Series: Part 2 of 6
CLIMB THE LADDER OF SUCCESS WITH CoPs

Key Factors for Patient Rights, Admission & Discharge 484.50

This is the second of six articles in a Simione series about the NEW Centers for Medicare & Medicaid Services (CMS) Conditions of Participation (CoPs) for Home Health. These regulations are scheduled to take effect in July 2017.

The new CoPs include revisions of the existing patient rights standards, as well as the addition of three new standards. The overall focus of these standards is direct involvement of the patient and his/her representative in the total care delivery process to achieve better health outcomes – with an emphasis on patient health literacy and accessibility of one's health information. Some of the key changes include the following:

- Enhancement of the Notice of Rights process to include:
  - Specific information and timeframes for both written and verbal notifications
  - Prescriptive notification process when there is a legally appointed or designated representative making healthcare decisions
  - Inclusion of contact information for the administrator
  - Guidance for communicating patient rights information

- Inclusion of prescriptive guidance for honoring court decisions related to patient competence and legal capacity when exercising his/her patient rights

- Expansion of existing rights to include new language, which must be added to the Notice of Rights:

  - Being free from verbal, mental, sexual and physical abuse, including injuries of unknown source, neglect and misappropriation of property
  - Participate in, be informed about, and consent for/refusal of care with respect to ALL assessments, not just the comprehensive assessment time points
  - Being informed of expected outcomes of care from all disciplines providing services, including patient identified goals with respect to participation in, being informed about, and consent to/refusal of care, along with any factors that could impact treatment effectiveness
  - Receive all services outlined in the plan of care

- Being advised of the names, addresses, and telephone numbers of five specific federally-funded and state-funded entities that service the area where the patient resides (Agency on Aging, Center for Independent Living, Protection and Advocacy Agency, Aging and Disability Resource Center, and the Quality Improvement Organization or QIO).
    - It is important that home health agencies take time to explore other community, state and federal resources available in their specific area and include this information in the patient's rights documentation.
- Being informed of the right to access auxiliary aids and language services

- Removal of Advance Directives as a patient right, even though this is still a requirement in accordance with federal and state regulations

- Addition of the NEW standard for Transfer and Discharge, which requires the home health agency to provide copies of its transfer and discharge policies to the patient and MANDATES seven specific reasons that the home health agency may transfer or discharge a patient. These reasons include:

    - Patient acuity requires a higher level of care that the home health agency can provide. Additionally, CMS states the home health agency must arrange a safe and appropriate transfer to other care entities.
    - Patient or payer will no longer pay for services
    - Patient goals are met as agreed upon by the physician and home health agency
    - Patient refuses care or requests transfer or discharge
    - Patient or person in patient's home demonstrates disruptive, abusive, or uncooperative behavior that impedes the delivery of care and treatment.

      Additionally, CMS outlines the steps the agency must take before the home health agency can discharge for cause including the following:

        - Notify patient, representative, if appropriate, and physician
        - Make efforts to resolve the issues presented by the demonstrated behavior
        - Provide contact information for other agencies or providers who may be able to provide care to the patient and representative, if appropriate
        - Document the problem and efforts made to resolve the issue and place in the clinical record
    - Patient death
    - Closure of the home health agency

- Addition of the NEW standard for Investigation of Complaints, which adds more detailed direction regarding the patient complaint process. This includes the documentation required about the complaint, its resolution and the mitigation efforts put into place to prevent further incidences. Additionally, CMS states the home health agency is responsible for asking the necessary questions to "determine" the cause of unknown injuries.

- Addition of the NEW standard for Accessibility in which information must be provided to patients and representatives, if any, in plain language and a manner that is accessible and timely to persons

with disabilities and limited English proficiency. CMS mandates auxiliary aids and services as well as language services (oral and written), and that interpreters be provided at no cost to the patient.

It is important to remember that this CoP is focused on patient-directed care, and documentation of appropriate communication and patient involvement must be in the clinical record. Simione recommends that home health agencies consider the following strategies to prepare for these new requirements:

- Home health agencies will need to review the intake and admission processes, along with corresponding tools to ensure collection of accurate documentation regarding legal authority for making healthcare decisions. Many factors must be considered:
  - How will the agency communicate with legal representatives?
  - How will this communication be documented?
  - How will required approvals and signatures be obtained?

- Home health agencies may need to update admission documentation to include prompts for clinicians to document that both oral and written Notice of Rights were provided. The new regulations mandate the following:

  - Written notice must be provided during the initial evaluation visit and prior to furnishing care
  - Oral notice must be provided by the second visit to allow time for the patient and/or representative to ask questions and have them answered to facilitate a good understanding of their rights
  - Proof of both written and oral notification must be documented in the clinical record

- Agency leadership must determine the process(es) to ensure collaboration and communication with the legal representative in care planning development and updates. These processes must be communicated to and implemented by the intake and clinical teams.

- Clinical case conferences may be one strategy for identifying, communicating and addressing patient communication issues/barriers. This can also be a time to discuss and document the patient and/or representative's active involvement and true partners in their plan of care. To achieve this, many clinicians will need additional training to collaborate effectively with the patient and discover the patient's perceived strengths, goals and care preferences.
- Agencies should identify specific language barriers, including disabilities or limited English proficiency. Does your agency have a prevalence of limited English speaking patients and/or representatives? Your agency may choose to have admission documents translated if a specific language population is identified in your service area. Additionally, agencies should ensure the availability of language translation services and services for hearing-impaired and visually impaired patients.

- As a reminder, the standard for Advance Directives has been removed from Patient Rights, but the same requirements do exist under another standard and in many state regulations. Agencies will

want to continue to identify the presence of advance directives and follow current policies and procedures for collection, documentation and execution of advance directives.

CMS believes that when patients and representatives understand their rights and recommended services to be provided, home health agencies and physicians, along with their patients, will develop a plan of care that is more comprehensive and more likely to achieve desired outcomes. In keeping with CMS's intent of this CoP, many clinicians will need additional training to collaborate and communicate effectively with the patient and/or representative to ensure an understanding of the rights, despite language and/or communication barriers.

To assure readiness with these CoP revisions and additions, agencies must evaluate their policies, tools and operational processes to ensure compliance. At a minimum, the agency must review and update its Notice of Rights, Transfer and Discharge policies and tools, Patient Complaint policy, tools and process, and policies addressing sensory-impaired patients and limited English proficient patients. CMS mandates specific language and prescriptive steps for these areas in the new rules. Education of all staff is imperative for effective execution and implementation of the new CoPs, while continuing to provide high-quality care.

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, conduct a CoPs Readiness Assessment for clinical operations, and provide staff training to support successful implementation of these requirements as well as improvements in quality and efficiency for key performance measures.

Contact us at 844-215-8820 or www.simione.com/contact

About Simione Healthcare Consultants

Founded in 1966, Simione Healthcare Consultants embodies a diverse group of business talent across the U.S. to provide accessible, cost-effective business solutions for the home health and hospice organizations. Key areas of expertise include operations, compliance and risk, finance, sales and marketing, cost reporting, information technology, and mergers and acquisitions. Simione supports performance improvement across the healthcare continuum, engaging agencies, hospitals, health networks for more effective delivery of home health and hospice care. More than 1,500 organizations use Simione's experts and tools to improve quality, reduce costs, and minimize risk to drive business performance.