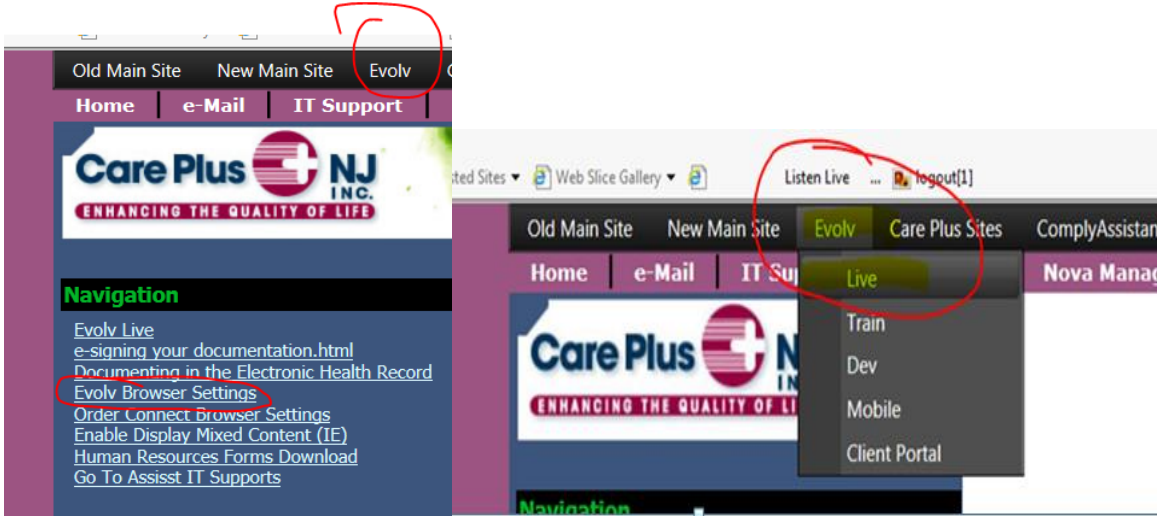


Workflow effective July 1, 2017 – Care Plus Documentation Workflow (All Programs including Fee for Service and CCBHC)

Evolv is accessed from our Care Plus Intranet. Evolv can only be used on Internet Explorer and your computer must be configured for Evolv. Be sure you log into Evolv “LIVE.” You can find step by step instructions to configure your computer on the Intranet page or you can contact the IT Department at ext. 6011 and they can assist you.

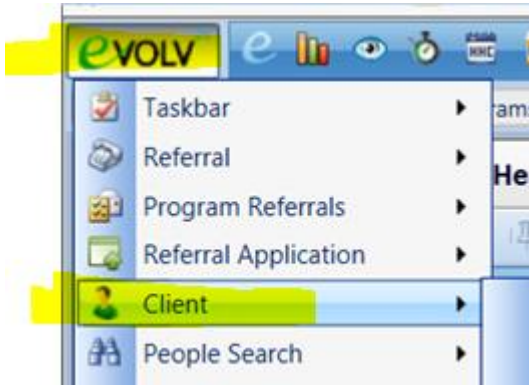


Log In using your computer login name and password.

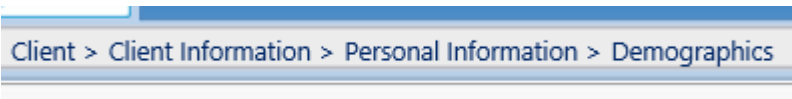
The screenshot shows the Evolv login page. At the top is the Care Plus logo with the tagline 'Healthy minds, healthy bodies.' Below that is the 'eVOLV' logo and 'Version 9.0 build 8026'. The main section is a login form titled 'Enter your login name and password' with a note '(Passwords are Case Sensitive)'. It contains three input fields: 'Login Name', 'Password', and 'Domain' (pre-filled with 'mchc'). There is a checkbox for 'Active Directory' which is checked. Below the form are 'Proceed' and 'Cancel' buttons. At the bottom of the page is the Netsmart logo and copyright information: 'Copyright © 1999, 2014 Netsmart Technologies. All Rights Reserved. This software contains confidential and proprietary information developed by Netsmart and is protected by copyright and trademark law. Unauthorized reproduction or distribution of this software is prohibited. For additional licenses, please click [here](#).'

Workflow effective July 1, 2017 – Care Plus Documentation Workflow (All Programs including Fee for Service and CCBHC)

Required Documentation for all Clients - Go to the Client module; Click on the Evolv button and select Client:



First you want to ensure basic demographic information is collected on your client. All Programs must complete these demographics fields. Please complete the following:



- 1.) Type of Residence – address including zip code, street, city, state, is mailing address, and effective date
- 2.) Race
- 3.) Ethnicity
- 4.) Is Veteran?
- 5.) Marital Status
- 6.) Languages – Spoken Primary Language & Primary Language Proficiency and Primary Reading Language (if applicable complete secondary and tertiary languages)

Here are the breadcrumbs for the documentation requirements once you begin seeing the client:



- 1.) CPNJ Handbook Receipt – [Client>Case Management>Service Management>Service Entry>Care Plus program](#)
- 2.) Health Pain & Nutrition Screen - [Client>Case Management>Service Management>Service Entry>Care Plus program](#)
- 3.) Initial Intake Form - [Client>Case Management>Service Management>Service Entry>Care Plus program](#)
- 4.) Authorizations to Release PHI (be sure to get authorizations for outside providers, especially Pediatrician/Primary Care Physicians at the time HPN is completed) [Client>Client Information>Relationships>Consents](#)
- 5.) PHQ9/PHQ-A (Depression Screening) - [Client>Case Management>Service Management>Service Entry>Care Plus program](#)
- 6.) AUDIT or CRAFFT (Alcohol/drug Screening) - [Client>Case Management>Service Management>Service Entry>Care Plus program](#)
- 7.) Initial Comprehensive Assessment [Client>Case Management>Service Management>Service Entry>Care Plus program](#)

Workflow effective July 1, 2017 – Care Plus Documentation Workflow (All Programs including Fee for Service and CCBHC)

- a. Comp Assessment Addendums - [Client>Case Management>Service Management>Service Entry>Care Plus program](#)
- b. Once the Initial Comp Assessment is completed, a Comp Assessment Review is done upon changes in client's condition, at the time of enrollment into an additional program; and/or annually
- 8.) Suicide Risk Assessment (when applicable) [Client>Case Management>Service Management>Service Entry>Care Plus program](#)
- 9.) Danger to Others/Property Assessment (when applicable) - [Client>Case Management>Service Management>Service Entry>Care Plus program](#)
- 10.) Face to Face service entries [Client>Case Management>Service Management>Service Entry>program client is enrolled in](#)
- 11.) Placement Disruptions [Client>Client Information>Critical Information>Placement Disruption](#)
- 12.) Alerts/Restrictions [Client>Client Information>Critical Information>Alerts/Restrictions](#)
- 13.) Treatment Plan – completed upon intake and updated every 90 days (may vary depending on your specific program requirements) [Client>Case Management>Service Management>Plan Development>Planning](#)
 - a. **re-administer Screening Tools at each Tx Plan Review
 - b. **ensure findings from HPN, Screening Tools and Addendums are incorporated into Client's Goals and Objectives on the Treatment Plan
- 14.) Aftercare Planning event – completed upon discharge from the program [Client>Case Management>Service Management>Service Entry>program client is enrolled in](#)

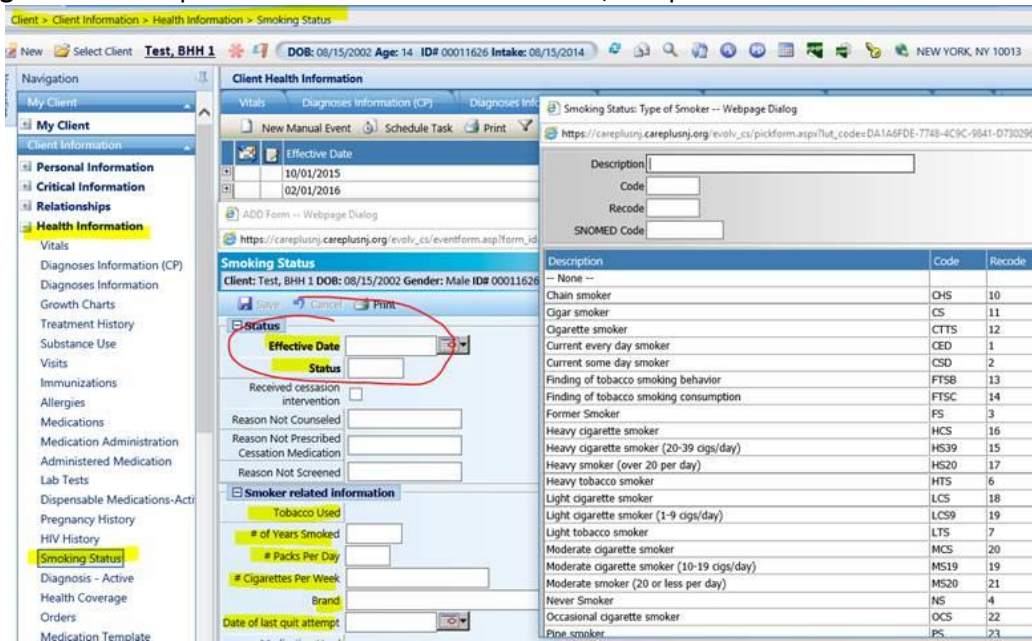
CCBHC Measures Documentation- Clinic Led Created

- 1.) **Vitals** – enter height, weight, systolic/diastolic BP – if our device includes temperature, pulse or respiration, include

The screenshot displays a web-based form for documenting vital signs. The breadcrumb trail at the top reads: Client > Client Information > Health Information > Vitals. The client information bar shows: Test, BHH 1, DOB: 08/15/2002, Age: 14, ID# 00011626, Intake: 08/15/2014. The left navigation pane is expanded to 'Health Information' > 'Vitals'. The main form area is titled 'Physical Characteristics' and includes a 'Date Tested' dropdown menu. Below this are input fields for: Height in Inches (Use Decimals), Height Percentile, Weight in Lbs (Use Decimals), Weight Percentile, BMI (%), BMI, Systolic Blood Pressure, Diastolic Blood Pressure, Pulse (bpm), Respiration (b/min), and Temperature (F). The 'Date Tested' field and several other input fields are highlighted in yellow.

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2.) **Smoking Status** – Complete the Status...if client is smoker, complete the bottom section for more detail.



Clinic Measures:

Measure: Preventive Care and Screening: Adult Body Mass Index (BMI) Screening and Follow-Up (BMI-SF)

BMI Recorded is outside of normal parameters during the encounter or during previous 6 months

- Age 65 years and older BMI < 23 or > 30 kg/m²
- Age 18-64 years BMI < 18.5 or > 25 kg/m²

Possible Interventions for out of range BMI:

- Adult BMI Follow up is documented as Other Activity (“Lifestyle Education Regarding Diet” provided) OR,
- Adult BMI - Referral for Weight Assessment is documented as Other Activity, OR
- Medication prescribed thru Order Connect

| | |
|--------------------|---|
| -- None -- | |
| Activities - Other | *Adult BMI - Follow Up |
| Activities - Other | *Adult BMI - Referral for Weight Assessment |

Measure: Weight Assessment for Children/Adolescents: Body Mass Index Assessment for Children/Adolescents (WCC-BH)

Documented BMI for youth age 3-17 during the encounter or during previous 6 months.

Interventions for out of range BMI for youth:

- Counsel on Physical Activity AND
- Counsel on Nutrition

| | |
|--------------------|---|
| Activities - Other | *Child/Adolescent Nutrition Counseling for BMI |
| Activities - Other | *Child/Adolescent Physical Activity Couns for BMI |

Workflow effective July 1, 2017 – Care Plus Documentation Workflow (All Programs including Fee for Service and CCBHC)

Measure: Preventive Care & Screening: Tobacco Use: Screening & Cessation Intervention (TSC)

Percentage of consumers aged 18 years and older who were screened for tobacco use one or more times within 24 months AND who received cessation counseling intervention if identified as a tobacco user.

Intervention for Tobacco User:

- Adult Smoking Cessation Counseling provided for 3-10 minutes OR
- Adult Smoking Cessation Counseling provided for greater than 10 minutes OR
- Prescribe Medication thru Order Connect

| Participating Staff/Notes | Other Activities | Assessments | Participants |
|---------------------------------------|------------------|-------------|--------------|
| Other Related Activities | | | |
| Type | Duration | From Time | To Time |
| *Adult Smoking Cessation & Counseling | 00:10 | 10:00 AM | 10:10 AM x |

Measures: Preventive Care and Screening: Unhealthy Alcohol Use: Screening and Brief Counseling (ASC)

Adult clients screened at least once within the last 24 months for unhealthy alcohol use using the AUDIT AND who received brief counseling if identified as an unhealthy alcohol user (score of 8 or higher)

- Adult Unhealthy Alcohol Use Brief Counseling

| | |
|--------------------|---|
| Activities - Other | *Adult Unhealthy Alcohol Use Brief Counseling |
|--------------------|---|

Measure: Child and Adolescent Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-BH-C)

Measure: Adult Major Depressive Disorder (MDD): Suicide Risk Assessment (SRA-A) Percentage of consumer visits for those consumers aged 6 through 17 years and age 18+, with an active diagnosis of major depressive disorder at the time of the encounter with an assessment for suicide risk conducted.

Intervention:

- Complete the Suicide Risk Assessment v2 in its entirety
- Prescribers will document their full Suicide Risk Assessment in their progress note & document **Suicide Risk Assessment - MDD D- in the Other Activities

| | |
|--------------------|------------------------------------|
| Activities - Other | **Suicide Risk Assessment - MDD Dx |
|--------------------|------------------------------------|

Measure: Screening for Clinical Depression and Follow-Up Plan (CDF-BH)

Percentage of consumers aged 12 and older screened for clinical depression on the date of the encounter using an age-appropriate standardized depression screening tool, and if positive, a follow-up plan is documented on the date of the positive screen. This measure is stratified by age group (ages 12 to 17, ages 18 to 64, and age 65 and older). PHQ9 used for Adults and PHQ-A used for Adolescents.

Possible Interventions:

- Medication prescribed thru Order Connect OR,
- Suicide Risk Assessment performed (see measure above), OR
- Follow Up Plan for Depression is documented as Other Activity

| | |
|---|------------------------------------|
| PHQ9 - Patient Health Questionnaire v3 | |
| PHQA - Patient Health Questionnaire-Adolescents | |
| Activities - Other | *F/U for Depression Age 18+ |
| Activities - Other | *F/U Plan for Depression Age 12-17 |

**Workflow effective July 1, 2017 – Care Plus Documentation Workflow
(All Programs including Fee for Service and CCBHC)**

Measure: Depression Remission at Twelve Months (DEP-REM-12)

Adult consumers 18 years of age or older with Major Depression or Dysthymia who reached remission 12 months (± 30 days). Re-administer the PHQ9 at 12 months (± 30 days). Clients with a score of 5 or less have achieved Remission.

Reconcile the Flag after you documented your intervention or prescribed medication thru Order Connect.

