## Interaction Tracker, Task, CNA-OB, Care Plan and Case Notes in VirtualHealth: overview for CMHRP teams

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<th>What is it?</th>
<th>Interaction Tracker</th>
<th>Task</th>
<th>CNA-OB</th>
<th>Care Plan</th>
<th>Case Notes</th>
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<td><strong>Examples</strong></td>
<td>• Documentation of all contacts or attempted contacts (phone call, face-to-face) with or on behalf of the patient and/or provider, referral source, community agency, etc.</td>
<td>• A prompt for yourself or another person when there is something specific to follow up on.</td>
<td>• Information gathered from patient, provider, previous and current VH information (i.e. claims data, assessments, medications, care plans, etc.), EMR, etc.</td>
<td>• Platform used to document patient goals and progress toward reaching goals.</td>
<td>• Automated case notes are generated when the user completes certain activities for a patient.</td>
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| | | • The system generates a task with the next upcoming intervention on a member’s care plan. | • PT reported information | Comprehensive plan of care. Goals are patient driven and derived from problems & needs identified in the CNA-OB. Goal development & follow up (interventions & progress/outcome) are documented in the Care Plan. | The CM may document a case note manually to “note” something of relevance in the highlighted box, then select “Add Text”.
| | | Captures what needs to be done; a reminder to yourself of what you need to do. | | | Users may create case notes to capture brief details but should NOT document interactions or interventions within Case Notes. Users may view “Case Notes” to see a list of autogenerated actions taken within VH. |

### How is it created?

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### Examples

1. The CM meets patient at the prenatal care provider office. OBCM documents successful contact in the interaction tracker.
2. The CM attempts to meet with the patient at the prenatal care provider office. When the patient does not come in, the CM documents an unsuccessful attempt to interact with the patient.
3. CM sends referral to Food Bank of North Carolina on behalf of the patient.
1. The system generates a task to conduct outreach to a patient when a new OB ADT referral is received.
2. The CM creates a task for herself to call the patient about her ultrasound results.
3. Provider reports patient has missed past two prenatal appointments.
1. Per ABC OB-GYN EMR, patient has history of asthma.
2. Pt reports she is having difficulty with food stamp allotment lasting throughout month; she receives $83.00 per month in SNAP.
3. Provider reports patient has missed past two prenatal appointments.
1. CM documents Interventions/activities completed as they relate to specific patient identified goals.
2. For more details/examples see Care Plan section in Step by Step Documentation Guide.
1. Initial MIIS and any change in MIIS should be noted by CM in a Case Note.
2. Upon receiving referral, the CM should document in a case note reviewing initial patient information (such as EMR, WIC, patient medications, previous assessment(s), claims data etc.).
3. CM may briefly note something of relevance, such as the due date changed as a result of an ultrasound on a specific date.
4. Completion of case reviews/chart audits can be noted in case note.