

Overview

Based on certain milestones within a patient's care process, the status of a patient can change from registered (REG), referred (REF), admitted (ADM), etc. These assigned status levels are based on a variety of actions (i.e., completing a referral, starting a SOC visit, entering a discharge date). In addition to these main status levels, agencies may also further classify patients with particular labels that aid in ensuring patients receive special attention. The following information describes how the status and classification of patients is managed.

Patient Status Abbreviations

Each patient in NDoc has an assigned status. This status determines what functions are accessible and what may be charted. The following table defines each status and how this affects NDoc functionality.

STATUS	FUNCTIONALITY
ADM (Admitted)	Patient has been admitted, but not discharged. All active patients remain on admitted status until a discharge is charted in NDoc. All charting modules are accessible. Admitted patients automatically download to assigned users' client device during data synchronization.
CAN (Cancelled)	When cancelled, patients are inaccessible in routine searches and accessing charting routines prompts messaging preventing access to the functionality. Each agency can determine how they wish to apply this status to patients. One example of use would be to remove an accidental duplication of a patient. The cancelled patient is not exported through any interfaces (OASIS, billing, Telehealth, etc.). You can view them in some reports. When a cancelled patient is un-cancelled, they go to ADM or REF status.
DSC (Discharged)	Patient converts to discharged status upon choosing Discharge Patient in Patient Status. Patients discharged from one discipline, but remaining open to another remain in admitted status. Patients who are DSC status continue to download during data synchronization for several additional days, allowing the user time to complete all necessary paperwork relating to the discharge.
HLD (Hold)	Some patient referral information has been charted, but Referral is incomplete and has been filed as a "Hold" (used when hospital discharge/agency admission is pending, admission is uncertain or charting is not yet complete). No referrals have been charted in Patient Status.
REF (Referred Not Yet Seen)	Patient has a completed referral in the system, but has not had any visits charted, thus is considered by NDoc to be "referred, but not yet seen". All charting modules are accessible.
REG (Registered)	Patient has been assigned an account (ID) number; no NDoc charting has been recorded.
RNS (Referred but Never Seen)	Patient has been referred, but will never be seen. When these patients have a RNS reason entered in Patient Status, the status becomes RNS. (please note that RNS patients may not have any charted visits)
SNA (Seen but Not Admitted)	Patient was referred and had an initial visit, but was not accepted for admission. When these patients have a SNA reason entered in Patient Status, the status becomes SNA. (please note that SNA patients must have only one charted visit)
TRF (Transferred)	Patient has a transfer date charted but does not have a corresponding ROC date charted or has been discharged.

Patient Status Functionality Basics

Managing a patient's status requires an understanding of the activities that occur in the NDoc Patient Status function. This option is available within multiple modules for ease in access:

- Care Pilot>Patient Disciplines

- Administration>Patient>Patient Disciplines
- Operations>Patient>Patient Disciplines

Within Patient Status, the following are the actions users can take related to setting or changing a patient's status:

- Document Transfer or ROC dates
- Apply certain statuses to a patient based on specific parameters:
 - **SNA (Seen and Not Admitted)** - Changes patient status and only allowed based on these parameters:
 - Patient status is not canceled (CAN) or discharged (DSC).
 - If this is a Homecare patient, they must have one to two visits.
 - If this is a Hospice patient, they must have one to three visits.
 - **RNS (Referred and Never Seen)** - Changes patient status and only allowed based on these parameters:
 - Patient status is not canceled (CAN) or discharged (DSC).
 - If this is a Homecare patient, they must have no charted visits.
 - If this is a Hospice patient, they can have up to one visit, and cannot have a status of admitted (ADM).

NOTE: Once the SNA or RNS status is applied to the patient record, the action cannot be reversed. To restore the account, the patient must be registered again. Users should see that previous SNA or RNS account to then use as the link to set up this new record for charting. For cases of SNA accounts, agencies can also use the Move Visit function to move the visit to the new account. If agencies wish to remove the original SNA or RNS from tracking, they can take the step to make them a Cancelled patient.

- Chart the Discharge date along with any discharge planning narrative fields
- For hospice accounts, the Admit to Hospice and documenting of Level of Care occurs here.
- Perform certain tasks:
 - Unfile Referral – places a completed Patient Referral on hold
 - Cancel Patient – Removes a patient from active searches. This action carries substantial consequences so it should be used judiciously.
- Modify charted dates, hospice admission charting, cancel discharges, SNA, and RNS

For additional guidance on how to navigate within the Patient Status function, please refer to the internal help text via the help text using the ? icon.

Special Functions within Patient Status – Unfile Referral and Cancel Patient

The Patient Status function includes two unique actions that are strictly controlled by permissions. These two activities are Unfile Referral and Cancel Patient. Specifically, access to the functionality and the ability to see the buttons to perform these actions are permissions based. User types that are assigned these functions are set up within the User Access Control settings under Administration>System>Settings. Each are described below:

Unfile Referral

This option allows users to place a completed referral on hold in order to make changes. The specifics are described in the Editing a Referral section under **Error! Reference source not found..** Additional details are available via the help text using the ? icon.

Cancel Patient

This function allows agencies to remove a patient from the system. Additional details are available via the help text using the ? icon. The following are important considerations when employing this option:

- **Reasons to Cancel:** Agencies may establish internal procedures to qualify a patient for cancelled status (e.g., a patient may have been entered into the system more than once accidentally).
- **Before Using the Function:** Have the account number available and consider inserting a note into the Patient Alert located under the Patient Profile function. The Patient Alert is viewable in the Patient Summary accessed via the Start Menu, Patient Header and via hyperlinks in certain reports.
- **What Happens When a Patient Is Cancelled:** The patient moves to CAN (Cancel) status. When cancelled, patients are inaccessible in routine searches and accessing charting routines prompts messaging preventing access to the functionality. To access these accounts, open the Patient Search filter and select the “CAN-Search CANCELLED Patients Only” filter.
- **When it Can Be Used:** A patient cannot be cancelled if:
 - They have more than two charted visits. Deleted visits do not count.
 - Someone is currently charting on the patient at the agency.
 - There is unprocessed charting remaining on the server (use Administration>Patient>Process Patient Now).
- **Important Considerations and Impact of Cancelling:**
 - All scheduled visits are deleted and non-recoverable.
 - Any charted visits are deleted, but can still be viewed using Reports> Patient>Patient Record
 - Deleted (Visit) routine.
 - Any visit charting on a clinician’s client device is lost if the patient is changed to cancelled status on the server before the client syncs.
 - Patients cancelled on the server are flagged for deletion from a user’s client device. Once the cancellation has been processed on the server and the user performs a sync, the patient is no longer accessible on the client device.
 - Cancelled patients are not exported via any interfaces to 3rd party programs (ex: OASIS, billing, Telehealth, etc.) and to prevent issues with the billing the account’s SSN is changed to 999-99-9999.
 - Cancellation of the patient cannot be reversed. Users are warned to confirm whether they wish to proceed. If the cancellation occurs, users can register the account again as the cancelled option will display as a match in registration. Additionally, users can view charted visits via Reports>Patient>Patient Record (Deleted Visit) for reprinting and charting if necessary.

Patient Status Settings

Located under Administration>System>Settings>Patient Status, the following is a breakdown of the settings page:

RNS (Referred but Never Seen) Settings

Allow users to error physician orders?:	☒ Yes ☐ No
Allow users to error medication orders?:	☒ Yes ☐ No
Discharge disciplines with Reason:	(Select) ▼

These settings allow an agency to manage RNS charting, including:

- Allowing users to automatically error/delete either all physician orders or all medication orders (or both) when charting an RNS patient. If agencies prefer not to allow clinicians to trigger those order changes, select NO.
- Designate the Discipline Discharge Reason (from the Discipline Discharge Reason – Administration>System>Tables) to be automatically applied to the disciplines when charting RNS.

SNA (Seen but Not Admitted) Settings

Allow users to error physician orders?:	☒ Yes ☐ No
Allow users to error medication orders?:	☒ Yes ☐ No
No charted visits required for hospice patients?:	☒ Yes ☐ No
Discharge disciplines with Reason:	(Select) ▼

These settings allow an agency to manage SNA charting, including:

- Allowing users to automatically error/delete either all physician orders or all medication orders (or both) when charting an SNA patient. If agencies prefer not to allow clinicians to trigger those order changes, select NO.
- Handling visits for hospice SNA patients is a little different because the admit to hospice process is different. In this case, if users are able to chart a SNA for hospice patients that has no charted visits then YES should be checked. If not, then set the option to NO and hospice patients must have at least one visit charted.
- Designate the Discipline Discharge Reason (from the Discipline Discharge Reason – Administration>System>Tables) to be automatically applied to the disciplines when charting SNA.

Transfer (without Patient Discharge) Settings

Require Location?:	☐ Yes ☒ No
Require Facility?:	☒ Yes ☐ No
Allow users to delete incomplete physician orders?:	☒ Yes ☐ No
Allow users to discontinue physician orders?:	☒ Yes ☐ No
Allow users to place physician orders 'On Hold'?:	☒ Yes ☐ No
Allow users to delete incomplete medication orders?:	☒ Yes ☐ No
Allow users to discontinue medication orders?:	☒ Yes ☐ No
Allow users to place medication orders 'On Hold'?:	☒ Yes ☐ No
Allow users to delete uncharted scheduled visits?:	☒ Yes ☐ No

These settings allow an agency to manage transfer options, including:

- Set required logic for location and/or facility when charting a transfer
- Allowing users to automatically manage (i.e., delete incomplete, discontinue, place on hold) all physician orders or all medication orders (or both) when charting a transfer. If agencies prefer not to allow clinicians to trigger those order changes, select NO.
- Provide option to delete uncharted scheduled visits at transfer.

ROC (Resumption of Care) Settings

Carry forward Anticipated 1st Visit Date?:	☒ Yes ☐ No
Allow users to resume physician orders that were placed 'On Hold'?:	☒ Yes ☐ No
Allow users to resume medication orders that were placed 'On Hold'?:	☒ Yes ☐ No

These settings allow an agency to manage ROC charting, including:

- Carrying forward the value of the last anticipated first visit date.
- Allowing users to automatically resume physician orders or medication orders (or both) that were placed on hold in the course of charting the transfer.

Discharge Settings

Require Location?:	☒ Yes ☐ No
Require Facility?:	☒ Yes ☐ No
Allow users to delete incomplete physician orders?:	☒ Yes ☐ No
Allow users to discontinue physician orders?:	☒ Yes ☐ No
Allow users to delete incomplete medication orders?:	☒ Yes ☐ No
Allow users to discontinue medication orders?:	☒ Yes ☐ No
Discharge Date - maximum number of days in the past allowed:	3
Discharge Date - maximum number of days in the future allowed:	4
Allow users to discharge patient with referred disciplines?:	☒ Yes ☐ No
Discharge disciplines with Reason:	therapeutic goals attained ▼
Allow users to create a 'discharge patient' physician order?:	☒ Yes ☐ No
Default 'discharge patient' Order Text:	
This is the default discharge patient order text entered in Patient Status Settings	

These settings allow an agency to manage discharge charting, including:

- Set required logic for location and/or facility when charting a discharge
- Allowing users to automatically manage (i.e., delete incomplete or discontinue) all physician orders or all medication orders (or both) when charting a discharge. If agencies prefer not to allow clinicians to trigger those order changes, select NO.
- Setting the maximum number of days in the past that users can chart a discharge date. Note this entry cannot be more than 300 days in the past.
- Setting the maximum number of days in the future that users can chart a discharge date. Note this entry cannot be more than 10 days in the future.
- Allow users to automatically discharge the referred disciplines when charting a discharge. If agencies prefer to have the disciplines discharged prior to charting, then select NO.
- If the automated discharge is selected, agencies must select the Discharge Reason that will be used when the active disciplines are automatically discharged. Reasons labeled with an asterisk * are inactive entries within the Discharge Reason Table.
- Allow users to create a discharge service physician order - Y/N. This controls if a user can automatically add a Discharge Patient Order when discharging a patient within the Patient Status routine. If not, set the option to No. Note: if yes, the option exists to add default text to discharge patient order.

Priority Code

Priority Codes entries reflect the patient's need-for-service hierarchy in the event of a disaster and may be used to help prioritize patients that need to be reassigned due to the unexpected absence of an employee. The codes are assigned via:

- Visit Charting/Sign-On and Sign-Off screens
- Data Entry/Non-NDoc Visit Charting
- Modify Charted Visit

The assigned codes are then reflected within Patient Summary under the Demographics tab and within a variety of reporting tools (Census Report, Emergency Preparedness, etc.). The available codes are the product of the Priority Code table located under Administration>System>Tables and are editable to conform to agency policy.

Priority Code Table Edit Mode: ☐ Add ☒ Change

Number:

Status: ☒ Active ☐ Inactive

Abbreviation:

Text:

Note: This is a pre-built table consisting of 1-6 codes. The contents were reviewed upon implementation. Edits made to the existing codes will be applied to all entries. Use the Edit Mode – **Add** or **Change** buttons to control actions.

Users only see the **Abbreviation** text within the drop-down screens.

Priority Code Table Edit Mode: ☐ Add ☒ Change

Number:

Status: ☒ Active ☐ Inactive

Abbreviation:

Text:

On-Call Priority Code

On-Call Priority levels are designed to draw attention to On-Call events and rank the hierarchy of need. The codes are charted within Patient Activity during the course of entering On-Call Activity and the codes are based on a pre-built, editable table under Administration>System>Tables>On-Call Priority and are reported within the Patient Activity Reports.

On-Call Priority Table Edit Mode: ☐ Add ☒ Change

Show: ☒ Active Only ☐ Inactive Only ☐ All

Select:

Number: Description:

Status: ☒ Active ☐ Inactive

Cancel Save

Add On-Call

Date: Start Time: End Time:

Reason: Other Reason:

☒ Inbound ☐ Outbound

From: Name:

To: Name:

Priority:

Visit:

Summary:

☐ Disc notified ☐ Pt/cg/f medical

☐ Order Written

Transportation Assistance Level (TAL) Classifications – [New York Regulation]

Overview

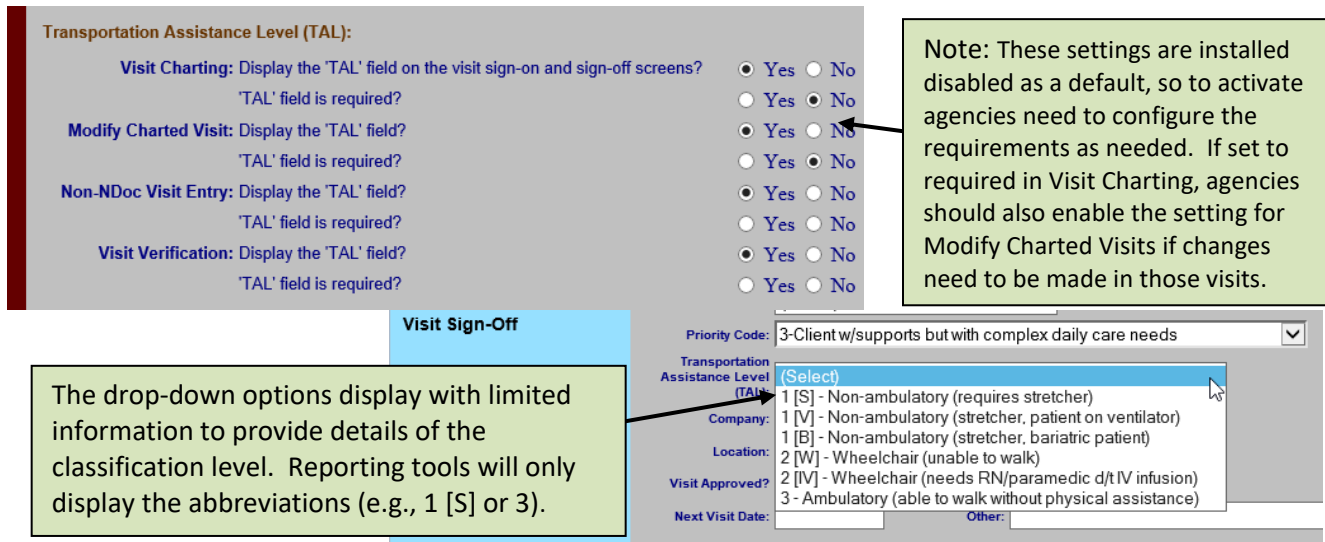
Effective June 1, 2016, all home care and hospice agencies in the State of New York were required to classify patients with one of three transportation assistance levels. The classification system was designed to provide a snapshot of the transportation needs of patients to improve emergency preparedness efforts. The classification system was broken down into three basic categories - non-ambulatory, wheelchair, and ambulatory. With an **announcement** in September 2017, the New York State Department of Health announced the intention to revise the classifications for greater specificity. The TAL classifications are as follows:

TAL	Full Description	NDoc Classification Labels
TAL – 1 Non-Ambulatory	Non-ambulatory-Stretcher: Clinically unable to be moved in a seated position, and may require equipment including but not limited to oxygen, cardiac monitors, or other biomedical devices to accompany them during movement. Non-ambulatory-Vent: Clinically unable to be moved in a seated position, and require equipment including but not limited to mechanical ventilators, oxygen, cardiac monitors, or other biomedical devices to accompany them during movement. Non-ambulatory-Bariatric: Clinically unable to be moved in a seated position, and may require equipment including but not limited to oxygen, mechanical ventilators, cardiac monitors, or other biomedical devices to accompany them during movement. These patients/residents require transportation using a wider stretcher.	TAL 1 [S] - Non-ambulatory (requires stretcher) TAL 1 [V] - Non-ambulatory (stretcher, patient on ventilator) TAL 1 [B] - Non-ambulatory (stretcher, bariatric patient)
TAL – 2 Wheelchair	Intravenous infusion lines should be converted to saline locks or discontinued for transport. These patients/residents may be escorted by a non-clinical staff member. Patients/residents with a continued IV infusion must be escorted by a nurse or paramedic during transport.	TAL 2 [W] - Wheelchair (unable to walk) TAL 2 [IV] - Wheelchair (needs RN/paramedic d/t IV infusion)
TAL – 3 Ambulatory	Patients/residents able to walk the distance from their in-patient location to the designated loading area without physical assistance, and without any likelihood of resulting harm or impairment.	TAL 3 - Ambulatory

Administration (Settings and Display)

Similar to the Priority Code, the TAL classification is assigned at visit sign-off. These are fixed codes within the system, so there is no companion table accessible for edits by agencies. The presence of the codes in various charting screens can be controlled through visit settings.

To activate the TAL settings, go to Administration>System> Settings>Visits>Add/Modify Visit Settings and scroll down the page to the Transportation Assistance Level (TAL) settings.



Transportation Assistance Level (TAL):

Visit Charting: Display the 'TAL' field on the visit sign-on and sign-off screens? ☐ Yes ☒ No
 'TAL' field is required? ☐ Yes ☒ No

Modify Charted Visit: Display the 'TAL' field? ☐ Yes ☒ No
 'TAL' field is required? ☐ Yes ☒ No

Non-NDoc Visit Entry: Display the 'TAL' field? ☐ Yes ☒ No
 'TAL' field is required? ☐ Yes ☒ No

Visit Verification: Display the 'TAL' field? ☐ Yes ☒ No
 'TAL' field is required? ☐ Yes ☒ No

Visit Sign-Off

Note: These settings are installed disabled as a default, so to activate agencies need to configure the requirements as needed. If set to required in Visit Charting, agencies should also enable the setting for Modify Charted Visits if changes need to be made in those visits.

The drop-down options display with limited information to provide details of the classification level. Reporting tools will only display the abbreviations (e.g., 1 [S] or 3).

Priority Code: 3-Client w/supports but with complex daily care needs

Transportation Assistance Level (TAL): (Select)

- 1 [S] - Non-ambulatory (requires stretcher)
- 1 [V] - Non-ambulatory (stretcher, patient on ventilator)
- 1 [B] - Non-ambulatory (stretcher, bariatric patient)
- 2 [W] - Wheelchair (unable to walk)
- 2 [IV] - Wheelchair (needs RN/paramedic d/t IV infusion)
- 3 - Ambulatory (able to walk without physical assistance)

Company: Location: Visit Approved? Next Visit Date: Other:

Reporting

To assist in identifying patients classified with TAL levels, agencies can use the Priority Report or the Emergency Preparedness under Reports>Census. This report is designed for disaster preparedness efforts and reporting. The TAL classification as well as the Priority Code are included in the report. The filter options for each TAL level can be used to generate the total number of patients assigned a particular level.

Patients at Risk for Hospitalization

Overview

As patient care has increasingly focused on reducing avoidable hospitalizations and emergency department use, Thornberry Ltd. has sought to provide a variety of means by which an organization can manage their census appropriately.

Identifying “At Risk” Patients

Patients can be identified as having a “Risk for Hospitalization” via NDoc using three different approaches:

- **Field Charting** – CMS has incorporated a specific M00 question that allows agencies to flag a patient as at risk for hospitalization based on specific signs and/or symptoms. Thornberry has also included a specific **Current Status** field serving a similar function for non-OASIS charting.
 - **M1033** (DE#8210) – Charting of any value other than “10 – None of the Above” for **M1033 – Risk for Hospitalization: Which of the following signs or symptoms characterize this patient as at risk for hospitalization?**
 - **Current Status: Risk for Hospitalization** (DE#8173) – Charting of any value other than “no significant finding”
- **NDoc Score** – NDoc uses charted data that may indicate a higher likelihood of a patient being hospitalized and calculates a score based on that data. Agencies determine what score will constitute a risk value that triggers logic applied to dashboard reminders and highlighting in the patient header. The setting to control this logic is found under Administration>System>Settings>Employee Dashboard under the **Risk for Hospitalization: Include alert only when the Score is higher than:** __ setting. Each item listed below accounts for one point toward the tally of the patient’s risk for hospitalization.
 1. Diagnoses Factors
 - a. High Risk Diagnoses: Primary or one of the five secondary diagnoses contain one of a list of high risk diagnoses (I50, L98, J44, B20, E11, L89, S31.809, S31.10, S41.009, T81)

- b. Recent Diagnoses: Primary or any secondary diagnoses have an onset date within the past 30 days
 - c. More than 2 Secondary Diagnoses: Primary and first two secondary diagnoses have a value
- 2. Compliance Factors
 - a. Med Compliance: Patient non-compliance with any oral, inhalant, and/or injectable meds , based on **Medication Regimen Compliance** (DE#102035) responses
 - b. Diet Compliance: Patient non-compliance with diet based on **Dietary Intake** (DE#100945) responses
- 3. Mental Status
 - a. Current mental status includes cognitive issues, depression, confusion, disorientation, delirium and/or memory loss based on **Current Status: Mental State** (DE#183) responses
- 4. Clinical Factors
 - a. Home Therapies: Patient receives intravenous, parental and/or enteral therapy based on **[M1410] Respiratory Treatments: utilized at home** (DE#6072) responses
 - b. Dyspnea: Patient dyspneic with moderate or minimal exertion or at rest based on **[M1400] When is the patient dyspneic or noticeably Short of Breath?** (DE#6071) responses
 - c. Dyspnea since SOC: Patient dyspneic with minimal exertion or at rest, and/or requires frequent rest periods based on **New Tolerance Level** (DE#100860) responses
 - d. Catheter: Urinary catheter or Type is latex, silicone or straight based on **[M1610] Urinary Incontinence or Urinary Catheter Presence** (DE#6074) or **Cath Care – Type** (DE#100993) responses
 - e. Lung Sounds: **Lung sounds** (DE#101271-101275) responses include diminished, rales or rhonchi
 - f. Prognosis: **Prognosis** (DE#186) is poor
 - g. Med Regimen: Patient requires assist with oral, inhalant and/or injectable meds based on **Medication Regimen Compliance** (DE#102035) responses
 - h. Fall Risk: **Current Status: Risk to Fall** (DE#627) indicates a fall in the last three months
- 5. Other Factors
 - a. Inpatient Referral Source: **[M1000] From which of the following Inpatient Facilities was the patient discharged with the past 14 days** (DE#8022) indicates anything other than “NA – Patient was not discharge from an inpatient facility”
 - b. Lives alone: Response to **Patient Lives Alone** (DE#2988) indicates “Yes”
 - c. Payor Source: Payor source is Medicaid based on **[M0150] Current Payment Sources for Home Care** response
- **3rd Party** – We acknowledge that there are cases in which customers may be involved in a larger healthcare organization (ACO, etc.) that has identified an algorithm for identifying patients at risk for hospitalization. To facilitate the agency’s management of patients identified by a cooperating entity, a field has been included in Operations>Intake>Patient Referral>Source called **Identified as a risk for hospitalization by third party**. This field is also available within Administration>Patient>Special Edit should the need arise to check the box or clear it following the completion of the referral.

Results of Identifying “At Risk” Patients

Each method of identification results in NDoc reacting in specific ways to alert users of the need to manage the patients differently than others.

1. **Problem List** - Appropriate charting triggers the **Safety>risk for hospitalization** problem and the corresponding Instructions and Outcomes for only the **Field Charting** method of risk identification. Once all Instructions and Outcomes are resolved, the patient is no longer considered “At Risk.”

2. **Report** – Appropriate charting causes the patient to display on the Reports>QA>Risk for Hospitalization report for the following methods of risk identification:
 - a. **Field Charting**
 - b. **NDoc Score** (Please note: by default, any patient with a score greater than 5 is considered a risk and included on the report. However, the report allows users to change the score parameter for inclusion in the report at run to a higher or lower default value.)
 - c. **3rd Party Identification**
3. **Dashboard** – Appropriate charting causes the patient to display on the Employee Dashboard in the Risks/Alerts section with a Type of “Risk for Hospitalization” and a description indicating what caused the patient to be flagged as at risk for the following methods of risk identification:
 - a. **Field Charting**
 - b. **NDoc Score** (based on the designated Agency Setting value)
 - c. **3rd Party**
4. **Patient Header (optional)** – In order to facilitate a system wide recognition of any patient considered at risk, the status (e.g., ADM, REF) in the patient header can be highlighted, and made an active button for documentation of policies and procedures currently in place for patients at risk for hospitalization (similar to the Agency Button function) based on agency preferences located under Administration>System>Tables>Agency Button>At Risk.
 - a. **Indicate “at risk for hospitalization” in patient header: Yes/No** – If “No” is selected, no highlighting will occur. If “Yes” is selected, customers must indicate which of the three methods of risk identification they would prefer to use trigger an alert/active button in the patient header.
 - b. **Document policies and procedures in place for patients at risk for hospitalization** – If “Yes” is selected in response to **Indicate “at risk for hospitalization” in patient header**;, the resulting highlighted status in the patient header also serves as a button that can be clicked to present recorded policies and procedures relevant to the patient’s being at risk. Customers can record their policies and procedures on the **At Risk** screen under **Agency Button**.

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Removal of “At Risk” Identification

- **Field Charting** - Once all Instructions and Outcomes are resolved, the patient is no longer considered “At Risk” and will no longer display on the dashboard, in the report, or be identified as at risk via the patient header (if customer has chosen to identify in the header).
- **NDoc Score** - If charted values falls below the designated value within the Employee Dashboard Settings, the patient is no longer considered “At Risk” and will no longer display on the dashboard, in the report, or be identified as at risk via the patient header (if customer has chosen to identify in the header).
- **3rd Party** - If the check in the **Identified as a risk for hospitalization by third party** field is removed, the patient is no longer considered “At Risk” and will no longer display on the dashboard, in the report, or be identified as at risk via the patient header (if customer has chosen to identify in the header). Outside of the Referral, this field is only accessible via Administration>Patient>Special Edit.

Risk for Hospitalization Reporting (Reports>QA)

Patients listed on the report have been determined to be at higher than normal risk for hospitalization. The report sorts by status, then by team; within team by case manager, then from highest risk to lowest risk. Recognizing that each customer may find one method of risk identification more valid than another, this report can be run to display patients identified as “At Risk” based on any of the aforementioned identification methods. The report can also be run for patient by Company or Status.