Northern Light Health

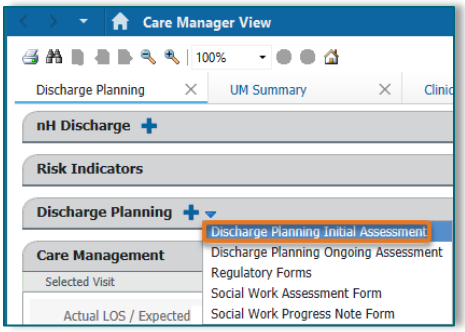
From the Office of Clinical Informatics

Cerner Millennium
Care Management PowerForm Review

January 12, 2022

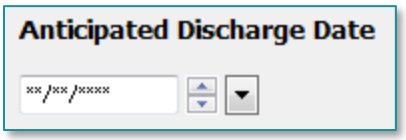
In conjunction with the Readmission Prevention project, modifications have been made to Care Management PowerForms.

Discharge Planning Initial Assessment



This form is completed on all patients that have a Care Manager Consult order at the time of admission.

- Access this form within the Discharge Planning MPage by clicking the blue plus sign within the Discharge Planning component.
- Anticipated Discharge Date
  - The field is located near the bottom of the **Current Assessment** section.
  - This should be documented on all patients.
  - The date will pull into the **naviHealth Discharge** tool, as it is a required field.



  - Anticipated Date of Discharge will flow to the **Discharge Planning Ongoing Assessment** form.
  - Anticipated Date of Discharge documentation will provide the **PPD** (Predicted Date of Discharge) timeframe on the UM Worklist and Discharge Planning Worklist.
  - The information will automatically flow to Clairvia.

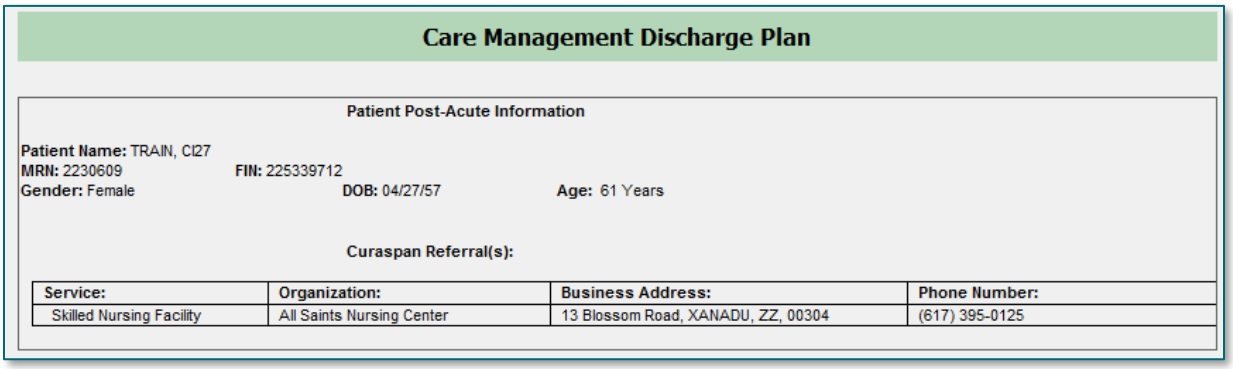
Care Management Progress Note

- The Care Management Progress Note is in both the **Discharge Planning Initial Assessment** and the **Discharge Planning Ongoing Assessment** forms.
  - The initial assessment is documented in the Care Management Progress Note section of the **Discharge Planning Initial Assessment** form.
  - If the patient is in the Emergency Department (ED), the ED Care Manager would document the initial and ongoing assessments in this section while the patient remains in the Emergency Department.
  - Care Managers should document the **date and time** at the beginning of the documentation and the Care Manager's **initials** at the end of the documentation.
    - Documentation in the **Discharge Planning Initial Assessment** form will flow to the Care Management Progress Note section of the **Discharge Planning Ongoing Assessment** form.
    - Adding the date/time documentation will make it easier when reviewing the note to determine when each documentation took place.

- **Daily Care Management Progress Note** updates take place in the Care Management Progress Note section in the **Discharge Planning Ongoing Assessment** form.

Discharge Planning Ongoing Assessment

- This form is completed on all patients with a Care Manager Consult order throughout the hospital stay.
  - The **CM Discharge Plan** section has a template that will populate from naviHealth when placement or services are booked through naviHealth.
    - Care Managers no longer manually document what agencies have been booked for the patient.



Care Management Discharge Plan

Patient Post-Acute Information

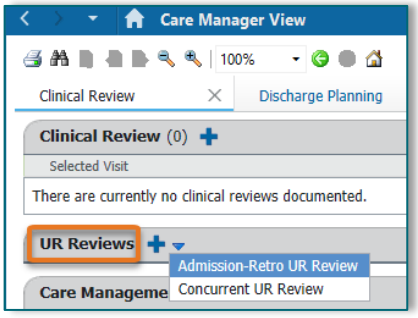
Patient Name: TRAIN, CI27
MRN: 2230609 **FIN:** 225339712
Gender: Female **DOB:** 04/27/57 **Age:** 61 Years

Curaspan Referral(s):

Service:	Organization:	Business Address:	Phone Number:
Skilled Nursing Facility	All Saints Nursing Center	13 Blossom Road, XANADU, ZZ, 00304	(617) 395-0125

Concurrent UR Review and Admission Retro UR Review Forms

- The **Concurrent UR Review** and the **Admission Retro UR Review** forms are located within the **Clinical Review** MPage. Selecting the blue carat in the **UR Reviews** component will display the forms.
- The Concurrent UR Review and the Admission Retro UR Review forms are completed by the **UR (Utilization Review)** nurse and are used to build the case for the payer.
  - **Concurrent UR Review** – used to document concurrent reviews.
  - **Admission Retro UR Review** – used for documenting retrospective reviews.



- EMMC, Mercy, and AR Gould can send both forms electronically to the Payer from the Clinical Review MPage.

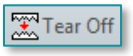
- Pertinent information listed below is added to these forms in the free text fields to avoid the payer having to sift through complete documents.
  - New or continued symptoms
  - Vital signs
  - Diagnostics/laboratory results
  - Plan of Care
- For ease of completion of the form, utilize **copy and paste** to help populate some of the fields.
  - Open the document or part of the EHR desired for copying and highlight the information.
  - While holding the **Ctrl** key, click the letter **C** to copy the highlighted information.
  - Open the **Concurrent UR Review** form and click in the appropriate field.
  - Hold the **Ctrl** key and click the letter **V** to paste the copied information.

Tear Off

The Tear Off functionality can be used to view another area of the chart while documenting in a form.

STEP 1: Open the patient's chart to the area desired to be viewed while documenting in a form.

STEP 2: Click the **Tear Off** button in the toolbar. Selecting the button is the equivalent of taking a screenshot of the page.



- Navigation to other areas of the chart cannot occur from the **Tear Off.**
- The **Tear Off** will display in the bottom task bar of the computer screen and will make it appear as if the patient's chart is opened twice.

STEP 3: Navigate to the form desired for documentation and document as appropriate.