Care Planning and Coordination

Review the patient's prior visits

1. **Open a patient's chart and click Chart Review.**
2. **Select the "Encounters" tab to view prior visits.**

NOTE: When a patient has a visit from outside of Trinity Health TogetherCare it appears in the activity toolbar. Hover over this icon to view a list of all the external organizations that the patient has data from and see when this information was last updated.

Download a Visit Summary

If Trinity Health TogetherCare has consent on file to download a document from a visit with another organization, click ⬇ **Request visit summary** to download and view the document.

Review the Patient's Care Gaps

The Care Gaps activity shows you a list of the patient's care gaps from Trinity Health TogetherCare. You can see the status of each care gap, as well as when the care gap is due and when it was last completed. Select the Patient tab and click Care Gaps to view them.

Resolve a Care Gap

When you complete a care gap, you can indicate that it's been resolved. For example, you can resolve a Cholesterol Screening care gap if you received lipid results from an outside source. For some care gaps, you can attach files of supporting documentation to show that patients received the necessary care.

1. **Click the care gap name.**
    a. Alternatively, click ☑ **Resolve** in the row corresponding to the care gap.
2. **Enter the date on which the care gap was resolved.**
3. **If the Documentation section appears, drag and drop a file from your computer to attach supporting documentation.**
    a. If you don't want to drag and drop a file from your computer, click Add file to browse for the file on your computer and select it.
    b. Any files that you add must be smaller than the maximum allowed file size and be of an appropriate type.
        i. The maximum allowed file seize appears in a message below the Add file button.
        ii. To see which types of files you can add, hover over ⓘ.
4. **Optionally enter a comment and click ☑ Resolve.**

NOTE: To resolve multiple care gaps at once, select the check box next to each care gap you want to resolve and click **"Resolve selected."**

Postpone a Care Gap

You can postpone a care gap to change its due date. For example, you might postpone a flu shot if the patient is currently ill.

1. Click ⏱ **Postpone** in the row corresponding to the care gap.

2. Alternatively, click the care gap name and go to the **Postpone** tab.

3. Enter the date you want to postpone the care gap until.

4. Select a reason for postponing the care gap.

5. Optionally enter a comment and click ⏱ **Postpone.**

Discontinue or Resume a Care Gap

When a care gap is discontinued for a patient, it's prevented from ever coming due but remains in the list of the patient's care caps for clinical reference. For example, a child's parents might ask that their child not be vaccinated, so you can then discontinue the vaccination care gap. If the child elects to receive the vaccine after he turns 18, you could then resume the care gap.

1. Click Discontinue or Resume in the row corresponding to the care gap.
   a. Alternatively, click the care gap name and go to the **Discontinue** tab or the **Resume** tab.

2. If you're discontinuing a care gap, you might be required to select a reason for doing so depending on the settings of the web application.

3. Optionally enter a comment and click 🚫 **Discontinue** or ➡ **Resume**.

Manage the History for a Care Gap

You can see each time a care gap was satisfied for a patient. You can also remove any occurrences that you don't think should be satisfied.

1. Click 📝 **Manage History** in the row corresponding to the care cap.

2. To remove an occurrence that shouldn't be satisfied, click 🗑 **Remove.**

Send Messages to the Patient's Care Team

1. From SnapShot, click **Plan of Care** on the report toolbar.

2. Go to the **Care Team** section and click **Message Care Team**.

3. Write the message that you want to send in the **Note** text box.

4. Select the check box for each member of the patient's care team that you want to send the message to.

5. Click ✔ **Send.**

Document Assessments (Post-Discharge Clinician Only)

You can use the Assessments activity to complete assessments for a patient that have been assigned to you by Trinity Health TogetherCare. When you complete the assessment, other members of the patient's care team can see the results.

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1. Select the **Care Management** tab and click **Assessments**.
2. Click on the name of an assessment to open it.
3. Document answers for each question in the assessment.
4. Optionally click 🗋 to enter a comment.
5. Click ✔ **Submit Assessment**.

NOTE: See how an assessment was documented in the past for a patient with the View Assessment History report. The report shows how each question was answered and when that answer was recorded.
Select the option next to an assessment and click "View Assessment History."
Alternatively, you can see documented assessments for a patient on the Encounters tab of Chart Review.

Review Your Assigned Tasks

The **Tasks** activity shows a list of all the tasks that are assigned to you or a pool that you're signed in to. For example, you might see tasks to help recently discharged patients with their daily needs, such as purchasing groceries.

The **Active** tab shows you a list of the tasks that you still need to complete. Overdue tasks appear with a red date in the **Due** column. You can view additional details about a task by clicking the corresponding task row. As you complete these tasks, they are moved to the **Completed** tab. The **Completed** tab shows your assigned tasks that have since been completed, including tasks that were completed by someone else. Select the **Tasks** tab to review your tasks.

Filter Which Tasks you see

You can filter the list of tasks by the patient they're associated with, and by when the tasks are due or have been completed.

Select a patient's name in the menu that's located in the top left of the activity to see only tasks associated with that patient.

On the **Active** tab, change the date in the Show tasks with due dates up until field and click Search to see only tasks that have a due date on or before the date that you enter.

On the Completed tab, use the date range fields to show only tasks that were completed between the dates that you enter.

Complete a Task

1. On the **Active** tab, click a task name.
2. Enter a date in the **Completed date** field to mark the task as complete.
3. Document the outcome of the task.
4. Optionally enter comments.
5. Click **Accept**.

NOTE: If you want to quickly document that you completed a task today without having to enter the date or document an outcome click "Complete".

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Mark a Completed Task as Active

If a task was mistakenly completed, you can mark it as active so that it appears on the **Active** tab.

1. **On the Completed tab, click a task name.**
2. **Clear the Completed date field.**
3. **Click Accept.**

Document a note (Post-Discharge Clinician Only)

You can document notes to provide more information about the care that you provide for a patient. For example, you might call a patient and then write a note that details your conversation. Other clinicians can then see this note, so they stay informed about the patient's care.

1. **Select the Patient tab and then click Notes from the activity menu.**
2. **Click Add to document a new note.**
3. **If you need to create an addendum for notes that you recently signed, click the link in the note preview to open it for editing.**

NOTE: If you need to see notes that you previously deleted, click "Show deleted"

Review a Care Plan

The Care Planning activity uses a hierarchical structure to show you all the problems, goals, and interventions that comprise a patient's care plan. All the problems in the care plan appear with their associated goals below them. Next to each goal, an icon appears to indicate the patient's progress toward meeting the goal. If the progress of a goal is on track, 🎄 appears next to the goal name. If the goal is not on track, 🧍 appears instead. If the progress of a goal hasn't been assessed, 🧍 appears.

If a goal is marked as long-range, any short-term goals that are linked to it appear below it.

Below each goal, the related interventions appear, which correspond to tasks.

If you want to see only the associated problems for the care plan, click Collapse All to hide the goals and tasks. You can then click the row of each individual problem to expand its associated goals, and then click the row of each individual goal to expand its associated tasks. If you want to see all the problems, goals, and tasks for the care plan again, click **Expand All.**

NOTE: Only one care plan appears in the activity at a time. To view a different active care plan for the patient, select it from the menu at the top of the activity.

The patient might have some care plans that were previously marked as complete or were deleted. To review these care plans, click "Show Completed" or "Show Deleted" and then select the care plan from the menu at the top of the activity.

You can also use the "Show Completed" amd "Show Deleted" buttons to view any previously completed or deleted problems, goals, or tasks related to the care plan that you're currently viewing.

Add a Care Plan

Click New Care Plan to search for a care plan to add for the patient. After you select a care plan, it's added along with all the associated problems, goals, and tasks.

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Modify the care plan

You can edit components of the care plan, such as problems and goals, to mark them as complete. You can also add components to document additional treatment that the patient needs.

- To add a problem to the Care Plan, click **New Problem.**
- To add a goal to a care plan problem, click **New Goal** next to the corresponding problem.
- To add a task to a goal, click **New Task** next to the corresponding goal.

To edit a given component of the care plan, click the component name. A window then appears where you can edit details about the component. For example, you might edit a problem to mark it as resolved.

Click **Edit Care Plan** to edit information about the entire care plan, such as its name, or to mark the care plan as completed or to delete it.

NOTE: If you want to quickly document that you completed a task today without documenting additional details, click ✔ in the row corresponding to the task.

If you want to delete a task, click 🗑 Delete.

You can reactivate any tasks that you complete or delete by using the Show Completed and Show Deleted buttons at the top of the activity to view the task, and then clicking ↰.

Post-Discharge Care Referrals

Affiliate post-discharge care facilities can use EpicCare Link to connect directly with case managers and help ensure that discharged patients experience a seamless transition of care to post-discharge care facilities.

The post-discharge care clinician is a specialized user intended for clinicians who work in post-discharge care facilities, such as nursing homes, hospice care, and skilled nursing facilities. In EpicCare Link, the post-discharge care user opens a request via In Basket sent from a Trinity employee who is preparing a patient for discharge. You can review the report about the patient and then accept or decline the request for placement.

If you accept the placement, and the Trinity employee selects your facility to receive the patient, you receive access to the patient's chart in EpicCare Link.

Respond to a service request

1. Open your Service Requests In Basket folder.
2. Review each message.

- Click **Accept** of **Decline** depending on whether you can provide the requested service. If you decline, you're prompted to enter a reason for declining the request.
- If you need more information before you decide, click **"Reply"** to send a message back.
- Tip: set up text notifications in the chapter *Updating Program Settings*