CoP Series

Care Planning &
Care Coordination
2017 Home Health
Conditions of Participation:
Care Planning and Care Coordination

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Instructions for Contact Hours

In order to successfully complete this educational activity, you must:
• Participate in the entire activity
• Complete the evaluation by clicking the hyperlink here
Objectives

• Recognize the 2017 Conditions of Participation revisions related to patient assessment and interdisciplinary care planning
• Describe the revised ‘Comprehensive Assessment of Patients’ standards
• Describe the new Condition of Participation ‘Care Planning, Coordination of Services and Quality of Care’
• Identify methods and key best practices to help agencies meet the required standards and positively impact quality of care

Strategic Management Model

“What do we know?”

“What do we need to do about it?”

“What does it mean?”

“We are revising the HHA requirements to focus on a patient-centered, data-driven, outcome-oriented process that promotes high quality patient care at all times for all patients.”

Centers for Medicare & Medicaid Services (CMS), HHS.
Home Health CoP Final Rule
Effective July 13, 2017

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What do we know?

What do we need?

What does it mean?

484.55 Comprehensive Assessment of Patients

Four Standards:

a. Initial assessment of patients
b. Completion of the comprehensive assessment.
c. Contents of the comprehensive assessment
d. Update of the comprehensive assessment

484.55,c,(1) Contents of the Comprehensive Assessment

New required assessment content:

- Current psychosocial, functional and cognitive status; NEW
- Patient's strengths, goals and care preferences; NEW
- Patient's progress toward patient goals and measurable outcomes identified by HHA;
- Caregiver willingness, ability, availability and schedule; NEW
- Other available patient supports; and
- Patient's representative (if any).
484.55, d, (2) Updates of the Comprehensive Assessment

“…Within 48 hours of the patient’s return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician-ordered resumption date;”

484.60 Care Planning, Coordination of Services and Quality of Care

“…The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur as a result of implementing and coordinating the plan of care. The individualized plan of care must also specify the patient and caregiver education and training. “…

484.60 Care Planning, Coordination of Services and Quality of Care

Five Standards:

a. Plan of Care
b. Conformance with physician orders
c. Review and revision of the plan of care
d. Coordination of care
e. Discharge or transfer summary

• Eliminates the 60 day summary
484.60,a, Plan of Care

1. Include description of risk for ER visits and hospitalization and all interventions that address risks. NEW
2. Patient/caregiver education and training to facilitate discharge
3. Include patient-specific interventions and education; measurable outcomes and goals identified by the HHA and patient.
4. All orders, including verbal orders must be recorded in the plan of care

✓ LPNs permitted to accept verbal orders per state

484.60,b, Conformance with Physician Orders

“...must document the orders in the patient's clinical record, and sign, date, and time the orders. “

484.60,c, Review and Revision of the Plan of Care

“i) Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians issuing orders for the HHA plan of care.”
484.60,c, Review and Revision of the Plan of Care

“(ii) Any revisions related to plans for the patient’s discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient’s primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any).”

484.60,d, Coordination of Care

1. Assure communication with all physicians involved in the plan of care.
2. Integrate orders from all physicians to assure coordination.
3. Integrate all services to assure the identification of patient needs, patient safety, treatment effectiveness and the coordination of care provided by all disciplines.

✓ Clinical Manager provides oversight to care and personnel

Coordination of Care, cont.

4. Coordinate care delivery to meet the patient’s needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.

5. Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.
**New 484.60(e): Written Information to the Patient**

1. Visit schedule, including frequency of visits by HHA and contract staffing.
2. Patient medication schedule/ detailed instructions and demonstrator.
3. Any treatments to be administered by HHA and contract staffing including therapy services.
4. Any other pertinent instruction related to the patient’s care and treatments.
5. Name and contact information of the HHA clinical manager.

**Interdisciplinary Care**

Notify patient, patient rep, caregiver and physician with each significant change to POC.

**484.75 Skilled Professional Services**

- IDT approach to home health care is expected.
- Active participation of all disciplines required.
- Partnering with the patient, representative and caregiver in planning of care required.
- Clinical Manager role responsible for interdisciplinary care.
484.50 Patient Rights

Pt and Pt representative informed...in a language and manner the individual understands.

- Written visit schedule w/frequency, medications, treatments and clinical manager name/contact info
- Updates on Plan of care- ongoing
- Written notice of transfer and discharge policy
- Administrator's contact information
- Regional Agency on Aging resources and more…
- Investigation of Complaints Standard

484.80 Health Aide Services

- Reorganized into 9 standards
- Focus on Competency and performance.
- New training: Communications skills, including the ability to read, write and verbally report…
- New training: Recognizing and reporting changes in skin condition.

✓ Recognize a state approved CNA training/evaluation program.

Strategic Management Model

What do we need to do about it?

What does it mean?
Contents of the Comprehensive Assessment

Person-centered care and coordinated efforts to reduce hospitalization:

“What Matters Most to the Patient?”

Compare patient-goal to IDT members’ goal(s):

• Do they line up? If they differ, ask WHY?

• How do the disciplines ‘see’ the patient, optimally and realistically, at discharge?

Utilize what matters most to the patient to motivate involvement in the plan of care, (motivating language).

“You have a responsibility to participate in the plan of care…”

“Because we are working together it is important for us to know what matters most to you…”

What Matters Most to Your Patient?

A lead-in to a patient’s goal is embedded in the consent process. Manager supports CoP:

Script this key dialogue.

Define when to use it.

Define where to document.

Explain how to integrate into the care plan and expectation of motivating language throughout the POC, by IDT.

Supervise these key performance behaviors at ‘homeside’.

Monitor correlating ACH % and visit utilization patterns.
Care Planning Excellence Grounded in QAPI/Management Collaboration

**Collaborative Process**

QAPI, Clinical Operations/Management and Members of IDT

Identify trends in clinical care planning needs related to:
- monitoring of adverse events (484.65)
- trending of infection rates (484.70)
- trending of underlying drivers for ER & ACH (484.65)
- focused, goal-driven visit utilization

Provide education and ongoing care plan expectations

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484.60 Elevates Care Management

Care Management process assumes we are continuously learning:

*How do we (the IDT) achieve the optimal outcome within the most efficient use of ‘best-practice’, interdisciplinary visits?*

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Effective Care Management Requires a Designated ‘Owner’ of Every Patient

*“21st Century Case Management”*

- Who within IDT for the patient, ‘owns’ the care plan and care coordination?
- Has agency defined where and how coordination is to be achieved?
  - Secure Text? How does this get integrated into EMR?
  - Physician Communication?
Federal Guidelines, in general, protect vulnerable people in need.

Prepare your clinical managers to LEAD to ACCOUNTABILITY, promoting advocacy gained through compliance.

Four Months…

1. Name accountable leaders
2. Review CoP Final Rule and Interpretive Guidelines
3. Policy and procedure review
4. Establish/review Care Management model
5. Hardwire expectations and use of best practice care planning strategies
6. Utilize your EHR where possible
7. Utilize outcomes in QAPI Program

“It’s not what you know that matters, it’s what you do with what you know.”