Overview / POC Content - locator 21, 22

POC Skilled Care Section paragragh	Patient is at risk for emergency room visits and ACH related to diagnoses and clinical symptom control rating, hospitalizations within the last year, risk for falls, and risk for medication issues. The following planned disciplines, visit frequencies, patient-centric Goals and Interventions are based on assessment findings and support the prevention of ACH, the promotion of disease management (see above diagnoses, prescribed diet, equipment, activity limitations) and a timely discharge to self-care.
Recommended Visit Frequency	
Low Risk	Low risk: 3 wk 1, 1 wk 3
Moderate Risk	Moderate risk: 3w1,2w2,1w3
High Risk	High risk: In-home: 3wk 2, 2 wk 2, 1 wk 2; Telephone visits between In-home: 4 wk 2, 1 wk 4
Standard Orders	**Visit Intervention Summary:**
Instruct on:	condition/symptom/disease management; sign/symptoms management and when to notify RN/Therapist or physician and when emergency care is needed; pulse monitoring; weight monitoring; edema monitoring and management, skin care and wound prevention; adaptive positioning and breathing techniques (dyspnea); cardiac rehab/cardiac preventive measures; medication management, effectiveness, purpose, side effects, new/changed medications; diet; activity targets; emergency/safety and fall prevention measures
Skilled Assessment with focus on:	symptom management; cardiac assessment (vitals, orthostatic blood pressure, weight, edema, dyspnea, pulse oximetry); medication effectiveness, side effects, compliance; activity level/tolerance; safety, fall prevention; psychosocial and coping status; coping with disease management; care coordination/management
Patient Education Tools	CHF Step by Step Book, CHF Stoplight, Weight/Symptom/Activity Log (Chronic Cardiac), Shortness of Breath (Dyspnea), Limit Fluids, Tracking Sodium, Medication Schedule, My Medication Information

Goals

Patient/caregiver will verbalize S/S of worsening condition to report to RN / Therapist or Physician or to call

Patient will maintain stable physiological status and S/S of improved cardiac output (vitals, labs, weight, edema, dyspnea, cardiovascular status) within normal limits for patient.

Patient will demonstrate maintenance of intact skin in edematous areas.

Patient/caregiver will demonstrate knowledge of disease process, treatment goals (medications, diet, activity, safety) and self-care management.

Patient/caregiver will demonstrate COMPLIANCE with treatment plan and incorporate treatment principles into daily routine (diet, activity, treatments, safety, etc).

Patient will demonstrate compliance with cardiac rehabilitation program.

Patient will demonstrate knowledge/verbalize medication regimen, symptoms of effectiveness, when to notify physician and has a medication management system in place to assist with compliance, as needed.

Patient/caregiver will demonstrate compliance with MEDICATION schedule with or without the use of compliance aids.

Patient/caregiver will demonstrate compliance with prescribed nutrition/fluid requirements.

Patient will demonstrate progression within planned activity level.

Patient/caregiver will demonstrate knowledge and compliance with injury or FALL prevention activities.

Patient will demonstrate ability to maintain safety in home environment without injury or FALLS.

Patient/caregiver will demonstrate participation in plan of care and verbalize knowledge and agreement with the plan of care.

Patient/caregiver will verbalize plan for follow-up visits with physician or other services and is empowered to be an active participant in these interactions.

Patient/caregiver will verbalize understanding of, utilize and manage a personal health record (PHR) to facilitate communication and ensure continuity of care planning across settings.

Patient/caregiver will verbalize community resources available and how to contact them.

Visit Interventions (shaded = perform every visit)

Care Element and Interventions	Outcomes and Checklists
Disease Process	
Assess/verify patient identity with name and date of birth, if new to homecare associate.	Verified patient identification:
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.	Verbalizes (patient and/or legal representative/HIPAA representative) understanding of Patient's Rights and Responsibilities and demonstrates written copy is in the home.
Assess cardiac/circulatory status: VS; heart rate/rhythm; orthostatic BP, dyspnea, lung sounds, cough, chest/cardiac pain, weight and edema.	
Evaluate weight/symptom log.	Demonstrates weight consistent with goals.
Assess (since the last visit) if the patient used the ER, Hospital or unplanned physician office	No Hospital or ER Use. No Unplanned physician visit.
Provide contact phone numbers and who to contact during evenings and weekends for symptoms/concerns.	Verbalizes how to monitor for adverse symptoms, who to contact, and phone numbers to use during evenings and weekends with symptoms/concerns.
Provide teaching techniques and strategies that enhance and promote health literacy (improved knowledge and compliance with care requirements).	Health literacy promotion activities planned: Health literacy promotion activities provided:
Evaluate knowledge of S/S to report to RN/Therapist or Physician and those that need immediate medical attention. (Refer to Zone/Red Flag Plan). Use Teach Back Method to determine comprehension. Ask patient to repeat IN THEIR OWN WORDS.	Verbalizes S/S to report to RN/Therapist or Physician and those that are an emergency and require immediate medical attention (i.e., Call 911).
Instruct on use of weight/symptom log.	Verbalizes purpose of and plans to use of weight/symptom log.
Instruct on meaning of ejection fraction and how it affects the treatment plan.	Verbalizes meaning of ejection fraction and how it affects the treatment plan.
Evaluate ability to take pulse, demonstrate as needed, and instruct on when to report pulse findings to RN/physician.	Verbalizes importance of taking pulse and when to report pulse. Demonstrates / verbalizes ability to take pulse and record findings.
Instruct to record weight daily (same time, similar clothing) and to report (per physician order) weight gain.	Verbalizes importance of monitoring daily weight and to report weight gain of > 2 lbs in one day or 5 lbs in 1 week (or as ordered).
Instruct on causes of, how to monitor, and measures to control edema.	Measures to control edema instructed/evaluated: Verbalizes causes of edema and measures to reduce or control edema.

Instruct on self-monitoring techniques related to cardiac condition and actions to take with abnormal findings.	Self-monitoring activities instructed related to cardiac condition: Verbalizes self-monitoring techniques related to cardiac condition actions to take with abnormal findings.
Instruct on importance of good skin care to edematous areas; s/s of and how to prevent skin breakdown and what to report.	Measures to prevent skin breakdown instructed: Verbalizes skin care measures to edematous areas.
Evaluate return demonstration of pulse taking and ability to interpret results.	Demonstrates ability to correctly take and interpret pulse readings.
Instruct to avoid stressors that may precipitate exacerbation of disease (including fatigue, temperature extremes and infection).	Stressors that exacerbate disease instructed: Verbalizes importance of avoiding stressors like fatigue, temperature extremes and infections.
Instruct on cardiac rehab program elements and goals.	Verbalizes purpose and elements of cardiac rehabilitation program.
Evaluate compliance with self-monitoring activities related to cardiac condition and actions to take with abnormal findings.	Self-monitoring activities related to cardiac condition evaluated: Demonstrates compliance with self-monitoring activities related to cardiac condition and actions to take with abnormal findings.
Instruct on reasons to avoid (limit) alcohol.	Verbalizes two (2) reasons to avoid (limit) alcohol consumption.
Instruct on potential effects of noncompliance with plan of care.	Verbalizes principles of treatment and potential consequences of noncompliance.
Evaluate ability to manage health status independently.	Demonstrates confidence in ability to manage health status independently.
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	Demonstrates correct medications in the home, medications reconciled. Verbalizes correct medication/supplement schedule and has written schedule for reference.
Assess for medication effectiveness/symptom control, side effects, compliance, other issues and for medication changes, review and update medication profile (reconcile medications) as needed.	Demonstrates effective symptom control expected from medications. Demonstrates no S/S of adverse effects of medication. Demonstrates compliance with medication/supplement schedule.

Instruct on purpose, action and side effects and how to monitor effectiveness of one or two medication/supplements and how and when to report medication problems.	Verbalizes purpose, action, level of effectiveness, side effects, and when and how to report problems with medication/supplement(s) instructed this visit.
	Verbalizes HIGH RISK medication(s) and need for higher level caution and self-monitoring for issues or side effects (if applicable).
Instruct on strategies to improve medication self-administration (pill box / medi-planner / med pre-fill) and simplification plan to support a manageable system and compliance.	Verbalizes importance of and need for a simple plan/system in place for taking medications.
	Verbalizes how to use medi-planner.
	Verbalizes plans to use medi-planner to ensure compliance with medications.
Instruct on why it is important for current healthcare providers (including pharmacies) to have a complete list of medication/supplements; and why it is recommended to use one pharmacy.	Verbalizes reasons why current healthcare providers (including pharmacies) have a complete list of medication/supplements; and why it is recommended to use one pharmacy.
Evaluate knowledge of the importance for a realistic plan for refilling medications before running out and evaluate if the patient/caregiver has a plan in place.	Verbalizes realistic plan for obtaining medications and importance of refilling medications before running out.
Instruct not to take over-the-counter medications and supplements without consulting physician, especially those high in	Verbalizes importance of consulting with physician before using over-the-counter medications.
Instruct on S/S of electrolyte (sodium, potassium, calcium) imbalance related to medications and actions to take.	S/S of electrolyte (sodium, potassium, calcium) imbalance related to medications instructed/evaluated:
	Verbalizes three (3) S/S of electrolyte imbalance and appropriate actions to take.
Evaluate and update medication profile with patient / caregiver and evaluate knowledge of actions, doses, side effects and times of medications to continue following discharge.	Verbalizes purpose, side effects, doses, times and when to call with problems for medication(s) being continued following discharge.
Evaluate and ensure current list of medications is left in home before discharge from services.	Current list of medications is in the home:
Instruct on diuretic administration schedule to minimize interruptions with sleep (take last dose between 4 pm - 5 pm).	Verbalizes plan to take diuretic earlier in day to minimize interruptions with sleep.
Nut/Hyd/Elim	
Instruct on hidden sources of sodium in commercial foods; provide written information as needed.	Verbalizes sources of hidden sodium in commercial foods.
Instruct on dietary restrictions of no added salt: use fresh or frozen foods, avoid canned and other foods high in salt, avoid using salt in cooking or at table.	Verbalizes three (3) foods high in sodium and three (3) foods low in sodium.
Instruct on S/S of dehydration, effects on disease process and actions to take.	S/S of dehydration instructed/evaluated:

	Verbalizes three (3) S/S of dehydration and appropriate actions to take.
Instruct on foods high in potassium if on potassium-depleting diuretic; provide list of foods containing potassium.	Patient/caregiver will demonstrate knowledge of disease process, treatment goals (medications, diet, activity, safety) and self-care management. Verbalizes three (3) foods high in potassium.
Instruct on salt substitutes and need for physician approval and how to flavor foods with herbs and spices.	Verbalizes approved salt substitutes.
Activity	
Evaluate whether activity shows adequate progress.	Demonstrates progression with planned activity schedule.
	Demonstrates ability to ambulate a minimum of twenty minutes without adverse symptoms (if applicable and target).
Instruct to change from lying, sitting and standing positions slowly.	Verbalizes importance of, and demonstrates, changing positions slowly (lying to sitting, lying to standing and sitting to standing).
Instruct on importance of frequent rest periods, pacing activities and avoiding overexertion.	Verbalizes importance of frequent rest periods and pacing activities.
Instruct to elevate feet/legs when sitting or lying and have patient demonstrate position options.	Demonstrates appropriate methods to elevate lower extremities. Verbalizes need to elevate lower extremities above heart level when sitting or lying (VENOUS DISEASE).
Instruct on and demonstrate use of semi Fowlers or full Fowler's position to decrease dyspnea and orthopnea (improve breathing).	Verbalizes/demonstrates semi or full Fowler's positions to improve breathing.
Evaluate compliance with activity measures to improve cardiac status.	Demonstrates compliance with activities to improve cardiac status: gradual increases, feet/legs elevated, positioning, etc.
Evaluate compliance with activity schedule.	Demonstrates compliance with planned activity schedule.
Safety	
Assess for correct/safe equipment use including assistive devices used in transfer activities.	Demonstrates safe use of equipment or assistive devices used in transfer activity.
Instruct on basic home safety precautions to prevent injuries/falls.	Home safety measures instructed: Verbalizes basic home safety precautions to prevent injuries/falls. Verbalizes how to prevent safety hazards while performing ADLs/IADLs (bathroom, kitchen, hallways, working areas, etc.).
Instruct on principles of Standard Precautions (proper handling/disposal of items coming in contact with body fluids).	Verbalizes three (3) principles of Standard Precautions.
Evaluate compliance with Standard Precautions.	Demonstrates compliance with Standard Precautions (if appropriate).
Evaluate compliance with safe use of equipment or assistive devices, instruct as needed.	Assistive Device Safety Observed: Demonstrates safe use of equipment or assistive devices.
Evaluate compliance with home safety precautions to prevent injuries/falls.	Home safety measures evaluated: Demonstrates compliance with safety precautions to prevent injuries/falls.

Evaluate ability to maintain care/safety in home environment.	Demonstrates ability to maintain safety in current environment without an injury or fall.
Psychosocial	
Assess patient/caregiver psychosocial, emotional, coping, alertness and sleep status.	Patient demonstrates effective coping skills.
	Caregiver demonstrates adequate coping skills.
	Patient demonstrates adequate patterns of sleep.
	Caregiver verbalizes adequate patterns of sleep.
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.	Verbalizes knowledge of plan of care, barriers to care and plans to address barriers to care, if applicable.
Assess ability to purchase necessary supplies, food, etc., needed for treatment.	Verbalizes/demonstrates ability to purchase appropriate food, medications and supplies to manage disease process.
Evaluate perception of progress toward addressing primary concerns and goals for care.	Demonstrates / verbalizes progress toward personal goals for care.
Instruct on use of positive coping strategies.	Verbalizes three (3) positive coping strategies.
Evaluate adaptation to disease process and treatment requirements.	Verbalizes satisfactory adaptation to disease process.
Interteam/Community	
Instruct on, review plan of care including disciplines, visit frequencies, discharge plan and support involvement of patient/family in plan of care.	Verbalizes understanding of and agreement with the plan of care, barriers to care and demonstrates involvement in the plan and goals for care.
	Verbalizes knowledge of discharge plans.
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.	Patient/caregiver received and verbalizes understanding of written care planning instructions, based on the signed Plan of Care, to keep in the home that includes the visit schedule, patient medication schedule/instructions, treatments to be administered by Home Health Agency personnel, other pertinent instruction related to the patient's care and treatments that the Home Health Agency will provide, and name and contact information of the Home Health Agency clinical manager.
POST-HOSPITAL: Instruct pt/cg on need for primary care or specialist physician or other service follow-up appointments that need to be made within 7 days post hospital discharge. Identify barriers and assist in making and attending appointment(s) or provide phone numbers and timeframes.	Barriers to attending physician or other healthcare provider office visits:
	POST-HOSPITAL: Verbalizes follow-up services/appointments that need to be scheduled, including physician appt within 7 days of discharge, and how to schedule and plans to attend appointment..
Instruct on the importance of a Personal Health Record (PHR), its components, and the need to share with all healthcare providers.	Verbalizes importance of maintaining a current PHR and the need to share the PHR with all healthcare providers.

Evaluate need for and/or initiate case communication or documentation of communication. Assess for next physician appointment (Date).	
POST-HOSPITAL: Identify if follow-up physician appointments have been made for within 7 days of discharge from hospital. Intervene to set up appointments if not scheduled.	POST-HOSPITAL: Demonstrates that follow-up appointments with primary care provider and/or specialist are scheduled within 7 days of discharge from hospital.
Provide opportunity to practice and role play questions for PCP/ specialist in preparation for follow-up visits or next scheduled visit.	Demonstrates ability to write questions for PCP/specialist in PHR in preparation for follow-up visit.
Evaluate plan of care including visit calendar with patient/caregiver and identify if changes are needed.	Verbalizes participation in and agreement with visit calendar and plan of care (including changes in plan of care).
POST-HOSPITAL: Assess if physician follow-up appointment was kept within 7 days of discharge from hospital.	POST-HOSPITAL: Demonstrates physician follow-up appointment was kept within 7 days of discharge from hospital.
Instruct on community resources and support groups that can assist in maintaining positive health behavior, meeting long-term care needs and evaluate ability to access resources.	Verbalizes community resources available and how to contact them. Demonstrates ability to access community resources.
Initiate discussion of discharge/transition plans with patient/caregiver.	Verbalizes agreement with discharge plans.
Evaluate and update patient's Personal Health Record (PHR) with changes in medications, diet, activity, allergies, s/s to monitor, etc.	Demonstrates Personal Health Record (PHR) is up-to-date.
Evaluate knowledge of and agreement with discharge plans.	Verbalizes knowledge of and agreement with the discharge plan.
Initiate referral to community support group of interest at or before discharge.	
Instruct on how and why to reorder, obtain equipment, supplies, medications and lab tests following discharge.	Verbalizes importance of obtaining equipment, supplies, medications and lab tests following discharge.
Instruct on importance of follow-up with physician/other services.	Verbalizes importance of follow-up visits with physician and other services.
Evaluate plans for obtaining equipment, supplies, medication prescription refills and lab tests after discharge.	Verbalizes/demonstrates plan to obtain equipment, supplies, medications and lab tests.
Evaluate plans to follow-up with physician/other services.	Verbalizes/demonstrates plan for follow-up visits with physician and other services.