



Help *at* Home[®]
Care to Live Your Life.

GATHER & GROW - Q1 2025

Care Coordination

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Care Coordination – Overview

- *Purpose of Care Coordination*
- *Who to coordinate with and When*
- *Where to document care coordination*
- *Business Associate Agreements*
- *Transfer summaries*
- *Decreasing PA hours*
- *Coordination at discharge*



Care Coordination – What and Why

WHAT DOES IT MEAN –

- **Coordinating** care is the organization of patient care activities between the client and other participants in their healthcare to **improve** the patient’s overall quality of care.

WHY WE HAVE A “CARE COORDINATION” PROCESS –

- This **promotes** greater quality, safety, and efficiency of care, resulting in improved outcomes for the patient.
- **Decreases** chance for duplication of services.
- **Focus** on the exchange of information between disciplines.

HOME HEALTH CoPs -

- **484.60(d) Standard: Coordination of care.** The HHA (HOME HEALTH AGENCY) must:
 - 484.60(d)(1) **Assure communication** with all physicians involved in the plan of care.
 - 484.60(d)(2) **Integrate orders** from all physicians involved in the plan of care **to assure the coordination** of all services and interventions provided to the patient.
 - 484.60(d)(3) **Integrate services**, whether services are provided directly or under arrangement, to **assure the identification** of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.
 - 484.60(d)(4) **Coordinate care delivery** to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.
 - 484.60(d)(5) **Ensure** that each patient, and his or her caregiver(s) where applicable, **receive ongoing education and training** provided by the HHA (agency), as appropriate, regarding the care and services identified in the plan of care. The HHA (agency) must **provide** training, as necessary, to ensure a timely discharge.

[Coordination of Care_Adaptive](#)

[Coordination of Care_Help at Home](#)



Care Coordination – Who to Coordinate with and When

WHO -

#1 – HHA always.

One of THE MOST IMPORTANT persons you can coordinate care with. Include ALL routine caregivers (or the Skilled Nurse if applicable).

Will document the discussion and best practice is to also update the service plan with any specifics.

#2 – PCP always.

The provider that ORDERS our services for the client.

#3 – Patient always (or the Patient's POA, HCR, Informal/Primary Caregiver, if applicable).

Important for clients who are unable to make their own medical decisions, even if they are NOT involved in their care.

The client has a right to be involved in the development of the plan of care and any changes in that plan. At a minimum, the client agrees to the plan of care prior to the beginning of services and as subsequent changes occur.

#4 - Others (this includes those in the home and outside the home) –

■ **Specialists/Medical Provider**

- ◆ Cardiology? Pulmonology? Oncology? How often?

■ **Outpatient Services**

- ◆ Wound center? Dialysis center? Infusion center? Pain center? How often and what do they manage?

■ **In Home Agencies *** we want to SPEAK with these agencies, not just fax a POC *****

- ◆ unskilled providers (Personal Care Agency/Waiver/Supported Living)
- ◆ skilled providers (PT/OT/ST/SN, Hospice) What days? Payer source? How many total hours? Plan to continue/discharge?

WHEN –

SOC, RC and with changes. May be completed as often as necessary, but at least every 60 days, to review all areas of client needs.

Care Coordination – Where to Document Care Coordination

Where -

#1 – Comprehensive Assessment Always.

Care Coordination section (or OASIS Summary Checklist)

Care Coordination (Practitioners/Care Provider/Services Provided)			
Name: Dr. Smith	Name: Help at Home Companion Care	Name: Interim	Name: Stella
Specialty: PCP	Specialty: ATTC hours	Specialty: Skilled nursing	Specialty: Help at Home HHA
Service Provided: Primary care	Service Provided: 150 hours/month	Service Provided: F/C care- 3x/week	Service Provided: HHA services
Phone Number: 812 867 5309	Phone Number: 812 314 2205	Phone Number: 317 867 5309/317 123 4567	Phone Number: 812 314 2205

Dr. Sharma- pulmonologist- manages COPD/asthma. POC will be faxed for care coordination. Reviewed POC with patient and HHA in person at visit. Reviewed POC with care supervisor Charlotte via email on 9/29/22. POC will be faxed to Interim for care coordination. Interim provides foley cath changes/management 3 times/week.

#2 - POC Always.

Orders section above the Admission Summary
BEST PRACTICE – add it to the 60-day summary

Care Coordination- Dr. Vucescu is the patient's primary physician. Visit completed on 9/9/22. Spoke with Olivia from Dr. Vucescu's office on 9/7/22 at 1:25pm for VSOC for home health services for 4 hours of service 7 days a week over the next 60 days. To include assistance with personal care, meal prep, light housekeeping, etc. Patient participated in the plan of care.
Care Coordination with Courtney Crouch, CS, regarding 120 waiver hours through Help at Home Companion Care. Amedysis- nursing services for wound care 3x/week, PT and OT pending- POC will be faxed for coordination. Dr. Montgomery- podiatrist- manages wounds on feet- POC will be faxed for care coordination. Reviewed POC with patient, HHA Susan (working ATTC hours) at visit.

#3 - Communication notes in the client Activities tab

Type will be care coordination

Start Time	Notes	Type	End Time	Share Level	Modified On	Modified By	Created On	Created By
2/25/2025 3:49 PM	Spoke with Joe, RN at Interim Ho...	Care Coordina...	2/25/2025 4:04 PM	Everyone	2/25/2025 3:49 PM	mbundy	2/25/2025 3:49 PM	mbundy

#4 – Attachments

upload fax confirmation sheets for all shared POCs. Ask for theirs in return

type	Sub Type	Notes	Browse	View	Thumbnail	Share level	Format
Document		client medicalid 12.20.24				Everyo...	.pdf
Document		original vsoc 12.20.24				Everyo...	.pdf
Document		recert home obs tool 12.20.24				Everyo...	.pdf
Document		fax success vsoc 12.20.24				Everyo...	.msg
Document		recert med list 12.20.24				Everyo...	.pdf
Document		original poc 12.22.24				Everyo...	.pdf
Document		fax success poc 12.22.24				Everyo...	.msg
Document		Care Coord: Dr.Raza Cardiology fax success				Everyo...	.msg
Document		Care Coord: Dr.Craig Pain Management fax success				Everyo...	.msg
Document		Care Coord: Dr.Moore Neuro fax success				Everyo...	.msg

Care Coordination – Business Associate Agreements

- Important part of coordination and worth 15 points on your RNCM quarterly audit under care coordination
- Complete for coordination purposes and establishes primary agency
 - Also provides information related to coordinating shared HIPAA data and process of notifying other agency of HIPAA breaches
- Primary Agency-The higher service level
 - Medicare or skilled services
 - HHA over Waiver
- Complete BAA for any other in-home providers
 - BAA is required for waiver services provided through HAH/Adaptive or through outside agency.
 - Assisted living facilities, hospice, skilled agencies, group homes, etc.
- Once signed by administrator and business associate, upload to the admission cert period
- What if the other agency refuses to sign or does not return BAA?
 - Always notify the other agency you are sending a BAA
 - Fax the BAA a few times (2-3) and call to follow up if it is not returned
 - Have administrator sign BAA
 - Upload copy signed by admin to admit cert period
 - Upload fax success to verify BAA sent to outside agency

HHA- usually our agency

PDN- for extended hourly nursing versus sending a home nurse for med box refill, cath management etc.

Companion Care- ATTC/HMK or DD waiver services (through our agency or outside agency)

Skilled intermittent home health- PT/OT/SN for med box refills, etc.

Hospice-

Assisted living- use for an assisted living or for group homes. (Can update the responsibilities/services to reflect what you need)

PRELIMINARY STATEMENTS

The purpose of this agreement is to provide coordination for services being offered between two or more agencies. The following agency will assume responsibility to ensure client safety, client is receiving appropriate services for their care, and be accountable as the primary agency in the patient care:

Agency: _____

Patient: _____

Responsibilities	Help at Home	
Primary Agency		
Private Duty Non-Medical HHA <ul style="list-style-type: none"> • Extended hourly • Personal care • Light housekeeping • ADL assistance 	***	***
Private Duty Nursing <ul style="list-style-type: none"> • Extended hourly • Personal care • Medication administration • Wound care • Enteral feedings • Infusion Therapy • Physician plan of care 	***	***
Companion Care <ul style="list-style-type: none"> • Housekeeping • Errands • Companionship 	***	***
Skilled Intermittent Home Health Services <ul style="list-style-type: none"> • Case Management • Skilled nursing, PT, OT, ST 	***	***
Home Health Hospice <ul style="list-style-type: none"> • Case Management • Skilled nursing, PT, OT, ST 	***	***
Assisted Living Community <ul style="list-style-type: none"> • Housing • Medication Administration 	***	***



Care Coordination – Transfer Summaries

- Purpose: To assure continuity of care by providing pertinent information to another health care provider or facility when a client's needs cannot be met by the agency

Send when patient is admitted to hospital/skilled facility or when discharging services

- Send within 24 hours of knowledge of transfer
- **Call other agency to coordinate care and give report to a nurse**
 - Document nurse name and time report given in MatrixCare
 - If unable to speak to a nurse document the request to give report in MatrixCare
 - Get fax number and send the transfer summary
- **Fax transfer summary and required forms:**
 - med profile, current POC, advance directives/code status forms
- **Upload original transfer summary, fax success of transfer summary, and required forms to attachments**
- **Fill out info based on most recent comp assessment**
- **Document additional details on potential discharge home in MC communications during their entire stay**
 - Include if discharged to another hospital or skilled facility
 - Call at least 1x/week for an update on patient's potential discharge from facility

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Transfer Summary Form

Transfer From: HELP AT HOME Date of Transfer: _____
Transfer To: _____ Report Given to: _____ Fax# _____
Patient's Name: _____ DOB: _____ Gender: Male Female
Status of Patient at Time of Transfer: Good Fair Guarded Poor
Client Emergency Contact: _____ Relationship: _____ Phone# _____
Contact Person: _____ Healthcare Rep/POA Legal Guardian
Code Status: Full Code DNR DNI Out of Hospital DNR Attached Other: _____
Reason for Transfer/Special Instructions:

Respiratory Needs: None Oxygen Device Flow Rate: _____ CPAP BiPAP
Skin Condition: No Wounds Pressure Wound Surgical Wound Diabetic Other: _____
Site: _____ Size: _____ Stage (Pressure): _____
At Risk Alerts: None Falls Pressure Ulcer Aspiration Elopement Seizure
Weight Bearing Status
Left Leg: Non-Existent Limited Full
Right Leg: Non-Existent Limited Full
Functions
Ambulation: Independent Assistance Required Unable
Transfer: Independent Assistance Required Unable
Toilet: Independent Assistance Required Unable
Feed: Independent Assistance Required Unable
Bowel: Continent Incontinent
Bladder: Continent Incontinent
Catheter: None Foley Suprapubic Condom Intermittent
Attached Documents: Advance Directive Current Medication Profile Current Plan of Care
Sending Contact Name/Title: _____ Phone: _____

Care Coordination – Decreasing PA hours

- **Why do we need to decrease PA hours?**
 - Prevent duplication of services
 - Prevent payment issues -We bill Medicaid. Skilled providers can bill Medicare or Medicaid- due to the higher service level (Medicare or skilled services in general), their billing request will trump ours- so we may not get paid if we do not decrease our hours based on how many visits/week the other agency is providing services
- **When do we decrease PA hours?**
 - Decrease when a new skilled agency starts in home- PT, OT, SN, etc.- after our services have been in place
 - **Do not need to decrease if skilled services are already approved when we admit a patient**
 - Decrease our PA hours by how many visits/week the other agency is providing
- **How do we explain this to patients?**
 - Billing concern to prevent duplication of services
 - Required for us to continue to provide services
- **When do we increase hours back to usual?**
 - When other agency discharges their services
- **Quick note**
 - **Send decrease order when other agencies begin services**
 - ◆ Unskilled HHA hours funded by Medicaid PA to be decreased by (??) hours per week. Due to skilled services being provided by (agency) for (therapies). PA hours will be resumed as previously ordered once skilled services are discontinued
 - **Send increase hours order when other agency discharges-**Only send the increase order when you confirm with the other agency that they have discharged services
 - ◆ Unskilled HHA hours funded by Medicaid PA to be increased by (??) hours per week as previously ordered due to skilled services provided by (agency) for (therapies) being discontinued.

DECREASE HOURS

New skilled agency provides OT 2x/week and 1 SN med box refill.

We decrease our PA by 3 hours/week.

If patient has **4 hours/day x 5 days/week**, we will decrease our total PA by 3 hours/week.

Patient can choose which days/week hours can be decreased, but we need to decrease our HHA hours by 3 total hours/week.

Ex: 3 hours/day x 3 days/week, 4 hours/day x 2 days/week.

Care Coordination – Coordination at Discharge

- Discharge documentation is closely reviewed by state auditors
- For clients who are going to another agency- give report and send transfer summary to the outside agency
 - Another homecare provider, facility, etc.
- Be sure to document that PCP and family/patient notified of discharge in MatrixCare communications. State will call to confirm.
- Call other agency to give report
- Send transfer summary and other forms
- Upload copy of transfer summary and fax success sheets to attachments



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Use the "Shape Fill" to change colors.



