FREQUENTLY ASKED QUESTIONS FROM THE WEBINAR

Succeeding with the New

Conditions of Participation
for Home Health

by

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COMPLIANCE NOTE: At press time for this FAQ, the Centers for Medicare and Medicaid Services (CMS) proposed delaying implementation of the new home health Conditions of Participation (CoPs) from July 13, 2017 to January 13, 2018. Nevertheless, we are publishing these responses to the questions asked by attendees during our recent webinar, *Succeeding with the New Conditions of Participation* presented by Jill Dyer, BSN, RN, HCS-D, HCS-O and Sharon Harder. The webinar is available on-demand at kinnser.com/cops.

Jill and Sharon emphasize that, as of this writing, CMS has not published interpretive guidelines concerning the new CoPs, which many believe contributed to the delay. As Sharon put it during the webinar; “It is possible that some of our thinking could be reversed based on future CMS guidance.” We anticipate that those interpretive guidelines will be available in the coming months.

Home health providers should bear in mind that the new CoPs have been delayed, not cancelled. The changes in the CoPs are complex and far-reaching, and now agencies have an additional six months to prepare. It is vitally important for providers to understand the new CoPs and to create an action plan to be in compliance by January 13, 2018. Home health has experienced this “ready, set... wait” pattern several times in recent years. The same thing happened more than once with ICD-10. Like ICD-10, the new CoPs may be delayed, but they will be implemented eventually.

Q: What are the new requirements for the governing board, and who should be a member of that group?

A: The CoPs make it clear that the governing board will be expected to assume overall policy-level responsibility and full legal authority over agency operations. That generally means management of operations, provision of home health services, financial management, and budgetary and quality reviews. The governing board will be directly responsible for reviewing quality improvement efforts, administering the QAPI program, and generally ensuring compliance with applicable laws, regulations, and the CoPs. The governing board will be responsible for supervising the agency administrator, who will conduct the agency’s business based on direction from the board.

Remember that the new CoPs no longer provide for the professional advisory committee (PAC), and much of what this body has done in the past now shifts to the governing board. For many agencies, the governing board has been largely ceremonial and uninvolved.
in direction of the agency’s operations, but under the new CoPs, that will change.

As a result, the members of your governing board must be prepared to engage in discussion and work designed to further the business objectives of the agency in a compliant manner that is aligned with the Conditions of Participation.

Q: Can you explain subunits, branches, and drop sites and how each is affected by the new CoPs?

A: Subunits and branches have been historically defined within the Medicare CoPs. Drop sites have not. Essentially, a subunit is a semi-autonomous division of a home health agency that serves patients who are not located in the immediate service area of the parent agency. Subunits must independently meet the Conditions of Participation and are subject to surveys. Branches, on the other hand, are not autonomous and share daily administrative oversight with the parent. Indeed, the parent is directly involved in all decision making regarding branch operations, and branches must be proximately located to the parent, generally serving patients in the same geographic area as the parent. Historically, CMS has not recognized or defined drop sites, which are generally recognized and enabled by state law. Drop sites are conveniently located, temporary offices from which staff members may obtain supplies, complete charts, and make calls without the need to return to the main office. As noted, drop sites have no status relative to the CoPs.

The new CoPs eliminate subunits, and agencies that have them will need to follow guidance to convert them to branch offices. This is an area where additional CMS guidance will be very important.

Q: We understand that the requirement for 60-day summaries has been eliminated. Does that mean that we no longer need to have case conferences?

A: The 60-day summary requirement is, indeed, eliminated under the new CoPs; however, that does not mean that your agency should cease to have case conferences. Remember that the CoPs are very patient centered and quality focused, and this means that the agency will be expected to continually concentrate on the quality and timeliness of the care provided. In turn, that es-
ablishes the expectation that an interdisciplinary team will be devoted to this task to ensure ongoing and sufficient attention to coordination of care. Also, remember that home health aides will be required to participate as members of the interdisciplinary group.

Q: Please help us understand the differences among the roles of administrator, clinical supervisor, and clinical manager.

A: The administrator is the individual who is charged with the overall, day-to-day administrative management of the agency. Generally, the administrator need not be a clinician and can be a qualified business manager with the requisite amount of home health supervisory experience as required by the CoPs and state law. The new CoPs impose additional qualification requirements on the administrator relative to educational attainment, which has not been a requirement in the past. The clinical supervisor is a term that is synonymous with director of nursing. This individual guides, from a policy perspective, the overall clinical program of the agency, interpreting service needs of the overall patient population, and working with the administrator and governing board to implement policies and procedures designed to foster appropriate patient care. The clinical manager is a newly required role designed to interact, on a day-to-day basis, with clinicians in the field to ensure that services are aligned with plans of care and continually focused on patient needs. Many agencies already have case managers who essentially function in this role.

Q: What are the qualifications for the administrator?

A: Most states have very distinct qualification requirements for the role of administrator. You should be sure to check your state’s requirements in this regard because the most stringent set of qualifications will establish the requirement. Generally, under the CoPs, the administrator must be appointed by and report to the governing board. The administrator is responsible for the agency’s day-to-day operations, must ensure that qualified staff are employed, and must ensure that, in his/her absence, a qualified, pre-designated person is authorized in writing to act in the administrator’s stead and available during all operating hours. In order to qualify for the job, the administrator must, after the CoPs take effect, be a licensed physician, a registered nurse, or a person who holds an undergraduate degree with at least one year of supervisory experience in health service or home health administration. Notably, current administrators who do not meet this set of qualifications are grandfathered by the CoPs for the period during which they remain in their current positions.

Q: What are the clinical manager qualifications?

A: The clinical manager must be a licensed physician, physical therapist (PT), speech-language pathologist (SLP), occupational therapist (OT), audiologist, social worker, or registered nurse (RN).

Q: What documentation do you suggest regarding power of attorney (POA) and patient representatives?

A: The new standards provide for each patient to select his/her representative, who will be an integral part of the care planning and delivery process. This individual does not have to hold a health care POA, however. Moreover, many states have specific forms and verbiage for health care POAs, and the CoPs do not impose any requirement for the agency to require POAs of designated patient representatives.

Q: What do we need to have on our patient rights forms, and when do they have to be signed?

A: First, there must be both written and verbal notices to the patient and his/her representative. Verbal notices should be given in a
“conversational tone” and documented in the record no later than the second visit. Written notices must be signed within four business days of the start of care (SOC) and should be signed by both the patient and his/her representative.

Written admission documents should include:
- Information about the administrator, including name and contact information
- OASIS privacy notices
- A space for identification of the designated patient representative and his/her relationship to the patient and POA status
- Information about honoring court decisions concerning competency and the role of the appointed representative
- Information concerning the patient’s right to have his/her property and person treated with respect
- Information concerning the patient’s right to be free from verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, neglect, and misappropriation of property
- Information about the patient’s right to make complaints regarding treatment or care without reprisal or discrimination
- Information concerning the patient’s right to be informed about the care to be provided and to consent to or refuse care in advance
- Information about the care that will be provided, including the plan of care, disciplines that will furnish care and planned visit frequencies, revision of the plan of care, expected outcomes (including goals, risks, and benefits), and any other factors that could influence care
- A statement that the patient has a right to receive all of the services outlined in the plan of care
- Information about the confidential clinical record and access under HIPAA
- Information about the extent to which payment for services is expected from Medicare, Medicaid, or other federal programs including charges for services that may not be covered

The patient must receive a copy of the individualized plan of care, including revisions or additions that are made to the document.

- Information about the agency’s transfer and discharge policies and procedures
- Information about proper notice in advance of services being furnished if the agency believes that the service(s) may be non-covered care or in advance of reduction or termination of ongoing care
- Availability of and access to information concerning the Medicare hotline together with the names, addresses, and telephone numbers of the Area Agency on Aging, Center for Independent Living, the local agency responsible for elder protection and advocacy, the Aging and Disability Resource Center, and the quality improvement organization (QIO)
- Information about the right to access auxiliary aids and language services and how to access them

Q: What is required on the plan of care that is provided to the patient?

A: The patient must receive a copy of the individualized plan of care, including revisions or additions that are made to the document.

The written instructions that are provided to the patient and/or representative or caregiver must include:
- The visit schedule, which includes visit frequencies
- Medication schedule and instructions with medication names, dosage, and frequency with which medications will be administered by the agency (if that is the case) and
- The treatments and education that will be provided by the agency.
Q: Can we discharge a patient due to HMO or other insurances that are not accepted by our agency?
A: The agency may discharge the patient if payment for services is not available.

Q: What is the time frame on the transfer and discharge summaries?
A: The discharge summary must be sent to the primary care practitioner or the health care professional who will be providing care and services to the patient following discharge within five days of discharge. A transfer summary must be sent within two business days for a planned transfer (when the patient’s care will be immediately continued at a health care facility) or within two business days of the agency becoming aware of an unplanned transfer.

Q: Can you explain the 48-hour rule for resumption of care?
A: Previously, the CoPs required a resumption of care to be completed within 48 hours of discharge from an inpatient setting. The new rules allow for agencies to see the patient within the 48-hour window or on a date that is ordered by the physician.

Q: Can you clarify the timestamp for verbal orders?
A: This simply means that, in addition to recording the date on which the verbal order is received, the receiving clinician must also document the time that the order was taken. Remember, verbal orders are “spoken” orders, such as task orders.

Q: Can you clarify the new requirements surrounding the plan of care?
A: CMS is expected to, but has not yet, provided guidance on this. The new CoPs have a section (484.60) that addresses care planning coordination of services and quality of care. This section contains information on what is required to be on the plan of care, and 484.60(a) (2)(i-xv) includes both previous and new items, including the patient’s risk for ER and rehospitalization as well as interventions that will be employed to address and mitigate those risks.

Q: What are the requirements for communicating a revised plan of care?
A: This is another area where we are waiting on definitive guidance from CMS. The new CoPs state that a revised plan of care must...
be communicated to the patient, the patient representative (if any), the caregiver, all physicians issuing orders for home health services, the patient’s primary care practitioner, or the health care professional who will be responsible for providing care post-discharge, and others who will be responsible for providing care after discharge from home health services. The CoPs also state that the agency should assure communication with all physicians involved in the plan of care.

Q: What must be included in the “visit schedule” that is provided to the patient and caregiver?

A: The revised CoPs state that the agency must provide a visit schedule. It is reasonable to assume that this means a schedule of the days, and perhaps specific times or ranges of times, that the patient can expect to be visited and by what discipline. This is another area where we would expect to see more definitive guidance from CMS.

Q: What are the changes that apply to home health aides?

A: Home health aides may now receive training and competency evaluation from a state approved program, as long as it meets the requirements outlined in the CoPs. Changes to the required training include hair shampooing in a sink, tub, and bed and recognizing/reporting changes in skin condition together with the ability to read, write, and verbally report clinical changes. The competency evaluation must be completed prior to the aide providing care and must include observation of the aide performing tasks with a patient. All aides must also have annual on-site evaluations and must still be supervised every 14 days. Agencies should remember that the new requirements apply to all aides, and those currently in the agency’s employ must receive documented training prior to the effective date of the CoPs.

about the authors

Sharon S. Harder has over three decades of executive management experience in the healthcare industry. She has served in financial and operational leadership roles in a variety of health care organizations ranging from a major healthcare professional association to large post-acute health care providers. As president of C3 Advisors, LLC, Sharon engages with clients to develop and implement the strategic vision required to improve their profitability and competitive position in the rapidly transforming healthcare marketplace. Learn more at C3Advisors.com.

Jill Dyer, BSN, RN, HCS-D, HCS-O is a senior-level home health executive with progressive management experience in home health. Jill was co-owner and administrator of a 350+ patient home health agency, a position in which she served from 2005 to February of 2012. Jill is certified as a home care coding and OASIS specialist, and is an accomplished nurse with 33 years of experience as a home health administrator, home health director of nursing, and nurse consultant for home health.

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