# Access the Portal

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

# ND Login

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

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

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

# Navigating the Portal

The portal landing page arranged in a series of Tabs for users to select from based on the intended activity. Below is a summary of each of the Tabs, along with what information and functionality is provided in each.

| | |
|---|---|
| **My Activity** | Default portal view that provides a listing of the logged-in user's assigned applications/participant. Users can click into their assigned participant's Application Files to complete work for each participant. |
| **Pending Records** | View primarily used by a program's Master and Support Administrators to:<br>• Respond to new Referrals issued by the Community Connect program<br>• Review Outcomes Billings that the Community Connect program did not approve as submitted (following each billing and reconciliation period) |
| **Applications** | View for users to see current and historical listings of a program's applications. Here, users can:<br>• Click into participant's Application Files to complete work<br>• Export datasets<br>• Use a search bar to narrow results by any of the column values |
| **Releases, Referrals, Care Plans, Case Notes, Outcomes Billing, Participant Updates** | Views for users to see complete listings of a program's application-based work-type history. In each of these tabs, users can:<br>• Click into the records to view/print<br>• Export datasets<br>• Use a search bar to narrow results by any of the column values |
| **Agency** | This tab provides high-level information about a Program, including:<br>• Program Address, website, phone, email address<br>• Regional Participation and Referral Status<br>• Program Contact List<br>  ○ Contact demographics (email, phone, regional participation)<br>  ○ Contact's current and historical application assignments<br>  ○ Master/Support Administrators can update Program Contact demographics and enter an End Date to terminate that contact's access to the system. |

# Respond to a Referral

1. Navigate to the Pending Records Tab
2. Click on the Referral ID or click the down arrow and Edit
3. In the Referral Form:
   a) Accept the Referral and assign the Care Coordinator by clicking on the magnifying glass. (Note- only care coordinators available in the participant's region will show up here for selection.)
   b) Refuse the Referral and provide a reason for refusal.

## Update Participant Demographics (and Assign/Reassign Peer Support and Care Coordinators)

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

## Create a Care Plan

1. Navigate to the Participant's Application file
2. Click on New Care Plan
   - Enter the Participant's Strengths and Reason for Referral into the Program
   - Click Next
3. Add Care Plan Goal
   - Enter Goal Description
   - Select the application Outcomes Domain
   - Enter any comments/reminders/ideas about this goal in Goal Provider Comments
   - Click Next
4. Add Goal Action Steps
   - Click Create
   - Describe Action Step in the Action Step field
   - Enter the Action Step Start Date (as the date you intend to start, or leave blank if unknown)
   - Click Submit
   - Repeat steps under this section (section 5) until all Action Steps for the goal have been added
   - Click Next
5. Review Care Plan overview
   - If additional Goals should be added, repeat steps 3 and 4 until Care Plan is complete
   - To add new Action Steps to existing Goals, use the down arrow on the Goal to edit the applicable goal
   - When Care Plan is completed, click Submit at the bottom of the screen.

## Add Case Notes

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

# Create a Monthly Outcomes Billing

1. Click New Outcomes Billing and respond to the Engagement and each Outcomes question based on the Application File review.
2. Enter the first date of the reporting month using the date picker. (Always select the 1st).
3. Respond to the Engagement and Outcomes questions based on the review of participant's Care Plan/Case Notes and provide comments for each.
4. Select the Level of Service achieved for the reporting period based on the Engagement and Outcomes question responses.
    - Click the Magnifying Glass
    - Place a checkbox in the appropriate Level of Service
    - Click Select

**Responding to Engagement and Outcomes Questions**

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

**Selecting the Appropriate Level of Service**

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

# Submit a Participant Update

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

# Modify a Program Contact's Profile

Master/Support Administrators can modify contact profiles, including demographic updates, regional assignments, adding or removing roles, and adding end dates to terminate user access.

1. Navigate to the Agency Tab, Program Contact section
2. Click the down arrow next to the contact's name and select Edit
   - To update contact demographics, change the applicable information
   - To update assigned roles, regional participation, or add an end date:
     - Under the Contact Account Begin End Date box, and click the down arrow and select Edit
     - Make desired updates
     - Click Submit
3. Click Submit

# Questions?

This document is intended to be a high-level resource for individuals who have already reviewed the comprehensive Provider Portal Guidance. For all questions or issues that weren't able to be resolved utilizing the Portal Guidance please email comconnect@nd.gov or call 701-298-4636.