Hospice Care Plan – Back Office

Last updated 10/20/2023





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Overview

To support hospice field clinicians creating and maintaining an evolving, personalized care plan, a new Care Plan model, replacing Pathways, has been created. Problem Sets, comprised of Problems, Goals, Interventions, and a Discipline assignment, are used to create a flexible Care Plan visible to all team members involved in the patient's care in both PointCare and the Back Office.

A PointCare branch setting has been added for hospice branches to enable Care Plan functionality that is available both inside and outside of a visit.

An interdisciplinary view of the current care plan is also accessible throughout the patient's service duration via Medical Records in PointCare and the Back Office.

Updates to the following Back Office components have been made to provide visibility into the personalized care plan:

- Hospice Plan of Care Order
- Hospice SOC Workflow
- Hospice Add On Order
- Hospice Add On Workflow
- Hospice Recertification Plan of Care Update Order
- Hospice Recert Workflow
- Hospice IDG Comprehensive Assessment and Plan of Care Update Report
- Visit Note Interventions Provided, Interventions Not Provided, Goals Met tabs
- Plan of Care Update Order

Care Plan

A new view, accessible in Medical Records and via the Care Plan button in various workflow stages (outlined below), has been created to provide visibility into the current, interdisciplinary Care Plan.

Users will need to be assigned the system function "VIEW HOSPICE PERSONALIZED CARE PLAN" to access the Care Plan within Clinical Input.



• Clinical Input > right-click > Medical Records Info



Clinical Input > Medical Records Info button



• Edit/View Hospice Plan of Care will be hidden for all Care Plan patients.

Care Plan: Empty State

If Care Plan data has not yet been established or cannot be returned for any reason, users will receive notification that there is "No Care Plan data currently available for this patient."





If the Care Plan view is open when Care Plan information is synced from PointCare, users will need to close and reopen the view to see the view populated.

Care Plan: Current Care Plan

The current, interdisciplinary Care Plan can be viewed grouped by Problems. The Care Plan is not editable from the Back Office – any corrections/updates will need to be made within PointCare.

Care Plan	Q CARE PLAN REPORT
WOUND CARE	WOUND CARE
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	PAIN MANAGEMENT
	PAIN IS MANAGED AT A LEVEL ACCEPTABLE TO THE PATIENT SKILLED NURSING TO ADMINISTER PAIN MEDICATIONS AS PRESCRIBED SN

Left pane = Table of Contents

• Clicking on a Problem will scroll the "content view" to the selected Problem.

Right pane = Content View

• Comprised of "Problem Cards" to group related Goals and Interventions for the shared Problem.

Anatomy of a Problem Card:

EMOTIONAL/PSTCHOSOCIAL
Goal PSYCHOSOCIAL SUPPORT AND COUNSELING WILL BE OFFERED TO PATIENT THROUGHOUT THEIR STAY Intervention ASSESS PATIENT'S NEEDS THROUGH OUT THE DYING PROCESS CH Discipline

Search capability within the Care Plan module is currently set to "fuzzy search" meaning results in the content view will be based on approximate matches instead of exact string matching.

The Search will return results across all Problems, Goals, Interventions, and Disciplines.

Care Plan: Comprehensive Care Plan Report

The Comprehensive Care Plan Report provides hospice agencies an electronic and hard copy of a patient's comprehensive care plan and its changes over time. The report is designed to help team members facilitate conversations with surveyors showing an individualized and evolving care plan throughout the patient's service duration.

At the patient's admission, the care team can view the current care plan. During recertification, the care team can also view historical information that can be provided to any external



stakeholders (surveyors, physicians, etc.) as needed. This report fulfills the requirement that agencies must be able to provide printed documents if requested, or for an additional developmental request (ADR) or Medicare administrative contractor (MAC).

The Comprehensive Care Plan Report replaces the Resolution Report.

The report can be viewed and printed from the Care Plan module (Clinical Input > Medical Records Info > Care Plan).

On the Care Plan screen, click Care Plan Report.



Report highlights include:

- Crosses all benefit periods.
- Prints problems grouped by problem set.
 - **P**: represents the problem
 - G: represents the goal associated with the problem. There can be multiple goals per problem. When a goal has been ended (resolved), the resolution text displays below the goal line.
 - I: represents the intervention associated with the goal and the associated discipline. There can be multiple interventions per goal.
- Displays the date when problems, goals, and/or interventions were added, edited, and ended, and the associated worker name and title of who made the change.
- Includes the goal met and intervention resolution reason, when available. Added, edited, and ended dates display for each change.
- The most recently added problem sets are displayed at the top.
- If an item is added and edited in the same visit, only the add date will display and show the worker that edited it last.
- If an intervention or goal was ended (resolved) and added again, the report will display each date the item was added, ended, and added back.



In addition to accessing the Comprehensive Care Plan report from the Care Plan module (Clinical Input > Medical Records Info > Care Plan > Care Plan Report, the report can be launched from the following locations:

- Clinical Input > Reports > Print Medical Record
- Clinical Input > right-click > Reports > Print Medical Record
- Clinical Input > Patient Snapshot > See All > Print Medical Record
- Workflow Console > Review Coordination Notes > right-click stage > Medical Records Info > Print Medical Record
- Workflow Console > Review/Update Care Plan stage > View Care Plan
- IDG Console > right-click patient > Medical Records Info > View Care Plan
- IDG Console > Medical Records Info

On the **Print Medical Record for** screen, when the **Hospice POC Report/Comprehensive Care Plan Report** check box is selected, patient episodes with Pathways will print the Hospice POC Report and patient episodes with a Care Plan will print the new Comprehensive Care Plan Report.



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elect Reports	
Patient Information Report Include Coordination Note Types (ALL) Episode Summary Report DASIS Home Health Patient Tracking Sheet Call Report DASIS Home Health Patient Tracking Sheet Patient Verification Report Patient Medications Report Patient Supplies Report Aide Care Plan Report Patient Coordination Note Report Aide Care Plan Report Patient Coordination History Report Patient Vaccination History Report Patient Order Report Patient Calendar Report Visit Note Report Visit Note Report	Include Medical Treatment Code Visits YES Vital Signs Report Wound Assessment Tool Report Wound Record Report Hospice POC Report/Comprehensive Care Plan Report IDG Summary Report Hospice POC Comprehensive Assessment Report Hospice IDG Comprehensive Assessment and Plan Of Care Update Report Hospice Recert Summary Report Hospice Daily Encounter Report Period Summary Report QI Reports Election Statement Addendum Request History Report
Print Consolidated Medical Record Allow Start and End Dates outside of Episode Date F	lange

If a date range is selected that spans multiple episodes, or if multiple episodes are selected in Clinical Input, and some episodes have Pathways data and some have Care Plan data, then both the Hospice POC Report and the Comprehensive Care Plan Report will be displayed.

Note: When you select *multiple episodes* from Clinical Input and choose Print Medical Record, you will also be prompted to enter a date range. You must enter a range to continue, but the dates have no bearing on which episodes are printed. The medical records for the episodes selected in Clinical Input will be printed.

The screen for the workflow stage **Review/Update Care Plan** was updated to display the Comprehensive Care Plan Report.

For patient episodes with Pathways, the Edit/View Hospice POC button will display.

Review/Up	date Car	e Plan for
		View Patient Order Report 🔮
		Edit/View Hospice POC
	\square	Edit/View Team Members
	St	age Completed Cancel Ø



For patient episodes with a Care Plan, the View Care Plan button will display.



Similarly, in the IDG Console, either the option to **View/Update Hospice Plan of Care** or the option to **View Care Plan** will be displayed based on whether the selected patient is on Pathways or Care Plan.

Discharge-Transfer Summary Report – Enhancements

The Discharge-Transfer Summary Report has been updated to include the following enhancements.

The report displays hospice Person-Centered Care Plan details to help ensure accuracy for reporting on a patient's clinical data when the report is sent to outside facilities.

The new Care Plan section displays information similar to the Comprehensive Care Plan Report. This section is displayed for patients who have a Care Plan and it replaces the Distinct Outcomes section.

Note that the Distinct Outcomes section will still display for Pathways patients.

If the patient has no Care Plan items at discharge, the Care Plan section is not displayed in the report.

If the Goal has been resolved, re-opened, and then resolved again, the most recent resolved date is shown.

Information is grouped by Problem Set:

- P - Represents the Problem

- G – Represents the Goal associated with the Problem. There can be multiple Goals per problem. When a Goal has been ended (resolved), the resolution text displays below the Goal line.

- Ended Date - Displays the date when Problems and Goals were ended. If the Goal has been resolved, re-opened, and then resolved again, the most recently resolved date is

displayed in this section.

Discipline		No. Visits Provided	Patient Last Seen by Discipline on	
\$N		3	01/04/2024	
	Totals:	3		
Care Plan				
				Ended Date
P: PAIN MANAGEMEN	T/ALTERED COMFORT			
G: OBJECTIVE SIGNS	AND SYMPTOMS OF PAIN WILL IM	IPROVE WITH PRESCRI	BED INTERVENTIONS	
P: EMOTIONAL DISTR	ESS			
G: PATIENT/CAREGIVI DYING PROCESSP/ DEATH AND THE D	ER ACCEPTS HELP AND HAS DEC ATIENT/CAREGIVER ACCEPTS HE YING PROCESS	REASED ANXIETY/STRE	SS/FEAR REGARDING DEATH AND THE D ANXIETY/STRESS/FEAR REGARDING	1/4/2024
Reason: GOAL IS M	ET 01/04			
G: PATIENT/CAREGIV	ER VERBALIZES UNDERSTANDING	G OF ORIGIN/CAUSE OF	TERMINAL AGITATION	
G: PATIENT/CAREGIVI ANXIETY/AGITATIO	ER VERBALIZES/DEMONSTRATES	APPROPRIATE MEASU	RES TO MINIMIZE/CONTROL	
G: PATIENT/EAMILY/C			DDECCION COMPTONIC	1/4/2024



Hospice Plan of Care Order

Existing Hospice Plan of Care Order has been updated to include Goals and Interventions established during the admission visit.

Edit Hospice POC Order > Order Text

Edit Hospic	e POC Order for						-		\times
General Info	Order Text Goal Text Allerg	jies Functional Limitations	Activities Permitted	Mental Statuses	Medications	Supplies	Diagnoses	Edit/Viev	vC ∢ ▶
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Drag a col	umn header here to group by t	hat column.							
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2	TEACH PATIENT/FA	MILY/CAREGIVER HOW T REGIVER FUNDAMENTAL	O USE/MEASURE P/ PRINCIPLES OF EFI	AIN BY USING * FECTIVE PAIN M	TOOL/SCALE ANAGEMENT	AND REPO	ORTING ME	CHANISM	S

- Order Text tab contains all Interventions added during the admission visit.
- Display text to notify users that any changes made within the Order Text tab will only update the order output and will not modify the patient's current Care Plan.
- Interventions "nested" under the same parent Goal will appear within a single Order Text grid row.

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- "Add" allows free-text entry for additional items to be included solely on the Hospice POC Order.
- Order Text search field to add new Pathway items has been removed.

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• Selecting a grid row and clicking "Edit" allows updates/corrections to be made to those items solely on the Hospice POC Order.

Note: To Save & Close any edits to Order Text, asterisks must be removed, or a validation will display. A validation **will not** display when clicking Save & Close out of edit view of the order itself if there are asterisks present.

Edit Hospice POC Order > Goal Text

Edit Hospic	e POC Order f	or							-		\times
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Sequence	⊽ Go	al Text									7
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2	PA	TIENT SEL	F-IDENTIFI	IED PAIN THRESHOL	D OF * BY * USING *	SCALE					

- Goal Text tab contains all Goals added during the admission visit.
- Display text to notify users that any changes made within the Goal Text tab will only update the order output and will not modify the patient's current Care Plan.
- Goals "nested" under the same parent Problem will appear within a single Goal Text grid row.

Add Hospice F	POC Goal Text	
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Spell Check	Save & Close 🔡	∽ Cancel Ø

- "Add" allows free-text entry for additional items to be included solely on the Hospice POC Order.
- Goal Text search field to add new Pathway items has been <u>removed</u>.





• Selecting a grid row and clicking "Edit" allows updates/corrections to be made to those items solely on the Hospice POC Order.

Note: To Save & Close any edits to Goal Text, asterisks must be removed, or a validation will display. A validation **will not** display when clicking Save & Close out of edit view of the order itself if there are asterisks present.

Hospice Certification and Plan of Care Order Report

This Hospice POC Order Report will continue to have the information from the Order Text tab appear in the **Orders of Discipline and Treatments** section and the information from the Goal Text tab appear in the **Goals** section.

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THE LICENSED PROFESS	IONAL WHOSE SIGNATURE	APPEARS ATTESTS THAT THE PH	YSICIAN'S ORDERS WERE RECEIVED ON: 2/26/2020.
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Hospice SOC Workflow

Pathway access throughout the various SOC workflow stages has been replaced with Care Plan access for patients that have Problem Sets.

The Care Plan button will open the view of the patient's current Care Plan.

Review Hospice SOC Evaluation Documentation

Care Plan is required to be viewed to stage complete the task.

If Care Plan data cannot be returned, the Edit/View Hospice Plan of Care button will be present (and required) to allow processing of workflow.





Initial Review of Hospice POC

Care Plan is required to be viewed to stage complete the task.

If Care Plan data cannot be returned, the Edit/View Hospice Plan of Care button will be present (and required) to allow processing of workflow.



Review/Edit/Approve Hospice POC

Care Plan is not required to be viewed to stage complete the task.

If Care Plan data cannot be returned, the Edit/View Hospice Plan of Care button will be present (but not required) to allow processing of workflow.





Hospice Add On Order

The existing Hospice Add On Order has been updated to include Goals and Interventions established during the corresponding add on visit.

For Hospice Add On Orders created from a PointCare visit, the "Discipline" field will be grayed out and unable to be modified.

Edit Hospice Add On Order > Order Description

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- Order Description tab contains all Interventions added during the corresponding add on visit.
- Display text to notify users that any changes made within the Order Description tab will only update the order output and will not modify the patient's current Care Plan.
- "Get Order Text from Treatment Codes" button to add new Pathway items has been removed.

Note: To Save & Close any edits to the Order Description tab, asterisks must be removed, or a validation will display.

Error	
8	The (*) character is not allowed in the Order Description. Please replace any (*) characters with valid text.
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Edit Hospice Add On Order > Goal Text

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- Goals tab contains all Goals added during the corresponding add on visit.
- Display text to notify users that any changes made within the Goals tab will only update the order output and will not modify the patient's current Care Plan.
- "Get Goal Text from Treatment Codes" button to add new Pathway items has been removed.

Note: To Save & Close any edits to the Goals tab, asterisks must be removed, or a validation will display.

Error	
8	The (*) character is not allowed in the Goal Text. Please replace any (*) characters with valid text.
	ОК



Hospice Add On Order Report

The Hospice Add-Order Report will continue to have the information from the Order Description tab appear in the **Order Description** section and the information from the Goals tab appear in the **Goals** section.



Hospice Add On Workflow

Pathway access in Add On workflow stage has been replaced with Care Plan access for patients that have Problem Sets.

The Care Plan button will open the view of the patient's current Care Plan.

Review Hospice Add On Evaluation Documentation (Stage 3011)

Care Plan is required to be viewed to stage complete the task.

If Care Plan data cannot be returned, the Edit/View Hospice Plan of Care button will be present (and required) in order to allow processing of workflow.

Review Hospice Add On Evaluation Docum	entation for
\checkmark	Visit Note
$\overline{\checkmark}$	Review Hospice Add On Order 🗐
0	Care Plan
	Stage Completed Cancel Ø



Hospice Recertification Plan of Care Update Order

The existing Hospice Recertification Plan of Care Update Order (HRPOCU) has been updated to include current Goals and Interventions for all disciplines.

The Pathway/Care Plan tab to add/review Pathway items has been removed.

Verbiage on the existing asterisks validation referring to the "Order Text" has been updated to correctly reflect the validation being in place for the Order Description tab. The behavior of this validation has not been modified.

 Previous language: "The (*) character is not allowed in the Order Text. Please replace any (*) characters with valid text."



• Updated language: "The (*) character is not allowed in the Order Description. Please replace any (*) characters with valid text."

Error	
8	The (*) character is not allowed in the Order Description. Please replace any (*) characters with valid text.
	OK

Note: The legacy Hospice Recertification Order will not be updated to include Care Plan information.

Edit Hospice Recertification Plan of Care Update Order > Orders

Order Date: Order Type: ID Patient: Physician/Physician Physician/Physician Primary Physician* Secondary Physician: NA Y N N Verbal Order Secondary Physician: NA Y N N Verbal Order Secondary Physician: Note: N N Y N N Verbal Order Date: Time: Content Research(s): Content Research(s): Content Research(s): Content Research(s): Medications Supplies Verbal Order Date: Time: Content Research(s):		ABN Delivered	Order Read Back To	Hospice CTI Order for Primary
	Inder Date: Order Time: Order Type: HOSPICE RECERTIFICATION PLA			Physician?
Considering and the second of the secon	rimary Physician* Secondary Physician		<u>.</u>	
Send To Physician Wound Care Order Send To Physician Wound Care Order Send To Medical Director Wordel Order Date: Time: Content Reason(5): Conten	X Q	م		
Verbal Order Medications Medicat	Send To Physician Wound Care Order Send To Facility NO Send To Medical Director Date: Time:	TE: After Order Type is box(es) will show. Intent Reason(s):	s selected, the appropriate co	ntent reason
Vider Description Order Orde	Verbal Order 🔅 😥	Medications Supplies	3	
Order Goods Level Of Core Calendar Medications Stapplies The order listed below reflect the current interventions for the benefit period. Any changes made to the Care Plan will impactifies orders. TEACH PATIENT/FAMILY/CAREGIVER HOW TO USE/MEASURE PAIN BY USING * TOOL/SCALE AND REPORTING MECHANISMS TEACH PATIENT/FAMILY/CAREGIVER FUNDAMENTAL PRINCIPLES OF EFFECTIVE PAIN MANAGEMENT SUPPORT, LISTENING, AND PRESENCE PARTICIPATION IN SACRED OR SPIRITUAL RITUAL OR PRACTICES PRAY WITH OR FOR PATIENT/FAMILY/CAREGIVER, USING PRAYERS FAMILIAR TO THEIR RELIGIOUS BACKGROUND PROVISION OF SPIRITUAL, SUPPORT AND CARE AS BASED ON THE FAMILY/CAREGIVER IDENTIFIED GOAL ASSESS PATIENT/FAMILY/CAREGIVER RESOURCES AND PROVIDE * (SPECIFY TEMS) ASSESS LEARNING PATIENT/CAREGIVER READINESS, LEARNING BARRIER, SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND THE FUNERAL AND BURIAL PLANNING ASSISTANCE X		Calendar Diagnos	es 🗵 Level Of Care	
SUPPORT, LISTENING, AND PRESENCE PARTICIPATION IN SACRED OR SPIRITUAL RITUAL OR PRACTICES PRAVIMITH OR FOR PATIENT/FAMILY <u>CAREGIVER</u> USING PRAYERS FAMILIAR TO THEIR RELIGIOUS BACKGROUND PROVISION OF SPIRITUAL SUPPORT AND CARE AS BASED ON THE FAMILY <u>CAREGIVER</u> IDENTIFIED GOAL ASSESS PATIENT/FAMILY <u>CAREGIVER</u> RESOURCES AND PROVIDE * (SPECIFY ITEMS) ASSESS FARMING PATIENTICAREGIVER READINESS, LEARNING BARRIER. SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND TH FUNERAL AND BURIAL PLANNING ASSISTANCE *	TEACH PATIENT/FAMILY/CAREGIVER HOW TO USE/MEASURE PAIN B	BY USING * TOOL/SCALE A	ND REPORTING MECHANISMS	
PARTICIPATION IN SACRED OR SPIRITUAL RITUAL OR PRACTICES PRAY WITH OR FOR PATIENT/FAMILY <u>CAREGIVER</u> USING PRAYERS FAMILIAR TO THEIR RELIGIOUS BACKGROUND PROVISION OF SPIRITUAL SUPPORT AND CARE AS BASED ON THE FAMILY <u>CAREGIVER</u> IDENTIFIED GOAL ASSESS PATIENT/FAMILY <u>CAREGIVER</u> RESOURCES AND PROVIDE *(SPECIFY ITEMS) ASSESS LEARNING PATIENT/ <u>CAREGIVER</u> READINESS, LEARNING BARRIER, SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND TH FUNERAL AND BURIAL PLANNING ASSISTANCE	SUPPORT, LISTENING, AND PRESENCE			
PRAY WITH OR FOR PATIENT/FAMILY <u>CAREGIVER</u> USING PRAYERS FAMILIAR TO THEIR RELIGIOUS BACKGROUND PROVISION OF SPIRITUAL SUPPORT AND CARE AS BASED ON THE FAMILY <u>CAREGIVER</u> IDENTIFIED GOAL ASSESS PATIENT/FAMILY <u>CAREGIVER</u> RESOURCES AND PROVIDE * (SPECIFY ITEMS) ASSESS LEARNING PATIENT/ <u>CAREGIVER</u> READINESS, LEARNING BARRIER, SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND TH FUNERAL AND BURIAL PLANNING ASSISTANCE	PARTICIPATION IN SACRED OR SPIRITUAL RITUAL OR PRACTICES			
PROVISION OF SPIRITUAL SUPPORT AND CARE AS BASED ON THE FAMIL YCAREGIVER IDENTIFIED GOAL ASSESS PATIENT/FAMIL YCAREGIVER RESOURCES AND PROVIDE * (SPECIFY ITEMS) ASSESS LEARNING PATIENT/CAREGIVER READINESS, LEARNING BARRIER, SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND TH FUNERAL AND BURIAL PLANNING ASSISTANCE	PRAY WITH OR FOR PATIENT/FAMILY/CAREGIVER, USING PRAYERS	FAMILIAR TO THEIR RELIG	IOUS BACKGROUND	
ASSESS PATIENT/FAMILY/CAREGIVER RESOURCES AND PROVIDE * (SPECIFY ITEMS) ASSESS LEARNING PATIENT/CAREGIVER READINESS, LEARNING BARRIER, SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND TH FUNERAL AND BURIAL PLANNING ASSISTANCE	PROVISION OF SPIRITUAL SUPPORT AND CARE AS BASED ON THE F	AMILY/CAREGIVER IDENT	IFIED GOAL	
ASSESS LEARNING PATIENT/CAREGIVER READINESS, LEARNING BARRIER, SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND TH FUNERAL AND BURIAL PLANNING ASSISTANCE	ASSESS PATIENT/FAMILY/CAREGIVER RESOURCES AND PROVIDE *	(SPECIFY ITEMS)		
FUNERAL AND BURIAL PLANNING ASSISTANCE	ASSESS LEARNING PATIENT/CAREGIVER READINESS, LEARNING BA	RRIER, SPECIFIC EDUCAT	IONAL NEEDS, HOW THEY MAY BE	EST LEARN AND TH
٤	FUNERAL AND BURIAL PLANNING ASSISTANCE			
	<			>



- Orders tab contains all active Interventions as of R/E/A Hospice Recert Order workflow being opened by a user.
- Display text to notify users that any changes made to the Care Plan from PointCare will be reflected within the read-only text.
- "Spell Check" button has been removed since the text is read-only. Any necessary corrections must be made from PointCare.

Note: The presence of asterisks within the Orders tab will not prevent Save & Close.

Edit Hospice Recertification Plan of Care Update Order > Goals

Edit Patient Order for			- 🗆 ×
Order Details			Generate
Order Date:* Order Time:* Order Type:*	ABN Delivered To Patient:	Order Read Back To Physician/Agent Of Physician?	Hospice CTI Order for Primary Physician?
Primary Physician:* Secondar X Q	y Physician:	<u> </u>	
Send To Physician Send To Medical Director Date: Verbal Order	cility NOTE: After Order Type is box(es) will show. Content Reason(s): Medications @ Supplies	selected, the appropriate cor	ntent reason
Medical Director:"	Calendar Diagnose	s ☑ Level Of Care	
The goals listed below reflect the current goals for the benefit period. Any PATIENT SELF-IDENTIFIED PAIN THRESHOLD OF * BY * U:	hanges made to the Care Plan will impact these goa SING * SCALE	als.	^
PATIENT/FAMILY/CAREGIVER WILL EXPRESS A RELIEF OF SPIRITUAL SUPPORT WILL BE PROVIDED AS DEFINED BY	* SYMPTOMS OF SPIRITUAL SUFFERING NEEDS OF FAMILY/CAREGIVER TO INC	G BY * CLUDED *	
PATIENT/FAMILY WILL COMMUNICATE EFFECTIVELY THE FUNERAL AND BURIAL PLANNING ASSISTANCE WILL BE F	OUGH * (SPEECH OR SOME ALTERNAT	IVE FOR OF COMMUNICATION)	
PSYCHOSOCIAL SUPPORT AND COUNSELING WILL BE OF	FERED TO PATIENT THROUGHOUT TH	HEIR STAY	
-			~
x			>
		Save & Close	Cancel Ø

- Goals tab contains all active Goals as of R/E/A Hospice Recert Order workflow being opened by a user.
- Display text to notify users that any changes made to the Care Plan from PointCare will be reflected within the read-only text.
- "Spell Check" button has been removed since the text is read-only. Any necessary corrections must be made from PointCare.
- "Get Goal Text from Treatment Codes" button to add new Pathway items has been removed.
- The previous validation to prevent asterisks in the Goals tab has been removed.



Hospice Recertification Plan of Care Update Order Report

The Hospice Recertification Plan of Care Update Order Report will continue to have the information from the Orders tab appear in the **Orders** section and the information from the Goals tab appear in the **Goals** section.





Hospice Recert

Workflow to review, edit, and approve the Hospice Recertification Plan of Care Update Order will continue to generate based on the existing Hospice Recertification Process system setting.

Review/Edit/Approve Hospice Recert Order

The HRPOCU Orders and Goals tabs will be refreshed with the current Care Plan information each time the Review/Edit/Approve Hospice Recert Order workflow stage is opened. A final refresh of the Care Plan data will be completed when clicking Stage Complete to approve the HRPOCU.



Once approved, the HRPOCU Orders and Goals tabs will no longer be updated as changes are made to the patient's Care Plan.

If the HRPOCU is unapproved, the Orders and Goals tabs will once again be refreshed with the current Care Plan information each time R/E/A Hospice Recert Order workflow is opened by a user.

Hospice IDG Comprehensive Assessment & POC Update Report

The "Current Problem List" section is replaced with a "Care Plan" section that reflects the current Problem Sets across all disciplines, listed in alphabetical order.

3	Hospice IDG Co Plan c	omprehensive A of Care Update F	ssess Report	ment and	ł	
Clin	int: Ins	ured ID:		Primary Payo	ж	
\$0	C Date:	st- Inis	IDG Meet	ing Date:	n Jan	
et. c	s dy , more share a more strained	e	W21 0		, v	
Car	e Plan					
		Ac	ded	Edited	Ended	Worker
P	US 148727 PROBLEM A	09/	2/2023			
G:	US 148727 GOAL A2 - MANY UNIQUE INTERVENTIONS	09V	2/2023			
t;	SN - US 148727 INTERVENTION A2C	097	2/2023			
t: E	SN - US 148727 INTERVENTION A2C SN - US 148727 INTERVENTION A2A	09/	22/2023 22/2023			
i: I: G:	SN - US 148727 INTERVENTION A2C SN - US 148727 INTERVENTION A2A US 148727 GOAL A1 - ONE UNIQUE INTERVENTION	09% 09% 09%	2/2023 22/2023 22/2023			
l: I: G: I:	SN - US 148727 INTERVENTION A2C SN - US 148727 INTERVENTION A2A US 148727 GOAL A1 - ONE UNIQUE INTERVENTION SN - US 148727 INTERVENTION A1A	960 960 960 960	22/2023 22/2023 22/2023 22/2023 22/2023			

- The Care Plan section includes the Problem, Intervention, and Goal information for the patient. It also shows the date the item was added, edited, or ended, and the worker and the associated discipline.
- The report reflects the Care Plan information at the time the hospice physician signed the meeting. As the Care Plan is updated in the future, signed meetings cannot be updated.
- Surveyors are now able to see the changes in the patient's care in response to changes in the patient condition.
- Care Plan section of the report will update with the patient's current Care Plan information until the Medical Director signature has been added to the IDG Meeting Details.



Visit Notes

The existing Back Office Visit Note has been updated to include Goal and Intervention information from the corresponding visit.

Visit Note > Interventions Provided



- Shows all Interventions that had "Has the intervention been provided on this visit?" answered Yes to within PointCare.
 - o Intervention "Outcome" details will show in the Details/Comments section.
- If no Interventions were answered Yes to "Has the intervention been provided on this visit?", the Interventions Provided tab will be blank.

Visit Note > Interventions Not Provided

🕹 Visit N	ote for								\times
General	Time	Mileage	Vital Signs	Emergency Preparedness	Assessment	Narrative	Interventions Provided	Interventions Not Provided	Goals M ү 🕨
1. TEA	CH FAM DE1	IILY/CARE	GIVER IMPOF IMENTS: NO1	RTANCE OF GIVING MEDICA	TIONS TIMELY				^

- Shows all Interventions that had "Has the intervention been provided on this visit?" answered No to within PointCare.
 - o Intervention "Outcome" details will show in the Details/Comments section.
- If no Interventions were answered No to "Has the intervention been provided on this visit?", the Interventions Not Provided tab will be blank.

Visit Note > Goals Met



Shows all Goals that were documented as met within the corresponding PointCare visit.
 Goal Met "Reason" details will show in the Details/Comments section.



• If no Goals were met within the corresponding PointCare visit, the Goals Met tab will be blank.

Visit Note > Goals Not Met

O Visit Note	for							\times
Vital Signs	Emergency Preparedness	Assessment	Narrative	Interventions Provided	Interventions Not Provided	Goals Met	Goals Not Met	Med U 🔒
								^

Currently this tab will always be blank as all established Goals for the patient will remain a part of the current Care Plan until updated as met in PointCare.

Visit Note Report

The Visit Note Report will continue to have the Interventions Provided, Interventions Not Provided, and Goals Met values presented in the matching sections.

Visit Note Report					
Client: Client DOB: In tyati/gt/o	MR No:	Legacy MR No:	مدمنی بر جی		
Narrative Interventions Provided 1. TEACH PATIENT/FAMILY/CAREGI DETAILS/COMMENTS: TEST RESOL 2. TEACH FAMILY/CAREGIVER FUN DETAILS/COMMENTS: PROVIDED A	VER HOW TO USE/MEASURE PAIN BY US .VED DAMENTAL PRINCIPLES OF EFFECTIVE NND RESOLVED	SING * TOOL/SCALE AND REPORTING	MECHANISMS		
Interventions Not Provided 1. TEACH FAMILY/CAREGIVER IMPO DETAILS/COMMENTS: NOT RESOLY Goals Met 1. PATIENT SELEJDENTIFIED PAIN	VED	ELY			
DETAILS/COMMENTS: GOAL MET	Client Signature:				



Plan of Care Update Order

The Plan of Care Update Order will no longer appear as an option for selection in both PointCare and the Back Office for any patients utilizing the Care Plan model.

Back Office

Clinical Input > Medical Records Info > Orders > Add > Order Type

O Add Patient Order for				-		\times			
O Order Detaile									
Order Date:* Order Time:*	Order Type:*	ABN Delivered To Patient:	Order Read Back To Physician/Agent Of Physician?						
		<u>N/A</u>	Y •						
Primary Physician:*	HOSPICE ADD-ON HOSPICE DISCHARGE HOSPICE PHYSICIAN ORDER	0							
Sond To Physician Wound C		the Order Turns							
box(es) will show.									
Primary Physician:*	HOSPICE DISCHARGE HOSPICE PHYSICIAN ORDER are Order Send To Facility NOTE: A br	م After Order Type i ox(es) will show.	is selected, the appropriate cont	ent reas	ion				