From the Office of Health Informatics

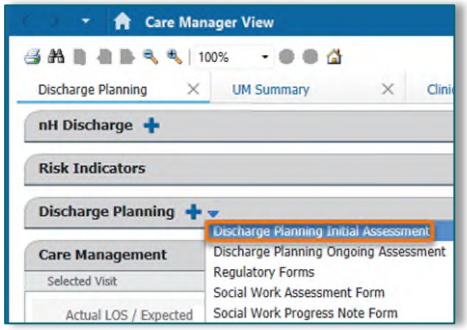
Acute Care Management Care Management PowerForm Review

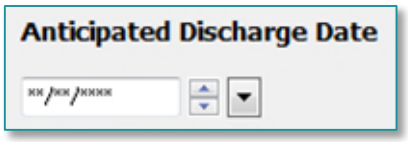
July 24, 2025

The purpose of the Discharge Planning Initial and Ongoing Assessment forms is to ensure timely, coordinated discharge planning for patients with a Care Manager Consult order by documenting key information such as the anticipated discharge date and care management progress notes that integrates with hospital systems and tools to support continuity of care and efficient transitions.

Discharge Planning Initial Assessment

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





- Access the 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.

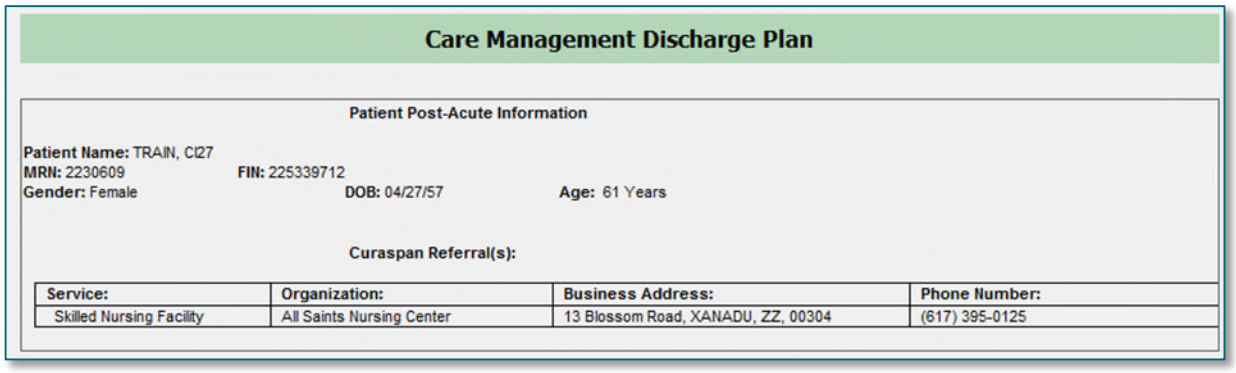
- Documentation in the **Discharge Planning Initial Assessment** form will flow to the Care Management Progress Note section of the **Discharge Planning Ongoing Assessment** form.
- Adding the date/time documentation will make it easier when reviewing the note to determine when each documentation took 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 WellSky (formerly careport and 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