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GETTING STARTED

Step 1: HR Activation

When getting started with HospiceMD, we recommend adding and activating staff members first.

This can be done by anyone with the Administrator, HR, or Admin Assistant staff level. See the Add New Employee section in the Admin Control Panel or under HR Reports for instructions. You can access the Add New Employee link in HR Reports by clicking the Reports Tab and locating the Human Resource section in the Administrative column.

Begin by adding the first name, last name, and email address of the employee. This should be the email address they will use to log in to HospiceMD.

Select whether they will be active/inactive, and designate their staff level under the ACCESS LEVEL AND STATUS section. The rest of the information may be added at this time or at a later date.

Edit employees you have already added through the View/Edit Current Employee section. From there you can add or edit their information, change their access level, and send a temporary password email.

- Note: When you need to edit an employee who has already been added, you must ALWAYS select View/Edit Current Employee and select their name from the drop down menu at the top of the page. Similarly, never attempt to add a new employee through the View/Edit Current Employee section. This may cause you to overwrite another employee’s information.

MIGRATING PATIENTS

Step 2: Intake

Begin by adding current patients into HospiceMD. See the Patient List section for instructions on adding a patient.

Enter and Save the patient’s Demographics information. Once a patient is saved, visiting staff can begin adding their visit notes and assessments directly through HospiceMD.

Remember to add the patient’s level of care, staff assignment, and frequency of visit. This can all be done through the Plan of Care module. Visit staff will only have access to patients they have been assigned to in the Staff Assignment.

Level of Care [RC, 2/21/2014] click here

Frequency of Visit [LIND: 1 per Week - ], [RNC: 2 per Week - ] click here

Staff Assignment click here
**Step 3: Creating the Plan of Care and Medications List**

Once you have added the Demographics information for all existing patients, you may begin creating the Plan of Care and the Current Medications List.

Plan of Care: Begin adding the existing Problems, Interventions and Goals through the Issues/Outcome module.

Click the to open the Add New Issue window. See the Add New Issue section for instructions on adding Problems, Goals, and Interventions for each focus area in a patient’s Plan of Care. Once you have added all issues for that patient, they will be automatically inserted into the Patient’s Current Plan of Care.

To add the patient’s current medications, expand the TX/Med/DME module and select Add New Order. (You can expand any module by clicking the to the left of the green folder.

Select ‘Migrating Med List’ from the Ordered By drop down menu and continue with your order. You may then enter all of the medications, DME, Treatments, etc. for the patient. Refer to the Physician’s Order section for instructions on completing an order.

**Step 4: Certification of Terminal Illness (CTI)**

Create the CTIs for each patient in order to access the current one. These can be accessed by expanding the Physician module and selecting CTI. If the Dates of Service, Diagnosis and Allergies panel in the Demographics page has been completed, HospiceMD will automatically create the first CTI.

To create the next CTI in line, click the ‘Add New Certification’ button in the CTI module.

- Note: HospiceMD will not allow a CTI to be created if it is not within 30 days of the end of the current period.
Once you have successfully migrated patients and activated hospice staff in HospiceMD, hospice staff may begin using the patient care models. Each patient care model is covered in this guide. Every new user is encouraged to browse the guide.
DASHBOARD

This is the HospiceMD home screen. All users will be taken to Dashboard as soon as they log in. The information displayed will vary by user, their designated access level, and the patients they have been assigned.

My Message
This section will display all new or unread messages. You can click ‘Open’ to open the message, or head directly to the Message Center to view all of your messages. Messages that have been ‘Read’ will no longer appear in the My Message section.

My Signature
This section will display all items that require your signature. These include IDG notes, Orders, Assessments, etc. Your access level and discipline will determine which items requiring signature will appear in this section. You can go directly to the item by clicking the ‘Open’ link to the right of the item.

When signing IDG or medication orders, you will be taken directly to the next item on the list that requires your signature.

My Task
If your hospice is using the Monthly Schedule on HospiceMD, the My Task section will display a reminder of the visits you are scheduled for on the day you log on. For MDs, Administrators, and Case
Managers this section will also display upcoming certifications and the number of days left until they are due.

- The My Task section will notify you of upcoming recertifications **30 days prior** to the start of the new benefit period.

### New Issues
This section is primarily for the Director of Nursing or Case Manager and will display all new issues that have been added since the last review of the Plan of Care for each patient to which they are assigned. Clicking the ‘Open’ link will take you to the Add/Update section of the Plan of Care where all new issues will be highlighted in yellow. In Add/Update mode you can make any necessary changes and either save or save and sign the Plan of Care.
MONTHLY SCHEDULE

The Monthly Schedule is located in the Dashboard. Click the icon for a calendar view of routine Staff Schedules.

**Filter:** Access level will determine whether you will be able to see all staff schedules or only your own. To Filter the calendar schedule by Staff and/or Patient, select the names you would like to see from the Staff and Patient drop down menus.

**Schedule/Notes Status:** Each scheduled visit will be color coded. You can also filter the schedule by note status by clicking the checkbox next to each status.

- Visits in Green mean the visit note for that patient has been completed by the assigned staff member and signed.
- Visit notes in Orange mean the assigned staff member has created the visit note for that patient, but has not yet signed it.
- Visit notes in red mean the assigned staff member has not created a visit note for this patient.

**Set Weekly Schedule:** Click the link to set the weekly schedule for a staff member. The following two items must be completed for each patient before you will be able to set a schedule:

1. Set Staff Assignment
2. Set Frequency of Visit

Select the staff member from the drop down menu.
This will display all patients this staff member is assigned to along with the assigned frequency for their discipline. Use the drop down menu for each day to select the visit schedule for this patient. The options include: Weekly, Bi-weekly, Alt Bi-weekly, 1st week of the month, 2nd week of the month, 3rd week of the month, and Last week of the month.

**Example:** RN frequency is set to 2 per week for patient John Smith. This RN will be scheduled to visit the patient every Tuesday and Thursday. Select ‘Weekly’ for Tuesday and Thursday and click **Save** or **Update**. This will calendar the RN for John Smith every Tuesday and Thursday starting on the date that this Frequency was assigned.
From this page you can search for and view all patients entered into HospiceMD. Using the PATIENT SEARCH drop down menu, you can select to view:

- Active patients
  - To change a patient status from ‘Pending’ to ‘Active’ you need to enter a Start of Care Date in the Diagnosis and Dates of Service panel.
- Patients Pending admission
- Patients Discharged in last 30 days
- Patients whose family/caregivers are currently receiving Bereavement services
- Non-Admits
  - To change a patient status from ‘Pending’ to ‘Non-admit’ create a Discharge Summary form for that patient and select ‘Non-Admit’ in the reason drop down menu.
- All (Admits Only)
  - Patients will be displayed 15 per page. For patient lists with a higher number of results, page numbers will be displayed at the bottom center of the list. Click each page number to navigate the list.
  - Narrow the patient search by typing in a Name and/or From and To Dates in the Patient Search field.

Add a new patient by clicking next to the ‘Search by Patient Name’ field or by clicking ‘Add New Patient’ at the bottom left corner of the page. This will take you to the Admissions page.

Search for a specific patient by typing their First Name, Last Name, or MR# in the ‘Search Patient By Name’ box at the top left corner of the page.

Sort the patient by clicking directly on the column header. For example, to sort patients by last name, click ‘Last Name’ in the dark gray bar header.

Click Print>> for a printer friendly version of the list you are currently viewing. From there you can use your browser’s print function or Ctrl+P to print the list.
Click **Go Back>>** to return to the **PATIENT LIST** home page.

<table>
<thead>
<tr>
<th>MR_No</th>
<th>First Name</th>
<th>Last Name</th>
<th>DOB</th>
<th>Primary Diagnosis</th>
<th>Referring MD</th>
<th>Attending MD</th>
<th>SOC</th>
<th>EOC</th>
<th>Care Days</th>
</tr>
</thead>
<tbody>
<tr>
<td>03132-664</td>
<td>Jane</td>
<td>Smith</td>
<td>03/08/1960</td>
<td></td>
<td></td>
<td></td>
<td>03/22/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>041311-728</td>
<td>John</td>
<td>Smith</td>
<td>05/01/1990</td>
<td>ES Alzheimer (121.8)</td>
<td></td>
<td></td>
<td>05/06/2013</td>
<td></td>
<td></td>
</tr>
<tr>
<td>00123-645</td>
<td>Julian</td>
<td>Davis</td>
<td>06/01/1990</td>
<td>ES CVA (434.8)</td>
<td></td>
<td></td>
<td>05/23/2013</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

TOTAL PATIENT COUNT: 3
The patient Demographics page contains a patient’s basic information normally obtained upon Admission. In order to Save a new patient, only the Personal Information Panel must be completed. You can return to the Demographics page at any time to complete the rest of the Panels.

- Some Panels, like the Place of Service and Authorized Representative/Emergency Contact, can only be accessed once you have saved a patient by clicking ‘Save’ at the bottom of the Demographics page.

You can choose to expand all of the panels available by clicking ☑ on the top right corner of the Demographics Page, right below the Patient Information Bar. Or you can expand each panel separately by clicking anywhere on the Panel Header or ☑ on the right side of the Panel Header. To collapse the Panels, click ☑ or anywhere in the Panel Header.
Personal Information

Enter the patient’s personal information in the corresponding fields. MR#, Last Name, First Name and Date of Birth (DOB) are all required fields. These fields must be complete before you can Save a new patient.

**MR#:** Assign a Medical Record Number. It must be individual to each patient and it is chosen according to your hospice’s medical record numbering system. Once a number is entered, HospiceMD will search for any other patients with this same MR#. If the MR# you entered has previously been used, you will see a message in red at the top right corner of the page stating “**MR# already exists in the database. Please enter a different one.**” and you will need to assign a different number. This field is required.

**SSN:** Input the patient’s Social Security number. HospiceMD will search for any patients with this same number in order to prevent duplicate patient entries.

**DOB:** Enter the patient’s date of birth in this format: MM/DD/YYYY. Make sure to enter all four digits for the year as a two digit year can be read as being from the 1900s or the 2000s (ie. Inputting 1/1/20 could be reformatted to 1/1/2020). The patient’s age will be displayed directly to the right of the DOB field. This field is required.

**MAIL ADDRESS:** Enter the patient’s mailing address. Entering the Zip Code will automatically populate the CITY and STATE fields.

- Note this field is for the mailing address only. The patient’s Place of Service address will be entered in the [Place of Service](#) panel.

**Diagnosis and Dates of Service**

**REF DATE:** Enter the date the patient referral was received in this format: MM/DD/YYYY.
**SOC:** Start of Care. Input the Start of Care Date in this format: MM/DD/YYYY. Once the SOC date is entered, the field will lock. Only the Admin staff level will be able to change the SOC after it is saved. All existing CTIs will have to be deleted in order to unlock the SOC field.

**Re-Cert:** The re-certification date is automatically populated based on the patient’s Start of Care date and Starting Cert #.

**PRIMARY/SECONDARY DX:** Enter the patient’s primary and secondary diagnosis, where applicable. Recognized Diagnoses and ICD-9 Codes can be auto completed by making a selection from the drop-down menu that will appear once you begin typing a recognizable diagnosis. Click on your selection to auto-complete the field.

- The Primary and Secondary Diagnosis as well as Comorbidities are also automatically populated based on the Nursing Assessment.

**ALLERGIES:** Note this field can only be accessed once a new patient has been saved. If the patient has any known allergies, click on the button to add the allergy. This will open the View/Edit Patient Allergies window. Once the Demographics page is saved, the list of Allergies will be displayed on the Patient Information Bar at the top of the patient’s page along with the patient’s basic information.

**EOC:** The End of Care date will be automatically populated once a Discharge Summary is complete. The staff member completing the Discharge Summary must enter an End of Care Date.

**DISC CODE:** The Discharge Code will be automatically populated once a Discharge Summary is complete. The staff member completing the Discharge Summary must enter a Reason For Discharge.

**XFER/RE-ADMIT:** Designate whether the patient is a New Admission, Transfer, or Re-Admit. The default is set to New Admission. If the patient is a New Admission, the field does not need to be altered. If the patient is not a new admission, make a selection from the drop-down menu.

- If you select ‘Transfer From Another Hospice’, you will see additional fields for XFER FROM and CERT VALID TO. Complete these fields to ensure HospiceMD will track all recertification periods accurately.

**STARTING CERT#:** Designate under what certification period the patient is being admitted from the drop-down menu. If the patient is a New Admission or is still in their first certification period, the field does not need to be altered.

- Note that ‘New Admission’ only applies to patients who have never previously received hospice services and will be starting on certification period #1.

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**Abbreviation Key:**

Disc Code: Discharge Code  
DX: Diagnosis  
EOC: End of Care  
NKA: No Known Allergies  
SOC: Start of Care  
XFER: Transfer
View/Edit Patient Allergies

Enter the patient’s allergy in the ‘Add New Allergy’ field and click ‘Insert’. Once you click ‘Insert’ the window will automatically close and take you back to the patient’s Demographics page. You can revisit this window at any time to see the patient’s list of allergies or to add, edit or delete an allergy.

To exit the window without making any changes, click the ‘Close’ button at the bottom right corner of the window.

Place of Service (POS)

In order to access this panel, a new patient must be saved first. To save a new patient make sure the MR#, Date of Birth and First and Last Name fields are completed and click ‘Save’ at the bottom of the Demographics page. Once saved, you can access the POS Panel by clicking on the Panel header or clicking on the right hand side of the Panel Header.

This panel must be updated individually from the rest of the Demographics page. Once a Place of Service has been entered, click ‘Update POS’ at the bottom left corner of the panel to save that Place of Service and add it to the list. More than one Place of Service can be added.
If you do not click ‘Update POS’ after you have entered a new POS, clicking ‘Save’ on the Demographics page will NOT save the information you entered. You must click ‘Update POS’ in the panel in order to save the information.

Enter the Place of Service information using the specified fields and drop-down menus.

**TYPE:** Designate the type of Place of Service being entered by selecting a type from the drop-down menu. If the type you selected is the current Place of Service, click the ‘Set this type as current POS’ button to the right of the ‘Type’ field. If the POS changes in the future you can return to this Panel and add or designate a different POS as the Current POS.

**ADD NEW POS TYPE:** If the POS type you are trying to enter is not listed in the drop-down menu, enter the type in the box next to ‘Add new POS type’ and click the add button. This will add the type of POS you just entered to the ‘Type’ drop-down menu.

**ADDRESS, CITY, STATE-ZIP:** Enter the POS address in the corresponding fields. If you have chosen Home as the POS ‘Type’, the ‘Address’ fields will be automatically populated based on the patient’s Mailing Address information entered in the Personal Information Panel.

Once finished click ‘Update POS’. You will see a message at the bottom of the panel stating Information Updated Successfully. Your new or edited POS will be saved even if you do not ‘Save’ the entire Demographics Page. You can edit any POS after you have saved it by coming back and selecting the POS from the ‘Type’ drop-down menu.

- Once you have saved a POS you will see an icon on the bottom right corner of the POS Panel depicting a map and pushpin 📍. If you click on this icon, a new tab will open into Google Maps with directions from your hospice’s primary address to the Place of Service you are currently viewing.

**Delete POS:** Select the POS from the ‘Type’ drop-down menu, confirm that you have selected the correct POS, and click ‘Delete POS’ on the bottom left corner of the panel. A pop up window will appear asking “Are you certain you want to delete this POS?” Click ‘OK’ to delete the POS or ‘Cancel’ to close the pop-up window without deleting and return to the Demographics page.
Authorized Rep (AR)/Emergency Contact (EC)

In order to access this panel, a new patient must be saved first. To save a new patient make sure the MR#, Date of Birth and First and Last Name fields are completed and click ‘Save’ at the bottom of the Demographics page. Once saved, you can access the Authorized Rep (AR)/Emergency Contact (EC) panel by clicking on the Panel header or clicking on the right side of the Panel Header.

This panel must be updated individually from the rest of the Demographics page. Once a Contact has been entered, click ‘Update Contact’ at the bottom left corner of the panel to save that Contact and add it to the list. More than one Contact can be added.

If you do not click ‘Update Contact’ after you have entered a new Contact, clicking ‘Save’ will NOT save the information you have entered. You must click ‘Update Contact’ in the panel in order to save the information.

Enter the Contact information using the specified fields and drop-down menus.

**CONTACT:** Once you have saved a contact, you can select them from the drop-down menu. Once selected, you can edit, delete or set that contact as the main contact by clicking the ‘Set this as a Main’ button to the right of the drop-down menu.

**ADD A NEW CONTACT:** You can add a new contact by entering the last and first names in the fields at the top right corner and clicking the button, then entering the remaining information in the panel, or simply by entering all of the information in the panel.

Once All of the applicable information has been entered, Click ‘Update Contact’. You will see a message at the bottom of the panel stating *Information Updated Successfully*. Your new or edited Contact will be saved even if you do not ‘Save’ the entire Demographics Page. You can edit any Contact after you have saved it by coming back and selecting it from the ‘Contact’ drop-down menu.

**Delete Contact:** Select the Contact from the drop-down menu and click ‘Delete Contact’ on the bottom left corner of the panel. A pop up window will appear asking “Are you certain you want to delete this Contact?” Click ‘OK’ to delete the Contact or ‘Cancel’ to close the pop-up window without deleting and return to the Demographics page.
Insurance

In order to access this panel, a new patient must be saved first. To save a new patient make sure the MR#, Date of Birth and First and Last Name fields are completed and click ‘Save’ at the bottom of the Demographics page. Once saved, you can access the Insurance panel by clicking on the Panel header or clicking on the right side of the Panel header.

This panel must be updated individually from the rest of the Demographics page. Once a Pay Source has been entered, click ‘Update Pay Source’ at the bottom left corner of the panel to save that Pay Source and add it to the list. More than one Pay Source can be added.

If you do not click ‘Update Pay Source’ after you have entered a new Pay Source, clicking ‘Save’ will NOT save the information you have entered. You must click ‘Update Pay Source’ in the panel in order to save the information.

Enter the Insurance information using the specified fields and drop-down menus.

**CURRENT PAY SOURCE:** To enter information for a pay source, select either Primary or Secondary from the drop-down menu. Once you have saved a Pay Source, you will see it next to the Primary or Secondary options in the drop down menu. Once selected, you can edit, delete, or set the Pay Source as the default by clicking the ‘Set this as default’ button to the right of the drop-down menu.

**INSURANCE:** Designate the insurance company from the drop-down menu. If an insurance company is not listed, click the button. A new tab will open in which you can ‘Add a New Insurance Provider’.

Once all of the information has been entered, click ‘Update Pay Source’. You will see a message at the bottom of the panel stating *Information Updated Successfully*. Your new or edited Pay Source will be saved even if you do not ‘Save’ the entire Demographics Page. You can edit any Pay Source after you have saved it by coming back and selecting it from the Pay Source drop-down menu.
**Delete Pay Source**: Select the pay source you would like to delete from the Pay Source drop-down menu and click ‘Delete Pay Source’ on the bottom left corner of the panel. A pop up window will appear asking “Are you certain you want to delete this Payer?” Click ‘OK’ to delete or click ‘Cancel’ to close the pop-up window without deleting and return to the Demographics page.

**Eligibility Form/Verify Insurance**: Clicking the eligibility form button will automatically generate a form with the patient’s information which you can print and fax to HospiceMD to check the patient’s eligibility. If your organization also uses HospiceMD’s billing services, you will be able to click the ‘Verify Insurance’ button to verify insurance on your organization’s account. Contact your administrator for information on verifying eligibility.

**Add New Insurance Provider**: Click on the + on the top right of panel or the + next to the ‘INSURANCE’ field to add new insurance carrier information. Enter the pay source information using the specified fields and drop down menus. Click Insert to save the new pay source. It will be added to the List of all Insurance Providers.

- The options in the **Source Type** drop down menu reflect the categories used by the California Department of Public Health. Currently the CADPH has not provided a clear definition of Medi-Cal Managed Care, therefore, until further information is given, continue using the Managed Care option for all Managed Care companies.

To Edit an already existing pay source, in the List of all Insurance Providers click the ‘Edit’ Button to the right of that entry.

- Note you will be able to **Edit** the pay source directly within the list. Click ‘Update’ to save the changes.
Referral Source & Attending MD

**MEDICAL DIRECTOR/PCP**: Select the Medical Director and Primary Care Physician (PCP) from the drop-down menus. Once you make a selection, you will see the MD’s Phone, Fax, and NPI numbers displayed directly below their name. Your system Administrator is responsible for inputting the MD data. Contact him/her if an MD is not listed.

You can add a new MD to the PCP drop down menu by clicking the button to the right of the drop-down menu. This will open a new window in which you can Add New Referring MD Information. Once saved, you may pick that physician from the drop-down menu.

You must click ‘Save’ at the bottom of the demographics page to save this Panel, but you are free to work on other panels until you are ready to save the entire page.

**Add New Referring MD Information**

Enter the MD’s and any applicable contact information in the corresponding fields.

**Practice**: Choose the MD’s practice from the drop-down menu. To add a new practice, click the button.

Once all of the information is entered, click ‘Save’ to add this MD to the ‘Referring MDs List’ at the bottom of the page. Once the MD has been added, exit out of the window to return to HospiceMD.
To **Edit** an already existing MD, in the **Referring MDs List** click the ‘Edit’ Button to the right of that entry.

- Note you will be able to Edit the MD directly within the list. Click ‘Update’ to save the changes.

### Add New Practice Information

To add a new practice, enter the practice information into the corresponding fields. Once complete, click ‘Save’ at the bottom of the form to add this practice to the ‘List of all Practices’. Once the practice has been added, click the ‘Close’ button on the top right corner of the page and return to HospiceMD.

### Vendors

Your system Administrator is responsible for creating the list of vendors you can select for this panel. Assign the Pharmacy, DME Company and any other vendors providing services to this patient by selecting the main vendor and any alternates as applicable from the drop-down menu. Contact your system administrator if a vendor is not listed.

You must click ‘Save’ at the bottom of the demographics page to save this Panel, but you are free to work on other panels until you are ready to save the entire page.
Mortuary Info

Enter the information of the mortuary the patient or caregiver has designated, if any, in the corresponding fields.

You must click ‘Save’ at the bottom of the demographics page to save this Panel, but you are free to work on other panels until you are ready to save the entire page.
The consents page allows you to upload and record documentation collected during a patient’s Admission.

To attach a file, click ‘Choose File’ in the gray **Attach Document** box and select the file you would like to upload. You will see the name of the file you uploaded next to the ‘Choose File’ button. Once you have saved this form, you will see a paperclip at the top right corner of the gray box. You can click on the paperclip icon or on ‘Details’ to view your uploaded document. Click ‘Remove’ to delete the uploaded document.

- Note you are only able to upload one file. The file must be in .doc, .pdf, or .jpg format.

Click the box to the right of each item you have on file and enter the ‘Start of Care’ in the corresponding field in this format: MM/DD/YYYY.

You can then save the information you entered and uploaded by clicking ‘Save’ or clicking ‘Signature’ once you have completed the form. You will see **Saved Successfully!** at the top right corner of the form to indicate your information has been saved. You can save the information you have entered without signing the form or click ‘Close’ to exit the form and return to the Admissions Page.

Once you click ‘Signature’ you will see **Signed on:** followed by the details of your signature.

<table>
<thead>
<tr>
<th>Patient Name:</th>
<th>Doe</th>
<th>John</th>
<th>051321-438</th>
</tr>
</thead>
<tbody>
<tr>
<td>(Last)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(First)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(M)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>MR#</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Attach Document**

<table>
<thead>
<tr>
<th>Check all completed documents on file. (Documents available on hard copy)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed Consent</td>
</tr>
<tr>
<td>Election of Hospice</td>
</tr>
<tr>
<td>POLSTR / DNR</td>
</tr>
<tr>
<td>Change of Hospice (if applicable)</td>
</tr>
<tr>
<td>POA/Advance Directive</td>
</tr>
<tr>
<td>Sent Bedside Charts</td>
</tr>
<tr>
<td>Effective Start of Care (SOC)</td>
</tr>
</tbody>
</table>

I have reviewed the checked items and have hard copy on file.

**Signature**

[Save]

[Close]
## STAFF ASSIGNMENTS

### Staff Assignment

<table>
<thead>
<tr>
<th>MD</th>
<th>(MD)</th>
<th>(MD)</th>
<th>(MD)</th>
<th>(MD)</th>
</tr>
</thead>
</table>

- **CM**
- **RN**
- **LVN**
- **HA**
- **MSW**
- **SC**
- **BC**
- **VOL**

Select the staff who will be assigned to **this** patient by clicking on the box directly to the left of their name. Once you have selected all applicable staff, click ‘Save’ at the bottom right corner. You will see **Staff Assignment Saved Successfully!** to indicate your selections have been saved and the assigned names will be displayed in the **Plan of Care** and **IDG Notes**.

### Abbreviation Key:

- **BC**: Bereavement Counselor
- **CM**: Case Manager
- **SC**: Spiritual Counselor
- **VOL**: Volunteer

Selected staff members will receive a text message and/or email notifying them that they have a new patient assignment, though no patient information will be provided in the message.

Once an assigned staff member logs on, they will be able to see the assigned patient’s...
information according to their access level. Once you are finished with this section, click ‘Close’ at the bottom right corner to return to the Admissions Page.

- Access levels are assigned by the system administrator or designee; as are mobile phone numbers and email addresses.

PATIENT CHART CHECK LIST

<table>
<thead>
<tr>
<th>MODULE</th>
<th>STATUS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Consents</td>
<td>✗</td>
</tr>
<tr>
<td>Initial Assessment</td>
<td>✗</td>
</tr>
<tr>
<td>Comprehensive Assessment (Complete within 5 days of SOC)</td>
<td>✗</td>
</tr>
<tr>
<td>Psychosocial Assessment (Complete within 5 days of SOC)</td>
<td>✗</td>
</tr>
<tr>
<td>Spiritual Assessment (Complete within 5 days of SOC)</td>
<td>✗</td>
</tr>
<tr>
<td>Bereavement Assessment (Complete within 5 days of SOC)</td>
<td>✗</td>
</tr>
<tr>
<td>Recertification</td>
<td>✔</td>
</tr>
<tr>
<td>Discharge</td>
<td></td>
</tr>
</tbody>
</table>

This page will list all the items that are required to be completed for each patient according to CMS’s Conditions of Participation for Hospice Care.

To the right of each item under the ‘STATUS’ column you will see either a ✔ to indicate that the requirement has been met or a ✗ to indicate that the item is either not complete or has not been signed. To open each individual page, click on the ‘Open’ button to the left of each item.
This page lists a history of all previously created Assessments. The Nursing Assessment is set as the default for this link. However, each staff member will only be able to see the Assessments allowed by their access level. For example, an MSW will only have access to the Psychosocial Assessment.

**Status:** A ✔️ in the ‘Status’ column means that the Assessment has been completed and signed by the appropriate staff member. A ✗ will indicate Assessments which have either not been completed or not been signed.

- Note that once an Assessment has been signed, it will be locked either immediately or after a set amount of days, as designated by your system administrator. You can edit the Assessment up until the ‘Lock Date’.
  Once locked, the assessment can no longer be edited. If you need to make changes to a locked assessment or have signed an assessment accidentally, contact your system administrator.
  Signing and saving an assessment will be covered in the [Adding a New Assessment](#) section.

For staff members with access to assessments created by other staff members, you can choose to only view assessments which you have created by clicking in the box next to “Show only that belongs to me” at the top right corner of the History of Assessment page.

The first time you create a Nursing Assessment, you will be given the option of creating an Initial Comprehensive or a Recert/Update Assessment.

The first Spiritual and Psychosocial Assessments created will be labeled as a Comprehensive Assessment. All subsequent assessments can be labeled as Comprehensive, Update, or Re-Cert.

To **Open** a previously created Assessment, click the ‘Open’ button to the left of the Assessment. To create a new assessment, click ‘Add New Assessment’ at the bottom of the page or click ☺️ to the right of History of Assessment.
ADDING A NEW ASSESSMENT (All)

The yellow box contains basic information on when and how the Assessment was done. Enter the details of how and when the Assessment was conducted in the corresponding fields. Clicking the ‘Calc’ button will calculate the duration of the visit.

- If this is not the Initial or Comprehensive Assessment, you can select either an ‘Update’ or ‘Re-Cert’ Assessment by selecting the appropriate circle next to ‘Reason for Assessment’.
- Note you will not have this option when creating an Initial Assessment.

**Entered By/Entry Date**: These fields will be automatically populated based on the HospiceMD account being used and the date the Assessment is being created.

**Staff Assigned/Discipline**: If the staff member who conducted the Assessment is different than the staff member entering the information into HospiceMD (ie the Assessment was done on paper by the RN, but another authorized staff member is entering the information into HospiceMD) then the staff member who conducted the Assessment and their discipline is selected form the drop-down menu. If a name is not listed, contact your system administrator.

**Attach Document**: You can attach the hardcopy of the Assessment if done on paper, or any relevant documents by clicking the ‘Choose File’ button in the ‘Attach Document’ box. You are only able to attached PDF and JPEG files.

**Delete an Assessment**: To delete an Assessment that has not been locked, click the ‘Delete’ button at the top or bottom right corner of the Assessment page. If you need to delete an Assessment that has already been locked, contact your system administrator.
# Assessment Panels

When completing the assessment panels, you can expand or collapse all panels by clicking ☑️ or ☐️, respectively. You can also open and close each panel individually by clicking anywhere in the Panel Header or the ☐️ ☑️ icons on the right side of the panel header.

**Add an Issue:**

In certain assessment panels you will have the option of creating a new issue by clicking the ‘Add Issue’ link or ☑️ to the left of ‘Add Issue’. This will open a new window in which you can input the details of the issue including goals and deadlines. Once you have added a new issue, the issue will become part of the patient’s **PLAN OF CARE** and open issues will be automatically included in the **IDG Notes**.
Saving and signing the Assessment:

Once you have completed each panel you can save your assessment by clicking the ‘Save’ button on the top or bottom right corners of the Assessment page. You will see Information Saved Successfully! to confirm the assessment has been saved. The Assessment will not be marked as complete until you have signed the Assessment. To sign the assessment, click the ‘Signature’ button at the bottom right corner of the page.

- Note that you will not be able to sign the Assessment without first completing the Narrative, Vitals, and certain other panels depending on the type of Assessment. You will be prompted on which panels you are required to complete when you attempt to sign the assessment.
- Once signed, the Assessment will be locked either immediately or after a set amount of days, as designated by your system administrator. You can edit the Assessment up until it becomes Locked.
Nursing Assessment

When creating an Assessment for a new Patient, you will have the option of creating either an Initial/Comprehensive Assessment or a Recertification or Updated Assessment. Click the appropriate link to be taken to that Assessment Form.

Comprehensive Assessment:
To create the Comprehensive Assessment, click **Add New Assessment** from the **History of Assessments** page.

**Click on each panel header to open the individual panels or click on the ☑☐ icons. Pain and KPS/PPS are required in order to save the Assessment.**

**Pain:**

![Pain Screening](image)

This panel is required before an Initial Assessment can be saved. In response to CMS’s Quality Reporting requirements, HospiceMD will track all responses in this field and generate QAPI reports based on these responses. (Accessing these reports will be covered under the **REPORTS** section.) This section is also being tracked in the HIS Admission Report.

If required to complete a **Physical Pain Assessment**, click on the link to open the Physical Pain Assessment window.

**KPS/PPS/FAST/NYHA score effecting ADL?**

![KPS/PPS/FAST/NYHA score effecting ADL?](image)

Click directly on the KPS, PPS, FAST or NYHA links in this panel to open a reference sheet on the different scoring systems. Selecting a score from the drop down menu next to each will provide a definition of the score to the right of that drop down menu. These scores are automatically inserted into a patient’s LCD Eligibility form. (See **COMPLIANCE**)

- KPS and PPS are required fields.
- HospiceMD will detect what other scores are necessary depending on the disease type selected in the patient’s **Demographics**.
Body System:

Click directly on each focus area to expand the panel and input the information using the specified fields and drop down menus. To Add an Issue click the ‘Add Issue’ link or the + on the top right corner of each focus area.

Primary/Secondary Diagnosis and Comorbidities:

Any primary and secondary diagnosis and comorbidities entered into these fields will be automatically populated in the Diagnosis and Dates of Service panel of the patient’s Demographics page and vice versa.

- Note: It is important to ensure that only necessary and approved changes are made to this panel, as this will directly affect the patient’s personal information page and could potentially affect their eligibility for Hospice.
### Nature & Condition of Terminal Illness/LCD Eligibility:

<table>
<thead>
<tr>
<th>Illness Trajectory and reason for hospice admission</th>
</tr>
</thead>
<tbody>
<tr>
<td>The following conditions exist as evidenced in or reported by: [ ] Medical history [ ] Patient [ ] PCG/Family</td>
</tr>
<tr>
<td>Hx of ER Visit / hospitalizations in the last 12 months: [ ] None</td>
</tr>
</tbody>
</table>

#### Terminal Stage Determination for Disease Type

1. Disease with metastasis at presentation (a must be met)
   - a. Has the cancer metastasized and is untreatable at presentation? [ ] Select
   - OR
2. Progression of cancer from an earlier stage of disease to metastatic disease (a or b must be met)
   - a. Has the cancer metastasized regardless of therapy? [ ] Select
   - b. Has patient been ruled out as a candidate or declines further curative therapy? [ ] Select
   - OR
3. Certain cancers with poor prognosis (All must be met)
   - a. Patient has suspicious large tumor and refuses definitive diagnosis? [ ] Select
   - b. Patient has declined in functional status? [ ] Select
   - c. Patient has significant, unintentional weight loss? [ ] Select

Select the patient’s Primary Disease from the ‘Terminal Stage Determination for Disease Type.' HospiceMD will automatically generate the conditions that must be met for hospice eligibility according to CMS’ Local Coverage Determination Guidelines. This information is used to populate Eligibility in the Compliance section.

### Admissions Order:

"On completion of assessment and medical history available to me, I have discussed patient's status with the Physician. Based on information of patient status that I provided to the Physician and his review of patient’s medical history (if available to him, the Physician has issued an order to admit this patient to hospice. His initial order on Level of Care, Frequency of Visit and any applicable Meds/DME/Treatment is entered below. This is a Phone order I read back and verified."

- **Level of Care** ([click here])
- **Frequency of Visit** ([click here])
- **Treatment/Meds Order** ([click here])

Before signing the Assessment, read through the Admissions Order statement and designate the Level of Care, Frequency of Visit, and Treatment/Meds Order by clicking the (click here) link to the right of each section.
To **Open** a previously created IDG click ‘Open’ to the right of the IDG Meeting information bar.

To view only most recent IDG Meeting for this patient, click in the box to the right of ‘Current IDG’ above the IDG Meeting header.

The first IDG created for this patient will always be labeled as INITIAL. Subsequent IDGs will be labeled as UPDATED.

**Creating a New IDG Meeting:**

To create a new IDG Meeting, click ‘Add New IDG’ at the bottom of the History of IDG Meetings page. This will take you to the NEW IDG REVIEW/UPDATE TO PLAN OF CARE page. You can also add a new IDG by clicking to the right of History of IDG Meetings.
New IDG Review/Update

Entered By/Date: These fields will automatically populate according to the person who is logged in to HospiceMD and the date the IDG is being created.

The yellow box contains basic information of when and how the IDG was conducted.

- Note that the Date and Time of the actual Meeting might different from the Entry Date if you are creating the IDG Review on a different date than that of the meeting.

Once you have verified the information you entered, click ‘Continue With IDG’. This will automatically save your new IDG and open the IDG NOTES page. You can also exit without saving the new IDG by clicking ‘Close’. This will take you back to the HISTORY OF IDG MEETINGS page.
To make changes to the IDG Meeting information previously entered in the NEW IDG REVIEW/UPDATE page, edit the desired information in the yellow box and click Save at the top or bottom right corners of the IDG Notes page. You will see *Information Saved Successfully!* at the top right corner.

To expand or collapse all tabs in the IDG NOTES page click ⧲ or ⧲, respectively, above the Open Issues panel.

**Save IDG Notes**: Click ‘Save’ at the bottom or top right corners of the IDG Notes page. Assigned staff members will be responsible for signing the IDG by clicking the corresponding ‘Signature’ buttons located at the bottom of the page. They will also be reminded via the My Signature section of the Dashboard. Once signed, the ‘Signature’ icons will display the signature details.
**Delete IDG Notes:** Click ‘Delete’ at the bottom or top right corner of the IDG Notes page. You will receive a pop-up window asking “Are you sure you want to delete this IDG?” Click ‘OK’ to delete or ‘Cancel’ to close the pop-up window and return to the IDG.

**POC Summary:** The POC Summary will provide a basic overview of the patient including a list of their current medications, DME, and treatments. Click the *(click here)* link to open the POC Summary.

- The POC Summary will be saved within each IDG as it is as of the date of the IDG. Therefore you can refer back to each POC Summary by opening previous IDGs.

**IDG Discussion:**

The IDG discussion is divided into Clinical, Spiritual, Psychosocial, and Other fields in order to facilitate the flow of discussion and ensure that each discipline is being considered during the discussion. The Physician Order section provides a section where any new orders or changes to existing medications, DME, or levels of care can be documented and addressed.
Open Issues – Problem/Intervention/Goals/Status:

This panel will list all of the patient’s open issues created by staff through Assessments, Visit Notes, the Plan of Care, or previous IDG Meetings. The open issues are grouped by focus area. To expand or collapse Open Issues click ☰ or ☱ on the right of each Panel Header or click anywhere in the Panel Header.

- Issues that have been added since the last IDG meeting are displayed in yellow.
- To Import New Issues that may have been added after the IDG was created but before the actual date of the IDG, click ‘Import New Issues’.

If any change is necessary to the current PLAN OF CARE, make the appropriate selection from the POC ACTION drop down menu and update the INTERVENTION, GOAL, and TARGET and RESOLVED DATES as necessary. The POC ACTION menu default will always be ‘No Change’.

- To create a Physician Order for that change click the ‘Save/Create Physician Order’ link at the bottom right corner of the open issue. The Physician will receive a notification on HospiceMD of the order.

To save changes made to any of the Open Issues, click ‘Save’ at the bottom or top right corner of the IDG Notes page. You will see Information Save Successfully! at the top right corner.
**Level of Care/Frequency of Visit/Staff Assignment:**

<table>
<thead>
<tr>
<th>Level of Care click here</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency of Visit click here</td>
</tr>
<tr>
<td>Staff Assignment click here</td>
</tr>
</tbody>
</table>

These panels will indicate the current level of care, frequency of visit, and staff assignments in parentheses within the Panel Headers. If changes are determined necessary for any of these fields, click the ‘click here’ link to the right of the Panel Headers. This will open a new window in which you can make the desired changes. When finished, close the window to return to the IDG Notes page.
ADD NEW LEVEL OF CARE

Enter the Level of Care information using the specified fields and drop-down menus.

Click the ‘Add’ Button to save the new level of care. You will see Level of Care Added Successfully! and the new Level of Care will be listed under History of Level of Care.

Edit or Delete an existing Level of Care:

Select the Level of Care by clicking ‘Select’ on the left side of the Level of Care you would like to edit. Once you click ‘Select’ your selection will be highlighted in orange and the Page Header will change from Add New Level of Care to Editing Level of Care #. Make the desired changes to the From Date and Care Level drop-down menus and click ‘Update’. If you are Deleting a Level of Care entry, click the ‘Delete’ button. You will receive a pop-up window asking “Are you sure you want to delete this item?” Click ‘OK’ to delete your selection or ‘Cancel’ to return to your selection without deleting. Click ‘Cancel’ to deselect the Level of Care.

Click ‘Close’ at the bottom right corner of the window or exit out of the window to return to HospiceMD.
ADD NEW FREQUENCY OF VISIT
Enter the Frequency of Visit information using the specified fields and drop-down menus.

Click ‘Add’ to add this new entry. You will receive a pop-up window asking “Do you have a physician order to add/change frequency of staff?” Click ‘OK’ to add or click ‘Cancel’ to return to Add New Frequency of Visit without adding.

Once successfully added you will see Level of Care Added Successfully! and the new Visit Frequency will be listed under History of Frequency of Visit.

Edit or Delete an existing Frequency of Visit:

Select the Frequency of Visit by clicking ‘Select’ on the left side of the Visit Frequency you want to edit. Once you click ‘Select’, your selection will be highlighted in orange and the Page Header will change from Add New Frequency of Visit to Editing Frequency of Visit #. Make the desired changes to From Date, Discipline, No of Visit, and/or Period drop-down menus and click ‘Update’. If you are Deleting a Frequency of Visit entry, click the ‘Delete’ button. You will receive a pop-up window asking “Are you sure you want to delete this item?” Click ‘OK’ to delete your selection or ‘Cancel’ to return to your selection without deleting. Click ‘Cancel’ to deselect the Frequency of Visit.
Click ‘Close’ at the bottom right corner of the window or exit out of the window to return to HospiceMD.

**STAFF ASSIGNMENT**
See [Staff Assignment](#) under ADMISSIONS.

<table>
<thead>
<tr>
<th>Abbreviation Key:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BC</strong>: Bereavement Counselor</td>
</tr>
<tr>
<td><strong>CC</strong>: Continuous Care</td>
</tr>
<tr>
<td><strong>CM</strong>: Case Manager</td>
</tr>
<tr>
<td><strong>HM</strong>: Homemaker</td>
</tr>
<tr>
<td><strong>IP</strong>: Inpatient Care</td>
</tr>
<tr>
<td><strong>MIS</strong>: Miscellaneous</td>
</tr>
<tr>
<td><strong>NU</strong>: Nutritionist</td>
</tr>
<tr>
<td><strong>PT</strong>: Physical Therapist</td>
</tr>
<tr>
<td><strong>RC</strong>: Routine Care</td>
</tr>
<tr>
<td><strong>RSP</strong>: Respite Care</td>
</tr>
<tr>
<td><strong>SC</strong>: Spiritual Counselor</td>
</tr>
<tr>
<td><strong>SN</strong>: Skilled Nurse</td>
</tr>
<tr>
<td><strong>Vol</strong>: Volunteer</td>
</tr>
</tbody>
</table>
This page will display the Current Plan of Care. No changes can be made to the Plan of Care within this page. Only Level of Care, Frequency of Visit, and Staff Assignment can be edited within the Current Plan of Care.

You can choose to view only the Current POC or Add/Update POC by clicking in the circle directly to the left of your selection.

- Only staff members with authorized access will be able to edit the Plan of Care. All changes, corrections or additions to the Plan of Care are done in Add/Update POC. Contact your system administrator with access level questions.
- In the Add/Update POC view, issues that have been added since the last review of the POC will be displayed in yellow.
**Level of Care/Frequency of Visit/Staff Assignment**: These panels will indicate the current level of care, frequency of visit, and staff assignments in parentheses within the Panel Headers. If changes are determined necessary for any of these fields, click the ‘click here’ link to the right of the Panel Headers.

This will open a new window in which you can make the desired changes. When finished, close the window to return to the Plan of Care page.

**DME/MEDS**: To view a list of the current Durable Medical Equipment (DME) and Medications (MEDS) for this patient, click the ‘(click here)’ link to the right of the Panel Header. This will open a new tab in your internet’s browser. Close the tab to return to HospiceMD.

Click ‘Close’ at the bottom right corner of the Plan of Care Page to return to the patient’s Demographics page.

**Intervention & Goals**

<table>
<thead>
<tr>
<th>Intervention &amp; Goals</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADL</td>
</tr>
<tr>
<td>CARDIO-PULMONARY</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>ISSUE: (Potential for altered respiratory status r/t; ) (Date: 7/6/2013)</th>
</tr>
</thead>
<tbody>
<tr>
<td>GOAL: Early detection of upper respiratory infection.</td>
</tr>
<tr>
<td>INTERVENTION: Assess / monitor cardiac status every visit.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>TARGET DATE:</th>
<th>RESOLVED DATE:</th>
<th>STATUS: Ongoing</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>NEUROLOGICAL/MENTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>PAIN</td>
</tr>
</tbody>
</table>

All issues listed in the Interventions & Goals panel are categorized and populated from issues created by authorized staff through Assessments, IDG Meetings, and Visit Notes.

To expand or collapse all panels within the Interventions & Goals panel click ▲ or ▼, respectively, located to the right and directly above the Panel Header. You can also expand or collapse each panel individually by clicking ▲▼ on the right side of each Panel Header or by clicking anywhere in the Panel Header.

- In the Add/Update POC section you will be able to edit the Goals and Interventions as well as close any issue. Click ‘Save at the top or bottom right corners or ‘Signature’ to finalize the Plan of Care and any changes made.
Close an Issue: There are two ways to close an issue within the Plan of Care

1. To close an issue that is already being addressed in the Plan of Care or that should not be in the patient’s Current Plan of Care, click the checkbox next to ‘Duplicate Issue’. This will remove the issue from the Current Plan of Care, but it will remain in the History of Issues.

2. If an issue has been resolved, enter the date the issue was resolved in the corresponding field. If the date is before the ‘Resolve by Date’ or if there is no ‘Resolve by Date’ then the STATUS will change to RESOLVED.

- Note: if there is a ‘Resolve By Date’ entered, the ‘Resolved Date’ must be earlier or the same as the Resolve By Date in order for the issue to close as resolved. If the Resolved date is later, the Status will be changed to ‘QAPI Issue’ and will remain in the Plan of Care for edits.
### POC Summary

**DNR / CARE LEVEL**

**FUNCTIONAL LIMITATION / ADL Need**

**ACTIVITIES PERMITTED**

**MENTAL STATUS**

Patient is has potential to be:

**DISASTER TRIAGE**

**FOCUS AREAS**

**ADL**

**DIET**

**MEDICATION**

| ADMINISTERED BY: | (1) - SNF Nurse, (2) - Self, (3) - Fam/PCC, (4) - Hospice Nurse, (84) - SNF & Hospice Nurse, (284) - Self & Fam/PCC, (284) - Self & Hospice Nurse, (384) - Fam/PCC & Hospice Nurse, (2384) - Self & Fam/PCC & Hospice Nurse |

**TREATMENT**

**OTHER**

**DME**

**SUPPLIES**

**LAB**

**FREQUENCY OF VISIT**

Medication Profile Reviewed for: Contraindications, Side Effects, Interactions, Duplications and Lab Therapy Drugs

Patient is Compliant with Meds/Treatment ☐ Yes ☐ No

 Attending Physician: Label

Orders/Meds have been Reviewed/Recapped By ___________________________ Date: ____________

The **POC Summary** will display pertinent patient information taken from the latest assessments and visit notes. For hospices that opt to provide this information to their patients, the **POC Summary** can be printed and signed and given to the family or placed in the bedside chart according to policy.

Click the ‘Print Page’ link at the top right corner of the window to print.
ISSUES/OUTCOME

HISTORY OF ISSUES

This page will display All previously created issues for this patient. To expand or collapse each panel, click either the ☰ or ☰, respectively, or click anywhere in the Panel Header. You will see the following details for each issue:

The Date the issue was created

A description of the issue

A Target Date for resolution of the issue if one was added

The Resolved Date for the issue if one was added

And the current Status of the issue; whether it was Resolved, Ongoing, Closed or UNRESOLVED

- Note if an issue is unresolved, meaning the Target Date for resolution of the issue has passed, an Alert will be generated for this issue.
- Staff with the appropriate access level can make changes and updates to these issues through the Add/Update section of the Plan of Care.

Abbreviation Key:

Org: Origin (where the issue was created)
A: Assessment
C: Communication/Progress Note
V: Visit Note
ADD NEW ISSUE

You can add a new issue from patient Assessments, Visit Notes, Communication Log, and the Issues/Outcomes module by either clicking the ‘Add Issue’ link when available or clicking the next to ‘Add Issue’. All new Issues are automatically added to the Plan of Care and sent to the Case Manager’s and Director of Nursing’s Dashboard for review.

In the Add New Issue window, select the focus area from the drop down menu directly under ‘Problem/Needs’ header. There are automatic entries available in each category: Problem/Needs, Goals, and Interventions. Select the box directly to the left of each entry to add it to the text box below. You can select more than one entry. You also have the option of entering your own text in the yellow box or editing your selections as necessary.

- Problem/Needs in red text are used in documenting patient decline.

Once you have entered the desired information click ‘Save’ in the lower right corner. Your issue will be added to the History of Issues directly below the Add New Issue box.

You can then continue adding issues or click ‘Close’ to exit the Add New Issue page.

To Delete an issue, click the Delete link in the far right column of the issue in the ‘History of Issues’.

- Note: You will no longer be able to delete issues once the Plan of Care has been reviewed and signed by the Case Manager or DPCS. (This includes IDG reviews)
This page provides a history of Physician’s orders for this patient.

You can filter the types of orders you are viewing by selecting and deselecting the categories in the top right corner of the page. If a box is checked, those types of orders will be displayed in the list.

To **Open** a previously placed order, click the ‘Open’ button to the left of that order.

To **Add** a new Physician Order, click the ‘Add New Physician Order’ at the bottom of the page or click on the to the right of **Physicians Orders**.

### New Physicians Order

Enter the Order information using the specified fields and drop down menus. The Entered By/Entry Date fields will be automatically populated based on the HospiceMD account being used and the date the order is being created.

**Attach Image**: You can attach a copy of the handwritten order or other relevant document by clicking the ‘Choose File’ button. Once uploaded, the file name will appear to the right of the ‘Choose File’ button.

Click ‘Continue with Order’ to create the Order or ‘Close’ to return to the Physician’s Orders page without saving.
Edit Physicians Order

The gray box will display all of the information entered in the previous New Physicians Order page. You can edit the Ordered By, Order Date, and Attach Image fields.

If you attached a file in the previous page, you will see a paper clip icon in the Attach Image box. Click the paper clip icon or the ‘Details’ link to view the uploaded file. Click the ‘Remove’ link to remove the attached file.

Continue on to the next page for detailed instructions on adding items to the order. When finished entering the order, click ‘Save’ at the bottom of the page. You will see Information Saved Successfully! at the bottom of the page.

- Every new order will be sent to the MD for a Signature. It will be displayed in his/her Dashboard.
Delete an Order: Click the ‘Delete’ button at the bottom of the page. You will receive a pop-up window asking “Are you sure you want to delete this Order?” Click ‘Ok’ to delete to ‘Cancel’ to return to your Order.

Click ‘Close’ at the bottom of the page to exit the Edit Physician’s Order form and return to the Physician’s Order page. You will see your new order added to the Orders List. If you do not see your new order, make sure the type is checked at the top right corner of the page.

Order Details:

Enter the Physician’s Order using the specified fields and drop-down menus.

Always click the ‘Add’ button after entering a new item. The item will be added to the ‘List of Orders’.

You can link a specific Medication, Treatment, or DME order to an issue in the Plan of Care. Select the issue from the drop down menu. Once added, the item ordered will be displayed in the Plan of Care directly under the issue selected.

- If you need to add a new issue, click the ☉ to the right of the drop down menu to open the Add New Issue window. Once finished, click ☉ to refresh the issues list.

Abbreviation Key:

<table>
<thead>
<tr>
<th>Payer</th>
<th>Abbreviation</th>
</tr>
</thead>
<tbody>
<tr>
<td>H</td>
<td>Hospice</td>
</tr>
<tr>
<td>I</td>
<td>Insurance</td>
</tr>
<tr>
<td>P</td>
<td>Patient</td>
</tr>
</tbody>
</table>

If a vendor or Payer is not listed in the drop-down menu, contact your system administrator. The fields in the order details box will adjust according to the Type of order you choose from the ‘Type’ drop-down menu.

Refills: Select ‘Refill’ from the drop down menu next to ‘Type’. The ‘Order’ field will turn into a drop down menu from which you can browse all medications that have been previously ordered. Selecting the medication will also auto complete the remaining fields based on the previous order.
**Discontinue**: Select ‘DC’ from the drop down menu next to ‘Type’. The ‘Order’ field will turn into a drop down menu form which you can browse all current medications. Selecting the medication will also auto complete the remaining fields based on the current order.

Once you have entered the Order Details, click the ‘Add’ button on the bottom right corner of the Order Details box. You will see *Item Added Successfully!* to the left of the ‘Add’ button. Your Order will be added to the List of Items Ordered.

- Reminder: If you do not click the ‘Add’ button, your item will not be saved to the order, even if you click ‘Save’ at the bottom of the page.

To **Edit** an order already on the list, click the Select link to the left of the order. The order you selected will become highlighted and you can make the desired changes directly in the Order Details fields and drop-down menus. Update, Delete, and Cancel options will replace the ‘Add’ button on the bottom right corner of the Order Details box. **Always click ‘Update’ to save your changes.**

<table>
<thead>
<tr>
<th>List of Orders</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Type</strong></td>
</tr>
<tr>
<td>Select</td>
</tr>
<tr>
<td>Select</td>
</tr>
</tbody>
</table>
CERTIFICATION LIST

To Add a Physician’s Certification, click ‘Add New Certification’ or click the ﾖ next to the Certification List header.

The first time you create a certification, you will have the option of selecting whether you will be completing the PCP Certification or the Medical Director Certification.

Date Sent: This is the date the certification is created. The system will automatically create a re-certification 30 days prior to the start of the new benefit period. Once the re-certification is created, a notice will be sent to the MD’s My Task section on the Dashboard.

You can either create the certification yourself or the system will create one automatically. If you are creating a certification for a patient who is a readmit or transfer and not starting on the first 90 day period, you must select READMIT or TRANSFER in the Dates of Service, Diagnosis, & Allergies Panel and select the appropriate STARTING CERT#. This will create the appropriate certification for the patient.

Deleting a CTI: You may delete a CTI as long as the status of the CTI is still pending. If the status has changed to Done, meaning that an MD or authorized staff member has completed and signed the CTI, then only the Admin and CM staff levels will be able to delete.

- Note that CTIs must be deleted in order starting with newest first. You will not be able to delete a CTI out of sequence.
- In order to avoid discrepancies in Certification dates, the Start of Care Date in the Demographics page can only be changed once all existing CTIs are deleted.
Patient and Medical Director Information is automatically populated based on the patient’s Demographics information and the Medical Director information entered by your System Administrator.

**Nursing Narrative**: This field will be automatically populated with the RN’s latest Assessment Narrative.
**Certification based on:** The Medical Director or designee completing the form must check either box and complete the Visit information. Time can be entered directly in the field or changed with the set of arrows directly to the right of the ‘Time’ fields.

**Narrative:** The Narrative field must be complete, otherwise the form will be labeled as incomplete, even after it is signed, and an alert will be generated for this Certification.

To save the form, click ‘Save’ at the bottom of the Certification form. You will see *SavedSuccessfully!* to confirm your entries have been saved.

If the assigned MD does not have access to HospiceMD in order to Sign the form, you can click the ‘Print’ button at the bottom of the page in order to print a hardcopy.

**Signature:** Either the assigned MD or Nurse Practitioner can provide an electronic signature; or the designee completing the form on HospiceMD can sign as ‘Signature on file’ if a hardcopy is available. The Signature information will appear on the ‘Hospice Medical Director Signature’ line.

Click ‘Close’ to exit the form and return to the **Certification List** page.
Referring MD Certification

Patient and Referring MD information is automatically populated based on the patient’s Demographics information and the Referring MD information entered by your system administrator. The Certification number and period is also automatically calculated.
**Narrative:** The Narrative field must be complete, otherwise the form will be labeled as incomplete, even after it is signed and an alert will be generated for this Certification.

Click ‘Save’ at the bottom of the form in order to save any changes you have made to this Certification. You will see *Saved Successfully!* at the bottom of the form.

To print a hardcopy of this form to send to the Referring MD click ‘Print’ at the bottom of the form. Verify that your hospice’s fax number at the bottom of the page is correct. If it is not, contact your system administrator.

**Signature:** If the Referring MD has access to HospiceMD he/she can sign by clicking the ‘Signature’ button at the bottom left corner of the form. If the designee is completing the form, they can acknowledge a hardcopy with signature is on file by clicking the ‘Signature’ button. The details of the signature will be displayed on the Signature line.

Click ‘Close’ to exit the form and return to the **Certification List** page.
The **MD Visit List** page will provide a list of all the MD visit notes created with the newest at the top. You can view any previously created visit note by clicking the ‘Open’ button to the right of that visit note.

To Add a New MD visit click ‘Add New MD Visit’ at the bottom of the page or click ☰️ to the right of the page header.
**New MD Visit Note**

**Entered By/Entry Date**: These fields will be automatically populated based on the HospiceMD account being used and the date the order is being created.

**Staff Assigned/Discipline**: If the assigned MD is not the person entering the information into HospiceMD then the assigned MD is entered using the drop-down menus. If a name is not listed, contact your system administrator.

**Attach Image**: You can attach the hardcopy of the MDs Visit Notes if done on paper, or any relevant documents by clicking the ‘Choose File’ button under Attach Image.

The yellow box contains basic information on when and how the Visit was done. Enter the details of how and when the Visit was conducted in the corresponding fields. Clicking the ‘Calc’ button will calculate the duration of the visit. Select the ‘Place of Service’ and ‘MD Visit Type’ from the drop-down menus.

To expand or collapse all panels in the MD Visit Notes Section, click ☑ or ☐, respectively, found underneath the Visit information box. You can also expand or collapse each panel individually by clicking ☑ ☐ on the right of the panel or by clicking anywhere in the panel header.
**Form Type:** You can either select to complete the long or short visit form. The short visit form simply contains the **Narrative**, while the long contains **Subjective** and **Objective** panels in addition to the **Narrative**.

<table>
<thead>
<tr>
<th>Subjective</th>
</tr>
</thead>
<tbody>
<tr>
<td>History</td>
</tr>
<tr>
<td>Review of Systems</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Objective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical Exam</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Narrative</th>
<th>Level of Complexity</th>
<th>Select One</th>
</tr>
</thead>
</table>

**Subjective/Objective/Narrative:** Complete the fields where applicable. The Narrative must be complete, otherwise, the Visit Note will be marked as incomplete, even after it has been signed, and an alert will be generated for this Visit Note.

To Save the visit note click ‘Save’ at the bottom of the page. You can also ‘Close’ the window to return to the **MD Visit List** page.

**Signature:** The assigned MD or designee can sign the form by clicking ‘Signature’ at the bottom left corner of the page. Clicking ‘Signature’ will lock the form, either immediately or after a set number of days, and prohibit any future edits. Do not sign the form until you have verified all of the information entered is correct and the ‘Narrative’ has been filled out. Once you click ‘Signature’ you will return to the **MD Visit List** page.
VISIT NOTES

The **Visit Notes** page will provide a list of all of the Visit Notes created for this patient with the newest at the top. The ‘**Status**’ column will display a ✗ for visit notes which are incomplete or not signed. A ✔ will be displayed for notes which are complete, signed, and reviewed by the assigned supervisor. A ⚠ will be displayed next to notes which are complete and signed, but have not yet been reviewed by the assigned supervisor.

If a document has been attached to the visit note, a paperclip icon will be displayed to the right of the ‘**Status**’ column. Click on this icon to open the attached file.

To **Open** a previously created visit note click the ‘Open’ button to the left of that visit note.

- Note that you can edit and save changes to visit notes until they are **Locked**. Signing a visit note will lock that note, either immediately or within a set number of days, and prohibit any future changes.

**Adding a New Visit Note:**

To add a new visit note click the ‘Add New Visit Note’ at the bottom of the page or click ➕ to the right of the page header.

**Icon Key:**

- ✗ : Not Signed
- ⚠ : Signed, but not Reviewed by QA
- ✔ : Signed and Reviewed by QA
New/Edit Visit Note

Created By/Created Date: These fields will automatically populate according to the staff member who is logged in to HospiceMD and the date the visit note is being created.

Staff Assigned/Discipline: If the staff member who conducted the visit is different than the staff member entering the information into HospiceMD (ie the visit was documented on paper by the visiting nurse, but another authorized staff member is entering the information into HospiceMD) then the staff member who conducted the visit and their discipline is selected from the drop-down menu. If a name is not listed, contact your system administrator.

Attach a Document: You can attach a hardcopy of the visit notes by clicking ‘Choose File’. Once you choose a file, you will see the file name displayed in the ‘Attach a Document’ Box.

- Note that you are only able to upload a single file.
The yellow box contains basic information on when and how the visit was done. Enter the details of how and when the visit was conducted in the corresponding fields. You can enter **Time In** and **Out** directly into the field or use the up and down arrows directly to the right of each field. HospiceMD will calculate the duration of the visit.

To expand or collapse all panels click on 

or 

, respectively, above the initial **Pain** panel. To expand or collapse each panel individually click the double down or double up arrows at the right of each Panel or click anywhere in the Panel Header.

To **add a new issue** to the **Plan of Care** in the panels where the option is available, click the ‘Add Issue’ link or click 

. A window will open in which you can add and save a new issue for this patient. This issue will automatically be added to the **Plan of Care**.

**Pain**: Due to CMS Quality Reporting requirements. If the Comprehensive and Initial Assessment were done together, therefore only allowing for the initial question of whether or not a patient was uncomfortable because of pain, the first visit note opened will ask the question of whether or not the pain was brought to a comfortable level within 48 hours of admission. If the question was already answered in a previous assessment or visit note, then the Pain panel will simply ask if the patient’s pain is controlled.

**Vitals and Measurements**: The Height (Ht), Weight (Wt) and MAC fields will automatically be carried over into the next visit note created. The BMI is calculated automatically based on the information entered into these three fields.

**Narrative**: The narrative must be completed in order for the Visit Note to be considered complete. If the staff member inputting the Visit Note is not the staff member who made the visit and has uploaded a copy of the Visit Note in the ‘Attach Document’, the Narrative will automatically display “Hard copy of staff notes is attached.”

**Signs and Symptoms/Alteration in Status**: If an issue has been previously created for a focus area, that focus area will be displayed in red. Click directly on each focus area to expand it.

**Save/Delete/Close**: Click ‘Save’ at the bottom right corner of the page to save changes made to the Visit Note. You must always save your changes before closing the page or exiting HospiceMD. You can also delete the current visit note by clicking ‘Delete’ or close out of the current Visit Note and return to the **Visit Notes** list by clicking ‘Close’.

**Signature**: Click ‘Signature’ to sign and save the Visit Note.

- Note that once a Visit Note has been signed, it will be locked either immediately or after a set amount of days, as designated by your system administrator. Once locked it can no longer be edited. If you need to make changes to a locked Visit Note or have signed it accidentally, contact your system administrator. You can make changes to a Visit Note up until the time the form is locked.
**Reviewed By**: The assigned supervisor must Review the Note and click ‘Reviewed By’. The Visit Note status will display ⚠ until the visit note is signed by the reviewer, at which time the status will change to ✔ if the Visit Note was completed correctly.

Once the note is reviewed, it will also automatically lock.
HEALTH AIDE (HA)

VISIT NOTES FOR HOSPICE AIDE

The Visit Notes for Hospice Aide page will provide a list of all of the Visit Notes created by the Hospice Aide with the newest at the top.

The ‘Status’ column will display ✗ for visit notes which are incomplete or not signed. A ✓ will be displayed for notes which are complete, signed, and reviewed by the assigned supervisor. A ⚠ will be displayed next to notes which are complete and signed, but have not yet been reviewed by the assigned supervisor.

To **Open** a previously created visit note click the ‘Open’ button to the left of that visit note.

- Note that you can edit and save changes to visit notes until they are Locked. A note will lock either immediately or after a set number of days of signing, as designated by your system administrator.

**Adding a New Visit Note:**

To add a new visit note click the ‘Add New Visit Note’ at the bottom of the page or click ➕ to the right of the page header.

**New/Edit Hospice Aide Visit Notes**

**Entered By/Entry Date:** These fields will automatically populate according to the staff member who is logged in to HospiceMD and the date the visit note is being created.
**Staff Assigned/Discipline:** If the staff member who conducted the visit is different than the staff member entering the information into HospiceMD then the staff member who conducted the visit and their discipline is selected from the drop-down menu. If a name is not listed, contact your system administrator.

**Attach a Document:** You can attach a hardcopy of the visit note by clicking ‘Choose File’. Once you choose a file, you will see the file name displayed in the ‘Attach a Document’ Box.

- Note that you are only able to upload a single file.

The yellow box contains basic information on when and how the visit was done. You can enter **Time In** and **Out** directly into the field or use the up and down arrows directly to the right of each field. Click ‘Calc’ to calculate the duration of the visit.
All Panels will consist of two columns. The left column contains instructions from the Supervising RN to the Hospice Aide based on the Plan of Care for Hospice Aide. The right column contains checkboxes where the Hospice Aide will check off the assigned tasks as they are completed.

To expand or collapse all panels click on  or  , respectively, above the initial Ambulation panel. To expand or collapse each panel individually click  at the right of each Panel or click anywhere in the Panel Header.

**Save/ Close:** Click ‘Save’ at the bottom right corner of the page to save changes made to the Visit Note. You must always save your changes before closing the page or exiting HospiceMD. To close out of the current Visit Note and return to the Visit Notes for Hospice Aide click ‘Close’.

**Signature:** Click ‘Signature’ to sign and save the Visit Note. This will Lock the visit note either immediately or after a set number of days. Once the form is locked, you will no longer be able to make any changes. If the form has been signed by accident or changes are necessary, contact your system administrator or supervisor.

- In order to sign the visit note, the **HA Comments** field must be complete.

**Reviewed By:** The assigned supervisor must Review the Note and click ‘Reviewed By’. The Visit Note status will display  until the visit note is signed by the reviewer, at which time the status will change to  if the Visit Note was completed correctly.
The Plan of Care for Hospice Aide page will display all previously created Plans of Care for the Hospice Aide to follow. The most current Plan of Care is displayed at the top and is used to create the RN Instructions in the Hospice Aide Visit Note.

To add a New Plan of Care click ‘Add/Update New Plan of Care’ at the bottom of the page or click to the right of the page header.

When creating an updated Plan Of Care, the information will be copied from the previous Plan of Care.

**New/Edit Hospice Aide POC**

- **Entered By/Entry Date**: These fields are automatically populated based on the staff member logged in to HospiceMD and the Date the Plan of Care is being created.

- **Staff Assigned/Discipline**: If the RN who created the POC is different than the staff member entering the information into HospiceMD (ie the plan of care was documented on paper by the RN, but another authorized staff member is entering the information into HospiceMD) then the RN who created the POC is selected from the drop-down menu. If a name is not listed, contact your system administrator.
Enter the Plan of Care information using the specified fields, checkboxes and drop-down menus. The Hospice Aide will use this Plan of Care to complete his/her visit notes.

To expand or collapse all panels click on ▼ or ▲, respectively, above the initial Ambulation panel. To expand or collapse each panel individually click ▼▲ at the right of each Panel or click anywhere in the Panel Header.

**Save/ Close:** Click ‘Save’ at the bottom right corner of the page to save changes made to the Visit Note. You must always save your changes before closing the page or exiting HospiceMD. To close out of the current Visit Note and return to the Plan of Care for Hospice Aide click ‘Close’.

**Signature:** Click ‘Signature’ to sign and save the POC. This will Lock the POC either immediately or after a set number of days. Once the form is locked, you will no longer be able to make any changes. If the form has been signed by accident or changes are necessary, contact your system administrator.

- In order to sign the visit note, the RN Additional Instructions field must be complete.
COMM/PROGRESS LOG

COMMUNICATION LOG

This page provides a list of all previously created communication entries for this patient with the newest at the top. To view an entry click ‘Open’ on the left side of that entry.

To add a new communication log entry, click ‘Add New Communication Log’ at the bottom left corner of the page or click + to the right of the page header.

Add New Communication Log
**Entered By/Entry Date**: These fields are automatically populated based on the staff member logged in to HospiceMD and the Date the communication entry is being created.

**Event Date/Event Type**: Enter the date of the event you are recording and select the proper Event Type from the drop down menu.

**Comments**: Enter the details of the communication entry. A preview of this information will appear in the Communication Log.

Click ‘Save’ to save the entry and add it to the Communication Log or click ‘Cancel’ to exit the entry without saving and return to the Communication Log.

Once an entry has been saved, it will be displayed in the Communication Log. When you open a saved entry, you will then have the option to ‘Edit’ or ‘Delete’ the entry, or to create a ‘New’ one by clicking on the appropriate button at the bottom left of the form.

**Send Message**: Once an entry has been saved, you can send that entry as a message to another HospiceMD user by clicking the Send Message link at the bottom right corner of the form. This will create a message with a description of the entry in the Subject line and the Comments of the entry in the Message Body.

**Add to IDG Issue**: If it becomes necessary to add an issue based on the communication, select the focus area from the drop-down menu and click Add Issue or click directly on the Add Issue link to enter the details. This issue will be added to the Plan of Care and IDG Notes once it is saved.

If you would like to add an issue to an already saved entry, click ‘Edit’ at the bottom left corner of the form. This will grant you access to the Add to IDG Issue section.
This page will display any images uploaded to the patient Image Database with the oldest at the top. The details of each image are displayed along with a thumbnail view of the image. To open the image, click the Details link to the right of the image. This will open a new tab in your internet browser.

**Upload Image to Database:** To upload an image, click ‘Choose File’. You can also enter an image title or description into the ‘Image Description’ field. Once you have selected the image, click ‘Upload’ to the right of the ‘Image Description’ field and the image will be added to the Image Database.

To **Delete** an image, click the recycle bin icon on the right. You will receive a pop-up window asking “are you sure you want to delete this Image?” Click ‘OK’ to delete the image or ‘Cancel’ to return to the Image Database.
Enter the Report of Death and Disposal of Controlled Drugs information using the specified fields and drop-down menus.

Click ‘Save’ to save the information entered or ‘Close’ to exit the form without saving and return to the patient’s Demographics page. Once saved you will see Saved Successfully! at the bottom of the form.

When the appropriate staff member is ready to sign the form, clicking ‘Signature’ will save the current form and the details of the signature will be displayed in the ‘Signature’ box.
Enter the Discharge Summary information using the specified fields and drop-down menu.

**Reason for Discharge/EOC:** These entries will be used to auto complete the ‘EOC’ and ‘Disc Code’ fields of the [Diagnosis and Dates of Service](#) panel in the patient’s [Demographics](#) page. You must save this form in order to auto-complete these fields in the [Demographics](#) page.

Click ‘Save’ to save the information entered or ‘Close’ to exit the form without saving and return to the patient’s Demographics page. Once saved you will see **Saved Successfully!** at the bottom of the form.

When the appropriate staff member is ready to sign the form, clicking ‘Signature’ will save the current form and the details of the signature will be displayed in the ‘Signature’ box.
This page will list all previously created Bereavement Assessments with the newest at the top.

**Status**: A ✓ in the ‘Status’ column means that the Assessment has been completed and signed by the appropriate staff member. A ❌ will indicate Assessments which are either not complete or not signed.

- Note that once an Assessment has been signed it will either immediately, or after a set number of days, be locked or can no longer be edited. If you need to make changes to a locked assessment or signed an assessment accidentally, contact your system administrator.

To **Open** a previously created Assessment, click the ‘Open’ button to the left of the Assessment. To create a new assessment, click ‘Add New Assessment’ at the bottom of the page or click ⬇️ to the right of the page header.
INITIAL BEREAVEMENT ASSESSMENT

Entered By/Entry Date: These fields will be automatically populated based on the HospiceMD account being used and the date the Assessment is being created.

Staff Assigned/Discipline: If the staff member who conducted the Assessment is different than the staff member entering the information into HospiceMD then the staff member who conducted the Assessment and their discipline is selected from the drop-down menu. If a name is not listed, contact your system administrator.

Attach Image: You can attach the hardcopy of the Assessment if done on paper, or any relevant documents by clicking the ‘Choose File’ button under Attach Image.

The yellow box contains basic information on when and how the Assessment was done. Enter the details of how and when the Assessment was conducted in the corresponding fields. Clicking the ‘Calc’ button will calculate the duration of the visit.

Adding an Issue:

In certain assessment panels you will have the option of creating a new issue by clicking the ‘Add Issue’ link or to the left of ‘Add Issue’. This will open a new window in which you can input the details of the issue. Once you have added a new issue, the issue will become part of the Bereavement Plan of Care.
**Saving and signing the Assessment:**

Once you have completed each panel you can save your assessment by clicking the ‘Save’ button on the top or bottom right corners of the Assessment page. You will see *Information Saved Successfully!* to confirm the assessment has been saved. The Assessment will not be marked as complete until you have signed the Assessment. To sign the assessment, click the ‘Signature’ button at the bottom left corner of the page. Upon signing, the form will become locked either immediately or within a set amount of days, as designated by your system administrator. Once the form is locked you will see ‘Form Locked’ at the top right corner of the Assessment page and you will be unable to make any changes or delete the Assessment.

- Note that a new assessment cannot be saved unless the required fields in the **1. Primary Bereaved** panel are complete.

**Delete an Assessment:**

To delete an Assessment that has not been signed, click the ‘Delete’ button at the top or bottom right corner of the Assessment page. If you need to delete an Assessment that has already been signed, contact your system administrator.

**Panels**

When completing the assessment panels, you can expand or collapse all panels by clicking ☰ or ☰, respectively, just above the first panel. You can also open and close each panel individually by clicking anywhere in the Panel Header or on ☰ on the right side of the panel header.

**1. Primary Bereaved**

Enter the Primary Bereaved information using the specified fields and drop-down menus.

**Last Name, First Name, Address, City, State, Zip code, and Relationship to Patient** are all required fields. You cannot save a new Assessment without completing these fields.

**Copy AR Information:** To auto complete the fields using the information entered in the Authorized Representative/Emergency Contact panel of the Demographics page, click ‘Copy AR Information’. This will fill in the appropriate fields based on information entered for the Authorized Representative (AR).
2. Risk Stressors For This Bereavement

<table>
<thead>
<tr>
<th>Risk/Stressor</th>
<th>Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide ideation/intent</td>
<td>0</td>
</tr>
<tr>
<td>Possible alcohol / substance abuse</td>
<td>0</td>
</tr>
<tr>
<td>History of mental health concerns</td>
<td>0</td>
</tr>
<tr>
<td>Extreme dependency</td>
<td>0</td>
</tr>
<tr>
<td>Extreme anger, guilt, fear</td>
<td>0</td>
</tr>
<tr>
<td>Ambivalent / Conflicted relationship</td>
<td>0</td>
</tr>
<tr>
<td>History of family violence</td>
<td>0</td>
</tr>
<tr>
<td>Sense of hopelessness</td>
<td>0</td>
</tr>
<tr>
<td>Estranged or isolated from support system</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate coping skills</td>
<td>0</td>
</tr>
<tr>
<td>Multiple losses (in recent losses in the narrative section)</td>
<td>0</td>
</tr>
<tr>
<td>Difficulty coping with past losses</td>
<td>0</td>
</tr>
<tr>
<td>Traumatic death circumstances</td>
<td>0</td>
</tr>
<tr>
<td>Inadequate financial resources</td>
<td>0</td>
</tr>
<tr>
<td>Mental health concerns or change in health status</td>
<td>0</td>
</tr>
<tr>
<td>Neglect of appearance</td>
<td>0</td>
</tr>
<tr>
<td>Exhaustion</td>
<td>0</td>
</tr>
<tr>
<td>Signs of spiritual distress</td>
<td>0</td>
</tr>
<tr>
<td>Unprepared for death</td>
<td>0</td>
</tr>
<tr>
<td>Disenfranchised grief</td>
<td>0</td>
</tr>
<tr>
<td>Legal Concerns</td>
<td>0</td>
</tr>
<tr>
<td>Other (specify)</td>
<td>0</td>
</tr>
</tbody>
</table>

Click on the box to the left of each Risk/Stressor to apply it to this assessment. The Score will automatically populate in the right hand column when a risk/stressor is selected.

**Total**: HospiceMD will add up the scores of the selected risk/stressor and indicate whether this is a LOW, MODERATE or HIGH RISK bereaved at the bottom of the panel.
3. Additional Bereaved

Enter information for additional bereaved individuals using the specified fields.

4. Narrative

The narrative must be complete in order for the Assessment to be labeled complete in the status column once it is signed. Remember that once an assessment is locked, it can no longer be edited.
Once a Bereavement Assessment is created, you can create a Bereavement Plan of Care. The POC will automatically populate the information from the Initial Bereavement Assessment into the POC form including the ‘Primary Bereaved’ and Risk Level. The Risk Level panel will change depending on whether the bereaved is Low, Moderate or High. Each level will contain a different set of interventions.

To save the POC, click the ‘Save’ button on the bottom or top right corners of the form and click ‘Signature’ to finalize the POC.
See Initial Bereavement Assessment
BEREAVEMENT LETTERS

The Bereavement Letters section will track all letters that have been sent out for a Discharged patient according to their Bereavement POC. All letters can be automatically generated through the Bereavement Letters section in Post Death Support.

POST DEATH SUPPORT

This section will allow the Bereavement Counselor to keep track of all bereavement activity.

Bereavement Communication Note
Use the designated fields and drop down menus to add a communication note to the Bereavement Communication Log. Once complete click the ‘Add Note’ button. This will drop your communication note in the Communication Log.

To edit an existing communication note, click ‘Select’ to the left of that note. This will move the information to the Communication Note Form.

Make the desired changes and click ‘Update’. If you need to delete a note, click the ‘Delete’ button.

**Bereavement Letters**

Once a patient is Discharged due to death, refer to this section for due dates on the bereavement letters. Once a letter becomes due, it will be highlighted. If it is overdue, the date will display in red with an accompanying ‘Overdue’ notice.

To create and send a letter, click the ‘Open’ button. This will auto generate the letter due based on your hospice’s template. The bereaved information is pulled from the **Bereavement Assessment**’s ‘Primary Bereaved’ fields.
Note: Even though the letter is automatically generated, you may still make edits as necessary. Click anywhere in the letter text to make changes.

Click Signature to electronically sign the letter. This will change the letter status in the tracking table to ‘SIGNED’.

Click Print to extract your letter. The electronic signature will not show on the printout. Once you click the print button, the status on the tracking table will change to ‘SENT’.

- Once a letter is SENT, the next time you click open, the next letter in line will be displayed.
- You may still access SENT bereavement letters through the History of Bereavement Letters.
The LCD HOSPICE ELIGIBILITY DETERMINATION form is completed using information provided in the latest Nursing Assessment as well as in the patient’s Demographics. Eligibility is determined using the patient’s Disease LCD guidelines.

To exit the LCD Eligibility form click ‘Close’ at the top or bottom right corners of the form.
To view the LCD Guidelines for the patient’s Disease, click the LCD Guidelines link in the Compliance tab. A pop up window like the one above will open specific to the patient’s disease. Click ‘Close’ to return to HospiceMD.
INCIDENCE/OCCURRENCE

HISTORY OF INCIDENCE/OCCURRENCE

This page will display all previously created reports of falls, adverse reactions or sentinel events. To the right of each report under the ‘Status’ column you will see either a ✓ to indicate that the report has been completed and signed or a ✗ to indicate that the report is either not complete or has not been signed. To open each individual report, click on the ‘Open’ button to the left of each report.

To Create a new incident report, click ‘Add New Incident’ at the bottom left corner of the page or on the next to the page header.

New/Edit Incidence/Occurrence

Date Entered/Entered By: These fields will be automatically populated based on the HospiceMD account being used and the date the report is being created.

Type of Incidence/Occurrence: Select the appropriate type of incident from the drop down menu. This will determine the panels made available in the report form.
Once complete, you can ‘Save’ the report, ‘Close’ to return to the Incidence/Occurrence page, or click ‘Signature’ to finalize the report.

- Note that in order for a report to be complete, the narrative field must be complete and the form must be signed. Upon signing, the form will be locked either immediately or within a set number of days, as designated by your system administrator. The form can no longer be edited once it is locked.

**Fall:**

Enter the Fall Incident information using the specified fields and drop-down menus. Click ✗ or ✧ to the right of the panel headers to expand or collapse a panel or click anywhere in the panel header.

### Fall

<table>
<thead>
<tr>
<th>Field</th>
<th>Options</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date Reported</td>
<td></td>
</tr>
<tr>
<td>Date of Fall</td>
<td></td>
</tr>
<tr>
<td>Time of Fall Reported</td>
<td>02:00 PM</td>
</tr>
<tr>
<td>Witnessed by</td>
<td>Select</td>
</tr>
<tr>
<td>Place</td>
<td>Select</td>
</tr>
<tr>
<td>Area of Fall</td>
<td>Select</td>
</tr>
<tr>
<td>Type of Surface</td>
<td>Select</td>
</tr>
<tr>
<td>Medication used</td>
<td>Select</td>
</tr>
<tr>
<td>Activity at the time of fall</td>
<td>Select</td>
</tr>
<tr>
<td>Injury</td>
<td>Select</td>
</tr>
<tr>
<td>Injury Type</td>
<td>Select</td>
</tr>
<tr>
<td>Other Injury specify</td>
<td></td>
</tr>
</tbody>
</table>

**Add Issue:** While completing a fall report, if it is necessary to add an issue to the Environment/Safety section of the Plan of Care, click the ‘Add Issue’ link or the ✗ located at the top right corner of the Fall panel.

**Narrative:** This is a required field.
Adverse Reaction:

Enter the Adverse Reaction incident information using the specified fields and drop-down menus. Click ☑️ or ☐️ to the right of the panel headers to expand or collapse a panel or click anywhere in the panel header.

Add Issue: While completing an Adverse Reaction report, if it is necessary to add an issue to the Environment/Safety section of the Plan of Care, click the ‘Add Issue’ link or the ☐️ located at the top right corner of the Adverse Event panel.

Narrative: This is a required field.
Sentinel Event:

Enter the Sentinel Event information using the specified fields and drop-down menus. Click ☰ or ☰ to the right of the panel headers to expand or collapse a panel or click anywhere in the panel header.

**Add Issue:** While completing a Sentinel Event report, if it is necessary to add an issue to the Environment/Safety section of the Plan of Care, click the ‘Add Issue’ link or the ☰ located at the top right corner of the Sentinel Event panel.

**Narrative:** This is a required field.
The **Staffing** section will assist you with preparing schedules, completing your Time Sheet, assigning patient staff, and keeping track of your visits. Every employee will have access to these links based on their assigned access level. (For access level questions, please contact your system administrator.)

**Staff Assignment**

<table>
<thead>
<tr>
<th>Name</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jane Smith</td>
</tr>
<tr>
<td>John Smith</td>
</tr>
<tr>
<td>John Doe</td>
</tr>
</tbody>
</table>
When you open the ‘Staff Assignment’ Link, you will see a list of all active patients. Click Open on each patient to access and make changes to their individual Staff Assignment.

My Schedule
My Schedule will display a table of assigned patients and the days on which you are scheduled to make a visit. To open a specific patient, click ‘Select’ in the far right column. This will take you to the patient’s Demographics page. The Case Manager or Nursing Director are responsible for setting staff schedules.

My Timesheet
My Timesheet will display a list of your timesheets. Timesheets are created by the system administrator and can be accessed when he/she has designated.

Status: Will be either ‘Incomplete’ if the Timesheet has not been submitted, ‘Submitted’, or ‘Approved’ if the Timesheet has been submitted and approved by the designated supervisor.

Date From-Date To: These dates are set by your system administrator according to your hospice’s payroll.

Approved By/Approved Date: Every Timesheet must be approved by the designated supervisor. These columns will display which staff member approved the timesheet and on what date.

To Open a timesheet, click the OPEN button to the left of the desired timesheet.

![STAFF TIME SHEET](image)
Visit Staff will immediately see the visits for which they have completed Visit Notes displayed in the Timesheet table.

- To add Mileage to these visits, enter the mileage in the corresponding field on the right of each entry and click ‘Save’ next to the mileage box.
- If Visit Times are incorrect, check the Visit Note for that date and make corrections to the time as necessary. For a visit note that has already been locked, contact your system administrator.
- The timesheet will not initially show visits that were created after the timesheet was generated. To add these visits to the timesheet, click ‘Update Timesheet’.

To Add Activity to the Timesheet table, input the activity information using the specified fields and drop-down menus. Visit staff can add activity not taken from their patient visits using this section.

You can Edit an entry by clicking ‘Select’ in the far left column. Edit the entry in the Add Activity box and click Update, Delete or Cancel on the bottom right corner of the Add Activity box.

**Patient Schedule**
See Monthly Schedule

**Staff Schedule**
See Monthly Schedule

**Staff Timesheet**
Staff Members with access will have a list of all timesheets submitted by all employees. Click the ‘Open’ button to open a specific timesheet. You will be able to ‘Sign for Approval’ or return the timesheet to the staff member for corrections by entering notes in the ‘Correction/s required’ field and clicking the ‘Return for Correction’ button.

**On-Call Assignment**

To designate a RN or LVN to be on call, click the corresponding check box next to their name and click ‘Save’. You will see Staff on Call Saved Successfully! to confirm your selection.
The selected LVN or RN will have full access to the Patient List should the need arise for them to access the patient’s information or make any notes.

- The Case Manager or DON must remember to remove the staff member from On-Call Assignment once their shift is over to ensure they do not have continued access to all patient information.
Message Center

Unread messages will be displayed in the **My Message** section of the Dashboard. Click ‘Open’ to open the message. Once opened, the message will be marked as ‘Read’ and will no longer appear under **My Message**.

![Message Center Interface](image)

All messages in your **Inbox** will be displayed in the Inbox Panel. The information displayed will include the date and time the message was sent, from who, and the subject of the message. The **From** section will display the system generated initials for that user. You will be able to see the user’s full name once you open the message. Click ‘Open’ on the left side to open a message.

![Inbox Interface](image)

When a message has been opened, the system will automatically mark the message as ‘Read’ by placing a checkmark in the ‘Read’ column. Read messages will no longer appear on your **Dashboard**.

![Outbox Interface](image)

**Outbox** (outgoing) messages will not automatically appear once you open the Message Center the way **Inbox** messages do. Click anywhere on the **Outbox** panel header or on the [ ] on the top right corner to view your **Outbox** messages.
Outgoing messages that have been opened by the recipient will have a checkmark in the ‘Read’ column.

- You can view the date and time the message was opened by hovering over the ‘Read’ checkmark.

Messages that have been sent directly from the Communication Log will display the log information to identify it as a Communication Log message:


Create New Message:
To create a new message click the ‘Create New Message’ button directly under your Inbox or click the to the right of the page header.

Create your new message using the specified fields and drop down menus. Click ‘Send’ on the bottom right corner to send you message or ‘Cancel’ to close the message without sending and return to the Message Center.

- Note that you will be unable to send a message without a ‘Subject’. Make sure the Subject line is filled in before sending.

Date/Time: Note that the Date/Time are automatically generated once the message is created.

To: Select the ‘To’ drop down menu to see a list of ‘Active’ HospiceMD users within your hospice’s network. Select the intended recipient from the list of users.

- Employees who have been labeled as ‘Inactive’ will not be displayed in the drop down menu.
**Attach a File:** You can attach a file to the message by clicking the ‘Choose File’ button located in the bottom left corner of your new message. Once you have selected a file, the file name will appear to the right of the ‘Choose File’ button. You can choose to give the file a different name that will appear in the message by typing in the ‘Attach File Name’ field, but this is not required.

![Attach File Example](image)

Once you’ve sent your message it will be displayed in your recipient’s inbox with a paperclip on the far right corner.

![Inbox with Attachment](image)

To open an attachment in a message, you can simply click the paper clip icon or access the attachment by opening the message.

- Note that due to security reasons, you are only able to successfully send PDF and JPEG files.
ADMIN

Staff members with access can use the Admin section to add Referring MD and Practice information and edit or add employees, vendors, and insurance companies. This information is used in the patient’s Demographics page, when creating new orders, and elsewhere throughout HospiceMD.
Practice Information/Referring MD

Add New Practice Information

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Site</th>
<th>Address1</th>
<th>Address2</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone</th>
<th>Fax</th>
</tr>
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</tbody>
</table>

Add New Referring MD

List of all Practices

<table>
<thead>
<tr>
<th>Practice Name</th>
<th>Site</th>
<th>Address1</th>
<th>Address2</th>
<th>City</th>
<th>State</th>
<th>Zip</th>
<th>Phone</th>
<th>Fax</th>
</tr>
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</tr>
</tbody>
</table>

Add a new referring practice using the specified fields and drop-down menus. The only required field is the ‘Practice Name’. Click ‘Save’ and the bottom left corner of the ‘Add New Practice Information’ box to add that practice to the ‘List of all Practices’ on the bottom section of the page.

- When adding a referring MD, you will be required to select the practice to which he/she belongs. Therefore, if you have a referring MD who does not belong to a specific practice, it is advisable to create a ‘None’ or ‘NA’ practice under which to group those MDs you cannot link to a specific practice.

**Edit a Practice:** To edit a practice you have already added to the list, click the ‘Edit’ button to the left of that practice in the ‘List of all Practices’. You may then edit that practice information directly within the list. In place of the ‘Edit’ button, there will now be ‘Update’ and ‘Cancel’ buttons. Click ‘Update’ to save your changes or ‘Cancel’ to go back without saving.

You can add a new referring MD directly from the Practice page by clicking the next to ‘Add New Referring MD’ above the ‘List of all Practices’.
Add New Referring MD:

Add a referring MD using the specified fields and drop-down menus. Only the ‘Practice’ and ‘MD’ name fields are required. Click Save to add the referring MD to the ‘Referring MDs List’ for the ‘Practice’ you selected.

Once you select a ‘Practice’ from the drop-down menu list of Practices you will see a list of MDs that belong to that practice listed in the ‘Referring MDs List’ on the bottom section of the page.

Edit a Referring MD: click the ‘Edit’ button the left of the MD you would like to edit in the ‘Referring MDs List’. You may then edit that MD’s information directly within the list. In place of the ‘Edit’ button, there will now be ‘Update’ and ‘Cancel’ buttons. Click ‘Update’ to save your changes or ‘Cancel’ to go back without saving.
Add a new employee by clicking the Add New Employee link and use the specified fields and drop down menus.

- Note that depending on the browser and the version you are using, you might need to input telephone numbers in this specific format: (111)222-3344 or 111-222-3344.

To View or Edit an already existing employee you MUST go through the View/Edit Current Employee link. Select the employee from the ‘Employee’ drop down menu at the top of the page.

Abbreviation Key:

- **BC**: Bereavement Counselor
- **CM**: Case Manager
- **HM**: Homemaker
- **MIS**: Miscellaneous
- **PT**: Physical Therapist
- **SC**: Spiritual Counselor
- **SN**: Skilled Nurse
- **Vol**: Volunteer
- **Cont Staff**: Contracted Staff
- **DON**: Director of Nursing
- **HR**: Human Resources
- **NP**: Nurse Practitioner
- **SW**: Social Worker
- **PCP**: Primary Care Physician
Do not attempt to add a new employee through the View/Edit Current Employee Link. You will risk overwriting a current employee.

**Discipline**: The selected discipline plays a role in determining the individual’s access level. Contact HospiceMD support with questions regarding access levels.

**Assign Access Level and Status**

This section controls what modules of HospiceMD the staff member has access to. Pay particular attention when selecting the ‘Staff Type’ and ‘Staff Level’.

**Login Initials**: The login initials are automatically generated according to the individual’s first and last name.

**Staff Level**: Each title in the drop down menu has access to specific modules within HospiceMD. The Administrator level has access to ALL of HospiceMD. CM’s and DON’s have access to their assigned patients’ entire Medical Record and are able to review and sign other staff members’ notes and unlock locked forms if necessary.

If you can’t find a title that specifically matches the one you are looking for, remember that the titles are simply there to dictate what the individual can access; therefore a single title can apply to several different positions. Contact HospiceMD with questions regarding access levels.

**Activate a New Employee**

Once you have finished inputting the information for a new employee, input their email address using the fields on the top right corner of the page. The email address will be the employee’s **UserID**. Click the yellow ‘Send Email’ button on the bottom right corner. The system will prompt you to verify that the information you have entered is correct.

The employee will receive an email to that address providing them with a link to HospiceMD and a temporary password. That employee can then log in using that temporary password and their email address as their UserID.
Forgot/Change Password

**Change Password:** To change your password, go to the **MY ACCOUNT** section. Input your current or temporary password and click ‘VERIFY’. Input your new password in both the ‘New Password’ and ‘Confirm Password’ fields and click ‘Save’.

**Forgot Password:** Click the ‘Forgot Password’ link directly above the ‘Login’ button on the home page.

You will then be prompted to input your UserID. This will be the email address you use to log in to HospiceMD. Once you click ‘Continue’, you will receive an email from HospiceMD with a temporary password.

- Note that as a security feature, if you log in with a temporary password after having clicked the ‘Forgot Password’ link, you will not have access to any patient information. Contact your system administrator to have your access level and status reassigned.
HOSPICE ITEM SET

HIS Tracking

Pending Completion: Will notify you of all patients admitted after July 1, 2014 for which a HIS Admission or HIS Discharge report has not been completed. A report is considered Complete once it has been signed.

The Due date for an Admissions Report is the Start of Care Date plus 14 days. The Due Date for a Discharge Report is the Start of Care Date plus 7 days.

- Note: You are not required to submit a Discharge Report for patients admitted prior to July 1, 2014. See the HIS Manual V1.01 for more information

Ready for Submission: Once a HIS Report has been signed for a patient, it will move into the Ready for Submission section. This means the form is ready to be exported from HospiceMD and submitted to CMS using the QIES Submission System for Providers.

The Due Date for the Admission and Discharge Reports is the Start of Care Date plus 30 days.

Confirmed Submission: When a HIS Report is submitted to CMS through the QIES Submission System for Providers, a confirmation page with a Submission ID number is automatically generated. The user responsible for exporting and submitting the HIS Report should enter that Submission ID number into the HIS Report in HospiceMD once the file is accepted by the QIES system. Once that number is entered, the item will move from Ready for Submission to Confirmed Submission.

This will also allow for HospiceMD to generate modification or inactivation records if necessary.
Completing, Exporting and Submitting HIS Reports

**Step 1: Complete**

To Access the HIS Admission and Discharge Reports, open a patient’s file and expand the **Compliance** module. You can also open a report directly from the HIS tracking table on the Dashboard.

Click on either HIS Admission or HIS Discharge. The report is automatically generated based on the information already entered into the patient’s clinical record.

- Note: The report will continue to update as new information is entered until it is signed.

**Review the information on the report for completeness and accuracy.** If Data is incomplete, incorrect, or missing, review the HIS Data Crosswalk for details on where the data items are coming from.

- Note: The HIS Report will not pick up information from a source that requires signature (ie. Assessments) if that source has not been signed.

Once all information has been reviewed, click the Signature button. You will see the following prompt:

Select **OK** to sign the HIS Report or **Cancel** to return to the report without signing.

Once signed, the report is considered complete and it will be moved from **Pending Completion** to **Ready for Submission** in the **HIS Tracking**. The **Ready to Export** button will also become available.
**Step 2: Export**

In order to submit the HIS Report to CMS, you must first export it. All files submitted through the QIES system to CMS must be in .xml .zip format.

Click the **Ready to Export** button within the HIS Report to download the file onto a local drive. The file will be downloaded in the format specified by CMS (XML .zip). You will not need to make any additional changes to the file or its format.

- **Note:** You must download the file onto a local drive. You will not be able to access any network drives once you have established a remote connection to the QIES Submission system.

**Step 3: Submit**

To begin the submission process, open the following link in **Internet Explorer**: [https://www.qtso.com/cmsnet.html](https://www.qtso.com/cmsnet.html) and click the **CMSNet – Submission Access** link.

Login in using your CMSNet User ID and Password and follow the submission instructions found in the Hospice Submission User’s Guide ([https://www.qtso.com/hospicetrain.html](https://www.qtso.com/hospicetrain.html)).

Once you have successfully uploaded the HIS Report you will receive a Hospice File Submission Confirmation Page which will contain a **Submission ID**.

- **Note CMS recommends printing and retaining all reports, confirmation pages, and Final Validation Reports.**

Once you verify that the file was accepted in the Final Validation Report, (See the CASPER Reporting User’s Guide at [https://www.qtso.com/hospicetrain.html](https://www.qtso.com/hospicetrain.html) for instructions on accessing and reading the Final Validation Report) return to HospiceMD and enter the **Submission ID** in **Submission Confirmation Number** field.

- **IMPORTANT:** Do not enter the Submission ID number until you have verified on the Final Validation Report that the file was accepted by the QIES system.

This will move the Report from the Ready for Submission to Confirmed Submission in **HIS Tracking**.

- **Note CMS recommends printing and retaining all reports, confirmation pages, and Final Validation Reports.**
Rejections, Modifications and Inactivations

Rejected Files:

If the Final Validation Report shows that the file has been rejected:

1. Review the list of possible Errors located at https://www.qtso.com/download/Guides/hospice/Users_Sec5.pdf and determine what corrections need to be made to the rejected file.

2. Once the file is corrected within HospiceMD, it will need to be resubmitted as a ‘New Record’. Follow the Export and Submit steps above.
   - Note: You will be able to submit a ‘New Record’ as long as you have not entered the Submission ID into the HIS Report in HospiceMD.

Approved Files that require Modification or Inactivation

See the Hospice Item Set Manual V.1.01 for information on which records require inactivation or modification.

Modifications:

If your Report has been accepted by the QIES system, but you have to submit a modification:

1. Enter the Submission ID from the approved file into the HIS Report on HospiceMD. The ‘Type of Record’ will change from ‘Code 1: Add New Record’ to ‘Code 2: Modify Existing Record’.

2. Make the corrections necessary in the patient chart and review your file for accuracy.

3. Follow the Export and Submit steps above.

Inactivations:

If the Report has been accepted by the QIES system, but requires an inactivation:

1. Enter the Submission ID from the approved file into the HIS Report on HospiceMD and save.

2. Click the ‘Check Here to Inactivate’ box to create an Inactivation Record.

3. Follow the Export and Submit steps above.
**Additional Guides and Resources**

- QTSO Help Desk: 877-201-4721 or help@qtso.com
- CMSNet Help Desk: 888-238-2122
- CMS Net Registration Instructions: [https://www.qtso.com/download/CMSNet_Online_Enrollment.pdf](https://www.qtso.com/download/CMSNet_Online_Enrollment.pdf)
- Training Videos for the QIES Submission System, including registration, submission and accessing CASPER Final Validation Reports, can be found at [https://www.qtso.com/webex/qiesclasses.php](https://www.qtso.com/webex/qiesclasses.php)
  
  Click on the **HOSPICE** link to access the videos
- **Hospice Submission User’s Guide** and the **CASPER Reporting User’s Guide**:
  
  [https://www.qtso.com/hospicetrain.html](https://www.qtso.com/hospicetrain.html)