CARE TRANSITIONS LEADERS MEETING

Project: Conditions of Participation (CoPs)

Bruce Saffran BS, RN
Quality Improvement Facilitator

CONDITIONS OF PARTICIPATION (CoPs) AND CONDITIONS FOR COVERAGE (CfCs)

Background: CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs.

Problem Statement: Vermont hospitals need to understand and implement complex sets of conditions to successfully meet the standards evaluated during regulatory surveys.

What we do: Through the FLEX grant, VPQHC provides Vermont Critical Access Hospitals assistance with understanding the most current updates to CoPs; and with guidance on potential areas of deficiency in policy, procedure and environment, including conducting unit-specific mock surveys.

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ORGANIZATIONS RESPONSIBLE FOR CONDITIONS OF PARTICIPATION (CoPs)/CONDITIONS FOR COVERAGE (CfCs)

Ambulatory Surgical Centers (ASCs)
Community Mental Health Centers (CMHCs)
Comprehensive Outpatient Rehabilitation Facilities (CORFs)
Critical Access Hospitals (CAHs)
End-Stage Renal Disease Facilities
Federally Qualified Health Centers
Home Health Agencies
Hospices
Hospitals
Hospital Swing Beds
Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID)
Organ Procurement Organizations (OPOs)
Portable X-Ray Suppliers
Programs for All-Inclusive Care for the Elderly Organizations (PACE)
Clinics, Rehabilitation Agencies, and Public Health Agencies as Providers of Outpatient Physical Therapy and Speech-Language Pathology Services
Psychiatric Hospitals
Religious Nonmedical Health Care Institutions
Rural Health Clinics
Long Term Care Facilities
Transplant Centers

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CHANGES TO HOSPITAL/CAH CONDITIONS OF PARTICIPATION (CoPs) PUBLISHED SEPTEMBER 30, 2019

Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

- Adds discharge planning as a condition of participation for CAHs in 42 CFR 485.642

Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

- Adds infection prevention and control and antibiotic stewardship programs as a condition of participation for CAHs in 42 CFR 485.640 (Effective March 30, 2020)
- Revises 42 CFR 485.641 to require a quality assessment and performance improvement program as a condition of participation for CAHs (Effective March 30, 2121)
- Encourages CAHs seek technical assistance from State Flex Programs

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NEW DISCHARGE PLANNING CoPs SUMMARY

- Discharge planning is the process of preparing to move patients from acute care into post-acute care
- Proposed rule was first published in 2015
- Effective 11/29/2019

- Hospitals/CAHS must actively use a discharge planning process that involves patients and/or patients' representatives and takes into account data on quality measures and resource use measures.

- Hospitals/CAHs must discharge, transfer, or refer patients with their applicable medical information at the time of discharge, transfer, or referral.

- Hospitals/CAHs must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area.

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NEW DISCHARGE PLANNING CoPs DETAILS

- (a) Standard: Discharge planning process. 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.

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NEW DISCHARGE PLANNING CoPs DETAILS

- (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.

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NEW DISCHARGE PLANNING CoPs DETAILS

- (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.

NEW DISCHARGE PLANNING CoPs DETAILS

- b) Standard: Discharge of the patient and provision and transmission of the patient's necessary medical information. The hospital must discharge the patient, and also transfer or refer the patient where applicable, along with all necessary medical information pertaining to the patient's current course of illness and treatment, post-discharge goals of care, and treatment preferences, at the time of discharge, to the appropriate post-acute care service providers and suppliers, facilities, agencies, and other outpatient service providers and practitioners responsible for the patient's follow-up or ancillary care.

- (c) Standard: Requirements related to post-acute care services. For those patients discharged home and referred for HHA services, or for those patients transferred to a SNF for post-hospital extended care services, or transferred to an IRF or LTCH for specialized hospital services, the following requirements apply, in addition to those set out at paragraphs (a) and (b) of this section:

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NEW DISCHARGE PLANNING CoPs DETAILS

- (1) The hospital must include in the discharge plan a list of HHAs, SNFs, IRFs, or LTCHs that are available to the patient, that are participating in the Medicare program, and that serve the geographic area (as defined by the HHA) in which the patient resides, or in the case of a SNF, IRF, or LTCH, in the geographic area requested by the patient. HHAs must request to be listed by the hospital as available.

- (i) This list must only be presented to patients for whom home health care post-hospital extended care services, SNF, IRF, or LTCH services are indicated and appropriate as determined by the discharge planning evaluation.

- (ii) 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.

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NEW DISCHARGE PLANNING CoPs DETAILS

- (iii) The hospital must document in the patient's medical record that the list was presented to the patient or to the patient's representative.

- (2) The hospital, as part of the discharge planning process, must inform the patient or the patient's representative of their freedom to choose among participating Medicare providers and suppliers of post-discharge services and must, when possible, respect the patient's or the patient's representative's goals of care and treatment preferences, as well as other preferences they express. The hospital must not specify or otherwise limit the qualified providers or suppliers that are available to the patient.

- (3) The discharge plan must identify any HHA or SNF to which the patient is referred in which the hospital has a disclosable financial interest, as specified by the Secretary, and any HHA or SNF that has a disclosable financial interest in a hospital under Medicare.

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CHANGES TO HOSPITAL/CAH CONDITIONS OF PARTICIPATION (CoPs) EFFECTIVE OCTOBER 12, 2018

Revisions to SOM Appendix A for Hospitals and Appendix W for Critical Access Hospitals (CAHs) to address new and revised regulations and interpretive guidelines related to Swing Bed Services.

https://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/2018Downloads/R183SOMA.pdf

https://www.kyha.com/assets/docs/EventDocs/2019/CAHCOPS2019SwingBeds.pdf

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NEW SWING BED COPS DETAILS

- Choice of physician under tag C 361-still a requirement but clarified
- Name of provider so resident can contact under tag 361-clarified
- Reporting abuse and the time to do so under tag 381-new changes
- Plan of care under tag 399 and new changes and clarifications
- PASARR- clarification and has never been a requirement to do one and still isn't under 388

NEW SWING BED COPS DETAILS

- Provide a culturally competent and trauma informed plan of care under 388-clarification and new additions
- Transfer and discharge and notification of ombudsman under tag 373 and 388- new requirements and much more detailed
- Dental care- changes and clarifications under tag 404
- Nutrition- changes and new requirements under tag 410

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QUESTIONS?

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THANK YOU!

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