From the Office of Clinical Informatics

Northern Light Health

Netsmart - Hospice

Master Cheat Sheets

Table of Contents

Updated 2/9/24

IMPORTANT: If using the cheat sheet electronically, select the section header to be taken to the specific workflow flyer for more information.

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 separately to its 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.

Netsmart - Admission Visit

- ✓ For **Visit #1 Initial Visit** or **Visit #2 Comprehensive Asmt**, see instructions later in this document.
- ✓ Upload documents completed during the visit (ex. Admission Consent) to OnBase individually.
- ✓ Tap Attachments tile to view referral documents.
- ✓ If the address on the Today screen is in red font, confirm correct address on the Basic screen Active, Default and Service Location should only be checked off for the correct address.

Assessments

- Resource Type: **Your Resource type**.
- Template: **Hospice Hospice SN.**
- Visit type: **Initial Visit.**
  - In Assessment, **Type of Visit** is **Comprehensive.**

Assessment questions that should NOT be select, especially during an Admission: Specific answers.

Question:	**What Not to Do:**
F2200 Hospitalization preference/NQF 1641 treatment preference/NQF spiritual/religious concerns	Do not choose Per agency policy social worker or chaplain will discuss with patient/responsible party.
J0905 Pain Active Problem	If they have pain medications, they may not have pain at admission although pain is still an active problem.
J0900 Pain Screening/D. Type of standardized pint tool used	Do not choose 9**. No standardized tool used** because you always assess for pain.

Location of Pain	Do not choose **No detailed documentation this visit.** Instead, choose **Patient unable to specify location** to document you attempted to assess.
J0910 Lower Extremity of Pain	Do not choose **Unable to assess this visit**.
NQF 1639/J2030 Dyspnea Screening	Do not choose **Absence of dyspnea** if the treatment is the reason they do not have dyspnea at admission.
NQF 1638/J2040 Dyspnea Treatment	Do not choose **None.**
NQF 1617 Bowel Regimen (N0520)	Do not choose **No.** Choose **No, but there is a documentation of why a bowel regimen was not initiated or continue**.
Medication Teaching/Mediations taught this visit	Do not choose **No medications taught** *(during Admission)*.
Care Management tab/Physician Contact	Do not choose **No contact required/made** *(during Admission)*.

- Add second Assessment
  - Resource Type: **Your Resource type**.
  - Template: **Bereavement.**
  - Visit type: **Initial Visit**.

➢ Admissions & Status

If the patient will not be admitted (call Manager first), change the patient status to Clinical (reason patient is not being admitted). Example – Clinical Died before Admission.

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: Review and update Caregiver, if needed.
STEP 4: Confirm/change **Acuity** to **GIP General Inpatient** or RO **Routine,** as applicable.
STEP 5: Tap the back arrow in the 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.

➢ 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 **+** in the lower right to add a new Care Plan.
- Use the Search box or scroll down to select a Care Plan.
  - Care Plans added at Admission start with *.
    - In the search field, enter * to view/choose Care Plans.

STEP 3: Tap **+** in the right of Goals and Interventions to add to each, as necessary.
- Add Aid Care Plan, if applicable, by searching H550.
- Change Discipline to AID Aide to select specific interventions or goals for the patient.

- **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 is **I**.
  - Clinical Note added for a Hospice Addendum, Use Code is **A**.
- Tap **Include intermediate summary to Cert/Recert orders** and **Send to Portal**.
- **Certification Item#**: **Always** select **Assessment Information for Physician Review**.
- Add: **Ordering Physician, End Physician,** and date of Admission as **End Date,** update if needed**.**

➢ Medications

Adding medications

- Patient Readmitted
  - Tap three dots in the lower right to **Reactivate** 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 in the 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

STEP 1: Tap **+.**

STEP 2: Tap **Kits.**
STEP 3: Tap the name of the **Kit.**
STEP 4: Tap the **X** for any medication within the Kit which should not be added to the chart.
STEP 5: Tap **Next**
STEP 6: Add **Special Instructions**, if necessay, then save.

- Manually adding medications

STEP 1: Tap **+**
STEP 2: 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 3: Add Required information for each medication.
  - **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 4: Tap arrow in the top left to save then sync the chart.
STEP 5: Tap **Medications** tile.

- After adding any medications, tap the three dots in the lower right, then select **Drug-Drug** to review the Drug/Drug Interactions.
  - Tap **Cancel**, then tap **Cancel** again to return to chart.

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 that 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 in 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** in 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 in the top left, 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 **+** in the 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**.
  - If applicable, add a Note at the end of the Notes box. 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.**

- If applicable, add visits to **Patient Calendar** based on Visit Frequency for Aide.
  - For Aide, add one week of visits using Resource **Unassigned (your area)** and **Resource Type** Home Health Aide.
- Create Task for Scheduling to assign the remainder of the Aide visits.
  - Task Code - Need to Schedule assigned discipline.
  - Assigned to - Enter Scheduling then choose the one for your area.
  - Comment - Schedule HHA visits. Include how many visits a week and the town/facility where the patient is being seen.

➢ 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 (can free text information too) or tap 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 admission visit, add information in Netsmart and an Incident Report.
  - Do not document falls here that occurred before 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 to 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** tile for information.
    - Add **Disease** using drop down and Admission date as **Start Date**.

➢ Care Team

- Add your name for your discipline if you will continue to see the patient.
    - This signifies you are part of the Care Team for the patient so you can receive updates.
    - You do not need to add your name as Admitting Clinician if you did part or all of the Admission.
- 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

If the address on the Today screen is in red font, confirm correct address on the **Basic** screen and theses boxes are checked: **Active**, **Default** and **Service Location** before adding visits. Remove check mark for these fields for any other addresses.

- Basic
    - Review information on screen for accuracy and completeness.
        - Add **Preferred Name** and/or **Preferred Pronoun** if provided.
    - Review the **Note**s **(ReadOnly)** 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.
        - This can also be added/edited on the **Today** screen.
- Demographics
    - Add **Disaster/Evac Status** and **Alert**.
        - Answer Yes if the Alert Care Plan was added**.**
    - 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.
- Tap **+** in the lower right to add a new person.
  - Enter last name in **Name/ID** box.
    - Use boxes on right to designate roles.
      - Indicate at least **one** Primary Caregiver.
    - Check off **Designated Alternate Signatory** if the person will be signing at the end of the visit.
    - Add **NOK Next of Kin** for anyone who should receive Bereavement services.
    - If choosing POA, upload the document in OnBase under document type **Advanced Directives**. If the specific document is an **Appointment of Representative**, upload under that Document type.
  - If a person is not found in the database, tap **+** to the right of the **Name** box to add a new Resource to the database.

NOTE: If a family/friend should be removed from the chart, contact your manager to delete.

➢ Immunizations

- Add any Immunizations administered during visit.

➢ Payer/Authorizations

- Confirm correct Payer is in the chart. If not, email copy of Insurance card to #VNA Intake (your area).

Visit #1 Initial Visit *Completed by RN*

➢ Assessments

- Add first Assessment
  - Resource Type: Your Discipline.
  - Template: **Determining Terminal Illness.**
  - Visit type: **Initial Visit.**
- Add second Assessment
  - Resource Type: Your Discipline.
  - Template: **Bereavement**.
  - Visit type: **Initial Visit**.

➢ Clinical Monitoring

STEP 1: Tap **+** to add any vital signs, measurements or lab values obtained.

STEP 2: Tap **Done**.

➢ Admissions & Status

If the patient will not be admitted (call Manager first), change the patient status to **Clinical (reason patient is not being admitted).** Example – **Clinical Died before Admission**.

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: Review and update Caregiver, if needed
STEP 4: Confirm/change **Acuity** to **GIP General Inpatient** or RO **Routine,** as applicable.
STEP 5: Tap the back arrow in the 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.

➢ Care Plan/Charting

- **Adding Care Plans**

STEP 1: Tap **Care Plan Editing**.
STEP 2: Tap **+** in the lower right to add a new Care Plan.
  - Use the Search box or scroll down to select the Code Status and any Care Plan for care provided at the visit.

STEP 3: Tap **+** in the right of Goals and Interventions to add to each, as necessary.
  - Add Aid Care Plan, if applicable, by searching H550.
  - Change Discipline to AID Aide to select specific interventions or goals for the patient.

➢ Clinical Note

- Use Code is **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: see Admission visit section for instructions.

➢ 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 that 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.

- VSOC (**Verbal Start of Care**) Date is located at the top, enter the date of visit and tap **Sign**.
- Confirm there is a Visit Frequency for Visit #2.

➢ Calendar

STEP 1: Tap **Calendar** and confirm visit #2 is scheduled.
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: Add visits to Patient Calendar based on Visit Frequency for Aide, if applicable.

- For Aide, add one week of visits using **Resource Unassigned (your area)** and **Resource Type Home Health Aide.**

STEP 4: Create Task for Scheduling to assign the remainder of the Aide visits.

- Task Code: **Need to Schedule assigned discipline**.
- Assigned to: **Enter Scheduling then choose the one for your area**.
- Comment: **Schedule HHA visits. Include how many visits a week and the town/facility where the patient is being seen**.

➢ Care Team

- Tap **Admitting Clinician** in left column.
  - Add your name for your discipline if you will continue to see the patient.
    - This signifies you are part of the Care Team for the patient so you can receive updates.
  - You do not need to add your name as Admitting Clinician if you did part or all of the Admission.
- Enter **CODE Status**.

➢ Basic/Demographics

If the address on the Today screen is in red font, confirm correct address on the Basic screen and theses boxes are checked: Active, Default and Service Location before adding visits. Remove check mark for these fields for any other addresses.

- Basic
  - Review information on screen for accuracy and completeness.
    - Add **Preferred Name** and/or **Preferred Pronoun** if provided.
  - Review the **Note**s **(ReadOnly)** 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 to display on the **Today** screen for all clinicians to view.

- Demographics
  - Add **Disaster/Evac Status** and **Alert** and fill in any section with ***Selection Required***. Do not add **Start Date** to any line.
    - Answer **Yes** if the Alert Care Plan was added**.**

➢ Adverse Events

- Falls
  - Do not document falls here which occurred before the Admission.
  - If patient falls during visit, add information below in Netsmart and an Incident Report.
    - **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 to 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. Tap **Attachments** tile for information. Add **Disease** using drop down and Admission date as **Start Date**.

➢ Family/Friends

- Confirm information is correct with patient or family.
  - 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.
  - Enter last name in **Name/ID** box.
  - Use boxes on right to designate roles – always check off a **Primary Caregiver.**
- If a person should be removed from the chart, contact your manager to have it deleted.

➢ Payer/Authorizations

- Confirm correct Payer is in the chart.
  - If not, email copy of Insurance card to #VNA Intake(*your area*).

Visit #1 Initial Visit *completed by MSS, SC or Therapy*

- This visit takes the place of your Secondary Evaluation.

➢ 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 in the 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, Died before Admission).

➢ Assessments

- First Assessment
  - Resource Type: **Your Discipline.**
  - Template: **Your Discipline.**
  - Visit type: **Initial Visit**
- Add second Assessment
  - Resource Type: **Your Discipline.**
  - Template: **Bereavement.**
  - Visit type: **Initial Visit.**

➢ Care Plan/Charting

- **Adding Care Plans**

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

- Use the Search box or scroll down to select a **Code Status Care Plan**.
  - Care Plans added at Admission start with *.
    - In the search field, enter * to view/choose Care Plans.
      - Add any Care Plans for care you provided.

STEP 3: Tap **+** in 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 three dots in the lower right and tap Discontinue.

➢ Clinical Note

- Use Codes: **O & C**.
- Tap: **Print on 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.**
  - Notes with an end date are under **All** at lower left.

➢ Visit Frequency

- Patient status on **Admissions & Status** screen must be updated to **Field Admit** before editing Visit Frequencies.
- Confirm Cert Period on Visit Frequency screen is listed in left column.
  - If it says Prospect, submit a help desk ticket to have the Cert dates recalculated.

➢ Calendar

- Add your discipline visits to the Calendar based on the Visit Frequency added.

➢ Care Team

- You do not need to add your name as Admitting Clinician if you did part or all of the Admission.
- Add your name under your discipline if you will continue to see the patient. This signifies you are part of the Care Team for the patient updates.
- Enter CODE Status and any other information you obtain.

➢ Basic/Demographics

If the address on the **Today** screen is in red font, confirm correct address is checked off on the Basic screen for Active, Default and Service Location before adding visits.

- Basic
  - Review information on screen for accuracy and completeness.
    - Add **Preferred Name** and/or **Preferred Pronoun** if provided.
- 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 to display on the **Today** screen for all clinicians to view.

➢ Family/Friends

- Confirm information is correct with patient or family.
- Tap **+** at lower right to add a new person from existing database. Enter last name in **Name/ID** box. Use boxes on right to designate roles – always check off a **Primary Caregiver.** 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.

➢ Payer/Authorizations

- Confirm correct Payer is in the chart. If not, email copy of Insurance card to **#VNA Intake (your area).**

Visit #2 Comprehensive Assessment Visit *completed by RN*

➢ Assessments

- Resource Type: **Your Discipline**.
- Template: Your Discipline (**Hospice Hospice SN** for nurse).
- Visit type: **Initial Visit**.
  - In Assessment, **Type of Visit** is **Comprehensive.**
- Review left column to confirm Bereavement Assessment was completed.
  - If not, add the Assessment.

➢ Medications

- Review medications entered during Visit #1, update as necessary.
- Confirm **Comfort pack** is in the home.
  - If patient has taken any medications from Comfort pak, add the medication(s) to chart using **Kits** button to select correct medication.
  - If Medications are added, after synching 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.

➢ Care Plan/Charting

- **Adding Care Plans**

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

- Use the Search box or scroll down to select a Care Plan.

- Care Plans added at Admission start with *.
    - In the search field, enter * to view/choose Care Plans.

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

- Add Aid Care Plan, if applicable, by searching H550.
- Change Discipline to AID Aide to select specific interventions or goals for the patient.

- **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.

➢ Visit Frequency

STEP 4: Add a new Visit Frequency. Tap **PRN** in the lower left to enter PRN Visit Frequencies. Add a care plan for Aide if necessary.

- 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 in the top left, then sync the chart.

➢ Calendar

- Add visits to Patient Calendar based on Visit Frequency for Nursing, and Aide if applicable, for the full certification period.
    - For Aide, add one week of visits using Resource **Unassigned (your area)** and **Resource Type** Home Health Aide.
- In the Scheduling Note, add the name of the town/facility where patient is being seen.
- For Aide, add one week of visits using Resource **Unassigned (your area)** and **Resource Type** Home Health Aide.
- Create Task for Scheduling to assign the remainder of the Aide visits.
    - Task Code - **Need to Schedule assigned discipline.**
    - Assigned to - Enter **Scheduling** then choose the one for your area.
    - Comment - Schedule HHA visits. Include how many visits a week and the town/facility where the patient is being seen.

➢ 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 (can free text information too) or tap 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.

➢ Care Team

- Add your name for your discipline if you will continue to see the patient.
  - This signifies you are part of the Care Team for the patient so you can receive updates.
    - You do not need to add your name as Admitting Clinician if you did part or all of the Admission.
- Add any other known information (ex-Funeral Home, Cat, or Dog in Home, DME Supplier).

Secondary Evaluation

➢ Assessments

- Resource Type: **Your Resource Type.**
- Template: **Your Discipline**.
- Visit type: **Initial Visit.**

➢ Care Plan/Charting

- **Adding Care Plans**

STEP 1: Tap **Care Plan Editing**.
STEP 2: Tap **+** in the lower right to add a new Care Plan.
  - Use the Search box or scroll down to select a Care Plan.
    - Care Plans added at Admission start with *.
      - In the search field, enter * to view/choose Care Plans.

STEP 3: Tap **+** in the right of Goals and Interventions to add to each, as necessary.
  - Add Aid Care Plan, if applicable, by searching H550.
  - Change Discipline to AID Aide to select specific interventions or goals for the patient.

- **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**.
    - Notes with an end date are under **All** at lower left.

➢ Visit Frequency

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

STEP 2: Add a new Visit Frequency. Tap **PRN** in 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** (unless Admission was >1 week ago) 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 3: Tap arrow in the top left, 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 **+** in the 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**.
    - If applicable, add a Note at the end of the Notes box. 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.**

➢ Care Team

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

Routine Visit *(including Respite visits)*

➢ Assessments

- Resource Type: **Your Resource Type.**
- Template: **Your Discipline.**
- Visit type: **Routine Visit.**
  - For SN, in the Assessment under Type of visit, choose **Routine Visit** then choose **Symptom Management** in the left column to customize the Assessment.

- Clinical Monitoring: *Nurses only*

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

- 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.
  - Tap **Send to Portal**.

- Admissions & Status: ***Respite only***
  - If first visit after patient is in Respite:
    - Scroll down to **Acuity** field.
    - Change Acuity to **Respite.**

Hospice Informative

- Assessments: *Optional (only completed by RN)*
  - Resource Type: **SN Registered Nurse**.
  - Template: **Determining Terminal Status** (if visit becomes an Admission, use **Initial** visit).
  - Visit type: Initial Visit.

- Clinical Monitoring: *Optional (only completed by RN)*

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

- Clinical Note: *required for all Disciplines*
  - Use Code: **C**.
  - Tap: **Send to Portal**.

Hospice Death Visit

Discharge Visits

- Admissions & Status
  - Update **Status** to **Field Patient Died (location where patient passed).**

- Update **Status Date** if necessary.
- Add time of death under **Status Time**.

- Tap arrow at top left to Save. Warnings will appear:
  - **This patient has open goals or interventions. Do you wish to proceed?** This is a reminder to end all of the Care Plans, Tap **OK**.
  - **All scheduled visits after (today's date) will be removed,** Tap **OK.**
  - **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.**
  - **There are active medications for this patient. Please discontinue all active medications before discharge.** Tap **OK.**
- Tap **Do not Create End Sup Order** box.
- Tap **Done.**

➢ Care Plan/Charting

- **Adding Care Plans**

STEP 1: Tap **Care Plan Editing**.
STEP 2: Tap **+** in the lower right to add a new Care Plan.
  - Use the Search box or scroll down to select H610 Discharge Care Plan.

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

- **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 is **O**.
- **Effective Date**: Date of death.
- Add Certification Item#: **Assessment Information for Physician Review** (last one on the list).

➢ 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 off If not, tap box.

➢ Calendar

- Confirm all future visits were discontinued.

- If not, tap the 3 dots then tap **Delete Visits.**
- Change **End Date** to three months out to cover the cert period.
- Tap **Filter.**
- Tap the box to the left of **Resource Type** to choose all future visits
- Tap **Done.**

➢ Care Team

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

Hospice Live Discharge w/Visit

Discharge Visits

➢ Admissions & Status

- Update **Status** to **Field Discharge (reason patient discharged).** Update **Status Date** if necessary.
- Tap arrow at top left to Save. Warnings will appear:
  - **This patient has open goals or interventions. Do you wish to proceed?** This is a reminder to end all of the Care Plans. Tap OK.
  - **All scheduled visits after (today's date) will be removed.** Tap OK.
  - **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**
  - **There are active medications for this patient. Please discontinue all active medications before discharge.** Tap **OK.**
    - Tap **Do not Create End Sup Order** box.
    - Tap **Done.**

➢ Care Plan/Charting

- **Adding Care Plans**

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

- Use the Search box or scroll down to select H610 Discharge Care Plan.

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

- **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 is **O**.
- Change **Effective Date,** if not discharged today.
- Add Certification Item#: **Assessment Information for Physician Review** (last one on the list).

➢ Medications
- Confirm all medications were discontinued, left column will be blank.
  - If still active, tap the 3 dots then tap **Discontinue.**

➢ 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 are discontinued.
  - If not:
    - Tap the 3 dots then tap **Delete Visits.**
    - Change **End Date** to three months out to cover the cert period.
    - Tap **Filter.**
    - Tap the box to the left of **Resource Type** to choose all future visits.
    - Tap **Done.**

➢ Care Team
- Confirm end dates are added to all active Care Team types.
  - If not, add discharge date as end date.

Agency Discharge – NO visit

➢ Admissions & Status
- Update **Status** to **Field Discharge (reason patient discharged).**
  - Update **Status Date** if necessary.
- Tap arrow at top left to Save. Warnings will appear:
  - **This patient has open goals or interventions. Do you wish to proceed?** This is a reminder to end all of the Care Plans. Tap OK.
  - **All scheduled visits after (today's date) will be removed.** Tap OK.

        - **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.**
        - **There are active medications for this patient. Please discontinue all active medications before discharge.** Tap **OK.**
    - Tap **Do not Create End Sup Order** box.
    - Tap **Done.**

- Clinical Note
    - Use Code is **O**.
    - Change **Effective Date** if not discharged today.
    - Add Certification Item#: **Assessment Information for Physician Review** (last one on the list).

- Medications
    - Confirm all medications were discontinued, left column will be blank.
        - If still active, tap the 3 dots then tap **Discontinue** or add End Date to each medication.

- 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 off.

- Calendar
    - Confirm all future visits are discontinued. If not:
        - Tap the 3 dots then tap **Delete Visits.**
        - Change **End Date** to three months out to cover the cert period.
        - Tap **Filter.**
        - Tap the box to the left of **Resource Type** to choose all future visits.
    - Tap **Done.**

- Care Team
    - Confirm end dates are added to all active Care Team types. If not, add discharge date as end date.

Discipline Discharge - with visit

- Assessment
    - Resource Type: **Your Discipline.**
    - Template: **Your Discipline.**
    - Reason for Assessment: **Routine visit.**

➢ Care Plans / Charting

STEP 1: Tap **Care Plan Editing**.
STEP 2: Tap **+** in the lower right to add Discharge Care Plan.
- Use the Search box or scroll down to select a Care Plan.

STEP 3: Tap **+** in the right of Goals and Interventions to add to each, as necessary.
STEP 4: Chart the final outcome of Goals/Intervention.

➢ Clinical Notes

- Use Codes: **O & C.**
- Tap: **Send to Portal.**
- Certification Item#: Always choose **Assessment Information for Physician Review** (end of list).
- Add: Ordering Physician if it did not auto populate.

➢ Visit Frequency

- End current Visit frequencies for your Discipline.
  - Tap **Do Not Create End Order**.
- Future Visit Frequencies, edit End date to be the same as Start date for that Visit Frequency.
  - Tap **Do Not Create End Order**.

➢ Calendar

- Delete remaining visits from calendar for your discipline.
  - Tap 3 dots at lower right.
  - Tap **Delete Visits**.
- Change **End Date** to three months out to cover the cert period.
  - Tap **Filter**.
  - Tap the box for each visit to delete.
    - To delete all visits, tap box to the left of **Resource Type.**
  - Tap **Done**.

➢ Care Team

- Add End date on line with your name.
- Send an email to Care Team members to notify of Discipline Discharge for your discipline.

Discipline Discharge – NO visit

➢ Care Plans / Charting

- Add Intervention Discharge for your discipline to document Provider order.
  - Add other Discharge Interventions you performed during your visit.

- Tap **Discontinue** under 3 dots at right to discontinue Care plans.
- Add visit date as End Date.

➢ Clinical Notes

- Use Codes: **O & 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.
  - Tap **Do Not Create End Order**.
- Future Visit Frequencies, edit End date to be the same as Start date for that Visit Frequency.
  - Tap **Do Not Create End Order**.

➢ Calendar

- Delete remaining visits from calendar for your discipline.
  - Tap 3 dots at lower right.
  - Tap **Delete Visits**.
- Change the **End Date** to three months out to cover all future visits.
  - Tap **Filter**.
  - Tap the box for each visit to delete. To delete all visits, tap box to the left of **Resource Type.**
- Tap **Done**.

➢ Care Team

- Add End date on line with your name.
- Send an email to Care Team members to notify of Discipline Discharge for your discipline.