Coordinated Access Processes

Care Manager Module

Care Manager Support:

Email: seniorshealth.southzoneeducation@albertahealthservices.ca for questions, corrections and access requests. Your e-mail will be answered within 24 hours.

Your Test Client Name:_____

PHN/ULI #:_____

Contents

Introduction to Meditech Basics

What is Meditech?

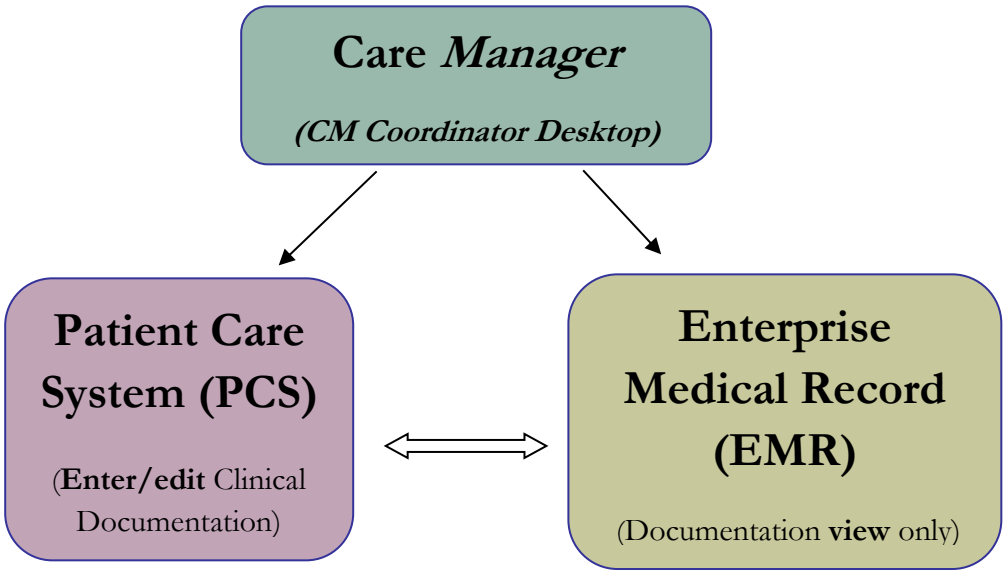
- Meditech is a software information management system used by Healthcare Organizations around the world for electronic clinical documentation.
- Meditech was developed in Boston so some fields and functions are not used. It is used by most zones in Alberta Health Services, but the extent of its use varies within each zone.
- Meditech integrates with other systems (e.g. NetCARE, Provincial Alberta Continuing Care Information System).

What are the benefits to Meditech?

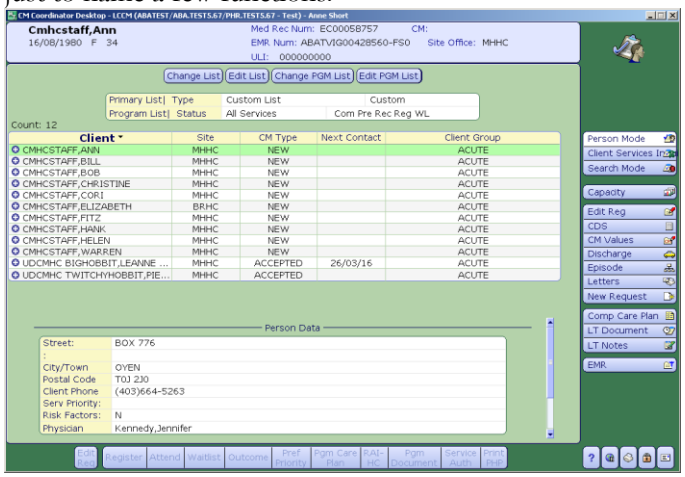
- share information electronically within Continuing Care
- access to timely, reliable and up-to-date client information
- electronic entry of client demographics and clinical assessments for data reporting
- information is entered in a consistent format

Care Manager vs. Patient Care System (PCS) vs. Enterprise Medical Record (EMR)

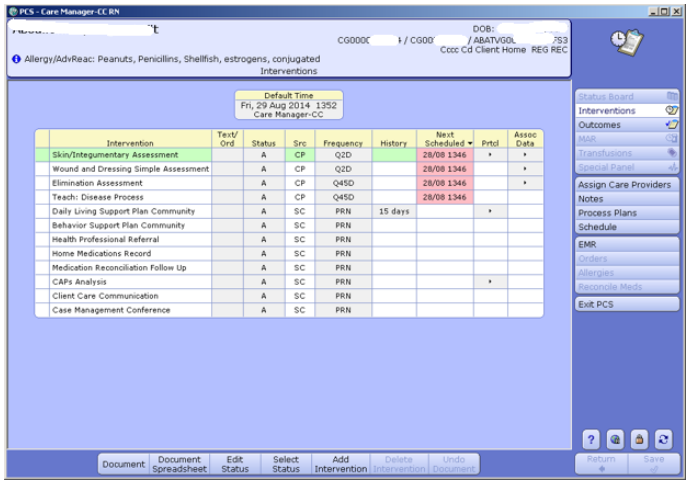
Meditech operates between Care Manager, Patient Care System and the Enterprise Medical Record. Which system you access will depend on the task you are performing.



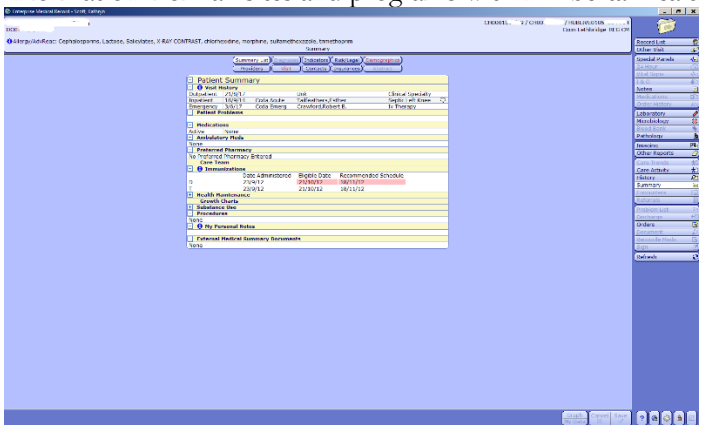
CM Coordinator Desktop in Person Mode is where all Home Care clients will be registered and demographic details recorded. Clinicians can also register Programs, complete a RAI-HC assessment, and authorize services, just to name a few functions.



Patient Care System (PCS) is where clinical information is **documented** on a client's Lifetime or Program Account. **Documentation should be done using standard upper and lower case rules.**

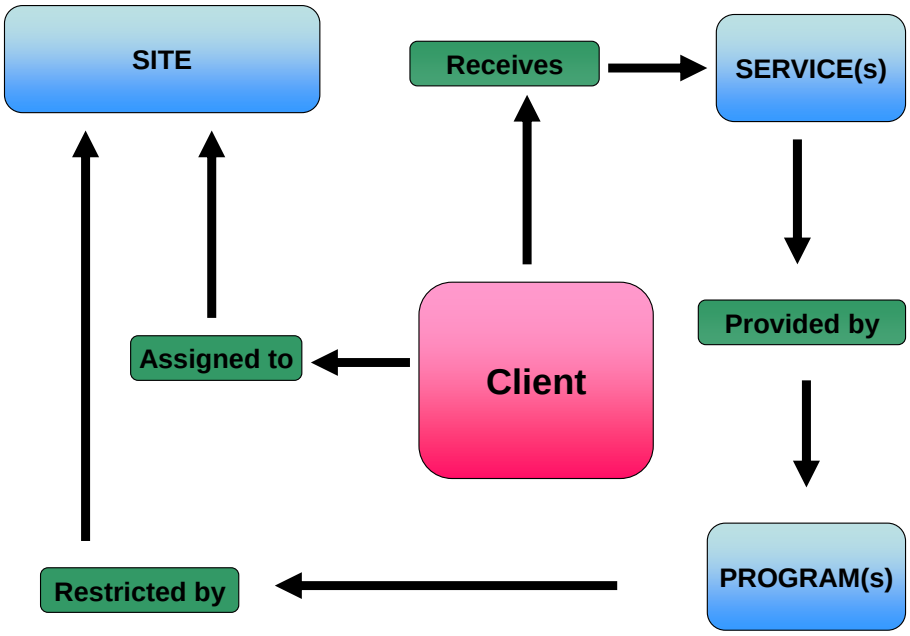


The Enterprise Medical Record (EMR) is where clinicians view current or historical documentation that was entered in PCS or has been scanned into the client's electronic record. Clinicians will have access to **view** client information from all sites and programs within Alberta Health Services.



Understanding the Language of Meditech: Site/Services/Programs

The Client is assigned to a **Site** and receives **Services** that are provided by a **Program**.



Site (should reflect the care setting where the **primary** services are currently provided)

- client can only have one site at a time
- restricts the Programs available to meet a client's needs
- must be changed when client moves to a new site

Service(s) (a high level description of the type of care a client requires in order to meet their needs)

- can have multiple service types occurring at once
- the choice of service determines the default list of Programs available for the registered site

Program(s) (lower level name of the setting or group providing the service)

- can have multiple Programs at the same time
- documentation and care plan occurs on the main Program account where care is being provided

Electronic Documentation & Security

Both Regulated and Non-Regulated Health Care Professionals are responsible for ensuring they follow appropriate guidelines when using electronic documentation.

General Charting Principles in PCS

- Use upper and lowercase, and proper sentence structures,
- There is an **Intent** section at the top of most assessments for information purposes, **DO NOT** document anything in this section,
- Circle selections mean you can select only one option,
- Square selections mean you can select more than one option,
- Comment boxes are for free text,
- Some assessments are on multiple pages which are identified in the upper right corner of the screen.

Documentation

- Can include Client Assessment data, clinical findings, care plans, Interventions, Client goals, critical pathways, medication administration, risk Assessments, and discharge planning. "Staff will document immediately after care has been provided, or within the same scheduled shift that care has been provided" *(Home Care Policy and Procedure #3.2.20).*
- Must be comprehensive, accurate, timely, and clearly identify who provided the care/service. It must be objective, factual and reflect appropriate use of abbreviations. *(CARNA, September, 2006).*
- Health Care Professionals must sign off any entries; signatures are considered valid if used to demonstrate accountability specifically by that person. *(CNO, 2004)*
- Incorrect entries must be corrected indicating the person making the correction and when it was made. Previously entered data that is part of the record should not be deleted.
- Late entries must clearly be identified noting the date and time late entry was made.

Downtime Procedure

Chinook Zone: Downtime files can be found in the Shared Drive.
Palliser Zone: Downtime files can be found in the Shared Drive. Check with Site Manager and Super users.

Electronic Records and Security

- Entries made and stored in an electronic health record are considered a permanent and legal part of Client records.
- Access to Client information should occur only when that professional is involved with the Client and his/her plan of care. Authorized individuals; people providing services or acting on behalf of AHS granted access to Personal and Health Information on a "need to know basis".

Users are responsible for updating their passwords. Passwords should not be easily deciphered.

NEVER reveal or allow anyone else access to your personal identification number (PIN) or password as it acts as a personal signature and identify YOU as the person accessing and documenting Client information. Users are responsible for all actions performed under their user ID login.

- Use only systems that have secured access.
- Do not use automatic login procedures (automatic password saving).

- Protect Client information displayed on monitors by locking workstation. Keep devices in users possession at all times.
- Transport information securely by logging off when not using the system or when walking away from or leaving the terminal.

Employer Expectations Regarding E-documentation (Alberta Health Services)

All AHS employees and others acting on behalf of AHS shall:

- Take reasonable precautions to ensure AHS IT resources are placed to prevent potential risks from unauthorized access, security threats, and environmental hazards.
- Report breaches of privacy/security to your immediate supervisor. Cooperate with investigations into breaches of confidentiality, requests for access to information and other activities in order to be in compliance with FOIPP and HIA.

Personal information and Health Information shall only be collected; accessed and/or used when the requirements of the FOIPP, the HIA, and other applicable legislation have been met.

Protection and Privacy of Health & Personal Information

Policy Statement: all Personal and Health Information under the control or custody of AHS, in any format, is confidential and shall only be available to Authorized Persons. Authorized persons collecting, accessing, using, or disclosing personal and Health Information shall comply with all applicable legislation and AHS policies. Authorized Persons shall use the Information responsibly and appropriately, and maintain the confidentiality, security, integrity, and accuracy of the Information. Breaches of confidentiality shall be considered grounds for disciplinary action up to and including dismissal.

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-privacy-protect-ia.pdf#search=approved%20protection%20of%20privacy.pdf

Access to Information (Physical, Electronic, Remote)

Policy Statement: AHS shall employ physical administrative and technical access controls at all facilities for areas continuing information processing and storage, IT Resources, Information, and Information systems Such controls include but are not limited to surveillance video, alarms, card and key controlled entry doors, access codes, staff identification badges, unique user IDs and passwords, Access levels and privileges' shall be restricted to the minimum required to fulfill and individuals' role and responsibility with AHS.

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-access-information.pdf#search=approved%20access%20to%20information.pdf

Contractor Requirements for Security of Information and IT resources

Policy Statement: Contractors granted access to AHS information or IT resources shall implement and maintain controls for the security of information and IT resources and comply with applicable AHS policies and information Security Program Standards.

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-contractor-requirements.pdf#search=contractor%20requirements%20for%20security.pdf

Information Technology (IT) Acceptable Use

Policy Statement: The IT resources of AHS, including the internet and electronic forms of communication ("email") are intended for AHS business purposes. Users using AHS IT resources shall comply with applicable

AHS policies and procedures including, but not limited to those related to user ID's, password, emails, information security, privacy and confidentiality. Users, as representatives of AHS shall use proper judgment when using the internet, email or other IT Resources.

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-it-acceptable-use.pdf#search=approved%20accepTable%20use.pdf

Delegation of Authority and Responsibilities for Compliance with FOIPP and HIA

Policy Statement: Authorized persons responsible for collection, access, use, disclosure retention of Personal and Health Information shall comply with the requirements of *Freedom of Information and Protection of Privacy Act (Alberta)* (FOIPP), the Health Information Act (Alberta) ("HIA") and with applicable AHS policies.

https://extranet.ahsnet.ca/teams/policydocuments/1/clp-ahs-pol-doa-foipp-hia.pdf#search=approved%20delegation%20of%20authority%20foipp%20hia.pdf

Documentation & Security References

College and Association of Registered Nurses of Alberta. (2006). Documentation Guidelines for Registered Nurses. Edmonton, AB: Author
Kirkley, D. & Renwick, D. (2003). Evaluating clinical information systems. Journal of Nursing Administration, 33 (12), 647.

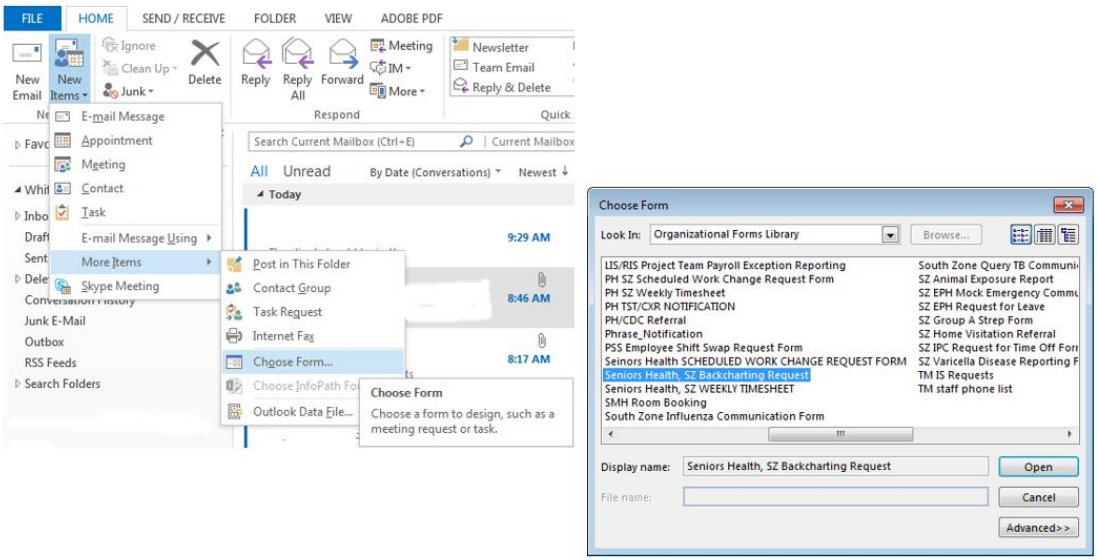
Back Charting

Note: late entries greater than 72 hours will require special changes to your charting access. To change your access you will need to email: SeniorsHealth.SouthZoneEducation@ahs.ca, cc your manager and complete the back charting form (see below).

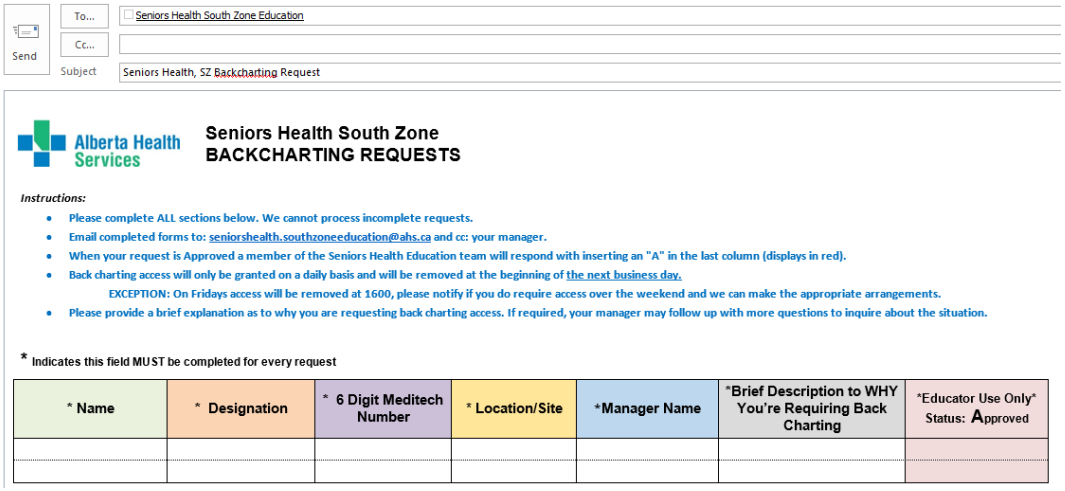
Accessing the Back Charting Form on Outlook

a. Open Outlook

b. In top left of Mail page, Click 'New Items' → 'More Items' → 'Choose Form…' → and open 'Seniors Health, SZ BACK CHARTING FORM'



c. The back charting form will display like this. Follow all instructions and E-mail completed from to seniroshealth.southzoneeducation@ahs.ca



Send | To... Seniors Health South Zone Education | Cc... | Subject: Seniors Health, SZ Backcharting Request

Alberta Health Services

Seniors Health South Zone
BACKCHARTING REQUESTS

Instructions:

- Please complete ALL sections below. We cannot process incomplete requests.
- Email completed forms to: seniorshealth.southzoneeducation@ahs.ca and cc: your manager.
- When your request is Approved a member of the Seniors Health Education team will respond with inserting an "A" in the last column (displays in red).
- Back charting access will only be granted on a daily basis and will be removed at the beginning of the next business day.
  EXCEPTION: On Fridays access will be removed at 1600, please notify if you do require access over the weekend and we can make the appropriate arrangements.
- Please provide a brief explanation as to why you are requesting back charting access. If required, your manager may follow up with more questions to inquire about the situation.

* Indicates this field MUST be completed for every request

* Name	* Designation	* 6 Digit Meditech Number	* Location/Site	*Manager Name	*Brief Description to WHY You're Requiring Back Charting	*Educator Use Only* Status: Approved

Accessing the Back Charting Form on the Shared Drive

Adding Shared Drive to your computer

Adding Shared Drive to your computer

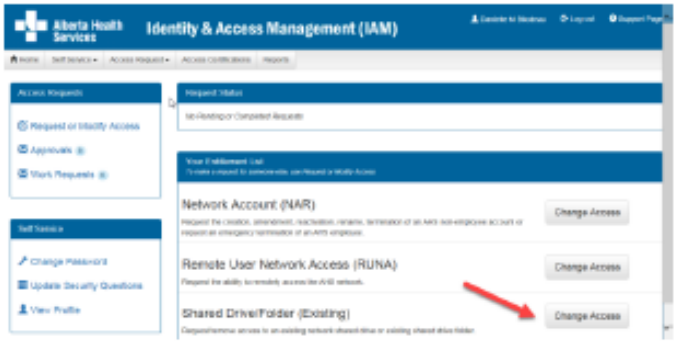
a. Type in Identity and Access Management in "Everything" Search field on Insite.

b. Click on "Identity & Access Management (AHS IAM) Insite"

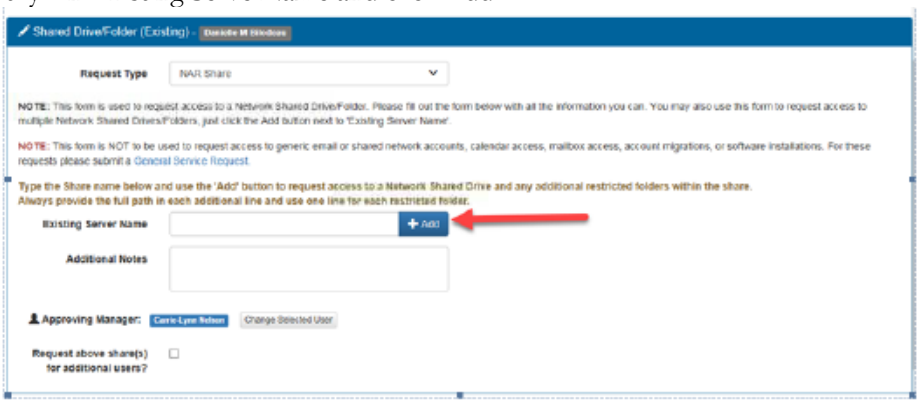
c. Scroll down and click on "IAM Login"

d. Enter your AHS network Username and Password (the Username and Password you use to login to a computer.

e. Click "Change Access" beside Shared Drive/Folder (Existing).

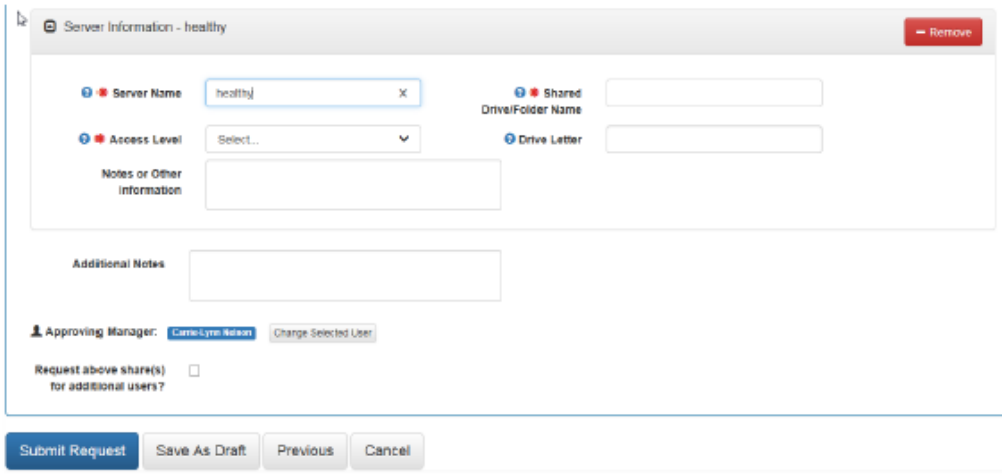


f. Enter "healthy" in Existing Serve Name and click Add



g. Enter the following information:

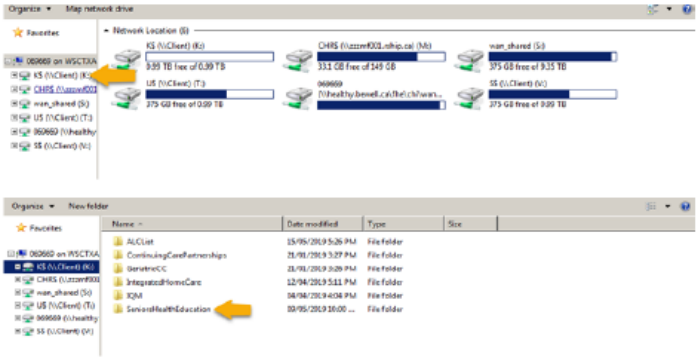
Shared Drive/Folder Name: Seniors Health Education
Access Level: Read Only
Drive Letter: K
Click "Submit Request"



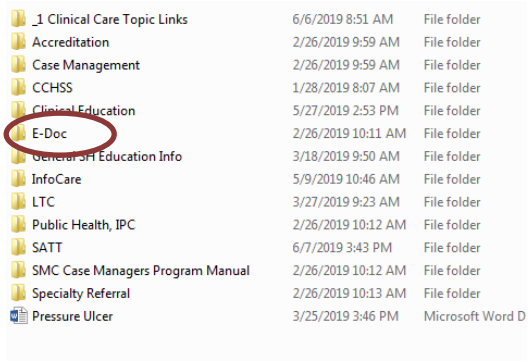
Using Shared Drive for Electronic Documentation Resources

a. Open 

b. Open Windows Explorer, Select the "K" drive, and the choose SeniorsHealthEducation

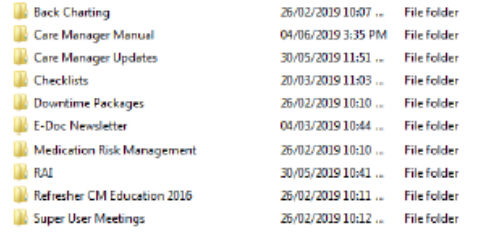


c. Access the E-doc Education Folder



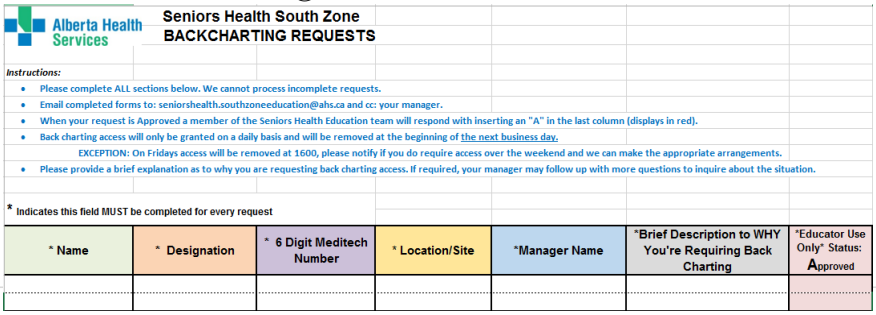
_1 Clinical Care Topic Links	6/6/2019 8:51 AM	File folder
Accreditation	2/26/2019 9:59 AM	File folder
Case Management	2/26/2019 9:59 AM	File folder
CCHSS	1/28/2019 8:07 AM	File folder
Clinical Education	5/27/2019 2:53 PM	File folder
E-Doc	2/26/2019 10:11 AM	File folder
General SH Education Info	3/18/2019 9:50 AM	File folder
InfoCare	5/9/2019 10:46 AM	File folder
LTC	3/27/2019 9:23 AM	File folder
Public Health, IPC	2/26/2019 10:12 AM	File folder
SATT	6/7/2019 3:43 PM	File folder
SMC Case Managers Program Manual	2/26/2019 10:12 AM	File folder
Specialty Referral	2/26/2019 10:13 AM	File folder
Pressure Ulcer	3/25/2019 3:46 PM	Microsoft Word D

d. In the E-doc folder you will find the Care manager Manual folder as well as the Back charting folder as well as other E-doc related updates and education packages



Back Charting	26/02/2019 10:07 ...	File folder
Care Manager Manual	04/06/2019 3:35 PM	File folder
Care Manager Updates	30/05/2019 11:51 ...	File folder
Checklists	20/03/2019 11:03 ...	File folder
Downtime Packages	26/02/2019 10:10 ...	File folder
E-Doc Newsletter	04/03/2019 10:44 ...	File folder
Medication Risk Management	26/02/2019 10:10 ...	File folder
RAI	30/05/2019 10:41 ...	File folder
Refresher CM Education 2016	26/02/2019 10:11 ...	File folder
Super User Meetings	26/02/2019 10:12 ...	File folder

e. The Outlook back charting form will display like this. Follow all instructions and E-mail completed from to seniroshealth.southzoneeducation@ahs.ca



Alberta Health Services — **Seniors Health South Zone BACKCHARTING REQUESTS**

Instructions:

- Please complete ALL sections below. We cannot process incomplete requests.
- Email completed forms to: seniorshealth.southzoneeducation@ahs.ca and cc: your manager.
- When your request is Approved a member of the Seniors Health Education team will respond with inserting an "A" in the last column (displays in red).
- Back charting access will only be granted on a daily basis and will be removed at the beginning of the next business day.

EXCEPTION: On Fridays access will be removed at 1600, please notify if you do require access over the weekend and we can make the appropriate arrangements.

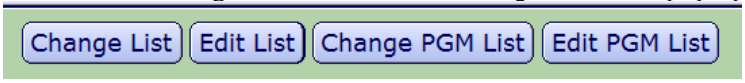
- Please provide a brief explanation as to why you are requesting back charting access. If required, your manager may follow up with more questions to inquire about the situation.

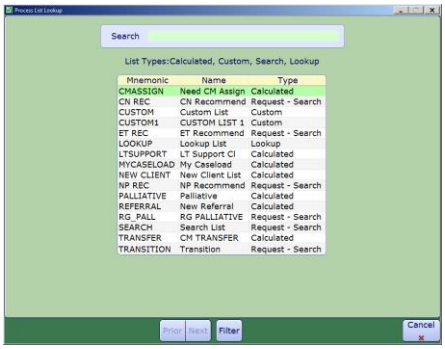
* Indicates this field MUST be completed for every request

* Name	* Designation	* 6 Digit Meditech Number	* Location/Site	*Manager Name	*Brief Description to WHY You're Requiring Back Charting	*Educator Use Only* Status: Approved

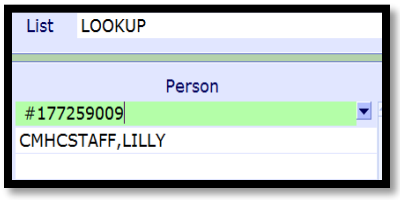
First: Determine if a client is Registered in Care Manager

1. Select header button **Change List**, then select **Lookup List** in the pop up box.



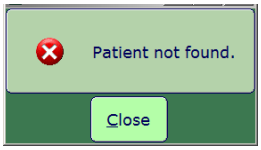


2. Enter the clients PHN number (# sign with no space) #777745269 or enter the client's last name, first name

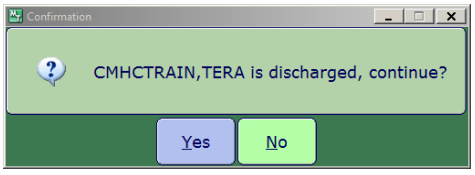


If the name displays select green check to save 

Then determine if the client has an active episode see page 15

a. If a Pop up displays 

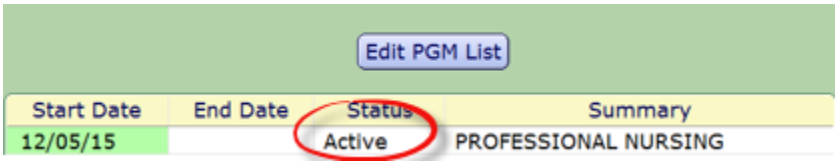
This client has never been registered in Care Manager.
Then proceed to Process #1 on page 17

b. If this pop up displays 

this means the client has been registered in Care Manager historically.
Then proceed to Process #2 on page 22

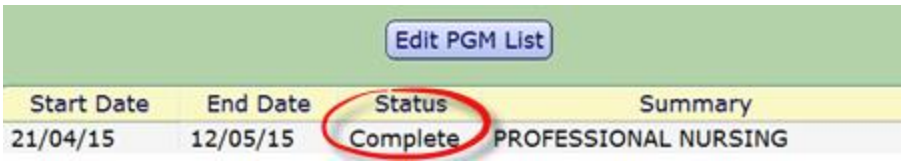
Second: Determine if the client found in Care Manager has an Active Episode of Care

1. On the C**M Coordinator Desktop** screen select the client
2. Select the Right Menu Button, **Episode**
3. Determine if the **Episode** is **Active**



a. If the **Episode** is **Active** - follow **Process #1 on page 17**

b. If the E**pisode is Complete –** follow **Process #4 on page 27**



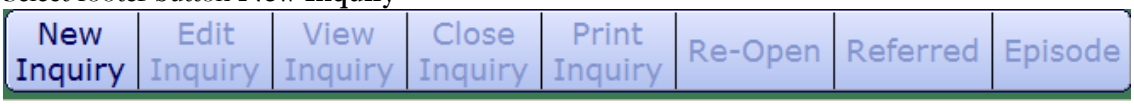
c. If there is no **Episode - follow Process #4 on page 27**

Client Services Inquiry (CSI)

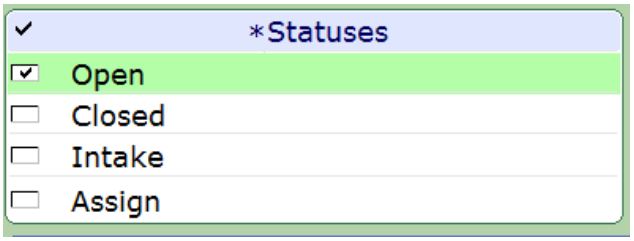
This routine is used by Coordinated Access staff to track and manage new referrals.

- Select right menu button **Client Services Inq**

- Select footer button **New Inquiry**



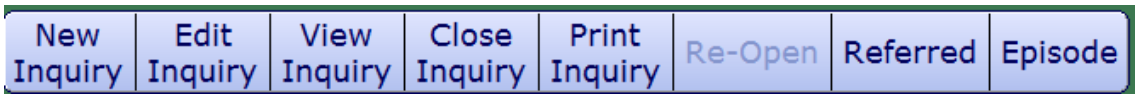
- The button "Select" on the top of the screen will display (Open, Assign, All, Closed, Intake and Select) are called the View buttons (work like on/off buttons). They are used to change the type of Lists displayed. The check marks to the left indicates your current selections.



Status List Descriptions:

Open List – displays all clients with an open status, meaning the inquiry has not yet been dealt with or completed. Changes can be made to the Client Inquiry in this status. Clients will be displayed in the color Blue.
Assign List – displays the clients that have been assigned a User in the Inquiry Process. This could be used to assign clients to a specific Access Centre staff member as a reminder to follow-up. (This is not being used at present.)
Closed List – displays the clients that have not required a referral to Community Care; and the Inquiry is closed/completed. The client's name will remain on this list for 30 days.
Intake List – displays the clients that have had an Intake and Registration completed and have been assigned to an office. Changes cannot be made in this status.

CSI Footer Button Definitions



New Inquiry – records a new Inquiry made Coordinated Access via phone, fax, printer, or walk-in.
Edit Inquiry – allows edits to the **Open Inquiries** that have not had an Intake/ CM Reg info completed.
Close Inquiry – is used to complete an Inquiry.
Intake/Reg – is used to register clients into Community Care.
View Inquiry – allows an Inquiry to be viewed and includes an Audit of all the activity surrounding the Inquiry
Re-Open Inquiry – allows an Inquiry to be reopened because further follow-up is required. This can change a Closed status to an Open status so the Inquiry can be updated.
Print Inquiry – prints the Inquiry. Not being used.
Referred Inquiry – PA ring - not being used.

Process # 1 Client has never been registered in Care Manager

Client needs to be Registered in Care Manager

Note: **ALWAYS** find the ULI (PHN number) which can be located in the EMR by selecting "**View all Visits**," "**Summary**" and then "**Demographics**" or you may look the client up in Netcare.

Step 1: Client Services Inquiry (Registering the Client)

1. Select right menu button **Client Services Inq** 

2. Select footer button **New Inquiry**

- **Referral Source Tab**: **Referral Source** and **Referral Method** must be completed. Do a look-up (F9) highlight choice and press **Enter**.
- **Contact Tab**: complete **Contact Information** (may or may not be the same as the referral source; when "Contact Information" is unknown,type in "**U,U**."
- **ULI#**
    - **Reason** (look-up, may select more than one reason but the list in order or priority)
    - **Client Data**: insert PHN into ULI field
    - **Site** (look-up, assign to Access Centre [CH Meditech] or specific office [PA Meditech])
    - **Search MPI?** Insert **"Y". MPI=Master Patient Index**

Pop up: check the client listed at the top of the screen: that the Client's name, DOB is correct, if so click the client name. Select **Update Inquiry** if information is correct. Fields with Account numbers will fill in. (You may be prompted to select correct client. If so, check DOB, address, and PHN. With the 2nd confirmation check address and if correct choose to file.)

3. Fill **Site** field, and fill **Reason** field
4. **File** with the green check mark to return to the **CSI** screen.

Step 2: Edit Reg Screen

1. On the **Client Services Inquiry** screen – select the correct client
2. Select footer button **Episode** 

3. **Edit Reg** screen opens. -**This information should be verified with the client**. Ensure work done in Caps Lock (**all uppercase),** **verify information found in each of the 9 screens before filing (Save).**

Note: **for discrepancies related to client's name or date of birth: email Data Integrity and follow the instructions:** Rural.HIM.DataIntegrityStaff@albertahealthservices. In the **subject line** state which ring of Meditech you are needing help in (**Chinook or Palliser ring of Meditech**) within the body of the email give the **client's ULI number**, **what is the error** is that needs correction and **what was used to validate** the error. (Changes to Name, DOB need to be verified by viewing birth certificate or Alberta health care card).

Complete the following screens in **Edit Reg**. All items with an **asterisk (*)** indicates data reportable to **ACCIS**:

Client | Contact | Addtl Census | Guarantor | Insurance | Risks | Prov/Site | Service Loc | Allergies

Client Button:

- **clients mailing address**
- **Language** (F9 look up available) – item reportable to AHS
- **Postal Code**
- **Resid Cd** – Community based off of postal code
- **Country –** should be CA

Contact Button:

- **Next of Kin-second** contact in case of emergency
- **Person to Notify –first** contact in case of emergency can use **SP**-same place; **SNOK**-same as next of kin.

Addtl Census Button:

- **leave bank:** use **Client Contacts** in **LT Document**.

Note: Any Confirmation pop ups must be answered with Yes or No to update or leave addresses unchanged. Read information in each screen carefully.

Guarantor Button:

- confirm the name of the Guarantor (this is the person who will pay bills.)

Insurance Button:

- Insurance: **AHC** should default

Risks Button:

- insert "**Y**" for Yes if a risk identified or "N" for No – if answering Yes complete the **Safety Risk assessment** in the Lifetime Account

Prov/Site Button:

- Do not use **Primary Care or Other** field
- **Family Physician** should be filled out and/or corrected (use upper case, first 4 letters last name, F9 and select the correct physician. If no family physician leave blank.
- **Reason for Visit** will default as **"Receiving Continuing Care Services".** If this information has been changed then delete an d click out of field. Click back into field again and the above will auto populate.

Service Location Button: **w**here care will be received.

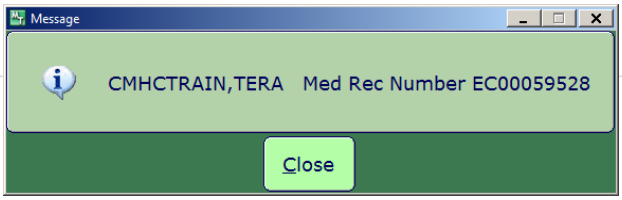
- **From Date** – would be the date you are registering the client
- **Level of Care** – select **Other** if client is in hospital - use down arrow or F9
- **Homeless** – if the client is homeless enter **Y** if not enter **N.**

Note: The computer will automatically update the Service Location Postal Code to Z1Z 1Z1

- **Street -** If rural address, enter "**Rural-See Directions**." Add specifics, i.e. lot number. Add additional directions if required especially for rural residences. (Can use shortcuts, eg. **SP** for Same Place brings address from **Client** screen, **however the address must be entered on clients who have never been registered in Care Manager)**.

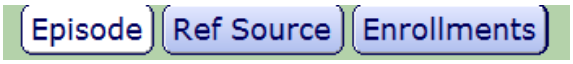
Allergies Button: **View only;** allergies will be entered/updated via **EMR or PCS**.

File after all information has been reviewed. ✔ A message box appears, select Close

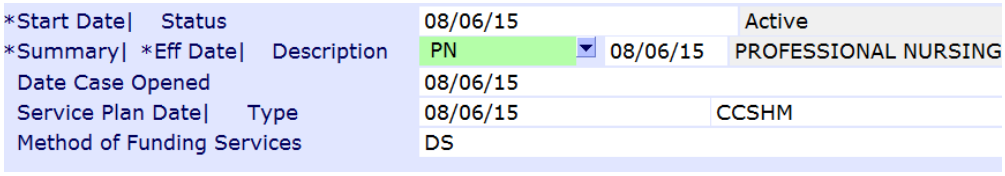


Note: If Registration screens will not File indicating information is missing in Insurance screen:
Out of Region then remove **Out of Region** Insurance by highlighting and deleting from field then File.
Self-Pay Insurance: If Self-Pay insurance present, plus AHC insurance, remove Self-Pay by Highlighting and deleting from field then File. Ensure that AHC is on the first line.
If you cannot File, the **Edit Reg** email for assistance to:
SeniorsHealth.SouthZoneEducation@albertahealthservices.ca

Step 3: Edit Episode

Edit Episode screen opens: 

- **Start date** – **do not edit** (this should be the date that the CSI was created)



- **Summary field** –for summary description for the **Episode** use drop down arrow or F9 and enter date (refer to page 61 for choices).
- **Service Plan Decision Date** – would be the same as the start date
- **Service Plan Type** do a F9 and select Hospital transfer to Home. File using green checkmark

Note: Client is now Registered in Care Manager with an Active Episode and Lifetime Account

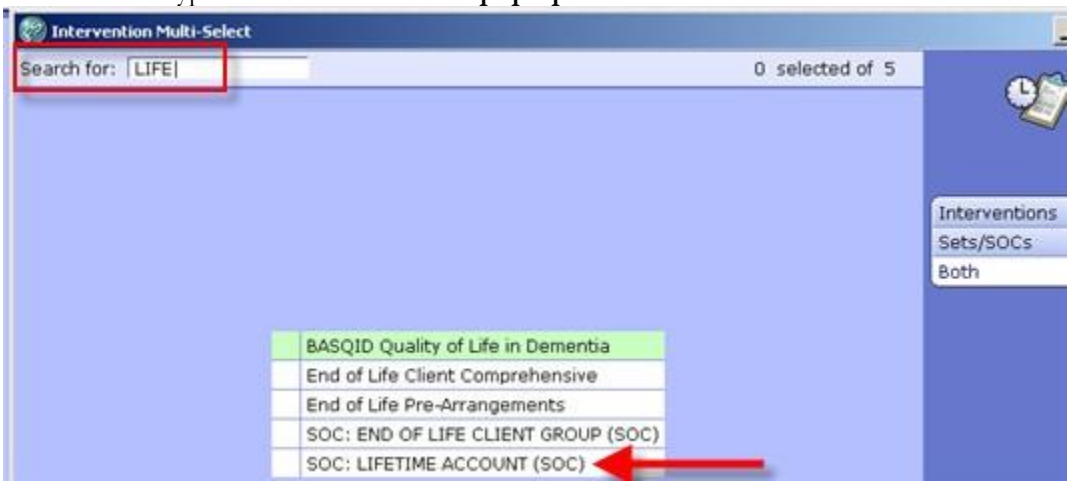
Step 4: Lifetime Account documentation

1. Once the **Episode** is filed, the system will take you to the **CM Coordinator Desktop** screen
2. Select the **LT Document** button. This will take you into **PCS/WORKLIST** in the **Lifetime Account**

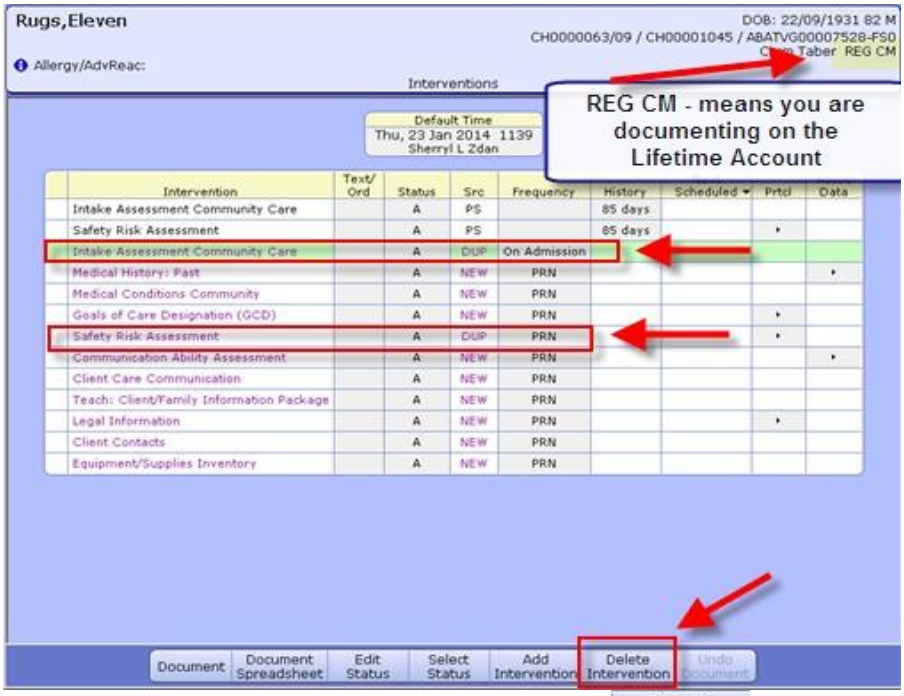
3. You will know you are charting on the **Lifetime Account** by looking at the following in the upper right corner

4. Select **Add intervention**

5. In **Search** field type **LIFE and a list will pop up**



6. Select **SOC:LIFETIME ACCOUNT**
7. **Add & Close** and then **File**
8. **<u>If duplicate interventions are listed on the Lifetime Account:</u>**
   In **PCS /Worklist** the interventions that have the **DUP** in the **Src** column – can be deleted by selecting that line and putting a checkmark in the box to the left of the intervention and clicking "**Delete**" on the Footer menu



9. Select '**Delete Intervention'** on the Footer menu

10. The line will be removed. Go to the next duplicate and repeat the steps. When all the duplicate interventions have been removed. Select '**Save'.**

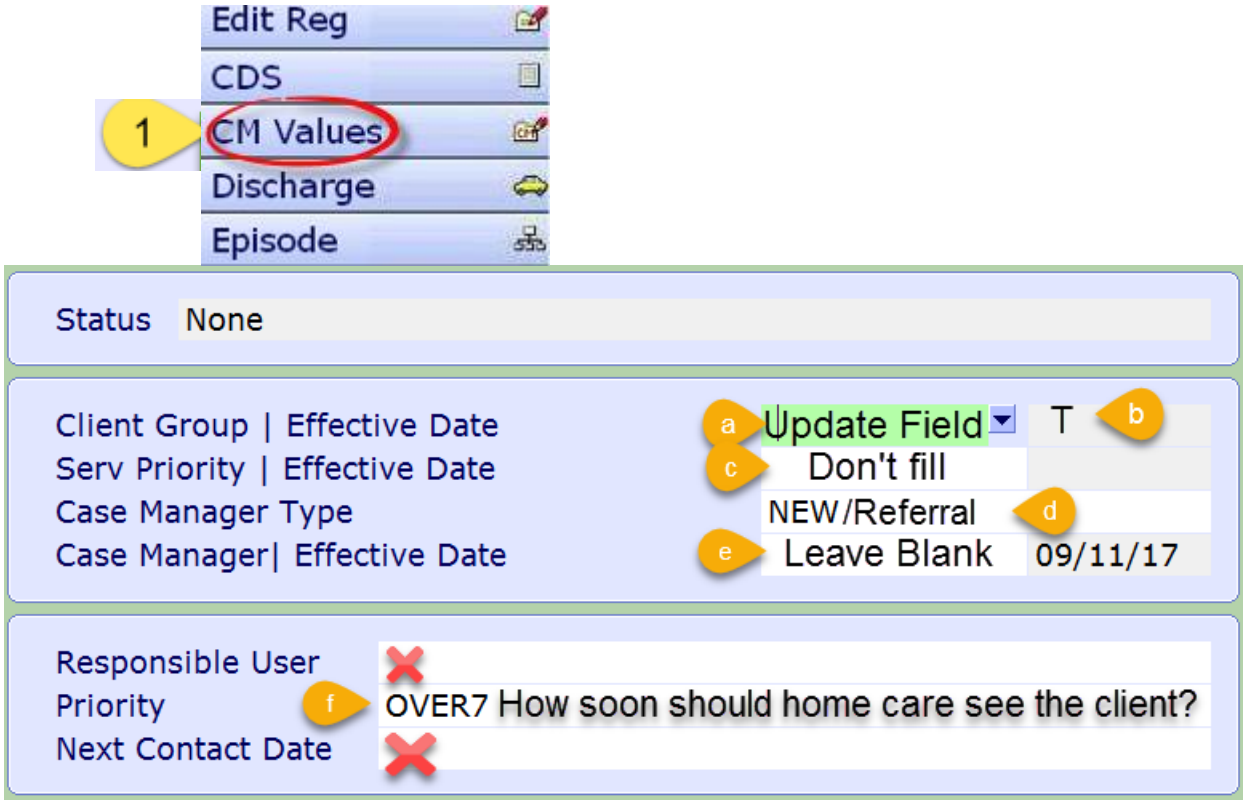
11. Now only the **Interventions** that have the status of **Active** will be displaying
12. Complete **Intake Assessment Community Care**. (refer to **<u>page 65)</u>** to see intervention and info on completing the **Client Group** section).
13. Complete the **Safety Risk Assessment**. A '**Yes**' or '**No**' must be indicated for each section. If unable to assess, indicate this in the **Comment** box in each section of the Assessment

Step 5: CM Values

1. Select Right Menu button **CM Values** – **CM Coordinator Desktop** screen
   a) **Client Group** - this is determined through the **Intake Assessment**
   b) In the next field you must manually enter Effective Date = **T** for today
   c) **Serv Priority** – Do not fill
   d) **Case Manager Type** – select **New** (CH Meditech) or **Referral** (PA Meditech) delete any other value. This is entered when it is known that the Community Care will be getting involved otherwise leave blank until this is determined. This generates the client's name on **New referral list** (PA Meditech) or **Need CM Assign list** (CH Meditech) at the Home Care office..
   e) **Case Manager** - must be blank
   f) **Priority** - when **Home Care** to make contact - F9 Look up
2. **Once all required areas are filled in, file** using green checkmark

Note: If Client Group previously entered DELETE and update with result of Client Group from the new Intake Assessment
Note: Case Manager Type must always be NEW
Note: Delete any old "Case Manager" numbers

Below is a visual of the Steps to address the CM Values as stated above:



Process # 2 Client has been discharged from Care Manager

Step 1: Client Services Inquiry (CSI) - Registering the Client

1. Select right menu button **Client Services Inq** 

2. Select footer button **New Inquiry**

   Referral Source Tab: **Referral Source** and **Referral Method** must be completed. Do a look-up (using F9 or drop down arrow), highlight choice and press Enter.

   Contact Tab: complete **Contact Information** (may or may not be the same as the referral source; when **Contact Information** is unknown, use "**U,U**."

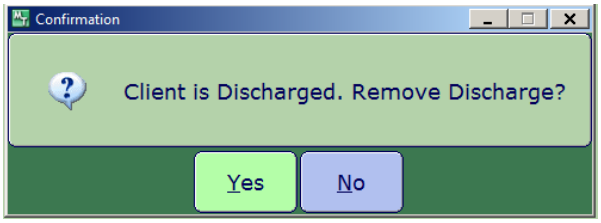
   - o **Reason -** look-up, may select more than one reason but list in order of priority
   - o **Client Data**: insert PHN into ULI field
   - o **Site** (look-up, assign to **Access Centre** [CH Meditech] or **specific office** [PA Meditech])
   - o **Search MPI?** Insert **"Y".**

Pop up: check the client listed at the top of the screen: Ensure that the Client's name, DOB is correct, if so click the client's name. Select **Update Inquiry** if information is correct. Fields with Account numbers will fill in.

- o Fill **Site field**, and fill **Reason** field
- o **File with the green check mark to return to the CSI screen.**

Step 2: Remove Discharge

1. On the **Client Services Inquiry** screen – select the correct client
2. Select footer button **Episode**.
3. The following **Confirmation** box will display – select **'Yes' to remove the Discharge**



4. **Edit Reg** screen opens. -This information should be verified with the client. Ensure work done in caps lock (**all uppercase),** **do not file (green check mark) until all tabs verified.**

Note: for discrepancies related to client's name or date of birth: email Data Integrity and follow the instructions: Rural.HIM.DataIntegrityStaff@albertahealthservices. In the **subject line** state which ring of Meditech you are needing help in (**Chinook or Palliser ring of Meditech**) within the body of the email give the **client's ULI number, information that requires** correction and which **legal documents** were used to **validate** correct information. (**Changes to Name, DOB need to be verified by viewing birth certificate or Alberta health care card).**

Complete the following screens in **Edit Reg**. All items with an **asterisk (*)** indicates data reportable to **ACCIS**:

Client | Contact | Addtl Census | Guarantor | Insurance | Risks | Prov/Site | Service Loc | Allergies

Client Button:

- o **Client's mailing address**
- o **Language** - (F9 look up available) – item reportable to AHS
- o **Postal Code**
- o **Resid Cd –** Community based off of postal code
- o **Country** – should be CA

Contact Button

- o Next of Kin-**second** contact in case of emergency
- o Person to Notify –**first** contact in case of emergency can use **SP**-same place; **SNOK**-same as next of kin.
- o **Addtl Census: leave bank:** use **Client Contacts** assessment in **LT Document**.
- o **Any Confirmations pop ups must be answered with "Yes" to update or "N o" to leave as before. (Read carefully)**

Guarantor Button **c**onfirm the name of the **Guarantor** (this is the person who will pay bills.)

Insurance Button: Insurance: **AHC** should default

Risks Button: insert **Y** for Yes if a risk identified or **N** for No – if answering Yes complete the **Safety Risk assessment** in the **Lifetime Account**

Prov/Site Button:

- o do not use **Primary Care or Other** field
- o **Family Physician** should be filled out and/or corrected (use upper case, first 4 letters last name, F9 and select the correct physician) If no family physician leave blank.
- o **Reason for Visit** will default as **"Receiving Continuing Care Services".** If any other information has been changed then delete and click out of field. Click back into field again and information will auto populate.
- o **Preferred pharmacy**-not used at this time.

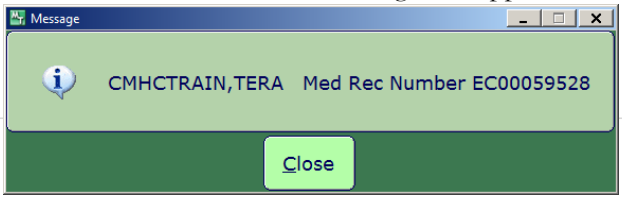
Service Location Button: **w**here client's personal care will be received:

- o **From Date** – would be the date you are registering the client
- o **Level of Care** –select **Other** if the client is in hospital - use down arrow or F9 for other options
- o **Congregate Site** – a predetermined list will auto populate for selection based off of the Level of Care field
- o **Homeless** – if the client is homeless Enter **Y** if not enter **N**
- o **Street -** The addresses for every SL3, SL4 and SL4D have been standardized and reported to Alberta Health. If rural address, enter **Rural-See Directions**. Add specifics, i.e. lot number.

Add additional directions if required especially for rural residences. (Can use shortcuts, eg. **SP** for Same Place brings address from Client screen , **however the address must be entered on clients who have never been registered in Care Manager).**

Allergies Button: is **view only;** allergies will be entered/updated via **EMR or PCS**.

- o **File** after all Tabs have been reviewed. ✔ A message box appears, select close to continue.

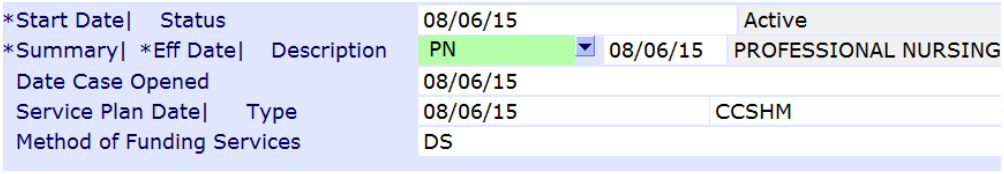


Note: If Registration screens will not File indicating information is missing in Insurance screen: **Out of Region** then remove **Out of Region** Insurance by highlighting and deleting from field then File.
Self-Pay Insurance: If Self-Pay insurance present, plus AHC insurance, remove Self-Pay by Highlighting and deleting from field then File. Ensure that AHC is on the first line.
If you cannot File, the **Edit Reg** email for assistance to:
SeniorsHealth.SouthZoneEducation@albertahealthservices.ca

Step 3: Edit Episode

Edit Episode screen opens: 

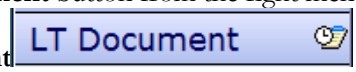
1. **Start date** – **do not edit** (this should be the date that the CSI was created)



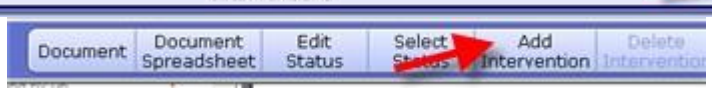
2. **Summary field** - enter a summary description for the Episode (refer to page 61 for descriptions) File entry.
3. **Service Plan Decision Date** – would be the same as the start date
4. **Service Plan Type** - select **Hospital transfer to Home** - use the drop down arrow or F9

Note: **Client is now registered in Care Manager with an Active Lifetime account**

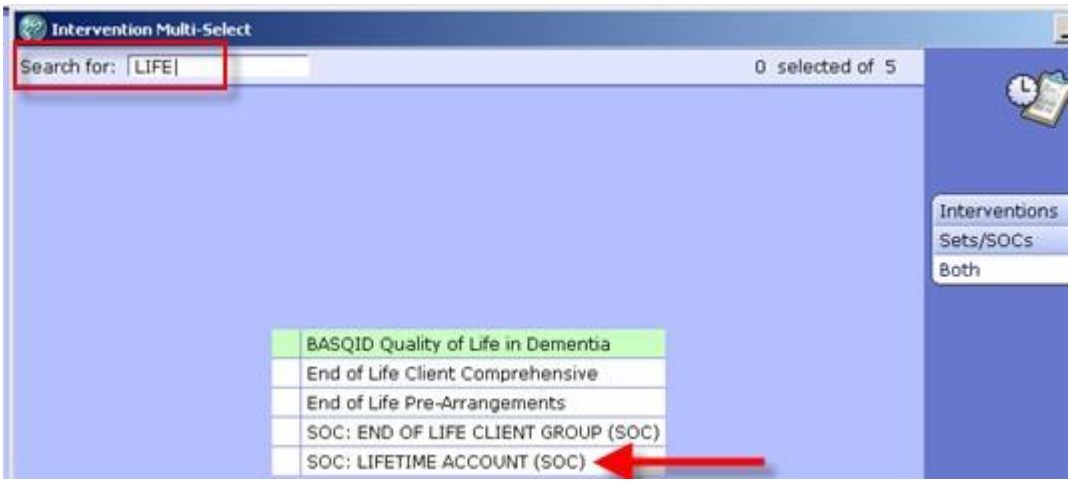
Step 4: Lifetime Account documentation

1. Once the **Episode** is filed, the system will take you to the **CM Coordinator Desktop** screen
2. Select the **LT Document** button from the right menu. This will take you into **PCS/WORKLIST** in the **Lifetime Account** 

3. You will know you are charting on the **Lifetime Account** by looking at the following in the upper right corner

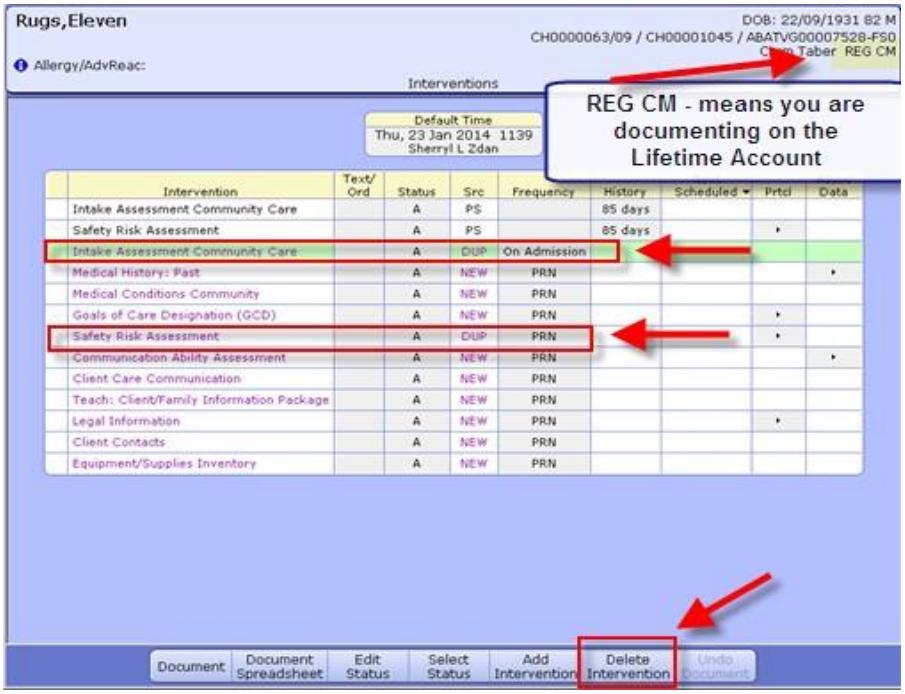
4. Select **Add intervention** 

5. In the Search field type **LIFE** to add the **Lifetime Account SOC**



6. Select **'LIFETIME ACCOUNT'**,
7. Select **Add & Close** and then **File**
8. **<u>If duplicate interventions are listed on the Lifetime Account:</u>**

   In **PCS /Worklist** the interventions that have the **DUP** in the **Src** column – can be deleted by selecting that line and put a checkmark in the box to the left of the intervention.



9. Select '**Delete Intervention'** on the Footer menu 

10. The line will be removed. Go to the next duplicate and repeat the steps.
11. When all the duplicate interventions have been removed. Select '**Save'.** 

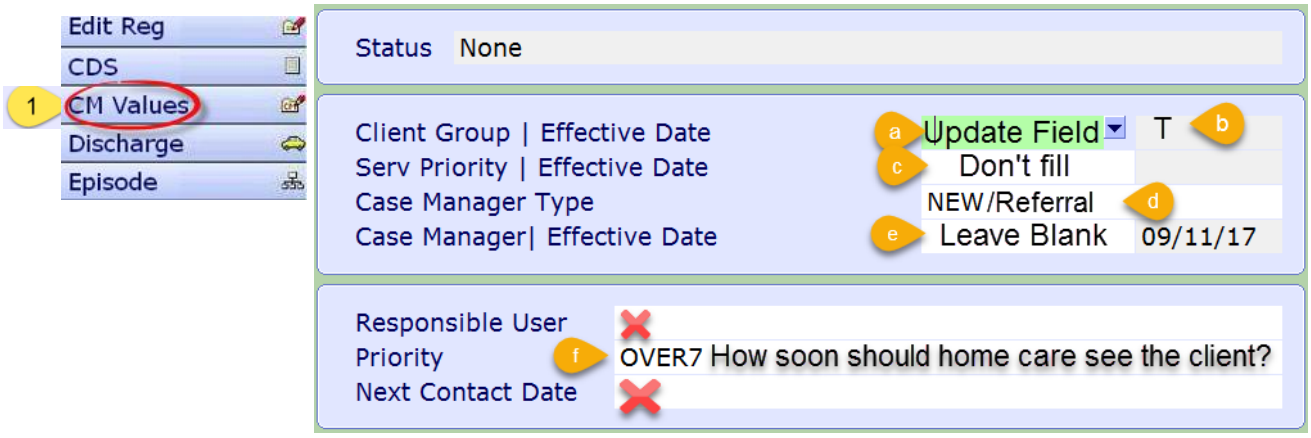
12. Now only the **Interventions** that have the status of **Active** will be displaying
13. Complete **Intake Assessment Community Care -** refer to **page 56** to see intervention and info on completing the **Client Group** section).
14. Complete the **Safety Risk Assessment**. A '**Yes**' or '**No**' must be indicated for each section. If unable to assess, indicate this in the C**omment** box in each section of the Assessment

Step 5: CM Values

1. Select Right Menu button **CM Values** – **CM Coordinator Desktop** screen
   - **a)** **Client Group** - this is determined through the **Intake Assessment**
   - **b)** In the next field you must manually enter Effective Date = **T** for today
   - c) **Serv Priority** – Do not fill
   - d) **Case Manager Type** – select **New** (CH Meditech) or **Referral** (PA Meditech) delete any other value. This is entered when it is known that the Community Care will be getting involved otherwise leave blank until this is determined. This generates the client's name on **New referral list** (PA Meditech) or **Need CM Assign list** (CH Meditech) at the Home Care office..
   - e) **Case Manager** - must be blank
   - f) **Priority** - when **Home Care** to make contact - F9 Look up
2. **Once all required areas are filled in, file** using green checkmark

Note: If Client Group previously entered DELETE and update with result of Client Group from the new Intake Assessment
Note: Case Manager Type must always be NEW
Note: Delete any old "Case Manager" numbers

Below is a visual of the Steps to address the CM Values as stated above:



Process #4: Client found in Care Manager

Completed Episode of Care or has never had an episode:

This means the client is registered to a **LONG TERM CARE FACILITY** and needs an **EPISODE OF CARE**created.

Step 1: Client Services Inquiry (CSI) - Registering the Client

- Select right menu button **Client Services Inq** 

- Select footer button **New Inquiry**

  Referral Source Tab: **Referral Source** and **Referral Method** must be completed. Use drop down arrow or F9, highlight choice and press **Enter**.

  Contact Tab: complete **Contact Information** (may or may not be the same as the referral source; when **Contact Information** is unknown, use "**U,U**."
  - **Reason** (look-up, may select more than one reason but list in order of priority)
  - **Client Data**: insert PHN into ULI field
  - **Search MPI?** Insert **"Y".**
  - **Site** (look-up, assign to **Access Centre** [CH Meditech] or **specific office** [PA Meditech])

Pop up: check the client listed at the top of the screen: that the Client's name, DOB is correct, if so click the client name. select **Update Inquiry** if information is correct. Fields with Account numbers will fill in.

  - **File** with the green check mark to return to the **CSI screen.**

Step 2: Edit Reg

1. On the **Client Services Inquiry** screen – select the correct client
2. Select footer button **Episode**
3. **Edit Reg** screen opens. -This information should be verified with the client. Ensure work done in caps lock (**all uppercase),** **do not file (green check mark) until all tabs verified.**

Note: for discrepancies related to client's name or date of birth: email Data Integrity and follow the instructions: Rural.HIM.DataIntegrityStaff@albertahealthservices. In the **subject line** state which ring of Meditech you are needing help in (**Chinook or Palliser ring of Meditech**) within the body of the email give the **client's ULI number, information that requires** correction and **which legal documents** were used to **validate** correct information. (**Changes to Name, DOB need to be verified by viewing birth certificate or Alberta health care card).**

Complete the following screens in **Edit Reg**. All items with an **asterisk (*)** indicates data reportable to **ACCIS**:

Client | Contact | Addtl Census | Guarantor | Insurance | Risks | Prov/Site | Service Loc | Allergies

Client Button:

- o client's mailing address
- o Language – use drop down arrow or F9– item reportable to AHS
- o Postal Code
- o Resid Cd – Community based off of postal code
- o Country – should be CA

Contact Button:

- o Next of Kin-**second** contact in case of emergency
- o Person to Notify –**first** contact in case of emergency can use **SP**-same place; **SNOK**-same as next of kin

Addtl Census Button: **leave bank** use **Client Contacts** assessment in **LT Document**.

- o **Any Confirmations pop ups must be answered with "Yes" to update or "N o" to leave as before. (Read carefully)**

Guarantor Button: **c**onfirm the name of the **Guarantor** - this is the person who will pay bills.

Insurance Button: Insurance: **AHC** should default

Risks Button: insert **Y** for Yes if a risk identified or **N** for No – if answering Yes complete the **Safety Risk assessment** in the **Lifetime Account**

Prov/Site Button:

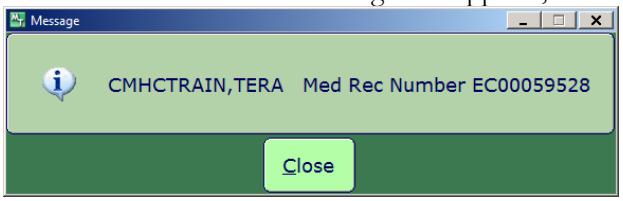
- o **Primary Care or Other –** leave blank
- o **Family Physician -** should be filled out and/or corrected - use upper case, first 4 letters last name, F9 and select the correct physician. If no family physician leave blank.
- o **Reason for Visit** will default as **"Receiving Continuing Care Services".** If any other information has been changed then delete and click out of field. Click back into field again and information will auto populate

Service Loc Button: **w**here client's personal care will be received:

- o **From Date** – would be the date you are registering the client
- o **Level of Care** –select **Other** as the client is in hospital - use down arrow or F9
- o **Homeless** – if the client is homeless Enter **Y** if not enter **N**
- o **Street -** If rural address, enter **Rural-See Directions**. Add specifics, i.e. lot number. Add additional directions if required especially for rural residences. (Can use shortcuts, eg. **SP** for Same Place brings address from Client screen , **however the address must be entered on clients who have never been registered in Care Manager).**

Allergies Button: is **view only;** allergies will be entered/updated via **EMR or PCS**.

1. **File** after all Tabs have been reviewed. ✔ A message box appears, select close



Step 3: Edit Episode:

1. **Start date** – **do not edit** (this should be the date that the CSI was created)

*Start Date| Status	08/06/15		Active
*Summary| *Eff Date| Description	PN	08/06/15	PROFESSIONAL NURSING
Date Case Opened	08/06/15		
Service Plan Date| Type	08/06/15		CCSHM
Method of Funding Services	DS		

2. **Summary field** - enter a summary description for the Episode (refer to page 70 for descriptions. File entry.
3. **Service Plan Decision Date** – would be the same as the start date
4. **Service Plan Type** - select **Hospital transfer to LTC** - use down arrow or F9

Note: Client is now registered in Care Manager with an Active Episode and Lifetime account

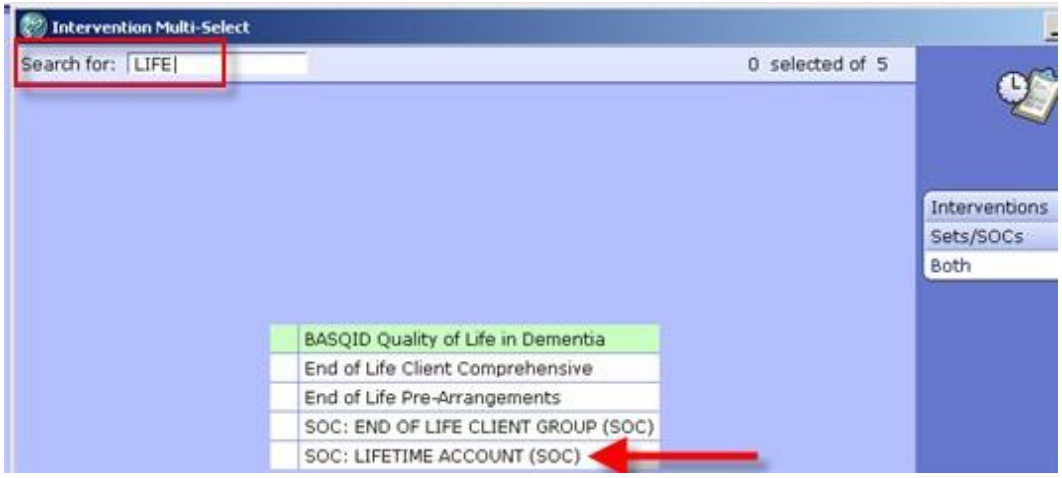
Step 4: Documenting in Lifetime Account

1. Once the **Episode** is filed, the system will take you to the **CM Coordinator Desktop** screen
2. Select the **LT Document** button from the Right Menu.. This will take you into **PCS/WORKLIST** in the **Lifetime Account**

3. You will know you are charting on the **Lifetime Account** by looking at the following in the upper right corner

4. Select **Add Intervention**

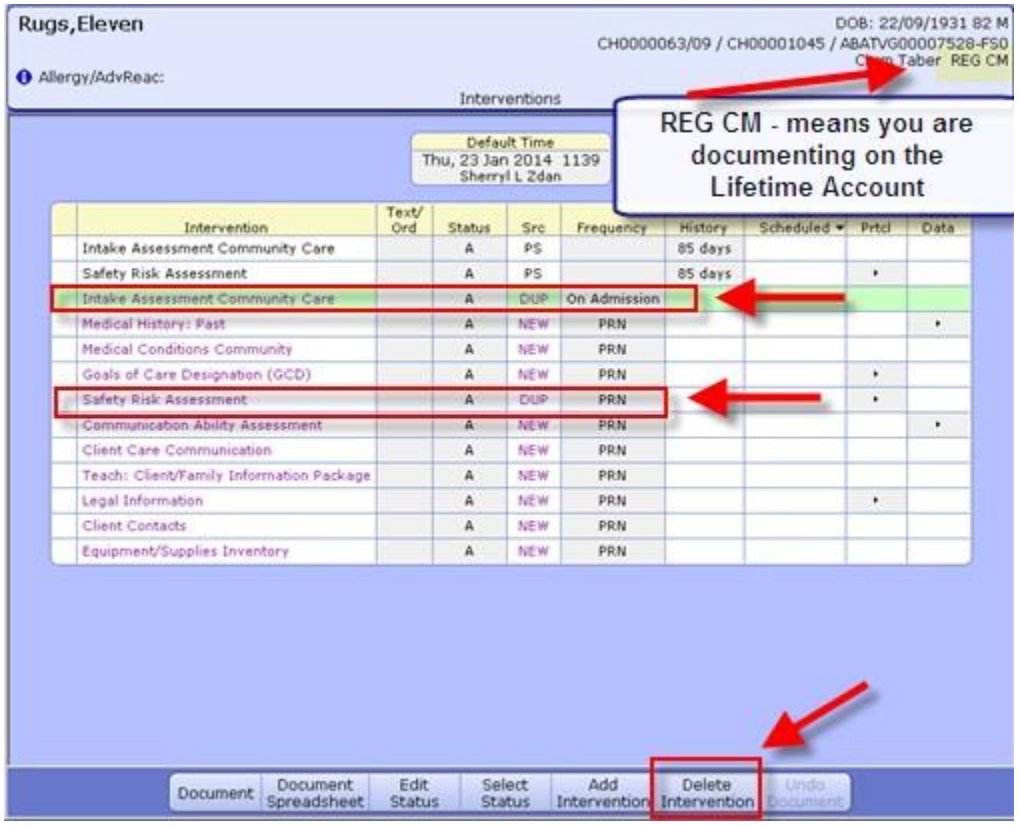
5. In the Search field type **LIFE** to add the **Lifetime Account SOC**



6. Select **'LIFETIME ACCOUNT'**, then select **Add & Close** and then **File**

7. **<u>If duplicate interventions are listed on the Lifetime Account:</u>**

   In **PCS /Worklist** the interventions that have the **DUP** in the Src column – can be deleted by selecting that line (put a checkmark in the box to the left of the intervention)



8. Select '**Delete Intervention'** 

on the bottom toolbar and the Intervention will removed

9. Go to the next duplicate and repeat the steps

10. When all the duplicate interventions have been removed. Select '**Save'** 

11. The Interventions that have the status of **Active** will be displaying

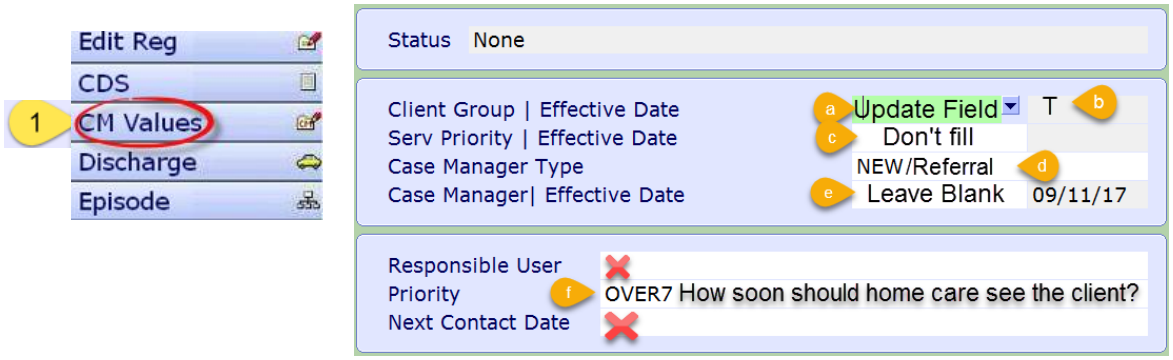
12. Complete **Intake Assessment Community Care** - refer to page 65 to see intervention and info on completing the Client Group section

Step 5: CM Value

1. Select Right Menu button **CM Values** – **CM Coordinator Desktop** screen
   - **a)** **Client Group** - this is determined through the **Intake Assessment**
   - **b)** In the next field you must manually enter Effective Date = **T** for today
   - c) **Serv Priority** – Do not fill
   - d) **Case Manager Type** – select **New** (CH Meditech) or **Referral** (PA Meditech) delete any other value. This is entered when it is known that the Community Care will be getting involved otherwise leave blank until this is determined. This generates the client's name on **New referral list** (PA Meditech) or **Need CM Assign list** (CH Meditech) at the Home Care office..
   - e) **Case Manager** - must be blank
   - f) **Priority** - when **Home Care** to make contact - F9 Look up
2. **Once all required areas are filled in, file** using green checkmark

Note: If Client Group previously entered DELETE and update with result of Client Group from the new Intake Assessment
Note: Case Manager Type must always be NEW
Note: Delete any old "Case Manager" numbers

Below is a visual of the Steps to address the CM Values as stated above:

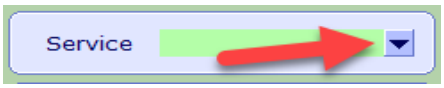


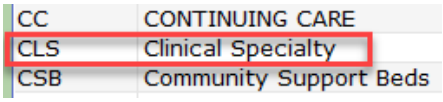
Waitlisting Clients in Care Manager

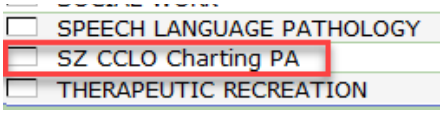
Waitlisting Process:

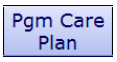
1. Receive request for Placement
2. Determine if client is a registered client in current HCIS by looking client up on the Coordinatory Desktop Screen
   - If Yes continue to Step 3
   - If No, do a CSI (Client Services Inquiry), then proceed to step 3.
3. Add the Clinical Specialty Program
   - Select New Request 

   - In the Service Field, F9 and selct Clinical Specialty
   - In the Program Selection Field, select All
   - Use the arrow on the right to scroll down the list until you see – **SZ CCLO Charting**
   - Select **SZ CCLO Charting**
   - Then Select Register
   - In the Start Date enter the date that you received clients placement paperwork



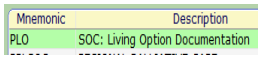




4. Select the SZ CCLO Chartng program
   - Select Pgm Care Plan on the bottom toolbar 

   - Select Enter on the bottom toolbar
   - Select Additional Care Plan

   - Select Standard of Care tab, then select the drop down arrow 

   - Select – **SOC: Living Option Documentation**; then Save 

   - You can click "Yes" to go to Worklist

5. When in PCS, you will document all relevant documentation regarding placement and waitlisting on this program.
   - You will primarily use the intervention called: **CCLO Flowsheet**
   - When done documenting you will Save your charting
6. You will now need to waitlist client for the appropriate program(s) **(See pg 33-34)**
   - Use Pref/Priority button to enter the preference ranking of each Program recommended for Placement (i.e. 1, 2, 3 etc). **(See pg 63-64)**

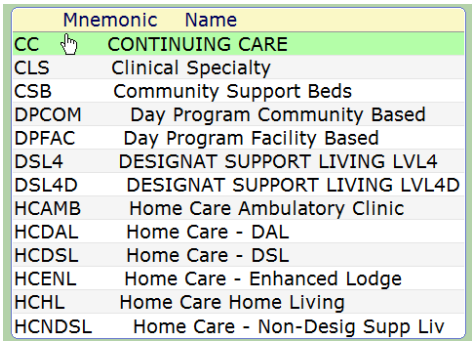
7. Document all necessary information within the Living Option CDS **(See pg 36-40)**

How to Waitlist:

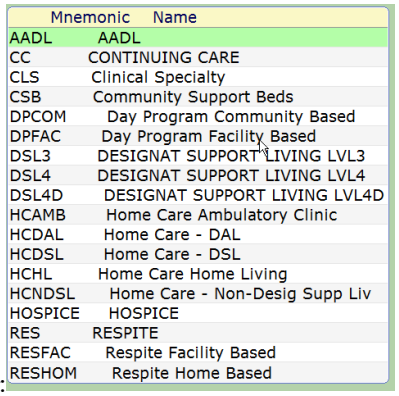
In Care Manager on the clients program screen select New Request

1. To add the appropriate Waitlist **Program**
   - Select Right Menu button 

   - F9 or drop down arrow at **Service**: program See below for details

Chinook Ring: 

Mnemonic	Name
CC	CONTINUING CARE
CLS	Clinical Specialty
CSB	Community Support Beds
DPCOM	Day Program Community Based
DPFAC	Day Program Facility Based
DSL4	DESIGNAT SUPPORT LIVING LVL4
DSL4D	DESIGNAT SUPPORT LIVING LVL4D
HCAMB	Home Care Ambulatory Clinic
HCDAL	Home Care - DAL
HCDSL	Home Care - DSL
HCENL	Home Care - Enhanced Lodge
HCHL	Home Care Home Living
HCNDSL	Home Care - Non-Desig Supp Liv

Palliser Ring: 

Mnemonic	Name
AADL	AADL
CC	CONTINUING CARE
CLS	Clinical Specialty
CSB	Community Support Beds
DPCOM	Day Program Community Based
DPFAC	Day Program Facility Based
DSL3	DESIGNAT SUPPORT LIVING LVL3
DSL4	DESIGNAT SUPPORT LIVING LVL4
DSL4D	DESIGNAT SUPPORT LIVING LVL4D
HCAMB	Home Care Ambulatory Clinic
HCDAL	Home Care - DAL
HCDSL	Home Care - DSL
HCHL	Home Care Home Living
HCNDSL	Home Care - Non-Desig Supp Liv
HOSPICE	HOSPICE
RES	RESPITE
RESFAC	Respite Facility Based
RESHOM	Respite Home Based

   - Select **Site** or **All**, then check left of Program that is reflects where client is to be waitlisted.
   - select footer button **Waitlist**
   - Start Date is the date the Living Options package is received, should usually be T for Today**, then**

- Clients being waitlisted for **Home Care – Enhanced Lodge/Designated Support Living 3** select:
  - In Chinook ring of Meditech:
    - Home Care – Enhanced Lodge (Cardston Chinook, Coaldale Sunny South, Crowsnest Pass York Creek, Fort Macleod Pioneer, Leth Columbia, Leth Golden Acres, St Therese Enhanced, Magrath Community, Milk River Prairie Rose, Picture Butte Piyami, Pincher Creek, Vista Taber Clearview)
  - In Palliser ring of Meditech:
    - DSL3 Designat Support Living LVL3 – (Cypressview or Pleasant View)
    - HCDSL Home Care - DSL -(Orchard Manor Enhanced)

- Clients being waitlisted for **Designated Supportive Living Level 4/Designated Assisted Living** select:
  - In Chinook ring of Meditech:
    - DSL4 Designat support living LVL4 – (Coaldale Sunny south, Leth St Michaels)
  - In Palliser ring of Meditech:
    - DSL4 Designat Support Living LVL4 – (Good Samaritans, Leisure Way, Masterpiece, Meadow Ridge, Southand Meadows, Sunrise Gardens, Wellington
    - HCDAL Home Care – DAL – (DAL– Not Specified, Haven DAL, Meadowlands, Valleyview)

- Clients being waitlisted for **Designated Assisted Living Cottages/Designated Supportive Living Level 4 D** select:
  - In Chinook ring of Meditech:
    - HCDAL Home Care – DAL – (Lee Crest Cottage, Extendicare Cottage, Legacy Lodge Cottage, Park Meadows Cottage, St. Therese Cottages, West Highland Cottage, Magrath Cottage, Piyami Cottage, Vista Village Cottage, Prairie Ridge, Linden View)
    - DSL4 D Designat Support Living D– (Coaldale Sunny South, Leth St. Michaels)
  - In Palliser ring of Meditech:
    - DSL4D Designat Support Living LVL4D – (Good Samaritans, Leisure Way, Masterpiece, Meadow Ridge, Southalnd Meadows, Sunrise Garden)

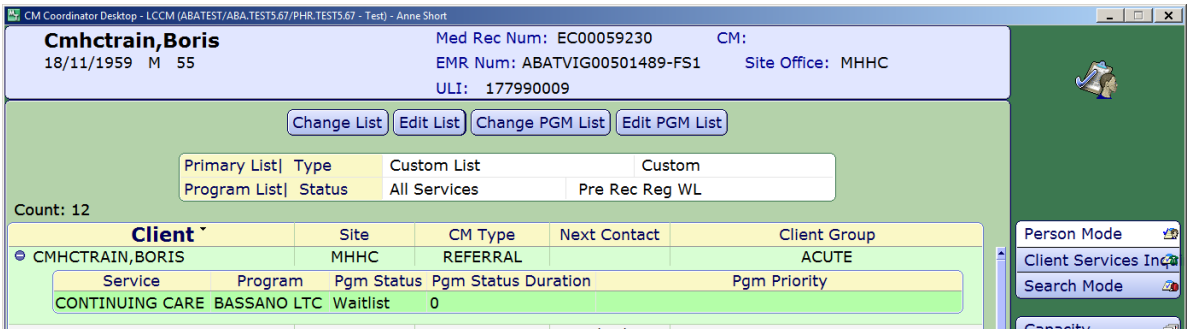
- Clients being waitlisted for **Continuing Care** select:
  - In Chinook ring of Meditech:
    - CC Continuing Care – (Cardston, Coaldale, Crowsnest Pass, Fort Macleod, Edith Cavell, St. Michaels, Milk River, Raymond, Taber)
  - In Palliser ring of Meditech:
    - CC Continuing Care – (Bassano, Bow Island, Books, Good Samaritans, Masterpiece River Ridge, Oyen, Riverview Care Centre, Southland Meadows, Sunnyside Care Centre, Valleyview

- Once you have selected the Service, the Program Criteria opens you will either select Open or Secure [Palliser Ring], Couples or Locked [Chinook] as appropriate.
- The **Waitlist Date field** will open. The date entered should be the current date or the date Coordinated Access was given the information. This can be backdated. Then green check to **Save.**

Preference and Priority Fields

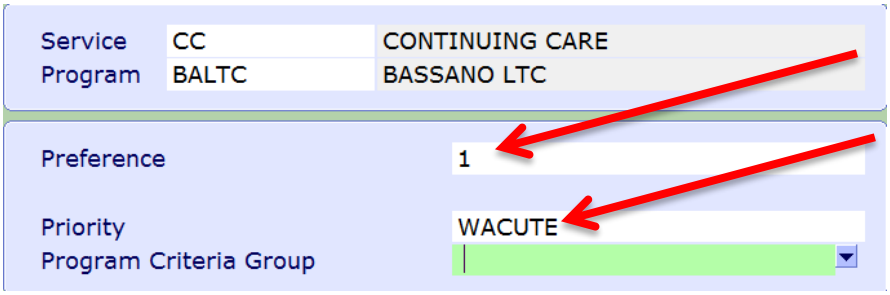
The **Preference** and **Priority** field needs to be completed next: See page 63-64 for further definitions of the priorities.

- Highlight Waitlisted program, then select footer button 



The **Priority field** is a F9

- Complete the Program Criteria Group. Then File.



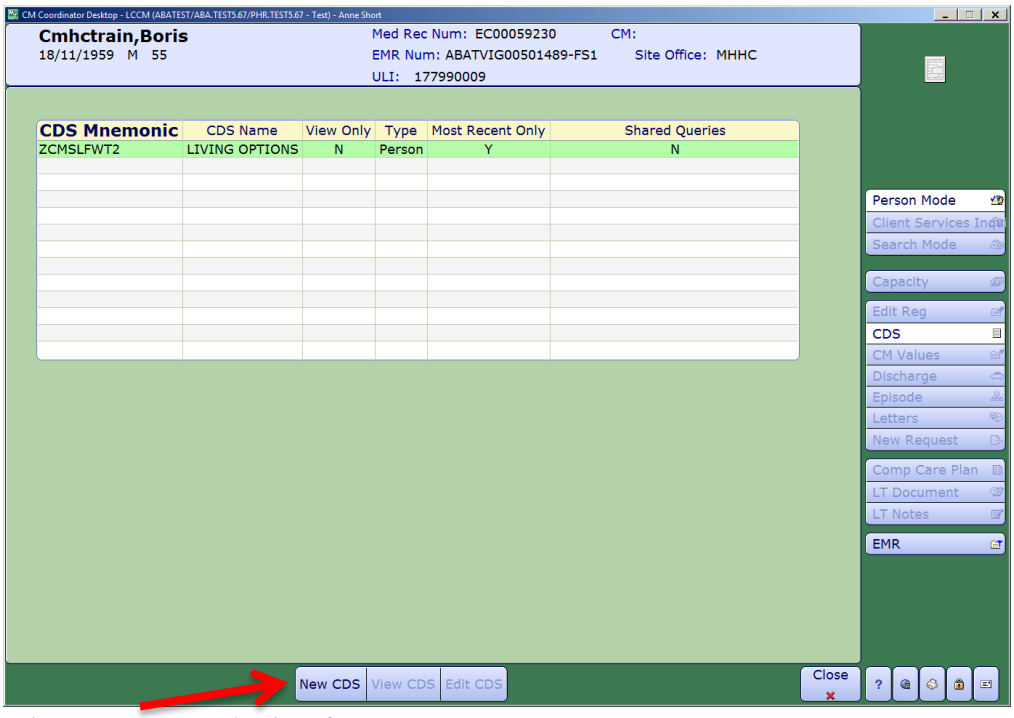
- If a client is to be waitlisted for more than one site repeat the above steps.

- Document on the **LT Notes** on the CM Coordinator Desktop

Living Option Customer Defined Screen (CDS)

Next the **Living Option CDS** needs to be started.

- Select your client and then select right menu button CDS, this will take you to the CDS Summary screen

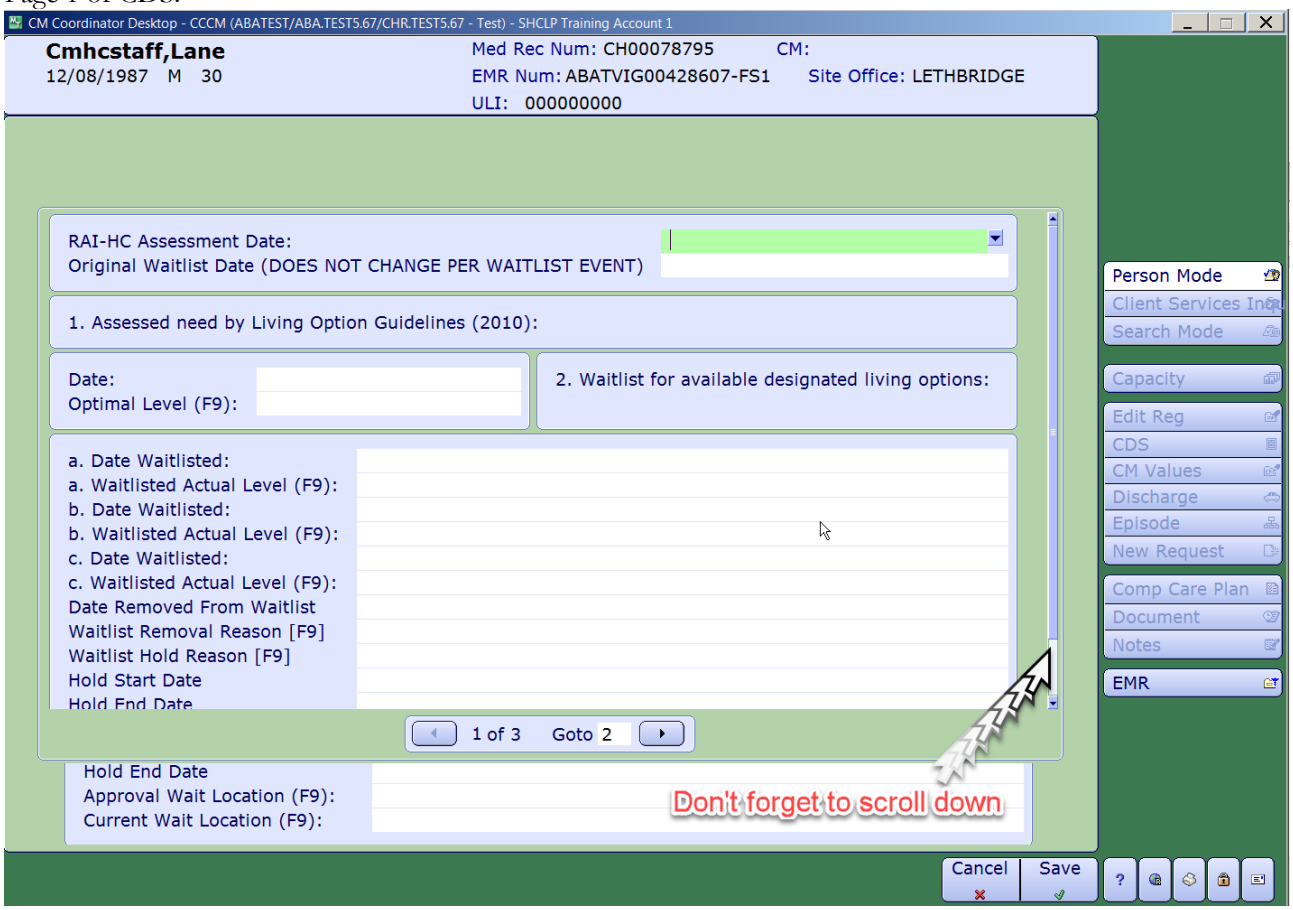


Select New CDS to begin a form

- This is the Living Options CDS – it is a **3 page CDS** - this must be updated for any of the following reasons:
  - started at time of the client being waitlisted
  - if client removes self from waitlist
  - if the waitlist gets put on Hold
  - when a bed gets offered
  - if a site refuses a client
  - if the admission is put on Hold
  - when the client is admitted
  - if not admitted to preferred choice, when their oreferred choice is then offered this would be updated again
  - if client declines preferred bed

- All Date fields are DD/MM/YY

Page 1 of CDS:



- **Field number:**
  1. **Assessed need by Living Option Guidelines** (2010):
     - Reflects the actual level of Living Option that will meet the client's current needs.
     - Choices of Level are: DSL3, DSL4, DSL4D and LTCF.

  2. **Waitlist for current available designated living options**:
     - Date must be completed before the Level can be entered.
     - Choices of Level are: DSL3,DSL3D,DSL4,DSL4D,LTCF,LTC.
     - If client is also going to be waitlisted for a first available bed at a higher level that information would go on line 2b.

- **Date removed from Waitlist** – actual date

  Reasons for removing from Waitlist in this area:

  -If a client was NEVER placed before & requests to be removed from waitlist or

  -If a client was NEVER placed before & dies enter the date here.

- **Waitlist Removal Reason** – F9

Mnemonic	Responses
CLIENT	Client/Family Request
DEATH	Death
DECLINE	Declined First Available
HEALTH ST	Health Status Change
ISSUES	Outstand Placement Issues
REF SERV	Refer Service Out of Zone

- **Waitlist Hold Reason**: F9 – then you have to enter a start date and an end date when this is determined. The client is on a waitlist and a bed has not been offered.

  -If a client dies, & were on hold the date of death would be "Hold End Date"
  -If a client is in a Temporary Living Options (TLO) & something happens that next move is put on "HOLD" this does not get entered in the CDS. This would be documented in the LTNotes.

Mnemonic	Responses
DECLINE	Declined First Available
FAMILY	Family Delay
ISSUES	Outstand Placement Issues
OUTBREAK	Sending Site on Outbreak
REVIEW	Care Type Under Review
UNSTABLE	Medically Unstable

- **Approval Wait Location**: this is descriptive of where the client was at the time the assessed need was determined. The data in this filed will not change as we are capturing where they were at the time they were put on the waitlist. F9:
  - Subacute Units are: Brooks – Subacute Unit C; Medicine Hat – 2N; Lethbridge – 5B; St. Michael's - PARP

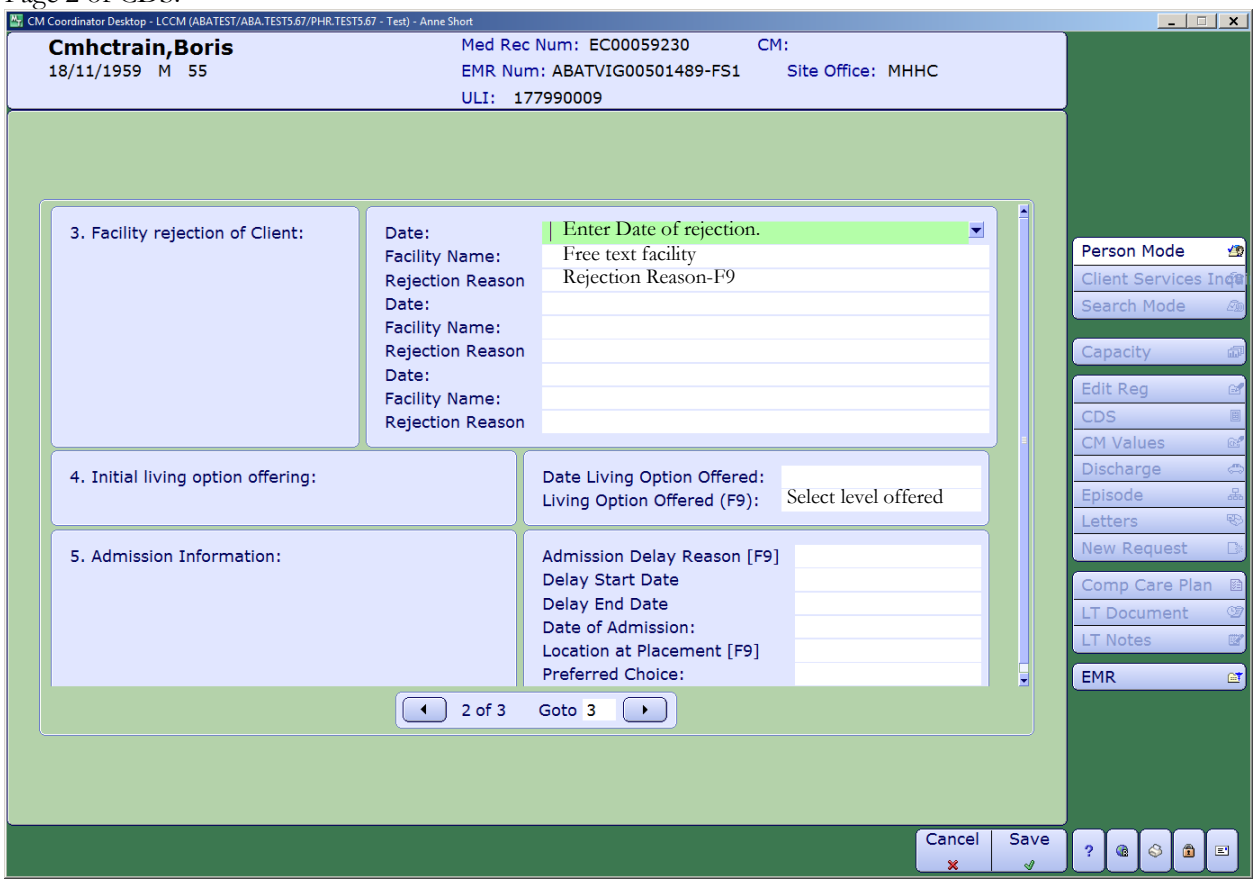
Mnemonic	Responses
ACUTE	Acute Care
CSB	Community Support Bed
HOME	Home Living
LTCF	Longterm Care Facility
NONDES SUP	Nondesig. Support. Living
PRIVATE	Non-Publicly Funded
SL3	Supportive Living 3
SL4	Supportive Living 4
SL4D	Supportive Living 4D
SUBACUTE	Subacute

- **Current Wait Location**: this is descriptive of where the client currently is. F9 same lookup as above. This field needs to be updated ongoing to accurately reflect where the client is waiting from.

  -If a client takes a TLO we never change the Current Wait Location as this is only to capture where the client is/was at the time of offering.
  -If client is approved in home and ends up in CSB (Community Support Bed) or hospital then you would change.

- Now use the 

Page 2 of CDS:



- Field number:

3. **Facility Rejection of Client:**
   - Date:
   - Facility Name: Free text
   - Rejection Reason: F9

4. **Initial Living Option Offering:** Document the date a living option was offered, and which level was offered; Choices are: DSL3, DSL3D, DSL4, DSL4D, LTCF, and LTCFD.

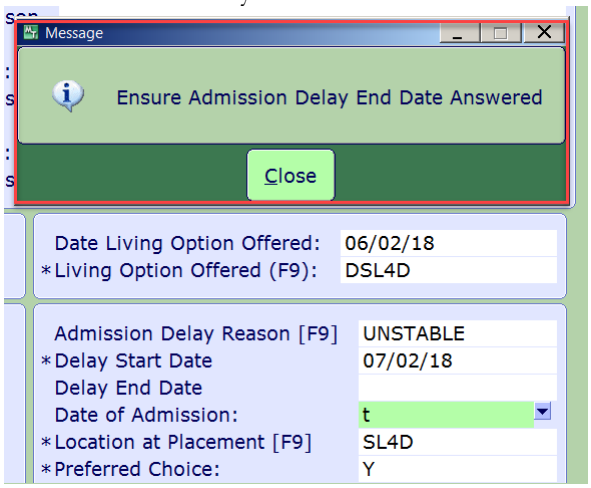
5. **Admission Information:**
   - Admission Delay Reason: If there is an admission delay - use **F9** to select the reason and enter the **Delay Start Date**. You would use this when a bed has been offered to a client. **Don't forget to put an end date when the delay is over.**
   - Date of Admission
   - Location at Placement: F9 look up
     -this should match the Current Wait Location
   - Preferred Choice: Yes or No

6. **Preferred Living Option:**
   - Offered Preferred: when the client's preferred living option is available, document the date it was offered.
   - Declined Preferred: if the client declines the preferred bed and will stay in their current bed
     -document the date they declined
     -if a client is in TLO and **passes away**, put in date of death
   - Admitted to Preferred: document the date the client is admitted to their preferred bed.

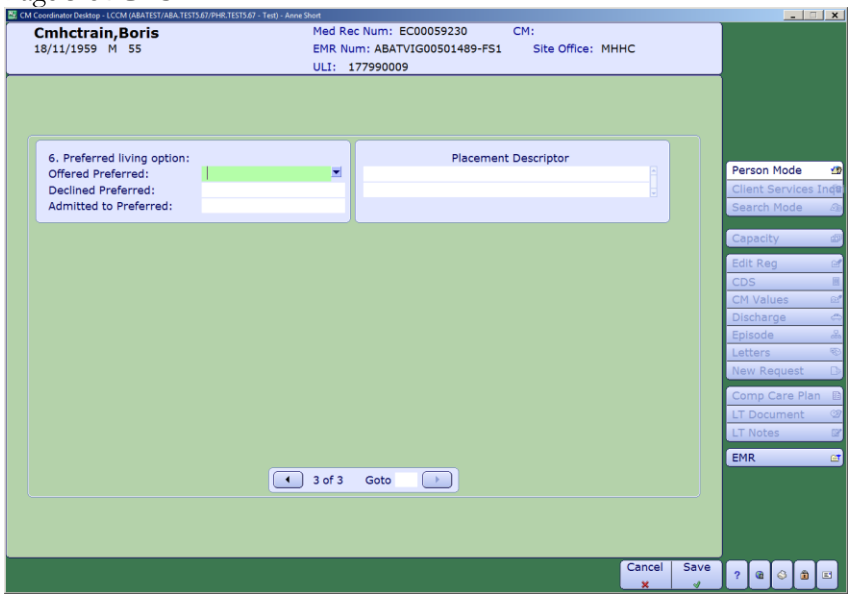
NOTE: ***To back up a field - use the Shift and Tab buttons on your keyboard together. ***
If a field to the right is blank you may have to enter a date and then go to the far right and delete and then use Shift and Tab button together to move to the left.

Warning Message:

- When entering Date of Admission - the warning message ONLY pops up IF you enter a date in the Date of Admission field and the Admission Delay Reason AND Admission Delay Start Date have values, and there is no value in the Delay End Date.



Page 3 of CDS:



- If client refuses site of choice then the only thing that is filled in on the CDS is page 3 Declined Preferred
- Client passes away, you would only enter the expired date on page 3 in the Declined Preferred field

Admission to a SL3, SL4 or SL4D

- Select the correct client and press the ⊕ button to show the Programs
  1. Select the **waitlisted program** that the client is being admitted to
  2. Select **register** and enter the **actual date of the admission**. This cannot be future dated but can be backdated if needed.
  3. Then go to the **Living Option CDS** and update the CDS.
  4. Enter a note on the **Notes**

Below you will find a visual to help you with the above process

- If the client has gone to their site of choice, any other waitlisted programs would be Outcommed. This is done by selecting this waitlisted program and then selecting the footer button Outcome
- You would document the Outcome field, date this. File.

- The clients' episode of care would continue.

Housekeeping items: Update Edit REG:
Census – the mailing address of the facility
Service Location:
Homeless: should be a N
From Date – date of admission
Level of Care – F9 and select appropriate level
Congregate Site – F9 and select appropriate site, this will default the address into the fields to the left.
Prov/Site: Ensure correct Site

Admission to a Continuing Care Facility

Below are the scenarios you may come across and the steps involved are a little different for each one.

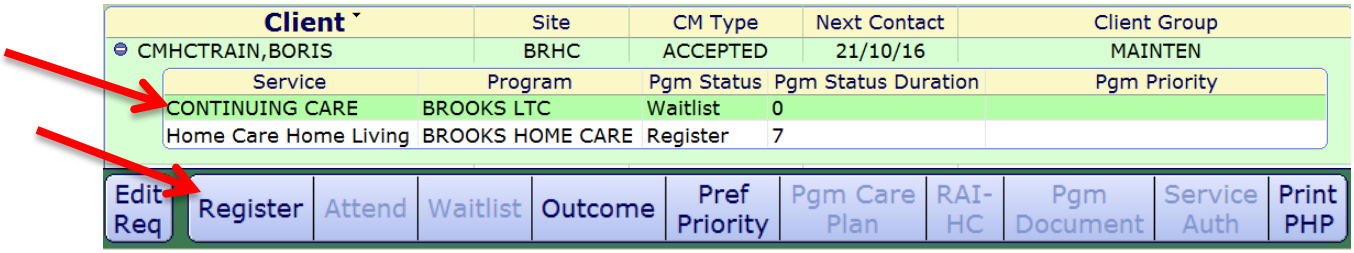
- A client is moving to an AHS Operated Continuing Care Facility site of choice – page 42
- A client moves to a non –AHS operated Continuing Care Facility – page 47
- A client is moving to an AHS Operated Continuing Care Facility but is waitlisted for SL4(D) – page 48
- A client moves to a non AHS operated Continuing Care Facility but is waitlisted for a SL4 (D) –page 49

A client is moving to an AHS Operated Continuing Care Facility

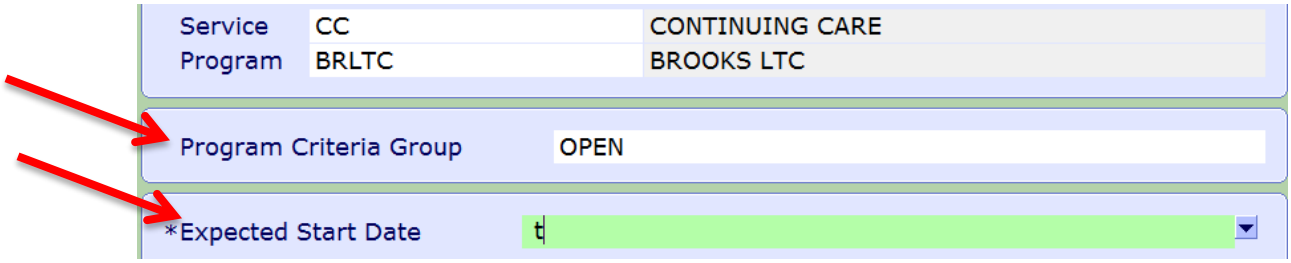
In CH ring: Cardston, Coaldale, Crowsnest Pass, St. Michael's, Milk River, Raymond and Taber
In PA ring: Bassano, Bow Island, Brooks, Oyen

As soon as the AHS Continuing Care Facility informs Coordinated Access that the client will be accepted at a date in the future, the client's program status would be changed to Pre-registered.

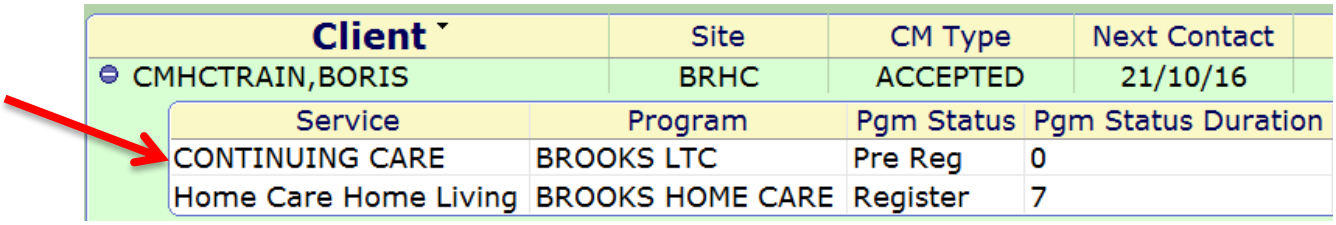
- On Program screen, select the waitlisted Continuing Care Facility, select Register



- Insert Program Group Criteria and Start Date as usual, File 



- Program will automatically go to a Pre-Registered status



- Once the client has actually gone into the Facility, the Facility will register the client and the screen will then display "Register."

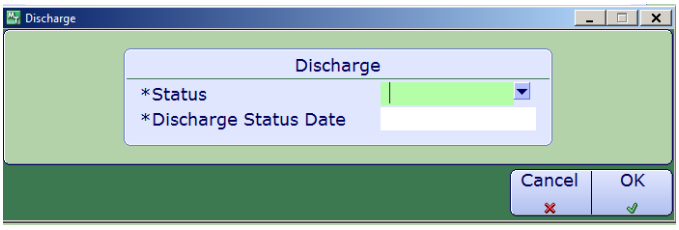
Service	Program	Pgm Status	Pgm Status Duration
CONTINUING CARE	BROOKS LTC	Register	0

- Once LTC Facility status is Register, discharge any Registered Program(s) as usual.

- Discharged Program(s) will show as Complete

If the client has gone to bed of choice

- The Client Group in the CM Values will be changed to LTC Facility and have the date the same as the admission date to the facility.
- Then the episode needs to be unlinked from the Continuing Care program. See page 44
- Then the Episode of Care needs to be ended. See page 45
- **DO NOT DISCHARGE FROM LIFETIME ACCOUNT, CANCEL-RED "X"**
  -This will discharge the client not just unlink the episode

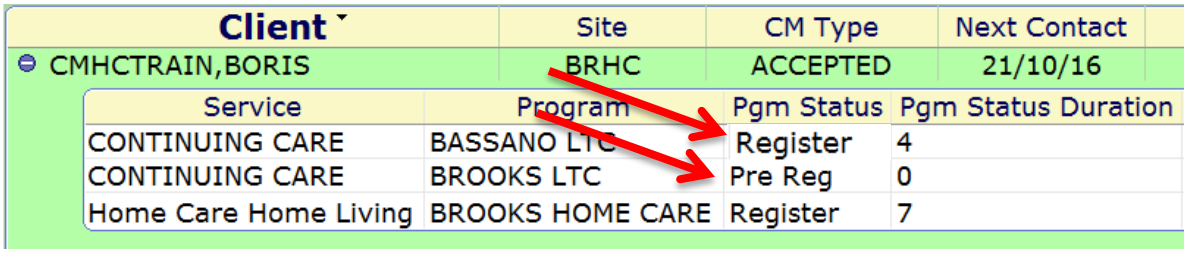


If the client has gone to a first available bed

- If the client has gone to a first available bed, the episode remains active.
- Return to the CDS to document Number 6 on page 39-40 called **Preferred Living Option:**
- The Client Group in the CM Values will then be changed to Awaiting Bed of Choice and have the date the same as the admission date to the facility.

Unlinking a Program from the Episode

- Highlight the Continuing Care Waitlisted or Continuing Care Registered Program

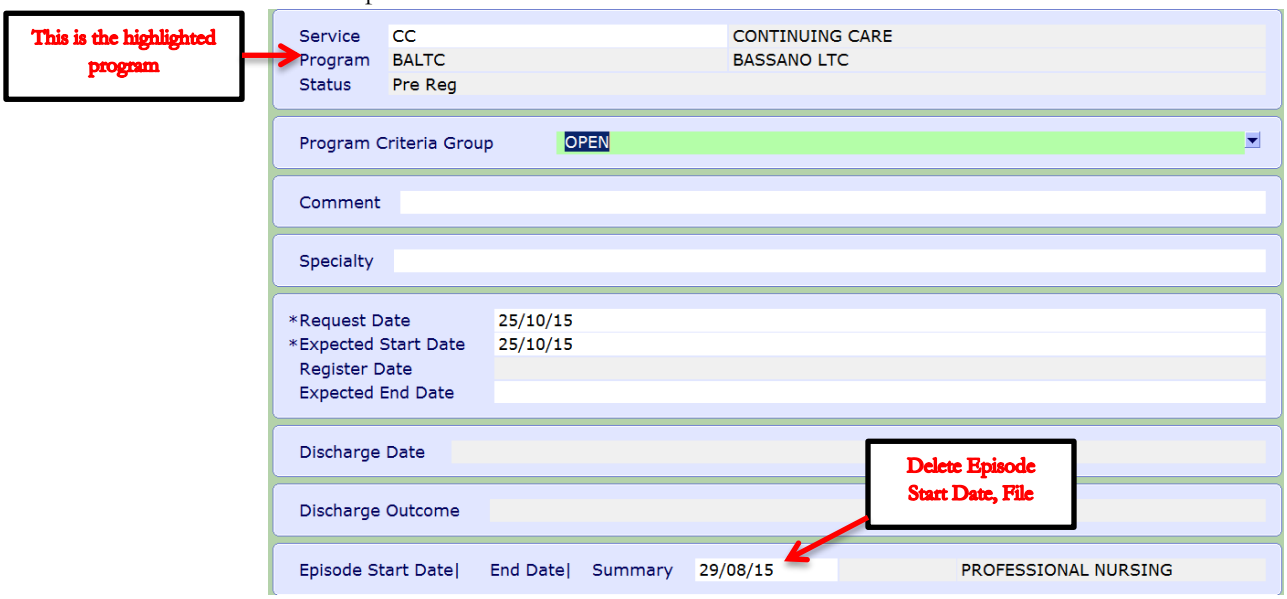


Client	Site	CM Type	Next Contact
CMHCTRAIN,BORIS	BRHC	ACCEPTED	21/10/16

Service	Program	Pgm Status	Pgm Status Duration
CONTINUING CARE	BASSANO LTC	Register	4
CONTINUING CARE	BROOKS LTC	Pre Reg	0
Home Care Home Living	BROOKS HOME CARE	Register	7

- Select the Footer button on the left **Edit Req**

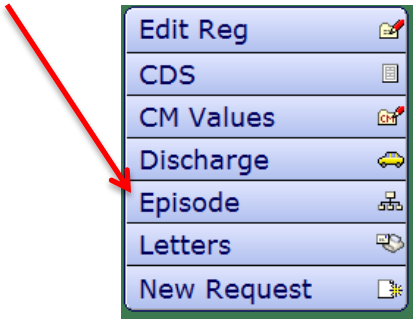
- Select the Episode Start Date field



- Delete the Start Date and enter then file.
- Repeat for all Registered Continuing Care Programs.
- Waitlisted LTC/SL4/SL4D programs should be outcome if client has gone to their site of choice.

Now End Episode of Care

- Choose Episode from right tool bar



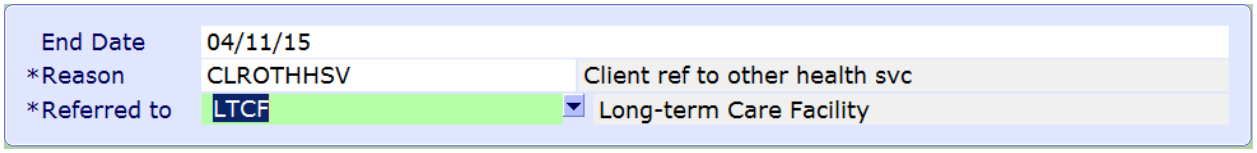
- Select: Edit Episode
  - If Episode is selected, there should be no Waitlisted or Registered Programs in the summary list

Start Date	End Date	Status	Summary
29/08/15		Active	PROFESSIONAL NURSING
28/08/15	13/10/15	Complete	PROFESSIONAL NURSING
07/04/15	27/08/15	Complete	PROFESSIONAL NURSING
07/04/15	07/04/15	Complete	PROFESSIONAL NURSING

Service	Program	Pgm Status	Pgm Status Duration	Pgm Priorit
Clinical Specialty	MEDICINE HAT HOSPITAL	Complete	55	
DESIGNAT SUPPORT LIVING LVL3	CYPRESSVIEW FOUNDATION DSL3	Complete	57	
Home Care Ambulatory Clinic	MEDICINE HAT AMBULATORY CLINIC	Complete	56	
Home Care Home Living	BASSANO HOME CARE	Complete	58	
Home Care Home Living	CHINOOK CONDOS	Complete	56	
Home Care Home Living	CHINOOK CONDOS	Complete	55	
Home Care Home Living	CHINOOK CONDOS			
Home Care Home Living	MEDICINE HAT HOME CARE			
Home Care Home Living	OCCUPATIONAL THERAPY			
Home Care Home Living	PHYSIO THERAPY			
Home Care - Non-Desig Supp Liv	CHINOOK ASSISTED LIVING			

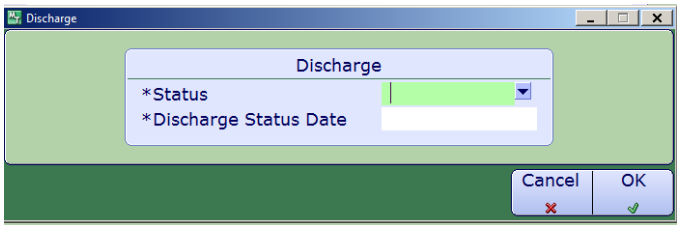
No Waitlisted or Registered Programs should show

- Select the Edit Episode footer button, enter End Date, do F9 Lookup, select reason: Client referred to other health services and referred to Long Term Care Facility. File

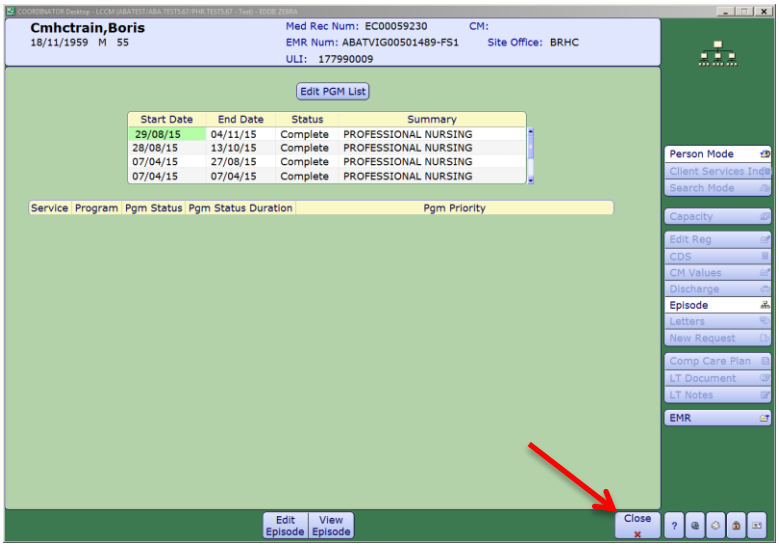


- Upon filing you will go to the Lifetime Account discharge

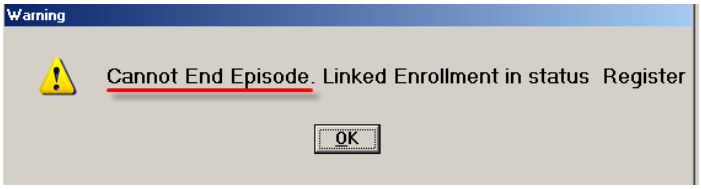
- **DO NOT DISCHARGE FROM LIFETIME ACCOUNT, CANCEL-RED "X"**
  -This will discharge the client not just unlink the episode



- You will be returned to Edit Episode screen, select "**Close"** toExit. Episode will now be ended.



- Note, if when trying to end the Episode, this warning appears, there is a Program that needs to be unlinked (Note that the below Warning box will be green in colour, but say the same message)



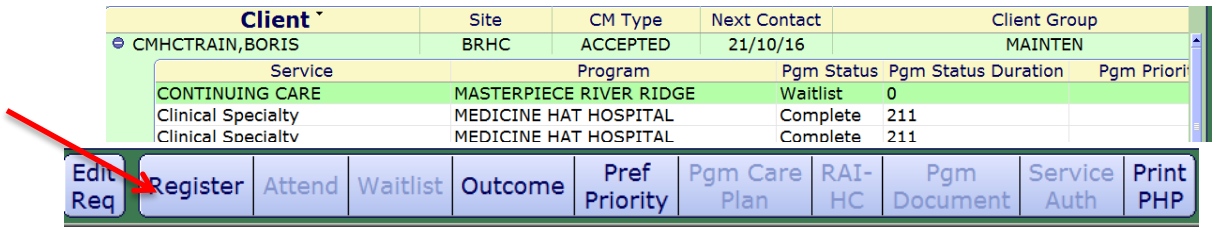
Housekeeping items: Update CM REG:
Census – the mailing address of the facility
Service Location:
Homeless: should be a N
From Date – date of admission
Level of Care – F9 and select appropriate level
Congregate Site – F9 and select appropriate site, this will default the address into the fields to the left
Prov/Site: Ensure correct Site
Assign Values
Client Group: Long Term Care Facility
Case Manager: is Placement Coordinator

- Client will remain on Community Care with active Lifetime Account, but Community Care Episode will have ended.

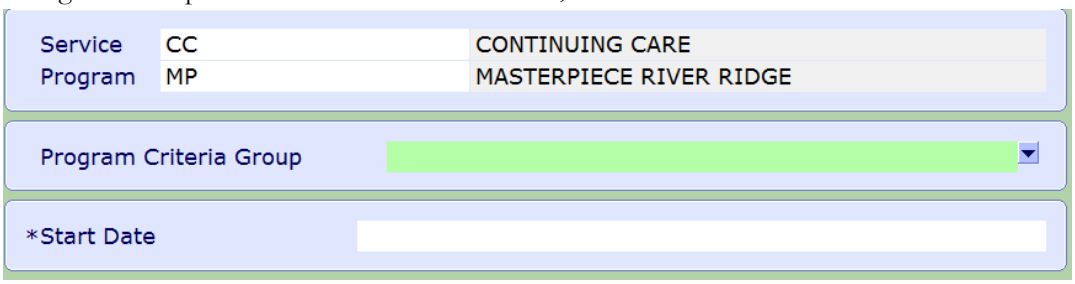
A client moves to a non –AHS operated Continuing Care Facility

In CH ring: Edith Cavell, Fort Macleod
In PA ring: Good Samaritans, Masterpiece River Ridge, Riverview Care Centre, Sunnyside Care Centre and Valleyview

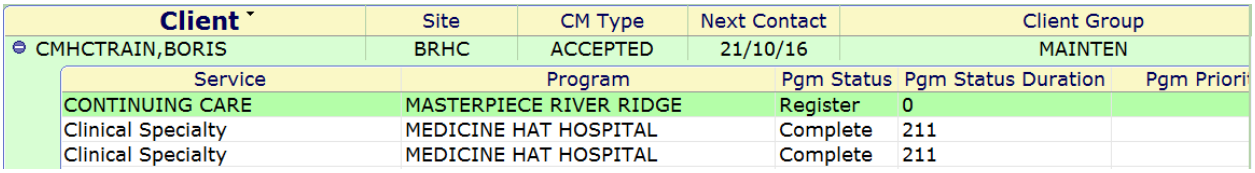
- On Program screen, select the waitlisted LTC Facility, select the Register button



- Insert Program Group Criteria and Start Date as usual, File



- Program will automatically go to a Registered state



- Discharge the program where the client came from.

If the client has gone to bed of choice

- Then the episode needs to be unlinked from the Continuing Care program. See page 44
- Then the Episode of Care needs to be ended. See page 45
- Client will remain on Community Care with active Lifetime Account, but the Community Care Episode will have ended.

If the client has gone to a first available bed

- If the client has gone to a first available bed, the episode remains active.

Housekeeping items: Update CM REG:
Census – the mailing address of the facility
Service Location:
Homeless: should be a N
From Date – date of admission
Level of Care – F9 and select appropriate level
Congregate Site – F9 and select appropriate site, this will default the address into the fields to the left.
Prov/Site: Ensure correct Site
Assign Values
Client Group: Long Term Care Facility
Case Manager: is Placement Coordinator

A client is moving to an AHS Operated Continuing Care Facility but is waitlisted for SL4 (D)

In CH ring: Cardston, Coaldale, Crowsnest Pass, St. Michael's, Milk River, Raymond and Taber
In PA ring: Bassano, Bow Island, Brooks, Oyen

Client	Site	CM Type	Next Contact	Client Group
CMHCTRAIN,BORIS	BRHC	ACCEPTED	21/10/16	MAINTEN

Service	Program	Pgm Status	Pgm Status Duration	Pgm Priority
CONTINUING CARE	BROOKS LTC	Pre Reg	0	
DESIGNAT SUPPORT LIVING LVL4	SUNRISE GARDENS DSL4	Waitlist	0	
Home Care Home Living	BROOKS HOME CARE	Register	13	

- As soon as the LTC Facility advises that client will be accepted at a date in future, the LTC programs status is changed to Pre-registered.

- To Pre –Register the client, on the Program screen, select the LTC Facility, select the Register button, fill out Program Group Criteria if applicable, and Start Date, file

Client	Site	CM Type	Next Contact	Client Group
CMHCTRAIN,BORIS	BRHC	ACCEPTED	21/10/16	MAINTEN

Service	Program	Pgm Status	Pgm Status Duration	Pgm Priority
CONTINUING CARE	BROOKS LTC	Pre Reg	0	
DESIGNAT SUPPORT LIVING LVL4	SUNRISE GARDENS DSL4	Waitlist	0	
Home Care Home Living	BROOKS HOME CARE	Register	13	

- Once client has actually gone into the Facility, the Facility will register the client and the screen will then display "Register."

CONTINUING CARE	Cardston Continuing Care	Register

- Discharge the other Registered Program(s) as usual, Discharged Program will show as Complete

Home Care Home Living	Lethbridge Client Home	Complete

- Do not end the episode, as client will eventually be admitted to the SL4 or SL4D
- Once the client has a bed at the SL4 (D), the client will be discharged by the Continuing Care Facility (CC Facility Program will say Complete) the client can then be registered into the SL4 (D).

Housekeeping items:

Update CM REG:

Census – the mailing address of the facility
Service Location:
Homeless: should be a N
From Date – date of admission
Level of Care – F9 and select appropriate level
Congregate Site – F9 and select appropriate site, this will default the address into the fields to the left.
Prov/Site: Ensure correct Site

Assign Values

Client Group: Awaiting Bed of Choice
Case Manager: in CH ring – the Case Manager remains in PA ring – Placement Office

A client moves to a non AHS operated Continuing Care Facility but is waitlisted for a SL4 (D)

In CH ring: Edith Cavell, Fort Macleod
In PA ring: Good Samaritans, Masterpiece River Ridge. Riverview Care Centre, Sunnyside Care Centre and Valleyview, Southland Meadows

Once client moves to non-AHS Continuing Care Facility:

- Discharge Registered Program(s) as usual
- Register client into non - AHS LTC Facility as usual
- Do not end episode, as client will eventually be admitted to the SL4 (D)
- Once the client has a bed at the SL4 (D), discharge the client from the non AHS Continuing Care Facility as usual. Client can then be registered into the SL4 (D) as per usual.

Housekeeping items:
Update CM REG:
Census – the mailing address of the facility
Service Location:
Homeless: should be a N
From Date – date of admission
Level of Care – F9 and select appropriate level
Congregate Site – F9 and select appropriate site, this will default the address into the fields to the left.
Prov/Site: Ensure correct Site
Assign Values
Client Group: Awaiting Bed of Choice
Case Manager: in CH ring – the Case Manager remains in PA ring – Placement Office

Discharge Processes

Discharging Deceased Clients in AHS Continuing Care Sites

In CH ring: Cardston, Coaldale, Crowsnest Pass, St. Michael's, Milk River, Raymond and Taber
In PA ring: Bassano, Bow Island, Brooks, Oyen

Discharging Deceased (Expired) in an AHS operated Continuing Care site

The site will discharge the program but we must discharge the Lifetime Account. Before discharging the Lifetime account, and see if there are other programs still in active status and if there is an active Episode.

- After clicking the it will display the active programs the client is enrolled in and an Active Episode; these programs must be outcomed. You would outcome the program(s) and end the episode, which would take you to the Lifetime account discharge.

Service	Program	Pgm Status	Pgm Status Duration	Pgm Priority
CONTINUING CARE	Crowsnest Pass Continuing Care	Register	98	
Clinical Specialty	Regional Palliative Program	Register	162	

Start Date	End Date	Status	Summary
17/03/17		Active	PROFESSIONAL NURSING

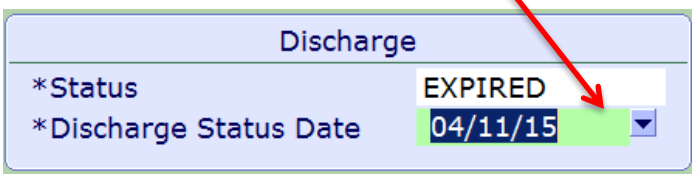
- The date that you would use for the discharge date would be **the actual date that the client died**
- Some Documentation should be done in Lt Notes about the notification of the client's death.

If no other active programs continue below:

- On Case Management screen select Discharge
- Highlight Discharge
- F9 lookup at Status, select Expired

Mnemonic	Name
DISCHARGE	Discharge
EXPIRED	Expired
MERGED	Merged Lifetime Account
REGERR	Incorrect LTA Registration

- Insert the Date that the client Expired, file



- Lifetime Acct will no longer have a green dot.

Client Deceased in Non-AHS Continuing Care Sites

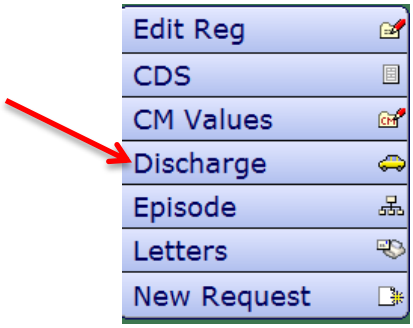
In CH ring: Edith Cavell, Fort Macleod
In PA ring: Good Samaritans, Masterpiece River Ridge. Riverview Care Centre, Sunnyside Care Centre and Valleyview, Southland Meadows

Process is 2 Steps
Step 1- determine if the LTC program is the only active program if other active Programs follow below:

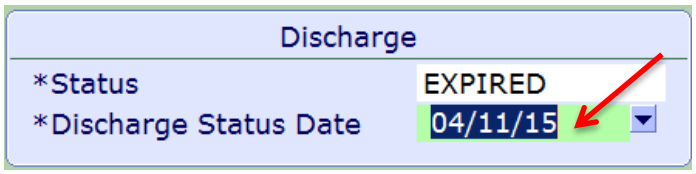
- Check if there are other programs that still have a registered status. If you see the Palliative Program in a registered status complete the following steps
- Discharge the Palliative Program for the date the client died
- Check if there is an Active Episode (there should be one) discharge this for the reason of Expired along with the date being reflective of the **actual date the client died**.
- Notify Palliative Care that the client died and the date of the death

Service	Program	Pgm Status	Pgm Status Duration
CONTINUING CARE	Crowsnest Pass Continuing Care	Register	98
Clinical Specialty	Regional Palliative Program	Register	162

- Document in Care Manager the notification of the clients death along with the date
- Otherwise if no other programs select Continuing Care Facility is highlighted, select "Discharge" from right side toolbar



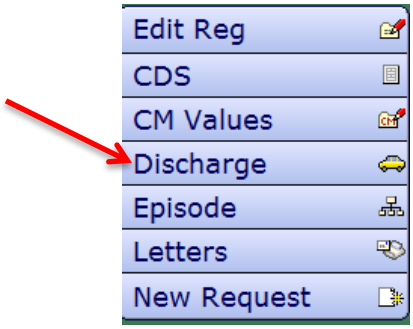
- Do F9 lookup at Outcome, choose Client Expired, press Enter



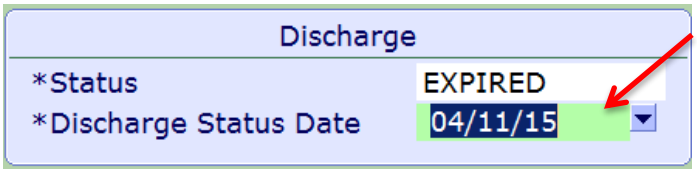
- Insert the Date, **(the actual date that the client died)** - file,
- Program will be completed and no longer show on Programs screen

Step 2- Discharge Lifetime Account as follows:

- On Care Manager screen select Discharge button
- Highlight Discharge
- F9 lookup at Status, select Expired



- Insert the **Date that the client Expired**, file



- In the EMR, the Lifetime Acct and LTC Facility will no longer have a green dot.

Appendix A: Documentation Basics and Principles

General Charting Principles

- Use upper and lowercase, and proper sentence structures,
- There is an **Intent** section at the top of most assessments for information purposes, **DO NOT** document anything in this section,
- Circle selections mean you can select only one option,
- Square selections mean you can select more than one option,
- Comment boxes are for free text,
- Some assessments are on multiple pages which are identified in the upper right corner of the screen.

Documentation

- Can include Client Assessment data, clinical findings, care plans, Interventions, Client goals, critical pathways, medication administration, risk Assessments, and discharge planning. "Staff will document immediately after care has been provided, or within the same scheduled shift that care has been provided" *(Home Care Policy and Procedure #3.2.20)*.
- Must be comprehensive, accurate, timely, and clearly identify who provided the care/service. It must be objective, factual and reflect appropriate use of abbreviations. *(CARNA, September, 2006)*.
- Health Care Professionals must sign off any entries; signatures are considered valid if used to demonstrate accountability specifically by that person. *(CNO, 2004)*
- Incorrect entries must be corrected indicating the person making the correction and when it was made. Previously entered data that is part of the record should not be deleted.
- Late entries must clearly be identified noting the date and time late entry was made.

Back Charting

Note: late entries greater than 72 hours will require special changes to your charting access. To change your access you will need to email: SeniorsHealth.SouthZoneEducation@ahs.ca and provide your 6 digit Meditech number and your manager's name.

Electronic Records and Security

- Entries made and stored in an electronic health record are considered a permanent and legal part of Client records.
- Access to Client information should occur only when that professional is involved with the Client and his/her plan of care. Authorized individuals; people providing services or acting on behalf of AHS granted access to Personal and Health Information on a "need to know basis".

Users are responsible for updating their passwords. Passwords should be not easily deciphered.

NEVER reveal or allow anyone else access to your personal identification number (PIN) or password as they act as a personal signature and identify YOU as the person accessing and documenting Client information.

Users are responsible for all actions performed under their user ID login.

- Use only systems that have secured access.
- Do not use automatic login procedures (automatic password saving).
- Protect Client information displayed on monitors by locking workstation. Keep devices in users possession at all times.
- Transport information securely by logging off when not using the system or when walking away from or leaving the terminal.

Viewing Documentation in EMR

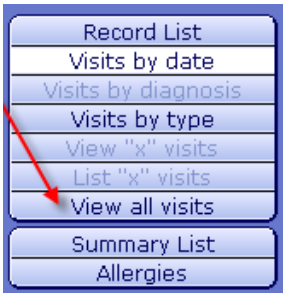
There are several ways to access the EMR:

- Select the F11 key
- Select the EMR Icon on the Main Menu
- Select the EMR Link of the right side of the Meditech screen 
- From PCS, select EMR 

To access your client from the Case Management screen:

- Highlight Client on the Case Management screen.
- Select Programs, select Program Routines, RN's select Program Care Plan
- The Process Plans of Care screen opens. Select the EMR Link button or F11 key
- The EMR screen for the client opens. Select Other Visit from right toolbar—this enables you to view all electronic documents on your client

- Select View All Visits from right toolbar.



How to Add SOC Intervention in the Lifetime Account

This will be required if the **SOC: Lifetime Account** is not already present in **LT Account** or some assessments from the SOC set are missing (you may see this on clients that have been on Home Care prior to Meditech Update 2014)

If the client **already has assessments** in the **Lifetime Account** they will be listed on the screen when you enter the PCS environment (**Worklist**). If you need to add the SOC: Lifetime Account, click on footer button "**Add Interventions**" to open the "**Search for**" field.

Note: If the client is new and there are no previous assessments listed, the "**Search for**" field will automatically open.

a. In the "**Search for**" field, enter the word **"Life".**
b. Place check mark beside **"SOC: Lifetime Account"**
c. Click **"Add & Close"**
d. Interventions you have added should be magenta on the screen. You can then document as needed on these Interventions.

Note: If any of these assessment were added previously (they already existed on the **Worklist**) you will see **DUP** in magenta under the **Src Column**. These assessments must be deleted as each assessment should only appear once on the **Worklist**.

How to Delete Duplicate Interventions in Lifetime Account

If Duplicate Assessments are added this will be indicated by **DUP** in magenta under the **Src Column:**

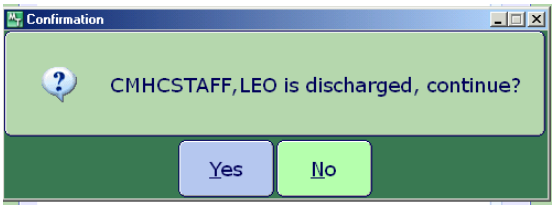
a. Highlight the single **Duplicate Assessment** or place **checkmarks to** the left of all the Duplicate Assessments that you wish to Delete (**Prior** to any documentation being completed on the Duplicate Intervention)

b. Select **Delete** Intervention from the bottom tool bar. This will remove the Interventions from your Worklist.

How to Chart if Client has been Discharged/Deceased before charting was completed

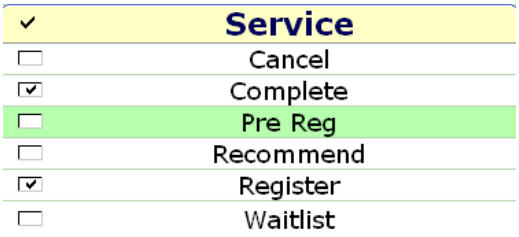
These steps allow the User to chart, for example, something needed/missed to be edited after client was discharged. (Do not register the client into any program a 2nd time).

1. On the **Change List**, choose **Lookup List** to search for Client
2. If a pop up message appears indicating the Client is discharged , choose "Yes"



3. On the CM Coordinator Desktop screen, choose **Edit PGM List**

4. On the **Status** screen, choose place a checkmark beside "**Complete**" and SAVE

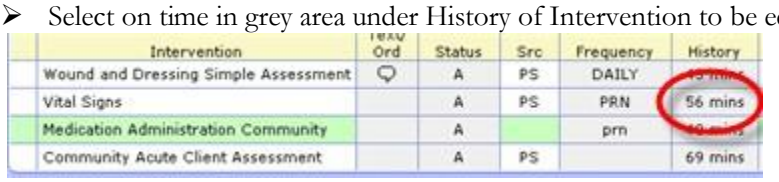


5. Highlight the **Program** and open the **Program Account** by clicking on the **(+)** to the left of the Client's name
6. On the Footer menu click on **Pgm Document** and document in **PCS/Worklist** as usual. Remember to date as usual.

Editing Documentation

You may edit your <u>own</u> Intervention documentation **for <u>3</u> days** (including weekends). This is only done if an error or omission is made in documentation. A history is kept. The original document is also viewable. To edit past 3 days, please contact the Seniors Health education team at: SeniorsHealth.SouthZoneEducation@albertahealthservices.ca

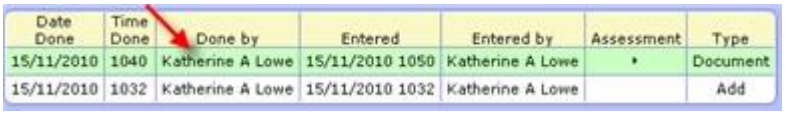
- Navigate to **PCS Interventions** screen where charting was originally done (screen says PCS in top left corner)
- Select on time in grey area under History of Intervention to be edited



Intervention	Ord	Status	Src	Frequency	History
Wound and Dressing Simple Assessment		A	PS	DAILY	
Vital Signs		A	PS	PRN	56 mins
Medication Administration Community		A		prn	
Community Acute Client Assessment		A	PS		69 mins

- The Intervention History opens. There may be multiple lines. Select the entry you wish to edit so it

appears in green. (Look for your name in "Done by" column) select again to open



Date Done	Time Done	Done by	Entered	Entered by	Assessment	Type
15/11/2010	1040	Katherine A Lowe	15/11/2010 1050	Katherine A Lowe	•	Document
15/11/2010	1032	Katherine A Lowe	15/11/2010 1032	Katherine A Lowe		Add

- Once Assessment open, make all changes to the Intervention. Select Return at right lower screen. The edit is shown in the top column in magenta 

- Select Return again. Edit-Date/Time appears under the Intervention in magenta 

- Select Save. Only the edited Intervention appears in the Notes in the EMR.

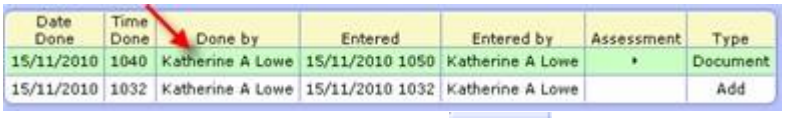
Undo Documentation

Documentation done in error may be undone by the User for 3 days (including weekends). After 3 days, please contact the Seniors Health education team at SeniorsHealth.SouthZoneEducation@ahs.ca

- Reasons for documentation to undo:
  - Done on wrong client
  - Wrong Date/Time
  - Wrong Visit/Account (i.e. wrong Program)
  - Other reason
- Navigate to PCS Interventions screen where charting was originally done (screen says PCS in top left corner)

Intervention	Ord	Status	Src	Frequency	History
Wound and Dressing Simple Assessment		A	PS	DAILY	
Vital Signs		A	PS	PRN	56 mins
Medication Administration Community		A		prn	
Community Acute Client Assessment		A	PS		69 mins

- Intervention screen opens in PCS showing Interventions
- Select into grey area under History of the Intervention to be undone
- The Intervention History opens. There may be multiple lines. Click the entry you wish to undo so it appears in green. (Look for your name in "Done by" column) You may open it to ensure it is the correct document to undo, and close it by clicking Return. (Note: once undone, cannot get back)



Date Done	Time Done	Done by	Entered	Entered by	Assessment	Type
15/11/2010	1040	Katherine A Lowe	15/11/2010 1050	Katherine A Lowe	•	Document
15/11/2010	1032	Katherine A Lowe	15/11/2010 1032	Katherine A Lowe		Add

- Select **Undo** from the bottom toolbar. 

- Select one **Reason** for the Undo. Select OK. (If you select "Other" you must type the reason, i.e. duplicate entry, then select OK)

- Undo line appears in magenta. Select Return 

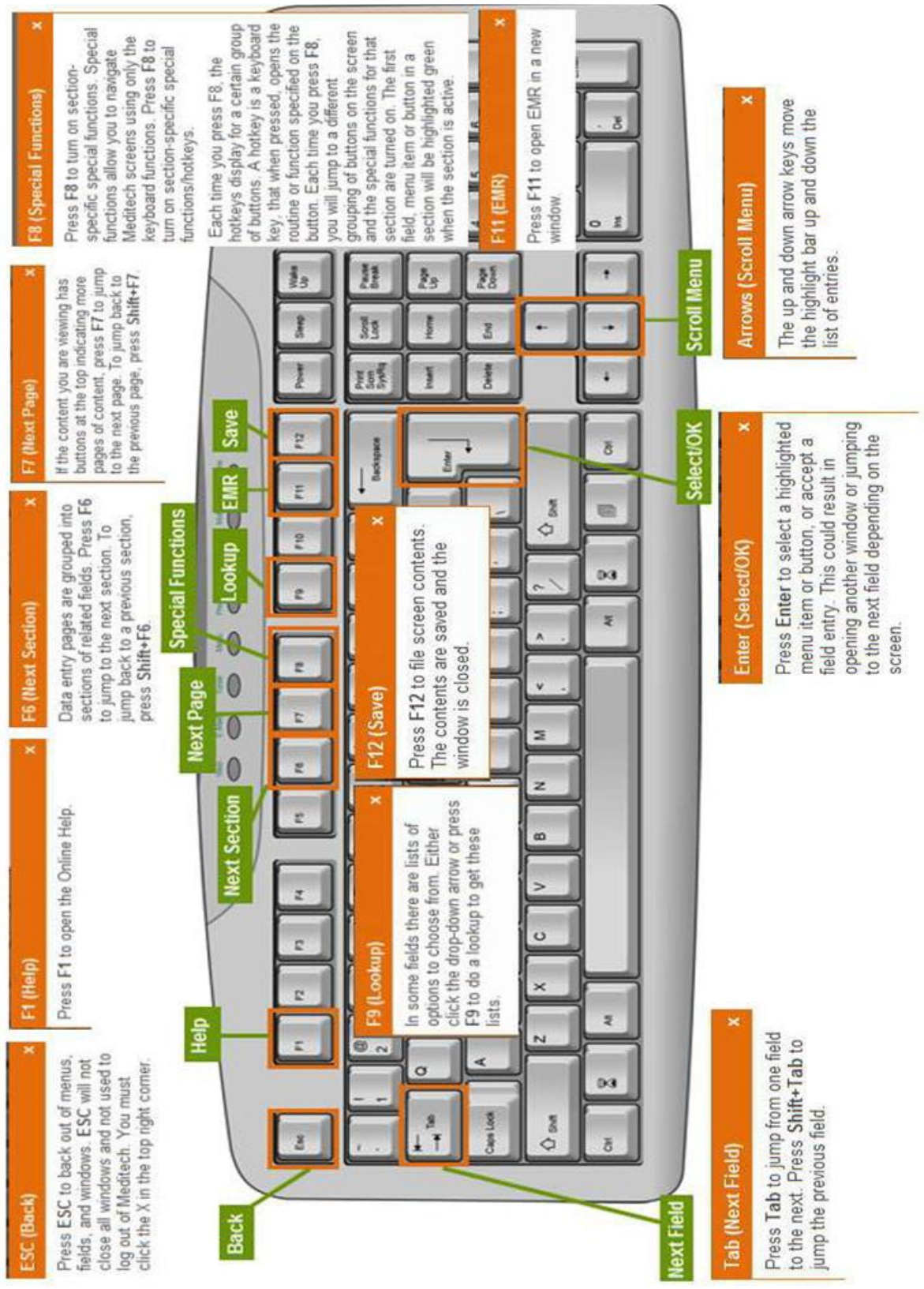
- The Undo appears under the Intervention in magenta. Select Save 

- Click into the grey area under History to see that a record is kept of the Documentation which was Undone
- In EMR, the documentation will not show under Notes. However in Spreadsheet under Date it will be shown as Undone.

Appendix B: Meditech Short Cuts

T	In Date fields: T = today Date displays as: DDMMYYYY or day, month, year
T+n (T+3)	In date field: T+3=three days in the future. May use other amount of days
T-n (T-2)	T-2=two days in the past. May use other amount of days.
N	In Service Authorization or MDS: N=New
N/LASTNAME	In Name fields: N/plus last name, or portion thereof, will narrow search for Case Manager
SP	Same as Patient / Same Place
SNOK	Same as Next of Kin
SPTN	Same as Person to Notify
SR	Same as Referral
SAC	Same as Caller
Postal Code	In CM Edit Reg, Census Tab, enter Postal Code in City, and the correct information defaults into City, Province, Postal Code, and Residential Code
Shift + Tab	Moves cursor to the next field
Space Bar followed by Enter	When looking a client up, use space bar followed by enter and the last client accessed should default in. Always check to ensure it is the client you want to be accessing.
alt + underlined letter	"Hot key" is used instead of clicking on the button with a mouse
Press Delete + Tab	To Delete a line of information in Care Manager
?___	When looking for interventions typing a "?" followed by the letters in an intervention EG (?Tele) will bring up all interventions with Tele in it.
Ctrl+PrtScn Or Ctrl+Print Screen	Hold Ctrl button down as you press your Print Screen button (should be approximately on the right side of the keyboard along the top buttons) This will make a copy of your full computer screen that you can copy into an email, or copy a word document.
TAB (forward) and SHIFT + TAB (back)	To move curser ACROSS a line

Keyboard Shortcuts



Appendix C: Terms/Definitions Relating to Meditech & Care Manager Module

AADL – Alberta Aids to Daily Living

ACCIS — Alberta Continuing Care Information System. The ACCIS system collects data specific to Home Care patients including demographic data, admission data, RAI, intervention data, transfers and discharges.

Account Number - A consecutive numbering system that gives each person a unique number for the current registration.

ADL Hierarchy—This Outcome Measure from the MDS-HC measures ADL performance. It is a 6-point value with 0 reflecting Independence and 6 reflecting total dependence. It is a valid measurement of ADL function and is also reliable to assess ADL impairment over time

AHS – Alberta Health Services

AIS—Assessment Intelligence System. Web based ELearning Solutions which provide additional computer based learning for Inter-RAI assessments, including the RAI-HC and RAI 2.0.

Assessment—A health care organization-defined questionnaire used to collect client information also called Interventions

CAPs—Client Assessment Protocols. The presence of an accurate MDS-HC assessment lays the ground work for all processes that follow, including identification of problems, causes and associated conditions, and specification of necessary care goals and related approaches to care. CAPs provide guidelines for further assessment and individualized care planning. The RAI-HC can trigger up to 30 different CAPs

CDS—Customer Defined Screen. Screens created that will capture data not captured on standard MEDITECH screens (example: CSB Type)

CHESS Scale—This outcome scale from the MDS-HC is a 6-point scale designed to be a predictor of health instability and frailty. A score of 0 means the client has no symptoms present while the high-end score of 5 represents a client with very unstable medical conditions and a poor long-term survival rate. A score of 5 at the time of assessment would be predictive of a length of life of less than 30 days

CIHI—Canadian Institute for Health Information. An independent, national, not-for-profit organization working to improve the health of Canadians and the health care system by providing quality health information. CIHI works closely with Inter-RAI to support comprehensive assessment through standardized education. They also work with Healthcare Agencies to support implementation and in turn, receive submission data in relation to Government policy

CM – Care Manager -Community Care Module: Home Care, Continuing Care (Placement Office), Community Rehabilitation Program, Specialty Programs, e.g. DEP, Seniors Resource, Chronic Disease

CPS—**Cognitive Performance Scale**. Calculated from the **RAI-HC**, it is a hierarchical index used to rate the **cognitive status** of clients. It has been validated against the Mini Mental State Examination and the Test for Severe Impairment. It has a score of 0, Intact, to 6, very severe impairment

CSI Status- Indicates client's status in the Client Service Inquiry. The status is: Open, Assign, Intake & Closed

CWS—Community Wide Scheduling

Downtime—A description of when the computer system is not available due to system outage, or lack of connectivity with our laptops

DRS—Depression Rating Scale. The DRS can be used as a clinical indicator of depression. Scores above 3 indicate depressive disorders

E-charting—Electronic Charting—Charting done electronically in the computer as opposed to on paper

EMR—Enterprise Medical Record. The EMR represents the patient's online medical record. A tool to view all clinical and administrative data for a patient in one centralized location. Visit data is streamlined, centralized, updated on a real-time basis, and never purges. The **EMR collects, stores, and displays clinical data for patients**

File - The Meditech word to "save" or record the added information into the client's electronic record. The File function is used to "send" orders to the performing department.

Frequency—The number of times that an Intervention is administered to a client. Also referred to as directions

HCRS—Home Care Reporting System

HCQIs—Home Care Quality Indicators

Intervention—A task or action that a caregiver performs that is directly related to client care also called Assessments

Intervention Status—An Intervention can have any of the following statuses:
Active (A)—are current care delivery responsibilities
Cancelled (X)—entered in error –use only in rare cases
Complete (C)—no longer necessary in the current phase of care, but which appears on the plan of care to show a true picture of the client's progress
Discharged (D)—are no longer being delivered because a client has been released from the current program or from Community Care
Inactive (I)—an inactive item
Hold (H)—has been temporarily stopped
Stopped (S)—a system generated status when an Intervention as reached the stop date. Would not be selected by the end user

MAPLe—Method for Assigning Priority Level. The MAPLe is an algorithm that uses data from the RAI-HC to create a score that is an indicator of stability of the client's current health and living situation. It assists with identifying clients at risk for requiring a change in living/support options

MDS-HC Status- Indicates the status of the MDS-HC Assessment. The Statuses available are: Draft, Complete, Finalized and Xcancelled.

Mnemonic- An abbreviation or code for items on a selection list, e.g. facility, service, program, physician, etc.

MPI – Master Patient Index

Omaha System — Contains Problems, Modifiers and Outcomes and enables the building of client specific Careplans

Omaha Modifiers — Refers to two sets of terms (Individual, Family, Community and Health Promotion, Potential, Actual) used in conjunction with problems, which allows practitioners to identify to whom the problem pertains and degree of severity in relation to client strengths, concerns, risk factors , signs and symptoms

Omaha Outcomes —
Knowledge Outcome: Ability of client to remember and interpret information (what the client knows)

Behaviour Outcome: Observable responses, actions, or activities of the client fitting the occasion or purpose (what the client does)
Status Outcome: Condition of the client in relation to objective and subjective defining characteristics (number and severity of client's signs and symptoms or predicament)

Omaha Problems —A potential or actual need that requires Intervention by a caregiver

Outcome Scales—A series of related items from the RAI-HC that are grouped together to help describe the client. The Outcome Scales available from the MDS-HC include the CPS, DRS, ADL Hierarchy, CHESS, Pain Scale, ADL Short Form, ADL Long Form, IADL Difficulty, IADL Summary, IADL Involvement, and MAPLe

Pain Scale—An **Outcome Scale** from the **RAI-HC** that has been shown to be highly predictive of pain when compared to the Pain Thermometer, Numeric Rating Scale, Visual Analog Scale and the Verbal Descriptor Scale. It has a range from 0, no pain to 3, severe daily pain

PCS—Patient Care System. On-line, multidisciplinary clinical documentation, driven by the Patient's (Client's) Plan of care

PHN—Personal Health Number (see ULI)

Plan of Care—A group of **Problems**, **Outcomes**, and **Interventions** assigned to a client

Process Plans—Name of the screen where **Plan of Care** is seen in Meditech

Program Status- Indicates the status of a Program. The statuses available are: Recommend, Register, Complete, Waitlist and Cancel.

Protocol—A protocol is a instruction or information on how to perform a procedure regarding policy, procedures, or research studies
RAI HC — Resident Assessment Instrument for Home Care

Service Authorization Status -The Service Auth Status help the End-User identify what process the Authorization Form is in. The Statuses available are: Draft, Compiled, Accepted, Finalized and Xcancelled.

Sites - The Care Centre or Community Health Centre where the client's is registered.

Status of an Intervention in Process Plans of Care -The Status of an Intervention in the Process Plans of Care Screen can be one of the following: Active (A), Complete (C), Hold (H), Inactive (I) and XCancel (X.) In the Process Plans of Care screen if the Status of an Intervention is not in the *"Active"* Status, then the End-User will NOT be able to create a Service Authorization Form needing that specific Intervention

ULI—Unique Lifetime Identifier. Usually the same as the PHN

Unit Number- The Meditech program's name for the client's Medical Record Number. Patients have the same Unit number for all visits to a facility, allowing the Health Records department to keep old charts together.

VI—Seen on the Process Plans of Care screen in front of Interventions which are assigned to a Vendor. The **V** appears once the Service Authorization takes effect

Worklist—Accessed from the Process Plans of Care screen through the W button. A list of Interventions scheduled for a client

Alberta Continuing Care Information System (ACCIS) Item Definitions

List of Records that will be submitted to ACCIS and a sample of some of the data contained in those records.

- ID Record - Identification Record - this data is collected at time of patient registration and episode creation.
    - Name, Birthdate, ULI, Site, Episode Start Date
- AD Record - Admission Record - this data is collected at time of patient registration and episode creation.
    - Postal Code, Date Case Opened, Service Plan Date and Type, Method of Funding, Referral Source, CM Values
- SD Record - Service Details Record
    - Interventions documented via PCS, RAI-HC Finalized or any Service Authorization
- RH Record – contains RAI- HC data
- MD Record – Medications from the RAI- HC
- UR Record – Update Record
    - Fields are updated by CM: Gender, Birth Date, Client Type, Primary Language, Service Plan Code, Method of Funding Services, or Postal Code of Residence
- TR Record – Transfer record
    - generated when changing a client's site to another site within Meditech
    - All documentation, Service Authorizations will need to be completed prior to transferring
- DC Record – Discharge
    - Episode has ended
    - Items included would be End Date, Reason or Referred To
- DE Record – Delete record
    - Such items that will generate a DE would be: PCS documentation undone, Service Authorization marked as not occurring or RAI-HC cancelled.

Preference & Priority Definitions (Changes effective Dec 2015)

IMMCOM

If the needs of patients waiting in community cannot be safely managed in their current environment for more than 48 hours and are at risk of Acute Care admission, these patients shall be designated as 'Immediate in the Community'.
This will have a Program priority rank of a 1.

TEMPCOM

Patients who refused an offer of an alternate Designated Living Option as a temporary measure but agree to purchased care and/or extensive family involvement as a temporary measure.
This will have a Program priority rank of a 1.

FIRST

Client has accepted a Temporary Living Option.
This will have a Program priority rank of a 1.
Examples:

- client requesting a certain facility (SL4) but no beds available and has agreed to being admitted to a different site but the same level
- client assessed for SL4 but no beds available and client has agreed to being admitted to a Long Term Care bed temporarily
- client has chosen to go to a Private Pay option temporarily to wait for the most preferred site of choice

REQALT

Client has been admitted to their facility of choice but is now requesting a different site at the same level which would occur under a new waitlist date.
These clients would NOT have the Living Option CDS completed.
This will have a Program priority Rank of a 1.
Examples:

- In SL4 @ Wellington -> wanting SL4 Good Samaritans
- In SL4D at West Highlands -> wanting SL4D at Park Meadows

NEWLEVEL

Client has already been placed in a continuing care setting. These clients have been subsequently reassessed as requiring a new level of care; they need to be placed on the waitlist for that level of care and for the date that this was determined. **The CDS would be completed with all new information.**

This will have a Program priority rank of 1.

Examples:

- Client in SL3 now needs SL4
- Client in SL4 now needs LTC
- Client in SL4D now needs SL4
- Client in LTC now needs SL4

WACUTE

Client is waiting in an Acute Care Hospital or on a Subacute unit
This will have a priority level of a 2.
Examples of Acute Care:

- Bassano Health Centre, Blairmore Health Centre, Bow Island Hospital, Brooks Hospital, Cardston Hospital, Chinook Regional Hospital, Medicine Hat Regional Hospital, Oyen, Pincher Creek Hospital, Raymond and Taber

Examples of Subacute Units

- Brooks Hospital on the Subacute Unit C, Chinook Regional Hospital on 5B; St. Michaels Health Centre on PARP; Medicine Hat Hospital on 2N Subacute unit

URCOM

Clients waiting in Home Care Home Living and Home Care Non-Designated Living programs. This would also include clients in Private Assisted Living facilities and in Long Term Care Centres if assessed for a lower Level of Care.
This will have a priority level of a 2.

WCSB

Clients waiting in a Community Support Bed.
This will have a priority of a 2.
Examples:

- The Community Support beds are located in Cardston, Coaldale, Crowsnest Pass, Fort Macleod, Lethbridge, Magrath, Milk River, Picture Butte, Pincher Creek, Raymond, Medicine Hat and Taber

HOLD

The clients application is hold or on delay.
This will have a Program Priority rank of a 6.

OOR, OPOC, RECIP

These will no longer be used. **Use the Bed Matching Descriptor on the Living Option Screen to note Out of Zone or Out of Province clients.**

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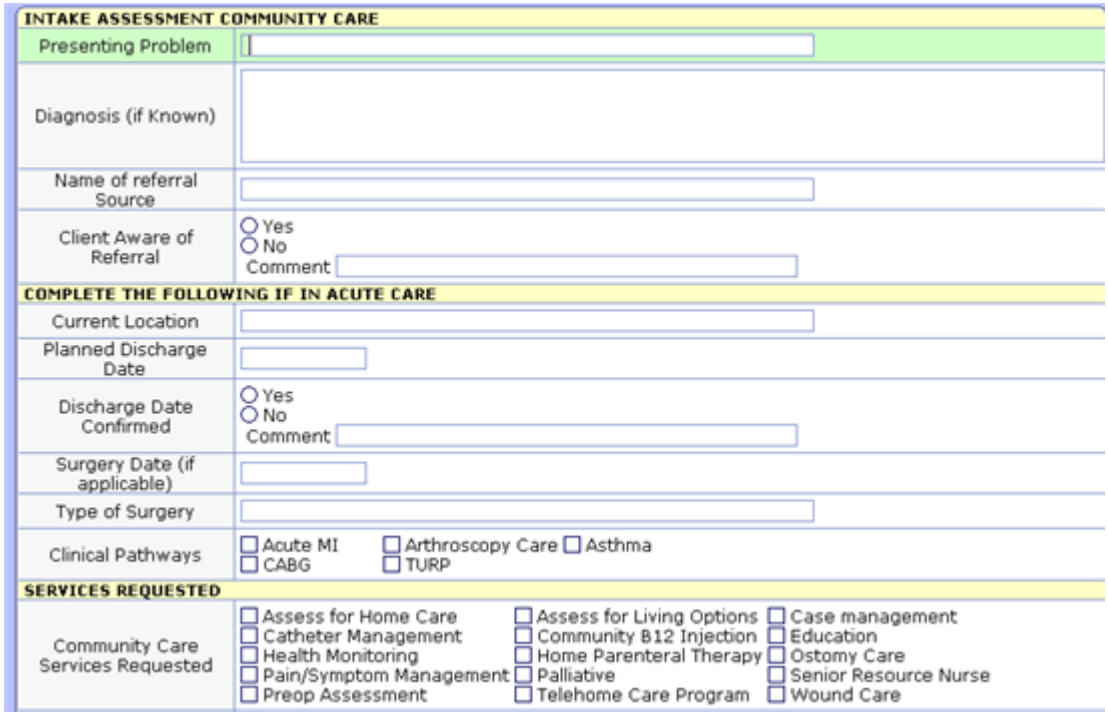
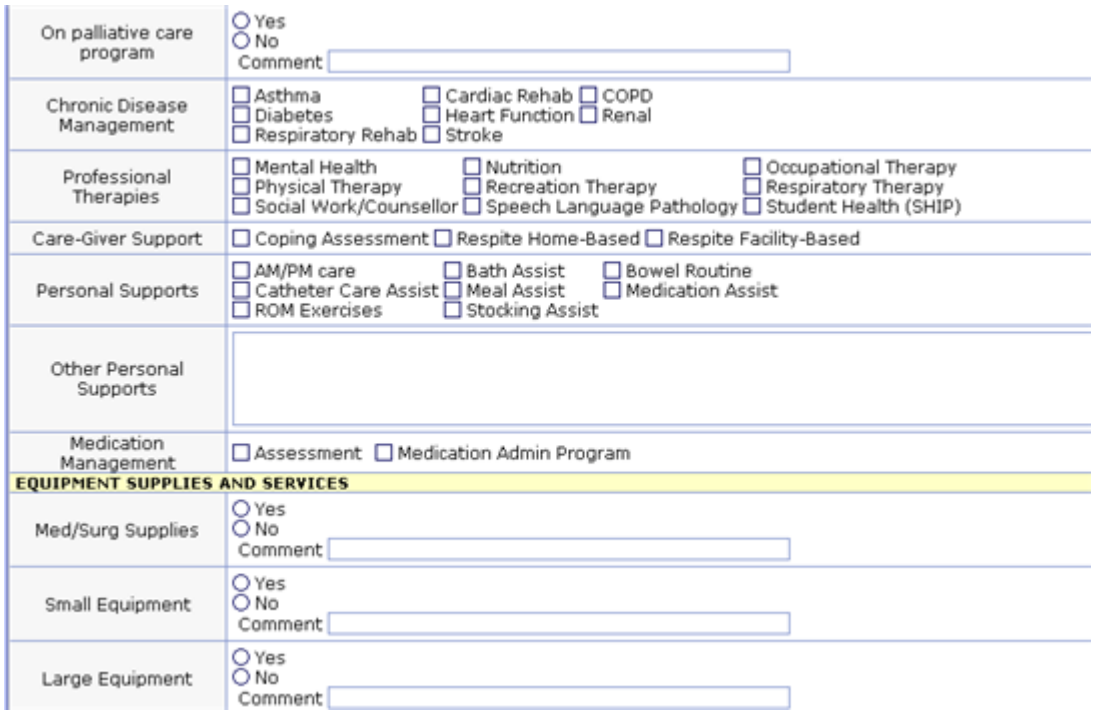
Appendix D: The Intake Assessment Community Care

Allows the end users to briefly summarize the Services and Equipment supplies needed, it also has an algorithm to determine the correct **Client Group.**



INTAKE ASSESSMENT COMMUNITY CARE	
Presenting Problem	
Diagnosis (if Known)	
Name of referral Source	
Client Aware of Referral	○ Yes ○ No Comment
COMPLETE THE FOLLOWING IF IN ACUTE CARE	
Current Location	
Planned Discharge Date	
Discharge Date Confirmed	○ Yes ○ No Comment
Surgery Date (if applicable)	
Type of Surgery	
Clinical Pathways	☐ Acute MI ☐ Arthroscopy Care ☐ Asthma ☐ CABG ☐ TURP
SERVICES REQUESTED	
Community Care Services Requested	☐ Assess for Home Care ☐ Assess for Living Options ☐ Case management ☐ Catheter Management ☐ Community B12 Injection ☐ Education ☐ Health Monitoring ☐ Home Parenteral Therapy ☐ Ostomy Care ☐ Pain/Symptom Management ☐ Palliative ☐ Senior Resource Nurse ☐ Preop Assessment ☐ Telehome Care Program ☐ Wound Care



On palliative care program	○ Yes ○ No Comment
Chronic Disease Management	☐ Asthma ☐ Cardiac Rehab ☐ COPD ☐ Diabetes ☐ Heart Function ☐ Renal ☐ Respiratory Rehab ☐ Stroke
Professional Therapies	☐ Mental Health ☐ Nutrition ☐ Occupational Therapy ☐ Physical Therapy ☐ Recreation Therapy ☐ Respiratory Therapy ☐ Social Work/Counsellor ☐ Speech Language Pathology ☐ Student Health (SHIP)
Care-Giver Support	☐ Coping Assessment ☐ Respite Home-Based ☐ Respite Facility-Based
Personal Supports	☐ AM/PM care ☐ Bath Assist ☐ Bowel Routine ☐ Catheter Care Assist ☐ Meal Assist ☐ Medication Assist ☐ ROM Exercises ☐ Stocking Assist
Other Personal Supports	
Medication Management	☐ Assessment ☐ Medication Admin Program
EQUIPMENT SUPPLIES AND SERVICES	
Med/Surg Supplies	○ Yes ○ No Comment
Small Equipment	○ Yes ○ No Comment
Large Equipment	○ Yes ○ No Comment

Lower Leg Assessment	○ Yes ○ No Comment
Incontinence Assessment	○ Yes ○ No Comment
Equipment Loan	○ Yes ○ No Comment
Other Services	☐ Day Programs ☐ Dementia Support Team ☐ Developmental Disability ☐ FCSS ☐ Foot Care ☐ Lifeline ☐ Meals on Wheels ☐ Seniors Outreach Programs ☐ Specialized Assess Unit ☐ Volunteer Services
CLIENT GROUP	
Client Group Instructions	Not all the questions in this section are required to be answered. Start with the "Client's Needs Are Time Limited" question. Follow and ANSWER the green highlighted sections only. The Client Group will auto-populate at the end of the section.
Client's Needs Are Time Limited	◉ Yes ○ No
Has End Stage Disease with Anticipated Death Within 6 months	○ Yes ○ No

Always answer the first question.

Then follow the green background as this will take you to the next question dependent on your answer.

Improvement with Goal Orientated Functional Rehabilitation	○ Yes ○ No Goal orientated, functional rehabilitation refers to a process designed to improve what the individual can do for themselves (given whatever deficits they have) rather than focusing on those factors that impact function (i.e., range of motion, strength, sensation, pain, etc.).
Immediate or Urgent Needs Time Limited up to 3 mos or Less	○ Yes ○ No If client's needs are time limited and 'Yes' was selected above, then 'No' cannot be selected here. If 'No' is chosen, an error message will occur when documentation is saved.
Stable Health and Living Arrangement and Personal Resources	○ Yes ○ No
Stable Health, Professional Services With No Case Management	○ Yes ○ No Professional Services in clinic or home required for longer than 3 months. No Personal Support or Respite Services provided.
Temporarily Admitted to a Long Term Care Facility	○ Yes ○ No
Temporary Admission to LTC or Supportive Living	○ Yes ○ No
Temporary Admitted for Respite or Convalescence	○ Yes ○ No
Client Group	
ADDITIONAL COMMENTS	
Intake Assessment Additional Comments	

Note: The Client Group that displays, will be entered in to the CM Values Client Group and dated for the same date of the Intake Assessment.

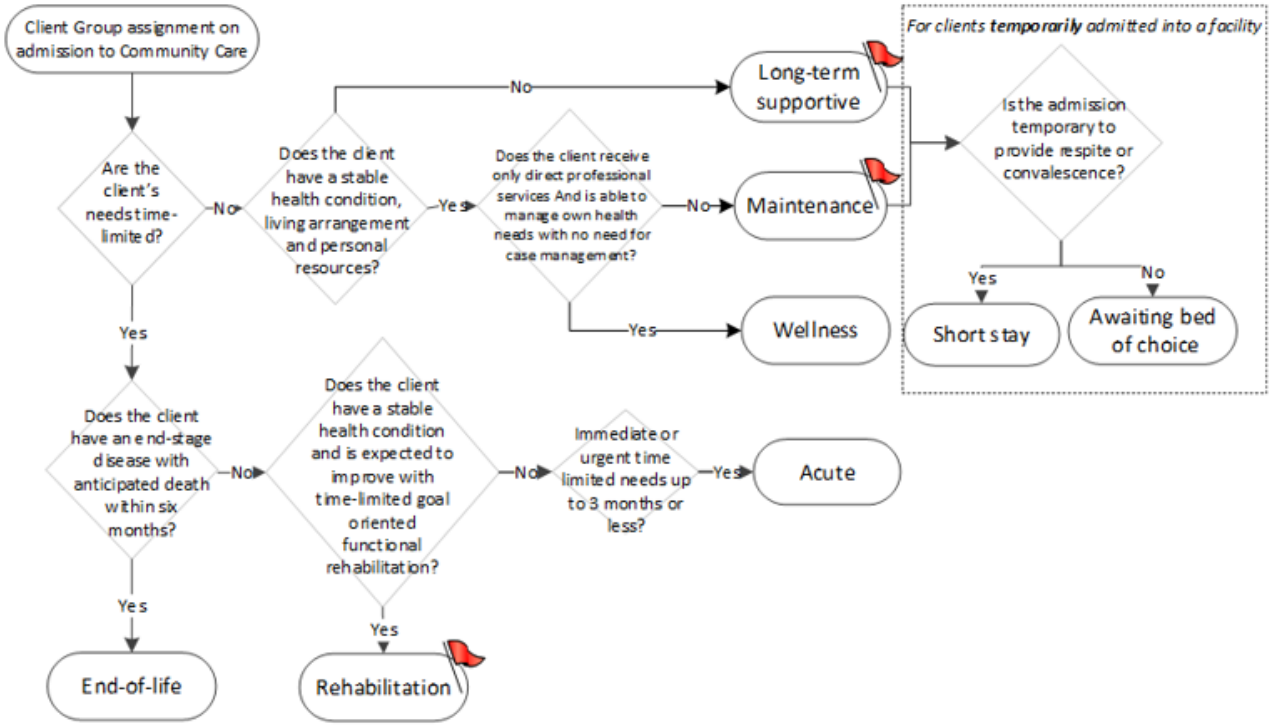
Appendix E: Client Group Definitions

All clients will be assigned to a client group based on their health status. The type will be initially assigned by the Access Centre RN or Community Transition Team RN, but will be reviewed by the Case Manager after an initial assessment is done and changed if appropriate. It may also be changed when there is a significant change in the client's status. When assigning client group, refer to the primary need/goal of care.

Note: The Client Group must match the value CM Values of CM Coordinator Desktop screen. The Intake intervention is always done first then the client group that is generated through the **Intake is entered into the CM Values.**

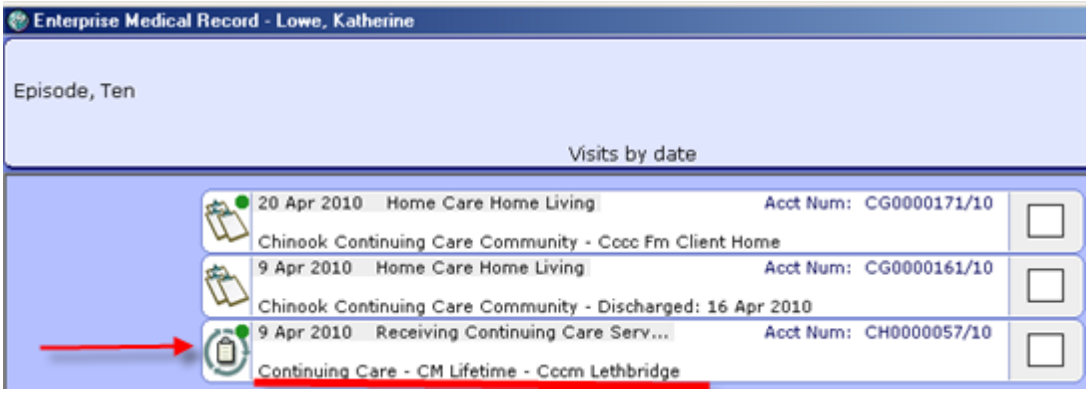
- **Acute:** a client who needs immediate or urgent time limited (up to 3 months or less) interventions to improve or stabilize a medical or post-surgical condition.
- **End of Life:** a client with an end-stage disease for whom death is anticipated within six months; however, the timeline for death should not be the pivotal criteria for determining end-of-life as a client's group.
- **Rehabilitation**: a client with a stable health condition that is expected to improve with a time-limited focus on goal-orientated, functional rehabilitation. The rehabilitation care plan specifies goals and expected duration of therapy.
- **Long-term Supportive:** a client who is at significant risk of institutionalization due to unstable, chronic health conditions, and/or living condition(s) and/or personal resources.
- **Maintenance:** a client with stable chronic health conditions, stable living conditions and stable personal resources, who requires ongoing support to remain at home.
- **Awaiting Bed of Choice:** a client who has been transferred to a long-term care facility; however, the facility is no their preferred bed of choice. The client remains a community care client, regardless of the need for services, until they are successfully transferred to their preferred bed of choice.
- **Wellness:** receives only professional service for a single unmet need and does not require case management by AHS Continuing Care. The Wellness client has stable health condition(s), living arrangements and personal resources and is otherwise able to identify and manage his/her health needs. A Wellness client is expected to require AHS Continuing Care services for longer than 3 months.
- **Short Stay:** a maintenance or long-term supportive client that is temporarily residing (up to 28 days or less) in a supportive living or long-term care facility (i.e. respite services)

Appendix F: Client Group Decision Tree



Appendix G: Episode Functionality

- An Episode refers to the Admitting and Discharging of a client into Services and Programs.
- The original Episode and completion of CM Registration will create a Lifetime Account Number.



- An Episode will have a Start and a Stop date. Therefore each admission for Community Care services is an Episode.
- A client may have several different Episodes if they have received Community Care services numerous times.
- A client who receives services at home then later moves to a lodge, without an interruption in service, will have one Episode of care but will have been enrolled in two different Programs during the Episode of care.
- The Episode is created as a part of the Registration process

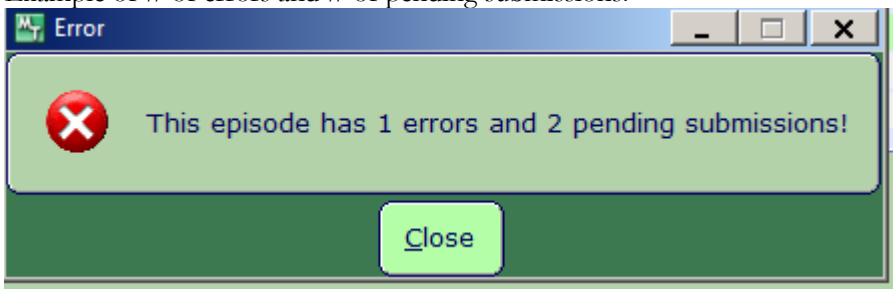
Episode Summary Descriptions

AADL Assessment	▪ Formal assessment for Alberta Aides to Daily Living authorization of equipment and/or supplies
Allied Health Assess/Treat	▪ Formal assessment, treatment, education and/or monitoring by allied health professional
Assess For Living Option	▪ Formal assessment to determine appropriate living option and accessing AHS controlled living options
Clinical Nutrition Consult	▪ Formal assessment, treatment, education and/or monitoring by clinical nutrition professional
Complex Pediatrics	▪ Formal case management, assessment and/or treatment where the client is under the age of 18 and has complex health conditions or care needs.
Home Parenteral Therapy	▪ Formal assessment, treatment, education and/or monitoring of a client receiving parental therapy within the home
Palliative Care	▪ Formal case management, assessment and/or treatment by a palliative care specialist within the client's home
Personal Supports	▪ Services (Instrumental Activities of Daily Living and Activities of Daily Living) to maintain a client in their current living setting. Formal assessment and/or monitoring will be provided to determine required services
Post Hospital Follow-up	▪ Formal assessment, treatment, education and/or monitoring of a client recently discharged from hospital (non-surgical admission)
Post Surgical Follow-up	▪ Formal assessment, treatment, education and/or monitoring of a client recently discharged from hospital (surgical admission)
Professional Nursing	▪ Formal case management, assessment and/or treatment for adult clients
Wellness Services	▪ Assessment, treatment, and/or education services provided in a community setting for clients who have stable health conditions (no case management services provided)
Wound Care	▪ Formal case management, assessment and/or treatment for clients currently experiencing a wound that requires professional treatment

Error messages that might display when Ending an Episode

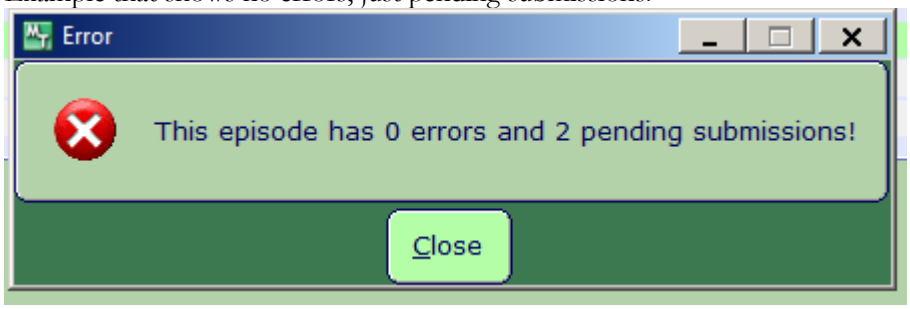
When entering an End Date on an episode, if the episode has any outstanding errors or pending submissions, the number of each will be displayed to the user.

Example of # of errors and # of pending submissions:



If you receive this message DO NOT END the Episode. Click OK. You are taken back to the episode screen, Exit out of the Episode. Contact Seniorshealth.southzoneeducation@ahs.ca so the errors can be corrected prior to ending the episode.

Example that shows no errors, just pending submissions:



The episode can be ended in this case. Click OK takes you back to the Episode screen and the Episode can then be ended.

Outcoming Program & Ending an Episode of Care

Definition: Continuing Care: For the purpose of this document Continuing Care includes all services being provided within the AHS Seniors Health streams of Home Living, Supportive Living, Transition Services, Clinical Specialty Services, and Long Term Care (LTC) Facility Living.

A. Outcoming a Program: Choosing a Program Outcome Reason. When a Program is no longer required for a client, the Program is completed and a *Program Outcome Reason* is selected, based on the reason the client no longer requires the Program. The current Episode remains active if the client is still receiving some services/programs from Continuing

- Refer to Table A: Program Outcome and Episode Completion Descriptors including Definitions for Continuing Care.

B. Ending an Episode of Care (Discharge): Choosing an Episode Completion Reason

When a client is no longer receiving any services from Continuing Care, the Episode is completed and an *Episode Completion Reason* is selected based on the reason the client no longer requires further services.

- The Episode will also be completed once a Continuing Care client in the LTC Facility Living stream is in their bed of choice – See Note 3
- Applicable Episode Completion Reasons will have a different mnemonic than the Program Outcome Reasons mnemonic; however both will have the same descriptor and definition/explanation as listed in Table A.

Table A: Program Outcome and Episode Completion Descriptors Including Definitions for Continuing Care

Program Outcome Reason Mnemonic	**Episode Completion Reason Mnemonic**	**Descriptor**	**Definition/Explanation**
CANCEL	N/A	Cancel Program	• Program was Recommended or Waitlisted and is no longer required by the client.
CMEX	EXPIRED	Client Expired	• Client deceased and services are no longer required
CMINCPR	N/A	Incorrect Program	• Program was Recommended or Registered in error or an alternate equivalent Program has been selected.
CMMERGE	MERGED	Client Merged	• **Do not use** - Selection is used only by advanced users in consultation with Heath Information Management (HIM) • Program/Episode closed because the client's file will be discharged and merged into a second active file.
CMMVRG	MOVED	**Client moved, Episode ended**	• Episode will be completed because client has moved to a new HCIS/Zone ****Change to definition****
CMNLE	CLNLELIG	No longer eligible for service	• Client does not meet criteria for continued services and Program is ended.
CMNLR	N/A	**Service/Program Complete**	• Client and Health Care Professional in agreement to end services of Program as unmet needs have now been met. Current Episode remains active as client is still receiving some services or Programs from Continuing Care. * *See note 1*
CMNLRED	CLNLRSV	**No service reqd, Episode end**	• Client is no longer receiving any service or program from Continuing Care, Episode ended **See note 1*

Program Outcome Reason Mnemonic	Episode Completion Reason Mnemonic	Descriptor	Definition/Explanation
CMROHS	CLROTHHSV	**Refer other serv, Episode end**	• Service/Program ended as client to receive services **not available from within Continuing Care** (e.g. WCB, Veterans Affairs, community rehab). **OR** client is moving to a bed of choice within the LTC Facility stream. Episode ended. * *See note 3* ****Change to definition****
CMSTOHS	STOHS	Service term due to OH&S issue	• Service or Program terminated related to an OH&S issue(s) • This relates to situations that pose a risk for staff that cannot be managed including physical environment and other situations (e.g. very obese client unwilling to use adequate equipment for transfers)
CMTRPRG	N/A	**Client transferred**	• Episode remains active but client is now registered into a new service or program. **See note 2*
CMUNCONT	UCONTC	Unable to contact/reach client	• Health Care Professional unable to make contact or reach the client in person or by telephone after multiple attempts
CMWDT	CLWTSV	Cl withdrew/terminated service	• Client elected to withdraw or terminate services of a program with or without support of Health Care Professional. • Used when further professional or support services could be provided, but the client has refused any additional services.
N/A	REGERR	Incorrect LTA Registration	• **Do not use** - Selection is used only by advanced users in consultation with Heath Information Management (HIM) • Lifetime Account was incorrectly registered

* Items in **bold print** highlight definitions and descriptors that have changed significantly

Note 1: The *Program Outcome or Episode Completion Reason*: "*No longer requires Service*" has been replaced by "*Service/Program Complete*" and "*No service reqd Episode end*". Please ensure you have a clear understanding of when to correctly use each of these reasons.

Note 2: It is very important to have a good understanding of a client transfer. Do not end the Episode when the client is still receiving services in Continuing Care Program (unless they are now in a LTC Facility Living stream in their bed of choice).

Use *"Client transferred"* when the primary responsibility for the client's needs has changed to a different Continuing Care Program (e.g. Home Care program is being completed and another program is being recommended or is registered, the person responsible for the other program will now become the case manager).

Do not use *"Client transferred"* for caseload transfers within a program (e.g. transferring from one nurse to another nurse within the same office).

Use another Program outcome reason when your Program is finished but the Program with primary responsibility for the client's needs remains unchanged (e.g. Home Care Nurse is the case manager, client has both a Home Care and an OT program registered. OT is now done providing service to the client, the reason for completion of the OT program would be *"Service/Program Complete"*).

Note 3: A client who has moved into a LTC Facility and is in their bed of choice, the Episode is ended. The LTC facility program will remain in a register status.

If the client later requires services from another Continuing Care Program, an Episode and new Program registration will be opened for that Program.

"Client moved, episode ended" would not be used for a client moving into a Supportive Living facility within our HCIS/Zone as the client will continue with service on the current active Episode.

Undo Ended Episodes/Outcommed Programs done in Error

Certain users can undo a Lifetime Account Discharge or Programs done in error. Contact seniorshealth.southzoneeducation@ahs.ca to have this undone.

Appendix H: CSI (Client Services Inquiry)

New Client Presents to Home Care

If a new client presents to Home Care, we must look them up in the Care Manager module to determine whether or not they are already registered in Care Manager.

1. Click on highlighted **CM 5.67** line in the **Applications** Menu,
2. click the highlighted **CM Coordinator Desktop** line in the **Seniors Health** Menu to get to the **CM Coordinator Desktop**.
3. Click on header button **Change List** at the top of the **CM Coordinator Desktop** screen to select look up list:
4. Curser defaults to Person field. Enter one of the following:
    - Client's LASTNAME,FIRST NAME (no spaces)
    - # ULI number
    - CH/EC number (if known)
5. Use **Enter** key, **F9**, or drop down arrow to search for the client.
    a. If client's name appears, select F12. One of two things will happen:
        i. Client's name will appear on the screen with the CH/EC number. This means they are a **current** Home Care client, do not complete **Client Service Inquiry**. Refer client to appropriate Case Manager or chart as needed.
        ii. If the prompt "Client is discharged, continue?" appears, this means they were a previous Home Care client, but have been discharged from the program (their Episode has ended).
        iii. Select **No**. Refer to step 1 below so they can be readmitted to Home Care through **Client Service Inquiry CSI.**
    b. If you get a popup: "Warning: Person not found!" this means they are not a current or past Home Care client. Click **OK**. Proceed to instructions for **Client is a New Home Care Client** to begin **Client Service Inquiry (CSI).**

Client is a New Home Care Client

If a new client presents to Home Care, you may be required to begin the CSI (Client Services Inquiry), depending on your office procedure. Once you have established that the client is **not** currently a Home Care client and has **not** been a Home Care client in the past (refer to instructions for **New Client Presents to Home Care)** you can begin the CSI process:

1. Exit the Lookup list and click on the right menu button single click on "**Client Services Inquiry**."

2. Select footer button **New Inquiry**. This will take you to the New Inquiry screen.

    a. Document **Referral Source Tab**
        i. Referral Source - do an **F9** to select referral source (highlight and double click).
        ii. Must complete referral source's name (LASTNAME,FIRST NAME) and phone number (fill in numbers and it will convert to proper form).
        iii. Referral Method - do an **F9** and select how the referral came to the office
        iv. The rest of the information is optional
    b. Complete **Contact Tab**
        v. Contact information is the person that the health care professional would need to contact in order to follow up on the referral (can enter SR if it is the same as the Referral Source).

vi. Tab to Reason field and do an **F9** to bring up a list - can select as many as you want by simply ensuring you are on a blank line and then do an **F9**.
vii. Tab to Client Data and enter client's name (LASTNAME,FIRST NAME), date of birth (day,mon,year - put in numbers in correct order and it will convert to proper form), age will default in, enter sex & ULI number (contact Meditech Help if no ULI).
viii. Tab to Site and do an **F9** to enter in the office this client will be under.
ix. For Search MPI (Master Patient Index) enter "**Y**", use tab key or **F12** and a Partial Lookup will appear, do an **F12**. The system is trying to find a match for this client. Read and follow prompts appropriately. If Maiden/Other appears, do **F12** again.
x. Assign to User tab - **leave blank**.
xi. File **F12** or green check mark. Then confirm file by selecting **"Yes"**.

The client's name will now appear in Red on the CSI screen, which means the client has been recorded in the system and is waiting to be followed up by someone.

Viewing the CSI Screens

1. The CSI screen will only allow you to see the offices you have access to, which may vary for each person. The screen will default to show only the inquiries that are in the OPEN (in the color Blue) status and will only show information entered in the last 180 days. Clients in this Blue color mean the inquiry has not been dealt with or completed and requires follow-up.
2. You can change this default view by:
   a. To narrow down offices viewed or change dates viewed
      i. Use the **Select** button-this button allows a search by status, site, dates, client name, and/or inquiry date.
         1. Single click with your mouse on the field you want change.
         2. To add items: Use **F9** in the field, then highlight the information you are searching for and then select by clicking on it or using the up and down arrow and then enter.
         3. To delete: highlight the item listed in the field and use the delete key.
         4. Once you have entered all the information you want, file with green check or **F12.**
   b. To view all inquires in the last 30 days for the offices you have access to use the **All** Button.
      i. Names in Blue are open and need to be followed up by a professional (see below).
      ii. Names in Black have been dealt with. They did not require a Home Care assessment or admission and have been closed.
      iii. Names in Red have been entered in CSI and the client was admitted to Care Manager and now need an assessment. These clients can now be found under Person Process. See instructions on **Looking up Clients in Care Manager**.

Clients in your offices that appear in Blue on the CSI will need to be:

1. Followed up by the Intake person/Team Lead and Registered client in Care Manager.
2. **OR** if client does not require Home Care services (i.e. information only or AADL only). the CSI can be closed. Follow your office procedure for who is able to close the CSI.

Closing a CSI

If the client does not require a Professional Assessment/Care Manager registration, the CSI can be closed:

1. Highlight the client's name with a single mouse click and then click on the **Close Inq** button on the right side of the screen.
2. The client's name will disappear on the original CSI default screen and can be seen in Green when you select the **All** Button or the **Closed** Button.

Care Manager Pre/Post Training Survey: Individual Training Needs Assessment

Name: _____Date: _____

Professional Title: _____Site: _____

1. **Work and Patient History**
   A. How long have you worked as a Home Care Provider?
   ☐ < 1 year ☐ 1 to 2 years ☐ 3 to 5 years ☐ >5 years

2. *Self-Assessment of knowledge, skills, and attitudes*

   Listed below are some knowledge, skills, and attitudes specific to Home Care's role in care planning for Clients. Please read them and then circle the number in the right column that best represents your level of knowledge, skills, and attitude TODAY.

   1 = low ◄——————————————► **5 = high**

	PRE		POST
Knowledge of what Meditech Care Manager is	1 2 3 4 5 N/A		1 2 3 4 5 N/A
Navigating CM Coordinator Desktop, LT Acct, and Enterprise Medical Record (EMR)	1 2 3 4 5 N/A		1 2 3 4 5 N/A
Level of comfort with completing Client Service Inquiries and opening Episodes of Care	1 2 3 4 5 N/A		1 2 3 4 5 N/A
Skill in adding Lifetime Acct SOC and charting on interventions within the LT Acct	1 2 3 4 5 N/A		1 2 3 4 5 N/A
Skill in completing Living Options Customer Defined Screen	1 2 3 4 5 N/A		1 2 3 4 5 N/A
Skill in Waitlisitng and Registering clients into SL3/SL4/SL4D and LTC programs	1 2 3 4 5 N/A		1 2 3 4 5 N/A
Skill in discharging deceased clients from Care Manager	1 2 3 4 5 N/A		1 2 3 4 5 N/A

3. *Personal learning*
   How do you best acquire and retain information? Check all that apply.

   ☐ WRITTEN ☐ ORAL ☐ VISUAL ☐ HANDS-ON

What do you want to get out of this Course?

_____

_____

_____

_____

Feedback and additional comments

_____

_____

_____