From Assessment to Action

How what you observe impacts the plan of care and the patient outcomes!

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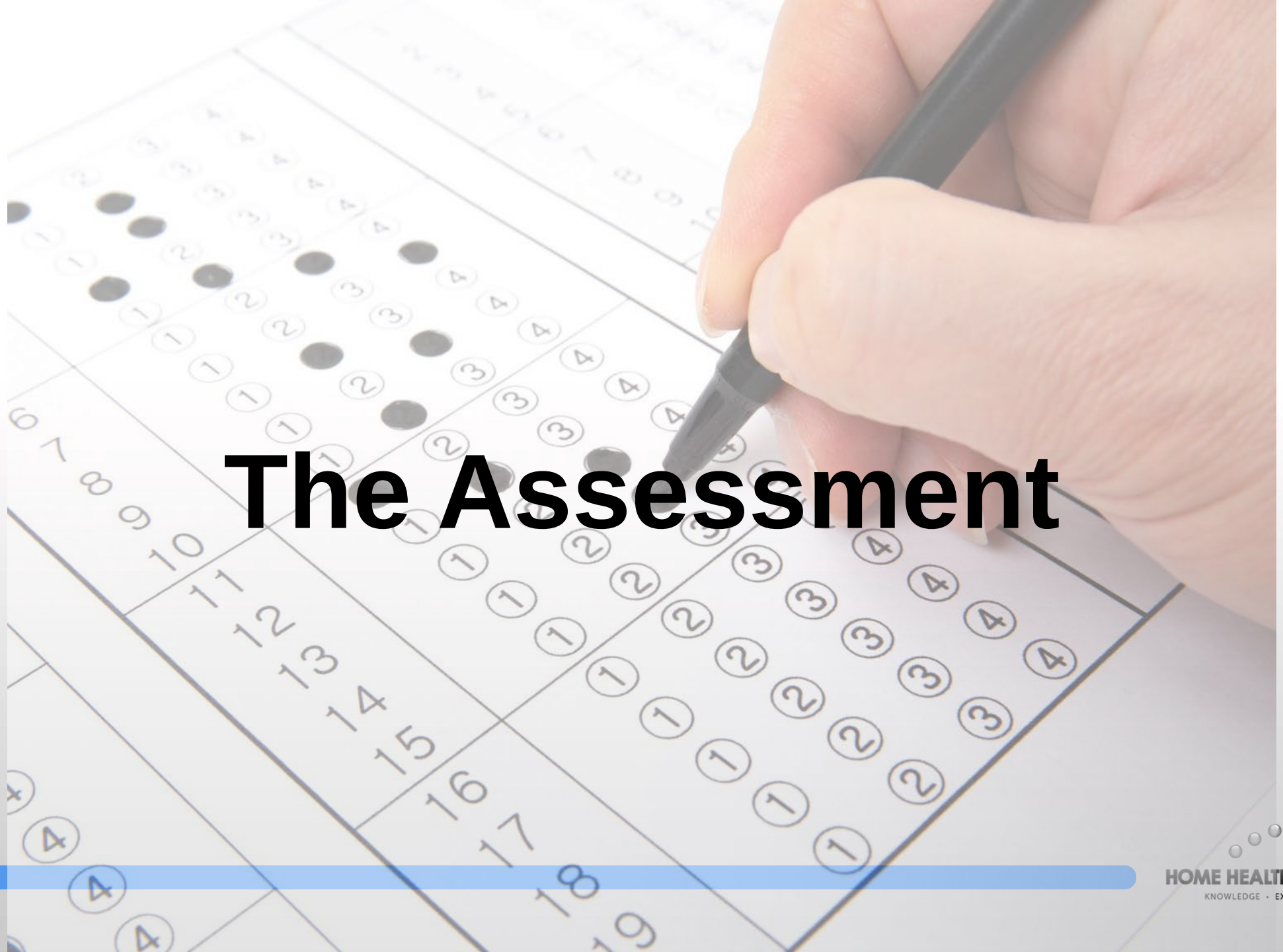
acevedo consulting incorporated
HOSPICE FUNDAMENTALS
HOME HEALTH FUNDAMENTALS

Summer 2023

Case Study…Joe Cool

- 85 year old, Joe, admitted from hospital after an exacerbation of CHF and COPD.
- Joe has been in and out of the hospital a number of times in last year.
- Assessment: Joe had a number of his medications still in the pharmacy sacks, still stapled. Joe reports he tries to “hold on” to his meds with fear he may not afford them in the future. He is to be using a nebulizer twice daily, but he reports is uses it “as needed”. Joe has oxygen ordered continuously a 3l, but assessed he only uses it when SOA after exertion. Joe reports he is unable to do his “normal ADLs” because he is just “too winded”.



The Assessment

HOME HEALTH FUNDAMENTALS
KNOWLEDGE • EXPERTISE • COMMON SENSE

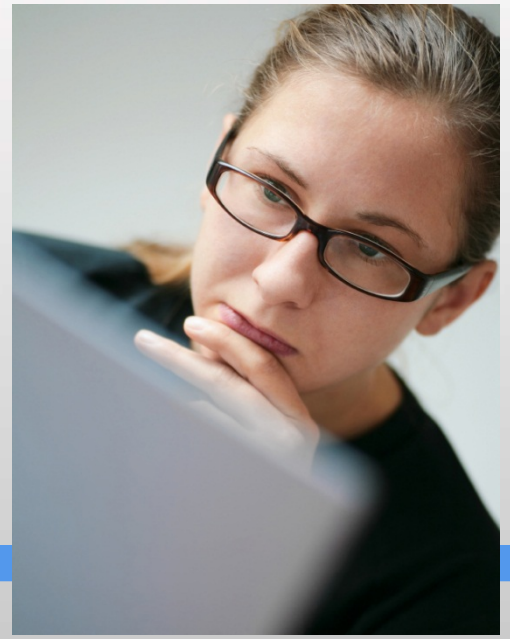
Your Assessment

- “Immediate care needs and support”
  - Home safety/environmental concerns
  - Vitals
  - Head to toe assessment
  - Reason for skilled services
  - Does patient have medications needed?
  - Emergency plan
  - Need for other disciplines

- The clinician may have to complete the comprehensive assessment if problems found in meeting immediate care needs.

Your Assessment

- Determine eligibility for the Medicare home health benefit
  - Need for skilled nursing, PT or SLP
  - Homebound
  - Physician ordered
  - Payer checklist
  - SOC checklist- Did we forget anything?



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Must Knows…

- CMS Medicare Benefit Policy Manual
  - www.cms.gov/manuals/Downloads/bp102c07.pdf
- Nursing ordered? Why does patient need?
  - Observation/Assessment- show recent changes in condition, medication or treatment
  - Technical skilled service- have appropriate diagnosis for injections, catheter changes, infusions, complex wound care
- Therapy ordered?
  - Show recent changes in functional ability
  - If not, may establish a maintenance program

Best Strategies

- No “Kitchen Table” assessment!
- Must include:
  - Observation
  - Interview
  - Caregiver (when available)
  - History/Prior level of function (referral/family/pt)

Observe (and interview)

- Observe the “harder” tasks- and can make some assumptions regarding easier tasks. “Show me…(examples)”– Includes bedroom (or where the patient sleeps and where clothes are kept), and bathroom
  - Where are clothes kept?
  - How is bath set up? Can I see you transfer? Can you reach to wash everywhere?
  - Can you remove/put on socks/shoes?
  - Are you able to get in and out of bed?
  - How do you manage these couple steps down into the living room?
  - How do you organize your medications?

Interview (and Assess)

Examples (not all included!)

- Pain- not only current- “recent relevant past”, plus- did the patient stop an activity because it was painful?
- Dyspnea- day of assessment- but include any reported shortness of breath

Remember Joe?

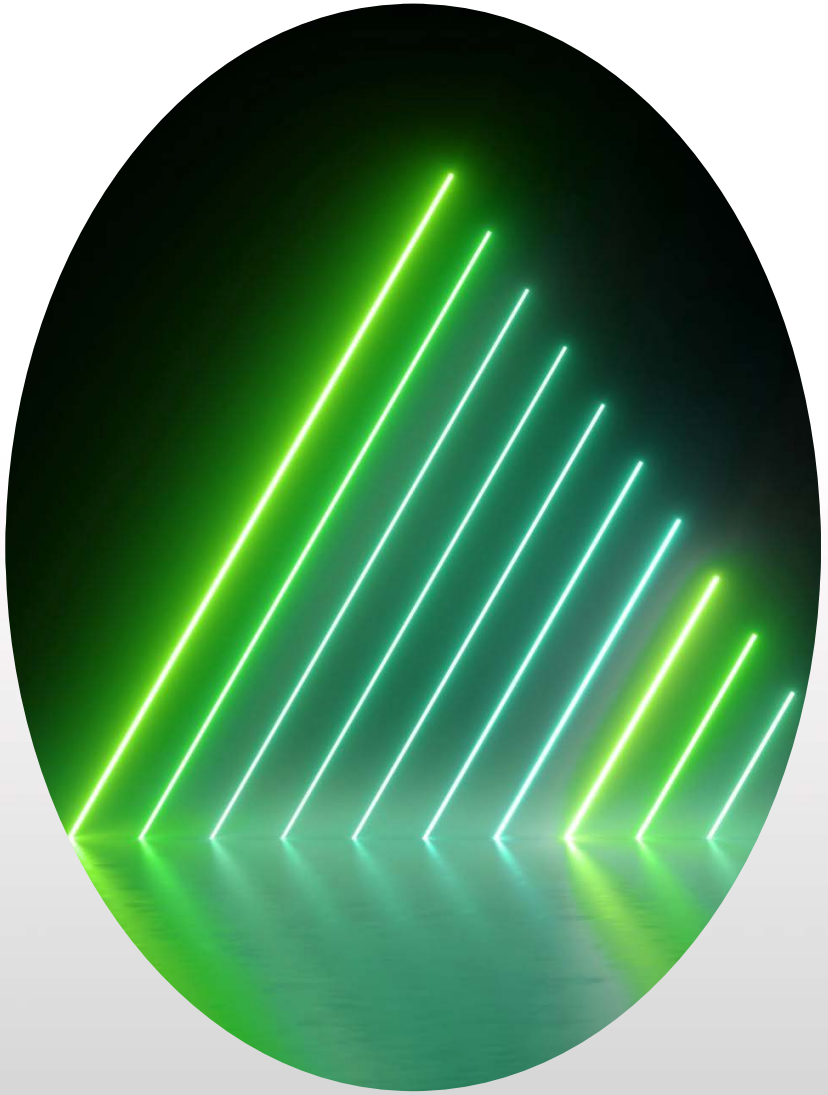
- Where do you think we have risks for inaccurate OASIS data for him?
- Where do you think we have opportunity for Joe to improve?
  - Due to OASIS guidance (moving from assessing with O2 off for M1400 to assessing with O2 ON for M1400)
  - Clinically impacting
  - Functionally impacting

Caregivers Input

- Impacts POC
- Impacts the caregiver items, such as M1100 and M2100
- Does not impact ability- patient and safety assessed for NEED for assist- but doesn't report in functional items if the patient HAS the assistance needed
  - Example… Patient needs assist to get to and from the toilet. Wife typically assists, and patient can perform safely with this level of assistance. Today, when you are completing your recert assessment, the patient has a commode next to the bed. He says his wife insisted he use this today, because she had to go out of town for the day. He can transfer safely on his own to and from the commode/bed.

Reassessments

- We must reassess for needs to update POC on a continuous basis
  - Resumption
  - Recerts
  - “Other follow ups”
- What’s working, what’s not working
- Additional needs, and goals met



The Plan of Care

Plan of Care, Per COPs=

- (i) All pertinent diagnoses;
- (ii) The patient’s mental, psychosocial, and cognitive status;
- (iii) The types of services, supplies, and equipment required;
- (iv) The frequency and duration of visits to be made;
- (v) Prognosis;
- (vi) Rehabilitation potential;
- (vii) Functional limitations;
- (viii) Activities permitted;
- (ix) Nutritional requirements;
- (x) All medications and treatments;

Plan of Care (2)=

- (xi) Safety measures to protect against injury;
- (xii) A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors.
- (xiii) Patient and caregiver education and training to facilitate timely discharge;
- (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;
- (xv) Information related to any advanced directives; and
- (xvi) Any additional items the HHA or physician may choose to include.

How Do you Determine WHO's in POC?

- Orders
- Assessment
- Medical necessity per assessment?
- Auth (can we update?)
- Patient preferences
- (Unfortunately staffing sometimes)
  - Advise physician- put in their hands if need to change POC or agencies

Who Determines FREQUENCY for POC?

- Orders
- Assessment
- Medical necessity per assessment?
- Hospital risk/front loading
- Auth (can we update?)
- Patient preferences
- Understanding utilization/payer
- Working as a team* Especially with PDGM!
- (Unfortunately staffing sometimes)
  - Advise physician- put in their hands if need to change POC or agencies

Following Orders

- Did we provide care and document per POC and updated orders?
- Did we report to the physician any vitals or other measures outside the parameters?
- Did the Home Health Aide follow the plan of care?

Recertification/30-day Review

PROVIDERINSIGHTS

1.) Does the patient still have needs for nursing or therapy related to unmet goals? If yes, continue to #2- if no, discharge from care, unless payer will pay for non-skilled care only.
2.) Is this a payer who requires authorization? If yes, proceed to seek orders and authorization. If "no"- proceed to #3.
3.) Is this a traditional Medicare patient? If yes, the agency must determine coverage by considering homebound status, and the following:

Nursing:

- A. Is there still a "hands-on" skill below that the patient needs? If yes= Covered service for recertification, If no= Go to "B"
  - Ongoing skilled wound care such as wound vac, packing, full thickness wound
  - Vitamin B12 or other IM injections with appropriate diagnoses to support
  - IV medication administration
  - Foley/suprapubic catheter changes
- B. For ongoing assessment or teaching:
  - Has there been a **medication or treatment order change** in **last three weeks?**
  - Has there been a new or exacerbated condition in last three weeks (requiring medication or treatment changes)
  - If yes to one of above, covered services for recertification. If no- consider DC from nursing/ca

Therapies:

- Are there still skilled modalities, such as ultrasound, that the patient needs?
- Are the other manual modalities (therapeutic exercises, gait training, ADL training, balance work) **advancing/changing with the professional assessment and adjustments of plan of care? (not repetitive each visit)**
  - Note: Due to Jimmo vs Sebalius case, we do not need to see improvement to qualify for home health- but it is NOT considered to take skills of therapist to simply perform repetitive modalities that could be taught to non- therapist
- Has there been a change in setting? Caregiver? Function?
- Is it reasonable to meet goals?

Care Still Appropriate?

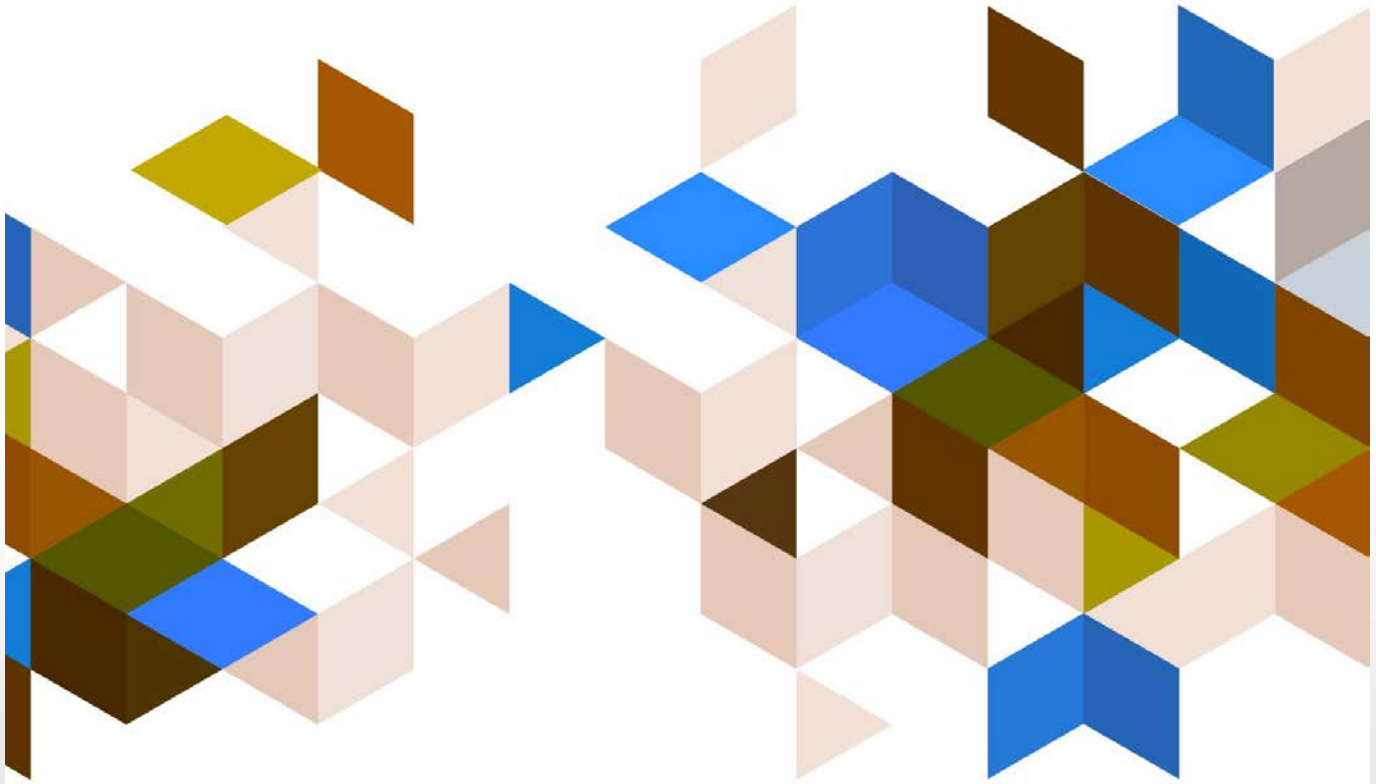
- Does the patient still need same care ?
  - Ongoing foley catheter change?
- Does the patient need different care?
  - New wound, new medication, new diagnosis, incident
  - Patient caregiver now independent with wound care…
  - Current care not working? BS elevated (or too low), BP remains elevated

Different Care

- If interventions worked, we may review if we should decrease
- If current care is not- shall we increase services? If new meds, treatments- should we increase services to ensure working?
- Should we look at a payer change?

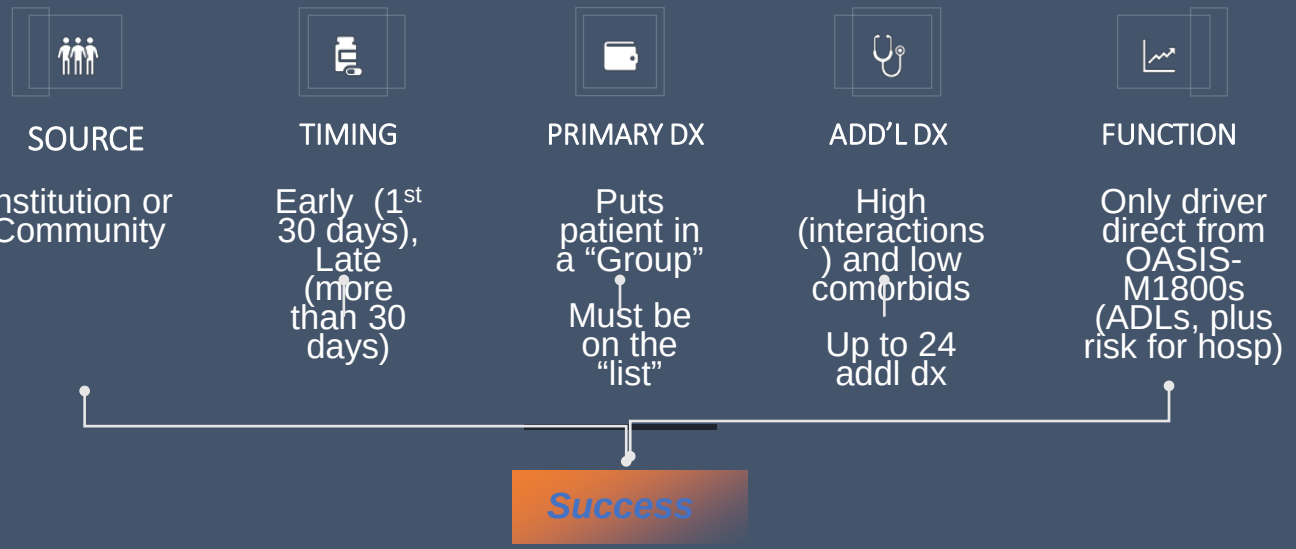
Payer Requirements Still Met?

- If Medicare we are assessing each visit for homebound status
- If Medicare we are covered for 3 weeks for assessment – when the patient needs it
- If no further changes/needs, or no longer HB- is there another payer?
- If an acute change happens, while patient on Medicaid- you will review if Medicare is an option (Medicaid is LAST)



POC and PDGM

MEDICARE PAYMENT PDGM COMPONENTS



PDGM Can Motivate Us to be BETTER-

- Better at seeking out quality referral sources
- Better at gathering information upfront
- Better at screening at intake
- Better at documenting the need for home health
- Better at planning appropriately, using the team efficiently
- Better at coding specificity
- Better at case management
- Better at ensuring benchmarks for physician orders are met
- Better at ensuring the patient needs are met in the home!
- Better at maintaining high quality goals for timeliness of documentation

What have we learned in PDGM?

- Regulatory and compliance requirements didn’t change, including Face-to-Face
- Cycle time must be reduced each step of the process:
  - Referral and intake
  - Admission and assessment
  - OASIS and Plan of Care completion
  - Documentation
  - Scheduling
- Accuracy must be improved
- Utilization must be carefully monitored
- Case Management and Coordination key to achieving quality outcomes

Intake is a Key for PDGM Success!

- Accurate information begins here
- Important to consider it from the “customer” point of view - intake process must remain customer friendly
  - Centralize the intake process to a team with customer service training
- Must be clinical input for decisions on complex care and regulatory compliance
- Determine Admission Source and Timing
  - Facility liaisons and community engagement/sales should assist with this
  - If Hospital referral - determine if ER or Observation stay vs. inpatient
- Obtain approval from PCP to follow
- FTF compliance and payment assurance begins HERE!

How do you do intake?

- Referral accuracy important in determining reimbursement
- Gather patient secondary diagnosis information for co-morbidities
- Eliminate Unacceptable Primary Diagnoses at Intake
- Implement scripting for intake staff
- Develop a checklist of required items including:
  1. Home health diagnosis
  2. Physician Face to Face and supporting documentation
  3. Any other general diagnosis information
  4. Accurate referral source – if institutional determine if qualifying inpatient stay
  5. Requested services
  6. Supporting documentation from physician, facility, etc. supporting home health

What Would YOU Do?!

What Would You Do?

- Medicare patient, seen every week
- Hospitalized for pneumonia
- You resume care- and assess:
  - Cough
  - Rales
  - Temp 100
  - Yellow sputum

What Would You Do?

- On call RN receives call- on Friday eve
- Patient fall-
  - c/o headache and nausea
  - Wife reports his hand strength is unequal
- Directed to go to ER
- Heard from family that ER didn't keep patient- home late on Friday

What Would You Do?

- Patient catheter leaking
- Monthly cath change orders only
  - Last cath change was last week
- When changing cath, a pressure ulcer found on sacrum

- This RN changed cath and applied bacitracin and gauze– Is this what YOU would do?

What Would You Do?

- You are the case manager- you find that the patient doesn’t always have his meds when you go to set them up. He says that he just doesn’t have the money lately.

Be Empowered!

- CMS Home Health Agency Center
  - www.cms.gov/center/hha.asp
- CMS Medicare Benefit Policy Manual
  - www.cms.gov/manuals/Downloads/bp102c07.pdf
- CMS State Operations Manual
  - www.cms.gov/Surveycertificationgeninfo/downloads/SCLetter11_11.pdf
- CMS OASIS C Guidance Manual
  - www.cms.gov/HomeHealthQualityInits/14_HHQIOASISUserManual.asp
- CMS OASIS Q&As
  - www.qtso.com/hhadownload.html

Questions.?

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