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Conditions of Participation for Home Health Agencies

OVERVIEW

On January 9th, the Centers for Medicare and Medicaid Services (CMS) issued a final rule that will update the Conditions of Participation (CoP) for home health agencies (HHAs) that participate in Medicare and Medicaid. The final rule updates clinical record requirements and formalizes skilled professional services criteria. It requires the implementation of: an integrated communication system, quality assessment and performance improvement (QAPI) program, infection and control program, and emergency preparedness program. This document summarizes key provisions of the rule.

Unless otherwise noted, the provisions of the rule will go into effect on July 13, 2017. The text of the final rule is available here.

CLINICAL RECORDS

The final rule will allow HHAs to maintain and send patient clinical records in electronic form. This is intended to ease the administrative burden of HHAs that already store this information electronically. The clinical record must be provided to the patient, in electronic form or hard copy, within four days of a request.

Initial Assessment

Under the final rule, a registered nurse will be required to complete an initial assessment visit to determine the patient's immediate care and support needs. The assessment must be conducted within two days of the referral, patient's return home, or start date of care.

Comprehensive Assessment

HHAs will be required to complete a comprehensive assessment of each patient within five days of the start of care. The assessment must document the patient's: current state of health (including psychological and cognitive status), care preferences and goals, need for home care, treatment plan, discharge plan, medications, available supports, legal representatives, and eligibility for the Medicare home health benefit.

The comprehensive assessment must be updated in the last five days of every 60-day period and whenever there is a change in health status.

OASIS Data

Under the final rule, HHAs will be required to report OASIS collected data to CMS within 30 days of completing the comprehensive patient assessment. Required OASIS data includes: clinical record items, demographics, patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only. OASIS assessment data must be transmitted electronically to CMS.

Plan of Care

HHAs will be required to provide patients with an individualized plan of care that includes: all diagnoses; the patient's mental, psychological, and cognitive state; required services and supplies; frequency and duration of visits; prognosis; rehabilitation potential; functional limitations; activities permitted; nutritional requirements; medications and treatments; plan to prevent injury, emergency department visits, and hospital re-admissions; patient and caregiver education and training; and advanced directives.

The individualized plan of care must be updated by the patient's physician once every 60 days or whenever there is a change in the patient's condition.

CARE COORDINATION

The plan of care and any changes to the plan of care must be communicated to the patient, the patient's caregiver and/or legal representative, and all providers involved in the patient's care plan. HHAs must provide ongoing education and training to the patient and caregivers regarding the care plan.

HHAs will be required to implement an integrated communication system that facilitates active care coordination between the HHA and the patient's providers.

QAPI

Under the final rule, HHAs must develop an agency-specific QAPI program that uses quality indicator data, including measures derived from OASIS, to monitor safety of services and quality of care. The program must be capable of showing measurable progress and opportunities for improvement on quality indicators, such as: emergency care, hospital admissions and re-admissions, and medical errors. If an opportunity for improvement is identified, the HHA must implement actions to address the problem.

The HHA must maintain records of the QAPI program and be prepared to demonstrate its operation to CMS.

Performance Improvement Projects

Effective January 13, 2018, HHAs will be required to conduct individualized performance improvement projects. The HHA will be responsible for documenting the project's need and tracking progress toward achieving the project's goals.

INFECTION PREVENTION AND CONTROL PROGRAM

The rule requires HHAs to implement and maintain an infection prevention and control program that is specific to the HHA and complies with accepted standards of practice from national HHA accrediting organizations. HHAs will be required to provide infection prevention education to personnel, patients, and caregivers.

PERSONNEL CRITERIA

The final rule formalizes the requirements and responsibilities of HHA staff, including skilled professional and home health aides.

Skilled Professional Services

The rule requires that skilled professionals are actively involved in patient care services, including: patient assessments, the interdisciplinary plan of care, caregiver counseling and education, the QAPI program, and HHA in-service training.

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Skilled professional services include: skilled nursing services, physical therapy, speech-language pathology, and occupational therapy.

Home Health Aide Services

The final rule specifies the necessary requirements and responsibilities of qualified home health aides. Qualified home health aides must satisfactorily complete a competency evaluation program that is offered by a registered nurse with at least two years of nursing experience and one year of home health care experience.

A home health aide may provide care that is ordered by a registered nurse or other appropriate skilled professional. Authorized duties include: simple therapy or nursing service procedures, assistance in ambulation or exercises, administering medications that are ordinarily self-administered, reporting changes in the patient's condition, and participating on the interdisciplinary team. Once a home health aide has been certified, he or she must complete at least 12 hours of in-service training each year.

PATIENT RIGHTS

Under the final rule, the patient, caregivers, and/or representatives must be informed of the patient's rights in a language and form that is understandable to that individual. The patient has the rights to:

- Be free from discrimination and abuse, including injuries of unknown source, neglect, and misappropriation of property;
- Participate in, consent to, or refuse care;
- Be advised of HHA services that are covered by Medicare, Medicaid, or other federally-funded programs. If the HHA believes that a certain service is not covered, the HHA will be required to provide written notice in advance of delivering that service or terminating care;
- Be informed of home health information and advocacy resources; and
- Be informed to the right of access to auxiliary aids and language services.

Written Notices

During the initial evaluation visit, HHAs will be required to provide written information to patients and caregivers regarding: scheduled visits, medication instructions, treatment summary, care instructions, the contact information of a HHA clinical manager, and an OASIS privacy notice.

Within four days of the initial evaluation, the HHA will be required to provide written notice of the patient's rights and responsibilities and the HHA's transfer and discharge policies.

The HHA will be required to obtain signed confirmation that the patient or the patient's representative has received the written notice.

Verbal Notice

Before the completion of a second visit from a skilled professional, the patient and/or the patient's representative must receive verbal notice of the patient's rights and responsibilities.

Transfer and Discharge Policies

Under the final rule, HHAs may only transfer or discharge a patient if:

- The transfer or discharge is necessary for the patient's welfare;
- The patient is no longer willing or able to pay for services;
- The patient's provider and the HHA agree that the patient no longer requires HHA services;
- The patient refuses services; or
- The patient's behavior seriously impairs the HHA's ability to deliver care.

If the transfer or discharge is occurring because the HHA cannot meet the patient's needs, the HHA must arrange for the safe transfer to a more appropriate care entity.

EMERGENCY PREPAREDNESS PLAN

The rule requires that HHAs develop and maintain an emergency preparedness plan that is based on a facility-based and community-based risk assessment. The HHA must provide emergency preparedness training to all staff and conduct exercises to test the emergency plan at least once a year