From the Office of Health Informatics

Home Care and Hospice Discharge Visits (All Types)

June 11, 2025

There are several types of Discharges, each type has specific requirements necessary for the patient record. While not all tiles require documentation, it may require review and edit, as necessary.

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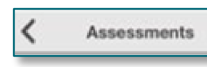
Agency Discharge

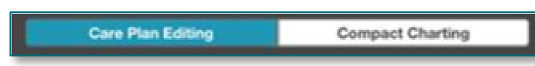
- Discharge with visit
- Discharge no visit
- Hospice Live Discharge
- Discharge no OASIS no Visit – **Start at Step 2**
- Hospice Death Visit – **Start at Step 2**

STEP 1: Tap **Assessments**.



- Assessments previously completed for the patient display on the left.
- Tap the **plus sign** in the lower right.
  - Select the **Template** and **Visit Type** (**SOC Discharge** or **Routine** visit) if not auto populated. For Agency Discharge No Visit, chose **OASIS only** (if applicable).
  - Tap the box for **D/T Summary** then choose **Discharge from Agency**.
    - To add after assessment is started, tap the three dots in the lower right to tap **D/T Summary** at any time.
  - Tap **Done**.

STEP 2: Tap **Care Plan/Charting**.



- Tap **Care Plan Editing** in the bottom of the screen.
- Tap the **plus sign** in the lower right of screen.
- Enter **Disc** in the Search box then tap the **Discharge Care Plan**.
- Tap the **plus sign** to the far right of **Interventions.**
  - Tap the box to add **Discharge from home health services** or appropriate **Hospice Discharge Intervention** and any other applicable Interventions performed. This will send the order to the Provider.
  - Tap **Ordering Physician** to select the appropriate Provider if not auto populated.
  - Tap **Done**.
  - Document on any active Interventions.
- Tap the three dots in the lower right.
  - Tap **Discontinue.**
    - Tap **Care Plan** in left column to discontinue.
  - Repeat for each Care Plan to discontinue.
  - Tap the < **back arrow** in the top left to save the Care Plans/Charting and return to charting page.

STEP 3: Tap **Visit Frequency (VF)**.

- Tap each VF in left column to add discharge date as **End Date** to each active VF.
  - Important: Tap **Do not created end sup order** box.
- Visit Frequencies starting in the future - add an End Date that matches the VF Start Date.
  - Important: Tap **Do not created end sup order** box.
- Tap the < **back arrow** to save the information and return to the charting page.

STEP 4: Tap **Clinical Note**.

- The clinical notes completed for the patient display on the left.
  - Navigate between **Active** and **All** at lower left to see notes with End dates.
- Tap the **plus sign** to add a new clinical note.
  - Use Code is **D**.
  - Paste the applicable note template to ensure all required documentation is complete.
  - Add discharge date as **End Date**.
- Tap the < **back arrow** to save the information return to the charting page.

STEP 5: Tap **Admissions /Status**.

- Navigate to **Status** and tap the dropdown arrow to choose the applicable Discharge status.
- Edit **Status Date** if patient discharge was before today.
- Tap the < **back arrow** to save the status and return to the charting page.
- Warning alerts will display if applicable:
  - Warning: **This patient has open goals or interventions. Do you wish to proceed?**
    - Tap **OK**.
    - After saving new Patient Status, tap **Care Plan/Charting** to end Care Plans.
  - Warning: **All scheduled visits after (today's date) will be removed.**
    - Only billable visits will be deleted. Any other visits will need to be deleted manually on the **Day** screen on the Patient Calendar.
    - Tap **OK**.
  - Warning: **Care Team will be ended and future end dates will be updated to the Discharge date. Care Team with future start date will be deleted.**
    - Tap **OK**.
  - Warning: **There are active medications for this patient. Please discontinue all active medications before discharge.**
    - Tap **OK**.

- **Discontinue Medications** screen
  - Add **End Physician** (if not auto populated).
  - Important: Tap **Do not Create End Sup Order** box.
- Tap **Done**.
- Tap < **back arrow** in the top left to save the documentation.

STEP 6: Tap **Sync** in the bottom right-hand corner. 

Discipline Discharge

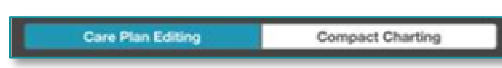
- Discipline Discharge with Visit
- Discipline Discharge No Visit – **Start at Step 2**

STEP 1: Tap **Assessments.**

- The assessments previously completed for the patient display on the left.
- Tap the **plus sign** in the lower right. ⊕
  - Select the **Template** from the dropdown and the **Visit Type** (Routine) if not auto populated.
  - Tap the box for **D/T Summary** then choose **Discharge from this discipline**.
    - To add after assessment is started, tap the three dots in the lower right to tap **D/T Summary** at any time.
  - Tap **Done.**
- When finished or leaving the screen, tap the < **back arrow** in the top left to save the documentation and return to the charting page.

STEP 2: Tap **Care Plan/Charting**.

- Tap **Care Plan Editing** at the bottom of the screen.
- Tap the **plus sign** in lower right of screen. ⊕



- Enter **Disc** in the Search box then tap the **Discharge Care Plan**.
- Tap the plus sign to the right of **Interventions.**
  - Tap the box to add **Discharge from (discipline)** and any other applicable Interventions performed.
  - Tap **Ordering Physician** to select the appropriate Physician if not auto populated.
  - Tap **Done.**

    - Document on any active Interventions.
- Tap the three dots at the lower right.
    - Tap **Discontinue.**
        - Tap Care Plan in left column to discontinue.
            - If applicable, complete Health Status Evaluation.
            - Tap **Done**.
    - Repeat for each Care Plan to discontinue.
    - Tap the < **back arrow** in the top left to save the **Care Plans/Charting** and return to charting page.

<u>STEP 3</u>: Tap **Visit Frequency**.

- Tap each VF in left column to edit End Date to be discharge date.
    - Tap **Do not created end sup order** box below **Physician ID** box.
- Visit Frequencies starting in the future should have an End Date that matches the Start Date of the VF.
    - Tap **Do not created end sup order** box below **Physician ID** box.
- Add **Change Reason**.
- Enter passed in pop-up box to **Submit Visit Frequency** order.
- Tap the < **back arrow** to save the information and return to the charting page.

<u>STEP 4</u>: Tap **Clinical Note**

- The clinical notes completed for the patient display on the left.
    - Navigate between **Active** and **All** tabs at lower left to view previous clinical notes, as necessary.
- Tap the **plus sign** to add a new clinical note.
    - **Use Code** is **OC**.
    - Use the applicable note template and ensure that all required documentation is complete.
    - **Certification Item** is **Assessment Information for Physician Review** (end of the list).
    - Add **Ordering Physician.**
- Tap the < **back arrow** to save the information return to the charting page.

<u>STEP 5</u>: Tap **Care Team**.

- Add **End date** to line(s) for Discipline.

- Tap the < **back arrow** to save the status and return to the charting page.

<u>STEP 6</u>: Tap **Sync** in the bottom right-hand corner.

<u>STEP 7</u>: Tap **Calendar**

- Tap three dots at lower right.
- Tap **Delete Visits.**
- Change **End Date** to two months from today to cover current cert period.
- Tap **Filter.**
- Tap box at left of each visit to delete.
- Tap **Done.**
- Warning appears showing how many visits are being deleted. Tap **Delete.**

How to change the Visit Type

➢ **Visit not started**

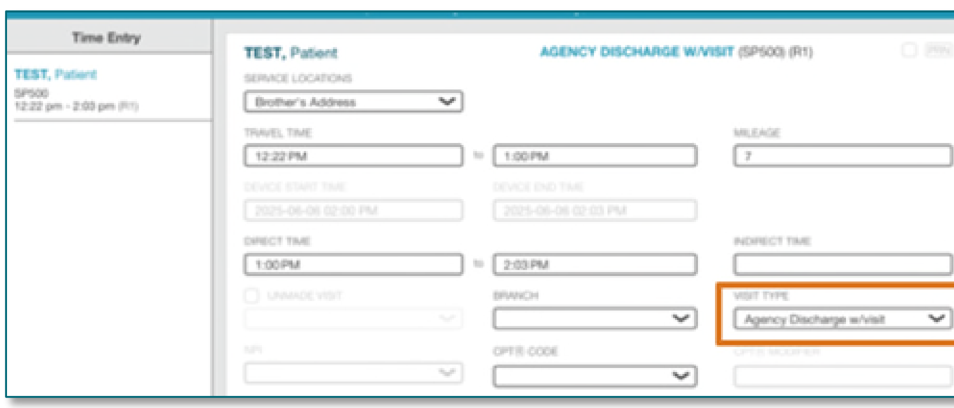
- Update the visit type on the patient **Calendar** for that patient visit and tap **Done.**

➢ **Visit which has been started**

<u>STEP 1</u>: From the menu, tap **Time Entry.**

<u>STEP 2</u>: Tap the patient's name in the left column then update the **Visit Type** using the dropdown arrow.

<u>STEP 3</u>: Tap patient's name in the left column to save.



<u>STEP 4</u>: Tap the patient's name (above **Service Locations**) to return to the patient chart.

Add an Oasis Only Assessment to a Visit

If an Assessment is complete, add an **OASIS only** Assessment to visit to document the OASIS questions.

➢ **Adding to an existing visit**

- Tap **Visit Type** on Today screen to open Patient chart.
- Tap **Assessments.**

- Tap the **plus sign** to add new Assessment. ⊕
  - Click dropdown arrow under Template to tap **OASIS Only**.
  - Under **Visit Type**, select the appropriate visit type requiring an OASIS Assessment.
- Tap **Done** to open the assessment template.

➢ **Adding to a visit more than 7 days ago**

- On the **Today** screen, tap the magnifying glass to search for the patient to open the chart.
- Tap **Assessments**.
- Tap the **plus sign** to add new Assessment. ⊕
  - Tap the date twice to open a calendar. Tap the original visit date.
  - Click dropdown arrow under Template to tap **OASIS Only**.
  - Under **Visit Type**, select the appropriate visit type requiring an OASIS Assessment.
- Tap **Done** to open the assessment template.