WellSky.

Identifying the Focus of Care & Documentation Strategies

Identifying the Focus of Care & Documentation Strategies

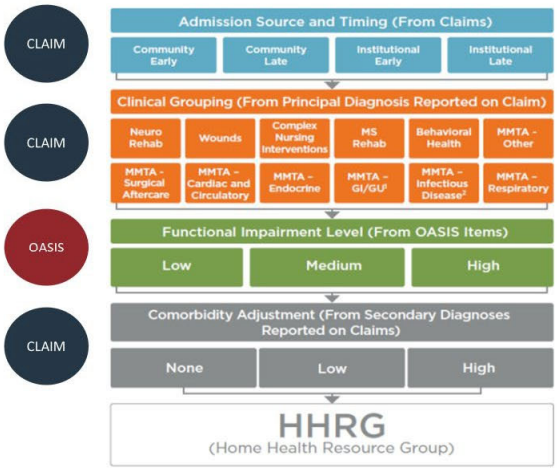
Presented by: Amanda Gartner, Sr. Education Manager

Agenda

- Understand the elements of the PDGM model
  - Accurate Clinical Grouping
  - Acceptable/non-acceptable diagnoses
- Face to Face requirement that provides the *reason for home* health
  - Common errors in identifying primary reason for home health
- Identifying skilled need and FOC through practice scenarios
- Steps to identify focus of care using F2F and clinician assessment

PDGM Overview

- Each 30-day payment period is grouped into one of 432 HHRGs based on these factors



Admission Source
- Institutional (prior 14 days) or;
- Community referral

Admission Timing
- Early billing episode – first 30 days ONLY
- Everything after 30 days considered LATE

Clinical Group
- 12 groups based on Primary diagnosis
- Does not pull from M1021 although that's what we may complete for client to get it on the claim

Functional Level
- M1800s ADLs + M1033 Risk for Hospitalization

Comorbidities
- Low - One qualified dx code
- High - Two qualified dx codes used together
  - Can only get Low OR HIGH not both

In total there are 2*2*12*3*3 = 432 possible case-mix adjusted payment groups

3

Primary Diagnosis Categories

TABLE 1: PDGM CLINICAL GROUPS

CLINICAL GROUP	PRIMARY REASON FOR HOME HEALTH ENCOUNTER IS TO PROVIDE:
Musculoskeletal Rehabilitation	Therapy (PT/OT/SLP) for a musculoskeletal condition
Neuro/Stroke Rehabilitation	Therapy (PT/OT/SLP) for a neurological condition or stroke
Wounds - Post-Op Wound Aftercare and Skin/ Non-Surgical Wound Care	Assessment, treatment and evaluation of a surgical wound(s); assessment, treatment and evaluation of non-surgical wounds, ulcers burns and other lesions
Complex Nursing Interventions	Assessment, treatment and evaluation of complex medical and surgical conditions
Behavioral Health Care	Assessment, treatment and evaluation of psychiatric and sub-stance abuse conditions
Medication Management, Teaching and Assessment (MMTA) • MMTA –Surgical Aftercare • MMTA – Cardiac/Circulatory • MMTA – Endocrine • MMTA – GI/GU • MMTA – Infectious Disease/Neoplasms/ Blood-forming Diseases • MMTA –Respiratory • MMTA – Other	Assessment, evaluation, teaching, and medication management for a variety of medical and surgical conditions not classified in one of the above listed groups. The subgroups represent common clinical conditions that require home health services for medication management, teaching, and assessment.

4

Primary Diagnosis Examples

Neuro Rehab

ICD-10Code	Description
I69.35-	Hemiplegia and hemiparesis following cerebral infarction
G20	Parkinson's disease
G30.9	Alzheimer's disease, unspecified
A81.00	Creutzfeldt-Jakob disease, unspecified
T85.79XA	Infection and inflammatory reaction due to other internal prosthetic devices, implants and grafts, initial encounter
I67.2	Cerebral atherosclerosis

Musculoskeletal Rehab

ICD-10Code	Description
Z47.1	Aftercare following joint replacement surgery
M15.0	Primary generalized (osteo) arthritis
M54.02	Panniculitis affecting regions of neck and back, cervical region
M54.31	Sciatica, right side

5

Primary Diagnosis Examples

Wounds

ICD-10Code	Description
–	Assessment, treatment and evaluation of surgical/non-surgical wound(s), ulcers, burns and other lesions
E11.621	Type 2 diabetes mellitus with foot ulcer
	Venous stasis ulcers
T21.32XD	Burn of third degree of abdominal wall, subsequent encounter
I170.231	Atherosclerosis of native arteries or right leg with ulceration of thigh
I83.211	Varicose veins of right lower extremities with both ulcer and inflammation

Complex Nursing Interventions

ICD-10Code	Description
–	Assessment, treatment and evaluation of complex medical and surgical conditions
Z43.5	Encounter for attention to cystostomy
Z46.6	Encounter for fitting and adjustment of urinary device
Z43.0	Encounter for attention to tracheostomy

6

Primary Diagnosis Examples

ICD-10 Code	Description
–	Assessment, treatment and evaluation of psychiatric and substance abuse conditions
F25.0	Schizoaffective disorder, bipolar type
F32.9	Major depressive disorder, single episode, unspecified
F10.10	Alcohol abuse, uncomplicated
F43.12	Post-traumatic stress disorder, acute

6- MMTA Conditions + Other

ICD-10 Code	Description
E78.5	Hyperlipidemia, unspecified
E89.821	Postprocedural hematoma of an endocrine system organ or structure following other pro cedure
E86.0	Dehydration
I10	Essential (primary) hypertension
E11.9	Type 2 diabetes mellitus without complications

7

PDGM Non-Acceptable Codes

CMS has stated the reason for these non-acceptable codes is three-fold:

- Codes show either the patient is not appropriate for home health;
- The patients are too acute for HH;
- Codes are not specific enough

The term "unspecified" alone does not make the code non-acceptable

8

Top Non-Acceptable Codes

Diagnosis	Description
M62.81	Muscle weakness (generalized)
G62.9	Polyneuropathy, unspecified
R62.7	Adult failure to thrive
H81.10	Benign paroxysmal vertigo, unspecified ear
M25.551	Pain in right hip
M54.5	Low back pain
M54.9	Dorsalgia, unspecified
R26.89	Other abnormalities of gait and mobility
B34.8	Other viral infections of unspecified site
G24.9	Dystonia, unspecified
H81.20	Vestibular neuronitis, unspecified ear
H81.399	Other peripheral vertigo, unspecified ear
L89.159	Pressure ulcer of sacral region, unspecifie..
M06.9	Rheumatoid arthritis, unspecified
M25.511	Pain in right shoulder
M25.512	Pain in left shoulder
M25.552	Pain in left hip
M25.561	Pain in right knee
M25.562	Pain in left knee
M48.00	Spinal stenosis, site unspecified

9

Root Cause Considerations

Symptoms can be related to several diagnosis / conditions and requires the underlying cause. Query referral source or physician to help identify if you are unable to.

What symptoms are present?

- Falls
- Mental status changes
- Behavior disturbance
- Pain
- Mobility deficits
- Weakness
- Weight changes
- Shortness of breath
- Chest Pain

Underlying Cause or specifics

- Musculoskeletal conditions
  Late effect from fall/fractures
  Dementia
- Diabetes
  Cardiac/CHF
- Pulmonary conditions UTI
- Neurological conditions other

10

Unspecified Condition

Examples requiring additional specificity or laterality

- Fractures
- Osteoarthritis
- Neoplasms
- Cerebral Infarction
- Pressure Ulcer

What additional information is needed?

- Laterality – the affected side of the body (left knee, right hemiplegia, etc.)
- Specific site – knee, hip, sacrum etc.
- Late effect of – Dysphagia, Paralysis, etc.

11

CVA / Stroke Considerations

Coding an Acute CVA is not allowed as primary in Home Health and history of does not impact comorbidity capture and potential patient care plan needs

Are there deficits/late effects from the CVA?

Swallowing

Abnormal gait

Paralysis of limbs

Cognitive impairment

Dominant side or laterality specifics

Patient's dominant side impacts coding and gives insight into how the patient may be impacted for recovery

Left sided CVA vs Right sided may be shown in CT scans or other radiologic reports and are accepted tools for confirmation of the anatomical site

Left vs Right side CVA is impactful to the ADLs

12

Face to Face

13

Face to Face Requirement

Prior to certifying a patient's eligibility for the home health benefit, the certifying physician must document that he or she, or an allowed non-physician practitioner (NPP) has had a Face-to-Face (F2F) encounter with the patient.

A certification is anytime that a Start of Care OASIS is completed to initiate care.

The physician or allowed practitioner must include a brief narrative describing the clinical justification of this need as part of the certification, or as a signed addendum to the certification;

Face-to-face requirements as of January 1, 2015- Present

- It must occur within 90 days of the SOC date or 30 days after (look for the most recent F2F)
- *Encounter needs to be related to the primary reason for home health*
- Encounter performed by physician or allowed nonphysician practitioner (NPP)
- *Need for skilled nursing on an intermittent basis, or physical therapy, or speech-language pathology, or have a continuing need for occupational therapy*
- Certifying physician must document the date of the F2F encounter

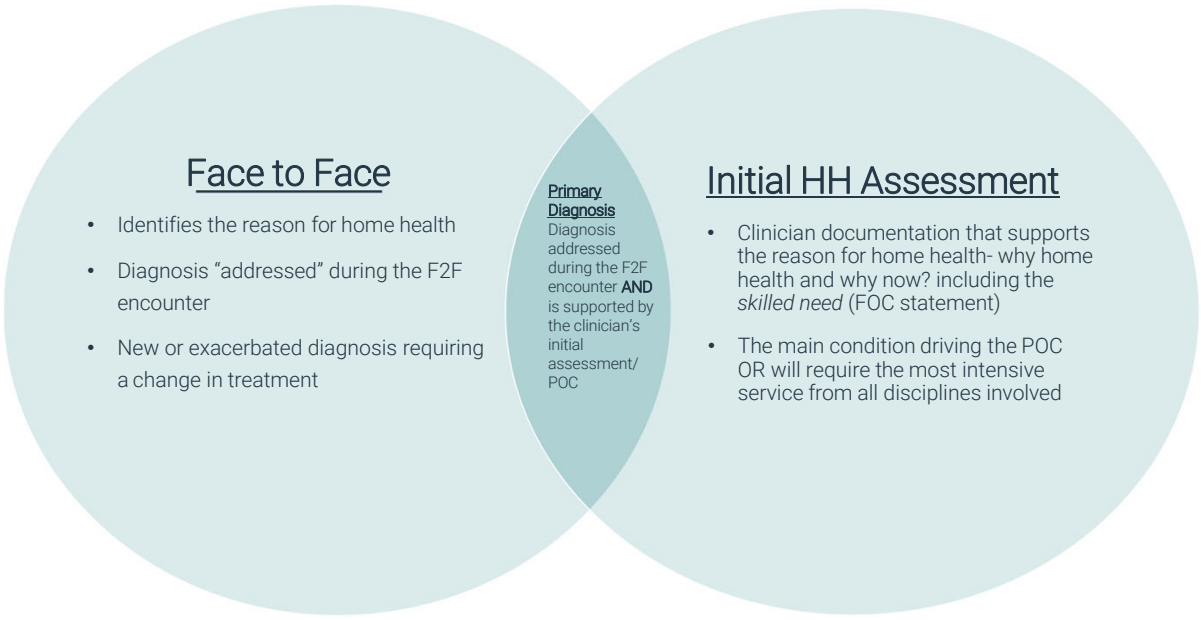
Source: https://www.palmettogba.com/palmetto/jmhhh.nsf/DID/BXUJBY2653

14

Face to Face & Home Health Certification Documentation

- Most often found in clinical and progress notes (community referral) and/or discharge summaries or H&P (institutional referral)
- The F2F encounter must be related to the *primary reason for home health services*
  - The F2F must also support the skilled need, and agencies HH may provide supporting documentation to substantiate (skilled need and homebound status)
- *The synthesis of progress notes, discharge summaries, & HHA documentation help create a longitudinal clinical picture of the patient's health status*

15



16

Common Errors and Resolution Strategies

Problem:
- Clinician may not have access to F2F at time of their assessment or they do not read the F2F to know what is the *primary reason for home health*

Resolution:
- Ensure clinicians understand the certification requirements and why the F2F & reason for home health must align with the clinician focus of care
- Ensure clinicians have access to the F2F and read it prior to initial assessment

17

Common Errors and Resolution Strategies

Problem:
- MD F2F only provides a symptom code (non-acceptable dx)
- General weakness (no etiology or reason for general weakness listed)

Resolution:
- Educate intake teams on non-acceptable dx and query physicians prior to admission
- Educate referring physicians on non-acceptable dx and what is needed

18

Common Errors and Resolution Strategies

Problem: F2F encounter must be the primary reason for home health but the clinician FOC is not r/t to F2F

- Diagnosis listed on F2F documentation but not addressed.
- Clinician chooses a FOC not "addressed" on the F2F but is a stable chronic condition.
- Example: MD F2F encounter r/t hair line fracture and needing PT for gait training; the patient also has HTN but is stable and was not "addressed" by MD however HTN was listed as the primary FOC by the clinician.

Resolution:

- Educate clinicians on how to read the F2F and identify what has been "addressed" by the physician during the encounter.
- Primary reason for home health cannot be a stable/chronic condition that was not addressed by the physician during the encounter (e.g., treatment change or new or worsened condition that needs monitoring).

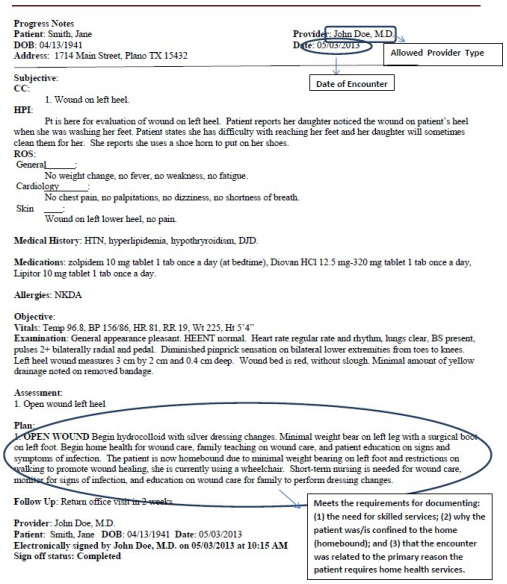
19

Resolution Continued and Understanding What is Addressed on F2F

- What does "addressed" mean?
  - Within the F2F encounter look for:
    - A condition that is new or is an exacerbated condition that has worsened
      - What is the physician primarily addressing with the pt/cg during the encounter?
    - Treatment change to an existing condition (e.g., medication change)

20

Reading the Face to Face to Find What is Being Addressed



Progress Notes
Patient: Smith, Jane
DOB: 04/13/1941
Address: 1714 Main Street, Plano TX 15432

Provider: John Doe, M.D.
Date: 05/03/2013

Allowed Provider Type

Date of Encounter

Subjective:
CC:
1. Wound on left heel.
HPI:
Pt is here for evaluation of wound on left heel. Patient reports her daughter noticed the wound on patient's heel when she was washing her feet. Patient states she has difficulty with reaching her feet and her daughter will sometimes clean them for her. She reports she uses a shoe horn to put on her shoes.
ROS:
General ____:
No weight change, no fever, no weakness, no fatigue.
Cardiology ____:
No chest pain, no palpitations, no dizziness, no shortness of breath.
Skin ____:
Wound on left lower heel, no pain.

Medical History: HTN, hyperlipidemia, hypothryroidism, DJD.

Medications: zolpidem 10 mg tablet 1 tab once a day (at bedtime), Diovan HCt 12.5 mg-320 mg tablet 1 tab once a day, Lipitor 10 mg tablet 1 tab once a day.

Allergies: NKDA

Objective:
Vitals: Temp 96.8, BP 156/86, HR 81, RR 19, Wt 225, Ht 5'4"
Examination: General appearance pleasant. HEENT normal. Heart rate regular rate and rhythm, lungs clear, BS present, pulses 2+ bilaterally radial and pedal. Diminished pinprick sensation on bilateral lower extremities from toes to knees. Left heel wound measures 3 cm by 2 cm and 0.4 cm deep. Wound bed is red, without slough. Minimal amount of yellow drainage noted on removed bandage.

Assessment:
1. Open wound left heel

Plan:
1. **OPEN WOUND** Begin hydrocolloid with silver dressing changes. Minimal weight bear on left leg with a surgical boot on left foot. Begin home health for wound care, family teaching on wound care, and patient education on signs and symptoms of infection. The patient is now homebound due to minimal weight bearing on left foot and restrictions on walking to promote wound healing, she is currently using a wheelchair. Short-term nursing is needed for wound care, monitor for signs of infection, and education on wound care for family to perform dressing changes.

Follow Up: Return office visit in 2 weeks.

Provider: John Doe, M.D.
Patient: Smith, Jane **DOB**: 04/13/1941 **Date**: 05/03/2013
Electronically signed by John Doe, M.D. on 05/03/2013 at 10:15 AM
Sign off status: Completed

Meets the requirements for documenting: (1) the need for skilled services; (2) why the patient was/is confined to the home (homebound); and (3) that the encounter was related to the primary reason the patient requires home health services.

21

Common Error and Resolution

Problem: Intake team misreads F2F and may use "proxy" primary diagnoses like HTN to move the referral forward.

Resolution

- "Medical History" or "Problem List" indicate additional or supporting diagnosis history but **NOT the FOC.**
- FOC typically resides in documentation focused on the patient "Assessment" or "Plan".
- Note missing elements of a diagnosis such as laterality or the etiology of a wound that may create query, or that you do not have a valid diagnosis to qualify for home care admission.
- Using a standard open wound dx as a placeholder in previous scenario sets up the clinician to identify need for wound care orders, supplies etc. and aligns to the reason for homecare admission.
- If Intake needs to place a "diagnosis" in the EMR to move the record in workflow provide an applicable diagnosis specific to why the patient is being referred to home health.

22

Skilled Need & FOC

23

Conditions Patient Must Meet to Qualify for Home Health Services

To qualify for the Medicare home health benefit, beneficiary must meet the following requirements:

- Be confined to the home;
- Under the care of a physician or allowed practitioner;
- Receiving services under a plan of care established and periodically reviewed by a physician or allowed practitioner;
- Be in need of skilled nursing care on an intermittent basis or physical therapy or speech- language pathology; or
- Have a continuing need for occupational therapy.

24

Qualifying Skill: Defined by Chapter 7

1

Agency must identify if the patient has a "qualifying skill" to bill Medicare

- 3 qualifying skills: SN, PT, ST
- Once a patient has qualified for home health, with SN, PT, or SLP needs- then OT can stand alone

2

Home Health Skilled Nursing

- Observation and Assessment
- Teaching and Training
- Skilled procedures

3

Home Health Therapy PT, OT, SLP

- Functional ability including cognitive ability
- Establish home maintenance program

25

Examples Skilled Need & FOC

Example:

Patient admitted to hospital with increased temp and cough. Tested negative for flu and COVID.

HH Referral/F2F includes - RN/PT

MD Assessment - patient has pneumonia due to infectious organism

Plan is to continue Budesonide, Doxycycline, Promethazine and Mucinex.

Patient is weak, new to oxygen and MD started a new nebulizer - Albuterol

Past Medical History:

- Left breast cancer
- Osteoporosis
- Hypertension
- Migraines
- Back pain

- **HH referral.** Pneumonia is the *reason for home health (F2F)*
- **Skilled Need/FOC Pneumonia**
  - Skilled nursing - Disease management around respiratory status to ensure clinical condition and treatment stabilize (observation and assessment & teach train).
    - Thorough respiratory assessment (e.g., record any adventitious lung sounds and O2 sats).
    - Unstable vitals like elevated temp.
    - Teaching including patient response to oxygen and new medications.
    - Interventions and goals in POC around best practices in assessing/monitoring a patient with pneumonia.
  - Therapy - improve strength and conditioning; increase activity as tolerated (restorative therapy)
    - Short - and long-term goals
    - Patient response to treatment and goals for next visit

26

Examples Skilled Need & FOC

Example:

Patient in the VA clinic with chief complaint of deconditioning/residual right-side weakness.

HH Referral/F2F includes - **PT**

MD Assessment - patient has been bedridden for short time following recent CVA. Needs rehabilitation for deconditioning.

Plan Order PT for fall prevention, gait training, establish home exercise program, transfer training, strengthening.

Past Medical History:

- Type 2 DM
- Aphasia
- Stroke with right-sided weakness (March 2024)
- Epilepsy
- Unspecified dementia
- Enlarged prostrate
- HTN
- Afib
- Hyperlipidemia

- **HH referral**. Right-sided weakness *reason for home health (F2F)*
  - CVA late effect - hemiplegia and hemiparesis following CVA right side

- **Skilled Need/FOC** Right-sided weakness due to recent CVA
  - Physical therapy - improve patient function as much as possible through gait training, strengthening and begin home exercise program.
    - Short - and long-term goals
    - Patient response to treatment and goals for next visit

27

Examples Skilled Need & FOC

Example:

Patient had an ICD implant left shoulder on 11/14 and went to wound clinic on 12/15 after finding a hole in the incision. The incision required debridement and patient developed malaise, cough, dizziness and mild hypotension and was admitted.

F2F/H&P

Wound Dehiscence

- Consult Infectious disease
- Wound and blood culture were obtained on admission. Started on IV antibiotics in preparation for device extraction
- 12/21 device extraction
- Wound VAC was placed with sponge changes per WOCN
- Discharged on oral antibiotics and HH nursing to change wound VAC 3x/week

Chronic Heart Failure

- EF in October was 30 to 40%
- Device interrogation during admission prior to explant showed no episodes of dysrhythmia and she was V pacing 100%
- She had some intermittent IV Lasix requirements but was successfully transition back to oral therapy prior to discharge. She also remained on beta-blacker, and spironolactone.
- At discharge she was euvolemic. Her admit wt. was 195lbs and at time of discharge 192lbs.

Peripheral Artery Disease

- She was complaining of right leg pain during admission. Arterial duplex showed no evidence of hemodynamically significant stenosis
- Pain improved by the time of discharge
- She will continue her statin and Plavix.

- **HH referral**. Wound dehiscence is the *reason for home health (F2F)*

- **Skilled Need/FOC** Wound dehiscence
  - Skilled nursing - Wound care (VAC) to right shoulder (skilled hands-on care)

Requires the most intensive service

28

Referrals/Response Letter

To:
From:
Sent: 05/14/2024 16:21:35
Subject: Patient Referral
Regarding:

Face to Face

We are referring to you for evaluation and treatment. Skilled Nursing: Home Safety Evaluation, Physical therapy:
Dx: R26.89, Home Health- ADL's, Wound care: Dx: S51.801

Sincerely,

rashmi chha

Encounter - 05/14/2024

SEEN BY		SEEN ON	
		05/14/2024	
HEIGHT	WEIGHT	BMI	BLOOD PRESSURE
66.0 in	111.2 lbs	17.9	109/67
TEMP	PULSE	RESP RATE	HEAD CIRC
97.1 F	87.0 bpm	16.0 rpm	N/A

CC
Hospital FU (NWMCS) (Appt time: 5/14/2024 10:45:00 AM) (Arrival time: 10:40 AM)
S
The patient is a 69 year old female coming in for follow up from the ED visit

had a fall on 5/9 after a trip and landed on rt side with rt shoulder and arm and forearm pain and rt eye orbital pain and hematoma
Has
ROS - 8 system comprehensive review done , positive symptoms noted as above in subjective.
Ongoing medical problems: Hypothyroidism, allergies, history of Astrocytoma.
O

A
Diagnoses attached to this encounter:

(I10) Essential (primary) hypertension
(E03.9) Hypothyroidism, unspecified
P
1. Has high risk fall , has been weak in legs , feels dizzy and needs HH PT and nursing for safety eval and help with ambulation .Has lot of weakness and sob with it , is very tired , cant walk or exert much
Provided referral for home health and PT and nursing for better care as she is homebound due to dizziness and weakness and instability with high fall risk .She needs skilled nursing disease management , home safety evaluation , PT evaluate and treat and mobility training and therapeutic exercises Patient needs assistance with walking and daily activities.
SIGNED BY
This encounter is not yet electronically signed.

Referral electronically submitted by **05/14/2024 04:21PM**

Sample of Incorrect Primary DX Documented

Clinician stated Focus of Care HTN

Note Date 05/17/2024 **Note Type** **Entered By** **Note Status** Active
Last Update **Last Updated By**

Note
PRIMARY DX (INCLUDING MANIFESTATIONS) THAT REPRESENTS THE MOST INTENSE SERVICES FOR HOME CARE: (SEVERITY FROM 0-4)

DIAGNOSIS: HTN
SEVERITY:
ONSET OR EXACERBATION?
DATE:

NOTE: PRIMARY DX SHOULD MATCH YOUR FOCUS OF CARE AND BE SUPPORTED BY THE PATIENTS PROVIDER IN THE RECORD.

SECONDARY DX (INCLUDING MANIFESTATIONS) THAT REPRESENT CO-MORBIDITIES AND UNSTABLE/ONGOING DX: (COMORBIDITIES THAT MUST ALWAYS BE LISTED ARE: DM, HTN, COPD, CAD, PVD, CHF, CA, BLINDNESS AND PARKINSONS)

2. DIAGNOSIS:MALIGNANT NEOPLASM OF BRAIN
SEVERITY:
ONSET OR EXACERBATION?
DATE:2004

3. DIAGNOSIS:STROKE
SEVERITY:
ONSET OR EXACERBATION?
DATE:

4. DIAGNOSIS:APHASIA
SEVERITY:
ONSET OR EXACERBATION?
DATE:

5. DIAGNOSIS:WEAKNESS/DIZZINESS
SEVERITY:
ONSET OR EXACERBATION?
DATE:

6. DIAGNOSIS: MULTIPLE GROUND LEVEL FALLS RESULTING IN INJURIES

Great template to help support and provide skilled need and primary reason for home health in a centralized location

Impact to Incorrectly Identify Primary Diagnosis

HIPPS	Case Mix	Wage Index	RAP Billed	Claim Billed	Period Timing	Admission Source	Clinical Grouping	Impairment Level	Comorbidity Adjustment	(at OASIS lock) ($)	Est/Actual Revenue ($)
3HA11	0.5667	0.8551	N	N	Late	Community	MMTA - Cardiac	Low	None	1,009.07	1,009.07
1HA11	0.9274	0.8551	N	N	Early	Community	MMTA - Cardiac	Low	None	2,055.79	1,651.32
										3,064.86	2,660.39

Early, Community — **Medium** Impairment

Wound — **None** Adjustment

Code	Description
S51.801D	UNSPECIFIED OPEN WOUND OF RIGHT FOREARM, SUBS ENCNTR
S72.141D	DISPL INTERTROCH FX R FEMUR, SUBS FOR CLOS FX W ROUTN HEAL
S22.31XD	FRACTURE OF ONE RIB, RIGHT SIDE, SUBS FOR FX W ROUTN HEAL

RN/SN	PT/PTA	OT/COTA	
1/8	0/0	0/0	
ST	HHA	MSW	Total
0	0	0	9

Total Revenue	$2,7
Supplies	(18.83)
Visits	(617.35)
Trips	0.00
Margin 74.97%	$2,070.50

Late, Community — **Medium** Impairment

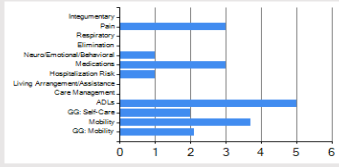
Wound — **None** Adjustment

Code	Description
S51.801D	UNSPECIFIED OPEN WOUND OF RIGHT FOREARM, SUBS ENCNTR
S72.141D	DISPL INTERTROCH FX R FEMUR, SUBS FOR CLOS FX W ROUTN HEAL
S22.31XD	FRACTURE OF ONE RIB, RIGHT SIDE, SUBS FOR FX W ROUTN HEAL

RN/SN	PT/PTA	OT/COTA	
1/7	0/0	0/0	
ST	HHA	MSW	Total
0	0	0	8

Supplies	0.00
Visits	(535.24)
Trips	0.00
Margin 71.71%	$1,460.12

HOME HEALTH, WOUND CARE — **1st** Episode



RN/SN	PT/PTA	OT/COTA	
0/17	0/0	0/0	
ST	HHA	MSW	Total
0	0	0	17

Revenue	$4,798.00
Supplies	(18.83)
Visits	(1152.60)
Trips	0.00
Margin 73.59%	$3,530.62

Estimated Loss of revenue $2,137.61

31

Example of F2F Addressing HTN

1. Benign essential hypertension
I10: Essential (primary) hypertension
- clonidine HCl 0.1 mg tablet - Take 1 tablet(s) every day by oral route at bedtime for 90 days. Qty: (90) tablet Refills: 3 Pharmacy: WALGREENS DRUG STORE [redacted] Note to Pharmacy: PLEASE NOTE THAT WE ARE CHANGING HER FROM PRN TO QHS--THANKS

2. Long-term drug therapy
Z79.899: Other long term (current) drug therapy

Discussion Notes
WE ARE GOING TO HAVE HER TAKE CLONIDINE 0.1 MG Q HS, IN HOPES OF AVOIDING ANY REBOUND HTN FROM PRN USE & IN HOPES OF BETTER CONTROL OF HER BP.

Return to Office
- PAOLA [redacted] MD for Cypress MAWV at IMA

Encounter Sign-Off
Encounter signed-off by PAOLA [redacted] MD, 05/0

Obstetric History
Reviewed Obstetric History

TOTAL	FULL	PRE	AB. I	AB. S	ECTOPICS	MULTIPLE	LIVING
2	2						2

Past Medical History
Discussed Past Medical History
HYPERTENSION: Y
URINARY/BLADDER/KIDNEY PROBLEMS: N - bladder hyperactivity

Screening
None recorded.

HPI
SHE'S HERE AS A W/I WITH ACCELERATED HTN--HER BP READING AT WHITE HALL THIS AM WAS 204/86 WITH A HR OF 70. SHE TOOK A DOSE OF CLONIDINE & REPEAT READING WAS 172/68. SHE'S HAD 2 CLONIDINE TODAY, BUT SHE DOESN'T TAKE IT ON A SCHEDULED BASIS. SHE DID TAKE ONE OVER THE WEEKEND.

32

Identifying Focus of Care

33

Focus of Care Identifiers

The following 3 items MUST be met:

1. The clinician FOC should align with the MD reason for HH (F2F)
   - Be *addressed* in the face to face (the only condition eligible to be your HH focus of care)
   - Condition that will receive the most intensive service
2. Clinician FOC should align with F2F **and** be supported in the Plan of Care
   - FOC must have interventions and goals in the POC
3. Clinician FOC should align with the F2F **and** be supported by the POC **and** clinician's documentation around *skilled need*

34

Identifying the FOC

- Step 1: Prep for Initial Assessment & Read F2F Encounter (orders for HH)
  - You must read the F2F encounter and identify what is the reason for home health; what did the physician address in the patient encounter that led to needing skilled home health care.
- Step 2: Complete Initial Assessment
  - Assess patient and determine home health eligibility including skilled need. HHA information can be corroborated with the certifying physician or allowed practitioner's.
    - This means that the HHA documentation along with the certifying MD medical records create a clinically consistent picture that the patient is eligible for Medicare HH services.
  - Potential Next Step(s):
    - MD reason for home health does not align with clinician initial assessment findings and a NEW F2F is needed within 30 days.
    - No skilled need or homebound to meet Medicare eligibility requirements.
- Step 3: Complete the OASIS & POC
  - The comprehensive assessment and POC should address the primary reason for home health (F2F) and all other comorbidities that will impact the POC.
  - Clinician documentation addresses the *skilled need for home health care.*

35

Focus of Care Best Practices

- Establish a dedicated team (marketing/Intake) - Ensure proper documentation is obtained from ordering provider at *time of referral*
- Training - ensure that all team members are trained on current regulations, coding practices and documentation requirements.
- Identify the F2F or reason for home health (clearly labeled) and flag for clinician to review prior to admission.
  - Write FTF on the appropriate documents being used for the certification OR scan in with label of FTF - noting the date.
- Add any additional "corroborating" evidence to the POC for the provider to sign off re: homebound and skilled need.
- PRO TIP! Create a solid "why HH, why now" template for the admission summary. Copy and paste that into the POC and now when the ordering provider signs - this is now part of the FTF documentation/corroboration.

36

Clinician Template Helpful to Standardize Documentation Requirements

CURRENT STATUS *

- Describe the patient's condition including mental status, S/S, appearance, environment, needs etc.

SINCE LAST IN-HOME VISIT: *

- Note any changes in how the patient feels daily, MD visits, changes to meds, falls or other events

SKILLED NEED/FOC - Why home health and why now: *

- This is discipline specific to the current visit; what was the skilled need for services you provided today?

- RESPONSE TO TODAY'S VISIT: TOLERATED (* WITH / WITHOUT) DIFFICULTY AND (* DID / DID NOT) REQUIRE * MEDICATION/PROMPTING/CUES/REMINDERS TO COMPLETE *

PLAN FOR NEXT VISIT: *

- Provide details on what focus will be next visit, meds, teaching injection, follow up with patient on MD visits in-between your in-home visits etc.

37

Questions?

Contact us at learning@wellsky.com

38