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:

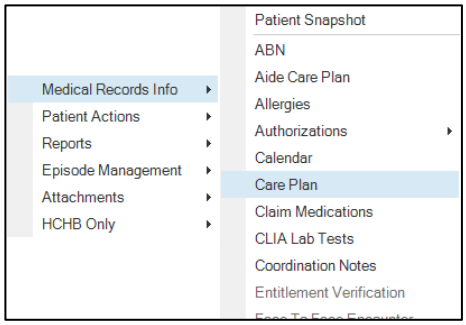
- Hospice Plan of Care Order
- Hospice SOC Workflow
- Hospice Add On Order
- Hospice Add On Workflow
- Hospice Recertification Plan of Care Update Order
- Hospice Recert Workflow
- Hospice IDG Comprehensive Assessment and Plan of Care Update Report
- Visit Note - Interventions Provided, Interventions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

Care Plan

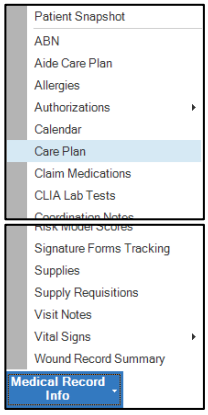
A new view, accessible in Medical Records and via the Care Plan button in various workflow stages (outlined below), has been created to provide visibility into the current, interdisciplinary Care Plan.

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



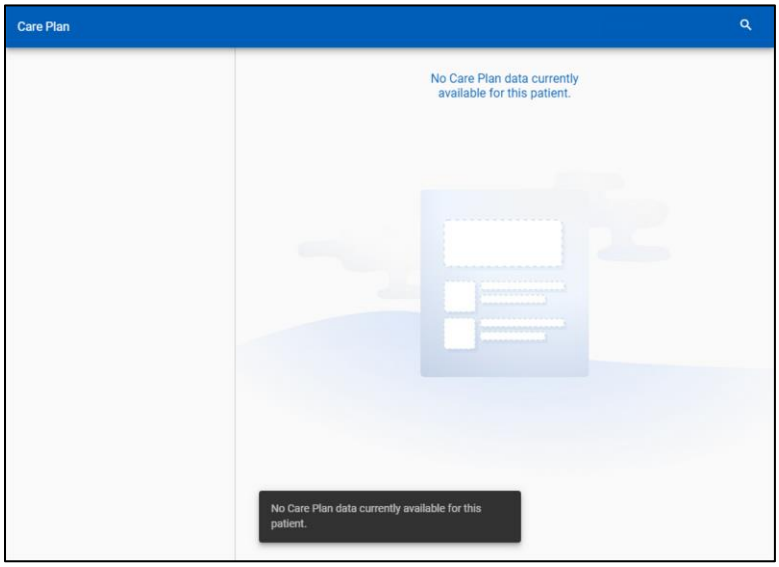
- Clinical Input > Medical Records Info button



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

Care Plan: Empty State

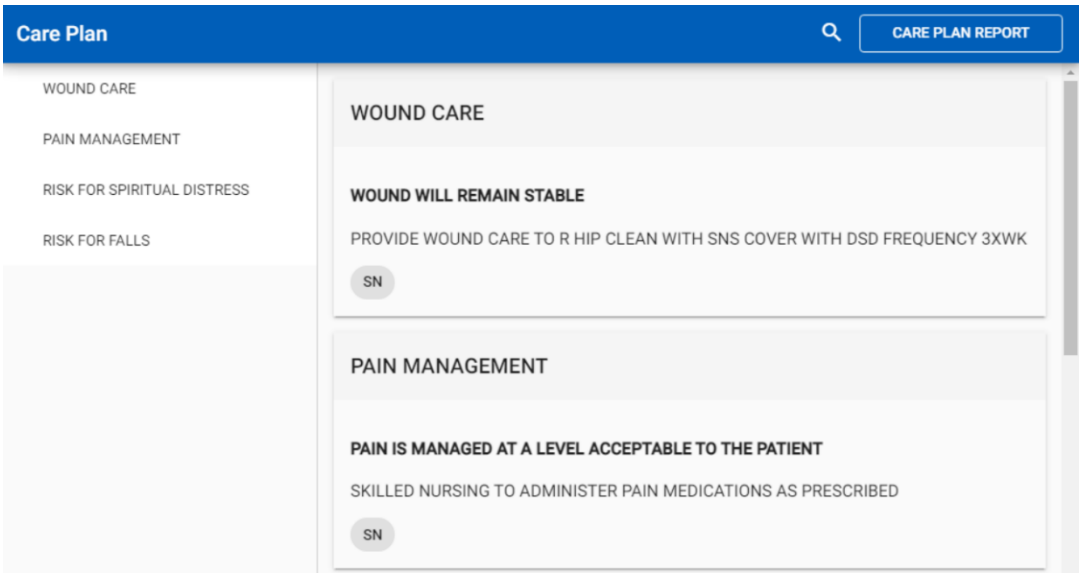
If Care Plan data has not yet been established or cannot be returned for any reason, users will receive notification that there is “No Care Plan data currently available for this patient.”



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.



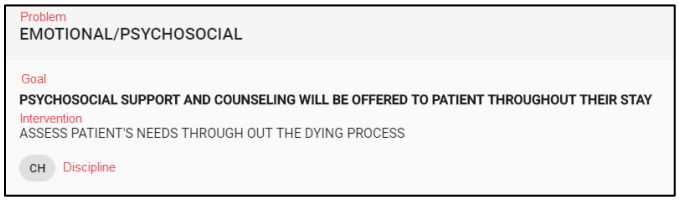
Left pane = Table of Contents

- 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:



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.

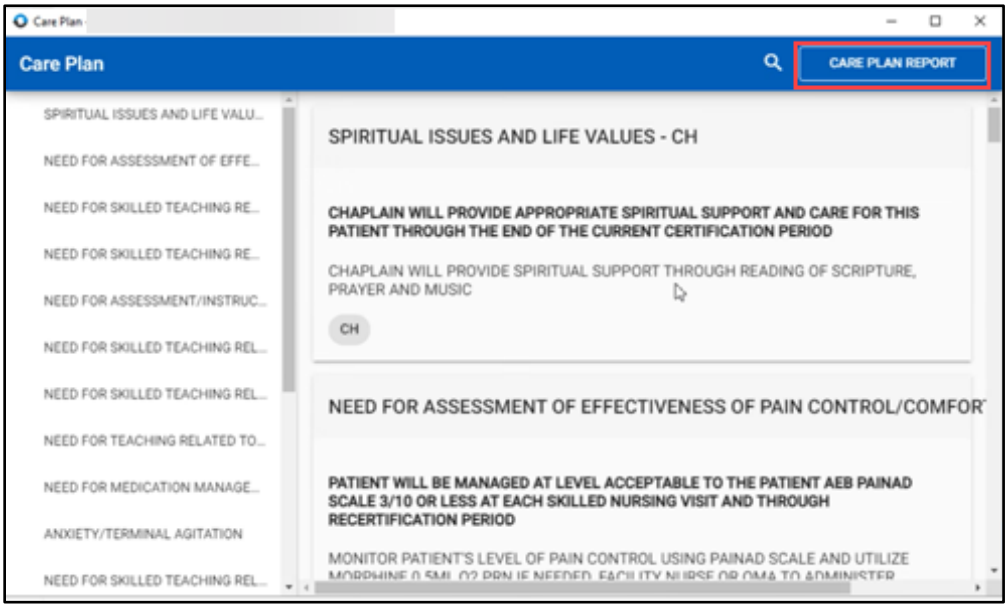
At the patient's admission, the care team can view the current care plan. During recertification, the care team can also view historical information that can be provided to any external

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.

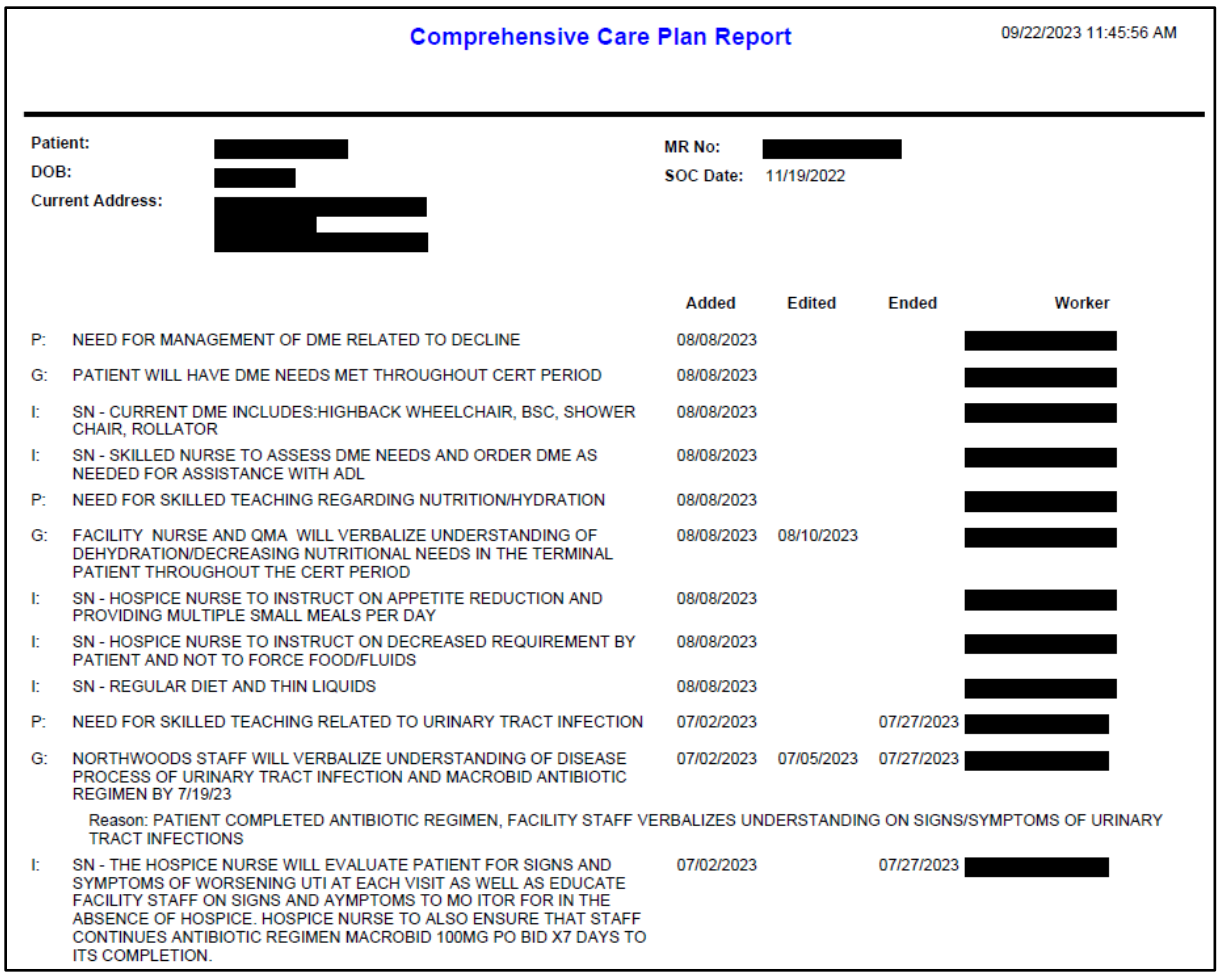
The report can be viewed and printed from the Care Plan module (Clinical Input > Medical Records Info > Care Plan).

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.



Comprehensive Care Plan Report 09/22/2023 11:45:56 AM

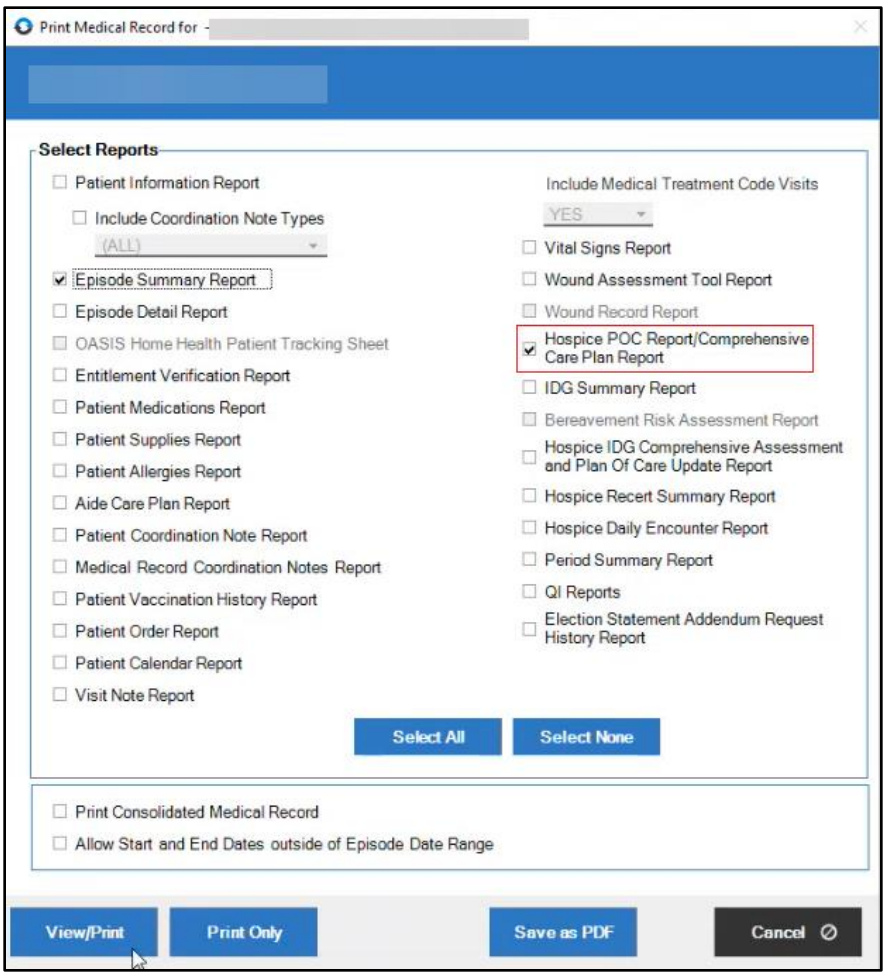
Patient: [redacted] **MR No:** [redacted]
DOB: [redacted] **SOC Date:** 11/19/2022
Current Address: [redacted]

		Added	Edited	Ended	Worker
P:	NEED FOR MANAGEMENT OF DME RELATED TO DECLINE	08/08/2023			[redacted]
G:	PATIENT WILL HAVE DME NEEDS MET THROUGHOUT CERT PERIOD	08/08/2023			[redacted]
I:	SN - CURRENT DME INCLUDES:HIGHBACK WHEELCHAIR, BSC, SHOWER CHAIR, ROLLATOR	08/08/2023			[redacted]
I:	SN - SKILLED NURSE TO ASSESS DME NEEDS AND ORDER DME AS NEEDED FOR ASSISTANCE WITH ADL	08/08/2023			[redacted]
P:	NEED FOR SKILLED TEACHING REGARDING NUTRITION/HYDRATION	08/08/2023			[redacted]
G:	FACILITY NURSE AND QMA WILL VERBALIZE UNDERSTANDING OF DEHYDRATION/DECREASING NUTRITIONAL NEEDS IN THE TERMINAL PATIENT THROUGHOUT THE CERT PERIOD	08/08/2023	08/10/2023		[redacted]
I:	SN - HOSPICE NURSE TO INSTRUCT ON APPETITE REDUCTION AND PROVIDING MULTIPLE SMALL MEALS PER DAY	08/08/2023			[redacted]
I:	SN - HOSPICE NURSE TO INSTRUCT ON DECREASED REQUIREMENT BY PATIENT AND NOT TO FORCE FOOD/FLUIDS	08/08/2023			[redacted]
I:	SN - REGULAR DIET AND THIN LIQUIDS	08/08/2023			[redacted]
P:	NEED FOR SKILLED TEACHING RELATED TO URINARY TRACT INFECTION	07/02/2023		07/27/2023	[redacted]
G:	NORTHWOODS STAFF WILL VERBALIZE UNDERSTANDING OF DISEASE PROCESS OF URINARY TRACT INFECTION AND MACROBID ANTIBIOTIC REGIMEN BY 7/19/23	07/02/2023	07/05/2023	07/27/2023	[redacted]
	Reason: PATIENT COMPLETED ANTIBIOTIC REGIMEN, FACILITY STAFF VERBALIZES UNDERSTANDING ON SIGNS/SYMPTOMS OF URINARY TRACT INFECTIONS				
I:	SN - THE HOSPICE NURSE WILL EVALUATE PATIENT FOR SIGNS AND SYMPTOMS OF WORSENING UTI AT EACH VISIT AS WELL AS EDUCATE FACILITY STAFF ON SIGNS AND AYMPTOMS TO MO ITOR FOR IN THE ABSENCE OF HOSPICE. HOSPICE NURSE TO ALSO ENSURE THAT STAFF CONTINUES ANTIBIOTIC REGIMEN MACROBID 100MG PO BID X7 DAYS TO ITS COMPLETION.	07/02/2023		07/27/2023	[redacted]

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.

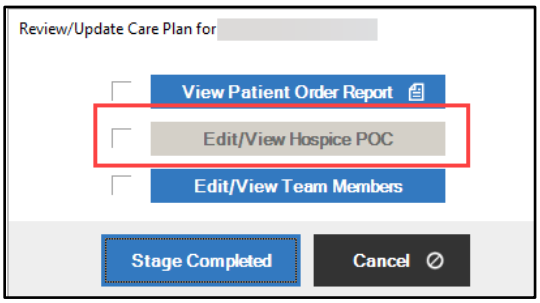


If a date range is selected that spans multiple episodes, or if multiple episodes are selected in Clinical Input, and some episodes have Pathways data and some have Care Plan data, then both the Hospice POC Report and the Comprehensive Care Plan Report will be displayed.

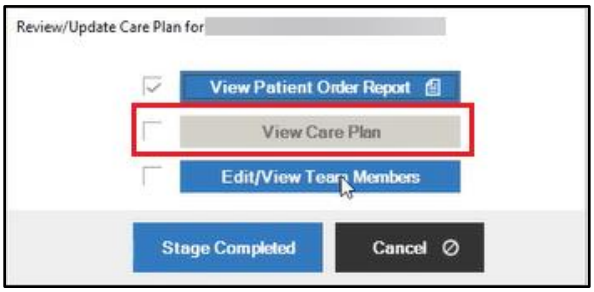
Note: When you select *multiple episodes* from Clinical Input and choose Print Medical Record, you will also be prompted to enter a date range. You must enter a range to continue, but the dates have no bearing on which episodes are printed. The medical records for the episodes selected in Clinical Input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



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.

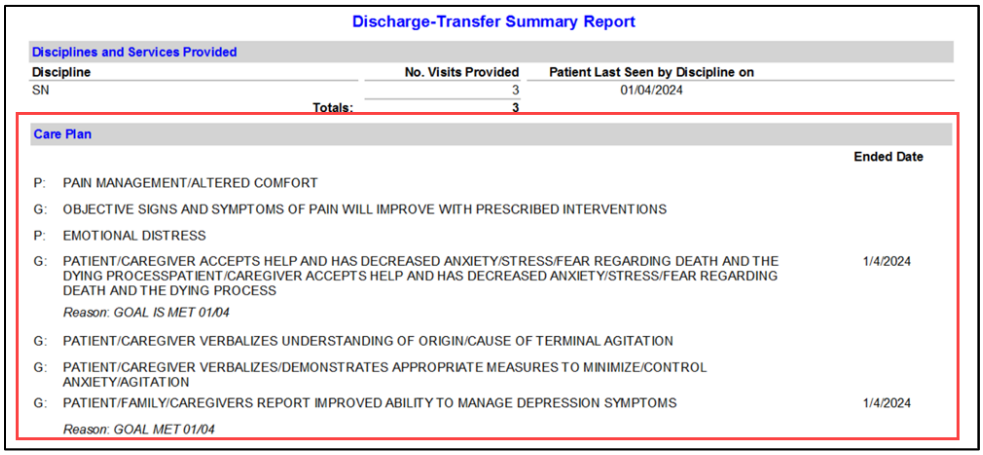
If the Goal has been resolved, re-opened, and then resolved again, the most recent resolved date is shown.

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.



Discharge-Transfer Summary Report

Disciplines and Services Provided

Discipline	No. Visits Provided	Patient Last Seen by Discipline on
SN	3	01/04/2024
Totals:	3	

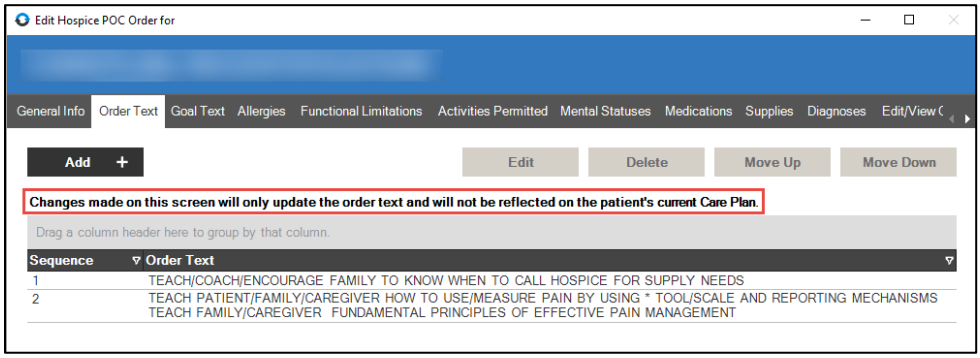
Care Plan

		Ended Date
P:	PAIN MANAGEMENT/ALTERED COMFORT	
G:	OBJECTIVE SIGNS AND SYMPTOMS OF PAIN WILL IMPROVE WITH PRESCRIBED INTERVENTIONS	
P:	EMOTIONAL DISTRESS	
G:	PATIENT/CAREGIVER ACCEPTS HELP AND HAS DECREASED ANXIETY/STRESS/FEAR REGARDING DEATH AND THE DYING PROCESSPATIENT/CAREGIVER ACCEPTS HELP AND HAS DECREASED ANXIETY/STRESS/FEAR REGARDING DEATH AND THE DYING PROCESS *Reason: GOAL IS MET 01/04*	1/4/2024
G:	PATIENT/CAREGIVER VERBALIZES UNDERSTANDING OF ORIGIN/CAUSE OF TERMINAL AGITATION	
G:	PATIENT/CAREGIVER VERBALIZES/DEMONSTRATES APPROPRIATE MEASURES TO MINIMIZE/CONTROL ANXIETY/AGITATION	
G:	PATIENT/FAMILY/CAREGIVERS REPORT IMPROVED ABILITY TO MANAGE DEPRESSION SYMPTOMS *Reason: GOAL MET 01/04*	1/4/2024

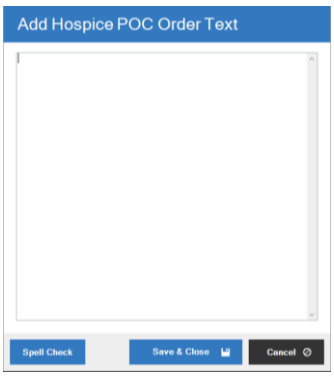
Hospice Plan of Care Order

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

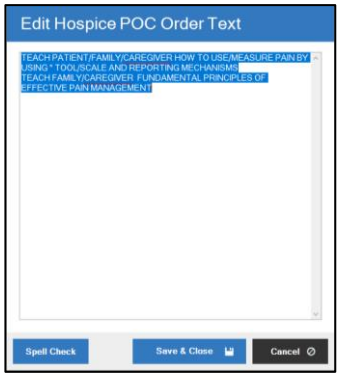
Edit Hospice POC Order > Order Text



- 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.



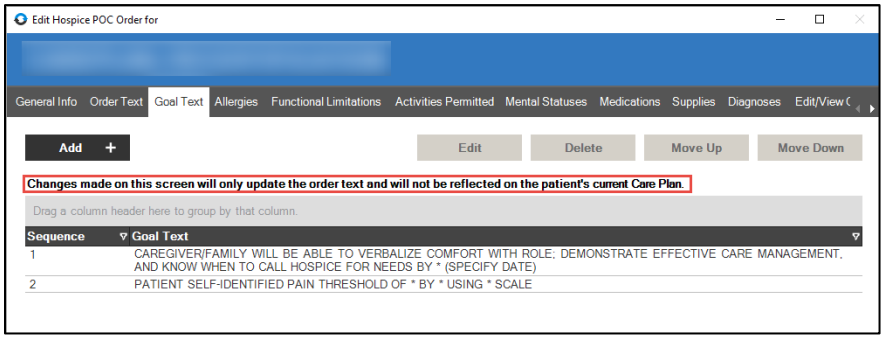
- "Add" allows free-text entry for additional items to be included solely on the Hospice POC Order.
- Order Text search field to add new Pathway items has been removed.



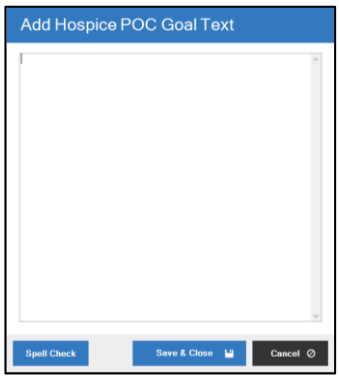
- Selecting a grid row and clicking “Edit” allows updates/corrections to be made to those items solely on the Hospice POC Order.

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.

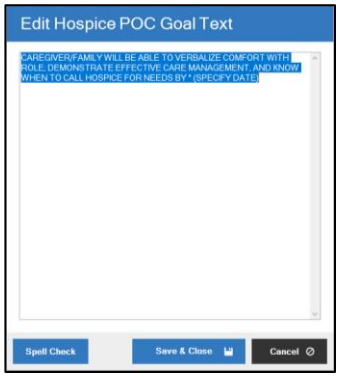
Edit Hospice POC Order > Goal Text



- 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” 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 removed.

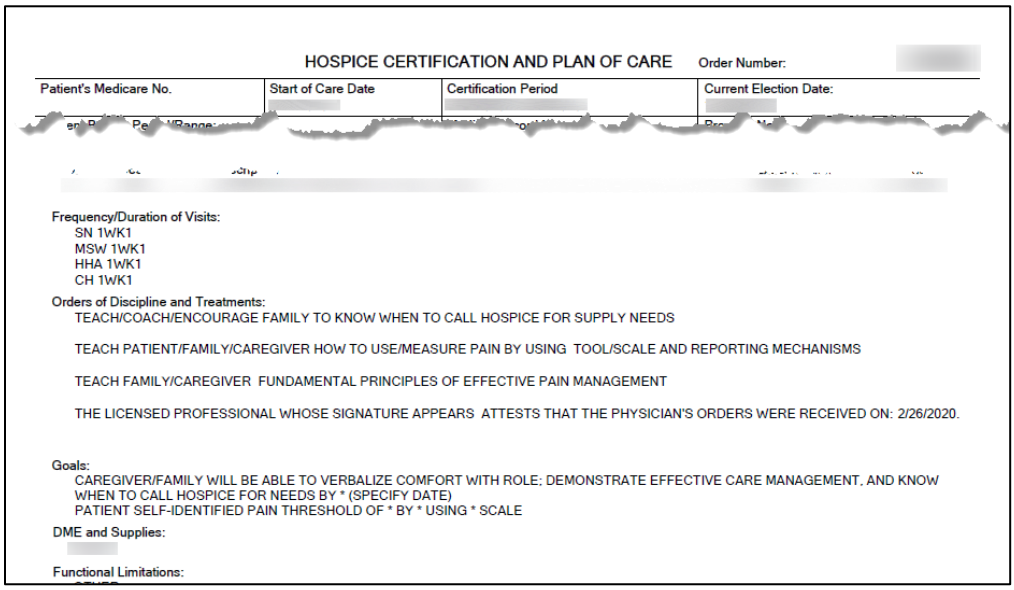


- Selecting a grid row and clicking “Edit” allows updates/corrections to be made to those items solely on the Hospice POC Order.

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.



HOSPICE CERTIFICATION AND PLAN OF CARE Order Number:

Patient's Medicare No.	Start of Care Date	Certification Period	Current Election Date:

Frequency/Duration of Visits:
SN 1WK1
MSW 1WK1
HHA 1WK1
CH 1WK1

Orders of Discipline and Treatments:
TEACH/COACH/ENCOURAGE FAMILY TO KNOW WHEN TO CALL HOSPICE FOR SUPPLY NEEDS

TEACH PATIENT/FAMILY/CAREGIVER HOW TO USE/MEASURE PAIN BY USING TOOL/SCALE AND REPORTING MECHANISMS

TEACH FAMILY/CAREGIVER FUNDAMENTAL PRINCIPLES OF EFFECTIVE PAIN MANAGEMENT

THE LICENSED PROFESSIONAL WHOSE SIGNATURE APPEARS ATTESTS THAT THE PHYSICIAN'S ORDERS WERE RECEIVED ON: 2/26/2020.

Goals:
CAREGIVER/FAMILY WILL BE ABLE TO VERBALIZE COMFORT WITH ROLE; DEMONSTRATE EFFECTIVE CARE MANAGEMENT, AND KNOW WHEN TO CALL HOSPICE FOR NEEDS BY * (SPECIFY DATE)
PATIENT SELF-IDENTIFIED PAIN THRESHOLD OF * BY * USING * SCALE

DME and Supplies:

Functional Limitations:

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

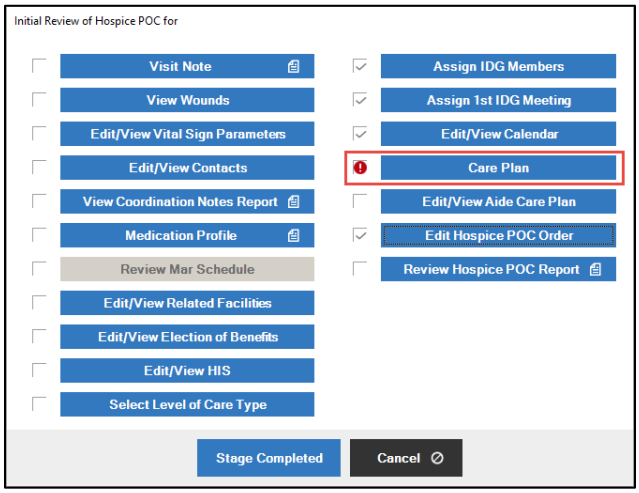
Care Plan is required to be viewed to stage complete the task.

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.

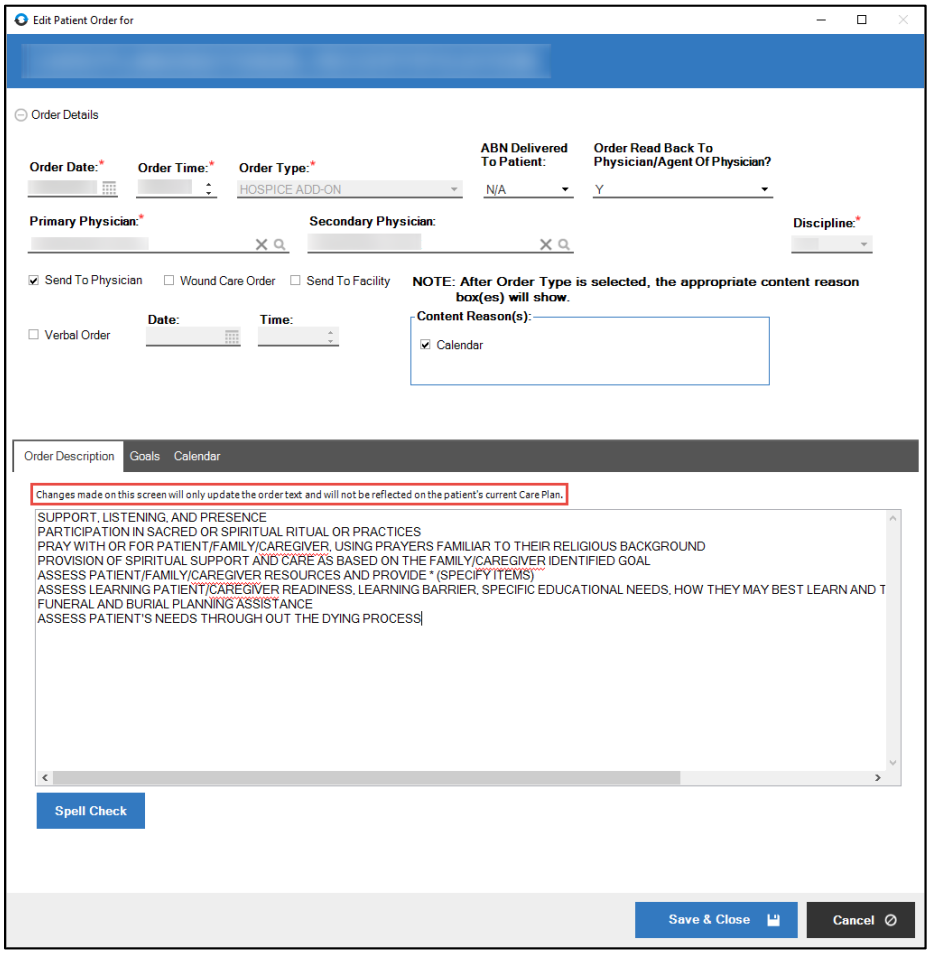
If Care Plan data cannot be returned, the Edit/View Hospice Plan of Care button will be present (but not required) to allow processing of workflow.

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.

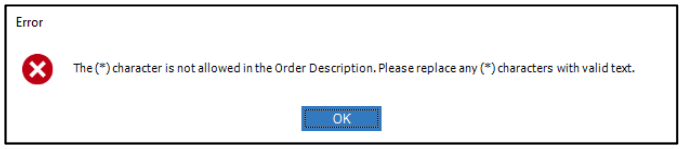
For Hospice Add On Orders created from a PointCare visit, the “Discipline” field will be grayed out and unable to be modified.

Edit Hospice Add On Order > Order Description

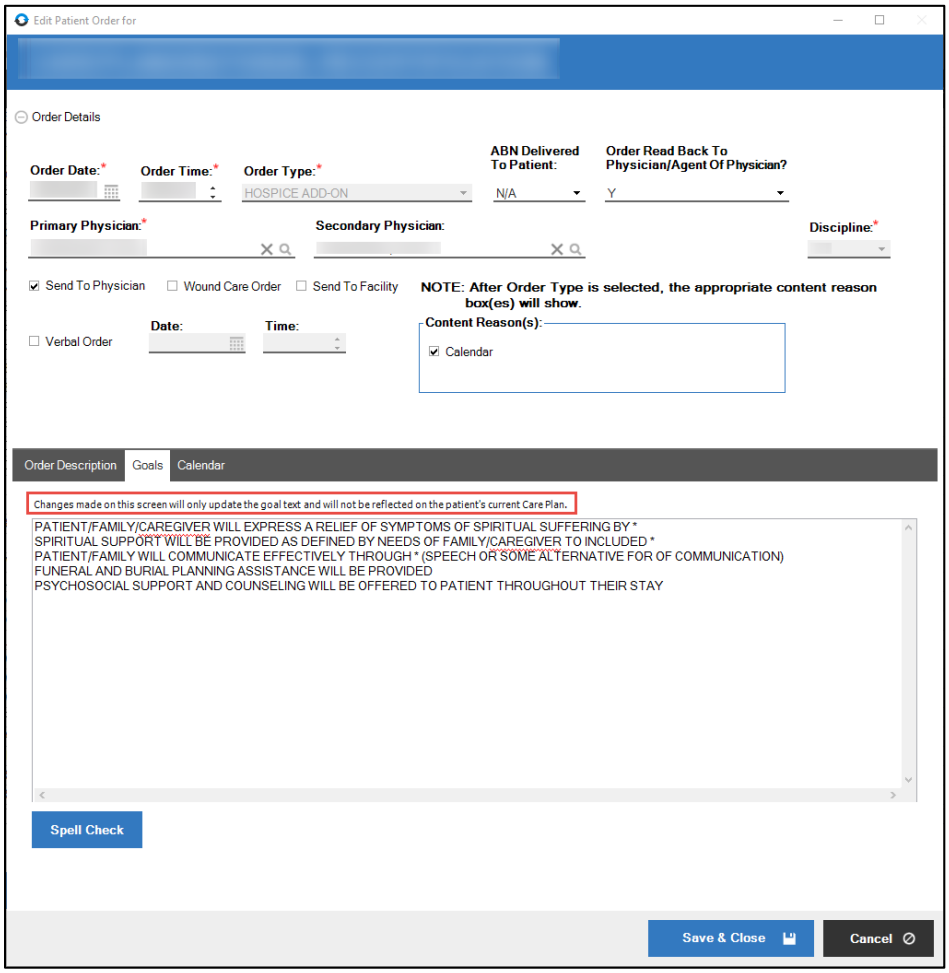


- Order Description tab contains all Interventions added during the corresponding add on visit.
- Display text to notify users that any changes made within the Order Description tab will only update the order output and will not modify the patient’s current Care Plan.
- “Get Order Text from Treatment 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.

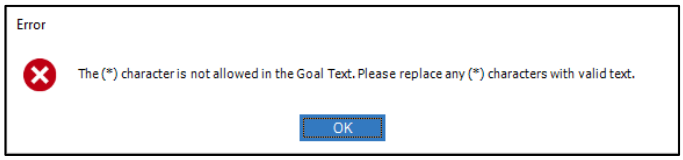


Edit Hospice Add On Order > Goal Text



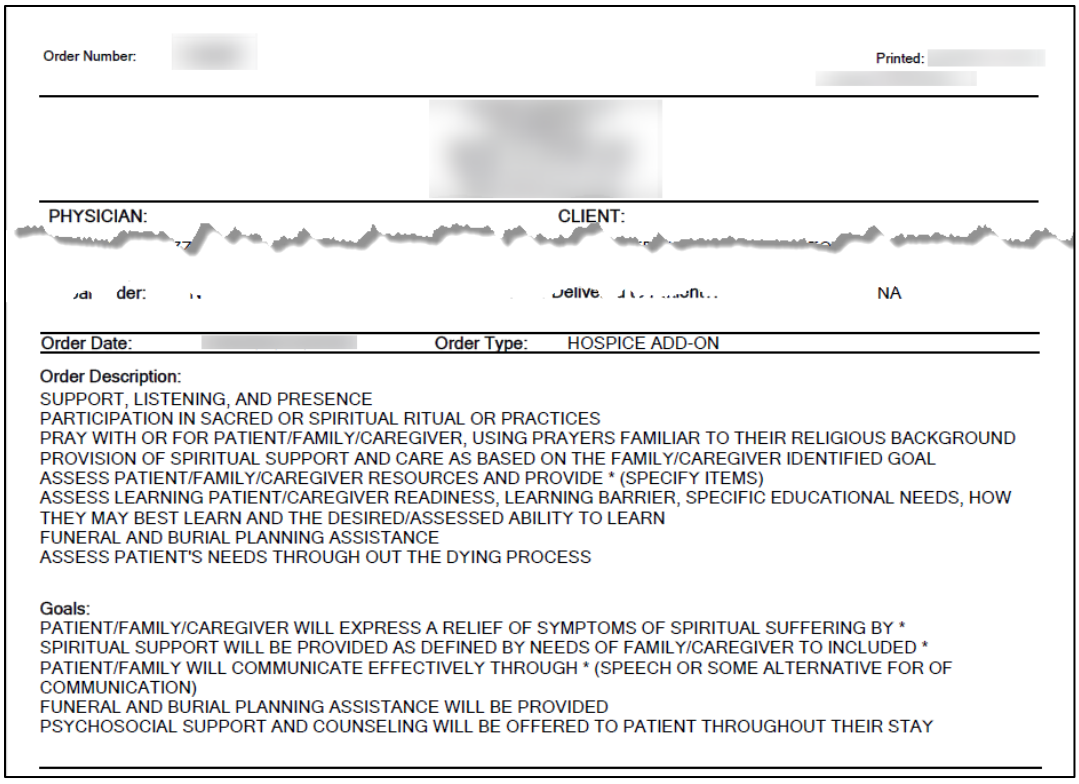
- Goals tab contains all Goals added during the corresponding add on visit.
- Display text to notify users that any changes made within the Goals tab will only update the order output and will not modify the patient's current Care Plan.
- "Get Goal Text from Treatment Codes" button to add new Pathway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

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



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.



Order Number: [redacted] Printed: [redacted]

[redacted]

PHYSICIAN: CLIENT:

[redacted] NA

Order Date: [redacted] Order Type: HOSPICE ADD-ON

Order Description:
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 ITEMS)
ASSESS LEARNING PATIENT/CAREGIVER READINESS, LEARNING BARRIER, SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND THE DESIRED/ASSESSED ABILITY TO LEARN
FUNERAL AND BURIAL PLANNING ASSISTANCE
ASSESS PATIENT'S NEEDS THROUGH OUT THE DYING PROCESS

Goals:
PATIENT/FAMILY/CAREGIVER WILL EXPRESS A RELIEF OF SYMPTOMS OF SPIRITUAL SUFFERING BY *
SPIRITUAL SUPPORT WILL BE PROVIDED AS DEFINED BY NEEDS OF FAMILY/CAREGIVER TO INCLUDED *
PATIENT/FAMILY WILL COMMUNICATE EFFECTIVELY THROUGH * (SPEECH OR SOME ALTERNATIVE FOR OF COMMUNICATION)
FUNERAL AND BURIAL PLANNING ASSISTANCE WILL BE PROVIDED
PSYCHOSOCIAL SUPPORT AND COUNSELING WILL BE OFFERED TO PATIENT THROUGHOUT THEIR STAY

Hospice Add On Workflow

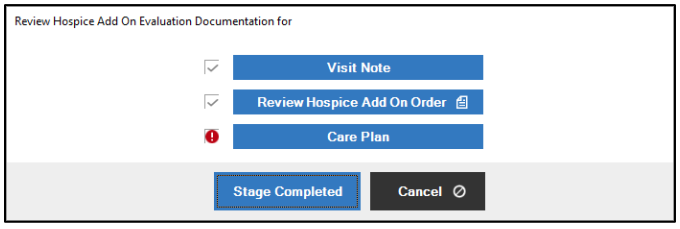
Pathway access in Add On workflow stage has been replaced with Care Plan access for patients that have Problem Sets.

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.



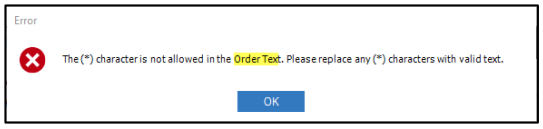
Hospice Recertification Plan of Care Update Order

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.

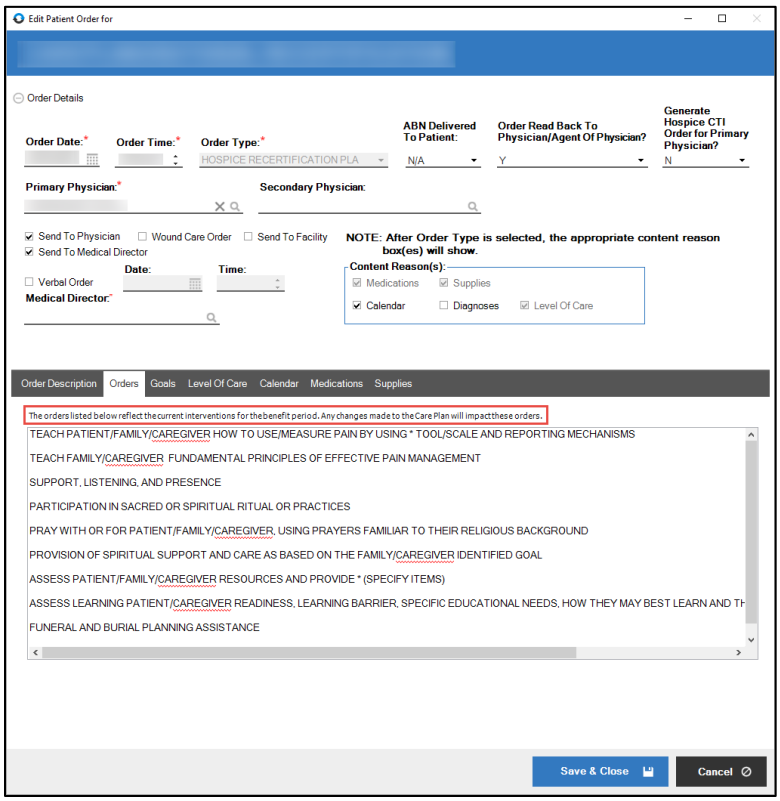
- Previous language: “The (*) character is not allowed in the Order Text. Please replace any (*) characters with valid text.”



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

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

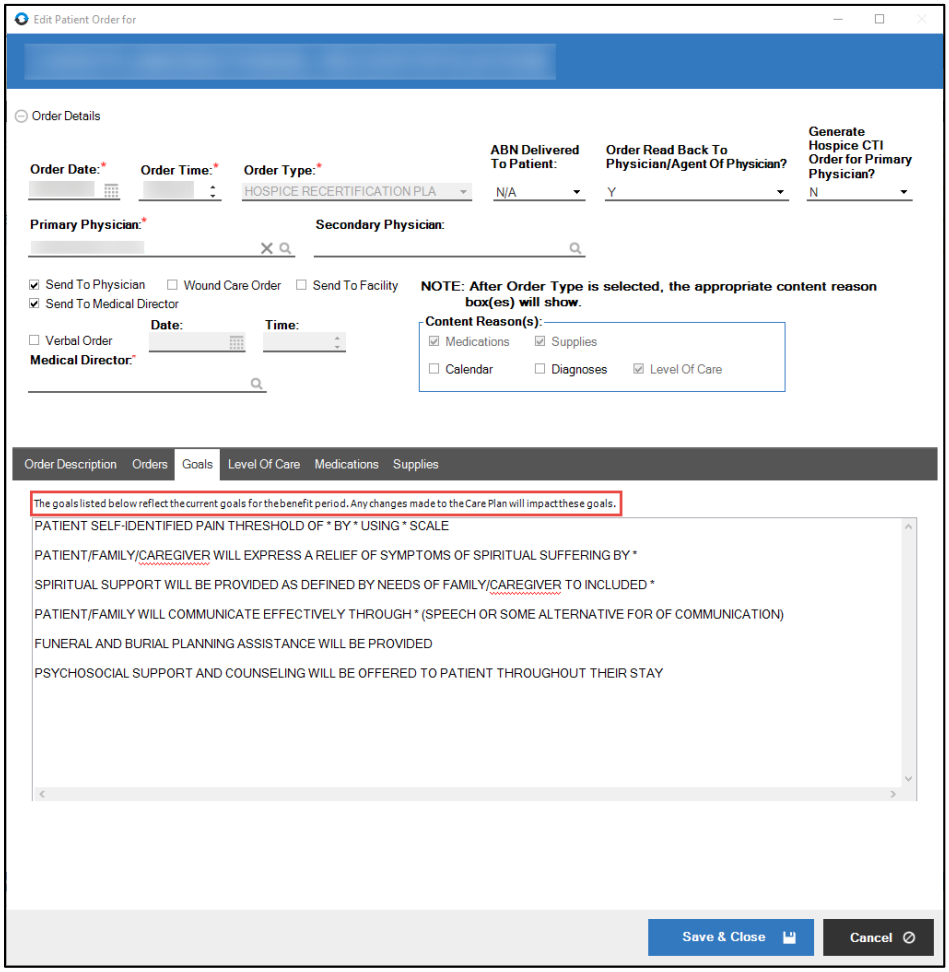
Edit Hospice Recertification Plan of Care Update Order > Orders



- 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.

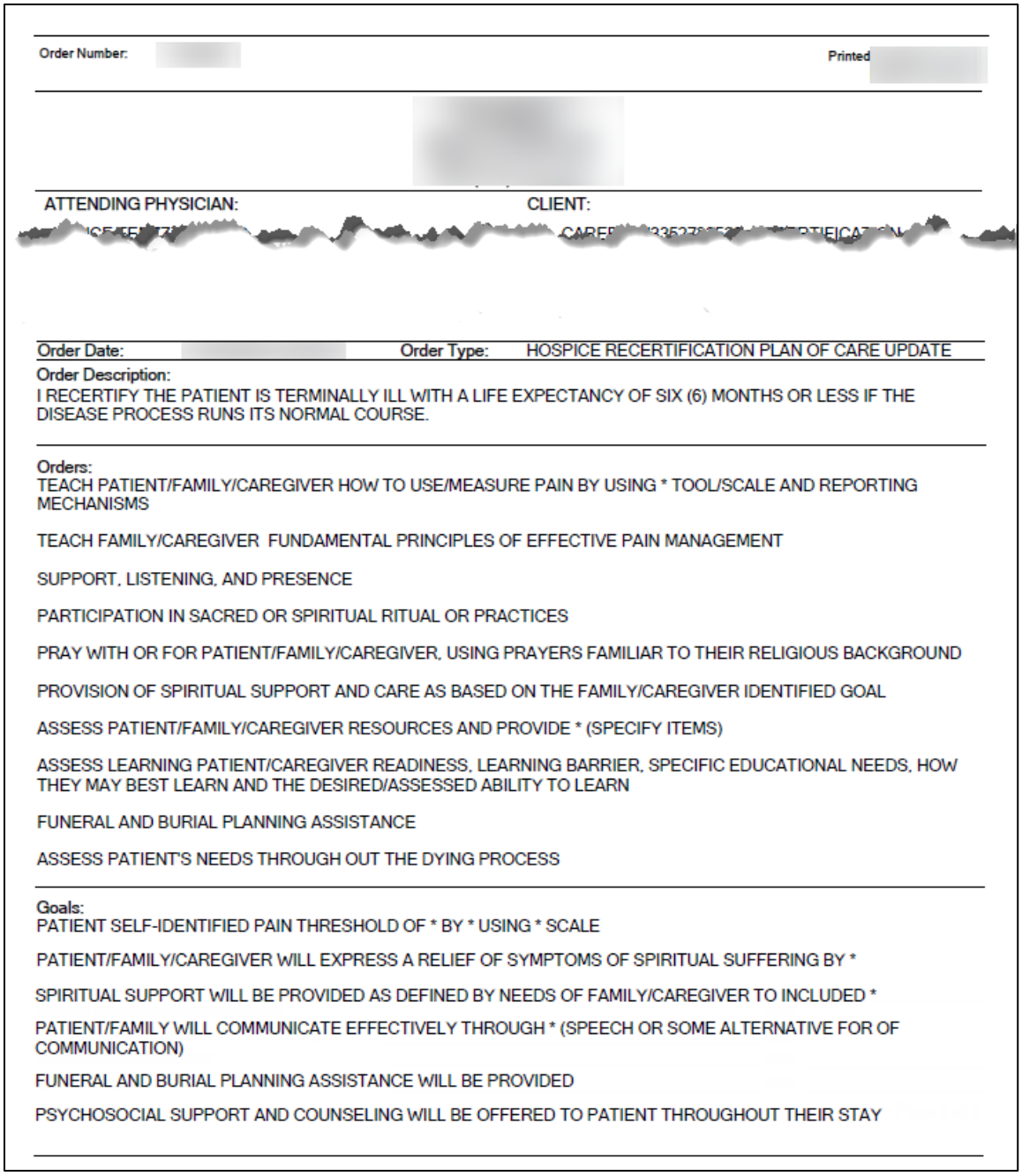
Edit Hospice Recertification Plan of Care Update Order > Goals



- 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.



Order Number: Printed

ATTENDING PHYSICIAN: CLIENT:

Order Date: Order Type: HOSPICE RECERTIFICATION PLAN OF CARE UPDATE

Order Description:
I RECERTIFY THE PATIENT IS TERMINALLY ILL WITH A LIFE EXPECTANCY OF SIX (6) MONTHS OR LESS IF THE DISEASE PROCESS RUNS ITS NORMAL COURSE.

Orders:
TEACH PATIENT/FAMILY/CAREGIVER HOW TO USE/MEASURE PAIN BY USING * TOOL/SCALE AND REPORTING MECHANISMS

TEACH 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 ITEMS)

ASSESS LEARNING PATIENT/CAREGIVER READINESS, LEARNING BARRIER, SPECIFIC EDUCATIONAL NEEDS, HOW THEY MAY BEST LEARN AND THE DESIRED/ASSESSED ABILITY TO LEARN

FUNERAL AND BURIAL PLANNING ASSISTANCE

ASSESS PATIENT'S NEEDS THROUGH OUT THE DYING PROCESS

Goals:
PATIENT SELF-IDENTIFIED PAIN THRESHOLD OF * BY * USING * SCALE

PATIENT/FAMILY/CAREGIVER WILL EXPRESS A RELIEF OF SYMPTOMS OF SPIRITUAL SUFFERING BY *

SPIRITUAL SUPPORT WILL BE PROVIDED AS DEFINED BY NEEDS OF FAMILY/CAREGIVER TO INCLUDED *

PATIENT/FAMILY WILL COMMUNICATE EFFECTIVELY THROUGH * (SPEECH OR SOME ALTERNATIVE FOR OF COMMUNICATION)

FUNERAL AND BURIAL PLANNING ASSISTANCE WILL BE PROVIDED

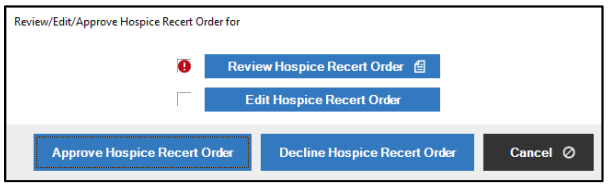
PSYCHOSOCIAL SUPPORT AND COUNSELING WILL BE OFFERED TO PATIENT THROUGHOUT THEIR STAY

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.

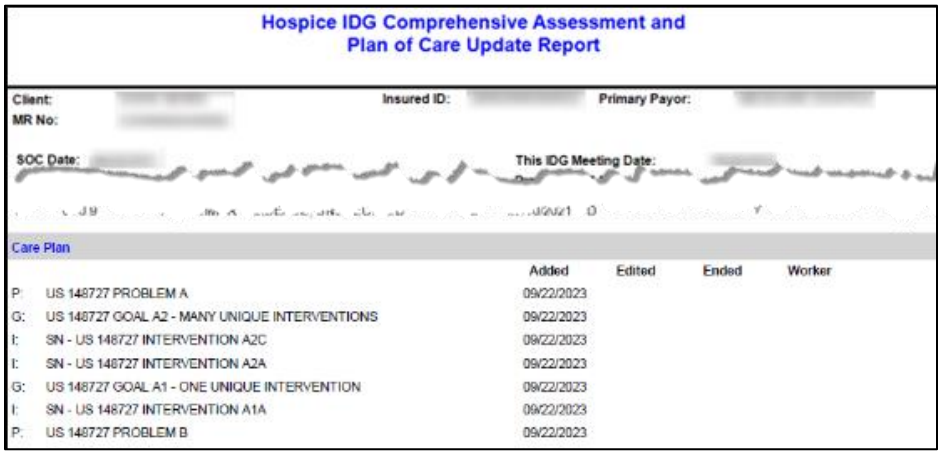


Once approved, the HRPOCU Orders and Goals tabs will no longer be updated as changes are made to the patient's Care Plan.

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.

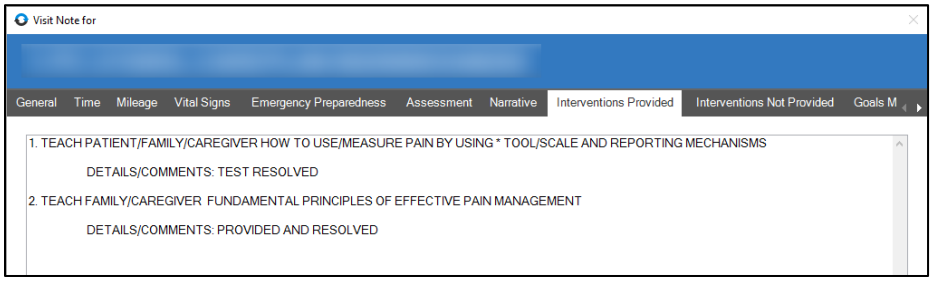


- The Care Plan section includes the Problem, Intervention, and Goal information for the patient. It also shows the date the item was added, edited, or ended, and the worker and the associated discipline.
- The report reflects the Care Plan information at the time the hospice physician signed the meeting. 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

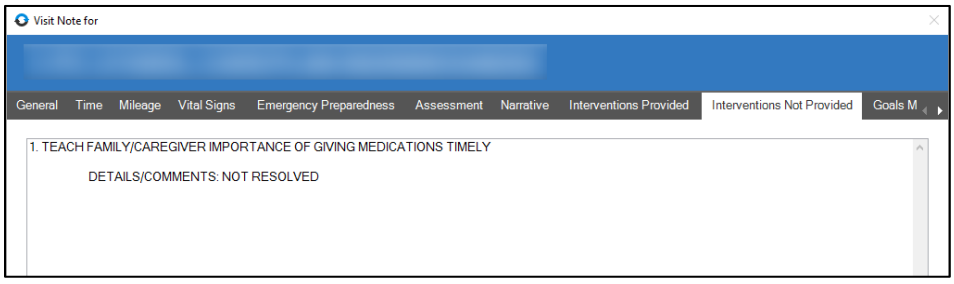
The existing Back Office Visit Note has been updated to include Goal and Intervention information from the corresponding visit.

Visit Note > Interventions Provided



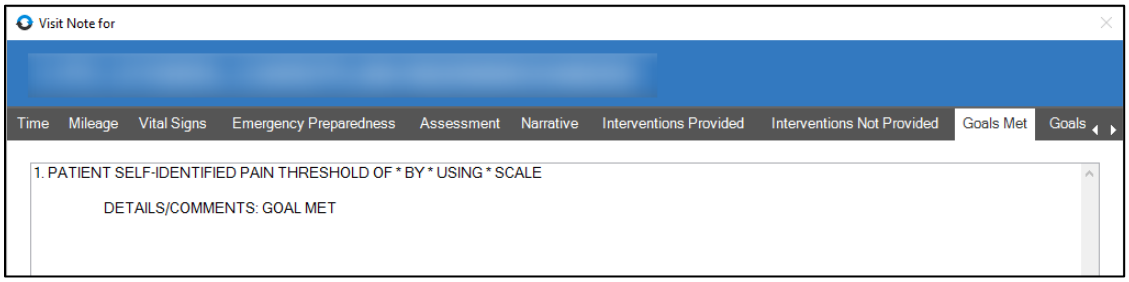
- Shows all Interventions that had “Has the intervention been provided on this visit?” answered Yes to within PointCare.
    - Intervention “Outcome” details will show in the Details/Comments section.
- If no Interventions were answered Yes to “Has the intervention been provided on this visit?”, the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

Visit Note > Interventions Not Provided



- Shows all Interventions that had “Has the intervention been provided on this visit?” answered No to within PointCare.
    - 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.

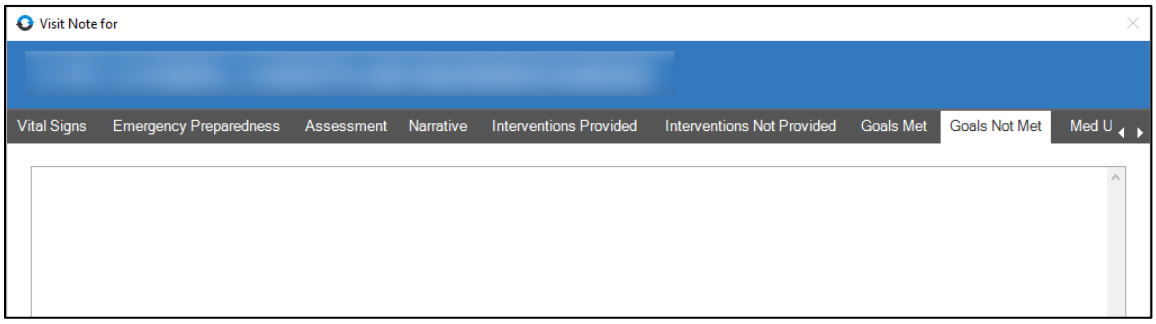
Visit Note > Goals Met



- 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.

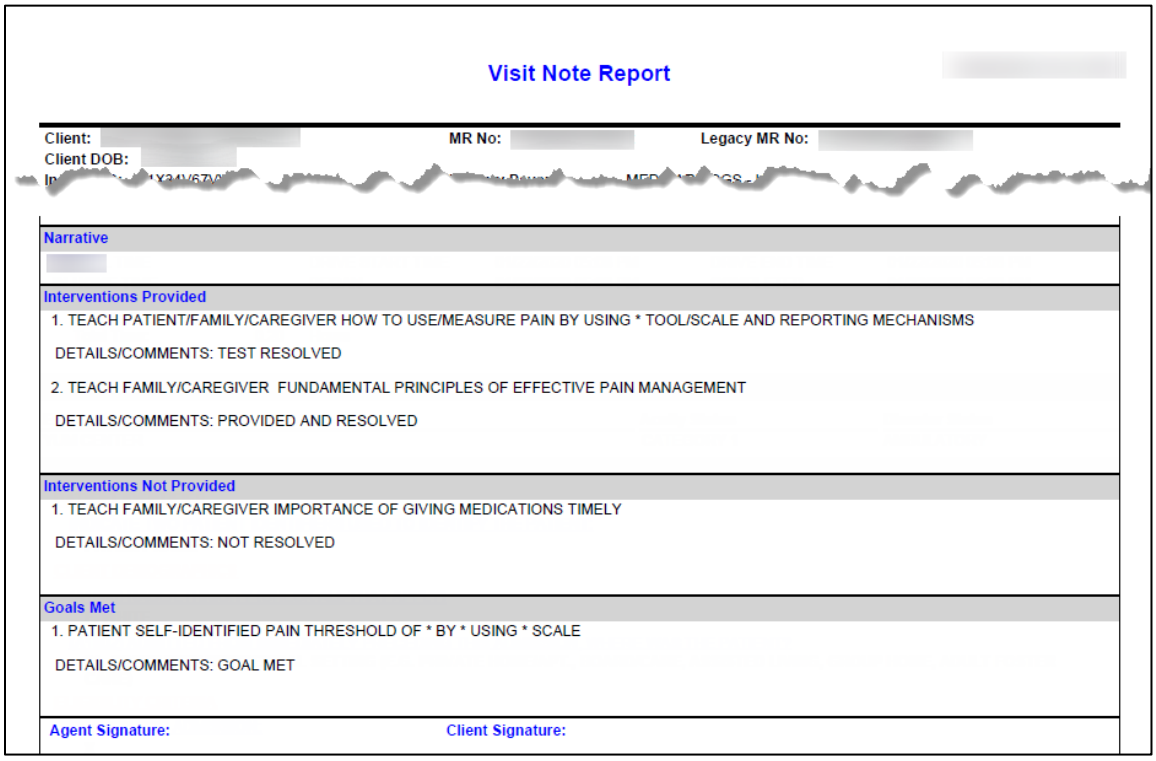
Visit Note > Goals Not Met



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: MR No: Legacy MR No:
Client DOB:

Narrative

Interventions Provided

1. TEACH PATIENT/FAMILY/CAREGIVER HOW TO USE/MEASURE PAIN BY USING * TOOL/SCALE AND REPORTING MECHANISMS

DETAILS/COMMENTS: TEST RESOLVED

2. TEACH FAMILY/CAREGIVER FUNDAMENTAL PRINCIPLES OF EFFECTIVE PAIN MANAGEMENT

DETAILS/COMMENTS: PROVIDED AND RESOLVED

Interventions Not Provided

1. TEACH FAMILY/CAREGIVER IMPORTANCE OF GIVING MEDICATIONS TIMELY

DETAILS/COMMENTS: NOT RESOLVED

Goals Met

1. PATIENT SELF-IDENTIFIED PAIN THRESHOLD OF * BY * USING * SCALE

DETAILS/COMMENTS: GOAL MET

Agent Signature: 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