There is a newer version of this book. You are viewing the first edition of this title. Check out the second edition for more up to date information. On August 8, 2011, the Centers for Medicare & Medicaid Services released the final ruling and commentary for the new implementation of the MDS changes set to take effect on Oct. 1, 2011. The Reimbursable Therapy Minutes will be the deciding factor in determining whether a Change of Therapy (COT) OMRA (Other Medicare Required Assessment) will be required, if at all. Most of our skilled nursing facilities are using some type of tracking tool for managing the prospective payment system minutes. Some are computerized, while others are still using paper forms. The Change of Therapy (COT) observation week must be scheduled exactly seven days following the previous MDS or observation week. If there has been a change in RUG category, then a Change of Therapy (COT) OMRA must be done and the reimbursement will drop or increase to the new RUG until another change occurs. CMS decided to assume all SNFs should offer seven-day rehab options, so facilities that traditionally offered Monday through Friday services will face immense challenges with the new Change of Therapy (COT) OMRA. This book has been updated to discuss the new MDS assessment schedule, the allocation of group therapy minutes, the revised student supervision provisions, the End of Therapy (EOT) Other Medicare Required Assessment (OMRA) and new resumption items, and the new PPS assessment- Change of Therapy (COT) OMRA (Other Medicare Required Assessment). The long term care industry has anticipated the new MDS 3.0. RUG IV coding requires the therapist to specifically account for the time captured during the look back period. This book could help occupational therapists, physical therapists and speech therapists understand Medicare standards for subacute care programs to be compliant with Medicare MDS 3.0 standards and state regulations. Documenting and billing strategies are also discussed in this book to attain maximum reimbursement. A list of commonly used ICD-9 codes is also provided. Appropriate billing and documentation should be present in the medical record. Medicare is increasingly reviewing therapy claims to ensure that the therapy provided required the skills of a therapist. The Mandated program, Recovery Audit Contractions, recovered 1 billion dollars during their 3 year demonstration project. This book covers establishing medical necessity, refusing to care for a resident, restraints, safety, creating incident reports, supervising assistive personnel and resident privacy. Coding and billing for subacute and long term care settings are also encompassed in this book, along with denial and appeal management, regulatory guidelines for insurers and improving cash flow with denial management strategies. Proper coding and documentation ensures that facilities will keep their money upon a post payment medical record audit.

Reimbursement and Reducing Denials Rick Gawenda, PT Up-to-speed with Medicare documentation requirements for 2009 and beyond? Increase cash flow and reduce Medicare claim denials by using strategies provided in the Third Edition of "The How-To Manual for Rehab Documentation." Written by national consultant Rick Gawenda, PT. Since our last edition, there have been significant changes to the rules and regulations surrounding documentation in therapy settings. And now that the RACs are underway it is even more important to have accurate and thorough documentation. Mistakes can lead to delayed payments and denials, so how do ensure that you are in compliance with the current guidelines? Make it easy. Order your copy of "The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials." Written by author and national consultant Rick Gawenda, PT, of Gawenda Seminars, this book and CD-ROM set focuses on the clinical aspects of documentation and offers proven methods to strengthen documentation and decrease the frequency of denials. Gawenda encourages documentation methods that have worked for him and help you conquer potentially tough concepts such as maintenance therapy and CPT codes. What's new in the third edition? Clarification of certification and re-certification requirements regarding how long they are valid for and how soon they need to be signed Explanation of delayed certification tips to write function-based short- and long-term goals Updated examples of well-written goals

Updated payer documentation guidelines for evaluations, progress reports, daily notes, discharge reports, and re-evaluations "The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials" outlines proper documentation strategies starting from the moment a patient registers and receives treatment to billing for time and services. Gawenda encourages documentation methods that have worked for him and help you conquer potentially tough concepts such as maintenance therapy and CPT codes. This comprehensive book and CD-ROM, helps you: Improve therapy billing through better documentation Prevent denials as a result of better documentation practices Maintain quality assurance through proper documentation Optimize your reimbursement from both Medicare and third-party payers Avoid audits and targeted medical reviews Document care in a more efficient way Take the critical steps to verify therapy benefit coverage prior to a patient's initial visit Support skilled therapy services with inclusion of required documentation Understand Medicare certification and recertification time frames and requirements for all therapy settings Understand and use the most commonly used CPT codes and modifiers in rehabilitation therapy Table of Contents: Chapter 1: The Role of the Registration Staff Registration Basics Benefit Verification Preregistering Chapter 2: Initial Documentation Evaluation Format Documentation Components Evaluation Process Objective Criteria Assessment Documentation Goals POC Documentation Creating a Solid Foundation Chapter 3: Certification and Recertification Physician Referrals Physician Referral Denials Outpatient Therapy Settings Certification and Recertification SNF Part A Therapy Services Reimbursed Under the Prospective Payment System (PPS) Home Health Agency Part A Therapy Services Chapter 4: Daily Documentation Daily Documentation Documentation Requirements Home Exercise Programs (HEPs) Plan Documentation Chapter 5: Progress Reports, Discharge Reports, and Reevaluations Progress Reports Discharges Reevaluations Chapter 6: Maintenance Therapy What is an FMP? Coverage Criteria Documentation Requirements Billing Cover All Your Bases Chapter 7: Wound Care Under Medicare Discharge Criteria Additional Pointers Appendix A: Navigating the CMS Web site Getting Started Final Word Make it easy to understand CMS' documentation guidelines No need to download and interpret the guidance from the CMS Web site yourself. Author Rick Gawenda, PT, has done the work for you. His documentation practices are sure to help you receive optimal compensation for the services you perform as a therapist. Nearly half of all rehab claim denials are STILL due to improper documentation. Ensure proper documentation for services provided and decrease the frequency of denials. Order "The How-To Manual for Rehab Documentation, Third Edition: A Complete Guide to Increasing Reimbursement and Reducing Denials" today!

Long-Term Care Skilled Services: Applying Medicare's Rules to Clinical Practice Avoid common mistakes that compromise compliance and payment Take the mystery out of skilled services and know when to skill a resident based on government regulations, Medicare updates, the MDS 3.0, and proven strategies. "Long-Term Care Skilled Services: Applying Medicare's Rules to Clinical Practice" illustrates the role played by nurses, therapists, and MDS coordinators in the application and documentation of resident care. Don't miss out on the benefits and reimbursement you deserve, as author Elizabeth Malzahn delivers clear, easy-to-understand examples and explanations of the right way to manage the skilled services process. This book will help you: Increase your skilled census and improve your facility's reputation with the support of your entire staff Avoid under- and overpayments from Medicare

"Every NP should own a copy of this book!" - The Nurse Practitioner Journal. Written by a nurse practitioner who is also a practicing attorney, Nurse Practitioner's Business Practice and Legal Guide, Second Edition provides the unique point of view of an author who knows what legal and business problems arise on a daily basis. The second edition to this best seller will teach you: -How to write an effective business plan using the most up-to-date information and planning strategies. -How to avoid malpractice and other lawsuits. -What rights an employed NP has. -What to do if rejected for payment. -How to effectively negotiate managed care contracts. -How to get the highest marks on performance report cards. -What must take place for NPs to become primary care providers. -What decisions need to be made before starting a practice. -How to handle patient flow. -And more! Nurse practitioners and NP students who read this book will have a solid foundation of knowledge with which they may continue their practice confidently and effectively, whether it be in developing an employment relationship, undertaking a business venture, giving testimony before the state legislature, composing a letter to an insurance company about an unpaid bill, teaching at a school of nursing, or serving as president of a state or national organization.

"Larger Format! Accessible and user-friendly, this updated edition contains information that is essential for nursing home administrators as well as educators and professionals preparing for licensure. It presents the latest federal guidelines and the procedures used by federal surveyors in certifying facilities for participation in Medicare and Medicaid. It is the only text that provides a comprehensive index to nursing home federal requirements. The volume spans every aspect and service of a nursing home, from telephone access and comfortable lighting to urinary incontinence treatment and proper drug storage. Administrators who implement these regulations will ensure outstanding quality assurance and risk management programs in place. New to the Fifth Edition is inclusion of the Centers for Medicaid and Medicare Services Forms used by surveyors.

Thoroughly updated for its Second Edition, this comprehensive reference provides clear, practical guidelines on documenting patient care in all nursing practice settings, the leading clinical specialties, and current documentation systems. This edition features greatly expanded coverage of computerized charting and electronic medical records (EMRs), complete guidelines for documenting JCAHO safety goals, and new information on charting pain management. Hundreds of filled-in sample forms show specific content and wording. Icons highlight tips and timesavers, critical case law and legal
Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation Barbara Acello, MS, RN and Lynn Riddle Brown, RN, BSN, CRNI, COS-C

Initial assessments can be tricky—without proper documentation, home health providers could lose earned income or experience payment delays, and publicly reported quality outcomes affected by poor assessment documentation could negatively impact an agency's reputation. Ensure that no condition or symptom is overlooked and documentation is as accurate as possible with Home Health Assessment Criteria: 75 Checklists for Skilled Nursing Documentation. This indispensable resource provides the ultimate blueprint for accurately assessing patients' symptoms and conditions to ensure regulatory compliance and proper payment. It will help agencies deliver more accurate assessments and thorough documentation, create better care plans and improve patient outcomes, prepare for surveys, and ensure accurate OASIS reporting. All of the book's 75-plus checklists are also available electronically with purchase, facilitating agency-wide use and letting home health clinicians and field staff easily access content no matter where they are. This book will help homecare professionals: Easily refer to checklists, organized by condition, to properly assess a new patient Download and integrate checklists for use in any agency's system Obtain helpful guidance on assessment documentation as it relates to regulatory compliance Appropriately collect data for coding and establish assessment skill proficiency

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10.1. Endocrine Assessment Documentation 10.2. Diabetes Assessment Documentation 11: Eyes, Ears, Nose, Throat Assessment Documentation 11.1. Eyes, Ears,

Documentation Manual for Speech Language Pathology is a complete guide to documenting medical speech-Language treatment. It is an easy-to-use resource that includes case histories and sample forms that can be copied and used in practice. Medicare documentation process for hospitals, skilled nursing facilities, and home health rehabilitation agencies is included. Documentation in private practice schools and other settings is also covered.

It is with great pride that the Psychologists in Long Term Care (PLTC) have sponsored The Professional Educational Long-Term Care Training Manual, and now its second iteration, Geropsychology and Long Term Care: A Practitioner’s Guide. Education of psychologists working in long-term care settings is consistent with PLTC’s mission to assure the provision of high-quality psychological services for a neglected sector of the population, i.e., residents in nursing homes and assisted-living communities. To this end, direct training of generalist psychologists in the nuances of psychological care delivery in long-term care settings has been a major priority. It is a tribute to the accelerating nature of research in long-term care settings that a revision is now necessary. After all, the Professional Educational Training Manual's initial publication date was only in 2001. However, in the intervening years, much progress has been made in addressing assessment and intervention strategies tailored to the needs of this frail but quite diverse population. It is so gratifying to be able to say that there is now a corpus of scientific knowledge to guide long-term care service delivery in long-term care settings.

Did you know that plants and plant products can be used to improve people's cognitive, physical, psychological, and social functioning? Well, they can, and Horticulture as Therapy is the book to show you how! If you are already familiar with the healing potential of horticultural therapy, or even practice horticultural therapy, this book will help you enrich your knowledge and skills and revitalize your practice. You will learn how horticultural therapy can be used with different populations in a variety of settings, what resources are available, effective treatment strategies, and the concepts behind horticultural treatment. The first comprehensive text on the practice of horticulture as therapy, this one-of-a-kind book will enable the profession to educate future horticultural therapists with fundamental knowledge and skills as they embark on careers as practitioners, researchers, and educators. You come to understand the relationship between people and plants more deeply as you learn about: vocational, social, and therapeutic programs in horticulture special populations including children, older adults, those who exhibit criminal behavior, and those with developmental disabilities, physical disabilities, mental health disorders, or traumatic brain injury use of horticultural therapy in botanical gardening and community settings adaptive gardening techniques applied research documentation and assessment in horticultural practice Horticulture as Therapy establishes, integrates, and communicates a foundation of knowledge for horticultural therapists, other therapists, horticulturists, students, research scientists, gardeners, and others interested in this special and unique kind of therapy. By reading Horticulture as Therapy, you will see how you can make a difference in the health and well-being of so many people, today and tomorrow.

University of Wisconsin-Milwaukee School of Nursing's comprehensive charting and documentation manual for students and practitioners.

Elizabeth I. Gonzalez, RN, BSN Are you looking for training assistance to help your homecare staff
enhance their patient assessment documentation skills? Look no further than "Clinical Documentation Strategies for Home Health." This go-to resource features home health clinical documentation strategies to help agencies provide quality patient care and easily achieve regulatory compliance by: Efficiently and effectively training staff to perform proper patient assessment documentation Helping nurses and clinicians understand the importance of accurate documentation to motivate improvement efforts Reducing reimbursement issues and liability risks to address financial and legal concerns This comprehensive resource covers everything homecare providers need to know regarding documentation best practices, including education for staff training, guidance for implementing accurate patient assessment documentation, tips to minimize legal risks, steps to develop foolproof auditing and documentation systems, and assistance with quality assurance and performance improvement (QAPI) management. "Clinical Documentation Strategies for Home Health" provides: Forms that break down the functions and documentation requirements of the clinical record by "Conditions of Participation," Medicare, and PI activities Tips for coding OASIS Examples of legal issues such as negligence Case studies and advice for managing documentation risk (includes a checklist) Comprehensive documentation and auditing tools that can be downloaded and customized Table of Contents: Key aspects of documentation Defensive documentation: Reduce risk and culpability Contemporary nursing practice Clinical documentation Nursing negligence: Understanding your risks and culpability Improving your documentation Developing a foolproof documentation system Auditing your documentation system Telehealth and EHR in homecare Motivating yourself and others to document completely and accurately

Handbook of Home Health Standards: Quality, Documentation, and Reimbursement includes everything the home care nurse needs to provide quality care and effectively document care based on accepted professional standards. This handbook offers detailed standards and documentation guidelines including ICD-9-CM (diagnostic) codes, OASIS considerations, service skills (including the skills of the multidisciplinary health care team), factors justifying homebound status, interdisciplinary goals and outcomes, reimbursement, and resources for practice and education. The fifth edition of this "little red book has been updated to include new information from the most recently revised Federal Register Final Rule and up-to-date coding. All information in this handbook has been thoroughly reviewed, revised, and updated. Offers easy-to-access and easy-to-read format that guides users step by step through important home care standards and documentation guidelines Provides practical tips for effective documentation of diagnoses/clinical conditions commonly treated in the home, designed to positively influence reimbursement from third party payors. Lists ICD-9-CM diagnostic codes, needed for completing CMS billing forms, in each body system section, along with a complete alphabetical list of all codes included in the book in an appendix. Incorporates hospice care and documentation standards so providers can create effective hospice documentation. Emphasizes the provision of quality care by providing guidelines based on the most current approved standards of care. Includes the most current NANDA-approved nursing diagnoses so that providers have the most accurate and up-to-date information at their fingertips. Identifies skilled services, including services appropriate for the multidisciplinary team to perform. Offers discharge planning solutions to address specific concerns so providers can easily identify the plan of discharge that most effectively meets the patient's needs. Lists the crucial parts of all standards that specific members of the multidisciplinary team (e.g., the nurse, social worker) must uphold to work effectively together to achieve optimum patient outcomes. Resources for care and practice direct providers to useful sources to improve patient care and/or enhance their professional practice. Each set of guidelines includes patient, family, and caregiver education so that health care providers can supply clients with necessary information for specific problems or concerns. Communication tips identify quantifiable data that assists in providing insurance case managers with information on which to make effective patient care decisions. Several useful sections make the handbook thorough and complete: medicare guidelines; home care definitions, roles, and abbreviations; NANDA-approved nursing diagnoses; guidelines for home medial equipment and supplies. Small size for convenient carrying in bag or pocket! Provides the most up-to-date information about the newest and predominant reimbursement mechanisms in home care: the Prospective Payment System (PPS) and Pay For Performance (P4P). Updated terminology, definitions, and language to reflect the federal agency change from Health Care Financing Administration (HCFA) to Centers for Medicare & Medicaid Services (CMS) and other industry changes. Includes the most recent NANDA diagnoses and OASIS form and documentation explanations. New interdisciplinary roles have been added, such as respiratory therapist and nutritionist.
It's not the quantity of clinical documentation that matters—it's the quality. Is your clinical documentation improvement (CDI) program identifying your outliers? Does your documentation capture the level of ICD-10 coding specificity required to achieve optimal reimbursement? Are you clear on how to fix your coding and documentation shortfalls? Providing the most complete and accurate coding of diagnoses and site-specific procedures will vastly improve your practice's bottom line. Get the help you need with the Clinical Documentation Reference Guide. This start-to-finish CDI primer covers medical necessity, joint/shared visits, incident-to billing, preventative care visits, the global surgical package, complications and comorbidities, and CDI for EMRs. Learn the all-important steps to ensure your records capture what your physicians perform during each encounter. Benefit from methods to effectively communicate CDI concerns and protocols to your providers. Leverage the practical and effective guidance in AAPC’s Clinical Documentation Reference Guide to triumph over your toughest documentation challenges. Prevent documentation deficiencies and keep your claims on track for optimal reimbursement: Understand the legal aspects of documentation Anticipate and avoid documentation trouble spots Keep compliance issues at bay Learn proactive measures to eliminate documentation problems Work the coding mantra—specificity, specificity, specificity Avoid common documentation errors identified by CERT and RACs Know the facts about EMR templates—and the pitfalls of auto-populate features Master documentation in the EMR with guidelines and tips Conquer CDI time-based coding for E/M The Clinical Documentation Reference Guide is approved for use during the CDEO® certification exam.

"[The book] lists all the federal requirements that are evaluated by state surveyors during the annual survey visit to nursing homes and for complaint visits. The exhibit section contains forms used by surveyors to gather data during the survey visit. Visually, the format makes the regulations easy to read. If nursing home staff used the book to prepare for a survey, they would be well prepared." Marcia Flesner, PhD, RN, MHCA University of Missouri-Columbia From Doody's Review The Federal government, together with more than 50 advocacy groups, has spent the past 40 years writing and refining the rules and guidelines in this manual. This book presents the latest federal guidelines and protocols used by federal surveyors in certifying facilities for participation in Medicare and Medicaid funding. It is an essential resource for long-term care facilities to have on hand to be ready for a survey at any time. It provides information straight from CMS'S Internet-Only Manual-in print and at your fingertips for easy access. Divided into four accessible and user-friendly parts, this manual includes: Federal requirements and interpretive guidelines Rules for conducting the survey Summary of the requirements for long-term care facilities and surveyors CMS forms commonly used by surveyors This newly updated and revised edition spans every aspect and service of a nursing home and represents the latest requirements to ensure that outstanding quality assurance and risk management programs are in place. New to This Edition: Section on how to use manual Summarization of federal requirements Updated definitions of Medicare and Medicaid Compliance requirements with Title VI of the Civil Rights Act of 1964 SNF/Hospice requirements when SNF serves hospice patients SNF-based home health agencies Life safety code requirements Changes in SNF provider status Surveyor qualifications standards Management of complaints and incidents New medical director guidelines

Patient-centered, high-quality health care relies on the well-being, health, and safety of health care clinicians. However, alarmingly high rates of clinician burnout in the United States are detrimental to the quality of care being provided, harmful to individuals in the workforce, and costly. It is important to take a systemic approach to address burnout that focuses on the structure, organization, and culture of health care. Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being builds upon two groundbreaking reports from the past twenty years, To Err Is Human: Building a Safer Health System and Crossing the Quality Chasm: A New Health System for the 21st Century, which both called attention to the issues around patient safety and quality of care. This report explores the extent, consequences, and contributing factors of clinician burnout and provides a framework for a systems approach to clinician burnout and professional well-being, a research agenda to advance clinician well-being, and recommendations for the field.

An excellent resource for new or seasoned NPs and PAs! The Nurse Practitioner in Long-Term Care addresses the growing trend to utilize the nurse practitioner in the skilled nursing facility (SNF) to manage patients in long-term care and serves as a practical resource for managing those conditions commonly encountered in the geriatric patient. It includes an introduction to nursing homes,
medication management, practical health promotion/disease prevention, and management of common clinical conditions specific to the skilled and long term care nursing home settings. It will also address important topics such as elder abuse, legal issues, reimbursement, and regulatory issues. Subjects covered are pertinent to everyday practice and this text is useful in graduate programs for nurse practitioners and clinical nurse specialists as well as for physician’s assistant (PA) students.

"[The book] lists all the federal requirements that are evaluated by state surveyors during the annual survey visit to nursing homes and for complaint visits. The exhibit section contains forms used by surveyors to gather data during the survey visit. Visually, the format makes the regulations easy to read. If nursing home staff used the book to prepare for a survey, they would be well prepared." Marcia Flesner, PhD, RN, MHCA University of Missouri-Columbia From Doody's Review The Federal government, together with more than 50 advocacy groups, has spent the past 40 years writing and refining the rules and guidelines in this manual. This book presents the latest federal guidelines and protocols used by federal surveyors in certifying facilities for participation in Medicare and Medicaid funding. It is an essential resource for long-term care facilities to have on hand to be ready for a survey at any time. It provides information straight from CMS’s Internet-Only Manual in print and at your fingertips for easy access. Divided into four accessible and user-friendly parts, this manual includes: Federal requirements and interpretive guidelines Rules for conducting the survey Summary of the requirements for long-term care facilities and surveyors CMS forms commonly used by surveyors This newly updated and revised edition spans every aspect and service of a nursing home and represents the latest requirements to ensure that outstanding quality assurance and risk management programs are in place. New to This Edition: Section on how to use manual Summarization of federal requirements Updated definitions of Medicare and Medicaid Compliance requirements with Title VI of the Civil Rights Act of 1964 SNF/Hospice requirements when SNF serves hospice patients SNF-based home health agencies Life safety code requirements Changes in SNF provider status Surveyor qualifications standards Management of complaints and incidents New medical director guidelines Complete and accurate documentation is one of the most important skills for a physical therapist assistant to develop and use effectively. The new Second Edition of Documentation Basics: A Guide for the Physical Therapist Assistant continues the path of teaching the student and clinician documentation from A to Z. Mia Erickson and Rebecca McKnight have updated this Second Edition to reflect changes of the American Physical Therapy Association and the ever-evolving profession. Updated inside Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition: * The discussion on integrating disability into documentation * The discussion on how a PTA can show medical necessity and need for skilled care * The discussion on using documentation to communicate with other providers * Writing the assessment and plan to coincide with the initial documentation * Sample notes completed on forms * More examples and practice, including physical agents, school-based services, pediatrics, traumatic brain injury, spinal cord injury, and interventions consistent with the Guide to Physical Therapist Practice * Medicare reimbursement in different settings * The importance of consistent, reliable, and valid measurements * How to improve communication and consistency between documentation by the PT & the PTA The discussion on disableness has also been updated, shifting away from the Nagi Model toward the International Classification of Functioning, Disability, and Health (ICF). In addition, the PTA Normative Model has been integrated throughout to include more information on clinical decision making. New inside Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition: * Navigating the PT plan of careA step-by-step model for PTAs to use as they navigate the initial PT documentation and plan of care * How the PTA uses the PT goals from the initial examination and evaluation Positive and negative aspects of using electronic documentation and a discussion on integrating SOAP notes and the problem-oriented medical record into electronic documentation * Sample notes and discussion of documentation in school-based settings, early intervention, skilled nursing settings, in-patient rehabilitation, and direct access * Medicare Parts C and D * Cash-based services and pro bono services Instructors in educational settings can visit www.efacultylounge.com for additional material to be used for teaching in the classroom. Documentation Basics: A Guide for the Physical Therapist Assistant, Second Edition is the perfect guide for all physical therapist assistant students and clinicians who want to update and refine their knowledge and skills in documentation.

2015 Third Edition. 205 pages. 136 Home Health Nursing Care Plans with 39 Medication Care Plans in
the book and on the CD. 23 Skilled Charting Guidelines. The Home Health nursing care plans and plan of care forms in this book cover every nursing diagnosis and care plan problem that may be generated from the OASIS-C Form for the nursing plan of care. Also includes Pain Care manual. Terminology is based on OASIS-C language and nursing diagnosis definitions and classifications as outlined by the North American Nursing Diagnosis Association (NANDA). The home health nursing care plan format follows the care plan standards from the American Nurses Association. The first section of the book covers regulations and standards for nursing care plans, Home Health Nursing care plan components, and Quality Measures and Outcome Measures. Because the terminology of the home health nursing care plan is based on OASIS-C language, it is very easy to see which care plans and plan of care forms are triggered by the OASIS-C entries. The home health nursing care plans can be used to supplement the nursing plan of care, and are also extremely useful for teaching patients and caregivers.

"This text covers conceptual information, leadership skills and current issues and trends. It provides clear and concise information about the best practices and quality improvement for the most common clinical conditions seen in home care." --Cover.

"[The book] lists all the federal requirements that are evaluated by state surveyors during the annual survey visit to nursing homes and for complaint visits. The exhibit section contains forms used by surveyors to gather data during the survey visit. Visually, the format makes the regulations easy to read. If nursing home staff used the book to prepare for a survey, they would be well prepared."

-Marcia Flesner, PhD, RN, MHCA University of Missouri-Columbia From Doody's Review Nursing homes are now the most highly regulated environments in the United States, in the service of maximizing the quality of each resident's life. This user-friendly guide has been updated to provide all of the requisite information needed by nursing home staff to prepare for a visit from federal surveyors. It provides the most current federal guidelines and the procedures used by federal surveyors in certifying facilities for participation in Medicare and Medicaid funding. It describes every aspect and service of a nursing home that is subject to inspection and includes the nearly 20% of new requirements established during the past three years, with an emphasis on the new Minimum Data Set 3.0. The guide not only presents federal requirements and explanatory guidelines but also explains how to best interpret these guidelines so nursing home staff can be optimally prepared for a survey visit. It reflects changes in regulations regarding end-of-life care, nasogastric tube regulations, and rights to establish advance directives. The guide also provides information straight from CMS's Internet-Only Manual. New Features of Eighth Edition: Describes how to best use the updated manual Focuses on Minimum Data Set 3.0 Explains clearly how to interpret the new requirements, 20% of which have been updated Presents new quality measures Includes new CMS forms Reflects changes in regulations regarding end-of-life care, nasogastric tube regulations, and rights to establish advance directives

Tired Of Being Hassled for Documentation as a Nurse in a LTC/SNF?A Straight-To-The-Point Guide From MDS Coordinators: What Exactly It Is We Need From Your Medicare Documentation. An easy to use reference made for Nurses in the long term care setting. We have gathered that in Nursing school we're taught to document or "it didn't happen" and on the job tells you to document but you're never given the specifics of what exactly is needed. This is why this reference guide was created by MDS Coordinators for LTC/SNF Nurses. Who better to hear it from than MDS Nurses themselves? Bridging the knowledge gap 1 Nurse at a time!

Contains the knowledge essential to prepare for licensure and employment as a nursing home administrator. Using as its basis the guidelines of the National Association of Boards of Examiners of Nursing Home Administrators, this work includes sections on: Distinguishing delirium from dementia; Psychosis from agitation; GERD; and Glycemic control.

The shifting demographic toward a "graying" population -- coupled with today's reality of managed care -- makes the need for high-quality, cost-effective psychiatric services within the nursing care setting more urgent than ever. As we increase the number of our years, it is also imperative that we enhance the quality of those years. The product of the American Psychiatric Association's (APA's)
Council on Aging and its Committee on Long-Term Care and of the Elderly, the Manual of Nursing Home Practice for Psychiatrists stands out because it focuses on the "how" -- not the "why" -- of nursing home care. Of exceptional importance is its detailed discussion of the Minimum Data Set (MDS), a structured assessment required by both Medicare and Medicaid for all residents of skilled nursing facilities. Divided into six sections, this "how to" volume contains practical information readers can use right away, from getting reimbursed by insurance companies to handling nursing facility politics: Clinical -- History; evaluation and management of psychiatric problems in long-term care patients; an overview of the MDS; sexuality within the nursing home care setting Regulatory -- Introduction to the Nursing Home Reform Act of 1987 (part of OBRA-87) and its implications for psychiatric care; details about the Resident Assessment Instrument (RAI), which includes the MDS, the Resident Assessment Protocols (RAPs), and Utilization Guides specified in the State Operations Manual (SOP) Financial -- Documentation, reimbursement, and coding; what to look for when contracting with nursing homes Legal and ethical -- The dehumanizing effect of diagnostic labels and the ethical issues inherent in regulating daily schedules (e.g., bed, meal, and bath times); nursing home placement; competence and decision-making ability; comfort care for end-stage dementia; coping with Alzheimer’s disease; and the role of caregivers Summary and Future Perspectives -- A detailed vision about how psychiatrists can improve the diagnosis and treatment of nursing home patients Appendixes and bibliography -- Staffing recommendations and assessment instruments Edited by a distinguished authority and former chair of the APA’s Committee on Long-Term Care and Treatment of the Elderly, this comprehensive volume will appeal to a wide audience of professionals: from general psychiatrists, nurse practitioners, and clinical nurse specialists, to primary care physicians and residents.

This critically acclaimed work makes the case for collaboration and shows that it can be greatly enhanced with conscious understanding and systematic effort. As a healthcare specialist who has worn many hats from direct care giver to case manager to documentation specialist, Colleen Stukenberg is able to – Show how to build trust and communication and demonstrates specific opportunities where collaboration can make all the difference Identify ways that quality of care and financial factors overlap and the advantages that can be garnered through an understanding of this Explain how those in different roles view information through different types of knowledge and how an understanding of each perspective makes it easier to find the best source for important answers Discuss the education and ever-increasing role of the clinical documentation specialist who is often involved in all facets of a patient’s progress, from intake and admission right up through discharge. As the author points out, good healthcare is dependent on the right person performing the right role, which promotes excellent collaboration. And when people are allowed to function in their proper roles, job satisfaction increases, which in itself leads to better attitudes, which then leads to even deeper levels of collaboration and with it, the successful promotion of safe, quality care.

Using a clear, hands-on approach to learning front office skills, Medical Office Administration, 4th Edition prepares you for a successful career as an administrative medical office assistant. Performing procedures with SimChart® for the Medical Office (SCMO), you’ll practice day-to-day tasks as if you were in an actual office setting. This new edition adds updated content to support use of the electronic health record, new Affordable Care Act information, insurance/billing/coding content, and SCMO activities woven throughout the text. Covering administrative tasks from appointment scheduling to medical billing, this work text helps you develop the knowledge and skills you need to think critically and respond confidently to the challenges you’ll encounter on the job. Access to SimChart for the Medical Office sold separately. A conversational writing style makes it easier for you to read and understand the material. Stopping points provide you with thought-provoking questions or activities to break up the narrative in manageable segments. HIPAA Hints ensure that you comply with HIPAA mandates. Real-world examples apply important concepts to the medical office setting. Interactive electronic procedure checklists spell out the individual steps required to complete a full range of administrative procedures, and are based on CAAHEP competencies. NEW! SimChart® for the Medical Office (SCMO) throughout text allows you to practice common administrative tasks with real-world office management software. NEW! Coverage of the Affordable Care Act and ICD-10 prepares you for what you’ll encounter on the job. NEW! Medical Assisting mapping tables tie into CAAHEP and ABHES competencies. NEW! High-quality illustrations and updated screenshots helps reinforce content.