Patient Admission Orientation for Home Health Care

Statement of Confidentiality
This booklet may contain protected health information. Persons other than you and your health care providers must have your permission to view this booklet.

Who to Call:

Branch Number: ______________________________

Supervisor Number: ______________________________

REGIONS

Bay City
2110 16th Street, Suite 7
Bay City, MI 48708
(989) 667-2320
1 (800) 840-3147

Davison
1515 Cal Drive
Davison, MI 48423
(810) 496-8888
1 (800) 862-3132

Lansing
2815 S. Pennsylvania Ave., Suite 4
Lansing, MI 48910
(517) 975-9900
1 (800) 722-9449

Mt. Pleasant
501 South Mission St.
Mt. Pleasant, MI 48858
(989) 772-6785
1 (800) 356-7321

Sterling Heights
12900 Hall Road, Suite 200
Sterling Heights, MI 48313
(586) 323-6290
1 (800) 451-0481

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Office Hours/After-Hours Coverage

Instructions: The information below should be used as a quick reference source in case an emergency occurs. Have this information readily available and keep it where it can easily be located. It is also recommended that you inform individuals close to you, such as a relative, caregiver, neighbor, etc., where the information is located.

Patient Name: ______________________________ **Date of birth:** ______________

Social Security #: ____________________ **Tel #:** ______________________________

Address: ____

Diagnosis: ____

Office Hours:

Monday through Friday from 8:00 a.m. to 5:00 p.m. (except during agency observed holidays).

After-Hours Coverage:

We provide 24-hour on-call service, 7 days per week to ensure you have access to necessary home care services. If you contact the office after-hours, your call will route to the operator at the McLaren hospital within the service area. Identify yourself as a McLaren Homecare patient and the operator will promptly have the on-call homecare nurse contact you.

The on-call nurse will assist callers with their concerns and attempt to resolve the situation over the phone. In the event that the problem is not resolved, the nurse may arrange a visit. Note, our staff does not carry medications with them and only give medications to patients that are ordered by a physician. Medical supplies and equipment are typically not delivered after regular business hours.

In Case of Emergency:

McLaren Homecare does not operate an emergency service. **In the event of an emergency, call 911 immediately.** If the patient is admitted to the hospital, or taken to the emergency room, contact the McLaren Homecare branch office.

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Section I: Welcome

Thank you for choosing McLaren Homecare for your home health needs. We look forward to working with you, your family, your physician and other health care professionals on your care team, to make your care at home as comfortable as possible.

We believe that health care is a basic human right. It must be available, coordinated and provided in a comprehensive way, combined with other human services when appropriate. We recognize that every human being has personal rights which must be respected and should not be violated. The management and staff of McLaren Homecare will do our best to address questions or concerns you may have with regard to your plan of care. We are guided by the following beliefs:

- That it is important to take care of your family like we would our own.
- That providing care for families in their home, with the best people, makes a difference.
- That the best place to receive your healthcare is in your home.
- In caring for patients as if they were our only patient.
- That taking care of people with dignity and respect where they live is the noblest purpose we can achieve.
- In caring for every patient at home as if they were family.
- That it is a privilege to care for patients and their families in their home, one patient at a time.
- That working together we can embrace each patient as if they were part of our family to provide them with comfort and care in their home.

Our agency is a subsidiary of McLaren Health Care. We are committed to ensuring your rights and privileges as a home health care patient are protected and this booklet has been designed to help you understand the home health care process and explain your rights as a patient. If you have additional questions, please do not hesitate to ask us.

Sincerely,
The Management and Staff of McLaren Homecare

Section II: Overview of Home Health Agency

Our Policies:

Home health care is an important part of the continuous health care system and it will be provided in the most cost-effective way possible. McLaren Homecare shall operate and furnish services in compliance with all applicable federal, state, and local laws and regulations and disclosure and ownership information. As state and federal regulations change, there may be additions or changes to this book as necessary. Each agency branch office has a complete patient care policy and procedure manual. It is available upon request to view at the agency office during regular business hours.

Our Admission Criteria:

This agency is a subsidiary of McLaren Health Care and in compliance with Title VI of the Civil Rights Act of 1964, with Section 504 of the Rehabilitation Act of 1973 and with the Age

Discrimination Act of 1975. We do not discriminate on the basis of race, color, religion, sex, national origin, age or disability with regard to admission, access to treatment or employment. We will make every effort to comply with these and similar statutes.

- Admission to this agency can only be made under the direction of a physician
- Admission is based upon the patient's specified care needs and homebound status
- Services required for patient care must be available either directly, or through coordination with other organizations

If our agency cannot meet these needs, or the patient's home environment cannot accommodate our services, we cannot admit you or continue to provide services to you.

Our Services:

McLaren Homecare can provide a service or a combination of services in your home. Services will be appropriate for the patients care needs will be planned, coordinated and made available under the direction of their physician. Our agency is certified under various state and federal programs. If there is a program specific to your care needs that you are interested in, contact our agency to confirm if we participate in the program, as eligibility is determined by state and/or federal agencies). Our services include:

- **Registered Nurse (RN) —** The RN communicates with your physician to update your plan of care. They assess patients and provide nursing interventions including, teaching, supervision and direct care individualized to the patient's health related needs.
- **Licensed Practical Nurse (LPN) —** The LPN supplements the nursing care to patients as provided by the plan of care designated by a RN.
- **Home Health Aides (HHA) —** The HHA provides personal care and/or assists with medical treatments under the direction and supervision of the RN.
- **Physical Therapist (PT) —** The PT will evaluate and treat motor function limitations and instructs patients with regard to assistive and prosthetic care.
- **Occupational Therapist (OT) —** The OT works with patient's to maximize their ability to perform activities of daily living (ADLs) such as bathing, dressing, and toileting, cooking and eating, and make recommendations to enhance a patient's functional ability.
- **Speech Therapist —** Evaluates and treat speech, communication and swallowing disorders.
- **Medical Social Worker (MSW) —** Provides short-term therapeutic counseling and referrals to community agencies.

Patient Financial Obligations:

Our agency accepts Medicare, Medicaid, workers compensation, private insurance or private pay as payment for services. Some insurers may limit the number and type of home care visits that they will pay for and may require pre- certification, co-payments, or both. We will inform you, your family, caregiver or guardian of all charges and methods of payment before or upon admission. And, if there are changes to our services or charges, you or your responsible party will be advised. If you have any questions about charges or insurance billing, please call our office.

Special Medicare Home Health Information:

Our agency is certified and licensed to provide home healthcare to Medicare patients. We follow federal guidelines governing admission and service provisions for Medicare patients. Admission can only be made upon recommendation of a licensed physician when the patient meets the qualifying requirements including needing skilled home healthcare services and meeting the homebound status. Medicare patients may receive a Medicare Summary Notice (MSN) after we submit a final claim for services. Please note, this is not a bill, rather the MSN shows the services and charges billed to Medicare on your behalf, as well as the amount Medicare paid.

If you change insurance companies during the course of treatment please notify this agency immediately. If you are enrolled in a Medicare Managed Care Plan, a private HMO or hospice, the original Medicare Plan may not pay for the services you are receiving.

Medicare Guidelines Used to Establish Coverage:

The following is required for Medicare to pay for your home health care services:

- Medicare covers home health services for individuals who are confined to their homes and are in need on an intermittent basis for skilled nursing care, or physical therapy, speech-language pathology, occupational therapy, medical social work and/or home health aide services.
- To qualify for coverage, a patient must be under the care of a physician who certifies the need for care and that the individual is confined to their home. If the services are not reasonable or medically necessary and have not been specifically ordered by your physician, Medicare will not pay for those services.
- A recent change in the law adds a new requirement to qualify for Medicare coverage. To encourage greater involvement of the physician in a patient's home health services, the new law requires that the patient be seen face-to-face by the physician, or certain non-physician practitioners working with the physician, before home health services start or soon thereafter.

Patient Satisfaction:

You are very important to us. If at any time something is unclear with regard to our services, or the care you receive, please let us know. If you have a concern, please contact the McLaren Homecare branch office and ask to speak with the Home Health Manager.

At the end of your care, you may receive a patient satisfaction survey from an independent company. Our agency has contracted with Strategic Healthcare Programs (SHP), a vendor approved by the Centers for Medicare and Medicaid Services (CMS) to conduct the Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. If you are covered under Medicare or Medicaid, SHP may contact you by mail or phone to discuss your experience and satisfaction with our agency. Our agency also may contact you by mail or phone to assess your satisfaction with our care, or to check on services we are providing. Your comments help us to improve our services and ensure we are meeting and exceeding your expectations.

Plan of Care, Treatment and Services:

A plan of care will be created with you on admission and updated as needed to ensure that you are receiving appropriate services. The plan of care is based upon identified problems, needs and goals, physician orders for medication, care, treatments and services. Your plan of care is designed to increase your ability to care for yourself and effective pain management is an important part of your treatment. It may include, nursing care, medication management, psychosocial needs, personal care, rehabilitation therapy, and discharge planning.

We encourage you, your caregiver or your designee to participate in the development of the plan of care and any revising of this plan and we will provide necessary medical information to assist you.

Every patient has the right to be treated with respect, consideration, and dignity, including the right to privacy and to have their health care information protected. You have the right to know your treatment options and take part in decisions about your care. You will be notified if another individual will be present during your visit for safety, education or supervision purposes. Parents, guardians, family members, or others that you choose can speak for you if you cannot.

Patients have the right to consent or decline to participate in proposed research studies or human experimentation or to have those studies fully explained before they consent. We do not participate in any experimental research, except under the direction of your physician and with your written consent.

Between agency visits, there must a designated individual responsible for your care. This person must be a willing, able and available caregiver and may be you, a family member, a friend or a paid caregiver.

Medication Reviews:

Medication reviews aim to help you better understand your medications and may help to identify issues, such as an interaction between your medications, changes that may be needed in dosage, etc. At admission and upon discharge, we will work with the patient to make a list of their current medications (including over the counter, vitamins and natural health products). While under our care, the list will be compared to medications ordered by the patient's physician. Patients have the right to refuse any medication or treatment procedure. However, should you do so, we may require a written statement from you releasing the agency from all responsibility resulting from your refusal and we recommend you review your decision with your physician.

Medical Records:

Your medical record is maintained by our staff and is a means of communication and documentation related to your care including, health status/progress notes, physician orders, preventive health services, treatment, planning, and delivery of care. Our medical record standards reflect the importance of confidentiality and provides protection against loss, destruction, tampering or unauthorized use. Refer to our Notice of Privacy Practices, which details how your protected health information may be used by us, and/or disclosed to others and how you can access it.

Discharge, Transfers and Referrals:

There are multiple instances whereby discharge, transfer or referral from this agency may occur, including:

- the patient has reached their treatment goals
- the patient's medical needs require a transfer
- the discharge or transfer is necessary for the protection of agency staff
- the discharge or transfer is according to the physician's order, or the patient fails to follow the physicians orders
- nonpayment of services rendered or the patient no longer meets insurance coverage or Medicare guidelines
- the patient does not have a face-to-face encounter with their physician, which is required by CMS in accordance with the Patient Protection Affordable Care Act

In the event of a discharge or transfer to another facility, our agency will give an advanced notice to the patient, the patient's parent, family, spouse, significant other, legal representative and physician (if applicable). This applies to all transfers or discharges, except in the case of an emergency. Notice of the discharge, transfer or transfer will be documented in the patients chart. If you are transferred or discharged to another organization, we will provide the information necessary for your continued care and will coordinate your referral to available community resources as needed.

If you made the decision to transfer from another agency and were under an established plan of care, Medicare requires us to coordinate the transfer. After your elected transfer date to our agency, the initial home health agency will no longer receive Medicare payment on your behalf, nor continue to provide you with Medicare covered services.

Notice of Medicare Non-coverage: At least two days before your covered Medicare services are scheduled to end, we will ask you or your authorized representative to sign and date a Notice of Medicare Non-Coverage Form. If you or your authorized representative are not available, we will attempt to make contact by phone, and then mail the notice. If you disagree with your services ending, you must contact the Quality Improvement Organization (QIO) via the phone number listed on the form no later than noon of the day before your services are to end to ask for an immediate appeal.

Problem Solving Procedure

McLaren Homecare is dedicated to delivering quality care, helping you reach your maximum level of independence. We provide clinically excellent, compassionate care to you where you are most comfortable — the place you call home. We are committed to ensuring that your rights are protected. If you believe our staff has not followed our policies, or in any way denied you your rights, please follow the steps below to voice your complaints/grievances without fear of reprisal or discrimination:

1. Contact your agency branch office to speak with the supervisor (available 24 hours a day) as most issues can be discussed and resolved at this level. However, if your concerns remain unresolved, please ask to speak with the home care manager of the agency branch office.

2. Contact the State Home Health Agency hotline at 1-800-882-6006. The hotline receives complaints or questions about local home health care agencies, or you may lodge a complaint concerning the advance directive requirements. The hotline operates from 8:00 a.m. to 5:00 p.m., Monday through Friday {except holidays). Voicemail is available 24 hours a day. If voicemail answers, leave a message and your call will be returned. Or, go to The Department of Licensing and Regulatory Affairs (LARA) website at www.michigan.gov/lara to submit a complaint using the complaint form (BCHS-361) by mail, fax, or email. For more information contact: Department of Licensing & Regulatory Affairs Bureau of Community and Health Systems - Health Facility Complaints

    PO Box 30664
    Lansing, MI 48909
    Phone: 517-241-4712 / Fax: 517-241-2635
    Email: BCHS-Complaints@michigan.gov
3. If you suspect abuse or neglect, call contact the Michigan Department of Human Services statewide hotline 24 hours a day at 1-855-444-3911. If it is an emergency, please call 911. Agency employees who suspect or have reasonable cause to believe that an adult has been abused, neglected, or exploited have a legal obligation and are required by law to immediately file an oral report with the county office of the Department of Human Services in which the abuse, neglect or exploitation is suspected or believed to have occurred.

Section III: Patient Rights and Responsibilities

As a home care provider, we are committed to serving you with compassion, care, skill, and respect. You have choices, rights and responsibilities and we have an obligation to protect and promote these rights while you are under our care. Your family or your legal representative may exercise these rights for you in the event that you are not competent or able to exercise them for yourself.

You Have The Right To:

- To have a relationship with our staff based on honesty and ethical standards of conduct, and as appropriate to be involved in discussions and resolutions of conflicts and ethical issues related to your care.
- Both the patient and caregiver have the right to mutually treat each other with friendliness, courtesy, respect and personal dignity – including mutual respect for each other's cultural, psychosocial, spiritual and personal values, beliefs and preferences.
- To receive the appropriate or prescribed service in a professional manner without discrimination relative to your social status, age, sex, race, religion, ethnic origin, political belief, sexual orientation, or physical or mental handicap. Our staff is prohibited from accepting gifts or borrowing from you.
- To be fully informed, orally and in writing in a manner that you can understand.
- To lodge a complaint, either on your own or by a family member. Your complaint will be heard, reviewed and if possible, resolved. The agency will document the complaint as well as the

resolution of the complaint and you, your family and staff have the right to know the results of the complaint. Refer to the Problem Solving Procedure section of this booklet for the complete process regarding care, services, or a lack of respect for property.

- To be able to express concerns or grievances or recommend modifications to your home care service without fear of coercion, discrimination or reprisal. Nor should you expect unreasonable interruption of care, treatment or services for doing so.
- To be advised of the State Home Health Agency hotline at 1-800-882-6006. The hotline receives complaints or questions about local home health care agencies, or you may lodge a complaint concerning the advance directive requirements. The hotline operates from 8:00 a.m. to 5:00 p.m., Monday through Friday {except holidays). Voicemail is available 24 hours a day. If voicemail answers, leave a message and your call will be returned.
- To be free from neglect or abuse, be it mental, verbal, sexual, physical abuse or neglect, involuntary seclusion, or exploitation including humiliation, intimidation or punishment. If you suspect abuse or neglect, call contact the Michigan Department of Human Services statewide hotline 24 hours a day at 1-855-444-3911. If it is an emergency, please call 911. Agency employees who suspect or have reasonable cause to believe that an adult has been abused, neglected, or exploited have a legal obligation and are required by law to immediately file an oral report with the county office of the Department of Human Services in which the abuse, neglect or exploitation is suspected or believed to have occurred.
- To choose your health care providers and the ability to communicate with those providers.
- To receive accurate and understandable information about your pain, health, diagnosis, prognosis, and treatment.
- To be informed of the names and professional titles of staff that will provide care and the proposed frequency of visits.
- To be fully informed in advance about the care and treatment to be furnished or any changes in the care or treatment to be furnished; to be fully informed of expected outcomes, barriers to treatment; and (except with respect to an individual determined to be incompetent) to participate in planning care in treatment or changes in care of treatment.
- To make informed decisions concerning medical care, including the right to accept or refuse treatment and the right to formulate an advance directive (known in Michigan as Durable Power of Attorney for Health Care) for patients 18 years or older.
- To be informed of the agency's policy on Client Advance Directives including a description of an individual's rights under State Law (whether statutory or as recognized by the courts of the State) and how such rights are implemented by the agency.
- To have your health providers address and comply with your wishes pertaining to end-of-life decisions. Your health providers shall comply with your advance directives in accordance with state laws and receive care without conditions or discrimination based on the execution of advance directives.
- To refuse or discontinue care, treatment and services without fear of reprisal or discrimination, to the extent permitted by law. While you may refuse part or all of your care plan, if you refuse to comply with the plan of care and your refusal threatens to compromise our commitment to

quality care, then we or your physician may be forced to discharge you from our services and refer you to another source of care.

- Have your property treated with respect and privacy during care and security in interactions with agency staff.
- Privacy including confidentiality of written, verbal and electronic communications, including your medical records, personal information about your health, social and financial circumstances, or about what takes place in your home.
- Refuse, or revoke consent, to be filmed or recorded for filming, or recording of care, treatment and services for purposes other than identification, diagnosis or treatment.
- To be informed of the agency's policy and procedures regarding access and disclosure of clinical records as permitted by law.
- To expect the home health care agency to maintain confidentiality regarding your care and request the agency to release information written about you only as required by law or with your written authorization.
- To be fully informed orally and in writing, in language or form understandable to the client, prior to initiating services, of the following:
    - All information related to care and treatment in order to make informed decisions.
    - To be informed to the extent of which payment may be made under Medicare or any other insurance and be informed of charges not be covered under Medicare or other insurance, for which the client will be required to pay.
    - Any changes in the charges for items and services for which the client may be required to pay.
    - Disclosure information regarding any beneficial relationships the organization has that may result in profit for referring the organization.
    - Billing and payment procedures and any changes in the information provided on admission as they occur within 30 days from the date that the organization is made aware of the change.
- To receive high quality, excellent care
- To have pain assessed and resolved to the best of the agency's ability and as a patient expect:
    - Proper, respectful, informed and nondiscriminatory pain management and care.
    - To have your pain managed with collaborative and multidisciplinary efforts.
    - To have your questions and concerns about pain and pain treatments addressed.
    - To have the right to make informed decisions about your pain treatment.
    - To work with your nurse to develop a pain management plan.
    - Review and modify a plan of care if you have unrelieved pain.
- To be referred to another provider organization promptly if the home health agency is unable to meet your needs or if you are not satisfied with the care you are receiving.
- To participate in decisions regarding life-sustaining care or withholding resuscitation.
- To be informed of the home health care agency's policy regarding resuscitation of patients unless a valid "Do Not Resuscitate" (DNR) order is in effect and available in the medical record.
- To receive instructions and be told what to do in case of an emergency.

Patient Responsibilities:

- To provide an accurate history.
- To engage a physician and remain under medical supervision.
- To communicate changes in the plan of care and/or unexpected changes in your condition to agency staff.
- To follow through on the established plan of care as instructed by your staff and assume responsibility for outcomes if you do not follow the care, treatment or service plan.
- To ask questions when you do not understand about your care, treatment, services or other instructions about what you are expected to do.
- To discuss pain relief options with your nurse and ask what to expect regarding pain management.
- Ask for pain relief when pain first begins and tell your nurse if your pain is not relieved.
- Help your nurse assess your pain and work with your nurse to develop a pain management plan.
- Tell your nurse and about any worries you have about taking pain medication
- Treat agency personnel with dignity, courtesy and respect.
- To notify the agency in advance if you wish to cancel service(s) and /or prescribed treatments.
- To notify the agency in advance if unavailable for a scheduled visit.
- To supply medications, equipment, or supplies that the agency is unable to provide.
- To inform the home health care provider of complications or side effects to prescribed treatment.
- To advise the agency of any problems or dissatisfaction with the services provided.
- To provide accurate insurance and/or financial information.
- To notify the agency of any changes in physician or insurance coverage including if you decide to enroll in a Medicare or private Health Maintenance Organization (HMO) or hospice.
- Promptly meet any financial obligations and responsibilities as agreed upon with this agency and carry out mutually agreed responsibilities.
- To notify the agency of the existence of, or any changes made to an advance directive.
- To provide a safe environment for staff (such as keeping pets confined, putting away weapons or not smoking during your care), as actions that endanger the client or staff’s safety may be cause for termination of services(s).
- To identify an alternative plan and/or caregiver in the event of an emergency or natural disaster.
- To accurately report symptoms, follow your medical plan, ask questions and share concerns regarding your condition and treatment.
- To the extent possible, you should become independent in care by using yourself, family or other resources.

Home Health Agency

Outcome and Assessment Information Set (OASIS)

Statement of Patient Privacy Rights (Medicare/Medicaid)

As a home health patient, you have the privacy rights listed below.

- **You have the right to know why we need to ask you questions.**

  We are required by law to collect health information to make sure:
  1. you get quality health care, and
  2. payment for Medicare and Medicaid patients is correct.

- **You have the right to have your personal health care information kept confidential.**

  You may be asked to tell us information about yourself so that we will know which home health services will be best for you. We keep anything we learn about you confidential. This means, only those who are legally authorized to know, or who have a medical need to know, will see your personal health information.

- **You have the right to refuse to answer questions**.

  We may need your help in collecting your health information. If you choose not to answer, we will fill in the information as best we can. You do not have to answer every question to get services.

- **You have the right to look at your personal health information**.
  - We know how important it is that the information we collect about you is correct. If you think we made a mistake, ask us to correct it.
  - If you are not satisfied with our response, you can ask the Centers for Medicare & Medicaid Services, the federal Medicare and Medicaid agency, to correct your information.

> You can ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information which that Federal agency maintains in its HHA OASIS System of Records. See the back of this Notice for CONTACT INFORMATION. If you want a more detailed description of your privacy rights, see the back of this Notice: PRIVACY ACT STATEMENT - HEALTH CARE RECORDS.

Notice About Privacy For Patients Who Do Not Have Medicare or Medicaid Coverage

- **As a home health patient, there are a few things that you need to know about our collection of your personal health care information.**
  - Federal and State governments oversee home health care to be sure that we furnish quality home health care services, and that you, in particular, get quality home health care services.
  - We need to ask you questions because we are required by law to collect health information to make sure that you get quality health care services.
  - We will make your information anonymous. That way, the Centers for Medicare & Medicaid Services, the federal agency that oversees this home health agency, cannot know that the information is about you.
- **We keep anything we learn about you confidential.**

This is a Medicare & Medicaid Approved Notice.

PRIVACY ACT STATEMENT - HEALTH CARE RECORDS

THIS STATEMENT GIVES YOU ADVICE REQUIRED BY LAW (the Privacy Act of 1974).

THIS STATEMENT IS NOT A CONSENT FORM. IT WILL NOT BE USED TO RELEASE OR TO USE YOUR HEALTH CARE INFORMATION.

I. AUTHORITY FOR COLLECTION OF YOUR INFORMATION, INCLUDING YOUR SOCIAL SECURITY NUMBER, AND WHETHER OR NOT YOU ARE REQUIRED TO PROVIDE INFORMATION FOR THIS ASSESSMENT. Sections 1102(a), 1154, 1861(o), 1861(z), 1863, 1864, 1865, 1866, 1871, 1891(b) of the Social Security Act.

Medicare and Medicaid participating home health agencies must do a complete assessment that accurately reflects your current health and includes information that can be used to show your progress toward your health goals. The home health agency must use the "Outcome and Assessment Information Set" (OASIS) when evaluating your health. To do this, the agency must get information from every patient. This information is used by the Centers for Medicare & Medicaid Services (CMS, the federal Medicare & Medicaid agency) to be sure that the home health agency meets quality standards and gives appropriate health care to its patients. You have the right to refuse to provide information for the assessment to the home health agency. If your information is included in an assessment, it is protected under the federal Privacy Act of 1974 and the "Home Health Agency Outcome and Assessment Information Set" (HHA OASIS) System of Records. You have the right to see, copy, review, and request correction of your information in the HHA OASIS System of Records.

II. PRINCIPAL PURPOSES FOR WHICH YOUR INFORMATION IS INTENDED TO BE USED

The information collected will be entered into the Home Health Agency Outcome and Assessment Information Set (HHA OASIS) System No. 09-70-9002. Your health care information in the HHA OASIS System of Records will be used for the following purposes:

- support litigation involving the Centers for Medicare & Medicaid Services;
- support regulatory, reimbursement, and policy functions performed within the Centers for Medicare & Medicaid Services or by a contractor or consultant;
- study the effectiveness and quality of care provided by those home health agencies;
- survey and certification of Medicare and Medicaid home health agencies;
- provide for development, validation, and refinement of a Medicare prospective payment system;
- enable regulators to provide home health agencies with data for their internal quality improvement activities;
- support research, evaluation, or epidemiological projects related to the prevention of disease or disability, or the restoration or maintenance of health, and for health care payment related projects; and
- support constituent requests made to a Congressional representative.

III. ROUTINE USES

These "routine uses" specify the circumstances when the Centers for Medicare & Medicaid Services may release your information from the HHA OASIS System of Records without your consent. Each prospective recipient must agree in writing to ensure the continuing confidentiality and security of your information. Disclosures of the information may be to:

1. the federal Department of Justice for litigation involving the Centers for Medicare & Medicaid Services;
2. contractors or consultants working for the Centers for Medicare & Medicaid Services to assist in the performance of a service related to this system of records and who need to access these records to perform the activity;
3. an agency of a State government for purposes of determining, evaluating, and/or assessing cost, effectiveness, and/or quality of health care services provided in the State; for developing and operating Medicaid reimbursement systems; or for the administration of Federal/State home health agency programs within the State;
4. another Federal or State agency to contribute to the accuracy of the Centers for Medicare & Medicaid Services' health insurance operations (payment, treatment and coverage) and/or to support State agencies in the evaluations and monitoring of care provided by HHAs;
5. Quality Improvement Organizations, to perform Title XI or Title XVIII functions relating to assessing and improving home health agency quality of care;
6. an individual or organization for a research, evaluation, or epidemiological project related to the prevention of disease or disability, the restoration or maintenance of health, or payment related projects;
7. a congressional office in response to a constituent inquiry made at the written request of the constituent about whom the record is maintained.

IV. EFFECT ON YOU, IF YOU DO NOT PROVIDE INFORMATION

The home health agency needs the information contained in the Outcome and Assessment Information Set in order to give you quality care. It is important that the information be correct. Incorrect information could result in payment errors. Incorrect information also could make it hard to be sure that the agency is giving you quality services. If you choose not to provide information, there is no federal requirement for the home health agency to refuse you services.

NOTE: This statement may be included in the admission packet for all new home health agency admissions. Home health agencies may **request** you or your representative to sign this statement to document that this statement was given to you. **Your signature is NOT required.** If you or your representative sign the statement, the signature merely indicates that you received this statement. You or your representative must be supplied with a copy of this statement.

CONTACT INFORMATION

If you want to ask the Centers for Medicare & Medicaid Services to see, review, copy, or correct your personal health information that the Federal agency maintains in its HHA OASIS System of Records:

Call 1-800-MEDICARE, toll free, for assistance in contacting the HHA OASIS System Manager.
TTY for the hearing and speech impaired: 1-877-486-2048.

Notice of Privacy Practices

Version effective: September 23, 2013

This notice describes how health information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

WHO WILL FOLLOW THE PRACTICES OUTLINED IN THIS NOTICE?

McLaren Health Care ("McLaren") provides health care to our patients in partnership with physicians, health care providers, and other professionals and organizations in an organized health care arrangement (hereinafter referred to as we, our or us). This is a joint Notice of our information privacy practices. The practices in this Notice will be followed by:

- Any health care professional who participates in an organized health care arrangement with us to assist in providing treatment to you. These professionals may include, but are not limited to, physicians, allied health professionals, and other licensed health care professionals;
- All subsidiaries and departments of our organization, except our health plans, including hospital, emergency department, outpatient services, mobile units, skilled nursing, clinics/ hospital-owned physician practices, urgent care centers, home health, hospice, cancer center, and retail outlets as well as those outside our system with whom we've contracted for assistance in providing services.
- Our employees, staff and volunteers, including corporate offices and affiliates.

A complete list of McLaren organizations covered by this Notice may be found on our Website; if you do not have a computer you may request a list by calling our Compliance Line.

OUR PLEDGE TO YOU

We understand that health information about you is private and personal, and we are committed to protecting it. Each time you visit a hospital, physician or other health care provider, a record of your visit is made. This Notice applies to the records of your care at McLaren, whether created by facility staff or your personal physician. Other health care providers providing treatment to you may have different practices or Notices regarding their use and disclosure of health information about you maintained in their own offices or clinics.

We are required by law to make sure that health information that identifies you is kept private, give you this Notice of our legal duties and privacy practices concerning your health information, and follow the terms of the Notice that is currently in effect.

CHANGES TO THIS NOTICE

We may change our practices from time to time. Changes will apply to health information we already hold, as well as new information after the change occurs. If we make a significant change in our practices, we will change our Notice and post the new Notice in prominent locations in our facilities and on our Website at www.mclaren.org/privacy.

OUR USE AND DISCLOSURE OF YOUR HEALTH INFORMATION FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

Your health information, linked with your name or other identifying information is used in many ways such as providing care, obtaining payment for your care and running our business. Disclosures of your health information for purposes described in this Notice may be made in

writing, orally, electronically, or by facsimile. As permitted by HIPAA and Michigan State law, we may use or disclose your health information for several purposes. Here are some examples of how we may use or disclose your health information.

Treatment: We may use your health information to provide you with medical care in our facilities or in your home. We also may share your health information with others who provide care to you, such as hospitals, nursing homes, doctors, nurses, physician assistants, medical and nursing students, therapists, technicians, emergency service and transportation providers, medical equipment providers, pharmacies, and others involved in your care. For example, different hospital departments may share your health information to coordinate your prescriptions, laboratory, x-rays and other medical needs.

Payment: We may use and disclose your health information as needed to get paid for the medical care that we provide to you or to assist others who care for you to get paid for that care. For example, we may share your health information with a billing company or with your health insurance plan to obtain prior approval for your care or to make sure your plan will cover your care.

Health Care Operations: We may use or disclose your health information for our quality assurance activities and as needed to run our health care facilities. We may use your health your health information in combination with other patients' health information to compare our efforts and to learn where we can improve
our care and services. We also may use or disclose your health information to get legal, auditing, accounting and other services and for teaching, business management and planning purposes. We may disclose your information to businesses and individuals (e.g., medical transcription service) who perform services for us involving health information as long as they agree to protect the privacy of that information.

Media Condition Reports: We may release your health information for an update to the media if the media requests information about you using your full name. The following information may be disclosed: your condition described in general terms such as "good," "fair," "serious" or "critical." You have the right to request that this information not be released.

Appointments Reminders: We may use your health information to contact you about upcoming appointments. These reminders may be communicated by using the following methods: text message, email, mail and telephone.

On-Site Contacts: While in our facilities, we may need to contact you by overhead page or ask you to write your name on a sign-in sheet. In these instances, we take reasonable precautions to protect your privacy.

Individuals Involved in Your Care or Payment for Care: We may share health information about you with a friend or family member who is involved in your medical care, with others whom you designate as involved in your medical care or with disaster relief authorities so that your family can be notified of your location and condition.

Patient Directory: We may include certain limited information about you in the patient directory while you are a patient at any of our hospitals. This information may include your name, location in the hospital, your general condition as well as your religious affiliation and may also be released

to people who ask for you by name. You have the right to opt out of being listed in our patient and/or religious directory.

Treatment Alternatives, Health Benefits, and Services: We may use and disclose your health information to tell you about treatment alternatives, and health-related benefits and services. We may use your information to tell you about our products or services or to provide gifts of nominal value to you or your family.

Fundraising Activities: We may use certain information, including, but not limited to, name, address and phone number, to contact you to raise money for a McLaren hospital. The money raised will be used to expand and improve the services and programs we provide to the community. You have the right to opt out of fundraising communications.

Research: Under certain circumstances, we may use or disclose health information about you, for research purposes, without your authorization. However, the information would be limited to health information needed in preparation for conducting research (e.g. to help look through records with specific medical conditions to aide in finding a cure). Research projects must be cleared through a special approval process before any health information is disclosed to the researchers and the researchers will be required to protect the health information they receive.

Releases Required by Law: We may use health information about you without your prior permission for several other reasons. Subject to applicable law, we may give out health information about you to other persons or entities to carry out their duties for (a) public health purposes (such as births, deaths, public health surveillance); (b) abuse, neglect or domestic violence reporting; (c) health oversight audits or inspections; (d) coroners or medical examiner services; (e) funeral arrangements; (f) organ donation; (g) tracking of FDA-regulated products; (h) worker's compensation purposes; (i) emergencies, such disaster relief efforts; (j) data de-identification; and (k) data aggregation. We also share health information with others when required by law, such as in response to a request from law enforcement in specific circumstances or in response to valid judicial or administrative order. We may share immunization records with schools if required by state law, and if you or a parent, guardian or other individual acting in the place of a parent agrees.

Releases Requiring Your Permission: We will not use or disclose your health information without your written authorization, except as listed above. Except in limited circumstances, use or disclosure of psychotherapy notes, or use and disclosure of health information for marketing purposes, or the sale of health information require specific written permission. If you give us written permission, you can cancel that permission, except for uses and disclosures already made based on your permission.

YOUR RIGHTS REGARDING HEALTH INFORMATION ABOUT YOU

Access and Copies: In most cases, you have the right to look at or get a copy of health information that we use to make decisions about your care. If you request copies of the information, however, we may charge a fee for cost of copying, mailing or other related supplies. If we deny your request to look at the information or get a copy of it, you may give us a written request for a review of that decision. In some instances your health information may not be available due to our retention policy.

Correct or Update: If you believe that information in our records about you is incorrect or if important information is missing, you have the right to request that we change the records, by submitting a request in writing and including your reason for requesting the change. We may deny your request to change a record if the information was not created by us; if it is not part of the health information kept by us; or if we determine the record is complete and correct. If we deny your request to change, you may submit a written request to review that denial.

List of Disclosures: You have the right to ask for a list of disclosures made after April 14, 2003. This list will not include the times that information was disclosed for treatment, payment, or health care operations, or information provided directly to you or your family, or information that was disclosed with your authorization.

Confidentiality: You have the right to request that health information about you be shared with you in a confidential manner, such as sending mail to an address other than your home.

Notification of a Breach: If our actions result in a breach of your unsecured health information we will notify you of that breach.

Restrict Disclosures to Your Health Plan: You may request that we not share health information with your health plan about care or services you received, if you pay in full out of pocket for those services and make the request in writing at the time the services are provided.

Copies of Our Notice of Privacy Practices: You may ask for a copy of our current Notice at any time. If the Notice was sent to you electronically, you may request a paper copy.

Complaints: If you have any questions about this Notice of Privacy Practices, or questions or complaints about the handling of your health information, you may contact the Information Privacy Officer, in writing or call or submit a report to our Compliance Line. You may also send a written complaint to the Secretary of the United States Department of Health and Human Services. You will not be penalized for filing a complaint.

Who to Contact: To exercise any of the rights described above, please send a written request to our Information Privacy Office at the address listed below, or download and complete the Privacy Request form located on www.mclaren.org/ privacy. If you do not have access to a computer, then you may call our Compliance Line and request a form be mailed to you. Completed forms may be mailed to our address below, emailed to privacy@mclaren.org or faxed to (810) 342-1450.

McLaren Health Care
Information Privacy Office. Suite C
G-3235 Beecher Road
Flint, MI 48532
Compliance Line: 1-866-642-2667

Section IV. Advance Directives

All of us who provide you with health care services are responsible for following your wishes: however, there may be times when you may not be able to decide or make your wishes known. If you have not given prior instructions, no one else will know what you want. Advance Directives let you make your wishes for treatment known in advance.

What is an advance Directive? It is a written document that you use to give instructions about your health care, which may be implemented at a future time should you be unable to make decisions for yourself. There are three types of Advance Directives:

- Durable Power of Attorney of Health Care;
- Living Will; and
- Do Not Resuscitate (DNR) oder.

What is a Durable Power of Attorney for Health Care? It is a document in which you give another person (A Patient Advocate) the power to make medical treatment and related personal care custody decisions for you. You can choose anyone you trust to be your Patient Advocate as long as the person is at least 18 years old. If you want your Patient Advocate to be able to refuse treatment and let you die, you have to say so specifically in the document. It is a good idea to name an alternate Patient Advocated in case the first person is unwilling or unable to act when the time comes. Discuss your wishes with family, friends, advisors, caregivers and physician. A Durable Power of Attorney for Health Care goes into effect only when you are not able to make decisions for yourself.

What is a Living Will? It is a written statement of your choices about medical treatment. You do not need to name a Patient Advocate. There is not a Living Will in Michigan; however, courts and health care providers still find Living Wills valuable.

What is a DNR? It is a written order from a physician that stays resuscitation should not be attempted if a person suffers cardiac or respiratory arrest. Unless the physician has written specific "Do Not Resuscitate," it is our policy that every patient will receive Cardiopulmonary Resuscitation (CPR).

It is your right to decide about the medical care you will receive. You have the right to be informed of treatment. You also have the right to accept, refuse or discontinue any treatment at any timeMany people want to decide ahead of time what kinds of treatment they want to keep them alive. **Advance Directives let you make your wishes for treatment known in advance.** The following is an overview of Michigan's advance directive law:

The Michigan Designation of Patient Advocate for Health Care is a legal document that lets you name someone to make decisions about your medical care, including decisions about life support, if you can no longer speak for yourself. The Designation of a Patient Advocate for Health Care is especially useful because it appoints someone to speak for you any time you are unable to make your own medical decisions, not only at the end of life. It becomes effective when your doctor and one other physician or licensed psychologist examine you and determine in writing that you are unable to make medical treatment decisions. The written determination becomes part of your medical record and must be reviewed at least once a year.

You have the right to give your Patient Advocate, your caregivers and your family and friends written or spoken instructions about what medical treatment you want and don't want to receive. Even though there is not yet a Michigan state Living Will law, courts and health care providers still find Living Wills valuable. Those taking care of you will pay more attention to what you have written about your treatment choices or what you have said to others, whether in a Patient Advocate Designation or a Living Will, because they can be more confident they know what you would have wanted.

State law requires that you sign your Declaration in the presence of two witnesses, who must also sign the document to show you voluntarily singed the Designation in their presence; and that you appear to be of sound mind and under no duress, fraud or undue influence. The witnesses cannot be your spouse, parents, children, grandchildren, brothers or sisters, anyone who could be your heir or who is named to receive something in your will, an employee of a company that insures your life or health, your doctors or any employees of the facility or agency providing health care for you. Friends or co-workers make good witnesses since they see you often and can, if necessary, swear that you acted voluntarily and were of sound mind when you made out the form.

The person you appoint at your Patient Advocate will make decisions about your medical care if you become unable to do so. Your Patient Advocate may be a family member or a close friend whom you trust to make serious decisions. This person must be an adult who clearly understands your wishes and is willing to accept the responsibility of making medical decisions for you. Your Patient Advocate (and alternate if any) must receive a copy of the document and date and sign an accept to the Declaration before he or she can make any medical decisions on your behalf.

You can cancel your Declaration at any time and in any manner. If your revocation is not in writing, you must have a witness to your revocation sign a written description of the revocation, and if possible, notify your patient advocate. Your Designation is automatically revoked if your death occurs; if your patient advocate resigns or is removed for some reason; if you execute a subsequent Designation; if you have explicitly made a provision for revocation in the document; or if you name your spouse as your patient advocate and your marriage ends (unless you have named an alternate).

Agency Policy on Advance Directives

Our agency complies with the Patient Self-Determination Act of 1990, which requires us to:

- Provide you with written information describing your rights to make decisions about your medical care
- Document advance directives prominently in you medical record and inform all staff
- Comply with requirements of state law and court decisions with respect to advance directives
- Provide care to you regardless of whether or not you have executed an advance directive

An ethics committee is available to provide options, suggestions and alternatives to issues presented to them. The Committee serves in an advisory capacity when ethical issues, such as the withdrawal or withholding of life-sustaining treatments arise during the care of patients with or without an advance directive. Discussion shall involve the patient and/or designated

representatives, the home care staff involved in the patient's care and the patient's physician. If you or someone you know has an ethical question, please contact our Ethics Committee.

Unless the physician has written a specific **Do Not Resuscitate (DNR)** order, it is our policy that every patient will receive cardiopulmonary resuscitation (CPR). If you do not wish to be resuscitated, you, your family, your Patient Advocate or your durable power of attorney for health care (DPAHC) must request DNR orders from your physician. These orders are documented in your medical record and routinely reviewed ; however, y**ou may revoke your consent to such an order at any time.**

Section V: Emergency Preparedness

McLaren Homecare has an emergency plan in place, in order for us to be able to continue patient care services in the event of an emergency (i.e. inclement weather, hurricane, tornado, flood, earthquake, fire, etc.). We will make every effort to continue home care visits and ensure your medical needs are met, however the safety of our staff must be considered as well.

If road conditions are too dangerous to travel, our staff will contact you by phone, if possible, to let you know they are unable to make your scheduled visit. If you evacuate to another location or an emergency shelter, please contact our office as soon as possible.

Our agency assigns all patients a priority level code. The patient's code assignment is updated as needed and determines the order by which the agency responds to our patients during an emergency or disaster. Patient priority level codes and other information are maintained in the agency office and may be used to assist Emergency Management Services (EMS) in the event of an emergency. Based on your code assignment, you will be contacted for medical attention as follows:

- Level I: Within 24 hours
- Level II: Within 24-48 hours
- Level III: Within 48-72 hours

In case of bad weather or other situations, including power outages, lightening, flood, tornado, or winter storms, that might prevent our staff from reaching you, turn to your local radio and/or TV station(s) and follow the instructions with regard to preparations and safety (i.e. take cover, evacuate, etc.). Please notify our office if you evacuate to another location or an emergency shelter.

In Case of Emergency

- Call 911 or your local EMS for ambulance, fire or police and provide the following information:
    - Describe the emergency
    - Street address or directions
    - Telephone number you are calling from
- Alert responding units by
    - Turning on the house lights
    - Flashing yard/porch lights
    - Sending person to wave to responding unit

Emergency Preparedness

If you are involved in a natural disaster, (i.e. hurricane, tornado, flood, earthquake or fire), follow these instructions:

- Shelter in place and if you must leave home call and notify the agency. Provide us with the new address and phone number where you can be reached.
- Go the nearest hospital outside the disaster area if you need emergency medical care or supplies.
- If you have no electricity at your home, minimize opening the refrigerator or freezer. If you are oxygen dependent keep at least 8 hrs. of oxygen tanks on hand.

Home Emergency Kit Supplies

At a minimum, have the basic supplies listed below. Keep supplies in an easy to carry emergency preparedness kit that you can use at home or take with you in case you must evacuate, i.e. backpack.

- Water (can put into a clean milk jug or soda bottles)
- Nonperishable food that you do not need to cook
- Flashlights / battery operated lamps
- Medications and medical items
- Manual can opener, cups, plates and utensils
- Battery powered radio & extra batteries
- Rock salt or sand for walkways & extra fuel

What to Bring With You to a Shelter During an Evacuation

Most shelters use generators to have electric power. If you need to go to a shelter, bring your electrical medical devices (such as an oxygen concentrator) with you. Note, pets are usually not allowed in shelters for the protection of others.

- Medications (2 week supply), medical supplies and equipment
- Medical equipment (i.e. wheelchair, walker, cane, etc.)
- Special foods if you have dietary needs & a manual can opener
- Light weight folding chair, extra clothing, hygiene items and glasses
- Important papers, Valid ID with current name and address
- Home Health folder

Basic Home Safety

Many accidents in the home can be prevented by eliminating hazards. Use the list below to help identify potential hazards in your home. If you have concerns or questions about patient safety, please speak with your nurse/therapist, or call the agency at any time.

General Information:

- Install proper locks and keep doors locked. Ask visitors to identify themselves before opening the door. Open the door only if you know the person, or if you are expecting that person
- Be cautious with sharp objects
- Mark glass doors and windows with decals

Medication Safety:

- Keep all medications in original containers and label clearly.
- Write medication schedule and take only as prescribed and be aware of side effects of medications.

Poison Prevention:

- Label all poisons and keep all substances in their original containers.
- Don't mix cleaning products, such as chlorine and ammonia and store cleaning agents away from foods and medications.
- Have syrup or IPECAC on hand.
- Know the Poison Control Center number: 1-800-222-1222.

Fall Prevention:

- Remove all scatter rugs forever and tack down the edges of all carpets.
- Never leave articles of clothing on the floor and keep boxes out of hallways or stairwells.
- Keep electric cords, telephone cords, newspaper, magazines and other clutter away from walking areas.
- Use handrails that are sturdy and strong.
- Avoid use of extension cords.
- Lift feet when walking and wear proper fitting shoes with non-ski soles.
- Do activities and exercises to improve balance and strengthen legs and do not attempt to climb or use ladders.
- Be careful if using tranquilizers.
- Have sufficient lighting throughout house.

Bathroom:

- Install grab bars or handrails by toilet and tub and install a stable tub/shower seat.
- Place skid-proof floor covers and tub/shower mats in bathroom.

Kitchen:

- Store commonly used items within easy reach and use a cart to move heavy or awkward objects.
- Avoid the use of floor wax. Use the non-skid type and never walk on wet floors.

Stairs:

- Install handrails and always use them.
- Place a strip of bright tape on the top and bottom step on each staircase and non-skid threads on steps.

Bedroom:

- Use nightlight in hall between bedroom and bathroom.
- Take your time, get up from bed or chair slowly to avoid dizziness.
- Sit on the edge of the bed or in a chair when putting on socks, shoes, or slacks.
- Ensure that side rails are in upright position on hospital beds.

Living Room:

- Avoid sharp-cornered furniture, rearrange furniture placement and always lock wheels.
- Utilize proper transfer techniques (ex. chair to bed or toilet).
- Utilize proper ambulation techniques; use walker, cane or crutch as prescribed.
- Utilize wheelchair safety and install ramps; 12 foot ramp for 1 foot rise.

Fire Safety:

- Make an escape plan; then practice it.
- Keep at least one fire extinguisher; check the charge often.
- Be aware that nylon catches fire.
- Do not every smoke in bed!
- Be very careful with space heaters; do not tip them!
- Make sure your electrical wiring is not frayed and is free of shorts.
- Keep electrical appliances away from water and unplug after use.
- Have smoke detectors properly located; check battery monthly.
- Store flammables properly.
- Turn off oven and stove; clearly mark controls on stove.
- Be cautious around any open flame heater or fireplace.
- Do not use lighted matches or lighters around any suspected natural gas leaks.

Burn Prevention:

- Always check hot water for temperature; label hot and cold faucets.
- Keep pot handles turned to the back of the stove and open lids away from you to avoid steam burns.
- Keep flammable towels away from the stove.
- Use heating pads with caution and do not apply directly to skin. Use them only on low (unless doctor/nurse states otherwise) and check the area frequently for redness.

Medical Equipment Safety:

- The company that supplies your medical equipment should instruct you in the safe use of each item.
- If you have question or need assistance with any item, please ask your nurse!
- Do not use an item unless you are sure it is working properly. If it is not working, notify the company that brought it to you immediately.

Cold Weather Precautions:

- Avoid icy sidewalks and porch steps and always cover head, hands and feet if you are going out.
- Use warm blankets, clothes and socks.

Oxygen Safety

- Use oxygen only as directed
- Oxygen can be a high fire risk as it causes an acceleration of flame in the presence of flammable substances and open flames
- Do not smoke around oxygen and you should post "No Smoking" signs throughout the home
- Store oxygen cylinders away from heat and direct sunlight, in a well-ventilated area and not under outside porches or decks or in the trunk of a car.
- Do not allow oxygen to freeze or overheat
- Keep oil/petroleum products (i.e. Vaseline, oily lotions or creams, hair dressings, etc.), grease and flammable material away from your oxygen system
- Avoid using aerosols (such as room deodorizers or hair spray) near oxygen
- Dust the oxygen cylinder with a cotton cloth and avoid draping or covering the system with any material
- Keep open flames (such as gas stoves and candles) at least 10 feet away from the oxygen source.
- Have electrical equipment properly grounded and avoid operating electrical appliances (including electric razors and hairdryers) while using oxygen
- Keep electrical equipment that may spark at least ten feet from the oxygen system.
- Use 100% cotton linens and clothing to prevent sparks and static electricity.
- Place oxygen cylinders in position to prevent tipping, secure to the wall, or place on its side on the floor.
- Have a backup portable oxygen cylinder in case of a power or oxygen concentrator failure.
- Alert property management of oxygen use when living in a multi-dwelling residence.

Infection Control at Home

Infectious illnesses are caused by germs—usually bacteria or viruses. You should stay clean and practice good hygiene to help stop the spread of infection. If you have any signs or symptoms of an infection that are listed below, you should notify your physician or home health caregiver:

- Pain, tenderness, redness or swelling
- Inflamed skin, rash, sores or ulcers
- Pain when urinating
- Confusion, nausea, vomiting or diarrhea
- Fever or chills, sore throat, cough
- Noticeable increased tiredness or weakness
- Green or yellow colored pus

Stop the spread of germs — Wash your hands often. This is especially important before and after preparing food, before eating, and after using the toilet. You should keep tissues hand at home, at work and in your pocket. Be sure to throw away used tissues and then clean your hands. If you don't have a tissue, cover your mouth and nose with the bend of your elbow or hands when sneezing or coughing. If you use your hands, wash them right away. Also, prepare and store foods properly, keep your pets healthy and control pests that can transmit disease, such as insects and rodents by using fewer pesticides

Help your body fight germs — Eat well, stay fit, and get enough sleep and if you are sick, avoid close contact with others. Make sure to get vaccinated (both children and adults need immunizations). Check with your doctor or nurse to see what shots you and your family might need.

Prevent antibiotic resistance — Antibiotics cure bacterial infections, not viral infections such as colds or flu, most coughs and bronchitis, sore throats not caused by strep, or runny noses. Taking antibiotics for viral infections, such as a cold, cough, the flu, or most bronchitis, will not cure the infections, keep others from catching the illness, or help you feel better.

Section VI. Emergency Care Plan

Please call the nurse at the home care office that services you if you experience any of the following symptoms/problems:

What to Do?	Call my Home Health Agency When:	CALL 911 WHEN:
I hurt	New pain OR pain is worse than usual Unusual bad headache Ears are ringing My blood pressure is above: ____/____ Unusual low back pain Chest pain or tightness of chest RELIEVED by rest or medication	Severe or prolonged pain Pain/discomfort in neck, jaw, back, one or both arms, or stomach Chest discomfort with sweating/nausea Sudden severe unusual headache Sudden chest pain or pressure & medications don't help (e.g. Nitroglycerin as ordered by physician), OR Chest pain went away & came back
I have trouble breathing	Cough is worse Harder to breathe when I lie flat Chest tightness RELIEVED by rest or medication My inhalers don't work Changed color, thickness, odor of sputum (spit)	I can't breathe! My skin is gray OR fingers/lips are blue Fainting Frothy sputum (spit)
I have fever or chills	Fever is above ______ °F Chills/can't get warm	Fever is above _____ °F with chills, confusion or difficulty concentrating
Trouble moving or fell	Dizziness or trouble with balance Fell and hurt myself Fell but didn't hurt myself	Fell and have severe pain
I see blood	Bloody, cloudy, or change in urine color or foul odor Gums, nose, mouth or surgical site bleeding Unusual bruising	Bleeding that won't stop Bleeding with confusion, weakness, dizziness and fainting Throwing up bright red blood or it look like coffee grounds
Trouble thinking	Confused Restless, agitated Can't concentrate	Sudden difficulty speaking
My weight or appetite changed	I don't have an appetite Lost _____lbs in ______ days Gained _____lbs in 1 day OR _____lbs in ______ days Feet/ankles/legs are swollen	
I don't feel right	Weaker than usual Dizzy, lightheaded, shaky Very tired Heart fluttering, skipping or racing Blurred vision	Sudden numbness or weakness of the face, arm or leg Sudden difficulty speaking/slurred words Suddenly can't keep my balance

<table>
<tr><th>What to Do?</th><th colspan="2">Call my Home Health Agency When:</th><th>CALL 911 WHEN:</th></tr>
<tr><td>I feel sick to my stomach</td><td colspan="2">Throwing up
New coughing at night</td><td>Can’t stop throwing up
Throwing up blood</td></tr>
<tr><td>Bowel troubles</td><td colspan="2">Diarrhea
Black/dark OR bloody bowel movement
No bowel movement in ______ days
No colostomy/ileostomy output in ______ hours/days</td><td></td></tr>
<tr><td>Trouble urinating</td><td colspan="2">Leaking catheter
No urine from catheter in hours
Have not passed water in hours
Urine is cloudy
Burning feeling while urinating
Belly feels swollen or bloated</td><td></td></tr>
<tr><td>I am anxious or depressed</td><td colspan="2">Always feeling anxious
Loss of appetite
Unable to concentrate
Trouble sleeping
Loss of hope
Constant sadness</td><td>I have a plan of hurting myself or someone else</td></tr>
<tr><td>My wound changed</td><td colspan="2">Change in drainage amount, color or odor
Increase in pain at wound site
Increase in redness/warmth at wound site
New skin problem
Fever is above ______°F</td><td>Fever is above ______°F with chills, confusion or difficulty concentrating
Bleeding that won’t stop</td></tr>
<tr><td rowspan="2">I have Diabetes and I’m . . .</td><td colspan="2">Thirsty or hungry more than usual
Urinating a lot
Vision is blurred
I’m feeling weak
My skin is dry and itchy
Repeated blood sugars greater than _______ mg/dl</td><td>Fruity breath
Nausea/throwing up
Difficulty breathing
Blood sugar greater than ______ mg/dl</td></tr>
<tr><td>Shaky
Sweating
Extreme tiredness
Hungry
Have a headache
Confusion
Heart is beating fast
Trouble thinking, confused or irritable
Vision is different
Repeated blood sugars less than _________mg/dl</td><td>Take: 3 glucose tablets, OR 1/2 glass of juice, OR 5-6 pieces of hard candy, OR
Wait: 15 minutes & re-check blood sugar
If your blood sugar is still low and symptoms do not go away:
Eat a light snack: 1/2 peanut butter OR meat sandwich, 1/2 glass milk
Wait: 15 minutes & re-check blood sugar</td><td>Low blood sugar not responding to treatment
Unable to treat low blood sugar at home
Unconsciousness
Seizures</td></tr>
<tr><td>Other problems</td><td colspan="2">Feeding Tube clogged
Problems with my IV/site</td><td></td></tr>
</table>

Section VII. Pain Assessment Tools

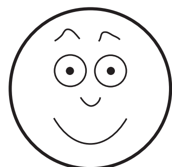
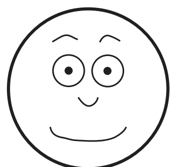
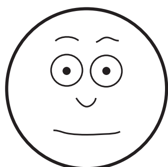
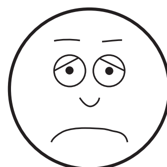
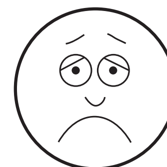
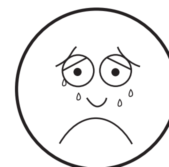
Non-verbal Clues

Moaning
Grimacing
Crying
Restlessness
Withdrawal
Weakness
Skin pale in color
Slow or fast heart rate
Difficulty breathing
Excessive perspiration
Guarding, lack of mobility
Low or high blood pressure

Verbal Clues

The patient should rank their pain on the numeric scale 0 - 10. 0 being no pain and 10 being the worst pain.

Pain Scale

0	2	4	6	8	10
None	Mild	Moderate	Severe	Very Severe	Worst Possible

Consent Summary

As part of the admission process,we ask for your consent to treat you, to release information relative to your care and to allow us to collect payments directly from your insurer. You or your legal representative must sign this consent before we can admit you.

Consent for Treatment: We require your permission before we can treat you. The treatments that we provide will be prescribed by your doctor and carried out by professional health care staff. Without your consent or the consent of your representative, we cannot treat you.

You may refuse treatment at any time. If you decide to refuse treatment, we may ask you for a written statement releasing us from all responsibility resulting from such action .

Release of Information: Your medical record is strictly confidential and protected by federal law. We may release protected health information as explained in our Notice of Privacy Practices in order to carry out treatment, payment and/or health care operations. Protected health information may be received or released by various means including telephone, mail, fax, etc. Patient outcome data (OASIS) will be collected and may be electronically transmitted to the state for use by Medicare.

Authorization for Payment: We will directly bill your insurer for the services which we provide to you. This allows us to collect payments on your behalf.

While you are under our care, we will coordinate all of your therapy needs and medical supplies. If you obtain therapy services or supplies on your own, Medicare will not pay you or the supplier, and you will be responsible for the total cost.

Consent to Film or Record: You consent for us to record or film your care, treatment and services and allow us to use the photographs/recordings for internal use (e.g., performance improvement, education), for documenting your medical condition or for insurers to document your condition for payment purposes.

Consent to contact: We may release your protected health information to you by various means including telephone, email, mail, fax, etc. You consent for us and our service providers to contact you at any address (including email), telephone number (including wireless number or ported landline phone) you provide. The use of automated phone dialing systems or prerecorded message calls, or sending text messages to your phone may also be used to contact you.

Consent for Testing: In an unlikely event that an employee inadequately sustains a needle stick, a blood sample will be tested so the employee may be treated for prevention of disease.

Advance Directives: You must tell us if you have an advance directive so that we may obtain a copy to allow us to follow your directives. We will provide you care whet her or not you have executed an advance directive, but having an advance directive may have an impact on the type of care provided during emergency situations.

McLaren HOMECARE

Admission Consent

Instructions: This form Is used to acknowledge receipt of our orientation booklet and confirm your understanding and agreement with Its contents. Your signature below Indicates your approval.

Patient Rights and Responsibilities: I acknowledge that I have been made aware of my rights and responsibilities as a patient (including OASIS rights), and I understand them. The state home health hotline number, its purpose and hours of operation have been provided and explained to me. I acknowledge that I have chosen this agency to provide home health care. No employee of this agency has solicited or coerced my decision in selecting a home health agency.

Consent For treatment: I hereby give my permission for authorized personnel of your agency to perform all necessary procedures and treatments as prescribed by my physician for the delivery of home health care. I understand that the agency will supervise services provided, I may refuse treatment or terminate services at any time and the agency may terminate their services to me as explained in my orientation. I agree and consent to the home care plan and payment as outlined in this admission booklet. I have been informed and understand the information provided on emergency, medication and safety instructions. I understand that this is the initial plan of care. I will be notified by the agency in advance each time there is a change made to my plan of care. The initial service(s) and visit frequencies are as follows:

SN: ______________ OT: ______________ SW: ______________ RD: ______________ PT: ______________
SLP: ______________ HHA: ______________ Other: ______________

Release of Information: I acknowledge receipt of the Notice of Privacy Practices and was given an opportunity to ask questions and voice concerns. I understand that the agency may use or disclose protected health information about me to carry out treatment, payment or health care operations. The agency may release information to or receive information from insurance companies, health plans, Medicare, Medicaid or any other person or entity that maybe responsible for paying or processing for payment any portion of my bill for services;any person or entity affiliated with or representing for purposes of administration, billing and quality and risk management ;any hospital, nursing home or other health care facility to which I may be/have been admitted; any assisted living or personal care facility of which I am a resident ; any physician providing my care; family members and other caregivers who are part of my plan of care;licensing and accrediting bodies;and other health care providers in order to initiate treatment.

Patient Copy

Authorization for Payment: I certify that the information given by me in applying for payment under Title XVIII of the Social Security Act is correct. I consent to the release of all records required to act on his request. I request that payment of authorized benefits from Medicare, Medicaid or other responsible payor be made in my behalf to McLaren Homecare. I have been given/ explained the Advance Beneficiary Notice and have agreed to the care/services.

If I have Medicare Part A benefits, I understand that McLaren payments will be accepted as payment in full and I have no financial liability, unless I have been notified in writing that service(s) will not be covered by Medicare and wish to receive the care or service. I understand that while I am under the agency's care, the agency will coordinate all of my therapy needs and medical supplies. If I obtain therapy services or supplies on my own, Medicare will not pay me or the supplier, and I will be responsible for the total cost.

If I have other insurance, I may be for the co=payment and any charges that my insurance will not cover. I will refer to the rates for service provided by the agency for the exact dollar amounts that I may be required to pay. I understand that I am responsible for all amounts not paid by my insurance. If I am a Private Pay patient, I agree to pay for all services rendered by the agency.

Health Insurance Claim Number: ______________________________

Consent to Film or Record: I hereby consent for the agency to record or film my care, treatment and services and allow the agency to use the photographs/recordings for their internal use, for documenting my medical condition or for insurance providers to document my condition for payment purposes.

Consent to contact: I understand that, from time to time, McLaren Healthcare Corporation, its subsidiaries and affiliates (collectively, "McLaren") may contact me to (1) discuss any past, current or future services provided by McLaren, as permitted under HIPAA; (2) discuss the accounting, billing or other financial information (such as insurance information and service fees) for past, current or future services provided by McLaren; and (3) discuss collections of any past due amounts or my eligibility for payment assistance or forgiveness programs.

I consent and agree to McLaren and its service providers (a) contacting me at any address (including e-mail) or telephone number (including wireless number or ported landline phone number) that I may provide to McLaren; (b) using automated phone dialing systems or prerecorded message calls when contacting me; and (c) sending text messages to my phone number, to carry out the purposes McLaren has identified above. I agree to McLaren sharing my contact information, including my

wireless number and e-mail address, with service providers (including a collection agency) with whom McLaren contracts to assist it in pursuing these interests, but I understand that McLaren will not share my phone number(s) with third parties for their own purposes without my consent. I understand that standard telephone minute and text charges may apply.
I further understand that I do not have to consent to receive autodialed or prerecorded message calls or texts to receive services from McLaren. I may choose to revoke my consent for receiving autodialed or prerecorded message calls or texts by contacting a McLaren Customer Representative to inform them of my preferences using the following email address:
Email: MessageOptOut@mclaren.org

Consent for Testing: I understand that it is the policy of this agency pursuant to and under Michigan Law that tests for HIV or other serious communicable diseases may be performed upon me or samples of my body fluids without my consent in the event that any health care professional sustains a percutaneous,mucous membrane or open wound exposure to my blood or other body fluids.

Advance Directives: I understand that the Federal Patient Self-Determination Act of 1990 requires that Ibe made aware of my right to make health care decisions for myself. I understand that I may express my wishes in a document called an Advance Directive so that my wishes may be known when I am unable to speak for myself.

1. **I have made a Living Will.** ☐ **No** ☐**Yes** *(if yes, provide a copy to the agency.)*
2. **I have made a Patient Advocate Designation.** ☐ **No** ☐**Yes** ☐ **I was informed and will consider later.** *(if yes, write the name and phone number of the advocate.)*
3. **I have a DNR Order.** ☐ **No** ☐**Yes**
4. **I have a Medical Durable Power of Attorney for Health Care.** ☐ **No** ☐**Yes** **Name:**________________

Patient Signature	Date	Responsible Person or Legal Guardian Signature
Agency Representative Signature	Date	Printed Name & Relationship of Person Above

☐ Patient unable to sign due to: ________________

Patient Copy

Patient Name: ________________ **Patient ID:** ________________
Last First MI

McLaren HOMECARE

Notification of Fee Determination

☐ **Original Notice** ☐ **Change Notice** **DOB:** ____________________

Policy Holder: ____________________ **Policy Holder S.S.#** ____________________

Payment Sources:
Primary: ____________________

Secondary: ____________________

Services Provided	Estimated Insurance coverage	Estimated client cost
☐ Skilled Nursing	Per Visit	Per Visit
☐ Physical Therapy	Per Visit	Per Visit
☐ Speech Therapy	Per Visit	Per Visit
☐ Occupational Therapy	Per Visit	Per Visit
☐ Social Work	Per Visit	Per Visit
☐ Home Health Aide	Per Visit	Per Visit
☐ Registered Dietitian	Per Visit	Per Visit
☐ Routine Hospice	Per Visit	Per Visit
☐ Medical Supplies	Per Visit	Per Visit

Deductible: __________ **Co-Pay:** __________

Out of pocket: __________ **Met:** ☐ **Yes** ☐ **No**

Services covered at 100% when out of pocket met

Information obtained from: ____________________

Verified by: __________ **Date:** __________

PPS: ____________________

MSP: ____________________

HMO: ____________________

Hospice Episodes: ____________________

Case Managed: ☐ **No** ☐ **Yes** **By who:** ____________________

Other: ____________________

If you have insurance, your insurance company will be billed for services provided as described above. The amounts indicated are subject to review and change upon which you will be notified in writing by McLaren Homecare Group. If you do not have insurance, or if your insurance company does not pay the full amount of the charge, you will be billed for the charge. The estimated client cost per visit is based on information received by your insurance company at intake.

I authorize and request the above named insurance company to make direct payment to McLaren Homecare Group for any and all service coverage provided by them. I understand I am financially responsible for any and all charges not covered by insurance and I agree to pay McLaren Homecare Group for these charges.

Start of Care Date: ____________________

____________________ ____________________ ____________________
Signature of Financial Responsible Person Date: Agency Representative Signature Date

Patient Copy

Patient Name: ____________________
Last First MI

Pt. ID#: __________ **Date:** __________
Agency Representative Signature Date

McLaren
HOMECARE

Patient Drug Profile

Patient Name: ______________________ **Sex:** ☐ Male ☐ Female **Patient ID:** ______________________

Age: __________ **Height:** __________ **Weight:** __________ **Pharmacy:** __________ **Phone:** __________

Physician & Phone: ____

Diagnosis: ____

Allergies or Sensitivities: ____

START DATE	DESCRIPTION DOSAGE, FREQUENCY, ROUTE	DOSAGE CHANGES	CHANGE DATE	CLASS (*)	DISC. DATE	INSTRUCTED DATE/INITIAL		REVIEWED DATE/INITIAL	
	v								

SIGNATURE	TITLE	INITIAL	SIGNATURE	TITLE	INITIAL	SIGNATURE	TITLE	INITIAL

McLaren
HOMECARE

Patient In-Home Record

Patient Name: ______________________________ **Patient ID:** ______________

DNR: __________ **Fall Risk:** __________ **Hospitalization Risk:** ______________________

Key Vital Sign Ranges: __________ __________ __________ **(Call doctor if out of this range)**

DATE	TIME	B/P	PULSE	RESP.	TEMP	WT	BM	GLU	TEACHING/PROCEDURE/INFO	INITIALS

SIGNATURE	TITLE	INITIAL	SIGNATURE	TITLE	INITIAL	SIGNATURE	TITLE	INITIAL

rev (10/2015)

McLaren

HOMECARE

Patient In-Home Record

Patient Name: ______________________________ **Patient ID:** ______________

DNR: __________ **Fall Risk:** __________ **Hospitalization Risk:** ______________________

Key Vital Sign Ranges: __________ __________ __________ **(Call doctor if out of this range)**

DATE	TIME	B/P	PULSE	RESP.	TEMP	WT	BM	GLU	TEACHING/PROCEDURE/INFO	INITIALS

SIGNATURE	TITLE	INITIAL	SIGNATURE	TITLE	INITIAL	SIGNATURE	TITLE	INITIAL

rev (10/2015)

McLaren HOMECARE

Certified Discharge Instructions

Nursing Instructions

Date of Discharge: _______/_______/_______

☐ Continue to follow diet

☐ Take all medications as ordered by physician

☐ Keep current list of all medications and take to physician appointments

Monitor:

☐ Weight ☐ Blood Pressure
☐ Pulse ☐ Blood Sugar

Report signs of infection:

☐ Wound ☐ Incision
☐ Lungs ☐ Urinary Tract Infection

☐ Safety/Fall Prevention Instructions/Recommendations: __________

☐ Wound care instructions: __________

☐ Other: __________

PT Instructions

Date of Discharge: _______/_______/_______

☐ Continue with Home Exercise Program:

☐ Safety/Fall Prevention Instructions/Recommendations:

☐ Equipment Recommendations:

☐ Other:

OT Instructions

Date of Discharge: _______/_______/_______

☐ Continue with Home Exercise Program:

☐ Safety/Fall Prevention Instructions/Recommendations:

☐ Equipment Recommendations:

☐ Other:

ST Instructions

Date of Discharge: _______/_______/_______

☐ Continue with Home Exercise Program:

☐ Safety/Fall Prevention Instructions/Recommendations:

☐ Equipment Recommendations:

☐ Other:

Social Work Assessment/Instructions

Date of Discharge: _______/_______/_______

Dietitian Assessment/Instructions

Date of Discharge: _______/_______/_______

☐ Diet: __________

☐ Other: __________

Clinician Signatures/Date:

RN: __________ PT: __________ OT: __________

ST: __________ MSW: __________ RD: __________

Patient Name: __________ **Patient ID:** __________

Last *First* *MI*

rev (10/2015)

McLaren HOMECARE

Home Visit Schedule

Patient Name: ______________________ Patient ID#: ______________ Patient DOB: ______________

Patient Phone: ____________________ Address: ____________________________________

Physician Name: ____________________________________ Patient DOB: ______________

Episode Dates: ______________

DISC	FREQ	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Home Visit Schedule

Patient Name: ______________________ **Patient ID#:** ______________ **Patient DOB**: ______________

Patient Phone: ______________________ **Address:** ______________________________

Physician Name: ______________________________ **Patient DOB**: ______________

Episode Dates: ______________

DISC	FREQ	SUNDAY	MONDAY	TUESDAY	WEDNESDAY	THURSDAY	FRIDAY	SATURDAY

Notes

Notes

Your Professional Health Care Staff

Nurse: ____________________ ____________

Supervisor: ____________________ ____________

Home Health Aide: ____________________ ____________

Physical Therapist: ____________________ ____________

Occupational Therapist: ____________________ ____________

Speech Therapist: ____________________ ____________

Social Worker: ____________________ ____________

____________________ ____________

HOMECARE

Important Phone Numbers (Patient to complete)

911 or Ambulance/Police/Fire	Poison Control
Hospital	HME (Oxygen)
Doctor	Electric Company
Doctor	Phone Company
Non-Emergency Transportation	Water Company
Pharmacy	Family