Home Health Line

Regulatory news, benchmarks and best practices to build profitable home care agencies

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OASIS

New self-care and mobility items among biggest concerns in proposed OASIS-D

To ensure communication and consistency across assessments, have physical therapists cross-train nurses on setting discharge goals. This will help agencies prepare for OASIS-D items GG0170 (Mobility) and GG0130 (Self-care).

CMS recently released an all-item set version of OASIS-D along with a crosswalk, itemized list of OASIS-D data elements and supplemental analysis that includes estimates on how long CMS believes the revised assessment will take to complete.

*(see **OASIS**, p. 5)*

Comply with new CoPs

Train intake to gather more detail, ensure patient rights process is efficient

To help comply with the new patient rights requirements in the revised Home Health Conditions of Participation (CoPs), agencies should train intake employees to ask key questions about patients and their representatives.

According to the draft interpretive guidelines, the agency must provide the patient and the patient's legal representative (if any) a number of things during the initial evaluation visit — in advance of furnishing care to the patient [§484.50(a)(1)].

*(see **Rights**, p. 7)*

OSHA

Put the brakes on distracted driving: Ban cell phone use behind the wheel

For employees who drive on agency time, the issue of distracted driving isn't just about the safety of the employee and others on the road — it's also the about potential for employer liability.

Many agencies nationwide don't have a distracted driving policy, and many others don't have a version that's fleshed out. Those agencies should implement a detailed policy, says Eileen Maguire, a partner at Indianapolis-based Gilliland, Maguire & Harper, P.C.

"The importance of this cannot be minimized at all," she says. "An employer can be held liable for an employee's accident if the accident takes place during the course of their employment." If it can be shown that the accident was caused because the employee was texting for work while driving, this would likely impact the employer's overall liability costs, she says.

The Occupational Safety and Health Administration (OSHA) requires employers to have "a clear, unequivocal and enforced policy against texting while driving" and for employers to "remove any incentives that may motivate employees to text while behind the wheel."

Violations of OSHA policies can result in fines ranging from $12,000 to as much as $129,000 for a willful violation.

If an employee texts or talks on a cell phone while driving on company time and crashes, law enforcement and attorneys will look at whether the agency has a distracted driving policy, whether the agency enforces it and whether the agency has documented training, Maguire says.

Distracted driving could prove costly

Although 47 states have banned texting by drivers and 15 states forbid hand-held phone use behind the wheel, the U.S. Centers for Disease Control and Prevention estimates nine people are killed every day from an accident involving a distracted driver.

According to the World Health Organization, two seconds of distraction dramatically increases the likelihood of being involved in an automobile accident.

While an employer's insurer is ultimately liable for an accident, Maguire says, if the crash was caused by texting or cell phone use and the company doesn't have a clear policy in place, employers could be on the hook for much more.

Over the past decade, companies have paid millions to the families of individuals who died in crashes caused by employees' distracted driving, and most of the payouts came from companies that didn't have a policy in place or whose policies the courts declared to be ambiguous.

Agency ensures policy is followed

Dale Brock, president and administrator of two Visiting Angels locations in Fort Worth, Texas,

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implemented a distracted driving policy more than four years ago. Brock ensures caregivers in the field are aware that the agency won't permit texting or talking on hand-held phones while caregivers are driving.

Since that time, Texas has passed legislation making the use of anything other than a hands-free device while driving a Class C misdemeanor.

Texas' law validates the agency's decision to include such language in a policy, Brock says. "It's for the protection of the employee, the clients we transport and the agency from a risk management standpoint."

In addition to enforcing the policy, which Maguire drafted, Brock checks driving records of his employees through the Department of Motor Vehicles annually. This indicates whether employees received a distracted driving violations or other citations.

Brock says employees are trained on the distracted driving policy at the time of hire, and that they keep it "front of mind," especially with the high numbers of law enforcement officers "watching out" for violators now that the law has changed.

In your policy, explain that employees will face disciplinary action — up to and including termination — if they commit violations, Maguire says. She advises agencies to outline consequences for subsequent distracted driving violations and ensure the policy and disciplinary procedures are enforced.

Visiting Angels' policy states that distracted driving violations will be subjected to the same progressive discipline applied to other policy violations. Violators receive a verbal warning for the first violation and a written warning for the second, with the potential for termination for repeat violations. Brock only has had to issue one warning.

An alternative to progressive discipline would be to require employees to lock phones in the trunk while driving after the first violation, Maguire says.

For continuous offenders, an agency is "going to have to do a risk assessment," she says. "If an employee is consistently violating the policy, you're looking at a higher risk of liability exposure if that employee ultimately causes an accident due to distracted driving."

Outline expectations of driver safety

- **Ensure language you use is clear.** Policies should state that texting or calling in the vehicle isn't permitted, Maguire says.

Sample language from a policy Maguire created: "Caregivers may not use a hand-held cell phone while operating a motor vehicle — whether the vehicle is in motion or stopped at a traffic light or stop sign. This includes, but is not limited to, answering or making phone calls, engaging in phone conversations and reading or responding to emails, instant messages and text messages. If caregivers need to use their phones or other electronic devices, they must pull over safely to the side of the road or another safe location."

Policies should encourage employees to stow phones while driving and ensure employees don't feel compelled to answer work-related communications on the road, suggests Chris Hayes, Travelers insurance company's second vice president of risk control transportation.

- **Don't limit yourself to cell phones.** Language in policies should address GPS use and other technology, Hayes says. For instance, policies may state that GPS use is allowed, but the navigation must be set prior to driving and the device must be secured and not obstruct the driver's ability to see the road.

In addition, Maguire says policies should discuss other bad habits employees should steer clear of behind the wheel, such as "eating, putting on makeup, changing the radio station or music, and reaching for items in the back seat of the vehicle."

- **Ensure you train employees on the policy and have them acknowledge their receipt and understanding of the policy in writing.** Documentation of training and receipt of the policy by employees can help an agency's defense if it is involved in distracted driving litigation due to an employee's accident, Maguire says.

— Angela Childers (angela.childers@gmail.com)

Related link: *View a sample policy from Gilliland, Maguire & Harper at http://bit.ly/2HFs2LA.*

Patient assessment & care documentation

Clinical visit notes are like Jenga — with weak infrastructure, claims topple

Ensure documentation from your agency's clinicians goes beyond an electronic medical records (EMR) system's check box charting.

Visit notes should tell the full story of a patient's care and achievement toward goals listed in the plan of care. Otherwise your agency could face claims denials for providing services a Medicare contractor feels aren't medically justified.

Successful clinical documentation involves clinicians building "a little bridge from note to note," says Kristi

Bajer, vice president of clinical operations for OperaCare LLC in Socorro, N.M. OperaCare's automated QA and compliance systems work to assure documentation is compliant with the conditions of payment and participation while the nurse is in the patient's home.

Clinical notes don't stand alone, Bajer says. Clinicians must look back to prior notes and build on that.

Ensuring notes describe the patient's journey — that each note stands alone and is still part of the continuum — has been major target for claims reviewers for the past several years, and it remains a target, says Michael McGowan, founder and president of OperaCare.

That's a major problem for agencies. A large percentage of clinicians don't build the bridge adequately, Bajer says.

The Medicare Benefit Policy Manual indicates clinical notes must document the history and physical exam pertinent to the day's visit (including the response or changes in behavior to previously administered services); the skilled services applied on the current visit; the patient/caregiver's immediate response to the skilled services provided; and a plan for the next visit based on the rationale of prior results.

It's crucial for agencies to avoid language that's vague or subjective, contends McGowan, a former OASIS coordinator for CMS.

Explain downsides of checkboxes

EMR systems are largely to blame for the lack of detail in visit notes, and agencies that use paper charting often achieve greater success, Bajer and McGowan agree.

EMR has made charting less personal, preventing nurses from truly explaining the care that was necessary and the care that was provided, says Joe Osentoski, reimbursement recovery and appeals director for Quality In Real Time (QIRT) in Troy, Mich.

But several EMR systems allow agencies to build a template to allow for more detailed notes, and Bajer encourages agencies to build such a template.

"Make sure clinicians are empowered with the knowledge that checkboxes aren't enough," Osentoski says. "It's an incomplete note if you only checkboxes. You guys are clinicians. You're professionals. Tell that story. What did you do? Why did you do it? And how did the patient respond to it?"

Monitor, avoid the use of these phrases

Pay close attention to the words and phrases below. Some should be avoided, while others only should be used in combination with greater detail.

1. "Generalized weakness." This phrase by itself leads to a number of questions, Osentoski says. Among the questions: When, where, how often and what is being done about this?

By itself, the word "generalized" is subjective and too general, he adds.

2. "Observed" or "monitored." Reviewers want to know what clinicians did and what they saw, Osentoski says.

3. "Occasionally," "intermittently" or "at times." This language is too general. Instead, clinicians should explain how often something happened.

4. "Patient tolerated treatment well." That phrase is too vague, Osentoski says. Explain what happened. For example, a clinician would be more successful by explaining the patient "had complaints of pain or discomfort during wound care procedure."

5. "Continue plan of care." Reviewers will want to know what focus clinicians will have for the next visit. Specific details listed would help demonstrate that your next visit won't be repetitive, Osentoski adds.

6. "Continue medication teaching" or "Caregiver instructed in medication management." Reviewers will want to know what you're teaching and what medications you're discussing. A clinician would be more successful by indicating, for example, that she plans to teach the patient about common side effects from Coumadin.

7. "Patient verbalized understanding of teaching." Be more specific by explaining what you taught the patient and how you ensure the patient understood, Osentoski says. A clinician might say she used the teach-back method to ensure the patient understood guidance about properly taking a new medication.

8. "Medications given as ordered" or "Wound care done as ordered." Clinicians should explain what medications they're providing or what wound care treatments they're providing.

9. "Gait steady" or "Ambulates independently without difficulty." If that's the case, a reviewer might question why the patient needs home care.

10. "Considerable and taxing effort to leave home" or "patient needs assistance to leave home." This language is too generic and is often contradicted by specific clinical items. Other language to avoid when it comes to homebound status: Patient cannot leave home unassisted and patient needs assistance for all activities. Instead, you might explain that the patient "requires

a walker for safe ambulation due to shuffling gait and high fall risk secondary to Parkinson's disease." — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Related link: *Read the Medicare Benefit Policy Manual at http://go.cms.gov/1Q8Qmqn.*

Billing

New CMS transmittal explains how rural add-on payments will be processed

Rural agencies might have to wait a while before they get 3% add-on payments for claims submitted in early 2018.

A new transmittal from CMS indicates that claims submitted April 2 and beyond will automatically receive 3% add-on payments while claims submitted from Jan. 1 through April 1 will have to be reprocessed automatically, says attorney Robert Markette of Indianapolis-based Hall, Render, Killian, Heath & Lyman.

Medicare Administrative Contractors will have up to six months after the transmittal's April 2 implementation date to start reprocessing claims, but in reality they're likely to do so much sooner than that, Markette says.

"They can't keep sitting on them," he says. "Once the Pricer is updated, it should be fairly straightforward. Plus, I imagine there will be a huge outcry if they drag their feet."

Rural add-on payments ended beginning Jan. 1, 2018. But in February, Congress passed the Bipartisan Budget Act of 2018. This act contained a number of provisions affecting home health agencies, including extending 3% rural add-on payments through 2018.

CMS explains what episodes will pay

As a result of rural add-on payments, the 2018 national, standardized 60-day episode payment rate will increase to $3,130.83 from $3,039.64 for rural agencies that submit quality data, the transmittal states.

Meanwhile, the 2018 national, standardized 60-day episode payment rate will increase to $3,068.83 from $2,979.45 for rural agencies that do not submit quality data. (*See chart, below.*)

Beginning in 2019, rural add-on payments will change and be reduced over time (*HHL 2/12/18*).

Agencies in rural counties with the greatest usage of home health will receive 1.5% add-on payments during 2019 and 0.5% add-on payments during 2020.

Agencies in counties with a population density of six people or fewer per square mile will receive 4% add-on payments in 2019, 3% in 2020, 2% in 2021 and 1% in 2022.

And agencies in other rural counties will receive 3% add-on payments in 2019, 2% in 2020 and 1% in 2021. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Related link: *Read the CMS transmittal at http://go.cms.gov/2pxbUVA.*

OASIS

(continued from p. 1)

The new documents offer providers a clearer picture of what the revised assessment, slated to take effect Jan. 1, 2019, will look like (*HHL 3/19/18*).

"The biggest problem is going to be GG0170," predicts Arlynn Hansell, owner of Therapy and More, LLC in Cincinnati.

2018 per-visit amounts for care provided in rural areas

Due to rural add-on payments for home health agencies, the per-visit rate for a skilled nurse from an agency that submits quality data will increase to $147.70 from $143.40. For an agency that doesn't submit quality data, the per-visit rate will increase to $144.78 from $140.56. (*See story, above.*)

	For agencies that DO submit quality data			For agencies that DO NOT submit quality data		
Discipline type	**2018 per-visit rate**	**Multiply by the 3% rural add-on**	**2018 rural per-visit rate**	**2018 per-visit rate**	**Multiply by the 3% rural add-on**	**2018 rural per-visit rate**
Aide	$64.94	x1.03	$66.89	$63.65	x1.03	$65.56
Social worker	$229.86	x1.03	$236.76	$225.31	x1.03	$232.07
OT	$157.83	x1.03	$162.56	$154.70	x1.03	$159.34
PT	$156.76	x1.03	$161.46	$153.65	x1.03	$158.28
Skilled nurse	$143.40	x1.03	$147.70	$140.56	x1.03	$144.78
Speech-language pathologist	$170.38	x1.03	$175.49	$167.00	x1.03	$172.01

Source: *CMS Transmittal 2047*

While a single piece of this item capturing lying to sitting on the side of the bed is on OASIS-C2, the item will ask for significantly more information on OASIS-D. Parts a, b, and d through s will be added on OASIS-D.

Each part of GG0170 and GG0130 will require a performance score and a discharge goal at start of care (SOC) and resumption of care (ROC). Discharge goals for these new areas are not currently part of the regular course of care, says Jennifer Sandel, co-owner of Home Care Services Solutions in Battle Creek, Mich.

CMS is accepting comments on OASIS-D through May 11.

Conflicting answers could pose problem

Hansell believes this mobility item and the new self-care item will be particularly difficult and time consuming for nurses to complete. The new items also may lead to conflicting answers, in part, because some elements are a near duplication of existing items.

For instance, GG0130G asks about the patient's ability to dress lower body not including footwear. Existing item M1820 (Ability to dress lower body) also asks about ability to dress, but the question does include shoes. Both items are present on OASIS-D.

These nuances could lead to confusion and mismatched responses, because the items are not asking the exact same thing, says J'non Griffin, president and owner of Home Health Solutions LLC in Carbon Hill, Ala.

BENCHMARK of the Week

Most agencies will spend more on QA — but not intake — roles in 2018

About 64% of agencies will spend more on quality improvement/assurance roles in 2018 than they had the prior year, according to the 163 respondents to a question on *HHL's* 2018 Trends Survey. But only 19.5% of respondents plan to spend more on intake in 2018 than they had in 2017. (*See story, p. 1.*)

	Spend more	Spend less	No change
Intake	19.5%	3.1%	77.4%
Nursing	44.0%	0.0%	56.0%
Quality improvement/ assurance	63.5%	1.3%	35.2%
Therapy	18.2%	8.8%	73.0%
Billing	14.4%	2.5%	83.1%
Coding	25.2%	1.8%	73.0%

Source: HHL's *2018 Trends Survey*

Differences in the level of response to these items could be a flag for auditors, Griffin says.

Some agencies are already getting audited because of similar challenges with the existing GG0170C and M1850 (Transferring), Hansell says.

In her comments submitted to CMS, Hansell suggests eliminating the duplicate items and instead using the data from the new GG items to meet any existing outcome measure or case-mix requirements.

"Why are we doing double work, that's crazy," Hansell says.

Time expectations under dispute

OASIS-D involves the removal of 75 data elements from SOC, 75 elements from ROC, 20 elements from follow-up, 42 elements from transfer, 1 data element from death at home and 34 elements from discharge.

While some elements including the GG items are also being added, CMS estimates OASIS-D will take less time to complete at most time points, because more elements are being removed. CMS estimates the assessment will take 11.4 fewer minutes to complete at SOC, ROC and transfer, 2.7 fewer minutes at discharge and .6 fewer minutes at follow-up.

Death at home is expected to take .9 more minutes to complete.

But Hansell does not agree with all of the time projections.

"In what universe can you do start of care in 47 minutes? That's if the patient is not talking to you," Hansell says.

Depending on how mobile a patient is, completing the GG section alone could take 40 to 45 minutes, Hansell estimates.

Some patients could take several minutes just to walk from their recliner to the bedroom in order to demonstrate lying to sitting on the side of the bed, Hansell says. CMS estimates do not take this kind of thing into account, she says.

Do this to prepare for GG items

- **Have therapists demonstrate regularly.** Ask your agency's physical therapists to cross-train nurses on how to properly assess for GG0170, Sandel recommends.

Have therapists verbalize the process of testing a patient in each area required as part of the item and share the reasoning used to set an acceptable discharge goal.

This kind of demonstration can help nurses better understand the patient from a therapist's perspective. Do this kind of training once a quarter.

"I've always thought that since it's a multidisciplinary document we have to have nurses teach therapists how they look at skin and therapists teach how they do [activities of daily living]," Sandel says.

- **Focus on proper definition of safety.** Ensuring clinical staff understand how to evaluate safety is a good exercise to prepare for these GG items, Sandel says.

Some clinicians may evaluate the ability to complete activities of daily living (ADLs) as an isolated exercise, rather than taking the full picture into account.

A patient with severe dementia, for instance, may be able to walk around and have the motor ability to dress. But without someone to remind the patient to get dressed or what article of clothing comes next, that patient will not complete the task. The patient needs someone around to make sure she does what needs to be done and stays safe.

For this patient completing the task may be possible but safety takes more than the task itself into account.

"Make sure to assess ability and not performance," Sandel says.

- **Push for therapy visits to happen timely.** Getting therapists into the home within the five-day window to answer these GG items may help with accuracy, Griffin says.

An agency could have physical therapists assess for these items on all patients or at least compare notes with the assessing clinician as long as those visits happen timely.

- **Standardize agency policy for OASIS collaboration.** These new GG items are driving interdisciplinary care coordination, Griffin says.

Because the expansion of the one-clinician rule is somewhat vague, however, Hansell recommends establishing a written policy around what OASIS collaboration and the one-clinician rule mean for your agency.

Make sure all agency staff consistently follow this written policy. — *Kirsten Dize (kdize@decisionhealth.com)*

Related links: *View the comparison of OASIS-C2 to OASIS-D at https://bit.ly/2DQpnfO. View the itemized list of OASIS data elements at https://bit.ly/2G3cv7E. View the version of OASIS-D and other supporting analysis at http://go.cms.gov/1RXfsuE. Comment at http://bit.ly/2paPHfO.*

Rights

(continued from p. 1)

Among those things: Written notice of the patient's rights and responsibilities, an OASIS privacy notice and contact information for the agency administrator — including the administrator's name, business address and business phone number to receive complaints.

In advance means that agency staff "must complete the task prior to performing any hands-on care or any patient education," according to the draft guidelines.

And when it comes to the notice of rights and responsibilities and an agency's transfer and discharge policies, patients must be able to confirm that they were provided the documents in "a language they understood and in a manner which accommodated any disability," the draft guidelines state.

The draft guidelines state that agencies may delay notification of rights and responsibilities until an interpreter is present telephonically, physically or electronically to verbally translate [§484.50(a)(3)]. This, the guidelines state, may be delayed no later than the second visit.

This appears to break from the definition of "in advance," contends Gerrianne Griffin, performance improvement coordinator for home care, hospice and hemodialysis for Brookhaven Memorial Hospital Medical Center in Patchogue, N.Y. But it won't be an issue for her agency because it uses CyraCom, an interpreter service that's available 24/7.

Regardless, your agency will be more prepared if intake employees work in advance to ensure patients and legal representatives are able to understand patient rights.

That will add perhaps 5 to 10 minutes of work per patient for those employees, industry experts say. But it also will prevent your agency's clinicians from wasting considerably more time by traveling to a patient's home for an initial visit, only to discover the patient can't understand her rights and it won't be possible to provide care that day.

Asking several additional questions will be a big change for some agencies' intake employees. Right now in many agencies, all the nurse has when she heads to the patient's home "is a little piece of paper that says, 'RN to evaluate and treat,'" says Arlene Maxim, a home health expert based in Troy, Mich.

In home health now, many clinicians start providing hands-on care even before offering the patient an explanation of rights, Maxim notes. But if an agency doesn't supply that info in advance of providing care under the revised CoPs, the agency could be cited on a survey.

What should intake begin to do?

Before the clinician steps in the door, your agency should be armed with the knowledge that it will be able to outline rights in a manner the patient and legal representative understand, Maxim says.

As a result, it's advisable that intake staff carefully ascertain the need for language or auxiliary aids so that they can be made available at the time of initial visit, Maxim says. The patient's clinical record should include evidence that your agency facilitated the availability of auxiliary aids as needed, the draft guidelines state.

The guidelines provide agencies with a long list of auxiliary aids and services that could be used. Among those things: qualified interpreters on-site or through video remote interpreting (VRI) services; real-time computer-aided transcription services; telephone handset amplifiers; assistive listening devices; and telephones compatible with hearing aids.

More technology to consider using: taped texts; Braille materials and displays; screen-reader software; magnification software; and large-print materials.

Note: The draft guidelines state that written notice can be provided in hard copy form unless the patient requests that the document be provided electronically. The guidelines don't provide further detail about acceptable timeframes for providing an electronic copy.

Maxim recently created a supplemental intake form for the revised CoPs. Agencies can use this form to gather information they'll need to comply with the revised CoPs. (*See form, insert.*)

Key things intake should ask

- **Determine whether the patient has a preferred language that isn't English.** If a hospital is the referral source, for instance, the discharge planner likely has that type of information, says J'non Griffin, owner and president of Home Health Solutions in Carbon Hill, Ala.

But that isn't typically a question intake employees have asked. Make sure the intake employee documents the language that the patient prefers.

- **Determine whether patients have disabilities that would prevent them from understanding their rights.** If intake staff identify in advance that the patient is blind, for example, the clinician could bring a patient rights form in Braille.
- **Identify whether the patient has a legal representative.** If you're not already asking this at intake, you need to start. If the patient does have a legal representative, get that person's contact information. Hospitals should have this information already, so intake could ask the hospital's discharge planners for that information, J'non Griffin says.

The term "legal representative" means the person has formal, legal decision-making authority — such as a court-appointed guardian or a person designated under a power or attorney as having health care decision-making authority. That is different from a patient-designated representative, who doesn't have legal authority.

Have intake ask for a copy of documentation such as power of attorney paperwork confirming that the representative has legal authority. — *Josh Poltilove (jpoltilove@decisionhealth.com)*

Related link: *View the draft interpretive guidelines at http://bit.ly/2Aih4HV.*

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