GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Health Care Finance

Office of the Senior Deputy Director/Medicaid Director **Transmittal # 16-23**

TO: Home Health Agencies and EPD Waiver Providers

FROM: Claudia Schlosberg, J.D.
Senior Deputy Director and State Medicaid Director

DATE: July 29, 2016

SUBJECT: **PCA Time and Activity Sheet**

As the result of a joint effort between DHCF staff and members of our provider community, a taskforce was convened in March 2015 to develop a time and activity sheet to help improve the quality of Personal Care Aide (PCA) documentation and more accurately account for direct care activities that are delivered on any given date of service. The accompanying form, which is being distributed with this transmittal, will be used as a guide to assist providers in developing a document that best meets the needs of their respective agencies.

Again, this time and activity sheet is not intended to serve as a template or a universal timesheet. It is incumbent on each agency to develop protocols describing, in detail, how to complete and utilize the forms in accordance with their business practices. However, DHCF asks that timesheets capture the elements reflected on the example provided as they directly reference the Agency's second Emergency and Proposed PCA rule, which was published on April 22nd, 2016. The second emergency and proposed rulemaking incorporates language set forth in the recently published rule on reimbursement (Section 5015), published on January 15th, 2016 at 63 DCR 000589. Section 5015 governing reimbursement was adopted on December 31, 2015, and became effective for services rendered beginning January 1, 2016. The remaining sections will become effective, subject to approval by CMS of the corresponding State Plan Amendment.

Questions regarding this transmittal can be directed to Ieisha Gray, Director, Long Term Care Administration at ieisha.gray@dc.gov or (202) 442-5818.

ABC Home Health Agency, Inc.
1234 wonderland avenue, suite 777
Any town, Anywhere 00000

Beneficiary Name: _____ **Beneficiary ID#**_____ **Place of Service:** _____

HHA/ PCA Name: _____ **HHA/PCA NPI#**_____

Week of _____/_____/_____ **Through** _____/_____/_____

Is Care Plan in Home: ☐ **Yes or** ☐ **No**
If no, please contact the office to obtain a copy.

ALL TASKS MUST BE PERFORMED PER THE PLAN OF CARE FOR THE CLIENT

HHA's must observe, document, and report beneficiary's physical condition, behavior, and appearance and report all services provided on a daily basis:

Beneficiary and aide must sign and date daily for all activities performed.

Date:							
Day of week	***Sun***	***Mon***	***Tue***	***Wed***	***Thu***	***Fri***	***Sat***
Time In:							
Time Out:							
Daily Total Hours:							
Activities of Daily Living - Cueing or Hands-on Assistance with the following functions							
Bathing: **(T) Tub SH (Shower (SP) Sponge (PC) Perineal Care**							
(SC) Shampoo/Condition Hair (CB) Comb/Brush Hair							
Oral/dental care (D) clean dentures (S) Shave							
(D) Dressing (L) Layout Clothing							
(S) Skin Care (F) Foot Care (N) Nail Care **Note: Clean and file only**							
Bathing Total Time:							
Toileting - Cueing or Hands-on Assistance with the following functions							
Toileting: (B) Bathroom/Commode Incontinence care							
Assisting with Bowel and Bladder Elimination							
Assisting with incontinence- Empty urinary drainage bag Y (yes) N (No) or NA (no catheter)							
Monitoring urine in/output according to POC **Y (yes) N (No) or NA**							
Toileting Total Time:							
Eating/Meal Preparation - Cueing or Hands-on Assistance with the following functions							
Meal/Snack preparation (according to the dietary guideline)							
Assist with Feeding Cueing-setting up							
Eating/ Meal PreparationTotal Time:							
Mobility							
Range of Motion Exercise per PT/OT Care Plan							
Assist/Supervise with Ambulating **(S) Self/ (C) Crutch (AWC)Assist Walker/Cane (WC) Wheelchair**							
Transfer – Bed/chair/ wheelchair/commode **Hoyer Lift**							
Position Change every 2 hours. **Indicate which side L, R, back or sitting**							
Mobility Total Time:							
Special Maintenance - Promoting Safe, Living Environment/Universal Precautions/Infection Control of areas occupied by and or used in the delivery of care to the beneficiary.							
Free of Clutter, trip hazards, rugs (BA) Bathroom (K) Kitchen (BD) Bedroom (LA) Living Area							
Practice Infection Control (Sanitize and Disinfect) **(BA) Bathroom (K) Kitchen** **(BD) Bedroom (soiled linen/ clothing) (LA) Living Areas** **(DME) Durable Medical Equipment (cane, walker, wheelchair etc.)**							
Accompany to Medical/Dental appt. recreational/community activities according to POC. **N (no) Y(yes) None (NA)**							
Medications Reminder Y (yes) N (No) or R(refused)							
Assistance with telephone use							
Shopping for items related to beneficiary's meals according to dietary guidelines and /Errands related to health needs.							
Observe Beneficiary physical condition, behavior, and appearance ******Complete Narrative on Reverse of this page******							
Other: If other activities were provided according the plan of care, and were not included above, a full narrative description of personal care services rendered to the recipient must be completed.							
Special Maintenance Total Time:							

SUN:
Beneficiary Signature _____
Date _____
HHA Signature _____
Date _____

MON:
Beneficiary Signature _____
Date _____
HHA Signature _____
Date _____

TUE:
Beneficiary Signature _____
Date _____
HHA Signature _____
Date _____

WED:
Beneficiary Signature _____
Date _____
HHA Signature _____
Date _____

THU:
Beneficiary Signature _____
Date _____
HHA Signature _____
Date _____

FRI:
Beneficiary Signature_____
Date _____
HHA Signature _____
Date _____

SAT:
Beneficiary Signature _____
Date _____
HHA Signature _____
Date _____

Acknowledgments and Required Signatures

After the caregiver has documented his/her time and activity, the recipient must draw a line through any dates and times he/she did not receive service. Review the completed time sheet for accuracy before signing. It is a federal crime for both the beneficiary and PCA to provide false information on billings for Medical Assistance payments. Your signatures verify the time and services entered above are accurate and that the services were performed as specified in the Care Plan. **PCA shall attest that he/she does not work for another agency during the hours documented on timesheet.**

PATIENT/RESPONSIBLE PARTY SIGNATURE _____ **DATE**_____

PCA/HHA SIGNATURE_____ **DATE**_____

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Date/Time	Client Daily Condition (√ Check all that apply) **Please document any changes regarding the client's physical condition, behavior, appearance and other changes that you may observe. Call Nurse/Office immediately for changes and incidents that occur with the client. If emergency, call 911 and notify office immediately.**
Sunday _____	Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforce wound dressing ❒ Yes ❒ No Comment(s): _____ Did you observe any change in the client's behavior? ❒ Alert ❒ Confused Comment(s): _____ Any redness, open sores, wounds on client's body? ❒ Yes ❒ No If yes is nurse aware? ❒ Yes ❒ No Did a Fall Occur? ❒ Yes ❒ No Additional Comments:_____ _____ _____
Monday _____	Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforce wound dressing ❒ Yes ❒ No Comment(s): _____ Did you observe any change in the client's behavior? ❒ Alert ❒ Confused Comment(s): _____ Any redness, open sores, wounds on client's body? ❒ Yes ❒ No If yes is nurse aware? ❒ Yes ❒ No Did a Fall Occur? ❒ Yes ❒ No Additional Comments:_____ _____ _____
Tuesday _____	Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforce wound dressing ❒ Yes ❒ No Comment(s): _____ Did you observe any change in the client's behavior? ❒ Alert ❒ Confused Comment(s): _____ Any redness, open sores, wounds on client's body? ❒ Yes ❒ No If yes is nurse aware? ❒ Yes ❒ No Did a Fall Occur? ❒ Yes ❒ No Additional Comments:_____ _____ _____
Wednesday _____	Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforce wound dressing ❒ Yes ❒ No Comment(s): _____ Did you observe any change in the client's behavior? ❒ Alert ❒ Confused Comment(s): _____ Any redness, open sores, wounds on client's body? ❒ Yes ❒ No If yes is nurse aware? ❒ Yes ❒ No Did a Fall Occur? ❒ Yes ❒ No Additional Comments:_____ _____ _____
Thursday _____	Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforce wound dressing ❒ Yes ❒ No Comment(s): _____ Did you observe any change in the client's behavior? ❒ Alert ❒ Confused Comment(s): _____ Any redness, open sores, wounds on client's body? ❒ Yes ❒ No If yes is nurse aware? ❒ Yes ❒ No Did a Fall Occur? ❒ Yes ❒ No Additional Comments:_____ _____ _____
Friday _____	Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforce wound dressing ❒ Yes ❒ No Comment(s): _____ Did you observe any change in the client's behavior? ❒ Alert ❒ Confused Comment(s): _____ Any redness, open sores, wounds on client's body? ❒ Yes ❒ No If yes is nurse aware? ❒ Yes ❒ No Did a Fall Occur? ❒ Yes ❒ No Additional Comments:_____ _____ _____
Saturday _____	Did you observe any change in the client's physical condition? ❒ Yes ❒ No ❒ Pain Reinforce wound dressing ❒ Yes ❒ No Comment(s): _____ Did you observe any change in the client's behavior? ❒ Alert ❒ Confused Comment(s): _____ Any redness, open sores, wounds on client's body? ❒ Yes ❒ No If yes is nurse aware? ❒ Yes ❒ No Did a Fall Occur? ❒ Yes ❒ No Additional Comments:_____ _____ _____

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Instructions for Personal Care Aide (PCA) Time and Activity Documentation:

This form documents time and activity between one (1) PCA and one (1) beneficiary. Each Provider shall maintain adequate documentation substantiating the delivery of allowable services provided in accordance with the PCA service authorization and the beneficiary's plan of care for each service provided to the beneficiary.

Dates of Service: Enter the date in mm/dd/yy format for each date you provide service. The client must draw a line through any dates and times PCA services were not provided.

Time IN/Time OUT: Enter time you started/stopped providing care in hours and minutes. Indicate AM or PM next to the time.

Daily Total Hours: Add the time for all activities delivered daily to the recipient on this entire time sheet.

Activities: For each activity performed on the day of service, enter the total amount of time. If you provide a service more than once a day, document total time and indicate in your comments for the day the total number of times a service is delivered to the recipient.

Total Time: Add the total time per category that you spent with this recipient for the care documented. **Time**

The following are general descriptions of activities of daily living and instrumental activities of daily living.

Activities of Daily Living – Personal hygiene includes assisting the recipient with hair care, oral care, nail care, shaving hair, applying cosmetics and deodorant, care of eyeglasses, contact lenses, hearing aids and applying orthotics. Starting and finishing a bath or shower, using soap, rinsing, drying, inspecting skin, applying lotion. Assisting in the bathroom with transfers, mobility, positioning and removing all clothes and towels from the floor**.**

Toileting – Bowel/bladder elimination and care, transfers, mobility, positioning, feminine hygiene, use of toileting equipment or supplies, cleansing the perineal area and inspecting skin and adjusting clothing.

Eating/Meal Prep Personal care may include assisting the recipient with all activities as needed in the kitchen to include hand washing, applying of orthotics needed for eating, feeding, preparing meals and grocery shopping. Personal care may also include Universal Standard Precautions activities during the performance of meal preparation including sanitizing surfaces, dishes and utensils used during meal preparation and feeding.

Transfers/Mobility – Moving from one seating/reclining area or position to another, transfers, mobility, and positioning. Moving from one place to another, including using a wheelchair.

Positioning – Assisting or moving the person to a different position or turning the client for necessary care and comfort or to relieve pressure areas.

Range of Motion/Exercise – Assist with exercise program as prescribed by MD, PT, and/or OT.

Special Maintenance promoting safe, comfortable living environment/ Universal Precautions/Infection Control -. Performing tasks to promote a safe, sanitary and comfortable environment in locations occupied by beneficiary to prevent infection and falls. Including activities such as decontamination of soil surfaces and clothes. Maintaining an environment free of clutter, trip hazards and spills to prevent falls.

IADLs (Instrumental Activities of Daily Living) -Covered service for recipients, such as: Meal planning and preparation, basic assistance with paying the bills, shopping for food, and items related to health needs, integral to the personal care assistance services. Assisting with recipient's communication by telephone, and other media, and accompanying the recipient with traveling to medical/dental appointments and participation in the community activities.

Medication Reminder – Reminding the recipient to take medication as prescribed by physician.

Physical/Behavioral Observation and reporting: Describe any noticeable changes in the client, including bruises, swelling, discoloration, increased pain, decreased mobility, decreased appetite, any wounds, etc. and/or behavioral changes or activities such as redirecting, intervening, monitoring behavior. Document if changes were reported.

Other – If other activities were performed according to plan of care, and were not included above, PCA must complete a full narrative description of personal care services rendered to the recipient.

Hospitalization/Admission Dates: PCA services shall not be provided in a hospital, nursing facility, intermediate care facility, or other living arrangement, which includes personal care as part of the reimbursed service. List any dates the client spent in the hospital during the pay period.

Acknowledgement and Required Signatures: Recipient/responsible party prints the recipient's first name, middle initial, last name, and Recipient ID (for identifying purposes). Recipient/responsible party signs and dates form. PCA prints his/her first name, middle initial, last name, individual PCA NPI Number (for identifying purposes). PCA signs and dates. Remember, it is a federal crime to provide false information on billings for Medical Assistance payments. Your signature verifies the time and services entered above are accurate and that the services were performed as specified in the care plan