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Module 4 Types of HealthCare Settings

Home Health Care

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Objectives

- [ ] Describe what Home Health Care is and identify who it serves
- [ ] Identify the interdisciplinary Home Health team and the services they provide
- [ ] Explain essential documentation and workflow requirements in Home Health

What is Home Health Care?

- Home Health care brings medical services directly into the patient's home.
- It’s for patients who are well enough to leave the hospital but still require professional care, such as wound dressing, IV therapy, medication management, or physical therapy.
- Unlike Home and Community-Based Services (HCBS), which provide personal and social support, Home Health focuses on skilled medical care under a doctor's order.
- Home health enables patients, usually elderly or post-surgery, to recover safely at home.
- Nurses, therapists, and aides make scheduled visits to monitor progress and reduce hospital readmissions.

What Services Are Provided?

Skilled Services

Skilled nursing (injections, wound care, catheter care) and therapy services (PT, OT and ST)

Patient and caregiver education

Supporting recovery with education and personalized care plans tailored to individual needs.

What Services Are Provided?

Medication and pain management

Personal Care Assistance

Home Health Aides assist patients with personal care, helping maintain daily living activities for better quality of life.

What Services Are Provided?

Psychosocial Support

Medical Social Workers provide essential psychosocial support to patients and families, aiding in emotional well-being.

Rehabilitation

Therapists focus on rehabilitation, offering physical, occupational, and speech therapy services.

What Services Are Provided?

End of Life & Palliative Care

- Pain and symptom management
- Emotional and spiritual support
- Education for families about the dying process
- Coordination with hospice teams (if applicable)
- Personal care to maintain comfort
- Assistance with equipment such as oxygen, hospital beds, or mobility aides
- End-of-life care may be provided through home health, hospice partnerships, or as part of a transition to hospice care.

Who Provides the Care?

- A multidisciplinary team delivers care in coordination with a physician:
- Registered Nurses (RNs) – assess conditions, administer medications, perform wound care.
- Licensed Practical/Vocational Nurses (LPNs/LVNs) – provide routine care under RN supervision.
- Physical, Occupational, and Speech Therapists – restore mobility, self-care, or communication.
- Medical Social Workers – help with community resources and psychosocial needs.
- Home Health Aides (HHAs) – assist with personal care under supervision.
- All services must follow a physician-approved plan of care.

Regulations and Documentation

- Home health is one of the most tightly documented care types.
- Every patient must have:
  - OASIS (Outcome and Assessment Information Set) assessments
  - A signed physician plan of care
  - Visit notes (with time, date, and electronic signature)
  - EVV data for in-home verification
- This documentation supports both clinical care and compliance with Medicare and CMS billing rules.

Home Care Nomenclature

Home Health Care does not use the same physical-location hierarchy as hospitals or long-term care because services are delivered in the patient’s home, not inside a facility with units, rooms, or beds. However, Home Health does have its own operational nomenclature that developers must understand.

Home Care Nomenclature cont’d

Home health documentation is organized around:

- Patient (or "client" in some agencies)
- Primary address where care is delivered
- Episode of care (usually 60 or 30 days, depending on agency structure)
- Plan of care (physician-ordered)

Home Care Nomenclature

-Patient identification Core elements

Core Elements

- Patient Name
- Service Address
- Episode Start/End Dates
- Primary Diagnosis + Secondary Conditions
- Physician of Record

Visit-Level Nomenclature-

Every visit type has a standardized naming system based on role and purpose.

Abbreviation	Visit Type	Meaning
SOC	Start of Care	Initial admission assessment by RN or therapist
ROC	Resumption of Care	Restarting services after a hospital stay
Recert	Recertification	Required reassessment for continued care
SNV	Skilled Nursing Visit	Wound care, assessments, medication management
PT/OT/SLP Visit	Therapy Visit	Rehab or functional restoration
MSW	Medical Social Work	Resources, psychosocial support
HHA	Home Health Aide Visit	Personal care (hygiene, ADLs)

These visit-type codes appear in scheduling, documentation, and billing.

Discipline Codes (Role-Based Nomenclature)

Home health agencies categorize staff by discipline

Code	Discipline
RN	Registered Nurse
LPN/LVN	Licensed Practical/Vocational Nurse
PT	Physical Therapy
OT	Occupational Therapy
SLP/ST	Speech Therapy
MSW	Medical Social Worker
HHA	Home Health Aide

These codes drive: Scheduling, Workflow assignment, Documentation templates, and Electronic Visit Verification (EVV)

Task-Based Nomenclature

Tasks are linked to the Plan of Care and authorization.

Examples:

- Wound Care: Daily Dressing Change
- Medication Reconciliation
- IV Antibiotics
- Gait Training (PT)
- ADL Assistance (HHA)
- Caregiver Education

Each task is coded so the system can track:

- Completion
- Frequency (daily, weekly, PRN)
- Discipline responsible

Location Nomenclature

- Unlike LTC or hospitals, Home Health uses service addresses rather than units or floors.
- Structure:
- Patient → Address → Visit Type → Discipline → Task List
- Example:
- Jane Doe → 112 Pine Street → SNV → RN → Wound Care + Medication Review

Documentation Nomenclature

Home health documentation is standardized across the U.S.:

- OASIS (Outcome and Assessment Information Set)
  - Required for all Medicare-certified agencies
- POC (Plan of Care) / 485 Form
- Visit Notes
- EVV Records (GPS, timestamp)
- Skilled Intervention Notes

These serve as both:

- clinical documentation, and
- legal documentation of services provided.

Status & Workflow Codes

- Agencies universally use patient status codes such as:

Code Meaning
Active - Receiving services
On Hold - Temporarily paused (usually when the patient is hospitalized)
Discharged - Completed services
Unsuccessful- Unable to admit / refused admission

In Summary, Home Health Nomenclature =

- Patient → Address → Episode → Discipline → Visit Type → Tasks → Documentation

Home Health Nomenclature = Patient → Address → Episode → Discipline → Visit Type → Tasks → Documentation

No “unit/floor/wing” structure exists because the home is the setting.

Key Development Considerations

- OASIS Integration: Create innovative forms with built-in logic that flag missing or inconsistent data (e.g., vital signs or functional scores).
- Care Plan Linking: Tie every visit and task to the patient's care plan and authorization.
- Billing Logic: Connect OASIS data to PDGM payment categories; prevent billing until required documentation is complete

Key Development Considerations

- Offline Mode: Support mobile data capture in rural areas or homes without Wi-Fi.
- HIPAA Security: Encrypt all home-captured data and use two-factor authentication for nurses accessing patient charts.
- Analytics: Include dashboards for tracking missed visits, documentation errors, and readmission risk.

Nurses must record data that supports Medicare payments, making every note, photo, and signature part of the official medical record. As a developer, your task is to convert nurses' workflows into structured data that matches Medicare and Medicaid billing standards. MyNursePal Pro's effectiveness relies on accurate, compliant, and streamlined documentation so nurses can prioritize patient care over paperwork.

Coming Next

Module 5

Home and Community Based Service Programs (HCBS)