FULL RANGE HEALTH SERVICES®
Your Life. Your Goals. Your Way.

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January 27, 2021
Location: Zoom Call
Agenda

Shout Outs: Welcome to the New Team Members!

Agenda

1. **COVID-19 Review/CDC Guidelines**
    a. Changes to guidelines
    b. COVID-19 Vaccination Declination Form

2. **Common Problems**
    a. SOC Paperwork
    b. Pharmacy Information
    c. Discharge Paperwork/Summary Note
    d. Acuity Status
    e. Immunization Information
    f. Allergies
    g. Visit Frequency
    h. Emergency Contacts
    i. Medication Issues
        i. High Risk
        ii. Over the counter
        iii. End dates
    j. Safety Measures

3. **Wound Infection**
    a. Prophylaxis Antibiotics are **NOT** an infection. We do not need an Infection Report written for these medications.

Reminders

1. *Documentation* -Tip/Reminder
    a. Please always be specific with your documentation! Exp. Instead of using the word "equipment"… please list the specific type of equipment – grab bars, shower chair, walker etc.

Next Team Meeting: Week of 3/15 – Same time and place! Zoom!

Renaissance

HOME HEALTH

Compassionate Care. Every Patient. Every Time.

Common Problems

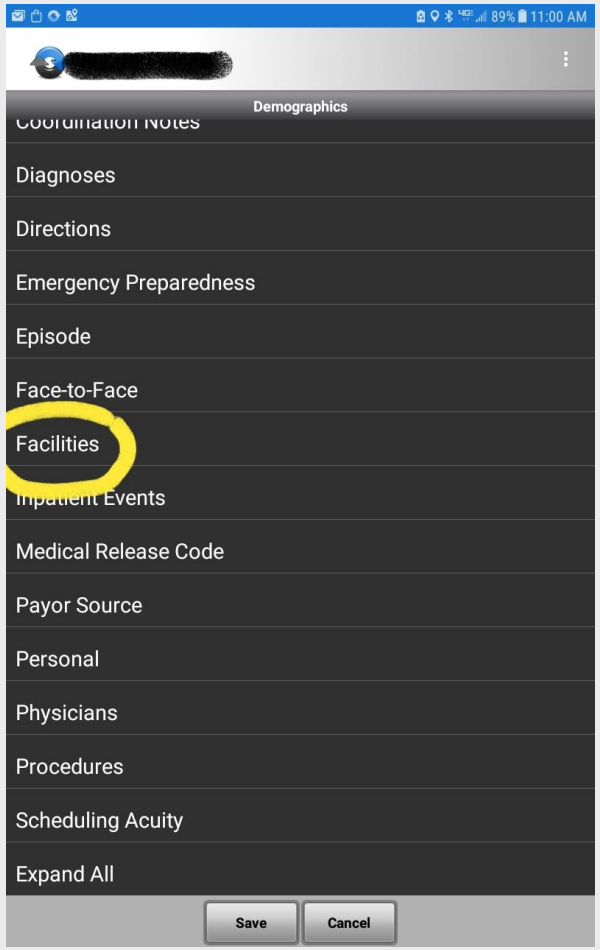
SOC paperwork

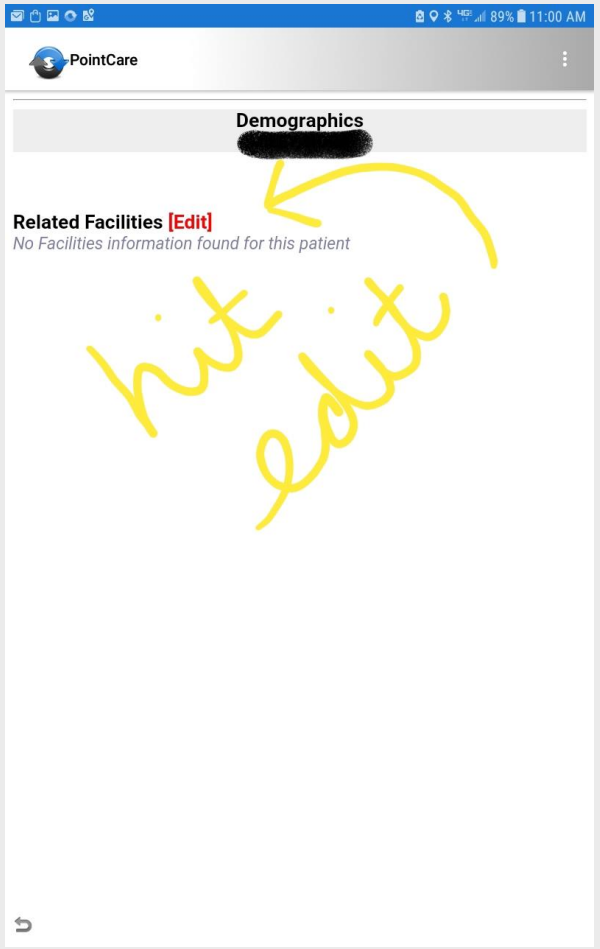
- We need SOC paperwork back within 24 hours.
- It needs to be filled out completely and accurately.
- This holds up billing.
- It is a Medicare requirement.

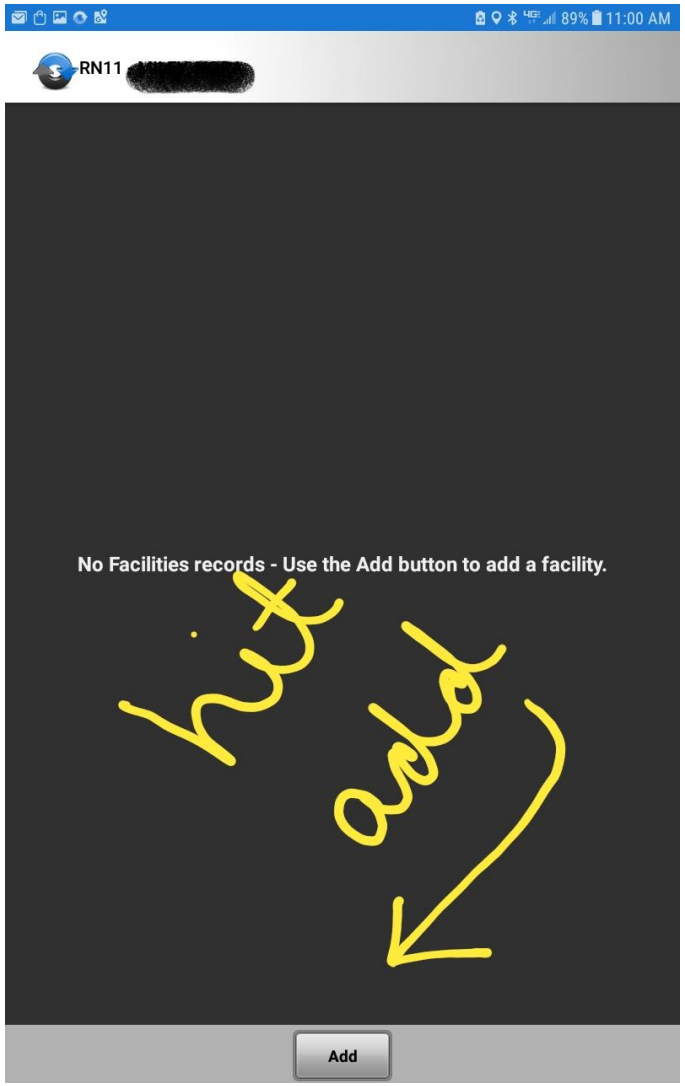
Pharmacy Info

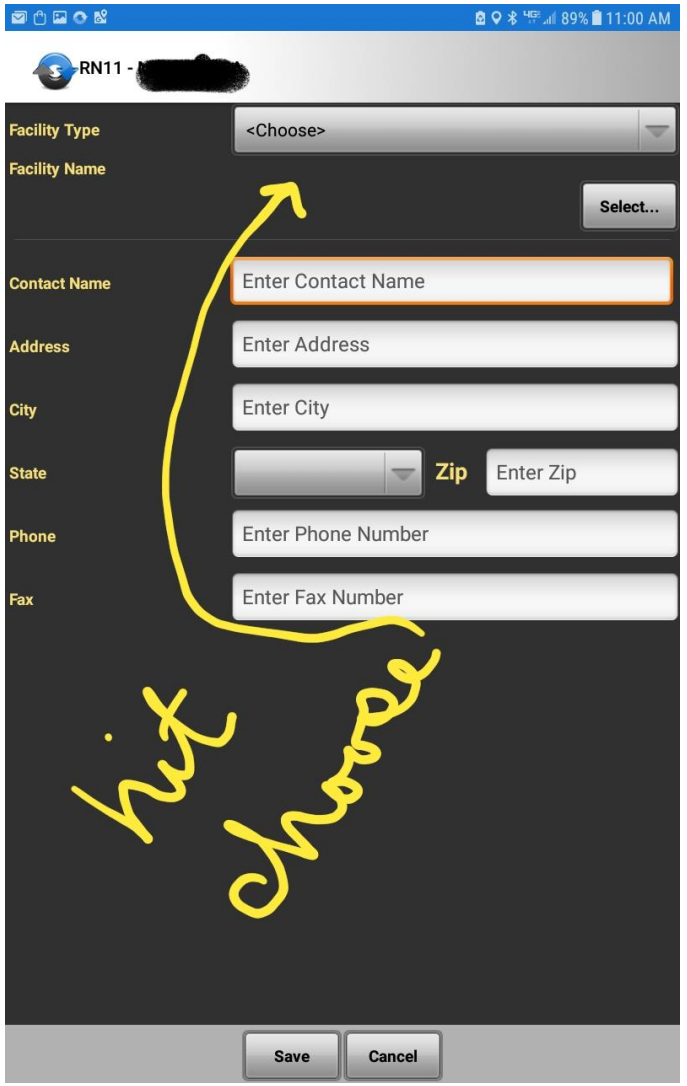
- Enter Pharmacy into FACILITIES section under the Demographics tab, in Point Care, if not an option, then.
  - *Selective Refresh to see if added since your last Refresh (can be done at home after your visit) if still not there*
  - *Enter info in SOC note and*
  - *Add note, "REQUEST TO ADD NEW PHARMACY"*
- SOC note and Pharmacy note MUST be written, if not entered directly into Point Care
- MUST be ADDED to Medication sheet as well

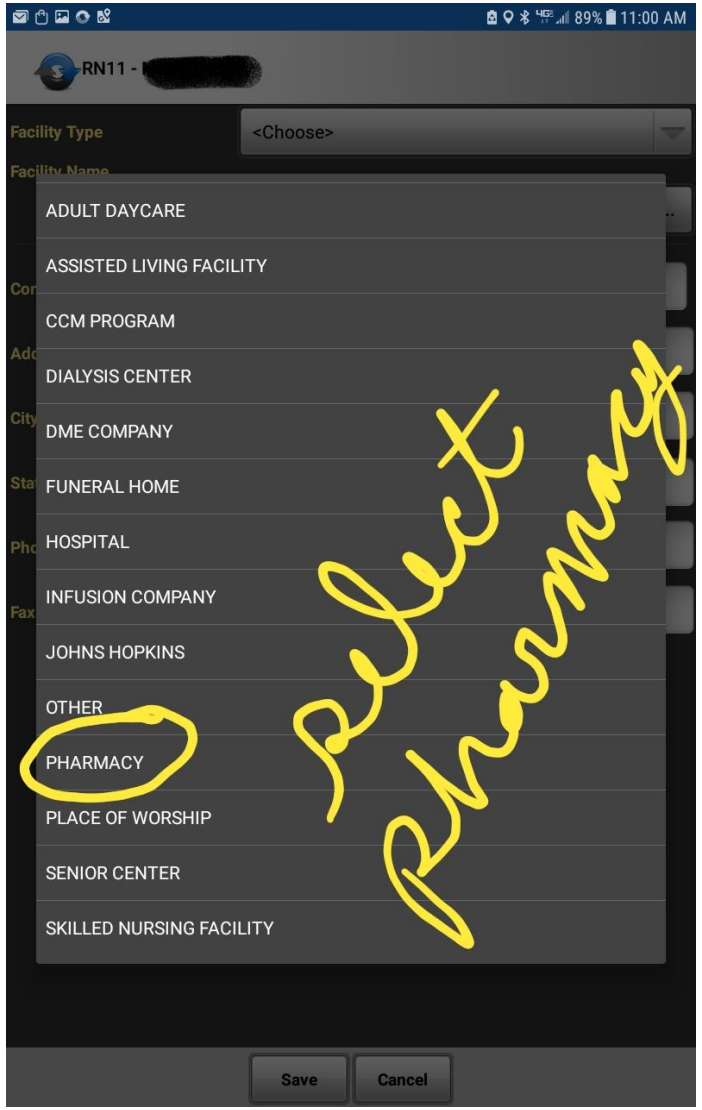
How to add Pharmacy: Step by Step Located under Demographics

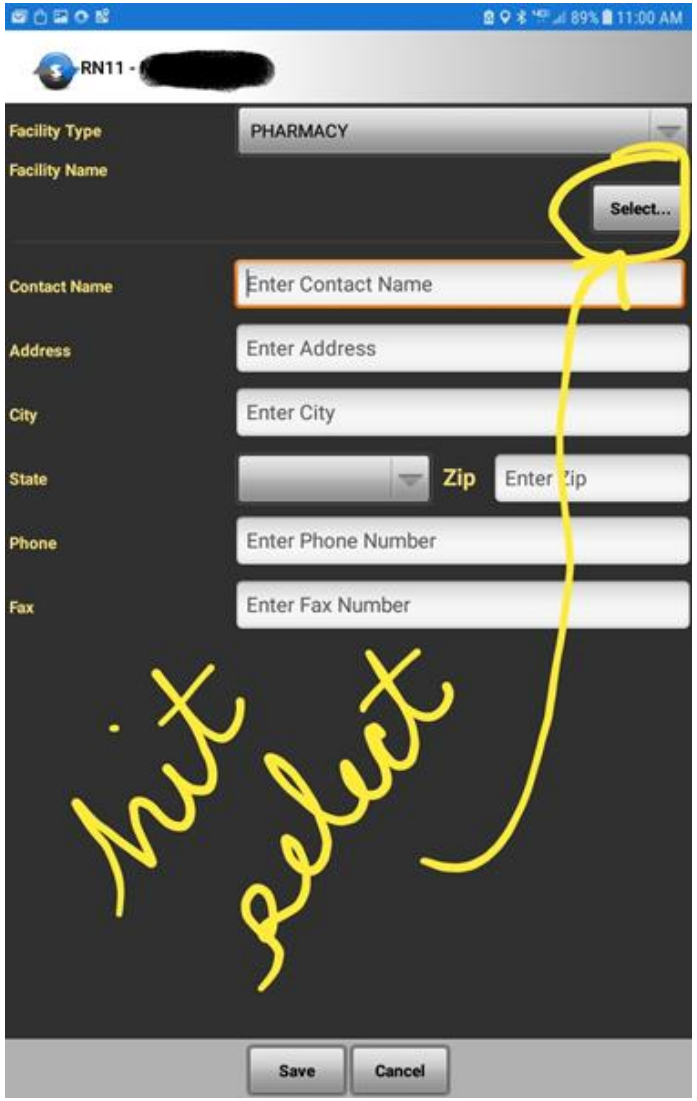


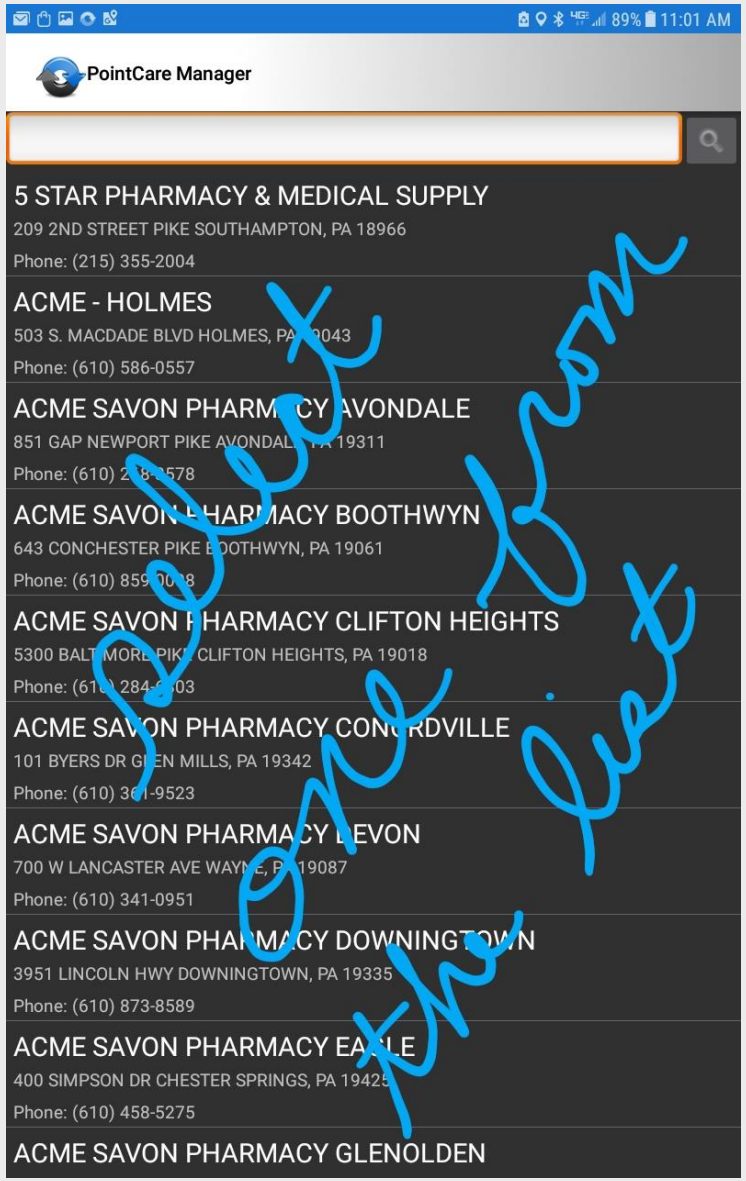


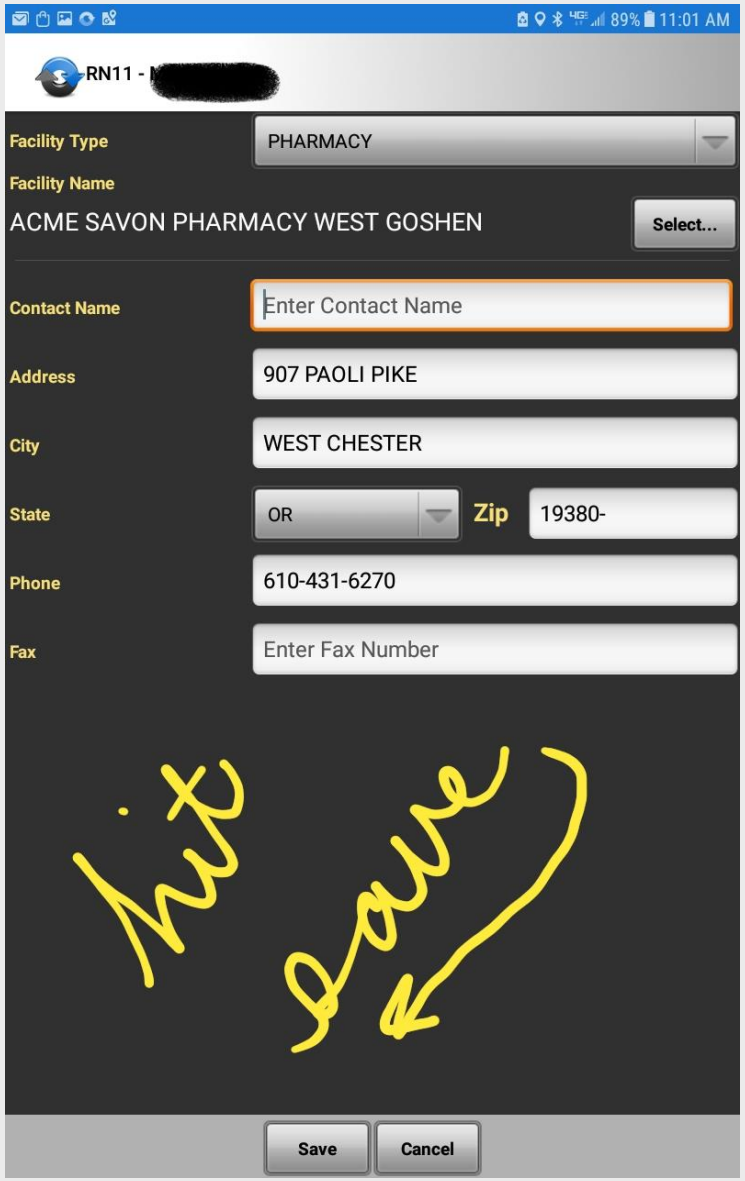


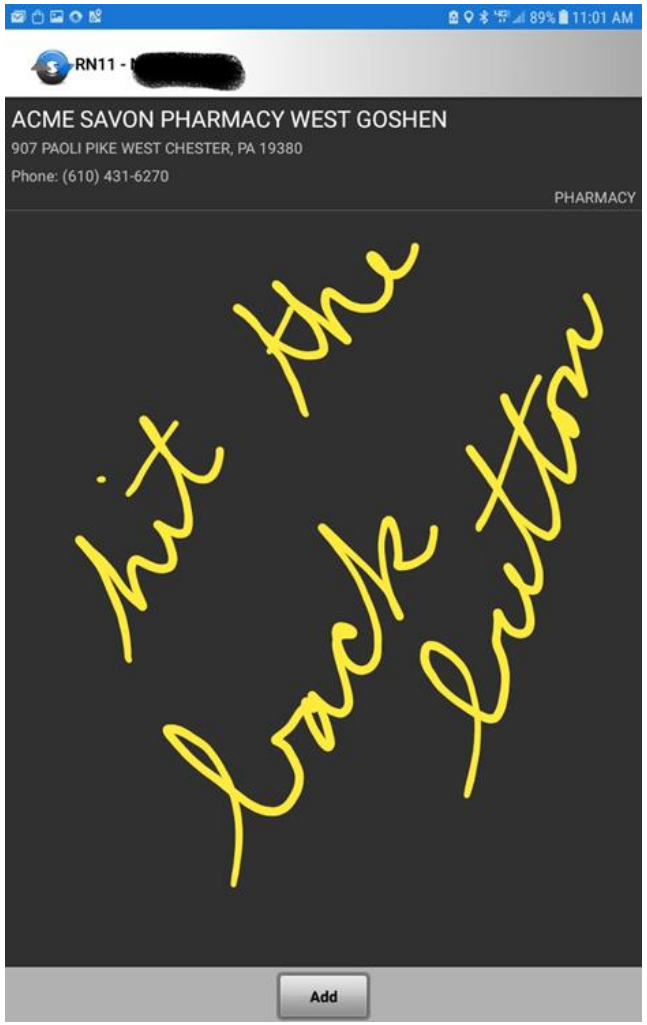


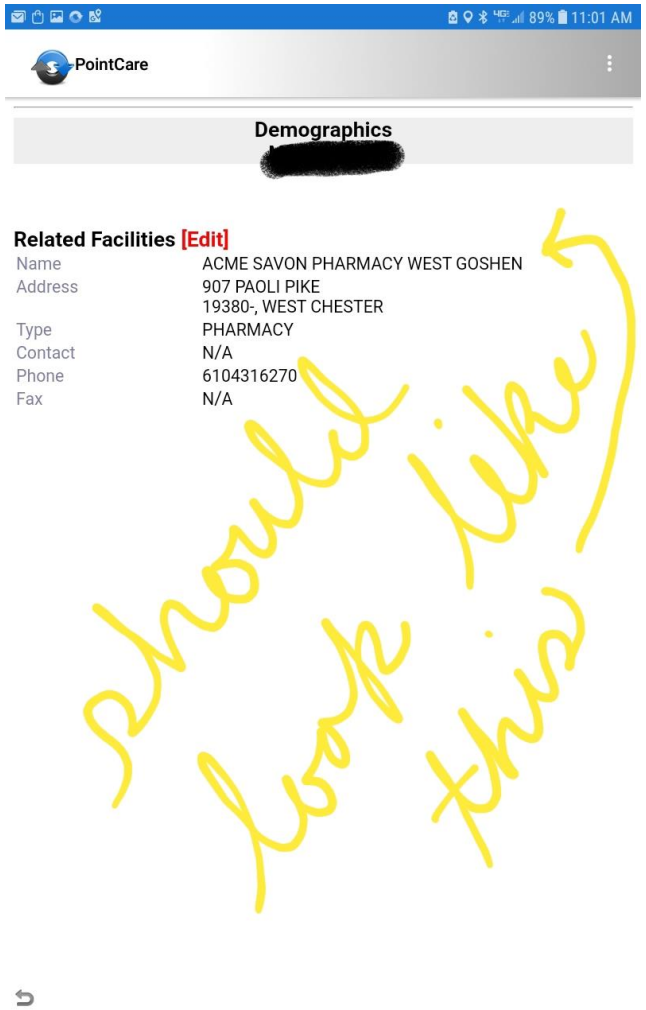










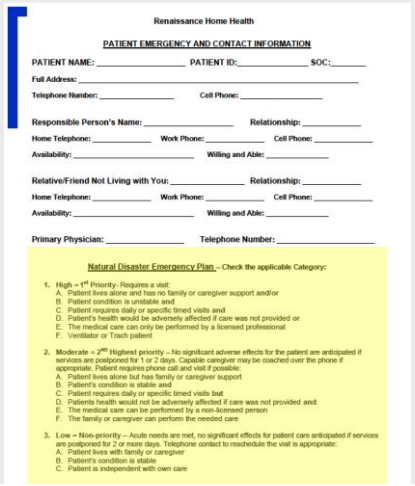


Discharge Paperwork and DC Summary Note

- The Forms and Note MUST be written, by ALL DISCIPLINES.
- Needed due to Medicare regulations
- Should be sent in within 24 hours
- What forms are needed
  - *DC Summary for all disciplines*
  - *NOMNC – completed by last person, at least 48 hours prior to DC*
  - *HHCCN – by ALL Disciplines*

Acuity status

- Acuity status on Emergency Contact Form need to match Patient Chart
- Most patients are Low, some are Moderate, very few are HIGH.
- HIGH means:
  - *Lives alone or NO SUPPORT*
  - *UNSTABLE*
  - *REQUIRES DAILY VISITS*
  - *MEDICAL CARE PROVIDED BY MEDICAL PROFESSIONAL ONLY*



Renaissance Home Health

PATIENT EMERGENCY AND CONTACT INFORMATION

PATIENT NAME: _____ PATIENT ID:_____ SOC:_____

Full Address: _____

Telephone Number: _____ Cell Phone: _____

Responsible Person's Name: _____ Relationship: _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Availability: _____ Willing and Able: _____

Relative/Friend Not Living with You: _____ Relationship: _____

Home Telephone: _____ Work Phone: _____ Cell Phone: _____

Availability: _____ Willing and Able: _____

Primary Physician: _____ Telephone Number: _____

Natural Disaster Emergency Plan – Check the applicable Category:

1. High = 1st Priority- Requires a visit:
   A. Patient lives alone and has no family or caregiver support and/or
   B. Patient condition is unstable and
   C. Patient requires daily or specific timed visits and
   D. Patient's health would be adversely affected if care was not provided or
   E. The medical care can only be performed by a licensed professional
   F. Ventilator or Trach patient
2. Moderate = 2ND Highest priority – No significant adverse effects for the patient are anticipated if services are postponed for 1 or 2 days. Capable caregiver may be coached over the phone if appropriate. Patient requires phone call and visit if possible:
   A. Patient lives alone but has family or caregiver support
   B. Patient's condition is stable and
   C. Patient requires daily or specific timed visits but
   D. Patients health would not be adversely affected if care was not provided and
   E. The medical care can be performed by a non-licensed person
   F. The family or caregiver can perform the needed care
3. Low = Non-priority – Acute needs are met, no significant effects for patient care anticipated if services are postponed for 2 or more days. Telephone contact to reschedule the visit is appropriate:
   A. Patient lives with family or caregiver
   B. Patient's condition is stable
   C. Patient is independent with own care

Circle appropriate number

Natural Disaster Emergency Plan – Check the applicable Category:

1. **High = 1st Priority-** Requires a visit:
   A. Patient lives alone and has no family or caregiver support **and/or**
   B. Patient condition is unstable **and**
   C. Patient requires daily or specific timed visits **and**
   D. Patient's health would be adversely affected if care was not provided **or**
   E. The medical care can only be performed by a licensed professional
   F. Ventilator or Trach patient

2. **Moderate = 2ND Highest priority** – No significant adverse effects for the patient are anticipated if services are postponed for 1 or 2 days. Capable caregiver may be coached over the phone if appropriate. Patient requires phone call and visit if possible:
   A. Patient lives alone but has family or caregiver support
   B. Patient's condition is stable **and**
   C. Patient requires daily or specific timed visits **but**
   D. Patients health would not be adversely affected if care was not provided **and**
   E. The medical care can be performed by a non-licensed person
   F. The family or caregiver can perform the needed care

3. **Low = Non-priority –** Acute needs are met, no significant effects for patient care anticipated if services are postponed for 2 or more days. Telephone contact to reschedule the visit is appropriate:
   A. Patient lives with family or caregiver
   B. Patient's condition is stable
   C. Patient is independent with own care

Immunization information

- Please add this information into PointCare so it is documented
  - *Flu*
  - *Pneumonia*
  - *Shingles*

- Flu season is from Oct thru March, so when answering the question, about the Flu vaccine, and the case was opened or closed within this time frame the answer is YES.

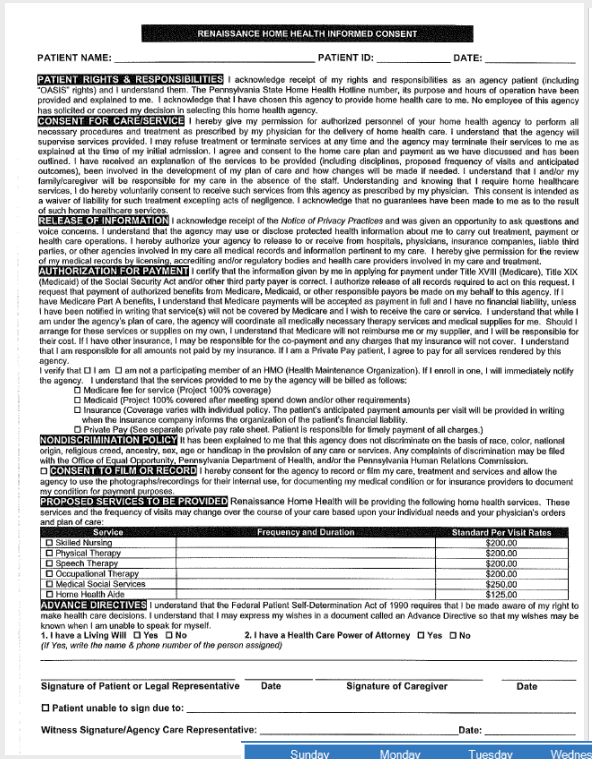
Allergies

- Just because they may or may not be added in the chart at intake, they must be asked at SOC, to the patient.
- Allergies change and people develop new ones over time. We need to get them ACCUATELY documented in the chart.
  - *For accuracy*
  - *Medicare Requirement*
  - *Medication reconciliation*
  - *Reduce Re-Hospitalizations*

Visit frequency

- Visit Frequency MUST Match
  - *SOC Consent*
  - *Initial POC form*
  - *Calendar visits plotted*
- **Why…?**

Because it is a Medicare Regulations



RENAISSANCE HOME HEALTH INFORMED CONSENT

PATIENT NAME: _____ PATIENT ID: _____ DATE: _____

PATIENT RIGHTS & RESPONSIBILITIES I acknowledge receipt of my rights and responsibilities as an agency patient (including "OASIS" rights) and I understand them. The Pennsylvania State Home Health Hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care to me. No employee of this agency has solicited or coerced my decision in selecting this home health agency.

CONSENT FOR CARE/SERVICE I hereby give my permission for authorized personnel of your home health agency to perform all necessary procedures and treatment as prescribed by my physician for the delivery of home health care. I understand that the agency will supervise services provided. I may refuse treatment or terminate services at any time and the agency may terminate their services to me as explained at the time of my initial admission. I agree and consent to the home care plan and payment as we have discussed and has been outlined. I have received an explanation of the services to be provided (including disciplines, proposed frequency of visits and anticipated outcomes), been involved in the development of my plan of care and how changes will be made if needed. I understand that I and/or my family/caregiver will be responsible for my care in the absence of the staff. Understanding and knowing that I require home healthcare services, I do hereby voluntarily consent to receive such services from this agency as prescribed by my physician. This consent is intended as a waiver of liability for such treatment excepting acts of negligence. I acknowledge that no guarantees have been made to me as to the result of such home healthcare services.

RELEASE OF INFORMATION I acknowledge receipt of the *Notice of Privacy Practices* and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. I hereby authorize your agency to release to or receive from hospitals, physicians, insurance companies, liable third parties, or other agencies involved in my care all medical records and information pertinent to my care. I hereby give permission for the review of my medical records by licensing, accrediting and/or regulatory bodies and health care providers involved in my care and treatment.

AUTHORIZATION FOR PAYMENT I certify that the information given by me in applying for payment under Title XVIII (Medicare), Title XIX (Medicaid) of the Social Security Act and/or other third party payer is correct. I authorize release of all records required to act on this request. I request that payment of authorized benefits from Medicare, Medicaid, or other responsible payors be made on my behalf to this agency. If I have Medicare Part A benefits, I understand that Medicare payments will be accepted as payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and I wish to receive the care or service. I understand that while I am under the agency's plan of care, the agency will coordinate all medically necessary therapy services and medical supplies for me. Should I arrange for these services or supplies on my own, I understand that Medicare will not reimburse me or my supplier, and I will be responsible for their cost. If I have other insurance, I may be responsible for the co-payment and any charges that my insurance will not cover. I understand that I am responsible for all amounts not paid by my insurance. If I am a Private Pay patient, I agree to pay for all services rendered by this agency.

I verify that ☐ I am ☐ am not a participating member of an HMO (Health Maintenance Organization). If I enroll in one, I will immediately notify the agency. I understand that the services provided to me by the agency will be billed as follows:

- ☐ Medicare fee for service (Project 100% coverage)
- ☐ Medicaid (Project 100% covered after meeting spend down and/or other requirements)
- ☐ Insurance (Coverage varies with individual policy. The patient's anticipated payment amounts per visit will be provided in writing when the insurance company informs the organization of the patient's financial liability.
- ☐ Private Pay (See separate private pay rate sheet. Patient is responsible for timely payment of all charges.)

NONDISCRIMINATION POLICY It has been explained to me that this agency does not discriminate on the basis of race, color, national origin, religious creed, ancestry, sex, age or handicap in the provision of any care or services. Any complaints of discrimination may be filed with the Office of Equal Opportunity, Pennsylvania Department of Health, and/or the Pennsylvania Human Relations Commission.

☐ CONSENT TO FILM OR RECORD I hereby consent for the agency to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

PROPOSED SERVICES TO BE PROVIDED Renaissance Home Health will be providing the following home health services. These services and the frequency of visits may change over the course of your care based upon your individual needs and your physician's orders and plan of care:

Service	Frequency and Duration	Standard Per Visit Rates
☐ Skilled Nursing		$200.00
☐ Physical Therapy		$200.00
☐ Speech Therapy		$200.00
☐ Occupational Therapy		$200.00
☐ Medical Social Services		$250.00
☐ Home Health Aide		$125.00

ADVANCE DIRECTIVES I understand that the Federal Patient Self-Determination Act of 1990 requires that I be made aware of my right to make health care decisions. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself.

1. I have a Living Will ☐ Yes ☐ No **2. I have a Health Care Power of Attorney** ☐ Yes ☐ No

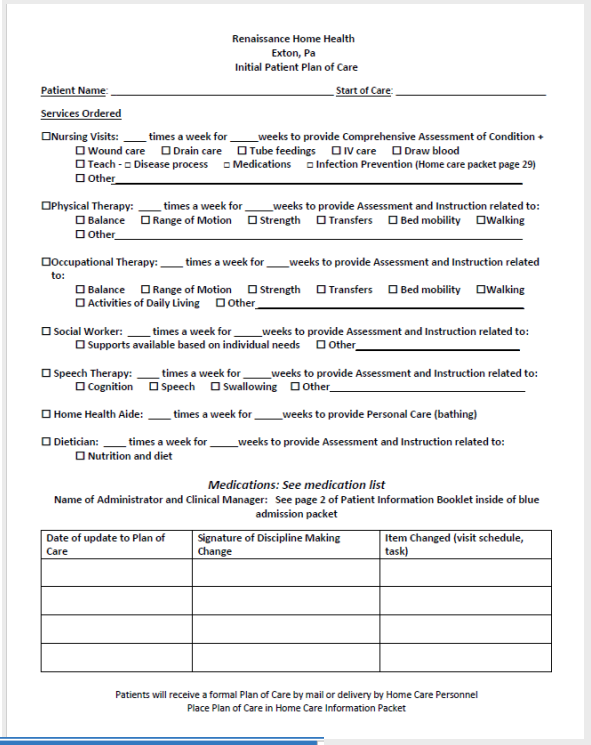
(If Yes, write the name & phone number of the person assigned)

_____ _____ _____ _____

Signature of Patient or Legal Representative **Date** **Signature of Caregiver** **Date**

☐ **Patient unable to sign due to:** _____

Witness Signature/Agency Care Representative: _____ **Date:** _____



Renaissance Home Health
Exton, Pa
Initial Patient Plan of Care

Patient Name: _____ Start of Care: _____

Services Ordered

☐Nursing Visits: ____ times a week for ____weeks to provide Comprehensive Assessment of Condition +
☐ Wound care ☐ Drain care ☐ Tube feedings ☐ IV care ☐ Draw blood
☐ Teach - ☐ Disease process ☐ Medications ☐ Infection Prevention (Home care packet page 29)
☐ Other_____

☐Physical Therapy: ____ times a week for ____weeks to provide Assessment and Instruction related to:
☐ Balance ☐ Range of Motion ☐ Strength ☐ Transfers ☐ Bed mobility ☐Walking
☐ Other_____

☐Occupational Therapy: ____ times a week for ____weeks to provide Assessment and Instruction related to:
☐ Balance ☐ Range of Motion ☐ Strength ☐ Transfers ☐ Bed mobility ☐Walking
☐ Activities of Daily Living ☐ Other_____

☐ Social Worker: ____ times a week for ____weeks to provide Assessment and Instruction related to:
☐ Supports available based on individual needs ☐ Other_____

☐ Speech Therapy: ____ times a week for ____weeks to provide Assessment and Instruction related to:
☐ Cognition ☐ Speech ☐ Swallowing ☐ Other_____

☐ Home Health Aide: ____ times a week for ____weeks to provide Personal Care (bathing)

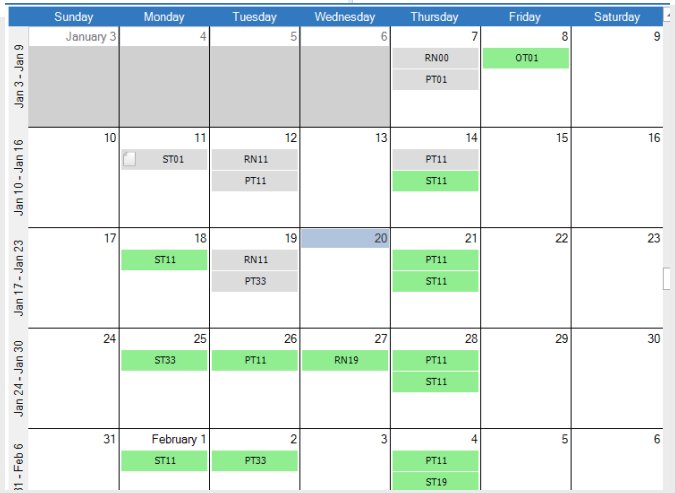
☐ Dietician: ____ times a week for ____weeks to provide Assessment and Instruction related to:
☐ Nutrition and diet

Medications: See medication list

Name of Administrator and Clinical Manager: See page 2 of Patient Information Booklet inside of blue admission packet

Date of update to Plan of Care	Signature of Discipline Making Change	Item Changed (visit schedule, task)

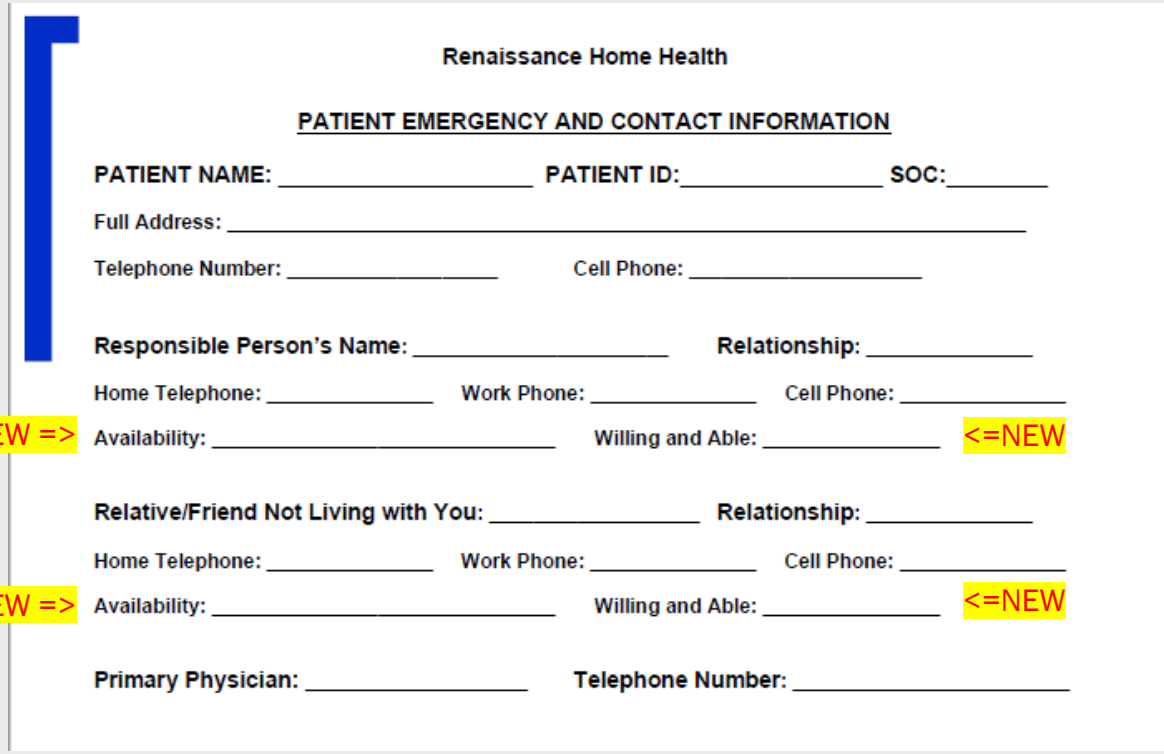
Patients will receive a formal Plan of Care by mail or delivery by Home Care Personnel
Place Plan of Care in Home Care Information Packet



	Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday
Jan 3 - Jan 9	January 3	4	5	6	7 RN00 PT01	8 OT01	9
Jan 10 - Jan 16	10	11 ST01	12 RN11 PT11	13	14 PT11 ST11	15	16
Jan 17 - Jan 23	17	18 ST11	19 RN11 PT33	20	21 PT11 ST11	22	23
Jan 24 - Jan 30	24	25 ST33	26 PT11	27 RN19	28 PT11 ST11	29	30
31 - Feb 6	31	February 1 ST11	2 PT33	3	4 PT11 ST19	5	6

Emergency Contacts

- Contacts must be added to Emergency Contact Form, and form MUST be completed FULLY. The form has some changes, please don't ignore the info, it is there for a reason, if you don't understand what to put, contact us, we will help you.
- Tablet Contact section and this form should be the same
- NEW => Please Add these details
  - **Availability – 24/7, Weekends, Certain Weekdays?**
  - ***Willing and Able – Write "YES" if they are willing and able***



Renaissance Home Health

PATIENT EMERGENCY AND CONTACT INFORMATION

PATIENT NAME: _____ **PATIENT ID:**_____ **SOC:**_____

Full Address: _____

Telephone Number: _____ **Cell Phone:** _____

Responsible Person's Name: _____ **Relationship:** _____

Home Telephone: _____ **Work Phone:** _____ **Cell Phone:** _____

NEW => **Availability:** _____ **Willing and Able:** _____ <=NEW

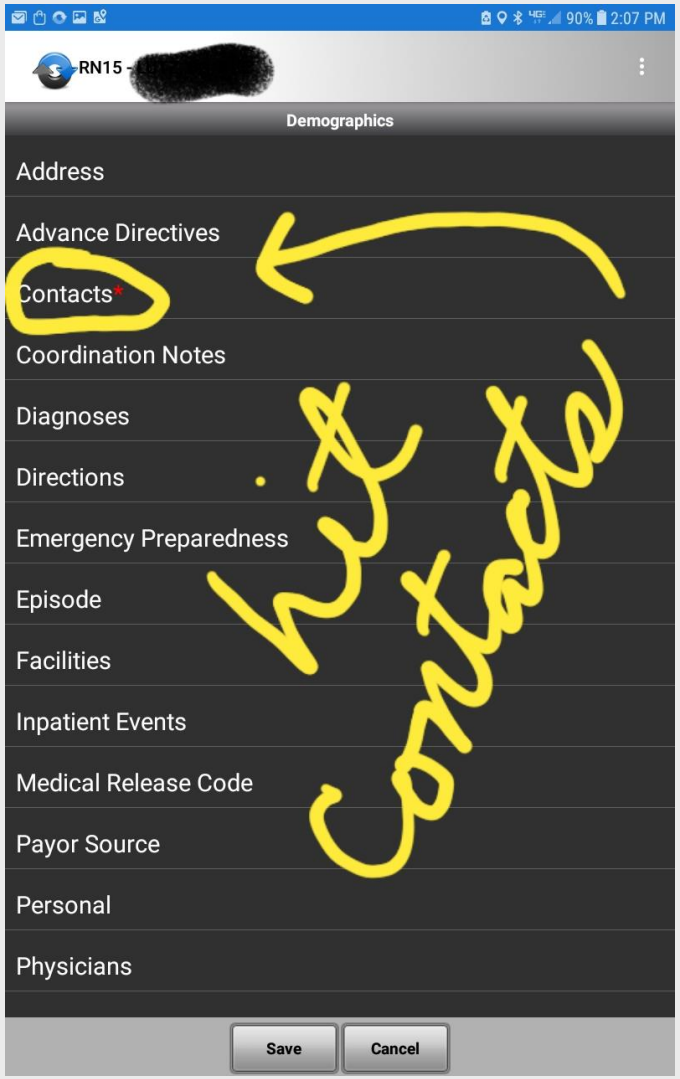
Relative/Friend Not Living with You: _____ **Relationship:** _____

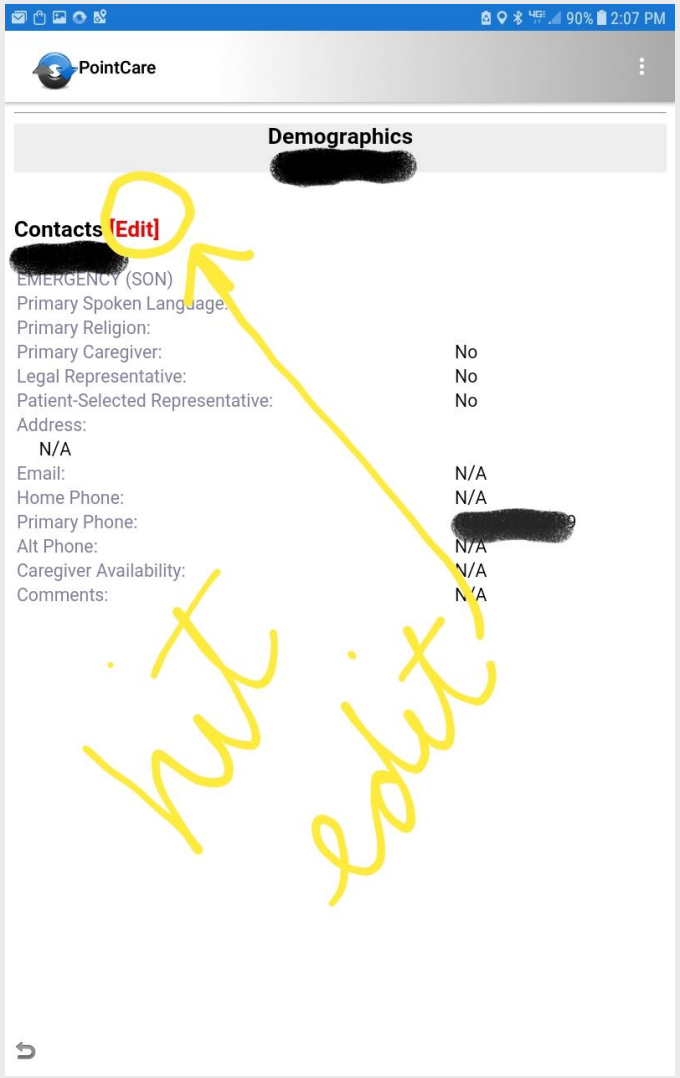
Home Telephone: _____ **Work Phone:** _____ **Cell Phone:** _____

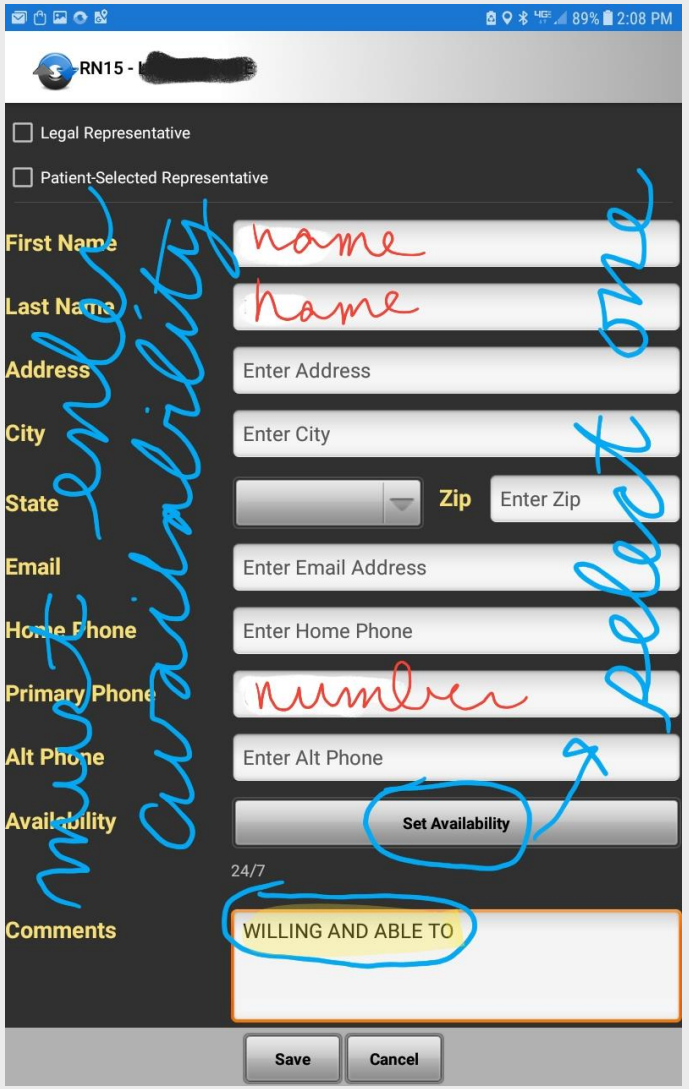
NEW => **Availability:** _____ **Willing and Able:** _____ <=NEW

Primary Physician: _____ **Telephone Number:** _____

How to add EMERGENCY CONTACTS into Point Care







Medication issues -- High Risk

- **CONTROLLED SUBSTANCES**
  - (Oxycontin, Percocet, Hydrocodone, Etc.)
- **DIABETIC MEDICATIONS: ORAL AND INSULIN**
  - (NPH, Regular, Metformin, Glyburide, Etc.)
- **IMMUNOSUPPRESSANT AGENTS**
  - (Corticosteroids (Prednisone), Cyclosporine's, MS, Lupus, Crohn's disease drugs)
- **DIURETICS**
  - (Lasix, Spironolactone, HCTZ, etc.)
- **ANTICOAGULANTS**
  - (Warfarin, Plavix, Eliquis, Xarelto, etc.)
- **POTASSIUM**
- **DIGOXIN**

Medications – Over the Counter Meds

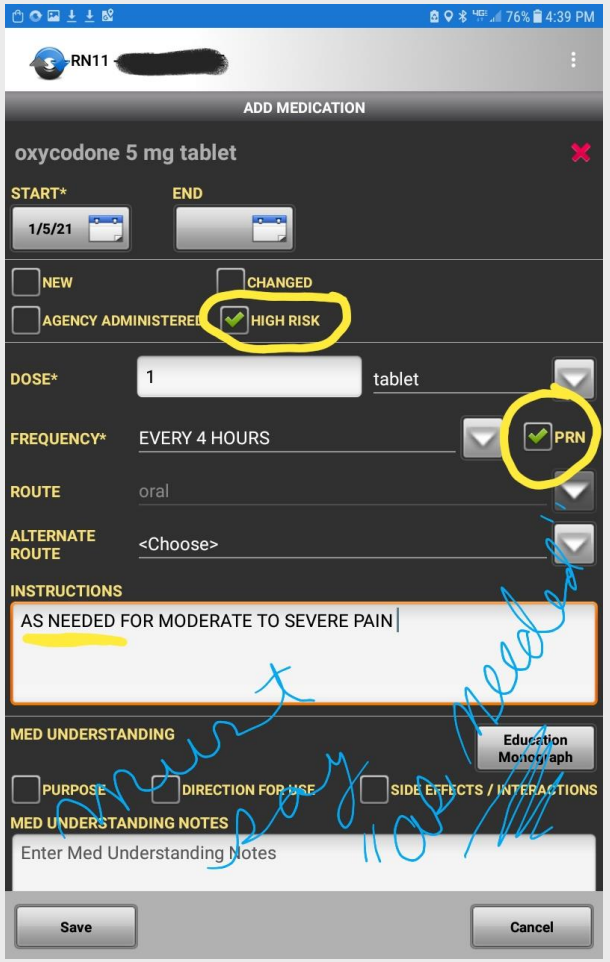
- Oxygen is a medication
- What over the Counter Meds they are on?
  - *Tylenol, Motrin, Aspirin, Pepcid, etc*
  - *Creams – dry skin, pain, itching, etc*
  - *Lotions – for pain, itching, etc*
  - *Vitamins – Multi, B complex, etc*
  - *Holistic Meds – ones they buy on Amazon, infomercial*
  - *Wound Care Meds – Santyl, Medi-Honey, etc*

Medications with End Dates

ACETAMINOPHEN 325 MG TABLET, 2 TABLET, EVERY 4 HOURS *Instructions: TAKE 2 TABLET EVERY 4 HOURS AS NEEDED FOR PAIN*	From 1/21/2021
ASPIRIN 81 MG TABLET,DELAYED RELEASE, 1 TABLET, 2 TIMES DAILY *Instructions: TAKE 1 TABLET X2 DAILY FOR 30 DAYS*	From 1/19/2021 to 2/18/2021
ATORVASTATIN 10 MG TABLET, 10 MG, EVERY AM *Instructions: TAKE 10MG EVERY MORNING*	From 1/20/2021
CELECOXIB 200 MG CAPSULE, 1 CAPSULE, DAILY *Instructions: TAKE 1 CAPSULE DAILY DAILY FOR 7 DAYS*	From 1/20/2021 to 1/26/2021
CEPHALEXIN 500 MG CAPSULE, 1 CAPSULE, 3 TIMES DAILY *Instructions: TAKE 1 CAPSULE X3 DAILY FOR 5 DAYS*	From 1/19/2021 to 1/23/2021
DOCUSATE SODIUM 100 MG CAPSULE, 1 CAPSULE, 2 TIMES DAILY *Instructions: TAKE 1 CAPSULE X2 DAILY FOR 10 DAYS*	From 1/19/2021 to 1/28/2021
HYDROXYUREA 500 MG CAPSULE, 1 CAPSULE, 2 TIMES DAILY	From 1/19/2021
OXYCODONE 5 MG TABLET, 1 TABLET, EVERY 4 HOURS *Instructions: TAKE 1 TABLET EVERY 4 HOURS AS NEEDED FOR SEVERE PAIN*	From 1/19/2021

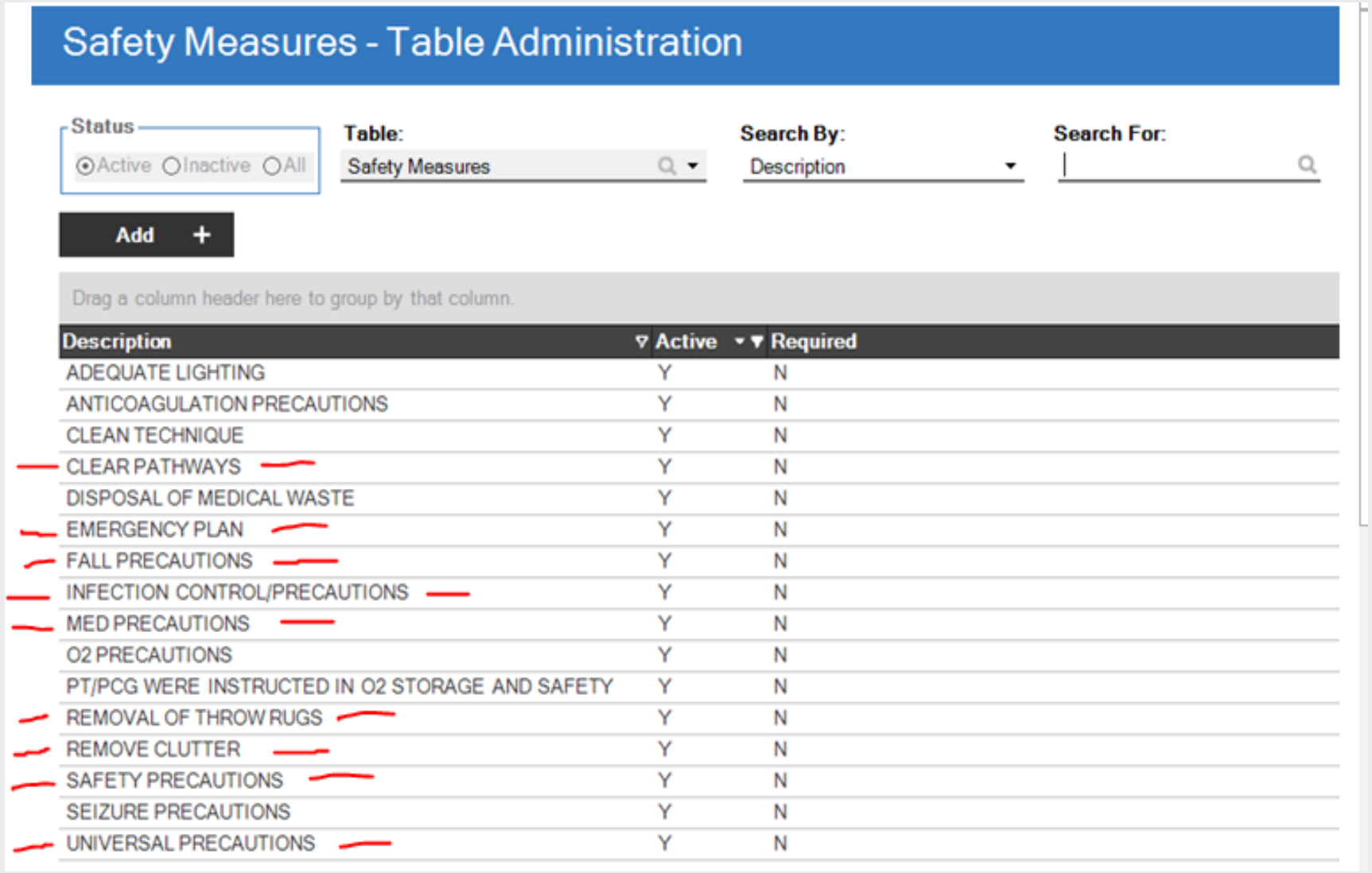
Medication Info

- End Date
- High Risk
- PRN
- Frequency
- Instructions



Safety Measures

These should be ADDED TO ALL SOC but NOT limited too these only



Infection Report

- Prophylaxis Antibiotics **DO NOT** need an infection report. We do not need an Infection Report written for these medications. Despite what you might have been told prior.
- Hospital infections are not an infection on us.
- Infections are those that are acquired during our care, a UTI, wound infection, etc. – These need a report
- **NOT something they came home with or are being protected as prophylaxis.**

Renaissance
HOME HEALTH

Compassionate Care. Every Patient. Every Time.

Questions?