

# South Zone – Care Manager Manual

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## Transition Team

### MEDITECH Environment:

#### Care Manager Support:

**Email:** [seniorshealth.southzoneeducation@albertahealthservices.ca](mailto: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 #:** \_\_\_\_\_

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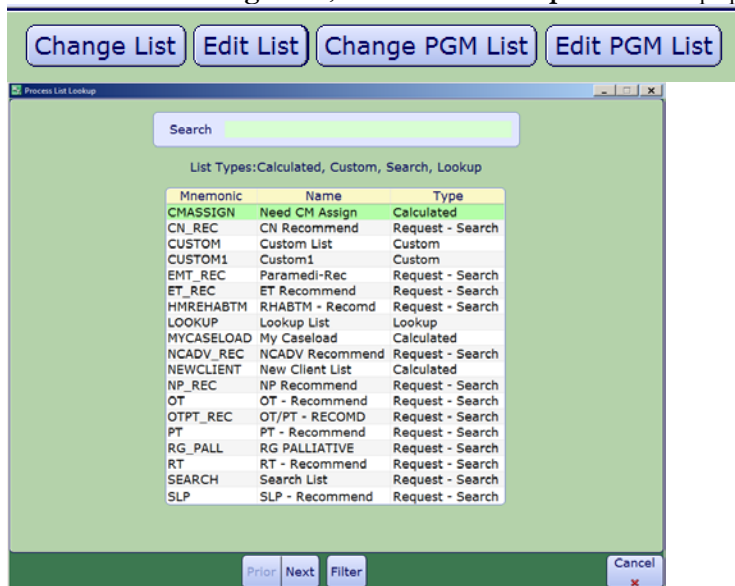
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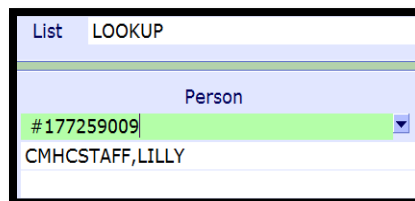
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**First: Determine if the Client is Registered in Care Manager (use ULI to avoid duplicating clients)**

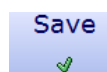
1. Select header button **Change List**, then select **Lookup List** in the pop up box.



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



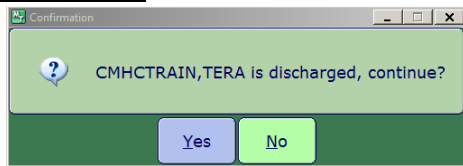
- a. If the name displays select green check to save



**Then determine if the client has an active episode see page 7**

- b. If a Pop up displays  This client has never been registered in Care Manager

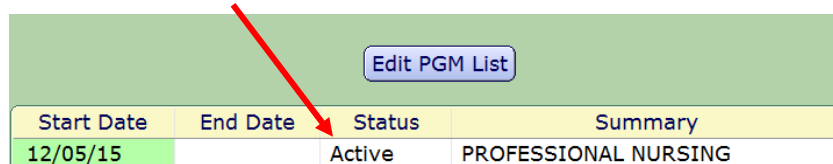
**Then proceed to Process #2**

- c. If this pop up displays  this means the client has been registered in Care Manager historically.

**Then proceed to Process #3**

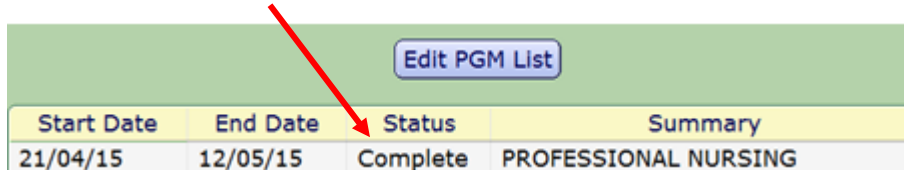
## Second: Determine if the Client Found in Care Manager has an Active Episode of Care

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



Edit PGM List			
Start Date	End Date	Status	Summary
12/05/15		Active	PROFESSIONAL NURSING

- a. If the **Episode** is Active - follow Process #1
- b. If the **Episode** is Complete – follow Process #4



Edit PGM List			
Start Date	End Date	Status	Summary
21/04/15	12/05/15	Complete	PROFESSIONAL NURSING

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

## Process #1: Client found in Care Manager and has an Active Episode of Care

If client being seen in the Emergency Department first:

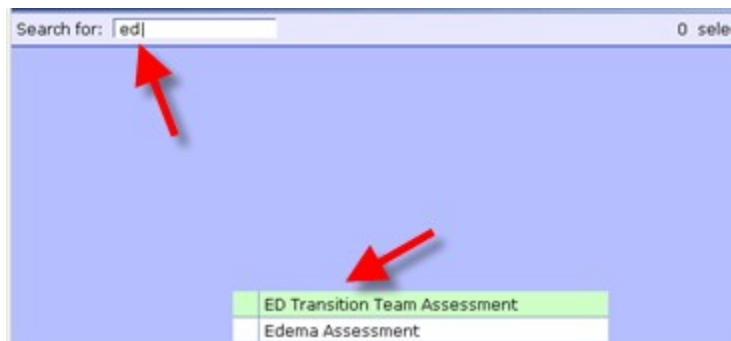
1. **CM Coordinator Desktop** Screen –select the **LT Document** right menu button. This will take you into **PCS/Worklist** on the **Lifetime Account**.



2. From the Footer menu select **Add intervention**



3. Add the **ED Transition Team Assessment** charting intervention

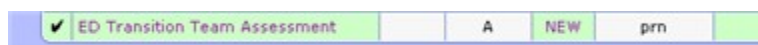


4. Select **ED Transition Team** Intervention by clicking into the field to the left of the intervention



5. Select **Add and Close**

6. Select **ED Transition Team** Assessment



7. Select **Document** from the Footer menu

8. Enter the date and time ( must reflect actual time )

9. Document in the intervention

**Note:** Proceed to Step 2 on page 9 to add Hospital program and SOC.




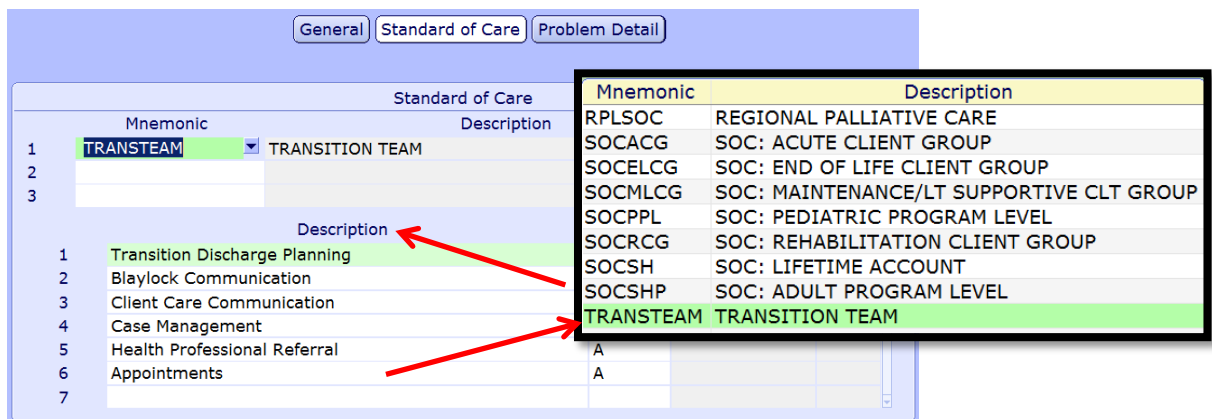
If client being seen on the unit for the first time

### Step 1: Register the Acute Hospital Program

1. Select **New Request** from the right menu button
2. Do a lookup (F9) or drop down arrow at **Service** and select **Clinical Specialty**
3. Select **Site** or **All**, then click to the left of the appropriate **Acute Hospital program**
4. Select **Register** from the footer menu
5. Start Date is **T** for Today, green check to **File**

### Step 2: Adding the Transition Team Standard of Care (SOC)

1. Click on the **(+)** to open the Program 
2. Highlight the **Acute Hospital** program
3. Select footer button **Pgm Care Plan**
4. On the **Process Plans** screen, select **'Enter'** footer button, select **'Additional Care Plan'**
5. Select **Standard of Care** header button.
6. Click into the empty field under **Mnemonic** column, do a lookup (F9) or drop down arrow
7. Select the **Transition Team**



Standard of Care	
Mnemonic	Description
1	TRANSTEAM TRANSITION TEAM
2	
3	

Description	
1	Transition Discharge Planning
2	Blaylock Communication
3	Client Care Communication
4	Case Management
5	Health Professional Referral
6	Appointments
7	

1. **File** green check to **Save**
2. **Duplicate Interventions** screen displays - See page 41
3. Say **"Yes"** to **"Go to Worklist"**. If you are not ready to chart select then select **"No"**.
4. Chart under the **Acute Hospital** program

**Note:** The Acute Hospital program will not be Outcomed (ended) until the client leaves the hospital

- Document any phone calls or other information as needed in Acute Hospital program
- Update the clients status in the CM Values to **"Updated"** and contact the case manager with any changes
- Document phone call to Home Care to determine when and if they can see the client.
- If Added Care Funding to be used document arrangement of same.

## No Accessible Visits/Status Board Messages

**Note:** When you go to **PCS/Worklist** to chart and if the screen is called **“STATUS BOARD”** or **“NO ACCESSIBLE VISITS”**, exit **PCS/Worklist** and try again. Sometimes Meditech needs a minute or two to file.

When you go to **PCS/Worklist** to chart and on the screen you see the following message **“NO ACCESSIBLE VISITS”**, exit **PCS/Worklist**. Then look on the **Process Plans** screen. If the word **NEW** is displaying instead of **CG 00123455 (CH Meditech)** or **DZ 00123456 (PA Meditech)** this means **the program did not file correctly**. The clients PHN number and an explanation of what is going on should be sent to:  
[SeniorsHealth.SouthZoneEducation@albertahealthservices.ca](mailto:SeniorsHealth.SouthZoneEducation@albertahealthservices.ca)


**Note:** If the hospital program gets discharged accidentally or before the client leaves Acute Care - **DON'T ADD** the Acute Hospital program again – EMAIL the **client's name** or **PHN number** and a note to:  
[SeniorsHealth.SouthZoneEducation@albertahealthservices.ca](mailto:SeniorsHealth.SouthZoneEducation@albertahealthservices.ca)

## Process # 2 Client has never been registered in Care Manager

### Client needs to be Registered in Care Manager

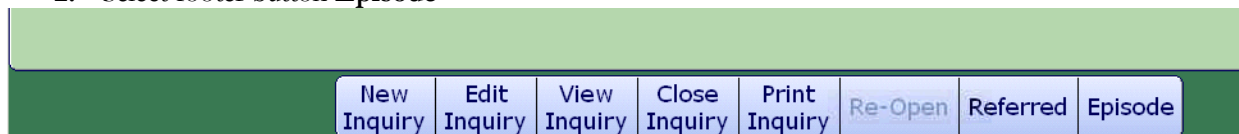
**Note:** ALWAYS find the ULI (PHN number) which can be located in the EMR by selecting “View all Visits”, “Summary” and then “Demographics” or you may look the client up in Netcare.

#### Step 1: Client Services Inquiry (Registering the Client)

1. Select right menu button **Client Services Inq** 
2. Select footer button **New Inquiry**
  - a. **Referral Source Tab:** Referral Source and Referral Method must be completed. Do a look-up (F9) highlight choice and press **Enter**.
  - b. **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” for Contact name)
  - c. ULI #
    - o Client Data: insert PHN into ULI field
  - d. 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 2<sup>nd</sup> confirmation check address and if correct choose to file.) . If you don’t “Y” MPI you will duplicate client.
  - e. Fill **Site** field, and fill **Reason** field
    - o Site (look-up, assign to Access Centre [CH Meditech] or specific office [PA Meditech])
    - o Reason (look-up, may select more than one reason but the list in order or priority)
  - f. **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](mailto: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. (Change 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 Button:

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

#### 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 blank: 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:

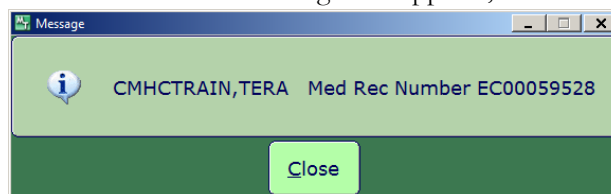
- Do not use **Primary Care or Other** field
- Site must be what office the client is being seen in. **Note if being followed only by Transition Team put in “Leth Community Transition Team”.**
- **Family Physician** should be filled out and/or corrected (use upper case, first 4 letters last name, F9 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 and click out of field. Click back into field again and the above will auto populate.
- Site- LBCOMTT

**Service Location:** Where care will be received:

- **From Date** – would be the date you are registering the client
- **Through Date:** leave blank
- **Level of Care** – select **Other** as the client is in hospital - use down arrow or F9
- **Homeless** – if the client is homeless enter **Y** if not enter **N**
- **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:** View only; allergies will be entered/updated via **EMR or PCS or LT Account**.

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



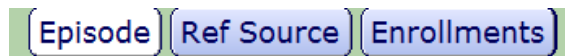
**Note:** If Registration screens will not File indicating information is missing in Insurance screen: **Out of Region** remove **Out of Region** Insurance by highlighting and deleting from field then File. **Self-Pay Insurance:** If Self-Pay insurance present, plus AHC insurance, remove Self-Pay by 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)

*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** –for summary description for the **Episode** use drop down arrow or F9 and enter date (refer to Appendix F for choices).
3. **Service Plan Decision Date** – would be the same as the start date
4. **Service Plan Type** Do a F9 lookup and select **Hospital Transfer to Home**. File using green checkmark
5. **Service Plan Date, Type and Method of Funding** is not completed on intake but to be completed on discharge only.

**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



Rugs, Eight

DOB: 12/06/1934 79 M

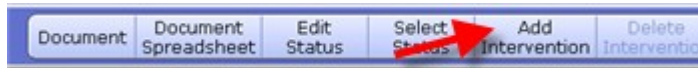
CH0000060/09 / CH00001042 / ABATVG00007448-ESN

Allergy/AdvReac:

Interventions

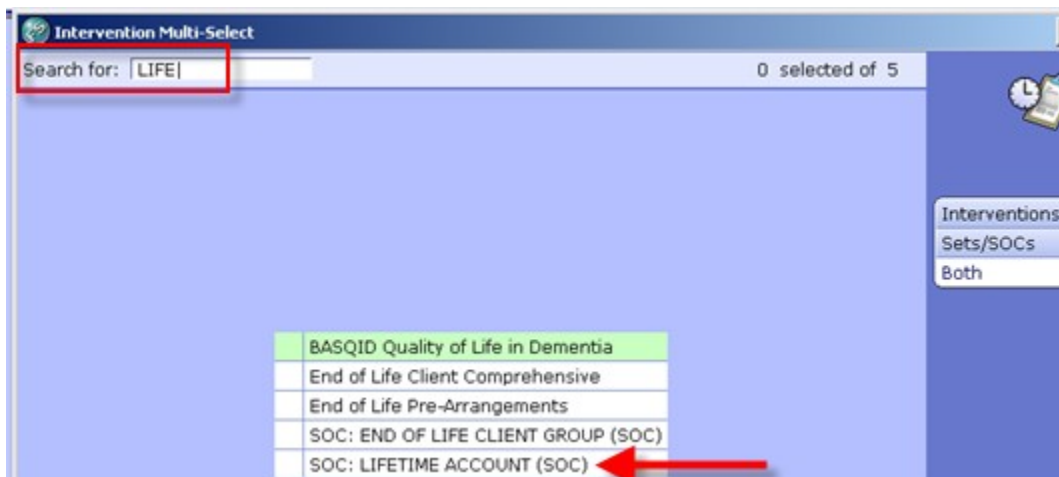
Ccm Tab: **REG CM**

4. Select **Add intervention**



Document Document Spreadsheet Edit Status **Select Status** Add Intervention Delete Intervention

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



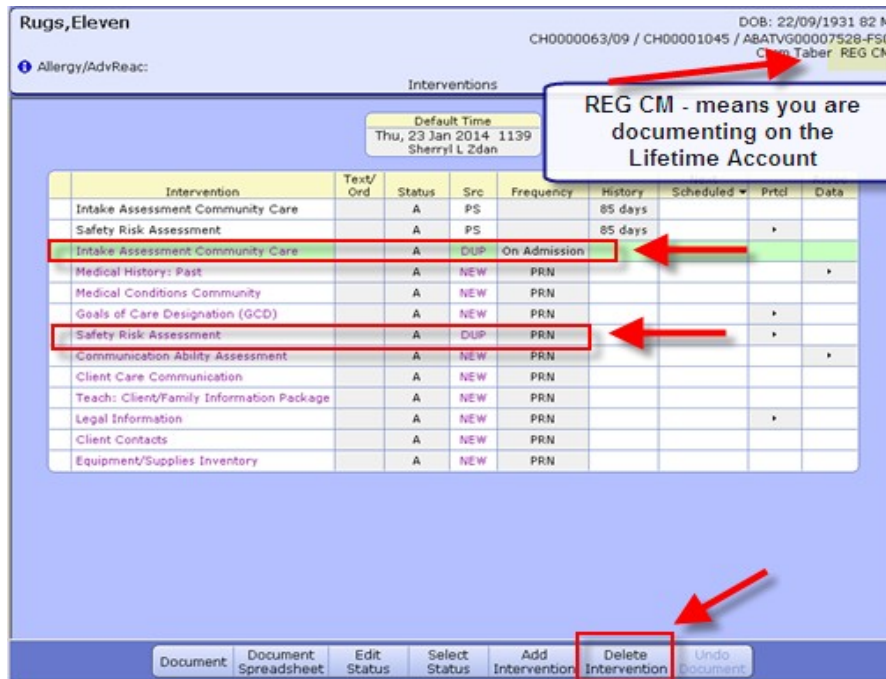
Intervention Multi-Select

Search for: **LIFE** 0 selected of 5

BASQID Quality of Life in Dementia
End of Life Client Comprehensive
End of Life Pre-Arrangements
SOC: END OF LIFE CLIENT GROUP (SOC)
<b>SOC: LIFETIME ACCOUNT (SOC)</b>

Interventions  
Sets/SOCs  
Both

6. Select **SOC:LIFETIME ACCOUNT**
7. **Add & Close** and then **File**
8. **If duplicate interventions are listed on the Lifetime Account:** 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



**REG CM - means you are documenting on the Lifetime Account**

Intervention	Text/Ord	Status	Src	Frequency	History	Scheduled	Prcd	Data
Intake Assessment Community Care		A	PS		85 days			
Safety Risk Assessment		A	PS		85 days			
Intake Assessment Community Care		A	DUP	On Admission				
Medical History: Past		A	NEW	PRN				
Medical Conditions Community		A	NEW	PRN				
Goals of Care Designation (GCD)		A	NEW	PRN				
Safety Risk Assessment		A	DUP	PRN				
Communication Ability Assessment		A	NEW	PRN				
Client Care Communication		A	NEW	PRN				
Teach: Client/Family Information Package		A	NEW	PRN				
Legal Information		A	NEW	PRN				
Client Contacts		A	NEW	PRN				
Equipment/Supplies Inventory		A	NEW	PRN				

Footer buttons: Document, Document Spreadsheet, Edit Status, Select Status, Add Intervention, **Delete Intervention**, Undo Document

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 Appendix C 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 **Comment** box in each section of the Assessment

### Step 5: CM Values

1. Select Right Menu button **CM Values** – CM Coordinator Desktop screen

**Note:** If client to be **discharged from Emergency Department** - confirm by phone call to Home Care office their ability to see the client to set up services if they can't, pursue **Added Care funding** and document all phone calls etc.

**Note:** If client to be admitted to hospital – **Home Care** needs may not be known yet

- 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
  - g) **Next Contact Date** – delete out and leave blank
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:



**Edit Reg** 

**CDS** 

**1** **CM Values** 

**Discharge** 

**Episode** 

---

**Status** None

---

Client Group | Effective Date  **Update Field**  **T** 

Serv Priority | Effective Date  **Don't fill** 

Case Manager Type  **NEW/Referral** 

Case Manager | Effective Date  **Leave Blank** 09/11/17 

---

Responsible User 

Priority  **OVER7 How soon should home care see the client?**

Next Contact Date 

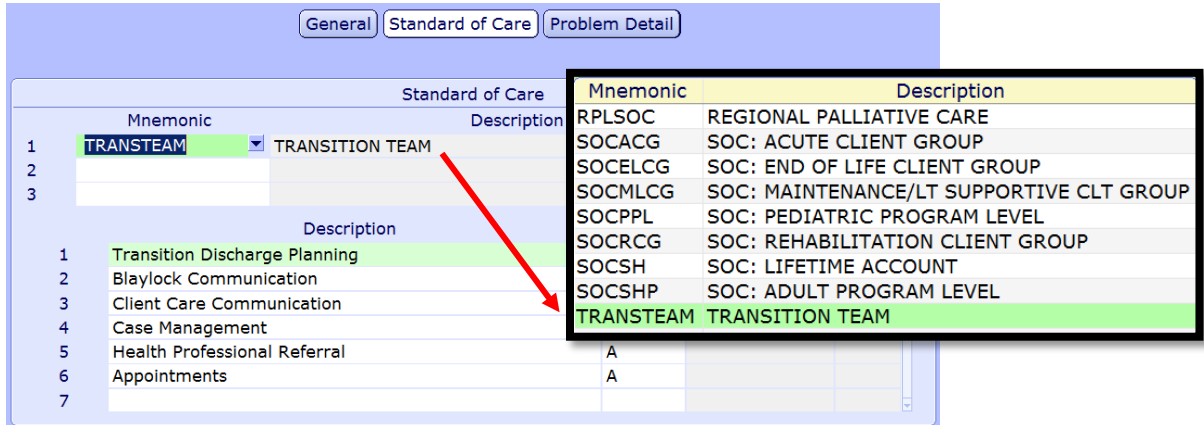
#### Step 6: Register Hospital Program

1. Register the appropriate hospital **Program**
2. Select Right Menu button **New Request**
3. Select '**Clinical Specialty**' use the drop down arrow at Service or F9
4. For **Program Selection** click beside **Site** or **All**
5. At the bottom of the screen, place a checkmark beside the appropriate Program
6. Select footer button **Register**
7. Start Date is **T** for Today, green check to **File**

#### Step 7: Adding the Standard of Care (SOC) to Hospital Program

1. To open the Program click on (+) to the left of client's name.
2. Highlight to select the hospital **Program**
3. Select footer button **Pgm Care Plan**
4. On the **Process Plans** screen, select **Enter** footer button, select **Additional Care Plan**
5. Select **Standard of Care** header button.
6. Click into the empty field under **Mnemonic** column, click on drop down arrow or F9 to open menu
7. Add **Transition Team SOC**





Standard of Care	
Mnemonic	Description
1	TRANSTEAM
2	
3	
1	Transition Discharge Planning
2	Blaylock Communication
3	Client Care Communication
4	Case Management
5	Health Professional Referral
6	Appointments
7	

Mnemonic	Description
RPLSOC	REGIONAL PALLIATIVE CARE
SOCACG	SOC: ACUTE CLIENT GROUP
SOCCLCG	SOC: END OF LIFE CLIENT GROUP
SOCMLCG	SOC: MAINTENANCE/LT SUPPORTIVE CLT GROUP
SOCPL	SOC: PEDIATRIC PROGRAM LEVEL
SOCRCG	SOC: REHABILITATION CLIENT GROUP
SOC SH	SOC: LIFETIME ACCOUNT
SOC SHP	SOC: ADULT PROGRAM LEVEL
TRANSTEAM	TRANSITION TEAM

8. **File** - if Duplicate Interventions screen displays – refer to Duplicate Intervention section of this manual
9. Say **Yes** to **Go to Worklist**. If not ready to chart select **No**.
10. Chart under this **Program**
11. The hospital program will **not be discharged until the client leaves the hospital**

**Note:** Document any phone calls or other information as needed.  
 Document phone call to Home Care to determine when and if they can see the client.  
 If Added Care Funding to be used document arrangement of same.

**Note:** When you go to 'PCS' to chart and if the screen is called "**STATUS BOARD**" or "**NO ACCESSIBLE VISITS**" exit PCS and try again. Sometimes Meditech needs a minute or two to file. When you go to 'PCS' to chart and on the screen you see the following message "**NO ACCESSIBLE VISITS**", exit PCS. Then look on the 'Process Plans' screen if the word **NEW** is displaying instead of **CG 00123455 (CH Meditech)** or **DZ 00123456 (PA Meditech)** this means the program did not file correctly. The client's PHN number and an explanation of what is going on should be sent to: [SeniorsHealth.SouthZoneEducation@albertahealthservices.ca](mailto:SeniorsHealth.SouthZoneEducation@albertahealthservices.ca)

**Note:** If the hospital program is discharged before the clients leaves or by accident – **DON'T ADD** the Hospital program again. **EMAIL** the client's name or PHN number and a note to: [SeniorsHealth.SouthZoneEducation@albertahealthservices.ca](mailto:SeniorsHealth.SouthZoneEducation@albertahealthservices.ca)

## Process # 3 Client has been discharged from Care Manager

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

(If you get a pop up that states “Client is discharged, ok?” Click NO and stop and use this step, CSI).

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 Client Data: insert PHN into ULI field
- o Search MPI? Insert “Y”. MPI= **Master Patient Index**. There will be a Pop up. Check the client listed at the top of the screen. Ensure the Client’s name & DOB is correct, if it is, click the client’s name. Select **Update Inquiry** if information is correct. Fields with Account numbers will fill in.

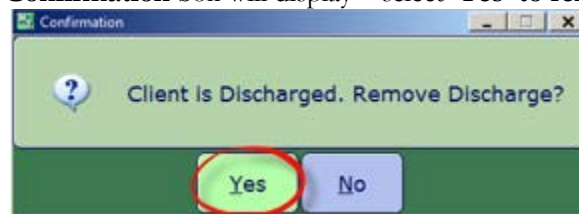
**Note: If you do not put a “Y” in the MPI field you will duplicate client.**

- o Fill Site field, and fill Reason field
  - o Site (look-up, assign to **Access Centre** [CH Meditech] or **specific office** [PA Meditech])
  - o Reason - look-up, may select more than one reason but list in order of priority
- o **File with the green check mark to return to the CSI screen.**

Note: Do not assign client to user even if you do know who the receiving case manager may be. Just leave black and proceed.

### 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 on this screen is in all uppercase, **do not file (green check mark) until all tabs verified.**

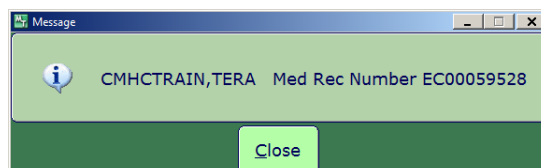
**Note:** For discrepancies related to client’s name or date of birth: email Data Integrity and follow the instructions: [Rural.HIM.DataIntegrityStaff@albertahealthservices](mailto:Rural.HIM.DataIntegrityStaff@albertahealthservices). In the subject line state which ring of Meditech you are needing help 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:**
  - o Client's mailing address
  - o Postal Code
  - o Resid Cd – Community based off of postal code
  - o Country – should be CA
  - o Language - (F9 look up available) – item reportable to AHS
  - o Home Phone – Clients primary contact number
- **Contact:**
  - 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: leave bank:** use **Client Contacts** assessment in **LT Document**.
  - o **Any Confirmations pop ups must be answered with “Yes” to update or “No” to leave as before. (Read carefully)**
- **Guarantor:** confirm the name of the **Guarantor** (this is the person who will pay bills.)
- **Insurance:** Insurance: **AHC** should default
- **Risk Screen:** 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:**
  - 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.
- **Service Location:** where 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:** is **view only**; allergies will be entered/updated via **EMR or PCS**.

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

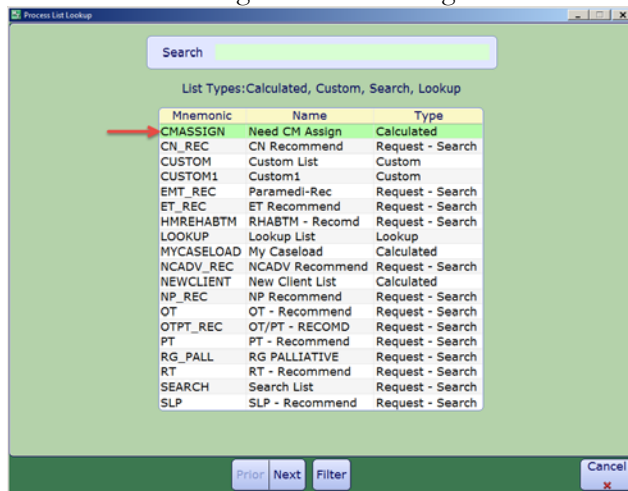


**Note:** If Registration screens will not File indicating information is missing in Insurance screen: **Out of Region** then remove **Out of Region** Insurance by highlighting and deleting from field then File. **Self-Pay Insurance:** If Self-Pay insurance present, plus AHC insurance, remove Self-Pay 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](mailto:SeniorsHealth.SouthZoneEducation@albertahealthservices.ca)

**Step 3: Edit Episode**

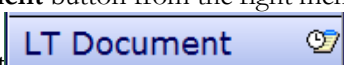

Edit Episode screen opens:

1. **Start date – do not edit** (this should be the date that the CSI was created)
- |                            |           |          |                               |
|----------------------------|-----------|----------|-------------------------------|
| *Start Date                | Status    | 08/06/15 | Active                        |
| *Summary                   | *Eff Date | 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** – for summary description for the Episode use drop down arrow or F9 and enter date (refer to Appendix F for choices).
  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
  5. **Service Plan Date, Type and Method of Funding** is not completed on intake but to be completed on **discharge only**.
  6. Save.
  7. You will get the Process List Look Up pop up. Select **Need CM Assign** to have client added to new referral list to be assigned a Case Manager.



**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 (REG CM means lifetime account)

**Rugs, Eight** DOB: 12/06/1934 79 M  
 CH0000060/09 / CH00001042 / ABATV000007448-FS0  
 Ccm Taber REG CM

Allergy/AdvReac: Interventions

1. Select **Add intervention**
2. In the Search field type **LIFE** to add the **Lifetime Account SOC**

**Intervention Multi-Select**

Search for: **LIFE** 0 selected of 5

- BASQID Quality of Life in Dementia
- End of Life Client Comprehensive
- End of Life Pre-Arrangements
- SOC: END OF LIFE CLIENT GROUP (SOC)
- SOC: LIFETIME ACCOUNT (SOC)

3. Select **'LIFETIME ACCOUNT'**,
4. Select **Add & Close** and then **File**
5. **If duplicate interventions are listed on the Lifetime Account:**

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.

**Rugs, Eleven** DOB: 22/09/1931 82 M  
 CH0000063/09 / CH00001045 / ABATV000007528-FS0  
 Ccm Taber REG CM

Allergy/AdvReac: Interventions

Default Time  
Thu, 23 Jan 2014 11:39  
Sherryl L Zdan

**REG CM - means you are documenting on the Lifetime Account**

Intervention	Text/Ord	Status	Src	Frequency	History	Scheduled	Ptcd	Date
Intake Assessment Community Care		A	PS		85 days			
Safety Risk Assessment		A	PS		85 days			
Intake Assessment Community Care		A	DUP	On Admission				
Medical History: Past		A	NEW	PRN				
Medical Conditions Community		A	NEW	PRN				
Goals of Care Designation (GCD)		A	NEW	PRN				
Safety Risk Assessment		A	DUP	PRN				
Communication Ability Assessment		A	NEW	PRN				
Client Care Communication		A	NEW	PRN				
Teach: Client/Family Information Package		A	NEW	PRN				
Legal Information		A	NEW	PRN				
Client Contacts		A	NEW	PRN				
Equipment/Supplies Inventory		A	NEW	PRN				

Document Document Spreadsheet Edit Status Select Status Add Intervention **Delete Intervention** Undo Document

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

**Delete  
Intervention**

7. The line will be removed. Go to the next duplicate and repeat the steps.

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

**Save**

9. Now only the **Interventions** that have the status of **Active** will be displaying
10. Complete **Intake Assessment Community Care** - refer to Appendix C for assessment and information on completing the **Client Group** section).
11. 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

**Note:** If client to be **discharged from Emergency Department** - confirm by phone call to Home Care office their ability to see the client to set up services if they can't, pursue **Added Care funding** and document all phone calls etc.

**Note:** If client to be admitted to hospital – **Home Care** needs may not be known yet

- 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 (after discharge) - F9 Look up
- g) **Next Contact Date** – delete out and leave blank

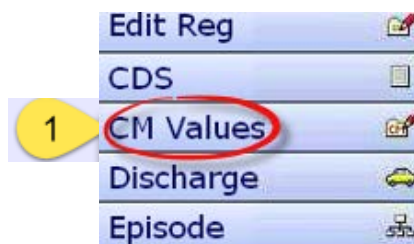
2. Once all required areas are filled in, file using green checkmark

**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:*





Status **None**

Client Group | Effective Date **Update Field** **T**

Serv Priority | Effective Date **Don't fill**

Case Manager Type **NEW/Referral**

Case Manager | Effective Date **Leave Blank** **09/11/17**

Responsible User **OVER7**

Priority **How soon should home care see the client?**

Next Contact Date

### Step 6: Register Hospital Program

1. Select Right Menu button 'New Request'
2. Select **Service** - use drop down arrow or F9: select '**Clinical Specialty**'
3. Select **Site** or **All**, place checkmark beside **Program** that is reflective the acute hospital; select footer button '**Register**'
4. For **Program Selection** click beside **Site** or **All**
5. **Start Date** is **T** for Today, **green check to File**

### Step 7: Adding the Standard of Care to Hospital Program

1. To open the Program click on **(+)** beside client's name
2. Select the hospital Program
3. Select footer button '**Pgm Care Plan**'
4. On the '**Process Plans**' Screen, select '**Enter**' footer button menu - select '**Additional Care Plan**'
5. Select **Standard of Care** header button.
6. Click into the empty field under **Mnemonic** column, click on drop down arrow or F9 to open menu
7. Add **Transition Team**

General Standard of Care Problem Detail

Standard of Care

Mnemonic	Description
1 <b>TRANSTEAM</b>	TRANSITION TEAM
2	
3	

Description

1	Transition Discharge Planning
2	Blaylock Communication
3	Client Care Communication
4	Case Management
5	Health Professional Referral
6	Appointments
7	

Mnemonic	Description
RPLSOC	REGIONAL PALLIATIVE CARE
SOCACG	SOC: ACUTE CLIENT GROUP
SOCCLCG	SOC: END OF LIFE CLIENT GROUP
SOCMLCG	SOC: MAINTENANCE/LT SUPPORTIVE CLT GROUP
SOCPL	SOC: PEDIATRIC PROGRAM LEVEL
SOCRCG	SOC: REHABILITATION CLIENT GROUP
SOCSSH	SOC: LIFETIME ACCOUNT
SOCSSHP	SOC: ADULT PROGRAM LEVEL
<b>TRANSTEAM</b>	<b>TRANSITION TEAM</b>

8. **File** (Duplicate Interventions screen displays – See Duplicate Intervention section of this manual)
9. Say **"Yes"** to Go to Worklist. If not ready to chart select **No**.
10. Chart under this **Program**
11. The hospital program will not be discharged until the client leaves the hospital

**Note:** Document any phone calls or other information as needed.  
Document phone call to Home Care to determine when and if they can see the client.  
If Added Care Funding to be used document arrangement of same.

**Note:** When you go to 'PCS/Worklist' to chart and the screen is called "STATUS BOARD" or "NO ACCESSIBLE VISITS", exit PCS/Worklist and try again. Sometimes Meditech needs a minute or two to file. When you go to 'PCS/Worklist' to chart and on the screen you see the following message "NO ACCESSIBLE VISITS", exit PCS/Worklist. Then look on the Process Plans screen if the word NEW is displaying instead of **CG 00123455(CH Meditech)** or **DZ 00123456 (PA Meditech)** this means the program did not file correctly and requires Meditech to fix. Email the client's name & PHN # to [SeniorsHealth.SouthZoneEducation@albertahealthservices.ca](mailto:SeniorsHealth.SouthZoneEducation@albertahealthservices.ca)

**Note:** If the hospital program is discharged before the client is discharged or by accident – **DON'T ADD** the hospital program again – email the client's name or PHN # with an explanation to: **\*This will make it look like client was admitted to hospital twice.**  
[SeniorsHealth.SouthZoneEducation@albertahealthservices.ca](mailto:SeniorsHealth.SouthZoneEducation@albertahealthservices.ca).



## Process #4: Client found in Care Manager (LTC)

### 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

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 **Client Data:** insert PHN into ULI field
- o **Search MPI?** Insert “Y”. MPI= **Master Patient Index**. There will be a Pop up. Check the client listed at the top of the screen. Ensure the Client’s name & DOB is correct, if it is, click the client’s name. Select **Update Inquiry** if information is correct. Fields with Account numbers will fill in.

**Note: If you do not put a “Y” in the MPI field you will duplicate client.**

- o Fill **Site field**, and fill **Reason** field
  - o **Site** (look-up, assign to **Access Centre** [CH Meditech] or **specific office** [PA Meditech])
  - o **Reason** - look-up, may select more than one reason but list in order of priority
- o **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**.

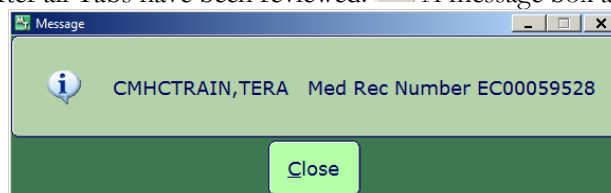
**Note:** for discrepancies related to **client’s name** or **date of birth**: email Data Integrity and follow the instructions: [Rural.HIM.DataIntegrityStaff@albertahealthservices](mailto:Rural.HIM.DataIntegrityStaff@albertahealthservices). In the **subject line** state which ring of Meditech you are 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:**
  - o client's mailing address
  - o Postal Code
  - o Resid Cd – Community based off of postal code
  - o Country – should be CA
  - o Language – use drop down arrow or F9– item reportable to AHS
  - o Home Phone – Clients primary phone number
- **Contact:**
  - 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: leave bank:** use **Client Contacts** assessment in **LT Document**.
  - o **Any Confirmations pop ups must be answered with “Yes” to update or “No” to leave as before. (Read carefully)**
- **Guarantor:** confirm the name of the **Guarantor** - this is the person who will pay bills.
- **Insurance:** Insurance: **AHC** should default
- **Risk Screen:** 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:**
  - 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 Location:** where 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:** is **view only**; allergies will be entered/updated via **EMR or PCS**.

After completing, **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 | 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 41 for choices. 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
  5. **Service Plan Date, Type and Method of Funding** is not completed on intake but to be completed on discharge only.

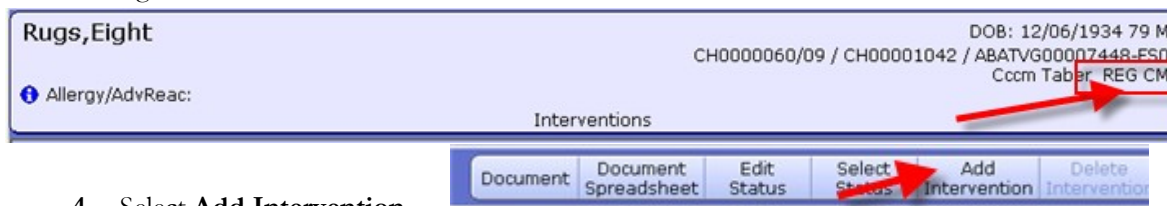
**Note: Client is now registered in Care Manager with an Active Lifetime account**

**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



Rugs, Eight

DOB: 12/06/1934 79 M

CH0000060/09 / CH00001042 / ABATVG00007448-ESN

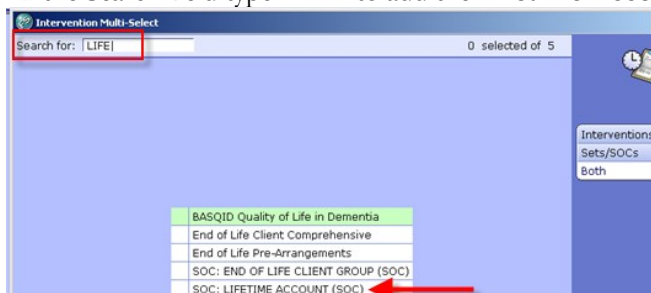
Ccm Tabler REG CM

Allergy/AdvReac:

Interventions

Document Document Spreadsheet Edit Status Select Status Add Intervention Delete Intervention

4. Select **Add Intervention**
5. In the Search field type **LIFE** to add the **Lifetime Account SOC**



Intervention Multi-Select

Search for: LIFE 0 selected of 5

Interventions

Sets/SOCs

Both

BASQID Quality of Life in Dementia

End of Life Client Comprehensive

End of Life Pre-Arrangements

SOC: END OF LIFE CLIENT GROUP (SOC)

SOC: LIFETIME ACCOUNT (SOC)

6. Select **'LIFETIME ACCOUNT'**, then select **Add & Close** and then **File**
7. **If duplicate interventions are listed on the Lifetime Account:**  
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)

Rugs, Eleven

DOB: 22/09/1931 82 M  
CH0000063/09 / CH00001045 / ABATVG00007528-F50  
Cm Taber REG CM

Allergy/AdvReac:

Interventions

Default Time  
Thu, 23 Jan 2014 11:39  
Sherryl L Zdan

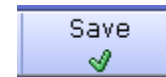
**REG CM - means you are documenting on the Lifetime Account**

Intervention	Text/Ord	Status	Src	Frequency	History	Scheduled	Prtcl	Data
Intake Assessment Community Care		A	PS		85 days			
Safety Risk Assessment		A	PS		85 days			
Intake Assessment Community Care		A	DUP	On Admission				
Medical History: Past		A	NEW	PRN				
Medical Conditions Community		A	NEW	PRN				
Goals of Care Designation (GCD)		A	NEW	PRN				
Safety Risk Assessment		A	DUP	PRN				
Communication Ability Assessment		A	NEW	PRN				
Client Care Communication		A	NEW	PRN				
Teach: Client/Family Information Package		A	NEW	PRN				
Legal Information		A	NEW	PRN				
Client Contacts		A	NEW	PRN				
Equipment/Supplies Inventory		A	NEW	PRN				

Document Document Spreadsheet Edit Status Select Status Add Intervention **Delete Intervention** Undo Document

8. Select '**Delete Intervention**' on the bottom toolbar and the Intervention will be 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 appendix C to see intervention and info on completing the Client Group section
13. Once the **Episode** is filed, **Process List** lookup screen pops up.
14. Select **Lookup List**, then hit space bar and **Enter** to add client to the list
15. Answer **Yes** to **Pop up Confirmation** box, green check to **File**
16. The system will take you to the **CM Coordinator Desktop** with your client listed

CM Coordinator Desktop - LCCM (ABAT1131/ABAT1131/ABAT1131/ABAT1131) - Active Sheet

**Cmhctrain, Tera**  
28/09/1945 F 69

Med Rec Num: EC00059528 CM:  
EMR Num: ABATV1G00506018-F50 Site Office: MHHC  
ULT: 177393009

Change List Edit List Change PGM List Edit PGM List

Primary List Type Lookup List  
Program List Status All Services Pre Rec Reg WL

Count: 1

Client	Client Group	Next Contact	CM Type	Site
CMHCTRIN,TERA				MHHC

Person Data

Person Mode  
Client Services Inc  
Search Mode  
Capacity  
Edit Reg  
CDS  
CM Values  
Discharge  
Episode  
Letters  
New Request  
Comp Care Plan  
LT Document

**Step 5: CM Value**

1. Select Right Menu button **CM Values** – **CM Coordinator Desktop** screen

**Note:** If client to be **discharged from Emergency Department** - confirm by phone call to Home Care office their ability to see the client to set up services if they can't, pursue **Added Care funding** and document all phone calls etc.

**Note:** If client to be admitted to hospital – **Home Care** needs may not be known yet

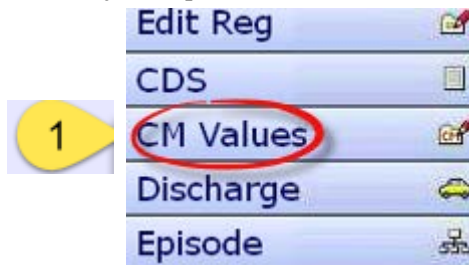
- a) **Client Group** - this is determined through the **Intake Assessment**
  - b) In the next field you must manually enter Effective Date = **T** for today
  - c) **Serv Priority** – Do not fill
  - d) **Case Manager Type** – select **New** (CH Meditech) or **Referral** (PA Meditech) delete any other 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:*



Status **None**

Client Group | Effective Date **a** Update Field **b** T

Serv Priority | Effective Date **c** Don't fill

Case Manager Type **d** NEW/Referral

Case Manager | Effective Date **e** Leave Blank 09/11/17

Responsible User **f** **OVER7** How soon should home care see the client?

Priority

Next Contact Date

### Step 6: Registering the Hospital Program

1. Add the appropriate hospital **Program**
  - Select Right Menu button **New Request**
  - F9 or drop down arrow at **Service**: select **Clinical Specialty**
  - Select **Site** or **All**, then check left of Program that is reflective the acute hospital; select footer button **Register**
  - Start Date is T for Today, **green check to File**
2. The hospital program will not be discharged until client leaves hospital

### Step 7: Adding the Standard of Care to the Hospital Program

1. To open the **Programs** use (+) to the left of client's name
2. Highlight to select the hospital **Program**
3. Select footer button '**Pgm Care Plan**'
4. On the '**Process Plans**' Screen, select '**Enter**' footer button, select '**Additional Care Plan**'
5. Select **Standard of Care** header button.
6. Click into the empty field under **Mnemonic** column, use drop down arrow or F9
7. Add **Transition Team SOC**

General Standard of Care Problem Detail

Mnemonic	Description
1 <b>TRANSTEAM</b>	TRANSITION TEAM
2	
3	

Description	Status
1 Transition Discharge Planning	A
2 Blaylock Communication	A
3 Client Care Communication	A
4 Case Management	A
5 Health Professional Referral	A
6 Appointments	A
7	

Mnemonic	Description
RPLSOC	REGIONAL PALLIATIVE CARE
SOCACG	SOC: ACUTE CLIENT GROUP
SOCELCG	SOC: END OF LIFE CLIENT GROUP
SOCMLCG	SOC: MAINTENANCE/LT SUPPORTIVE CLT GROUP
SOCPL	SOC: PEDIATRIC PROGRAM LEVEL
SOCRCG	SOC: REHABILITATION CLIENT GROUP
SOCSSH	SOC: LIFETIME ACCOUNT
SOCSSHP	SOC: ADULT PROGRAM LEVEL
<b>TRANSTEAM</b>	<b>TRANSITION TEAM</b>

8. **File**
9. Say "Yes" to "Go to Worklist". If not ready to chart select **No**.
10. Chart under this **Program**
11. The hospital program will not be discharged until the client leaves the hospital



## Discharge Processes

### Process 1 Client discharged Home from Acute Care has Case Manager

1. Determine if a **Service Authorization** needs to be updated. Follow process in **Service Authorization** Module (West Zone only)
  - If required, a new **Service Authorization** is made in the Program where client lives or will receive services.
  - If the **Program** is not already present on the CM Coordinator Desktop,, **Register** into appropriate **Service/Program**. (E.g. Home Care Home Living if at home, Home Care Non Designated Supportive Living if in regular lodge)
2. **Discharge** the **Acute Hospital** Program – once charting is done and the client has left the acute care facility
3. Highlight the **Acute Care Hospital** Program
4. Select the **Outcome** button on the Footer menu. Use down arrow or F9 and choose: “**No Longer Requires Service**”. Date: T for today or the date client left hospital
5. **File**.

**Note:** Remember, Coordinated Access staff must always Register any client who goes to any Supportive Living 3, Supportive Living 4(Dementia) or Long Term Care Facility. Sometimes Coordinated Access is not aware of Admission date so a phone call as FYI is okay.

### Process 2 Client Discharged to PARP (CH Meditech only)

#### From Acute Care and has a Case Manager

1. **Outcome** the **Acute hospital** program
  1. Highlight the **Acute Care Hospital Program**
  2. Select **Outcome** button from footer menu
  3. **Outcome:** use down arrow or F9: usually choose “**No Longer Requires Service**”
  4. **Date:** T for today -or date the client left hospital
  5. **File**
2. Register the **PARP** Program:
  1. Select ‘**New Request**’
  2. Select ‘**Clinical Specialty**’
  3. Select ‘**PARP**’
  4. Select ‘**Register**’ Enter correct date of admission

### Process 3 Client being discharged to PARP (CH Meditech only)

#### From Acute Hospital and needs a Case Manager

1. On **CM Coordinator Desktop** select **CM Values** from the right menu
  - Ensure **New** is displaying in the **Case Manager Type** field
  - **IMPORTANT** as this will populate the **NEEDS CM ASSIGN** list
2. Select **Edit Reg** from the right menu and ensure the **Site** in the **Prov/Site** screen displays the name of the **office** reflective of where the **Case Manager**, if not then change **Site**
3. **Outcome** the **Acute hospital** program

- On the **CM Coordinator Desktop** highlight the **Acute Care Hospital Program**
  - Select **Outcome** button from footer menu and use down arrow or F9
  - Choose **“No Longer Requires Service”**
  - **Date:** T for today (or date the client left hospital)
  - **File**
4. Register the **PARP** Program:
- On the **CM Coordinator Desktop** from the right menu select **New Request**
  - Use the drop down arrow or F9 and select **Clinical Specialty**
  - Place a checkmark to the left of the **PARP** program
  - On the footer menu select **Register** enter correct date of admission

#### Process 4 Client being discharged to Community Support Bed

#### From Acute Hospital and has a Case Manager

1. **Outcome** the **Acute** hospital program
  - On the **CM Coordinator Desktop** highlight the **Acute Care Hospital Program**
  - Select **Outcome** button from footer menu and use down arrow or F9
  - Choose **“No Longer Requires Service”**
  - **Date:** T for today (or date the client left hospital)
  - **File**
2. Register the **CSB** Program:
  - On the **CM Coordinator Desktop** from the right menu select **New Request**
  - Use the drop down arrow or F9 and select **Community Support Bed**
  - Place a checkmark to the left of the **appropriate Community Support Bed** program
  - On the footer menu select **Register** enter correct date of admission (cannot be future dated)
  - On the **CM Coordinator Desktop** highlight the **CSB** program
  - From the footer menu select **Edit Req**
    - In the **Comments** field enter the reason for the CSB admission (**Convalescence, Infirmary**)

#### Process 5 Client being discharged to St. Mike’s Palliative Care Unit (CH Meditech)

#### From Acute Care Hospital and has a Case Manager

1. **Outcome** the **Acute** hospital program
  - On the **CM Coordinator Desktop** highlight the **Acute Care Hospital Program**
  - Select **Outcome** button from footer menu and use down arrow or F9
  - Choose **“No Longer Requires Service”**
  - **Date:** T for today (or date the client left hospital)
  - **File**
2. Register the **PCU** Program:
  - On the **CM Coordinator Desktop** from the right menu select **New Request**
  - Use the drop down arrow or F9 and select **Clinical Specialty**
  - Place a checkmark to the left of the **Lethbridge St Michaels PCU** program
  - On the footer menu select **Register** enter correct date of admission
3. On the **CM Coordinator Desktop** screen:
  - Select **New Request** from the right menu
  - Select the **Service** - use the drop down arrow or F9 of **Clinical Specialty**



- Select **PCU**
- Select **'Register'** enter correct date of admission

**Process 6 Client being discharged Home from Acute Hospital and has NO Home Care**  
**May apply to Clients returning to one of the Kainai or Piikani (CH Meditech) Siksika (PA Meditech) Reserves or returning Out of Region**

**End the Episode** (discharging client from Home Care)

- On the **CM Coordinator Desktop** select **Episode**
- From the footer menu select **Edit Episode**
- If more than one episode displayed select the episode with the Status of Active
- Ensure the fields of information are completed.
- Select the **End Date** field and enter date.
- Select the **'Reason'** field and select **"No Longer Requires Service"**
- Select **"Discharge"**
- In the **Discharge Date** field enter: **T** for today (or date client left hospital)
- **File twice** – this will file the lifetime account discharge and the ending of the episode

**Process 7 Client being discharged from Acute Hospital and needs to have a Case Manager Assigned**

1. On **CM Coordinator Desktop** select **CM Values** from the right menu
  - **Client Group** – should have been entered from the Intake Assessment
  - **Case Manager Type** - Ensure **New** (West) or **Referral** (East) is entered in the field
    - **IMPORTANT** as this will populate the **NEEDS CM ASSIGN** list
    - This information is entered when it is determined that Home Care will be involved otherwise leave blank until this has been determined.
    - This information generates the client's name on a New Referral List (East) or Need CM Assign (West) at the Home Care Office
  - **Case Manager** – remains blank
  - **Priority** – date when Home Care is to make contact – use drop down arrow or F9
  - **File** with green checkmark
2. Select **Edit Reg** from the right menu and ensure the **Site** in the **Prov/Site** screen displays the name of the office reflective of where the **Case Manager, if not then change Site**
3. **Outcome (end)** the **Acute hospital** program
  - On the **CM Coordinator Desktop** highlight the **Acute Care Hospital Program**
  - Select **Outcome** button from footer menu and use down arrow or F9
  - Choose **"No Longer Requires Service"**
  - **Date:** **T** for today (or date the client left hospital)
  - **File**

**Note:** If you accidentally discharge client in error or by accident – **DO NOT ADD** the program again – email the client's name or PHN # with an explanation to: **\*This will make it look like client was admitted twice.**  
[SeniorsHealth.SouthZoneEducation@albertahealthservices.ca](mailto:SeniorsHealth.SouthZoneEducation@albertahealthservices.ca)

## Process 8 Client being Discharged from Acute Hospital

### Returning to Long Term Care Facility

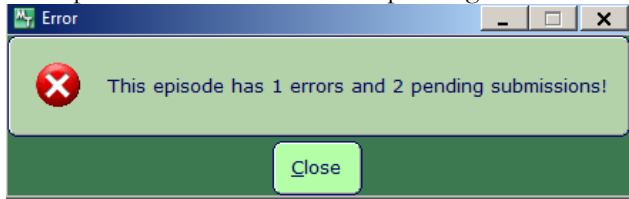
1. **Outcome(end) the Acute hospital program**
  - On the **CM Coordinator Desktop** highlight the **Acute Care Hospital Program**
  - Select **Outcome** button from footer menu and use down arrow or F9
  - Choose **“No Longer Requires Service”**
  - **Date:** T for today (or date the client left hospital)
  - **File**
2. **End the Episode** (discharging client from Home Care)
  - On the **CM Coordinator Desktop** select **Episode**
  - From the footer menu select **Edit Episode**
  - If more than one episode displayed select the episode with the Status of **Active**
  - Ensure the fields of information are completed.
  - Select the **End Date** field and enter date.
  - Select the **‘Reason’** field and select **“Client ref to other health service”**
  - In the **“Referred to”** field – Select **“Long Term Care Facility”**
  - **Press save**
  - **Red X** out of Discharge screen (**you DO NOT WANT to DISCHARGE LIFETIME ACCOUNT**)
  - Select **“YES”** to Exit
  - You will return to the Edit Episode screen – select **YES** to **File**
  -

**Note:** The episode is ended but the **Lifetime Account remains active** as the client is receiving services in a **Long Term Care facility**

### Error messages that might display when Ending an Episode

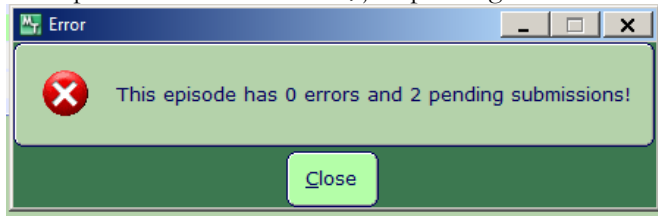
When entering an End Date on an episode, if the episode has any outstanding errors or pending submissions, the number of each will be displayed to the user.

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](mailto: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.

### Accidental Ended Episodes/Outcommmed Programs

Certain users can undo a Lifetime Account Discharge or Programs done in error.

Contact [seniorshealth.southzoneeducation@ahs.ca](mailto:seniorshealth.southzoneeducation@ahs.ca) to have this undone.

## 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.

### 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

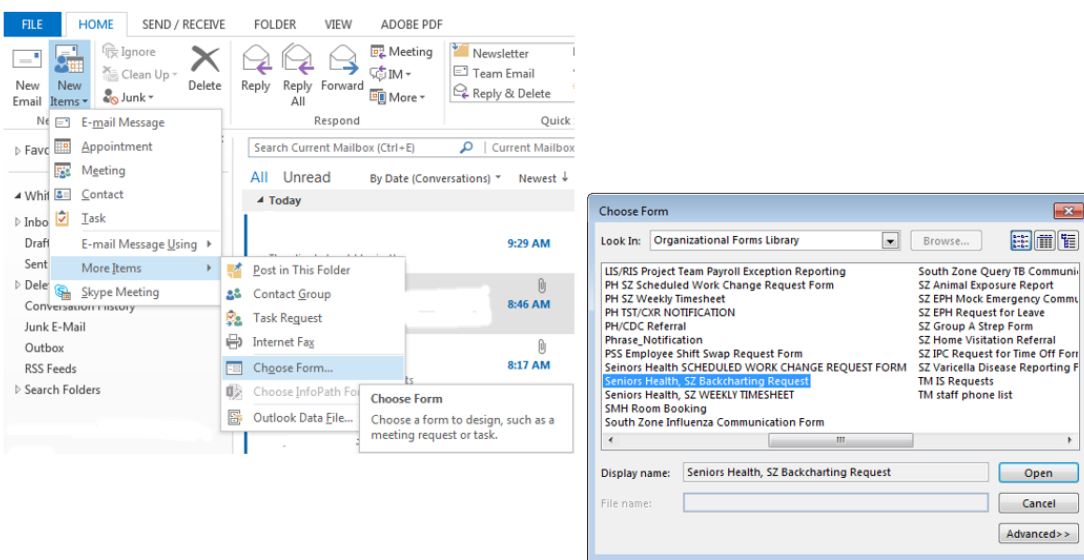
## Back Charting

**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](mailto: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 form to [seniorshealth.southzoneeducation@ahs.ca](mailto:seniorshealth.southzoneeducation@ahs.ca) and cc your manager in the request.

To:

Cc:

Subject: Seniors Health, SZ Backcharting Request

Send



**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](mailto: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.

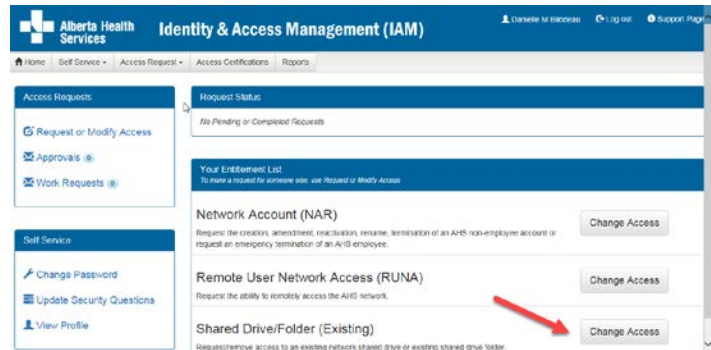
\* Indicates this field MUST be completed for every request

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

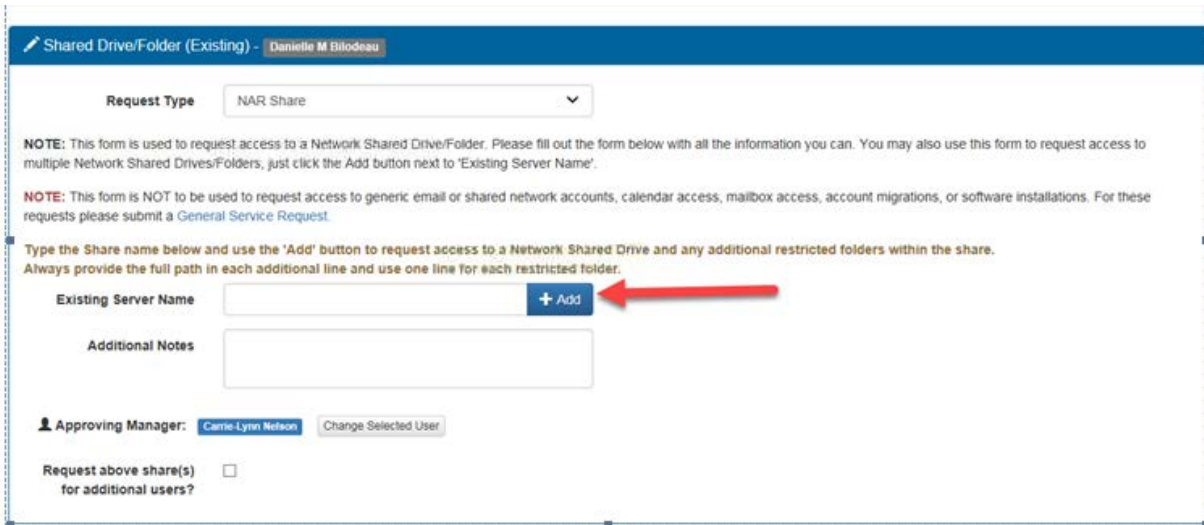
## Accessing the Back Charting Form on the Shared Drive

### Adding Shared Drive to your computer

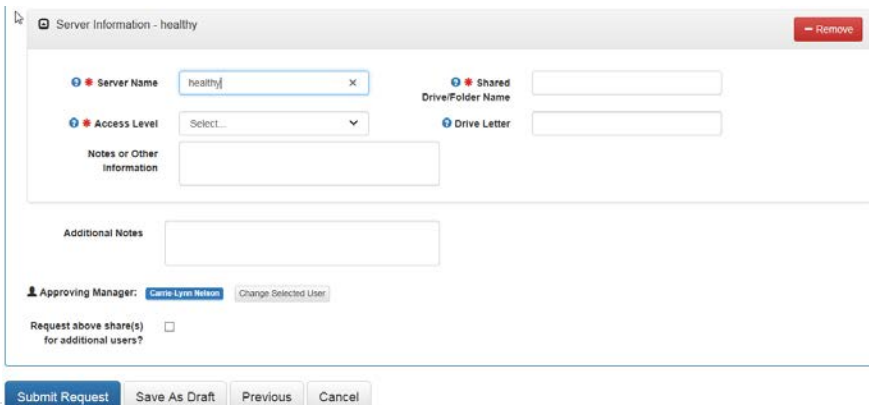
- Type in Identity and Access Management in “Everything” Search field on Insite.
- Click on “Identity & Access Management (AHS IAM) Insite”
- Scroll down and click on “IAM Login”
- Enter your AHS network Username and Password (the Username and Password you use to login to a computer).
- Click “Change Access” beside Shared Drive/Folder (Existing).



- Enter “healthy” in Existing Serve Name and click Add



- Enter the following information:  
**Shared Drive/Folder Name:** Seniors Health Education  
**Access Level:** Read Only  
**Drive Letter:** K  
Click “Submit Request”

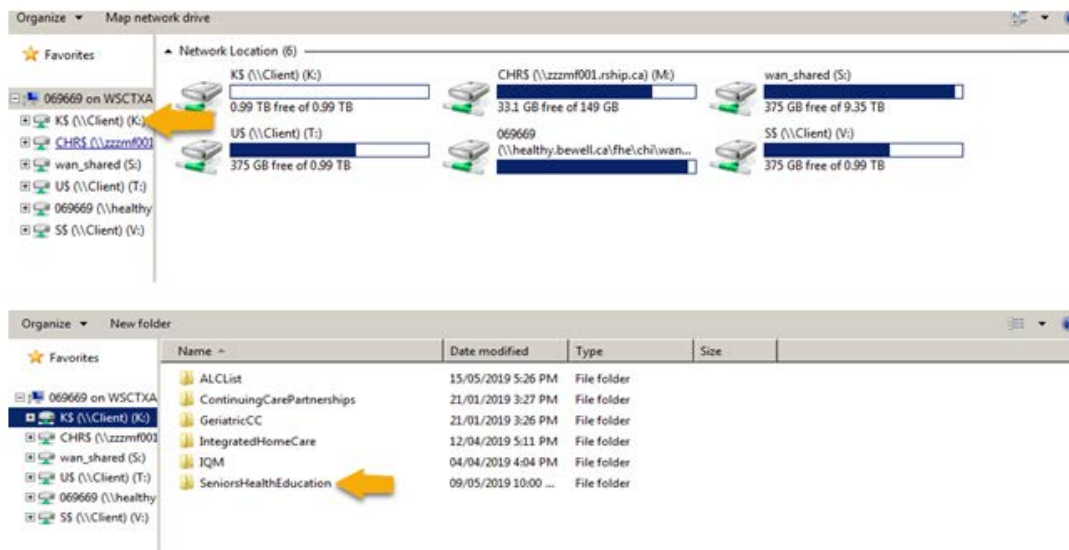


## Using Shared Drive for Electronic Documentation Resources



a. Open

b. Open Windows Explorer, Select the “K” drive, and then choose SeniorsHealthEducation



c. Access the E-doc Education Folder


_1 Clinical Care Topic Links	26/02/2019 10:13 ...	File folder
Accreditation	26/02/2019 9:59 AM	File folder
Case Management	26/02/2019 9:59 AM	File folder
CCHSS	28/01/2019 8:07 AM	File folder
Clinical Education	27/05/2019 2:53 PM	File folder
E-Doc	26/02/2019 10:11 ...	File folder
General SH Education Info	18/03/2019 9:50 AM	File folder
InfoCare	09/05/2019 10:46 ...	File folder
LTC	27/03/2019 9:23 AM	File folder
Public Health, IPC	26/02/2019 10:12 ...	File folder
SMC Case Managers Program Manual	26/02/2019 10:12 ...	File folder
Specialty Referral	26/02/2019 10:13 ...	File folder
Pressure Ulcer.docx	25/03/2019 3:46 PM	Microsoft Word D... 173 KB
Thumbs.db	04/04/2019 7:05 AM	Data Base File 155 KB

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 form to [seniorshealth.southzoneeducation@ahs.ca](mailto:seniorshealth.southzoneeducation@ahs.ca) and cc your manager in the request.

 <b>Seniors Health South Zone BACKCHARTING REQUESTS</b>						
<b>Instructions:</b> <ul style="list-style-type: none"> <li>Please complete ALL sections below. We cannot process incomplete requests.</li> <li>Email completed forms to: <a href="mailto:seniorshealth.southzoneeducation@ahs.ca">seniorshealth.southzoneeducation@ahs.ca</a> and cc: your manager.</li> <li>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).</li> <li>Back charting access will only be granted on a daily basis and will be removed at the beginning of <u>the next business day</u>.</li> </ul>						
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.						
<ul style="list-style-type: none"> <li>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.</li> </ul>						
* 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: <b>Approved</b>

## Viewing Documentation in EMR

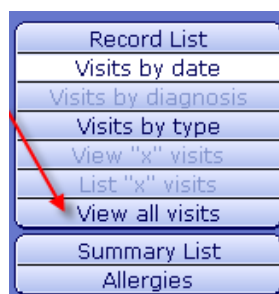
There are several ways to access the EMR:

- 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.



- In the “Search for” field, enter the word “Life”.
- Place check mark beside “SOC: Lifetime Account”
- Click “Add & Close”
- 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

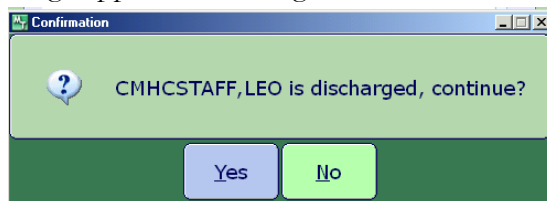
If Duplicate Assessments are added this will be indicated by **DUP** in magenta under the **Src Column**:

- 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)
- 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 2<sup>nd</sup> time).

- On the **Change List**, choose **Lookup List** to search for Client
- If a pop up message appears indicating the Client is discharged , choose “Yes”



- On the CM Coordinator Desktop screen, choose **Edit PGM List**
- On the **Status** screen, choose place a checkmark beside “**Complete**” and SAVE

✓	<b>Service</b>
<input type="checkbox"/>	Cancel
<input checked="" type="checkbox"/>	<b>Complete</b>
<input type="checkbox"/>	Pre Reg
<input type="checkbox"/>	Recommend
<input checked="" type="checkbox"/>	Register
<input type="checkbox"/>	Waitlist

- Highlight the **Program** and open the **Program Account** by clicking on the **(+)** to the left of the Client’s name
- 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 own Intervention documentation **for 3 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](mailto: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	TRAV Ord	Status	Src	Frequency	History
Wound and Dressing Simple Assessment		A	PS	DAILY	63 mins
Vital Signs		A	PS	PRN	56 mins
Medication Administration Community		A		prn	60 mins
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](mailto:SeniorsHealth.SouthZoneEducation@ahs.ca)

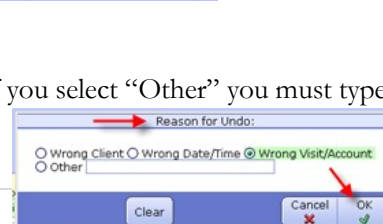
- Reasons for documentation to undo:
  - Done on wrong client
  - Wrong Date/Time
  - Wrong Visit/Account (i.e. wrong Program)
  - Other reason
- Navigate to PCS Interventions screen where charting was originally done (screen says PCS in top left corner)


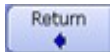
Intervention	TRAV Ord	Status	Src	Frequency	History
Wound and Dressing Simple Assessment		A	PS	DAILY	63 mins
Vital Signs		A	PS	PRN	56 mins
Medication Administration Community		A		prn	60 mins
Community Acute Client Assessment		A	PS		69 mins

- 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.

### Deleting Duplicate Interventions in the Program Account

On a Newly admitted client to **Care Manager** – Palliative Team may already have seen the client, if so they have added their **SOC**.

1. On the **Enter/Edit Patient's Additional problems/interventions** screen of the **Acute hospital** program, there could be a **SOC** already added.
2. After adding your **Standard of Care**, if there are duplicate interventions the screen below will appear. Follow the directions below to remove the duplicate charting interventions
3. The asteriks (\*) that appear to the left of the Interventions indicate that the Intervention has previously been added (in this case by Palliative Team). The word "filed" appears below the Intervention.
4. To remove **Duplicate Intervention** that does not have an asterik (\*) or the word "Filed", Click or Tab into the Status column and choose "I" to Inactivate Intervention.
  - a. Use the down arrow to scroll to Line #2
  - b. Tab or Click into the Status column and choose "C" for Complete or "I" for Inactive
  - c. Repeat with Line #4
  - d. File

Check Duplicates					
		Intervention	Plan/SOC	Problem	Src * Status
1	*	Appointments	TRANSTEAM		SC A
2		Appointments	RPLZSOC		SC A
3	*	Client Care Communication	TRANSTEAM		SC A
4		Client Care Communication	RPLZSOC		SC A
5	*	Case Management Conference	TRANSTEAM		SC A
6		Case Management Conference	RPLZSOC		SC A

FILED

On the **Process Plans** screen, both **Standards of Care** are present with the duplicate Interventions showing in the status of Complete. In **PCS/Worklist** only the Active Interventions appear.


PLAN		Additional problems/interventions	A	27/07/15 0913			
SOC		REGIONAL PALLIATIVE CARE	A				
	I	Palliative Care Intake	A				
	I	Palliative Care Recommendations	A				
	I	Palliative General Physical Assessment	A				
	I	Palliative Performance Scale	A				
	I	Client Care Communication	A				PPS
	I	Case Management Conference	A				
	I	Home Medications Record	A				
	I	Appointments	A				
	I	Medication Reconciliation Follow Up	A				
SOC		TRANSITION TEAM	A				
	I	Transition Discharge Planning	A				
	I	Blaylock Communication	A				
	I	Client Care Communication	C				
	I	Case Management Conference	C				
	I	Health Professional Referral	A				
	I	Appointments	C				

## 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 + <u>underlined letter</u>	“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



**ESC (Back)** x  
Press ESC to back out of menus, fields, and windows. ESC will not close all windows and not used to log out of Meditech. You must click the X in the top right corner.

**F1 (Help)** x  
Press F1 to open the Online Help.

**F5 (Next Section)** x  
Data entry pages are grouped into sections of related fields. Press F6 to jump to the next section. To jump back to a previous section, press Shift+F6.

**F7 (Next Page)** x  
If the content you are viewing has buttons at the top indicating more pages of content, press F7 to jump to the next page. To jump back to the previous page, press Shift+F7.

**F8 (Special Functions)** x  
Press F8 to turn on section-specific special functions. Special functions allow you to navigate Meditech screens using only the keyboard functions. Press F8 to turn on section-specific special functions/hotkeys.  
Each time you press F8, the hotkeys display for a certain group of buttons. A hotkey is a keyboard key, that when pressed, opens the routine or function specified on the button. Each time you press F8, you will jump to a different grouping of buttons on the screen and the special functions for that section are turned on. The first field, menu item or button in a section will be highlighted green when the section is active.

**F9 (Lookup)** x  
In some fields there are lists of options to choose from. Either click the drop-down arrow or press F9 to do a lookup to get these lists.

**F12 (Save)** x  
Press F12 to file screen contents. The contents are saved and the window is closed.

**F11 (EMR)** x  
Press F11 to open EMR in a new window.

**Back**  
Press Back to return to the previous screen.

**Next Field**  
Press Tab to jump from one field to the next. Press Shift+Tab to jump the previous field.

**Next Section**  
Press F6 to jump to the next section.

**Next Page**  
Press F7 to jump to the next page.

**Special Functions**  
Press F8 to turn on section-specific special functions.

**Lookup**  
Press F9 to do a lookup to get these lists.

**EMR**  
Press F11 to open EMR in a new window.

**Save**  
Press F12 to file screen contents.

**Select/OK**  
Press Enter to select a highlighted menu item or button, or accept a field entry. This could result in opening another window or jumping to the next field depending on the screen.

**Scroll Menu**  
The up and down arrow keys move the highlight bar up and down the list of entries.

**Arrows (Scroll Menu)** x  
The up and down arrow keys move the highlight bar up and down the list of entries.

## Appendix C: 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	<input type="text"/>
Diagnosis (if Known)	<input type="text"/>
Name of referral Source	<input type="text"/>
Client Aware of Referral	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>
COMPLETE THE FOLLOWING IF IN ACUTE CARE	
Current Location	<input type="text"/>
Planned Discharge Date	<input type="text"/>
Discharge Date Confirmed	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>
Surgery Date (if applicable)	<input type="text"/>
Type of Surgery	<input type="text"/>
Clinical Pathways	<input type="checkbox"/> Acute MI <input type="checkbox"/> Arthroscopy Care <input type="checkbox"/> Asthma <input type="checkbox"/> CABG <input type="checkbox"/> TURP
SERVICES REQUESTED	
Community Care Services Requested	<input type="checkbox"/> Assess for Home Care <input type="checkbox"/> Assess for Living Options <input type="checkbox"/> Case management <input type="checkbox"/> Catheter Management <input type="checkbox"/> Community B12 Injection <input type="checkbox"/> Education <input type="checkbox"/> Health Monitoring <input type="checkbox"/> Home Parenteral Therapy <input type="checkbox"/> Ostomy Care <input type="checkbox"/> Pain/Symptom Management <input type="checkbox"/> Palliative <input type="checkbox"/> Senior Resource Nurse <input type="checkbox"/> Preop Assessment <input type="checkbox"/> Telehome Care Program <input type="checkbox"/> Wound Care
On palliative care program	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>
Chronic Disease Management	<input type="checkbox"/> Asthma <input type="checkbox"/> Cardiac Rehab <input type="checkbox"/> COPD <input type="checkbox"/> Diabetes <input type="checkbox"/> Heart Function <input type="checkbox"/> Renal <input type="checkbox"/> Respiratory Rehab <input type="checkbox"/> Stroke
Professional Therapies	<input type="checkbox"/> Mental Health <input type="checkbox"/> Nutrition <input type="checkbox"/> Occupational Therapy <input type="checkbox"/> Physical Therapy <input type="checkbox"/> Recreation Therapy <input type="checkbox"/> Respiratory Therapy <input type="checkbox"/> Social Work/Counsellor <input type="checkbox"/> Speech Language Pathology <input type="checkbox"/> Student Health (SHIP)
Care-Giver Support	<input type="checkbox"/> Coping Assessment <input type="checkbox"/> Respite Home-Based <input type="checkbox"/> Respite Facility-Based
Personal Supports	<input type="checkbox"/> AM/PM care <input type="checkbox"/> Bath Assist <input type="checkbox"/> Bowel Routine <input type="checkbox"/> Catheter Care Assist <input type="checkbox"/> Meal Assist <input type="checkbox"/> Medication Assist <input type="checkbox"/> ROM Exercises <input type="checkbox"/> Stocking Assist
Other Personal Supports	<input type="text"/>
Medication Management	<input type="checkbox"/> Assessment <input type="checkbox"/> Medication Admin Program
EQUIPMENT SUPPLIES AND SERVICES	
Med/Surg Supplies	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>
Small Equipment	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>
Large Equipment	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>

Lower Leg Assessment	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>
Incontinence Assessment	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>
Equipment Loan	<input type="radio"/> Yes <input type="radio"/> No Comment <input type="text"/>
Other Services	<input type="checkbox"/> Day Programs <input type="checkbox"/> Dementia Support Team <input type="checkbox"/> Developmental Disability <input type="checkbox"/> FCSS <input type="checkbox"/> Foot Care <input type="checkbox"/> Lifeline <input type="checkbox"/> Meals on Wheels <input type="checkbox"/> Seniors Outreach Programs <input type="checkbox"/> Specialized Assess Unit <input type="checkbox"/> Volunteer Services
<b>CLIENT GROUP</b>	
Client Group Instructions	<input type="text"/> 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	<input checked="" type="radio"/> Yes <input type="radio"/> No
Has End Stage Disease with Anticipated Death Within 6 months	<input type="radio"/> Yes <input type="radio"/> No
<div style="border: 1px solid black; padding: 5px; display: inline-block;">         Always answer the first question.       </div> <div style="border: 1px solid black; padding: 5px; display: inline-block; margin-left: 20px;">         Then follow the green background as this will take you to the next question dependent on your answer.       </div>	
Improvement with Goal Orientated Functional Rehabilitation	<input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> Yes <input type="radio"/> No
Stable Health, Professional Services With No Case Management	<input type="radio"/> Yes <input type="radio"/> 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	<input type="radio"/> Yes <input type="radio"/> No
Temporary Admission to LTC or Supportive Living	<input type="radio"/> Yes <input type="radio"/> No
Temporary Admitted for Respite or Convalescence	<input type="radio"/> Yes <input type="radio"/> No
Client Group	<input type="text"/>
<b>ADDITIONAL COMMENTS</b>	
Intake Assessment Additional Comments	<input type="text"/>

**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 D: Client Group Definitions

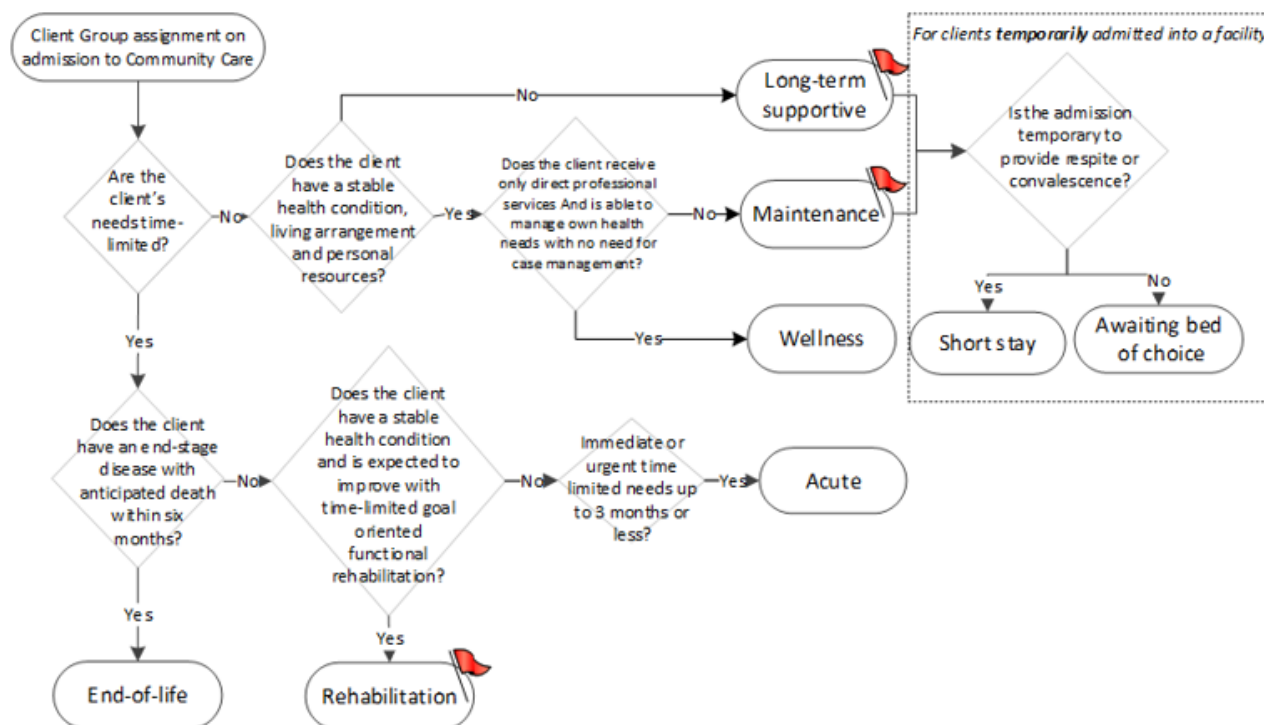
All clients will be assigned to a client group based on their health status. The type will be initially assigned by the Access Centre RN or Community Transition Team RN, but will be reviewed by the Case Manager after an initial assessment is done and changed if appropriate. It may also be changed when 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.

**Note:** ACUTE does not mean Hospital it means Home Care needs are less than 90 days

- **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 not 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 E: Client Group Decision Tree



## Appendix F: Episode Summary Choices

AADL Assessment	<ul style="list-style-type: none"> <li>Formal assessment for Alberta Aides to Daily Living authorization of equipment and/or supplies</li> </ul>
Allied Health Assess/Treat	<ul style="list-style-type: none"> <li>Formal assessment, treatment, education and/or monitoring by allied health professional</li> </ul>
Assess For Living Option	<ul style="list-style-type: none"> <li>Formal assessment to determine appropriate living option and accessing AHS controlled living options</li> </ul>
Clinical Nutrition Consult	<ul style="list-style-type: none"> <li>Formal assessment, treatment, education and/or monitoring by clinical nutrition professional</li> </ul>
Complex Pediatrics	<ul style="list-style-type: none"> <li>Formal case management, assessment and/or treatment where the client is under the age of 18 and has complex health conditions or care needs.</li> </ul>
Home Parenteral Therapy	<ul style="list-style-type: none"> <li>Formal assessment, treatment, education and/or monitoring of a client receiving parental therapy within the home</li> </ul>
Palliative Care	<ul style="list-style-type: none"> <li>Formal case management, assessment and/or treatment by a palliative care specialist within the client's home</li> </ul>
Personal Supports	<ul style="list-style-type: none"> <li>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</li> </ul>
Post Hospital Follow-up	<ul style="list-style-type: none"> <li>Formal assessment, treatment, education and/or monitoring of a client recently discharged from hospital (non-surgical admission)</li> </ul>
Post Surgical Follow-up	<ul style="list-style-type: none"> <li>Formal assessment, treatment, education and/or monitoring of a client recently discharged from hospital (surgical admission)</li> </ul>
Professional Nursing	<ul style="list-style-type: none"> <li>Formal case management, assessment and/or treatment for adult clients</li> </ul>
Wellness Services	<ul style="list-style-type: none"> <li>Assessment, treatment, and/or education services provided in a community setting for clients who have stable health conditions (no case management services provided)</li> </ul>
Wound Care	<ul style="list-style-type: none"> <li>Formal case management, assessment and/or treatment for clients currently experiencing a wound that requires professional treatment</li> </ul>

## Appendix G: Method of Funding

METHOD OF FUNDING SERVICES DEFINITIONS		
Mnemonic	CM Summarized Definition	ACCIS Definition
BF	Block Funded	<ul style="list-style-type: none"> <li>Is a method of funding where an a delivery site receives funds from Alberta Health Services in exchange for providing services to clients who reside in a congregate living setting (e.g. LTC, Supportive Living 3, 4, 4D) <b>** Not a Lodge **</b></li> </ul>
DS	Direct Service	<ul style="list-style-type: none"> <li>Is a method of funding where clients receive services from staff that are employed / funded directly by Alberta Health Services</li> </ul>
FFS	Fee for Service - Contracted	<ul style="list-style-type: none"> <li>Is a method of funding where services are contracted out to a service agency that invoices Alberta Health Services</li> </ul>
SM	Self-Managed	<ul style="list-style-type: none"> <li>Is a method of funding where a client receives funds from Alberta Health Services and is empowered to hire their own caregiver(s) to meet their assessed needs. Guardian Managed Care arrangements are considered a form of self-managed care</li> </ul>

**Note: In the event that a client is receiving services that are funded by multiple methods, code the funding category that covers the majority of the services for that client.**

## Appendix H: 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	<ul style="list-style-type: none"> <li>• Program was Recommended or Waitlisted and is no longer required by the client.</li> </ul>
CMEX	EXPIRED	Client Expired	<ul style="list-style-type: none"> <li>• Client deceased and services are no longer required</li> </ul>
CMINCPR	N/A	Incorrect Program	<ul style="list-style-type: none"> <li>• Program was Recommended or Registered in error or an alternate equivalent Program has been selected.</li> </ul>
CMMERGE	MERGED	Client Merged	<ul style="list-style-type: none"> <li>• <b>Do not use</b> - Selection is used <u>only</u> by advanced users in consultation with Health Information Management (HIM)</li> <li>• Program/Episode closed because the client's file will be discharged and merged into a second active file.</li> </ul>
CMMVRG	MOVED	Client moved, Episode ended	<ul style="list-style-type: none"> <li>• Episode will be completed because client has moved to a new HCIS/Zone <b>**Change to definition**</b></li> </ul>
CMNLE	CLNLELIG	No longer eligible for service	<ul style="list-style-type: none"> <li>• Client does not meet criteria for continued services and Program is ended.</li> </ul>
CMNLR	N/A	Service/Program Complete	<ul style="list-style-type: none"> <li>• Client and Health Care Professional in agreement to end services of Program as unmet needs have now been met. <u>Current Episode remains active as client is still receiving some services or Programs from Continuing Care.</u> * See note 1</li> </ul>
CMNLRED	CLNLRSV	No service reqd, Episode end	<ul style="list-style-type: none"> <li>• Client is no longer receiving any service or program from Continuing Care, Episode ended *See note 1</li> </ul>

Program Outcome Reason Mnemonic	Episode Completion Reason Mnemonic	Descriptor	Definition/Explanation
CMROHS	CLROTHHSV	<b>Refer other serv, Episode end</b>	<ul style="list-style-type: none"> <li>Service/Program ended as client to receive services <b>not available from within Continuing Care</b> (e.g. WCB, Veterans Affairs, community rehab). <b>OR</b> client is moving to a bed of choice within the LTC Facility stream. Episode ended. *See note 3 <b>**Change to definition**</b></li> </ul>
CMSTOHS	STOHS	Service term due to OH&S issue	<ul style="list-style-type: none"> <li>Service or Program terminated related to an OH&amp;S issue(s)</li> <li>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)</li> </ul>
CMTRPRG	N/A	<b>Client transferred</b>	<ul style="list-style-type: none"> <li>Episode remains active but client is now registered into a new service or program. *See note 2</li> </ul>
CMUNCONT	UCONTC	Unable to contact/reach client	<ul style="list-style-type: none"> <li>Health Care Professional unable to make contact or reach the client in person or by telephone after multiple attempts</li> </ul>
CMWDT	CLWTSV	Cl withdrew/terminated service	<ul style="list-style-type: none"> <li>Client elected to withdraw or terminate services of a program with or without support of Health Care Professional.</li> <li>Used when further professional or support services could be provided, but the client has refused any additional services.</li> </ul>
N/A	REGERR	Incorrect LTA Registration	<ul style="list-style-type: none"> <li><b>Do not use</b> - Selection is used <u>only</u> by advanced users in consultation with Health Information Management (HIM)</li> <li>Lifetime Account was incorrectly registered</li> </ul>

\* 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.

## Appendix I: Service Authorization

Service Authorizations will be completed for clients who receive Support Services provided by South Zone Home Support Aides or external partners of the region (A few examples: Lethbridge Family Services Urban and Rural, Cypress View Foundation, South Country Village and CBI Home Health). Service Authorizations will also be done on clients living in Designated Assistive Living Facilities.

### Required Information for Vendor Client Profile – Authorization

Documentation on the following Interventions is required prior to authorization of any services to enable use of the new Client Profile – Authorization. This new client profile blends clinical background with the Daily Living Support Plan, CC: Interventions into one form. The Service Authorization must be completed in the program where the client will be receiving the services in.

#### Safety Risk Assessment – Mandatory

This is part of the Lifetime Account SOC. This assessment captures any environmental / behavioural risks and safe visit instructions. This should be done on first initial visit then reviewed annually or in the event of a change.

#### Medical Conditions Community – Mandatory

This is part of the Lifetime Account SOC. Use this assessment to briefly describe the primary medical problem and three co-morbidities that contribute to the client need for home care services. Ensure the client is aware of this information and consents to it being shared.

#### Daily Living Support Plan – Mandatory

This is part of the Adult Program Account SOC. This is documented on the specific program account that is reflective of where the client will be receiving their services. This assessment describes the clients Activities of Daily Living needs. Review and complete the entire assessment (it is 2 pages long). Do not forget estimated height and weight.

Recall Values can be used to recall the most recent RAI-HC responses to some questions. Each section must be viewed to verify that it reflects the client's current status.

#### Behaviour Support Plan – Optional

This is part of the Program Account SOC. This is documented on the specific program account that is reflective of where the client will be receiving their services. Use this assessment if there any potential behaviour issues. Complete only the sections that apply to the client.

**When these assessments have been charted on then proceed with creating a Service Authorization.**

**Transition Team Service Authorizations generally run for 7 days after discharge from hospital, at that time Home Care reviews service needs**



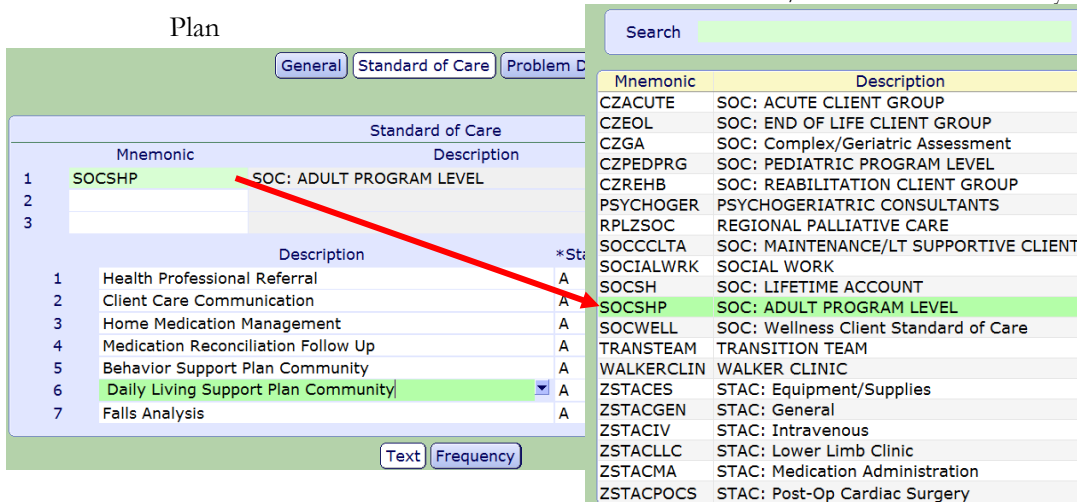
## How to Access Service Authorizations

- To access the Service Authorization routine, select the footer button PGM Careplan on the Cm Coordinator Desktop Screen.
- Select the program that is descriptive of where the client will be receiving their services in. Ensure the client is registered in the correct program. **(A service auth cannot be done ahead of time when a client is moving between levels of care [ from HCHL to SL3} it has to be done after the client has moved )**
- All CC: Interventions must be linked to an associated problem. They are linked directly to the Behaviour Outcome.
- All Service Authorization Interventions start with CC: (Example: CC: Am Care). These Interventions do not appear on the Worklist (PCS Blue Screen).
- Remember you must complete the 3 Mandatory Interventions first before starting the Service Authorization (You Will Have to add the SOC: Adult Program Level to document on the Daily Living Support Plan).

## Creating a Service Authorization

### Adding the SOC: Adult Program Level

- Highlight the program where the Service Authorization will be built
- Select footer button **PGM CARE PLAN**
- On the 'Process Plans' Screen select the footer button **ENTER**
- Select **Additional Care Plan** from the list,
- This takes you to the **Enter/Edit Additional problems/interventions** screen,
- Select the header button **Standard of Care**
- Add the **SOC: ADULT PROGRAM LEVEL** to add/document on the Daily Living Support Plan



The screenshot shows the 'Standard of Care' screen. On the left, there is a table with columns 'Mnemonic' and 'Description'. The first row is 'SOC: ADULT PROGRAM LEVEL' with mnemonic 'SOCSHP'. Below it are several other items, including 'Daily Living Support Plan Community' which is highlighted. On the right, there is a search table with columns 'Mnemonic' and 'Description'. The first row is 'SOC: ADULT PROGRAM LEVEL' with mnemonic 'SOCSHP'. A red arrow points from the 'SOC: ADULT PROGRAM LEVEL' item in the left table to the 'SOC: ADULT PROGRAM LEVEL' item in the right table.

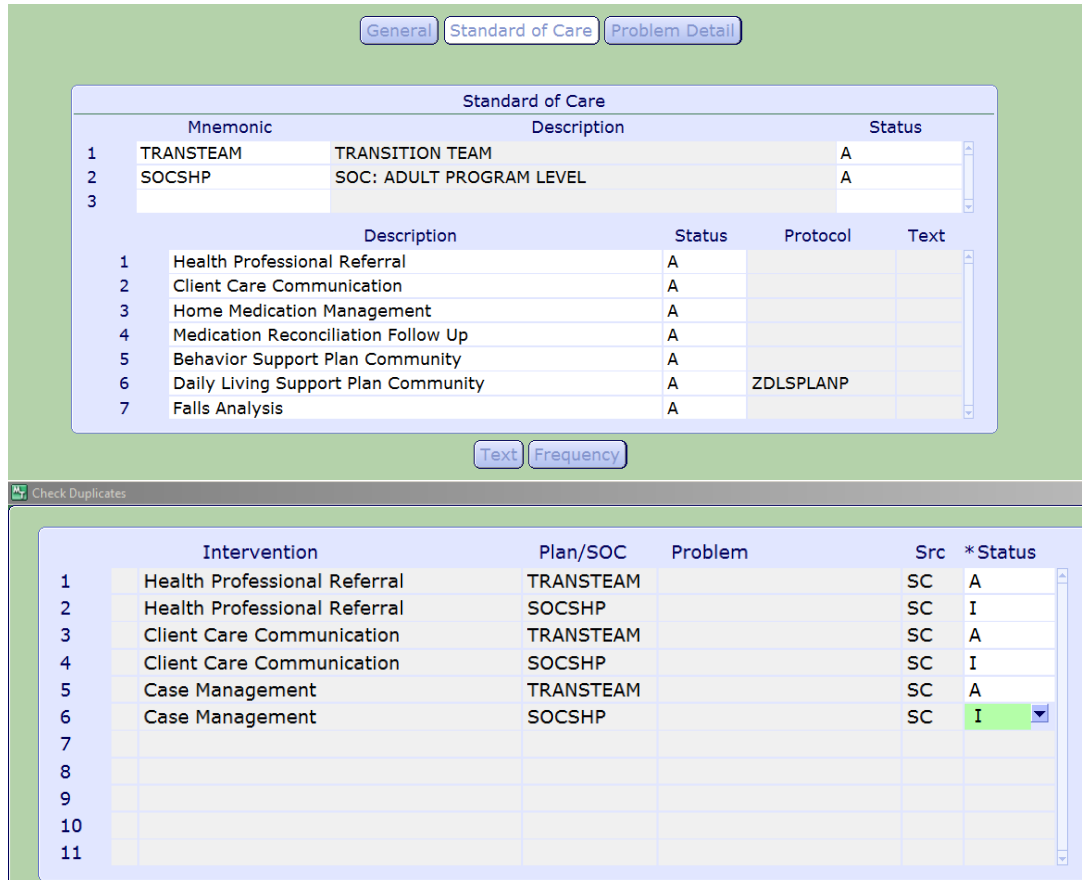
Mnemonic	Description
CZACUTE	SOC: ACUTE CLIENT GROUP
CZEOL	SOC: END OF LIFE CLIENT GROUP
CZGA	SOC: Complex/Geriatric Assessment
CZPEDPRG	SOC: PEDIATRIC PROGRAM LEVEL
CZREHB	SOC: REABILITATION CLIENT GROUP
PSYCHGER	PSYCHOGERIATRIC CONSULTANTS
RPLZSOC	REGIONAL PALLIATIVE CARE
SOCCLTA	SOC: MAINTENANCE/LT SUPPORTIVE CLIENT
SOCIALWRK	SOCIAL WORK
SOCSH	SOC: LIFETIME ACCOUNT
SOCSHP	SOC: ADULT PROGRAM LEVEL
SOCWELL	SOC: Wellness Client Standard of Care
TRANSTEAM	TRANSITION TEAM
WALKERCLIN	WALKER CLINIC
ZSTACES	STAC: Equipment/Supplies
ZSTACGEN	STAC: General
ZSTACIV	STAC: Intravenous
ZSTACLLC	STAC: Lower Limb Clinic
ZSTACMA	STAC: Medication Administration
ZSTACPOCS	STAC: Post-Op Cardiac Surgery

**Note: Do not add interventions to the header button General → Additional Intervention**

### Duplicate Interventions in Acute Program

If Duplicate Assessments are added this will be indicated by the “Check Duplicate” popup box.

- Highlight the **status** of the **Duplicate Assessment** that is linked to the SOC: Adult (SOCSHP) under the Plan/SOC column. (complete this **Prior** to any documentation on the Duplicate Intervention)
- Change the status to **Inactive (I)** in for the duplicate intervention SOCSHP intervention
- Select **green check** in bottom right to save.



The screenshot shows a software interface with two main sections. The top section, titled 'Standard of Care', has tabs for 'General', 'Standard of Care', and 'Problem Detail'. It contains a table with columns: Mnemonic, Description, and Status. Below this is another table with columns: Description, Status, Protocol, and Text. The bottom section, titled 'Check Duplicates', contains a table with columns: Intervention, Plan/SOC, Problem, Src, and \*Status. The status 'I' (Inactive) is highlighted in green for the second row of the 'Check Duplicates' table.

Standard of Care		
Mnemonic	Description	Status
1 TRANSTEAM	TRANSITION TEAM	A
2 SOCSHP	SOC: ADULT PROGRAM LEVEL	A
3		

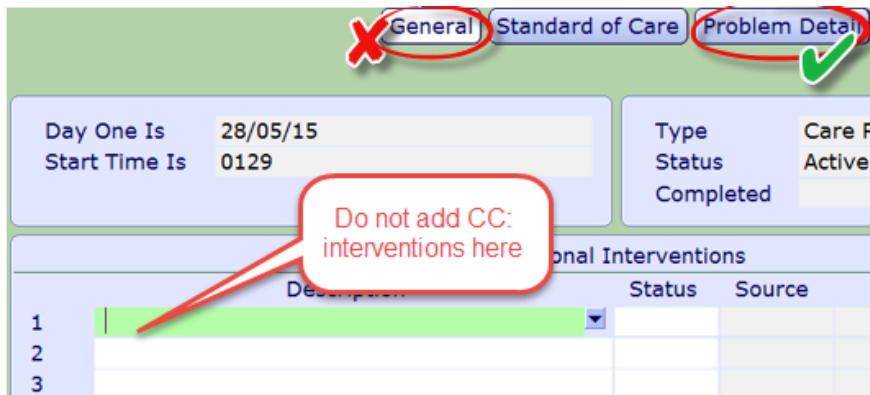
Description	Status	Protocol	Text
1 Health Professional Referral	A		
2 Client Care Communication	A		
3 Home Medication Management	A		
4 Medication Reconciliation Follow Up	A		
5 Behavior Support Plan Community	A		
6 Daily Living Support Plan Community	A	ZDLSPLANP	
7 Falls Analysis	A		

Intervention	Plan/SOC	Problem	Src	*Status
1 Health Professional Referral	TRANSTEAM		SC	A
2 Health Professional Referral	SOCSHP		SC	I
3 Client Care Communication	TRANSTEAM		SC	A
4 Client Care Communication	SOCSHP		SC	I
5 Case Management	TRANSTEAM		SC	A
6 Case Management	SOCSHP		SC	I
7				
8				
9				
10				
11				

### Linking CC: Interventions to an associated problem.

- Highlight the program where the Service Authorization will be built
- Select footer button **PGM CARE PLAN**
- On the ‘Process Plans’ Screen select the footer button **ENTER**
- Select **Additional Care Plan** from the list,
- This takes you to the **Enter/Edit Additional problems/interventions** screen,
- Select the header button **Problem Details** to access Problem and link CC intervention.

**Note: Do not add interventions to the header button General → Additional Intervention**



Day One Is 28/05/15  
Start Time Is 0129

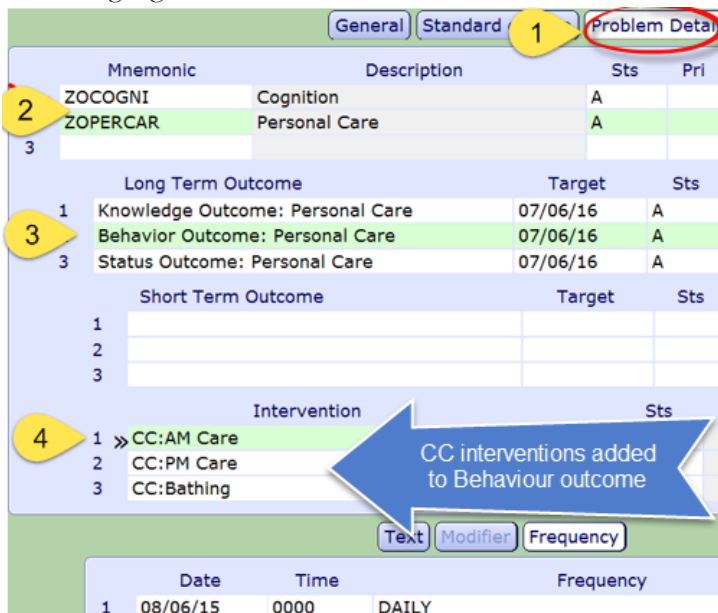
Type Care F  
Status Active  
Completed

Do not add CC: interventions here

	Description	Status	Source
1			
2			
3			

Ensure you have highlighted header button **Problem Detail** first before adding a Problem.

- Highlight Problem (2), then Behavior Outcome (3), to access CC: Interventions (4). Below CC: AM Care is highlighted.



General Standard **1** Problem Detail

Mnemonic	Description	Sts	Pri
ZOCOINI	Cognition	A	
ZOPERCAR	Personal Care	A	
3			

Long Term Outcome		Target	Sts
1	Knowledge Outcome: Personal Care	07/06/16	A
3	Behavior Outcome: Personal Care	07/06/16	A
3	Status Outcome: Personal Care	07/06/16	A

Short Term Outcome		Target	Sts
1			
2			
3			

Intervention	Sts
1 >> CC:AM Care	
2 CC:PM Care	
3 CC:Bathing	

CC interventions added to Behaviour outcome



Text Modifier Frequency

Date	Time	Frequency
1 08/06/15	0000	DAILY

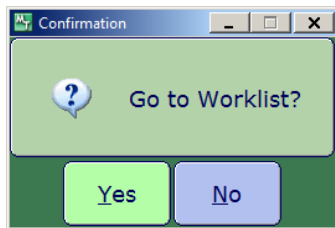
- Click on the CC: Intervention to highlight it. Click on the Frequency button. This will give you the ability to **ADD/EDIT** the Frequency here.

If you need to add more CC: Interventions go to the blank line- Type in CC (use Capital letters) press the F9. All Service Authorization Interventions start with CC:

See Appendix for complete list of CC: Interventions

- **Date Field** enter - t for today. **DO NOT backdate here.** The start date of the authorization is captured elsewhere.
- **Time Field** enter- 0000
- **Frequency** - do a F9 or  and the look up list will display. Do this for each CC: Intervention. Select the best frequency that describes the client's needs. See Appendix J for more details about frequencies.
- F12 or  to save

On the Process Plans of Care Screen you will get a Pop up – select ‘No’ unless you want to document information at this time.



- On the ‘Process Plans of Care, you will see the linkage of the CC: Intervention to the Behaviour Outcome

Process Plans - LCCC/BRHC (ABATEST/ABA.TEST5.67/PHR.TEST5.67 - Test) - Anne Short

**Cmhstaff, Bill**  
DOB: 03/09/1967 47 M

DZ0000388/15/DZ00058758/ABATVIG00428561-FS1  
MEDICINE HAT COMMUNITY - - REG RCR

Ⓢ Allergies/AdvReac: Penicillins

Overall Length of Stay  
Days | Hours

Include Statuses A, H, S, C, I, D.  
Suggested Problems Y

0 of 28 Selected

Type	Description	Sts	Pri	Start/Target Frequency	Day/LeV	LOS	Protocol
<input type="checkbox"/> SOC	SOC: ADULT PROGRAM LEVEL	A					
<input type="checkbox"/> I	Daily Living Support Plan Community	A		.PRN			LDLSUPPORT
<input type="checkbox"/> I	Health Professional Referral	A		.PRN			
<input type="checkbox"/> I	Client Care Communication	A		.PRN			
<input type="checkbox"/> I	Home Medications Record	A		.PRN			
<input type="checkbox"/> I	Medication Reconciliation Follow Up	A		.PRN			
<input type="checkbox"/> I	Behavior Support Plan Community	A		.PRN			
<input type="checkbox"/> SOC	SOC: ACUTE CLIENT GROUP	C					
<input type="checkbox"/> I	Acute Client Comprehensive	C		.On Admission			
<input type="checkbox"/> SOC	SOC: MAINTENANCE/LT SUPPORTIVE CLT GR...	A					
<input type="checkbox"/> I	Case Management Conference	A		.On Admission			
<input type="checkbox"/> I	CAPs Analysis	A		.PRN			ZCAPS
<input type="checkbox"/> P	Cognition	A					
<input type="checkbox"/> LO	Knowledge Outcome: Cognition	A		27/05/16			
<input type="checkbox"/> I	Teach: Disease Process	A		.PRN			
<input type="checkbox"/> LO	Behavior Outcome: Cognition	A		27/05/16			
<input type="checkbox"/> LO	Status Outcome: Cognition	A		27/05/16			
<input type="checkbox"/> I	CAM: Confusion Assessment Method	A		.prn			
<input type="checkbox"/> I	Molloy Standardized Mini-Mental (SMMSE)	A		.PRN			ZMMSEM
<input type="checkbox"/> I	Montreal Cognitive Assessment (MoCA)	A		.PRN			ZMOCA
<input type="checkbox"/> P	Personal Care	A					
<input type="checkbox"/> LO	Knowledge Outcome: Personal Care	A		07/06/16			
<input type="checkbox"/> LO	Behavior Outcome: Personal Care	A		07/06/16			
<input type="checkbox"/> I	CC:AM Care	A		DAILY			
<input type="checkbox"/> I	CC:PM Care	A		HS			
<input type="checkbox"/> I	CC:Bathing	A		MoTh			
<input type="checkbox"/> LO	Status Outcome: Personal Care	A		07/06/16			


Person Mode  
Client Services Ind  
Search Mode  
Capacity  
Edit Reg  
CDS  
CM Values  
Discharge  
Episode  
Letters  
New Request  
Comp Care Plan  
LT Document  
LT Notes  
EMR

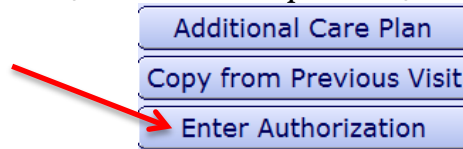
Enter Edit Worklist View Print History Selections +/-

EMR Close ?

- In the **‘Type’ Column** – when there is an ‘I’ this will indicate it is an Intervention. You have now added support services to the Plan of Care. The next step is to create an Authorization Form of the Plan of Care.

### Enter the Authorization Information

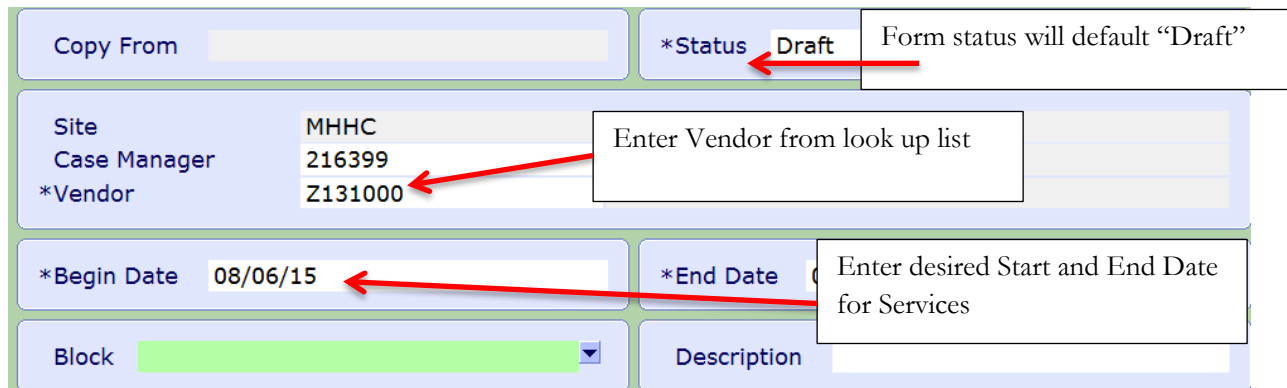
- Select footer button **PGM CARE PLAN**
- On the 'Process Plans' Screen select the footer button **ENTER** 
- Select **Additional Care Plan** from the list,
- This takes you to the **Enter/Edit Additional problems/interventions** screen,



- The 'Authorization Form by Client' will display. The clients name will automatically default in
- With the cursor in the 'Auth Number' field, enter **"N"** for New and press enter

The 'General Information' Screen will open. If there are no previous authorizations to Copy from the cursor will go directly to the Vendor Field.

### Entering the General Information




Copy From  \*Status **Draft** Form status will default "Draft"

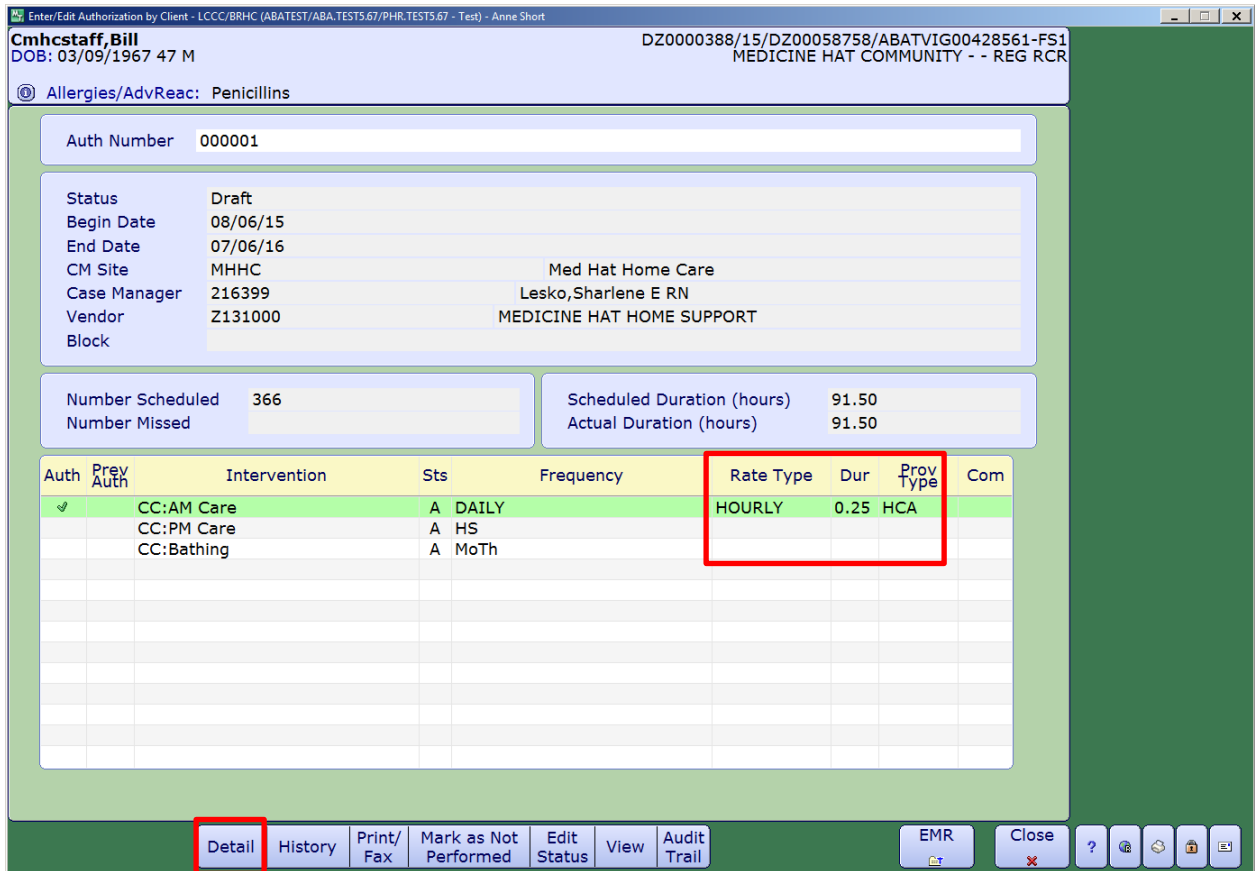
Site **MHHC**  
Case Manager **216399**  
\*Vendor **Z131000** Enter Vendor from look up list

\*Begin Date **08/06/15** Enter desired Start and End Date for Services \*End Date

Block  Description

- Fill in **VENDOR** field first before entering begin date
- Leave the **'Block' Field** empty – we are not currently using
- The Case Manager name will automatically defaults
- The **'Begin Date'** – will be the date you want the service to start
- The **'End Date'**- should not go beyond T+ 365.
- The **'Description Field'** – left blank unless in Medicine Hat with the facility of Garden Apartments
- Press F 12 or  to save

### The 'Authorization Form by Client' Screen



Enter/Edit Authorization by Client - LCCC/BRHC (ABATEST/ABA.TEST5.67/PHR.TEST5.67 - Test) - Anne Short

**Cmhstaff, Bill**  
DOB: 03/09/1967 47 M

DZ0000388/15/DZ00058758/ABATVIG00428561-FS1  
MEDICINE HAT COMMUNITY - - REG RCR

Ⓒ Allergies/AdvReac: Penicillins

Auth Number 000001

Status Draft  
Begin Date 08/06/15  
End Date 07/06/16  
CM Site MHHC  
Case Manager Lesko, Sharlene E RN  
Vendor Z131000  
Block MEDICINE HAT HOME SUPPORT

Number Scheduled 366  
Number Missed  
Scheduled Duration (hours) 91.50  
Actual Duration (hours) 91.50

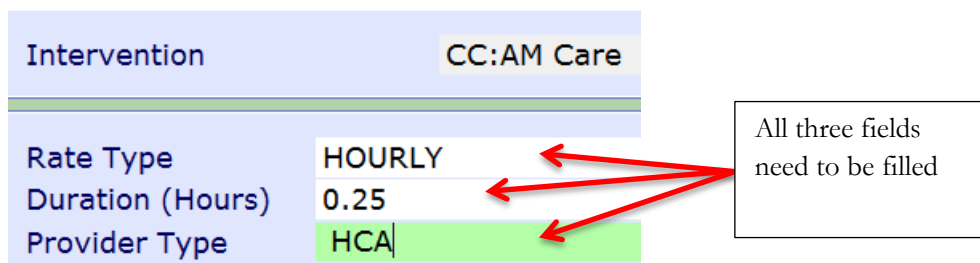
Auth	Prev Auth	Intervention	Sts	Frequency	Rate Type	Dur	Prov Type	Com
✓		CC:AM Care	A	DAILY	HOURLY	0.25	HCA	
		CC:PM Care	A	HS				
		CC:Bathing	A	MoTh				

Detail History Print/Fax Mark as Not Performed Edit Status View Audit Trail

EMR Close ? [Icons]

**Note:** If frequencies don't display correctly on this screen, return to the 'Process Plan of Care' screen to enter/edit them. (Red X twice to get there) If you have forward dated the frequency it will not display in the authorization form until that date. DO NOT forward date frequencies.

- Select the 'Details' footer button. A Screen will pop called 'Enter Intervention Detail'



Intervention CC:AM Care

Rate Type HOURLY  
Duration (Hours) 0.25  
Provider Type HCA

All three fields need to be filled

- **Rate type** – select 'Hourly' (Only use HOURLY).
- **Duration** – Service times will go up by increments of 5 minutes (see next page for time Meditech conversion chart\_

**MEDITECH Values conversion chart**

MEDITECH Values conversion chart			
Service Time (minutes)	MEDITECH Auth time (hours)	Service Time (minutes)	MEDITECH Auth time (hours)
5	0.08	35	0.58
10	0.16	40	0.66
15	0.25	45	0.75
20	0.33	50	0.83
25	0.41	55	0.91
30	0.5	60	1

- **Provider Type** – enter [HCA](#) (this is the provincially accepted term for reporting care provided by a personal care aide) or [LPN](#). **DO NOT use other care provider types.**
- **Comment Text Box**– Leave Blank (**Remember that all client specific information should be captured in the Daily Living support Plan**)
- Select footer button PRINT/FAX will print the service authorization
- Pop up prompt box will state “Auth form printed. Change status to Compiled?”
- Select YES
- Close screen with red X in bottom right

**Home Support Office or Coordinator (Medicine Hat & Brooks Office Only)**

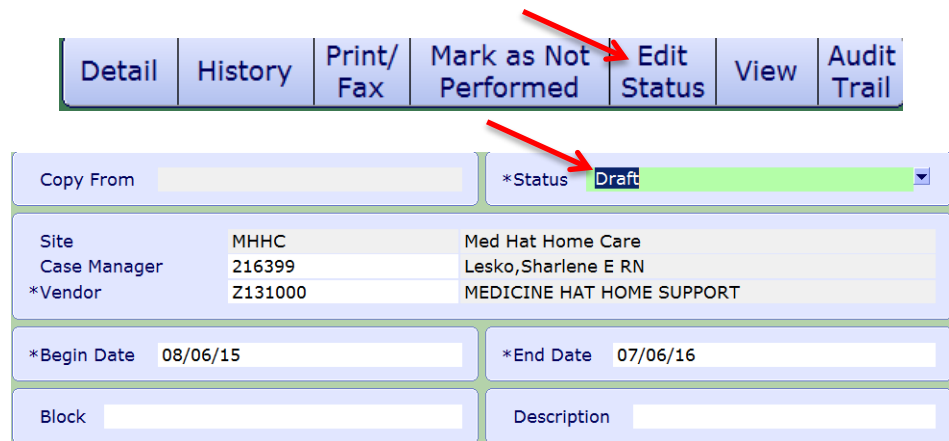
- Print the service auth in the status of ‘Draft’ and give to the support office / coordinator.
- The Service auth will be updated regarding specific dates for service.
- Then the Service Auth status will be changed to ‘Accepted’.
- The Home Support Coordinator /clerk will change the previous Service Auth status to ‘Finalized’
- Then change the status to ‘Compile’. Fax the Community Client Profile – Vendor to the agency (Vendor). At times the agency may need to be called about the services or the urgency regarding the starting of a Service Authorization.

**Once it has been faxed or confirmation has been received from the ‘Vendor’ change the status to ‘Accepted’**



## Changing the Status of Service Authorization to Accepted


- On Process Plans of Care Screen select the Enter footer button.
- Select the 'Enter Authorization Form' from the list
- F9 and select the Authorization in 'Draft/Compiled Status'
- Then select the 'Edit Status' footer button and then go to the 'Form Status' field

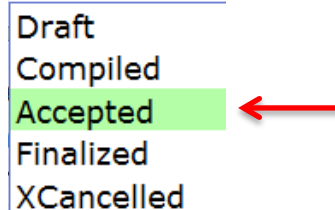


Detail	History	Print/ Fax	Mark as Not Performed	<b>Edit Status</b>	View	Audit Trail
--------	---------	---------------	--------------------------	------------------------	------	----------------

Copy From			*Status	Draft
Site	MHHC	Med Hat Home Care		
Case Manager	216399	Lesko, Sharlene E RN		
*Vendor	Z131000	MEDICINE HAT HOME SUPPORT		
*Begin Date	08/06/15	*End Date	07/06/16	
Block			Description	

- Click in the 'Form Status' field and press F9 or  to look up. The following look up list will be displayed.



Draft
Compiled
<b>Accepted</b>
Finalized
XCancelled

- Select 'Accepted' and F12 to File. Select 'Yes' to File. The 'Enter/Edit General Information' screen will now display the 'Form Status' of 'Accepted'. **This service authorization can no longer have any changes made.**

## Statuses of Service Authorizations Definitions

- **Draft** – service authorization being created
- **Compiled** – authorization completed and sent to Vendor or Home Support office. The authorization will be scheduled to begin.
- **Accepted** – the care is being provided
- **Finalized** – the service auth is no longer active
- **XCancelled** – the service authorization was made in error.

## Viewing the Service Authorization in an 'Accepted Status'

Enter/Save Authorization by Client - LCCC/894C (ABA1551/ABA1551567/9461551567 - Tag) - Assoc Share

**Cmhstaff,Bill**  
DOB: 03/09/1967 47 M

DZ0000388/15/DZ00058758/ABATVIG00428561-FS1  
MEDICINE HAT COMMUNITY - - REG RCR

Ⓢ Allergies/AdvReac: Penicillins

Auth Number 000001

Status **Accepted**

Begin Date 06/06/15  
End Date 07/06/16  
CM Site MHHC  
Case Manager 216399  
Vendor Z131000  
Block


Med Hat Home Care  
Lesko, Sharlene E RN  
MEDICINE HAT HOME SUPPORT

Number Scheduled 366  
Number Missed

Scheduled Duration (hours) 91.50  
Actual Duration (hours) 91.50

Auth	Prev Auth	Intervention	Sts	Frequency	Rate Type	Dur	Prov Type	Com
✓		CC:AM Care	A	DAILY	HOURLY	0.25	HCA	
		CC:PM Care	A	HS				
		CC:Bathing	A	MoTh				

Detail History Print/Fax Mark as Not Performed Edit Status View Audit Trail EMR Close

- In the **Auth Column** – if there is a  mark that means the CC: Intervention is included in this authorization
- If the frequency and rate type have been correctly entered, the 'Scheduled and the Scheduled Duration' fields are calculated and displayed for the length of the authorization
- In the **Form Status field** – you will see the Service Authorization in the status of 'Accepted'

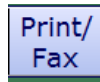
**All new authorizations MUST have the status of 'Accepted' once we confirm the care is being provided.**

## Printing New Client Profile – Service Authorization

This client profile is a composite of general information, safety / risk assessment and clinical information gathered from the Patient Care System (PCS) documentation system. Along the information provides parties with a description of the client's daily living and personal care requirements. The profile is used in conjunction with service authorizations to explicitly request the provision of particular service for the client. The client profile is generally broken down into the following sections.

Section	Description
General Data	<ul style="list-style-type: none"> <li>Client Identifiers</li> <li>Address and Next of Kin</li> <li>Client risks and safe visit plan</li> <li>Medical Conditions Community</li> <li>Allergies</li> </ul>
Daily Living and Behaviour Support Plan	<ul style="list-style-type: none"> <li>PCS – Daily Living Support Plan               <ul style="list-style-type: none"> <li>Covers all personal care and mobility needs</li> <li>Specific support and management details</li> <li>Comments and strategies for greater independence</li> </ul> </li> <li>PCS – Behaviour Support Plan               <ul style="list-style-type: none"> <li>Specific identified behaviours and support plan</li> </ul> </li> </ul>
Support Plan Details	<ul style="list-style-type: none"> <li>Effective date of service authorization</li> <li>Details of CC: Interventions with frequency and durations</li> </ul>

- To Print the new Client profile – Select footer button 'Print/Fax'



## Changing an Authorization to Finalized

- Finalize a Service Authorization when:
  - **Any** changes to a Service Authorization must be made. Example changing the frequency of an intervention; needing to add another CC: Intervention. A new one must be created with the appropriate changes.
  - The service authorization is no longer required. Examples: client is discharged; changes living streams (moves from home to DSL).
- Go to the 'Process Plans of Care' Screen to finalize the authorization. Select the 'Enter ' button and then select the 'Enter Authorization'
- In the 'Auth Number' field press F9 or drop down arrow, select the 'ACCEPTED' authorization; the one with the most recent date will be at the bottom.
- Select the 'Edit Status' footer button. The screen below will display
- Select the 'Form Status' field and F9 to select 'FINALIZED'

Copy From		*Status	Accepted	Change the End Date to be reflective of the last day of services. This date should flow to the start date of the next Service Authorization.
			Draft	
Site	MHHC	Med Hat Hom	Compiled	
Case Manager	216399	Lesko, Sharlen	Accepted	
Vendor	Z131000	MEDICINE HA	Finalized	
Begin Date 08/06/15		*End Date	08/06/15	
			XCancelled	

- Change the 'End Date' to reflect the actual date of the ending of this service auth.
- If you FINALIZE an authorization in Error contact [seniorshhealth.southzoneeducation@albertahealthservices.ca](mailto:seniorshhealth.southzoneeducation@albertahealthservices.ca) – this can be unfinalized.

### Changes to an Accepted Service Authorization

**A service authorization cannot be modified. Instead it must be Finalized** and a New service authorization must be created with the required changes.

Type of Changes	
Change Needed	What Screen to make the changes on
Change a frequency of a CC: Intervention	Process Plans of Care – through the T button then the Authorization Form by Client
Remove/Stop a CC: Intervention	Process Plans of Care – through the T button then the Authorization Form by Client
Add a CC: Intervention	Process Plans of Care – through the T button then the then the Authorization Form by Client
Change the Duration of a CC: Intervention	Authorization Form by Client
Edit Comments on a CC: Intervention	Authorization Form by Client
Change Start or End Dates	Authorization Form by Client
Change the name of the Vendor	Authorization Form by Client
Change the Provider Type for a CC: Intervention	Authorization Form by Client

**When any changes need to be made to an existing Service Authorization the following must always occur:**

- The 'Accepted Service Authorization' must be changed to "Finalized" also change the 'End Date' to be reflective of when these changes are happening
- Make the changes needed on the 'Process Plans of Care' Screen
- Create New Service Authorization
- Then the current Service Authorization status would be changed to "Accepted"

### Care Needs have increased

**Example:** Clients needs have changed and the frequency and duration of AM Care has increased

- Change the current Service Auth status to Finalized. Go to the 'Process Plans of Care' screen (ensure you have the correct client and correct program) Select the 'Enter' footer button and then



- Do a F9 and select the last line in an 'Accepted Status' ( there should only be one)
- Select the **'Edit'** footer button and then enter a date in the End Date field ( this should be reflective of the actual end date) and change the status to 'Finalized'.

Copy From		*Status	Accepted
Site	MHHC	Med Hat Home	
Case Manager	216399	Lesko, Sharlen	
Vendor	Z131000	MEDICINE HA	
Begin Date	08/06/15	*End Date	08/06/15

Dropdown menu for \*Status: Accepted, Draft, Compiled, Accepted, **Finalized**, XCancelled. Red arrows point to 'Accepted', 'Finalized', and '08/06/15'.

- When you change the status to 'Finalize' you will get the following:

*Enter New End Date	08/06/15
---------------------	----------

- Green check or F12 – then green check again to file.
  - You will be returned to the Enter/Edit Authorization by Client screen
- Then the 'Form Status' field will change to Finalized

Status	<b>Finalized</b>
Begin Date	08/06/15
End Date	08/06/15
CM Site	MHHC
Case Manager	Med Hat Home Care
Vendor	Z131000
Block	MEDICINE HAT HOME SUPPORT
Number Scheduled	1
Number Missed	
Scheduled Duration (hours)	0.25
Actual Duration (hours)	0.25

Auth	Prev Auth	Intervention	Sts	Frequency	Rate Type	Dur	Prov Type
✓		CC:AM Care	A	DAILY	HOURLY	0.25	HCA

-  twice back to the Process Plans of Care screen

- On the 'Process Plans of Care' screen select the CC: Intervention that you need to change. Select the 'Edit' button and then 'Edit Frequency'

Process Plans - LCCC/BRHC (ABATEST/ABA.TEST5.67/PHR.TEST5.67 - Test) - Anne Short

**Cmhstaff,Bill** DOB: 03/09/1967 47 M DZ0000388/15/DZ00058758/ABATVIG00428561-FS1 MEDICINE HAT COMMUNITY - - REG RCR

Ⓢ Allergies/AdvReac: Penicillins

Overall Length of Stay  
Days | Hours

Include Statuses A, H, S, C, I, D.  
Suggested Problems Y

0 of 28 Selected

Type	Description	Sts Pri	Start/Target Frequency	Day/Le	LOS	Protocol
<input type="checkbox"/> SOC	SOC: ADULT PROGRAM LEVEL	A				
<input type="checkbox"/> I	Daily Living Support Plan Community	A	.PRN			LDLSUPPORT
<input type="checkbox"/> I	Health Professional Referral	A	.PRN			
<input type="checkbox"/> I	Client Care Communication	A	.PRN			
<input type="checkbox"/> I	Home Medications Record	A	.PRN			
<input type="checkbox"/> I	Medication Reconciliation Follow Up	A	.PRN			
<input type="checkbox"/> I	Behavior Support Plan Community	A	.PRN			
<input type="checkbox"/> SOC	SOC: ACUTE CLIENT GROUP	C				
<input type="checkbox"/> I	Acute Client Comprehensive	C	.On Admission			
<input type="checkbox"/> SOC	SOC: MAINTENANCE/LT SUPPORTIVE CLT GR...	A				
<input type="checkbox"/> I	Case Management Conference	A	.On Admission			
<input type="checkbox"/> I	CAPs Analysis	A	.PRN			ZCAPS
<input type="checkbox"/> P	Cognition	A				
<input type="checkbox"/> LO	Knowledge Outcome: Cognition	A	27/05/16			
<input type="checkbox"/> I	Teach: Disease Process	A	.PRN			
<input type="checkbox"/> LO	Behavior Outcome: Cognition	A	27/05/16			
<input type="checkbox"/> LO	Status Outcome: Cognition	A	27/05/16			
<input type="checkbox"/> I	CAM: Confusion Assessment Method	A	.prn			
<input type="checkbox"/> I	Molloy Standardized Mini-Mental (SMMSE)	A	.PRN			ZMMSEM
<input type="checkbox"/> I	Montreal Cognitive Assessment (MoCA)	A	.PRN			ZMOCA
<input type="checkbox"/> P	Personal Care	A				
<input type="checkbox"/> LO	Knowledge Outcome: Personal Care	A	07/06/16			
<input type="checkbox"/> LO	Behavior Outcome: Personal Care	A	07/06/16			
<input type="checkbox"/> I	CC:AM Care	A	DAILY			
<input type="checkbox"/> I	CC:PM Care	A	HS			
<input type="checkbox"/> I	CC:Bathing	A	MoTh			
<input type="checkbox"/> LO	Status Outcome	A	07/06/16			

Buttons: Edit Plan of Care, Edit Status, Edit Text, Edit Frequency, Suggested Problems, Stop Plan of Care, Undo Stopped Plan of Care

Buttons: Enter, Edit, Work, EMR, Close

- On the 'Change Frequency' screen enter a date in the empty line and enter date and enter 0000 in the 'Time' field and then do a F12 in the Frequency field

Intervention		CC:AM Care	
	Date	Time	Frequency
1	08/06/15	0000	DAILY
2	08/06/15	0000	MoWeFr

- Then F12 and File. Notice the new frequency.

<input type="checkbox"/> P	Personal Care	A	
<input type="checkbox"/> LO	Knowledge Outcome: Personal Care	A	07/06/16
<input type="checkbox"/> LO	Behavior Outcome: Personal Care	A	07/06/16
<input type="checkbox"/> I	CC:AM Care	A	MoWeFr
<input type="checkbox"/> I	CC:PM Care	A	HS
<input type="checkbox"/> I	CC:Bathing	A	MoTh

- Select the 'Enter' footer button

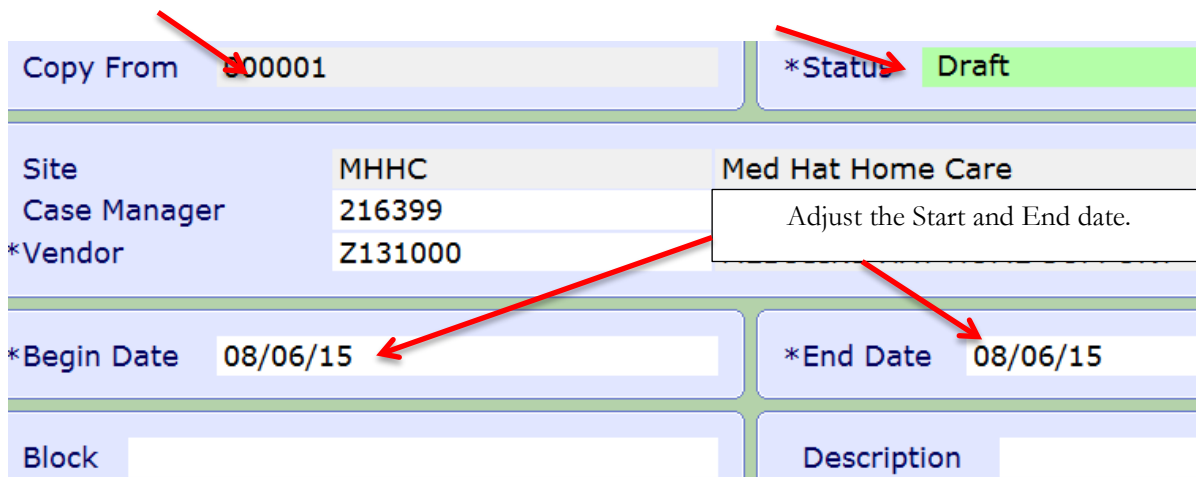


- On the 'Authorization Form by Client' screen enter N for a new authorization. In the 'Copy From' field do a F9. Select the previous Finalized Authorization ( this will allow to copy from the previous one)

Copy From		*Status	
<div> <div></div> <div></div> </div>			
Site	MHHC	Med Hat Home Care	
Case Manager	216399	Lesko,Sharlene E RN	
*Vendor			
*Begin Date		*End Date	
Block	Description		
Number	Status	Description	Begin Date End Date
000001	Finalized	MEDICINE HAT HOME SUPPORT	08/06/15 08/06/15

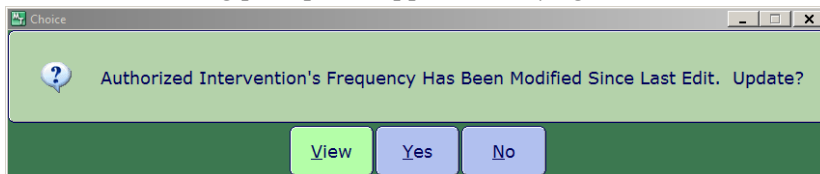


- In the 'Copy From' field - it displays the number of the Service Auth you have copied from. Change the 'Begin and End Date' fields. **Transition Team will authorize for a 7 day period.** The 'Status' field is draft. File and select 'Yes' to confirm.



Copy From	000001	*Status	Draft
Site	MHHC	Med Hat Home Care	
Case Manager	216399		
*Vendor	Z131000		
*Begin Date	08/06/15	*End Date	08/06/15
Block		Description	

- The following prompt will appear identifying that edits have been made

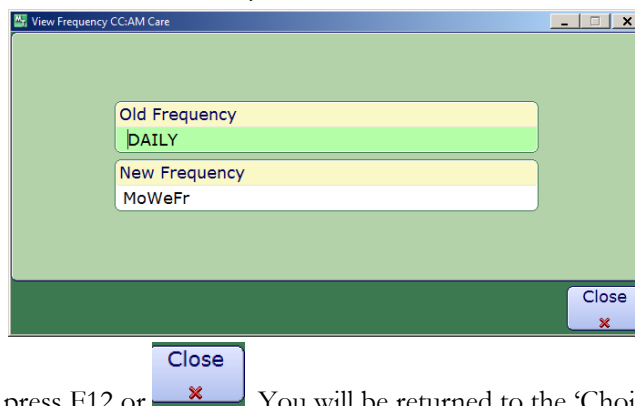


Choice

Authorized Intervention's Frequency Has Been Modified Since Last Edit. Update?

View Yes No

You have 3 choices to select from: **View, Yes or No.** Select '**View**' to see the changes.




View Frequency CCAM Care

Old Frequency  
DAILY

New Frequency  
MoWeFr

Close

- To exit the screen, press F12 or . You will be returned to the 'Choice window. If the edits are correct, select 'Yes' to update the frequency. If the edits are incorrect, select 'No'.

**Note:** that the 'Auth Number' has changed. The 'Begin and End Dates' are different and the 'Frequency' has been changed.

Auth Number	000002		
Status	Draft		
Begin Date	08/06/15		
End Date	08/06/16		
CM Site	MHHC	Med Hat H	
Case Manager	216399	Lesko, Sharlen	
Vendor	Z131000	MEDICINE HAT H	
Block			
Number Scheduled	1	Schedule	
Number Missed		Actual D	

Auth	Prev Auth	Intervention	Sts	Frequency
✓	✓	CC:AM Care	A	MoWeFr
		CC:PM Care	A	HS
		CC:Bathing	A	MoTh

- If the duration needs to be changed select the line and then select the 'D' button and make adjustments. Comments can be changed at this time.
- Then File and select 'Print/fax' footer button to view and ensure that everything is correct. After viewing the service auth X out and select Yes to change the status to 'Compile'
- Fax the new service auth to the Vendor and then change the status to **'ACCEPTED'**

### Care Needs have Decreased

Example: Clients needs have changed and the frequency and duration of PM Care has decreased and they no longer require the weekly bath.

- On the current Service Auth change the 'End Date' and change the status to 'Finalized'.

- Go to the 'Process Plans of Care' screen (ensure you have the correct client and correct program)  
Select the 'Enter' button and then

Additional Care Plan
Copy from Previous Visit
Enter Authorization

- Do a F9 and select the last line in an 'Accepted Status' ( there should only be one service auth in an 'Accepted' status)

Number	Status	Description	Vendor	Begin Date	End Date
000002	Accepted		MEDICINE HAT HOME SUPPORT	08/06/15	08/06/15
000001	Finalized		MEDICINE HAT HOME SUPPORT	08/06/15	08/06/15

- Select the **'Edit'** footer button and then enter a date in the End Date field ( this should be reflective of the actual end date) and change the status to 'Finalized'.

Copy From

\*Status **Accepted**

Site MHC Med Hat Home

Case Manager 216399 Lesko, Sharlene

Vendor Z131000 MEDICINE HAT

Begin Date 08/06/15

\*End Date 08/06/15


Draft  
Compiled  
Accepted  
**Finalized**  
XCancelled

- When you change the status to 'Finalize' you will get the following:

\*Enter New End Date **08/06/15**

- Green check or F12 – then green check again to file.

Close

-  twice back to the Process Plans of Care screen

- On the 'Process Plans of Care' screen check the box to left of the CC: Intervention that you need to change. Select the **'Edit'** button and then **'Edit Frequency'**. Enter the date and then in the time enter 0000 and in the Frequency do F9 or the Frequencies section of this manual. Then File.

- Then select the CC: Intervention that you need to stop. Then select the 'Edit' button and select

'Edit Status'. Then select 'Complete' by clicking circle to the left. Green check to save

Save

<input type="checkbox"/>	P	Personal Care	A	
<input type="checkbox"/>	LO	Knowledge Outcome: Personal Care	A	07/06/16
<input type="checkbox"/>	LO	Behavior Outcome: Personal Care	A	07/06/16
<input type="checkbox"/>	VI	CC:AM Care	A	MoWeFr
<input checked="" type="checkbox"/>	I	CC:PM Care	A	HS
<input type="checkbox"/>	I	CC:Bathing	A	MoTh

Intervention

CC:PM Care

Status A

New Status

☐ Active

☒ Complete

☐ Hold

☐ Inactive

☐ Cancel

- Now select the 'Enter' button, select 'Enter Authorization Form' from the drop down list. Enter 'N' for new authorization and select enter which will take you to the Enter/Edit General Information screen.
- In the 'Copy From' field select the authorization that you just finalized which should be the last one.

Copy From  Do F9 to see previous service authorization

Number	Status	Description	Vendor	Begin Date	End Date
000002	Finalized	MEDICINE HAT HOME SUPPORT	08/06/15	08/06/15	
000001	Finalized	MEDICINE HAT HOME SUPPORT	08/06/15	08/06/15	

Change the Begin Date and the End Date. F12 or

- Then View or say Yes to Update

Choice

Authorized Intervention's Frequency Has Been Modified Since Last Edit. Update?

- Note that the 'Auth Number' has changed. The 'Begin and End Dates' are different and the 'Frequency' has been changed. There is no longer any CC: Bath Intervention

Auth Number **000003**

Status **Draft**

Begin Date **08/06/15**

End Date **08/06/15**

CM Site **MHHC**

Case Manager **216399**

Vendor **Z131000**


Block

Number Scheduled **1**

Number Missed

th	Prev Auth	Intervention	Sts
	✓	CC:AM Care	A MoWeFr
		CC:Bathing	A MoTh



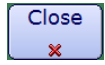
- If the duration needs to be changed select the line and then select the 'Details' footer button and make adjustments. Comments can be changed at this time.

- Then File and select 'Print/fax' footer button to view and ensure that everything is correct. After viewing the service auth  out and select 'Yes' to change the status to 'Compile'

- Fax the new service auth to the Vendor and then change the status to **'ACCEPTED'**


## An additional CC: Intervention needs to be added

Example: Clients needs have changed and you need to add the intervention CC: Wound Care

- On the current Service Auth change the 'End Date' and change the status to 'Finalized'.
- Go to the 'Process Plans' screen (ensure you have the correct client and correct program).
- To add an additional CC: Intervention we must review the current Omaha problems and link the CC: Intervention to the correct problem. Sometimes you may have to add a new Omaha problem first.
- First change the status of current Service Authorization to Complete. Ensure the End Date is changed to reflect the correct date.
- From the 'Process Plans of Care' screen select the 'Enter' footer button and then select 'Additional Care Plan'. In this example the Omaha problem of 'Skin' has been added.
- Select each Outcome to set Target Dates. The Intervention CC: Wound Care is linked to the Behaviour Outcome. Highlight the CC: Wound Care Intervention then select the Frequency button below to enter the date, time, and frequency. F12 or Green check to file.
- Now select the 'Enter' button, select 'Enter Authorization' from the drop down list. Enter 'N' for new authorization and select enter which will take you to the Enter/Edit General Information screen.
- In the 'Copy From' field select the authorization that you just finalized which should be the last one.
- Change the Begin Date and the End Date and F12 or select . Select 'Yes' to File Plan of Care.
- Select the new CC: Intervention and then select the 'Details' footer button. Enter the 'Rate Type, Duration and Provider Type'. Select the .
- Then File and select 'Print/fax' footer button to view and ensure that everything is correct. After viewing the service auth  and select 'Yes' to change the status to 'Compile'
- Fax the new service auth to the Vendor and then change the status to 'ACCEPTED'.



### Completing a CC: Intervention

Example: Client no longer requires PM Care

- On the current Service Auth change the 'End Date' and change the status to 'Finalized'.
- On the 'Process Plans of Care' screen select the CC: Intervention that needs have the status changed to 'Complete'
- Select the choice of 'Complete'
- Now the status will show as 'Complete'
- Select the 'E' button; select 'Enter Authorization'; Enter 'N' for new in the 'Auth Number' field.
- On the 'Enter/Edit Form by Client' screen; select the 'Copy From' field and do a F9 select the last 'Finalized' authorization. Review 'Site and Vendor'. Change the 'Begin and End Date' fields. Use the Enter key to key through the other fields.
- F12 or select the .
- Note that PM care no longer displays.
- Then File and select 'Print/fax' footer button to view and ensure that everything is correct. After viewing the service auth X out and select 'Yes' to change the status to 'Compile'
- Fax the new service auth to the Vendor and then change the status to 'ACCEPTED'.

### Reinstating a CC: Intervention that had been previously changed to Complete

Example: The client now requires bathing assistance again.

- On the current Service Auth change the 'End Date' and change the status to 'Finalized'
- On the 'Process Plans of Care' screen select the CC: Intervention that has the status of 'C' (Complete). Select the 'Edit' button and select by clicking circle to left of 'Active'. Review the frequency and make changes if needed.
- Select the 'Enter' button; select 'Enter Authorization Form'; Enter 'N' for new in the 'Auth Number' field.
- On the 'Enter/Edit Form by Client' screen; select the 'Copy From' field and do a F9 select the last 'Finalized' authorization. Review 'Site and Vendor'. Change the 'Begin and End Date' fields. Use the Enter key to key through the other fields.
- F12 or select the  Select 'Yes to the File?.'
- Now select the line with Bathing and then select the 'Details' footer button. Enter the 'Rate Type, Duration and Provider Type'. File or select the .
- Then File and select 'Print/fax' footer button to view and ensure that everything is correct. After viewing the service auth X out and select 'Yes' to change the status to 'Compile'
- Fax the new service auth to the Vendor and then change the status to 'ACCEPTED'.

**To Discontinue a Service Authorization**


Example: Client admitted to Long Term Care and personal care services are no longer required.

- First you complete the Problems by making a final documentation in each 'Outcome'. ( This gives a final picture of how the client is upon discharge)
- Then change the status of each "Problem" to complete.
- Select the 'Edit Status' button. Change the 'End Date' to reflect the actual date of the service auth being 'Finalized'. In the 'Form Status' field select 'Finalized'.
- Then select 'Yes'. F12 or . Select 'Yes' to the File ?.

**You can select all lines of information on the 'Process Plans of Care' screen by using the "SHIFT and Down arrow keys together on your keyboard. The background color will turn blue. Then select the 'T' button and select 'Edit Status'; select 'Complete'**

**Or**

**When you complete the 'Program' (by selecting the reason why for the program being completed and date it – this will automatically change all Problems and Interventions statues to 'Complete'**

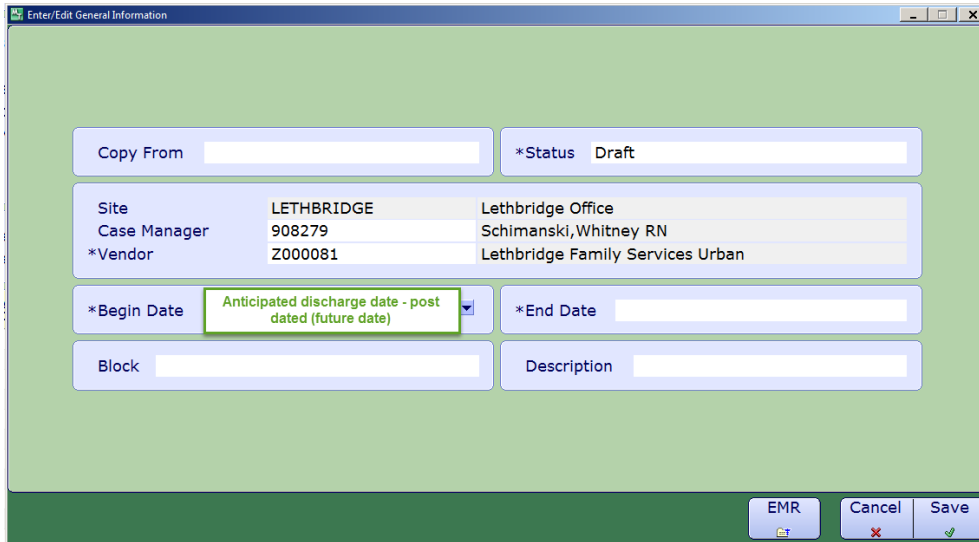
- Select the 'Edit Status' button. Change the 'End Date' to reflect the actual date of the service auth being 'Finalized'. In the 'Form Status' field select 'Finalized'.
- Then select 'Yes'. F12 or . Select 'Yes' to the File ?.

**Setting Up Services with Vendor before Discharge**
**Process 1: Existing Home Care Clients with Open Home Care Program**

Set up the services in the existing Home Care Home Living Program. With the Home Care program selected complete these steps:

1. In the Pgm Care Plan add your appropriate CC: interventions.
2. Document on the Daily Living Support Plan in the PCS. Use recall values and ensure that you are reviewing and making changes as needed. Save.
3. Create a new "N" service authorization with the start date post-dated to when the anticipated discharge date will be that services are to begin. Complete all the details for the CC: interventions. Leave the Service Auth in *Draft* status until discharge date so if there are any errors or changes you are able to make them. Save the Service Authorization.



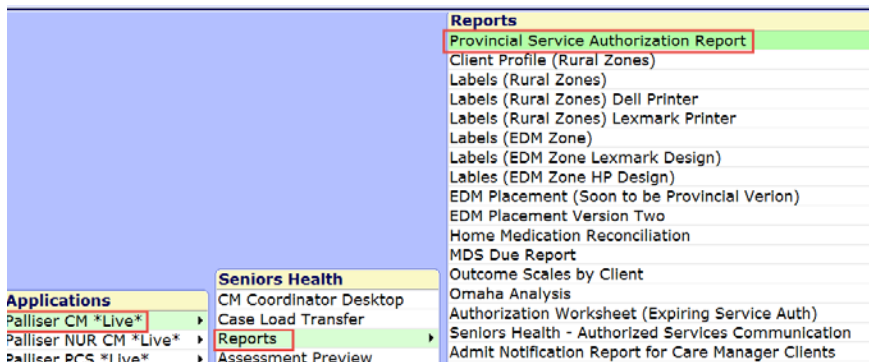


4. Print the *Draft* Service Authorization and fax to the appropriate vendor.
5. Once the client is being discharged make any updates as needed and change the status to *Accepted* and re-fax to the vendor.

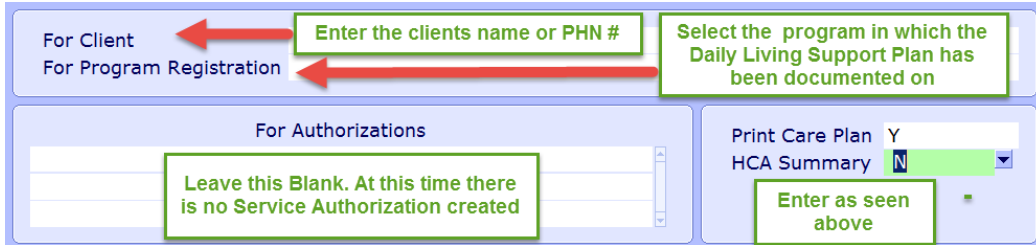
### Process 2: New Referrals/Non-Existing Home Care Clients

We cannot register the Home Living program before the date the client is being discharged. We would use the following process when we need to print the Daily Living Support Plan along with information from the Client Profile. This will be beneficial when sending initial information to a vendor (agency) before discharge date.

1. We would use the following process when we need to print the Daily Living Support Plan along with information from the Client Profile. This will be beneficial when sending initial information to a vendor (agency) before discharge date.
2. Document on the Daily Living Support Plan in the Acute (Hospital) Program. To add the DLSP go into the Comp Care Plan and add the SOC: Adult Program Level under the Standard of Care Tab. Inactivate any duplicate interventions. The DLSP will be a linked assessment for you to document on in the PCS.
3. From the Applications Screen, select CM Live, then select Reports then select Provincial Service Authorization Report



4. The following screen opens and follow the directions below:
  - In the Program Registration section:
    - If you are working with Transition Team, you would select the hospital program.



The screenshot shows a software interface for program registration. It is divided into two main sections: 'For Client / For Program Registration' and 'For Authorizations'.

**For Client / For Program Registration:**

- On the left, there are two radio buttons: 'For Client' and 'For Program Registration'. A red arrow points from a green box labeled 'Enter the clients name or PHN #' to the 'For Client' radio button.
- On the right, there is a dropdown menu. A red arrow points from a green box labeled 'Select the program in which the Daily Living Support Plan has been documented on' to this dropdown menu.

**For Authorizations:**

- On the left, there are three empty text input fields. A green box labeled 'Leave this Blank. At this time there is no Service Authorization created' is positioned over the first two fields.
- On the right, there are two dropdown menus: 'Print Care Plan' (set to 'Y') and 'HCA Summary' (set to 'N'). A green box labeled 'Enter as seen above' is positioned below these two dropdowns.

5. Select OK and then either preview or print.

## Appendix J: Frequencies

Frequency F9 (Drop down List) {Combination of both Meditech rings}

MEDITECH Format (Mnemonic)	Description	MEDITECH Format (Mnemonic)	Description
2XWEEK	2 Times Weekly	BRKFST	Breakfast
3XWEEK	3 Times Weekly	BRKFST, LUNCH	Breakfast and Lunch
4XWEEK	4 Times Weekly	DAILY	Daily
5X DLY	5 Times a Day	HS	Daily at Bedtime
5XWEEK	5 Times Weekly	LUNCH	Daily at Lunch
6XWEEK	6 times Weekly	LUNCH, SUPPER	At Lunch and Supper
AM, LUNCH, BEDTIME	In Morning, at Lunch at Bedtime	PRN	As Needed
AM, LUNCH, SUPPER, BED	Daily in the Am, Lunch, Supper and Bedtime	ONCE	Once Only
AMHS	Daily in Morning and at Bedtime	Q2DW	Every 2 Days
BEDTIME	Daily at Bedtime	Q4HWA	Every 4 Hours while awake
AS DIRECTED	As Directed	QAM	Daily in the Mornings
AS ORDERED	As Ordered	QID	4 Times a Day
BID	Twice Daily	TID	Three times a Day
BIDM	At Breakfast and Supper	Weekly	1 Time Weekly

### Comments

- Only use weekly formats when day of the week is not predetermined. If the day of the week is important use MEDITECH Format for Days of the week.
- PRN should only be used in Interventions that are not done on a regular basis and the schedule cannot be determined

### Monthly and Every # of Weeks

- Entered as QnnD format – eg: every 6 weeks is Q42D
- Use Q28D for a monthly intervention that must fall on the same day of the week each month

## Specific Days of the Week Format

MEDITECH FORMAT	Day of the Week
Mo	Monday
Tu	Tuesday
We	Wednesday
Th	Thursday
Fr	Friday
Sa	Saturday
Su	Sunday

## MEDITECH Frequency Formats:

NB: Capital letters, commas and spacing are important and must be used correctly

Directions for Format	Example	Meaning
QnnD ( every nn days)	Q2D	Beginning at the specified start date and every 2 days thereafter
QnnH (every nn hours)	Q4H	Beginning at the specified start time and every 4 hours thereafter
Q14D	Q14 Days	Once every other week
Multiple time entries separated by a comma	08,10,12,16	0800,1000,1200,1600
A sequence of two letter abbreviation for days of the week; no spacing between	MoWeFr	Monday, Wednesday, and Friday
A combination of specific days and times with the @symbol	MoWeFr@08,17	Every Monday, Wednesday and Friday at 0800 and 1700

## Appendix K: Choosing the Correct Program (West Zone only)

To determine which Service and Program to register identify:

- where the client lives  
and/or
- where the client is being seen

**Note:**

Clients in **SL3, SL4, SL4D** or **LTC** should have these Programs registered by **Coordinated Access**

**A. Clients living in a HOME or APARTMENT with NO COMMUNAL (shared) Meals:**

- Choose **Service: HCHL: Home Care Home Living**
- Choose **Program: Client Home** (determined by Community)

Clients who have **Self or Guardian Managed Care:**

- Choose **Service: HCHL: Home Care Home Living**
- Choose **Program: Self or Guardian Managed Care**

Clients who live outside **former Chinook Region** or on a **Reserve:**

- Choose **Service: HCHL: Home Care Home Living**
- Choose **Program: Out of Region**

**B. Client lives in **group setting** where there are **communal** (shared) meals:**

- Choose **Service: HCNDL: Home Care Non-Designated Supportive Living**
- Choose **Program: Regular Lodges** (choose appropriate lodge)

**C. Client lives in **Rosewood Villa** or **Adaptacare**:**

- Choose **Service: HCDSL Home Care – DSL**
- Choose **Program: Rosewood Villa or Adaptacare**

**D. Client is admitted to **Acute Care** and client requires a RAI-HC or other documentation:**

- Choose **Service: Clinical Specialty**
- Choose **Program: Community Acute Hospital** (based on Site)

**E. Client on **PARP** or **Palliative Care Unit**:**

- Choose **Service: Clinical Specialty**
- Choose **Program: St. Mike's or St. Mike's PCU**

**F. Client in a **Community Support Bed**:**

- Choose **Service: Community Support Bed**
- Choose **Program: choose appropriate Program**

**G. Client with an **IV**:**

- Choose **Service: Clinical Specialty**
- Choose **Program: HPTP or HPTP Palliative**

**H. Client at **Bridges Program**: (Note: Community or Facility Based)**

- Choose **Service: Day Program Community Based**
- Choose **Program: Lethbridge Bridges**
- Choose **Program: Day Program Facility Based**
- Choose **Program: Rural Bridges**

**I. Client receiving services in **Ambulatory Clinic**:**

- Choose **Service: Home Care Ambulatory**
- Choose **Program: Community Ambulatory Clinic**

**J. Client is in **Long Term Care** and requires services or reassessment:**

**Note:** NEVER chart under any **Long Term Care Facility Program** where the Client resides in an AHS operated facility. Referral will be needed for Coordinated Access to do a CSI. The documentation will be in the Service of Clinical Specialty and the Program of Community Assessment (the community where the client resides, eg. Cardston).

**Note:** Clients in **Prairie Ridge Mental Health Unit** are registered into **Raymond Community Assessment** for charting/RAI-HC

- Choose **Service: Clinical Specialty**
- Choose **Program: Community Assessment**

**AHS operated:**

In **CH ring**: Cardston, Coaldale, Crowsnest Pass, St. Michael's, Milk River, Raymond and Taber

In **PA ring**: Bassano, Bow Island, Brooks, Oyen

**For non-AHS sites documentation can be completed in the following Programs**
**Non AHS facilities:**

In **CH ring**: Edith Cavell, Fort Macleod

In **PA ring**: Good Samaritans, Masterpiece River Ridge. Riverview Care Centre, Sunnyside Care Centre and Valleyview

## Appendix L: Transition Quick Reference

When a client is admitted to Home Care, this begins an Episode of Care. The Episode captures the entire duration of care within the Continuing Care portion of the client's Services, even though they may receive Services in several Programs during the Episode. The Episode continues until all Programs are Complete and the client is discharged from Continuing Care. If the client is discharged and later readmitted, a new Episode of Care is started.

Within the Episode in Meditech, there are two types of accounts. One is the Lifetime Account and the other is the Program Account. This account contains client information that crosses all Continuing Care programs. It includes information that is general enough and important for everyone to know, and so is accessible to all Programs. Each client will only ever have one Lifetime Account in each reporting ring. The Program Account is specific to the Episode of care and what interdisciplinary teams are involved in a client's care. Clients can be registered in multiple programs (I.e. Hospital, home living, etc.).

Below is a quick reference that outlines the important steps that need to be completed in the Episode, Program and Lifetime accounts.



# Episode

Ensure the client has an active Episode of care OR complete the CSI process to open an active Episode.

To remove a client's discharge QR to register the new client in Care Manager

- Access the **Client Services Inquiry** and select **New Inquiry** from the footer
- Fill out the **Referral Source** and **Referral Method** in the Ref Source tab
- In the Contact Tab complete the required fields: Contact Name, ULI, Search MPI, Site and Reason

*Contact Name   Phone	Med Rec	EHR	ULI
Mother's Name			
Client Name			
Birthdate	Age		
ULI	000000000		
Sex			
Search MPI	Y		
Med Rec Num			
EHR Num			
*Site	ACCESS		
Reason(s)			
Drop Down			

- Choose the **Episode** button on the footer to remove the clients discharge (for clients who have been discharged from HC only)
- Finish with completing all the **Edit Reg** ensuring that all sections with an \* are filled out in the required tab **Client** **Contact** **Addtl Census** **Insurance** **Risks** **Prov/Site** **Service Loc** **Allergies**

The Client is now registered in Care Manager

Confirm in the **Episode** tab that the client has an Active Episode with an open end date

Start Date	End Date	Status	Summary
02/10/18		Active	PROFESSIONAL NURSING

## Lifetime Account

(i.e.: All Seniors Health Clients)

- Access the **LT Document**
- Select **Add Intervention** from the footer button and search/add the **SOC: LIFETIME ACCOUNT (SOC)**
- Delete the (duplicate) interventions
- On Admission to determine client group (ie. Acute) document on the **Intake Assessment Community Care**
- Document on the **Safety Risk Assessment**

Do Not Forget to go into the **CM Values** and complete the required fields: Client Group, Case Manager Type and Priority

*Client Group   Effective Date	LTSUPPORT
Serv Priority   Effective Date	NEW
Case Manager Type	
Case Manager Effective Date	
Responsible User	
Priority	7DAYS
Next Contact Date	

## Program Account(s)

- Access the **New Request** to Register your **CLS Clinical Specialty** hospital program  
☒ **Lethbridge Acute Hospital** or home living program  
**Pgm Care Plan** add the **Standard of Care**
- In the hospital **TRANSTEAM TRANSITION TEAM**
- Document in the Program PCS on Transition interventions as needed

## Appendix M: Case Study Transition Team

### Day 1:

A new referral client to home care will be discharged from hospital to private home tomorrow.

The client had abdominal surgery 12 days ago for a hernia repair. He's anxious about going home and would like to have some personal supports for bathing.

The client will need assistance with wound care as he is unable to reach the wound.

The client lives alone and has a cat. English is his first language.

His **medical history** is type two diabetes, Obesity, high blood pressure, dyslipidemia, and high cholesterol.

### CSI information:

- Clients address is [1124 2<sup>nd</sup> Ave. E., Lethbridge, Alberta](#) or [1124 2<sup>nd</sup> Ave. E., Medicine Hat, Alberta](#).
- next of kin is Sister, Agnes, Who lives in Edmonton Alberta at [2728 White Mud Ave.](#) phone number is [780-565-2143](#).
- Person to notify is Nosy, Neighbor at [1120 2<sup>nd</sup> Ave., East Lethbridge Alberta](#). Phone number [403-388-0181](#).

### Lifetime Account:

- Add **SOC: Lifetime Account**, edit duplicate interventions.
- Document on the **Intake Assessment** indicating the physicians orders for wound care Protocol.

### Program Account:

- Do a **New Request** and add **Clinical Specialty (West) Hospital** or **(East) Hospital**.
- Go to **Program Care Plan**.
- Add Transition Team standard of care to the program account **Clinical Specialty (West) Hospital** or **(East) Hospital**
- Add **Blaylock** assessment to **Additional Interventions** section under the **General** button **(West only)**.
- Document on the **Blaylock assessment (West only)**.
- Document **Transition Discharge Planning** assessment.

### Day 2:

Client is going home today. In the hospital program:

- Document on **Transition Discharge Planning** assessment **(Transition Team)**.
- Update **Blaylock assessment (West only)**.

**(West only)** Enter a **New Request** for **Home care Home Living (West) Home Care**.

- Add SOC: **Adult program** under the Standard of Care tab
- Add the problem of **Personal Care** under the Problem Details tab.
- Edit modifiers document outcomes edit CC: interventions and keep only **CC: bathing**
- Document **Daily Living Support Plan** and outcome ratings.
- Create a **Service Authorization** for bathing services twice a week.



**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, Patient Care System (PCS), 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 Episode of Care	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Skill in understanding Lifetime Account vs. Program Account	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Skill in adding Acute Hospital Program	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Skill in adding Transition Standard of Care	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Skill in creating/editing Service Authorizations	1	2	3	4	5	N/A		1	2	3	4	5	N/A
Level of comfort with Outcoming Transition program	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?*

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*Feedback and additional comments*

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