Care Coordination in the New CoP’s

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Objectives

• Define care coordination
• State new Conditions of Participation for Care Coordination
• Identify care coordination key information at comprehensive assessment time points
• Relate care coordination to goal achievement and reducing acute care hospitalizations
Four New CoP’s

• Patient rights
• Care planning, coordination of services and quality of care
• Quality assessment and performance improvement (QAPI)
• Infection prevention and control
NEW CONDITIONS OF PARTICIPATION
Definition of Care Coordination

• “Use a patient-centered, interdisciplinary approach that recognizes the contributions of various skilled professionals and their interactions with each other to meet the patient’s needs.” (CoP’s)

• Facilitate coordination, communication and collaboration with clients, clients’ families and caregivers, members of the interprofessional health care team, and others in order to achieve target goals and maximize positive care outcomes. (Case Management Society of America)
Shared Decision-Making Model

A mutually respectful exchange that recognizes the individuality of the patient, and a process in which responsibility is divided among the patient, physician and agency
Coordination of Care

• HHA must integrate services, whether provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient’s safety and treatment effectiveness, the coordination of care provided by all disciplines, and communication with the physician.
Coordination of Care

• HHA must coordinate care delivery to meet each patient’s needs, and to involve the patient, representative (if any), and caregivers in the coordination of care activities.

• HHA must ensure each patient and caregiver receives any training necessary for a timely discharge from the HHA. Each skilled discipline is responsible for educating pt/cg about care and services appropriate to the discipline.
Physician Coordination

• Explore methods to engage patients and physicians responsible for oversight of their care in the care planning and management process
• Clearly establish and update treatment goals and plans
• Facilitate communication between HHA, all physicians and other providers involved in the plan of care during HH services and after discharge
Physician Coordination

• HHA must promptly alert the physician... to any changes in patient’s condition or needs that would suggest that measurable outcomes are not being achieved and/or that the HHA should alter the plan of care
Interdisciplinary Teams

- Interdisciplinary teams work together, each member contributing their knowledge and skills, interacting with and building upon each other, to enhance patient care.
- May develop interdisciplinary team models based on the experiences and knowledge developed by similar care providers, or may develop their own strategies and structures to create effective working teams.
Integration of Orders

• Communication between multiple physicians
• Coordination of orders for interventions, services, medications and goals
• Ensure integration of services and avoid duplication or contradictory physician orders
New Standard 484.110

• (6)(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient’s discharge; or
• (ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient’s care will be immediately continued in a health care facility; or
• (iii) A completed transfer summary that is sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.
Documentation

• Coordination of care entails assuring patient needs are consistently assessed, addressed in the POC, that care is delivered in a timely and effective manner, and that goals of care are achieved. HHAs may document these activities in a manner that suits their needs to demonstrate compliance.

• CMS says in Comments: we did not propose, nor are we finalizing, specific documentation or implementation requirements for the provision of care planning, coordination, etc.
Coordination of Care

• Communication with physician
• Communication between different clinicians visiting patient
• Communication among disciplines
• Communication w/pt, cg, family
Physician Coordination

• SOC: patient status, medication reconciliation, approval of POC (including interventions in M2250)
• Recertification: reason for continuation, order changes, approval of POC
• ANY changes in patient condition or adverse s/sx, complications
• ALL missed visits by all disciplines
• Progress updates on wounds
• Goals: progress, revisions to POC
• At transitions: DC plan, office visits, ED and inpatient admissions
Interdisciplinary Coordination

- RN – LPN
- Nursing – Therapy
- PT – OT – PTA – COTA
- Home Health Aide (personal care)
- MSW
Who Does What?

RN, PT, OT, SLP

• Comprehensive assessment
• Develop Plan of Care interventions and goals
• Evaluate progress toward goals, determine effectiveness of POC
• Revise interventions and/or goals with physician input

LPN, PTA, COTA, HHAide

• Perform individual treatments / interventions
• Determine patient response to treatments performed at visit
• Provide information to RN or therapist about the effectiveness of treatment activities
Interdisciplinary Coordination

- SOC (within 5 days)
- ROC (within 2 days)
- Prior to recertification
- Discontinuation of a discipline
- Prior to discharge
- Any problems, complications, sx of exacerbations or adverse events
SOC Conference Points

• Primary diagnosis, focus of care
• Top 5 other diagnoses
• Problem issues
  – Pain, meds, wound care, fall risk
• Patient coping, understanding, motivation
  – Patient’s goals for home care services
• Support / caregiving situation
• Risk for hospitalization, interventions
• Coordination to meet problem issues
• Homebound status and medical necessity
ROC Conference Points

• Reason for hospitalization
• Interventions to reduce re-hospitalization risk
  – Changes needed to prevent repeat
• Primary and other diagnoses
• Problem issues
• Support situation and patient coping, etc.
• Revisions to plan of care and goals
  – Focus and responsibilities of each discipline
• Homebound status, medical necessity
Recertification Conference Points

- Verify Homebound status
- Evaluate progress toward goals on POC
- Review scores on SOC/ROC OASIS items for outcome measures, evaluate current scores
- Determine if outcome improvement possible and interventions needed to achieve
- Medically necessary skilled care
- Revise goals and plan of care if indicated
- Identify specific responsibilities for each discipline to prepare pt/cg for discharge, evaluate if achievable within this cert period
- Decide if recert or discharge
Discharge of Discipline Conference Points

• Goals for discipline achieved
• Identify any unachieved goals, reasons
• Review specific improvement on OASIS items related to outcome measures
• Identify any other changes in plan of care as a result of discipline discharge
  – Plan for PT/INR, dc home health aide, etc.
Discharge Conference Points

• Review goals on POC, evaluate if achieved
• Review scores on OASIS items, assess if improvement achieved on outcomes
• Identify if teaching done, understanding level:
  – All medications
  – Diabetes and foot care if DM diagnosis
  – Pain management
  – Prevention of falls, pressure ulcers
• Assess readiness for discharge and follow up, link to community resources
Patient/Family Coordination

• Identification of significant players, defining “caregivers” requiring coordination role
• Determining areas of coordination, align goals
• Focus on training and education
• Prepare for transitions and discharge
• Documentation points
Patient Performance

- Document assessment of pt/cg knowledge level, describe any deficit, tailor teaching interventions to address deficit
- *If no knowledge deficit identified for patient or caregiver, no need for skilled teaching!*
- Document assessment of pt/cg ability to demonstrate tasks, cues needed, assistance needed, safety concerns
Caregiver Assistance

• If patient is unable to perform task safely, document the following:
  – Reason assistance is necessary
  – Degree and type of assist needed
  – Who will provide assist and their availability
  – Knowledge/ability of caregiver to perform task for patient, teaching done with caregiver
  – Caregiver demonstration of task performance
Education and Training

• Document knowledge deficit and need for education appropriate to each discipline
• Document specific information taught
• Evaluate understanding using “teach back” and/or return demonstration
• Include education on healthcare follow up post discharge
  – PCP appointments, med refills, labwork, s/sx to report, who to call for problems
Patient/Caregiver Education Issues

• Lack of documentation of knowledge deficit
• No explanation why further education needed when “full understanding” achieved
• “Teaching topics” vague
• Response to teaching not specific and measurable
• “Barriers to education” not supported by other documentation in record
• No follow up assessment of recall
Coordination to Reduce ACH

Build on Care Planning:

• Assessment
  – Risk Assessment for ED or hospitalization
• Problem identification
• Goal setting
• Interventions
• Evaluation of progress
• Discharge planning
Care Coordination

DOCUMENTATION POINTS
Care Coordination

• Patient has the right to accept or refuse disciplines / treatment

• Each discipline should document discussion of their interventions and goals with patient and caregivers

• Document communication between disciplines, patient/caregiver, physicians at key time points

• Validate decisions to recertify or discharge patient
Interdisciplinary Coordination

• Opportunity to support medical necessity, homebound status and skilled need for medically necessary homecare
• Information from all disciplines should agree
• Avoid contradictions between disciplines
• Follow up on problems identified
• Provide supporting education and assessment of effectiveness of interventions
Discharge/Transfer Summary

- HHA must compile a discharge or transfer summary for each discharged or transferred patient
- Summary must be supplied to other healthcare providers as patient transitions from HHA services to another appropriate health care setting
  - DC Summary within 5 business days of agency’s Discharge of patient from services
  - Transfer Summary within 2 business days of planned transfer to a health care facility, or of agency becoming aware of unplanned transfer
Discharge/Transfer Summary

• Initial reason for referral to HHA
• Brief description of HHA care
• Description of patient’s clinical, mental, psychosocial, cognitive and functional status at SOC and at end of care
• List of all services provided by HHA
• Start and end dates of HHA care
• Most recent drug profile
• Recommendations for follow up care
• Current individualized plan of care
• Additional documentation that assists in post-DC or transfer continuity of care, or as requested by receiving provider
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