XYZ HHA Policy & Procedures for Assessments & Reassessments

TITLE: PATIENT/CLIENT ASSESSMENT AND REASSESSMENT

POLICY #: 002
EFFECTIVE DATE: XXXXXX
REVIEWED/REVISED DATE: XXXXXX
POLICY TYPE:
PAGE: Clinical Non-Clinical

Job Title of Reviewer: Director, Clinical Services

PURPOSE: To define, in writing, the scope of patient/client assessments and reassessments to be performed and the timeframes for completion by XYZ HHA professional clinical staff.

POLICY STATEMENT:

1. Appropriate patient/client care is determined by an assessment of patient/client needs. The following process is needed to determine these needs:
   a. Data gathering of patient's/client's physical and psychosocial status and health history;
   b. Data analysis, to produce information needed about each patient/client care needs, and to identify if any additional information is required;
   c. Care decisions based on identified patients/clients needs and care priorities.

2. The assessment involves direct observation, measurement, and interaction with the patient, client and/or their family.

3. This process is ongoing, and continues throughout the patient's/client's episode of home care.

4. All assessment and reassessments will be documented in the patient's/client's clinical record and be signed and dated by the appropriate professional manually or electronically.

EXCEPTIONS: Outcome and Assessment Information Set (OASIS) will not be completed on patients under the age of 18, patients who are receiving maternal (prepartum, antepartum, postpartum) services, patients who are neither Medicare nor Medicaid, or who are receiving personal care only services.

Occupational Therapy will only perform the initial assessment if they are the only ordered discipline for Part B Medicare

(Out Patient services) or another third party payor other than Medicare Part A.

DEFINITIONS:

Client – Person receiving personal care and/or chore services only. A physician's order is not needed.

CMS – Centers for Medicare and Medicaid Services (Former Health Care Financing Administration).

Outcome and Assessment Information Set (OASIS) – A HCFA mandated standard core data set to be completed as part of a comprehensive assessment at specific time points.

Patient – Person receiving skilled services. A physician's order is required.

Start of Care (SOC) – The date of the first reimbursable visit by any discipline.

PROCEDURE:

1. The initial assessment determines the patient's/client's need for care and services, the type of care and services to be provided, and the need for further assessment.

2. The initial assessment will be done by a RN unless it is a therapy-only case. In this circumstance, the primary therapist (Physical, Speech, or Occupational Therapist) will conduct the initial assessment.

3. The initial assessment is begun at start of care (SOC) and will be completed within 48 hours of SOC. OASIS will be completed within 5 days of the SOC.

4. Other professional disciplines ordered at SOC, will complete their initial evaluations within five days of the SOC or the physician ordered date, whichever is first.

5. The initial assessment of patients/clients, as appropriate, will include an evaluation of:
   a. The patient's/client's medical history;
   b. pertinent physical findings;
   c. age-specific and gender-specific findings;
   d. the patient's/client's problems and needs;
   e. psychosocial status;
   f. nutritional status and risk;
   g. the home environment;
   h. equipment;
   i. prescribed and over-the-counter medications;
   j. the patient's/client's family or support system and the care they are capable and willing to provide;
   k. preventive and periodic health screenings;
   l. laboratory results;
   m. history of chemical dependency;

n. the patient, client and family's educational needs;
o. cultural and religious practices;
p. emotional barriers;
q. desire and motivation to learn;
r. physical or cognitive limitations;
s. communication styles;
t. language barriers;
u. pain;
v. safety; and
w. possible abuse and/or neglect. (See XYZ HHA Policies: "Identification, Treatment, and Reporting of Suspected Abuse" and "Domestic Violence Identification, Treatment, and Reporting")

6. The initial assessment, as appropriate, includes a functional status assessment that may include:
   a. cognitive level;
   b. independence in eating, toileting, transferring, walking, shopping, cleaning, doing laundry, bathing, dressing, and preparing food;
   c. mobility;
   d. continence;
   e. ability to operate and maintain equipment;
   f. communication skills; and
   g. emotional response to current health status.

7. The initial patient assessment for rehabilitative services will include an in-depth functional assessment, as appropriate. This assessment will include, but is not limited to:
   a. Physical Therapy services:
      1) range of motion;
      2) muscle strength;
      3) gait/ambulation;
      4) transfers in various settings;
      5) bed mobility;
      6) safety;
      7) use of assistive devices;
      8) use of orthotic/prosthetic devices
   b. Speech Therapy services:
      1) verbal expression;
      2) reading comprehension;
      3) auditory memory/comprehension;
      4) alaryngeal communication;
      5) visual/spatial/perceptual functioning;
      6) swallowing.
   c. Occupational Therapy services:
      1) range of motion;
      2) ability to perform activities of daily living (ADLs) and/or instrumental activities of daily living (IADLs);
      3) fine motor coordination;
      4) environment.

8. The initial patient assessment for medical social services will include, as appropriate:
    a. mental/emotional status;
    b. patient income/source;
    c. financial assets;
    d. housing needs;
    e. family and community relationships;
    f. caregiver support;
    g. ability of the patient to remain safely in their home.

9. The initial assessment and reassessments for infants, children, and adolescents (under the age of 18) will also include, as appropriate:
    a. developmental age;
    b. length or height;
    c. head circumference;
    d. weight;
    e. growth and developmental functional level;
    f. emotional, cognitive, and communication needs;
    g. educational, social, daily activity needs;
    h. rehabilitation, habilitation, and support needs;
    i. immunization status; and
    j. family or guardian expectations for involvement in patient care and services.

10. Patient/client reassessments will occur periodically during the course of care or services. Each patient/client is reassessed when the patient's/client's;
    a. condition significantly changes;
    b. diagnosis changes; and/or
    c. care environment or support system changes.

11. Patient reassessments will occur periodically during the course of care or services as required by law and regulation to document patient status. The appropriate OASIS form will be completed. Each patient is reassessed at the following timeframes:
    a. Recertification:
        1) Follow-Up OASIS to be completed at the patient's home within the last 5 days of the current 60-day certification period.
        2) Current patient needs will be included in the recertification Plan of Care (CMS 485).
    b. Transfer to an inpatient facility (for at least 24 hours for other than diagnostic testing):
        1) Transfer OASIS to be completed within 48 hours of the transfer date or discovery of such transfer.
    c. Resumption of home care after an inpatient stay;
        1) A visit to the patient's home will be made within 24 hours of the facility discharge or on the physician ordered date;

2) Resumption of Care (ROC) OASIS will be completed within 48 hours of this visit;
3) each professional discipline ordered will reassess the patient and write a supplemental order for the services to be provided;
4) the Patient Care Plan will be updated on all disciplines after the patient has been reassessed.

d. Significant Change in Condition (SCIC) OASIS will be completed within 48 hours of the knowledge of a major decline or improvement in a patient's health status;
   1) At least 2 of the following criteria must be met to qualify as a major improvement:
      a) resolution of a wound;
      b) stopping infusion therapy;
      c) stopping enteral nutrition;
      d) three or more medications discontinued;
      e) major improvement in caregiver ability or availability or environment; or
      f) major improvement in 2 or more Activities of Daily Living (ADL).
   2) At least 1 of the following criteria must be met to qualify as a major decline;
      a) New diagnosis with new orders;
      b) Initiation of one or more disciplines;
      c) New wound formation;
      d) Starting infusion therapy;
      e) Starting enteral nutrition;
      f) Two or more new medications started;
      g) Increase of 2 or more visits per week;
      h) Major decline in functional status affecting 2 or more ADLs
      i) Major deterioration in caregiver ability or availability;
      j) Major deterioration in the environment; or
      k) 2 unscheduled physician appointments in one week.

e. Discharge:
   1) Prior to anticipated discharge, all patients will be reassessed as to goal/outcome attainment;
   2) Discharge OASIS will be completed within 48 hours of the actual discharge date or the discovery of the unanticipated discharge date.

15. Clients receiving only home health aide services will be re-assessed at least once every 60 days.

16. Clients receiving homemaker/chore services only will be re-assessed at least once every 6 months

17. Patient/client assessment and reassessment findings will be communicated to the patient/client care team, as appropriate, utilizing the following methods:

a. Team conferencing;
b. Case communication/collaboration (verbal or written);
c. Telecommunication; and
d. Assessments/reassessments are accessible by other disciplines assigned to the case via the laptop computer system.

18. The patient/client always has the right to refuse to answer any questions during assessment visits. The patient/client has the right to refuse assessment visits altogether or to ask for a different day. This will be documented in the clinical record.

RESPONSIBILITY: It will be the responsibility of XYZ HHA directors and managers of clinical services to see that all personnel adhere to this policy.

It will be the responsibility of clinical staff to assess patients/ clients and to report changes to the physician as appropriate.

REFERENCES: Federal Register (Vol. 64, No. 117) June 18, 1999. "Medicare and Medicaid Programs; Mandatory Use, Collection, Encoding, and Transmission of Outcome and Assessment Set (OASIS) for Home Health Agencies and Privacy Act of 1974"

Community Health Accreditation Program, Standards of Excellence, Millennium Edition 2002.

Rule 59A-8.022 Florida State Minimum Standards for Home Health Agencies, Revised October 2001.

Medicare Conditions of Participation, 42CFR484.

AUTHOR(S): RN, director, QI & Compliance
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ATTACHMENT(S): None

APPROVALS:

Signatures indicate approval of the new or reviewed/revised policy.		**Date**
Reviewer's Signature:		
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Committees/Sections:		
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