SUBJECT:	**ASSESSMENT**	
REFERENCE #:	MD-CL-004	
LINE OF BUSINESS:	CERTIFIED HOME HEALTH, PRIVATE DUTY HOME CARE, MEDICAID WAIVER DIRECTED CARE, OTHER DIRECTED CARE	
EFFECTIVE DATE:	**01/06/2014**	**PAGE:** 1 OF: 6
REVISED DATE:	07/10/2020	

Note: This multi-divisional policy applies to the business divisions identified above. All references to Conditions of Participation (CoPs), Home Health, and/or ACHC Home Health standards apply only to patients serviced under the Certified Home Health (HH) line of business. All references to Private Duty and/or ACHC Private Duty standards apply only to patients serviced under the Private Duty Home Care (PDN) line of business. References to Companion (CCS) apply only to patients serviced under the Companion Services line of business.

1. REGULATORY REFERENCES:

1.1. CoP: §484.55
1.2. ACHC: HH5-2A.01, HH5-2B, HH5-2C, HH5-2C.01, HH5-2C.02, HH5-2E, PD5-2A; PD5-3A, PD5-3B, PD5-3C, PD5-3D, PD5-3E, PD5-3N, PD5-3O, PD5-3P

2. PURPOSE:

2.1. To define the timelines and process for patient/client assessment.

3. POLICY:

3.1. Each client/patient referred for services will have an initial assessment, as per state licensure, rules or regulations. The initial assessment will determine eligibility, care and support needs of the client/patient. Findings from the initial assessment will be used in the development of the Plan of Care/Service.

3.2. Each patient/client admitted for therapy services will have a discipline specific assessment completed within the timelines as defined within this policy. The assessment shall be based on patient/client need or perceived need and functional status. The assessment shall be documented and maintained in the medical record whether services continue or not. The assessment shall be appropriate to the patient/client diagnosis and age.

3.2.1. The discipline therapy assessment should include, but is not limited to:

3.2.1.1. Environmental Component-the identification of safety or health hazards and/or the presence of adequate living arrangements. The completion of a Home Assessment to include potential safety or security hazards (e.g. throw rugs, furniture layout, bathroom safety, cluttered stairways, fire risks, smoke detectors). The therapy clinician shall provide instructions and interventions directed toward minimizing safety risks and preventing injury.

3.2.1.2. Functional Limitations Component-As applicable, include the patient's current mobility, restrictions, utilization of assistive devices and medical equipment.

3.2.1.3. Physical Health Component-To include the patient diagnosis and other necessary information that could impact the level of services required to meet the patient's needs.

3.2.1.4. The discipline specific therapy assessment should adhere to current standards of practice. This includes the utilization of the *International Classification of Functioning, Disability and Health* (ICF) and the biopsychosocial model as well as evidence-based practices.

3.2.1.4.1. Therapy clinicians shall engage in the assessment process to include, but not limited to: history; a review of all body systems, body functions and structures; performance of patient specific tests and measures to identify potential or existing problems; establish a diagnosis and prognosis; establish a patient specific plan of

care; synthesize the assessment data to determine if a referral or consultation is necessary with another health care provider.

3.3. As applicable, each admitted patient/client with orders for Medical Social Services shall have a discipline specific assessment completed. The assessment shall be based on patient/client need or perceived need. The assessment shall be appropriate to the patient/client diagnosis and age. The assessment shall be documented and maintained in the medical record or system or record whether services continue or not.

3.4. The reassessment of the patient shall be completed at regular intervals or as frequently as the patient/client's condition warrants due to a major decline or improvement in health status.

3.4.1. An evaluation of the patient status will be completed during each shift/ visit.

3.5. Based on assessment findings, the plan of care/service will be developed and/or revised including problems, needs, goals, and outcomes.

3.6. **For Home Health – Accredited**:

3.6.1. An initial comprehensive assessment will be completed for every accepted referral within 48 hours after referral is accepted, within 48 hours of hospital discharge date or on the date as ordered by the physician.

3.6.1.1. Delays in the initial comprehensive assessment will be documented on the Patient Referral and Intake Form (PRIF) or system of record and as required, the physician will be notified of any delay in the start of care.

3.6.2. The comprehensive assessments must be conducted by a registered nurse, unless physical therapy or speech language pathology is the only requested service for that patient/client. In those cases, the physical therapist or speech therapist may conduct the assessment.

3.6.2.1. As required, an OASIS comprehensive assessment will be completed within five (5) calendar days of the patient/client's start of care date which is considered to be the first billable visit. If the patient/client's services are considered therapy only and the skilled nurse completes the initial assessment, then the start of care date is the date that Therapy completes the initial assessment.

3.6.2.1.1. The OASIS data will be collected during the comprehensive assessment. The assessment tool must use the current version of the OASIS data set

3.6.2.2. Outcomes and Assessment Information Set (OASIS) data must be collected on all Medicare/Medicare HMO, Medicaid or Medicaid HMO patient/clients receiving skilled services, except maternity patient/clients, and patient/clients under the age of 18. OASIS data collection is not required for patient/clients who are receiving only personal care or support services (homemaker services).

3.6.3. A follow-up comprehensive assessment or recertification is conducted by a qualified clinician to identify the patient's current health status and continued need(s) for home health services.

3.6.3.1. Medicare patients and other Federal/State funded specific programs requiring OASIS completion and eligibility for continued services must be assessed, including homebound status.

3.6.3.2. A follow-up comprehensive assessment is conducted by a qualified clinician within 48 hours of a patient's discharge from the hospital, or within 48 hours of agency

knowledge of the hospital discharge, or on the date as ordered by physician. This assessment is referred to as a Resumption of Care (ROC).

3.6.3.2.1. The follow-up comprehensive assessment must be completed by the qualified clinician prior to any other service resuming care following a patient's discharge from the hospital. The RN or PT/SLP must complete the comprehensive assessment before the aide and/or LPN may resume care.

3.6.4. A follow-up comprehensive recertification assessment must be performed within the last five (5) days of the current 60-day certification period, i.e. between and including days 56 – 60.

3.6.5. As applicable, a comprehensive discharge assessment will be completed as described in policy ***MD-CL-013: Discharge of Patients.***

3.6.6. Medicare patients and other Federal/State funded specific programs requiring OASIS completion, eligibility for continued services must be assessed, including homebound status.

3.6.6.1. For patients requiring the Outcomes and Assessment Information Set (OASIS), the assessment will include the current version of the OASIS form.

3.6.7. **For Private Duty – Accredited**:

3.6.7.1. **Private Duty Nursing**: The initial assessment must be completed within 48 hours of referral or within 48 hours of the client's/patient's return home from a hospitalization, or on the physician-ordered start of care date and is completed by a Registered Nurse (RN).

3.6.7.2. The purpose of the initial assessment is to evaluate the immediate care/service and support needs of the patient. The initial assessment will determine if the patient is accepted for care/services and considers if there is reasonable expectation that the patient's medical, nursing, and social needs can be adequately met in the patient's place of residence by the office.

3.6.7.2.1. Within five days of the start of care date, a comprehensive assessment of the patient will be completed. This comprehensive assessment may be completed as part of the initial assessment as long as the patient's condition warrants.

3.6.7.2.2. If required by state or the applicable state Medicaid program, the comprehensive assessment will include OASIS data-set elements.

3.6.7.2.2.1. For offices that are required to collect and/or transmit OASIS data-set elements for qualified Medicaid patients, refer to policy *HH-CL-24: OASIS Collection and Transmission* for full description.

3.6.7.3. The plan of service is reviewed at least once every 60 days or when there is a change in the client/patient's response to therapy, when physician orders change, or at the request of the patient/client. For patients serviced under the Medicaid Waiver Directed Care/Other Directed Care business lines, the plan of service is reviewed at least once every 6 months, or when there is a change in the client/patient's response to therapy, when physician orders change, at the request of the patient/client, unless state laws or program requirements establish more frequent review.

3.6.7.3.1. If the service is ordered by a physician, there is evidence of communication to the physician regarding the patient/client's condition and orders are received prior to the change in the Plan of Service is implemented.

3.6.7.3.2. If new or revised treatment goals are indicated, these changes are documented in the record and reflected in any subsequent Plan of Service documents.

3.6.8. **For Private Duty Aide**: The initial assessment must be conducted and care/service implemented within seven (7) days of the referral or on the date requested by the client/patient and is completed by a RN or a qualified clinician as per state licensure, rules or regulations.

3.6.8.1. An assessment is performed on patients/clients referred for Aide services and documented in the patient/client record. The assessment is based on patient/client need or perceived need and includes an evaluation of the patient/client's physical and functional status. The assessment is documented whether services continue or not.

3.6.8.2. The plan of service will be reviewed at least once every 90 days unless state laws or program requirements require **more** frequent review.

3.6.8.3. For patients serviced under the Medicaid W aiver Directed Care/Other Directed Care business lines, the plan of service will be reviewed at least once every 6 months unless state laws or payer requirements establish more frequent review.

3.6.9. The plan of care/service review will include documentation in the medical record or system or record which demonstrates consideration of the plan of service for:

3.6.9.1. Appropriateness (care/service being provided is still necessary)

3.6.9.2. Effectiveness (patient/client outcomes/response to care/service)

3.6.9.3. To determine is all needed care/services are being provided

3.6.9.4. Changes in patient/client's condition

3.6.9.5. Level of satisfaction with care/service being provided

4. <u>DEFINITIONS:</u>

4.1. Direct Care Staff: Those individuals that provide or direct care to the patient in his/her home or alternate care setting. It does not include non-clinical office or support staff.

4.2. Office clinical leader: The individual in the office who is the highest ranking clinician overseeing clinical issues. This individual may carry the title Clinical Manager, Director of Clinical Operations or other title as assigned.

4.3. Qualified clinician: A Registered Nurse, unless Physical, Occupational Therapy or Speech Language Pathology is the only qualifying ordered service for that patient. In those cases, the Physical, Occupational Therapist or Speech Language Pathologist may conduct the assessment. The clinician who is responsible for evaluation and coordination of services for the patient. A patient may have more than one qualified clinician during the course of care.

5. PROCEDURE:

5.1. The office clinical leader or clinical designee will confirm that a qualified clinician is assigned to complete the comprehensive assessment within the appropriate timelines for admission, ROC, and/or reassessment of the patient/client.

5.1.1. The qualified clinician shall notify the office clinical leader or clinical designee and/or physician of assessment findings or when there is a change in the patient condition which might warrant a change in medication and/or a change to the plan of care/service.

5.1.2. The Plan of Care/Service will be established in accordance with policy and procedure.

5.1.2.1. For Home Health Accredited: Refer to ***policy HH-CL-007: Home Health Certification and Plan of Care (485)*** for full description.

5.1.2.2. For Private Duty Accredited, Medicaid Waiver Directed Care, or Other Directed Care: Refer to policy ***MD-CL-007: Plan of Care*** for full description.

5.1.2.3. As applicable to changes in the patient's status, physician supplemental orders will be received and documented in accordance with policy ***HH-CL-010: Processing of Physician Orders.***

6. STATE/PROGRAM SPECIFIC REQUIREMENTS:

STATE	REQUIREMENT
Indiana	For Home Health Aide (HHA) cases the HHA will notify the qualified clinician immediately for all changes in patient condition such as falls, injuries, pain, or Illness. Within 24 hours of agency knowledge, a Registered Nurse (RN) will make the determination whether the patient's situation requires immediate attention, i.e. emergency medical response (911), RN assessment, etc. The physician will be notified of any changes in the patient's condition to include agency intervention, and patient outcomes. In addition, the qualified clinician will document within the patient's medical record the changes in patient condition to include physician notification and patient outcomes.

Virginia	12VAC5-381-300. Skilled services. A. The organization shall provide a program of home health services that shall include one or more of the following: 1. Nursing services; 2. Physical therapy services; 3. Occupational therapy services; 4. Speech therapy services; 5. Respiratory therapy services; or 6. Medical social services. B. All skilled services delivered shall be prescribed in a medical plan of care that contains at least the following information: 1. Diagnosis and prognosis; 2. Functional limitations; 3. Orders for all skilled services, including: (i) specific procedures, (ii) treatment modalities, and (iii) frequency and duration of the services ordered; 4. Orders for medications, when applicable; and 5. Orders for special dietary or nutritional needs, when applicable. The medical plan of care shall be approved and signed by the client's primary care physician. C. Verbal orders shall be documented within 24 consecutive hours in the client's record by the health care professional receiving the order and shall be countersigned by the prescribing person. D. The primary care physician shall be notified immediately of any changes in the client's condition that indicates a need to alter the medical plan of care. E. The medical plan of care shall be reviewed, approved, and signed by the primary care physician at least every 60 days. F. There shall be a director of skilled services, who shall be a physician licensed by the Virginia Board of Medicine or a registered nurse, responsible for the overall direction and management of skilled services including the availability of services, the quality of services and appropriate staffing. The individual shall have the appropriate experience for the scope of services provided by the organization. G. The organization shall develop and implement policies and procedures for the handling of drugs and biologicals, including procurement, storage, administration, self-administration, and disposal of drugs and shall allow clients to procure their medications from a pharmacy of their choice. H. All prescription drugs shall be prescribed and properly dispensed to clients according to the provisions of Chapters 33 (§ 54.1-3300 et seq.) and 34 (§ 54.1-3400 et seq.) of Title 54.1 of the Code of Virginia and the regulations of the Virginia Board of Pharmacy, except for prescription drugs authorized by § 54.1-3408 of the Drug Control Act, such as epinephrine for emergency administration, normal saline and heparin flushes for the maintenance of IV lines, and adult immunizations, which may be given by a nurse pursuant to established protocol.

7. REVISIONHISTORY:

Version Number	Effective Date
Version 1 (Initial Effective Release)	01/06/2014
Version 2	04/07/2014
Version 3	09/01/2014
Version 4	10/05/2015
Version 5	03/05/2019
Version 6	07/10/2020