



DMAS Specialized Care Long Stay Hospital Checklist

Specialized Care Required SA Information

ADULT

Circle which **one** of the following two requirements that are met:

1. Require mechanical ventilation;

OR

2. Have a complex tracheostomy and **ALL** of the following answered:
 - a. Tracheostomy – circle one and provide explanation:
 - o Potential for weaning or
 - o The inability to be weaned;
 - b. Nebulizer treatments – circle one
 - o Nebulizer treatments are followed by chest PT (Physiotherapy) at least 4 times per day and are provided by a Licensed Nurse or Licensed Respiratory Therapist
 - o Nebulizer treatments at least 4 times a day and provided by a Licensed Nurse or Licensed Respiratory Therapist;
 - c. Pulse oximetry monitoring is ordered at least every shift? YES / NO
 - d. Is the respiratory assessment and documentation completed every shift by a Licensed Respiratory Therapist or Trained Nurse? YES / NO
 - e. What is the Physician's order for oxygen therapy?
 - f. Is tracheostomy care done at least daily? YES / NO
 - g. Is there a Physician's order for suctioning as needed? YES / NO
 - h. Is the Member deemed to be at risk to require subsequent mechanical ventilation and provide explanation? YES / NO

PEDIATRIC/ADOLESCENT – Is the member <21 Years of Age? YES / NO

Circle which **one** of the following three requirements are met:

1. **Physical Rehabilitative Services**
 - a. Circle therapy modalities ordered:
 - o Physical Therapy
 - o Occupational Therapy
 - o Speech Pathology Services
 - b. Therapy Order:
 - a) Do all therapy sessions total a minimum 6 sessions per day? YES / NO
 - b) Is each therapy ordered at minimum 15 minutes per session? YES / NO
 - c) Is each therapy ordered 5 days per week? YES / NO

- d) If 'NO' to any of the above questions, document what are the current therapy orders?
- e) For re-certifications, document the Member's progress with the overall rehabilitative Plan of Care (POC) on a monthly basis;

OR

2. **Special Equipment** – Circle which of the following is ordered by the physician and provide an explanation for reason ordered based on documentation found on the physician's orders and/or progress notes.
- a. Mechanical ventilator,
 - b. Respiratory therapy equipment (that has to be supervised by a Licensed Nurse or Respiratory Therapist),
 - c. A monitoring device (respiratory or cardiac),
 - d. Kinetic therapy, etc.

OR

3. **Special Services** – Circle which of the following is ordered by the physician and provide an explanation for reason ordered based on documentation found on the physician's orders and/or progress notes:
- a. Ongoing administration of intravenous medications or nutrition (i.e., TPN, antibiotic therapy, narcotic administration, etc.);
 - b. Special infection control precautions (universal or respiratory precaution; this does not include hand-washing precautions only for isolation for normal childhood diseases such as measles, chicken pox strep throat, etc.);
 - c. Dialysis treatment that is provided within the facility (i.e. peritoneal dialysis);
 - d. Daily respiratory therapy treatments that must be provided by a Skilled Nurse or a Respiratory Therapist;
 - e. Extensive wound care requiring debridement, irrigation, packing, etc. more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body);
 - f. Ostomy care requiring services by a Licensed Nurse; and
 - g. Care for terminal illness.

Long Stay Hospital Required SA Information

ADULT – Circle one of the following three requirements that are met:

1. Physical Rehabilitative Services

- a. Circle which therapy modalities ordered:
 - o Physical Therapy
 - o Occupational Therapy
 - o Speech Pathology Services
- b. Therapy Order
 - o Is each therapy ordered at minimum 5 days per week? YES / NO
 - o Is each therapy ordered at minimum 1 hour per day? YES / NO
 - o If 'NO' to any of the above questions, document what are the current therapy orders?
 - o For re-certifications, document the Member's progress with the overall rehabilitative Plan of Care (POC) on a monthly basis;

OR

2. Special Equipment – Circle which one of the following is ordered by the physician and provide an explanation for reason ordered based on documentation found on the physician's orders and/or progress notes.

- a. mechanical ventilator,
- b. respiratory therapy equipment (that has to be supervised by a Licensed Nurse or Respiratory Therapist),
- c. a monitoring device (respiratory or cardiac),
- d. kinetic therapy, etc.

OR

3. Special Services – Circle which one of the following is ordered by the physician and provide an explanation for reason ordered based on documentation found on the physician's orders and/or progress notes:

- a. Ongoing administration of intravenous medications or nutrition (i.e. total parenteral nutrition (TPN), antibiotic therapy, narcotic administration, etc.);
- b. Special infection control precautions such as universal or respiratory precaution (this does not include hand washing precautions only);
- c. Dialysis treatment that is provided on-unit (i.e. peritoneal dialysis);
- d. Daily respiratory therapy treatments that must be provided by a Licensed Nurse or a Respiratory Therapist;
- e. Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e. Grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body); or
- f. Multiple unstable ostomies (a single ostomy does not constitute a requirement for special care) requiring frequent care (i.e. suctioning every hour, stabilization of feeding, stabilization of elimination, etc.)

PEDIATRIC – Is the Member <21 Years of Age? YES / NO

Circle **one** of the following three requirements that are met:

1. Physical Rehabilitative Services

- a. Circle which therapy modalities ordered:
 - ☐ Physical Therapy
 - ☐ Occupational Therapy
 - ☐ Speech Pathology Services
- b. Therapy Order
 - a) Is each therapy ordered at minimum 5 days per week? YES / NO
 - b) Is each therapy ordered at minimum 45 minutes per day? YES / NO
 - c) If 'NO' to any of the above questions, document what are the current therapy orders?
 - d) For re-certifications, document the Member's progress with the overall rehabilitative Plan of Care (POC) on a monthly basis;

OR

2. Special Equipment - Circle which one of the following is ordered by the physician and provide an explanation for reason ordered based on documentation found on the physician's orders and/or progress notes.

- a. Mechanical ventilator,
- b. Respiratory therapy equipment (that has to be supervised by a Licensed Nurse or Respiratory Therapist),
- c. A monitoring device (respiratory or cardiac),
- d. Kinetic therapy, etc.

OR

3. Special Services - Circle which one of the following is ordered by the physician and provide an explanation for reason ordered based on documentation found on the physician's orders and/or progress notes:

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- b. Special infection control precautions such as universal or respiratory precaution (this does not include hand washing precautions only or isolation for normal childhood diseases such as measles, chicken pox, strep throat, etc.);
- c. Dialysis treatment that is provided within the facility (i.e. peritoneal dialysis);
- d. Daily respiratory therapy treatments that must be provided by a Licensed Nurse or a Respiratory Therapist;
- e. Extensive wound care requiring debridement, irrigation, packing, etc., more than two times a day (i.e., grade IV decubiti; large surgical wounds that cannot be closed; second- or third-degree burns covering more than 10% of the body);
- f. Ostomy care requiring services by a Licensed Nurse;
- g. Services required for terminal care.