

MGH

SOCIAL SERVICE DEPARTMENT

INPATIENT BILLING SYSTEM

CLINICIAN MANUAL

Original: August 21, 1998
Maya Levy

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IMPORTANT POINTS TO REMEMBER

The Basics:

- Each clinically significant in-person or telephone contact is entered as an “Intervention.”
- The approximate time spent during the intervention is entered in 15-minute increments, rounded up, to a maximum of 2 hours.
- “Descriptors” are then entered to describe the major issues addressed during the intervention.
- “Notices” may then be entered at your discretion to alert other social workers to issues that may require further attention in the future.
- Group work is entered differently from standard interventions (see page 7).

When should work be entered?

- All work must be entered into the system **after** 12-Noon on the day the work was done and **before** 11 AM the following business day. It is strongly suggested that you enter work by the end of the day.
- You may not access the system between 11 AM and Noon.

“Discharging” Patients from your “Service Pool”

- Patients should remain in your list of active patients, or “service pool,” when you have a planned intervention. You should discharge patients from your service pool when you have no plan for another intervention.

Unit Number

- All work must be entered under a patient’s “Unit Number” (hospital identification number). It is necessary to obtain this number either directly from the patient, from the patient’s medical record, from PCIS (Patient Care Information System) or from Patient Registration.

Old Work

- For each patient, you should review any work previously entered by other social workers by viewing “Old Work.” (See page 16)

Symbols

-  Means “short cut.”



- In the system, click on this symbol to exit a screen. ***Always use the door to exit. Do not use the “x” in the upper right corner of the screen unless no door is visible.***

WORK ELEMENT DEFINITIONS

Work elements are data used to identify, describe, and categorize work that is done. There are three different types of work element that are entered into the system: Interventions, Descriptors, and Notices.

- ❖ **INTERVENTIONS:** Interventions indicate with whom an interaction took place, and the amount of time spent on the interaction. An intervention is any clinically significant in-person or telephone contact with another person. Contact with brief interruptions should be considered a single intervention. Time is entered in increments of 15 minutes, rounded up, to a maximum of 2 hours.
 - **Intervention with Patient.**
 - **Intervention with Family/Significant Other.**
 - **Intervention with Patient and Family/S.O.**
 - **Intervention with *Non-MGH* Collateral Person/Agency on Behalf of *Specific Patient*.**
 - MGH Health Centers and off-site MGPO practices are considered “MGH,” therefore, do not enter contact with these centers under this intervention.
 - **Interdisciplinary Team Meeting *with Pt and/or Family, on Behalf of Specific Patient*.**
 - Definition: Previously organized discussion about a specific patient including the patient and/or family, and at least one other discipline and/or outside agency member. For meetings where patients are discussed consecutively, such as psychiatry rounds, enter a separate intervention for each patient interviewed with the approximate amount of time spent with each patient.
 - **Interdisciplinary Team Meeting *without Pt and/or Family, on Behalf of Specific Patient*.**
 - Definition: Previously organized discussion about a specific patient with at least one other discipline and/or outside agency member. For meetings where patients are discussed consecutively, such as psychiatry rounds, enter a separate intervention for each patient discussed if you were significantly involved in the discussion.
 - **Intervention with MGH Staff *while on-call from outside hospital only, on Behalf of Specific Patient*.**
 - **Cancer Resource Room** - Enter this intervention once for each *assigned* CRR shift worked, along with the amount of time worked on your shift. Do not enter descriptors with this intervention.
 - **Advocacy within MGH** – Interventions with clinical or non-clinical MGH staff for the purpose of obtaining services, resources, or information for a specific patient or patient's family. Routine exchange of information should not be included.
- ❖ **DESCRIPTORS:** Descriptors describe the ***major*** issues addressed ***during*** an intervention. Do not include every issue a patient has, rather only the major issues addressed during the intervention. See *Work Element Codes and Brief Definitions* for a full list of descriptors.
 - At least one descriptor must be used with each intervention except Non-Billable Group and Cancer Resource Room.
 - Descriptors must be used in conjunction with an intervention.
 - As many descriptors as apply to an intervention may be used.
- ❖ **NOTICES:** Notices are used to alert other social workers to issues that may require further attention. See *Work Element Codes and Brief Definitions* for a full list of Notices.
 - Notices may be used with or without an intervention.
 - Notices are to be used at your discretion.

GROUP-WORK

All non-billable group-work is entered into the Inpatient Billing System. (Billable group-work is entered into the *Ambulatory* Billing System. Speak to your supervisor or the Clinical Systems Coordinator if you are uncertain which system you should be using.)

For groups consisting of members who have contracted for regular attendance:

For each member in the group, you enter a group-work element based on the number of attendees in the group. Your choices are “group of 2” through, “group of 10.” Do not enter time, Descriptors, or Notices with group-work elements. Time is automatically assigned.

For “Drop-In Groups” open to anyone, where members are not contracted for regular attendance:

Each Drop-In Group needs a 7-digit code to substitute for a Unit Number. You may pick any series of seven numbers or letters. Once you have chosen a code, you must use it consistently for that group. Pam Burton, extension 6-2651, keeps a list of group codes. You must notify Pam of the code you intend to use in order to insure that no one else has used the same code.

The first time you enter a new Drop-In Group, you must also enter a fictitious first and last name, and gender. You will also be prompted to enter the “patient’s location.” Enter “WACC-LL.”

Enter the work element “Drop-In Group.” Do not enter time, Descriptors, or Notices with group-work elements. Time is automatically assigned.

HOW TO ACCESS THE INPATIENT BILLING SYSTEM

Step 1

Log onto your computer

Step 2

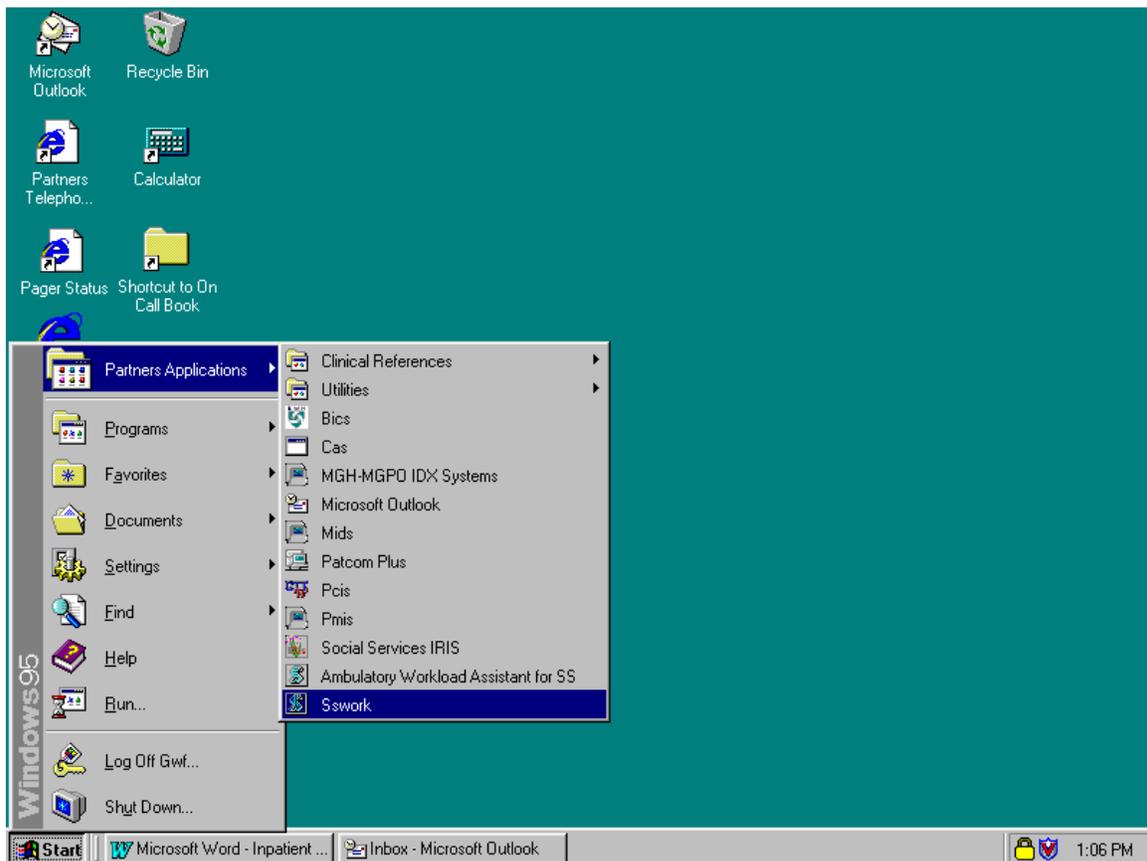
Click the START button

Step 3

Scroll to PARTNERS APPLICATIONS

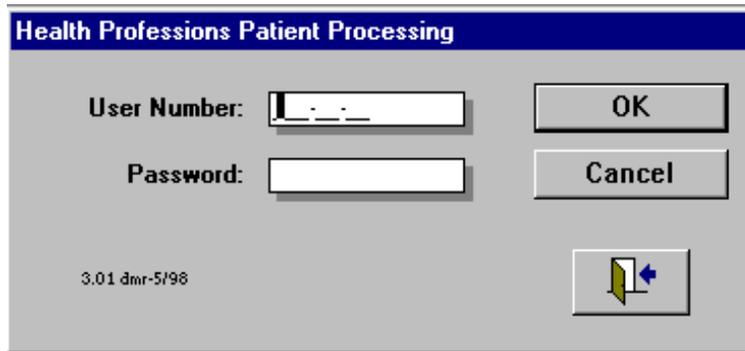
Step 4

Point to and Click on SsWORK



Step 5

A box will appear requesting your USER NUMBER and PASSWORD.
In USER NUMBER field: enter your employee ID# (this # is on the back of your ID tag)



Step 6

Press the TAB key on your keypad.

Step 7

In PASSWORD field: enter your password (same as password used to log onto your computer)

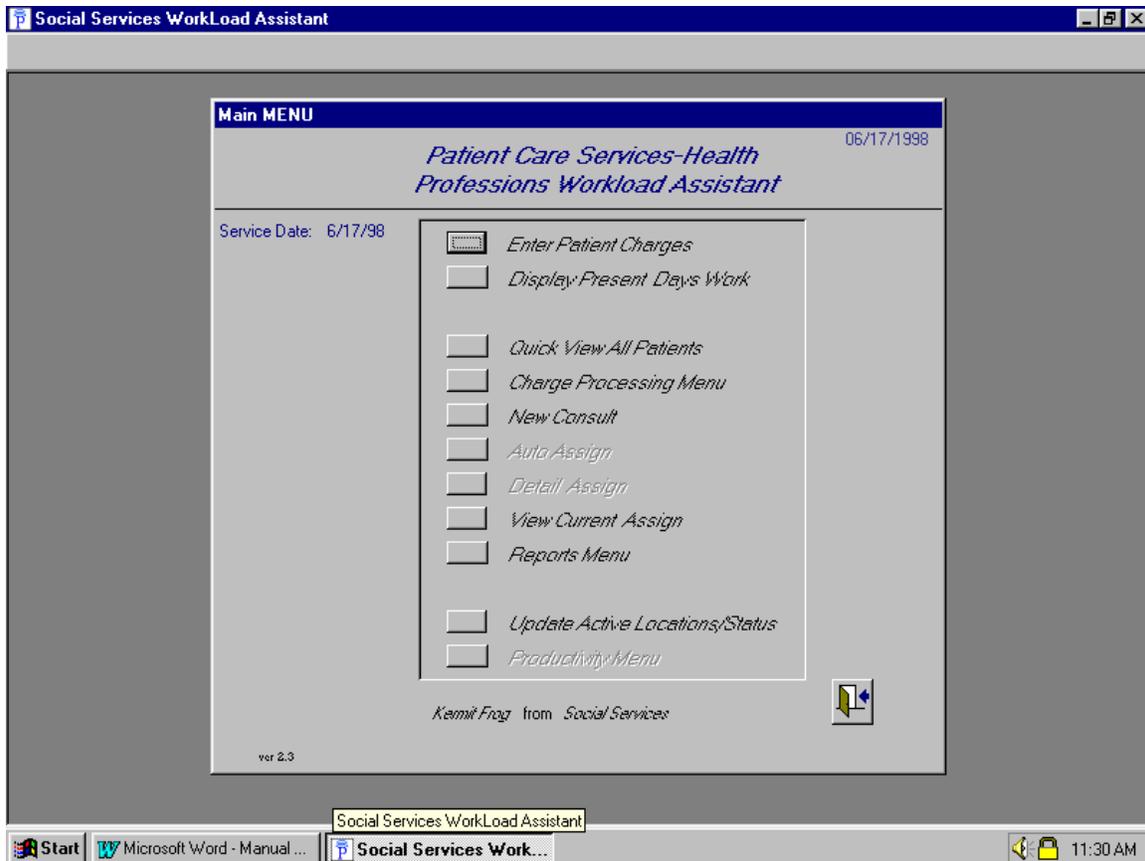
Step 8

Press the ENTER key or click on 

NOTE: BE PATIENT, as the system takes a few seconds to respond!

Main MENU

After successfully logging onto the system, the *Main Menu* will appear on your screen as follows:



All of the options highlighted are available to you. To access a certain option, click once on the button to the left of the option.

SCREEN NAME: *Enter Patient Charges*

All daily work is recorded on this screen.

(This screen is not actually for charges. This program was designed for other health professions that use the system for billing. Social Service does not use this system for this purpose.)

Purpose:

- retrieve new patients and record interventions with patient/family
- retrieve patients already in your service pool and record interventions with patient/family
- edit patient information
- review work previously done for a patient

HOW TO ENTER PATIENT INFORMATION FOR A NEW PATIENT

Step 1

Access the System (as shown on p. 8)

Step 2

Click once on ENTER PATIENT CHARGES from the *Main Menu*.

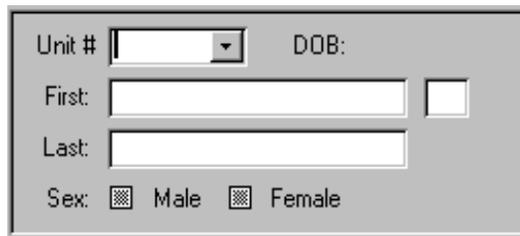
A screen will appear titled “Patient Master”:

The screenshot shows the 'Patient Master' window within the 'Work Load Assistant' application. The window is titled 'Patient Master' and contains the following fields and controls:

- Unit #: 000004 (dropdown)
- DOB: 01/26/1910
- Building: WACC (dropdown)
- Floor: LL (dropdown)
- Room: (empty)
- Admission: 11/06/2001
- Med Svc: (empty)
- First: SANTA
- Last: CLAUS
- Sex: Male Female
- Clinical Services: M-Orthopaedics (dropdown)
- Team: Surgery (dropdown)
- Assigned Staff: Bill Fair (dropdown) with an 'Assign' button
- Assistant Staff: (empty) with an 'UnAssign' button
- Procedure, Quant, Description, Provider table with a scrollable area.
- Navigation buttons: Home, Left, Right, End.

Step 3

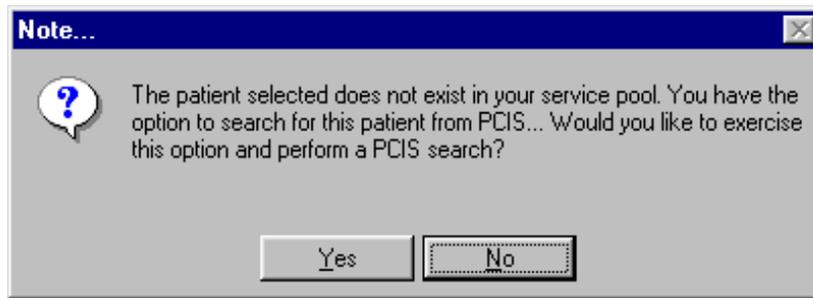
In UNIT # field: type in the patient's unit # and press ENTER



A screenshot of a patient entry form. It features a 'Unit #' dropdown menu, a 'DOB:' label, 'First:' and 'Last:' text input fields, and a 'Sex:' section with radio buttons for 'Male' and 'Female'.

Step 4

Since the patient is new and does not currently exist in your service pool, a window will appear titled “Note...”:

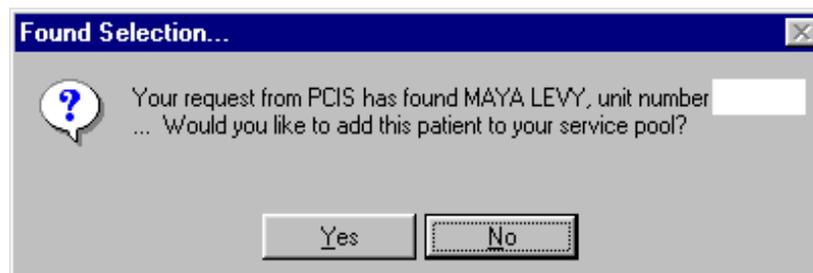


- Click YES, and the system will perform the search to retrieve the patient from PCIS.

(If you click NO, the system will NOT perform the search and the *Patient Master* screen will remain the same.)

Step 5

If the patient is in the PCIS system and has been found, another window will appear titled “Found Selection...”:

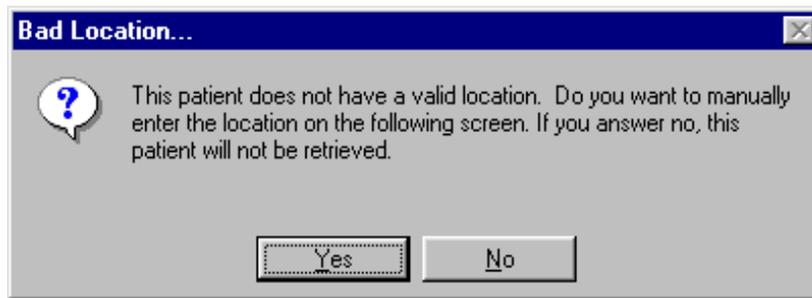


- If this is correct, click YES and the patient will be added to your pool.

(If you click NO, the patient will NOT be added to your pool, and the *Patient Master* screen will remain the same.)

Step 6 (FOR PATIENTS WHO ARE NOT CURRENTLY ADMITTED TO THE HOSPITAL!)

If this patient is not currently admitted to the hospital, a window will appear titled “Bad Location...”:



(a) Click YES, an additional window will appear titled "frmManualPatientEntry":

A form titled "frmManualPatientEntry" with the following fields and controls:

- UnitNumber:** [Text box]
- Birth Date:** [Text box]
- Admission Date:** [Text box containing "06/17/1998" and a label "mm/dd/yyyy"]
- First Name:** [Text box containing "MAYA"]
- Middle:** [Text box]
- Last Name:** [Text box containing "LEVY"]
- Sex:** [Dropdown menu showing "F"]
- Building:** [Dropdown menu]
- Floor:** [Dropdown menu]
- Room:** [Text box]

At the bottom of the form are two buttons: "Close & Save" and "Close & Cancel".

(If you click NO, the patient will not be retrieved and the **Patient Master** screen will remain the same.)

(b) Step 1

Click on the  symbol in the BUILDING field. A drop-down list of all the buildings of the hospital will appear.

Step 2

Scroll through the list and find the location for this patient.

Step 3

Click on the location.

Step 4

Repeat steps 1-3 for the FLOOR field.



☞ Begin to type in the first few letters of the location (building or floor) in the field, until it appears, and press ENTER.

(a) Click on CLOSE & SAVE to transfer this information onto the **Patient Master** screen.

(If you click on CLOSE & CANCEL the information will not be retrieved and transferred into your source pool.)

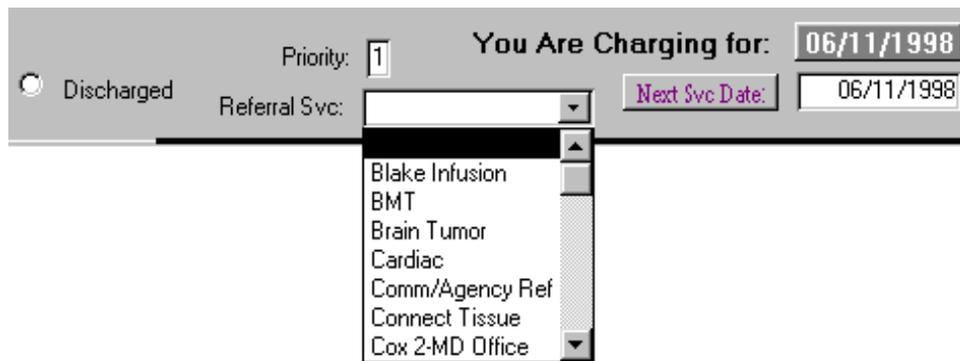
Step 7

(a) Click on the  symbol in the CLINICAL SERVICE field. A drop-down list of all the Clinical Services will appear.

(b) Scroll through the list and locate the Clinical Service for this patient.

(c) Click on the Clinical Service for this patient.

☞ Begin to type in the first few letters of the source in the field, until it appears, and press ENTER.



Priority: 1 You Are Charging for: 06/11/1998
 Discharged Referral Svc: [dropdown] Next Svc Date: 06/11/1998

- Blake Infusion
- BMT
- Brain Tumor
- Cardiac
- Comm/Agency Ref
- Connect Tissue
- Cox 2-MD Office

Step 8

(a) Click on the  symbol in the PROCEDURE field. A drop-down list of all the interventions, descriptors, and notices will appear.

(b) Scroll through the list and locate the intervention for this patient.

(c) Click on the intervention for this patient.

☞ If you know the intervention #, type it in the field and press ENTER.

Procedure	Quant	Description	Provider	Price
100	0	Psychosocial Assessment	Maya Levy	
100		Psychosocial Assessment		
101		Abuse and/or Neglect		
102		Domestic Violence		
103		Emot/Soc Resp to Illness/Hos..		
104		End of Life/Bereavement		
105		Behavior Inter with Care		
106		Decision-making reg Hos/Comm		
107		Substance Abuse/Addictions		

Step 9

In the Quantity field, enter between 1 and 8, where 1 = 15 minutes, 2 = 30 minutes, 3 = 45 minutes, etc. up to 8 = 120 minutes, depending on the amount of time spent on the intervention.

Procedure	Quant	Description	Provider	Price
100	0	Psychosocial Assessment	Maya Levy	

Step 10

After entering the intervention, a new blank procedure field appears. Enter one or more Descriptors, then one or more Notices as needed. (See section on "Work Element Definitions" for explanation of when to use descriptors and notices). Notices and Descriptors always have a quantity of 1.

Step 12

If you have any notes that you would like temporarily saved in the system regarding this patient, you may type them in the white rectangular box on the bottom of the screen.

TYPE NOTES HERE

NOTE: Once a patient is discharged from your service pool, the typed notes are deleted!

Work Load Assistant

Patient Master

Unit #: [] DOB: [] Building: [] Admission: []
First: [] Floor: [] Med Svc: []
Last: [] Old Work [] Room: []
Sex: Male Female Search Location []

You Are Charging for: 12/07/2001

Discharged Clinical Services: [] Team: Unknown []

Assigned Staff [] Assign Assistant Staff [] UnAssign

Procedure	Quant	Description	Provider

Alias []

Step 13

Check previous work done for the patient by clicking here.

YOU ARE DONE RECORDING THE WORK ELEMENTS FOR THIS PATIENT! The work elements will be automatically and permanently saved in the system at 11 AM the following business day.

IF YOU MAKE A MISTAKE:

The system will not allow you to delete a work element once you have entered it. If you entered a work element by mistake, simply enter "0" for the quantity prior to 11:00 AM the next business day. The element will be visible until 11 AM the next business day, but at that point it will disappear and it will not be counted.

HOW TO ENTER PATIENT INFORMATION FOR A PATIENT ALREADY IN YOUR SERVICE POOL

Step 1

Access the System (as shown on p. 8)

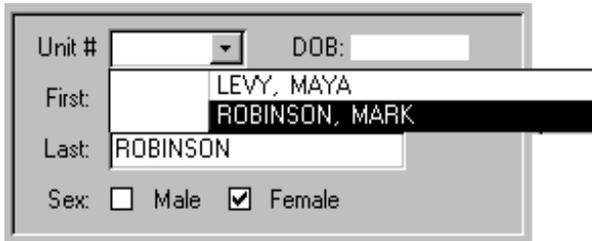
Step 2

Click on ENTER PATIENT CHARGES from the *Main Menu* screen. The **Patient Master** screen will appear.

Step 3

- Click on the  symbol in the UNIT # field. A drop-down list of all the patients in your service pool will appear.
- Scroll through the list and locate the patient for whom you wish to enter patient information.
- Click on this patient's name or unit #. The patient's information will now be transferred into the fields.

 If you know the patient's unit #, type it in the field and press ENTER.

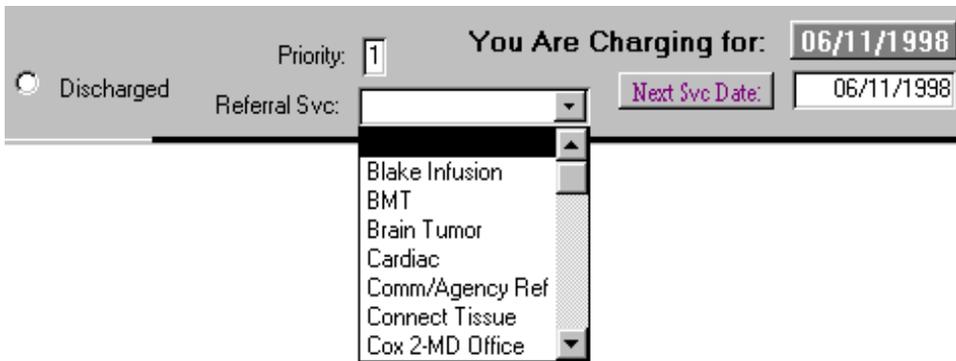


Unit #  DOB:
First: LEVY, MAYA
ROBINSON, MARK
Last: ROBINSON
Sex: Male Female

Step 4

- Click on the  symbol in the CLINICAL SERVICE field. A drop-down list of all the Clinical Services will appear.
- Scroll through the list and locate the Clinical Service for this patient.
- Click on the Clinical Service for this patient.

 Begin to type in the first few letters of the source in the field, until it appears, and press ENTER.



Discharged Priority: 1 You Are Charging for: 06/11/1998
Referral Svc:  Next Svc Date: 06/11/1998
Blake Infusion
BMT
Brain Tumor
Cardiac
Comm/Agency Ref
Connect Tissue
Cox 2-MD Office

Step 5

- Click on the  symbol in the PROCEDURE field. A drop-down list of all the interventions, descriptors, and notices will appear.
- Scroll through the list and locate the intervention for this patient.
- Click on the intervention for this patient.

 If you know the intervention #, type it in the field and press ENTER.

Procedure	Quant	Description	Provider	Price
100	0	Psychosocial Assessment	Maya Levy	
100		Psychosocial Assessment		
101		Abuse and/or Neglect		
102		Domestic Violence		
103		Emot/Soc Resp to Illness/Hos..		
104		End of Life/Bereavement		
105		Behavior Inter with Care		
106		Decision-making reg Hos/Comm		
107		Substance Abuse/Addictions		

Step 6

If you have additional interventions, from different sessions to enter for the patient, repeat step 5.

Procedure	Quant	Description	Provider	Price
100	0	Psychosocial Assessment	Maya Levy	

Step 7

If you have any notes regarding this patient, which you would like saved in the System, you may type them in the white rectangular box on the bottom of the screen.

|TYPE NOTES HERE



NOTE: Once a patient is discharged from your service pool, the typed notes are deleted!

The work elements will be automatically and permanently saved in the system at 11 AM the following business day.

IF YOU MAKE A MISTAKE:

The system will not allow you to delete a work element once you have entered it. If you entered a work element by mistake, simply enter "0" for the quantity prior to 11:00 AM the next business day. The element will be visible until 11 AM the next business day, but at that point it will disappear and it will not be counted.

HOW TO EDIT PATIENT INFORMATION FROM THE ENTER PATIENT CHARGES SCREEN

How to Change the Location of the Patient

Step 1

Click on the  symbol in the BUILDING field. A drop-down list of all the buildings of the hospital will appear.

Step 2

Scroll through the list and find the updated location for this patient.

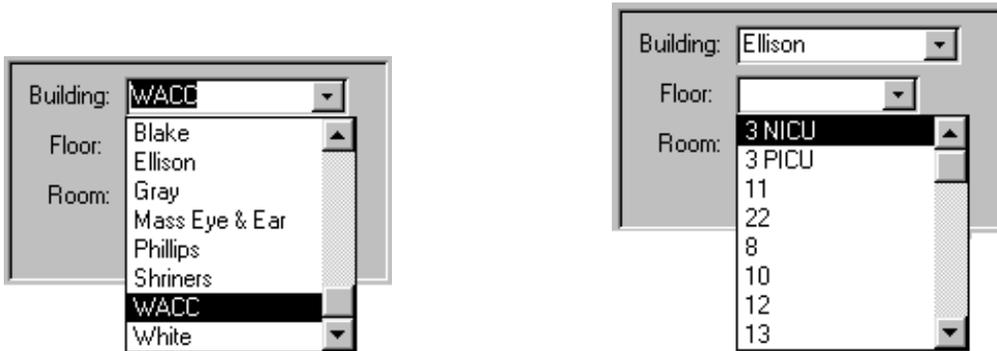
Step 3

Click on the updated location.

Step 4

Repeat steps 1-3 for the FLOOR field.

 Begin to type in the first few letters of the updated location (building or floor) in the field, until it appears, and press ENTER.



How to Change the Social Worker Assigned to the Patient

Step 1

Click on the  symbol in the ASSIGNED STAFF field. A drop-down list of all social workers will appear.

Step 2

Scroll through the list and find the new Social Worker assigned to this patient.

Step 3

Click on his/her name.

 Begin to type in the first few letters of the new Social Worker in the field, until his/her name appears, and press ENTER.

How to Assign an Assistant Social Worker

Follow the same directions as above in the ASSISTANT STAFF field.

Assigned Staff

- Kathleen Ryan
- Marie Elena Gioiella
- Mark Robinson
- Maya Levy**
- Pamela Burton
- Rachel Goldberg
- Susan Fitzgerald
- Tony Jenkins

NOTE: You do not have to be the current assigned social worker in order to be credited for the work you enter. If you logged into the system, the system will automatically credit you with the work you enter. Only change the assigned social worker if the primary social worker for the patient is changing.

Clinical Service

Enter the medical, psychiatric, or surgical service that is providing care to the patient at the time that you provided care to the patient. The clinical service should be changed in the system if there is a change in the clinical service following the patient.

Step 1

Click on the  symbol in the CLINICAL SERVICE field. A drop-down list of all the Clinical Services will appear (see complete list on next page).

Step 2

Scroll through the list and find the Clinical Service working with the patient.

Step 3

Click on the Clinical Service.

 Begin to type in the first few letters of the Clinical Service in the field, until it appears, and press ENTER.

Discharged Priority: You Are Charging for:
 Referral Svc:

- Blake Infusion**
- BMT
- Brain Tumor
- Cardiac
- Comm/Agency Ref
- Connect Tissue
- Cox 2-MD Office

NOTE: This change can also be made through the *Quick View All Patients* screen on page 24.

CLINICAL SERVICES

MS- MED./SURG.

Burns/Plastic
Cardiac
General Surgery
Medicine House
Medicine Private
Neuro
Orthopaedics
Thoracic
Trauma
Urology
Vascular

T-TRANSPLANT/DIALYSIS

Heart Transplant
Hemodialysis
Kidney Transplant
Liver Transplant
Lung Transplant
Multi-Organ Transplant
Peritoneal Dialysis (CAPD)

A-Ambulatory

Dermatology
EAP
Infectious Disease
Neuro
OB/GYN
Primary Care IMA/Health Centers
Primary Care MGPO
Surg/Surg Specialties

E-Emergency Department

Emergency Medicine
Medical Walk-In

O-ONCOLOGY

Bone Marrow Transplant (BMT)
Brain Tumor
Breast
Connective Tissue
Gastro-Intestinal
General Hematology/Oncology (Gen'l Hem/Onc)
Genito/Urinary (GU)
Gynecology (GYN)
Head and Neck
Proton Beam
Skin/Melanoma
Thoracic

W-WOMEN AND CHILDRENS

Gynecology (GYN)
Neonatology
Obstetrics
Peds- Hem/Onc
Peds- Medicine
Peds-Ortho
Peds- Surgery
Peds- Trauma

S-SOCIAL WORK

Used when the clinical service is *only* Social Work.
No other clinical service is involved.

P-PSYCHIATRY

Addiction Service
Adult Psychiatry
Child Psychiatry
Partial Hospitalization

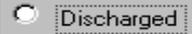
Discharge

You are responsible for discharging patients from your service pool. You may keep patients in your service pool when you have a plan for intervention which you will initiate, such as:

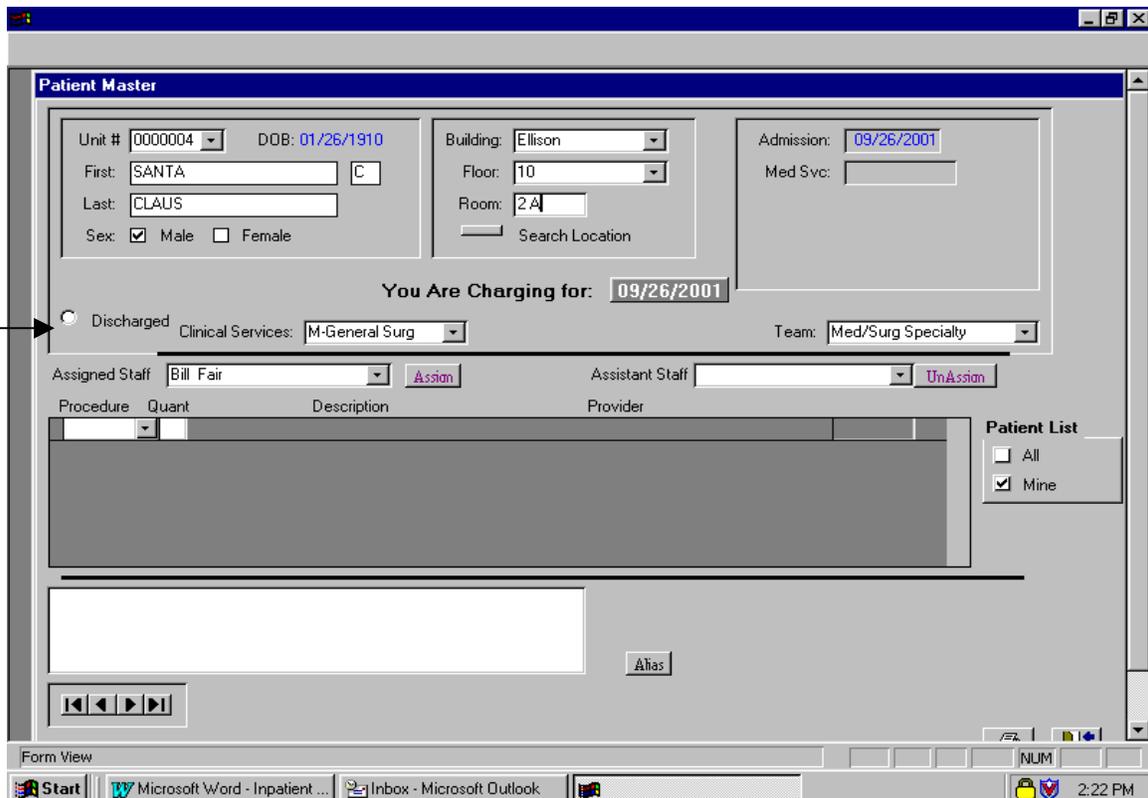
- Your stated plan is to see the patient in each site of care during their treatment phase (i.e. inpatient, then in ambulatory care, or vice versa).
- You offer a patient a next appointment.
- You tell the patient you will contact them after discharge.
- You tell the patient you will contact them post termination or between infrequent ambulatory visits.

You must discharge patients from your service pool when you have no plan for a future intervention.

To change the discharge status of the patient, click once on the white circle in the discharge field.

- If the patient is discharged, there should be a black dot in the white circle. 
- If the patient remains as an inpatient, the circle should remain white. 

NOTE: This change can also be made through the *Quick View All Patients* screen on p.24.



The screenshot shows the 'Patient Master' form with the following details:

- Unit #: 0000004, DOB: 01/26/1910
- First: SANTA, Last: CLAUS, Sex: Male
- Building: Ellison, Floor: 10, Room: 2A
- Admission: 09/26/2001
- Discharged: (highlighted with a white circle)
- Clinical Services: M-General Surg
- Team: Med/Surg Specialty
- Assigned Staff: Bill Fair
- Assistant Staff: (empty)
- Procedure table with columns: Procedure, Quant, Description, Provider
- Patient List: All, Mine

NOTE: If you discharged a patient accidentally, you may simply re-enter the patient's unit number to bring them back into your service pool.

SCREEN NAME: *Display Present Days Work*

Purpose:

- This screen lists all patients and the # of interventions, descriptors, and notices per patient that you recorded in the system for that workday.

HOW TO ACCESS “DISPLAY PRESENT DAYS WORK”

Click on DISPLAY PRESENT DAYS WORK from the *Main Menu*. A window will appear titled “Totals by Staff by Service Date”:

The screenshot shows a window titled "Social Services WorkLoad Assistant" with a sub-window titled "Totals By Staff by Service Date". The sub-window has a "Service Date:" field with the value "05/22". Below this is a table with three columns: "UnitNumber", "Patient Name", and "Billed TX". The table contains one row with a blank unit number, "LEVY MAYA", and "3". At the bottom of the sub-window, there is a "Totals for.... Kermit Frog" section with a "Patient Count:" field containing "1" and a "Billed TX" field containing "3". There are also icons for printing and refreshing. The Windows taskbar at the bottom shows the Start button, open applications including "Microsoft Word - Manual 2...", "Social Services Work...", and "untitled - Paint", and the system clock showing "10:34 AM".

UnitNumber	Patient Name	Billed TX
	LEVY MAYA	3

Totals for.... Kermit Frog

Patient Count: 1

Billed TX: 3

SCREEN NAME: *Quick View of All Patients*

This screen summarizes all the patients that are within the system according to an alphabetical listing of the social workers assigned.

Purpose:

- quickly view the discharge status and Clinical Service of each patient
- change the discharge status and Clinical Service of each patient
- discharge multiple patients at one time

HOW TO VIEW ALL PATIENTS IN A SUMMARIZED FORMAT

Click QUICK VIEW ALL PATIENTS from the *Main Menu* screen. A window will appear titled “Quick View”:

The screenshot shows a window titled "Social Services WorkLoad Assistant" containing a smaller window titled "Quick View". The "Quick View" window displays a table with the following columns: Patient, Assigned, Next Service Date, Referral Source, Evening, and DC'd. The table lists 18 patients with their names, assigned social workers, service dates (all 6/29/98), referral sources, and discharge status (radio buttons).

Patient	Assigned	Next Service Date	Referral Source	Evening	DC'd
JOSE	Erin Swiontek	6/29/98	EI-Comm/Agency	<input type="radio"/>	<input type="radio"/>
GEORGE	Erin Swiontek	6/29/98	EI-ED	<input type="radio"/>	<input type="radio"/>
NIKITA	Erin Swiontek	6/29/98	EI-ED	<input type="radio"/>	<input type="radio"/>
MICHAEL	Kathleen Ryan	6/29/98	M1-House	<input type="radio"/>	<input type="radio"/>
RUTH	Kathleen Ryan	6/29/98	EI-SelfReferral	<input type="radio"/>	<input type="radio"/>
KATHERINE	Kathleen Ryan	6/29/98		<input type="radio"/>	<input checked="" type="radio"/>
DEBORAH	Kathleen Ryan	6/29/98	M1-House	<input type="radio"/>	<input checked="" type="radio"/>
MARY	Kathleen Ryan	6/29/98	M1-House	<input type="radio"/>	<input checked="" type="radio"/>
PASQUALE	Kathleen Ryan	6/29/98	M1-House	<input type="radio"/>	<input type="radio"/>
IRENE	Kathleen Ryan	6/29/98	M1-House	<input type="radio"/>	<input type="radio"/>
SANDRA	Kathleen Ryan	6/29/98	M1-House	<input type="radio"/>	<input type="radio"/>
ROSEMARIE	Marie Elena Gioiella	6/29/98	D-GYN	<input type="radio"/>	<input type="radio"/>
CANDACE	Marie Elena Gioiella	6/29/98		<input type="radio"/>	<input type="radio"/>
JOHN	Marie Elena Gioiella	6/29/98		<input type="radio"/>	<input type="radio"/>
DIANE	Marie Elena Gioiella	6/29/98	D-GYN	<input type="radio"/>	<input type="radio"/>
MARTHA	Marie Elena Gioiella	6/29/98		<input type="radio"/>	<input type="radio"/>

Two arrows point from the text below to the "Referral Source" and "DC'd" columns of the table.

To change the clinical service, click and choose here.

To discharge a patient from your service pool, click here.

SCREEN NAME: *Reports Menu*

Purpose:

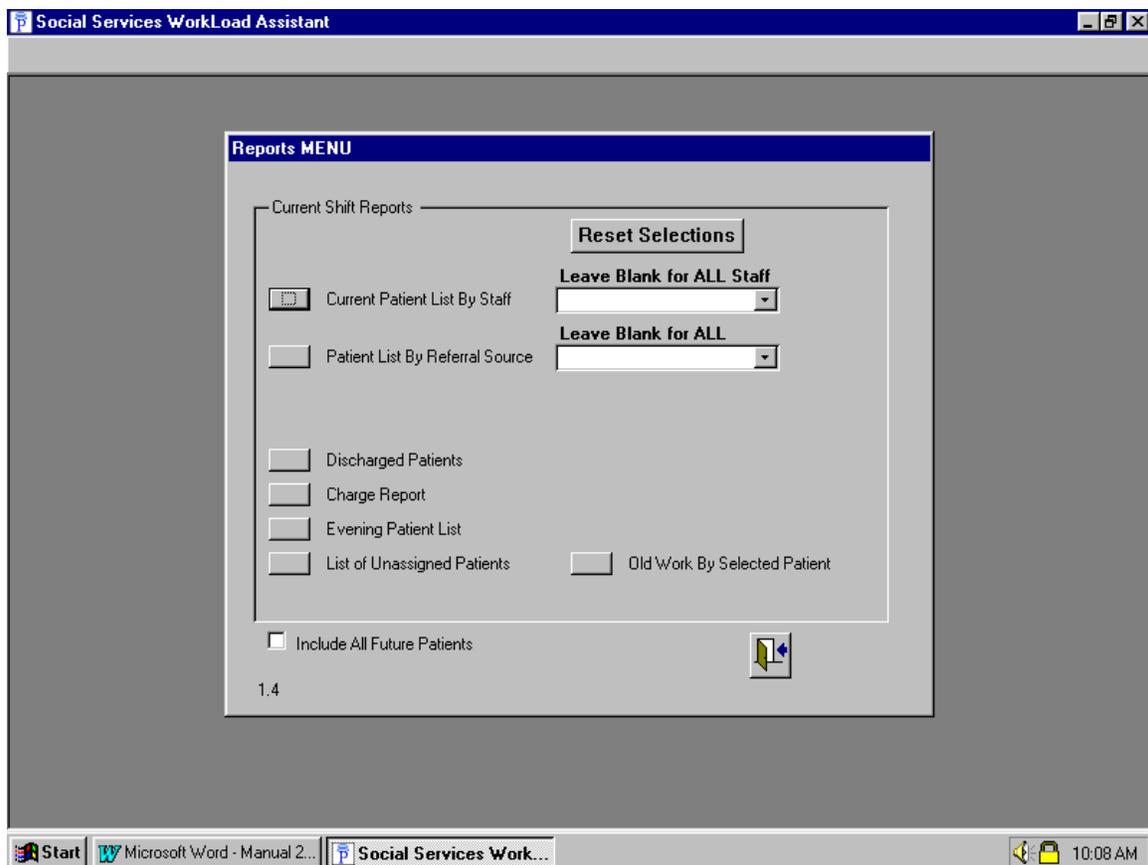
- Provides reports compiled from patient information

Reports Include:

- Current Patient List by Staff
- Current Patient List by Clinical Service
- List of Discharged Patients
- History of Social Sources Provided to Patient

HOW TO ACCESS THE REPORTS MENU

Click on REPORT MENU from the *Main Menu*. A window will appear titled “**Reports Menu**”:



HOW TO ACCESS A REPORT

- To access a report, click once on the button to the left of the report desired.

- ❖ **Always check the report “Old Work by Selected Patient” for any newly assigned patients.**
 - From the Main MENU click on “Reports MENU.”
 - Click on “Old Work by Selected Patient.”
 - Enter the patient’s unit number.



SCREEN FEATURES

- ❖ **Display Present Days Work**
 - lists all patients and # of interventions per patient for the day

- ❖ **Quick View**
 - discharge multiple patients at one time
 - change referral source of patient

- ❖ **View Current Assign**
 - distribute the workload
 - change Social Worker assigned to the patient

- ❖ **Reports Menu**
 - List of Current Patients by Staff/ all Staff
 - includes demographic information, location and comment section
 - List of Patients by Referral Source/ all Referral Sources
 - includes demographic information, location and comment section
 - List of Discharged Patients
 - List of Patients Assigned to Staff
 - List of Evening Patients
 - List of Unassigned Patients
 - Old Work by Selected Patient -Patient History
 - includes service date, all past interventions, descriptors, notices and provider

CANCER RESOURCE ROOM

You should enter any *scheduled* time spent in the Cancer Resource Room.

Procedure:

- 1) In the Unit Number field, enter "CRRM" plus your initials. If you have only two initials, enter an "x" as your middle initial. Example: CRRMPXB
- 2) The first time you input this "unit number," it will not already be a part of your service pool. Take the following steps:
 - a) The system will give you the option of searching PCIS. Choose "yes".
 - b) After the system searches PCIS and does not find this unit number, you will be given the option of manually entering "the patient", choose "yes".
 - c) In the *First Name* field, enter **Cancer**.
 - d) In the *Last Name* field, enter **Room**.
 - e) In the *Sex* field, enter **F**.
 - f) In the *Location* field, enter **WACC-LL**.
 - g) In the *Team* field, enter your team.
- 3) Choose intervention code 117, *Cancer Resource Room*.
- 4) In the Quantity field, enter 1 through 8, where 1 = 15 minutes, 2 = 30 minutes, etc., based on the approximate amount of time spent on your shift. Do not enter any descriptors or notices with Cancer Resource Room.

LATE OR MISSING WORK

Definition: Work not entered because of computer failure or personal reasons.

1. If you are working but fail to record your patient activities for that day, you must notify Phyllis Robertson by e-mail as to why your work was not entered for the service date. (Please note, you have up to 11:00 AM the next business day after service date to enter work.)
2. Once you have notified Phyllis, you should then enter your work, however be aware that work entered late will be credited for the service date on which it is entered (not the date on which you did the work.)
3. In the event there is a computer failure, an all voice mail will announce when work may be entered.
4. The system is monitored daily. A report is printed as to who entered work and the amount of work entered. It is then compared to the payroll report. If you fail to enter work and you are not recorded as taking earned time or conference time on that day, you will receive an e-mail from Phyllis. You will then be required to explain by e-mail as to why your work was not entered. This report is distributed to the Leadership Team on a weekly basis.

ON-CALL / ON-SITE POLICY:

On-call work is essential to good patient care and is a responsibility all clinical staff carry. Consequently, work should be accounted for as are other patient care activities. The Inpatient Billing System gives us the data to:

- a. Review referrals and do quality monitoring;
- b. Trace patterns of types of referrals, time of referral and location of patient when referred;
- c. Monitor need for staff and needed hours.

On-call activities (by phone and when called into the hospital) entered into the System are included in your monthly Direct Patient Care Reports. Credit is given for the work without adding the hours during which you carried the beeper or came in On-call, thus increasing your percentage of direct care time.

ON-CALL PHONE CONTACTS FROM HOME:

1. Always ask for patient's unit number.
2. On the next business day, enter the work in the Inpatient Billing System
3. In Clinical Service field enter the appropriate Clinical Service.
4. In Team field enter *On-Call from Home*. If you subsequently come into the hospital for this case, enter *On-Call in Hospital* as the "Team."
5. If you spoke to a staff person, enter the Intervention code # 116, *Intervention with MGH Staff while on-call from outside hospital*. Enter the time spent on the phone call. Enter descriptors to describe the issues addressed. Enter notices as appropriate.
6. If you spoke to the patient or family member, enter the appropriate intervention, time, notices, and descriptors as described previously.

ON-CALL IF YOU COME INTO THE HOSPITAL:

1. Always get the patient's unit number.
2. On the next business day, enter the work in the Inpatient Billing System.
3. In Clinical Service field enter the appropriate Clinical Service.
4. In Team field enter *On-Call in Hospital*.
5. Enter work elements as normal. While in the hospital during an on-call shift, talking with staff is not entered as it is when calling in from home. The system is used the same way as it is during the week.

ON-SITE

1. Always get the patient's unit number.
2. Enter the work in the Inpatient Billing System during your on-site shift, or prior to 11 AM the next business day.
3. In Clinical Service field enter the appropriate Clinical Service.
4. In Team field enter *On-Site*.
5. Enter work elements as normal.

Remember to complete an On-Call / On-Site Log-sheet for each day you were on-site or on-call.

Unknown Unit Number:

If a patient is known to have an MGH unit number, this number should be obtained. If it is not possible to obtain the unit number or if you work with someone who is not an MGH patient, you should enter the work as described below:

1. **Choose** “*Enter Patient Charges*”
2. In the unit number field **type** *unk*(*Plus a four digit number of your choice*) for example: unk1234. **Press enter**. This will become your unknown patient’s temporary unit number. If a patient’s name appears after entering assigned unit number (unk####), try a different 4-digit number sequence.
3. A message will appear that reads “ *The patient does not exist in your service pool. You have the option to search for this patient in PCIS.....* **Choose “yes”**. The system will search PCIS based on the unit number you assigned. When the system completes its search, you will be informed that “*The patient selected does not exist in any database. Do you want to manually enter this patient?* **Choose “yes”**. **Enter patient information, Close & Save.**
4. Once you have entered the unknown patient using the unit number prefix, *unk* plus 4-digits of your choice, that patient will remain in your service pool until you discharge the patient. You will need the number you assigned in order to enter subsequent interventions
4. Keep a list of numbers you assign to each of your unknown patients. This will make it possible for you to continue to enter work under this patient until an MGH unit number is assigned.
5. Contact the Clinical Systems Coordinator if an official unit number is later assigned to the patient so the previous work can be “attached” to that unit number.

INPATIENT BILLING SYSTEM

WORK ELEMENT CODES & DEFINITIONS

Revised 1/24/01

Code	Title in the System	Brief Definition
INTERVENTIONS		Enter Quantity of Time where 1=15 min, 2=30 min, etc.
110	I-Int. w/Patient	Intervention with Patient
111	I-Int. w/Family	Intervention with Family or Significant Other
112	I-Int. w/Pt & Fam	Intervention with Pt and Family/S.O.
113	I-Int. w/Non-MGH Collat	Intervention with Non-MGH Collateral Person/Agency
114	I-Team Meeting w/Pt/Fam	Interdisciplinary Team Meeting with Pt and/or Family
115	I-Team Meeting, No Pt/Fam	Interdisciplinary Team Meeting without Pt and/or Family
116	I-Int. w/Staff while On-Call	Intervention with MGH Staff while on-call from outside hospital only
117	I-Cancer Res. Room	Cancer Resource Room Shift (no descriptors)
118	I-Advocacy within MGH	Intervention with MGH Staff to obtain services, resources, or info for patient
GROUP INTERVENTIONS		Quantity is always "1" – Time is automatically assigned. Do not enter Descriptors or Notices with Group Interventions.
702	Non-Billable Group of 2	Members contract for attendance.
703	Non-Billable Group of 3	
704	Non-Billable Group of 4	
705	Non-Billable Group of 5	
706	Non-Billable Group of 6	
707	Non-Billable Group of 7	
708	Non-Billable Group of 8	
709	Non-Billable Group of 9	
710	Non-Billable Group of 10	
711	Drop-in Group	
DESCRIPTORS		Enter at least one for each Intervention entered. Quantity is always 1. Describe only the major issues addressed in the intervention, <i>not</i> every issue the patient has.
721	D-Addiction	Addiction issues including addiction or abuse of substances, or process addictions such as gambling, overeating, etc.
722	D-Anger	Issues related to anger.
723	D-Anxiety	Issues related to anxiety.
724	D-Assessment	General information gathering not related to a specific issue.
725	D-Behavior Management	Issues related to management of maladaptive behavior.
726	D-Child Abuse/Neglect	Issues related to child abuse or neglect. (Also see "Emotional Trauma" and the <i>Notice</i> , "Mandated Report.")
727	D-Cultural	Cultural issues.
728	D-Depression	Issues related to depression.
729	D-Disability	Issues related to disability.
730	D-Disabled Abuse/Neglect	Issues related to disabled abuse or neglect. (Also see "Emotional Trauma" and the <i>Notice</i> , "Mandated Report.")
731	D-Domestic Violence	Issues related to domestic violence. (Also see "Emotional Trauma.")

732	D-Eating Disorder	Issues related to an eating disorder.
733	D-Elder Abuse/Neglect	Issues related to elder abuse or neglect. (Also see “Emotional Trauma” and the <i>Notice</i> , “Mandated Report.”)
734	D-Emotional Trauma	Issues related to emotional trauma caused by physical, emotional, or sexual abuse, traumatic injury, assault, witnessing of traumatic events, etc.
735	D-Financial	Financial issues.
736	D-Grief/Bereavement/Loss	Grief, bereavement or loss issues.
737	D-Homelessness	Issues related to homelessness.
738	D-Hospitalization/MGH	Issues with hospitalization or managing the MGH System.
739	D-Housing	Housing issues other than homelessness.
740	D-Illness	Issues related to medical illness or treatment. (<i>Avoid using this descriptor by itself. Consider what other issues related to the illness were also addressed.</i>)
741	D-Injury	Issues related to injury. (<i>Avoid using this descriptor by itself. Consider what other issues related to the injury were also addressed.</i>)
742	D-Legal	Issues related to criminal or civil matters, or substituted judgement.
743	D-Mania	Issues related to mania including management of manic behavior.
744	D-Parenting	Issues related to parenting.
745	D-Pregnancy/Childbirth	Issues related to pregnancy or childbirth.
746	D-Psychosis	Issues related to psychosis including management of delusions or hallucinations.
747	D-Relationship	Issues related to personal relationships <i>other than</i> child/disabled/elder abuse, domestic violence, or parenting issues.
748	D-Resources	Issues related to need for assistance with hospital or community resources.
749	D-Self-care	Issues related to inadequate self-care.
750	D-Self-esteem	Issues related to self-esteem.
751	D-Self-harm	Issues related to self-harm such as self-injury.
752	D-Sexuality/Gender	Sexuality/Gender issues.
753	D-Social Skills	Issues related to social skills.
754	D-Social Supports	Issues related to inadequate social supports.
755	D-Spirituality	Spirituality or religious issues.
756	D-Suicidality	Issues related to suicidal ideation, plans, or attempts.
757	D-Vocation/Education	Issues with occupation or school, including unemployment.
758	D-Other	Any issues that do not at all fit into the above categories.
COMM. CARE DESCRIPTORS		For use by Community Care Team Only.
840	D-Rep Payee	Family Care Representative Payee.
841	D-Home Visit	Home Visit.
842	D-RN Assess	RN Assessment.
843	D-RN Monitor	RN Monitoring.
844	D-RN/FCP Plan Adjust	RN/FCP Health Plan Adjustment.
845	D-RN/FCP Home Eval.	RN/FCP Home Evaluation.
846	D-Community Visit	Community Visit.
NOTICES		Enter as needed at your discretion, except one of the two “interpreter” notices should be entered each time an interpreter is used, and “mandated report” should be entered once for each mandated report filed.
850	N-Addiction Service	Addiction Service consulted or involved.
851	N-Chaplain	Chaplain consulted or involved.
852	N-Child Protection Team	Child Protection Team consulted or involved.

853	N-Contact This S.W.	Use to notify future social workers to contact you about this patient.
854	N-DPPC	Disabled Persons Protection Commission Involved.
855	N-DSS	Department of Social Services Involved.
856	N-Elder Services	Elder Protective Services Involved.
857	N-Guardian	Patient has a Guardian.
858	N-Proxy	Patient has a Health Care Proxy.
859	N-Power of Attorney	Patient has appointed Power of Attorney.
860	N-HAVEN	HAVEN was consulted or involved.
861	N-Off Scope	Patient was Off Scope (Hidden by Security for added protection or privacy).
862	N-Other Outside Agency	Other Outside Agency Involved.
863	N-Psychiatry	Psychiatry consulted or involved.
864	N-Restraining Order on Other	Patient has Restraining Order on another person.
865	N-Restraining Order on Pt	Restraining Order on Patient from another person.
866	N-Assess For Safety	Caution is recommended - may be safety issues affecting Pt, staff or others.
867	N-Security	Security consulted or involved.
868	N-Official MGH Interpreter Used	Interpreter used from MGH Interpreter Service. <i>(Should be entered every time an MGH Interpreter is used).</i>
869	N-Unofficial Interpreter Used	An unofficial interpreter was used. <i>(Should be entered every time an unofficial interpreter is used).</i>
870	N-Mandated Report Filed by SW	Enter once for each mandated report <i>filed by you.</i>

GLOSSARY

Discharge

Deleting a patient from your list of active patients or “service pool.” This *does not* mean discharged from the hospital.

Drop-Down

A drop-down field allows you to either type directly in the field, or click on a drop-down arrow  to choose from the list.

Field

A rectangular space on the screen where information can be entered.

Clinical Service

Service from which the patient was referred. (E.g. House Medicine, Urology Surgery, NICU etc.)

Service Pool

A list of patients for whom you are actively providing care or services.

Unit Number

A patient’s hospital identification number. All work entered into the system must be entered under a Unit Number.

Work Element

Data used to identify, describe, and categorize work that is done. Interventions, Descriptors and Notices are all work elements.