Developing and Following Your Plan of Care

Satellite Conference
and Live Webcast
Wednesday, April 22, 2009
2:00 - 4:00 p.m. (Central Time)

Produced by the Alabama Department of Public Health
Video Communications and Distance Learning Division

Faculty

Becky Leavins, RN
Nurse Consultant
Bureau of Home & Community Services
Alabama Department of Public Health

Shirley Offutt, BSN, RN
Nurse Consultant
Bureau of Home & Community Services
Alabama Department of Public Health

Objectives

- Identify criteria for admission to home care services
- Know the components in the Plan of Care (POC)
- Understand listing and changing medications and supplies

Objectives

- List the four appropriate Functional Limitations and Activities Permitted
- Recognize and implement appropriate goals, rehabilitation potential and discharge plans

Establishing the Plan of Care (POC)

- What happened to the CMS 485?
  - Approval for the form expired in 2002
  - Instructions were removed from the CMS website in August of 2007
  - There are no official forms or instructions

Plan of Care

- ADPH will continue to use the 485 format with all 28 locators
- Medicare no longer requires that Home Health Agencies (HHA) utilize the 485 format but HHA's must include all items listed in the Conditions of Participation (COP) 484.18(a)

Plan of Care

- The 485 form includes all of the criteria listed in the COP's
  - The ADPH Home Health Comprehensive Assessment includes data to complete the 485 form

Medicare Admission

- Patients are accepted for treatment on the basis that the required skill(s) are reasonable and necessary
- Expectation that the patient's medical and social needs can be met adequately in the patient's place of residence

Medicare Admission

- If the patient is unable to care for self there is a willing and able care person
- The Home Health Agency has the resources to meet the needs of the patient

Plan of Care Comprehensive Assessment

- According to the COP's tag # 484.18 (a) the POC should include
  - Pertinent diagnosis
  - Mental status
  - Types of service and equipment required
  - Frequency of visits

Plan of Care Comprehensive Assessment

- According to the COP's tag # 484.18 (a) the POC should include
  - Prognosis
  - Rehab potential
  - Functional limitations

Plan of Care Comprehensive Assessment

- Activities permitted
- Nutritional requirements
- Medications and treatments
- Any safety measures to protect against injuries
- Instructions for timely discharge or referral
- Any other appropriate items

Criteria for Home Health Admission

- Medicare criteria
  - Patients are accepted for treatment on the basis of a reasonable expectation that the patient's medical, nursing, and social needs can be met adequately by the agency in the patient's place of residence

Criteria for Home Health Admission

- Medicare criteria
  - Care follows a written POC
  - POC established and periodically reviewed by a doctor of medicine, osteopathy, or podiatrist

Criteria for Home Health Admission

- A skilled nursing service is a service that must be provided by a registered nurse or a licensed practical (vocational) nurse under the supervision of a registered nurse to be safe and effective

Criteria for Home Health Admission

- In determining whether a service requires the skills of a nurse, the reviewer considers both the inherent complexity of the service, the condition of the patient and accepted standards of medical and nursing practice

Criteria for Home Health Admission

- Some services may be classified as a skilled nursing service on the basis of complexity alone
  - Intravenous & intramuscular injections
  - Insertion of catheters
  - Treatment of the patient's illness or injury

Criteria for Home Health Admission

- In some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service
  - Occurs when the patient's condition is such that the service can be safely and effectively provided only by a nurse

Criteria for Home Health Admission

- 40.1.2.1
  - Observation and assessment of the patient's condition when only the specialized skills of a medical professional can determine patient's status
- (Rev. 1, 10-01-03)
- A3-3118.1.B.1, HHA-205.1.B.1

Criteria for Home Health Admission

- Observation & assessment of patient's condition by nurse are reasonable & necessary skilled services when the likelihood of change in patient's condition requires skilled nursing personnel to identify & evaluate patient's need for possible modification of treatment or initiation of additional medical procedures until patient's treatment regimen is stabilized.

Criteria for Home Health Admission

- Where a patient was admitted to home health care for skilled observation because there was reasonable potential of complication or further acute episode, but didn't develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode.

Criteria for Home Health Admission

- Information from the patient's medical history may support the likelihood of a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond 3-week period.

Criteria for Home Health Admission

- Such indications as abnormal/fluctuating vital signs, weight changes, edema, symptoms of drug toxicity, abnormal/fluctuating lab values, and respiratory changes on auscultation may justify skilled observation and assessment.

Criteria for Home Health Admission

- These indications are such that it is likely that skilled observation and assessment by a licensed nurse will result in changes to the treatment of the patient, then the services would be covered.
- There are cases where patients who are stable continue to require skilled observation & assessment.

Criteria for Home Health Admission

- Observation and assessment by a nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the patient's condition, and there is no attempt to change the treatment to resolve them.

Criteria for Home Health Admission

- 40.1.2.2 - Management and Evaluation of a Patient Care Plan
- (Rev. 1, 10-01-03)
- A3 -3118.1.B.2, HHA-205.1.B.2

Criteria for Home Health Admission

- Skilled nursing visits for management and evaluation of the patient's care plan are also reasonable and necessary where underlying conditions or complications require that only a registered nurse can ensure that essential non-skilled care is achieving its purpose.

Criteria for Home Health Admission

- For skilled nursing care to be reasonable & necessary for management & evaluation of patient's plan of care, the complexity of the necessary unskilled services that are a necessary part of the medical treatment must require the involvement of skilled nursing personnel to promote the patient's recovery & medical safety in view of the patient's overall condition.

Criteria for Home Health Admission

- Medicaid criteria
  - Verify Medicaid home health eligibility
  - Verify number of visits left for remaining calendar year
  - Verify if duel eligibility or Patient 1st

Criteria for Home Health Admission

- Medicaid criteria
  - If Patient 1st, obtain an Alabama Medicaid Referral Form completed by primary physician
  - Determine if patient has a Medicaid Waiver Case Manager

Criteria for Home Health Admission

- Other payor sources
  - The Supervisor should
    - Verify that ADPH is a participating provider, if not alert referral source
    - Complete the Horizon Homecare Third Party Insurance Verification Form and submit to Third Party Billing
    - Negotiate visit rate if per visit (seek direction from HCD)

Criteria for Home Health Admission

- Other payor sources
  - The Supervisor should
    - Consult with HCD to determine if referral can be accepted based on requirements of the third party payor and payments amounts
    - Determine if the payor is a Medicare Advantage Plan in order to follow Medicare regulations

Outcome and Assessment Information System (OASIS)

- Federally mandated in August 1999
- Assessment involves collecting data on multiple aspects of the patient and their environment

Assessment

- Complete OASIS by "Show Me, Don't Tell Me" method
- Assessment and clinical note should paint a picture of your patient

Plan of Care

- Categorized format that includes pertinent information from the patient assessment
- Paints a picture of the patient
  - Diagnosis
  - Medications
  - Homebound status
  - Care to be provided
  - Expected outcomes

Diagnosis

- Principle diagnosis
  - Most acute condition for which the most intensive service is provided
  - Drives most of the interventions on the plan of care

Diagnosis

- Pertinent diagnosis
  - All conditions that co-exist at the time the POC was established or which developed subsequently, or that affect the treatment or care of the patient

Co-Morbidities

- List any co-morbidities that affect the patient's responsiveness to treatment and rehabilitative process
  - Even if the condition is not the focus of homecare, co-morbidities should be coded since they impact the patient's POC

Co-Morbidities

- Common co-morbidities are
  - Diabetes
  - HTN
  - CAD
  - PVD
  - Blindness
  - Status post amputation
  - History of Neoplasm
  - Chronic Neurological Disease

Medications

- List medications prescribed by all physicians and over-the-counter medications
- Each medication should have the dose, route, frequency, and indication for as needed (PRN)

Medications

- All antibiotics should have an end date
  - If an antibiotic is used as a prophylactic, this should be listed in the instructions
- Remember oxygen is considered a medication and should be listed in locator 10

Medication

- A change in medication (dosage, frequency within the last 60 days) should be noted with a 'C' by the medication to indicate a change
- A new medication (within the last 30 days) should be noted with an 'N' by the medication to indicate this is a new medication

Supplies

- Must have a supporting diagnosis
- Must be necessary to carry out the plan of care
- Must have a physician's order
  - Reporting supplies support the patient's severity level
  - Should include supplies being rented from a DME company

Functional Limitations Activities Permitted

- Should support homebound status
  - "Up as tolerated and independent at home" is not measurable and should not be used in assessing functional status
  - Avoid using in locator 18a and/or locator 22 as a long-term goal

Functional Limitations Activities Permitted

- Should support therapy status
- Should support home health aide status

Homebound Status

- Conditions of participation
  - If the patient does in fact leave the home, the patient may nevertheless be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or are attributable to the need to receive health care treatment.

Homebound Status

- Conditions of participation

"Occasional absences from the home for non-medical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences…

Homebound Status

- Conditions of participation

… are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home." A patient's homebound status is not violated by attendance of religious services or attendance at…

Homebound Status

- Conditions of participation

  … a State licensed, State certified, or State accredited medical adult day care center.

Orders

- Must support Medicare, Medicaid, Insurance coverage
- Must include details of all treatments provided by ordered disciplines

Frequency and Duration

- Specific for each discipline
  - Cannot write "0w1"
    - Zero is a place holder
  - Can write "3w1" effective week of January 5

Frequency and Duration

- As needed (PRN) visits must be quantified and qualified, contain the same items as a routine order and include the circumstances requiring the PRN visit

Frequency and Duration

- Not acceptable
  - "2 PRN visit to assess for change in condition"
- Acceptable
  - "2 PRN SN visits to change foley catheter due to occlusion"

Goals

- Should correlate with service provided and be
  - Realistic
  - Reasonable
  - Relevant
  - Achievable
  - Quantifiable/Measurable

Goals

- Should pull together the POC and reflect what you expect the outcomes to be
- Each goal must have an end date

Rehabilitation Potential

- This is the physician's expectation of the patient's ability to meet their goals
- Should include an estimated time for achievement

Discharge Plans

- Should document who will care for the patient after discharge

References

- Beacon Health, *Mastering the Plan of Care* – 2008.
- Beacon Health, *Beginning the Initial Assessment Process* – 2008.
- Decision Health Coding Book – 2008
- Official Coding Guidelines - 2008
- MO230, MO240, MO246 – Lisa Martin, RN, HCS-D