Applying the Home Health Waivers

CMS Changes for Flexibilities in Home Health and What they Mean in the Real World!

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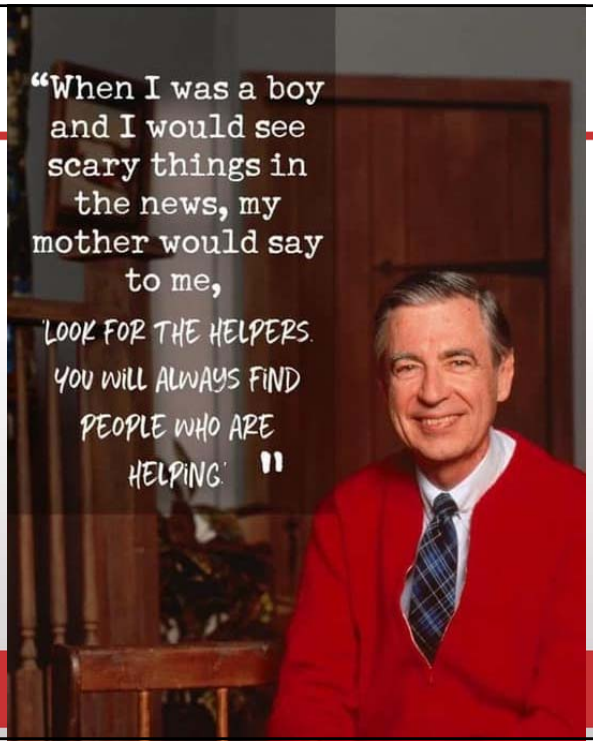
KNOWLEDGE • EXPERTISE • COMMON SENSE

A Special Presentation by Annette Lee
Of Hospice Fundamentals



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A Glimpse in Time to Current…

- January 31st- HHS declared public health emergency
- March 10th CMS addresses HHAs
- March 13th- a National Emergency Declared and opened up 1135 Waivers
  - Blanket - State -Agency specific
- March 27th CARES Act Signed into Law
- March 30th CMS issues an Interim Final Rule "Medicare and Medicaid Programs; Policy and Regulatory Revisions in Response to the COVID-19 Public Health Emergency"

CMS/CDC/OCR/State Daily Updates= Explaining Daily Updates to Your Team

Tale of Two Months

- January 31st- HHS declares a Public Health Emergency
- February 6th, CMS issues first guidance for all healthcare providers on emergency preparedness and infection control https://www.cms.gov/files/document/qso-20-09-all.pdf
- This started the orchestra of government agencies' work
  - OCR released guidance on flexibilities and mandates share COVID patient information for public health purposes
  - CDC updates daily www.cdc.gov

CMS Directs Home Health 3/10/20

- CMS issues first memo specifically to home health agencies
- https://www.cms.gov/files/document/qso-20-18-hha.pdf
- Directs need to assess emergency plan
  - Directs need to screen staff and volunteers
  - Directs need to screen patients
  - Discusses PPE

National Emergency Declared 3/13/20

- CMS issued it's first COVID guidance to state surveyors on infection control in facilities and restriction of visitors
  - Healthcare personnel are exempt
  - https://www.cms.gov/files/document/3-13-2020-nursing-home-guidance-covid-19.pdf
- Under a national emergency, CMS has authority to provide additional guidance, and additional **flexibilities** under the "1135 waivers"

1135 Waivers- 3/13/20

- CMS issued first "Blanket Waivers" -- These are applicable to all. Examples include:
  - **Expansion of telehealth to facilitate a visit between a patient and physician, and not be put at risk by going to a physician's clinic during an emergency (reiterated in the Interim Final Rule)**
  - **Triage of survey activities** to focus on immediate jeopardy and infection control
- https://www.cms.gov/files/document/covid19-emergency-declaration-health-care-providers-fact-sheet.pdf
- States, associations or organizations may also request in writing a waiver for other specific "asks"
- See your state's waivers at: https://www.cms.gov/About-CMS/Agency-Information/Emergency/EPRO/Current-Emergencies/Current-Emergencies-page

HIPAA Flexibilities 3/17/20

- Regarding telehealth visits the OCR published guidance relaxing strict guidelines re: security
  - "Effective immediately, the Office of Civil Rights (OCR) will exercise its enforcement discretion and will not impose penalties for noncompliance with the regulatory requirements under the HIPAA Rules against covered health care providers in connection with the good faith provision of telehealth during the COVID-19 nationwide public health emergency"
  - A covered health care provider can use any nonpublic facing remote communication product that is available to communicate with patients
  - Applications allowed: Apple FaceTime, Facebook Messenger video chat, Google Hangouts video, or Skype However, public facing communication should not be used in the provision of telehealth.
  - Applications not allowed: Facebook Live, Twitch, TikTok, and similar video communication applications.

Relief for Home Health Quality Reporting & RAPs 3/23/20

- RAPS will be extended to 90 days before auto cancel to allow more time for 30 day claim to be submitted
- CMS announced relief from quality reporting timeframes
- Extension for quality reporting of OASIS and CAHPS
- No penalty for delayed submissions during emergency
  - OASIS exception through June 30th, 2020
  - Home Health CAHPS exception through September 30th, 2020
  - https://www.cms.gov/newsroom/press-releases/cms-announces-relief-clinicians-providers-hospitals-and-facilities-participating-quality-reporting

CARES Act 3/27/2020

- Coronavirus Aid Relief and Economic Security Act-
  - https://www.congress.gov/116/crec/2020/03/25/CREC-2020-03-25-pt1-PgS2063-3.pdf
- Major provisions for hospice and home health
  - Changed SSA to allow PA and NP to order and certify for Home Health (Sec 3708)
  - Encouraged HHS to look at how to use remote visits in home health
- Provides relief for HHAs in form of HHS payment (based on Medicare initially)

MAJOR CHANGE in CARES Act for HH: NP/PA may ORDER and CERTIFY HH

- This changed the Social Security Act- which is a permanent change
  - All of the other changes are "waivers" which are only for the timeframe of the emergency period
- Within the law- it states that CMS must make the regulatory changes to match up with the change in the SSA "within six months" of the enacting of CARES.
  - Three days later CMS states they are adopting a "policy of non-enforcement" from 3/1/20 regarding the allowance of NP and PA for orders/certifications for home health care- basically telling industry "go forth!"
- Interim Final Rule extends the flexibility of the NP/PA for HH orders/certifications to Medicaid nationally
  - Warned must be acting within their allowed scope of service as defined by state
  - http://scopeofpracticepolicy.org/

CMS "FACT SHEET" with HH Waivers and Interim Final Rule 3/30/20 (effective retro 3/1/20)

- Addressed "telehealth" in home health
- Homebound definition
- Initial assessment by phone
- Comprehensive assessment timeframe- 30 days
- Quality data timeframes
- RCD
- Supervisory visits remote
- OT can perform initial and comprehensive assessments when therapy is in the home (added as a blanket waiver 4/10/20) https://www.cms.gov/files/document/summary-covid-19-emergency-declaration-waivers.pdf

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Operational changes

Keeping the Team and Patients Safe

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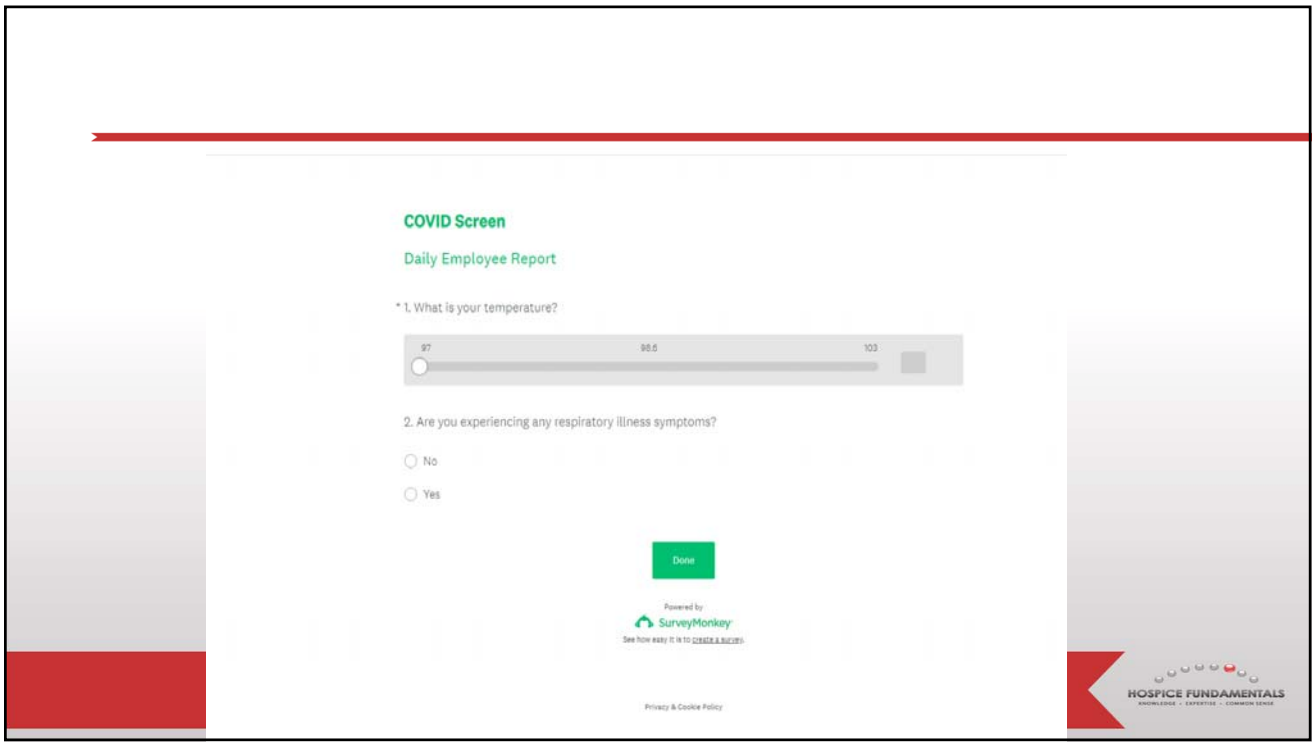
Reduce Office Exposure

- Work from home
- Supply "drive up times"
- Require hand hygiene for all who enter office with sanitizer
- Wear cloth mask in office, unless in private work area
- Keep office door locked with signage to call the office
- No contact deliveries just inside door- or vendor must wear mask
- Re-arrange staff to ensure social distancing is maintained
- No in-person group meetings

Infection Control- Assess Team and Patients

- March 10th CMS guidance instructs HHAs to monitor all staff and patients prior to providing care each day
- Temps/ respiratory s/s of each team member providing care daily should be reported
- Call patients prior to visits to ensure no temp or other s/s
- Where is this documented?



Emergency Plans Initiated

- Do you have an emergency point person? Team?
- Daily huddles to discuss new cases, potential cases, staffing changes and PPE
- Ensure training and communication is clear- even though it is changing
  - Think of your last survey or last mock survey re: infection control-
  - Support your weakest links!
- How are you communicating clearly the ongoing changes?
  - IDPH- Current- mask and eyewear/shield for all visits (4/16)
- How are we planning for limited staffing, resources, etc?

CLEAR, Dated Information to Staff

- **UPDATE ON PERSONAL PROTECTIVE EQUIPMENT 4/7/20**
- **GLOVES**- Wear a new set of gloves for each patient each visit. Dispose of in trash at client's home.
- **GOGGLES/GLASSES/FACE SHIELDS**- Wear during all patient visits . Wash with soap and water or disinfectant between ALL patient visits.
- **GOWNS**- Wear during patient visits if suspected symptoms, patients with active symptoms or on quarantine, PUI or waiting on testing, and/or (if approved) on visits to COVID positive patients.
  - Disposable gowns- Remove and dispose of at patient's home in trash bag.
  - Washable gowns, ponchos, coveralls- Remove and disinfect non-cloth garments between patient visits. If cloth garment, bag at patient home. Launder between each patient visit.
- **MASKS** - All masks: Wash hands before putting the mask on, before taking it off, and after storing or disposing of the mask. Use caution to not touch breathing areas on interior with unwashed hands. Please review the following video for the basics for mask donning and doffing. This seems like a simple task, but we all need the reminder! https://youtu.be/bo-PEzHE7iw
- **Cloth or Dust mask**- *Primary use: You may wear at any time during work activities or in public.* These may now be required at entry to many senior living sites. They may be washed and reused indefinitely. Do not wear on visits if patient has any symptoms unless also wearing a face shield. It is also ok to wear a cloth mask in AL/IL facilities that do not have active PUI or confirmed active cases, or when in the general community/traveling to and from patient's houses. MAX USE IS ONE WORK DAY, BUT MUST BE CHANGED IMMEDIATELY IF ENCOUNTERING ANY PATIENTS WITH SYMPTOMS.
- **Surgical or Nursing mask**- *Primary use: Wear during home health patient visits.* Dispose of if soiled or after use with patients with symptoms, on quarantine, PUI, or COVID positive. MAY USE FOR MULTIPLE PATIENTS IF NO SYMPTOMS AND CARE TAKEN TO PRESERVE MASK. MAX USE IS ONE WORK DAY.
- **N-95 respirator mask**- *Primary use: Wear during patient visits if suspected symptoms, Patients with active symptoms or on quarantine, PUI or waiting on testing, and/or (if approved) visit to COVID positive patient.*
  - You are allowed to wear a cloth mask or a face shield over your N-95 in order to keep it clean and extend its use. HOWEVER, ONLY A CLEAN/UNUSED CLOTH MASK MAY BE WORN OVER N-95 OR SURGICAL MASK TO HELP KEEP IT CLEAN DURING PATIENT VISITS. Use of a face shield may also be considered to protect the N-95 masks.
  - DO NOT THROW N-95 MASKS AWAY AS WE MAY BE ABLE TO USE AN APPROVED CLEANING TECHNIQUE. IF SOILED OR HAVE USED FOR MAX USES, BAG, DATE, SIGN AND RETURN TO HOME HEALTH OFFICE.

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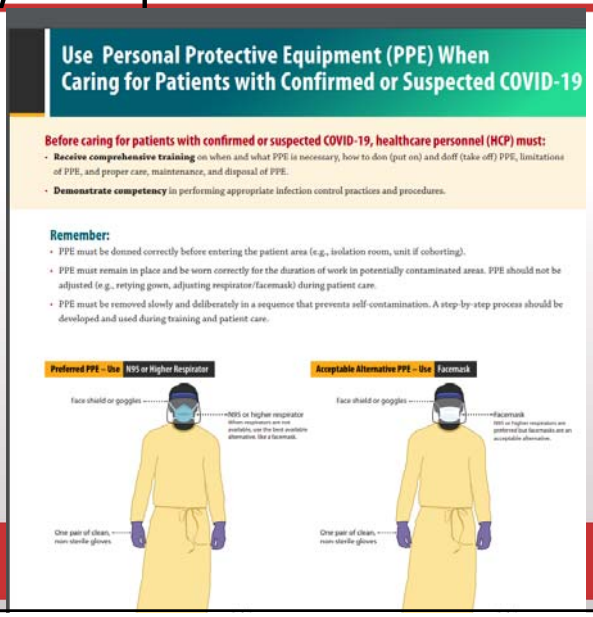
PPE- Understanding the Hierarchy- Preferred, Acceptable and Crisis Mode



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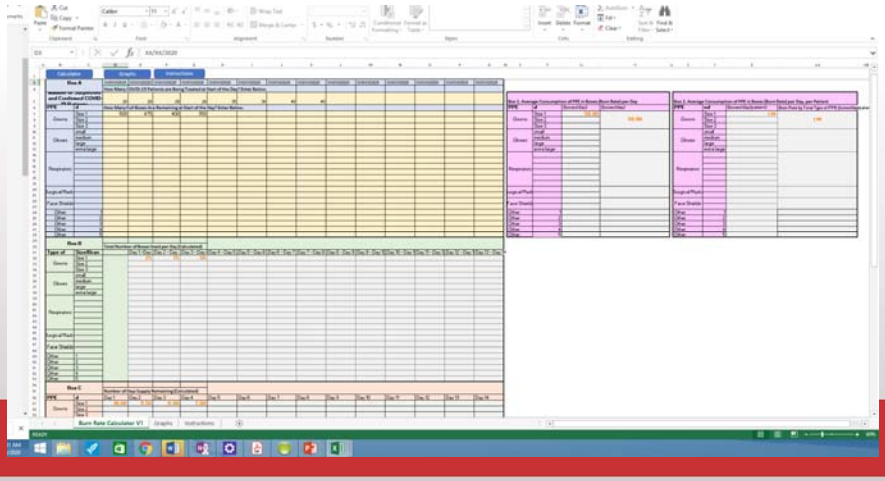
Who's Tracking Your PPE?



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PPE or TPE? ALWAYS refer to CDC.GOV

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VISITS: Reduce Risk by Reducing Items Exposed- What do You Need to Take In?

- Do NOT take bags into homes, unless absolutely necessary- Keep 6 feet from patient
- Use a non-permeable barrier- like wax paper and dispose prior to leaving home
- Try to use disposable equipment, if available
- Leave computer/tablet in the car and chart after proper hygiene when returned to car after visit
- Do not have patient sign for visits if not absolutely necessary (like at admission)
- If COVID + or PUI, leave BP in home
  - BP cuff can only be sanitized, not disinfected
- Alcohol prep pads are NOT enough to clean items
  - https://www.epa.gov/pesticide-registration/list-n-disinfectants-use-against-sars-cov-2

High Risk Situations

- Nebulizer- do not enter area where nebulizer occurred for three hours
- CPR- Could do Chest compressions only- or agency could have policy to only call 9-1-1

Flexibilities in Action

Flexibilities with a New Referral

- The initial assessment (48 hour timeframe) can be met with a phone call!
  - Immediate care needs
  - Do they meet the benefit?
  - All 65+/ and /or patients with co-morbidities will be considered Homebound during crisis
- FTF with Dr/NP/PA can be completed via "telehealth" (audio and video)
  - HHA staff can coordinate with patient's provider and use Facetime, Viber, etc
  - A visit for HHA and a visit for the practitioner
- Can take orders from an NP or PA for home health
  - Federally allowed
  - Check your state at: http://scopeofpracticepolicy.org/

Flexibilities for FTF encounter

- **No FTF Yet? No problem!**
- The 1135 wavier specifically cited provider "telehealth" could be completed from any site!
- If you have capability to do Facetime, or Viber or many other two-way communication apps- you have the capability to facilitate a "visit" with the **patient to a physician or NP/PA**! This may be used in a **palliative care patient,** for whom you are billing the provider's visit, or, it could be used by **home health to help facilitate a "Face to Face" visit with the patient's physician**, so the patient can qualify for home health, and not be put at risk, by going to the physician's clinic during this emergency. The physician must now document the visit,and can bill it.
- The home health will request that visit documentation to ensure compliance with eligibility for the Medicare or Medicaid benefit.

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Flexibilities with HIPAA for Communications

- Facetime and other 1:1 apps ARE OK with HIPAA during Emergency Period
- For any of you that have IT departments stating you can't do this due to HIPAA, please note the OCR took care of this - and attached is also the document in which the **OCR stated they would waive any HIPAA concerns regarding communications for telehealth visits during this emergency.**
- **See handout from OCR**

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Flexibilities with Visits: Reducing Exposure while Meeting Needs

- Are all disciplines essential? Are we able to do some visits remotely? CMS is ENCOURAGING "TELEHEALTH", or remote encounters to reduce risk- and IME is PAYING for TELEHEALTH/Telephony/remote visits
- Here's the fact: Healthcare, including Home Health are "Essential services". So, even if your community is under local rules to stay at home- we are exempt from that. You do NOT want to say too loudly that our visits are not "necessary" or someone may ask why in the world we have been doing these visits- and getting paid for these visits in the first place then! So, yes, we will visit our patients.
- Medicare does NOT include remote visits on claim.
  - Check with your MEDICAID – IOWA IS paying when it is FEASIBLE to meet the intent of visit and need virtually (audio or audio/visual)
  - April 2nd Letter- IL 2126

Reducing Exposure- Continued

- It may be appropriate to reduce risk of exposure to the patient by investigating if less "in person" visits can be performed than what was originally ordered. Think about how family may be more motivated to learn the procedure, or you may set up medications for a longer period of time- or the patient may request a bath weekly instead of 2-3 times per week. A safe, methodical reduction in visits that won't harm the patient is a great plan- but ensure you obtain orders for the reduction, communicate with the patient/family and if home health, provide the HHCCN.
  - Update your POC to say which visits are remote vs in person
  - Be clear with intent of remote visits- not just a chat
  - Documentation on POC and in "visits"
    - Example: CHF patient- initially 3x/week and step down to 2x/week.
      - May, with physician approval determine after first two in-person visits that you will do everything else remotely. Episode threshold was "2" and is met.
      - Update POC to remote visits 3x/week to assess patient weight, activity level, quality of respirations per patient report, ankle edema and medications
      - Therapy can do exercises remotely with patient to increase activity tolerance and maximize cardio-resp status

Other Flexibilities with Visits

- Comprehensive assessment timeframes- 5 days to 30 days
  - Needed for payment by Medicare and some other PDGM payers
- OASIS Submission- waived 30 days (will have to be submitted prior to billing for MC)
- Quality Outcomes, & penalties for late submission not applicable until 6/30
- Supervisory visits can be remote
  - Example: Catheter patient seen monthly for SN visit. Has aides 3x/week and the RN would perform visit every 2 weeks for supervision of aide.
  - Updated example during emergency: Catheter patient seen monthly for SN visit. Aides reduced to weekly, with addition of more family support. SN performs weekly phone calls to family to assess if needs are being met, asking questions about skin integrity, catheter, urine, hydration, etc.

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Reducing Risk- Balancing with Right Care for the Right Patient- at the Right Time

- CMS answered NAHC questions:
- Q: Does the clinician have to monitor all the vital signs? if so requires equipment in home to be used by the patient?
  - A.Information required to be obtained during a visit, virtual or on -site, will depend on the POC and the clinical co ndition of the patient.
- Q: Other than SOC OASIS, can all other OASIS assessments be done by telehealth? OASIS data still has to be submitted to CMS before payment is received?
- A.CMS response :Telehealth is an option for the update of the comprehensive assessment i f the patient agrees to other in-person visits. As per the Interim Final Rule with Comment i ssued 3/30/20, HHAs can provide more services to beneficiaries using telehealth within th e 30 day episode of care, so long as it's part of the patient's plan of care and does not repl ace needed in-person visits as ordered on the plan of care. We acknowledge that the use of such technology may result in changes to the frequency or types of in-persons visits out lined on existing or new plans of care. The plan of care should be modified to reflect whic h visits will be made in person, and which visits will be conducted via telehealth.

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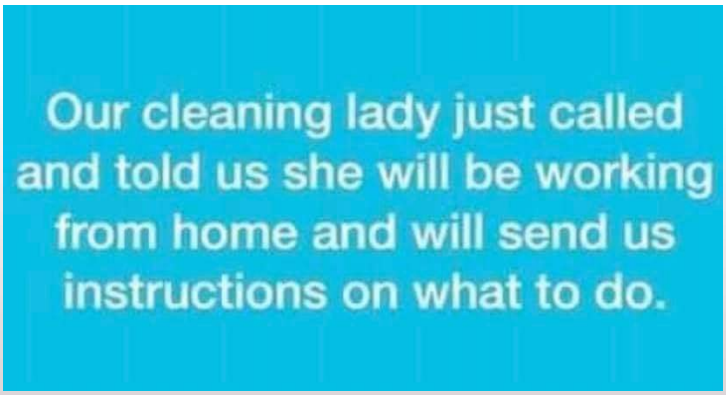
Not ALL Visits Can be Remote…



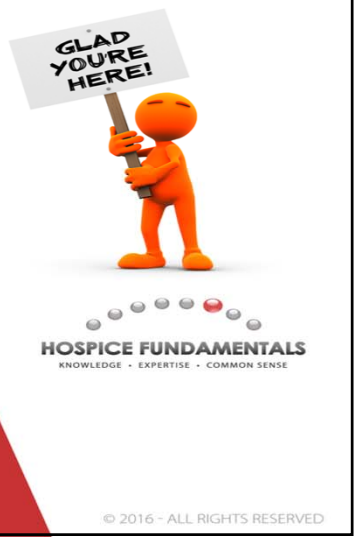
Barriers to Care: Fear of Exposure

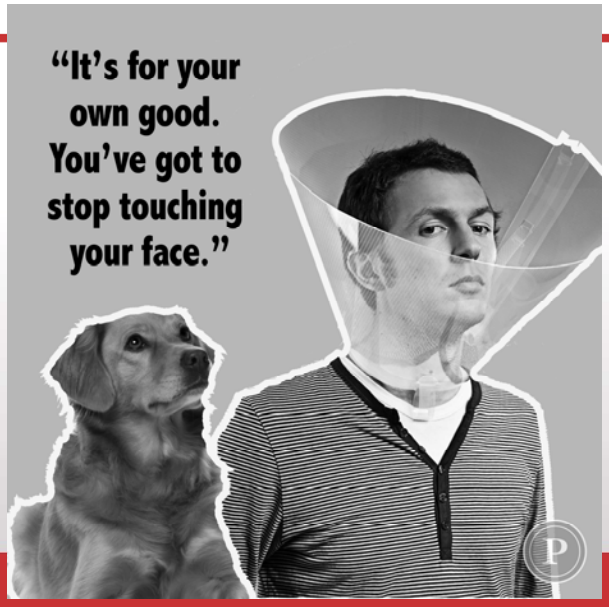
- Many **ALFs are not letting HH or hospice staff into their buildings**, and **nursing facilities** (who are under a NO visitor rule from CMS, from which we are exempt) are **refusing to let hospice staff visit their patients.**
- Here's the fact: Assisted livings/group homes, etc are not under CMS jurisdiction- and can institute rules to protect their residents. We may not be able to continue to serve these patients under home health. I encourage you to show the ALF the language from CMS to nursing homes that states no visitors- except healthcare workers... but at the end of the day, it is their call.
- What should we do? Home Health- place the patient on “hold” if unable to visit. Provide as much support as possible to the patient and family by phone. They certainly could be very upset that your team can no longer visit. Communicate the plan to "hold" in person services due to the facility request with the patient, responsible parties, and physician(s). If this hold continues through the end of the certification we may have to look at a late recertification or eventual discharge

Other Good News--- GRACE

- Grace in Surveys
- Audits (except fraud)
- RAPs
- Advance Payments
- Stimulus Payments (based on MC payments initially, then promising to focus on higher Medicaid agencies)

State Surveys' Remote Infection Control Surveys





State Survey Infection Control Surveys

- 1.) This is all remote, and they are providing these across the state for all provider types.
- Directives found on page 27 of the attached CMS tool, found at: https://www.cms.gov/files/document/qso-20-20-allpdf.pdf
- 2.) The "survey" focuses only on your ability to respond to this crisis through emergency planning, communication, staffing, infection surveillance and infection control.
- 3.) Since it is a remote survey- this information will be gathered by phone, your policies and your plans, primarily. The surveyor may also ask to look at a medical record.
- 4.) There will not be a normal "2567" Statement of deficiencies- but instead, DIA will provide feedback on what is working and what needs improved in these areas.

List of Items to Prepare

- 1. A list of all current staff with phone numbers and staff's titles (both direct employees and contract staff)
- 2. A list of all current patients with dx, services provided, and phone numbers
- 3. An email address, who to correspond with and send results to
- 4. Staff education provided regarding infection control/Covid-19
- 5. Written standards, policies, and procedures regarding: undiagnosed respiratory illness and Covid-19
- 6. Emergency Preparedness policy for a Pandemic
- 7. Policy for when to implement emergency staffing
- 8. Policy for cleaning and disinfecting
- 9. Complaint incidents for the past 3 months
- 10. QAPI regarding infection control for the past 3 months
- 11. Copy of self assessment that you have done for COVID 19/Infection Control

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Intentional Focus for Staff and Patient Safety

- 1. Hand hygiene
  2. Use of PPE per current CDC guidelines- and plans if lack of PPE
  3. Transmission-Based Precautions
  4. Patient care (including patient placement);
  5. Infection prevention and control standards, policies and procedures (hand hygiene, PPE, cleaning and disinfection, surveillance);
  6. Visitor entry (i.e., screening, restriction, and education);
  7. Education, monitoring, and screening of staff; and
  8. Emergency preparedness – staffing in emergencies

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Hand Hygiene

- Are staff performing hand hygiene when indicated?
  If alcohol-based hand rub (ABHR) is available, is it readily accessible and preferentially used by staff for hand hygiene?
  Staff wash hands with soap and water when their hands are visibly soiled (e.g., blood, body fluids), If there are shortages of ABHR, hand hygiene using soap and water is used instead?
  Do staff perform hand hygiene (even if gloves are used) in the following situations:
  • Before and after contact with patients;
  • After contact with blood, body fluids, or visibly contaminated surfaces or other objects and surfaces in the care environment;
  • After removing personal protective equipment (e.g., gloves, gown, facemask); and
  • Before performing a procedure such as an aseptic task (e.g., insertion of an invasive device such as a urinary catheter, manipulation of a central venous catheter, medication preparation, and/or dressing care).
  Interview appropriate staff to determine if hand hygiene supplies are readily available

Policies and Procedures

- ___Did the facility establish a facility-wide IPCP including written standards, policies, and procedures that are current and based on national standards for undiagnosed respiratory illness and COVID-19?
  ___Does the facility's policies or procedures include when to notify local/state public health officials if there are clusters of respiratory illness or cases of COVID-19 that are identified or suspected?
  ___Concerns must be corroborated as applicable including the review of pertinent policies/procedures as necessary.
  ___Did the facility develop and implement an overall IPCP including policies and procedures for for undiagnosed respiratory illness and COVID-19? Yes No (see appropriate IPC tags for the provider/supplier type)

Infection Surveillance

- ___Does the facility know how many patients in the facility have been diagnosed with COVID-19 (suspected and confirmed)?
___The facility has established/implemented a surveillance plan, based on a facility assessment, for identifying, tracking, monitoring and/or reporting of fever, respiratory illness, or other signs/symptoms of COVID-19.
___The plan includes early detection, management of a potentially infectious, symptomatic patient and the implementation of appropriate transmission-based precautions/PPE.
___The facility has a process for communicating the diagnosis, treatment, and laboratory test results when transferring patients to an acute care hospital or other healthcare provider.
___Can appropriate staff (e.g., nursing and leadership) identify/describe the communication protocol with local/state public health officials?
___Interview appropriate staff to determine if infection control concerns are identified, reported, and acted upon.
___Did the facility provide appropriate infection surveillance?

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Educating and Monitoring

• Is there evidence the provider has educated staff on COVID-19 (e.g., symptoms, how it is transmited, screening criteria, work exclusions)?
• How does the provider convey updates on COVID-19 to all staff?
• Is the facility screening all staff at the beginning of their shift for fever and signs/symptoms of illness? Is the facility actively taking their
temperature and documenting absence of illness (or signs/symptoms of COVID-19 as more information becomes available)?
• If staff develop symptoms at work (as stated above), does the facility:
o have a process for staff to report their illness or developing symptoms;
o place them in a facemask and have them return home for appropriate medical evaluation;
o inform the facility's infection preventionist and include information on individuals, equipment, and locations the person came in
contact with; and
o Follow current guidance about returning to work (e.g., local health department, CDC: https://www.cdc.gov/coronavirus/2019-ncov/healthcare-facilities/hcp-return-work.html).
Did the facility provide appropriate education, monitoring, and screening of staff?

Staffing in Emergencies

- ___Policy development: Does the facility have a policy and procedure for ensuring staffing to meet the needs of the patients when needed during an emergency, such as a COVID-19 outbreak?
  ___Policy implementation: In an emergency, did the facility implement its planned strategy for ensuring staffing to meet the needs of the patient?
  (N/A if emergency staff was not needed)
  ___Did the facility develop and implement policies and procedures for staffing strategies during an emergency?

THANK YOU!

QUESTIONS?

CONTACT: ANNETTE@HOSPICEFUNDAMENTALS.COM