SUBJECT: eCW Care Planning Module	EFFECTIVE: 2019
DEPT: MEDICAL	REVISED : 3/10/2021
APPROVED BY: HCHC Medical Director	PAGE 1 OF 19
POLICY OWNER: Director of Operations	POLICY AUTHOR: Clinical IT & Quality Coordinator

PURPOSE AND BACKGROUND

To establish a process for using the eClinicalWorks (eCW) Care Planning for Behavioral Health module to manage patients with behavioral health needs. The module allows users to enroll patients in specific health programs, assign Care Teams, identify each patient's problems, define goals and interventions, and develop care plans in collaboration with each patient to address his or her specific needs.

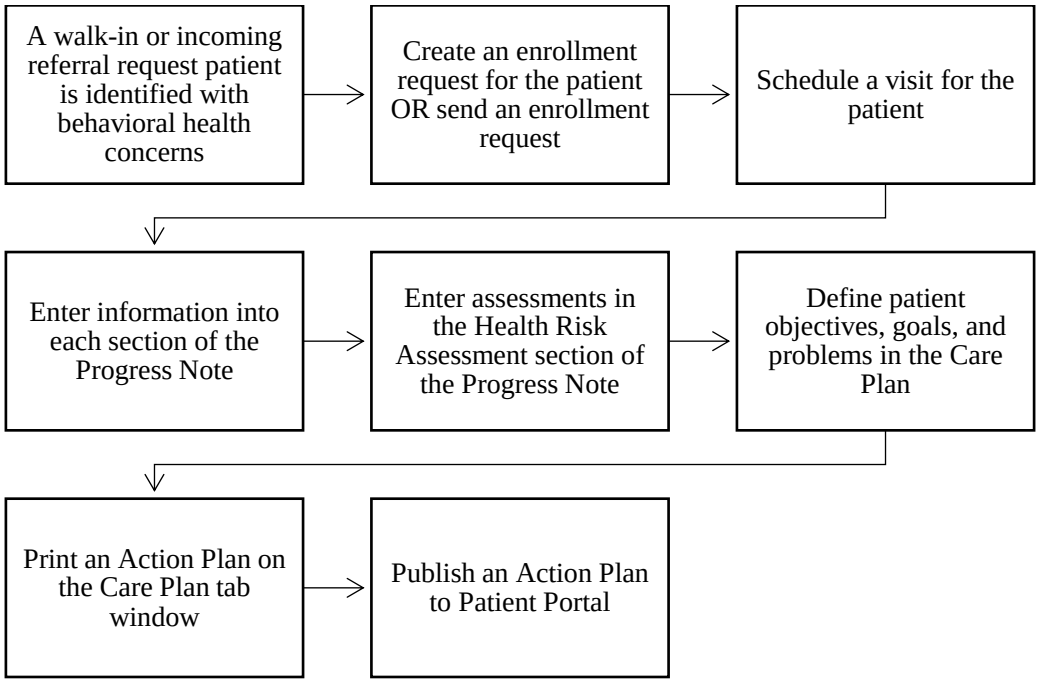
SCOPE

This protocol applies to all sites of Healthy Community Health Center (HCHC). This protocol covers the following:

1. Module Workflow Overview flowchart
2. Enrollment
3. Health Risk Assessment
4. Care Planning
5. Printing & Publishing Action Plans (detailed workflow in Appendix C)
6. Detailed workflows for new patients (Appendix A) and established patients (Appendix B)

WORKFLOW OVERVIEW

New patients start at the first box of the flowchart. Established patients (i.e. have had an initial enrollment, care plan assessment, and treatment plan completed) start at the third box.



PROCEDURE

Enrollment

The enrollment process needs to be completed for any new patient (i.e. has not had an initial enrollment, care plan assessment, and treatment plan completed). Providers and clinical staff can create an enrollment request for the patient from the Patient Hub window if the user has permission. If the user does not have permission to enroll a patient, the user can send an enrollment request through the Enroll window. During enrollment, the user will also assign a Care Team (Care Manager, Care Coordinator, Care Giver, and Provider) to the patient in the Care Team window. A detailed workflow is included in **Appendix A**.

Health Risk Assessment

When a patient presents for a behavioral health visit, a Health Risk Assessment section will show on the Progress Note. The user can add assessment information - such as the patient's barriers to compliance, living situation, and self-management ability - in the Assessment window. The patient's responses to the health risk assessment will display in the Progress Notes window. The Health Risk Assessment workflow for new patients is included in **Appendix A**, and for established patients in **Appendix B**.

Care Planning

After clicking on the Care Plan section of the Progress Note, the user can define objects, goals, and problems for the patient within the Care Plan window. Goals are general statements of what the patient wants to achieve, and objectives are the skills the patient must learn to reach the goal. The user can view an established patient's existing Care Plan Problems and work with the patient to set new goals. Additionally, the user can show the goal status by adjusting the slider tool to show the percentage of the goal completed. When a goal is completed, the user can mark the goal as *Closed* and document a reason.

When a chart contains sensitive information about a patient, the user may add a confidential note by clicking *Confidential Note*. This note will be protected by the Patient Security Access Codes (PSAC) feature which restricts access to the record.

The user will sign the care plan by clicking *Sign* on the Visit Tab. On the Print Visit window, the care plan can be locked and saved. Information entered in the Care Planning module will then display in the Progress Note for the current appointment. To view, edit, or print a care plan, the user will open the patient's PHM Hub, click on the *Care Plan* tab, and select the orange arrow which will open the options menu. A detailed workflow for creating, editing, and printing a care plan is included in **Appendix A** for new patients and **Appendix B** for established patients.

- **Reviewing Care Plans**
  A user can set up a care plan for recurrent review through the Review Set Up tab on the Problems window, in addition to assigning multiple reviewers for care plan reviews, if needed. From the Care Plan Review window, a patient can also sign his or her care plan.

Printing & Publishing Action Plans

An action plan contains a set of guidelines for a patient based on the care plan developed at the visit. The patient will typically receive a printout of the action plan at the end of the visit. The user can access the action plan from the Care Plan window by clicking on the orange arrow next to the visit and selecting *Print Action Plan* from the drop-down menu. In the Action Plan window, users can select and update item actions, and print the action plan. Action plans can be published to the Patient Portal after a care plan has been locked, if *Enable* CCMR *Action Plan on Patient Portal* is marked *Yes* in Feature Settings. A detailed workflow for creating, editing, and printing an action plan for both new and established patients is included in **Appendix C**.

REFERENCES

eCW PHM – Care Planning for Behavioral Health – V10 – Oct 2017
eCW PHM – Care Planning for Behavioral Health – V11 – May 2018
https://my.eclinicalworks.com/eCRM/jsp/knowledge-widget-docs.jsp?pgId=3&kid=1
(Population Health > Population Health Core > Care Planning for Behavioral Health)

Guide to Creating Mental Health Treatment Plans – ICANotes.com
https://www.icanotes.com/2018/08/24/guide-to-creating-mental-health-treatment-plans/

POLICY APPROVAL

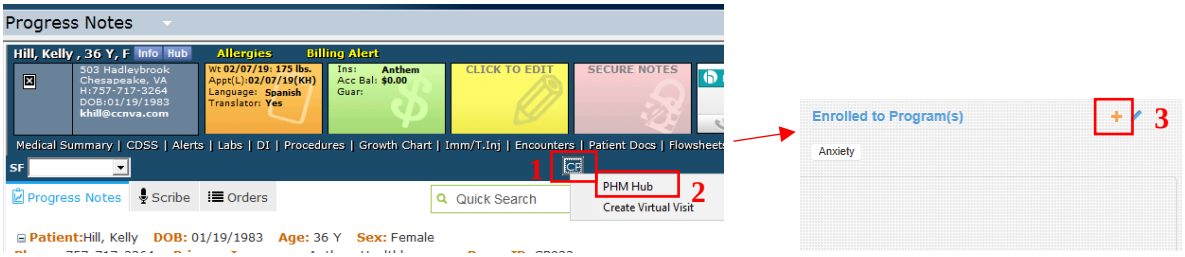
The HCHC Board of Directors designates approval authority for the development, review, and management of all clinical operational policies to the HCHC Leadership Team; including but not limited to the Executive Director, Chief Financial Officer, and/or Medical Director. Clinical operational policies may be evaluated and managed by the appropriate committee, as designated by the Executive Director; including but not limited to the Quality Improvement Committee and/or Risk and Compliance Committee.

Appendix A
BH Module New Patient Workflow

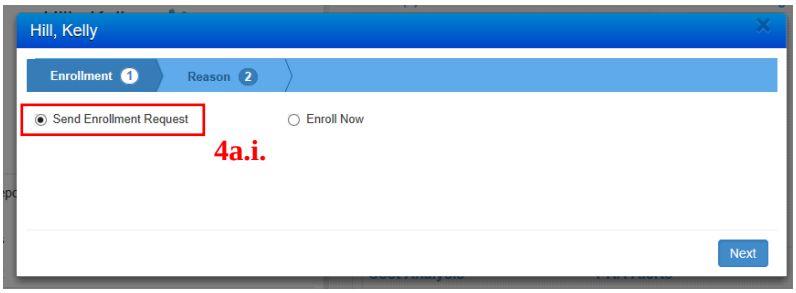
Once an appointment is on the schedule or a virtual visit has been created, the user can access the behavioral health care plan.

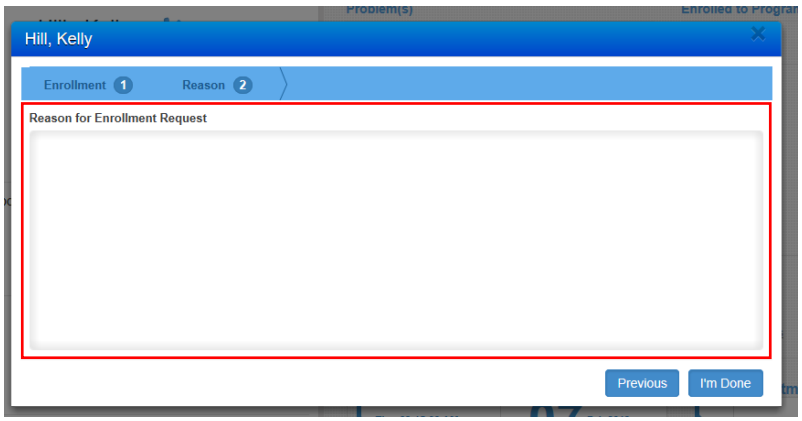
Enrollment

1. To enroll the patient, click on the orange *CP* button at the top of the Progress Note.
2. In the drop-down menu, click *PHM Hub*.
3. In the PHM Hub, click on the orange cross in the top right of the *Enrolled to Program(s)* section.

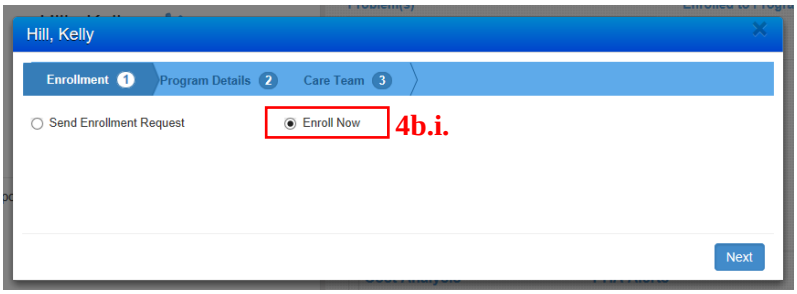


4. The *Enrollment* window appears.
    a. If the user does <u>not</u> have permission to enroll a patient, the user can send an enrollment request.
        i. Select *Send Enrollment Request* and click *Next*.
        ii. The *Reason* tab should appear.
        iii. Enter the reason for the enrollment request.
        iv. Click *I'm Done*. This sends the request.

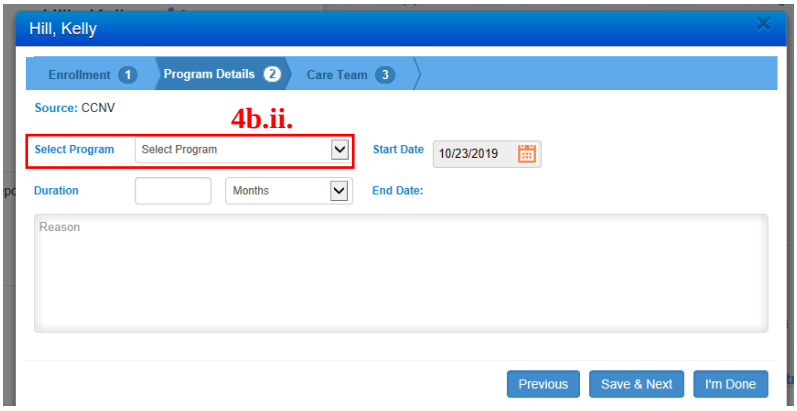




b. If the user has permission to enroll a patient, the user can enroll the patient.
   i. Select *Enroll Now* and click *Next*.

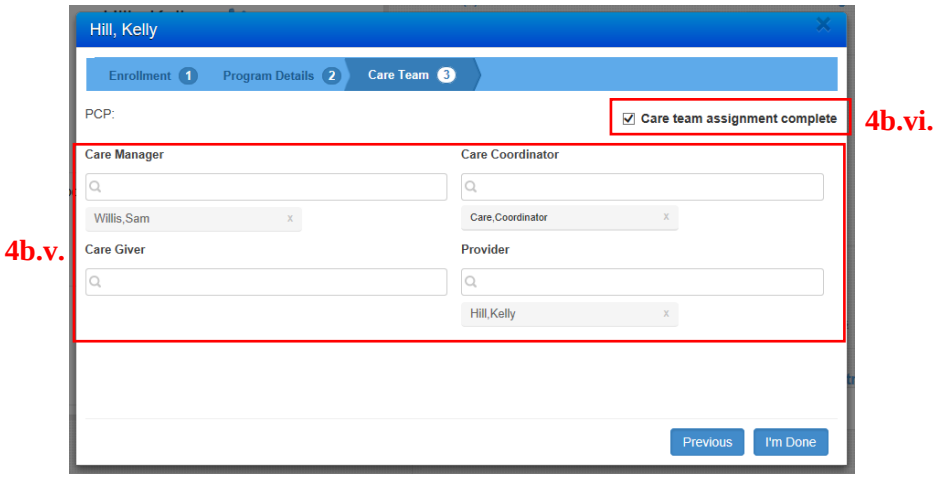


   ii. In the *Select Program* box, select the correct program from the drop-down list.
   iii. Select a duration and start date.
      1. The start date will default to today's date.
      2. The duration will calculate relative to the start date (e.g. 6 months duration will set the end date as 6 months from the start date)



   iv. Click *Save & Next*. The Care Team tab appears.

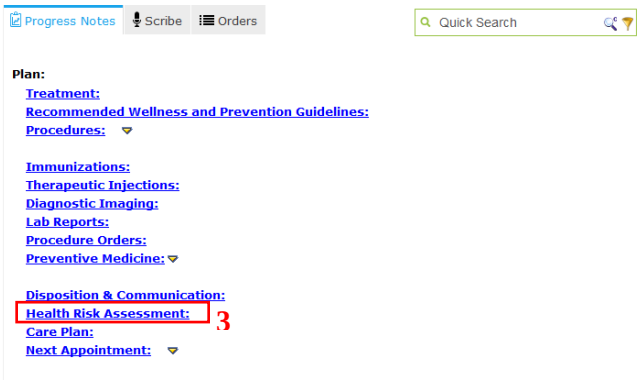
v. Enter names for Care Manager, Care Coordinator, Care Giver, and Provider and select from the drop-down list.
vi. When finished, check the box next to *Care team assignment complete*.
vii. Click *I'm Done* when finished to save the enrollment. The patient is now enrolled.



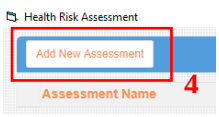
5. Verify in the *Enrolled to Program(s)* section that the patient is enrolled in the behavioral health program.

Health Risk Assessment

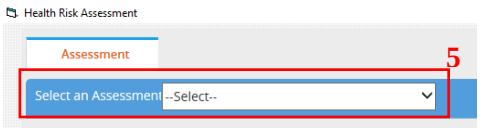
1. Open the Progress Note.
2. Scroll down to the *Plan* section of the Progress Note.
3. Click on *Health Risk Assessment*. A *Health Risk Assessment* window opens.



4. Click on the *Add New Assessment* button on the top left of the window.



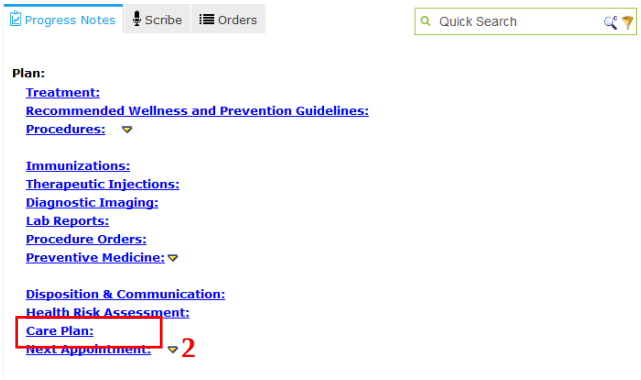
5. In the *Select an Assessment* bar, select the type of assessment to be performed from the drop-down menu.
    a. Users can build their own assessments, if needed.



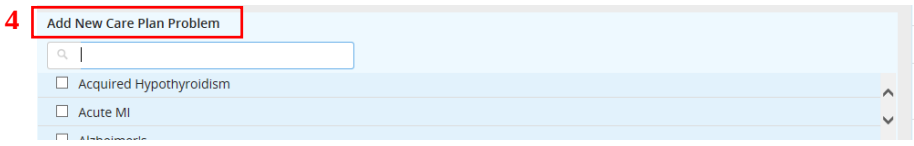
6. Complete the assessment with the patient's input.
7. When finished entering responses, review and click *Save*. The screen should return to the *Health Risk Assessment* window.
8. If needed, add another assessment.
9. After all Health Risk Assessments are completed, they will appear in the *Health Risk Assessment* section of the Progress Note.

Care Plan

1. Return to the Progress Note.
2. In the *Plan* section of the Progress Note, click on *Care Plan*.
3. The *Care Plan* window appears.



4. Because a new patient will not have any Care Plan Problems listed yet, the user must type the problem into the text box beneath *Add New Care Plan Problem* in the *Care Plan* window and select a problem.

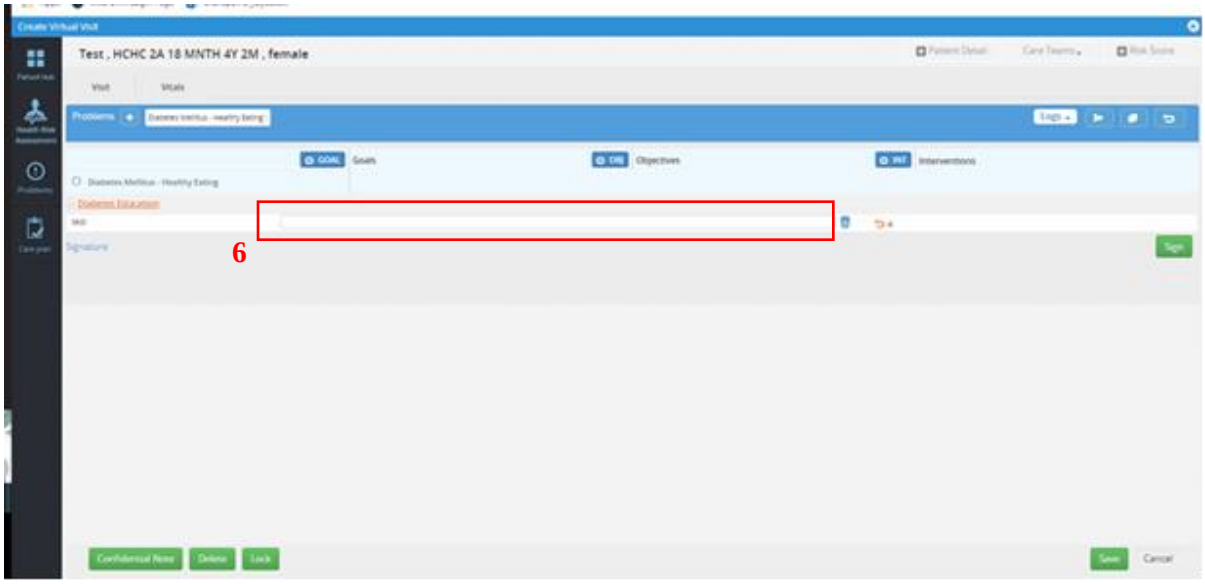


5. Click *Yes* when asked "Do you want to add problem to the patient's record?" if it is the correct problem.

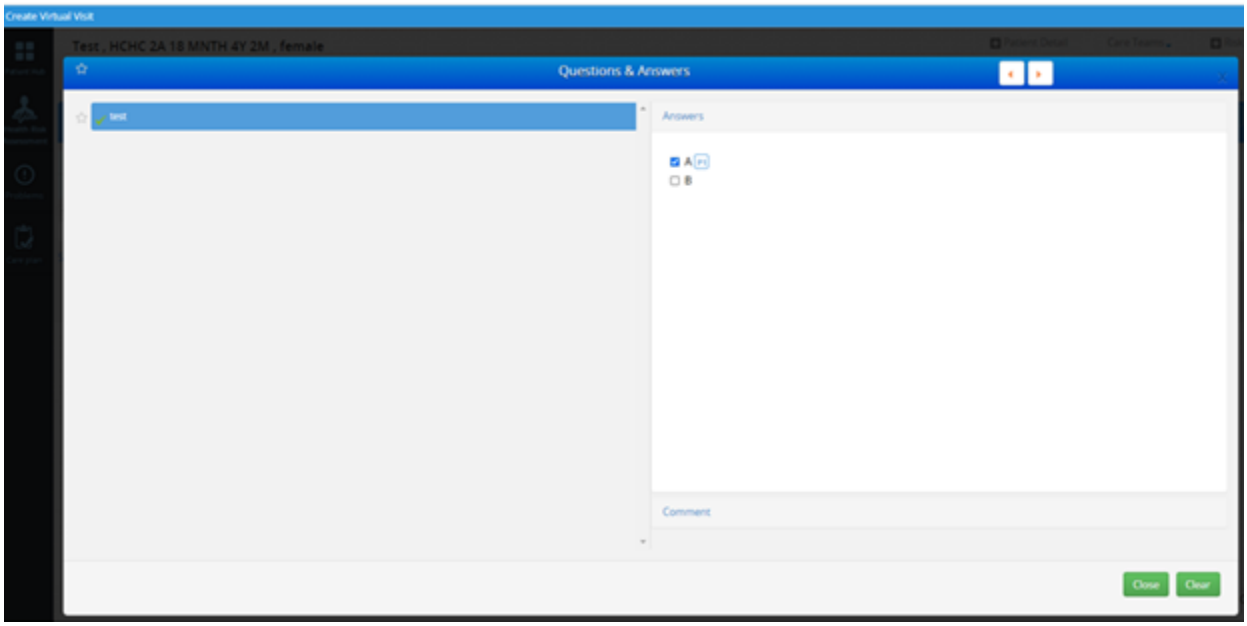
****If you want to add Goals, Objectives, and Interventions using the Care Pathways feature, continue with #6. If not, skip to #12.****

Workflow for Using the Care Pathways Feature:

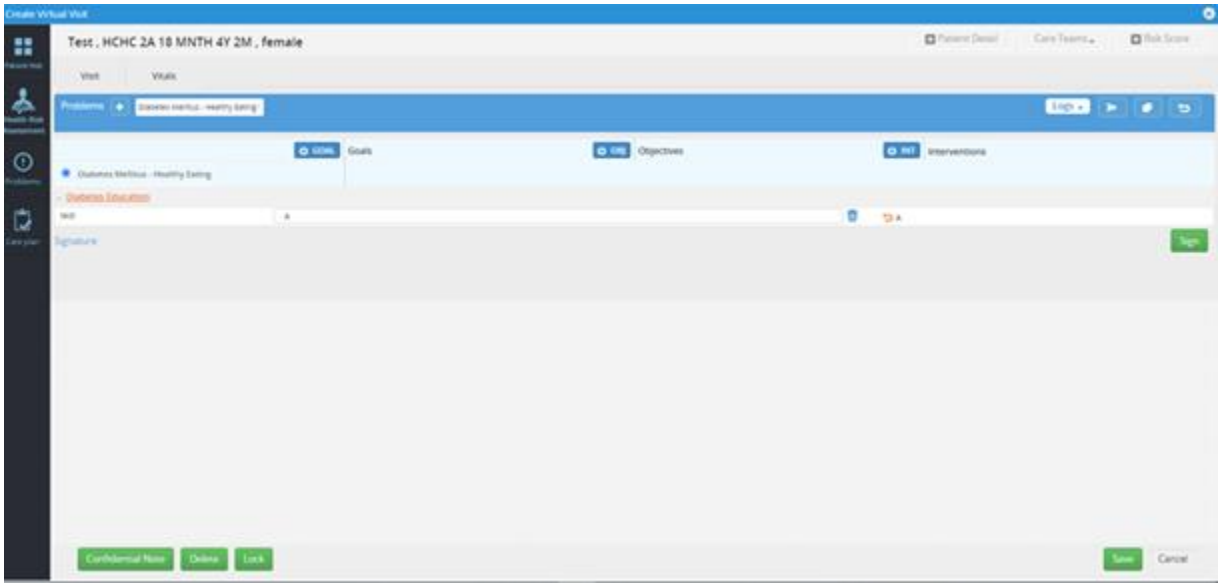
6. The *Problems* window appears. You should see a screen with the problem you just added, and a Diabetes Education section below it (the orange word) that has a question below it. Click into the white box on the question line (to the left of the blue trash can).



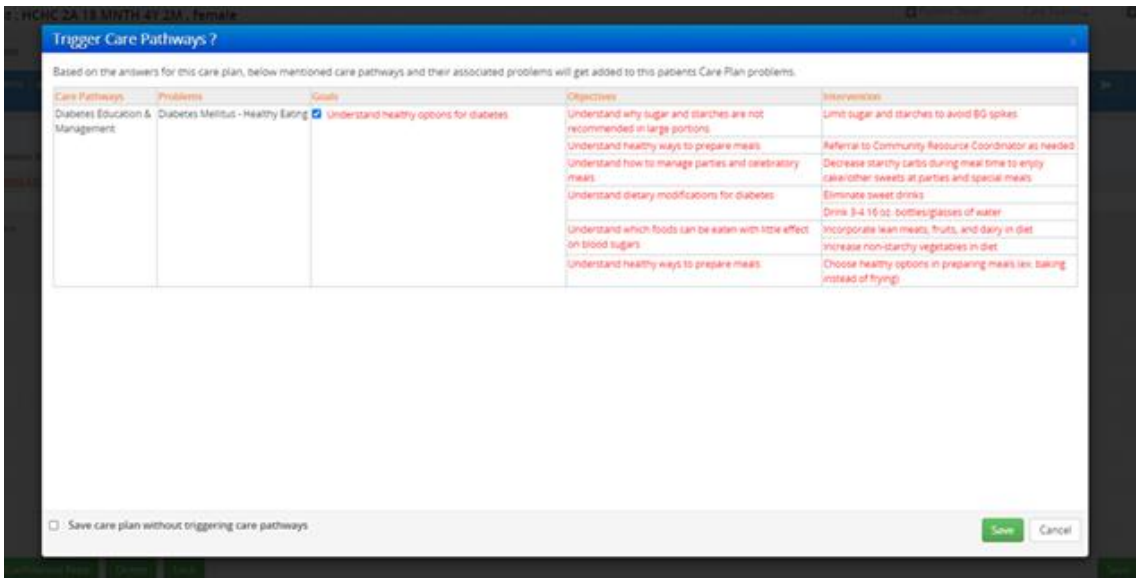
7. This opens up a Questions & Answers window. To trigger the Care Pathway for this condition, you need to provide the answer to the question that will trigger the pathway. Currently, this is the answer that has a "P" in a box beside it. Check the box next to this answer, and click the green "Close" button at the bottom of the window.



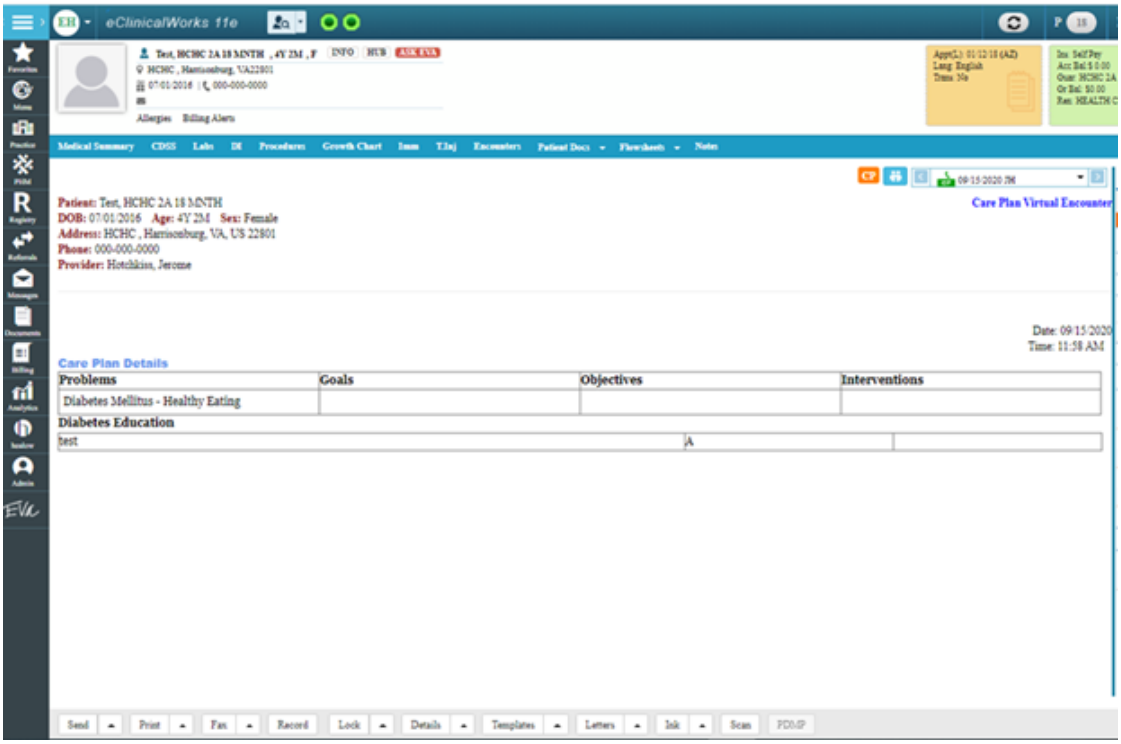
8. When you close the Questions & Answers window, it should take you back to the Care Plan section of the module. You will see your problem listed and the "Yes" answer to the question. Click the green "Save" button at the bottom right to confirm the care pathway.



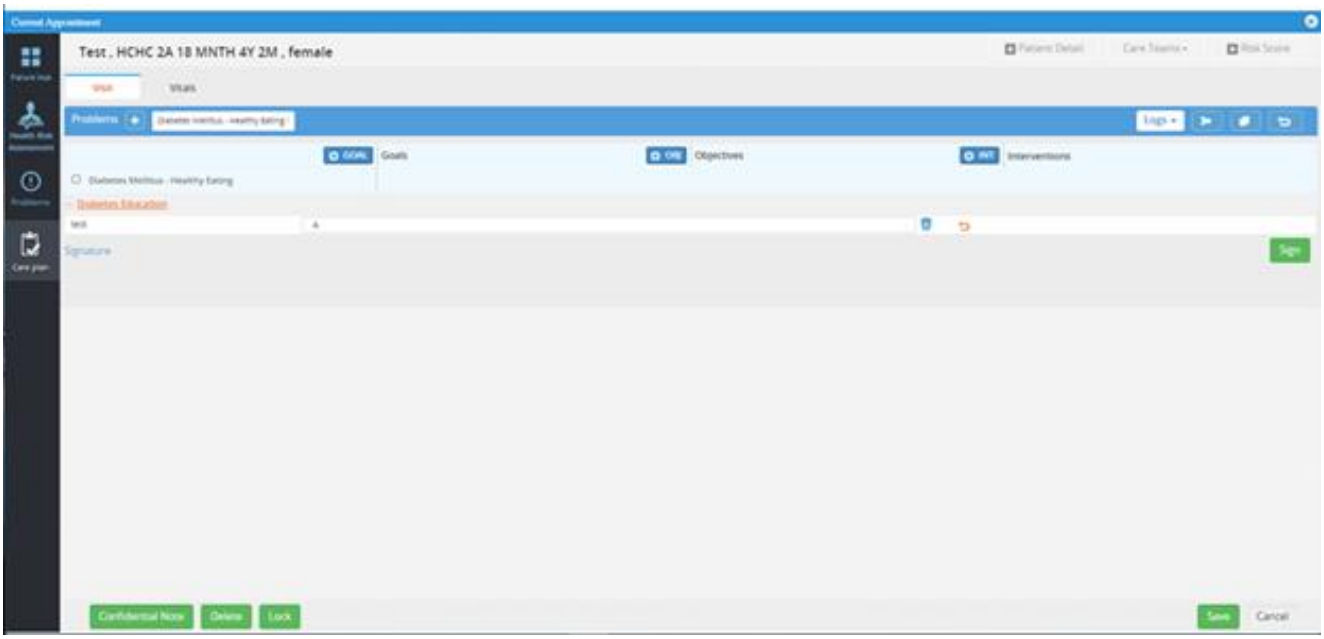
9. A window will appear, asking if you want to trigger the care pathway. Click "Save" to trigger it.



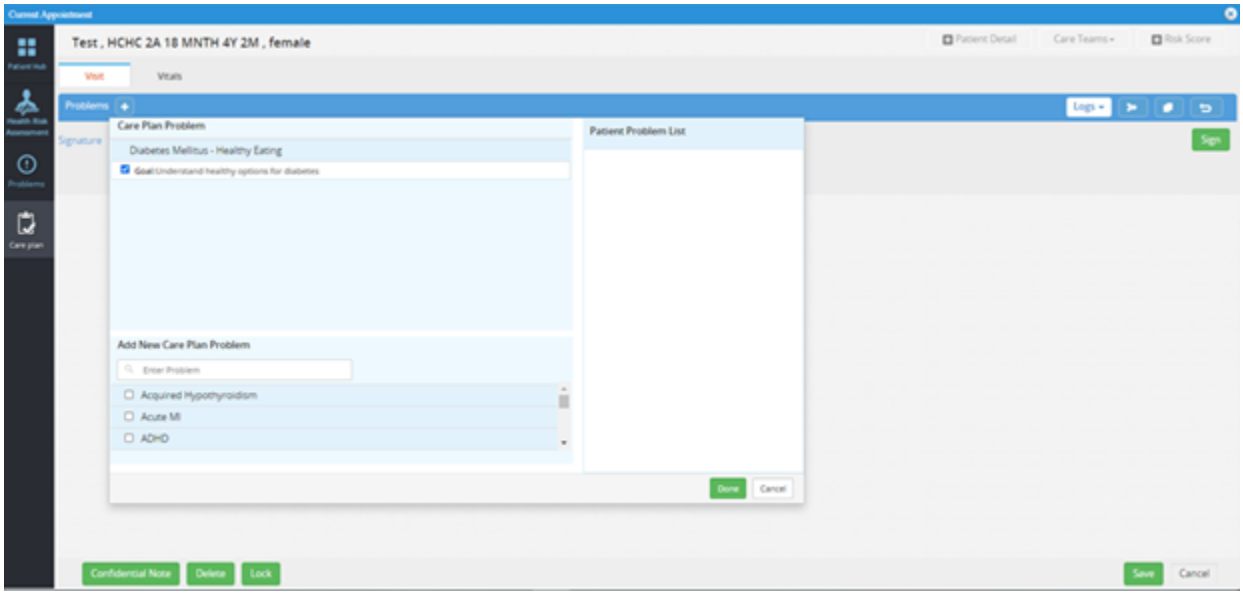
10. Exit the Care Planning module and go back to the Progress Note. **Here, if it is the <u>first</u> care planning visit you are having with the patient, you should notice a quirk of the Care Pathways feature created by eCW – none of the things you entered are showing up.** This is because when eCW developed the module, they created it so the Goals, Objectives, and Interventions just pulled in <u>would not appear</u> in the first Progress Note created for the patient.



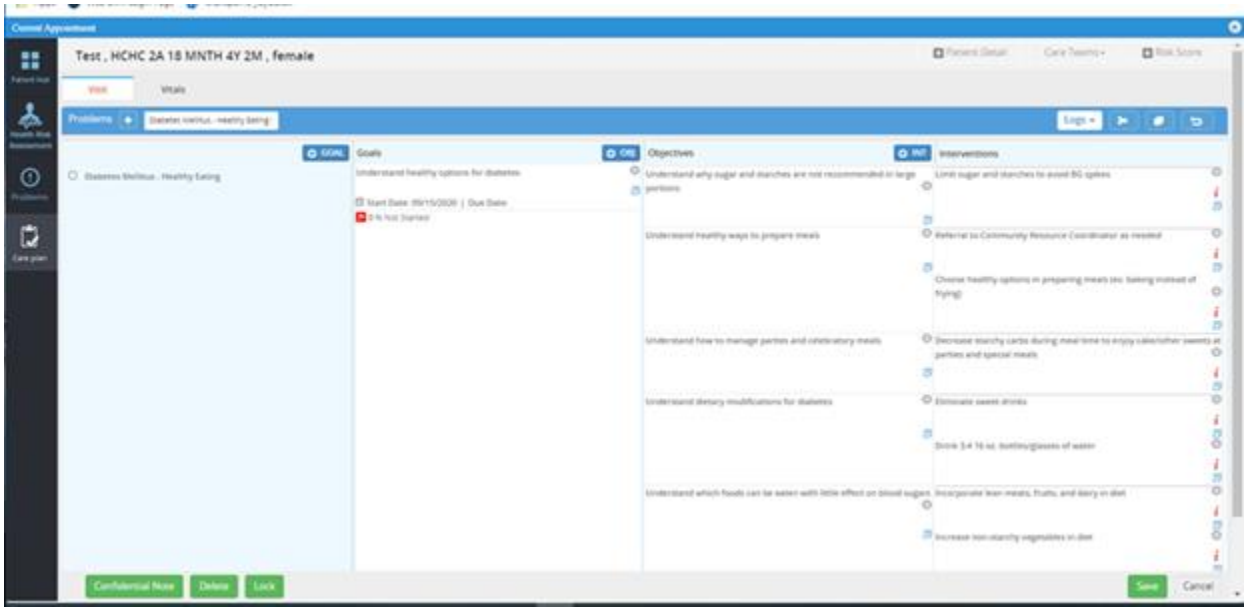
11. **The workaround for this is as follows:**
    a. Go back into the Care Plan section of the module. Find the blue bar that says "Problems" and find the white box that says the Problem named (e.g. "Diabetes Mellitus – Healthy Eating") on that bar. Click the "X" in the white box and click on it to delete the problem.



    b. After you delete the problem, click on the "+" on the blue Problem bar, and **Add back the problem you just deleted** by clicking the box beside the problem, then click the green "Done" button.

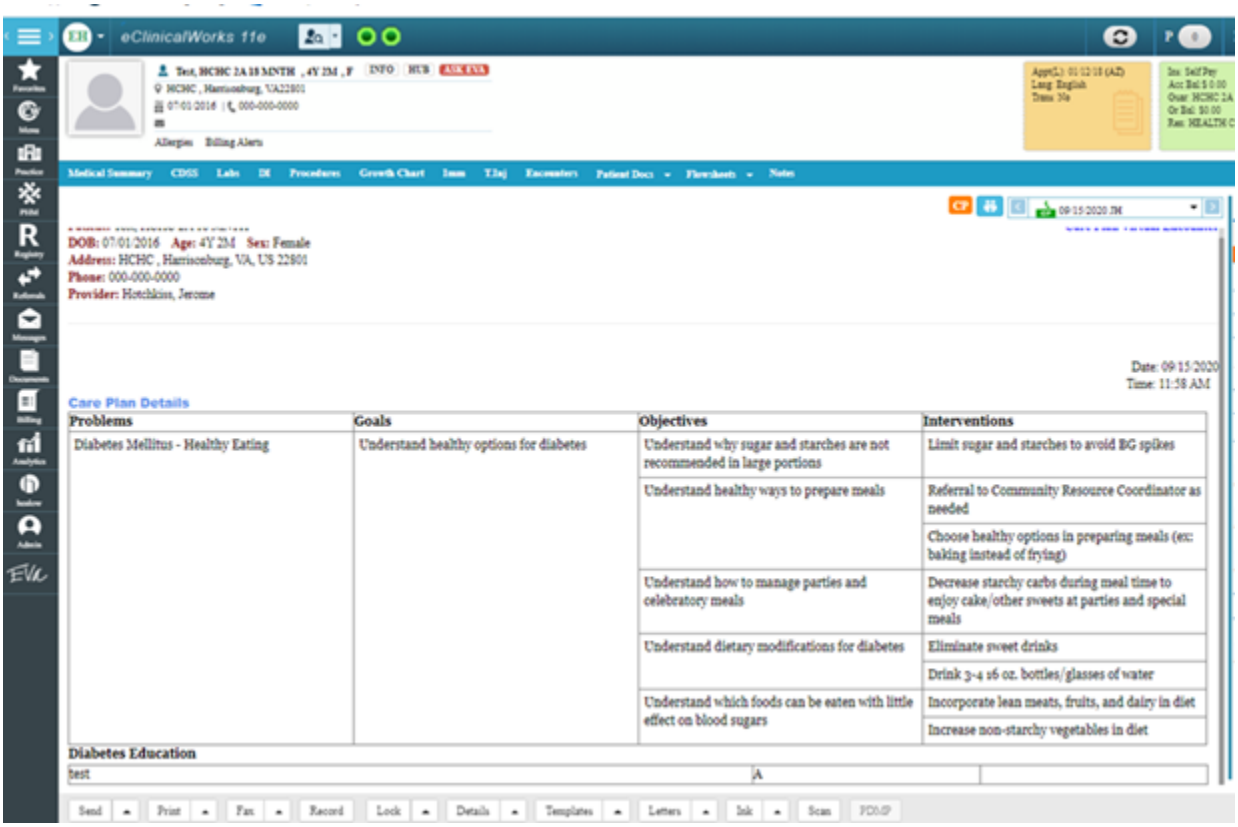


c. **This tricks the module** into thinking it's the second time you're working on this problem, so it has pulled in the Care Pathway.



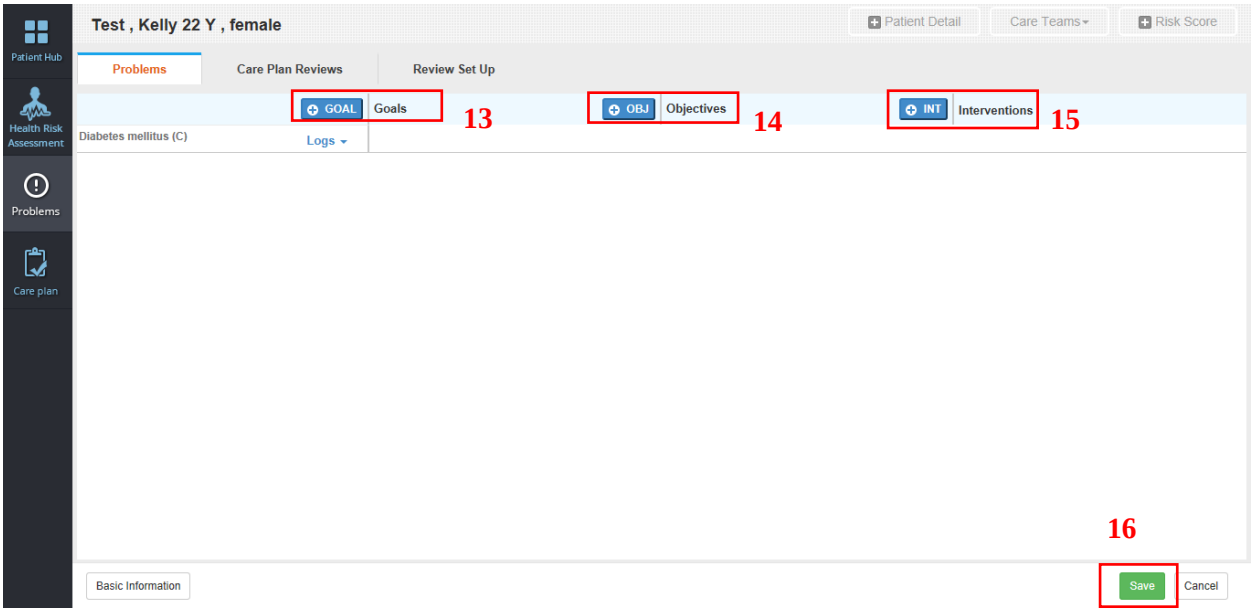
d. Check in the Progress Note to make sure everything for the Care Pathway now appears.

****<u>Note:</u> You will only need to use this workaround for the first care planning visit you have with a patient. The care plan should appear in subsequent visits without the workaround.****



Workflow for Adding Goals, Objectives, and Interventions <u>Without</u> Using the Care Pathways Feature:

12. Click on the problem.
13. Add a Goal to the problem by clicking on the *+GOAL* button and typing in the goal or selecting from the list.
    a. *Optional:* Click on the blue *Edit* icon to free-text any Notes to describe the goal.
14. Add Objectives to the problem and free-text any Notes.
15. Add Interventions to the problem and free-text any Notes.
16. When finished entering Goals, Objectives, and Interventions, click *Save* at the bottom of the window to complete the treatment plan.



17. Return to the Progress Note and verify all pieces needed to complete the intake are finished.

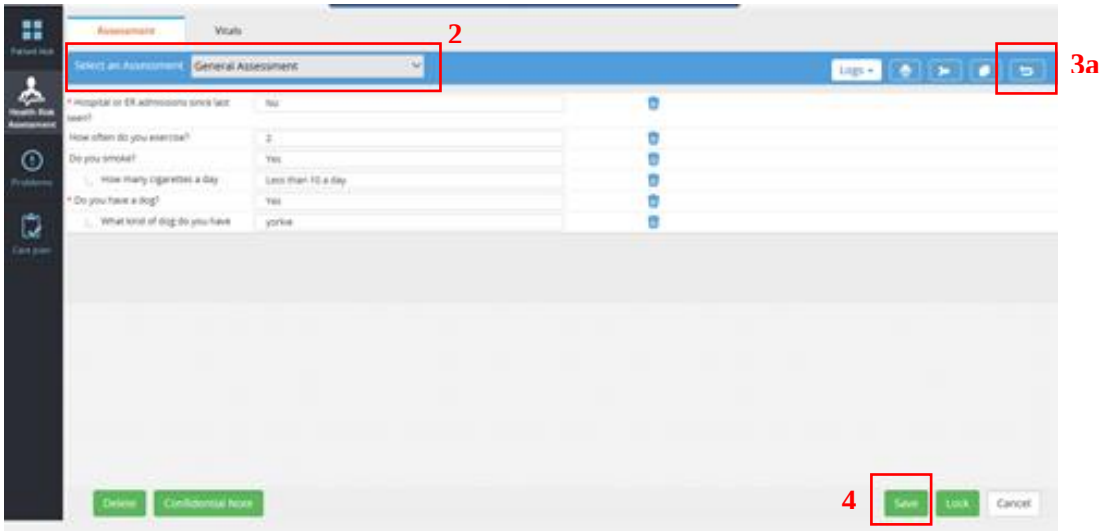
Appendix B
BH Module Established Patient Workflow

A patient is "established" if they were previously seen at HCHC and an initial enrollment, care plan assessment, and treatment plan were completed. The workflow for the established patient visit will depend on the needs for the current encounter. Once a visit for an established patient is on the schedule, the user can access the behavioral health care plan.

Health Risk Assessment

If a follow-up assessment is needed, the user can go to the *Plan* section of the current Progress Note and click on the *Health Risk Assessment* section to complete a new assessment.

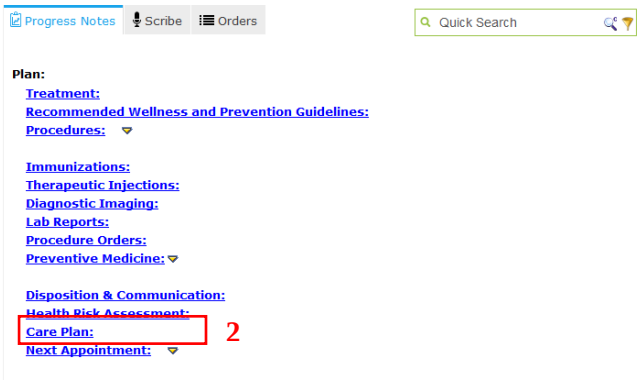
1. Click on the *Add New Assessment* button on the top left of the window.
2. In the *Select an Assessment* bar, select the type of assessment to be performed from the drop-down menu.
    a. Users can build their own assessments, if needed.
3. The assessment can be completed as if it is a new assessment (as is done for a new patient) OR answers from the last assessment can be pulled into the current assessment.
    a. To pull in previous answer, click on the curved arrow button – the *Copy Previous HRA* button – in the top right corner of the assessment window
    b. The *Previous Assessments* window will appear.
    c. Select the last assessment date and click *OK*. This will pull in all of the answers from the previous assessment.
    d. Answers can be changed, removed, or added as needed.



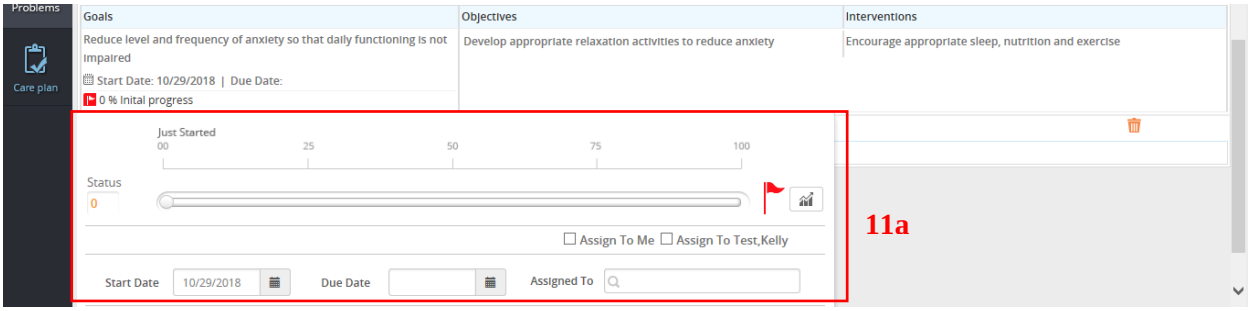
4. When finished entering responses, review and click *Save*. The screen should return to the *Health Risk Assessment* window.
5. If needed, add another assessment.
6. After all Health Risk Assessments are completed, they will appear in the *Health Risk Assessment* section of the Progress Note.

Care Plan

1. Return to the Progress Note.
2. In the *Plan* section of the Progress Note, click on *Care Plan*.
3. The *Care Plan* window appears.



4. For an established patient, pull forward the Goal documented in the previous visit.
    a. Click on the box beside Goal.
5. The user may also add another problem by typing into the text box beneath *Add New Care Plan Problem* in the *Care Plan* window and selecting a problem, then adding the problem to the patient's record.
6. Once the previous Goal is selected, click the *Add* button on the bottom right of the window to bring the Goal into the current encounter.
7. The *Problems* window appears.
8. Click on the problem.
9. If needed, add a Goal to the problem by clicking on the *+GOAL* button and typing in the goal or selecting from the list.
    a. *Optional:* Click on the blue *Edit* icon to free-text any Notes to describe the goal.
10. To add Objectives to the first Goal, make sure the first Goal is selected (indicated by the check mark beside the Goal title).
11. For any Goals that were new on the previous visit, the user can update the Goal by clicking on the red flag icon.
    a. A slider appears. The user can adjust the slider to say what percentage of the goal is complete.
    b. Note: New Goals should be left as 0% complete, as they have not yet been acted upon.



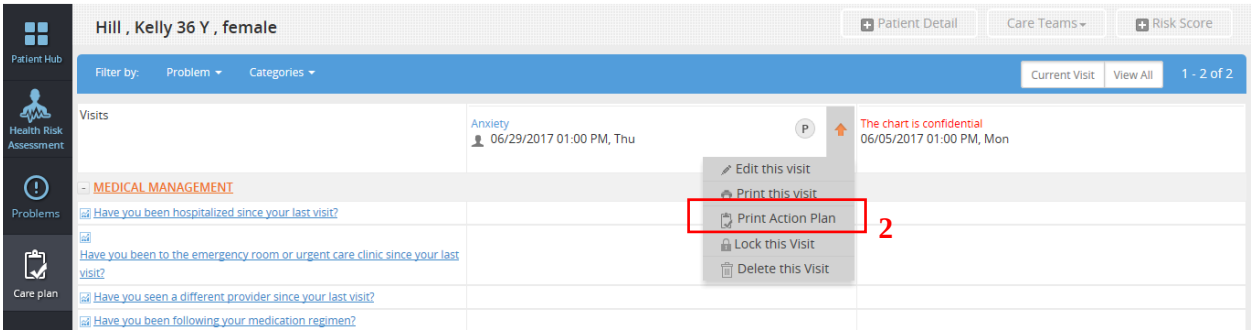
12. When finished entering Goals, Objectives, and Interventions, click *Save* at the bottom of the window to complete the treatment plan.
13. The *Care Plan* window appears again. Review all of the patient's care plans at once from the *Care Plan* window.
    a. The new visit is on the far right, and the old visits are to the left of the new visit.
    b. From this window, the user can print today's Action Plan, enter billing codes, and lock the visit.
14. Return to the Progress Note and verify all pieces needed to complete the intake are finished.

Appendix C
BH Module Printing & Publishing Action Plans

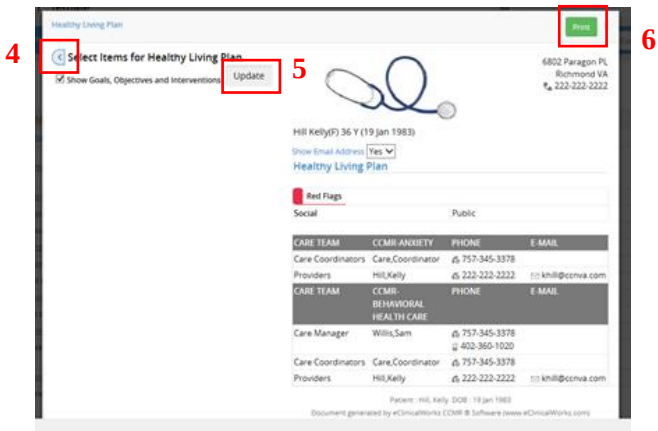
An action plan contains a set of guidelines for a patient based on the care plan developed at the visit. The patient will typically receive a printout of the action plan at the end of the visit.

Printing an Action Plan

1. In the Care Plan window, click the orange arrow next to the visit.
2. Select *Print Action Plan* in the drop-down menu.
3. The Action Plan window opens.



4. Display the Action Plan settings by clicking the left arrow on the left upper corner of the Action Plan window.
5. Click *Update* and update any items, as needed.
6. Click *Print* in the upper right corner of the window to print the Action Plan.



Publishing an Action Plan

Once a care plan has been locked, an action plan can be uploaded to the Patient Portal.

1. In the Admin band, click on *Patient Portal Settings*.

2. The Patient Portal Settings window opens.
3. Click on Visit Summary Conf to configure sections to display in the portal Visit Summary. This includes the Action Plan.
4. Check the box next to *Action Plan* to ensure the action plan is published on the Patient Portal, and click *Save* at the bottom of the screen.