Northern Light Health | Optum

From the Office of Health Informatics

MatrixCare

Clinical EHR Flash Flyer

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MatrixCare Go-Live

Known Issues & Updates

Comfort Pack Not Visible in Medication Profile

- The patient's Comfort Pack is not currently displayed within the medication profile.
  - At this time, there is no clinician-facing method to view this information in MatrixCare.
  - This is currently being worked on by Hospice leaders to identify best practice and workflow.

Care Plan Not Displaying on some Visits

- Home Health Aides (HHAs) will not be able to complete visit documentation if a care plan has not been added for their discipline.
  - HHAs cannot create or assign care plans. If no care plan is available, contact the office for assistance.
- Some patients may not have a care plan displaying within their visit in MatrixCare.
  - For a care plan to be visible, it must be entered under the appropriate clinician discipline. If the care plan is not associated with the correct discipline, it will not be available for viewing within the visit.

Some Hospice Patients Not Displaying in MatrixCare

- We are aware of an issue where some Hospice patients may not appear in MatrixCare as expected.
  - These patients have not yet been loaded into MatrixCare. Teams are working to identify affected patients and complete the loading process so they become available within the system.

Important Reminders

Complete Visits in Editing Status

- Visits with a status of **Editing** have been started but **have not yet been submitted**. Please review your Tasks daily and complete any outstanding documentation.
- Visit Statuses:
  - **Scheduled:** Visit is on your schedule and has not been started. Document the visit, move the visit, or change it to a Missed Visit as appropriate.
  - **Editing:** Visit documentation has been started but not submitted.
  - If documentation is complete, open the visit and select Review and Submit to finalize and submit the visit.

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- **New:** An order has been created but not submitted. Open the order, review it, and select Submit in the upper-right corner.
- **Active:** An order has been submitted and is waiting to synchronize.

Enter Clinical Notes in Communication Notes

- Clinicians should put their clinical notes within communication notes.
- Communication Note Type for IDG meetings, POD notes and Triage Notes should be entered as a prep note.

Please Close and Submit Your Visits

- When visits are not closed and submitted promptly, the impact can be significant. Incomplete visits can affect clinical workflows, reporting, billing, and the visibility of patient information across the care team.

Mark Orders in Error, Do Not Discontinue

- When an order has been entered incorrectly, do not discontinue the order. Instead, the order should be marked in error.

Use Plan of Care Orders for Initial Orders

- Initial patient orders should be entered as **Plan of Care** orders rather than **Verbal Orders**.
- Using the correct order type ensures the patient's plan of care is established appropriately and supports accurate documentation and workflow management.

Discipline Orders

- Home Health transition patient's will have a discipline order entered within AFO (Agency Front Office).

Outcome Goals

- Outcome Goals are intended for Home Health patients only. Hospice patients do not require Outcome Goals.

CNA Discipline Selection

- Clinicians whose discipline is CNA should document under HHA (Home Health Aide) to ensure consistency across records.

Hospice Contact Information

- For hospice patients, both a **Primary Caregiver** and an **Emergency Contact** must be documented. The Primary Caregiver receives surveys, while the Emergency Contact is displayed on the facesheet and is used for disaster triage and emergency communications.

Order Entry Reminder: Avoid Erroring Out an Entire Order Group

- To avoid the need to error out an entire order group due to a mistake, enter visit frequency orders in **separate order groups for each discipline**.
- **Example:** RN visit frequency orders should be entered in a different order group than HHA/Aide visit frequency orders. Keeping disciplines separate makes it easier to update or correct orders without impacting unrelated disciplines.

No Certification Period Available

- If a certification period is not available, clinicians should reach out to their **Clinical Manager** for assistance.

INR and Lab Results

- **INR results and other laboratory values are pulled directly from Oracle Cerner into MatrixCare.** Clinicians should be aware that this information originates from Oracle Cerner and may update based on the data available in that system.

Not Taking Under Care (NTUC)

- Clinical staff must contact their Clinical Manager to discuss any potential Not Taking Under Care (NTUC) situations before proceeding with documentation.
- Clinical Managers

STEP 1: Orders: Error out all orders.
STEP 2: Communication: Document a Communication Note. Confirm the field staff's Communication
  - Note has been completed before proceeding to the next step.

STEP 3: Admission Settings: Update the Admission Status to Reject Accepted Referral.

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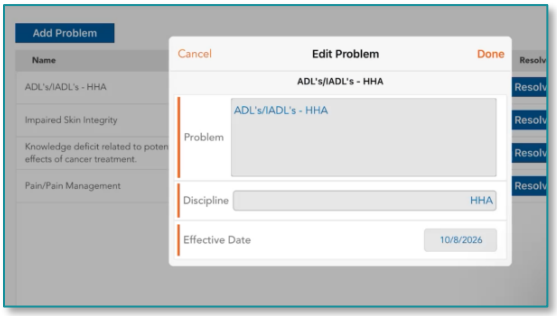
Frequently Asked Questions

NEW: What should I do if a Home Health Aide (HHA) care plan was accidentally added under the RN discipline?



- If an RN accidentally selects RN instead of HHA when creating a care plan, the care plan can be edited and the discipline can be changed to HHA. This will ensure the care plan is associated with the correct discipline for documentation and visit management

NEW: How do I acknowledge lab results at one time?

- To acknowledge lab results, clinicians can tap each individual result within the Status section and acknowledge them one at a time.
- To acknowledge multiple results at once, select the pencil icon, choose all applicable results, and then acknowledge them simultaneously. See the screenshot below for reference.

UPDATE: What note type should I use?

- Clinicians should document additional clinical information in **Communication Notes**. When selecting a note type, use the appropriate coding guidance (see note type table below). In general, **timepoint visits** (such as SOC and other initial visits) should be documented as **Prep Notes**, while routine visits should be documented as **Interdisciplinary Notes**. A separate **narrative note** is not required.

Note Type	Documentation Content	Comments
Prep Notes	➢ Time Points (SOC, ROC, Evals, DC, Reassessments, Transfer) ➢ Significant change in status ➢ Pod Notes	➢ Prep notes are often used to contribute to HO IDGs and proof of interdisciplinary collaboration for HH.
Interdisciplinary Note	➢ Routine Visits	
Patient/Caregiver	➢ Welcome calls from schedulers ➢ Communication to patient/care calls	

	(K400/documentation/pt call)	
Physician	➢ Any phone call to the physician to communicate patient care and status	➢ If physician consultation is required for a specific visit timepoint, add the information to the Prep Note – ie hospice admits/CTI conversations
DME	➢ Calls made for durable medical equipment ➢ Emails/communication between staff and/or CTC re: DME	
Triage	➢ Care calls taken ***during the day*** by Hospice CTC	
On-Call	➢ Triage RNs	
Adverse Event	➢ Patient falls	

What should you do if you need to unassign a visit or reassign a visit that is already assigned to another staff member?

- To reassign a visit, first remove the current assignment and then assign the visit to the correct staff member. This can be done whenever a visit needs to be transferred from one team member to another.
- In the mobile app, clinicians cannot unassign a visit or reassign a visit to another clinician once it has been assigned. If a visit needs to be unassigned or reassigned, contact your Clinical Manager or Scheduling team to make the change in AFO.
- If you would like to take over a visit that is assigned to another clinician, navigate to the patient's calendar and use the **Claim Visit** option to assign the visit to yourself, if appropriate.

Where do I enter lab orders in MatrixCare?

- Lab orders and other clinical orders, such as INRs, Foley catheter changes, and staple removals, should be entered in the patient's chart under Other Orders. This provides a central location for clinicians to review active orders and helps reduce the risk of important orders being overlooked.

- Lab orders can also be entered through the Care Plans section. Search for Lab within Care Plans and select the appropriate lab order for the patient.

Can vital sign parameters be customized for an individual patient?

- Yes. Vital sign parameters can be customized at the individual patient level within MatrixCare. These customizations are made within the patient's chart, under Flow Sheets (not within the visit note). Updating parameters at the patient level allows clinicians to document and monitor vital signs based on the patient's specific care needs and provider orders.

What should I do if a medication is documented without an NDC code?

- A missing NDC (National Drug Code) is often caused by customizing the medication name when selecting it from the medication database. When a medication is entered as a custom medication, the NDC code may not save, and features such as drug interactions, allergy warnings, and medication leaflets may not be available.
- If a medication was documented without an NDC code, the order group will need to be corrected and resubmitted.

STEP 1: Locate the order group containing the medication.
STEP 2: Mark the order group **In Error**.
STEP 3: Copy the order group.
STEP 4: In the copied order group, select the medication that needs to be corrected.
STEP 5: Choose an alternate medication sentence that populates an NDC code.
STEP 6: Verify that the NDC code is present.
STEP 7: Ensure all dates are backdate so the corrected orders reflect the original order date to maintain accurate documentation.
STEP 8: Click **Save and Submit**.

How do I fix incorrect care plan dates?

STEP 1: Navigate to **Patient Record > Care Plan** and review the effective dates for the care plan problems, interventions, and goals.
STEP 2: If the care plan has **not** been documented against, update the effective dates directly on the care plan items.
STEP 3: If the care plan **has already been documented against**, remove the affected care plan items and re-enter them using the correct effective dates.
STEP 4: Verify the care plan status. If the items are in **Pending** status, open the problem and select **Set All to In Progress**.
STEP 5: Confirm that the care plan discipline matches the visit discipline. Mismatched disciplines may prevent clinicians from documenting against the care plan.

How do I add a physician under Contacts when the physician is not available when entering an order?

- Tap Add Physician and add the physician to the patient's chart. Once added, the physician will be available for selection when entering the order.

I used Netsmart. What are the equivalent terms in MatrixCare?

Netsmart Term	MatrixCare Term
Consumer	Patient
Episode	Episode / Certification Period
Admission	Admission
Discharge	Discharge
Transfer	Transfer
Service Line	Care Type / Program
Task / Scheduled Task	Visit / Task
Route	Schedule
Frequency	Discipline Order
Clinical Form	Clinical Document / Assessment Form
Documentation	Charting
Plan of Care (POC)	Plan of Care / Orders
Physician Order	Order
Order Tracking	Order Management
Pending Orders	Orders Pending Signature
Medication Profile	Medication List
Administered Med	Medication Administration
Download Schedule	Sync Schedule
Upload Visit	Sync / Submit Visit

➢ Dashboard	➢ Home / Schedule View
➢ Visit Verification	➢ EVV / Visit Confirmation
➢ Worklist	➢ Task List / Dashboard
➢ Inbox	➢ Messaging / Tasks
➢ Caregiver	➢ Caregiver / Aide
➢ Supervisor	➢ Manager / Supervisor

For a Recertification Visit, what should I do if the Discipline Order screen displays "No Certification Visit?"

- If the Discipline Order screen displays **No Certification Visit,** contact a team member with **AFO access** to add the required Discipline Order and associated visits.

How can I narrow my medication search results?

- To reduce the number of search results, include the medication strength when searching. For example, search for **Morphine 20** instead of just **Morphine** to display fewer, more specific medication options.

How do I change a visit to a Missed Visit?

- If the visit is already on your task list:

STEP 1: Open the scheduled visit from the task list.
STEP 2: Select a visit note and continue to the Administrative screen.
STEP 3: Change the Visit Type to **Missed Visit**.
STEP 4: Select the **Follow-up Non Visit Note**.
STEP 5: Complete the required documentation, including the reason for the missed visit and whether the physician was notified.
STEP 6: Ensure the **Time In/Time Out** reflects at least 1 minute before completing the note.

- If the missed visit is not on your task list:

STEP 1: Open the patient's service calendar.
STEP 2: Select the date of the missed visit and choose **Add Visit**.
STEP 3: Set the Visit Type to **Missed Visit** and save.
STEP 4: Synchronize the device if needed.
STEP 5: Open the missed visit from your task list and complete the Follow-up Non Visit Note with the required details.

- If you are unable to select **Missed Visit** or the option is unavailable, contact your office or a team member with AFO access for assistance.

How do I end and submit a visit?

STEP 1: Open the visit from the task list and select the appropriate visit note.
STEP 2: Complete the Administrative section, including required details such as visit times and service information.
STEP 3: Navigate through the visit documentation and complete all required assessment sections.
STEP 4: When documentation is complete, go to the Review and Submit screen.
STEP 5: Review the visit for any missing required information. Red indicators identify sections that must be completed before submission.
STEP 6: Once all required fields are complete, select Submit to finalize and end the visit.

- All required documentation must be completed before a visit can be submitted. Any red indicators on the **Review and Submit** screen must be resolved before submission is allowed.

How will clinicians capture time spent on care calls?

- At this time, clinicians should document time spent on care calls using the **Admin/Office Time for now** timesheet code.

How do I unassign a visit from myself?

- To unassign a visit, contact scheduling for your area.
  - To delete a visit, navigate to the patient's Service Schedule and delete the visit from the schedule.

Where can I find patient information before completing a Start of Care (SOC) visit?

- For a Start of Care (SOC) visit, referral information can be reviewed under Admission Info. However, in most cases, the information needed will be located under Clinical Documents. If no patient information is available in either location, contact Intake for additional details.

Why Isn't Mileage Auto-Populating Between Visits?

- The mileage auto-calculation feature is functioning as intended; however, the calculated mileage is not displayed within the mobile app.
- Mileage is tracked automatically in the background and can be reviewed by office staff through the **Employee Mileage - MAC** report or the **Clinical Employee Time Tracking - MAC (Custom)** report.

AFO Clinical Manager: How do I add a certification period so visits can be scheduled?

STEP 1: Verify that the patient's admission dates are correct under **Admission Settings**.

STEP 2: Navigate to **Clinical Documents > Plan of Care.**

STEP 3: Select **Add New Cert Period** to create the certification period and allow visits to be scheduled.

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How Do I Close a Shift After a Patient Has Passed Away and Documentation Is Complete?

- Clinical Managers and RNs can close shifts once all shift notes have been reviewed and the required documentation has been completed.
- To close a shift:

STEP 1: Open the patient record in Agency Front Office (AFO).
STEP 2: Navigate to **Inpatient Entry.**
STEP 3: Locate the appropriate shift.
STEP 4: Select **Actions.**
STEP 5: Click **Close Shift.**

What Should I Use for an Unscheduled or PRN Visit?

- Clinicians who need to complete an unscheduled or PRN visit, select the Unscheduled Visit option. Choose Follow-Up Visit and then select the appropriate service code for the visit being performed. This will ensure the visit is documented under the correct discipline and visit type.

Can I make changes to my assessment after I submit a visit?

- No. Once a visit has been submitted, it is placed in **Review** status and can no longer be edited by the clinician. If changes are needed, the visit must be reassigned back to you by the QA team. Once reassigned, you will be able to update the assessment and resubmit the visit as needed.

Can documents be uploaded when there is no internet or cellular service available?

- No. Documents cannot be uploaded without an internet or cellular connection. However, you can add documents while working in offline mode, and they will automatically sync once service is restored.

What is the difference between a pinned document and an unpinned document on my device? Does pinning a document save it to my device?

- When a patient chart is **pinned** in the MatrixCare Clinical app, it is stored on your device and available for offline access. Pinned charts are considered **"on device"** and can be viewed even when an internet connection is unavailable.
- If a patient chart is **unpinned**, it will be removed from the device during the next sync and will no longer be available offline. Additionally, documents can only be viewed without connectivity if they were pinned prior to losing internet or cellular service. Otherwise, an active connection is required to access them.

Why do some items in the Review of Systems section have a green checkmark while others do not?

- A green checkmark indicates all required questions within that section have been completed. If a section does not display a green checkmark, one or more mandatory questions still need to be answered.

How do I document a Hospice Informing visit?

- Hospice Informing visits should be documented using a **Communication Note**. Select the appropriate patient and create a Communication Note to record the informing visit and any related details.

When a patient is discharged, am I automatically removed as an assigned contact, or can I remove myself from the patient's care team?

- Patients should only continue to appear on your list of assigned patients if they are in **Discharge Pending** status. Once the discharge process is completed and the patient is no longer in Discharge Pending status, they should no longer appear as an assigned patient.

Can photos be edited within the app?

- No. Photos cannot be edited within the app. Photos can only be **uploaded or deleted**. If changes are needed, the photo must be deleted and replaced with a new upload.

Can I assign a visit to another clinician?

- No. Visits cannot be assigned to another clinician from within the app.
- Any visit assignment changes must be managed through the appropriate scheduling or office workflow.

Can a specific time be assigned to a visit on the calendar?

- No. Visits cannot be scheduled into a specific time slot on the calendar. The calendar displays scheduled visits, but it is not designed to assign appointments to designated times.

Can staff access or download a discharged patient's chart after the patient has been fully discharged? Do staff need the Bereavement Coordinator role to access these charts?

- A patient must remain in **Discharge Pending** status to be visible on the tablet, regardless of discipline or role. Once the patient has been fully discharged, the chart is no longer available on the tablet.

How does geolocation work in areas with little or no cellular service?

- If you will be working in an area with limited or no connectivity, **pin the patient chart before losing service**. This allows you to continue documenting and performing your work in offline mode. The app will store the information locally on the device and automatically sync the data once internet or cellular service is restored.

Can medications be modified by a provider? If medications are updated by Agency Front Office (AFO), how will the nurse know there are changes?

- Yes. Medications can be modified by a provider and updated in AFO. When a medication change is made, the Medication Administration Record (MAR) will reflect the update under the New tab, allowing nurses to easily identify medication changes.

How do I start a visit?

- To start a visit, tap the patient's name, select a visit note, and then enter a time in.

For questions regarding process and/or policies, please contact your unit's Clinical Educator. For questions regarding workflow, please place a ticket to Health Informatics. For any other questions please contact the Customer Support Center at: 207-973-7728 or 1-888-827-7728

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