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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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.

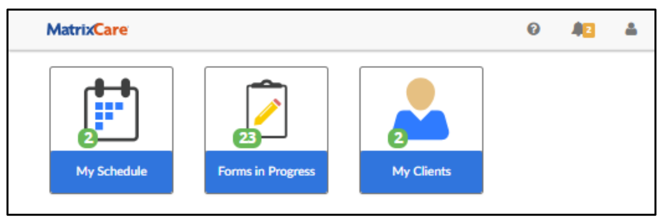
Note: It is recommended that mobile skilled professional users use a device no smaller than an iPad mini for an optimal user experience.

Signing in to the Mobile Application

To sign in to the MatrixCare Home Care Mobile application:

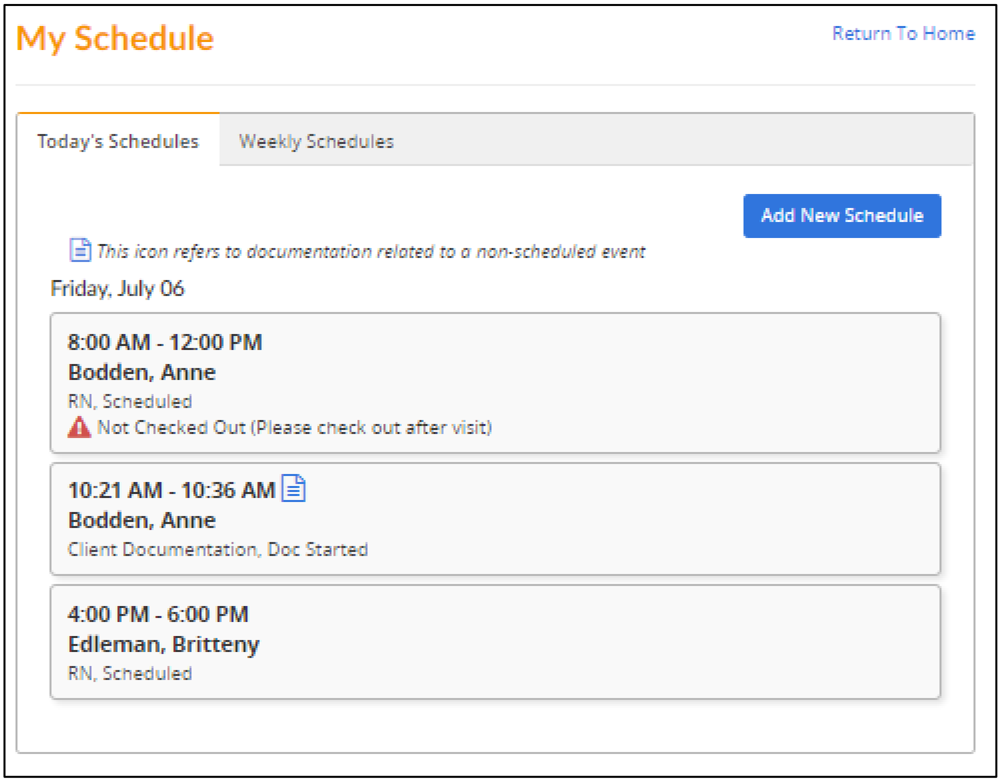
1. On your device, access the **MatrixCare Home Care URL** that you previously bookmarked.
2. On the Sign in page, enter your **Username** and **Password.**
3. Tap **Sign In**.

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:



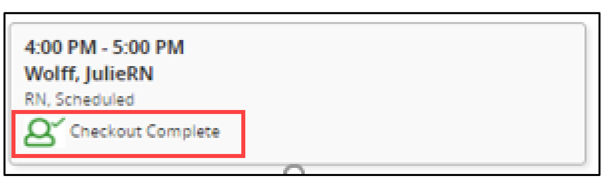
- MatrixCare - Tapping the MatrixCare logo returns you to the home page.
- **Help** - Tapping the question mark image provides a quick tour of main functions on each page of the application.
- 2 **Notifications** - Tapping the bell image displays a dropdown menu that allows you to view notifications 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.

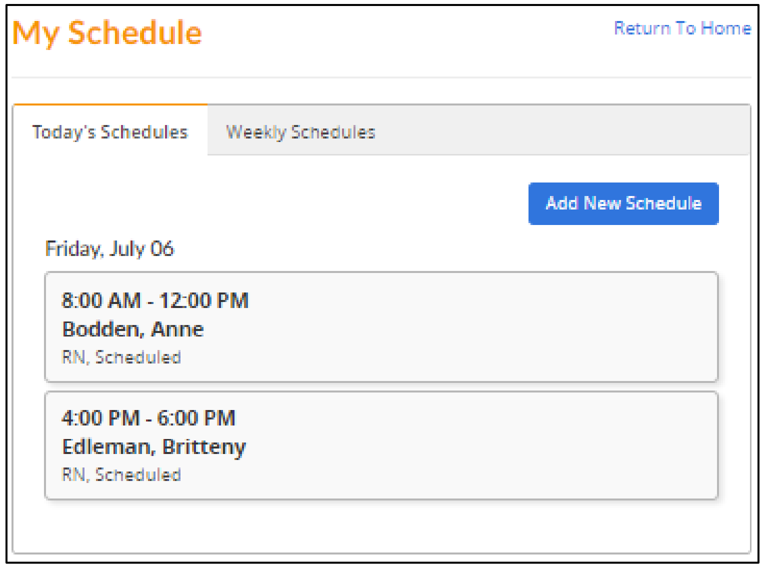
  - The green checkout icon indicates when the schedule has been checked out from the client visit and is complete.



My Schedule

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

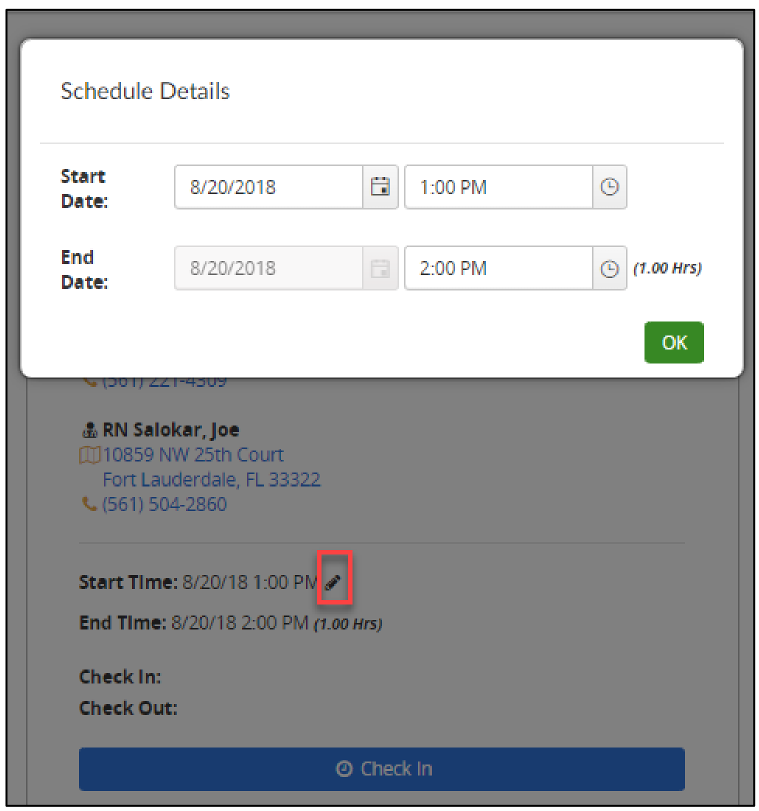
1. Tap the **My Schedule** tile. Today's schedules page appears showing a list of clients you are scheduled to visit today. For a weekly view of your schedule tap the Weekly Schedules tab.
2. Tap on the client name to view the schedule details.



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.

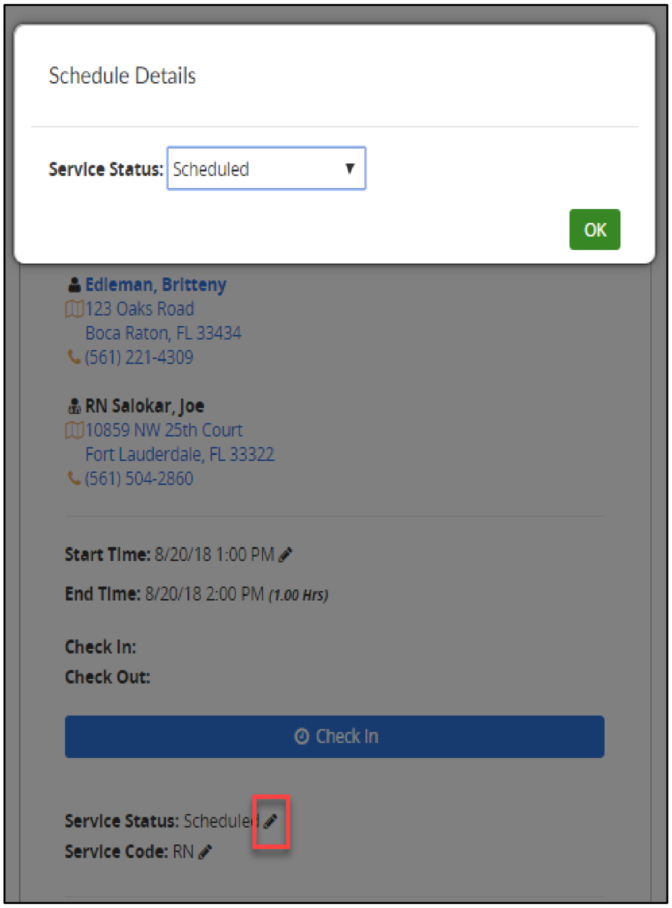


Note: Once you are checked in to the client visit, you cannot modify the date or times. The end date updates automatically as needed based on the end time.

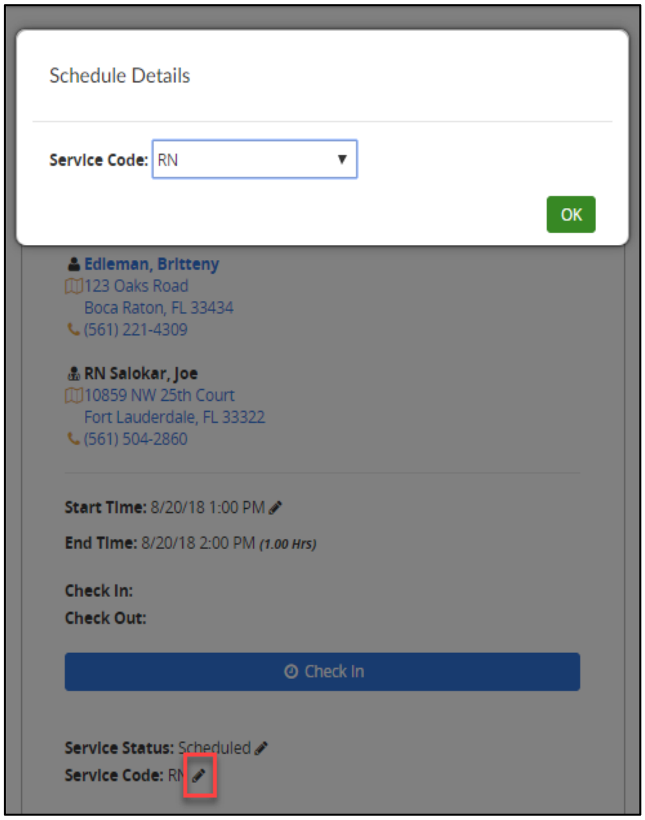
The skilled professional user can view and modify the Service Status on their client's schedule. When the skilled professional user is viewing the Schedule Details page they will see a "pencil" button next to the Service Status. Tapping the pencil shows a list of the Service Statuses.

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.

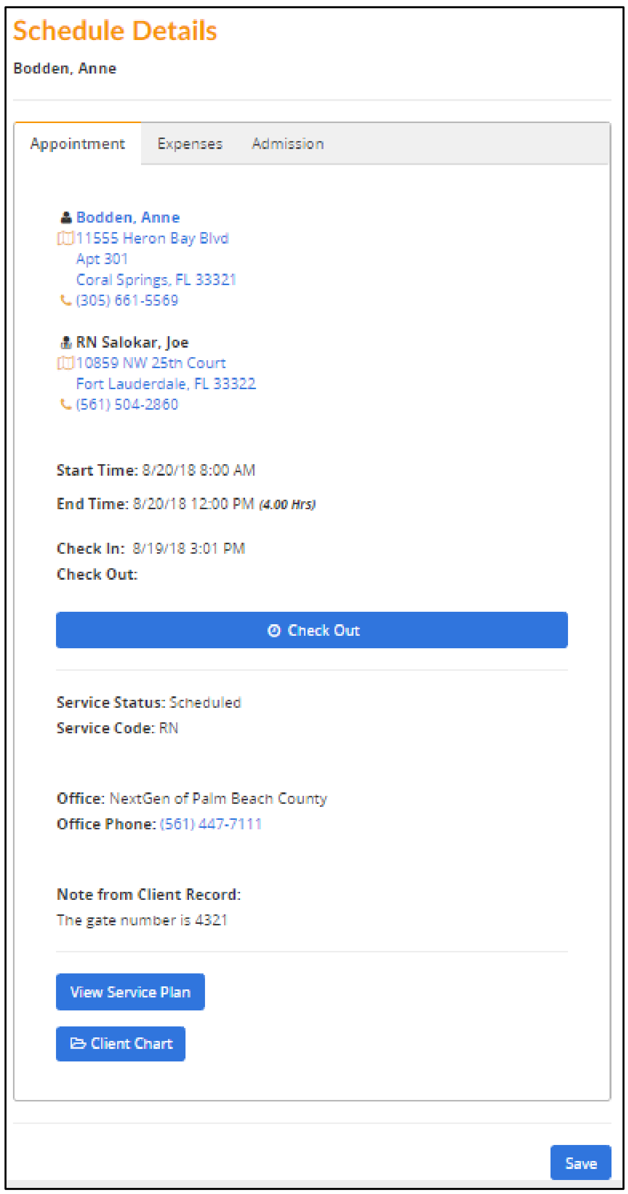
Checking in at the Client Location

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.



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

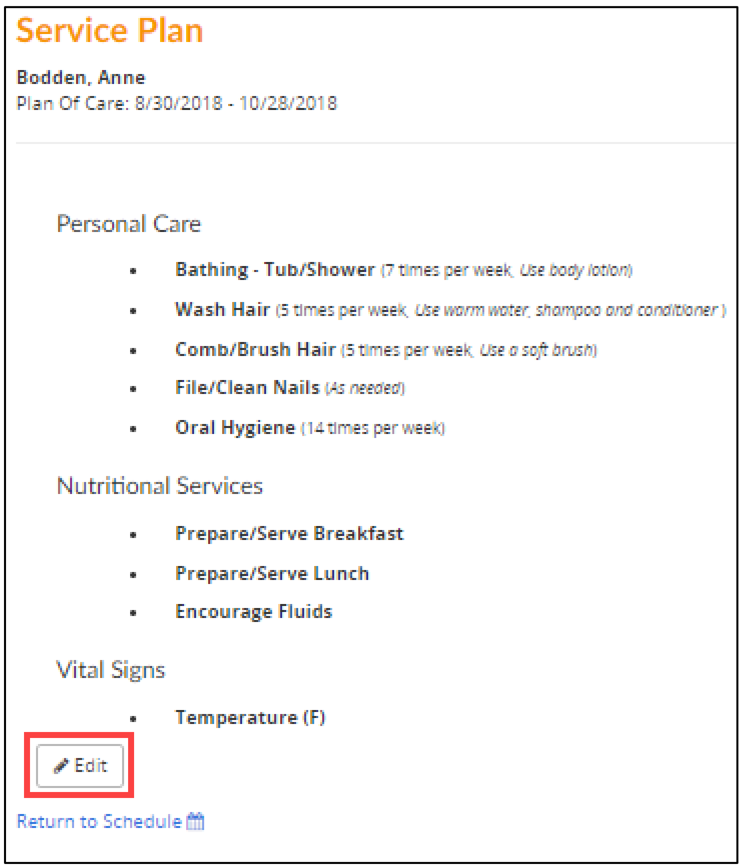
1. Tap the **View Service Plan** button. You can now view the Service Plan details that includes the client name, Plan Of Care dates and the service plan tasks and frequency. The client's Published Service Plan will display if one is available to review the list of tasks and frequency.

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

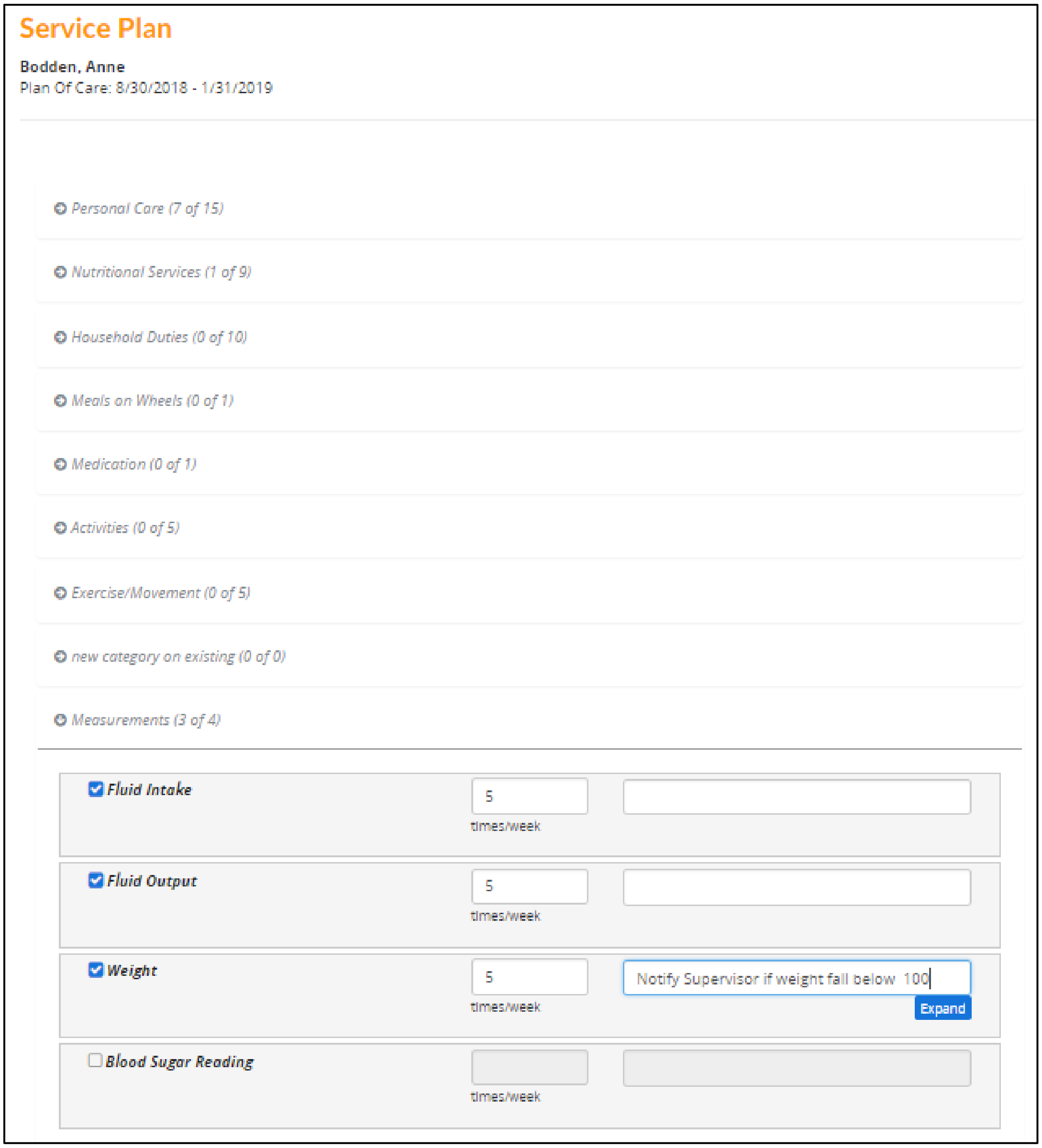
2. If no changes are needed, tap the **Return to Schedule** link at the bottom of the page.

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.



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.

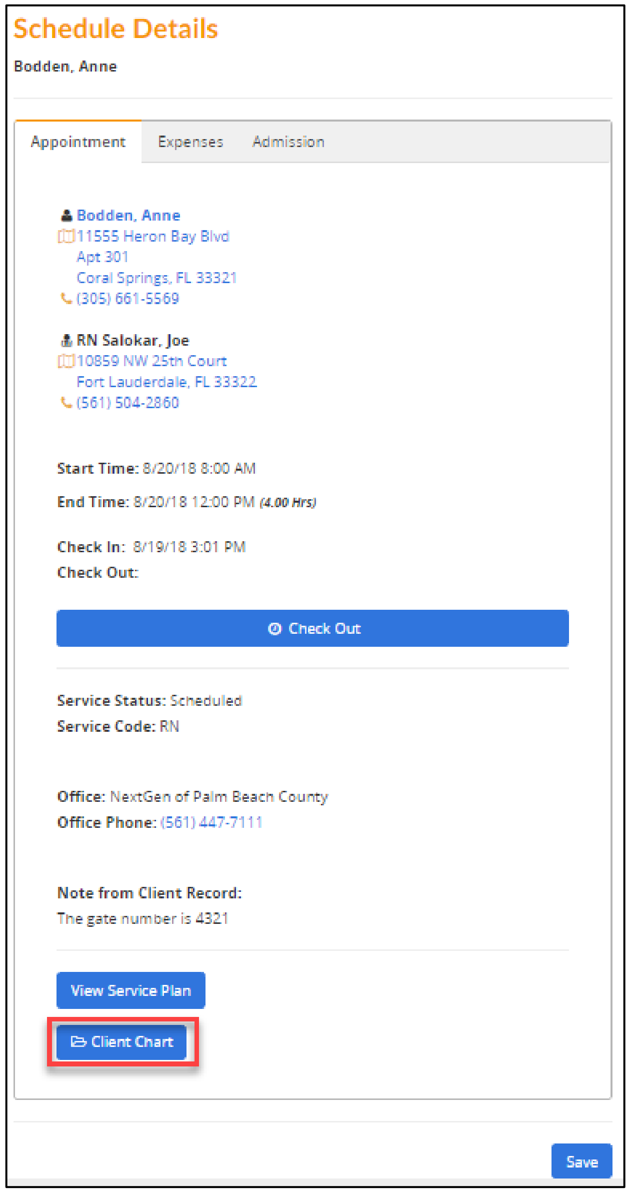
Accessing the Client Chart when Checked in to a Schedule

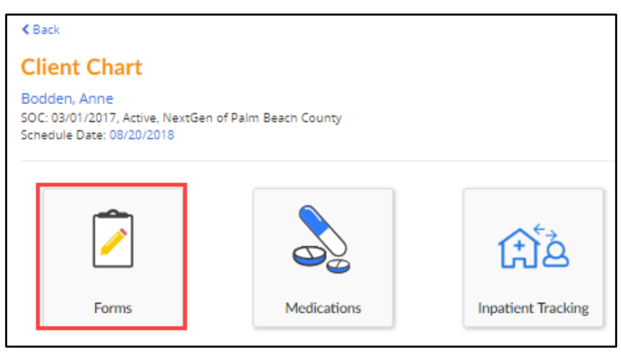
Tap the **Client Chart** button to display the Client Chart page.

Accessing Forms

To access forms:

1. Tap the **Forms** tile.

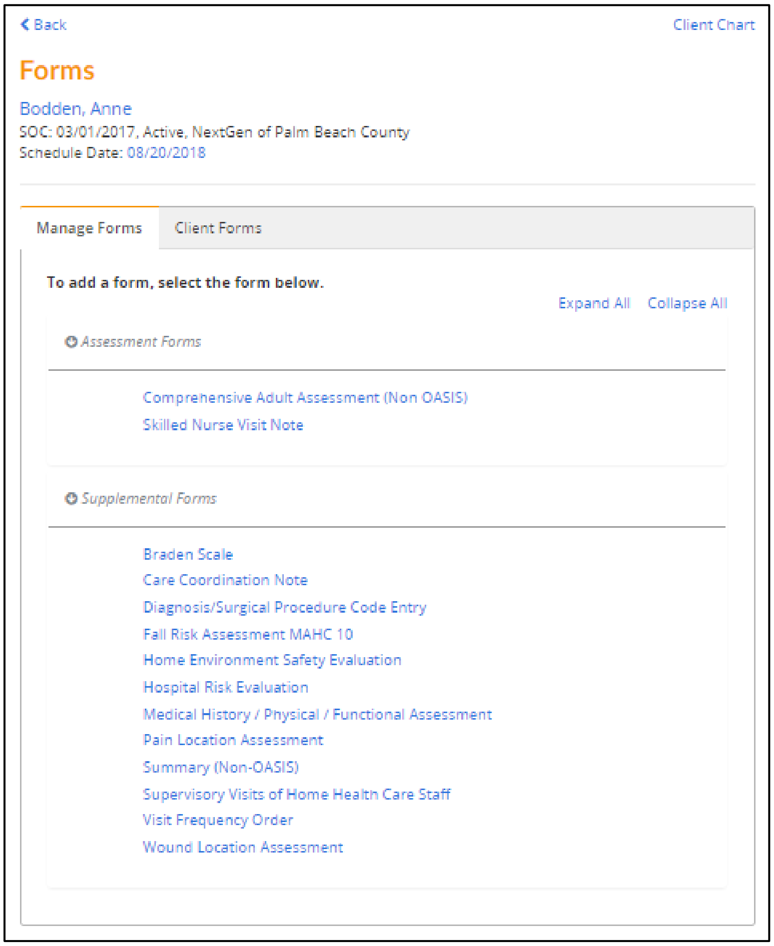




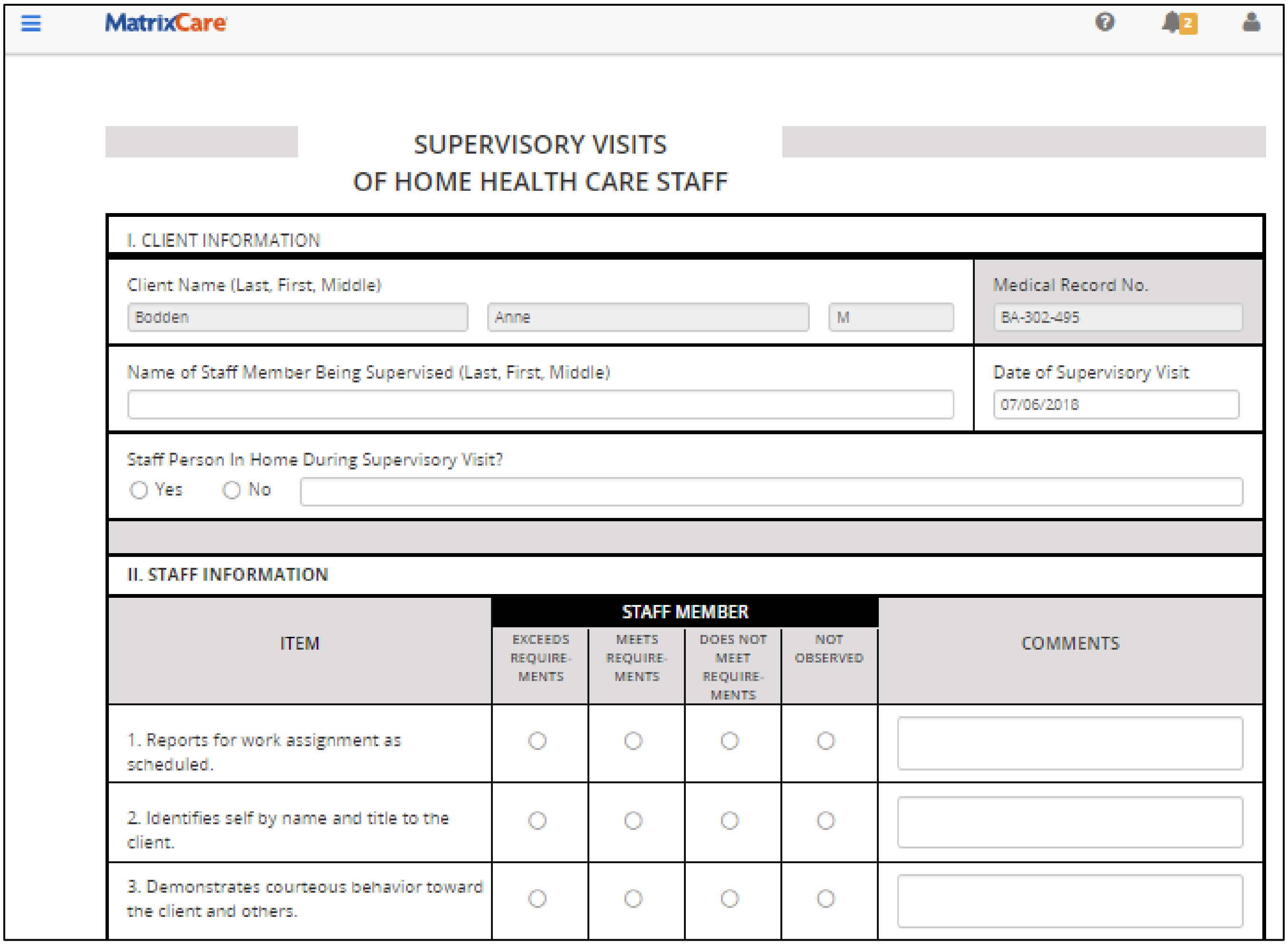
The Forms page appears which displays the name of the client and the date of the schedule. On the Manage Forms tab, tap **Expand All** to view each type of form that can be created for the client. The forms created will be associated with this schedule.

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


MatrixCare

SUPERVISORY VISITS
OF HOME HEALTH CARE STAFF

I. CLIENT INFORMATION

Client Name (Last, First, Middle) Bodden / Anne / M	Medical Record No. 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

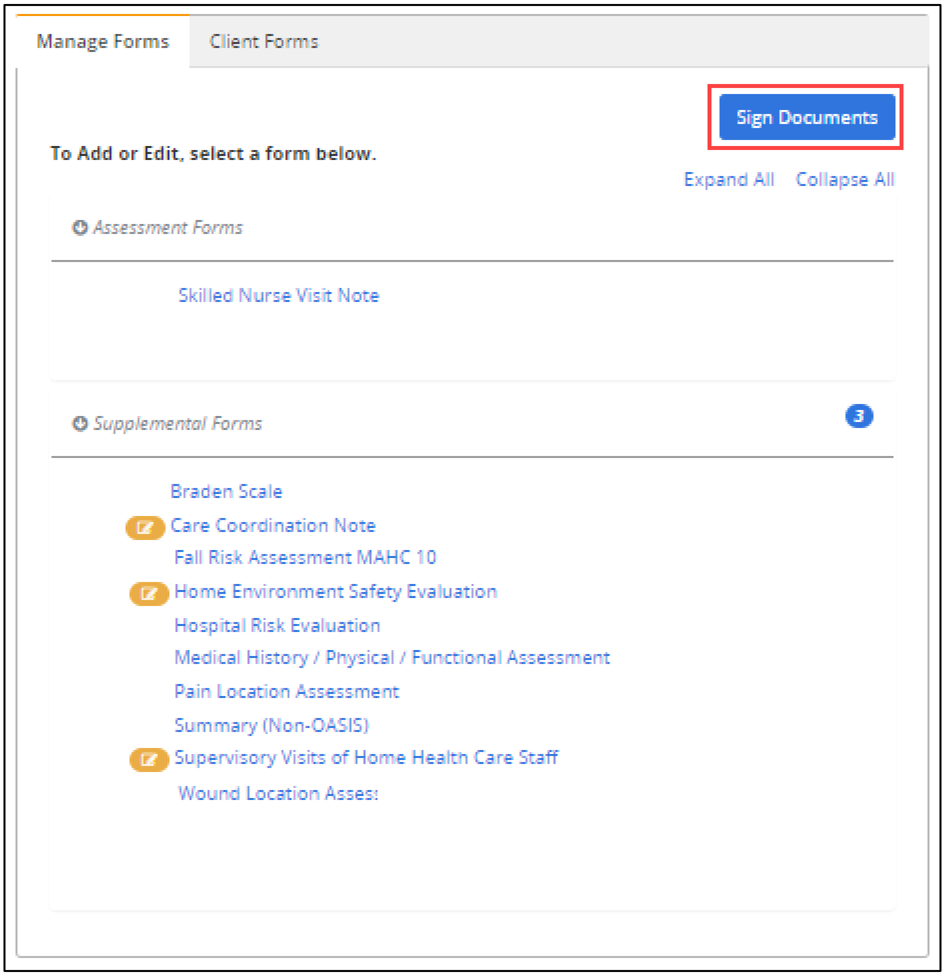
ITEM	STAFF MEMBER				COMMENTS
	EXCEEDS REQUIRE-MENTS	MEETS REQUIRE-MENTS	DOES NOT MEET REQUIRE-MENTS	NOT OBSERVED	
1. Reports for work assignment as scheduled.					
2. Identifies self by name and title to the client.					
3. Demonstrates courteous behavior toward the client and others.					

Default information in the form includes:

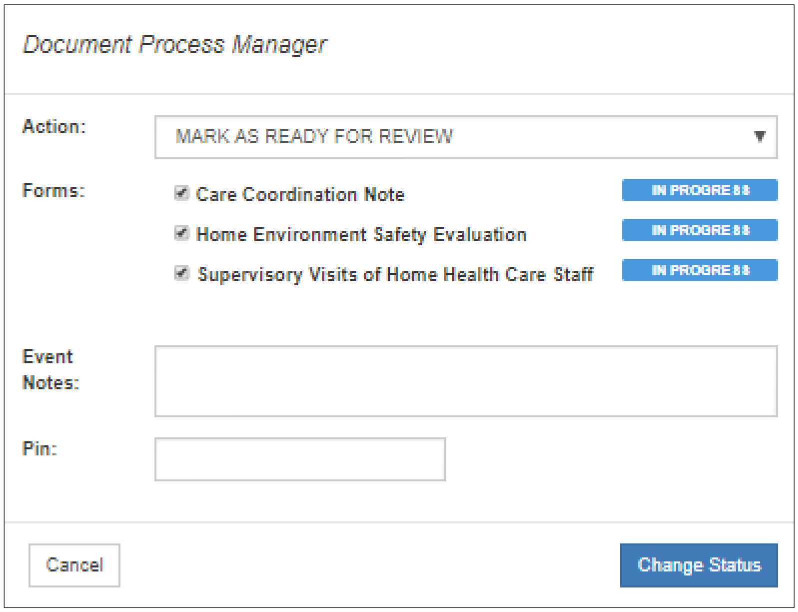
- Name of Client (Last, First and Middle) - which is populated from the Client record
- Medical Record No. - is populated from the Admission Medical Record Number
- Date - defaults to the schedule date and can be edited
- Person Completing this Form - defaults to the caregiver name on the schedule

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.

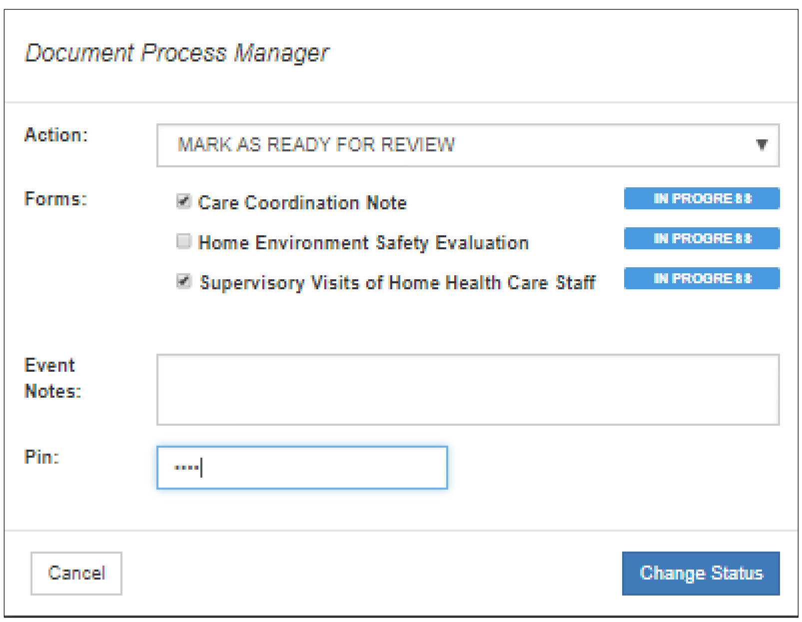
   Note: A orange and white pencil icon appears next to the form link showing that the form has been created and is in progress for that scheduled visit.
6. After forms are created, the form links will have an orange and white pencil icon to the left showing that they are in progress. The blue and white 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.



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.



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.

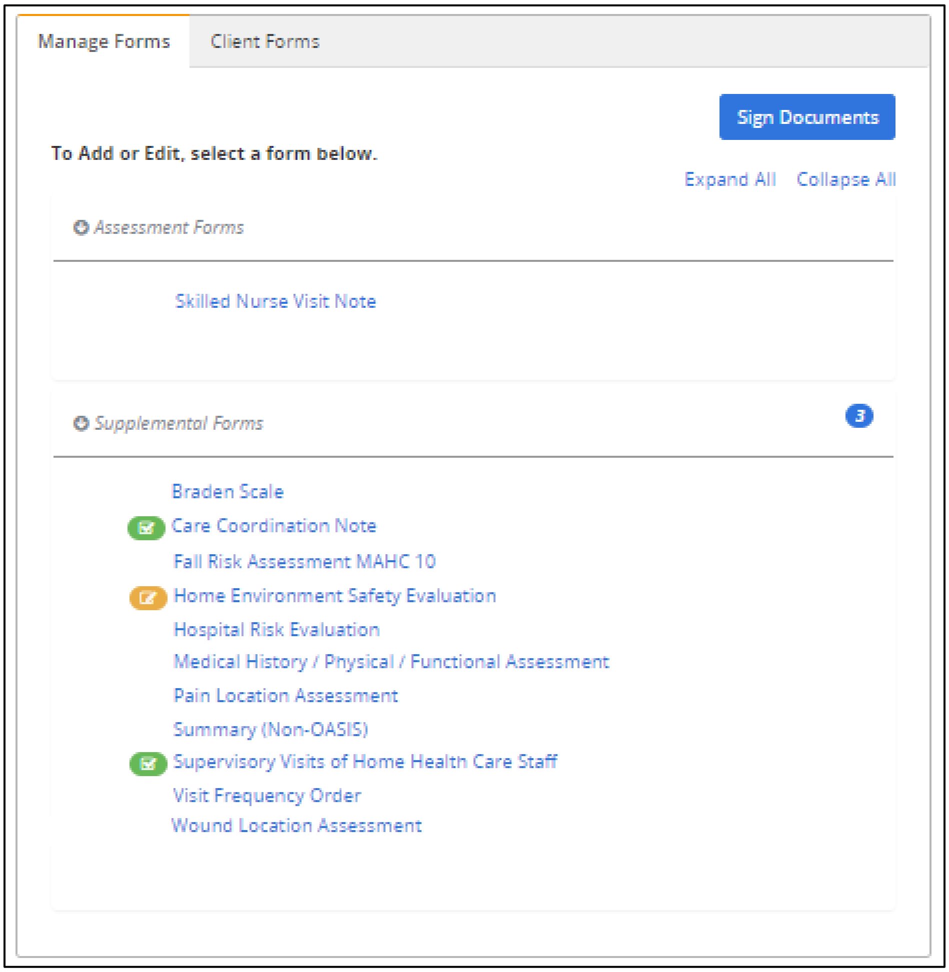
    Note: If you want to go back to the forms page to make additional changes tap **Cancel**.

11. Sign the form by entering your PIN. Tap **Change Status** 

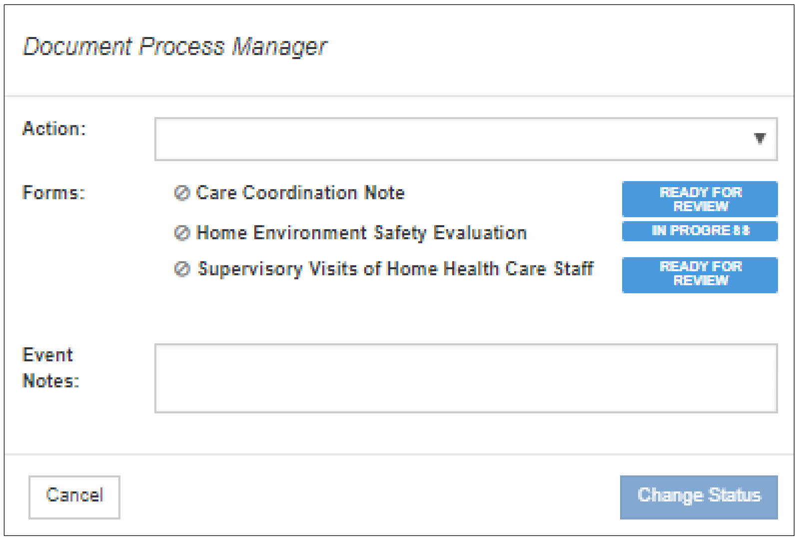
to complete the forms. These forms are sent to the office for review and approval. The Form page appears with a green check mark next to the form button indicating it is no longer in progress.

    Note: If you do not enter a PIN or enter the wrong pin, a message "PIN is invalid" 

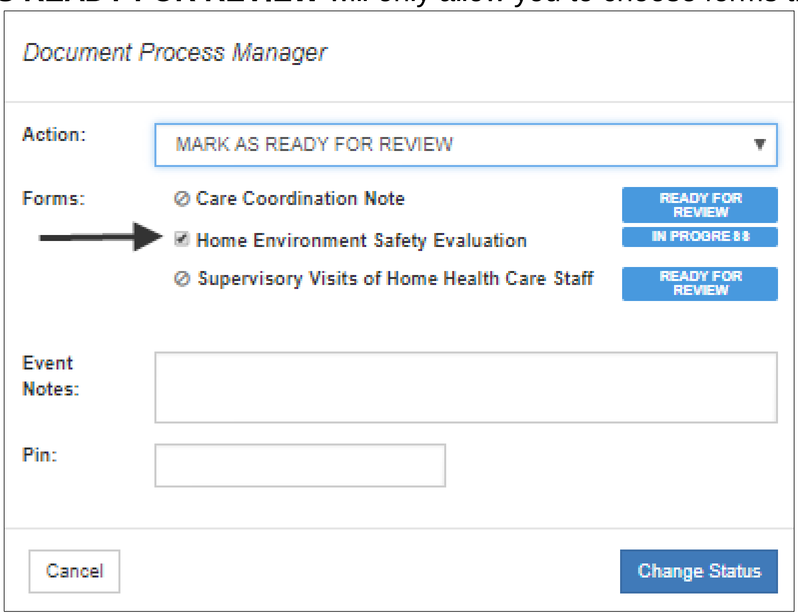
appears in red. If you forgot your caregiver PIN, navigate to your account setting and select **Manage Signature Pin** to change your PIN.



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.

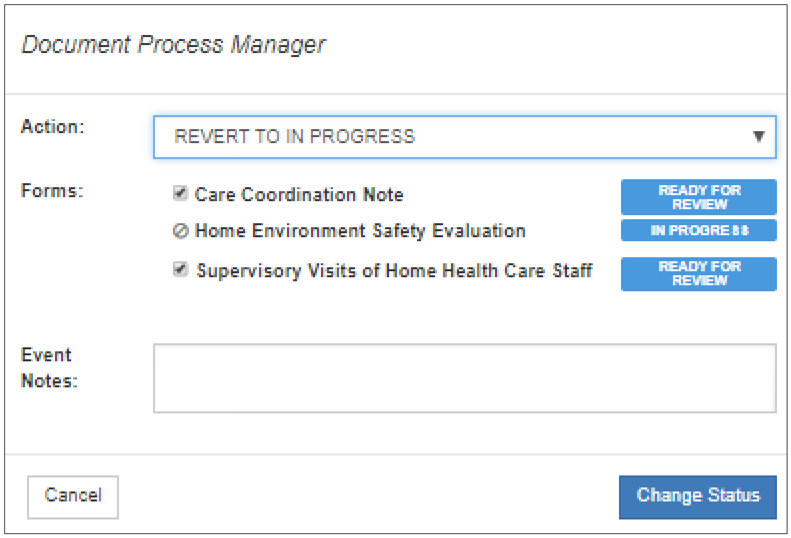


Selecting **MARK AS READY FOR REVIEW** will only allow you to choose forms that are in progress.



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.



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

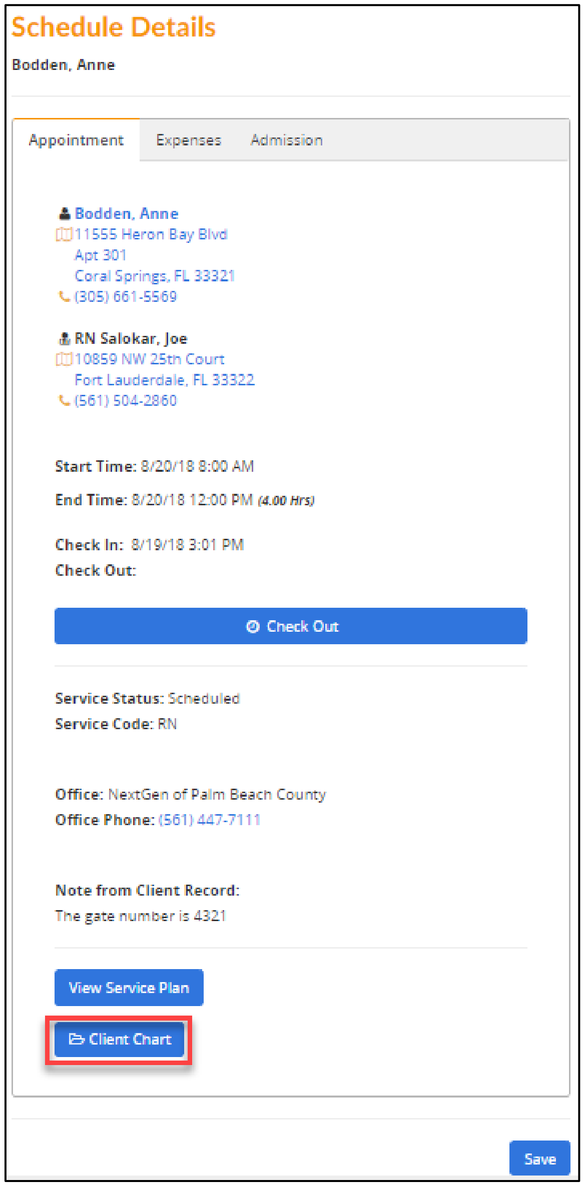
No PIN number is required when changing a form back to in progress. A PIN is required when a form is changing from in progress to ready for review. Depending on the selected action and the status of the form, the form may or may not be available for selection.

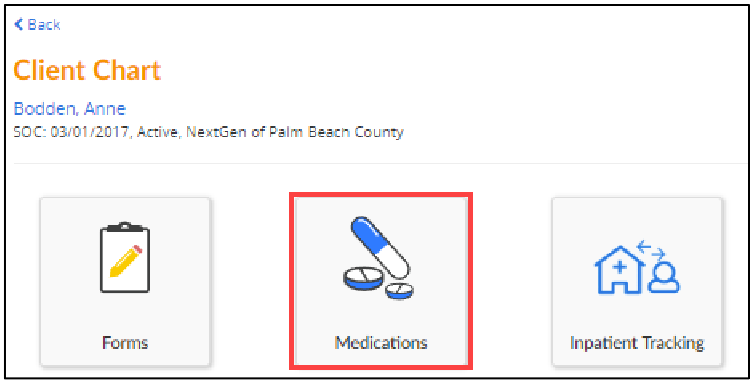
Accessing, Adding and Viewing Client Medication Information

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.



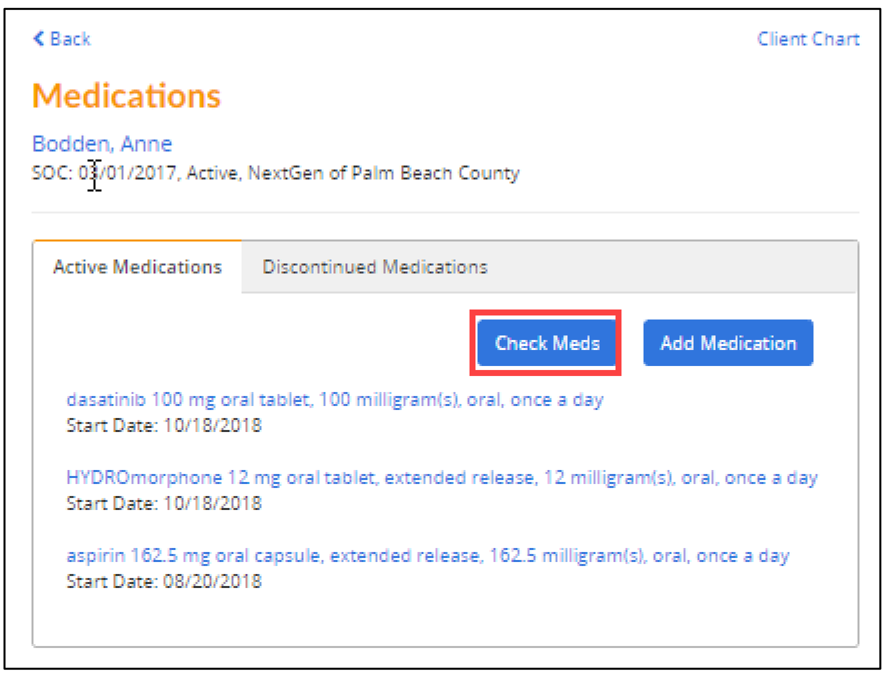


3. Tap the **Medications** tile. The Medications page displays the Active Medications tab listing the medications the client is currently taking or will start taking on a future date. The **Check Meds** button provides you with any details of Drug to Drug interactions and Dosage details of results to 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”.

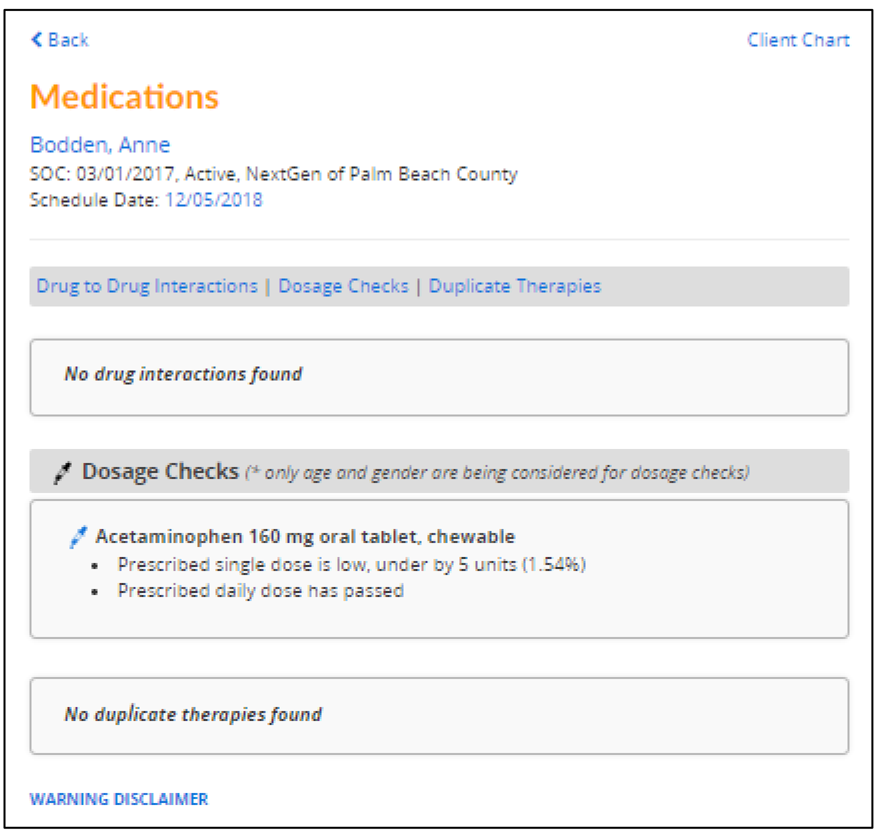
Dosage Checks:

- 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”.

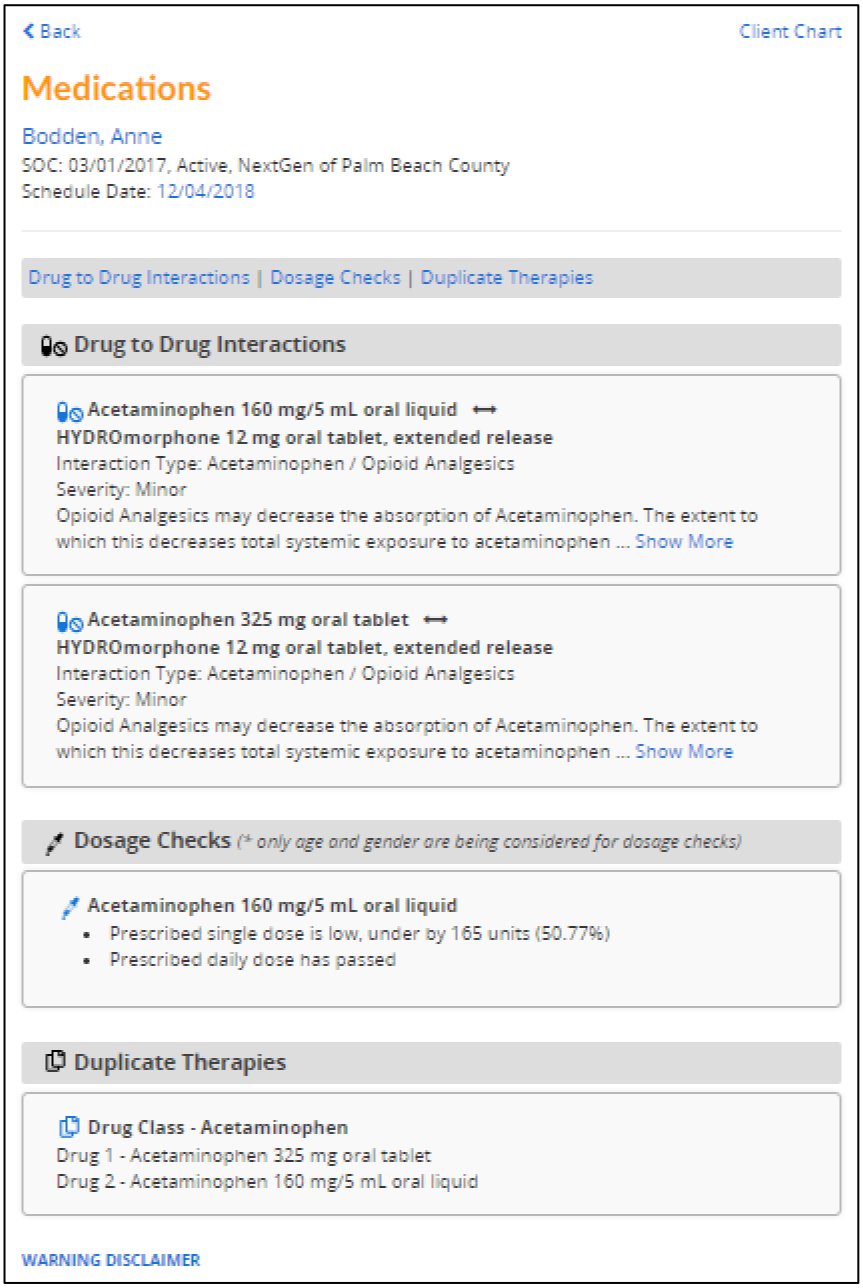
Duplicate Therapies:

- 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:

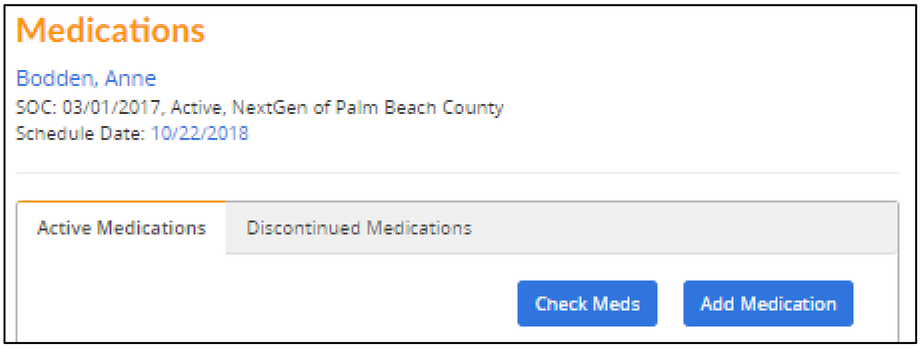


The following is an example of a client with medication warnings found:



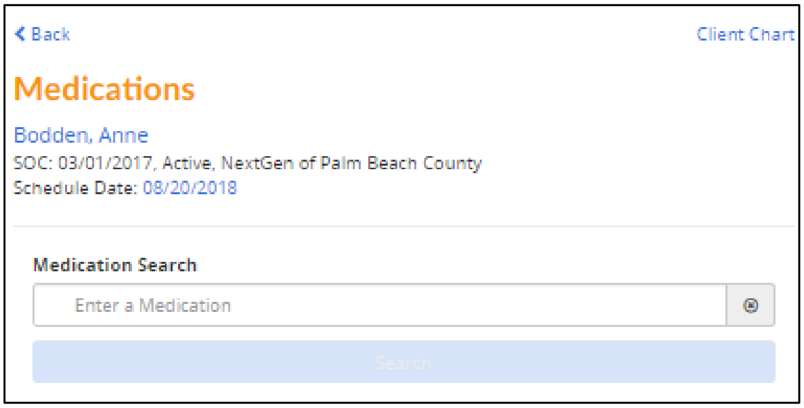
Adding a Medication

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

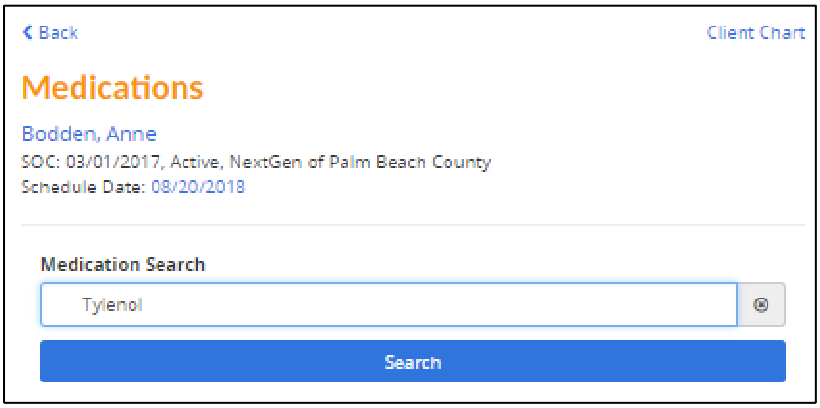


Note: If you are not checked into a client, you cannot add medications.

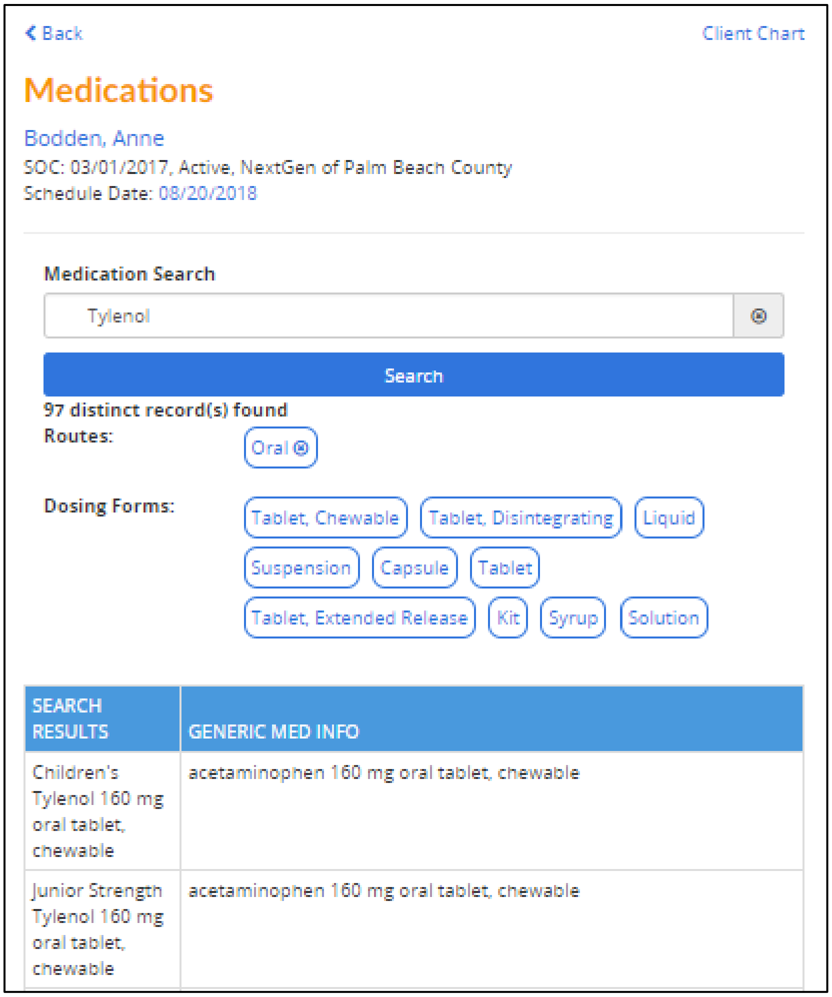
The application allows you to search for a medication by entering three or more characters.



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



3. Tap **Search**.

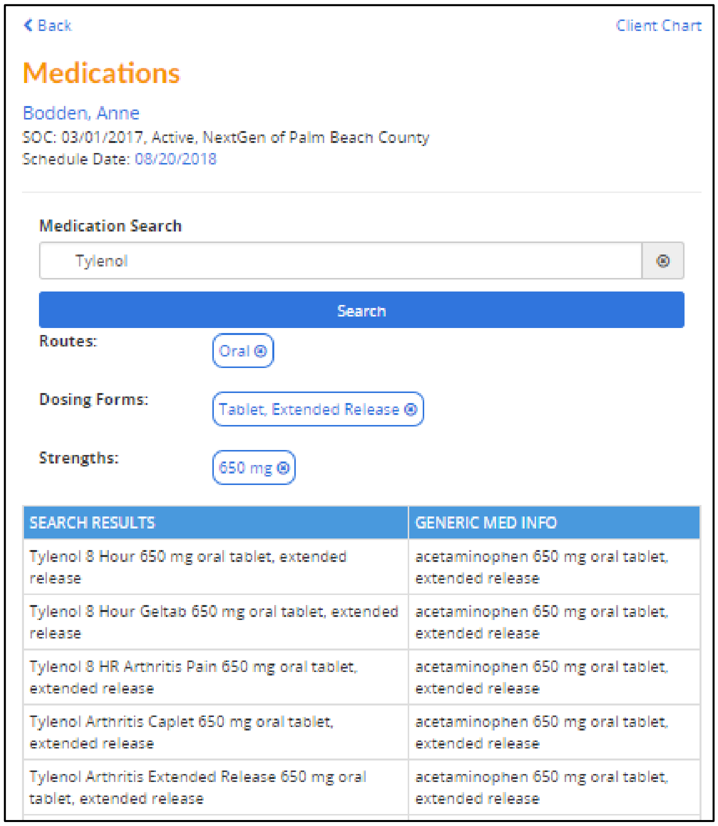

Back
Client Chart
Medications
Bodden, Anne
SOC: 03/01/2017, Active, NextGen of Palm Beach County
Schedule Date: 08/20/2018
Medication Search
Tylenol
Search
97 distinct record(s) found
Routes:
Oral
Dosing Forms:
Tablet, Chewable
Tablet, Disintegrating
Liquid
Suspension
Capsule
Tablet
Tablet, Extended 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

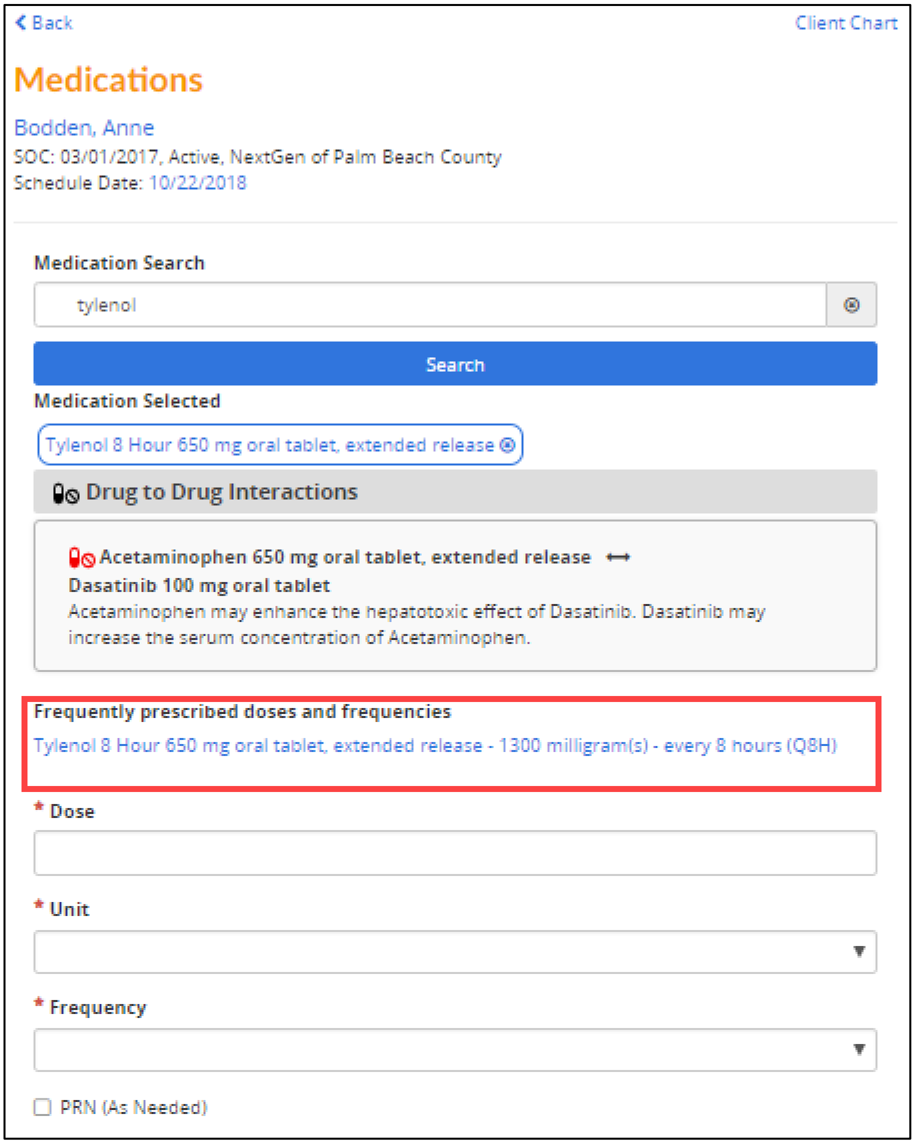
A list of options appears for you to select the medication routes, dosing forms and strengths. When tapping options, the application filters the specified medication(s). For example, if you select a dosing form of **Tablet, Extended Release**, the application will filter to display just those medications.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



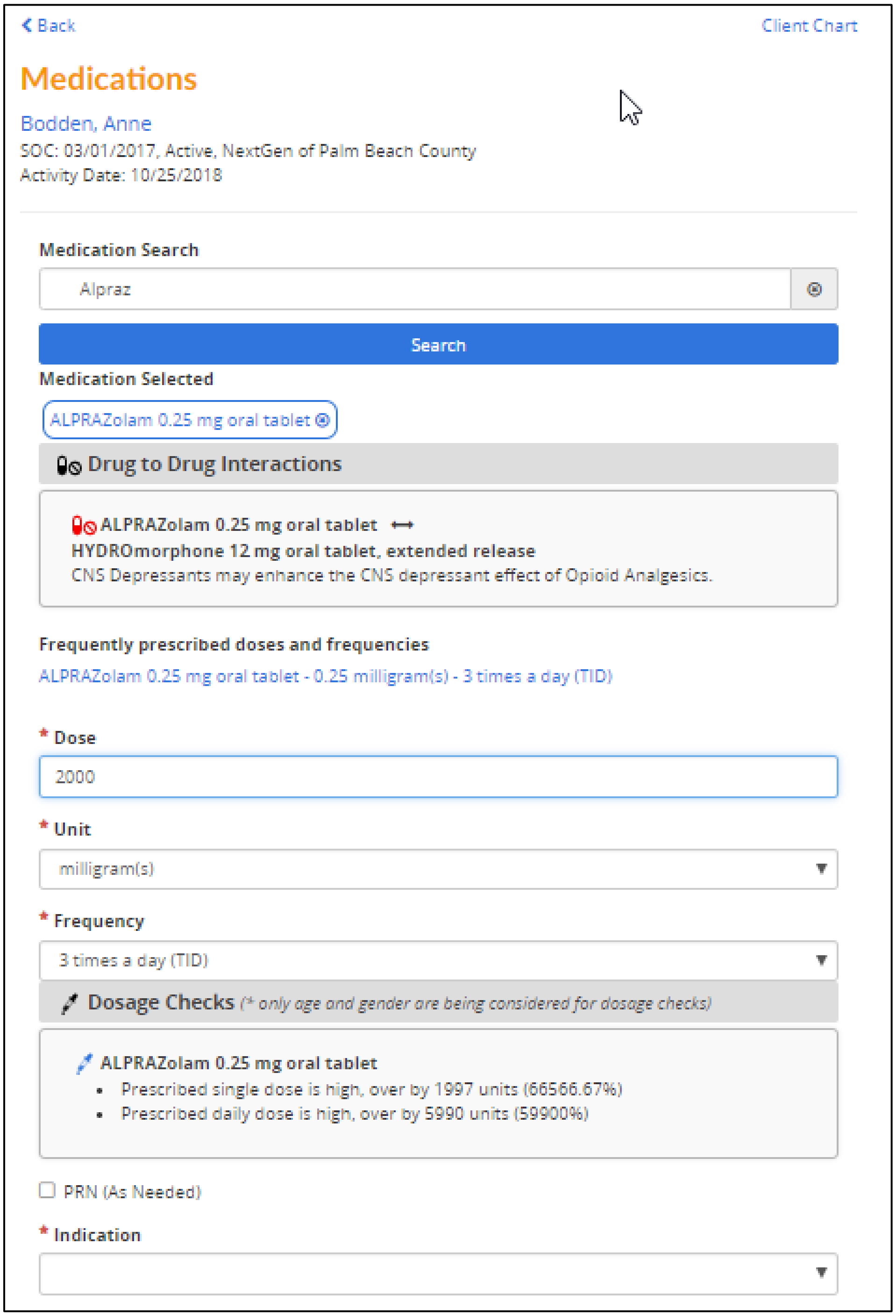


5. The frequently prescribed doses and frequencies for the selected medication will display when available. Tap, to select a **Frequently prescribed doses and frequencies** to populate the dose, unit and frequency fields if applicable. Or you can manually enter the dose, unit and frequency in the individual 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:



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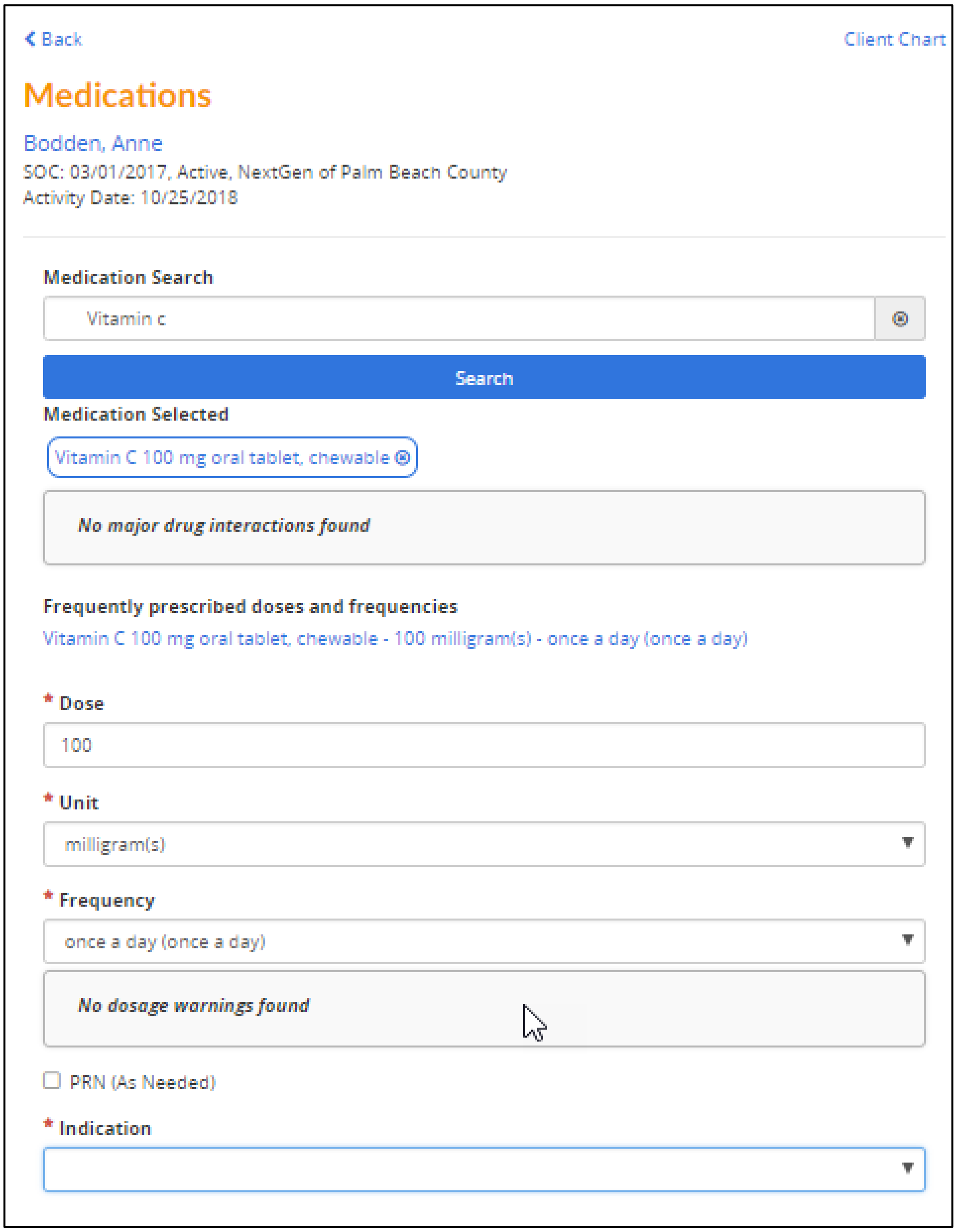
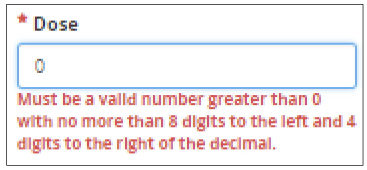
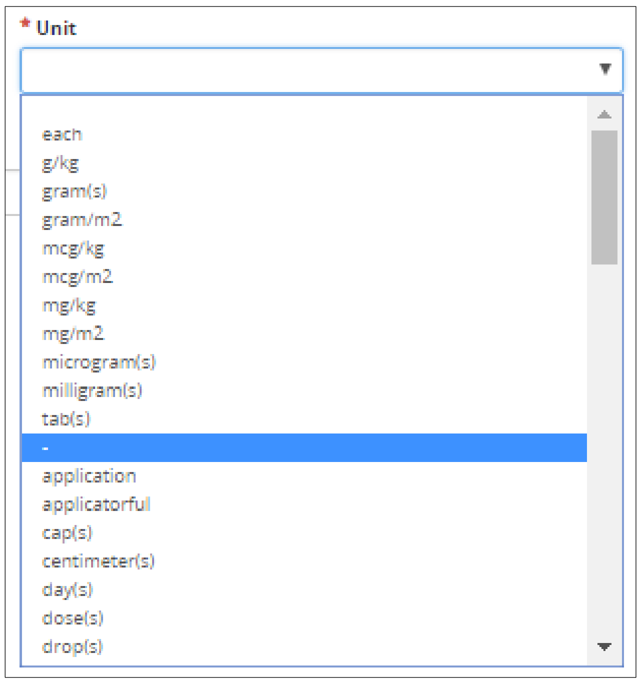


6. Tap to add, modify or select an item in the following medication fields.

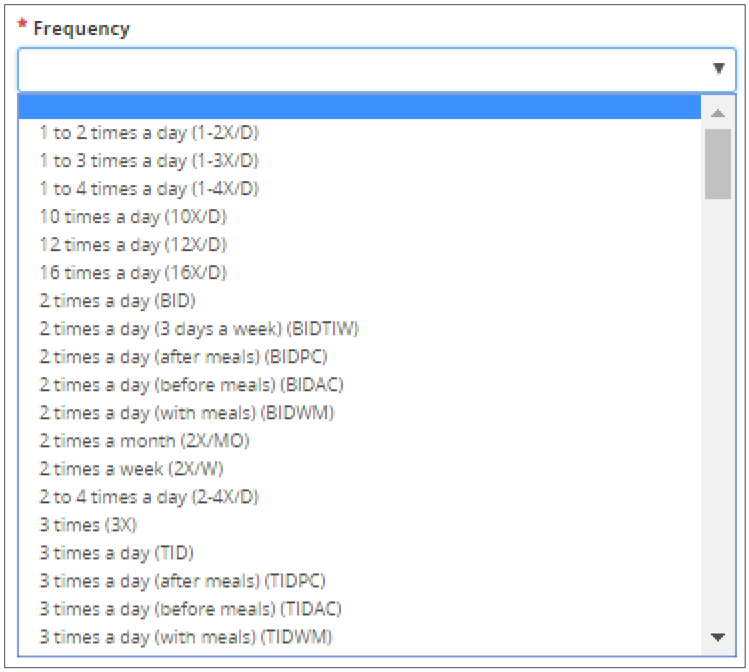
- **Dose** – must be a valid number greater than zero with no more than eight digits to the left and four digits to the right of the decimal.



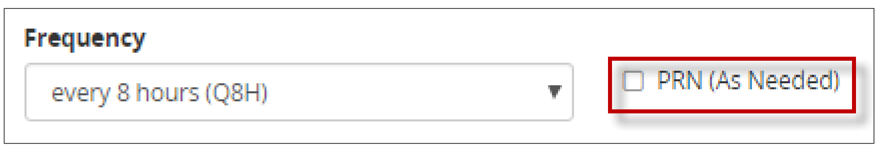
- **Unit** – a list box will display the commonly prescribe units for the selected medication when available at the top of the list. Then the list box may show a dash and then shows all the potential unit types available after.



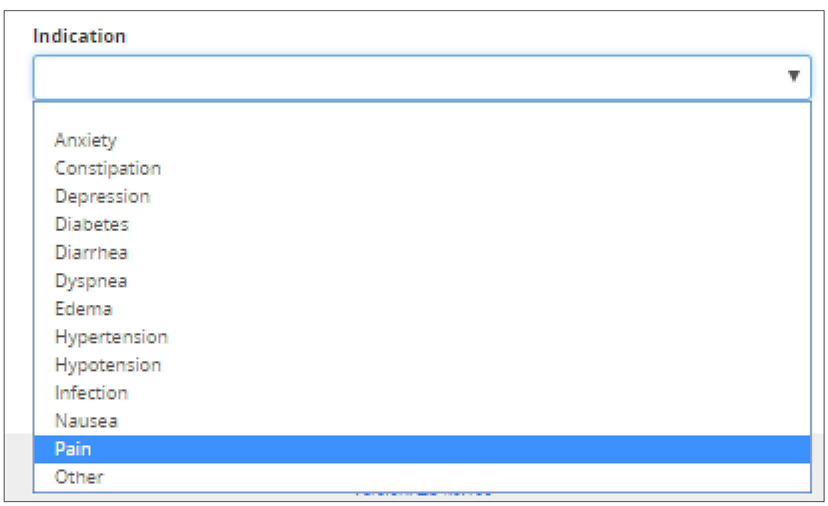
- **Frequency** – a list box of options shows how often the medication should be taken.



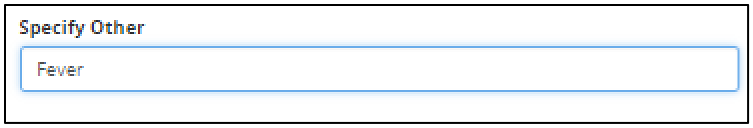
7. Check the PRN box, if the medication is prescribed as needed.



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

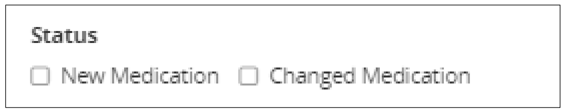


Note: If you select an Indication of **Other**, a Specify Other text box appears requiring you to enter the reason for the medication. You can enter a maximum of 50 characters in the field.

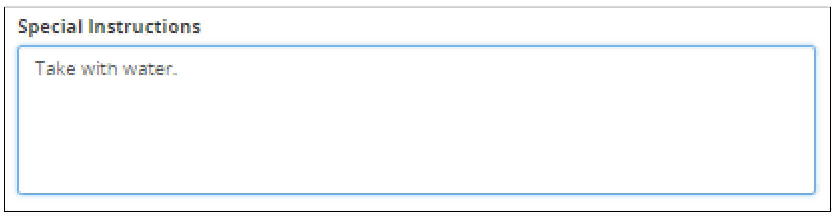


Additional fields will display after Indication is selected.

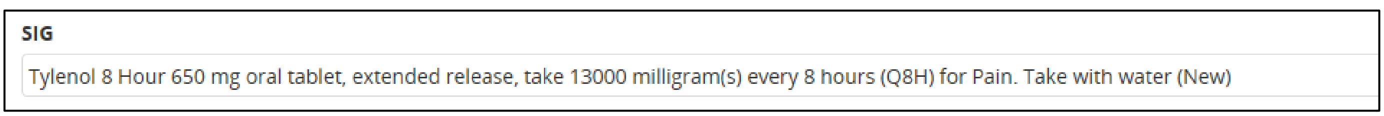
9. Status; if applicable, tap one of the check boxes:
    - **New Medication**
    - **Changed Medication**



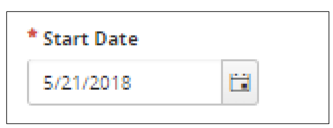
10. Enter special instructions. You can enter a maximum of 250 characters in the field.



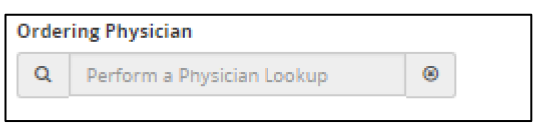
11. SIG is the Physician's instruction for how the patient should use the medication. The SIG is auto-populated based on the medication entry data fields above and is read only. Verify the SIG information is correct. The SIG is what gets printed on reports and should match the instructions the Physician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

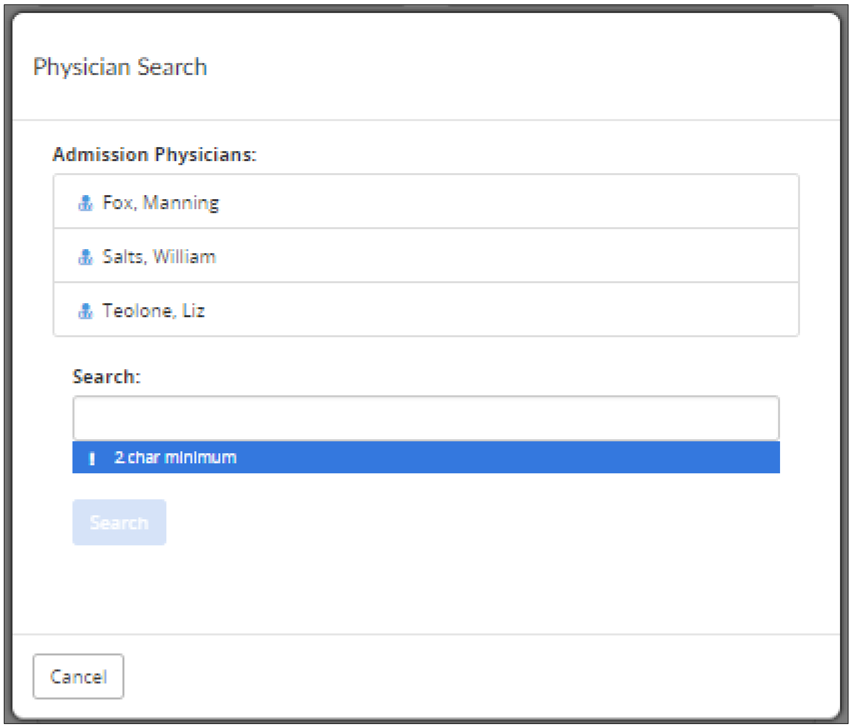


12. The Start date default date is the schedule date or todays date when not coming from a schedule and can be modified by tapping on the date picker.

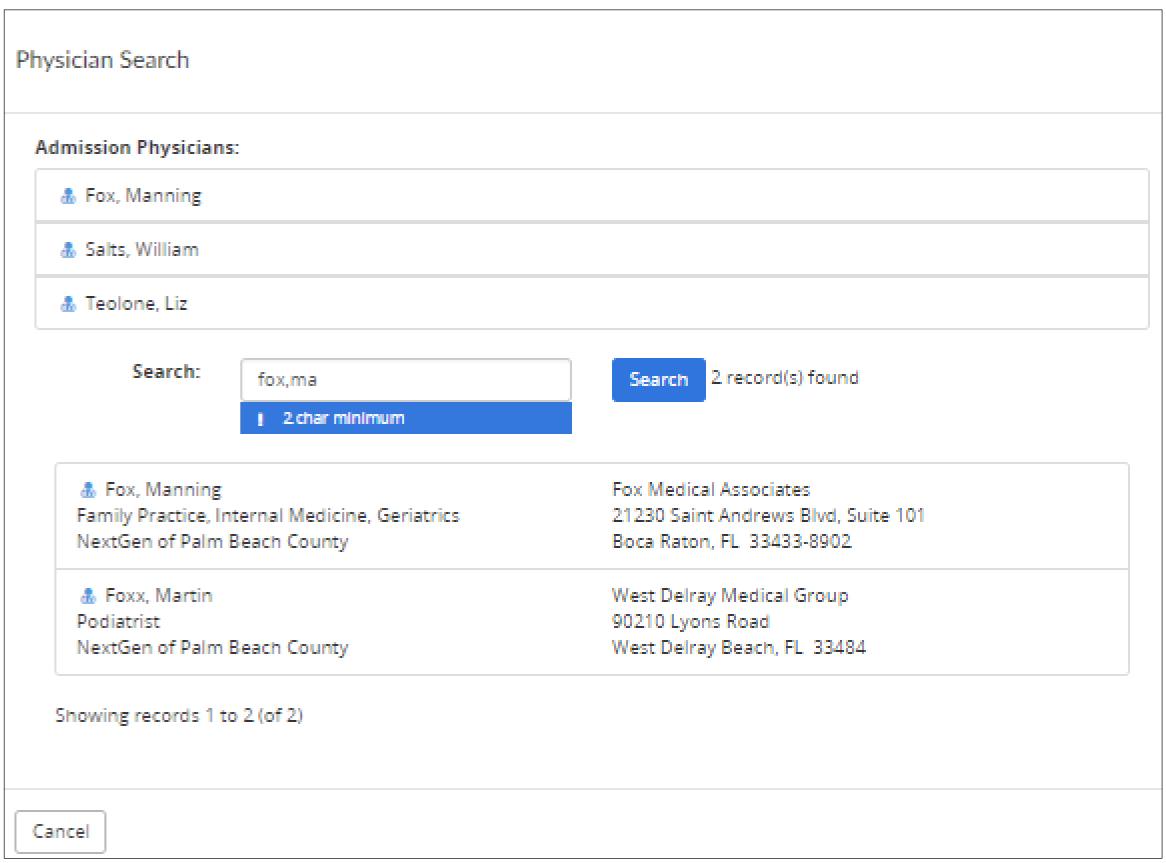


13. The Ordering Physician field is optional. The Primary Physician from the Admission Physicians tab is defaulted. To enter or change the Ordering Physician, tap the magnifying glass to search and then select the physician that prescribed the medication.

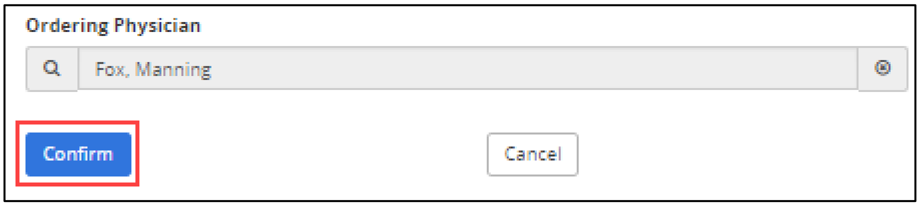




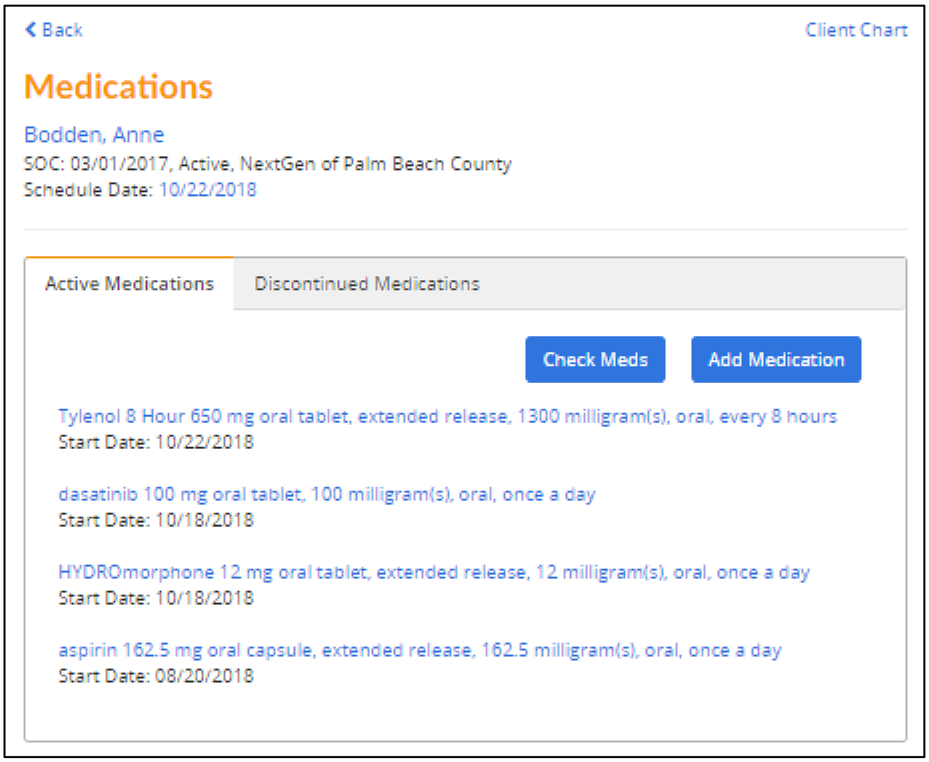
Note: You must enter a minimum of two characters when searching for a physician. You can search by the first two characters of the last name, or the last name and first two characters of the first name or by entire last name, first name and tap **Search**.



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

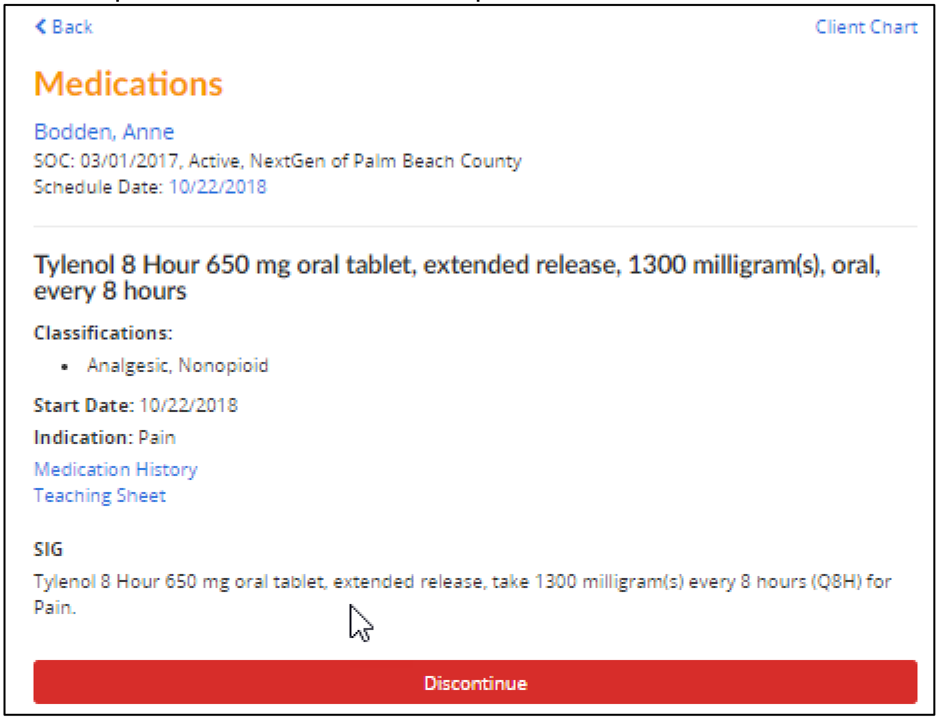


The new medication now displays in the list on the Active Medications tab. Active medications are sorted by start date in reverse chronological order.



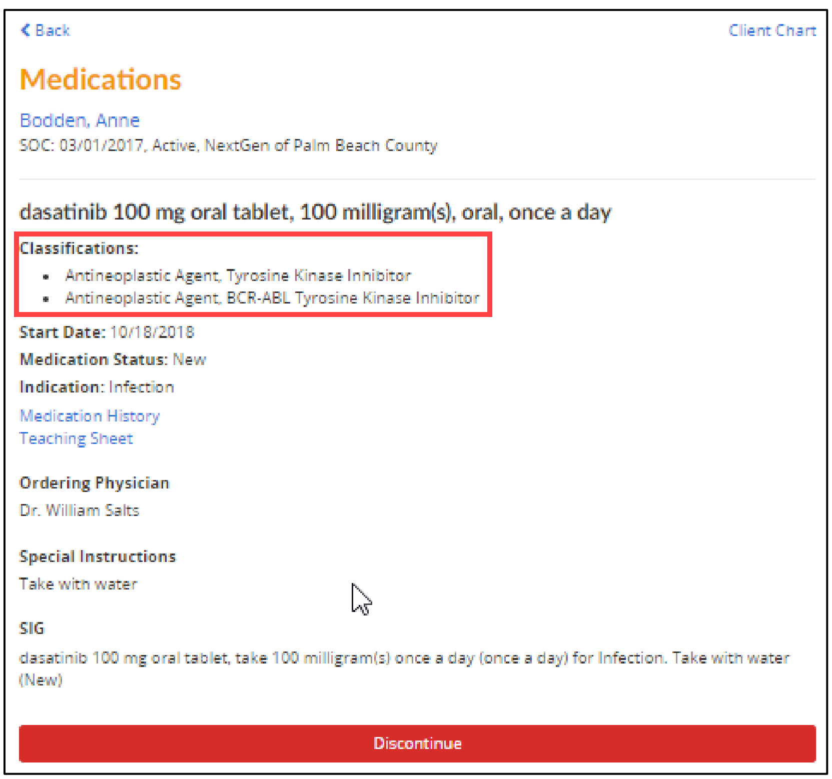
Follow the previous steps to enter additional medications for the client.

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



Medications Classifications

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



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.

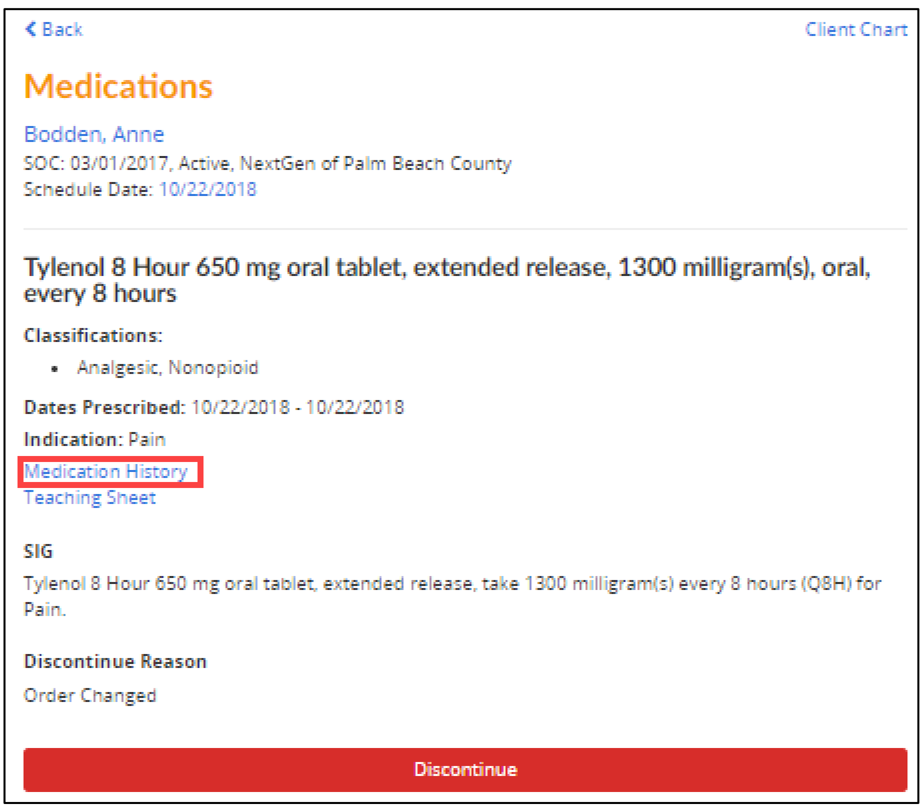
A Chart History page opens displaying Record history for the selected medication.

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

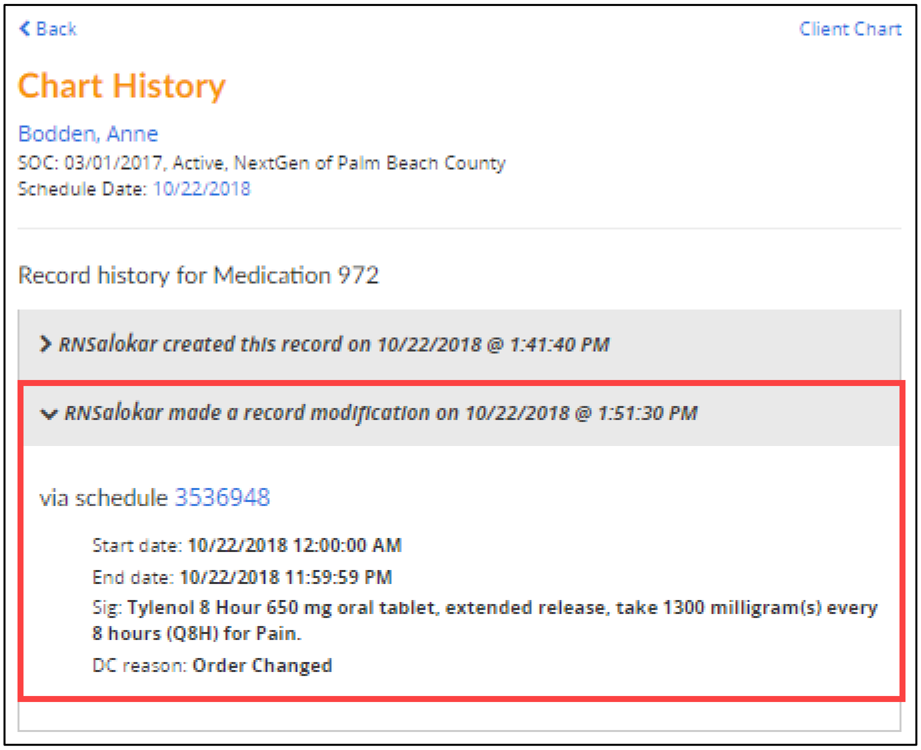
- User's name and the date and time of when medication was created or modified.
- Activity or Schedule change reference ID
- Start Date
- End Date (if discontinued)
- SIG
- Discontinue reason (if discontinued)

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.

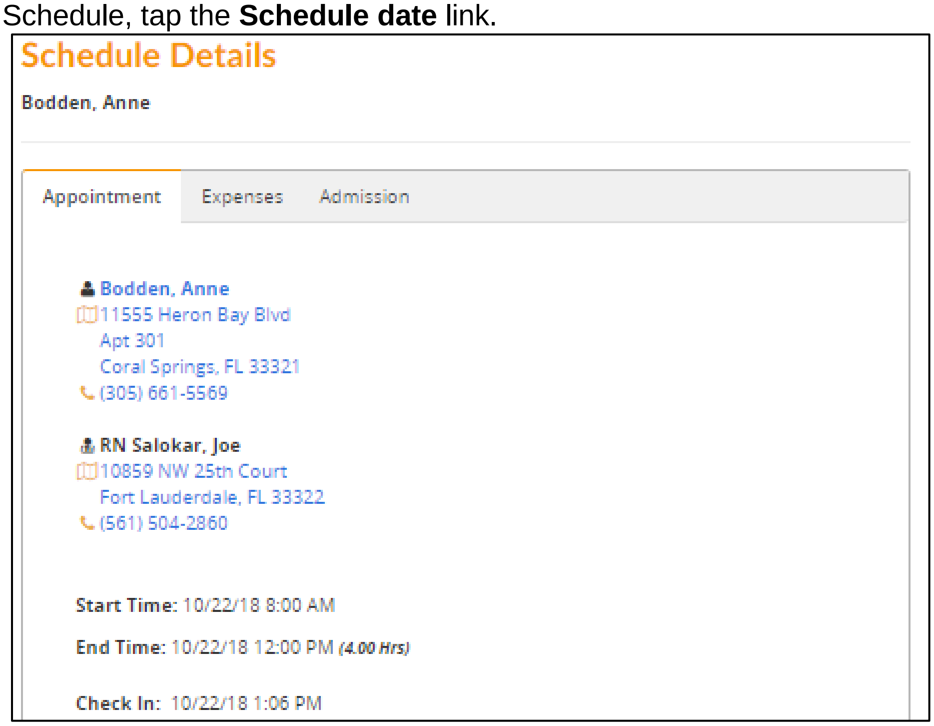


A Chart History page shows a history of entries that can be expanded to show more historical detail about the client's medication.



The information is view only and cannot be modified.

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

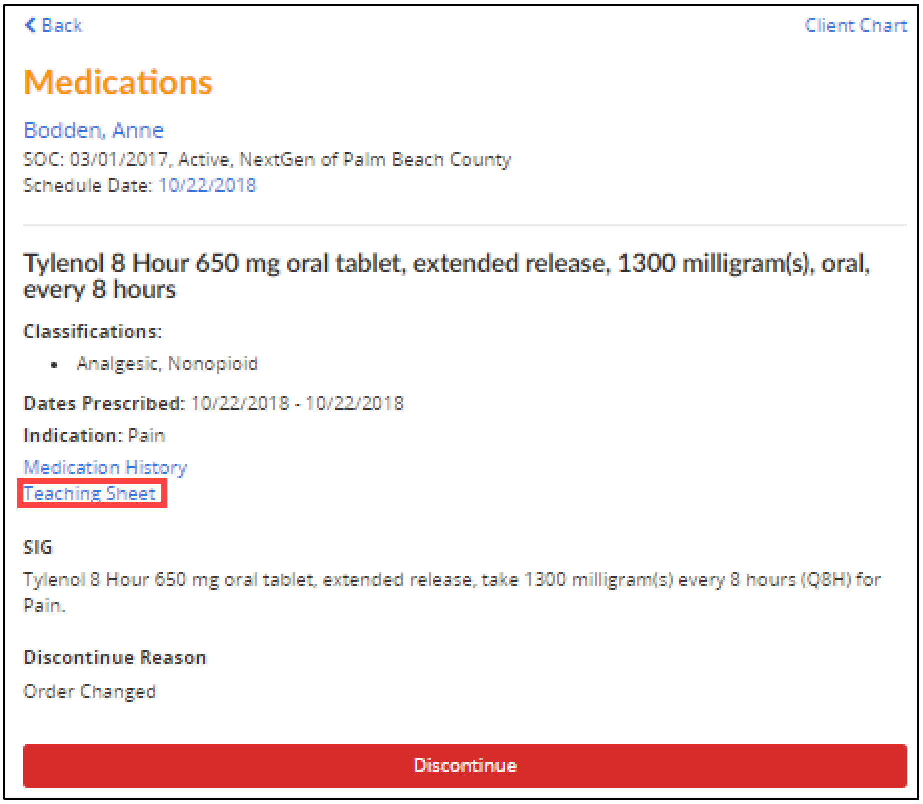


Medication Module – Teaching Sheet

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, Elixsure 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?

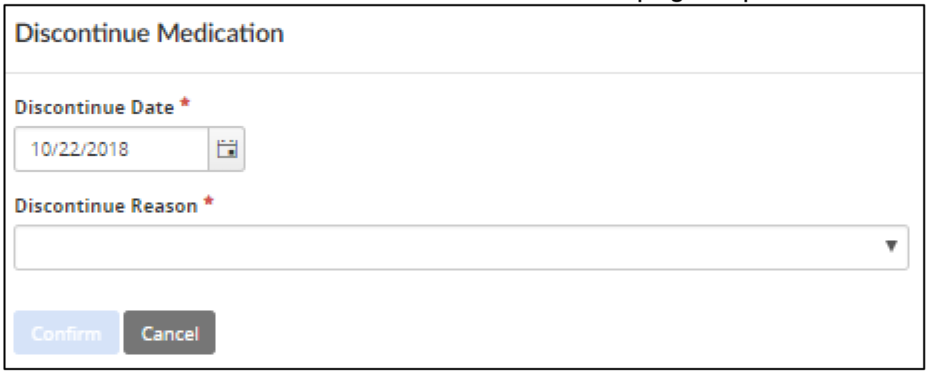
- You should not take acetaminophen if you are allergic to it, or if you have severe liver disease.
- **Do not take acetaminophen without a doctor's advice if** you have ever had alcoholic liver disease (cirrhosis) or if you drink more than 3 alcoholic beverages per day. You may not be able to take acetaminophen.
- 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.**

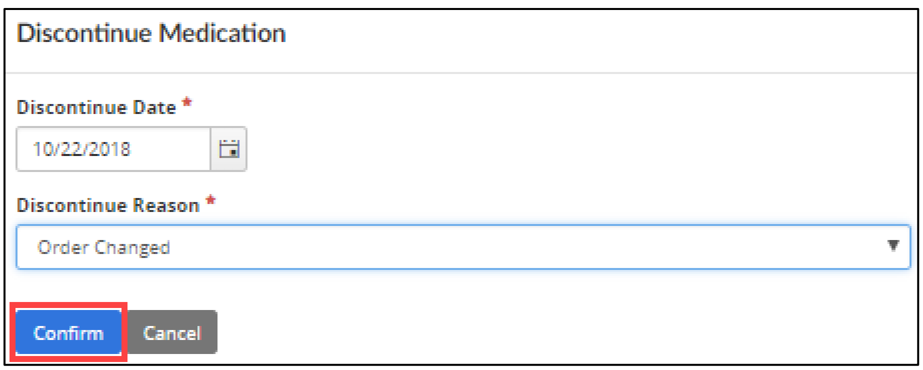
Discontinuing a Medication

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

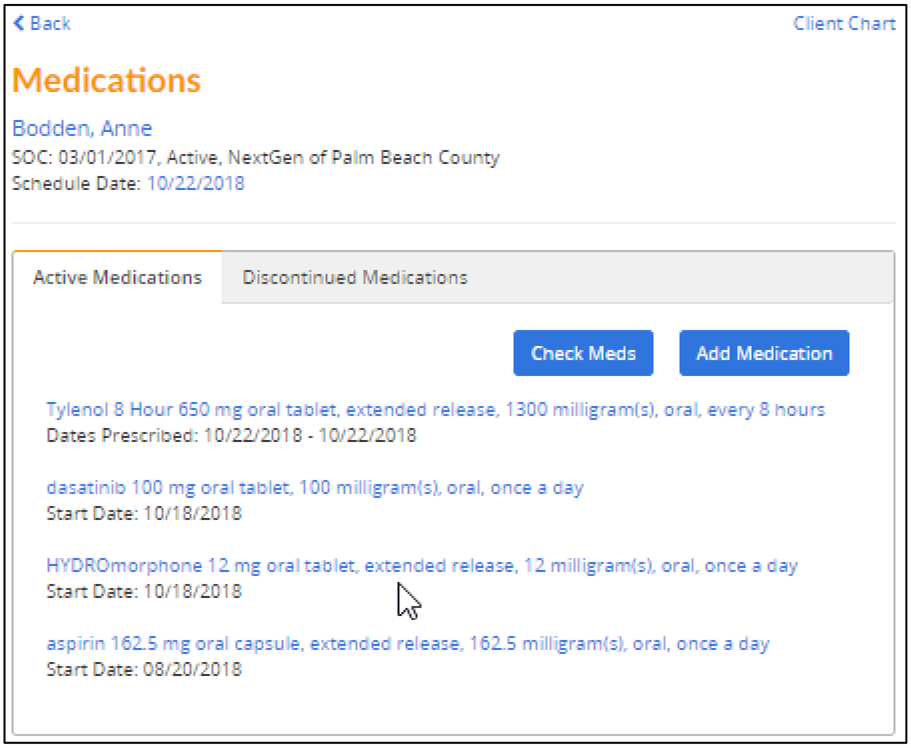


2. Enter the date the medication will be discontinued. The default date is the schedule date or todays date and can be changed by tapping the date picker when not coming from a schedule.
3. Enter the reason for discontinuing the medication.

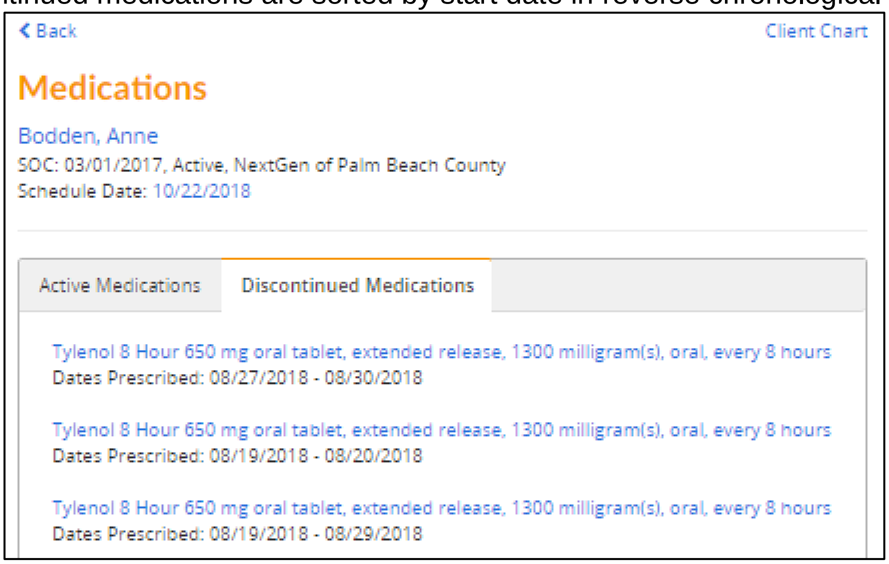
   Note: If you select an Discontinue Reason of **Other**, a Please Specify Other text box appears requiring you to enter the reason for the discontinuation of medication. You can enter a maximum of 50 characters in the field.



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.



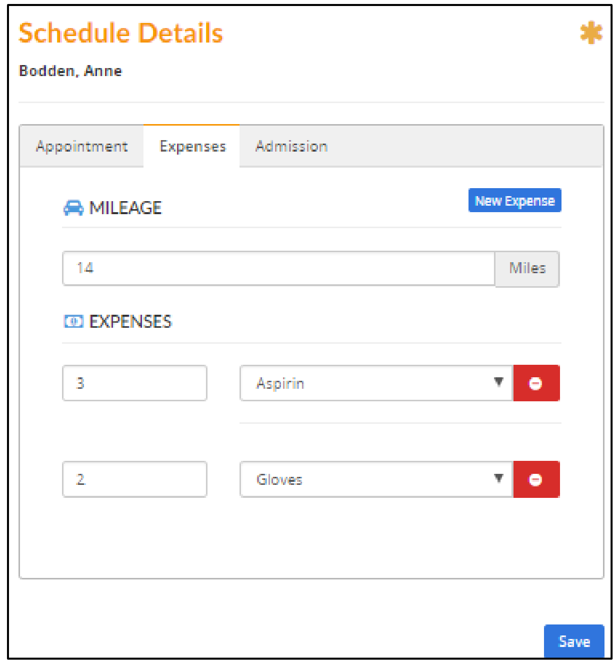
Entering Mileage and Client Expenses

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** 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 conformation message appears for you to continue or cancel.
3. Tap **Save** to complete your expenses.

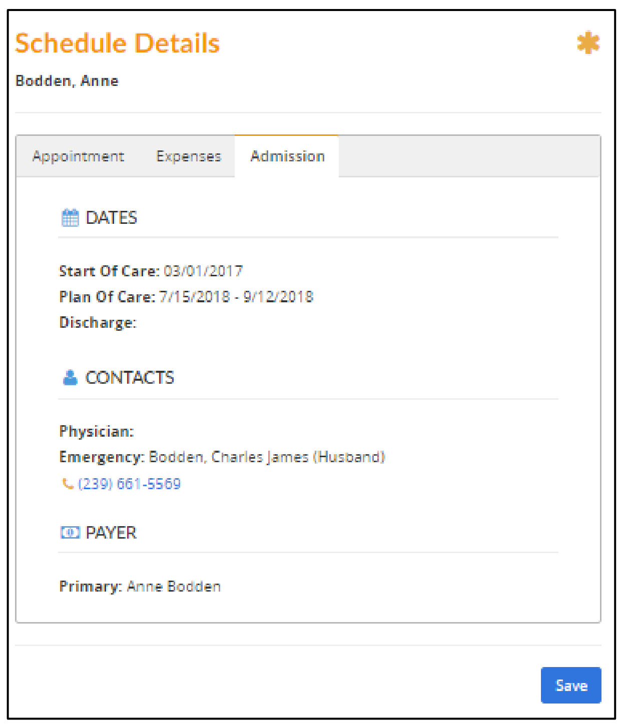


Viewing Client Admission

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.

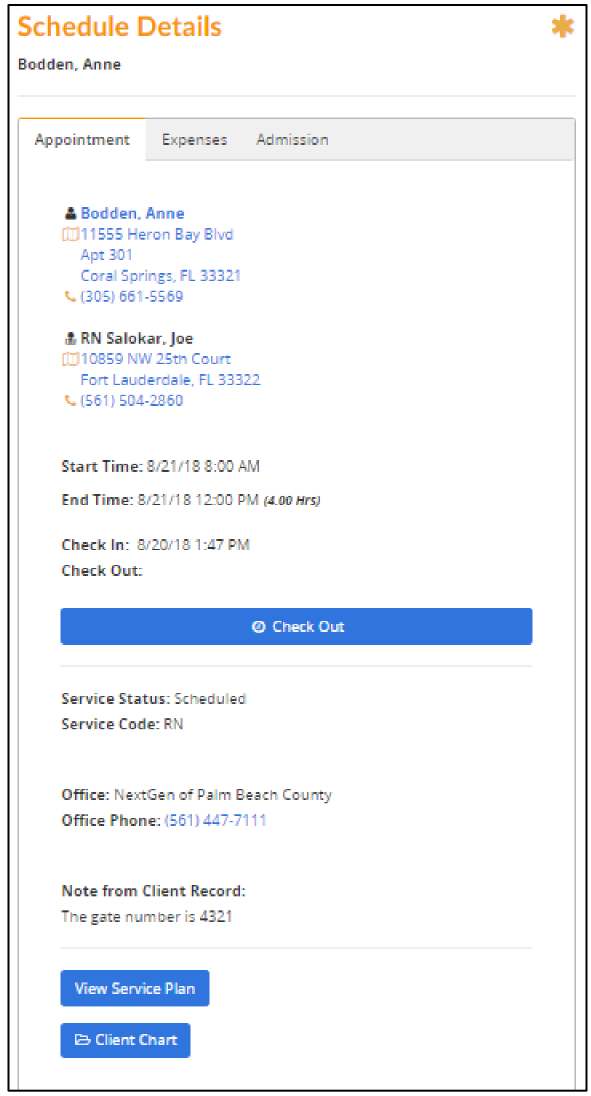


Checking Out of the Client Location and Publishing a Service Plan

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:

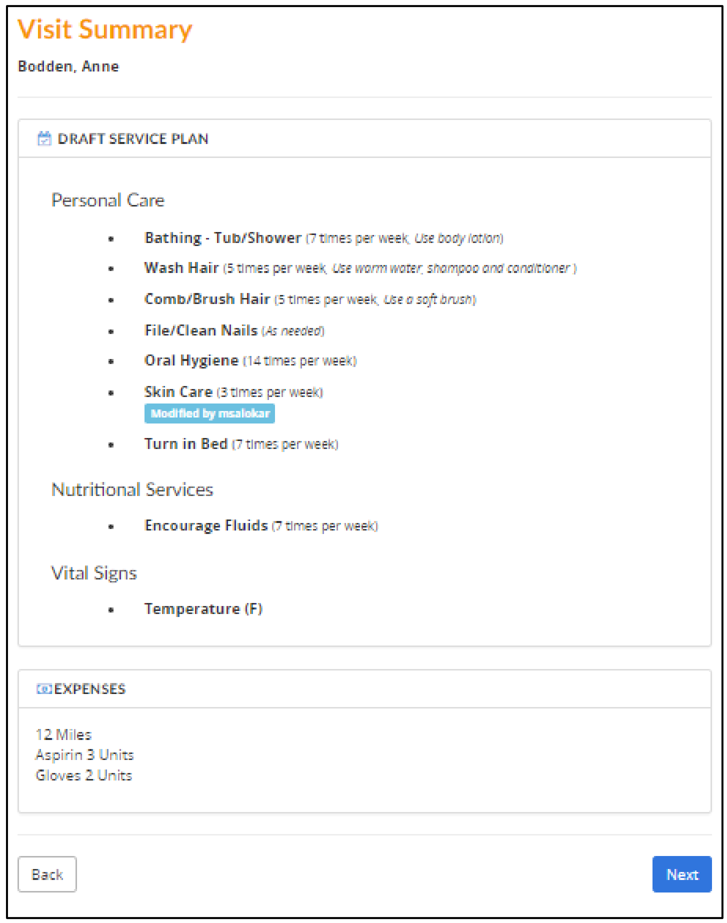
1. On the **Appointment** tab, scroll down and tap **Check Out**.



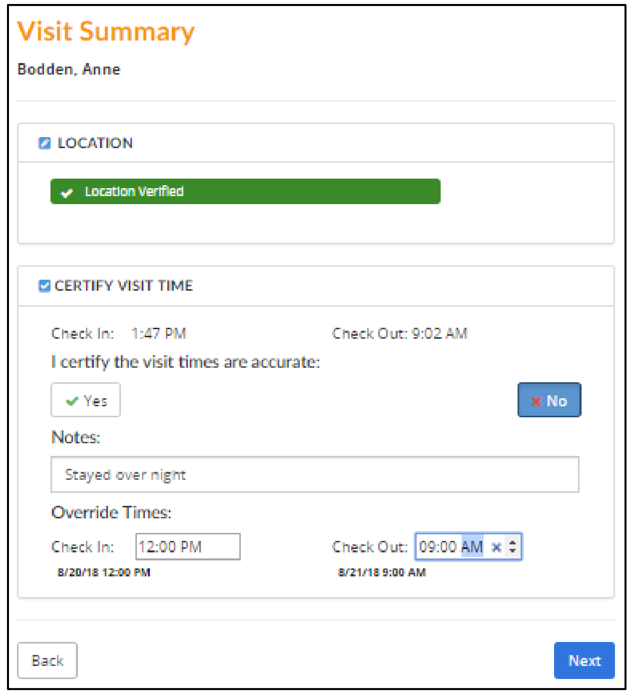
2. A Visit Summary shows the following information for your client visit:

    - 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**.

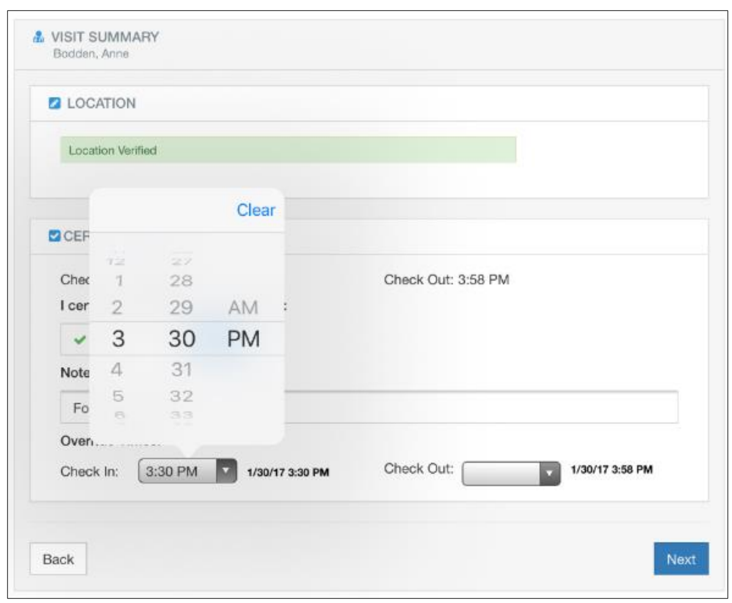


4. The Visit Summary Review page displays showing your GPS location results status. You must certify the visit time is accurate by reviewing the Check In and Check Out times. Tap **Yes** or **No** to certify the visit times.
5. If the caregiver answers **Yes**, the Notes field is optional and the caregiver 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.

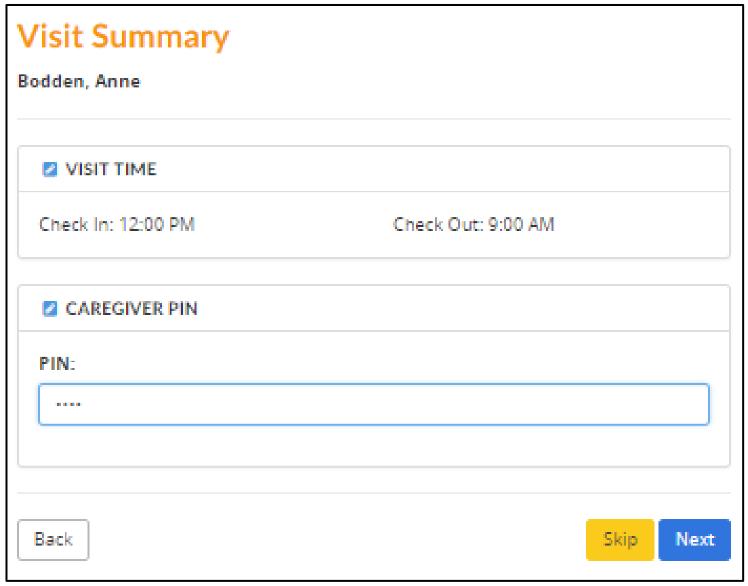
7. Tap **Next.**



8. Enter your 4-digit Caregiver PIN.

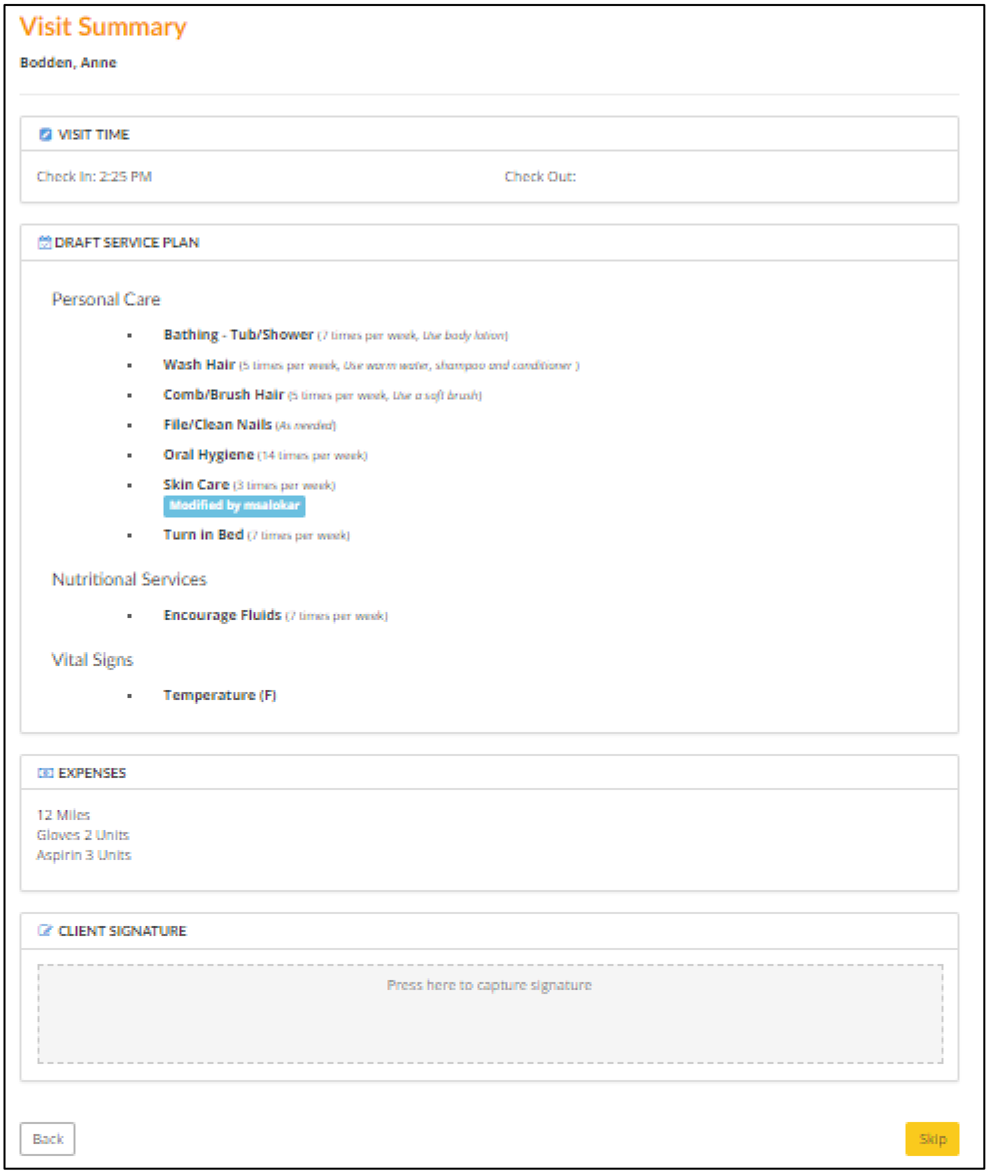
Note: If you do not enter a PIN or enter the wrong pin, a message “PIN is invalid” appears in red. If you forgot your caregiver PIN, navigate to your account setting and select **Manage Signature Pin** to change your PIN.

9. Tap **Next.**

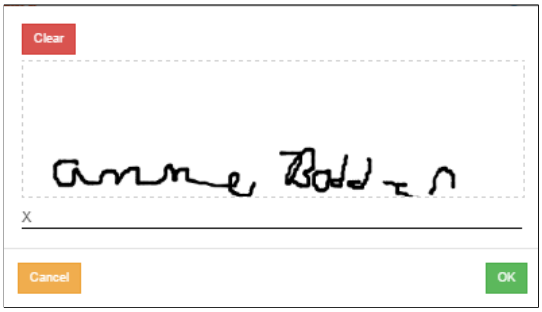


10. Scroll to the bottom of the page, rotate the device (if needed) and tap on the **Capture Client Signature** pane. This page is for the client to review the visit summary and sign.

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

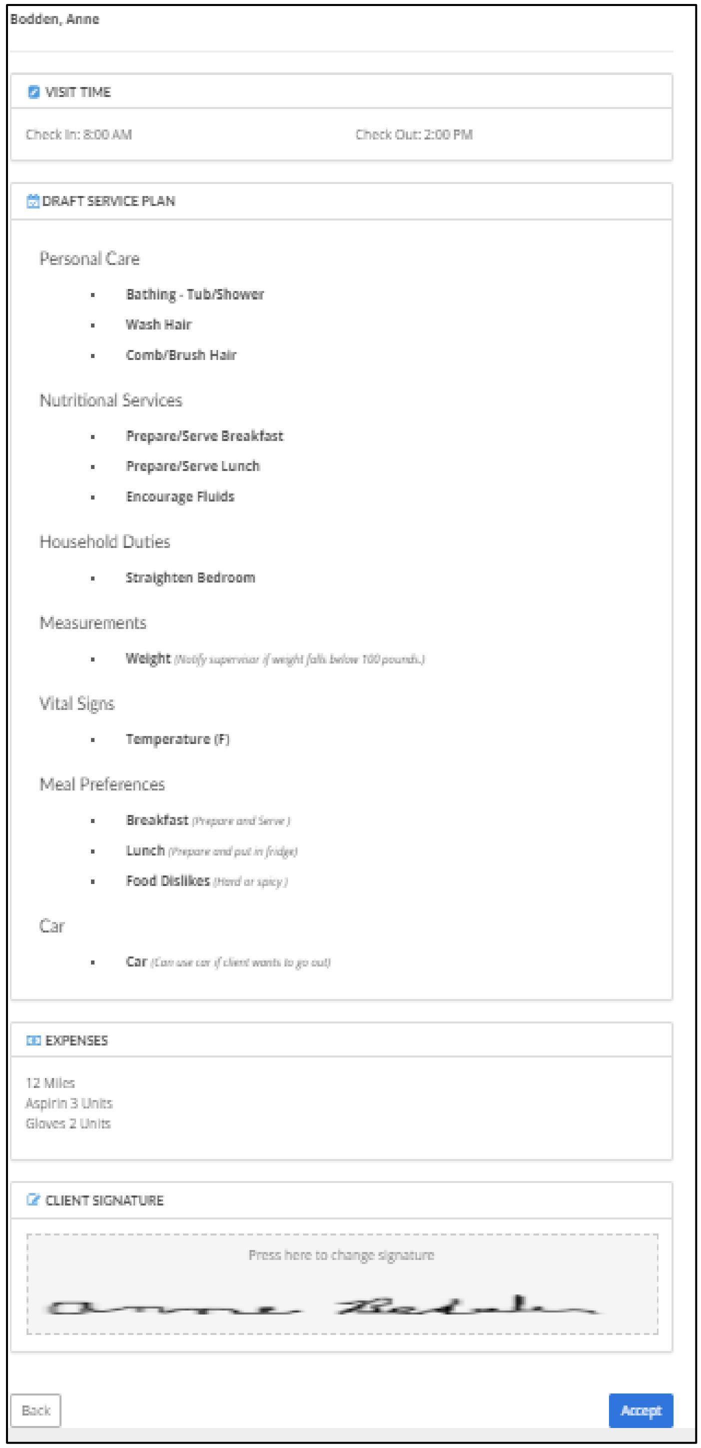

Visit Summary
Bodden, Anne
VISIT TIME
Check In: 2:25 PM
Check Out:
DRAFT SERVICE PLAN
Personal Care
Bathing - Tub/Shower (7 times per week, Use body lotion)
Wash Hair (5 times per week, Use warm water, shampoo and conditioner)
Comb/Brush Hair (5 times per week, Use a soft brush)
File/Clean Nails (As needed)
Oral Hygiene (14 times per week)
Skin Care (3 times per week)
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.

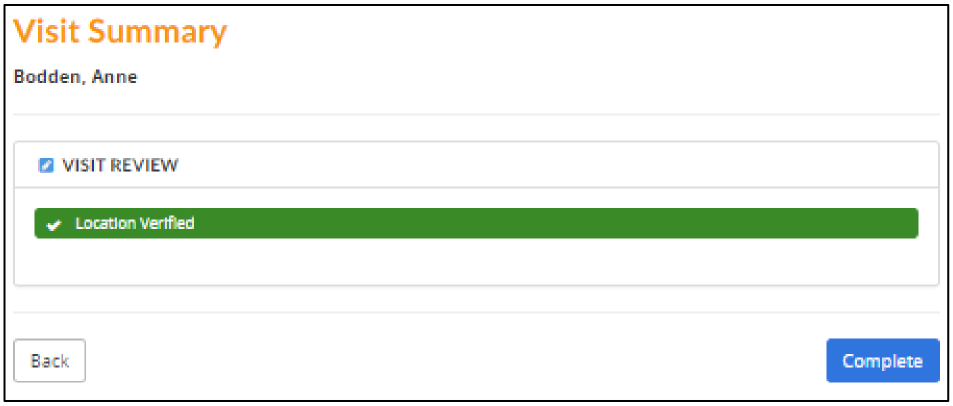


12. After signing tap **OK**.

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

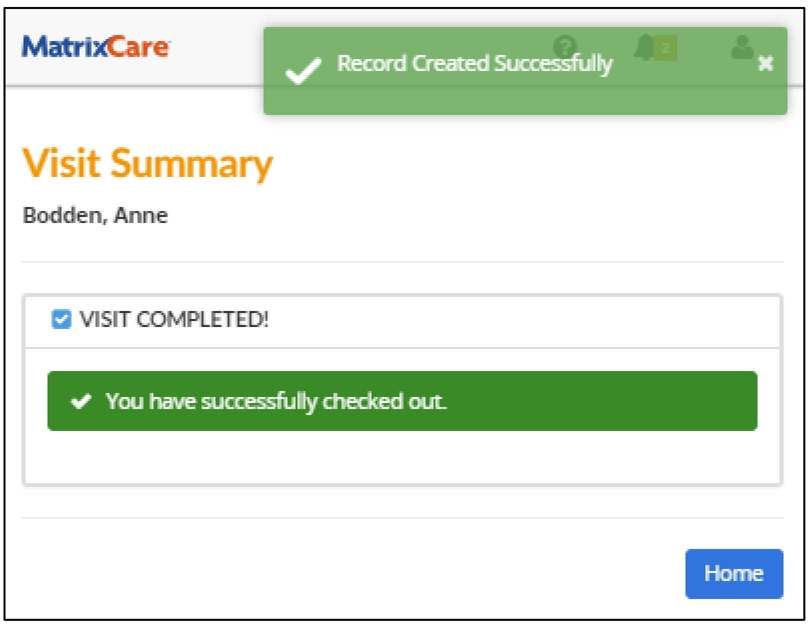


14. Tap **Complete** to record the checkout.



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.



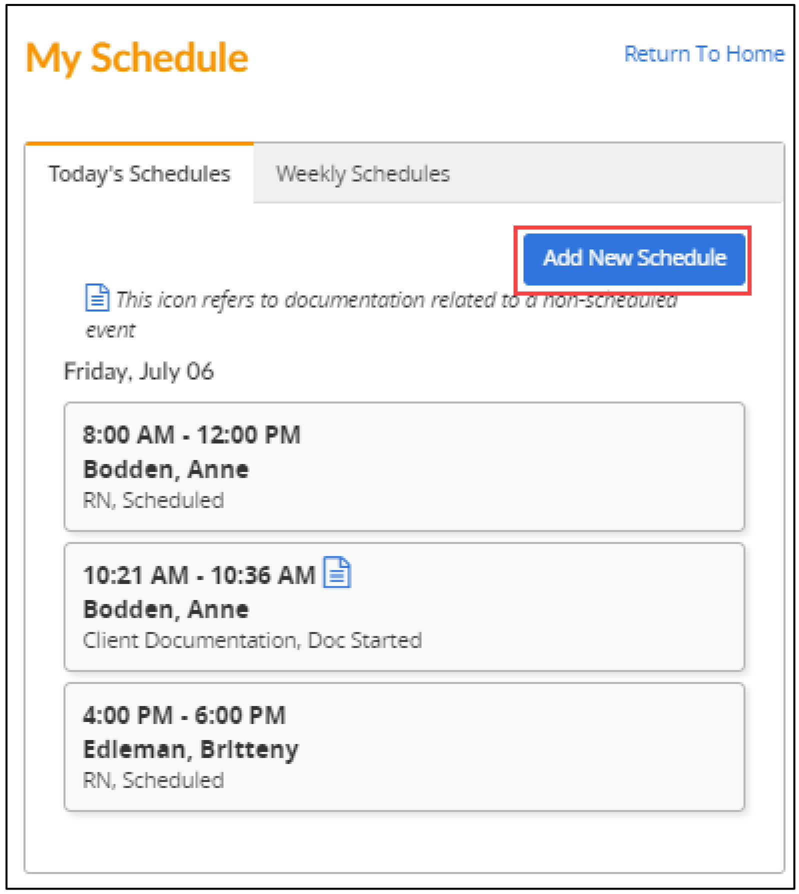
Pressing **Home** brings you back to the tiles on the main page.

Adding a New Schedule UPDATED

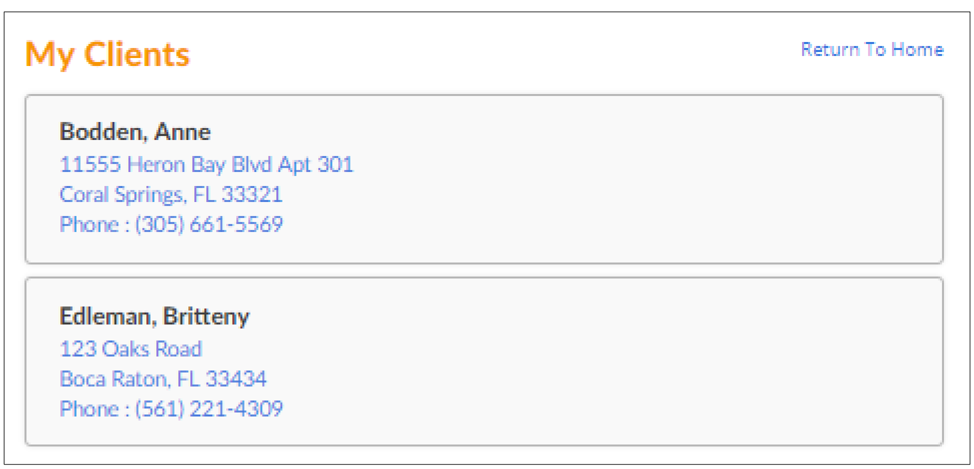
A skilled professional user can create a new schedule by tapping the **Add New Schedule** button when viewing Today's Schedules.

To add a new schedule on an existing client:

1. From the Home Page tap **My Schedule** to display Today's Schedules.

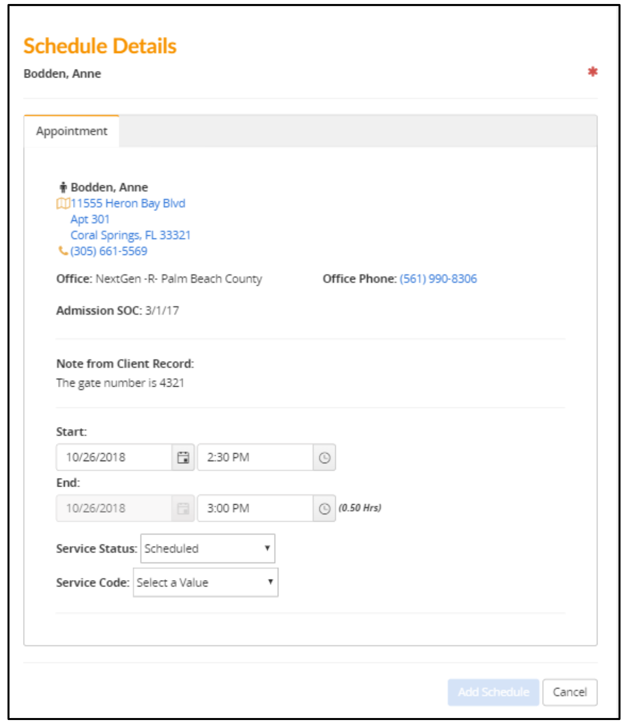


2. Tap **Add New Schedule** and the My Client list displays.
3. Select the client you want to create the new schedule for.



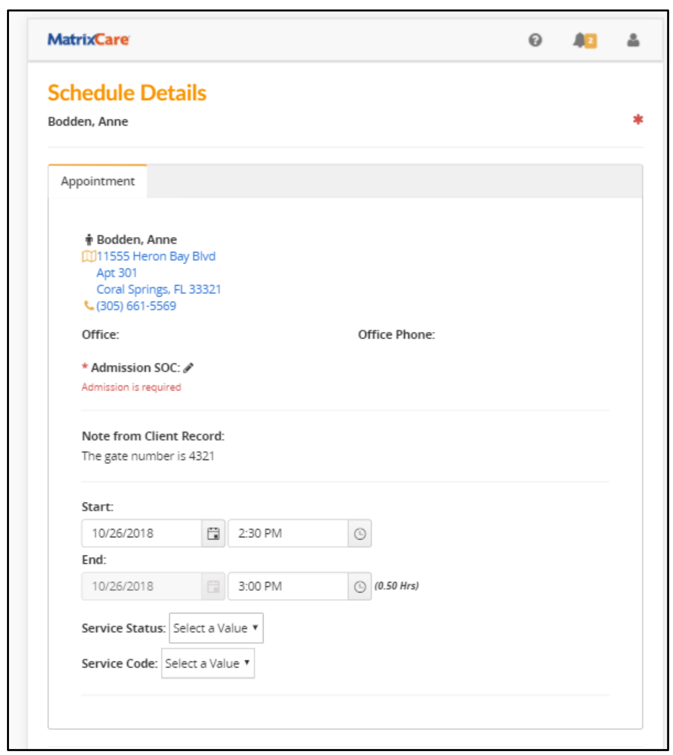
The Appointment tab displays with the Schedule information.

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



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.



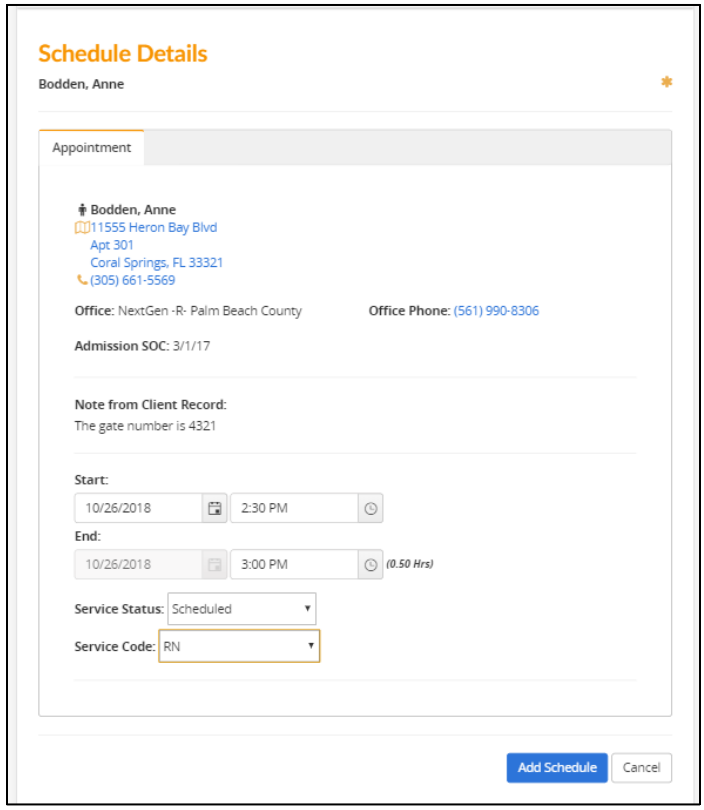
- An Admissions pop-up appears displaying multiple Admissions with the following information; Payer, Office, SOC Date, Discharge Date and Admission Status. Select one of the appropriate Admissions for your new schedule. The following shows an example of a client with multiple Admissions to select from.

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**.



Confirmation messages will display and the new schedule is added.

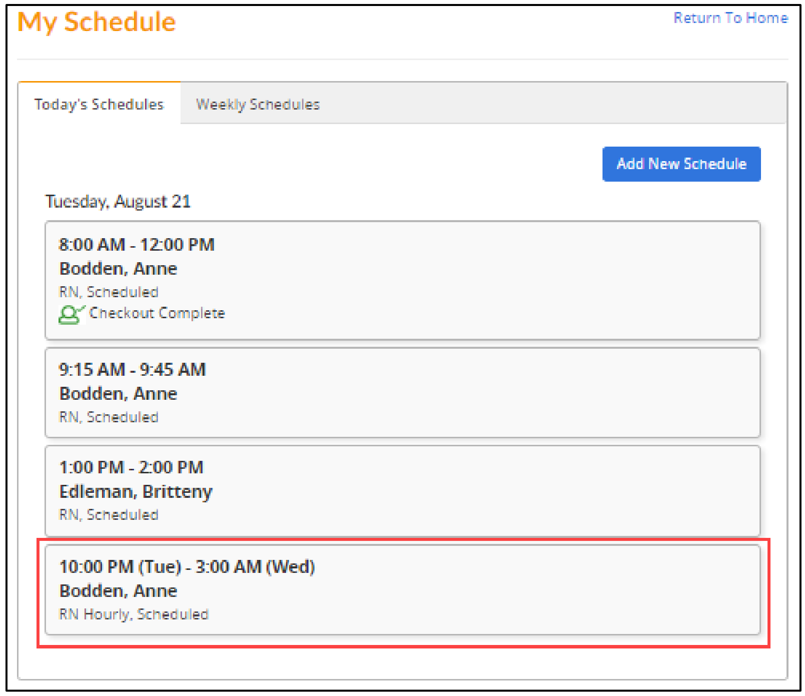
Tap the MatrixCare Logo go back to the Home page or you can sign out of the mobile application.

Overnight Schedules

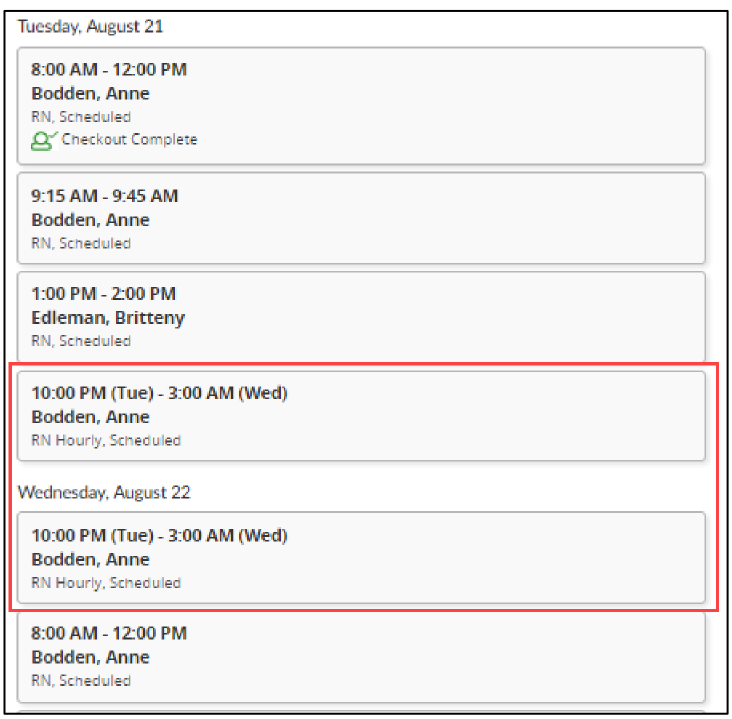
A Caregiver with an overnight schedule that ends on the current date, can see that schedule on my Today's Schedules or Weekly Schedules so it's easy to find when checking out from a client visit.

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:



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).

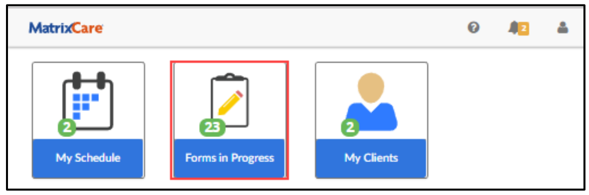


Forms In Progress

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

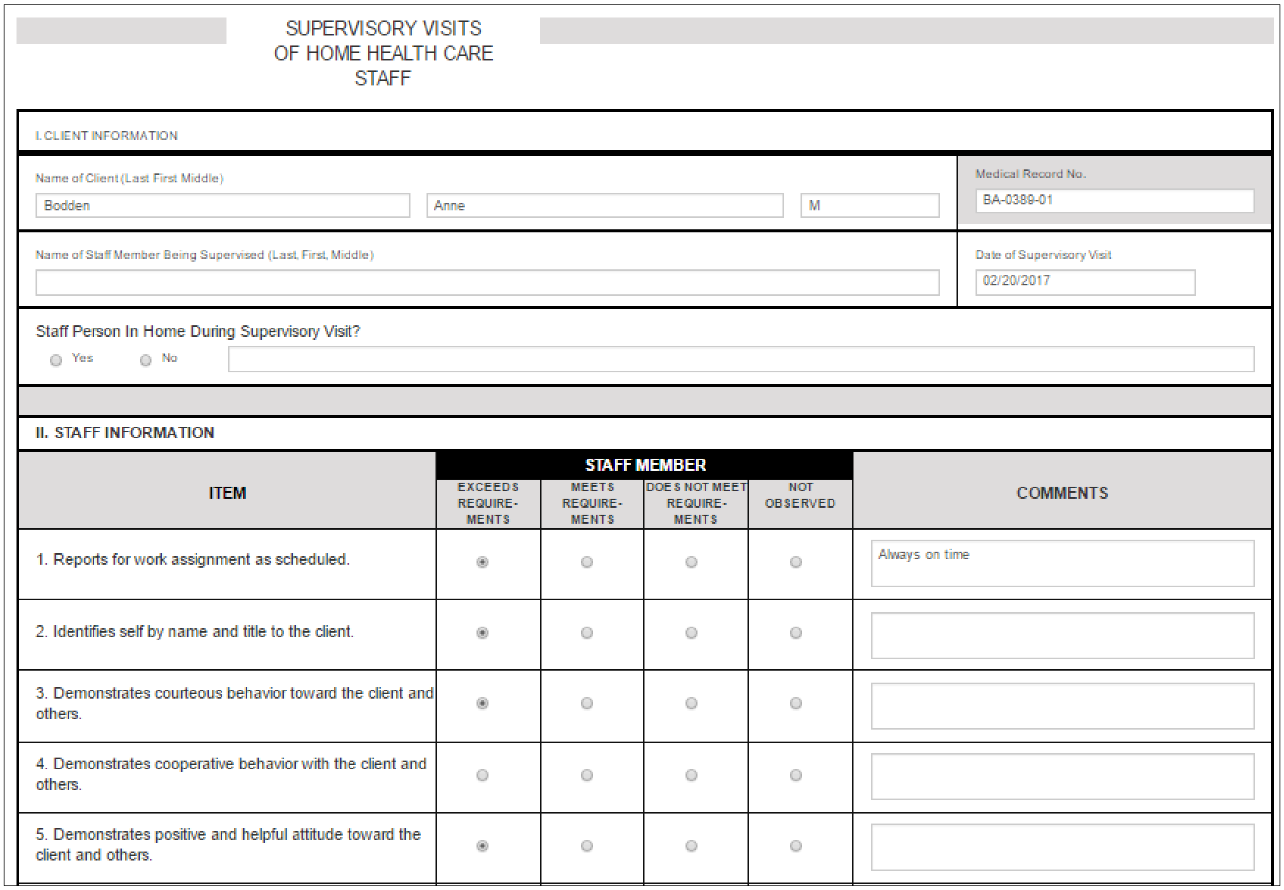
Forms In Progress

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): Bodden | Anne | M

Medical Record No.: 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?

Yes No

II. STAFF INFORMATION

ITEM	STAFF MEMBER EXCEEDS REQUIRE-MENTS	MEETS REQUIRE-MENTS	DOES NOT MEET REQUIRE-MENTS	NOT OBSERVED	COMMENTS
1. Reports for work assignment as scheduled.	◉	○	○	○	Always on time
2. Identifies self by name and title to the client.	◉	○	○	○	
3. Demonstrates courteous behavior toward the client and others.	◉	○	○	○	
4. Demonstrates cooperative behavior with the client and others.	○	○	○	○	
5. Demonstrates positive and helpful attitude toward the client and others.	◉	○	○	○	

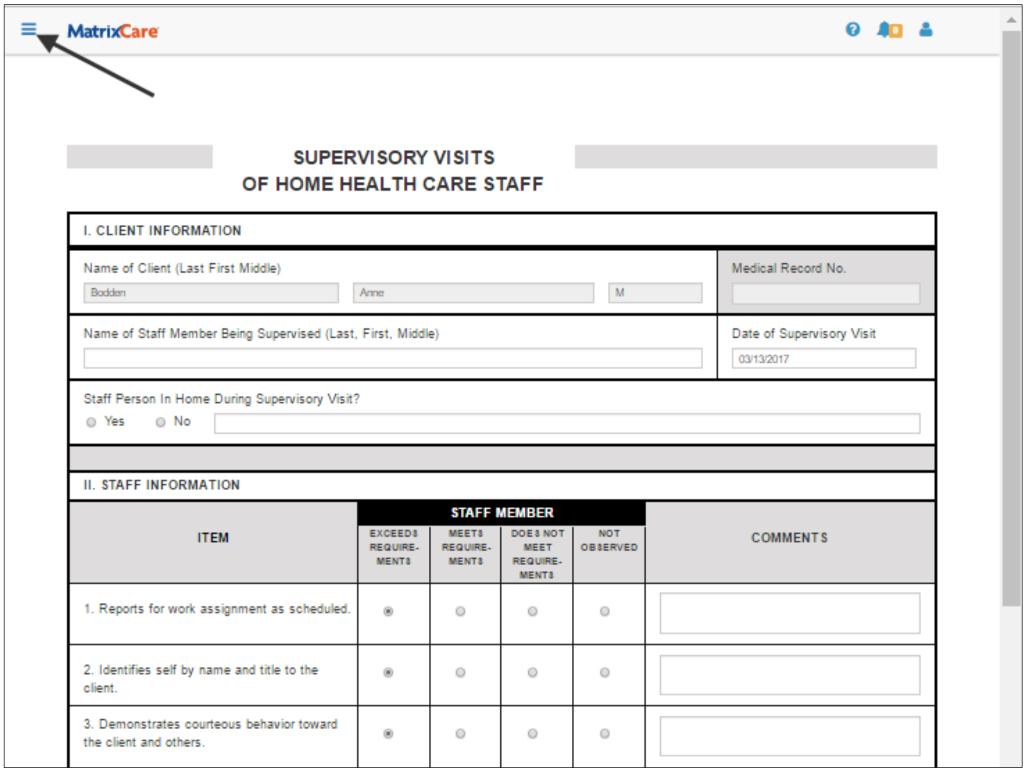
2. Fill out the form.
3. Scroll down the form and tap **Save**.

Settings Forms on the Schedule to Ready for Review Status

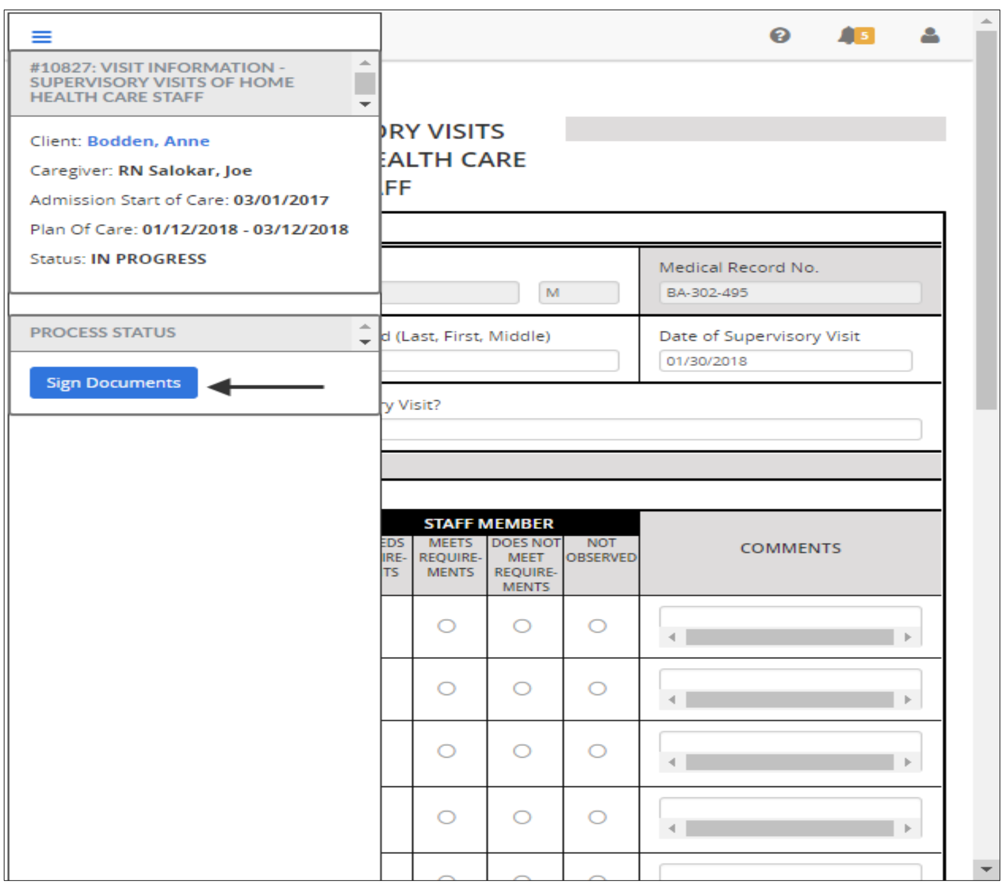
A skilled professional user can sign their completed forms when setting them to “Ready for Review Status”. The office user has the ability to review and approve or revert the forms back to In Progress after the skilled professional user has completed them.

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

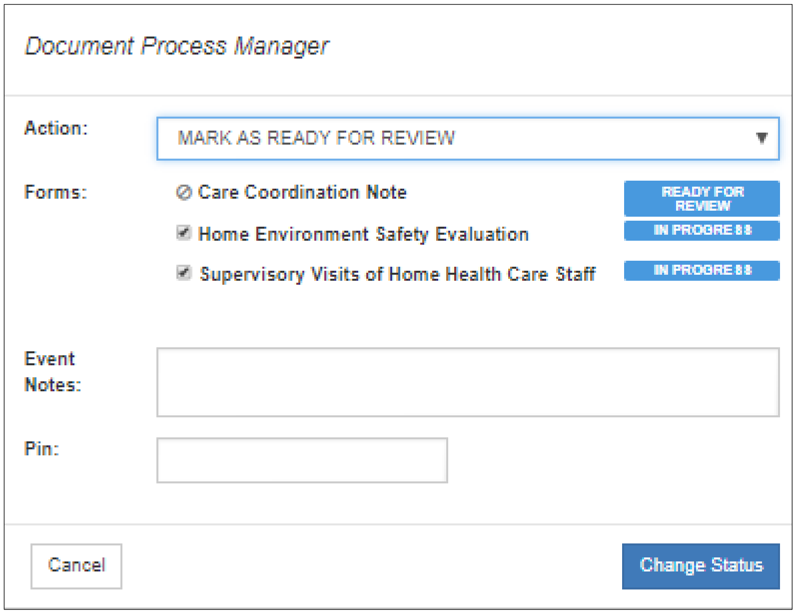
1. On the Home page, tap **Forms in Progress**.
2. On the Forms in Progress page, tap the blue form **ID** link.
3. On the main tool bar, in the top left corner, tap the hamburger ≡ button to display the navigation panel. The navigation panel shows the detail about the form.



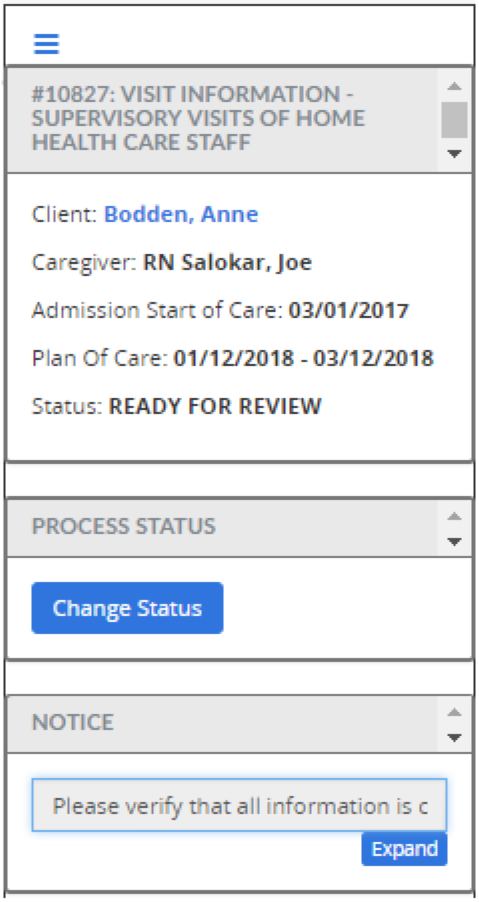
4. Tap **Sign Documents**.

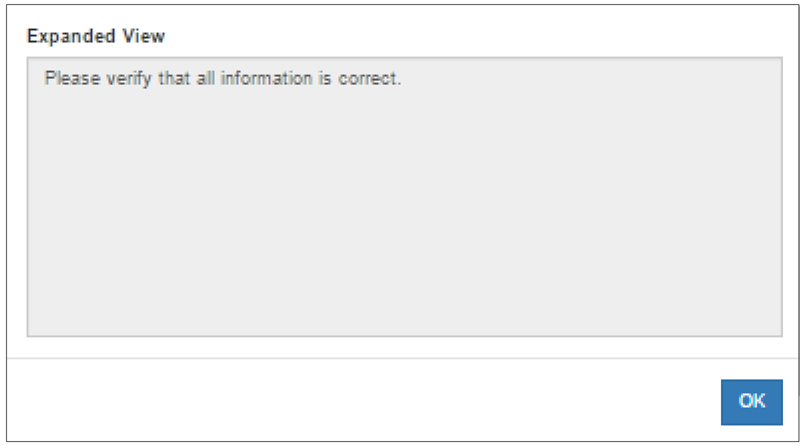


The Document Process Manager popup appears.



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.





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

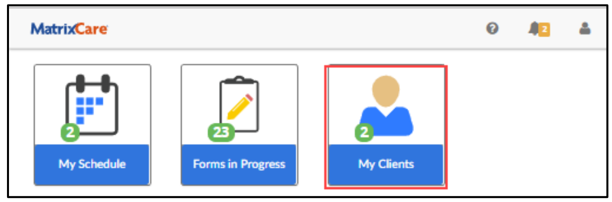
Note: The button label in the navigation menu will be “Sign Forms” when the form is in “In Progress.” The button will change to “Change Status” when the form is in “Ready for Review” or “Reviewed and Approved.”

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.

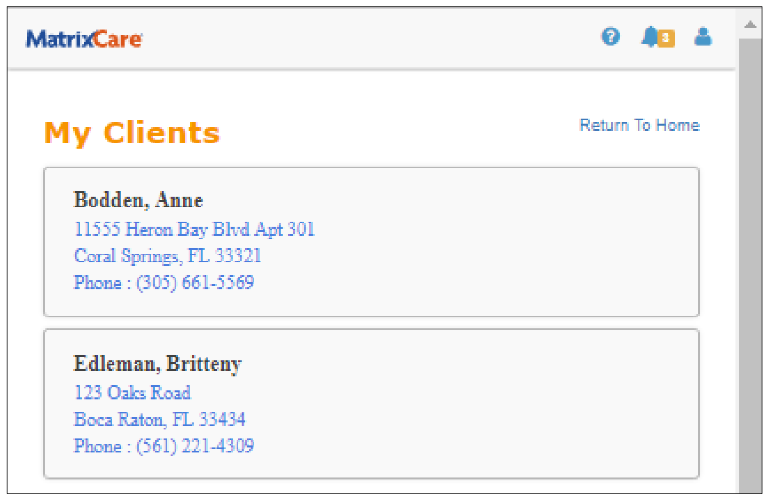
My Clients UPDATED

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.



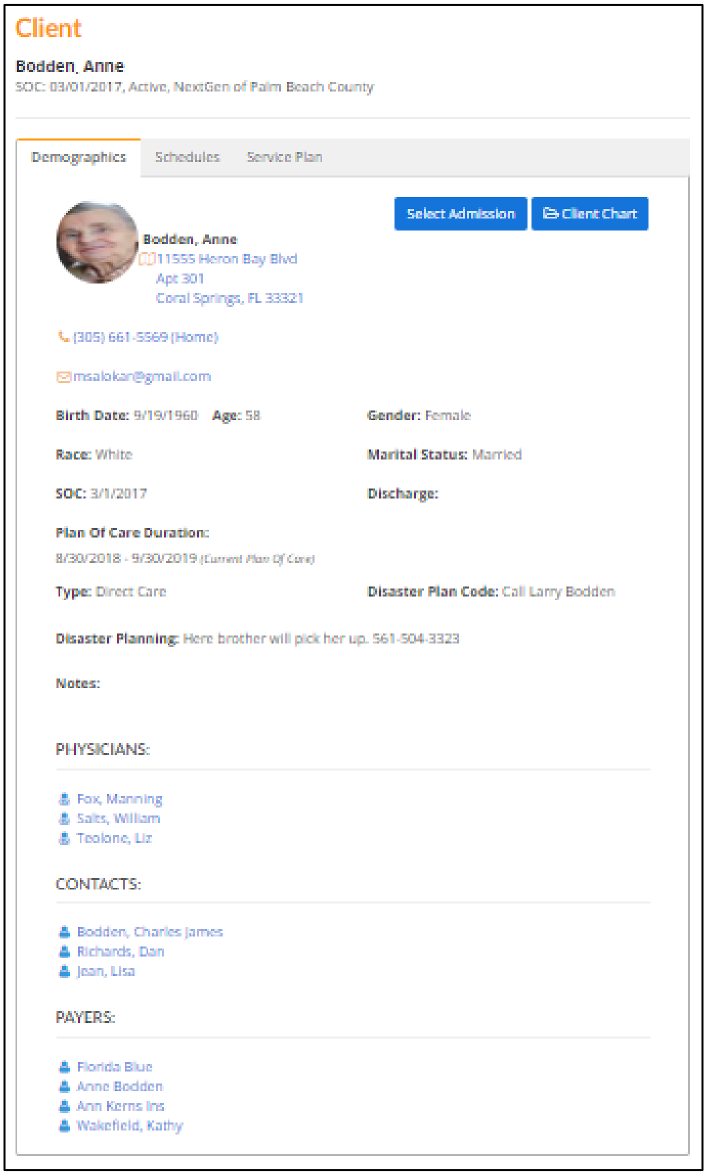
2. Tap the client information to view My Clients details.



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.



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.

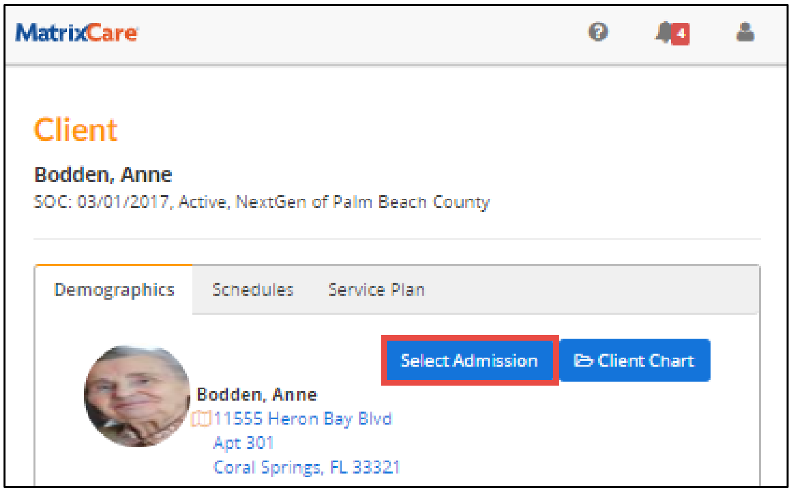
The Client and Schedule details pages header previously showed the clients status. Now the pages show the SOC date, admission status and the office of the displayed admission.

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.



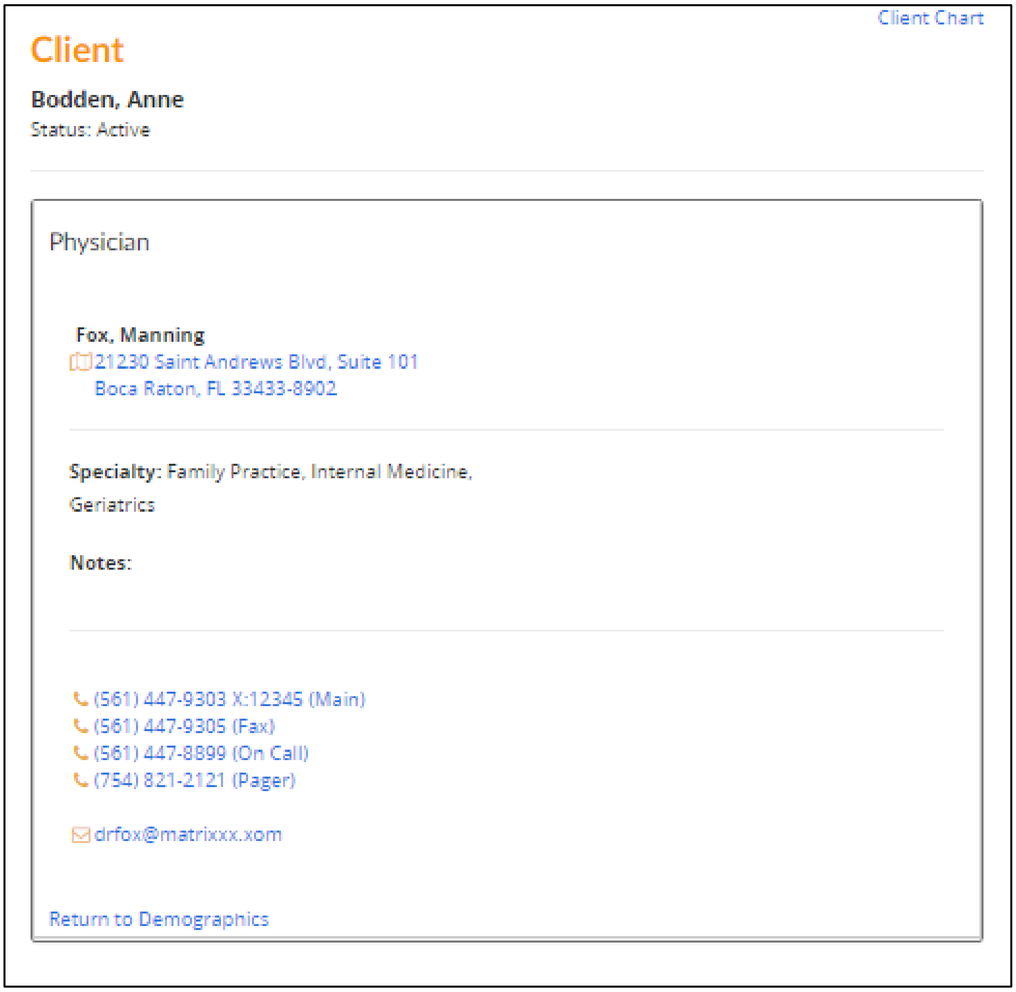
1. When tapping **Select Admission**, the client's admissions will display in descending start of care date order.

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.

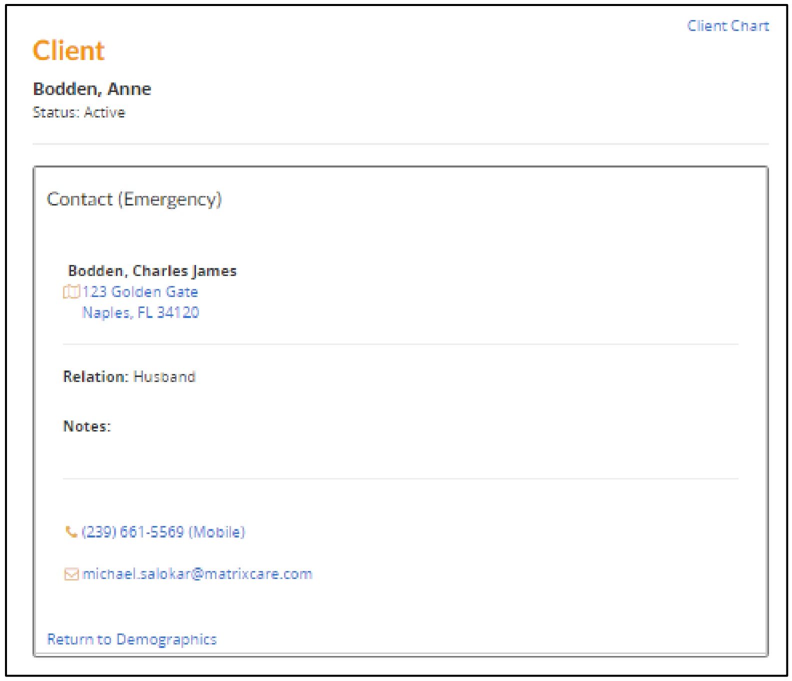
Note: For more information on the Plan Of Care Duration end date modification, refer to the "Recertify Plan of Care Dates" section in this guide.

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.

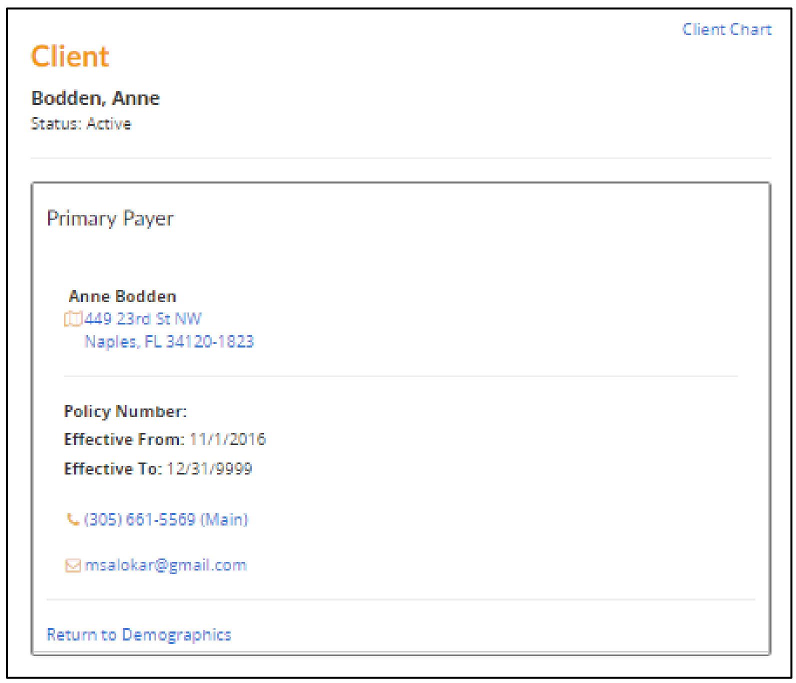


- To view Contact details, tap on the contact's name to view the contact type (such as; Emergency or Family.) The contact's full name and address appears. The Relation to the client appears and any notes about the contact. Also listed are the contact's phone numbers and phone type.



- 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

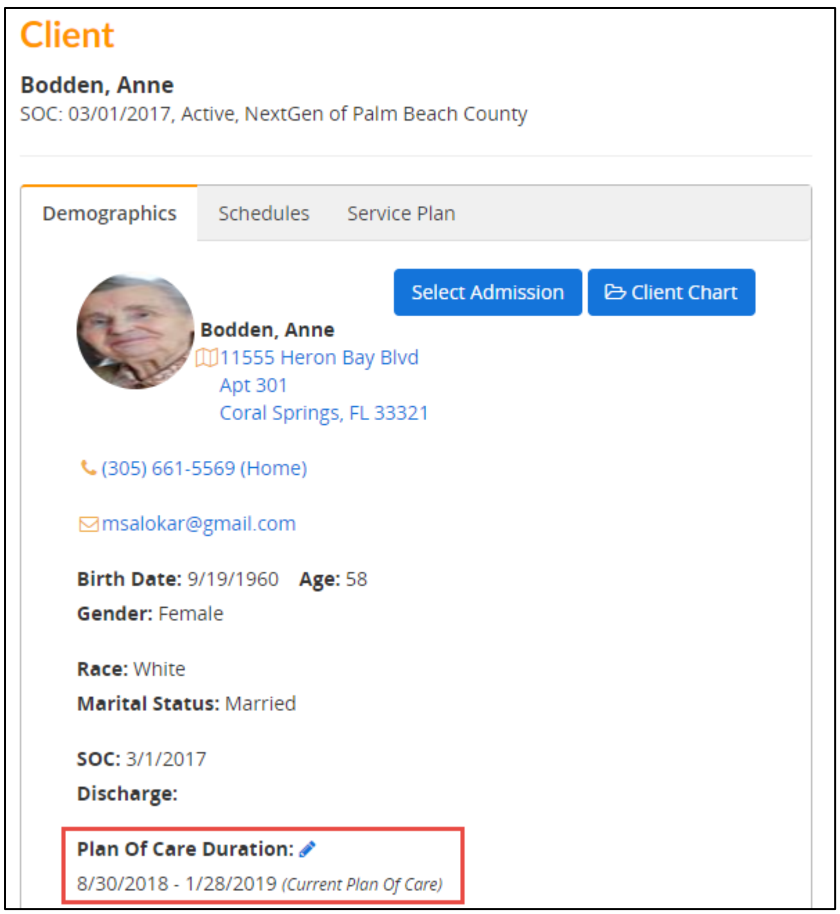
The Clinician can enter recertification plan of care dates or extend the current plan of care via a mobile device for Clients with an active admission, when the current plan of care ends within 14 days and no future plan of care exists.

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.

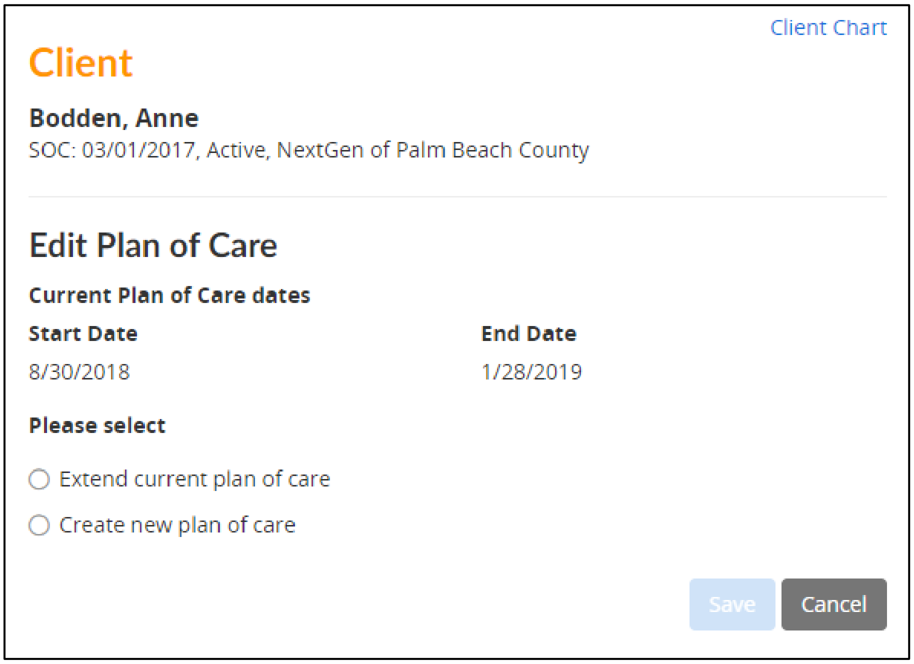


Extending a Current Plan of Care UPDATED

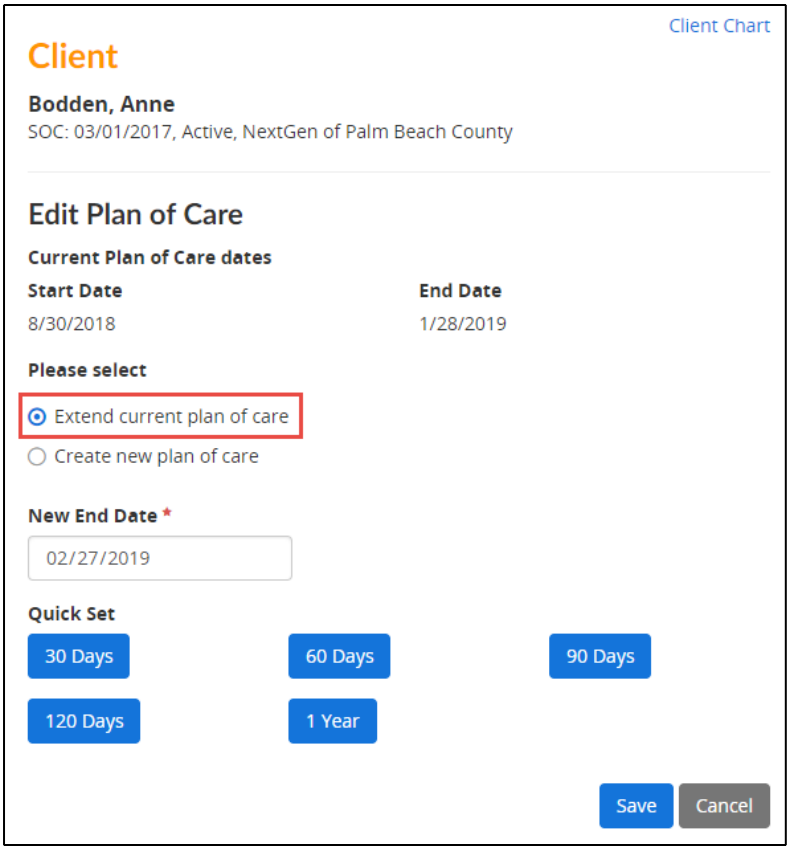
The Clinician can extend the current plan of care dates via a mobile device for Clients with an active admission, when the current plan of care ends within 14 days and no future plan of care exists.

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.

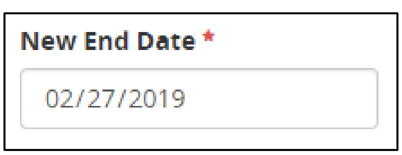


2. On the Edit Plan of Care page, tap the **Extend current plan of care** radio button and then enter the new end date. You can type the date, use the date picker, or select a quick set date.



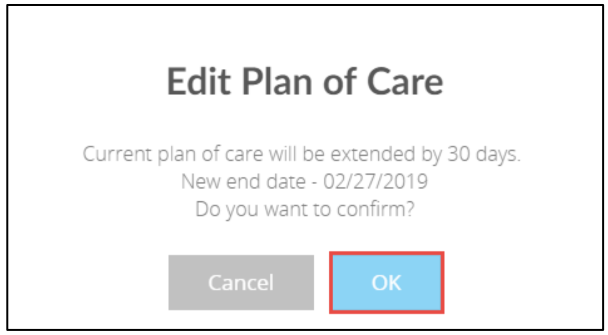
- The default End Date is 30 days, however, a set of days have been provided for the exact number of days to extend the plan of care. Days can be entered by tapping on the Quick Set buttons:
  - 30 Days
  - 60 Days
  - 90 Days
  - 120 Days
  - 1 year

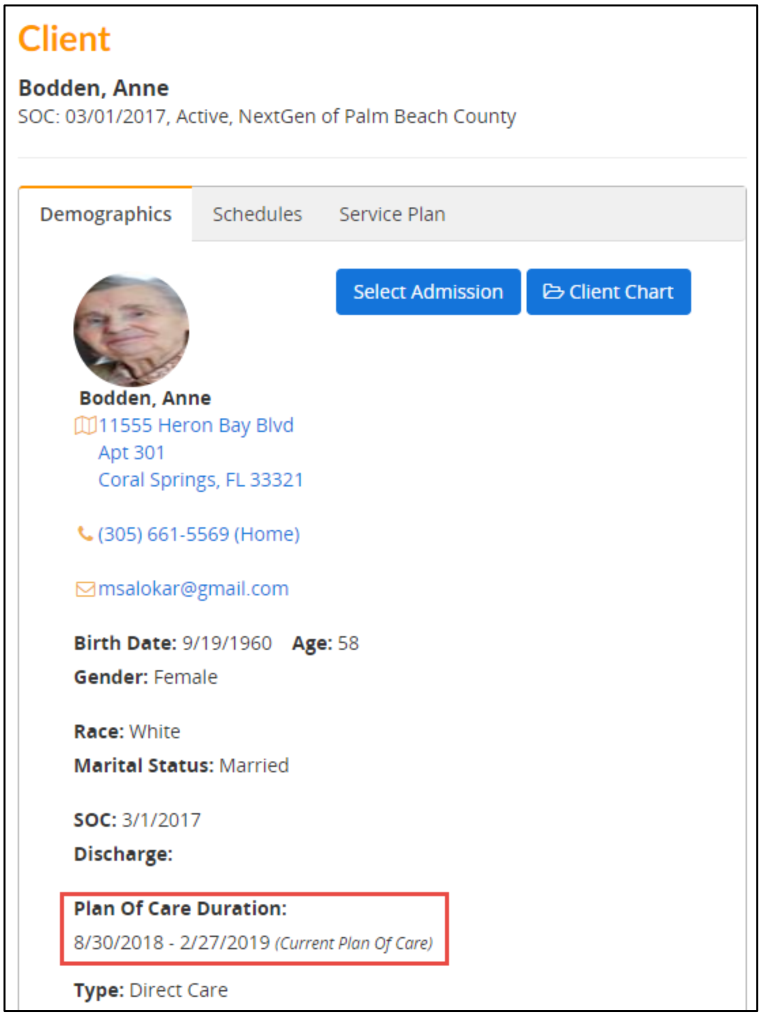
Or you can manually enter an end date in the “New End Date” field by using the date picker.



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.

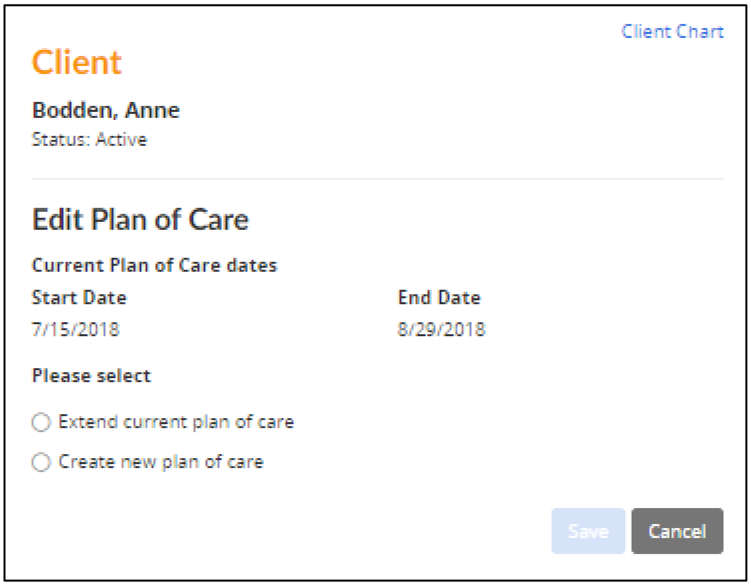




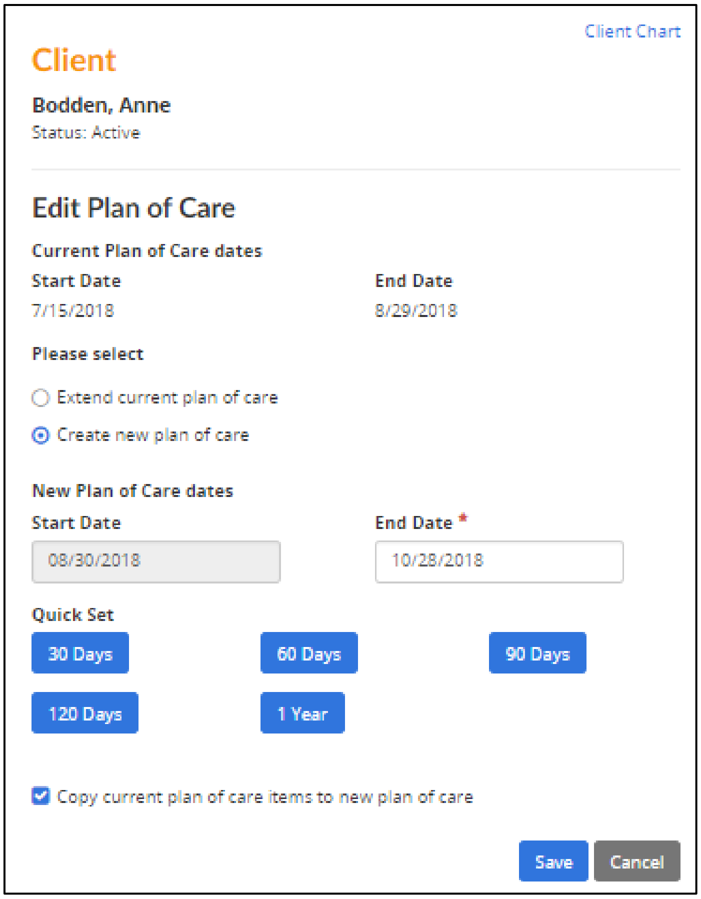
Creating a New Plan of Care Date

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.

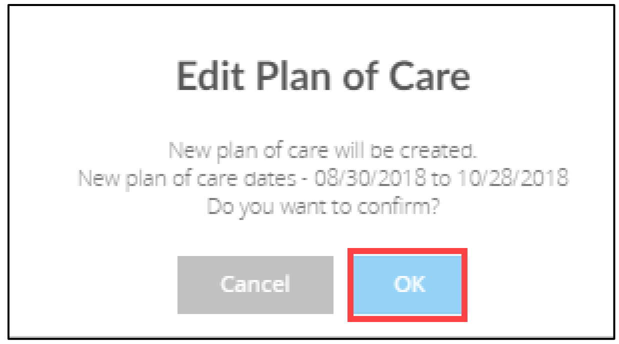


2. On the Edit Plan of Care page, tap the **Create new plan of care** radio button and enter the New Plan of Care end date. You can type the date, use the date picker, or select a quick set date.



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

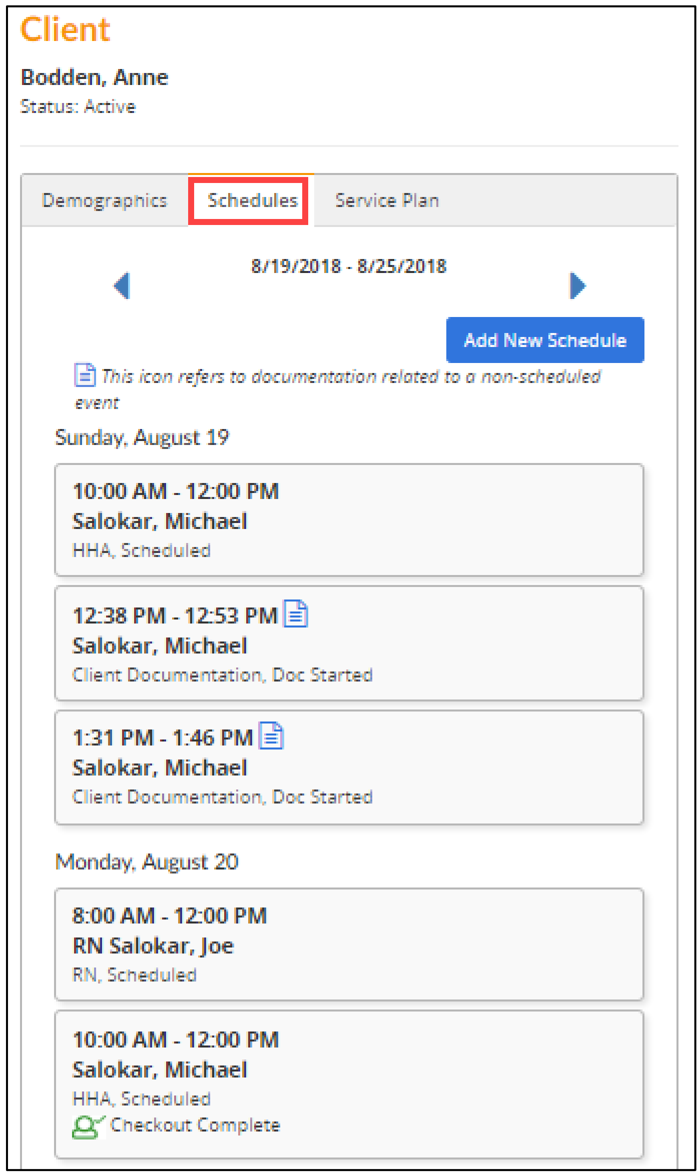
To view a client's weekly appointment schedule, do the following:

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.



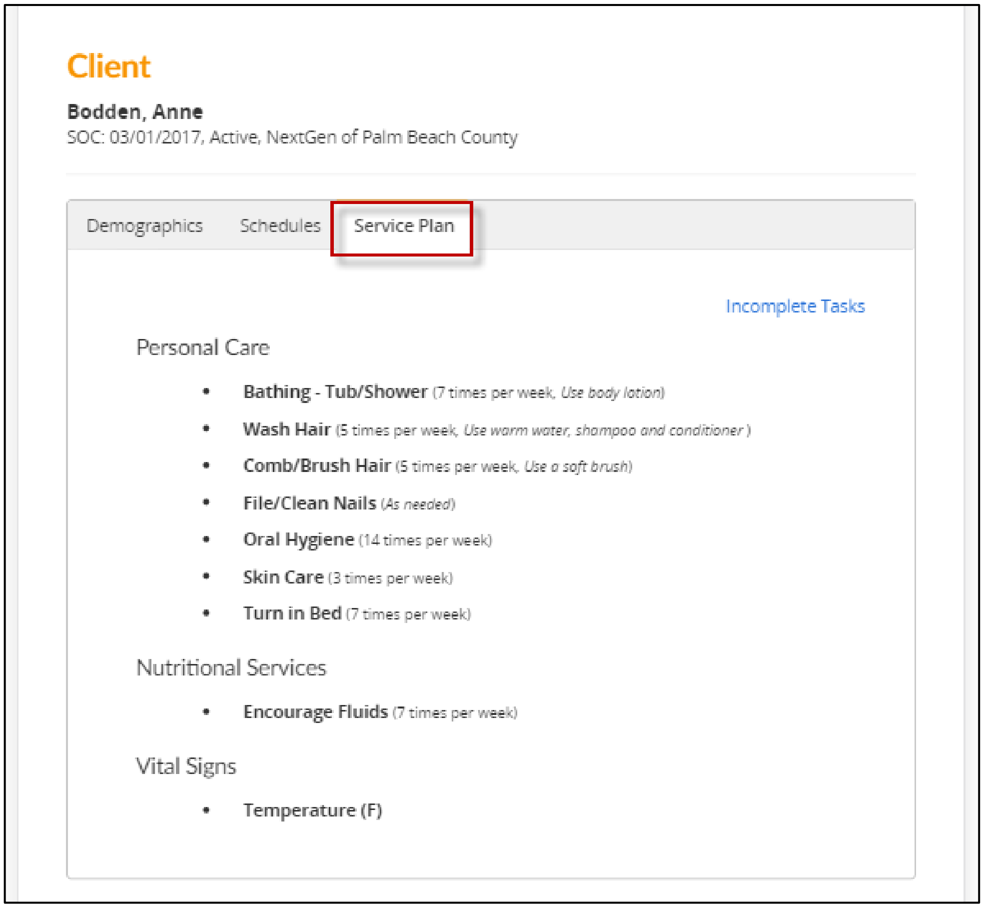
Viewing Clients Service Plan

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.

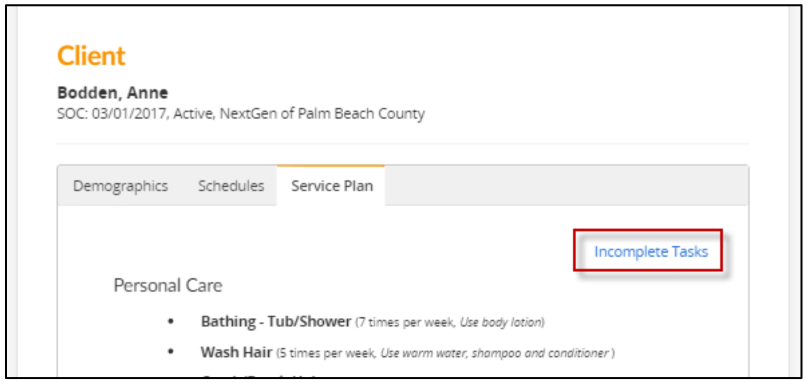
The Service Plan tab displays a list of tasks and frequency that is requested to be completed by the Caregiver. The tasks displayed are from the client's published service plan record.

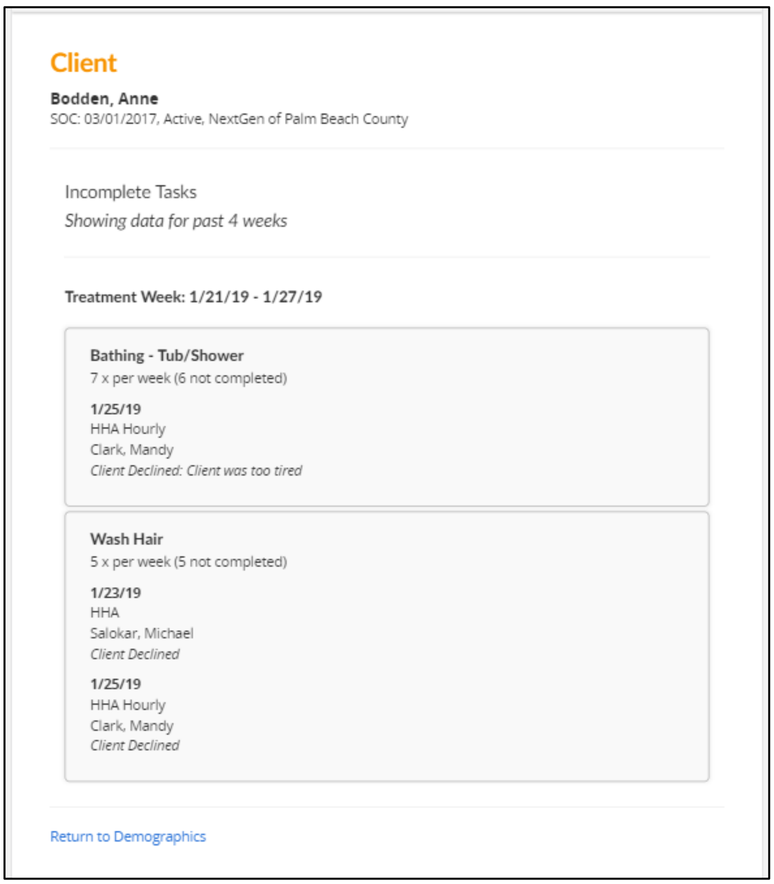
Note: If a Service Plan has not been published for the Client, a message appears stating "There is no published service plan."



Viewing Incomplete Tasks

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.





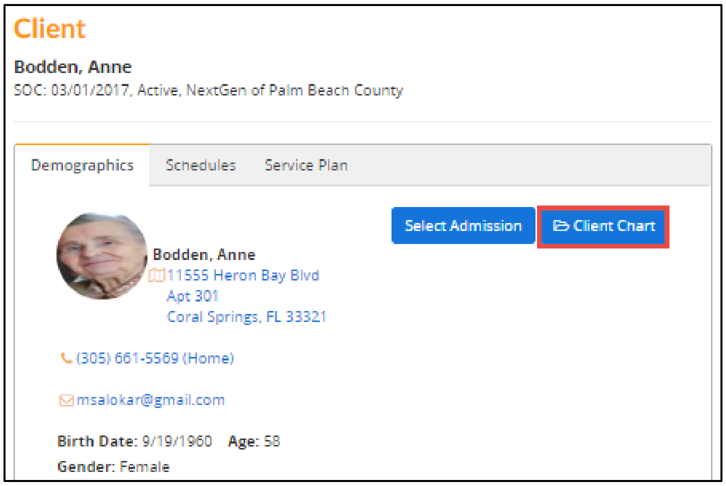
Viewing Clients Chart

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

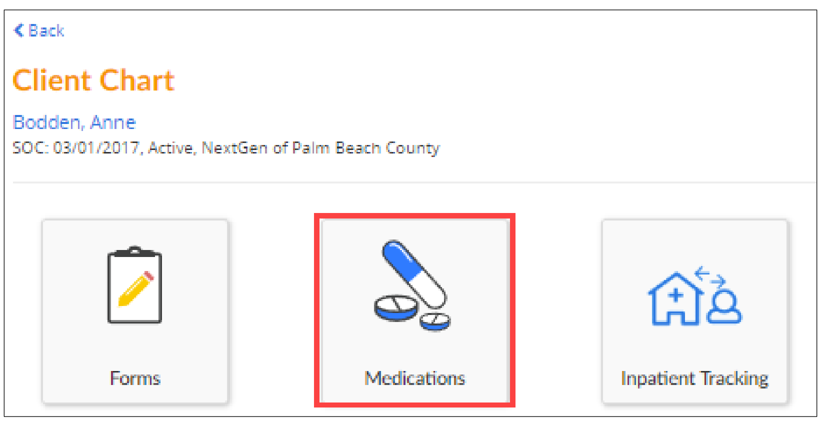
Creating Document Forms without an Associated Schedule

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.



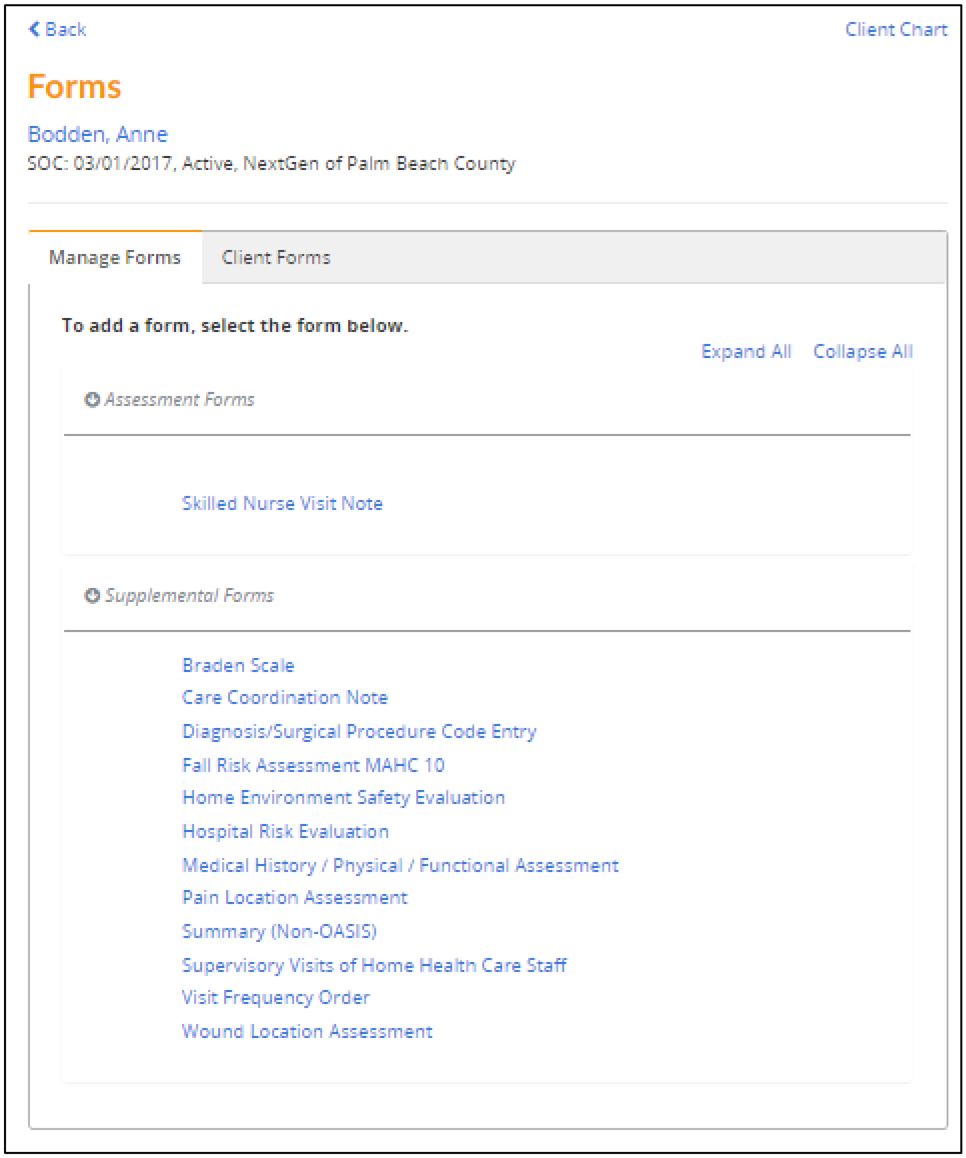
The Forms page appears allowing you to select two tabs:

- 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.

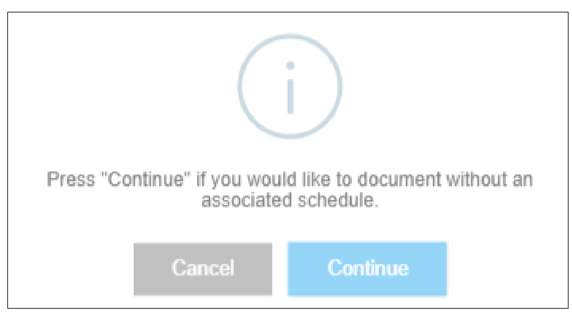
1. To show all forms, tap **Expand All**. To hide all forms, tap **Collapse All**.
2. Tap on the form you want to create and a popup message appears prompting you to continue creating a document without an associated schedule.

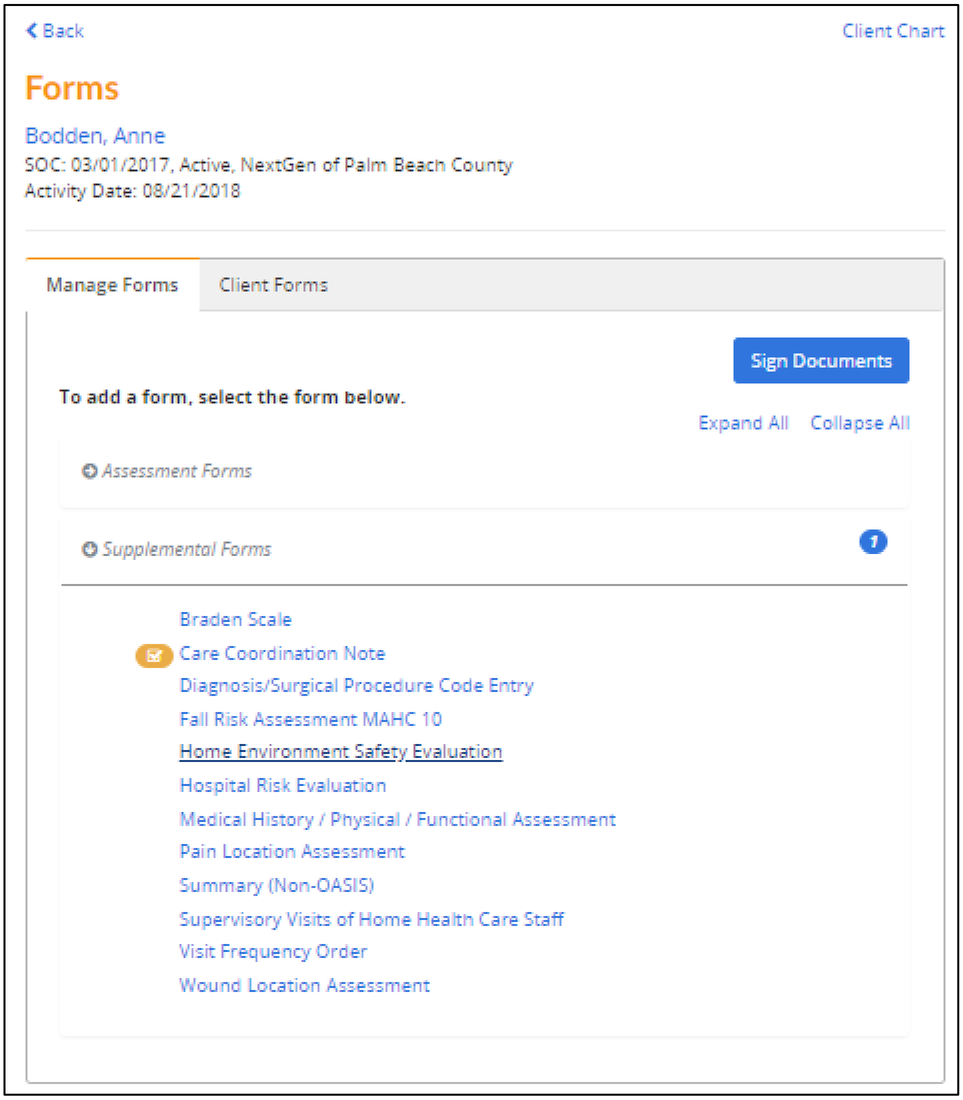


3. Tap **Continue** and a record is created and the form will display.
4. Fill out the form you want to create and tap **Save** and the record will be updated.

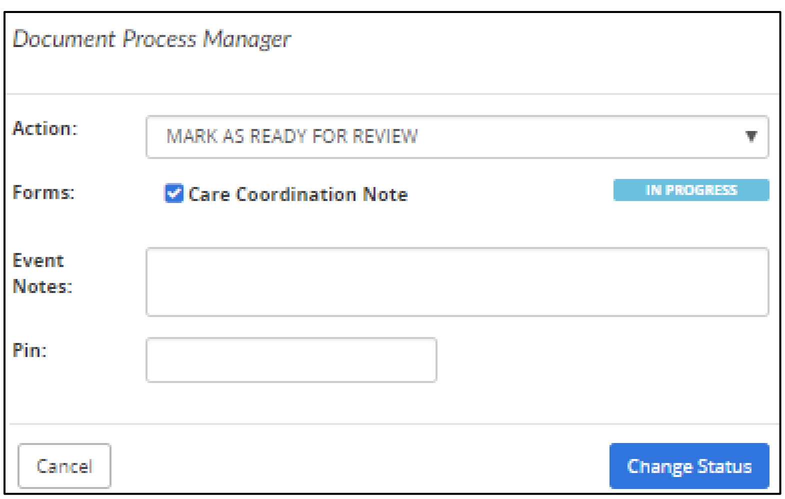
   Note: These forms are associated to an activity and not a schedule.

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.

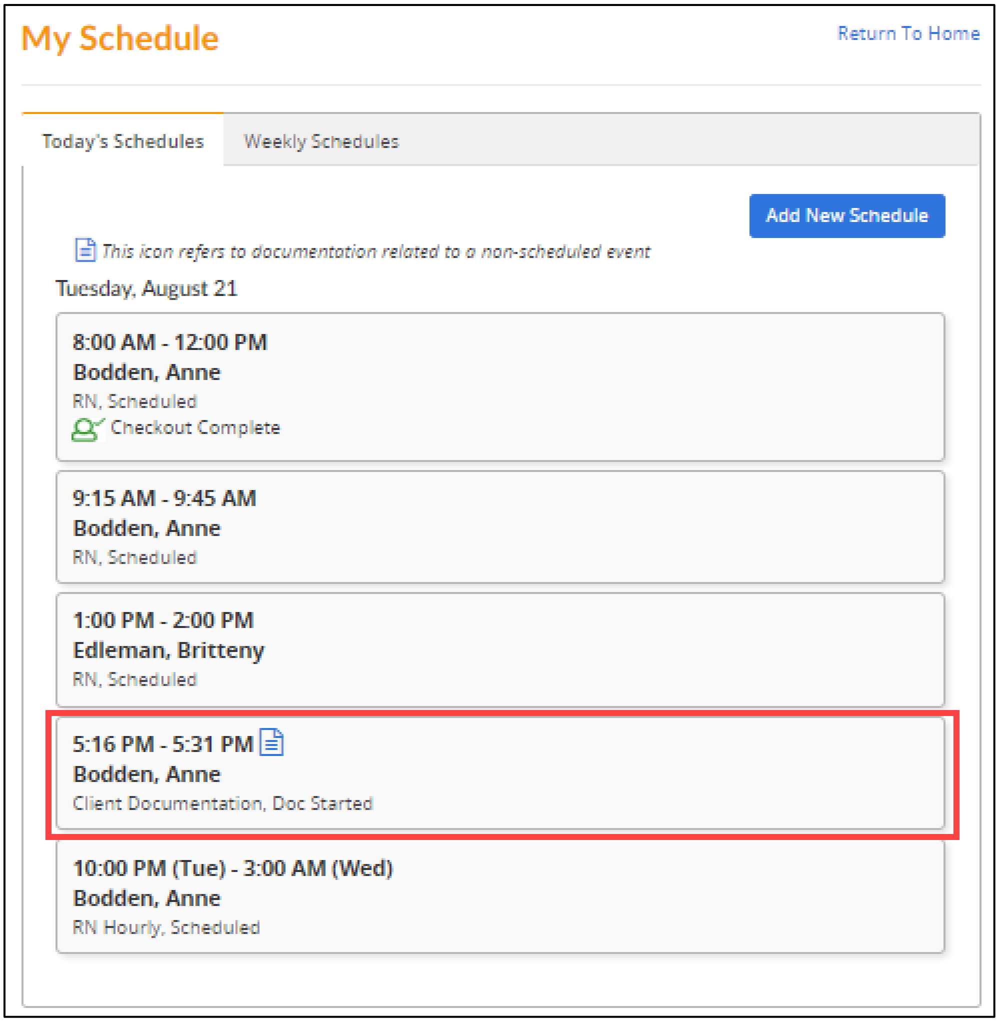


8. The Action drop down list will default to **MARK AS READY FOR REVIEW**.

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.

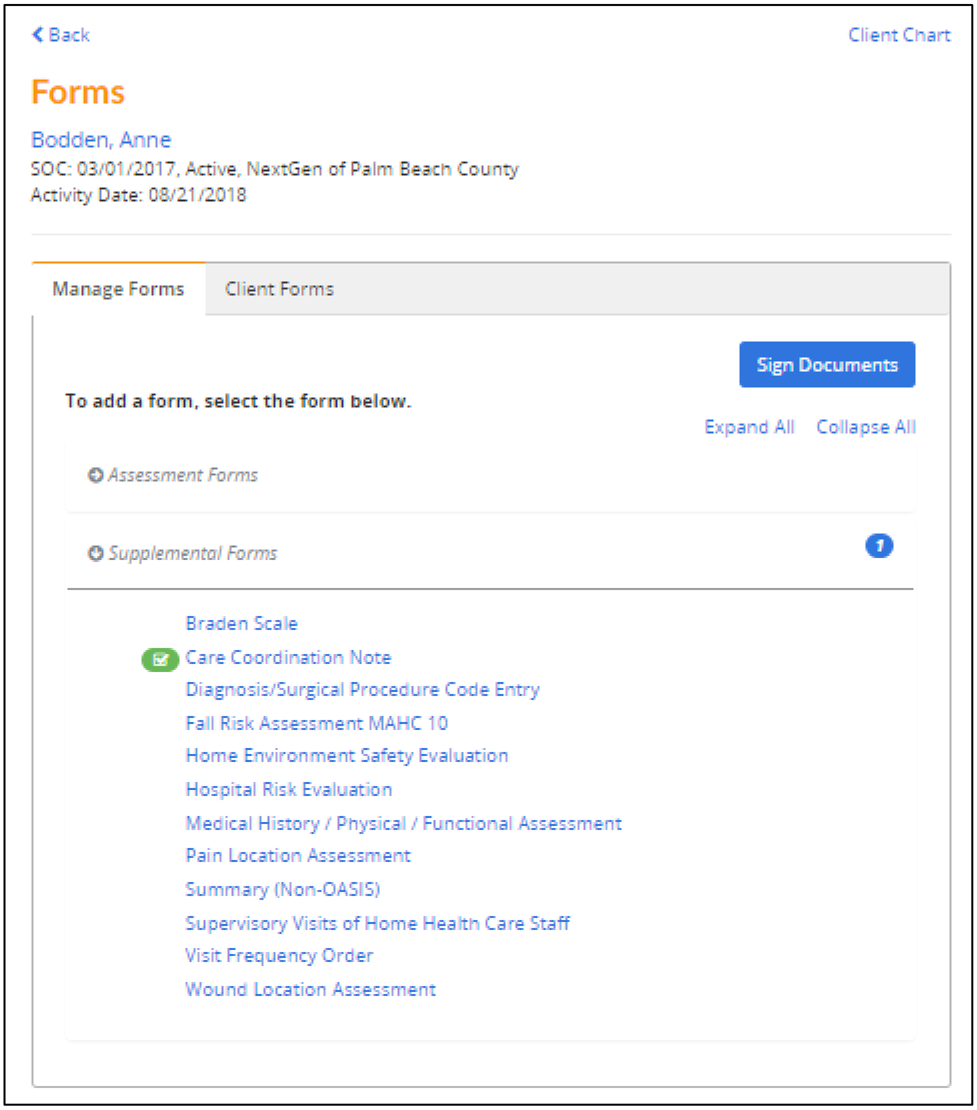
    When you are done with the forms, tap the Client Chart link, to return to the Client Chart page.

    Note: Tap **My Schedule** to view your Todays 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:

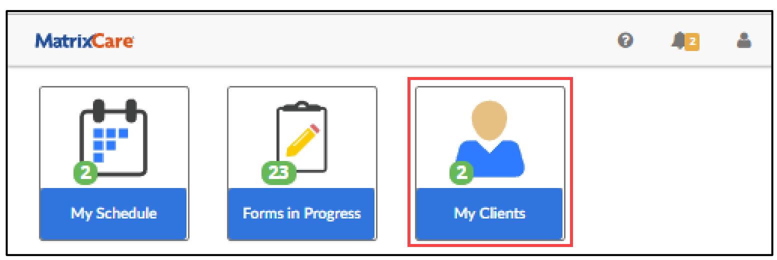
- Facility name the client was admitted to
- Type of facility
- Admission date
- Reason for admission
- Discharge date
- Discharge disposition

Accessing Inpatient Tracking Information

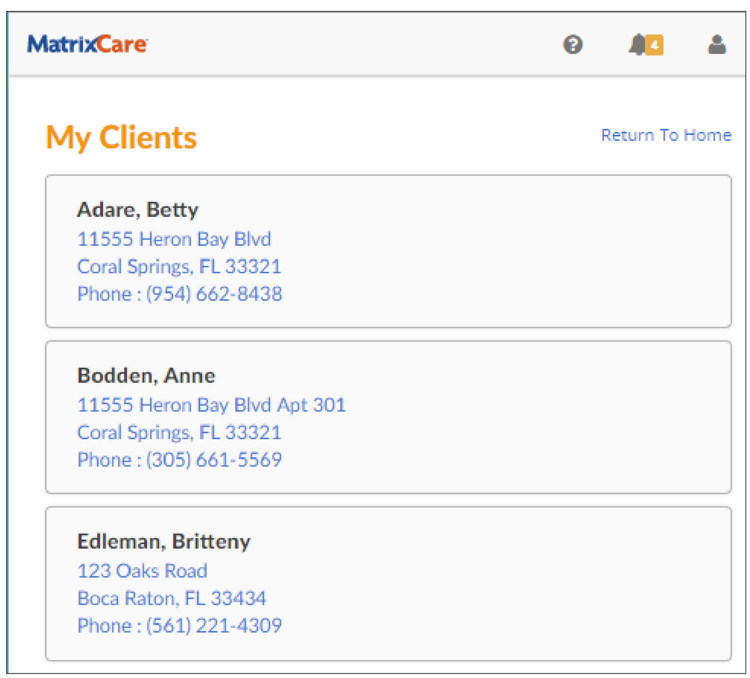
To access Inpatient Tracking information:

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

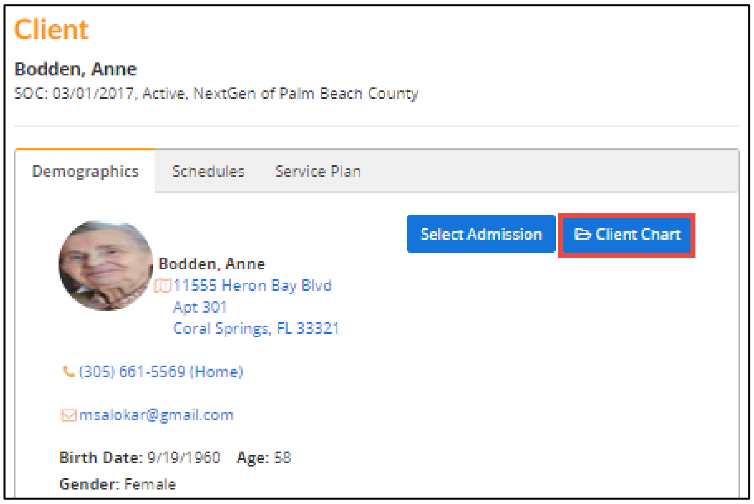
Note: You can access the Inpatient Tracking from the Client Chart from both My Clients and a Schedule.



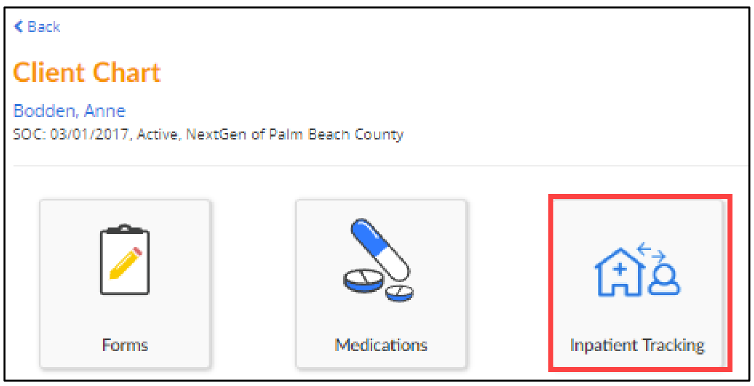
2. Select an existing **Client**.



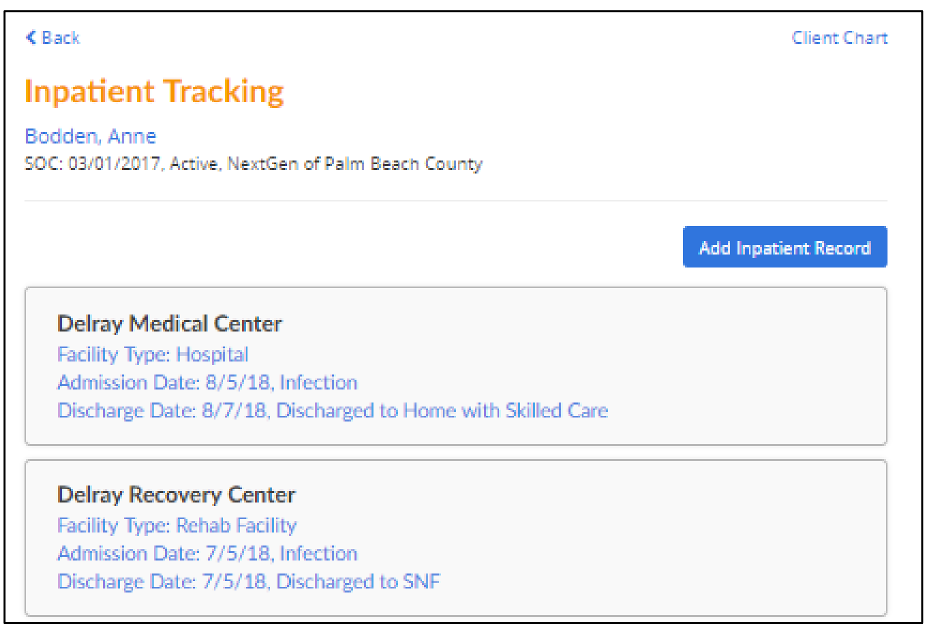
3. Select **Client Chart**.



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



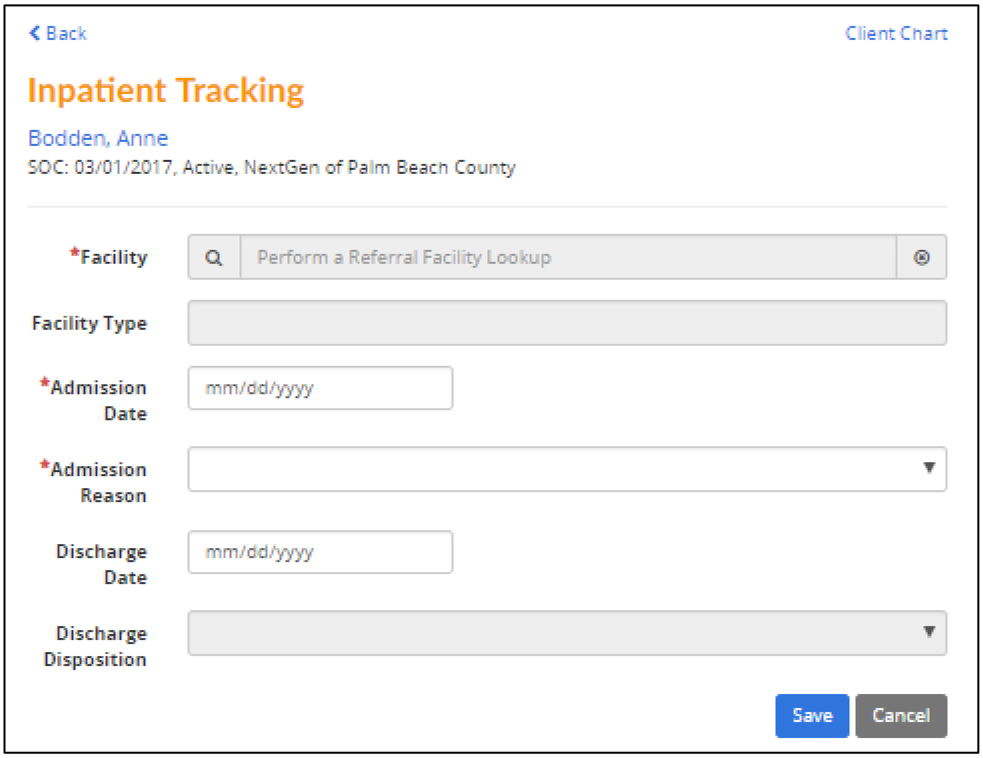
5. The Inpatient Tracking page appears.



Adding Inpatient Tracking Records

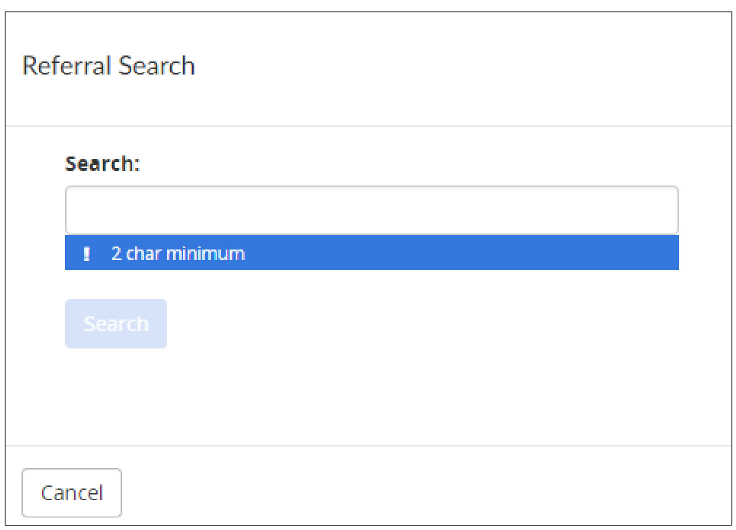
To add an Inpatient Tracking Record:

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

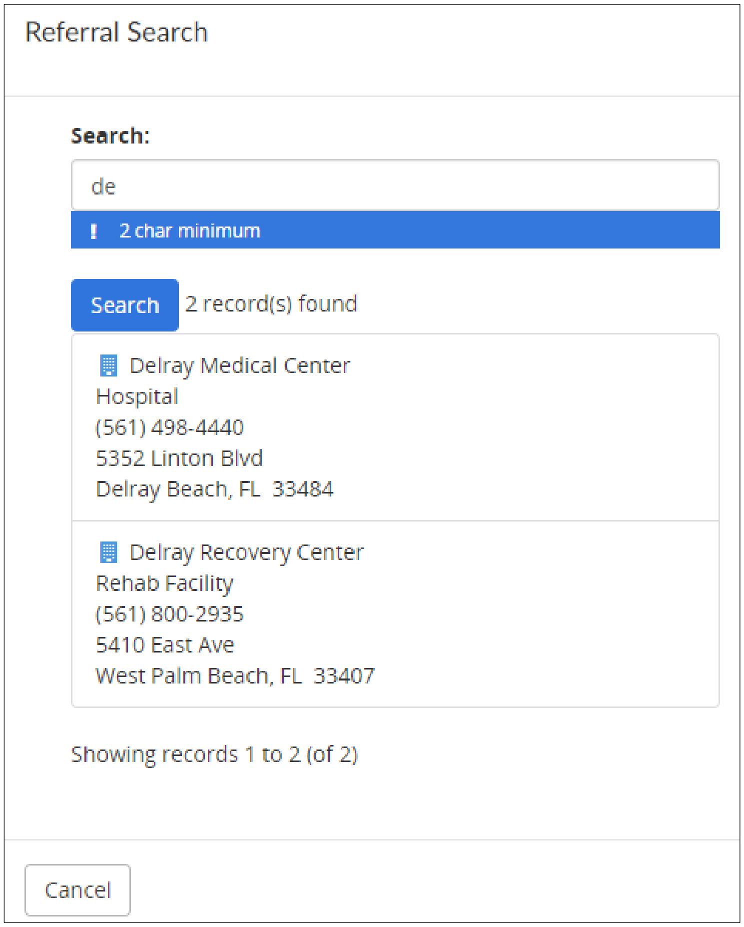


Each client's Inpatient Tracking record displays the following fields:

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.



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.

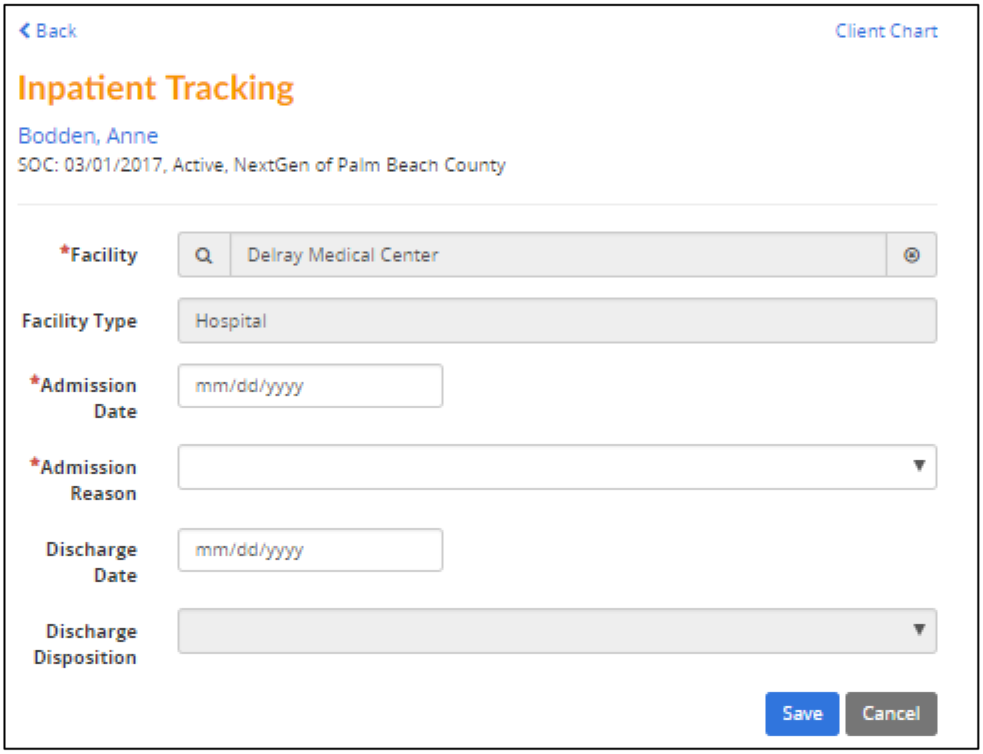


All active referral sources that are associated with the clients "Belongs to Office" will display showing the information as populated on the Referral Source record.

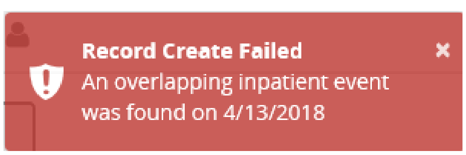
- Company Name
- Referral Type
- Primary Phone Number
- Address (Address 1 and 2, City, State and Zip)

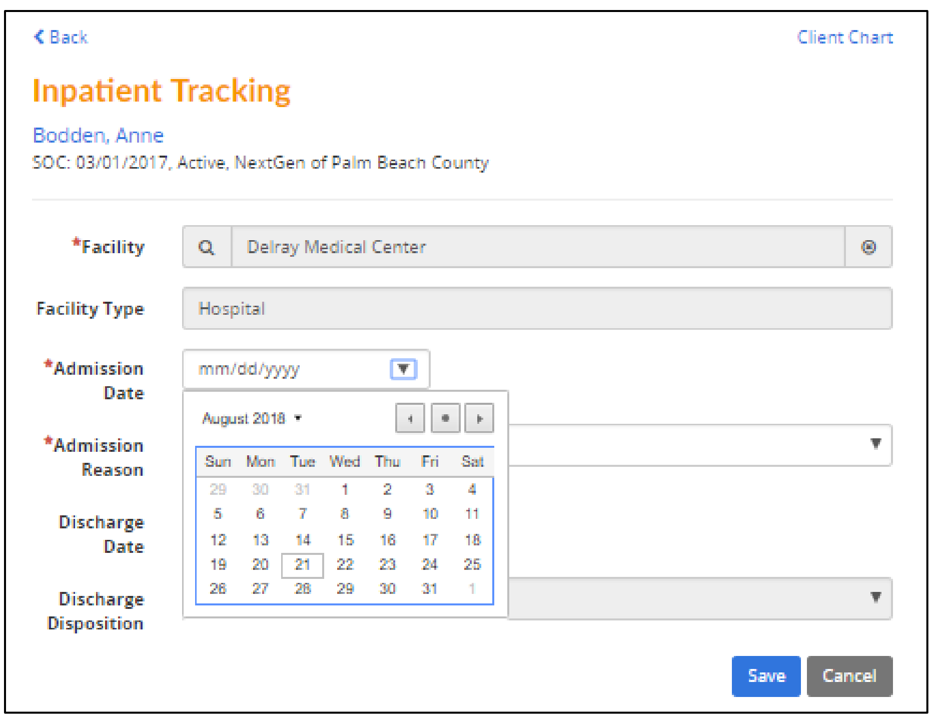
3. Select the facility, the view returns to the Inpatient Tracking detail page and the facility name appears in the field.

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



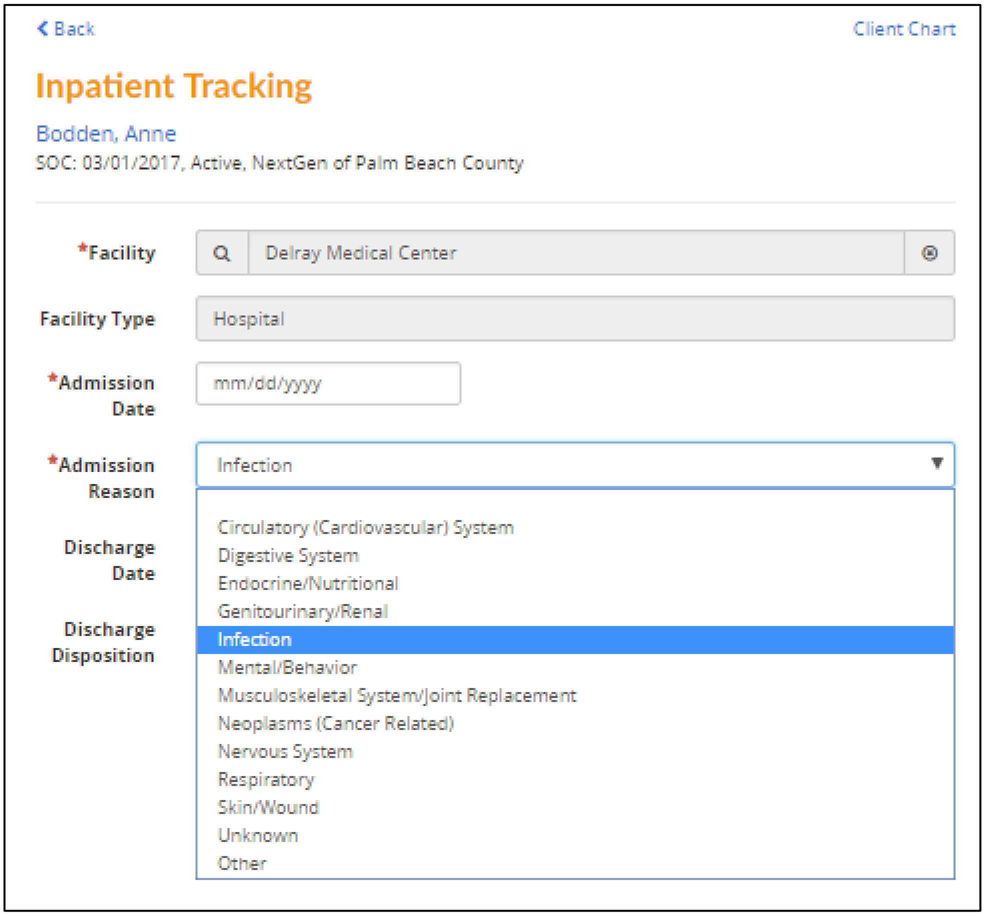
- **Admission Date** - Select a date from the date picker when you tap into the Admission Date field. **Note**: The Admission Date can be the same date as the discharge date of a previous entry, but cannot overlap another entry. A save error will display, showing the Admission Date of the overlapping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





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

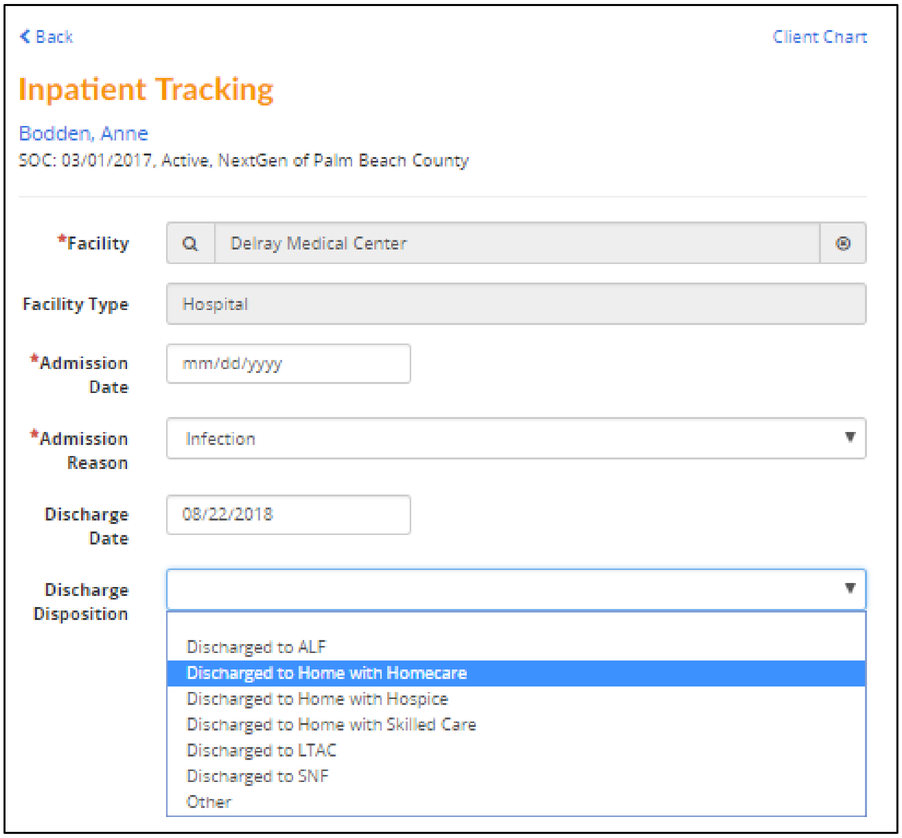
  Important! Admission Reasons are not configurable at this time.
  When **Other** is selected, a text box appears requiring you to enter the reason for the admission. You can enter a maximum of 50 characters in the field.



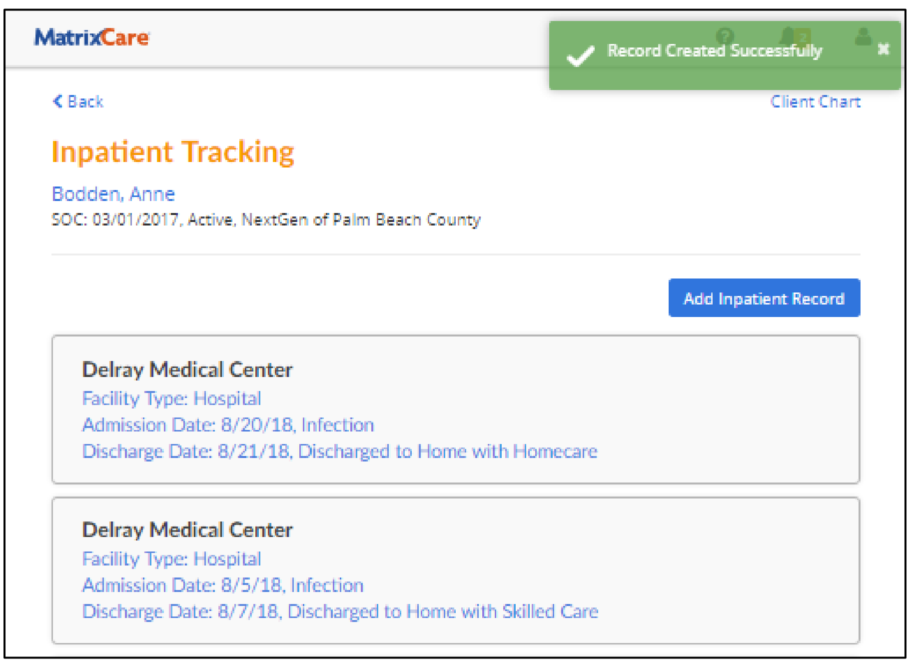
- **Discharge Date** - Select a date from the date picker, when you tap in the Discharge Date field. The discharge date is not required on the most recent entry.

  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.



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



- 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)	Captures patient information for transfer/referral and/or discharge summary for non-OASIS patient discharges. Additional default fields include: • **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.