Help at Home®

Care to Live Your Life.

Gather and Grow!

Admissions-

Session # 3 Post Admission Charting

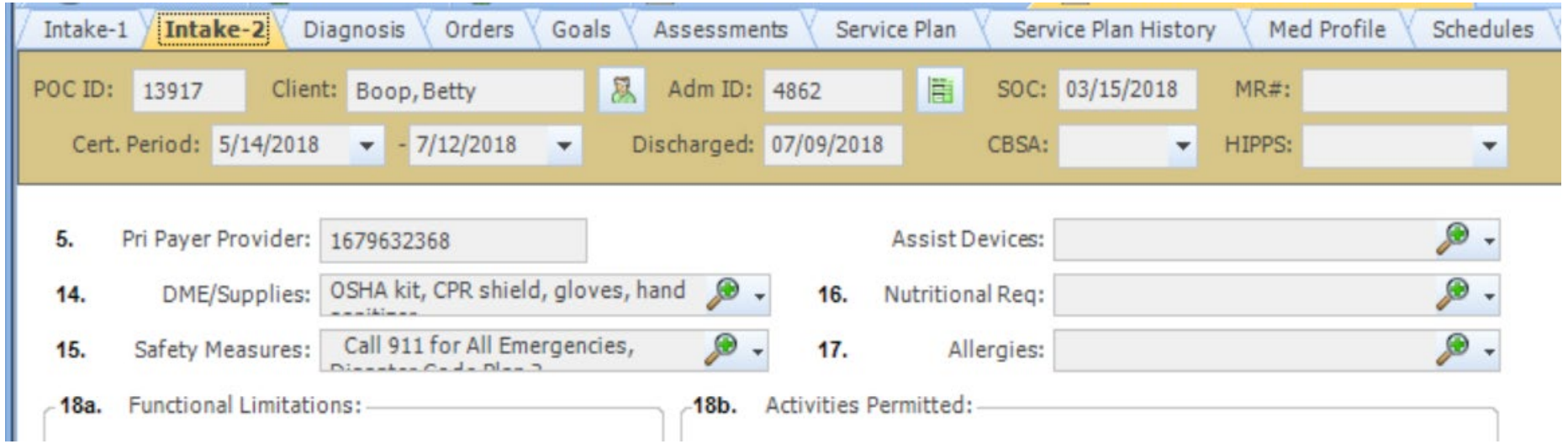
Reminders and Tips

Before visit:

- Request H&P and med list when asking for verbal and F2F

During visit:

- Comprehensive assessment is your guide. Fill it out completely in home.
- POC and Comp MUST match. Use it to plug information into POC - Intake 2.



Intake 2

Yellow Plan of Care Tab→Intake-2 Tab:

___ DME/Supplies: add any DME (i.e., walker, nebs, 02, glucometer and testing supplies, incontinence supplies, etc.) pg. 18 comprehensive assessment

___ Safety Measures: quick note (call 911, universal precautions, home safety — type in # (1,2,3,4), then add any other precautions applicable to that patient. Pg. 17 comprehensive assessment

— Assist Devices: any devices that are listed in DME /Supplies that would assist client with ADLs/iADLs/care.

___ Nutrition: type of diet, how they eat (i.e., heart healthy diet, eats by mouth). Add any special precautions (i.e., aspiration, needs to sit upright, G-tube feed type/schedule, low/med/high nutritional risk. Pg. 8 comprehensive assessment

— Allergies: pg. 1 comprehensive assessment

___ Functional Limitations/Activities Permitted. Pg. 16 comprehensive assessment

— Mental Status. Pg. 3 comprehensive assessment

— Prognosis: check what applies. Pg. 1 comprehensive assessment

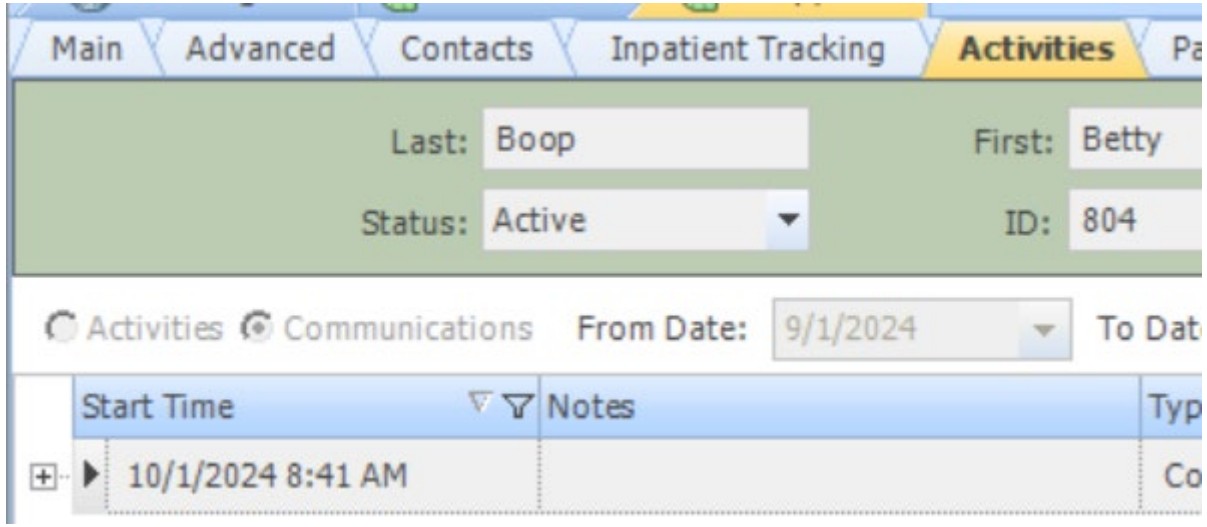
___ Advanced Directives: must enter something— if none click 'other' and type "Full Code, no advanced directives at this time" pg. 1 comprehensive assessment

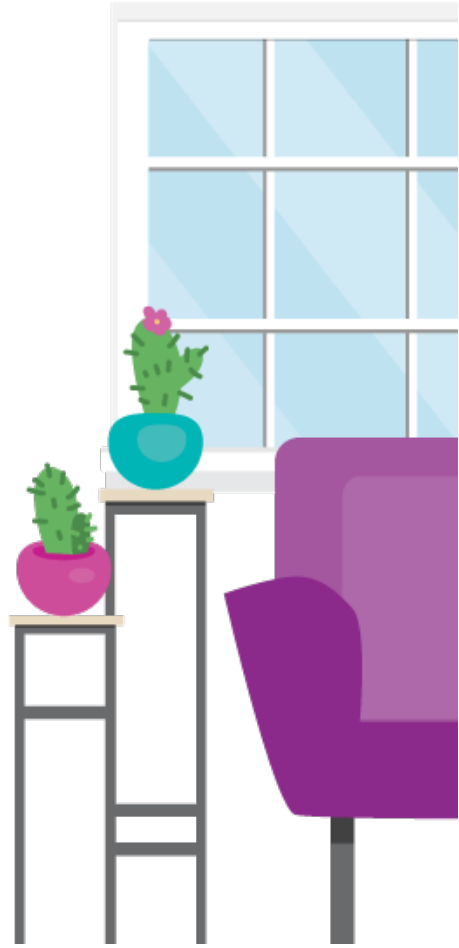
___ Cognitive/Psychosocial Status: pick which applies. Pg. 14 comprehensive assessment

___ Hospital Risk Factor — should match comprehensive assessment — needs a home health aide intervention. Pg. 20 comprehensive assessment

After Visit

- Braden and Home Safety are marked competed
- Call PCP with any changes and medications needing Dx
- Communicate change in hours to PCP and office
- **Document conversations in 'Activities-Communications'**
  - In **real time** or 'late entry' . Do not backdate.





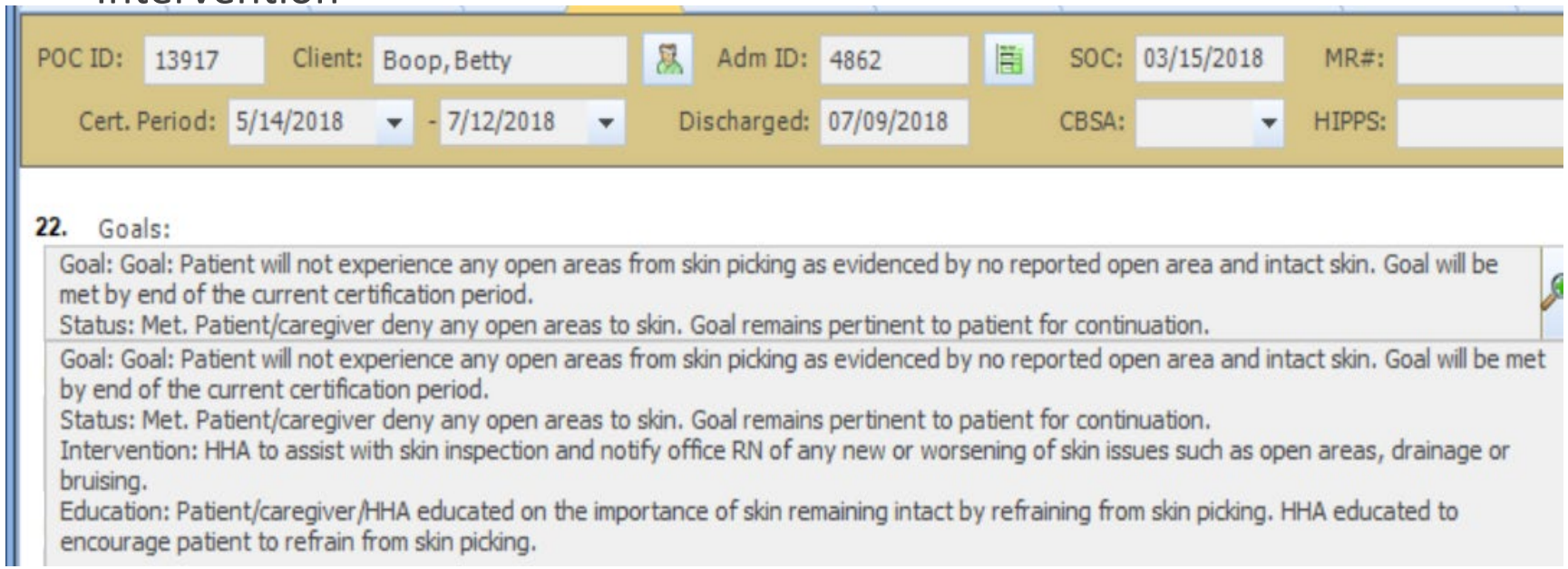
***Sign, date, and time orders before sending to PCP**

- **Care coordination**-BIG 3: Patient, PCP, HHA
- Primary caregiver (spouse), HCR (parent, guardian), POA. If not there, call
- **Education/training** provided to client and caregiver in the last 60 days. Add who you educated.
  - Education can be about anything- how we will help a patient meet their goals, education about new/changed medication, symptoms to report to PCP/RN, etc. Auditors love when our POC's are patient specific and updated from RC to RC.
- **Schedule RC, SV, QA under 'Activities-Activities'**
  - RC visit every 60 days. Enter SV if there will be >60 days between the admit and when next RC is due.
  - QA visit 30 days out

- **UBO4-2 Tab**: Add ICD-10 code for primary diagnosis in BOX 66.
- **UBO4-1 Tab**: in BOX 4, type '323' / in BOX 14 (next to admission 13 hour) type '9'.

- **Diagnosis**
  - Search ICD link
  - Check that codes are billable
  - Primary is listed first in MatrixCare

- **Agency Goals and Patient Specific Goal**
  - Goal
  - Status
  - Intervention



Timeframes According to Regulations and Policies

- Medication interaction must be sent within 24 hours of admission
  *All medication interactions must match a POC Dx
- Start of Care POC must be sent within 5 days (not business days)
- All attachments must be uploaded within 14 days of visit
- All signed orders received from physician within 60 days
- Oasis forms must be uploaded to IQIES within 30 days (send to administrator within 7 days)

Attachments Tab

- Patient Medicaid Eligibility
- MD Medicaid, NPI, and License Verification
- Admission Packet
- Face to Face Unsigned/Signed
- VSOC Unsigned/Signed
- Medication Interaction Order Unsigned/Signed

(With medication interaction report attached to order)

- Medication Profile-Signed and dated
- Completed Intake/Referral Form with RNCM Signature
- Admission Booklet Signature Page
- Client Signature Form
- Fax Success-Orders to physician
- Care Coordination Fax Success
- BAA, if applicable
- POA Documentation, if applicable
- Advance Directive, if applicable

- Medicaid Portal Access email Shirley Driscoll: sdriscoll@helpathome.com

Copies in sleeves for home binder

- Individual Emergency Plan form
- All consents from admission packet
- Home Safety Evaluation
- Plan of Care
- HHA Service Plan
- Med Profile
- Med Interactions
- Patient Admission Booklet (with information completed for administrator)
- Advanced Directive (if applicable)
- Printed HHA Schedule for next 30 days
- Specialty manuals if applicable (hoyer, ceiling lift, sit to stand, etc)

Help at Home Knowledge Center Links

PA Admission Checklist – Help at Home Knowledge Center

MatrixCare: Creating a PA Plan of Care (POC) – Help at Home Knowledge Center

Admission Charting Documents – Help at Home Knowledge Center

Clinical Audit Tool_5.16.23.pdf (helpathome.com)

Free 2024 ICD-10-CM Codes (icd10data.com)

Date Duration Calculator: Days Between Dates (timeanddate.com)

medicaid reimbursement spreadsheet - 7-2024 update.xlsx (sharepoint.com)

Clinical Timelines According to Regulations & Policies – Help at Home Knowledge Center

MatrixCare: Emergency Management Category Guide – Help at Home Knowledge Center