

# MAT-SAM Operations Manual

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## Entering an incomplete patient in SAM

Client information is first entered into SAM at the time the agency receives the referral. This information flows to MAT so that when a Start of Care assessment is created as much information as possible can be prefilled. This eliminates double-entry of data. It is recommended that in addition to the left side of the first tab of SAM's client screen, as much of the client referral tab as possible should be entered so that the doctor, ICD-9-CM codes, hospitalization, and Medicare/Medicaid IDs can be prefilled onto the MAT Start of Care when it is created.

At the time your agency is taking the referral, you must determine if the patient has been seen by the agency before. If the patient is not seen in SAM's client list it should be entered as a new patient. If the client appears in SAM's patient list as discharged, that client record should be readmitted using the readmit button on the first page of the client screen.

To summarize:

1. All client information begins with the entry of an incomplete patient in SAM.
2. Incomplete patients then have a Start of Care assessment document completed in MAT, normally by a mobile caregiver with a Tablet PC.
3. Once the Start of Care assessment is completed, it is sent to the office for review.
4. After the document passes review in the office, it is sent to SAM. This process automatically creates the following in SAM: Plan of Care, OASIS, verified visit, and a patient status change to active.

If the plan of care is manually entered into SAM, duplicate work is being done – let the Start of Care assessment information in MAT create the Plan of Care in SAM.

It is not uncommon to have a low confidence level in the quality of the initial referral information at the time client information is entered into SAM. The spelling of the patient name may be incorrect, the birth date and SSN might be heard incorrectly, numbers in the Medicare and Medicaid ID might be transposed, diagnosis information might be missing, and the wrong doctor might be chosen. Although every effort should be made to keep these mistakes to a minimum, SAM and MAT are designed to treat this referral information as "best guess" type information. This information flows to MAT and is prefilled on the MAT Start of Care document when the caregiver visiting the patient performs the first assessment visit. It is up to this caregiver to review the prefilled information and verify its accuracy, because once this document is completed, reviewed, and sent to SAM, the "best guess" information in SAM will be updated with the verified information and will never be updated again via a MAT document – after the Start of Care document is sent to SAM, all updates to this SAM information must be done in SAM. The information that is updated in SAM by the first Start of Care document is the patient's name, SSN, birth date, sex, start of care date, and admission source.

## Completing the First Assessment Visit / Start of Care document on the Mobile Unit

In order for a mobile caregiver to use MAT to complete the first assessment visit on his Tablet PC, he must have had a tablet PC assigned to him and he must sync. When he syncs, he will see on his device all of the patients recently tagged as "incomplete" and "hold" as well as all "active" patients that he has been scheduled to see during the last month and all of the patients he is scheduled to see in the future. If the caregiver needs to visit a patient that is not in this list, the "Select On-Demand Patient (s)" button can be used to grab specific patients (and their documents) during the sync. This is a very useful feature for "On-Call" nurses.

Once the caregiver successfully syncs he is ready to enter the Start of Care. He should complete as much of this document as possible at the patient's home. Certain fields are read only and are prefilled with information already entered in SAM. These fields have a diamond indicator. Clicking on a diamond indicator will explain from where the information came.

The Start of Care assessment is very important as information from this assessment will...

1. Verify and update the core client information, and this core information will display on every subsequent document in "read only" locators.
2. Cause a Start of Care OASIS to be created in SAM. This will be the foundation for how the agency is reimbursed for the patient's care
3. Set the base line for the patient's outcomes. Medicare tracks certain patient wellness data points to monitor the effectiveness of home care agencies. It is undesirable for an agency to report poor patient outcomes (outcomes where the values at time of discharge show little or no improvement). Some outcomes relate to how the patient's

self-reliance has improved in bathing, transferring, ambulation, and taking their oral meds. Other outcomes relate to the patient's frequency of pain, shortness of breath, urinary incontinence, and status of their surgical wound. The reason for their hospital stays as well as what type of emergent care they received are also tracked. See SAM's Clinical Outcomes report for more information.

4. Initially populate the medication profile, which is used by every subsequent document as an aid to document subsequent changes in the patient's medications
5. Cause the plan of care to be created in SAM. The care plan includes the goals for the patient care as well as identified problems and the interventions to be performed. The print button at the top of the Start of Care document provides quick reports for reviewing the portions of the assessment that will flow to the 458 (p485 preview) as well as overviews of the entered Goals (Goal Profile) and Problems & Interventions (Problems and Interventions Profile).
6. Provide valuable information for caregivers performing subsequent visits. If it is determined that Therapy will be needed for the patient, it is even more important to complete and send the assessment to the office so that the therapist can sync and have access to the information – otherwise the therapist will be forced to complete his evaluation document without the aid of inheriting any information from the Start of Care Assessment.

MAT is designed so that most, if not all, of the assessment and visit documents can and should be completed in the patient's home at the time of the visit. The most efficient use of MAT is achieved when:

1. The caregiver syncs with the office in the morning before the day's first visit
2. The caregiver completes each visit's document during the visit, including the use of the document's built-in review feature.
3. At the end of the day the caregiver syncs with the office and sends the completed document to the office

The farther a caregiver diverges from this recommended process the more cumbersome his documentation task will be. If the caregiver does not use the "review" feature before sending the document to the office, and if the office finds inconsistencies (by using the same feature), the caregiver will probably receive the document back for rework. This communication loop should be minimized as it requires more work for the office and caregiver, and slows down the process of documentation.

Very early in the patient episode, the office might need to schedule the first few visits for an incomplete patient because the assessment caregiver advised the office the visits were needed and has yet to complete and send the Start of Care to the office. These visits should be scheduled in SAM once the patient is associated with a payer and the appropriate allowed skills for that payer. In MAT, the caregivers completing the early visit notes in MAT (the notes done without the benefit of inheriting information from the Start of Care) can still be completed and sent to SAM, thus verifying the scheduled visits. Once the Start of Care from MAT is sent to SAM, the patient status will be updated, the plan of care will be created, the OASIS will be created and linked to the SAM plan of care, and the Start of Care visit will be verified. At this point, doctor order type compliance rules can be added in SAM (if they were not created during the sending of the Start of Care from MAT).

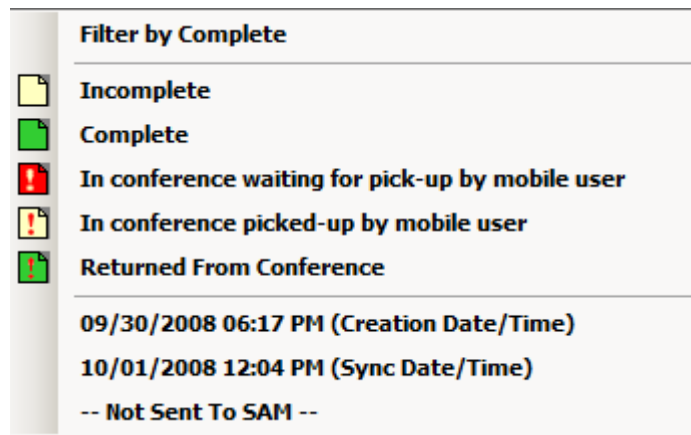
## Processing Documents at the Office

Besides entering the initial client data for each patient into SAM, it is the office's job to review each MAT document and send it to SAM so that the patient status can be updated, plans of care and verbal orders can be sent to the physicians, OASIS can be sent to the state, compliance rules can be added, and visits can be verified so that the employee can be paid and billing can be performed.

The documents are separated into four views: Patients, Incomplete, Complete, or Documents Owned by Mobile Users. The patient view organizes documents within a patient list, and the remaining views organize documents by their status. The primary working view in the office is the completed view.



The "Completed Document" view in MAT shows all documents that have been completed by both the mobile caregivers and the office staff entering from paper. Every document that is green (completed) should be reviewed before sending it to SAM. In any of the document views, right clicking on any of the document icons to the far left will provide you with the following menu...



The first selection on the menu, "Filter by -----", provides the ability to order the screen by the type of document icons, which are described within the menu. So, if you wanted to see just the completed documents, right clicking on any completed document icon and then left clicking on "filter by " will show just the completed documents. The bottom of the menu shows the document's creation, sync, and Sent-To-SAM date and times. On the completed view, only complete and "return from conference" documents will show.

Because this view displays all of the "completed" and "returned" documents, it is not uncommon that it will contain hundreds of documents. If the volume of completed documents becomes large, it becomes important to divide the work so that more hands can be brought to bear. This can be accomplished in two ways:

1. use the completed view to review and send the clinical portion of the documents
2. use the visit view to review and send the visit portion of the clinical documents

The visit view is a subset of the completed document view – it shows only the completed documents that have a visit page – Coordination notes and Reconciliation documents will not show in the view – only assessment and visit note type documents that have information on their visit pages will show in the view. Unlike the other document views, the visit view does not show the document when a row is selected. Instead, a screen showing how the visit will be sent to SAM is shown. **The purpose of the visit view is to provide a fast, efficient way of sending the visit portion of any document to SAM so that it may be paid and billed as quickly as possible. Once the visit portion of the document is sent it will not appear in the visit view again. However, the clinical portion of the document still shows in the completed view, so the lengthier task of reviewing the documents clinical content can be deferred.**

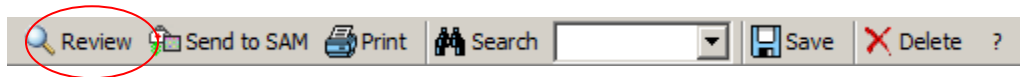
The "\$" column in all views will display a \$ for any document that is currently preventing the creation of the final claim in SAM. The SAM user responsible for billing will receive a message on the PPS log that a final claim for a patient cannot be created because the patient has completed documents in MAT that have not yet been sent to SAM – this of course is done to prevent a bogus final claim from being created, thereby avoiding the laborious rework involved with fixing such a claim. **Documents preventing a final claim from being created will have a dollar sign, and by clicking on the column heading all such documents will be grouped together. It is strongly recommended that these documents be processed before others.**

The "R" column indicates that a document has been clinically reviewed. This is useful because one person can be responsible for clinically reviewing documents while another can be responsible for sending the document to SAM. This is a good idea because reviewing a document for clinical content is an entirely different skill set from sending the document to SAM. If an agency divides the work in this fashion, the clinical reviewer need only work on documents that are missing the "R" indicator, and the user responsible for sending documents to SAM only need work on the documents that have the "R" indicator.

By taking advantage of the visit view, along with the "\$" and "R" columns, even agencies with a hundred mobile users can keep up with the office flow of documents.

Reviewing a document in MAT is recommended before sending it to SAM. The Review button at the top of most documents is a great help with this process. Clicking the review button causes a set of consistency checks to run. A review summary will display any consistency checks that failed – on the Start of Care document, more than 60 consistency checks occur. For OASIS-based documents, PPS score and payment information will also be provided. For OASIS-based discharge documents, the outcomes for that episode will be shown. This review is available to the mobile caregiver, but believe it or not, sometimes he does not take the time to run the review. RiverSoft recommends notifying the mobile caregiver of any

consistency failures via the conference feature on each document. Information from the review summary can be cut and pasted into the conference page, along with any other advice the mobile caregiver needs in reworking the document. Then, by deselecting the "All conference items below have been addressed", the document will be removed from the completed view and will be placed in the "Document Owned by Mobile Users" View until it is received by the mobile caregiver – it lands in the mobile caregiver's incomplete view the next time he syncs.



If the completed view is empty or a document you are expecting to see is not in the completed view, you can see if the document exists on a caregiver's device or is in the sync pipeline by using the "Document Owned by Mobile Users" View.



This view shows all of the documents that are not available to the users in the office because they are either...

1. Incomplete on a tablet pc
2. Complete on a tablet pc but not sent to the office yet (synced)
3. In conference and waiting to be retrieved by a mobile user the next time they sync
4. In conference and on a table pc waiting for a caregiver to complete the conference item and send it back to the office.

If the office is waiting on a particular document and it is not in the completed view, by looking in the "Document Owned by Mobile Users" View it can be determined if the caregiver has begun the document before that last sync. If the caregiver began but did not complete the document it will show as "incomplete" in this view.

MAT has the ability to show these types of documents because every sync of a tablet PC causes every document on that device to be copied to the office's server and each document is only made available to the office based on its status. If a laptop is destroyed or lost, the documents that are marked as "owned" by the lost device can be changed to belong to the office so that they can be completed in the office. Only RiverSoft has the ability to do this - to take advantage of this feature you must call RiverSoft support.

## Sending the Start of Care to SAM

Once the Start of Care document has been reviewed and possibly conferenced it is ready to be sent to SAM. By opening the Start of Care document and clicking on the "Send to SAM" button, the mostly automated process of sending the document is begun. During the process, the user is prompted to choose one of the payers from the set of payers that have been linked to the patient in SAM. If the list is empty, that means that no payer has been associated with the patient in SAM – this must be done before the document can be sent. For this reason and others, RiverSoft advises that the sending of MAT documents to SAM should be done by someone well trained in SAM and while SAM is opened in another window.

Once a patient's payer is selected, MAT will update the patient status to active (if it is not already active), the plan of care will be created and associated with the selected payer, and the OASIS will be created and linked to the created plan of care. At this point, a screen will display showing the SAM visits that have been scheduled for the patient. Selecting one of these visits causes it to be verified according to the date and times on the Start of Care document's visit page. If none of the visits are appropriate, the option to create a new verified visit should be used.

Since one of the primary purpose of a Start of Care document is to verify core client information in SAM, sending a Start of Care document causes the following SAM client information to be updated: client name, SSN, birth date, sex, start of care date, and admission source. After the Start of Care is sent, this particular SAM information will never be updated again by a MAT document – It may only be updated in SAM.

If the flow option "ComplianceRules" is set to true, whenever a document containing the "Orders: Services" page is sent to SAM, the user will be presented with a screen allowing him to create compliance rules in SAM. This automates the process of manually entering compliance rules in SAM and will save several minutes each time the feature is used.

MAT has the ability to configure how certain items flow from MAT to SAM including how the client's comment is updated, how the plan of care is populated, and how visits and transportation flow. Please contact RiverSoft about these options if you need things to flow differently.

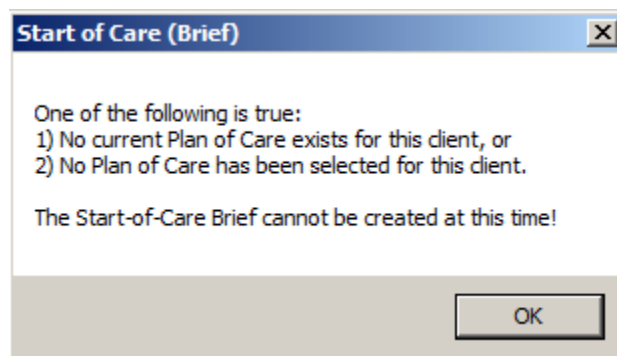
Once a plan of care or OASIS is created in SAM via sending a MAT document, it is only changeable in SAM. A document in MAT can only be sent to SAM one time. This mimics the paper process where the source assessment documents are used as input to the entry of electronic care plans and OASIS in SAM. Paper assessment documents are of course updateable by the author but only some of those updates affect the plan of care and the OASIS. Once a document is sent from MAT to SAM it is up to the author of the document and the office staff to evaluate the need to manually update the plan of care or OASIS information in SAM based on updates to MAT source documents.

**When any MAT document is successfully sent to SAM or Accepted, it disappears from the completed document view.** It can be accessed from the patient view for viewing, printing, or even rework by selecting the appropriate patient and then from the patient menu selecting either "Filed Documents" or "Show Patient's Documents".

## Completing a Start of Care (Brief) in MAT

When you automate with MAT after using SAM for some time, there will be active patients in SAM that already have care plans and OASIS. To avoid having to enter a Start of Care in MAT, a shorter document is available to "prime the MAT pump". The Start of Care (Brief) document is a very short document containing only the information MAT needs to carry forward to other documents (SAM basic patient info, SAM medication data, legal, language, religion, etc). Completing this document allows subsequent MAT documents to inherit this information. **If a Start of Care (Brief) is not completed for already active patients, subsequent documents will be missing information.**

The purpose of the Start of Care (Brief) document is to mine information in SAM and store it in MAT so that it can flow forward to subsequent MAT documents. When a Start of Care (Brief) document is created, MAT checks to see if there is a current plan of care in SAM. If there is not, the following message will appear and the Start of Care (Brief) will not be created.



If the active patient has multiple simultaneous plans of care, MAT will present a list of these and require that one be chosen as the source for the creation of the Start of Care (Brief).

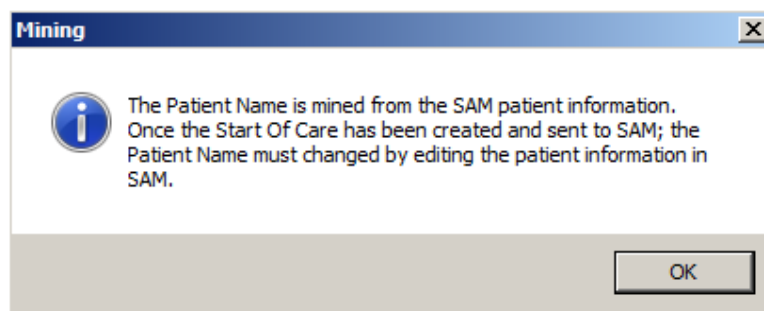
**Incomplete patients must be started by one of the other Start of Care Documents.**

## Information that will flow forward to subsequent MAT documents

A patient's core demographic information is shown on the Patient Info page of any MAT document. Some of the information is mastered in SAM (like name and birth date) and some is mastered on the initial Start of Care document (like the Medicare Number).

Incomplete	Patient Info
<input type="checkbox"/> Clinical	<input type="checkbox"/> (M0040) Patient Name:
<input checked="" type="checkbox"/> Patient Info	Mary (First) BAGNATO (Last)
<input type="checkbox"/> Demographics	(MI) (Last) (Suffix)
<input type="checkbox"/> Patient History	
<input type="checkbox"/> Regimen Change	
<input checked="" type="checkbox"/> Living	<input type="checkbox"/> Phone: (555) 443-8806 <input type="checkbox"/> (M0066) Birth Date: 05/30/1977 Age: 31
<input type="checkbox"/> Living Arrangements	
<input type="checkbox"/> Support	
<input type="checkbox"/> Vital Signs	<input type="checkbox"/> Address: 100 White Road
<input type="checkbox"/> Eyes	
<input checked="" type="checkbox"/> Ears	<input type="checkbox"/> ZIP Code: 06385- WATERFORD, CT / NEW LONDON 06385
<input type="checkbox"/> Nose	
<input type="checkbox"/> Throat	
<input type="checkbox"/> Mouth, Head, & Neck	
<input type="checkbox"/> Pain	
<input type="checkbox"/> Integumentary	<input type="checkbox"/> Marital Status: Single <input type="checkbox"/> (M0069) Sex: 2 - Female <input type="checkbox"/> (M0064) Social Security Number: 048-27-2833
<input checked="" type="checkbox"/> Braden Scale	<input type="checkbox"/> Emergency Contact Information:
<input checked="" type="checkbox"/> Body Diagram	<b>In case of Emergency, notify:</b> Kathy Green <b>Relationship:</b> head of Lighthouse
<input checked="" type="checkbox"/> Wound Site Chart	<b>Home Phone:</b> (860) 445-7626 <b>Work Phone:</b> ( ) - - <b>Cell Phone:</b> ( ) - -
<input type="checkbox"/> Open Wound	<input type="checkbox"/> (M0063) Medicare Number: NA <input type="checkbox"/> (M0065) Medicaid Number: NA 002089066
<input type="checkbox"/> Respiratory	<input type="checkbox"/> (M0072) Primary Referring Physician ID: APPLGATE, BRENDA L (G20692-1255437752) (860-444-9010) <input type="checkbox"/> UK
<input type="checkbox"/> Respiratory Home	<input type="checkbox"/> Other Physician/Specialty: <input type="checkbox"/> UK
<input type="checkbox"/> Cardiac & Circulatory	<input type="checkbox"/> Physician Specialty:
<input type="checkbox"/> Genitourinary	<input type="checkbox"/> Primary Prescriber/Physician:
<input type="checkbox"/> Urinary	<input type="checkbox"/> Secondary Prescriber/Physician:
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Pharmacy Name: <input type="checkbox"/> Phone: ( ) - -
<input type="checkbox"/> Elimination Other	<input type="checkbox"/> Legal Documents patient has executed: (Mark all that apply.)
<input type="checkbox"/> Gastrointestinal	<input checked="" type="checkbox"/> None <input type="checkbox"/> Advance Directive <input type="checkbox"/> Living Will <input type="checkbox"/> Copy Obtained
<input type="checkbox"/> Nutritional	<input type="checkbox"/> Durable Power of Attorney/Health Care Proxy
<input type="checkbox"/> Endocrine	<input type="checkbox"/> Location of original document(s) checked
<input type="checkbox"/> Reproductive	<input type="checkbox"/> Do Not Resuscitate (DNR)
<input type="checkbox"/> Musculoskeletal	Is there a DNR Order? 0 - No <input type="checkbox"/> If Yes, was DNR discussed with Patient? <input type="checkbox"/>
<input type="checkbox"/> Neurological	Copy Obtained? <input type="checkbox"/> If No, MD Contacted to obtain copy? <input type="checkbox"/>
<input type="checkbox"/> Cognitive	<input type="checkbox"/> Interpreter: <input type="checkbox"/> Phone: ( ) - -
<input type="checkbox"/> Emotional	<input type="checkbox"/> Needs Interpreter Name: <input type="checkbox"/>
<input type="checkbox"/> Depressive	<input type="checkbox"/> Religion: christian <input type="checkbox"/> Language: English
<input type="checkbox"/> Behavioral	
<input type="checkbox"/> Ambulate & Transfer	
<input type="checkbox"/> Toileting & Bathing	
<input type="checkbox"/> Dressing	
<input type="checkbox"/> Feeding	
<input type="checkbox"/> Grooming	
<input type="checkbox"/> Laundry & Housekeep	
<input type="checkbox"/> Telephone	
<input type="checkbox"/> Transport & Shopping	
<input type="checkbox"/> Medication Management	
<input type="checkbox"/> Fall Risk Assessment	
<input checked="" type="checkbox"/> Fall Prevention	
<input type="checkbox"/> Risk Factors	
<input checked="" type="checkbox"/> Risk Hospitalization	
<input type="checkbox"/> Medications at Home	
<input type="checkbox"/> Equipment	
<input type="checkbox"/> Equipment Management	
<input checked="" type="checkbox"/> Homecare Diagnosis	
<input checked="" type="checkbox"/> Homecare Surgical	
<input type="checkbox"/> Homecare Prognosis	
<input type="checkbox"/> Admission	
<input type="checkbox"/> Disaster Risk	
<input type="checkbox"/> Services	
<input type="checkbox"/> Plan of Care	
<input type="checkbox"/> Orders: Services	
<input type="checkbox"/> Orders: Interventions	
<input type="checkbox"/> Orders: Clinical Summ	
<input type="checkbox"/> Goals	
<input checked="" type="checkbox"/> Allergies & Medication	
<input checked="" type="checkbox"/> 485 - Comments	
<input type="checkbox"/> Visit Date/Time	

A diamond indicates that the associated information is mined (or read) from previous documents to display on the current document. Clicking on any diamond indicator will explain from where the data was mined as well as where to go in MAT or SAM to update the information. In some cases, the information can be updated on the current document.



## How Medication Data Flows In MAT

A patient's medications, the complete list of the medications currently being taken by the patient, should be entered during the Start of Care visit. This information flows forward to the next clinical document and appears on the "Allergies &

Medications” page with a white background and a diamond indicator. The white background indicates that the medication was copied from a previous document and the diamond indicates that the medication will be refreshed if the current document is reopened. A complete color legend can be found by clicking the question (?) at the top right of the “Allergies & Medications” page.

## Allergies & Medications

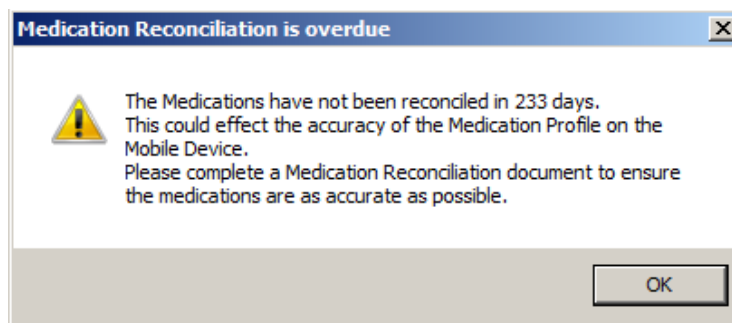


These “carried over” medications are used to aid in the documentation of a discontinuation or alteration of a medication. New medications may also be added. **Although the “carried over” medications appear on the document, for instance a visit note, they are not considered part of the document – they are merely there to aid the caregiver in documenting the change to a patient’s medications during that visit.**

When the Medication Profile or any MAT document containing the “Allergies & Medications” page is opened, MAT finds the last Medication Reconciliation, Start of Care, Recertification, or Resumption document and uses these medications as a baseline. Then, all medication changes that have been documented on subsequent visit notes, coord notes, and verbal orders are layered on top to create a current list of medications. This “Medication Mining” is done to provide all caregivers with the latest information about a patient’s medications.

If multiple caregivers document the same medication because they are performing back to back visits and are syncing infrequently (**infrequent syncing causes one caregiver to be blind to the documents of another**), it is quite possible that multiple entries will occur for the same medication in the patient’s medication profile. These duplications can be fixed via a Medication Reconciliation document. This document allows medication entries to be “Deleted” so that they will become invisible to all future documents.

It is standard practice for most agencies to perform a complete review of a patient’s medications at least every 60 days. This is accomplished in MAT via a recertification, resumption, or medication reconciliation document. When any MAT document containing the “Allergies & Medications” page is opened and MAT detects that one of these documents has not been done in the last 60 days, the user will be alerted with the following dialogue box...



If it is an agency’s standard operating procedure for each nurse on each visit to review all of the patient’s medications, it is recommended that the item at the bottom of the Allergies and Medications page is used.

Patient medications have been reviewed by nurse for potential adverse effects and drug reactions, ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy and non-compliance with drug therapy.

Medications have been reviewed as described above.

Checking this option will remove the diamonds from the carried over medications, meaning that no medications will be carried over, or mined, when the document is subsequently opened – the medications will be “locked down” because MAT does not want the “reviewed” information to change dynamically. Turning the medication mining off eliminates confusion because when the document is opened weeks later the medications will be the same as they were when the “Medications have been reviewed as described above” option was checked. Unchecking the option will bring the diamonds back, causing medication mining to be re-activated.

## How Goals flows forward in MAT

MAT provides a goal tracking feature so that a patient's goal set can be easily seen and updated by all of a patient's caregivers and then finally dispositioned at the time of discharge. Any goal that is still ongoing at the time of discharge will cause an alert during the review of the discharge document.

Goals defined for a patient's care should be entered in the Start of Care document. Each goal is associated with a skill, like skilled nursing or physical therapy, and begins life with a status of ongoing. These goals flow to subsequent documents, with skilled nursing goals flowing to skilled nursing documents, and only physical therapy goals flow to the PT eval and PT notes, and so on. During a visit note, a caregiver can update a goal's narrative if appropriate. They can also update the status to "Met" or "Not Met" based on the patient's current situation. Marking a goal as "Met" or "Not Met" causes the goal to be dispositioned, or ended, making it no longer ongoing.

If a new goal is identified during a visit, it must be added using a verbal order document. This is so that it will flow to SAM's verbal order allowing the patient's doctor to be notified. New goals can also be added via recertification and resumption documents – these new goals will also flow to a SAM plan of care or verbal order allowing the patient's doctor to be notified. Also, if the appropriate MAT option is on, goals can be added at the time of discharge.

When a Start of Care document is sent to SAM, the goals flow to locator 22 on SAM's plan of care (485). When a verbal order is sent to SAM, the verbal order's goals, which should be only the goals that have been added or changed, flow to SAM's verbal order under the goals section.

Whenever the Care Profile or any MAT document containing the "Goals" page is opened, MAT reads the goals from previous documents and displays it findings on the current document.

For a legend of background colors and a detailed explanation of how MAT goals flow, click on the question mark (?) at the top right of the "Goals" page.

Goals		
Goals cannot be added here. You must add the Goal on a Verbal order. Use the Verbal Order button at the top of this document to generate the Verbal Order and add the Goal.		
Goals: <span style="float: right;">View Edit</span>		
Status	Skill	Goal
Ongoing	SN	Demonstrate med compliance at 100% with prepour regime established
Narrative:		
Ongoing	SN	Identify appropriate diet, BP>80/60<160/90, BS>70<300 the next 60 days
Narrative:		
Ongoing	SN	compliant to check BS; and BS>70<250
Narrative:		
Ongoing	SN	Continue to Demonstrate med compliance at 100% with

## How Problems and Interventions flow forward in MAT

MAT provides a Problems & Interventions tracking feature so that a patient's problems and the tasks (interventions) that must be done to address those problems can be easily seen and updated by all of a patient's caregivers and then finally dispositioned at the time of discharge. Each problem may have one or more interventions. Any problem that is still ongoing at the time of discharge will cause an alert during the review of the discharge document. A problem is ongoing until all of its interventions are marked as "completed" and the problem is marked as "resolved".

Problems & Interventions defined for a patient's care should be done in the Start of Care document. Each problem is associated with a skill, like skilled nursing or physical therapy, and begins life with a status of ongoing. These problems flow to subsequent documents, with skilled nursing problems flowing to skilled nursing documents, and only physical

therapy problems flowing to the PT eval and PT notes, and so on. During a visit note, a caregiver can mark any ongoing problem as “resolved” that has had all of its interventions “completed”. This causes the problem to be dispositioned, or ended, making it no longer ongoing. Also, any of interventions may be marked as “completed”.

If a new problem is identified during a visit, it must be added using a verbal order document so that it will flow to SAM’s verbal order allowing the patient’s doctor to be notified.

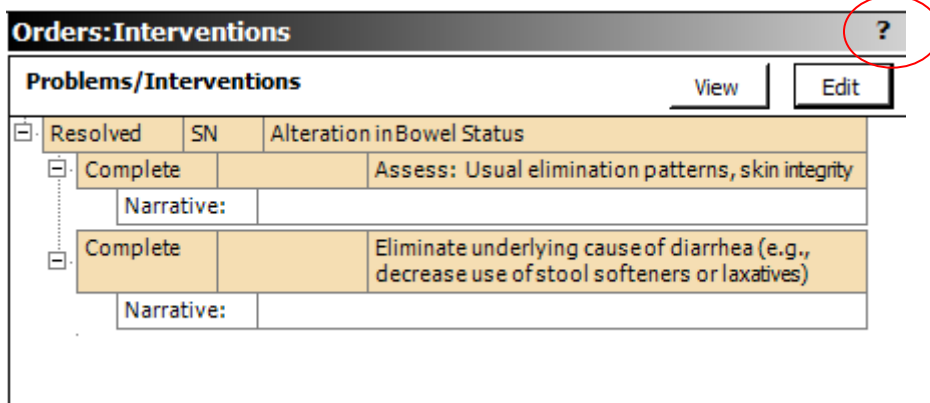
When a Start of Care document is sent to SAM, the problems and interventions flow to locator 21 of SAM’s plan of care (485). When a verbal order is sent to SAM, only the changed verbal order’s problems & interventions flow to SAM’s verbal order under the problems & interventions section. There is a flow option that governs how these changes flow to SAM:

VoFlowItems	VoFlowOnlyModifiedInterventions	<input type="checkbox"/> false
-------------	---------------------------------	--------------------------------

If this is off (set to false), if any of a problem’s interventions are updated, then the problem and all of its interventions will flow to the verbal order – this could lead to VERY verbose verbal orders in SAM if your problems are very general and contain many interventions. By turning this flow option on (set to true), only the problem and the interactions that have been updated will flow to the verbal order, greatly reducing the size of the verbal order.

Whenever the Care Profile or any MAT document containing the “Orders: Interventions” page is opened, MAT reads the problems & interventions from previous documents and displays its findings on the current document.

For a legend of background colors and a detailed explanation of how MAT problems & interventions flow, click on the question mark (?) at the top right of the “Orders: Interventions” page.



## How other information flows forward in MAT

The first true Start of Care document created in MAT will be prefilled with client data from SAM as well as the referral data (if entered), most notably the primary and secondary physicians, two diagnoses, one surgical procedure, and the Medicare and Medicaid numbers. From then on, new Mat documents will mine data from previous MAT documents. The only exception is general client data which is mined from the SAM client table to get the latest data for the client name, address, phone, birth date, sex, and SSN – this data is designated with a diamond mark by their label.

Data will carry over to Subsequent MAT documents based on the document type. Recertification documents will inherit those values from the previous MAT document that created a 485, including the M0230, M0240, and M0246 diagnoses as well as the surgical procedures. The Discharge General document will pull the surgical procedures, diagnoses, vital signs, and service orders from the most recent Start of Care, Resumption, or Recertification MAT document. Visit Notes (Behavioral Med, SN) will inherit the height vital signs, and the Visit Note (Pediatric) will inherit other vital sign data such as temperature, pulse, respirations, weight and length.

## Completing Documents Out of Order

The first document for any patient should be a Start of Care. If the patient is active in SAM at the time you begin using MAT, the first document to be completed should be a Start of Care (Brief) – see that section for a complete discussion of why.

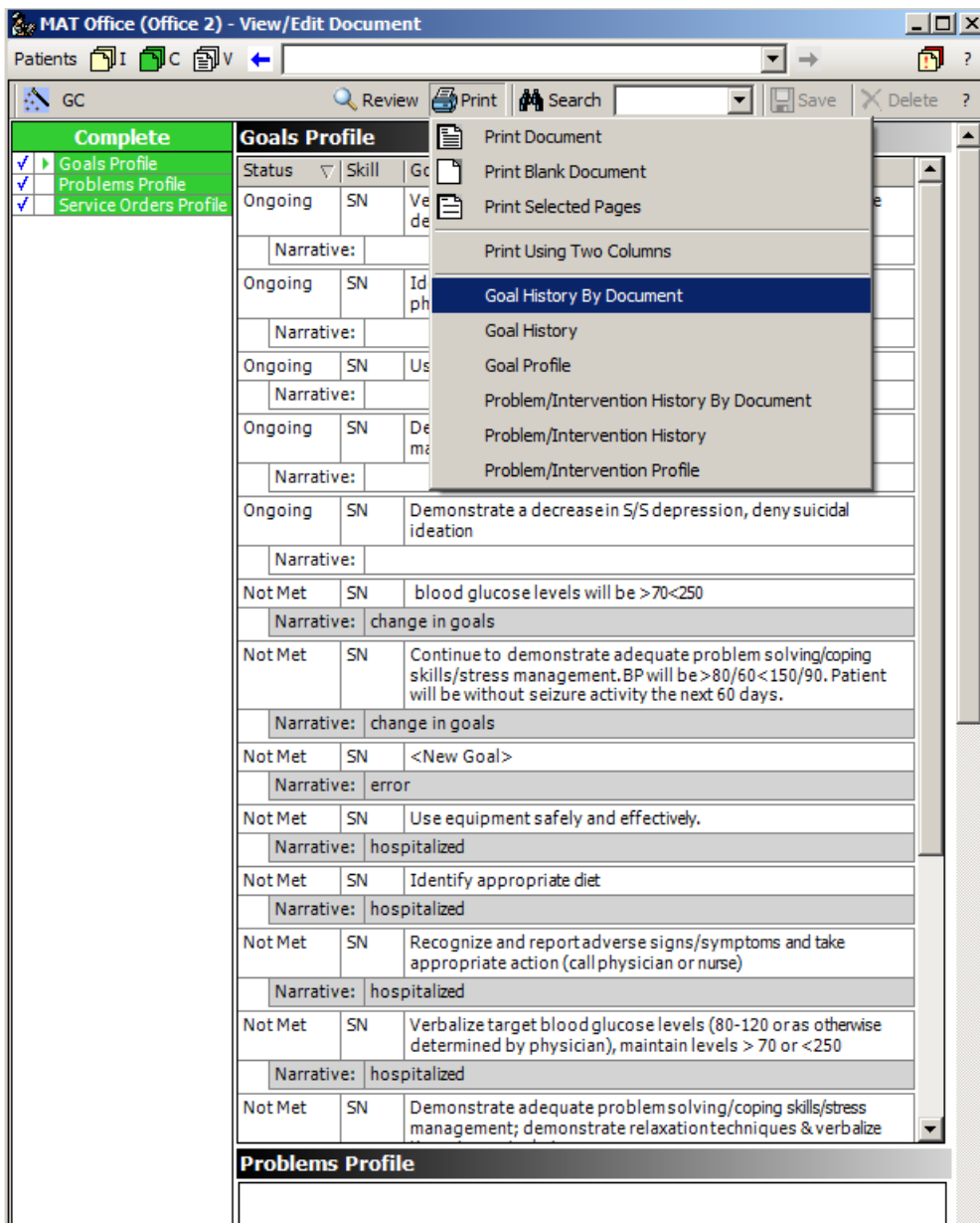
If visit notes or evaluations are done prior to the Start of Care, the caregivers completing these early documents will not be able to benefit from the “carry over” of data in MAT, and confusion might ensue. For instance, if the caregivers completing these documents are expecting to see the patient’s medications, but because this information has not been completed in a Start of Care document and sent to the office (synced) they do not see the patient’s medications, they might be tempted to enter all of the medications. Then, when this document and the Start of Care document are finally sent to the office, the medication profile will have duplications. These duplications must be resolved via a Medication Reconciliation document, thus causing the office staff extra work. The easiest way to avoid this extra work is to inform all caregivers that when they are completing evaluation or visit documents early in a patient’s care to not concern themselves with completing any information that should be completed by the caregiver responsible for completing the Start of Care document.

In patient episodes where both skill nursing and therapy are required, it is important yet challenging to coordinate the planning and assessment of both skills. These challenges disappear if the Start of Care (PT) is done by the physical therapist. But if the Start of Care is done by a nurse and the PT eval is done by a PT, two points of coordination need to occur:

1. Portions of the PT evaluation must appear on the plan of care in SAM. If the PT evaluation is done first and then sent to SAM, there will be no plan of care in SAM to choose, so the send will fail. The PT evaluation must be sent to SAM after the Start of Care is reviewed and sent to SAM. If done in this order the user will be given the option of whether to merge the PT eval information onto the existing (and unmailed) SAM care plan, or whether to create a verbal order attached to the current SAM care plan.
2. There are certain questions on the Start of Care which that create a baseline for how the patient’s outcome will be scored. These questions pertain to bathing, transferring, ambulation, oral meds, pain frequency, Dyspnea, urinary incontinence, etc. A physical therapist has the training to more accurately ascertain the answer to these questions which can lead to better outcome scores (these scores show in MAT during the review of the discharge document and are available in SAM in the Clinical Outcomes Report). For this reason, it can be very important to allow the physical therapist to review and provide advice to the nurse on how to answer some of these questions. We recommend that office staff send a MAT Mobilegram to the therapist to request that they review the Start of Care and respond with a Mobilegram directly to the Start of Care’s author with any relevant advice or critique. See the section of MAT Mobilegrams for more information.

## **The Care Profile and Why it is Useful**

MAT provides an overview of the current status of a patient’s care in the Care Profile, which is available on the patient menu. The care profile contains the current status of a patient’s Goals, Problems & Interventions, and service orders. During a patient’s care, anyone with access to MAT, either in the office or on a mobile Tablet PC, can quickly see which goals and problems have been dispositioned and which are ongoing. The history of the goals and problems documentation is also available by clicking the print menu at the top of the Care Profile. The Care Profile is a report, so no changes can be done – all updates to a patient’s goals and problems must be accomplished via one of the standard MAT documents.



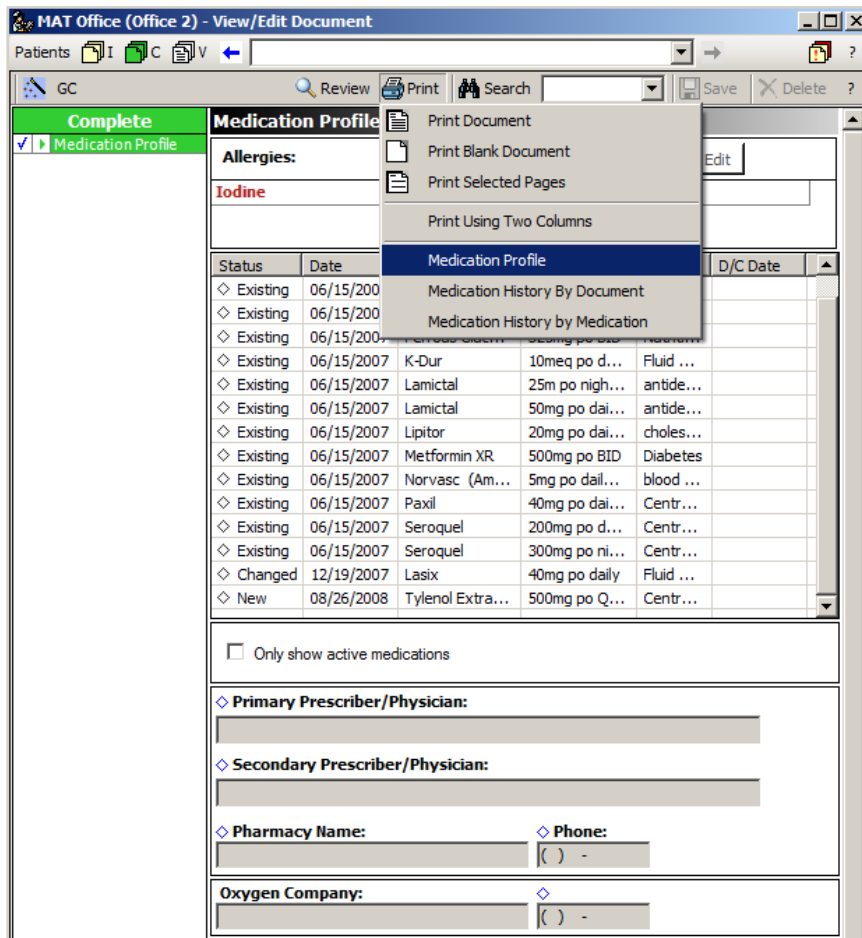
## The Medication Profile and Why is it Useful

The Medication Profile is available from the patient menu and shows the medications which the patient is currently taking. This same information is available on the "Allergies & Medications" page which is on most MAT documents.

When the Medication Profile is opened, MAT finds the last Medication Reconciliation, Start of Care, Recertification, or Resumption document and uses these medications as a baseline. Then, all medication changes that have been documented on subsequent visit notes, coord notes, and verbal orders are layered on top to create a current list of medications. This "Medication Mining" is done to provide all caregivers with the latest information about a patient's medications.

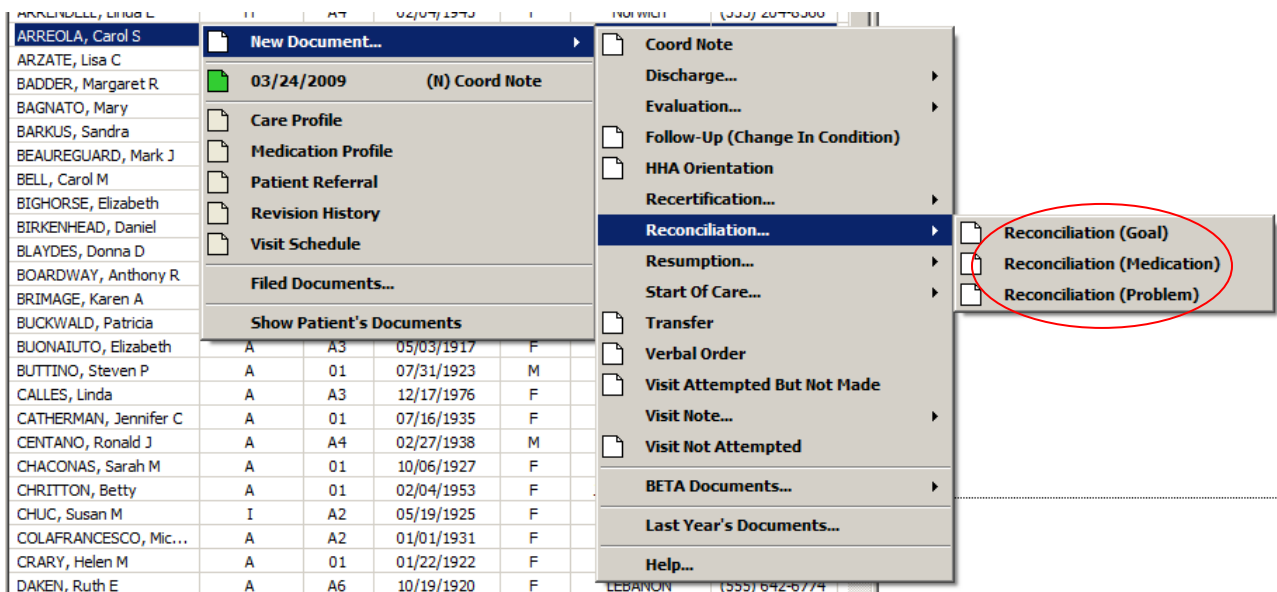
The medication profile may be printed using the Print button at the top and choosing the Medication Profile option.

To investigate when and on what document a particular medication was added or changed, choose the "Medication History by Medication" option from the print menu. The "Medication History by Document" option shows a list of all of the patient's documents that changed medications in document date order and what medication information changed on each document.



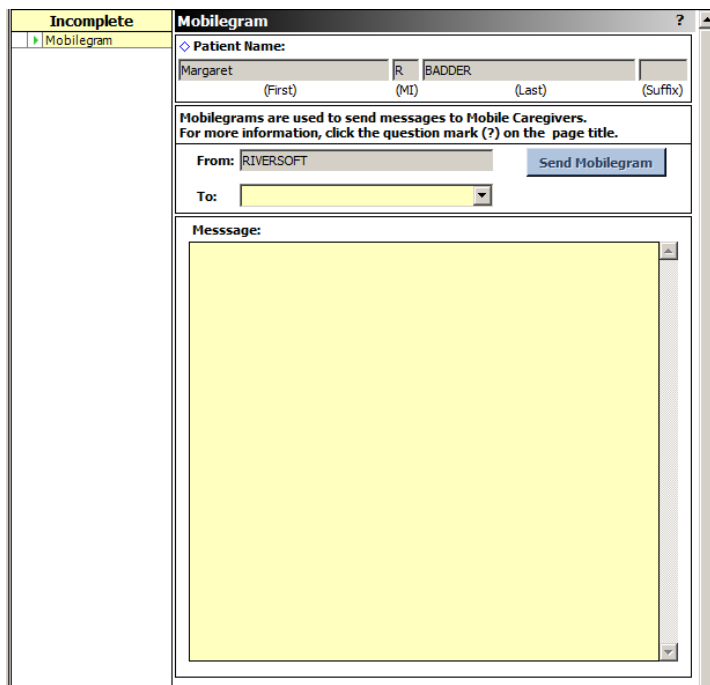
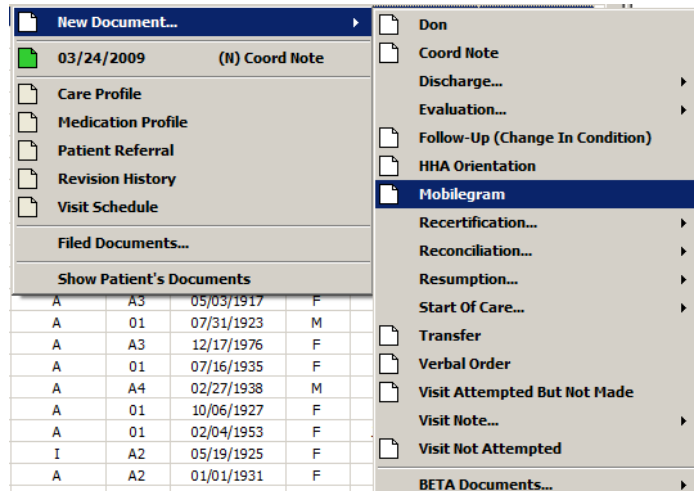
## Reconciliation documents

The section on "Completing Documents Out of Order" explains how a patient's medication profile or care profile (current goals and problems/interventions) can become populated with duplicate or erroneous entries. The reconciliation documents provide the tool needed to fix the problems, while providing an audit trail of who fixed the problems and when.



# Completing a Mobilegram

This patient document will allow a MAT user to create an incomplete document to be sent to a mobile MAT user to serve as a message concerning the care or the documentation of a particular patient. Sending a Mobilegram to a mobile user will cause him receive the patient on his Tablet PC, even if that patient is normally not seen by that caregiver.



This feature is useful for asking a caregiver to perform the final discharge documentation for a patient, or for asking a physical therapist to review a start of care document and send his advice to the start of care author.

Remember, Mobilegrams are to be used to send messages to Mobile caregivers who have Tablet PCs. If you send a Mobilegram to a MAT office user, the Mobilegram will be stuck in the "Document Owned by Mobile Users" View.



It will get stuck in this view because all Mobilegrams pass through this view on the way to their mobile recipient, and since a Mobilegram sent to an office user has no mobile recipient, it will languish here in Mobilegram purgatory – until someone rescues it. To rescue a Mobilegram, open the "Document Owned by Mobile Users" view and right-click the doctype field on the Mobilegram and select "Redirect the Mobilegram to the office". This will place the Mobilegram in the "Incomplete Document" view so that the person to which the Mobilegram is addressed can mark it as read.

## Completing a Care Coordination Note or Coord Note

Whenever a comment regarding the care of a patient must be made part of the patient's clinical chart, and the comment is not part of or related to a patient visit, a care coordination note can be used. This has no corresponding component in SAM - it is strictly a clinical comment and has no effect on the patient's current care plan, orders, or OASIS. Because of this, no review of this document is necessary - instead of sending the document to SAM it is simply accepted to remove it from the completed document view.

## Completing a Verbal Order in MAT

A verbal order document should be created in MAT any time a change occurs in the patient's situation that needs a doctor's review and signature. PT and OT evaluations normally create verbal orders when they are sent to SAM, but if the underlying plan of care in SAM has not been mailed, an option is provided to merge the contents of the evaluation onto the existing plan of care in SAM.

When performing a visit and completing the corresponding visit note in MAT, most facts about the visit need only be documented on the visit note and do not require a doctor's review. However, anything that requires a doctor's review must be placed on a verbal order. MAT has a verbal order button at the top of all of the visit notes to make this process as efficient as possible. A preview of the verbal order is available from the print menu at the top of the verbal order document.

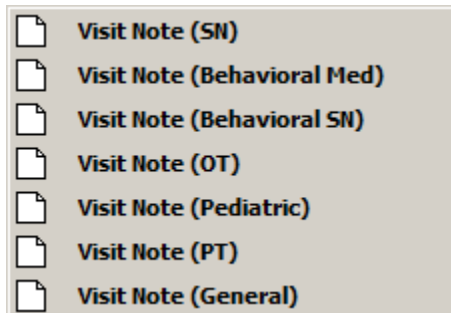
If a new goal or problem is identified, it must be documented by a new verbal order. While completing this verbal order it is very useful to see the current goal and problem profile of the patient. These profiles are available from the print menu at the top of the verbal order document.

The screenshot shows the MAT Office (Office 2) - View/Edit Document window. The title bar indicates the date is 09/19/2008 and the document type is (O) Verbal Order. The interface includes a menu bar with options like GC, Review, Send to SAM, Print, Search, Save, and Delete. A left-hand navigation pane lists various document components, with 'Complete' highlighted in green. The main content area displays the 'Revision to Plan of Care' form. Key fields include: Order Effective Date (09/19/2008), Patient Name (Margaret Slater), Primary Referring Physician (SLATER, DENNIS E), Doctor to Receive Verbal Order (TRAMONTOZZI, MARK E), and Case Manager (BJORGEN, Laura A). A 'Diagnoses' section is visible at the bottom, with a table header for ICD-9-CM, Diagnosis Text, Status Date, Diag Status, and VO Status. A context menu is open over the 'Print' button, showing options like 'Print Document', 'Print Blank Document', 'Print Selected Pages', 'Print Using Two Columns', 'Verbal Order Preview', 'Goal Profile', and 'Problem/Intervention Profile'.

To see all of the verbal orders and plans of care that have flowed to SAM and have not been printed and mailed to the doctor's, use the Plan of Care Tracking report in SAM. This report can show verbal order and plans of care that have not been mailed so that the office staff can print and process all verbal orders and care plans that have come in from MAT.

## Completing a Visit Note in SAM

The Visit Note is the most used document in MAT, as the different flavors provide for the documentation of the day to day care of a patient.



All notes have few things in common: the patient's vital signs can be updated, goal status can be updated, problem/interventions can be updated, the visit date and time must be recorded, and the signature requirements for both the employee and patient must be satisfied. New goals cannot be added on a visit note – this must be done on a verbal order. The same is true with adding a new problem. Any change to a medication that requires the review of the attending physician should not be done on the visit note but rather a verbal order. Because of this, there is a Verbal Order button at the top of the all visit notes that allows quick creation of a verbal order to document any appropriate situational change discovered at the time of the visit.

Besides moving a visit note from the completed view to the patient's filed documents, the main reason for sending a visit to SAM is to verify a visit in SAM for payroll and billing. During this send process, the sender will have the following choices:

1. Which of the scheduled visits in SAM this visit verifies
2. Verification of the mileage and travel pay
3. Decision of whether this caregiver has already been paid for the visit
4. Verification of the visit's "Non-Billable" nature
5. Whether the visit is to be paid at holiday rates
6. Verification of a payer change during this visit
7. Verification that the visit is to be paid over and above the caregiver's normal salary
8. Review any narrative to the SAM visit's comment area.

For the vast majority of visits, once the appropriate visit is selected from the visit list (which is displayed once the Send to SAM button is clicked), the selected visit is updated with the current visit note's date and time information and verified. The current visit note is then removed from the completed view to the patient's filed documents.

For Medicare home care patients, visit notes are the main documentation required for a patient after the initial start of care is complete. When completed, reviewed, and sent to SAM, each note will cause a visit in SAM to be verified, in turn allowing the nurse to be paid and the visit to be billed. Other documents in MAT mark the significant milestones in a patient's care, including:

- 1) Evaluation of patient for non-nursing services (PT Eval and OT Eval)
- 2) Transfer to a facility of Hospital – (Transfer)
- 3) Resumption of care after patient is discharged from a facility of hospital – (Resumption)
- 4) Resumption of care within 5 days of the patient's original certification end date – (Resumption with Recert)
- 5) Mid-episode assessment for a change in condition – (Follow Up – Change in Condition)
- 6) Discharge one of the services from the patient – (Discharge (General))
- 7) Discharge the patient – (Discharge (OASIS), Discharge (Pediatrics), Discharge from Agency (OASIS))

Details about the completion of these documents are available in subsequent sections of this document.

## Completing a Visit Attempted But Not Made in MAT

If a caregiver visits a patient's home but cannot complete the visit, the attempt should be documented to show the agency made a good faith attempt to perform the visit and to allow the caregiver to be compensated for their time. When this type of document is sent to SAM and the AllowShowUpPayItem flow option is on, the sender will be asked if a "Show Up" pay item should be created in SAM.

Incomplete	Visit Attempted but Not Made
<input type="checkbox"/> Visit Attempted but Not Made <input checked="" type="checkbox"/> Conference	<div style="border: 1px solid #ccc; padding: 5px;"> <p><b>Visit Attempted but Not Made</b></p> <p> <input type="text" value="Lisa"/> (First)    <input type="text" value="C"/> (MI)    <input type="text" value="ARZATE"/> (Last)    <input type="text" value=""/> (Suffix)         </p> <p> <b>Birth Date:</b>  <input type="text" value="06/21/1953"/> </p> <hr/> <p> <b>Visit attempted by:</b> <input type="text"/> </p> <p> <b>Visit attempted on:</b> <input type="text"/> <input type="text"/> <input type="text"/>  <small>Visit Date    Start Time    End Time</small> </p> <hr/> <p> <b>Mileage:</b> <input type="text"/> </p> <hr/> <p> <b>Client Notified?</b> <input type="text"/>    <b>Date:</b> <input type="text"/>    <b>Time:</b> <input type="text"/>    <b>Type of Visit:</b> <input type="text"/> </p> <hr/> <p> <b>Name of Physician Notified:</b> <input type="text"/> <input type="checkbox"/> N/A         </p> <p> <b>Date Physician Notified:</b> <input type="text"/>    <b>Method of Notification:</b> <input type="text"/>    <b>Physician's Fax:</b> <input type="text"/> </p> <hr/> <p> <b>Document Completed By:</b> <input type="text" value="RIVERSOFT"/>    <b>Date:</b> <input type="text"/> </p> <hr/> <p> <b>How Were Patient's Needs Met?</b>  <input type="text"/> </p> <hr/> <p> <b>Reason/Comments why visit could not be made:</b> <input type="text"/> <input type="button" value="View"/> <input type="button" value="Edit"/> </p> <hr/> <p> <b>I certify the accuracy of the above medical record.</b> <input type="button" value="Clear"/> <input type="checkbox"/> Signature On File         </p> <hr/> <p style="text-align: center;"> <b>Employee Signature</b>  <input type="text"/> </p> <hr/> <p> <b>Conference</b>  <input type="checkbox"/> Clinically Reviewed by: <input type="text"/> </p> <p>           Uncheck the checkbox below to return the document to the mobile caregiver.         </p> <p> <input checked="" type="checkbox"/> All conference items below have been addressed         </p> </div>

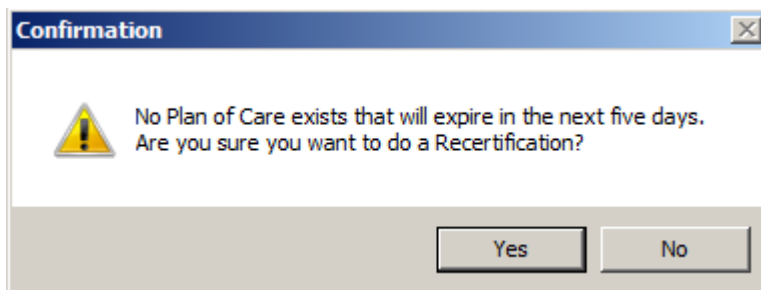
## Completing a Visit Not Attempted in MAT

It should be documented in a patient's chart whenever an agency realizes that a planned visit cannot be made. Sending this document to SAM will provide the sender with the ability to mark a scheduled SAM visit as cancelled.

Incomplete	
<input checked="" type="checkbox"/>	Visit Not Attempted
<input checked="" type="checkbox"/>	Conference
<b>Visit Not Attempted</b> (M0040) Patient Name: Carol (First) S ARREOLA (Last) (Suffix) Birth Date: 08/09/1926	
Visit Planned for: <input type="text"/> <input type="text"/> Visit Date Start Time	
Client Notified? <input type="text"/> Date: <input type="text"/> Time: <input type="text"/> Type of Visit: <input type="text"/>	
Name of Physician Notified: <input type="text"/> <input type="checkbox"/> N/A	
Date Physician Notified: <input type="text"/> Method of Notification: <input type="text"/> :Physician's Fax <input type="text"/>	
Document Completed By: <input type="text"/> Date: <input type="text"/>	
How Were Patient's Needs Met? <input type="text"/>	
Reason/Comments why visit could not be made: <input type="text"/> <input type="button" value="View"/> <input type="button" value="Edit"/>	
<input type="button" value="Clear"/> <input type="checkbox"/> Signature On File	
Supervisor Signature <input type="text"/>	
I certify the accuracy of the above medical record. <input type="button" value="Clear"/> <input type="checkbox"/> Signature On File	
<input type="text"/>	
Employee Signature <input type="text"/>	
<b>Conference</b> <input type="checkbox"/> Clinically Reviewed by: <input type="text"/> Uncheck the checkbox below to return the document to the mobile caregiver. <input checked="" type="checkbox"/> All conference items below have been addressed	

## Completing a Recertification in MAT

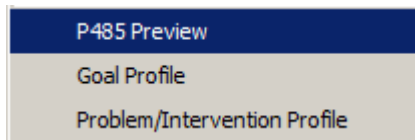
If a patient is not discharged during the period for which they are certified at the time of the Start of Care, the patient must be recertified. For Medicare and Medicare-like payers, this certification period is 60 days and the recertification visit can be done during any of last 5 days of the recert (a message in MAT will remind you). Also, if MAT detects that a recertification is not appropriate because of the lack of a previous Start of Care or recert, a MAT message will be triggered.



A recertification document establishes a fresh baseline for the patient medications (see medication reconciliation) and continues the flow of information concerning the patient's goals and problem & interventions. When a recertification

document flows to SAM it causes a new plan of care to be created which will act as the recertification for an existing SAM plan of care – the certification begin date on the new plan of care will be the day after the previous SAM plan of care's certification end date. Sending this document to SAM also cause a Recertification OASIS to be created.

Because a plan of care is created by sending a Recertification, the print menu at the top of this document allows a preview of a compiled plan of care (485) for ease of review. The goal and problem/intervention profiles are also available so that the status of these can be updated and verified.



## Completing a Transfer

Whenever a patient is admitted to a care facility or hospital for what is believed to be a temporary stay, the patient's transfer from the agency's care to the facility should be documented with a transfer document. When the transfer document is sent to SAM, the patient's status will be updated from active to hold, a Transfer OASIS will be created, and any visits schedule for the patient in SAM will be placed on hold.

## Completing a Resumption

When a patient is to receive further care from the agency immediately after being transferred from a care facility or hospital, the agency should document the resumption of care. If this resumption visit is done within 5 day's of the patient's recertification period, a "Resumption with Recert" document should be done because a recertifying plan of care is needed. Otherwise, a normal Resumption document should be completed. When either document is sent to SAM, the patient's status will be updated from Hold to Active and a Resumption OASIS will be created. The difference is in whether or not a plan of care is created – a normal resumption document will cause a verbal order to be created in SAM, while a "Resumption with Recert" will cause a recertifying plan of care to be created in SAM.

## How Information Flows to SAM's Plan of Care

There are certain documents in MAT that contain information that is required for a plan of care and not required for a verbal order (revision to a plan of care). The documents that contain this information and can therefore create plans of care in SAM are:

1. Start of Care – all except the brief
2. Recertification
3. Resumption with Recertification

The following documents create verbal orders in SAM:

1. Verbal Order
2. Evaluation
3. Resumption
4. Follow-Up

The Options section of the Application Details allows a great amount of flexibility as to which care plan information is allowed to flow to SAM care plans and verbal orders.

Poc485FlowItems	AllowEmployeeSignatureToFlowToP485	<input type="checkbox"/>
Poc485FlowItems	ClinicalSummary.BloodPressure	<input type="checkbox"/>
Poc485FlowItems	ClinicalSummary.ClinicalSummaryComments	<input type="checkbox"/>
Poc485FlowItems	ClinicalSummary.ClinicalSummaryLegal	<input type="checkbox"/>
Poc485FlowItems	ClinicalSummary.ClinicalSummaryM0246	<input type="checkbox"/>
Poc485FlowItems	ClinicalSummary.Pulse	<input type="checkbox"/>
Poc485FlowItems	ClinicalSummary.Respiration	<input type="checkbox"/>
Poc485FlowItems	ClinicalSummary.Temperature	<input type="checkbox"/>
Poc485FlowItems	ComplianceRules	<input type="checkbox"/>
Poc485FlowItems	DischargePlans	<input type="checkbox"/>
Poc485FlowItems	Goals	<input type="checkbox"/>
Poc485FlowItems	HomeboundStatusReasons	<input type="checkbox"/>
Poc485FlowItems	LongTermPlans	<input type="checkbox"/>
Poc485FlowItems	ProblemsAndInterventions	<input type="checkbox"/>
Poc485FlowItems	PTInstructions	<input type="checkbox"/>
Poc485FlowItems	RehabilitationPotential	<input type="checkbox"/>
Poc485FlowItems	SendDiscontinuedMedsForLastCert	<input type="checkbox"/>
Poc485FlowItems	ServiceOrders	<input type="checkbox"/>

It is recommended that when beginning with MAT that all of the options be turned on until the first few SAM care plans (created by sending MAT documents to SAM) can be reviewed. Then, any information that is not deemed necessary to your agency's care plans can have its corresponding flow of information from MAT turned off.

## Discharging a Patient in MAT

There are three different levels of "Discharging a Patient" in MAT:

1. Discharging a service
2. Discharging a patient's payer
3. Discharging a patient

Each of these is covered in detail in other sections of this document, but what they all have in common is that they document the end of some type of care being provided to the patient. Sometimes multiple disciplines are required to care for a patient (for example nursing and physical therapy) and one of the disciplines may resolve their goals before the other and therefore need to document this resolution – this is done by discharging a service. Once the last of the services has resolved its goals, the patient should be discharged from the agency if the patient is only receiving services under one payer source. If the patient is receiving care from another payer source, for instance personal care provided by a Medicaid, third party insurance, or private pay source, the patient should only be discharged from the payer source and not the agency. The choice between payer and agency level discharge is made by the person sending the discharge document to SAM at the time the document is sent. Be careful during the send process to not discharge a patient from the agency if there are other services (probably unskilled) that must continue to be provided.

Besides either discharging the patient from a payer or from the agency, OASIS based discharge document will cause the appropriate discharge OASIS to be created in SAM. At that point, the outcome information available in this OASIS information will then be available in SAM's Clinical Outcomes report.

Discharge is the point in time where the care of the patient should be reviewed. The review function will provide much of this, as it will:

1. Provide outcomes scores on the Discharge (OASIS) documents with matching SOC OASIS
2. Provide alerts if any ongoing goals are detected

3. Provide alerts if any ongoing problems are detected.

Even though MAT provides these automated features, in the end it is the responsibility of the agency's clinical staff to perform a thorough review of the quality of the care that has been rendered to the patient.

## Discharging a Service using Discharge General

Sometimes multiple disciplines are required to care for a patient (for example nursing and physical therapy) and one of the disciplines may resolve their goals before the other and therefore need to document this resolution – this is done by discharging a service using the Discharge (General) document.

If the Discharge Types of D/C from Nursing Only, D/C from Therapy (PT) Only, or D/C from Therapy (OT) Only is chosen, when this document is sent to SAM no option will be given to discharge the patient in SAM from a payer or the agency. Also, if one of these options is chosen, it may be required that the doctor be notified, so a verbal order should be created and sent to SAM.

If the Discharge Type of D/C from Agency or D/C Due to Death is chosen, when the document is sent to SAM the user will be given the choice of discharging the patient in SAM either from one of their payers or from the agency.

Once the last skill is discharged from a patient, a Mobilegram document should be created to notify the primary caregiver to perform the Discharge from Agency (to discharge the last skill).

The Discharge General does not contain the OASIS outcome questions and therefore will not provide any outcome scores or PPS information within its review.

## Discharging a Patient from a Payer or from the Agency

When a patient is receiving services from an agency under multiple payer sources and care plans, it becomes important to be able to discharge one of the streams of care for one of the payer sources. This is called discharging a patient from a payer and can be done with a Discharge from Agency (OASIS), Discharge (Pediatric) or a Discharge (General) document. When sending a Discharge Death at Home (OASIS), the sender is not given the opportunity to just discharge one of the patient payer's for obvious reasons. The decision to discharge one of the patient payer sources or to discharge the patient completely from the agency is made at the time the document is sent to SAM.

## Discharging a Patient Due to Death

If a patient dies, if a Start of Care (OASIS) exists for the patient then a Discharge Death at Home (OASIS) document should be completed. Sending this document to SAM will discharge the patient from the agency and create an OASIS record in SAM.

If the patient does not have an OASIS based Start of Care, the Discharge (General) document should be used and the Discharge Type of DC due to Death should be chosen. When this document is sent to SAM the patient will be discharge from the agency.

## Discharging a Pediatric Patient

If a pediatric patient was admitted with Start of Care (Pediatric) document, please discharge them with a Discharge (Pediatric) document, even if they are no longer younger than 18.

## Sending Messages to Caregivers

From time to time it is important to send out a message to all of your caregivers. The message might announce an event, inform everyone as to an operational change that is being implemented, or provide general reminders for how problems that more than just a few caregivers are having in completing their documentation.

To send a broadcast message to all mobile caregivers, use the "Edit Announcements" button on the Application Details page.

Administration	
Edit Phrases	<input type="button" value="Edit Phrases"/>
View Phrases	<input type="button" value="View Phrases"/>
Edit Problems	<input type="button" value="Edit Problems"/>
Edit Medications	<input type="button" value="Edit Medications"/>
Edit Announcements	<input type="button" value="Edit Announcements"/>
Edit Options	<input type="button" value="Edit Options"/>

Type the message to be broadcast and then click the "Send Announcement to all MAT Mobile users"...

The screenshot shows a window titled "MAT Office (Office 2) - Application Details". Inside, there is a dialog box for "Enter Announcement". The dialog has a text area containing the message: "We are having Roland's going way party on Friday, April 17th, at 5:30. There will be alcohol, clowns, and a bird calling contest, so we hope you can all attend as we send Roland off to his new home at Happy Restful Peaceful Quite Acres." Above the text area, it says "MAX (2000 characters) 1763 remaining". At the bottom of the dialog, there are two buttons: "Send Announcement to all MAT Mobile users" and "Clear all Pending Announcements".

The next time each mobile user syncs, they will receive this message on their "Successful Sync" screen. Once they click their "Click to Continue" button, the message is acknowledged and they will not receive the message again.

# MAT Reports

There are two types of reports in MAT that can help the mobile caregivers prioritize their visit schedules. These two reports are accessible from the main MAT menu:



The Recertification Due report will show a list of patients with certification end dates on their last plan of care between 14 days ago and 14 days from now. The nurses responsible for performing the recertification visits should use this report to ensure that the each patient's recertification visit is done no earlier than 5 days before the end of the patient's certification period, and no later than the end of the patient's certification period.

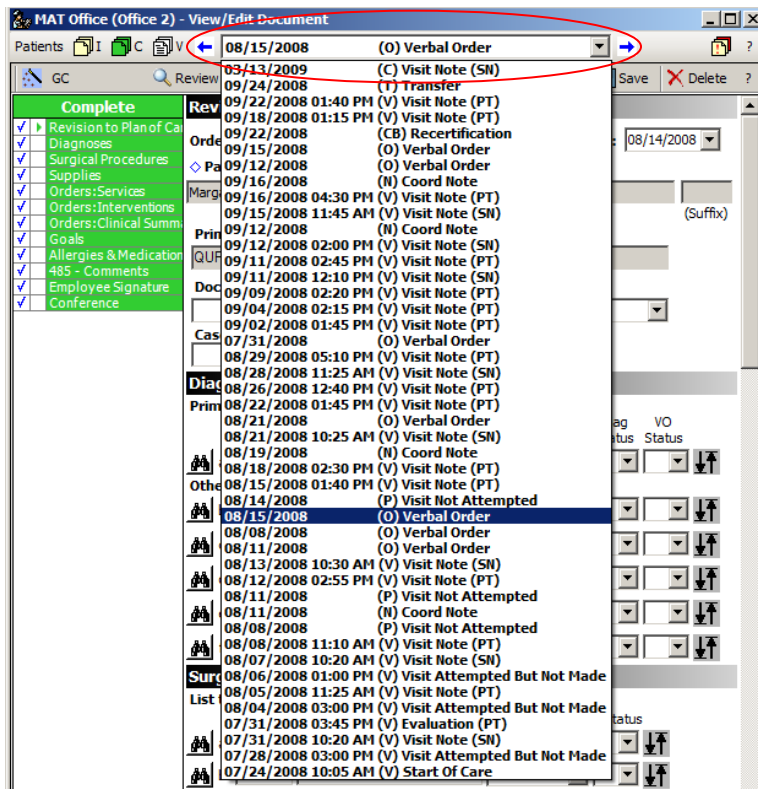
The Authorizations Due report will show list of patients with insurance/payer authorizations ending between 14 days ago and 14 days from now. Caregivers responsible for performing assessment visits and submitting verbal orders or other documentation in order to facilitate the request of new insurance/payer authorizations should habitually use this report as reminder.

## When to Use Paraprofessional Documents

The core assessment documents, like the Start of Care, Recert, Resumption, and Discharge, are based on the OASIS data set and are therefore lengthy. When the patient is not a "Medicare-Like" patient and a shorter assessment document will do, use the Paraprofessional version of the assessment. These documents take less time to complete and will not cause OASIS information to be created in SAM.

## Accessing all of a patient's documents – Chart Reviews

When reviewing a patient's chart, it is important to see a summary of the patient's care and to be able access individual patient documents quickly. The patient summary is available on the care profile and shows the disposition of the patient's goals, their problems and interventions, and a summary of the skills provided. The quickest way to review a patient chart, document by document, is by using the patient document pull-down at the top of any MAT document. By selecting a document from this pull-down, the current document is closed and the selected document is opened.



The blue arrows to the left and the right of the pull-down will quickly move you to the previous or next document in the current patient's chart.

## **What to do if a Tablet is lost or stolen**

If a Tablet PC is lost, stolen, or run over by a steam roller or marching band, another Tablet PC should be configured for the affected caregiver and synced. This will provide a mechanism to not only finish the incomplete documents, but also to see what patient information was at risk (if the laptop was stolen). Configuring a Tablet PC is explained in detail in the MAT Quick Start Guide.

## **Monitoring MAT usage by document type and caregiver**

It can be very useful to see which caregivers are completing what and how many documents – this allows the office to see how the Tablet PCs are being utilized and who their most prolific documenters are. On the last page of the Application Detail page (accessible by clicking the "?" mark at the top right of the main MAT menu), the button "View Document Counts" will provide access to document usage information.

MAT is designed to speed the completion and increase the quality of assessment and visit notes. However, two other benefits of great importance are the greater speed at which plan of care, verbal order, OASIS, patient status, and visit information can be created in SAM (via the Send To SAM feature) and the greatly enhanced ability of the agency to review patient documents at the time of completion and as part of a chart review. By monitoring your caregiver usage, your agency can gauge for itself if the correct people have been outfitted with a Tablet PC and MAT.