GRAVITY
HEALTHCARE•CONSULTING

Is your Home Health Agency ready for the Final Rule to the Conditions of Participation?

Medicare-certified home health agencies have almost doubled from 6,461 in 1990 to 12,268 in 2014 due to longer life expectancy, advanced medical interventions, and decreased length of stay in hospitals and skilled nursing facilities. The increased utilization of home health services coincides with the rising expenditure related to home health services. Home health care expenditures in the United States have continually increased from $12.5 billion in 1990 to $83.2 billion in 2014. Due to increased benefit and utilization of home health services, it was time for the Conditions of Participation (CoPs) to be updated to reflect our current healthcare initiatives.

It has been 20 years since there has been a final revision to the CoPs for home health agencies (HHA). The final rule to the CoPs is scheduled to be effective on July 13th, 2017, though there is some speculation that the new administration may decide to delay or cancel implementation. Centers for Medicare & Medicaid Services has revised the CoPs to increase focus on HHAs providing patient-centered care, while delivering quality treatments that are measurable. The final rule addresses areas that were revised in attempt to eliminate unnecessary burdens on HHAs. If you haven't started already, it is vital for your HHA to understand and begin the process of implementing the final rule. Failure to comply or adapt to the final rule will have a significant impact on financials, outcomes, and the quality of patient care.

The objectives of the white paper are to review the revisions of the final rule and determine if the modifications will achieve the goal of all HHAs delivering "patient-centered, data-driven, outcome-oriented processes that promote high quality patient care at all times for all patients." It is important to recognize that CMS did receive recommendations from home health providers, professional associations, consumer advocates, and other governmental agencies, who participate in HHA regulation and oversight to provide information to create standards that are achievable and measurable.

157 Baltimore Street, Suite 200, Cumberland MD 21502

gravityhealthcareconsulting.com

GRAVITY
HEALTHCARE•CONSULTING

484.2 Definitions

Under the final rule, there have been multiple terminology modifications for HHAs. Parent home health agency and branch office are a few of the highlighted changes. A parent home health agency is defined as the direct support and administrative control of a branch office. A branch office is defined as an approved location or site for which a home health agency provides services to a geographical location by the parent home health agency. The parent home health agency has full administrative and regulatory control of the branch office. A branch office is no longer required to meet the CoPs independently, as the parent home health agency will have full administrative control. The parent home health agency must be available to respond and meet the needs of any situation that could occur in respect to patient care or administration at the branch office.

Another provision to the definitions section affects the term "subunits." Any subunit that operates under its own provider number will be considered a distinct home health agency and must meet the CoPs independently. Depending on your state regulations, a location operating as a "subunit" will need to apply to become a "branch" and receive direct support and administrative control from the parent home health agency.

484.50 Patient Rights

CMS is focused on increasing communication through verbal and written notifications of the patient's rights to the patient and/or appropriate patient representative. An HHA must obtain patient or the legal representative's signature confirming they have received a written copy of the patient's notice of rights and responsibilities. The HHA must provide written notice of the patient's rights and responsibilities and the HHA transfer or discharge policies to a patient and/or patient representative within 4 business days of the initial start of care. The information must be understandable to individuals with disabilities or limited English ability. Having the patient's rights and responsibilities available in multiple written languages will assist the patient and/or patient representative with complying and understanding.

Verbal notice of patient's rights and responsibilities must be provided free of charge and in a language, understandable to the patient and/or patient representative. This must be completed by a person who is a skilled provider of the HHA no later than the second visit. An interpreter may be required and they must be competent in interpreting the appropriate language to the patient.

484.55 Comprehensive Assessment of Patients

In comprehensive assessment of patients section, there are a few updates and carryovers from the previous CoPs. The comprehensive assessment (start of care visit) must be performed within 48 hours of the referral or 48 hours of the patient's return home, or the date specified on the physician order. The documentation for the comprehensive assessment must be completed no later than 5 calendar days and in

157 Baltimore Street, Suite 200, Cumberland MD 21502

GRAVITY
HEALTHCARE•CONSULTING

accordance with the patient's immediate needs. HHAs that have clinicians who struggle with completing documentation within regulation timeframe should hold their clinicians accountable and develop tracking processes to be compliant with regulations. Failure to comply with documentation requirements puts your agency at risk for federal and state violations and reduces the coordination and overall quality of patient care. Research about point of service documentation and accuracy of delayed documentation. (Refer to Blog for additional discussion - www.gravityhealthcareconsulting.com/blog.html)

For people who are utilizing a Medicare Benefit and have an order for nursing, it is required for a registered nurse to complete the comprehensive assessment to determine justification for services and homebound status. If a registered nurse isn't ordered by a physician, then a physical therapist or speech- language pathologist may complete the comprehensive assessment. Occupational therapists are prohibited from performing the initial comprehensive assessment.

Home health providers have been questioning for years why occupational therapists are unable to perform a comprehensive assessment. The final rule didn't revise the verbiage for who is eligible to perform the comprehensive assessment. In section 484.55 (a)(2) of the CoPs, it states "when rehabilitation therapy service (speech language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional." However, the State Operations Manual (SOM) Appendix B: Guidance for Surveyors for Home Health Agencies states, "For the Medicare home health benefit, occupational therapy services provided at the start of care alone do not establish eligibility; therefore, occupational therapists may not conduct the initial assessment visit under Medicare." In the same section of the SOM, it states "For non-Medicare patients, if the need for a single therapy service establishes initial home health eligibility, the corresponding practitioner, (including a physical therapist, speech-language pathologist, or occupational therapist) can conduct the initial assessment visit."

After the initial assessment has been completed by an approved skilled professional (registered nurse, physical therapist, or speech-language pathologist), and over time an occupational therapist is the only skilled provider still delivering home health services, then an occupational therapist can perform the Oasis assessments. This includes the resumption of care, recertification, transfer, and discharge assessments. There is no definitive time frame for how long or when in the patient's care that occupational therapy can be the only skilled provider.

157 Baltimore Street, Suite 200, Cumberland MD 21502

gravityhealthcareconsulting.com

GRAVITY
HEALTHCARE•CONSULTING

The CoPs appear to reflect a rule that states an occupational therapist is eligible to perform an initial assessment, but the interpretative guidelines of the SOM Appendix B for home health agencies states that occupational therapists are unable to determine eligibility for Medicare patients receiving home health. The SOM Appendix B hasn't been officially released or updated to reflect the changes to the CoPs final rule. While performing the revisions to the SOM, there is opportunity to change the qualifications for who is eligible to perform an initial comprehensive assessment for home health patients with Medicare benefits. Occupational therapists in skilled nursing, long term care, and outpatient are eligible to perform the initial evaluation and stand alone when providing services to patients with Medicare benefits receiving occupational therapy services. Is it time for a change? (Refer to Blog for additional discussion - www.gravityhealthcareconsulting.com/blog.html)

484.60 Care Planning, Coordination of Services, and Quality of Care

The trend impacting patient – centered care throughout the final rule is the consistency of patients and/or patient representatives receiving detailed written information. Providing written documents that are specific to the patient's treatment will increase communication between the provider and patient and/or patient representative, assist with care coordination, timely plan of care updates, and deliver a higher quality of care. CMS is requiring that each patient and/or patient representative receive an individualized written plan of care that will include visit schedule with frequency of visits, HHA personnel who will be working the patient, any treatments to be provided by the HHA personnel, patient medication instructions, including medication name, dosage, frequency, and schedule, and the name and contact information of the clinical manager. The clinical manager is the supervisor of all patient services and responsible for coordinating the skilled services provided by home health personnel.

Information Required in Writing for the Patient
1. Visit schedule and frequency of visits
2. HHA personnel who will be working with the patient
3. Any treatments to be administered by the HHA personnel
4. Patient Medication Instructions, including medication name, dosage, frequency, and schedule
5. Name and contact information for the clinical manager of the HHA

157 Baltimore Street, Suite 200, Cumberland MD 21502

484.65 Quality Assessment and Performance Improvement

The Quality Assessment and Performance Improvement (QAPI) program is an agency-wide program that involves all agency services by tracking data with the goal of improving agency outcomes, analyzing adverse patient events, and identifying any immediate issue that could threaten the safety and health of patients. The QAPI program must be documented, including the frequency of when data is collected. This must be approved by HHAs governing bodies. After identifying areas of performance improvement, HHA's must implement a plan of action and measure the success of the actions.

Beginning January 18th, 2018, HHAs will be required to implement Performance Improvement Projects. The documentation must include the reason for the project and the date for which progress is measured. There are no requirements for the number of performance improvement projects required, but the amount should coincide with the complexity of services provided by each agency.

An integral part of the QAPI program is the infection prevention and control (484.70) section. The infection and control program must consist of a plan that will identify infectious and transmittable diseases, plan of actions performed to improve disease prevention, and agency-wide education for all employees, patients, and caregivers. Due to the evolving changes in healthcare that warrant increased utilization of home health, will there be additional mandated measures to preventing the spread of infectious disease in home health? (Refer to Blog for additional discussion - www.gravityhealthcareconsulting.com/blog.html)

484.80 Home Health Aide Services

In section 484.40, there are detailed revisions to the home health aide program and competency requirements. The competency requirements for the home health aide training program include, but are not limited to, competent communication skills (verbal and written), delivering safe techniques in performing personal hygiene and grooming tasks, having the physical, emotional, and developmental needs to work with the population serviced by the HHA, and recognizing and reporting changes in skin conditions. Home health aides must receive 12 hours of in-service training in a 12-month period. The 12 hours of training can occur while treating a patient if the appropriate skilled professional is providing the training. To observe and assess skills, a registered nurse must perform an annual on-site visit with a home health aide while the aide is

157 Baltimore Street, Suite 200, Cumberland MD 21502

providing services to a patient. It is still required for a skilled professional to make an onsite visit at least every 14 days to any patient receiving care from a home health aide. The home health aide doesn't have to be present during the supervisory visit.

In- service training for home health aides can be offered by any organization, but the training must be supervised by a registered nurse. A few examples of HHAs not qualified to provide a home health aide training program or competency program are an agency that has been found to provide substandard care, compliance deficiencies compromising the health and safety of patients, or suspension of Medicare payments. Qualifications for providing a home health aide training program and competency program are listed in detail in section 484.40 of the CoPs. Increasing the requirements for a home health aide is consistent with the overall purpose of the revisions of the CoPs. Improving home health aide patient care skills, documentation, and overall communication will positively impact the outcomes for patients and caregivers.

484.105 Organization and Administration of Services

In attempt to coordinate and deliver consistent information and care to patients, HHAs will be required to have one or multiple clinical managers to direct, coordinate, and communicate to patients, patient's representative, and home health personnel. This includes coordinating referrals, ensuring the needs of the patients are addressed, and the plan of care is continually updated to reflect patient - centered care. In section 484.115, a clinical manager can be a physician, registered nurse, physical therapist, speech-language pathologist, occupational therapist, audiologist, or social worker. The clinical manager has a vital role in the overall coordination, delivery, quality, and outcome of the patient's home health services. A person qualified for this position should have experience delivering patient care services and extensive understanding of all home health services, agency's policies and procedures, and federal and state regulations.

484.110 Clinical Records

In the clinical records section, there has been the removal of a few of the previous requirements. In the revised CoPs, the requirement for HHA to send a written summary report to the following physician every 60 days was deleted. A completed discharge summary is to be sent to the following physician within 5 business days of the patient discharge from care or within 2 business days of a planned transfer. If a patient had an unplanned transfer (discharge to hospital, SNF, etc.), the HHA is required to send a transfer summary to the following physician within 2 business days of being informed of the transfer.

The quarterly review of clinical records or charts audits for the evaluation of the agency program has been removed. HHA are required to continually review a patient's clinical record for every episode of care (60 days) to determine if continuing services is justifiable and the plan of care is appropriate. CMS has determined that on average an HHA reviews 70 clinical records a year for a total of 105 hours a year. Medicare has reduced requirements in the clinical records section by not implementing a new condition and removing the regulation for quarterly clinical records review.

157 Baltimore Street, Suite 200, Cumberland MD 21502

gravityhealthcareconsulting.com

GRAVITY
HEALTHCARE•CONSULTING

484.115 Personnel Qualifications

The final rule has revised personnel qualifications in section 484.115. Modifications to key administrative positions involve the home health agency administrator and clinical manager. Before July 13th, 2017, an administrator can be a physician, registered nurse, or a person who has training and experience in health care or a program related to health care. On or after July 13th, 2017, an administrator must be a physician, registered nurse, or hold an undergraduate degree. Coupled with the previous statement, the administrator must also have at least one year of supervisory or administrative experience in home health care or associated health care program. The complexity of home health regulation and multi-discipline oversight requires an administrator, who has extensive home health experience and up-to-date knowledge to handle all aspects of the home health agency. This includes operations, finances, clinical oversight, following federal and state regulations, leading and creating efficient processes, marketing oversight, and ability to hold clinicians accountable for patient - centered care.

The clinical manager is an integral part of CMS's focus for HHA to provide patient - centered care and coordinate appropriate services that are supported by detailed clinical documentation. Qualifications for a clinical manager is a person who is either a licensed physician, registered nurse, physical therapist, occupational therapist, speech-language pathologist, audiologist, or social worker. According to the CoPs, there are no other defined requirements needed for a person to be a clinical manager in a home health agency. (Refer to Blog for additional discussion - www.gravityhealthcareconsulting.com/blog.html)

Conclusion

Home health is an essential part of the continuum of care and continues to be a significant focus on reducing hospital, skilled nursing, and inpatient readmission rates and length of stay. Accountable Care Organizations (ACOs) and healthcare partnerships continue to grow throughout the United States. Home health agencies with high patient outcomes, low hospital re-admission rates, and outstanding patient surveys are the agencies that are selected to be a preferred provider in ACOs.

The revision of the CoPs is an important update to reflect the current era of delivering and regulating high quality of care that is patient – centered with documentation and data that supports the necessity of services. Valued based purchasing (VBP), Zone Program Integrity Contractors (ZPIC), and the Office of Inspector General (OIG) focus on reviewing data to

157 Baltimore Street, Suite 200, Cumberland MD 21502

gravityhealthcareconsulting.com

GRAVITY
HEALTHCARE•CONSULTING

justify the necessity of home health services, improve patient outcomes, and identify home health fraud. These systems or organizations will correlate with the final rule of the CoPs on focusing on patient - centered care that is justifiable by documentation that is trackable. Questions continue to surround the implementation of the final rule to the CoPs. Will the new administration delay or cancel the final rule of the CoPs? Is it possible that the SOM Appendix B for home health agencies be revised to reflect the final rule by July 13th, 2017?

Is your home health agency prepared for the final rule of the CoPs? If you are a home health agency that could benefit from educational services on the CMS home health final rule for Conditions of Participation, home health processes, OASIS documentation, mock surveys, medical records audits, or any other additional needs - please do not hesitate to contact me. My information is listed below. Gravity Healthcare Consulting offers an array of webinars and customized services such as mock audits, clinician training, chart reviews, process development, on site CEU training, and policies and procedures. We look forward for the opportunity to assist you and your agency any way we can.

Devin Kassi [PT, DPT]
Home Health Consultant

Cell: 240.609.6163
Email: dkassi@gravityhealthcareconsulting.com

References

1. Centers for Medicare and Medicaid Services. Final Rule CMS-3819-F. Available January 12, 2017, at https://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html

2. State Operations Manual Appendix B -Guidance to Surveyors: Home Health Agencies. Available August 12, 2005, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_b_hha.pdf

3. Medicare Benefit Policy Manual. Available May 11, 2015, at https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/bp102c07.pdf

4. Statista. Number of Medicare Home Health Agencies in the United States. Available 2017, at https://www.statista.com/statistics/195318/number-of-medicare-home-health-agencies-in-the-us/

5. Statista. Home Health Expenditures in the United States since 1960. Available 2017, at https://www.statista.com/statistics/184783/home-health-expenditures-in-the-us-since-1960/