



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-1	Intake-2	Diagnosis	Orders	Goals	Assessments	Service Plan	Service Plan History	Med Profile	Schedules		
POC ID:	13917	Client:	Boop, Betty	Adm ID:	4862	SOC:	03/15/2018	MR#:			
Cert. Period:	5/14/2018	-	7/12/2018	Discharged:	07/09/2018	CBSA:		HIPPS:			
5. Pri Payer Provider:	1679632368	Assist Devices:		14. DME/Supplies:	OSHA kit, CPR shield, gloves, hand	16. Nutritional Req:		15. Safety Measures:	Call 911 for All Emergencies, Disaster Code Blue	17. Allergies:	
18a. Functional Limitations:		18b. Activities Permitted:									

Intake 2

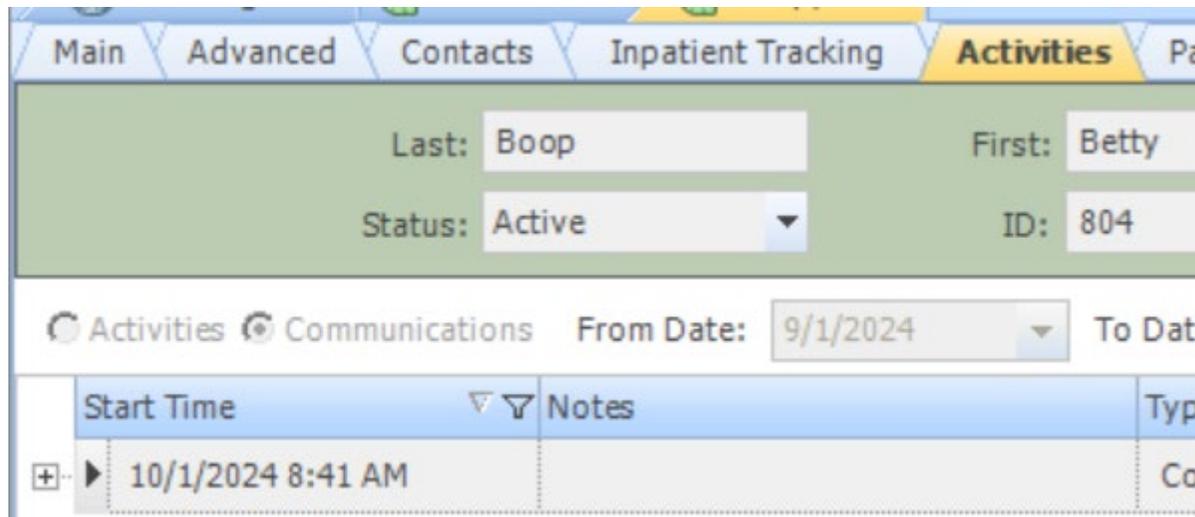
Yellow Plan of Care Tab→Intake-2 Tab:

- ___ DME/Supplies: add any DME (i.e., walker, nebs, O2, 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

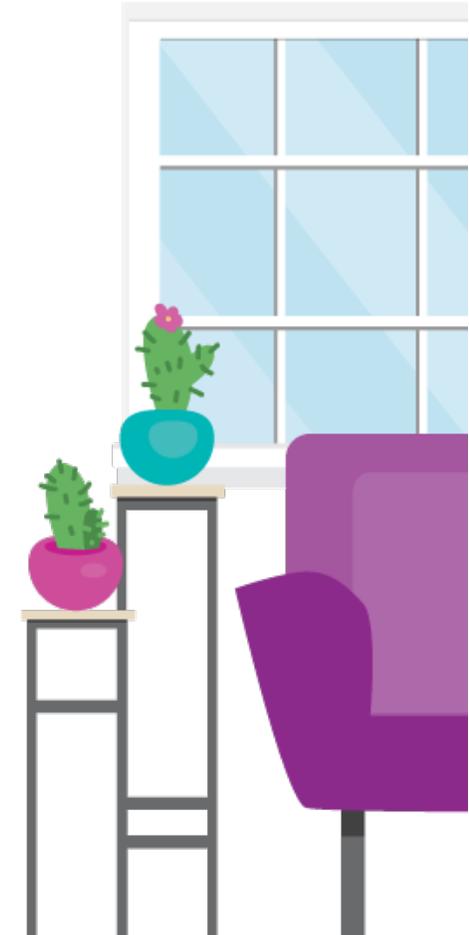
- Braden and Home Safety are marked competed
- Call PCP with any changes and medications needing Dx
- Communicate change in hours to PCP and office
- **Document conversations in ‘Activities-Communications’**
 - In **real time** or ‘late entry’ . Do not backdate.



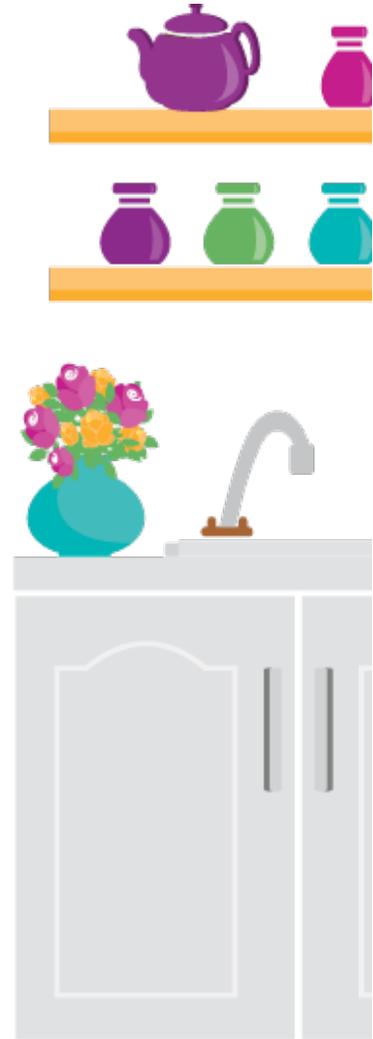
The screenshot shows a software interface with several tabs: Main, Advanced, Contacts, Inpatient Tracking, and Activities. The 'Activities' tab is selected. Below the tabs, there are input fields for patient information: Last: Boop, First: Betty, Status: Active (dropdown), and ID: 804. Below this, there are radio buttons for 'Activities' and 'Communications', with 'Communications' selected. There are also 'From Date' and 'To Date' dropdowns, with 'From Date' set to 9/1/2024. At the bottom, there is a table with columns for Start Time, Notes, and Type. The first row in the table shows a start time of 10/1/2024 8:41 AM.

Start Time	Notes	Type
10/1/2024 8:41 AM		Co

***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'.



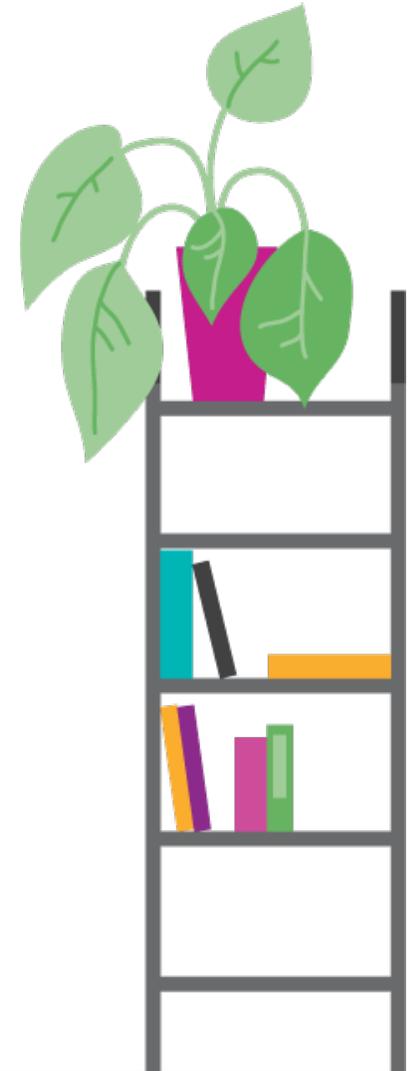
- **Diagnosis**
 - ◆ Search ICD link
 - ◆ Check that codes are billable
 - ◆ Primary is listed first in MatrixCare
- **Agency Goals and Patient Specific Goal**
 - Goal
 - Status
 - Intervention

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22. Goals:

Goal: Goal: Patient will not experience any open areas from skin picking as evidenced by no reported open area and intact skin. Goal will be met by end of the current certification period.
 Status: Met. Patient/caregiver deny any open areas to skin. Goal remains pertinent to patient for continuation.

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 Status: Met. Patient/caregiver deny any open areas to skin. Goal remains pertinent to patient for continuation.
 Intervention: HHA to assist with skin inspection and notify office RN of any new or worsening of skin issues such as open areas, drainage or bruising.
 Education: Patient/caregiver/HHA educated on the importance of skin remaining intact by refraining from skin picking. HHA educated to encourage patient to refrain from skin picking.



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)

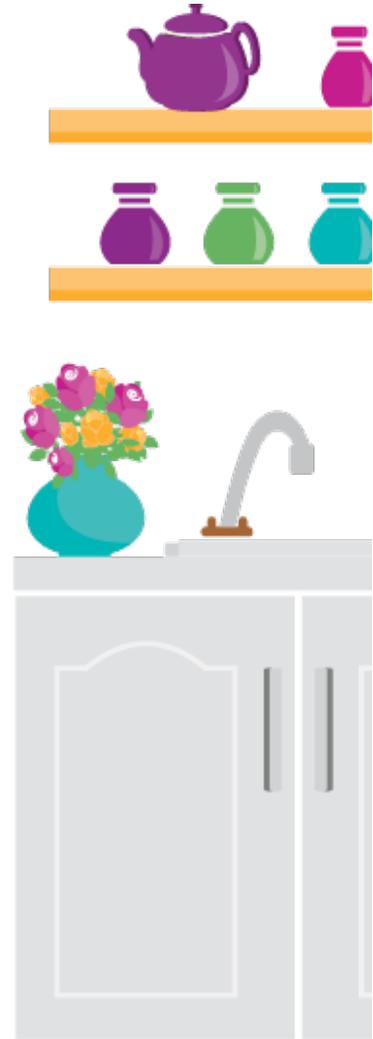


Attachments Tab

- 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@helppathome.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](#)