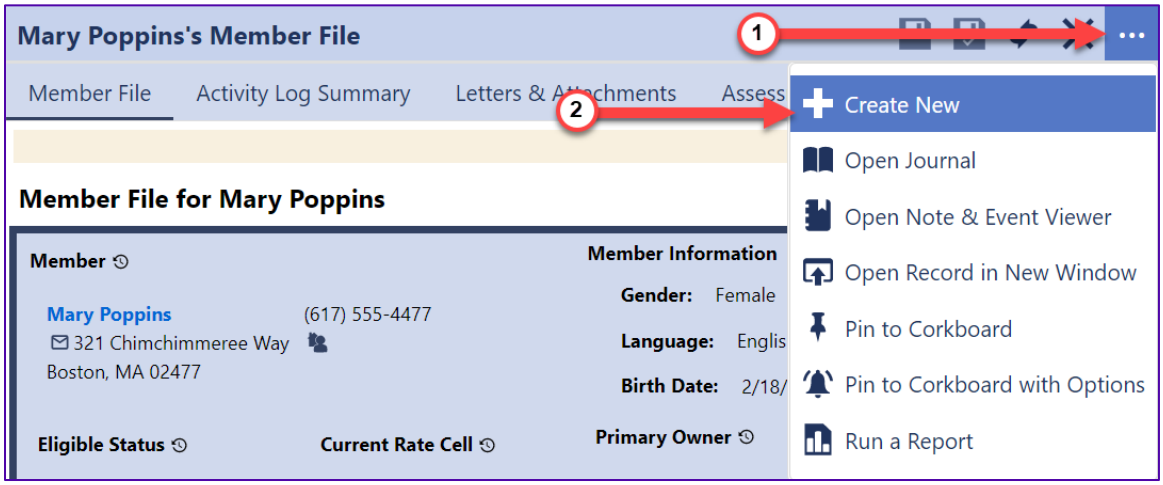
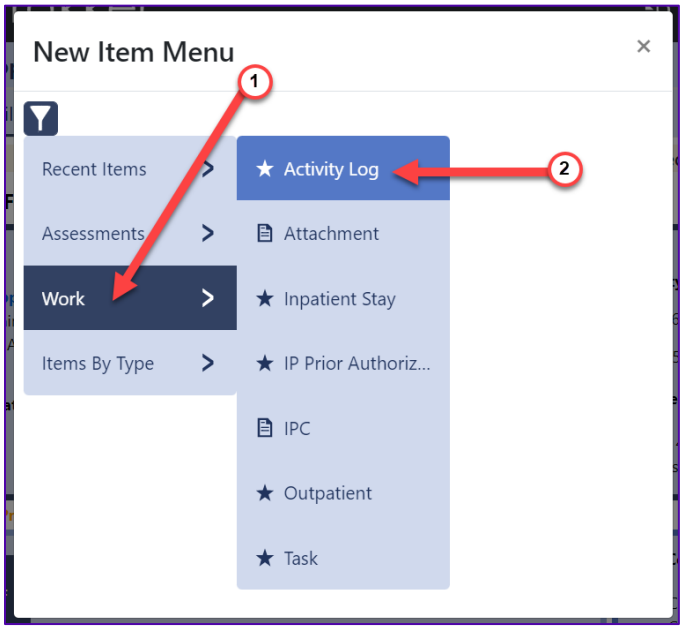
A **Clinical Note** is required for all member visits and serve as a narrative account of your assessment; questions and concerns from the member and/or caregiver(s); follow-up for future visits and documentation of your care planning efforts. In CaseTrakker, there is a **Clinical Note Template** that is used by the RN Care Manager for the Initial and Annual Visits, which is accessible in the **Standard Text** menu.

Begin by creating an **Activity Log**:

1. In the Member File, click ···, then click + Create New.



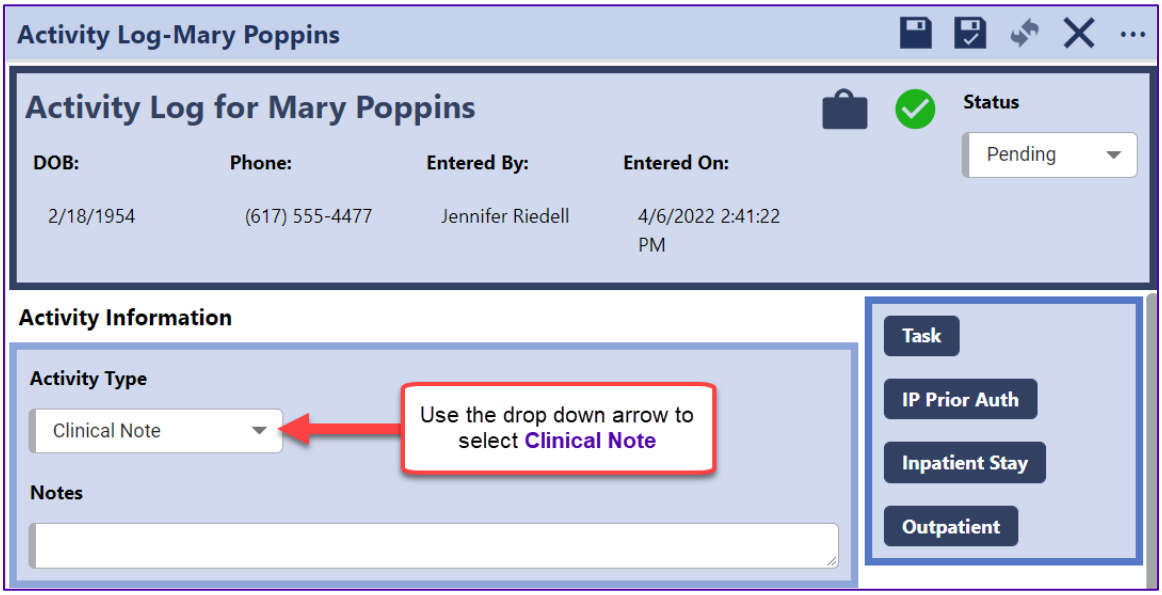
2. The New Item Menu will appear in a popup window. Activity Logs can be found quickly by selecting Work, then clicking Activity Log.



If you know the Item you want, but aren't sure where it is in the **New Item Menu**, click ▼ to search the entire list. The **New Item Menu** will be filtered as you type.

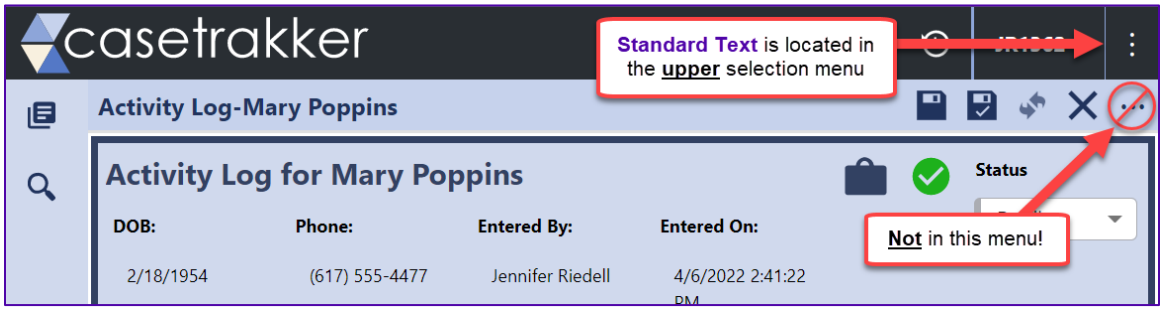
While there is a quick link on the **Activity Log Summary** screen to Click here to create a new Activity Log, it is highly recommended that users create their **Activity Logs** by clicking ··· and + Create New at the top of the screen. Using the shortcut on the screen will not show all options available when you create an **Activity Log** through the ···.

Once you have opened a new **Activity Log**, select **Activity Type**: Clinical Note using the drop down.



To insert Standard Text in your Activity Log:

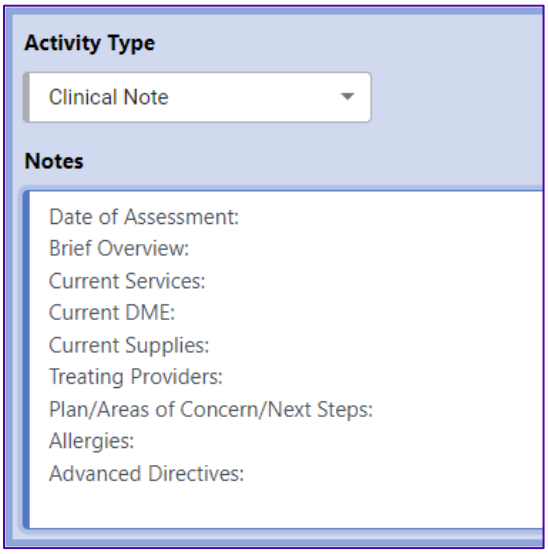
1. Click the selection menu (⋮) at the very top of your CaseTrakker window.



2. Select **Standard Text** from the menu.

3. In the **Standard Text Menu**, scroll to the bottom to access **SCO CM** templates.

4. Scroll back up the **Standard Text Menu** to find the **Clinical Note Template**. When you click Clinical Note, the text of this template will be copied to your computer and the popup will close.
5. Back in the **Activity Log**, click in the **Notes** field and paste (CTRL+V) the template. *(see below)*



Complete the **Clinical Note Template** using the guidelines below. The left column contains the header as it appears in the **Clinical Note Template**, and the right column details the information that should be provided (as it applies to the member).

Header	Information to include:
Date of Assessment:	• "**In-home assessment completed [date and time].**"
Brief Overview:	• Document "**Obtained verbal consent from member to discuss PHI in front of family/caregiver [name].**" if no AOR in place. • Description of member: Age; language spoken (include whether an interpreter used, family interpreted or CHW is fluent); pertinent medical/behavioral health diagnoses; appearance (obese, frail); nutritional status; cognitive status • Condition of living space (home or apartment; elevator or stairs; neat, cluttered, etc.); who lives with member; who provides support; any additional social supports

Header	Information to include:

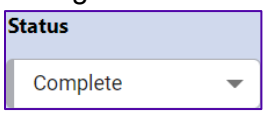
Brief Overview (cont.):	• Activities involved in and how member spends their time
	• ADL/IADL function
	• Recent falls, hospitalization, ED visits and their current picture outcomes
	• How member is taking medications (on own, cueing, others admin); what do they use (pill box filled by daughter, MD2, pill bottles), and compliance with medications.
	• Member's concerns about their medical/behavioral health or their overall care
	• Document any teaching delivered to member and/or caregivers
	Don't forget to Task the SCO Clinical Consultant if the member reports:
	  • Increased shortness of breath (SOB) when speaking or with mild activity
	  • New onset of pain that is decreasing their ability to complete ADLs independently
	  • Unsteady gait, dizziness, recent fall or abnormal gait test
	  • Pain, if not controlled with meds

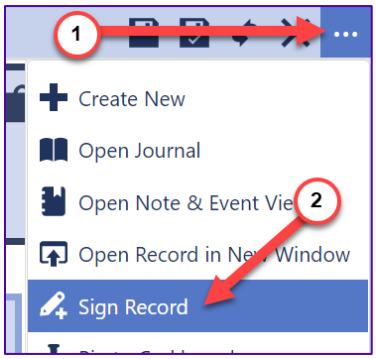
Current Services:	• Include all services provided and the problems being addressed • *Example:* ADH 5 days/week to ensure med compliance, improve safety and manage depression **Don't forget to Task the Primary Owner (if not yourself) if the member is requesting additional services or has any questions/concerns with their existing 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 **Don't forget to Task the Care Coordinator if the member is having any issues with their current DME.** **Don't forget to Task the Primary Owner (if not yourself) if the member is requesting additional DME or has any questions/ concerns with their existing DME.**
Current Supplies:	• Include all supplies, where they are being ordered from and what needs are met • *Example:* Pullups for urinary incontinence ordered through Byram. **Don't forget to Task the Care Coordinator if the member is having any issues with their current supplies.**

Header	Information to include:
Current Supplies (cont.):	**Don't forget to Task the Primary Owner (if not yourself) if the member is requesting additional supplies or has any questions/ concerns with their existing supplies.**
Treating Providers:	• Include MDs the member has seen within the last 3 months, dates of next appointments and information on pertinent past visits • Identify how member gets to their appointments (family, escort, on own)
Plan/Areas of Concern/Next Steps:	**See examples below, which you can edit as needed to the member's situation. If there are no areas of concern, copy and paste the last entry in your Clinical Note.** • *Area of Concern/Next Steps:* Risk for fall related to unsteady gait and report of uncontrolled pain. Telephone call to the RNCM from the member's home to report concerns. RNCM to follow-up with plan of action and review assessment. • *Area of Concern/Next Steps:* Member requesting additional HM services. RNCM notified via Task to review assessment and report member's request for additional services. • *Area of Concern/Next Steps:* No areas of concern at this time. Member stable. RNCM notified via Task to review assessment. Don't forget to include "**Verbal approval from member on Plan of Care and Service Plan.**"
Allergies:	Document any new allergies. If there are no new allergies, document "**No new allergies.**" **If there are new allergies, be sure to add them on the main Member File screen.**
Advanced Directives:	Document changes to the member's Goal of Care (longevity, function, comfort, or member does not wish to answer), type of document, location of document and any additional notes. If there are no changes, document "**No changes to Goal of Care/Advanced Directives.**" **Make sure the "Goal of Care" on the Member File screen matches your entry in the CA.** **If there are changes to the member's Goal of Care or new Advanced Directives, be sure to add them on the main Member File screen.**

Once you are finished, mark your Clinical Note as Complete, add your Signature, then Task the SCO Clinical Consultant: *(Instructions on next page)*

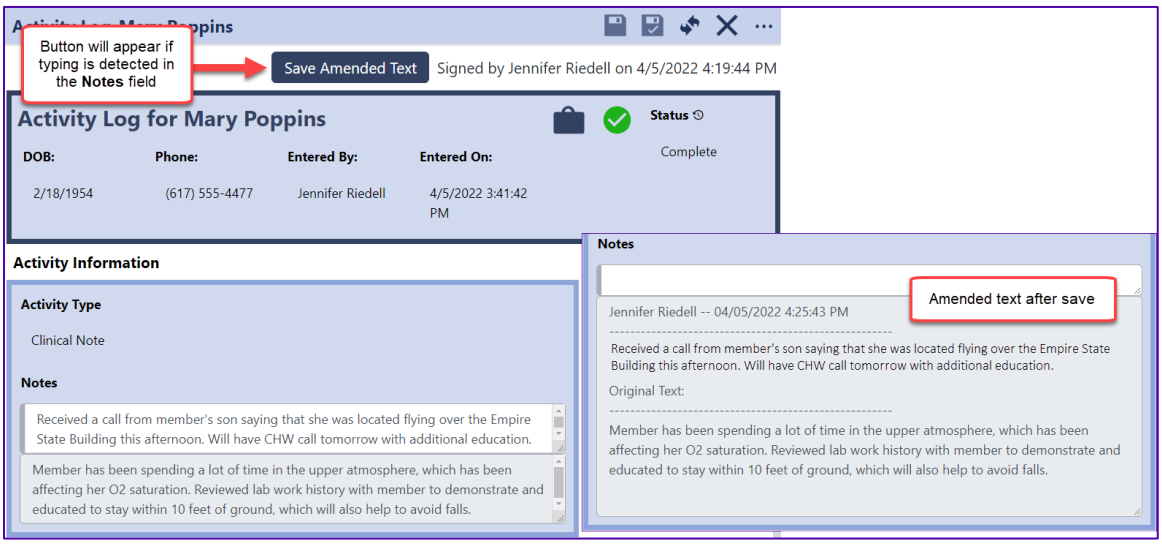
1. Change the **Status** of the Activity Log to **Complete**, then click 💾.





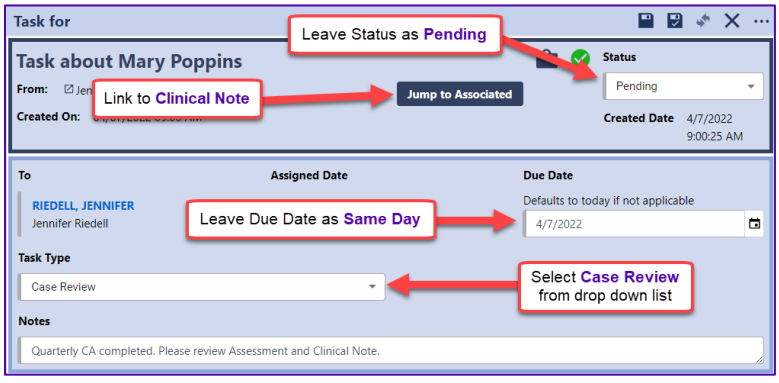
2. Once the Activity Log has finished saving, click ··· and Sign Record.

3. Once you click **Sign Record**, the text in the Activity Log will be locked, so no more changes could be made. If you need to add additional information, begin typing in the Notes field. A Save Amended Text button will appear as you type. Click the button when you are finished, and the amended text will be date and time stamped above the original note text.



4. Click the ✅ in the upper right hand corner of the **Activity Log.** This will open a **Task** with a link directly back to your **Clinical Note**.

5. Send the **Task** to the SCO Clinical Consultant, using **Task Type: Case Review**. Leave the **Status** as **Pending** and the **Due Date** with the same date the Task is being sent.



6. In the Notes section, call out any areas of concern, member requests, or questions (refer to the 📝 in the Clinical Note Template instructions above). Otherwise, document, "**Quarterly CA completed. Please review Assessment and Clinical Note.**"