Community Connect

Provider Portal Guidance

Table of Contents

Provider Portal Guidance
Community Connect

This guidance is intended for providers of the Community Connect Program who are looking for guidance on navigating the Provider Portal and completing standard actions within it. For additional information about program operations and requirements, review the Community Connect Provider Guidance.

I. Portal Access

The Community Connect Provider Portal is a web-based system that offers online access. Click here to access the Portal.

A. Qualify for and Request Access

Prior to accessing the system, each Program Contact (Care Coordinator or Peer Support Specialist must complete the following steps:

- Attend a program onboarding meeting with your program's Community Connect Administrator or Peer Support Administrator
- Submit a request for portal access to comconnect@nd.gov and include the following:
  - First and Last Name
  - Email Address
  - Phone Number
  - Regional Participation
  - Role(s): Master/Support Admin, Care Coordinator, Peer Support Specialist

  Please note, the portal access request form must be submitted by the supervisor
- Attend Care Coordination and/or Peer Support training

B. Respond to Portal Invitation Request

When the Community Connect program team has completed reviewing your organization's access request and creating a profile for your new Program Contact, that person will receive an invitation to access the Provider Portal sent to the email address provided for them in the access request.

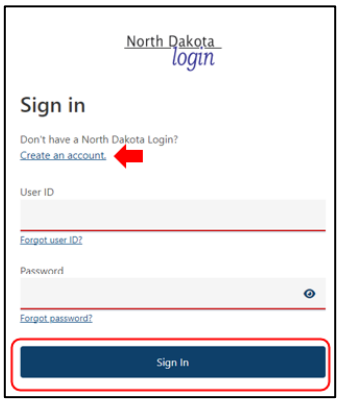
- Review the Email Instructions
- Click the Invitation Link, which will take you to the ND Login screen

C. Create and/or Link ND Login Account

The Community Connect Provider Portal utilizes the ND Login for limiting and monitoring access.

- Individuals who already have an ND Login may use their existing ND Login
- Individuals who do not already have an ND Login should click on Create an Account

For help with this step of the login process only, complete the ND Login Contact Support Form.



D. Application Access

Upon gaining access to the Portal, users will be able to see a shared data set of participant information that includes all applications for which your program has accepted referrals for.

To gain access to a new Community Connect participant's Application File, the following steps must be completed by BHD Administration:

1. Validate a Release of Information for your organization
2. Send a Referral to your organization

When the above steps have been completed, your organization will be able to see the participant's application in the Pending Records- Pending Applications view. At this point you will only be able to view the Participant's application and demographic information.

Upon Referral acceptance, the Application File will now be present in the Active Applications view and your organization will be able to create new records and view your program's records within the Application File in accordance with each user's role(s) in the system.

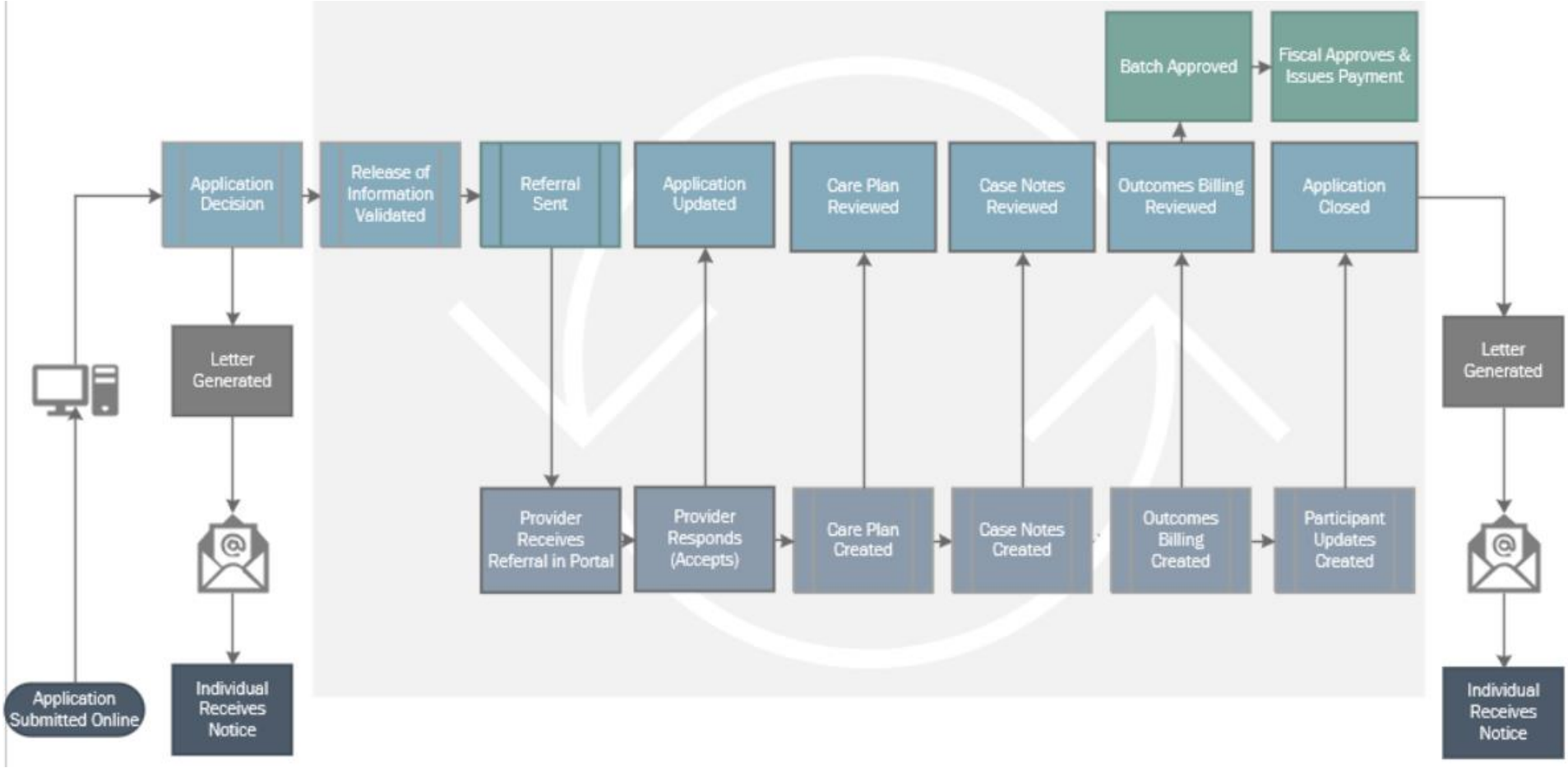
E. Role-Based Accessibility

The provider portal relies upon each user's assigned roles (Master/Administrative Support, Care Coordinator, Peer Support Specialist) to determine which actions a user can take within the portal. The table below provides a summary of all allowed actions for each user. Specific steps for completing the activities below are detailed in upcoming sections of this guidance.

Activity	Admin	CC	PSS
Referral Response	X		
Assign/Reassign Care Coordinators	X		
Assign/Reassign Peer Support Specialists	X		
Update Participant Demographics	X	X	X
Create Care Plan	X	X	X
Modify Care Plan	X	X	X
View Care Plan	X	X	X
Create Case Notes	X	X	X
View Case Notes	X	X	X
Create Monthly Outcomes Billing	X	X	
Modify Monthly Outcomes Billing (<5th of each month)	X	X	
View Monthly Outcomes Billing	X	X	X
Create Participant Update	X	X	
Modify Participant Update	X	X	
View Participant Update	X	X	X

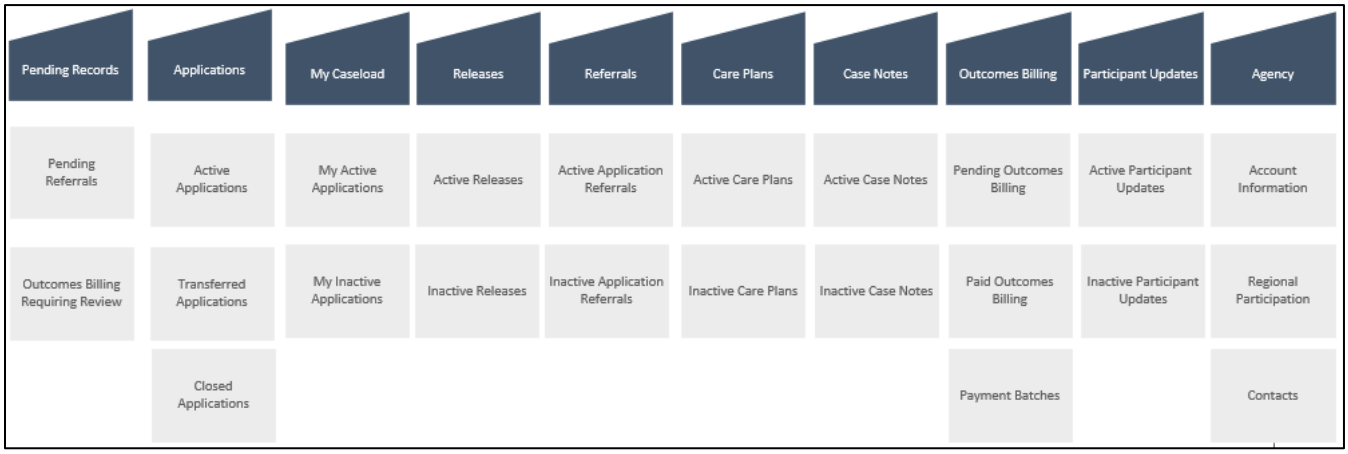
II. Participant Journey Overview

The following map shows an overview of a participant's journey through the Community Connect Program, and demonstrates the significant collaboration between the CC program and your organization in assisting program participants



III. Provider Portal Layout

Upon Logging into the Community Connect Provider Portal, users arrive at the portal's landing page, which is arranged in a series of Tabs for users to select from based on the intended activity.



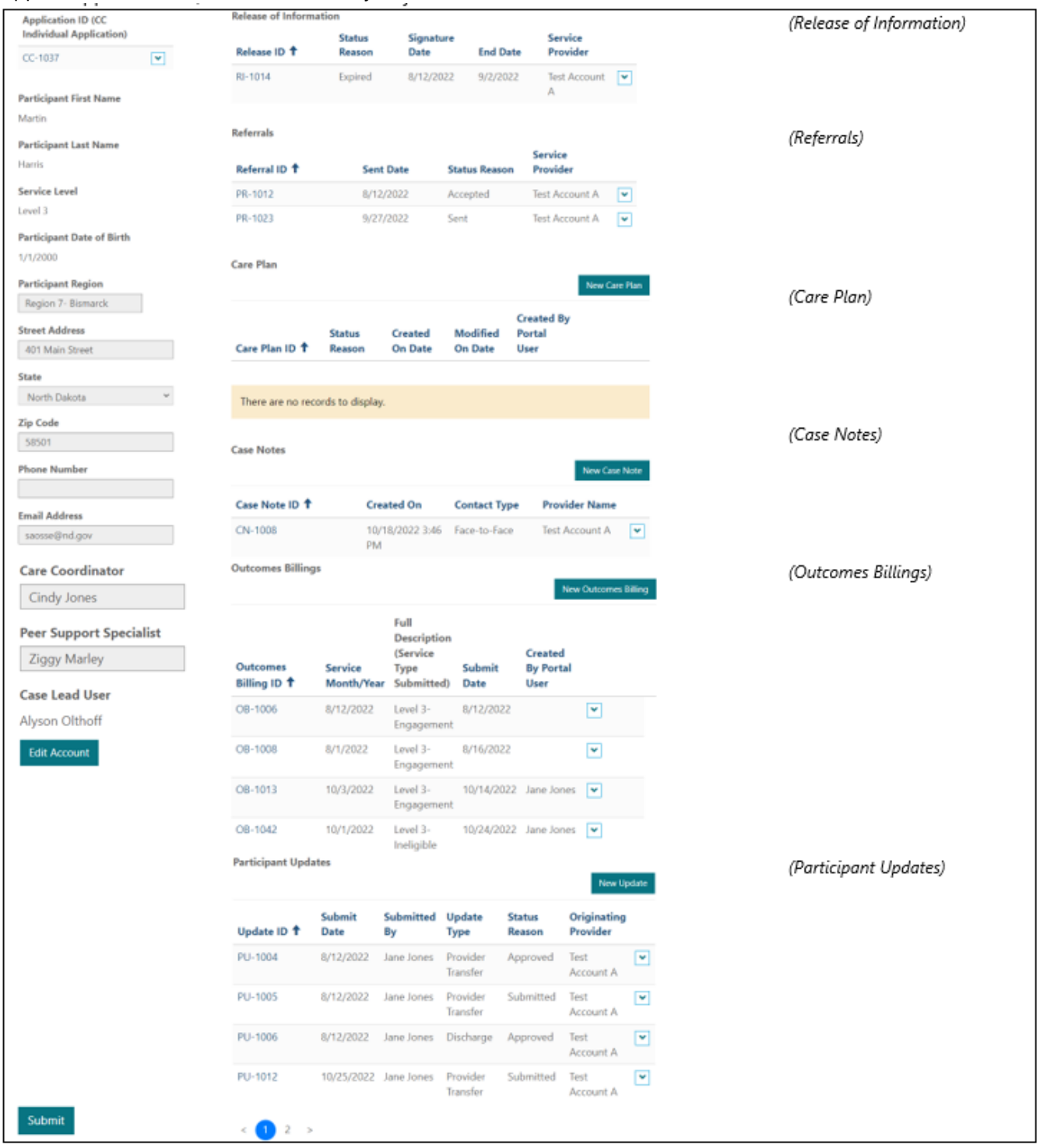
Below is a summary of each of the Tabs, along with what information and functionality is provided in each:

Pending Records	View primarily used by a program's Master and Support Administrators to: • Respond to new Referrals issued by the Community Connect program • Review Outcomes Billings that the Community Connect program did not approve as submitted (following each billing and reconciliation period)
Applications	View for users to see current and historical listings of a program's applications. Here, users can: • Click into participant's Application Files to complete work • Export datasets • Use a search bar to narrow results by any of the column values
My Caseload	Default portal view that provides a listing of the logged-in user's assigned applications/participant. Users can click into their assigned participant's Application Files to complete work for each participant.
Releases, Referrals, Care Plans, Case Notes, Outcomes Billing, Participant Updates	Views for users to see complete listings of a program's application-based work-type history. In each of these tabs, users can: • Click into the records to view/print • Export datasets • Use a search bar to narrow results by any of the column values

Agency	This tab provides high-level information about a Program, including:
	• Program Address, website, phone, email address
	• Regional Participation and Referral Status
	• Program Contact List
	  ○ Contact demographics (email, phone, regional participation)
	  ○ Contact's current and historical application assignments
	  ○ Master/Support Administrators can update Program Contact demographics and enter an End Date to terminate that contact's access to the system.

IV. Participant Application File Layout

Almost all work completed within the Provider Portal System occurs under the context of a participant's Application File, which has a standard layout as follows:



(Release of Information)

(Referrals)

(Care Plan)

(Case Notes)

(Outcomes Billings)

(Participant Updates)

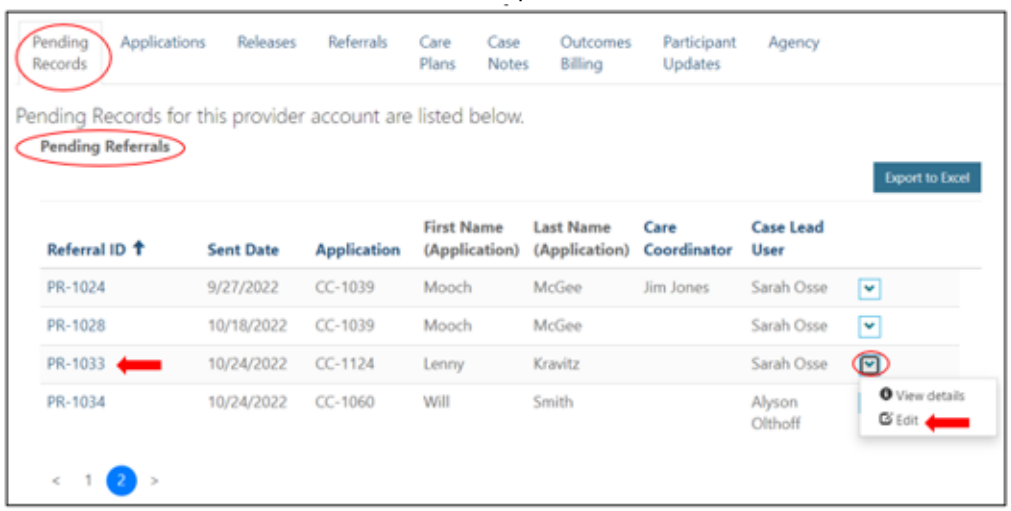
V. Referrals

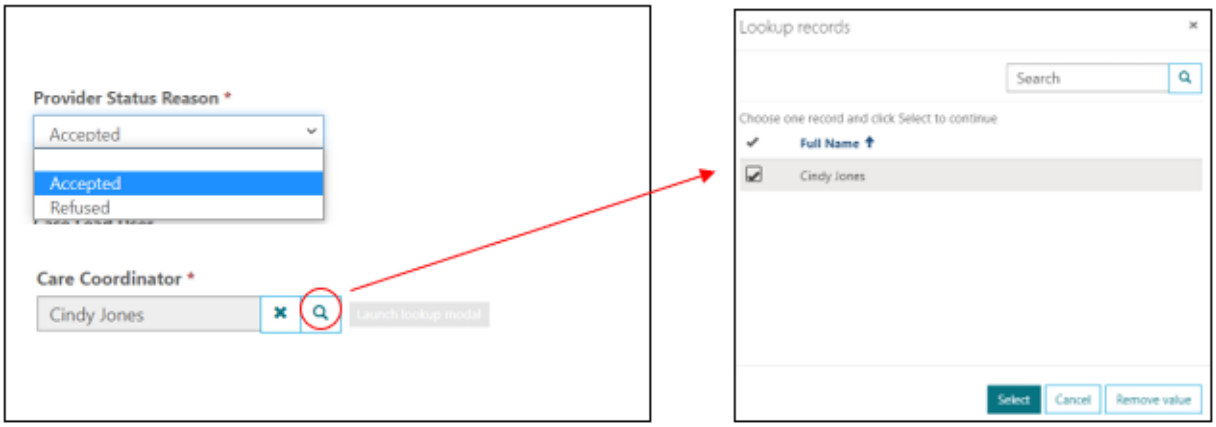
When Community Connect approves a participant application it is assigned to a Program Case Lead. One of the Case Lead's responsibilities is to collect and validate the participant's Release of Information for their selected provider, at which point they can issue the Referral to the participant's selected provider.

When a Case Lead sends a Referral to your organization, that Referral will show in the Pending Records Tab, under the Pending Referrals view. Only users with Master/Support Administrator roles can respond to a Referral.

To respond to the Referral:

1. Click on the Referral ID or click the down arrow and Edit
2. In the Referral Form:
   - Accept the Referral and assign the Care Coordinator by clicking on the magnifying glass. *(Note- only care coordinators available in the participant's region will show up here for selection.)*
     Accepting the Referral will automate the following:
     - Email communication to the Care Coordinator and Program Email
     - Application will show up in the Applications Tab under Active Applications
     - Application will show up in the assigned Care Coordinator's My Caseload Tab
   - Refuse the Referral and provide a reason for refusal.



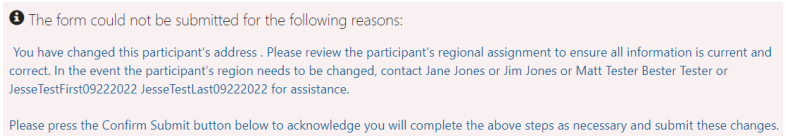


VI. Updating Participant Application-Level Information

A. Participant Demographic Changes

All users can make changes to a participant's address, email address, phone number. Only Master/Support Administrators can update a participant's regional assignment as this may require reassignment of Care Coordinator and/or Peer Support Specialist.

1. Navigate to the Participant's Application File
2. Click on Edit Account
3. Make changes in applicable fields
4. Click Submit
5. Review the standard error status message for important reminders about potentially required next steps (e.g., address changes that affect a participant's region require Master/Support Administrators review for reassignment of care coordinator/peer support specialist).

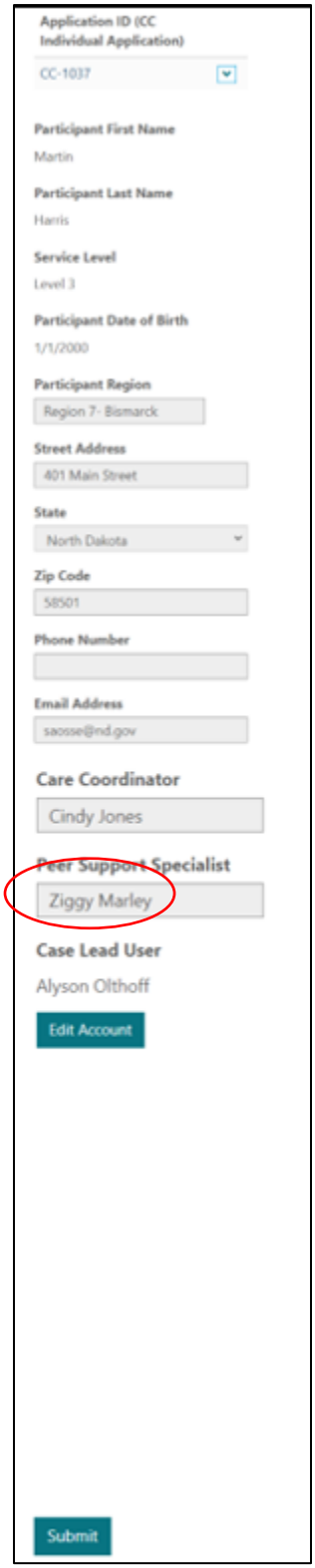


6. Click Submit

B. Assigning Peer Support Specialists; Updating Care Coordinator/Peer Support Specialist Assignment

For participants who elect to receive peer support, the Master/Support Administrator will manually add the Peer Support Specialist to the participant's Application File by completing the following steps:

1. Navigate to the Participant's Application File
2. Click on Edit Account
3. Click the magnifying glass next to Peer Support Specialist to launch the Program Contact lookup
4. Select the applicable Program Contact. *(Note- Peer Supports must be assigned to the participant's region in order to be selected.)*
5. Click Submit
6. Review any error messages that the system may provide and make necessary adjustments.
7. Click Submit (at the very bottom of the Application File on the left-hand side)



VII. Care Plans

Creation of a participant's Care Plan is a vital component of the Community Connect program and should serve as a living document that is updated and evolves as a participant's needs and goals change. Providers should refer to the Community Connect Provider Guidance for additional information on creating quality Care Plans.

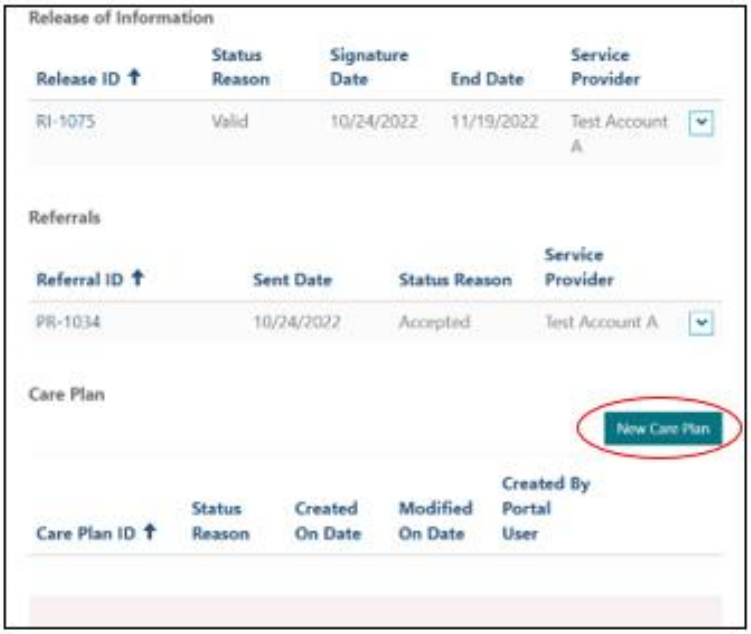
A. Create a Care Plan

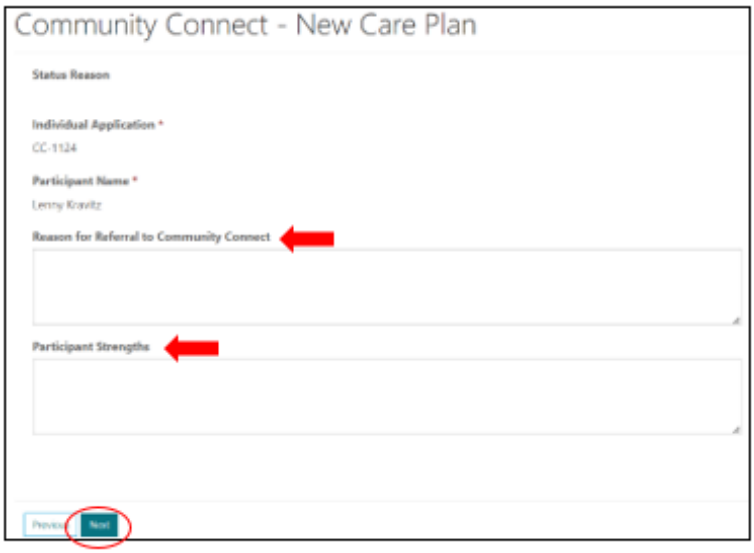
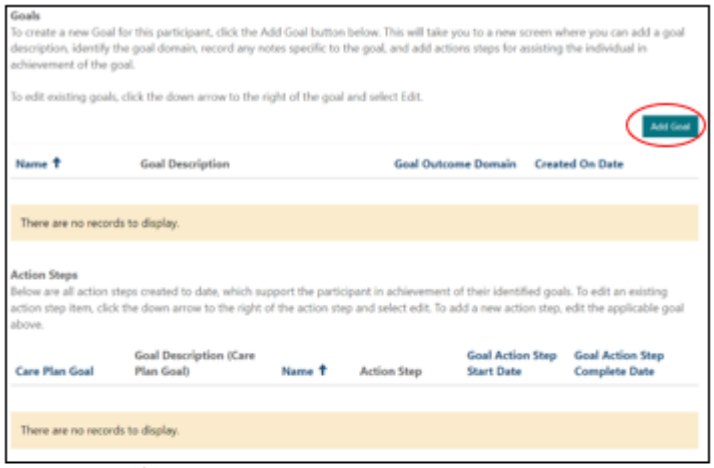
Creating a Care Plan consists of three main steps, with each step being contingent upon the previous step:

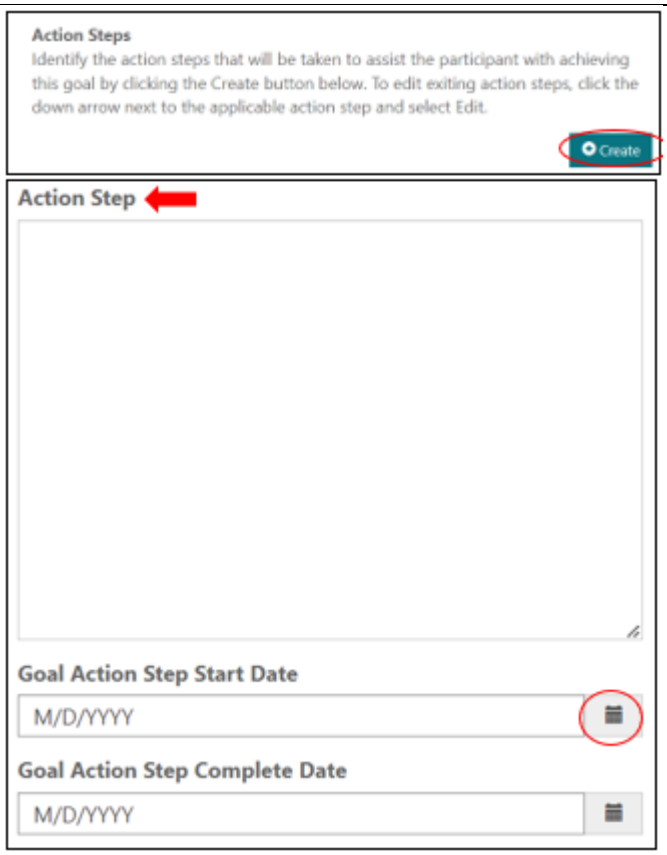
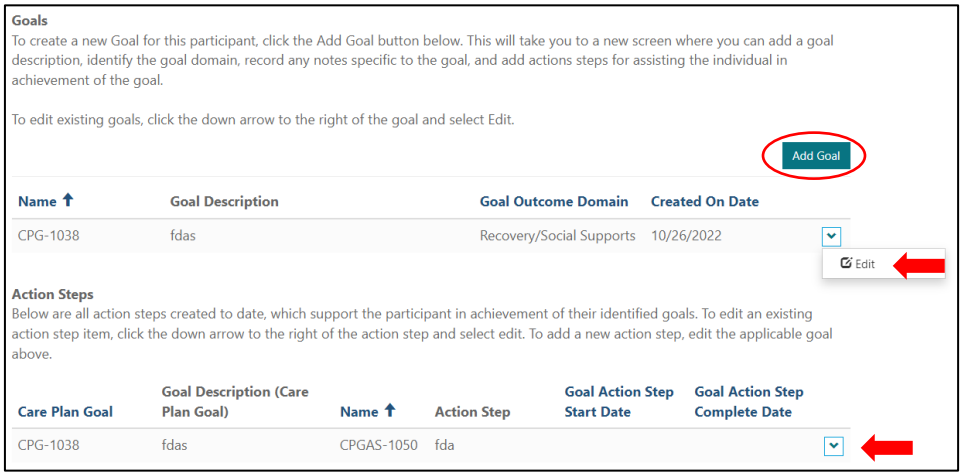
- Create the Care Plan
  - Add Goal(s)
    - Add Goal Action Step(s)

While each Participant can only have 1 active Care Plan at a time, the Care Plan can include as many goals as determined by the participant, and each Goal can include as many Action Steps as determined beneficial by the participant and Care Coordinator.

The table below shows the steps for creating a Care Plan:

1.	Navigate to the Participant's Application File and click on Create New Care Plan	

2.	In the Care Plan Form: • Enter the Participant's Strengths and Reason for Referral into the Program • Click Next	
3.	Add Care Plan Goal • Click on Add Goal • Enter Goal Description • Select the application Outcomes Domain • Enter any comments/reminders/ideas about this goal in Goal Provider Comments • Click Next	 

4.	Add Goal Action Steps • Click Create • Describe Action Step in the Action Step field • Enter the Action Step Start Date (as the date you intend to start, or leave blank if unknown) • Click Submit • Repeat steps under this section (section 5) until all Action Steps for the goal have been added • Click Next	
5.	Review Care Plan overview The system will drop you into a Care Plan Overview screen, where you can see high-level information about the participant's Care Plan. • If additional Goals should be added, repeat steps 4 and 5 until Care Plan is complete • To add new Action Steps to existing Goals, use the down arrow on the Goal to edit the applicable goal • When Care Plan is completed, click Submit at the bottom of the screen.	

B. Modifying a Care Plan

Throughout each month, Care Coordinators are expected to modify a participant's Care Plan to record:

- Entry of new Goals
- Completed Action Steps
- Entry of new Action Steps
- Provider Goal comments (as determined helpful by the Care Coordinator)

To modify a Care Plan, navigate to the Participant's Application File and click the down arrow next to the Care Plan and select Edit.

The next steps are largely the same as those for creating a new Care Plan but will depend on the specific thing you're trying to achieve.

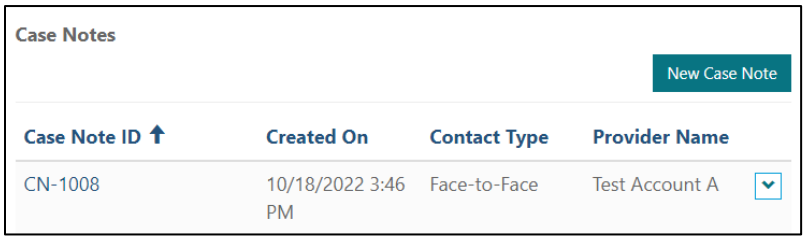
To create a new Goal *(And add associated Action Steps)*	• See steps 3 and 4 from the Create a Care Plan section for detailed instructions
To modify an existing Goal	• Click on the down arrow next the Goal you're trying to modify and click Edit • See steps 3 and 4 from the Create a Care Plan section for detailed instructions
To create a new Action Step under an existing Goal:	• Click on the down arrow next the Goal you're trying to modify and click Edit • See step 4 from the Create a Care Plan section for detailed instructions
To edit an existing Action Step:	• Under the Action Steps view within the Care Plan, click the down arrow and select Edit • Modify as needed

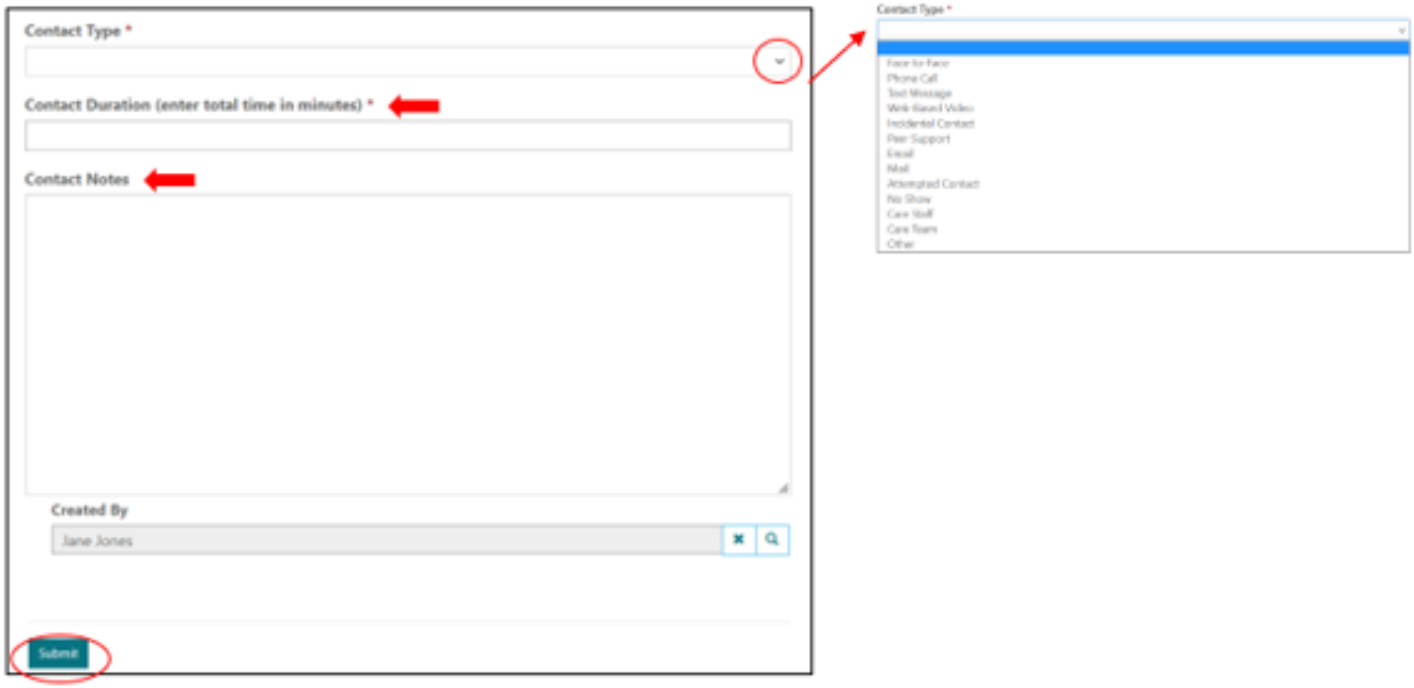
VIII. Case Notes

Care Coordinators and Peer Support Specialists are expected to add Case Notes to the participant's Application File each time an attempt to contact the individual is made.

To create a Case Note:

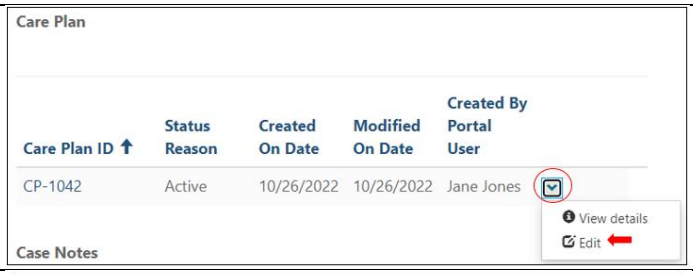
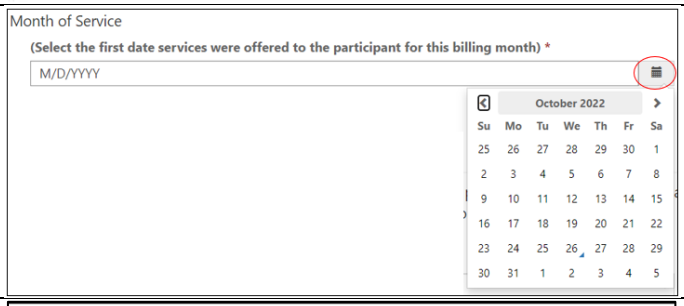
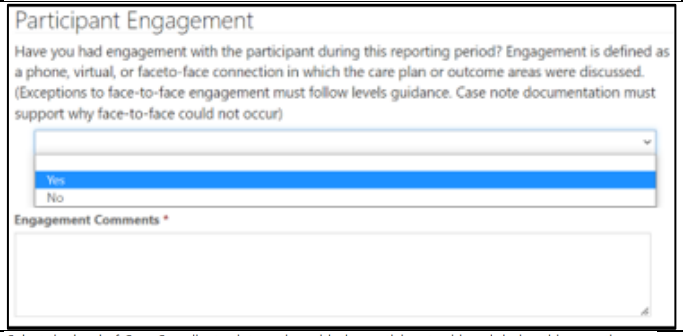
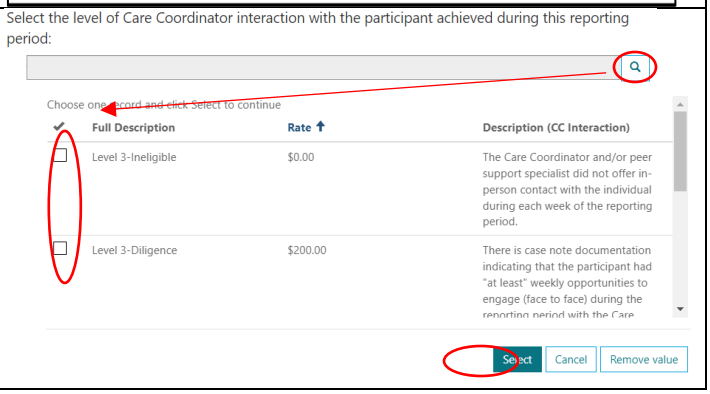
1. Navigate to the participant's Application File
2. Click New Case Note
3. Identify the Contact Type from the dropdown
4. Enter the Contact Duration (total time spent in minutes)
5. Enter contact notes
   - When the attempt is unsuccessful (the participant doesn't reciprocate) the note should indicate whether a voicemail /text request was made for the participant to reach back out.
   - When the attempt is successful (the participant engages in communication) the note should provide a high-level summary of the discussion.
6. Click Submit





IX. Outcomes Billing

Each month, your organization must complete an Outcomes Billing for each assigned/active participant.

1.	Review the Participant's Care Plan and Case Notes for monthly progress/effort To view Care Plan or Case Note details, click the down arrow and click View Details	
2.	Click New Outcomes Billing and respond to the Engagement and each Outcomes question based on the Application File review	
3.	Enter the first date of the reporting month using the date picker (Always select the 1st)	
4.	Respond to the Engagement and Outcomes questions based on the review of participant's Care Plan/Case Notes and provide comments for each See table that follows for assistance with correctly identifying engagement/ outcomes responses	
5.	Select the Level of Service achieved for the reporting period based on the Engagement and Outcomes question responses. • Click the Magnifying Glass • Place a checkbox in the appropriate Level of Service • Click Select	

The table below provides a high-level summary of how to answer the Outcomes Billing questions, which are intended to guide both providers and the program with determining the level of services achieved.

	Select Yes if	**Select No if**	**Select N/A if**
Engagement	Phone, virtual, or face-to-face connection in which the care plan or outcome areas were discussed was achieved	Care coordinator was not able to effectively engage with the participant during the reporting month. **Selecting No here will cause all other answers to lock in at N/A*	
Housing	The participant is living in a place that best meets their needs and is safe and supportive of recovery or they are making progress towards this goal.	The participant is not living in a place that best meets their needs and is safe and supportive of recovery and they are not making progress towards this goal.	The participant was not engaged during the reporting period
Employment	The participant is making progress towards or maintaining their employment/finance goals	The participant is not making progress towards or maintaining their employment/finance goals	
Recovery	The participant is demonstrating effort to reduce their substance use or the harm associated with their use and/or improve their mental health functioning	The participant is not demonstrating effort to reduce their substance use or the harm associated with their use and/or improve their mental health functioning?	
Criminal Justice	The participant is avoiding law enforcement engagement resulting in arrest, criminal charge, or probation violation resulting in initiation of revocation	The participant is not avoiding law enforcement engagement resulting in arrest, criminal charge, or probation violation resulting in initiation of revocation	

The system will limit users from entering service levels that do not align with requirements define in Provider Guidance. Below is high-level guidance to assist users with making accurate service level determinations.

Highest level of Care	**Ineligible**	**Diligence**	**Engagement**	**Outcomes**
Level 1	• Engagement not achieved • 0 Outcomes Achieved • Case Notes do not demonstrate efforts to engage participant	N/A	• Engagement achieved • 1-2 Outcomes Achieved • Care Plan/ Case Notes support progress in Outcomes areas	• Engagement achieved • 3+ Outcomes Achieved • Care Plan/ Case Notes support progress in Outcomes areas
Level 2		• Engagement achieved • 0 Outcomes Achieved • Case Notes demonstrate efforts to engage participant unmet		
Level 3				

For additional information about making determining the level of service and reimbursement rates, see Community Connect Provider Guidance.

X. Participant Updates

To notify the Community Connect Program of change requests relating a participant's engagement with the program, your organization can use the Participant Update form. There are three types of changes included for submission under this form:

Level of Care Change	Use this form option when your organization determines a participant would benefit from a lower or higher level of care. To submit this participant update type, you will need to provide: • Level of care you believe the participant should be in • Explanation for this decision
Program Discharge	Use this form when your organization has determined it may be appropriate to discharge a participant from the program. To submit this participant update type, you will need to provide: • Last Date of Participation • Reason for Discharge • Explanation for this decision

Provider Transfer	Use this form when your organization has determined it is necessary to transfer a participant to another participating provider.
	
	To submit this participant update type, you will need to provide:
	• Region the participant will be participating in
	• Whether the participant has already selected a new provider
	  ○ If so, who
	  ○
	• Explanation for this decision

To submit a Participant Transfer:

1. Navigate to the Participant's Application File
2. Click on New Participant Update
3. Provide form responses as needed for each participant update type (outlined above.)
4. Click Submit

Your Participant Update form will be reviewed by the Community Connect program within 7 business days of your submission and will provide an email summary of decision. For Discharges approved, the system will automate a communication to the participant's assigned Care Coordinator and/or Peer Support Specialists.

Your organization can always look up the status of a Participant Update form as well by reviewing the participant's Application File or by navigating to the Participant Update Tab within the Portal.

XI. Agency-Level Information

Within the Agency Tab all users can view the following information about the Agency:

- Agency Demographics, such as address, email, phone, website
- Regional participation and Referral status
- Program Contact List

To modify Agency-level demographics, contact the Community Connect Program Lead or email comconnect@nd.gov.

Within each Contact provided in the Program Contact list, users are also able to view/ modify (Master/Support Administrators only) information about the contact such as:

- Contact Demographics, such as email, phone, preferred method of Contact
- Account Begin/End Dates
- Active/Inactive application assignments

To edit a contact, Master/Support Administrators can click the down arrow next to that contact's name.

A. Update Contact Demographics

To update contact demographics, change the applicable information and click Submit.

B. View/Modify a Contact's Assigned Role(s)

To modify a Contact's assigned roles (e.g., to grant administrator privileges to a Care Coordinator):

1. Under Contact Account Begin End Date, click the down arrow next to your program's name and click edit.

2. Update the Role selections as applicable

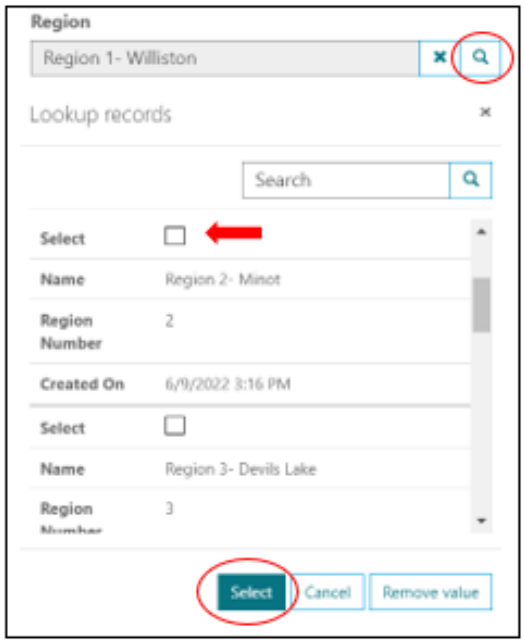
3. Click Submit (in the Contact Account Begin End Date edit box)
4. Click Submit (in the Contact Summary box)

C. View/Modify a Contact's Regional Participation

1. Under Contact Account Begin End Date, click the down arrow next to your program's name and click edit.

2. Under the Regional Participation box, click the down arrow and select Edit

3. Click the Magnifying glass to open the Region lookup, place a check into the new Region, click Select

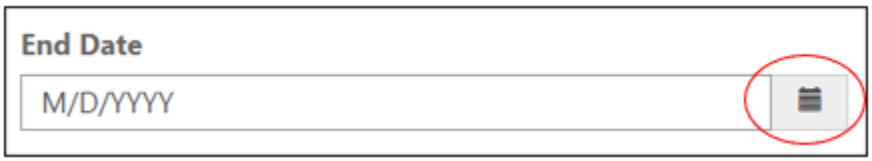


4. Click Submit

D. Modify a Contact's Add an End Date (terminate their access)

1. Under Contact Account Begin End Date, click the down arrow next to your program's name and click edit.

2. Click on the Date Picker Box and enter the Contact's last date of access



3. Click Submit

XII. Frequently Asked Questions

This section includes frequently asked questions and will be updated regularly.

A. How do I add a new Care Coordinator or Peer Support Specialist to my Organization's access?

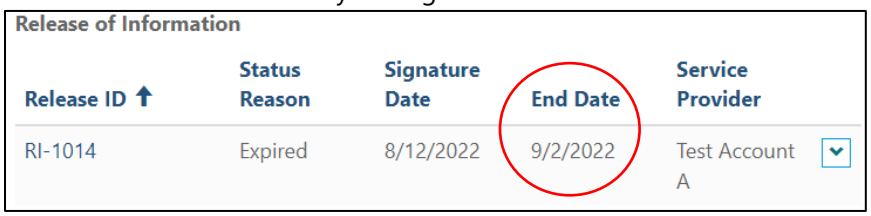
Review the prerequisites and required steps for adding new program contacts outlined in the Portal Access section.

B. Why can't I get logged in?

- Review the steps in the Portal Access section.

C. Why can't I create any new forms for a Participant?

- Do you have appropriate Roles assigned?
  - See Role-Based Accessibility and Modify a Contact's Assigned Role(s) for details
- Has your organization accepted the Referral?
  - See Referrals for details
- Is the Release of Information still valid?
  - To verify if a Release of Information is still valid, navigate to the participant's Application File and review the End Date for your organization's ROI.



D. Why isn't one of my Care Coordinators/Peer Support Specialists showing up on the Referral Form or in the participant's Application file?

The system will only display the Care Coordinators and/or Peer Support Specialists assigned to the participant's indicated Region.

- To check the participant's region, visit the Applications tab and review that participant's data row
- To check the Care Coordinator/Peer Support Specialist region assignment, see the detailed steps outlined in View/Modify a Contact's Regional Participation

E. Why does my Account Profile show that my organization is not participating in a specific region that we do participant in?

Regional participation assignments are managed by the Community Connect Program Lead. For questions, please email comconnect@nd.gov or call 701-298-4636.

F. Why does my Account Profile show that my organization is not accepting new referrals in a specific region when we are?

Regional Referral Status is managed by the Community Connect Program Lead. For questions, please email comconnect@nd.gov or call 701-298-4636.

G. Can I delete records from the Portal?

Deleting records is not allowed within the Portal. If you would like a record to be deleted, please submit your request via email to comconnect@nd.gov or call 701-298-4636.

H. Can I print records from the Portal?

Yes! Your organization can print any record submitted through the Portal by clicking the down arrow on the applicable record and clicking View Details. This will open the record in a new screen and present the user with the option to Print in the upper right hand corner of the screen.

I. Why do the different views within the portal offer Export to Excel options?

The portal views were built with export options to offer a way for users to evaluate and analyze their cumulative records in Excel.

J. How can I quickly find the record(s) I'm looking for?

The portal was designed to make finding your records as easy and user-friendly as possible. Below are some tips for searching for records in the portal:

- Tab views are split up with the records that would be considered 'active' for your organization on the top and those records that would be considered 'inactive' for your organization at the bottom.
- Clicking on the column headers within each view will sort the results by that column value
- Most views offer a search bar to assist users with finding their records quickly
    - The search bar will look for matches on the entered value within any of the columns in that view that are blue
    - To perform a search on a partial match, use the "*" at the beginning of your search word
        - Example: To search for an application using only the numerical portion of an application id you can type in CC-1234 or you can enter *1234
        - Example: to search for Jacqueline Smith aka Jackie Smith, you can enter in:
            - Jacqueline to see all Jacqueline results
            - Jackie to see all Jackie results
            - *Jac to see all results that have the 'jac' values
                - This type of search would include Jackie, Jacqueline, Jack, Jackson, etc.

K. I'm struggling to use the Portal- can I get personalized training?

To request personalized training, please submit your request via email to comconnect@nd.gov or call 701-298-4636.

L. What if I'm having an issue not outlined in this Guidance?

For all questions or issues that weren't able to be resolved utilizing the Portal Guidance and/or this Troubleshooting section, please email comconnect@nd.gov or call 701-298-4636.