E-Alliance Extra

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CMS Revises Requirements Regarding Aide Training and Use of Pseudo Patients

(from NAHC Report)

PLEASE NOTE: This is an FYI at this time. Currently, Missouri does not allow the use of pseudo patients. CMS will permit states to implement more stringent requirements than what's in the federal regulations. Therefore, MAHC will be discussing with the Bureau of Home Care and Rehab Standards their thoughts on lifting the ban and implementing CMS' position on the use of pseudo patients.

A recent final rule released by the Centers for Medicare & Medicaid Services (CMS) relating to burden reduction is receiving applause especially from the home health community. The final rule, Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, allows home health agencies to assess aide competency by observing an aide performing the skill with either a patient or a pseudo-patient as part of a simulation. CMS is also revising the requirement at § 484.80(h) related to completing a full competency evaluation when an aide is found to be deficient in one or more skills. Instead of completing a full competency evaluation, an aide would only be required to complete retraining and a competency evaluation directly related to the deficient skills. These are two areas NAHC has been advocating for since these changes were originally made to the home health conditions of participation and interpretive guidelines.

For clarity, CMS is adding the following two definitions to the home health conditions of participation.

- "Pseudo patient means a person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the home health aide trainee and must demonstrate the general characteristic to the primary patient population served by the HHA in key areas such as age, frailty, functional status, and cognitive status."

- "Simulation means a training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate

substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking."

Because this is a clarification of an already-existing rule to codify longstanding policy, CMS is waiving the notice of proposed rulemaking for the use of a pseudo patient and simulation with home health aides. There is a 60-day comment period, however these changes are effective in the interim.

We should point out that these changes are applicable to home health agencies only. Hospices are required as part of a competency evaluation program or training and competency evaluation program to observe an aide's performance of certain tasks with a patient. See 418.76(c)(1). There are no interpretive guidelines for this standard and some survey entities have applied language of the home health regulation and past interpretive guidelines to hospice providers. Therefore, when the home health interpretive guidelines were finalized and did not specify that a pseudo patient was allowed, some hospices were held to the same standard. In other cases, survey entities never applied the home health interpretive guidelines and required hospices to observe an aide's performance of certain tasks with a patient. Those hospices with survey entities that allowed the use of a pseudo patient, then rescinded that allowance based on the home health interpretive guidance changes, may re-initiate the allowance of pseudo patients. Some hospices may not see any change in interpretation.

For home health agencies CMS is also limiting the requirements for verbal (meaning spoken) notification of all patient rights to those rights related to payments made by Medicare, Medicaid, and other federally funded programs, and for potential patient financial liabilities, as specified in the Social Security Act. HHAs will still be required to provide written notice of all patient rights to all HHA patients. CMS reminded HHAs that they are still responsible for complying with the Americans with Disabilities Act (ADA) Section 504 of the Rehabilitation Act when communicating with all patients regarding all subjects, including the notice of patient rights. HHAs must provide equal access to individuals with disabilities, including the provision of auxiliary aids and alternate formats, including, but not limited to, the provision of qualified interpreters, large print documents, Braille, digital versions of documents, and audio recordings.

One proposal that did not get finalized is the removal of the requirement at § 484.110(e) that the requested clinical record copy must be provided at the next home visit, while retaining the requirement that the information must be provided within 4 business days. Comments received varied from support of the proposed removal to complete opposition to suggestions for different timeframes and having only certain portions of the records applicable to a timeframe. Therefore, CMS is not finalizing the proposal and is considering the comments for future rulemaking.

For hospices, CMS is removing the procedural requirements at § 418.106(a)(1), where the hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures and State law, who is an employee of or under contract with the hospice to ensure that drugs and biologicals meet each patient's needs. To the extent that patient outcomes are not being achieved due to problems with medication management, both the hospice's internal QAPI program and the external hospice survey process will be capable of identifying and addressing those problems according to CMS.

Relative to communication from hospices to patients regarding the safe storage and disposal of medications, CMS proposed to replace the requirement at § 418.106(e)(2) that hospices provide a physical paper copy of policies and procedures, which are written to guide the actions of hospice staff, with a requirement that hospices provide information regarding the use, storage, and disposal of controlled drugs to the patient or patient representative, and family, which can be developed in a manner that speaks to the perspectives and information needs of patients, families, and caregivers. This information would be provided in a more user-friendly manner, as decided by each hospice. Hospices would be free to choose the content and format(s) that best suits their needs and the needs of their patient population. Regardless of the format chosen, this information would have to be provided to patients, families and caregivers in a manner that allowed for access to the information on a continual, as-needed basis. Hospices would still be required to discuss the information regarding the safe use and disposal of controlled drugs with the patient or representative, and the family/caregiver(s), in a language and manner that they understand to ensure that these parties are effectively educated (418.106€(2)(B)). Due to changes included in section 3222 of the SUPPORT Act, however, CMS does not believe it is appropriate to finalize this proposed change. CMS does encourage hospices to develop easily understood materials that explain safe storage, use, and disposal of controlled drugs to patients, their families, and caregivers in addition to meeting the regulatory requirement to provide a copy of the hospice's clinical policies and procedures.

CMS is also allowing hospices to defer to State licensure requirements for qualification of their hospice aides, regardless of the State licensure content or format, thus allowing states to set forth training and competency requirements that meet the needs of their populations. In the absence of state requirements, hospice aides must meet the federal requirements. Hospices in all states will continue to be required to comply with the existing requirements that hospice aides may only perform those skills that are consistent with the training that the aide has received (§ 418.76(g)(2)(iv)), and that, if an area of concern is verified by the hospice during an on-site aide supervision visit, then the hospice must conduct, and the hospice aide must complete, a competency evaluation in accordance with § 418.76(c) and (h)(1)(iii).

For hospices that provide hospice care to residents of a Skilled Nursing Facility (SNF) or Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICFIID), CMS is requiring hospices to work with their chosen Skilled Nursing Facility and intermediate care facility partners to educate facility staff about the hospice philosophy of care and specific hospice practices. CMS believes this will encourage collaboration between both entities; and will avoid duplication of efforts with other hospices that are orienting the same facility staff.

Long Awaited Discharge Planning Rule Posted *(from NAHC Report)*

It has taken four years for the final rule for discharge planning for hospitals, critical access hospitals, and home health agencies to be posted. This rule also impacts hospices, as it changes the requirements for referring patients from these facilities to hospice care. This final rule is slated to be published in the Federal Register on September 30, 2019 and be effective on November 29, 2019.

The proposed rule was published in November 2015 and a one-year delay for the final rule was announced last October.

In the proposed rule, the Centers for Medicare & Medicaid Services (CMS) outlined an elaborate discharge planning process for home health providers when patients are discharged to another post-acute care provider. Additionally, CMS planned to require a lengthy list of information to be provided to a receiving facility or practitioner whenever a patient is discharged from home health services. CMS delayed the final rule due to significant policy issues that needed to be resolved in order to address all of the issues raised by public comments to the proposed rule and to ensure appropriate coordination with other government agencies. In its comments on the proposed rule, NAHC highlighted concerns with the burden the proposed requirements would have on home health providers. CMS also failed to recognize the uniqueness of home health care providers in its proposals for discharge planning.

In the response to comments received from the proposed rule, CMS stated that it did not intend to implement requirements that were not aligned with HHA processes or were unduly burdensome. And, we see in this final rule, that CMS did not finalize some of its most burdensome proposals because they did not align with HHA processes or were addressed elsewhere. Specifically, since the new Medicare conditions of participation for home health in 2017 addressed the involvement of the physician in the HHA discharge planning process, CMS withdrew its proposal to require that the physician responsible for the plan of care be involved in the ongoing process of establishing the discharge plan. CMS also withdrew the majority of the other general discharge planning requirements proposed. CMS indicated it is committed to working with stakeholders to identify specific needs and concerns regarding discharge planning in the HHA care setting that may warrant future efforts, and to explore all options for achieving positive patient outcomes.

For HHAs, CMS finalized the following:

- **484.58 Condition of participation: Discharge planning.**

- Standard: Discharge planning. An HHA must develop and implement an effective discharge planning process. For patients who are transferred to another HHA or who are discharged to a SNF, IRF or LTCH, the HHA must assist patients and their caregivers in selecting a post-acute care 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. The HHA must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

- Standard: Discharge or transfer summary content.

(1) The HHA must send all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, to the receiving facility or health care practitioner to ensure the safe and effective transition of care.

(2) The HHA must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner.

This will require home health agencies to become familiar with, if not already so, quality measures and data on resource use measures of SNF, IRF and LTCH facilities. HHAs will want to ensure education is provided to their staff who will be assisting patients in choosing these types of facilities, and that these staff are able to explain to the patient/caregiver how to interpret the relevant data without swaying the patient/caregiver to choose a particular facility.

CMS did lessen the burden for HHAs by having a broader, more flexible requirement for the exchange of information when patients are discharged from home health to a SNF, IRF or LTCH facility. The proposed list of information to be shared was extensive. CMS commented that additional information that may be necessary and requested by the receiving facility include such items as a copy of the patient's current plan of care or latest physicians' orders.

Relative to discharge planning requirements for hospitals, CMS is requiring that a timely discharge planning evaluation take place for those patients likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and that this include an evaluation of a patient's likely need for appropriate post-hospital services, including, but not limited to, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services. The results of the evaluation must be discussed with the patient and included in their medical record. This may result in more referrals to hospice care. The hospital must also assist patients, their families, or the patient's representative in selecting a post-acute care 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. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. This will, therefore, require hospitals to have information about the availability and quality data of hospice and home health services for when it is necessary based on the patient's discharge plan. Hospitals have long been required to provide information about the availability of home health agencies, if the home health agency asks for its availability to be shared; but, they've not been explicitly required to share information on hospice availability or to share quality measure data for HHAs.

The specific requirements for hospitals relative to discharge planning and the evaluation are enumerated below. The requirements of critical access hospitals (CAH) are similar and can be found in the final rule.

The hospital's discharge planning process must identify, at an early stage of hospitalization, those patients who are likely to suffer adverse health consequences upon discharge in the absence of adequate discharge planning and must provide a discharge planning evaluation for those patients so identified as well as for other patients upon the request of the patient, patient's representative, or patient's physician.

(1) Any discharge planning evaluation must be made on a timely basis to ensure that appropriate arrangements for post-hospital care will be made before discharge and to avoid unnecessary delays in discharge.

(2) A discharge planning evaluation must include an evaluation of a patient's likely need for appropriate post-hospital services, including, but not limited to, hospice care services, post-hospital extended care services, home health services, and non-health care services and community based care providers, and must also include a determination of the availability of the appropriate services as well as of the patient's access to those services.

(3) The discharge planning evaluation must be included in the patient's medical record for use in establishing an appropriate discharge plan and the results of the evaluation must be discussed with the patient (or the patient's representative).

(4) Upon the request of a patient's physician, the hospital must arrange for the development and initial implementation of a discharge plan for the patient.

(5) Any discharge planning evaluation or discharge plan required under this paragraph must be developed by, or under the supervision of, a registered nurse, social worker, or other appropriately qualified personnel.

(6) The hospital's discharge planning process must require regular re-evaluation of the patient's condition to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(7) The hospital must assess its discharge planning process on a regular basis. The assessment must include ongoing, periodic review of a representative sample of discharge plans, including those patients who were readmitted within 30 days of a previous admission, to ensure that the plans are responsive to patient post-discharge needs.

(8) The hospital must assist patients, their families, or the patient's representative in selecting a post-acute care 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. The hospital must ensure that the post-acute care data on quality measures and data on resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

For patients enrolled in managed care organizations, the hospital must make the patient aware of the need to verify with their managed care organization which practitioners, providers or certified suppliers are in the managed care organization's network. If the hospital has information on which practitioners, providers or certified supplies are in the network of the patient's managed care organization, it must share this with the patient or the patient's representative.

Clearly, the final rule keeps with CMS' continued commitment to help patients make informed decisions about their care. The final rule does still prohibit providers from steering patients toward any particular post-discharge provider and requires hospitals to disclose financial relationships with home health agencies and other provider types.