Help at Home®

Care to Live Your Life.

Clinical Recharge

June 2025

Agenda & Welcome

- Documentation
- QA Process
- Home Observation vs Supervisory Visit
- Repeat Hospitalizations
- Information Recap
- Authorization Review
- Clinician of the Quarter

Welcome to……..

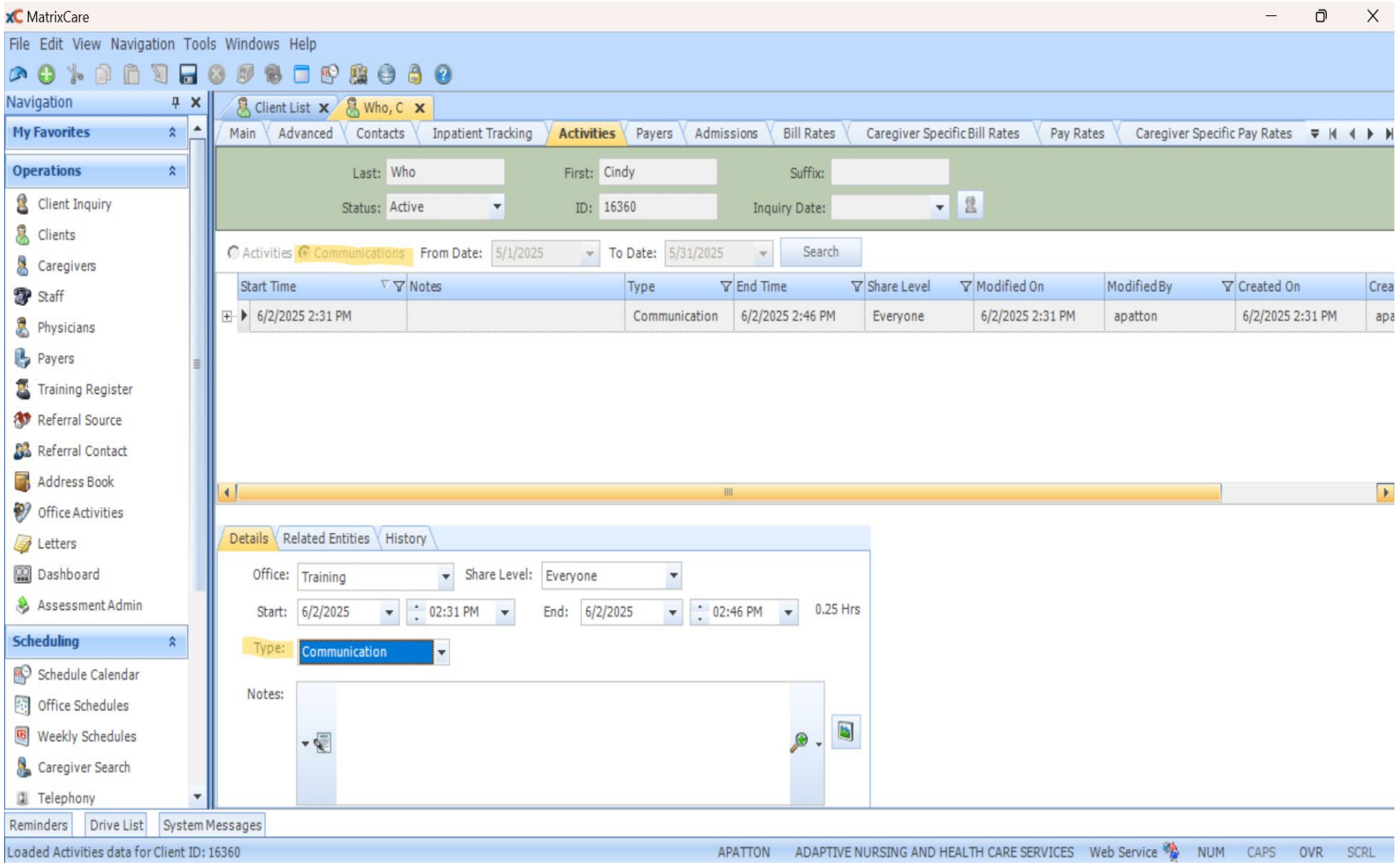
Janice Johnson – Terre Haute RNCM
Brittany Branam – Lafayette RNCM
Hagan Lawson – Winchester RNCM
Lindsey Brown – Muncie RNCM
Morgan Price – Admission Nurse
Bailey Rayl – Logansport RNCM
Jaime Moffitt – Richmond RNCM

Documentation

Communication and Follow-Up

Who?	What?	When?
• Patient • POA/Legal Guardian • Primary Care Physician • Specialists (if applicable) • Care Supervisors • Branch Manager • Program Coordinators (if applicable) • Other Home Health/Waiver Agencies • Outpatient Services (i.e. dialysis, infusion therapy, etc.) • HHA • Hospitals	Any conversation relating to the patient: • Grievance/Complaint • Reporting of unusual findings • Care Coordination • Phone Conversations • Scheduling concerns/changes • Education • Emergency Preparedness • Missed Visits • QA (PDN and in the event you are assisting the Clinical Assistant) • FOLLOW-UP **Any conversation regarding education/re-education of the HHA-Be sure you add them to related entities	**As soon as possible** after the event/conversation. Include: • Who you spoke with • Date you spoke with them • Services that are provided, if care coordination • Concerns/findings/conversation detail • If follow-up is needed **If communication/follow-up documentation is entered Late, insert 'Late Entry' at the beginning of the note.

Communication & Follow Up



Communication & Follow Up

- Any education/care coordination completed in the home during your visit can be documented on your assessment or supervisory note.
- If there is any follow-up and/or conversations outside of your visits, those things need to be documented within communications and labeled appropriately.
- Be sure to follow the Grievance Checklist for any Grievance filed: https://support.helpathome.com/hc/en-us/articles/27767944682519-Gather-and-Grow-11-13-24-complaints-and-grievances
- Reminder to keep documentation notes factual and free from opinion, professionally written and grammatically correct.
- Documentation should be our best friend in an audit situation ☺

- IF IT IS NOT DOCUMENTED, IT DID NOT HAPPEN!!!

QA

WHAT, WHY and HOW care is documented

QA (Quality Assurance)

- 100% of Home Health Aide (HHA), Respite Home Health (RHHA) or Skilled Nurse (SN) documentation will be reviewed to ensure services are carried out as ordered and note items that need follow up.

Their documentation is:

- Proof what services were provided (should follow the POC),
- Proof of time worked for billing submission ("timesheets"),
- Part of the client's medical record.

HHA/SN documentation methods:

- HHA using the ***MatrixCare App***
  - Preferred method for HHA cases. They use their phone to clock in, mark tasks, document findings, clock out.
  - Usually referred to as DVS (daily visit sheets).
- HHA using the ***Telephony Method***
  - Used when there is poor cell service or HHA has no smart phone.
  - Caregiver is to call number from client's phone. Must follow COPY OF SERVICE PLAN IN HOME and enter number that corresponds to ordered task.
  - No way for the HHA to make notes. Will have to call into the office and report findings or the reason a task not completed.
- SN documentation only ***Paper documentation***
  - Flow sheets, MARs, Narrative note, etc. from the SN. Each form requires the RNCM to initial and date at the bottom.

QA

WHEN to QA documentation

Frequency of QA depends on service type(s) of the client:

- HHA/RHHA services – QA should be completed every 30 days
  - Can be completed sooner. Prefer not to go over 30 but 32 days is still ok.
- SN services- QA should be completed weekly
  - Can be completed two weeks at a time but flowsheets must be uploaded within 14 days of shift worked.

Scheduling QA in the client's activities:

Client chart > activities tab > activities > Top left click green + to add new activity, add date due, category, type, result and click save.

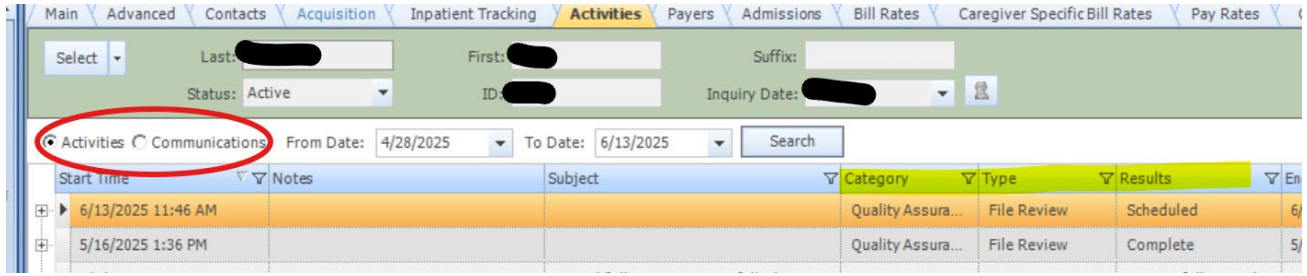
- For HHA clients –

  Admitting RN should schedule FIRST QA 30 days out from SOC in client's activities.

  Once QA is completed and charted, mark that activity completed and schedule next QA 30 days out.

- For SN clients –

  Admitting RN should schedule FIRST QA 7 days out from SOC in client's activities. Once QA is completed and charted, mark that activity completed and schedule next QA 7 days out.



What client is due for QA?

In MatrixCare on the left side, under operations > office activities > choose your office > date ranges > click get activities.

QA

HOW to pull the HHA documentation for review

Documentation method determines how you review:

If the caregiver uses the ***MatrixCare App –***

- Click office schedules under navigation tool bar (left side of screen) > Choose office and dates > Click Get Schedules
- Click dropdown under client and select client name > Click dropdown under service and select service you are reviewing (HHA/RHHA) > Click Print
- Select Daily Visit Sheets from dropdown message > Say Yes to pop up message

If the caregiver uses the ***Telephony Method -***

- Go to client's chart > scroll to far-right side to 'reports' tab. Click to open
- Scroll down to bottom and click on 'Tasks Report Detailed'
- Ensure Office, Client, Time display, Formatting and Schedule Status (set to completed) is all correct.
- Choose date for Period Begin (will only pull one week at a time) > click view report
    - Not to be confused with Telephony –where the care supervisors clear out shifts that flag for EVV errors.

All documentation to be reviewed for 30 days. Last QA covered the dates 4/10/25 – 5/10/25. Must start next QA with date of 5/11/25.

Any missed QA, must go back and review.

Link to Help at Home Knowledge Center 'How To' for QA:

https://support.helpathome.com/hc/en-us/articles/15364777062679-MatrixCare-DVS-Telephony-Review

QA

WHO is responsible

The RNCM owns the Client's Medical Record, including the QA.

- QA purpose = review of documentation to ensure the Plan of Care (POC) is followed.
  1. The RN wrote the POC,
  2. the Physician signed the POC,
  3. Insurance authorized services and
  4. the HHA carries out the many of the POC orders.

Delegation:

- Initial QA of HHA documentation – **CAN** be delegated to the Clinical Assistant.
- Follow up on QA findings – **CANNOT** be delegated to the Clinical Assistant.
- Any QA of SN documentation - **CANNOT** be delegated to the Clinical Assistant.

If the Clinical Assistant is unable to perform the weekly QA, they will be asking other Clinical Assistants for their assistance.
If no other Clinical Assistants can perform the weekly QA, the QA will fall on the RNCM to complete.

Clinical Chart Audit:

QA – 10 points

HHA service plan – 10 points

		• Medication indication matches diagnosis.		
9.	**Quality Assurance (QA)**	• QA completed and education/follow-up provided as applicable by RN	**10 points**	5/5 charts
10.	**HHA Service Plan**	• HHA service plan is published before start of new cert period. • HHA service plan supports medical necessity	**10 points**	5/5 charts

QA

WHAT is reviewed

The POC outlines what tasks in general the HHA will perform for the client.

- HHA to provide 4 hours per day 5 days per week…..
- HHA/Family to report any hospitalizations, falls, medication changes, or unusual occurrences to the office..
- HHA to assist with all ADLs such as bathing (shower), hair care, dressing, nail care (no clipping), incontinence care, meal prep…
- ASPIRATION PRECAUTIONS: HHA to observe Aspiration Precautions….

The service plan (sometimes called the Aide Care Plan) should reflect the POC orders. ** Service plan should match POC **

- Be specific with days of the week, if possible. This will help to identify when care is not provided.

HHA/RHHA - RNCM or Clinical Assistant to look for:

- Ordered tasks -
  - Completed = check mark
  - NOT completed = left unchecked and note made why
- Unusual findings or anything written by the HHA
- Anything written from the HHA
- Missing signatures of the client/Missing PIN of the HHA
- BATHING AND PERSONAL CARE DOCUMENTED?

	Category	Task	Frequency	Plan Notes
☑	Activity	Mobility Assist (w/transfers) (19)	5 x Week	assist with transfers from chair and bed
☑	Activity	Assist with Ambulation (WC/Walker/Cane) (18)	5 x Week	assist with ambulation(rollator)
☑	Bath	Tub/Shower (1)	5 x Week	assist with showering daily
☑	Household Services	Change Bed Linens (35)	1 x Week	change bed linens weekly

	Category	Task	Measurement	Not Completed Reason	Notes
☑	Activity	Mobility Assist (w/transfers) (19)			
	Plan Notes: assist with transfers from chair and bed				
☑	Activity	Assist with Ambulation (WC/Walker/Cane) (18)			
	Plan Notes: assist with ambulation(rollator)				
☑	Bath	Tub/Shower (1)			
	Plan Notes: assist with showering daily				
☑	Household Services	Change Bed Linens (35)			
	Plan Notes: change bed linens weekly				

SN – RNCM to look at:

- Flow sheets, MARs (match the POC?)
- Narrative note, (charting q2 hour?)

RNCM to initial and date at the bottom of each page and upload to EMR.

QA

HHA documentation

Plan of Care (Doctor's Orders)

Created with the client by RNCM. Outlines needs that will be met by HHA

RNCM creates Service Plan (Aide Care Plan)

Service Plan to match Plan of Care

HHA documentation follows Service Plan

Correct HHA documentation = we are following the Plan of Care/Doctor's orders

	Category	Task	Frequency	Plan Notes
☑	Bath	Tub/Shower (1)	3 x Week	Monday, Wednesday, Friday before dialysis
☑	Bath	Sink Bath (45)	4 x Week	Sunday, Tuesday, Thursday, Saturday
☑	Household Services	Change Bed Linens (35)	1 x Week	Monday

The GOAL is to follow the Plan of Care

Option 1) HHAs to check task on service plan indicating task was completed or acknowledged.
No further documentation required.

Option 2) HHAs to leave task on service plan unchecked indicating task was NOT completed.
A note is required WHY the task was NOT completed.

All tasks on service plan should be addressed every shift.
If task is NOT DAILY – add the DAY of the week to the plan notes.
This requires the RN to add specifics to the service plan

On Monday, they will check 'Change Bed Linens' task.
On Tuesday, the HHA would leave task 'Check Bed Linens' task UNCHECKED and note "completed on Monday".

If refused, HHA will make note. If client, directs otherwise, HHA will make note. This may mean the RNCM should modify the service plan and potentially the POC.

Only exception is unusual findings – can leave UNCHECKED

QA

WHAT to document and WHERE to document

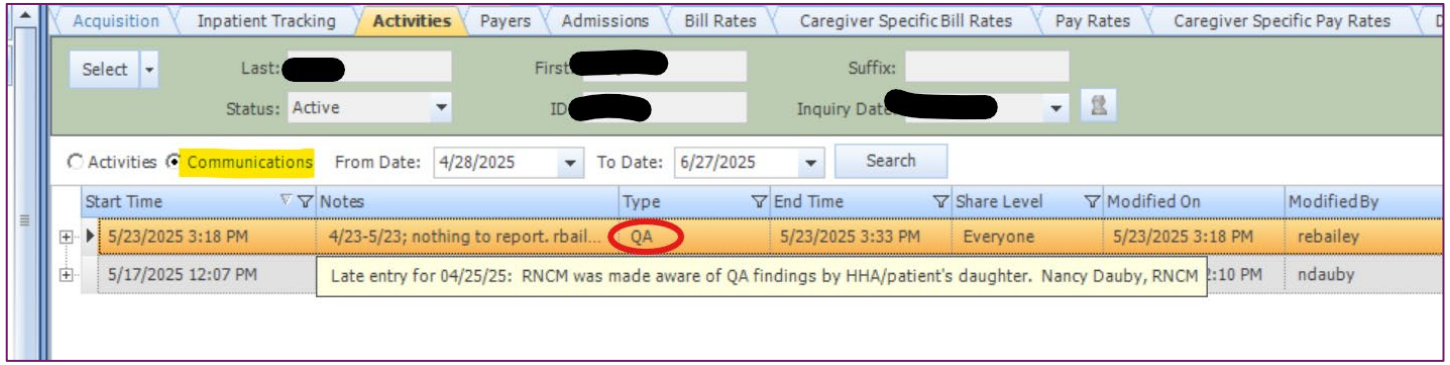
All findings will be documented in the client record.

Client chart > activities > choose communications > add new communication and make TYPE “QA”.

Clinical Assistants email all findings to the RNCM and Branch Manager and will indicate information was passed on.

If anything requires follow up:

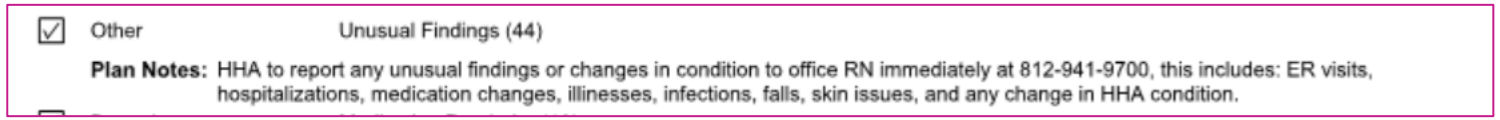
- anything **clinical** in nature such as unusual findings, not following POC, etc. will be followed up on and documented by the RNCM.
  - RNCM to make additional QA entry to document follow up.
  - If the QA needs follow up – do we need to educate the caregiver or modify the service plan?
  - If the items does NOT need follow up – just add note in chart, ‘no follow up needed’ or ‘HHA following POC’.
- anything **operational** in nature such as no location, missing signatures, etc. will be followed up on by the BM/CS.
  - BM/CS to make additional QA entry to document follow up.



QA

Examples – finding for RNCM follow up

HHA documentation on 3/28:



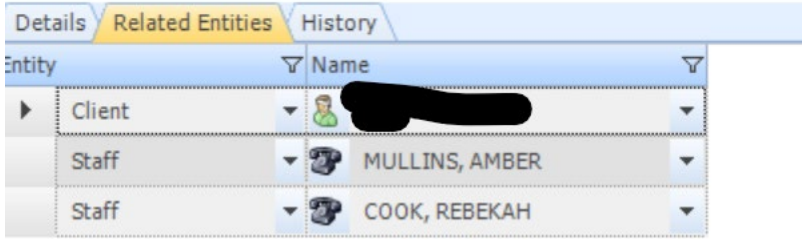
Clinical Assistant findings – In client's communications (type QA):

Dates QA'd 3/25-4/25; 3/28, 4/1, unusual findings marked. rn notified. rbailey,ma

RNCM follow up – In client's communications (type QA):

RNCM reeducated hha to not mark unusual findings on 4/1 and hha verbalized understanding. hha shift worked 4/2, unusual findings not marked. hha, rebekah cook has not worked any shifts since 4/2. amullins, rncm

Suggest to add related entities to QA note so HHA education is also in HHAs personnel file: ->

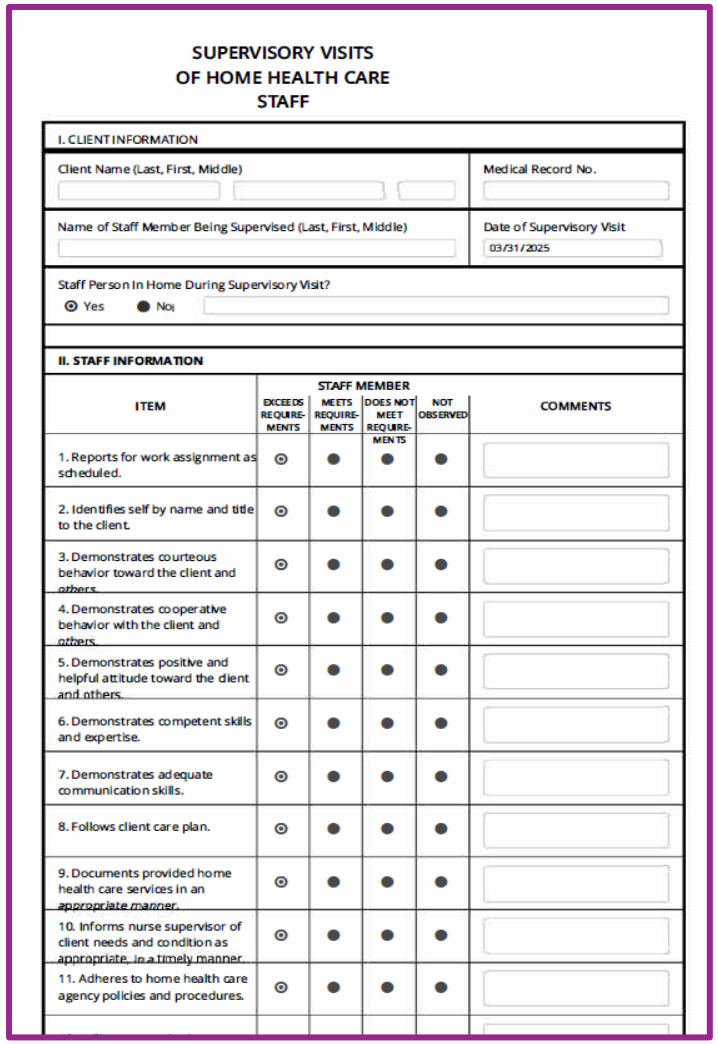


Supervisory versus Home Observance Visits

- Supervisory visits
  - Goal of supe visits- ensure agency staff is providing quality care and patient is satisfied with services and their HHA/nursing staff
  - Skilled nursing cases
    - Supes are required every 14 days for dual discipline (patient has both HHA and skilled nursing) cases
    - Supes are required every 30 days for skilled nursing cases with LPN's
    - Supes are NOT required for RN-only skilled nursing cases
  - HHA-only cases
    - Supes are required every 60 days
    - HHA does **not** need to be present to complete a supervisory visit
- Home observation visits- required twice/year for every HHA
  - Goal of home observance visits- ensure every HHA is providing competent, hands-on personal care in accordance with agency and state standards
  - Best practice is to observe each HHA every 6 months
  - HHA **must** be working an HHA shift for RN to complete a home observance
  - Home observances are not required for RN's/LPN's
    - RN/LPN's only need an annual comp to ensure they are providing competent nursing care
- Complete a home observation tool form at each home visit to verify all forms are present in the home chart. Complete questions about the HHA- present/not present, personal care observed- as applicable.

Supervisory Visits- Documentation

- Supervisory visits
  - Complete a Matrix Supervisory Visit of Home Health Staff form OR an Adobe Supe Visit Form
    - Complete Matrix Supe Visit form at every RC



SUPERVISORY VISITS
OF HOME HEALTH CARE
STAFF

I. CLIENT INFORMATION

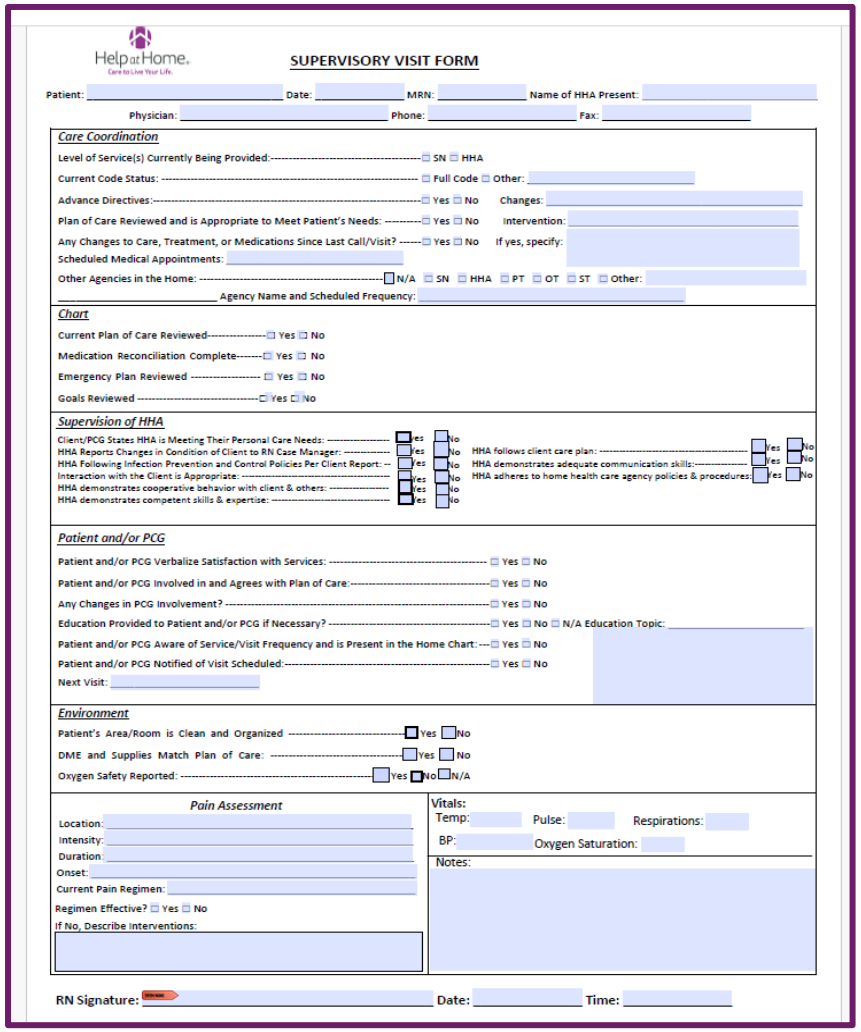
Client Name (Last, First, Middle)	Medical Record No.
Name of Staff Member Being Supervised (Last, First, Middle)	Date of Supervisory Visit: 03/31/2025

Staff Person In Home During Supervisory Visit?
◉ Yes ● No

II. STAFF INFORMATION

ITEM	STAFF MEMBER: EXCEEDS REQUIREMENTS	MEETS REQUIREMENTS	DOES NOT MEET REQUIREMENTS	NOT OBSERVED	COMMENTS
1. Reports for work assignment as scheduled.	◉	●	●	●	
2. Identifies self by name and title to the client.	◉	●	●	●	
3. Demonstrates courteous behavior toward the client and others.	◉	●	●	●	
4. Demonstrates cooperative behavior with the client and others.	◉	●	●	●	
5. Demonstrates positive and helpful attitude toward the client and others.	◉	●	●	●	
6. Demonstrates competent skills and expertise.	◉	●	●	●	
7. Demonstrates adequate communication skills.	◉	●	●	●	
8. Follows client care plan.	◉	●	●	●	
9. Documents provided home health care services in an appropriate manner.	◉	●	●	●	
10. Informs nurse supervisor of client needs and condition as appropriate, in a timely manner.	◉	●	●	●	
11. Adheres to home health care agency policies and procedures.	◉	●	●	●	

Complete Adobe Supe Visit form at Extra supes



Help at Home.
Care to Live Your Life.

SUPERVISORY VISIT FORM

Patient: Date: MRN: Name of HHA Present:
Physician: Phone: Fax:

Care Coordination

Level of Service(s) Currently Being Provided: ☐ SN ☐ HHA
Current Code Status: ☐ Full Code ☐ Other:
Advance Directives: ☐ Yes ☐ No Changes:
Plan of Care Reviewed and is Appropriate to Meet Patient's Needs: ☐ Yes ☐ No Intervention:
Any Changes to Care, Treatment, or Medications Since Last Call/Visit? ☐ Yes ☐ No If yes, specify:
Scheduled Medical Appointments:
Other Agencies in the Home: ☐ N/A ☐ SN ☐ HHA ☐ PT ☐ OT ☐ ST ☐ Other:
Agency Name and Scheduled Frequency:

Chart

Current Plan of Care Reviewed ☐ Yes ☐ No
Medication Reconciliation Complete ☐ Yes ☐ No
Emergency Plan Reviewed ☐ Yes ☐ No
Goals Reviewed ☐ Yes ☐ No

Supervision of HHA

Client/PCG States HHA is Meeting Their Personal Care Needs: ☐ Yes ☐ No
HHA Reports Changes in Condition of Client to RN Case Manager: ☐ Yes ☐ No
HHA Following Infection Prevention and Control Policies Per Client Report: ☐ Yes ☐ No
Interaction with the Client is Appropriate: ☐ Yes ☐ No
HHA demonstrates cooperative behavior with client & others: ☐ Yes ☐ No
HHA demonstrates competent skills & expertise: ☐ Yes ☐ No
HHA follows client care plan: ☐ Yes ☐ No
HHA demonstrates adequate communication skills: ☐ Yes ☐ No
HHA adheres to home health care agency policies & procedures: ☐ Yes ☐ No

Patient and/or PCG

Patient and/or PCG Verbalize Satisfaction with Services: ☐ Yes ☐ No
Patient and/or PCG Involved in and Agrees with Plan of Care: ☐ Yes ☐ No
Any Changes in PCG Involvement? ☐ Yes ☐ No
Education Provided to Patient and/or PCG if Necessary? ☐ Yes ☐ No ☐ N/A Education Topic:
Patient and/or PCG Aware of Service/Visit Frequency and is Present in the Home Chart: ☐ Yes ☐ No
Patient and/or PCG Notified of Visit Scheduled: ☐ Yes ☐ No
Next Visit:

Environment

Patient's Area/Room is Clean and Organized ☐ Yes ☐ No
DME and Supplies Match Plan of Care: ☐ Yes ☐ No
Oxygen Safety Reported: ☐ Yes ☐ No ☐ N/A

Pain Assessment

Location:
Intensity:
Duration:
Onset:
Current Pain Regimen:
Regimen Effective? ☐ Yes ☐ No
If No, Describe Interventions:

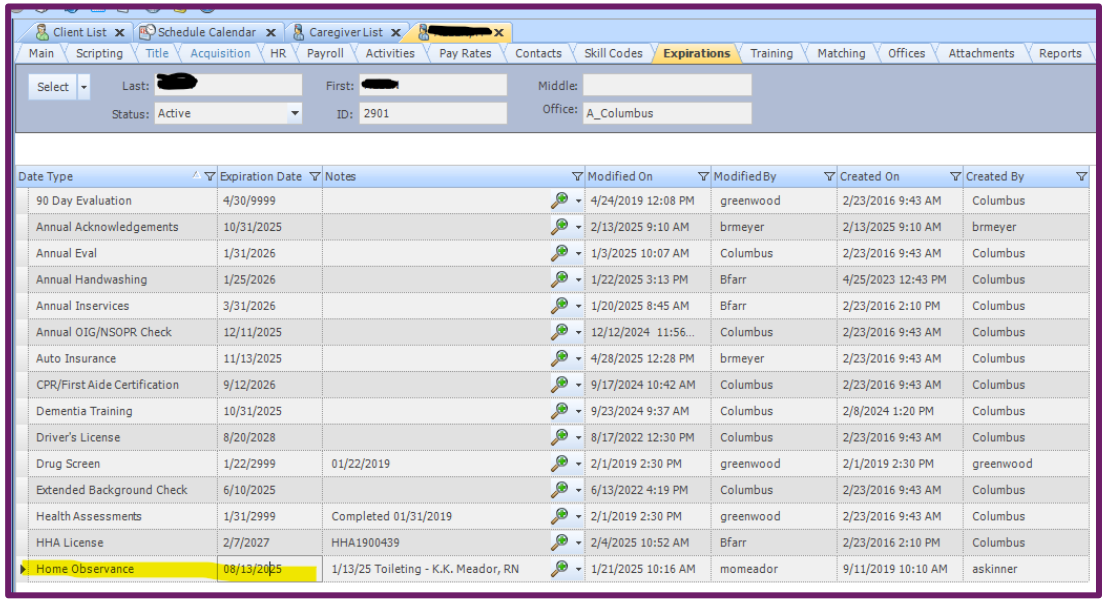
Vitals:
Temp: Pulse: Respirations:
BP: Oxygen Saturation:

Notes:

RN Signature: Date: Time:

Home Observance Visits- Documentation

- Complete an Adobe Home Visit Observation Form
- Must observe personal care- bathing, hair care, toileting, skin care- for visit to qualify as the 2x/year home observance of the HHA
  - Tasks such as transfers/repositioning, ambulation assist, light housekeeping, med reminders, etc. do NOT meet home observance requirement
- Upload observance form to POC attachments. Do not upload form to HHA's file in Matrix
- Home obs. expiration is tracked in caregiver expirations. When a home obs. is done, update the expiration to 6 months from when obs. was completed.
- Enter communication note under the HHA to document what personal care task was observed, any issues noted, and follow up education if issues were observed.
  - Communication note type will be "home observation"
  - Add patient to note as "related entity"
  - Example note: Purdue Pete, HHA, was observed providing a shower during client visit on 3/26/25. No concerns with care observed. A Armuth, RN
- Do not delete any old home obs. notes under HHA's home observance expirations



Date Type	Expiration Date	Notes	Modified On	Modified By	Created On	Created By
90 Day Evaluation	4/30/9999		4/24/2019 12:08 PM	greenwood	2/23/2016 9:43 AM	Columbus
Annual Acknowledgements	10/31/2025		2/13/2025 9:10 AM	brmeyer	2/13/2025 9:10 AM	brmeyer
Annual Eval	1/31/2026		1/3/2025 10:07 AM	Columbus	2/23/2016 9:43 AM	Columbus
Annual Handwashing	1/25/2026		1/22/2025 3:13 PM	Bfarr	4/25/2023 12:43 PM	Columbus
Annual Inservices	3/31/2026		1/20/2025 8:45 AM	Bfarr	2/23/2016 2:10 PM	Columbus
Annual OIG/NSOPR Check	12/11/2025		12/12/2024 11:56...	Columbus	2/23/2016 9:43 AM	Columbus
Auto Insurance	11/13/2025		4/28/2025 12:28 PM	brmeyer	2/23/2016 9:43 AM	Columbus
CPR/First Aide Certification	9/12/2026		9/17/2024 10:42 AM	Columbus	2/23/2016 9:43 AM	Columbus
Dementia Training	10/31/2025		9/23/2024 9:37 AM	Columbus	2/8/2024 1:20 PM	Columbus
Driver's License	8/20/2028		8/17/2022 12:30 PM	Columbus	2/23/2016 9:43 AM	Columbus
Drug Screen	1/22/2999	01/22/2019	2/1/2019 2:30 PM	greenwood	2/1/2019 2:30 PM	greenwood
Extended Background Check	6/10/2025		6/13/2022 4:19 PM	Columbus	2/23/2016 9:43 AM	Columbus
Health Assessments	1/31/2999	Completed 01/31/2019	2/1/2019 2:30 PM	greenwood	2/23/2016 9:43 AM	Columbus
HHA License	2/7/2027	HHA1900439	2/4/2025 10:52 AM	Bfarr	2/23/2016 2:10 PM	Columbus
Home Observance	08/13/2025	1/13/25 Toileting - K.K. Meador, RN	1/21/2025 10:16 AM	momeador	9/11/2019 10:10 AM	askinner

Assessment & Individualized Care Planning

Home Health providers can help hospitals reduce readmission rates during the critical 30 days following discharge from the hospital.

Comprehensive Assessment:

- Evaluate patient's physical, cognitive, psychosocial, and environmental status.

Risk Identification:

- History of hospital admissions
- Medication mismanagement
- Poor disease control (e.g., CHF, COPD, diabetes)
- Lack of social support or transportation

Individualized Care Plan:

- Tailor interventions to identified risks and patient goals
- Set achievable, measurable goals

Interventions to Reduce Hospitalization Risk

Medication Management

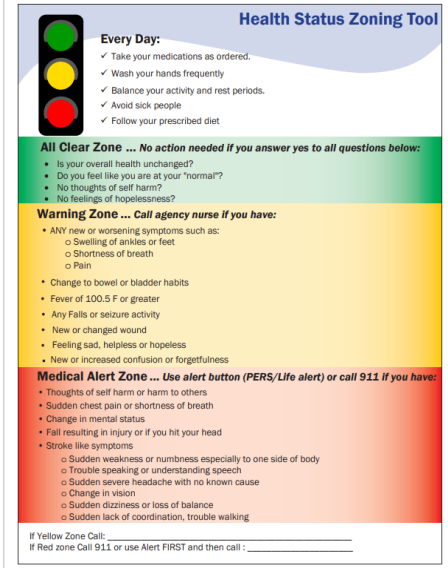
- Ensure they fill and reconcile medication as soon as possible after hospital discharge.
- Educate patient/caregiver on purpose, dosage, timing, and side effects.
- Pill organizers, alarms, or caregiver reminders.

Disease Management

- **CHF**: Daily weights, low-sodium diet, fluid restriction.
- **COPD**: Pursed-lip breathing, oxygen safety, inhaler technique, smoking cessation if applicable
- **Diabetes**: Blood glucose monitoring, diet, foot care.
- Educate on planning and preparing a disease specific diet such as heart healthy, diabetic, etc. --- shopping and meal prep as needed.

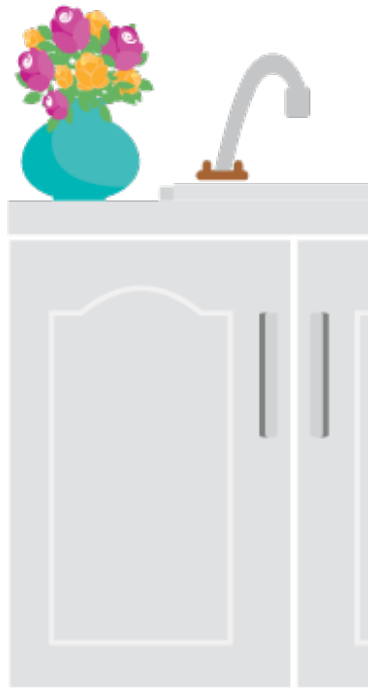
Symptom Recognition

- Teach early warning signs (e.g., weight gain in CHF, SOB in COPD).
- Develop an action plan:
  - When to call nurse/doctor.
  - When to go to ER vs. using telehealth.
  - COPD Zone Tool



Fall Prevention

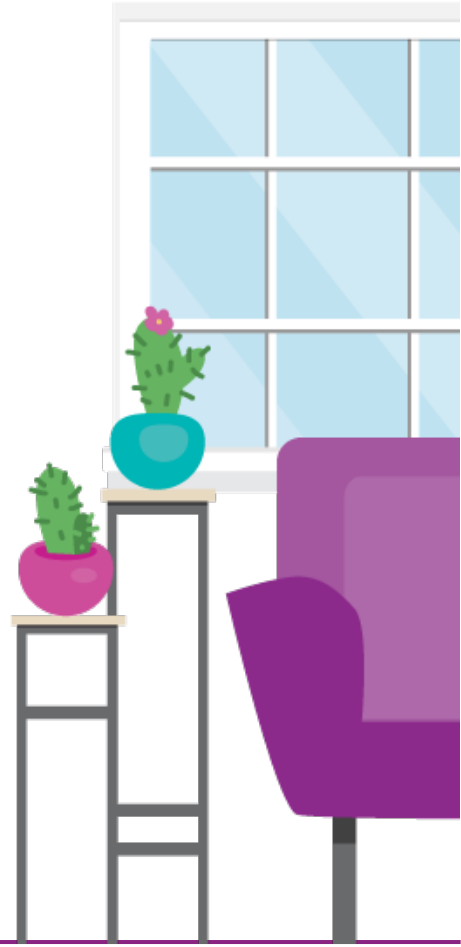
- Home safety assessment (remove rugs, add grab bars, good lighting).
- Mobility support (walker/cane education, PT referral).
- 19482065401111 ---- Fall Risk Self Assessment if applicable; "discuss the why it matters"



Patient and Caregiver Education

Education

- Disease process and management
- Medication purpose and side effects
- Symptom tracking and reporting
- Nutrition and fluid guidelines
- Use of medical equipment (e.g., nebulizer, glucose meter)
- Use teach-back method to confirm understanding.
- Provide written and visual materials in preferred language.
- Diseases & Conditions Patient Handouts - Dynamic Health



Care Coordination and Communication

Healthcare Providers

- Timely communication with PCP and specialists.
- Notify providers of changes in status or needs.

Family and Caregivers

- Involve in care planning and education.
- Provide support resources (respite care, counseling).

Community Resources

- Connect with:
  - Transportation services
  - Meals on Wheels
  - Home-delivered pharmacy
  - Social workers or case managers

Documentation & Follow-Up

- Document patient goals, progress, and interventions.
- Set follow-up visits or calls to monitor adherence and status.
- Update care plan as patient needs evolve.

Recap of Recent Changes

Discharge Policy Change

- Medication list and therapies no longer required on the discharge summary
- Discharge summary no longer requires MD signature

Administrator Notification

- Any referrals meeting this criteria need to be sent to the administrator for review prior to admission
  - Any referral requesting 8 or more hours per day
  - Any referral requesting overnight hours
  - Any referral under the age of 18
  - All skilled nursing referrals
    - Reminder ---- We DO provide skilled nursing as an agency!

Recap of Recent Changes

Order Tracking

- RN to send all orders to the MD upload order with their signature to the POC attachments. Once they have attempted to get the order signed 2 times, they will copy their offices clinical assistant on the 3rd attempt.
- Clinical Assistants will run the order tracking report in Matrix at least 2 times a month to ensure POC's are signed and returned within the 60-day window.
    - The "due date" must be entered by the nurse on the order

Chart Audit changes and Reminders

- Christine Newell (Nurse Auditor) will be added to all follow up from chart audits
    - All findings need to be corrected within 2 weeks – Christine will track and follow up through completion
- Chart audit point deduction will only occur for QA if the nurse is missing follow up that is clinical in nature.
- QA nurses will be auditing 20% of nurse's caseload ----- in some cases this means 6 charts will be pulled for audit
- Passing score is 85% or higher
- Chart audits are completed at:
    - 90 days
    - Quarterly until 2 consecutive passing scores are achieved (excluding 90-day audit)
    - Annually once 2 consecutive passing scores are achieved ----- if scored <85%, will return to quarterly cadence

Authorization Reminders

Absolutes that HAVE to be in the POC

- Other services or therapies in the home
  - · If patient DOES receive other services or therapies, type of services and number of hours must be listed.
  - · If patient DOES NOT receive other services or therapies, this needs to be stated.
  - (This information missing from the POC is the #1 reason we are getting denials)
- Patient living arrangements
  - · POC must state if client lives alone or with others
    - List who all lives in the home (do not put "family")
  - POC needs to state if children in the home are minors
  - POC needs to state if adults are attending school if this is the reason they cannot provide care
  - POC needs to state if others in the home are 70+ years old
  - POC needs to state if others in the home are disabled or unable to provide care due to health issues
  - POC needs to state if others are uncomfortable providing care (refusal or privacy)
  - ·POC needs to state if others are preferred caregiver
  - POC needs to state if others work outside of the home
- Patients attending school/ABA clinics:
  - Range must reflect hours for school days and non-school days
  - Summary must state days and times patients are attending school and when HHA services will be provided (before, during, after)

*******All documents need to go in the first recertification of the active PA admission*******

Authorization Reminders Continued.....

Necessary Documentation for New Admissions and Renewals

- Face to Face
  - · New Admission – F2F needs to be within 90 days of admission date
  - · Renewals – F2F needs to be within 365 days of PA renewal date
    - Authorization Tab in PA admission is the easiest way to see when a PA needs to be renewed
- Work letters
  - · Anyone that resides with the patient
    - between the ages of 18 and 69 that work remotely or outside of the home
    - Preferred Caregiver
  - · Letters must state that person is an active employee, state work schedule, estimate of hours worked weekly, and have a live signature
- School Calendars/Schedules
  - · Calendar needed for patients that attend primary-high school
  - · School Schedule and Calendar for those that reside with patient

Authorizations continued...

Increases and Reconsiderations

- Increase Requests
  - Signed order with new range and reason extra hours are needed
  - F2F within the last 365 days
  - Work letters/school schedules for those that live with patient
- Reconsiderations
  - Detailed summary – this needs to include more detail than what has already been provided in the summary portion of the POC

Authorizations continued.....

Timelines for each Provider

- MHS
  - · New admissions
  - o Unsigned POC within 2 days of start of care
  - o Signed POC and other documents within 2 weeks of start of care
  - · PA Renewals
  - o Unsigned POC within 2 days of start of new PA
  - o Signed POC and other documents within 2 weeks of renewal date PA
  - · PAs are for 60 days
- Anthem Pathways
  - · New Admissions
  - o Unsigned POC within 5 days of start of care
  - o Signed POC and other documents within 15 days of start of care
  - · PA Renewals
  - o Unsigned POC within 5 days of start of renewal date of PA
  - o Signed POC and other documents within 15 days of renewal date of PA
  - · PAs are 180 days

Authorizations continued……

Timelines for each Provider

- Anthem Hoosier Care Connect, HIP, and Hoosier Healthwise
  - · New Admissions
    - Unsigned POC within 5 days of start of care
    - Signed POC and other documents within 15 days of start of care
  - · PA Renewals
    - Unsigned POC within 5 days of start of new PA
    - Signed POC and other documents within 15 days of renewal date of PA
  - · PA is 91 days long
- Humana
  - · New Admission
    - Signed POC and other documents within 30 days of start of care date
  - · PA Renewals
    - o Signed POC and other documents within 30 days of renewal date of PA
  - · PA is 60 days long

Authorizations continued…….

Timelines for each Provider

- Traditional Medicaid
  - · New Admissions
    - Signed POC and other documents within 25 days of start of care date
  - · PA Renewals
    - Signed POC and other documents within 25 days of renewal date of PA
    - · PA is 180 days long
- UHC
  - PA is not required for Home Health Care at this time.

Questions???

Clinician of the Quarter

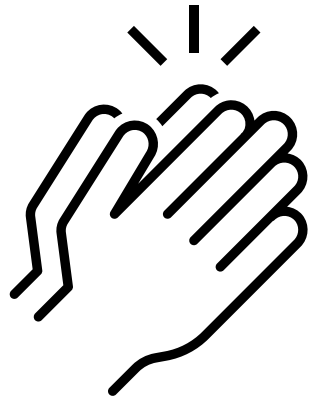
- **What???** Opportunity to show recognition and appreciation to a RNCM

- **When???** 1 RNCM recognized each quarter

- **How???**Nominated and voted on by Indiana Clinical Leadership
  - Takes into account the big picture
    - Attitude
    - Teamwork
    - Compliance
    - Chart audit scores
    - Caseload
    - Etc……

Clinician of the Quarter

Shout outs……



- Teresa Beal (Winchester)
  - “always going above and beyond”, “never complains even when doing 12+ visits in a week”, “empathetic and willing to go the extra mile for her clients”
- Tammy Anderson (Lafayette)
  - “great teamwork”, “always helpful – giving advice and helping to mentor the new nurses in the North territory”, “excellent charting and documentation”
- Joseph Stork (Indy East)
  - “team player”, “very compassionate with his clients and their families”, “amazing nurse and co-worker”, “always willing to help others”
- Nancy Dauby (New Albany)
  - “fantastic nurse”, “very knowledgeable and positive”, “consistent and always willing to help”, “remains the constant while supporting her peers in the office”

Q2 2025 Winner.....

Tiffany Lex (Terre Haute)

While each of the Terre Haute nurses have been rock stars since Ashley has been on maternity leave, Tiffany Lex has gone above and beyond. Tiffany has ensured all visits are completed and Ashley's caseload has been covered all while precepting the new RNCM in the office. Tiffany has assisted the new nurse from day 1 to ensure she is fully supported. Tiffany is always pleasant to deal with and cares about her clients so much. Tiffany has taken over a skilled client while Ashley is on leave, and she has worked with Nikki and Lydia to learn all the ins and outs of the skilled nursing requirements. She has never complained about any of what has been asked of her and always has her work completed on time. Tiffany has maintained 30+ clients on her caseload consistently

Thank you, Tiffany, for all that you do for your clients, peers, caregivers, and coworkers around you!

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