Deep Dive into the Final Home Health Interpretive Guidelines

HCANYS

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Our World is Changing

Pre-Claim

Consumer Needs

2019 Regulatory Updates

Documentation Requirements

Excellence: Best Practices

PDGM

CoP Final IGs

Shrinking Funding

Staff Shortages

OASIS-D

Exceptional Customer Services

MAC Audits

Educate & Probe

What's Next?

Value Based Purchasing

Objectives

- Detail the Final Interpretive Guidelines that Clarify Several Home Health Conditions of Participation;
- Discuss Key Changes in the Final Guidance;
- List Strategies to Successfully Implement the Revised CoPs;
- Share Recent Survey Focus Items Under the Updated CoPs.
- Take Aways: NYS Surveyor Clinical Record Review Form
  NYS Surveyor Personnel Record Review Form
  NYS QAPI & Infection Control Survey Tool

CoP Updates: Care Impact

- Culture Changes: A Challenge for Providers
  - Patient Centered & Outcome Based
  - Data Driven
  - Integrated, Interdisciplinary Care Models

- Paradigm Change in Care Delivery
  - Role Expansion & Changes
  - Clinical Practice & Protocol Changes
  - New Language; New Requirements
    - "Comply with accepted professional standards & principles"

- Bottom Line on Care Models
  - Care Management Focus; Coaching; Patient Engagement
  - Survey Oversight Changes: Final Interpretive Guidelines

CoP Final IG's Here

- **Released August 31, 2018: Check Your *Policy Updates***
  - **IGs: Inform Survey Protocols & Actions**
  - **IGs: Provide Guidance on the Intent of the Regulations**
- **Final IG Clarifications**
  - **Patient Rights**
  - **Accessibility**
  - **Initial Comprehensive Assessment**
  - **Written Info to the Patient**
  - **Plan of Care**
  - **Coordination of Care**
  - **QAPI**
  - **Infection Control**

Patient Rights

- **484.50 Patient Rights *(G406-G488)***
  - **Prescriptive in detail of information that must be provided**
  - **Admission Packet; Notice; Policies & Procedures Updated with Revised CoPs**
- **Condition is Now Six Standards**

(a) Notice of Rights
(b) Exercise of Rights
(c) Rights of the Patient
(d) Transfer & Discharge
(e) Investigation of Complaints
(f) Accessibility

484.50 Patient Rights

- **CoP Updates: Goals**
  - **Enhancement of Notice of Rights**
    - ✓ Specific information and timeframes for both verbal & written
    - ✓ Inclusion of contact information for HHA Administrator
    - ✓ Guidance for communicating patient rights information
    - ✓ Guidance for honoring court decisions related to legal capacity
  - **Expansion of Existing Rights**
    - ✓ Being informed of all care & services prior to delivery
    - ✓ Being informed of expected outcomes and goals
    - ✓ Being advised of federal and state funded local programs
    - ✓ Being informed of the right to access language services & auxiliary aids
  - **New Standards**
    - ✓ Transfer & Discharge Policies & Accessibility Resources
    - ✓ Investigation of Complaint Processes

Patient Rights

- **Notice of Rights *(G410)***

  Provide the Patient and the Patient's Legal Representative (if any), the following information during the initial visit, in advance of furnishing care to the patient

  1. **Written & verbal notice in a language understandable to the patient and accessible to patients with disabilities**
     - ➢ No later than completion of second skilled visit
  2. **Contact Information for HH Agency Administrator**
  3. **OASIS Privacy Notices**
  4. **Patient Legal Representative Signature**
     - ➢ No later than 4 business days of initial evaluation visit

- **Final IGs: Provide Information During Initial Visit & In Advance of Providing Care (Removed Patient-Select Rep)**

Patient Rights: Final IG's

- **In Advance: Means the HHA staff must complete the task prior to performing any hands-on care or any patient education**
- **Legal Representative: Is an individual who has been legally designated or appointed as the patient's health care decision maker. When there is no evidence that a patient has a legal representative, such as a guardianship, a power of attorney for health care decision-making, or a designated health care agent, the HHA must provide the information directly to the patient**
- **Final IG Clarification: Removed Patient-Selected Representative from G410.**
- **G410: Provide the Patient & the Patient's Legal Representative, if any, the Required Notice Information *Prior to Providing Care***
- **G412: Requires Written Notice to Patient-Select Representative**

Written Notice of Rights

- **G412: Written Notice of Patient Rights**
  - **Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities.**
- **To ensure patients receive appropriate notification:**
  - **Written notice to the patient or their representative of their rights and responsibilities under this rule should be provided via hard copy unless the patient requests that the document be provided electronically**
    - **The information must be provided in a language or format familiar to the patient or his/her representative**
    - **Language assistance should be provided through the use of competent bilingual staff, contracts or formal arrangements**
    - **All agency staff should be trained to access the use of interpretation services**
- **Definition: Representative means patient's legal representative or a patient-selected representative.**

More on Written Notice of Rights

- **G418*:* Obtain the Patient's or Legal Representative's Signature Confirming That He or She Has Received a Copy of the Notice of Rights and Responsibilities**
- **G420: Provider Verbal Notice of the Patient's Rights & Responsibilities in the Individuals' Primary or Preferred Language**
  - **No later than the completion of the second visits from a skilled professional**
  - **Document the discussion and that the patient and/or representative was able to confirm understanding**
- **G422: Provide Written Notice of the Patient's Rights & Responsibilities and the HHA's Transfer & Discharge Policies to a Patient-Selected Representative, if any, within 4 Days of the Initial Evaluation Visit**
  - **Check Policy & Protocol on This Item**  **Not Removed from IGs**

More on Notice of Rights

- **Notice of Rights includes**
  - **List of Consumer Protection Agencies, language services and their contact information**
  - **Written and Verbal Notice in preferred language**
  - **Agency must provide patient and patient's legal representative the following at the time of the initial evaluation**
    - **Written notice of the patient's rights & responsibilities under the final rule and written documentation of the agency's transfer and discharge policies;**
    - **Contact information for the Agency's Administrator including Name, Business Address, Business phone number for complaints**
    - **OASIS Privacy Notice**
- **Understandable; Verified; Time Frame Changes**

Patient Rights

- **Patient Rights: G426-G450**
  1. **Have property & person treated with respect**
  2. **Be free from verbal, mental, sexual, & physical abuse, including injuries of unknown source, neglect & misappropriation of property**
  3. **Make complaints regarding treatment or care**
  4. **Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to**
     - **Completion of the comprehensive assessment**
     - **Care furnished based on the comprehensive assessment**
     - **Establishing & revising the plan of care**
     - **The disciplines that will furnish the care**
     - **The frequency of visits**
     - **Expected outcomes of care, including identified goals, & anticipated risk & benefits**
     - **Any factors that could impact treatment effectiveness**
     - **Any changes in the care to be furnished**
  5. **Receive all services outlined in the Plan of Care**
  6. **Have a confidential clinical record & access to it in accordance with 45 CFR Parts 160 & 164 & HIPAA Standards**

More Updates Here

- **G430: Be Free from Verbal, Mental, Sexual, and Physical Abuse, including Injuries of Unknown Source, Neglect and Misappropriation of Property**
  - **Injury of unknown source is an injury that was not witnessed by any person and the source of the injury cannot be explained by the patient**
- **The Patient has a Right to be Free from Abuse from the HHA Staff and Others in His or Her Home Environment**
  - **The HHA should address any allegations or evidence of patient abuse to determine if immediate care is needed, a change in the plan of care is indicated, or if a referral to an appropriate agency is warranted.**
- **IG Update: Removed "The patient may experience normal day-to-day bumps and minor abrasions as they go about their lives. These minor occurrences should be recorded by the HHA staff once they are aware of them and follow-up should be conducted as indicated."**
- **Check Your Policy & Protocol on This Item: Remove Above, if Needed**

Patient Rights: Complaints

- **G476-G488 Investigation of Complaints**
  - **Investigate all complaints of the following:**
    - **Treatment or care**
    - **Mistreatment, neglect, or verbal, mental, sexual, and physician abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA.**
  - **Document both the existence of the complaint and its resolution**
  - **Take action to prevent further potential violations, including retaliation while the complaint is being investigated**
- **G488 Any HHA staff (whether employed directly or under arrangement) who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse including injuries of unknown source, or misappropriation of property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law.**

Further Clarification for Reporting

- **G488 All Agency Staff Must Report Immediately**
- **Final IG Update: "Immediately Means Reporting an Incident May be Influenced by the Individual Situation. However, the Reporting Must be Accomplished as Soon as Possible Following the Discovery."**
- **How Do Staff Identify and Report These Incidents in Your Agency?**
- **Check Your Policy & Protocol for Updated Language.** ***Immediate Means without Delay***

Patient Rights: Accessibility

- **G490 Accessibility**
  - **Information must be provided to patients in plain language and in a manner that is accessible and timely to:**
    - **Patients with disabilities**
      - **Auxiliary aids at no cost in compliance with ADA**
    - **Limited English Proficiency (LEP)**
      - **Language services at no cost including oral <u>and</u> written translations**

- **Final IG Update: Additional Surveyor Guidance**
  - **Section 504 of the Rehabilitation Act and the ADA protect qualified individuals with disabilities from discrimination on the basis of disability in the provision of benefits and services**
  - **Concerns Related to Potential Discrimination Issues Under 504 Should be Referred to the Office of Civil Rights for Further Review**

Action Plan for Patient Rights

- **Review All Patient Rights Policies & Procedures**
  - **Remove requirements of providing patient rights to patient-selected representative before initiating care**
  - **Ensure written patient rights notice and transfer/discharge policies are still provided to the patient-selected representative within 4 days of the initial evaluation visit**
  - **Remove the requirements that all agency staff need to report minor bruises and abrasions to leadership for further investigation**
  - **Be sure to add the requirement to immediately report, without delay, for potential or actual abuse, neglect, mistreatment, and/or misappropriation of property……..as defined by CoPs**
- **Review All Related Agency Protocols**
  - **Reporting & investigating complaints and or actual or potential abuse, neglect, mistreatment……..**
- **Timeframe & Documentation Requirements**

More on Action Plans

- **Educate Staff on Changes**
  - **Ensure patient & representative, if any, understands the patient rights and responsibilities as well as the transfer/discharge policies**
  - **Understand when and how to immediately report any actual or potential incidents of abuse, neglect, mistreatment,…..**
- **Reminders**
  - **Spend time each visit reviewing patient rights and care plan**
- **Bottom Line**
  - **Clinical documentation is critical here**
  - **How do staff document the verbal review of Patient Rights & Responsibilities?**

Surveyor Focus

- **Surveyor Focus with Patient Rights**
  - **Patient Admission Packet includes ALL revised Patient Rights & Responsibilities**
  - **Patient Rights Policies & Procedures explain rights in detail & in the patient's preferred language**
  - **Home Visits**
    - **Interview Patient and/or representative to see if they understand the Patient Rights & Responsibilities, including transfer/discharge policies**
    - **Patient/family interview to answer questions on Plan of Care, disciplines involved, date of next home visit and how to make a complaint, if needed**
    - **Does Admission Packet include an updated list of "relevant" state funded programs in local region**

Comprehensive Assessment

- **CoP Update Goals: G510-G550**
  - **Enhanced Assessment**
    - ✓ Content expanded to include current health, psychosocial, functional and cognition status
    - ✓ Requires inclusion of patient's strengths, goals and care preferences
    - ✓ Inclusion of the willingness and availability of the primary caregiver to care for patient
    - ✓ Inclusion of the primary caregivers schedule of availability to care for the patient
    - ✓ Requires the identification of measurable patient quality outcome goals
    - ✓ Requires inclusion of measurable progress toward quality outcome goals
  - **Expansion of Timeframes for Assessment Updates**
    - ✓ Resumption of Care (ROC) may include a physician-ordered resumption date
  - **Requires Provider to Expand Assessment Content & Details**

Other Survey Patient Rights Citations

- **Patient Rights is # 1 for Survey Citations**
  - **Services not provided as indicated on the POC**
    - Missed visit physician notification & follow-up
  - **Patient participation in the POC not detailed**
    - During initial visit & ongoing during each visit
    - With changes in the POC
  - **Failure to document all complaints on behalf of patients & caregivers**
    - Adequately investigate & resolve all complaints
    - To document the investigation & resolution of all complaints
- **Considerations**
  - **Policy to detail the what, who, where and how of complaint processes**

Initial Assessment

- **G514: Initial Assessment Visit**
  - **Must be conducted by an RN to determine immediate care & support needs**
  - **Establish eligibility for Medicare Home Health Benefit, including homebound status**
  - **Initial assessment must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date**
  - **When Rehabilitation Services is the only discipline(s) ordered by the physician, this service is responsible for determining program eligibility, completing the comprehensive assessment and Plan of Care**
- **Final IGs Update:**
  - **"A HHA that is unable to complete the initial assessment within 48 hours of referral or the patient's return home, shall not request a different start of care date from the ordering physician to ensure compliance with the regulation or accommodate the convenience of the agency."**

More on the Initial Assessment

- **G514: Initial Assessment Visit**
- **Final IGs Update:**
  - **"An HHA that is unable to complete the initial assessment within 48 hours of referral or the patient's return home, shall not request a different start of care date from the ordering physician to ensure compliance with the regulation or accommodate the convenience of the agency."**
  - **"In instances where the patient requests a delay in the start of care date, the HHA would need to contact the physician to request a change in the start of care date and such change would need to be documented in the medical record."**
- **What are Your Protocols & Practices?**
  - **Acceptance and delay of admissions**
  - **Intake/Liason and Admission Staff**
  - **Week-end Protocols**
- **Clinical Documentation**
  - **Physician contact and update; New SOC date; Patient reason(s) for requesting an admission delay**

Comprehensive Assessment

- **G520 Comprehensive Assessment**
  - **The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.**
- **Final IG Updates**
  - **"The SOC date is considered the first visit where the HHA actually provides hand on, direct care services or treatments."**
  - **"If the initial assessment visit is completed without direct care, the date of the initial assessment visit would not be the SOC date."**
  - **The comprehensive assessment must be completed within 5 calendar days of the first visit where the HHA provides hands on, direct care services/treatments to the patient."**

How Do You Document?

G526-G542 Content of the Comprehensive Assessment

- **The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information**
  - **The patient's current health, psychosocial, functional and cognitive status (beyond the OASIS)**
  - **The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA**
  - The patient's ongoing need for home care
  - The patient's medical, nursing, rehabilitative, social and discharge planning needs
  - A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy
  - **The patient's primary caregiver(s), if any, and other available supports**
    - **Willingness & ability to provide care**
    - **Availability & schedules**
  - **The patient's representative (if any)**
  - **Incorporation with current version of OASIS Data Set**

- **Other Considerations**
  - **Additional to OASIS**

Action Plan for Assessment Updates

- Assess Current Agency Policies
  - Initial Assessment
  - Comprehensive Assessment
- Assess Current Agency Protocols
  - How do you count 5 days for completion of the comprehensive assessment?
- Documentation Requirements
  - M090 SOC Date
- Educate Staff on Assessment Changes
  - Common Assessment Gaps
- Other Considerations
  - The Reality
  - What processes do you have in place when you do not have staff to admit patients?

Surveyor Focus

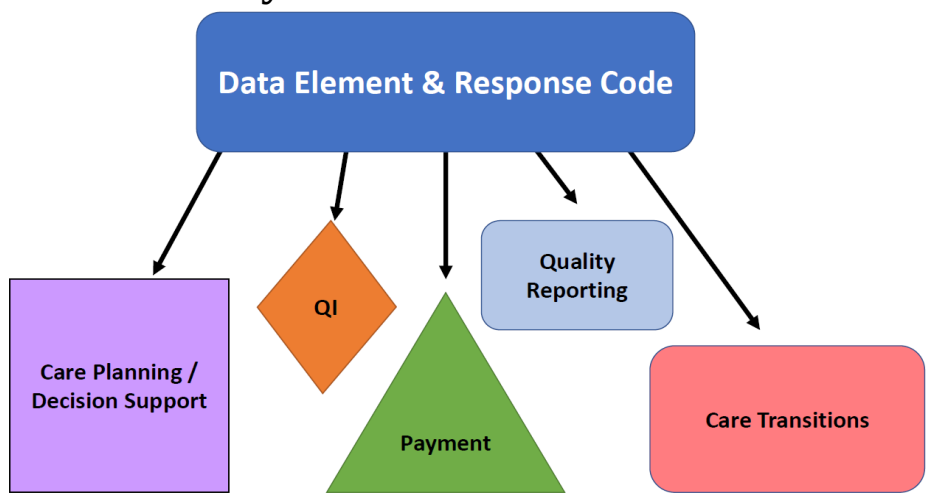
- Surveyor Focus with Initial & Comprehensive Assessment
  - Initial assessment visits delayed without notification of physician on delay
  - Initial assessment delayed due to staffing
  - Initial assessment visit delayed “due to patient request”, but documentation does not indicate reason for patient delay request
- Focus Items
  - Patient Admission Packet Updates to include ALL revised Patient Rights & Other Requirements
  - Patient BOR explains rights in detail and in the patient’s preferred language

More on Surveyor Focus

- **Comprehensive Assessment: Blanks**
  - **Patient Care Preferences**
  - **Caregiver Willingness & Availability**
  - **High Risk Variables for Emergent Care and/or Hospitalization**
  - **Emergency Preparedness Plan (In Clinical Record & Home)**
- **Clinical Documentation**
  - **How Does Your EMR Address These Items?**
  - **Are These Items Optional in Your EMR?**
  - **Consider Adding to Your Clinical Record Review**
  - **CMS Highly Values Patient Care Preferences in Care Planning & Scheduling**

Assessment to Care Plan

Do They Correlate & Make Sense?



Care Planning

- **Key CoP Goals: G570-G598**
  - **Enhances**
    - ✓ **Individualizes Plan of Care that identifies patient-specific measurable outcomes and goals**
    - ✓ **Requires all patient orders be included in the Plan of Care and include signature, date and time of orders**
    - ✓ **Requires all Plan of Care revisions to be communicated to the patient, representative, caregiver and physician**
    - ✓ **Requires the physician responsible for signing the Plan of Care be responsible for signing all changes on recertification of care & services**
    - ✓ **Requires integration of orders from all physicians and all services provided directly and/or under contract**
    - ✓ **Requires written information is provided to patient, including visit schedule & frequency, medication schedule/instructions, treatments, other pertinent information, and name & contact information of the Clinical Manager**
  - **CMS Clarifies Physician & HHA Responsibilities**

More on Plan of Care

- **All patient care orders, including verbal orders must be recorded in the plan of care**

  "The plan of care is an evolving document that outlines the patient's journey throughout the HHA care and treatment. As new orders are given to initiate or discontinue an intervention, the new plan of care is updated to reflect those changes. New versions of the plan of care are created as needed to assure that each clinician is working on the most recent plan of care, with older versions being filed away in the clinical record in any manner that meets the needs of the HHA."

- **Plan of Care Provides an Historical Journey of Patient Care & Services**
- **Plan of Care must be Individualized to Patient/caregiver Needs, Goals and Measurable Outcomes.**
  - **How will the clinician customize each Plan of Care in your EMR?**

Plan of Care Must Haves

- (i) All pertinent diagnoses;
- (ii) The patient's mental, psychosocial, & cognitive status;
- (iii) The types of services, supplies, and equipment required;
- (iv) The frequency & duration of visits to be made;
- (v) Prognosis;
- (vi) Rehabilitation potential
- (vii) Functional limitations;
- (viii) Activities permitted;
- (ix) Nutritional requirements;
- (x) All medications & treatments;
- (xi) Safety measures to protect against injury;

Source: Federal Register/Vol 82, No. 9/ Friday, January 13, 2017/ Rules & Regulations, Page 4582

More on POC Must Haves

- **The Individualized Plan of Care Must Also Include:**

  (xii) A description of the patient's risk for emergency department visits & hospital readmission, and all necessary interventions to address the underlying risk factors;

  (xiii) Patient & caregiver education & training to facilitate timely discharge;

  (xiv) Patient-specific interventions & education; measurable outcomes & goals identified by the HHA & the patient;

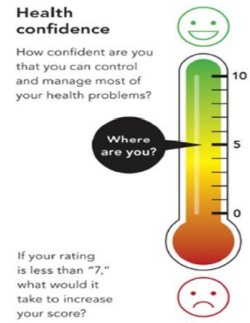
  (xv) Information related to any advanced directives; and

  (xvi) Any additional items the HHA or physician may choose to include.

Source: Federal Register/Vol 82, No. 9/ Friday, January 13, 2017/ Rules & Regulations, Page 4582

Care Planning

- **Patient Goal(s)**
  - **List Some Common Patient Goals**
    - **Pain less than 3 when walking**
    - **Not return to the hospital again**
    - **Get rid of this cane**
    - **Cook my own meals**
    - **Shower by myself in my own shower**
- **Care Plan: Specific and Individualized**
  - **By Diagnosis and Plan of Care**
- **Specific Measurable Goals**
  - **Quantify: Goal of 7 or higher on the Wasson Health Tool**
- **Goal Progression: How in Your EMR?**



Review & Revision of Care Plan

- **G588 & G590: Review & Revisions to POC**
  - **The individualized POC must be reviewed & revised by the physician who is responsible for the home health POC & the HHA as frequently as the patient's condition or needs require, but no less frequently than every 60 days, beginning with the SOC date.**
  - **The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the POC should be altered.**
- **Final IG Update**
  - **Eliminated that physician orders do not automatically restart the timeframe for physician POC review**

Verbal Physician Orders

- G576 Physician Orders including Verbal Orders
  - All physician orders, including verbal orders, must be recorded in the POC
- Final IG Updates
  - "All patient care orders, including verbal orders, are part of the POC. The POC should be revised to reflect any verbal order received during the 60 day certification period so that all staff are working from a current plan."
  - "It is not necessary for the physician to sign an updated POC until the patient is recertified."
  - "The recertification POC is updated to reflect all current ongoing orders including any verbal orders received during the 60 day period."

More on Physician Orders

- G576 Physician Orders
  - All physician orders, including verbal orders, must be recorded in the POC.
- Final IG Updates
  - "Pulse oximetry is a ubiquitous assessment tool, often used as a part of routine vital signs across health care providers. Routine monitoring of vital signs, including pulse oximetry, do not require a physician order."
- Other Considerations
  - Pulse Oximetry Parameters are still needed on the POC
  - Accreditation Standards

Integrating Physician Orders

- **G604 Integrating Orders**
  - **Integrate orders from all physician involved in the POC to assure the coordination of all services and interventions provided to the patient**
- **Final IG Update**
  - **Eliminated the requirement for the responsible physician to identify any other relevant physicians that should be contacted for orders to be included in the POC.**
  - **"The clinical manager or other staff designated by the HHA is responsible for integrating orders from all relevant physicians involved with the HHA POC & ensuring the orders are approved by the responsible physician."**

FAQ

- **The CoPs require that all patient care orders, including verbal orders, be recorded in the plan of care. Additionally, the CoPs require that the individualized plan of care be reviewed and revised by the physician who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than every 60 days, beginning with the start of care date. Revisions in the plan of care must be communicated to all physicians ordering home health services as well as the patient, patient representative, and caregiver.**
- **Considerations**
  - **The physician must review & sign the revised plan of care at least every 60 days on recertification for care and services**
  - **Who notifies the relevant physicians of changes in the POC?**

Basic Care Planning

- What Surveyors Say About Care Planning
  - Not Cookie Cutter
  - Not Checklists
  - Not Generic with EMR's
- More on Surveyor Examples
  - Parameters Need to be Specific to the Patient
  - Identify Baseline Data for Each Patient
  - Consider Specific Goals Based on Diagnoses & Education
- Be Sure to Document Patient's Agreement with Their Plan of Care
  - Patient participating and in agreement with the Plan of Care

More on Care Plans

- Specific, Measurable Goals
  - Able to ascend/descend one flight of stairs with rail independent within 3 weeks
  - Establish a regular elimination pattern within 3 weeks and through-out certification period
  - Utilize adaptive equipment to manage self care within 6 weeks
  - Improve score on Tinetti from 19/28 to 25/28 within 4 weeks
  - Demonstrate optimal glucose control through diet and medication regimen within 4 weeks
- What Are Other Common Specific POC Goals?

Action Plan for Care Planning

- **Assess Current Agency Policies**
  - **Check Policy for POC Episode Dates**
  - **Check Policies for Who is Responsible to Notify All Relevant Physicians for POC Changes**
- **Assess Current Agency Protocols**
  - **Integrating POC with All Updates & Revisions**
- **Documentation Requirements**
  - **What are Your EMR Options?**
- **Ensure Staff Understand Care Planning Requirements**
  - **Plan of Care must indicate risk(s) for re-hospitalization, and interventions to reduce emergent care & re-hospitalization**
  - **Patient specific goals and measurable outcomes must be on the POC**
  - **Process & Documentation for IDT Communication & Coordination**

More Surveyor Focus

- **Surveyor Focus with Care Planning**
  - **Care Plan is not specific and individualized**
  - **Care Plan does not identify patients risk(s) for emergency department visits and re-hospitalization**
  - **Care Plan does not identify patient-specific measurable outcomes and goals**
  - **Care Plan does not include all required elements, including information related to advanced directives**
- **Other Common Surveyor POC Issues**
  - **Physician notification of patient changes**
  - **Accurate and complete medications**
  - **Services not provided as indicated in the POC**

Care Coordination

Key CoP Goals G600-G622: Coordination of Care: The HHA must

- **Assure communication with all physicians involved in the plan of care**
- **Integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient**
- **Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by the disciplines**
- **Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities**
- **Ensure that each patient and his or her caregiver(s) , where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary to ensure timely discharge.**

Care Coordination: How?

- **CMS Expects Greater Communication & Care Coordination Among Providers**
  - **Interdisciplinary in Nature**
  - **Case Conferencing** → **Documentation Needs**
  - **Effective Collaboration between Disciplines**
  - **Clear Communication**
  - **Continuity of Care**
- **Providers to Evaluate Current Care Practices**
  - **Realignment of Care Delivery**
  - **RN and/or Therapist Accountable for Continuity of Care**
  - **Discuss Your Current IDT Care Processes**
    - **Team Conferences; IDT Communication & Updates**

How Do You Provide & Document?

G612-G622: Written Information to the Patient

The HHA must provide the patient and caregiver with a copy of written instructions outlining

- **Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA (contract staff & HH aides)**
- **Patient medication schedule/instructions, including medication name, dosage and frequency which medications will be administered by HHA personnel and personnel acting on behalf of the HHA**
- **Any treatments to be administered by HHA personnel and personnel acting in behalf of the HHA, including therapy services**
- **Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs**
- **Name and contact information of the HHA Clinical Manager**

- **Consideration: Do You Use This Information Every Visit?**
  - **Document Changes & Review with Patient & Receive Approval**

Written Information to Patient

- **G612-G622: Written Information to the Patient**
  - **The HHA must provide the patient and caregiver with a copy of written instructions outlining visit schedule, medication schedule, any treatments, any other pertinent information, and the name and contact information of the HHA Clinical Manager.**

- **Final IG Update**
  - **"Must be provided to the patient and/or their caregiver and representative, if any, no later than the next visit after the POC has been approved by the physician."**
  - **"The written information should be updated as the POC changes."**

Per Visit Documentation Considerations

- **Consider How to Document**
  - Reviewing Patient Rights SOC & Per Visit (Verbal)
  - Patient/Representative Agreement with POC & Any Changes/Updates (Participates in the Plan of Care)
  - Patient Preferences
  - Goal Progression
  - Barriers to Learning
- **How About**
  - Language Preferences & Options
  - Other Aid Options for Visual/Hearing Impaired
  - Language Line Services (LEP: Limited English Proficiency)
  - Caregiver/Family Education: Engagement

Action Plan for Care Coordination

- **Assess Current Agency Policies**
  - Check Policy for Timing of Written Information in the Home
  - Check Policies for Updating Written Information
  - Ensure staff understand their role with the use of all patient written information in the home
  - How do you simplify the written information in the home?
- **Assess Current Agency Protocols**
  - Updating HH Staff, including the HH Aide schedule in the home
- **Ensure Staff Understand Care Coordination Requirements**
  - Use & updating written information in the home
  - Inclusion of other materials in the written information packet
    - Zone Sheets
    - HEP
  - Documentation for IDT Communication & Coordination

More Surveyor Focus

- **Surveyor Focus with Coordination of Care**
  - **Physician is not notified of patient changes**
  - **Team members are not updated on a timely basis with patient POC changes**
  - **Written information in the home is not current or accurate**
  - **Written information in the home is not understood by the patient and/or patient's caregiver**
- **Other Surveyor Coordination Considerations**
  - **Timing of written patient information**
  - **Accurate and complete medication list with all required elements**
  - **Services not provided as indicated in the POC**

QAPI

- **Key CoP Goals: G640 - G660**
  - **Requirements for Quality Assessment Performance Improvement**
    - ✓ **Data driven, agency wide quality assessment & performance improvement program**
    - ✓ **Reflect the complexity of all agency services**
    - ✓ **Governing authority responsible for QAPI oversight**
    - ✓ **Utilizes quality data to track performance and ensure improvement is sustained**
    - ✓ **Performance Improvement Projects (PIPs) to conduct focused agency improvement efforts**
  - **Infection Control will Integrate into the QAPI Program**
    - ✓ **Expanded to Infection Prevention & Control (Surveillance Items)**
  - **New Conditions**
    - ✓ **QAPI & Infection Prevention & Control**

More on Program Data

- **Reliable, Valid Data Sources**
  - **CMS CASPER Reports**
    - ✓ **Potentially Avoidable Events**
    - ✓ **Risk Adjusted Quality and Process Outcomes**
    - ✓ **CMS STAR Ratings Reports**
  - **Home Care Compare Data & PEPPER Reports**
  - **HH-CAHPS (Patient Satisfaction Data)**
- **Other Relevant Data**
  - **Required QAPI Items**
    - ✓ **Incidents & Occurrences**
    - ✓ **Complaints**
    - ✓ **Infection Control Rates**
    - ✓ **Medication Errors**

More on QAPI Standards

- **Program Activities**

  (1) The HHA's performance improvement activities must

  (i) Focus on high risk, high volume, or problem prone areas;

  (ii) Consider incidence, prevalence, and severity of problems in those areas; and (Examples……..)

  (iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients

  (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions.

  (3) The HHA must take actions aimed at performance improvement, and after implementing those actions, the HHA must measure its success and track performance to ensure that improvement are sustained

- **Providers Must Consider How to Improve Outcomes and Sustain Outcomes Once Improved**

Performance Improvement Projects

- **G658 Performance Improvement Projects (PIPs)**
  - **The number & scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services & operations**
  - **The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects**

- **Final IGs**
  - **"The HHA should have at least one performance improvement project either in development, on-going or completed each calendar year."**

- **How Does Your Agency Select PIPs?**

Tips on QAPI

- **Ensure Agency has Quality Designee**
  - **Track & Trend Current CMS CASPER Data**
  - **Track, Trend & Analyze Pertinent Agency Data**
    - **Adverse Events**
    - **Discharge Summaries/Reports**
    - **Hospital Readmissions**
    - **Injuries**
    - **Emergent Care**
  - **Utilize QAPI Data to Educate Clinicians on Priorities**
  - **Involve Clinicians on Quality Teams (PIP's)**

- **Access Resources on Best Practices**
  - **CDC.gov**
  - **HHQI.org**
  - **CMS Centers for Innovation**
  - **VNAA.org**

Infection Prevention & Control

- **Key CoP Goals: G680-G686**
  - **The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases**
  - (a) **Prevention: The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases**
  - (b) **Control: The HHA must maintain a coordinated agency wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement program. The infection control program must include:**
    - (1) **A method for identifying infectious and communicable disease problems and**
    - (2) **A plan for the appropriate actions that are expected to result in improvement and disease prevention**
  - (c) **Education: the HHA must provide infection prevention & control education to staff, patients, and caregiver(s).**

Infection Prevention & Control Plan

- **Purpose**
  - **Monitors, identifies & reduces the risks of infections for both employees & patients**
- **Goals**
  - **Prevent & control infections & communicable diseases**
  - **Maintain active surveillance or early detection**
  - **Identify infectious diseases that place patients/ and employees at risk**
  - **Prioritize & address infection risks**
  - **Improve compliance with handwashing**
  - **Collaborate with local/State DOH & CDC on re-emergence of new infections and/or epidemics**

More on Infection Prevention

- **Review & Update Staff Education**
  - **CMS expects providers to cite in all policies & procedures best practice standards source (APIC)**
- **Review & Update Patient/Caregiver Education**
  - **Written; Verbal & Demonstration**
    - ✓ **Handwashing (CDC or WHO)**
    - ✓ **Coughing**
    - ✓ **Influenza Vaccine**

- **Implement Infection Prevention Processes**
  - **Joint Visit IC Compliance Program**
  - **Track & Trend Results to Report to QAPI**
- **Incorporate Infection Prevention & Control into QAPI**

Infection Prevention

- **G682 Infection Prevention**
  - **The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.**

Final IGs

- **Hand Hygiene: Eliminated the statement that "alcohol-based hand sanitizers are the most effective products for reducing the number of germs on the hands of health care providers."**
- **Further clarifies: "Hand hygiene includes both hand washing with either plain or antiseptic-containing soap and water, and the use of alcohol-based products that do not require the use of water."**
- **"In the absence of visible soiling of hands, approved alcohol-based products for hand disinfection are preferred over antimicrobial or plain soap and water."**

Action Plan for QAPI & IC

- Assess Current Agency QAPI Policies
  - Number & scope of PIPs annually
- Assess Current Agency IC Policies
  - Check Hand Hygiene Policy for updated clarifications
- Educate Leadership & Staff on QAPI & IC Updates
  - Board Oversight & Resource Allocation
  - Required QAPI Elements
  - Updated PIP Requirements
  - Required Infection Prevention & Control Updates
  - Leadership & Staff Access to QAPI & IC Expertise
- Other Considerations
  - Staff Education on Hand Hygiene Updates
  - Consider Integrating IC & Hand Hygiene with Joint Supervisory Visit
    - Report into QAPI

Surveyor Focus

- Surveyor Focus with QAPI
  - Data Access & Use (CASPER Reports & AE's)
  - Interdisciplinary Approach to QAPI & PIPS
  - Prioritizing of PIPs
  - Achieving and Sustaining Outcome Goals
- Surveyor Focus with Infection Prevention & Control
  - Staff Education: Universal Precautions & Hand Hygiene
  - Patient Education: Admission Packet
  - Home Visits
    - Handwashing
    - Bag Technique
  - Infection Surveillance: Patients & Staff

Home Health Aide Services

- **Key CoP Goals:** G750-G828 HH Aide Services
  - Home Health Aide Competencies
    - ✓ Expansion of communication skills to include ability to read, write & verbally report clinical information to patients, representatives, caregivers & HHA staff
    - ✓ Expansion of hygiene and grooming tasks
    - ✓ Addition of new competency to recognize and report changes in skin condition
  - Expansion of Home Health Aide Supervision Criteria
    - ✓ Following patient's POC
    - ✓ Maintaining open communication with patient, caregivers, family…
    - ✓ Demonstrating competency with assigned tasks
    - ✓ Complying with infection prevention & control standards
    - ✓ Reporting patient changes
    - ✓ Honoring patient rights
  - Assignment & Integration into IDT Care Team

More on Home Health Aide

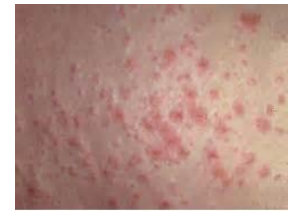
- Home Health Aide Services
- More on Standard Updates
  1. Content & Duration of Home Health Aide Classroom and Supervised Practical Training
     - ➢ Training program must address communication skills including the skills to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as the Home Health Agency (HHA) staff
  - 2. HHA's are responsible for training home health aides, as needed, for skills not covered in the basic checklist
    - ➢ Recognizing and reporting changes in skin condition
- Competency Evaluations
  - HHA must maintain documentation to support above

Communication

- **Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff**
  - **Demonstrates competency in all communication skill sets**
    - **Read, Write & Verbally Report Patient Clinical Information**
    - **Expands from Therapeutic Communication to Effective Reporting**
  - **Applies communication skill sets to patient scenarios**
    - **When & How to Effectively Report Changes**
- **Agency Must Document Competency**
  - **Observed Competency**
  - **Multiple Scenarios to Demonstrate Competencies**

Skin Changes

- **Recognizing & Reporting Skin Changes**
  - **Skin Scan During Personal Care**
  - **Identifying Skin Changes**
    - **Color Changes**
    - **Temperature**
    - **Texture (Turgor); Edema; Swelling**
    - **Redness; Bruises, Rashes; Tears, Lacerations; Burns; Wounds**
    - **Scratch Marks**
  - **Patient Response to Touch**
  - **Patient Behaviors with Skin**
    - **Itching**
    - **Tenderness**



- **Reporting Any Skin Changes (Real Time)**

More on Competency Updates

- **The Competency Evaluation Must Include**
  - **Evaluation of aide's performance of the following tasks by observing an aide's performance of the task with a patient**
    1. **Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff**
    2. **Reading & recording temperature, pulse, and respiration**
    3. **Appropriate & safe techniques in performing personal hygiene & grooming tasks that include:** ***(see next slide for detailed tasks)***
    4. **Safe transfer techniques & ambulation**
    5. **Normal range of motion & positioning**
- **The remaining competencies may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient**

More on Competency Updates

- **Observed Competencies Must Also Include:**
  - **Appropriate & safe techniques in performing personal hygiene & grooming tasks include**
    - **(A) Bed bath**
    - **(B) Sponge, tub, & shower bath**
    - **(C) Hair shampooing in sink, tub, & bed**
    - **(D) Nail & skin care**
    - **(E) Oral hygiene**
    - **(F) Toileting & elimination**
    - **(G) Safe transfer & ambulation**
    - **(H) Normal range of motion & positioning**

- **Final IGs:**
  - **For individuals who met the qualifications for HH aides prior to 1/13/18, new training content in these requirements may be completed via in-service training**

More on Competencies

- **The remaining competencies may be evaluated through written examination, oral examination, or other observation of a home health aide with a patient**
  1. **Observation, reporting, & documentation of patient status and the care or service furnished**
  2. **Basic infection prevention & control procedures**
  3. **Basic elements of body functioning & changes in body function that must be reported to an aide's supervisor**
  4. **Maintenance of a clean, safe, & healthy environment**
  5. **Recognizing emergencies & the knowledge of instituting emergency procedures & their application**
  6. **The physical, emotional, & developmental needs of & ways to work with the populations serviced by the HHA**

More on Competencies (cont'd)

- **The remaining competencies may be evaluated through written examination, oral examination, or other observation of a home health aide with a patient**
  7. **The physical, emotional, & developmental needs of & ways to work with the populations serviced by the HHA, including the need for respect for the patient, his or her privacy, and his or her property**
  8. **Adequate nutrition & fluid intake**
  9. **Recognizing & reporting changes in skin condition, and**
  10. **Any other task that the HHA may choose to have an aide perform as permitted under state law**

The HHA is responsible for training home health aides, as needed, for skills not covered in the basic checklist

Duties of Home Health Aides

- **G802: Duties of Home Health Aides**
  - **The duties of the home health aide include assistance in administering medications ordinarily self-administered**

Final IGs:

- **"Assistance in administering medications means the HH aide may take only a passive role in this activity. Assistance may include items such as:**
  - **Bringing a medication to the patient either in a pill organizer or a medication container as requested by the patient or caregiver;**
  - **Providing fluids to take with the medications;**
  - **Reminding the patient to take a medication;**
  - **Applying a topical product, such as a non-prescription cream, to intact skin per home health aide instructions in how to apply it."**

Action Plan for HH Aide Updates

- **Assess Current Policies & Forms**
  - **Check expanded competencies in agency policies**
  - **Check policy on HH aides assisting with medications**
  - **Check HH aide Plans of Care**

- **Check Expanded Competencies in Agency Policies & Forms**
- **Check Software Vendor Updates**
  - **Home Health Aide POC Updates for assisting with medications**
- **Educate Leadership & Staff**
  - **Revised Aide Tasks (Communication & Skin Changes)**
  - **Ensure Staff are Educating Aides on Sup Visits**
- **Other Considerations**
  - **Aide Personnel File Review for Updates**
    - **Skin & Communication Competencies**
  - **Check Vendor Compliance Audits for Required Competencies**

Surveyor Focus

- **Surveyor Focus with Home Health Aides**
  - **Supervision every 14 days**
  - **Updated & individualized aide POC**
  - **RN supervisory responsibilities in multi-disciplinary cases**
  - **Updating HH aide on POC changes**
  - **How do you include the HH aide in your IDT?**
- **Other Considerations**
  - **Staff Education: HH Aide Assistance with Medication Updates**
  - **Home Visits**
    - **HH Aide can speak to their role with assistance with medications**
    - **HH aide understands all aspects of the aide POC**
  - **Documentation Requirements for Clinical Staff & Aides**

Clinician Role Expansion

- **Care/Case Management Responsibilities**
  - Episode Management (Referrals to All Required Disciplines; Visit Utilization)
  - Communication & Coordination
  - Care Conferencing
  - Emergent Care & Acute Hospitalizations: Proactive Risk Management
- **Accountability**
  - Expanded Clinical Documentation
  - Clear Understanding of CoP Priorities
  - Timely Referrals for All Services
  - Integrated Chronic Care Management

- **HCR Demands Enhanced Health Care Outcomes**

2018 CoP Survey Results

- **Patient Rights: Survey Citations**
  - Complete Consents (including financial disclosures)
  - Verbal & Written Patient Rights
  - Community Resource Agencies (In Admission Packet)
  - Name & Contact for Administrator & Clinical Manager
  - Complaint Process & Transfer/Discharge Policies
- **Care Planning: Survey Citations**
  - Patient/Representative Agrees with POC and ALL Changes
- **Coordination: Physician and Patient/Representative**
- **EDP: All Required Elements**
- **Bottom Line: Clinical Documentation is Critical**

More on Early Survey Results

- **Care Planning:**
  - **Patient Materials for Plan of Care Needs are Inadequate**
    - **Calendar: All disciplines including aides**
    - **Discipline Specific Measurable Goals**
    - **Understandable format for patients**
    - **Updated Medications: All Required Elements**
- **Coordination: With All Team Members: How?**
- **POC: ER/ACH Diversion Specific to Patients**
  - **Not Generic EMR ACH Diversion Strategies**
- **QAPI/Infection Control**
    - **Adverse Event Audits**
    - **QAPI Data for PIPs**
    - **IC Data & Prevention Practices**

Care Management Considerations

- **Assessment Clarity**
  - **Patient Goal(s) & Priorities**
  - **Visit Plan (Re-Visit Note)**
- **Care Management**
  - **Communication**
  - **Coordination of Care**
  - **Right Visit at the Right Time**
- **Do We**
  - **Front Load Our Visits?**
  - **Make Quick Referrals to Team Members?**
  - **Taper Visits on the Care Plan?**
  - **Assess ACH Risks & Address in Plan of Care?**

Diversion Strategies

- **Care Plan Considerations**
  - **Address High Risk Items (OASIS M1033)**
  - **Examples: Specific Care Plan Interventions**
- **Patient/Caregiver/Representative**
  - **Clear Goal Discussion**
  - **Patient/Caregiver Tools**
- **What Can We Do to Decrease Re-Hospitalizations?**
  - **Identify High Risk Patients**
  - **Front Load Visits**
    - **Week-end Visits as Needed**
  - **Engage & Coach Family Members and Caregivers**
  - **Plan of Care: Emergent Care & ACH Diversion Strategies**

COPD Management Plan

	SYMPTOMS	ACTION	MEDICATIONS
WELL	WHEN I AM WELL I • (appetite) • (activity) • (sputum) • (sleep)	LIFESTYLE TIPS • Stop smoking and avoid smoky places • Exercise every day • Always keep enough medicine	Reliever ☐ @ ☐ puffs as required ☐ @ ☐ puffs ☐ Other ☐ @ ☐ puffs ☐ times a day ☐ @ ☐ puffs ☐ times a day ☐ @ ☐ times a day Or:
WORSENING	BECOMING UNWELL • More breathless, wheezy or coughing • Change in amount and/or colour of sputum • Tired, not hungry	WHAT TO DO • If you have a fever and/or yellow/ green sputum start antibiotics and see your doctor • Clear sputum with huff and cough techniques • Eat little and often • Use the breathing tips (in this leaflet)	Continue your usual medications. Start the following medications: ☐ times a day
SEVERE	REALLY UNWELL If no better in ☐ days	Contact the doctor for an urgent review Daytime tel: After hours tel:	Continue your usual medications. Start the following medications: ☐ times a day
EMERGENCY	EMERGENCY • Very short of breath at rest • Chest pains • A feeling of agitation, fear, drowsiness or confusion • High fever	Dial 111 for an ambulance	Patient Name: Doctor: Date plan prepared: / / By: Review Date: / / By:

More on Hospitalizations

- High Risk Re-Hospitalization Months
  - Data Drill
  - Trends
  - Givens

- ALL Hospital Discharges
  - Do you have an appt. with primary physician?
  - Does patient have all medications?
  - Heart Failure & COPD Teach Tools
  - Zone Tools: When to Call for Help

Call Us First

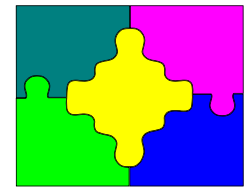
- Fact
  - Patients who see a physician within 7-10 days post D/C decrease re-hospitalization by over 30%

More on Best Practices

- HHVBP: Prior to Discharge
  - Medication Reconciliation & Dispensing
  - Equipment Delivery & Set-Up
  - Patient & Caregiver Engaged in Plan & Goals
  - Pre-Admission Identification of High Risk(s)
  - Physician Appointment Made
  - Transportation & Caregiver Confirm Physician Appointment

- Admission
  - Same Day as Discharge
  - High Risk Items Addressed on First Day in Home
- Second Day Visit: Week-end Visit Priorities

Leadership Strategies



- **Assess Survey Readiness with CoPs**
  - **Read Final Interpretive Guidelines**
  - **Establish Action Plan with Priorities**
- **Focus on the Priorities**
  - **Analysis of Current Programs, Policies & Practices**
  - **Prescriptive & Clarified CoP Final IG Changes**
  - **Secure Software & Documentation Updates**

- **Leadership & Staff Education**
  - **CoP & Final IG Specific**
  - **Staff Tools for IDT, Communication, Care Management**
- **Secure Agency Resources: Education & Expertise**

Resource Web Sites

www.cms.gov
Centers for Medicare & Medicaid Services

www.gpo.gov/fdsys/pkg/FR-2017-01-13/pdf/2017-00283.pdf
Federal Register CoP Final Rule 1/13/2017

http://www.health.ny.gov
New York State Department of Health

www.ahrq.gov/workingforquality
Agency for Healthcare Research & Quality

www.ihi.org
Institute for Healthcare Improvement

www.hhqi.org
Home Health Quality Improvement