HEALTHWYSE MOBILE: DISCHARGE

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Version 3.0

This module contains instructions on how to discharge a patient using HealthWyse Mobile. You can discharge a patient from a particular discipline of care (**Discipline Discharge**), or you can discharge a patient from your agency (**Agency Discharge**). It is important to complete and sign any orders that may be required for a patient prior to initiating the discharge process. Also, for an **Agency Discharge**, make sure all the work related to other disciplines has been finished.

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INTRODUCTION TO THE DISCHARGE MODULE

This module contains instructions on how to discharge a patient using HealthWyse Mobile. You can discharge a patient from a particular discipline of care (**Discipline Discharge**), or you can discharge a patient from your agency (**Agency Discharge**). It is important to complete and sign any orders that may be required for a patient prior to initiating the discharge process. Also, for an **Agency Discharge**, make sure all the work related to other disciplines has been finished.

Initiating an **Agency Discharge** or a **Discipline Discharge** will create a **Workflow,** which always includes **Review**, **Document**, and **Complete**. For Home Health it will also include a **Summary** component with an agency discharge. The **Document** component will contain either a **Discharge OASIS, Agency Discharge form** or a **Hospice Assessment** as appropriate.

MODULE OBJECTIVES

- Demonstrate the ability to perform a patient discharge
- Complete the Discharge Review component
- Complete the Discharge Document component
- Demonstrate the ability to complete the Discharge Complete component
- Identify the process for documenting a possible patient as **Not Taken for Care**

COMPLETE A DISCHARGE WITH A VISIT

If you are conducting a visit with the patient you must complete the applicable workflow for the visit first, and then complete the discharge. This means that if you are seeing the patient for a routine visit, you would complete the Routine Visit Workflow first. Once the Routine Visit Workflow is complete, you need to initiate the Discharge Workflow.

Typically, agencies do not have specific discharge visit reasons. If for some reason your agency chooses to have discharge visit reasons configured and they are mapped to the workflow you selected, you can chose them as a reason either when the workflow is initiated or by changing it on the Visit tab in the Complete Component. Selecting a discharge visit reason in the visit workflow does not initiate the Discharge Workflow, nor does it turn the current visit workflow into a Discharge Workflow.

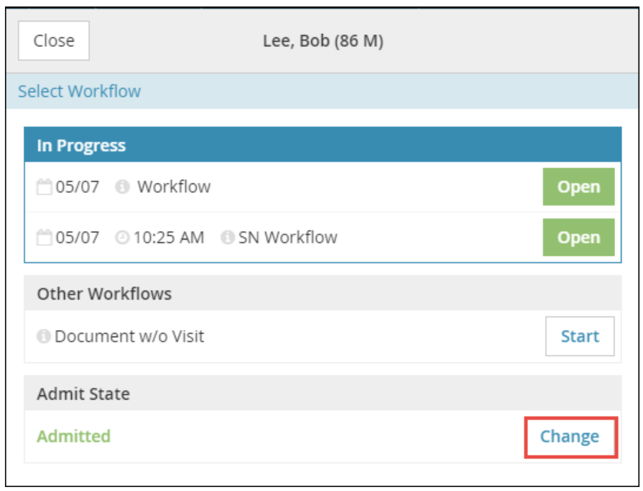
COMPLETING THE DISCHARGE WORKFLOW

The Discharge Workflow is required for all Discipline and Agency discharges.

START THE DISCHARGE WORKFLOW

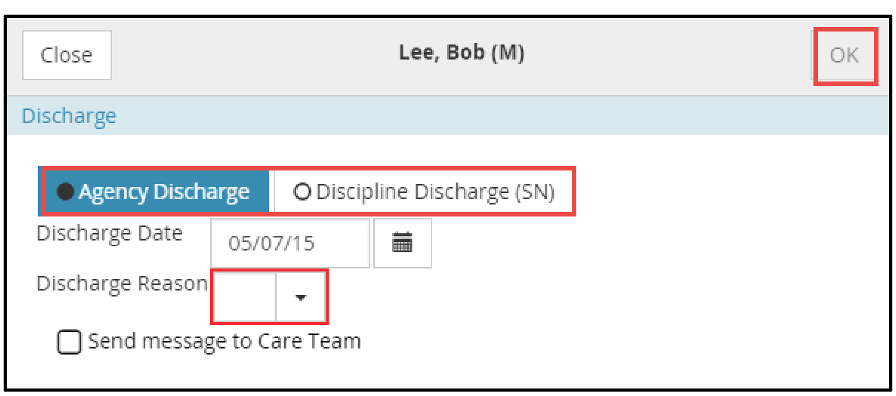
1. From the **Patient Information** screen, tap the **Go** 

 button.
2. A pop-up window will display with the patient's **Admission Status** (**AdmitState**) displayed at the bottom. Tap the **Change** button.



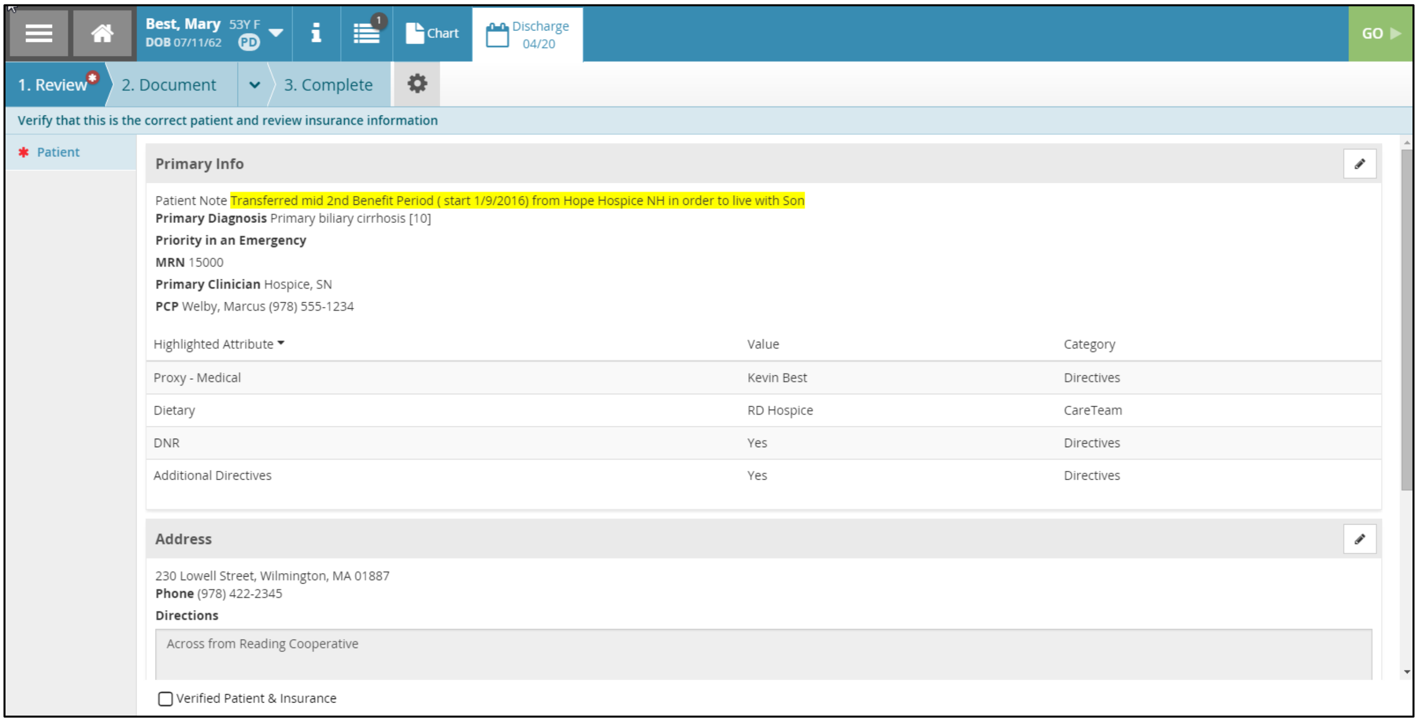
3. Tap the **Discharge** button to initiate a Discharge. *Note: Hospice agencies only have the option to Discharge, Home Health will also see a Hold button.*

4. Select which type of Discharge to perform, either an **Agency Discharge** or a **Discipline Discharge**.
5. Input the date that the Discharge will be effective.
6. Select the appropriate **Discharge Reason** from the drop-down list. This list will be different depending on the type of discharge (agency or discipline) and on whether the patient is **Home Health** or **Hospice**.
7. If you want to notify the Care Team of the discharge, check the **Send Message to Care Team** box.
8. Tap the **OK** button to begin the Discharge process. This will generate a **Discharge Workflow**.

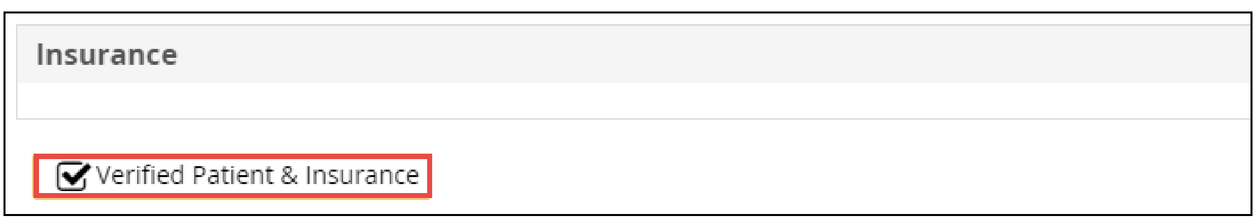


REVIEW COMPONENT

The **Review** Component of the **Discharge Workflow** allows you to review and verify the patient’s basic information and insurance.

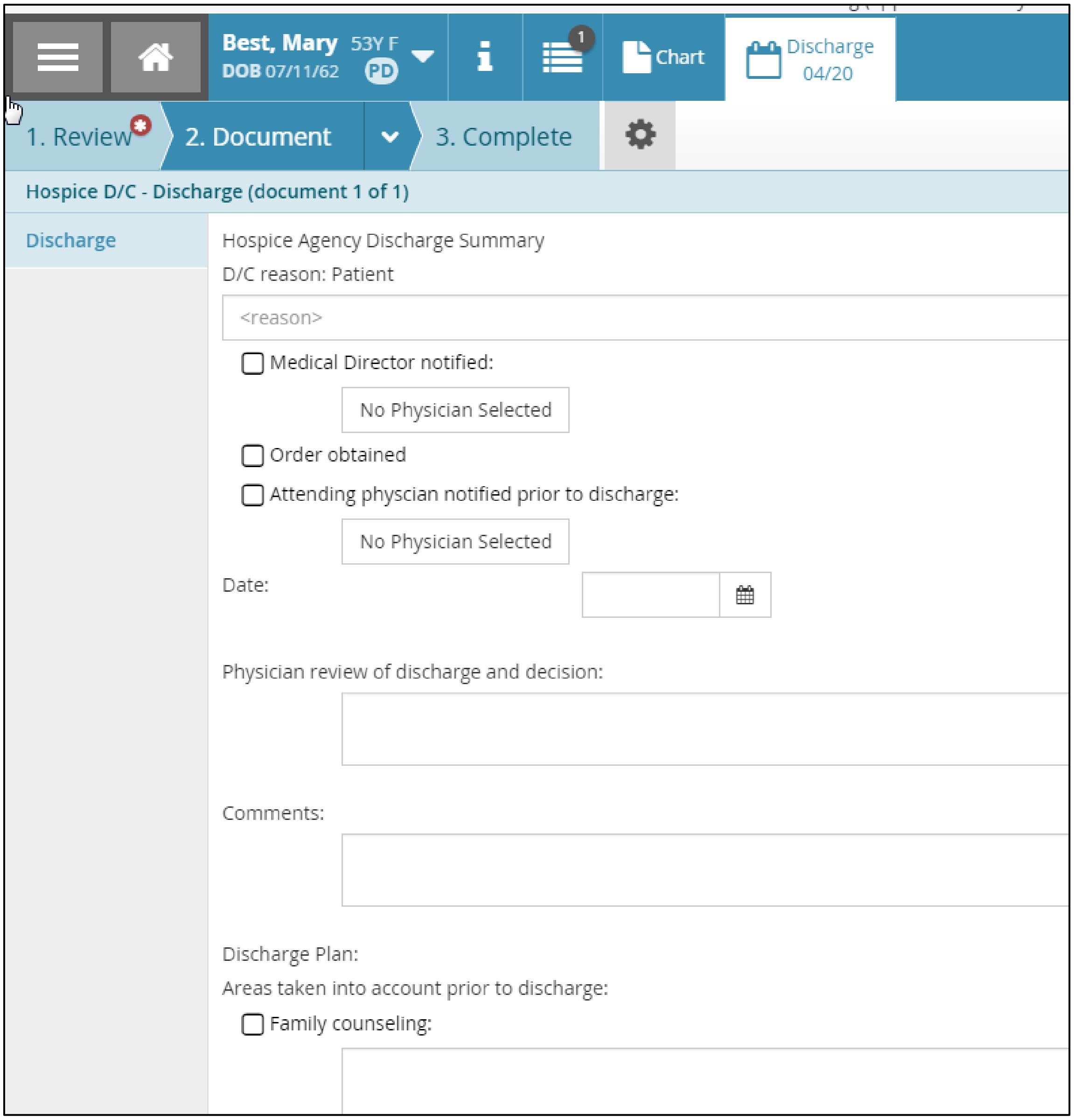


1. Read through and verify all current **Patient** information, including **Primary Info**, **Address**, and **Insurance**.
2. If you need to make any changes to this information, it will need to be done outside of the Workflow, from inside the **Patient Chart**.
3. Once you have verified the information to be complete and accurate, tap to check **Verified Patient & Insurance**.



DOCUMENT COMPONENT

The **Document** component in a Workflow generated for a patient Discharge will contain either a **Discharge OASIS**, **Agency Discharge form,** or a **Hospice Discharge** If any additional documentation is required, be sure to tap the **Workflow Options** icon and add the appropriate forms.



1. Tap the **Document** component to pull up the forms.
2. Complete the forms required for **Discharge**. You will need to complete all required fields within the documents in order to complete the visit, these will be outlined for you in red.
3. If you need to add additional forms to complete your workflow:
   a. Tap the **Workflow Options**.
   b. Select **Add Form**.
   c. Scroll or search for the form(s) from the list.

d. Tap to select the form(s). This is a multi-select list, so each form tapped will be added. If a form is selected automatically, tap the red X next to the form name in the **Forms To Be Added** section below the list.
e. Tap **OK** when you have selected all needed forms.

SUMMARY COMPONENT

In a Home Health Workflow initiated for a Discharge, a **Summary** component is included. This component summarizes the care provided by your agency and focuses on the patient's plan for after discharge.

1. Tap the **Summary** component.
2. Fill in the fields on the page, using the table below as a guide.

Field Name	Field Type	Description
Date Physician Notified	Calendar	Input the date that the physician was notified about the patient having been discharged.
D/C Plan	Drop-down	Select who will be taking care of the patient after they've been discharged. This includes self care as well as the care of family and supportive services.
D/C Plan → Comment	Free text	Add any extra details regarding the plan for the patient's care moving forward.
Prognosis	Drop-down	Select the patient's prognosis for the future: • Poor • Guarded • Fair • Good • Excellent
Advance Directives	Drop-down	Select Advance Directives: • None • Living Will • Durable POA • Health care Proxy
DNR Order in Place	Drop-down	Select whether or not this patient has a DNR order in place.
Diet	Free text	Enter any notes about the patient's diet.
Problems identified	Free text	Write down any problems that may be important to note.
Goals status	Free text	Write down the status of your patient's therapy goals at the time of their discharge.
Summary of care provided	Free text	Describe and summarize the care that has been provided to the patient.
Referrals made	Drop-down	List the types of services that your patient has been referred to, if any.
Referrals → Comments	Free text	Write down any additional details regarding your patient's referrals that

		may be important to note.
Discharge instructions	Drop-down	Select any instructions that should be carried out after the patient is discharged.
Discharge instructions → Comments	Free text	Write down any additional information applicable to the discharge instructions.

COMPLETE COMPONENT

Before completing the Discharge workflow for a patient, make sure you have signed any orders that may be required. The **Complete** component of a **Discharge** Worfkflow consists of three steps:

- **Time Sheet**
- **Validate**
- **Sign & Complete**

TIME SHEET

The Time Sheet tab in the Discharge workflow is future functionality. Currently, it reflects the time on your Timesheet in HWM, but it does not go to your Timesheet/DAR in OfficeWyse.

If your agency's policy is to pay for the time spent completing a discharge outside of a visit, you need to add that time using a non-visit reason on your Timesheet.   If you are completing the Discharge as part of a visit your time should be captured as part of the visit.

VALIDATE

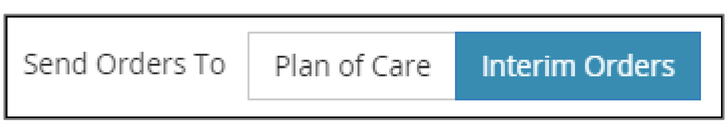
In the Validate**,** you will double check that you have finished all of the Workflow items, Steps, Forms, and correct any items marked with a red asterisk * until all tasks are completed, which will be marked by a green checkmark ✔.

1. Tap on the **Complete** component. This will bring you to the **Validate** step.
2. Review the page. All items marked with a red asterisk (*) require review and an action. Completed areas will be indicated with the green checkmark ✔.
3. Correct any issues indicated. Tap the **Correct** button next to each issue to return to the area of the workflow requiring attention.

SIGN & COMPLETE

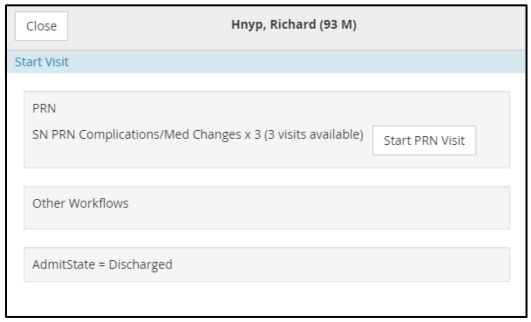
In the **Sign and Complete** step, any outstanding orders for your patient and discipline will be listed. At the top of the screen, select how to proceed with the orders; indicate whether the listed orders are to be added to the **Plan of Care** or treated as **Interim Orders**.

1. Tap the **Sign & Complete** step.
2. Review the list of orders and changes for completion and accuracy.
3. Leave the checked checkbox in the **Sign** column for orders and changes you wish to sign. Tap to uncheck.
4. If the **Plan of Care** has already been signed. Any orders indicated here will be treated as **Interim Orders**, as indicated by the highlighted button **Interim Orders**.



5. If needed, tap to type a **Clinical Summary** in the box at the bottom of the page to add additional information regarding your patient.

6. Once you have verified this page is accurate, tap **Sign Discharge** at the bottom left of the screen to complete the **Discharge**. Once you have done this, the patient will be discharged, and their **Admissions Status** will be updated.



If you are not the Primary Clinician, and you are trying to sign the Dischage, an alert will display stating that signing locks the patient chart. It shows as a yellow circle with an exclamation point rather than a green check mark.

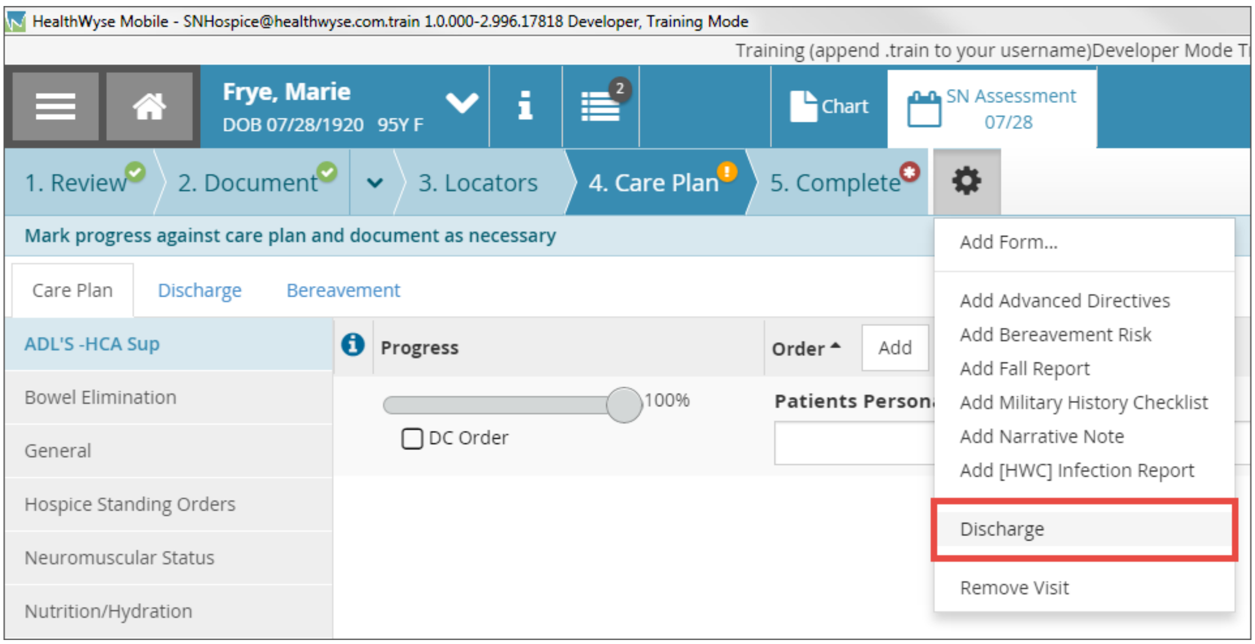
FUTURE FUNCTIONALITY: DISCHARGE DURING A VISIT

This functionality is currently inactive.

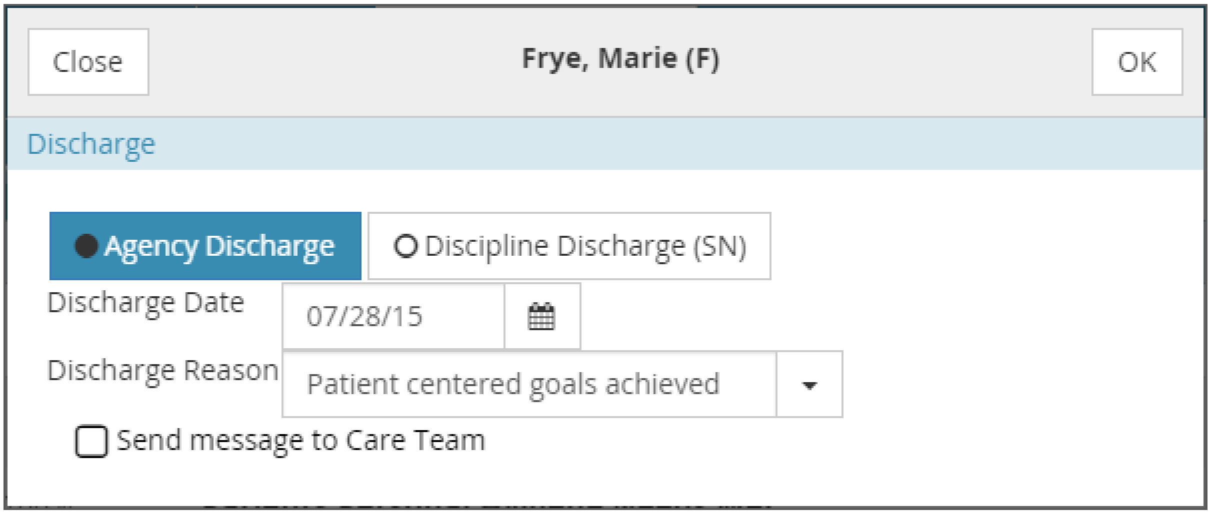
There may an instance where a discharge will be completed during a visit. If a visit results in a discharge, you are able to initiate the Discharge Workflow through a visit workflow.

In order to Discharge during a visit, do the following:

1. Tap the Workflow Options ⚙ icon and select Discharge.



2. Select the appropriate values for the following fields:
   - Agency Discharge or Discipline Discharge
   - Discharge Date
   - Discharge Reason
   - Send message to Care Team



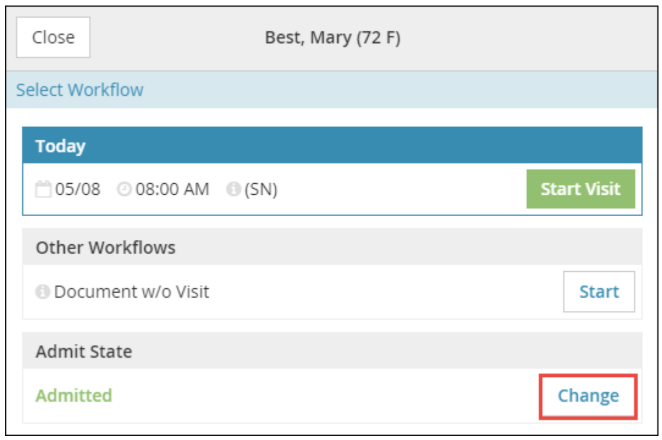
3. Select **OK** to return to the visit and complete the components as appropriate.

NOT TAKEN FOR CARE

When it's decided that a patient will **not** be **taken for care**, this needs to be documented through the discharge process. (See **Discharge** lesson for detailed information on discharges.) It is important to utilize this process and the Not Taken for Care discharge reasons as it drives reporting that allows your agency to analyze data about this population.

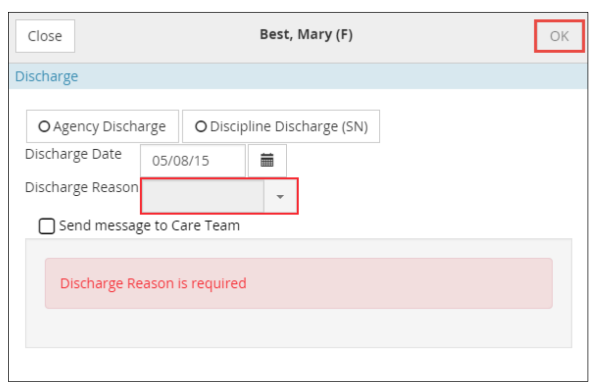
Follow these steps to start a workflow that will discharge the patient and indicate they were **Not Take for Care, (NTFC)**.

1. Tap the **Go** button.
2. The **Start Visit** screen will display. Tap the option to **Change** the **status Admit State** of the patient.



3. Tap the **Discharge** button that appears.

4. Verify the **Date.**
5. From the **Reason** dropdown, select one of the **Not Taken for Care** reasons as the **Reason** for the discharge. These include:
   - **NTFC –Hospice Criteria Not Met**
   - **NTFC – No Skilled Home Health Need**
   - **NTFC – Not Homebound**
   - **NTFC – Other**
   - **NTFC – Other Agency**
   - **NTFC – Out of Area**
   - **NTFC – Referral Canceled**
   - **NTFC – Refused Care**



6. Tap **OK** to finalize and launch the **Discharge Workflow**.

7. See **Discharge Workflow** lesson to complete the workflow and effectively **Discharge** the patient.