Northern Light Health

From the Office of Clinical Informatics

Integrated Care Management
Community Health Worker Workflow

February 7, 2023

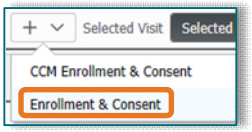
This flyer provides an overview of the Community Health Worker (CHW) workflow.

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.

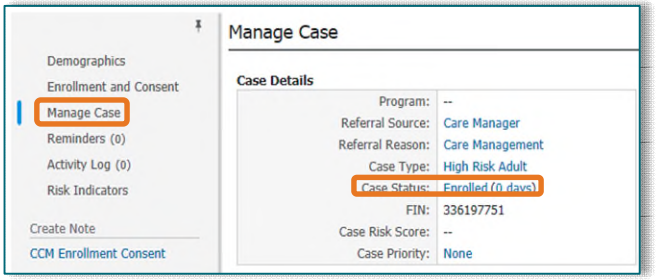
STEP 2: Select the **Enrollment** MPage and navigate to the **Enrollment and Consent** component.



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

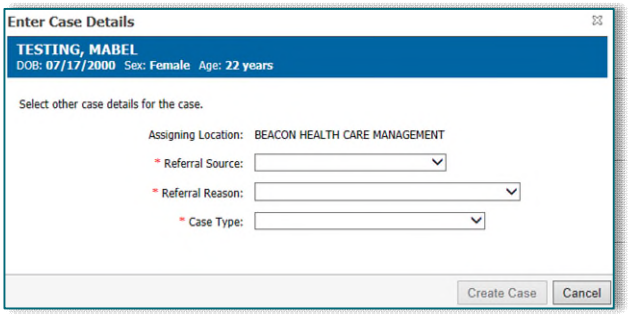
STEP 1: From the **Care Manager Dashboard**, select **Search for a Person**.

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

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

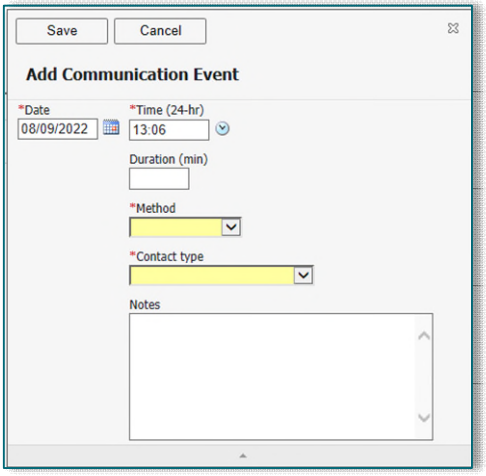
STEP 4: Search the patient's name and date of birth within the **Encounter Search** window. Select the appropriate BH_CHW patient encounter, then select **OK**.

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



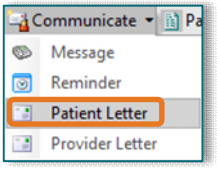
Active Case MPage

- **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.

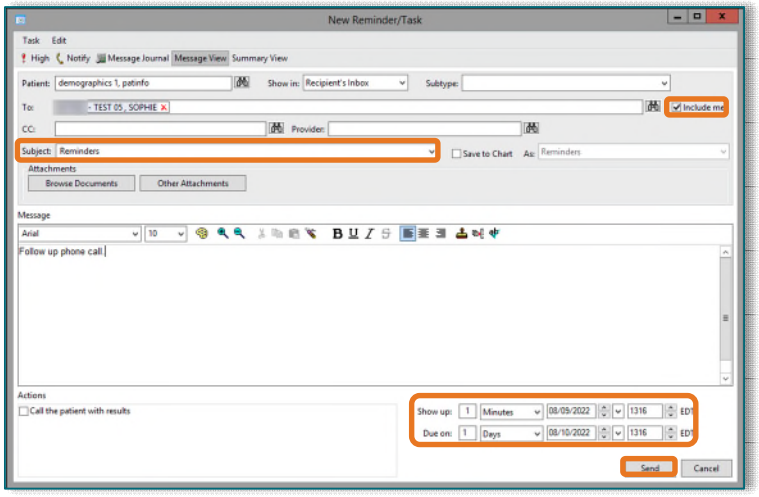


  - The current date and time will default and can be modified to reflect the time of the event.
    - **Contact Type**: If contact was made with the patient, select **Patient** from the drop down. The patient's name automatically populates.
  - If unable to connect with the patient, select **Patient**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

- Upon completion of the successful initial outreach to the patient, a **Welcome Letter** is sent. In the toolbar, select the **Communicate** drop-down arrow, and select **Patient Letter**.



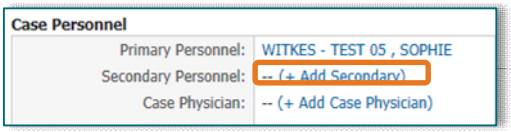
  - The **Create Letter** window opens. To create the letter, select the appropriate auto text, then select **OK**.
    - A window displays for printing, so the letter may be mailed to the patient accordingly.
    - The letter saves to the patient's chart under **Documentation**.



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

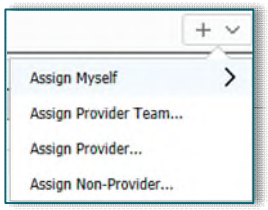
- After the initial call is made, a reminder is created for the follow-up call. In the **Reminders** component, select the plus icon. Once complete, select **Send**.
  - The patient's information automatically populates. Check the **Include Me** box to populate your information to the **To** field.
  - Document in the **Message** field details regarding the reminder.

- **CCT Staff**: Reminders are used to schedule all types of follow-up contact, including 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**.

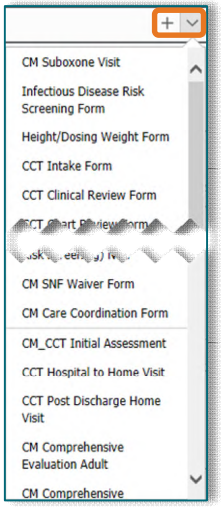


➢ **Care Team**: Displays a list of care managers, physicians, and specialists involved in the patient's care.

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

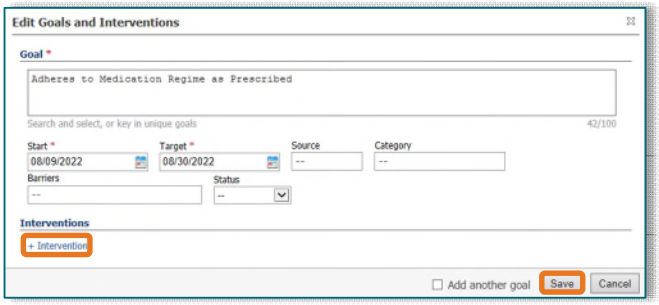
➢ **Screenings and Assessments**: Access forms for documentation. Select the plus drop-down arrow to display available forms.

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



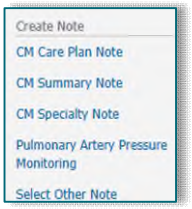
➢ **Care Plan: N**avigate to the Care Plan component and select the plus icon. The **Edit Goals and Interventions** window opens to add goals to be met by the patient. Select **Add Another Goal** to add additional goals, then select **Save** when complete.

- 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.



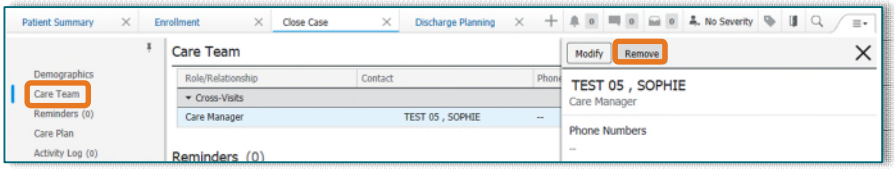
- To add an intervention to the goal, select the **Intervention** hyperlink.

- **Hierarchical Condition Categories (HCC)**: Provides information from HealtheIntent on unsatisfied categories that may need follow-up with primary care. Information within HealtheIntent is reference information and can be used to discuss needs for care with the PCP and the patient.
- **Create Note:** View note options under **Create Note**. Select the desired template to open the Note window.
  - Information documented in the Workflow MPages populates 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 your favorites list by selecting the star icon.



Closing a Case

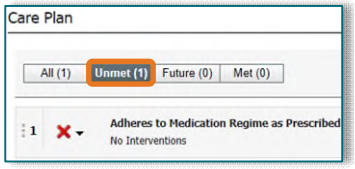
<u>STEP 1</u>: On the **Close Case** MPage, navigate to the **Care Team** component, and remove self from the **Care Team**.



<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.

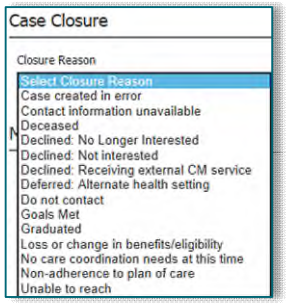
- Goals can be filtered to view **Unmet** goals.



<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 drop down, 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 falls 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**.