HOSPICE CLINICIAN TRAINING MANUAL

March 2022

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LOGGING IN

Go to www.axxess.com and select **LOGIN**, located in the upper, right-hand corner.

Enter the username and password then select **Secure Login**.

The username is the email address assigned to the user's account when it was created. The password was created by the user from a link that was sent to this email address. This password will also be the user's electronic signature.

If the user forgets their password, select the **Having trouble logging in?** hyperlink and a link will be sent to this email address. Here the user can reset their password, however, the electronic signature will remain the same. After the correct username and password are entered, the following message will display:

Select **OK** and the user will see the Axxess Planner.

AXXESS PLANNER

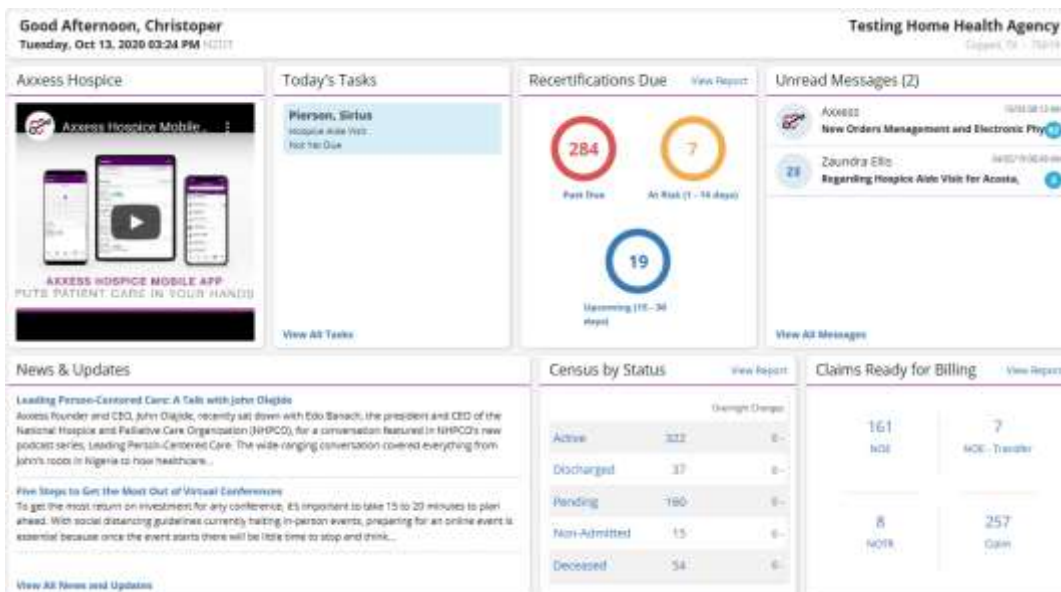On the left-hand side of the screen is a list of organizations that the user works with, as well all the products to which their organization is subscribed, select the organization listed under Hospice to move forward.

DASHBOARD

The **Dashboard** opens upon log in. Filter for branches (if more than one) by selecting the drop-down menu. Below are the eight tiles that will appear:

1. Welcome Panel - Displays the user's name, date, name and location of the organization.
2. Video - Built-in educational videos uploaded by Axxess.
3. Today's Tasks - Displays the user's daily scheduled tasks. This list is sorted by day and visits distinguished by Scheduled (blue), Completed (green) and Missed (red). There is a hyperlink to **View All Tasks**.
4. Recertifications Due - Shows a visual representation of Recertifications that are Past Due, At Risk and Upcoming. Selecting a circle will take the user to a list of those patients.
5. Unread Messages - This tile shows all unread messages. Users are linked to the messages that are showing and a hyperlink to **View All Messages,** which takes the user to the Message Center.
6. News & Updates - This shows links to Axxess-generated blog posts, educational articles, regulatory updates and other important information.
7. Census by Status - Shows the current active census by status and changes overnight. Selecting the status number will take the user to a list of patients filtered for that status.

NOTE: Focus for clinician should be on active, discharge, deceased, and admission changes.

8. Claims Ready for Billing - Shows claims that are ready but not yet sent. Selecting the type of claim will take the user to a list of the claims ready for billing of that type.
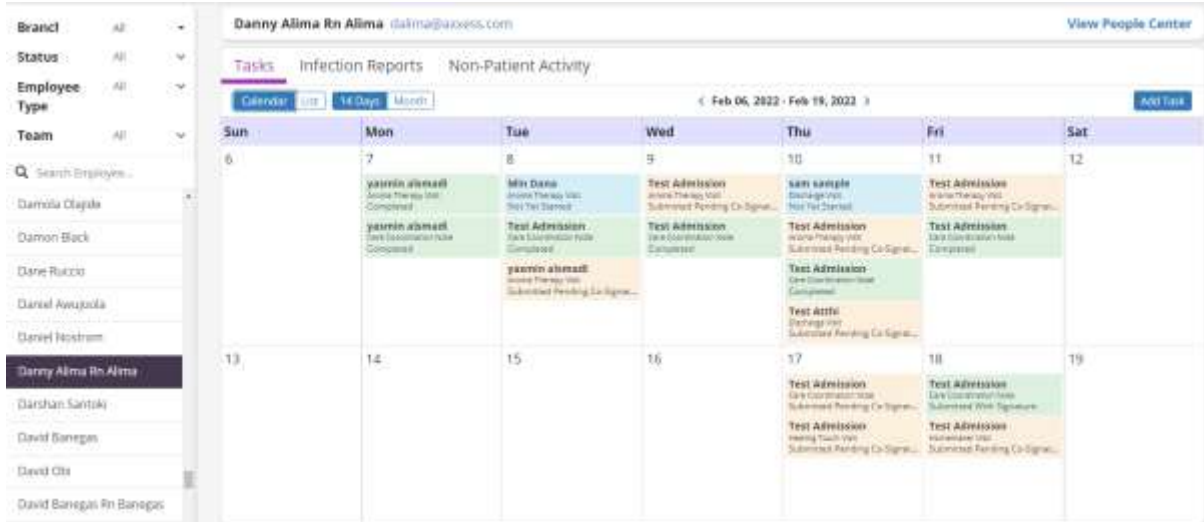
Today's Tasks
Select the **View All Tasks** hyperlink in the bottom left corner of the tile to view the entire list of scheduled tasks.

The top of the page will show the user's name and email address tied to the account and a hyperlink to **View People Center**. The top left of the page allows for the filtering of employees. Filter by search for a specific employee, branch,

status, employee type or team to narrow results. Users can also scroll down the list of employees.

The default view for the Employee Schedule is 14 days. The calendar can be viewed as 14 days or by month. Toggle through days and months by selecting the ❮ or ❯ arrow with the date being shown in between them. Today's date will have a black circle around the number. Select the **Add Task** button to add a task. View the list of missed visits in the schedule by selecting the **List** view tab. The **List** view has options to delete, update, download, print or view details of the tasks.

Visits are distinguished by the following colors:

Blue = Scheduled
Green = Completed
Red = Missed
Orange = Returned for review

Infection Reports

The **Infection Reports** tab of the Employee Schedule has the same navigation functionality as the **Tasks** tab, except instead of adding tasks, users can add infection reports.
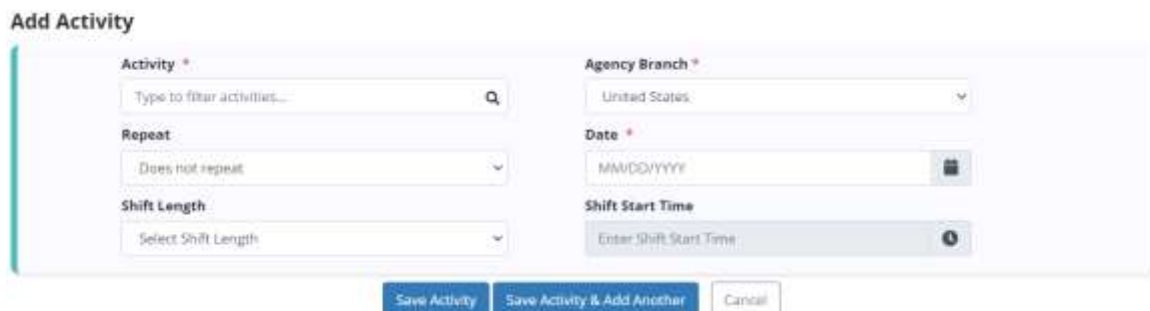
Select the **Add Infection Report** button in the top right corner of the screen. Complete the required fields and select **Save Report**, **Save & Open Report**, **Save & Add Another**, or **Cancel**. These can also be added during assessments and in the list menu under **Infection Log**.
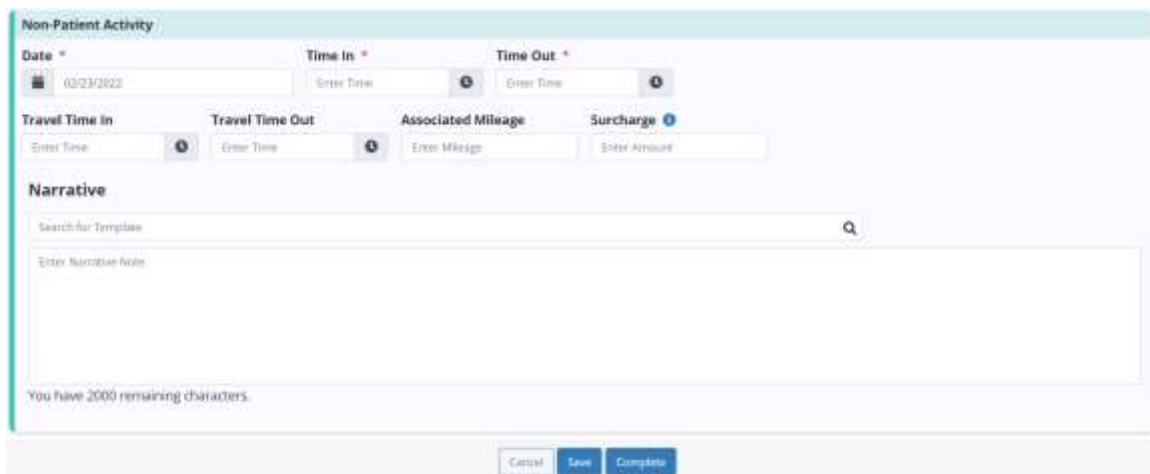

Non-Patient Activity

The **Non-Patient Activity** tab of the Employee Schedule has the same navigation functionality as the **Tasks** tab, except instead of adding tasks, users can add non-patient activity.

Select the **Add Activity** button in the top right corner of the screen. Start writing the name of the activity and choose. Select the agency branch (if more than

/Axxess

one). Choose if the activity is repeated and the date. If applicable, enter the shift length and shift start time. When finished, select **Save Activity** to complete, **Save Activity & Add Another** to complete and fill in another blank activity form, or **Cancel**.

Once a non-patient activity has been scheduled, it will appear on the **Non-Patient Activity** tab in the employee's schedule. Select the activity to begin documenting the activity details. When the form opens, fill out the required details for the activity. Select **Complete** to finalize any changes or select **Save** to save progress and return later to complete the document. Select **Cancel** to cancel any changes and return to the employee schedule

Non-patient activity can be edited by selecting the three-dot menu in the calendar list view and selecting **Reopen Activity**. Select a reason next to reason for addendum and select **Start Addendum**. If the activity has been exported to payroll, only the narrative section can be edited. Once the appropriate changes are made, select **Save** or **Confirm Changes.** When a user has made an error on a non-patient activity, the activity can be deleted if it has not been exported to payroll.
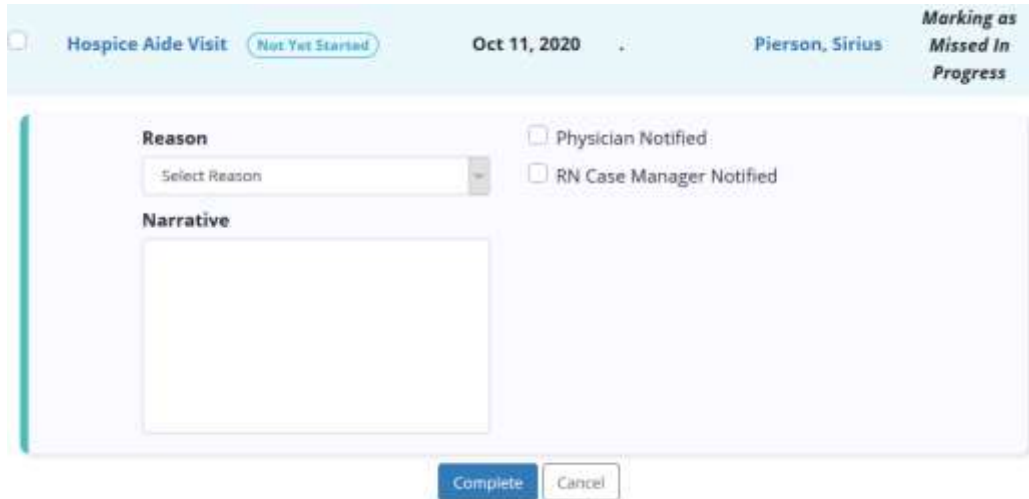
Missed Visit
Mark visits as missed in the Patient Schedule if they are scheduled either prior to or on the current date. Select the red sticky note icon.

Choose a reason why the visit is being missed. Select whether physician and/or RN case manager was notified. When selected, find physician and/or RN case manager by typing their name in the search field. Then write in the free text

Narrative details about the missed visit. Then select the **Complete** button at the bottom.

The clinician will then electronically sign the document by selecting the checkbox then select the **Complete** button.

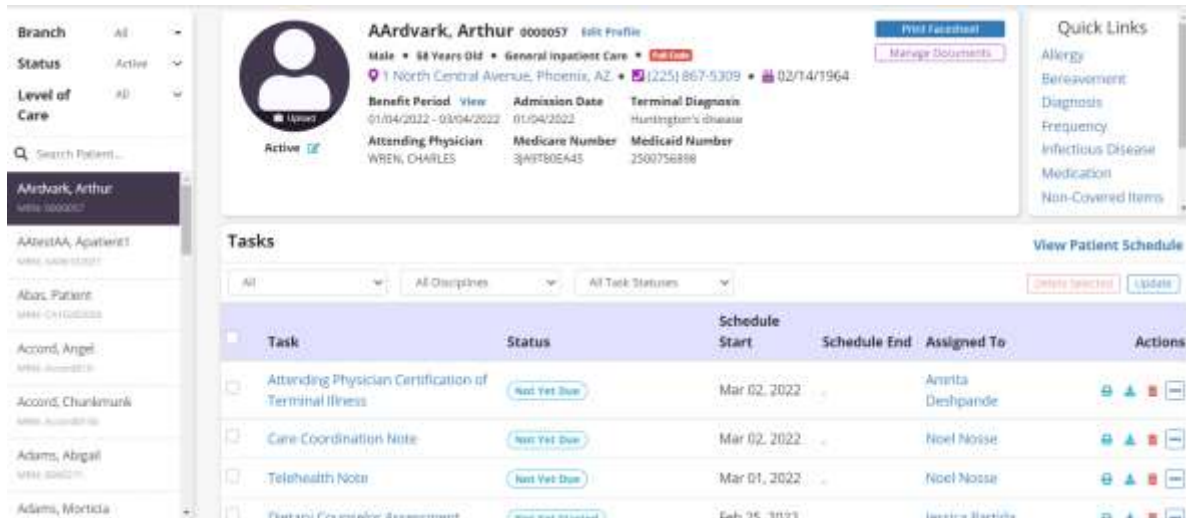## EDIT PROFILE
User Name/Profile

While managing their profile, users can:
- Change the name that other users will see
- Change their password
- Enable a 2-Factor Verification for more security
- Review Audit Events

The user can then choose to go **Back to AxxessHospice** or **Log Out**.

PATIENT CHARTS
Patients/Patient Charts

Filter by:

- Branch - Choose the branch (if more than one).
- Status - Choose from active, discharged, pending, non-admitted, deceased.
- Level of Care - Choose from Routine, Respite, Continuous Care or General Inpatient.
- Patient Search - Start typing a name and the list narrows down to match.

The patient's snapshot at the top of the screen gives a quick view of the patient's demographics. There are hyperlinks to the patient's address and phone number. Select **Edit Profile** to view the patient's full demographics, payer information, clinical information, physician(s), pharmacy and DME, authorized contacts, emergency preparedness, advance directives and referral information.

There is a button to **Print Facesheet** and a button to **Manage Documents,** which is for patient attachments. There is also a hyperlink to quickly jump to **View Patient Schedule**. A list of visits/tasks in the current episode will display at the bottom of the screen. Filter the benefit period, discipline and task status drop-down menus to change viewing parameters.

QUICK LINKS
Allergy

This pulls a list of all added allergies for the patient. Select the **Print Allergy Profile** button for a PDF version to view and/or save. Select the **Deactivate** hyperlink under the Actions column to inactivate active allergies. Select the **Restore** hyperlink to reactivate or inactivate allergies. Select the **Edit** hyperlink to make updates. Select the **Add Allergy** button to add.
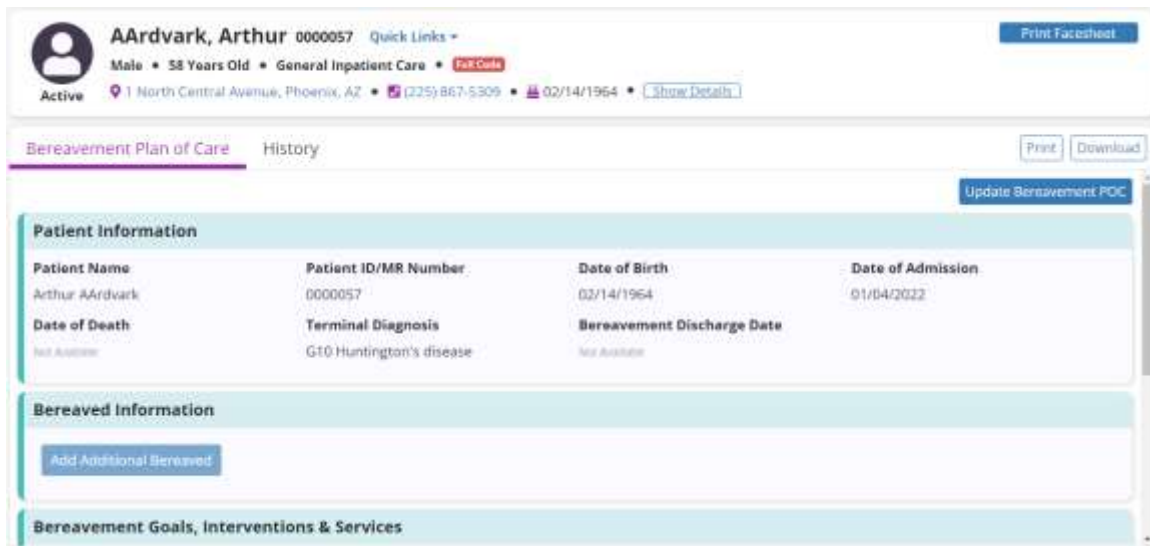
Enter the Allergy Name, Reaction, Type, Start Date and other available information. Select the **Save Allergy** button or select **Save and Add Another** for additional allergies.

Bereavement
Bereavement Plan of Care enables users to document goals, interventions and services related to bereavement before and after a patient's death. Users must have permission to view and manage the Bereavement Plan of Care.

To print or download a copy of the Bereavement POC, select **Print** or **Download** in the top right corner of the screen. To view a record of changes made to the Bereavement Plan of Care, navigate to the **History** tab.

The Bereavement POC can be updated regardless of the patient's status. To update the Bereavement POC, click **Update Bereavement POC** to activate all action buttons on the **Bereavement Plan of Care** tab. The **Patient Information** section will pre-populate with the patient's demographic info. To update this information, navigate to the patient's chart under the **Patients** tab and update the information as needed. The bereavement discharge date field under Patient Information will auto-populate when the patient is discharged from bereavement.

To add bereaved contacts to the Bereavement POC, select **Add Additional Bereaved** under Bereaved Information. Up to ten bereavement contacts can be added per patient. The auto-fill box under **Add Additional Bereaved** can be used to add one of the patient's existing authorized contacts. Selecting a contact

from this list will automatically populate the contact's information from the patient's chart. If the bereaved contact needs to be added as an authorized contact for the patient, select **Add Contact** to open the patient's chart and add the contact.
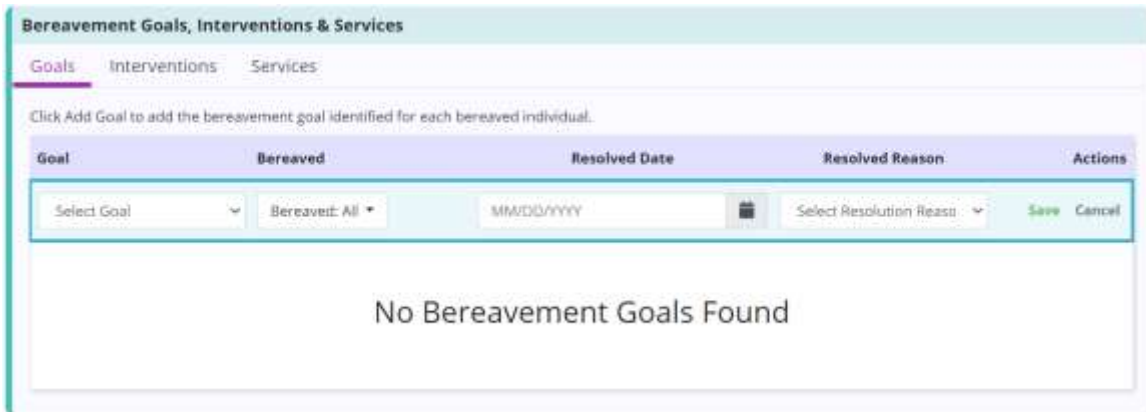
If the bereaved contact is not one of the patient's authorized contacts, manually enter the contact's information to the Bereavement Plan of Care and select **Save Contact.**

Add Bereavement Goals, Interventions and Services

Navigate to the **Goals** tab under Bereavement Goals, Interventions & Services. Select **Add Goal** and select a goal from the goal drop-down menu. Each goal will be assigned to all bereaved contacts unless specific individuals are selected from the bereaved menu. A resolved date and resolved reason can be documented in the resolved date and resolved reason fields as each bereaved individual moves through the bereavement process.
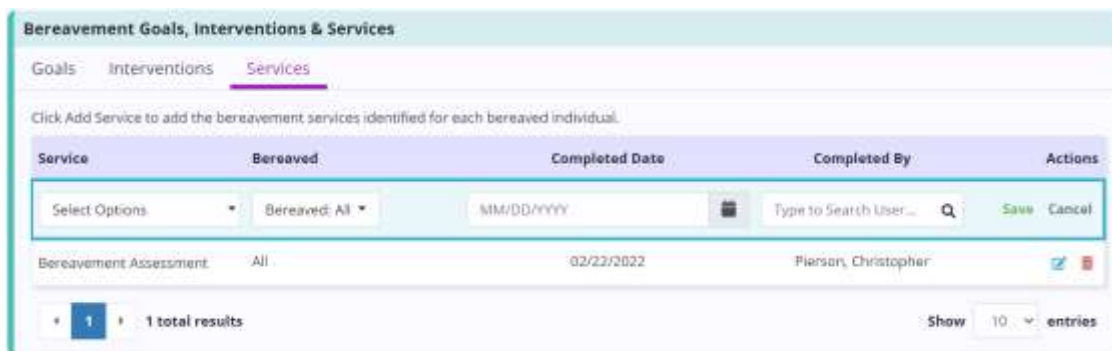
To add an individualized goal, select other from the goal menu and enter the specific goal. Select **Save** to save the goal to the Bereavement POC.

To add an intervention to the Bereavement POC, navigate to the **Interventions** tab. Select **Add Intervention** and select an intervention from the intervention drop-down menu. Each intervention will be assigned to all bereaved contacts unless specific individuals are selected from the bereaved menu.

To add an individualized intervention, select other from the intervention menu and enter the specific intervention. Select **Save** to save the intervention to the Bereavement POC.

To add a service to the Bereavement Plan of Care, navigate to the **Services** tab. Select **Add Service** and select a service from the service drop-down menu. Each service will be assigned to all bereaved contacts unless specific individuals are selected from the bereaved menu.

To add an individualized service, select other from the service menu and enter the specific service. Select **Save** to save the service to the Bereavement POC.

Goals, interventions and services can be edited by selecting the icon or deleted by selecting the icon.

Sign or Discharge from Bereavement
Select the green **Update & Sign** button to save changes and update the Bereavement POC. A signed copy will be available in the **History** tab, where it can be printed or downloaded at any time.

Once a patient's contacts have completed the bereavement program, the patient can be discharged from bereavement. To discharge a patient from bereavement, resolve each goal on the **Bereavement Plan of Care** tab and select **Discharge from Bereavement**. Enter the discharge date and select **Discharge.**

This will end the bereavement period for the patient. Bereavement tasks will not be added to the patient's schedule after the bereavement discharge date. If at any point bereavement services need to be resumed, navigate to the **Bereavement Plan of Care** and select **Resume Bereavement.**

Diagnosis

Shows the list of previously ordered diagnoses. Select the **View Details** hyperlink to see the specific diagnoses including code, description, related and start date. Select the 🖨 icon to print or the ⬇ icon to download under the Actions column.

Select the ✐ icon to change whether the diagnosis is related. Then select the green **Add** hyperlink to save any changes.

ICD-10 Code	Description	Related	Start Date		Resolved Date	Actions
I67.1 (Terminal Diagnosis)	Cerebral aneurysm, nonruptured		04/01/2020		Current	✐
I30.0	Acute nonspecific idiopathic pericarditis	Yes	02/01/2020		Current	✐
G30.1	Alzheimer's disease with late onset	Select Related ▾	01/01/2020	📅	Current	Add Cancel

Frequency

View active, inactive and discontinued frequencies by discipline, benefit period or date range. See all frequencies by selecting the **Expand All** button or minimizing them by selecting the **Collapse All** button. Print the frequencies by selecting the **Print** button in the top right. Select the 🗑 icon under the Actions column to remove frequencies, then select the **Yes, Delete** button to confirm.

Disciplines: All ▾	Benefit Period	05/28/2020 - 07/26/2020 ▾	Date Range	05/28/2020 - 07/26/2020		Expand All Collapse All Update Frequencies	
Discipline	**Visit Frequency**	**PRN**	**Start Date**	**End Date**	**Scheduled Visits**	**Available Visits**	**Actions**
Active Frequencies (4) Hide All							
Dietary Counselor	(2w2)	No	Jun 15, 2020	Jun 27, 2020	0	4	
Medical Social Worker	(1w1)	No	Jun 15, 2020	Jun 20, 2020	0	1	
Skilled Nurse	(1w2)	No	Jun 15, 2020	Jun 27, 2020	1	1	View Scheduled Tasks
Skilled Nurse	(1)	Yes 💬	Jul 25, 2020	Jul 26, 2020	0	1	
Discontinued Frequencies (1) Hide All							
Skilled Nurse	(2w3)	No	Jun 15, 2020	Jun 27, 2020	0	0	

Select the **View Scheduled Tasks** hyperlink to see the list of tasks with hyperlinks to each task and their status. Select the **Update Frequencies** button to begin the order process.

Select the **Create Physician Order** button unless there are other orders to associate. New physician order date will be auto generated to the date it was created. Find physician tied to order and select the **Create** button.

ⓘ Updates will be added to **ASHWANI AGARWAL**, Order scheduled on **10/15/2020**.						View Order Change Order Done	
Disciplines: All ▾	Benefit Period	09/19/2020 - 11/17/2020 ▾	Date Range	09/19/2020 - 11/17/2020		Expand All Collapse All Add Visit Frequency	
Discipline	**Visit Frequency**	**PRN**	**Start Date**	**End Date**	**Scheduled Visits**	**Available Visits**	**Actions**
Active Frequencies (0)							

Discontinue - Select the **Discontinue** hyperlink, enter the Discontinue Date and then select the **Discontinue Frequency** button.

Add Frequency - Select the **Add Visit Frequency** button. Choose the Benefit Period, Discipline, enter the Visit Frequency, enter the Start Date and choose whether the frequency is PRN. Select the **Save Frequency** button when complete or **Save & Add Another** button for additional frequencies.

Infectious Disease
View previous or add COVID-19 screenings. Select the **View** hyperlink to see previous answers.

Select the **Add COVID-19 Screening** button. Choose the person screened and enter their name. Enter the date of screening and time of screening. Then answer the questions, select the screening acknowledgement checkbox and select the **Sign Screening** button or select the **Sign & Add Another** for additional screenings.

COVID-19 Screening

Complete the following screening questions and select a risk level for the patient and/or household members based on agency policies and procedures.

Person Screened *   Name   Date of Screening *   Time of Screening *

Patient   ▼   Accord, Angel   📅 10/15/2020   Enter Time   🕐

☐ Refused Screeening

Have you traveled internationally within the last 14 days to a country with sustained community transmission?

○ No   ○ Yes

Do you have signs or symptoms of COVID-19, such as fever, chills, cough, shortness of breath, difficulty breathing, fatigue, muscle or body aches, headache, new loss of taste or smell, sore throat, congestion, runny nose, nausea, vomiting or diarrhea?

○ No   ○ Yes

In the last 14 days, have you had contact with someone diagnosed with COVID-19, under investigation for COVID-19, or with a respiratory illness?

○ No   ○ Yes

Do you live in an area where community-based spread of COVID-19 is occurring?

○ No   ○ Yes

Risk Level:

○ Low   ○ High

☐ Screening Acknowledgement: I have screened the above-selected person prior to providing care. Agency policies and procedures were followed to prevent the spread of COVID-19 based on the results of this screening or refusal to complete the screening.

[Sign Screening]   [Sign & Add Another]   [Cancel]

Medication

Alfonzo, Greg JH45885   Quick Links ▾   [Print Facesheet]

Male • 1 Years Old • No Level of Care Selected • Full Code

Active   📍 4545 Spring Valley Road, Farmers Branch, TX • 📞 (151) 515-6456 • 📅 10/07/2018 • [Show Details]

Drug Interactions Result on All Active Medications

[Major Drug Interaction **1**]   [Moderate Drug Interaction **3**]   [Minor Drug Interaction **2**]

Medication Profile   Detailed Drug Interaction Report   Orders   Signed Medication Profile
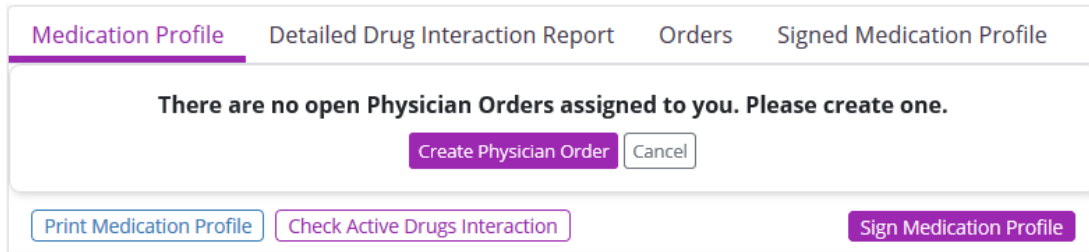
[Print Medication Profile] [Check Active Drugs Interaction]   [Sign Medication Profile] [Update Medications]

Medication Name Dosage/Route/Frequency	Indication	Start Date Discontinue Date	Added Physician Discontinued Physician	Administered By	Actions
Active Medications (6) Hide All					
[Default] 📄 Coumadin 15 • Po • Daily [⊘ Hospice]	Test	Mar 31, 2019 .		Caregiver	Edit
[Default] 📄 Apomorphine 14 • Po • Daily [⊘ Hospice]	Test	Feb 24, 2019 .		Caregiver	Edit
[Default] 📄 Childrens Ibuprofen 15 • Po • Daily [⊘ Hospice]	Test	Jan 27, 2019 .		Caregiver	Edit

Add a Medication - Select the **Update Medications** button and then select the **Create Physician Order** button unless there are other orders to associate.
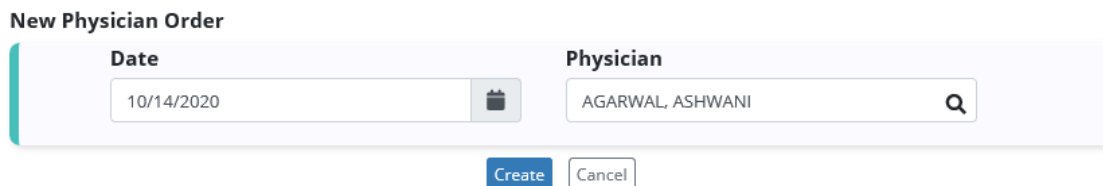
| Medication Profile | Detailed Drug Interaction Report | Orders | Signed Medication Profile |

There are no open Physician Orders assigned to you. Please create one.

Create Physician Order Cancel

Print Medication Profile Check Active Drugs Interaction   Sign Medication Profile

New Physician Order date will be auto generated to the date it was created. Find physician tied to order and select the **Create** button.
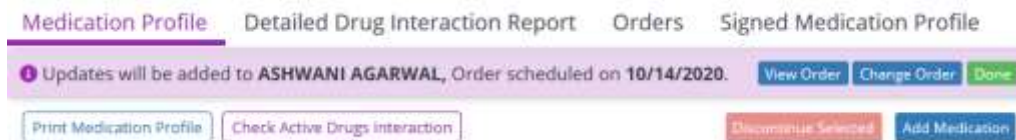
New Physician Order

Date	Physician
10/14/2020	AGARWAL, ASHWANI

Create Cancel

Select the **Add Medication** button once the new physician order is created.
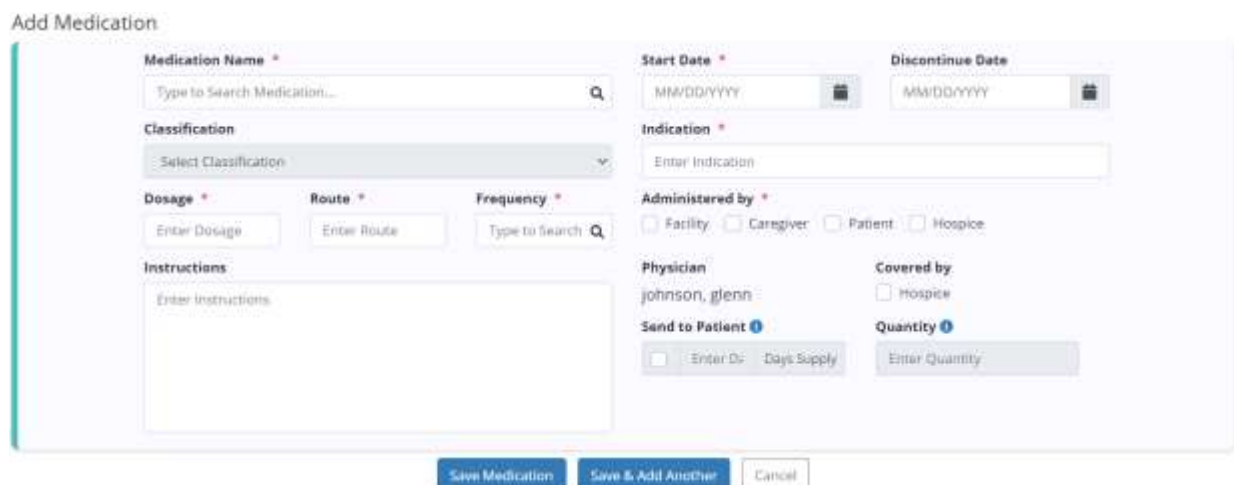
| Medication Profile | Detailed Drug Interaction Report | Orders | Signed Medication Profile |

ⓘ Updates will be added to **ASHWANI AGARWAL**, Order scheduled on **10/14/2020**.   View Order Change Order Done

Print Medication Profile Check Active Drugs Interaction   Discontinue Selected Add Medication

Fill in the following **Add Medication** window:

Add Medication

Medication Name *	Start Date *	Discontinue Date
Type to Search Medication...	MM/DD/YYYY	MM/DD/YYYY

Classification | Indication *
Select Classification | Enter Indication

Dosage *	Route *	Frequency *	Administered by *
Enter Dosage	Enter Route	Type to Search	☐ Facility ☐ Caregiver ☐ Patient ☐ Hospice

Instructions | Physician | Covered by
Enter Instructions | johnson, glenn | ☐ Hospice

Send to Patient ⓘ | Quantity ⓘ
☐ Enter Da Days Supply | Enter Quantity

Save Medication Save & Add Another Cancel

- Medication name - Begin typing the description of the medication, a drop-down box will appear with all the medications listed in the software. Medications not listed can be added. However, only medications selected from the drop-down box will be checked for drug interactions.
- Classification - If a medication from the database is entered, this area will give suggested classifications.
- Dosage, Route & Frequency - Enter medication details.
- Instructions – Enter any instructions required for medication administration.
- Start Date - Enter or select calendar icon to choose date.
- Discontinue Date - Enter if applicable.
- Indication - Enter the reason why medication is being taken.
- Administered by - Select one or more checkboxes from Facility, Caregiver, Patient and/or Hospice.
- Covered by Hospice - Indicate whether medication will be covered by organization by selecting checkbox.

The following alert will appear in Medications, select the **View Order** button.

⚠ You have **1 Physician Order** to sign and complete. [View Order]
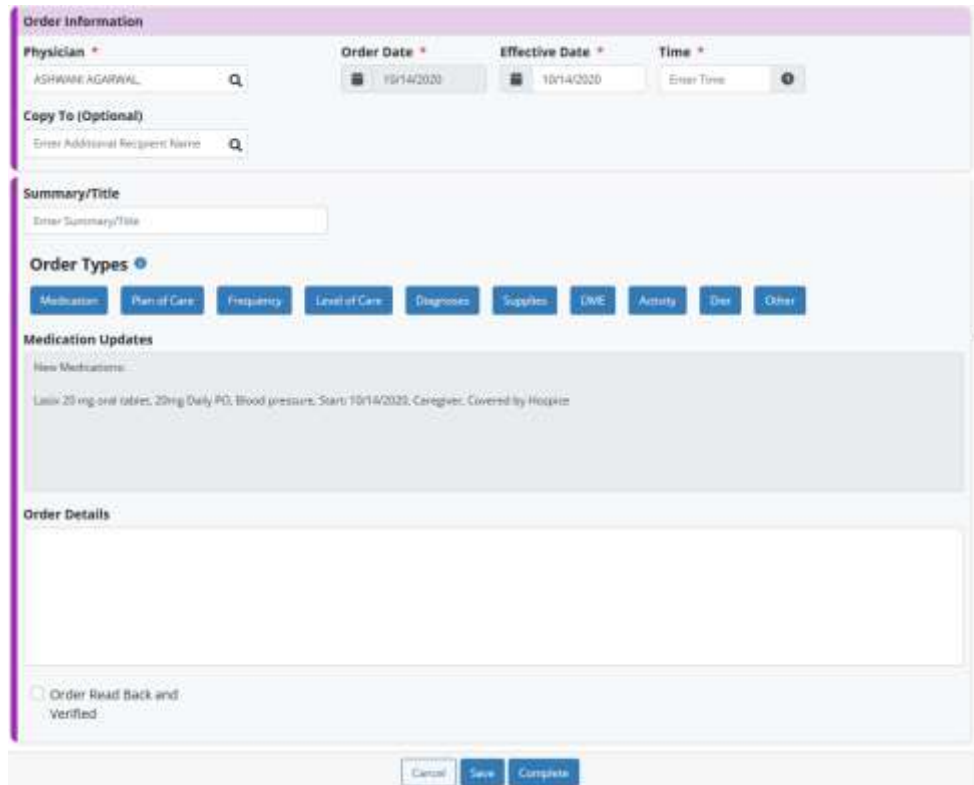
Select the **View Order** hyperlink.

⚠ You have **1 Physician Order** to sign and complete.

⚠ - *Physician order requires signature*

	Task Name	Status	Start Date	Assigned to	Physician	Total Drugs	
⚠	Physician Order	(Saved)	Oct 14, 2020	Christoper Cj	Agarwal, Ashwani	1	View Order

Lasix 20 Mg Oral Tablet
(Active)

Fill in the order time, enter the summary/title and order details, indicate whether order read back and verified, then select the **Complete** button.

A pop-up window appears asking for the user's electronic signature. Select the checkbox and then select the **Complete** button.
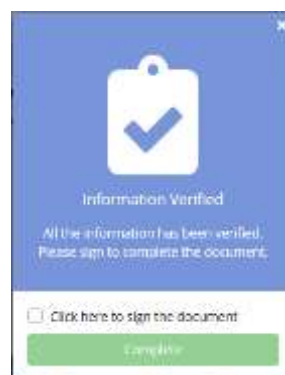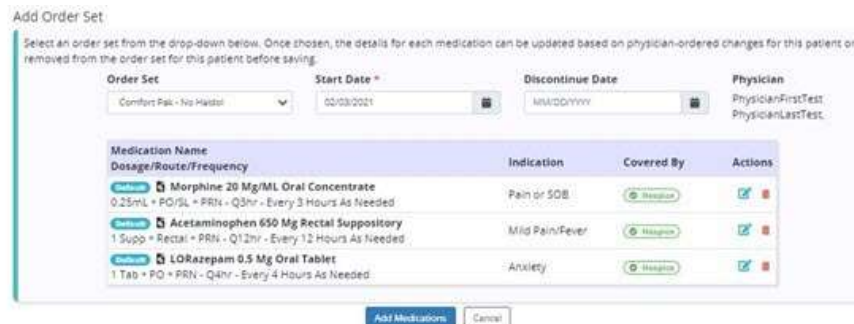
A confirmation pop-up will appear saying, "Success! You have successfully completed the note." Choose to Close or **Go to Patient Chart**.

Add an Order Set - Once a medication order set has been created in the Custom Medications section, it can be added to a patient's medication profile. Select **Update Medications** to select or create a physician order for the new medications. Select **Add Order Set** to add a medication order set to the patient's

profile. In the **Add Order Set** window, select an order set and enter a start date and discontinue date. The physician will populate automatically based on the physician selected on the order.

Once an order set is selected from the **Order Set** menu, a list of medications in the order set will appear. Users can edit or delete medications before adding them to the patient's profile, based on any specifications given by the physician. Select **Add Medications** to add the list of medications to the patient's medication profile.

The medications will appear in the patient's active medications list and in the patient's eMAR. Medications added through an order set will appear with an icon, so users can quickly identify which medications were added through a medication order set.

Discontinue a Medication - Discontinue medications by following the previously shown order creation process. Select the checkbox next to the medication to discontinue, then select the **Update Medications** button, then select the **Create Physician Order** button.

Users then must choose the physician order tied to the medication by selecting the green **Select Order** button. A button will then appear, allowing to **Discontinue Selected**. Confirm the discontinue date and time (auto generates to today's date and time) and select the **Discontinue Medications** button.

A disappearing green pop-up window will confirm the medication has been discontinued, and the medication will now be listed in the Discontinued Medications section of the Medication Profile. The discontinue order will also need to be signed and completed.

Interactions - Drug interactions will be automatically checked with each new medication order. They also can be run manually by selecting the **Check Active Drugs Interaction** button.

To view drug interactions, select the **Detailed Drug Interaction Report** tab.

Drug interactions will be listed out one by one. Choose to view all or just major or moderate by selecting either tab at the top of the list. The whole report can be downloaded/printed as a PDF file by selecting the **Print** button in the top right.

Medication Profile - Select the **Print Medication Profile** button to automatically download the PDF version of the medication profile. Below is a printed medication profile.

Agency Information						
Testing Home Health Agency, Inc Dallas Parkway 16000, 1717 E Belt Line Road Coppell, TX 75019 666-666-6666 (Office) , 666-666-6666 (Fax) **Provider Number:** 1234567899			**MEDICATION PROFILE**			

Patient Name: Alfonzo, Greg

Patient Information						
Date of Birth: 10/07/2018		**MRN:** JH45885		**Benefit Period:** 04/24/2020 - 06/22/2020		
Attending Physician: IONIS, ZAUNDRA		**Primary Diagnosis:** Other rupture of muscle (nontraumatic), left shoulder		**Comorbidities:** Disorders of muscle in diseases classd elswhr, left shoulder		

Active Medication(s)

Start Date	Medication	Classification	Indication	Through Date	Covered By Hospice	Administered By
02/04/2019	apomorphine 14 daily po	central nervous system agents	test		No	Caregiver
01/27/2019	Childrens Ibuprofen 15 daily po	central nervous system agents	test		No	Caregiver
04/15/2019	aliskiren-hydrochlorothiazide 10 mg once a day oral	antihypertensive combinations	water pill		Yes	Patient
05/20/2020	Lasix 20 mg oral tablet 1 daily po	cardiovascular agents	Blood thinner		Yes	Caregiver

Discontinued Medication(s)

Start Date	Medication	Classification	Indication	D/C Date
03/31/2019	Children's Tylenol 15 test po	central nervous system agents	test	05/16/2019
03/31/2019	Coumadin 15 daily po	coagulation modifiers	test	05/14/2020

Select the purple **Sign Medication Profile** button to sign, which will show the following page and includes patient information, medications, drug interactions, active allergies and signature. Select the signature checkbox, enter the date signed and then select the green **Sign Medication Profile** button.

Sign Medication Profile   Close

Patient Information

Benefit Period Associated	Terminal Diagnosis	Comorbidities	Attending Physician
04/24/2020 - 06/22/2020	Other rupture of muscle (nontraumatic), left shoulder	Disorders of muscle in diseases classd elswhr, left shoulder	JONES, ZAUNDRA

Active Medications (4)

Medication Name Dosage/Route/Frequency	Indication	Start Date Discontinue Date	Added Physician Discontinued Physician	Administered By
Default Lasix 20 Mg Oral Tablet 1 • Po • Daily Hospice	Blood Thinner	May 20, 2020	Ashwani Agarwal	Caregiver
Default Apomorphine 14 • Po • Daily Hospice	Test	Feb 24, 2019		Caregiver
Default Childrens Ibuprofen 15 • Po • Daily Hospice	Test	Jan 27, 2019		Caregiver
Default Aliskiren-hydrochlorothiazide 10 Mg • Oral • Once A Day Hospice	Water Pill	Apr 15, 2019	Zaundra Jones	Patient

Drug Interactions

Moderate Drug Interaction 7

View Drug Interaction Report

Active Allergies

No Active Allergies Found.

Signature

☐ Medication Regimen Review Acknowledgment: I have reviewed all the listed medications for potential adverse effects and drug reactions, including ineffective drug therapy, side effects, drug interactions, duplicate drug therapy, medication allergies, and noncompliance with drug therapy and reviewed significant findings with the physician.

Date Signed *
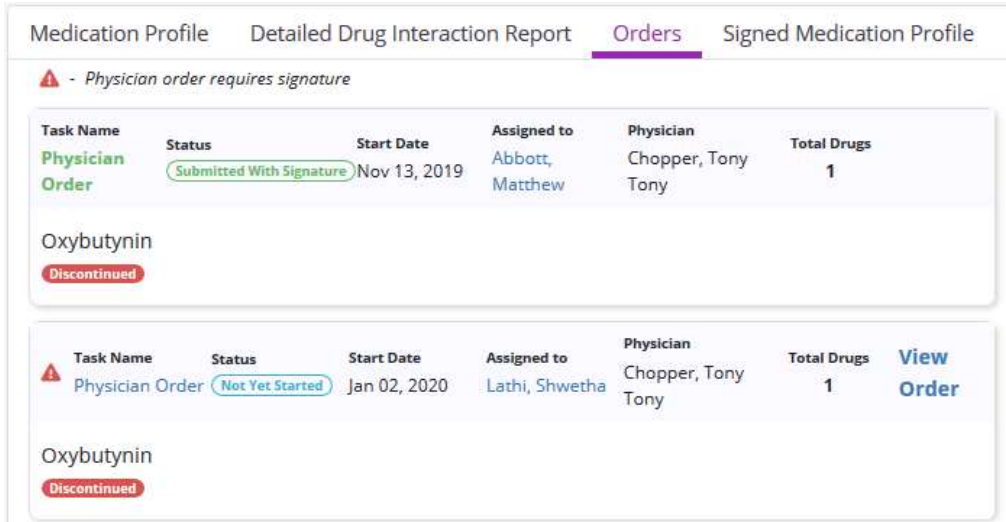
MM/DD/YYYY

Sign Medication Profile   Cancel

View previous signed medication profiles by going to the **Signed Medication Profile** tab. Select the 🖨 icon to print and/or the ⬇ icon to download under the Actions column.

Medication Profile	Detailed Drug Interaction Report	Orders	Signed Medication Profile

Signed By	No. of Active Medications	Signature Date	Actions
Saikrishna Vinnakota RN, LCSW, BCC	1	05/01/2020	🖨 ⬇

◄ 1 ► 1 total results   Show 10 ⌄ entries

Users can view all associated medication orders in the **Orders** tab. Select the **View Order** hyperlink to view specifics for orders that have not been submitted.
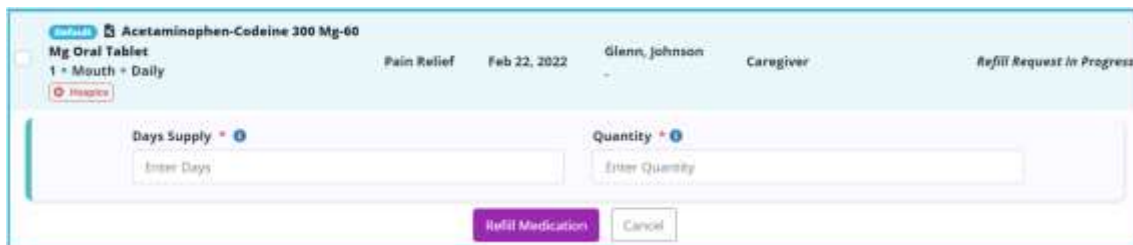
Medication Dispensing Management (Optional Integration)

Axxess Hospice enables organizations with active pharmacy integrations to manage patient medications throughout the ordering process. Through the integration with Hospice Pharmacy Solutions (HPS), clinicians can submit information about medication orders, refills and delivery cancellation requests while completing documentation during patient visits. To perform medication dispensing activity in the medication profile, organizations must activate the HPS pharmacy integration. Contact Axxess to activate.

Refill Medications - Active medications can be refilled for patients without physician orders. From the medication profile, select the purple **Refill** hyperlink next to the medication to be refilled. Enter the days supply and quantity to be sent to the patient. Select the **Refill Medication** button to send the refill information to the pharmacy.

To send multiple refills at once, check the boxes next to the medications you want to refill.

Select **Refill Selected** in the top right corner and enter the days supply and quantity for each medication. Select **Remove** to remove a medication from the refill request. Select **Refill Medications** to send the refill information to the pharmacy.

Dispensing Medications - Dispensing information can be viewed for each medication sent to the patient through the pharmacy integration. In the medication profile, a badge below each medication identifies medications that have been dispensed and how many times the medication has been sent to the patient.

Select the badge to view dispensing details, including the dispense date, days supply, quantity, the user who requested the delivery, and delivery cancellation information if a cancellation request has been sent.

This information can also be reviewed by selecting **View Dispenses** from the **Actions** menu.

Delivery Cancellation - For delivery cancellation, select **View Dispenses** from the Actions menu or select the dispenses badge for the medication you want to cancel. Select **Cancel Delivery** on the delivery you want to cancel.

The dispensing information will update to reflect the user who submitted the delivery cancellation and the date the cancellation was made. A badge will be added to the row so users can easily identify canceled deliveries in the dispensing information for that medication.

Non-Covered Items

As part of the regulatory changes finalized in the CMS Final Rule for FY 2022, hospice organizations are required, as of October 1, 2022, to update the addendum to include a furnished date and reason why the patient/representative refused to sign if applicable. This addendum, the Patient Notification of Hospice Non-Covered Items, Services and Drugs, will provide the requester with an accounting of items, services, and drugs which have been determined by the hospice to be unrelated to the patient's terminal diagnosis and related conditions and therefore not covered by the hospice. Document the notification of patients and caregivers of this right, document the request for an addendum, document relatedness and generate an addendum to deliver to the patient or caregiver. Users must have patient chart, visits and medication profile permissions in their user profile to perform the process.

The **Non-Covered Items** page allow users to generate and manage the addenda for a patient. To add a new addendum for a patient, select **Generate Addendum** and enter the requested date, requested by, the name of the requester and the furnished date. If the patient is requesting the addendum, their name will automatically populate in the name field. Once entered, select **Generate Addendum** to create, view, and update the addendum.
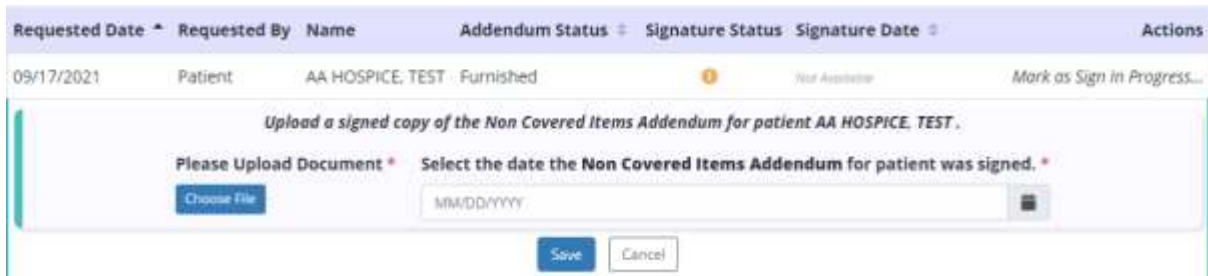
Once created the **Patient Notification of Hospice Non-Covered Items**, **Services**, and **Drugs** form will be pre-populated with the following information:

- General Information
- Diagnoses Related to the Terminal Illness
- Diagnoses Unrelated to the Terminal Illness
- Non-Covered Items, Services, and Drugs
- Note
- Right to Immediate Advocacy
- Acknowledgement of non-covered items, services, and drugs not related to my terminal illness and related conditions

Select **Cancel** to remove any changes made to the form, select **Save** to save any changes, and select **Complete** to mark the form as ready to send to the patient/representative. All generated forms for a patient will be visible on the Non-Covered Items page. Once a form has been completed, it will be in "To Be Sent" status. Select the 🖨 or ⬇ icon to print or save a copy of the form. Select 🖉 to make changes to the form or select 🗑 to remove the form.

Once the form has been printed and delivered to the requester, select the green **Mark as Sent** hyperlink from the Actions column. The status of the document will then update to "Furnished". Once the form has been signed or refused to sign by the requester, select **Mark as Signed** or **Refused to Sign** to upload the document. Then enter the date signed or refused and select **Save.**

Once the form has been uploaded and marked as **Signed** or **Refused to Sign**, the signature status column will display a ✅ if signed or ❌ if refused to sign as well as the date. If the signature status needs to be updated, choose the ⋯ to update the status.

eMAR

Users can track medication administration history in the Electronic Medication Administration Record (eMAR). Users must have eMAR permissions in their user profile to perform the process. A list of the patient's active medications appears on the eMAR screen.

The time period filter enables users to select a **Daily**, **Weekly**, or **Monthly** view of the eMAR, and the date arrows enable users to change the day, week or month. To return to the current day, select **Today** next to the time period filter. In the Show Medications menu, users can filter medications by taken, refused, or unable to take. By default, the filter will be set to view all**.**

To document a medication action, select the day or time in the medication timeline. In the Add Medication Action window, the medication and dosage will populate in the medication and dosage field. The date and time fields will populate based on where the user selected the timeline. Users can adjust these fields as needed. Under medication action, select **Taken**, **Refused** or **Unable to Take**. The name of the user adding the medication action will populate in the clinician field. Users with permission to reassign medications can edit the clinician field. Enter the clinician's initials under clinician initials. If a family member or caregiver administered the medication, check the Given by Family/Caregiver box. Enter comments as needed and select **Save** to finish documenting.

Once added, the medication action will appear on the eMAR at the documented date and time.

Select or hover over a medication action to view the clinician, comments and edit or delete the medication action. Select the ✎ to update the action or select the 🗑 to delete the action. Users must have permission to edit and delete medication actions using these icons. If a medication has been discontinued or is not yet active, the medication row will be disabled and actions cannot be added.

To download the current view of the eMAR, select the **Download eMAR** button in the header. To select a different time period, use the Daily, Weekly or Monthly buttons or the arrows to select the desired time period for download. Users can also access the eMAR by selecting the **View eMAR** hyperlink in a patient's Medication Profile**.**

Plan of Care
This link will take the user to the Plan of Care (POC) for the patient. It will be visible in three tabs:

Comprehensive Plan of Care - Showing all areas of the POC in a non-editable view. Users can **Print** or **Download** by selecting the buttons in the top right. The POC is split between patient information, provider information, diagnoses, clinical information and additional orders.

| Comprehensive Plan Of Care | Problem Statements | History | | | Print | Download |

Patient Information

First Name	MI	Last Name	Suffix		Date of Birth	Gender	MRN
Angel	h	Accord			08/15/1960	Female	Accord010

Address Line 1		Address Line 2	City		State	ZIP	Medicare Number
16000 Dallas Pkwy			Dallas		TX	752486607	321654887A

Medicare Beneficiary Identification	Location				PhoneNumber		
56985478965	Home - Q5001				Home: (214) 575-7711		

Legal Representative	Attending Physician
	JONES , ZAUNDRA NPI: 1902803224
	4591 SOCASTEE BLVD
	MYRTLE BEACH, SC 295887209
	(843) 497-5929 (Office), (843) 293-1115 (Fax)

Admission Date	Level of Care	Benefit Period Start Date	Benefit Period End Date
11/13/2019		05/11/2020	07/09/2020

Provider Information

Provider Name	Provider NPI	Address Line 1	Address Line 2	City
Testing Home Health Agency, Inc	1234567899	Dallas Parkway 16000	1717 E Belt Line Road	Coppell

State	ZIP
TX	75019

Diagnoses

Terminal Diagnosis	Comorbidities
I67.1 Cerebral aneurysm, nonruptured	I30.0 Acute nonspecific idiopathic pericarditis
	G30.1 Alzheimer's disease with late onset

Clinical Information
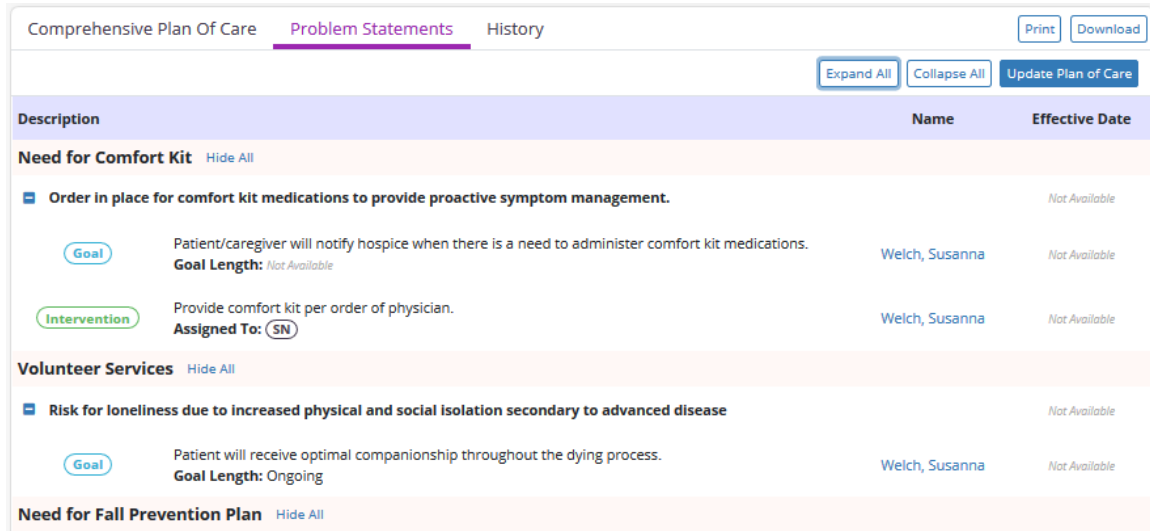
Medications	Allergies
LORazepam 0.5 mg oral tablet, 2 tab oral 3 times daily, anxiety, Start: 05/11/2020, Caregiver, Patient, Hospice, Covered by Hospice	123, New Allergy, Peanut Allergy, poop

DME	Supplies

Diet	Activities

Emergency Preparedness	Visit Frequencies
Emergency Triage: Moderate	
The patient's symptoms are managed at this time and services may be postponed and replaced with telephone contact without detriment to the patient.	

Evacuation

Advance Directives
Full Code

Additional Orders

SN Evaluation Performed. Need for Hospice Services Indicated
Physician Contact:
Verbal Certification Received:
Pronouncement of Death:

Problem Statements - Showing the problems/goals/interventions with ability to update. Users can **Print** or **Download** by selecting the buttons in the top right.

Expand each problem area by selecting the **View All** hyperlink then expand each problem statement by selecting the icon to view the intervention and goal. See all interventions and goals by selecting the **Expand All** button or minimizing them by selecting the **Collapse All** button.

Description		Name	Effective Date
Need for Comfort Kit Hide All			
⊟ Order in place for comfort kit medications to provide proactive symptom management.			Not Available
(Goal)	Patient/caregiver will notify hospice when there is a need to administer comfort kit medications. **Goal Length:** Not Available	Welch, Susanna	Not Available
(Intervention)	Provide comfort kit per order of physician. **Assigned To:** (SN)	Welch, Susanna	Not Available
Volunteer Services Hide All			
⊟ Risk for loneliness due to increased physical and social isolation secondary to advanced disease			Not Available
(Goal)	Patient will receive optimal companionship throughout the dying process. **Goal Length:** Ongoing	Welch, Susanna	Not Available
Need for Fall Prevention Plan Hide All			

Comprehensive Plan Of Care **Problem Statements** History [Print] [Download]

[Expand All] [Collapse All] [Update Plan of Care]

Select the **Update Plan of Care** button to make changes, then select the **Create Physician Order** button.
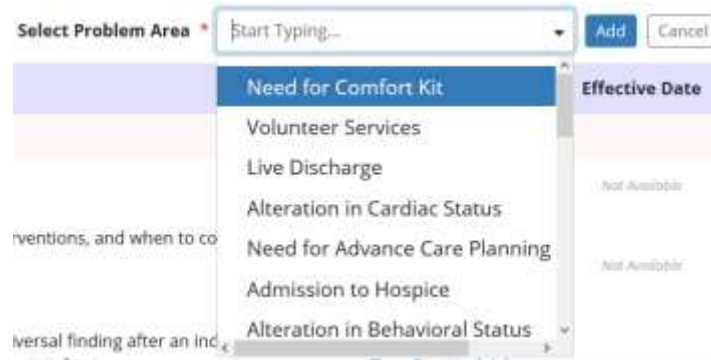
Comprehensive Plan Of Care **Problem Statements** History [Print] [Download]

There are no open Physician Orders assigned to you. Please create one.

[Create Physician Order] [Cancel]

[Expand All] [Collapse All] [Update Plan of Care]

New Physician Order date will be auto-generated to the date it was created. Find physician tied to order and select the **Create** button.

New Physician Order

Date	Physician
10/15/2020	AGARWAL, ASHWANI

[Create] [Cancel]
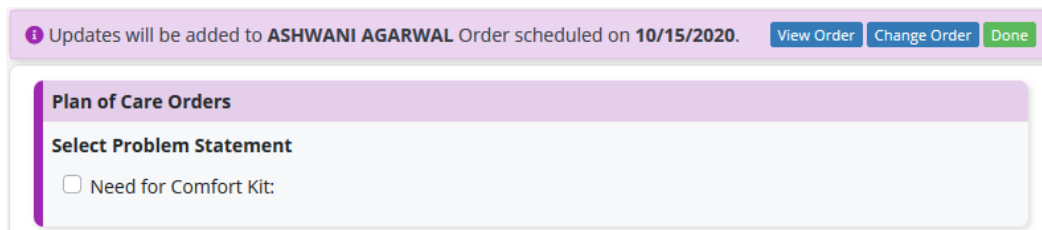
Select the **Add Problem(s)** button once the new physician order is created.

Comprehensive Plan Of Care **Problem Statements** History [Print] [Download]

ⓘ Updates will be added to **ASHWANI AGARWAL**, Order scheduled on **10/15/2020**. [View Order] [Change Order] [Done]

[Expand All] [Collapse All] [Update Problem Statements] [Add Problem(s)]

Start typing a problem area or select the drop-down area to browse the available list. Select the **Add** button once the desired problem area is found.

Select the problem statement checkbox and make optional edits to the description.

Select the goal(s) by selecting the checkbox(es), make edits to the text and choose a goal length. Select the intervention(s) by selecting the checkbox(es), make edits to the text and choose which discipline to assign to (able to choose from than one). Select the **Complete** button when finished.

A green confirmation pop-up will show saying, "Success! You have successfully added Problem(s)." Then choose to **Go to Plan of Care** or Close.

Goals

☑ Verbalize Understanding of Medications:

> Patient/caregiver will verbalize understanding of administration, dosing, and indication for each comfort kit medication.

Goal Length

[▼]

☐ Verbalize Proper Storage:

☐ Call Hospice for Initial Use:

☐ Other:

Interventions

☑ Perform: Provide Comfort Kit:

> Provide comfort kit per order of physician.

Assign to:

[|]

SN	︿
☐ Tead | MSW | cations:

NOTE: Asterisks must be removed with patient related information to save.

History - Showing pending and active POC for patient. Select the **Name** hyperlink to view the POC.

Comprehensive Plan Of Care	Problem Statements	History			
Name			**Start Date**	**Assigned to**	**Status**
Initial Plan of Care			09/30/2019	Thibodeaux, Travis	Active
Physician Order - Need for Comfort Kit			12/13/2019	Welch, Susanna	Pending
Physician Order - Volunteer Services			12/13/2019	Welch, Susanna	Pending
Physician Order - Need for Fall Prevention Plan			01/23/2020	Barkins, Lorna	Pending
Physician Order - Alteration in Comfort: Pain			01/23/2020	Barkins, Lorna	Pending
Recert Plan Of Care			01/10/2020	Santos, Jean	Active
Physician Order - Need for Infection Management			04/02/2020	Noack, Heidi	Pending
Physician Order - Need for Infection Management			04/02/2020	Cinquegrana, Brandon	Pending

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Vital Signs

View vital sign logs that enable clinicians to monitor patient status and provide helpful insights into eligibility and treatment decisions. To access the vital sign logs, users must have permission to view patient charts. The vital signs log displays all the patient's vital signs and additional measurements for the last 90 days. Select a date range from the filter at the top of the log or click the **Vital Signs** or **Additional Measurements** tabs to view the desired data.

Vital Signs   Additional Measurements

Date Range   11/26/2021 - 02/24/2022

Date	Entered By	Task	Pulse	Blood Pressure (mmHg)	Temperature	Respirations (/min)	O2 Saturation (%)	Actions
02/15/2022	Partida, Jessica	Skilled Nurse Visit	76 Apical Sitting	173/85 Sitting (L)	98 °F Oral	10	15 On Oxygen	No Actions
02/07/2022	Partida, Jessica	Skilled Nurse Visit	58 Apical Standing	186/80 Lying (R)	96 °F Temporal	10	10 On Room Air	No Actions
01/26/2022	Partida, Jessica	Skilled Nurse Visit	68 Apical Lying	173/85 Lying (L)	89 °F Temporal	10	15 On Oxygen	No Actions

◄ 1 ► 3 total results   Show 50 ∨ entries

Vital signs, including pulse, blood pressure, temperature, respirations and O2 saturation will automatically be logged when documented during patient visits. Vital signs that are documented as unable to be obtained will be indicated as such in the log. Additionally, any vital signs that are not documented during a visit will be blank in the log.

Additional measurements, including mid-arm circumference (cm), height, weight, BMI, PPS/KPS, FAST and NYHA will also be logged when documented during patient visits and will appear on the **Additional Measurements** tab in the log. Any additional measurements that are not documented during a visit will be blank in the log.

Vital Signs   Additional Measurements

Date Range   11/26/2021 - 02/24/2022

Date	Entered By	Task	Mid-Arm Circumference (cm)	Height	Weight	BMI	PPS/KPS	FAST	NYHA	Actions
02/15/2022	Partida, Jessica	Skilled Nurse Visit	20 R	52 in	148 lbs	27	90% / 90%	1	I	No Actions
02/07/2022	Partida, Jessica	Skilled Nurse Visit	10 R	52 in	150 lbs	23	90% / 70%	5	III	No Actions
01/26/2022	Partida, Jessica	Skilled Nurse Visit	10 R	6 in	145 lbs	23	60% / 90%	2	II	No Actions

◄ 1 ► 3 total results   Show 50 ∨ entries

The log can also be accessed from the **Vital Signs/Additional Measurements** section of all clinical documentation. Finally, the log can be accessed from the **Scales/Measurements** section of the **IDG Summary** in the **IDG Center**.

Symptom Ratings

View symptom ratings logs that enable clinicians to monitor patient status and provide helpful insights into eligibility and treatment decisions. To access the symptom ratings logs, users must have permission to view patient charts. The symptom ratings log displays the patient's documented symptom ratings and pain scores for the last 90 days. To see data, select a different date range from the filter at the top of the log.

Date Range	11/26/2021 - 02/24/2022													
Date	Entered By	Task	Pain	Anxiety	Appetite	Constipation	Depression	Dizziness	Dyspnea	Nausea	Sleep Pattern	Vomiting	Weakness	Actions
02/07/2022	Partida, Jessica	Skilled Nurse Telehealth Note	2	2	0	2	0	0	2	3	1	1	No Actions

◄ **1** ► 1 total results   Show 50 ∨ entries

The log can also be accessed from the **Symptom Ratings** section of some clinical documents. Finally, the log can be accessed from the **Scales/Measurements** section of the **IDG Summary** in the **IDG Center**.
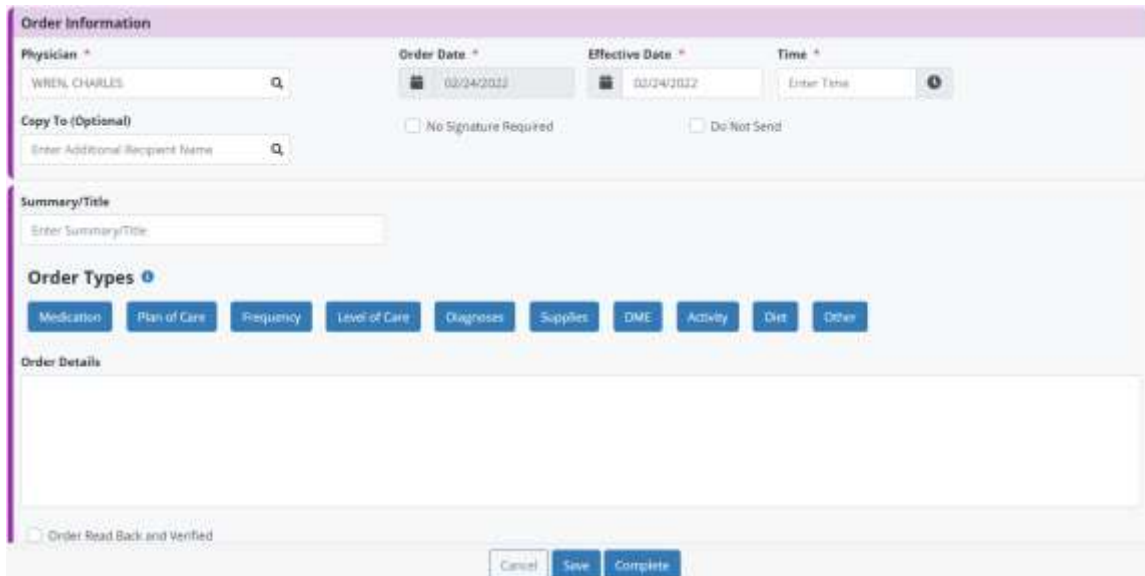
NEW ORDERS

Schedule/Patient Schedule/Add Task/Physician Order

Choose physician order when adding a new task then select the order on the calendar and fill out the following fields:

- Physician - Defaults to attending physician, editable with ability to change physician to any physician in patient chart using type ahead or add new physician.
- Copy To - Text box with ability to add any physician in patient chart using type ahead or add new physician.
- Effective Date - Enter date, defaults to current date. Date can be in the past.
- Time - Editable text box with time picker.
- No Signature Required or Do Not Send - Select either checkbox if applicable.

- Summary/Title - Text box with ability to enter letters and numbers.

Order Information

Physician *
WREN, CHARLES

Copy To (Optional)
Enter Additional Recipient Name

Order Date *
02/24/2022

Effective Date *
02/24/2022

Time *
Enter Time

☐ No Signature Required

☐ Do Not Send

Summary/Title
Enter Summary/Title

Order Types ⓘ

Medication | Plan of Care | Frequency | Level of Care | Diagnoses | Supplies | DME | Activity | Diet | Other

Order Details

☐ Order Read Back and Verified

Cancel | Save | Complete

- Order Types:
  - Medication
  - Plan of Care
  - Frequency
  - Level of Care
  - Diagnosis
  - Supplies
  - DME
  - Activity
  - Diet
  - Other
- Enter the order details in free text space.
- Select whether the order is Order Read Back and Verified.

Select the **Save** button to return to later or select the **Complete** button when finished.

SCHEDULE ACTIVITY
Schedule/Patient Schedule

The functionality works the same as the Employee Calendar. See *Task Calendar* section above. Visit frequencies are seen by selecting the **View Frequency Profile** hyperlink at the top of the calendar. Scheduled visits can be moved by selecting the visit, dragging and dropping inside another day in the Medicare week. Frequencies can be made monthly, with visits being moved within the current month.

SCHEDULING A VISIT (PERMISSIONS BASED)
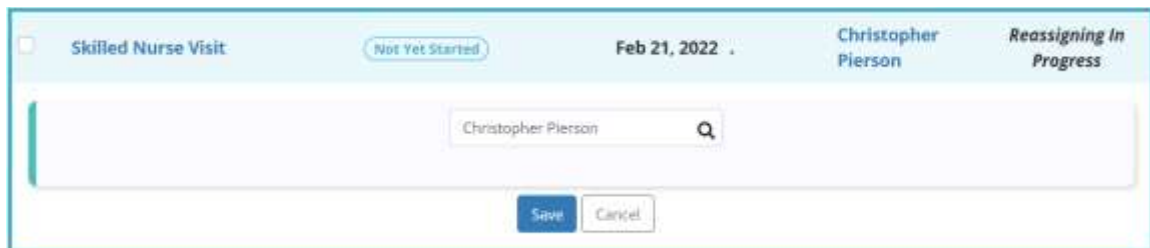Select the **Add Task** button to schedule a visit.

Repeat the task either weekly, biweekly, flexible or monthly. Choose Flexible under the repeat drop-down to add multiple tasks under the date entry. Enter the date, for reference the current benefit period dates are shown. Once the date is chosen, the payer will auto-generate the patient's primary payer. Start typing the name of the task or choose from the drop-down list. Then start typing the name of the employee and results will narrow for choices. Choose a shift length from 1-12 hours in hour increments. If a shift length is chosen, then a Shift Start Time must be chosen. Select the on-call visit checkbox if applicable. Select the **Save Task & Add Another** button if there is more than one task to add or select **Save Task** for adding a single task.

Manage individual tasks by choosing any of the five options under the Action column next to each task. Reassign, missed visit (current/past due tasks), print, download or delete a task.
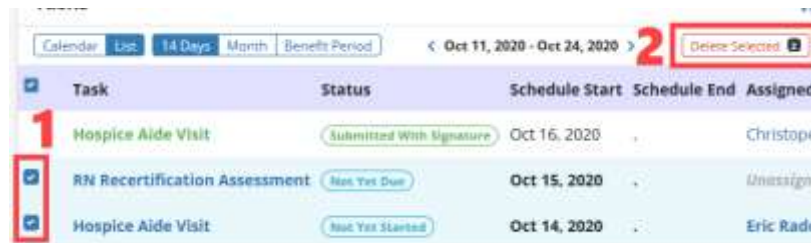

If the user chooses to reassign a single task, select the three-dot button, then choose **Reassign**. A search option will appear to find another clinician. Once found, select the **Save** button to complete.

Deleting Visits (Permissions Based)

To delete visits (before completion), select the checkbox to the left of the task name and then select the **Delete Selected** button in the top right of the chart schedule. To delete all tasks (before completion), select the checkbox in the purple column header, which selects all visits, and select **Delete Selected**.

/Axxess

HOSPICE RN ASSESSMENTS

When charting information in the RN Initial/Comprehensive Assessment visit, some information has already been pulled from the patient's profile. Answer all required questions for the rest of the visit. These are indicated by red asterisks. Even though the following example is for RN, the colors below apply to all clinical documents for all disciplines.

- **Green Boxes** - Information in the green boxes are the HIS questions that will be exported to CMS.
- **Purple Boxes** - These questions generate POC orders.
- **Blue Boxes** - Physical assessment questions.
- **Teal Boxes** - Visit information, patient profile, incident/accident/infection, reports, care coordination notes, etc.

Initial Plan of Care (IPOC) - Hospice RN Initial/Comprehensive Assessment and RN Initial Assessment create the Initial Plan of Care (IPOC) for creating initial orders for care. Except for demographic information, all data that will flow to the Initial Plan of Care is from the summary section, including physician orders section and patient/caregiver goals. There is a button in the Plan of Care Review section to initiate a brief Initial Plan of Care to address the immediate care needs of the patient/caregiver.
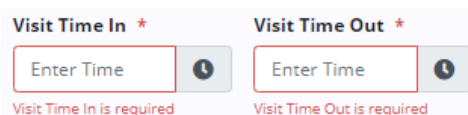
Plan of Care Orders - In purple sections at the bottom of RN Initial/Comprehensive and RN Comprehensive Assessments, there are areas to document the POC needs for the problem area being assessed. If asterisks (*) are present, then the system is requiring customized information.

Throughout clinical documentation for each discipline, required fields are identified with red asterisks. When **Save** or **Complete** is selected, each required field is automatically checked for completion. If any information is missing, a warning message alerts the user to complete the missing information.

Items that are left blank or have incorrect information will be highlighted in red and a brief explanation of the error will be provided.

The software will automatically move to the next field that requires correction so that each item can be corrected before attempting to save or complete the document again. Once all necessary corrections have been made, a success message will appear on completion.

The HIS scrubber can be run on-demand at any time by selecting the **Check Errors** button at the bottom of the RN Initial/Comprehensive Assessment and the RN Comprehensive Assessment. The system will make sure all HIS questions are answered and not conflicting. When the inconsistency is selected, the user will be taken to the area of the inconsistency. The area will also slightly shake visibly.
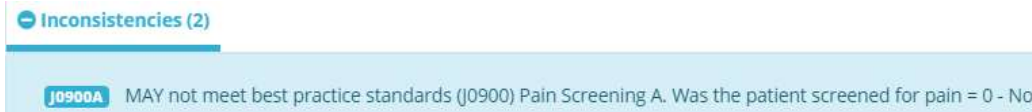
In addition to **Check Errors**, the software will also automatically run the HIS scrubber for the RN Initial/Comprehensive Assessment and RN Comprehensive Assessment when the **Complete** button is selected in these documents. Any errors, inconsistencies or warnings will display at the top of the assessment.

Use the arrow buttons to move between each error, inconsistency and/or warning. As the users moves through each message, the software will automatically move to the appropriate section and highlight the information that needs to be reviewed or corrected. Select **Show All** to view all errors, inconsistencies and warnings as a list. Select **Collapse** to close the list and return to the document.

Once all necessary corrections have been made, select **Check Again** to re-check the document by the HIS scrubber. All errors must be corrected before the document can be completed to prevent the HIS data from being rejected by CMS. While all errors must be corrected, documents can be completed if inconsistencies and warnings remain.

If no warnings or errors are found, then a green disappearing notification will show confirming, "Success."

Select the **Save** button to keep the progress of the visit. Select **Complete** when the user is done with documentation. A popup will appear, and the user must select the checkbox to sign the document then select **Complete**.

The Initial Plan of Care is visible after the RN Initial Assessment or RN Initial/Comprehensive Assessment has been approved from the QA Center. A draft view will be visible from the Action menu prior to final approval of content.

Visits and non-patient activities display warning messages for the following scenarios:

- When a user enters the travel start time but not the travel end time.
- When a user enters the travel end time but not the travel start time.
- When the travel time exceeds one hour.
- When the visit and travel times overlap.
- When the visit time exceeds three hours.

On any of the above warning messages, users can select **Go Back** to return and correct the travel/visit times or **Complete** to complete the note as is.

Add Addendum

To add a document addendum, go to *Schedule/Patient Schedule* or *Employee Schedule*. Toggle to the **List** view and locate the task to update. Select **Add Addendum** from the Actions menu. This action will only be available for completed tasks that are assigned to the user.

Enter the Reason for the Addendum and select the **Start Addendum** button to begin making changes. If necessary, the reason for the addendum can be updated after changes have been made to the document.

Once the changes are complete, select the **Confirm Changes** button at the bottom of the screen. Review the reason for the addendum and update as needed. To complete the addendum, select **Complete** and sign the document. Select **Cancel** to return to the document and continue making changes. Once the document has been signed, it will be sent to the QA Center for review.

Documents with addenda will be labeled with an **Addendum** badge displaying the number of addenda associated with the task. To view the document versions, select the badge or select **View Addendum** from the more menu in the Actions column.

When the **Addendum** badge or **View Addendum** button is selected, a table will open to display each completed version of the document, the status of each version, the user who completed the document, and when the document version was completed. Select the 🖨 or 📥 icon to view a document.
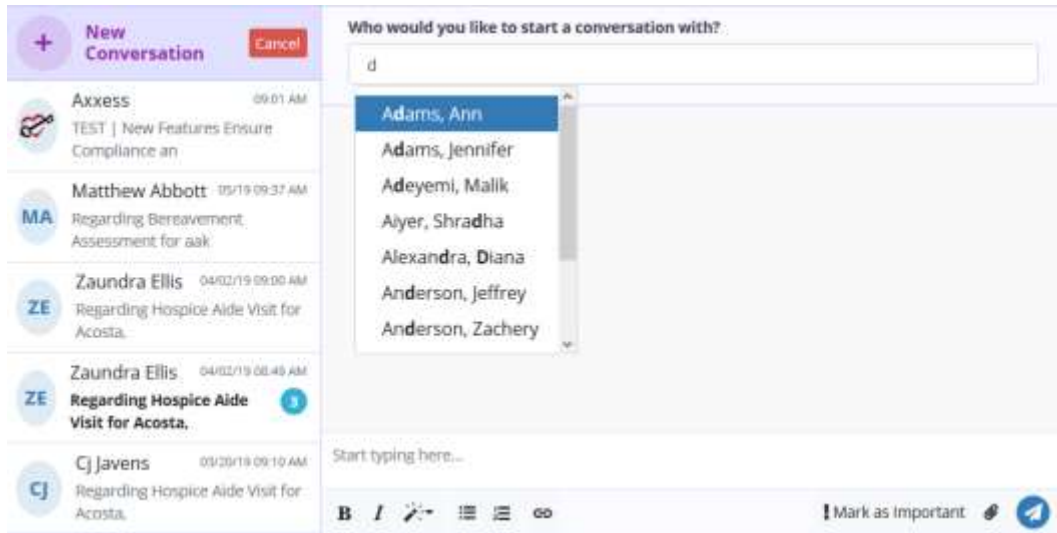
MESSAGE CENTER

The Message Center is a place for all staff to communicate internally related to patient care with functionality to attach items and message groups as well as individuals. There are two ways to access notifications/messages:

1. Select the envelope icon at the top right side of the page.
2. My Dashboard has a hyperlink to **View All Messages** at the bottom of the Unread Messages tile.
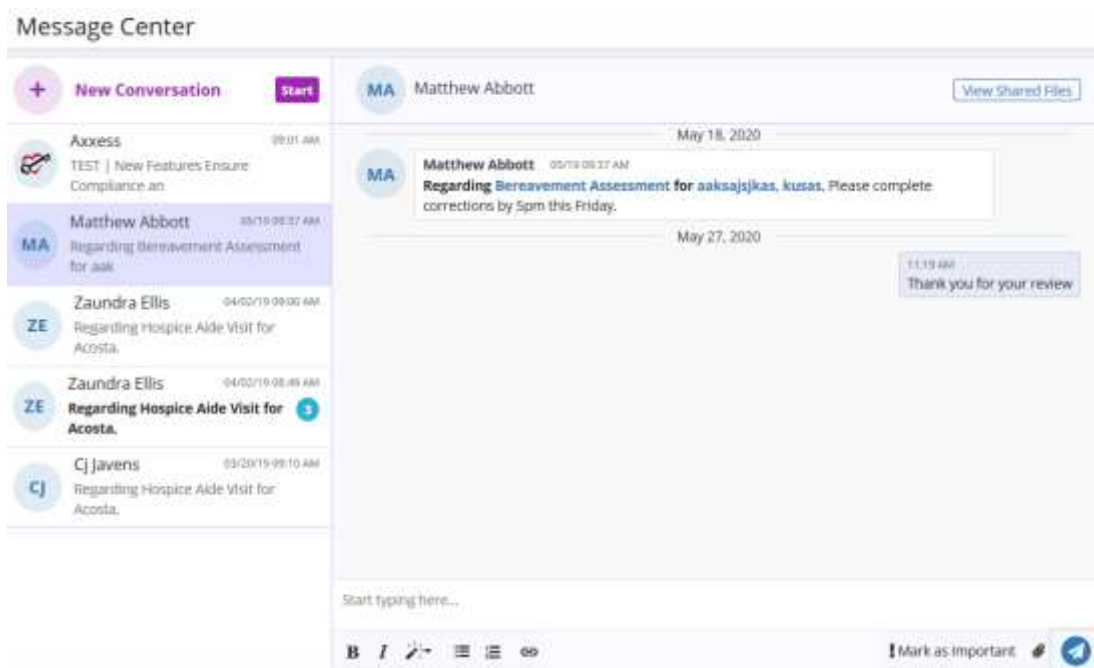
Search through conversations by entering text in the search field. Select the purple Start button create a new conversation.

New Conversation - Start typing the name of a desired user in the organization, then select when given a choice from drop down options.

Start writing the conversation in the text box at the bottom of the page that says, "Start typing here..." Change text in the bar right below the text box.

! - Mark the importance of a message.

& - Add attachment to message.

◢ - Send message.

HELP CENTER

A great resource that is available 24/7 is our Help Center. It is a place to get answers to frequently asked questions or watch videos on all our Axxess products. Our Help Center can be accessed by selecting *Help/Help Center* or https://www.axxess.com/help/.