



Session Guide: Non-Skilled Documentation

After this session, clinical staff who conduct start of care appointments will be able to:

- Create a care plan for non-skilled services

Care Planning During the Initial Appointment in Client Flow

You are a care coordinator for a non-skilled agency.

When you receive a referral, you need to establish a care plan for the new client.

You have the option of creating a care plan in one of three ways:

- **Most detailed** – For a full head to toe assessment, you use a Comprehensive Assessment.
- **Medium detailed** – For cases that do not require a full assessment, you use the Initial/Follow up HHA/HMKR assessment.
- **Easy option** – You open the client's record and go to the Care Plan tab to select tasks.

When the care plan is complete, tasks flow to the Care at Home Non-Skilled application, where home health aides perform the tasks and document that they are complete.

Overview

Your client's care plan specifies services they require in their home. You can begin your care plan either while completing an assessment (from Care at Home or the Home Care web portal), or from the Care Plan tab (web portal). After completing the care plan, tasks appear in the client's appointment within the Care at Home application.

Workflow Considerations

- Which method will your agency use to create care plans: Comprehensive Assessment, Initial Follow Up Assessment, or the Care Plan tab in the client chart?
- Will you use the Care at Home mobile application to do an initial assessment?
- Does your agency provide physician-ordered non-skilled services? If so, do you require a 485 plan of care and OASIS?
- How does the clinician alert the rest of the care team that the client has been successfully admitted? The Intake Coordinator should then Complete the Intake, so all staff are aware client is now Open.

Creating a Care Plan

Note: Use the Services section only when the agency obtains physician orders for the client's care.

Procedure

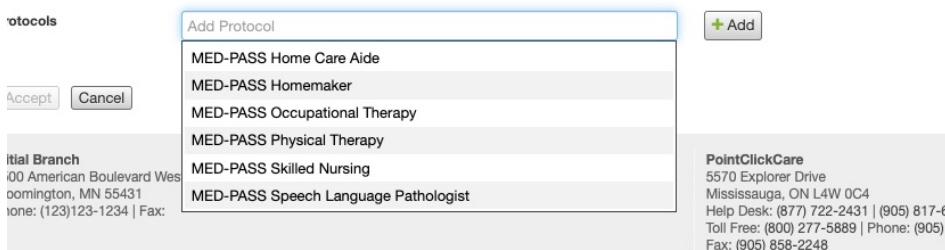
1. Based on your agency's policies, begin your Care Plan from one of the following:
 - **MED-PASS Comprehensive Assessment** for a full head to toe assessment with care plan and POC order that auto-generates.
 - **MED-PASS Initial /Follow up HHA/HMKR assessment.** This includes safety assessment/ADLS, care plan, and fall risk assessment.
 - **Directly from the Client's chart.** Open the client's chart and select **Case Details > Care Plan** tab.
2. If using an assessment, enter information according to your agency's policies.
 - If using the Care at Home application, the assessment automatically appears when you start an appointment.
 - If creating the assessment from the web portal, navigate to the client chart and select **Case Details > Charting**. Click **Add** to select the assessment.

3. Access the care plan:

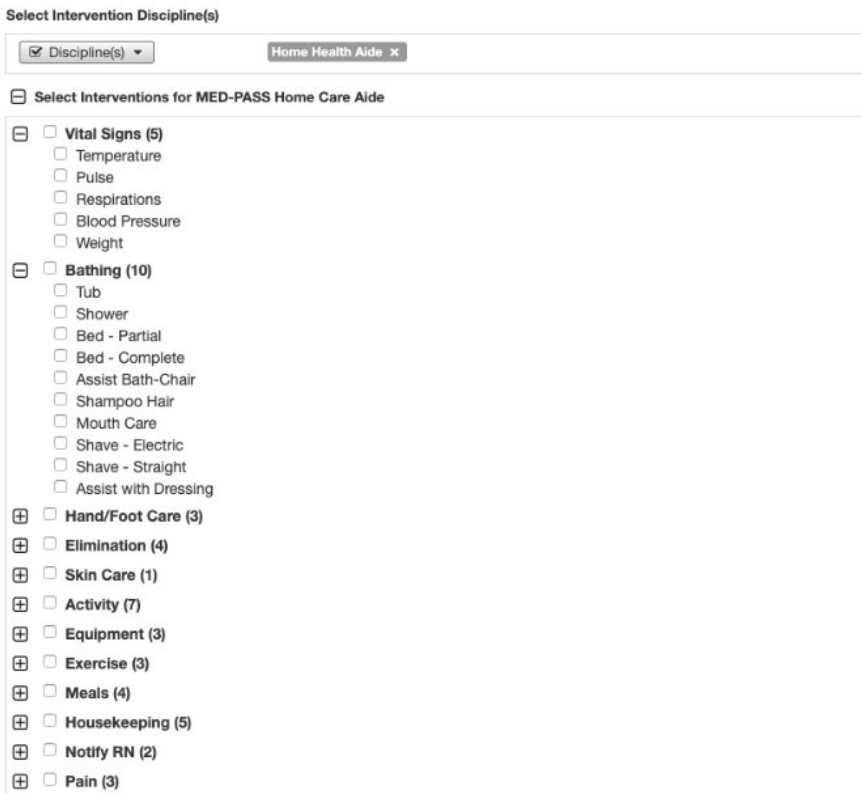
- To access the care plan from an assessment, click the page index at the bottom of the assessment and select **Care Plan**.
- To access the care plan from the client’s record, open the client’s chart and select **Case Details > Care Plan**.

4. If required by your agency, enter service frequencies. (Only used when the agency obtains physician orders for the client’s care.)

5. In the **Protocol** field begin entering either **Home Care Aide** or **Homemaker**. Select the protocol and click **Add**.



6. Manage your Interventions. Click + to expand an item. Click – to collapse.



To include an Intervention as part of the client’s Care Plan, click the selection box.

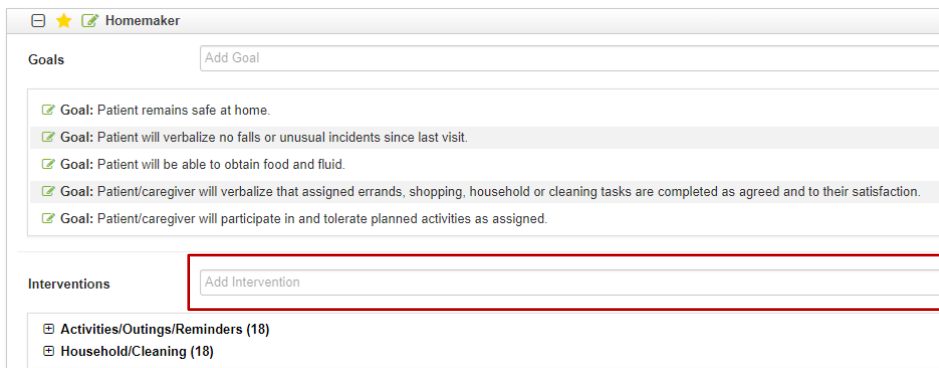
7. To add the protocol to the client’s Care Plan, click **Add** at the end of a protocol. To add another protocol, begin typing the new protocol name in the **Add Protocol** field, select from the list, and then click **+Add** to add it to the care plan.
8. When your Care Plan is complete, do one of the following:
 - If using the Care Plan tab, click **Accept**.
 - If using an assessment, be sure to **Sign** your assessment so that the information flows to the Care Plan tab.

Creating a Custom Goal or Intervention

It may be necessary to create a unique, custom Intervention for your client.

Procedure

1. While creating a Care Plan, click the **Add Intervention** field.



2. Enter your custom text.
3. Click **+Add**. The new Intervention appears at the bottom of your list.



4. Remember to save changes to your Care Plan by doing one of the following:
 - If using the Care Plan tab, click **Accept**.
 - If using an assessment, be sure to **Sign** your assessment so that the information flows to the Care Plan tab.

Associated Reports

Home Care Aide Report	Shows a summary of tasks performed by a Home Care Aide during visits
Patient Visit Report	Shows care plan updates made during a visit.

Associated Dashboards

EVV Held Appointments	Shows appointments submitted with issues. Suggested Use: Monitor daily. Determine issue, resolve, and review appointment so it may be released for payroll and billing.
Patient Unreviewed Appointments	Shows appointments not yet submitted as expected Suggested Use: Monitor weekly. Determine if the problem is related to late documentation. If so, determine why the documentation is late and review the appointment. If it is a missed visit, change status to Cancelled.
Unassigned Appointments	Shows open appointments with no employee assigned.

Notes