



Client Assignment and Registration System
Texas Health and Human Services

WebCARE Manual

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Introduction

Overview of the CARE System

About CARE

The Client Assignment and Registration (CARE) System registers and tracks Texas Health and Human Services (HHS) individuals throughout the mental health and mental retardation service delivery system. This mainframe system has been in existence for over twenty years. A statewide data communications network links state schools, state hospitals, and community centers to CARE.

The central mainframe CARE system database is the operational repository for statewide individual information. A separate [Mental Retardation and Behavioral Health Outpatient Warehouse \(MBOW\)](#), formerly Consumer Analysis Data Warehouse (accessed through Business Objects – InfoView) contains completed and static operational information for reporting and analysis purposes.

Mainframe CARE

The mainframe CARE system uses unique, statewide individual identification numbers to maintain descriptive information, such as demographics, county of residence, financial status, diagnostics, commitment status and mental health and mental retardation needs. Client reports, in addition to individual population statistical data, are available through on-line inquiry and standard production report generation.

Major Functions of Mainframe CARE

The mainframe CARE system supports the following major mental health Resiliency and Disease Management (RDM) functions:

- screening and registering individuals
 - recording individual movement (assignment) throughout the service delivery system
 - diagnostics, assessment, and level of care provided for individuals
 - generating reports that profile individuals and components.
-

Overview of the CARE System, Continued

Resiliency and Disease Management (RDM) RDM is a model for the provision of community-based mental health services for adults with bipolar disorder, schizophrenia, or clinically severe depression and for children or adolescents with serious emotional illness. RDM promotes the provision of high quality and effective community-based mental health services by individual-specific information that identifies a person's mental healthcare needs, matches those needs to a particular mental health rehabilitative service(s), and evaluates and improves the effectiveness of the service provided.

About WebCARE When Texas Department of Mental Health and Mental Retardation implemented RDM, the mainframe CARE system was selected as the operational system but required some programming changes. WebCARE was developed to modernize the CARE system and to incorporate RDM requirements. WebCARE's purpose is to improve the integrity and consistency of individual data available for statewide resource management. Following the restructure of the human services system in 2004, WebCARE is operated by the Health and Human Services Commission in cooperation with the Department of State Health Services (behavioral health and Resiliency and Disease Management) and Department of Aging and Disability Services (mental retardation).

WebCARE Functions WebCARE, the web-based front-end to the mainframe CARE system, provides registration, diagnostics, and assessment screens, as well as workflow and data management reporting capability. All data is stored in the same files/database on the mainframe for both CARE and WebCARE. Data may be entered into these files through WebCARE, CARE mainframe screens, or batch files.

About this Manual This manual will focus on the WebCARE RDM functionality.

WebCARE System Documentation

Introduction

The following documents are available to help you use the WebCARE system. Whenever text is blue and underlined, a hyperlink is available. If this manual is being read electronically, point the cursor at the hyperlink and a hand  will appear. Click on the link and, if you are connected to the Internet and HHSC Intranet, your browser will display the referenced text.

Note: Some documents require [Adobe Acrobat Reader®](#).(pdf files).

User Guide	Description
WebCARE Manual	This manual explains how you can use the WebCARE system's Resiliency and Disease Management (RDM) functions. It contains descriptive information about how the WebCARE system functions, procedural information about using WebCARE, and WebCARE Screen Field Tables, Error Codes and Related Business Rules.
CARE Reference Manual	The manual contains detailed information that you may occasionally need to use in working with mainframe CARE or WebCARE screens. It contains, for example: <ul style="list-style-type: none">• Decode Tables – codes and values used in WebCARE• Component Codes – codes and values sorted differently• County and Local Service Area Codes – codes, names and LSA's• AAMD Classifications – codes and values• DSM Codes – codes and values• Glossary – alphabetical list of mainframe CARE and WebCARE system terms and definitions.
RDM Program Manual	The manual addresses Resiliency and Disease Management as well as documentation and tools for implementation.

WebCARE Forms

Introduction

When entering a new individual in WebCARE, the process is to enter:

1. a registration record,
2. a diagnostics record,
3. an assessment record,
4. an assignment record in mainframe CARE, and
5. monitor the individual record for needed updates via reports until the individual has been discharged and the record has been completed.

Note: Individuals are identified as “Clients” in the mainframe CARE and WebCARE system.

WebCARE Forms

To facilitate the entry of information into WebCARE, forms were created. WebCARE has the following data entry modules with associated forms:

- [Client Registration](#)
- [Client Diagnostics](#)
- [Adult Uniform Assessment](#) and [Instructions/Schedule](#)
- [Child/Adolescent Uniform Assessment](#) and [Instructions/Schedule](#)

Each form listed above has additional pages that list the:

- Field Name (as it is displayed on the screen),
 - Type (**R**equired, **D**isplayed Only-Unchangeable, **O**ptional, or a combination), and
 - Contents of the field (explanation of what is entered in the field).
-

Confidentiality and Security of Consumer Records, Continued

Confidentiality and Security of Consumer Records

All CARE and WebCARE Users

The information contained in the mainframe CARE / WebCARE (CARE) system is confidential. The same legal requirements and Commissioner's rules, as with all other consumer records, govern this information. Everyone who uses the CARE system is responsible for ensuring the confidentiality and security of the consumer data stored in the system.

In accordance with Chapter 414, Subchapter A, Texas Administrative Code on Protected Health Information, *CARE information should not be divulged to anyone not authorized to view, hear, or otherwise learn the contents of the information in question.*

Security and Confidentiality Rules

The rules regarding security and confidentiality must be observed at all times. Failure to comply with these rules can result in a violation of both state and federal law, and may result in prosecution.

Component Administrators

Only staff members selected by a component's administration (Superintendent, Director or Executive Director or other officially designated individual) may be authorized to use the CARE system. It is recommended that each component assign the CARE user access function to one or two knowledgeable center staff.

Those staff members given access to CARE should be selected because they need CARE access to perform their duties. They can be given one of five types of access to CARE.

Type of Access	Description
CARE Access and Component Inquiry	Allows initial access to the CARE system and provides the ability to view all component data. All CARE system users must be authorized at this level.
Client Inquiry – Statewide	Allows user to view all consumer data statewide and to use the online consumer-related reporting function.
Component Data Entry	Allows user to add, change, and delete component data. Users given this level of authorization can only add, change, or delete data for that user's component. Only two users at any one component will be given access to the component data entry. This gives access for changes in component name, address, contacts, QA Fees Rates, and Critical Incident Data.

Confidentiality and Security of Consumer Records, Continued

Component Administrators, continued

Type of Access	Description
Client Data Entry at Component	Allows user to add, change, and delete consumer data (other than diagnostic data). A user given this level of authorization can only access data about consumers at that user's component. State hospitals, state schools and state centers must indicate whether a CARE user should be authorized to enter: campus-based consumer data only, community-based consumer data only, or both campus- and community-based consumer data.
Diagnostic Data Entry at Component	Allows user to add, change, and delete consumer diagnostic data. Users given this level of authorization can only add, change or delete diagnostic data about consumers at that user's component.

Authorize CARE Access To authorize CARE access for your component, submit the appropriate completed [Enterprise Security Management](#) forms for each staff member authorized by your component's administration to use the CARE/WebCARE system

Centers: CARE and WebCARE Access Forms For centers to access mainframe CARE and WebCARE, the following forms are required. These forms can also provide access to mainframe JHS Exporter (reports) and HHS Intranet (for CARE documentation):

- [EASM SM 002 – Security and Privacy Agreement \(SPA\)](#) – This is a one-time submission for a new user requesting access. When the user information is entered in the security tracking system, an annual email will be sent to the user to re-affirm their SPA agreement online. If a user does not comply with this request, access will be denied or removed until such time as compliance is achieved.
- [IS 030 – Client Assignment & Registration System \(CARE\)](#)

Centers: EDTS Access Forms For selected center staff, access to the Electronic Data Transfer System (EDTS) to download daily WebCARE or batched transactions:

- [EASM SM 002 – Security and Privacy Agreement \(SPA\)](#)
- [Electronic Transmission Agreement \(ETA\)](#)

Confidentiality and Security of Consumer Records, Continued

Centers: FTP
Access Form

For selected center staff, access to use File Transfer Protocol (FTP) to transfer batch files to mainframe CARE:

- [IS 510 – Mainframe FTP](#)
-

WebCARE
Training

WebCARE Training is highly recommended before accessing WebCARE. To request training, see your center's training coordinator. If training is not available at your center, send an email to:

RDM@dshs.state.tx.us

User ID and
Temporary
Password

Information Services will assign a user ID and temporary password to each authorized CARE user. Upon receipt of the password, each CARE user must change the password. The password should be something that is easily remembered, but not obvious. For example, a user would not choose as the password his or her initials or those of any family members. All passwords must meet the minimum definition found in the [Information Security Standards and Guidelines](#).

Change CARE
Access Status

To change access status for CARE, call the Help Desk.

Protect PCs and
Peripherals

Personal computers and peripherals should be shielded from viewing and protected from access by unauthorized individuals.

Confidentiality and Security of Consumer Records, Continued

Rules for CARE/
WebCARE Users

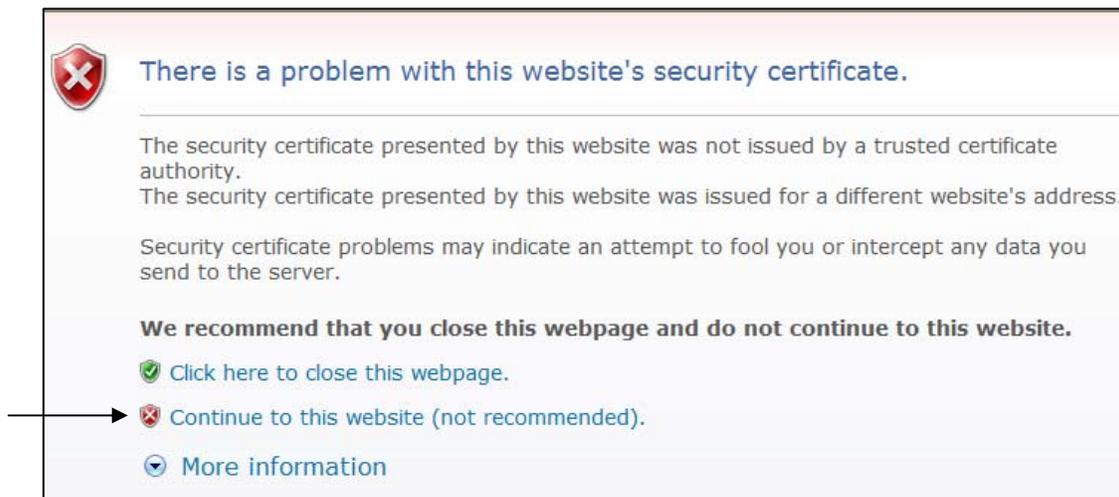
You are required to observe the following CARE/WebCARE rules:

Rule	Details
Maintain the secrecy of your account/user ID and your password	If you must write your Account/User ID and Password down, do not leave them where they can be seen by anyone other than you. If you suspect that someone has discovered your password or has breached security of the data in any way: <ul style="list-style-type: none">• Change your password immediately.• Call the Help Desk at 512-438-4720 or 1-888-952-HELP (4357) and report the date and time you believe your User ID and Password was known to someone else and any other details known.• Notify your local Center's administration.
Maintain the security of your personal computer (pc)	<ul style="list-style-type: none">• Do Not leave your pc unattended when you are logged in to CARE/WebCARE.• Do Not position your monitor so that others can see the screen.• Do Not allow others to user your pc while you are logged on to the network.

Accessing the WebCARE System

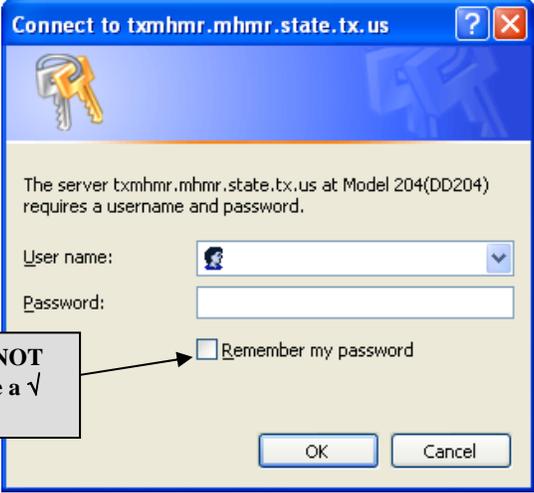
Access WebCARE WebCARE requires an Internet browser (e.g. Internet Explorer or Netscape Navigator) for access. If your personal computer is connected to the Internet, start your browser.

Step	View	Action
1	--	<p>In the Address (at the top of the screen, type the following Uniform Resource Locator (URL) exactly as it is written (or copy and paste the link into the Address): https://txmhm.mhmr.state.tx.us:3610/PROD/WCARE/RDM</p> <p>This will begin production WebCARE. For quicker access, this URL can be saved as a Favorite (for Internet Explorer) or a Bookmark (for Netscape Navigator).</p> <p>For training or practice, use the WebCARE Demonstration system. In the Address (at the top of the screen, type the following URL exactly as it is written (or copy and paste the link into the Address): https://txmhm.mhmr.state.tx.us:3610/dem/wcare/dem/m</p> <p>This will begin the WebCARE Demonstration system. This version of WebCARE has no “real” data; do not enter any real data. Use Demo User Name: F55TR01, Password: TRAIN01, and SSN: 111-11-1111.</p> <p><u>Result: A Security Alert message is displayed.</u></p>



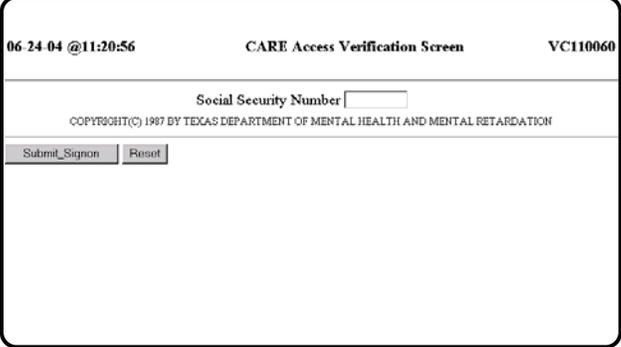
Accessing the WebCARE System, Continued

Access WebCARE, continued

2	A sample <u>Security Alert</u> message is shown on the previous page.	<p>Select Continue to this website (not recommended).</p> <p>Result: The <u>Enter Network Password</u> screen is displayed.</p>						
3	<p>A sample screen is shown below.</p>  <p>Change Password</p> 	<p>Enter the User Name (Identification Code) and password issued by ESM and click OK.</p> <table border="1" data-bbox="940 527 1502 1203"> <thead> <tr> <th data-bbox="940 527 1143 562">If ...</th> <th data-bbox="1143 527 1502 562">Then...</th> </tr> </thead> <tbody> <tr> <td data-bbox="940 562 1143 1020">You are prompted to change your password</td> <td data-bbox="1143 562 1502 1020">Change your mainframe CARE password using QWS3270 or your normal terminal emulator. This will change both your mainframe CARE and WebCARE passwords simultaneously. Important: If you change your password at this screen (for WebCARE only), your mainframe CARE password will be out of sync and you must call the Help Desk for assistance at 512-438-4720 or 1-888-952-4357.</td> </tr> <tr> <td data-bbox="940 1020 1143 1203">You only have WebCARE access (and will NOT access mainframe CARE)</td> <td data-bbox="1143 1020 1502 1203">Use the following instructions.</td> </tr> </tbody> </table> <p>Bugs Bunny needs a new password. His old one is 'Carrots' and Bugs wants to change his password to 'Lettuce.'</p> <p>To update his password, Bugs would:</p> <ol style="list-style-type: none"> 1. enter his User ID in the User Name field, 2. tab to the next field, 3. type his old password (no spaces), 4. type a colon (no spaces), and 5. then type his new password in the Password field. 6. Click <OK>. <p>Important: DO NOT select "Save this password in your password list" for security reasons. If you forget your password or have any technical problems, call the Help Desk at 512-438-4720 or 1-888-952-HELP (4357).</p> <p>Result: The CARE Access Verification Screen is displayed.</p>	If ...	Then...	You are prompted to change your password	Change your mainframe CARE password using QWS3270 or your normal terminal emulator. This will change both your mainframe CARE and WebCARE passwords simultaneously. Important: If you change your password at this screen (for WebCARE only), your mainframe CARE password will be out of sync and you must call the Help Desk for assistance at 512-438-4720 or 1-888-952-4357.	You only have WebCARE access (and will NOT access mainframe CARE)	Use the following instructions.
If ...	Then...							
You are prompted to change your password	Change your mainframe CARE password using QWS3270 or your normal terminal emulator. This will change both your mainframe CARE and WebCARE passwords simultaneously. Important: If you change your password at this screen (for WebCARE only), your mainframe CARE password will be out of sync and you must call the Help Desk for assistance at 512-438-4720 or 1-888-952-4357.							
You only have WebCARE access (and will NOT access mainframe CARE)	Use the following instructions.							

Accessing the WebCARE System, Continued

Access WebCARE, continued

Step	View	Action
4	<p>A sample <u>CARE Access Verification Screen</u> is shown below.</p> 	<ul style="list-style-type: none"> • Enter your social security number without dashes, and • Press <Enter>, or • Click the <Submit_Signon> button. <p>Before moving to the next screen, please read any notices that are displayed under the <Submit_Signon> and <Reset> buttons.</p> <p><u>Note:</u> This screen will display when you first enter WebCARE and after a period of inactivity.</p>

Using and Exiting WebCARE

Using WebCARE After successfully completing the security screens, the WebCARE Main Menu is displayed. Since WebCARE is a web-based system, normal browser functionality can be expected. It is recommended, however, that the **Back** button not be used to return to a previous screen because data may have changed and using the **Back** button *will not refresh the data*. Navigation links are provided at the bottom of each screen to move between screens that are not listed as a menu item and to exit WebCARE.

Exiting WebCARE When you have finished using WebCARE, select the **Q_Quit** link at the bottom of any screen. This will exit you from the WebCARE session and you may close your browser window.

The screenshot shows the WebCARE Main Menu interface. At the top, there is a header area with the date and time '05-26-05 @13:41:13', the title 'M:CARE Main Menu', and the user ID 'VC110100'. Below the header is a table of menu items, each with a blue underlined link and a text description. At the bottom of the screen, there is a green underlined link labeled 'Q_Quit'. A callout box on the left points to the 'Q_Quit' link with the text 'Use these navigation links instead of the BACK button.' Another callout box points to the header area with the label 'Header'.

Link	Description
100	Client Name Search
200	General Client Inquiry
300	General Client Update
390	Case Maintenance
400	Registration/ Demographics Update
500	Component Profile Inquiry
600	Component Data Entry
B00	Performance/ Workload Budget Data Entry
M00	Performance/ Workload Data Entry
778	Contract Reporting System
1100	ICF/MR Menu
1600	NorthSTAR Menu
RDM	Resiliency & Disease Management Menu

[Q_Quit](#)

WebCARE System

WebCARE Main Menu

WebCARE Main Menu

The WebCARE Main Menu (M:CARE Main Menu—Item M of the mainframe CARE system) is composed of the following modules:

Item ID	Description
100	Client Name Search
200	General Client Inquiry
300	General Client Update
390	Case Maintenance
400	Registration/ Demographics Update
500	Component Profile Inquiry
600	Component Data Entry
B00	Performance/ Workload Budget Data Entry
M00	Performance/ Workload Data Entry
778	Contract Reporting System
1100	ICF/MR Menu
1600	NorthSTAR Menu
RDM	Resiliency & Disease Management Menu

Q Quit

Restricted Access

Access to most of the Main Menu modules is restricted. Only those with access to confidential individual data across the entire service delivery system will be able to access these modules.

Main Menu Modules

Menu Options Although this manual focuses on the Resiliency and Disease Management (RDM) module, a brief description or listing of all the modules **As of December, 2007** and their related menus follow:

Modules	Description
100 – Client Name Search <i>(Restricted Access)</i>	<p>The Client Name Search function allows you to determine whether a prospective individual has been registered previously and, if so, to review the individual’s assignment history.</p> <p>Name Search uses data collected during the individual screening process to produce a listing of possible “matches,” of individuals with similar demographic characteristics who are registered in the system.</p> <p>Search criteria are: Client Last Name, First Name, ID, Medicaid Recipient Number, Component Code/Local Case Number, SSN, Sex, Ethnicity, Age (+ or – 5 Years), Birth date, MH/MR, MH Authority, MR Authority, Assignment Status, Residential County, and Component Type. This name search will look for the Medicaid number entered into CARE files.</p>
200 – General Client Inquiry <i>(Restricted Access)</i>	<p>The General Client Inquiry is composed of six inquiries and searches:</p> <ul style="list-style-type: none"> • 192 – DHS Medicaid Eligibility Search I • 193 – DHS Medicaid Eligibility Search II • 222 – Display of All Movements for a Client • 249 – Permanency Planning Review Approval Status • 286 – Critical Incident Data Inquiry • 771 – DSM/ICD Code and Text Search
300 – General Client Update <i>(Restricted Access)</i>	<p>The General Client Update provides seven methods for updating individual records:</p> <ul style="list-style-type: none"> • 330 – Diagnostics • 336 – State Operated ICF/MR Client Movements • 337 – Non-state Operated ICF/MR Client Movements • 346 – MH Adult Uniform Assessment for RDM • 360 – Death / Separation of Client
390 – Case Maintenance <i>(Restricted Access)</i>	<p>The Case Maintenance menu is for updating or deleting local case numbers and requesting individual identification information:</p> <ul style="list-style-type: none"> • 395 – Local Case Number: Delete • 396 – Local Case Number: Change • 397 – Request Client ID Information

continued on next page

Main Menu Modules, Continued

Menu Options continued

Modules	Description
400 – Registration / Demographics Update <i>(Restricted Access)</i>	The Registration function in this module allows you to add, update, and display a limited number of individual’s identifying and demographic data and component identifying information. <ul style="list-style-type: none"> • 410 – Add Case to ID / Demographics • 413 – Medicaid / Medicare Number • 420 – Client Name • 430 – Client Address • 431 – Client Correspondent
500 – Component Profile Inquiry <i>(Restricted Access)</i>	<ul style="list-style-type: none"> • 530 – Component Names in Component Code Order • 565 – County Inquiry • 569 – ICF / MR Provider Information • 570 – ICF / MR Contract Information • 571 – ICF / MR Provider / Contract List • 572 – QAF Inquiry for Provider
600 – Component Data Entry <i>(Restricted Access)</i>	<ul style="list-style-type: none"> • 686 – Critical Incident Data
B00 – Performance / Workload Budget Data Entry <i>(Restricted Access)</i>	<ul style="list-style-type: none"> • B35 – FY 04 Thru 08 Performance/workload Expenditure/budget Data Entry • B36 – FY 04 Thru 08 Performance/workload Budget Amendments Data Entry • B33 – FY 04 Thru 08 Performance/workload in Kind Local Match Data Entry • B34 – FY 04 Thru 08 Performance/workload in Kind Local Match Amendment Entry • B40 – FY 04 Thru 08 Performance/workload Budget/expense Edits • 778 – *** Review Data Already Entered
M00 – Performance / Workload Data Entry <i>(Access Restricted to Central Office Only)</i>	<ul style="list-style-type: none"> • M62 – Performance/workload MH/MR Target Entry • M33 – CMGR Amendment Approval • F11 – Freeze/ Unfreeze Performance/ Workload I.A or II.A
778 – FY 05/06 Contract System Reporting <i>(Restricted Access)</i>	<ul style="list-style-type: none"> • Report by Component, Quarter, and Fiscal Year

continued on next page

Main Menu Modules, Continued

Menu Options continued

Modules	Description
1100 – ICF / MR Menu <i>(Restricted Access)</i>	<p>ICF/MR Data Entry</p> <ul style="list-style-type: none"> • 336 – State Operated Client Movements • 337 – Non-state Operated Client Movements • 360 – Death / Separation of Client • 1121 – Living Options Process Maintenance • 1123 – Provider MR/RC Assessment • L29 – Authority MR/RC Assessment • 1125 – QA Fees Entry / Update By Provider • 1126 – QA Fees Semi-annual Revenue Entry • 1127 – QAF Entry / Update By SG 5 Provider • 1128 – QAF Semi-annual Revenue By SG 5 Provider <p>Demographics Update</p> <ul style="list-style-type: none"> • 410 – Add Case to ID / Demographics • 413 – Medicaid / Medicare Number • 420 – Client Name • 430 – Client Address • 431 – Client Correspondent <p>Case Maintenance</p> <ul style="list-style-type: none"> • 395 – Local Case Number: Delete • 396 – Local Case Number: Change <p>Additional Component Data</p> <ul style="list-style-type: none"> • 683 – ICF / MR Provider Characteristics • 684 – ICF / MR Provider Email Address Maintenance <p>ICF/MR Inquiry</p> <ul style="list-style-type: none"> • 100 – Client Name Search • 192 – DHS Medicaid Eligibility Search I • 193 – DHS Medicaid Eligibility Search II • 222 – Display of All Movements for a Client • 286 – Critical Incident Data Inquiry • 565 – County List • 569 – Provider Information • 570 – Contract Information • 571 – Provider Contract List • 572 – QAF Inquiry for Provider • 771 – DSM / ICD Code and Text Search • 1161 – Daily Census Report • 1163 – Clients with Service Authorizations / Client Assessments Changed During Period • 1164 – Computed Service Authorizations / Client Assessments / Medicaid Eligibility By Id • 1165 – MR/RC Assessment Expiration • 1168 – MR/RC Assessment Summary • 1182 – MR/RC Assessment Pending • 1183 – Individual MR/RC Assessment • 1185 – Permanency Plan Status Report • 1187 – MRA Contact Information • Download User Documentation

Main Menu Modules, Continued

Menu Options continued

Modules	Description
1600 – NorthSTAR Menu <i>(Restricted Access)</i>	Inquiry <ul style="list-style-type: none"> • 1650 – Name Search • 1660 – Clients Registered Online Today • 1665 – State Hospital Enrollees • 1670 – Name Search - No Medicaid Information • 1675 – Persons in State Hospital - not Enrolled • 1680 – Persons Registered Online - not Enrolled Data Entry <ul style="list-style-type: none"> • 1625 – Registration • 1640 – Enrollment • 1645 – Client Information Update • 1655 – Address Update • 430 – CARE Address Update • 431 – CARE Correspondent Address Update
RDM – Resiliency & Disease Management	Data Entry <ul style="list-style-type: none"> • 325 - Client Registration • 330 - Diagnostics • 164 - MH Child Uniform Assessment for RDM • 169 - Provider Appeal for Child RDM Assessments (NorthSTAR Only) • 346 - MH Adult Uniform Assessment for RDM • 347 - Provider Appeal for Adult RDM Assessments (NorthSTAR Only) Workflow / Reports <ul style="list-style-type: none"> • 246 – Incomplete/Provider Complete Assessments – Adult • 247 – Assessments Expiring By Section – Adult • 248 – Assessments to Expire – Adult • 251 – Completed Assessments – Adult • 252 - Autoclosures - Adult • 264 – Incomplete/Provider Complete Assessments – Child • 265 – Assessments Expiring – Child • 267 – Completed Assessments – Child • 268 - Autoclosures - Child

RDM: Resiliency & Disease Management Module

Introduction

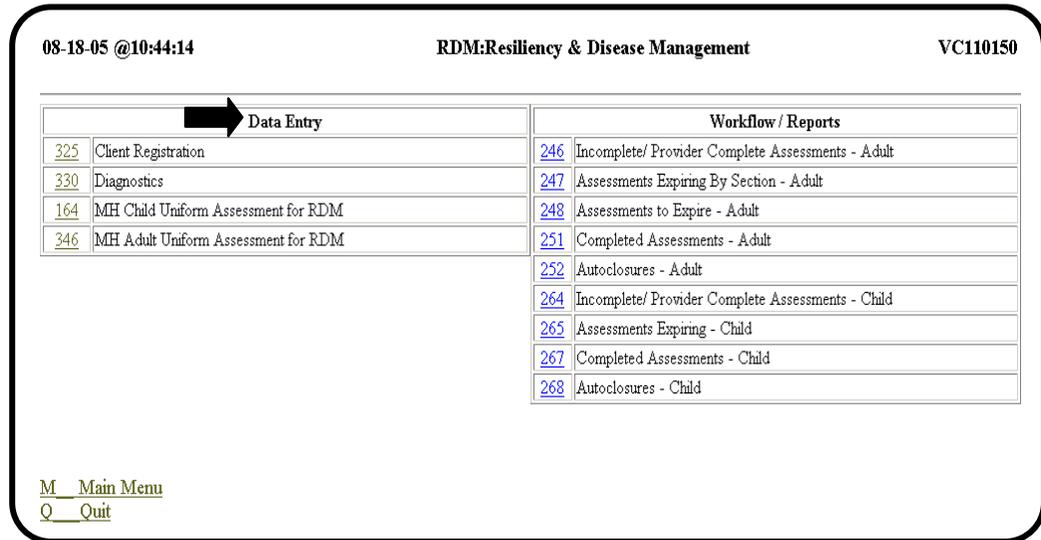
In this manual and in WebCARE,

- **RDM** refers to the Resiliency and Disease Management *module* of WebCARE.
 - **RDM** is the acronym used for the Resiliency and Disease Management model. RDM is a systematic approach for needs assessment and service delivery that:
 1. Assures a more uniform approach to assessment and service assignment;
 2. Provides evidence-based services that are appropriate to address the needs of adults with severe mental illness and children and adolescents with serious emotional disturbance;
 3. Establishes statewide utilization guidelines to help ensure that individuals receive the proper amount of each service provided;
 4. Establishes fidelity standards that will help to ensure that the services that are provided conform to current clinical standards; and
 5. Provides a means of objectively measuring both provider performance and individual outcomes.
-

RDM Data Entry

Introduction

After selecting **RDM** from the M: CARE Main Menu, the following screen is displayed.



Functions

In the WebCARE RDM module, there are two groups of functions: **Data Entry** and **Workflow / Reports**.

Data is Entered

Individual data may be entered in three ways:

- WebCARE screens
 - CARE mainframe screens, or
 - [Batch File](#) (data is collected from a local system—batched—and electronically transferred via File Transfer Protocol [FTP] to a file on the mainframe. The data is then checked for errors and loaded into the CARE database.)
-

RDM CARE Daily Extract

A daily extract of all new, successfully entered RDM CARE records is placed in a directory accessible to local centers and can be transferred to the center via Electronic Data Transfer System (EDTS) for record verification and use by the provider's local system.

RDM Workflow / Reports

Introduction

Workflow / Reports is a method of viewing previously entered data. It is organized so that you can quickly identify outstanding, expiring, or incomplete data. A sample screen is shown below.

The screenshot shows a software interface with a title bar containing '08-18-05 @10:44:14', 'RDM:Resiliency & Disease Management', and 'VC110150'. Below the title bar is a menu with two main sections: 'Data Entry' and 'Workflow / Reports'. The 'Workflow / Reports' section is highlighted with a black arrow. At the bottom left of the menu, there are options: 'M Main Menu' and 'Q Quit'.

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

M Main Menu
Q Quit

Business Rule: Adults

Adult individuals who are members of the **Target Population** Diagnosis of Schizophrenia or Bipolar Disorder - or a diagnosis of Major Depression (with GAF <50) and members of the **Priority Population** (MH diagnosis and GAF < 50) who have been determined by a Licensed Practitioner of the Healing Arts (LPHA) to have a medical need for the services, require a Client Registration record, Diagnostics record, and the appropriate Assessment record. Individuals whose services are totally paid by a third party do not require an assessment record.

For more information on Priority Populations and Target Populations, see [Performance Contract](#).

Business Rule: Children/ Adolescents

Child/Adolescent individuals (children ages 3 through 17) with a diagnosis of mental illness who exhibit serious emotional, behavioral or mental disorders and who:

1. have a serious functional impairment; or
2. are at risk of disruption of a preferred living or child care environment due to psychiatric symptoms; or
3. are enrolled in a school system's special education program because of a serious emotional disturbance.

RDM Workflow / Reports, Continued

Business Rule: Child/adolescent individuals are children ages 3 through 16.
Children/ Individuals who are 17 or 18 years of age may be eligible for either
Adolescents child/adolescent services or adult services.
continued

RDM Examples

Examples To illustrate the use of the RDM module, two vignettes (one for an adult and one for a child/adolescent) are presented and the appropriate steps for entering the data for these fictional people will follow in the next chapters.

Child/Adolescent Peter Piper is a 5-year-old Caucasian male diagnosed with ADHD. His father reports that he talks back, is bossy and demanding, is impulsive, accident-prone, and has poor attention. He reports that Peter can be very aggressive to both adults and other children, doesn't follow rules, and has sneaked out of the house on several occasions. He reports that Peter has been kicked out of five daycares. Peter frequently destroys his toys, sometimes burning them. Peter's father reported that Peter fell off a playscape and lost consciousness briefly at age 4. He has never received any mental health treatment.

Peter will start school in several months, but is currently being cared for at a new daycare. Peter's mother left the home when Peter was 2 years old and is not currently a part of his life. Peter's father reports he works a lot and is frustrated with all of the calls he gets from daycare because of Peter's behavior. Peter's father states that he may lose his job if Peter gets thrown out of this daycare. There is no other family or support system in the area.

The Qualified Mental Health Professional-Community Service (QMHP-CS) at the service center diagnosed Peter with "Attention Deficit Hyperactivity Disorder, Combined Hyperactive-Impulsive and Inattentive Type".

RDM Examples, Continued

Of the three Principal Diagnosis Categories:

- Externalizing Disorders
- Internalizing Disorders, and
- Bipolar, Schizophrenia or related Disorders),

Peter has an **Externalizing Disorder** and qualifies to receive services.

For a more comprehensive explanation about Peter, see the [User's Manual for the CA-TRAG](#).

Adult

Miguel de Cervantes is 19 years of age and has been diagnosed with Schizophrenia. The director of the homeless shelter where he lives brought him to his Licensed Professional of Healing Arts (LPHA). He denies suicidal ideation recently or in the past.

- Psychiatric History** Miguel has had no recent hospitalizations. He is homeless and living in shelters. He is pleasant but quite psychotic and experiences persistent feelings of “double exposure” (i.e., believing he is being controlled and exposed by another “self”, namely Don Quixote).
- Substance Use History** Miguel seems to have a history of substance dependence (most notably marijuana) although he was never able to get involved with a recovery program. Over the past few years, however, he has become increasingly involved instead with abuse of cold pills (mostly for the speedy effect) but also for reported relief of “double exposure.”
- Social History** Miguel has a sister and father who live about 5 hours away. He sees them infrequently, and they are worried about him, yet they are unable to provide assistance or monitoring. He has been quite isolative and has no real friends. He is currently unemployed, and he has not held a job for more than a couple weeks at a time during the past year. He has been arrested twice within the past three months, with one misdemeanor conviction for drug possession and another misdemeanor conviction for theft.
- Mental Status** Miguel appears oriented, but is disorganized, rambling, and loose. He reports auditory hallucinations and paranoid ideation. Miguel adamantly denies any intent to self-harm, only to get high. He denies that his behavior is risky and doesn't really want to stop using, but agrees to get help if it will make his sister and father happy.
-

RDM Examples, Continued

Adult
(continued)

Of the three Principal Diagnosis Categories:

- Schizophrenia or related disorders,
- Bipolar Disorders, and
- Major Depression Disorders,

Miguel de Cervantes has **Schizophrenia** and qualifies to receive services.

For a more comprehensive explanation about Miguel, see the [User's Manual for the Adult-TRAG](#).

325: Client Registration

Introduction

Client registration is the act of identifying a person as an individual of the Texas Health and Human Services (HHS) Service Delivery System. An individual/client is a person who is registered in the CARE/WebCARE system. Until a person is registered, they cannot be assigned to a service.

Registration Guidelines

A person...	In the CARE/WebCARE System...
is registered	<ul style="list-style-type: none"> • After staff determines that <ol style="list-style-type: none"> 1. the person has a problem properly addressed by services provided by HHS, and that 2. the person is eligible for services, and • At the time, a staff member begins to provide services to the person.
is not to be registered	<p>If the individual contacts an HHS Service Delivery System component seeking assistance and is:</p> <ul style="list-style-type: none"> • told that HHS is not the appropriate service provider for that problem, and/or • referred to a service provider outside HHS, without the provision of services by HHS.

Services

If a screening requires more staff time than usual, consider that the screener may have actually begun to provide billable services. Examples of services include, but are not limited to:

- administering standard tests to determine whether an individual needs HHS services
 - contacting other service providers to arrange services for an individual
 - general service delivery activities.
-

Registration

The registration function in this module allows you to add, update, and display an individual's identifying, demographic data, and component identifying information. In addition, reports can be produced for groups of individuals by selected demographic characteristics. The data entry features of WebCARE Client Registration are presented in this section.

325: Client Registration, Continued

Client Registration Screen The [325: Client Registration](#) screen is used to generate a unique, statewide client identification number and to record such data as a client's name, sex, ethnicity, birth date, social security number, presenting problem, address, county of residence and local case number at your component.

Individuals are Registered Once The CARE system maintains an unduplicated count of individuals. ***The registration process is designed to ensure that individuals are registered only once.*** After you submit the prospective individual's data, the system searches all registered clients to determine whether the prospective new individual is already registered.

Data Entry ***A client Registration record must be completed before a diagnosis or an assessment (including those for crisis individuals) may be entered. This function is the same for an adult or child/adolescent.***

Note: For a description of each screen field, see the screen field table on the pages following the [Client Registration](#) form. See also the list of [Component Codes](#) (your local center identifier) and the individual's [County of Residence](#).

Client Registration Form It is recommended that registration data be entered immediately into WebCARE by the person who registered the individual; however, the [Client Registration](#) form may be printed and completed with the individual's most current data prior to WebCARE data entry if data entry will be delayed. WebCARE forms are subject to change.

continued on next page

325: Client Registration, Continued

325: Client Registration Screen When 325: Client Registration is selected, the following screen is displayed.

08-18-05 @12:45:01
325: Client Registration
VC111360

**Enter the Following to Generate CARE
Statewide Client Identification Number**

Component Code	030
Local Case Number	<input type="text"/>
Client Last Name/ Suf	<input type="text"/>
Client First Name	<input type="text"/>
Client Middle Name	<input type="text"/>
Sex	<input type="text"/>
Ethnic/ New Fed Race	<input type="text"/>
Fed Ethnicity	<input type="text"/>
Client Birthdate (mmddyyyy)	<input type="text"/>
Social Security Number (n=none,u=unknown)	<input type="text"/>
Medicaid Number	<input type="text"/>
Medicare Number	<input type="text"/>
Presenting Problem	<input type="text"/>
Registration Effective Date (mmddyyyy)	08182005
Registration Effective Time (hhmm A/p)	1245P
Street Address	<input type="text"/>
City	<input type="text"/>
State	<input type="text"/>
Zip Code/ Suffix	<input type="text"/>
County of Residence	<input type="text"/>
Legal Guardianship	<input type="text"/>
Marital Status	<input type="text"/>
Estimated Annual Gross Family Income	<input type="text"/>
Family Size	<input type="text"/>

Submit_Request
Reset

[Return to General Client Update](#)
[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Example only:
Component Code displayed will be for your local center.

These two fields are automatically filled but may be changed.

The text for **Required** fields are blue and **Optional** fields are green.

325: Client Registration, Continued

Registration Screen Example If no existing **Component Code** and **Local Case Number** combination is found and all required fields are completed, the **325: Client Registration** screen displays the client's data prepared for entry into WebCARE. The following is an example for Peter Piper, our fictitious child.

08-18-05 @12:59:53		325: Client Registration		VC111367
Client Last Name/ Suf	PIPER	Client ID	33987	
Client First Name	PETER	Component Code		030
Client Middle Name	PEPPER	Local Case Number		0000009996
Sex			M	
Ethnicity				
Fed Race			W	
Fed Ethnicity			N	
Client Birth Date			01012000	
Social Security Number			450450450	
Medicaid Number				
Medicare Number				
Presenting Problem			1	
Registration Effective Date			08182005	
Registration Time (hhmm A/P)			1245P	
Street Address			1111 PICKLED PEPPER	
City			AUSTIN	
State			TX	
Zip			78701	
Current County of Residence			227	
Legal Guardianship			1 - MINOR	
Marital Status			5 - NEVER MARRIED	
Estimated Annual Gross Family Income			10000	
Family Size			3	
Ready to Add (Y/N)				<input type="checkbox"/>

Submit_Update

Warning You must enter a **Y** in the READY TO ADD (Y/N) box. If an **N** is entered in the READY TO ADD (Y/N) box or the box is left blank and the **Submit_Update** button is selected, **all data is lost** and you are returned to the blank **325: Client Registration** data entry screen.

325: Client Registration, Continued

Statewide ID Displays

After successfully submitting the record, the following screen header displays with the client's newly generated statewide identification number (for Peter Piper, his new number is 33987). The form is reset (except for the Component Code) so that additional client Registrations may be entered.

A screenshot of a web application interface. At the top, a message reads: "CASE NUMBER 0000009996 ADDED TO CLIENT NUMBER 33987." Below this, the header shows "08-18-05 @13:03:53" on the left, "325: Client Registration" in the center, and "VC111360" on the right. The main content area is titled "Enter the Following to Generate CARE Statewide Client Identification Number". It contains two input fields: "Component Code" with the value "030" and "Local Case Number" with an empty field. A callout box on the left points to the top of the screen with the text: "All messages display at the top of the screen."

One Duplicate Combination

If only one exact duplicate *Component Code* and *Local Case Number* combination is entered, the following error message (in a red font) displays:

****MSG: 1907 THIS LOCAL CASE NUMBER ALREADY EXISTS FOR YOUR COMPONENT**

Note: Other error messages may occur during data entry. See [Error Codes and Related Business Rules](#) in this manual.

continued on next page

325: Client Registration, Continued

Several Duplicate
Combinations

If there are several duplicate *Component Code* and *Local Case Number* combinations the [325: Matching Client Characteristics](#) screen will display. Characteristics, such as name, social security number, and sex of the individual are used to select potential duplicate individuals. The following screen is displayed after entering duplicate information for Peter Piper, our fictitious child.

09-30-04 @14:48:16 325: Matching Client Characteristics VC111362

EXACT								
ID	LAST NAME	FIRST NAME	MI	SEX	ETH	BIRTH DATE	SSN	ACTION
	COUNTY		MEDICAID		MEDICARE			
34274	PIPER	PETE		F	W	01-01-2000	450450450	VIEW
	TRAVIS							

POSSIBLE								
ID	LAST NAME	FIRST NAME	MI	SEX	ETH	BIRTH DATE	SSN	ACTION
	COUNTY		MEDICAID		MEDICARE			
33987	PIPER	PETER	PEPPE	M	W	01-01-2000	450450450	VIEW
	TRAVIS							

[Return to General Client Update](#)
[Return to Resiliency & Disease Management Menu](#)

Note: In this case, the options are: adding a local case number to an existing client by selecting the **Add_Case_To_** button or creating a new ID by selecting the **Create_New_Id** button, if the person is not listed.

330: Diagnostics

Introduction

WebCARE allows you to record and update diagnostic data for individuals. You can add new diagnostic data, as well as change and delete previously submitted data. Diagnostic data must be entered before assessment data, except when the individual is in crisis.

For crisis individuals only: **“Treat then TRAG”**

When Diagnostic Data is Collected

In general, diagnostic data is collected about an individual (for both adult and child/adolescent) when one of the following three events occurs:

- a component determines that an individual will be served,
 - an individual is reevaluated at the time of the annual staffing (every 365 days or at any other time that diagnostic update is needed), or
 - an individual dies.
-

TIMA Scales

Diagnostics data will determine which Texas Implementation of Medical Algorithms ([TIMA](#)) scales will be applied.

Note: For a description of each screen field, see the screen field table on the pages following the [Client Diagnostics](#) form.

Enter Diagnosis or Print Client Diagnostics Form

It is recommended that diagnostic data be entered immediately into WebCARE by the person who diagnosed the individual; however, the [Client Diagnostics](#) form may be printed and completed prior to WebCARE data entry, if data entry will be delayed. CARE forms are subject to change. The following examples and additional information are provided for completion of the [330: Diagnostics](#) screen.

Business Rule

The *Decision Date* is linked to the adult and child/adolescent assessments. The client Diagnostics decision date must be up to **365 days** prior to the *Assessment Date* for:

- Section 1: Adult-TRAG & Recommended Level of Care
 - Section 1: Child/Adolescent TRAG
-

330: Diagnostics, Continued

Principal Diagnosis

The individual's *Principal Diagnosis Axis* is required. Using [DSM](#) codes, enter:

- 1=Axis I (Psychiatric Syndrome or Mental Health - MH)
- 2=Axis II (Personality and Specific Developmental Disorder or Mental Retardation - MR)

Axes

Diagnostic data for Mental Health (MH) is added into the Level/Axis matrix using the following Axes:

Axis	Description
Axis I - Psychiatric / MH Diagnosis from the Diagnostic and Statistical Manual of Mental Disorders (DSM Codes)	Level 1 is for most significant, Level 6 is least significant Axis 1, Level 1 is required if Principal Diag. Axis is 1= Axis I (MH). If MH, "Reason for Action" is 3 (Death) then Level 1 is required.
Axis II - Personality Developmental Disorders (DSM Codes).	Level 1 is for most significant, Level 4 is least significant If MR, "Reason for Action" is 3 (Death) then Level 1 is required.
Axis III - Physical Impairments from The International Classification of Diseases, 9th Revision, Clinical Modification (ICD Codes).	Level 1 is for most significant, Level 6 is least significant Level 1 is required for a "Reason for Action" of 2=Reevaluation. Enter 'None' if no physical impairments and do NOT enter the Axis III Date. The Axis III Date is required if an ICD-9-CM Code is entered.
Axis IV - Psychosocial and Environmental Stressors (Axis IV Decode Table)	See top of page 6 of the Decode Table.
Axis V - Highest-Level Adaptive Functioning – Current and Past Year. (Axis V Decode Table)	See pages 6-7 of the Decode Table. Current Global Assessment of Functioning (GAF) Score is required.

330: Diagnostics, Continued

Additional Diagnostic Data

Additional diagnostic data recorded for Mental Retardation (*MR*) *Individuals* includes:

- Current and potential Adaptive Behavior Levels ([ABL Decode Table](#)). See page 4.
Required if Principal Diag Axis IS 2 (MR).
 - Primary, secondary and tertiary American Association on Mental Deficiency ([AAMD Decode Table](#)) classifications.
For MR Individuals Only.
 - [Genetic defect](#). See page 15. *For MR Individuals Only.*
 - [Cranial Anomaly](#). See page 12. *For MR Individuals Only.*
 - [Sensory Impairment](#). See page 31. *For MR Individuals Only.*
 - [Perception](#). See page 28. *For MR Individuals Only.*
 - [Convulsive Disorder](#). See page 12. *For MR Individuals Only.*
 - [Psychiatric Impairment](#). See page 29. *For MR Individuals Only.*
 - [Motor Dysfunction](#). See page 20. *For MR Individuals Only.*
 - Intelligence Quotient (IQ) score, test date and [test type](#). See page 18.
 - Social Quotient (SQ) score, test date and [test type](#). See page 34.
-

330: Diagnostics Screen

With the diagnostic information necessary for data entry, continue in WebCARE by selecting [330: Diagnostics](#). The first screen will require the Component Code and the Local Case Number to link to the Registration record. Submit the request, and then the Diagnostic history for your individual will be displayed, if there is previously entered diagnostic information.

330: Diagnostics, Continued

First Record

If this is the first record for your individual, the following screen is displayed. The following screen is for our fictitious individual, Peter Piper.

08-18-05 @13:58:07		330: DIAGNOSTICS		VC111370	
Last Name	PIPER	Client ID	33987		
Suffix	.	Component	030		
First Name	PETER	Local Case Number	0000009996		
Middle Name	PEPPER				
<input type="button" value="Create_New"/>					
Return to Request Without Updating					
Return to General Client Update Menu					
Return to Resiliency & Disease Management Menu					
Return to CARE Main Menu					
Quit					

continued on next page

330: Diagnostics, Continued

Create a
New Record

Create a new Diagnostic record by selecting **Create_New**. When the screen is completed correctly; the following screen will be displayed.

THE FOLLOWING INFORMATION HAS BEEN PROCESSED:

08-18-05 @14:12:51 330: DIAGNOSTICS VC111375

Last Name	PIPER	Client ID	33987
Suffix	.	Component	030
First Name	PETER	Local Case Number	0000009996
Middle Name	PEPPER	MH Pri Pop	Y

Type Of Entry:

Decision Date (mmddyy)	070105	Form Time (hhmma/p)	0211P
Reason for Action	1 - ADM/ PROV	Principal Diag Axis	1 - AXIS I
Location:			
	Level 1	Level 2	Level 3
Axis I	31401	31281	
Axis II			
Axis III			
Axis III Date (mmddyy)			
Axis IV	A B C		
Axis V	Current	49	Past Year

Current ABL		Potential ABL	
Primary AAMD	Secondary AAMD	Tertiary AAMD	
Genetic	Cranial Anomaly	Sensory Impairment	
Perception	Convulsive Disorder	Psy Impairment	
Motor Dysfunction	AAMD Date (mmddyy)		
DSM Version	4 ICD Version	9 AAMD Version	77

IQ Score	IQ Test Date (mmddyy)	IQ Test Type
SQ Score	SQ Test Date (mmddyy)	SQ Test Type

[Return to General Client Update Menu](#)
[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Previous
Diagnostic Data

If the client has previous diagnostic data for your component, WebCARE displays a summary of that diagnostic data. This data is provided so you will not need to reenter information that has stayed the same since the previous diagnosis.

330: Diagnostics, Continued

WebCARE Rule

For a child/adolescent, only the diagnosis entered on Axis 1, Level 1 will be used for assessment calculations. For an adult, any diagnosis entered along Axis 1 (any level) may be used. If one of the diagnoses entered is part of the target population (schizophrenia or related, bipolar, or major depression) then this diagnosis is selected for assessment calculations.

08-18-05 @14:30:05 330: DIAGNOSTICS VC111370

Last Name	PIPER	Client ID	33987
Suffix	.	Component	030
First Name	PETER	Local Case Number	0000009996
Middle Name	PEPPER		

Create_New

	DECISION DATE	TIME	REASON	PRIN DIAG	
Update	07/01/2005	0211p	1 - Adm/ Prov	31401	Delete

[Return to Request Without Updating](#)
[Return to General Client Update Menu](#)
[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Update Incorrect
Diagnosis or Enter
Reevaluation

To update an incorrect Diagnosis, select the Update button, make corrections and click **Update** at the bottom of the screen. To enter a reevaluation, select **Create_New** and enter the new diagnosis. The most recently entered diagnostic data is displayed first, followed by all others in reverse chronological order. Any data added using **Create_New** will be utilized by WebCARE for the Level of Care-Recommended (LOC-R) on the person's assessment but will not change the previous diagnostic data.

Review Assessment

Since Assessment Level of Care Recommended (LOC-R) may change with a change in diagnosis, it is recommended that the person's assessment be reviewed and updated following submittal of new Diagnostic data.

Enter Assessment
Record

The next step is to enter an assessment record for the individual.

330: Diagnostics, Continued

Key Points

- A diagnosis must be determined and entered in the CARE system before a Uniform Assessment can be entered, except when an individual is in crisis at Intake. When the individual is no longer in crisis, a Diagnostics record is required before an Update assessment record can be entered.
- Diagnosis must be reevaluated and updated for each individual every 365 days.
- Diagnosis data will determine which TIMA scales will be applied.

346: MH Adult Uniform Assessment for RDM

Overview

The Adult Uniform Assessment is an instrument designed to assist in the selection of a benefit package and financing methodology for public mental health services in the state of Texas. The Mental Health Adult Uniform Assessment for Resiliency and Disease Management module of the WebCARE system is designed to record the individual's assessment data, with the primary goal of using standard, quantifiable measures to guide the choice of service needs and to make appropriate "level of care" decisions.

Business Rule: **Age**

An adult is any person 19 years of age or older. An individual age 17 or 18 may be served as either an adult or child/adolescent. Any individual who is age 16 or under is a child/adolescent. An individual who is being served as a child/adolescent will be discharged from child/adolescent services on their 19th birthday when an adult Intake record is entered to continue services.

Note: For specific instructions on completing the [Adult Uniform Assessment form](#), refer to [Adult Form Completion and Schedule](#).

Online Data Entry

Online data entry by those completing the assessment is preferred.

Centralized Data Entry

For centralized data entry, it is recommended that the MH Adult Uniform Assessment for Resiliency & Disease Management form be printed from the link above and completed prior to WebCARE data entry. WebCARE forms are subject to change. Examples and additional information is provided below for completion of the 346-MH Adult Uniform Assessment for RDM screen.

Local center authority or Utilization Management staff authorize service packages. If a data entry clerk is entering data, the form must be signed by the authorizer and must be in the individual's clinical records.

346: MH Adult Uniform Assessment for RDM, Continued

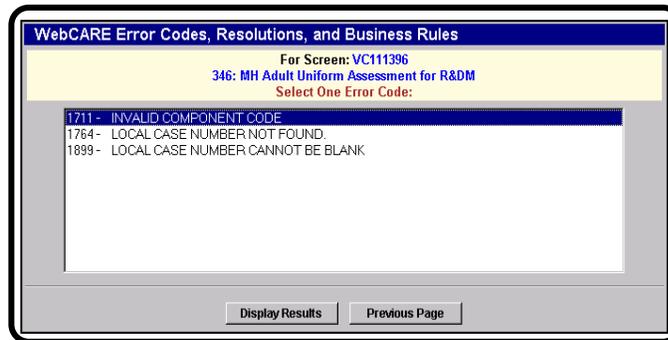
Sequence of Assessment Types

The expected sequence of completed assessment types is:

1. One Crisis (if individual is in crisis before an Intake or following a Discharge). No Discharge assessment is required.
 2. One Intake (If Intake Non-Admission – LOC-R=9 and LOC-A=9, then no Update or Discharge assessment is required) – used for initial admission into services, after a Discharge, or for Crisis Follow-up services after a hospital discharge.
 3. One or more Update(s) – used for periodic reassessments, usually every 90 days.
 4. One Discharge – used when services will no longer be provided.
-

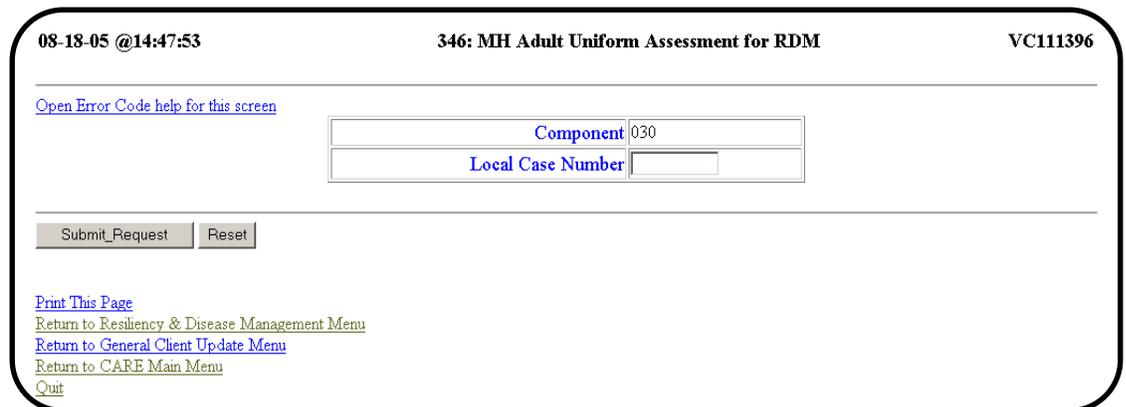
WebCARE Error Code Help

If you receive an error code when entering data, click on **Open Error Code help for this screen**. A new window will appear that has the Error Code, Resolution, and Business Rules database. Select the error code from the list and **Display Results**. Close this new window when finished.



Request Screen

From the RDM Menu, select 346: MH Adult Uniform Assessment for RDM. The following screen will be displayed.



346: MH Adult Uniform Assessment for RDM, Continued

Enter Data Enter the Component Code and Local Case Number for the adult to be assessed and select **Submit_Request**.

Note: Miguel de Cervantes, the fictitious adult, will be used as an example.

No Diagnostics Record If no diagnostics record is found for the individual, the following screen will be displayed:

08-18-05 @15:15:18 346: MH Adult Uniform Assessment for RDM VC111396

[Open Error Code help for this screen](#)

Last Name	DECERVANTES	Client ID	35700
Suffix	.	Component	030
First Name	MIGUEL	Local Case Number	0000009994
Middle Name	.		

NO DIAGNOSIS ON FILE

Enter a diagnosis on 330: Diagnostics first.

[Create_New](#)

[Print This Page](#)
[Return to Request Without Updating](#)
[Return to Resiliency & Disease Management Menu](#)
[Return to General Client Update Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

A diagnostics record must be entered for all individuals in WebCARE.

Business Rule: Crisis Individuals

For *Crisis Individuals only*, a Crisis assessment may be entered *before* a diagnostics record. However, when the individual is no longer in Crisis, a diagnostics record is required before an Intake assessment record may be entered. For a list of all Business Rules, see [Error Codes and Related Business Rules](#).

346: MH Adult Uniform Assessment for RDM, Continued

Diagnostic Record Exists – First Assessment If a Diagnostics record has been entered and this is the first assessment record, the following screen is displayed.

08-18-05 @15:21:43 346: MH Adult Uniform Assessment for RDM VC111396

[Open Error Code help for this screen](#)

Last Name	DECERVANTES	Client ID	35700
Suffix	.	Component	030
First Name	MIGUEL	Local Case Number	0000009994
Middle Name	.		

LAST DIAGNOSIS COMP:030 / DIAGNOSIS DATE:07-01-2005 / PRINCIPAL DIAGNOSIS:29510 / AXIS 5:49 / TRAG CATEGORY:SCZ

Create_New

[Print This Page](#)
[Return to Request Without Updating](#)
[Return to Resiliency & Disease Management Menu](#)
[Return to General Client Update Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Previous Assessment

If previous assessments for this individual have been entered, the same screen will appear but the prior assessments will be listed in reverse chronological order. The most recent completed record and any incomplete records are modifiable with a **Correct/Modify** button. All other entries will be viewable only with a **Look_At** button.

WebCARE Rule: Prompt Completion

For **Incomplete** assessments, after 30 days with no updates or modifications, the **Incomplete** record will be deleted. **Complete** assessment records, for up to 7 days after completion, may be modified or deleted. If the **Section 2: Authorized Level of Care (LOC-A)** date is future-dated for notification of appeals, the future-dated record can be modified or deleted for up to 7 days after the LOC-A ASSESSMENT DATE. After 7 days, the **Complete** assessment will be viewable only with a **Look_At** button. Note: Only an authority or UM can delete a complete assessment within 7 days.

346: MH Adult Uniform Assessment for RDM, Continued

Create Assessment Record To create a new assessment record, select **Create_New**. The following screen is displayed. A sample screen is shown below and continued on the next page.

07-10-08 @16:40:00
346: MH Adult Uniform Assessment for RDM
VC11139'

[Open Error Code help for this screen](#)

Last Name	DECERVANTES
Suffix	.
First Name	MIGUEL
Middle Name	.

Client ID	35700
Component	030
Local Case Number	0000009994

Type Of Entry:

Assessment Type Reason for Discharge

Location: Discharge Date (mmddyyyy)

Referred to

Section 3: Diag - Spec Clinical Rating Scales

A. Schizophrenia Algorithm (PSRS & BNSA)

Total Positive Symptom Rating Scale (PSRS) (4-28)

Total Brief Negative Symptom Assessment (BNSA) (4-24)

B. Bipolar Algorithm (BDSS)

Total Brief Bipolar Disorder Symptom Scale (BDSS) (10-70)

C. Major Depress Algorithm (QIDS-SR & QIDS-C)

Total Quick Inventory of Depressive Symp (QIDS) (0-27)

QIDS Version

D. Assessment Date (mmddyyyy)

E. Extended Review Period Requested :

Assessed By:

Credentials :

Notes (Limit to 220 Characters)

Section 1: Adult TRAG & Recommended LOC

A. Adult - TRAG Dimension Ratings

1. Risk of Harm
2. Support Needs
3. Psych Related Hosp
4. Functional Impairment
5. Employment Problems
6. Housing Instability
7. Co-occurring Subst Use
8. Criminal Justice Involvement
9. Depressive Symptomatology (MDD Only)

B. Calculated LOC-R

C. LOC-D Provider Recommended Deviation

D. TCOOMMI Consumer ?

E. Assessment Date (mmddyyyy)

Assessed By:

Credentials :

Notes (Limit to 220 Characters)

Section 2: Authorized Level of Care (LOC-A)

A. Authorized Level of Care (LOC-A)

B. Reasons for Deviation From LOC-R

1. Resource Limitations
2. Consumer Choice
3. Consumer Need
4. Cont Care Per Um Guide
5. Other

C. Authorization Date (mmddyyyy)

Subject to Medicaid Fair Hearing

Authorized By:

Credentials :

Notes (Limit to 220 Characters)

Section 4: Community Data

A. Residence Type (Current)

B. Paid Employment Type (Current)

C. Main Reason for Being Out of Labor Force

D. Assessment Date (mmddyyyy)

Notes (Limit to 220 Characters)

Form Status

Comment

COMP: 030 / CASE NO: 0000009994 / LAST NAME: DECERVANTES / FIRST NAME: MIGUEL

346: MH Adult Uniform Assessment for RDM, Continued

Create Assessment Record Continued Note: For Miguel de Cervantes, our fictitious adult, an Intake assessment will be entered. For more information on each field, refer to the additional pages for the [MH Adult Uniform Assessment for Resiliency & Disease Management \(CARE-UA-RDM\)](#) form.

Sections 1, 3, and 4 Fields **The Section 1: Adult-TRAG & Recommended Level of Care, Section 3: Diagnosis-Specific Clinical Symptom Rating [TIMA] Scales, and Section 4: Community Data** fields may be entered at once by the provider. Since WebCARE calculates the LOC-R, the LOC-R is not visible until the **Submit_Update** button is selected. Change the FORM STATUS to **Incomplete** or **Provider Complete** and select the **Submit_Update** button.

Section 2 Fields A Local Mental Health Authority (LMHA) Utilization Management or authorized staff person must enter **Section 2: Authorized Level of Care LOC-A** data. If the Recommended Level of Care (LOC-R) does not match the LOC-A, at least one appropriate deviation reason must be selected. The general comment field is intended for communication between the staff who perform the assessment and the authorizer or UM. Note: When an assessment is complete, only an authority or UM can delete the assessment within 7 days.

Form Status Field The following table describes the options for the FORM STATUS field.

Form Status	Description
Incomplete	Intended for use by the provider to indicate that the data entered is partial and will be completed soon.
Provider Complete	Intended for use by the provider to indicate that the data entered is complete and ready for the authority or Utilization Management review and authorization.
Complete	Intended for use by the authority or Utilization Management staff to indicate that all data has been entered and the center is finished with the assessment.

If the Form Status is marked **Incomplete** or **Provider Complete** for more than 30 days without being changed, the WebCARE [Auto-Delete](#) process will automatically delete the assessment.

For Update Assessments, if the Form Status is marked **Provider Complete** and the prior authorization is still valid, the assessment form will be [AutoCompleted](#). If the Provider wants the individual to be re-authorized or prefers that the Authority (UM staff) review the assessment, the **Authority Review Requested?** check box may be selected.

346: MH Adult Uniform Assessment for RDM, Continued

Form Status Field (continued) When assessment forms are marked complete, modifications can be made for up to 7 days. The authority may also delete the entire assessment form within those 7 days. On the 8th day, assessments may be viewed only; no changes can be made.

Crisis Assessments While Receiving Services The primary focus during a crisis must be TREATMENT: **“Treat, then TRAG”**

If the individual is already receiving services, treat the crisis and then re-TRAG after the crisis is resolved. Crisis services are included in all WebCARE service packages and the crisis does not need to be recorded in WebCARE.

If an individual does not respond to attempts to stabilize the crisis and needs Crisis Stabilization Unit (CSU) or hospital services, do not change the individual’s service package until after the individual has been stabilized and released. It is then appropriate to re-administer the RDM assessment, and if indicated by the TRAG scores or clinical judgment, to assign the individual to a different service package.

Crisis Assessments Before Receiving Services When an individual is not currently receiving services, is in crisis, and the crisis is entered into WebCARE, most of the assessment requirements are suspended.

A Registration record *is required* to be completed before entering any other information.

A Diagnostics record is NOT required.

A Crisis Assessment record *is required*. The timeline for crisis resolution is 7 days.

346: MH Adult Uniform Assessment for RDM, Continued

Following a
Crisis

Following crisis resolution (which can be sooner than 7 days), enter an Intake Assessment.

- If the individual is a member of the Target population (individuals with schizophrenia and related disorders, bipolar disorder, or major depression with a GAF \leq 50), the LPHA may enter a diagnostics record and assign the individual to a service package.
 - If the individual is a member of the Priority population (individuals who are not Target population but who are at great risk), an LPHA may enter a diagnostics record and override the individual into a service package in accordance with the Adult UM Guidelines.
 - If the individual is ineligible for services, the individual may be served for up to 30 days in Service Package 5 – Crisis Follow-up after the diagnostics record is completed. Service Package 5 – Crisis Follow-up is intended to complete the stabilization process and is also appropriate after an individual is discharged from a State Hospital.
-

Out of Area
Crisis

If an ongoing individual at one center requires crisis services from a different center:

- The crisis for the individual can be entered at the “Out of Area” center using the E=Crisis Assessment Type.
 - This crisis record will NOT impact any of the service package timelines from the individual’s “home” center. The “home” center is not required to discharge the individual during the crisis period.
 - When the crisis has been resolved at the “Out of Area” center, the individual may return to the “home” center, continue services at the “Out of Area” center, or other.
 - If the individual returns to the “home” center for treatment, no further WebCARE entries are required for the “Out of Area” center.
 - If the individual continues treatment at the “Out of Area” center, the individual must be discharged from the “home” center. The “Out of Area” center then becomes the “home” center and an Intake assessment is required.
-

346: MH Adult Uniform Assessment for RDM, Continued

Crisis While on
the Waiting List

Individuals in crisis that were previously assessed with a LOC-A of 8=Waiting for All Services require a Crisis Assessment. The Waiting List assessment does not prevent a Crisis Assessment from being entered and both assessments are treated as separate events. The individual will remain on the waiting list as if the crisis had not occurred.

If the center provides additional services after the crisis has been resolved, an Intake Assessment is required.

Crisis Assessment
Section 1 Fields

For a *Crisis assessment only*, enter data in the following **Section 1: TRAG & Recommended Level of Care Adult-TRAG Dimension Ratings** fields.

Field	Description
RISK OF HARM *	Select 4 or 5 .
FUNCTIONAL IMPAIRMENT *	Select 5 .
CO-OCCURRING SUBSTANCE USE *	Select 5 .
ASSESSMENT DATE	The date of the assessment.
ASSESSED BY	The name of the person who performed the assessment.
CREDENTIALS	The highest credentials of person who performed the assessment
FORM STATUS	Select Incomplete or Provider Complete .

* For a crisis assessment with a level of care deviation (LOC-D) of 0, only one dimension rating is required (i.e., Risk of Harm, Functional Impairment, or Co-Occurring Substance Use).

Select the **Submit_Update** button.

346: MH Adult Uniform Assessment for RDM, Continued

Crisis Assessment Section 2 Fields The authority or Utilization Management staff will enter data in the **Section 2: Authorized Level of Care (LOC-A)** fields.

Field	Description
AUTHORIZED LEVEL OF CARE (LOC-A)	Select 0=Crisis Services .
AUTHORIZATION DATE	The date that the level of care was authorized and the Authorization Begin Date. (MMDDYYYY format)
AUTHORIZED BY	The name of the person who authorized the assessment.
CREDENTIALS	The highest credentials of person who authorized the assessment.
NOTES	Enter any notes for this section of the assessment.
FORM STATUS	Select Complete .

Select the **Submit_Update** button.

Note: Crisis Services are authorized for **7 days only**. If an H0-36 (Adult Crisis Stabilization) Assignment has been entered for the individual, Crisis Services are authorized for up to **14 days**.

WebCARE Rule

The **Section 1: TRAG ASSESSMENT DATE** is compared to *all other dates on the assessment* to verify that these dates pass the business rules. The **Section 2: LOC-A AUTHORIZATION DATE** must be within 14 days of the **Section 1: TRAG ASSESSMENT DATE**. Exception: If the **Section 2: LOC-A SUBJECT TO MEDICAID FAIR HEARING** check box is checked, the **Section 2: LOC-A AUTHORIZATION DATE** must be within 30 days of the **Section 1: TRAG ASSESSMENT DATE** to allow for Medicaid Fair Hearing notification letter processing. All other section dates must be within 30 days of the **Section 1: TRAG ASSESSMENT DATE**.

346: MH Adult Uniform Assessment for RDM, Continued

Results Screen After entering appropriate data, choosing the Form Status, entering any comments for the entire assessment, and selecting **Submit_Update**, the following screen is displayed (continued).

07-10-08 @16:42:23		346: MH Adult Uniform Assessment for RDM		VC111397
Open Error Code help for this screen				
Last Name	DECERVANTES		Client ID	35700
Suffix	.		Component	030
First Name	MIGUEL		Local Case Number	0000009994
Middle Name	.			
Type Of Entry:		Inquire		
Assessment Type	A - INTAKE		Reason for Discharge	
Location:			Discharge Date (mmddyyyy)	
			Referred to	
Section 1: Adult TRAG & Recommended LOC		Section 3: Diag - Spec Clinical Rating Scales		
A. Adult - TRAG Dimension Ratings 1. Risk of Harm 2. Support Needs 3. Psych Related Hosp 4. Functional Impairment 5. Employment Problems 6. Housing Instability 7. Co-occurring Subst Use 8. Criminal Justice Involvement 9. Depressive Symptomatology (MDD Only)		A. Schizophrenia Algorithm (PSRS & BNSA) 3 Total Positive Symptom Rating Scale (PSRS) (4-28) 20 4 Total Brief Negative Symptom Assessment (BNSA) (4-24) 20 1 4 B. Bipolar Algorithm (BDSS) 4 Total Brief Bipolar Disorder Symptom Scale (BDSS) (10-70) 5 4 3 C. Major Depress Algorithm (QIDS-SR & QIDS-C) 3 Total Quick Inventory of Depressive Symp (QIDS) (0-27) QIDS Version D. Assessment Date (mmddyyyy) 08102005 E. Extended Review Period Requested : Assessed By: MANO LAMANCHA Credentials : 1 - QMHP-CS		
B. Calculated LOC-R 3 - SERV PACK 3 C. LOC-D Provider Recommended Deviation D. TCOOMMI Consumer ? E. Assessment Date (mmddyyyy) 08102005 Assessed By: MANO LAMANCHA Credentials : 1 - QMHP-CS Notes		Section 4: Community Data		
Section 2: Authorized Level of Care (LOC-A) A. Authorized Level of Care (LOC-A) 3 - SERV PACK 3 B. Reasons for Deviation From LOC-R 1. Resource Limitations NO 2. Consumer Choice NO 3. Consumer Need NO 4. Cont Care Per Um Guide NO 5. Other NO C. Authorization Date (mmddyyyy) 08102005 Subject to Medicaid Fair Hearing Authorized By: MANO LAMANCHA Credentials : 1 - QMHP-CS Notes		A. Residence Type (Current) 4 - HOMELESS B. Paid Employment Type (Current) 4 - NOT IN LF C. Main Reason for Being Out of Labor 4 - UNAB LOC/KP Force D. Assessment Date (mmddyyyy) 08102005 Notes		
Form Status		C - COMPLETE		Comment
COMP: 030 / CASE NO: 0000009994 / LAST NAME: DECERVANTES / FIRST NAME: MIGUEL				
As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.				
Signature of LPHA: _____		LPHA Credentials: _____		Date: _____
<input type="button" value="Return_Request"/>				

346: MH Adult Uniform Assessment for RDM, Continued

Section 2 Data A Local Mental Health Authority (LMHA) Utilization Management or authority staff person must enter **Section 2: AUTHORIZED LEVEL OF CARE (LOC-A)**. Note: Only an authority can delete a complete assessment within 7 days.

Reasons for Deviation When the REASONS FOR DEVIATION FROM LOC-R are required (LOC-R does not match LOC-A), then appropriate reasons should be selected. When the LOC-A is lower intensity than the LOC-R, **Resource Limitations** and **Consumer Choice** are appropriate reasons. If the LOC-A is higher intensity than the LOC-R, **Consumer Need** and **Continuity of Care** are appropriate reasons.

The Reasons for Deviation are:

- Resource Limitations – Used when the Adult LOC-R was more intensive than the LOC-A because there are not enough resources to offer the more intensive service package.
 - Consumer Choice – Used when the individual did not want the more intensive service package recommended.
 - Consumer Need – Used when the Adult LOC-R was less intensive than the LOC-A because (based on the authority’s or UM’s clinical judgment and other information) the individual needs a more intensive service package.
 - Continuity of Care per UM Guidelines – Used when the individual has been served in a more intensive service package, has improved, but still requires the higher intensity service package to become stabilized.
 - Other – Used when none of the other deviations describe the reason for deviation. Enter details regarding the deviation in the Notes field.
-

346: MH Adult Uniform Assessment for RDM, Continued

Authorizations After an individual has an Intake Assessment, an Update Assessment must be entered every **90 days**, except for Extended Review Period that is every 180 days. The authorization period differs depending on the Level of Care Authorized and the authorization must be re-authorized or changed within the period listed below:

<u>Level of Care (LOC)</u>	<u>Authorization Period Valid for Up To:</u>
Service Package 0 – Crisis Services	7 days (one time)
Service Package 1	365 days
Service Package 2	180 days
Service Package 3	180 days
Service Package 4	180 days
LOC 5 – Crisis Follow-up	30 days
LOC 6 – Individual Refuses Services	0 days
LOC 8 – Waiting for All Authorized Services	365 days (Intake)
LOC 9 – Not Eligible for Services	0 days

WebCARE Rule

The **Section 2: LOC-A AUTHORIZATION DATE** is the date the LOC-A becomes effective, must be the same or after the **Section 1: TRAG ASSESSMENT DATE**, and must be within 14 days of the **Section 1: TRAG ASSESSMENT DATE**. Exception: When the **Section 2: LOC-A SUBJECT TO MEDICAID FAIR HEARING** check box is checked, the **Section 1: TRAG ASSESSMENT DATE** must be within 30 days of the **Section 1: TRAG ASSESSMENT DATE** to allow for Medicaid Fair Hearing notification letter processing.

Section 3 Data

The **Section 3: Diagnosis-Specific Clinical Rating (TIMA) Scales** are required for target population diagnoses for Intake, Update, and “Completed Services” Discharge assessments. The rating entered must match the diagnosis entered on the **330: Diagnostics** screen.

If the diagnosis entered is not one of the target population diagnoses, no algorithm ratings are entered. The **Section 3: Diagnosis-Specific Clinical Rating Scales ASSESSMENT DATE**, **ASSESSED BY**, and **CREDENTIALS** are always required, even when a rating has not been entered.

If the diagnosis is for Schizo-affective Disorder, either the Schizophrenia Algorithm or the Bipolar Algorithm may be entered.

346: MH Adult Uniform Assessment for RDM, Continued

Data Collection Diagnosis-Specific Symptom Measures are routinely obtained at every physician visit and are assessed by physicians or other qualified staff. The results are recorded on the Clinical Record Form (CRF) and are part of the clinical chart, according to the Texas Implementation of Medication Algorithm (TIMA) guidelines. Only one algorithm should be reported and all symptom measures associated with the other algorithms should be left blank.

Extended Review Period Requested For an Update record, the EXTENDED REVIEW PERIOD REQUESTED box in **Section 3: Diagnosis-Specific Clinical Rating Scales** may be checked for the small number of highly stable ongoing individuals in Service Package 1 who are not scheduled to see a provider for another 180 days. Checking this box will extend the 90-day requirement for re-assessment to 180 days.

Section 4 Data **Section 4: Community Data** can be entered at any time by Provider Qualified Mental Health Professional (QMHP) staff (including LVN's). This data is required for Intake and "Completed Services" Discharge Assessments and is updated every 365 days. The **Section 4: Community Data ASSESSMENT DATE** must be completed within 30 days of the **Section 1: TRAG ASSESSMENT DATE**.

If PAID EMPLOYMENT TYPE is "Not in the Labor Force", then MAIN REASON FOR BEING OUT OF LABOR FORCE must be entered, otherwise leave this field blank.

Return Request After selecting **Return_Request** near the bottom of the screen, WebCARE returns you to the following screen so that other individual data may be entered.

08-18-05 @16:27:51 346: MH Adult Uniform Assessment for RDM VC111396

[Open Error Code help for this screen](#)

Component	030
Local Case Number	

Submit_Request Reset

[Print This Page](#)
[Return to Resiliency & Disease Management Menu](#)
[Return to General Client Update Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

346: MH Adult Uniform Assessment for RDM, Continued

Authorize Level
Of Care

When Miguel's record is ready for Utilization Management staff to authorize his level of care, data entry will continue with the following screen:

08-18-05 @16:30:43 346: MH Adult Uniform Assessment for RDM VC111396

[Open Error Code help for this screen](#)

Last Name	DECERVANTES		Client ID	35700
Suffix			Component	030
First Name	MIGUEL		Local Case Number	0000009994
Middle Name				

LAST DIAGNOSIS COMP:030 / DIAGNOSIS DATE:07-01-2005 / PRINCIPAL DIAGNOSIS:29510 / AXIS 5:49 / TRAG CATEGORY:SCZ

	DATE	LOCR	TYPE	STATUS	LOC - AUTHORIZED			Delete
					LEVEL	BEGIN	END	
Inc <input type="button" value="Modify/Authorize"/>	08/01/05	Serv Pack 3	Intake	Prov Comp				<input type="button" value="Delete"/>

WebCARE Rule: 7 Days

A complete record can only be modified or deleted for up to 7 days. After 7 days, the complete record is viewable only with a **Look_At** button. If the **Section 2: Authorized Level of Care (LOC-A)** date is future-dated for notification of appeals, the future-dated record can be modified or deleted for up to 7 days after the LOC-A ASSESSMENT DATE.

Update Record

Select the **Modify/Authorize** button to update Miguel's record. In the center of the screen, the TYPE OF ENTRY is **Change**. When the appropriate information is entered and the **Submit_Update** button is selected, the screen is populated with all the processed information. Select **Return_Request** near the bottom of the screen to continue.

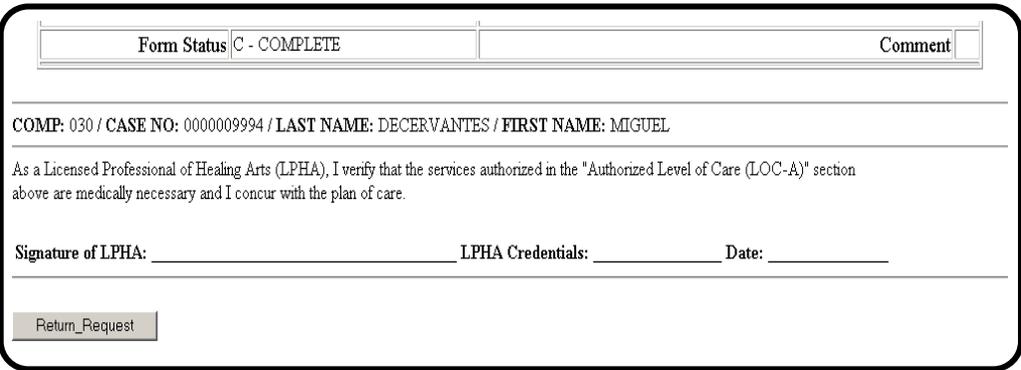
Assignment Record

An assignment record should be entered in mainframe CARE to document where a person is receiving services and to track the individual's movement throughout the service delivery system.

346: MH Adult Uniform Assessment for RDM, Continued

Intake Record Completed in Error If the Intake record is completed in error and the **Delete** button is visible, select the **Delete** button and enter a new record by selecting **Create_New**. Note: Only an authority can delete a complete assessment within 7 days.

Medical Necessity At the bottom of completed *Intake* and *Update* records, a statement can be printed and signed by hand regarding medical necessity.



The screenshot shows a web-based form interface. At the top, there are two input fields: "Form Status" containing "C - COMPLETE" and "Comment". Below these is a header line with the text "COMP: 030 / CASE NO: 0000009994 / LAST NAME: DECERVANTES / FIRST NAME: MIGUEL". The main body of the form contains a paragraph: "As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the 'Authorized Level of Care (LOC-A)' section above are medically necessary and I concur with the plan of care." Below this paragraph is a signature line: "Signature of LPHA: _____ LPHA Credentials: _____ Date: _____". At the bottom left of the form area is a button labeled "Return_Request". A black arrow points from the left margin to the signature line.

continued on next page

346: MH Adult Uniform Assessment for RDM, Continued

Status is Complete but Evaluation Information Changes The status for the Intake record is **Complete**, meaning the center is finished with the assessment. If any information in **Sections 1, 2, 3, or 4** of the Uniform Assessment for Miguel changes because a:

- Review has occurred,
- TRAG dimension adjusts,
- Community Data item alters, or
- Different Level of Care is deemed necessary

then an Update record will be added. To enter an Update record, select **Create_New**. A sample screen is shown below.

08-18-05 @16:54:44 346: MH Adult Uniform Assessment for RDM VC111396

[Open Error Code help for this screen](#)

Last Name	DECERVANTES		Client ID	35700
Suffix	.		Component	030
First Name	MIGUEL		Local Case Number	0000009994
Middle Name	.			

LAST DIAGNOSIS COMP:030 / DIAGNOSIS DATE:07-01-2005 / PRINCIPAL DIAGNOSIS:29510 / AXIS 5:49 / TRAG CATEGORY:SCZ

➔ Create_New

		DATE	LOCR	TYPE	STATUS	LOC - AUTHORIZED			
						LEVEL	BEGIN	END	
Inq	Correct/Modify	08/01/05	Serv Pack 3	Intake	Complete	Serv Pack 3	08/10/05	02/07/06	Delete

⬆

Extended Review Period Requested

For an Update record, the EXTENDED REVIEW PERIOD REQUESTED box in **Section 3: TIMA Scales** may be checked for the small number of highly stable ongoing consumers in Service Package 1 who are not scheduled to see a provider for another 180 days. Checking this box will extend the 90-day requirement for re-assessment to 180 days.

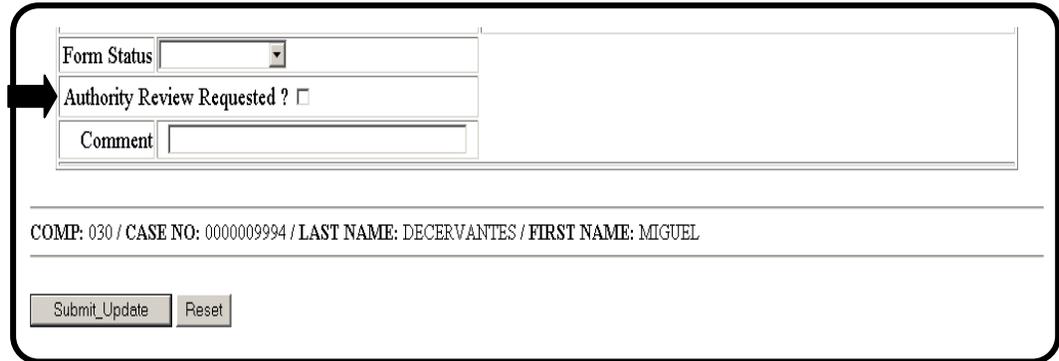
AutoComplete

If the authorization period has not expired and the Update record passes all the rules for completion, then when **Provider Complete** is selected, the FORM STATUS will automatically change to **Complete**.

346: MH Adult Uniform Assessment for RDM, Continued

If AutoComplete
Should *not* be
Applied

If this AutoComplete process should not be applied to this assessment, select the Authority Review Requested? box below the FORM STATUS field and add comments to alert the authority staff person or Utilization Management to review this record and change the LOC-A. The Authority Review Requested? field will not display unless the previous record is an Intake or Update.



The screenshot shows a web form with the following elements:

- A dropdown menu labeled "Form Status".
- A checkbox labeled "Authority Review Requested ?" with an arrow pointing to it from the left.
- A text input field labeled "Comment".
- A horizontal line separating the form from the patient information.
- Text below the line: "COMP: 030 / CASE NO: 0000009994 / LAST NAME: DECERVANTES / FIRST NAME: MIGUEL".
- Two buttons at the bottom: "Submit_Update" and "Reset".

Create Discharge
Assessment

When Miguel is ready to be discharged from the center and will no longer receive services, create a discharge assessment by selecting the **Create_New** button. For data entry purposes, the DISCHARGE DATE may be dated up to 30 days prior to today's date. If Miguel's services were changing, a Discharge Assessment would not be entered. Miguel would be reevaluated (Update Assessment entered) and authorized into the appropriate service package.

WebCARE Rule: Discharge

Discharge Dates for DISCHARGE REASON **C=Level of Care Services Complete** may be future-dated up to 14 days for planned discharges. All sections of the Adult Assessment are required for DISCHARGE REASON **C=Level of Care Services Complete**. All other reasons for discharge may not be future-dated and do not require any sections to be completed. Exception: If the SUBJECT TO MEDICAID FAIR HEARING box is checked, most reasons for discharge may be future-dated up to 30 days, except for J = Incarcerated in Jail or Prison.

Reasons for
Discharge

There are eight discharge Reasons, but only seven reasons can be selected from the drop-down menu:

C – Level of Care Service Complete. Use this reason when the person's needs have been met and there is no further need for services (also known as "Planned Discharge"). The Discharge Date can be future-dated up to 14 days from today's date.

346: MH Adult Uniform Assessment for RDM, Continued

E – Elected a New Provider. Use this reason when a person chooses to leave the current center provider to receive services from a different provider.

J – Incarcerated in Jail or Prison. Use this reason when a person is incarcerated for long periods of time. Do not discharge a person if in jail overnight or for a short-term stay. Continuing services following a short-term stay provides a smoother return into the community. Persons in Service Packages 1, 2, or 3 can be incarcerated up to 30 days before being discharged. Persons in Service Package 4 can be incarcerated up to 90 days without being discharged. **Note:** The person must receive documented service activity during these time periods.

M – Moved out of Local Service Area. Use this when the person has moved out the LSA. **Note:** If the individual is hospitalized short-term and is returning to the LSA after release, a discharge is not required.

N – Never Returned for Services within Authorized Service Period, not to exceed 6 months. Use this reason when a person has been authorized for services and then:

- refuses services,
- doesn't show up for services, or
- cannot be found.

This option is selected only after a documented “good faith” effort (at least two attempts to contact the person through phone calls, letters, home or job visits, or program alerts) has been made to locate and contact the person.

P – Change in NorthSTAR Eligibility. Use this reason when a person's Medicaid eligibility changes the person's NorthSTAR eligibility, and thus, NorthSTAR enrollment. This reason may be used when the person's Medicaid eligibility initiates an enrollment into or out of NorthSTAR.

X – (System Generated) Auto-Closed. This option cannot be selected from the drop-down list and is automatically entered by WebCARE when an assessment has expired (authorization period has elapsed or assessment has expired).

Z – Other. This option is used for discharges related to Death or other reasons not listed above. Enter details in the COMMENTS field.

346: MH Adult Uniform Assessment for RDM, Continued

Discharge Record The following screen displays the summary of a Discharge record:

08-24-05 @16:17:28 346: MH Adult Uniform Assessment for RDM VC111396

[Open Error Code help for this screen](#)

Last Name	DECERVANTES	Client ID	35700
Suffix	.	Component	030
First Name	MIGUEL	Local Case Number	0000009994
Middle Name	.		

LAST DIAGNOSIS COMP:030 / DIAGNOSIS DATE:07-01-2005 / PRINCIPAL DIAGNOSIS:29510 / AXIS 5:49 / TRAG CATEGORY:SCZ

		DATE	LOC	TYPE	STATUS	LOC - AUTHORIZED			
						LEVEL	BEGIN	END	
Inq	<input type="button" value="Correct/Modify"/>	08/15/05		Discharge	Complete				<input type="button" value="Delete"/>
Inq	<input type="button" value="Look_At"/>	08/01/05	Serv Pack 3	In	Complete	Serv Pack 3	08/10/05	02/07/06	

Discharge Record is Complete

When the Discharge record has been completed, (all sections completed for REASON FOR DISCHARGE is **C=Level of Care Services Complete**), the authority or Utilization Management staff will change the FORM STATUS to **Complete**.

Key Points

- **Section 1** is completed every 90 days by LMHA QMHP staff at Intake or by Provider QMHP staff at Update, unless an Extended Review Period is requested in Section 3.
- **Section 1: TRAG** Assessment Date is compared to all other assessment dates to verify that these dates pass the business rules.
- The **Section 2: LOC-A** AUTHORIZATION DATE is the date the LOC-A becomes effective, must be the same or after the **Section 1: TRAG ASSESSMENT DATE**, and must be within 14 days of the **Section 1: TRAG ASSESSMENT DATE**. If **Section 2: LOC-A SUBJECT TO MEDICAID FAIR HEARING** has been checked, then the **Section 2: LOC-A** Authorization Date must be within 30 days of the **Section 1: TRAG** Assessment Date.
- All other section dates must be within 30 days of the **Section 1: TRAG** Assessment Date.

164: MH Child/Adolescent Uniform Assessment for RDM

Overview

The Child/Adolescent Uniform Assessment is an instrument designed to assist in the selection of a benefit package and financing methodology for public mental health services in the state of Texas. The Mental Health Child/Adolescent Uniform Assessment for Resiliency and Disease Management module of the WebCARE system is designed to record the individual's assessment data, with the primary goal of using standard, quantifiable measures to guide the choice of service needs and to make appropriate "level of care" decisions.

Business Rule: **Age**

Any individual age 16 or under is a child/adolescent. An individual age 17 or 18 may be served as either an adult or child/adolescent. An adult is any person 19 years of age or older. An individual who is being served as a child/adolescent will be discharged from child/adolescent services on their 19th birthday when an adult Intake record may be entered to continue services. When a person has been authorized for adult services, they may not return to child/adolescent services. A REASON FOR DISCHARGE of **A=No Longer Meets Child Criteria for Services** will be entered.

Note: For specific instructions on completing the [Child/Adolescent Uniform Assessment Form](#), refer to [Child Form Completion and Schedule](#).

Online Data Entry

Online data entry by those completing the assessments is preferred.

Centralized Data Entry

For centralized data entry, it is recommended that the [Child & Adolescent Uniform Assessment for Resiliency & Disease Management](#) form be printed and completed prior to WebCARE data entry. CARE forms are subject to change. Examples and additional information is provided in this section for completion of the 164: MH Child/Adolescent Uniform Assessment for RDM screen.

Utilization Management staff authorize service packages. If a data entry clerk is entering data, the form must be signed by the authorizer and must be in the individual's clinical records.

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Sequence of Assessment Types

The expected sequence of completed assessment types is:

1. One Crisis (if individual is in crisis before an Intake or following a Discharge).
 2. One Intake (If Intake Non-Admission – LOC-R=9 and LOC-A=9, then no Update or Discharge assessment is required) – used for initial admission into services, after a Discharge, or for Aftercare services following a hospital discharge.
 3. One or more Update(s) – used for periodic reassessments, usually every 90 days. For Extended Review Period for Service Package 4-Aftercare, the reassessment is required every 180 days.
 4. One Discharge – used when services will no longer be provided.
-

Crisis Assessments While Receiving Services

The primary focus during a crisis must be TREATMENT:
“Treat, then TRAG”

If the individual is already receiving services, treat the crisis and then re-TRAG after the crisis is resolved. Crisis services are included in all services packages and the crisis does not need to be recorded in WebCARE. Crisis Services for Children/Adolescents include 24-hour triage, crisis assessment, case coordination, physician services, and inpatient hospitalization, if indicated.

If an individual does not respond to attempts to stabilize the crisis, do not change the individual’s service package until after the individual has been stabilized. It is then appropriate to re-administer the RDM Assessment, and if indicated by the CA-TRAG scores or clinical judgment, to assign the individual to a different service package.

Crisis Assessments Before Receiving Services

When an individual is not currently receiving services, is in crisis, and the crisis is entered into WebCARE, most of the assessment requirements are suspended.

Crisis Services are recommended for children or adolescents in any diagnostic category who have a rating of 5 for Risk of Self-Harm or for Co-Occurring Substance Use. A child or adolescent who presents a serious risk of harming another, regardless of the CA-TRAG dimension ratings, is recommended for Crisis Services. Intensive Crisis Residential is usually short-term (24-hour) residential services provided to a child or adolescent who is demonstrating a psychiatric crisis that cannot be stabilized in a less restrictive setting.

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Records Required
for Crisis

A Registration record *is required* to be completed before entering any other information.

A Diagnostics record is NOT required.

A Crisis Assessment record *is required*. The timeline for crisis resolution is 7 days.

Following a
Crisis

Following crisis resolution (which can be sooner than 7 days), enter an Intake Assessment.

- If the individual is ineligible for services, the individual may be served for up to 30 days in Service Package 5 – Crisis Follow-up after the diagnostics record is completed. Service Package 5 – Crisis Follow-up is intended to complete the stabilization process and is also appropriate after an individual is discharged from a State Hospital.
-

Out of Area
Crisis

If an ongoing individual at one center requires crisis services from a different center:

- The crisis for the individual can be entered at the “Out of Area” center using the E=Crisis Assessment Type.
 - This crisis record will NOT impact any of the service package timelines from the individual’s “home” center. The “home” center is not required to discharge the individual during the crisis period.
 - When the crisis has been resolved at the “Out of Area” center, the individual may return to the “home” center, continue services at the “Out of Area” center, or other.
 - If the individual returns to the “home” center for treatment, no further WebCARE entries are required for the “Out of Area” center.
 - If the individual continues treatment at the “Out of Area” center, the individual must be discharged from the “home” center. The “Out of Area” center then becomes the “home” center and an Intake assessment is required.
-

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Crisis While on
the Waiting List

Individuals in crisis that were previously assessed with a LOC-A of 8=Waiting for All Services require a Crisis Assessment. The Waiting List assessment does not prevent a Crisis Assessment from being entered and both assessments are treated as separate events. The individual will remain on the waiting list as if the crisis had not occurred.

If the center provides additional services after the crisis has been resolved, an Intake Assessment is required.

Crisis Assessment

For a ***Crisis assessment only***, the E=Crisis Assessment Type is selected; the authority or Utilization Management staff will enter data in the following **Section 3: Authorized Level of Care** fields.

Field	Description
LOC-A	Select 0=Crisis Services .
AUTHORIZATION DATE	The date the Level of Care services were authorized. Also, the Authorization Begin Date. (MMDDYYYY format)
AUTHORIZED BY	The name of the person who authorized the assessment.
CREDENTIALS	The highest credentials of the person authorizing the assessment.
NOTES	Enter any notes for this section of the assessment.

Risk of Self-Harm/
Co-Occurring
Substance Abuse

If either the RISK OF SELF-HARM or CO-OCCURRING SUBSTANCE USE fields are set to **5** by the provider when completing **Section 1: Child/Adolescent TRAG**, then the AUTHORIZATION DATE, AUTHORIZED BY, and CREDENTIALS (highest credentials of person authorizing the assessment) fields for **Section 1: Child/Adolescent TRAG** are required. Exception: Exception: For a crisis assessment with a level of care deviation (LOC-D) of 0, only one dimension rating is required (i.e., Risk of Self-Harm, or Co-Occurring Substance Use). No other fields are required in Section 1. Complete **Section 3: Level of Care Authorized** with 0=Crisis Services, then the AUTHORIZATION DATE, AUTHORIZED BY, and fields for **Section 3: Level of Care Authorized** The Crisis Services are authorized for *7 days only*.

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Request Screen

From the RDM Menu, select 164: MH Child Evaluation Assessment for RDM. The following screen will be displayed.

The screenshot shows a web application interface. At the top left, it displays the date and time: "08-24-05 @16:50:57". In the center, the title is "164: MH Child & Adolescent Uniform Assessment for RDM". At the top right, the user ID is "VC152170". Below the title, there is a link: "Open Error Code help for this screen". The main area contains two input fields: "Component" with the value "030" and "Local Case Number" which is empty. At the bottom, there are two buttons: "Submit_Request" and "Reset".

Note: Peter Piper, the fictitious child, will continue to be used as an example.

Error Code Help

If you receive an error code when entering data, click on **Open Error Code help for this screen**. A new window will appear that has the Error Code, Resolution, and Business Rules database. Select the error code from the list and **Display Results**. Close this new window when finished.

The screenshot shows a window titled "WebCARE Error Codes, Resolutions, and Business Rules". The window content includes: "For Screen: VC111396", "346: MH Adult Uniform Assessment for R&DM", and "Select One Error Code:". Below this is a list of error codes: "1711 - INVALID COMPONENT CODE", "1764 - LOCAL CASE NUMBER NOT FOUND.", and "1899 - LOCAL CASE NUMBER CANNOT BE BLANK". At the bottom of the window, there are two buttons: "Display Results" and "Previous Page".

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

No Diagnostics Record

If no diagnostics record is found for the individual, the following screen will be displayed.

08-24-05 @17:20:52 164: MH Child & Adolescent Uniform Assessment for RDM VC152170

[Open Error Code help for this screen](#)

Last Name	PIPER		
Suffix	.	Client ID	35742
First Name	PETER	Component	030
Middle Name	PEPPER	Local Case Number	0000009993

**** NO DIAGNOSIS ON FILE ****

A diagnostics record must be entered for all individuals in WebCARE.

Business Rule: Crisis Individuals

For *Crisis Individuals only*, a Crisis assessment may be entered *before* a diagnostics record. However, when the individual is no longer in Crisis, a Diagnostics record is required before an Intake assessment record may be entered. For a list of all Business Rules, see [Error Codes and Related Business Rules](#).

Diagnostic Record Exists - First Assessment Record

If a Diagnostics record has been entered and this is the first assessment record, the following screen will display:

08-24-05 @17:24:43 164: MH Child & Adolescent Uniform Assessment for RDM VC152170

[Open Error Code help for this screen](#)

Last Name	PIPER		
Suffix	.	Client ID	35742
First Name	PETER	Component	030
Middle Name	PEPPER	Local Case Number	0000009993

LAST DIAGNOSIS COMP:030 / EFFECTIVE DT:07-01-2005 /PRINCIPAL DIAG:31401 /AXIS 5:49 /TRAG CATEGORY:EXT

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Previous
Assessment

If previous assessments for this individual have been entered, the same screen will display but the prior assessments will be listed in reverse chronological order. The most recent entry will be modifiable with a **Correct/Modify** button. Other entries may also be modifiable, but will be limited such that the sequence business rules are preserved.

**WebCARE Rule:
Prompt Completion**

For **Incomplete** assessments, after 30 days with no updates or modifications, the **Incomplete** record will be deleted. **Complete** assessment records, for up to 7 days after completion, may be modified or deleted. After 7 days the **Complete** assessment will be viewable only with a **Look_At** button. If the **Section 3: Authorized Level of Care (LOC-A)** date is future-dated for notification of appeals, the future-dated record can be modified or deleted for up to 7 days after the LOC-A ASSESSMENT DATE.

continued on next page

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Create Assessment Record To create a new assessment record, select **Create_New**. The following screen will display. A sample screen is shown below.

07-10-08 @16:46:19
164: MH Child & Adolescent Uniform Assessment for RDM
VC152171

[Open Error Code help for this screen](#)

Last Name	OKLAHOMA	Client ID	38342
Suffix	.	Component	030
First Name	DALLAS	Local Case Number	000000099
Middle Name	.		

Type Of Entry:

Assessment Type Reason for Discharge

Location Discharge Date (mmddyyyy)

Referred to

Referral Source

At Risk of Placement ED (special Education)

Section 1: Child / Adolescent TRAG

Diagnosis: 2971 Delusional Disorder
 Diagnostic Qualifier

A. Ohio Scales

1a. Parent Ohio Problem Severity Scale Score (0-100)

1b. Parent Ohio Functioning Scale Score (0-80)

2a. Youth Ohio Problem Severity Scale Score (0-100)

2b. Youth Ohio Functioning Scale Score (0-80)

3a. Worker Ohio Problem Severity Scale Score (0-100)

3b. Worker Ohio Functioning Scale Score (0-80)

B. CA-TRAG Dimension Ratings

1. Problem Severity - Ohio Scale Score

2. Functioning - Ohio Scale Score

3. Risk of Self-harm

4. Severe Disruptive or Aggressive Behavior

5. Family Resources

6. History of Psychiatric Treatment

7. Co-occurring Substance Use

8. Juvenile Justice Involvement

9. School Behavior

10. Psychoactive Medication Treatment?

C. Successfully Completed Service Package 1 or 2?

D. Level of Care Decisions

Calculated Level of Care Recommendation (LOC-R)

E. LOC-D Provider Recom. Deviation

F. FOSTER CARE

G. TCOOMMI Consumer?

H. Assessment Date (mmddyyyy)

I. Extended Review Period Requested

Assessed By

Credentials

Notes (Limit to 220 Characters)

Section 2: Community Data

Within Last 90 Days:

A. Number of Arrests

B. School Days Missed

C. Primary Residence Type

D. Assessment Date (mmddyyyy)

Notes (Limit to 220 Characters)

Section 3: Authorized Level of Care (LOC-A)

A. Actual Level of Care Authorized
 LOC-A

B. Reasons for Deviation From LOC-R

Resource Limitations

Consumer Choice

Cont Care Per Um Guide

Consumer Need

Other

C. Authorization Date (mmddyyyy)

Subject to Medicaid Fair Hearing

Authorized By

Credentials

Notes (Limit to 220 Characters)

Form Status

Comment

Prior Comment

COMP: 030 / CASE NO: 000000099 / LAST NAME: OKLAHOMA / FIRST NAME: DALLAS

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Create Assessment Record (continued) Note: For Peter Piper, our fictitious child, an Intake assessment will be entered. For more information on each field, refer to the additional pages for the [Child and Adolescent Uniform Assessment for Resiliency & Disease Management Form \(CARE-CUA-RDM\)](#)

Sections 1 and 2 Fields The **Section 1: Child/Adolescent TRAG** and **Section 2: Community Data** fields may be entered at once. Since WebCARE calculates the LOC-R, the LOC-R is not visible until the **Submit_Update** button is selected.

Do not enter zeroes for Ohio Scales Scores if no scores have been collected. A zero value is valid and will affect the results of the TRAG calculation. The Ohio Scales must be entered in pairs: (Parent/Primary Caregiver (1a and 1b), Youth-ages 12-17 (2a and 2b), or Worker/Agency Provider (3a and 3b). More than one set of scales may be entered; however, only one set of scales will be used to calculate the LOC-R.

Form Status Field The following table describes the options for the FORM STATUS field.

Form Status	Description
Incomplete	Intended for use by the provider to indicate that the data entered is partial and will be completed soon.
Provider Complete	Intended for use by the provider to indicate that the data entered is complete and ready for the authority or Utilization Management review and authorization.
Complete	Intended for use by the authority or Utilization Management staff to indicate that all data has been entered and the center is finished with the assessment.

If the Form Status is marked **Incomplete** or **Provider Complete** for more than 30 days without being changed, the WebCARE [Auto-Delete](#) process will automatically delete the assessment.

For Update Assessments, if the Form Status is marked **Provider Complete** and the prior authorization is still valid, the assessment form will be [AutoCompleted](#). If the Provider wants the individual to be re-authorized or prefers that the Authority (UM staff) review the assessment, the **Authority Review Requested?** check box may be selected.

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Form Status Field
(continued)

When assessment forms are marked complete, modifications can be made for up to 7 days. The authority may also delete the entire assessment form within those 7 days. On the 8th day, assessments may be viewed only; no changes can be made.

Submit Update

Select the **Submit_Update** button.

Diagnostics
Qualifier

If a child or adolescent is diagnosed with a disorder (DSM-IV code entered on the Diagnostics screen in Axis I, Level 1) that can be either internalizing or externalizing symptoms, a separate field is displayed at the top of **Section 1: Child/Adolescent TRAG**. The **DIAGNOSTIC QUALIFIER** drop-down box is displayed and “Internalizing”, “Externalizing”, or “Not Yet Stable” must be selected before the LOC-R is calculated.

The screenshot displays a web-based assessment form. At the top, there are several input fields: 'Assessment Type' (dropdown), 'Reason for Discharge' (dropdown), 'Discharge Date (mmddyyyy)' (text), 'Location' (text), and 'Referred to' (dropdown). Below these are 'Referral Source' (dropdown), 'At Risk of Placement' (checkbox), and 'ED (special Education)' (checkbox). The main content area is divided into two sections: 'Section 1: Child / Adolescent TRAG' and 'Section 2: Community Data'. In Section 1, the 'Diagnosis: 2930 Delirium Due to ... (indicate the General Medical Condition)' is shown. Below it is the 'Diagnostic Qualifier' dropdown menu, which is open and shows three options: 'I - INTERNALIZING', 'E - EXTERNALIZING', and 'N - NOT YET STABILIZED'. A black arrow points to this dropdown menu. Below the dropdown are 'A. Ohio Scales' with sub-items '1a. Parent Ohio Problem Severity Scale Score (0-80)' and '1b. Parent Ohio Functioning Scale Score (0-80)', and '2a. Youth Ohio Problem Severity Scale Score (0-100)'. Each sub-item has a corresponding input field. Section 2, 'Section 2: Community Data', includes 'Within Last 90 Days:' with sub-items 'A. Number of Arrests', 'B. School Days Missed', 'C. Primary Residence Type' (dropdown), and 'D. Assessment Date (mmddyyyy)' (text).

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Results Screen After entering appropriate data and selecting **Submit_Update**, the following screen is displayed.

07-10-08 @16:46:19	164: MH Child & Adolescent Uniform Assessment for RDM	VC152171													
Open Error Code help for this screen															
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 30%;">Last Name</td><td>OKLAHOMA</td></tr> <tr><td>Suffix</td><td>.</td></tr> <tr><td>First Name</td><td>DALLAS</td></tr> <tr><td>Middle Name</td><td>.</td></tr> </table>	Last Name	OKLAHOMA	Suffix	.	First Name	DALLAS	Middle Name	.	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 30%;">Client ID</td><td>38342</td></tr> <tr><td>Component</td><td>030</td></tr> <tr><td>Local Case Number</td><td>000000099</td></tr> </table>	Client ID	38342	Component	030	Local Case Number	000000099
Last Name	OKLAHOMA														
Suffix	.														
First Name	DALLAS														
Middle Name	.														
Client ID	38342														
Component	030														
Local Case Number	000000099														
<input type="text" value="Type Of Entry:"/> <input type="button" value="Inquire"/>															
<p>Section 1: Child / Adolescent TRAG</p> <p>Diagnosis: 2971 Delusional Disorder Diagnostic Qualifier E - EXTERNALIZING</p> <p>A. Ohio Scales</p> <p>1a. Parent Ohio Problem Severity Scale Score (0-100) 24 1b. Parent Ohio Functioning Scale Score (0-80) 54 2a. Youth Ohio Problem Severity Scale Score (0-100) 2b. Youth Ohio Functioning Scale Score (0-80) 3a. Worker Ohio Problem Severity Scale Score (0-100) 3b. Worker Ohio Functioning Scale Score (0-80)</p> <p>B. CA-TRAG Dimension Ratings</p> <p>1. Problem Severity - Ohio Scale Score 24 2. Functioning - Ohio Scale Score 54 3. Risk of Self-harm 2 4. Severe Disruptive or Aggressive Behavior 4 5. Family Resources 4 6. History of Psychiatric Treatment 2 7. Co-occurring Substance Use 2 8. Juvenile Justice Involvement 3 9. School Behavior 2 10. Psychoactive Medication Treatment? NO C. Successfully Completed Service Package 1 or 2? NO</p> <p>D. Level of Care Decisions Calculated Level of Care Recommendation (LOC-R) 2.1 - INTENSV OUTPT - MULTI-SYST THER</p> <p>E. LOC-D Provider Recom. Deviation</p> <p>F. FOSTER CARE NO G. TCOOMMI Consumer? NO H. Assessment Date (mmddyyyy) 03152007 I. Extended Review Period Requested NO</p> <p>Assessed By ASDF Credentials 1 - QMHP-CS Notes</p>	<p style="text-align: center;">Section 2: Community Data</p> <p style="text-align: center;">Within Last 90 Days:</p> <p>A. Number of Arrests 2 B. School Days Missed 2 C. Primary Residence Type 1 - PRIVATE RESIDENCE D. Assessment Date (mmddyyyy) 03152007</p> <p>Notes</p> <hr/> <p style="text-align: center;">Section 3: Authorized Level of Care (LOC-A)</p> <p>A. Actual Level of Care Authorized LOC-A 2.1 - INTENSV OUTPT - MULTI-SYST THER</p> <p>B. Reasons for Deviation From LOC-R</p> <table style="width: 100%;"> <tr><td>Resource Limitations</td><td style="text-align: right;">NO</td></tr> <tr><td>Consumer Choice</td><td style="text-align: right;">NO</td></tr> <tr><td>Cont Care Per Um Guide</td><td style="text-align: right;">NO</td></tr> <tr><td>Consumer Need</td><td style="text-align: right;">NO</td></tr> <tr><td>Other</td><td style="text-align: right;">NO</td></tr> </table> <p>C. Authorization Date (mmddyyyy) 03152007</p> <p>Subject to Medicaid Fair Hearing NO Authorized By POU Credentials 1 - QMHP-CS Notes</p>	Resource Limitations	NO	Consumer Choice	NO	Cont Care Per Um Guide	NO	Consumer Need	NO	Other	NO				
Resource Limitations	NO														
Consumer Choice	NO														
Cont Care Per Um Guide	NO														
Consumer Need	NO														
Other	NO														
<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 30%;">Form Status</td><td>C - COMPLETE</td></tr> </table>	Form Status	C - COMPLETE	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr><td style="width: 30%;">Comment</td><td></td></tr> <tr><td>Prior Comment</td><td></td></tr> </table>	Comment		Prior Comment									
Form Status	C - COMPLETE														
Comment															
Prior Comment															
<p>COMP: 030 / CASE NO: 000000099 / LAST NAME: OKLAHOMA / FIRST NAME: DALLAS</p> <p>As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.</p> <p>Signature of LPHA: _____ LPHA Credentials: _____ Date: _____</p>															
<input type="button" value="Return_Request"/>															

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Note: Warning messages for child/adolescent data can be found at the top of the screen. Warnings do not prevent submission of information but provide important information regarding the data entered. In this case, verify data accuracy since the Ohio Scales Scores are outside expected results when compared to the dimension ratings.

Section 2 Data

The **Section 2: Community Data** fields can be entered at any time by Provider Qualified Mental Health Professional (QMHP) staff (including LVNs), but the date must be within 30 days of the **Section 1: Child/Adolescent TRAG ASSESSMENT DATE**.

For Intake and Update Assessments, this section is required every 90 days (or 180 days for Extended Review Period) and for “Completed Services” Discharges. Leave this section blank for Crisis Assessments and for Discharges other than “Completed Services”.

Section 3 Data

A Local Mental Health Authority (LMHA) Utilization Management or authorized staff person must enter **Section 3: Authorized Level of Care LOC-A** data. If the Recommended Level of Care (LOC-R) does not match the LOC-A, at least one appropriate deviation reason must be selected. The general comment field is intended for communication between the staff who perform the assessment and the authorizer or UM. Note: When an assessment is complete, only an authority or UM can delete the assessment within 7 days.

Exception: For LOC-A Y = YES Waiver, the Authorization Date must be entered within 30 days after the Section 1: TRAG Assessment Date entered

Notes: When an assessment is complete, only an authority can delete the assessment. For Update assessments, the LOC-A Assessment Date may be future-dated to allow for individual notification. The future-dated LOC-A Assessment date must also be within 14 days of the **Section 1: CA-TRAG ASSESSMENT DATE**.

Reasons for Deviation

When the REASONS FOR DEVIATION FROM LOC-R are required (LOC-R does not match LOC-A), then all appropriate reasons should be selected. When the LOC-A is lower intensity than the LOC-R, **Resource Limitations** and **Individual Choice** are appropriate reasons. If the LOC-A is higher intensity than the LOC-R, **Individual Need** and **Continuity of Care** are appropriate reasons. LOC-A of Y = YES Waiver is not included in the order of intensity. If the actual Level of Care Authorized (LOC-A) is Y = YES Waiver, and the Level of Care Recommended (LOC-R) is 9 = not eligible, then Consumer Need must

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

be the only Reason for Deviation. If LOC-A is Y for any LOC-R (other than 9), then Consumer Choice must be the only Reason for Deviation.

Reasons for Deviation (continued)

The Reasons for Deviation are:

- Resource Limitations – Used when the Adult LOC-R was more intensive than the LOC-A because there are not enough resources to offer the more intensive service package.
 - Individual Choice – Used when the individual did not want the more intensive service package recommended or when the eligible individual chooses to participate in the YES Waiver and has any LOC-R other than 9 = not eligible.
 - Continuity of Care per UM Guidelines – Used when the individual has been served in a more intensive service package, has improved, but still requires the higher intensity service package to become stabilized.
 - Individual Need – Used when the Adult LOC-R was less intensive than the LOC-A because (based on the authority’s clinical judgment and other information) the individual needs a more intensive service package or when the eligible individual chooses to participate in the YES Waiver and has a LOC-R of 9 = not eligible.
 - Other – Used when none of the other deviations describe the reason for deviation. Enter details regarding the deviation in the Notes field.
-

Authorizations

After an individual has an Intake Assessment, an Update Assessment must be entered every **90 days**, except for Extended Review Period that is every 180 days. The authorization period differs depending on the Level of Care authorized and the authorization must be re-authorized or changed within the period listed below:

<u>Level of Care (LOC)</u>	<u>Authorization Period Valid for Up To:</u>
Service Package 0 – Crisis Services	7 days (one time)
Service Package 1.1 or 1.2	90 days
Service Package 2.1, 2.2, 2.3, or 2.4	90 days
Service Package 4	180 days
LOC 5 – Crisis Follow-up	30 days
LOC 6 – Individual Refuses Services	0 days
LOC 8 – Waiting for All Authorized Services	365 days (Intake)
LOC 9 – Not Eligible for Services	0 days
LOC Y – YES Waiver	365 days

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

WebCARE Rule

The **Section 3: LOC-A** AUTHORIZATION DATE is the date the LOC-A becomes effective, must be the same or after the **Section 1: CA-TRAG** ASSESSMENT DATE, and must be within 14 days of the **Section 1: CA-TRAG** ASSESSMENT DATE. Exception: When the **Section 3: LOC-A** SUBJECT TO MEDICAID FAIR HEARING check box is selected, the **Section 3: LOC-A** AUTHORIZATION DATE must be within 30 days of the **Section 1: CA-TRAG** ASSESSMENT DATE. EXCEPTION: FOR LOC-A Y = YES WAIVER, THE AUTHORIZATION DATE MUST BE ENTERED WITHIN 30 DAYS AFTER THE SECTION 1: TRAG ASSESSMENT DATE ENTERED

Return Request

After selecting **Return_Request** near the bottom of the screen, WebCARE returns you to the following screen so that other individual data may be entered. Notice that the Component Code remains:

08-29-05 @10:25:48 164: MH Child & Adolescent Uniform Assessment for RDM VC152170

[Open Error Code help for this screen](#)

Component	030
Local Case Number	

[Print This Page](#)
[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

continued on next page

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Authorize Level of Care

When Peter's record is ready for Utilization Management or authority staff to authorize his level of care, data entry will continue with the following screen:

WebCARE Rule: 7 Days

A complete record can only be modified or deleted for up to 7 days. After 7 days, the complete record is viewable only with a **Look_At** button. If the **Section 3: Authorized Level of Care (LOC-A)** AUTHORIZATION DATE is future-dated for notification of appeals, the future-dated record can be modified or deleted for up to 7 days after the **Section 3: Authorized Level of Care (LOC-A)** AUTHORIZATION DATE.

Note: Only an authority or UM staff can delete a complete assessment within 7 days.

Update Record

Select the **Modify/Authorize** button to update Peter's record. In the center of the screen, the TYPE OF ENTRY is **Change**. When the appropriate information is entered and the **Submit_Update** button is selected, the screen is populated with all the processed information. Select **Return_Request** near the bottom of the screen to continue.

Intake Record Completed in Error

If the **Intake** record is completed in error and the **Delete** button is visible, select the **Delete** button and enter a new record by selecting **Create_New**. Note: Only an authority or UM staff can delete a complete assessment within 7 days.

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Assignment Record An assignment record should be entered in mainframe CARE to document where a person is receiving services and to track the individual's movement throughout the service delivery system.

Business Rule

Child/Adolescent individual's assessments must be reviewed every 90 days. If a *Crisis* record has been completed, an *Intake* record must be entered to continue services. After an *Intake* record has been completed, either an *Update* record or a *Discharge* record must be entered

For a list of all Business Rules, see [Error Codes and Related Business Rules](#).

WebCARE Rule: Date Edits

To allow for data entry of assessments and updated authorizations, WebCARE permits the following:

- The **Section 1: Child/Adolescent TRAG ASSESSMENT DATE** can be up to 30 days before today's date but not future dated.
- The **Section 2: Community Data ASSESSMENT DATE** can be up to 30 days before or after the **Section 1: Child/Adolescent TRAG ASSESSMENT DATE** and up to 30 days before or after the **Section 3: Authorized Level of Care (LOC-A) AUTHORIZATION DATE**.
- The **Section 3: Authorized Level of Care (LOC-A) AUTHORIZATION DATE** must be within 14 days of the **Section 1: Child/Adolescent TRAG ASSESSMENT DATE** and within 30 days of the **Section 2: Community Data ASSESSMENT DATE**. Exception: For LOC-A Y = YES Waiver, the Authorization Date must be entered within 30 days after the Section 1: TRAG Assessment Date entered.

Sample Screen

A sample **Complete Intake** record is shown below.

08-29-05 @11:00:58 164: MH Child & Adolescent Uniform Assessment for RDM VC152170

[Open Error Code help for this screen](#)

Last Name	PIPER	Client ID	35742
Suffix	.	Component	030
First Name	PETER	Local Case Number	0000009993
Middle Name	PEPPER		

LAST DIAGNOSIS COMP:030 / EFFECTIVE DT:07-01-2005 / PRINCIPAL DIAG:31401 / AXIS 5:49 / TRAG CATEGORY:EXT

	DATE	LOC-R	TYPE	STATUS	LOC - AUTHORIZED			Delete
					LEVEL	BEGIN	END	
Inq <input type="button" value="Correct/Modify"/>	08/01/05	Brief Outpatient - External	Intake	Complete	Brief Outpatient - External	08/01/05	10/30/05	

Status

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

Changes	<p>Complete The status for this <i>Intake</i> record is Complete, meaning the center is but Evaluation finished with this assessment. If any information in Sections 1, 2 or 3 of the <u>Uniform Assessment</u> for Peter Piper changes because a:</p> <ul style="list-style-type: none">• 90-day or other review has occurred,• TRAG dimension adjusts,• Community Data item alters, or• different Level of Care is deemed necessary <p>then an Update record must be added. To enter an <i>Update</i> record, select Create_New.</p>
Create Discharge Assessment	<p>When Peter Piper is ready to be discharged from the center and will no longer receive services, create a <i>Discharge</i> assessment by selecting the Create_New button. In this case, Peter would be discharged on a future date.</p>
Reasons for Discharge	<p>There are eight Discharge Reasons, but only seven reasons can be selected from the drop-down menu:</p> <p>C – Level of Care Service Complete. Use this reason when the person’s needs have been met and there is no further need for services (also known as “Planned Discharge”).</p> <p>E – Elected a New Provider. Use this reason when a person chooses to leave the current center provider to receive services from a different provider.</p> <p>J – Texas Youth Commission (TYC). Use this reason when a person is incarcerated for long periods of time. Do not discharge a person if incarcerated overnight or for a short-term stay. Continuing services following a short-term stay provides a smoother return into the community. Persons in Service Packages 1.1, 1.2, 2.1, 2.2, 2.3, or 2.4 can be incarcerated up to 30 days before being discharged. Note: The person must receive documented service activity during these time periods.</p> <p>M – Moved out of Local Service Area. Use this when the person has moved out the LSA. Note: If the individual is hospitalized short-term and is returning to the LSA after release, a discharge is not required.</p>

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

N – Never Returned for Services within Authorized Service Period, not to exceed 6 months. Use this reason when a person has been authorized for services and then:

- refuses services,
- doesn't show up for services, or
- cannot be found.

This option is selected only after a documented “good faith” effort (at least two attempts to contact the person through phone calls, letters, home or job visits, or program alerts) has been made to locate and contact the person.

P – Change in NorthSTAR Eligibility. Use this reason when a person's Medicaid eligibility changes the person's NorthSTAR eligibility, and thus, NorthSTAR enrollment. This reason may be used when the person's Medicaid eligibility initiates an enrollment into or out of NorthSTAR.

X – (System Generated) Auto-Closed. This option cannot be selected from the drop-down list and is automatically entered by WebCARE when an assessment has expired (authorization period has elapsed or assessment has expired).

Z – Other. This option is used for discharges related to Death or other reasons not listed above. Enter details in the COMMENTS field.

WebCARE Rule: Discharge

Discharge Dates for DISCHARGE REASON **C = Level of Care Services Complete** may be future-dated up to 14 days for planned discharges. All sections of the Child/Adolescent Assessment are required for DISCHARGE REASON **C = Level of Care Services Complete**. All other reasons for discharge may NOT be future-dated and do not require any sections to be completed. Discharge Dates may be dated up to 30 days prior to today's date. Exception: If the SUBJECT TO MEDICAID FAIR HEARING box is checked, most reasons for discharge may be future-dated up to 30 days, except for J = Texas Youth Commission.

The following screen shows a **Discharge** record that was created on 8/19/2005 but displays a date of 8/29/05 (the future date of discharge):

164: MH Child/Adolescent Uniform Assessment for RDM, Continued

08-29-05 @11:10:34 164: MH Child & Adolescent Uniform Assessment for RDM VC152170

[Open Error Code help for this screen](#)

Last Name	PIPER	Client ID	35742
Suffix	.	Component	030
First Name	PETER	Local Case Number	0000009993
Middle Name	PEPPER		

LAST DIAGNOSIS COMP:030 / EFFECTIVE DT:07-01-2005 / PRINCIPAL DIAG:31401 / AXIS 5:49 / TRAG CATEGORY:EXT

	DATE	LOCR	TYPE	STATUS	LOC - AUTHORIZED			Delete
					LEVEL	BEGIN	END	
Inq <input type="button" value="Correct/Modify"/>	08/29/05		Discharge	Complete				<input type="button" value="Delete"/>
Inq <input type="button" value="Correct/Modify"/>	08/05/05	Brief Outpatient - External	Update	Complete	Brief Outpatient - External	08/05/05	11/03/05	
Inq <input type="button" value="Correct/Modify"/>	08/01/05	Brief Outpatient - External	Intake	Complete	Brief Outpatient - External	08/01/05	10/30/05	

Discharge Record is Complete

When the Discharge record has been completed, (all sections are completed for REASON FOR DISCHARGE is **C=Level of Care Services Complete**), the authority or Utilization Management staff will change the FORM STATUS to **Complete**. Note: Only an authority or UM staff can delete a complete assessment within 7 days. A complete Discharge Assessment closes any mainframe CARE Assignments (TC codes) for the person.

Key Points

- **All Sections** are completed every 90 days by LMHA QMHP staff at Intake or by Provider QMHP staff at Update, unless an Extended Review Period is requested in **Section 1: CA-TRAG**.
- **Section 1: TRAG ASSESSMENT DATE** is compared to all other assessment dates to verify that these dates pass the business rules.
- The **Section 3: LOC-A AUTHORIZATION DATE** must be within 14 days of the **Section 1: TRAG ASSESSMENT DATE**. If **Section 3: LOC-A SUBJECT TO MEDICAID FAIR HEARING** has been checked, then the **Section 3: LOC-A AUTHORIZATION DATE** must be within 30 days of the **Section 1: TRAG ASSESSMENT DATE**. Exception: For LOC-A Y = YES Waiver, the Authorization Date must be entered within 30 days after the Section 1: TRAG Assessment Date entered.
- All other section dates must be within 30 days of the **Section 1: CA-TRAG ASSESSMENT DATE**.

This is the final step for a child/adolescent.

RDM Workflow / Reports

Introduction

The Workflow / Reporting modules in the WebCARE system allows one to display or print specific individual information and component information. These reports are provided to assist centers in reducing partially completed records and to help identify assessments requiring updates, resulting in timely and sequential completion of assessments. These reports may also be used for files batched to WebCARE and for Electronic Data Transfer System (EDTS) files created by WebCARE. For more information, see [Batch Processing and EDTS](#) of this manual.

Reports

246 Incomplete/Provider Complete Assessments - Adult

Business Rule

All **Incomplete** or **Provider Complete** records will be completed within 30 days. The goal is to prevent the entry of partial records that are not completed in a timely manner.

WebCARE Rule

All **Incomplete** or **Provider Complete** records older than 30 days will be deleted from the operational system.

Review Report Continuously

It is recommended that this report be reviewed continuously by the Utilization Management or authority staff to identify records requiring authorization.

RDM Workflow / Reports, Continued

Select Report

To identify outstanding adult assessments requiring update or completion, select 246 RDM Incomplete/Provider Complete Assessments – Adult on the RDM Main Menu.

08-29-05 @16:42:26 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

Request Screen screen is shown below.

A sample 246: RDM Incompl/Provider Compl Assessments-Adult

08-29-05 @16:45:08 246:RDM Incompl/Provider Compl Assessments-Adult VC110370

[Open Error Code help for this screen](#)

Component 030

[08222005] Through [08292005]

Options

Location []

Include : Incomplete	<input checked="" type="checkbox"/>	Include : Provider Complete	<input checked="" type="checkbox"/>	Sort By	Case <input type="radio"/>	Date <input type="radio"/>	Lastup Id <input type="radio"/>	Provider Location <input type="radio"/>
-------------------------	-------------------------------------	--------------------------------	-------------------------------------	------------	----------------------------	----------------------------	------------------------------------	--

[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

RDM Workflow / Reports, Continued

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the dates through which you are checking for Incomplete or Provider Complete records. <u>Note:</u> The second date of the date range must be today's date or a past date. Today's date is automatically populated and a date one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed.
3	Click the box to select whether you want to include Incomplete records, Provider Complete records or both. <u>Note:</u> The default is set to both types of partially completed records.
4	Click to include Incomplete or Provider Complete records and select the appropriate SORT BY radio button. You can sort the report by local case number, date or the ID of the person who last updated the record or provider location. This step is optional.
5	Select Submit_Request when all the options have been set.

No Records Found If no records are found, then no **Incomplete** or **Provider Complete** records meet the criteria set for the report. You may broaden the criteria for a more thorough search.

Records are Found If records are found, a screen similar to the one below will be displayed. All records are modifiable and should be completed as soon as practical.

08-29-05 @16:48:49 246:RDM Incompl/Provider Compl Assessments-Adult VC110370

[Open Error Code help for this screen](#)

Component 030

01-01-2005 Through 08-29-2005

Options

Location

Include : Incomplete YES Include : Provider Complete YES Sort By

3 RECORD(S) FOUND.

	DATE	NAME	CASE	LOCR	TYPE	STATUS	LOCA	LAST UPDATED BY	LOCATION
	02/10/05	Day, Rainy	0000001020	Serv Pack 1	Update	Prov Comp	Serv Pack 1	6551711	
	02/23/05	Mug, My	0000002030	Not Eligible	Intake	Incomplete	Serv Pack 1	6552382	030
	08/01/05	Nothing, Sometimes	0000321321	Sp4 - Act	Intake	Incomplete		6552382	

RDM Workflow / Reports, Continued

Two Records Listed for One Case

If two Incomplete/Provider Complete records are listed for one Case, the oldest assessment must be completed first. This situation usually occurs when an individual is in crisis and a Crisis assessment has been entered. The Crisis assessment is awaiting authorization but in the meantime, the individual has recovered quickly and an Intake Assessment is entered before the Crisis assessment has been authorized and completed.

Change Record

When you select the **Modify** or **Authorize** button, the 346: Adult Uniform Assessment screen for changing a record displays. A sample screen is shown below.

08-29-05 @16:51:38 346: MH Adult Uniform Assessment for RDM VC111397

[Open Error Code help for this screen](#)

Last Name	DAY	Client ID	33995
Suffix	.	Component	030
First Name	RAINY	Local Case Number	0000001020
Middle Name			

Type Of Entry: ←

Assessment Type: Reason for Discharge:

Location: Discharge Date (mmddyyyy):

Referred to:

Section 1: Adult TRAG & Recommended LOC		Section 3: Diag - Spec Clinical Rating Scales	
A. Adult - TRAG Dimension Ratings		A. Schizophrenia Algorithm (PSRS & BNSA)	
1. Risk of Harm	<input type="text" value="2"/>	Total Positive Symptom Rating Scale (PSRS) (4-28)	<input type="text" value="4"/>
2. Support Needs	<input type="text" value="2"/>	Total Brief Negative Symptom Assessment (BNSA)	<input type="text" value="4"/>

Enter Data to Complete Record

Enter all required information to complete the record (usually entered by the authority or Utilization Management staff) and select **Submit_Update** at the bottom of the screen. The completed screen will display. Select **Return_To_List** to return to the 246: RDM Incomplete/ Provider Complete Assessments list of outstanding records. The record you just completed is no longer in the list because it has been completed. A sample screen is shown below.

RDM Workflow / Reports, Continued

08-29-05 @16:57:28
246:RDM Incompl/Provider Compl Assessments-Adult
VC110370

[Open Error Code help for this screen](#)

Component 030

01-01-2005 Through 08-29-2005

Options

Location

Include : Incomplete YES
Include : Provider Complete YES
Sort By

2 RECORD(S) FOUND.

	DATE	NAME	CASE	LOCR	TYPE	STATUS	LOCA	LAST UPDATED BY	LOCATION
Modify	02/23/05	Mug, My	0000002030	Not Eligible	Intake	Incomplete	Serv Pack 1	6552382	030
Modify	08/01/05	Nothing, Sometimes	0000321321	Sp4 - Act	Intake	Incomplete		6552382	

247: Assessments Expiring by Section – Adult

Purpose The purpose of 247: RDM Assessments Expiring by Section – Adult is to provide a tool to monitor when an individual should be scheduled for another evaluation so that a new assessment is entered in a timely manner.

Assessments Expire WebCARE assessments expire when any of the following conditions exists:

1. The **Section 1: TRAG** has not been updated within 90 days (or 120 days in WebCARE to allow for data entry). Exception: **Extended Review Period** for adults has been selected, then 180 days (or 210 days in WebCARE to allow for data entry), or
2. The **Level of Care Authorized (LOC-A) End Date** has been reached (or 30 days after the **End Date** in WebCARE to allow for data entry). The **Level of Care Authorized (LOC-A) End Date** is calculated based on the service package selected.

Select Report Select 247: RDM Assessments Expiring by Section – Adult on the RDM Main Menu.

08-30-05 @08:32:28 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

M Main Menu
Q Quit

247: Assessments Expiring by Section – Adult, Continued

Request Screen

Select 247: RDM Assessments Expiring by Section – Adult. When a completed assessment has been complete for over 7 days, the record is no longer modifiable. When a complete but expired record is displayed, the **Look_At** button is visible. A sample screen is shown below.

Note: Occasionally, an **Incomplete** or **Provider Complete** assessment will display on an expiring report. The record may still be modifiable.

08-30-05 @08:35:34 247: RDM Assessments Expiring By Section - Adult VC110372

[Open Error Code help for this screen](#)

Component 030

Expiring Between 08302005 And 09062005

Options

Location

Section 1

Sort By Case Date Lastup Id Provider Location

Submit_Request Reset

[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the dates of potentially expiring records.
3	Use the drop down menu to select Section 1 (90-day TRAG rule), Section 2: LOC-A End Date , or other workflow issues in Sections 3 or 4 .
4	Click to include Incomplete or Provider Complete records and select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, or provider location. This step is optional.
5	Click Submit_Request when all the options have been set.

247: Assessments Expiring by Section – Adult, Continued

No Records Found If no expiring records are found for the component, date range, and section combination, the following screen is displayed.

The screenshot shows the application interface with the following elements:

- Header: 08-30-05 @08:38:29, 247: RDM Assessments Expiring By Section - Adult, VC110372
- Link: [Open Error Code help for this screen](#)
- Form Fields:
 - Component 030
 - Expiring Between 08-30-2005 And 09-06-2005
 - Options
 - Location
 - Section 1
 - Sort By Date
- Message: NO RECORDS FOUND. (indicated by a black arrow pointing to the text)

At Least One Record is Found If at least one expiring record is found for the component, date range, and section combination entered, a screen similar to the following screen is displayed.

The screenshot shows the application interface with the following elements:

- Header: 08-30-05 @08:41:20, 247: RDM Assessments Expiring By Section - Adult, VC110372
- Link: [Open Error Code help for this screen](#)
- Form Fields:
 - Component 030
 - Expiring Between 01-01-2005 And 09-06-2005
 - Options
 - Location
 - Section 1
 - Sort By Date
- Message: THERE WERE 8 RECORDS FOUND.
- Table:

	SECTION 1 DATE	NAME	CASE	LOCR	TYPE	STATUS	LOCA	LAST UPDATED BY	LOCATION
Look_At	10/19/04	Cup, Coffee	0000000021	Serv Pack 1	Update	Complete	Serv Pack 1	6551711	
Modify	11/01/04	Eraser, Brick	0000001018	Sp4 - Act	Intake	Incomplete	Sp4 - Act	6551711	
Look_At	11/01/04	Decervantes, Miguel	0000001616	Serv Pack 3	Intake	Complete	Serv Pack 3	6552383	
Modify	02/23/05	Mug, My	0000002030	Not Eligible	Intake	Incomplete	Serv Pack 1	6552382	030

Remove a Record To remove a record from the expiring list, enter an Update or Discharge record. If an **Incomplete** or **Provider Complete** assessment exists for the individual, then their previous assessment will not be on this list.

248: Assessments to Expire - Adult

Purpose

The purpose of the 248: RDM Assessments to Expire – Adult is to provide a tool that considers all sections of the assessment to monitor when an individual should be scheduled for another evaluation so that a new assessment is entered in a timely manner. The 248: RDM Assessments to Expire – Adult is the same report as 247: RDM Assessments Expiring by Section – Adult except that Sections 1 and 2 are checked at the same time. This report is designed to show which assessments will expire according to existing business rules.

Note: Occasionally, an **Incomplete** or **Provider Complete** assessment will display on an expiring report. The record may still be modifiable.

WebCARE

Assessments Expire

WebCARE assessments expire when any of the following conditions exists:

1. The **Section 1: TRAG** has not been updated within 90 days (or 120 days in WebCARE to allow for data entry). **Exception:** EXTENDED REVIEW PERIOD for adults has been selected, then 180 days (or 210 days in WebCARE to allow for data entry), or
 2. The **Level-of-Care Authorized (LOC-A) END DATE** has been reached (or 30 days after the END DATE in WebCARE to allow for data entry).
-

Select Report

Select 248: RDM Assessments to Expire – Adult on the RDM Main Menu.

08-30-05 @08:45:29 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

M Main Menu
Q Quit

248: Assessments to Expire – Adult, Continued

Request Screen

A sample 248: RDM Assessments to Expire – Adult request screen is shown below.

10-12-07 @08:43:57 248: RDM Assessments To Expire - Adult VC110374

[Open Error Code help for this screen](#)

Component

Through

Options

Location

Sort By Case Date Lastup Id LOC Authorized Provider Location

THIS REPORT HAS BEEN MODIFIED, IT NOW CONTAINS A SECTION 1 EXPIRATION DATE

[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the dates of potentially expiring records.
3	Enter the location in the LOCATION field, if appropriate.
4	Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, the Level of Care Authorized, or by the provider location.
5	Click Submit_Request when all the options have been set.

continued on next page

248: Assessments to Expire – Adult, Continued

No Expiring
Records Found

If no expiring records are found for the component, date range, and location combination, the following screen is displayed.

10-12-07 @08:51:20 248: RDM Assessments To Expire - Adult VC110374

[Open Error Code help for this screen](#)

Component 030
10-12-2007 Through 10-19-2007
Options
Location
Sort By <input type="text" value="Date"/>

NO RECORDS FOUND.

[Return to Request](#)
[Return to Resiliency & Disease Management Memu](#)
[Return to CARE Main Memu](#)
[Quit](#)

Record is Found

If at least one expiring record is found for the component, date range, and location combination entered, a similar screen to the following screen is displayed.

10-12-07 @08:53:10 248: RDM Assessments To Expire - Adult VC110374

[Open Error Code help for this screen](#)

Component 030
10-12-2005 Through 10-19-2007
Options
Location
Sort By <input type="text" value="Date"/>

5 RECORD(S) FOUND.

	SECT. 1 DATE (EXP. DATE)	LOCA END DATE	NAME	CASE	LOCR	TYPE	STATUS	LOCA	LAST UPDATED BY	LOCATION
<input type="button" value="Look_At"/>	04/02/05 (07/01/05)	04/03/06	Magnolia, Maria	0000004444	Serv Pack 1	Intake	Complete	Serv Pack 1	6552382	
<input type="button" value="Look_At"/>	04/08/05 (07/07/05)	04/07/06	Mouse, Minnie	0000012345	Serv Pack 1	Intake	Complete	Serv Pack 1	655TR01	
<input type="button" value="Look_At"/>	07/22/05 (10/20/05)	07/21/06	Stuff, Some	0000000654	Serv Pack 1	Update	Complete	Serv Pack 1	655TR02	
<input type="button" value="Look_At"/>	08/04/05 (11/02/05)	08/03/06	Miles, Miles	0000000789	Serv Pack 1	Intake	Complete	Serv Pack 1	655TR01	
<input type="button" value="Look_At"/>	08/04/05 (11/02/05)	08/03/06	Jones, Bill	0000000999	Serv Pack 1	Intake	Complete	Serv Pack 1	655TR01	

248: Assessments to Expire – Adult, Continued

Remove Records
from List

To remove these records from the expiring list, enter an **Update** or **Discharge** assessment. If an **Incomplete** or **Provider Complete** assessment exists for the individual, then their previous assessment will not be on this list.

251: Completed Assessments - Adult

Purpose

The purpose of the 251: RDM Completed Assessments – Adult report is for data verification and for printing the completed assessment that has the Medically Necessary statement for signature.

Business Rule

WebCARE assessments are complete when all sections of the assessment have been entered and have passed all business rules and it has been marked **Complete** by the center. If a Medicaid individual is receiving services (**Intake** or **Update** assessment), the Medically Necessary statement must be signed by the LPHA.

Select Report

Select 251: Completed Assessments – Adult on the RDM Main Menu.

08-30-05 @08:59:13 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

M Main Menu
Q Quit

251: Completed Assessments - Adult, Continued

Request Screen

A sample 251: RDM Completed Assessments – Adult request screen is shown below.

Note: If seven days has passed, the record is no longer modifiable and the **Look_At** button is visible.

08-30-05 @09:01:07 251: RDM Completed Assessments - Adult VC110376

[Open Error Code help for this screen](#)

Component 030
[08232005] Through [08302005]
Options
Location []
Autocompleted Only ? <input type="checkbox"/>
Sort By Case <input type="radio"/> Date <input checked="" type="radio"/> Lastup Id <input type="radio"/> LOC Authorized <input type="radio"/> Location <input type="radio"/>

Submit_Request Reset

[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the dates of completed records. <u>Note</u> : The second date of the date range must be today's date or a past date. Today's date is automatically populated and a date one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed.
3	Enter the location in the LOCATION field, if appropriate.
4	Click to select AUTOCOMPLETED ONLY? if you prefer to view AutoCompleted records Only. Refer to the beginning of this chapter for more information on AutoCompletion.
5	Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, the date that the Level of Care was authorized, or by the provider location.
6	Click Submit_Request when all the options have been set.

251: Completed Assessments - Adult, Continued

No Records Found If no completed records are found for the component, date range, and location, the following screen is displayed.

08-30-05 @09:02:55
251: RDM Completed Assessments - Adult
VC110376

[Open Error Code help for this screen](#)

Component 030
08-23-2005 Through 08-30-2005
Options
Location
Autocompleted Only ? NO
Sort By <input type="text"/> Date

NO RECORDS FOUND.

Records are Found If at least one completed record is found for the component, date range, and location combination entered, the following screen is displayed.

08-30-05 @09:04:40
251: RDM Completed Assessments - Adult
VC110376

[Open Error Code help for this screen](#)

Component 030
01-01-2005 Through 08-30-2005
Options
Location
Autocompleted Only ? NO
Sort By <input type="text"/> Date

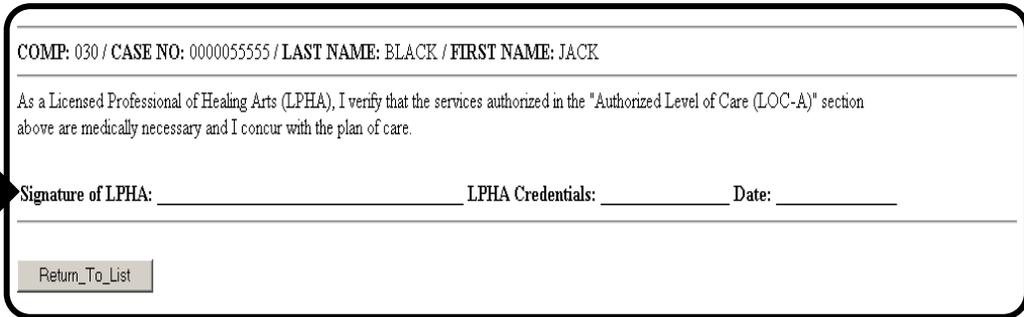
54 RECORD(S) FOUND.

	DATE	NAME	CASE	LOCR	TYPE	STATUS	AUTO COMP LETED	LOCA	LAST UPDATED BY	LOCATION
Look_At	01/01/05	Black, Jack	0000055555	Serv Pack 2	Update	Complete	No	Serv Pack 1	6552382	
Look_At	01/10/05	Black, Jack	0000055555		Discharge	Complete	No		6552382	
Look_At	01/10/05	Black, Jack	0000055555	Crisis Serv	Intake	Complete	No	Sp4 - Act	6552382	
Look_At	01/18/05	Day, Rainy	0000001020	Serv Pack 1	Update	Complete	No	Serv Pack 1	6551711	
Look_At	01/21/05	Black, Jack	0000055555	Serv Pack 1	Update	Complete	No	Waiting	6552382	

251: Completed Assessments - Adult, Continued

Medicaid
Individual

If an individual listed is a Medicaid individual, select **Look_At** to print and sign the Medically Necessary statement at the bottom of the screen. A sample screen is shown below.



COMP: 030 / CASE NO: 0000055555 / LAST NAME: BLACK / FIRST NAME: JACK

As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.

Signature of LPHA: _____ LPHA Credentials: _____ Date: _____

252: Autoclosures – Adult

Purpose

The purpose of the 252: RDM Autoclosures – Adult report is for data verification and for authority or Utilization Management staff to review adult assessments that were automatically deleted.

Select Report

Select 252: Autoclosures – Adult on the RDM Main Menu.

08-30-05 @09:10:36 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

[M](#) Main Menu
[Q](#) Quit

continued on next page

252: Autoclosures – Adult, Continued

Request Screen

A sample 252: RDM Autoclosures – Adult request screen is shown below.

08-30-05 @09:12:43 252: RDM Autoclosures - Adult VC110380

[Open Error Code help for this screen](#)

Component 030

[08232005] Through [08302005]

Options

Location []

Sort By Case Date Lastup Id LOC Authorized Location

Submit_Request

[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the dates of Autoclosed records. <u>Note:</u> The second date of the date range must be today's date or a past date. Today's date is automatically populated and a date one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed.
3	Enter the location in the LOCATION field, if appropriate.
4	Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, the date that the Level of Care was authorized, or by the provider location.
5	Click Submit_Request when all the options have been set.

252: Autoclosures – Adult, Continued

No Records Found If no completed records are found for the component, date range, and location, the following screen is displayed.

The screenshot shows a web application interface with the following elements:

- Header: 08-30-05 @09:17:37, 252: RDM Autoclosures - Adult, VC110380
- Link: [Open Error Code help for this screen](#)
- Form fields:
 - Component 030
 - 08-23-2005 Through 08-30-2005
 - Options
 - Location
 - Sort By Date
- Message: **NO RECORDS FOUND.** (indicated by a black arrow)
- Footer links:
 - [Return to Request](#)
 - [Return to Resiliency & Disease Management Menu](#)
 - [Return to CARE Main Menu](#)
 - [Quit](#)

Records are Found If at least one completed record is found for the component, date range, and location combination entered, the following screen is displayed.

The screenshot shows the same web application interface as above, but with the following differences:

- Header: 08-30-05 @09:20:18, 252: RDM Autoclosures - Adult, VC110380
- Form fields:
 - Component 030
 - 01-01-2001 Through 08-30-2005
 - Options
 - Location
 - Sort By Date
- Message: 1 RECORD(S) FOUND.
- Table:

	DATE	NAME	CASE	TYPE	STATUS	LAST UPDATED BY	LOCATION
Look_At	12/17/03	Redoak, Rodney	0000000001	Discharge	Complete	LC027389	

264: Incomplete/Provider Complete Assessments – Child

Purpose The purpose of the 264: RDM Incomplete/Provider Complete Assessments – Child report is to identify outstanding child/adolescent assessments requiring update or completion.

Business Rule All **Incomplete** or **Provider Complete** records will be completed within 30 days. The goal is to prevent the entry of partial records that are not completed in a timely manner.

WebCARE Rule All **Incomplete** or **Provider Complete** records older than 30 days will be Autoclosed and deleted from the operational system.

Review Daily It is recommended that this report be reviewed daily.

Select Report Select 264: Incomplete/Provider Complete Assessments - Child on the RDM Main Menu.

08-30-05 @09:22:41 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

[M](#) [Main Menu](#)
[Q](#) [Quit](#)

264: Incomplete/Provider Complete Assessments – Child, Continued

Request Screen

A sample 264: RDM Incomplete/Provider Complete Assessments – Child request screen is shown below.

08-30-05 @09:24:38
264:RDM Incompl/Provider Compl Assessments-Child
VC150370

[Open Error Code help for this screen](#)

Component 030

Through

Options

Location

Include : Incomplete

Include : Provider Complete

Sort By
 Case
 Date
 Lastup Id
 Provider Location

Submit_Request
Reset

[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the dates of Incomplete or Provider Complete records. <u>Note:</u> The second date of the date range may not be a future date and the first date may not be before the second date.
3	Enter the location in the LOCATION field, if appropriate.
4	Click to include Incomplete or Provider Complete records and select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, or the provider location.
5	Click Submit_Request when all the options have been set.

264: Incomplete/Provider Complete Assessments – Child, Continued

No Records Found If no records are found, then no **Incomplete** or **Provider Complete** records meet the criteria set for the report. You may broaden the criteria for a more thorough search. The following screen is displayed if no records are found.

08-30-05 @09:26:19 264:RDM Incompl/Provider Compl Assessments-Child VC150370

[Open Error Code help for this screen](#)

Component 030		
08-23-2005 Through 08-30-2005		
Options		
Location		
Include : Incomplete <input type="checkbox"/> YES	Include : Provider Complete <input type="checkbox"/> YES	Sort By <input type="text"/> Date

NO RECORDS FOUND.

Records are Found If records are found, a screen similar to the one below will be displayed. All records are modifiable and should be corrected as soon as practical. To authorize a Level of Care, select the **Authorize** button. To change a record, select the **Modify** button to the left of the record to be updated.

08-30-05 @09:28:40 264:RDM Incompl/Provider Compl Assessments-Child VC150370

[Open Error Code help for this screen](#)

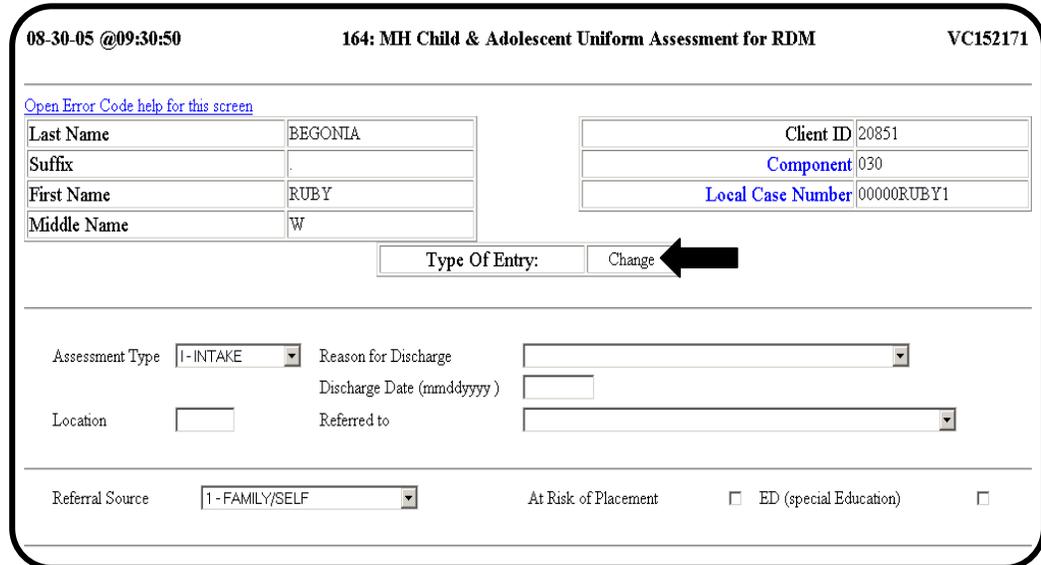
Component 030		
01-01-2005 Through 08-30-2005		
Options		
Location		
Include : Incomplete <input type="checkbox"/> YES	Include : Provider Complete <input type="checkbox"/> YES	Sort By <input type="text"/> Date

2 RECORD(S) FOUND.

	DATE	NAME	CASE	LOCR	TYPE	STATUS	LOCA	LAST UPDATED BY	LOCATION
Modify	05/01/05	Begonia, Ruby	00000ruby1	Treatment Foster Care	Intake	Incomplete		6552383	
Authorize	08/16/05	Numbers, Sequenced	0000321654	Brief Outpatient - Internal	Update	Prov Comp		6552382	

264: Incomplete/Provider Complete Assessments – Child, Continued

Change Assessment As an authority, when you select the **Authorize** button, the 164: MH Child & Adolescent Uniform Assessment for RDM screen for changing an assessment displays.



08-30-05 @09:30:50 164: MH Child & Adolescent Uniform Assessment for RDM VC152171

[Open Error Code help for this screen](#)

Last Name	BEGONIA	Client ID	20851
Suffix	.	Component	030
First Name	RUBY	Local Case Number	00000RUBY1
Middle Name	W		

Type Of Entry: ←

Assessment Type: Reason for Discharge:

Discharge Date (mmddyyyy):

Location: Referred to:

Referral Source: At Risk of Placement: ED (special Education):

Enter Data

Enter all required information to complete the record, change the FORM STATUS to **Complete** and select **Submit_Update** at the bottom of the screen. The completed screen will display. Select **Return To List** to return to the 264: RDM Incomplete/Provider Complete Assessments – Child list of outstanding records. The record you just completed is no longer in the list because it has been marked **Complete**.

265: Assessments Expiring - Child

Purpose

The purpose of the 265: Assessments Expiring – Child report is to identify all potentially expiring child/adolescent assessments. All Child/Adolescent Assessments expire after 90 days.

Select Report

Select 265: Assessments Expiring – Child on the RDM Main Menu.

08-30-05 @09:33:38 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

M [Main Menu](#)
Q [Quit](#)

continued on next page

265: Assessments Expiring – Child, Continued

Request Screen

A sample 265: Assessments Expiring – Child screen is shown below.

08-30-05 @09:35:37 265: RDM Assessments Expiring - Child VC150372

[Open Error Code help for this screen](#)

Component 030

08302005 Through 09062005

Location

Sort By Case Date Lastup Id Provider Location

Submit_Request

[Return to Resiliency & Disease Management Menu](#)
[Return to CARE Main Menu](#)
[Quit](#)

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the date range of potentially expiring child/adolescent assessments.
3	Enter the location in the LOCATION field, if appropriate.
4	Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, or the provider location.
5	Click Submit_Request when all the options have been set.

265: Assessments Expiring – Child, Continued

No Records Found If no expiring records are found for the component and date range combination, the following screen is displayed.

Note: Occasionally, an **Incomplete** or **Provider Complete** assessment will display on an expiring report. The record may still be modifiable.

08-30-05 @09:50:04 265: RDM Assessments Expiring - Child VC150372

[Open Error Code help for this screen](#)

Component 030
08-30-2005 Through 09-06-2005
Location
Sort By <input type="text" value="Date"/>

NO RECORDS FOUND.

Record is Found If at least one expiring record is found for the component, date range, and section combination entered, the following screen is displayed.

08-30-05 @09:53:25 265: RDM Assessments Expiring - Child VC150372

[Open Error Code help for this screen](#)

Component 030
10-09-2004 Through 09-06-2005
Location
Sort By <input type="text" value="Date"/>

THERE WERE 2 RECORDS FOUND.

	DATE	NAME	CASE	LOCR	TYPE	STATUS	LOCA	LAST UPDATED BY	LOCATION
<input type="button" value="Look_At"/>	07/11/04	Mcgrath, Glenda	0000000333	Brief Outpatient - Internal	Intake	Complete	Brief Outpatient - Internal	6552382	
<input type="button" value="Look_At"/>	03/15/05	Piper, Peter	0000009997	Crisis Service	Crisis	Complete	Crisis Service	6552383	

Remove Records From List

To remove these records from the expiring list, enter an **Update** or **Discharge** assessment. If an **Incomplete** or **Provider Complete** assessment exists for the individual, then their previous assessment will not be on this list.

267: Completed Assessments - Child

Purpose

The purpose of this report is for data verification and for printing the completed assessment that has the Medically Necessary statement for signature.

Business Rule

WebCARE assessments are complete when all sections of the assessment have been entered, have passed all business rules, and have been marked **Complete** by the center. If a Medicaid individual is receiving services (**Intake** or **Update** assessment), the Medically Necessary statement must be signed by the LPHA.

Select Report

Select 267: Completed Assessments – Child on the RDM Main Menu.

08-30-05 @09:55:17 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
325	Client Registration	246	Incomplete/ Provider Complete Assessments - Adult
330	Diagnostics	247	Assessments Expiring By Section - Adult
164	MH Child Uniform Assessment for RDM	248	Assessments to Expire - Adult
346	MH Adult Uniform Assessment for RDM	251	Completed Assessments - Adult
		252	Autoclosures - Adult
		264	Incomplete/ Provider Complete Assessments - Child
		265	Assessments Expiring - Child
		267	Completed Assessments - Child
		268	Autoclosures - Child

M Main Menu
Q Quit

267: Completed Assessments – Child, Continued

Request Screen

A sample 267: RDM Completed Assessments – Child screen is shown below. If seven days has passed and if a completed assessment expires, the record is no longer modifiable and the **Look_At** button is visible.

08-30-05 @09:57:09 267: RDM Completed Assessments - Child VC150376

[Open Error Code help for this screen](#)

Component 030

[08232005] Through [08302005]

Options

Location []

Sort By Case Date Lastup Id LOC Authorized Provider Location

Submit_Request Reset

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the dates of completed records. <u>Note:</u> The second date of the date range must be today's date or a past date. Today's date is automatically populated and a date that is one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed.
3	Enter the location code in the LOCATION field, if appropriate.
4	Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, date the Level of Care was authorized, or provider location.
5	Click Submit_Request when all the options have been set.

267: Completed Assessments – Child, Continued

No Records Found If no completed records are found for the component, date range, and location, the following screen is displayed.

08-30-05 @09:59:12 267: RDM Completed Assessments - Child VC150376

[Open Error Code help for this screen](#)

Component 030
08-30-2005 Through 08-30-2005
Options
Location
Sort By <input type="text" value="Date"/>

NO RECORDS FOUND.

Completed Record is Found If at least one completed record is found for the component, date range, and location combination entered, a screen similar to the following is displayed.

08-30-05 @10:01:11 267: RDM Completed Assessments - Child VC150376

[Open Error Code help for this screen](#)

Component 030
01-01-2005 Through 08-30-2005
Options
Location
Sort By <input type="text" value="Date"/>

31 RECORD(S) FOUND.

	DATE	NAME	CASE	LOCR	TYPE	LOCA	LAST UPDATED BY	LOCATION
Look_At	01/01/05	Baker, Alice	0000003334	Brief Outpatient - External	Intake	Brief Outpatient - External	6552383	
Look_At	01/01/05	Baker, Alice	0000003334	Intensv Outpt - Multi-syst Ther	Discharge		6552383	

267: Completed Assessments – Child, Continued

Medicaid
Individual

If an individual listed is a Medicaid individual, select **Look_At** to print and sign the Medically Necessary statement at the bottom of the screen.

COMP: 030 / CASE NO: 0000009993 / LAST NAME: PIPER / FIRST NAME: PETER

As a Licensed Professional of Healing Arts (LPHA), I verify that the services authorized in the "Authorized Level of Care (LOC-A)" section above are medically necessary and I concur with the plan of care.

Signature of LPHA: _____ LPHA Credentials: _____ Date: _____

268: Autoclosures - Child

Purpose

The purpose of the 268: RDM Autoclosures – Child report is for data verification and for authority or Utilization Management staff to review adult assessments that were automatically deleted.

Select Report

Select 268: Autoclosures – Child on the RDM Main Menu.

08-30-05 @10:06:18 RDM:Resiliency & Disease Management VC110150

Data Entry		Workflow / Reports	
<u>325</u>	Client Registration	<u>246</u>	Incomplete/ Provider Complete Assessments - Adult
<u>330</u>	Diagnostics	<u>247</u>	Assessments Expiring By Section - Adult
<u>164</u>	MH Child Uniform Assessment for RDM	<u>248</u>	Assessments to Expire - Adult
<u>346</u>	MH Adult Uniform Assessment for RDM	<u>251</u>	Completed Assessments - Adult
		<u>252</u>	Autoclosures - Adult
		<u>264</u>	Incomplete/ Provider Complete Assessments - Child
		<u>265</u>	Assessments Expiring - Child
		<u>267</u>	Completed Assessments - Child
		<u>268</u>	Autoclosures - Child

M Main Menu
Q Quit

268: Autoclosures - Child, Continued

Request Screen

A sample 268: RDM Autoclosures – Child screen is shown below.

Step	Action
1	Enter your Component code in the COMPONENT field, if Component code has not already been entered.
2	Enter the dates of Autoclosed records. <u>Note:</u> The second date of the date range must be today's date or a past date. Today's date is automatically populated and a date that is one week in the past is entered for the first date. The first date cannot be after the second date. Either date may be changed.
3	Enter the location code in the LOCATION field, if appropriate.
4	Click to select the appropriate SORT BY radio button. You can sort the report by local case number, date, the ID of the person who last updated the record, date the Level of Care was authorized, or provider location.
5	Click Submit_Request when all the options have been set.

268: Autoclosures - Child, Continued

No Records Found If no completed records are found for the component, date range, and location, the following screen is displayed.

08-30-05 @10:11:55 268: RDM Autoclosures - Child VC150380

[Open Error Code help for this screen](#)

Component 030
08-23-2005 Through 08-30-2005
Options
Location
Sort By <input type="text" value="Date"/>

NO RECORDS FOUND.

Completed Record is Found If at least one completed record is found for the component, date range, and location combination entered, a screen similar to the following is displayed.

08-30-05 @10:15:33 268: RDM Autoclosures - Child VC150380

[Open Error Code help for this screen](#)

Component 030
01-01-2001 Through 05-26-2005
Options
Location
Sort By <input type="text" value="Date"/>

1 RECORD(S) FOUND.

	DATE	NAME	CASE	TYPE	LAST UPDATED BY	LOCATION
<input type="button" value="Look_At"/>	02/26/05	Day, Sunny	000000b234	Discharge	LC027389	

Automated Processes

Automated Processes

WebCARE has three automated processes that are designed to keep mainframe CARE/WebCARE data accurate:

- Autoclose
 - AutoComplete
 - Auto-Delete
-

Autoclose

Adult and child/adolescent Crisis, Intake, or Update assessments are Autoclosed 30 days after their **Section 1: TRAG** or **LOC-A** authorization expires retroactive to the date of expiration of the authorized period. **Section 1: TRAG ASSESSMENT DATE** expires after 90 days unless **EXTENDED REVIEW PERIOD REQUESTED?** has been selected (**Section 1: TRAG ASSESSMENT DATE** expires after 180 days instead of 90 days). For **LOC-A 8=Waiting List**, the expiration is set to 365 days.

If a new assessment has not been started, the expired assessment is Autoclosed and a Discharge record is created with a **DISCHARGE REASON** code of **X**. A comment is added to the assessment that states that either the **LOC-A** or **TRAG** has expired. The newly created record will be included in the regular Electronic Data Transfer System (EDTS) file for the center that produced the expired/Autoclosed assessment.

If the assessment is Autoclosed and a Discharge record is created, this Discharge record, like any other Discharge record, will cause the termination of any open mainframe CARE community-based assignments for the individual. The assignments will be terminated based on the date of the discharge and the assignment code will be removed from the **ASSIGN_CD** field for discharge record sent to EDTS.

The center's method of entry (batch or online) will not affect the Autoclose process.

***Note:** A "No Overlapping Authorization" batch process is also run on a nightly basis. This process checks for authorizations that cover the same period for the same individual and changes the prior **LOC-A AUTHORIZATION END DATE** to the day before the *new* **LOC-A AUTHORIZATION BEGIN DATE**. If a Discharge record is found, the **LOC-A AUTHORIZATION END DATE** for the prior Intake or Update record will be changed to the day before the Discharge Date.

Automated Processes, Continued

AutoComplete

This is the process by which selected adult only **Provider Complete** Update assessments are automatically changed to **Complete** status.

After a provider has entered **Sections 1: Adult TRAG, 3: Diagnosis Specific Clinical Symptom Rating [TIMA] Scales, and 4: Community Data** (may be auto-filled if the data has not expired), the form is marked **Provider Complete**. The AutoComplete process validates the assessment against all of the business rules regarding completeness.

If the assessment passes the business rules for completeness, then the AutoComplete process will change the Form Status to **Complete**. This new status is processed immediately and will be displayed on the result screen.

If the assessment does not pass a business rule for completeness or the **AUTHORITY REVIEW REQUESTED?** check box is checked, then the assessment will remain at **Provider Complete** status and the authority or Utilization Management staff must modify/authorize the assessment. If the **AUTHORITY REVIEW REQUESTED?** check box is checked, the AutoCompletion process is interrupted. If the provider wants the authority (usually the Utilization Management staff) to review the assessment and manually change the FORM STATUS to **Complete**, the provider checks the **AUTHORITY REVIEW REQUESTED?** check box.

If the authorization period from the prior assessment will expire in less than 90 days, the **Section 2: LOC-A** will not be preloaded and the authority will need to fill in all of **Section 2: LOC-A**. The purpose for this requirement is to ensure that when the **Section 1: TRAG** is updated (valid for 90 days from **Section 1: TRAG** Assessment Date) that the **Section 2: LOC-A** is still appropriate and the new **Section 2: LOC-A** authorization period is valid for the same 90 days.

Auto-Delete

If an **Incomplete** or **Provider Complete** record is not updated for over 30 days, the **Incomplete** or **Provider Complete** record will be Auto-Deleted. All data entered on the deleted assessment must be re-entered. No record of the prior **Incomplete** or **Provider Complete** assessment is retained in WebCARE.

Error Codes and Related Business Rules

CARE / WebCARE System The CARE / WebCARE system was designed and developed based on Texas Department of State Health Services (DSHS) business rules. These rules were designed to meet the requirements set forth by legislation, clinical best practices, and procedural best practices of various community centers.

Since the CARE system was originally implemented in the early 1980's, many business rules have changed and CARE has changed to reflect the new requirements. WebCARE was introduced to meet the new needs for Internet access to CARE. WebCARE is a front-end system to the CARE database and contains error codes and edits that enforce business rules in much the same way as the mainframe CARE screens do.

Error Resolutions In an effort to ease the transition from CARE to WebCARE, a database was designed to display the error codes that may be encountered in WebCARE and the associated business rules for those errors. There are also error resolutions to assist in deciphering the error messages and to suggest ways to correct the error.

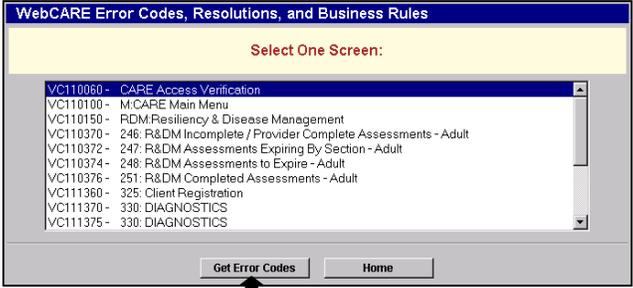
Error Codes Used Throughout CARE Because error codes may be used throughout the CARE system, the screen number along with the error code will be required to determine which business rule and error resolution best fits your situation.

Using the Error Codes and Related Business Rules Database

Access the WebCARE Error Code, Resolution, and Business Rule Database

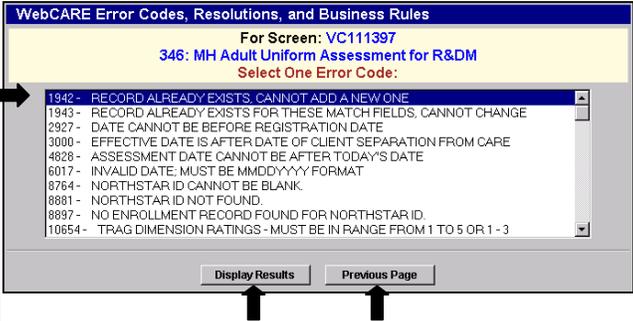
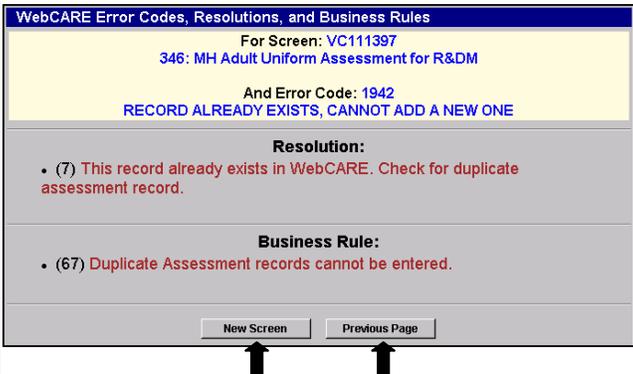
Access to the WebCARE Error Code, Resolution, and Business Rule Database requires an Internet browser (like Internet Explorer). If your personal computer is connected to the Internet, start a new browser session. This way you can simultaneously use WebCARE in one browser window and have the WebCARE Error Code, Resolution, and Business Rule Database available in a different browser window. You must also have access to the legacy MHMR Intranet (see [Confidentiality and Security of Consumer Records](#) for more information).

The following table describes the steps taken to view Error Codes, Resolutions, and Business Rules.

Step	View	Action
1	--	<p>If, while you are using WebCARE, an error message displays and you want to look up information about the error message:</p> <ul style="list-style-type: none"> • Write down the screen number where the error message appeared. The screen number can be found in the upper right corner of the browser window (it usually begins with VC). • Write down the error number (usually 4-5 numbers long in a red font with a description following it. It may also be preceded by 'Msg:').
2	--	<ul style="list-style-type: none"> • Start a new browser session. • In the Address (at the top of the browser, type the following Uniform Resource Locator (URL) exactly as it is written (or click the link below): <p>http://www2.hhsc.state.tx.us/655/cis/training/files/webcare/frm_DisplayResolution1.asp</p> <p><u>Result:</u> The <u>WebCARE Error Codes, Resolutions, and Business Rules</u> screen is displayed.</p>
3	<p>A sample screen is shown below.</p> 	<p>To view the Error Code:</p> <ul style="list-style-type: none"> • Select the Screen Number from the list. • Click the Get Error Codes button. <p><u>Result:</u> A screen is displayed with only the associated error codes for the screen selected.</p>

Using the Error Codes and Related Business Rules Database, Continued

Table, continued

Step	View	Action
4	<p>A sample screen is shown below</p> 	<ul style="list-style-type: none"> • Select the noted WebCARE error code. Verify that the screen name and error message is the same as the WebCARE screen and the error you received. • Select the Display Results button to view the associated Resolutions and Business Rules. • Select the Previous Page button to return to the list of screens. <p>Result: The Resolutions and Business Rules for the screen and error code combination selected are displayed.</p>
5	<p>A sample screen is shown below.</p> 	<ul style="list-style-type: none"> • Select the New Screen button to select a different screen. • Select Previous Page to return to the list of error codes listed for the current screen.

List All Business Rules

For a list of all Business Rules (grouped by section and then in no particular order) in Microsoft Excel format:

- In the Address (at the top of the browser, type the following Uniform Resource Locator (URL) exactly as it is written (or click the link below):

<http://www2.hhsc.state.tx.us/655/cis/training/files/webcare/technicalmanual/Appendix:%20Business%20Rules%20by%20Sections.xls>

Contract Requirements

Business Rules have also been derived from Performance Contract requirements. Some functionality in WebCARE may appear to cause Appropriateness report inconsistencies, but exceptions are listed in the contract. For more details on contract requirements, see:

FY 2008 Performance Contract:

<http://www.dshs.state.tx.us/mhcontracts/ContractDocuments.shtm>

Batch Processing and Electronic Data Transfer System (EDTS)

Enter Data Into CARE

There are two methods for entering data into the CARE system:

1. Direct data entry into the mainframe CARE system through a 3270 terminal emulator or through WebCARE using a web browser. R&DM *Adult and Child/Adolescent Uniform Assessments* for new and/or ongoing consumers may only be entered via WebCARE.
2. Batch submittal of data using File Transfer Protocol (FTP) to the mainframe. For *Adult and Child/Adolescent Uniform Assessments* information, batch files will be accepted into the CARE system after the center completes the Batch Certification process. Reports may be generated for centers and viewed through JHS Exporter. For more details, see the following documents:
 - [Batch Information](#)
 - CARE X/PTR Report Listing
 - ◆ [CARE XPTR Numeric List](#)
 - ◆ [CARE XPTR by Directory](#)

EDTS

An EDTS transactional file is created on a daily scheduled basis. When data is entered into WebCARE (either by batch or online data entry), it will be copied to the extract file. That file is placed in a directory specifically for the center submitting the data and may be transferred to the center for reporting or updating the local system. The files are part of the Electronic Data Transfer System (EDTS). For more information on EDTS, see the following documents:

- [General Information About EDTS Files](#)
- [Adult EDTS Layout](#)
- [Child EDTS Layout](#)
- [Diagnosis EDTS Layout](#)
- [Registration EDTS Layout](#)

WebCARE Data Movement Diagram

On the following page, the WebCARE Data Movement Diagram provides a visual representation of flows through the various systems. Start at the upper left corner and move in a clockwise direction.

WebCARE Data Movement Diagram

