The Impact of the IMPACT ACT on Your Home Health Agency Practice

Oklahoma Association of Home Care and Hospice
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WHAT IS IMPACT?

Improving Medicare Post Acute Care Transformation
• Federal legislation passed October 6, 2014
• Stated purpose – “an important step forward in improving the quality of health care for millions of Americans, providing consumers and government critical information regarding outcomes and cost.”
  – Improvement of Medicare beneficiary outcomes
  – Provider access to longitudinal information to facilitate coordinated care
  – Enable comparable data and quality across PAC settings
  – Improve hospital discharge planning
  – Research
Why the Attention on PAC Care?

1. Escalating costs associated with PAC
2. Lack of data standards/interoperability across PAC settings
3. Goal of establishing payment rates according to the individual characteristics of the patient, not the care setting
4. Preparation for bundled care initiatives across provider spectrum.

What Does IMPACT Require?

• Requires Standardized Patient Assessment Data that will enable:
  • Data Element uniformity
  • Quality care and improved outcomes
  • Comparison of quality and data across post-acute care (PAC) settings
  • Improved discharge planning
  • Exchangeability of data
  • Coordinated care

Design Rationale for IMPACT

• Objective 1:
  Identify key design rationale behind IMPACT 2014 as it relates to standardized assessments.

1. Designed to improve quality of health care by **standardizing assessments across the spectrum of post-acute care** (PAC) will require additional adjustments at both SOC and DC assessments
   - CARE Item Set – implemented as the model post acute care assessment strategy to complement the goals of standardization.
   - Minimum Data Set (MDS) for Nursing Homes
   - Patient Assessment Instrument (IRF) for Inpatient Rehabilitation Facility
   - OASIS for Home Health Agencies

2. Designed to assure patients and/or caregivers have adequate information and input in decision-making
   - Built into the language of the proposed COPs affecting all PAC providers
Design Rationale for IMPACT

3. Designed to eliminate the *silo focused approach to quality measurement and resource utilization*
   - Hospitalizations and re-hospitalizations
   - Re-hospitalizations after discharge from PAC providers
   - Discharge to community
   - Pressure ulcers
   - Medication reconciliations
   - Incidence of major falls
   - Patient preferences
   - Average total Medicare cost per beneficiary
Design Rationale for IMPACT

4. Requires the Secretary to publish regulations to modify COPs and to develop interpretive guidelines to require that Home Health Agencies take into account:
   - Quality measures
   - Resource use measures
   - Other measures to assist PAC providers, patients and the family of patients with discharge planning
     - Treatment preferences of patients and caregivers
     - Patient’s goals of care

Source: MLN Connects: “The IMPACT Act of 2014 and Data Standardization” October 21, 2015
What is Standardization?
Standardizing Function at the Item Level

Source: MLN Connects: “The IMPACT Act of 2014 and Data Standardization” October 21, 2015
Quality Measure Domains and Timelines

Source: MLN Connects: “The IMPACT Act of 2014 and Data Standardization” October 21, 2015

Quality Measure Domains and Timelines

Source: MLN Connects: “The IMPACT Act of 2014 and Data Standardization” October 21, 2015
CARE ITEM SET – for Home Health

CARE Item Set - Admission
CARE Item Set - Discharged
CARE Item Set - Expired


Important Website for Continued Information

Changes in OASIS-C1 - 2017

Proposed rule for 2017 has incorporated several OASIS item changes to correlate the tool to the CARE Item Set.

OASIS Proposed Changes 2017

Design Rationale for IMPACT - Discharge

• Objective 2:
  Identify key design rationale behind IMPACT 2014 as it relates to the addition of a new COP for discharge planning
Proposed Rule for Discharge Planning

Federal Register/Vol. 80, No. 212/Tuesday, November 3, 2015/Proposed Rules
DEPARTMENT OF HEALTH AND HUMAN SERVICES Centers for Medicare & Medicaid Services
42 CFR Parts 482, 484, and 485 [CMS–3317–P] RIN 0938–AS59
Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies

Who Is Impacted by IMPACT D/C Planning Requirements?

• Hospitals (IP)
• Critical Access Hospitals (CAH)
• Long Term Care Hospitals (LTCH)
• Inpatient Rehabilitation Facilities (IRF)
• Home Health Agencies (HHA)
• Skilled Nursing Facilities (SNF)
• NOTE: Nursing Facilities (NF) are not impacted by this federal regulation
SO, HERE WE ARE WITH NEW STANDARDS FOR DISCHARGE PLANNING

§484.58

Discharge Requirements for HHA - Current

• §484.48 Condition – Clinical Records
  “A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.”

The HHA must inform the attending physician of the availability of a discharge summary. The discharge summary must be sent to the attending physician upon request and must include the patient’s medical and health status at discharge.
Proposed COP Revisions

• October 9, 2014 CMS proposed adding a new standard for discharge or transfer summary requirements, but, due to IMPACT requirements, this proposed standard has been withdrawn.

• Two **New Standards** now proposed under § 484.58
  484.58(a) “Discharge Planning Process
  484.58(b) “Discharge or Transfer Summary Content

484.58 (a) Discharge Planning Process

“We propose to add § 484.58 which would require that HHAs develop and implement *an effective discharge planning process that focuses on preparing patients and caregivers/support person(s) to be active partners in post-discharge care, effective transition of the patient from HHA to post-HHA care, and the reduction of factors leading to preventable readmissions*.”
484.58 (a) Discharge Planning Process

Objective 2:
Identify key requirements under the proposed COP standard “Discharge Planning Process”

Key Requirements – Discharge Planning Process

1. The HHA’s discharge planning process must ensure that the discharge goals, preferences, and needs of each patient are identified and result in the development of a discharge plan for each patient.

2. The HHA discharge planning process requires the regular re-evaluation of patients to identify changes that require modification of the discharge plan, in accordance with the provisions for updating the patient assessment at current § 484.55 (with OASIS reassessments)
Key Requirements – Discharge Planning Process

3. HHAs must continue to abide by federal civil rights laws, including Title VI of the Civil Rights Act of 1964, the Americans with Disabilities Act, and section 504 of the Rehabilitation Act of 1973, when developing a discharge planning process.
   a. HHAs should take reasonable steps to provide individuals with limited English proficiency or other communication barriers, or physical, mental, cognitive, or intellectual disabilities meaningful access to the discharge planning process, as required under Title VI of the Civil Rights Act, as implemented under 45 CFR 80.3(b)(2).
   b. Without appropriate language assistance or auxiliary aids and services, discharge planners would not be able to fully involve the patient and caregiver/support person in the development of the discharge plan.
   c. Furthermore, the discharge planner would not be fully aware of the patient’s goals for discharge.

Key Requirements – Discharge Planning Process

4. The physician responsible for the home health plan of care must be involved in the ongoing process of establishing the discharge plan.

5. The HHA must consider the availability of caregivers/support persons for each patient, and the patient’s or caregiver’s capacity and capability to perform required care, as part of the identification of discharge needs.

6. Requires that the discharge plan address the patient’s goals of care and treatment preferences.
Key Requirements – Discharge Planning Process

7. Requires that the HHA assist patients and their caregivers in selecting a PAC provider by using and sharing data that includes, but is not limited to: HHA, SNF, IRF, or LTCH data on quality measures and data on resource use measures (applies to transfers to one of these facilities)
   a. HHA must be available to discuss and answer patient’s and their caregiver’s questions about their post-discharge options and needs;
   b. HHA must ensure that the PAC data on quality measures and data on resource use measures are relevant and applicable to the patient’s goals of care and treatment preferences.
   c. HHA must not make the decision about PAC for the patient or caregiver

Key Requirements – Discharge Planning Process

8. Focus must be on person-centered care to increase patient participation in post discharge care decision making.
   a. Person centered care focuses on the patient as the locus of control, supported in making their own choices and having control over their daily lives.

9. HHAs must establish specific time frames for completing the evaluation and discharge plans based on their patient’s needs and taking into consideration the patient’s acuity level and time spent in home health care.

10. Results of the evaluation must be discussed with the patient/caregiver
Key Requirements – Discharge Planning Process

11. All pertinent data available to the HHA must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the patient’s discharge or transfer.

484.58 (a) Discharge Planning Process

Objective 2: (in review)

Identify key requirements under the proposed COP standard “Discharge Planning Process”

1. Completed with OASIS development; updated as condition changes and/or with follow-up OASIS assessments; results discussed with patient/CG
2. Must take into account language and disability barriers in the development of the DC plan
3. Timeliness is critical to prevent delays in transfer (specified by agency?)
4. Patient centered; takes into account patient’s goals and treatment preferences
5. Considers availability, willingness and capacity of caregivers for post discharge care
6. All available and pertinent data must be included in the discharge plan
7. Must involve the attending physician (copied to, signature???)
484.58 (a) Discharge Planning Process

Objective 2: (in review)
Identify key requirements under the proposed COP standard “Discharge Planning Process”

8. For transfers to other HHAs, SNF, IRF, IP providers, agency must provide information on quality measures and resource utilization for the PAC providers; must discuss measures as these relate to the patient goals or treatment needs

9. Agency must timely produce a transfer or discharge summary that meets the requirement of the new standard

484.58 (b) Discharge or Transfer Summary

Content

Objective 3:
Identify key requirements under the new COP standard ‘Discharge or Transfer Summary”

New Standard:
• requires that the HHA send necessary medical information to the receiving facility or health care practitioner.
• Specifies content of the summary
• Any items that are not applicable should have an N/A response provided
484.58 (b) Discharge or Transfer Summary

Content

Required Contents of the Summary
1. Demographic information, including but not limited to name, sex, date of birth, race, ethnicity, and preferred language;
2. Contact information for the physician responsible for the home health plan of care;
3. Advance directive, if applicable;
4. Course of illness/treatment;
5. Procedures;
6. Diagnoses;
7. Laboratory tests and the results of pertinent laboratory and other diagnostic testing;
8. Consultation results;
9. Functional status assessment;
10. Psychosocial assessment, including cognitive status;
11. Social supports;
12. Behavioral health issues;
13. Reconciliation of all discharge medications (both prescribed and over-the-counter);
14. All known allergies, including medication allergies;
15. Immunizations;
484.58 (b) Discharge or Transfer Summary

Content

Required Contents of the Summary

16. Smoking status;
17. Vital signs;
18. Unique device identifier(s) for a patient’s implantable device(s), if any;
19. Recommendations, instructions, or precautions for ongoing care, as appropriate;
20. Patient’s goals and treatment preferences;
21. The patient’s current plan of care, including goals, instructions, and the latest physician orders; and
22. Any other information necessary to ensure a safe and effective transition of care that supports the post-discharge goals for the patient.

Sources of Data Needed for Summary

Referral form
Patient transfer data from hospital, SNF, LTAC, IRF, physician’s treatment records
Physician face-to-face documentation (treatment record)
OASIS assessments
Medication profiles
Physician orders
Discharge plan
How Can This Information Be Obtained?

Obtain transfer information from facility where patient is discharged, if applicable
Obtain data from physician treatment record
OASIS data items
Medication profiles
Patient inquiry
Caregiver and support persons inquiry
Software reports (in development)

Getting Ready for Implementation

Objective 3:
Identify key preparation steps the home health management team should consider in preparing for the new requirements
Getting Ready for Implementation

1. Stay abreast of implementation deadlines
2. Implement new assessment items for OASIS changes as these are finalized.
3. Decide who will serve as your agency’s discharge planner? Field RNs? MSW? specially designated individual
4. Determine who will be responsible for gathering data on all PAC providers in your service area
5. Determine who will be responsible for obtaining quality measures and utilization of resource data for the PACs
6. Identify key data fields from assessments that will need to populate the discharge plan

Getting Ready for Implementation

7. Review intake processes to assure that inpatient facilities and other PACs facilitating transfer to your agency provide adequate transfer data prior to or at admission to service
8. Develop a process grid/questionnaire for identifying caregiver or support team involvement in the plan
9. Develop questionnaire for determining patient goals and treatment preferences
10. Determine how physician’s will be involved in the plan development and evaluation
11. Identify training needs in your agency
12. Implement rules as these become finalized
Getting Ready for Implementation

13. Update your annual QAPI plan to include evaluation of the effectiveness of the discharge planning process and adequacy of the discharge/transfer summary
14. Implement surveyor readiness plan

Getting Ready for Implementation - IMPACT

Make sure your quality data and utilization of resources is stellar!

Accurate
Timely
Comparable to Competition
Readily Available for other PACs