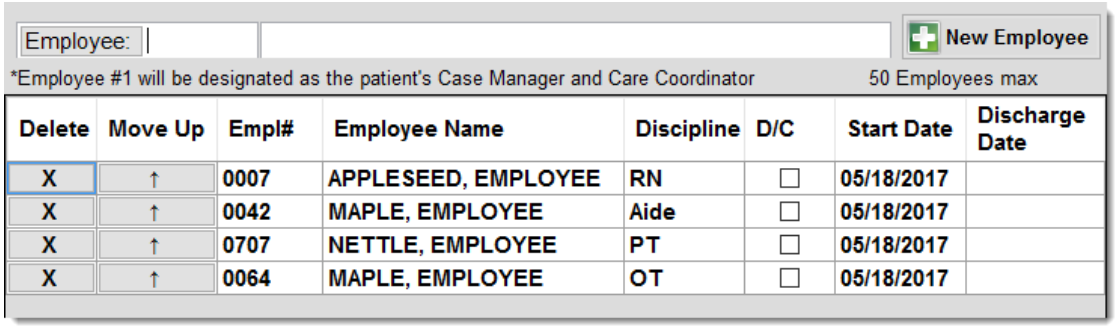
This section will list updates already implemented in Barnestorm to comply with new CoP rules. See the next section which will list other CoP updates we will be working on.

CoP Requirement
An expanded patient care coordination requirement that makes a licensed clinician responsible for all patient care services, such as coordinating referrals and assuring that plans of care meet each patient's needs at all times.

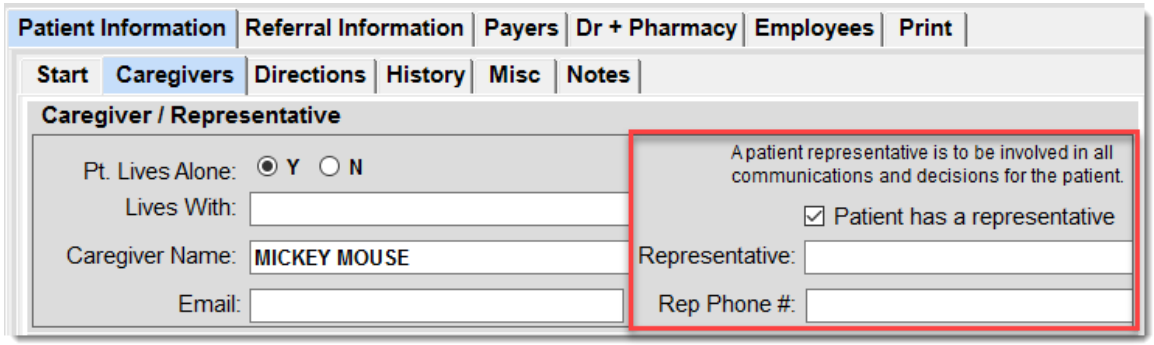
Barnestorm Update
Referral > Employees: Updated Employee #1 spot to be labeled as Case Manager/Care Coordinator. Patient Info updated the description as well.



Delete	Move Up	Empl#	Employee Name	Discipline	D/C	Start Date	Discharge Date
X	↑	0007	APPLESEED, EMPLOYEE	RN	☐	05/18/2017	
X	↑	0042	MAPLE, EMPLOYEE	Aide	☐	05/18/2017	
X	↑	0707	NETTLE, EMPLOYEE	PT	☐	05/18/2017	
X	↑	0064	MAPLE, EMPLOYEE	OT	☐	05/18/2017	

CoP Requirement
Allow the patient to identify a "patient representative" to be involved in all communications and decisions, or to state that there is none.

Barnestorm Update
Referral > Caregivers: Added a spot to enter Representative name and phone number. Information will show up on Patient Info as well.

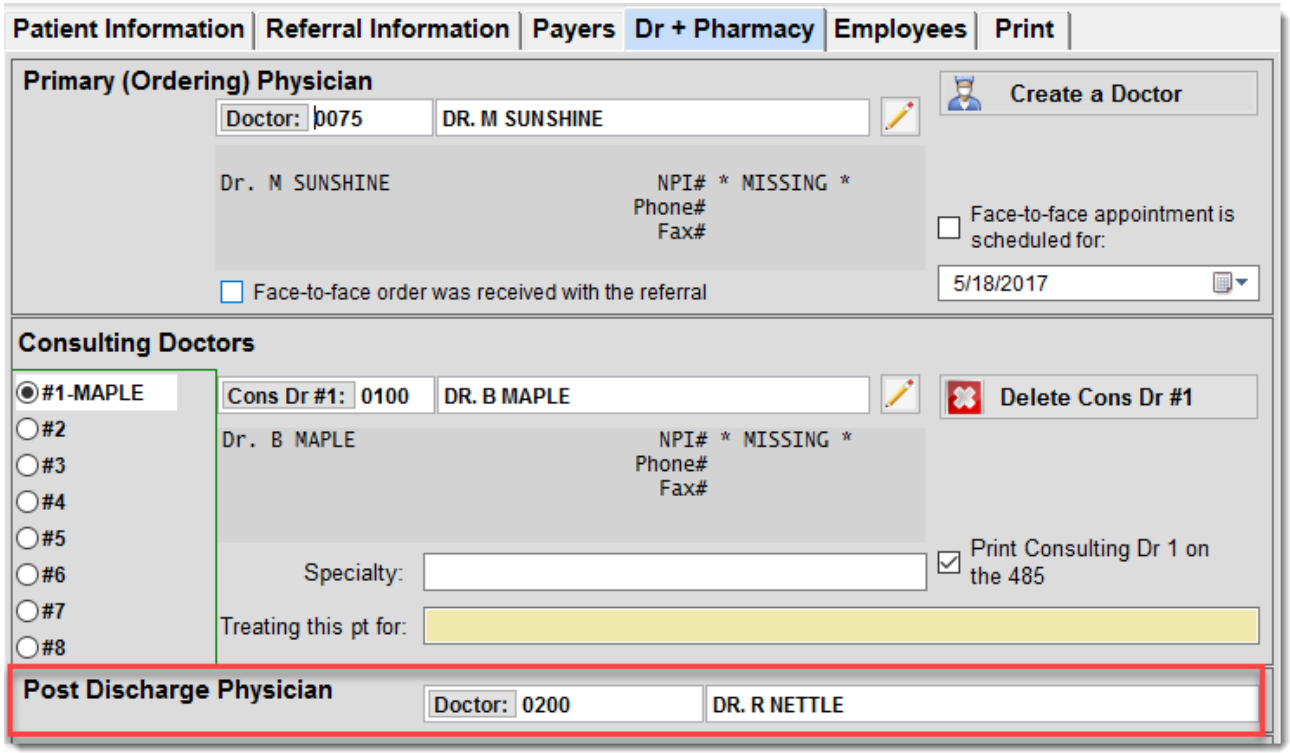


CoP Requirement

Identify the patient's primary care practitioner or other health care professional who would be responsible for providing care and services to the patient after discharge from the HHA (if any).

Barnestorm Update

Referral > Dr+Pharmacy: Added a spot to identify the post discharge physician. Information will show up on Patient Info as well.

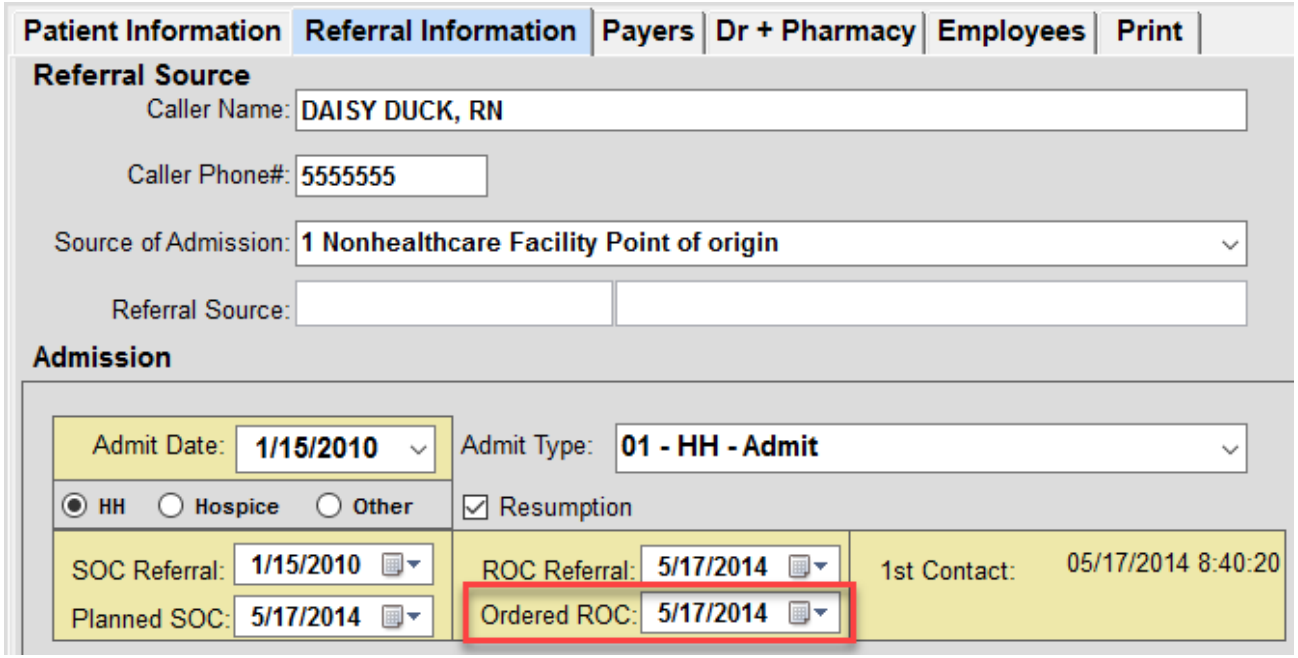


CoP Requirement

Adding the physician ordered resumption of care date as an alternative to the fixed 48 hour time frame for a post-hospital reassessment allows physicians to specify a resumption of care date that is tailored to the particular needs and preferences of each patient.

Barnestorm Update

Referral > Referral Information: Updated resumption date to Ordered ROC.



Below is a list of the new Condition of Participation Effective January 2018. Items listed in red have already been updated in Barnestorm (items previously listed).

COP Requirement	Status in Barnestorm	Location in Barnestorm
General		
Revisions to simplify the organizational structure of home health agencies while continuing to allow parent agencies and their branches.	N/A	N/A
Information that is provided to patients would have to be provided to the individual in plain language, and in a manner that is both accessible and timely.	N/A	N/A
A requirement for a data-driven, agency-wide quality assessment and performance improvement (QAPI) program that continually evaluates and improves agency care for all patients at all times.	Update?	Waiting for additional clarification
An expanded comprehensive patient assessment requirement that focuses on all aspects of patient wellbeing.	Existing	clinical, mental, psychosocial, cognitive and functional status screens in POC
Administrative / QI / Clinical Review		
The HHA would also have to measure, analyze, and track quality indicators, including adverse patient events, as well as other indicators of performance so that the agency could adequately assess its processes, services, and operations.	Existing	Reports 13.39, 13.29, 07.08, and HHVBP reports
Referral / Admission		
A comprehensive patient rights statement that clearly enumerates the rights of home health agency patients and the steps that must be taken to assure those rights.	N/A	N/A, admission package
Allow the patient to identify a "patient representative" to be involved in all communications and decisions, or to state that there is none	Update	Referral > Patient Info > Caregivers
Identify the patient's primary care practitioner or other health care professional who would be responsible for providing care and services to the patient after discharge from the HHA (if any)	Update	Referral > Doctors
The patient's primary caregiver(s), if any, and other available supports (new);	Update	POC > Assessment > Contact
Adding the physician ordered resumption of care date as an alternative to the fixed 48 hour time frame for a post-hospital reassessment allows physicians to specify a resumption of care date that is tailored to the particular needs and preferences of each patient.	Existing	M0102 - that's been there for quite a while Also ROC date on Referral

If HHA services are initiated following a patient's hospital discharge, we require that the HHA include an assessment of the patient's level of risk for hospital emergency department visits and hospital re-admission. We proposed that HHAs would be required to include in the patient's individualized plan of care all appropriate interventions that are necessary to address and mitigate identified risk factors that contribute to the HHA's establishment of a particular risk level for a patient.	Existing	Referral > Patient Info > Start > Risk level tied to the emergency preparedness: fall risk, re-hospitalization risk, evacuation needs, electricity required, oxygen, IV, negative pressure wound care

Clinical		
A new infection prevention and control requirement that focuses on the use of standard infection control practices, and patient/caregiver education and teaching.	Existing	Infection Tracking in POC and reporting in Office
The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. HHAs would be expected to provide education on "current best practices" to staff, patients, and caregivers.	Existing Existing	Infection Tracking in POC and reporting in Office CCN for Infectious Diseases Codes > Employee Date Tracking, new tracking item for Infectious Diseass Education
The 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.	Existing	Med Sheets > Schedule & Instructions 485 / Plan of Care
A streamlined skilled professional services requirement that focuses on appropriate patient care activities and supervision across all disciplines.	Existing	Supervision screen in POC on visit note for Supe for aide, LPN, PTA
The comprehensive assessment must accurately reflect the patient's status, and would assess or identify (as applicable) the following:		
The patient's current health, psychosocial (new), functional (new), and cognitive (new) status;	Existing	POC Assessment
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);	Existing	485 / Plan of Care
The patient's continuing need for home care;	Update	New Homebound screen
The patient's medical, nursing, rehabilitative, social, and discharge planning needs;	Existing	485 / Plan of Care (nothing new)
A review of all medications the patient is currently using;	Existing	POC Assessment > Medication Review
The comprehensive assessment must include information about caregiver willingness and ability to provide care, and availability and schedules.	Existing	485 / Plan of Care

Communication		
A requirement for an integrated communication system that ensures that patient needs are identified and addressed, care is coordinated among all disciplines, and that there is active communication between the home health agency and the patient's physician(s).	Existing	CCNs and Orders
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.	Existing	Orders
Develop a form for HHA staff (and contract visiting staff), to immediately report to the HHA or other appropriate authorities any incidences of mistreatment, neglect, or abuse, and/or any misappropriation of patient property, which they have noticed during the normal course of providing services to patients.	Existing	CCN with new T-box code
A requirement that assures that patients and caregivers have written information about upcoming visits, medication instructions, treatments administered, instructions for care that the patient and caregivers perform, and the name and contact information of a home health agency clinical manager.	Existing Existing Update	485 / Plan of Care Medication Schedule & Instructions Possibly a new screen in Barnestom to allow a summary of orders to be printed, written in plain language
Discharge or transfer summary The HHAs is required to compile a discharge or transfer summary for each discharged or transferred patient. The summary would be required to include the following: The initial reason for referral to the HHA; A brief description of the patient's HHA care; A description of the patient's clinical, mental, psychosocial, cognitive, and functional status at the start of care; A list of all services provided by the HHA to the patient; The start and end dates of HHA care; A description of the patient's clinical, mental, psychosocial, cognitive; and functional status at the end of care; The patient's most recent drug profile; Any recommendations for follow-up care; The patient's current individualized plan of care; and Any additional documentation that would assist in the continuity of post-discharge or transfer care, or that was requested by the receiving practitioner or facility.	Update	Orders > Discharge and Transfer Summary content needs a way to present the patient's clinical, mental, psychosocial, cognitive, and functional status at the start of care and currently (at transfer or d/c) that's consistent and readable

Staffing		
An expanded patient care coordination requirement that makes a licensed clinician responsible for all patient care services, such as coordinating referrals and assuring that plans of care meet each patient's needs at all times.	Update	Referral > Employee
New personnel qualifications for home health agency administrators and clinical managers.	Existing	Codes > Employee Date Tracking, new tracking items
The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. HHAs would be expected to provide education on "current best practices" to staff, patients, and caregivers.	Existing Existing	Infection Tracking in POC and reporting in Office CCN for Infectious Diseases Codes > Employee Date Tracking, new tracking item
It is essential for all medical social services to be provided under the overall supervision of a Master of Social Work (MSW) prepared social worker who meets the requirements of §484.115. (and SW that are not MSW need to have activity supervised and approved)	Existing	Codes > Employee Date Tracking, new tracking item for SW
Aide training and competency evaluation, performed by an RN. 12 hours of in-service training required every 12 months. When a patient is receiving skilled care, the home health aide supervisor (RN or therapist) must make an onsite visit to the patient's home no less frequently than every 14 days. The home health aide would not have to be present during this visit. If a potential deficiency in home health aide service was noted by the home health aide supervisor, then the supervisor would have to make an on-site visit to the location where the patient was receiving care in order to observe and assess the home health aide while he or she is performing care. In addition to the regularly scheduled 14-day supervision visits and the as-needed observation visits, HHAs would be required to make an annual on-site visit to a patient's home to observe and assess each home health aide while he or she is performing patient care activities. The HHA would be required to observe each home health aide with at least one patient. If home health aide services are provided to a patient who is not receiving skilled care, the RN must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each home health aide while he or she is performing care. If a deficiency in home health aide services was verified by the home health aide supervisor during an on-site visit, then the agency would have to conduct, and the home health aide would have to complete, a competency evaluation.	Existing	Codes > Employee CEU Classes, new tracking CEUs for each aide Schedule > Comment to indicate need for Aide Supe on visit per Employee Date Tracking report POC > Aide Supe screen Schedule > Comment to indicate need for Aide Supe on visit per Employee Date Tracking report POC > Aide Supe screen Codes > Employee Date Tracking, new tracking item for competency evaluation