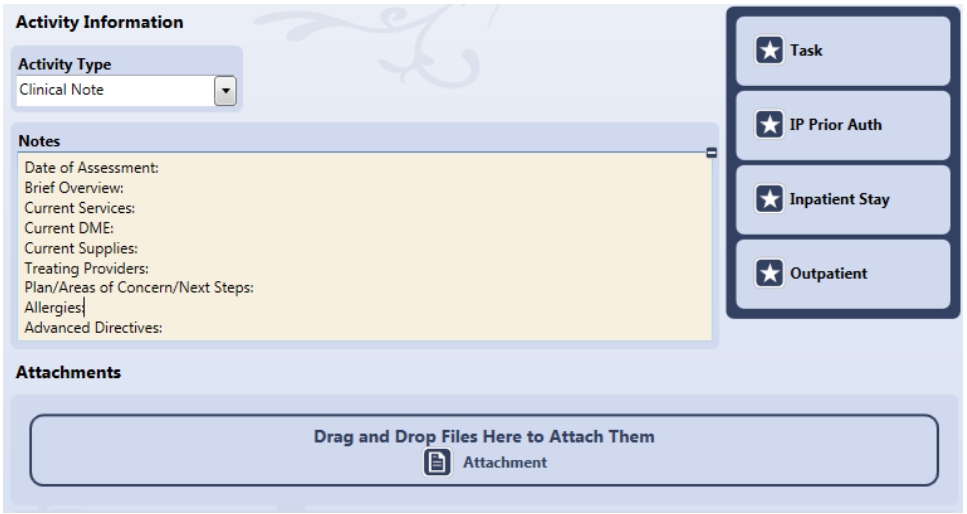
To add the Initial/Annual Note:

1. Open the member's file.
2. Click the + icon, then "Work" and "Activity Log."

3. Under Activity Type, select "Clinical Note." In the Notes section, right click and select "Standard Text", "SCO CM," and "Clinical Note" to populate the note template.



4. Populate the specifics of the Clinical Note template with the information on the following pages.

Date of Assessment: Date assessment was completed. Identify if the assessment was telephonic.

Brief Overview:

- Description of member: Age; language spoken (was interpreter used or family); pertinent medical diagnoses; appearance (obese, frail); nutritional status; cognitive status
- Condition of living space (home, apartment, elevator, neat, cluttered, etc.); who lives with member; who provides support; any social supports
- Activities involved in and how member spends their time.
- ADL/IADL function
- Recent falls, hospitalization, ED visits and their current picture outcomes
- Current medical picture, functional changes, brief head to toe
- Describe current treatments for active diagnoses (COPD = inhalers/O2; CHF = diuretics/water restriction; etc) and member's ability to comply with MD orders
- How member is taking medications (on own, cueing, others admin); what do they use (pill box filled by daughter, MD2, pill bottles), and compliance with medications. Member's concerns about their medical picture or their overall care
- Document Medication Review completed during visit
- Document progress on advanced directives and Goals of care
- Document teaching delivered to member and family

Current Services:

- What is being provided and the problems being addressed
    - Example: ADH 5 days/week to assure med compliance, improve safety, and manage depression
- Include any changes to HCBS from this visit
    - Example: PCA hours increased from 10/weekly to 15/weekly due to increased weakness and to provide improved nutrition
- Document any suggested services that member has declined
- Document VNA services, include if telehealth is being used, and disciplines seeing member (PT, OT, SN).
- **"This Care Manager's treatment plan supports continuation of these services."**

Current DME: List of all equipment in the home and if it is adequate. If not adequate, what is needed and why it is not present.

Current Supplies: All supplies, where they are being ordered from, and what needs are met.

- Example: Pullups for urinary incontinence ordered through Byram.

Treating Providers: Document all MDs who are involved in member's care, dates of next appointments, and information on pertinent past visits. Can add phone numbers if it is helpful. Document how member gets to their appointments (family, escort, on own)

Plan/Areas of Concern/Next Steps:

- List problems you have identified and the actions taken.
  - Example: Member's pain is 10/10. RNCM to reach out to PCP to work to provide better management.
- As appropriate, make sure that these problems are also on the POC.
- Document that member has agreed to the POC.
- Document follow up "as needed"
  - Example: Contact member after MD appointments for outcome; Contact VNA to coordinate goals, request telehealth.

Allergies: Document allergy type, reactions, and any additional notes. **Be sure to document allergies on the main Member File screen.**

Advanced Directives: Document Goals of Care (longevity, function, comfort, or member does not wish to answer), type of document, location of document, and any additional notes. **Be sure to document Advance Directives on the main Member File screen.**