Medicare Home Health 2024

Back with More in 2024

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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

MAHC
MISSISSIPPI ASSOCIATION FOR HOME CARE

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Disclaimer

The content in this presentation is intended for JM Home Health providers and is current as of this presentation. Any changes or new information superseding this information is provided in articles with publication dates after the date of this presentation at www.palmettogba.com.

Objectives

The learner will be able to:

- Define components of an effective home health compliance program
- Define high risk areas for home health utilization
- Verbalize understanding of the components of Home Health care planning
- Verbalize top improper payment errors and action to prevent these errors

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Compliance

Benefits of a Compliance Program

- Concretely demonstrate to employees and the community at large the home health agency's strong commitment to honest and responsible provider and corporate conduct
- Provide a more accurate view of employee and contractor behavior relating to fraud and abuse
- Identify and prevent illegal and unethical conduct
- Tailor a compliance program to a home health agency's specific needs

Compliance Program Guidance for Home Health Agencies (hhs.gov)

Benefits of a Compliance Program

- Improve the quality, efficiency, and consistency of patient care
- Create a centralized source for distributing information on health care statutes, regulations, and other program directives related to fraud and abuse and related issues
- Formulate a methodology that encourages employees to report potential problems
- Develop procedures that allow the prompt, thorough investigation of alleged misconduct by corporate officers, managers, employees, independent contractors, consultants, nurses, and other health care professionals
- Initiate immediate, appropriate, and decisive corrective action

Compliance Program Guidance for Home Health Agencies (hhs.gov)

Seven Fundamental Elements to an Effective Compliance Program

- Implementing written policies, procedures, and standards of conduct
- Designating a compliance officer and compliance committee
- Conducting effective training and education
- Developing effective lines of communication
- Enforcing standards through well-publicized disciplinary guidelines
- Conducting internal monitoring and auditing
- Responding promptly to detected offenses and developing corrective action initiatives

Special Areas of OIG Concern

- Billing for services not provided
- Falsifying records
- Paying kickbacks for patient referrals
- Hiring individuals with criminal records
- Failing to refund overpayments
- Billing for medically unnecessary services
- False cost reports
- Credit balances — failure to refund

Special Areas of OIG Concern

- Home health agency incentives to actual or potential referral sources (e.g physicians, hospitals, patients, etc.) that may violate the anti-kickback statute or other similar federal or state statute or regulation
- Billing for services provided to patients who are not confined to their residence (or ‘‘homebound’’)
- Billing for visits to patients who do not require a qualifying service
- Over-utilization and underutilization
- Knowing billing for inadequate or substandard care
- Insufficient documentation to evidence that services were performed and to support reimbursement
- Billing for unallowable costs of home health coordination

Special Areas of OIG Concern

- Billing for services provided by unqualified or unlicensed clinical personnel
- False dating of amendments to nursing notes
- Falsified plans of care
- Untimely and/or forged physician certifications on plans of care
- Forged beneficiary signatures on visit slips/logs that verify services were performed
- Improper influence over referrals by hospitals that own home health agencies
- Patient abandonment in violation of applicable statutes, regulations, and federal health care program requirements

Special Areas of OIG Concern

- Duplication of services provided by assisted living facilities, hospitals, clinics, physicians, and other home health agencies
- Knowing or reckless disregard of willing and able caregivers when providing home health services
- Failure to adhere to home health agency licensing requirements and Medicare conditions of participation
- Knowing failure to return overpayments made by federal health care programs

Home Health Claims at Risk for Incorrect Billing

- Beneficiaries did not always meet the definition of “confined to the home”
- Beneficiaries were not always in need of skilled services
- HHAs did not always submit OASIS data in a timely fashion
- Services were not always adequately documented

Medicare Home Health Agency Provider Compliance Audit: Total Patient Care Home Health, LLC, A-06-16-05005 (hhs.gov)

Beneficiary Not Homebound—Entire Episode

The physical therapy evaluation documentation for one beneficiary showed that, from the start of the episode, the patient was able to independently walk on even and uneven surfaces and negotiate stairs without requiring assistance. There were no ongoing medical contraindications to leaving the home or any structural or mobility barriers. For the entire episode, leaving home did not require a considerable or taxing effort, and the medical information provided did not support that the patient was homebound.

Medicare Home Health Agency Provider Compliance Audit: Total Patient Care Home Health, LLC, A-06-16-05005 (hhs.gov)

Beneficiary Not Homebound—Partial Episode

Records showed that the patient was initially homebound. She was being treated for a shoulder fracture and required a partial shoulder replacement. In addition, she had shortness of breath with weakness and decreased endurance. By a later date in the episode, the beneficiary was able to ambulate 250 feet without an assistive device and no reported weakness, and she had been discharged from home-based physical therapy to attend outpatient therapy treatments. At this later date in the episode, leaving home did not require a considerable or taxing effort, and the medical information provided did not support that the patient remained homebound.

Medicare Home Health Agency Provider Compliance Audit: Total Patient Care Home Health, LLC, A-06-16-05005 (hhs.gov)

Beneficiary Did Not Require Skilled Services

A beneficiary with multiple co-morbid medical conditions affecting her mobility was homebound. A physical therapy evaluation was indicated to assess the patient's mobility and need for an assistive device and home exercise program. At that evaluation the patient had no pain, shortness of breath, fatigue, or weakness. Her memory deficit included a failure to recognize person, place, and lack of ability to recall events of the last 24 hours, with impaired decision making. The patient did not have capacity to respond to the cognitive aspect of physical therapy. She needed a repetitive exercise program, not continued physical therapy.

Medicare Home Health Agency Provider Compliance Audit: Total Patient Care Home Health, LLC, A-06-16-05005 (hhs.gov)

G Tags

G122 §484.14 Condition: Organization, Services, and Administration

- Standard: Coordination of patient services
  - **G143 Maintain liaison & support plan of care objectives**
  - **G144 Documentation shows effective care coordination**
  - **G145 Summary to physician at least every 60 days**

G156 §484.18 Condition: Acceptance of patients, plan of care & medical supervision

  - G157 All patients' needs adequately met in residence
  - G158 Care follows written plan/reviewed by physician

- Standard: Plan of care
  - G159 Plan of care covers all pertinent diagnoses
  - G160 Physician approves additions and modifications
  - G161 Specific orders for therapy services
  - G162 Personnel participate in development

G156 §484.18 Condition: Acceptance of patients, plan of care & medical supervision

- Standard: Periodic review of plan of care
  - **G163 Reviewed at least every 60 days or more frequently**
  - **G164 Alert physician of changes in condition**
- Standard: Conformance with physician orders
  - **G165 Administer drugs/treatments ordered by doctor**
  - **G166 Verbal orders put in writing/signed/dated**
  - **G300 Verbal orders accepted by authorized personnel**

G168 §484.30 Condition: Skilled Nursing Services

  - G169 Skilled nursing by or supervised by RN
  - G170 In accordance with the plan of care
- Standard: Duties of the registered nurse
  - G171 Makes the initial evaluation visit
  - G172 Regularly re-evaluates the patient's nursing needs
  - G173 Initiates the plan of care and necessary revisions
  - G174 Services requiring specialized nursing skill
  - G175 Preventive/rehabilitative nursing procedures
  - G176 Prepares clinical & progress notes, coordinates services, informs physician of changes
  - G177 Counsels patient/family in meeting all needs
  - G178 Participates in in-service programs, supervise/teach
- Standard: Duties of the licensed practical nurse
  - G179 Furnishes services in accordance with policies
  - G180 Prepares clinical and progress notes
  - G181 Assists physician/RN with specialized procedures

G184 §484.32 Condition: Therapy Services

  - G185 Services are performed by qualified therapist
  - G186 Assists physician in evaluating/developing plan of care
  - G187 Prepares clinical and progress notes
  - G188 Advises/consults with family/personnel
  - G189 Participates in in-service programs
- Standard: Supervision of PT & OT assistants
  - G190 Supervised by a qualified PT/OT
  - G191 Assists in preparing clinical notes and reports
  - G192 Participates in patient education and in-services
- Standard: Supervision of speech therapy Services
  - G193 Provided by or under a qualified SLP/Audiologist

Top 10 Standard-Level Deficiencies for 2021

Rank	% of surveys	Citation content
1	12.7%	G574 –The individualized plan of care must include the following: (i) All pertinent diagnoses; (ii) The patient's mental, psychosocial, and cognitive status; (iii) The types of services, supplies, and equipment required; (iv) The frequency and duration of visits to be made; (v) Prognosis; (vi) Rehabilitation potential; (vii) Functional limitations; (viii) Activities permitted; (ix) Nutritional requirements; (x) All medications and treatments; (xi) Safety measures to protect against injury; (xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors. (xiii) Patient and caregiver education and training to facilitate timely discharge; (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient; (xv) Information related to any advanced directives; and (xvi) Any additional items the HHA or physician may choose to include

Top 10 Standard-Level Deficiencies for 2021

Rank	% of surveys	Citation content
3	6.0%	G572 – Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration. If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan

Top 10 Standard-Level Deficiencies for 2021

Rank	% of surveys	Citation content
6	4.8%	G580 - Drugs, services, and treatments are administered only as ordered by a physician
7	4.8%	G710 – Providing services that are ordered by the physician as indicated in the plan of care
8	4.6%	G578 – Conformance with physician orders
10	3.8%	G590 – The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered

Deficiencies Noted by Surveyors

- Incomplete documentation:
  - **Incomplete or missing physician orders**
    - Medications
    - Treatments
- Conflicting documentation—information inconsistent on:
  - **OASIS**
  - **Plan of care**
  - **Clinical notes**
  - **Summaries between different disciplines**

Deficiencies Noted by Surveyors

- Issues with Goals
  - **Vague**
  - **Unrealistic goals**
- Missed visits
  - **Visits not made at the frequency ordered on the plan of care**
  - **No explanation for missed visits**
  - **No documentation that the physician was notified of missed visits and reasons**

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Program for Evaluating Payment Electronic Report

- Visit https://pepperfile.cbrpepper.org/
- Links to the portal can be found on the PEPPER homepage: https://pepper.cbrpepper.org/

What Is PEPPER?

- Program for Evaluating Payment Patterns Electronic Report (PEPPER) summarizes Medicare claims data statistics for one provider in “target areas” that may be at risk for improper Medicare payments
- PEPPER compares the provider’s Medicare claims data statistics with aggregate Medicare data for the nation, jurisdiction, and the state
- PEPPER cannot identify improper Medicare payments!

PEPPER Target Areas

- Areas identified as potentially at risk for improper Medicare payments (e.g., coding or billing errors, unnecessary services)
- A target area is constructed as a ratio:
  - **Numerator = episodes/payments/etc. identified as potentially problematic**
  - **Denominator = larger reference group**
- Reported as either a:
  - **Rate (numerator/denominator different units); or**
  - **Percent (numerator/denominator same units)**

Top Clinical Group

Clinical Group Description	Total Periods for Clinical Group	Prop. Of Periods for Clinical Group to Total Periods	Average Number of Visits for Clinical Group
E — Musculoskeletal Rehabilitation	1,760,444	20.9%	9.3
H — MMTA Cardiac & Circulatory	1,506,872	17.9%	8.3
C — Wounds	1,155,741	13.7%	10.3
B — Neuro/Stroke Rehabilitation	927,208	11.0%	9.6
L — MMTA Respiratory	663,580	7.9%	8.9
I — MMTA Endocrine	573,588	6.8%	10.8
J — MMTA Gastrointestinal/Genitourinary	415,071	4.9%	8.5
K — MMTA Infectious Disease	388,479	4.6%	8.3
A — MMTA Other	297,010	3.5%	8.4
G — MMTA Surgical Aftercare	287,835	3.4%	8.9
D — Complex Nursing Interventions	268,363	3.2%	6.4
F — Behavioral Health Care	192,259	2.3%	7.6
All	**8,436,450**	**100%**	**9.1**

HIPPS Code Utilization Palmetto GBA

Overview Category		Dollars Current	Dollars Previous	Dollars Per Claim Current	Dollars Per Claim Previous	Number of Claims Current	Number of Beneficiaries Current	Number of Providers Current
3HC21	Late - Community; MMTA - Cardiac - High; Low	223,877,277	207,469,363	1,406	1,415	159,277	79,028	3,531
3CC31	Late - Community; Wound - High; High	168,726,412	148,746,761	2,257	2,110	74,751	27,121	3,006
3HB21	Late - Community; MMTA - Cardiac - Medium; Low	161,586,955	137,116,687	1,221	1,227	132,339	64,641	3,653
3EC21	Late - Community; MS Rehab - High; Low	146,461,518	128,748,251	1,619	1,636	90,439	58,457	3,395
3CC21	Late - Community; Wound - High; Low	125,454,006	123,416,610	1,987	1,912	63,125	29,191	3,065
3CB31	Late - Community; Wound - Medium; High	110,052,444	105,965,466	2,014	1,884	54,639	24,214	2,879
2EC11	Early - Institutional; MS Rehab - High; None	107,989,807	166,624,647	2,413	2,407	44,755	44,338	2,536
3EC11	Late - Community; MS Rehab - High; None	104,216,684	167,125,140	1,496	1,526	69,676	47,600	3,288
3HA21	Late - Community; MMTA - Cardiac - Low; Low	103,249,332	83,755,124	1,034	1,009	99,816	42,488	3,483
2EC21	Early - Institutional; MS Rehab - High; Low	102,785,114	83,248,696	2,496	2,484	41,187	40,826	2,583
3CA31	Late - Community; Wound - Low; High	102,276,997	77,182,737	1,837	1,681	55,678	20,427	2,830
3EB21	Late - Community; MS Rehab - Medium; Low	100,580,490	72,365,848	1,371	1,375	73,371	45,868	3,463
3CB21	Late - Community; Wound - Medium; Low	99,926,564	96,186,865	1,753	1,689	57,016	30,391	3,061
3BC21	Late - Community; Neuro - High; Low	99,453,552	85,137,516	1,776	1,772	56,001	29,171	3,151
3IC21	Late - Community; MMTA - Endocrine - High; Low	92,457,909	92,897,316	1,788	1,731	51,718	22,975	3,055
3BB21	Late - Community; Neuro - Medium; Low	90,251,729	68,416,061	1,604	1,628	56,260	31,437	3,199

Average Number of Periods

Statistics	CY2020	CY2021	CY2022
Count of periods	9,078,901	9,266,171	8,444,980
Count of beneficiaries served	3,275,502	3,355,178	3,097,218
Rate of Target to Denominator	2.77	2.76	2.73
Average Medicare Payment for Target	$1,790	$1,822	$1,877
Sum of Medicare Payments for Target	$16,251,006,311	$16,886,446,106	$15,848,899,019

ALOS

- There were 4,379,629 paid claims that met the criteria
- 1,432,543: total number of Provider-Beneficiary combination
- Mean LOS: Average of Length of Stay = Total LOS / number of episodes within 12 months
- % Diabetes: Percent of all beneficiaries with diabetes condition
- % Wound Care: Percent of all beneficiaries with wound condition
- % Alzheimer's: Percent of all beneficiaries with Alzheimer condition
- Disbursement per Bene: Average provider disbursement per beneficiary
- Length of Stay: Length of stay within a facility during the 12-month period

ALOS

Provider ID	Median LOS	Mean LOS	Number of Benes	Number of Claims	% SSI	% Diabetes	% Wound Care	% Alz-heimer's	% Hyper-tension	% Benes w/ Multiple Providers	% Claims with Discharge	Disbursement per Bene	Length of Stay
Total	55.0	82.3	1,432,543	4,379,629	0.3	7.9	4.0	1.6	5.4	15.9	30.4	5,108	117,899,245
Ala.	57.0	84.7	52,753	164,134	0.4	8.3	4.0	1.4	5.9	13.6	30.3	4,525	4,466,444
Ark.	56.0	77.2	29,712	84,979	0.2	7.6	3.8	1.2	4.4	10.3	32.7	4,359	2,294,226
Fla.	43.0	67.5	304,114	804,228	0.3	5.5	3.9	1.5	3.3	23.3	38.4	4,719	20,514,847
Ga.	55.0	72.3	72,298	196,303	0.3	6.3	4.7	1.5	4.1	14.0	34.8	4,613	5,226,808
Ill.	50.0	76.7	125,306	362,585	0.2	8.7	4.1	1.2	6.7	15.6	34.9	5,380	9,605,480
Ind.	48.0	67.9	48,289	124,618	0.3	5.9	4.3	1.1	2.8	12.6	36.4	4,686	3,276,892
Ky.	50.0	72.2	39,605	108,416	0.5	6.5	4.3	1.2	2.9	10.3	35.8	4,492	2,858,737
La.	60.0	107.1	48,141	184,107	0.3	11.6	4.2	1.8	9.3	14.5	22.2	5,569	5,154,553
Miss.	60.0	105.2	48,566	183,768	0.4	11.5	4.4	1.8	10.9	10.4	23.2	5,553	5,108,654
N.C.	48.0	65.6	81,687	204,802	0.4	6.1	4.2	1.7	2.8	13.4	37.1	4,333	5,358,711
N.M.	57.0	85.0	15,160	46,879	0.3	7.3	4.5	1.3	4.9	13.3	26.5	5,141	1,289,194
Ohio	42.0	65.3	95,415	240,055	0.4	5.3	3.2	1.6	2.5	14.0	38.0	4,312	6,227,475
Okla.	60.0	121.5	61,111	261,558	0.2	12.2	3.9	1.5	7.6	14.8	18.3	6,365	7,424,702
S.C.	49.0	67.3	66,965	171,729	0.4	6.6	4.2	1.2	3.9	13.7	37.8	4,375	4,507,580
Tenn.	59.0	91.7	62,434	209,181	0.5	8.1	4.5	2.0	5.3	13.5	28.3	5,092	5,727,671
Texas	60.0	109.6	238,552	927,699	0.3	11.2	3.7	1.8	9.1	17.3	20.5	6,378	26,141,042
Other	48.0	64.0	42,435	104,588	0.5	5.3	4.0	2.1	2.9	1.9	40.3	4,721	2,716,229

Improper Payment

Comprehensive Error Rate Testing

Service-Specific Overpayment Rate

	Claims Reviewed	Sample Dollars Overpaid	Total Sample Dollars Paid	Projected Dollars Overpaid	Overpayment Rate
Home Health	1,206	$279,040	$2,020,420	$1,230,945,533	7.7%

Improper Payments by Error Category

	Projected Improper Payments	Improper Payment Rate	Percentage of Service Type Improper Payments by Type of Error					Percent of Overall Improper Payments
			No Doc	Insufficient Doc	Medical Necessity	Incorrect Coding	Other	
Home Health	$1,230,945,533	7.7%	1.4%	38.6%	46.8%	2.8%	10.4%	3.8%

MR Top Ten Denials Qtr 4

	Denial Code	Denial Code Description	Count of Claims Denied by Bill Type	Percent of Claims Denied to Total Claims Denied by Bill Type
1	56900	Auto Denial - Requested Records not Submitted	1,223	57.5
2	5FF2F	Face to Face Encounter Requirements Not Met	480	22.6
3	5F023	No Plan of Care or Certification	234	11.0
4	5FNOA	Unable to Determine Medical Necessity of HIPPS Code Billed as Appropriate OASIS Not Submitted	53	2.5
5	5F301	Information Provided Does Not Support the Medical Necessity for Therapy Services	31	1.5
6	5A301	Information Provided Does Not Support the Medical Necessity for Therapy Services	29	1.4
7	5F041	Information Provided Does Not Support the Medical Necessity for This Service	25	1.2
8	5T070	Visits/Supplies/DME Billed Not Documented/Not Documented As Used	22	1.0
9	5F072	No Physician's Orders for Services	16	0.8
10	5T072	No Physician's Orders for Services	15	0.7

Mississippi HH MR Denials CY 2024

Denial Code	Denial Description	Claims
NONE	NONE	129
56900	Auto Denial - Requested Records not Submitted	49
5A301	Info Provided Does Not Support the M/N for Therapy Services	4
5F023	No Plan of Care or Certification	12
5F041	Info Provided Does Not Support the M/N for This Service	2
5F301	Info Provided Does Not Support the M/N for Therapy Services	13
5FF2F	Face to Face Encounter Requirements Not Met	19
5FT10	Doc Does Not Support Homebound Status	2

Therapy Medical Necessity Denials

Denial Code	Denial Description	Claims Count	Submitted Charges
5A301	Info Provided Does Not Support the M/N for Therapy Services	137	$187,566.48
5F301	Info Provided Does Not Support the M/N for Therapy Services	231	$310,038.72

5A301/5f301 Denials by State

State	Claims Count	Submitted Charges
Arkansas	11	$12,676.39
Florida	171	$225,690.89
Georgia	2	$1,466.61
Illinois	15	$20,316.64
Indiana	7	$11,403.02
Louisiana	10	$30,170.07
Mississippi	17	$17,604.15
New Mexico	5	$4,915.01
North Carolina	32	$31,196.21
Ohio	31	$51,267.63
Oklahoma	5	$2,050.02
Other	1	$1,875.01
Other	4	$7,220.02
South Carolina	1	$604.48
Tennessee	8	$10,215.05
Texas	48	$68,934.00

5A301/5f301 Denials by Diagnosis

Diagnosis Description	Claims Count	Submitted Charges
A00-B19 B21-B99 Certain infectious and parasitic diseases	2	$3,200.02
C00-D49 Neoplasms	6	$4,371.65
D50-D89 Diseases of the Blood and Blood-Forming Organs and Certain Disorders Involving the Immune Mechanism	2	$1,125.02
E00-E07, E09-E89 Endocrine, Nutritional and Metabolic Diseases	17	$29,100.13
F01-F99 Mental, Behavioral and Neurodevelopmental Disorders	11	$13,734.14
G00-G29, G31-G99 Diseases of the Nervous System	36	$39,910.40
G30 Alzheimer's	6	$12,788.84
I00-I09, I26-I28, I70-I99 Diseases of the Circulatory System	18	$27,285.15
I10-I16 Hypertensive Diseases	35	$49,806.63
I20-I25 Ischemic Heart Disease	8	$9,174.03
I30-I5A Other forms of heart disease	5	$8,400.03
I69 Sequelae of cerebrovascular disease	31	$37,818.29
J00-J08,J19-J39,J48-J99 Diseases of the Respiratory System	11	$13,748.05
J09-J18 Flu and Pneumonia	1	$680.01
J189 Pneumonia, unspecified organism.	4	$4,400.03
J40-J47 Chronic lower respiratory diseases	14	$29,271.11

5A301/5f301 Denials by Diagnosis

Diagnosis Description	Claims Count	Submitted Charges
K00-K95 Diseases of the Digestive System	6	$6,085.04
L00-L99 Diseases of the Skin and Subcutaneous Tissue	8	$17,266.61
M00-M99 Diseases of the Musculoskeletal System and Connective Tissue	48	$70,567.44
N00-N29, N70-N99 Diseases of the Genitourinary System	1	$1,800.00
N30-N39 Other diseases of the urinary system	2	$1,750.01
N390 Urinary tract infection, site not specified	3	$2,165.03
N40-N53 Diseases of male genital organs	1	$2,000.00
R00-R99 Symptoms, Signs and Abnormal Clinical and Laboratory Findings, Not Elsewhere Classified	3	$2,675.02
S00-S51, S53-S81, S83-T88 Injury, Poisoning and Certain Other consequences of external Causes	50	$60,867.80
S51811D Laceration without foreign body of right forearm, subsequent encounter	1	$1,250.00
S52531D Colles' fracture of right radius, subsequent encounter for closed fracture with routine healing	1	$3,750.01
S81801D Unspecified open wound, right lower leg, subsequent encounter	1	$1,800.00
S81802D Unspecified open wound, left lower leg, subsequent encounter	1	$700.00
S81812D Laceration without foreign body, left lower leg, subsequent encounter	1	$271.00
S82092D Other fracture of left patella, subsequent encounter for closed fracture with routine healing	1	$1,437.91
S82452D Displaced comminuted fracture of shaft of left fibula, subsequent encounter for closed fracture with routine healing	1	$1,350.01
S82851D Displaced trimalleolar fracture of right lower leg, subsequent encounter for closed fracture with routine healing	3	$6,969.50
U00-U85 Codes for special purposes	2	$2,180.01
Z00-Z99 Factors influencing health status and contact with health services	27	$27,906.28

Mississippi 5A301/5f301 Denials by Diagnosis

Diagnosis Code	Diagnosis Description	Claims Count	Submitted Charges
D473	C00-D49 Neoplasms	1	$1,050.01
G20	G00-G29, G31-G99 Diseases of the Nervous System	1	$432.01
I69320	I69 Sequelae of cerebrovascular disease	1	$1,950.00
M47816	M00-M99 Diseases of the Musculoskeletal System and Connective Tissue	1	$300.00
F03A3	F01-F99 Mental, Behavioral and Neurodevelopmental Disorders	1	$600.01
I110	I10-I16 Hypertensive Diseases	1	$450.01
I69320	I69 Sequelae of cerebrovascular disease	1	$600.01
I69341	I69 Sequelae of cerebrovascular disease	1	$1,572.01
I69354	I69 Sequelae of cerebrovascular disease	1	$1,200.01
M159	M00-M99 Diseases of the Musculoskeletal System and Connective Tissue	1	$1,350.01
M160	M00-M99 Diseases of the Musculoskeletal System and Connective Tissue	1	$1,350.01
M170	M00-M99 Diseases of the Musculoskeletal System and Connective Tissue	2	$1,800.02
M19071	M00-M99 Diseases of the Musculoskeletal System and Connective Tissue	1	$1,200.01
M5417	M00-M99 Diseases of the Musculoskeletal System and Connective Tissue	1	$1,350.01
M792	M00-M99 Diseases of the Musculoskeletal System and Connective Tissue	1	$1,050.01
S72141D	S00-S51, S53-S81, S83-T88 Injury, Poisoning and Certain Other consequences of external Causes	1	$1,350.01

UPIC Findings

- Cloned documentation
- OASIS completed without clinical documentation to support findings
- Visits missed without explanation

UPIC Findings

- Entire sections were identical from note to note for several patients
- Documentation included another beneficiary's information
- Contradictory documentation (between nursing and therapy, OASIS)
- Start of care plan of care noted all medications as New (define "new" and "changed")
- Nurse documented contradictory statements in visit notes

UPIC Findings

- Invalid Advance Beneficiary Notices (ABNs)
- Documentation not submitted for review
- Lack of Therapy Services (Neuro-Rehab, musculoskeletal diagnoses but no therapy)
- Service Times (all visits same length; times overlap for patients in same location)
- Audio-Only Physician Encounters

Inadequate Documentation of Service Performed

- Interventions performed are not related to patient needs
- Not clear on what is being performed
- Cloning of prior service
- Repetition or reinforcement of care is needed but not explained

Adequate Visits Documentation

- Fit into a realistic plan of care
- Address the focus of home health
- Identify new issues and follow-up
- Document skilled reasonable and necessary actions
- Discontinued when no longer necessary
- They address issues that home health can impact
- Involve the patient/caregivers to the greatest extent possible

Poor Documentation

- No changes in medications, treatments, or condition
- Changes in condition without physician communication
- Teaching on “old” medications, “old” diagnoses
- Teaching is generic
- Repetitive teaching on topics without reason identified
- Goals are generic, non-measurable
- Statements of “unstable [blood pressure, blood glucose]” without supporting documentation

Compliant Documentation

- Avoid generic/generalized statements
- Avoid check-boxes only
- Identify when care is unskilled/custodial
- Identify when skilled care is no longer needed

How to Avoid Medical Necessity Denials

- Nursing procedures are performed as ordered and show skilled need (e.g., not simple wound care)
- Therapy interventions show a skilled need
- All changes in medication, treatment, and condition are documented
- Care is for more than “monitoring” beneficiary condition

Medical Necessity Case Study

- The patient was admitted to the agency and recertified with a primary diagnosis of low back pain and multiple vaguely coded comorbidities. The submitted documentation included all nursing visits for the episode.
- Nursing was ordered for assessment and instruction. The patient had no new or changed medication requiring teaching instruction—there was enough time for instruction during the previous episodes. According to a nurse's documentation, the patient was stable. There was no mention of any exacerbations of a chronic medical condition. There were no hospitalizations or emergency department visits throughout the episode.
- Neither the patient's condition nor the skilled care provided would necessitate the need for skilled nursing services. Skilled nursing and all therapy was denied because the documentation did not support services that are medically reasonable and necessary.

Chart Conundrums: Home Health Agencies Face Documentation Hurdles — For The Record Magazine

A Face-to-Face Encounter Case Study

- The patient was seen by the physician on August 12 for a urinary tract infection (UTI). There was no hospital admission. A referral was made by the physician's office with subsequent admission to the agency on September 15 with a primary diagnosis of coronary artery disease and comorbidities of chronic kidney disease and diabetes. There was no mention of UTI on the referral since it had been resolved earlier.
- A request was made by the MAC for a single episode of care. A face-to-face encounter form was submitted to support the requirement. The physician encounter/progress note and discharge summary from the inpatient facility were absent. The form indicated the reason for the referral was "dyspnea and frequent falls." The reason for the patient being homebound was stated as "requires taxing effort to leave home."
- Although the nursing notes and therapy notes were well documented, the entire episode of care, including nine nursing visits and 19 therapy visits, was denied because the face-to-face encounter documentation did not support the requirement substantiating the patient's need for skilled services and the homebound status

Chart Conundrums: Home Health Agencies Face Documentation Hurdles — For The Record Magazine

Skilled Therapy

- Service is complex, requiring knowledge and skills of clinician
- Consistent with severity of illness/injury
- Considered specific, safe, and effective for the patient's condition
- Provided with the expectation that the condition will improve in a reasonable, predicable period of time
- Teaching exercises, techniques, precautions based on beneficiary's illness or injury
- Should have rehab/neuromuscular Dx and if focused on goals which are achievable and working toward is the patient making progress?

https://www.nahc.org/wp-content/uploads/2017/10/AM15-506.pdf

Skilled Therapy Documentation

- Comprehensive assessment utilizing measurable tests
  - **TUG**
  - **Tinetti**
- Specific goals stated
- Functional capacity and deficits: safety, range of motion, ADLs, mobility, strength, balance
- Changes in functional capacity – describe the clinical condition and status
- Evidence of care coordination with physician, other team members
- Support homebound status and medical necessity
- Describe home exercise program — describe type of exercise, number of repetitions, pounds/weights of each type of exercise
- Plans for follow-up past discharge

Social Services

- Obtaining community and financial resources
- Obtaining alternative living arrangements
- Review of financial status
- Arrange for meal service, home-delivered medications, etc.
- Protective concerns
- Other items where there are impediments to the POC being successfully implemented (e.g., cannot afford medications, no food in the home, safety issues, etc.)

Social Services Documentation

- Requires “Skilled” Social Services
- Support medical necessity
- Communication coordination with physician, other team members
- Intervention/resolution supporting POC being successfully implemented
- Beneficiary’s problems and goals for SW intervention are clearly stated
  - Unusual home/social environment is documented/identified
  - Clinical findings/developments that impact pt’s ability to participate/follow POC
  - Physician orders describing specifically the need for SW
  - All other clinician team member visit notes are congruent with SW documentation (e.g., infestation, pets, financial problems, etc.)

Home Health Aides

Services May Be Reasonable If:

- Services meet definition of covered aide services
- Specific physician's orders for services
- Clear and specific documentation
- SN, PT, ST needed on intermittent basis
- Where there is a continued need for OT alone (in subsequent recertification periods) the patient meets the requirement for the need of a qualifying discipline and home health aide services can be provided

Home Health Aides

- Reasonable and Necessary:
  - **Incidental services can be provided during the course of the visit as long as the primary purpose of the visit is to provide personal care**
    - Incidental services: light cleaning, shopping, taking out trash, etc.
- The frequency of visits must be reasonable, depending on patient's condition
- Documentation in the skilled notes must be able to support the frequency of aide services – this is especially important with daily visits
- Note: Aide care and documentation must adhere to the patient's Aide POC

Home Health Aides

Services needed to:

- Facilitate treatment
- Prevent deterioration
- Maintain health
- Assessment and OASIS describes patient's functional limitations and inability to perform ADLs
- POC Orders include visit frequency, duration and care (personal care, ADL assistance)

Utilization

Visit by Discipline (Rolling Year)

State	Periods per Beneficiary	Visits per Period	% LUPAs	% Outliers
Alabama	2.02	8.36	19.38	3.85
Arkansas	1.96	9.06	17.24	4.41
Florida	1.94	10.70	15.47	10.02
Georgia	1.91	8.61	20.15	3.54
Illinois	1.98	8.29	16.34	5.01
Indiana	1.83	9.17	18.42	6.31
Kentucky	1.86	8.64	19.01	4.29
Louisiana	2.24	8.20	21.70	2.12
Mississippi	2.20	8.06	18.01	2.80
New Mexico	2.08	8.87	19.57	7.27
North Carolina	1.85	8.37	21.89	3.46
Ohio	1.88	9.19	18.48	7.01
Oklahoma	2.44	8.72	17.69	4.91
South Carolina	1.82	8.19	20.59	2.34
Tennessee	2.09	8.42	17.71	3.07
Texas	2.34	8.86	15.58	7.48
Other	1.78	8.34	20.93	2.59
All States	2.05	8.99	17.56	5.94

Visit by Discipline (Rolling Year)

State	42X	43X	44X	55X	56X	57X
Alabama	8.70	5.45	5.27	9.92	1.42	6.65
Arkansas	8.53	5.23	5.44	11.14	1.67	9.18
Florida	10.13	5.38	5.88	13.12	1.47	15.14
Georgia	8.40	4.91	5.12	9.62	1.46	5.91
Illinois	8.15	4.64	4.37	10.19	1.29	9.37
Indiana	8.29	5.05	4.93	9.92	1.57	9.73
Kentucky	8.02	4.86	4.73	9.82	1.42	9.22
Louisiana	8.17	5.21	5.76	11.91	1.54	12.91
Mississippi	9.33	5.97	6.06	11.42	1.41	9.44
New Mexico	9.78	6.30	6.70	10.13	1.80	10.82
North Carolina	8.27	4.61	4.66	9.58	1.39	6.01
Ohio	8.42	4.94	5.86	10.08	1.45	9.78
Oklahoma	9.66	5.70	5.93	13.54	1.38	16.77
South Carolina	8.02	4.43	4.65	8.89	1.57	6.09
Tennessee	9.75	5.40	5.37	10.56	1.74	8.86
Texas	10.37	6.58	7.21	13.28	1.46	17.23
Other	7.53	4.05	4.22	9.06	1.68	7.14
All States	9.18	5.22	5.60	11.59	1.49	12.10

Disbursement

State	Provider Disbursement 2023H2	Provider Disbursement 2023H1	Provider Disbursement 2022H2	Prov. Count 2023H2	Prov. Dis. per Provider 2023H2	Bene Count 2023H2	Prov. Dis. per Bene 2023H2	Prov. Dis. per Bene 2023H1	Prov. Dis. per Bene 2022H2	Covered Charge 2023H2	Claim Count 2023H2
AL	110,636,080	119,032,167	126,136,930	107	1,033,982	28,636	3,864	3,839	3,803	260,158,629	75,893
AR	62,176,274	64,124,244	68,639,315	75	829,017	16,154	3,849	3,732	3,725	208,689,341	40,251
FL	693,444,394	729,156,450	726,235,247	855	811,046	157,760	4,396	4,287	4,277	906,090,794	385,534
GA	158,545,800	167,239,934	175,899,940	92	1,723,324	38,740	4,093	4,068	4,060	319,149,932	93,153
IL	324,407,987	339,439,966	351,818,067	499	650,116	67,948	4,774	4,621	4,590	338,289,409	173,558
IN	105,235,022	112,614,693	119,499,932	150	701,567	25,189	4,178	4,119	4,131	157,779,067	57,922
KY	79,846,135	87,750,756	95,367,714	82	973,733	20,595	3,877	3,864	3,869	230,773,591	48,599
LA	126,219,814	131,489,866	140,882,821	168	751,308	27,828	4,536	4,460	4,510	276,670,205	86,305
MS	125,163,244	134,423,418	141,230,219	41	3,052,762	28,073	4,458	4,400	4,430	287,701,849	84,625
NC	167,289,011	178,822,778	189,371,735	146	1,145,815	42,474	3,939	3,882	3,848	203,128,855	96,265
NM	36,712,445	38,651,357	41,724,489	69	532,064	8,494	4,322	4,375	4,458	44,409,989	22,409
OH	200,611,506	206,235,187	208,419,248	301	666,483	50,886	3,942	3,844	3,811	298,482,403	116,833
OK	186,409,806	189,167,824	202,716,024	217	859,031	36,303	5,135	4,981	5,030	190,975,925	124,814
SC	138,454,505	146,363,863	155,845,215	67	2,066,485	35,584	3,891	3,856	3,941	227,974,502	81,098
TN	151,085,464	159,707,200	165,438,910	103	1,466,849	35,383	4,270	4,219	4,208	356,969,111	99,257
TX	729,465,672	767,836,720	786,534,387	1,474	494,889	136,830	5,331	5,249	5,246	818,085,951	440,910
Other	100,120,142	101,745,741	101,814,110	50	2,002,403	24,179	4,141	4,085	4,046	241,039,363	52,021
Total	3,495,823,301	3,673,802,164	3,797,574,302	4,496	777,541	780,005	4,482	4,398	4,395	5,366,368,918	2,079,447

Appeals QTR 1

	Jan	Feb	Mar	Total			
Redeterminations							
Affirmed	760	289	403	**1452**		**Affirmed**	57.9%
Dismissed	54	64	41	**159**		**Dismissed**	6.3%
Reversed	324	205	367	**896**		**Reversed**	35.7%
Redeterminations Total	**1138**	**558**	**811**	**2507**			
QICs							
Affirmed	142	186	130	**458**		**Affirmed**	73.5%
Dismissed	4	5	1	**10**		**Dismissed**	1.6%
Reversed	59	41	55	**155**		**Reversed**	24.9%
QICs Total	**205**	**232**	**186**	**623**			
ALJs							
Affirmed	96	74	48	**218**		**Affirmed**	53.2%
Dismissed	5	7	4	**16**		**Dismissed**	3.9%
Reversed	131	27	18	**176**		**Reversed**	42.9%
ALJs Total	**232**	**108**	**70**	**410**			

Appeals QTR 1

Redeterminations					QICs					ALJs			
	Affirmed	Dismissed	Reversed			Affirmed	Dismissed	Reversed			Affirmed	Dismissed	Reversed
AL	4	2	5		AL					AL	1		
AR	2		2		AR	107		12		AR	1		
CA	3	1	1		CA					CA			
CO		2			CO	1				CO			
FL	157	29	155		FL	112	2	22		FL	9	1	8
GA	13		12		GA	2		1		GA	3		1
IL	182	11	131		IL	85	1	80		IL	31		3
IN	27	2	4		IN	15				IN	2		3
KS		1			KS					KS			
KY	71	1	20		KY	6				KY	2	1	5
LA	74	2	39		LA	29		1		LA	22	2	10
MI					MI					MI	2		1
MS	21		20		MS					MS	7	2	2
MT	1				MT					MT			
NC	11	1	25		NC	10	1	9		NC	4	1	6
NM	17	1	20		NM	6				NM	1		1
OH	41	14	52		OH	12		2		OH		2	
OK	318	10	31		OK	10		2		OK	13	1	75
PA	1				PA					PA		1	
SC	2		6		SC	5				SC	2		2

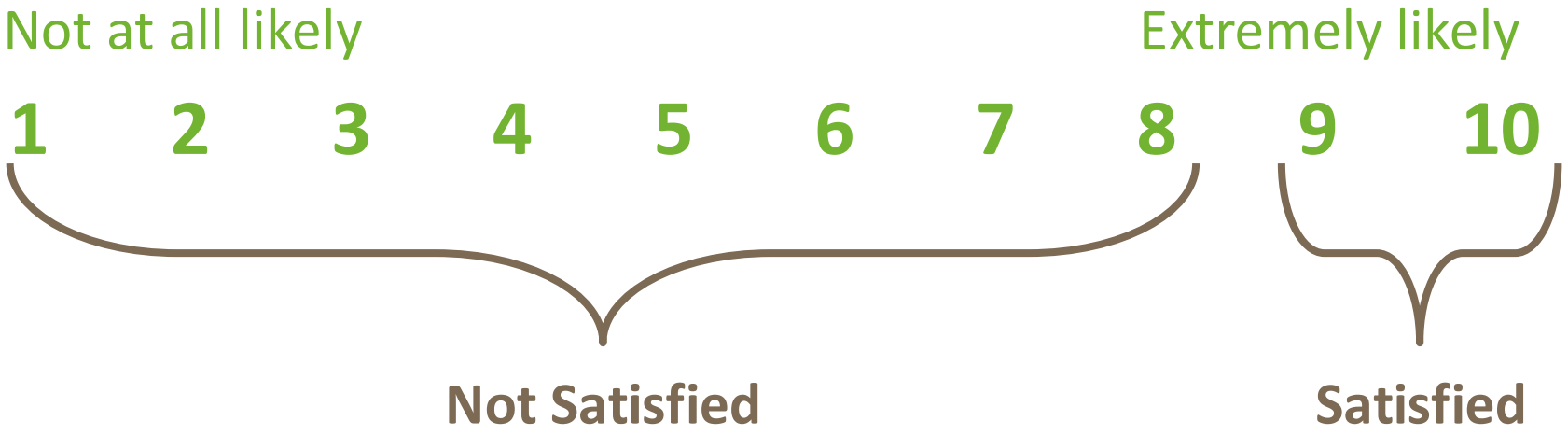
Customer Experience Survey

Overall, how satisfied are you with your MAC?

- ☐ **Extremely satisfied**
- ☐ **Somewhat satisfied**
- ☐ **Neither satisfied nor dissatisfied**
- ☐ **Somewhat dissatisfied**
- ☐ **Extremely dissatisfied**

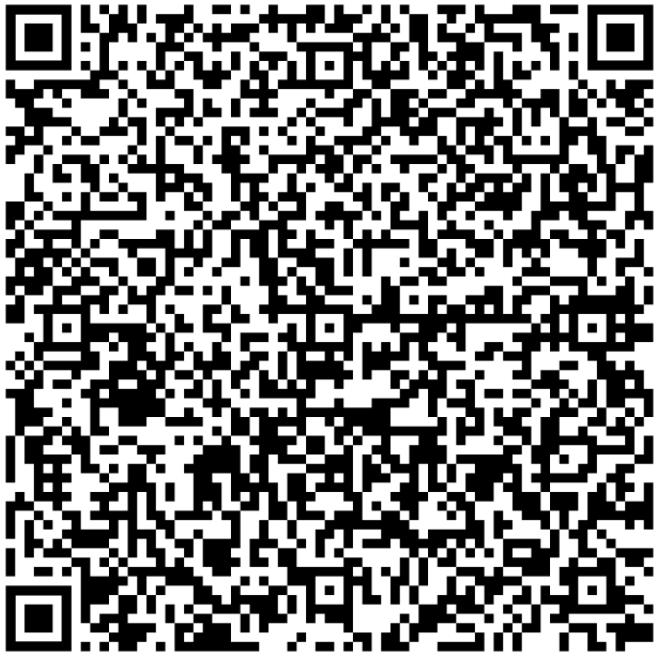
Customer Experience Survey

How likely are you to recommend our education to a colleague or peer?



Customer Experience Survey

FEEDBACK



Don’t forget to complete the feedback survey!

https://tinyurl.com/mw4kuwkp

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Plan of Care

What's on a Home Health Care Plan?

- Services needed
- Which health care professionals should give these services
- Frequency of visits
- Medical equipment needed
- Goals/expected outcomes

https://www.medicare.gov/whats-a-home-health-care-plan

Plan of Care Elements

- All pertinent diagnoses
- Patient's mental, psychosocial, and cognitive status
- Types of services, supplies, and equipment required
- Frequency and duration of visits to be made
- Prognosis
- Rehabilitation potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments
- Safety measures to protect against injury
- Description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors
- Patient and caregiver education and training to facilitate timely discharge
- Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient
- Information related to advanced directives
- Any additional items the HHA or physician chooses to include

Plan of Care: Therapy

- Course of therapy treatment must be established by the physician after any needed consultation with the qualified therapist
- Plan of Care should address:
  - **Measurable therapy treatment goals**
  - **Frequency and duration of therapy services**
  - **Specific procedures and modalities**

Nursing Process vs. Therapy Process

NURSING PROCESS

- Assessment
- Nursing diagnosis
- Expected outcome
- Plan
- Intervention
- Evaluation

THERAPY PROCESS

- Assessment
- Problem
- Goal
- Plan
- Intervention
- Evaluation

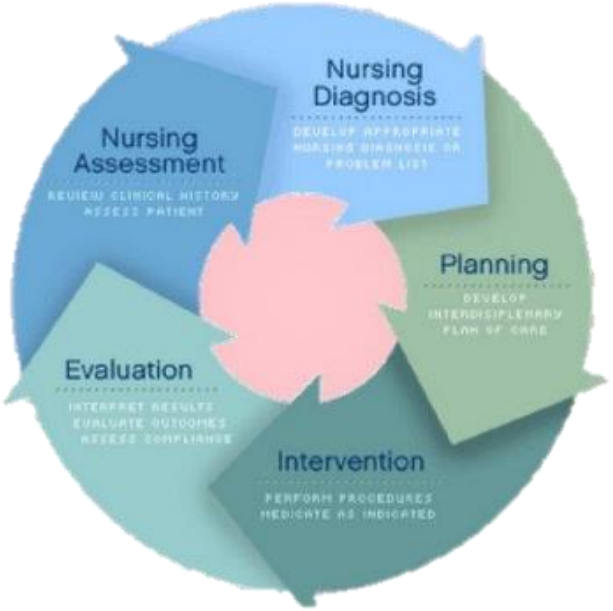
Care Plan Fundamentals

A nursing care plan should include:

- The What: What does the patient suffer from? What do they risk suffering from?
- The Why: Why does your patient suffer from this? Why do they risk suffering from this?
- The How: How can you make this better?

((Mariam Yazdi, "4 Steps to Writing a Nursing Care Plan," Nurse.org, March 23, 2018: https://nurse.org/articles/nursing-care-plan-how-to/))

Nursing Process



Nursing Process

- The term “Nursing Process” was first used/ mentioned in 1955 by Lydia Hall, a nursing theorist, wherein she introduced 3 steps:
  - **Observation**
  - **Administration of care**
  - **Validation**
- Since then, nursing process continues to evolve:
  - **It used to be a 3-step process**
  - **Then a 4-step process (APIE)**
  - **Then a 5-step (ADPIE)**
  - **Now a 6-step process: ADOPIE — Assessment, Diagnosis, Outcome, Identification, Planning, Implementation and Evaluation**

Nursing Process: Assessment

- Assessment
- Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation

https://www.rnpedia.com/nursing-notes/fundamentals-in-nursing-notes/assessment-first-step-nursing-process/

Assessment

- Description
  - **Systematic and continuous collection, validation and communication of client data as compared to what is standard/norm**
  - **Includes the client's perceived needs, health problems, related experiences, health practices, values and lifestyles**
- Purpose
  - **To establish a data base (all the information about the client):**
    - Nursing health history
    - Physical assessment
    - The physician's history and physical examination
    - Results of laboratory and diagnostic tests and material from other health personnel

Assessment

- Subjective data
  - **Also referred to as Symptom/Covert data**
  - **Information from the client's point of view or described by the person experiencing it**
  - **Information supplied by family members, significant others; other health professionals are considered subjective data**
    - Example: pain, dizziness, ringing of ears/Tinnitus
- Objective data
  - **Also referred to as Sign/Overt data**
  - **Those that can be detected observed or measured/tested using accepted standard or norm**
    - Example: pallor, diaphoresis, BP=150/100, yellow discoloration of skin

Source of Data

- Primary source — data directly gathered from the client using interview and physical examination
- Secondary source — data gathered from:
  - **Client's family members**
  - **Significant others**
  - **Client's medical records/chart**
  - **Other members of health team**

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Nursing Process: Diagnosis

- Assessment
- Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation

https://www.rnpedia.com/nursing-notes/fundamentals-in-nursing-notes/diagnosis-second-step-nursing-process/

Medical Diagnosis

- Made by the physician or advanced health care practitioner that deals more with the disease, medical condition, or pathological state only a practitioner can treat
- Normally does not change
- Nurses are required to follow the physician's orders and carry out prescribed treatments and therapies

Nursing Diagnosis

- Purpose
  - **Identify health care needs and prepare a Nursing Diagnosis**
- To diagnose in nursing
  - **Analyze assessment information and derive meaning from this analysis**
- Nursing Diagnosis
  - **Statement of**
    - Client's potential or actual health problem resulting from analysis of data
    - Client's potential or actual alterations/changes in his health status
    - Describes a client's actual or potential health problems that a nurse can identify and for which she can order nursing interventions to maintain the health status, to reduce, eliminate or prevent alterations/changes
- Is the problem statement that the nurse makes regarding a client's condition which she uses to communicate professionally
- It uses the critical-thinking skills analysis and synthesis in order to identify client strengths and health problems that can be resolves/prevented by collaborative and independent nursing interventions

Diagnosis Comparison

Parameters of Comparison	Nursing Diagnosis	Medical Diagnosis
Focus	This type of diagnosis focuses more on care for a patient	This type of diagnosis focuses more on the Etiology of a patient
Meaning	There is a process of identification in this type of diagnosis of all the possibilities of risks and problems in a patient	There is a process of identification in this type of diagnosis of a clear medical entity that caused the illness to a patient
Identification	This identifies the signs and symptoms of an illness of a patient	This identifies the pathology that caused the illness to a patient
Main Feature	This helps to focus on the reactions in physical and psychological reactions of a patient	This helps to focus on the actual illness of a patient

Difference Between Nursing Diagnosis and Medical Diagnosis (With Table) — Ask Any Difference

Collaborative Problems

- Potential problems that nurses manage using both independent and physician-prescribed interventions
- These are problems or conditions that require both medical and nursing interventions with the nursing aspect focused on monitoring the client's condition and preventing development of the potential complication
  - **Nursing diagnosis is directed towards the patient and his physiological and psychological response**
  - **Medical diagnosis, on the other hand, is particular with the disease or medical condition**

Comparison Example

NURSING DIAGNOSIS	MEDICAL DIAGNOSIS
Ineffective Airway Clearance	Pneumonia
Disturbed Body Image	Amputation
Risk for Unstable Glucose	Type 2 Diabetes Mellitus
Impaired Urinary Elimination	Post-op Prostatectomy
Self Care Deficit: Dressing	Cerebrovascular Accident

https://nurseslabs.com/wp-content/uploads/2019/02/Comparison-of-Select-Nursing-and-Medical-Diagnoses-v2020.png

Actual Nursing Diagnosis

- A client problem that is present at the time of the nursing assessment. It is based on the presence of signs and symptoms.
- Examples:
  - **Imbalanced Nutrition: less than body requirements r/t decreased appetite nausea**
  - **Disturbed Sleep Pattern r/t cough, fever and pain**
  - **Constipation r/t long term use of laxative**
  - **Ineffective Airway Clearance r/t to viscous secretions**
  - **Noncompliance (Medication) r/t unknown etiology**
  - **Noncompliance (Diabetic diet) r/t unresolved anger about diagnosis**
  - **Acute Pain (chest) r/t cough secondary to pneumonia**
  - **Activity Intolerance r/t general weakness**
  - **Anxiety r/t difficulty of breathing and concerns over work**

Potential Nursing Diagnosis

- One in which evidence about a health problem is incomplete or unclear therefore requires more data to support or reject it; or the causative factors are unknown, but a problem is only considered possible to occur
- Examples:
  - **Possible nutritional deficit**
  - **Possible low self-esteem r/t loss job**
  - **Possible altered thought processes r/t unfamiliar surroundings**

Risk Nursing Diagnosis

- Clinical judgment that a problem does not exist, therefore no S/S are present, but the presence of risk factors indicates that a problem is only is likely to develop unless nurse intervenes or does something about it
- No subjective or objective cues are present therefore the factors that cause the client to be more vulnerable to the problem are the etiology of a risk nursing diagnosis
- Examples:
  - **Risk for Impaired skin integrity (left ankle) r/t decrease peripheral circulation in diabetes**
  - **Risk for interrupted family processes r/t mother's illness and unavailability to provide childcare**
  - **Risk for Constipation r/t inactivity and insufficient fluid intake**
  - **Risk for infection r/t compromised immune system**
  - **Risk for injury r/t decreased vision after cataract surgery**

Nursing Process: Outcome Identification

- Assessment
- Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation

Outcome Identification

Formulating and documenting measurable, realistic and client-focused goals that will provide the basis for evaluating nursing diagnosis.

SMART Goals

- Specific
- Measurable or Meaningful
- Attainable or Action-Oriented
- Realistic or Results-Oriented
- Timely or Time-Oriented

Hamilton P & Price T (2013) The Nursing Process, Holistic Assessment and Baseline Observations. In: Brooker C, Waugh A (eds) Nursing Practice: Fundamentals of Holistic Care. Mosby Elsevier, London. 303-336.

Writing Goals and Desired Outcomes

- Write goals and outcomes in terms of client responses and not as activities of the nurse
  - **Begin each goal with "Client will […]" help focus the goal on client behavior and responses**
  - **Avoid writing goals on what the nurse hopes to accomplish and focus on what the client will do**
- Use observable, measurable terms for outcomes
  - **Avoid using vague words that require interpretation or judgment of the observer**

https://nurseslabs.com/nursing-care-plans/

Writing Goals and Desired Outcomes

- Desired outcomes should be realistic for the client's resources, capabilities, limitations, and on the designated time span of care
- Ensure that goals are compatible with the therapies of other professionals
- Ensure that each goal is derived from only one nursing diagnosis
  - **Keeping it this way facilitates evaluation of care by ensuring that planned nursing interventions are clearly related to the diagnosis set**
- Make sure that the client considers the goals important and values them to ensure cooperation

https://nurseslabs.com/nursing-care-plans/

Nursing Process: Planning

- Assessment
- Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation

https://www.rnpedia.com/nursing-notes/fundamentals-in-nursing-notes/planning/

Planning

- Definition
  - **Involves determining before and the strategies or course of actions to be taken before implementation of nursing care**
  - **Client and family should be involved in planning**
- Purpose
  - **Determine the goals of care and the course of actions to be undertaken during the implementation phase**
  - **Promote continuity of care**
  - **To focus charting requirements**
  - **To allow for delegation of specific activities**

Nursing Interventions

- Plan nursing interventions/nursing orders to direct activities to be carried out in the implementation phase
- Nursing interventions
  - **Any treatment, based upon clinical judgment and knowledge, that a nurse performs to enhance client outcomes**
  - **They are used to monitor health status; prevent, resolve or control a problem; assist with activities of daily living; or promote optimum health and independence**
  - **They may be independent, dependent and independent/collaborative activities that nurses carry out to provide client care**
    - Independent Nursing Intervention: those activities that the nurse is licensed to initiate as a result of the nurse's own knowledge and skills
    - Dependent Nursing Intervention: those activities carried out on the order of a physician, under a physician's supervision, or according to specific routines
    - Interdependent/Collaborative: those activities the nurse carries out in collaboration or in relation with other members of the health care team

Nursing Process: Implementation

- Assessment
- Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation

https://www.rnpedia.com/nursing-notes/fundamentals-in-nursing-notes/implementation/

Putting the Nursing Plan into Action

- To carry out planned nursing interventions to help the client attain goals and achieve optimal level of health
- Activities
  - **Reassessing — to ensure prompt attention to emerging problems**
  - **Set priorities — to determine the order in which nursing interventions are carried out**
  - **Perform nursing interventions — these may be independent, impendent or collaborative measures**
  - **Record actions — to complete nursing interventions, relevant documentation should be done**
  - **Remember: Something that is not written is considered as not done at all**

Nursing Process: Evaluation

- Assessment
- Diagnosis
- Outcome Identification
- Planning
- Implementation
- Evaluation

https://www.rnpedia.com/nursing-notes/fundamentals-in-nursing-notes/evaluation/

Evaluation

- The final step is crucial to determine whether, after application of the nursing process, the client's condition or well-being improves
- Applies all that is known about a client and the client's condition, as well as experience with previous clients, to evaluate whether nursing care was effective
- Conducts evaluation measures to determine if expected outcomes are met, not the nursing interventions
- Expected outcomes are the standards against which the nurse judges if goals have been met and thus if care is successful
- Providing health care in a timely, competent, and cost-effective manner is complex and challenging. The evaluation process will determine the effectiveness of care, make necessary modifications, and to continuously ensure favorable client outcomes.
- Assessment the client's response to nursing interventions and then comparing that response to predetermined standards or outcome criteria

Fundamentals of Nursing: Human Health and Function: Printed Testbank (2nd Edition) by Ruth F. Craven, Constance J. Hirnle, Diane Mcgovern Billings, Karen L. Cobb, Mary Jane Shepherd Published 1996

Components of Evaluation

- Collecting the data related to the desired outcomes
- Comparing the data with outcomes
- Relating nursing activities to outcomes
- Drawing conclusion about problem status
- Continuing, modifying, or terminating the nursing care plan

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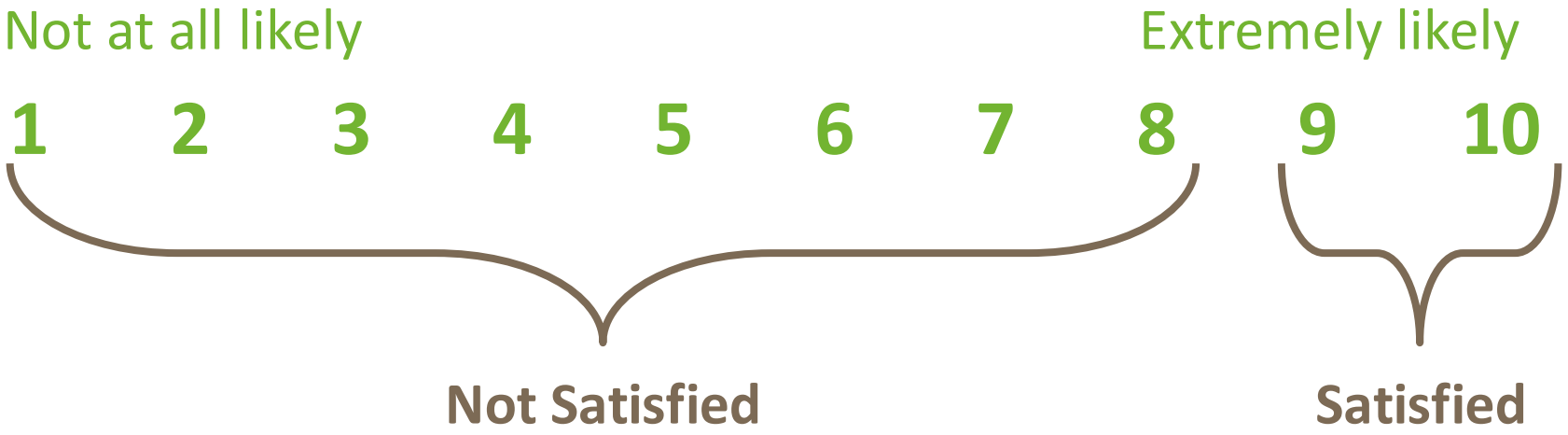
Overall, how satisfied are you with your MAC?

- ☐ **Extremely satisfied**
- ☐ **Somewhat satisfied**
- ☐ **Neither satisfied nor dissatisfied**
- ☐ **Somewhat dissatisfied**
- ☐ **Extremely dissatisfied**

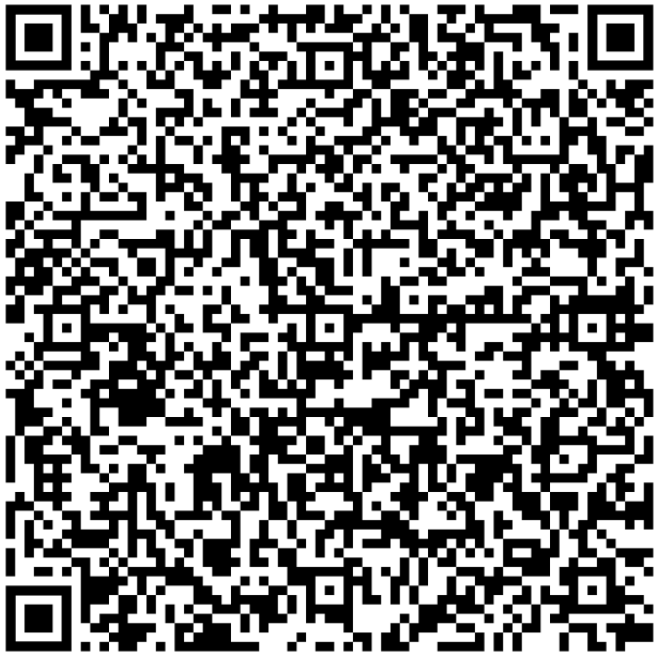
Customer Experience Survey

How likely are you to recommend our education to a colleague or peer?



Customer Experience Survey

FEEDBACK



Don’t forget to complete the feedback survey!

https://tinyurl.com/mw4kuwkp