Basics of Care Planning for Home Health Patients

Teresa Northcutt BSN RN COS-C HCS-D HCS-H WiAHC June 2017
Selman-Holman & Associates, LLC

Lisa Selman-Holman, JD, BSN, RN, HCS-D, COS-C
Home Health Insight—Consulting, Education and Products
CoDR—Coding Done Right
CodeProUniversity
5800 Interstate 35 North, Suite 301
Denton, Texas 76207
214.550.1477
972.692.5908 fax
Lisa@selmanholman.com
Teresa@selmanholman.com
www.selmanholmanblog.com
www.selmanholman.com
www.CodeProU.com
www.codingdoneright.com
Objectives

• State new CoP requirements for patient involvement care planning
• Discuss strategies to include patients and caregivers in care planning, goal setting and discharge planning
• Identify two key components of documentation to support care planning with patients, families and caregivers
Four New CoP’s

• Patient rights
• Care planning, coordination of services and quality of care
• Quality assessment and performance improvement (QAPI)
• Infection prevention and control
NEW CONDITIONS OF PARTICIPATION
Shared Decision-Making Model

A mutually respectful exchange that recognizes the individuality of the patient, and a process in which responsibility is divided among the patient, physician and agency
Individualized Plan of Care

• Agency accepts patients with a reasonable expectation that needs can be met in the patient’s residence
• Agency develops an individualized POC to address needs identified by the patient assessment
• Agency gives patient and representative a written copy of the POC
Patient Participation

• POC must include patient-specific measurable outcomes

• Patient has the right to participate in choosing goals and outcomes for care

• HHA must involve the patient, representative, and caregivers in coordinating care activities
  – Agency’s responsibility to support and foster collaboration and communication among disciplines caring for patient
Patient Participation

• HHA must ensure patient and caregiver receive ongoing training and education from the HHA on the care and services they are expected to implement...including education about post-discharge care duties and appropriate follow up with the patient’s PCP
Patient Participation

• HHA must notify patient, their representative, caregivers and physician when POC is updated
  – Due to a significant change in patient’s health status
  – Related to plans for patient’s discharge
Physician Coordination

- Explore methods to engage patients and physicians responsible for oversight of their care in the care planning and management process
- Clearly establish and update treatment goals and plans
- Facilitate communication between HHA, physicians and other providers during HH services and after discharge
Physician Coordination

- HHA must promptly alert the physician... to any changes in patient’s condition or needs that would suggest that measurable outcomes are not being achieved and/or that the HHA should alter the plan of care
Components of POC

- Pertinent diagnoses and conditions
- Mental, psychosocial and cognitive status
- Types of services, supplies, equipment
- Frequency and duration of visits
- Prognosis, rehab potential
- Functional limitations, activities permitted
- Nutritional requirements
- Medications and treatment
- Safety precautions to prevent injury
Components of POC (con’t)

• Patient/caregiver education and training
• Patient specific measurable outcomes and goals
• Any additional interventions ordered
• Consider social determinants that may contribute to poor health outcomes
• Assess and address factors that may create a barrier to good outcomes
• Coordination with community resources
New Requirement for Risk Assessment and POC

• HHA must include an assessment of the patient’s level of risk for Emergency Department visits and hospital re-admission
  – Must be patient’s *specific* risk factors
  – No specific tool or process defined for use

• Plan of Care must include all necessary interventions to address and mitigate the underlying risk factors
STRATEGIES FOR CARE PLANNING
Comprehensive Assessment

- Physical assessment, focus on pertinent diagnoses for POC
- Knowledge of disease processes and management
- Cognitive status, ability to learn
- Patient activation and engagement
- Support system, family/caregiver involvement, available resources for care
Goal Setting

• Patient’s goal(s) for home care
• Agency goals for treatment
• Measurable outcomes to achieve
• Physician input related to goals
• Are goals reasonable and able to be achieved by patient, family, and caregiver(s)?
Goal Setting

- Does the patient have to identify ALL the goals for the POC?
- Who else sets goals?
- Does the physician have to approve the goals on the POC?
- How do we show patient helped set goals and outcomes for care?

Goal Setting List
Aligning Goals

• Ultimate goal of HHA: delivering goal concordant care

• Patient generated goals of care may differ from physician established goals, HHA will successfully align goals of patient and physician into the Plan of Care
  – If direct conflict, HHA will educate patient about why the physician established goals must be used to guide care planning
Measurable Outcomes

• Should be jointly established by the patient, HHA, and physician(s)
• Should address goals pertinent to the Plan of Care, including:
  – Discipline-specific goals
  – Patient safety goals
  – Patient self-management goals
  – Goals to avoid unnecessary emergent care visits and hospital admissions
Interventions

• Ongoing assessment each visit
• Ordered intervention tasks
• Education and training, contracts
• Initiate community support services
• Measure progress toward goals
• Update and revise POC, including goals and interventions as needed
Care Planning

DOCUMENTATION POINTS
MAC Red Flags

• Admissions that were not based on a change in patient’s condition or on a discharge from a hospital or nursing facility, but on marketing
• Multiple episodes of observation and assessment of chronic conditions
• Discharges followed by re-admissions without any intervening change in patient condition
• Inconsistencies in patient treatment
Care Planning

• Patient has the right to accept or refuse disciplines / treatment

• Each discipline should document discussion of their interventions and goals with patient and caregivers
  – Include patient and caregiver/family goals
  – Consider Goal Setting List

• Individualized written Plan of Care given to patient
Education and Training

• Document knowledge deficit and need for education
• Identify primary/secondary learner
• Document specific information taught
• Evaluate understanding using “teach back” and/or return demonstration
• Include education on healthcare follow up post discharge
  – PCP appointments, med refills, labwork, s/sx to report, who to call for problems
Questions?? Send to
Lisa@selmanholman.com
Teresa@selmanholman.com
Sign up for Lisa’s blog at
www.selmanholmanblog.com