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Important Information

Tap Start Visit to begin your visit, tab End Visit when leaving a patient's residence to end the visit.

Tap the arrow at the top left to save documentation.

After confirming there is nothing under Open Charts, Reset Cache once a week by navigating to Settings > HomeCare to reset your cache.

Upload documents completed during the visit (ex. consents) using Onbase. As a reminder, upload each document seperately to it's respective document type.

Visit Documentation

Each visit type requires different steps to complete the information, to view a full workflow for a particular visit type, select the header of the workflow below to be taken to a more in-depth workflow, as necessary.

Admission / NTUC

- ✓ **Use the Attachments tile to view referral documentation.**
- ✓ **If assigned Visit #1 Initial Visit or Visit #2 Comprehensive Asmt:**
  - **Open Care Plan Interventions to determine what is your responsibility during the visit.**
    - **To find Care Plan for Initial Visit search *Immediate*.**
    - **To find Care Plan for Comprehensive Asmt Visit search *Comprehensive*.**

➢ **Assessments**

- **Resource Type**: Your Discipline.
- **Template**: Your Discipline (OASIS E) for HH patient.
- **Visit type**: 1- **Start of Care**–further visits planned (if payer requires OASIS) or **Initial** Visit.

➢ **Admissions & Status**

STEP 1: Tap the Status to update to Field Admit or Field Re-admit.

- Choose the option showing where the patient is located [ex: Field Admit (home)].

STEP 2: Update the Status date if not admitted today.

STEP 3: Tap the back arrow at top left to save the information.

- If warning message appears requesting additional information, tap OK.

Navigate to the Demographics tile and enter the missing information, once completed navigate back to the Admission and Status screen to update the patient status. NOTE: If a patient is not admitted and *you have already called your manager to inform them,* update the patient status to Clinical and the reason they do not need services (ex. Clinical no skill needed).

➢ Clinical Monitoring

STEP 1: Tap + to add any Vital signs, measurements or lab values obtained.
STEP 2: Tap Done.

- A box will show if any required information is missing. Tap to enter information.

➢ Care Plan/Charting

- **Adding Care Plans**

STEP 1: Tap Care Plan Editing.
STEP 2: Tap + at lower right to add a new Care Plan.

- Use the Search box or scroll down to select a Care Plan.
  - Care Plans generally added at Admission start with *.
    - In the search field, enter * to view/choose Care Plans.

STEP 3: Tap **+** at the right of Goals and Interventions to add to each, as necessary.

- To discontinue an individual Goal or Intervention, tap the arrow under Goal or Intervention and enter an End Date.
- To discontinue an entire Care Plan, tap the 3 dots at the lower right and tap Discontinue.

- **Care Plan Charting**

STEP 1: Tap **Compact Charting**.
STEP 2: Tap each Care Plan on left to document.

- Answering **Negative** requires a Milestone stating why the Goal or Intervention was not worked on during the visit.

➢ Clinical Note

- Use Code: **I.**
- Tap: **Include intermediate summary to Cert/Recert orders** and **Send to Portal.**
- Certification Item#: Always choose Assessment Information for Physician Review (at end of list)
- Add: **Ordering Physician, End Physician** and Date of Admission as **End Date** (update if needed**).**
  - Notes with an end date are under **All** at lower left.

➢ Medications

- Adding medications
  - Patient Readmitted:
    - Tap 3 dots at lower right to **Re-activate** medications which were discontinued at previous discharge.
      - If Reactivate is in gray, sync chart from Tile screen.

- Tapered Medications
  - If a medication is titrated, select Titrate Medication.
- Pending Medications
  - If **Pending Medications** displays at lower right, tap to see the list of Medications from the referral source.
    - Swipe left from the middle of the screen, then select **Include** for each medication to add to chart.
  - Tap **+ Add** to add any additional medications.
- Kits
  - If a kit needs to be added, tap **Kits**.
- To enter new medications

STEP 1: Start entering the medication name in the Search box, scroll to select the appropriate medication.
- Continue until all medications have been added then tap Next.

STEP 2: Add Required information for each medication.
- For an Admission **only**, all medications should have the provider overseeing the plan of care as the Ordering Physician regardless of the person who wrote the prescription.

STEP 3: Tap arrow at the top left to save then sync the chart.
STEP 4: Tap Medications tile.
STEP 5: On Medications screen, tap the 3 dots at lower right then select Drug-Drug to review the Drug/Drug Interactions.
- Tap **Cancel** then tap **Cancel** again to return to chart.

- Tap arrow at top left to Save then sync chart (icon at lower right).
-

NOTE: If a medication is not in the database, email #HCH Netsmart Medication Add Request with medication name, strength/volume, dose form, manufacturer, NDC number.

➢ **Visit Frequency**

✓ The **patient status** on **Admissions & Status** screen must be updated to **Field Admit** before editing Visit Frequencies.
- Confirm Cert Period is listed in left column.

✓ If it says "Prospect", check the **patient status** has been updated on the **Admissions & Status** screen.
- If it has been updated and it still says "Prospect", submit a help desk ticket to have the Cert dates recalculated.

STEP 1: VSOC (Verbal Start of Care) Date is located at the top, enter the date, and tap Sign.
STEP 2: Lupa threshold will display under the VSOC if applicable.
STEP 3: **Add visit date as End Date to the Visit Frequency entered by Intake staff.**

- Change Reason: enter Admission Complete

STEP 4: Add a new Visit Frequency. Tap PRN at the lower left to enter PRN Visit Frequencies.

- Complete the fields applicable for **Discipline**, number of **Visits**, **Physician ID**, and **Duration**.
  - Confirm date range is correct (no missing or overlap dates).
  - Tap **Cert/Recert** and **Do not create end sup order** boxes.
  - Enter **Discipline**, **Value** (# of visits), **Physician ID**, and **Reason**(s) for visits.
  - Tap **Cert/Recert** box. Do not add **End Date**.

STEP 5: Tap arrow at top left back then sync the chart.

➢ Calendar

STEP 1: Tap **Calendar.**
STEP 2: Tap **Show Details** in the lower left and then tap **All** to view Visit Frequencies.

- If new Visit Frequencies do not show, sync the chart again and Tap OK.

STEP 3: **Tap + at lower right.**

STEP 4: **Tap Nonrecurring to add one visit, Tap Recurring to add multiple visits.**

- **Nonrecurring**
  - **Resource** - change if needed.
    - If Resource is unknown, enter UNA in Search box to select Unassigned (your location).
  - Edit **Start Date**, if necessary.
    - Duration is 1 hour.
  - Edit **Resource Type**, if necessary.
  - Enter **Visit Type.**
  - Add a Note at the end of the Notes box, if applicable. the information will display on the Time Entry screen.
    - Ex. Enter **Town**, **Diagnosis** and if PTA or LPN visit is appropriate.
  - Tap **Done.**
- **Recurring** to add multiple visits.

- **Resource** - change if needed. If Resource is unknown, enter **UNA** in Search box to select Unassigned (your location).
- Edit **Start Date** if necessary.
- **Recurrence** –enter **number** and designate **Day** or **Week** (ex. 2 x a week).
  - Tap the box(es) for the specific Service Days.
  - **Every**: Add recurrence of days or weeks (leave as the)
  - **For**: Add number of days or weeks (for how long).
  - Add **Resource Type**, if not auto populated.
  - Add appropriate **Visit Type**.
    - If Insurance authorization is required and not yet approved for visits:
      - Enter Visit Type **Non-Billable Supervisor Use only**.
      - Create Task for Insurance Authorization (Task Code is **ADD**) with # of visits requested for your discipline.
    - Tap **30-day Reassessment** visit on the **Calendar** to edit Visit Type.
  - Add a Note at the end of this box to be viewed on the Time Entry screen.
    - Ex. Enter **Town**, **Diagnosis** and if PTA or LPN visit is appropriate.
- Tap **Done.**

➢ **General Clinical**

- Every screen must contain information.
- Tap each screen in left column to review, update, and add information as applicable.
  - Use the + at the top right of screen to add from list for section (free text is available) or check off boxes depending on the screen.
- **Safety**: Add **Basic Home Safety, Standard Precautions** for every patient in addition to any other Safety concerns.
- **Advance Directives**: Add **DNR** or **Full Code** and **Advance Directive YES** or **NO** for all patients.

➢ **Adverse Events**

- Falls
  - If patient falls during visit, add information below in Netsmart and an Incident Report. Do not document falls here that occurred before the admission.
    - **Injuries** – default is **None apparent**. Tap on appropriate selection if injuries evident.
    - **Reported by** – choose **Observed by Clinician**
    - **Physician** – add Provider notified. **Date** will default too today.

- **Notified by** – Free text your Last and First name. Enter **Time** notified.
- **Comments** – optional field to add information.

- Infections
  - Do not document here for admission. Infections diagnosed after admission are entered here.
- Infectious Diseases
  - Document infections diagnosed before patient was admitted. See **Attachments** for information. Add **Disease** using drop down and Admission date as **Start Date.**

➢ **Care Team**

- Do not add your name to Admitting Clinician, Visit #1 Int Visit or Visit #2 Comp Asmt.
- If you will continue to see the patient, add your name under your discipline.
  - This allows you to receive Tasks regarding the patient status.
- Enter **CODE Status**, **INFections**, **ALERT Staff**, **PREcautions**, and other known information.
  - Enter the capital letters at beginning of Care Team type in the Search box, (i.e., type INF for Infections, to search from list).

➢ **Basic/Demographics**

- **Basic**
  - Review information on screen for accuracy and completeness.
    - Add **Preferred Name** and/or **Preferred Pronoun** if provided.
  - Review the **Notes (Read Only)** section for further insurance information.
- **Addresses**
  - Confirm **Service Location, Default** and **Active** are checked off for correct address.
    - These boxes should not be checked off for any other address.
    - Change **Place of Service** using the drop down if patient is not being seen in their home.
  - Add pertinent information in **Staff Information** box which will display on the **Today** screen for all clinicians to view.
- **Demographics**
  - Add **Disaster/Evac Status** and fill in any section with ***Selection Required***. Do not add **Start Date** to any line.

➢ **Family/Friends**

- Confirm information is correct with patient or family.

- If designating a POA, necessary documentation should be uploaded to OnBase.

- Tap + in the lower right to add a new person.
  - Enter last name in **Name/ID** box.
    - Use boxes on right to designate roles.
    - Check off **Designated Alternate Signatory** if the person will be signing at the end of the visit.
      - If person is not found in the database, tap the + to the right of the **Name** box to add a new Resource to the database.
  - If a person should be removed from the chart, contact your manager to have it deleted.

➢ **Immunizations**
- Add any Immunizations administered during visit.

➢ **Payer/Authorizations**
- Confirm correct Payer is entered.

Secondary Evaluation

➢ **Assessments**
- **Resource Type:** Your Discipline
- **Template:** Your Discipline (OASIS E) for HH patient.
- Visit type is **Initial Visit** regardless of whether payer requires OASIS.

➢ **Clinical Monitoring**

STEP 1: Tap + to add any Vital signs, measurements or lab values obtained.
STEP 2: Tap Done.
- A box will show if any required information is missing. Tap to enter information.

➢ **Care Plan/Charting**
- **Care Plan Editing**

STEP 1: Tap Care Plan Editing.
STEP 3: Tap + at the right of Goals and Interventions to add to each. If adding for another discipline, change the discipline first before adding any Goals or Interventions.
- Select Print on Cert/Recert unless the visit is greater than 1 week after admission.
- To discontinue an individual Goal or Intervention, tap the arrow under goal or intervention and enter an End Date.
- To discontinue an entire Care Plan, tap the 3 dots at the lower right and tap Discontinue.

- **Care Plan Charting**

STEP 1: Tap Compact Charting
STEP 2: Tap each Care Plan on left to document.
  - Answering **Negative** requires a Milestone stating why the Goal or Intervention was not worked on during the visit.

➢ **Clinical Note**

- Use Codes: **O & C.**
- Tap: **Print on Cert/Recert** and **Send to Portal.**
- **Certification Item#**: Always choose **Assessment Information for Physician Review** (end of list).
- Add: **Ordering Physician, End Physician** and Date of visit as **End Date** (update if needed**).**
  - Notes with an end date are under **All** at lower left.

➢ **Medications**

- To enter new medications

STEP 1: Tap **+.** Start entering the medication name in the Search box, scroll to select the appropriate medication.
  - Continue until all medications have been added then tap Next.

STEP 2: Add Required information for each medication**.**
STEP 3: Tap arrow at the top left to save then sync the chart.
STEP 4: Tap Medications tile.
STEP 5: On Medications screen, tap the 3 dots at lower right then select Drug-Drug to review the Drug/Drug Interactions.
  - Tap **Cancel** then tap **Cancel** again to return to chart.

- Tap arrow at top left to Save then sync chart (icon at lower right).

➢ **Visit Frequency**

STEP 1: **Add visit date as End Date to the Visit Frequency entered by Intake staff.**
  - Change Reason: Enter Admission Complete

STEP 2: Add a new Visit Frequency.
  - Complete the fields applicable for **Discipline**, number of **Visits, Physician ID**, and **Duration**.
    - Confirm date range is correct (no missing or overlap dates).
    - Tap **Cert/Recert** and **Do not create end sup order** boxes.
    - Tap PRN at the lower left to enter PRN Visit Frequencies.

- Enter **Discipline**, **Value** (# of visits), **Physician ID**, and **Reason**(s) for visits.
- Tap **Cert/Recert** box. Do not add **End Date**.

STEP 3: Tap arrow at top left back then sync the chart.

➢ **Calendar**

STEP 1: Tap **Calendar**.
STEP 2: Tap **Show Details** in the lower left and then tap **All** to view Visit Frequencies.

- If new Visit Frequencies do not show, sync the chart again and Tap OK.

STEP 3: **Tap + at lower right.**

STEP 4: **Tap Nonrecurring to add one visit, Tap Recurring to add multiple visits.**

- **Nonrecurring**
  - **Resource** - change if needed.
    - If Resource is unknown, enter UNA in Search box to select Unassigned (your location).
  - Edit **Start Date**, if necessary.
    - Duration is 1 hour.
  - Edit **Resource Type**, if necessary.
  - Enter **Visit Type: Routine or Nursing Assessment**.
    - If insurance authorization is required, but not yet approves for visits:
      - Enter Visit Type Non-Billable Supervisor Use Only.
      - Create a Task for Insurance Authorization with number of visits requested for your discipline.
      - Tap 30-day Reassessment visit on Calendar to edit Visit Type.
  - Add a Note at the end of the Notes box, if necessary, information will display on the Time Entry screen.
    - Ex. Enter **Town**, **Diagnosis** and if PTA or LPN visit is appropriate.
  - Tap **Done.**
- **Recurring** to add multiple visits.
  - **Resource** - change if needed. If Resource is unknown, enter **UNA** in Search box to select Unassigned (your location).
  - Edit **Start Date** if necessary.
  - **Recurrence** –enter **number** and designate **Day** or **Week** (ex. 2 x a week).
    - Tap the box(es) for the specific Service Days.

- **Every**: Add recurrence of days or weeks (leave as the)
- **For**: Add number of days or weeks (for how long).
- Add **Resource Type**, if not auto populated.
- Add appropriate **Visit Type**.
    - If Insurance authorization is required and not yet approved for visits:
        - Enter Visit Type **Non-Billable Supervisor Use only**.
        - Create Task for Insurance Authorization (Task Code is **ADD**) with # of visits requested for your discipline.
    - Tap **30-day Reassessment** visit on the **Calendar** to edit Visit Type.
- Add a Note at the end of this box to be viewed on the Time Entry screen.
    - Ex. Enter **Town**, **Diagnosis** and if PTA or LPN visit is appropriate.

- Tap **Done.**

➢ **Care Team**

- Add your name for **your discipline** if you will continue to see the patient.
- Add any new information discovered.

Routine Visit / Nursing Assessment / PTA Routine Visit / LPN Routine Visit / Therapy Maintenance / Wound Eval / Pediatric Routine & Reassessment

➢ **Assessments**

- Resource Type: **Your Discipline.**
- Template: Your Discipline (OASIS E)
- Visit type: **Routine Visit,** regardless of whether payer requires OASIS.

➢ **Clinical Monitoring**

STEP 1: Tap + to add any Vital signs, measurements or lab values obtained.
STEP 2: Tap Done.

- A box will show if any required information is missing. Tap to enter information.

➢ **Care Plan/Charting**

STEP 1: Tap Compact Charting.
STEP 2: Tap each Care Plan on left to document.

- Answering **Negative** requires a Milestone stating why the Goal or Intervention was not worked on during the visit.

➢ **Clinical Note**

- Use Code: **C** or **O & C if** Note references Orders.
- Add: **Ordering Physician, End Physician** and Date of visit as **End Date** (update if needed).
    - Notes with an end date are under **All** at lower left.
- Tap **Send to Portal.**

30-day Reassessment visit only

➢ **Assessments**

- Resource Type: **Your Discipline.**
- Template: Your Discipline (OASIS E)
- Visit type: **Routine visit.**

➢ **Clinical Monitoring**

STEP 1: Tap + to add any Vital signs, measurements or lab values obtained.
STEP 2: Tap Done.

- A box will show if any required information is missing. Tap to enter information.

➢ **Care Plan/Charting**

STEP 1: Tap Compact Charting.

- Tap Care Plan Editing to add/edit Care Plans.

STEP 2: Tap each Care Plan on left to document.

- Answering Negative requires a Milestone stating why the Goal or Intervention was not worked on during the visit.

➢ **Clinical Note**

- Use Code: **C** or **O & C if** Note references Orders.
- Add: **Ordering Physician, End Physician** and Date of visit as **End Date** (update if needed).
    - Notes with an end date are under **All** at lower left.
- Tap **Send to Portal.**

➢ **Visit Frequency & Calendar**

- Add/edit as needed – see instructions under **Admission** section.

Recertification Visit – if patient's ROC is done within 5-day Recert window, see instructions for ROC/Recert

➢ **Assessments**

- Resource Type: Your Discipline.

- Template: Your Discipline (OASIS E)
- Visit type: **4- Recertification (follow-up) reassessment** (if OASIS required) or **Routine Visit.**

➢ **Clinical Monitoring**

STEP 1: Tap + to add any Vital signs, measurements or lab values obtained.
STEP 2: Tap Done.
- A box will show if any required information is missing. Tap to enter information.

➢ **Care Plan/Charting**

- **Care Plan Editing**

STEP 1: Tap Care Plan Editing to edit care plans.

- **Care Plan Charting**

STEP 1: Tap Compact Charting.
STEP 2: Tap each Care Plan on left to document.
- Answering **Negative** requires a Milestone stating why the Goal or Intervention was not worked on during the visit.

➢ **Clinical Note**

- Use Code: **I.**
- Tap: **Include intermediate summary to Cert/Recert orders** and **Send to Portal.**
- **Certification Item#**: Always choose **Assessment Information for Physician Review** (at end of list)
- Add: **Ordering Physician, End Physician** and Date of visit as **End Date** (update if needed**).**
    - Notes with an end date are under **All** at lower left.

➢ **Medications**

- Adding additional medications, as needed:

STEP 1: Tap +Add.STEP 2: Search for and add all new Medications. Tap Next.
STEP 3: Tap Print on Cert/Recert then tap Done.STEP 4: Tap arrow at the top left to save then sync the chart.
STEP 5: Tap Medications tile.
STEP 6: On Medications screen, tap the 3 dots at lower right then select Drug-Drug to review the Drug/Drug Interactions.
- Tap **Cancel** then tap **Cancel** again to return to chart

➢ **Visit Frequency & Calendar**

- Add/edit as needed – see instructions under **Admission section.**

- **General Clinical**
  - Tap each screen in left column to review, update, and add/edit information as applicable.
    - Use the + at the top right of screen to add from list for section (free text is available) or check off boxes depending on the screen.
- **Care Team**
  - Add your name for **your discipline** if you will continue to see the patient.
  - Add any new information discovered.

Discipline discharge with visit

- **Assessment**
  - **Resource Type:** Your Discipline.
  - **Template:** Your Discipline (OASIS E)
  - Reason for Assessment: **Routine visit.**
- **Care Plans / Charting**

  STEP 1: Tap Care Plan Editing.

  STEP 2: Tap + at lower right to add Discharge Care Plan for your discipline.
    - Include intervention for Discharge from for your discipline.

  STEP 3: Tap + at the right of Goals and Interventions to add to each, as necessary.
    - Include Intervention for Discharge from (your discipline) to document Provider order.

  STEP 4: Discontinue Goals and Intervention for your discipline.
    - To discontinue an individual Goal or Intervention, tap the arrow under goal or intervention and enter an End Date.
    - To discontinue an entire Care Plan, tap the 3 dots at the lower right and tap Discontinue.

  STEP 5: Chart final outcome for Goals and Interventions.
- **Clinical Notes**
  - Use Codes: O and C.
  - Tap: Send to Portal.
  - Certification Item: Always choose **Assessment Information for Physician Review** (end of list).
  - Add: Ordering Physician.
- **Visit Frequency**
  - End current Visit frequencies for your Discipline.
  - Future Visit Frequencies:

- Edit End date to be the same as Start date for that Visit Frequency.
- Check **Do Not Create End Order** box.

➢ **Calendar**

- Delete remaining visits from calendar for your discipline.

STEP 1: Tap **Calendar.**
STEP 2: Tap **the 3 dots.**
STEP 3: **Tap Delete visits.**
STEP 4: Update the End Date to two months out to cover the cert period.
STEP 5: Tap **Filter.**
STEP 6: Delete visits as appropriate.

- Tap the box to the left of resource type to delete all visits at once.
- Tap each visit to delete individual visits.

STEP 7: Tap **Done.**

➢ **Care Team**

- Add End date online with your name.
- Send an email to Care Team members to indicate a Discipline Discharge for your discipline.

Discipline discharge No Visit

➢ **Care Plans / Charting**

- Document on the active Care Plans, as necessary.
- Add Discharge Care Plan for your Discipline.
- Include Intervention for **Discharge from (your Discipline)** to document Provider order.
  - Tap **Discontinue** under 3 dots at right to discontinue Care plans.
  - Add visit date as End Date.

➢ **Clinical Notes**

- Use Codes: O and C.
- Tap: Send to Portal.
- Certification Item#: Always choose **Assessment Information for Physician Review** (end of list).
- Add: Ordering Physician.

➢ **Visit Frequency & Calenda**

- To end and delete visits – see instructions under **Discipline d/c with visit.**

➢ **Care Team**

- Add End date online with your name.

- Send an email to Care Team members to notify of Discipline Discharge for your discipline.

Agency discharge w/visit

➢ **Admissions & Status**

- This can be done at any time during the visit

STEP 1: Tap the Status to update to Field Discharge.

- Choose the option showing why the patient is being discharged.

STEP 2: Update the Status date if not discharged today.

STEP 3: Add facility at discharge.

- If patient is home, enter Home.

STEP 4: Tap the back arrow at top left to save the information.

- If warning message appears requesting additional information, tap OK:
  - **This patient has open goals or interventions. Do you wish to proceed?**
    - When the Care Plan screen is open, discontinue all Care Plans.
  - **All scheduled visits after (date of discharge) will be removed.**
    - Confirm when viewing **Calendar** visits were removed.
  - **Care Team will be ended.**
  - **There are active Medications for this patient.**
    - Add: **End Physician**
    - Tap: **Do not Create End Sup Order** box.
    - Tap **Done**
    - Tap the arrow at the top left to Save and open the **Tile** screen.
    - When Medications screen is open, confirm all Medications are discontinued.

➢ **Assessments**

- Resource Type: Your Discipline.
- Template: Your Discipline (OASIS E)
- Visit type: **9-Discharge from Agency** if OASIS required or **Routine Visit**
- **D/T Summary** – Discharge from Agency.
  - If not chosen before Assessment template opened, tap 3 dots menu then tap **D/T Summary.**

➢ **Care Plan/Charting**

STEP 1: Tap Care Plan Editing.

STEP 2: Tap + at lower right to add Discharge Care Plan for your discipline.

- Include Intervention **Discharge from home health services.**

STEP 3: Document on the active care plans.
STEP 4: Discontinue Goals and Intervention for your discipline.

- To discontinue an individual Goal or Intervention, tap the arrow under goal or intervention and enter an End Date.
- To discontinue an entire Care Plan, tap the 3 dots at the lower right and tap Discontinue.

➢ Clinical Note

- Use Code: **D.**
  - Change **Effective Date** if not discharged today.
- Tap: **Send to Portal.**
- Add: **Ordering Physician, End Physician** and **End Date** (today's date).

➢ Medications

- Confirm all medications were discontinued, left column will be blank.
  - If still active, tap the 3 dots then tap **Discontinue.**
- Add End Physician
- Tap Do not Create End Sup Order box.
- Tap Done
- Tap the arrow at the top left to Save and open the **Tile** screen.

➢ Visit Frequency

- End all Visit Frequencies.
  - For future dated Visit Frequencies, edit the End date to be the same as the Start date for that frequency.
- Confirm box for **Do not create end order** is checked.
  - If not, tap box.

➢ Calendar

- Confirm all future visits were discontinued.

STEP 1: Tap **Calendar.**
STEP 2: Tap **the 3 dots.**
STEP 3: **Tap Delete visits.**
STEP 4: Update the End Date to two months out to cover the cert period.
STEP 5: Tap **Filter.**
STEP 6: Delete visits as appropriate.

- Tap the box to the left of resource type to delete all visits at once.
- Tap each visit to delete individual visits.

STEP 7: Tap **Done.**

➢ **Care Team**

- Confirm all current Care Team entries were end dated. If not, add today's date as End Date.

Agency Discharge No Visit / Discharge No visit No OASIS

➢ **Admissions & Status**

STEP 1: Tap the Status to update to Field Discharge.

- Choose the option showing why the patient is being discharged.

STEP 2: Update the Status date if not discharged today.
STEP 3: Add facility at discharge.

- If patient is home, enter Home.

STEP 4: Tap the back arrow at top left to save the information.

- If warning message appears requesting additional information, tap OK:
  - **This patient has open goals or interventions. Do you wish to proceed?**
    - When the Care Plan screen is open, discontinue all Care Plans.
  - **All scheduled visits after (date of discharge) will be removed.**
    - Confirm when viewing **Calendar** visits were removed.
  - **Care Team will be ended.**
  - **There are active Medications for this patient.**
    - Add: **End Physician**
    - Tap: **Do not Create End Sup Order** box.
    - Tap **Done**
    - Tap the arrow at the top left to Save and open the **Tile** screen.
      - When Medications screen is open, confirm all Medications are discontinued.

➢ **Assessments**

- Only complete if patient's Payer requires OASIS.
  - If no OASIS required, change Visit Type to Discharge No visit No OASIS.
    - To determine if Payer requires OASIS, check Assessment template box.

- If the only Reason for Assessment options are Initial Visit, Routine Visit or ON Call Visit you do not need to document an Assessment.

- Resource Type: Your Discipline.
- Template: **OASIS Only**
- Visit type: **9 – Discharge from Agency**
- **D/T Summary** – Discharge from Agency.
  - If this was not chosen before Assessment template opened, tap 3 dots menu then tap **D/T Summary.**

➢ **Care Plan/Charting**

- **Care Plan Editing**

STEP 1: Tap Care Plan Editing.
STEP 2: Tap + at lower right to add Discharge Care Plan for your discipline.
  - Include Intervention **Discharge from home health services.**

STEP 3: Document on the active care plans.
STEP 4: Discontinue Goals and Intervention for your discipline.
  - To discontinue an individual Goal or Intervention, tap the arrow under goal or intervention and enter an End Date.
  - To discontinue an entire Care Plan, tap the 3 dots at the lower right and tap Discontinue.

➢ **Clinical Note**

- Use Code: **D.**
  - Change **Effective Date** if not discharged today.
- Tap: **Send to Portal.**
- Add: **Ordering Physician, End Physician** and **End Date** (today's date).

➢ **Medications**

- Confirm all medications were discontinued, left column will be blank.
  - If still active, tap the 3 dots then tap **Discontinue.**
    - Add End Physician
    - Tap Do not Create End Sup Order box.
    - Tap Done
  - Tap the arrow at the top left to Save and open the **Tile** screen.

➢ **Visit Frequency & Calendar**

- To end and delete visits – see instructions under **Agency d/c with visit.**

➢ **Care Team**

- Confirm all current Care Team entries were end dated. If not, add today's date as End Date.

Resumption of Care (ROC) (1st visit after Transfer back from facility) If patient's Recertification is due within 5-day window, code visit as a Resumption of Care (ROC) – see separate instructions for ROC/Recert.

➢ **Admissions & Status**

- Update **Status** to **Field return from facility.**
  - Change **Status Date** if visit was not done today.
- Tap arrow at top left to Save, then sync chart (icon at lower right).

➢ **Assessments**

- Resource Type: Your Discipline.
- Template: Your Discipline (OASIS E)
- Visit type: **3 - Resumption of Care (after inpatient stay)** if OASIS required or **Routine Visit**

➢ **Clinical Monitoring**

STEP 1: Tap + to add any Vital signs, measurements or lab values obtained.
STEP 2: Tap Done.

- A box will show if any required information is missing. Tap to enter information.

➢ **Care Plan/Charting**

- **Care Plan Editing**

STEP 1: Tap Care Plan Editing.
STEP 2: Tap + at lower right to add Care Plan for your discipline.
STEP 3: Update Goals and Interventions, as necessary
STEP 4: Discontinue Goals and Intervention for your discipline, if no longer pertinent to patient care.

- To discontinue an individual Goal or Intervention, tap the arrow under goal or intervention and enter an End Date.
- To discontinue an entire Care Plan, tap the 3 dots at the lower right and tap Discontinue.

- **Care Plan Charting**

STEP 1: Tap Compact Charting.
STEP 2: Tap each Care Plan on left to document.

- Answering **Negative** requires a Milestone stating why the Goal or Intervention was not worked on during the visit.

➢ **Clinical Note**

- Use Codes: **O and C.**
- Tap: **Send to Portal.**
- **Certification Item#**: always add **Assessment Information for Physician Review** (end of list).
- Add: **Ordering Physician.**

➢ **Medications**

- Patient Readmitted:
  - Tap 3 dots at lower right to **Re-activate** medications which were discontinued at previous discharge.
    - If Reactivate is in gray, sync chart from Tile screen.
- Pending Medications
  - If **Pending Medications** displays at lower right, tap to see the list of Medications from the referral source.
    - Swipe left from the middle of the screen, then select **Include** for each medication to add to chart.
  - Tap + **Add** to add any additional medications.
- Tapered Medications
  - If a medication is titrated, select Titrate Medication.
- Kits
- Kits
  - If a kit needs to be added, tap **Kits.**
- To enter new medications

STEP 1: Start entering the medication name in the Search box, scroll to select the appropriate medication.
- Continue until all medications have been added then tap Next.

STEP 2: **Add Required information for each medication.**
- For an Admission **only**, all medications should have the provider overseeing the plan of care as the Ordering Physician regardless of the person who wrote the prescription.

STEP 3: Tap arrow at the top left to save then sync the chart.
STEP 4: Tap Medications tile.
STEP 5: On Medications screen, tap the 3 dots at lower right then select Drug-Drug to review the Drug/Drug Interactions.
- Tap **Cancel** then tap **Cancel** again to return to chart.

- Tap arrow at top left to Save then sync chart (icon at lower right).

➢ **Visit Frequency**

- Intake will enter a Visit Frequency for one visit for every discipline assigned to patient.
  - End the Visit Frequency entered by Intake with the same date as the visit.
  - Enter new visit frequency(ies) including Home Health Aide as needed.
- Add PRN visit frequency if applicable.
  - Tap the arrow at the top left to save then sync the new Visit Frequencies before adding visits to the Calendar.

➢ **Calendar**

- Schedule visits based on Visit Frequency on patient's Schedule.
- If visits cannot be added due to Insurance Authorization, send a Task to Insurance Authorization requesting more visits – include your discipline and number of visits requested.
  - See instructions under the admission section for more information.

➢ **Care Team**

- Add yourself to Care Team under your Discipline if seeing patient on a regular basis to receive update notifications.
- Enter/Update: **Code status**, **Infections**, **Alerts**, **Precautions**, and other known information.

Resumption of Care (ROC)/Recertification (combined visit)

If patient's Resumption of Care (ROC) is done within 5-day Recertification window, use Visit Type Resumption of Care.

➢ **Admissions & Status**

- Update **Status** to **Field return from facility.**
  - Change **Status Date** if visit was not done today.
- Tap arrow at top left to Save then sync chart (icon at lower right).

➢ **Assessments**

- Resource Type: Your Discipline.
- Template: Your Discipline (OASIS E)
- Visit type: **3 - Resumption of Care (after inpatient stay)** if OASIS required or **Routine Visit**

➢ **Care Plan/Charting**

- **Care Plan Editing**

<u>STEP 1</u>: Tap Care Plan Editing.

STEP 2: Tap + at lower right to add Resumption of Care Care plan for your discipline.
STEP 3: Update Goals and Interventions, as necessary
STEP 4: Discontinue Goals and Intervention for your discipline, if no longer pertinent for patient care.

- To discontinue an individual Goal or Intervention, tap the arrow under goal or intervention and enter an End Date.
- To discontinue an entire Care Plan, tap the 3 dots at the lower right and tap Discontinue.

- **Care Plan Charting**

STEP 1: Tap Compact Charting.
STEP 2: Tap each Care Plan on left to document.

- Answering **Negative** requires a Milestone stating why the Goal or Intervention was not worked on during the visit.

➢ Clinical Note

- Use Code: **I.**
- Include in the clinical note that the visit is a Recertification.
- Tap: **Include intermediate summary to Cert/Recert orders** and **Send to Portal.**
- **Certification Item#**: always choose **Assessment Information for Physician Review** (at end of list).
- **Add Ordering Physician** and **End Physician.**

➢ Medications

- Patient Readmitted:
  - Tap 3 dots at lower right to **Re-activate** medications which were discontinued at previous discharge.
    - If Reactivate is in gray, sync chart from Tile screen.
- Pending Medications
  - If **Pending Medications** displays at lower right, tap to see the list of Medications from the referral source.
    - Swipe left from the middle of the screen, then select **Include** for each medication to add to chart.
  - Tap + **Add** to add any additional medications.
- Tapered Medications
  - If a medication is titrated, select Titrate Medication.
- Kits
  - If a kit needs to be added, tap **Kits.**
- To enter new medications

STEP 1: Start entering the medication name in the Search box, scroll to select the appropriate medication.
- Continue until all medications have been added then tap Next.

STEP 2: Add Required information for each medication.
- For an Admission **only**, all medications should have the provider overseeing the plan of care as the Ordering Physician regardless of the person who wrote the prescription.

STEP 3: Tap arrow at the top left to save then sync the chart.

STEP 4: Tap Medications tile.

STEP 5: On Medications screen, tap the 3 dots at lower right then select Drug-Drug to review the Drug/Drug Interactions.
- Tap **Cancel** then tap **Cancel** again to return to chart.

- Tap arrow at top left to Save then sync chart (icon at lower right).

➢ **Visit Frequency**
- Intake staff enter a Visit Frequency for one visit for each discipline assigned to patient. End the Visit Frequency using the visit date as the end date.
- Enter new visit frequency(ies) including Home Health Aide as needed.
- Add PRN visit frequency if applicable.
- Tap the arrow at the top left to save then sync the new Visit Frequencies before adding visits to the Calendar.

➢ **Calendar**
- Schedule visits based on Visit Frequency on patient's Schedule.
  - Navigate to the Admission section for more information on scheduling visits.
- If visits cannot be added due to Insurance Authorization, send a Task to Insurance Authorization requesting more visits, include your discipline and number of visits requested.

➢ **Care Team**
- Add yourself to Care Team under your Discipline if seeing patient on a regular basis to receive update notifications.
- Enter/Update: **Code status**, **Infections**, **Alerts**, **Precautions**, and other known information.

Partial Transfer

If notified via phone call patient has left their residence to go to a hospital/facility, add Partial Transfer to Calendar and Email #VNA – Intake (your area) to advise of Transfer. Include name of hospital/facility and date of transfer.

➢ **Clinical Note**
- Use Code is **C**.

- Add date of transfer and hospital/facility to the Note.
- Tap **Send to Portal.**

Full Transfer / Full Transfer no OASIS

If notified patient has been admitted to a hospital or facility.

➢ **Admissions / Status.**

- Update the patient's status to **Facility Transfer no D/C** (at end of list).
- Update the **Status Date** to the date the patient was admitted to hospital or facility.
- In the **Facility ID** field, enter name of the hospital or facility where patient was transported.
- Scroll to Class and Acuity.
  - If Class indicates Home Health and Acuity indicates OASIS Pending, an OASIS only assessment is required.
  - If Class indicates Non-OASIS and Acuity indicates Non-OASIS, change visit type to Full Transfer no OASIS. An Assessment is not required so skip Step 3 below.

➢ **Medications**

- A warning message will display: *Warning: There are active medications for this patient. Please discontinue medications before transfer,* Tap **OK.**
  - Tap: **End Physician** box to add Provider.
  - Tap: **Do not Create End Sup Order.**
  - Confirm **End date** is the date the patient was transferred,
  - This must be the same date as transfer date on the Admissions & Status screen.
  - Tap **Done.**
    - If the system does not open the Medications screen, tap Medications from the tile page.
      - Tap: the three dots in the lower right and tap **Discontinue.**
      - Tap: **End Physician** box to add Provider.
      - Tap: **Select All Medications** and **Do not Create End Sup Order.**
      - Review the end date (s) for accuracy to reflect when the patient was transferred.
      - Tap **Done.**

➢ **Assessment – only add Assessment if OASIS is required. Otherwise, skip this step.**

- Template: **OASIS Only.**
- Visit Type: 6 – Transferred to an inpatient facility -patient not discharged. If this is not available. no Assessment and visit type (on Time Entry screen) should be Full Transfer no OASIS.
- **D/T Summary:** Discharge from Agency.

  - If this was not chosen before Assessment template opened, tap 3 dots menu then tap **D/T Summary.**
- Tap Done.

➢ **Clinical Notes**

- Use Code is **D.**
- Indicate Full Transfer at the beginning of your note.
- Include the date of transfer and hospital/facility in the Note.
- Tap: Send to Portal.

➢ **Calendar**

STEP 1: Tap **Calendar.**
STEP 2: Tap **3 dots in the lower right.**
STEP 3: Tap Delete visits.
STEP 4: Update the End Date to two months out to cover the cert period.
STEP 5: Tap **Filter.**
STEP 6: Delete visits as appropriate.

  - Tap the box to the left of resource type to delete all visits at once.
  - Tap each visit to delete individual visits.

STEP 7: Tap **Done.**

➢ **Visit Frequency**

- End current **Visit Frequencies** using today's date.
  - For **Visit Frequencies** not yet started, change the **End Date** to be the same as the **Start Date.**
    - Leave **Do not Create End Sup Order** box checked (or check it off if not checked) and add **Change Reason** – Transfer complete.