From the Office of Health Informatics

AMB Care Management
Care Manager & CCT Workflow

August 4, 2025

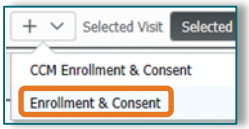
This flyer provides an overview of the Beacon Care Manager and CCT Workflow.

Enrolling a Patient

STEP 1: To enroll a patient, select the patient's name from the **Care Manager Dashboard Case List** to open the chart.

- The chart opens to the **Patient Summary** MPage, where users can view the patient's demographics, health plan, and case information.

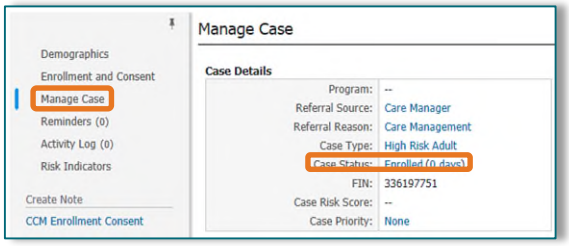
STEP 2: Select the **Enrollment** MPage and navigate to the **Enrollment and Consent** component.



STEP 3: Select the **plus sign** and select **Enrollment & Consent** to open the PowerForm.

STEP 4: If the patient is interested in services, select **Provides verbal consent for enrollment**, then select the green checkmark to sign the form.

STEP 5: Navigate to the **Manage Case** component to see the case status updated to **Enrolled**.



Manual Case Opening

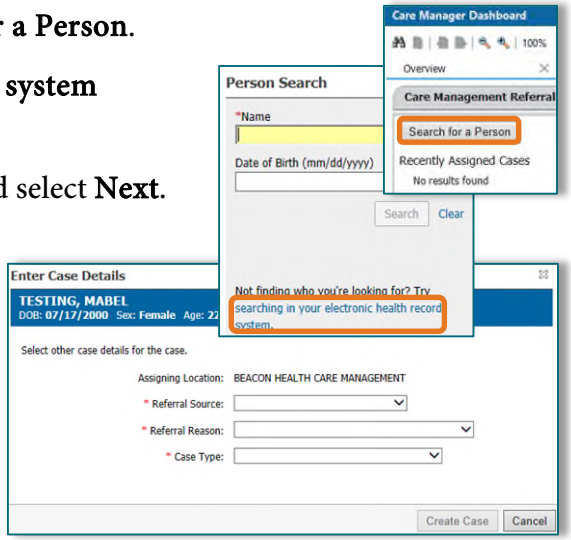
STEP 1: From the **Care Manager Dashboard**, select **Search for a Person**.

STEP 2: Select the **Searching in your electronic health record system** hyperlink.

STEP 3: Select the **Assigning Location** from the dropdown and select **Next**.

STEP 4: Search the patient's name and date of birth within the **Encounter Search** window. Select the appropriate patient encounter, then select **OK**.

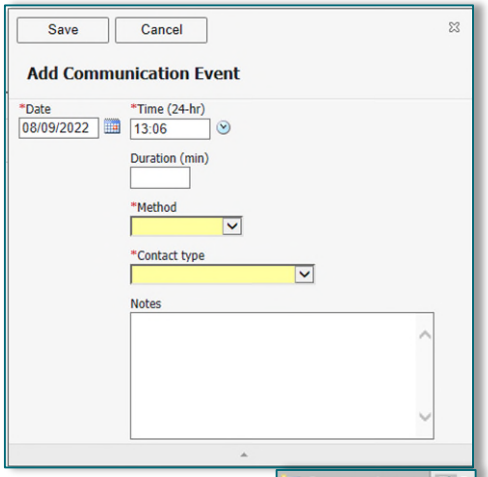
STEP 5: Enter the case details by selecting from the dropdown menus. Select **Create Case** to complete.



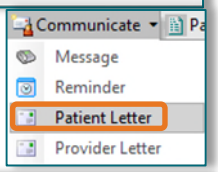
Active Case MPage

- **Activity Log**: Used to document all interactions with the patient, including attempts to reach the patient and home visits. To begin communication documentation, navigate to the **Activity Log** component and select the plus icon.

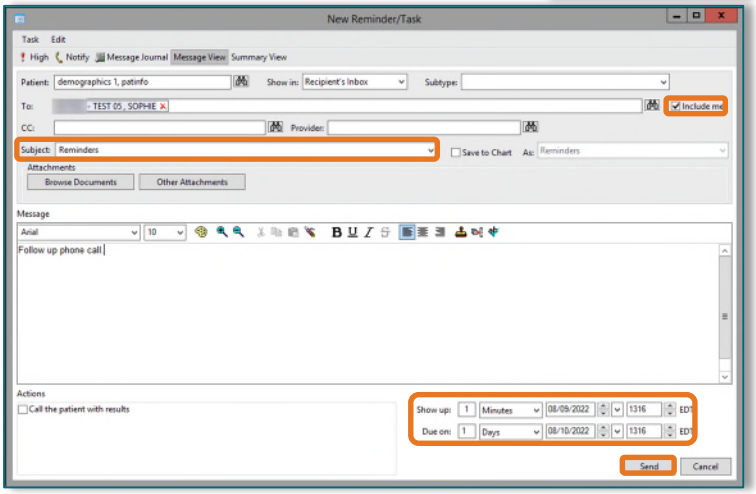
- The current date and time will default but can be modified to reflect the time of the event.
  - **Contact Type**: If contact was made with the patient, select **Patient** from the dropdown. The patient's name will automatically populate.
- If unable to connect with the patient, select **Patient** from the **Contact Type** dropdown, and select **Left Message** or **No Answer** in the **Outcome** dropdown.
- Required fields are indicated with a red asterisk. Once all details have been documented, select **Save**.



➢ Upon completion of the initial outreach to the patient, a **Welcome Letter** will be sent. In the toolbar, select the **Communicate** dropdown arrow, and select **Patient Letter**.



- The **Create Letter** window will open. To create the letter, select the appropriate auto text, then select **OK**.
  - A window will display for printing, so the letter may be mailed to the patient accordingly.
  - The letter will save to the patient's chart under **Documentation**.

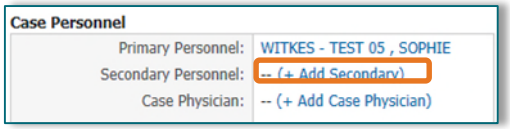


NOTE: **Reference material regarding which auto text should be used, will be provided by manager.**

➢ After the initial call is made, a reminder is created for the follow-up call. In the **Reminders** component, select the **plus** icon. Once complete, select **Send**.

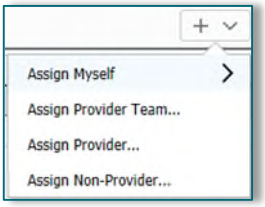
- The patient's information will automatically populate. Check the **Include Me** box to populate information to the **To** field.
- Document in the **Message** field details regarding the reminder.
- **CCT Staff**: Reminders are used to schedule home visits. When creating a reminder for a home visit, enter the details for the scheduled visit in the **Message** field.
  - For home visits, set the **Due On** date to the date of the visit.
- Indicate the time parameters for when the reminder is due by selecting a duration or a specific date.

- Note that the **Show up** field indicates when the reminder will populate to Message Center, this can be left as the default.



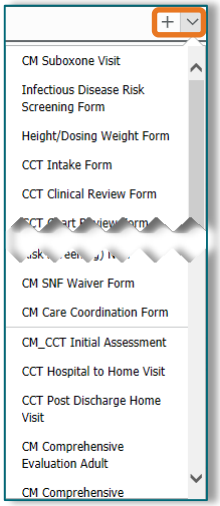
➢ **Manage Case**: Provides an overview of the patient case.

- Assign another Care Manager as the backup for the patient by selecting **Add Secondary**.
  - Enter the person's name, then select **Assign**.



➢ **Care Team**: Displays a list of care managers, physicians, and specialists involved in the patient's care.

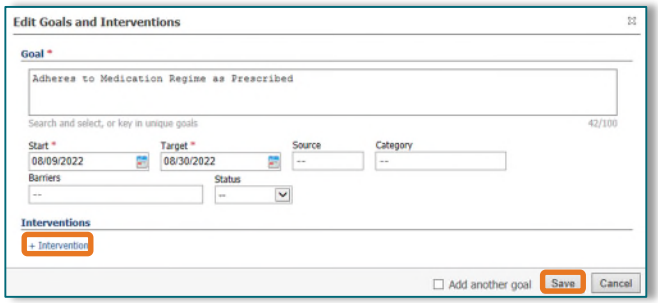
- To assign oneself as a care provider, select the **plus dropdown arrow** and select **Assign Myself**.
- If another provider is not listed, select **Assign Provider** to add them to the care team.



➢ **Screenings and Assessments**: Access forms for documentation. Select the plus dropdown arrow to display available forms.

- Options above the dividing line will open **PowerForms**.
- Options below the dividing line navigate the user to the **Interactive View I&O**.

➢ **Care Plan:** Navigate to the Care Plan component and select the plus icon. The **Edit Goals and Interventions** window will open to add goals to be met by the patient. Select **Add Another Goal** to add additional goals, then select **Save** when complete.



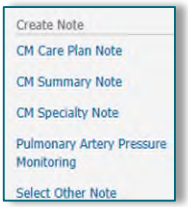
- Required documentation fields include **Start**, **Target**, **Source**, **Barriers**, **Status**, **Interventions**, and **Status of interventions**.
- The **Goal** field uses key word search to populate goal options.
- Fields with a red asterisk indicate required documentation.
- To add an intervention to the goal, select the **Intervention** hyperlink.

➢ **Hierarchical Condition Categories (HCC)**: Provides information from HealtheIntent on unsatisfied categories that may need follow-up with primary care.

➢ **New Order Entry:** select the order in the **New Order Entry** component.

- When the order is selected, the row will turn blue. The **Orders for Signature** bin updates with a green number, indicating the number of orders added to the bin. Once all orders have been added to the bin, select the **Orders for Signature** icon.
- All orders ready for signature will display. Orders can be removed by selected the **Remove** button. Modify orders by selecting the **Modify Details** button.
- Once all orders are ready for signature, select **Sign**.

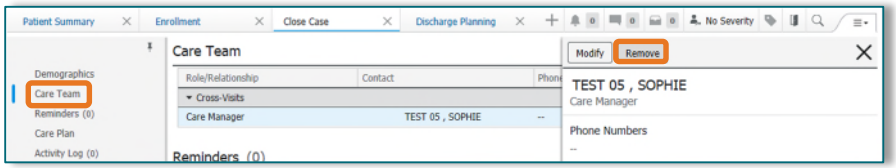
➢ **Create Note:** View note options under **Create Note**. Select the desired template to open the Note window.



- Information documented in the Workflow MPages will populate to the appropriate sections of the note. Note sections may be modified, as needed.
- Once the note is complete, select **Sign/Submit**. To send the note to a specific provider, enter the provider's name into the **Provider** name field. Select **Sign** when complete.
- Add frequently searched providers to favorites list by selecting the star icon.

Closing a Case

<u>STEP 1</u>: On the **Close Case** MPage, navigate to the **Care Team** component, and remove self from the **Care Team**.



<u>STEP 2</u>: Ensure all reminders have been completed in the **Reminders** component.

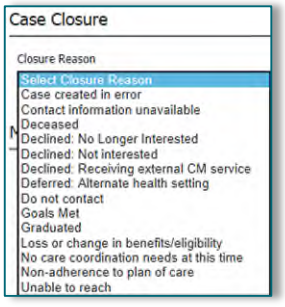
<u>STEP 3</u>: Ensure the care plan is up-to-date and completed in the **Care Plan** component.

- Goals can be filtered to view **Unmet** goals.

<u>STEP 4</u>: Confirm all communication events have been logged in the **Activity Log**.

<u>STEP 5</u>: Navigate to the **Case Closure** component, select the **Closure Reason** from the dropdown, and select **Close Case**.

- **Care Manager Staff**: Select **Goals Met** as the closure reason.
- **CCT Staff**: Select **Graduated** as the closure reason.



<u>NOTE</u>: **If closing the case due to inability to contact the patient after <u>two</u> attempts, indicate the reason as "Unable to Reach."**

<u>STEP 6</u>: Once the case is closed, the patient will fall off the case list.

Patient Declination Workflow

If a patient declines services, documentation of refusal is required.

STEP 1: In the **Enrollment** MPage, navigate to the **Enrollment and Consent** component, select the plus drop-down arrow, and select **Enrollment & Consent**.

STEP 2: Document **Refused to enroll in the program** in the PowerForm and sign the form.

STEP 3: Document the communication event in the **Activity Log** component. Indicate the **Outcome** as **Case Discussion**. Enter additional details in the **Notes** field, if needed. Once complete, select **Save**.

STEP 4: Navigate to the **Close Case** MPage and select the **Case Closure** component. Select the appropriate declination reason from the **Closure Reason** drop-down, then select **Close Case**.