Health Information Management (HIM)
Job Orientation & Training (JOT)

Table of Contents

Approximate Total Time= 28.5-30 hrs.

Unit 1: Introduction and Navigation

Purpose:
To identify the sites and communications where the majority of HIM and Electronic Medical Record (EMR) resources are located, and where you will be directed to throughout this training.

☐ Go to the [HIM Site](#) and bookmark or save to your Favorites in your web browser.

☐ Navigate to the [EMR site](#) and bookmark or save to your Favorites in your web browser.

☐ **Note:** Vital communications will be sent out via several types of email communication. Please ensure you are checking your email daily.

Total Approx. Time for Unit: 5 minutes

Unit 2: Legal Medical Record

Purpose:
- The GSS legal medical record consists of PointClickCare (PCC) and OnBase.
- The HIM role ensures that the location's electronic medical records and paper medical records (inpatient and community outpatient as applicable) are maintained.
- This unit will teach you how to access PCC Training Database for practice, PCC Live Database as part of the legal medical record, and PCC resources in the PCC database.

PointClickCare (PCC)
- ☐ Watch the 3-minute video Logging in and Out by clicking on this link.
- ☐ Log into the PCC Training Database using the below:
  a. Username: **gsstrain._____**   Example: *gsstrain.sd**him***
      (state abbreviation + him)
  b. Password: **welcome**

NOTE: The PCC training database is available to you for training purposes during your HIM JOT and after. **Do NOT enter resident information in the PCC training database**.
- ☐ Log out after you have looked around.
- ☐ Log into PointClickCare (PCC) (Live) now using the below:
  a. Username: **gss._____**   Example: *gss.jdoe1*
  b. Password: **(GSS password)**
  o From the PCC Home page, select **"?"** for the **Resource Hub** menu > Click **Customer Support Portal.**
  o Here is where you will locate helpful resources by typing the name in the search bar for the following:
    - Generating Clinical Charts
    - Viewing Clinical Charts
    - Documenting Medical Diagnoses
    - Ranking and Classifying Medical Diagnoses
    - HOW TO: Resolve/Strike out **Medical Diagnosis** From Resident's tab
    - Managing Diagnosis Notifications
    - Managing Diagnosis Sheets
    - Medical Diagnoses Reports and Dashboards
    - Completing and Updating Resident Detail
    - Accessing the Resident Demographics
    - Using the Resident Listing
    - Resident Information Reports and Dashboards

OnBase:
- ☐ Open **OnBase Unity Client Local from Sanford Apps>Storefront>Apps**.
  o This is the version of OnBase that the HIM role will use for scanning/indexing and re-indexing.
  o Once you open this for the first time you will find OnBase Unity Client Local on your toolbar or just listed in Sanford Apps on your computer.
- ☐ Go to the **EMR** site you bookmarked previously.

- Click on **Scan & Retrieval,** then **GSS List of OnBase Knowledge Based Articles for Skilled Nursing, O/P Therapy and Home Based Services**.
    - View the resources to become familiar with what is available.
    - View the resources under the Skilled Nursing and Outpatient Therapy – Unity Client.

Total Approx. Time for Unit: 45 minutes

Unit 3: Health Information Management (HIM) Resources

☐ **Learning Activity 1 - HIM Daily Tasks List**
1. Go to the **Electronic Medical Records (EMR) site** and click the **Health Information Management** menu item.
2. Complete these tasks and check each box.
   ☐ Locate **HIM Daily Tasks** document and identify who completes each item on the daily task list and when it is completed.
☐ **Learning Activity 2- HIM Admission, Discharge and Death Checklists**
1. Go to the **EMR** site and click the **Health Information Management** menu item.
2. Locate and review the following, identifying who completes each item on each list.
   ☐ HIM Admission Checklist
   ☐ HIM Discharge Checklist
   ☐ HIM Death Checklist

Total Approx. Time for Unit: 30 minutes

Unit 4: Medical Diagnosis Management

☐ **Learning Activity 1**: **ICD-10-CM Certificate Program**
  ☐ Complete the ICD-10-CM Certificate Program via the Success Center by following the below steps:
  - Navigate to **Inside Sanford**
  - Click on the **Success Center** on the top menu
  - Log in using your GSS username and password
  - Click on **My Learning**
  - Click on **ICD-10-CM Certificate Program** and complete
  - Email the **Certificate of Completion** to your HIM Senior Analyst upon full completion of the program.

☐ **Learning Activity 2: Diagnosis Management**
  ☐ Log into the PCC Training Database using the below:
    a. Username: **gsstrain._____**   Example: **gsstrain.sdhim**
       (state abbreviation + him)
    b. Password: **welcome**

  1. Compete the below tasks using the **PCC Medical Diagnosis Job-Aid** to guide you *(located on the **EMR Site** under **Health Information Management**)*.
    ☐ Select any fictitious resident in PCC Train under **Clinical>Residents**.
    ☐ In the **Med Diag** tab, enter the below ICD-10-CM codes into the diagnosis module:
      ▪ F03.90 Unspecified dementia without behavioral disturbance
      ▪ J44.1 Chronic obstructive pulmonary disease with (acute) exacerbation
      ▪ R53.1 Weakness (generalized)
    ☐ Rank/classify each diagnosis
    ☐ Mark one of the diagnoses as Therapy "T"
    ☐ Strike out one medical diagnosis
    ☐ Resolve one medical diagnosis

2. Use the Display Filters within the Diag Module in PCC to view Struck out or Resolved Medical Diagnoses.
    a. Click **⊞ Display Filters** to open the Display Filters
    b. Select or unselect the desired Status type:
        I. Active Diagnosis (checked automatically)
        II. Resolved
        III. Struck Out
3. Review the Diagnosis list to see the populated list of Diagnoses
    a. If the Diagnosis had been resolved, a date will appear in the **Resolved Date** column.
    b. If the Diagnosis had been struck out, a line will show crossed through the diagnosis description along with the reason for the strike out.

Learning Activity 3: Diagnosis Sheets
1. In PCC Train, complete the following tasks using the **Creating and Managing Diagnosis Sheets – PCC Financial** *(EMR Site under Health Information Management)* resource to guide you.
    ☐ Create a Primary Diagnosis Sheet using the first of the current month as the effective date.
    ☐ Create a Therapy Diagnosis Sheet (for all Med B Services, not just therapy services) using the first of the current month as the effective date.
    ☐ Use the filter options in the Diag Module in PCC to see only the resolved medical diagnoses.

Total Approx. Time for Unit: 16 hours

Unit 5: Medical Diagnoses Impact on Reimbursement

- ☐ **Learning Activity 1: Medical Diagnosis Coding Resources**
  1. Navigate to the **EMR site** and click on **Health Information Management** on the left hand menu.
  2. Review all of the resources pertaining to medical diagnoses and ICD-10-CM, including those for community outpatient therapy (if applicable).
- ☐ **Learning Activity 2: PCC Dashboards**
  - There are two dashboards in PCC directly related to Diagnosis Management and reimbursement. They are:
    1. **Diagnosis Notification Dashboard**
       - To access this dashboard, navigate to **PCC Live login>Clinical> Dashboards> Diagnosis Notification Dashboard**
       - Locate the Diagnosis Notification Dashboard and use the Diagnosis Notification Management job aid to review notifications and discuss them with your MDS coordinator.
    2. **Trial UB Dashboard with Warnings/Errors**
       - To access this dashboard, navigate to **PCC Live login>Admin>Dashboards>Trial UB Dashboard with Warnings/Errors**
       - You will receive notifications on the Trial UB Dashboard with Warnings/Errors in PCC. This Dashboard will give you information such as missing Diagnosis Sheets, diagnosis coding errors and missing provider information. Note: These types of errors are the only ones that HIM needs to address. There will be other types of errors that other parties will be responsible for.

Key Takeaways:
- HIM is responsible for the management of medical diagnoses upon admission, during stay and upon discharge, including the assignment of ICD-10-CM codes for current and active medical diagnoses in PCC.
- HIM is responsible for monitoring documentation for new or resolved diagnoses from admission to discharge to reflect the resident's current clinical condition and story.
- Primary Diagnosis Sheets must be generated for every resident upon admission using the admission date as the effective date for the first month of service, and the first of the month for each month of service after.
- Therapy diagnosis sheets must be generated for every resident receiving any Medicare Part B service (therapy, labs, telehealth, transportation, etc.) for that month of service using the admission date as the effective date if during the month of admission, and the 1st of the month for each month of service after.
- If there are any changes to diagnoses (new, resolved, ranking, classification, etc.) during a month, you will need to generate a new diagnosis sheet after the changes are made using the same effective date as the original diagnosis sheet for that month (admission date or 1st of that month).

- If there is a change of payor during the month, a new diagnosis sheet(s) will need to be generated using the effective date of that payor change.
- HIM and MDS should partner to ensure current active diagnoses are reflected in section I of the MDS, and that it is communicated when there are issues or when changes are needed so that proper steps (such as refreshing the MDS or resolving a diagnosis) can occur.
- Accurate medical diagnosis coding is imperative for telling the resident's current clinical story, and has a huge impact on reimbursement.

Total Approximate Time for Unit: 1 hour

Unit 6: Scanning and Indexing of Legal Medical Records

☐ **Learning Activity 1: Scanning of Legal Medical Record (LMR) Paper Documents**
- ☐ Review the **Scanning of Legal Medical Records (LMR) Paper Documents** policy on **Inside Sanford>Sanford Policies.**

☐ **Learning Activity 2: OnBase Resources**
- ☐ Go to the **EMR site>Scan & Retrieval** and click on the **GSS List of OnBase Knowledge Based Articles for Skilled Nursing, O/P Therapy and Home Based Services**
  - Become familiar with the following resources (job aids and videos available):
    - Scanner Ergonomics
    - Scanner Cleaning Process
    - GSS SNF, OPT & HBS - Patch Code Page Ordering & Printing
    - GSS SNF & OPT- Clinical Document Types Reference Guide
    - GSS SNF & OPT - Logging into OnBase using Unity Client
    - GSS SNF & OPT - Document Scanning using OnBase Unity Client
    - GSS SNF & OPT - Importing, Drag n' Drop and Virtual Printing using OnBase Unity Client
    - GSS SNF & OPT - Document Indexing using OnBase Unity Client
    - GSS SNF & OPT - Therapy Document Indexing using OnBase Unity Client
    - GSS SNF & OPT - Reindexing using OnBase Unity Client
    - GSS SNF & OPT - Document Retrieval using OnBase Unity Client
    - GSS SNF & OPT - Search and Retrieval using OnBase Unity Client Custom Query
    - GSS SNF & OPT - Sending Documents to Correction Workflow using OnBase Unity Client
    - Document or Batch Lock in Unity Client
    - GSS SNF & OPT – Generating OnBase Clinical Chart

☐ **Learning Activity 3: OnBase Scanning and Indexing**
1. From **Sanford Apps**, search for **OnBase Unity Client Local** and open.
2. Compete the following tasks utilizing the above resources. Check each box as completed.
   - ☐ Log into OnBase Unity Client Local
   - ☐ Scan paper clinical documents
   - ☐ Index documents in OnBase Unity Client Local
   - ☐ Search for multiple scanned documents in OnBase Unity Client Local via Retrieval and Custom Queries.
   - ☐ Log into PCC Live (https://login.pointclickcare.com/home/userLogin.xhtml)
     - o Under **Home>External Links** click **Document Search**
     - o Search for scanned documents.

☐ **Learning Activity 4: Focus Audit**
- On Inside Sanford>Sanford Policies, locate and review the **Focus Audit – Clinical Document Scan/Retrieval** policy.

Total Approx. Time for Unit: 2 hours

Unit 7: Telephone and Verbal Orders

☐ **Learning Activity 1: Policy**
1. Review the **Tracking Telephone/Verbal Orders** policy on **Inside Sanford>Sanford Policies**.

☐ **Learning Activity 2: Process**
1. Identify your location's process for tracking telephone verbal orders.
2. Where are the unsigned orders located and record below?
   a.
3. How often is HIM following up with the provider regarding unsigned orders? And by what means (phone, fax, in person, etc.)? Record your responses below.
   a. How often?
   b. What means?

Total Approximate Time for Unit: 30 minutes

Unit 8: History and Physical

What You Need to Know:
The health information management (HIM) department is responsible for the following tasks:
- Maintaining a tickler file for the following:
    - Admission required H&P
    - Updates to the H&P *(state laws and regulations must be reviewed to determine the need for updates to the H&P. Specific states may require a yearly update to the H&P.)*
    - Contacting physicians for completion of required H&P.
    - Documenting in the medical record any contact/communication with the physician to complete a required H&P. This documentation may be completed in the PN – Communication/Visit with Physician.
    - Contacting hospitals for copies of the H&P, if the resident is admitted following a hospitalization. This communication/contact must also be documented in the medical record.
    - Involving the medical director and/or location administration in cases when the attending physician has not responded to completing the H&P.

☐ **Learning Activity 1:**
1. Review the **History and Physical** and **PN – Communication/Visit with Physician** policies.

☐ **Learning Activity 2:**
1. Identify your location's process for tracking history and physical requirements and record below.
    - ❑
2. Identify your state's laws and regulations regarding updates to the H&P (for example, is there a yearly update requirement?). Record below:
    - ❑

Total Approximate Time for Unit: 30 minutes

Unit 9: Medical Professional Management

- HIM is responsible for managing medical professionals in PCC to include:
    - Running a **Medical Professional List** from PCC
    - Entering a new **Medical Professional** in PCC
    - Editing an existing **Medical Professional** in PCC
    - Ending a **Medical Professional** that is no longer active in PCC
    - Using the **NPI Registry Search**

- **Learning Activity 1: Enter a New Medical Professional with National Provider Index (NPI) Registry**
    1. Go to the **EMR** site and click on the **Health Information Management** left hand menu item.
    2. Open the **Managing Medical Professionals in PCC** document and review the process.
    3. In the PCC train environment for your location, enter a new medical professional with NPI.
        a. This medical professional can be made up since it is for practice in the PCC training database (not live).

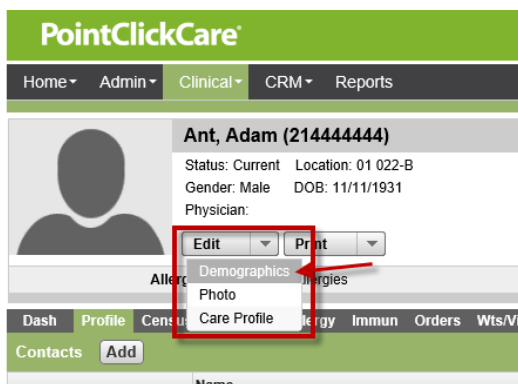**Total Approx. Time for Unit:** 30 min

Unit 10: Physician's Visits/Order Reviews

Policy & Procedure(s)/Resources:
- Physician Visit-Order Review Process for nonPE – Job Aid
- Physician/Practitioner Orders policy
- Physician's Visits policy
- Physician Visit/Order Review Tracker Spreadsheet – *EMR site*
- Change of Attending Physician policy

☐ **Learning Activity 1**
1. Log in to the **PCC Training Database** and navigate to the **Resident Detail Page** to set the **Physician Visit Order Review Schedule** upon admission.
2. Navigate to a resident's clinical record > click **edit** in header > **Demographics.**
3. Enter a date for the **Physician Visit & Order Review.**
   1. First entry is the admission date.
   2. Update each time the resident has a **Physician Visit/Order Review**.

☐ **Learning Activity 2:**
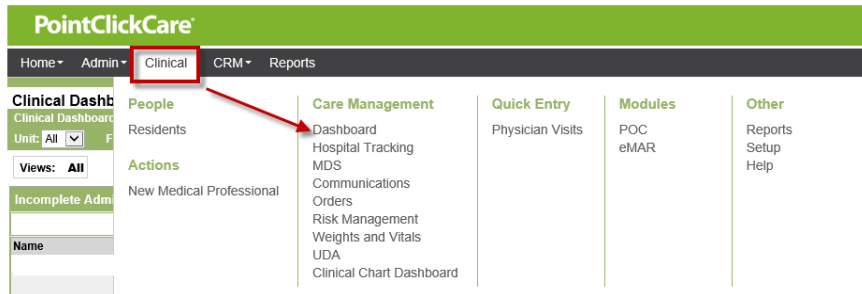1. Locate the **Quick Entry Order Review** by following the below steps. This functionality can be used to document subsequent Order Reviews.
2. **Clinical > Quick Entry > Physician Visits**
3. After setting filters as needed, select the name of the resident(s) visited.
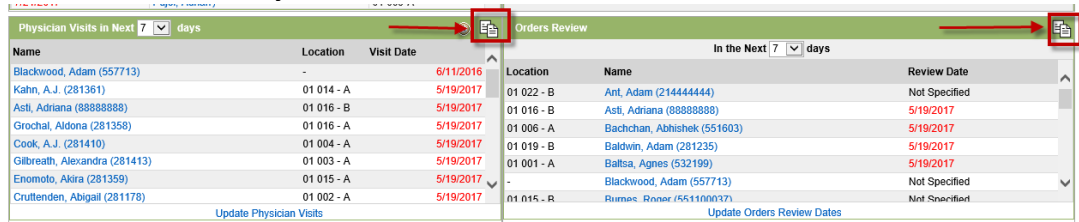4. Click **Mark as Visited**.
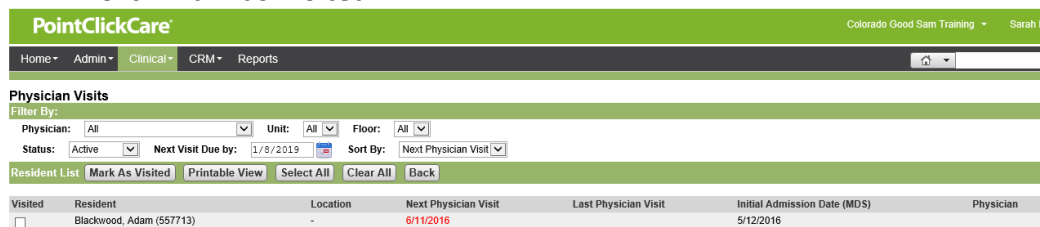
☐ **Learning Activity 3:**
1. Navigate to the **Clinical Dashboard** in the PCC Train environment.

2. Locate the **Physician Visit and Order Review Dashboards.**

3. Practice running reports by clicking the paper symbol in the right corner of the dashboard.

Hints and Tips

You can filter to see residents that are due for visits in the next 0-14 days. The dashboard shows the name of the resident, their location and next scheduled visit date per your system configuration. Red dates indicate that the Physician Visit is overdue. To document a Physician Visit, click the **Update Physician Visits** blue hyperlink on the bottom of the Dashboard. The **Quick Entry - Physician Visits** area appears. Follow the above **Quick Entry** instructions.

- Filter by **Physician, Unit, Floor, Status, Next Visit Due By**.
- Sort by **Next Physician Visit, Resident Name** or **Location**.
- Can create **Printable View**.

☐ **Learning Activity 4:**
1. Identify how your location is currently tracking physician visits/order reviews.
2. Review the **Physician Visit/Order Review Tracker spreadsheet** on the **EMR site>HIM** as a tool for tracking.

☐ **Learning Activity 5:**
1. Log into the PCC Live environment and run paperwork for the next set of physician visits/order reviews.
   - Run the **Medication Review Report** by following the below steps:
     - **Clinical > Reports**
     - Select **Medication Review Report** or **Order Summary Report** and practice filtering reports.

- Run the **Diagnosis Report New*** by following the below steps:
  - **Clinical > Reports**
  - Select **Diagnosis Report New*** and practice filtering the report.

PointClickCare

Home | Admin | Clinical | CRM | Reports

Diagnosis Report *NEW* - Report Setup

Report Options

Resident Number:	Leave blank for all residents
Resident:	clear
Unit:	All

Floor:	All
Status:	Current
Group By	Diagnosis
Sort By	Name
☐ Summary Only	
Report Output Format	PDF

Filter Options

Resident Fields

☐ Admission Date
☐ Primary Physician

Diagnosis Details

Diagnosis Date Range *   12/01/2018 to 12/31/2018

Status *

☑ Active
☐ Resolved
☐ Struck Out

Uncheck resolved DX →

☐ Code
☐ Rank
☑ Therapy
☐ Inactive Codes Only
☐ Classification

● Both ○ No ○ Yes

Diagnosis Audit Details

☐ Created Date
☐ Revision Date

***For Locations Utilizing Practitioner Engagement (PE) Only**
If you do not know if your location utilizes PE, ask your Administrator.
Some locations utilize Practitioner Engagement (PE), which is the ability for practitioners to electronically sign order reviews within PCC rather than signing a paper copy in wet ink.

☐ **Learning Activity 1**
1. Go to the **EMR** site and click on the **Practitioner Engagement** item on the left hand menu.
   ☐ Review the Practitioner Engagement: Training Resources List and check the box when complete.
2. Click **E-Sign Order Reviews** and review the below job aids and resources. Check each box when complete.
   - Complete Order Reviews
   - Practitioner Engagement Mark Order Reviews as Previously Signed in Wet Ink
   - Workflow for Physician Visit-Order Review Schedule in PCC

<u>Telehealth:</u>
All Telehealth visits will have supporting documentation that will either be scanned/indexed following the visit, or the provider will document directly into the EMR.
☐ **Learning Activity 1:**
1. Talk with your Administrator to determine if your location uses Telehealth services, and how you will be engaged to manage the supporting documentation of each Telehealth encounter. Record below:
   a. Answer:

2. Locate the **HIM Workflow for Telehealth Visits** on the **EMR Site** under **Health Information Management.**

Total Approximate Time for Unit: 1.5-2 hrs. (depending on PE)

Unit 11: Medicare Management

☐ **Learning Activity 1:**
- The HIM, case manager and/or designated employees should ensure the following:
  - The GSS #900 is completed, signed and dated by the attending physician, another physician familiar with the case or by a physician assistant, nurse practitioner or clinical nurse specialist who does not have a direct or indirect employment relationship with the SNF, but who is working in collaboration with the physician.
  - Admission certification is completed at the time of admission or prior to day 14. Enter the admission date prior to sending to the practitioner for signature and date.
  - Recertification is completed on or before day 14 of skilled coverage, and at intervals not exceeding 30 days thereafter.
  - The GSS #900 is maintained until the end of the episode of skilled care, and it is scanned/indexed in the medical record as completed each time.
- Navigate to **Inside Sanford** and click on the **Society Forms** tab on the left hand menu.
  - Review the **Physician Certification/Re-Certification** (GSS #900)
  - Review the **GSS#900 Instruction Sheet**

☐ **Learning Activity 2:**
1. Go to the **EMR Site> Health Information Management** and complete the following:
   - ☐ Locate the **Health Information Management (HIM) Medicare Team Meeting Checklist** and utilize this for these activities and moving forward for Medicare Team meetings.
2. Identify items on the checklist that HIM will be responsible for and complete the following:
   - ☐ Determine residents receiving services covered by Medicare Part A or Part B including Community Outpatient, as applicable.
     - Type **"Resident List Report"** in the search bar and hit enter.
     - Run the **Resident List Report *NEW*** (clinical or admin) report to include outpatients.(Note: It will be mixed with SNF residents) and work with your clinical team to determine which residents are on Med A, Med B and community outpatient.
   - ☐ Determine if therapy documentation (including Therapy Service Logs, Evaluations/Plans of Treatment/Updated Plans of Treatment, Therapy Discharge Summary, etc.) is up to date for scanning and indexing and signatures (as applicable).
   - ☐ Determine process for maintaining Physician Certification and Recertification (GSS #900) forms and therapy plans of treatments to ensure they have been distributed for signature, signed and returned in a timely manner and scanned/indexed into OnBase following each skilled episode of care.

☐ **Learning Activity 3:**
1. Go to the **EMR** site and click on **Record Requests/Disclosures** on the left hand menu.

- ☐ Locate and review the **PCC Clinical Chart – Medicare/Managed Care Review** as well as the **OnBase Clinical Chart – Medicare/Managed Care Review** to support the request for information for Additional Development Requests (ADRs) and other medical reviews.
- ☐ Determine the transmission status of Medicare-required MDS assessments and report the PDPM level for these assessments.
  - ▪ Collaborate with MDS coordinator.

Total Approx. Time for Unit: 1 hour

Unit 12: Minimum Data Set (MDS)

☐ **Learning Activity 1:**
1. Review the **Minimum Data Set Transmission Process** policy.
2. Collaborate with the MDS Coordinator to transmit a MDS (this is done at least weekly).
   a. *(HIM may complete the Entry Record and Death in Facility Record.)*
3. Discuss medical diagnosis/ICD-10-CM coding management in relation to MDS Section

☐ **Learning Activity 2:**
1. Log into **PointClickCare (PCC) Live.**
2. Under the **Clinical** dropdown at the top, navigate to the **Care Management** menu and click the **MDS** link.
3. Review **MDS portal** for warnings, errors and messages after MDS submission.
4. Review **Error Messages on Final Validation Report** located on the **EMR site** under the **MDS section**.

Total Approx. Time for Unit: 15 minutes

Unit 13: Community Outpatient Therapy

☐ **Learning Activity 1:**
1. Go to the **EMR** site and click on the **Health Information Management** tab on the left hand menu.
2. Go to the **Community Outpatient Therapy** section.
3. Read the following and check each box when you are finished.
   ☐ HIM Community Outpatient Therapy Admission Checklist
   ☐ HIM Community Outpatient Therapy Discharge Checklist

Total Approx. Time for Unit: 15 min.

Unit 14: Hospice

☐ **Learning Activity 1**

    ☐ Review the below section from the **HOSPICE SERVICES PROVIDED IN A SKILLED NURSING FACILITY** policy. Check the box when completed.

"Legal Medical Record documentation: "The medical records for residents who are under care of a hospice agency are property of the rehab/skilled care location. Hospice employees may document in the medical record and have access to the medical record. Hospice requests for copies of medical record documentation must be routed to the health information management department or designated location employees. Hospice employees are allowed full access to the medical record, as well as documentation stored and documented electronically, for those residents who are under current care of the hospice agency. Hospice employees must not access (read/review) medical records for residents who are not receiving hospice services, unless a referral has been made to hospice".

"Scanning/Indexing: "Physician/Practitioner orders – Hospice standing orders (as applicable) will be scanned and retrievable in OnBase – Outside Orders with a description field entry of hospice standing orders.
Hospice agency documentation will be integrated into the SNF medical record via scanning or documentation in the EMR."

"Physician visits/Order Reviews: Residents receiving hospice services must continue to be seen by a physician at the federally required intervals. See Physician's Visits in the HEALTH INFORMATION MANAGEMENT policies and procedures. The resident has the right to refuse to be transported to an outside visit and it would be appropriate for the clinical team to document this in a progress note in PointClickCare (PCC)."

    ☐ Meet with the clinical team and discuss how your location communicates with Hospice. Check the box when complete.

    ☐ Assure Hospice has access to forms for writing orders such as physician order forms. Check the box when complete.

Total Approx. Time for Unit: 15 min

Unit 15: EMR Integrations and Features

Does your location use Practitioner Engagement/e-signing (Y/N)
If No, move to PCC Therapy Tab.

Learning Activity 1:
If your location is utilizing Practitioner Engagement (PE), navigate to the **EMR Site**.
1. Click the **E-Sign Orders** link under **Practitioner Engagement**.
2. Review the following resources and check the boxes below when complete.
   - ☐ **Practitioner Engagement: Electronically Sign Orders**
   - ☐ **Practitioner Engagement: Mark Orders as Previously Signed in Wet Ink**
   - ☐ **Practitioner Engagement: Telephone-Verbal Order Reports**
   - ☐ **Practitioner Engagement: Workflow for Orders Pending Signature**

Learning Activity 2:
E-Sign Order Reviews
1. Click the **E-Sign Order Reviews** link under **Practitioner Engagement**.
2. Review the following resources and check the boxes below when complete:
   - ☐ **Practitioner Engagement: Complete Order Reviews**
   - ☐ **Practitioner Engagement: Mark Order Reviews as Previously Signed in Wet Ink**
   - ☐ **Workflow for Physician Visit-Order Review Schedule in PCC**

Learning Activity 3:
PCC Therapy Tab
PointClickCare has a therapy tab in the Clinical module. This tab is a tool only, and is not part of the legal medical record. Therapy documentation is automatically imported into the indexing queue based on the import schedule, and still needs to be indexed into OnBase for the clinical team to access it and for it to become part of the legal medical record. Plan of Cares (POCs) and Updated Plans of Care (UPOCs) still need to be printed from the indexing queue once imported, wet signed/dated, and scanned/indexed back into OnBase. The original, unsigned copy in the indexing queue can then be deleted.

Total Approx. Time for Unit: 15min-0.25 hours depending on what integrations they have.

Unit 16: Electronic Medical Record (EMR) Outage Process

Learning Activity 1:
1. Go to the **EMR** site. On the homepage, click on the **Click Here** for the PCC EMR Outage documentation and reference information.
2. Review the following resources and check each box when complete.
   - ☐ EMR Outage Process Document
   - ☐ EMR Outage Binder Cover – All Locations
   - ☐ EMR Outage Process Document Table of Contents
   - ☐ EMR Outage Poster Template All Locations-Centers to Update
   - ☐ EMR Outage Printing Instructions – All Locations
   - ☐ Self-Serve eMAR Backup process
   - ☐ eMAR Outage Process (Sanford Service Center Assisted Only)
   - ☐ PCC and OnBase Outage policy & procedure

Total Approx. Time for Unit: 1 hour

Unit 17: Health Department Survey

☐ **Learning Activity 1: Health Department Survey Process**
1. Navigate to the **QAPI- Rehab/Skilled** site by clicking on the following link: https://internal.sanfordhealth.org/entities/TheSociety/reg/Updates/Forms/AllItems.asp
2. Click on **Regulatory** then **Survey Resources.**
   a. Review all listed resources to help you understand the Health Department Survey.
3. On the **EMR** site click on the **Survey** tab on the left hand menu and review the following resources:
   o **CMS 672 – Census and Conditions Job Aid**
   o **CMS 802 – Resident Matrix Job Aid**
   o **Survey Entrance PCC & OnBase** resource
4. Discuss with your administrator and the QAPI Coordinator, the survey preparation process and the expectation of the HIM role within the preparation for and during an annual or complaint survey.

Approx. Total Time: 1 hour

Unit 18: Release of Information

Learning Activity 1:
- ☐ View the following HIM Teleconference on Release of Information (ROI):
  https://sanfordhealth.webex.com/sanfordhealth/ldr.php?RCID=7d2975e69b922cd1b573a6e8301e5837
  - ○ Recording password: 7qQqd2Cx

Job Aids, Tables, Other ROI Resources
- **Inside Sanford > Entities > The Society > Health Information Management > Release of Information Request and Disclosure Table**
  - ○ Request and Disclosure Table, Release of Information Unit
  - ○ Release of Information (ROI) Process Job Aid ((for submitting ROI requests to be reviewed by Corporate HIM/ROI team))
  - ○ Legal Medical Record Matrix for All Service Lines.
- **Inside Sanford > Entities > The Society > EMR (Electronic Medical Records) > Record Requests/Disclosures**
  - ○ PCC Legal Medical Record Clinical Chart
  - ○ PCC Clinical Chart – Medicare Managed Care Medical Record
  - ○ OnBase Clinical Chart Job Aid

Privacy Resources
- **Inside Sanford > Departments > Compliance and Privacy > Privacy > Documents > Pages > Record Disclosures, Amendments and Restrictions**

Total Approx. Time for Unit: 1 hour

Unit 19: Health Information Management (HIM) Policies and Procedures and GSS Forms

☐ **Learning Activity 1: Policies & Procedures**
1. Navigate to Inside **Sanford>Sanford Policies>filter Site to GSS>Corporate Functions> HIM**.
2. Review and become familiar with the HIM policies and procedures that will guide your daily work and serve as a resource.

☐ **Learning Activity 2: Forms**
1. Go to **Inside Sanford** and click on **Society Forms** on the left hand menu.
2. Read the **Search Tips** page
3. Click on **Filter Forms** on the top menu and review the filtering options
4. Click **Search** on the top menu and view a form

Total Approximate Time for Unit: 15 minutes

Glossary of Terms:

- **Document Search** – Search functionality through PointClickCare (PCC) to view/retrieve clinical documents for individual residents scanned into OnBase.
- **Federal tags (F-Tags)** - Federal regulations that govern skilled nursing facilities. A tag number is associated with each requirement found in the regulations.
- **Minimum Data Set (MDS)** – Federally mandated standard assessment from that Medicare and/or Medicaid certified nursing facilities must use to collect demographic and clinical data on nursing home residents; includes screening, clinical and functional elements.
- **Master Patient Index (MPI)** - Provides a reference for basic demographic, admission and discharge information for each patient admitted for community outpatient therapy.
- **Master Resident Index (MRI)** - Provides a reference for basic demographic, admission and discharge information for each resident admitted to the location for skilled nursing (SNF) and assisted living.
- **PDPM –** Patient Driven Payment Model for Medicare A stays.

Glossary of ROI Terms:

- **Authorization-** A resident/client's statement of agreement to the use or disclosure of protected health information to himself or herself or to a third party.
- **Business Associate -** A business associate (BA) is a person or organization who performs a function or an activity that involves the use or disclosure of protected health information (PHI) on behalf of the Good Samaritan Society and/or its centers/agencies/campuses.
- **De-Identification-** The process of converting individually identifiable information into information that no longer reveals the identity of the resident/client.
- **Directory Information-** The four pieces of information that are considered "Directory Information" include:
  - Resident/client name
  - Location in the center/campus (where they live in the healthcare community)
  - Condition described in general terms (e.g. "He is not feeling well." or "She is having a good day.")
  - Religious affiliation (available only to members of the clergy)
- **Disclosure-** To release, transfer, provide access to or divulge in any way a resident/client's health information to individuals or entities outside your center/agency/campus.
- **Minimum Necessary-**
  - Staff will only receive access to the portions of the records that are needed to accomplish their assigned duties and responsibilities.
  - Disclosure is to be limited to only that information that the resident/client or third party requires for the purpose of the disclosure. A resident/client or third party may request access or copies of the entire medical record if the entire medical record is what is needed to accomplish the purpose intended.
- **Protected Health Information (PHI) -** Information that is a subset of health information, including demographic information, and:
  - Is created or received by a healthcare provider, health plan, employer or healthcare clearinghouse; and
  - Relates to the past, present or future physical or mental health or condition of an individual; the provision of healthcare to an individual; or the past, present or future payment for the provision of healthcare to an individual; and
    - That identifies the individual; or
    - There is a reasonable basis to believe the information can be used to identify the individual.