Documentation in the Home Health Setting:
What's involved & Why It's so Critical

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Home health care is medical care provided in a patient's home. This care may include skilled medical care provided by nursing, physical therapy, occupational therapy and speech therapy. Non-medical skilled care, such as social services and home health aides, can also be provided. Home health care is an extension of medical care provided in a home that can be less expensive, convenient and effective and is an alternative to a hospital or skilled nursing facility.

As of 2018, there were over 11,000 Medicare certified home health agencies in the United States. Over 5 million Medicare beneficiaries received home health services totaling of 7 million episodes of care. [1] There continues to be a rise in home health demands with an increase in patients and spending over $102 billion. [2]

Home health agencies are certified to ensure they meet and follow federal safety and practice guidelines. These guidelines are found in the federal regulation 42 CFR Part 484 Home Health Services. It is under these regulations that Medicare sets forth the requirements for home health agency documentation.

In order to qualify for Medicare reimbursement, a home health agency must meet documentation requirements that are outlined in Medicare Conditions of Participation. These requirements follow evidenced based standards of care for documentation. This required documentation is two-fold, to receive Medicare reimbursement and to ensure quality of care. Standard of care for documentation, among other things, ensures that the care provided reflects the nursing process, follows the physician's orders and establishes a plan of care.

Accurate, reliable documentation allows clinicians to analyze data and acts a means to communicate the health status of the patient to other care providers to ensure continuity of care. An accurate and reliable record prevents fragmentation, repetition, and delays in care. It also provides a timeline for the sequence of events, symptoms, treatments, and responses. This ensures continuity of care to the patient when multiple participants and providers are involved in providing services to the patient. It also serves as a means to monitor a patient's condition and is important in identifying a change in a patient's condition that may be reflective of an impending emergency. In addition, documentation is evidence that patient care was provided.

According to 42 CFR Part 484.110, Medicare Conditions of Participation: Clinical records, the clinical record must include past and present documentation for every patient. This information must be accurate, follow the standards of care for documentation and be available to the physicians involved in their care.

The record must include:

- a comprehensive assessment
- interventions (medication administration, treatments, services, and response to interventions)
- the progress made towards the established goals in their plan of care
- contact information (patient family/legal guardian and physicians)
- completed discharge or transfer summaries
- documentation must be clear, complete, and authenticated (signature with title), date and timed
- the clinical records must be retained for 5 years.

Upon the start of care/treatment, a clinician will perform a complete assessment and evaluation of the patient. This assessment will establish a baseline to determine the progress of the patient's condition. It is from this assessment that the identification of any current or potential risks that need to be addressed are determined. Based on this complete assessment and identification of risks, a plan of care will be developed and implemented. The developed interventions are patient specific describing the care and services required to meet and address the needs of the patient. This plan of care will include attainable goals, treatments and specific measures for a desired outcome. Once developed, the plan of care will be reviewed with the patient, caregiver, and/or legal guardian to educate and to determine the patient's willingness to participate.

Throughout the patient's treatment episode, assessments will be completed, treatments will be provided, and the care plan will be reviewed. At any point while the patient is receiving home health services, they experience a change in condition or their needs change, a new assessment is completed, and their care plan is modified or revised.

Home health care plays a major role in allowing patients to return home while receiving necessary medical care and monitoring. It is through documentation that a patient receives quality of care and therefore it is imperative that the documentation is accurate, specific, and measurable. Contact us today if you would like to speak to one of our nursing experts.

[1] Home Health Quality Reporting Program. Updated 10/2/20, accessed 10/27/20

[2] Why Homecare is the Answer to 2020's Big Health Care Questions