Care Element	Intervention	Intervention Tags
Disease Process	Assess and verify that patient and patient's legal representative (if any) and/or HIPAA authorized representative received written notice/document of patient's rights and responsibilities in a language the patient understands at SOC visit or by the second visit.	484.50(a)(1), 484.50(a)(3)
	Provide teaching techniques and strategies that enhance and promote health literacy (improved knowledge and compliance with care requirements).	484.50(f)
	Instruct on potential effects of noncompliance with plan of care.	484.60(a)(1)Noncompliance
Medications	Assess (ask to see all medication & supplements) whether correct medications/supplements are in home. Review with patient/caregiver and reconcile medications, identify medication issues, make corrections and emphasize changes in regimen. Leave up-to-date medication profile and schedule in the home.	484.55(c)(5)
	Assess for medication effectiveness/symptom control, side effects, compliance, other issues and for medication changes, review and update medication profile (reconcile medications) as needed.	484.55(c)(5)
Nut/Hyd/Elim	Evaluate compliance with diet.	484.60(a)(1)Noncompliance
Activity	Evaluate compliance with activity measures to improve cardiac status.	484.60(a)(1)Noncompliance
	Evaluate compliance with activity schedule.	484.60(a)(1)Noncompliance
Safety	Evaluate compliance with Standard Precautions.	484.60(a)(1)Noncompliance
	Evaluate compliance with safe use of equipment or assistive devices, instruct as needed.	484.60(a)(1)Noncompliance
	Evaluate compliance with home safety precautions to prevent injuries/falls.	484.60(a)(1)Noncompliance
Psychosocial	Assess barriers to care (cultural, financial, cognitive, caregiver, environment, other), and identify plan to address barriers, and implement action plan and involve patient in action plan.	484.60(d)(4)
	Evaluate perception of progress toward addressing primary concerns and goals for care.	484.60(d)(4)
Interteam/	Instruct on, review plan of care including disciplines, visit frequencies, discharge plan and support involvement of patient/family in plan of care.	484.75(b)(2)
Community	Provide the patient/caregiver written care planning instructions, based on the signed Plan of Care, to keep in the home within 5 days of Initial Assessment.	484.60(e)
	Evaluate need for and/or initiate case communication or documentation of communication.	484.60(d)(3), 484.75(b)(7)
	Evaluate plan of care including visit calendar with patient/caregiver and identify if changes are needed.	484.75(b)(2), 484.50(c)(8), 484.60(d)(3), 484.50(c)(4)(viii), 484.50(c)(7)
	Initiate discussion of discharge/transition plans with patient/caregiver.	484.75(b)(2), 484.50(c)(8), 484.60(c)(3)(ii)
	Evaluate and update patient's Personal Health Record (PHR) with changes in medications, diet, activity, allergies, s/s to monitor, etc.	484.50(c)(4)(viii)
	Evaluate knowledge of and agreement with discharge plans.	484.75(b)(2), 484.50(c)(4)(viii)