

Cerner PowerChart Ambulatory EDUCATION

Accessing the Care Manager Organizer



1. Open the Care Manager Organizer.

Case by Status



New – Case(s) that have been assigned to the care manager, but no action has been taken.

Pending Enrollment – Case(s) that are opened but the Enrollment and Consent portion has not been completed.

Enrolled – Consent and Enrollment are completed, but a care management encounter needs to be completed.

Active – A care management encounter is complete, and the care manager is actively working with the patient.

Pending Closure – The initial identification reason is no longer applicable; the patient cannot be reached, or the patient has declined services.

Notes/Reminders

Notes/Reminders (0)
All Visits

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This component displays reminders assigned to the care manager.

Organizer Observation Notifications

Organizer Observation Notifications	≣• ⊘
All Visits	

The Organizer Observation Notifications shows a list of patients (in any status) that have recently had contact with the emergency department or inpatient setting. This information can be sorted by notification type and date.



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Care Management Referrals					
Care Management Referral	E → Care Management R	eferral allow manual ass	ignment of patients.		
Potential Cases (24) Manage Colu	Potential Cases are i ■ ■ ● Management, High F Management(Peds).	Potential Cases are identified by three algorithms: Disease Management, High Risk Adult and PMCA – Complex Chronic Care Management(Peds).			
Add a Patient to Case List					
Task Edit View Patient Chart Chart Image: Charges Charges Image: Calculator Ima	Open the Care Manager Organ	zer.			
Potential Cases (24)		≣- ⊘ 2.	Add the patient from		
Manage Filters Filtered by: Disease 2	Person Search: 🭳 c	Manage Columns	Click on the box next		
Manage Sorts Sorted By: Risk Score		b.	Click Assign Selected.		
Risk Score Shown: CARDIAC Risk Type Two * Assigni	ng Location: Community Care Managemen	t 🗸 🖢 Assign Selected 🛛 OR			
Person ent Visit D B S years Male DOB:	Last ED Visit Last Outpatient Visit	Payer/Health Plan/Line o	Search for a specific patient by entering the name in the search field.		
Care Management Referral 3. If a	referral is received, the patien	can be added manually	, by clicking on Search		

for a Person within the Care Management Referral tab. The Enter Case Details window will open.

Enter Ca	se Details		23
ZZTEST	, AZALEA		
	Assigning Location:	Community Care Management	
2	* Referral Source:	~	
	Referral Reason:	~	
	Case Type:		~
		Create Case	Cancel

- a. Enter the required details.
- b. Click Create Case.

Adjust Filters to Search for Eligible Patients Suggested by Automated Record Review

The system will automatically search for patients that are high risk and add these patients to the Potential Cases list. This task may yield high numbers of patients, which can be narrowed down through filters.

Potential Cases (24)			
Manage Filters	ered by: Disease Management		
Manage Sorts	2 ted By: Risk Score(Descending)		

Search for a Person

1. Click the Manage Filters button within the Potential Cases tab, to locate patients.



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Set Filters			X	a.	Select the desired Program from
* Program	Attributed Provider's	Organ	nization		the drop-down menu.
Disease Management a	 Select an Organiza 	ation	•	b.	Select the desired Health Plan
Payer	Health Plan				from the drop-down menu.
Select Payer	▼ Select Health Plan	1	b 🔽	с.	Click Apply.
			c Apply Cancel		
Potential Cases (24)					
Manage Filters 1 ered by: Disease M Manage Sorts 2 ted By: Risk Score(I	ianagement Descending)				
Manage Sorts	22				
Apply up to three levels of sorting.	Reset Sorts				
* Required fields are marked with an asterisk.					
* Primary Sort		2.	Click the Manage Sor	ts but	ton to further sort the patient list.
Risk Score a Add Level					
Last ED Visit		a.	Select the desired Pri	mary	Sort from the drop-down menu.
Total Recent ED Visits		b.	Click Apply.		
Last Inpatient Visit	Apply Cancel		,		
Last Outpatient Visit	Cancer				
Total Recent Outpatient Visits	nigh				

Viewing Potential Case Information

Unmet Measures Count

Potential Cases (24)				Manage (≡• 🔊
Person	Program Identified	Last Inpatient Visit	Last ED Visit	Last Outpatient Visit	Payer/Health Pl
 Doe, Jason S 1 42 years Male DOB: 05/04/1980 	High-Risk Senior 2 08/29/2014 21:52		03/05/2015 05:50 Total Recent Visits: 2	04/05/2015 07:30 Total Recent Visits: 1	Mock Payer Mock Payer
	+3 more		3 View Visit Details	View Visit Details	Mock Payer +1 more



- 1. Within the Potential Cases tab, click on the patient's name to open the patient's chart.
- 2. Click on the Program Identified hyperlink to open the Potential Case Details (image below).
- 3. Click on the View Visit Details hyperlink to view the patient's Last ED Visit.
- 4. Click on the View Visit Details hyperlink to view the patient's Last Outpatient Visit.



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Viewing Patient Information from the Case List

Care Manager Organizer						
Overview X	ase List	× +	2 ≡•			
Case List for: TSTAcctEisenga, CareMgA	mb3 Brandi 🗸 Case	Relationship: Primary and Secondar	y 🗸 🗧 Filter			
C Error loading columns. 1 column encountered an error. More Details						
Patient Information	Case Status		×			
demographics 1, pati 5 DOB: JAN 09, 1970	New 91 days	demographics 1, patin	fo			
Clark, Jennifer Lamo 78 DOB: FEB 06, 1944	Enrolled 76 days	Manage Case	≡• .			
Newsted, Jason Kei 67 N DOB: MAY 24, 1955	Active 70 days	⊿ Case Details				
*demographics 4, pat 5 DOB: JAN 19, 1970	Enrolled 13 days	Referral Source:	Caregiver			
Gilmour, David Matth 5	Enrolled	Referral Reason:	Multiple ED/Inpatient visits			
DOB: MAY 04, 1970	27 days	Case Type:	Disease Management			
		⊿ Case Dates				
		Date Assigned:	09/13/2022			
		Date Enrolled:				
		⊿ Case Personnel				

 Within the Case List tab, patient information can be viewed at a glance by clicking in the field next to the patient's name.

> Note: Clicking on the patient's name will open the patient's full chart. Click in the blank portion of the field next to the patient's name will open to the preview pane.

Clear All	×
Filters 2	
▼ Case Status	Clear
▼ Case Type	Clear
Communication Events Duration This Month	Clear
 < 20 minutes for current month < 20 minutes for last month 	

- 2. Click on the Filter button.
- 3. A commonly used filter is Communication Events Duration This Month. This will assist with Medicare and care coordination billing.