Home Health Conditions of Participation:
Charting a Course for Your Success

PART 4: Focus Patient Rights, Representatives, and Complaints

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Today’s Focus

- Patient Rights
  - Representatives
  - Notices
  - Exercise of Rights
  - Involvement in Care and Care Planning
  - Transfers and Discharges

- Complaints – Documentation, Investigation and Resolutions

- OASIS – Privacy and Data Submission
Breaking News – Interpretive Guidance

- Draft Interpretive Guidance were issued on October 27th


- CMS will not entertain individual comments, but will accept comments from NAHC

- Comments for NAHC’s consideration should be submitted to Mary Carr at mkc@nahc.org

- Today’s slides marked with 🌟 show the most recent draft interpretive guidance
Key Definition – Patient Representative

- Patient’s legal representative or a patient-selected representative who participates in care decisions
- Can be a family member or other patient advocate
- The patient determines the representative’s role to the extent possible
- Representative’s role based on the patient’s stated preference should be documented in the record
Key Definition – In advance

- Means that the agency’s staff must complete the task \textit{prior} to performing any hands-on care or patient education
- Will be a key definition during surveys and medical review
Patient Rights

“The patient and representative (if any) have the right to be informed of the patient’s rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights.”
§484.50 – Patient Rights

a) Notice of rights
b) Exercise of rights
c) Rights of the patient
d) Transfer and discharge
e) Investigation of complaints
f) Accessibility
§484.50 (a) - Notice of Rights

- Patient and his/her representative must receive the following in writing before care is provided:
  - Notice of Patient Rights and Responsibilities
  - Information concerning the agency’s transfer and discharge policies
  - Contact information for the Administrator
  - OASIS Privacy Notice

- The Notice must be signed by the patient and/or the legal representative and maintained in the patient’s record
**Written Notice of Patient Rights**

- If the patient’s representative is not legally appointed via a guardianship, POA or other legal instrument, information must be provided directly to the patient.

- If the patient has a legally designated representative, the written notice must be provided prior to initiating care, but there is one available exception to the timing of notice for the representative.

- If the patient declines notice to his/her representative, the agency should document the declination in the patient’s record.

- The form that is used should contain a confirmation statement that the Notice of Patient Rights has been received by the signer(s).
Legal Representative Exception

- If the patient’s legal representative is not available and the patient has not declined to have the representative informed as to patient rights and responsibilities,
  
  - The agency may provide the written documentation to the patient representative within four days of initiating care

- Information can be provided to the representative electronically or in written form through the mail
Administrator Contact Info

- Administrator information is for the purpose of enabling the patient or his/her representative to lodge a complaint.

- Viewed by CMS as an essential function of leadership.

- Name, business address and business phone number of the administrator are required as a part of the notice of rights.
OASIS Privacy Notice

- Must be in addition to other required notices such as HIPAA privacy

- This notice should be a part of the overall Patient Rights Notice and must be provided and documented at the initial assessment visit

- Applies to all patients for whom OASIS data is gathered
Verbal Notice of Patient Rights

- Verbal notice of patient rights and responsibilities must also be provided in the individual’s primary or preferred language,
- And, in a manner that the individual understands
- If an interpreter is needed to fulfill this requirement, the service must be offered without charge to the patient
- Verbal notice must be delivered no later than the second visit
Extenuating Circumstances

- CMS acknowledges that there are times when it may be difficult to find an interpreter for less common languages.

- CMS expects that the agency will exhaust all avenues including telephonic translation services, video conferencing or online translation of written documents.

- Such options are acceptable as long as they meet the patient’s needs.
Expected that an agency’s patients will be able to confirm during a survey patient visit or other interview that:

- Their rights and responsibilities, and
- The transfer and discharge policies of the agency were provided,
- In a language that the patient understood, and
- In a manner that accommodated any disability the patient might have
Interpretive Guidance – Patient Notices

- Should be a hard copy unless the patient requests an electronic notice

- If the patient’s understanding of English is limited, the information must be provided in a language or format familiar to the patient or his/her representative

- Use of bilingual staff, interpreters, formal arrangements with local organizations that provide translation services or telephonic interpretation for language assistance

- Agency staff should be trained to identify patients with language barriers and staff who have ongoing contact with patients should be trained in effective communication techniques including the use of an interpreter
Interpretive Guidance - Translation

- If the patient speaks a language that has not been translated by the agency into its written patient rights materials, the agency can delay the notification of patient rights and responsibilities until an interpreter is present to translate.

- The permitted delay only extends to the second visit.

- Agency should document that the verbal discussion of rights took place and that the patient or his/her representative was able to confirm understanding of the conversation.
§484.50 (b) - Exercise of Rights

- If there is lack of “legal capacity” based on a court decision or provision of state law,
- Rights of the patient may be exercised by the person appointed by the court to act on the patient’s behalf
- In the absence of a court appointed representative, the patient’s representative may exercise the patient’s rights
- If there is a court order as to the patient’s legal capacity, the patient may exercise his/her rights to the extent allowed by the court order
Interpretive Guidance – Exercise of Rights

- The agency should have documentation of any adjudication by a court which indicates that a patient lacks capacity to make health decisions.
- The documentation should include the name(s) of those who have been identified by the court to exercise the patient’s rights.
- The agency should have specific policies and procedures in place to direct how documentation of legal capacity is included in the patient record.
§454.50 (c) – Rights of the patient

1. To have his/her property treated with respect
2. To be free from verbal, mental, sexual and physical abuse including injuries of unknown source, neglect and misappropriation of property
3. To make complaints to the agency regarding treatment or care
4. To participate in and be informed about and consent or refuse care in advance of treatment
5. To receive services outlined in the POC
6. To have a confidential clinical record and access to that record
§484.50 (c) – Rights of the patient

7. To be advised of the extent to which payment may be expected from Medicare, Medicaid or any other federally funded program

8. To receive proper written notice, in advance of a change or discontinuation of service

9. To be advised of the state toll free home health hot line and contact information

10. To be advised of the contact information for federal and state entities that serve the patient’s area

11. To be free from discrimination or reprisal for exercising his/her right to voice grievances

12. To be informed of the right to access auxiliary aids and language services
Interpretive Guidance – Respect for Property and Person

- Policy and staff training focused on ensuring that patient property is respected both inside and outside the home
- Policy focused on agency consideration of patient requests within the parameters of the assessment and plan of care
- Patient treated as an active participant in the delivery of care
- Patient is informed of the visit schedule and changes to the schedule
- Visits should be on a schedule that is convenient to the patient and not necessarily the agency’s staff
Interpretive Guidance – Abuse, Injuries and Neglect

- Patient has a right to be free from abuse from the agency staff and others
  - Verbal abuse including written or gestured language
  - Mental abuse including threats, humiliation or threats
  - Sexual abuse
  - Physical abuse including corporal punishment and restrictive or intrusive procedures to control behavior

- Misappropriation of property – theft from the patient or his/her home

- Policies and procedures should be in place to establish the agency’s methods for ensuring respect for patients and their property and handling patient complaints or other allegations of improper conduct
Injuries of Unknown Source

- Not witnessed and patient cannot explain the injury
- Agency should carefully document and monitor the situation
- Allegations or evidence of abuse may warrant a change in the plan of care and/or referral to an appropriate agency for follow up
- Agency must intervene immediately as indicated by the circumstances if an injury is the result of an employee action and staff must be removed
- Agencies must be able to demonstrate knowledge of applicable state law
Interpretive Guidance – Filing Complaints

- Agency should have written policies for:
  - Acceptance of complaints
  - Processing of complaints
  - Review procedures
  - Resolution process

- Policies should include timeframes for conducting the investigation, documentation of outcomes and actions to be taken

- The patient’s record and home folder should confirm that information regarding the patient’s right to lodge a complaint was provided
Interpretive Guidance – Participation and Consent

- Patient must be given options regarding care choices and preferences
- Informed consent is not intended to be the function of a form
- Informed consent is ongoing as care changes and evolves
- All aspects of care and services and the manner services are to be delivered are a function of participation and consent
- There must be evidence in the record that the patient was consulted and that he/she consented to planned services and care
- Changes in the POC must be communicated to the patient no later than the visit that most closely follows the change
- Agency must document that the patient was informed of the change
More on Participation and Consent

- Extends to completion of assessments
- Disciplines that will furnish service and visit frequencies
- Expected outcomes of care including patient-identified treatment goals and benefits
- Any factors that could impact treatment effectiveness
Interpretive Guidance – Services in the POC

- The patient is entitled to receive all of the services and treatments outlined in the Plan of Care.
- Change may be required in the way POCs are set forth with tasks selected by assessing clinicians.
- Make sure that the POC includes only those tasks and treatments/assessments that are really needed by the patient.
- If a task is included in the Plan of Care, surveyors and reviewers are going to look for documentation that the service was performed.
Interpretive Guidance – Services in the POC

- CMS has clarified that the Plan of Care and amendments do not have to be provided to the patient and representative.

- But, other documentation must be provided within 5 days of the initial assessment.

1. Visit schedule with frequency of visits by discipline
2. Medication schedule and instructions
3. Treatments that will be administered
4. Pertinent instructions related to the patient’s care and treatments
5. Name and contact information of the agency’s clinical manager
Confidentiality of Patient Records

- Link to HIPAA privacy requirements
- Privacy Rule – protection of health information
- Security Rule – imposes security requirements for agencies and business associates regarding confidentiality and integrity of records
- Breach Notification Rule – requires covered entities to notify HHS of PHI breaches
- HIPAA rules also provide for patient rights to obtain copies of their own records and to request corrections
Patient Inspection of Records

- Patient has the right, upon verbal or written request, to receive current clinical records.
- This request would necessitate provision of the Plan of Care as well as other records.
- Electronic copies should be provided at no charge and hard copies must be charged at a rate not to exceed the community standard for photocopying the record.
- Timeframe for providing the information is within four business days or at the next home visit, whichever comes first.
Interpretive Guidance – Payment for Services and Changes in Care

- Patient’s record must include documentation that the patient was advised, prior to the start of services, of the extent to which services are expected to be reimbursed by Medicare.

- Documentation must include information as to payments that would be expected from the patient if other reimbursement were not available.

- If the patient’s condition changes and new or additional services are required, the same advance notification must occur with respect to those services.

- Notification must include information about the hot line and expedited appeal rights for diminution of services.
Interpretive Guidance – Federal and State Assistance

Patients must be given contact information – name, address and telephone number – of the following agencies:

- Area Agency on Aging
- Center for Independent Living
- Protection and Advocacy Agency
- Aging and Disability Resource Center
- Quality Improvement Organization
Interpretive Guidance – Freedom from Reprisal

- Discrimination against a patient who has filed a complaint is prohibited
- Discrimination is defined as treatment that differs from that provided to other patients following a complaint without justification of the disparity
- Examples include
  - Reduction of services
  - Discontinuation of services
  - Discharge without medical justification for the change
§484.50 d) – Transfers and Discharges

Agency may only discharge the patient under limited circumstances which must be documented in the notice to patients:

- Necessary for patient welfare
- Reimbursement no longer available
- Agency and physician agree that goals have been met
- Patient refuses services or elects to be transferred
- Discharge for cause based on agency policy
- Patient death
- Agency ceases to operate
Transfer and Discharge Notification

- Advance notice of the potential discharge or transfer should be provided.
- Patient preferences at the time of discharge or transfer must be documented and considered.
- Patients have the right to refuse the transfer which must be documented.
- Patients and representatives have the right to appeal the transfer or discharge decision.
- Ongoing communication with the patient and representative during the process is critical.
Interpretive Guidance – Transfer/DC for Patient Welfare

- Invoked when the patient requires more than intermittent service
- Transfer for specialized services that the agency cannot provide
- Expectation of potential adverse outcome that prompts the transfer/DC
- Patient and physician must be informed and documentation must be present in the record
- Alternative providers must be identified
- Transfer must be facilitated by the home health agency and patient medical record must be provided to the receiving entity prior to or upon transfer
Transfer/DC for Lack of Reimbursement

- Generally involves lack of ongoing medical necessity for services
- Notice must be provided at least two days in advance of complete discharge
- Some states require more notice that can go up to five days
- Lack of reimbursement due to agency failure to comply with coverage or eligibility requirements
Interpretive Guidance – Transfer/DC with Goals Met

- Intent is that when the patient is stabilized and health and safety goals have been sufficiently met, services would no longer be needed and discharge is appropriate.

- If patient disagrees with the discharge, he/she should be apprised of the opportunity to appeal the decision after receiving proper written notice of the intent to discharge.
Interpretive Guidance – Transfer/DC for Refusal of Services

- Patients have always had the right to refuse service
- Declines of a single type of service are differentiated from refusal of service
- Declining service from a particular discipline may not warrant discharge
- Refusals that would have potential adverse effects on the patient or compromise the agency’s ability to safely deliver care could warrant a DC
- Documentation of physician notification of discharge decisions should be committed to the patient’s record
- Measures that the agency took to educate the patient must also be documented
Interpretive Guidance – Transfer/DC for Cause

- Abusive or disruptive behavior
- Threats - both verbal and non-verbal
- Sexual harassment or other incidents involving the safety of staff
- Other impediments to the safe delivery of care
- Repeated declination of service or persistent and counterproductive hostile attitudes and behavior
Notification Requirements – DC for Cause

- Patient and physician must have advance notice that the DC is being considered
- Others also caring for the patient should also be notified prior to DC
- Clinical record must reflect
  - Problems encountered with the patient
  - Assessment of the situation
  - Communication with management and the physician
  - Plan for resolving issues
  - Resolution implementation results
DC for Cause – Immediate Action Exception

- When staff are threatened or endangered
- Can open the door for immediate action without a plan to resolve the situation
- Evidence should be in the record that the agency provided the patient and/or representative with information on alternate community resources
- Patients and representatives should also be given names of other agencies that might be able to provide service
Interpretive Guidance – Agency Cessation of Services

- Agency is unable to continue operations
- Sufficient notice of planned cessation of business is required
- Patients must be given information of other providers
- Agency must facilitate the safe transfer of patients to other agencies
Agency Issues – Lack of Available Staff

- Not addressed in the Interpretive Guidance but was covered in the FR comments

- Lack of staff is not considered an appropriate reason to discharge or transfer a patient

- Agency is responsible for assuring availability of staff when the patient is admitted for care
Agency Failures – Acquisition of the F2F

- Not addressed in the Interpretive Guidance but was covered in the comments in the FR
- Coverage requirements not being met due to failure to complete the F2F should be ‘exceptionally rare’ given the 120 day timeframe
- When the F2F requirement is not met, the agency cannot hold the patient accountable for payment
- The HHA is also precluded from an abrupt discharge the patient unless there is proper notification and a valid discharge reason
§484.50 (e) – Investigation of Complaints

- The agency must investigate all complaints made by patients, their representatives, caregivers and family
- Treatment or care that is – or fails to be – furnished
- Inconsistent treatment
- Inappropriate treatment
- Mistreatment, neglect or verbal, mental, sexual or physical abuse
- Misappropriation of property
Documentation and Handling of Complaints

- All complaints must be documented
- Includes both the existence of the complaint and the resolution that was achieved
- Action must be taken by the agency to avoid further potential violations including retaliation against the person who lodged the complaint
- Agencies should also pay close attention to state laws and requirements related to complaints
Complaints – Agency Staff Obligations

- Whether directly employed or providing services under arrangement
- Normal course of providing services to patients
- Identification of incidents or circumstances that could be suggestive of mistreatment, neglect, abuse or injury
- Identification of misappropriation of patient property
- All actual events or incidents must be promptly reported to the agency and other appropriate authorities
Interpretive Guidance - Complaints

- Systems must be in place to record, track and investigate complaints

- Written policies and procedures
  - Acceptance of complaints
  - Processing complaints
  - Complaint review and investigation timeframes
  - Resolution and outcomes
  - Communication
Interpretive Guidance - Complaints

- Complaint investigations should be part of the QAPI program

- During a survey the agency should be able to provide documentation to confirm that investigations were conducted

- Documentation should describe any actions taken by the agency to remove risks to the patient during complaint investigations
§484.50 (f) - Accessibility

- Information must be provided in plain language and in an accessible manner.
- Persons with disabilities must be given access to websites.
- Auxiliary aids and services may be required and cannot be at a cost to the patient.
- Those with limited English must be able to access interpretive services and written translations of documents at no cost to the patient.
§484.40 - Release of OASIS Information

- Agencies must have written contracts with third parties that process OASIS information.
- Contracts must obligate the parties to ensure protection of patient identifiable information contained in the medical record including OASIS data.
- Confidential patient information may not be released to the public.
§484.45 – Reporting of OASIS Information

- OASIS data must be encoded and transmitted to the CMS system within 30 days of the assessment completion
- OASIS data must accurately reflect the patient’s condition
- The transmittal format must meet CMS requirements
- Transmission software must conform to FIPS 140-2 standards
- Branch identification numbers must be included
Interpretive Guidance - OASIS

- Agencies are responsible for the policies of their vendors related to security, confidentiality of information, and impermissible uses or disclosures.

- Agencies must ensure that their workforces are compliant and that their vendors also have compliance procedures in place to protect the confidentiality of personal health information.

- “The HHA is ultimately responsible for compliance with these confidentiality requirements and is the responsible party if the agent does not meet the requirements.”
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