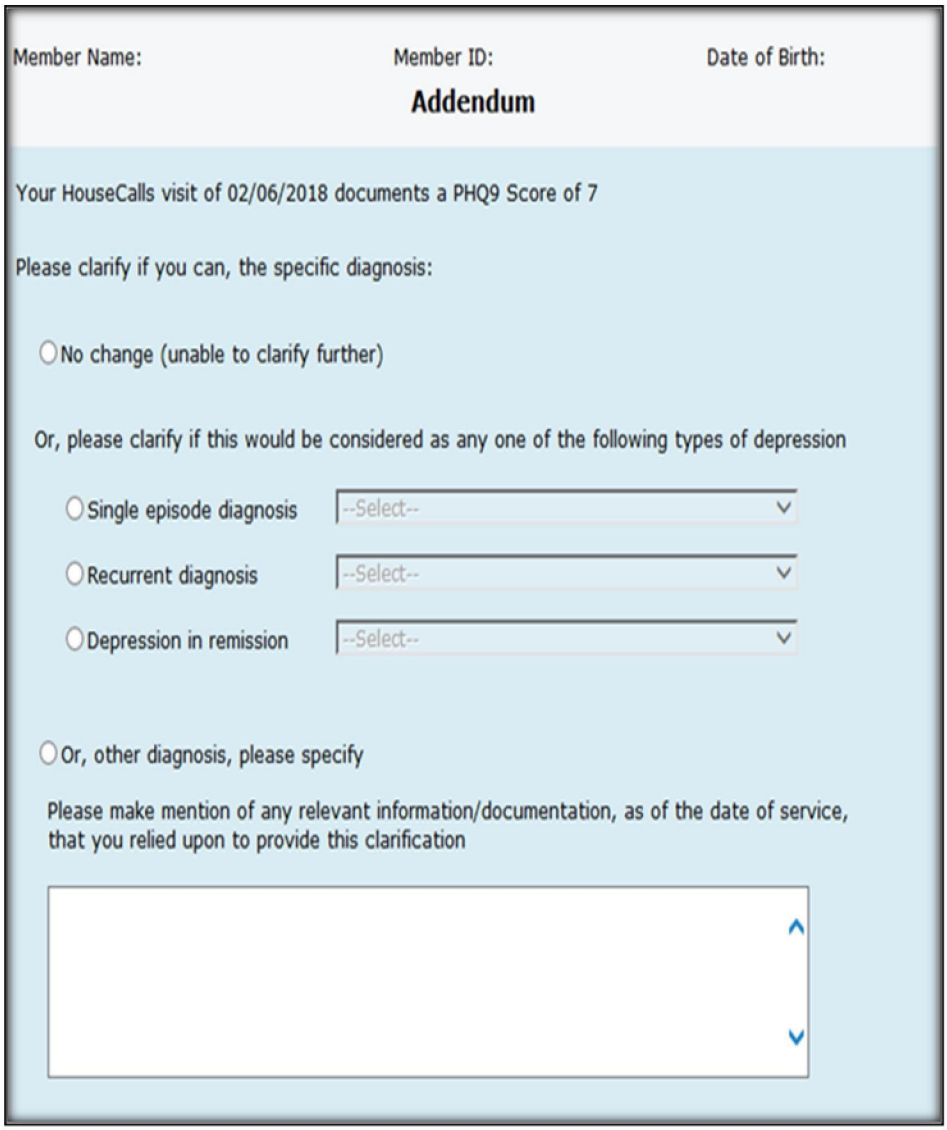

MDD Coversheet

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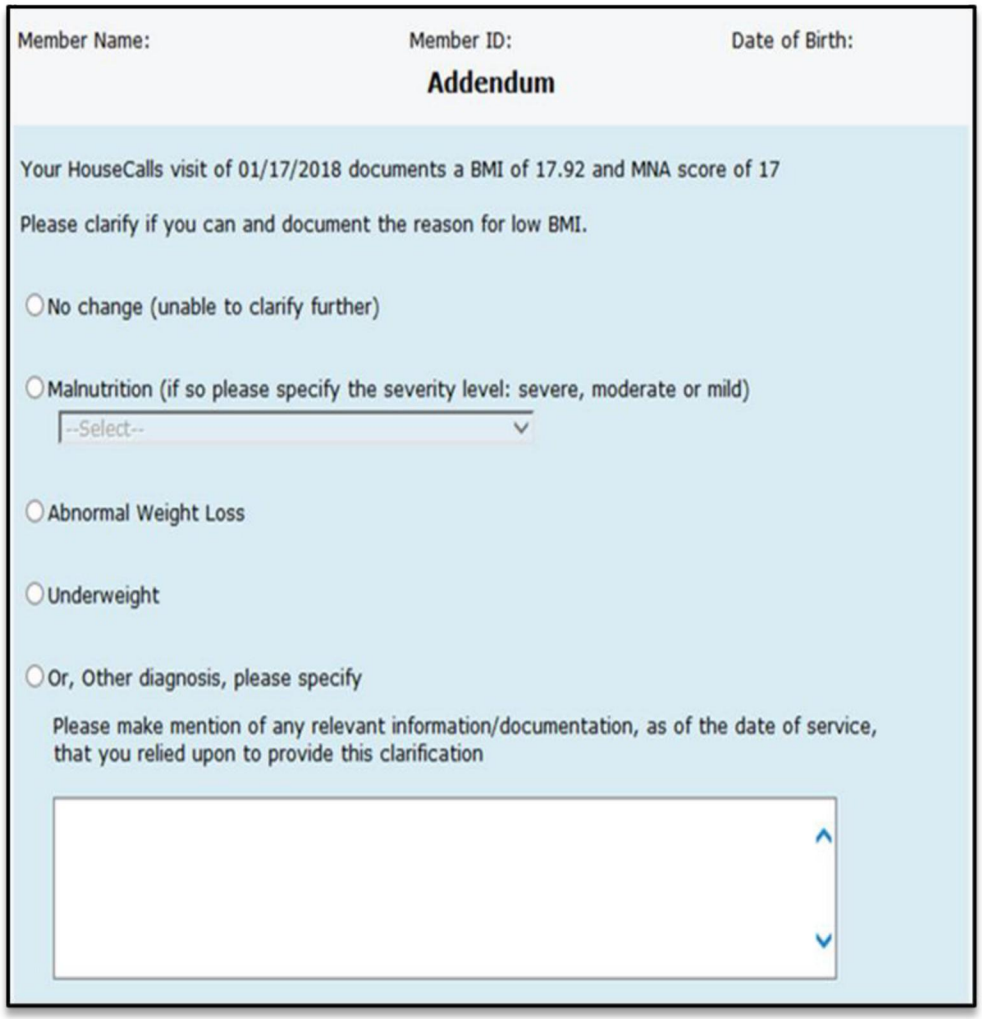

Protein Calorie Malnutrition

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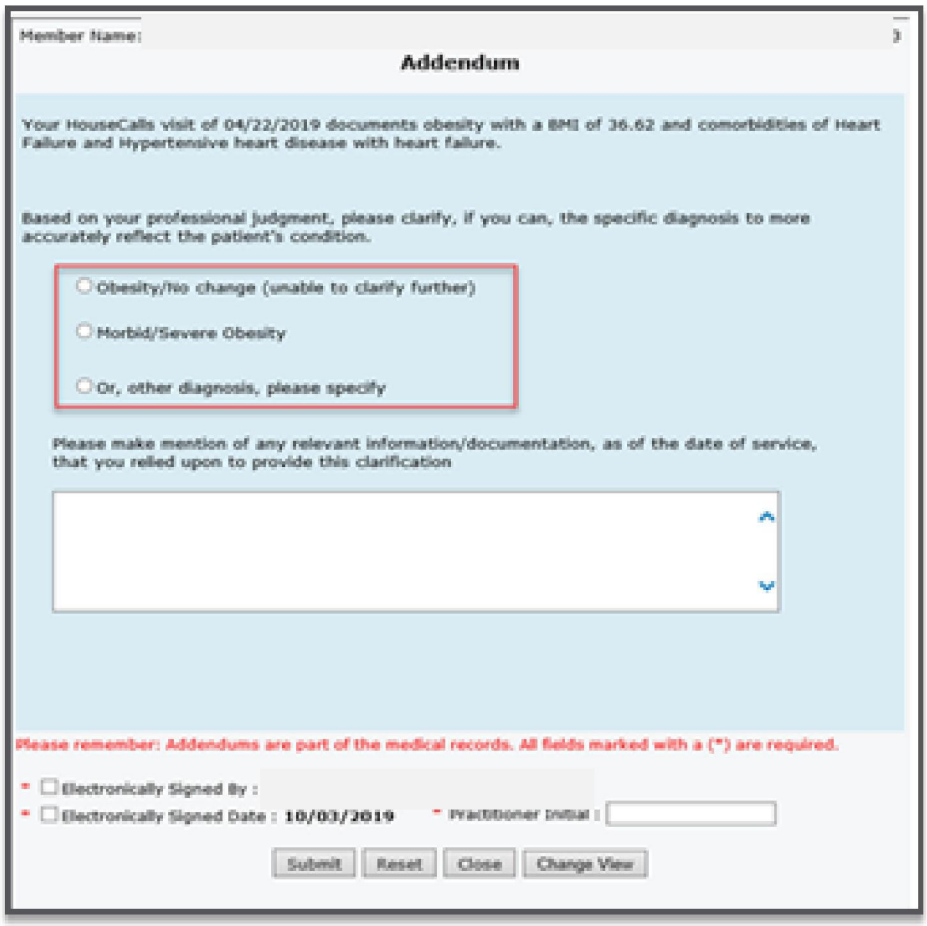

Morbid/Severe Obesity Coversheet

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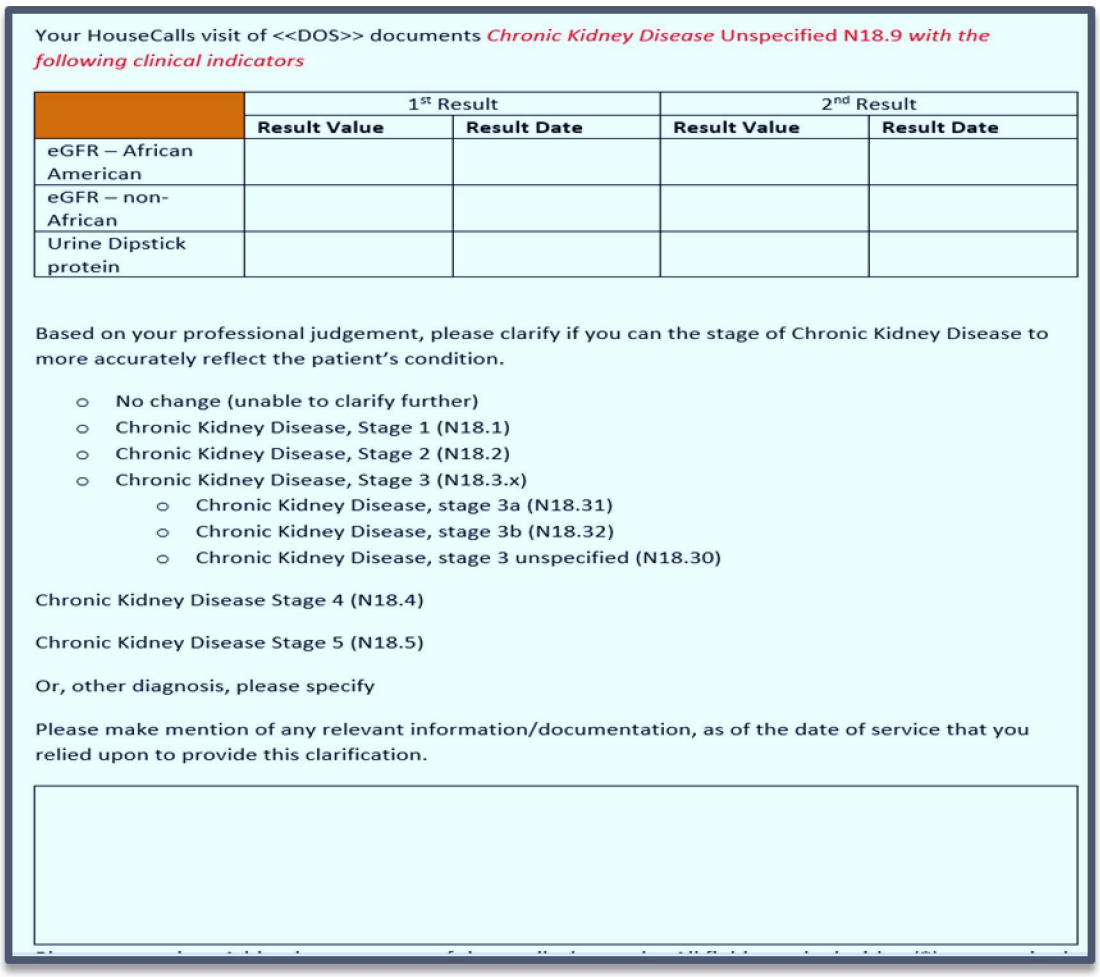

Your HouseCalls visit of <<DOS>> documents *Chronic Kidney Disease* Unspecified N18.9 *with the following clinical indicators*

	1st Result		2nd Result	
	Result Value	**Result Date**	**Result Value**	**Result Date**
eGFR – African American				
eGFR – non-African				
Urine Dipstick protein				

Based on your professional judgement, please clarify if you can the stage of Chronic Kidney Disease to more accurately reflect the patient's condition.

- No change (unable to clarify further)
- Chronic Kidney Disease, Stage 1 (N18.1)
- Chronic Kidney Disease, Stage 2 (N18.2)
- Chronic Kidney Disease, Stage 3 (N18.3.x)
  - Chronic Kidney Disease, stage 3a (N18.31)
  - Chronic Kidney Disease, stage 3b (N18.32)
  - Chronic Kidney Disease, stage 3 unspecified (N18.30)

Chronic Kidney Disease Stage 4 (N18.4)

Chronic Kidney Disease Stage 5 (N18.5)

Or, other diagnosis, please specify

Please make mention of any relevant information/documentation, as of the date of service that you relied upon to provide this clarification.

CKD Unspecified Coversheet

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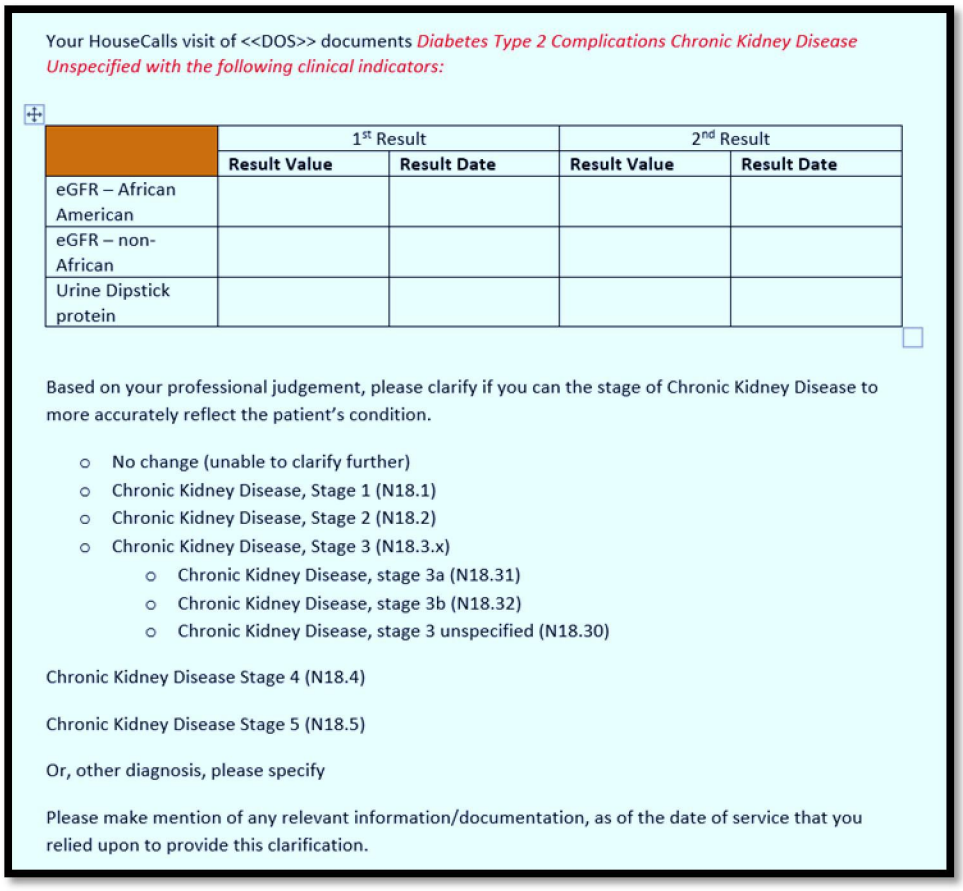

Your HouseCalls visit of <<DOS>> documents *Diabetes Type 2 Complications Chronic Kidney Disease Unspecified with the following clinical indicators:*

	1st Result		2nd Result	
	Result Value	**Result Date**	**Result Value**	**Result Date**
eGFR – African American				
eGFR – non-African				
Urine Dipstick protein				

Based on your professional judgement, please clarify if you can the stage of Chronic Kidney Disease to more accurately reflect the patient's condition.

- No change (unable to clarify further)
- Chronic Kidney Disease, Stage 1 (N18.1)
- Chronic Kidney Disease, Stage 2 (N18.2)
- Chronic Kidney Disease, Stage 3 (N18.3.x)
  - Chronic Kidney Disease, stage 3a (N18.31)
  - Chronic Kidney Disease, stage 3b (N18.32)
  - Chronic Kidney Disease, stage 3 unspecified (N18.30)

Chronic Kidney Disease Stage 4 (N18.4)

Chronic Kidney Disease Stage 5 (N18.5)

Or, other diagnosis, please specify

Please make mention of any relevant information/documentation, as of the date of service that you relied upon to provide this clarification.

CKD Diabetes Type 2 Coversheet

For all high frequency chart returns, the APC will evaluate the PDF of the assessment for evidential support. There will be pertinent information at the top of the coversheet to include specific information related to the diagnosis in question and can include medications, screening tools documented or other pertinent information. As shown in these CKD screenshots, the APC may have available the eGFR values based on the ethnic group of the member. The tablet on occasion may have eGFR values based on history and previous data for the member.

Practitioner Post Visit Review Process

The post visit review process allows the APC to review finalized assessments in the practitioner portal under the post visit amendment section. These assessments can be accessed for 48 hours and can be amended once during that time period. These charts are available once finalized anywhere from 3 hours to 24 hours in this section of the portal for your ability to add an addendum note. For example, if you forgot to include information regarding a referral or received additional information after finalizing a chart, you may go to the Post visit amendment section and document in this section of the portal. Steps to access the addendum notes include accessing the portal and selecting the blue hyperlink from the "Post Visit Amendment" section of the Completed Appointments portion of the portal page. Once this is opened, click on the PDF of the chart and the amendment sheet and PDF of the chart will be visible.

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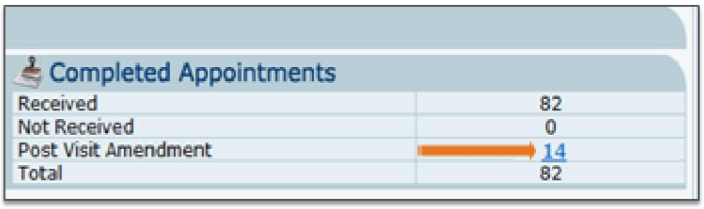
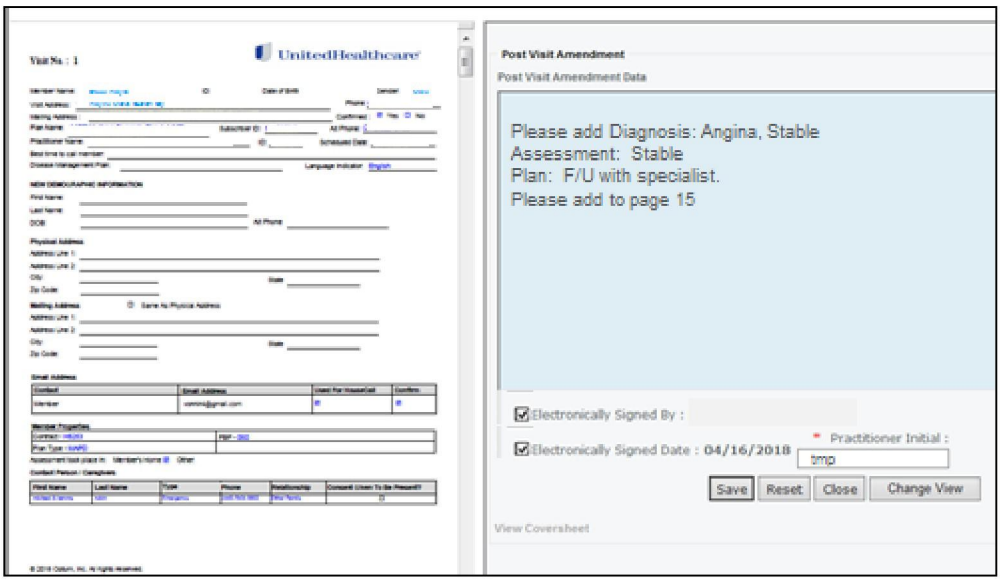




The post visit amendment comments should be added into the free text area. Below is an example:



Best Practices in Documentation

- Diagnoses
  - Support your documentation
  - Capture all applicable for the member
  - Each should have an appropriate plan
- Medication profile
- Star Measures
  - Urine collection for all members
  - Weight with scale on all members
- Screening measures and tools

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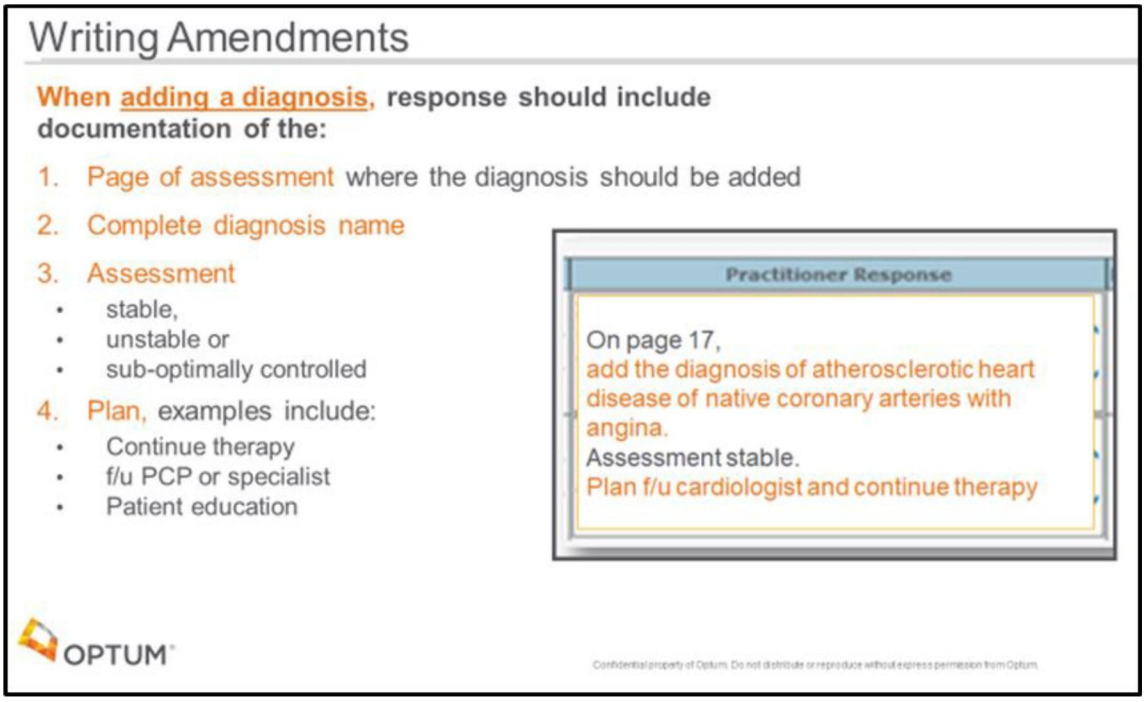

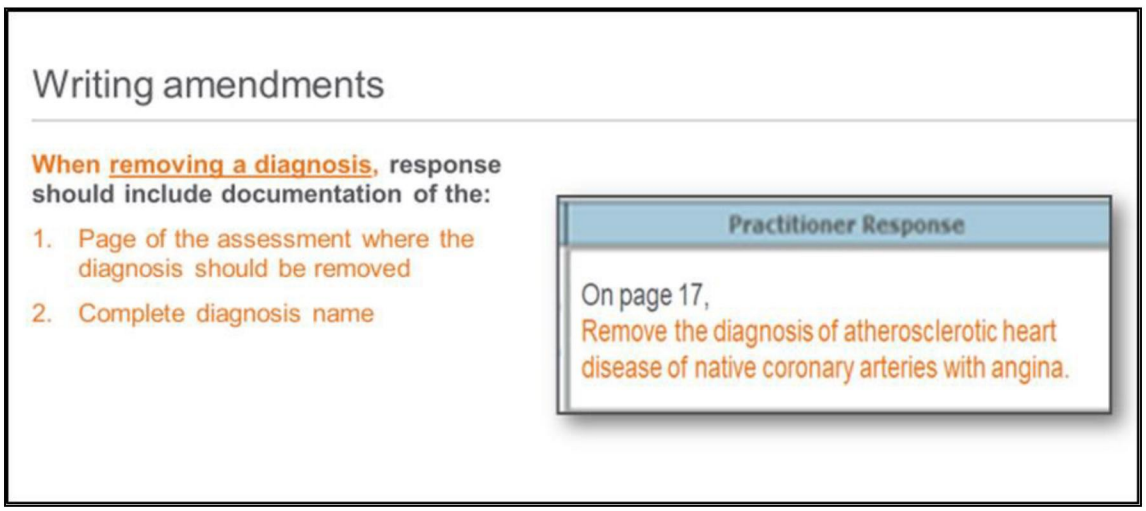

HouseCalls Clinical Education Team

- Please contact Education Team about questions regarding training or personal request for chart returns and contact CTMs regarding any queries. Be sure to provide your provider ID number and member ID number as well as date of visit and member's name so we may return the chart. Speak slowly and clearly.
- Helpdesk: **Monday-Friday 9AM-5PM EST**; **housecallspractitionertraining@optum.com**
- **Clinical Peer Review** Chart Returns: Contact CTMs Only
- **Coding Review** Chart Returns: Contact CTMs first and then Contact the HouseCalls Clinical Education Team
- **Addendum Review** Chart Returns: Contact your CTM or the HC Clinical Education Team for questions, as these are generated by a computer analysis.

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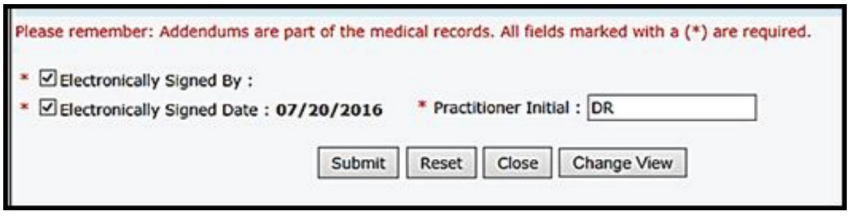
Resources

The APC may utilize the CEC (Clinical Education Center) for further assistance on reviewing job aids on diagnoses and the documentation process.

Chart Returns for Consistency

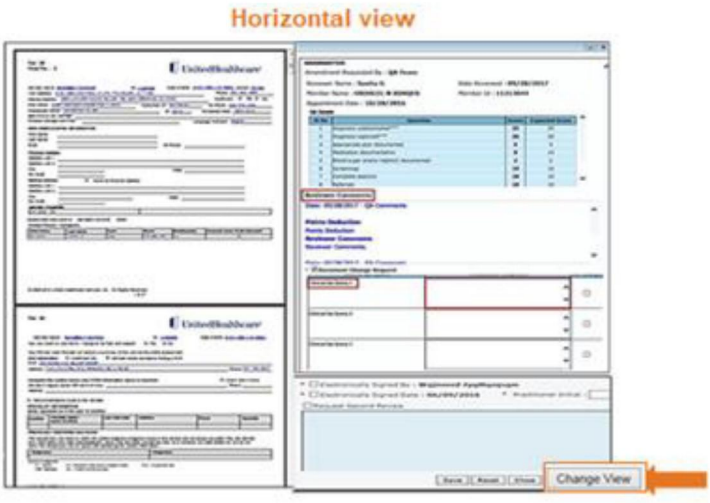
Permanent part of record	Refrain from negative language
Document succinctly	**Assessment & Plan for each diagnosis**
Address only what is requested from reviewer	

All returns should be electronically signed by with name, date and initials then click submit:



Change View of PDFs

This is the horizontal view and default of the document discrepancy or addendum. The chart will be on the left and the communication form from the QA team or coder will be on the right.



The APC can change the view by clicking on **Change View** as shown in the screenshot above, to be able to change from horizontal to vertical and toggle back and forth between PDF and coversheet.

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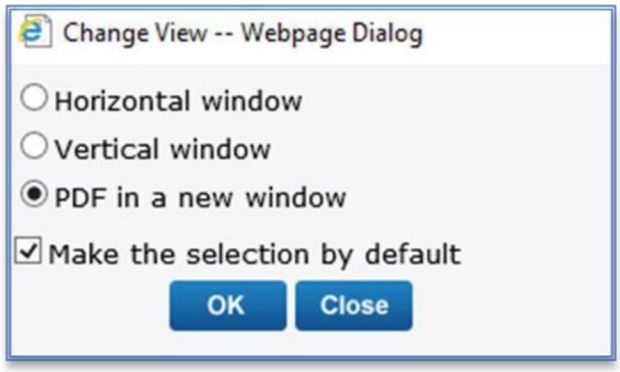

Best Practices & Resolutions to Common Issues

Overview

We strive to provide you with the tools to address both clinical and technological issues, and the resources to help you when in need.

- Review **best practices** for successful day to day operations
- Common pitfalls and their **resolutions**

Technology Trends & Resolutions

Common Issues & Points of Contact

- Malfunctions requiring contact to the **Clinical Support Center (CSC)**
  - **VPN Issue(s):** Unable to connect or secure a connection to Auto VPN
  - **MS Password:** Reset and/or Locked out
- Malfunctions requiring contact to your **CTM & CSC**
  - **Tablet:** Malfunctions
  - **Smart Card:** Activation issues, Lost, Stolen, and/or Defective
  - **eHouseCalls:** Unable to log in for a prolonged amount of time
- Reason requiring contact to your **CTM, Police, & CSC**
  - **Tablet:** Lost and/or Stolen

Equipment Issues

If you experience any issues with the following, please contact our Equipment team by email optum_equipment_team_DL@ds.uhc.com.

- Broken or Lost Stylus Pen(s)
- Car Charger
- Tablet Charger Cord

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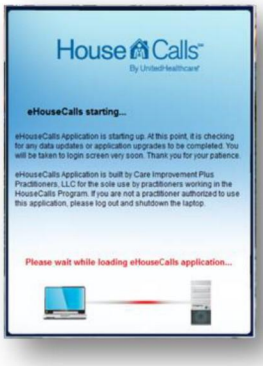
eHC Loading Malfunction: Error Possibilities

Loading Malfunction: Error Possibilities

- If your eHouseCalls gets stuck in an “eHouseCalls starting…” status and the program won't open:

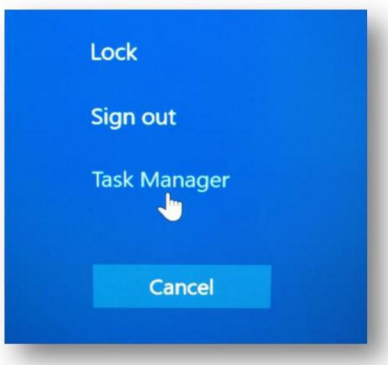


- If you have gotten locked out because you have entered the incorrect password in too many times, and it triggers a Timed Lock Out:



Loading Malfunction: Resolution

1. **CTRL + ALT + DEL**
2. Select **Task Manager**



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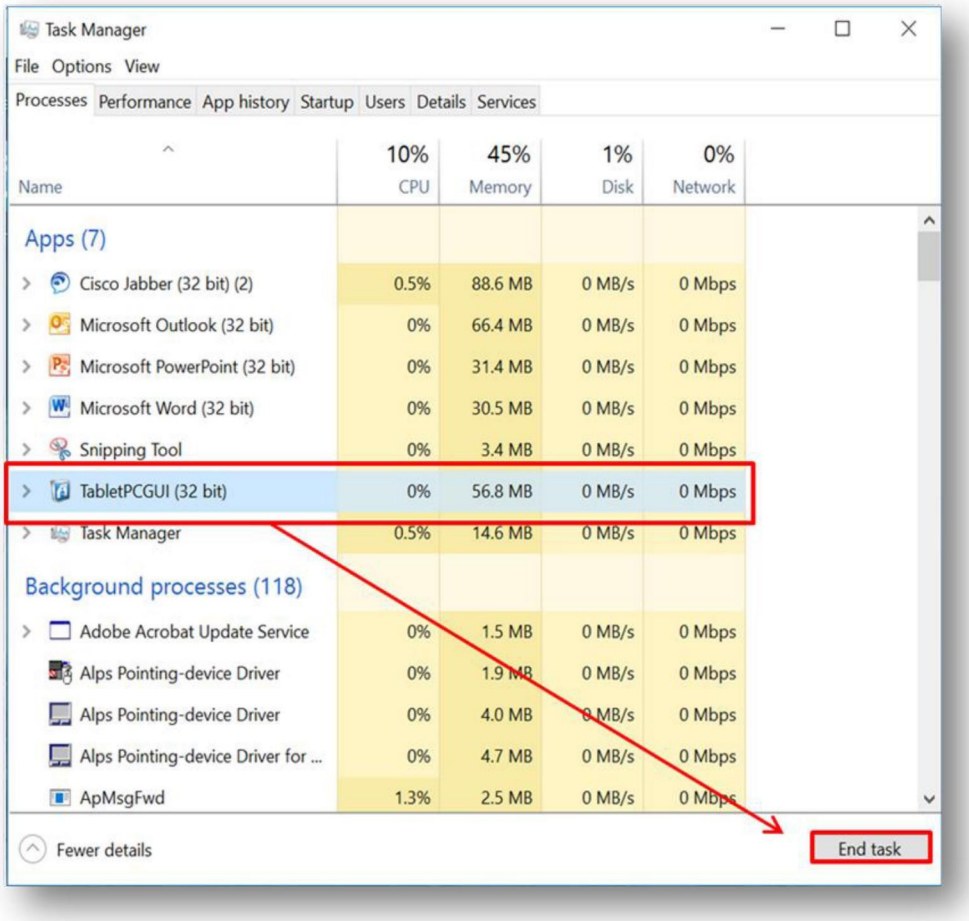
3. Scroll down and select **TabletPCGUI**
4. Select **End Task**
5. Launch **eHouseCalls** and **Login** again



Paper Assessments

Paper Assessment Policy

- Notify both your CTM and the CSC if your tablet is malfunctioning
- Complete visits on paper
- Transcribe assessments within 24 hours into your tablet if your tablet is repaired
- Use standard correction
  - If there are errors in the assessment, cross out the error with one line, and then initial and date each change **legibly**
- Shred all papers after the assessment is transcribed
- Request a UPS label to return paper charts
  - Fulfillment Operations: MailingDistributionGroup@xlhealth.com
  - On the e-mail request, copy your CTM; they will monitor the paper assessment process to ensure the assessment is received and processed timely
  - Fulfillment Operations will provide you with a UPS label and cover sheet template within 24 hours of receiving the e-mail request

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Securing & Handling Paper Assessment

- All paper assessments that cannot be transcribed to the tablet should be returned to Fulfillment within **48 hours**
- Each assessment should include the following identifiers
  - **Page 1**:
    - Member's first and last name
    - Member ID number
    - Member's date of birth
    - Member's address and phone number
    - Date of Visit
    - Practitioner's ID and name
    - Practitioner Signature & Credentials
  - **Page 2 and subsequent pages**:
    - Include **3 member identifiers**

Paper Assessment Reminders and Tips

When or if your tablet malfunctions, you will:

- Continue to document the assessment on paper
- Remember: iFOBT tests cannot be offered to the member
  - If the member was flagged for a FOBT test, you will not be able to offer this test for the member because you cannot enter a barcode into the tablet
- Completed paper assessments should be documented in the portal as Paper Assessment by selecting the checkbox
- If the member is a Special Needs Plan Member, the HRA tool should also be completed
- Contact both your CTM & the CSC
- **Blue or Black ink ONLY**
- Write Legibly
- **3 member identifiers**
- Date of the **actual visit**
- Ensure you provide your **signature** AND **credentials**
- Someone 21 or older must sign when or if a paper assessment is returned

Protecting Member Data

Part of quality is ensuring we protect our member's information.

- Only Necessary Information- as minimal as possible
  - HIPAA requires that we use and disclose only the minimum amount of PHI necessary to accomplish the task at hand
- Be aware: Carrying paper PHI with you on visits puts our members' information and our company at risk
  - This can lead to identify theft and embarrassment for the member, and loss of confidence in Optum

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- For Optum, an inappropriate disclosure of member information can lead to media attention, assessment of monetary penalties, and litigation

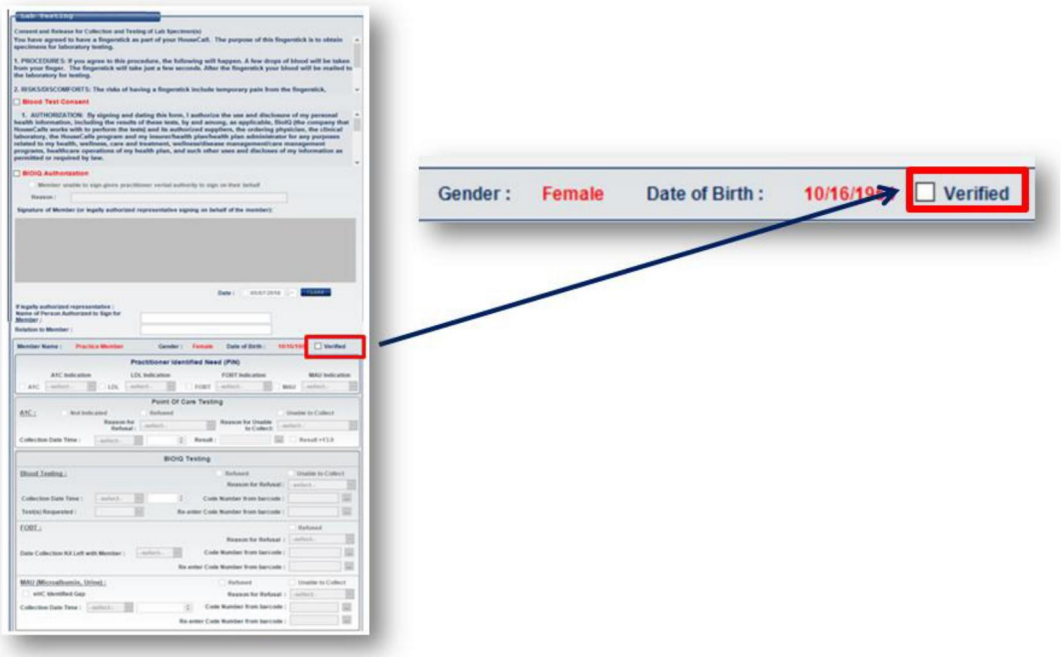
- Always keep PHI in your possession – do not leave it unattended
  - Do not leave PHI in your car or at a member's residence
  - Prevent inappropriate viewing:
    - Ensure that paper PHI in your possession is not visible to members or the public
    - Keep paper PHI in a manila or sealing envelope, inside a bag
- Incident Reporting
  - Lost PHI? You must immediately report the loss to Optum Privacy (privacy@optum.com)

Lab Issues

- Reminders:
  - The lab tool doesn't have to be RED to perform a test if the member meets criteria
  - There are two tests: iFOBT & A1C Now

Lab Consent

Select **VERIFIED**. You must check the Verify box first before proceeding with the remainder of the tool.



- iFOBT: Using a Paper Assessment
  - Do not provide the kit
  - Recommend Follow-Up
- A1C: Using a Paper Assessment
  - Perform the test
  - Remember the Criteria

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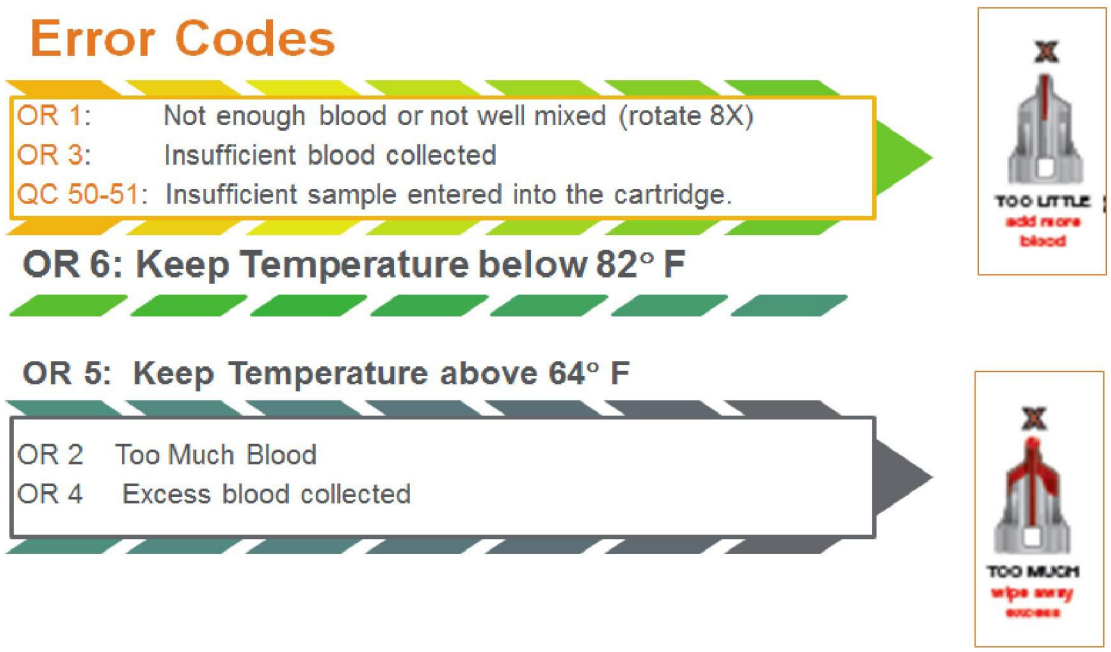
Error Codes

When performing labs in the home, you may receive an error code from time to time. Become familiar with the error codes to understand better how you can prevent further error codes in the future. There are several error codes which can occur. Some error codes are similar as to why they occur. There is a pamphlet within the A1CNow kit that provides you with the list of error codes. Be sure to place the monitor on a flat surface and know that if the hemoglobin is high in that member, you will not have incorrect results.



Non-Error Codes

- **09TL**
  - The monitors count down the number of tests performed and will only perform 20 tests. The monitor shows how many tests are left by displaying the number left before "**TL**".
  - Example: **09TL** = 9 tests are left
- **QCOK**
  - When the display finishes counting down, there is a cycle that will appear on the monitor "{QCOK", the test result (%A1c) and the number of tests left (09TL). These screens will cycle through for 10 minutes after the test result is reported, or until the next Test Cartridge is inserted.

Complaints & Grievances

- Required to report all complaints
- OptumCare receives, investigates, & manages all complaints:
  - HouseCalls Visit
  - Insurance Benefit/Plan
  - Other stakeholders

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- **Complaint:** Dissatisfaction expressed by a member
  - APC late arrival to the HouseCalls visit
  - Expression of plan dissatisfaction
  - Any grievance expressed during the visit

Reporting Complaints and Grievances

If the Member verbalizes dissatisfaction during a HouseCalls visit

1. Notify the HELPDESK
2. Once a Helpdesk agent is available, explain the member's situation
3. The agent will then speak with the member
4. A report will be submitted

The APC may speak on behalf of member. The following should be provided to agent:

- Member name
- Members full address; including city, state, & zip
- Member's date of birth
- Complaint details

The Complaint Management Policy is available to be reviewed on the CEC (Clinical Education Center) under the Policies section.

Wrap-Up

We want you to remember that as an APC, the technology you have may experience an issue at some point. However, it is most important that you remember to remain confident, don't get discouraged, and be honest with your members. If you express your frustration about your equipment in front of the member, that could cause the member to lose trust in their health plan. Always remain true to yourself and your abilities, and you will be successful!

- Technology issues: always remember to reach out to the **CSC: 1.855.247.8474, Option 4**
  - Refer to the technical troubleshooting guide under the Technology tab on the HouseCalls Clinical Education Center (CEC) for instances when you need to email the equipment team for resolution
- When you are seeing members and your computer malfunctions, continue the assessment on paper, and review the paper assessment policy. Contact your CTM if you have further questions.
- Remember, any mishandling of PHI can result in placing Optum and the member at risk of exposed information
- Labs: if you encounter error codes, review and remember these tips are provided in the A1C kits
- Always take the members seriously regarding their complaints and grievances; all must be reported to the Helpdesk

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HouseCalls Small Group Education

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Disclaimer

Use the Optum coding and documentation materials for reference only. They are not intended to replace the ICD-10-CM, CPT, and HCPCS authoritative references for procedure codes, and assigning and reporting diagnoses.

Clinical and coding decisions are based on the independent judgment of the treating physician or qualified health care practitioner, and the best interests of the patient.

The treating physician or qualified health care practitioner, and/or coding staff are responsible for determining and submitting accurate codes, charges, and modifiers for services rendered.



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Cancer diagnosis and documentation



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Cancer statistics



Most common cancers by gender

Prostate (27%)
Lung (12%)
Colorectal (8%)

In 2022 there will be about 268,490 **new cases of prostate cancer** diagnosed in the U.S.

Breast (31%)
Lung (13%)
Colorectal (8%)

An estimated **287,850 new cases** of invasive breast cancer are expected to be diagnosed in women in the U.S. in 2022.

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Documenting cancer: “active” versus “personal history of”

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Documentation tips

When documenting active cancer, the following should be included:



Location
Anatomic part of the body (specific site, laterality)



Lesion type
Histology results or cell type (if known)



Behavior
Pattern of spread

- Primary: Identified through neoplasm biopsy
- Secondary/metastatic: Originated elsewhere with spread to new anatomic location (document primary location first, then location of spread, and link)



Treatment
For cure or for maintenance such as:

- Chemotherapy
- Radiation therapy
- Immunotherapy
- Surgical intervention (removal)
- Brachytherapy
- Active surveillance (must be documented)

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Documentation tips

Documenting active cancer versus personal history of cancer is a frequent source of frustration for clinicians.



Coders can not make any clinical assumptions when capturing codes from provider documentation.



Documentation must clearly show the cancer is active/current for the cancer code to be selected.



If a coder cannot find documentation support for active cancer, they must default to “history of” and query the provider.

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Documentation tips

For cancer codes to be confirmed, it's important to understand the documentation requirements for active cancer.

Active cancer can be confirmed when there is:

- Evidence of current cancer (with or without active treatment)
- Active treatment - current treatment directed at the site of the cancer. May include:
  - Surgery, radiation therapy, chemotherapy, or a combination
  - Adjunct/adjuvant therapy (e.g., tamoxifen) following initial treatment of the cancer
- Evidence of current treatment

Example of active cancer: A patient with a glioblastoma s/p surgical resection, currently undergoing radiation therapy.



(CDC, 2022; NCI, 2022)

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UHG-SJC-007390

Documentation tips continued...

Active surveillance:

- Evidence of current cancer not undergoing any treatment (including surgery or any other type of treatment) with “watchful waiting” or monitoring for progression

Example: Malignant neoplasm of prostate initially diagnosed in an 85-year-old male with advanced COPD who has opted to not receive treatment for the cancer at this time but prefers to monitor with scheduled PSAs.

Routine surveillance:

- Monitoring for the recurrence of a cancer that has been cured or removed
- No evidence of current cancer

Example: A patient with a history of colon cancer excised and treated 3 years ago, currently having CEA levels monitored every 6 months.

Preventative treatment used for individuals with high risk of cancer (e.g., +BRCA) would not be considered under surveillance, since treatment is being used prophylactically and not for cancer that is present.



(CDC, 2022; NCI, 2022)

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UHG-SJC-007391

CMS documentation guidelines

When a primary malignancy has been…

Excised, *but additional treatment is directed to the site*

(e.g., additional surgery, radiation, chemotherapy).

Continue to document the primary malignancy until the treatment is complete and no evidence of the cancer remains.

Excised or eradicated from site, *and no further treatment is directed to that site. There is no evidence of any remaining primary malignancy.*

Document personal history of malignant neoplasm to indicate the former site of the malignancy.

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Case scenario

HPI: HPI: 78-year-old female seen at a HouseCalls visit. She recently had a mastectomy and completed chemotherapy for right breast cancer 6 months ago. There has not been evidence of cancer on continued routine surveillance with her oncologist. No meds.

VS: BP: 123/67 P: 82 R: 15

PE: Unremarkable

Which of the following would be appropriate?
(select all that apply)

A. **(C79.81) Secondary malignant neoplasm of breast**
B. **(Z85.3) Personal history of malignant neoplasm of breast**
C. **(C50.919) Malignant neoplasm of breast of unspecified site, female**
D. **A & B**

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Case scenario

HPI: HPI: 87-year-old male seen at a HouseCalls visit. Member has prostate cancer and completed initial evaluation with urologist where he discussed treatment options. He returns to urology next week for further discussion.

Vitals: BP: 122/67 P: 72 R: 14 T: 98.9

PE: Unremarkable

Labs: PSA: 47; 32 (1 month ago)

Which of the following would be appropriate?
(select all that apply)

A. **(C61) Malignant neoplasm of prostate**
B. **(R97.21) Rising PSA following treatment for malignant neoplasm of prostate**
C. **Neither A nor B**
D. **A & B**

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UHG-SJC-007395

Case scenario

HPI: 87-year-old male seen at a HouseCalls visit. Member has prostate cancer and completed initial evaluation with urologist where he discussed treatment options. He returns to urology next week for further discussion.

Vitals: BP: 122/67 P: 72 R: 14 T: 98.9

PE: Unremarkable

Labs: PSA: 47; 32 (1 month ago)

Which of the following would be appropriate?
(select all that apply)

A. (C61) Malignant neoplasm of prostate
~~B. (R97.21) Rising PSA following treatment for malignant neoplasm of prostate~~
~~C. Neither A nor B~~
~~D. A & B~~

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Leukemia, lymphoma, multiple myeloma, and related cancers

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Leukemia, lymphoma (non-Hodgkins) and myeloma



Achieve remission rather than cure



Diagnosis

should be aimed at identifying the current state of the cancer:

- Active
- Remission – no evidence of disease
- Relapse – disease returns during or after successful treatment



Documentation

If documentation details do not indicate stage of disease, the default diagnosis is “not having achieved remission.”

These are the only cancers classified in ICD-10-CM with “in remission.”

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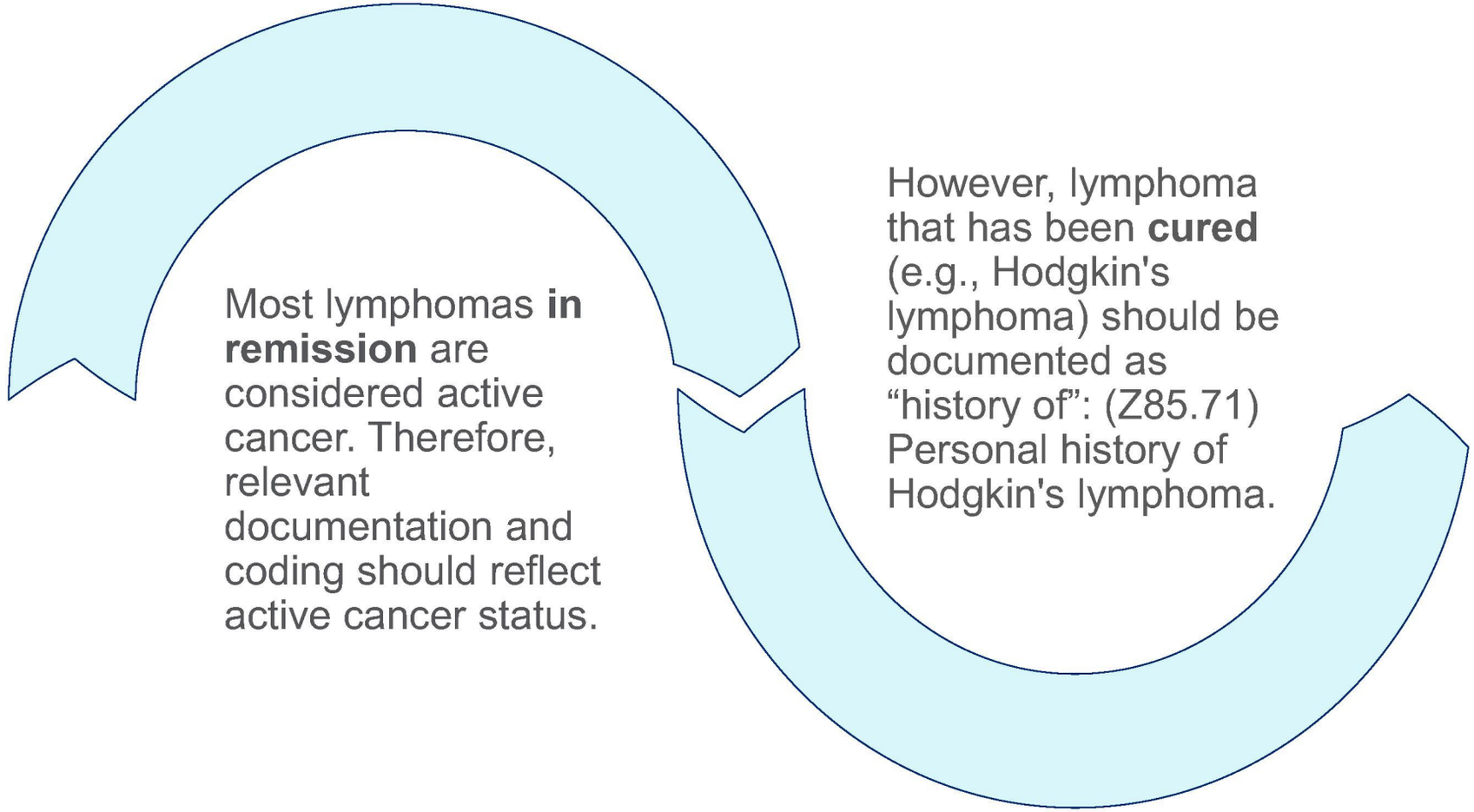
Lymphoma documentation



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(ICD-10-CM, 2022; Leukemia & Lymphoma Society, 2022)

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UHG-SJC-007399

Case scenario

HPI: 62-year-old male with acute myeloblastic leukemia s/p chemotherapy, currently considered in remission.

Which of the following would be the correct code and documentation?

A. A/P*: (Z85.6) Personal history of myeloblastic leukemia: patient is now in remission and no longer under active treatment. Will monitor for recurrence; f/u 3 months with appropriate labs.

B. A/P*: (C92.01) Acute myeloblastic leukemia, in remission: patient is now in remission and no longer under active treatment. Follow up with specialist.

*Example documentation is not for management purposes

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UHG-SJC-007400

Case scenario

HPI: 62-year-old male with acute myeloblastic leukemia s/p chemotherapy, currently considered in remission.

Which of the following would be the correct code and documentation?

~~**A. A/P*: (Z85.6) Personal history of myeloblastic leukemia: patient is now in remission and no longer under active treatment. Will monitor for recurrence; f/u 3 months with appropriate labs.**~~

B. A/P*: (C92.01) Acute myeloblastic leukemia, in remission: patient is now in remission and no longer under active treatment. Follow up with specialist.

*Example documentation is not for management purposes

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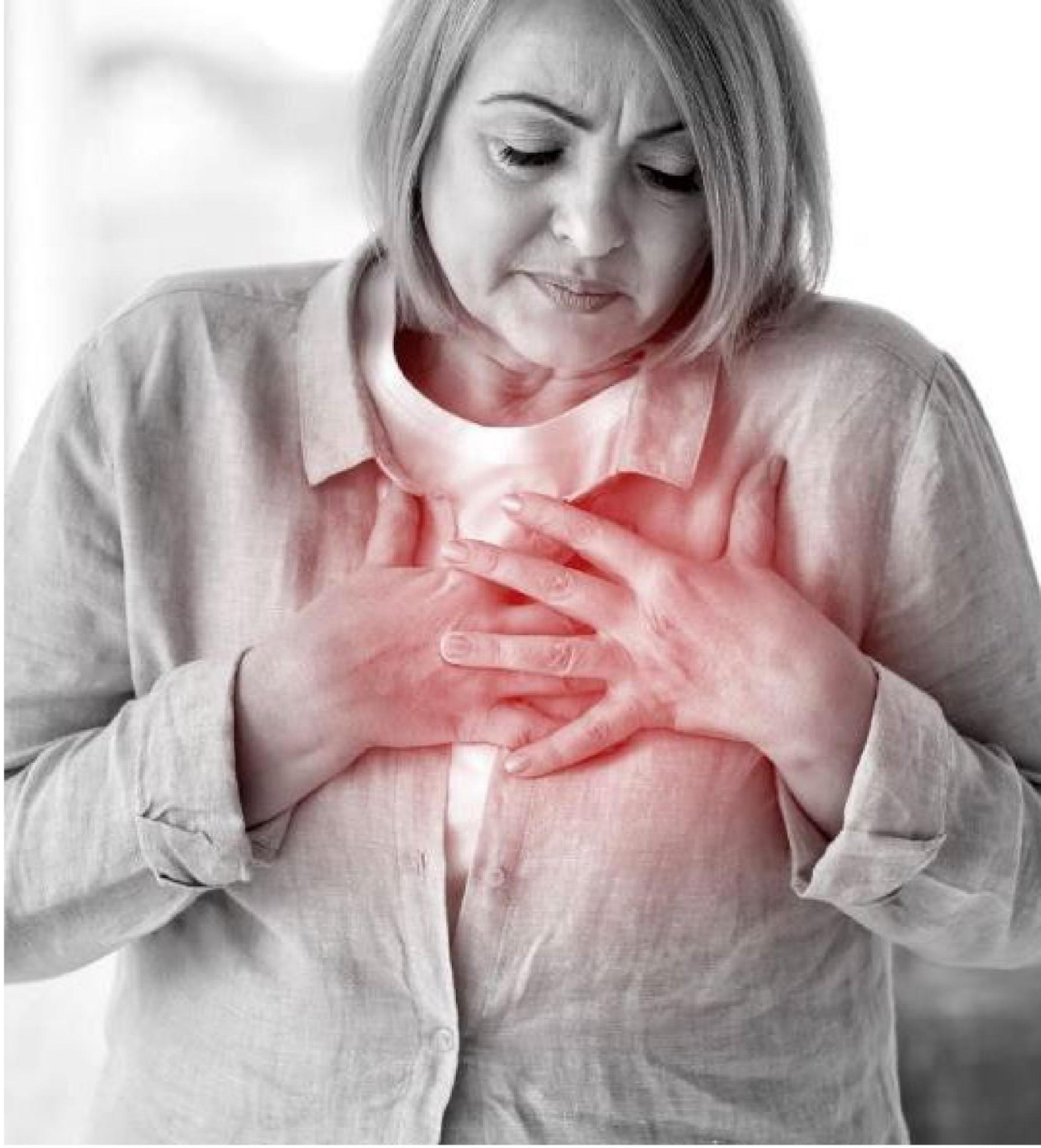
Heart failure documentation



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What is Heart Failure?

HF is a complex clinical syndrome that results from any structural or functional impairment of ventricular filling or ejection of blood.

Risk Factors

- Diabetes
- Hypertension
- Dyslipidemia
- Metabolic syndrome
- Tobacco use
- Alcohol consumption
- Illicit drug use
- Cardiotoxic chemotherapy, radiation
- Family history of sudden cardiac death, premature coronary artery disease, cardiomyopathy

Etiologies

- Ischemic heart disease
- Chronic obstructive pulmonary disease
- Hypertensive heart disease
- Valvular heart disease
- Rheumatic heart disease
- Cardiomyopathy
- Myocarditis

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(Bozkurt, 2021; Colucci WS, 2022; Hajouli S, 2022)

Left ventricular (LV) heart failure

Heart failure w/ reduced ejection fraction (HFrEF)

Systolic failure

"The left ventricle loses its ability to contract normally. The heart can't pump with enough force to push adequate blood into circulation."

Left ventricular ejection fraction (LVEF) ≤40 percent

HF w/ improved EF (HFimpEF)

Previous LVEF ≤ 40% and a follow-up measurement of LVEF > 40%

Heart failure w/ mid-range ejection fraction (HFmrEF)

Clinically* similar to diastolic

LVEF of 41 to 49 percent with symptoms indicative of HF

* If EF is 41-49% and heart failure is diagnosed but not specified, coding may default to coding for systolic HF (HFrEF). If clinically, the diagnosis is diastolic HF with EF between 41-49%, this needs to be clearly documented to be coded properly.

Heart failure w/ preserved ejection fraction (HFpEF)

Diastolic failure

"The left ventricle loses its ability to relax normally" due to cardiac muscle stiffness.

This results in impaired heart filling capacity.

LVEF ≥50 percent

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(Heidenreich PA, 2022; Hajouli S, 2022; Colucci WS, 2022)

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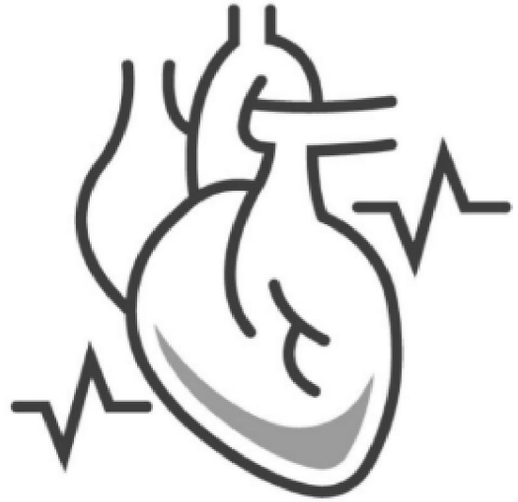
UHG-SJC-007404

Right ventricular (RV) heart failure

- Usually occurs as a result of left-sided failure.
- Left ventricular failure leads to increased fluid pressure which is transferred back through the lungs causing pulmonary hypertension and damaging the right side of the heart and most patients with right HF have some element of left HF.
- With RV failure, blood backs up, causing systemic venous congestion.



Results

- Early stages: edema of the lower extremities
- Advanced stages: ascites

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(Borlaug BA(a,b), 2022)

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UHG-SJC-007405

Framingham Diagnostic Criteria for Heart Failure

While it may not be common for you to establish a brand new heart failure diagnosis in the member's home, it's important to understand the clinical criteria for the diagnosis.

Major criteria

- Acute pulmonary edema
- Cardiomegaly
- Hepatojugular reflux
- Neck vein distension
- Paroxysmal nocturnal dyspnea or orthopnea
- Third heart sound (S3 gallop)
- Pulmonary rales
- Weight loss > 4.5 kg in 5 days in response to treatment

Minor criteria

- Ankle edema
- Dyspnea on exertion
- Hepatomegaly
- Nocturnal cough
- Pleural effusion
- Tachycardia (>120 beats per minute)

Heart failure is a clinical diagnosis. Clinical suspicion is based on risk factors.

Framingham HF Diagnostic Criteria is a reasonable guide to help make the diagnosis:

2+ Major criteria required (or 1, plus 2 minor criteria*) for diagnosis

* Minor criteria should only be selected if they cannot be explained by another comorbidity, e.g., dyspnea on exertion secondary to COPD.

(Colucci WS, 2022)

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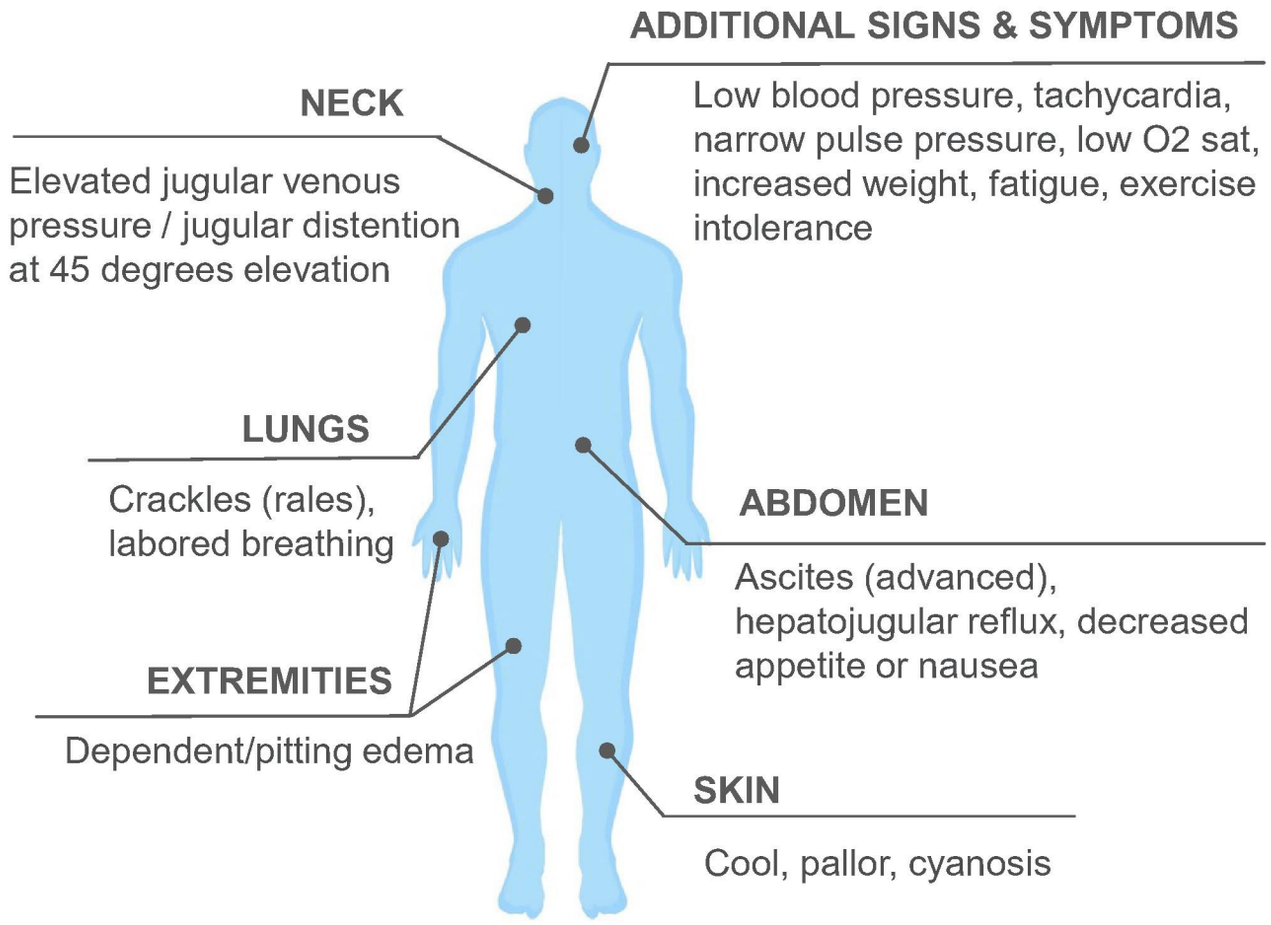
UHG-SJC-007406

Clinical Signs and Symptoms (not all-inclusive)



REVIEW OF SYSTEMS

CARDIOVASCULAR	
☐ Not Assessed	
☐ Reviewed and Negative	
Chest Pain	☐
Describe:	
Palpitations with symptoms	☐
With:	
Palpitations without symptoms	☐
Syncope	☐
Weighing at least 3x/week	☐
Dependent Edema	☑
Claudication	☐
Use Compression Hose	☐

CARDIOVASCULAR	
☐ WNL	☑ Abnormal
☐ NA or Unable to Assess	
Carotid Bruit	--select--
Regularly/Irregular	☐
Irregularly/Irregular	☐
S3	☑
S4	☐
Other abnormalities of heart beat	☐
Murmur	☐
If yes:	--select--
Type	--select--
Pacemaker	☐
Location:	--select--
ICD	☐
Location:	--select--
Edema	☑
Location:	Right Ped...
Left Degree:	1+
Right Degree:	1+

***Specialists, Medications, Clinical Review, ROS, and PE* section may substantiate the diagnosis.**

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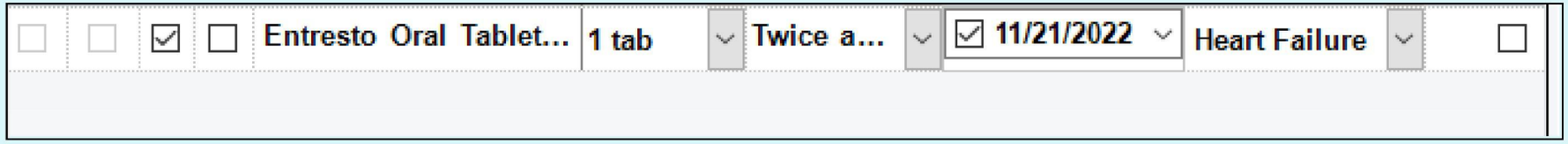
UHG-SJC-007407

Heart Failure Medications Routinely Prescribed

These medications are commonly prescribed in combination to manage the signs and symptoms of Heart Failure.

Heart Failure Medications Routinely Prescribed (not all inclusive)	
Angiotensin receptor-neprilysin inhibitors (ARNi)	sacubitril/valsartan (Entresto)
Beta Blockers	extended-release metoprolol succinate, bisoprolol, or carvedilol
Mineralocorticoid receptor antagonists (MRA)	spironolactone or eplerenone
Sodium-glucose cotransporter-2 inhibitors (SGLT2i)	dapagliflozin or empagliflozin
Diuretics for fluid retention	furosemide, bumetanide
ACEI or ARB	lisinopril, losartan

eHouseCalls Documentation



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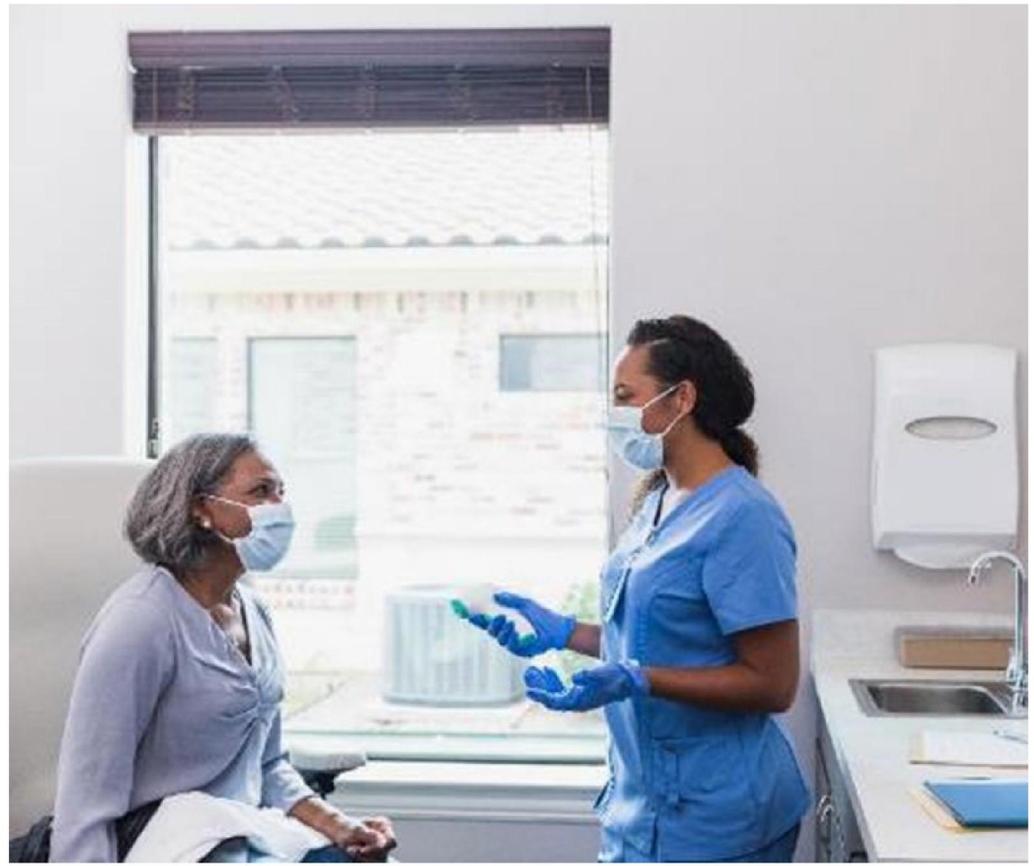
UHG-SJC-007408

When documenting HF, consider related conditions (not all-inclusive)

Examples of related conditions:

- Secondary hyperaldosteronism

- Conditions that can contribute to HF (not all inclusive)
  - CAD
  - Previous MI
  - Uncontrolled hypertension
  - Uncontrolled diabetes mellitus



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UHG-SJC-007409

Case scenario

HPI: 73-year-old female seen in the home. She has been previously diagnosed with MI, heart failure, hypertension, and hyperlipidemia. Her SOB and LE edema improved with her medications.

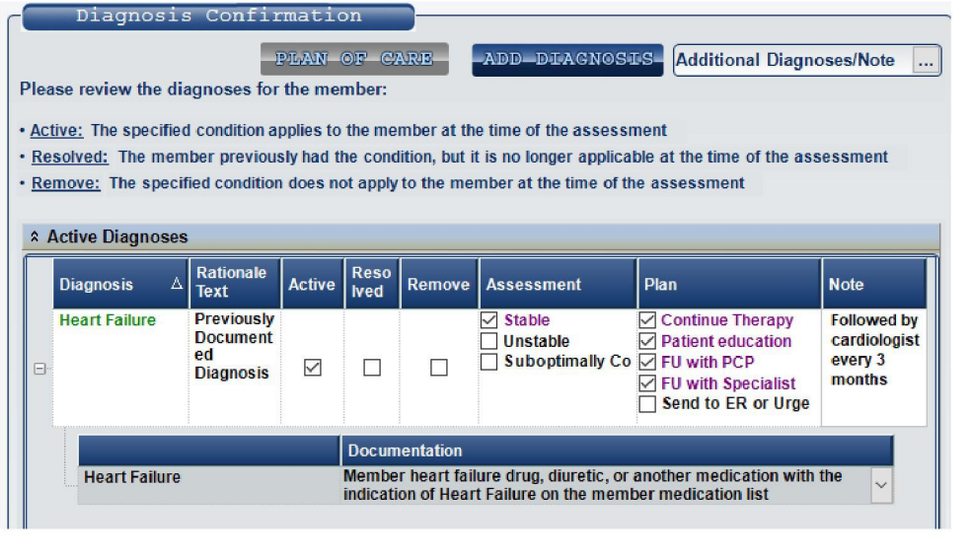
Meds: Carvedilol 25mg BID, Spironolactone 25mg QD, Lisinopril 10mg QD, and Atorvastatin 10mg QHS.

Exam: BP 140/88, HR 68 regular rate and rhythm, lung sounds clear bilaterally. No LE edema.

This information is fictional and not based on a real patient.

Appropriate documentation may include:

- (I50.9) Heart failure
- (E26.1) Secondary hyperaldosteronism due to HF, *dx supported by need for diuretic*
- (E78.5) Hyperlipidemia, unspecified
- (I11.0) Hypertensive heart disease with heart failure
- (I25.2) History of myocardial infarction



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UHG-SJC-007410

Secondary hyperaldosteronism diagnosis in heart failure and cirrhosis

In patients with **known** heart failure and/or cirrhosis, secondary hyperaldosteronism is considered a **clinical diagnosis based on evidence of volume expansion.**

Laboratory testing is not required to confirm diagnosis.

Clinicians **may** consider the following labs when clinically indicated:

- Serum electrolyte levels (potential **hypokalemia**, hyponatremia)
- Plasma aldosterone (elevated)
- Plasma renin activity (elevated)

Exam findings (not all inclusive):

- Edema
- Ascites
- Abnormal lung sounds
- Jugular vein distention (JVD)
- Weight gain

(Grossman AB, 2022; Papadopoulou-Marketou N, 2020; Morsy MS, 2017; Yancy CW, 2013; Kwo 2017)

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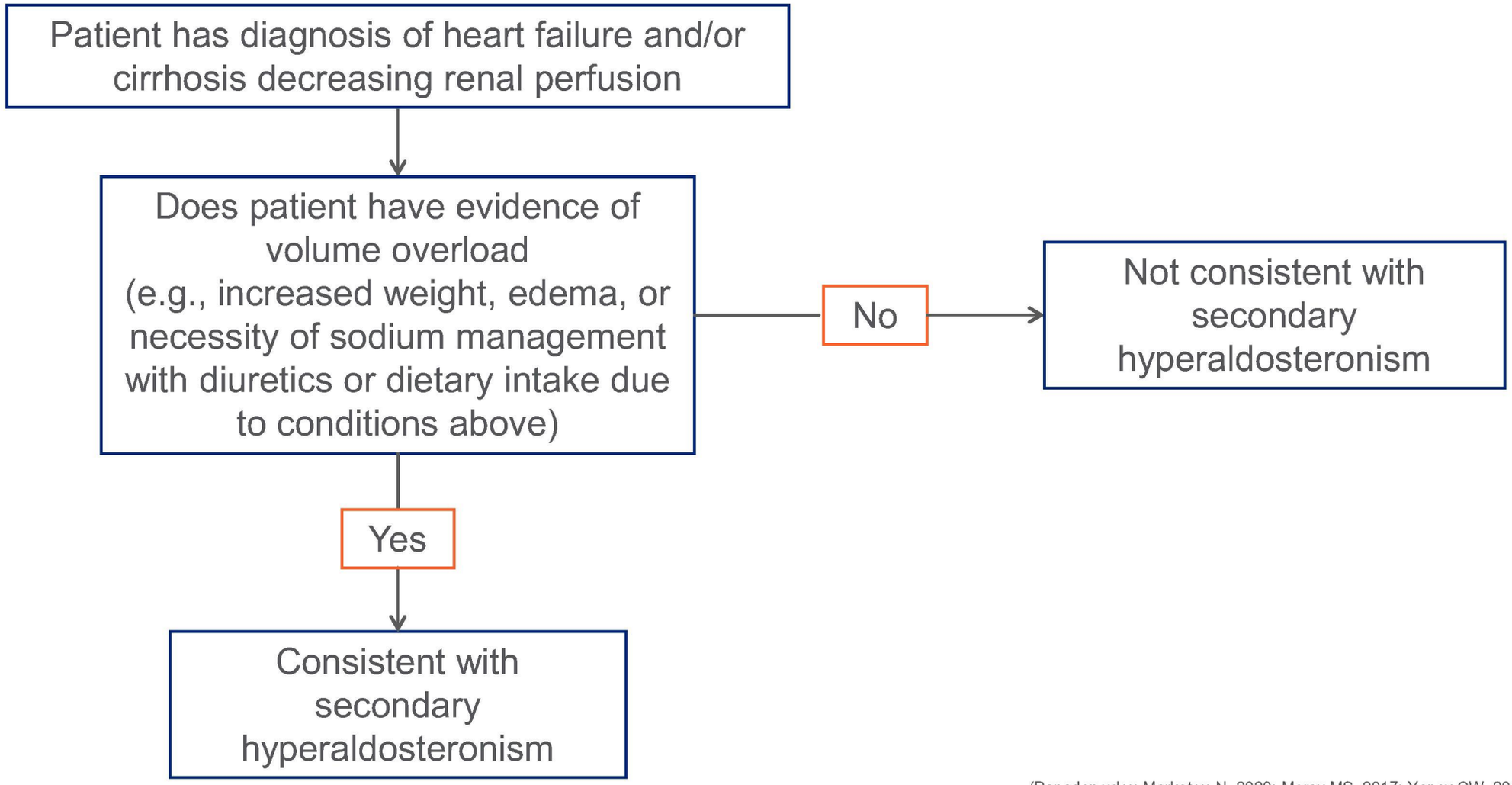
UHG-SJC-007411

Decision tree for secondary hyperaldosteronism in heart failure and cirrhosis



(Papadopoulou-Marketou N, 2020; Morsy MS, 2017; Yancy CW, 2013; Kwo PY, 2017)

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UHG-SJC-007412

Knowledge check

A patient with heart failure and associated fluid overload (increased weight, and edema, or necessity of sodium management with diuretics or dietary intake) likely has secondary hyperaldosteronism.

TRUE **FALSE**

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UHG-SJC-007413

Knowledge check

A patient with heart failure and associated fluid overload (increased weight, and edema, or necessity of sodium management with diuretics or dietary intake) likely has secondary hyperaldosteronism.

TRUE

~~**FALSE**~~

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UHG-SJC-007414

Knowledge check

Which of the following would lead you to consider a diagnosis of secondary hyperaldosteronism?

a. Heart failure with lower extremity edema
b. Prescribed furosemide in setting of heart failure or cirrhosis with ascites
c. Cirrhosis with ascites
d. Prescribed eplerenone in setting of heart failure or cirrhosis with ascites
e. All of the above

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Knowledge check

Which of the following would lead you to consider a diagnosis of secondary hyperaldosteronism?

a. Heart failure with lower extremity edema
b. Prescribed furosemide in setting of heart failure or cirrhosis with ascites
c. Cirrhosis with ascites
d. Prescribed eplerenone in setting of heart failure or cirrhosis with ascites
e. All of the above

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Secondary hyperaldosteronism documentation keys

Identify, document, and link to the causal condition.

For example:

- (**E26.1**) Secondary hyperaldosteronism due to (**I50.9**) Heart failure
- (**K70.31**) Alcoholic cirrhosis of liver with ascites and (**E26.1**) Secondary hyperaldosteronism

Best practice includes documenting supportive clinical findings and a plan of care.

(ICD-10-CM, 2022)

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FAQ

Q: Is the use of diuretics, beta blockers, or other medications used to treat heart disease sufficient to diagnose heart failure?

A: No, while medications and co-morbidities such as typical risk factors of HTN, T2DM, and others may be a clue that heart failure is present and should raise suspicion, these alone are not sufficient to make the diagnosis. The full clinical picture must be evaluated. The Framingham criteria are useful guides to diagnosing heart failure.

Q: If I document and code a condition that includes mention of heart failure, such as (I13.0) Hypertensive heart disease and CKD with heart failure and stage 1-4 CKD or unspecified CKD, do I still need to document and code heart failure?

A: Yes, heart failure is documented and coded separately from these combination codes. Use (I50.9) Heart failure unspecified or, if known, use the more specific codes (I50.22) Chronic systolic heart failure or (I50.32) Chronic diastolic heart failure. Don't forget to also document and code the other conditions, such as CKD, in the example above.

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FAQ

Q: In patients with heart failure and cirrhosis, is use of a diuretic required to diagnose secondary hyperaldosteronism?

A: No, this is considered a clinical diagnosis. If there is clinical evidence of associated volume overload (e.g., peripheral edema with no other cause identified) in these conditions, secondary hyperaldosteronism is likely present. Though labs and medications are not required to make the diagnosis, they support it (e.g., need for diuretics, presence of low potassium).

Q: Is documenting and coding secondary hyperaldosteronism alone sufficient?

A: No, the key is the term “secondary.” The clinician must document and code the *cause* of the secondary hyperaldosteronism, and link the two. Additionally, always provide appropriate supporting documentation for the diagnosis.

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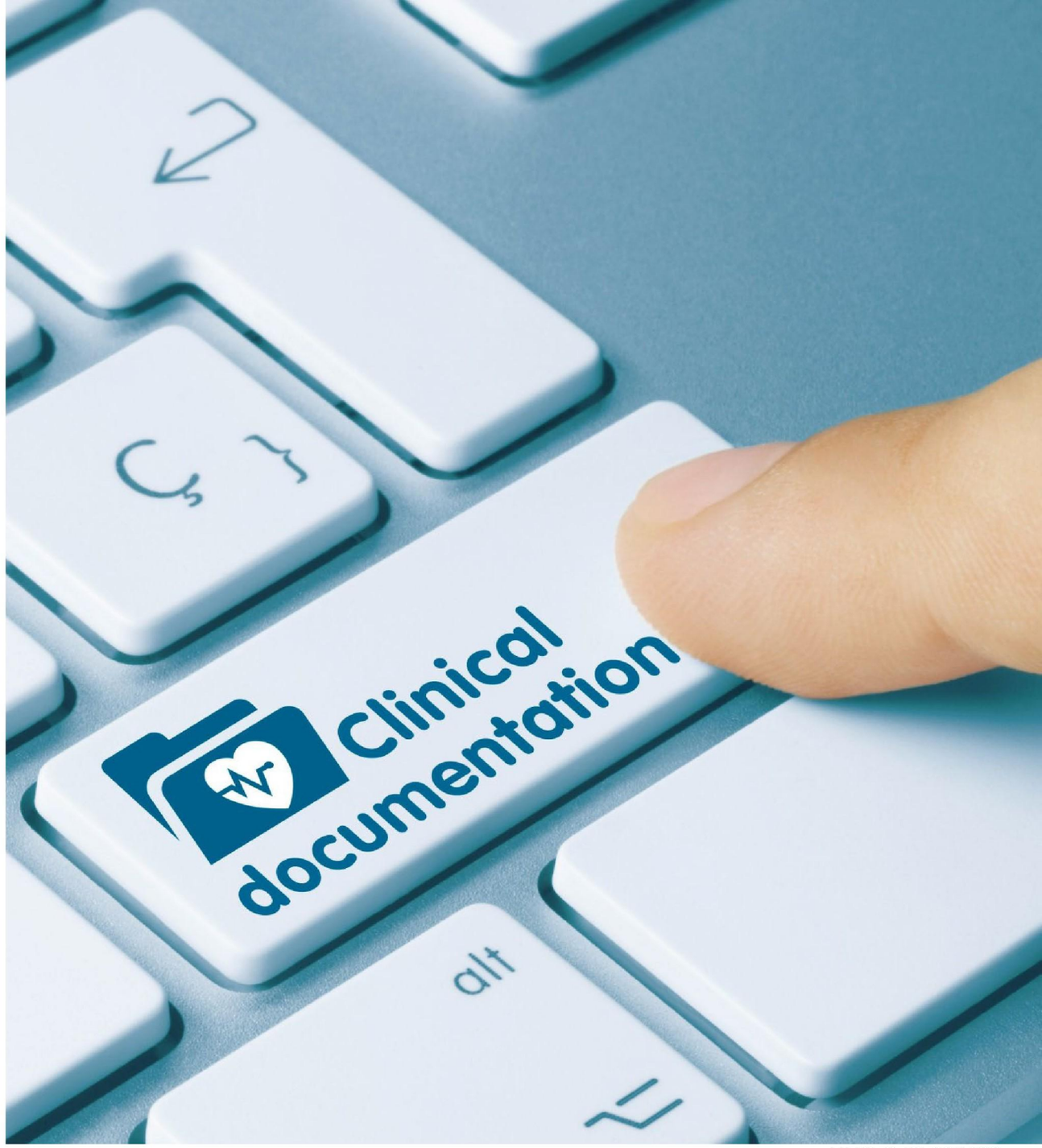
HouseCalls Atrial fibrillation/flutter and secondary hypercoagulable state: Documentation Best Practices



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Definitions

Atrial fibrillation (AFib)*

- Most-commonly treated cardiac arrhythmia
- Associated with an irregularly irregular ventricular rhythm and a lack of defined P waves

Atrial flutter

- Second most common arrhythmia
- Supraventricular tachycardia, with atrial rates that may be 300 bpm with ventricular rates of 150 bpm
- Resembles a characteristic “sawtooth” pattern on ECG

**For the purpose of this presentation, nonvalvular AFib is being discussed. This is defined as AFib occurring in the “absence of moderate-to-severe mitral stenosis or a mechanical heart valve”.*

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(Kumar K, 2022; Phang R, 2022; Rodriguez Ziccardi M, 2022, January CT, 2019)

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Atrial fibrillation prevalence

12.1 million people in the US will have AFib by 2030



Prevalence **increases** with age





Increases the risk of ischemic stroke **fivefold** and causes **1 in 7** strokes



> 33% of patients with atrial fibrillation are > 80 years old

(January CT, 2014; CDC, 2022)

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Classification of atrial fibrillation, based on duration of episodes
(Per American Heart Association/American College of Cardiology)

Classification	Description
Paroxysmal	AFib terminates spontaneously or with intervention within 7 days of onset. Episodes may recur randomly.
Persistent	Continuous AFib that is sustained > 7 days
Long-standing persistent	Continuous AFib > 12 months in duration
Permanent	Term used when the patient and clinician make a joint decision to stop further attempts to restore and/or maintain sinus rhythm

(January CT, 2014)

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Atrial flutter prevalence

Estimated 200,000 new cases per year



Commonly associated with atrial fibrillation



Commonly seen with underlying diseases such as pulmonary hypertension, chronic obstructive pulmonary disease, and heart failure



More frequent in men

(Rodriguez Ziccardi M, 2022; Phang R, 2022)

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Risk factors for atrial fibrillation

- Advancing age
- Hypertension
- Left ventricular hypertrophy
- Diabetes mellitus
- Heart disease and failure
- Obesity
- Obstructive sleep apnea
- Smoking
- Hyperthyroidism
- Alcohol use
- Previous cardiac surgery
- Family history and genetic variants

(January CT, 2014)

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Signs and symptoms of atrial fibrillation

Many patients are asymptomatic, and older adults may have minimal or atypical symptoms.

Symptoms may include:

- Palpitations
- Fatigue
- Weakness
- Dizziness
- Reduced exercise capacity
- Dyspnea at rest

PE may show an irregularly irregular rhythm or pulse.

(Kumar K, 2022; January CT, 2014)

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Risk factors for atrial flutter

Atrial flutter rarely occurs in a structurally normal heart.

Risk factors for atrial flutter include:

- Prior antiarrhythmic or ablation treatment for atrial fibrillation
- Prior myocardial infarction
- Prior cardiac surgery
- Heart failure
- Any condition that can cause atrial fibrillation

(Phang R, 2022)

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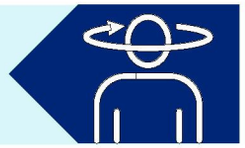
Signs and symptoms of atrial flutter

- Palpitations 
- Dizziness 
- Fatigue 
- Presyncope/syncope 
- Weakness 
- Anxiety 
- Mild to severe dyspnea 

PE may show tachycardia or an irregular rhythm.

(Phang R, 2022)

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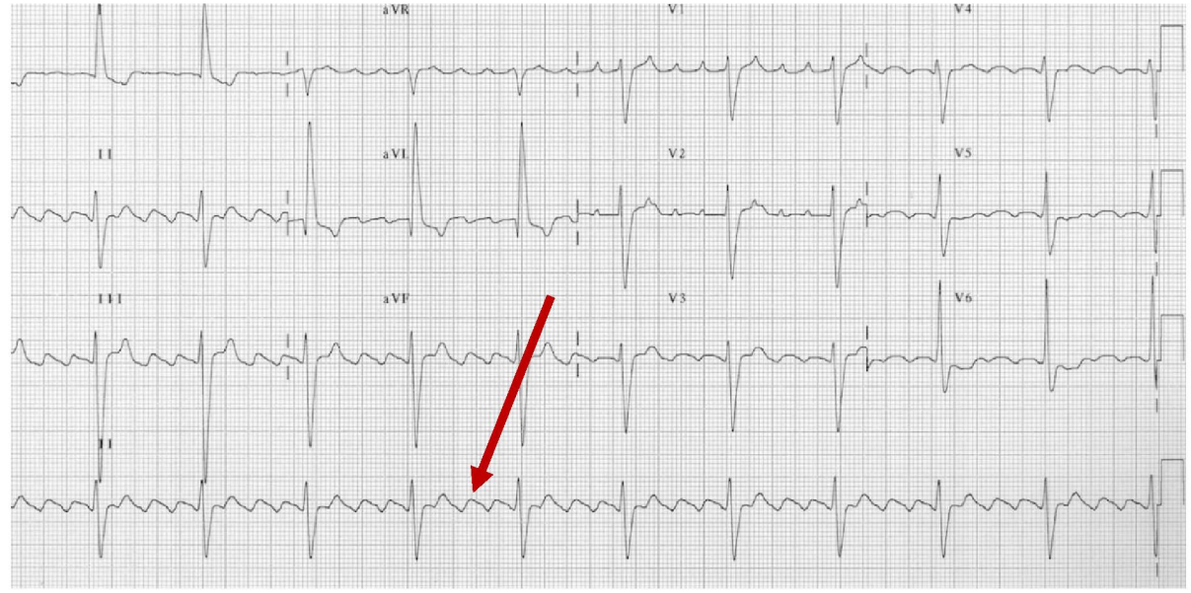
Diagnosing atrial flutter

The diagnosis of atrial flutter is usually based on the patient's clinical history and physical exam and can be confirmed by the classic "sawtooth" pattern on ECG. Other testing, such as ambulatory rhythm monitoring (e.g., telemetry, Holter monitor), or other cardiac monitoring systems (e.g., echocardiogram, exercise testing, or electrophysiology study) may be required.



(Burns E, 2021; Phang R, 2022)

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When to consider secondary hypercoagulable state due to AFib/atrial flutter

CHA_2DS_2-VASc score: Used to stratify a patient's risk of thromboembolic events and guide treatment decision-making for patients with nonvalvular AFib or atrial flutter.

Per the AHA/ACC/HRS 2019 guidelines:
In patients with nonvalvular AFib, the CHA_2DS_2-VASc score is recommended for assessment of stroke risk. (Class 1 recommendation)



The diagnosis of secondary hypercoagulable state is a clinical one, made based on the presence of the risk factors in the setting of the arrhythmia and the patient's CHA_2DS_2-VASc score. There is no specific need for coagulation factor testing in the setting of either arrhythmia.

(January CT, 2019)

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CHA_2DS_2-VASc stroke risk factors for nonvalvular AFib/atrial flutter

CHA_2DS_2-VASc risk factors	Score
Congestive heart failure/left ventricular dysfunction	1
Hypertension	1
Age ≥ 75 years*	2
Diabetes mellitus	1
Stroke/TIA/thromboembolism	2
Vascular disease (prior MI, PAD, or aortic atherosclerosis)	1
Age 65-74 years*	1
Sex **c**ategory (female = 1, male = 0)	1
Maximum score*	**9**
**Maximum score is 9 because age only counts once.*	

(January CT, 2014)

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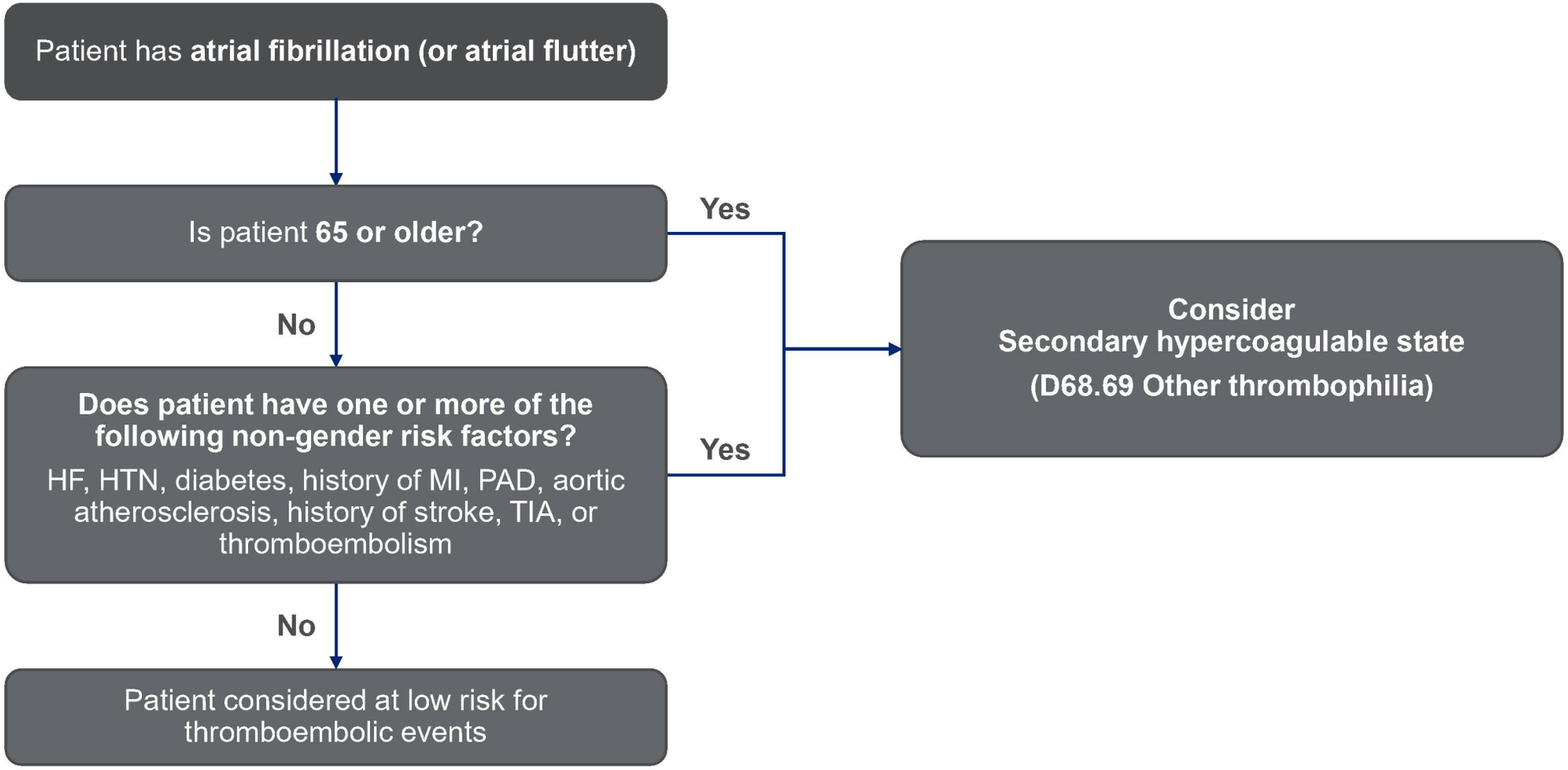
Considering secondary hypercoagulable state in atrial fibrillation/atrial flutter using the CHA_2DS_2-VASc risk factors



(Lip GYH, 2018)

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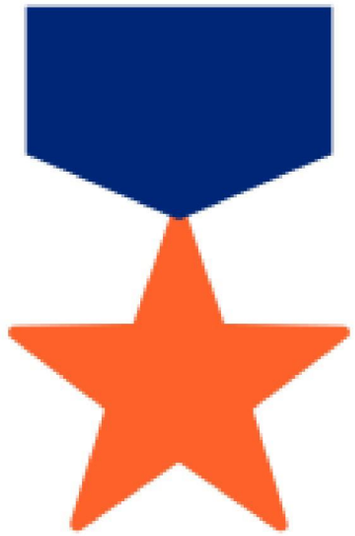

Documentation best practices

Choose the most appropriate and specific AFib/atrial flutter diagnosis and ICD-10-CM code depending on the type of arrhythmia.

Document “unspecified” if the type is unknown or undetermined.

If a secondary hypercoagulable state is present, document secondary hypercoagulable state **and** choose (D68.69) Other thrombophilia. **Clearly document** the link between the primary condition and the secondary hypercoagulable state.

(AHA, 2021; Bauer KA, 2022)

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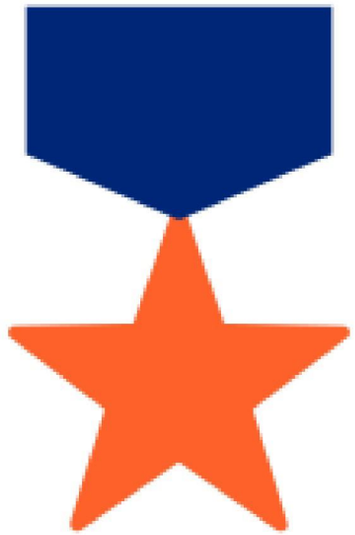

More documentation best practices

Document the patient's stroke risk factors and the benefits/risks of anticoagulation.

Document symptoms if present, exam findings (e.g., heart rate and rhythm) and current treatment plan, such as anticoagulants and rate/rhythm control medications.

Document discussions held with the patient and family regarding shared decision-making.

(AHA, 2021; Bauer KA, 2022)

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Case study

84-year-old female with AFib x 3 years, HTN, history of TIA who lives at home with her daughter.
Social history: No alcohol intake.

Medications: Carvedilol, lisinopril, atorvastatin, and apixaban.

ROS: Denies palpitations or dizziness.

PE: Vitals: BP: 122/84, P: 84, R: 18
CV: Irregularly irregular rate and rhythm.
Neuro: normal

What is this patient's CHA_2DS_2-VASc score?

Factors	Points
Age ≥ 75	2
Female gender	1
Prior TIA	2
HTN	1
CHA_2DS_2-VASc score	**6**

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UHG-SJC-007435

Case study

84-year-old female with AFib x 3 years, HTN, history of TIA who lives at home with her daughter.
Social history: No alcohol intake.

Medications: Carvedilol, lisinopril, atorvastatin, and apixaban.

ROS: Denies palpitations or dizziness.

PE: Vitals: BP: 122/84, P: 84, R: 18
CV: Irregularly irregular rate and rhythm.
Neuro: normal

Which diagnoses may be considered in her assessment?

(I48.11) Longstanding persistent atrial fibrillation
(D68.69) Secondary hypercoagulable state due to atrial fibrillation
(I10) Essential (primary) hypertension
(Z86.73) Personal history of transient ischemic attack (TIA), and cerebral infarction without residual deficits

Rationale:

All of the above should be included. Documentation should include the patient's CHA_2DS_2-VASc score (a total of 6), which increases her risk of CVA. Her secondary hypercoagulable state should be linked to the underlying condition of AFib. The past medical history of HTN and TIA should also be included.

Also, any discussions that were held with the patient (and caregiver) about the risks and benefits of her being treated with oral anticoagulants, as well as any abnormal bleeding precautions that were reviewed, should be documented as well.

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UHG-SJC-007436

FAQs

Question: Do all patients with atrial fibrillation or atrial flutter also have a secondary hypercoagulable state?

Answer: No. A diagnosis of secondary hypercoagulable state may not be appropriate for all patients with atrial fibrillation or atrial flutter. The diagnosis of secondary hypercoagulable state is a clinical one, made based on the presence of the risk factors for thromboembolic events in the setting of the arrhythmia. One tool that may be utilized to help the clinician determine risk of future thromboembolic events in the setting of nonvalvular atrial fibrillation is the CHA_2DS_2-VASc scoring system. If the clinician determines a secondary hypercoagulable state is present, it is best practice to clearly document and link back to the primary condition.

For reference, the acronym CHA_2DS_2-VASc stands for: **c**ongestive heart failure or left ventricular dysfunction, **h**ypertension, **a**ge greater than 75 years, **d**iabetes, prior **s**troke/TIA/or thromboembolism, vascular disease (prior MI, PAD, or aortic atherosclerosis), **a**ge 65-74, and **s**ex **c**ategory (female = 1, male = 0).

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FAQs

Question: Would it be appropriate to diagnose secondary hypercoagulable state in a patient with atrial fibrillation or atrial flutter on an anticoagulant?

Answer: It depends. The use of an anticoagulant alone is not diagnostic of a hypercoagulable state. The CHA_2DS_2-VASc score is the tool most commonly-used for patients with atrial fibrillation or atrial flutter to stratify their risk of thromboembolic events and guide treatment decision-making with regard to anticoagulation, along with the entire clinical picture. The score is currently recommended to assess stroke risk by the American Heart Association/American College of Cardiology and the Heart Rhythm Society.

Question: Is it necessary to perform coagulation testing in patients who have atrial fibrillation or atrial flutter to make the diagnosis of secondary hypercoagulable state?

Answer: No. The diagnosis of secondary hypercoagulable state is a clinical one, made based on the presence of risk factors in the setting of the arrhythmia and the patient's CHA_2DS_2-VASc score. There is no specific need for coagulation factor testing in the setting of either arrhythmia.

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FAQs

Question: If a patient's arrhythmia has resolved, do they still have a secondary hypercoagulable state?

Answer: No. If a patient's atrial arrhythmia has resolved, either spontaneously or due to treatment of any kind (e.g., ablation), they are no longer considered to have a secondary hypercoagulable state due to that condition, and it would be appropriate to resolve the diagnosis of secondary hypercoagulable state.

Question: Is the CHA2DS2-VASc score specific and only to be used for atrial fibrillation?

Answer: No. According to the 2019 American Heart Association/American College of Cardiology and the Heart Rhythm Society guidelines, "for patients with atrial flutter, antithrombotic therapy is recommended according to the same risk profile used for atrial fibrillation."

Question: When would it be appropriate to use (I48.91) Unspecified atrial fibrillation rather than a more specific diagnosis?

Answer: When atrial fibrillation is newly identified, documenting and coding it as (I48.91) Unspecified atrial fibrillation is acceptable until the specific type (paroxysmal, persistent, long-standing persistent, or permanent) has been determined based on the duration.

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Summary



Atrial fibrillation (AFib) is a common cardiac arrhythmia with an incidence that increases with age.

There are multiple factors/triggers that increase the risk of developing AFib.

Thromboembolism is a major complication of AFib. Risk measurement tools, such as the CHA_2DS_2-VASc score, along with shared decision-making, help guide treatment decisions.

For patients with atrial flutter, antithrombotic therapy is recommended using the same risk assessment used for AFib.

Supportive documentation is essential. When appropriate, consider and document secondary hypercoagulable state for patients with increased risk of thromboembolism and link it to the underlying arrhythmia.

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Substance use disorder diagnosis and documentation



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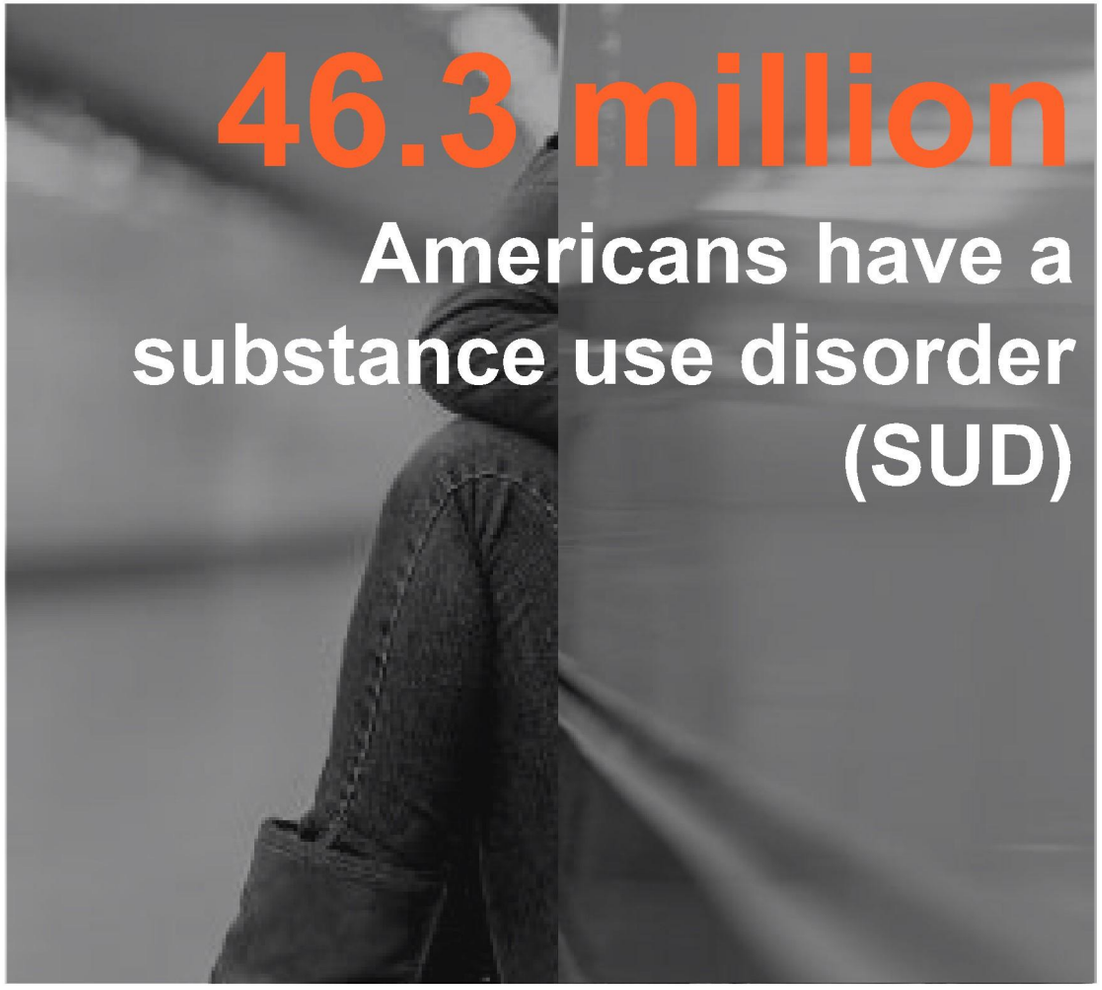
Self-reported prevalence



More than **1 in 10** adults over the age of 65 report binge drinking

(5 or more drinks on the same occasion for men, and 4 or more drinks on the same occasion for women)



(SAMHSA, 2022; NIDA, 2020)

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Substance use disorders screening

USPSTF recommendations:
Unhealthy drug use (Grade B): Screening recommended in adults 18 or older; should be implemented when accurate and effective diagnosis, treatment, and care can be offered or referred.

Alcohol use (Grade B): Screening recommended in primary care settings in adults 18 years or older, including pregnant women; provide those engaged in risky/hazardous drinking with brief behavioral counseling interventions.

Tobacco use (Grade A): The USPSTF recommends that clinicians ask all adults about tobacco use, advise them to stop using tobacco, and provide behavioral interventions and U.S. Food and Drug Administration (FDA)-approved pharmacotherapy for cessation to nonpregnant adults who use tobacco.

Examples of potential screening tools include:
- Tobacco Alcohol, Prescription medication, and other Substance use (TAPS) tool
- Alcohol Use Disorders Identification Test (AUDIT)
- Cut down, Annoyed, Guilty, Eye-opener (CAGE) tool

(USPSTF, 2018; USPSTF, 2020; NIDA, 2023)

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Definitions

Substance use disorder (DSM-5-TR): Defined by "cognitive, behavioral, and physiological symptoms indicating that the individual continues using the substance despite significant substance-related problems."

- Eleven diagnostic criteria that can be categorized as:
  - Physical dependence: Withdrawal syndrome upon substance use reduction or discontinuation (physiological symptoms)
  - Psychological dependence: Cognitive and behavioral symptoms
- Patients may experience symptoms of physical and/or psychological dependence either independently or concurrently.

Specific DSM-5-TR criteria required to make a diagnosis of substance use disorder (SUD) will be covered in more detail later in this presentation.

Physical dependence is one **component** of SUD but can exist separately as a standalone diagnosis. DSM-5-TR criteria are **not** required to diagnose physical dependence.

(APA, 2022; Savage SR, 2003)

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Physical dependence

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Physical dependence definitions

Physical dependence requires the presence of at least one of the following:

Withdrawal – Syndrome that occurs when blood/tissue concentration of a substance decreases in an individual with previous prolonged, heavy use of that substance

Tolerance – Requiring a significantly increased dose of a substance to achieve the desired effect *or* a noticeably reduced effect when the usual dose is consumed.



Physical dependence can occur within days or weeks of opioid or benzodiazepine use, even while adhering to therapeutic doses.

A person may have a physical dependence on a substance without having a substance use disorder.

(APA, 2022; Hood SD, 2014; Kosten TR, 2019)

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Approach to documenting physical dependence
(to be used in the absence of psychological dependence)

1	Name the specific substance of dependence. • In some cases of long-term use of a prescribed drug, it may be appropriate to document long-term (current) use of that substance in addition to the presence of physical dependence (e.g., “physical dependence on chronic methadone for pain management”).
2	Clearly document specific symptoms experienced by the patient, such as withdrawal or tolerance.
3	Document treatment plan.

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UHG-SJC-007447

Case study

HPI: 65-year-old female presents for 6-week follow-up s/p left hip ORIF. On continuous opioids for pain management. Patient's pain appears well controlled at this time. At current doses, patient is physically dependent and abrupt discontinuation will cause patient to experience withdrawal symptoms. Tolerating dose well, no signs of psychological dependence noted.

What would be an appropriate diagnosis to consider?

A. (F11.20) Opioid dependence, uncomplicated
B. (F11.23) Opioid dependence with withdrawal
C. (F11.93) Opioid use, unspecified with withdrawal
D. (F11.10) Opioid abuse, uncomplicated

(ICD-10-CM, 2022; Kosten TR, 2019)

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UHG-SJC-007448

Case study

HPI: 65-year-old female presents for 6-week follow-up s/p left hip ORIF. On continuous opioids for pain management. Patient's pain appears well controlled at this time. At current doses, patient is physically dependent and abrupt discontinuation will cause patient to experience withdrawal symptoms. Tolerating dose well, no signs of psychological dependence noted.

What would be an appropriate diagnosis to consider?

A. (F11.20) Opioid dependence, uncomplicated
~~B. (F11.23) Opioid dependence with withdrawal~~
~~C. (F11.93) Opioid use, unspecified with withdrawal~~
~~D. (F11.10) Opioid abuse, uncomplicated~~

Correct answer: A

Rationale: The correct answer accurately reflects the patient's physical dependence: (F11.20) Opioid dependence, uncomplicated. Options B and C are incorrect because the patient is not currently experiencing withdrawal. Option D reflects a substance abuse code that would not be used for physical dependence.

(ICD-10-CM, 2022; Kosten TR, 2019)

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Substance use disorder

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Approach to documenting SUD
(to be used when psychological dependence is present, with or without physical dependence)

1	Name the specific substance of dependence.
2	Clearly document specific symptoms experienced by the patient such as cravings, tolerance, escalating use, etc.
3	Determine severity (mild, moderate, or severe) based on DSM-5-TR criteria and document appropriately.
4	Specify remission status, if applicable.
5	Document treatment plan.

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Step 1: Name the substance

Clearly identify the substance of dependence in the documentation and select the appropriate ICD-10-CM code category.

(F10.-)	(F11.-)	(F12.-)	(F13.-)	(F14.-)
Alcohol	Opioids	Cannabis	Sedatives, hypnotics or anxiolytics	Cocaine

(F15.-)	(F17.-)	(F18.-)	(F19.-)
Amphetamines and other stimulants	Nicotine	Inhalants	Other psychoactive substances

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Step 2: Document symptoms (DSM-5-TR criteria)

Clearly document all symptoms experienced by the patient related to substance use. The DSM-5-TR groups the eleven diagnostic criteria for SUD into the following categories:

Impaired control	Social impairment	Risky use	Pharmacological criteria
1. Taking the substance in larger amounts/over longer period than originally intended	5. Failure to fulfill major role obligations (work, school, home)	8. Using substance in physically hazardous situations	10. Tolerance*
2. Persistent desire to cut down	6. Persistent social or interpersonal problems	9. Continued use despite psychological or physical problems	11. Withdrawal*
3. Significant time needed to obtain, use, or recover from substance use	7. Giving up or reducing important activities		
4. Craving			

*These criteria are not considered to be met for those individuals taking the substance solely under appropriate medical supervision.

To make a diagnosis of SUD, **at least 2 criteria** must be present for at least **12 months.** Note that criteria do not need to be present simultaneously to make the diagnosis.

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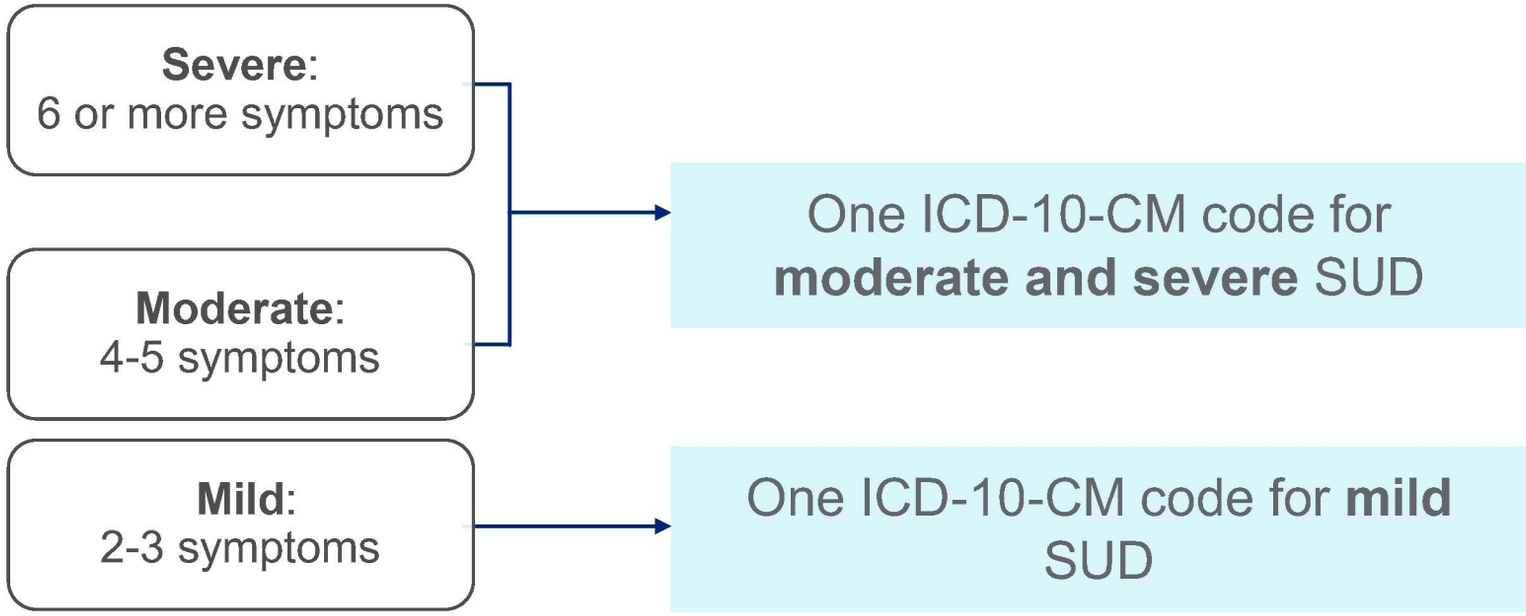
Step 3: Specify severity

Determine severity based on DSM-5-TR definitions. Then, clearly document the severity and choose the appropriate ICD-10-CM code.



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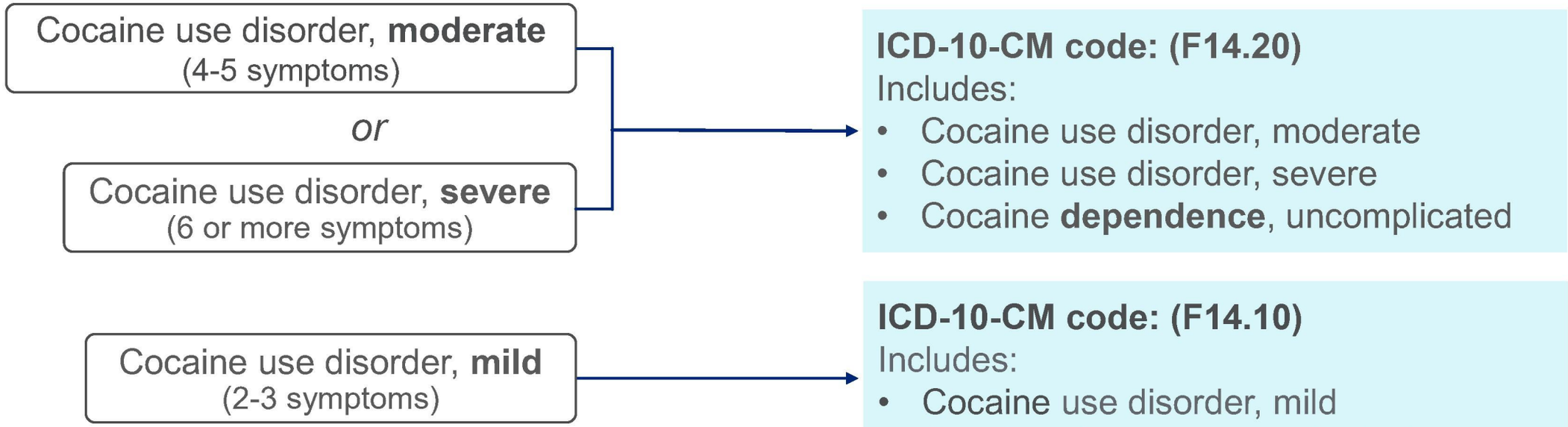
Step 3 (continued): Coding example based on severity

Consider an example of uncomplicated cocaine use disorder:



(ICD-10-CM, 2022; APA, 2022)

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Step 4: Specify remission status, if applicable

Clearly specify remission status, if applicable, based on DSM-5-TR definitions:

Early remission	Sustained remission
No SUD criteria* for **at least 3 months, but less than 12 months**	No SUD criteria* for **12 months or longer.**

**Craving does not count towards SUD criteria in these definitions (i.e., someone with craving and no other symptoms would be considered to be in remission).*

Note: Early and sustained remission share one ICD-10-CM code.

Example: The code for mild inhalant use disorder in remission (F18.11) includes:

- Inhalant use disorder, mild, in early remission
- Inhalant use disorder, mild, in sustained remission.

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Step 5: Document treatment plan

Clearly document the treatment plan and discussions/shared decision-making with the patient.

- Examples of SUD treatment options to include in documentation:
  - Medications
  - Outpatient counseling
  - Inpatient rehabilitation
  - Behavioral health care

Please use applicable treatment algorithms and/or place referral to Optum Behavioral Care, as appropriate.



(CDC. 2022; APA, 2022)

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UHG-SJC-007457

Case study

HPI: 65-year-old female presents requesting early lorazepam refill. States has been on lorazepam for over 10 years; it was prescribed TID, but patient admits to taking more often. Detailed assessment shows patient meets 4 of the DSM-5-TR criteria for SUD, including: consuming substance in larger amounts than intended, craving, recurrent use in physically hazardous situations, and continued use despite interpersonal problems caused by the substance.

What would be an appropriate diagnosis to consider?

A. (F13.14) Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder (lorazepam)
B. (F13.20) Sedative, hypnotic or anxiolytic use disorder, moderate (lorazepam)
C. (F13.21) Sedative, hypnotic or anxiolytic dependence, in remission (lorazepam)

(ICD-10-CM, 2022)

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UHG-SJC-007458

Case study

HPI: 65-year-old female presents requesting early lorazepam refill. States has been on lorazepam for over 10 years; it was prescribed TID, but patient admits to taking more often. Detailed assessment shows patient meets 4 of the DSM-5-TR criteria for SUD, including: consuming substance in larger amounts than intended, craving, recurrent use in physically hazardous situations, and continued use despite interpersonal problems caused by the substance.

What would be an appropriate diagnosis to consider?

A. ~~(F13.14) Sedative, hypnotic or anxiolytic abuse with sedative, hypnotic or anxiolytic-induced mood disorder (lorazepam)~~

B. **(F13.20) Sedative, hypnotic or anxiolytic use disorder, moderate (lorazepam)**

C. ~~(F13.21) Sedative, hypnotic or anxiolytic dependence, in remission (lorazepam)~~

Answer: B

Rationale: Patient meets criteria for a sedative, hypnotic or anxiolytic use disorder (lorazepam), moderate based on the presence of 4 criteria. Note that the **(F13.20)** includes both moderate and severe sedative, hypnotic, or anxiolytic use disorder. Also ensure that the documentation clearly specifies the name of the drug (in this case, lorazepam).

(ICD-10-CM, 2022)

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Summary



- Over 46 million Americans have self-reported a substance use disorder.
- Appropriate screening can help individuals obtain necessary diagnostic and treatment services.
- Physical dependence can often exist independently of SUD and should be documented when it exists.
- Best practices for documenting SUD include the following elements:
  - Identify the substance of dependence
  - Symptoms (DSM-5-TR diagnostic criteria)
  - Severity
  - Remission status, if applicable
  - Treatment plan

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Obesity diagnosis and documentation



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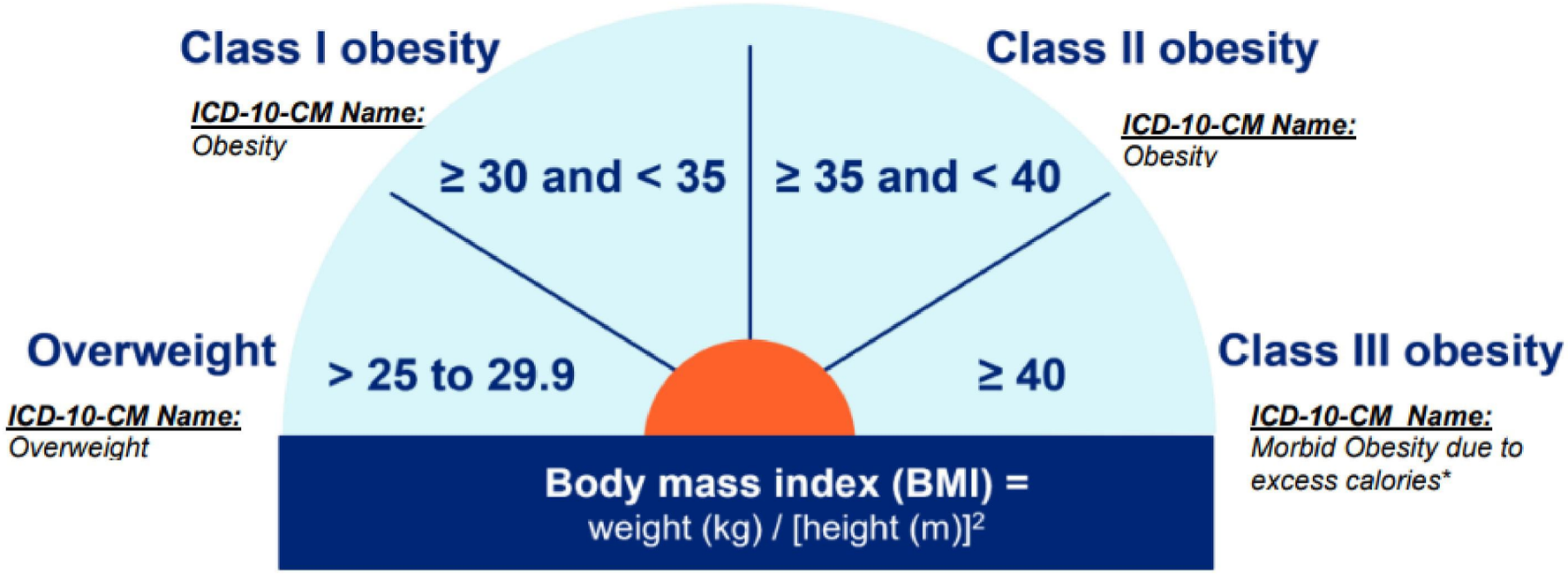
Clinical definition of obesity



(NHLBI, 2013; CDC, 2022)

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Prevalence of obesity in the U.S.

According to 2017–2018 data from the National Health and Nutrition Examination Survey (NHANES):

Nearly 1 in 3 adults are overweight.

30.7%

More than 2 in 5 adults have obesity.

42.4%

About 1 in 11 adults have severe obesity.

9.2%



~78 million adults over the age of 20 in the United States are obese

(CDC, 2022; NIDDK, 2021; Hamdy O, 2022)

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Documentation and coding

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Obesity with increased morbidity/mortality risk

Most commonly occurs in either of the two following situations:

01 BMI ≥ 40 with class III obesity (morbid obesity) **OR**

02 BMI ≥ 35 and < 40 with class II obesity (morbid obesity) PLUS one or more comorbidities, either made worse by the obesity or worsens the obesity itself.

Clinical judgment is required to determine when class II obesity adds an increased risk for developing another medical condition or is associated with increased morbidity and mortality from a comorbid condition.



Once a clinical diagnosis of **class II obesity with increased morbidity/mortality risk** or **class III obesity** is determined, the appropriate ICD-10-CM code associated with the diagnosis is (**E66.01) Morbid (severe) obesity due to excessive calories**.

(Hamdy O, 2022; ICD-10-CM, 2022)

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Common comorbidities associated with morbid (severe) obesity



In order to use **(E66.01) Morbid (severe) obesity (class II obesity)** for individuals with **BMI ≥ 35 and ≤ 39.9,** documentation must include the presence of one or more comorbidities

There is no "master list" of comorbid conditions, as more than 230 comorbid conditions have been observed with obesity.

Examples include, but are not limited to:*

- Coronary heart disease (such as myocardial infarction, angina, etc.)
- Hypertension
- Dyslipidemia
- Heart failure
- Atherosclerosis
- Diabetes mellitus type 2
- Osteoarthritis (on load-bearing joints)
- Obesity-related respiratory problems (such as obstructive sleep apnea, alveolar hypoventilation)
- A subset of cancers (such as hormone receptor-positive breast cancer, endometrial cancer, etc.)
- Severe stress incontinence
- Nonalcoholic fatty liver disease (NAFLD)

**List is not all-inclusive.*

(Perreault L(b), 2022; NHLBI, 2013; Hamdy O, 2022; CDC, 2022; ICD-10-CM, 2022)

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Documenting and coding tips



- Identify and document **class of obesity, BMI, and any co-morbidities**.
- In patients with **BMI ≥ 40** with class III obesity, consider documenting and coding (E66.01) Morbid (severe) obesity due to excess calories in addition to applicable diagnoses.
- In patients with **BMI ≥ 35 and < 40** with class II obesity, consider documenting and coding (E66.01) Morbid (severe) obesity due to excess calories if:
  - A co-morbid condition worsens the morbidity/mortality of the obesity (e.g.,T2DM, HTN) **and/or** obesity worsens the morbidity/mortality of the co-morbid condition (e.g., osteoarthritis).

In order for (E66.01) Morbid (severe) obesity due to excess calories to be accepted, documentation MUST state "morbid" or "severe" obesity.

(Bernard SP, 2019; ICD-10-CM, 2022)

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(E66.2) Morbid (severe) obesity with alveolar hypoventilation

This documentation may be appropriate in individuals with a BMI ≥ 40 (severe obesity) and evidence of daytime hypercapnia and sleep-disordered breathing (AKA obesity hypoventilation syndrome ("Pickwickian Syndrome")).

A diagnosis of alveolar hypoventilation is supported by documentation of a serum bicarbonate level ≥ 27 mEq/L or a room air arterial blood gas with a carbon dioxide level ≥ 45 mm Hg.

(Masa JF, 2019; ICD-10-CM, 2022)

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Case scenarios and documentation examples

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Morbid (severe) obesity documentation example

HPI: 73-year-old male here for routine follow-up for right hip pain.

PMH: Hip osteoarthritis

Meds: Acetaminophen prn pain

Exam: BP 135/79, HR 72, WT 250 lbs, HT 5’9”, BMI 39.9. CV: Normal S1/S2, Lungs: CTA, Abdomen and extremities with excessive adipose stores

Assessment:

(E66.01) Morbid (severe) obesity due to excess calories

(Z68.39) Body mass index 39.0-39.9, adult

(M16.11) Unilateral primary osteoarthritis, right hip

Rationale: Here we are showing the documentation of the patient's BMI and the corresponding Z code, as well as the reason for the hip pain that was the reason for his visit.

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UHG-SJC-007470

Case study

HPI: 67-year-old female for follow-up of HTN, CAD, and Type 2 DM. Pt concerned about her weight.

Vitals: BP 127/64, WT 229.2, HT 5’6”, BMI 37.0

PE: Well-developed, morbidly obese female.

Remainder of exam unremarkable.

This information is fictional and not based on a real patient.

Which of the following may be appropriate?
(select all that apply)

A. (Z68.37) Body mass index 37.0-37.9
B. (Z68.38) Body mass index 38.0-38.9
C. (E66.01) Morbid (severe) obesity due to excess calories
D. Both A and C

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UHG-SJC-007471

Case study

HPI: 67-year-old female for follow-up of HTN, CAD, and Type 2 DM. Pt concerned about her weight.

Vitals: BP 127/64, WT 229.2, HT 5'6", BMI 37.0

PE: Well-developed, morbidly obese female

Remainder of exam unremarkable.

This information is fictional and not based on a real patient.

Which of the following may be appropriate?
(select all that apply)

A. (Z68.37) Body mass index 37.0-37.9
~~B. (Z68.38) Body mass index 38.0-38.9~~
C. (E66.01) Morbid (severe) obesity due to excess calories
D. Both A and C

Answer: D.

Rationale: Patient has BMI above 35 with co-morbid conditions and excessive fat stores. Her DM, HTN, and CAD may all be made worse by her obesity.

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FAQ

What is a common cause of queries regarding morbid (severe) obesity documentation?

Documenting a BMI of less than 40 without documenting any comorbidities or without documenting “morbid” or “severe” obesity.

To document morbid (severe) obesity in someone with a BMI 35-39.9, do the co-morbidities need to be documented?

Yes, it is best practice. If class II obesity is present along with one or more co-morbidities, and in your clinical judgment the patient’s morbidity/mortality risk is made worse by the obesity plus co-morbidities, **documenting all conditions is required.** Best practice is to state there is morbid or severe obesity, and code (E66.01) Morbid (severe) obesity due to excess calories as well as the co-morbid condition(s).

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Summary

Obesity is a clinical diagnosis with nomenclature of class I, II, or III. However, ICD-10-CM does not contain or recognize this clinical nomenclature, so a clinician must state “morbid” or “severe” when documenting Class II or III obesity, when applicable.

Screening with BMI and, if indicated, evaluating for co-morbidities will help determine if documentation should include that the patient has obesity or has morbid (severe) obesity.

A BMI of 40 kg/m^2 or greater is evidence of a clinical condition that warrants proper documentation and correct coding for morbid (severe) obesity.

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Protein calorie malnutrition (PCM) and cachexia diagnosis and documentation



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Key definitions

Protein calorie malnutrition (PCM)

Refers to a nutritional status in which reduced availability of nutrients leads to changes in body composition and function

Cachexia

A complex metabolic syndrome related to underlying disease characterized by marked weight loss and muscle loss

(Gangadharan A, 2017; Bruera E, 2022)

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Significance of BMI and PCM

Abnormal BMI may indicate increased risk of mortality in individuals ≥ 65 years of age.

No universally agreed-upon BMI threshold that defines PCM

No screening recommendation for PCM based on BMI

However, for patients with a BMI of < 23 kg/m^2, it is appropriate to consider assessing for PCM, due to the increased mortality for older patients.

(Winter 2014)

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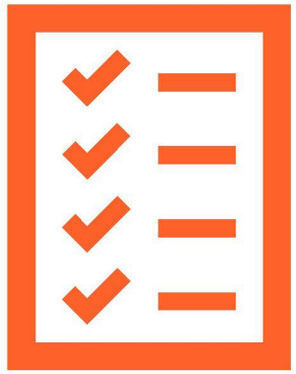
Examples of PCM screening tools



- American Society for Parenteral and Enteral Nutrition (ASPEN)
- Global Leadership Initiative on Malnutrition (GLIM)
- Subjective Global Assessment (SGA)
- Mini Nutritional Assessment (MNA)

(Queensland Gov., 2017; Nestlé, 2021)

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PCM diagnosis and documentation

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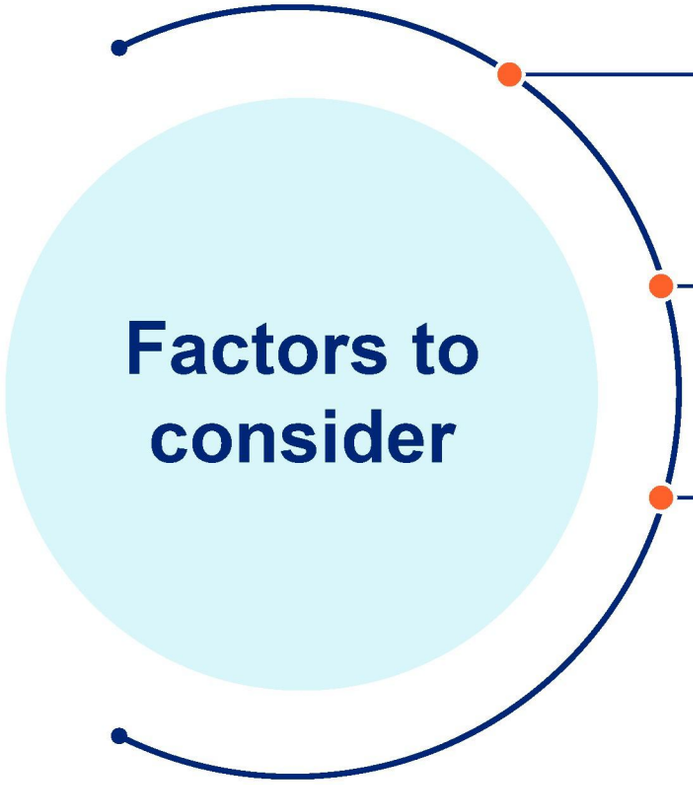
Determining PCM severity (mild, moderate, severe)

Determining PCM severity is based on clinical judgment.



Amount of weight loss as a percentage of baseline weight

Time frame of weight loss

Physical exam findings may include (not all-inclusive):

- Loss of muscle mass (e.g., temporal wasting)
- Loss of subcutaneous fat
- Edema
- Loss of handgrip strength or trunk strength

(House M, 2022; White JV, 2012)

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UHG-SJC-007480

When considering mild PCM:

*"There is **insufficient evidence** regarding their application in clinical settings to allow for further distinction to be made **between mild and moderate** forms of malnutrition at this time."*

Consensus statement from Academy of Nutrition and Dietetics and American Society for Parenteral and Enteral Nutrition

(White JV, 2012)

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When considering mild PCM:



Clinicians may consider a diagnosis of mild PCM when the criteria for moderate PCM are not met, but the patient's clinical presentation is consistent with malnutrition.

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ICD-10-CM codes for PCM

ICD-10-CM[1]	Descriptor
E43	Unspecified **severe** protein-calorie malnutrition
E44.0	**Moderate** protein-calorie malnutrition
E44.1	**Mild** protein-calorie malnutrition
E46	Unspecified protein-calorie malnutrition

Not an all-inclusive list

(ICD-10-CM, 2022)

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UHG-SJC-007483

Documenting PCM

Documentation should include specific clinical evidence such as **amount and time frame of weight loss and clinical findings to support PCM severity.**

If a patient has been diagnosed with PCM, ensure the physical exam is appropriately documented (i.e., constitutional exam **should not state** "well nourished").

PCM should be re-evaluated at each patient encounter and documented accordingly.

Examples

(E44.0) **Moderate** protein calorie malnutrition "evidenced by **5% unintentional weight loss in 1 month** and **mild muscle wasting**."

(E43.0) Unspecified **severe** protein calorie malnutrition, "evidenced by **> 7.5% unintentional weight loss in 3 months** demonstrated by **sunken facial features, temporal wasting and poor trunk control**."

(Optum EncoderPro Expert, 2022; White JV, 2012)

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Case scenario

HPI: 75-year-old female seen after 7-day hospital stay for lobar pneumonia, which has resolved. Appetite is mildly decreased since being home. She has lost 4 lbs since her admission, and 7 lbs in the last month (5% of baseline weight). Current BMI 19, down from 22. She is ambulating slowly, with assistance. Six months ago, she was completely independent and managing her finances.

PMH: HTN

PE: Demonstrates normal grip strength, bilaterally; mild loss of subcutaneous fat in arms; 1+ lower extremity edema

Which of the following would be appropriate? *(select all that apply)*

A. (E44.0) Protein calorie malnutrition, moderate
B. (I10) Essential hypertension
C (E43) Unspecified severe protein calorie malnutrition
D. (J18.1) Lobar pneumonia, unspecified organism

This information is fictional and not based on a real patient.

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UHG-SJC-007485

Case scenario

HPI: 75-year-old female seen after 7-day hospital stay for lobar pneumonia, which has resolved. Appetite is mildly decreased since being home. She has lost 4 lbs since her admission, and 7 lbs in the last month (5% of baseline weight). Current BMI 19, down from 22. She is ambulating slowly, with assistance. Six months ago, she was completely independent and managing her finances.

PMH: HTN

PE: Demonstrates normal grip strength, bilaterally; mild loss of subcutaneous fat in arms; 1+ lower extremity edema

Which of the following would be appropriate? *(select all that apply)*

A. (E44.0) Protein calorie malnutrition, moderate
B. (I10) Essential hypertension
~~C. (E43) Unspecified severe protein calorie malnutrition~~
~~D. (J18.1) Lobar pneumonia, unspecified organism~~

Answer: A & B.

Rationale: In this case example, we know this patient was hospitalized for pneumonia, but the HPI states this has since resolved so we would not include (D) Lobar pneumonia in our answer. Based on the physical exam findings (subcutaneous fat loss in arms and 1+ lower extremity edema) and amount of weight loss (5%) from baseline, the patient fits the criteria for moderate PCM. She has a PMH of HTN, so we want to carry that diagnosis forward as well.

This information is fictional and not based on a real patient.

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Cachexia diagnosis and documentation

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Cachexia diagnostic criteria

Weight loss of 5% of baseline weight in 12 months or less (or a BMI of < 20 kg/m^2)

AND

Presence of a known chronic disease (e.g., cancer, end-stage kidney disease, chronic pulmonary disease, heart failure, rheumatoid arthritis)

AND

At least 3 of the following factors:

1. Reduced muscle strength
2. Fatigue
3. Anorexia
4. Low fat-free mass index
5. Abnormal laboratory results
   - Elevated inflammatory markers: CRP > 5 mg/L or IL-6 > 4 pg/mL
   - Hgb < 12 mg/dL
   - Serum albumin < 3.2 g/dL

Although PCM may not be accompanied by cachexia, if a patient has cachexia, they often also have PCM. If both are present, they should both be documented and coded.

(Evans WJ, 2008)

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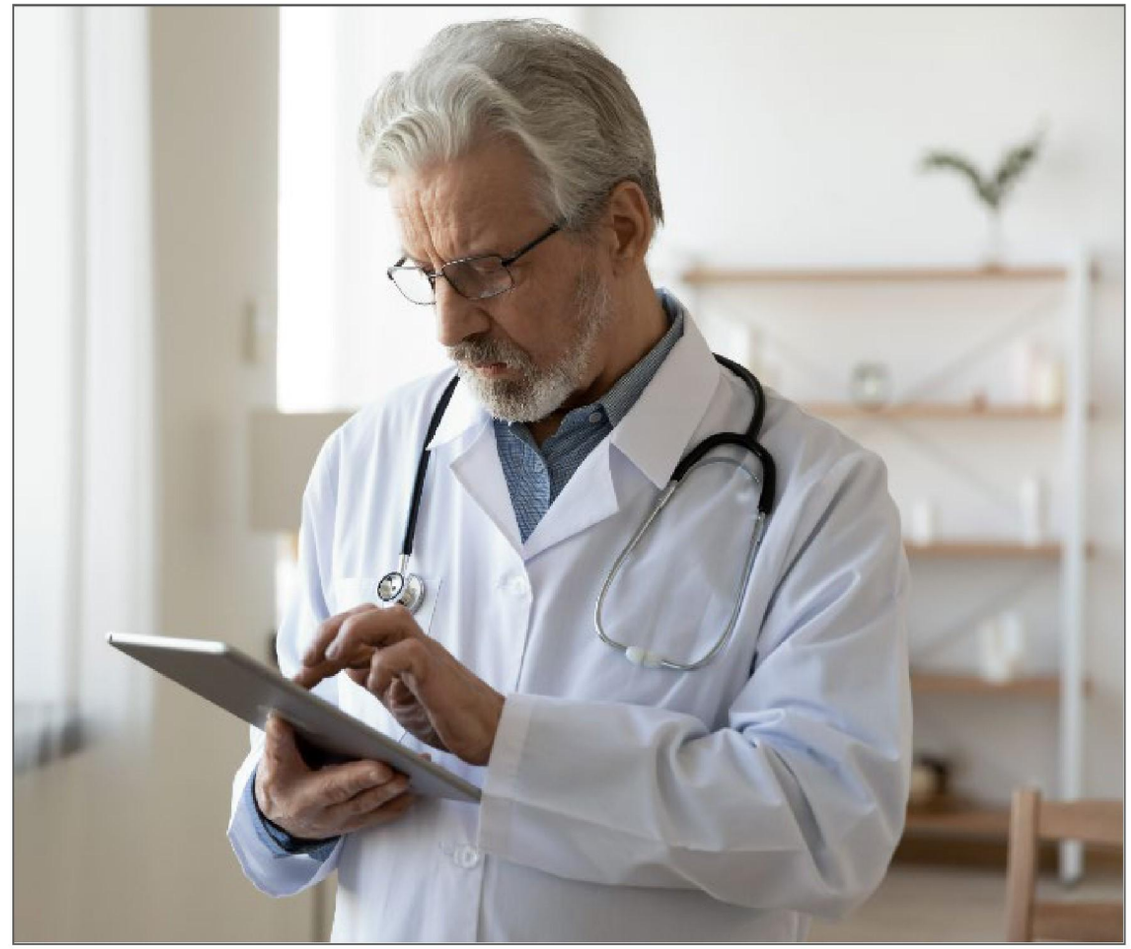
Protein calorie malnutrition and secondary immunodeficiency

A clinician *may consider* adding (D84.81) Secondary immunodeficiency due to diseases classified elsewhere if any of the following diagnoses are present:

- (E44.0) Moderate protein-calorie malnutrition
- (E43.0) Unspecified severe protein-calorie malnutrition
- (R64) Cachexia

Include clear linking language (e.g., “due to…”) between the state of immunodeficiency and its specific cause.



(Chinen J, 2010)

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Summary



- Protein calorie malnutrition (PCM) is inadequate intake leading to changes in body composition and function.
- Cachexia is not caused by PCM alone, but rather is a hypercatabolic state secondary to an advanced chronic condition.
- Many screening tools exist for PCM. Once diagnosed, PCM should be differentiated from cachexia and one or both should be documented, as appropriate.
- When PCM is present, document it as mild, moderate or severe based on clinical findings.

Nutritional assessment and treatment should be a routine part of care for all patients.

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HouseCalls Support Materials

Case studies, job aides and podcasts are housed on the **Clinical Education Center (CEC)**
Learner Dashboard (optum.com)

Text Tips are sent out to enrolled APCs three days a week, every week. Sign up for Clinical Text Tips: https://www.mycdqitips.com/ OR text **TIPS** to 67936 (Standard text messaging rates may apply, based on your mobile plan.)

HouseCalls Pocketguide https://core-optum.bravais.com/s/DEEq79f6fVhY0aySHopb

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Appendix

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For additional coding information, please refer to the current ICD-10-CM Browser Tool: https://icd10cmtool.cdc.gov/

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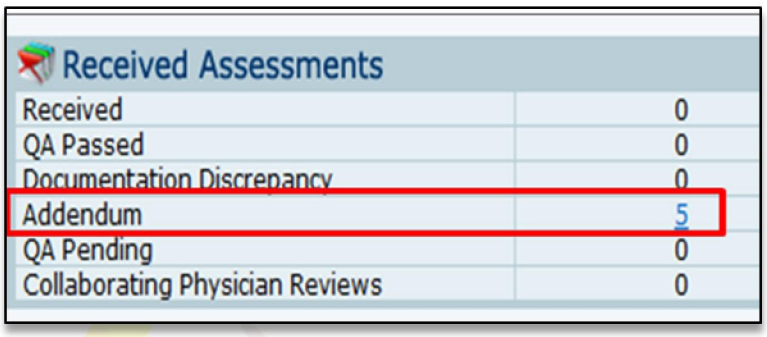
April 15, 2020

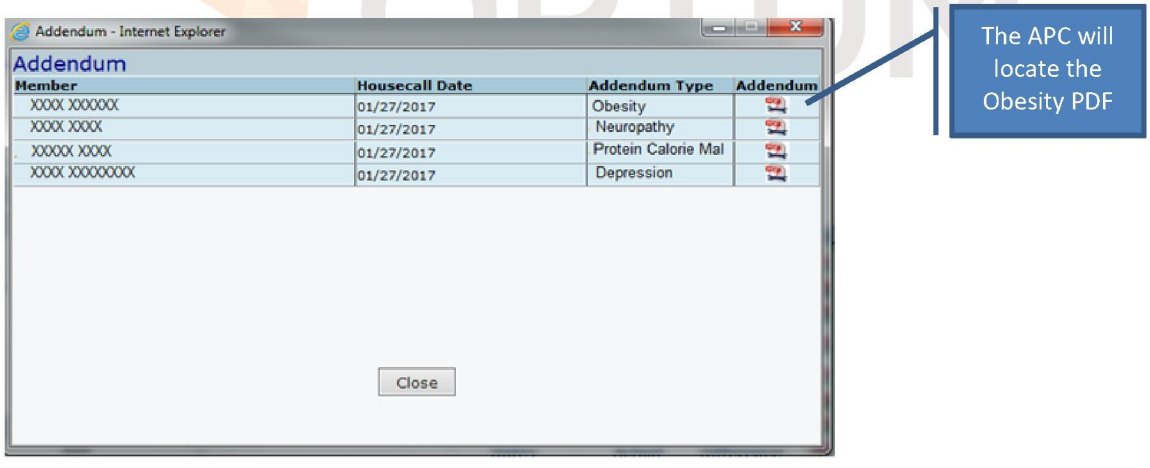
Morbid Obesity Clinical Evidence w/o Obesity Chart Return Instructions

Chart Return Process for Query for Morbid Obesity without documentation of Obesity:

Charts will be returned through the **Received Assessments** portion of the Practitioner Portal in the **Addendum** section.



The APC will select the blue hyperlink to open the list of assessments and coversheets available including specifics related to the charts returned and the diagnosis. (See below):



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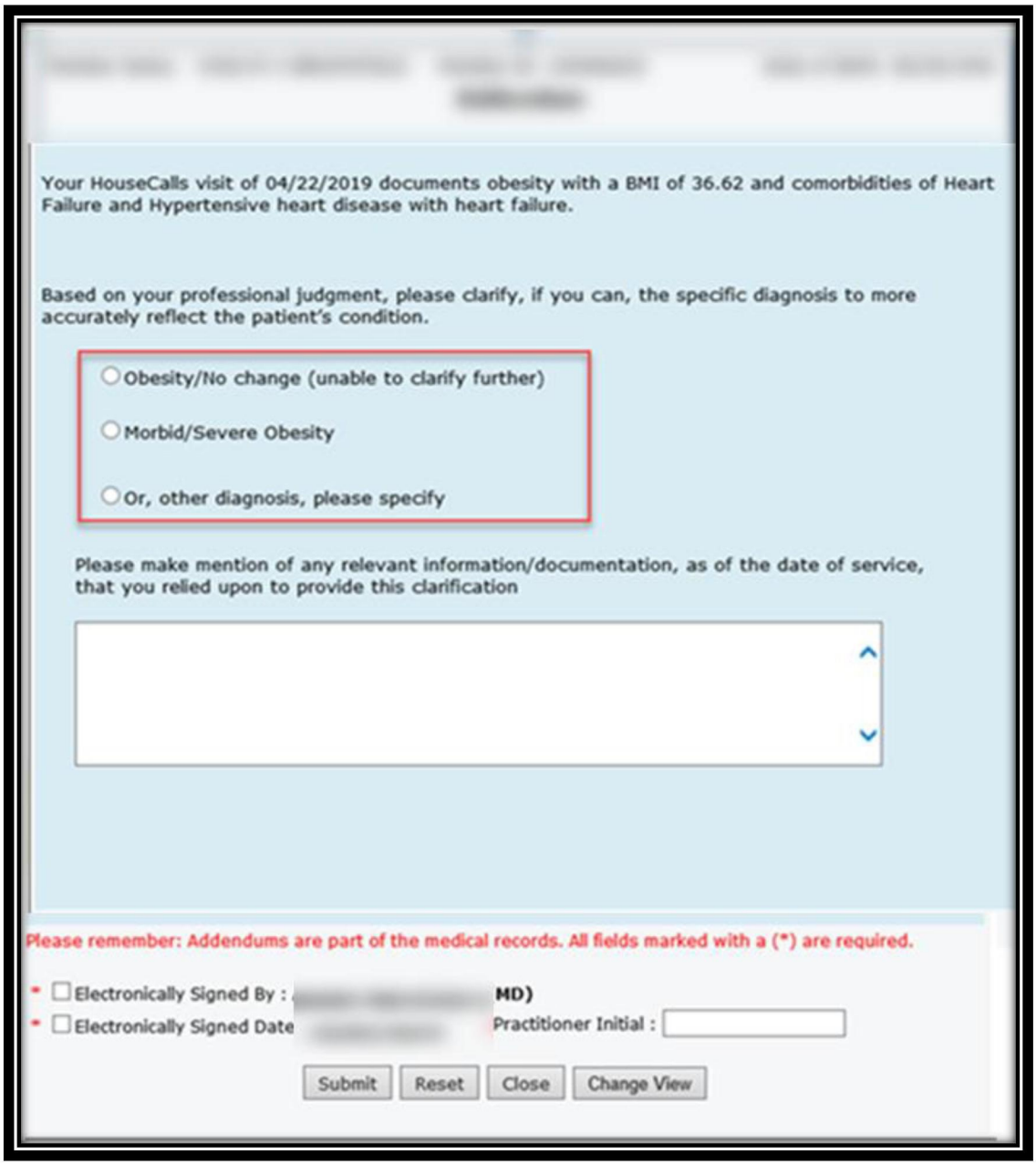
Morbid Obesity with Clinical Evidence without only and documentation of Obesity



- When the member has at least **ONE** co-morbidity and the BMI range is within **35.00-39.99,** the APC should consider Morbid Obesity as the active diagnosis.
- Be sure to review the query response and the chart for applicable data.
- Comments should only relate to the diagnosis being discussed in the query response.
- Clarify documentation only when clinically appropriate and add to the Comment text box.
- Choose the appropriate checkbox in the query and then place your comments in the text field below.
- Electronically sign by checking the two boxes, enter your initials, and then select **Submit** to return the document back to the reviewers.

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Angina Pectoris

Fast Facts:

- Angina pectoris is a result of myocardial ischemia due to an imbalance of myocardial blood supply and oxygen demand
- Angina has been estimated to occur in 9.8 million Americans annually
- Interestingly, only 18% of people with coronary attacks have angina
- Risk factors include a family history of arteriosclerosis, diabetes, cigarettes smoking, hypercholesterolemia and hypertension
- Angina occurs as frequently in men as it does women

Diagnosis

- It is important to remember angina or "chest discomfort" is usually the symptom of arteriosclerotic disease
- The type of angina can provide evidence regarding the severity of the arteriosclerotic disease
- **History:** The patient may recall angina in their history. In a patient presenting with classic angina and multiple risk factors for arteriosclerotic disease, the diagnosis of myocardial ischemia should strongly be considered
- **ROS:** The patient may state chest pain in the ROS. The practitioner may ask the following questions:
  - What brings on the pain?
  - What relieves the pain?
  - How does the pain feel?
  - How long does the pain last?
- **Medications:** If the member is on nitroglycerin or Renexa, the practitioner should consider angina as a diagnosis, even if the member is asymptomatic at the time of the visit

Signs and Symptoms

- Gradual onset of chest pressure or discomfort that is reproducible with some level of exertion
- Angina is described as a heaviness or squeezing sensation
- Angina can be precipitated by eating, exposure to cold or emotional stress
- Patients are relieved of the pain by either decreasing activity or rest
- Many patients are relieved of pain from nitroglycerin administration

Qualities of Angina pain:

- Quality of angina is characterized as a "discomfort" versus pain
  - Examples include: squeezing, tightness, pressure, burning
  - Levine sign: patient demonstrates pain by placing fist into the center of the chest
  - Constant, doesn't change with respiration or position
- Location and radiation
  - Referred pain: pain not felt in a specific spot, diffuse
- Timing
  - Angina occurs more often in the morning due to diurnal increase in sympathetic tone
- Duration and relief
  - Classic angina is relieved when the provoking factor is terminated
  - Typically, angina lasts anywhere from two to five minutes

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Classification of Angina:

- Stable Angina:
  - This pain occurs when the heart must work harder, usually during exertion
  - The pain doesn't come as a surprise
  - Usually, pain lasts a short time (5 minutes or less)
  - Pain relieved by rest
  - Pain relieved by nitroglycerin
- Unstable Angina:
  - Pain that often occurs at rest
  - Pain that comes as a surprise
  - Pain that is more severe and not relieved by rest. (Pain lasting for 30 minutes or longer)
  - Pain that is considered an emergency and requires immediate medical care
- Variant Chest Pain:
  - Pain that occurs at rest and during the night
  - Pain that tends to be severe
  - Pain is relieved by medication
  - Rare
- Unspecified Angina:
  - Angina not well defined
  - There is no prior history, or medications to substantiate this diagnosis
  - Patient verbalizes a positive finding of chest pain in the ROS

Treatment:

Medications to treat stable angina:

- Nitrates:
  - Initial treatment for patients, either with one or two episodes per week
    - An example of the first line therapy for angina would be nitroglycerin
  - Nitrates increase blood flow by relaxing the veins or arteries
  - If pain lasts longer than 5 minutes after the patient has taken 3 tablets, the patient should seek emergent treatment
  - If the patient is on nitroglycerin, the practitioner should consider angina as a diagnosis, even if the member is asymptotic at the time of the visit
- Ranolazine (Ranexa):
  - A treatment for angina and can be used in combination with beta-blockers and calcium channel blockers: Example: Renexa
  - This medication is currently the only FDA approved medication for chronic angina
  - Chronic angina is typically a member with small vessel disease or not a candidate for an intervention
  - If a member is on this medication the practitioner should consider an angina for diagnosis, even if the member is asymptotic at the time of the visit
- Beta-blockers:
  - Used to lower heart rate and blood pressure and decrease myocardial demand
- Anti-platelet therapy might also be seen in patients with angina

Documentation Requirements:

What will support the diagnosis?

- ACTIVE treatment:
  - Medication on page 4 of the assessment is an indication for the diagnosis of Angina
    - PRN or long term, antianginal or nitrate
    - Adjustment of above medications
    - Antianginal other than nitrate, documentation must indicate it is being used specifically for the angina

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Smart Logic

Smart logic is a feature that is based on the clinical findings documented in the encounter and is populated on page 15 for review and confirmation.

- The tablet will generate 'stable angina' based on medications such as nitroglycerine, Ranexa, Imdur, and Isordil
- The practitioner should use the best clinical judgement involving history, physical exam, and review of systems to make a determination of angina



Diagnosis in eHouseCalls application

- Stable angina
- Unstable angina
- Unspecified angina
- Angina Pectoris with documented spasm

Case Study #1:

HPI: 89 year old female with atherosclerotic heart disease s/p MI with angina, atherosclerosis of aorta, COPD, and CKD 3; Notes weight decreased 1 lb, ambulates with assistance, has walker but declined use. Still needs nitroglycerin sublingual sometimes; used 1X in the last 4 months.

MEDS: ASA 81 mg. QD, simvastatin 40 mg. QHS, Nitro stat 0.4 mg. PRN, Imdur ER 30 mg. QD.

EXAM: Lungs: CTA; Heart: RRR, SM 2/6; Abd: Soft, NT, ND; Ext: FROM, no edema.

ICD-10 Code & Description:	**I25.119 Atherosclerotic heart disease of native coronary artery w/ unspecified angina pectoris** I70.0 Athersclerotic of aorta E78.4 Hyperlipidemia J44.9 COPD N18.3 CKD stage 3 Z79.82 Long term use of aspirin

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Case Study #2:

HPI: 70 year old female, HTN, hyperlipidemia, CKD 3, and angina. Pt reports chest pain is random, no pattern & not associated w/ diet or exercise. Last nitroglycerin use was about a year ago. Cardiology advised may need angiogram and stent if continued use of nitroglycerin is necessary.

MEDS: Lisinopril/HCTZ 20/25mg. QD, Simvastatin 40 mg. QHS, Metoprolol tartrate 25 mg. BID, S/L Nitroglycerin 0.4 mg. PRN

EXAM: NAD; Heart: RRR; Lungs: CTAB; Abd: Soft, NT, ND; Ext: No edema.

ICD-10 Code & Description:	**I20.9 Angina pectoris, unspecified** I10 Hypertension E78.4 Hyperlipidemia N18.3 CKD stage 3

Case Study #3:

HPI: 68 year old member with HTN, known coronary disease, smoker. 3 weeks of exertional SOB with centralized pain radiating to left neck and arm, relieved at rest. Going up a hill and cold weather makes symptoms worse.

MEDS: ASA 81 mg. QD, simvastatin 80 mg. QHS, Nitrostat 0.4 mg. PRN, metoprolol tartrate 25 mg. BID

ICD-10 Code & Description:	**I20.9 Angina pectoris, unspecified was selected, but is incorrect.** **The correct diagnosis would be:** **I25.119 Atherosclerotic heart disease of native coronary artery w/unspecified angina pectoris** I10 Hypertension Z72.0 Tobacco Use Z79.82 Long term use of aspirin

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eHouseCalls Training Manual

Software Version 2.11.1.1
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08/14/2017

Table of Contents

TABLE OF CONTENTS **2**

LESSON 1 LOGIN & LOGOUT PROCEDURES **7**

LOGIN PROCESS 7
Powering on the Tablet *7*
First login: Windows *8*
Second login: Internet *11*
Third login: VPN *12*
Fourth login: eHouseCalls *15*
LOGOUT PROCESS 16

LESSON 2 LOCK & UNLOCK THE TABLET **17**

LOCK/UNLOCK TABLET BETWEEN MEMBER VISITS 17

LESSON 3 CHANGE TABLET ORIENTATION **18**

TO DOCUMENT ASSESSMENT DOCKED TO THE KEYBOARD (LANDSCAPE VIEW) 19

LESSON 4 CHANGE MS PASSWORD **21**

CHANGING YOUR MS PASSWORD 21
Prior to changing your MS Domain ID Password: *21*
Password requirements: *21*

LESSON 5 CHANGE VPN PERSONAL PIN **22**

LESSON 6 THE DASHBOARD **24**

DASHBOARD OVERVIEW 24
SCHEDULED APPOINTMENTS 25
Member Details *26*
Reschedule By Practitioner *27*
Request Do Not Visit *27*
Launch or Review an Assessment *28*
PAST APPOINTMENTS 29
ASSESSMENTS IN PROGRESS 29
REFERENCE DOCUMENTS 29
SYNCHRONIZATION STATUS 30
Verifying Connectivity Status *31*
Synchronizing Data *32*
Connecting to a Wi-Fi Network *33*
Upgrade the eHouseCalls Application *34*
BLANK ASSESSMENT 36
Blank Assessment (i.e. Member not on schedule) *36*

LESSON 7 EHOUSECALLS ASSESSMENT OVERVIEW **37**

TOOLS AND NAVIGATION 37
DATA ENTRY FIELDS 38

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Red Text 38
Numeric 38
Dates 39
Text Fields – Keyboard and Handwriting Tool 40
Add Row/Delete Row 41
Prepopulated Drop-Down Lists/Checkboxes 41
Using Your Stylus Pen 42
Switch Button 42
Diagnostic Toolbar 42
Navigation Toolbar 44

LESSON 8 DOCUMENTING THE ASSESSMENT 45

DOCUMENTING ASSESSMENT PAGE 1 45
Member Demographics 46
Member Properties 48
Assessment Location 48
Contact Person/Caregivers 49
PCP Information 50
DOCUMENTING ASSESSMENT PAGE 2 51
Specialist Information 52
Previously Identified Diagnoses 53
Surgery Details 54
Admissions 55
Emergency Room Visits 55
Diagnosis Cart 56
DOCUMENTING ASSESSMENT PAGE 3 59
Past Medical History 60
Social/Family History 62
Add Diagnosis 63
DOCUMENTING ASSESSMENT PAGE 4 64
Show Cart Button 65
Medications 65
Additional Supplements and Medical Devices 69
Pharmacy Adherence 69
Barriers to Adherence 70
MTM - Medication Therapy Management Tool 71
DOCUMENTING ASSESSMENT PAGE 5 72
Allergies 73
Pharmacy Questions/Referrals 74
Labs 75
Vaccination History 75
DOCUMENTING ASSESSMENT PAGE 6 76
Preventative Screenings 77
DOCUMENTING ASSESSMENT PAGE 7 79
Social History/Risk Factors 80
Family History 81
DOCUMENTING ASSESSMENT PAGES 8-10 82

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Documenting the Review of Systems (ROS) *83*
Documenting ROS Page 8 ..... *84*
Documenting ROS Page 9 ..... *85*
Documenting ROS Page 10 ..... *87*
DOCUMENTING ASSESSMENT PAGES 11-14 90
Documenting the Examination *91*
Documenting Exam Page 11 ..... *92*
Documenting Exam Page 12 ..... *93*
Documenting Exam Page 13 ..... *94*
Documenting Exam Page 14 ..... *96*
ADDRESSING THE DIAGNOSTIC TOOLBAR 98
HxAV - Summary of last Annual Visit *98*
STARS - Star Gap Measures *99*
ADL - Barthel Index of Activities of Daily Living *100*
MNA - Mini Nutritional Assessment *101*
PA - Pain Assessment *102*
COG - Mini-Cognitive Assessment *103*
PSY - Depression Screening Tool *104*
SOF - Summary of Findings *105*
FVIS - Flu Vaccination Information Sheet *106*
LAB - Blood, and FOBT Testing *107*
DOCUMENTING ASSESSMENT PAGE 15 110
Diagnosis Confirmation/Assessment and Plan *111*
Plan of Care *113*
DOCUMENTING ASSESSMENT PAGE 16 115
Member Education *116*
Practitioner Identified Urgent Clinical/Social Issues *117*
Additional Collaboration *117*
DOCUMENTING ASSESSMENT PAGE 17 118
Referrals *119*
Behavioral Health Referrals *120*
Recommendations *120*
DOCUMENTING ASSESSMENT PAGE 18 121
Ask Your PCP Letter *122*
DOCUMENTING ASSESSMENT PAGE 19 123
Assessment Notes *124*
Mandatory Messages *124*
Member Signature *125*
DOCUMENTING ASSESSMENT PAGE 20 126
Practitioner Accompaniment *127*
Could Not Be Completed *127*
Finalizing the Assessment *128*

LESSON 9 POTENTIAL VISIT SITUATIONS 129

INTERPRETER/TRANSLATOR MEMBER VISIT 129
ASSESSMENTS NOT STARTED (I.E. MEMBER NOT HOME) 129
ASSESSMENT WHICH COULD NOT BE COMPLETED (I.E. EMERGENCY) 130

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APPENDIX A SMART CARDS 131

SMART CARD READER TABLET LOCATION 132
HP Pro X2 Laptop Smart Card Location 132
SETTING UP YOUR PERSONAL SMART CARD PIN 132
Smart Card Registration Instructions 132
COMPLETING THE SMART CARD REGISTRATION 135
SMART CARD LOGIN (AFTER INITIAL SETUP) 138
CHANGE EXPIRED SMART CARD PIN 139
SMART CARD FAQ 141
Smart Card Distribution 141
Utilization of the Smart Card 141
Lost, Damaged, or Malfunctioning Smart Cards 142
Smart Card Access and Functionality 142
Smart Card Passwords 143
Smart Card Pop-Ups and Icons 143

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HouseCalls Overview

Housecalls combines the human touch of in-home medical examination with sophisticated technology and targeted health education to improve the health and quality of life for seniors. Our network of health care practitioners visits UnitedHealthcare Medicare Advantage members in their homes to collect critical insight unavailable outside the HouseCalls program. With this combination of unique information and hands-on care, we can build a strong foundation of trust, create stronger adherence to physician's orders and medication and craft a plan of customized care for each member that can be shared electronically with their care providers.

You will use the eHouseCalls software to document member data from your visit. This software was created in-house, by incorporating feedback from practitioners to design an assessment that is easy to use and enables you to document all issues while visiting with the member. When you finalize an assessment it is transmitted to our server. Any recommendations or referrals you requested will be forwarded to the correct departments. The information that HouseCalls practitioners collect is extremely valuable and will be incorporated into existing clinical services operated by UnitedHealthcare and its business partners to support ongoing member care management efforts.

We want to thank you for enabling us to bring this valuable service to our members. Welcome!

Training Expectations

Through training we will focus on documenting house calls visits in eHouseCalls. By the end of training you will be expected to know how to:

- Connect your tablet to a Wi-Fi network
- Connect to the VPN (Cisco AnyConnect)
- Log in and out of eHouseCalls properly
- Sync data from the tablet to our server
- Verify scheduled member appointments
- Status visits you are not able to start
- Navigate and document the eHouseCalls Assessment
- Finalize the Assessment
- Change your tablet password
- Setup your cellular phone (GOOD)

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Lesson 1 Login & Logout Procedures

Login Process

In order to protect member information and to launch the eHouseCalls (eHC) application, you will be required to complete the login process which consists of four separate instances in which you are required to enter a password. These instances include logging into: Windows, Internet, VPN, and eHouseCalls.

Powering on the Tablet

To power on the tablet

1. To power on your laptop, raise the laptop screen and slide the Power switch forward. The Power switch is located on the right hand side of the laptop, (see Figure 1.1). The boot up process will begin.

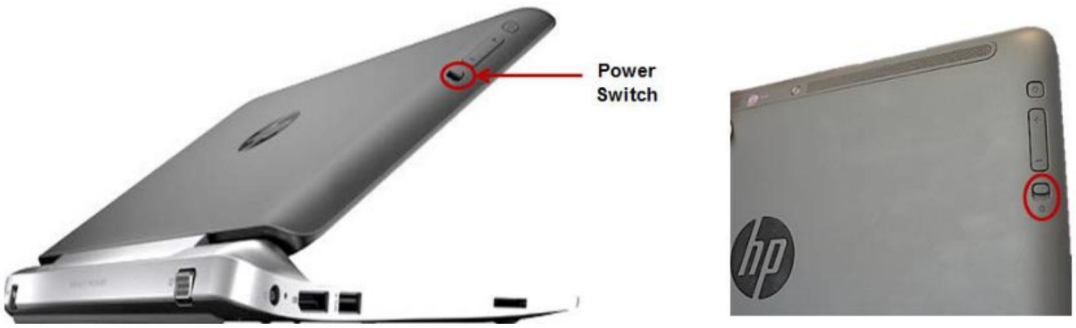

Figure 1.1. Power Switch

2. Once the boot up process begins, **DO NOT** press any other button on the laptop until you see the **CTRL+ALT+DEL** screen, signifying the boot up process has completed.

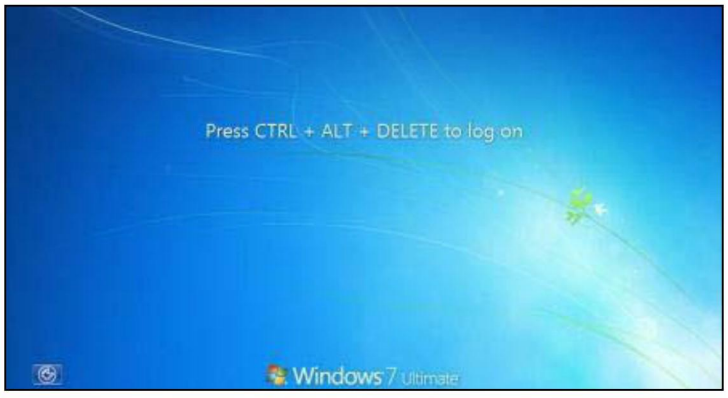

Figure 1.2. CTRL+ALT+DEL Screen

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First login: Windows

To log in to Windows

1. From the CTRL+ALT+DEL screen, perform the CTRL+ALT+DEL command by pressing the CTRL+ALT+DEL buttons simultaneously on your keyboard. The Legal Notice policy screen displays.



Figure 1.3. CTRL + ALT+ DEL Buttons

2. From the Legal Notice screen, click the OK button. The Log On screen displays.

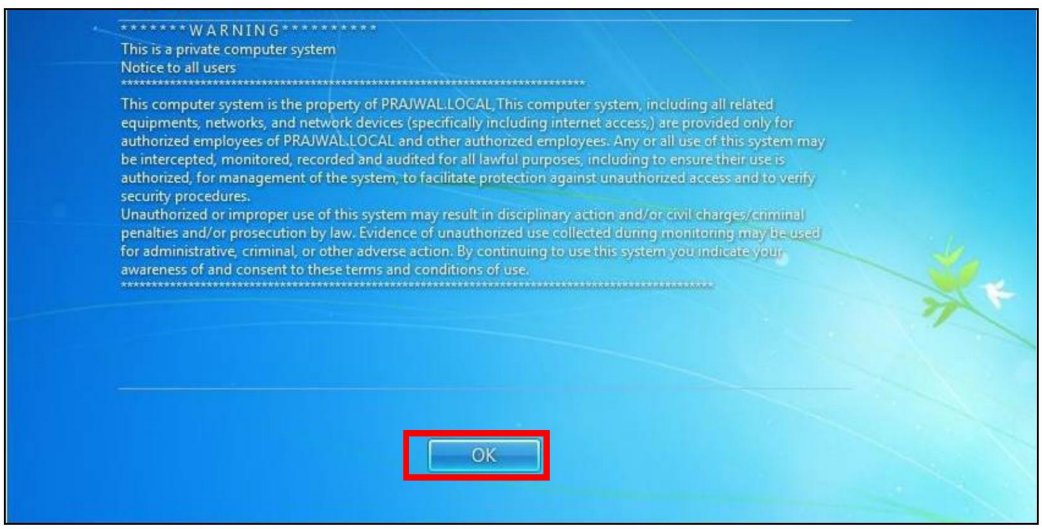

Figure 1.4. Legal Notice Screen

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3. From the Log On screen, input your **MS Domain ID Password** in the password field and press the **Return/Enter** key. The desktop displays.

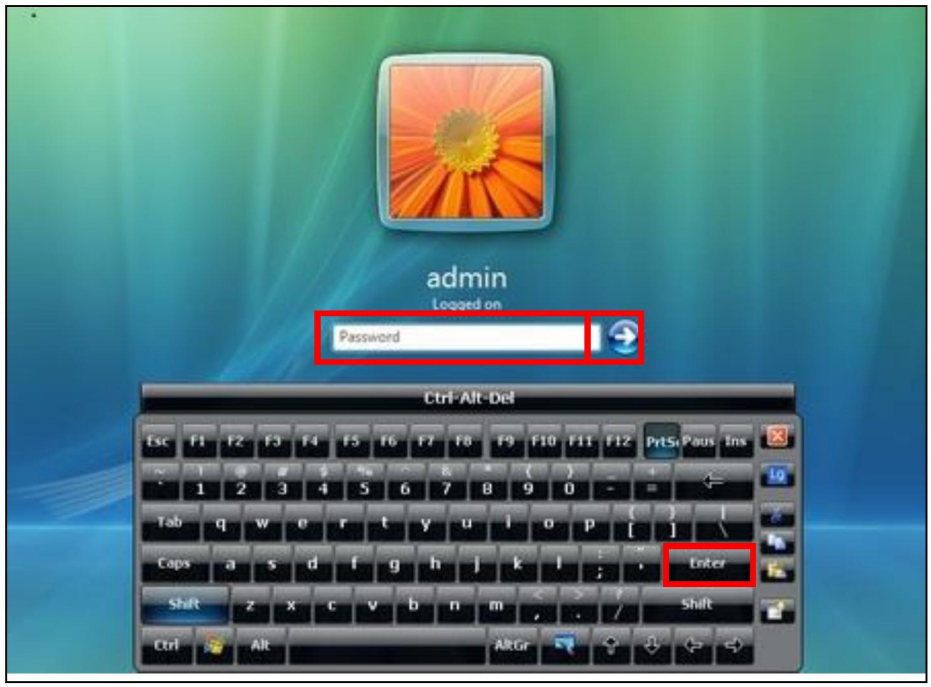

Figure 1.5. Log On Screen

4. Once you have logged into Windows, your desktop will display the blue eHouseCalls window. Click the **Cancel** button from the eHouseCalls window, (see Figure 1.6).

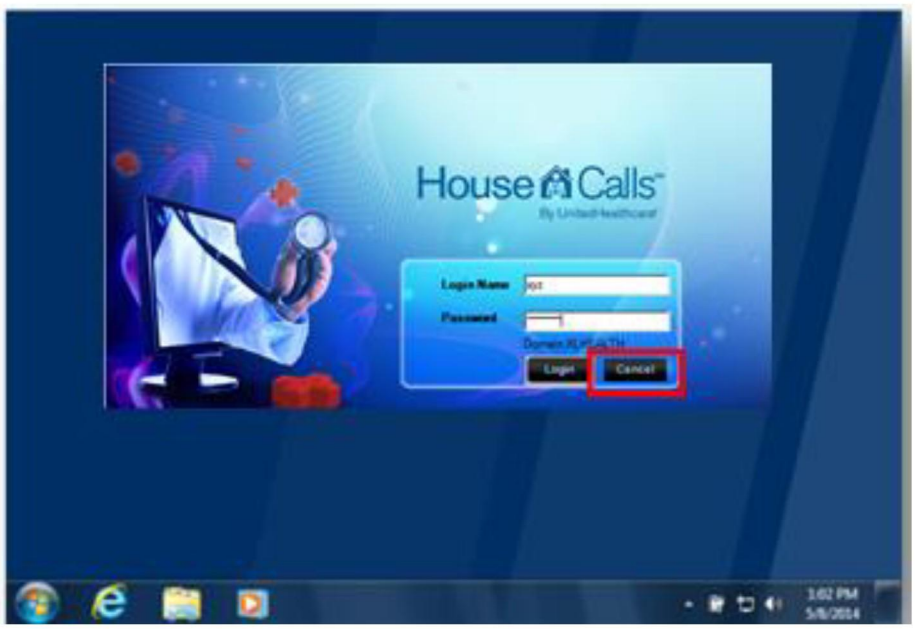

Figure 1.6. eHouseCalls Pop-Up Window

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5. Click the **EJECT** button located on the middle of the laptop dock, as shown below to eject the tablet from the laptop.



Figure 1.7. Ejecting the Tablet from the Laptop Dock

6. Locate your stylus pen docked within you tablet (see Figure 1.8), and pull out of the tablet.



Figure 1.8. Stylus Pen Location

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Second login: Internet

To connect to the internet

1. Navigate to the desktop system tray and click the orange fireball icon to connect to the GOBI Sim Card, (see Figure 1.9). The WIFI Connections window displays.



Figure 1.9. Desktop System Tray – Not Connected to Wi-Fi Icon

2. From the WIFI Connections window and from the Broadband Connection list, select "**Verizon**" and then select the **Connect** button.



Figure 1.10. Broadband Connection List – Verizon (SIM Card)

3. Wait one minute and then verify internet connectivity, by ensuring the icon in Figure 1.11 is shown in the desktop system tray.

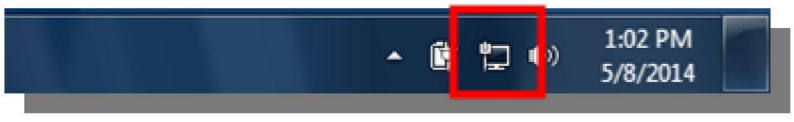

Figure 1.11. Desktop System Tray – Connected to Wi-Fi Icon

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Third login: VPN

Once you've successfully logged in to Windows you must log in to the VPN. The VPN connection enables you to send and receive data from your tablet to our secure server. The GOBI Sim Card should automatically connect you and establish internet connection.

A VPN connection is needed at least twice a day when you use the tablet; before you see members for the day, and at the conclusion of your work day. This login will require your personalized 8-digit pin and your RSA Token.

NOTE: If a member is added or removed from your schedule, you would need to connect to the VPN in order to see the data changes reflected on your tablet.



Figure 1.12. VPN Login Requirements

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To log on to the VPN

1. Connect or be sure you are connected to the Internet.
2. Launch the Cisco AnyConnect VPN Client by double-clicking the Cisco AnyConnect Secure VPN Client icon on the Windows Desktop, (see Figure 1.13).

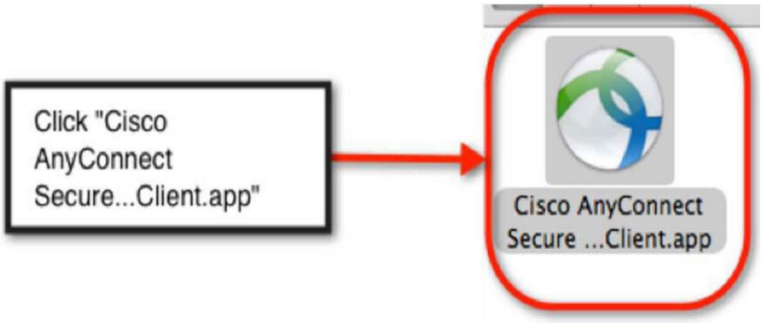

Figure 1.13. Cisco AnyConnect Secure VPN Client Icon

3. If there is no icon on your desktop, click the Start Button, click All Programs and then click Cisco AnyConnect Secure Mobility Client from the list of applications, (see Figure 1.14).

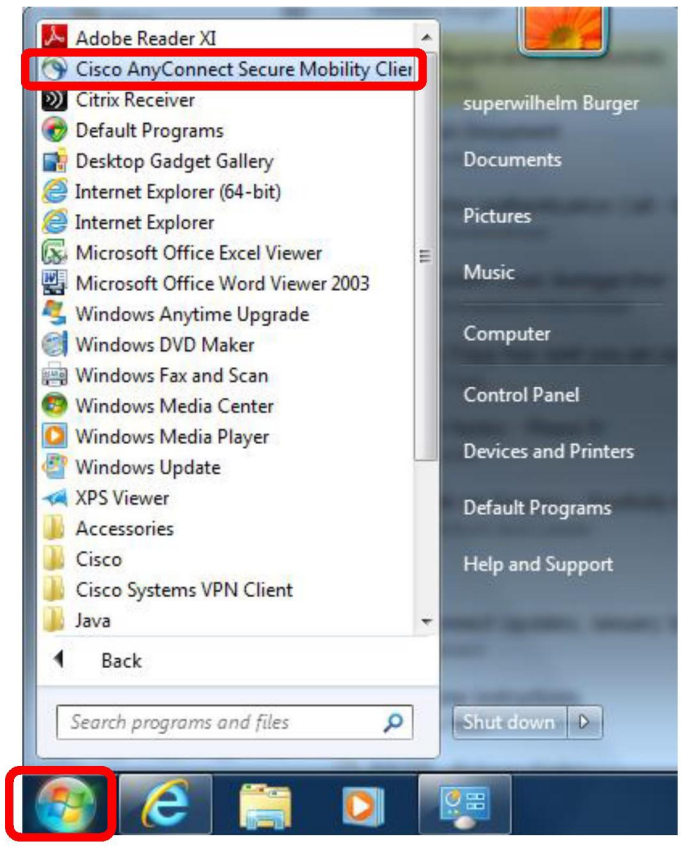

Figure 1.14. Start Button – All Programs Window

4. From the Cisco AnyConnect window select Plymouth, MN (if necessary) from the drop-down arrow and click the Connect button, (see Figure 1.15). The Cisco Login window displays.

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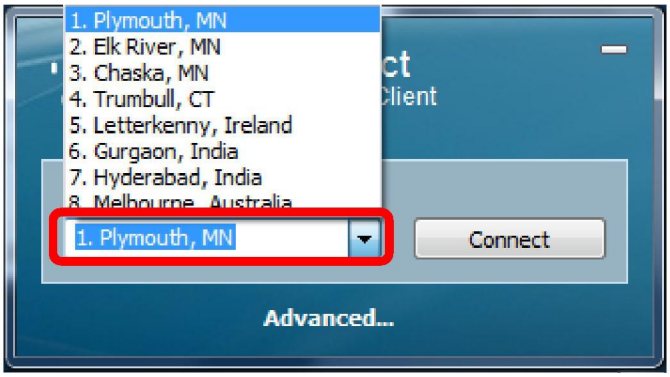

Figure 1.15. Cisco AnyConnect Screen

5. From the login window, in the Username field, input your MS Domain ID, (see Figure 1.16).

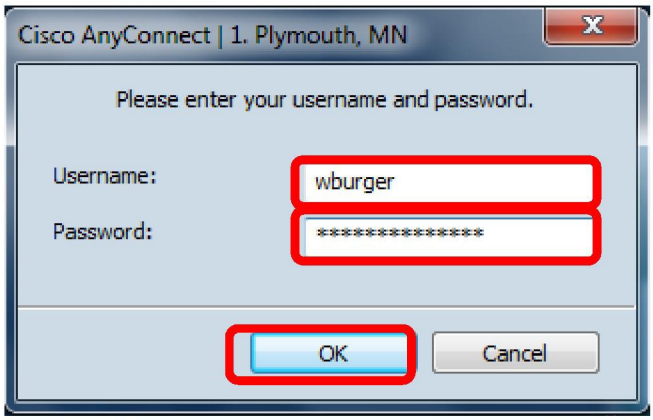

Figure 1.16. Cisco Login Window

6. In the password field, input your 8-digit PIN + the current 6-digit RSA Token Code (a total of 14 digits). If the timer on the RSA Token timer, (see Figure 1.12) has less than two bars, wait for a new code to generate and then input that Token Code.

7. Click the OK button. The desktop displays.

8. In your lower right desktop taskbar an orange lock icon verifies successful VPN connectivity, (see Figure 1.17).



Figure 1.17. Cisco AnyConnect Orange Lock Icon

NOTE: You do not need a VPN connection to conduct eHouseCalls assessments throughout your day. For all RSA Token issues, contact HouseCalls Tablet Support Help Desk.

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Fourth login: eHouseCalls

The last and final login will require you to login to eHouseCalls.

1. From the Desktop, double-click the eHouseCalls icon to launch eHouseCalls, (see Figure 1.18). The initial login window displays.

2. Once the eHouseCalls initial login window displays, ensure that your Login Name matches your MS Domain user name and then enter your MS Domain ID Password in the textbox provided.

3. Click the **LOGIN** button. The Dashboard displays.

NOTE: The eHouseCalls application login will allow a maximum of 3 login attempts and then you will be locked out for 10 minutes. After 10 minutes, you can try to log in again or you can restart your tablet to log in immediately.



Figure 1.18. eHouseCalls Icon



Figure 1.19. eHouseCalls Login Window

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Logout Process

At the end of each day, you must log out of eHouseCalls and properly shutdown your tablet.

To complete the logout process

1. Return to the Dashboard of eHouseCalls and select the **LOGOUT** button, (see Figure 1.20). The desktop displays.



Figure 1.20. eHouseCalls Logout Button

2. From the desktop, click the Windows start button and select the Shut down option, (see Figure 1.21). Your tablet will begin to shutdown.

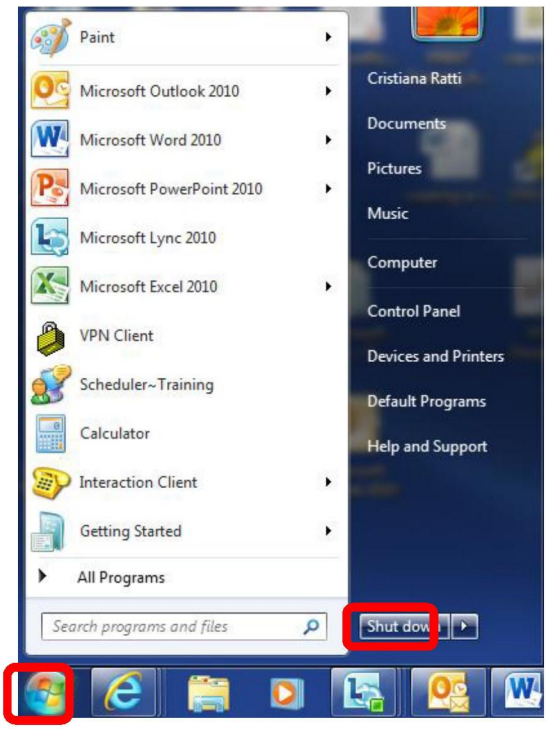

Figure 1.21. Windows Start Button and Shut down Option

3. Re-dock the tablet to the laptop dock (keyboard).

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Lesson 2 Lock & Unlock the Tablet

Lock/Unlock Tablet between Member Visits

Between member visits you must properly lock your tablet, in order to secure member data.

To lock & unlock your tablet

1. To perform the **CTRL+ALT+DEL** command, first press and hold the **Home/Windows** button with one hand. Then while holding the **Home/Windows** button, slide the **Power** switch briefly with your other hand, (see Figure 2.1).



Figure 2.1. CTRL+ALT+DEL Tablet Command

2. A list of functional options display. Select the **Lock this computer** button.

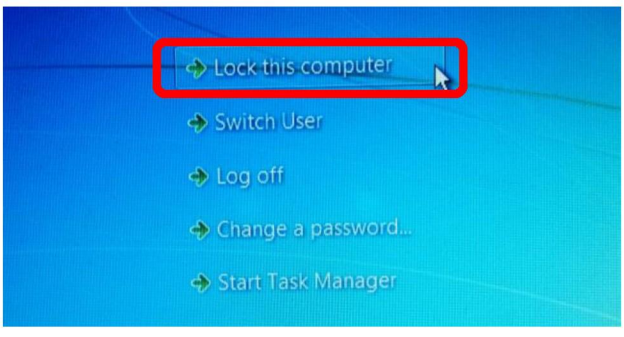

Figure 2.2. Function Options Window

3. The tablet will lock and the CTRL+ALT+DEL screen will display.
4. To unlock your tablet, perform the **CTRL+ALT+DEL** command and then enter your Tablet password in the password field and click the blue arrow to unlock.

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Lesson 3 Change Tablet Orientation

There are two orientations when using the tablet; Portrait and Landscape (see Figure 3.1). When you first eject the tablet screen from the keyboard, the screen orientation will **NOT** auto rotate to Portrait Orientation. The screen will auto-rotate to Portrait when you log into eHouseCalls. You will however, have the ability to toggle back and forth between Landscape and Portrait and document the assessment in either orientation. If the assessment is documented in Landscape, you must use the scroll bars to access all sections of each page.



Figure 3.1. Landscape Orientation (Left) & Portrait Orientation (Right)

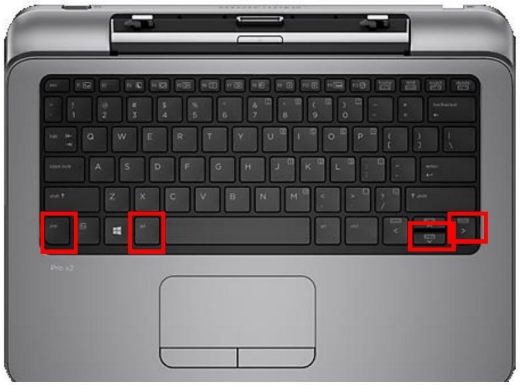
To toggle between Landscape and Portrait Orientation

To manually rotate/toggle your screen between Landscape and Portrait Orientation, click the following keys on your physical keyboard or black on-screen tablet keyboard:

Landscape Mode: CTRL + ALT + ←

or

Portrait Mode: CTRL + ALT + ↑



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To document assessment docked to the keyboard (landscape view)

To document the assessment in landscape orientation you must auto-hide the windows start menu toolbar, in order to enable all buttons and tools visibility within the assessment.

To Auto-Hide the Windows Start Menu Toolbar

1. Right-click anywhere within the Windows Start Menu Toolbar, a pop-window will appear.

2. From the pop-up window, select the ***Properties*** option, (see Figure 3.2). The Taskbar and Start Menu Properties window will appear.

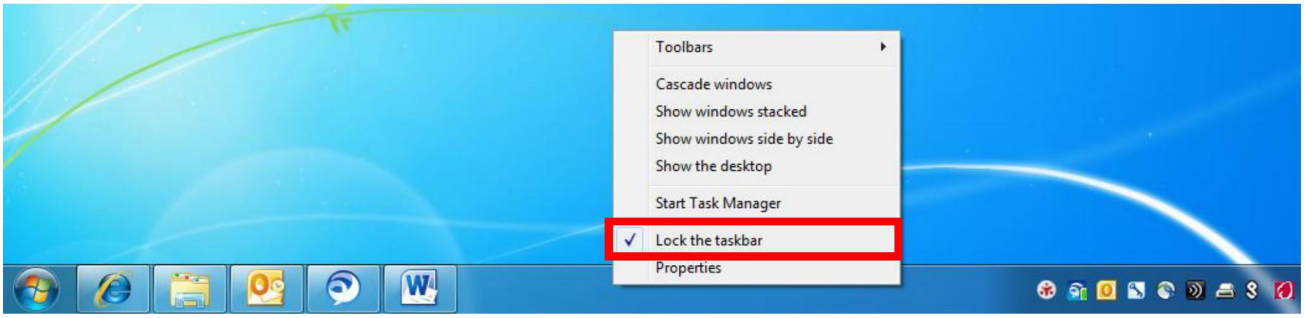

Figure 3.2. Window Start Menu Toolbar Pop-Up Window – Properties

3. From the Taskbar and Start Menu Properties window, select the ***Taskbar*** tab (see Figure 3.3).

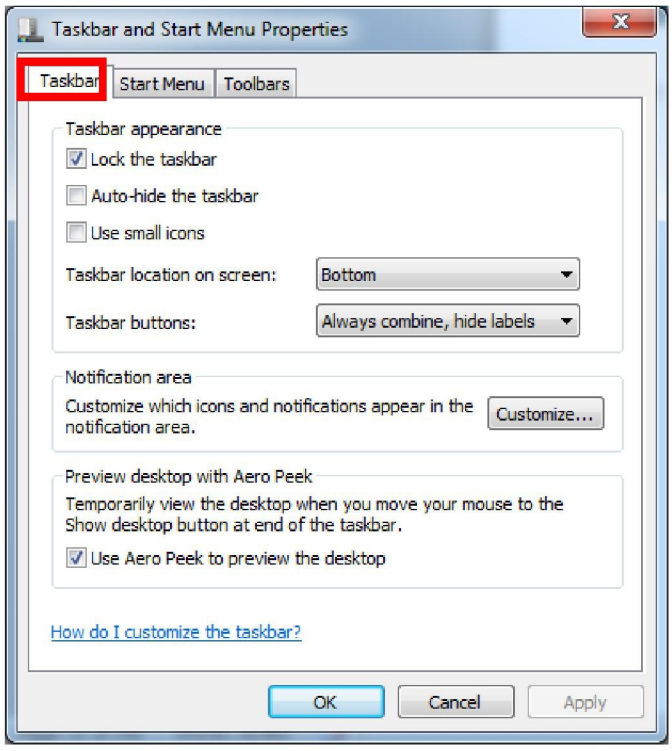

Figure 3.3. Taskbar and Start Menu Properties Window

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4. From the Taskbar tab select the ***Auto-hide the taskbar*** checkbox, then Click **OK**, (see Figure 3.4). This will hide the taskbar, enabling full visibility of the eHouseCalls Assessment.

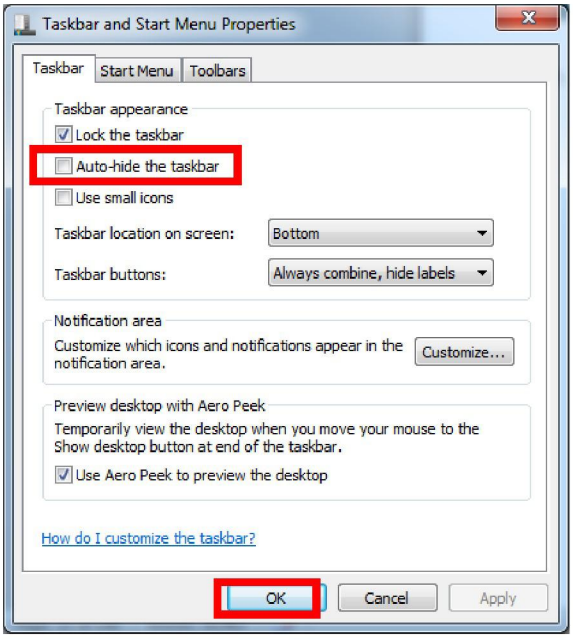

Figure 3.4. Auto-hide the Taskbar Checkbox

5. To move the taskbar to the right side of your screen, from the Taskbar Tab select the ***Taskbar location on screen*** drop-down list and select ***Right,*** and then click OK, (see Figure 3.5). This will move the taskbar to the right of your screen, rather than hiding the taskbar.

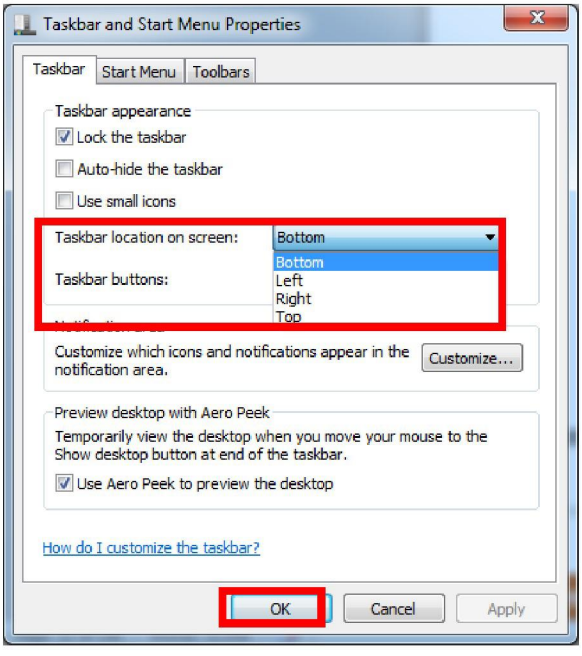

Figure 3.5. Taskbar Location on Screen Option (Right)

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Lesson 4 Change MS Password

Changing your MS Password

You are required to change your tablet password every 90 days, to ensure the security of member data. When your MS password is 21 days from expiring, you will begin to receive pop-up notifications. Always change your password using the process below.

Prior to changing your MS Domain ID Password:

- Shut down your company email/outlook webmail, if applicable
- If you have a company phone, shut the phone down
- You MUST be connected to CIPP (**Yes Yes**), see section, "Verifying Connectivity Status".
- Passwords cannot contain your name

Password requirements:

- Must be at least 8 characters
- Must contain at least one upper-case letter
- Must contain at least one lower-case letter
- Must contain at least one number
- Cannot repeat the last 10 passwords

To change your MS Password

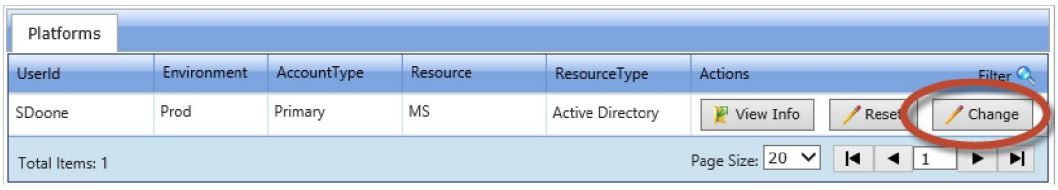
1. Log in to eHouseCalls and verify that your connectivity on the **Synchronization Status** screen indicates a ***Yes Yes*** status.

2. Click Close to exit the Synchronization Status screen

3. Navigate to the ***Secure*** application via your web browser: https://secure.uhc.com.
   If you click **Yes** from the pop-up notifications, you will be automatically redirected to Secure.

4. From the right-hand side of the screen, click **Reset Password.**

5. From the Self Service Reset Password screen, locate your UserId and click **Change.**



6. Enter your old password, and enter your new password, and then re-enter that same new password; then click **Submit**.

NOTE: Ensure that your new password adheres to the requirements listed above.

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Lesson 5 Change VPN Personal Pin

Your 8 Digit Personal PIN required for VPN login will expire annually. Always change your Personal PIN using the process below.

1. When you attempt to log into the Cisco AnyConnect VPN client on the day your PIN is scheduled to expire, you will be prompted with a screen that "Login failed," (see Figure 5.1).

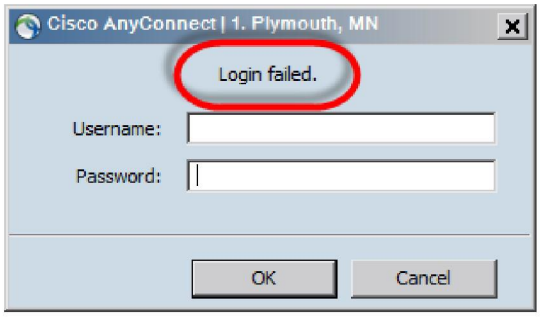

Figure 5.1. Login Failed Prompt

2. To set your new 8 digit Personal PIN, attempt to log in again. This time, **only input** the 6 digits on your token. **DO NOT** enter your old PIN. If done correctly, you will be prompted to "Enter a new PIN having 8 digits," (see Figure 5.2). If done incorrectly, the same step process below can be followed, but you will be prompted with an RSA SecurID, as shown below.

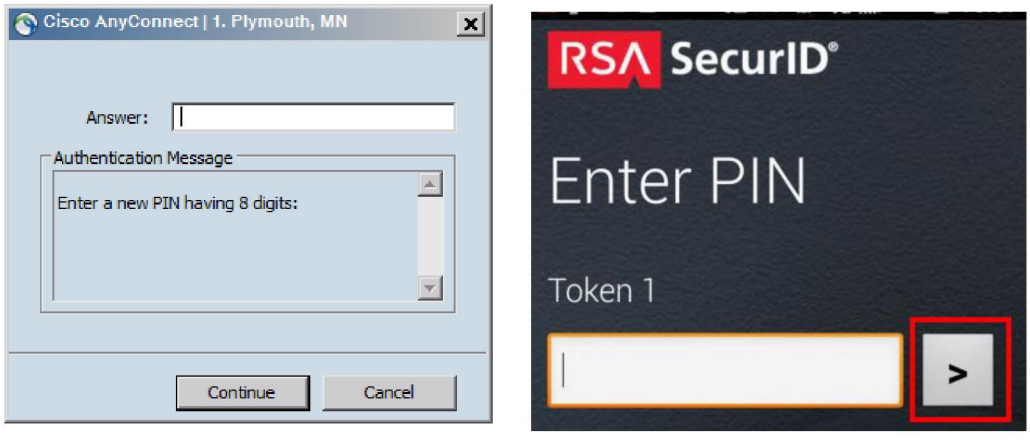

Figure 5.2. Enter a New Personal PIN and RSA SecurID Windows

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3. Select a new PIN following the requirements listed below and enter in the Answer field provided, as shown in Figure 5.2, and click **Continue**.

   Your new PIN must meet the following requirements:

   - Exactly 8 characters long
   - Can only be numbers (no leading zeros)
   - Cannot duplicate a previous PIN number
   - Must be non-sequential (ex. 12345678) and non-repeating (ex. 88888888)

4. Re-enter your new PIN again and click **Continue,** (see Figure 5.3). Remember to only enter the new PIN itself; **DO NOT** include your token numbers at this point.

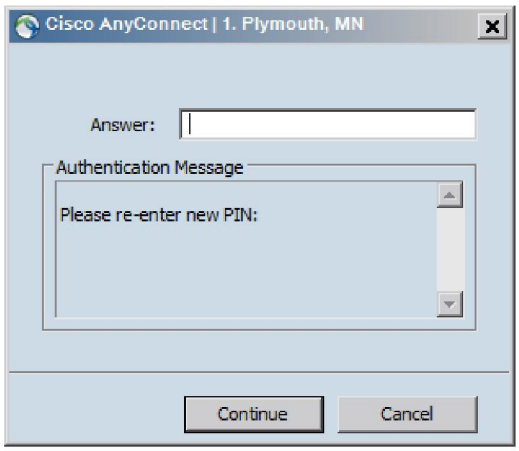

Figure 5.3. Re-Enter New PIN Window

5. If Cisco AnyConnect accepts your new PIN, you will see a message stating "PIN Accepted," (see Figure 5.4). If you have a hard token, wait for the numbers to change, and then log in as you normally would with your new **8 Digit Personal PIN + 6 Digit RSA Token Code.**

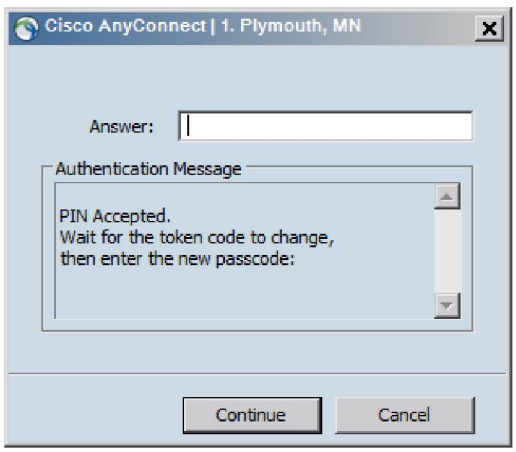

Figure 5.4. PIN Accepted Window

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Lesson 6 The Dashboard

Dashboard Overview

Once you have successfully logged into eHouseCalls, the dashboard displays. The Dashboard is where you document member information for your scheduled members, past appointments, and access your in-progress assessments. In addition, you will have access to Reference Documents, Blank Assessments for unscheduled members, and be able to verify connectivity status and synchronize member data.

NOTE: A notification will appear at the top of the dashboard notifying you if a version update is available for eHouseCalls software. For more information on how to upgrade, (see section "Upgrade the eHouseCalls Application").

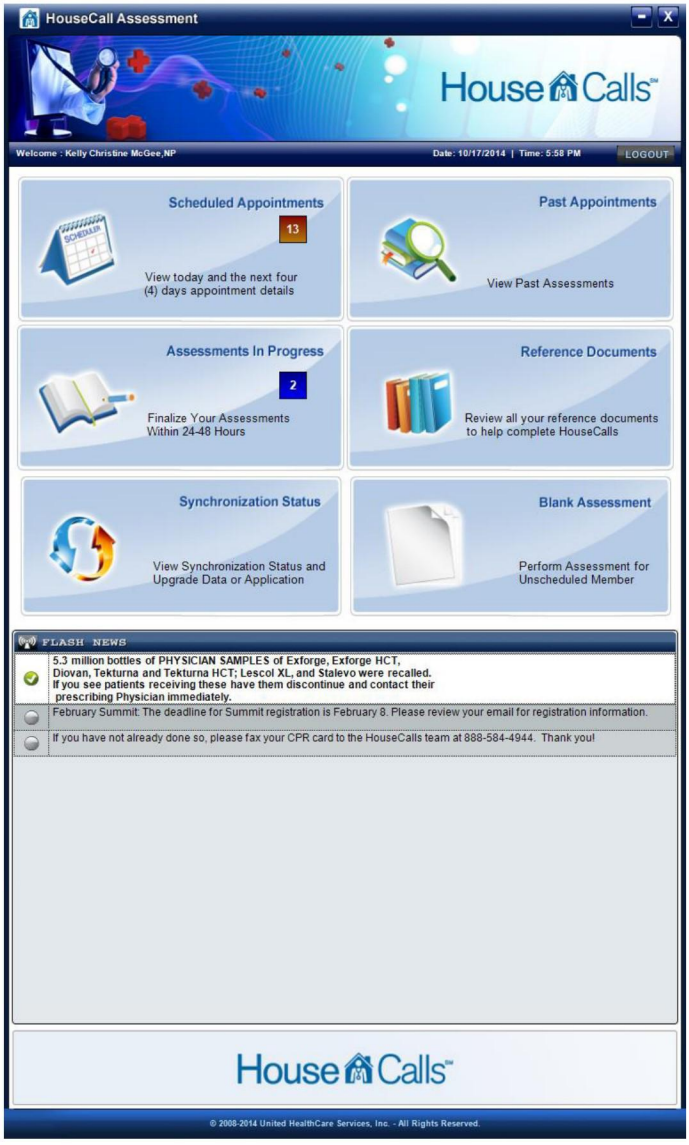

Figure 6.1. The Dashboard

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Scheduled Appointments

Shows all scheduled appointments for the current day and the next four work days (5 business days). This option is used to open a member's scheduled appointment and prepopulated assessment. This is the screen you will select when you are in a member's home. The numbers in the box indicate the number of assessments in that bucket.

Located at the top of the Scheduled Appointments page are navigation/filter buttons to display **All Appointments, Today's Appointments,** or **Tomorrow's Appointments.** There are also search fields (date range and current status) to filter to desired member details.

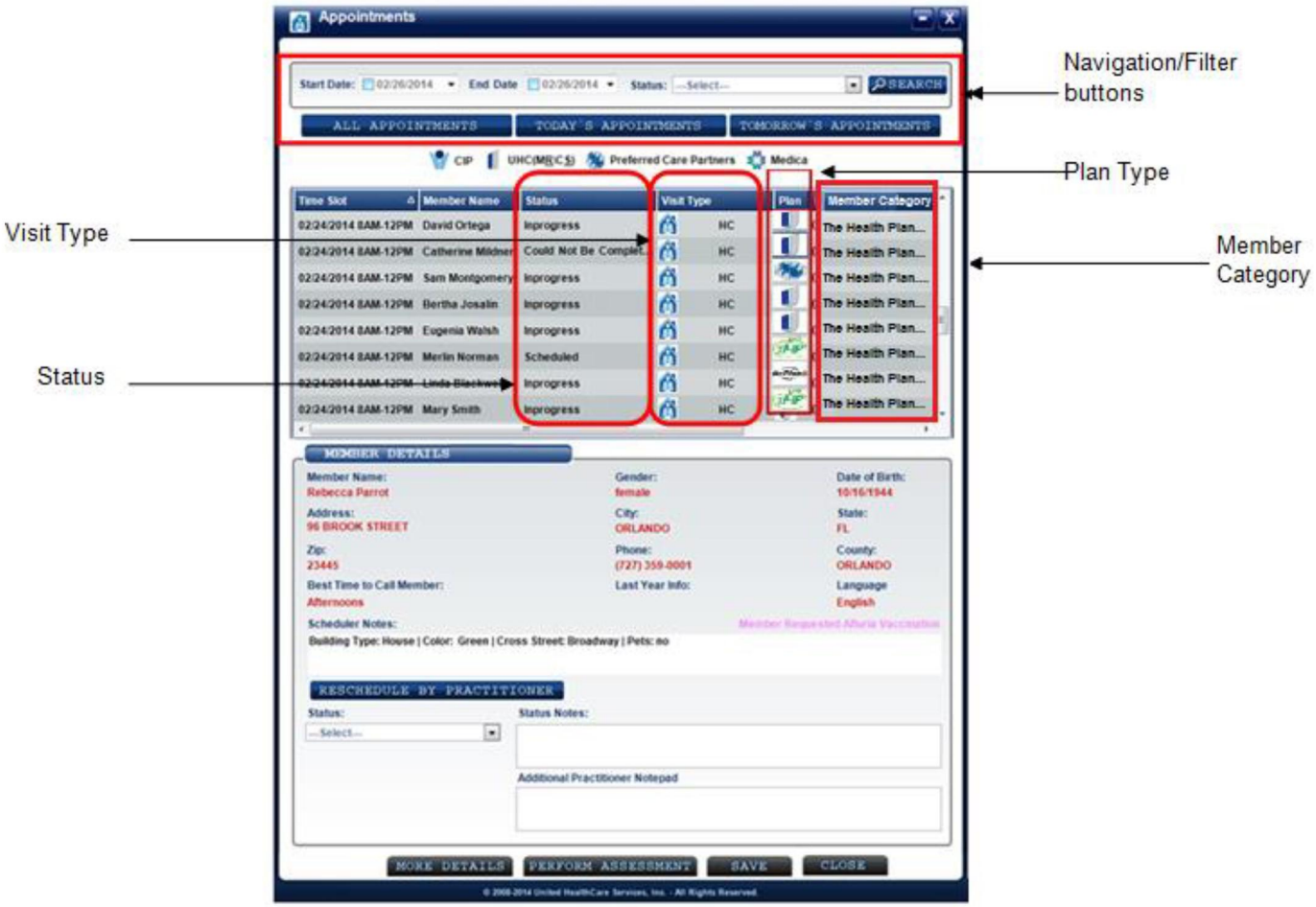

Figure 6.2. Scheduled Appointments Screen

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Table 6.1 indicates important fields in the Scheduled Appointments Screen that help to navigate, filter, and identify desired member details.

Table 6.1. Scheduled Appointments Fields

<table>
<tr><th>Field</th><th>Description</th></tr>
<tr><td>Time Slot</td><td>Indicates the block of time and data of a scheduled appointment.</td></tr>
<tr><td>Member Name</td><td>Indicates the name of the member you will be performing the visit with.</td></tr>
<tr><td>Phone</td><td>Indicates the phone number we have on file for the member. Note that this may not be the same phone number you use to contact the member in regards to their HouseCalls visit.</td></tr>
<tr><td>Status</td><td>Indicates the current status of the assessment.
<table>
<tr><th>Status</th><th>Description</th></tr>
<tr><td>Scheduled</td><td>Indicates a member has been scheduled, but the assessment has not been started.</td></tr>
<tr><td>In Progress</td><td>Indicates that you started the assessment but have not completed the visit, finalized the assessment, or indicated you could not complete the visit.</td></tr>
<tr><td>Completed</td><td>Indicates a completed visit at the member's house. Completed status is not the same as finalizing the assessment. Checking the Completed Visit checkbox means the follow-up survey for that member can be scheduled.</td></tr>
<tr><td>Documentation Finalized</td><td>Indicates the documentation has been finalized and Optum can QA the finalized assessments that are transmitted to us. You cannot make edits to assessments once they have been finalized, but you may view them in read-only mode.</td></tr>
<tr><td>Could Not Be Completed</td><td>Indicates that you started the assessment, but were unable to complete it. When you select this status, you do not need to mark Assessment Finalized. You will need to document a Reason as to why the assessment wasn't completed. You cannot make changes to an assessment in "Could not be Completed" status.</td></tr>
</table>
</td></tr>
<tr><td>Visit Type</td><td>Provides additional details about the visit including; whether the member needs an interpreter/translator, requires a PAD Screening, LAB tests such as FOBT or A1C, and/or members identified as a Post Discharge Visit (PDV).</td></tr>
<tr><td>Plan</td><td>Indicates the member's health plan. Member health plans include Care Improvement Plus (CIP), UnitedHealthcare (UHC), Preferred Care Partners (PCP), and Medica.</td></tr>
<tr><td>Member Category</td><td>Indicates different clients for the member.</td></tr>
<tr><td>Member ID</td><td>Unique HouseCalls Member ID number assigned to the member.</td></tr>
<tr><td>City</td><td>Indicates the city where the member resides.</td></tr>
<tr><td>Zip Code</td><td>Indicates the zip code where the member resides.</td></tr>
</table>

Member Details

The member details section includes additional details and is your second visual cue that you have successfully selected the right member's name/assessment. This section will include details including: member's address, phone number, last visit date (if they've had a previous Housecalls visit), and a small subset of scheduler notes. There will be a larger, more detailed list of scheduler notes available to you in the Practitioner portal and the CT will speak to this when they go over the Portal with you.

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Reschedule By Practitioner

Located at the bottom of the Scheduled Appointments grid is a blue “Reschedule by Practitioner” button. This is utilized in instances where you possibly arrive at a member’s home and discover they are not there, or you may not be able to find a member’s home, and etc. If a member is not home or you cannot locate a member, you are required to contact the Practitioner Helpdesk to advise, and allow them to attempt to reach the member before continuing on with your scheduled work day. You must notate that you contacted the Helpdesk in the notes section.

Request Do Not Visit

The Request Do Not Visit button is enabled for appointment in a “Scheduled” or “In Progress” status, and is used for instances where you feel unsafe or uncomfortable to perform a HouseCalls Visit and do not wish to be rescheduled with that member. If a Do Not Visit request was previously selected, the “Requested for DNV” text will be displayed in red next to the button.

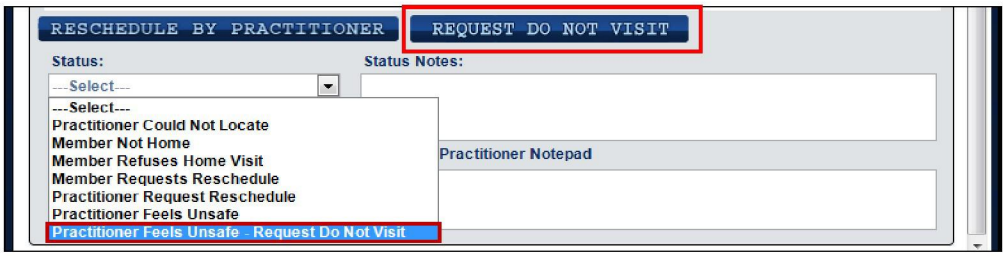

Figure 6.3. Practitioner Feels Unsafe – Request Do Not Visit

When you select the “Practitioner Feels Unsafe – Request Do Not Visit” option from the Status drop-down list, a **Do Not Visit** pop-up window will open. All fields in the Do Not Visit window are mandatory except Address Line 2. If any field is not entered, an alert message will display.

To Request a DNV

1. Click the **Request DNV** checkbox. The fields will become enabled.
2. Select Reason, Input Address (Address Line 1, City, State, Zip Code), and provide an explanation for the request.
3. Select **Save**, to submit the request. The Status in the top-right corner will update.
4. Click **Close** from the Do Not Visit pop-up window.



Figure 6.4. Do Not Visit Pop-Up Window

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Launch or Review an Assessment

To launch a scheduled appointment assessment

1. From the Dashboard, click **Scheduled Appointments**.
2. From the displayed window, select the desired member you want to document HouseCalls data for and click the **PERFORM ASSESSMENT** button, (see Figure 6.5).

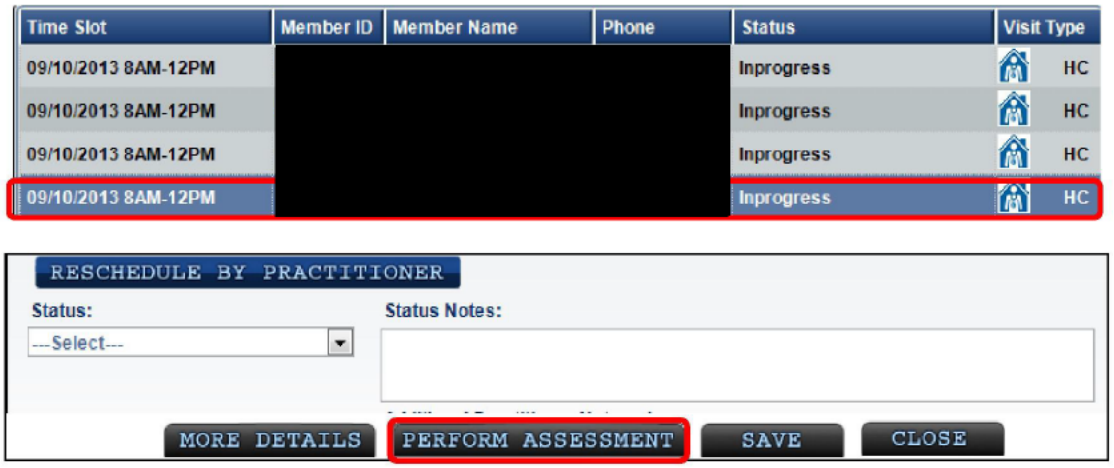

Figure 6.5. Scheduled Appointments – Perform Assessment Windows

3. From the *Member Details* box, select the **PERFORM (WITH MEMBER/UPDATE)** button, (see Figure 6.6). The member's assessment displays.

NOTE: Be sure to verify the member's DOB before moving forward with the assessment, to ensure that you are assessing the correct member.



Figure 6.6. Perform (With Member\Update) Button

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Past Appointments

Shows the last 15 days of finalized assessments. These assessments are read only and non-editable



Figure 6.7. Past Appointments

Assessments in Progress

Shows all assessments which have been started, but not finalized. Any assessments that need to be finalized can be accessed from this option. Statuses included: Completed and In Progress. A number on this bucket requires action by the practitioner within 24-48 hours.



Figure 6.8. Assessments in Progress

Reference Documents

Shows all assessments which have been started, but not finalized. Any assessments that need to be finalized can be Lists by category, all the documents in PDF format you may need for Evidence-Based Guidelines, Resource Phone Numbers and Clinical Updates. These are the same documents that are available and can be accessed from every page within the assessment. Note: These documents are available in read-only format; you cannot print from the tablet.

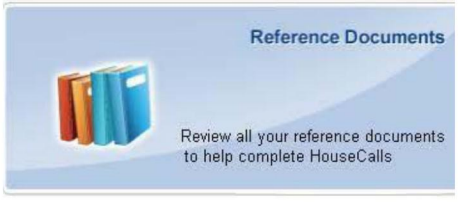

Figure 6.9. Reference Documents

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Synchronization Status

Once you have logged into eHouseCalls, it is important to verify your connectivity status to the internet or Wi-Fi network and VPN, synchronize your data, and upgrade the application (if needed). To access the *Synchronization Status* screen, click the **Synchronization Status** button on the Dashboard to perform these functions.



Figure 6.10. Synchronization Status

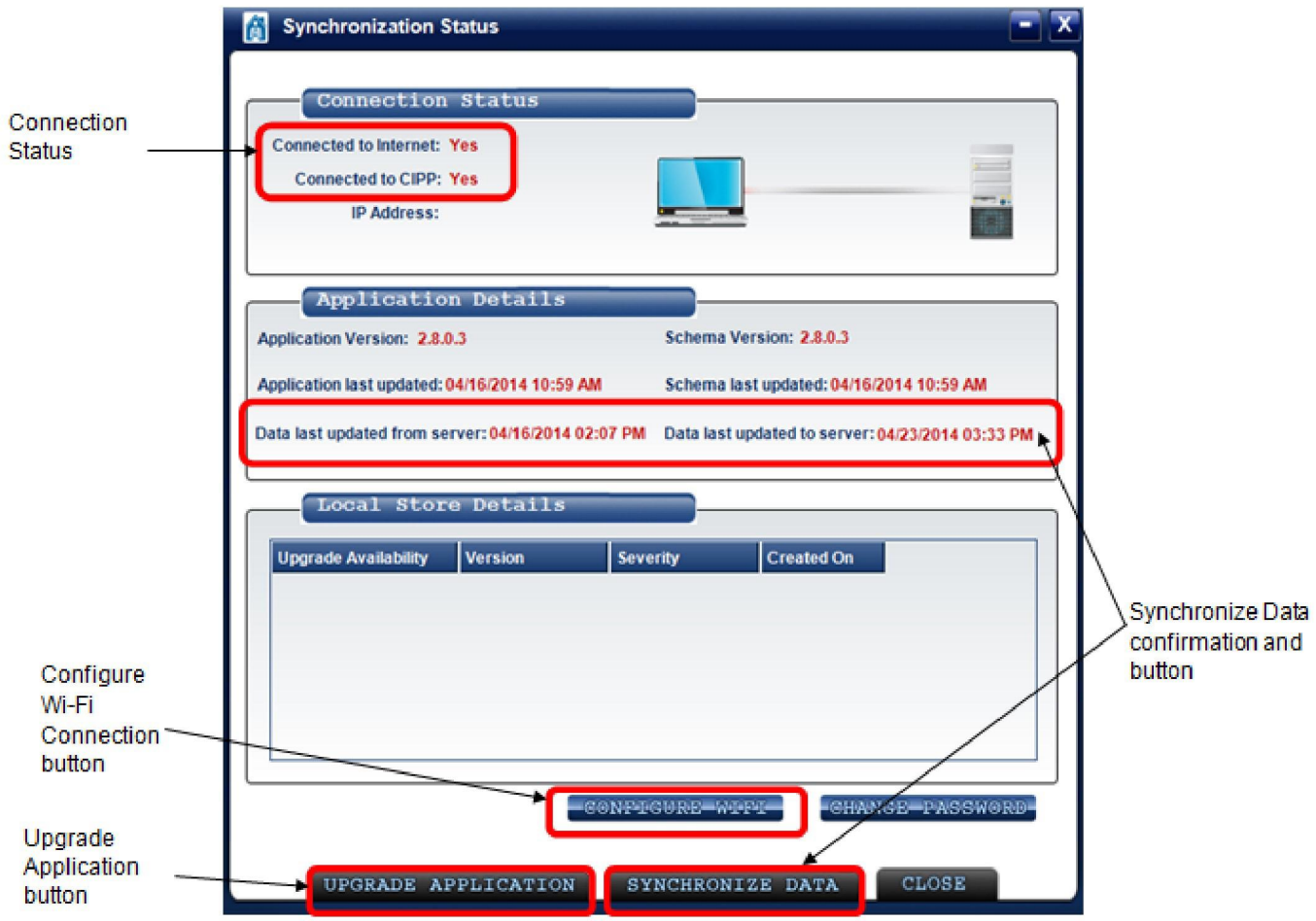

Figure 6.11. Synchronization Status Window

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Verifying Connectivity Status

Once you have logged into eHouseCalls, the first action to perform is to verify your connectivity status. When connected, a **Yes Yes** status should display. You must have **Yes** indicated for both connections so that you can transmit and receive data from the CIPP Server\VPN. This allows the scheduling data to be sent to your tablet and assessment data to be sent from your tablet.

To verify your connectivity status

1. Click on the **Synchronization Status** button on your *Dashboard*. The *Connection Status* section displays information about the status of your tablet's connection to the internet and to the CIPP server\VPN (virtual private network).

2. When connected, **Yes Yes** should display, (see Figure 6.12).

3. If either of these connections indicate **No**:

   - Reboot the computer, complete the login process, successfully reestablish an internet and VPN connection, and then try to synchronize once again.
   - Contact HouseCalls IT Support, if you are still unable to connect.

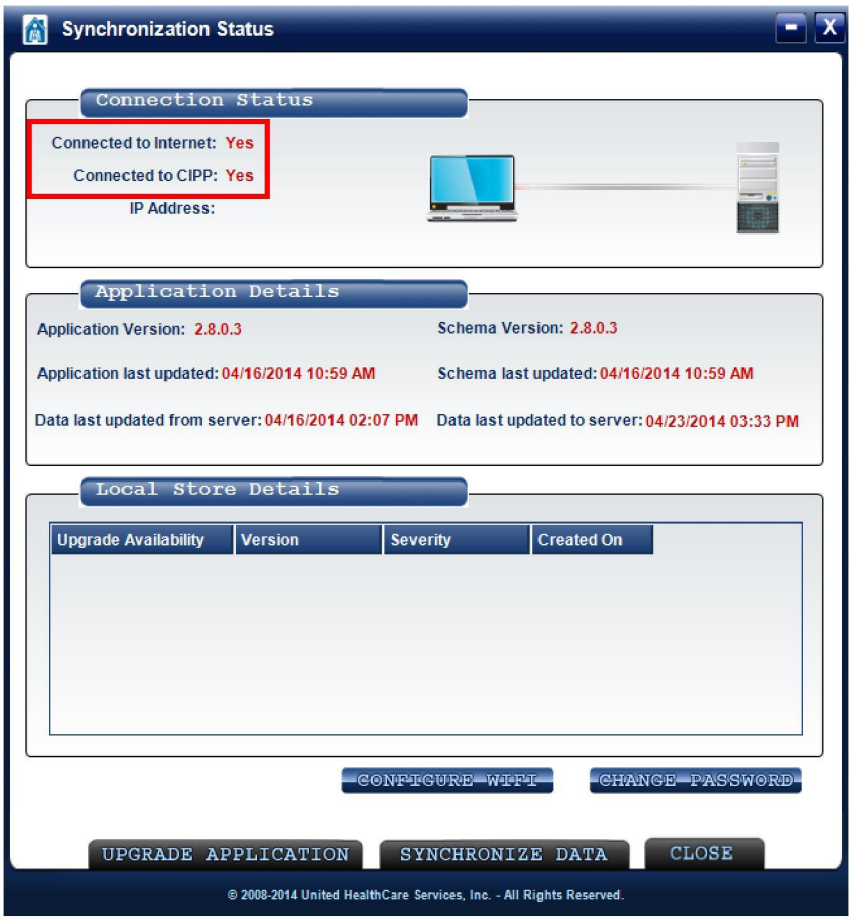

Figure 6.12. Connection Status

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Synchronizing Data

Once you have verified your connectivity status, you need to verify that you are receiving and sending data at least twice a day. To do this, you should synchronize your data once before you leave to see members and once again when you finish your assessments for the day. Additionally, you will synchronize data to see any changes to your schedule.

To synchronize your data

1. Confirm that you have a properly connected to the internet and VPN, (indicated by a **Yes Yes**) as explained in Verifying Connectivity Status section.

2. Press the **SYNCHRONIZE DATA** button, (see Figure 6.13). The dates should now display the current date/time the data was synchronized.

3. If the dates do not update, as shown in the figure below:

    - Reboot the computer and complete the login process once again.
    - If you are still unable to synchronize the data, please contact the **HouseCalls IT Support.**

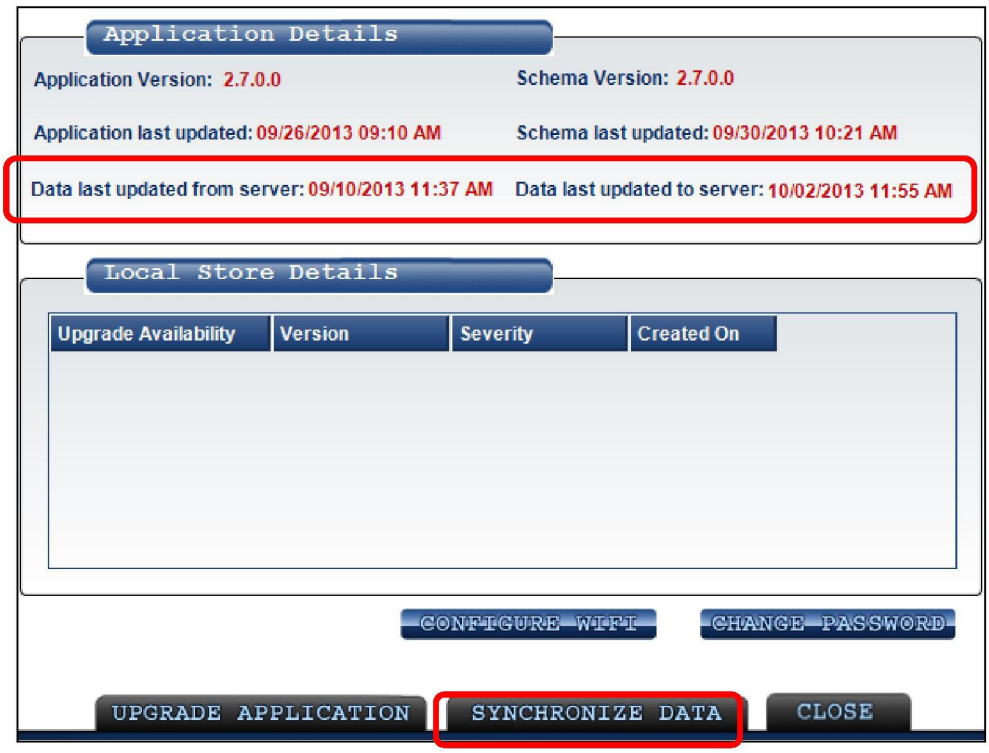

Figure 6.13. Sending and Receiving Data Button/Status

NOTE: Make sure the dates and times for Data last updated from server and Data last updated to server are updating every day you work for HouseCalls, when you are in live mode. In practice mode, only the Data last updated to server will update as you finalize practice assessments and synchronize data.

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Connecting to a Wi-Fi Network

You have the capability to connect to an alternate Wi-Fi network (e.g., your home wireless network or at a library or restaurant) from the *Synchronization Status* screen. Using an alternate Wi-Fi network will still allow you to connect to our server, in order to transmit and receive data.

To connect to an alternate Wi-Fi network

1. Click on the Configure Wi-Fi button from the Synchronization Status Screen, (see Figure 6.14). A list of available networks display in the Configure Wi-Fi Screen.



Figure 6.14. Configure Wi-Fi Button

2. From the available networks list, select the desired network and enter your password in the *Password* field if the Wi-Fi connection is password protected, (see Figure 6.15).

3. Press the **Refresh** button if you cannot see the desired Wi-Fi connection.

4. Click on **CONNECT, SAVE & CLOSE**, to connect to the desired Wi-Fi connection. Once a Wi-Fi connection is established the tablet will use this connection when it is available.



Figure 6.15. Configure Wi-Fi Screen

NOTE: By default, Keep mobile connection while configuring (Only to be checked by IT Support) checkbox remains unchecked. Never check this box unless you are on the phone with technical support and they ask you to check it.

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Upgrade the eHouseCalls Application

When there is a new version release of the eHouseCalls application, you will receive a message through the Practitioner Portal notifying you of any upcoming software updates, along with documentation detailing the software changes, and the schedule for WebEx training sessions to discuss the new release.

To perform an upgrade to the application

1. Read the Release notes before the update. Each update will have release notes to detail the changes in eHouseCalls.

2. Sign-up to attend one of the WebEx sessions; this will ensure you understand the update before the release update is pushed to your tablet.

3. When the application is ready to be released, you will receive a notification at the top of the Dashboard screen that an *Update is Available*, (see Figure 6.16).

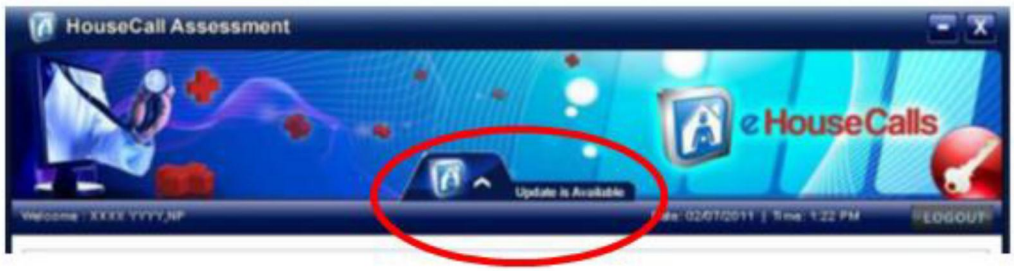

Figure 6.16. Update is Available Notification

4. Prepare to run the update on your tablet. Note that you can only update when you have an internet and VPN connection.

5. From the Dashboard, click the **Synchronization Status** button.



Figure 6.17. Synchronization Status Button

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6. From the Synchronization Status window, click the **UPGRADE APPLICATION** button, (see Figure 6.18). The application begins the update.

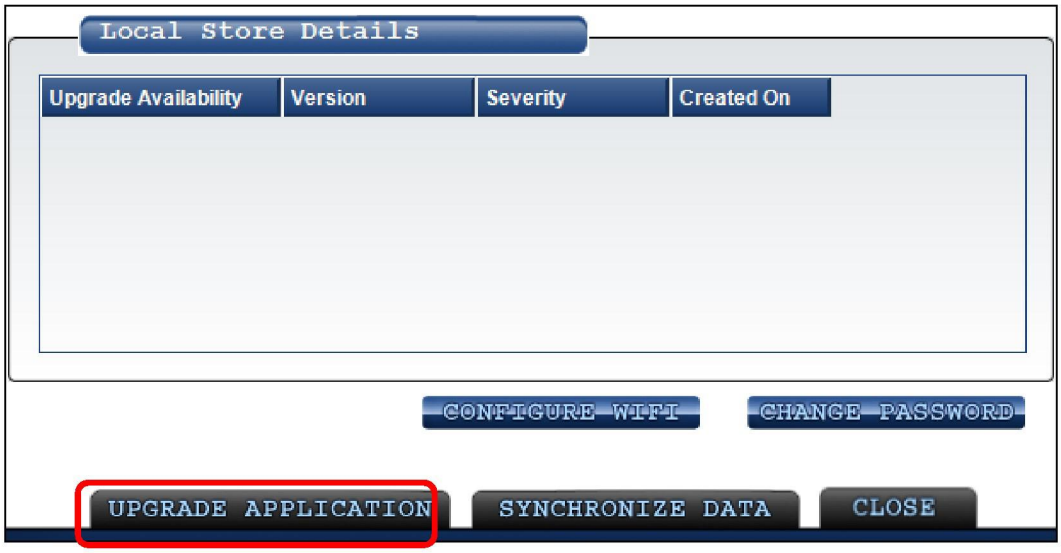

Figure 6.18. Upgrade Application Button

7. Once the application upgrade begins, the update will log you out of eHouseCalls and will prompt you to re-login to eHouseCalls.

8. To ensure comprehension of updates, use the practice assessment to familiarize yourself with the changes before performing an assessment with a member.

NOTE: The current version of eHouseCalls Training Manual will be available from the Reference Documents button on the tablet and available on the Practitioner Portal, by logging in and clicking on Technical Guides under Reference Documents on the Home page.

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Blank Assessment

This option is used to complete a blank assessment for a member who is not on your schedule. Also where you can access a practice assessment, to familiarize yourself with software upgrades.



FIGURE 6.19. BLANK ASSESSMENT

Blank Assessment (i.e. Member not on schedule)

If you have a member who would like to have a HouseCalls assessment performed, and that member is not on your schedule, you can complete a blank assessment in the tablet.

NOTE: You need to carry 8-10 blank paper assessments with you to your visits in the event that your tablet malfunctions, so that you are able to complete your visits.

For members who are not on your schedule, contact the Practitioner Helpdesk to confirm that the member is participating in our health plan, is eligible for a visit, and that you can fit them into your schedule. If the member is eligible, you can enter the member data from their membership card and complete an assessment on the tablet.

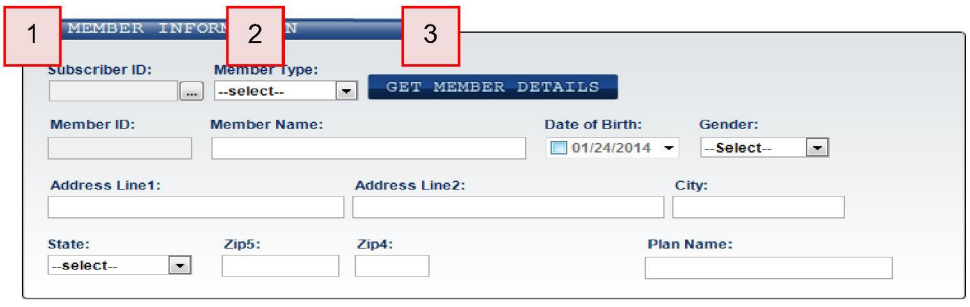

Figure 6.20. Blank Assessment

To document a blank assessment

1. From the dashboard, select **Blank Assessment.**
2. From the Blank Assessment window, enter the nine-digit ***Subscriber ID*** from the membership card in the textbox provided.
3. Select ***Member Type*** from the drop-down list.
4. Click the **GET MEMBER DETAILS** button, (see Figure 6.20).

NOTE: If there is a network connection available and communication is established with the VPN, the system will populate the demographic information for the member. If no network connection is available, the member info will not auto-populate.

5. Enter member's demographic information and Click **SAVE.** The assessment displays.

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Lesson 7 eHouseCalls Assessment Overview

Tools and Navigation

You will be required to utilize navigational tools and data-entry fields to document member information during the visits. At the top of each assessment prepopulated non-editable information is displayed including: your name, today's date, current time, the member name, member ID, member DOB, and age.

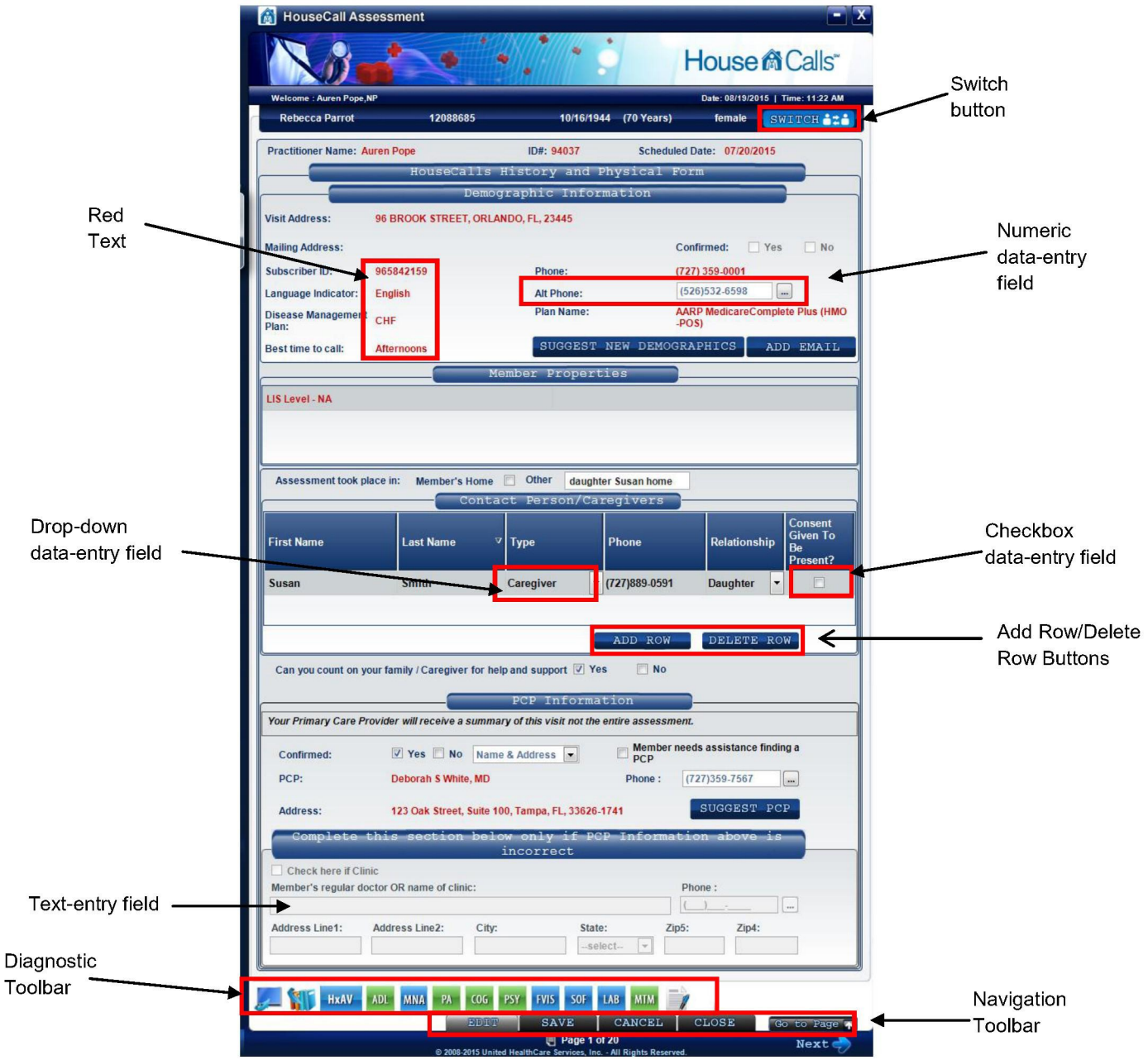

Figure 7.1. HouseCalls Assessment Layout

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Data Entry Fields

Red Text

Red Text indicates prepopulated, un-editable fields and/or mandatory fields that are required to be addressed in the assessment.

Numeric

For Numeric fields, such as Phone Numbers, the gray ellipses button is used.

To enter data via Numeric Data-Entry

1. Click on the gray ellipses button to the right of the data entry field. The keypad displays, (see Figure 7.2).



Figure 7.2. Numeric Data-Entry Fields

2. Use your stylus to input the appropriate numbers.
3. Press the **SELECT** button when finished and the number populates into the field.
4. To clear the data-entry, click the **CLEAR** button to clear the data in the field and start again
5. To cancel the data-entry, click the **CANCEL** button to cancel the request and close the pop-up box.

NOTE: The Backspace button will erase text to the left of your cursor and the Delete button will erase text to the right of your cursor. Start will move your cursor to the start of the field and End will move your cursor to the end of the text.

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Dates

When entering a date, you cannot type a date directly into the data-entry field. Dates are entered using the calendar feature.

To launch the calendar feature

1. Select the drop-down arrow next to the date field, (see Figure 7.3).

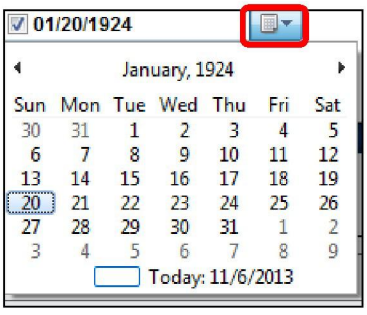
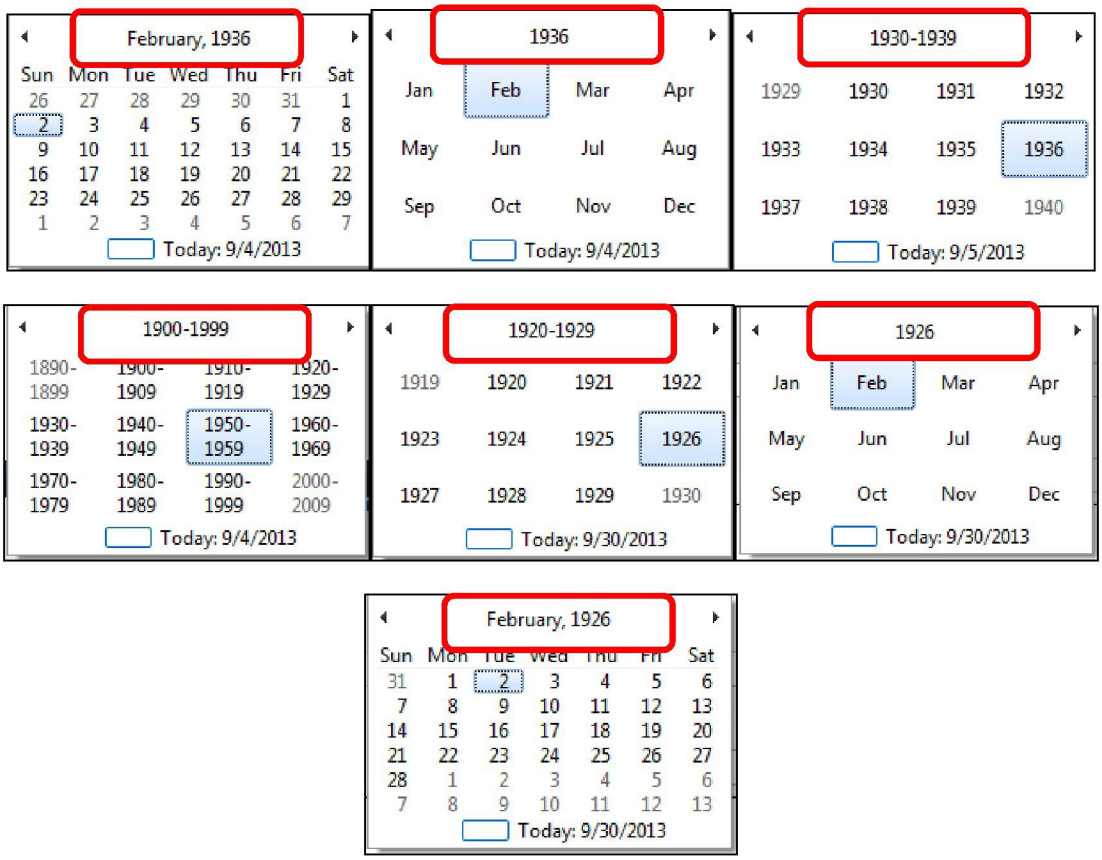


Figure 7.3. Date Field Drop-Down

2. Click on the header value between the Back and Forward arrows (i.e. February, 1936) and continue to click and drill-down the value header, until the desired date and year is displayed. The red box highlighted below indicates the location of the header (see below).
3. The member's date of birth will now be displayed in the date field (i.e. February 2, 1926).



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Text Fields – Keyboard and Handwriting Tool

Some fields require text entry. When you need to enter text, you have the option of using your keyboard or the writing tool. When your keyboard is displayed, two icons are present on the top left corner of the keyboard, (see Figure 7.4).

To use the keyboard to enter data select the **Keyboard** icon. Select the **Handwriting tool** icon to enter data using your handwriting tool. You have the ability to switch between the two tools by clicking the desired icon. Generally, whichever tool you used last will be the one to open.

If you want to move the keyboard out of the way on the screen, you can place your stylus above the numbers on your keyboard (see Figure 7.6) and drag the keyboard to a different location.



Figure 7.4. Keyboard and Handwriting Tools

NOTE: The handwriting tool also has mini-tutorials built in, where you can review how to correct, delete, split words or join letters together. Tap on the tutorial you want to review, and it will play. Tap on it again to stop playing the review, (see Figure 7.5).

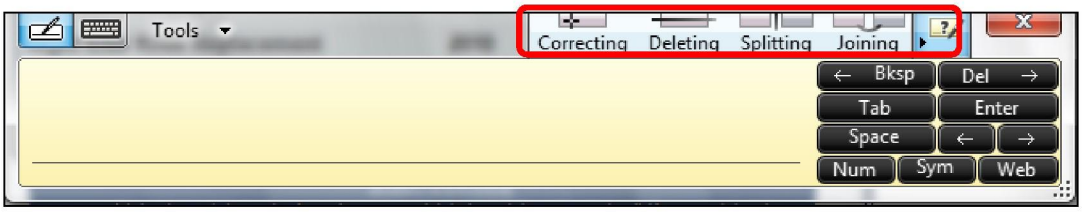

Figure 7.5. Handwriting Tool Multi-Tutorials

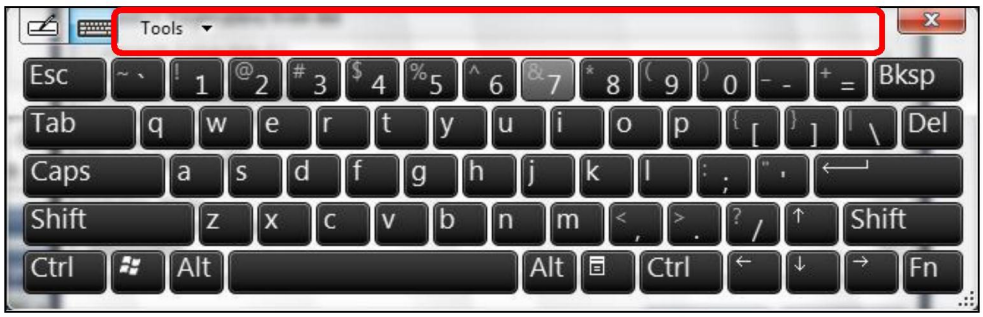

Figure 7.6. Moving Keyboard Placement

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Add Row/Delete Row

Not all sections in the assessment allow data input; some of the sections are read-only. If there is capability to enter or remove data within an assessment section, the **ADD ROW** and **DELETE ROW** buttons are enabled.

To Add/Delete Rows

1. To add a row of information, select the **ADD ROW** button, (see Figure 7.7).
2. To remove a row of data, highlight the desired row and select the **DELETE ROW** button. If a pop-up window displays, you will need to close it before you can select the **DELETE ROW** button.

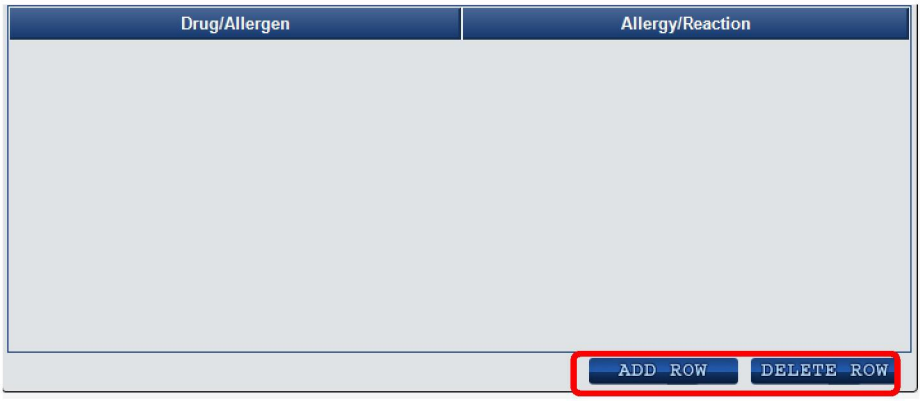

Figure 7.7. Add/Delete Row Button(s)

NOTE: You are only able to delete rows of information that you have manually entered; prepopulated rows of information cannot be deleted.

Prepopulated Drop-Down Lists/Checkboxes

There are two types of drop-down lists, single select and multi-select. You are unable to manually input data into a prepopulated drop-down list. If you have selected a value in error, deselect the option by unchecking the selected box and choose another option.



Figure 7.8. Drop-Down Lists/Checkboxes

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Using Your Stylus Pen

When using your stylus to make some selections, for example, the **SAVE** button, you will see a white hand pointer when your stylus is over the button. If you do not see this symbol, then your stylus is not over the button.

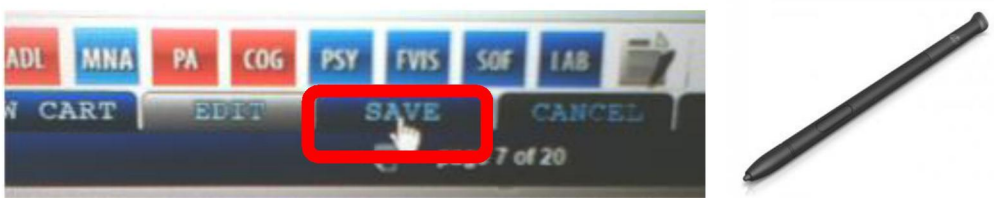

Figure 7.9. Save Button and Stylus Pen

NOTE: Your stylus works best at a 90-degree angle to the keyboard.

Switch Button

When you have assessments for multiple members in the same household the **SWITCH** button will be enabled. When you are in the assessment for one household member, and another household member has an assessment, a **SWITCH** button will appear on the assessment screen, which enables you to switch between both household members simultaneously. To switch to another household member, click on the **SWITCH** button, (see Figure 7.10).



Figure 7.10. Switch Button

Diagnostic Toolbar

Located at the bottom of each assessment page is the Diagnostic Toolbar, (see Figure 7.11). The Diagnostic Toolbar helps to assist you in navigating within the assessment, as well as to launch the Diagnostic Tools.

Tool icons appear in blue, red or green. A blue icon indicates that the tool is optional, while a red icon indicates a mandatory requirement. Once the mandatory requirements have been addressed, the corresponding icon will turn green.



Figure 7.11. Diagnostic Toolbar

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The first three tools enable you to access additional resources without closing the assessment of the eHouseCalls application. The remaining icons are the Diagnostic Tools. Some tools are required to be completed for every member and some tools are optional. A tool can become mandatory based on your answers documented in the assessment. Table 7.1 describes the Diagnostic Toolbar icons in brief detail.

Table 7.1. Diagnostic Tools and Functions

Tool	Button Icon	Description
Show Desktop		Minimizes the eHouseCalls application and takes you to the Windows desktop without closing the assessment. To return to the form, click on the eHouseCalls icon on the taskbar at the bottom of the screen.
Reference Documents		The same group of reference documents on the dashboard.
Summary of last Annual Visit		If the member has had a previous HC visit within the last year, a high level summary of that visit is available to you with this button. This can provide helpful info regarding the member.
Star Measure Status		If the member is identified as having Star Gap Measures, only then will the STARS tool display. Each gap will have one or more action items required in order to close the gap.
ADL		Barthel Index for Activities of Daily Living
MNA		Mini-Nutrition Assessment
PA		Pain Assessment Tool
COG		Mini-Cognitive Assessment
PSY		Depression Screening Tool and PHQ9
FVIS		Flu Vaccination Information Sheet
SOF		Summary of Findings from the current year's HouseCalls Visit
LAB		Documentation for Lab Tests: Blood and FOBT
MTM		Medication Therapy Management
Assessment Notes		Enables you to enter notes regarding your visit. This section might be used to enter personal information/indicators, such as housing conditions (cross st, color, duplex, dogs, etc.)

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