

FAQ

Clinical Back-Office Staff

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homecare  homebaseSM



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Revision Table

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Non-Service Line Specific

Device/Field Staff Related Questions

I scheduled a recert visit to get the patient into HCHB for the first time. Why won't it go down to the DEVICE?

Make sure to use a "04" service code. This is a transition recert to get the patient into HCHB initially. Once all of your patients have been transitioned in, you will no longer use the 04 codes.

The field staff is constantly calling me to rearrange the schedules. Help!

Think of all PointCare visits on a "check in/check out" basis. Once the visit has been scheduled to a field user, they are responsible for accepting/declining/rescheduling the visit and syncing it back. The workflow will tell you what to do (i.e., reassign the visit to someone else, move the visit to another date). You should never go into the schedule and change visits without the workflow telling you to do so. Do not set precedence and move visits for field staff – make them accountable.

I processed a Declined visit back to the original nurse to do. Why won't it go down to her device?

The software recognizes that the user declined the visit for that day and won't reprocess it back down. In order for the software to re-recognize that user, one of several things must occur and be done by the scheduler:

1. Cancel the visit and put the visit back in the requested state. Then reschedule the visit.
2. Move the visit to another day or change the worker. Then change it back to how it was originally.

Then the visit will be ready for the field user to synchronize to retrieve the visit.

I just added a new physician to our database. How does the PointCare user update their DEVICE to have that doctor?

Each DEVICE user can update their physician tables by going into Maintenance and Refresh Physicians table. The process takes less than 1 minute to complete once they're connected to the Internet.

How do I know if the visit is ready to be synced down by the field user?

You should reference the Agent Summary Report. You can run it by specific client or worker. Once the visit appears on the report in PENDING status, it's ready for the field user to sync it down.



One of my nurses went to look up a patient's medical records and could not locate the patient on the client tab on their PointCare device anymore. Why are they no longer there?

A patient's medical records will stay on a clinician's device after completing a visit for a period of 7 days. Then, if no additional visits are scheduled to the clinician's device the medical records for the patient will be removed from the device. However, if a clinician is setup as a Case Manager and Team Member for a patient then their medical records will remain on their device throughout the patient's episode or benefit period.

Workflow Related Questions

The Administrative On-Call workflow is very overwhelming to me. How can I better manage the tasks?

Make sure you have a copy of the Administrative On-Call Procedure from the HCHB user manual. The diagram/flow chart is very helpful to understand what you are responsible for processing while on call. Also, make sure to use the various workflow filters (i.e., by client, by task).

I don't understand why a task is not on my workflow to process.

Make sure to get a copy of the Workflow Document from your management team. This puts the workflow events/stages on paper like a diagram – so you can better understand the process. Once you understand the Workflow Document, click on the Workflow Summary tab to see where a specific patient currently exists in the flow.

An order was written for an extra skilled visit for O&A of a patient's response to a new medication. Why didn't the scheduler get the message to schedule the visit?

If the order written affects the patient's medication profile, calendar, supplies and/or vital sign parameters each of the applicable Content Reason boxes must be selected to direct the user into completing the order appropriately. These are called "Transactions". Transactions should be used to Add/Edit/Delete existing visits, supplies, meds, etc. Once the order is approved, workflow will generate to the next responsible position to complete the subsequent transaction.

How do I handle "Follow Up" tasks on my workflow?

Some tasks may be set up to escalate to the next level if the primary user hasn't performed a task within the designated timeframe. As an example, if the scheduler doesn't "Process Declined Visit" in the allotted time, it may escalate to the Clinical Supervisor's screen as "FU Regarding Delay to Process Declined Visit." Note: If you process the task, it will be removed from the scheduler's workflow screen.



Why won't an order show up on the workflow to be approved?

If an order contains unlisted medications, those unlisted items must be processed from the workflow before the order will show up to be approved.

MISC. Questions

How do I get a copy of the latest user training manual?

All manuals are posted in Homecare Homebase Central under the Resource Center section/User Manuals.

Why do we see the same patient listed several times in the Clinical Input screen?

As patients are recertified in HCHB, you will see the various episodes listed. Also, if patients are deemed a Non-Admit and then ultimately Admitted, you'll see different line items. Make sure to access the correct episode when entering orders, coordination notes, etc.

Why is the Agent Summary Report so important?

This report displays all visits that have been scheduled and are due back in the office. Bottom line is – if a visit is shown on the list, the DEVICE user has not finished it and synced it back to the office. This report should be run at least daily and field staff contacted to get the visits in.

Who do I contact when I need help or have problems?

Your agency has several designated “point persons” for field and office staff. These people are your first point of contact. These key people may contact HCHB's Customer Support Center if needed.

How do I enter a QI form for a patient?

All QI forms (Infection Control, Complaint, Occurrence, and Medication Error) can be entered on the DEVICE or in the office. Note: If your agency enables the system setting to complete these forms outside of a visit, you will find them within the Features Section of the patient's medical records. Within a visit they are found within the PRN section.

Why do we have so many different service codes?

Service codes are types of visits and drive exactly what forms/questions appear on the DEVICE for completion. Example: if a Sup Visit is scheduled, the PointCare user is given all of the supervisory visit forms for completion. You should be cognizant to schedule “like” codes with each other. For example, if a Pediatric Admission was performed, all subsequent visits should be Pediatric too.



Ditto for IV patients – if an IV admission was performed, all subsequent visit service codes should be IV too.

The payroll transmittal form cuts off and I can't see or print the full page. Why not?

This report is set up for legal size paper and has $\frac{1}{4}$ margins. If you are unable to preview/print the entire page, it is due to your printer default settings. Try switching to another local printer to see if that clears up the problem.



Home Health Specifics

Device/Field Staff Related Questions

How do I update the existing Problem Statements so that DEVICE users get appropriate Interventions and Goals?

The normal process would be to complete a Plan of Care Update Order which can be completed from back office or from within a PointCare visit. This will allow the client's pathway (or care plan) to be updated and will update the applicable interventions and goals available for documentation purposes. However, it is also possible to edit the existing Problem Statements, which will in turn generate new Interventions and Goals through Clinical Input and choose Visit Notes. Right-click on the RN00 visit, and choose the Edit/View Problem Statements/Care Plan option. If there was a ROC or FU visit after the RN00, then the last OASIS visit should be edited instead of the RN00. And then add-on visits would have their own set of Problem Statements to edit.

Why won't a recert visit show up on a device?

Recert visits won't show up until the new PENDING episode is created. This episode gets created when the recert option is chosen during the Recert/DC decision stage.

OASIS Questions

What are the definitions of the various OASIS status types?

Unlocked – The status until the Edit/Lock OASIS task is completed in workflow.

Locked – The Edit/Lock OASIS task has been completed and the OASIS data is ready to Send.

Do Not Send – for patients whose payor does not require data to go to Medicare and for any patient under the age of 18.

Accepted – Once a batch is submitted the return Validation Report indicates all OASIS that were Accepted.

Rejected – Once a batch is submitted the Validation Report indicates any OASIS that were Rejected, meaning correction of some key or non-key field(s) is needed.

Sent – A batch has been submitted but the validation report has either not come back or it been worked yet.

Key Field Correction – Key fields are highlighted in black and are more demographic in nature but can vary by type of OASIS assessment (see how to make corrections later in this document).



Non Key Field Correction – Non Key Fields are not highlighted and are clinical answers.

What should I do if the OASIS assessment is submitted and accepted by the state, and my agency determines that a correction must be made to a key field?

Right click on the assessment and mark it “accepted”. Then right click on the assessment and choose “inactive and correct key fields”. Make the necessary corrections to the key field.

Right click on the assessment and lock the assessment.

What items are considered ‘Key Fields’?

- Patient’s first and / or last name
- Social Security number
- Date of birth
- Gender
- Agency ID code
- Reason for completing assessment
- Date assessment completed (a key field only on recert or SCIC assessment where reason for assessment = 04 or 05).
- SOC Date (a key field only on SOC assessments where reason for assessment = 01). Resumption of Care Date (a key field only on resumption of care assessments where reason for assessment = 03).
- DC, death at home, transfer, death date (a key field only on transfer to inpatient facility assessments where reason for assessment = 06 or 07, death at home assessments where reason for assessment = 08 and discharge assessments where reason for assessment = 09).

What should I do if the OASIS assessment was submitted and accepted by the state and my agency determines that a correction should be made to a non-key field item?

Right click on the assessment and mark the assessment “accepted” if this hasn’t been done. Then right click on the assessment and choose “correct non-key fields”. Make the applicable corrections and re-submit the corrected assessment to the State. The correction number field will be incremented.

What should I do if the OASIS assessment was sent and rejected because the patient is a child and should have never been sent to the state?

Right click on the assessment and mark the assessment “rejected”. Then right click on the assessment and lock it. Once locked, right click on the assessment and mark the assessment as “do not send.” If you catch these assessments



before they are sent to the state (the assessment is still in the “locked” status), right click on the assessment and mark as “do not send.” If the care type is pediatric or perinatal the system will automatically mark them Do Not Send.

MISC. Questions

How do I indicate that a patient has been transferred to the hospital?

Go to clinical input, right click on the patient, select medical records info, go to orders and Add an order. Make sure to select “Hospital Hold” as the type of order. If your agency does not send these orders to the physician for signature, make sure there is an N in the box

“Send to Physician?” This kicks off the event to place the patient on hold: the order must be approved (even if it doesn’t go to the physician), the scheduler is then tasked to schedule a Transfer to Inpatient Facility data collection only “visit”. The remaining visits are removed from the calendar and the patient's status is automatically changed to “Hold.”

A Transfer to Inpatient Facility visit type can also be completed within clinical input by selecting visit notes and ‘Add Visit Note’. You will be prompted to choose the correct type of visit note to add. Complete the assessment and mark it done.

When a patient resumes their care after an inpatient hospital stay, what do I do?

Go to Clinical Input, right click on the patient, go to Medical Records Info and Add an Order. Make sure to select “Schedule ROC Visit” as the type of order to kick off the appropriate workflow (see separate Workflow document). Just schedule the one post hospital visit to be performed. The nurse/therapist who performs the post hospital visit will then set up the patient’s calendar, diagnoses, etc.

When I add an order, what are the various types used for?

- There are 9 different Order Types [485, Add On, Discharge from Agency, Follow-Up (SCIC), Hospital Hold, Physician Verbal Order, Plan of Care Update Order, Schedule ROC Visit, and
- Resumption of Care]. It’s very important that you select the appropriate type in order to kick off the appropriate workflow. It’s very important to know that:
- Discharge = is from the agency [not the discipline]
- Follow Up = is a SCIC [not a routine, regular order]
- Physician Verbal Order = “regular”, routine orders

Pay close attention to the order type selected!



Hospice Specific

Workflow Related Questions

When / how do I process the Recert Order Due workflow?

This order will generate at a specific timeframe established by your agency. When completing this workflow, you will be required to 'plot' the visits for each discipline who will remain in the patient's plan of care for the next benefit period. This information can be gathered at the IDG meeting when discussing the patient's eligibility criteria and confirming they will remain on service for another benefit period.

HIS Related Questions

What are the different HIS statuses?

- Lock – use to verify record completion.
- Unlock – used to unlock a previously locked record.
- Accept – marking a record accepted indicates that ASAP has accepted the record.
- Reject – marking a record rejected indicates that ASAP has rejected the record. Modify Key Field Correction – allows corrections to the bolded items in the record.
- Modify Non-Key Field Correction – allows corrections to all other items (not bolded) in the record.
- Inactivate – if a record has been sent to ASAP, has been accepted, and the corresponding event did not occur the erroneous record will be removed from ASAP.
- Do Not Send – HIS records marked Do Not Send is not eligible for file creation.

MISC. Questions

When I add an order, what are the various types used for?

- There are different Order Types [Hospice POC, Hospice Add On, Hospice Discharge, Physician Verbal Order, and Plan of Care Update Order]. It's very important that you select the appropriate type in order to kick off the appropriate workflow. It's very important to know that:
 - Discharge = is from the agency [not the discipline]
 - Physician Verbal Order = "regular," routine orders
- Pay close attention to the order type selected!



How do I change the patient's level of care during the benefit period?

A patient's level of care can be changed by writing a Hospice Physician Verbal Order. Select the patient in clinical input, right click, access medical records info and select Orders. Add a new order. Ensure the date / time reflects the correct date and time of the actual change in level of care for the patient.

How often should I review the IDG Console?

The IDG Console should be reviewed regularly to ensure the IDG dates listed are the actual dates the IDG meeting will occur. Keeping the meeting dates accurate ensures the clinician can access the IDG Meeting Note on the device timely. It is also important to verify the client has only one IDG meeting reason. If more than one exists, for example a 'recurring' meeting and a 'recert order due' meeting, the 'recurring' meeting should be voided and the 'recert order due' meeting will be completed. Voiding meetings timely will prevent duplicate IDG Meeting Notes for the clinician to complete for the same IDG meeting date.



Disclaimer

HCHB has made every effort to ensure that the information in this manual was correct at the time of publishing. All names, places, and examples are either the products of the author's imagination or used in a fictitious manner. Any resemblance to actual persons or actual events is purely coincidental.
