info@fms-regional.com
www.askFMS.com
PHONE: 800.213.4732
FAX: 866.824.5119

The Home Health Proposed Conditions of Participation

DeAnn Briscoe, RN BSN COS-C
Senior Clinical Education Consultant
Foundation Management Services

Objectives

- Describe the CMS proposed Conditions of Participation (CoPs) established for home health care
- Discuss plans of action a home health agency should take to prepare for changes in the proposed CoPs

Proposed CoP Changes

- Released on October 6, 2014
- First time in 17 years

Why New CoPs?

This is what CMS says…

- Focus on care delivered to patients by HHA
- Reflect an interdisciplinary view of patient care
- Allow HHA greater flexibility in meeting quality care standards
- Eliminate unnecessary administrative procedural requirements

Posted Comments

- Posted on www.regulations.gov
- Get your own copy:
  - http://www.gpo.gov/fdsys/pkg/FR-2014-10-09/pdf/2014-23895.pdf

QUICK TUTORIAL ON CoPs

Conditions of Participation (CoPs)

- Minimum health and safety standards to which providers and suppliers of health services must comply
- Embodied in Title XVIII of the Social Security Act (SSA) and other regulations of Department of Health and Human Services (DHHS)
- For the health and safety of individuals who receive services
- Home Health CoPs: SSA § 1891 and 42 CFR Part 484

Conditions of Participation (CoPs)

- Currently:
  - 15 CoPs with standards within the CoP
  - Survey process focuses on the 9 CoPs most closely related to delivery of high-quality patient care
    - A single problematic finding with an actual (or potential) poor outcome supports finding of non-compliance
    - Standard-level deficiency takes surveyor from Standard Level 1 survey to Partial Extended Level 2 survey
    - Citation of a condition-level deficiency takes surveyor to an Extended survey where all 15 CoPs are reviewed

Condition Level Deficiency

- *State Operations Manual, Appendix B – Guidance to Surveyors: Home Health Agencies says:
  - "…provider is not in compliance with the CoPs where the deficiencies are of such character as to substantially limit the provider's capacity to furnish adequate care or which adversely affect the health and safety or patients."
  - Condition level deficiencies defined per CoP

*Advance Copy, Appendix B-rev. 2/11/11

History of CoPs in a Nutshell

- 1987: existing CoPs established
- 1997: OASIS and new CoPs proposed
  - Not finalized
- 2003: Medicare Prescription Drug, Improvement, and Modernization Act prohibited use of old "non-finalized" regulations
- 2005: OASIS regulations regarding collection and transmission finalized
- 2006: Delayed revision of CoPs

PROPOSED CoPs

Overview of Changes

- Changes to structure
  - Renumbering
  - Standards combined
  - Standards integrated in new CoPs
- Creation of brand new CoPs
  - 484.65 Quality Assessment and Performance Improvement (QAPI)
  - 484.70 Infection Control

Overview of Changes

- Increase in patient rights requirements with more involvement of caregivers, family, and representative
- Increased coordination of care at transition from home health after discharge or transfer
  - Summary documentation requirement with specific timeframes
- Increased emphasis on interdisciplinary care planning with focus on outcomes and goals
- Increased responsibility and involvement of Governing body

Overview of Changes

- Specifics added where terms were vague
- Some regulations unchanged
- Deleted regulations
  - 60-day Physician Summary
  - Group of professionals or Professional Advisory Committee (PAC)
  - Quarterly record review
- Subunits will be eliminated

Goal of Changes

- Provide high quality of home health care to American public
  - Focus on patient and support system
  - Focus on outcomes of care
  - Substantiated by data

Method

- Less emphasis on administrative processes not contributing to patient outcomes
- Protect rights of the patient
- Increase in care coordination, care planning, service delivery, and quality assessment and performance improvement
- Integrate outcome-oriented, data-driven quality assessment and performance improvement program specific to the agency

New Table of Contents

- Subpart A – General Provisions
  - 484.1 Basis and scope
  - 484.2 Definitions
- Subpart B – Patient Care
  - 484.40 Condition of participation: Release of patient identifiable Outcome and Assessment Information Set (OASIS) information
  - 484.45 Condition of participation: Reporting of OASIS information
  - 484.50 Condition of participation: Patient rights
  - 484.55 Condition of participation: Comprehensive assessment of patients
  - 484.60 Condition of participation: Care planning, coordination of services, and quality of care

New Table of Contents

- Subpart B - Patient Care (cont)
  - 484.65 Condition of participation: Quality assessment and performance improvement (QAPI)
  - 484.70 Condition of participation: Infection prevention and control
  - 484.75 Condition of participation: Skilled professional services
  - 484.80 Condition of participation: Home health aide services

New Table of Contents

- Subpart C – Organizational Environment
  - 484.100 Condition of participation: Compliance with Federal, State, and local laws and regulations related to health and safety of patients
  - 484.105 Condition of participation: Organization and administration of services
  - 484.110 Condition of participation: Clinical records
  - 484.115 Condition of participation: Personnel qualifications

Four New Proposed CoPs

- Patient Rights - 484.50
  - Will emphasize HHA's responsibility to respect and promote the rights of each home health patient
  - Clarifies the rights for each patient
  - Revises the process for investigating and addressing patient rights violations

Four New Proposed CoPs

- Care planning, coordination of services, and quality of care - 484.60
  - Interdisciplinary team approach
  - Focus on care planning
  - Coordination of services
  - Quality of care processes

Four New Proposed CoPs

- Quality assessment and performance improvement (QAPI) - 484.65
  - Agency
  - Incorporation of ongoing quality assessment
  - Integration of data-driven goals
  - Evidence-based performance improvement program

Four New Proposed CoPs

- Infection prevention and control - 484.70
  - Follow accepted standards of practice to prevent and control transmission of infectious diseases
  - Required education of staff, patients and family members or other caregivers on accepted practices of infection control
  - Infection control incorporated into QAPI program

Proposed Removals

- 60-Day Physician Summary
  - Caution: will have to show communication with physician in other documentation
- Use group of professional personnel to advise its operation
- Quarterly evaluation of its program via chart reviews

Critical Improvements

- Enable surveyors to focus on outcomes of care
  - Regulations would specify that each patient receive necessary care based on assessed individual needs
  - Less focus on services and processes
- Strong QAPI requirement
  - Require continuous self-monitoring of performance and opportunities for improvement
  - Surveyor can assess how effectively agency is pursuing a continuous quality improvement agenda
  - Will require stronger documentation

Goal of the Improvements

- Improve patient-centered outcomes of care
- Data driven
- Engaging the patient, family and physician in care planning and care delivery processes
- CMS says:
  - "We believe that the overall approach of the proposed CoPs would provide HHAs with greatly enhanced flexibility."
- CMS expects:
  - Increased performance expectation for HHAs in achievement of needed and desired outcomes for patients
  - Increased patient satisfaction with provided services

Action Items

- Examine your weaknesses
- Develop strategies for improvement
  - Home Health Compare
  - Outcomes reports (Star Ratings)
  - Last state survey results
  - Clinical Record Review
  - Examine processes

How it will look

- Continue to be under 42 CFR part 484
  - Revisions, consolidations and eliminations = extensive changes in the organizational scheme
- Patient care related CoPs
  - Grouped together
  - Placed at beginning of part 484
- Organization and administration related CoPs
  - Placed after patient care related regulations
  - Separate subpart titled “Organizational Environment”

SPECIFIC CHANGES

Subpart A - General Provisions

Reorganization

- Deletion of § 484.1(a)(3)
  - Covered in other regulations

Clarification of § 484.2 definitions

- "Branch office" definition modified
  - Requirement that parent agency offer more than sharing of services
    - Provide supervision and administrative control of branches on daily basis
    - Branch will depend on parent's supervision and administrative functions to meet CoPs
    - Cannot function as independent entity

Subpart A - General Provisions

- Branch Office
  - Supervision and administrative control
    - Assure quality and scope of items
    - Services provided of "highest practicable" level for all patients to meet their medical, nursing and rehabilitative needs
  - Definition no longer requires branch office to be "sufficiently close"
    - Parent available to meet needs of any situation and
    - Respond to issues regarding patient care and administration
  - Violation of CoP in one branch office would apply to entire HHA

Subpart A - General Provisions

Other definition changes

- Clinical note
  - Term "timed" added
  - "response" added to "patient reaction"
  - "a given period of time" added to requirement to changes in condition
- In advance
  - Newly added
  - Agency staff must complete task prior to performing any hands-on care or any patient education

Subpart A - General Provisions

- Parent home health agency
  - Restated to "provides direct support and administrative control of a branch"
  - Removed reference to subunit
- Primary home health agency
  - Restated to include "accepts initial referral of a patient", "provides services directly to the patient or via another health care provider under arrangements (as applicable)"
- Proprietary agency
  - Simple wording change
  - Changed "profit making" to "for profit"

Subpart A - General Provisions

- Quality indicator
  - Newly added
  - "Specific, valid, and reliable measure of access, care outcomes, or satisfaction, or a measure of a process of care"
- Representative
  - Newly added
  - Patient's legal guardian or other person who participates in make decisions related to the patient's care or well-being
  - Includes person chosen by the patient, family member, or advocate for the patient
  - Patient determines role of the representative, to the extent possible

Subpart A - General Provisions

- Subdivision
  - Removed the word "subunits"
- Summary report
  - Removed words "progress notes"
- Supervised practical training
  - Newly added
  - Training in a practicum laboratory or other setting
  - Trainee demonstrates knowledge while providing covered services to an individual
  - Under the direct supervision of RN or LPN/LVN who is under the supervision of a RN

Subpart A - General Provisions

- Verbal order
  - Newly added
  - Physician order spoken to appropriate personnel and later put in writing for purposes of documenting as well as establishing or revising patient's plan of care
- Eliminated definitions
  - Bylaws
  - Supervision
  - Home health agency
  - Progress notes
  - Subunit

Other Definitions & Personnel Qualifications

- Moved to other areas
  - Personnel qualifications under § 484.4 moved to proposed § 484.80 Home health aide services and § 484.115 Personnel qualifications

Subpart B - Patient Care

- Release of Patient Identifiable OASIS Information
  - Same language, move from § 484.11 to § 484.40
- Reporting OASIS Information
  - Move from § 484.20 to § 484.45
  - Combines most of current requirements
  - Language reflects current technological terms

Patient Rights

- Patient Rights
  - Move from § 484.10 to § 484.50
  - Patient and representative (if any) rights in a language and manner the individual understands
  - Written notice of patient's rights and responsibilities must be understandable to persons with limited English proficiency and accessible to those with disabilities
    - Overview states alternate formats for persons with disabilities

Patient Rights

- Verbal notice of rights and responsibilities in individual's primary or preferred language, in manner patient understands
  - Free of charge
  - If necessary, use competent interpreter
  - Must be in advance of furnishing care to the patient during the initial evaluation visit

Patient Rights

Accessibility

- New standard for patients with limited English proficiency or disabilities
  - Provided information must be in plain language, accessible and timely in manner
  - Provide access through websites, auxiliary aids/services, oral interpreters, written translations, etc.

Patient Rights

- CMS expects agencies to develop a standard notice of rights for 484.50(a)
  - Signed notice documents compliance
  - Agencies accredited by a national accrediting organization will have notices which meet or exceed new requirements

Patient Rights

- Overview states representative could be family member or friend
  - Someone who helps the patient communicate, understand, remember and cope with interactions during the visit
  - Representative would not have to be legal representative
  - If patient unable to communicate directly and effectively with agency staff, agency may communicate with representative in the representative's primary or preferred language in a manner they can understand

Patient Rights

- Agency must provide notice of availability of assistance
  - Regardless of need for assistance or not
- Patient or representative may use interpreter of his or her own choice
  - Agency must ensure effective communication
- Document offer and refusal of professional interpreter in patient's clinical record

Patient Rights

- Provide contact information to patient and representative (if any)
  - Administrator's name
  - Business address and business phone
  - Purpose: complaint and specific patient rights violations; inquire about patient's care being provided

Patient Rights

- OASIS privacy notice
  - Provide copy to patient at same time as general patient rights
  - English and Spanish versions available at CMS website
- Patient or representative signature
  - Verifying receipt of copy of notice of rights and responsibilities

Patient Rights

- Exercise of Rights and Respect for Property and Person into two separate requirements
  - If patient adjudged incompetent by court, their rights may be exercised by court appointed person to act on the patient's behalf
  - If no court declaration, patient's representative may exercise patient's rights
  - If patient adjudged to lack legal capacity under state law by a court, patient is allowed to exercise own rights.

Patient Rights

- Patient rights reworded
  - Will need to revise Patient Rights statements
  - Includes "right to be free of free of verbal, mental, sexual, and physical abuse, including injuries of unknown source…"
  - Remember: written AND verbal notice in preferred language
  - Added requirement to list consumer protection agencies and their contact information

Patient Rights

- Copy of the Plan of Care and Updates
  - Patient would have right to a copy of his/her individualized plan of care to be kept in his his/her home
    - Anticipated risks and benefits
    - Factors that could impact treatment effectiveness
    - Changes in care to be furnished
    - Educate patient/family on how to store patient's plan of care in patient's home

Patient Rights

- Patient liability for Payment
  - Currently: notification of changes in liability as soon as possible and no later than 30 days of known changes
  - Proposed CoPs: "as soon as possible", "in advance of next home health visit"; no mention of 30 days

Patient Rights

- Admission, Transfer, & Discharge
  - Copies of agency policies for admission, transfer, and discharge prior to care being provided
    - Including listed criteria for transfer or discharge
    - Seven reasons listed in proposed regulations
    - Agency required to ensure safe and appropriate transfer when patient needs exceed agency's ability to provide service

Patient Rights

- Discharges due to disruptive, abusive, or uncooperative behavior of patient or others in the home to extent care of patient impaired or agency may not operate effectively
  - Specific steps must be followed prior to discharge
  - Overview warns agencies to take all reasonable steps to resolve safety and noncompliance issues prior to taking steps to discharge patient

Patient Rights

- Investigation of Complaints
  - Expands current complaint investigation
    - Less stringent than existing Texas rules regarding ANE
  - Agency requirement to:
    - Document existence and resolution of complaint
    - Take immediate action to prevent further potential abuse while investigation proceeding
    - Establish own policies and adhere to them

Patient Rights

Reporting Requirements

- Agency staff (employed directly or under arrangement) reports incidences of mistreatment, neglect, abuse and/or misappropriation of property
  - Noticed during normal course of providing care
  - Reported to agency administrator or other appropriate authorities (e.g., state and local law enforcement, health care ombudsmen, and State survey agencies)

Patient Rights

Home health hotline and resources

- Hotline information stays the same but moved to new standard
- Agency will advise of resources
  - Name, addresses, and telephone numbers of relevant Federally and State-funded consumer information, consumer protection, and advocacy agencies
    - Should select public service agencies that provide assistance free of charge

Patient Rights

Right to be free of discrimination

- No change in language but new regulation number

Patient Rights Compliance

- Policies updated with required information
- Evidence of written and verbal rights provided in language patient/representative understands
  - Suggestions: Patient Education booklet, signed consent with statement about rights, accessibility, etc.

Patient Rights Compliance

- Presence of copy of POC and any change orders
  - Ensure confidentiality of information in home
- Patient "reminder aids" regarding services (frequency, schedule of visits, complaint process)
  - Increased oversight to ensure patient aware of POC and changes
- POC individualized, outcome-oriented

Patient Rights Compliance

- Ensure all services on POC are received by patient
- Document patient/representative ability to understand
  - Cognitive ability
  - Native language
  - Educational level
- To ensure patient/representative understanding, review rights at each visit

Time Burden: Patient Rights

Regulation	Existing Agency Non-Accred	New Non-Accred	New Accred
484.50(a)	1 hours	8 hours	No added burden
484.50(e)	5 min	5 min	No added burden

Comprehensive Assessment of Patients

- Emphasis placed on patient participation in treatment process and establishment of patient-specific measureable outcomes/goals
- Majority remains unchanged
- Comprehensive assessment to include:
  - Current health, psychosocial, functional, and cognitive status
  - Strengths, goals, and care preferences including progress toward achievement of goals identified by patient and measureable outcomes identified by agency

Comprehensive Assessment of Patients

- Comprehensive assessment to include (cont):
  - Continuing need for home care
  - Medical, nursing, rehabilitative, social, and discharge planning needs
  - Review of all medications patient currently taking
  - Primary caregiver, if any, and other available supports
  - Patient's representative (if any)

Comprehensive Assessment of Patients

- Plan of care contents
  - Same requirements as before
  - Added language:
    - Patient-specific interventions and education
    - Measureable outcomes and goals identified by HHA and the patient
    - Information related to advance directives
- OASIS
  - ROC comprehensive assessment allowed to be performed on physician-ordered date (outside the current 48 hour requirement)

Comprehensive Assessment of Patients

- Key points:
  - Individualized patient care plans
  - Patient participation in care planning
  - Education and training to facilitate timely discharge
  - Examine your software's choices for interventions and goals—can they be customized for individualization?
  - Requirement for significant change in condition comprehensive assessment continues
  - Incorporation of an interdisciplinary team approach for services

Care Planning, Coordination of Services & Quality of Care

- Becomes § 484.60; replaces Coordination of patient services currently in § 484.18
- Patient is to receive copy of written POC
  - Includes any revisions
- Home care initiated after hospital discharge:
  - POC must include risk assessment description for ER visits as well as re-hospitalization
    - Risk: low, medium, high
  - Include all necessary interventions to address underlying risk factors

Care Planning, Coordination of Services & Quality of Care

Conformance with physician orders

- Verbal orders documented with signature, date and time

Review and revision of plan of care

- Prompt notification to physician of:
  - Changes in patient condition
  - Needs that suggest outcomes are not being achieved and/or that POC should be altered

Care Planning, Coordination of Services & Quality of Care

- Required notification to patient, representative (if any), caregivers and physician of updated plan of care due to significant change in health status
  - Also, revisions related to patient's discharge plan
- Communication with patient, representative, caregivers, physician and others who will continue to provide care after discharge from home health services

Care Planning, Coordination of Services & Quality of Care

Discharge or transfer summary

- Agency would prepare summary for each discharge or transfer
  - Already required
  - Mandatory requirement to send

Care Planning, Coordination of Services & Quality of Care

- Components of discharge or transfer summary
  - Summary of patient's care including reason for referral to home health
  - Clinical, mental, psychosocial, cognitive, function condition at time of start of care services and discharge by agency
  - Services provided
  - Start and end date of care by agency
  - Updated reconciled list of medications
  - Recommendations for ongoing care (e.g., outpatient PT)

Care Planning, Coordination of Services & Quality of Care

- Components of discharge or transfer summary (cont)
  - Patient's current plan of care including latest physician orders
  - Any other documentation to assist in post-discharge or transfer continuity of care
    - Any documentation requested by health care practitioner or facility responsible for providing care after discharge

Care Planning, Coordination of Services & Quality of Care

- Terms used frequently in proposed CoPs
  - Self-management
  - Patient-specific measureable outcomes and goals
  - Timely discharge from agency
- Emphasis placed on coordination of care for post-discharge from agency
  - Agencies responsible to assist patients in finding other providers to provide care after discharge

Survey Impact

- Emphasis on coordination of care of all services being provided
- Outcomes
  - Know your own outcomes
  - Surveyor examining as part of pre-survey preparation
- Written copies of plan of care and changes in patient's chart
  - Confidentiality of information
- Individualization of plan of care interventions and goals

Quality Assessment and Performance Improvement (QAPI)

- Replaces "Group of professionals" and "Evaluation of the agency's program"
  - Deletion of Professional Advisory Council (PAC) requirement
  - Deletion of their evaluation of the agency's program

Quality Assessment and Performance Improvement (QAPI)

- Agency's governing body ensures program reflects complexity of organization and all services provided
  - Focuses on indicators related to improved outcomes including hospital admissions and re-admissions
  - Agency's performance across spectrum of care including prevention and reduction of medical errors
- Program and process of QAPI documentation maintained

Quality Assessment and Performance Improvement (QAPI)

Five standards:

- Program scope
  - Must be capable of showing measureable improvement in indicators for which there is proof that indicators will improve health outcomes, patient safety, and quality of care
  - Agency measures, analyzes, and tracks quality indicators
  - Includes adverse patient events and other aspects of performance

Quality Assessment and Performance Improvement (QAPI)

- Program data
  - Quality indicators from OASIS and other relevant data
  - Use to monitor effectiveness and safety of services and quality of care
  - Identify opportunities for improvement
  - Frequency and detail of data collection determined by governing body

Quality Assessment and Performance Improvement (QAPI)

- Program activities
  - Focused on high risk, high volume, or problem-prone areas
  - Consider incidence, prevalence, and severity of problems
  - Immediate correction of identified problems (actual or potential) affecting health and safety of patients
  - Track adverse events, analyze causes, and implement preventative actions
  - Must take action and measure success and track performance to ensure improvements are sustained

Quality Assessment and Performance Improvement (QAPI)

- Performance improvement projects
  - Number and scope of projects conducted annually must reflect scope, complexity, and past performance of agency's services and operations
  - Must document QI projects undertaken, reasons for projects, and measureable progress achieved
- Executive responsibilities
  - Governing body responsible for program process and effectiveness
  - Findings of fraud or waste are appropriately addressed

Quality Assessment and Performance Improvement (QAPI)

- Program components synopsis:
  - Use of objective measures to demonstrate improved performance
  - Tracking of performance to assure improvements are sustained over time
  - Priority setting for performance improvement considering prevalence and severity of identified problems; must give priority to improvement activities that affect clinical outcomes
  - Participation in periodic, external quality improvement reporting requirements as may be specified by CMS

Quality Assessment and Performance Improvement (QAPI)

- Focus on proactive performance monitoring
- CMS estimates 4 hrs / year on policy writing

Sources of QAPI Data

- Home Health Compare
- Agency Patient-Related Characteristics Report
- Potentially Avoidable Events
- OBQI Outcome Report
- Complaint / Grievance Log
- Infection Log
- Last survey results (including complaint surveys)

Sources of QAPI Data

- Claim denials
- Incident / Risk Identification Reports
- OASIS Error Reports
- Clinical Record Review

Infection Prevention and Control

Three standards

- Prevention
  - Agency uses accepted standards of practice and use of standard precautions
- Control
  - Coordinated, agency-wide program for surveillance, identification, prevention, control, and investigation of infectious and communicable diseases
  - Must include method of identifying problems and appropriate actions to promote improvement and disease prevention
- Education
  - Infection control education provided to staff, patients, and caregivers

Infection Prevention and Control

- Expected to be integral part of QAPI program
- Current best practices education to staff, patient, and caregivers

Skilled Professional Services

- Consolidates “Skilled nursing”, “Therapy services”, and “Medical social services”
- Ongoing interdisciplinary team approach
- Development and evaluation of POC partnership with patient, representatives, and caregivers
- Shift of focus from administrative processes to outcomes of care

Home Health Aide Services

- Proposed to change to § 484.80
- Qualification requirements listed
- New skill requirement:
  - Recognizing and reporting changes to skin condition including pressure ulcers
- Required communication skills evaluation

Home Health Aide Services

- Only RN could deem home care aide tasks "satisfactory" for competency evaluation (can consult with other skilled professionals as appropriate)
- Twelve hours of annual in-service training supervised by RN
- Annual on-site visit to patient's home with each aide for observation and assessment of performance
- For non-skilled care, RN supervision at least every 60 days with aide present

Home Health Aide Services

- Focused supervisory visits (agency expected to develop method of documentation of sup visit)
  - Following plan of care
  - Completing tasks assigned
  - Communication with patient, representative, caregivers, and family
  - Demonstrated competence with assigned tasks
  - Compliance with infection prevention and control policies and procedures
  - Report of changes in patient condition
  - Honor of patient rights

Laboratory Services

- Prohibit agency from using own self-administered testing equipment in lieu of patient's self-administered equipment
  - Exception: patient's equipment believed to be inaccurate
    - Agency would assist patient to obtain accurate equipment
  - Exception: patient has not obtained equipment yet
    - Agency to assist patient to obtain equipment

Governing Body

- Expanded responsibilities to assume full legal authority and responsibility for:
  - Agency's overall management and operation
  - Provision of all home health services
  - Review of budget and operational plans
  - QAPI program
  - Fiscal operations

Clinical Manager

- New role
  - Qualified licensed physician or RN
  - Responsible for oversight of all personnel and all patient care services provided

Clinical Manager

- Oversight to include:
  - Making patient and personnel assignments
  - Coordinating patient care
  - Coordinating referrals
  - Assuring patient needs are continually assessed
  - Assuring development, implementation, and updates of individualized POC
  - Assuring development of personnel qualifications and policies

Clinical Records

- Added requirement:
  - Information in clinical record be accurate
  - Adhere to current clinical record documentation standards of practice
  - Be available to physician responsible for home health plan of care and appropriate agency staff
  - Contact information of physician and other health care professionals who will be responsible for patient's care after discharge

Clinical Records

- Patient's progress towards goals
- Discharge or transfer summary note sent to patient's primary care physician or other health care professional who will be responsible for care after discharge or transfer
  - Sent within 7 days after discharge or transfer
  - Sent within 2 days after discharge or transfer, if to a facility

Contents of Clinical Record

- Authentication
  - All entries legible, clear, complete, and appropriately authenticated, dated and timed
  - Includes signature and title (occupation) or a secure computer entry by a unique identifier, of a primary author who has reviewed and approved the entry

Retention of Records

- Simplified to 5 years after discharge of patient unless state law requires longer period

Retrieval of Clinical Records

- New standard
- Must be readily available to patient or appropriately authorized individual or entities upon request

Personnel Qualifications

- Reorganized
- Administrator requirements
  - Licensed physician, RN, or possess undergraduate degree
  - At least one year supervisory or administrative experience in home health care or related health care program
  - Governing body would determine what undergraduate degree would be required

When

- CMS required to finalize or scrap changes within 3 years
  - Experts predict 2016 for implementation
- Surveyors:
  - Require training
  - New forms / guidance

OTHER STUFF

To-Do List

- Education of staff
  - Improved documentation
  - Focus on measureable goals and outcomes
- Revision of policies

To-Do List

- Institute programs on re-hospitalization and ER visits
- Educate aides on recognition of skin integrity problems
- Strengthen coordination of care activities

Overall Cost

- CMS estimates cost to the industry will be:
  - > $148 million in the first year
  - Approximately $142 million in subsequent years
- Most expensive cost:
  - Requirement to verbally inform patients and their representatives of patient rights in a language and manner the individual understands
  - Requirement to provide language assistance services or auxiliary aids at the agency's expense

Overall Cost

- Other costs:
  - Investigation of all patient and family member complaints
    - Estimated cost: approximately $10,000/year

Conclusion

- Rest up…it's going to be a lot of work
- Prepare your staff
- Do what you can now…less to do later…
- Watch and wait

Comments & Questions?

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