Homeworks
SOC – Start of Care

Client Activity→

Find Patient

File (toolbar) → Patient Level

→put in first 3 letters of client's last name, first few of First Name

→Find and highlight name

→Patient level will appear

(Name: Green = Discharged; Orange = Pending; Black = Open to Service; Blue = Deceased)

On Patient Level → (view info on patient name screen)

→Edit → Rolodex → check address info (can not edit here)

→ VIEW CARD (correct address info if needed)

→ Directions tab → enter directions to home and Pharmacy name and phone number

→ Click Group

- Make sure "patient" is on right side, if not, highlight "patient" and Add → X

Save → Exit → Save

Click **Diagnosis Level** → View Diagnosis from Intake

To ADD

- Click + on tree (Left side of screen)
  - Type in yellow box (or click …)
    - Find ICD code by commonly used/IC9/body system/description and click SELECT
      - Verify start date, status onset or exacerbation → SAVE

To DELETE Diagnosis

- Click on Dx
  - Put in stop date = to day before start date
    - SAVE (on Ribbon Bar)
      - Click "Return to summary" (on Ribbon Bar)

Dx will now have a stop date

Procedure (Surgery & procedures)

Folder Icon (15th)

→ Procedure

→ AddNew

→Start date (Date of procedure)

→ Ellipsis button (Procedure _____ …)

→ Find ICD-9 Code

SELECT → Save

To Delete – procedure

Click on Procedure name then enter stop date (Day prior to SOC date)

Exit → Exit

Review Referral

Click Referral Level **- Do not <Add New>**

→ Click on current referral date (left side)

→ Edit → Add scheduled admit date/(SOC date) --correct if necessary

→ Assigned staff= admitting staff's name → Save

→ Click Misc Tab

→ Edit →View memo for orders & notes from intake

→ Cancel when done with review

→ Status must be "Pending" to continue

To view memos or scanned info → click Profile
(Memo will be listed in blue)

- Scanned documents will be under Images button.(On ribbon bar)

(See "To View an Image")

On referral enter ONLY scheduled admit date and assigned staff. Do not change any other dates or information on referral.

→ Save

Payors

Coins Icon

→ Review Reimbursors Tab for accuracy (coverage priority 1 is Primary Insurance)

→ If correct Exit

- If not correct – notify Intake Department

Physicians

MD Icon

→ check with patient for primary MD & consulting MD
→ Call physician to verify POC and who will sign 485

→ To add MD
→ AddNew
→ Find MD name
→ Enter Role/ Start Date/Address/
Associated Diagnosis (optional)
→ Save

→ To Delete MD
→ Click on MD name EDIT Put in stop date= to start date (if incorrect MD) =to day prior to SOC (if patient will no longer see MD)

* Be sure MD has correct address information
* MD signing 485 should be "Attending/Primary"--all others = "consulting"
* MD not in computer –
Send secure message to "Secure Msg-Add New Physician"
Select "New, Physician" and use as placeholder in orders

Make sure consents are signed before moving forward

Activate Admission

Click Admission Level

→ AddNew
Complete/Verify:
- Referral
- Admitted date
- Time
- Program (Home Health)
- Admitted by
- Admit from (Home)

→ SAVE

→ Add Records Popup
Division:
Team:
Branch
LOC: Routine
Location
Reimb Source
Reimb Plan:
Primary Diagnosis:
Attending MD:
OK
(Chart will be configured) – Name will change from orange to black

Billable Diags * To prioritize ICD codes for billing- must match OASIS

From Admission Level – Click Billable Diags

↳ Click ▷on tree (NOT ✚) – then click directly on Diagnosis listed on tree

↳ Verify start date = SOC
Verify physician = primary (must be the MD who will receive 485)

Click Blue ✚ in ICD box (to add codes)
Hold Ctrl key and highlight each Diagnosis needed
Click Green ⇨
→ SAVE

(Can use Green ⇧⇩ arrows to rearrange Diagnosis in list)
(Red **X** will Remove Diagnosis from list)
(Do not use Bullseye – it will change original intake codes.)

Scroll down to choose Primary Surgical Code

↳ Enter Primary surgical (if client had surgical procedure)

↳ SAVE (on Ribbon Bar)

↳ Answer NO to pop up

↳ Exit

MSP – MedicareSecondary Payor Form (under client Admission Level)

Click Reimbursors
→ Profile
→ Click "Attach Document"
→ MSP Click Questionnaire
→ Add (on bottom of box) <NOT "Add file">
→ Complete per patient info
→ Click "Completed" (on ribbon bar)
→ Click "Locked" (on ribbon bar)
→ Close (from drop down on upper left side)

Certification Period

Click Cert Periods (under client Admission Level)

→ Complete General Form

- Enter # of days in Cert (60)
- Verbal SOC date (from Referral Level)
- Receiving staff = name of staff doing admission
- Prognosis

→ Complete all Tabs

- Safety
- Nutritional
- Limitations
- Activities
- Mental Status
- Homebound

→ Save → Exit → Exit

Resource Assignment World Icon

→ AddNew

→ Duty – SN,PT, OT (SN case manager)
→ Admission
→ Employee : name
→ Date = SOC date
→ Check "primary Resource assignment" box for Case Manager & enter SOC date

SAVE

Note: Also add Oxygen Intermittent or Oxygen Continuous with Vendor (as appropriate)

Caregivers Caregiver Icon (2nd) (* could be in already from Intake)

Add New … → Enter 1st 3 of last and first names → Search

If found highlight and Select

If not found click Add New

Complete: Name, role, age, relationship

Rolodex

Search

See if in Rolodex already

If no records found, add name/address to Rolodex (Zip 11111=unknown)
→ Add

Complete address and phone #

Group: Caregiver

Save → Save

Advance Directive Pointing finger Icon (8th)

→ Add New

→ Select Advance Directive

→ Complete start date

→ SAVE

(* If patient has an Advance Directive → (Should request copy 3 times over 3 visits.)

Hospitalizations –

Yellow folder Icon

→ Hospitalization

→ Verify facility, dates, facility type

To enter new

<Add New>

→Hospital

Admit date

To: (Discharge Date)

Physician (if known)

Diagnosis (if known)

Facility type (Mandatory)

→ SAVE

Supply Orders Bandaid Icon (12th)

→ Quick Add

→ Choose "Name contains"

→ Type in name of item → search

→ Highlight item and click >>

Or <enter> Bringing item over to right

→ Then type in next supply and continue per above until all supplies entered

→ Next → Attach order to ⊙ Admission

Admission date – drop down

Physician

Status: New

→ Save

DME Wheelchair Icon (11th)

→ Quick Add

→ Choose "Name contains"

→ Type in name of item → search

→ Highlight item and click >>

Or <enter> Bringing item over to right

→ Then type in next supply and continue per above until all supplies entered

→ Next → Attach order to ⊙ Admission

Admission date – drop down

Physician

Status: New

→ Save

Allergies Lightning Bolt Icon (7th)

Add-- AddNew
Complete: Allergy Type
Medication (if Individual Drug Reaction chosen)
Allergen
Can check off symptoms that apply and severity level
→ Save
Medication Validation Screen – click "Cancel"

Medications Medicine Bottle Icon (10th)

→ Quick Add
→ Type in med name, press <Enter>
→ Highlight correct med, press <Enter>
→Type in next med continuing until all are entered on right of screen
→ Attach order to ⊙ Admission

→ NEXT
- Complete ordering physician, check "Read back," Status: New → NEXT
- Complete Quantity, Frequency, Route, Device (if appropriate), Comments (needed for prn meds)
- Save

To Choose Specific Days of the Week:
- Frequency: Button at end of field (clock)
  - Allows days of week to be added to frequency
    Add Frequency ⟶ click box to right
    ⟶ √ days of week desired
    This will add days to frequency (Example: 1 time a week on Sunday
    3 times a week on Mon/Wed/Fri)
  SAVE

To Enter Insulin Sliding Scale:
- Sliding Scale Button – Quantity __-__blank **units**
  Frequency: 4 times a day
  Route: Sub Q ⟶ click "Add Sliding Scale" box
  Value range description = "Blood sugar" or "Fasting blood sugar"
  Or "Fingerstick blood sugar" etc.
  Value range = (can't use Ø units) **Example only – use patient specific numbers**
  151-200 2 units
  201-250 4 units
  etc.
  Comments – if >400 call MD
  (Green box lights up)
  SAVE

Once all orders are saved Perform Med validation:

- Click on medicine bottle icon (10th)
- Highlight any medication
- Click "Validate" tile
- Review summary report on left
- Choose details and comment as appropriate on right
- Click SAVE

*All Documentation will pull into your note when you choose the Medication Regimen Preview Date & Time with your Name.

Visit Orders Nurse's Hat Icon (9th)

****NEVER QUICK ADD VISIT ORDERS****

→ Add New

→ Complete fields

- Discipline
- Start Date
- Admission ⊙
- Admission: _____ ▼ → drop down

Admission

1st week must be in DAYS

Example: If SOC was done on Tuesday

From 2 to 2
Every 5 Days freq
For 5 Days duration, then click Desc Order to complete visit order string.

→ From 2 to 2
Every 1 week freq
For 3 weeks duration

→ Save

To order other disciplines ie: HHA, PT, OT, ST

→ <New>

→ Status → new

→ Discipline PT

→ Ordering MD

→ Admission

For PT/OT/ST on Eval order:

From 1 to 1 visits
Every 6 days freq
For 6 day duration

Description: Eval & treat for _____

For MSW/RD

From 1 to 2 visits
Every 14 days freq
For 14 day duration

Description: Eval for _____

For HHA

If SOC Sun → Wed – can put in for HHA- 1st week in days → Desc Order → 2nd week on in weeks

If SOC TH → Sat – must ✔ with scheduler if HHA available
Or begin HHA the next week. (Must change start date to Sunday.)
Description: For ADL's and personal care

***See "Prior to Entering Careplan" Cheat Sheet**

Careplan/Clinical Pathways Table Icon (14th)

→ Goals & Interventions
→ Click on Problems, Goals, Interventions, Clinical Pathways
→ Click on ⚡ (lightning bolt = quick add)
→ Click ☑ next to care plans
→ Click ☑ next to desired problem

SCROLL DOWN THE PAGE:

<u>For all orders chosen complete General Details</u>

- Associate with Admission
- Choose Details
- Status – New
- Order Receipt Date
- Start Date
- Physician

<u>Careplan</u>

- Uncheck main title for "Goals" and "Interventions" **{ IMPORTANT STEP! }**
- Click each goal/intervention desired
- Click pencil and edit each goal/intervention
- Repeat above for each "Problem"

SAVE ALL→

Click SAVE on Ribbon Bar→ Click "Return to Summary" on Ribbon Bar

☒ out of screen

****NOTE: If SAVE button is not available check for goals/interventions surrounded by a red box. If yes, click pencil, click into the red box, hit space bar. – Red box should disappear and SAVE should now be available. Items seen as duplicates are surrounded by a red box as a warning.**

Contacts Contact Level

→ AddNew
→ Complete General form (payroll)

General tab:
- Time Type
- Date
- Admission
- Order (Be sure to pick the correct visit order string)
- Appt.
- Staff
- Service
- Visit Type
- Place of Service
- Branch

Time/Mileage Tab:
- Arrival
- Leave Time
- Mileage

Profile

"Do you want to create an appt?" YES
→ Profile attachment will open
→ Click "Attach document" (on ribbon bar)
- Find correct paperwork
  ie. OASIS C1 Start/Resumption of Care

→ "Add" on bottom (NOT Add File)

Complete Oasis

Once done click "Completed" (on ribbon bar)
Click "Recheck Profile" (on ribbon bar) Make corrections as needed.
LOCK OASIS for Medicare & Managed Medicare only
☒out of profile (on tab with document name)
Drop down on left → Close

Outside Service Orders -- Hand with Tray Icon (13th)

**For HomMed Monitoring
→ AddNew
→Service
→ HomMed Monitor
→ Status – New
→ Ordering physician
→ Receiving staff
→ Attached to ⊙ Admission
→SAVE

Rehabilitation Potential Table Icon (14th)

→ AddNew → Admission →Employee → Discipline → Date
→ Free type area (Example: Good, Fair, Poor, Guarded)
→ **Save**

Discharge Plan Table Icon

→ AddNew →Admission, Employee → Discipline → Date
→Free type area (Example: "When goals are met")
→ SAVE

Patient Summaries Table Icon

→ This is completed at discharge from homecare or discharge to another discipline and on Recertification
→On Recertification click "Print on POT"

HIPPA

→Click on Actions (Toolbar)
→HIPPA Privacy Regulations
→ Authorizations of Disclosure
→Type → Date → Free type in Memo
→SAVE

Disaster Plan Scale Icon

→ Acuity: Disaster Plan or Disaster Plan/High Risk Oxygen
→ Start date= SOC date
→ Acuity Level (1, 2 or 3)
→ Admission (current adm date)
→ SAVE

Alert/Pt Notification "A Icon" → Add → Description → Date – Free type for safety issues: pets, neighborhood, MRSA, VRE, CDiff, etc.
→SAVE

Immunizations

↳ Add New

↳ Vaccine: Enter Influenza or Pneumonia
Administration due: _blank_
Administration date: (enter date if pt received vaccine – if NOT, delete date))
Administration refusal date: (enter if pt refused)
Vaccine site: (blank)
Administered by agency: Yes/**No**/Contraindications (choose one)
Administered by: BLANK
Med
Route
Manufacturer
Lot #
} Leave blank

* Comments: (document where vaccine received or why refused—this is necessary for the discharge OASIS)

Vaccine information statement date: Blank
Vaccine information statement provided date: Blank
☐ Follow up required (leave blank)

SAVE → Click OK for pop up

* Repeat x2 for Flu/Pneumonia vaccines – Add New

Once SOC done:

Please send secure message to:

SN: SM – Admission

PT: SM Therapy Admission

If an insurance case→ please add auth request on secure messages and include group SM Insurance Auth Nurse.

If HHA → type in order string and include group - SM HHA Scheduler.

If OT/PT/ST/MSW→ type in request information.

*** Review your 485 when done with SOC → Homeworks Main Menu
GO to Reports → Chart Mgmt → Plan of Treatment (485) → Next → Choose cert period → Next→ Next → *cert period (Add) → Find pt name on right (Add)→ Preview