CareHub Training Guide

Version 6, January 2026

Welcome to CareHub!

We are delighted to have you join us at Intus Care! This training guide is designed to provide you with an understanding of CareHub's functionalities and features, ensuring that you can navigate and utilize the system effectively.

Our goal is to equip you with the knowledge and skills necessary to make the most of CareHub, ultimately improving the quality of care provided to participants.

In this guide, you will find detailed instructions on the following key areas:

- **Basic Navigation**: Learn how to navigate the CareHub application, use the menu options, and search for participants.
- **Profile Management**: Understand how to manage participant profiles, including updating information and accessing clinical records.
- **Enrollment and Disenrollment**: Get step-by-step instructions on enrolling and disenrolling participants in the CareHub system.
- **Task Management**: Discover how to manage tasks, add new tasks, and track progress.
- **Scheduling**: Learn how to manage participant appointments and handle scheduling requests.
- **Assessments**: Understand the process of completing assessments for participants.
- **Care Plans**: Explore how to create and manage care plans for participants.
- **Clinical Records**: Learn about the integration between CareHub and Clinical Record Elation (EMR) for managing clinical documentation.
- **Service Tracking**: Get insights into managing service requests and tracking their progress.
- **Quality Inbox**: Understand how to handle SDRs, grievances, and incidents.
- **Medication Administration**: Learn how to document medication administration using the MAR in CareHub.
- **Reporting**: Discover how to generate and customize reports within CareHub.
- **IDT Morning Meeting:** Learn about how to conduct a morning huddle and manage the associated tasks.

We hope this guide serves as a valuable resource for you as you begin your journey with CareHub. Should you have any questions or need further assistance, please do not hesitate to reach out to your Implementation or Training Team.

Contents

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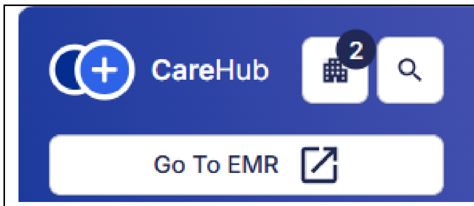
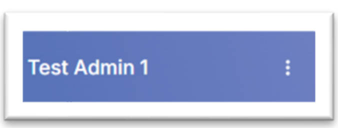
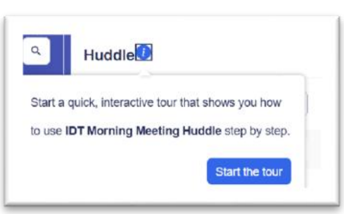
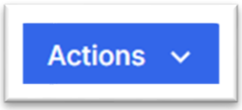
1. The Basics: Navigation

Objective: Overview of basic navigation in the CareHub application, search features and menu options.

Steps:

1. Upon Login to CareHub your default view will be on to the Huddle Section of the IDT Morning Meeting.
2. On the left-hand side of the screen, you will see a list of menu options to navigate to different sections of the CareHub system.

	**Center Icon:** Change your PACE Center and IDT Team. **Badge Icon:** To provide insight as to which Center and IDT Team are selected for the global filter. If there is no icon – that indicates that no global filters have been applied. **Search Icon:** Use to find Active, Deactivated, Enrolling & Disenrolling participants by: *First Name, Last Name, Member ID*. **Go to EMR:** To open the Clinical Record in a new tab in the Clinical Record Elation EMR.
	**Your name** will appear along with 3 dots that will show menu options (based on permission). • Sign Out will log you out of CareHub • Settings (based on permission) • Centers and Teams – Manage your PACE Center and IDT Teams • Users – Manage User Role, Privileges and Status • Scheduling Types – Manage Schedule Type Settings
	**Information Icon:** Will appear throughout the CareHub application, which will start a quick interactive tour of how to use that area step by step.

	**Actions:** In the top right corner to add: • New Tasks • New SDR • New Grievances • New Service • New Scheduling Requests
	**My Tasks:** List of In Progress and Not Started. There will also be a quick link to recently viewed participants for easy navigation to their profile.
	**Intus Suggestions:** • They are intelligent, context-aware prompts that help users take the next best action across CareHub. • Our recommendation engine analyzes clinical data, documentation patterns and care team workflows. • It then generates targeted, actional suggestions tailored to each user's role and responsibilities right within the CareHub experience.

IntusCare

Checklist:

- ✓ Filter views by PACE Center and ID team.
- ✓ Search for participants using the search bar.
- ✓ Open clinical record using "Go to EMR".
- ✓ Use the Actions button to add new tasks or requests.
- ✓ Navigate using the left-hand side panel.
- ✓ Click the information Icon to have a step-by-step tour of the page you are on.

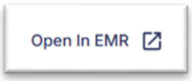
Knowledge Check:

- How do you filter views by pace center and team?
- What is the purpose of the blue actions button?
- What ways can you search for a new participant?

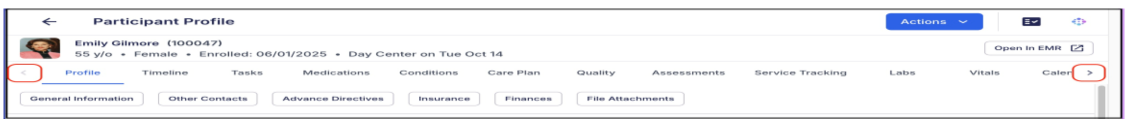
2.Profile Management

Objective: Overview of navigation of the participant profile within CareHub.

Steps:

1. View the participant's profile to see:
    1. Information in the Header (Synced with Clinical Record Elation (EMR).
    2. 

       link to access the participant's Clinical Record Elation (EMR).
    3. There is a list of sections of the participant profile across the top of the screen. The current selection will be highlighted in blue.
    4. **Profile:** This is the General Profile for the participant.

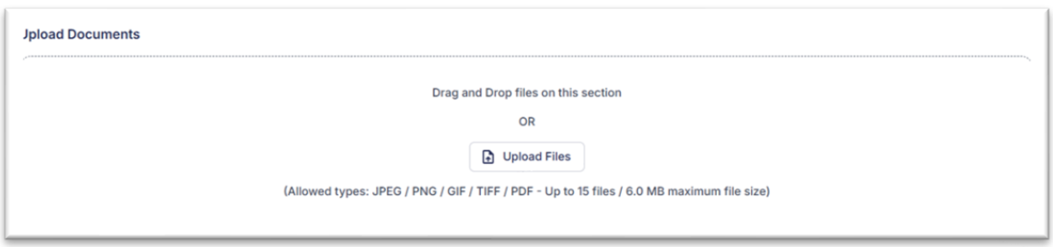


NOTE: The Profile has quick links across the top to jump to a specific section. There is updated viewing capability (especially if working on smaller screen) to scroll across Participant Profile

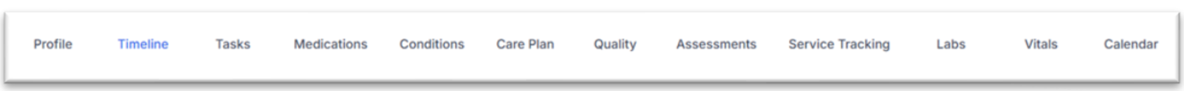
1. Upload a photo to the participant's profile.

2. Participant Summary
    1. Hover over to edit to update this information
3. General Information
    1. Participant Details
    2. Participant Assignment
    3. Living Situation
    4. Contact Information
    5. Social History Card

            1. Social History
    4. Other Contact
        1. Emergency Contact
        2. Caregiver Information
    5. Advanced Directives
        1. Code Status
            1. Synced with Clinical Record Elation (EMR)
            2. Automatically add to Huddle for review
    6. Insurance
    7. Finances
    8. File Attachments
        1. Drag and Drop or Upload files

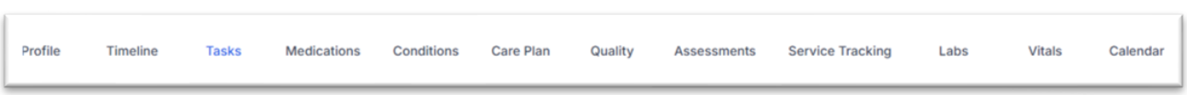


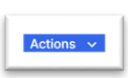
5. **Timeline:** This is a list of events that have taken place for the participant.



    1. Click on an event to see more information and use the Go to link to navigate to: Profile, Medication, Condition, Authorization etc. You are also able to leave comments on certain items in the timeline.

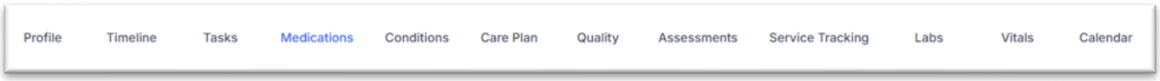
6. **Tasks:** This is a list of Tasks that are associated with the participant.



    1. You can: Search, Filter, Reassign and Delete from this screen.
    2. 

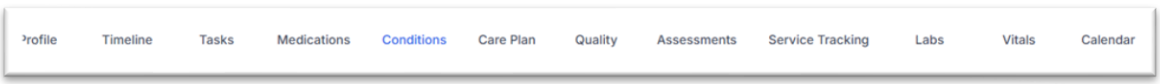
Use the blue actions button in the top right corner to add a New Task

7. **Medications:** This is a list of Active Medications that are synced from the Clinical Chart Elation (EMR).



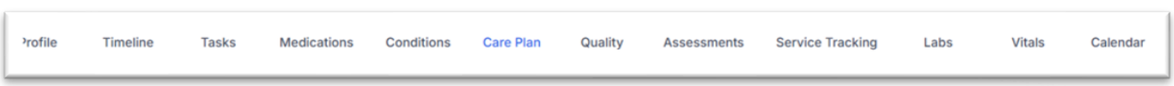
   1. You can Add Medications to the MAR for documentation
      1. Click the Refresh Medications button to update from the Clinical Chart Elation (EMR)
   2. View Past Administrations & Print the MAR
   3. Administer In-Center Medications
   4. Administer At Home Medications

8. **Conditions:** This is a list of Conditions that are synced from the Clinical Chart Elation (EMR).

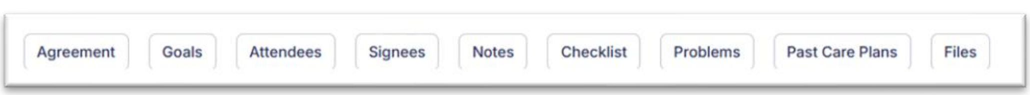


   1. You can: Search, Filter and Show Active only from this screen.
   2. Click on the Condition to show more information.

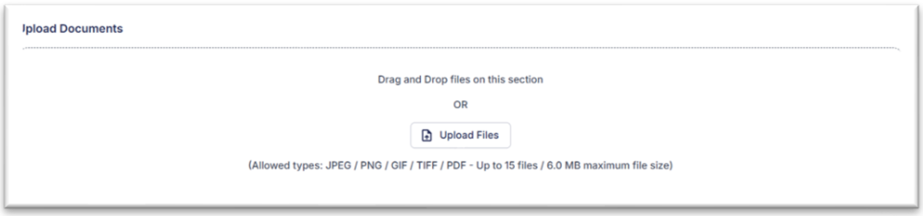
9. **Care Plan:** This is the Active Care Plan for the participant.



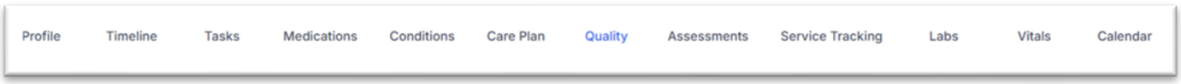
   1. Care Plan has quick links across the top to jump to a specific section.

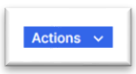


   2. Open Assessment Link
   3. Start a New Draft or Open Draft
   4. Print the Active Care Plan
   5. Upload Files
   6. View Past Care Plans
   7. Drag and Drop or Upload Files



10. **Quality:** This is a list of SDRs, Grievances & Incidents for the participant.

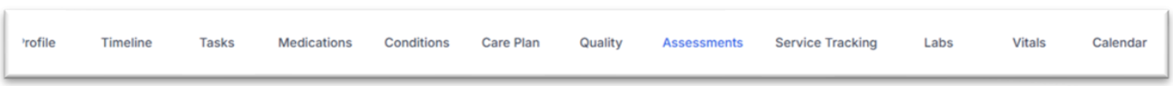


    1. View information and update existing
    2. 

    Use the blue actions button in the top right corner to add:
        1. New SDR
        2. New Grievance

NOTE: A new Incident must be added from the menu on the left-hand side of the screen.

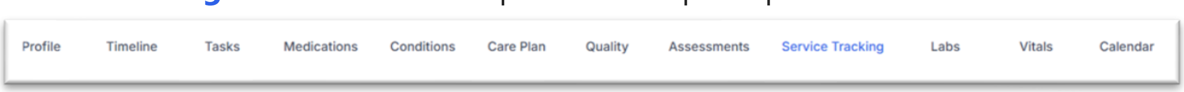
11. **Assessments:** This is a list of Assessments for the participant.

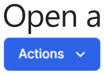


    1. You can: Search and filter
    2. Open and existing Assessment and update/add information.

NOTE: A new assessment must be started from the menu on the left-hand side of the screen.

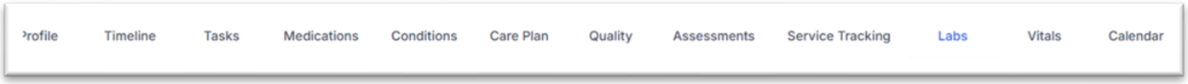
12. **Service Tracking:** This is a Service Requests for the participant.



    1. You can: Search and Filter
    2. Open an existing Service Request and update/add information
    3. 

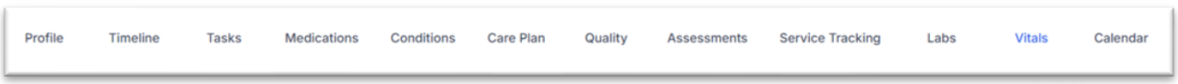
    Use the blue actions button in the top right corner to add a New Service.

13. **Labs:** This is a list of Labs that are synced from the Clinical Chart Elation (EMR).



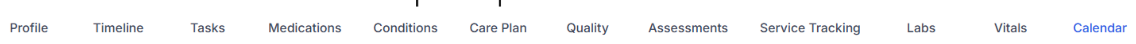
1. You can: Search and Filter
2. Click on a Lab Result to view more information and view a graph.

14. **Vitals:** This is a list of Vitals that are synced from the Clinical Chart Elation (EMR).

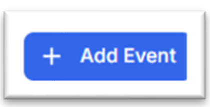


1. You can: Select a Start Date and End Date to filter
2. Show as a Flow Sheet or List using the toggle switch
3. In List view you can expand results and graph

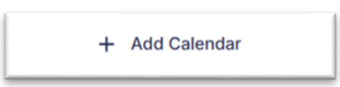
15. **Calendar:** This is a view of the participant calendar.



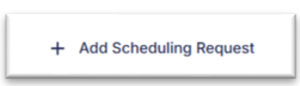
1. You can: Jump to Today, Change the date Range, Filter, change the view to Day, Week, Month, Year Agenda

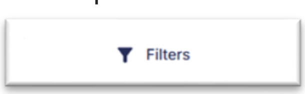
2. 

Use the blue Add Event button to add to the calendar

3. 

Use the Add Calendar button to view another calendar

4. Scheduling Queue
    1. 

    Use the Add Scheduling Request button to add a new request
    2. 

    Filter the pending requests

Checklist:

- ✓ View the participant's profile.
- ✓ Edit profile information.
- ✓ Upload a photo.
- ✓ See how the information flows between CareHub and the Clinical Record Elation (EMR).
- ✓ Explore the tabs and become familiar with what actions you can take from each section of the participant profile.

Knowledge Check:

- How do you edit profile information?
- What is the purpose of the "Open in EMR" link?
- How do you upload a file?
- What view options do you have of Labs and Vitals?
- How do you start a new assessment?
- How do you start a new incident?

Knowledge Base: (Additional information & training video)

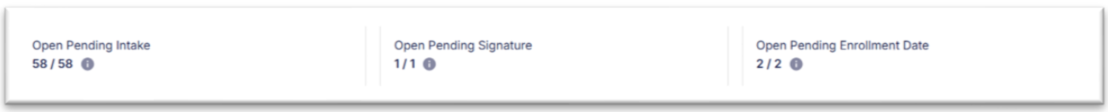
- PACE Participant Chart – IntusCare

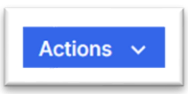
3.Enrollment [460.152] & Disenrollment [460.162 & 460.164]

Objective: To understand the process of enrolling and disenrolling participants in the CareHub system.

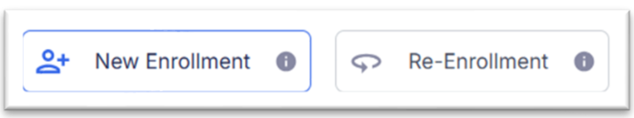
Steps:

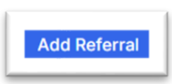
1. **Enrollments**
    1. Navigate to the Enrollments module on the left-hand side of the screen.
        1. Summary Cards at the Top of the Screen

            1. Hover over the information icon for more information.
        2. You can: Search, Filter & Use the toggle to view participants that are enrolled
    2. 

       Use the blue Actions button at the top of the screen to Add Referral
        1. Enrollment Type

        2. Complete all necessary information.
        3. 

           Use the blue Add Referral button at the bottom of the pop-up window to complete the Referral
        4.
    3. After the Referral is added, additional information must be entered to complete the enrollment process.
        1. Select the referral from the list that you just added.
        2. There are three stages to the Enrollment Process, which you will see across the screen:

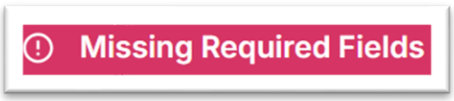
            ✓ Intake Process
            ✓ Agreement Signature
            ✓ Enrollment

1. Stages will change colors as they are completed.

Intake Process Stage:

- Before you can move to the next stage, complete Missing Required Fields in the Red Box

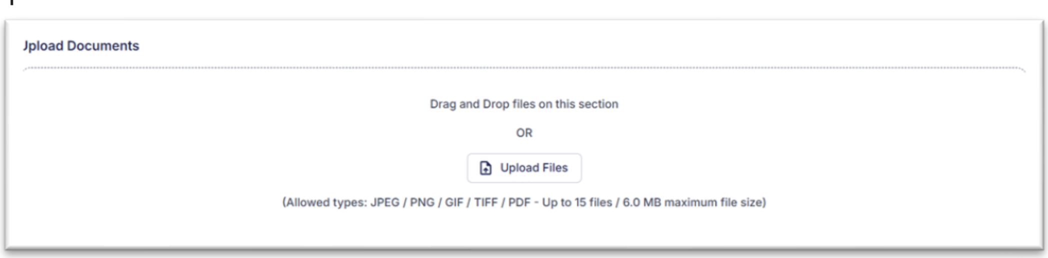


NOTE: This is the minimum required information. It is recommended to add as much information as possible to the participant's profile.

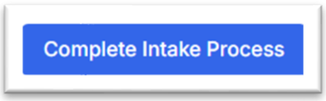
NOTE: Added validation as user enters an MBI (Medicare Beneficiary ID) in the Insurance section to ensure that the correct format is adhered to. No dashes are allowed; the system will default to uppercase, and 11 characters are required.

- Upload a photo of the participant

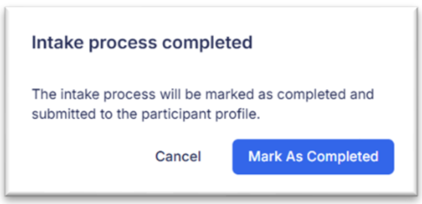
- Upload documents



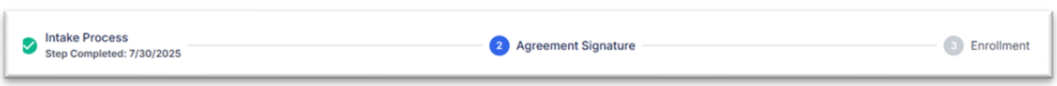
- Once the necessary information is added in the intake form, the:



Will turn blue, and you will be able to action and Mark As Complete to move to the next action.



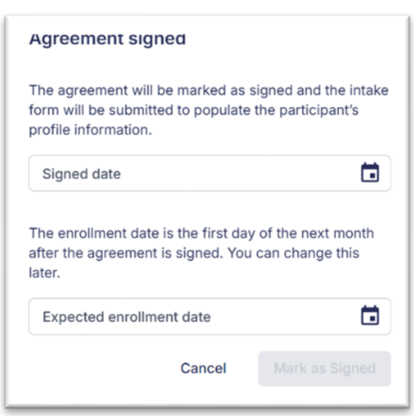
The Intake Process Stage will update to green, and you can move onto the next stage.



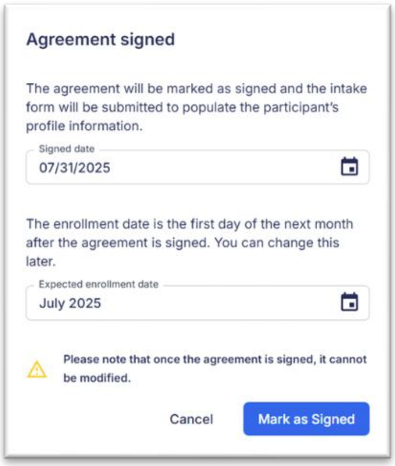
Agreement Signature Stage:

- Now that the Intake Process Stage is complete, the

Will appear, and you will be able to action and

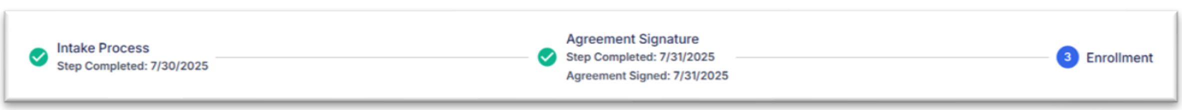


Enter Signed date and Expected enrollment date. (Expected enrollment month – first of the following month)

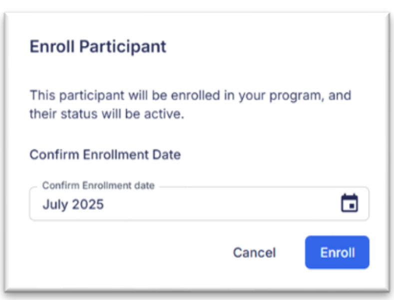


- Mark as Signed to move to the next action.

The Agreement Signature Stage will update to green, and you can move onto the next stage.



Enroll Participant Stage:

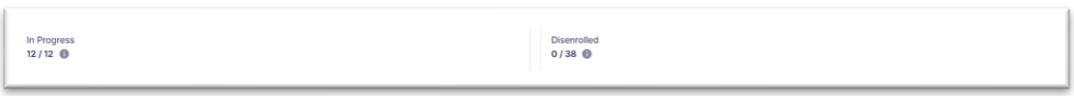


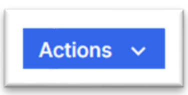
This action should be taken on the ***first day*** of the enrollment month. This will start the 30-day due date clock for the Comprehensive Assessment.

NOTE: Enrolling the participant before the first of the month may impact on the due dates.

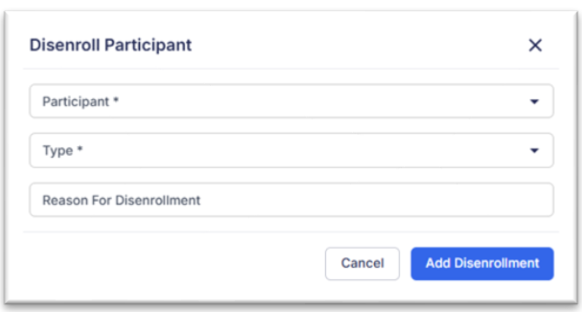
The Enrollment will update to green, and the participant is now enrolled in the PACE Center.

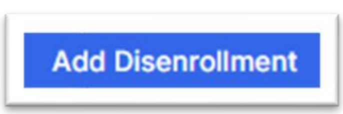
2. **Disenrollment:**
   1. Navigate to the Disenrollment module on the left-hand side of the screen.
      1. Summary Cards at the Top of the Screen



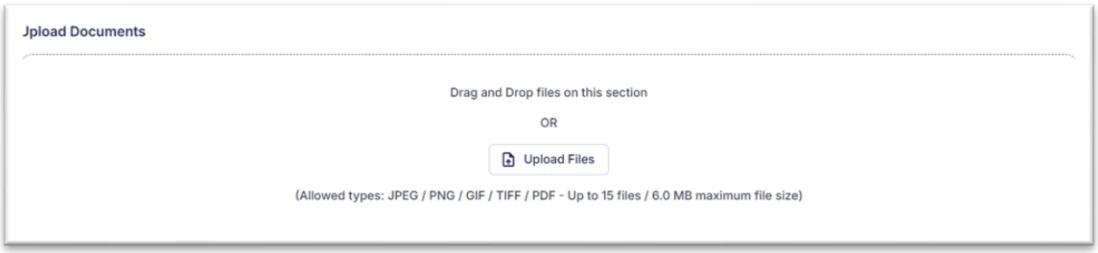
         1. Hover over the information icon for more information.
      2. You can: Search, Filter & Use the toggle to Show in progress.
   2. 

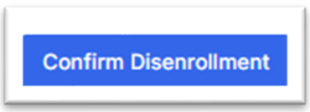
Use the blue Actions button at the top of the screen to Disenroll Participant



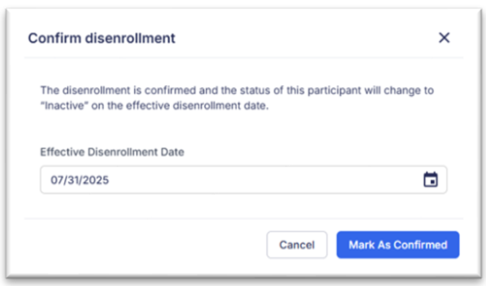
      1. Select Participant
      2. Type
      3. Reason for Disenrollment
      4. 

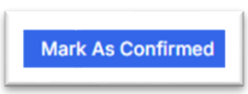
   3. After Add Disenrollment button is actioned:
      1. Additional information can be added.
      2. A Checklist can be added
      3. Drag and Drop or Upload Files



4. 

Use the Confirm Disenrollment button to complete the process.

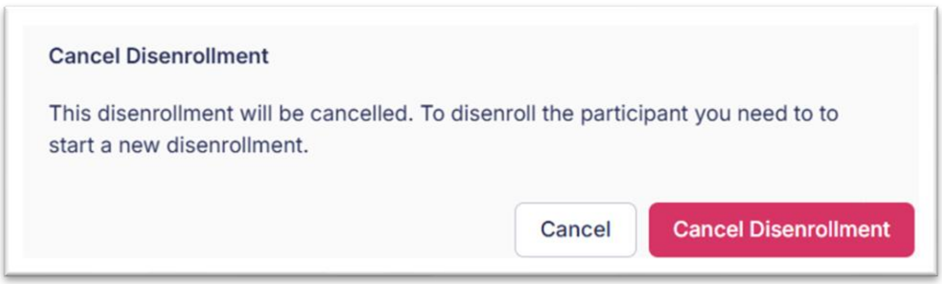


   1. Enter Effective date
   2. 

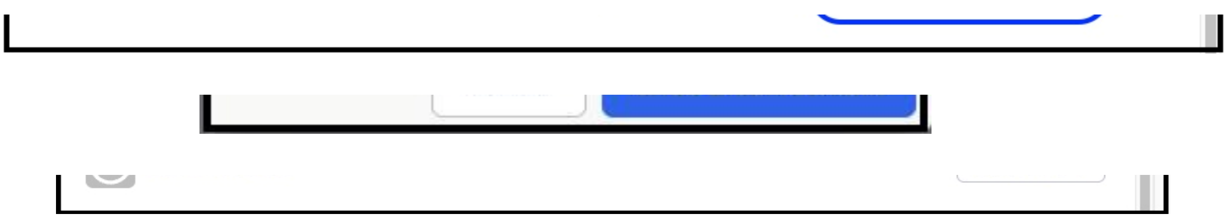
   3. Participant will change to “inactive” on the effective disenrollment date.

NOTE: Once a participant has been disenrolled, the participant and their Assessments (Upcoming & In Progress) and Care Plans (Draft) will be removed from Dashboard queue.

5. Cancel Disenrollment: If necessary, you can cancel this disenrollment for a participant prior to it being confirmed. Upon confirmation of the cancellation, a yellow bar will appear at the top of the disenrollment for confirmation



NOTE: Added ability for users to undo disenrollment. Actioning this will move the Participant back to the disenrolling stage where the user can then confirm the disenrollment with a new date or cancel the disenrollment.



Auto Generated Tasks for Enrollments:

Upon enrolling a new participant:

- Create initial comprehensive assessment
- Create care plan draft

Automatically trigger the following tasks:

- Assign participant to IDT team
- Review explanation of participant bill of rights
- Grievance process notification to participant
- Appeal process notification to participant

Checklist:

- ✓ Add a new referral
  - Complete the intake process
  - Upload necessary files
- ✓ Enrolling the participant into the PACE program
- ✓ Disenroll a participant
  - Complete the Disenrollment process
  - Upload necessary files

Knowledge Check:

- How do you add a new referral to CareHub?
- What steps are involved in completing the intake process?
- How do you add a new disenrollment in CareHub?

Knowledge Base: (Additional information & training video)

- Enrollment – IntusCare
- Disenrollment – IntusCare

Link to CMS Regulations:

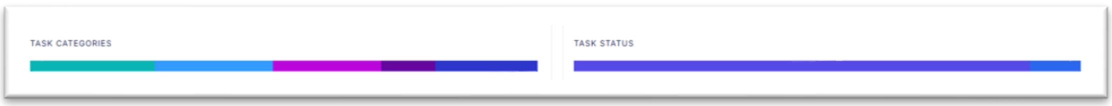
- eCFR :: 42 CFR 460.152 -- Enrollment process.
- eCFR :: 42 CFR 460.164 -- Involuntary disenrollment.
- eCFR :: 42 CFR 460.162 -- Voluntary disenrollment.

4.Task Management

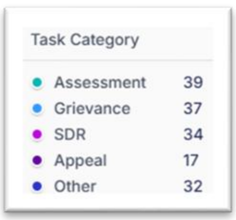
Objective: To manage tasks created for the IDT Team within CareHub.

Steps:

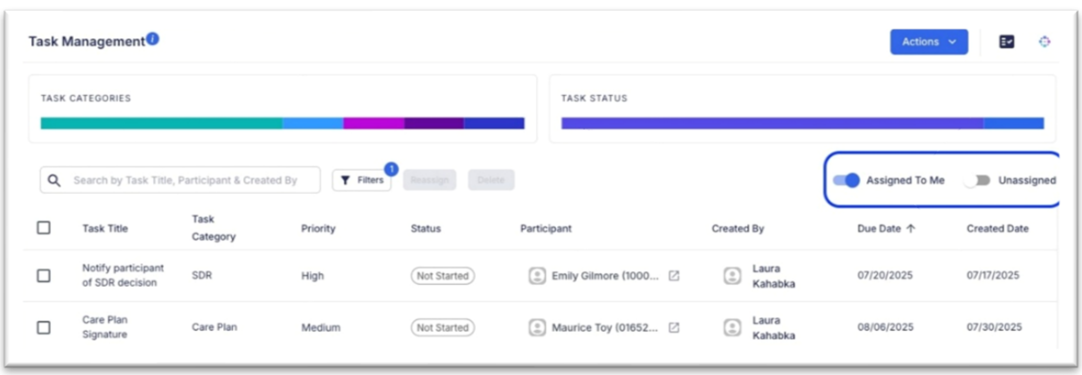
1. Navigate to the Tasks module on the left-hand side of the screen.
    1. Summary Cards at the Top of the Screen



    2. Hover over for more information about the breakdown of Tasks

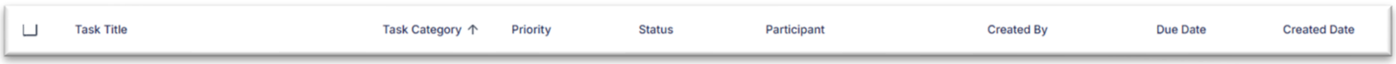


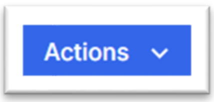
    3. You can:



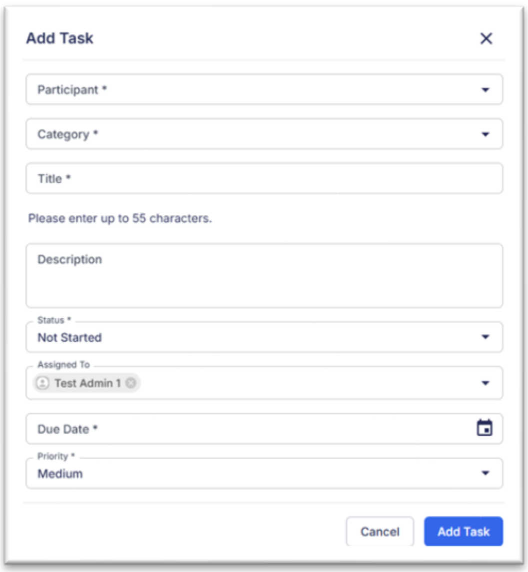
        1. Search
        2. Filters
            1. Task Category
            2. Priority
            3. Status
            4. Created By
            5. Due Date
            6. Created Date
            7. Assigned To
        3. Use the toggle to view:
            1. Assigned to Me
            2. Unassigned

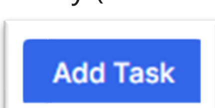
4. Select any header items to filter the list in current view



2. 

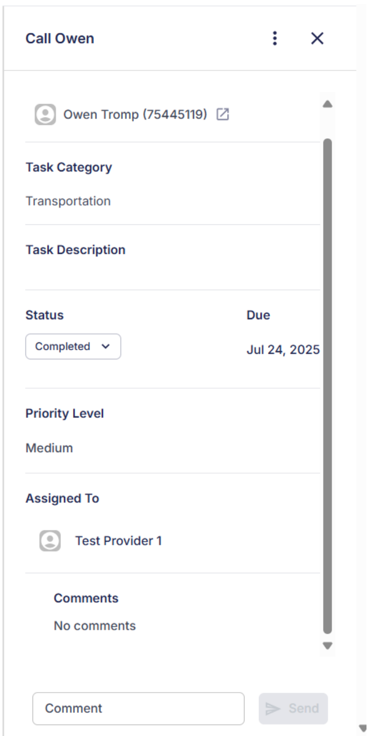
Use the blue Actions button at the top of the screen to Add a New Task



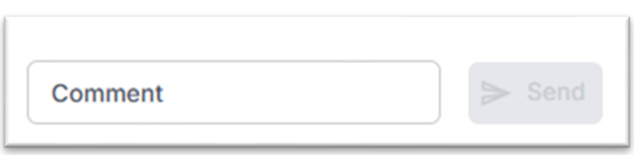
1. Select Participant
2. Select Category
3. Give the Task a Title
4. Enter a Description
5. Status
    1. Not Started
    2. Canceled
    3. Complete
    4. In Progress
6. Assign to
7. Due Date
8. Priority (Default is Medium)
9. 

When information is completed

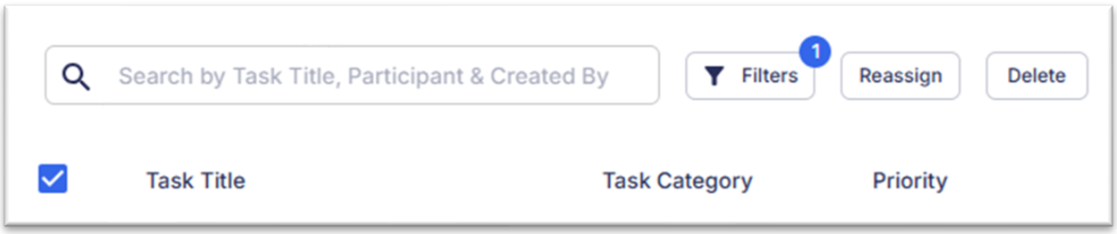
3. Click on any Task to open and see additional details:



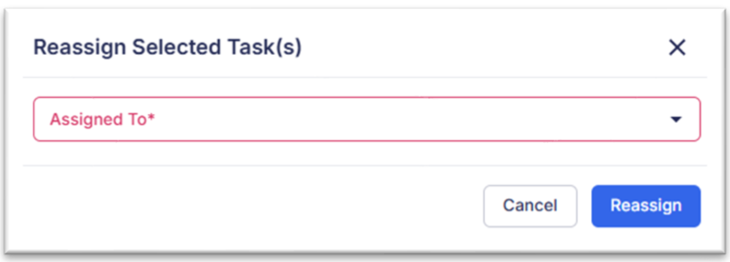
1. Click the 3 dots to Edit or Delete the Task
2. Fields:
    1. Participant
    2. Associated Documentation (View Huddle, Assessment, SDR etc.)
    3. Task Category
    4. Task Description
    5. Status & Due Date
    6. Priority
    7. Assigned To
    8. Comments
3. Add Comments (If applicable)



4. Using the Check box next to the Task, reassign as needed:

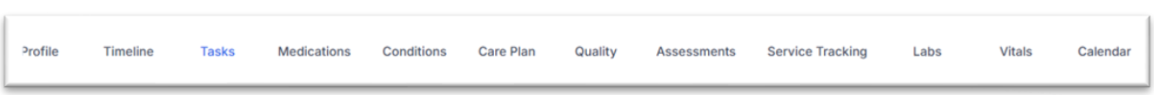


1. Select Task or Tasks
2. Reassign



3. Assigned to a new member of the Team

5. The navigation steps above can be completed from within the participant profile under the Tasks section. When in a specific profile, the tasks that show will only be for that participant.



Auto Generated Tasks:

Some Tasks are automatically generated based on actions take in CareHub. See notes in specific modules for more details.

Checklist:

- ✓ View tasks assigned to you or the center.
- ✓ Add A New Tasks using the Actions button.
- ✓ Reassign tasks as needed to another member of the team
- ✓ Update Task status or add a comment to this task.
- ✓ Navigate to a participant profile and view their tasks

Knowledge Check:

- How do you view tasks assigned to you?
- What steps do you take to add a new task?

Knowledge Base: (Additional information & training video)

- Tasks – IntusCare

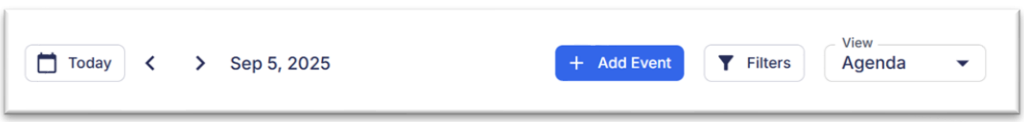
5.Scheduling [460.102 & 460.76]

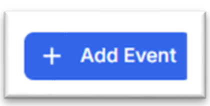
Objective: To manage participant appointments using the scheduling module.

Steps:

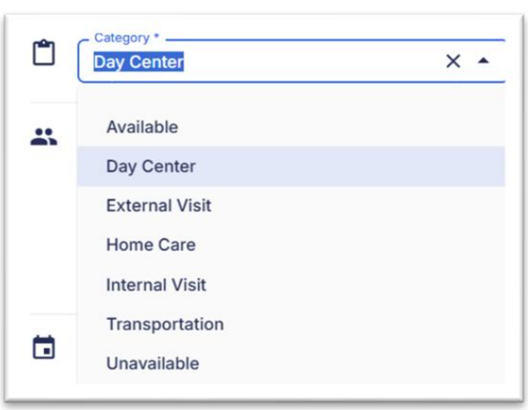
Center Calendar

1. Navigate to the scheduling section on the left-hand side of the screen.
    1. Selection Center Calendar
    2. You can:
        1. Jump to Today
        2. Change the date Range
        3. Filter
        4. Change the view to:
            1. Agenda
            2. Work Day, Full Day
            3. Work Week, Full Week
            4. Month, Year,
            5. Agenda

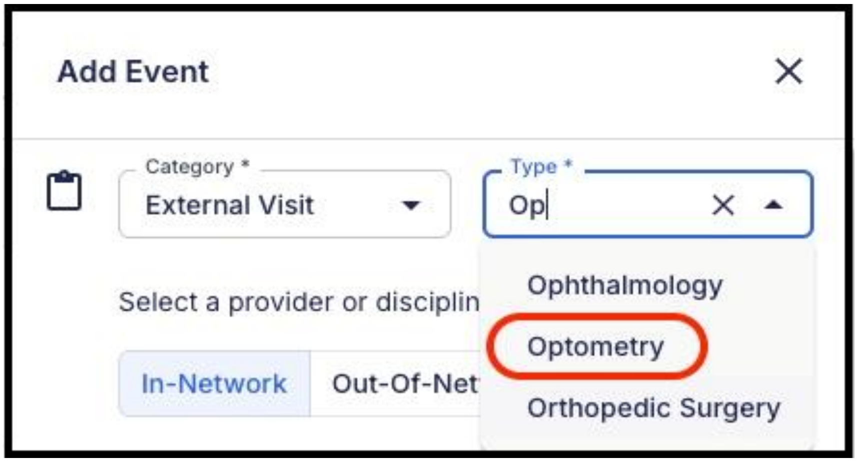


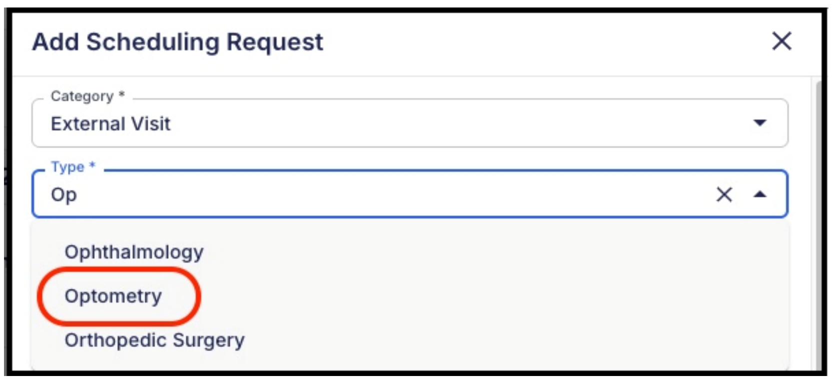
2. 

Use the blue Add Event button to add to the calendar.
    1. Based on the category, the fields within the Add Event box will be different. See table with more information.

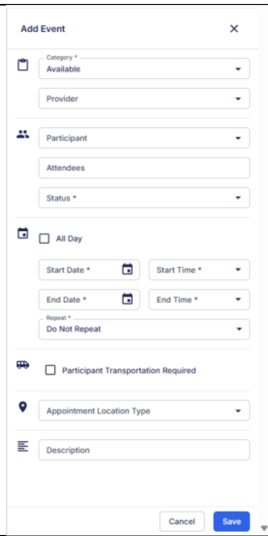
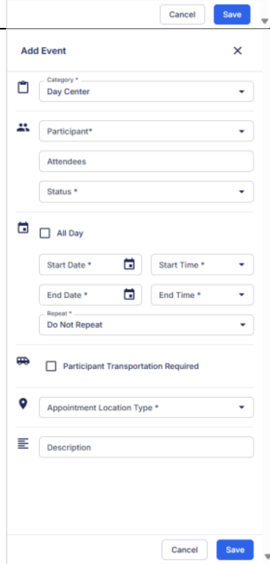
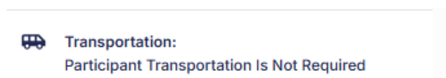
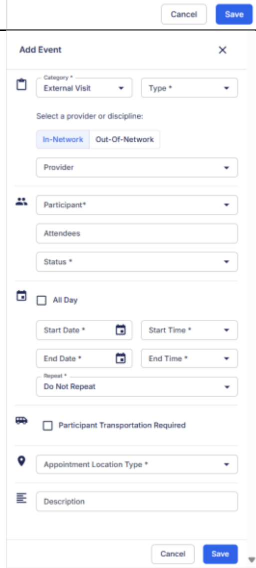
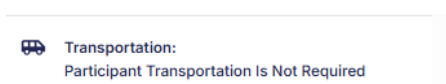


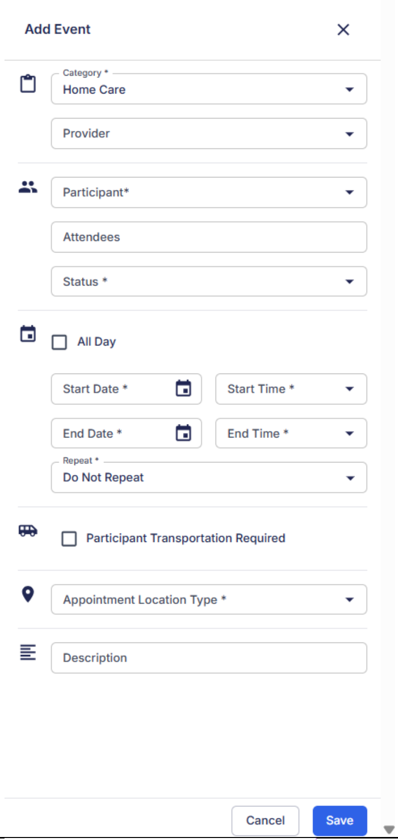
NOTE: Added new External Visit Type: Optometry



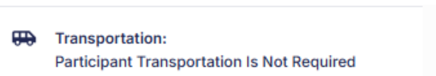
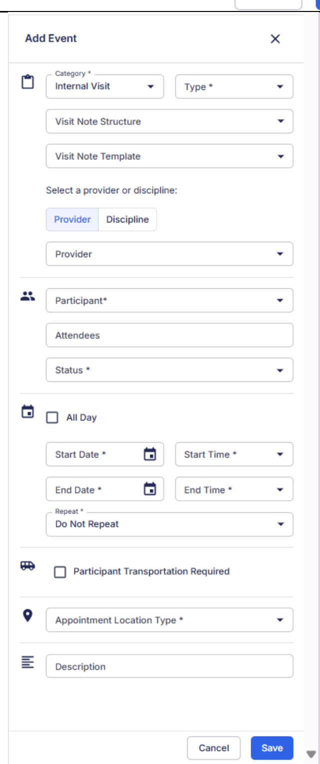


Category	Visual	Notes

Available		To be used to mark a calendar as available.
Day Center		To be used for Day Center events at the PACE Center. NOTE: If the Participant Transportation Required box is left unchecked, the event will show as not requiring transportation 
External Visit		To be used for External Visits to an outside provider. **NOTE:** The Type list will be customized to your PACE Center. **NOTE:** If the Participant Transportation Required box is left unchecked, the event will show as not requiring transportation 
Category	**Visual**	**Notes**

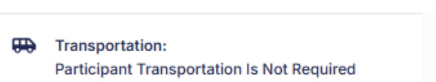
<table>
<tr>
<td>Home Care</td>
<td>
</td>
<td>To be used for Home Care events in the Participant Home.

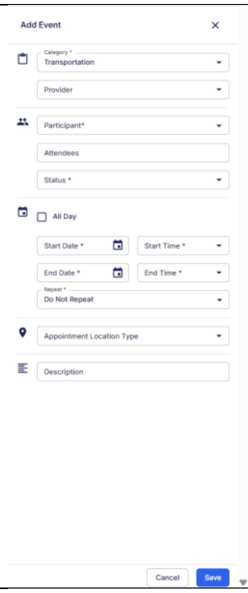
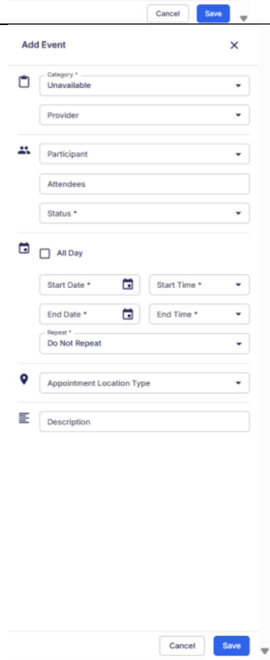
NOTE: If the Participant Transportation Required box is left unchecked, the event will show as not requiring transportation


</td>
</tr>
<tr>
<td>Internal Visit</td>
<td>
</td>
<td>To be used for Internal events at the PACE Center.

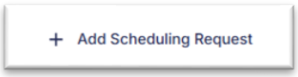
NOTE: The Type list will be customized to your PACE Center.

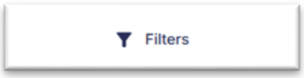
NOTE: If the Participant Transportation Required box is left unchecked, the event will show as not requiring transportation

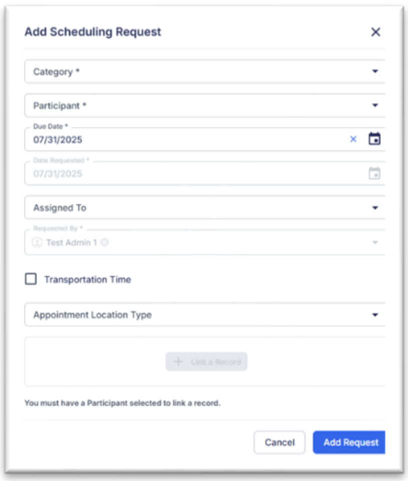

</td>
</tr>
<tr>
<td>Category</td>
<td>Visual</td>
<td>Notes</td>
</tr>
</table>

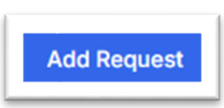
Transportation		To be used for Transportation events that the Participant requires.
Unavailable		To be used to mark a calendar as unavailable.

3. Scheduling Queue

1. 

Use the Add Scheduling Request button to add a new request
2. 

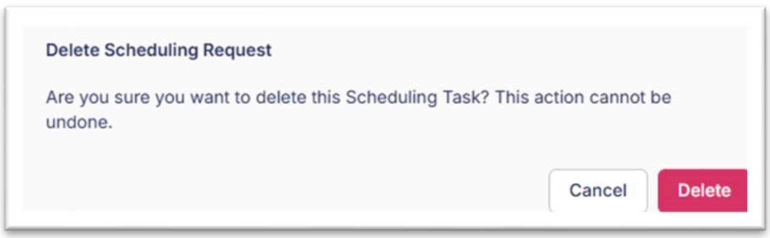
Filter the pending requests
3. 

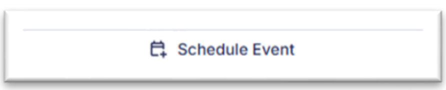
    1. Based on the category, the fields within the Add Scheduling Request box will be different.
        1. External Visit & Internal Visit will have a Type that will be customized to your PACE Center
    2. Participant
    3. Due Date (Defaults to today's date)
    4. Assigned To
    5. Requested By (Auto filled with your username)
    6. Transportation Time: How much time is needed:
        1. Before
        2. After
    7. Appointment Location Type
    8. Link to a Record in the Clinical Chart Elation (EMR)
    9. 

        1. Scheduling Request is now added to the Queue for Scheduling

3. Click on a Scheduling Request in the Queue to Schedule the Event, Edit or Delete it
    1. Click the 3 dots to Edit or Delete the Schedule Request

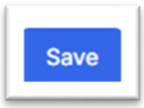
1. Edit
    1. Category
    2. Participant
    3. Location Type
    4. Scheduling Request Description
    5. Date Requested
    6. Assigned To
    7. Requested By
    8. Transportation Time Check Box
    9. Link a Clinical Chart Record in Elation (EMR)
2. Delete



2. 

Button to action it and a new window will appear
    1. Category
    2. Participant
    3. Provider
    4. Status – Will auto update to scheduled
    5. All Day Check Box
    6. Start Date & Start Time
    7. End Date & End Time
    8. Repeat
        1. Do not Repeat
        2. Daily
        3. Weekly
        4. Monthly
        5. Yearly
    9. Appointment Location Type
        1. In Center
        2. In Home
        3. Other
        4. Phone Video

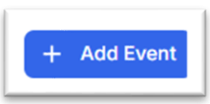
10. Appointment Address
11. Link a Record from the Clinical Chart Elation (EMR)
12. Show Optional Fields
    1. Description
3. When you have finished updating the Event, click the

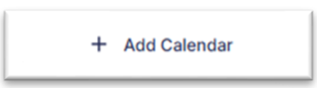


button at the bottom of the screen

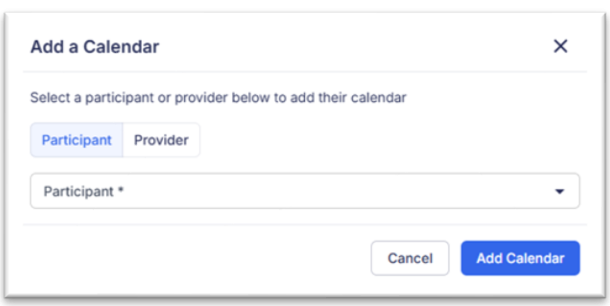
My Calendar

1. Navigate to the scheduling section on the left-hand side of the screen.
    1. Selection My Calendar
    2. You can: Jump to Today, Change the date Range, Filter, change the view to Day, Week, Month, Year Agenda

    3. 

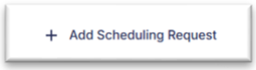
Use the blue Add Event button to add to the calendar.
    4. 

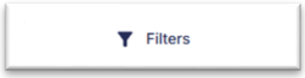
Use this button to add another calendar to your view.

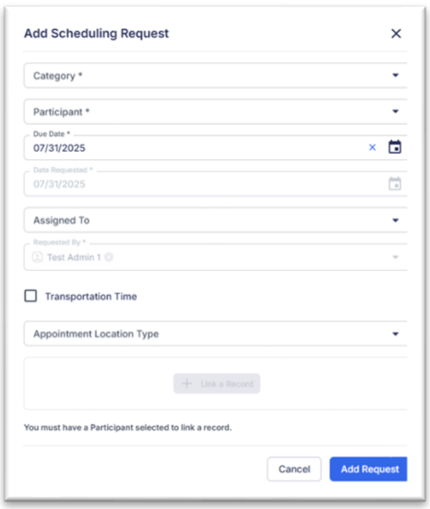


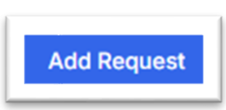
1. You can add a Participant or Provider to your view.
2. You can add multiple calendars to your view.

NOTE: Currently, you cannot save additional calendar to your view. You will need to add the calendar each time.

5. Scheduling Queue
    1. 

Use the Add Scheduling Request button to add a new request
    2. 

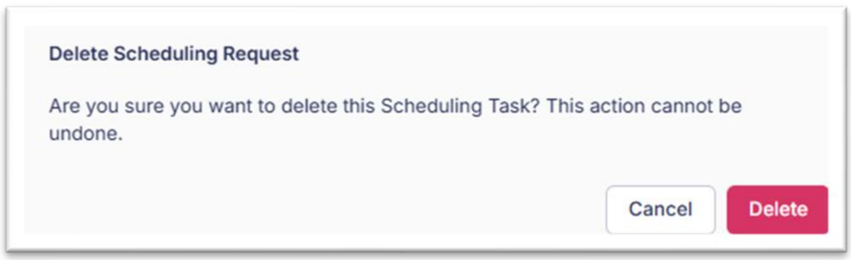
Filter the pending requests
    3. 

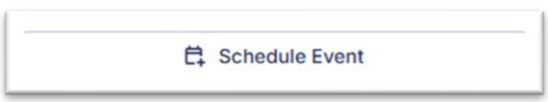
        1. Category
            1. External Visit & Internal Visit will have a Type that will be customized to your PACE Center
        2. Participant
        3. Due Date (Defaults to today's date)
        4. Assigned To
        5. Requested By (Auto filled with your username)
        6. Transportation Time: How much time is needed:
            1. Before
            2. After
        7. Appointment Location Type
        8. Link to a Record in the Clinical Chart Elation (EMR)
        9. 

        10. Scheduling Request is now added to the Queue for Scheduling

6. Click on a Scheduling Request in the Queue to Schedule the Event, Edit or Delete it
    1. Click the 3 dots to Edit or Delete the Schedule Request

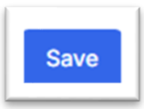
1. Edit
    1. Category
    2. Participant
    3. Location Type
    4. Scheduling Request Description
    5. Date Requested
    6. Assigned To
    7. Requested By
    8. Transportation Time Check Box
    9. Link a Clinical Chart Record in Elation (EMR)
2. Delete



2. 

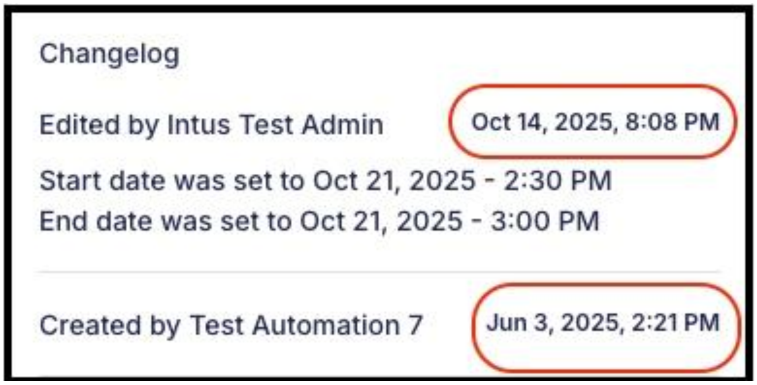
Button to action it and a new window will appear
    1. Category
    2. Participant
    3. Provider
    4. Status – Will auto update to scheduled
    5. All Day Check Box
    6. Start Date & Start Time
    7. End Date & End Time
    8. Repeat
        1. Do not Repeat
        2. Daily
        3. Weekly
        4. Monthly
        5. Yearly
    9. Appointment Location Type
        1. In Center
        2. In Home
        3. Other

        4. Phone Video
    10. Appointment Address
    11. Link a Record from the Clinical Chart Elation (EMR)
    12. Show Optional Fields
        1. Description
3. When you have finished updating the Event, click the

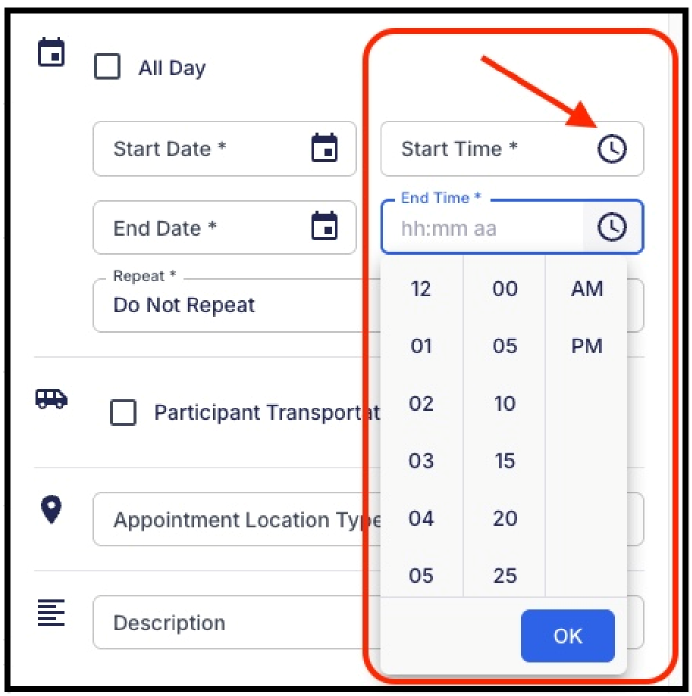


button at the bottom of the screen

Note: Addition of time stamp to Event Changelog to capture not only date, but also time Event was created/edited.

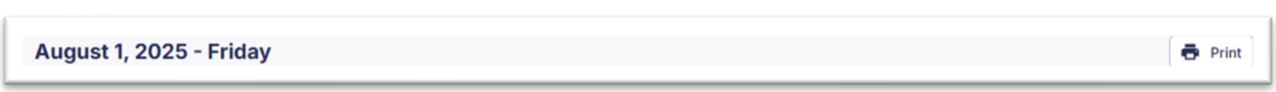


Adjustment to start and end time configuration to include 5-minute increments! Select hour, minute increment, and AM/PM:

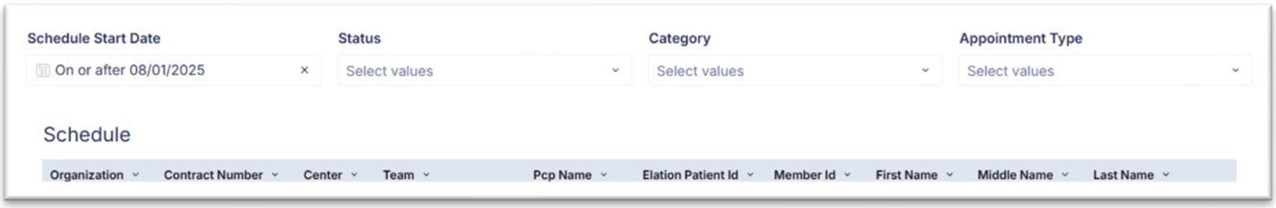


Printing:

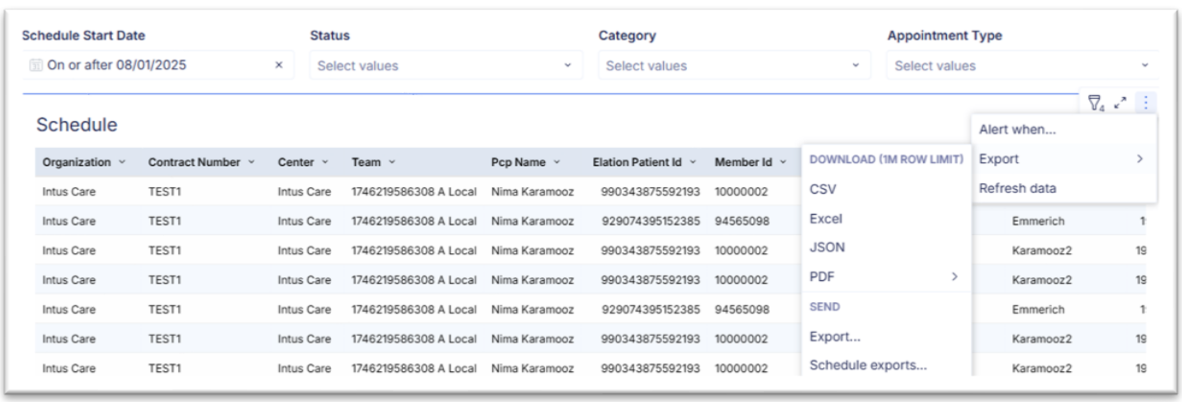
1. From either the My Calendar of Center Calendar, when in Agenda View, hover over the top date bar to see the print button:



2. From the Reports Menu>Standard Reports>Schedule you can Export, Download and Print additional schedule details based off your filter selections:



1. Filters Available
    1. Schedule Start Date
    2. Status
    3. Category
    4. Appointment Type
2. After you have selected your filters, hover over the right-hand side of the view for additional options:



Checklist:

- ✓ View the center calendar.
- ✓ Add scheduling requests.
- ✓ Schedule events from the queue.
- ✓ Edit or reschedule events as needed.
- ✓ Print the Agenda View
- ✓ Navigate to the Reports Menu and filter the schedule report

Knowledge Check:

- How do you add a scheduling request?

- What steps do you take to reschedule an event?
- How do you print the agenda view?
- Are there reports available for the Schedule?

Link to CMS Regulations:

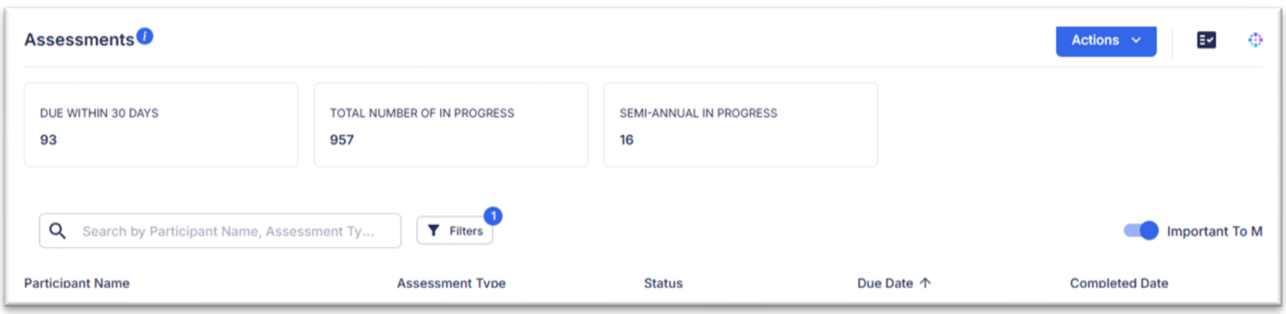
- eCFR :: 42 CFR 460.102 -- Interdisciplinary team.
- eCFR :: 42 CFR 460.76 -- Transportation services.

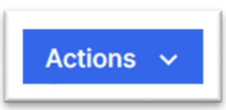
6.Assessments [460.106]

Objective: To complete assessments for participants.

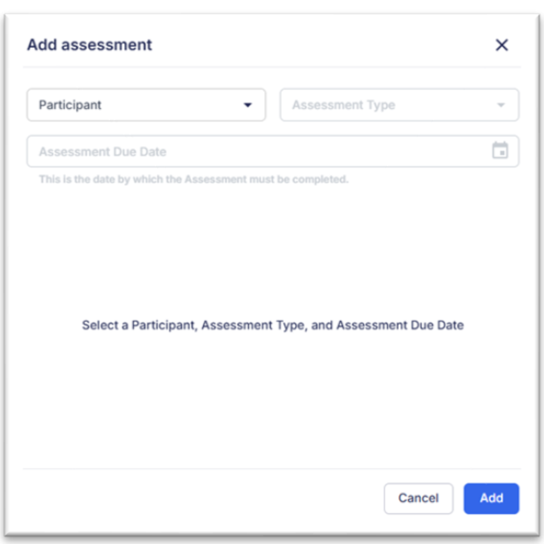
Steps:

1. Navigate to the assessment module on the left-hand side of the screen to view upcoming and in-progress assessments.
2. Summary cards will appear at the top of the screen

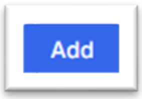


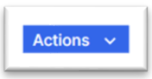
    1. You Can: Search, Filter, Important to me toggle switch on the right-hand side of the screen to see those assigned to you or all assessments
3. **Add Assessment**
    1. 

Use the Actions button at the top of the right-hand side to Add Assessment

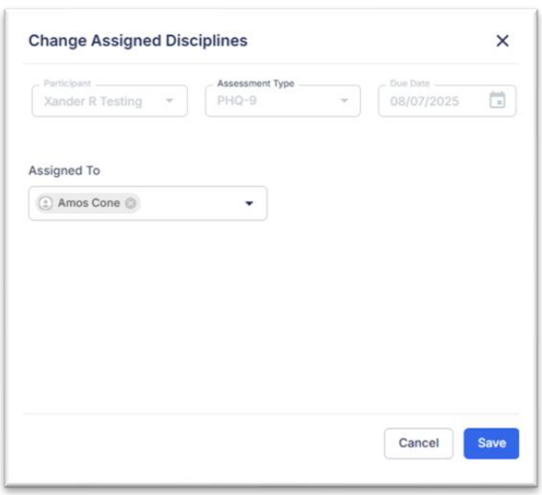


        1. Select the Participant

2. Assessment Type
    1. Select desired Assessment Type
    2. **NOTE:** You will notice that the Comprehensive & Semi-Annual Assessment are not available to select from the list. This are scheduled automatically by the system upon Enrollment.
3. Assessment Due Date
4. Assign To staff to complete
5. 

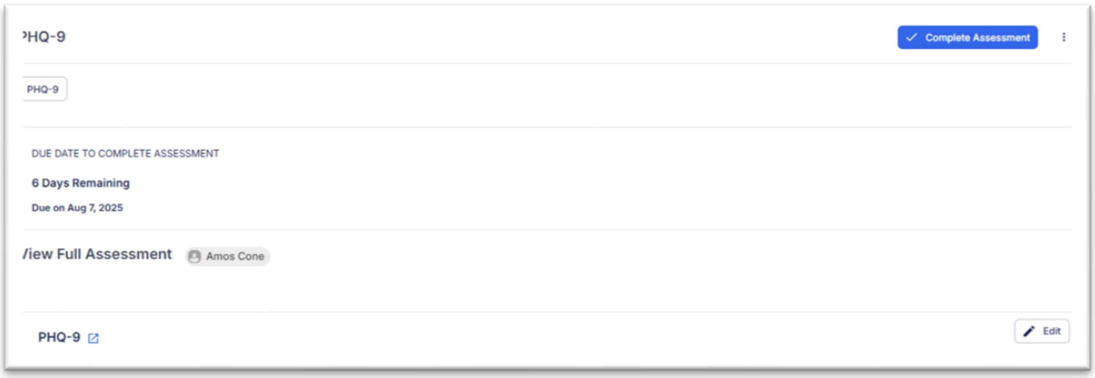
2. This will open the assessment in the Participant Chart and mark it as in progress since it has been assigned to a member of the IDT Team.
3. 

Use the Actions button at the top of the right-hand side to Change Assigned Disciplines:

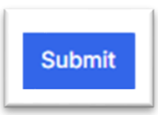


4. At the top of the screen, click the arrow to go back to the Assessment listing

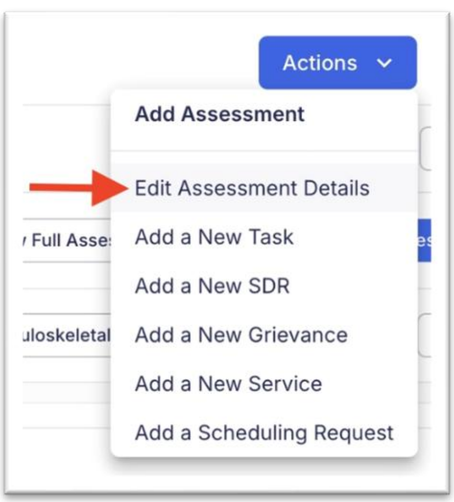
4. **Completing an Assessment**
    1. From the Assessment Menu or the Assessment section of the Participant Profile, select the Assessment that has been assigned to you.
    2. Click on the Assessment to open it.
    3. Hover over the section you want to complete for the Edit button to appear:



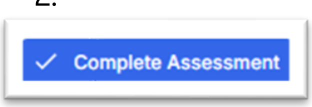
4. A new window will appear on the right-hand side of the screen
5. Complete the necessary information in the assessment.



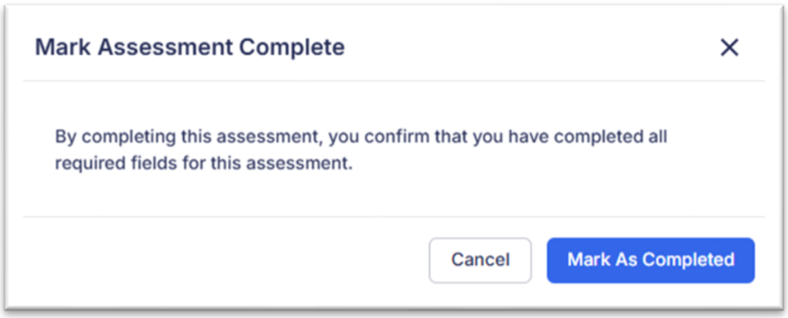
6. Use the Submit button at the bottom of the screen to save information.
7. If necessary before completing an assessment, you are able to Edit Assessment Details. This feature applies to assessments that are in progress (Comprehensive, Semi-Annual, SDR, standard screenings)
    1. Under Actions:



    2.



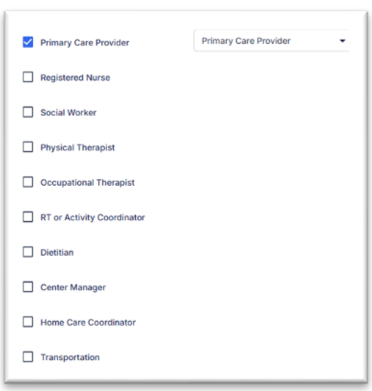
8. Use the Complete Assessment button to finalize the assessment.
9. Mark As Completed.



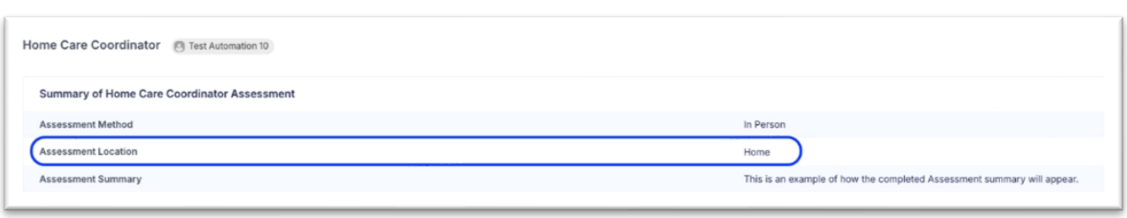
NOTES:

Comprehensive, Semi-Annual and Status Change Assessments are completed by more than one member of the IDT Team. You will see additional fields to assign sections of the assessment for completion.

Added discipline to Assignment option to include PCA (Personal Care Attendant) to align with Care Plan signees.

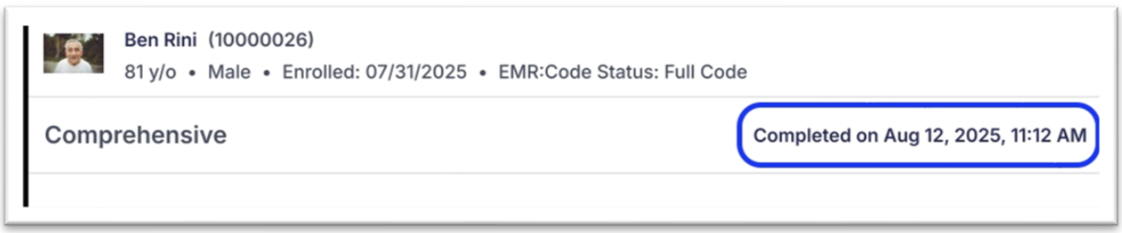


Assessments summaries include a required "Assessment location" field that maps to CMS Audit Universe reporting.

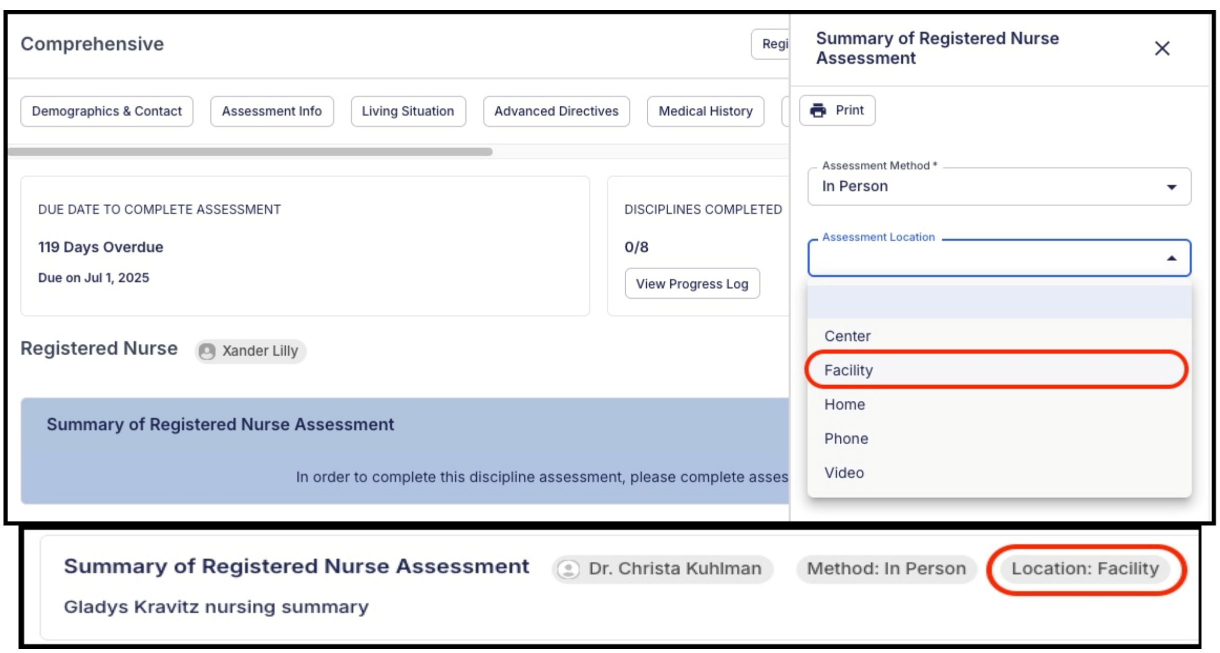


- Initial Comprehensive Assessment due date is based off the selected enrollment date. *Example:* Participant enrollment date is September 1st. Enrollment can be completed on August 29th, and Initial Comprehensive Assessment will be due September 30th.

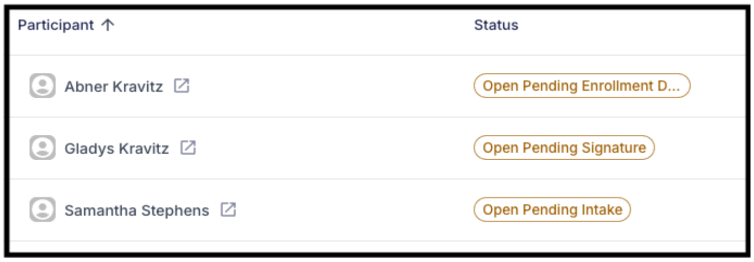
- Completed date & timestamp on printed assessments. **Note:** the PCP Assessment is not included in the Print option, please print from Elation.



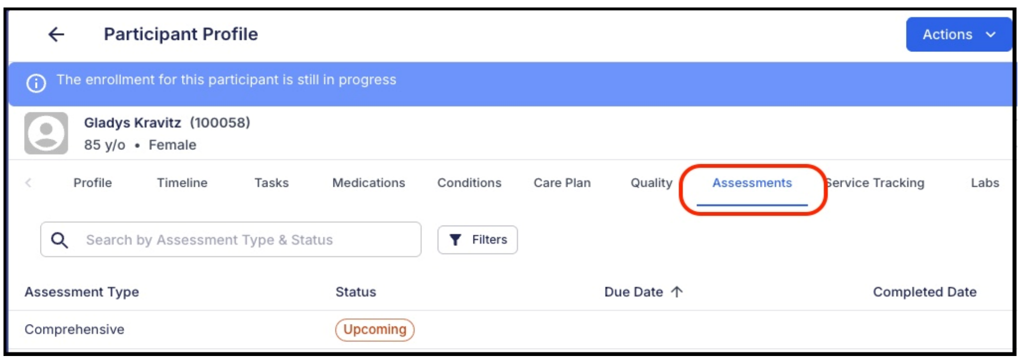
NOTE: There are now updated Summary Details to include "Facility" as an option for Assessment Location. This option applies to Comprehensive, Semi-Annual, Status Change, and SDR assessments.



Pending Participants with Enrollment status of "Open Pending Intake", "Open Pending Signature", and "Open Pending Enrollment Date" will have Comprehensive Assessment available in Participant Profile to action.



Participant Profile is created upon "Add Referral". Navigate to Assessments to find Comprehensive Assessment in "Upcoming" status without due date. (Due Dates will only appear once assessment assigned and status changes to "In Progress".)



NOTE: Users now have added ability to configure Comprehensive, Semi-Annual, and Status Change Assessments within the CareHub application.

This feature is available to users with Org Admin access through the 'Settings' feature in CareHub.

- Settings > Assessment Configurations > Edit
- Please note that changes made apply to 'Upcoming' assessments, not those 'In Progress'.

Auto Generated Tasks from Assessments:

Once a user assigns the disciplines on an assessment, then tasks will be sent out to those assignees upon the creation of the assessment. If a discipline is reassigned, then a new task is sent out to the new assignee while the previous task to the old assignee status is changed to 'Canceled'.

Updating the due date of Assessment will auto update the task due date for all disciplines. This change ensures assessment and task due dates stay aligned, with completed tasks excluded from automatic updates.

Checklist:

- ✓ View upcoming and in-progress assessments.
- ✓ Assign assessments to team members.
- ✓ Complete assigned sections of the assessment.
- ✓ Print an assessment
- ✓ Review the difference between a standard assessment and a comprehensive.

Knowledge Check:

- How do you Add Assessment to a participant?
- How do you assign assessments to team members?
    - What is the status of the assessment when you assign it?
- Why can you not start a new Comprehensive Assessment from the Actions button?

Knowledge Base: (Additional information & training video)

- [Assessments – IntusCare]

Link to CMS Regulations:

- [eCFR :: 42 CFR 460.104 -- Participant assessment.]

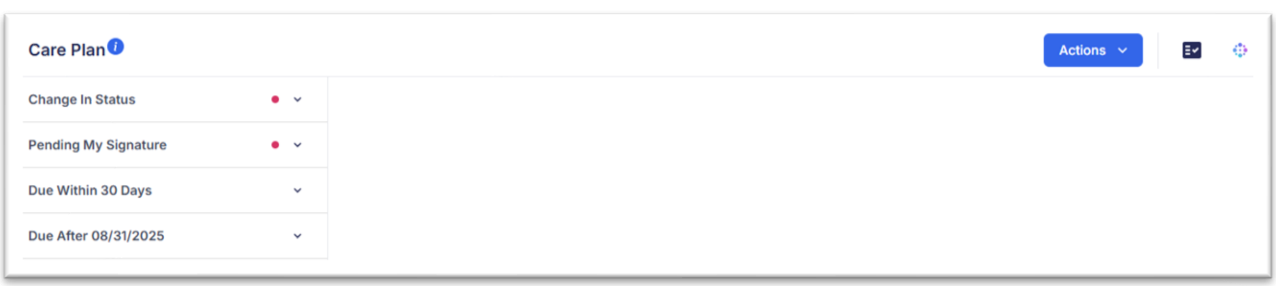
7.Care Plans [460.104 (b)]

Objective: To create and manage care plans for participants.

Steps:

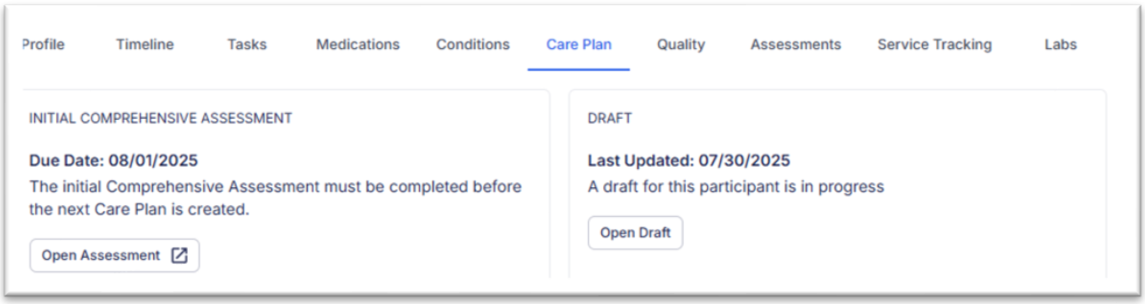
Management of Care Plans for the Center

1. Navigate to the Care Plan section on the left-hand side of the screen.
2. This will show a list of Care Plans Due in the following categories:



1. Change in Status
2. Pending My Signature
3. Due Within 30 Days
4. Due After (Date)

5. Use the "Carrott" to expand the list
    1. This will show the status of the Participant Care Plan:
        1. Overdue
        2. Draft in Progress
        3. Signing
3. Click on the participant's name to open the Care Plan



1. Summary Tiles will appear at the top
2. If a semi-annual or comprehensive assessment needs to be completed – it will show in this area before a Care Plan can be completed.
3. You can Open Draft from this screen. Once the Draft is open you will be able to Print if necessary.

4. Hover over a section for the Edit button to appear:

Creating a New Care Plan or Draft for Pending Participants with Enrollment status of "Open Pending Intake", "Open Pending Signature", and "Open Pending Enrollment Date" & Viewing Active Care Plan

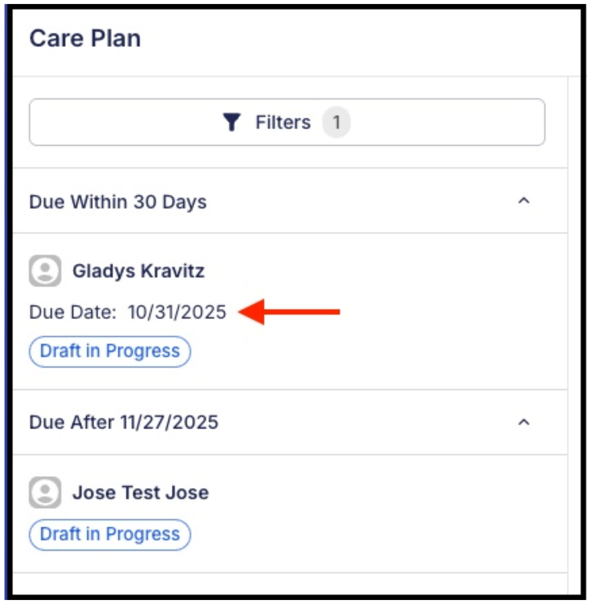
Pending Participants with Enrollment status of "Open Pending Intake", "Open Pending Signature", and "Open Pending Enrollment Date" will have option available in Participant Profile to action a Draft Care Plan.

Upon opening the Draft Care Plan for the first time, the user will be prompted to enter a Care Plan due date:

If no Care Plan due date is entered, a red banner will be displayed when the draft is open to "Set Care Plan Due Date":

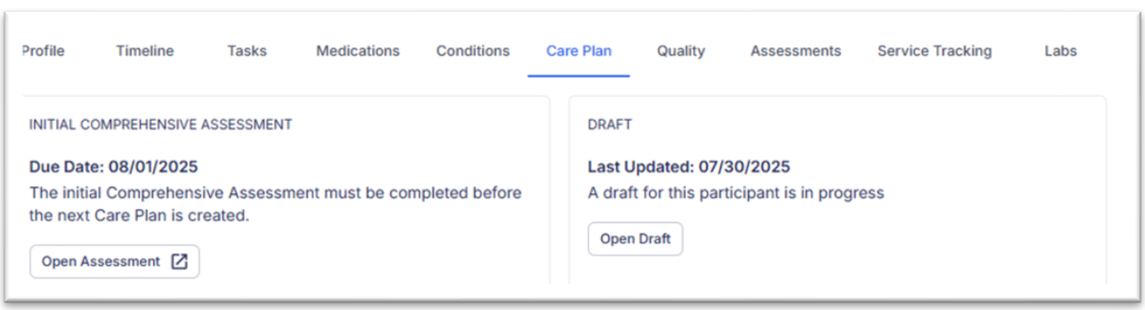
Once the due date is added- the banner will turn blue and allow edits "Change Care Plan Due Date":

The Care Plan queue will include the pending Participants. **Note:** if no due date, the Care Plan will display as due after 30 days:



Creating a New Care Plan or Draft & Viewing Active Care Plans for Enrolled Participants

1. Navigate to the Participant chart to create a new care plan or start a care plan draft for updating.



   1. If a semi-annual or comprehensive assessment needs to be completed – it will show in this area before a Care Plan can be completed.
   2. Open Draft to:
      1. Add Participant Goals
      2. Staff Attendees
      3. Required Signees
         1. User(s) can fulfill more than one discipline. Each discipline selected will display next to their signature.
      4. Notes

        5. Problems, Outcomes and Interventions
            1. Problems
                1. Problem Name
                2. Problem Description
                3. Link IDC10 Code
            2. Measurable Outcomes
                1. Measurable Outcome Name
                2. Description
            3. Interventions
                1. Intervention Name
                2. Description
                3. Addressed Factors (From Content Checklist)
                4. Assigned To
                5. Start & End Date
                6. Link Records

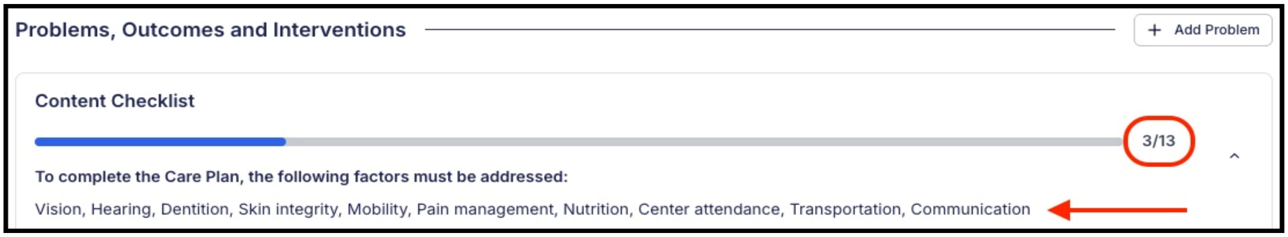
3. Content Checklist:

   Items are automatically checked as **Addressed** factors are **applied** through interventions. Alternatively, each factor can be manually marked as either "Covered" or "Not Needed" directly within the checklist, along with a brief explanation to justify the selection.

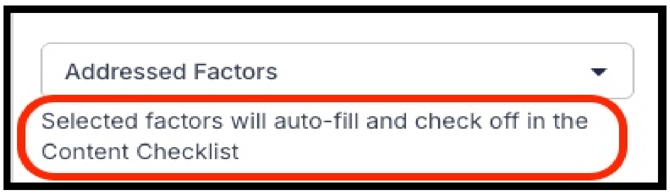
NOTE:

There is now an added link to PACE Federal Regulations to open an external link to reference eCFR::42 CFR Part 460 Subpart F.

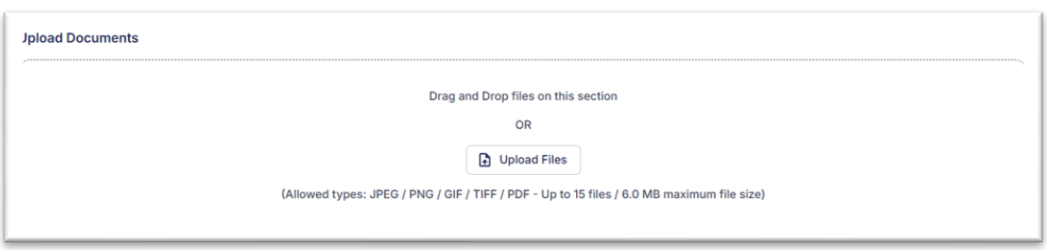
Updated Content Checklist to include progress bar, detailing any outstanding factors:

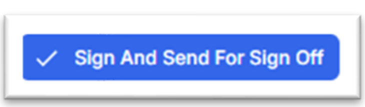


Address Factors message now appears that states selecting a factor(s) from the drop-down list will auto-fill and check off in the Content Checklist.

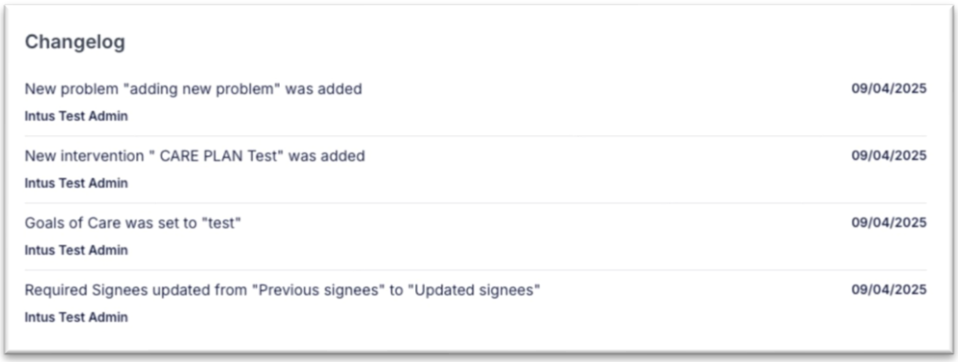


4. Participant Agreement
    1. Date
    2. Description of the method of review and outcome
5. Drag and Drop or Upload Files



6. 

When all sections of the Care Plan are completed and the Content Checklist has been addressed, you are ready to Sign and Send for Sign Off.
7. At the bottom of the Care Plan, you will see a Change log with information about the changes that have been made to it with Username information and a date stamp.



8. Past Care Plans:
    1. If the participant has a pervious Care Plan it will show in this section.
    2. Previous Care Plans can be viewed or printed.
    3. Previous Care Plans cannot be edited.

2. After the Care Plan is active, you can add NEW Problems, Outcomes and Interventions.
    1. https://www.loom.com/share/2d06c6a335cf41b1aac97fde671bbc74?sid=c1107a33-790c-45d9-b456-e0aff9891e4d

Auto Generated Tasks from Care Plans:

Once a user assigns the Required Signees on a Care Plan, tasks will be sent out to those signees upon the clicking of the Save and Send for Sign off button.

Checklist:

- ✓ Create a care plan.
- ✓ Add problems, outcomes, and interventions.
- ✓ Link records from assessments.
- ✓ Sign and send care plan for sign-off.

Knowledge Check:

- How do you create a care plan?
- What steps do you take to link records from assessments to the care plan?

Knowledge Base: (Additional information & training video)

- Care Plans – IntusCare

Link to CMS Regulations:

- eCFR :: 42 CFR 460.104 -- Participant assessment.

8.Clinical Record in Elation (EMR) [460.102]

Objective: To access and manage the clinical record in Elation.

Steps:

- **Integration**: CareHub and Elation EMR are integrated to provide a seamless experience for users. The clinical component, referred to as Elation, is where most of the provider's workflows are completed.

- **Navigation**: Users can navigate between CareHub and Elation EMR using the "Go to EMR" link in CareHub, which opens Elation in a new tab. This allows providers to switch between the two systems easily.

- **Clinical Documentation**: Providers complete their clinical documentation in Clinical Record Elation (EMR). This includes Visit Notes, Assessments, ePrescriptions, Medication Listing, Referrals, Orders, Labs.

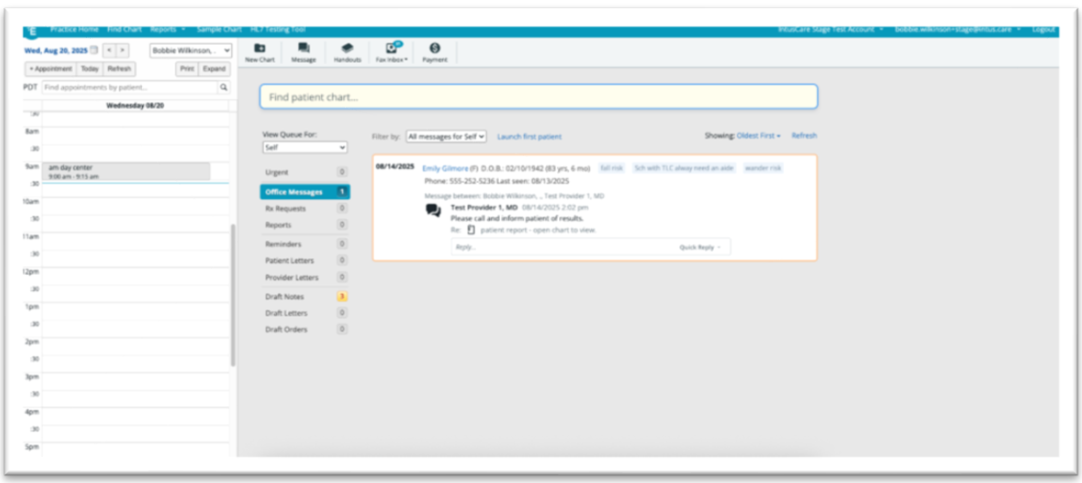
- **Linking Records**: From within CareHub, you will be able to link documentation from the Clinical Record in Elation (EMR) to numerous different areas in CareHub. This would include the Care Plan, Scheduling, Assessments, SDR's, Quality Inbox.

- **Messaging**: The Clinical Record Elation (EMR) is used for messaging (via office messages) related to clinical workflows. Messages can be sent within the clinical record to coordinate care.

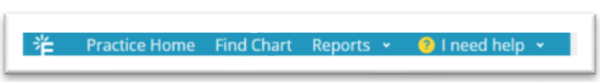
Elation Navigation

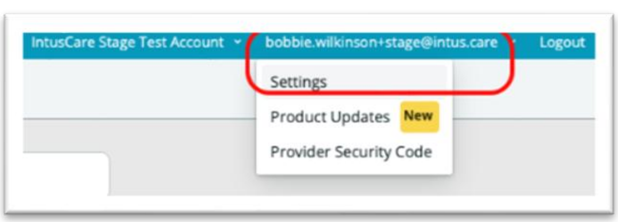
Objective: Overview of basic navigation in the Elation application, search features and menu options.

Steps: To access the Clinical Record Elation (EMR) use the 'Go to EMR' button on the **CareHub** dashboard and your default view will be on the home page.



Menu Bar

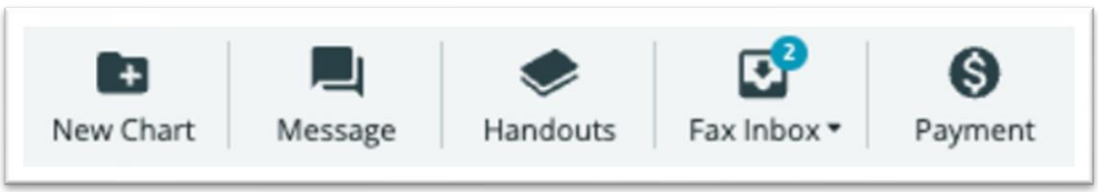
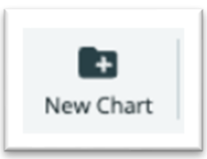
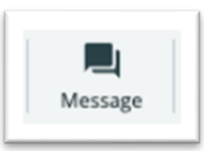
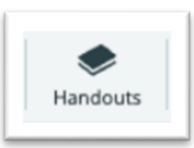
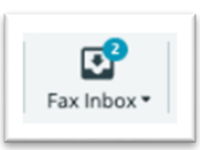
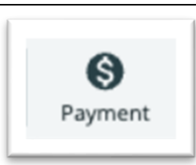




1. Practice Home - Elation home page
2. Find Chart
3. Reports

4. I Need Help – Elation Help Files
5. Location
6. Username Information
    1. Contains a drop down to provide access to setting
7. Logout

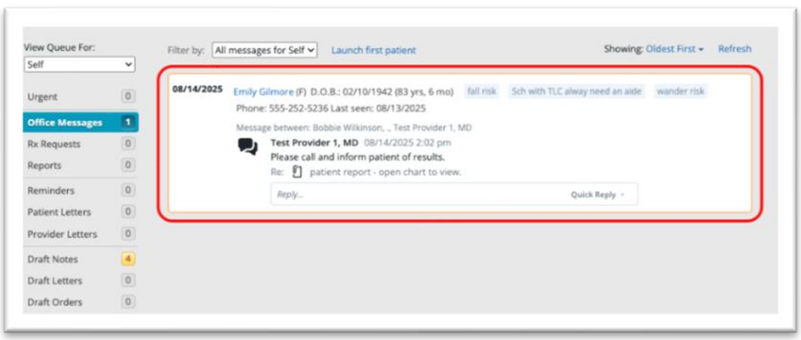
Additional Menu Options

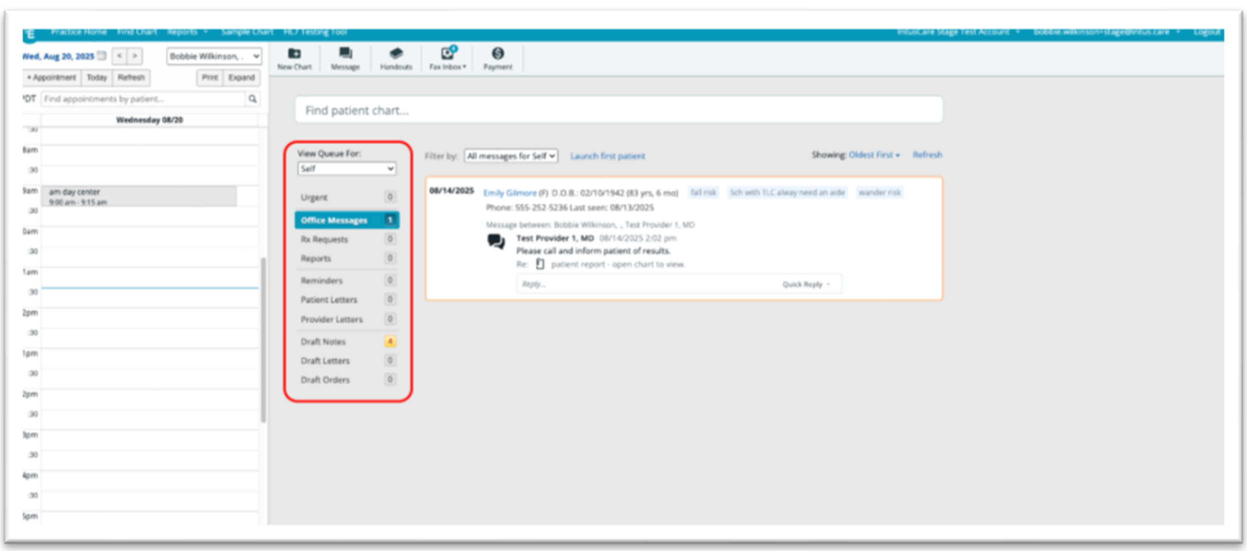
	
	**New Chart (Adult Day Center Only Patient Charts)** Allows you to create a new patient chart (All PACE enrolled participants will be enrolled through CareHub, see Enrollments section of this guide)
	**Message** Allows you to create and send a new message to clinical staff
	**Handouts** Allows you to upload and access patient educational handouts and materials
	**Fax Inbox** Allows you to view unfiled faxes
	**Payment (Not in use for PACE Organizations)**

Search Bar

- Allows you to search for a patient's clinical chart
- Allows you to search for documents using keywords or document tags

The central body of the Elation home page will contain the clinical user's inbox queue as well as a snapshot of the message



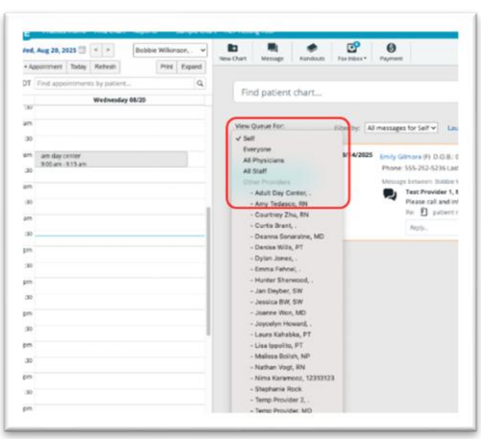


- **Urgent**: Allows you to view messages that have been marked as urgent or other urgent messages, for example, prescription refill requests that failed to send

- **Office Messages:** Allows you to view non urgent office messages

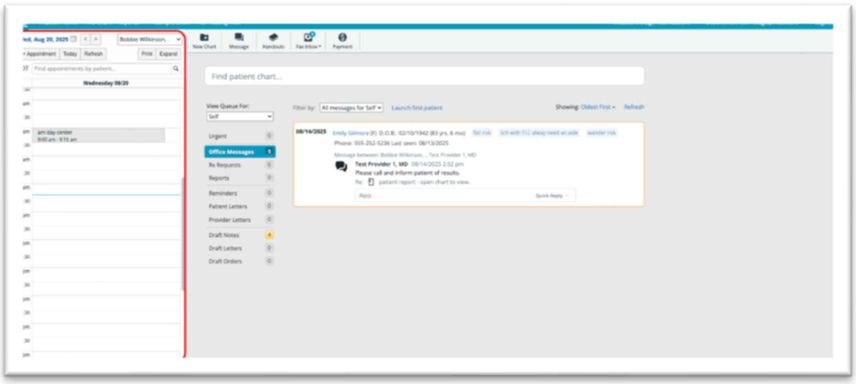
- **Rx Requests:** Allows you to view Rx requests sent from the pharmacy
- **Reports**: Allows you to view external consult notes that need review and sign off
- **Reminders:** Allows you to view important alerts related to important patient or staff tasks
- **Patient Letters**: Allows you to view patient messages, often with attached health information like lab results or visit notes, that a practice sends to a patient or external provider
- **Provider Letters**: Allows you to view provider messages, often with attached health information like lab results or visit notes, that a practice sends to a patient or external provider
- **Draft Notes**: Allows you to view any notes that are currently in a draft status that need to be completed and signed
- **Draft letters**: Allows you to view provider letters that are currently in a draft status that need to be completed and signed
- **Draft Orders**: Allows you to view referrals, lab orders and prescriptions that are in a draft status that need to be completed and signed

TIP: You have the ability to change the queue that you are viewing! Simply select the drop down to change the user.



Scheduling Calendar (Adult Day Center Only Patient Charts)

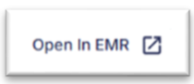
On the left-hand side of the screen, you will see a scheduling calendar that can be used.



Participant Clinical Chart [460.102]

Objective: Overview of navigation of the participant profile within Elation.

Steps:

1. Select the ‘Open in EMR’ 

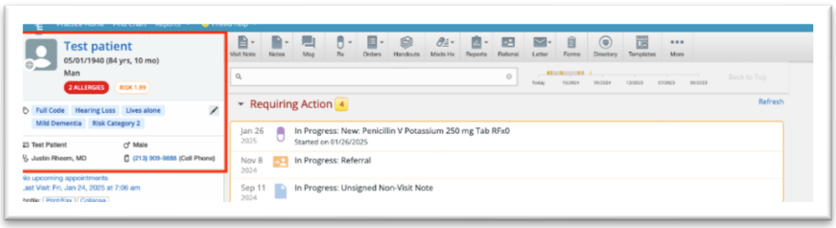
link within CareHub to access the participant's Clinical Record (EMR).
2. View the participant's profile to see:
   a. Participant’s clinical facesheet
   b. Chronological Record
   c. Outstanding Items
   d. Items Requiring Action
   e. Ability to create Visit Notes, Orders and Referrals, Messages, and more.

Participant Clinical Facesheet

Overview: The Clinical Facesheet appears in the left-hand panel of every participant’s chart, providing quick access to key clinical information such as medical history, medications, problems, and allergies. It remains visible and accessible throughout the chart—even while documenting a visit note, so providers can easily reference important information without navigating away from their workflow. It remains visible and accessible throughout the chart, allowing any user to view or update it as needed.

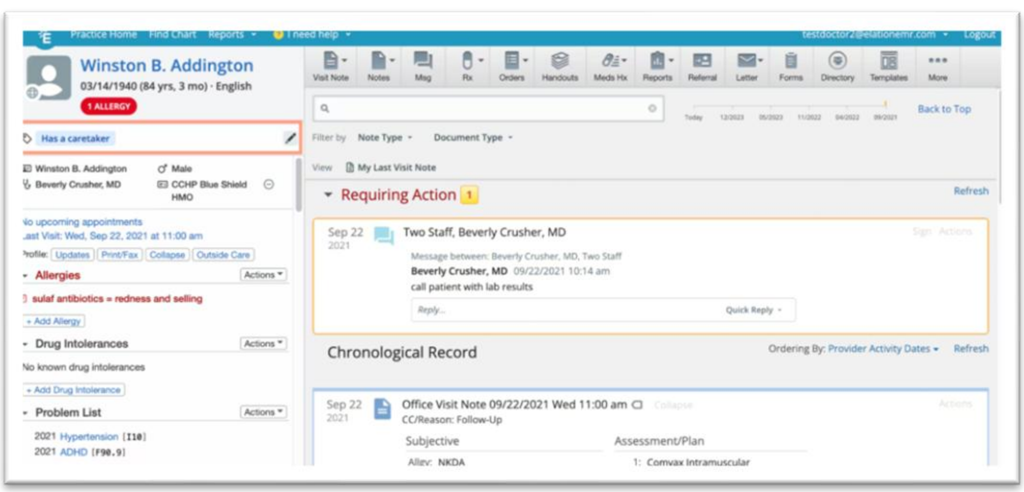
Demographics

The Clinical Profile is designed for efficiency and includes the display of full legal name listed, the participant’s sex at birth, cell phone number, the PCP that they are assigned to, as well as an IntusCare CareHub link. When documented within CareHub, the patient's preferred name (e.g., full name if different from legal) will be shown in the Clinical Profile in Elation, while other key information, such as insurance and contact details, remains easily accessible.



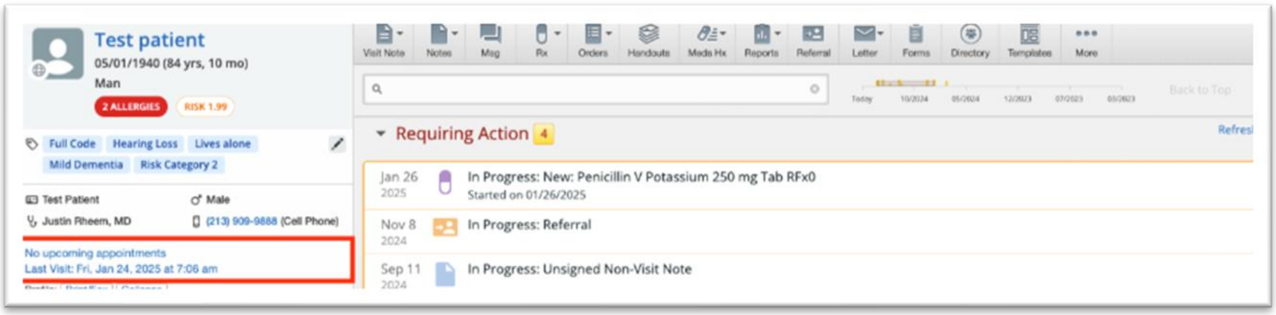
User Tips

✓ Users can add Patient Tags to a patient's chart. Patient Tags will allow you to see short notes about your patients without having to open their patient demographic section. You can also use the Patient List Report to easily search for patients by the Patient Tags in their chart.
✓ Patient Tags can be edited, removed or merged within user settings under 'Patient Tags'
✓ Patient Tags are located underneath the patient's name & date of birth in the patient chart.
✓ Any Patient Tags that are added within Elation will show in the Participant Profile within CareHub.



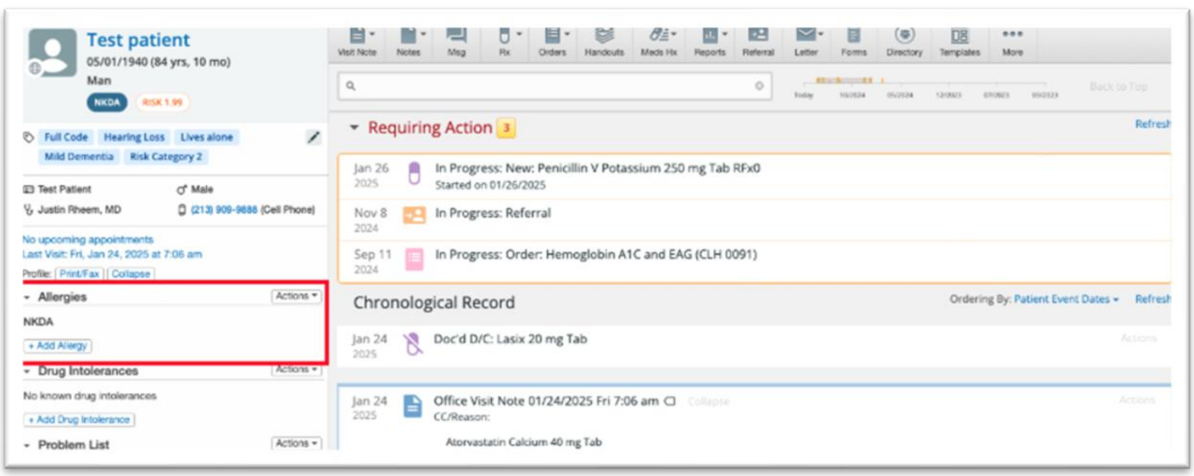
Appointments

Underneath the demographics overview, the next appointment date and time for the participant can be viewed (This information comes from last recorded office note - not the CareHub Schedule.)



Allergies

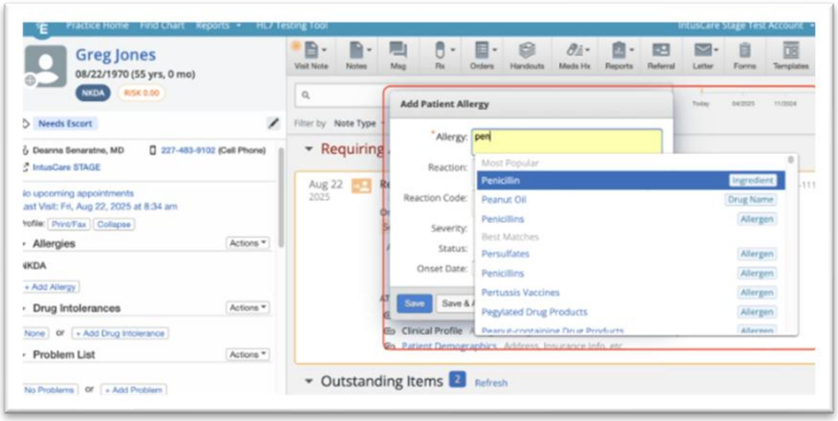
The allergies section can be used to document information about your participant's allergies. A default text of 'NKDA' will be displayed if there are no allergies listed.



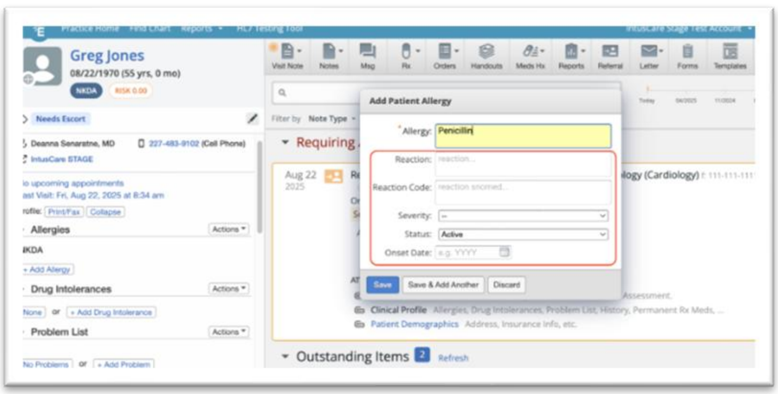
How-to Guide: Documenting an Allergy

1. Click on + Add Allergy in the Allergies section.

2. Type in the allergy and select from the drop down.
    1. Allergies can also be entered as free-text if a drop down option is not available.

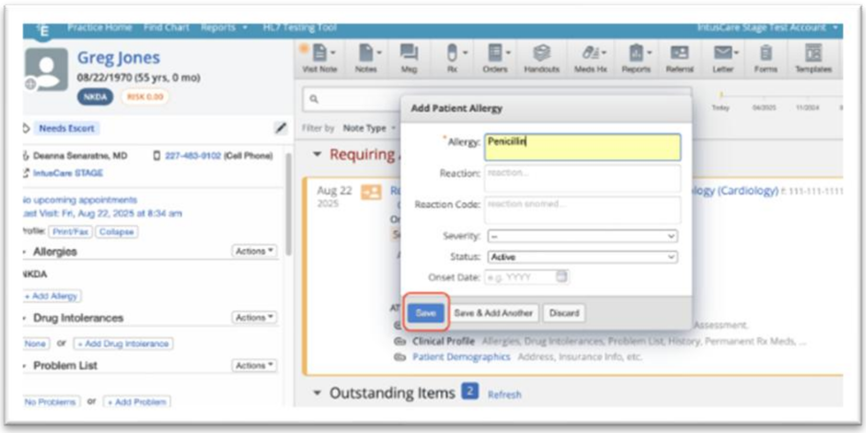


3. Fill in the following fields as needed

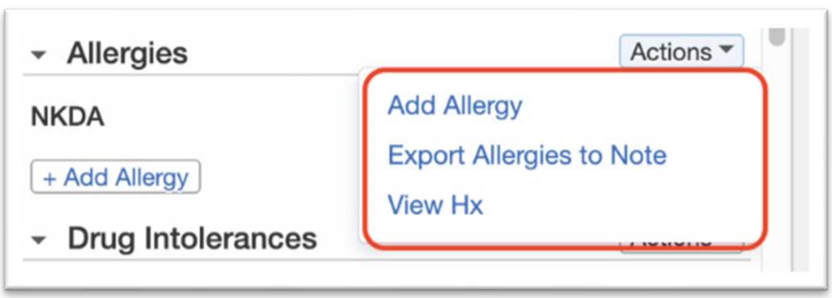


a. **Reaction *(optional)*** – Enter structured information describing the type of allergic reaction experienced (e.g., rash, shortness of breath).
b. **Reaction Code *(optional)*** – Input the corresponding SNOMED-CT (Systematized Nomenclature of Medicine – Clinical Terms) code for the reaction, if known.
c. **Severity *(optional)*** – Select the severity of the reaction: *Mild*, *Moderate*, or *Severe*.
d. **Status** – Indicates whether the allergy is currently active. The default status is *Active*.
e. **Onset Date *(optional)*** – Document the date the allergy began, if known.

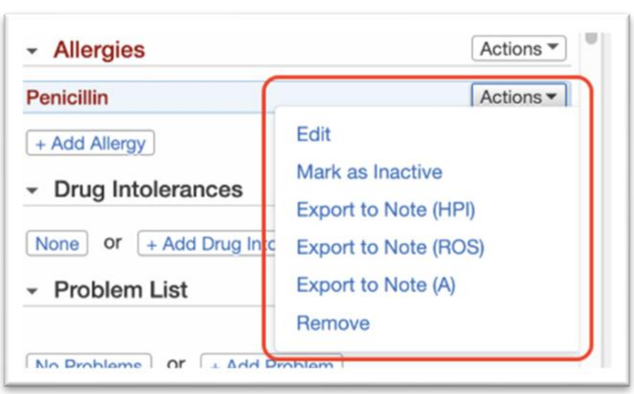
4. Click on Save or Save & Add Another if there are more allergies to be documented.



5. You can also view the participant's allergy history and export allergies to a visit note by clicking on the Actions drop down button.



6. To edit, export to notes, mark as inactive or remove an individual allergy, click on the actions drop down button next to the allergy you wish to edit.



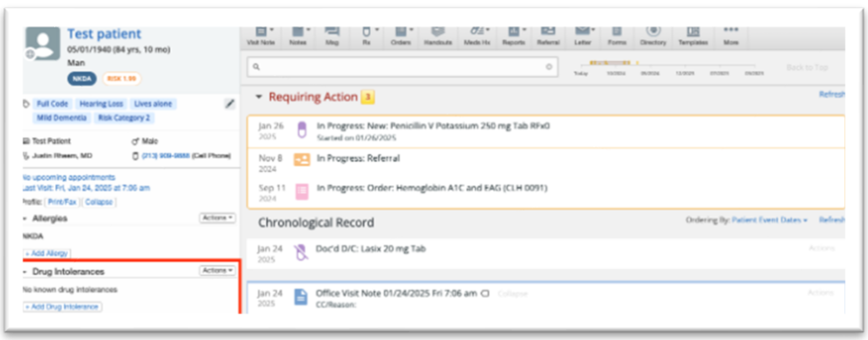
User Tips

✓ When selected from the database, the information will be used to detect potential allergic reactions when you prescribe medications and notify you of interactions.

✓ If the participant does not remember the exact month and date of the allergy, type in the year and press the "Tab" key on your keyboard. Elation will automatically set the date as January 1st of that year.

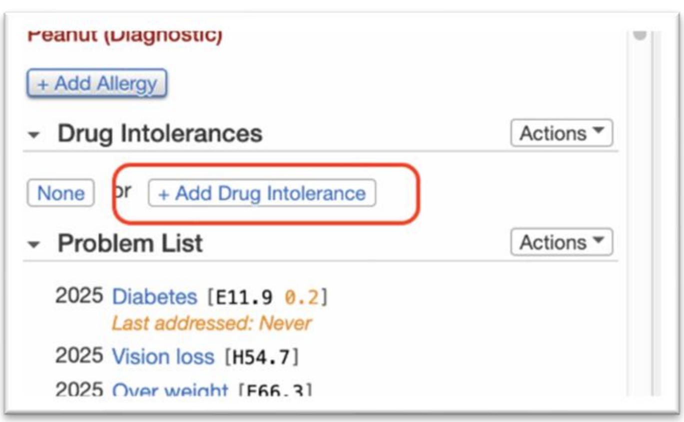
Drug Intolerance

The drug intolerance section can be used to document information about your participant's drug intolerances. A default text of 'No known drug intolerances' will be displayed if there are none listed.



How-to Guide: Documenting Drug Intolerances

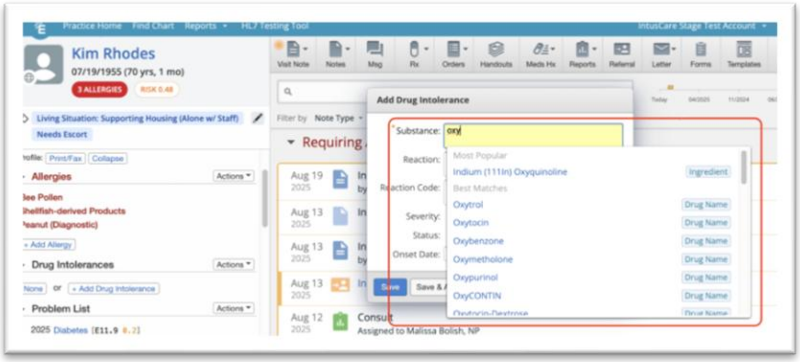
1. Click on + Add Drug Intolerance



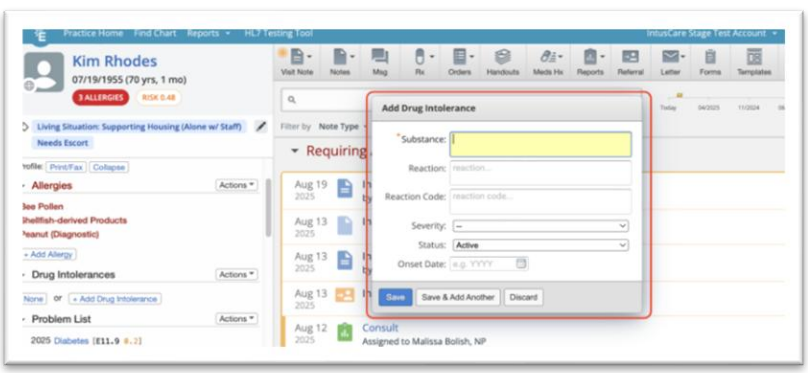
.

2. Type in the substance that the participant has a drug tolerance to.

a. Drug intolerance can also be entered as free text if a drop-down option is not available.



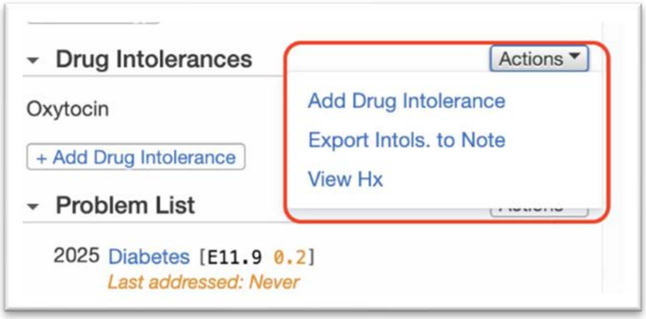
2. Fill in the remaining sections as needed.
   a. **Substance** – Use the drop-down menu to select the most accurate drug from Elation's database when documenting drug intolerance.
   b. **Reaction *(optional)*** – Enter structured information describing the type of reaction experienced (e.g., nausea, dizziness).
   c. **Reaction Code *(optional)*** – Input the SNOMED-CT (Systematized Nomenclature of Medicine – Clinical Terms) code for the reaction, if applicable.
   d. **Severity *(optional)*** – Select the severity of the reaction: *Mild*, *Moderate*, or *Severe*.
   e. **Status** – Indicates whether the intolerance is currently active. The default status is *Active*.
   f. **Onset Date *(optional)*** – Record the date the intolerance began, if known.



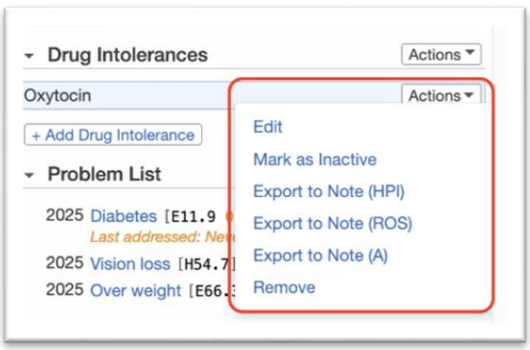
3. Click on Save or Save & Add Another.

4. Click on Actions

5. You can also view the participant's drug intolerance history and export intolerances to a visit note by clicking on the Actions drop down button.



6. To edit, export to notes, mark as inactive or remove an individual drug intolerance, click on the actions drop down button next to the drug intolerance you wish to edit.

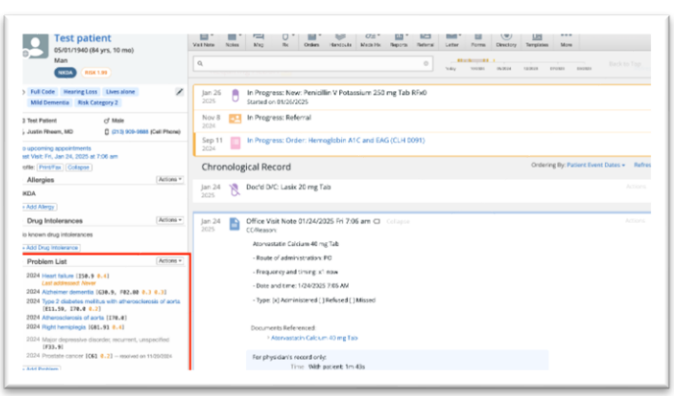


User Tip

✓ When selected from the database, the information will be used to detect potential drug reactions when you prescribe medications and notify you of interactions.

Problem List

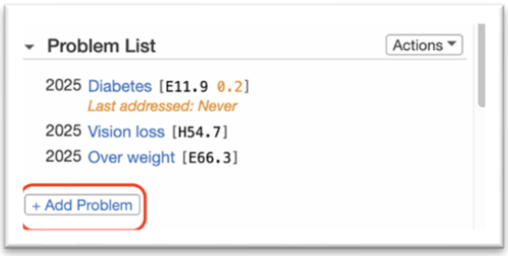
The problem list section provides a snapshot of the participant's problems and diagnoses.



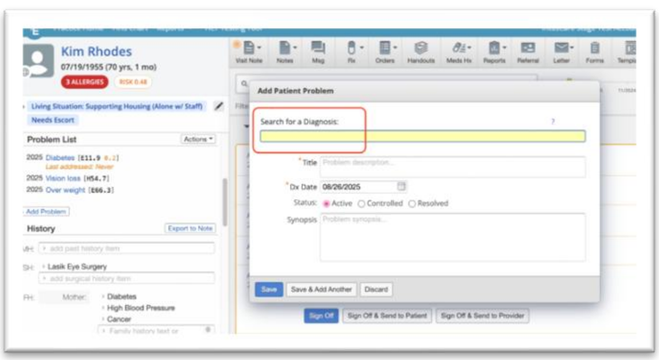
IntusCare

How-to Guide: Adding a Problem

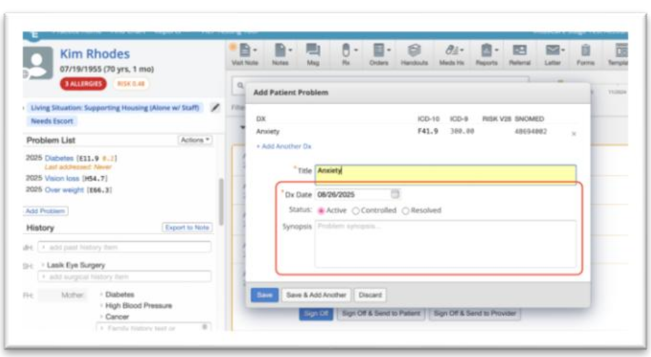
1. Click on + Add Problem



2. Type in the problem you want to add, Click the appropriate diagnosis.

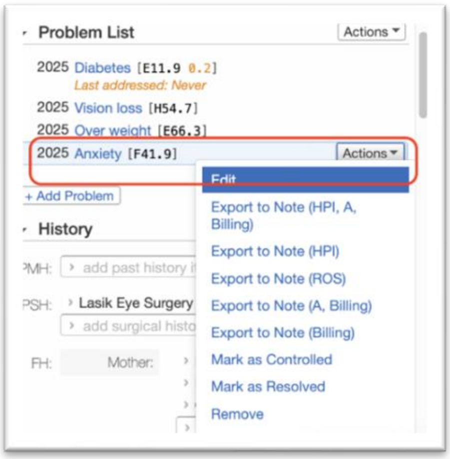


3. Fill in the remaining sections as needed.



4. Click on Save or Save & Add Another to add more diagnoses

5. To edit, export to notes, mark as inactive or remove an individual problem, click on the actions drop down button next to the problem you wish to edit.



User Tips

✓ Any problems that are added within the participants clinical chart will automatically transfer to the participants 'Conditions' tab within their Participant Profile in CareHub

✓ The problem list can be re-ordered manually if desired by hovering over the section and selecting the 'Hamburger' icon to drag and drop problems

✓ The search results will only show the best diagnosis for each ICD-9 + ICD-10 pair. If you want to see every possible diagnosis (including duplicates) prepend a "!" in front of your query (ex. "!bmi") and you will see all possible search results.

✓ The search tool includes common abbreviations to allow you to find problem codes and specific sub-diagnoses. For example:

1. "hbp" for high blood pressure
2. "fx" for fractures

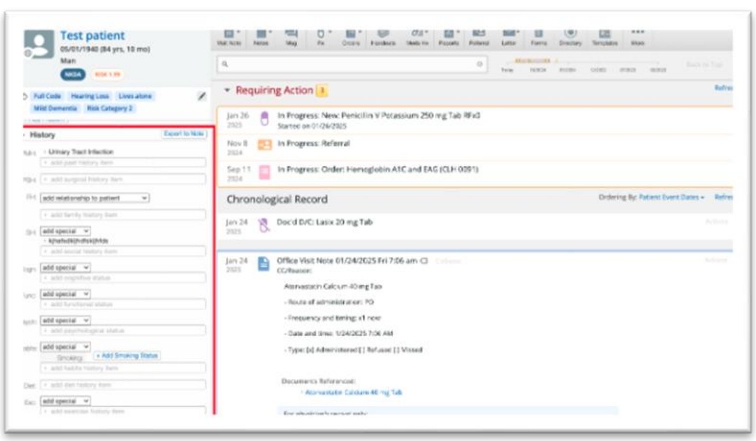
3. “po” for poorly controlled diagnoses

4. “w” - for well-controlled diagnoses

History

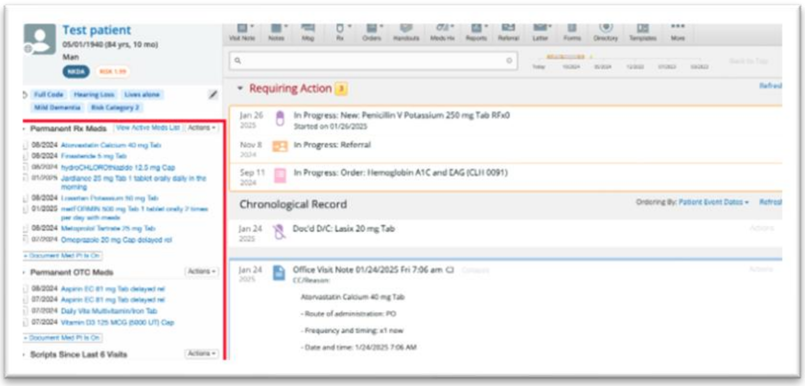
The History section is classified into subsections to allow you to easily fill in and reference details about your participants. Each section can be recorded in a structured or free-text manner.

Contains past medical, surgical, family history, social history, as well as any cognitive or psych statuses and functional statuses. Additionally, you can include diet and exercise information as well as participant habits.

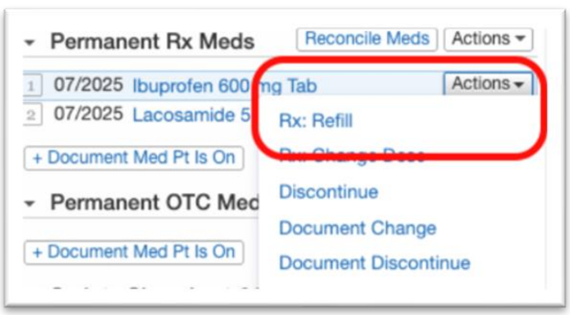


Medication

A participant’s current and historical medications can be documented in this section. Permanent medications that are prescribed or ordered will automatically be recorded in the *Permanent Rx Meds* or *Permanent OTC Meds* sections. You can also view copies of any scripts prescribed within the last 6 encounters under the *Scripts since last 6 visits* section.



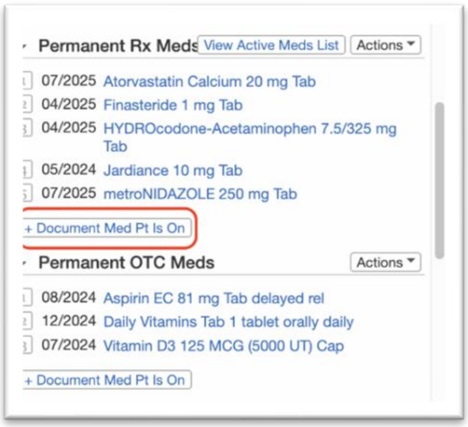
Hovering over medications allows you to see the 'Actions' button where you can create refills, start a change of dose or document discontinuations.



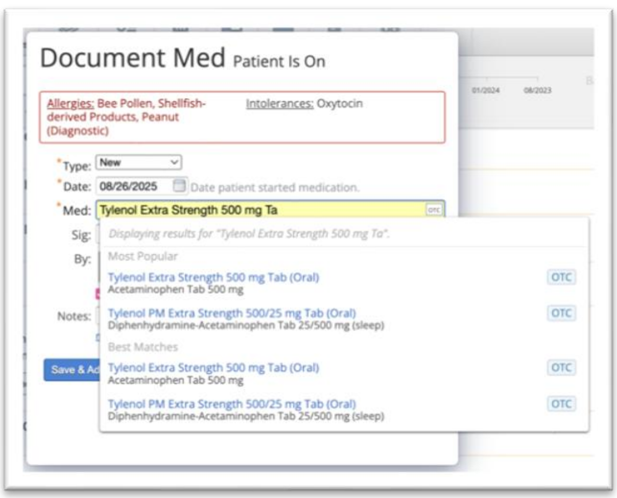
How-to Guide: Documenting Existing Medications

1. Click on + Document Med Pt Is On

a. Medications can be documented under the Permanent Rx Meds **or** Permanent OTC Meds sections

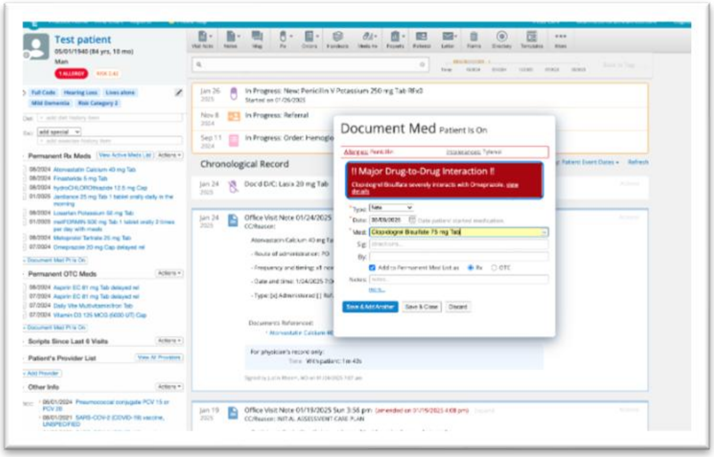


2. Type in and select the medication you wish to document.



a. Note that a Major Drug-to-Drug Interaction notification will pop up if there is a known interaction with another medication that the participant is on

IntusCare



3. Fill in the remaining sections as needed. Click on more to log the quantity of the medication, units and refills

4. Click on Save & Close or Save & Add Another.

User Tips

✓ As medications are documented, once saved, they will reflect within the participant's chronological record.

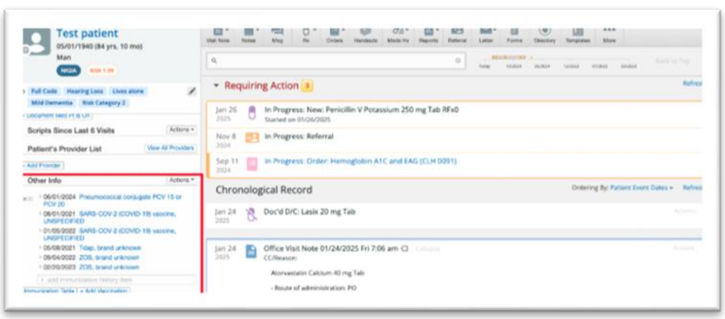
✓ If the participant does not remember the exact month and date the medication was started, type in the year and then press the "Tab" key on your keyboard. Elation will automatically set the date as January 1st of that year.

✓ Logging the quantity, units, and refills of the medications is useful to make medication refills easy.

✓ Documenting medication vs. Prescribing medication: Selecting the discontinue button on documented medication will not send a cancellation to the pharmacy. To actually communicate that discontinuation to the pharmacy, you would need to call. However, if a prescription was *prescribed* from Elation within the system and you were to discontinue the medication, it does send an electronic discontinuation to that pharmacy.

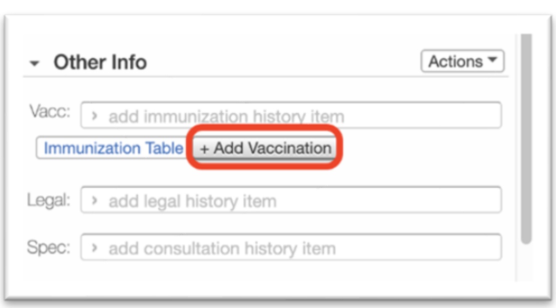
Vaccinations

The vaccination section allows you to document structured or free-text vaccination information. To view the participant's immunization table, click *Immunization Table*, or click on the Actions button to print the participant's immunization history.

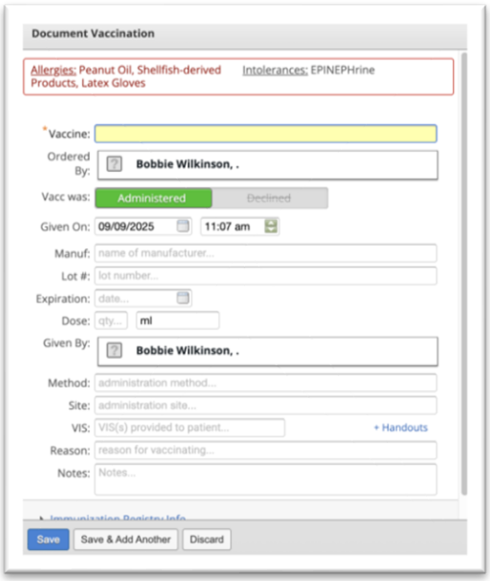


How to Guide: Adding a Vaccination

1. Select the '+Add Vaccination' button under the 'Other Info' section within the participant's facesheet

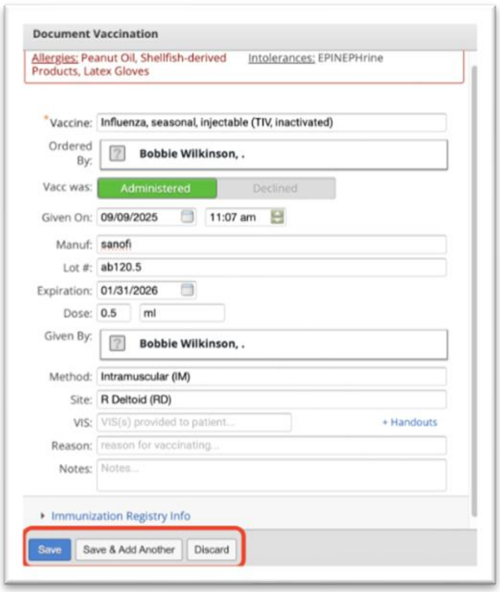


2. Fill out all required information



- Vaccine:
- Ordered By:
- Vacc was:
  - Administered
  - Declined
- Given On:
- Manuf:
- Lot #:
- Expiration:
- Dose:
- Given By:
- Method:
- Site:
- VIS:
  - + Handouts
- Reason:
- Notes:

3. Select Save, Save & Add Another or Discard

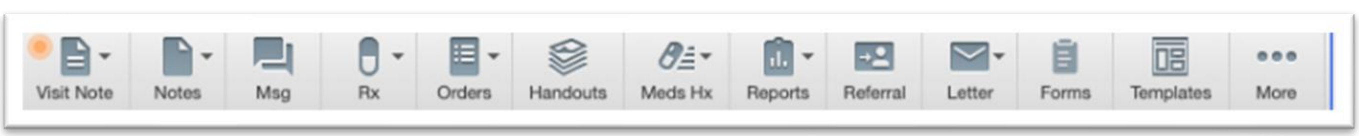


Health Maintenance

- If your organization uses MIPS, you do have the ability to turn those MIPS measurements on, then based off your participants age, sex at birth and problem list, if they qualify for certain screenings the system will flag those screenings for them.

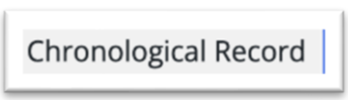
Body of Participant's Clinical Chart

Menu Bar



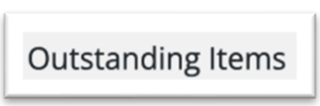
- **Visit Note** – Visit note types to have structured note layouts and formats.
- **Notes** - Non structured notes including Phone Notes, Non-Visit Notes, Email Notes and Point-of-Care Labs
- **MSG** – Internal office message tool to communicate regarding the patient. This is not a chat feature, anything documented here will live in the participant's chart
- **Rx** – Used to prescribe medication as well as perform other actions such as change prescriptions and order refills.
- **Orders** – Includes five order categories; Lab, Imaging, Cardiac, Pulmonary and Sleep.

- Handouts
- **Meds Hx** – Ability to view Medication History
- **Reports** – Can be referred to as your participant's 'electronic file cabinet.' The particiapant's lab results, specialty visits, documents, etc. will be stored here. This drop-down list is configured to your organization's needs.
- **Referral** – Used to send referrals to external specialties but for internal orders as well.
- **Letter** – Used to send a letter to an external provider and follows a similar procedure as a referral. You may also send a letter to your patient.
- **Forms**
- **Templates** – Used to house all visit note templates; PE, ROS, lab order sets, letter and referral templates. Your organization can create these templates within the system which will be visible to all users.
- **More**



- **Chronological Record**

- The "Chronological Record" is the central hub of a patient's chart, containing a complete, sortable history of their clinical care, including signed visit notes, orders, lab results, and messages, arranged from most recent to oldest.



- **Outstanding Items**

- "Outstanding Items" are open tasks or items within a patient's chart that are either assigned to another colleague or provider, or are awaiting a future action date, such as a scheduled office message delivery.

- This includes tasks like signed unfulfilled orders, referrals, certain patient forms, or messages waiting on other team members.

- **Requiring Action**

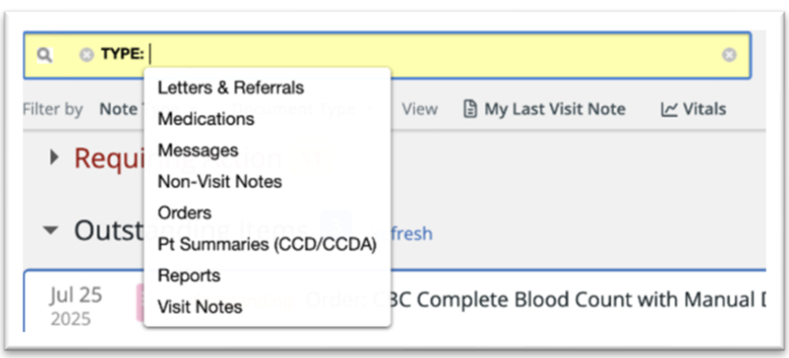
- The Requiring Action queue is at the top of your patient's chart and is outlined in yellow. If there are open items that are assigned to "you" and require your immediate attention, they will populate here. This can be:
- This section is *not* specific to one user, it will hold all unsigned notes for the participant as well as anything in progress such as orders, labs, referrals and notes. It will also hold incoming documents that need to be reviewed and signed off on.

User Tip

✓ The most recent dated item will come first. We recommend always addressing items in *Requiring Action* in a timely manner. If the item no longer requires your attention, you should take the appropriate actions to remove it from *Requiring Action*.

Searching for records in the patient's chart

Overview: Users can look for specific information in the patient's chart using the search box or built-in filters. The search box and filters will always appear at the top of the Chronological Record for convenience. You can also enter special search terms to pull up corresponding data tables or combine the search tool with [Document Tags] to build stronger searches. Documents **Requiring Action** or **Outstanding Items** are excluded.



The following built-in filters let you quickly search for specific types of documents:

- **Note Type** - Surface all visit notes with a specific visit note category.
- **Document Type** - Surface all documents that match one of the following document types:
- **Letters & Referrals**

- **Medications**
- **Messages**
- **Non-Visit Notes**
- **Order**
- **Pt Summaries (CCD/CCDA)**
- **Reports**
- **Visit Notes**
- **My Last Visit Note** - Jump to the last signed visit note.
- **Vitals** - Opens the vitals trend table.

Document Tags

Overview: Similar to Patient Tags, you can tag reports, visit notes, and non-visit notes in Elation to categorize them for better organization, and to make them easier to find via chart search and Patient List reporting search.

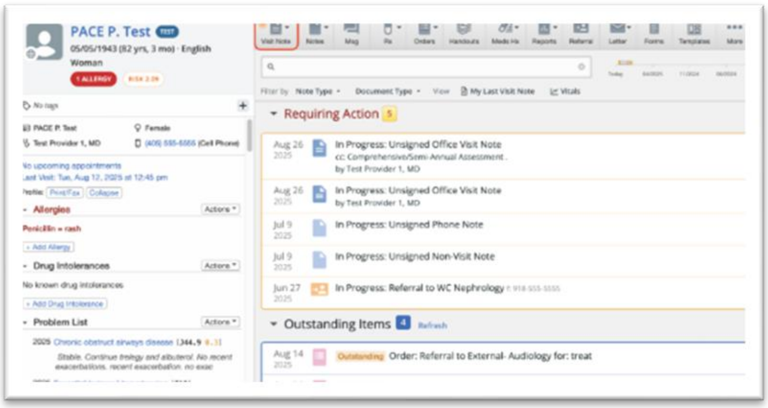
Why are document tags valuable?

🏷️Tagging your documents in Elation will help you find information faster and even keep track of your patients. Document tags allow you to categorize your reports and can pre-populate the title for you.

For example, by tagging Procedure Reports with their specific procedure name, like Colonoscopy, you can use the Patient List search to find patients who do not have any reports tagged with "colonoscopy," providing you with a list of patients who have not had that procedure documented in their chart.

Creating a Visit Note

Overview: In Elation, there are 6 different Visit Note Formats that provide you with different layouts for storing clinical information when documenting a clinical encounter. Each layout has its own characteristics that make it suitable for different documentation workflows and preferences. You can find the different visit note formats under the "Visit Note" button in the gray navigation bar.



What is the Visit Note feature?

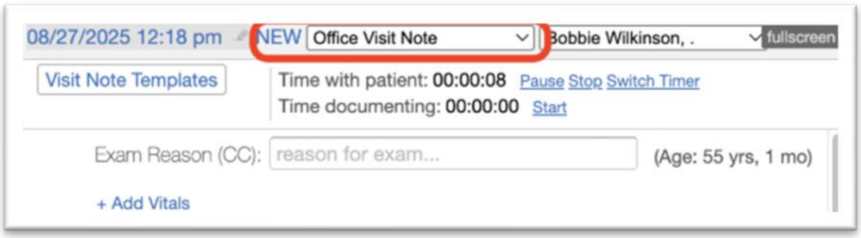
Elation's Visit Note feature is used to record a patient encounter. The Visit Note feature offers many structured fields for storing important details regarding a patient encounter.

Understanding Note Types & Categories

Note Type	Description
Simple Note	A single free-text field ideal for *narrative documentation* or *detailed notes without structure*.
SOAP Note	Divided into *four structured free-text sections*: Subjective (Problem), Objective, Assessment, and Plan.
Complete H&P (1 Column)	A *comprehensive format* for documenting *history* and *physical* exams in a single-column layout. You can also *import* relevant data *directly* from the Clinical Profile.
Complete H&P (2 Column)	Uses the *SOAP framework* with a side-by-side view: Subjective data appears on the *left*, while Objective, Assessment, and Plan sections are displayed on the *right* for a more structured, comprehensive view.
Complete H&P (2 Col – A/P)	Similar to the 2-column layout above but *combines* the Assessment and Plan into a *single section* for *streamlined* documentation.
Pre-Op Note	Based on the Complete H&P (1 Column) format, with *additional* fields for Date, Consultant, and Attending to capture *key details* related to an *upcoming* procedure or operation.

Visit Note Categories

The Visit Note Category specifies the heading or title of your note.



Documenting Visit Notes Best Practices:

✓ Users can insert patient information—such as allergies, drug intolerances, and problem lists—directly into the visit note from the facesheet, minimizing the need for duplicate documentation.

✓ For annual visits or chronic problem follow-ups, users can copy content from a prior visit note to streamline documentation. It is recommended that all copied content be reviewed for accuracy and relevance, with updates made based on the current visit.

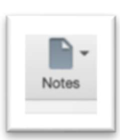
✓ Custom templates for visit notes, physical exams, and review of systems can be created to support consistent workflows across providers and staff.

Visit Note Templates

Overview: Visit Note Templates allow for a more streamlined and efficient workflow process for you and your teams by reducing repetitive documentation before, during, and after a participant encounter. This also encourages consistency across participant notes.

Templates can be added to any 'Visit Note'; however, they cannot be added to a 'Note.'

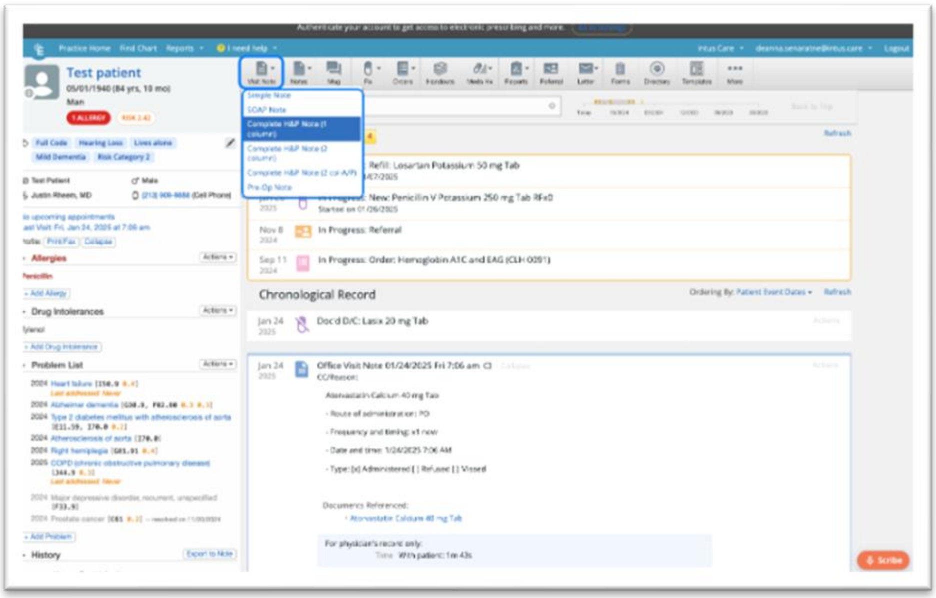
☑ - 

✗ - 

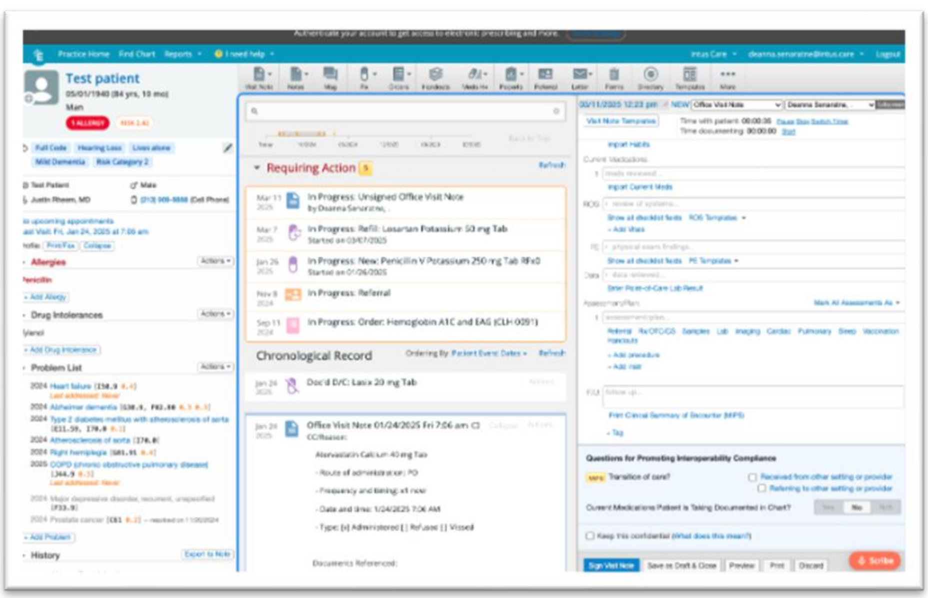
IntusCare

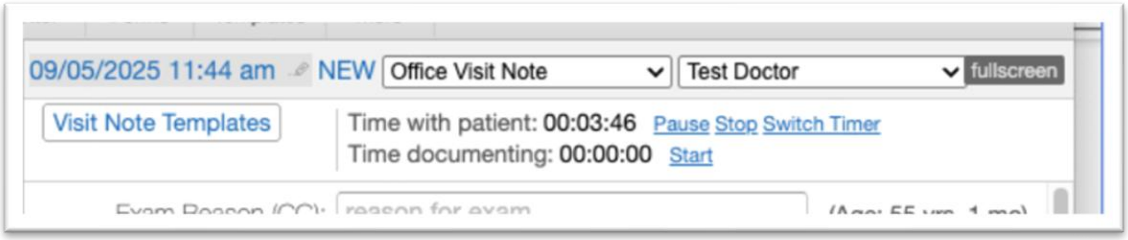
Starting a New Clinical Note

1. Select the visit note type under the Visit Note button within the participant's chart



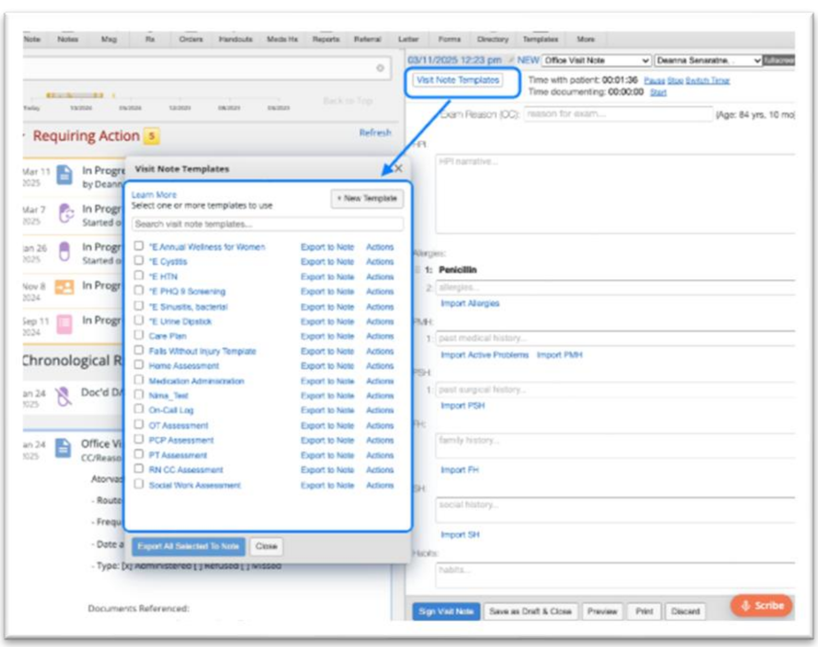
2. The note window will pop up on the right side of your screen while still allowing you to navigate and view the participant's chart without leaving the note.



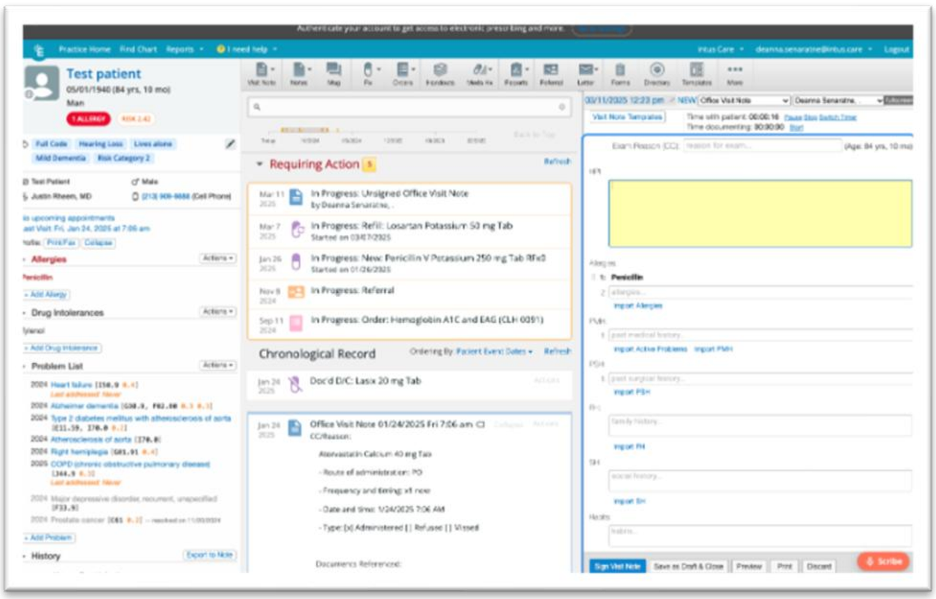


- Date and time of the visit note (this is hyperlinked and can be adjusted)
- Note type (this is configurable, and the note type can be changed by selecting the drop-down arrow)
- The name shown will default to whoever started the note but should reflect who is going to sign the note (to change this, simply select the drop-down arrow)

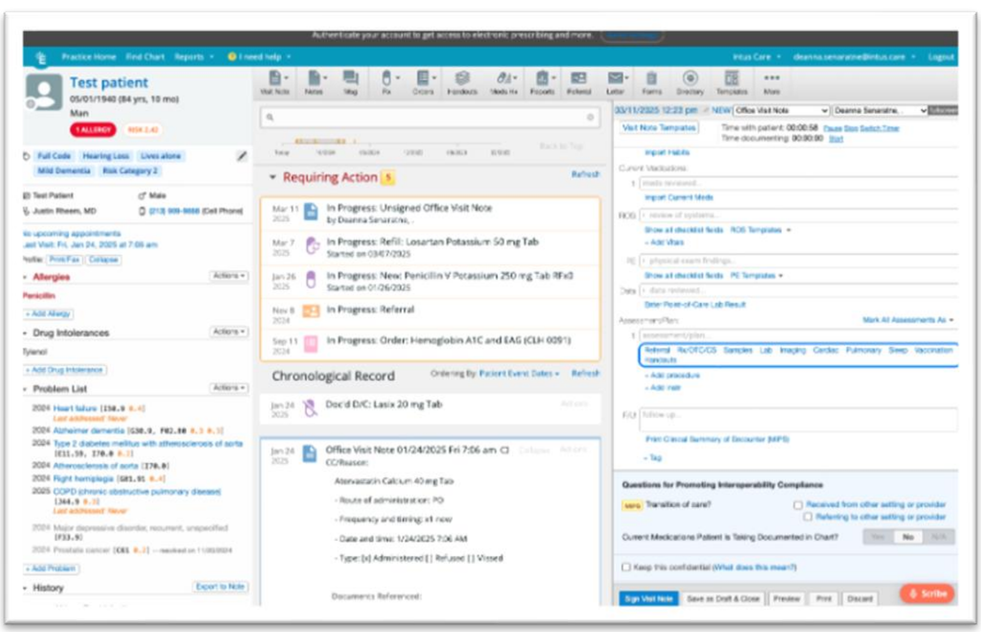
3. Once you have selected the note type, you can click the Visit Note Templates button to select the template you wish to add.



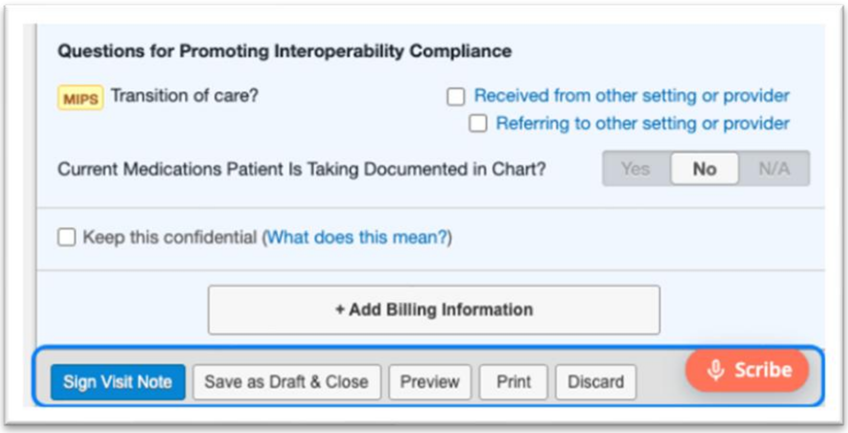
4. Fill out the sections of the note as needed. By clicking on the 'Import' button, you have the option to import information such as Allergies, Past Medical History and Social History quickly into the participant chart.



5. You have the ability to create referrals, prescriptions, lab orders and procedures directly from within the visit note.



6. Once the note has been completed, click Sign Visit Note.

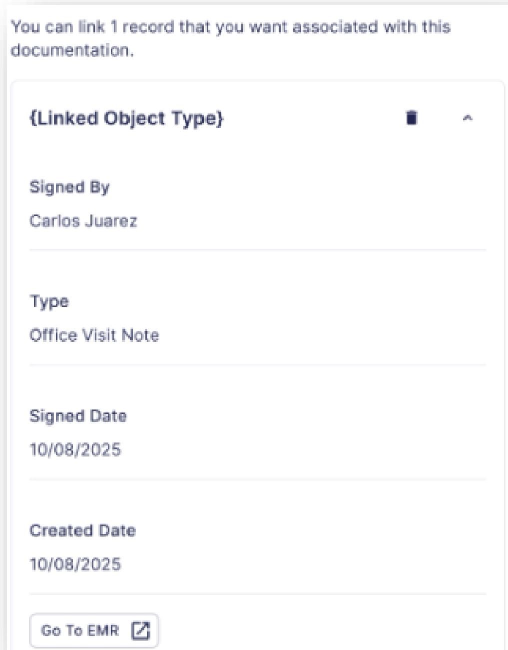


User Tips:

✓ To prevent duplicate notes, if a note is already in progress, a pop-up will appear prompting you to either open the existing note or create a new one.

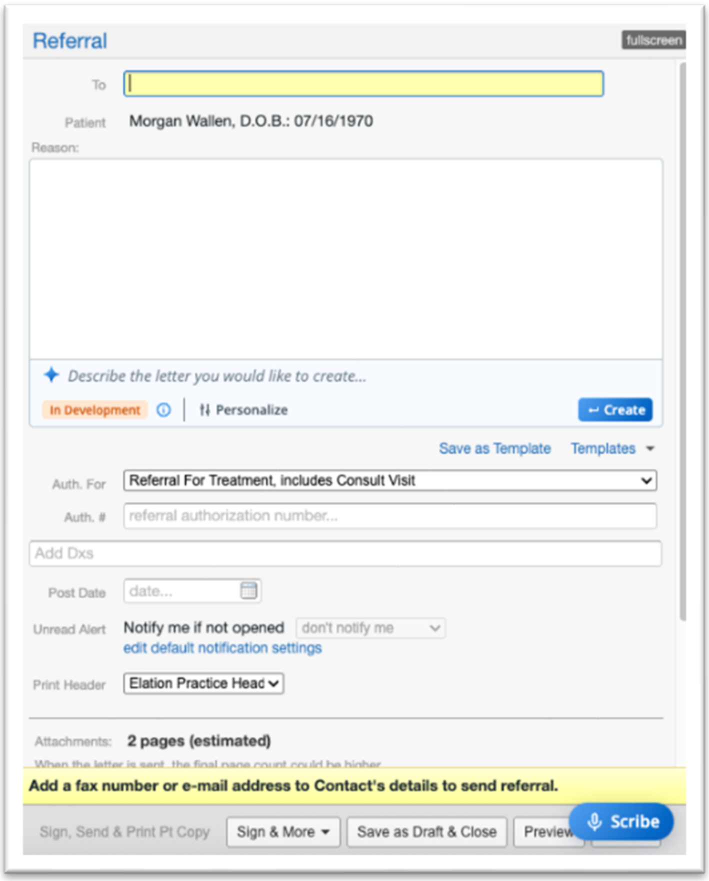
✓ You can insert content from a signed visit note into a new note. To do this, click the **Actions** button and select **New Note** or **New Note (HPI Only)** under the *Export to* section.

NOTE: Non-Visit Notes are now available to link as a new record type within CareHub, separate from Visit Notes. There are expanded details available for linked notes directly within CareHub and the linked note display now includes 'Signed By', 'Type', 'Signed Date', and 'Created Date' fields.



Ordering a Referral

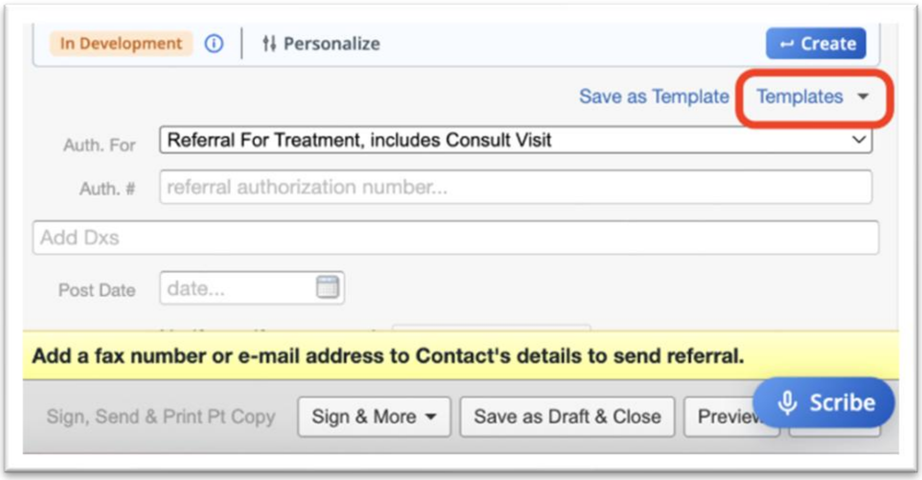
Overview: Referrals can be created either through a visit note, or by using the 'Referral' menu option within the participant's clinical chart.



- **To:** Who you would like to send the referral to
- **Reason**: You may begin free typing your documentation, or you can select 'Templates' to search and add a template into this section
- **Add Dxs** :You can add diagnoses and show dual coding
- **Post Date**: You can set a date in the future if you do not need to send out a referral immediately.
- **Attachments**: You can add chart items to attach such as visit notes, lab reports, consults or other patient forms
  - Additionally, you can attach everything within the participant's chart

User Tips:

✓ You can add a template to your referral! Templates help reduce repetitive documentation and encourage consistent workflows across providers and staff by clearly laying out the documentation needed to complete certain actions. This allows for a more efficient and streamlined workflow amongst your practice.

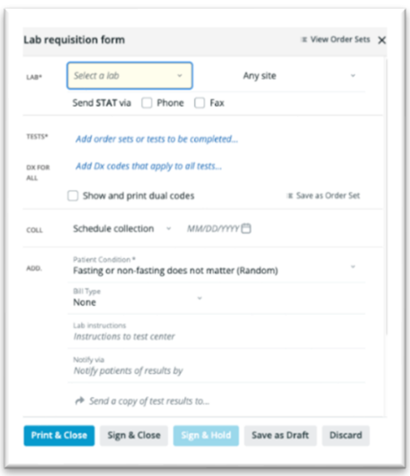


✓ You may see a yellow warning at the bottom of the referral stating, 'Add a fax number or e-mail address to Contact's details to send referral.' If you do not have that information, you can Sign and Print the referral, then link the referral to a visit not if desired.

Ordering a Lab

Overview: In Elation, an order is a medical directive from a provider to a patient or a testing facility for a specific medical test or service, such as a lab test, imaging, cardiac, pulmonary, or sleep study. Providers use structured order forms within the patient's chart to specify the requested tests, which can then be sent electronically to a vendor. Lab orders can be created either through a visit note, or by using the 'Orders' menu option within the participant's clinical chart.

Once selected, the Lab Requisition Form will appear.



Lab: Will default to the vendor that your organization is integrated with
Any Site: Can specify if the lab will be drawn at any site or in-house
Tests: You can add lab orders through an order set or individually. Tests may also be removed by hovering over the test and selecting the 'X'
Diagnosis: You can add a diagnosis that applies to all tests or specific tests. You can show and print dual codes
Collection Date: You can schedule a collection for a future date if applicable
Additional Items:
Patient Condition – You can state whether the patient will be fasting or not
Lab Instructions
Ability to notify participant
Ability to send a copy of the test result to an external specialist
Set Order
Used to set an order frequency which will live as a standard order within the participant's clinical chart
Reminder: Once all necessary information is entered, you can either E-Order which will send directly to the lab vendor, Sign and Close, Sign and Hold, Save as a Draft or Discard which will delete the request.

Ordering Prescriptions

Overview: Elation's ePrescribing capabilities allow providers to electronically prescribe medications quickly, accurately, and securely—directly within the participant's chart. Designed to support streamlined medication management for complex care populations like those in PACE, this reduces manual workflows and improves communication with pharmacies. Key features include:

- **ePrescription:** Send new prescriptions and refills directly to the participant's preferred pharmacy.
- **Drug Interaction & Allergy Alerts**: Receive automatic safety alerts for potential drug-drug interactions, allergies, and duplicate therapies.
- **Controlled Substances:** Securely prescribe controlled substances electronically, with required identity verification and audit trails.

Starting a New Prescription

There are two options to start a new prescription:

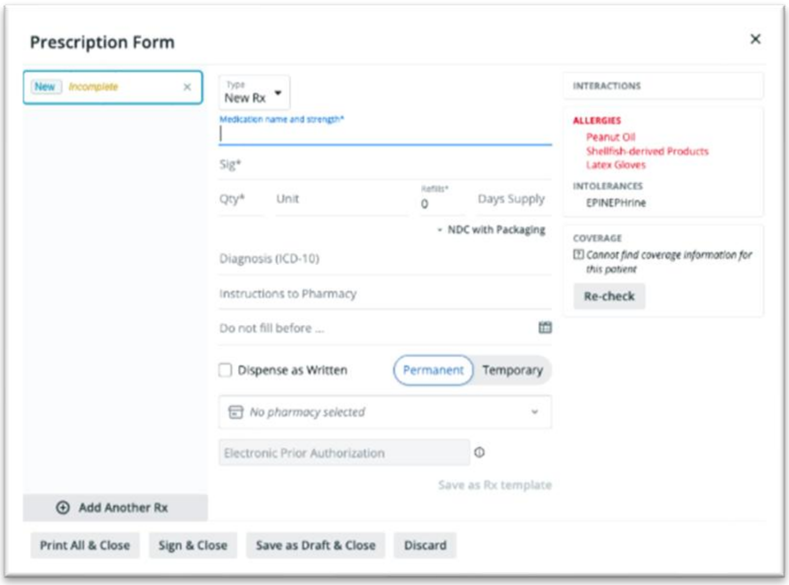
1. Click "Rx" -> "Prescription Form (Rx/OTC/CS)" at the top of any patient's chart
2. Click the "Rx/OTC/CS" button in a visit note or non-visit note draft

User Tip:

✓ If any prescriptions are controlled substance medications, you will be asked to enter your EPCS password and security code one time before they are sent to the pharmacy.

✓ The pharmacy selected for the first prescription will be the default for all prescriptions that are electronically sent. You can choose a different pharmacy if needed for specific prescriptions.

The following fields should be filled out as much as possible to effectively prescribe. Any required fields will have an asterisk (*).



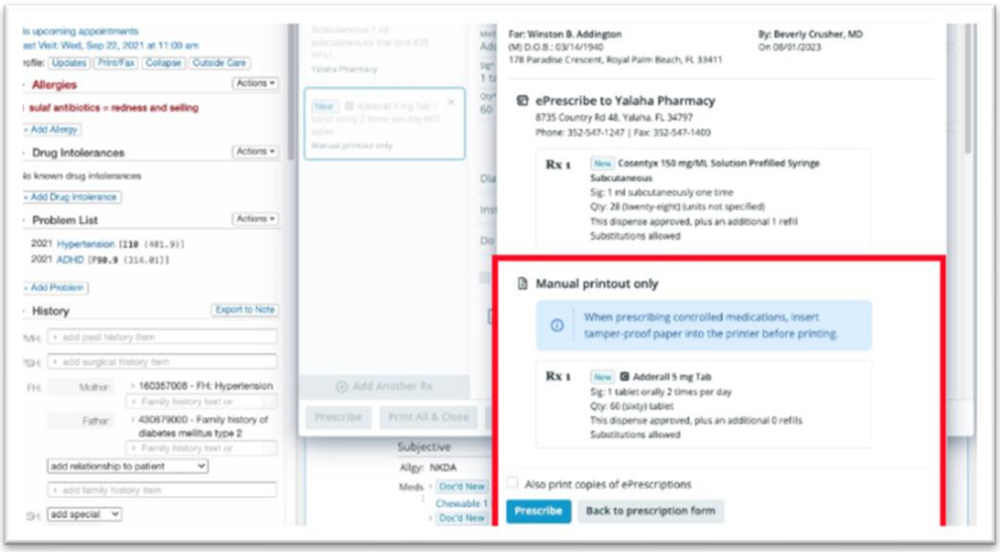
Sending Prescriptions to the Pharmacy

When you e-prescribe a medication, a Prescription Summary window will appear, displaying all relevant details associated with the order, including the designated pharmacy. Review the information carefully, then click Prescribe to send the prescription to the selected pharmacy.

In the CareHub production environment, you will see an ‘E-Prescribe’ blue button in the bottom left-hand corner that will allow you to electronically send those medications directly to your chosen pharmacy.

Printing Prescriptions

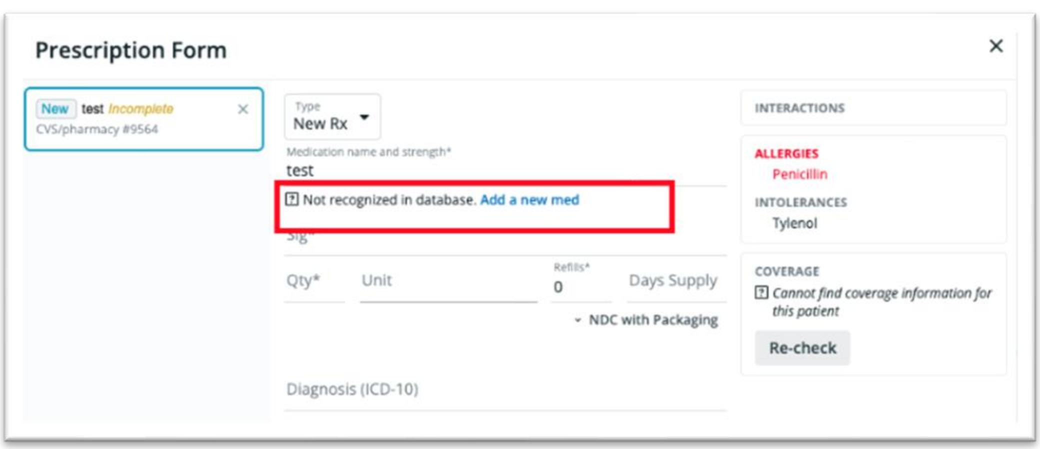
If you would like to print a prescription or print controlled substance prescriptions, the prescription summary will show which prescriptions will be printed. Click *Prescribe* in the summary window to send the designated prescriptions to the pharmacy and print prescriptions.



Manually Adding Medications to the Database

If you are unable to find a medication you want to prescribe, you can manually add a medication to the database following these steps:

1. Type the name of the medication in the medication name field and click out of the field.
2. Click *Add a new med.*
3. Edit the name, type, and strength as needed.
4. Click *Create Medication & Continue Rx.*



User Tip:

✓ Medications that are manually added to the medication database will not be associated with a National Drug Code (NDC). This means any details around allergy or drug interactions or formulary information will not be provided.

Creating Custom Rx Sigs

Custom sigs can be stored in the sig database for medication that is prescribed.

To create a custom sig:

1. Select the medication you want to prescribe in the prescription form.
2. Type your custom sig in the Sig field
3. Click *Create a custom sig for this med.*
4. Confirm the sig you want to save
5. Click *Save.*

To edit or delete a custom sig:

1. Click on your email on the top right corner of your Elation account.
2. Click *Settings.*
3. Click on the *Prescriptions* section.
4. Select the *Custom Rx Sigs* section.
5. Find the custom sig you want to edit or delete.
6. Click *Edit* or *Delete* and proceed as needed.

Creating Custom Rx Templates

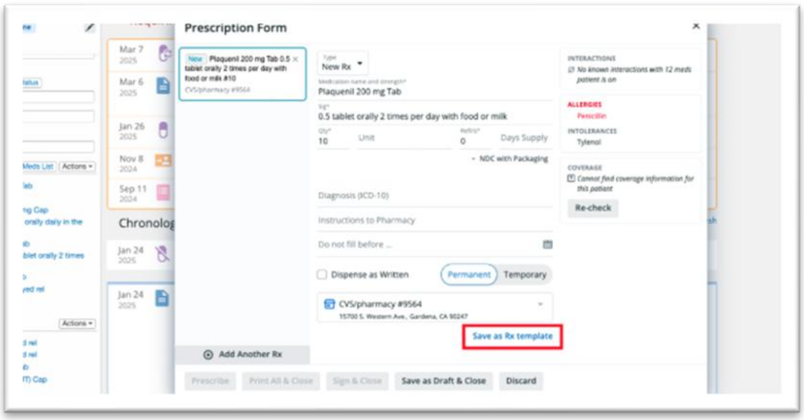
Custom Rx templates can be created within the Prescription Form or in the Settings page

To create from the Prescription Form:

1. Fill in the appropriate fields as needed: *Medication name & strength, Qty, Sig, Unit, Refills*

2. Click *Save as Rx Template.*

3. Click *Save*



To create from the Settings page:

1. Click on your email on the top right corner of your screen.

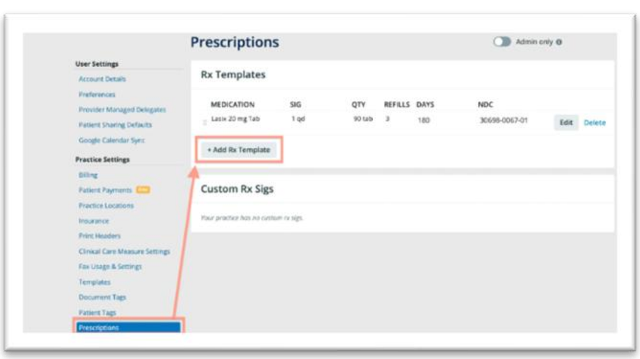
2. Click *Settings*

3. Click *Prescriptions* under *Practice Settings* on the left-hand column.

4. Select +*Add Rx Template.*

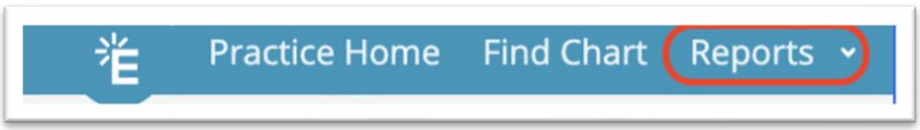
5. Fill in the appropriate fields as needed: *Medication name & strength, Qty, Sig, Unit, Refills*

6. Click *Save.*



Elation Reporting

Overview: Reporting within Elation includes accessing pre-built reports from the "Reports" button in the main navigation bar, such as the Patient List Report, Appointment Report, Clinical Quality Measures (CQM) Report, and Visit Note Dashboard, for insights into patient lists, appointments, clinical performance, and visit notes.



Reporting Drop Down

There are several available reporting options including:

- **Patient List Report:** Search your patient panel using various filters, such as demographics, last seen date, or lab values.
  - You can download as CSV to show a more detailed report
- **Billing Report**
  - Ability to create an unsigned visit note report
- **Visit Notes Dashboard:** An overview of visit note performance metrics.
- **Visit Notes List:** A detailed list of visit notes and billing status.
- **User Activity Log:** This report shows account activity and is an audit log of actions taken within the clinical chart.
- Filters are available

What is a Patient List Report?

The Patient List Report is a great tool for tracking, outreach and analysis. You can use the Patient List Report to find patients who match specific criteria based on structured data in their charts, for example, patient tags. You can also create detailed searches—for example, patients with certain diagnoses, medications, or lab results.

Available Filters

- **Provider**
- **General**
  - **Last Seen (Last Signed Visit Note)** Search for patients with signed visit notes within a specific timeframe.
  - **Order Status**
    - *Outstanding*

    - *Cancelled*
    - *Fulfilled*
  - **Order Hold Status**
    - *On hold* - Search for patients with held lab orders.
  - **Auto-Created Charts**
  - **Demographics**
  - **Age**
  - **Sex at Birth**
  - **Race**
  - **Ethnicity**
  - **Preferred Language**
  - **Preferred Contact Method**
  - **Patient Status**
  - **State**
  - **Clinical Data**
  - **Risk Score**
  - **Most Recent Lab Results**
  - **Active Problems in Clinical Profile**
  - **Permanent Medications in Clinical Profile**
  - **Active Allergies in Clinical Profile**
  - **Vaccinations in Clinical Profile**
  - **Patient Tags**
  - **Document Tags**
  - **CPT Codes**

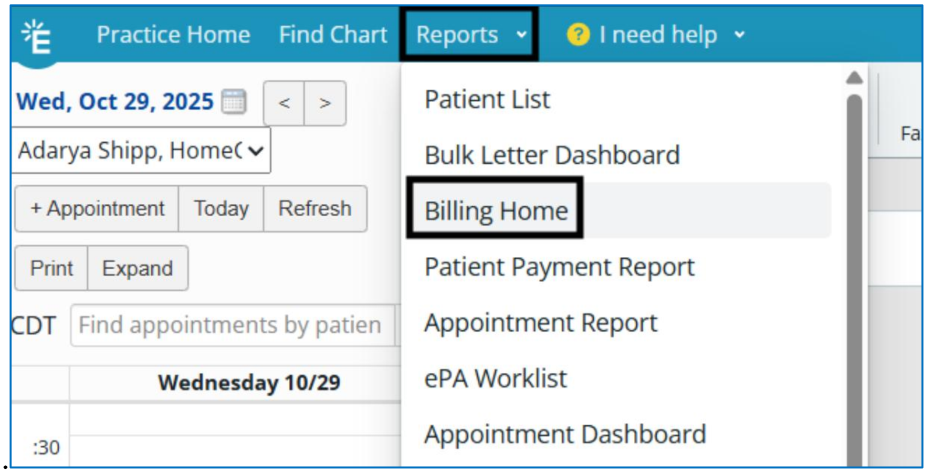
What is the Billing Home Report?

The Billing Report shows all billing information recorded in both signed and unsigned visit notes for the entire practice. The Billing Report allows you to follow up on any incomplete bills to ensure you have completed all of your coding to submit claims and receive reimbursement from insurance companies for services rendered to your patients

To access the Billing Report, select "Billing" from the *Reports* dropdown in the blue navigation bar.

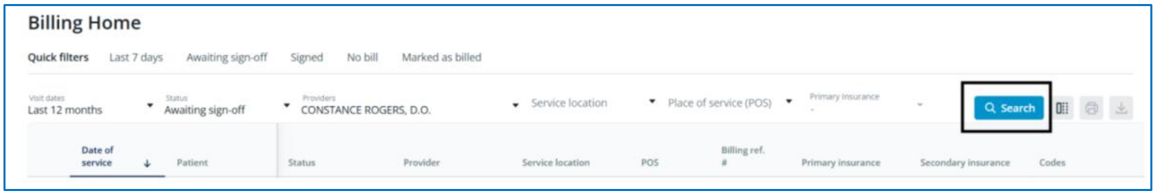
To create an Unsigned Visit Note Report:

1. From the Practice Home Page, select "Reports" and from the drop-down menu, select "Billing Home"



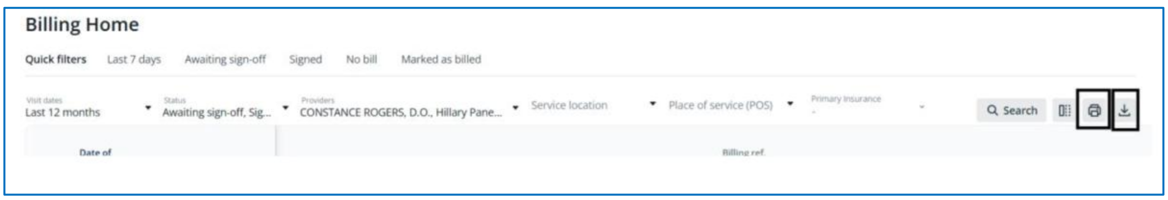
2. From the Billing Home page, use quick filters to select "Awaiting sign-off". You can then choose the visit dates (a date range or looking back at X number of days/months).

3. Navigate to the "Providers" drop-down and select every billable provider for the organization.
    a. After every provider has been added, select "Search"



The system will now provide the user with a list of encounters that do not have a signature from the selected providers within the designated time frame.

This report can be exported to Excel via the download option or printed via the print function.



Checklist:

- Familiarize yourself with the "Go to EMR" link in CareHub.
- Complete clinical documentation in Elation EMR.
- Link relevant clinical records from Elation to CareHub.
- Use CareHub for task management and messaging.

Knowledge Check:

- How do you navigate to Elation EMR from CareHub?
- What types of clinical documentation are completed in Elation EMR?
- How do you link a clinical record from Elation to CareHub?

Knowledge Base: (Additional information & training video)

- Clinical EMR (Elation) – IntusCare

Link to CMS Regulations:

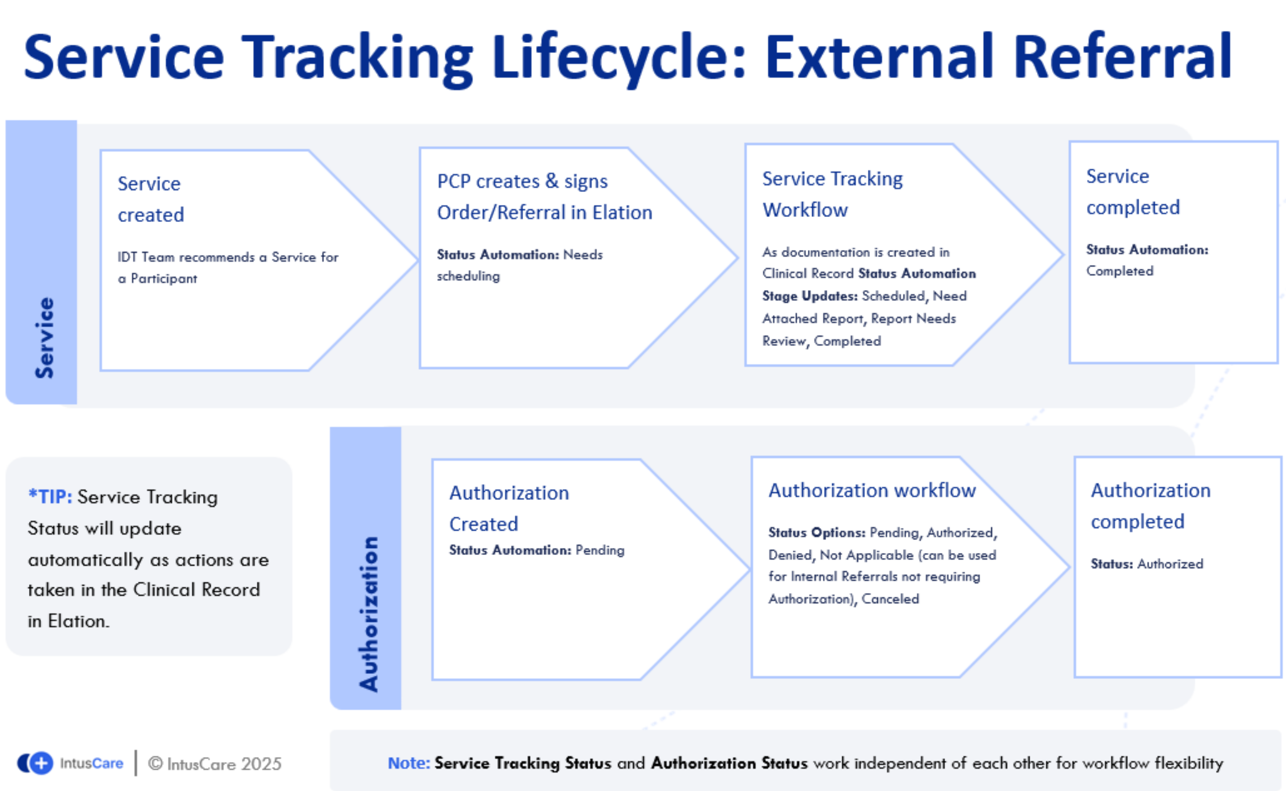
- eCFR :: 42 CFR 460.102 -- Interdisciplinary team.

9.Service Tracking [460.98]

Objective: Allows users to view and action the lifecycle of: PCP Orders, External Referrals, Internal Referrals, Unplanned Services (Admissions/ER/Urgent Care/DME), requested for a participant by the IDT Team. This will include all necessary documentation, scheduling, authorization (if applicable) and retrieval of medical records. The information below is the workflow map of how a Service is created.

Steps:

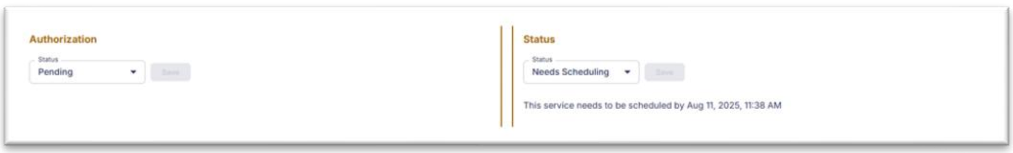
1. **PCP Orders & External Referral**



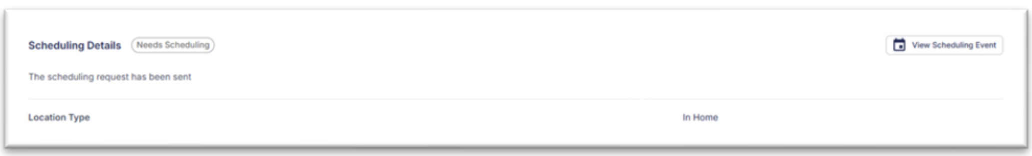
1. IDT Team recommends a Service for a Participant

2. PCP Creates & Signs Order/Referral in Clinical Record Elation (EMR)
    1. Orders and Referrals processed in Elation that contain an ICD 10 code will pull into CareHub and be included in the Authorization Details.

3. Service is automatically created in CareHub. Navigate to the Service Tracking menu or the Service Tracking section of the participant profile
4. Search for the Service and click to open it.



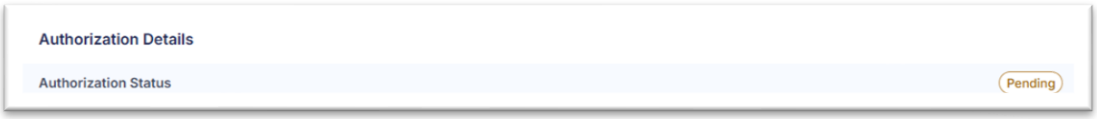
    1. Authorization is Pending
    2. Service is Needs Scheduling & creates a Scheduling Request.

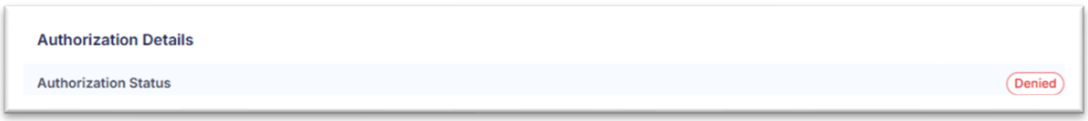


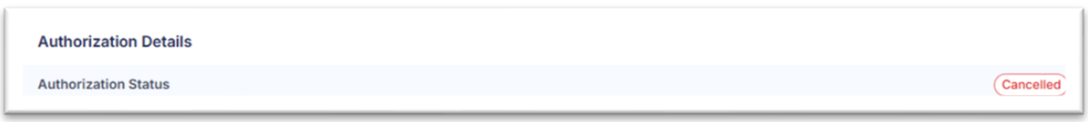
5. Authorization status will then need to be updated; this is a manual process following your Organizations SOP. The following status available:

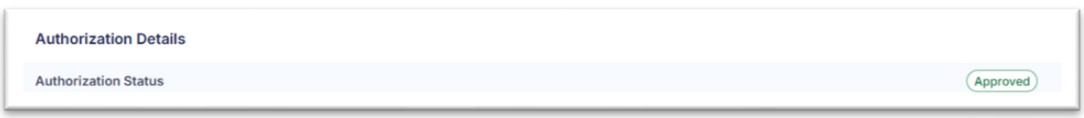
6. Once Authorization Status is updated it will change to green:

7. Additional details about the Authorization will show in the Authorization Details Section:

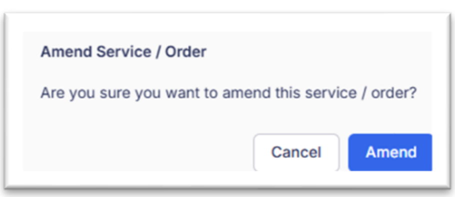




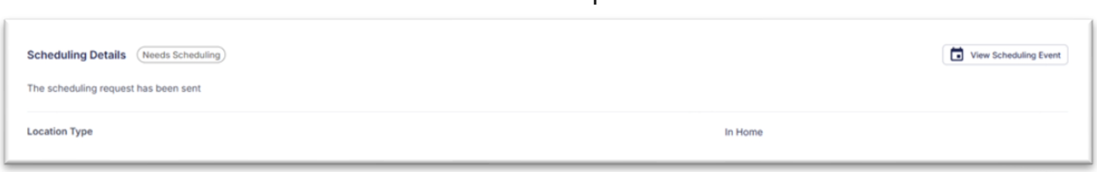




8. You can Amed the Authorization, if necessary, after the status has been updated:

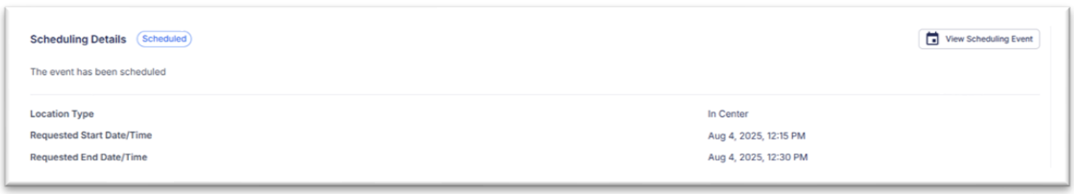


9. Service will need to be Scheduled via the Request



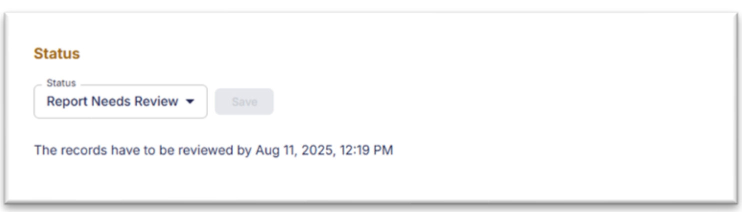
   1. View Scheduling Event
   2. This will take you to the Center Calendar for scheduling – See Scheduling section for instruction on Scheduling the event from the Que.

3. Once it has been scheduled, the Service Tracking Status will automatically update, and the appointment will be linked to the Service request:



10. 1 minute after the start of the appointment time for the event, the Service Tracking Status will automatically update to:

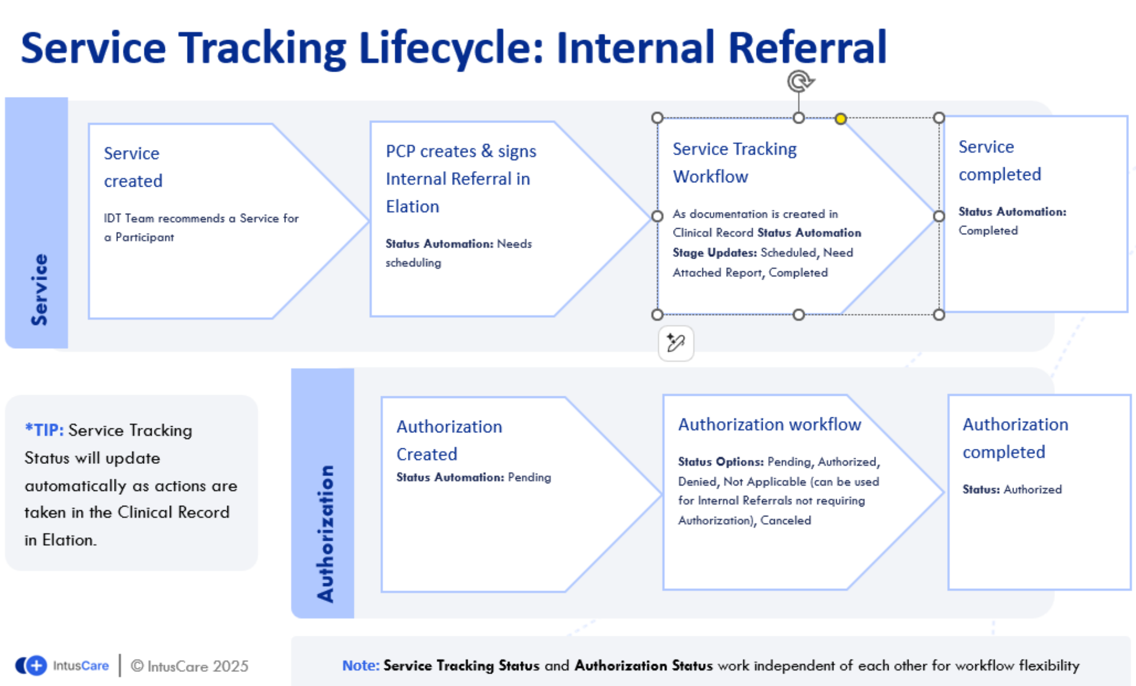
11. When the documentation is received from the External Provider via the Fax Inbox in the Clinical Record Elation (EMR) or manually uploaded and then attached to the referral, this will automatically update to:



12. Once the PCP has signed and reviewed the documentation in the Clinical Record Elation (EMR) this will automatically update to:

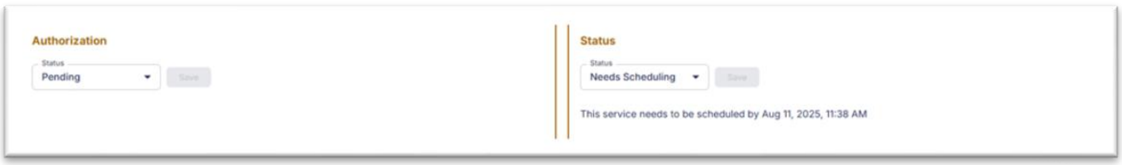
13.

2. Internal Referrals



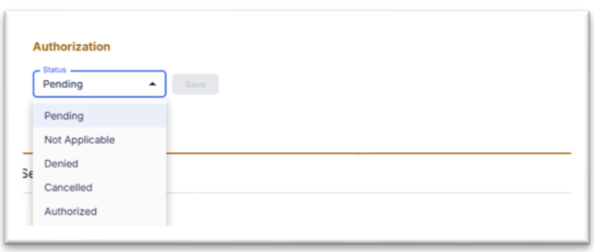
1. IDT Team recommends a Service for a Participant
2. PCP Creates & Signs Internal Referral in Clinical Record Elation (EMR)

3. Service is automatically created in CareHub. Navigate to the Service Tracking menu or the Service Tracking section of the participant profile
4. Search for the Service and click to open it



   1. Authorization is Pending
   2. Service is Needs Scheduling & creates a Scheduling Request.

5. Authorization status will then need to be updated; this is a manual process following your Organizations SOP. The following status available:

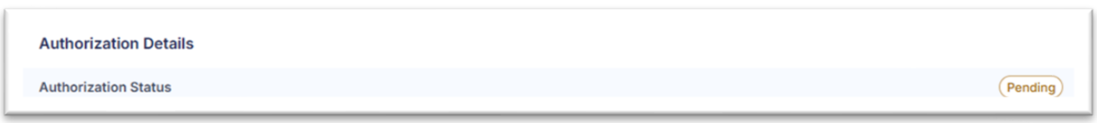


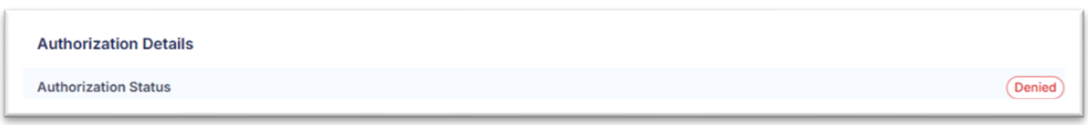
6. Once Authorization Status is updated it will change to green:

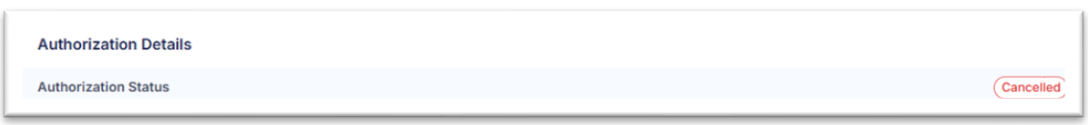
NOTE: As a requirement, these fields must be completed before Authorization status can be saved as "Authorized":

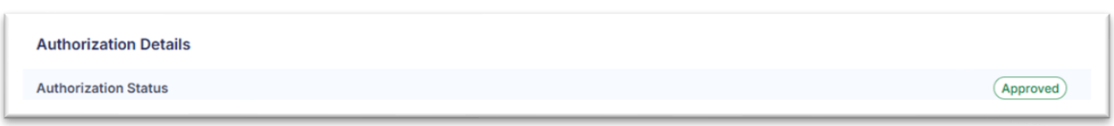
- Authorization Type
- Service Type
- Date of Service Start
- Date of Service End
- Authorized Quantity
- Authorized Quantity Units

7. Additional details about the Authorization will show in the Authorization Details Section:



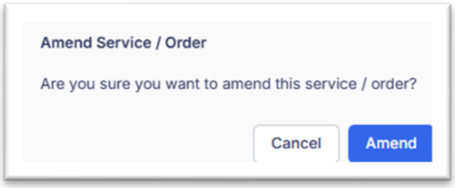




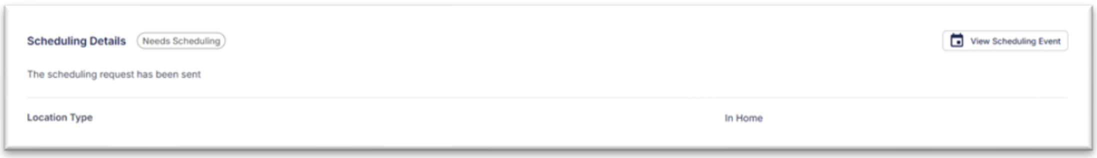


8. You can Amed the Authorization, if necessary, after the status has been updated:

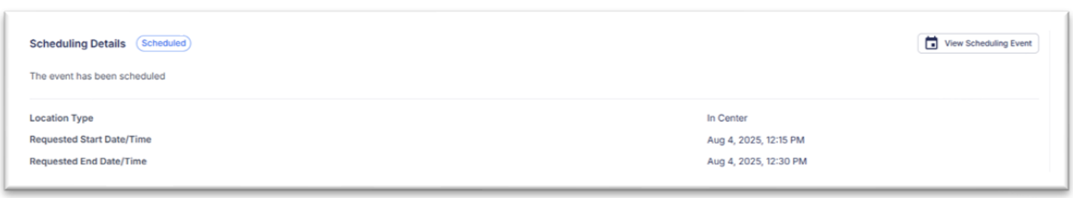
IntusCare



9. Service will need to be Scheduled via the Request (if necessary)



   1. View Scheduling Event
   2. This will take you to the Center Calendar for scheduling – See Scheduling section for instruction on Scheduling the event from the Que.
   3. Once it has been scheduled, the Service Tracking Status will automatically update, and the appointment will be linked to the Service request:



10. 1 minute after the start of the appointment time for the event, the Service Tracking Status will automatically update to:

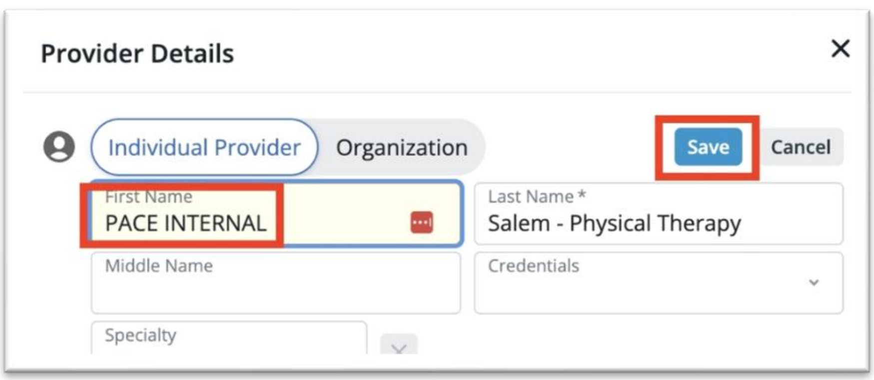
11. When the documentation is completed as a Visit Note in the Clinical Record Elation (EMR), the Service Tracking Status will automatically update to:

3. Creating Internal Providers in Elation:

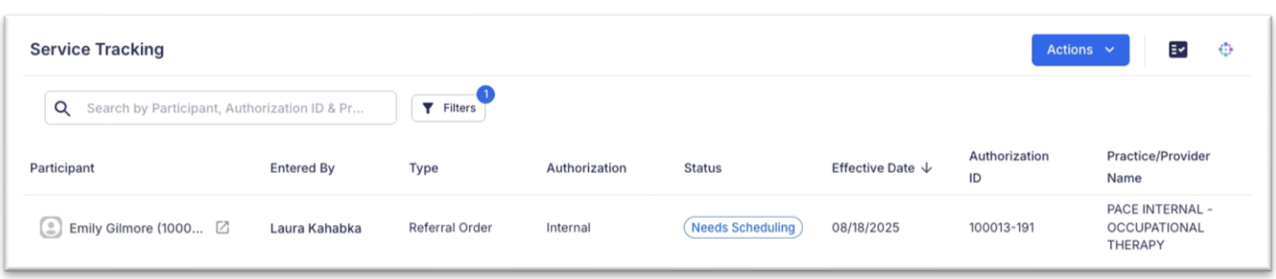
https://www.loom.com/share/217a63e833e74fe1a74188e1078d2fb4?sid=bd605f0e-ec93-46da-9928-df3f33b199fb

Configuration of Internal Referral Contacts in Elation.

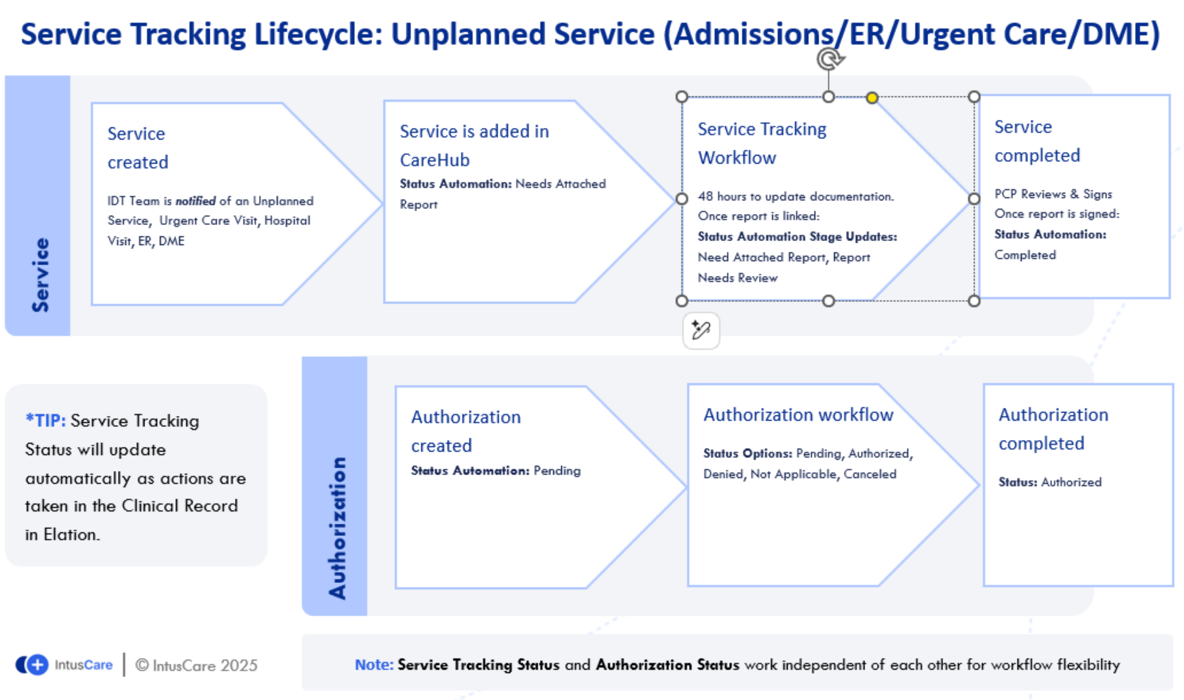
- First Name: PACE INTERNAL (this must be in ALL CAPS to work as designed)
- Last Name: Specialty (how this Group will appear in CareHub)



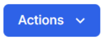
- Auto-assign Authorization status to Internal
- Adjust scheduling automation- Service Status set to “Needs Scheduling”, however Scheduling Request no longer auto created.



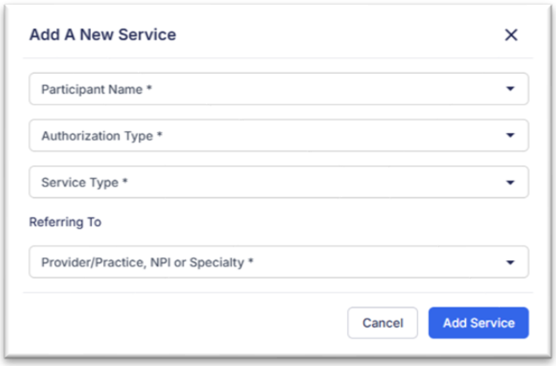
4. Unplanned Service

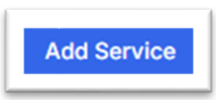


1. IDT Team receives notification of an Unplanned Service, Urgent Care Visit, ER or DME Request. We are using an ER Visit for an example here.
2. Service is manually created in CareHub. Navigate to the Service Tracking menu or the Service Tracking section of the participant profile

3. 

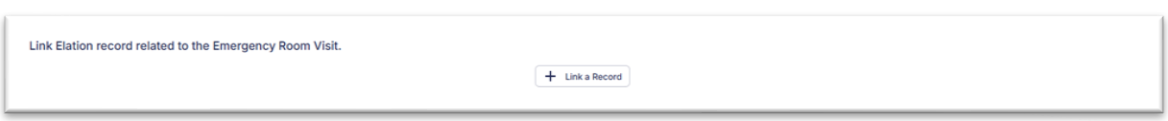
Use the blue Actions button at the top of the screen to Add a New Service



    1. Participant Name
    2. Authorization Type
    3. Service Type
    4. Referring To
    5. 

4. This will Open the Service

    1. Authorization is Pending
    2. Service is Needs Attached Report (Because it is an ER Visit)
5. Authorization status will then need to be updated; this is a manual process following your Organizations SOP
6. Under Link Elation record related to the Emergency Room Visit:



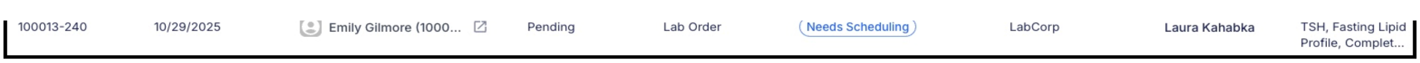
    1. Link a Record
    2. Select the associated record from the Clinical Chart Elation (EMR) record for the participant.
7. Status will now update to:

8. PCP to Review Hospital Report in Clinical Record Elation (EMR) and status Service Status will update automatically:

NOTE: There is now increased ability to utilize existing data to populate Authorization Details: if the Provider Network File contains Out of Network provider details, CareHub will populate information:

Out of Network Providers without Authorization Details loaded into CareHub will require user to populate all fields:

NOTE: There is now a revised view of Service Tracking Dashboard, moving the Authorization ID to the first column. There is an added new column "Order Name/Reason." The order name populates for Imaging Order and Lab Order. Referral reason displays for Referral Order.



Updated Authorization Type from "Skilled Nursing Facility" to create both "Long Term Skilled Nursing Facility" and "Short Term Skilled Nursing Facility".

Note: We did not update historical data.

NOTE: Updated availability of Service Status > Canceled. Only Services created in CareHub can be Canceled. Services created via Elation must be canceled in Elation.

There is now an updated Authorization Details section to include a calculator for: Select Calculator, Select Start Date and End Date, Frequencies, Quantities and Apply Calculations

Checklist:

- ✓ Understanding the difference between the 3 different workflows available for Service Tracking
- ✓ Link records to scheduled events.

Knowledge Check:

- How do you track external services?
- What steps do you take to manage quality inbox items?

Knowledge Base: (Additional information & training video)

- OVERVIEW: SERVICE TRACKING – IntusCare

Link to CMS Regulations:

- eCFR :: 42 CFR 460.98 -- Service delivery.

9.Quality Inbox: SDR's [460.121] & Appeals [460.122] Grievances [460.120], Incidents [460.136(a)(1)]

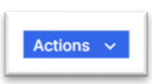
Objective: How to create, review, approve/partially approve and appeal (if necessary) SDRs, Grievances and Incidents

Steps:

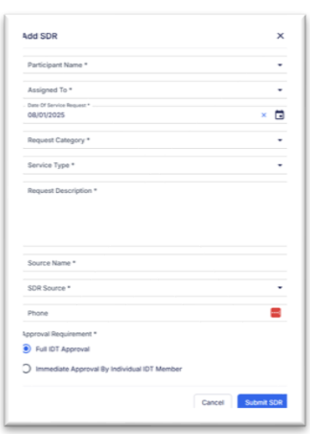
1. Navigate to the Quality Inbox

SDR

1. Summary cards will appear at the top of the screen

2. Hover over the information icon for more information.
3. You can: Search, Filter
4. 

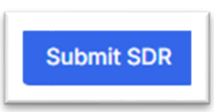
Use the Actions button on the upper right-hand side of the screen to Add SDR



1. Participant Name
2. Assigned To

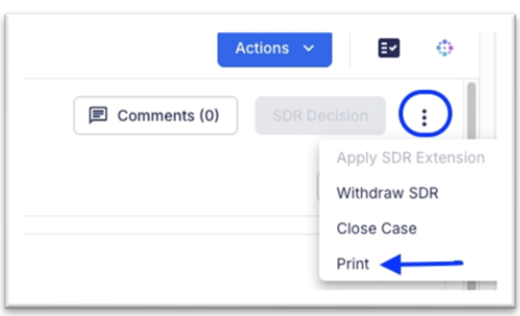
3. Date of Service Request
4. Request Category
    1. Continue
    2. Eliminate
    3. Increase
    4. Initiate
    5. Modify
    6. Reduce
5. Service Type
6. Request Description
7. Source Name
8. SDR Source
        2. Caregiver
        3. Designated Representative
        4. Participant

10. Phone
11. Approval Requirement
        1. Full IDT Approval
            1. SDR Full IDT Decision will pre-fill the signees based on the participant's assigned IDT (in their participant profile assignment
        2. Immediate Approval by Individual IDT Member

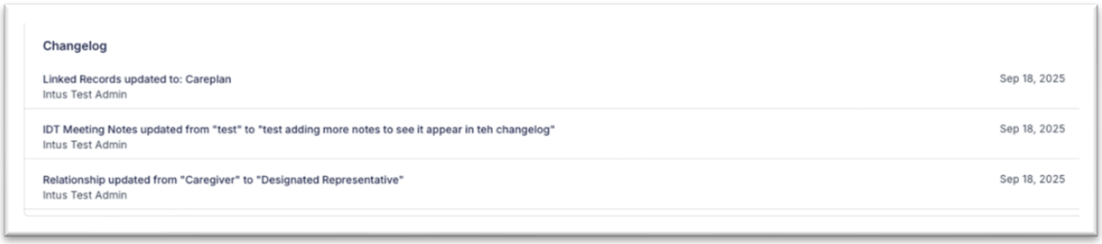
12. 

When all information is entered.

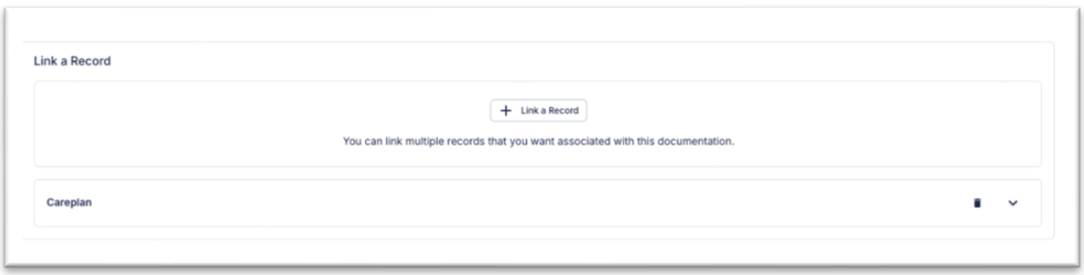
13. Printing
    1. After an SDR is submitted you will have the ability to Print a copy of the SDR if necessary.



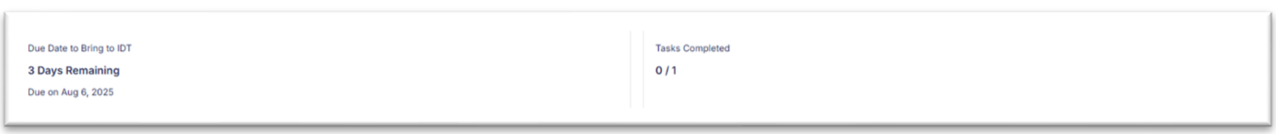
14. Once the SDR is submitted, you will see a change log on the details page to provide more visibility into updates, error tracking, accountability and audit readiness.



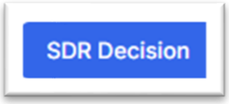
15. Once the SDR is submitted you can link multiple records to the SDR.

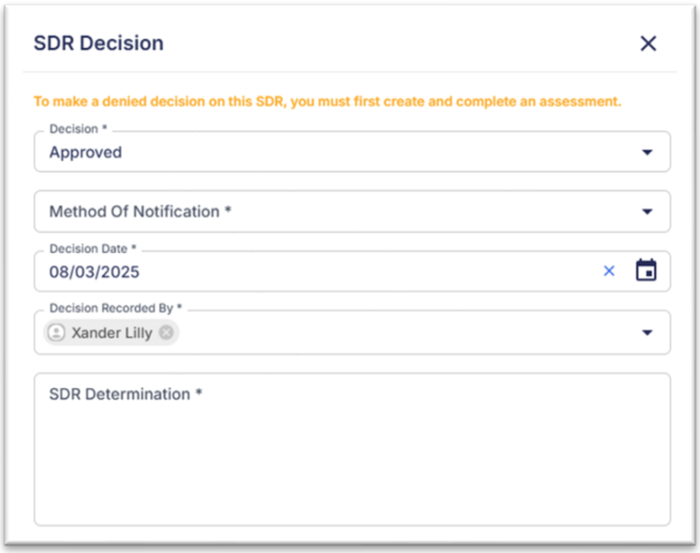


2. SDR Details Screen:



1. Summary cards will appear at the top of the screen
2. A Task to bring SDR request to IDT Team will automatically be created and the SDR will be added to the next Huddle for discussion
    a. Users are able to edit the IDT Morning Meeting Details "Notes" section up until SDR decision has been made (aka any state of Approved, Partially Denied, Denied).
3. Once the SDR has been discussed are documented you will be able to enter the SDR decision
    a. Mark the associated Task as complete.
4. If the SDR requires an assessment – that must be completed before denial or partial denial can be documented.
    a. A PCP Visit Note must be attached to the assessment from the Clinical Record in Elation (EMR) to complete the summary.

3. 

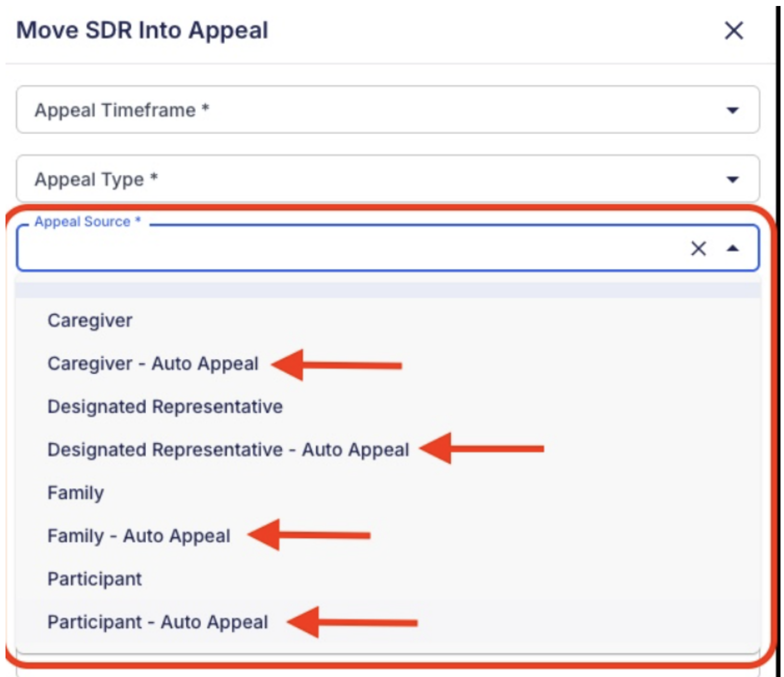


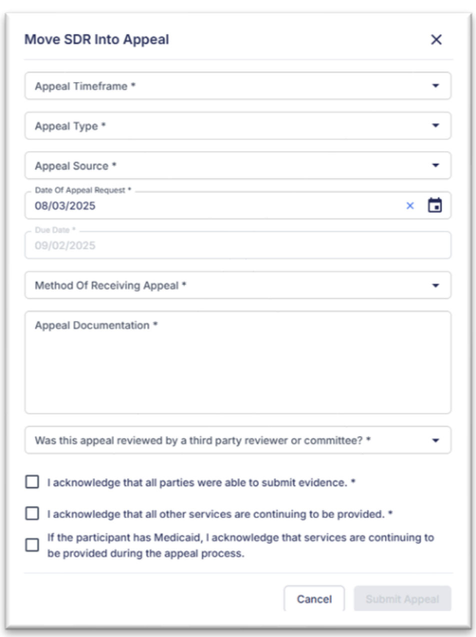
1. Decision
    1. Approved (Will be only option if an assessment has not been completed and attached to the SDR)
        1. Denied
        2. Partially Denied
    2. Method of Notification
        1. Oral
        2. Written
    3. Date
    4. Decision Recorded By
    5. SDR Determination
    6. Sign-Off
        1. Full IDT Approval
        2. Immediate Approval by Individual IDT Member.

After the Decision Cycle has been completed and members of the IDT Team have signed off, there will be additional options available under the 3 dots in the upper right-hand corner of the SDR. The ability to action these options will depend on the status of the SDR as it moves through the Appeal Process.

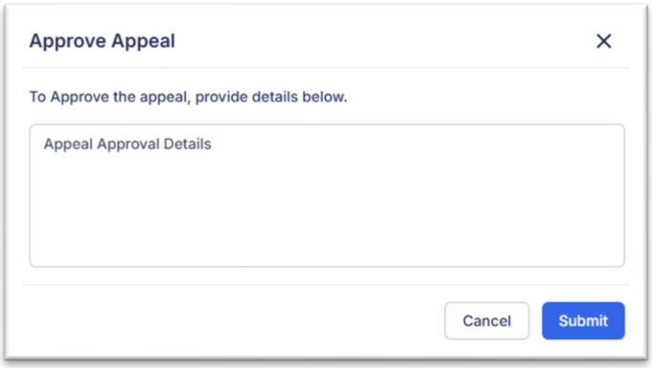
The SDR Appeal Source options are aligned with HPMS reporting requirements, specifically noting the Auto-Appeal option when a SDR is overdue.

1. Create Appeal

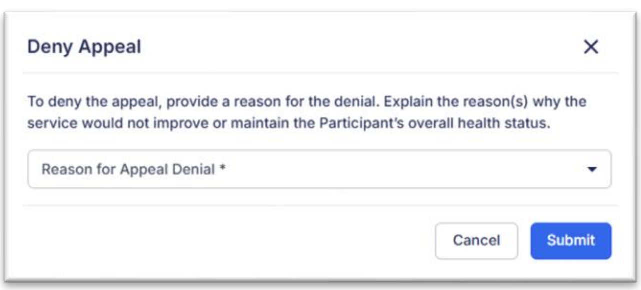




2. Approve Appeal

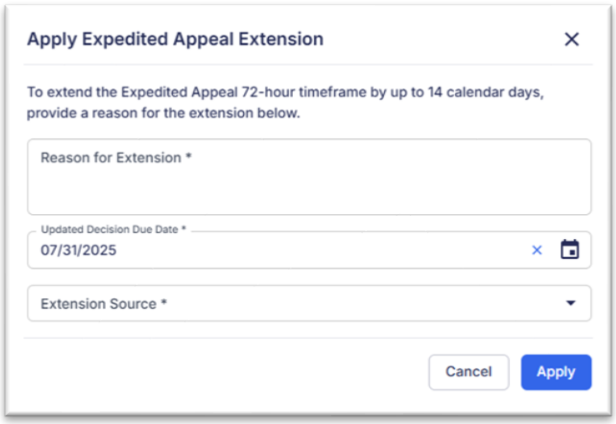


3. Deny Appeal

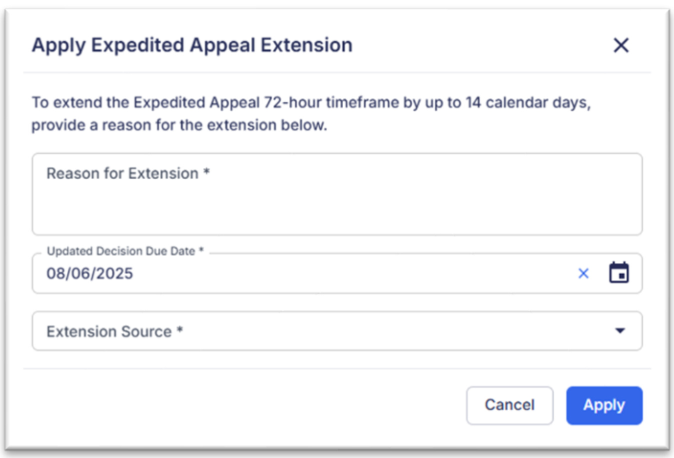


4. Partially Deny Appeal

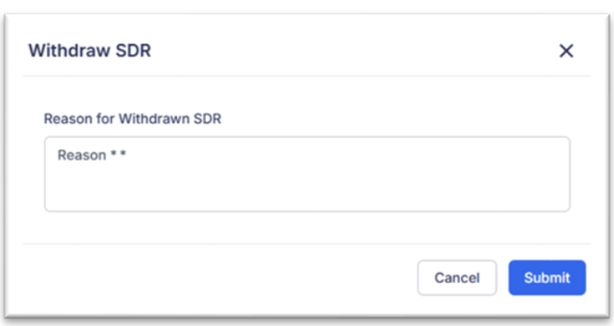
5. Apply Expedited Appeal Extension



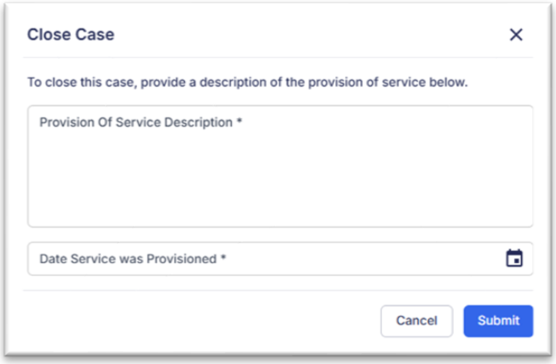
6. Apply SDR Extension



7. Withdraw SDR



8. Close Case.



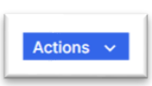
NOTE: Users will be prompted to add a ‘Date of Notification’ for SDR Decisions (Approved, Partially Denied, Denied, Withdrawn). This applies to full IDT or individual approval, and extended SDRs.

A Yellow banner will appear to prompt date entry, then populate details, which are included within the SDR record.

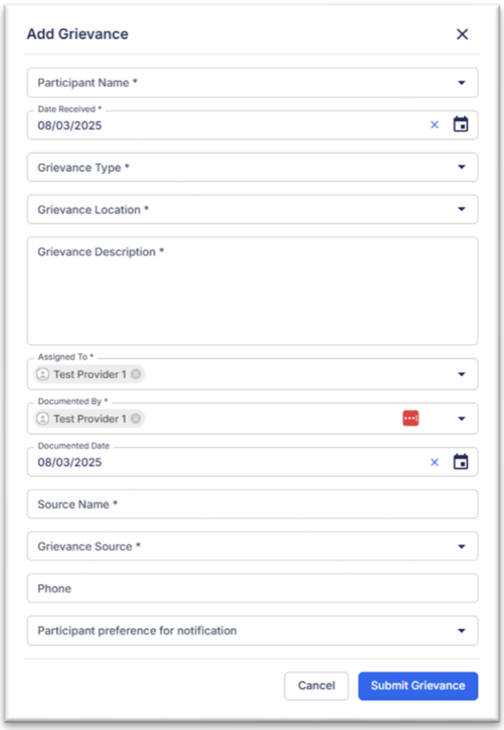
Users must document the date of decision notification to the participant as well as other details.

Grievances

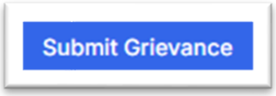
1. Summary cards will appear at the top of the screen

2. Hover over the information icon for more information.
3. You can: Search, Filter
4. 

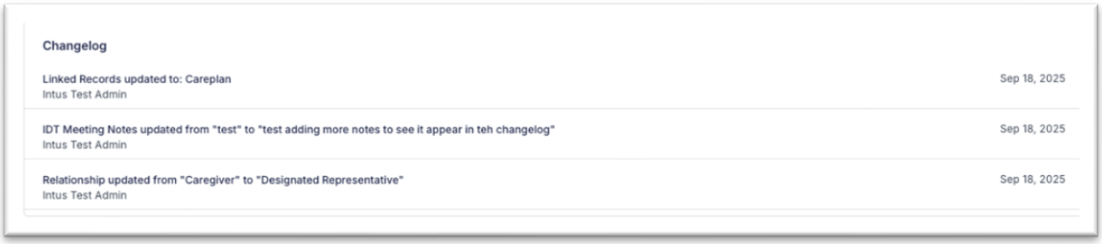
Under actions in the upper right-hand side of the screen – Add a New Grievance



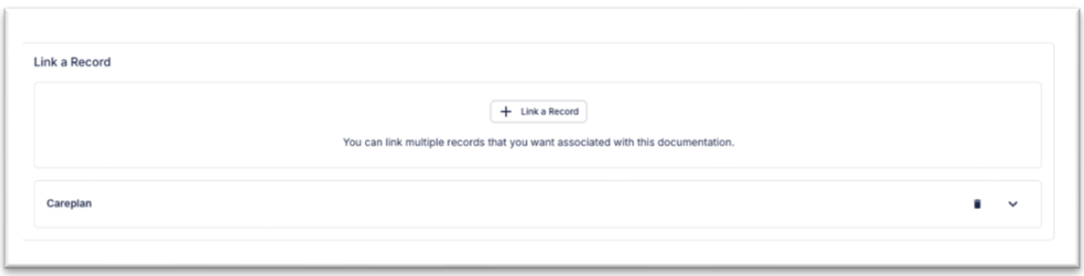
1. Participant
2. Date
3. Grievance Type
    1. Extensive list by category
4. Grievance Location
5. Grievance Description
6. Assigned To (Defaults to who is entering the Grievance)
7. Documented By (Defaults to who is entering the Grievance)
8. Documented Date
9. Source Name
10. Grievance Source
    1. Caregiver
    2. Family
    3. Participant
11. Phone
12. Participant preference for notification
    1. Oral
    2. Request not to receive the notification
    3. Unknown
    4. Written

5. 

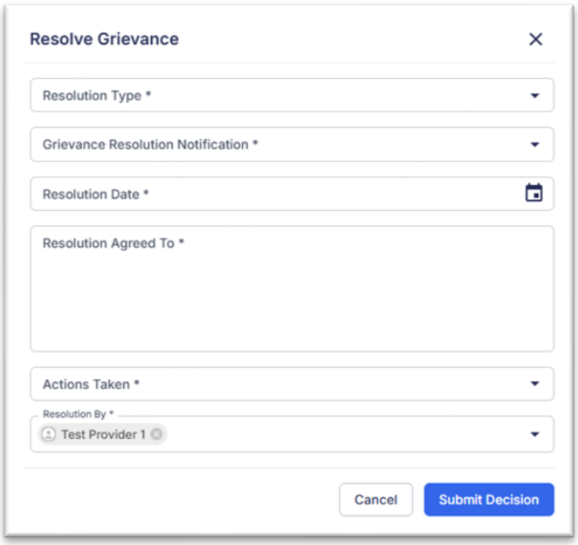
Once all information has been entered.
6. Once the Grievance is submitted, you will see a change log on the details page to provide more visibility into updates, error tracking, accountability and audit readiness.



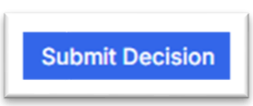
7. Once the Grievance is submitted you can link multiple records to the Grievance.



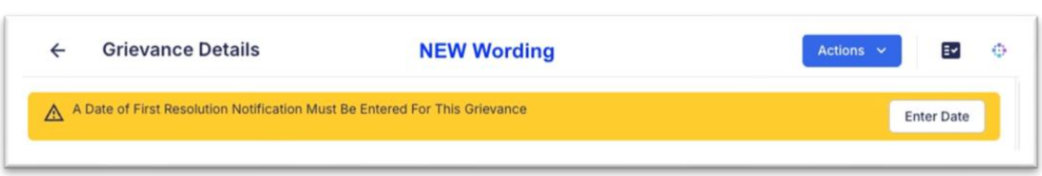
8. Complete investigation and enter additional information.
9. 



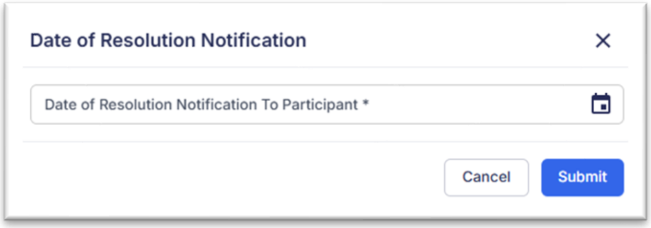
1. Resolution Type
    1. Alternative Resolution
    2. Resolved to Participant’s Satisfaction
2. Grievance Resolution Notification (Select all that apply)
    1. Oral
    2. Withhold notification
    3. Written
3. Date
4. Resolution Agreed To
5. Actions Taken
    1. Extensive list to choose from
6. Resolution By (Defaults to who is entering decision)

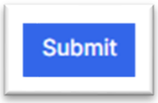


10.
11. After you Submit Decision – Update the associated Tasks
12. Date of Resolution Notification will appear at the top of the screen.
13.



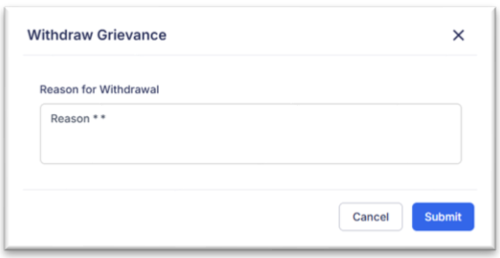
14. Click Enter Date Button



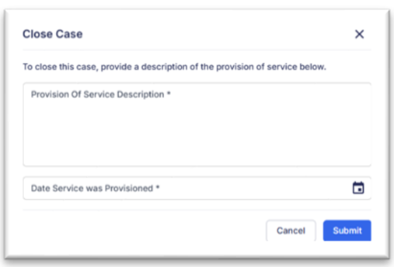
1. Enter Date
2. 

to Resolve Grievance

15. If necessary, under the 3 dots in the upper right-hand corner of the Grievance, you can:
    1. Withdraw Grievance

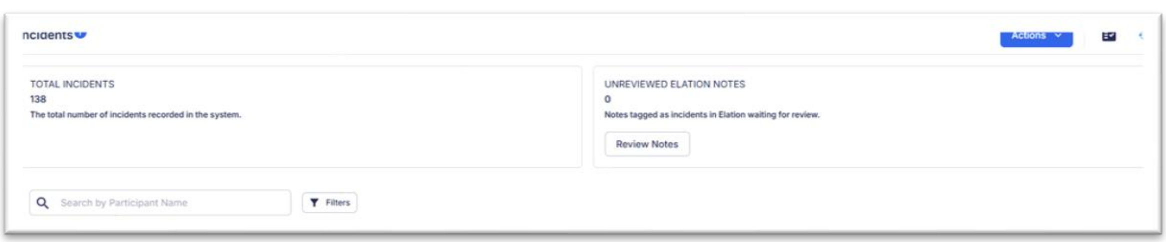


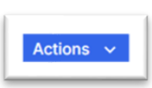
    2. Close Case



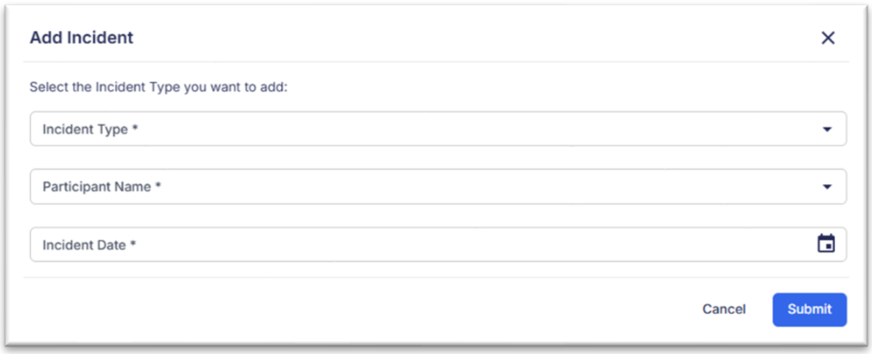
Incidents

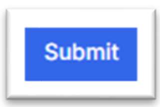
1. The summary card will appear at the top of the screen



2. Hover over the information icons for more information
3. You can: Search and Filter
4. 

Under actions in the upper right-hand side of the screen – Add Incident

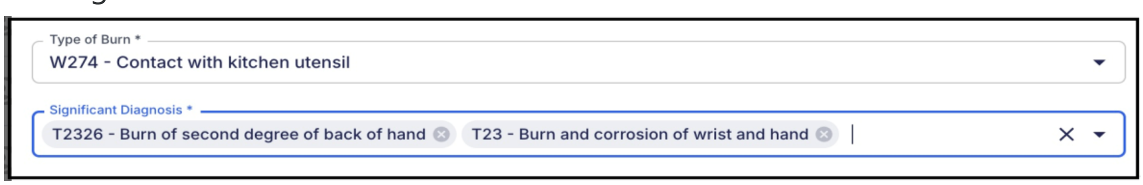


1. Incident Type
    1. Based on the Incident Type that is selected from the drop down, the additional fields will appear to document information about the Incident. These fields are tailored to the type.
2. 

To enter Incident

NOTE: Updated "Type of Burn" and "Significant Diagnosis" fields to be ICD drop-downs versus free text fields.

- Type of Burn - single select ICD
- Significant Diagnosis - multi-select ICD



Updated HPMS Incident selection to include in drop-down: Fires/Other Disasters, Foodborne Outbreak, Infectious Disease Outbreak, and Media Related Event.

5. A new window will appear, and additional information can be added
    1. Hover over a section for the ability to Edit

    2. Add Tasks

Unreviewed Clinical Chart Elation (EMR) Notes

On the summary page, Unreviewed Elation Notes will show notes tagged as incidents in Elation that are waiting for review. Click the Review Notes button to see a list of Participants will notes.

Auto Generated Tasks from Quality Inbox:

Grievance

When a grievance is created, two tasks are automatically triggered:

1. Resolve grievance
2. Notify participant of grievance resolution

SDRs + Appeals

When an SDR is created or an appeal is generated, the following tasks are automatically triggered:

1. Bring SDR request to IDT
2. Notify participant of SDR decision
3. Notify participant of SDR extension
4. Notify participant of appeal resolution
5. Notify of partial or fully adverse appeal decisions

Checklist:

- ✓ Enter a new SDR
- ✓ Enter a new Grievance
- ✓ Enter a new Incident
- ✓ Associate Tasks for follow up on the SDRs, Grievance, or Incident

Knowledge Check:

- If an incident is documented in the Clinical Record, which two actions must be completed on the note to be pulled into CareHub?
- Which step needs to be completed to Deny or Partially Deny an SDR?

Knowledge Base: (Additional information & training video)

- Quality Inbox – IntusCare

Link to CMS Regulations:

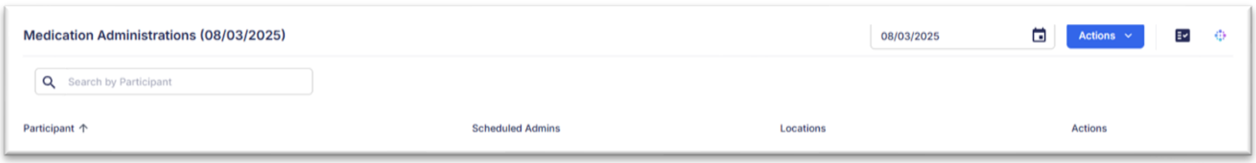
- eCFR :: 42 CFR 460.121 -- Service determination process.
- eCFR :: 42 CFR 460.122 -- PACE organization's appeals process.
- eCFR :: 42 CFR 460.120 -- Grievance process.
- eCFR :: 42 CFR 460.136 – Internal quality improvement activities.

10.Medication Administration (MAR) [460.102]

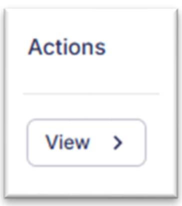
Objective: Participant Medication Administration via the MAR in CareHub. Medications listed as Permanent and OTC in the Clinical Record Elation (EMR) can be added to the MAR for documentation.

Steps:

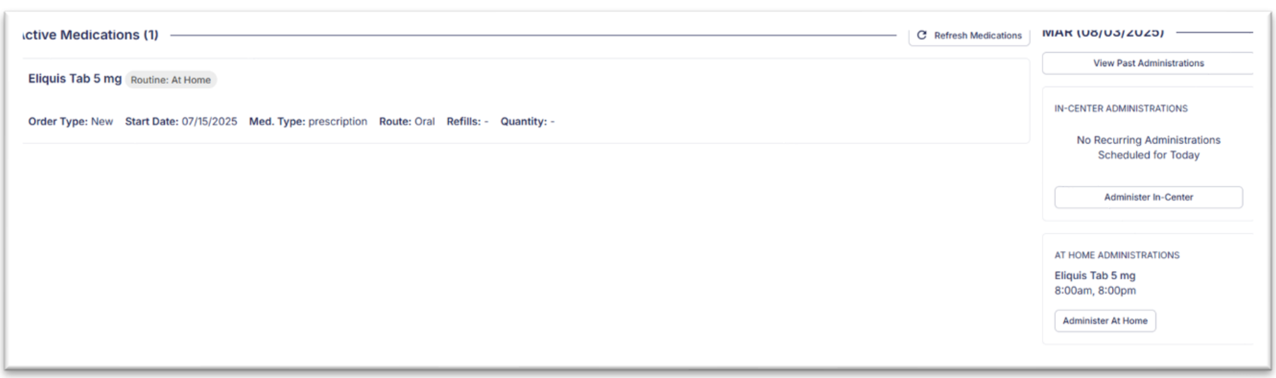
1. Navigate to the Med Administration section on the left hand-side of the screen.
2. A list of participants will appear that have medications for administration on the current date:



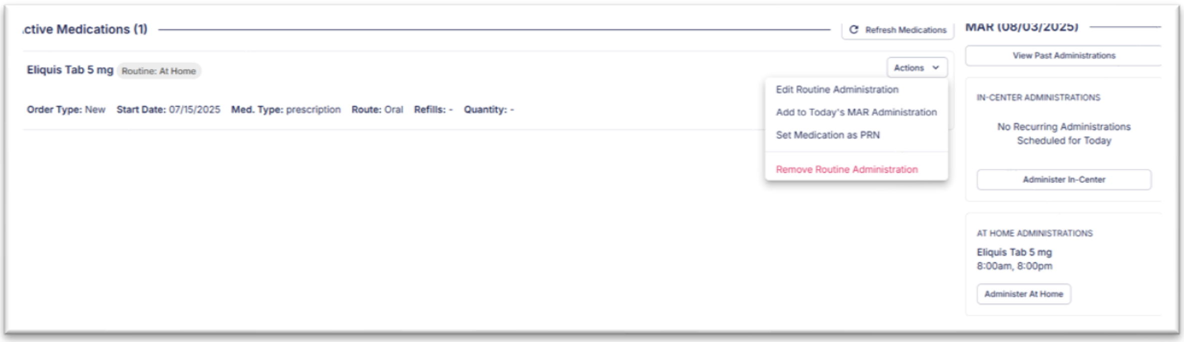
    1. You Can: Search
    2. Change the Date
3. After selecting a participant, under Actions click on the view:



4. You are now in the participants chart – you will now see a list of Active Medications (# of medications)



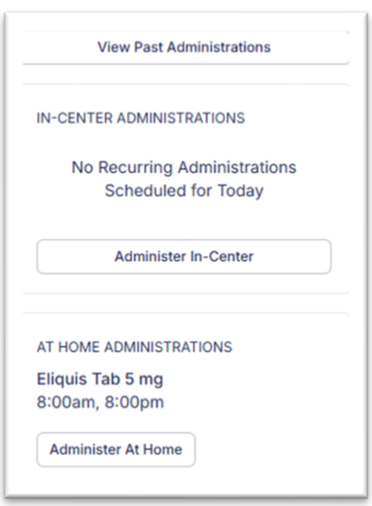
5. Hover over the medication on the list



6. Actions button will appear on the right-hand side
    1. Schedule Routine Medication
        1. Edit Routine Medication: If the medication is already added for documentation, you will be able to edit days, time of administration and add additional instructions for how a medication should be administered
        2. Remove Routine Medications: If the medication is already added for documentation, you will be able to remove it.
    2. Add to Today's MAR Administration

        If the medication needs to be added for the current day only
    3. Set Medication as PRN – this will add for documentation.

        Remove Medication as PRN: If the medication is added for PRN documentation, you can remove it.
7. On the right-hand side of the screen, medications will be displayed in cards that you are able to administer in-center or at home:



NOTE: There are now updated options for frequency of administration. Now, when adding medication to the MAR for routine administration, the options are weekly or monthly.

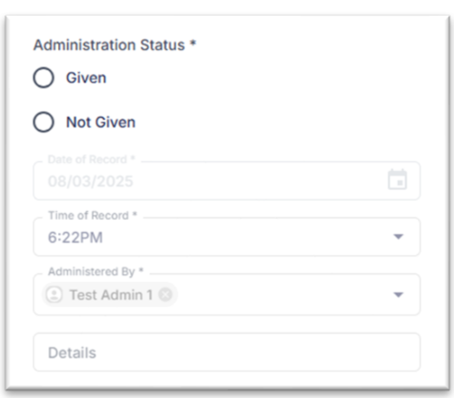
- Weekly - select frequency, location, days of the week, and administration time for each day selected
- Monthly - select frequency, location, monthly occurrence, day of week and specific time of administration

1. View Past Administration button will take you to the MAR to review previous documentation, Print the MAR and move to another month.

NOTE: Addition of Changelog to Past Administration View and Amend Recorded Administration: Select Administration > Select Ellipsis > View Full Administration History Log

2. Click the Administer In-Center or Administer at Home button to document or Add a PRN Medication.

3. Hover over the medication on the list and a Record button will appear on the right-hand side of the screen:



    1. Enter Administration Status

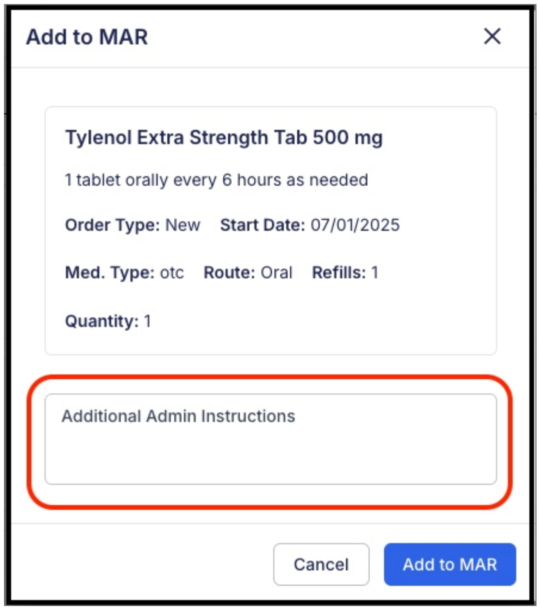
2. Date will be grayed out
3. Update time if necessary
4. Administered by will auto populate. This field is locked to aligned with the signed in user
5. Details – Add if necessary
6. Record
7. Medication will now update with status:
    1. Given
    2. Not Given

4. You will have the ability to Amend your documentation if necessary. Hover over the medication again to see and Amend button on the right-hand side of the screen. Update as necessary
    1. Amend

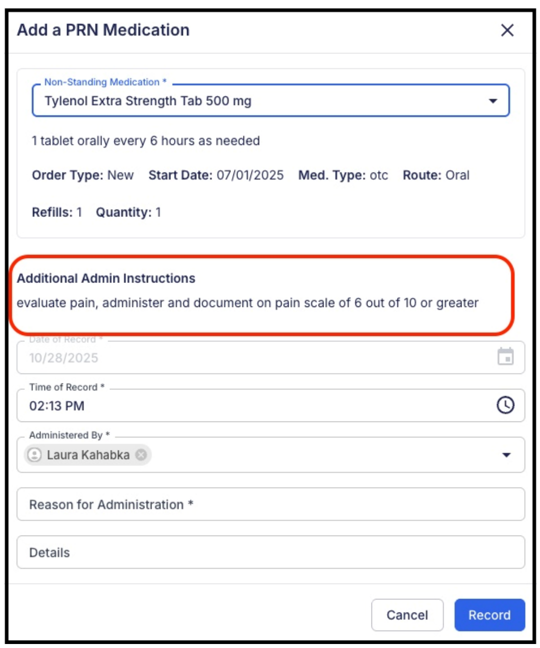
Users can add ***Additional Admin Instructions*** to PRN medications.

- Participant Profile > Medications > Active Medications > Actions > Set Medication as PRN:

IntusCare



- Additional instructions appear when recording the PRN medication administration to clearly understand when to administer:



Checklist:

- ✓ Access the participant's chart.
- ✓ Navigate to the medication administration section.

- ✓ Select the medication.
- ✓ Document administration details.
- ✓ Save the entry.
- ✓ Enter a new Medication in the Clinical Chart Elation (EMR) for a participant and then add it to the MAR documentation

Knowledge Check:

- What information must be documented during medication administration?
- How are the medications that appear for documentation in the Med. Administration tab managed?
- How do you Print the MAR?
- What does the Refresh Medications button do?

Knowledge Base: (Additional information & training video)

- Medication Administration (MAR) – IntusCare

Link to CMS Regulations:

- eCFR :: 42 CFR 460.102 -- Interdisciplinary team.

11.Reports [460.200]

Objective: Within CareHub there are Standard Reports that are available to the IDT Team for the management of the PACE Center.

Steps:

1. Access the reporting module in the system.
2. Select the type of report you want to generate from the list across the top of the screen
3. Customize the report parameters, such as date range and other values
4. Hover over the right-hand side of the report to Alert, Export or refresh the data

NOTE: CareHub Reporting Guide has a full list of reports. Ther are additional reports that are listed for reference of what is in development and are noted with COMING SOON.

Checklist:

- ✓ Access to the reporting module.
- ✓ Select the type of report.
- ✓ Customize the report parameters.
- ✓ Generate and review the report.
- ✓ Export the report if needed.

Knowledge Check:

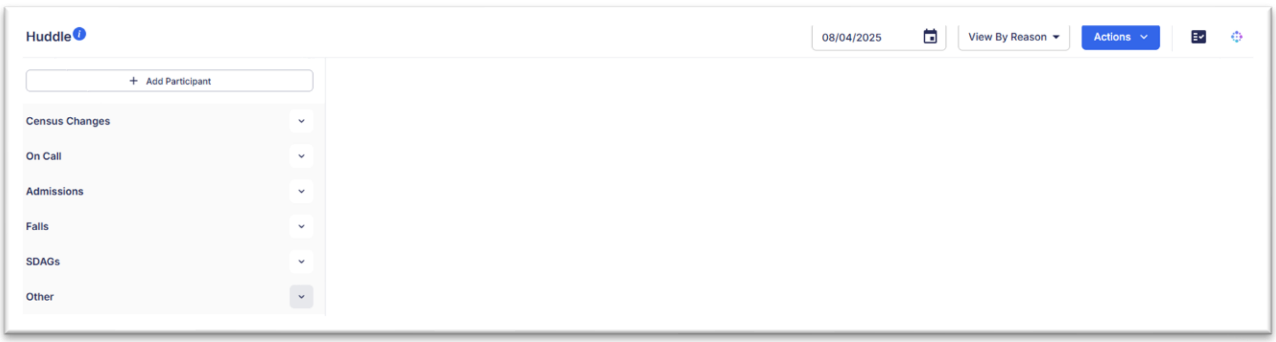
- What types of reports can be generated in the system, and how can they be used to improve program management?

12.IDT Morning Meeting [460.102]

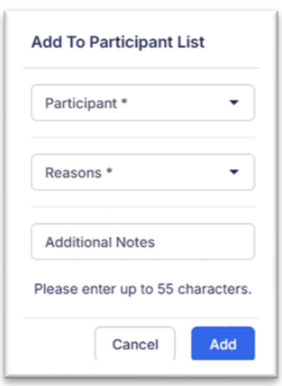
Objective: The primary goal of the IDT Morning Meeting is to review the status of participants, discuss any issues or concerns, and plan the day's activities. This meeting helps ensure that all team members are aware of the current situation and can collaborate effectively to provide the best care possible

Steps:

1. Navigate to IDT Morning Meeting on the left-hand side of the screen
2. Click on Huddle

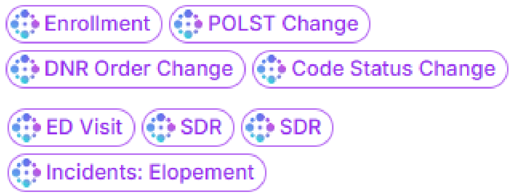


1. Hover over the information icon for more information
2. Add Participant to the next huddle

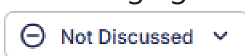


3. Sections will appear for discussion:
   1. Census Changes
   2. On Call
   3. Admissions
   4. Falls
   5. SDSGs
   6. Other
4. User the carrot next to a section to expand and discuss the participants

5. With Intus Suggestion turned on (recommended) you will see icon below the participants' names as to why they have been added to the Huddle:

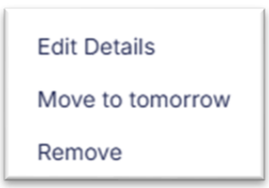


6. When you have discussed the participant, mark them as discussed by clicking on their tile and changing the button in the upper right-hand side of the screen from:



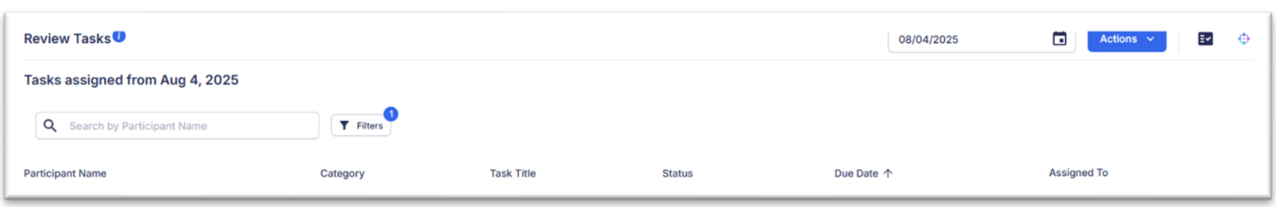
to


7. If you need to update the information for the participant, click on the 3 dots next to their name to:



   1. Edit the details, Move to tomorrow or Remove

3. Navigate to IDT Morning Meeting on the left-hand side of the screen
4. Click on Review Tasks
5.



   1. Hover over the information icon for more information
   2. You can: Search Filter and Change the Date
   3. This Task list will be a filtered list of Tasks Associated with the Morning Meeting.
   4. For instructions on updating tasks – See Section 4: Task Management

Auto Generated Tasks for IDT Morning Meeting:

Event	Triggered
Admissions	
Inpatient Admission	Triggered by adding an Authorization with Authorization Type = Inpatient Admission
Emergency Room Visit	Triggered by adding auth with auth type = Emergency Room Visit
Observation Stay	Triggered by adding auth with auth type = Observation Stay
Inpatient Psych	Triggered by adding auth with auth type = Inpatient Psych
Skilled Nursing Facility	Triggered by adding auth with auth type = Skilled Nursing Facility
LTAC	Triggered by adding auth with auth type = LTAC
Inpatient Rehab	Triggered by adding auth with auth type = Inpatient Rehab
Incidents	
Incident- Burns 2nd Degree or Higher	Triggered by adding an incident with Incident type
Incidents: Falls with Injury	Triggered by adding an incident with Incident type
Incidents: Falls without Injury	Triggered by adding an incident with Incident type
Incidents: Medication Administration Error	Triggered by adding an incident with Incident type
Incidents: Pressure Injury	Triggered by adding an incident with Incident type
Incidents: Abuse	Triggered by adding an incident with Incident type
Incidents: Adverse Drug Reaction	Triggered by adding an incident with Incident type
Incidents: Adverse Outcomes	Triggered by adding an incident with Incident type
Incidents: Elopement	Triggered by adding an incident with Incident type
Incidents: Equipment-Related Occurrences	Triggered by adding an incident with Incident type
Incidents: Motor Vehicle Accidents	Triggered by adding an incident with Incident type
Incident: Suicide Attempt	Triggered by adding an incident with Incident type
Enrollment & Disenrollment	
Newly enrolled participants	Triggered any time enrollment is marked as completed
Disenrollment	Triggered when a disenrollment is added button = “Add disenrollment”
Service Delivery Requests	
Service Delivery Request (SDR)	Any new SDR is created should be a trigger
Profile Updates	
Change in living situation	Triggered when: “Living Situation” field in the participant profile section changes
Change to Code Status	Triggered when a participant changes this field in the participant profile
Change to DNR Orders	Triggered when a participant changes this field in the participant profile
Change to POLST	Triggered when a participant changes this field in the participant profile
Assessments & Care Plans	
Care plan due in the next two weeks + Incomplete Comprehensive OR Semi-annual assessment	Time based

Checklist:

- ✓ Mark participants as discussed
- ✓ Move to the next huddle
- ✓ Review tasks associated with huddles and assign to IDT team member for follow up

Knowledge Check:

- What types of reports can be generated in the system, and how can they be used to improve program management?

Knowledge Base: (Additional information & training video)

- IDT Morning Meeting – IntusCare

Link to CMS Regulations:

- eCFR :: 42 CFR 460.102 -- Interdisciplinary team.