DEALING WITH DIFFICULT PATIENTS
Defining “Difficult”
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Objectives

- Identify strategies to address “non-compliant” patients
- Describe process to discharge a patient with unmet goals
  - Appropriate notifications
- Develop strategies to avoid accepting inappropriate patients and prevent “difficult patients”
Noncompliance with POC?

- STOP before you label the patient as non-compliant!
- Understanding of condition?
- Knowledge of steps to manage condition?
- Resources and support available to manage their condition?
- Commitment to wellness?
  - Patient-driven plan of care
Understanding of condition?

- Assess baseline of patient and family/caregiver understanding
  - Diagnoses and conditions
  - Impact on lifestyle
  - Prognosis, “wellness” potential
- First step to formulate POC
Knowledge of Management?

- Identify what patient and family/caregivers know about:
  - Medications
  - Diet
  - Activity guidelines
  - Infection control
  - Signs/symptoms to report
  - Healthcare follow up

- Develop interventions for POC to address knowledge deficits identified
Resources and Support?

- Determine tools available to patient to foster successful outcomes
  - Engaged caregivers
  - Financial resources
  - Environmental conditions
  - Ability to understand/learn

- Interventions to address deficits in resources or support services
Commitment to Wellness?

- Most challenging aspect of care
  - Recognition of need to alter current behaviors
  - Patient and caregiver willingness to change behaviors
  - Ability to sustain new behaviors
- Patient participation in goal setting
- Patient self-management contracts
Using Patient Contracts

- Obtain agreement to use
- *Patient* decides which actions to work on – not nurse or caregiver/family
- Set clear timelines to achieve actions
- Evaluate progress *every visit* to foster patient accountability, engage family
- Celebrate success at each action
- Build on success to tackle more challenging actions and changes in behavior
- Provide incentive to maintain and continue management actions
Behavior of person and/or caregiver that fails to coincide with a health-promoting or therapeutic plan agreed on by the person (or family) and the healthcare professional.

In the presence of an agreed-on therapeutic plan, the person or caregiver’s behavior is fully or partially nonadherent and may lead to clinically ineffective or only partially effective outcomes.

Nursing diagnosis of noncompliance: patient desires to comply with an agreed on therapeutic plan of care but cannot due to factors that prevent them from doing so.
Strategies for Noncompliance

- Evaluate/assure patient understands the plan of care
- Investigate for barriers that prevent patient from following plan of care
- Provide education on risks and benefits of following plan of care
- Implement specific interventions to enhance compliance
- Consider use of self-management contract with patient and/or family
“Willful failure” to follow POC

- Patient has freedom of choice
  - Understands and knows POC
  - Has resources and ability to do what he needs to follow the POC
  - Actively chooses not to follow the therapeutic POC
- Documentation is critical
- Medicare benefit coverage issue: time to discharge!
Discharge of the Patient

- When to discharge patient?
  - Goals on POC are achieved
  - Patient and family/caregivers are agreeable and ready for DC
    - Able to follow up for medical care
  - Physician orders have been completed
- OR patient no longer meets Medicare eligibility criteria
Discharge for Cause

- The patient’s home is an unsafe environment for agency staff
- Continuing home health services are contributing to a poor plan of care
- Failure of patient or family or caregiver to follow the plan of care

Also be careful:

- Patient no longer requires skilled services, but family wants agency to continue unskilled/non-qualifying care
You do not need approval from state surveyor’s office to discharge for cause.

Thoroughly document that you have attempted to resolve the problems leading to discharge and have attempted to meet all patient’s needs.

Regularly communicate with physician regarding patient issues, revision of POC interventions/goals and the circumstances leading to the agency’s decision to discharge the patient.
HHCCN: Home Health Change of Care Notice

Issued to original Medicare (i.e. Medicare FFS) beneficiaries when triggering event changes POC

Triggering events are reductions or terminations in home health care services

- Due to physician or provider orders or
- Due to HHA limitations in providing the specific service

Notification is required for changes in both covered and non-covered services listed in the POC, regardless of who is responsible for paying for the service
hhccn triggering events

- Reduction of a service: any decrease in services (frequency, amount, level of care) listed on the POC and provided by the HHA. HH agency reduces or temporarily stops a service listed on the POC during a spell of illness while continuing others, including when one HH discipline ends but others continue.

- Termination of services: when a HH agency ends delivery of all services for reasons not related to Medicare coverage.
Example HHCCN Reasons

- Agency must list the reason for the reduction or termination of services
- Agency must check ONLY one of the two checkboxes:
  - Your doctor’s or provider’s orders for your home care have changed: “Your doctor has changed your orders for wound care to every other day.”
  - Your home health agency has decided to stop giving you the home care listed: “Your dog has repeatedly threatened our staff, and we are unable to safely enter your home to provide care.”
- If care changes occur for both order changes and agency reasons simultaneously, the agency must issue two HHCCN forms.
Minimum of two copies must be provided: one for agency and at least one for beneficiary (may request extra copies)

In-person delivery of the HHCCN is preferred but not required; subcontractors may deliver

The beneficiary or representative must sign and date the HHCCN; agency may fill in date if requested by patient

If beneficiary/representative refuses to sign, HHA notes this refusal on the form and gives beneficiary a copy of annotated HHCCN form
HHCCN is NOT required

- Increase in care
- Changes in HHA personnel
- Changes in expected arrival or departure time, or date of visit
- Changes in brand of product provided
- Change in duration of visit length
- Lessening the number of items or services in cases when a range of services is included on the POC
- Changes in the mix of services delivered by a specific discipline
Advanced Beneficiary Notice

Issued to original Medicare (ie. Medicare FFS) beneficiaries for liability notification in situations where items or services normally covered by Medicare may not be paid for in this case because:

- Patient is not homebound
- Care is not medically reasonable and necessary, or is custodial instead of skilled
- Hospice patient is not terminally ill
ABN Triggering Events

- **Initiation**: beginning of new start of care episode, or beginning of treatment, and agency believes services will not be covered by Medicare
- **Reduction**: agency decreases a component of care (frequency, duration, etc.), beneficiary wants to continue to receive care that is no longer medically reasonable and necessary that agency believes will not be covered by Medicare (ABN is not issued every time a service is reduced)
- **Termination**: ABN is only issued at termination if the beneficiary wants to continue care that is no longer medically reasonable and necessary
ABN Delivery

- ABN must be delivered to beneficiary prior to providing the services in question.
- HH agency must allow time for informed decision by beneficiary and/or representative.
- Optional use: prior to providing service that is never covered by Medicare (not a Medicare benefit).
Limitation on Liability

- LOL only applies when a provider believes a Medicare covered service may be denied in a case because care is not medically reasonable and necessary, care is custodial, or patient is not homebound.
- If ABN is not given, or notice is defective, provider may not shift financial liability to beneficiary for the services if Medicare denies the claim.
- In addition, provider may risk sanctions for failure to deliver appropriate notice prior to providing the care in question.
<table>
<thead>
<tr>
<th>HHAs must provide notice:</th>
<th>Use:</th>
<th>Instead of:</th>
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<tr>
<td>prior to providing an item or service that is usually paid for by Medicare but may not be paid for in this particular case because:</td>
<td><strong>ABN</strong> (CMS-R-131)</td>
<td>HHABN Option Box 1</td>
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<tr>
<td>• it is not considered medically reasonable and necessary;</td>
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<td>• the care is custodial;</td>
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<td>• the individual is not confined to the home; or</td>
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<td>• the individual does not need intermittent skilled nursing care.</td>
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<td>prior to the HHA reducing or discontinuing care listed in the beneficiary’s plan of care (POC) for reasons specific to the HHA on that occasion.</td>
<td><strong>HHCCN</strong> (CMS-10280)</td>
<td>HHABN Option Box 2</td>
</tr>
<tr>
<td>prior to the HHA reducing or discontinuing Medicare covered care listed in the POC because of a physician ordered change in the plan of care or a lack of orders to continue the care.</td>
<td><strong>HHCCN</strong> (CMS-10280)</td>
<td>HHABN Option Box 3</td>
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Notice of Medicare Non-Coverage, also known as an expedited determination notice

Issued to original Medicare (ie. Medicare FFS) beneficiaries when *all Medicare covered services* are being terminated

If termination involves the end of all Medicare covered care and no further care is being delivered, *only* the NOMNC (Notice of Medicare Non-Coverage) form CMS-10123 is required

Beneficiary may request QIO review of DC
Examples from CMS

An HHA has initiated care for a beneficiary that has not yet had the required F2F encounter. The HHA believes the F2F encounter requirement will not be met in the allowed time frame and decides to stop providing care.

- This termination is due to HHA administrative decision, HHCCN must be given prior to discontinuation of services.

- Issuing the HHCCN does not affect financial liability but serves as a written change of care notice as required by the HH Conditions of Participation.
A physician orders discontinuation of all home health services or fails to order continued services.

- The NOMNC must be issued when all Medicare services are ending based on the physician’s orders.
- Since the NOMNC provides written notification of the upcoming termination of all HH care, it satisfies the regulatory requirement for change of care advisement (HHCCN issuance). Thus when the NOMNC is issued as required, a separate HHCCN is not required.
- When HHA services end because of physician orders, HHA has the option of issuing the NOMNC alone, or both the HHCCN and the NOMNC.
Hospice Discharge

- Beneficiary dies
- Beneficiary decides to revoke the hospice benefit
- Beneficiary transfers to another hospice
- Beneficiary moves out of area
- Beneficiary condition improves and is no longer considered terminally ill
- Beneficiary is discharged for cause
Hospice Revocation

- Patient or representative may revoke the election of hospice care at any time, *must be in writing*, and the signed statement must include date of revocation.
- The hospice cannot “revoke” a patient’s hospice election.
- Hospice agency must submit a timely Notice of Termination/Revocation (NOTR).
  - Timely = NOTR submitted to and accepted by the MAC within 5 calendar days after the effective date of discharge or revocation.
Hospice Discharge for Cause

- Requirements prior to discharge (CFR 418.26):
  - Advise the patient that a discharge for cause is under consideration
  - Make a serious effort to resolve the problem(s) presented by patient’s behavior or situation
  - Ascertain that patient’s proposed discharge is not due to patient’s use of necessary hospice services
  - Document the problem(s) and efforts made to resolve the problem(s) in patient’s medical record
  - Notify the Medicare contractor (MAC) and State Survey Agency of circumstances of impending discharge
    - Surveyor approval not required
Hospice Discharge for Cause

- Requirements prior to discharge (con’t):
  - May need to make referrals to other state or community agencies if appropriate (Adult Protective Services, etc.)
  - Obtain a written physician’s discharge order from the hospice medical director; any attending physician should be consulted and his review and decision included in the discharge note

- At discharge:
  - Submit timely Notice of Termination/Revocation (NOTR) unless a final claim is already filed
Surveyor Point of View

- Surveyors consider discharge for cause primarily a payment issue.
- HH is not required to notify surveyor bureau of impending DC, but Hospice is required.
- Surveyor will not review the medical record unless there is a complaint filed or happen to pull it for survey sample.
- Surveyor will check to make sure a HHCCN is in chart to meet regulatory requirements, and extraordinary circumstances should be clearly documented – this is where you are vulnerable to citation!
- For the ABN, surveyor will make sure agencies are doing them, but leave it to the MAC’s to determine specifics about when and how they are to be done.
Be Proactive!

- Gather all available information at referral
- Initial visit to determine patient eligibility for services under Medicare benefit AND whether your agency has the resources to meet the patient’s care needs
- Clearly explain the role of HH and expectations for patient/caregiver participation in POC
- Start discharge planning at SOC visit, make discharge planning an ongoing point
- Keep visits goal oriented, revise POC as needed
- Communicate with physician re: any problems with care delivery or progress to goals
Intake Strategies

- Develop an Intake-Initial Visit check list to identify appropriate patients
- Review and update policies on patient responsibilities, discharge for cause criteria and procedure
- Inservice staff on patient interaction, respect, how to spot concerns and reporting requirements for potential problems
- As always: documentation makes the difference!
References

Reference for notifications:

- HHCCN: Medicare Claims Processing Manual, Ch. 30, Section 60
- ABN: Section 50
Questions?

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