

**Managing in the
Complex
World of Homecare**

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**How do you know what you
don't know?!**

This class will focus on the regulatory and operational requirements for homecare agencies.

In this age of homecare, these are cumbersome and complex, and require the manager to be well versed, organized and able to prioritize.

OBJECTIVES

Understand the key regulatory and operational requirements that need to be met in a Homecare Agency.

Review of what various regulatory agencies require

Discuss difference between minimum and best practice standards to comply

Help new and old agency managers understand regulations

Suggestions on how to meet the overall picture.

Some managers of small agency have to do it "all"

What is the minimum you need to do to run a good quality agency.

Focus on what a manager must do to remain in continued survey readiness, while still being cost effective.

Identify various tasks that will be on the calendar for homecare agencies and how to comply.

And talk about all of the regulatory bodies and how to stay on track!

PPS OASIS COPs
State CAHABA RACs CAHPs

Spend Productive work days reaching GOALS, rather than continually putting out fires.

Prioritize activities to relieve stress

Avoid Crises

Delegate

Be Goal Driven Rather than Task Oriented

Hold staff accountable

Is your finger on the pulse?

- Many managers manage in the dark
- They don't really know how their agency is doing
- They gauge a week by saying "We are all really busy", and think that means it's a good week or bad week.
- DO you have key indicators, benchmarks to help you stay on track?

So to get started!

Back to the original question:

HOW DO YOU KNOW
WHAT YOU DON'T KNOW?!

This is what gets homecare managers in
BIG TROUBLE!

What can you read to find out?

Must reads:

- COPS
- State Regulations
- FI- CAHABA Guide to Billing
- Accrediting standards, if applicable

**Conditions of Participation
COPs**

- Dead give away is if a manager says, "What are COPs?"
- How can you know the rules if you don't read them and understand them?
- Means that to be Medicare Certified you must be in compliance with these Conditions to Participate in the program

**Conditions of Participation
COPs**

- Each Condition has standards associated with it
 - My philosophy:
- Don't worry too much about standard level deficiencies, **BUT NEVER GET A CONDITION LEVEL DEFICIENCY!**

**Conditions of Participation
COPs**

- What is the difference between a condition out and a deficiency?
- A deficiency means you were not compliant with one of the standards under a condition
 - You must then write a plan of correction
 - You will have a follow up state survey to check the compliance and completion of the action plan
 - Follow up depends on your state or accrediting body and the scope and severity of the deficiency

**Conditions of Participation
COPs**

- A Condition Out means you either are non compliant with the entire condition OR you were non compliant with several of the standards associated with it.
- When you get a condition out, the state or accrediting body notifies Medicare that you have a condition level deficiency
- You are at risk of losing your Medicare Certification if you do not correct quickly

**Conditions of Participation
COPs**

- You will do a plan of correction that must be approved
- The state or accrediting body will return in 45 days from the last day of your survey (in most cases)
- You must have improved greatly in this survey or your Medicare Certification can be terminated

**Conditions of Participation
COPs**

- What is the difference between a Condition and a Deficiency?
 - Example:
- Agency does not keep any patient's signed consents in the clinical record –
CONDITION OUT in Pt Rights
- On 1 Home Visit, there is no copy of the signed consent in the home folder-
Deficiency in Pt Rights

Conditions of Participation COPs

- Challenge is that the COPs won't say that specifically
- BUT, it does say that the pt must be informed in writing of their rights
- How do you know what you don't know?
- If you haven't been told, you may not know that a copy of the signed consent has to be in the home folder!

Conditions of Participation COPs

- Some are prescriptive, such as, must do a home health aide supervisory visit no less than every two weeks.
- But many are not prescriptive – they tell you what must be achieved, but do not tell you specifically how to do it.
- Example: does not say you have to use a 485 for the Plan of Care.....

State Regulations

- Kansas does have specific homecare regulations and a state license
 - READ THESE AND KNOW THESE!
- Many times I hear agencies say they don't understand why they got deficiencies or where did this come from and I find out that they have not read the COPs and State Regulations!

Accrediting Body Standards

- Again, accredited agencies that I survey, often do not know the standards!!! READ THEM!
- Main categories that are elevated from state and Medicare regulations:
 - Policies, Inservices, Competencies, Performance / Quality Improvement

CAHABA Guide To Billing

- CAHABA is the FI (Fiscal Intermediary) for most of the Midwest region.
- This will change soon as CAHABA has lost its Medicare Contract
 - ALL FI's have a Guide to Billing
 - This is Very helpful as it goes over Coverage requirements for homebound, skilled need – gives good examples

CAHABA Guide To Billing

- Most Managers do not know about this or they do not read it
- THIS will definitely help you to know what you don't know!

Homebound

Documentation should include:

- Considerable and taxing effort for the patient to leave the home.
- Brief and infrequent absences are acceptable.
- Leaving home for medical treatment is okay.

Skilled Need

- Skilled service requirement
- Medically reasonable and necessary
- How to determine a skilled need:
What are the patient's medical problems?
What are my interventions?
What are the goals?

Skilled Need

Teaching is a skilled need if:

- Initial teaching is done on a brand new order, medication, diagnosis, etc.
- Reinforcement of teaching for something that the patient may know but needs additional instruction.
- Re-teaching – patient has already received prior instruction.

Skilled Need

- Acceptable to do teaching for patient **and** caregiver.
- Must coordinate care with other clinicians so that the teaching plan is appropriate for the patient.
- Often see that the same medication is taught on several visits by several different nurses, as an example.

Skilled Need

- Injections – if it is considered a “self administered” medication, document objectively why patient is unable to administer (hand tremors, impaired cognitive function) and if there is no willing/able caregiver to do so. If oral is available, specify why injection is needed.
- Venipuncture is not a skilled need – many times I see that clearly the patient is being seen for blood draws, as there is no other intervention and skilled need documented.

Skilled Need

Psychiatric nursing can still be a skilled need. Homebound criteria can be a refusal to leave home, a disease process which prevents it, or the patient is unsafe leaving the home due to severe behavior issues.

Psych nursing can provide: evaluation of patient status, teaching of disease process and medications, psychotherapy and other skilled service. Must have a psych nurse to do the psychotherapy.

Ongoing skilled nurse vulnerabilities

When observation and assessment has been the qualifying skill for more than one 60 day episode, with a *chronic* primary diagnosis, such as:

Debility, CHF, CVA, COPD, diabetes, long term use of medications, schizophrenia, Parkinson's and Alzheimers

Document why the nurse is still needed!

Ongoing skilled nurse vulnerabilities

Document why the nurse is still needed:

Is it a procedure that requires the skills of a nurse
Example: catheter changes, complex wound

Support medical necessity of skills needed

Why injections

Document clearly why continued need for observation and assessment

Significant condition or treatment changes

Observation and Assessment

- Is there a significant change in treatment and/or condition?
- Is there teaching and/or training?
- Is this new for a patient? (EX: patient with DM for 10 years, and he is being taught diet and signs and symptoms of disease....why?)
- Why is teaching needed?

Examples

NO!!!

Not clearly supporting skilled nurse:

- OASIS completed with no additional assessment
- OASIS and general head-to-toe assessment without mention of change in condition
- OASIS and general teaching on previous meds

Examples

YES!!!

Clearly supporting skilled nurse visit:

- OASIS and head-to-toe assessment with documentation of significant changes in the condition and treatment of the patient
- OASIS completed and documentation of skilled nurse teaching wound care to family
- OASIS completed and documentation coordination with physician for further changes to treatment

Under the care of a Physician

Cannot be a Nurse Practitioner or Physician's Assistant

On referral, use caution if hospitalist or resident as MD. They often do not follow the patient when discharged, and will not sign 485

ADRs (Additional Development Requests)

CMS pays us and contracts with the FI's to **police** us to be following all of the above standards. They pay us without reviewing charts. SO....they ask for ADR's which means we have to send a chart in for their review.

FI reviews for Medical Necessity (skilled need) and homebound status.

EX: If they see that 5 notes in a row have the same documentation, and no progress, no new orders, no interventions, they will deny those visits.

ADRs

Some of the reasons targeted for ADR's that resulted in denials:

Primary Diagnosis with Diabetes, with a secondary of CHF (should CHF have been primary)

5 visits with 1 MSW visit (to see if it should be downcoded to a LUPA)

Primary diagnosis of long term anticoagulant (V58.61) – (is there really a skilled need or is it just for venipuncture of protimes)

ADRs

Top 5 denial reasons in 2008:

- Downcode due to incorrect primary diagnosis
- Therapy visits not medically necessary so not allowed. Downcode or denial
- Medical necessity not supported in the record. Downcode
- Skilled observation – initial approval, but then stable. Downcode or denial
- ADR information not received

ADRs

ADRs only come on the FISS system.

Must check weekly for ADRs.

A major reason for Denials in 2008 was that ADRs were not received!!!

And be sure to review your records prior to sending in. That way you will see if you are missing any documentation that can be entered. The chances of being able to "fix" or "find" any documentation is slim, as ADR's are typically over a year old.

FI's: "What do We Look For?"

- Review for technical component and eligibility
- Certification, orders, homebound and intermittent
- Homebound denials seen in claims where functional domain of OASIS shows patient is independent.
- They look for objective terms, such "a taxing effort", and match with functional questions on OASIS, such as SOB, pain, balance, and IADLs.
- When patient does occasionally go on outings, must document that it was a taxing effort. There are a high number of claims denied for not homebound – 74%!

OASIS Inconsistencies

Shows that there is not coordination of care, or that OASIS is not being answered correctly, or that scores are changed in office, etc:

Examples:

Short of breath < 20 ft; then PT states patient is able to ambulate 200 feet without any difficulty

Chairfast, unable to ambulate, then HHA notes state the patient walks to the bathroom with assistance that same day

OASIS

- The comprehensive assessment documentation and OASIS scores must paint a **TRUE** picture of your patient
- CMS “sees” the patient through these scores
- Be thorough, specific and accurate to secure appropriate episode payment
- Do the Comprehensive Assessment in the most accurate fashion!

Clinical Record Reviews

Real-life examples:

- PT primary with SN in on patient – should have nursing/ medical diagnosis and therapy diagnosis
- Abundance of gait abnormality as primary
- Diabetic uncontrolled when there is nothing to support this in the orders or the documentation
- Diabetic manifestations with nothing in orders or documentation to support this

Clinical Record Reviews

Real-life examples:

- Several therapy visits that indicates that the patient walked 200 ft x 2, with no other progress made, this will be downcoded or may even be denied
- Independent marked on ADLs, IADLs on therapy notes
- If the primary diagnosis is DM uncontrolled, and the patients BS is 120 and there are no new orders, the episode will be denied! If DM is controlled , but there is no documentation to support DM plan of care changes, teaching , etc, could be downcoded or denied

SO.....How do you stay compliant with all of these areas????

- Use your PI program to help you!
 - Choose activities to monitor that will focus on areas of compliance
 - Focus activities to ensure that you have no vulnerabilities to getting a condition out!
 - Do chart audits with not only compliance in mind, but also to prevent ADRs and ADR denials

SO.....How do you stay compliant with all of these areas????

- Do an assessment of your agency – MOCK SURVEY.
 - Be Objective !
 - Do just like a surveyor would! Use the COPs, State regs and Accrediting Standards
 - Do quarterly
 - Do an Action Plan and involve all of your staff
 - TEACH the regs to all of your staff to get buy in!

Use Key Indicators to keep your Finger on the Pulse!

- Productivity
- Case Mix Index
- Payor Mix
- Cost per Visit
- Budget and P&L Variances
- PPS Statistics – such as LUPAs

Use Key Indicators to keep your Finger on the Pulse!

- Referral Patterns
- Admissions
- Customer Satisfaction
- Outcomes - OBQI
- Clinical Audits
- Turnover

Productivity

- Biggest cost in homecare is Labor = Salaries= Productivity
- Should be measuring even if per visit
- Essential if hourly or salaried
- Also look at overtime
- Have guidelines that are expectations for staff to follow – ex: 1 “15” for routine visits to include travel (15), Doc (15), pt time (30-45)

Productivity

- Measure volume as well
- Or else a emp can do the required number of visits, but in an excessive amt of time
- Ex: 25 visits in 50 hours = 10 hours of overtime and poor productivity

Case Mix

- If yours is under 1, you are probably not making any profit
- Case Mix is based on Your Agency CM1.
- National Base Rate, then adjusted for your area is a Case Mix of 1 (approx \$2200)
- EX: OASIS scores equaling a CFS, turned into an HHRG, turned into a HIPPS code of higher than your base rate, will be higher than 2200 and higher than cm1

Case Mix

- Know it per patient and overall
- Episode Management to be sure are monitoring the Case Mix, the projected visits, the OASIS comprehensive assessment scoring and the Diagnoses and sequencing.

Episode Management

Total hip replacement
Primary dx: Aft joint replacement with MO246 as OA pelvis
Secondary dx: joint replaced hip, gait abnormality
MO420 – pain – daily (2)
Surgical wound at early partial granulation
No incontinence or dyspnea on exertion
Dressing upper body - if laid out or handed to patient
Dressing lower body - requires assistance
Bathing - unable to get in tub and bathed in chair
Toileting – independent
Transfers with assistance
Ambulates with device

Episode Management

- Clinical points - 1
- Functional points - 6
- Service - 12 (therapy planned)
- NRS - 4

Disciplines – frequency and duration:

SN: 2W1, 1W2, = 4 visits x \$130/visit = \$520.00

PT: 3W1, 2W4, 1W1 = 12 visits x \$130/visit = \$1,560.00

Episode Management

Cost = \$2,080.00

Revenue = \$3,282.58

Profit = \$1,202.58

Episode Management

Insulin dependent diabetic , CAD, htn

Primary dx: Diabetic with periph circ disorders
250.70

Secondary dx: Angiopathy in diabetes - 443.81, CAD -
414.01,
Htn-401.9

Mo 420 - pain - less often than daily

No decubs, stasis ulcers or surgical wounds

Mo 490 - dyspneic when walking more than 20 ft or
climbing stairs

Ambulates with assistive device

Episode Management

- Clinical points -9
- Functional points - 6
- Service - 0
- Supplies – 0

- C3F2S1 1CGKS

Episode Management

Disciplines – frequency and duration:
SN: 2W1, 1W8 = 10 visits x \$130/visit = \$1,300.00
HHA: 2W9 = 18 visits x \$50/visit = \$900.00

Cost = \$2,200.00

Revenue = \$2,091.81

Loss = <\$108.19>

Episode Management

Primary dx: CHF 428.0

Secondary - CAD 414.01, COPD,
COMPENSATED 496,
difficulty walking 719.7

Requires assist to dress upper and lower body
Requires someone present at all times while bathing
Pain - Less often than daily
Dyspneic with moderate exertion
Ambulates only with assist
Incontinent of urine during day and night

Episode Management

- Clinical points - 9
- Functional points - 8
- Service - 8 (therapy planned)
- Supplies - 0
- C2F3S3 1BHMS

Disciplines – frequency and duration:
SN: 2W1, 1W8 = 10 visits x \$130/visit = \$1,300
PT: 2W2 = 4 visits x \$130/visit = \$520
OT: 2W2 = 4 visits x \$130/visit = \$520
HHA: 2W9 = 18 visits x \$50 = \$900

Episode Management

Cost = \$3,240.00

Revenue = \$2,917.76

Loss = <\$322.24>

Episode Management

- You can see that if you are not proactive in episode management, you could be losing money and not know it.
- Review on admit and recert
- May not change at all, but are aware
- May see that dx or sequencing is incorrect after all disciplines are in
- Or may see that projected visits are too many

Episode Management

**KEEPS YOUR FINGER
ON THE PULSE!!!!**

Reporting Areas

How do you know what you don't know??

- Managers often are late on critical areas because they did not hand something into the government in a timely manner
- Do not put mail aside! I have seen that happen many times!
- Do a calendar with due dates on regular timepoints

Reporting Areas

- OASIS – submission to state
- CAHABA- credit reports, cost reports
- CMS- 855
- State- Annual State Report
- OSHA – Emp injury reports
- FDA- if equipment failure, Medical Device Act
- CDC, County Public Health- Communicable Disease

Spend Productive work days reaching GOALS, rather than continually putting out fires.

- Prioritize activities
- Delegate when possible and appropriate
- Be Goal Driven Rather than Task Oriented
- Hold staff accountable

Holding Staff Accountable

- Weak area for most Front Line Managers
- Once Expectation is clearly communicated, Manager Must hold the employee accountable
- Identify reason for lack of accountability:
 - More education needed
 - Did not understand Expectation
 - Is not willing or able to comply

Coaching and Counseling

- Follow up with employee in REAL TIME
- Do not wait for annual evaluation or termination!
- Have an Objective, Written Plan prepared
- Clearly explain expectation not met
 - Stick to the subject
 - Give specific examples
 - Share benchmark results of dept
- Ask employee for explanation

Coaching and Counseling

- Actively Listen
- Assure that employee stays on track
- If employee is defensive, do not become defensive – stay calm, remain firm but compassionate
- Offer further education
- Ask employee for solution
- Develop Action Plan with employee with timeline
- Set follow up meeting

Reward and Recognition

- Don't ignore the good staff and just focus on the squeaky wheels!
- Set up Regular Rewards and Recognition activities
- This means more to staff morale than increase in pay
- Homecare is tough! Lots of paperwork, travel, high acuity patients, must hustle....so Reward!

In Closing

- Keep on Top of the Industry
- YOU WILL find out What you Don't Know BY:
- Joining Listserves – KHCA, NAHC, Publication Listserves, and others- Great to hear people ask the questions that you don't know about!
- Get on CAHABA and CMS online email lists
- Go onto CMS open door forums
- Get 1-2 homecare publications

In Closing

- Homecare is a Complex industry and getting more complex by the day
- Reimbursement *is* Rocket Science
- Regulations *are* more difficult than any other area of healthcare
- Surveys *are* frequent
- *Many* regulatory bodies
- *Many* deadlines

In Closing

- SO.....
- Read the regs

- Keep your finger on the pulse of your agency
 - Episode management
 - Continued survey readiness
 - PI

In Closing

- Read the List Serves

- Read Homecare Publications

- Ask what you don't know!!!


