Care Planning and Care Coordination Under the New CoPs

Apryl Swafford RN, BSN, COS-C, HCS-D, HCS-H
APRYL SWAFFORD RN, BSN, COS-C, HCS-D, HCS-H
NEW CONDITIONS OF PARTICIPATION

- January 13, 2018
- Around patient-centered care
# MEDICAL MODEL VS. PATIENT CENTERED MODEL

<table>
<thead>
<tr>
<th>Medical Model</th>
<th>Patient-Centered Model</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient’s role is passive</td>
<td>Patient’s role is active</td>
</tr>
<tr>
<td><em>(Patient is quiet)</em></td>
<td><em>(Patient asks questions)</em></td>
</tr>
<tr>
<td>Patient is the recipient of treatment</td>
<td>Patient is a partner in the treatment plan</td>
</tr>
<tr>
<td><em>(Does not offer options)</em></td>
<td><em>(Patient asks about options)</em></td>
</tr>
<tr>
<td>Physician dominates the conversation</td>
<td>Physician collaborates with the patient</td>
</tr>
<tr>
<td><em>(Disease is the focus of daily activities)</em></td>
<td><em>(Offers options; discusses pros &amp; cons)</em></td>
</tr>
<tr>
<td>Care is disease-centered</td>
<td>Care is quality-of-life centered</td>
</tr>
<tr>
<td>*</td>
<td><em>(The patient focuses on family &amp; other activities)</em></td>
</tr>
<tr>
<td>Physician does most of the talking</td>
<td>Physician listens more &amp; talks less</td>
</tr>
<tr>
<td>Patient may or may not adhere to treatment plan</td>
<td>Patient is more likely to adhere to treatment plan</td>
</tr>
<tr>
<td></td>
<td><em>(Treatment accommodates patient’s cultures &amp; values)</em></td>
</tr>
</tbody>
</table>
MOVE TO PATIENT CENTERED CARE

- The IOM (Institute of Medicine) defines patient-centered care as: “Providing care that is respectful of, and responsive to, individual patient preferences, needs and values, and ensuring that patient values guide all clinical decisions.” May 15, 2015
8 ELEMENTS OF PATIENT CENTERED CARE

- Respecting patients’ preferences, values, and desire to stay informed
- Providing emotional support for patients’ concerns (e.g., anxiety)
- Ensuring patients’ physical comfort is managed (e.g., pain management)
- Informing and educating patients about their condition(s)
- Ensuring continuity of care and transitional assistance after patients are discharged
- Coordinating and integrating care between care providers, hospitals, and/or clinics
- Enabling of patients to access to care whenever care is needed
- Including family and friends as caregivers and decision makers
§ 484.60-CARE PLANNING AND CARE COORDINATION
§ 484.60 (A) STANDARD OF CARE

- Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration.

- If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan. Patient measurable outcomes may include such measurements as end-result functional and physical health improvement/stabilization, health care utilization measures (hospitalization and emergency department use), and potentially avoidable events.
§ 484.60 (A) STANDARD OF CARE-IG

- Patient goals are individualized to the patient based on the medical diagnosis, physician’s orders, comprehensive assessment and patient input. Progress/non-progress toward achieving the goals is quantified through measurable outcomes, which may be described as a patient’s response to a health care intervention.

- Periodically reviewed means every 60 days or more frequently when indicated by changes in the patient’s condition.
The patient’s physician provides orders for treatments and services. These orders are the foundation of the plan of care. The HHA includes goals for the patients, patient preferences and service schedules as a part of the plan of care.

If the HHA misses visits or services as required by the plan of care, it must notify the responsible physician of the missed visit if there is any potential for clinical impact upon the patient. The physician decides whether the patient visit may be skipped or additional intervention is required by the HHA due to the impact on the patient.
§ 484.60 (A) STANDARD OF CARE

- If the patient or the patient’s representative refuses care (such as dressing changes, essential medication or other services that could impact the patient’s clinical wellbeing) on more than one occasion the HHA attempts to identify the cause of the refusal. If the HHA is unable to identify and address the cause, the HHA must communicate with the patient’s responsible physician to discuss the options.

- The physician should not be approached to reduce the frequency of services based solely on the availability of HHA staff.

- In instances where the HHA receives a general referral from a physician that requests HHA services but does not provide the actual plan of care components (treatments and observations) for the patient, the HHA will not be able to create a comprehensive plan of care to include goals and services until a home visit is done and sufficient information is obtained to communicate with and receive approval from the physician.
§ 484.60 (A)(2)-CONTENTS OF THE CARE PLAN

Must Include:

- All pertinent diagnosis (all known diagnosis)
- The patient’s mental, **psychosocial, cognitive issues**
- The types of services, supplies, and equipment required.
- The frequency and duration of visits
- Prognosis
- Rehab potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments
- Safety measures to protect against injury
§ 484.60 (A)(2)-CONTENTS OF THE CARE PLAN

- Must Include:
  - A description of the patient’s risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors
  - Patient and caregiver education and training to facilitate timely discharge
  - Patient specific interventions and education; measurable outcomes and goals identified by the HHA and the patient
  - Information related to the advanced directive
  - Any additional items the HHA or physician may choose to include.
• Mental status is most generally screened by asking questions on orientation to time place and person.

• Psychosocial status may include, as relevant to the plan of care, interpersonal relationships in the immediate family, financial status, homemaker/household needs, vocational rehabilitation needs, family social problems and transportation needs.

• The risk of ER visits and hospitalizations is greatly influenced by increased concerns or needs identified in status elements.
HOW TO PREPARE

- Does your current documentation have an adequate psychosocial and cognitive assessment?
- Does your agency collect hospitalization risk assessments and if so, do you have criteria, or what you will do with this patient?
- How to identify and document patient goals and formulate the agency’s goals around that.
§ 484.60 (A)(3)-ALL ORDERS RECORDED IN THE POC

- All patient care orders, including verbal orders, must be recorded in the plan of care.
Drugs, services and treatments are ordered by the physician that establishes and periodically reviews the plan of care.

Influenza and pneumococcal vaccines may be administered per agency policy developed in consultation with a physician, and after an assessment of the patient to determine for the screening contraindications. The administration of these vaccines is an exception to §484.60(b)(1).

Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies.
§ 484.60 (B)-DRUG/TREATMENTS ORDERED BY MD

- When services are provided on the basis of a physician’s verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA’s policies, must document the orders in the patient’s clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA’s internal policies.
When services are furnished based on a physician's oral order, the order must be put into writing by personnel authorized to do so by applicable State laws and regulations as well as by the HHA’s internal policies. The orders must be signed and dated with the date of receipt by the nurse or qualified therapist (i.e., physical therapist, speech-language pathologist, occupational therapist, or medical social worker) responsible for furnishing or supervising the ordered services.

In the absence of a state requirement, the HHA should establish a timeframe for physician authentication, (i.e. method of obtaining the physician signature of verbal/telephone orders received). The signature may be written or in electronic form following the requirements of the particular system. A method must be established to identify the signer.
The individualized plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.
The signature and date of the review by the responsible physician verifies the interval between health care plan reviews.

The plan of care may include orders for treatment or services incorporated from physicians other than the responsible physician. These orders are approved by the responsible physician as an updated plan of care. With a change in patient condition, the HHA should notify the responsible physician and the physician(s) associated with the relevant aspect of care.

Interim changes in physician orders and the plan of care do not automatically restart the timeframe for physician review of the plan of care. However, if there is a significant change in the patient’s condition and the services to be provided by the HHA, the revised plan of care is sent to the responsible physician for review and approval which restarts the 60 day period for review of subsequent plans of care.
A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient’s progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.

Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians issuing orders for the HHA plan of care.
There must be evidence in the clinical record that the HHA has explained to the patient that a change to the plan of care has occurred and how this change will impact the care delivered by the HHA. The clinical record also documents, through notation that the revised plan of care was shared or by evidence of new orders received, that all relevant physicians providing care to the patient have been notified of the change in patient health status and associated changes to the plan of care.
§ 484.60 (C)-REVIEW AND REVISION TO POC

- Any revisions related to plans for the patient’s discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient’s 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).
§ 484.60 (C)-REVIEW AND REVISION TO POC IG

- Discharge planning begins early in the provision of care and must be revised as the patient’s medical condition or life circumstances change. As these changes are identified there must be evidence in the clinical record that the HHA discussed these changes with the patient, his/her representatives and the responsible physician.

- Other health care professionals who may need to be notified of discharge plan changes are those relevant physicians who are also contributing orders to the care plan.
WHAT IS CARE COORDINATION?
CARE COORDINATION

- Means different things to different people

BROAD DEFINITION

"Care coordination is the deliberate organization of patient care activities between two or more participants (including the patient) involved in a patient’s care to facilitate the appropriate delivery of health care services. Organizing care involves the marshalling of personnel and other resources needed to carry out all required patient care activities and is often managed by the exchange of information among participants responsible for different aspects of care."
PATIENT/FAMILY PERSPECTIVE

- Care coordination is any activity that helps ensure that the patient's needs and preferences for health services and information sharing across people, functions, and sites are met over time.

- Patients, their families, and other informal caregivers experience failures in coordination particularly at points of transition. Transitions may occur between health care entities and over time and are characterized by shifts in responsibility and information flow. Patients perceive failures in terms of unreasonable levels of effort required on the part of themselves or their informal caregivers in order to meet care needs during transitions among health care entities.
HEALTH CARE PROFESSIONALS PERSPECTIVE

- Care coordination is a patient- and family-centered, team-based activity designed to assess and meet the needs of patients, while helping them navigate effectively and efficiently through the health care system. Clinical coordination involves determining where to send the patient next (e.g., sequencing among specialists), what information about the patient is necessary to transfer among health care entities, and how accountability and responsibility is managed among all health care professionals (doctors, nurses, social workers, care managers, supporting staff, etc.). Care coordination addresses potential gaps in meeting patients' interrelated medical, social, developmental, behavioral, educational, informal support system, and financial needs in order to achieve optimal health, wellness, or end-of-life outcomes, according to patient preferences.
Caring for high-need, high-cost patients

**WHAT WORKS**

1. **Target** the population most likely to benefit
2. **Assess** patients' health-related risks and needs
3. **Develop** care plan centered around patients' needs and preferences
4. **Engage** patients and family members in managing care
5. **Connect** patients to appropriate follow-up and support services after hospital discharge
6. **Coordinate** care and facilitate communication among all care providers
7. **Monitor** progress
The HHA must:

- Assure communication with all physicians involved in the plan of care.
- Integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.
- Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.
§ 484.60 (D)-COORDINATION OF CARE

The HHA must:

• Coordinate care delivery to meet the patient’s needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.

• Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.
§ 484.60 (D) - COORDINATION OF CARE IG

The HHA must:

- Assure communication with all physicians involved in the plan of care.
- The physician who initiated home health care is responsible for the ongoing plan of care; however, in order to assure the development and implementation of a coordinated plan of care, communication with all physicians involved in the patient’s care is often necessary. While a patient may see several physicians for various medical problems, not all of the physicians would necessarily be involved in the skilled services defined in the home health plan of care. For this requirement physicians involved in the plan of care are those physicians who give orders that are directly related to home health skilled services.
The HHA must:

- Integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.
- Upon admission or upon any change in patient condition, the responsible physician identifies any other relevant physicians that should be contacted for orders to be included in the HHA plan of care. The clinical manager or other staff designated by the HHA is responsible for integrating orders from all relevant physicians involved into the HHA plan of care and ensuring the orders are approved by the responsible physician.
The HHA must:

• Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.

• The HHA schedules/provides care by various disciplines in a manner that:

• The agency manages the scheduling of patients taking into consideration the type of services that are being provided on a given day; a patient may become fatigued after a HH aide visit assisting with a bath just before a physical therapy visit, thus making the therapy session less effective.
The HHA must:

• Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.

• The agency manages pain during physical therapy or physical care (i.e. dressing changes or wound care) in order to minimize patient discomfort while maximizing the effectiveness of the therapy session.

• The agency works with the patient to recommend and make safety modifications in the home.

• The agency assures that staff who provide care are communicating any patient concerns and patient progress toward the goals of the plan of care with others involved in the patient’s care.
The HHA must:

- Coordinate care delivery to meet the patient’s needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.
- Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.
- The comprehensive assessment, patient-centered plan of care and the goals identified therein inform the training and education objectives for each patient. The goals of the HHA episode are established at admission and revised as indicated. With the discharge plan clearly identified, patient education and documentation of the patient response to the education begins upon admission and continues throughout the HHA services. The patient/caregiver responses to and comprehension of the training is monitored.
WRITTEN INFORMATION TO THE PATIENT
§ 484.60 (E) - INFORMATION TO PATIENT

The HHA must provide the patient and caregiver with a copy of written instructions outlining:

- Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.
- Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA.
- Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.
- Any other pertinent instruction related to the patient’s care and treatments that the HHA will provide, specific to the patient’s care needs.
- Name and contact information of the HHA clinical manager.
The HHA must provide the patient and caregiver with a copy of written instructions:

- Once the comprehensive assessment is completed (within 5 days of the initial visit) and the plan of care is approved by the responsible physician, the documents listed in must be provided to the patient and/or their representative.
- Clear written communication between the HHA and the patient and/or representative ensures that patients and families understand what services to expect from the HHA, the purpose of each service and when to expect the services.
§ 484.60 (E)-INFORMATION TO PATIENT-IG

- Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.
  - The most current written visit schedule provided to the patient is consistent with the most current plan of care.
§ 484.60 (E)-INFORMATION TO PATIENT-IG

- Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.
- Any other pertinent instruction related to the patient’s care and treatments that the HHA will provide, specific to the patient’s care needs.
- Name and contact information of the HHA clinical manager.
  - The name and contact information (telephone number must be provided and e-mail may be provided as well if the patient prefers electronic communication) must be provided to the patient. The HHA explains to the patient when the clinical manager should be contacted for discussion about their services.
You Choose!
QUESTIONS?

Apryl Swafford RN, BSN, COS-C, HCS-D, HCS-H
Home Health Solutions, LLC
888-418-6970
www.homehealthsolutionsllc.com
aprylswafford@homehealthsolutionllc.com