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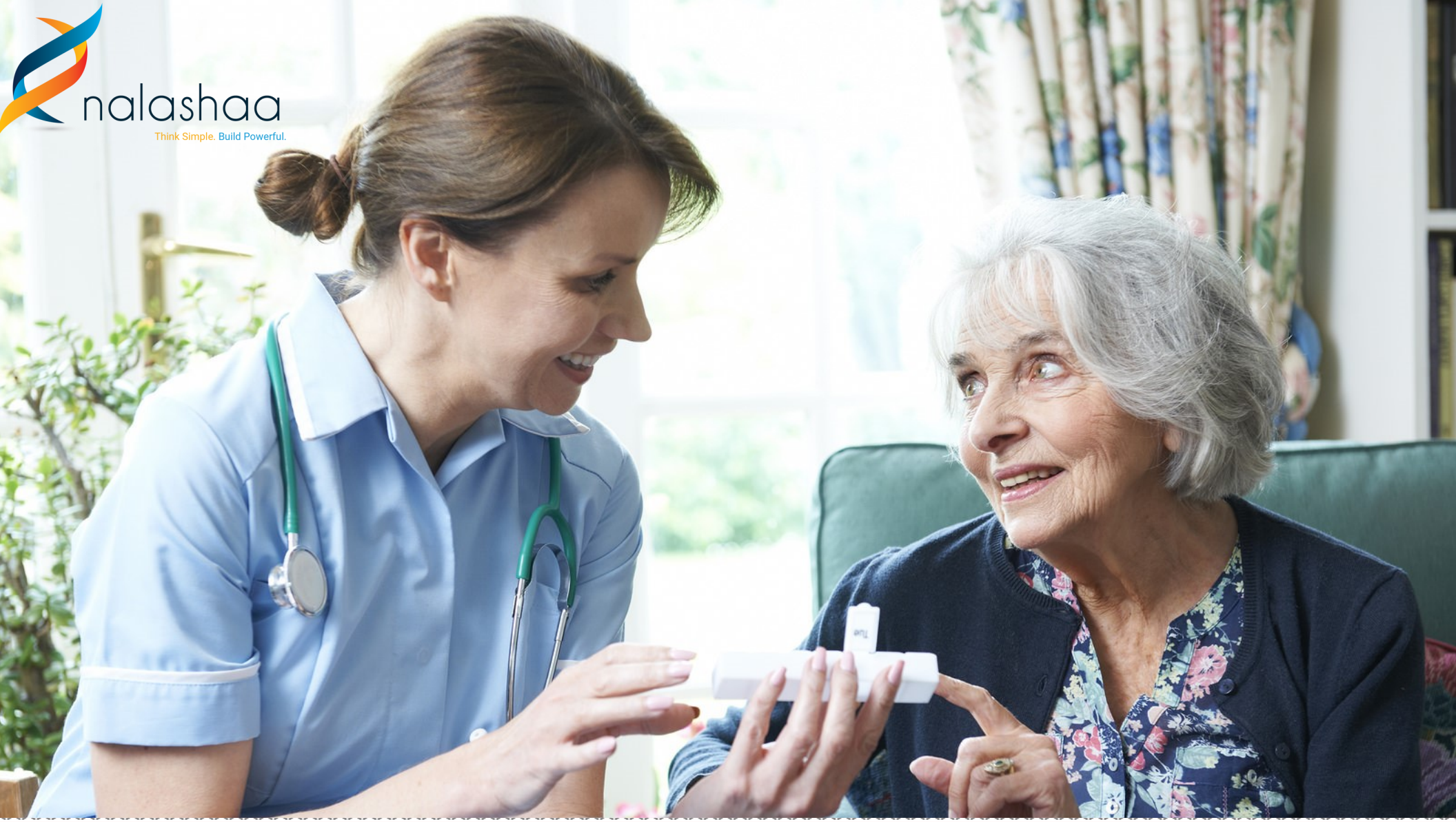

CMS Compliance Handbook for Home Health Agencies

Overview

Home Health Agency (HHA) is a key player in effective care delivery of patients with chronic conditions. The new home health **Conditions of Participation (CoPs)** finalized in January 2017 centers on how HHAs qualify to participate in Medicare and Medicaid by restructuring the requirements. The conditions emphasize on the care coordination, patient rights by following a structured approach.

The new rule takes effect July 13, 2017 with a proposed delay to January 13, 2018.

This gives agencies only a few months from today to implement changes to their policies, procedures and practices necessary to comply with the revisions.

CoPs focuses on organizational structure, patient-centered care, and oversight of staff to ensure patients are safely and effectively receiving services. This completes the efficient care delivery cycle from self-assessment of the Home Health Agencies (HHA) to quality of care delivered.

CoPs – a patient centered, data-driven, outcome oriented process that promotes high quality patient care at all times through efficient and lower-cost care!

HHAs must meet the Medicare HH CoPs in order to participate in the Medicare program. Agencies that fail to meet any of the HH CoPs are at risk, at a minimum, for the imposition of a number of sanctions and potentially at risk for program termination.

This presents an opportunity for EHR vendors to support their providers by easing the HHA workflow through incorporation of integrated communication system for efficient care coordination.

Spur of Changes

CMS has used the following guidelines to assist in development of the new HHA CoPs:

- Develop continuous, integrated care process across home health services
- Use a patient-centered, interdisciplinary approach that recognizes the contributions of various skilled professionals and their interactions to meet patient needs
- Stress quality improvements by incorporating an outcome-oriented, data-driven, quality assessment and performance improvement program specific to each HHA
- Eliminate the focus on administrative process requirements that lack adequate consensus or evidence of being indicative of achieving clinical outcomes or preventing harmful outcomes for patients
- Safeguard patient rights along with HHAs flexible approach to care delivery. The new requirements improve performance results for HHAs, helping them achieve desired outcomes for patients, and increasing patient satisfaction.

Impact on EHR Vendors

While the rule changes at an administrative level, it also brings a major change in the way HHAs need to handle the changes from a clinical standpoint. It is important that each set of CoP is tailored to specific statutory requirements and the EHRs are aligned with them. This ensures HHAs' efficiency and the flow is tailored to meet the agency data storage requirements.

OASIS

HHAs report to OASIS C2 starting Jan 1, 2017.

This is achieved using a direct telephone connection from HHA to the state agency or CMS OASIS contractor. However, with the new proposed rule, CMS added a requirement that the OASIS data can only be transmitted using electronic communications software that complies with the Federal Information Processing Standard (FIPS). To adhere to FIPS, an EHR should ensure *security and interoperability* for data exchange via a secured hashing algorithm.

HHAs can report process and outcome based measures for reporting OASIS. Dashboards indicating performance on each measure, highlighting occasions where the measures are not met and prompting interventions for them within workflows will better scores and ensure consistency.

Patient rights

Patient Rights are extensively modified and now divided into six separate standards:

1. Notice of Rights

HHAs must provide the patients and their legal representative, the following information at the initial evaluation visit, before providing care to the patient.

- written notice of the patient's rights and responsibilities and the HHA's transfer and discharge policies
- HHA administrator contact details
- OASIS privacy notice

EHRs must have the capability for *document management* so every HHA can create a template of the patient rights. This document has to be handed over during the initial visit, reviewed and signed prior to care. And, the EHR must track this step.

Additionally, the requirement also states that the patient or legal representative has the right to be informed of the patient's rights in a language and manner the individual understands; this requires multi-lingual support. These documents need to be signed by the patient or legal representative to represent acceptance.

HHAs also need to document patient decisions regarding the representative's role (if any) in a clear manner ensuring HHA staff complies with the patient's decision. The workflows now need to honor and validate

patient choices made, and these workflow changes made well in time, can help avoid regulatory lapses.

2. Exercise of Rights

This CoP eliminates the term incompetent and asks whether the patient "has been adjudged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction."

The HHA should review a copy of the court order, to verify authority of the legal representative and to determine to what extent the patient may exercise their rights. The information should be documented in the EHR for future reference.

3. Rights of the patient

One of the biggest changes to the CoPs is the addition of a patient bill of rights that must be clear and accessible to patients and staff. A detailed list of Patients Rights can be found here.

There are several new capabilities mandated to be added in the EHR like plan of care documentation, clinical records, etc. For all these changes, the main area that EHRs would focus on will be the *dynamic document templates*. This will allow for the care plan, progress, evaluation and health status outcomes to be tracked and a copy can be sent to the patient and physician.

4. Transfer and Discharge

HHAs can transfer or discharge a patient under following circumstances:

- necessary for the welfare of the patient
- Patient/payer will no longer pay for care
- the physician and HHA agree that the patient has achieved the measurable outcomes/goals stated in the plan of care
- the patient refuses services
- HHA determines, pursuant to a written policy, that the patient must be discharged for-cause
  - the patient dies
  - the HHA closes

The key consideration here is the requirement that discharges for-cause are handled pursuant to a written policy. Even though HHAs may well have number of policies on anti-discrimination; they need to be sure that they are able to pull these sources together from the EHR system. *Extensive tracking of every visit*, allows HHAs to see a summary report collating data from necessary segments from the EHR. Patients should be aware of the situation especially in cases where the patient denies services. Here the HHAs can attempt to resolve the concern using the summary document, identifying problems and giving a suitable solution.

A discharge or transfer summary should be sent to the patient's PCP or care team within 7 calendar days of discharge or if the patient is discharged to a facility for further care, to the receiving facility within 3 calendar days of discharge/ transfer.

5. Investigation of Complaints

CoP requires an HHA to *accept a complaint from the patient, patient representative or patient caregivers and family and track it within the EHR*. The entry will include the complainant, the complaint and date and time when the complaint was filed. Though every HHA will have their own way to tackle the complaints, they should be able to store the details of the resolutions to the incidences along with circumstances of complaint,

such as mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property. HHAs should be able to configure the possible resolutions or steps to perform based on the type of complaint, and this can be auto triggered by the system in similar future cases. This ensures flexibility to meet various levels of incidents and respond appropriately.

6. Accessibility

Information should be accessible to patients easily and in simple terms where their rights are clearly explained. Translations and oral interpreters are also mandated for those with limited English proficiency. *Patient Education resources* are a vital component for care coordination, to be accessible via websites or other auxiliary aids, during the duration of care.

Comprehensive assessment

A patient-specific comprehensive assessment needs to be conducted by HHA, documented and updated within five calendar days after the commencement of care. EHRs need to check patient eligibility for Medicare home health benefit, including patient's homebound status at the specified time. This would be linked to billing, and help in automation.

A comprehensive assessment accurately reflects patient status, by allowing clinicians assess and identify relevant information from the EHR.

Clinical examination will include:

Current health status, concern, psychosocial, functional and cognitive status

This can be achieved through a questionnaire asked to the patient and documented within the system. Example for patients with arthritis, functional status can capture if there is any dependency on cane. Similarly all other elements related to complete health status can be evaluated and documented using LOINC coding standards.

Patient's strengths, goals, care preferences, and progress

towards achievement of goals identified through measurable outcomes identified by the HHA. This can be tied to QAPI requirements using the initial set of OASIS data where outcomes can be measured.

Patient's continued need for home care

This will help in assessing the goal and the target areas the HHA needs to focus on.

Patient's medical, nursing, rehabilitative, and social and discharge planning needs

Needs captured to ensure all the equired items' are available for medical and nursing needs. Discharge needs to be documented to ensure a smooth transition from hospital to home.

Medication

Review of current medications to avoid medication refill earlier than expected.

Identification of Patient's primary caregiver (s)

if any, and other required support, including caregiver willingness and ability to provide care, their availability and schedule. The caregiver needs to be informed of the goals and the complete plan including current health status. The caregiver can then perform the health status evaluation on transition and outcomes.

Patient's representative

In case there are patient representatives, they need to be informed about the flow of care and the improvement milestones based on the goals set.

Care Plan Coordination & Quality

HHA must provide the patient with an individualized plan of care to meet patient specific needs identified in the assessment and any anticipative outcomes. The plan of care must also specify the patient and caregiver specific education and training needs.

Simplify processes by generating care plans within the EHR.

Plan of Care document

Drug information: Complete information of prescribed medications, dosage and timing

Services: While many EHRs still lack the capability to identify and track problems, goals, evaluations & interventions for the patient even as unstructured data, it can be achieved through a structured Care Plan document template type for HL7 C-CDA version 2.1

Treatment ordered by any physician: Goals and treatment reviewed by physicians are mandatory helping nurses give efficient care.

All interventions, including medication administration, treatments, services, and responses to those interventions, can be time stamped in accordance with the requirements. Clinicians can track the goals , contact information for the patient, representative (s), PCPs or other health care professional responsible for care and post-discharge services in the patient's plan of care.

Nurses can also receive verbal orders from a physician and they need to document it in the clinical record with date and time along with authentication.

Authentication may include an electronic signature and medical title using a secured computer utilizing a unique identifier; possibly a logged-in user authentication.

Another requirement is logging the time of the event, which not necessarily means the time when the documentation was entered into the record. These orders help to address concerns quick, but should also be authenticated in accordance with applicable state laws and regulations, as well as the HHA's internal policies.

Requisite EHR capabilities:

1. **Scheduler:** For timely reminders review and revise the plan of care.
2. **Document Templates**: There is a new requirement for "written information to the patient" which states that a written copy of the plan of care should be provided to the patient. So the document template should be built in a way that physician would enter the data only once but the documents will be generated for care giver and/or for patient containing the relevant information. Care-givers can respond to the physician on the care plan and any updates should be incorporated within the system for efficient tracking.
3. **Notification**: A notification feature for an HHA to notify the patient, representative

(if any), caregivers and the physician who is responsible for the HHA plan of care when the individualized plan of care is updated due to a change in the patient's health status or when patient's discharge plans are changed.

4. **Interoperability**: EHRs can follow a C-CDA standard for Care Plan for smooth delivery and easy care coordination between the physician and the HHA. This will satisfy the requirement that demand HHAs to ensure communication across all clinician involved and integrate orders from all clinicians involved in the care planning to ensure coordination of all interventions.
5. **Educational resources:** EHR should have the capability to send education and training resources for the patient and caregiver regarding care and services identified in the care plan. This would include written instructions outlining medications, visit schedule and any other pertinent details about patient's care and treatments.

* **Simplify care plans by generating it within the EHR and meet patient specific needs effectively.**
* **Verbal orders received also need to be documented, which required authenticating procedures in place.**
* **Automating processes in the EHR helps in coordination and delivers greater interoperability to systems.**

EHR Clinical Recording Capabilities

Current comprehensive assessment including all assessments from the most recent home health admission, clinical visit notes, and individualized plans of care needs to be properly tracked. The most recent assessment needs to be tracked separately, capable for filtering and quick views, when surveyors conduct HHA surveys. One of the requirement states entries in the clinical record must be **legible, clear, complete,** appropriately authenticated and timestamped, which is best achieved with a digital medium.

Retention of Records

The clinical records must be retained for at least 5 years unless state law requires a longer retention time. HHAs must have a policy for retaining clinical records if it discontinues operation and must inform the state agency where they will be stored. HHAs should be aware that five-years is the CMS requirement, but there might be other record retention requirements under federal and state regulations.

Protection of Records

Clinical records must be safeguarded from the loss or unauthorized use. HHA must also comply with HIPAA. EHRs can achieve this partially by implementing a feature to **automatically log off from the system** after a specified period of inactivity.

Retrieval of clinical records

Patient's clinical records; whether hard copy or electronic should be made readily available to a patient or appropriately authorized individuals or entities upon request (PHI compliant) and free of charge. EHRs can use the **document template feature** to **print** the clinical information. Some EHRs enable this via the patient portal to make clinical information, prescription data & refills and education materials accessible to the patients. **The clinical record needs to be made available to the patient at the next home visit or within four business days, whichever comes first.**

Refine Plan of care

HHA must promptly alert the physician issuing orders for the HHA plan of care of any changes in the patient's condition or needs that suggest that outcomes were not being achieved and/or that the plan of care should be altered. To ensure this across settings, the EHRs will need to support transition of care using interoperability for smoother exchange of data.

Quality Assessment & Performance Improvement

The new rule replaces two old CoPs (Group of Professional Personnel and Evaluation of the Agency's Program) with a single new CoP: **Quality Assessment and Performance Improvement (QAPI).**

QAPI is an effort by CMS to reduce medical errors and improve the quality of care in all settings, and this is a mandate for all HHAs. This CoP will go into effect in 2018 for HHAs who don't have QAPI in place already.

Building blocks of QAPI

Design and Scope
Plan should be comprehensive and must include all care and services HHA provides, balancing safety and quality of care with resident choice and autonomy

Feedback, Data systems and Monitoring
Emphasizes the establishment of systems for proactively identifying and using data to measure performance and identify opportunities for improvement.

Performance Improvement Projects (PIP)
Opportunities for improvement found across, are prioritized and incorporated into performance improvement projects.

Systematic Analysis and Systemic Action
Using a systematic, formal process for analysis, such as Root Cause Analysis; and then, ensuring that actions taken address changes or improvements to the system.

Governance and leadership
Address expectation that executive leadership must be actively engaged in QAPI

EHR Impact

The data-driven QAPI provision requires HHAs to show more data collection and performance projects with opportunities to demonstrate improvement. And this time it needs to be individualized for HHAs. This forces EHR to focus on *indicators for improved outcomes,* including use of emergency services, hospital admissions and readmissions. To demonstrate the quality indicators, EHRs will have to bind the objective data from the OASIS data set and other sources available. Reporting these quality indicators using reports show individual HHA addressing the specific areas of concern or weakness within HHA.

EHRs would now need to gear up and ensure the QAPI program is focused on all the HHAs areas.

So if EHR focuses on infection control, but HHAs area of concern is Occupational Therapy (OT) achieving desired outcome, the parent QAPI would not suffice. HHA would need to have its own QAPI on OT in place in addition to the parent's program. This implies EHRs will need to be built to support all the areas of HHAs be it infection control or OT.

EHRs must measure, analyze and track the quality indicators. The Program Data standard clearly mentions that QAPI program must utilize quality indicator data, including measures derived from OASIS. To do so, EHR will need to club objective data from the OASIS data set and other sources, track the improvement using the dashboards showing actual care outcomes, processes of care, patient satisfaction levels and quality indicators.

Infection Control & Prevention

A new CoP is added to provide greater focus on infection control processes and improvements. HHAs must follow accepted standards of practice, include infection control and prevention efforts in its QAPI and ensure all patients, staff and caregivers are educated about it. EHRs can add this as a first step when a new patient's care is about to get started, a new staff or a caregiver joins the care team or when a new disease outbreak happens.

Additionally there should be a checklist for HHAs to ensure they are educated at regular intervals. The document template feature within the EHR will help send emergency notifications to care givers and patients about identifying infectious and communicable diseases and a plan for appropriate actions.

This communication can be sent via documents, in-person or video demonstrations that can be shared, implying support of sharing videos will be an add-on feature by EHRs.

EHR components for QAPI

3 major EHR components to implement QAPI

Data Checklist

Using data to not only identify quality problems, but also identify opportunities for improvement, and setting priorities for action. Build a checklist on patient's goals for health, quality of life, daily activities and bringing meaningful progress in the patient care.

PIP plays a major role as it involves gathering information, organizing and interpreting it systematically to clarify the problems and achieve meaningful reporting and action.

Filling the gaps is another area where they may pick up patterns that have not been identified yet. Such projects are expected to be chosen to deal with "high risk, high volume, and problem-prone areas" related to

quality of care or life.

Clinical Decision Support

Evidence-based tools help guide approaches or interventions that are reflective of the best available evidence. Many tools are available to guide decision-making, however, when it comes to undertaking systemic change to eliminate problems at the source; the "users" of the system are the key element. Nothing can beat automated tracking of problems and with machine learning can ensure timely, qualified personnel interventions.

Clinical decision support not only helps in achieving the goal of better care, but also eliminates unnecessary evaluation. Based on the underlying problem, the interventions can be framed, some of which are:

- Protocol development
- Program planning
- Revision; for further maintenance

Dashboards

Along with analysis, a visual interpretation of data is instrumental in understanding the root cause of the problem. Most HHAs use OASIS data to prioritize quality opportunities and charter PIPs. This forms a key step in the process of translating data into action.

Charts can be used to specify the goal and current status. Additionally, HHA can track the performance of the aides using the dash-board, understand the improvement areas and perform corrective actions to overcome challenges.

Important tools to make QAPI process work include templates, flowcharts, worksheets and reporting forms or outlines.

Dashboards not only help generate ideas and reach decisions, they also keep information organized and accessible, enhancing communication within and across teams.

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732-602-2560 X 200

About the Author

Vijayalaxmi Kudekar, Healthcare Consultant

Vijaya is a Healthcare Expert at Nalashaa and has experience in business transformation, payer-provider integration, product design & implementation and healthcare system evaluation & selection. She has been actively involved in Meaningful Use, PQRS, HHVBP, CPC+, CCM and MACRA implementations and has extensive exposure to Clinical and Financial areas of the US healthcare ecosystem.

About Nalashaa

Nalashaa believes in simple solutions to derive meaningful insights and in exceeding your expectations. Our clarity of thought has earned us many laurels in this fast paced world where healthcare technology advancements are rolling out continuously.

Headquarter Office: 555 US Highway 1 South, Suite 170, Iselin, NJ 08830, USA