Barnestorm Tool:
Home Health Conditions of Participation
Policy and Procedure Checklist


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Patient Record Checklist

Standards of this CoP include:

- **Transfer and Discharge Policies provided to Patient**
- **Clinical Records**
- **Care Plan**
- **OASIS information**
- **Comprehensive assessment of patients**

Barnestorm Implementation:

- Add **Employee Date Tracking** for each policy.
- Use **Employee Tracking** to document the date that each employee was trained on policies.
- Use Referral > **Doctors** to track all physicians involved in care.
- Use **Orders** to send care communication to physicians.
- Use Patient Portal to share care plan, care communication, medications, and orders with physicians to coordinate care.
- Ensure that each visit includes completion of the **Care Goals** screen in Barnestorm POC visit assessment: Instructions here
- Use Barnestorm clinical Point of Care to document clinical visits, and ensure that all visit notes are completed at the time and location of the visit.
- Ensure that any patient transfer event is communicated swiftly to the clinical director and staff who build, verify, and send OASIS. Use **Messaging** to communicate quickly and ensure that communication is tracked.
- Ensure that each pertinent visit includes completion of the Review Meds screen in Barnestorm POC visit assessment.
- Use Reports > Oasis > 13.05 and **13.17** to track progress of Oasis.
- Use Orders > Discharge Type to generate a discharge summary within 5 business days.
- Use Referral **> Contacts** to track patient caregiver and representative.

Transfer and Discharge	Recommended Action	Barnestorm Implementation
Transfer and Discharge New Standard at §484.50(d). 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. 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: "(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; (2) when the patient or payer could no longer pay for the services provided by the HHA; (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; (4) when the patient refused HHA services or otherwise elected to be transferred or discharged (including if the patient elected the Medicare hospice benefit); (5) when there was cause; (6) when a patient died; or (7) when the HHA ceased to operate." 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. *(Please read the full standard. This information is provided as a summary.)*	***The following requirements need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:*** • provide each patient with written notice regarding the HHA's transfer and discharge policies. • 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 reasons specified by the regulation.	1. Add **Transfer and Discharge Policies** to the patient admission package. Add contact information for federally-funded and state-funded entities to admission package. 2. Use **Documents** in Barnestorm to ensure that a signed copy is scanned into the patient electronic record. 3. Add **Employee Date Tracking** for "**Training on Patient Transfer and Discharge Policies".** 4. Use Employee Tracking to ensure each employee has been trained on this policy.

Care Planning, Coordination of Services, and Quality of Care	**Recommended Action**	**Barnestorm Implementation**
§484.18, Acceptance of patients, plan of care, and medical supervision, now at §484.60, **Care planning, coordination of services, and quality of care.** • 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." 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.	***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:*** • 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.	1. Add wording to your organizational policies. 2. Use Referral > **Doctors** to track all physicians involved in care. 3. Use **Orders** to send care communication to physicians. 4. Use Patient Portal to share care plan, care communication, medications, and orders with physicians to coordinate care.

Clinical Records	Recommended Action	Barnestorm Implementation
§484.48 Clinical records revised at §484.110 • 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: (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. • 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.	***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:*** In accordance with Chapter 7 of the Medicare Benefit Policy Manual, the home health clinical notes must document as appropriate: • 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.	1. Use Barnestorm clinical Point of Care to document clinical visits, and ensure that all visit notes are completed at the time and location of the visit, per Medicare policy. 2. Ensure that each visit includes completion of the **Care Goals** screen in Barnestorm POC visit assessment. 3. Use Patient Portal to share care plan, care communication, medications, and orders with physicians to coordinate care. 4. Add **Employee Date Tracking** for "Training on Clinical Record Requirements**".** 5. Use **Employee Tracking** to ensure each employee has been trained on this policy.

Clinical Records (continued)	**Recommended Action**	**Barnestorm Implementation**
• 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.	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: • 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.	1. Use Barnestorm clinical Point of Care to document clinical visits, and ensure that all visit notes are completed at the time and location of the visit. 2. Ensure that each visit includes completion of the **Care Goals** screen in Barnestorm POC visit assessment.

Transfer Summary Deadline	**Recommended Action**	**Barnestorm Implementation**
New Standard at §484.110(a), • 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 at the time when the HHA becomes aware of the transfer. • 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.	***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:*** • 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. • Discharge summary deadline for completion is 5 business days. • Clinical record must include contact information for the patient's primary caregiver(s).	1. Ensure that any patient transfer event is communicated swiftly to the clinical director and staff who build, verify, and send OASIS. Use **Messaging** to communicate quickly and ensure that communication about patient transfers is tracked. 2. Ensure that the clinician completes and locks the transfer **OASIS** in Barnestorm. 3. Use Reports > Oasis > 13.05 and 13.17 to track OASIS process. 4. Use Orders > Discharge Type to generate a discharge summary. 5. Ensure the staff who export OASIS export and send the OASIS within 2 days from **Barnestorm Export OASIS**. 6. Add **Employee Date Tracking** for "Transfer Summary Deadline**".** 7. Use **Employee Tracking** to ensure each employee has been trained on this policy.


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Retrieval of Clinical Records	**Recommended Action**	**Barnestorm Implementation**
New Standard at §484.110(e), **Retrieval of clinical records** • 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 regarding the HHS Policy Priority to Accelerate Interoperable Health Information Exchange, including Use of Certified Electronic Health Record Technology.	***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:*** • 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).	1. Use Barnestorm clinical Point of Care to document all clinical visits. 2. Ensure that each pertinent visit includes completion of the **Care Goals** screen in Barnestorm POC visit assessment. 3. Use **Patient Portal** to share care plan, care communication, medications, and orders with patients as requested.

Comprehensive Assessment of Patients	**Recommended Action**	**Barnestorm Implementation**
§484.55 Comprehensive assessment of patients. 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."	***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:*** CMS proposed to require that 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; • 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.	1. Use Barnestorm clinical Point of Care to document clinical visits, and ensure that all visit notes are completed at the time and location of the visit. 2. Ensure that each comprehensive visit includes completion of the **Care Goals, Cognitive, Psychosocial, Functional, Homebound, and Review Meds** screens in Barnestorm POC visit assessment. If necessary, Barnestorm can assist you with making a new assessment type. 3. Use Referral > Contacts to track patient caregiver and representative. 4. Use available but non-required OASIS items in Barnestorm clinical Point of Care, such as on the Pain screen, on comprehensive visits.

Patient's Rights Checklist

Standards of this CoP include:

- **Patient's Rights**
- **Investigation of Complaints**
- **Written information to the patient.**

Barnestorm Implementation:

1. Add **Patient Rights** and **Investigation of Complaints** to the policies and patient admission package.
2. Use **Documents** in Barnestorm to ensure that a signed copy is scanned into the patient record: Link here
3. Use the **Patient Portal** to upload a copy of the Patient Rights for the patient, representative, and caregiver.
4. Add **Employee Date Tracking** for each new policy.
5. Use **Employee Tracking** to ensure each employee has been trained on each policy.
6. Use **Patient Portal** to share schedule, care plan, care communication, medications, and orders with patients and caregivers.
7. Use Barnestorm **Schedule** to schedule all clinical visits. This schedule automatically flows to the **Patient Portal**.
8. Ensure that each pertinent visit includes completion of the **Care Goals** screen in Barnestorm POC visit assessment.
9. Ensure that each pertinent visit includes completion of the **Review Meds** screen in Barnestorm POC visit assessment.
10. Use available but non-required OASIS items in Barnestorm clinical Point of Care, such as on the Pain screen, on regular visits.
11. Use Referral to track patient caregiver and representative.
12. Add CCN topic **Investigation of Complaint** to document new complaints under the Care Coordination feature.

Patient Rights	Recommended Action	Barnestorm Implementation
§484.10 **Patient's rights** revised at §484.50. At § 484.50, CMS revised patient rights provisions under six standards: (1) Notice of rights; (2) Exercise of rights; (3) Rights of the patient; (4) Transfer and discharge; (5) Investigation of complaints; and (6) Accessibility Added new §484.50(a)(4), requiring that the HHA provide written notice of the patient's rights and the HHA's discharge and transfer policies to a patient-selected representative within 4 business days after the initial evaluation visit. One of the biggest changes to the CoPs is the addition of a **patient bill of rights** that must be clear and accessible to patients and staff. While not a new concept, the changes include more assessment components, encompassing psychological, functional and cognitive states of patients. Agencies will have to collect patient preferences and demonstrate progress toward patients' identified goals—a new requirement. Home health providers must also identify family caregivers and their willingness and ability to help provide care. Proposed §484.50(c)(7) would retain the requirements of the current standard at §484.10(e), Patient liability for payment. This patient liability requirement would be related to the home health	***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:*** • Include in policies and training -Patient rights provisions under six standards: (1) Notice of rights; (2) Exercise of rights; (3) Rights of the patient; (4) Transfer and discharge; (5) Investigation of complaints; and (6) Accessibility _____ • Provide written notice of the patient's rights and the HHA's discharge and transfer policies to a patient-selected representative within 4 business days after the initial evaluation visit. • A signature confirming receipt of the notice of patient rights is only required from a patient or a patient's legal representative.	1. Add **Patient Rights** to the patient admission package from the Referral **> Print > Print Admission Package**. A Barnestorm rep can help with adding your document. 2. Use Documents in Barnestorm to ensure that a signed copy is scanned into the patient record. 3. Use the Patient Portal to upload a copy of the Patient Rights for the patient, representative, and caregiver. 4. Add **Employee Date Tracking** for "Training on Patient Rights**".** 5. Use **Employee Tracking** to ensure each employee has been trained on this policy.

advance beneficiary notice (ABN) and home health change of care notices; therefore, CMS proposed to reference the current requirements at §411.408(d)(2) and §411.408(f). HHAs would be required to comply with all ABN requirements, including restrictions related to who may receive the ABN on the patient's behalf. §484.10(a) Patient's rights revised at §484.50(a). Revised §484.50(a)(1) to clarify that it is the patient's legal representative that must be informed of the patient rights information prior to the start of care. Re-designated proposed §484.50(a)(4) as §484.50(a)(2), and clarified that a signature confirming receipt of the notice of patient rights is only required from a patient or a patient's legal representative. Revised §484.50(a)(3), requiring that the HHA must provide verbal notice of the patient's rights no later than the completion of the second visit from a skilled professional. Added new §484.50(a)(4), requiring that the HHA provide written notice of the patient's rights and the HHA's discharge and transfer policies to a patient-selected representative within 4 business days after the initial evaluation visit. Revised 484.50(b) to replace the term "incompetence" wherever it appears with the more precise term "lack legal capacity to make health care decisions."	• Patient's legal representative must be informed of the patient rights information prior to the start of care. • Collect patient preferences and demonstrate progress toward patients' identified goals • Identify family caregivers and their willingness and ability to help provide care. • Develop and implement new training programs that incorporate the required topics listed above. • Identify current staff, contractors and volunteers who must now receive training and the topics that must be covered.	

Investigation of Complaints	**Recommended Action**	**Barnestorm Implementation**
Investigation of Complaints §484.50(e). Re-designated proposed §484.50(a)(2) as §484.50(a)(1)(ii) and removed the requirement that HHA administrators are expected to receive patient questions. Revised §484.50(e)(1)(i) to clarify that the subject matter about which patients may make complaints is not limited to those subjects specified in the regulation. HHAs must investigate all such complaints. Revised §484.50(e)(1)(iii) to specify that HHAs must take action to prevent retaliation while a patient complaint is being investigated. Revised §484.50(e)(2) to specify that circumstances of mistreatment, neglect, abuse, or misappropriation of patient property must be reported in accordance with the requirements of state law.	***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:*** • HHAs must take action to prevent retaliation while a patient complaint is being investigated. • Circumstances of mistreatment, neglect, abuse, or misappropriation of patient property must be reported in accordance with the requirements of state law. • The subject matter about which patients may make complaints is not limited to those subjects specified in the regulation, and must be investigated by the HHA.	1. Add **Investigation of Complaints** to the policies. 2. Create a new CCN topic for "Investigation of Complaint". 3. Document any new complaint on the patient record using a CCN with the new topic Investigation of Complaint. 4. Add **Employee Date Tracking** for "Training on Investigation of Complaints**".** 5. Use **Employee Tracking** to ensure each employee has been trained on this policy.

Information to Patient	Recommended Action	Barnestorm Implementation
§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. The final rule includes a requirement that the HHA provide written instructions to both patients and their caregivers "outlining visit schedule including frequency of visits, medication schedule/instructions, treatments administered by HHA personnel and personnel acting on the behalf of the HHA, pertinent instructions related to patient care and the name and contact information of the HHA clinical manager." [§484.60(e)]	***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:*** • Provide written instructions to both patients and their caregivers outlining: ○ visit schedule including frequency of visits, ○ medication schedule/instructions, ○ treatments administered by HHA personnel and personnel acting on the behalf of the HHA, ○ pertinent instructions related to patient care and ○ the name and contact information of the HHA clinical manager	1. Use **Patient Portal** to share schedule, care plan, care communication, medications, and orders with patients and caregivers. 2. Use Barnestorm **Schedule** to schedule all clinical visits. This schedule automatically flows to the **Patient Portal**. 3. Ensure that each pertinent visit includes completion of the **Care Goals** screen in Barnestorm POC visit assessment. 4. Ensure that each pertinent visit includes completion of the **Review Meds** screen in Barnestorm POC visit assessment. 5. Use Referral > Contacts to track patient caregiver and representative. 6. Use available but non-required OASIS items in Barnestorm clinical Point of Care, such as on the Pain screen, on regular visits.

Emergency Preparedness Policy and Procedure Checklist

Standards of this CoP include:

- Emergency Plan;
- Emergency Preparedness Policies and Procedures;
- Communication Plan;
- Training and Testing;
- HHAs that are part of an integrated health system.

Barnestorm Implementation:

- Add **Emergency Plans** to the policies.
- Use the **Risk Indicator** on each patient under Referral in Barnestorm to categorize the risk level for each patient.
- Reports > Patients > 01.05: When needed, run report in Barnestorm to find high-risk patients with emergency contact info.
- Reports > Patients > 01.18: Patients with Oxygen report, lists patients with county and phone#.
- Ensure that **Employees** in Barnestorm includes all contact information (phone, address, email) for each staff member. Ensure that all inactive employees are terminated and have a termination reason.
- Use the **Patient Portal** to share information with patients and caregivers.
- Add **Employee Date Tracking** for "Emergency Plan**".**
- **Add Employee Date Tracking for "Annual Review of Emergency Plan".**
- Use **Reports > Employees > 08.23** to review current data keyed for each employee.
- Use **Employee Tracking** to ensure each employee has been trained on this policy, and that the date of Emergency Plan review is recorded.
- Upload the emergency plan review annually to Agency **Documents** in Barnestorm.

Emergency Preparedness	Recommended Action	Barnestorm Implementation
Emergency Preparedness – Sec. 484.102 The CoP for Emergency Preparedness was formerly located at 484.22. This CoP mirrors the Emergency Preparedness regulations for most Medicare certified providers, which were effective on November 16, 2016. This CoP requires HHAs to comply with all applicable federal, state and local emergency preparedness requirements. Emergency Plan, Sec. 484.102(a): The CoPs require the HHA to have an Emergency Plan ("Plan") that must be reviewed and updated at least annually. The Plan must be based on a facility- and community-based risk assessment utilizing an all-hazards approach. The Plan must include strategies for addressing emergency events as indicated in the risk assessment. It also must address patient populations that include what services the HHA can provide in an emergency and continuity of operations during an emergency. The Plan must include a process for cooperation and collaboration with all emergency preparedness officials in order to maintain an integrated response during an emergency situation. Policies and Procedures, Sec. 484.102(b): The CoPs require the HHA to develop and implement policies and procedures based on the Plan. These policies and procedures must be reviewed and updated at least annually. The policies and procedures must address how the HHA handles patients during a disaster that must be addressed in the comprehensive patient assessment for each patient. The HHA must have a procedure for informing state and local officials who would need to be evacuated from their homes due to an emergency. The HHA must have a procedure for determining how services will be provided when there is an interruption in services due to an emergency. This includes a requirement that the HHA notify state and local officials of any on-duty staff or patients they are unable to contact. The HHA must have a system for protecting patient information and the confidentiality of such information in the event of an emergency. The HHA is required to have a process on the use	***The following are the requirements which need to be in your Policy and Procedures:*** *Emergency Preparedness* ***as per the Conditions of Participation and included in staff training as applicable:*** Emergency Plan ("Plan") must be reviewed and updated at least annually The Plan must be based on a facility- and community-based risk assessment utilizing an all-hazards approach. The Plan must include strategies for addressing emergency events as indicated in the risk assessment. The plan must address patient populations that include what services the HHA can provide in an emergency and continuity of operations during an emergency. The Plan must include a process for cooperation and collaboration with all emergency preparedness officials in order to maintain an integrated response during an emergency situation. The HHA must have a procedure for informing state and local officials who would need to be evacuated from their homes due to an emergency. The HHA must have a procedure for determining how services will be provided when there is an interruption in services due to an emergency. This includes a requirement that the HHA notify state and local officials of any on-duty staff or patients they are unable to contact. The HHA must have a system for protecting patient information and the confidentiality of such information in the event of an emergency.	1. Add **Emergency Plans** to the policies. 2. Use the Risk Indicator on each patient under Referral > Start screen in Barnestorm to categorize the risk level for each patient. 3. **Reports > Patients** > **01.05**: When needed, run report in Barnestorm to find high-risk patients with emergency contact info. Many HHAs have a policy of printing and posting this report weekly in each office. 4. **Reports** > **Patients** > **01.18**: Patients with Oxygen report, lists patients with county and phone#. Many HHAs have a policy of printing and posting this report weekly in each office. 5. Ensure that **Employees** in Barnestorm includes all contact information (phone, address, email) for each staff member. **Use Reports > Employees > 08.23> Format 2 > Active**, to print active list and review data keyed.

of volunteers or other staffing to address surge needs during an emergency. Communication Plan, Sec. 484.102(c): The HHA must develop and maintain an emergency preparedness communication plan that must be reviewed and updated at least annually. The communication plan must have contact information for staff, contracted entities providing services to the HHA, patients' physicians, volunteers, emergency preparedness staff at all levels of government and other sources of assistance. The HHA must have a primary and alternative means of communication for contacting staff and emergency preparedness agencies. The HHA must implement a method for sharing patient information with other health care providers to ensure continuity of care. Training and Testing, Sec. 484.102(d): HHAs are required to develop and maintain an emergency training and testing program taking into account the Emergency Plan, Risk Assessment, Policies and Procedures and Communication Plan described above. The training and testing program must be updated at least annually. The training program must provide training on emergency preparedness policies and procedures. This training must be to staff, individuals providing services under arrangement and volunteers at least annually. The HHA must maintain documentation of the training. With regard to testing, the HHA must conduct exercises to test the emergency preparedness plan at least annually. The HHA must participate in a full-scale and community-based exercise on the emergency preparedness plan. If a community-based exercise is not accessible, the testing may be facility-based. A second community or facility-based exercise must also be conducted. This exercise must include a tabletop exercise, which includes a group discussion led by a facilitator. Integrated Health Care Systems, Sec. 484.102(e): If an HHA is part of an integrated health care system that includes other certified providers, the HHA has the option of choosing to be part of the health care system's emergency preparedness plan. If the HHA participates in the system-wide emergency preparedness plan, it must ensure the HHA's patient population and services offered are taken into account.	The HHA is required to have a process on the use of volunteers or other staffing to address surge needs during an emergency The HHA must develop and maintain an emergency preparedness communication plan that must be reviewed and updated at least annually. The communication plan must have contact information for staff, contracted entities providing services to the HHA, patients' physicians, volunteers, emergency preparedness staff at all levels of government and other sources of assistance. The HHA must have a primary and alternative means of communication for contacting staff and emergency preparedness agencies. The HHA must implement a method for sharing patient information with other health care providers to ensure continuity of care. Develop and maintain an emergency training and testing program taking into account the Emergency Plan, Risk Assessment, Policies and Procedures and Communication Plan. The training and testing program must be updated at least annually. The HHA must maintain documentation of the training. The HHA must participate in a full-scale and community-based exercise on the emergency preparedness plan. A second community or facility-based exercise must also be conducted. This exercise must include a tabletop exercise, which includes a group discussion led by a facilitator. If the HHA participates in the system-wide emergency preparedness plan, it must ensure the HHA's patient population and services offered are taken into account.	6. Ensure that all inactive employees are terminated and have a termination reason. Use **Reports > Employees > 08.23> Format 6** to look for discharge employees without a termination date. 7. Use the **Patient Portal** to share information with patients and caregivers. 8. Add **Employee Date Tracking** for "Emergency Plan**".** 9. **Add Employee Date Tracking for "Annual Review of Emergency Plan".** 10. Use **Employee Tracking** to ensure each employee has been trained on this policy, and that the date of Emergency Plan review is recorded. 11. Upload the emergency plan review annually to Agency **Documents** in Barnestorm.

Governance /Administration Policy and Procedure Checklist

Standards of this CoP include:

- **Definitions**
- **Parent-Branch Relationship**
- **Services Under Arrangement**
- **Services Furnished**
- **Outpatient Physical Therapy or Speech-Language Pathology Services**
- **Institutional Planning**
- **Organization, services and administration**
- **Compliance with Federal, State, and local laws, disclosure and ownership information, and accepted professional standards and principles**
- **Quality assessment performance improvement (QAPI).**

Barnestorm Implementation:

- Most of this stipulation requires changes to agency policies. These policies may be uploaded to Barnestorm **Documents** under the Agency folder. Employee Date Codes can be added for any items employees should be trained on, and the date of training for each employee can be recorded in Barnestorm.
- Add Staff Qualification Check to Employee Date Codes in Barnestorm and document the date when this item is checked for each employee.
- Upload Employee qualifications, copies of licenses, etc, to **Agency Documents** in Barnestorm.
- Use the **Infections** feature to add infections and Reports > Audit > 07.08 to track them.
- Use the **Fall History** to add falls and **Reports > Audit > 07.05** to track them.

Personnel Requirements	Recommended Action	Barnestorm Implementation
§484.1 Basis and Scope – revised Added a requirement at §484.105(b)(1)(i) that the **administrator** must report to the governing body. Added a requirement at §484.105(b)(1)(iv) that the administrator must ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. Revised §484.105(b)(2) to clarify that an individual that is pre-designated to fill the administrator role in the absence of the administrator (including the clinical manager) must be qualified to do so. At §484.105(c), CMS also proposes a new clinical manager role, who "would be a qualified licensed physician or registered nurse, identified by the HHA, who is responsible for the oversight of all personnel and all patient care services provided by the HHA, whether directly or under arrangement, to meet patient care needs." Revised §484.105(b)(1)(iii) to require that the administrator assures that a **clinical manager** is available during all operating hours. CMS stated that assuring the development of personnel qualifications, and policies and procedures, is a task more appropriately assigned to the administrator, rather than the clinical manager. CMS have revised the regulatory requirement at §484.105(b)(1)(iv) accordingly. The administrator may choose to delegate these tasks to others, including the clinical manager, as appropriate, while retaining the responsibility for assuring that tasks are completed and duties performed. Revised §484.105(c) to specify that one or more qualified individuals must provide oversight of all patient care services and personnel.	***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:*** • The **administrator** must report to the governing body. • The administrator must ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. • Must include in writing, the organizational structure, including lines of authority, and services furnished Ensure your **job descriptions, staff qualification requirements** are aligned with the staff qualifications and job responsibilities listed in the HH CoP for all positions.	• Ensure that each employee has a folder in Barnestorm **Documents** and that each folder includes their qualifications, job description, and copies of licenses, certifications, etc. • Ensure that each employee is checked upon hire for qualifications, and that this is recorded in Barnestorm in Employee Date Codes. • All agency policies may be kept in an Agency folder in Barnestorm **Documents**. • Ensure that every patient has a Case Manager specified in Barnestorm under Referral > **Employees**. The Case Manager should be the first employee listed. List all employees involved in patient care under the Case Manager.

Revised §484.105(c) Clinical manager by retaining a description of the clinical manager's duties while relocating the personnel specifications for this role to new §484.115(c), which sets for the specific personnel requirements for the clinical manager. The role of the clinical manager at §484.105(c). In particular, the clinical manager is responsible for assuring the development, implementation, and updates of the individualized plan of care. CMS believe that, in order to effectively assure the development, implementation, and updates of the individualized plan of care, there would have to be communication with all physicians involved in the plan of care and integration of orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient. The requirement to integrate orders from all physicians would include those orders related to medications. Medication orders may be for long-term maintenance issues (for example, cholesterol management medications) as well as shorter-term medications for temporary issues that may or may not be directly related to the reason that home health care was initiated (for example, pain management medications that may be used in the process of surgical recovery or may be used as part of a treatment plan for a strained back that the patient just happened to experience during the time that he or she receives HHA care). CMS would continue to expect that all services or interventions that are ordered are medically necessary, as supported by documentation in the patient's record, in accordance with the requirements of 42 CFR 409.44 and 409.45. Also in §484.105, CMS requires that an "HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs," to which end the HHA "must assure that administrative and supervisory functions are not delegated to another agency or organization," must assure that "all services not furnished directly are monitored and controlled," and "must set forth, in writing, its organizational structure, including lines of authority, and services furnished."		

Parent-Branch Relationship, Sec. 484.105(d): HHAs are required to report all branch locations to the state survey agency when the HHA is initially certified, when it is surveyed and anytime the parent HHA seeks to add or delete a branch location. The parent HHA is also required to provide administrative support and control over its branch locations. Distance between the parent and branch locations is no longer a consideration, provided the parent can show administrative control over the branch. CMS stated HHAs should refer to the State Operations Manual guidance on converting a branch to a subunit and stated they will issue a Survey and Certification letter after publication of the Final CoP to provide guidance on the change in terminology. **Services Under Arrangement**, Sec. 484.105(e): HHAs are required to have a written agreement with any entity or individual that provides services under arrangement to HHA patients. Even for services provided under arrangement, the HHA is responsible for the service provided including the manner in which the services are furnished. HHAs are required to make sure the entity or individual providing services under arrangement has not been denied enrollment in Medicare or Medicaid, excluded from any federal health care program including Medicaid, had its Medicare or Medicaid billing privileges revoked or has been debarred from any government program. CMS stated this may be accomplished via a "written and signed self-certification," which meets the requirement that the contracted entity or individual has not been excluded from a federal health care program. CMS recommended that HHAs "routinely" check the OIG List of Excluded Individuals and institute policies that contracted entities are in good standing. **Services Furnished**, Sec. 484.105(f): HHAs must provide skilled nursing services and at least one other therapeutic service in a place of residence used as the patient's home. The HHA must provide at least one of these required services directly but may obtain other required services under arrangement from another HHA or organization. **Outpatient Physical Therapy or Speech-Language Pathology Services**, Sec. 484.105(g):	***The following requirements need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:*** ○ **Parent-Branch Relationship** ○ **Services Under Arrangement** ○ **Services Furnished** ○ **Outpatient Physical Therapy or Speech-Language Pathology Services** ○ **Institutional Planning- Annual Operating Budget and Capital Expenditure Budget** ***The following requirements need to be in your Policy and Procedures for this section of the Conditions of Participation and included in staff training as applicable:*** **Branch office** means an approved location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The parent home health agency must provide supervision and administrative control of any branch office. It is unnecessary for the branch office to independently meet the conditions of participation as a home health agency. **Clinical note** means a notation of a contact with a patient that is written, timed, and dated, and which describes signs and symptoms, treatment, drugs administered and the patient's reaction or response, and any changes in physical or emotional condition during a given period of time. **In advance** means that HHA staff must complete the task prior to performing any hands-on care or any patient education. **Parent home health agency** means the agency that provides direct support and administrative control of a branch. Primary home health agency means the HHA which accepts the initial referral of a patient, and which provides services directly to the patient or via another health care provider under arrangements (as applicable). **Proprietary agency** means a private, for-profit agency. Public agency means an agency operated by a state or local government. **Quality indicator** means a specific, valid, and reliable measure of access, care outcomes, or satisfaction, or a measure of a process of care.

HHAs that provide outpatient physical therapy or speech-language pathology services must meet certain CoPs for Clinics, Rehabilitation Agencies and Public Health Agencies as Providers of Outpatient Therapy and Speech-Language Pathology Services found at 42 C.F.R. 485. **Institutional Planning**, Sec. 484.105(h): HHAs, under the direction of the governing body, are responsible for creating an overall plan and annual operating budget including a capital expenditure plan. **Annual Operating Budget**: The annual operating budget must include all anticipated income and expenses utilizing generally accepted accounting principles. Item-by-item identification of components of anticipated income or expense is not required. HHAs must have a capital expenditure plan for at least a three-year period. **Capital Expenditure Budget**: The capital expenditure plan must identify in "detail" source of financing for a capital expenditure of $600,000 or more. This final regulation has a wide array of things that must be considered when determining if a capital expenditure exceeds $600,000. The HHA must take into account such things as cost studies, surveys, designs, plans, legal and accounting fees, broker commissions and other activities that are essential to the capital expenditure being proposed. It should be noted this is not an all-inclusive list, so HHAs should pay close attention to what must be included in the capital expenditure plan per this new final regulation. If the source of capital financing is from Medicare, Medicaid or a Maternal and Child Health Block Grant, there are other requirements the HHA must satisfy. The capital expenditure plan must specify whether the proposed capital expenditure requires or is likely to require it conform with the Public Health Service Act or Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963. The capital expenditure plan must also specify whether the proposal has been submitted to and approved by the designated planning agency in accordance of Section 1122 of the Social Security Act, which addresses limitation on federal participation for capital expenditures.	**Representative** means the patient's legal representative, such as a guardian, who makes health-care decisions on the patient's behalf, or a patient-selected representative who participates in making decisions related to the patient's care or well-being, including but not limited to, a family member or an advocate for the patient. The patient determines the role of the representative, to the extent possible. **Subdivision** means a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the conditions of participation for HHAs. A subdivision that has branch offices is considered a parent agency. **Summary report** means the compilation of the pertinent factors of a patient's clinical notes that is submitted to the patient's physician. **Supervised practical training** means training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing covered services to an individual under the direct supervision of either a registered nurse or a licensed practical nurse who is under the supervision of a registered nurse. **Verbal order** means a physician order that is spoken to appropriate personnel and later put in writing for the purposes of documenting as well as establishing or revising the patient's plan of care.

§484.14 **Organization, services and administration** revised at §484.105

Revised the requirement at §484.105 to clarify that an HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs.

§484.14(a) revised at §484.105(f)

As stated in proposed § 484.105(f)(1), skilled nursing and one of the therapeutic services must be made available on a visiting basis in the patient's home. At least one service would be required to be provided directly by the HHA. CMS proposed a requirement for compliance with accepted professional standards and principles at § 484.105(f)(2). CMS would require that HHAs furnish all services in accordance with accepted professional standards of practice. CMS also proposed to require that all HHA services be provided in accordance with current clinical practice guidelines.

Quality assessment performance improvement (QAPI)	**Recommended Action**	**Barnestorm Implementation**
§484.16 Group of professional personnel. Deleted, see §484.65, **Quality assessment performance improvement (QAPI).** Revised §484.65 to require that QAPI program indicators include the use of emergent care services. CMS does not want to see cookie cutter QAPI domains and measures. They want you to build a program that reflects the patients that you serve in home health. In the final rule, CMS also proposes the replacement of two current HHA CoPs (§484.16, "Group of professional personnel," and §484.52, "Evaluation of the agency's program") with a single new data-driven, Agency-wide quality assessment and performance improvement (QAPI) program aimed at "reduc[ing] medical errors, and improv[ing] the quality of health care in all settings" [§484.65].	***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:*** • Require that QAPI program indicators include the use of emergent care services. • QAPI domains and measures must be formulated to address the patients being served by the HHA	•Use Barnestorm clinical Point of Care to document clinical visits, and ensure that all visit notes are completed at the time and location of the visit. •Ensure that each patient infection is documented in **Infections** in Barnestorm**.** Infection report 07.08 provides both counts and details on Infections recorded in Barnestorm. •Ensure that each patient fall is documented in **Fall History** in Barnestorm. Fall reports can be printed/uploaded from Reports > Audit > 07.05. •Ensure that each pertinent visit includes completion of the Review Meds screen in Barnestorm POC visit assessment. •Hospitalizations should be tracked under Facility History in Barnestorm and will pull up in various reports: Facility History, Reports > Oasis > 13.17, 13.05, 13.29. •Improvement in daily activities (ADLs) Reports > 13.42 OASIS Stats •Track patient progress using Report 13.42 OASIS Stats

Skilled Professionals to Physician Communication	**Recommended Action**	**Barnestorm Implementation**
§484.30 Skilled Nursing services, revised at §484.75 Skilled Professional Services. Revised §484.75(b)(7) to require skilled professionals to communicate with all physicians involved in the plan of care. Revised requirement specifically related to physician orders to allow HHAs to accept orders directly from multiple physicians who are involved in a patient's care at that point in time, regardless of whether those physicians are part of the same group practice or not.	***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:*** • Require skilled professionals to communicate with all physicians involved in the plan of care. • Allow HHAs to accept orders directly from multiple physicians who are involved in a patient's care at that point in time, regardless of whether those physicians are part of the same group practice or not.	1. Use Referral > Doctors to track all physicians involved in care. 2. Use **Orders** to send care communication to physicians. Use **Patient Portal** to share orders, care plan, care communication, medications, and orders with physicians to coordinate care.


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Personnel Requirements Checklist

Standards of this CoP include:

- **Job Descriptions, Personnel Qualifications and Policies**
- **Documentation that the requirements home health aide classroom and supervised practical training have been met**
- **Documentation of aide supervision according to COP specifications**

Barnestorm Implementation:

- Ensure that each employee has a folder in Barnestorm **Documents** and that each folder includes their qualifications, job description, and copies of licenses, certifications, etc.
- Ensure that each employee is checked upon hire for qualifications, and that this is recorded in Barnestorm in Employee Date Codes.
- All agency policies may be kept in an Agency folder in Barnestorm **Documents**.
- Add a new **Employee Date Tracking** item for each required HH aide classroom and supervised training**.**
- Use **Employee Tracking** to ensure each employee meets the training and supervision requirements.
- Track any expiring training or supervision and pull a report on expiring **Employee Tracking** items monthly to ensure all training and supervision requirements are met. **Codes** > **Other Basic Codes** > **Employee Date Tracking** contains all reporting.
- Ensure that every patient has a Case Manager specified in Barnestorm under Referral > Employees. The Case Manager should be the first employee listed. List all employees involved in patient care under the Case Manager Use Barnestorm **Schedule** to schedule all clinical visits. This schedule automatically flows to the **Patient Portal**. Ensure that any patient with aide services is scheduled for a supervision visit every 14 days at minimum.
- Optional: Create a new assessment type in Barnestorm for Aide Supervision Visit. Use this assessment type to create a separate set of required screens, and on the Barnestorm **Schedule** to indicate a supervision visit.
- Ensure that each pertinent visit includes completion of the **Care Goals** screen in Barnestorm POC visit assessment.
- Ensure that each pertinent visit includes completion of the **Aide Supe** screen in Barnestorm POC visit assessment.
- Use Referral to track patient caregiver and representative.
- Use Referral to track which aide(s) and other clinical staff are working with each patient.
- Use available but non-required OASIS items in Barnestorm clinical Point of Care, such as on the Pain screen, ADL screen, and Aide Plan screen, on regular visits.
- Use **Patient Portal** to share schedule, care plan, care communication, medications, and orders with patients and caregivers.


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Personnel Requirements	Recommended Action	Barnestorm Implementation
§484.1 Basis and Scope – revised Added a requirement at §484.105(b)(1)(i) that the **administrator** must report to the governing body. Added a requirement at §484.105(b)(1)(iv) that the administrator must ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. Revised §484.105(b)(2) to clarify that an individual that is pre-designated to fill the administrator role in the absence of the administrator (including the clinical manager) must be qualified to do so. At §484.105(c), CMS also proposes a new clinical manager role, who "would be a qualified licensed physician or registered nurse, identified by the HHA, who is responsible for the oversight of all personnel and all patient care services provided by the HHA, whether directly or under arrangement, to meet patient care needs." Revised §484.105(b)(1)(iii) to require that the administrator assures that a **clinical manager** is available during all operating hours. CMS stated that assuring the development of personnel qualifications, and policies and procedures, is a task more appropriately assigned to the administrator, rather than the clinical manager. CMS have revised the regulatory requirement at §484.105(b)(1)(iv) accordingly. The administrator may choose to delegate these tasks to others, including the clinical manager, as appropriate, while retaining the responsibility for assuring that tasks are completed and duties performed. Revised §484.105(c) to specify that one or more qualified individuals must provide oversight of all patient care services and personnel. Revised §484.105(c) Clinical manager by retaining a description of the clinical manager's duties while relocating the personnel specifications for this role to	***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:*** • The **administrator** must report to the governing body. • The administrator must ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies. • Must include in writing, the organizational structure, including lines of authority, and services furnished Ensure your **job descriptions, staff qualification requirements** are aligned with the staff qualifications and job responsibilities listed in the HH CoP for all positions.	• Ensure that each employee has a folder in Barnestorm **Documents** and that each folder includes their qualifications, job description, and copies of licenses, certifications, etc. • Ensure that each employee is checked upon hire for qualifications, and that this is recorded in Barnestorm in **Employee Tracking**. • All agency policies may be kept in an Agency folder in Barnestorm **Documents**. • Ensure that every patient has a Case Manager specified in Barnestorm under Referral > Employees. The Case Manager should be the first employee listed. List all employees involved in patient care under the Case Manager.

new §484.115(c), which sets for the specific personnel requirements for the clinical manager. The role of the clinical manager at §484.105(c). In particular, the clinical manager is responsible for assuring the development, implementation, and updates of the individualized plan of care. CMS believe that, in order to effectively assure the development, implementation, and updates of the individualized plan of care, there would have to be communication with all physicians involved in the plan of care and integration of orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient. The requirement to integrate orders from all physicians would include those orders related to medications. Medication orders may be for long-term maintenance issues (for example, cholesterol management medications) as well as shorter-term medications for temporary issues that may or may not be directly related to the reason that home health care was initiated (for example, pain management medications that may be used in the process of surgical recovery or may be used as part of a treatment plan for a strained back that the patient just happened to experience during the time that he or she receives HHA care). CMS would continue to expect that all services or interventions that are ordered are medically necessary, as supported by documentation in the patient's record, in accordance with the requirements of 42 CFR 409.44 and 409.45. Also in §484.105, CMS requires that an "HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs," to which end the HHA "must assure that administrative and supervisory functions are not delegated to another agency or organization," must assure that "all services not furnished directly are monitored and controlled," and "must set forth, in writing, its organizational structure, including lines of authority, and services furnished."		

HH Aide Training		
§484.36(a)(1), revised at §484.80(b) • At §484.80(b)(4), CMS proposed to require the HHA to maintain documentation that the requirements for content and duration of home health aide classroom and supervised practical training have been met. • §484.36(a)(2)(i) revised at §484.80(f)		1. Add a new **Employee Date Tracking** item for each required HH aide classroom and supervised training**.** 2. Use **Employee Tracking** to ensure each employee meets the training and supervision requirements. 3. Track any expiring training or supervision and pull a report on expiring **Employee Tracking** items monthly to ensure all training and supervision requirements are met. **Codes** > **Other Basic Codes** > **Employee Date Tracking** contains all reporting.

HH Aide Training		
§484.36(b)(2)(ii) revised at §484.80(h) • Revised §484.80(h)(1)(i) by adding a requirement that the registered nurse or other appropriate skilled professional who conducts supervision of a home health aide must be familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g). • Revised §484.80(h)(1)(ii) by removing the word "potential deficiency" and replacing it with "area of concern." • In proposed §484.80(h)(1), CMS proposed that if 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. • In proposed §484.80(h)(2), CMS would require that if home health aide services are provided to a	***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:*** • Require the registered nurse or other appropriate skilled professional who conducts supervision of a home health aide must be familiar with the patient, the patient's plan of care, and the written patient care instructions. • Require if 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. • If a deficiency in home health aide services was verified by the home health aide supervisor during an on-site visit,	1. Use Barnestorm **Schedule** to schedule all clinical visits. This schedule automatically flows to the **Patient Portal**. Ensure that any patient with aide services is scheduled for a supervision visit every 14 days at minimum. 2. Optional: Create a new assessment type in Barnestorm for Aide Supervision Visit. Use this assessment type to create a separate set of required screens, and on the Barnestorm **Schedule** to indicate a supervision visit. 3. Ensure that each pertinent visit includes completion of the **Care Goals** screen in Barnestorm POC visit assessment. 4. Ensure that each pertinent visit includes completion of the **Aide Supe** screen in Barnestorm POC visit assessment. 5. Use Referral > Contacts to track patient caregiver and representative. 6. Use Referral > Employees to track which aide(s) and other clinical staff are working with each patient.

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. • At proposed §484.80(h)(3), CMS would require that 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 in accordance with paragraph (c) of this section. • CMS also proposed to add a new paragraph at §484.80(h)(4) to ensure that home health aide supervision visits focus on the aide's ability to demonstrate initial and continued satisfactory performance in meeting essential criteria. Supervision visits would be required to assess the home health aide's success in following the patient's plan of care; completing tasks assigned to the home health aide; communicating with the patient, representative (if any), caregivers, and family; demonstrating competency with assigned tasks; complying with infection prevention and control policies and procedures; reporting changes in the patient's condition; and honoring patient rights. • §484.36(d) revised at §484.80(c) • §484.36(e) revised at §484.80(c)	then the agency would have to conduct, and the home health aide would have to complete, a competency evaluation • Home health aide supervision visits must focus on the aide's ability to demonstrate initial and continued satisfactory performance in meeting essential criteria. Supervision visits would be required to assess the home health aide's success in following the patient's plan of care; completing tasks assigned to the home health aide; communicating with the patient, representative (if any), caregivers, and family; demonstrating competency with assigned tasks; complying with infection prevention and control policies and procedures; reporting changes in the patient's condition; and honoring patient rights. • In addition to the RN, the competency evaluation must be done in consultation with other skilled professionals, as appropriate.	7. Use available but non-required OASIS items in Barnestorm clinical Point of Care, such as on the Pain screen, ADL screen, and Aide Plan screen, on regular visits. 8. Use **Patient Portal** to share schedule, care plan, care communication, medications, and orders with patients and caregivers.

Barnestorm Cloud Share and Patient Portal

Barnestorm Cloud Share and the new Barnestorm patient portal, MyHomeChart.com, are designed to meet new Conditions of Participation requirements for sharing information with patients, providers, therapists, approved caregivers, and others involved in patient care (listed specific applicable Conditions of Participation are included at the end of this document).

	Unhosted	Hosted	Cloud Share	Patient Portal
	No Internet Connection In Your Office Only You Maintain the Server	Hosted	Cloud Share	Patient Portal
	Nurses must be in the office to sync	Nurses sync from home or anywhere with connection	Nurses can view documents anywhere with connection	Nurses sync from home or anywhere with connection
	Documents shared with patients via paper	Documents shared with patients via paper	Documents shared with staff include everything: admissions, labs, etc.	Documents automatically shared with patients via Patient Portal
	Documents shared with caregivers and patient representatives via paper			Documents automatically shared via Patient Portal
	Documents shared with doctors via fax or MedSign	Documents shared with doctors via fax or MedSign	Documents shared with doctors via fax or MedSign	Documents shared with doctors automatically via Patient Portal

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Examples of How COP Requirements Met by HHA with Hosted, Cloud Share, and Patient Portal

COP Requirement	Unhosted	Hosted	Cloud Share	Patient Portal
484.50 Patient Rights a: Notice of Rights Provide written notice of rights, transfer and discharge policy to patient selected representative within 4 business days of initial evaluation visit.	Print documents from Barnestorm and deliver them to patient representative.		Get documents signed by patient, scan them in, and upload them to the server for paperless EHR records.	**Automatically shared.**
484.60 Care Planning Coordination of Services c: Revision to Plan of Care Physician must revise plan of care as frequently as patient's care requires and no less than every 60 days. Revisions, including those related to plans for discharge, must be communicated to patient, representative, caregiver, and all physicians issuing orders.	Print documents from Barnestorm and deliver them to patient, patient representative, and caregiver. Fax or use MedSign to send orders to physicians.	Print documents from Barnestorm and deliver them to patient, patient representative, and caregiver. Fax or use MedSign to send orders to physicians.	Scan documents and upload them to the server for paperless EHR records.	**Automatically shared.**
484.60 e: Written Information to Patient HHA must provide patient and caregiver written instructions on: visit schedule, patient medication schedule, treatments, pertinent instructions and name/contact information for Clinical Manager. Changes to patient schedule, Changes to patient meds	Print documents from Barnestorm and deliver them to patient & caregiver.	Print documents from Barnestorm and deliver them to patient & caregiver.	Scan documents and upload them to the server for paperless EHR records.	**Automatically shared.**
484.80 Home Health Aide Services Must include classroom and supervised practical training under supervision of. HHA responsible for training and documentation.	Use Barnestorm **Employee Date Tracking** to track training completion.	Use Barnestorm **Employee Date Tracking** to track training completion.	Share documents to the employee Cloud Share folder and send from Cloud Share to employee.	**Automatically shared.** **Use Barnestorm Employee Date Tracking to track training completion.**

Barnestorm Hosting

Barnestorm's web-based solution is Barnestorm Hosting, which gives you all the advantages of a web-based system, including:

- Access from anywhere if you have the Barnestorm app and a valid Barnestorm account.
- Clinicians can sync from anywhere with an internet connection, using our HIPAA-compliant secure system.
- Savings on IT services such as user accounts, installation, database backups, security.

Barnestorm Hosting setup includes:

- Seamlessly transitioning your data to the Cloud.
- Ensuring your data storage and transmissions are 100% HIPAA compliant.
- Acquiring and securing an internet presence (domain name) for your business.
- Building a top-of-the-line server customized to the specifications we determine for your number of clinical and office users.
- Setting up hourly snapshot backup of your data in case of catastrophe.
- Setting up local and remote nightly backups of Cloud Share for maximum redundancy.

Ongoing services provided by Barnestorm Hosting:

- Manage data access and firewall/security.
- Perform all windows updates and any other software upgrades as needed.
- Perform nightly backups.
- Create/remove users as needed.
- Scale server larger as your business grows.

Hosted Server Info:

- 64 bit, 4 virtual processors, 15GB memory, dual 40GB SSD drives, optimized for high network performance.*
- HIPAA Compliant.
- Guaranteed 99% uptime; discount provided when that is not met (subject to proof that the downtime was server issue, not a connection or internet issue).

*Server specifications are based on our vendor for HIPAA-compliant hosted services and may change.

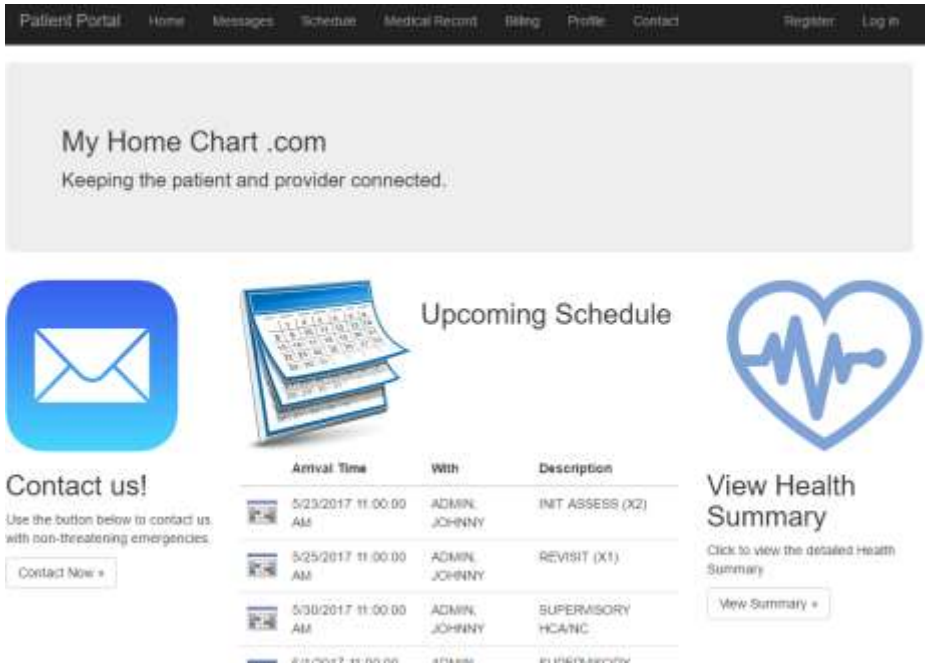
Barnestorm Cloud Share

Barnestorm Cloud Share is a secure electronic health record (EHR) storage and communication system that provides for electronic storage, retrieval, and secure sending of all patient records for all patients, providers, and approved caregivers.

1. Quickly view all documents listed for a particular patient.
2. Email a secure document or a link to any document to anyone outside of the agency, whether caregiver, therapist, provider, or physician.
3. Collect signed documents and automatically upload them.
4. Secure online repositories for not only patient documents, but, employee documents, agency documents, training documents, and many more.
5. Save employee and patient profile pictures.
6. Save wound images and other pictures to accompany visit documentation.
7. Store admission packages and allow them to be branded with your logo and text.
8. Allows inter-office emailing of documents and images.
9. Create a shared document with a time expiration on sharing.
10. Provides a smoother interface for interacting with documents.
11. Seamlessly share information to the patient portal about medications, teachings and anything else you can come up with!

Barnestorm Patient Portal

MyHomeChart.com provides a way for an agency to interact and keep in constant contact with the patient. Communication is simple and interactive: the agency can create as many accounts as they would like - one for schedulers, one for nurses, one general one and then they can all field questions from patients and caregivers via the portal, making communication must quicker and less intensive for clinicians. With MyHomeChart.com, your patients and their approved caregivers and providers can log into a portal system and view documents. What makes the Patient Portal exceptional is its ability to provide instant access to patient information, and the extension of that instant access across all providers involved in the patient's care. Patients can check their scheduled visits and pay their bills (if private pay), as well. All of following features are implemented effortlessly through Barnestorm software.



1. **Heath Summary** – provides an in depth view of a patients current health, including diagnoses, medications, allergies, immunizations, surgeries, events and facility history.
2. **Scheduling** – displays the upcoming schedule for the patient with the ability to cancel any upcoming appointments.
3. **Messaging** – allows two way communication between the patient and health care provider including vaccine reminders, schedule reminders, visit summaries and more. All messages are recorded as part of the health summary.
4. **Documents** – allows the health care provider to share documents with the patient including copies of signed forms, medication and health information and admission documents.
5. **Billing** – Allows the heath care provider to bill the patient through the portal. Payments will be accepted through the portal.
6. **Communication** – Allows approved individuals the ability to view parts or all of the patients portal and receive any updates via text or email.
7. **Security** – know that all of your information is locked up tight with two factor authentication and access controls.
8. **Control** – all features of the portal can be controlled easily from the portal dashboard within Barnestorm software. Approve viewers, receive and send messages, share documents and send bill reminders all from the same screen. Brand the website with your agency name, images and text to make it your own and make it a great experience for the patient.

New Conditions of Participation Met by Barnestorm Cloud Share and Patient Portal

The following are COP excerpts applicable to these applications; to view the complete COP changes required as of January 2018, please go to the CMS site.

484.50 Patient Rights

a: Notice of Rights

Provide to patient and representative during initial evaluation visit before providing care. Include rights, transfer and discharge policy, and be understandable to patient with limited English and assessable to those with disabilities. Include contact info for HHA administrator: name, business address and phone number to receive complaints. Include OASIS Privacy Notice. Obtain patient or legal representative's signature confirming receipt of Notice of Rights. Provide verbal notice in primary or preferred language using free interpreter if needed no later the completion of 2nd skilled visit. Provide written notice of rights, transfer and discharge policy to patient selected representative within 4 business days of initial evaluation visit.

484.60 Care Planning Coordination of Services, and Quality of Care

c: Review and Revision to Plan of Care

Physician must revise plan of care as frequently as patient's care requires and no less than every 60 days. HHA must promptly advise physician of changes that suggest objectives are not being achieved and POC must be altered. Revisions, including those related to plans for discharge, must be communicated to patient, representative, caregiver, and all physicians issuing orders.

d: Coordination of Care

HHA must assure communication with all physicians involved in PoC and integrate all physician orders and services, coordinate care delivery, ensure patients and caregivers get appropriate training including that necessary for discharge.

e: Written Information to Patient

HHA must provide patient and caregiver written instructions on: visit schedule, patient medication schedule, treatments, pertinent instructions and name/contact information for Clinical Manager.

484.70 Infection Prevention and Control

c: Education

HHA must provide infection control education for patients, staff, and caregivers

484.80 Home Health Aide Services

b: Content and Duration of Home Health Aide Classroom and Supervised Practical Training

Must include classroom and supervised practical training under supervision of RN for 75 hours, minimum 16 hours of classroom before 16 hours of supervised practical training. Program must address: communication skills, observation/reporting/ documentation, reading/recording of temp/pulse/respiration, basic infection prevention/control, body function and changes needing reporting, maintenance of clean/safe/healthy environment, recognizing emergencies and procedures, physical/ emotional and developmental needs including respect for patient privacy and property, safe techniques for personal hygiene and grooming, safe transfer techniques, normal range of motion and positioning, adequate nutrition and fluid intake, recognizing and reporting skin changes, other tasks permitted under State Law. HHA responsible for training and documentation.

c: Competency Evaluation
Must complete competency evaluation by written exam and observation by RN. HHA must maintain documentation.

484.102 Emergency Preparedness

c: Communication Plan
Communication Plan that complies with Federal, State and Local requirements updated annually that includes: names and contact info for staff, under arrangements services, patient's physicians, volunteers, Federal/State/Local emergency preparedness officials, other sources of assistance, primary and alternate means of communicating with staff and emergency preparedness officials, method for sharing information and medical documentation on patients with other health care providers, means of providing information on general condition and location of patients, means of providing information about HHAs needs and ability to provide assistance to Incident Command Center.

484.110 Clinical Records

d: Protection of Records
Must be protected against loss or unauthorized use and comply with rules on protected health information.

e: Retrieval of Clinical Records
Must be made available to patient on request free of charge at the next home health visit or within 4 business days if earlier.