PointClickCare®

Home Care

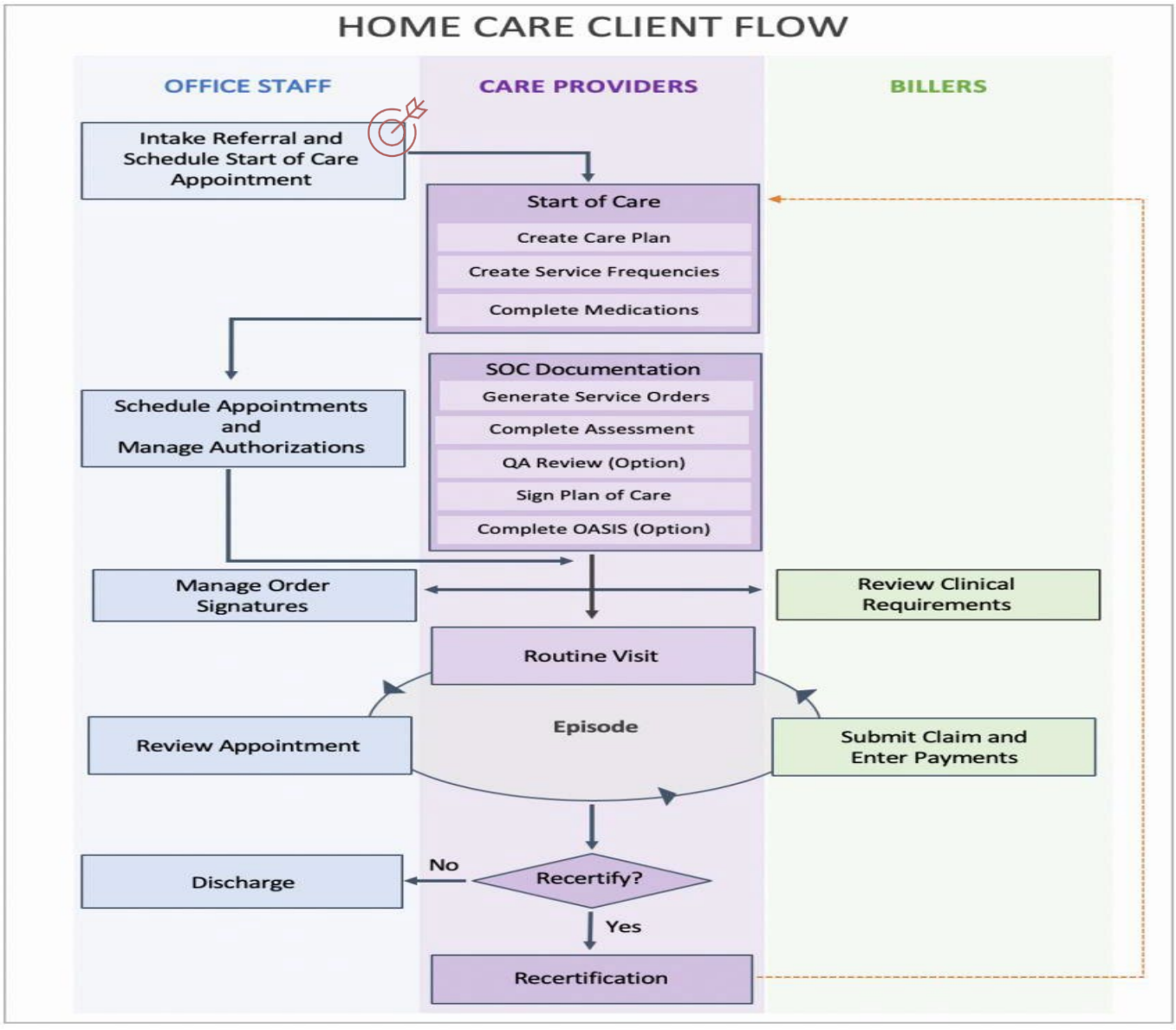
Session Guide:

Start of Care Appointment with OASIS

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

- Log into the Care at Home Clinical app
- Enter Medications
- Complete Skilled Services and Care Plan
- Complete assessment details
- Understand the functionality of locator questions
- Understand how syncing shares information with the Home Health Care web portal.

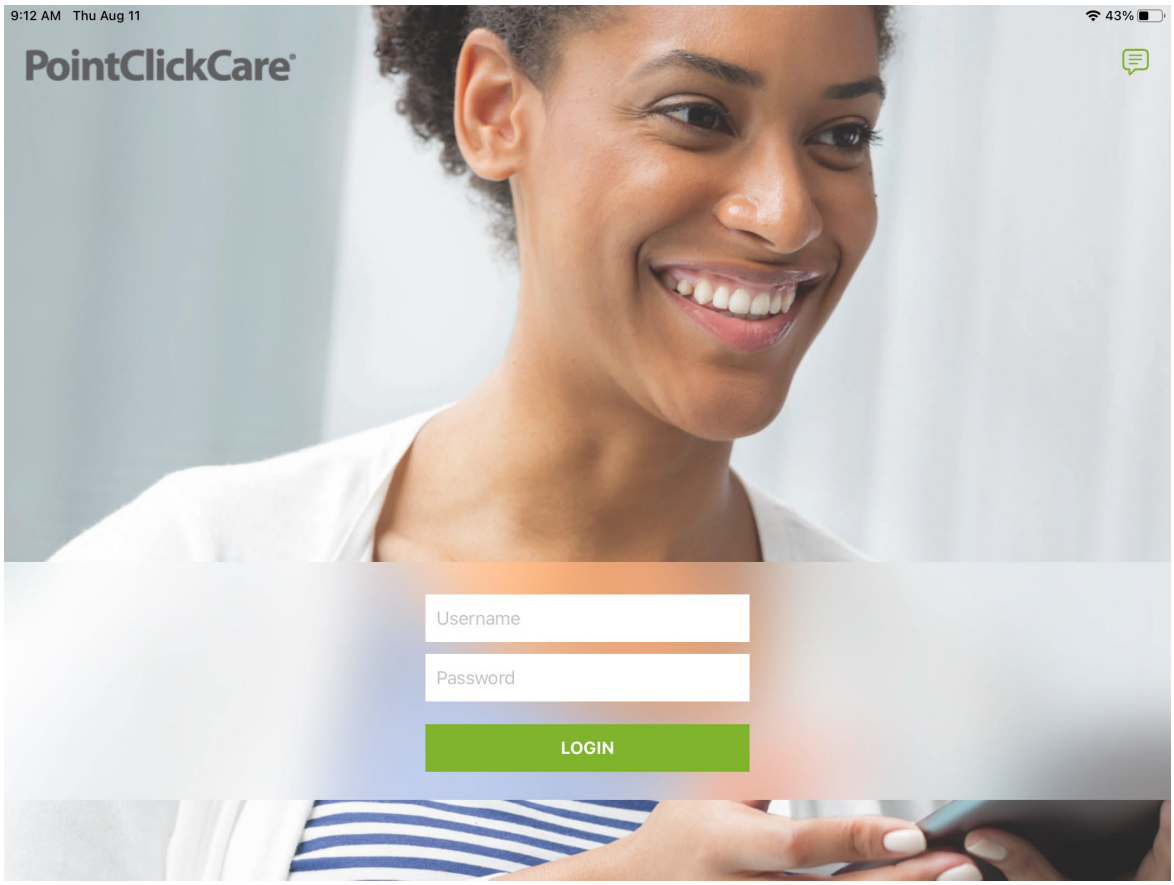
Start of Care Appointment in Client Flow



Completing a SOC/ROC/Recert Appointment in Care at Home Clinical

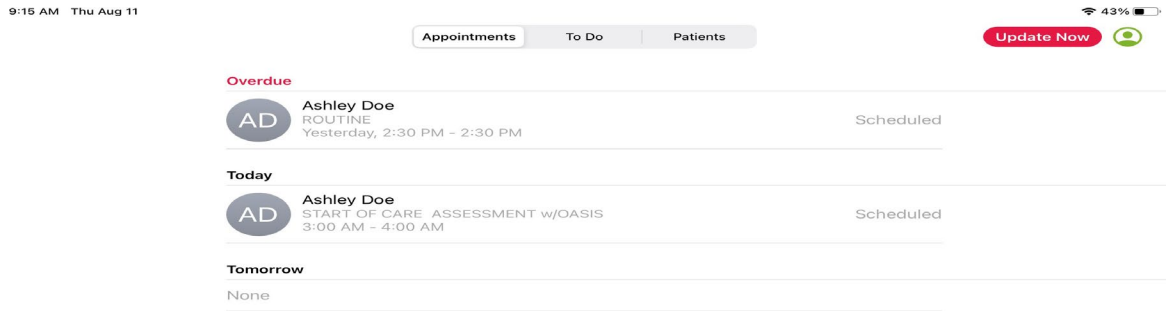
1. From the mobile device screen, tap the **Care at Home Clinical** icon.

2. Enter the **Username** and **Password**.

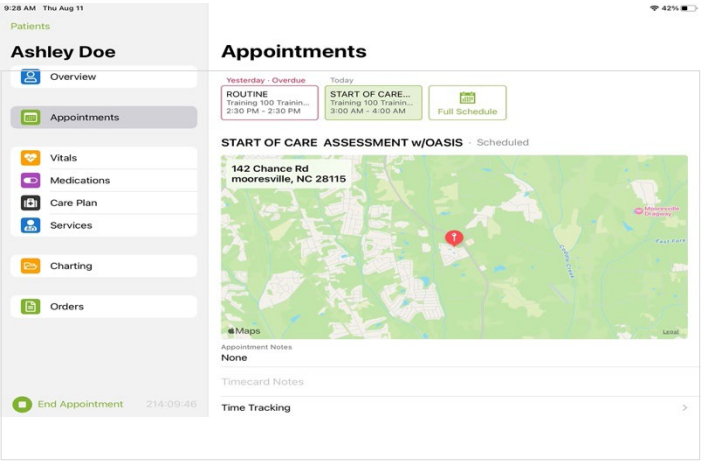


3. Tap **Login**. The appointments screen appears with scheduled appointments.

4. In the Care at Home Clinical application, your schedule for any overdue appointments, current and following day appointments will be visible under the appointments tab.

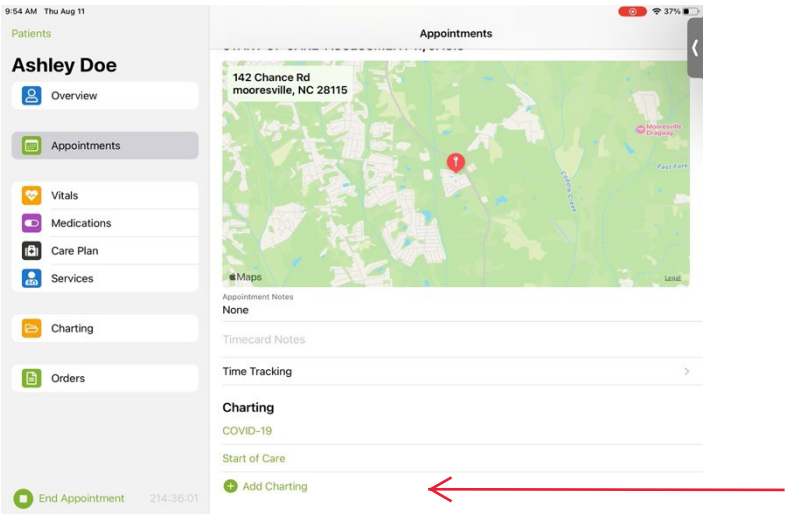


5. Tap the appointment to view patient appointment details.

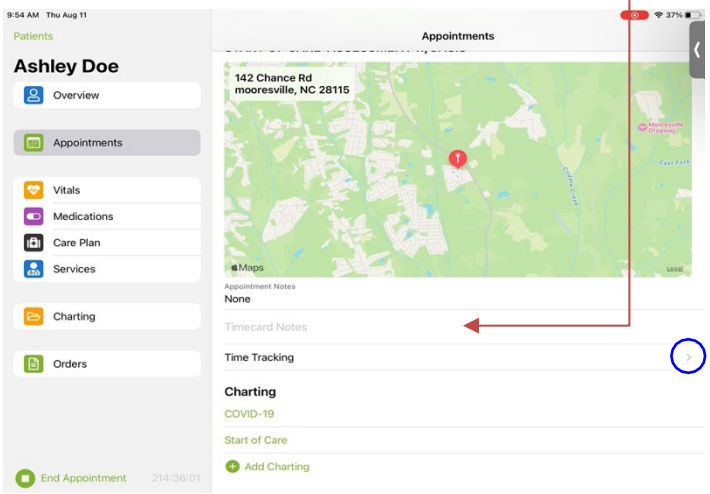


6. Appointment details such as past documentation are located on the left. Click "Overview" to view patient details such as Address, DOB, phone number, EID, Emergency preparedness rating, code status, cert period, Diagnosis, PCP, or alternate MD's.

Scroll Down for more options.



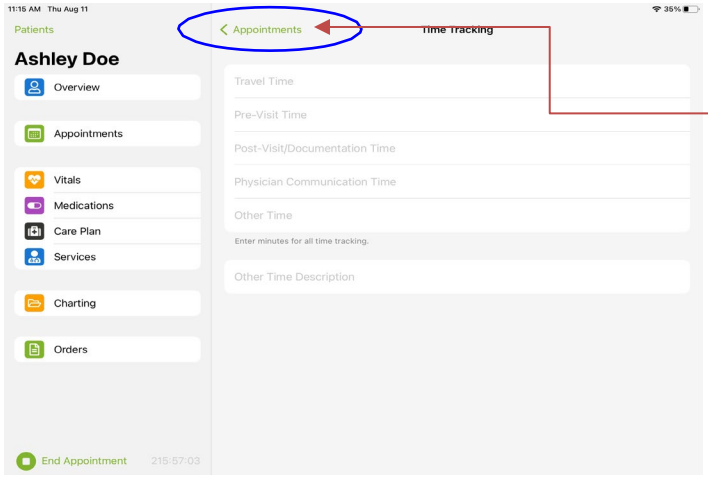
Tip: Assessment forms are automatically loaded in the appointment. If you need to choose a different assessment, tap **Add Charting**, and select another assessment in the appointment screen. Adding charting under the appointment tab will link the charting to the specific appointment.



Timecard Notes are used to relay messages back to your office admin team, i.e., need a different service type that what was scheduled, forgot to hit start/end, appt, etc. Once synced back this field will hold the appt and forced office admins to review the problem

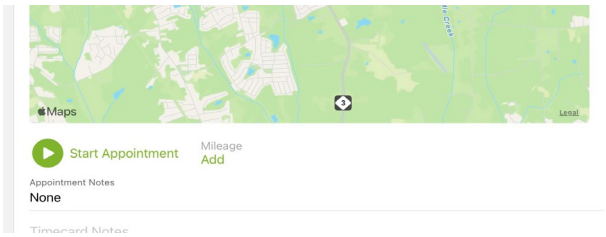
Per your agency's policy, you can track additional time outside the home. Document time in minutes (92 minutes, 32 minutes, etc.). For Time Tracking click gray arrow.

7. Once you click into the gray arrow to edit time tracking you may complete all needed information here.



To go back to your appointment, click on the green "Appointments" and it will take you back to your patient's appointment page.

8. To begin the appointment, tap the appointment and press **Start Appointment**.



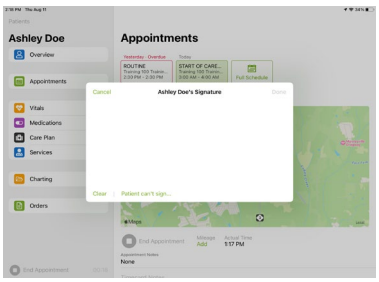
8. After completing as much information as you can in the patient's home, tap **Close and Save draft**.

    a. Tip: If you delete your draft it will show up as a struck-out document on web version and PointClickCare cannot retrieve deleted documents.

    b. ALERT: If you sign document before ending your appointment the end time stamp of your appointment will not show on the print version of the document. Please always save draft first, end appointment then sign document.

9. Tap **End Appointment**. This GPS locates and date/time stamps the end of the appointment.

10. Have your patient use their finger or a stylus to sign in the **Client's Signature** box. Note that your agency may be set up to indicate that a patient is unable to sign.



Tip: Remember that if you've Saved and Closed a document, you can reopen it after the appointment for further work via To-Do List in App.

11. Once you have reopened your document and completed the assessment, before you sign, you may Run the **Oasis Scrubber** (only applicable if your agency has an integration with SHP, Tip: when pressing this button, you will need an internet/cell connection since this button takes you to open a new page to login to SHP web site, your agency will provide you a login for SHP.)

12. Once you have completed documenting on your note you will tap **close and choose sign.**

13. Once you sign the SOC/ROC/Recert document this will push your document into the Pending QA workflow bin. When your document has completed QA review it will be sent back to you for review and corrections. You will complete these corrections via your To-Do list in the app.

Start of Care Documentation

Start of care details include:

1. Medications
2. Skilled Services and Care Plan
3. Start of Care with OASIS Assessment
4. To-Do List: Unsigned documents, QA workflow, Unsigned Orders

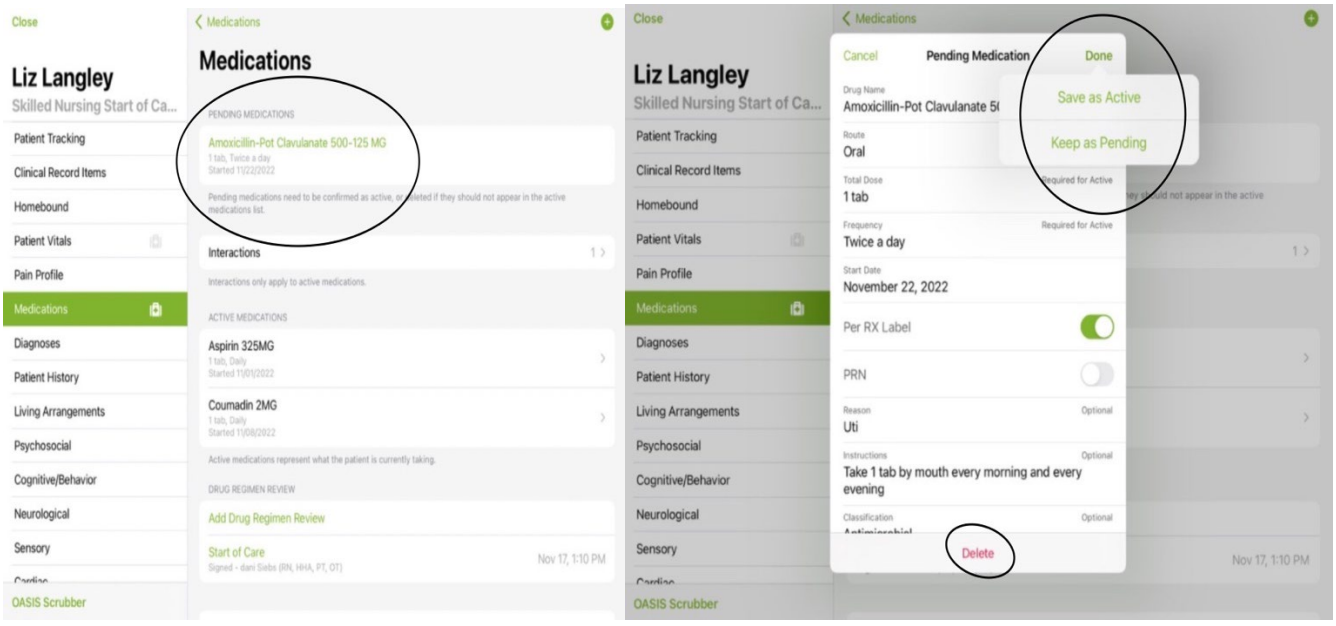
Complete as much information as possible in the patient home. Note that the start of care date entered in the assessment automatically determines the certification period. Any certification periods created outside the signed assessment will be disabled.

Medications

You may review current medications, add new medications, review/edit pending medications, complete a DRR and review medication interactions from this section of your assessment. Information from this section of your document will flow out immediately to tabs with any sync auto or manual.

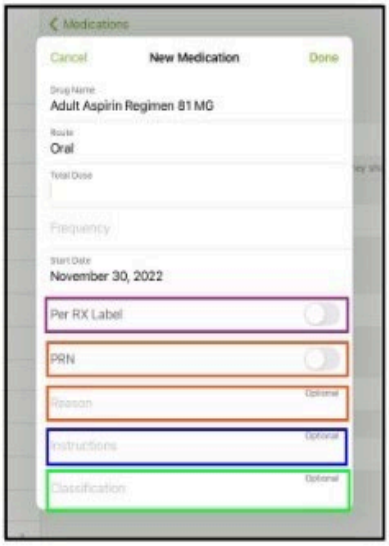
Review a pending medication:

a. Tap on pending medication to review details
b. Make changes if needed
c. Save as active, keep as a pending medication, or delete the medication.



Add a new medication:

a. Click “Medication Profile”
b. Click Add Sign "+".
c. Type the drug name. Select from potential matches. Always choose a match when available. This allows the system to produce drug-to-drug interactions.
d. Per agency policy complete Dose, Route, and Frequency. Best practice is to not use abbreviations.



Per RX Label:
On routine visits, this option determines if an order is created. If checked, no new supplemental order is created. If not checked, a new supplemental order is created.

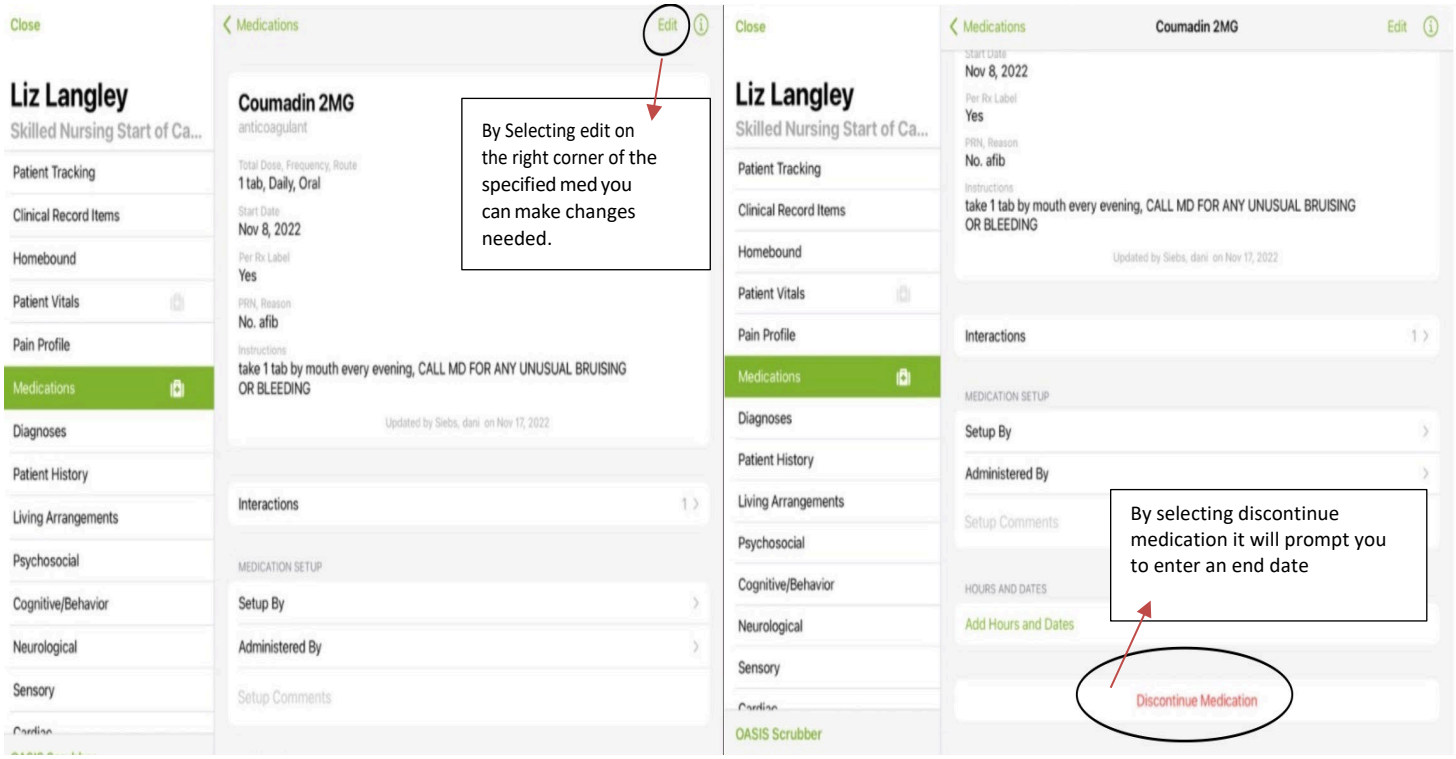
PRN:
For medications taken PRN (as needed) you must define a frequency, check the PRN box, and add a Reason.

Instructions:
This section prints out on the medication list that is given to the patient.

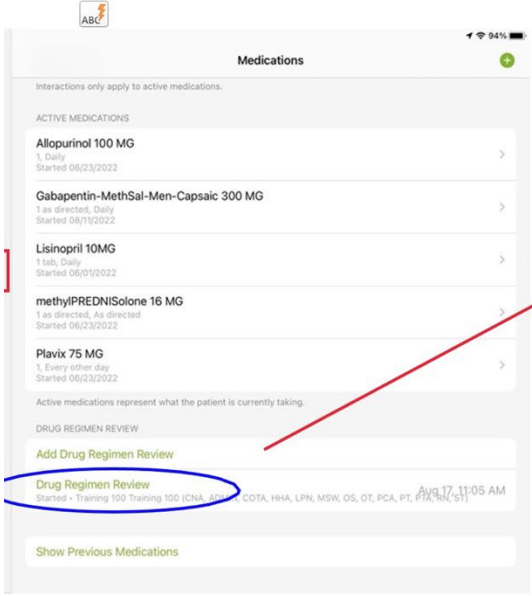
Classification is not a required field. You can chose from the drop down or free text your information. Follow agency policy for the Classification field.

Working with existing medications

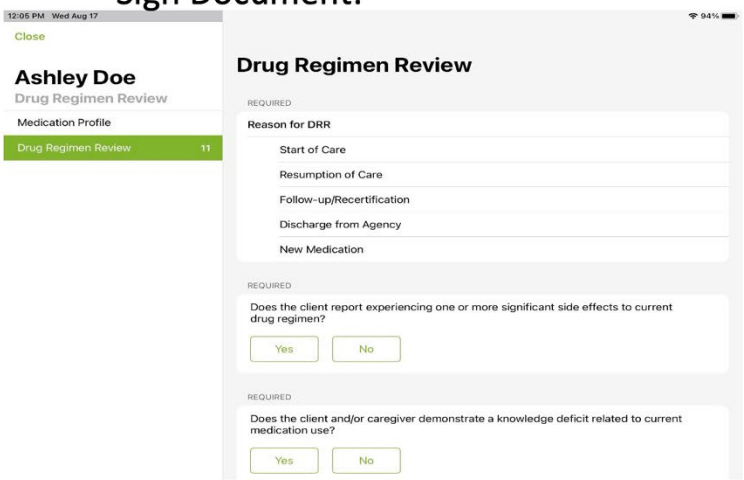
For existing meds on the Medications list, you can Edit or Discontinue.



Add Drug Regimen Review:



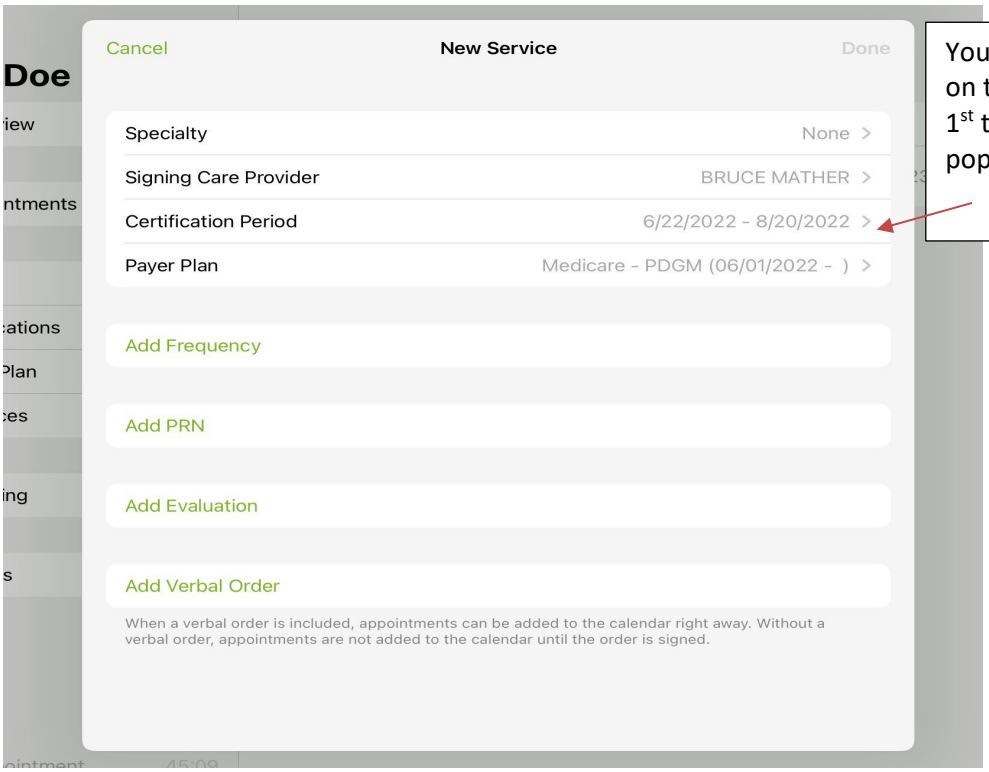
Answer 11 Question Review and Sign Document:



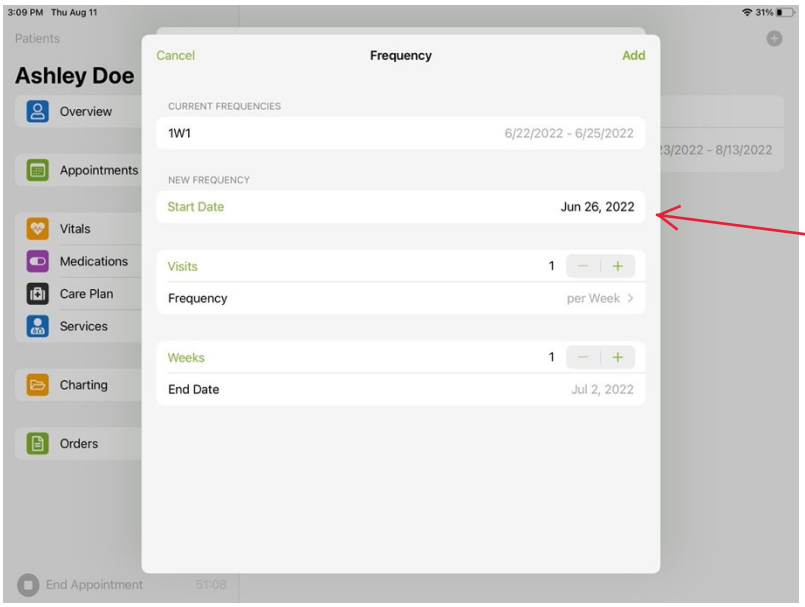
Add Service Frequencies for each specialty

Select **Add Service.**

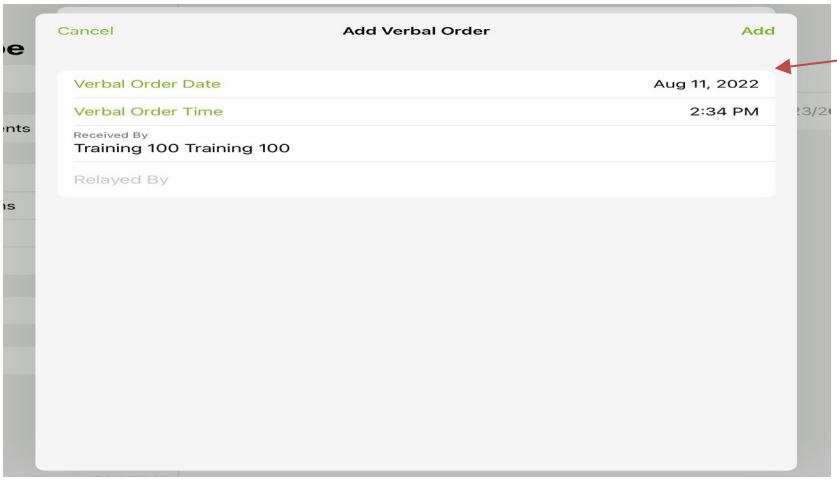
1. Enter **Service Details.** Pay particular attention to the **Payer Plan** and **Signing Care Provider** as they will auto populate the primary on file**.** If changes are needed, tap in, and make appropriate changes.
2. Choose the **Visit Type**: Frequency, PRN, or EVAL.
3. Verify the **Start Date** matches the start date of the service you are specifying.
4. Add Frequencies as necessary. Added frequencies are listed under Defined Services.



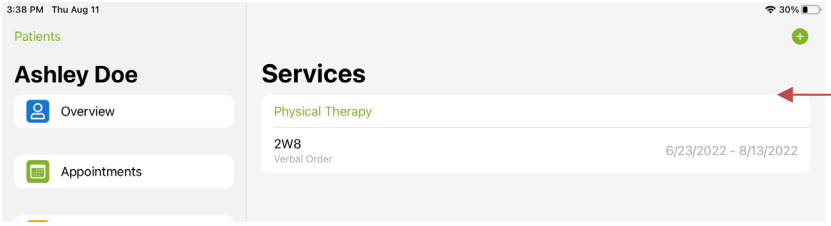
You should complete the soc date on the clinical record items section 1st to ensure your cert period auto populates for you



Verify the **Start Date** matches the start date of the service you are specifying.



Enter Verbal Order information. **A Verbal Order is required for auto-generation of your authorization so you may schedule future appointments. No VO, no way to schedule or review billable appointments.**



Review the Defined Services and verify the service dates are correct and that your verbal order is attached.

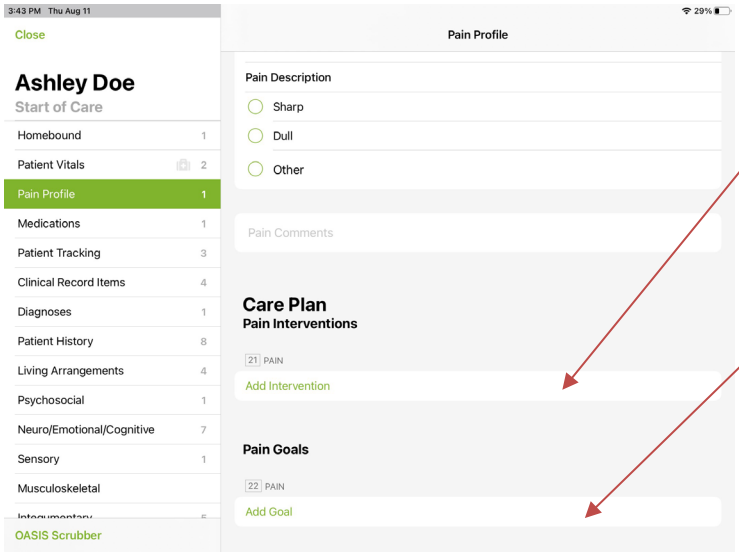
5. Continue adding services for all required specialties, including HHA. (Tip: Create HHA care plans outside of this note on the care plan tab in the app.) (see HHA Care plan guide)

Care Plan

Care planning items are available throughout the tabs categorized by the section headers. Select “add intervention/goal” you will see a list of templated interventions/goals, agency specific ones or you can create custom ones. You can select those that are applicable to your patient and customize/individualize as necessary.

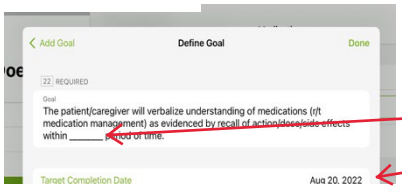
To add a Care Plan:

- In each section of the assessment, you can select specific goals and interventions.

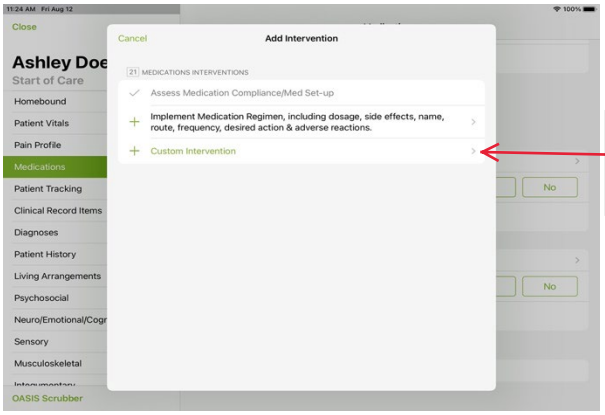


- Click **Add Intervention.**
- Select from templated intervention or create a custom one.
- Customize/individualize as necessary.
- Click Done.

- Click **Add Goal**.
- Select from templated intervention or create a custom one.
- Customize/individualize as necessary.
- Click Done.

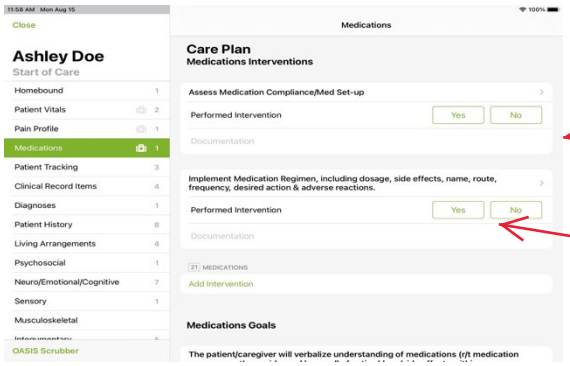


- Tap into fields to customize/ individualize information.



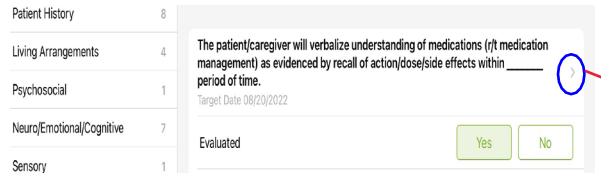
- Create custom Goals/Interventions

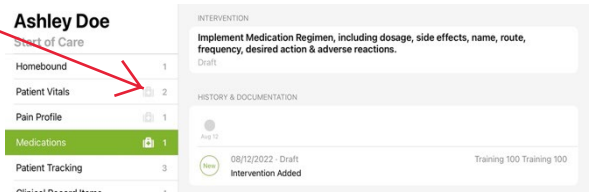
- You may document against your care plan after you have added it under the **Documentation** section. This information will be viewable in future assessments as historical documentation with clinician and date/time stamping.



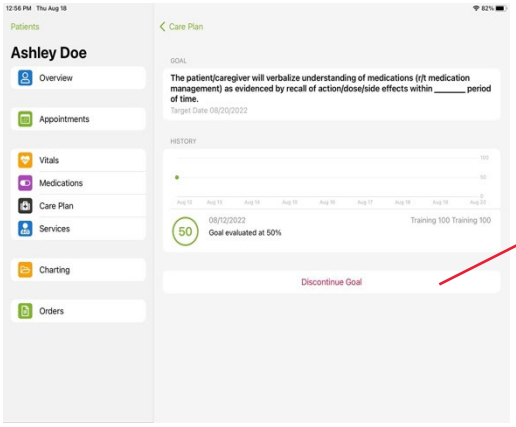
- Enter documentation details into Documentation field on Interventions and goals
- Mark Interventions as Performed "Yes" or "No"

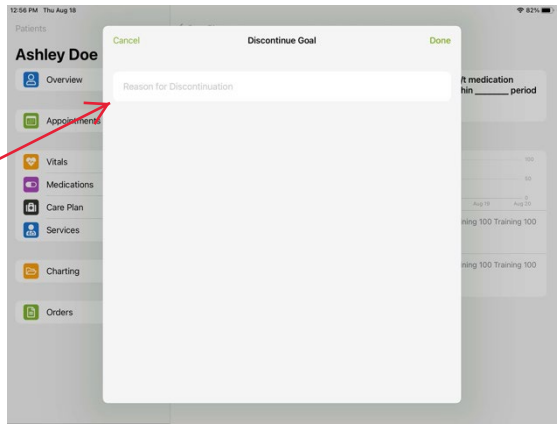
- To view documentation history, tap on a specific intervention or goal to view the details and history of documentation.





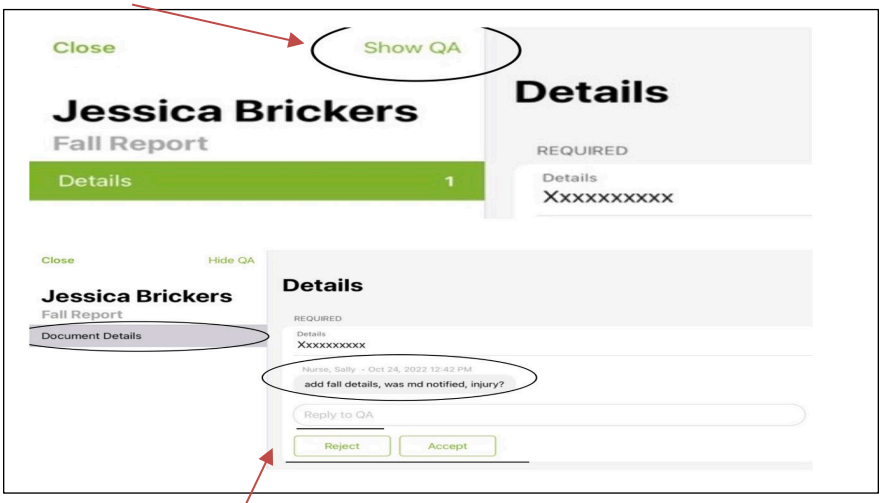
- To discontinue an intervention or goal, tap into the goal/intervention. Select "**Discontinue Goal/Intervention**". Then enter a reason for the discontinuation of goal/intervention, keep in mind reason for discontinuation could be goal/intervention complete/met. You may also mark a Goal as met by sliding the toggle to 100%.





Clinician QA Workflow

- Find your QA review documents in your To-Do list in the Application under "QA Review Complete" at the bottom of the To-Do List
- Tap on the document to view QA reviewer requested changes
- Tap {Show QA} to see changes requested



- Tap on each item,
  - Make edits if applicable
  - Reply to QA team if needed,
  - Mark accept or reject for each change requested
- Run Oasis Scrubber again if needed
- Tap {save and close} to come back later to finish or {Sign} if completed with changes
- These QA documents can go back and forth between QA team and clinician as many times as needed until the QA team locks the assessment
- Once QA is complete and assessment is locked your POC/485 order will populate your To-Do List under Unsigned orders. POC/485 orders can be viewed on the app but not singed. Please go to web version to review and sign your POC/485

Documentation

- Follow skip logic and answer all required questions prior to signing. If you miss any required questions the application will warn you and then also highlight them in red so you may go back and answer them.
- Add additional details to any sections necessary.
- Follow agency policy and procedures for required documentation.

Tips, Tricks and Reminders:

- Care at Home Clinical application will continuously auto-sync every 5 minutes when there is a connection to cell service or Wi-Fi. If no connection, the application will hold data until it finds a connection again.
- At the end of every day please do the following in chronological order for optimum performance:
    - Ensure under the person icon in the app (top right) that a full sync has completed and has a date/time stamp and that all documents have synced. If not, perform a manual sync by pressing on the Sync button and waiting for it complete the sync before closing the app.
    - Close the app by double tapping the home button and swiping the app off the page.
    - Plug iPad into power.
    - Connect iPad to wi-fi to ensure any overnight updates may take place.
- If you run into any issue while using the Care at Home clinical app you should send logs to PointClickCare by going to the login screen of the app and at the top right, tap on the chat box. In the chat box please give details including date/time issue happened, ensure you have a connection then and tap send. Please also notify your agency admin of the issue so they may also submit a support ticket to PointClickCare for review of the issue.
- DO NOT DELETE AND REINSTALL THE APP, unless advised to do so by a PointClickCare liaison. This could cause data loss and require you to re-document notes.

Workflow Considerations

- How does the clinician alert the rest of the care team that the client has been successfully admitted? Intake Coordinator should then Complete the Intake, so all staff are aware client is now Open.
- Consider agency policy on timely completion of documentation. Remember that the appointment will not reflect that it has been done until it is Synced from the mobile application.
- Consider agency policy regarding coding of the assessment. Remember that at least 1 diagnosis code must be entered to sign the assessment. If QA Review is on, these codes can be updated by your agency coder once it is signed and submitted for review.