

MatrixCare®

Integrated Care. Better Outcomes.

MatrixCare Home Care
Mobile for Skilled Professionals
User's Guide
Version: 2018 R7



2017 & 2018 Best in KLAS
for Long-Term Care Software

MatrixCare® Home Care Mobile for Skilled Professionals

This document was written for use with MatrixCare Home Care 2018 R7 (V1.58) or greater.

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Companies, names, and data used in examples herein are fictitious unless otherwise noted.

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General Information for Mobile Skilled Professionals

Features for the mobile skilled professional user include a home page showing Tiles for My Schedule, Forms in Progress, and My Clients. Under Schedule Details, the following tabs show Appointment, Expenses, and Admission information. You have the ability to view, modify, sign, and version the client's Plan of Care Service Plan. Under My Clients, names appear that link you to tabs about the client details, such as Demographics, Additional info, Contacts, and Service Plan.

Note: It is recommended that mobile skilled professional users use a device no smaller than an iPad mini for an optimal user experience.

Signing in to the Mobile Application

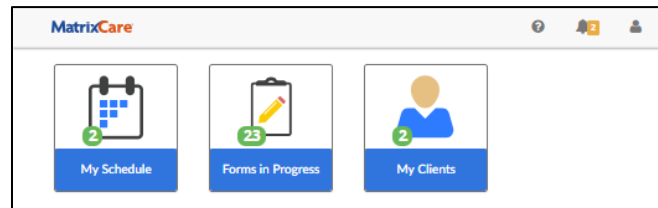
To sign in to the MatrixCare Home Care Mobile application:

1. On your device, access the **MatrixCare Home Care URL** that you previously bookmarked.
2. On the Sign in page, enter your **Username** and **Password**.
3. Tap **Sign In**.

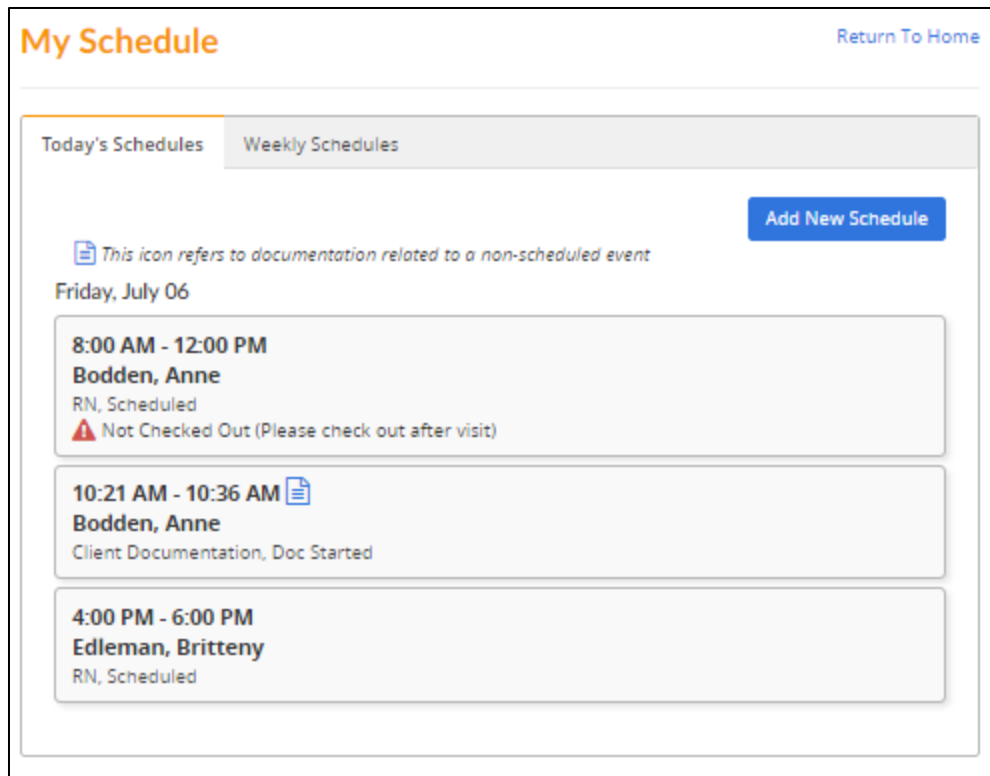


The following sections show the mobile skilled professional user how to do tasks associated with their client on their mobile phone or tablet. The following information provides a brief high level overview of the MatrixCare Home Care Mobile application for skilled professional users. The main features in this application include:

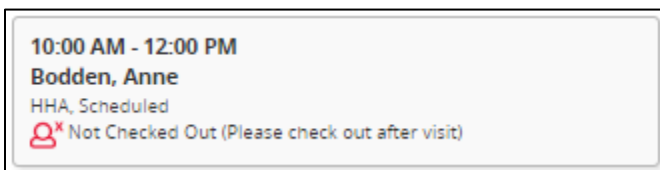
- **MatrixCare** - Tapping the MatrixCare logo returns you to the home page.
- **Help** - Tapping the question mark image provides a quick tour of main functions on each page of the application.
- **Notifications** - Tapping the bell image displays a dropdown menu that allows you to view notifications and activities sent to you by your Home Care Agency office. It also shows the number of notifications that are pending.
- **Account Settings** - Tapping the person image displays a list box that allows you to view your Home Care Agency office information, change your password or digital signature pin, and sign out of the system.



My Schedule - The green and white number on the tile shows the number of schedules for today. Tapping the My Schedule tile, displays a list of clients you are scheduled to visit today. Tap on a schedule to view more detail, and to check in and check out. The Weekly Schedules tab displays a list of clients that you are scheduled to visit this week, past weeks, or future weeks that are prescheduled. Mobile skilled professional users can add a new schedule to their existing clients by tapping on the Add New Schedule button. Adding a new schedule for your client is describe later in this guide. Once you are checked in, a reminder message appears above the scheduled time to "Please check out after visit". The reminder will display on schedules where the end day is 'today' and have been checked in but not yet checked out.



- **Forms in Progress** - The green and white number on the tile shows the number of the forms in the list. Tapping the Forms in Progress tile, displays a list of all forms for the user that are in progress. To open a form, tap the blue ID link. This allows the mobile skilled professional user to view and edit their client's forms from the list.
- **My Clients** - The green and white number on the tile shows the number of clients assigned. Tapping the My Clients tile, displays a list of clients that have assigned schedules within the past or in the next 60 days. The client information displayed, includes the name, address and phone number.
- The red checkout icon indicates when a schedule has been checked in, but not checked out.



- The green checkout icon indicates when the schedule has been checked out from the client visit and is complete.

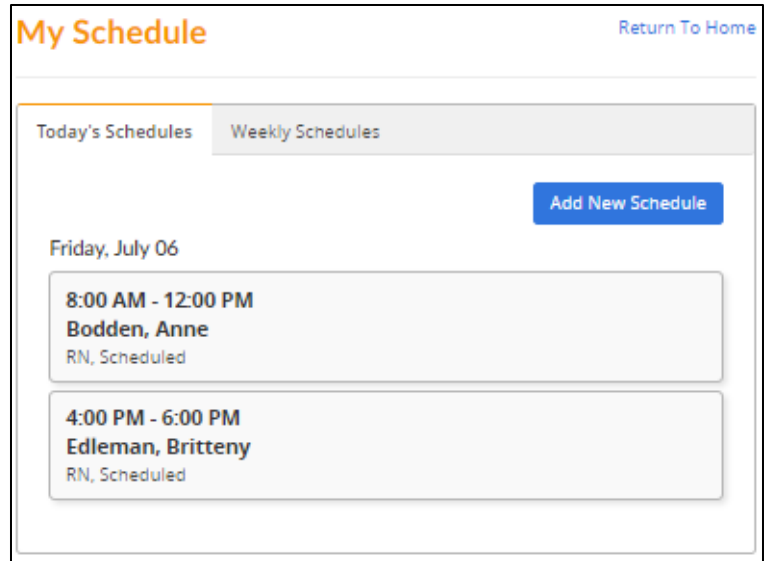


My Schedule

To view your current day's schedules details sent to you by your Home Care Agency office follow these steps:

1. Tap the **My Schedule** tile. Today's schedules page appears showing a list of clients you are scheduled to visit today. For a weekly view of your schedule tap the Weekly Schedules tab.
2. Tap on the client name to view the schedule details.

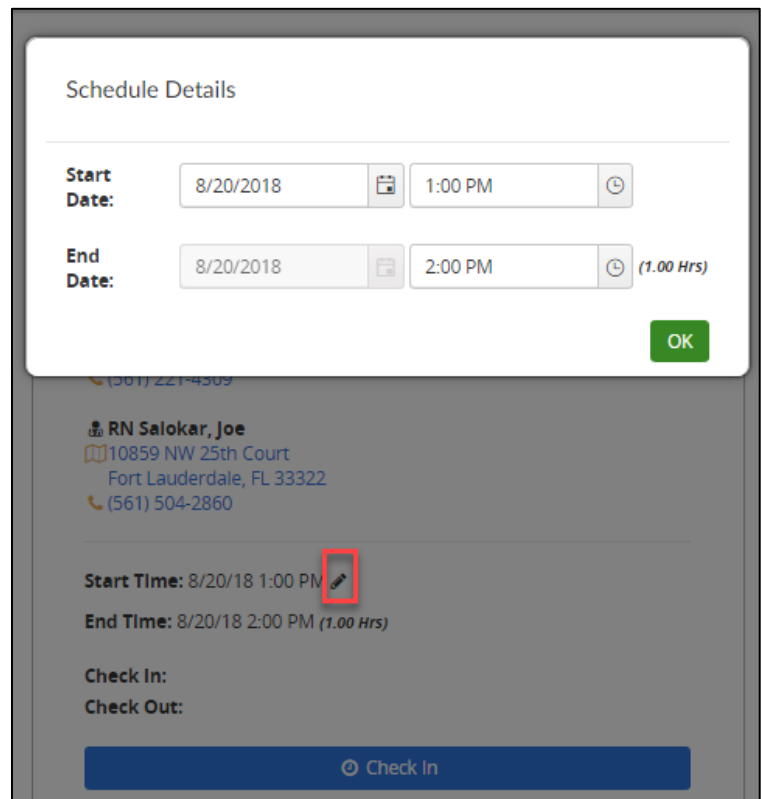
Note: Verify the date and time on your mobile device is correct. If your time is not accurate, check the UTC offset feature on your mobile device. To check that your mobile device shows the correct time zone, go to **Settings, General, Date & Time** then **Time Zone**.



The mobile skilled professional user can view and modify the start date and start and end times on their client's schedule. When the skilled professional user is viewing the Schedule Details page they will see a "pencil" button next to the Start Time. Tapping the pencil shows the start and end date/time.

The start date, start time and end time can be modified. Then tap **OK** and then tap **Save**. The new date/time is saved to the schedule details.

Note: Once you are checked in to the client visit, you cannot modify the date or times. The end date updates automatically as needed based on the end time.

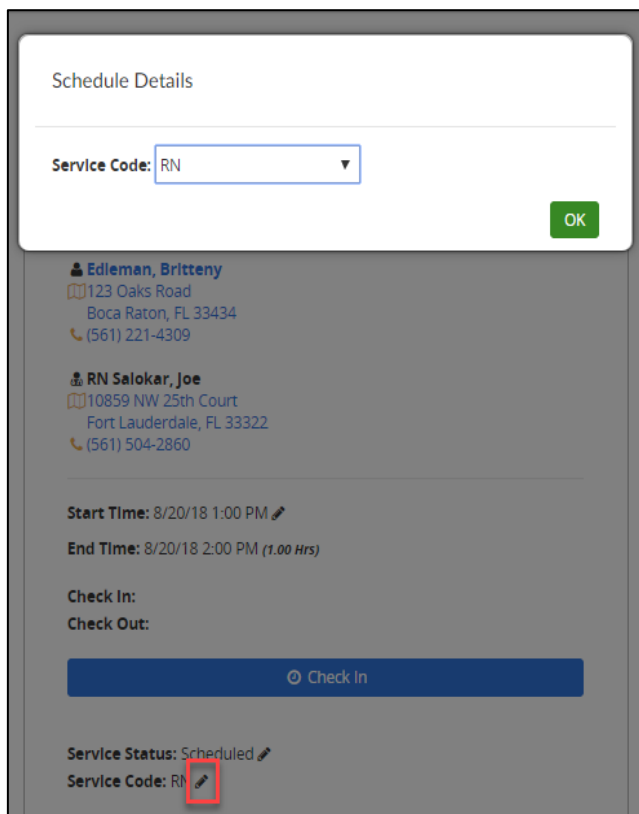
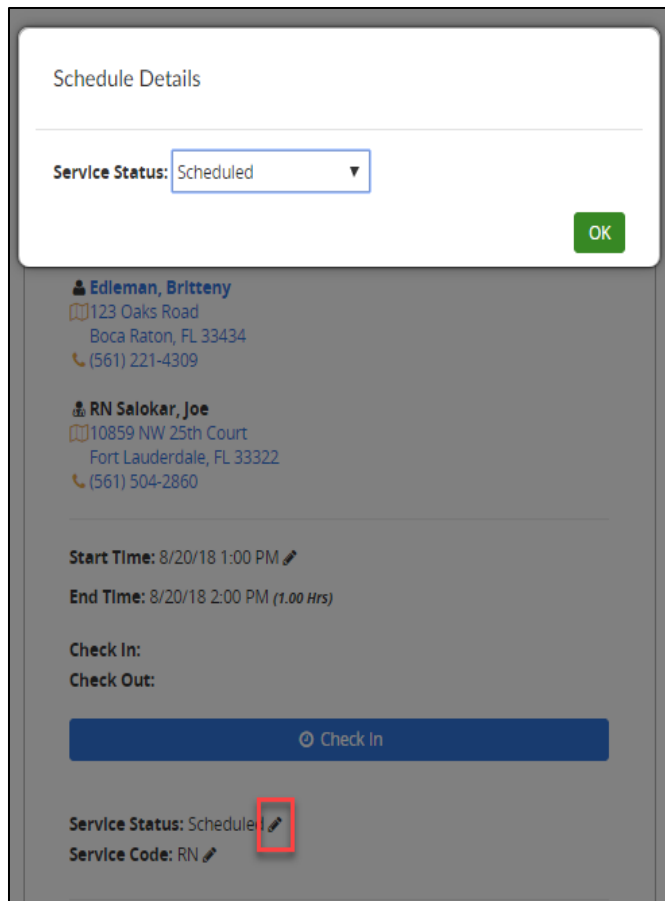


The skilled professional user can view and modify the Service Status on their client's schedule. When the skilled professional user is viewing the Schedule Details page they will see a "pencil" button next to the Service Status. Tapping the pencil shows a list of the Service Statuses.

Note: You cannot edit the Service Status when the current status is set to Completed or Telephony is completed or the schedule is checked in.

Select a Service Status from the list to change. Then tap **OK** and then tap **Save**. The new service status is saved to the schedule details.

The skilled professional mobile user can view and modify a Service Code on their client's schedule when it is not checked in, or in Completed or Telephony Completed status. When the skilled professional user is viewing the Schedule Details page they will see a "pencil" button next to the Service Code. Tapping the pencil shows a list of Service Codes.



Select a skilled Service Code from the list, such as RN. Then tap **OK** and then tap **Save**. The new service code is saved to the schedule details.

Checking in at the Client Location

After arriving at the client's location, you are ready to begin the check in process. The MatrixCare Home Care mobile application will verify your location.

To begin your client visit:

1. Tap **Check In**. This will record your GPS location and the date and time you arrived.

Note: The MatrixCare Home Care mobile application knows your location. If the application does not know your location a message appears requesting you to allow the application to know your current location. Tap **Allow** to complete the location process on your device. You may attempt to check in again to get a better location reading using **Retry Check In**. When your location is correct, the record will update successfully.

Schedule Details

Bodden, Anne

Appointment Expenses Admission

Bodden, Anne
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321
(305) 661-5569

RN Salokar, Joe
10859 NW 25th Court
Fort Lauderdale, FL 33322
(561) 504-2860

Start Time: 8/20/18 8:00 AM
End Time: 8/20/18 12:00 PM (4.00 Hrs)
Check In: 8/19/18 3:01 PM
Check Out:

[Check Out](#)

Service Status: Scheduled
Service Code: RN

Office: NextGen of Palm Beach County
Office Phone: (561) 447-7111

Note from Client Record:
The gate number is 4321

[View Service Plan](#)
[Client Chart](#)

[Save](#)

Note: Tapping the client name link opens the Client Details Demographics tab. The Service Status and Service Code fields are editable on schedules that are not checked in or in T or C status.

Viewing and Editing the Service Plan

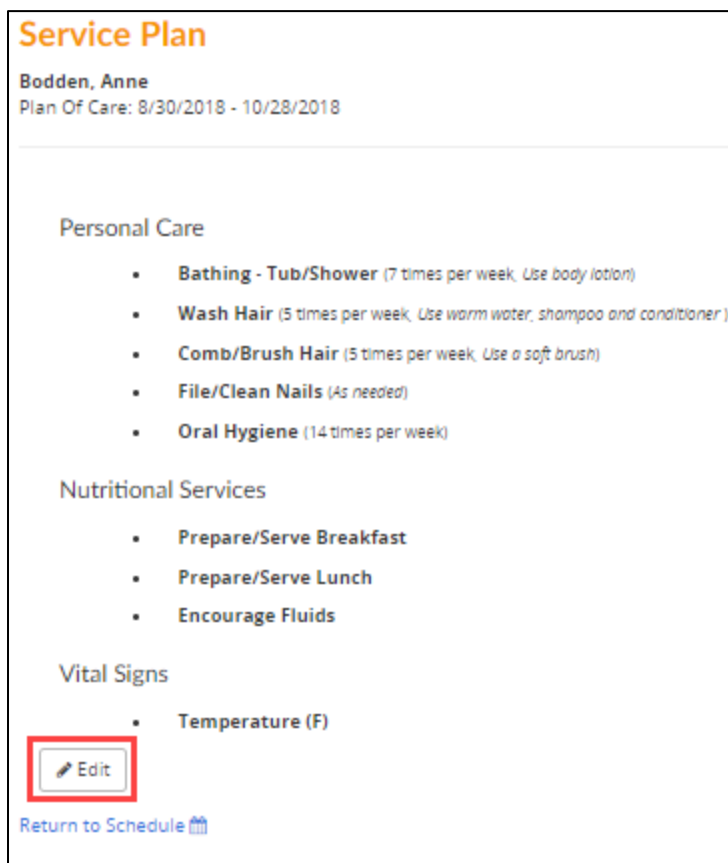
1. Tap the **View Service Plan** button. You can now view the Service Plan details that includes the client name, Plan Of Care dates and the service plan tasks and frequency. The client's Published Service Plan will display if one is available to review the list of tasks and frequency.

An Edit button is available to modify tasks to a draft service plan.

2. If no changes are needed, tap the **Return to Schedule** link at the bottom of the page.

Note: The skilled professional user must check in before they can edit the service plan. You do not need to check in to the schedule to view it, but you must check in to edit it.

3. To edit the clients service plan, tap **Edit** to open the Service Plan page



4. These pages show a list of all the categories of tasks that are available to choose. The task category will display the number of assigned tasks out of the total number of available tasks for the category. Tap on a task category to expand and display all the tasks in that category.

Service Plan

Bodden, Anne
Plan Of Care: 8/30/2018 - 1/31/2019

- Personal Care (7 of 15)
- Nutritional Services (1 of 9)
- Household Duties (0 of 10)
- Meals on Wheels (0 of 1)
- Medication (0 of 1)
- Activities (0 of 5)
- Exercise/Movement (0 of 5)
- new category on existing (0 of 0)
- Measurements (3 of 4)

| | | |
|---|--|---|
| <input checked="" type="checkbox"/> Fluid Intake | <input type="text" value="5"/> times/week | <input type="text"/> |
| <input checked="" type="checkbox"/> Fluid Output | <input type="text" value="5"/> times/week | <input type="text"/> |
| <input checked="" type="checkbox"/> Weight | <input type="text" value="5"/> times/week | <input type="text" value="Notify Supervisor if weight fall below 100"/> Expand |
| <input type="checkbox"/> Blood Sugar Reading | <input type="text"/> times/week | <input type="text"/> |

5. Tap in the checkbox to select or unselect a task.
6. Enter any notes that may be needed for the Home Health Aide.
7. Scroll to the bottom of the page and tap **Save**, the Schedule Details page appears.

Accessing the Client Chart when Checked in to a Schedule

Tap the **Client Chart** button to display the Client Chart page.

Accessing Forms

To access forms:

1. Tap the **Forms** tile.

Schedule Details
Bodden, Anne

Appointment Expenses Admission

Bodden, Anne
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321
(305) 661-5569

RN Salokar, Joe
10859 NW 25th Court
Fort Lauderdale, FL 33322
(561) 504-2860

Start Time: 8/20/18 8:00 AM
End Time: 8/20/18 12:00 PM (4.00 Hrs)
Check In: 8/19/18 3:01 PM
Check Out:

[Check Out](#)

Service Status: Scheduled
Service Code: RN

Office: NextGen of Palm Beach County
Office Phone: (561) 447-7111

Note from Client Record:
The gate number is 4321

[View Service Plan](#)
[Client Chart](#)

[Save](#)

[Back](#)

Client Chart
Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County
Schedule Date: 08/20/2018

[Forms](#) [Medications](#) [Inpatient Tracking](#)

The Forms page appears which displays the name of the client and the date of the schedule. On the Manage Forms tab, tap **Expand All** to view each type of form that can be created for the client. The forms created will be associated with this schedule.

Note: The Manage Forms tab does not appear until you are checked into a client visit.

2. Tap to select the **Assessment** or **Supplemental Forms** you want to create.

The screenshot shows a mobile application interface for managing forms. At the top, there is a navigation bar with a back arrow and the text 'Client Chart'. Below this, the title 'Forms' is displayed in orange. The client's name 'Bodden, Anne' is shown, along with her status 'SOC: 03/01/2017, Active, NextGen of Palm Beach County' and the 'Schedule Date: 08/20/2018'. A tabbed interface is present, with 'Manage Forms' selected and 'Client Forms' visible. A prompt reads 'To add a form, select the form below.' with 'Expand All' and 'Collapse All' options. Two categories are listed: 'Assessment Forms' and 'Supplemental Forms'. Under 'Assessment Forms', there are two items: 'Comprehensive Adult Assessment (Non OASIS)' and 'Skilled Nurse Visit Note'. Under 'Supplemental Forms', there is a list of ten items: 'Braden Scale', 'Care Coordination Note', 'Diagnosis/Surgical Procedure Code Entry', 'Fall Risk Assessment MAHC 10', 'Home Environment Safety Evaluation', 'Hospital Risk Evaluation', 'Medical History / Physical / Functional Assessment', 'Pain Location Assessment', 'Summary (Non-OASIS)', 'Supervisory Visits of Home Health Care Staff', 'Visit Frequency Order', and 'Wound Location Assessment'.

The form is created and will open for you to fill out.

**SUPERVISORY VISITS
OF HOME HEALTH CARE STAFF**

I. CLIENT INFORMATION

Client Name (Last, First, Middle) Medical Record No.
 Bodden Anne M BA-302-495

Name of Staff Member Being Supervised (Last, First, Middle) Date of Supervisory Visit
 07/06/2018

Staff Person In Home During Supervisory Visit?
 Yes No

II. STAFF INFORMATION

| ITEM | STAFF MEMBER | | | | COMMENTS |
|--|-----------------------|-----------------------|----------------------------|-----------------------|----------------------|
| | EXCEEDS REQUIREMENTS | MEETS REQUIREMENTS | DOES NOT MEET REQUIREMENTS | NOT OBSERVED | |
| 1. Reports for work assignment as scheduled. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="text"/> |
| 2. Identifies self by name and title to the client. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="text"/> |
| 3. Demonstrates courteous behavior toward the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="text"/> |

Default information in the form includes:

- Name of Client (Last, First and Middle) - which is populated from the Client record
- Medical Record No. - is populated from the Admission Medical Record Number
- Date - defaults to the schedule date and can be edited
- Person Completing this Form - defaults to the caregiver name on the schedule

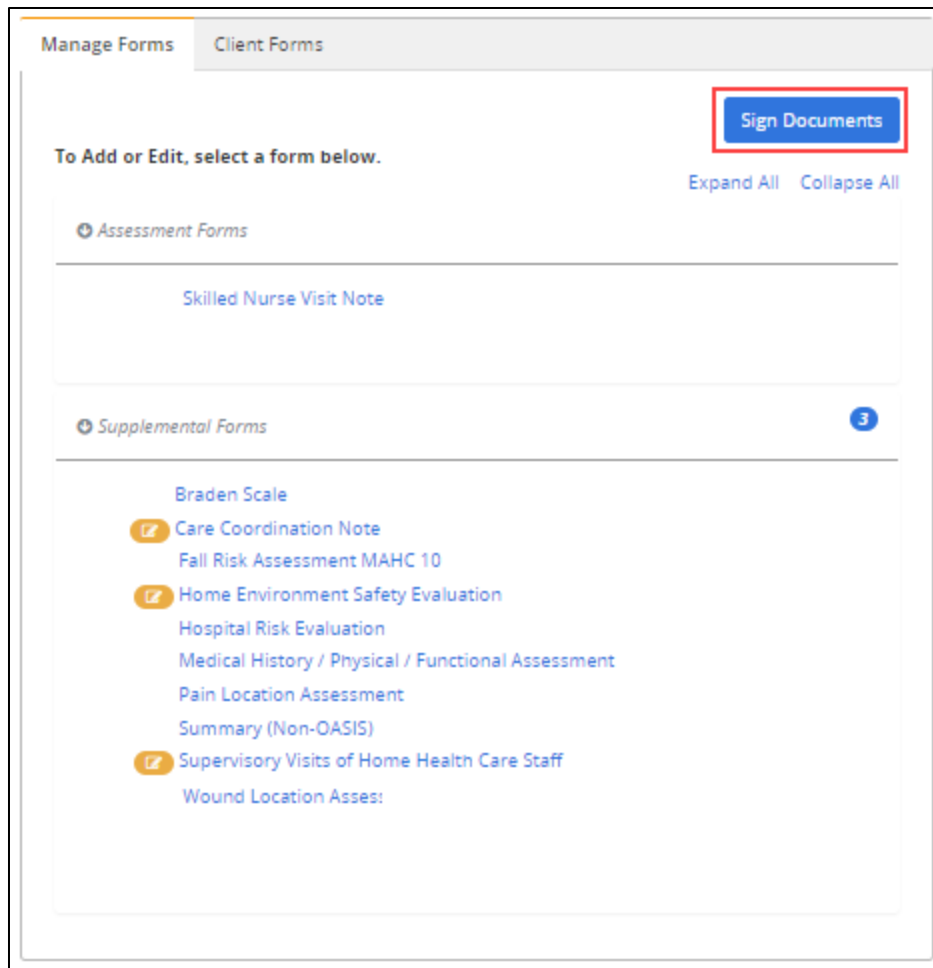
3. Fill out the form.

4. Scroll to the bottom of the form and tap **Save**.

5. Tap the **Back** link at the bottom of the form to go back to the Manage Forms page.

Note: A orange and white pencil icon appears next to the form link showing that the form has been created and is in progress for that scheduled visit.

6. After forms are created, the form links will have an orange and white pencil icon to the left showing that they are in progress. The blue and white number to the right of the headings shows the total amount of forms that are in progress.



7. A **Sign Documents** button appears after a form is created. Tap **Sign Documents**. The Document Process Manager popup appears. The Document Process Manager popup includes Actions such as “Mark as ready for Review” and “Revert to in Progress”. To change the status of the selected forms, when there is only one action available, it will default in to the Action field.

Document Process Manager

Action:

Forms:

- Care Coordination Note
- Home Environment Safety Evaluation
- Supervisory Visits of Home Health Care Staff

Event Notes:

Pin:

8. When all forms are In Progress, the Action shows as **MARK AS READY FOR REVIEW**. If forms are in different statuses, the Action field will be blank, then select the Action.
9. Each form associated to the schedule will have individual check boxes checked to apply the action based on the status of the form. Optionally, you can uncheck the check box on the form if you want to disable the action.

Document Process Manager

Action:

Forms:

- Care Coordination Note
- Home Environment Safety Evaluation
- Supervisory Visits of Home Health Care Staff

Event Notes:

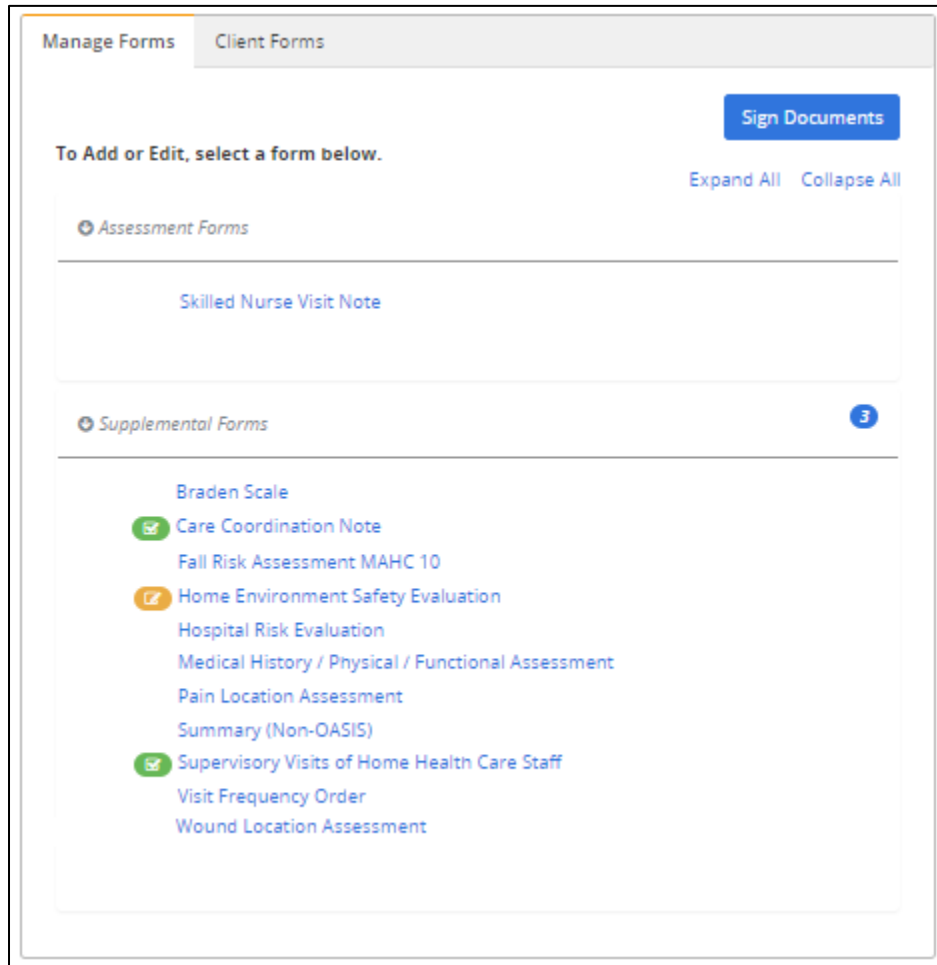
Pin:

10. Enter any internal event notes related to the forms that you would like the agency to know about. These notes will not show on the forms. These notes are for communication between the skilled professional user and the agency only. When an Event Note is added, a blue icon is shown in the “Forms In Progress” list, at the end of the form name to alert the user a note exists.

Note: If you want to go back to the forms page to make additional changes tap **Cancel**.

11. Sign the form by entering your PIN. Tap **Change Status** Change Status to complete the forms. These forms are sent to the office for review and approval. The Form page appears with a green check mark next to the form button indicating it is no longer in progress.

Note: If you do not enter a PIN or enter the wrong pin, a message “PIN is invalid” PIN is invalid appears in red. If you forgot your caregiver PIN, navigate to your account setting and select **Manage Signature Pin** to change your PIN.



When there is more than one action available, forms are in different statuses and the action field will be blank. Tap the drop-down arrow to select the desired action. The selected action will be applied to all forms that are checked.

Document Process Manager

Action:

Forms:

- Care Coordination Note READY FOR REVIEW
- Home Environment Safety Evaluation IN PROGRESS
- Supervisory Visits of Home Health Care Staff READY FOR REVIEW

Event Notes:

Selecting **MARK AS READY FOR REVIEW** will only allow you to choose forms that are in progress.

Document Process Manager

Action:

Forms:

- Care Coordination Note READY FOR REVIEW
- Home Environment Safety Evaluation IN PROGRESS
- Supervisory Visits of Home Health Care Staff READY FOR REVIEW

Event Notes:

Pin:

Enter your **PIN** and tap **Change Status** to complete the action.

To make changes to a form that is in **READY FOR REVIEW** status, change the Action to **REVERT TO IN PROGRESS**. The check mark box next to the form you want to revert will be automatically checked. You can optionally uncheck the check box on a form.

Document Process Manager

Action: REVERT TO IN PROGRESS ▼

Forms:

- Care Coordination Note READY FOR REVIEW
- Home Environment Safety Evaluation IN PROGRESS
- Supervisory Visits of Home Health Care Staff READY FOR REVIEW

Event Notes:

Tap **Change Status** to complete the action.

No PIN number is required when changing a form back to in progress. A PIN is required when a form is changing from in progress to ready for review. Depending on the selected action and the status of the form, the form may or may not be available for selection.

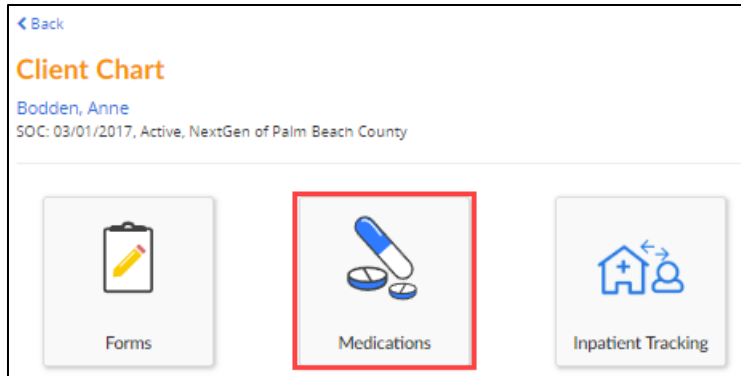
Accessing, Adding and Viewing Client Medication Information

A clinician or skilled professional user can now access, add and view client medication information on their mobile device when checked into a client visit or from My Clients>Client Chart.

To add and or view client medication information:

1. On the main mobile page, tap **My Schedule** tile and check in to the client visit.
2. Tap **Client Chart**. The Client Chart page appears showing the Medications tile.

The screenshot shows the 'Schedule Details' screen for a client named Anne Bodden. The screen is divided into several sections. At the top, there are tabs for 'Appointment', 'Expenses', and 'Admission'. Below the tabs, the client's name 'Bodden, Anne' is displayed, followed by her address: '11555 Heron Bay Blvd, Apt 301, Coral Springs, FL 33321' and her phone number '(305) 661-5569'. Below this, the provider's name 'RN Salokar, Joe' is shown, along with his address: '10859 NW 25th Court, Fort Lauderdale, FL 33322' and his phone number '(561) 504-2860'. The appointment details include 'Start Time: 8/20/18 8:00 AM', 'End Time: 8/20/18 12:00 PM (4.00 Hrs)', 'Check In: 8/19/18 3:01 PM', and 'Check Out:'. A blue button labeled 'Check Out' is visible. Below the appointment details, the 'Service Status' is 'Scheduled' and the 'Service Code' is 'RN'. The 'Office' is 'NextGen of Palm Beach County' and the 'Office Phone' is '(561) 447-7111'. A 'Note from Client Record' states 'The gate number is 4321'. At the bottom, there are two buttons: 'View Service Plan' and 'Client Chart', with the 'Client Chart' button highlighted by a red rectangle. A 'Save' button is located at the bottom right of the screen.

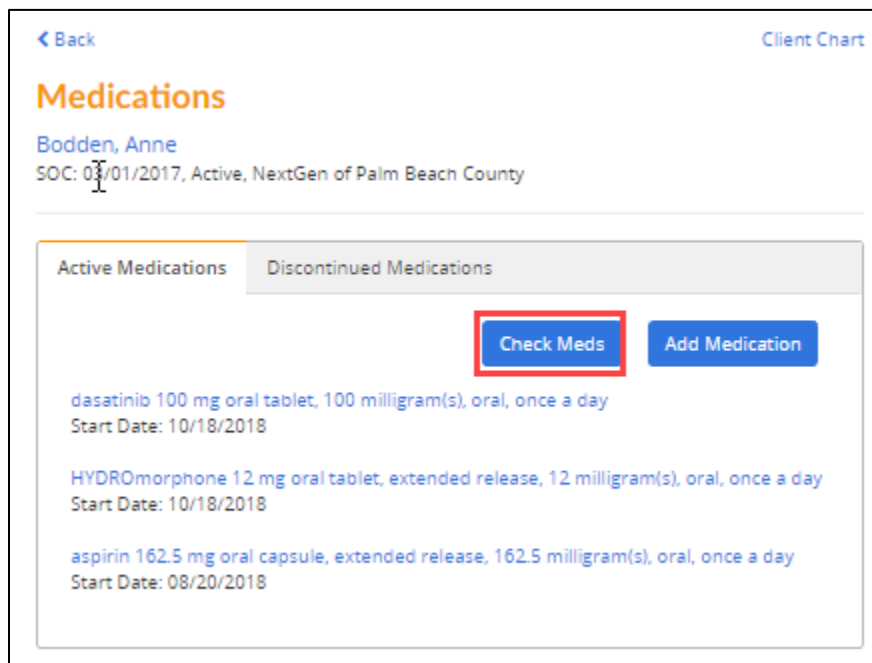


3. Tap the **Medications** tile. The Medications page displays the Active Medications tab listing the medications the client is currently taking or will start taking on a future date. The **Check Meds** button provides you with any details of Drug to Drug interactions and Dosage details of results to the medications. The **Add Medication** button allows you to enter a new medication. The Discontinued Medications tab lists the client’s discontinued medications.

Checking a Clients Medication

To run a client’s medication check:

1. When there is at least one active medication a “Check Meds” button appears. To run medications checks, tap **Check Meds**.



The Medications page, Drug to Drug Interactions, Dosage Checks and Duplicate Therapies results will be shown. Use the blue navigation links to go directly to the item you want to view.

Drug to Drug Interactions:

- Displays the medication names that interact with each other, Interaction Type, Severity and details.
- Interactions are displayed in severity order (Major, Moderate and Minor).
- If there are no Drug to Drug Interactions, then a message displays: “No drug interactions found”.

Dosage Checks:

- Client age and gender are required for dosage checks.
- Only age and gender are considered for dosage checks.
- Prescribed single dose and prescribed daily dose warning results appear.
- If there are no dosage warnings, then a message displays: “No dosage warnings found”.

Duplicate Therapies:

- Displays both duplicate medication names and dosage amounts.
- If there are no duplicate therapies, then a message displays, “No duplicate therapies found”

The following is an example of a client with no medication warnings found:

The screenshot shows a mobile application interface for a client named Anne Bodden. At the top, there are navigation links for 'Back' and 'Client Chart'. The main heading is 'Medications'. Below this, the client's name 'Bodden, Anne' is displayed, along with her SOC (03/01/2017), status (Active), and the provider (NextGen of Palm Beach County). The schedule date is listed as 12/05/2018. A horizontal bar contains three links: 'Drug to Drug Interactions | Dosage Checks | Duplicate Therapies'. The 'Drug to Drug Interactions' section shows 'No drug interactions found'. The 'Dosage Checks' section includes a note that only age and gender are considered. It lists 'Acetaminophen 160 mg oral tablet, chewable' with two bullet points: 'Prescribed single dose is low, under by 5 units (1.54%)' and 'Prescribed daily dose has passed'. The 'Duplicate Therapies' section shows 'No duplicate therapies found'. At the bottom, there is a 'WARNING DISCLAIMER' link.

The following is an example of a client with medication warnings found:


[← Back](#) [Client Chart](#)


Medications

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County
Schedule Date: 12/04/2018


[Drug to Drug Interactions](#) | [Dosage Checks](#) | [Duplicate Therapies](#)

Drug to Drug Interactions

 Acetaminophen 160 mg/5 mL oral liquid ↔
HYDRomorphine 12 mg oral tablet, extended release
Interaction Type: Acetaminophen / Opioid Analgesics
Severity: Minor
Opioid Analgesics may decrease the absorption of Acetaminophen. The extent to which this decreases total systemic exposure to acetaminophen ... [Show More](#)


 Acetaminophen 325 mg oral tablet ↔
HYDRomorphine 12 mg oral tablet, extended release
Interaction Type: Acetaminophen / Opioid Analgesics
Severity: Minor
Opioid Analgesics may decrease the absorption of Acetaminophen. The extent to which this decreases total systemic exposure to acetaminophen ... [Show More](#)

Dosage Checks *(* only age and gender are being considered for dosage checks)*

 Acetaminophen 160 mg/5 mL oral liquid

- Prescribed single dose is low, under by 165 units (50.77%)
- Prescribed daily dose has passed

Duplicate Therapies

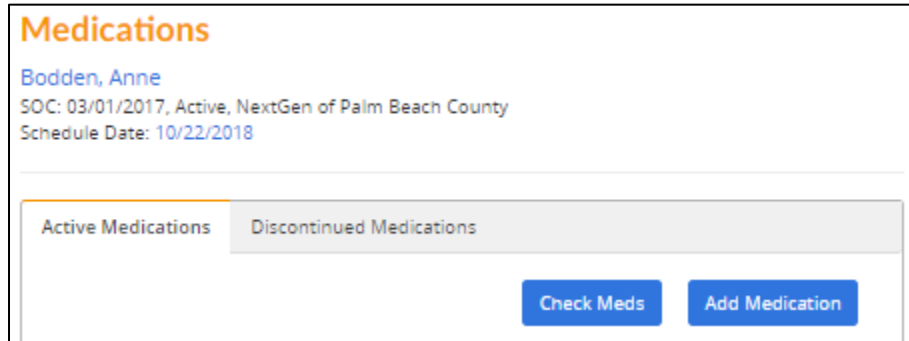
 Drug Class - Acetaminophen

Drug 1 - Acetaminophen 325 mg oral tablet
Drug 2 - Acetaminophen 160 mg/5 mL oral liquid

[WARNING DISCLAIMER](#)

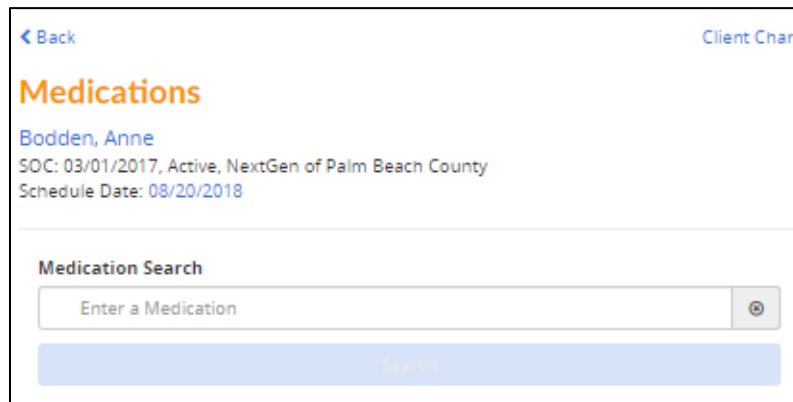
Adding a Medication

1. To add a medication, tap **Add Medication**.

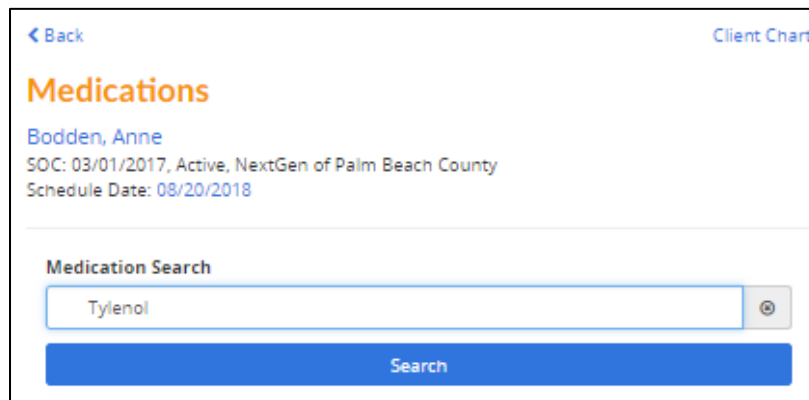


Note: If you are not checked into a client, you cannot add medications.

The application allows you to search for a medication by entering three or more characters.



2. Enter the medication you want to search for, such as Tylenol.



3. Tap **Search**.

Medications

Bodden, Anne

SOC: 03/01/2017, Active, NextGen of Palm Beach County

Schedule Date: 08/20/2018

Medication Search

Tylenol

Search

97 distinct record(s) found

Routes:

Oral

Dosing Forms:

Tablet, Chewable

Tablet, Disintegrating

Liquid

Suspension

Capsule

Tablet

Tablet, Extended Release

Kit

Syrup

Solution

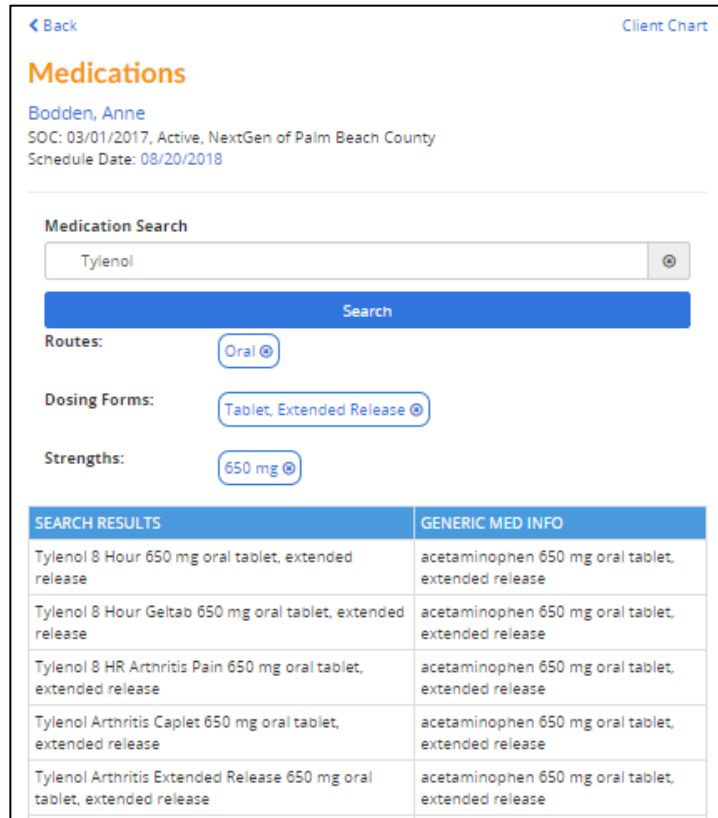
| SEARCH RESULTS | GENERIC MED INFO |
|--|--|
| Children's Tylenol 160 mg oral tablet, chewable | acetaminophen 160 mg oral tablet, chewable |
| Junior Strength Tylenol 160 mg oral tablet, chewable | acetaminophen 160 mg oral tablet, chewable |

A list of options appears for you to select the medication routes, dosing forms and strengths. When tapping options, the application filters the specified medication(s). For example, if you select a dosing form of **Tablet, Extended Release**, the application will filter to display just those medications. The available filters are optional.

The left hand column displays based on the “search” and the right hand column is the generic equivalent to the search results.

Note: The Medications list is populated using the Lexicomp tables when searching and selecting medications.

4. In the search results, tap a medication to select it.



Medications

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County
Schedule Date: 08/20/2018

Medication Search

Tylenol

Search

Routes: Oral

Dosing Forms: Tablet, Extended Release

Strengths: 650 mg

| SEARCH RESULTS | GENERIC MED INFO |
|---|--|
| Tylenol 8 Hour 650 mg oral tablet, extended release | acetaminophen 650 mg oral tablet, extended release |
| Tylenol 8 Hour Geltab 650 mg oral tablet, extended release | acetaminophen 650 mg oral tablet, extended release |
| Tylenol 8 HR Arthritis Pain 650 mg oral tablet, extended release | acetaminophen 650 mg oral tablet, extended release |
| Tylenol Arthritis Caplet 650 mg oral tablet, extended release | acetaminophen 650 mg oral tablet, extended release |
| Tylenol Arthritis Extended Release 650 mg oral tablet, extended release | acetaminophen 650 mg oral tablet, extended release |

[← Back](#) [Client Chart](#)

Medications

Bodden, Anne
 SOC: 03/01/2017, Active, NextGen of Palm Beach County
 Schedule Date: 10/22/2018

Medication Search

⊗

Search

Medication Selected

⊗

⚠ Drug to Drug Interactions

⚠ Acetaminophen 650 mg oral tablet, extended release ↔
 Dasatinib 100 mg oral tablet
 Acetaminophen may enhance the hepatotoxic effect of Dasatinib. Dasatinib may increase the serum concentration of Acetaminophen.

Frequently prescribed doses and frequencies

Tylenol 8 Hour 650 mg oral tablet, extended release - 1300 milligram(s) - every 8 hours (Q8H)

* Dose

* Unit

* Frequency

PRN (As Needed)

- The frequently prescribed doses and frequencies for the selected medication will display when available. Tap, to select a **Frequently prescribed doses and frequencies** to populate the dose, unit and frequency fields if applicable. Or you can manually enter the dose, unit and frequency in the individual fields. * equals required fields, these fields must be entered to save the medication.

Results of and medications that interact with each other will display if applicable:

- Major Drug to Drug Interactions will display after the medication is selected or a message “No major drug interactions found.”
- Dosage Checks will display the results after the Dose, Unit and Frequency fields are populated or the message “No dosage warnings found.”

The following is an example of a client with medication warnings found:

[← Back](#) [Client Chart](#)

Medications

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County
Activity Date: 10/25/2018

Medication Search

Search

Medication Selected

ALPRAZolam 0.25 mg oral tablet

Drug to Drug Interactions

ALPRAZolam 0.25 mg oral tablet ↔ HYDROmorphone 12 mg oral tablet, extended release
CNS Depressants may enhance the CNS depressant effect of Opioid Analgesics.

Frequently prescribed doses and frequencies
ALPRAZolam 0.25 mg oral tablet - 0.25 milligram(s) - 3 times a day (TID)

*** Dose**
2000

*** Unit**
milligram(s)

*** Frequency**
3 times a day (TID)

Dosage Checks (* only age and gender are being considered for dosage checks)

ALPRAZolam 0.25 mg oral tablet

- Prescribed single dose is high, over by 1997 units (66566.67%)
- Prescribed daily dose is high, over by 5990 units (59900%)

PRN (As Needed)

*** Indication**

The following is an example of a client with no medication warnings found:

← Back Client Chart

Medications

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County
Activity Date: 10/25/2018

Medication Search

Vitamin c ⊕

Search

Medication Selected

Vitamin C 100 mg oral tablet, chewable ⊕

No major drug interactions found

Frequently prescribed doses and frequencies
Vitamin C 100 mg oral tablet, chewable - 100 milligram(s) - once a day (once a day)

*** Dose**

100

*** Unit**

milligram(s) ▼

*** Frequency**

once a day (once a day) ▼

No dosage warnings found

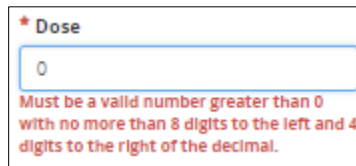
PRN (As Needed)

*** Indication**

▼

6. Tap to add, modify or select an item in the following medication fields.

- **Dose** – must be a valid number greater than zero with no more than eight digits to the left and four digits to the right of the decimal.

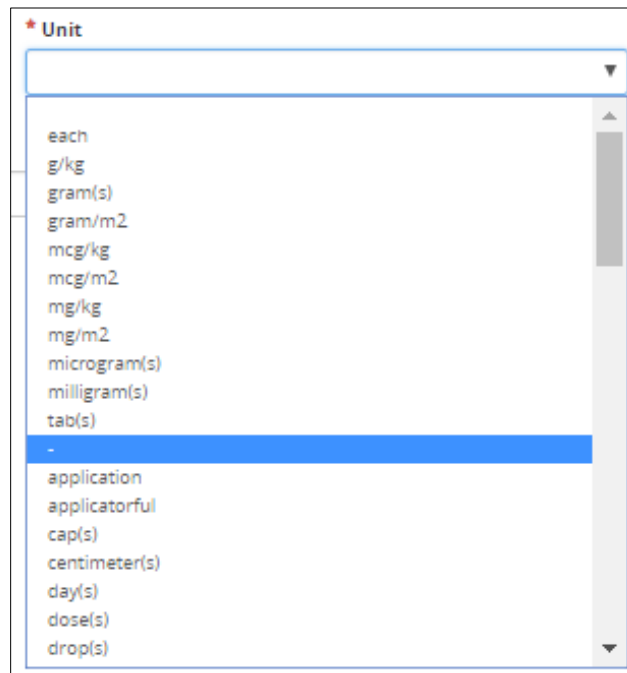


* Dose

0

Must be a valid number greater than 0 with no more than 8 digits to the left and 4 digits to the right of the decimal.

- **Unit** – a list box will display the commonly prescribe units for the selected medication when available at the top of the list. Then the list box may show a dash and then shows all the potential unit types available after.



* Unit

each

g/kg

gram(s)

gram/m2

mcg/kg

mcg/m2

mg/kg

mg/m2

microgram(s)

milligram(s)

tab(s)

-

application

applicatorful

cap(s)

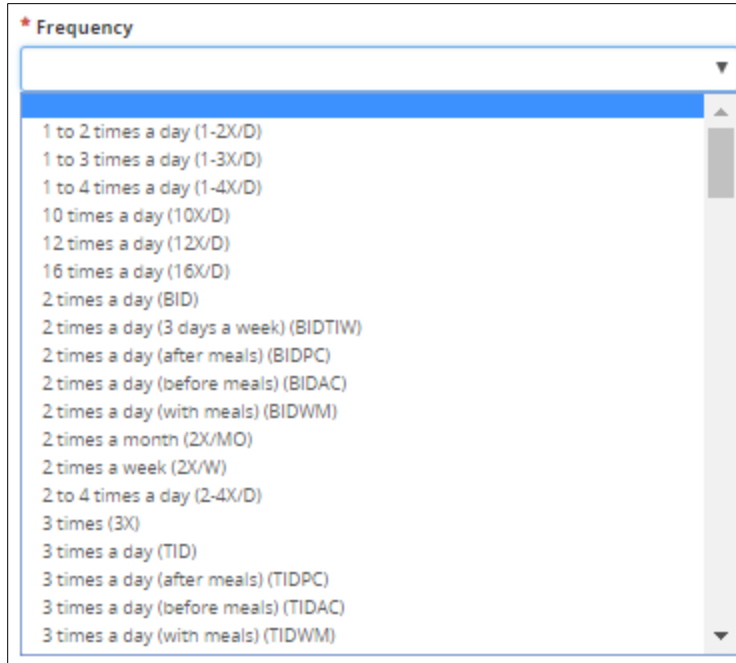
centimeter(s)

day(s)

dose(s)

drop(s)

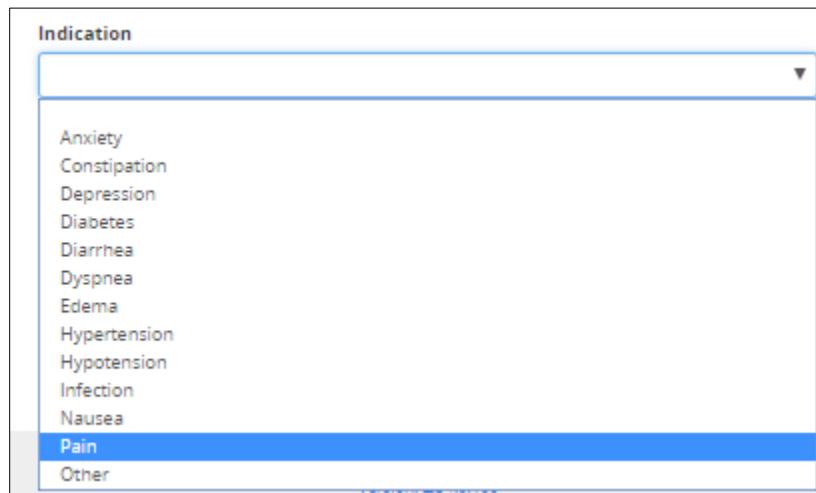
- **Frequency** – a list box of options shows how often the medication should be taken.



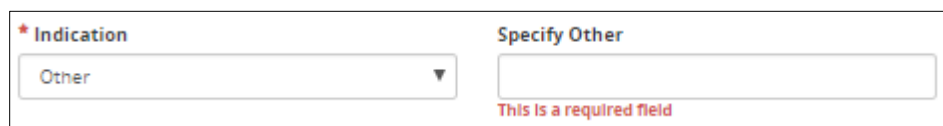
7. Check the PRN box, if the medication is prescribed as needed.



8. In the Indication list box select why the client is prescribed the medication.



Note: If you select an Indication of **Other**, a Specify Other text box appears requiring you to enter the reason for the medication. You can enter a maximum of 50 characters in the field.



Specify Other

Fever

Additional fields will display after Indication is selected.

9. Status; if applicable, tap one of the check boxes:

- **New Medication**
- **Changed Medication**

Status

New Medication Changed Medication

10. Enter special instructions. You can enter a maximum of 250 characters in the field.

Special Instructions

Take with water.

11. SIG is the Physician's instruction for how the patient should use the medication. The SIG is auto-populated based on the medication entry data fields above and is read only. Verify the SIG information is correct. The SIG is what gets printed on reports and should match the instructions the Physician has given for the medication.

SIG

Tylenol 8 Hour 650 mg oral tablet, extended release, take 13000 milligram(s) every 8 hours (Q8H) for Pain. Take with water (New)

12. The Start date default date is the schedule date or today's date when not coming from a schedule and can be modified by tapping on the date picker.

* Start Date

5/21/2018

13. The Ordering Physician field is optional. The Primary Physician from the Admission Physicians tab is defaulted. To enter or change the Ordering Physician, tap the magnifying glass to search and then select the physician that prescribed the medication.

Ordering Physician

Q Perform a Physician Lookup

Physician Search

Admission Physicians:

- Fox, Manning
- Salts, William
- Teolone, Liz

Search:

2 char minimum

Search

Cancel

Note: You must enter a minimum of two characters when searching for a physician. You can search by the first two characters of the last name, or the last name and first two characters of the first name or by entire last name, first name and tap **Search**.

Physician Search

Admission Physicians:

- Fox, Manning
- Salts, William
- Teolone, Liz

Search: fox,ma **Search** 2 record(s) found

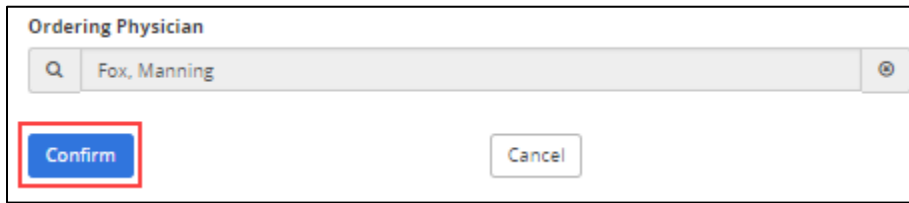
2 char minimum

| | |
|---|--|
| <ul style="list-style-type: none"> Fox, Manning Family Practice, Internal Medicine, Geriatrics NextGen of Palm Beach County | Fox Medical Associates 21230 Saint Andrews Blvd, Suite 101 Boca Raton, FL 33433-8902 |
| <ul style="list-style-type: none"> Foxx, Martin Podiatrist NextGen of Palm Beach County | West Delray Medical Group 90210 Lyons Road West Delray Beach, FL 33484 |

Showing records 1 to 2 (of 2)

Cancel

14. Tap to select a physician. After selecting a physician, tap **Confirm**.

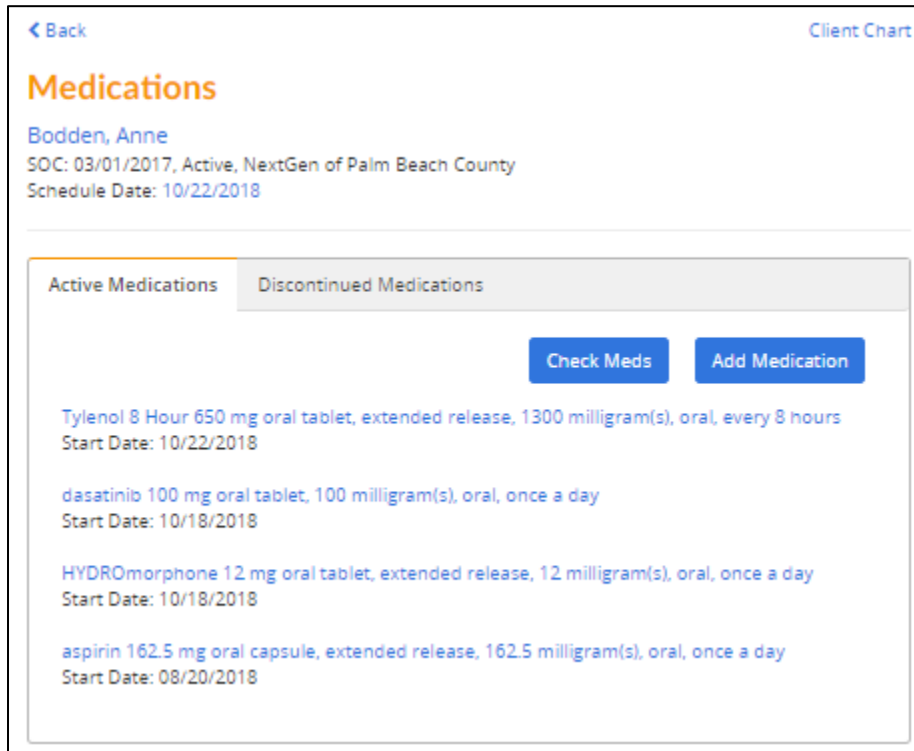


Ordering Physician

Q Fox, Manning

Confirm Cancel

The new medication now displays in the list on the Active Medications tab. Active medications are sorted by start date in reverse chronological order.



< Back Client Chart

Medications

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County
Schedule Date: 10/22/2018

Active Medications Discontinued Medications

Check Meds Add Medication

Tylenol 8 Hour 650 mg oral tablet, extended release, 1300 milligram(s), oral, every 8 hours
Start Date: 10/22/2018

dasatinib 100 mg oral tablet, 100 milligram(s), oral, once a day
Start Date: 10/18/2018

HYDROmorphine 12 mg oral tablet, extended release, 12 milligram(s), oral, once a day
Start Date: 10/18/2018

aspirin 162.5 mg oral capsule, extended release, 162.5 milligram(s), oral, once a day
Start Date: 08/20/2018

Follow the previous steps to enter additional medications for the client.

To view the details of a specific client medication, Tap the medication link.

The screenshot shows the 'Medications' page for a client named Anne Bodden. At the top, there are links for '< Back' and 'Client Chart'. The title 'Medications' is in orange. Below it, the client's name 'Bodden, Anne' is displayed, followed by 'SOC: 03/01/2017, Active, NextGen of Palm Beach County' and 'Schedule Date: 10/22/2018'. The main medication entry is 'Tylenol 8 Hour 650 mg oral tablet, extended release, 1300 milligram(s), oral, every 8 hours'. Under 'Classifications:', there is a single bullet point: 'Analgesic, Nonopioid'. Other details include 'Start Date: 10/22/2018', 'Indication: Pain', and links for 'Medication History' and 'Teaching Sheet'. The 'SIG' section contains the instruction: 'Tylenol 8 Hour 650 mg oral tablet, extended release, take 1300 milligram(s) every 8 hours (Q8H) for Pain.' At the bottom, there is a prominent red button labeled 'Discontinue'.

Medications Classifications

The Classifications for a medication display on the Medications Detail page.

The screenshot shows the 'Medications' page for a client named Anne Bodden. At the top, there are links for '< Back' and 'Client Chart'. The title 'Medications' is in orange. Below it, the client's name 'Bodden, Anne' is displayed, followed by 'SOC: 03/01/2017, Active, NextGen of Palm Beach County'. The main medication entry is 'dasatinib 100 mg oral tablet, 100 milligram(s), oral, once a day'. Under 'Classifications:', there are two bullet points: 'Antineoplastic Agent, Tyrosine Kinase Inhibitor' and 'Antineoplastic Agent, BCR-ABL Tyrosine Kinase Inhibitor'. Other details include 'Start Date: 10/18/2018', 'Medication Status: New', 'Indication: Infection', and links for 'Medication History' and 'Teaching Sheet'. The 'Ordering Physician' is listed as 'Dr. William Salts'. The 'Special Instructions' section contains the instruction: 'Take with water'. The 'SIG' section contains the instruction: 'dasatinib 100 mg oral tablet, take 100 milligram(s) once a day (once a day) for Infection. Take with water (New)'. At the bottom, there is a prominent red button labeled 'Discontinue'.

Medication Module – Medication History

Medications display a Medication History link on the details page.

Note: Entries made from a schedule, display the schedule ID as a link to the schedule.

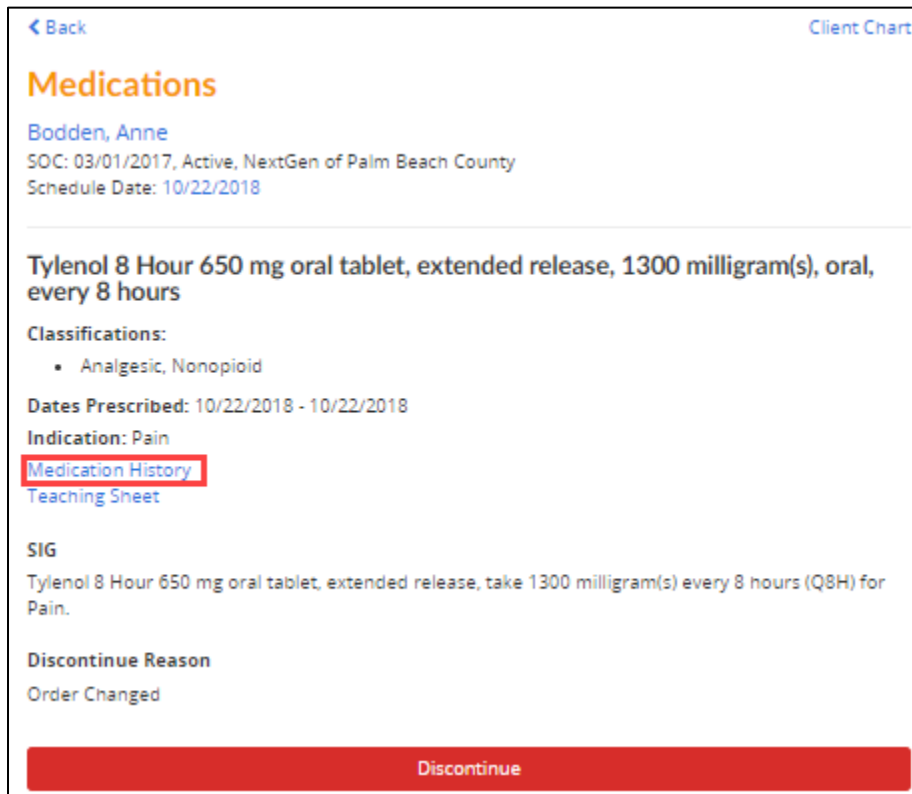
A Chart History page opens displaying Record history for the selected medication.

The following list describes the history information for a client's medication:

- User's name and the date and time of when medication was created or modified.
- Activity or Schedule change reference ID
- Start Date
- End Date (if discontinued)
- SIG
- Discontinue reason (if discontinued)

To view a client's Medication History:

1. On the Medications page, tap on a medication description.
2. On the Medications page, tap the blue **Medication History** link.



The screenshot shows a mobile application interface for medication management. At the top, there are navigation links for '< Back' and 'Client Chart'. The main heading is 'Medications' in orange. Below this, the patient's name 'Bodden, Anne' is displayed, along with her SOC information: 'SOC: 03/01/2017, Active, NextGen of Palm Beach County' and 'Schedule Date: 10/22/2018'. The medication name is 'Tylenol 8 Hour 650 mg oral tablet, extended release, 1300 milligram(s), oral, every 8 hours'. Under 'Classifications', it lists 'Analgesic, Nonopioid'. The 'Dates Prescribed' are '10/22/2018 - 10/22/2018' and the 'Indication' is 'Pain'. A red box highlights the 'Medication History' link, with a 'Teaching Sheet' link below it. The 'SIG' section shows the instruction: 'Tylenol 8 Hour 650 mg oral tablet, extended release, take 1300 milligram(s) every 8 hours (Q8H) for Pain.' The 'Discontinue Reason' is 'Order Changed'. At the bottom, there is a prominent red button labeled 'Discontinue'.

A Chart History page shows a history of entries that can be expanded to show more historical detail about the client's medication.



[← Back](#) [Client Chart](#)

Chart History

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County
Schedule Date: 10/22/2018

Record history for Medication 972

➤ RNSalokar created this record on 10/22/2018 @ 1:41:40 PM

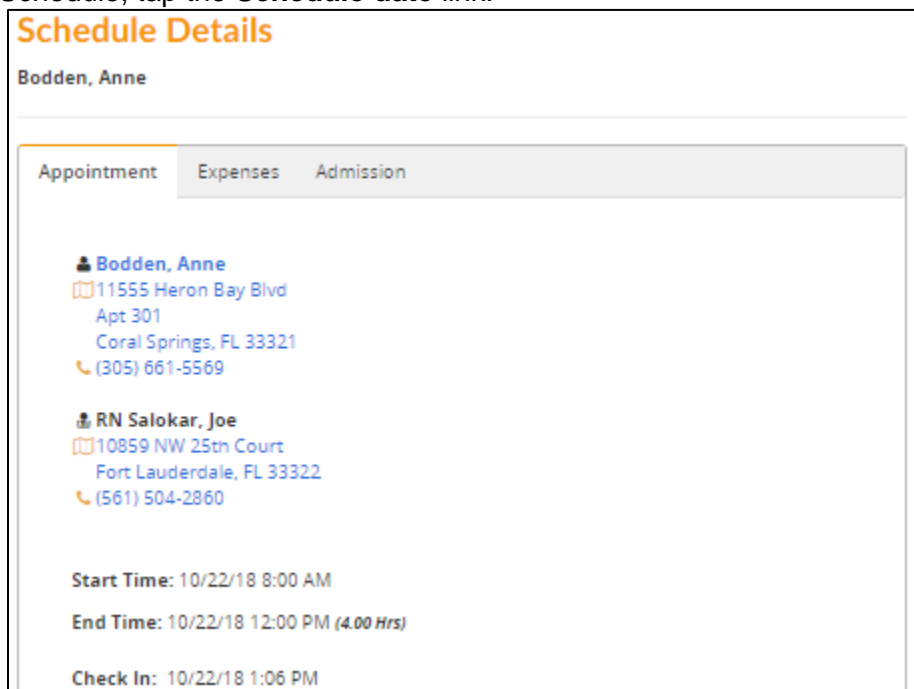
▼ RNSalokar made a record modification on 10/22/2018 @ 1:51:30 PM

via schedule [3536948](#)

Start date: 10/22/2018 12:00:00 AM
End date: 10/22/2018 11:59:59 PM
Sig: Tylenol 8 Hour 650 mg oral tablet, extended release, take 1300 milligram(s) every 8 hours (Q8H) for Pain.
DC reason: Order Changed

The information is view only and cannot be modified.

To return to the Schedule, tap the **Schedule date** link.



Schedule Details

Bodden, Anne

Appointment Expenses Admission

Bodden, Anne
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321
(305) 661-5569

RN Salokar, Joe
10859 NW 25th Court
Fort Lauderdale, FL 33322
(561) 504-2860

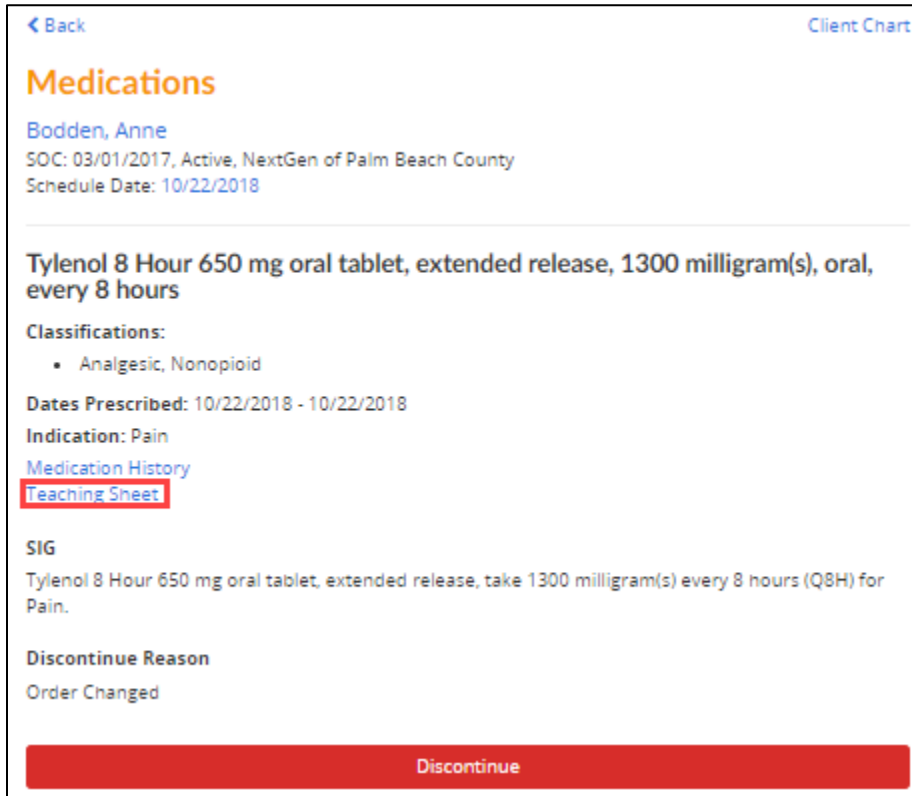
Start Time: 10/22/18 8:00 AM
End Time: 10/22/18 12:00 PM (4.00 Hrs)
Check In: 10/22/18 1:06 PM

Medication Module – Teaching Sheet

Medications display a Teaching Sheet link on the details page. Use this link to view the client's active medication information details.

To view the medication Teaching Sheet:

1. On the Medications details page, tap the **Teaching Sheet** link.



The Teaching Sheet page shows detailed information about the client's medication.






- The information is view only and cannot be modified.
- Teaching Sheets open in a new tab and can be printed using the device printer.
- In the back office, the user can right-click and select **Print** from the menu.
- To return to the Medications page, tap the **X** to close the Teaching Sheet tab.

acetaminophen (oral)

Pronunciation: a SEET a MIN oh fen

Brand: Actamin, Anacin AF, Apra, Bromo Seltzer, Children's Tylenol, Elixure Fever/Pain, Mapap, Medi-Tabs, Q-Pap, Silapap Childrens, Tactinal, Tempra Quicklets, Tycolene, Tylenol, Vitapap






What is the most important information I should know about acetaminophen?

-  You should not use this medication if you have severe liver disease.
-  An overdose of acetaminophen can damage your liver or cause death.
 - Adults and teenagers who weigh at least 110 pounds should not take more than 1000 milligrams (mg) at one time, or more than 4000 mg in 24 hours.
 - Children younger than 12 years old should not take more than 5 doses in 24 hours, using only the number of milligrams per dose that is recommended for the child's weight and age. Use exactly as directed on the label.
-  Avoid also using other medicines that contain acetaminophen (sometimes abbreviated as APAP), or you could have a fatal overdose.
-  Call your doctor at once if you have nausea, pain in your upper stomach, itching, loss of appetite, dark urine, clay-colored stools, or jaundice (yellowing of your skin or eyes).
-  Stop taking this medicine and call your doctor right away if you have skin redness or a rash that spreads and causes blistering and peeling.



What is acetaminophen?

- There are many brands and forms of acetaminophen available. Not all brands are listed on this leaflet.
- Acetaminophen is a pain reliever and a fever reducer.
- Acetaminophen is used to treat many conditions such as headache, muscle aches, arthritis, backache, toothaches, colds, and fevers.
- Acetaminophen may also be used for purposes not listed in this medication guide.

What should I discuss with my healthcare provider before taking acetaminophen?

-  You should not take acetaminophen if you are allergic to it, or if you have severe liver disease.
-  Do not take acetaminophen without a doctor's advice if you have ever had alcoholic liver disease (cirrhosis) or if you drink more than 3 alcoholic beverages per day. You may not be able to take acetaminophen.
-  Your doctor will determine whether acetaminophen is safe for you to use during pregnancy. Do not use this medicine without the advice of your doctor if you are pregnant.
-  Acetaminophen can pass into breast milk and may harm a nursing baby. Tell your doctor if you are breast-feeding a baby.
-  Do not give this medicine to a child younger than 2 years old without the advice of a doctor.

How should I take acetaminophen?

-  Use exactly as directed on the label, or as prescribed by your doctor. Do not use in larger or smaller amounts or for longer than recommended.
-  Do not take more than your recommended dose. An overdose of acetaminophen can damage your liver or cause death.
 - Adults and teenagers who weigh at least 110 pounds (50 kilograms): Do not take more than 1000 milligrams (mg) at one time. Do not take more than 4000 mg in 24 hours.
 - Children younger than 12 years old: Do not take more than 5 doses of acetaminophen in 24 hours. Use only the number of milligrams per dose that is recommended for the child's weight and age. Use exactly as directed on the label.

Discontinuing a Medication

1. To discontinue a medication, from the Medications details page, tap **Discontinue**.



Discontinue Medication

Discontinue Date *

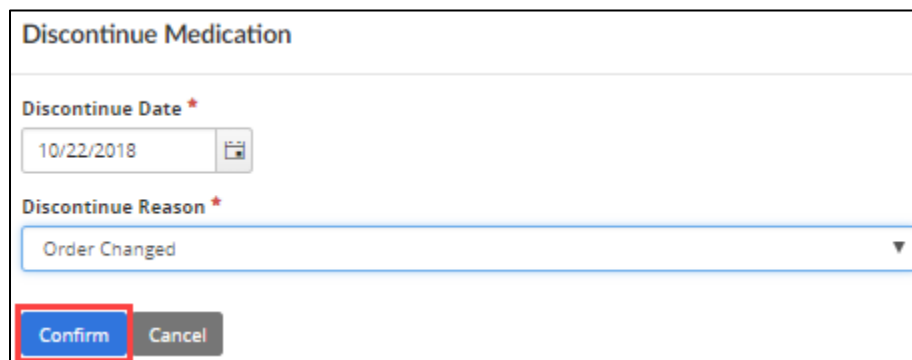
10/22/2018

Discontinue Reason *

Confirm Cancel

2. Enter the date the medication will be discontinued. The default date is the schedule date or today's date and can be changed by tapping the date picker when not coming from a schedule.
3. Enter the reason for discontinuing the medication.

Note: If you select an Discontinue Reason of **Other**, a Please Specify Other text box appears requiring you to enter the reason for the discontinuation of medication. You can enter a maximum of 50 characters in the field.



Discontinue Medication

Discontinue Date *

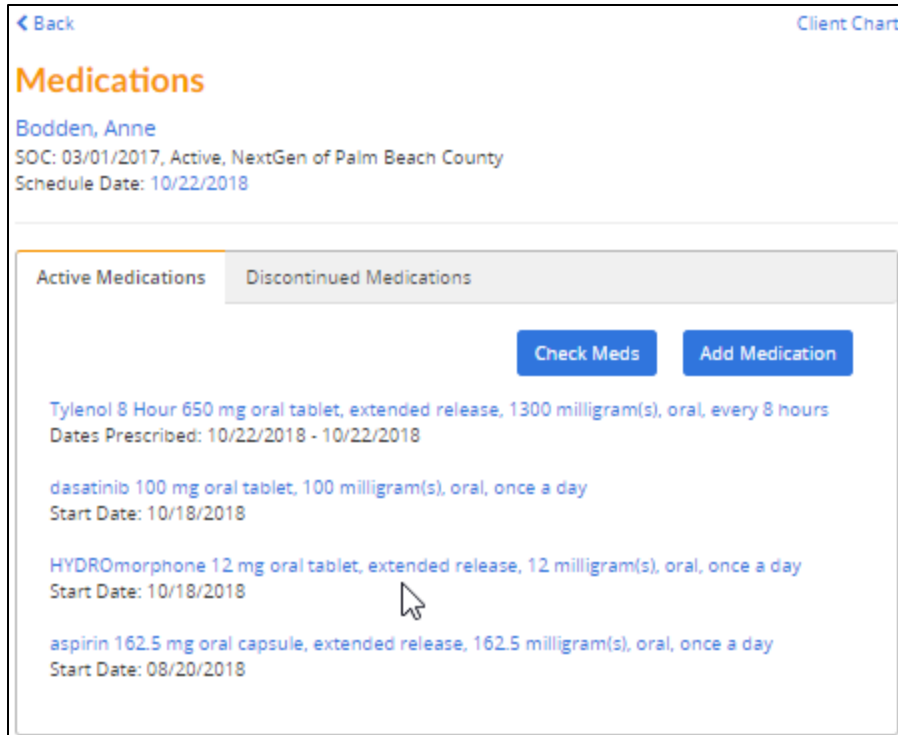
10/22/2018

Discontinue Reason *

Order Changed

Confirm Cancel

4. Tap **Confirm**. The view returns to the Active Medications tab.




5. Discontinued Medications appear on the Active Medications tab until midnight of the discontinued date (today or a future date), and then is moved to the Discontinued Medications tab. Discontinued medications are sorted by start date in reverse chronological order.




Entering Mileage and Client Expenses

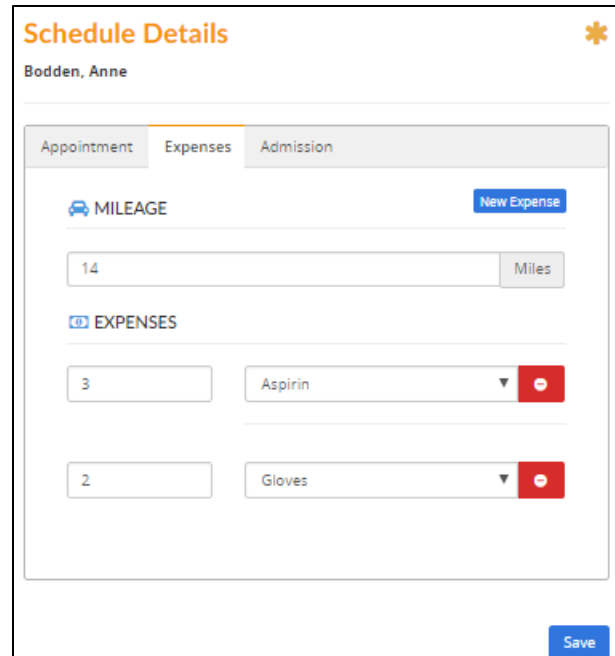
To enter expenses you incurred during the client visit, do the following:

1. On the Schedule Details page, tap **Expenses** tab. Add mileage incurred during your visit with the client.
2. Tap **New Expense**  and select additional expenses from the list box and enter a quantity amount.

Note: These expenses are reviewed and approved by your Home Care Agency office. An orange asterisk is shown in the upper right corner when changes are pending. When expenses are saved, the asterisk disappears.

Expenses can be deleted by tapping on the red delete icon  to the right of the expense description. A confirmation message appears for you to continue or cancel.

3. Tap **Save** to complete your expenses.



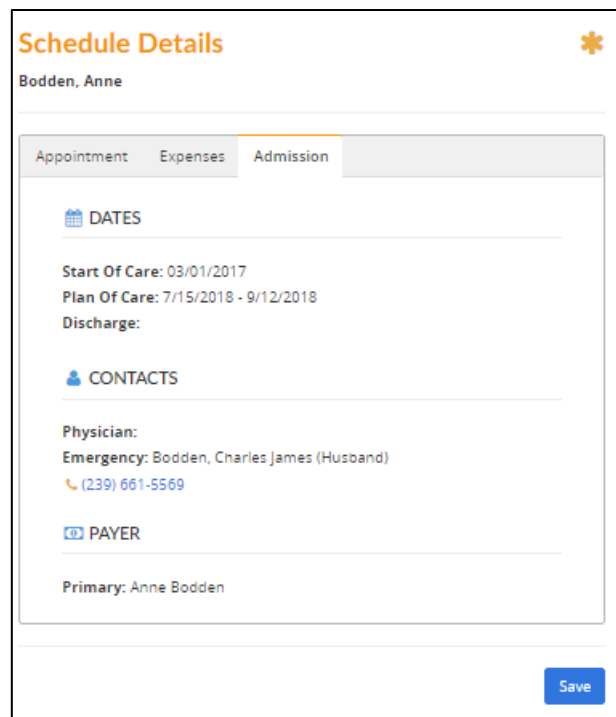
Screenshot of the Schedule Details page, Expenses tab. The page shows a 'MILEAGE' section with a text input field containing '14' and a 'Miles' label. Below it is an 'EXPENSES' section with two items: 'Aspirin' and 'Gloves'. Each item has a quantity input field (containing '3' and '2' respectively) and a red delete icon. A 'New Expense' button is in the top right, and a 'Save' button is in the bottom right.

Viewing Client Admission

To view client Admission information, do the following:

1. On the Schedule Details page, tap **Admission** tab. You can review the following client information:
 - **Dates** - Start Of Care, Plan of Care and Discharge dates
 - **Contacts** - Primary Care Physician and Emergency contact
 - **Payer** - Primary payer

Note: Items on the Admission tab are read only. Changes must be done by your Home Care Agency office.



Screenshot of the Schedule Details page, Admission tab. The page shows 'DATES' information: Start Of Care: 03/01/2017, Plan Of Care: 7/15/2018 - 9/12/2018, and Discharge. Below is 'CONTACTS' information: Physician: Emergency: Bodden, Charles James (Husband), (239) 661-5569. Below is 'PAYER' information: Primary: Anne Bodden. A 'Save' button is in the bottom right.

Checking Out of the Client Location and Publishing a Service Plan

After all tasks and reporting notes are complete and sufficient scheduled time has gone by, you are now ready to have the client sign the Daily Visit sheet to complete the checkout process.

To begin the checkout process:

1. On the **Appointment** tab, scroll down and tap **Check Out**.

Schedule Details ✱

Bodden, Anne

Appointment Expenses Admission

Bodden, Anne
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321
(305) 661-5569

RN Salokar, Joe
10859 NW 25th Court
Fort Lauderdale, FL 33322
(561) 504-2860

Start Time: 8/21/18 8:00 AM
End Time: 8/21/18 12:00 PM (4.00 Hrs)

Check In: 8/20/18 1:47 PM
Check Out:

Check Out

Service Status: Scheduled
Service Code: RN

Office: NextGen of Palm Beach County
Office Phone: (561) 447-7111

Note from Client Record:
The gate number is 4321

View Service Plan

Client Chart

2. A Visit Summary shows the following information for your client visit:

- Client name
- Draft Service Plan (when one exists) shows all the tasks and frequency to be done by the Home Health Aide.
Note: A frequency on an assigned task is completed from the Client page on the Service Plan tab and is optional.
- The Expenses area shows a summary of all items by units occurred during the client visit.

3. Tap **Next**.

Visit Summary
Bodden, Anne

DRAFT SERVICE PLAN

Personal Care

- **Bathing - Tub/Shower** (7 times per week, Use body lotion)
- **Wash Hair** (5 times per week, Use warm water, shampoo and conditioner)
- **Comb/Brush Hair** (5 times per week, Use a soft brush)
- **File/Clean Nails** (As needed)
- **Oral Hygiene** (14 times per week)
- **Skin Care** (3 times per week)
Modified by msalokar
- **Turn in Bed** (7 times per week)

Nutritional Services

- **Encourage Fluids** (7 times per week)

Vital Signs

- **Temperature (F)**

EXPENSES

12 Miles
Aspirin 3 Units
Gloves 2 Units


Back Next

4. The Visit Summary Review page displays showing your GPS location results status. You must certify the visit time is accurate by reviewing the Check In and Check Out times. Tap **Yes** or **No** to certify the visit times.
5. If the caregiver answers **Yes**, the Notes field is optional and the caregiver can tap **Next** to continue the check out.
6. If the caregiver answers **No**, the Notes field and at least one of the Override Time field is required to be filled in before continuing to complete the visit.
 - In the Notes field, the caregiver is required to explain why they answered No.
 - The Notes field has a maximum of 500 characters.
 - The caregiver is required to enter an Override Time for the Check In and/or Check Out field.
 - The **Next** button will not be enabled until all required fields are entered.

Important! The Check In and Check Out clock time picker can be different depending on the user interface of your device.

7. Tap **Next**.

8. Enter your 4-digit Caregiver PIN.

Note: If you do not enter a PIN or enter the wrong pin, a message “PIN is invalid”  appears in red. If you forgot your caregiver PIN, navigate to your account setting and select **Manage Signature Pin** to change your PIN.

9. Tap **Next**.

10. Scroll to the bottom of the page, rotate the device (if needed) and tap on the **Capture Client Signature** pane. This page is for the client to review the visit summary and sign.

Visit Summary
Bodden, Anne

VISIT TIME

Check In: 12:00 PM Check Out: 9:00 AM

CAREGIVER PIN

PIN:
.....

Back Skip Next

Note: If the client cannot sign in the pane, tap **Skip** or contact your Home Care Agency office for authorization options.

Visit Summary

Bodden, Anne

VISIT TIME

Check In: 2:25 PM

Check Out:

DRAFT SERVICE PLAN

Personal Care

- **Bathing - Tub/Shower** (7 times per week, Use body lotion)
- **Wash Hair** (5 times per week, Use warm water, shampoo and conditioner)
- **Comb/Brush Hair** (5 times per week, Use a soft brush)
- **File/Clean Nails** (As needed)
- **Oral Hygiene** (14 times per week)
- **Skin Care** (3 times per week)
Modified by msalokar
- **Turn in Bed** (7 times per week)

Nutritional Services

- **Encourage Fluids** (7 times per week)

Vital Signs

- **Temperature (F)**

EXPENSES

12 Miles
Gloves 2 Units
Aspirin 3 Units

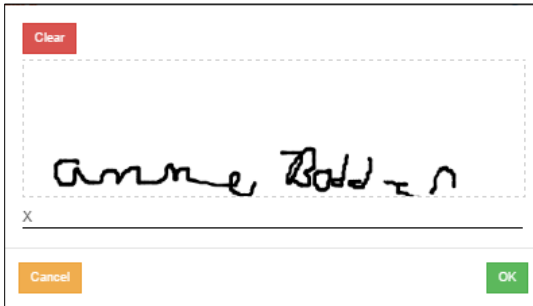
CLIENT SIGNATURE

Press here to capture signature

Back

Skip

11. Ask the client to sign on the line with their finger or provide a stylus for them to sign in the signature pane. Optionally, the client can tap **Clear** to resign again.



12. After signing tap **OK**.

13. Scroll down and tap **Accept**.

Bodden, Anne

VISIT TIME

Check In: 8:00 AM Check Out: 2:00 PM

DRAFT SERVICE PLAN

Personal Care

- Bathing - Tub/Shower
- Wash Hair
- Comb/Brush Hair

Nutritional Services

- Prepare/Serve Breakfast
- Prepare/Serve Lunch
- Encourage Fluids

Household Duties

- Straighten Bedroom

Measurements

- **Weight** (Notify supervisor if weight falls below 100 pounds.)

Vital Signs

- Temperature (F)

Meal Preferences

- **Breakfast** (Prepare and Serve)
- **Lunch** (Prepare and put in fridge)
- **Food Dislikes** (Hard or spicy)

Car

- **Car** (Can use car if client wants to go out)

EXPENSES

12 Miles
Aspirin 3 Units
Gloves 2 Units

CLIENT SIGNATURE

Press here to change signature

Anne Bodden

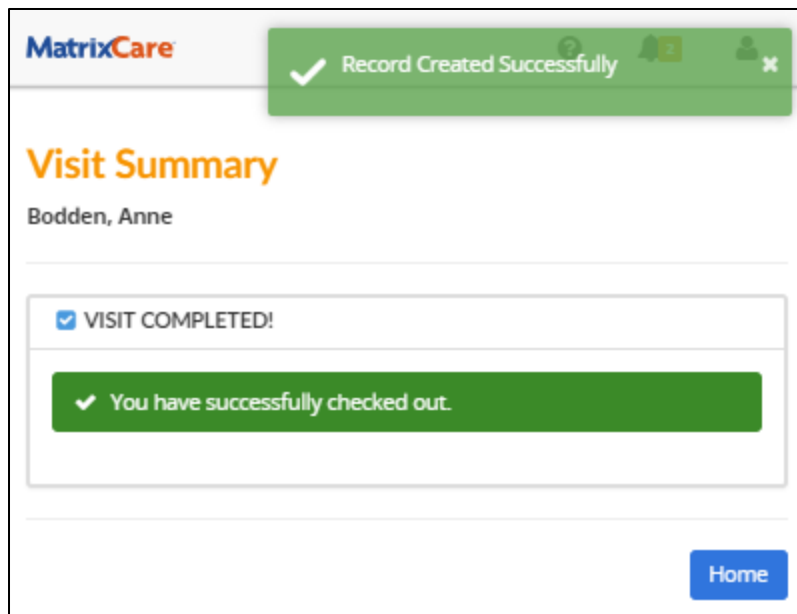
Back Accept

14. Tap **Complete** to record the checkout.



Note: Check out times that were not overwritten will continue to increment until **Complete** is tapped. Override times will not keep incrementing.

15. A message displays stating the record created successfully and you have successfully checked out of the visit. Tap **Home** to return back to the Home page or you can sign out of the mobile application.



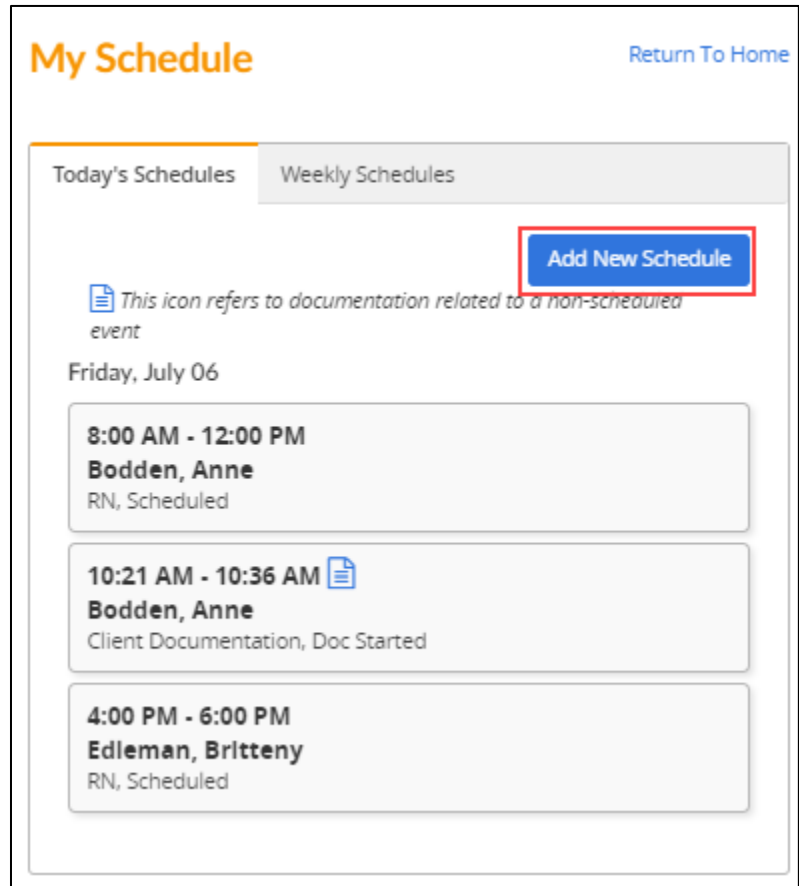
Pressing **Home** brings you back to the tiles on the main page.

Adding a New Schedule **UPDATED**

A skilled professional user can create a new schedule by tapping the **Add New Schedule** button when viewing Today's Schedules.

To add a new schedule on an existing client:

1. From the Home Page tap **My Schedule** to display Today's Schedules.
2. Tap **Add New Schedule** and the My Client list displays.
3. Select the client you want to create the new schedule for.



The Appointment tab displays with the Schedule information.

4. When there is one Admission for the schedule date, that admission will be the default admission.

Schedule Details
Bodden, Anne

Appointment

Bodden, Anne
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321
(305) 661-5569

Office: NextGen -R- Palm Beach County Office Phone: (561) 990-8306

Admission SOC: 3/1/17

Note from Client Record:
The gate number is 4321

Start:
10/26/2018 2:30 PM

End:
10/26/2018 3:00 PM (0.50 Hrs)

Service Status: Scheduled

Service Code: Select a Value

Add Schedule Cancel

When there is more than one admission available to select for the schedule date, tap the pencil next to the **Admission SOC** to view the Admissions list.

Note: The Admission is a required field in order to add a new schedule.

MatrixCare

Schedule Details
Bodden, Anne

Appointment

Bodden, Anne
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321
(305) 661-5569

Office: Office Phone:

* Admission SOC: Admission is required

Note from Client Record:
The gate number is 4321

Start:
10/26/2018 2:30 PM

End:
10/26/2018 3:00 PM (0.50 Hrs)

Service Status: Select a Value

Service Code: Select a Value

- An Admissions pop-up appears displaying multiple Admissions with the following information; Payer, Office, SOC Date, Discharge Date and Admission Status. Select one of the appropriate Admissions for your new schedule. The following shows an example of a client with multiple Admissions to select from.

Admissions:

| | |
|--------------------------|--------------------------------------|
| Payer: Boss Marks | Office: NextGen of Palm Beach County |
| SOC Date: 3/2/18 | Discharge Date: |
| Admission Status: Active | |
| Payer: Frank Jansen | Office: NextGen of Palm Beach County |
| SOC Date: 2/16/18 | Discharge Date: |
| Admission Status: Active | |
| Payer: Sophia Riya | Office: NextGen of Palm Beach County |
| SOC Date: 8/30/18 | Discharge Date: |
| Admission Status: Active | |

Cancel

Note: If the client has multiple admissions in a different office, the Service Status and Service Code will show blank. If a previously, selected service code matches the office, then the fields will automatically be populated with the correct Service Status and Service Code information.

5. The Start Date defaults to today and can be modified. The Start Time defaults to current time within 15 minutes and can be modified.
6. The End Date defaults to today, and cannot be modified. It will update automatically if the schedule crosses midnight. The End Time defaults to 30 minutes after the current time and can be modified.
7. The Service Status defaults to Scheduled, and can be modified. The Service Code does not default and a value must be selected.

Note: When all fields are populated, the Add Schedule button will be active.

8. Tap **Add Schedule**.

Schedule Details

Bodden, Anne

Appointment

Bodden, Anne
 11555 Heron Bay Blvd
 Apt 301
 Coral Springs, FL 33321
 (305) 661-5569

Office: NextGen -R- Palm Beach County Office Phone: (561) 990-8306

Admission SOC: 3/1/17

Note from Client Record:
The gate number is 4321

Start:
10/26/2018 2:30 PM

End:
10/26/2018 3:00 PM (0.50 Hrs)

Service Status: Scheduled

Service Code: RN

Add Schedule Cancel

Confirmation messages will display and the new schedule is added.

Tap the MatrixCare Logo go back to the Home page or you can sign out of the mobile application.

Overnight Schedules

A Caregiver with an overnight schedule that ends on the current date, can see that schedule on my Today's Schedules or Weekly Schedules so it's easy to find when checking out from a client visit.

For example, if a schedule extends over Tuesday night through Wednesday morning, the schedule will appear on both days, and it will include the start day and the end day in the list view. This applies to all extended schedules from the previous day.

This example shows **Today's Schedules** with a start time of 10:00 PM on Tuesday, August 21 and an end time of 3:00 AM on Wednesday, August 22:

My Schedule [Return To Home](#)

Today's Schedules Weekly Schedules [Add New Schedule](#)

Tuesday, August 21

- 8:00 AM - 12:00 PM
Bodden, Anne
RN, Scheduled
Checkout Complete
- 9:15 AM - 9:45 AM
Bodden, Anne
RN, Scheduled
- 1:00 PM - 2:00 PM
Edleman, Britteny
RN, Scheduled
- 10:00 PM (Tue) - 3:00 AM (Wed)
Bodden, Anne
RN Hourly, Scheduled

This example shows **Weekly Schedules** with a start time of 10:00 PM on Tuesday, August 21 and an end time of 3:00 AM on Wednesday, August 22. The schedule displays on Thursday (the day it starts) and also displays on Friday (the day it ends).

Tuesday, August 21

- 8:00 AM - 12:00 PM
Bodden, Anne
RN, Scheduled
Checkout Complete
- 9:15 AM - 9:45 AM
Bodden, Anne
RN, Scheduled
- 1:00 PM - 2:00 PM
Edleman, Britteny
RN, Scheduled
- 10:00 PM (Tue) - 3:00 AM (Wed)
Bodden, Anne
RN Hourly, Scheduled

Wednesday, August 22

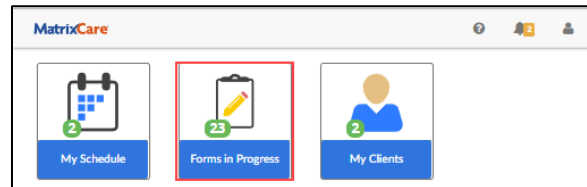
- 10:00 PM (Tue) - 3:00 AM (Wed)
Bodden, Anne
RN Hourly, Scheduled
- 8:00 AM - 12:00 PM
Bodden, Anne
RN, Scheduled

Forms In Progress

The skilled professional user can access their “Forms in Progress”. This will allow the skilled professional user to view and edit any client forms outside of the schedule.

To view forms that are currently in progress, do the following:

1. On the main mobile page, tap the **Forms in Progress** tile. A list of Forms appears, which provides a list view of all in progress forms from oldest to newest. Information in the “Forms In Progress” list view includes:



- **ID** - Form ID number. If the form is web-enabled form (look for a blue hyperlink), you will be able to open and fill out the form on your mobile device.
- **Client** - name of client associated with the form
- **Name** - form name **Note:** A blue icon is shown at the end of the form name informing you that an Event Note is available. Tap on the icon to view the event note.
- **Office** - name of office associated with the client’s admission
- **Date** - date of when the form was created

| Forms In Progress | | | | |
|-------------------|--------------|--|------------------------------|----------|
| ID | CLIENT | NAME | OFFICE | DATE |
| 8660 | Bodden, Anne | SN Daily Visit Note | NextGen of Palm Beach County | 3/31/17 |
| 9218 | Bodden, Anne | SN Daily Visit Note | NextGen of Palm Beach County | 5/03/17 |
| 9509 | Bodden, Anne | Home Environment Safety Evaluation | NextGen of Palm Beach County | 6/12/17 |
| 9835 | Bodden, Anne | Diagnosis/Surgical Procedure Code Entry | NextGen of Palm Beach County | 7/07/17 |
| 9836 | Bodden, Anne | Visit Frequency Order | NextGen of Palm Beach County | 7/07/17 |
| 9989 | Bodden, Anne | Supervisory Visits of Home Health Care Staff | NextGen of Palm Beach County | 7/25/17 |
| 10068 | Bodden, Anne | Home Environment Safety Evaluation | NextGen of Palm Beach County | 8/14/17 |
| 10547 | Bodden, Anne | Supervisory Visits of Home Health Care Staff | NextGen of Palm Beach County | 12/18/17 |

Note: Some forms may not be web-enabled, therefore they cannot be opened. Changes can only be made to Web-enabled forms. To have changes made to non-Web-enabled forms, you must contact your Home Care Agency office.

Opening, Filling Out and Saving a Client Form

1. To open and fill out a client form, tap on the blue form ID number link. The form opens to be filled out and saved.


| SUPERVISORY VISITS OF HOME HEALTH CARE STAFF | | | | | |
|---|-----------------------|-----------------------|----------------------------|---------------------------|----------------|
| I. CLIENT INFORMATION | | | | | |
| Name of Client (Last First Middle) | | | | Medical Record No. | |
| Bodden | | Anne | M | BA-0389-01 | |
| Name of Staff Member Being Supervised (Last, First, Middle) | | | | Date of Supervisory Visit | |
| | | | | 02/20/2017 | |
| Staff Person In Home During Supervisory Visit? | | | | | |
| <input type="radio"/> Yes <input type="radio"/> No <input type="text"/> | | | | | |
| II. STAFF INFORMATION | | | | | |
| ITEM | STAFF MEMBER | | | | COMMENTS |
| | EXCEEDS REQUIREMENTS | MEETS REQUIREMENTS | DOES NOT MEET REQUIREMENTS | NOT OBSERVED | |
| 1. Reports for work assignment as scheduled. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | Always on time |
| 2. Identifies self by name and title to the client. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 3. Demonstrates courteous behavior toward the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 4. Demonstrates cooperative behavior with the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 5. Demonstrates positive and helpful attitude toward the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

2. Fill out the form.
3. Scroll down the form and tap **Save**.

Settings Forms on the Schedule to Ready for Review Status

A skilled professional user can sign their completed forms when setting them to “Ready for Review Status”. The office user has the ability to review and approve or revert the forms back to In Progress after the skilled professional user has completed them.

To change the status of the form and put into Ready for Review Status:

1. On the Home page, tap **Forms in Progress**.
2. On the Forms in Progress page, tap the blue form **ID** link.
3. On the main tool bar, in the top left corner, tap the hamburger  button to display the navigation panel. The navigation panel shows the detail about the form.

SUPERVISORY VISITS OF HOME HEALTH CARE STAFF

I. CLIENT INFORMATION

Name of Client (Last First Middle): Bodden, Anne, M | Medical Record No.:

Name of Staff Member Being Supervised (Last, First, Middle): | Date of Supervisory Visit: 03/13/2017

Staff Person In Home During Supervisory Visit? Yes No

II. STAFF INFORMATION

| ITEM | STAFF MEMBER | | | | COMMENTS |
|--|-----------------------|-----------------------|----------------------------|-----------------------|----------|
| | EXCEEDS REQUIREMENTS | MEETS REQUIREMENTS | DOES NOT MEET REQUIREMENTS | NOT OBSERVED | |
| 1. Reports for work assignment as scheduled. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 2. Identifies self by name and title to the client. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 3. Demonstrates courteous behavior toward the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

4. Tap Sign Documents.

#10827: VISIT INFORMATION - SUPERVISORY VISITS OF HOME HEALTH CARE STAFF

Client: **Bodden, Anne**
 Caregiver: **RN Salokar, Joe**
 Admission Start of Care: **03/01/2017**
 Plan Of Care: **01/12/2018 - 03/12/2018**
 Status: **IN PROGRESS**

PROCESS STATUS

Sign Documents

SUPERVISORY VISITS OF HOME HEALTH CARE STAFF

Name of Client (Last First Middle): | Medical Record No. BA-302-495

Name of Staff Member Being Supervised (Last, First, Middle): | Date of Supervisory Visit: 01/30/2018

Staff Person In Home During Supervisory Visit?

| ITEM | STAFF MEMBER | | | | COMMENTS |
|--|-----------------------|-----------------------|----------------------------|-----------------------|----------|
| | EXCEEDS REQUIREMENTS | MEETS REQUIREMENTS | DOES NOT MEET REQUIREMENTS | NOT OBSERVED | |
| 1. Reports for work assignment as scheduled. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 2. Identifies self by name and title to the client. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |
| 3. Demonstrates courteous behavior toward the client and others. | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | |

The Document Process Manager popup appears.

Document Process Manager

Action: MARK AS READY FOR REVIEW ▼

Forms:

- Care Coordination Note READY FOR REVIEW
- Home Environment Safety Evaluation IN PROGRESS
- Supervisory Visits of Home Health Care Staff IN PROGRESS

Event Notes:

Pin:

Cancel Change Status

5. The Action drop down list will default to **MARK AS READY FOR REVIEW**.
6. If multiple forms are available, each form will have individual check boxes to enable or disable the action.
7. Enter any internal event notes related to the forms that you would like the office to know about. After the note is entered and the form is signed, a blue icon is shown at the end of the form name informing you that an Event Note is available to view. You can also see the note on the left-hand navigation panel. Tap on the **Expand** button to view the entire event note.

#10827: VISIT INFORMATION - SUPERVISORY VISITS OF HOME HEALTH CARE STAFF

Client: **Bodden, Anne**

Caregiver: **RN Salokar, Joe**

Admission Start of Care: **03/01/2017**

Plan Of Care: **01/12/2018 - 03/12/2018**

Status: **READY FOR REVIEW**

PROCESS STATUS

Change Status

NOTICE

Please verify that all information is c

Expand

Expanded View

Please verify that all information is correct.

OK

The note for the most recent status change will display in the navigation panel when a note is entered.

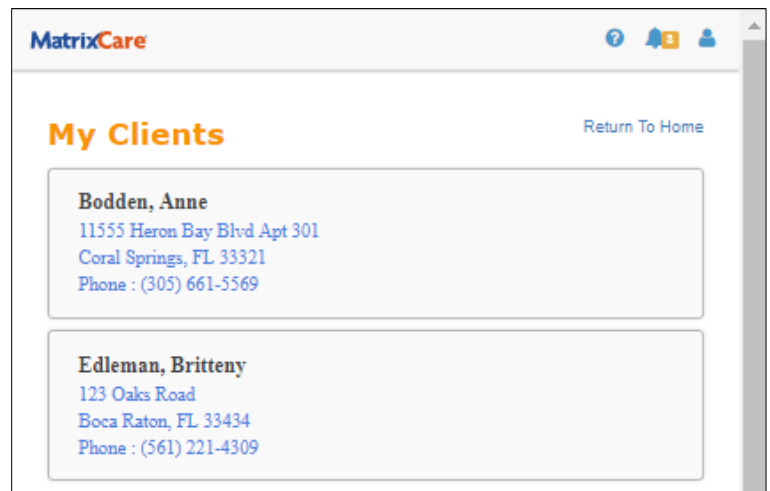
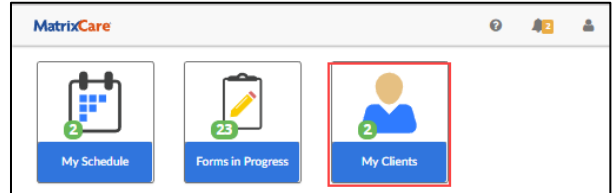
Note: The button label in the navigation menu will be “Sign Forms” when the form is in “In Progress.” The button will change to “Change Status” when the form is in “Ready for Review” or “Reviewed and Approved.”

8. Sign the form by entering your PIN. The digital signature will be populated on the signed document form in the office. You can skip adding your PIN, but the signed document form will not have your digital signature entered.
9. Tap **Change Status** to complete the form(s). The form is now ready to be reviewed by the agency for approval.
10. To view and submit additional forms in progress, press the Back link at the bottom of the form to return to the Forms In Progress list.

My Clients **UPDATED**

To view clients that you have been scheduled to visit in the last 60 days or next 60 days, do the following:

1. On the main mobile page, tap **My Clients** tile. A list of my clients appear with the client's name, address and phone number.
2. Tap the client information to view My Clients details.



The Demographics tab displays a picture of the client, along with all the client details. The Demographics tab can also be accessed by tapping on the client name in the Schedule Details Appointment tab.


The following information can be found on the My Clients Demographics tab:

- **Picture** - If a picture attachment exists on the clients record, then it will display on the Demographics tab. If the client record doesn't have a record picture attachment, then the blue ghost icon is shown.
- **Address** - Tap the address link and Google Maps opens showing a map of the location of the client's address. Use the Google Maps application to get more details on the location.
- **Phone number** - Tap the phone number link to call the client. This is dependent on your device being able to send and receive calls.
- **Email** - Tap the email link to send an email to the client. Your default email application will appear with the client's email in the "To" field.

Client

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County

Demographics Schedules Service Plan



Bodden, Anne
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321

Select Admission Client Chart

[\(305\) 661-5569 \(Home\)](#)
msalokan@gmail.com

Birth Date: 9/19/1960 **Age:** 58 **Gender:** Female
Race: White **Marital Status:** Married
SOC: 3/1/2017 **Discharge:**

Plan Of Care Duration:
8/30/2018 - 9/30/2019 (Current Plan Of Care)
Type: Direct Care **Disaster Plan Code:** Call Larry Bodden

Disaster Planning: Here brother will pick her up. 561-504-3323

Notes:

PHYSICIANS:

- Fox, Manning
- Salts, William
- Teolone, Liz

CONTACTS:

- Bodden, Charles James
- Richards, Dan
- Jean, Lisa

PAYERS:

- Florida Blue
- Anne Bodden
- Ann Kerns Ins
- Wakefield, Kathy

The Demographic tab includes information about the client, such as; birth date, age, gender, race, marital status, start of care date (SOC), discharge date (if applicable), plan of care duration dates, type of care, disaster plan code and disaster planning information. It also includes any client notes. The Mobile Notes field on the Client Demographics tab is populated from the Additional Notes field on the Advanced tab of the back office Client record. These notes are entered by the office. To make changes to these items, contact your Home Care Agency office.

Selecting Client Admissions **NEW!**

You can view and select the client's admissions information on the Client page on the Demographics tab. The Select Admission button enables you to select a specific admission to view and document in, when the client has more than one admission available.

When selecting a client that has one admission effective on today's date, that admission will display in the client details by default. A new admission information line displays in the header below the client's name showing the start of care date, admission status, and office for the displayed admission.

When selecting a client that has multiple admissions effective on today's date, or no admissions effective on today's date, no admission data will be displayed in client details by default. There will not be an admission information line in the header and the admission fields will be blank. You can press the Select Admission button to display a list of the client admission(s) and select one by tapping on it.

When selecting a client that does not have an admission or has an admission in an office you do not have permission to, the Select Admission button does not display.

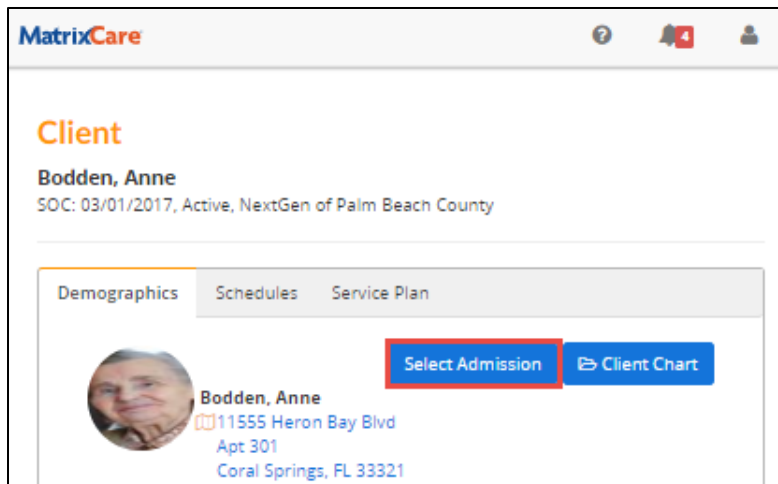
The Client and Schedule details pages header previously showed the clients status. Now the pages show the SOC date, admission status and the office of the displayed admission.

The Payers section on the Demographics tab displays payers from the Admission>Payers tab of the selected admission.

The following items display data specific to the selected admission:

- SOC
- Discharge
- Plan of Care Duration
- Physicians
- Payers
- Service Plan
- Client Chart – Medications and Forms

Note: Only admissions in offices that you have permission to will display or be available to select.



1. When tapping **Select Admission**, the client's admissions will display in descending start of care date order.



2. Tap on an admission to select it. The admission list will close, and that admission will display in Client Details. Or, pressing **Cancel** at the bottom of the list, or tapping outside the list will close the admission list and not change the admission in client details.

Note: For more information on the Plan Of Care Duration end date modification, refer to the “Recertify Plan of Care Dates” section in this guide.

The Demographic tab also includes contact information about the client’s Physicians, Contacts and Payers. The primary care physician is displayed at the top of the list, and is the Primary Physician from the client’s Admission record. Other Admission physicians are displayed in alphabetical order. The emergency contacts display first, followed by other contacts from the client’s Contact record. The primary payer is displayed at the top of the list, followed by other payers from the client’s payer record.

- To view Physician details, tap on the physician's name. The physician's full name and address appears. The physician's specialty and any notes about the physician are shown. Also listed are the physician's phone numbers and phone type.

[Client Chart](#)

Client

Bodden, Anne
Status: Active

Physician

Fox, Manning
📍 21230 Saint Andrews Blvd, Suite 101
Boca Raton, FL 33433-8902

Specialty: Family Practice, Internal Medicine, Geriatrics

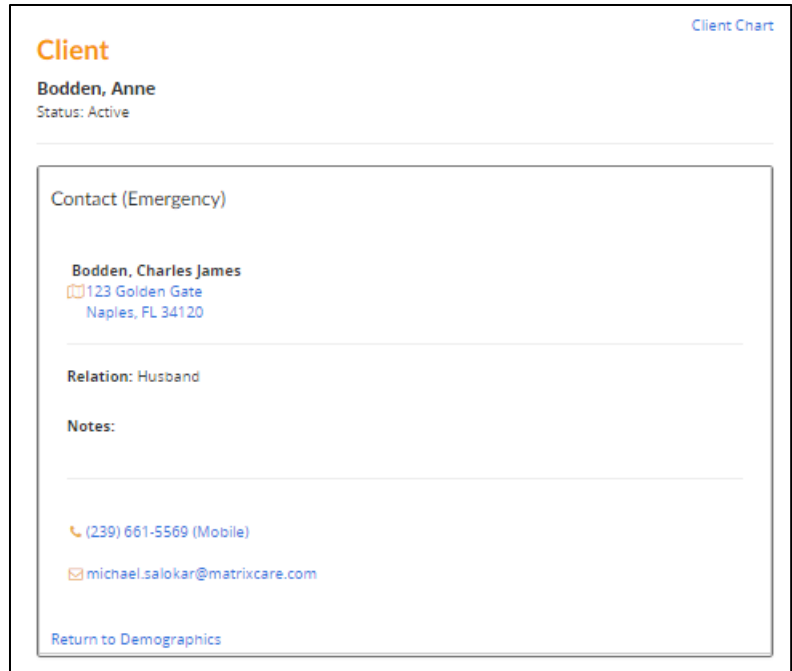
Notes:

📞 (561) 447-9303 X:12345 (Main)
📞 (561) 447-9305 (Fax)
📞 (561) 447-8899 (On Call)
📞 (754) 821-2121 (Pager)

✉️ drfox@matrixxx.com

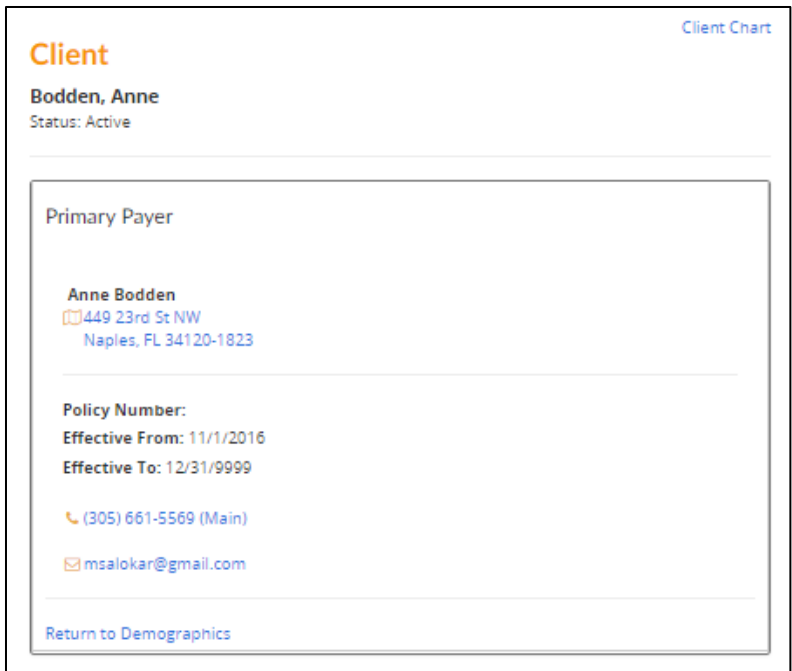
[Return to Demographics](#)

- To view Contact details, tap on the contact's name to view the contact type (such as; Emergency or Family.) The contact's full name and address appears. The Relation to the client appears and any notes about the contact. Also listed are the contact's phone numbers and phone type.



- To view Payer details, tap on the payer's name to view the payer type (such as; Primary, secondary, Tertiary or additional payer.) The payer's full name, address, phone number, email, policy number (if applicable) and effective from and to dates are shown.

Note: The information in these tabs are read only. To make changes, contact your Home Care Agency office. Use the web app back button to return back to the Client details page or tap the **Return to Demographics** link to go back to the main contacts page.



Recertify Plan of Care Dates

The Clinician can enter recertification plan of care dates or extend the current plan of care via a mobile device for Clients with an active admission, when the current plan of care ends within 14 days and no future plan of care exists.

The following are changes the Clinician can make for active clients up to 14 days prior to the end of the current plan of care:

- The current plan of care end date can be extended. The new end date defaults to 30 days and can be edited. The new end date must be greater than the current end date.
- A new recert plan of care can be created. The certification period defaults to 60 days, allowing the Clinician to modify the end date but not the start date. The end date cannot be before the start date, and cannot be after the discharge date when one exists. The copy forward feature is available and is checked by default. It will copy forward the same information as currently done via the back office. **Important!** Information copied forward is currently viewable in the back office system only.


Note: For additional information, see the POC (Plan of Care), How To's: Copy a POC (Plan of Care) help Topic to copy forward the clients plan of care.

On the My Clients > Client Demographics tab, the Plan of Care Duration will display an edit icon (pencil) 14 days prior to the end of the current plan of care date if there is not already a future plan of care date. The icon will allow the Clinician to create a new recertification plan of care.

Client

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County

Demographics Schedules Service Plan




Bodden, Anne
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321

[Select Admission](#) [Client Chart](#)

[\(305\) 661-5569 \(Home\)](#)
msalokar@gmail.com

Birth Date: 9/19/1960 **Age:** 58
Gender: Female
Race: White
Marital Status: Married

SOC: 3/1/2017
Discharge:

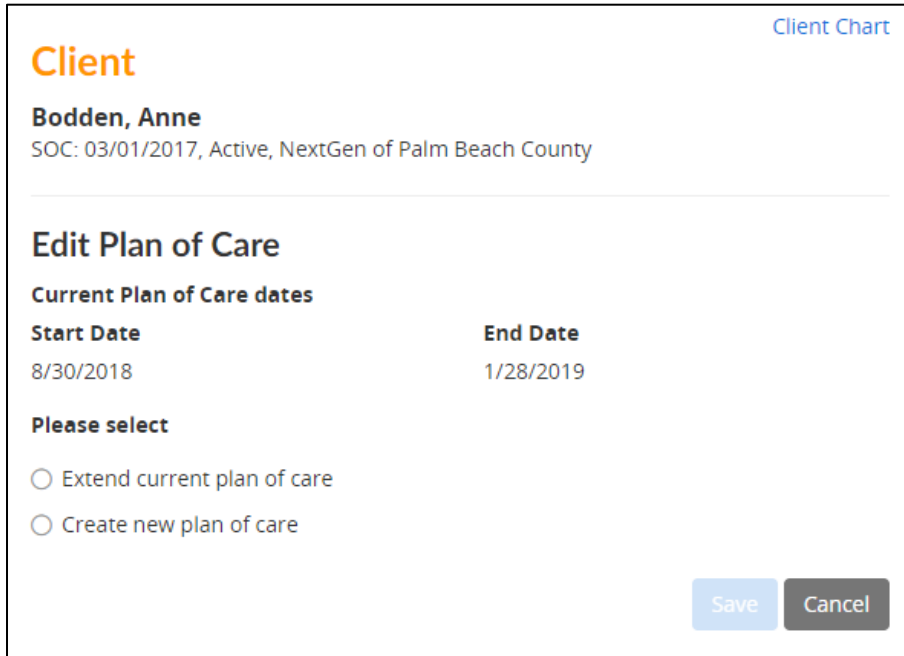
Plan Of Care Duration: 
8/30/2018 - 1/28/2019 (Current Plan Of Care)

Extending a Current Plan of Care **UPDATED**

The Clinician can extend the current plan of care dates via a mobile device for Clients with an active admission, when the current plan of care ends within 14 days and no future plan of care exists.

To extend the current plan of care end date:

1. On the Demographics tab, to the right of “Plan Of Care Duration” current dates, tap the **Pencil** button and the My Clients Edit Plan Of Care page appears.



The screenshot shows a mobile application interface for editing a client's plan of care. At the top, it identifies the client as 'Bodden, Anne' with a status of 'Active' and 'NextGen of Palm Beach County'. Below this, the 'Edit Plan of Care' section displays the current plan dates: Start Date 8/30/2018 and End Date 1/28/2019. There are two radio button options: 'Extend current plan of care' (which is selected) and 'Create new plan of care'. At the bottom right, there are 'Save' and 'Cancel' buttons.

| Current Plan of Care dates | |
|----------------------------|-----------|
| Start Date | End Date |
| 8/30/2018 | 1/28/2019 |

Please select

- Extend current plan of care
- Create new plan of care

Save Cancel

2. On the Edit Plan of Care page, tap the **Extend current plan of care** radio button and then enter the new end date. You can type the date, use the date picker, or select a quick set date.

Client Chart

Client

Bodden, Anne
 SOC: 03/01/2017, Active, NextGen of Palm Beach County

Edit Plan of Care

Current Plan of Care dates

| | |
|-------------------|-----------------|
| Start Date | End Date |
| 8/30/2018 | 1/28/2019 |

Please select

Extend current plan of care

Create new plan of care

New End Date *

02/27/2019

Quick Set

30 Days 60 Days 90 Days

120 Days 1 Year

Save Cancel

- The default End Date is 30 days, however, a set of days have been provided for the exact number of days to extend the plan of care. Days can be entered by tapping on the Quick Set buttons:
 - 30 Days
 - 60 Days
 - 90 Days
 - 120 Days
 - 1 year

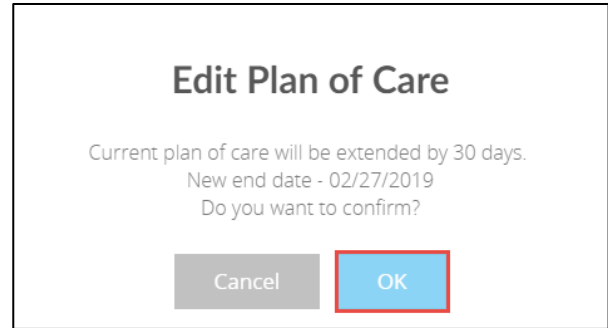
Or you can manually enter an end date in the “New End Date” field by using the date picker.

New End Date *

02/27/2019

3. Tap **Save**. The Edit Plan of Care confirmation appears prompting you to select Cancel or OK.
4. Tap **OK** to confirm that you want to extend the current plan of care with the new end date and the Demographics tab will appear. The extended plan of care dates will display in the Plan of Care Duration field.

Note: The edit pencil is no longer available when the end date is greater than 14 days.



Client

Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County

Demographics

Schedules

Service Plan

Select Admission

Client Chart

Bodden, Anne
📍 11555 Heron Bay Blvd
 Apt 301
 Coral Springs, FL 33321

📞 (305) 661-5569 (Home)

✉ msalokar@gmail.com

Birth Date: 9/19/1960 **Age:** 58
Gender: Female

Race: White
Marital Status: Married

SOC: 3/1/2017
Discharge:

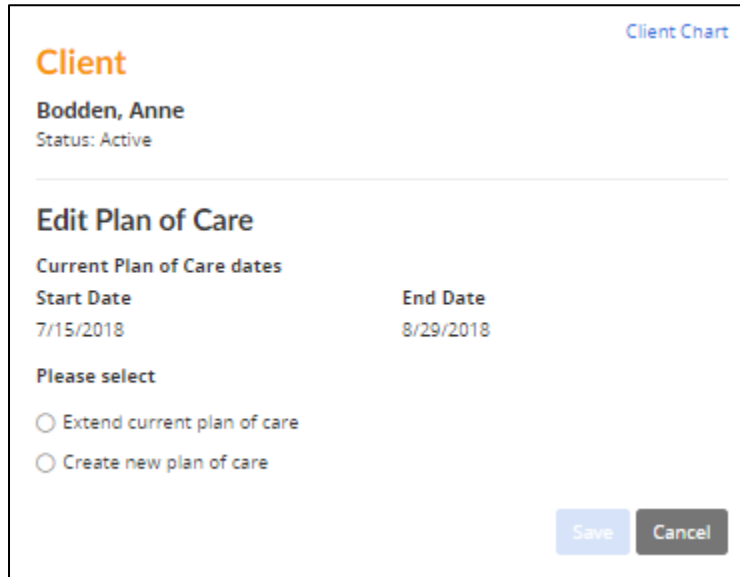
Plan Of Care Duration:
 8/30/2018 - 2/27/2019 (Current Plan Of Care)

Type: Direct Care

Creating a New Plan of Care Date

To Create a New Plan of Care Date:

1. On the Demographics tab, to the right of “Plan Of Care Duration” current dates, tap the **Pencil** button and the My Clients Edit Plan Of Care page appears.



The screenshot shows a mobile application interface for editing a client's plan of care. At the top, it displays the client's name 'Bodden, Anne' and status 'Active'. Below this, the section is titled 'Edit Plan of Care'. It shows the 'Current Plan of Care dates' with a 'Start Date' of 7/15/2018 and an 'End Date' of 8/29/2018. Underneath, there is a 'Please select' prompt with two radio button options: 'Extend current plan of care' and 'Create new plan of care'. At the bottom right, there are 'Save' and 'Cancel' buttons.

2. On the Edit Plan of Care page, tap the **Create new plan of care** radio button and enter the New Plan of Care end date. You can type the date, use the date picker, or select a quick set date.

Client Client Chart

Bodden, Anne
Status: Active

Edit Plan of Care

Current Plan of Care dates

| | |
|-------------------|-----------------|
| Start Date | End Date |
| 7/15/2018 | 8/29/2018 |

Please select

Extend current plan of care

Create new plan of care

New Plan of Care dates

| | |
|-------------------|-------------------|
| Start Date | End Date * |
| 08/30/2018 | 10/28/2018 |

Quick Set

30 Days 60 Days 90 Days

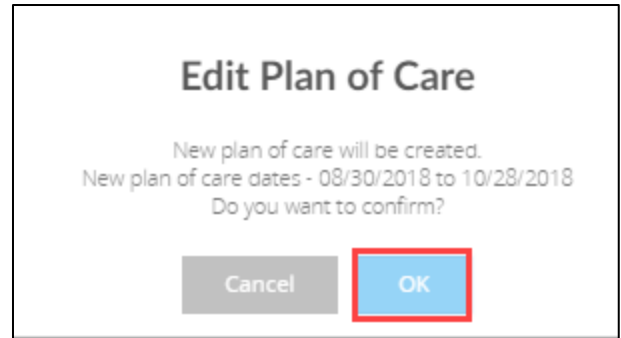
120 Days 1 Year

Copy current plan of care items to new plan of care

Save Cancel

3. On the New Plan of Care end date, the default End Date is 60 days, however, a set of days have been provided for the exact number of days for the plan of care to end. Days can be entered by tapping on the Quick Set buttons:
 - 30 Days
 - 60 Days
 - 90 Days
 - 120 Days
 - 1 year
4. When creating a new plan of care, the check box; “Copy current plan of care items to new plan of care” is checked by default and will copy your current plan of care data to the new plan of care. The checkbox can be unchecked if you do not want to copy.
5. Tap **Save**. The Edit Plan of Care confirmation appears prompting you to select **Cancel** or **OK**.

6. Select **OK** to confirm that you want a new plan of care to be created with the new dates and the Demographics tab will appear. The new plan of care dates will display in the Plan of Care Duration field. The edit pencil is no longer available.



Viewing Clients Weekly Schedule

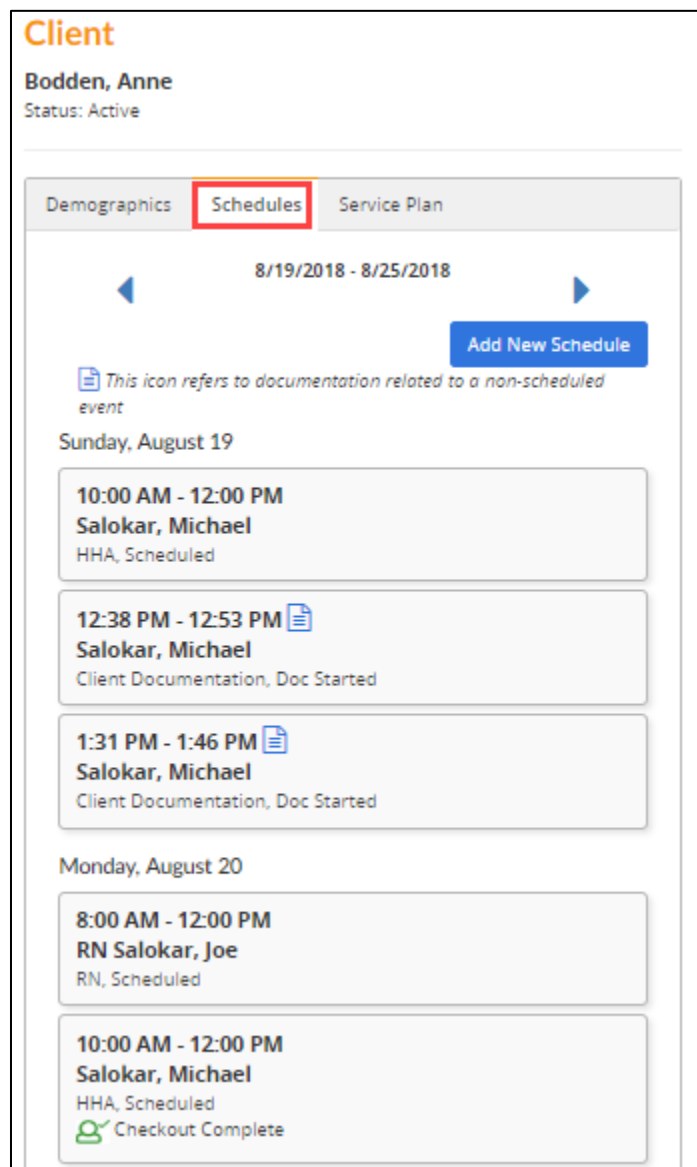
To view a client's weekly appointment schedule, do the following:

1. On the Client page, tap the **Schedules** tab.

A list of all the scheduled appointments for the week appears. The Weekly schedule includes:

- Date of the visit
- Time of the visit
- Name of the caregiver that will be visiting the client
- Service Code
- Current Status of the appointment

View the client schedule in weekly intervals by tapping the right and left arrows.



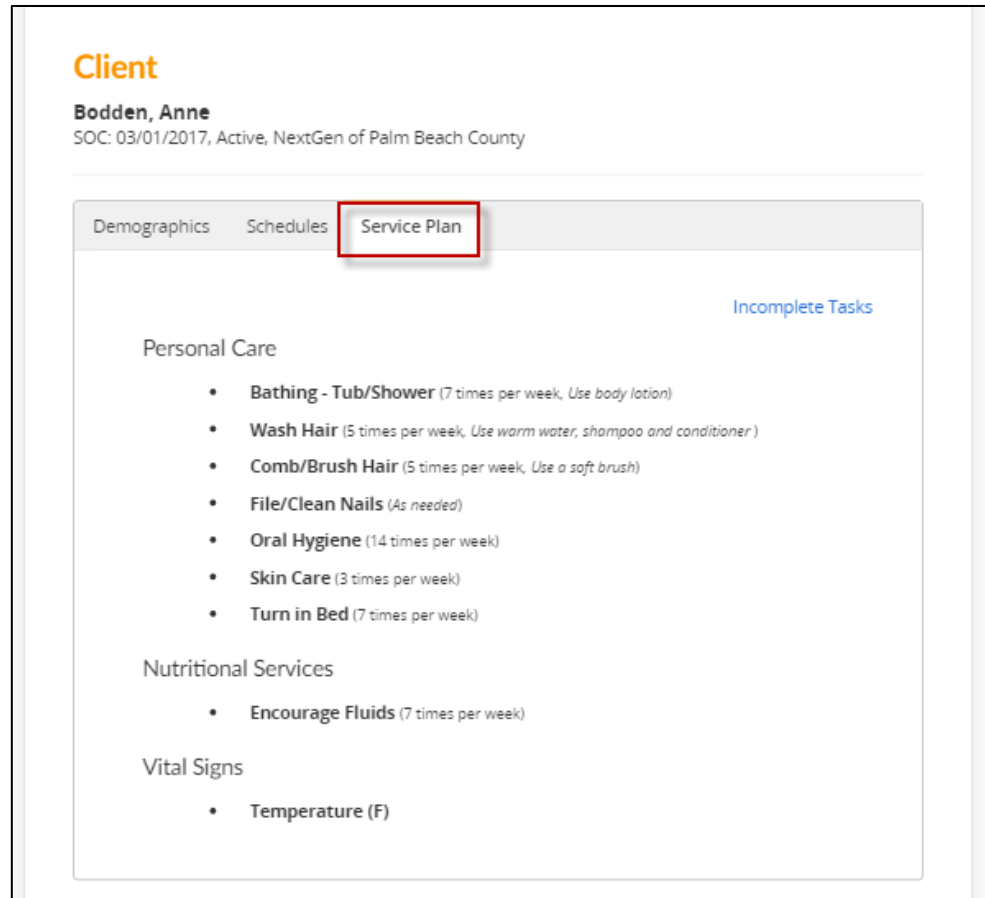
Viewing Clients Service Plan

To view a client's Service Plan, do the following:

1. On the My Clients page, tap the **Service Plan** tab. A list of all the tasks for the client service plan appears.

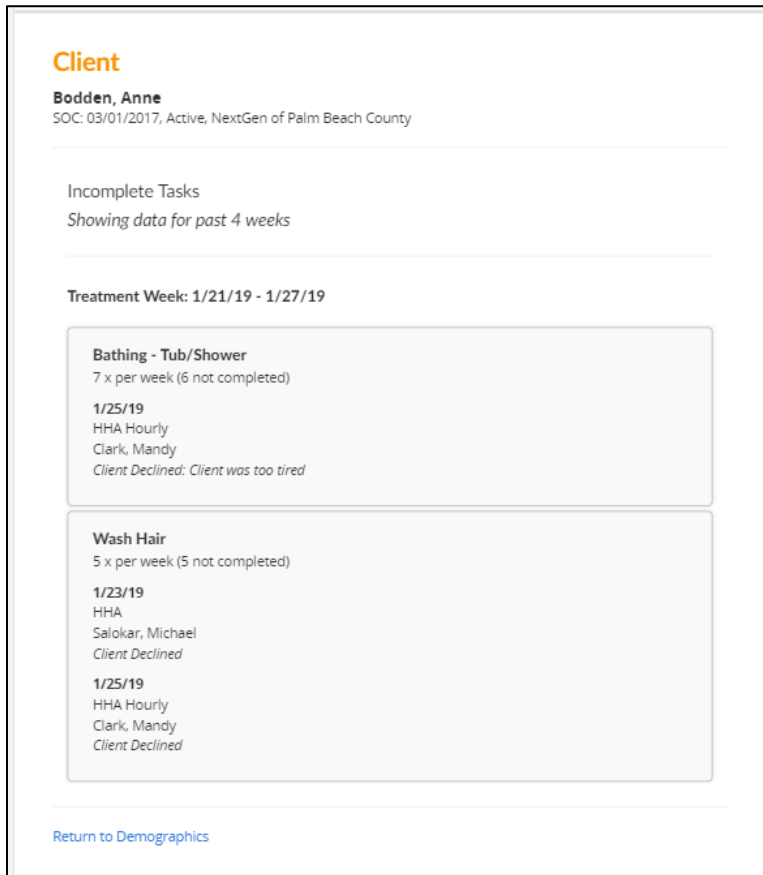
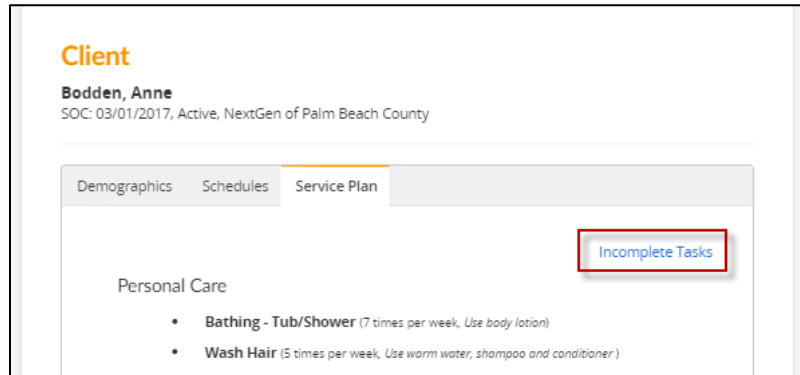
The Service Plan tab displays a list of tasks and frequency that is requested to be completed by the Caregiver. The tasks displayed are from the client's published service plan record.

Note: If a Service Plan has not been published for the Client, a message appears stating "There is no published service plan."



Viewing Incomplete Tasks **NEW!**

On the Service Plan tab, tap the Incomplete Tasks link. This will display a list, for the past 4 treatment weeks, of schedules with frequency tasks documented as not completed and the frequency was not met.



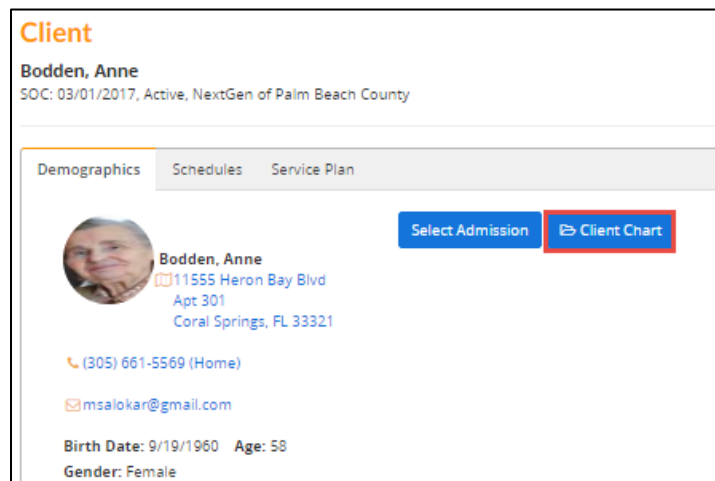
Viewing Clients Chart

Tapping the Client Chart button opens the Client Chart page showing tiles to access Forms, Medications and Inpatient Tracking.

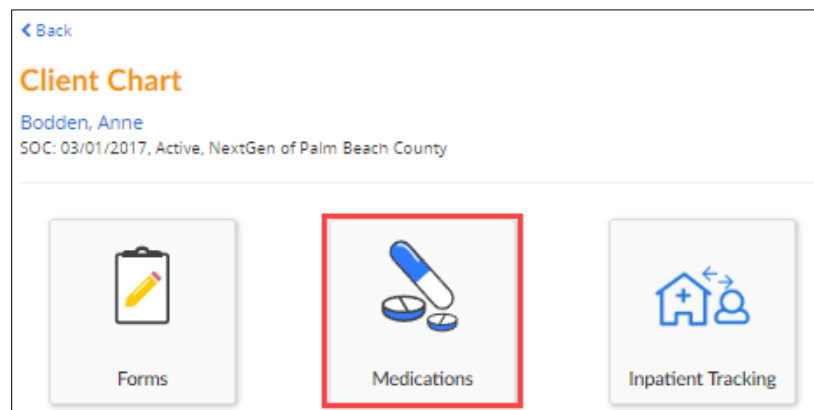
Creating Document Forms without an Associated Schedule

To create a client document form without a client schedule, do the following:

1. On the My Clients page, in the Demographics tab, tap **Client Chart**.



2. On the Client Chart page, tap the **Forms** tile.



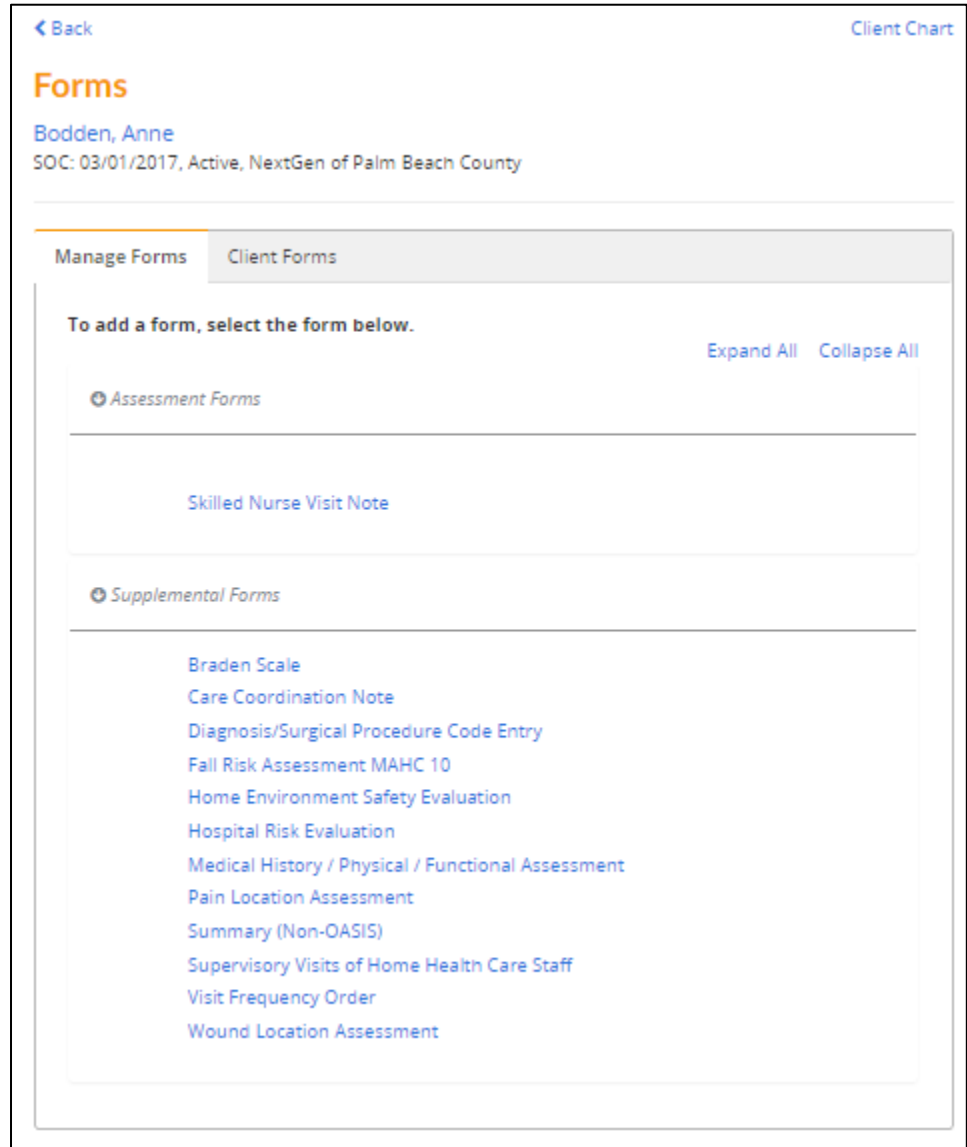
The Forms page appears allowing you to select two tabs:

- Manage Forms
- Client Forms

Manage Forms

The Manage Forms tab allows you to create documents without a client schedule. Assessment and Supplemental forms are available.

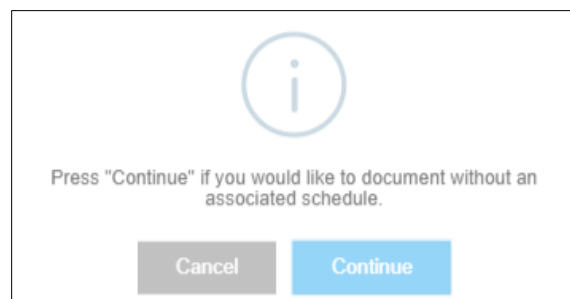
1. To show all forms, tap **Expand All**. To hide all forms, tap **Collapse All**.
2. Tap on the form you want to create and a popup message appears prompting you to continue creating a document without an associated schedule.

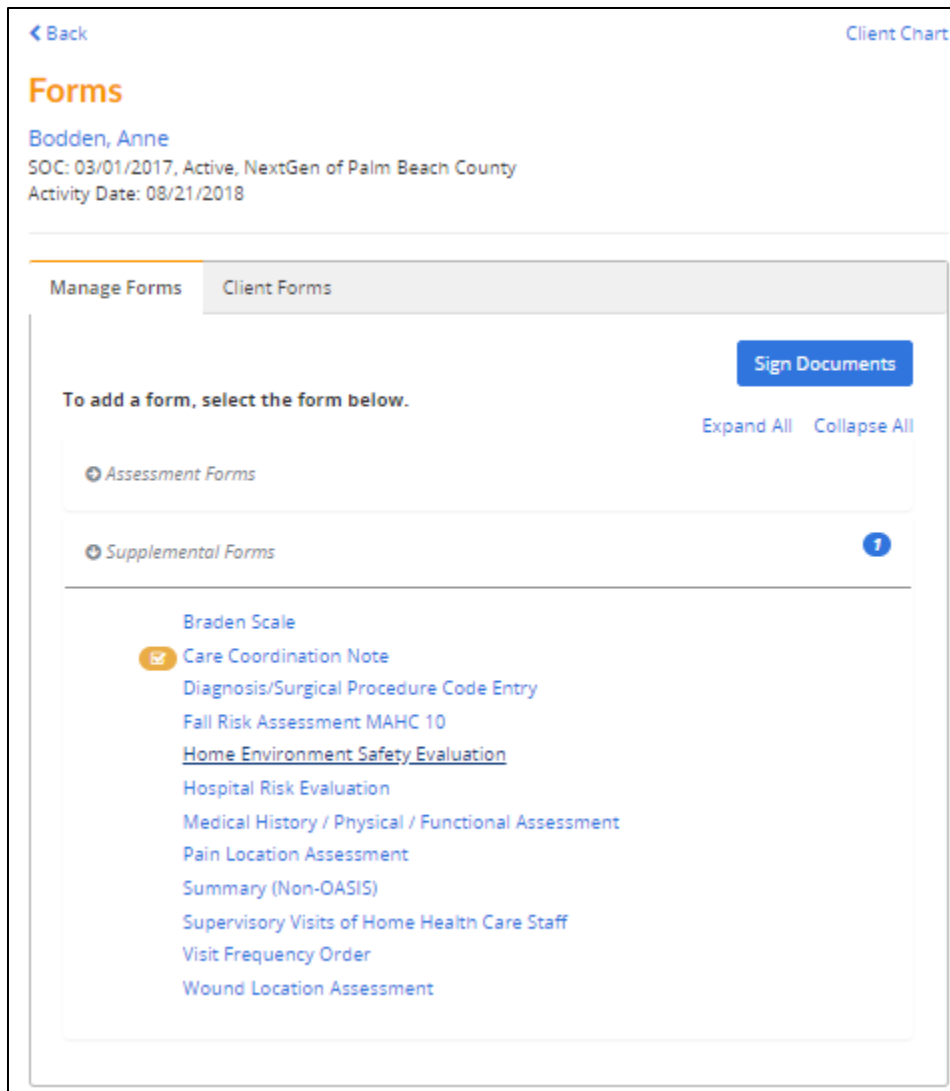


3. Tap **Continue** and a record is created and the form will display.
4. Fill out the form you want to create and tap **Save** and the record will be updated.

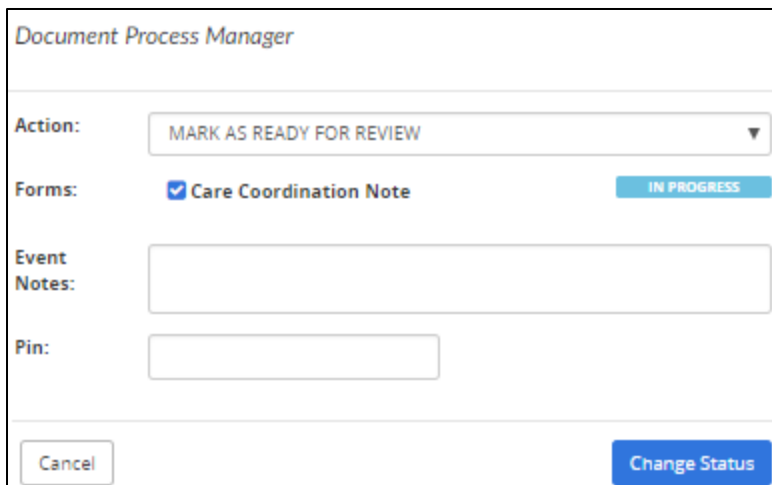
Note: These forms are associated to an activity and not a schedule.

5. You can create multiple client forms for an activity by tapping the **Back** link. The open form will be saved. The Forms page appears for that activity.
6. On the Manage Forms tab, expand to view the edited forms.





7. Tap **Sign Documents**. The Document Process Manager popup appears.

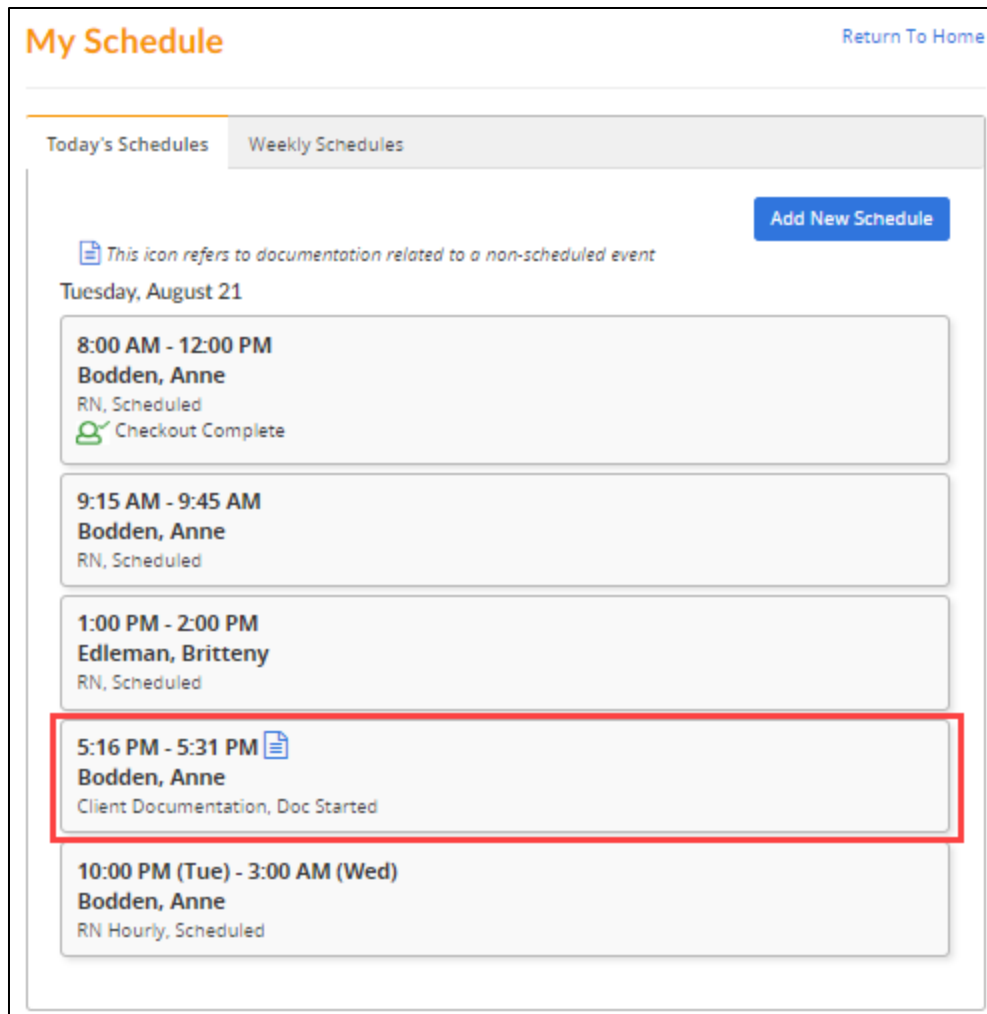


8. The Action drop down list will default to **MARK AS READY FOR REVIEW**.

9. If multiple forms are available, each form will have individual check boxes to enable or disable the action.
10. The Activity Start Date and Time defaults to when you created the first document and ends 15 minutes later. The Activity Date and Times can be modified as needed when all associated forms are in progress status.
11. Enter any internal event notes related to the forms that you would like the office to know about. After the note is entered and the form is signed, a blue icon is shown at the end of the form name informing you that an Event Note is available to view. You can also see the note on the left-hand navigation panel.
12. Sign the form by entering your PIN. The digital signature will be populated on the signed document form in the office.
13. Tap **Change Status** to complete the form(s). The form is now ready to be reviewed by the agency for approval in the back office.

When you are done with the forms, tap the Client Chart link, to return to the Client Chart page.

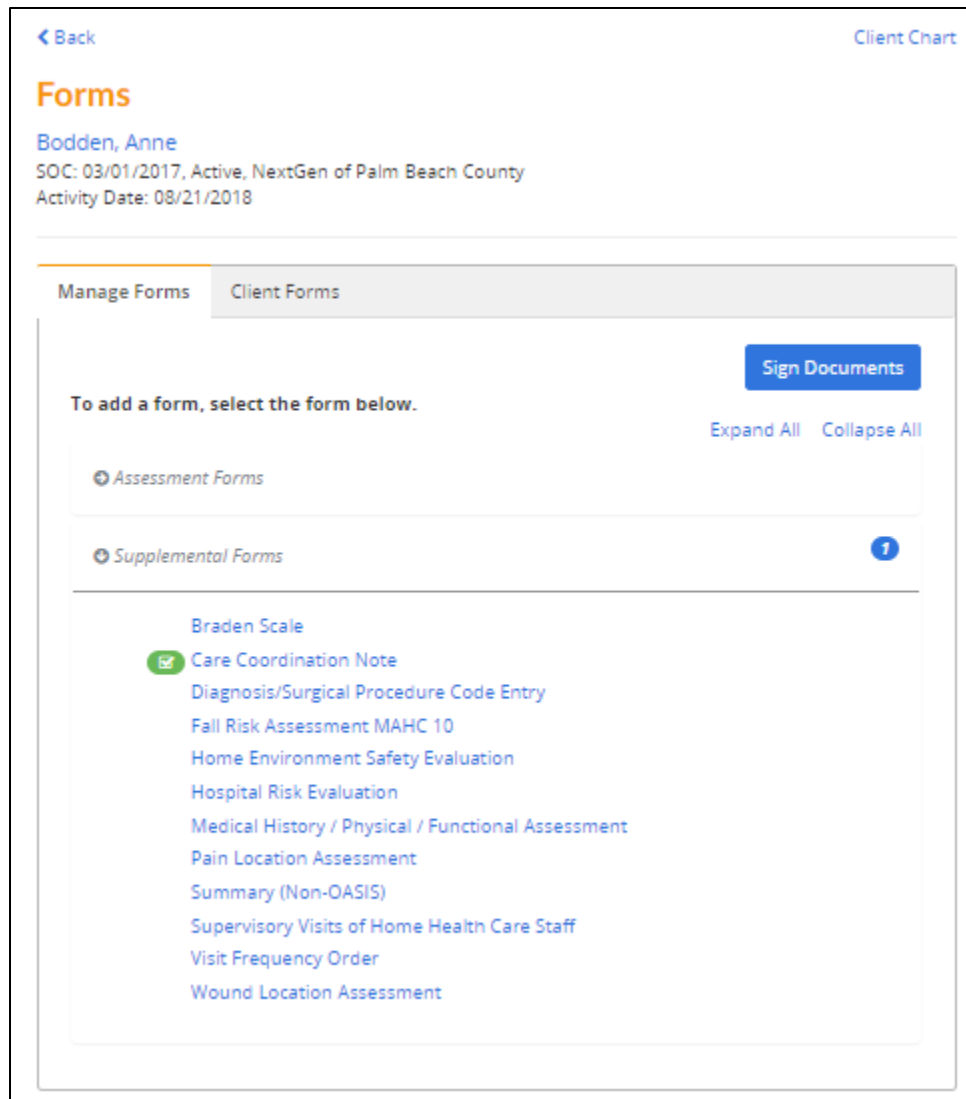
Note: Tap **My Schedule** to view your Today's or Weekly Schedules. The documentation activities can be accessed by tapping the "**Client Documentation**" items in the schedule. All client Documentation activities will have a Document icon next to the time and will state "**Doc Started**" under the client's name. "**The icon refers to documentation related to a non-scheduled event**" notification message is shown in the My Schedules page only when an activity is created in the list.



14. On the My Schedules page, tap the **Client Documentation** activity link and the Client Chart page for the activity appears. Tap the **Forms** button.

15. The following shows the Forms page for this activity, tap on the forms to view or complete your changes.

Note: Any forms that are currently in progress, are displayed in your Forms In Progress list.



Client Forms tab

The Client Forms tab shows all forms created from schedules and activities for the client for this certification period and the previous certification period.

Viewing and Creating an Inpatient Tracking Record

Skilled professional users can view, document and manage records to track inpatient stays for their clients (My Clients) on their mobile device. The Inpatient Tracking button appears on the Client Chart page. The Inpatient Tracking page allows you to view, document and track Inpatient stays for your Clients. The web page is accessed in the Client's record in the back office application, and in the Client's Client Chart on the mobile application. This information will be used in the future to create analytical dashboards in conjunction with evaluations to look at trends and possible risk for repeat hospitalizations.

The inpatient tracking fields available include:

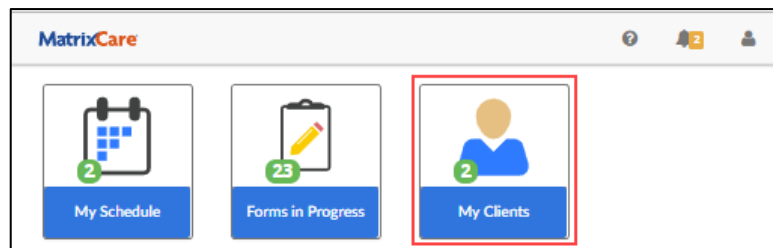
- Facility name the client was admitted to
- Type of facility
- Admission date
- Reason for admission
- Discharge date
- Discharge disposition

Accessing Inpatient Tracking Information

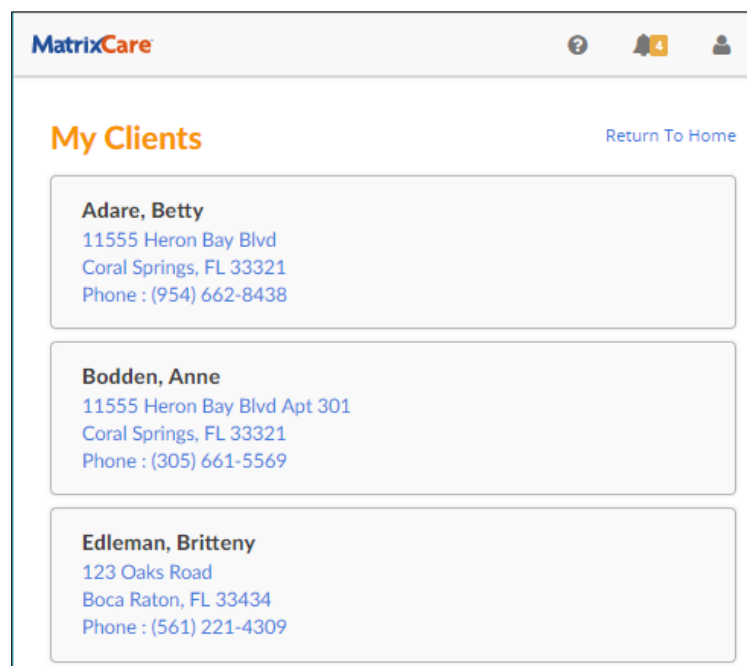
To access Inpatient Tracking information:

1. From the home page, select **My Clients** tile.

Note: You can access the Inpatient Tracking from the Client Chart from both My Clients and a Schedule.




2. Select an existing **Client**.



3. Select **Client Chart**.

Client
Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County

Demographics Schedules Service Plan

 **Bodden, Anne**
11555 Heron Bay Blvd
Apt 301
Coral Springs, FL 33321

[Select Admission](#) [Client Chart](#)


(305) 661-5569 (Home)
msalokar@gmail.com


Birth Date: 9/19/1960 Age: 58
Gender: Female


4. On the Client Chart page, select the **Inpatient Tracking** tile.

< Back

Client Chart
Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County

 Forms

 Medications

 Inpatient Tracking

5. The Inpatient Tracking page appears.

< Back Client Chart

Inpatient Tracking
Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County

[Add Inpatient Record](#)

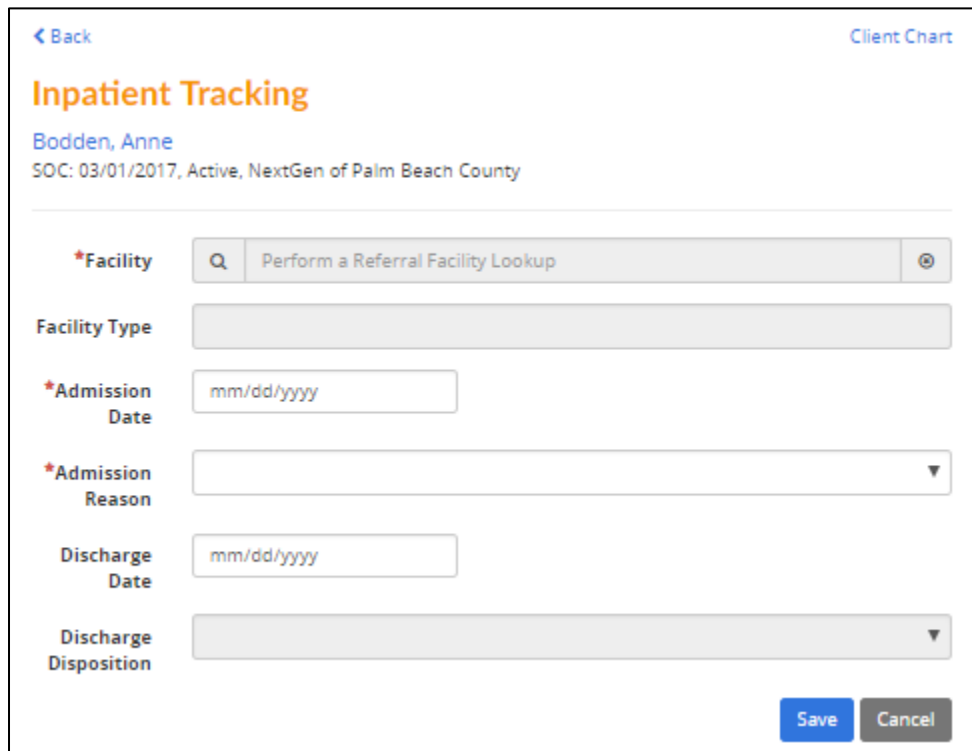
Delray Medical Center
Facility Type: Hospital
Admission Date: 8/5/18, Infection
Discharge Date: 8/7/18, Discharged to Home with Skilled Care

Delray Recovery Center
Facility Type: Rehab Facility
Admission Date: 7/5/18, Infection
Discharge Date: 7/5/18, Discharged to SNF

Adding Inpatient Tracking Records


To add an Inpatient Tracking Record:

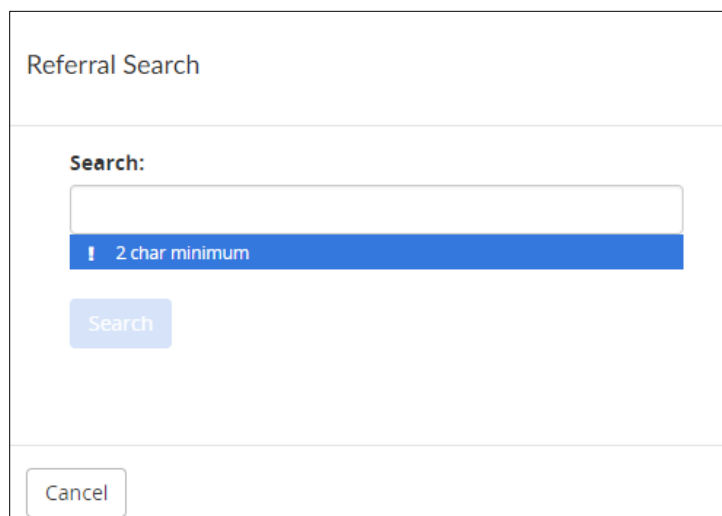
1. Select the **Add Inpatient Record** button. The Inpatient Tracking detail page appears.



The screenshot shows the 'Inpatient Tracking' form for a client named Anne Bodden. At the top left is a '< Back' link and at the top right is a 'Client Chart' link. The title 'Inpatient Tracking' is in orange. Below the title, the client's name 'Bodden, Anne' and 'SOC: 03/01/2017, Active, NextGen of Palm Beach County' are displayed. The form contains several fields: '*Facility' with a search icon and a text input containing 'Perform a Referral Facility Lookup'; 'Facility Type' with a text input; '*Admission Date' with a date input showing 'mm/dd/yyyy'; '*Admission Reason' with a dropdown menu; 'Discharge Date' with a date input showing 'mm/dd/yyyy'; and 'Discharge Disposition' with a dropdown menu. At the bottom right are 'Save' and 'Cancel' buttons.

Each client's Inpatient Tracking record displays the following fields:

2. **Facility** - This information is selected from the Referral Source List in the back office. Tap the magnifying glass  and the Referral Search window appears. The search is by company name from the Referral Source List in the back office.



The screenshot shows the 'Referral Search' window. It has a title 'Referral Search' at the top. Below the title is a 'Search:' label followed by a text input field. A blue error message bar below the input field says '! 2 char minimum'. Below the input field is a 'Search' button. At the bottom left of the window is a 'Cancel' button.

Note: You must enter a minimum of two characters when searching for a client. You can search by the first two characters of the last name, first two characters of the first name, or by entire last name, first name.

The screenshot shows a 'Referral Search' dialog box. At the top, the title 'Referral Search' is displayed. Below the title is a search input field containing the text 'de'. A blue error message bar below the input field reads '2 char minimum'. To the right of the input field is a blue 'Search' button. Below the search bar, the results are listed: '2 record(s) found'. The first result is 'Delray Medical Center Hospital' with contact information '(561) 498-4440' and address '5352 Linton Blvd, Delray Beach, FL 33484'. The second result is 'Delray Recovery Center Rehab Facility' with contact information '(561) 800-2935' and address '5410 East Ave, West Palm Beach, FL 33407'. At the bottom of the results list, it says 'Showing records 1 to 2 (of 2)'. A 'Cancel' button is located at the bottom left of the dialog box.

All active referral sources that are associated with the clients “Belongs to Office” will display showing the information as populated on the Referral Source record.

- Company Name
 - Referral Type
 - Primary Phone Number
 - Address (Address 1 and 2, City, State and Zip)
3. Select the facility, the view returns to the Inpatient Tracking detail page and the facility name appears in the field.

- **Facility Type** - This field is read only and displays from the Referral Type field on the **Additional Info** tab of the Referral Source record.

Inpatient Tracking
 Bodden, Anne
 SOC: 03/01/2017, Active, NextGen of Palm Beach County

*Facility: Delray Medical Center

Facility Type: Hospital

*Admission Date: mm/dd/yyyy

*Admission Reason: [Dropdown]

Discharge Date: mm/dd/yyyy

Discharge Disposition: [Dropdown]

Save Cancel

- **Admission Date** - Select a date from the date picker when you tap into the Admission Date field. **Note:** The Admission Date can be the same date as the discharge date of a previous entry, but cannot overlap another entry. A save error will display, showing the Admission Date of the overlapping record.

Record Create Failed
 An overlapping inpatient event was found on 4/13/2018

Inpatient Tracking
 Bodden, Anne
 SOC: 03/01/2017, Active, NextGen of Palm Beach County

*Facility: Delray Medical Center

Facility Type: Hospital

*Admission Date: mm/dd/yyyy

*Admission Reason: [Dropdown]

Discharge Date: [Dropdown]

Discharge Disposition: [Dropdown]

Save Cancel

| Sun | Mon | Tue | Wed | Thu | Fri | Sat |
|-----|-----|-----|-----|-----|-----|-----|
| 29 | 30 | 31 | 1 | 2 | 3 | 4 |
| 5 | 6 | 7 | 8 | 9 | 10 | 11 |
| 12 | 13 | 14 | 15 | 16 | 17 | 18 |
| 19 | 20 | 21 | 22 | 23 | 24 | 25 |
| 26 | 27 | 28 | 29 | 30 | 31 | 1 |

- **Admission Reason** - Select the list box to select a reason from the list.

Important! Admission Reasons are not configurable at this time.

When **Other** is selected, a text box appears requiring you to enter the reason for the admission. You can enter a maximum of 50 characters in the field.

The screenshot shows a mobile application interface for 'Inpatient Tracking'. At the top, there is a '< Back' button on the left and a 'Client Chart' link on the right. The title 'Inpatient Tracking' is displayed in orange. Below the title, the patient's name 'Bodden, Anne' and her SOC information 'SOC: 03/01/2017, Active, NextGen of Palm Beach County' are shown. The form contains several fields:

- *Facility**: A search bar containing 'Delray Medical Center'.
- Facility Type**: A dropdown menu set to 'Hospital'.
- *Admission Date**: A date picker field showing 'mm/dd/yyyy'.
- *Admission Reason**: A dropdown menu with 'Infection' selected. A list of other reasons is visible below it, including 'Circulatory (Cardiovascular) System', 'Digestive System', 'Endocrine/Nutritional', 'Genitourinary/Renal', 'Infection' (highlighted), 'Mental/Behavior', 'Musculoskeletal System/Joint Replacement', 'Neoplasms (Cancer Related)', 'Nervous System', 'Respiratory', 'Skin/Wound', 'Unknown', and 'Other'.
- Discharge Date**: A date picker field.
- Discharge Disposition**: A dropdown menu.

- **Discharge Date** - Select a date from the date picker, when you tap in the Discharge Date field. The discharge date is not required on the most recent entry.

Note: Discharge Date must be on or after the Admission Date.

- **Discharge Disposition** - Select a discharge disposition. This field is required when a discharge date is entered. If **Other** is selected, a text box appears requiring you to enter the discharge disposition. You can enter a maximum of 50 characters in the field.

< Back Client Chart
Inpatient Tracking
 Bodden, Anne
 SOC: 03/01/2017, Active, NextGen of Palm Beach County

*Facility:

Facility Type:

*Admission Date:

*Admission Reason:

Discharge Date:

Discharge Disposition:

3. Tap **Save**. The Inpatient Tracking list displays showing the new record.

MatrixCare Record Created Successfully
 < Back Client Chart
Inpatient Tracking
 Bodden, Anne
 SOC: 03/01/2017, Active, NextGen of Palm Beach County

[Add Inpatient Record](#)

Delray Medical Center
 Facility Type: Hospital
 Admission Date: 8/20/18, Infection
 Discharge Date: 8/21/18, Discharged to Home with Homecare

Delray Medical Center
 Facility Type: Hospital
 Admission Date: 8/5/18, Infection
 Discharge Date: 8/7/18, Discharged to Home with Skilled Care

- To modify the inpatient tracking information, select the inpatient tracking record to display the detail page, make any necessary changes, then tap **Save**.

Note: To delete the inpatient tracking information, contact your office manager to set up a permission.

Available Web-Enabled Forms

The skilled professional user will have access to view and fill in fields in the form with their devices.

Note: Some fields will have default information.

Default read only information that cannot be modified in all forms includes:

- **Client Name** - Last, First and Middle which is populated from the Client record
- **Medical Record No.** - is populated from the Admission tab Medical Record Number field
- **Person Completing this Form** - defaults to the caregiver name on the schedule

Default information that can be modified in all forms includes:

- **Date** - the date field defaults to the schedule date and can be modified

Note: In a signed document form, the Office information defaults automatically.

The following table provides a description of the available web-enabled forms.


| Category | Source | Form | Description |
|--------------|--------|---|---|
| Assessment | BRIGGS | 3569EB - Skilled Nurse Visit Note | Used to assess and document a nursing visit to a home care patient, including skilled and supervisory activities. Note: The user has the ability to create or view associated Pain Location and Wound Location forms within this assessment. |
| Supplemental | BRIGGS | 3166EHC - Braden Scale | Used for predicting pressure score risk. It is a clinically validated tool that allows nurses and other health care providers to reliably score a risk level for patients/clients developing pressure ulcers. The Total Score is calculated after all questions are answered and when tapping Save . |
| Supplemental | BRIGGS | 3577E - Care Coordination Note | Provides a way for caregivers/staff to document the coordination of client care. It may also be used to document information from care conferences or after hour calls. |
| Supplemental | BRIGGS | 3911EHC-13 - Fall Risk Assessment MAHC 10 | Used as a validated tool to assess a client's risk of falling in a home care setting. The Fall Risk Total score is calculated after tapping Save |

| Category | Source | Form | Description |
|--------------|------------|--|--|
| Supplemental | BRIGGS | 3542E - Home Environment Safety Evaluation | Identifies home safety needs and potential areas for client/patient education. It includes documenting of patient instructions, development of safety plans and identification of needed items. It also allows for documentation of a discussion regarding an emergency preparedness plan for the client/patient. |
| Supplemental | MatrixCare | Hospital Risk Evaluation | Used to evaluate Clients at the start of care, 30 days, 60 days, and 90 days post hospital discharge. It scores key areas such as Activities of Daily Living (ADLs) and Independent Activities of Daily Living (IADLs). It also documents risk factors associated with repeat hospitalizations. In the future, the data will be used in an analytic dashboard to show agency success in keeping clients out the hospital during the 90-day post discharge period. |
| Supplemental | BRIGGS | 3191E - Medical History/Physical/Functional Assessment | Provides a way to capture a client's medical history, in addition to providing documentation for a physical and functional assessment. Also used for Start of Care documentation and ongoing documentation for private duty non-medical clients. This is a multipage assessment with a page picker at the top and bottom of the form. The Functional Assessment Total Score is calculated after all the Functional questions are answered and you tap Save . Note: If you have any field validation errors, the form will not allow you to continue to the next page. |
| Supplemental | MatrixCare | Pain Location Assessment | Collects in-depth information related to location of pain, including pain symptom management. When creating a new form, the Origin and Location fields of the entries from the most recent signed form in the same admission will be copied into the new form. |

| Category | Source | Form | Description |
|--------------|------------|---|---|
| Supplemental | BRIGGS | 3583E - Summary (Non OASIS) | <p>Captures patient information for transfer/referral and/or discharge summary for non-OASIS patient discharges.</p> <p>Additional default fields include:</p> <ul style="list-style-type: none"> • Address - from the Client record • Phone - primary phone from the Client record • SOC - Start of Care date for the admission of the schedule • Most Recent Recert - Plan of Care start and end dates for the date of the schedule |
| Supplemental | BRIGGS | 3553E - Supervisory Visits of Home Healthcare Staff | For documenting a supervisory visit of a caregiver/staff member to a patient/client. |
| Supplemental | MatrixCare | Wound Location Assessment | Tracks in-depth patient information relating to location details and healing process on wounds. When creating a new form, the Location, Wound Type, Date Originally Reported, and Comments fields of the entries from the most recent signed form in the same admission will be copied into the new form. |

Signing out of the Mobile Application

To sign out of the MatrixCare Home Care Mobile application:

1. Tap **Account Settings**  button on the tool bar.
2. Tap **Sign Out**. A confirmation prompt appears allowing you to tap Yes or Cancel. Tap **Yes** to sign out.
3. The Signed Out page appears with a link to return back to the MatrixCare Mobile application. The sign out is complete.
4. Close the web app.

