Deep Dive into the Plan of Care

Why do we continue to struggle with Care Planning and Coordination

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Home Health Fundamentals'
2023 Winter Workshop

Planning and Coordination of Care

- At the core of what home health does
- Very autonomous, with the physician's approval/orders
- Patient centric
- Coordination more difficult because we aren't all working side by side at an office

Planning starts with assessment

- This is the nursing process!
  - Assessment
  - Planning
  - Doing
  - Evaluate– and then do it all over again!

Plan of care is both COP and Payment

- The COPs (survey) and the conditions for payment (chapter 7 of the Medicare Benefit Policy Manual) have the same list of requirements in the plan
  - Updated in 2018
  - Resulted in medical review denials, as well as survey issues when EMRs had not yet updated the Plan of Care components

§484.60 Condition of participation: Care planning, coordination of services, and quality of care.

- Patients are ***accepted*** for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence.
- Each patient must receive an ***individualized*** written plan of care, including any revisions or additions. 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. Services must be furnished in accordance with accepted standards of practice.

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BUT- we have to start with Assessment!

Task/Visit	Timeframe
Initial assessment- first visit to assess care needs and support and eligibility for Medicare services (if Medicare patient)	48 hours from referral or return home, or on physician ordered date
SOC- first billable visit by payer	To meet patient needs
Comprehensive assessment- holistic assessment, including the OASIS (when applicable)	Within five days from SOC, consistent with patient needs

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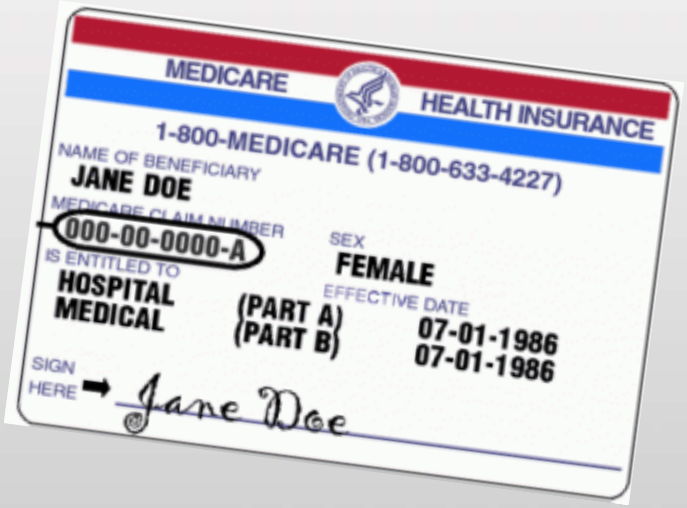
Initial Assessment Visit

- Definition: First clinician visit in the patient's home to:
  - Determine immediate care and support needs
  - Determine eligibility for the home health benefit, including homebound status (may determine if Medicare or Medicaid MCO)



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Timeframe

- The initial assessment must be completed within 48 hours from referral, or return home
- Or, if provided, on the physician ordered SOC date

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You've Got the "Who" "When" and "Why"…

Time Now for the "How"

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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.

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Your Initial Assessment

- Determine eligibility for the Medicare or other payer's home health benefit
  1. Patient must be under the care of a medical provider
  2. Patient must be homebound
  3. Patient must have a qualifying need/skill
  4. Had a FTF visit for the same reason as the need for home health
  5. Care services needed must be reasonably and medically necessary
  6. If a skilled nursing is a qualifier, the skilled nursing service must be intermittent
     - *Need of more than one-time nursing visit, but not daily visit (exception of insulin administration)*
     - *If Therapy and skilled nursing are ordered, in which therapy is the qualifier, skilled nursing may conduct a one-time visit*

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Content of the Comprehensive Assessment

§484.55(c) Standard: Content of the comprehensive assessment. The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:

- §484.55(c)(1) The patient's current health, psychosocial, functional, and cognitive status; (including history)
- §484.55(c)(2) The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA;
  - Consistent with the principles of patient-centered care, the intent in identifying patient strengths is to empower the patient to take an active role in his or her care, goals and interventions

Comprehensive assessment (con’t)

- §484.55(c)(3) The patient's continuing need for home care;
- §484.55(c)(4) The patient's medical, nursing, rehabilitative, social, and discharge planning needs;
- §484.55(c)(5) A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.
  - In rehabilitation therapy only cases, the patient’s therapist must submit a list of patient medications, which the therapist must collect during the comprehensive assessment, to an HHA nurse for review. The HHA should contact the physician if indicated.

Comprehensive assessment (con't)

- §484.55(c)(6) The patient's primary caregiver(s), if any, and other available supports, including their willingness, ability and availability
- §484.55(c)(7) The patient's representative (if any)
- And OASIS data (when mandated= Medicare/MA plans, Medicaid and managed Medicaid)

From Assessment to Care Planning/Coordination

§484.60(a)(2) The individualized POC must include

- (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;
- (xi) Safety measures to protect against injury;

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Contents of POC (con't)

- (xii) A description of the patient's risk for emergency department visits and hospital re-admission, 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.

New in 2018 Top citations related to contents of POC

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SMART Goals

- Specific:
  - 'Who' should be the patient and/or caregiver. If the patient has a cognitive impairment and/or unable to retain information, teaching/training should be directed at caregiver(s).
  - 'What' is the activity the patient/caregiver will perform.
- Measurable:
  - How will progress be measured/determined?
  - What objective measures/standardized tests results will be used?
- Achievable:
  - Set realistic goals for each patient considering their specific physical, cognitive, social and environmental barriers.
- Relevant:
  - Why is achieving this goal important to this patient?
  - Establish goals in partnership with your patient/caregiver.
- Time-Bound:
  - When will the goal be achieved?
  - What is the timeframe for achieving the goal?

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POC Helpful Hints

- Orders for interventions must include:
  - Who- discipline
  - When- frequency and duration (Be CAREFUL how these are written)
    - Example of monthly injections
  - What- what intervention specifically (remember your FIRST ones must be related to the same need as the FTF if SOC POC)
- **Start with what's "Paying the bill"-** the change in condition or need **related to the FTF** need
  - Then can follow up with the best practices

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Taking action in the Plan

Pay the bill:

- Address first what is the need for HH- defined by need for FTF visit at SOC
  - Recert may be different
- Any specific orders from the Dr for hands-on treatments
- What other needs did we find upon assessment

Best practices:

- What additional risks or best practices per M2401 and clinical practice

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Example: CHF Exacerbation (paying the bill)

- *SN 3w1, 2w3 and 2PRN for increased s/s of CHF including weight gain of 5# or more in 24 hours, or reports of increased shortness of air or edema*
- *Intervention(s):*
  - Clinician to instruct patient/caregiver on daily weight self-monitoring program, S/S of fluid overload to report to SN, and proper use of cardiac medications.
  - Clinician to assess weight or daily weight log every visit and report readings outside established parameters to provider.
  - Clinician to monitor for increased s/s of CHF: lung sounds, increased shortness of air and lower extremity edema
- *Goal(s):*
  - Patient/caregiver will verbalize/demonstrate understanding of daily weight self-monitoring program within 2 weeks.
  - Patient will be free from S/S of exacerbation of CHF within 4 weeks.
- *Notes:*
  - If patient has dx of CHF, I/G for weight monitoring should be included on each plan of care with parameters for provider notification of fluid overload.
  - If patient cannot stand on scale, measuring abdominal girth or calf circumference are alternative ways to monitor for fluid overload. Baseline measurements should be obtained at SOC.

60 or 30 days?

- The certification/POC covers us for 60 days- and needs re-reviewed and agreed upon by the ordering provider at least every 60 days
- Our billing periods are every 30 days for Medicare, and most payers
- Do you write your orders for 30 days, or 60 days…
  - Agency preference
  - Varies by type of patient
  - Risks to both
    - Run out of orders
    - Not supporting medical necessity

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Next up- Best practices (after the bill!)

- **FALLS:**
- *Criteria:* Diagnosis of fall/history of falls and/or Positive screen (MAHC 10 score of 4 or higher, TUG, etc.)
- *Intervention(s):*
  - Clinician to instruct patient/caregiver on fall prevention measures to reduce fall risk.
- *Goal(s):*
  - Patient/caregiver will verbalize/demonstrate understanding of fall prevention measures within 4 weeks.
  - Patient will remain free of fall and injury throughout episode of care.

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Additional Best Practices/M2401 Processes

- **DEPRESSION:**
- *Criteria:* Diagnosis of depression and/or positive screening
- *Intervention(s):*
  - *SN TO NOTIFY PHYSICIAN THIS PATIENT WAS SCREENED FOR DEPRESSION USING THE PHQ-2 SCALE AND MEETS CRITERIA FOR FURTHER EVALUATION FOR DEPRESSION
  - Clinician will assess patient every visit for S/S of depression and report new or worsening S/S to provider.
  - Clinician will assess effectiveness of antidepressant medications each visit and instruct the patient/caregiver in the proper use, side effects, interactions, and management of these medications.
- *Goal(s):*
  - Patient will not report or exhibit new or worsening S/S of depression during the episode.
  - Patient/caregiver will verbalize understanding of proper use, side effects, interactions and management of antidepressant medications within 5 weeks.

Pain Interventions and Goals

- **PAIN:**
- *Criteria:* Patient reports pain and/or patient has a diagnosis indicative of pain.
- *Intervention(s):*
  - Clinician to assess patient's pain level every visit and report to provider if patient reports pain is unacceptable, pain level greater than 7/10, pain medications is not effective, they are unable to tolerate pain medications and/or pain is affecting ability to perform normal activities.
  - Clinician to instruct patient/caregiver on nonpharmacologic pain relief measures, including relaxation techniques, massage, stretching, positioning, and/or hot/cold packs.
  - Clinician to instruct patient/caregiver on safe and proper use of pain medication.
- *Goal(s):*
  - Patient will not report or exhibit unmanaged pain >6/10 throughout episode.
  - Patient/caregiver will verbalize understanding of nonpharmacologic pain relief measures within 3 weeks.
  - Patient/caregiver will verbalize understanding of safe and proper use of pain medications within 1 week.
- Ensure goal is reasonable and appropriate for patient.

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And lastly, Pressure Ulcers from M2401

- **PRESSURE ULCER:**
- *Criteria:* Active pressure ulcer(s) and/or positive screening
- *Intervention(s):*
  - Clinician to instruct patient/caregiver on measures to prevent skin breakdown and maintain skin integrity to reduce risk of developing pressure ulcers.
  - Clinician to assess patient for areas of breakdown and impaired skin integrity every visit.
- *Goal(s):*
  - Patient/caregiver will verbalize/demonstrate understanding of pressure ulcer prevention measures within 2 weeks.
  - Patient skin integrity will remain intact throughout episode of care.
- *Note:* At SOC if risk noted, there should be I/G related to BOTH education on prevention & to assess skin every visit for breakdown. Every subsequent episode should have I/G for at least monitoring of skin integrity, assuming education was completed in first episode and risk remains.

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§484.60(a)(1) Plan of Care

- Each patient must ***receive the home health services that are written*** in an individualized plan of care that identifies patient-specific measurable outcomes and goals

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And, what if we DON'T??

- The patient's physician orders for treatments and services are the foundation of the plan of care. ***If the HHA misses a visit or a treatment or service as required by the plan of care, which results in any potential for clinical impact upon the patient, then the HHA must notify the responsible physician of such missed treatment or service.*** The physician decides whether the treatment or service may be skipped or whether additional intervention is required by the HHA due to the clinical impact on the patient.

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§484.60(d) Standard: Coordination of Care.

- §484.60(d)(1) Assure communication with all physicians involved in the plan of care.
- The **physician who initiated home health care is responsible** for the ongoing plan of care; however, in order to assure the development and implementation of a **coordinated plan of care**, **HHA communication with all physicians involved** in the patient's care is often necessary. While a patient may see several physicians for various medical problems, **not all of the physicians would necessarily be involved** in the skilled services defined in the patient's home health plan of care. With regard to this requirement, "physicians involved in the plan of care" means those **physicians who give orders that are directly related to home health skilled services.**

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More coordination and integration

- §484.60(d)(3) Integrate services, whether services are provided **directly or under arrangement,** to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.

    - Managing the **scheduling** of patients, **taking into consideration the type of services that are being provided on a given day.** For example, a patient may become fatigued after a HH aide visit assisting with a bath, thus making a physical therapy session scheduled for directly after the HH aide visit less effective.

    - Managing pain during physical therapy or physical care (i.e. dressing changes or wound care) in order to minimize patient discomfort while maximizing the effectiveness of the therapy session.

    - Working with the patient to recommend and make safety modifications in the home.

    - Assuring that **staff who provide care are communicating any patient concerns and patient progress toward the goals** identified in the plan of care with others involved in the patient's care.

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And, with the patient…

- §484.60(d)(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.
- §484.60(d)(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***.

§484.60(e) Standard: Written information to the patient.

The HHA must provide the patient and caregiver with a copy of written instructions outlining:

- Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.
- Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA.
- Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.
- Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs.
- Name and contact information of the HHA clinical manager.

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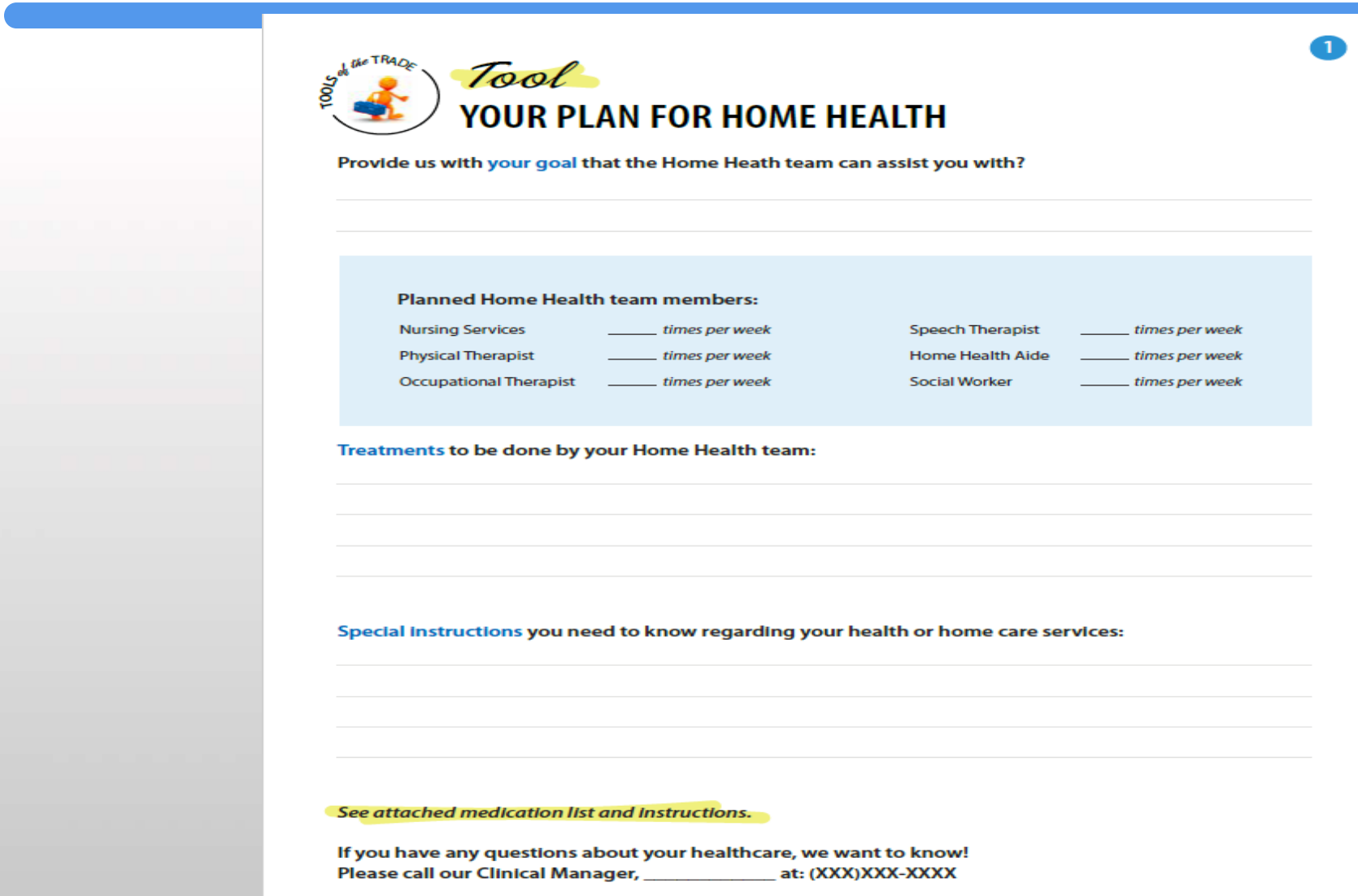
July 2023 Tool of the Trade



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Tool

YOUR PLAN FOR HOME HEALTH

Provide us with your goal that the Home Heath team can assist you with?

Planned Home Health team members:

Nursing Services	_____ *times per week*	Speech Therapist	_____ *times per week*
Physical Therapist	_____ *times per week*	Home Health Aide	_____ *times per week*
Occupational Therapist	_____ *times per week*	Social Worker	_____ *times per week*

Treatments to be done by your Home Health team:

Special Instructions you need to know regarding your health or home care services:

See attached medication list and instructions.

If you have any questions about your healthcare, we want to know!
Please call our Clinical Manager, _____ at: (XXX)XXX-XXXX

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Actions of a Prudent Home Health Agency™

1. Ensure competency by all team members to do a thorough assessment
2. Educate on and support a compliant POC – (QA, clinical manager, team meetings)
3. Ensure oversight for appropriate POC and that it was followed (in the Clinical manager's job per CMS)

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Questions?

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Your Name

Your Email

Your Phone

Contact Us

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