National Association for Home Care and Hospice
2013 March on Washington

Home Health Survey and Certification
Pat Sevast - Survey and Certification Group
Centers for Medicare & Medicaid Services
patricia.sevast@cms.hhs.gov
410-786-8135
March 18, 2013

OASIS-C Guidance Manual Updates

• The OASIS-C Guidance Manual has been updated in December 2012 to incorporate the prior errata and pertinent Q&A’s that needed clarity
  – OASIS Q&As are found at:
    – https://www.qtso.com/hhadownload.html

• Revisions to the Guidance Manual incorporating these and subsequent errata will be posted annually in December
Resources-OASIS Items

OASIS Home Page

OASIS data set
- OASIS Guidance Manual - Chapter 3
- Revised December 2012

Resources-OASIS Items

OASIS Training Modules
OASIS Training

• Series of modules to replace old web based training

• Modules posted
  – Patient Tracking Domain
  – Clinical Record Items Domain
  – Living Arrangements & Sensory Status
  – Integumentary Status Domain – Pressure Ulcers Part 1 and Part 2 and Stasis Ulcers, Surgical Wounds & Skin Lesions
  – Respiratory & Cardiac Status Domain
  – Elimination Status Domain

OASIS Training

• Modules (cont.)
  – Neuro/Emotional/Behavioral Status Domain
  – Medications
  – Care Planning and Interventions
  – ADLs/IADLS

• Others in Development
  – Overview and Conventions
  – Care Management, Therapy Need and Emergent care
  – Patient History and Diagnosis
OASIS-C1

- PRA package to be published with comment period
- Items to be revised for implementation of ICD-10 on 10/1/2014
- Other changes to update OASIS items based on research and testing

Additional Manuals

Resources for Data Transmission

OASIS Educations and Automation Coordinators

- QTSO help
  - Phone: 800-339-9313
  - E-mail: help@qtso.com

Process Measure Update

- Added to our toolkit - [www.youtube.com/user/CMSHHSgov](http://www.youtube.com/user/CMSHHSgov)
- Understanding PBQI
  - [http://www.youtube.com/user/CMSHHSgov#p/search/1/hNno1GIVAPA](http://www.youtube.com/user/CMSHHSgov#p/search/1/hNno1GIVAPA)
Accurately Responding to Process Items:

• Plan of Care Synopsis (M2250)
  http://www.youtube.com/user/CMSHHSgov#p/search/10/H7mdobdIXr4

• Focus on the Fall Risk Assessment (M1910)
  http://www.youtube.com/user/CMSHHSgov#p/u/3/qUFqZwQycY

• Focus on the Intervention Synopsis (M2400)
  http://www.youtube.com/user/CMSHHSgov#p/u/0/XrPj8GQJvG

OASIS Transmission

• OASIS submission is now tied to the
  – Conditions of Participation
  – Quality Measures – Pay 4 Reporting (P4R) and HH Compare
  – OBQI/OBQM (used for survey)
  – Conditions for Coverage/Payment

• The goal being accurate data in the National Repository for all Medicare/Medicaid payment sources
HH CAHPS

HHCAHPS Survey Participation
Periods

<table>
<thead>
<tr>
<th>For APU in</th>
<th>Participation Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>CY12</td>
<td>Submit an HHCAHPS data file containing data from a dry run of the HHCAHPS Survey for one or more months in CY10, Q3 and submit a data file for each month from October 2010 through March 2011</td>
</tr>
<tr>
<td>CY13</td>
<td>Submit an HHCAHPS Survey data file for each month from April 2011 through March 2012</td>
</tr>
<tr>
<td>CY14</td>
<td>Submit an HHCAHPS Survey data file for each month from April 2012 through March 2013</td>
</tr>
</tbody>
</table>

• HHCAHPS website:
  - https://www.homehealthcahps.org
• Contract with approved HHCAHPS vender
• Register for credentials
• Authorize an HHCAHPS vender
• For more information contact: hhachps@rti.org or call 1-800-354-0985
Conditions of Participation

- Appendix B of State Operations Manual
- Revisions proposed March 1997
- Publication delayed
- Revised Conditions in clearance now

Survey Frequency

- Statutory requirement to survey HHAs no less frequently than every 36 months
- Mission and Priority Document
  - States receive Tier 1 list – all statutory requirements
  - Tier 2 list - 5% Targeted sample based on algorithm - previous survey timing and quality
- Validation Surveys
  - Federal
  - Accrediting Organizations (AOs)
Surveyor Focus

- Quality of Care
- Patient Safety
- Outcome Oriented
- Types of Surveys
  - Standard Survey
  - Partial Extended
  - Fully Extended

Survey Tasks

- Pre-survey preparation
- Entrance Interview
- Information gathering
- Information analysis
- Exit Conference
- Formation of Statement of Deficiencies (2567)
Revised Surveyor Protocols

- Issued February 11, 2011, S&C letter 11-11
- Implemented May 2011
- Includes revised Appendix B with survey protocols
- Will be revised when guidance for Alternative Sanctions is completed

HHA Alternative Sanctions

- Legislated as part of OBRA “87
- Final regulation published as part of CY2013 Home Health PPS Rule, November 8, 2012
- Survey and Enforcement Requirements for Home health Agencies, 42 CFR 488, Survey, Certification and Enforcement Procedures,
CMS Expectations

• Provider remain in substantial compliance with Medicare program requirements as well as State law
  – Emphasis on continued rather than cyclical compliance
  – Enforcement mandates that policies be established to correct deficient practice and correction is lasting
  – HHAs take the initiative and responsibility for monitoring performance to sustain compliance

CMS Expectations

• Deficiencies will be addressed promptly
  – The standard is substantial compliance
  – Alternative sanctions could be imposed by CMS in lieu of immediate termination
  – Can remain in place for up to six months

• Individuals under the care of the HHA receive the care and services they need to attain and maintain their highest practicable functional ability
HHA Survey and Certification

- Subpart I – Survey and certification of Home Health Agencies
  - 488.700 – Basis and scope
  - 488.705 – Definitions
  - 488.710 – Standard surveys
  - 488.715 – Partial Extended surveys
  - 488.720 – Extended surveys
  - 488.725 – Unannounced surveys
  - 488.730 – Survey frequency and content
  - 488.735 – Surveyor qualifications
  - 488.740 – Certification of compliance or noncompliance
  - 488.745 – Informal Dispute resolution (IDR)

HHA Alternative Sanctions

- Subpart J – Alternative Sanctions for Home Health Agencies With Deficiencies
  - 488.800 – Statutory basis
  - 488.805 – Definitions
  - 488.810 – General provisions
  - 488.815 – Factors to be considered in selecting sanctions
  - 488.820 – Available sanctions
  - 488.825 – Action when deficiencies pose immediate jeopardy
HHA Alternative Sanctions (cont.)

- 488.830 – Action when the deficiencies at condition-level but do not pose immediate jeopardy
- 488.835 – Temporary management
- 488.840 – Suspension of payment for all new admissions
- 488.845 – Civil money penalties
- 488.850 – Directed plan of correction
- 488.855 – Directed in-service training
- 499.860 – Continuation of payments to an HHA with deficiencies

488.865 – Termination of provider agreement

FY 2011 - Top 10 Survey Deficiencies – Home Health

- G158 – Written Plan of Care established & periodically reviewed
- G337 – Assessment includes review of all medications
- G159 – Plan of Care covers diagnosis, required services, visits, etc.
- G236 – Record with past/current findings maintained for all patients
- G121 – Compliance with accepted professional standards/principles
Top 10 Survey Deficiencies
Home Health

• G170 – Skilled Nursing Services furnished in accordance with Plan of Care
• G143 – Coordination of Patient Services
• G229 – Supervisory visits if skilled care no less than once every 2 weeks
• G176 – RN prepares notes, coordinates, informs MD, other staff of changes
• G165 – Drugs and treatment administered only as ordered by physician

Top 10 OASIS Transmission Errors

• 286 – Warning – Inconsistent M0090/Submission Date
• 1000 – Fatal Record - Duplicate assessment
• 1002 – Warning – Inconsistent record sequence
• 320 – The submitted HIPPS_VERSION must match the calculated HIPPS_VERSION value
Top 10 OASIS Transmission Errors

- 1003 – Warning – Inconsistent effective date sequence.
- 262 – Warning – Inconsistent M0090 date
- 213 – Fatal Record – Invalid data value

Top 10 OASIS Transmission Errors

- 129 – Warning - Inconsistent M0090 date
- 257 – Warning – The submitted HIPPS_CODE must match the calculated HIPPS_CODE value
- 265 – Warning – New Patient
Other Resources

- HHA Center - http://www.cms.gov/Center/Provider-Type/Home-Health-Agency-HHA-Center.html
- HHA PPS – http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HomeHealthPPS/index.html

Other Resources (cont.)

Electronic Health Information Exchange
Initiatives

NAHC Spring Conference

CMS & ASPE Panel on Home Health Regulatory & Policy Issues

Jennie Harvell
Department of Health and Human Services
Office of the Assistant Secretary for Planning and Evaluation (ASPE)
March 18, 2013

Transitions of Care

- Medically-complex and/or functionally impaired individuals receive care from a wide array of ambulatory, acute hospital, post-hospital, and long-term services and supports delivered by numerous providers during single episodes and across multiple episodes of care.

- Transitions of Care are common.
  - Research found that in 2008:
    - 37.3% of hospitalized Medicare beneficiaries were discharged to HHA services;
    - of these HHA recipients, 28.1% were readmitted to the acute care hospital; and
    - 9% of beneficiaries discharged to HH were subsequently discharged to outpatient therapy

Source: http://aspe.hhs.gov/health/reports/2011/pacexpanded/index.shtml#ch1
Shared care

- Shared Care is common. For example:
  - HHAs and Physicians collaboratively develop the HH Plan of Care
  - Physicians deliver needed medical services
  - HHA staff deliver needed nursing, therapy, and aide services
  - Other community-based providers/caregivers deliver other needed services (e.g., DME suppliers, pharmacies, meals on wheels, informal caregivers, etc.)

Problems

- Health information is siloed, often not shared across providers, and not shared between health information systems.

- The lack of timely health information exchange results in:
  - Poor continuity and coordination care
  - Errors resulting in safety and quality problems
  - Redundancies in tests/other services
  - Avoidable ER admissions and Hospital readmissions
  - Unnecessary costs
Electronic HIE Initiatives

Request for Information

- HHS published an RFI on how to accelerate HIE including for persons who receive long-term/post-acute care services. Comments due: 5 p.m. 4/22/13

- The RFI seeks input on potential policy and programmatic changes to accelerate electronic HIE as well as new ideas that would be both effective and feasible to implement.

Other HIE Policies/Initiatives

- There are a variety of initiatives that have a focus on HIE in LTPAC including:
  - ONC sponsored grant programs
  - CMMI demonstration programs
  - ASPE sponsored research

- Medicare and Medicaid EHR Programs makes available incentive payments for Eligible Providers (e.g., acute care hospitals and physicians) for their meaningful use (MU) of certified EHRs.
  - Stage 2 MU Requirements (effective in 2104) include a focus on HIE
  - Stage 3 MU Requirements may increase HIE requirements
## Key EHR Meaningful Use Requirements

### Stage 2 Requirements.
Eligible Providers required to:

- Send interoperable “Summary Care Records” during transitions of care, which may include LTPAC.

- Summary Care Records must include, if known:
  - Care plans
  - Functional/Cognitive Status Information

- Specifies HIT standards for the interoperable exchange of documents (including sections and data elements) (i.e., uses the Consolidated-CDA (CCDA))

### Stage 3 Considerations.
Health IT Policy Committee (an advisory body to ONC) is considering:

- The data needed to be exchanged at times of transition of care

- Further specification regarding the exchange of care plans

- Need for standards for more robust interoperable HIE at times of transition of care, including the exchange of care plans, including the Home health plan of care

## Standards and Interoperability
### Longitudinal Coordination of Care Workgroup
Public/Private Workgroup, lead out of ONC, that:

- Advanced health IT standards used in the EHR MU Stage 2 program for functional/cognitive status; and

- Is advancing standards for the electronic exchange of:
  - more robust Transfer of Care Summary Documents, and
  - Care Plan Documents, including the Home health Plan of Care.
ToC and Care Plan Datasets

Transfer of Care

Consultation Request

Care Plan

Shared Care Encounter Summary

Home Health Plan of Care (Formerly the CMS-485)

Source: Larry Garber, MD. MA IMPACT Program/S&I LCC WG

S&I LCC WG Care Plan Recommendations

Recommended Care Plan Segments:

- Health Concerns
- Goals
- Instructions
- Interventions
- Outcomes
- Team Members
### HH PoC Sections

- Patient Demographics
- ICD-9 codes
- Meds
- DME/Supplies
- Safety measures
- Allergies
- Nutritional Requirements
- Functional Limitations
- Activities Permitted
- Mental Status
- Prognosis
- Orders
- Goals/Rehabilitation Potential/Discharge Plans

<table>
<thead>
<tr>
<th>HHA Name/Address</th>
<th>Physician’s Name and Address</th>
</tr>
</thead>
<tbody>
<tr>
<td>Start Of Care Date</td>
<td>Address</td>
</tr>
<tr>
<td>Certification Period</td>
<td></td>
</tr>
<tr>
<td>Nurse's Signature</td>
<td>Attending Physician's Signature and Date</td>
</tr>
</tbody>
</table>


### S&I LCC WG

  - Calendar of events on right
  - Scroll down (on left) to see link to: Longitudinal Coordination of Care (LCC)

- Standing LCC meetings:
  - Mondays at 11 AM ET:
    - Identifying value sets for HIE for transitions in care and care plans, including HH plan of care
    - Vendor Participation is needed. E.g.,
      - What content is already in your products?
      - Can this content be re-used for HIE?
  - Tuesdays at 10 AM ET
    - Developing the use case for the exchange of care plans, including HH plan of care

- LCC Initiative Coordinator: Evelyn Gallego
  - [evelyn.gallego@siframework.org](mailto:evelyn.gallego@siframework.org)
Questions?

- Contact:
  - Jennie.Harvell@hhs.gov

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**S&I LCC WG Care Plan Recommendations**

<table>
<thead>
<tr>
<th>Care Plan Segment</th>
<th>S&amp;I Definition</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Health Concerns</strong></td>
<td>Health concerns reflect the issues, current status and 'likely course' identified by the patient or team members that require intervention(s) to achieve the patient's goals of care, any issue of concern to the individual or team member. “Problems” and “diagnoses” will capture medical/surgical diagnosis but are insufficient to capture the full array of issues that are important to individuals. Health concerns include: Medical/surgical diagnoses and severity. Nursing/Allied Health/Behavioral Health issues. Patient reported health concerns. Behavioral/Cognition/Mood issues. Functional status, including ADL issues. Environmental factors (e.g. housing and transportation). Social factors including availability of support and relationships. Financial issues (e.g. insurance, eligibility for disability).</td>
</tr>
</tbody>
</table>
### S&I LCC WG Care Plan Recommendations

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<tr>
<td>Goals</td>
<td>A defined outcome or condition to be achieved in the process of patient care. Includes patient defined goals (e.g., prioritization of health concerns, interventions, longevity, function, comfort) and clinician specific goals to achieve desired and agreed upon outcomes.</td>
</tr>
<tr>
<td>Instructions</td>
<td>Information or directions to the patient and other providers including how to care for the individual's condition, what to do at home, when to call for help, any additional appointments, testing, and changes to the medication list or medication instructions, clinical guidelines and a summary of best practice.</td>
</tr>
<tr>
<td>Interventions</td>
<td>Actions taken to maximize the prospects of achieving the patient's or providers' goals of care, including the removal of barriers to success. Instructions are a subset of interventions.</td>
</tr>
<tr>
<td>Outcomes</td>
<td>Status, at one or more points in time in the future, related to established care plan goals.</td>
</tr>
<tr>
<td>Team Members</td>
<td>Parties who manage and/or provide care or service as specified and agreed to in the care plan, including: clinicians, other paid and informal caregivers, and the patient.</td>
</tr>
</tbody>
</table>
| Standards         | For Meaningful Use Stage 3 Requirements: Extend the Document Exchange standard required in the Stage 2 EHR Meaningful Use Programs to support the interoperable exchange of:  
* More robust transition of care documents; and  
* Care plans, including the home health plan of care |
HHS RFI on Accelerating HIE (Questions)

1. What changes in payment policy would have the most impact on the electronic exchange of health information, particularly among those organizations that are market competitors?

2. Which of the following programs are having the greatest impact on encouraging electronic health information exchange: Hospital readmission payment adjustments, value-based purchasing, bundled payments, ACOs, Medicare Advantage, Medicare and Medicaid EHR Incentive Programs (Meaningful Use), or medical/health homes? Are there any aspects of the design or implementation of these programs that are limiting their potential impact on encouraging care coordination and quality improvement across settings of care and among organizations that are market competitors?

3. To what extent do current CMS payment policies encourage or impede electronic information exchange across health care provider organizations, particularly those that may be market competitors? Furthermore, what CMS and ONC programs and policies would specifically address the cultural and economic disincentives for HIE that result in “data lock-in” or restricting consumer and provider choice in services and providers? Are there specific ways in which providers and vendors could be encouraged to send, receive, and integrate health information from other treating providers outside of their practice or system?
4. What CMS and ONC policies and programs would most impact post acute, long term care providers (institutional and HCBS) and behavioral health providers’ (for example, mental health and substance use disorders) exchange of health information, including electronic HIE, with other treating providers? How should these programs and policies be developed and/or implemented to maximize the impact on care coordination and quality improvement?

5. How could CMS and states use existing authorities to better support electronic and interoperable HIE among Medicare and Medicaid providers, including post acute, long-term care, and behavioral health providers?

6. How can CMS leverage regulatory requirements for acceptable quality in the operation of health care entities, such as conditions of participation for hospitals or requirements for SNFs, NFs, and home health to support and accelerate electronic, interoperable health information exchange? How could requirements for acceptable quality that involve health information exchange be phased in overtime? How might compliance with any such regulatory requirements be best assessed and enforced, especially since specialized HIT knowledge may be required to make such assessments?

7. How could the EHR Incentives Program advance provider directories that would support exchange of health information between Eligible Professionals participating in the program. For example, could the attestation process capture provider identifiers that could be accessed to enable exchange among participating EPs?

8. How can the new authorities under the Affordable Care Act for CMS test, evaluate, and scale innovative payment and service delivery models best accelerate standards-based electronic HIE across treating providers?

9. What CMS and ONC policies and programs would most impact patient access and use of their electronic health information in the management of their care and health? How should CMS and ONC develop, refine and/or implement policies and program to maximize beneficiary access to their health information and engagement in their care?

10. What specific HHS policy changes would significantly increase standards based electronic exchange of laboratory results?