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Series: Part 1 of 6

CLIMB THE LADDER OF SUCCESS WITH CoPs

Important Steps for Comprehensive Assessment, Care Planning & Care Coordination

Home Health providers across the nation are in the process of preparing for the new Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) Final Rule which will be effective July 13, 2017. CMS's new requirements seek to "develop a more continuous, integrated care process across all aspects of home health services, based on a patient-centered assessment, care planning, service delivery, and quality assessment and performance improvement." This article focuses on the CoPs and implementation strategies related to Comprehensive Assessment, Care Planning and Coordination of Care (CoPs 485.55, 484.60).

The new CoPs incorporate changes to initial assessment, comprehensive assessment and care planning and include an increased emphasis on integrated care planning and care coordination. Some of the key changes include the following:

- Enhances assessment and plan of care requirements: The content of the comprehensive assessment is more detailed and includes the patient's current health, psychosocial, functional and cognition status; and requires inclusion of the patient's strengths, goals and care preferences that may be used to demonstrate the patients progress toward achievement of the goals identified by the patient, as well as measurable outcomes identified by the provider.
- Expands the timeframes allowed for update to the comprehensive assessment to include the physician-ordered resumption date.
- Requires an individualized plan of care that identifies patient-specific measurable outcomes and goals.
- Requires that all patient care orders, including verbal orders, are recorded in the plan of care and include signature, date and time of orders.
- Requires that any revisions to the plan of care is communicated to the patient, representative (if any), caregiver, and the physician. CMS is clear in the Final Rule that the signature of the physician who is responsible for issuing orders related to the

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condition that led to the initiation of home health services sign on all iterations of the individualize plan of care.
- Requires integration of orders from all physicians and all services provided directly or under contract.
- Requires that written information is provided to the patient, including, but not limited to, the visit schedule and frequency, medication schedule /instructions, treatments to be administered by agency staff, any other pertinent information, name and contact information of the Clinical Manager.

CMS expects greater communication and care coordination among providers, and has added a requirement that agencies have a Clinical Manager to assist with coordination. Care conference and communication among team members is of great importance. Home health providers need to evaluate their current processes for care conferencing and regular communication between the interdisciplinary team members caring for a patient and revise as appropriate to meet this requirement.

In addition, care planning and case management will need to be more interdisciplinary than in the past. With patients at the center, clinicians must collaborate on best practice measures to eliminate unnecessary duplication while ensuring effective coordination of services to meet patient needs. Implementation of the new CoPs will encourage the realignment of care to a primary care team led by a registered nurse (RN) Case Manager (or licensed Therapist for rehab-only cases as applicable). The Case Manager is professionally accountable and responsible for the patients' continuity of care, and:

- Establishes therapeutic relationship with an individual patient/family
- Remains the Case Manager for the patient's entire length of stay
- Accepts responsibility for decision-making for the plan of care
- Identifies the patient's unique health needs and priorities, establishes an individualized plan of care, and communicates that plan to other members of the team
- Establishes plan of care and oversees the ongoing changes to the plan of care to meet patient needs and goals
- Is responsible for achieving clinical outcomes

Simione recommends the following strategies that home health providers can implement in preparation for these requirements:

- Evaluate current policies, documentation practices and process flows related to comprehensive assessment, care planning and coordination of services.

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- Determine the process for collection of information about each caregiver's willingness and ability to provide assistance, availability and schedule. This includes incorporation of this information into the patient's care plan.
  - As Case Managers, clinicians need to be knowledgeable of community, state and federal resources that may be available to assist patients and refer to Medical Social Work services as these needs are identified.
- Clinicians will need to use communication methods that encourage patients to participate in their own care and become real partners in decision-making.
  - Many clinicians will need additional training in assessment and case management to meet the holistic patient assessment requirements in the CoPs and to be able to communicate and collaborate effectively with patients to discover their perceived strengths, goals and care preferences.
  - Implement a true Case Management model to ensure care is effectively managed with efficient, effective and outcome-driven visit utilization, care coordination and care planning. Patient-centered care is achieved when the different disciplines work together to assess the patient's needs through true interdisciplinary teamwork.

Simione Healthcare Consultants understands that home health agencies want specific strategies will help them achieve compliance with the new CoPs, while demonstrating efficiency and effectiveness. Our expert consultants will work with your agency to evaluate the impact of these new requirements. We will conduct a CoPs Readiness Assessment to identify necessary changes in clinical operations and provide staff training on topics such as the Case Management Model process and implantation of best practice strategies to improve quality and efficiency for key performance measures.

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