

Tool: Home Health Conditions of Participation Policy and Procedure–Patient Record Checklist



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Tool: Home Health Conditions of Participation Policy and Procedure- Patient Record Checklist

Includes the following sections in the Conditions of Participation:

- Clinical Records
- Transfer and Discharge
- Care Plan
- OASIS information
- Comprehensive assessment of patients

Regulation	Recommended Action
<p>Transfer and Discharge New Standard at §484.50(d).</p> <ul style="list-style-type: none"> • Revised §484.50(a)(1)(i) to require that an HHA must provide each patient with written notice regarding the HHA’s transfer and discharge policies. This requirement was originally proposed at 484.50(d). • Revised §484.50(c)(10) to require HHAs to provide contact information for a defined group of federally-funded and state-funded entities. • Revised §484.50(d)(3) to clarify that discharge is appropriate when the physician and the HHA both agree that the patient has achieved the measurable outcomes and goals established in the individualized plan of care. The standard includes criteria in accordance with which an HHA can transfer, discharge, or terminate care for a patient. Under the standard, transfer, discharge, or termination of care can only be undertaken for one of the following reasons: 	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <ul style="list-style-type: none"> • require that an HHA must provide each patient with written notice regarding the HHA’s transfer and discharge policies. • require HHAs to provide contact information for a defined group of federally-funded and state-funded entities. • discharge is appropriate when the physician and the HHA both agree that the patient has achieved the measurable outcomes and goals established in the individualized plan of care. • The standard includes criteria in accordance with which an HHA can transfer, discharge, or terminate care for a patient. Under the standard, transfer, discharge, or termination of care can only be undertaken for one of the following reasons:

<p>“(1) if the physician responsible for the HHA plan of care and HHA agreed that the HHA could no longer meet the patient’s needs, based on the patient’s acuity;</p> <p>(2) when the patient or payer could no longer pay for the services provided by the HHA;</p> <p>(3) if the physician responsible for the HHA plan of care and HHA agreed that the patient no longer needed HHA services because the patient’s health and safety had improved or stabilized sufficiently;</p> <p>(4) when the patient refused HHA services or otherwise elected to be transferred or discharged (including if the patient elected the Medicare hospice benefit);</p> <p>(5) when there was cause;</p> <p>(6) when a patient died; or</p> <p>(7) when the HHA ceased to operate.”</p> <ul style="list-style-type: none"> • Revised §484.50(d)(1) to clarify that HHAs are responsible for making arrangements for a safe and appropriate transfer. • Revised §484.50(d) to remove the requirement for HHAs to provide patients with information regarding HHA admission policies and clarified that the “transfer and discharge policies” are those set forth in paragraphs (1) through (7) of this standard. 	<p>“(1) if the physician responsible for the HHA plan of care and HHA agreed that the HHA could no longer meet the patient’s needs, based on the patient’s acuity;</p> <p>(2) when the patient or payer could no longer pay for the services provided by the HHA;</p> <p>(3) if the physician responsible for the HHA plan of care and HHA agreed that the patient no longer needed HHA services because the patient’s health and safety had improved or stabilized sufficiently;</p> <p>(4) when the patient refused HHA services or otherwise elected to be transferred or discharged (including if the patient elected the Medicare hospice benefit);</p> <p>(5) when there was cause;</p> <p>(6) when a patient died; or</p> <p>(7) when the HHA ceased to operate.”</p>
<p>§484.11 Release of patient identifiable OASIS information revised at §484.40</p>	

<p>§484.18, Acceptance of patients, plan of care, and medical supervision, now at §484.60, Care planning, coordination of services, and quality of care.</p> <ul style="list-style-type: none"> • Revised §484.60(b)(4) to permit any nurse acting in accordance with state licensure requirements to receive verbal orders from a physician. • Added requirements at §484.60(d)(1) and (2) that HHAs must assure communication with all physicians involved in the plan of care, and integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient. • Moved proposed §484.60(a)(3) to §484.60(a)(2)(xii), making it applicable to all patients, and removed the terms “low,” “medium,” and “high.” 	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <ul style="list-style-type: none"> • permit any nurse acting in accordance with state licensure requirements to receive verbal orders from a physician. • HHAs must assure communication with all physicians involved in the plan of care, and integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.
<p>§484.18(a), revised at §484.60(a). Added a requirement at §484.60 that patient and caregiver receive education and training including written instructions outlining medication schedule/instructions, visit schedule and any other pertinent instruction related to the patients care and treatments that the HHA will provide, specific to the patient’s care needs.</p>	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <ul style="list-style-type: none"> • Patient and caregiver will receive education and training including written instructions outlining medication schedule/instructions, visit schedule and any other pertinent instruction related to the patients care and treatments that the HHA will provide, specific to the patient’s care needs.
<p>§484.18(b) revised at §484.60(c)</p>	

<p>§484.18(c) revised at §484.60(b). Revised §484.60(b)(1) to permit drugs, services and treatment to be ordered by any physician, not just the one responsible for the patient’s plan of care.</p> <ul style="list-style-type: none"> Revised §484.60(b)(4) to permit any nurse acting in accordance with state licensure requirements to receive verbal orders from a physician. 	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <ul style="list-style-type: none"> Permit drugs, services and treatment to be ordered by any physician, not just the one responsible for the patient’s plan of care. Permit any nurse acting in accordance with state licensure requirements to receive verbal orders from a physician.
<p>§484.20 Reporting OASIS information, revised at §484.45 Reporting OASIS information</p> <p>Revised 484.45(c)(2) to align the regulatory text with the current CMS guidelines for data transmission by replacing the requirement that test data be transmitted to the “state agency” with a requirement that test data be transmitted to the “QIES ASAP system.” CMS proposed to require that an HHA must, “Successfully transmit test data to the state agency or CMS OASIS contractor.” On January 1, 2015, CMS changed the OASIS transmission guidelines to require that an HHA must successfully transmit test data to the QIES ASAP System or CMS OASIS contractor. CMS have revised the final rule at §484.45 to reflect this change and maintain consistency between the transmission guidelines and the regulatory requirements.</p>	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <ul style="list-style-type: none"> OASIS transmission guidelines require that an HHA must successfully transmit test data to the QIES ASAP System or CMS OASIS contractor.
<p>§484.48 Clinical records revised at §484.110</p> <p>Clinical Records</p> <p>Content of Clinical Records</p> <ul style="list-style-type: none"> §484.48(a), revised at §484.110(c) §484.48(b), revised at §484.110(d) 	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p>

<ul style="list-style-type: none"> • Proposed § 484.110(a), “Contents of clinical record,” would retain the requirement that the record include clinical notes, plans of care, physician orders, and a discharge summary. • CMS proposed to require that the clinical record include: <ol style="list-style-type: none"> (1) The patient’s current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical visit notes, and individualized plans of care; (2) all interventions, including medication administration, treatments, services, and responses to those interventions, which would be dated and timed in accordance with the requirements of proposed § 484.110(b); (3) goals in the patient’s plan of care and the progress toward achieving the goals; (4) contact information for the patient and representative (if any); (5) contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA; and (6) a discharge or transfer summary note that would be sent to the patient’s primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA within 7 calendar days, or, if the patient is discharged to a facility for further care, to the receiving facility within 2 calendar days of the patient’s discharge or transfer. 	<p>In accordance with Chapter 7 of the Medicare Benefit Policy Manual, the home health clinical notes must document as appropriate:</p> <ul style="list-style-type: none"> • The history and physical exam pertinent to the day’s visit, (including the response or changes in behavior to previously administered skilled services) and • The skilled services applied on the current visit, and • The patient/caregiver’s immediate response to the skilled services provided, and • The plan for the next visit based on the rationale of prior results. Clinical notes should be written such that they adequately describe the reaction of a patient to his or her skilled care. Clinical notes should also provide a clear picture of CMS-3819-F 128 the treatment, as well as “next steps” to be taken. When the skilled service is being provided to either maintain the patient’s condition or prevent or slow further deterioration, Chapter 7 of the Medicare Benefit Policy Manual requires that the clinical notes must also: <ul style="list-style-type: none"> • Include a detailed rationale that explains the need for the skilled service in light of the patient’s overall medical condition and experiences, • Describe the complexity of the service to be performed, and • Describe any other pertinent characteristics of the beneficiary or home. • Finally, CMS requires the therapist to initially assess (and reassess at least every 30 calendar days) the patient using a method which allows for objective measurement of function and successive comparison of measurements. The therapist must document the measurement results in the clinical record.
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<ul style="list-style-type: none"> • CMS proposed to add a new standard at § 484.110(b) to require authentication of clinical records. • CMS proposed that all entries be legible, clear, complete, and appropriately authenticated, dated, and timed. • At § 484.110(c), CMS proposed to require that clinical records be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time. CMS would require, in § 484.110(c)(2), that HHA policies provide for retention of records even if the HHA discontinues operations. • CMS also proposed that the HHA would be required to notify the state agency as to where the agency's clinical records would be maintained. • CMS also proposed at § 484.110(d) to require that clinical records, their contents, and the information contained therein, be safeguarded against loss or unauthorized use. 	
<p>New Standard at §484.110(a),</p> <ul style="list-style-type: none"> • Revised §484.110(a)(6)(ii) by changing the transfer summary deadline for completion from 2 calendar days to 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility. • Added §484.110(a)(6)(iii), requiring that a completed transfer summary must be sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility 	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <ul style="list-style-type: none"> • Transfer summary deadline for completion is 2 business days for a planned transfer, if the patient's care will be immediately continued in a health care facility. • Completed transfer summary must be sent within 2 business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer.

<p>at the time when the HHA becomes aware of the transfer.</p> <ul style="list-style-type: none"> Added a requirement at §484.110(a)(4) that the clinical record must include contact information for the patient’s primary caregiver(s). Revised §484.110(a)(6)(i) by changing the discharge summary deadline for completion from 7 calendar days to 5 business days. 	<ul style="list-style-type: none"> Discharge summary deadline for completion is 5 business days. Clinical record must include contact information for the patient’s primary caregiver(s).
<p>New Standard at §484.110(b), Authentication</p>	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <ul style="list-style-type: none"> “Electronic signatures” may mimic paper signatures, complete with a signature and a title (occupation), or may be a secured computer entry by an identifier that is unique to the individual creating the entry. HHA should maintain the original, signed paper documents for purposes of authentication.
<p>New Standard at §484.110(e), Retrieval of clinical records</p> <ul style="list-style-type: none"> CMS proposed to add a new standard at §484.110(e), “Retrieval of clinical records.” CMS proposed that a patient’s clinical records (whether hard copy or electronic) be made readily available to a patient or appropriately authorized individuals or entities upon request. The provision of clinical records must be in compliance with the rules regarding protected health information set out at 45 CFR, parts 160 and 164. Finally, in the preamble material explaining §484.110, CMS provided information 	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <ul style="list-style-type: none"> Require that a patient’s clinical record (whether hard copy or electronic form) must be made available to a patient or appropriately authorized individuals or entities, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first).

<p>regarding the HHS Policy Priority to Accelerate Interoperable Health Information Exchange, including Use of Certified Electronic Health Record Technology.</p>	
<p>§484.55 Comprehensive assessment of patients.</p> <ul style="list-style-type: none"> • Added a requirement at §484.55(c)(6)(i) and (ii) that the comprehensive assessment must include information about caregiver willingness and ability to provide care, and availability and schedules. • The final rule also includes an expansion of the previous comprehensive patient requirement aimed at considering “all aspects of patient wellbeing”: To the existing requirements found in §484.55, CMS has added a new standard, “Content of the comprehensive assessment,” which requires the satisfaction of “[n]ew content requirements, such as an assessment of psychosocial and cognitive status, which [CMS] believe[s] would provide for a more holistic patient assessment.” 	<p><i>The following are the requirements which need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:</i></p> <p>CMS proposed to require that the comprehensive assessment must accurately reflect the patient’s status, and would assess or identify (as applicable) the following:</p> <ul style="list-style-type: none"> • The patient’s current health, psychosocial (new), functional (new), and cognitive (new) status; • The patient’s strengths, goals, and care preferences, including the patient’s progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA (new); • The patient’s continuing need for home care; • The patient’s medical, nursing, rehabilitative, social, and discharge planning needs; • A review of all medications the patient is currently using; • The patient’s primary caregiver(s), if any, and other available supports (new); and • The patient’s representative (if any) (new). • The assessment would also be required to incorporate items from the information collection set out in the OASIS data set, using the language and groupings of the OASIS items.