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Focus on Recruitment and Retention

BY: JENNIFER PARK, AHCC/BMSC MEMBERSHIP COORDINATOR

Monday morning, you walk into your home health agency and the whole office is empty. Are you dreaming or is this real? You start to panic, thinking, where are my employees? Are they that unhappy that they’ve all quit? This is a bit more dramatic than reality, but it could happen to you if you don’t hire and keep the right employees for your agency. This is even more important now, due to the transition to the new payment model, the Patient-Driven Groupings Model (PDGM).

As we lead up to these changes in 2020, most agency staff will need more education about the new requirements, and reasons to stay fully engaged during this challenging time. That will help reduce the possibility of staff turnover and lower the risk of being short-staffed. Agency managers should work to keep the communication open with their employees and create a culture where managers and employees feel comfortable collaborating and working together to get through difficult and stressful times. Recognizing accomplishments and giving positive feedback within the whole agency can also lead to opportunities for growth in your career.

The happier and more satisfied your employees are in your agency, the more positive recruitment and retention will be for your staff. This can help lead your agency to growth in size while you provide high-quality work — possibly five-star agency quality.

In this issue of AHCC Journal, we bring you a collection of articles that take a closer look at how to recruit and retain your staff as the PDGM transition date is right around the corner. We think that the information and tips in these articles will help your agency during this changeover period and will help you move into a positive new year. Look for a Q&A on some coding issues along with the usual updates from AHCC and our Board. Also, look for the AHCC Member Profile and the AHCC Board Member Profile.

As we close 2019 with this last issue of AHCC Journal, we would like to thank you for sharing your stories with us. We look forward to meeting more of you and sharing new stories with you in 2020. Please reach out to us at AHCCMembers@decisionhealth.com if you are interested in being featured in a future member profile.

As always, we love hearing from you with any ideas for how we can improve AHCC’s Quarterly Journal, suggestions for content we can offer on the AHCC website or any other thoughts you’d like to share. Please reach out to let us know what we can do for you. 💌
NOTE FROM THE BOARD

Bring coding and compliance together, and in with the new (but not out with the old)

BY: ROBERT MARKETTE JR., JD, CHC, HCS-C

Dear AHCC Member,

Welcome to the final issue of the AHCC Journal for 2019. As 2019 draws to a close, many of us look forward to Thanksgiving, Christmas and the holiday season. We look forward to time spent with friends and family, Christmas trees, stockings hung by the fireplace, Christmas carols, office parties, vacations and time away from work, and much more. For home health, however, the holiday season may hold some trepidation, as the arrival of 2020 means the beginning of CMS phasing out RAPs and the start of PDGM. This promises to make 2020 a year of significant change and opportunity in home health. Hospice providers won’t see as significant a change as home health will. Still, the rebasing of hospice payments and the growing scrutiny hospice is receiving from OIG, MedPAC and others, promises to continue to change how hospice operates.

Celebrate a successful 2019

In addition to the anticipation of the holidays, as the New Year approaches, people will look back over the previous year to see what was accomplished and to set goals for next year. As your AHCC Board looks back over 2019, we feel we have achieved many of our goals regarding providing you, our members, with more resources for coding and compliance. We had a successful year of AHCC Talks that covered a wide range of important topics for members through an often lively and always informative discussion among the Board members. These calls provided members with practical insights for addressing many compliance issues.

We had yet another successful Coding Summit in beautiful San Antonio. The pre-conference Member’s Day was a great time for the Board to interact with you and for you to not only interact with us, but to interact with your colleagues in coding and compliance. The main conference was even more informative, as members heard from many industry experts. In addition, the conference location, the Grand Hyatt right on the River Walk in San Antonio, was not only a wonderful hotel, but offered easy access to so much of San Antonio. (I know my wife and I enjoyed the opportunity to see the Alamo and to eat at many excellent restaurants on the River Walk.)

In addition to the anticipation of the holidays, as the New Year approaches, people will look back over the previous year to see what was accomplished and to set goals for next year.

We built on the success of our Coding Summit, when we hosted the AHCC Compliance Summit in Atlanta, at the Westin Peachtree. This multiple-day conference provided several days of training on a number of important topics for home health and hospice compliance professionals. We not only addressed the elements of compliance, but we also provided members with an opportunity to participate in an interactive tabletop compliance exercise and multiple opportunities to network with fellow compliance professionals, speakers, and the AHCC Board.
On top of that, as we look back on 2019, the Board is proud to have provided you with this quarterly Journal, which is filled with valuable coding and compliance insights, as well as the multiple whitepapers we produced this year on essential compliance topics including documentation and building a culture of compliance. Overall, for the AHCC Board, 2019 has been a great year in our efforts to improve the Coding and Compliance resources for the home health and hospice industry.

**Come together for 2020**

We look forward to building on this success in 2020. We will keep providing the monthly AHCC Calls, through which we hope to bring you helpful information related to PDGM and other pressing topics. The AHCC Calls will be supplemented by more whitepapers and the continuing publication of this Journal.

You will notice one change in 2020. Because we are the Association for Home Care Coding and Compliance, we decided that our Summit should be about coding and compliance. That means for 2020, we will be co-locating the Coding Summit and the Compliance Summit at the wonderful Paris Resort and Casino in Las Vegas. Co-locating these conferences will allow agency coding and compliance professionals to come to the same conference. The Board thinks that bringing all of our members together in one major event will help to bring coding professionals and compliance professionals together as members of AHCC. We are very excited about this move, as we think it will really help to drive home health and hospice compliance forward in the coming years.

We know that as we are looking back and planning for the future, you are as well. Your primary focus is likely PDGM, PDGM compliance, RAPs and related matters. Although the arrival of PDGM and other changes are important, you still have an agency to run, and that requires you to think about other matters. One of these is staffing. As you look back over 2019, you may have been presented with some staffing related challenges. Many agencies around the country have been facing a routine staffing shortage for some time. This is driven by
several factors. One of the primary factors has been the ongoing nursing shortage. Staffing has also been impacted by the steady rise in wages due to low unemployment rates. Another factor is the rise of non-healthcare competition for staffing. There is also the relatively stagnant level of reimbursement, which limits what agencies can offer.

“**When recruiting home health aides, it is even more challenging, because you are not only competing against other providers, but you are also competing against many non-healthcare businesses that can afford higher wages.**”

**Face the future with a full staff**

Agencies that faced staffing shortages and related issues in 2019, may be looking at 2020 and thinking about how to address those shortages. This staffing shortage may be restraining your ability to grow as an agency because the lack of staffing prevents you from taking all of the referrals you receive. The staffing shortage may have caused you to have to discharge patients whose needs you cannot meet due to lack of staffing. You may have reduced your marketing efforts to try to reduce referrals as a way to address the problem.

This issue of the AHCC Journal focuses on staff recruiting and retention because we understand this concern. We included both recruiting and retention, because it is not enough to just identify and hire new personnel. Agencies need to keep the staff they have. It is much more cost-effective to retain the staff you have than to have employees turning over. As agencies look to reduce costs under PDGM, reducing employee turnover may be an essential area of focus. Because retaining employees has a direct financial benefit to your agency, this quarter’s AHCC Journal has several articles on ways to retain your staff.

Of course, it is not enough to retain your current staff. If you want to grow, you need more staff, but adding staff members presents many challenges. Whether you are hiring nurses, therapists, or home health aides, you are facing stiff competition. As you recruit nurses and therapists, you are competing against hospitals, SNFs, and other facilities that offer higher wages. When recruiting home health aides, it is even more challenging, because you are not only competing against other providers, but you are also competing against many non-healthcare businesses that can afford higher wages.

In this environment, relying on the increased flexibility and “independence” offered by working in home health may no longer be sufficient to overcome the growing gap between the wages you can offer and those afforded by facilities and/or non-healthcare employers. This new environment calls for new recruiting strategies, and we hope you find the ones in this quarter’s Journal to be useful.

On behalf of the Board, we wish you a Merry Christmas and a Happy New Year. We look forward to working with you all in 2020 as we navigate PDGM and more.

Sincerely,
The AHCC Board

**ABOUT THE AUTHOR:**
Robert Markette, Jr., JD, CHC, HCS-C, Attorney with Hall, Render, Killian, Heath, & Lyman, P.C., is the Secretary of the AHCC Board.
AHCC UPDATES

Here’s what we’ve been up to at AHCC

AHCC Best Practice Papers
Our third quarter Premium Members-only AHCC Best Practice Paper focuses on ethical and correct coding processes. An important fundamental component of home health reimbursement and patient care is coding accuracy and compliance with ethical standards. This will become more crucial under the Patient-Driven Groupings Model (PDGM) that will take effect January 1, 2020.

Agencies will need to adjust their coding focus to a precise determination of primary and secondary diagnoses based on effective collaboration with the certifying physician. To achieve this, coding training and support will be essential, as well as will instructions on how to eliminate fraudulent practices. Correct coding processes that deliver more accurate diagnoses that are aligned with the focus of care will facilitate better outcomes for the patient and the agency.


AHCC Talk
Each month, members of the AHCC board join us for AHCC Talk, a live discussion about current issues in home health compliance. In November, we discussed the 2020 Home Health PPS Final Rule, which was posted to the Federal Register on October 31st. This reinforces the plan to implement the Patients-Driven Groupings Model (PDGM) on January 1st, 2020.

On the good news side of things, CMS has eased up on their plan to implement an 8.01% decrease for behavioral changes in order to calculate the 30-day payment rate in a budget neutral manner for 2020.

Here’s a quick refresher on those behavioral changes that CMS is looking out for:

CMS assumes agencies will:
- Change documentation and coding practices to put the highest-paying diagnosis code in the principal diagnosis slot to maximize payment,
- Include more secondary diagnoses in order to qualify for comorbidity adjustments, and
- Provide extra visits to avoid low-utilization payment adjustments (LUPAs).

The 2020 Final Rule moves forward with CMS’s plan to eliminate therapy thresholds as a factor in payment under PDGM and to move from a 60-day episode to a 30-day payment period.

Here’s a quick refresher on the PDGM grouper basics:
- PDGM will include 432 home health resource groups (HHRG) and 12 clinical. Case-mix will be determined based on admission source, institutional or community setting, timing — early or late clinical group, functional impairment level and comorbidity adjustment. And clinical groups will be based on the primary diagnosis code. Comorbidity adjustments will fall into one of three categories — no, low or high.
- We did see some positive updates in diagnosis codes included in the PDGM grouper in the final rule and this includes adding the dysphagia codes, R13.10-R13.19 as acceptable primary diagnoses, changing E11.9 Type 2 diabetes mellitus without complication from MMTA Other to the MMTA Endo Group, and
moving T87.89 other complications of amputation stump from MMTA Other to Wounds clinical group.

LUPAs were another area of change under PDGM, which was discussed in-depth on the last AHCC Talk. Basically, although payment episodes under PDGM will be shorter than under the current PPS, LUPAs can still occur; but, unlike the current PPS where a LUPA involves four or fewer visits during an episode, the threshold for the number of visits needed for an episode to be a LUPA under PDGM will vary.

The final rule also finalizes the addition of standardized patient assessment data elements (SPADEs); allows physical therapy assistance to furnish maintenance therapy; sets routine updates to the home infusion therapy payment rates for 2020, and payment provisions for these services in 2021 and future years; modifies payment regulations related to the content of the Home Health Plan of Care; makes changes to the value-based purchasing model; and hints at future changes to expand the reporting of OASIS data use for HHQRP to include data on all patients regardless of their payer.

We also asked AHCC Talk attendees to share what they are most concerned about as we gear up for the 2020 HHPPS final rule to go into effect.

**Basically, although payment episodes under PDGM will be shorter than under the current PPS, the threshold for the number of visits needed for an episode to be a LUPA under PDGM will vary.**

Results are in: 68% of our listeners said their biggest concern is the issues with primary diagnoses that aren’t on CMS’ list, 19% are concerned with the elimination of therapy thresholds as a payment factor, 8% are concerned with the payment reduction due to behavioral assumption, 5% said they were concerned with the impending changes to the OASIS and 0% — no listeners added another answer. What are you most concerned about as the 2020 HHPPS final rule goes into effect soon? We’d love to hear from you.

To join us for the next episode of AHCC Talk, register here: [https://attendee.gotowebinar.com/register/6870114079026530819](https://attendee.gotowebinar.com/register/6870114079026530819). To share your thoughts or suggestions for future episodes, email us at AHCCMembers@decisionhealth.com.

**New on the AHCC website**

- **AHCC Talk archive**: Did you miss listening in to an episode of AHCC Talk? You can catch up with our recordings of past episodes here: [https://ahcc.decisionhealth.com/Resources?resourceType=Free%20Webinars](https://ahcc.decisionhealth.com/Resources?resourceType=Free%20Webinars).
Get your office staff involved with improving client satisfaction and caregiver retention
An effective office staff is the key to a great business trajectory

BY: ANNE-LISE GERE

Don’t ignore the impact office employees have on client satisfaction and caregiver recruitment and retention. Doing so could cost your agency dearly.

High-caliber office staff helped one Colorado-based private duty agency grow to a mid-sized agency in a short period of time. Touching Hearts At Home had just two people working in the office, but the dedication and quality of work demonstrated by that small staff made agency growth possible.

If your caregivers are the lifeblood of your agency, your office staff serves as the backbone. They set the tone for your agency and play a major role in determining your business’ course. These employees don’t just keep office operations running smoothly, they also have a pronounced impact on caregiver and client satisfaction.

Take advantage of their part in client satisfaction

While your caregivers may have the closest contact with your clients, they don’t solely influence your client’s satisfaction — that actually falls to your office staff. In fact, client satisfaction with office staff “most closely correlated with a client’s likelihood to recommend a provider,” according to Rexburg, Idaho-based Home Care Pulse’s analysis of thousands of client satisfaction interviews.
Your client’s first impression of your agency is often based on your office staff. That’s because staff members handle and/or schedule both the client’s initial inquiry and assessment. These staff members also project and maintain your agency’s image through ongoing interactions with your clients. These interactions include scheduling care or regular assessment visits, answering client questions, and billing relations. If your office staff is indifferent or unprofessional, that reflects poorly on your entire agency.

A professional and caring office staff also provides a more consistent point of contact for clients, because office staff turnover is much lower than caregiver turnover in the home care industry. In 2017, the median caregiver turnover rate was 66.7%, according to the 2018 Home Care Benchmarking Study by Home Care Pulse. That same year, the overall median office staff turnover was just 30%, the study shows.

Use office staff to help keep caregivers

Your office staff also plays a key role in caregiver recruitment and retention. Office employees interact with caregivers daily and based on the quality of these interactions, caregivers either feel connected to your agency or alienated by their employer.

The professionalism and respect for your caregivers demonstrated through those daily interactions can make caregivers want to stay with your agency. On the other hand, negative interactions with your office staff may drive caregivers to quit.

A strong office staff also can help with recruitment efforts. By projecting a professional image through office staff, your agency is more likely to attract professional caregivers. There is also a high correlation between office support staff and how likely a caregiver is to recommend employment at an agency, according to Home Care Pulse.

Do this when hiring key office staff

Replace an employee who isn’t a good fit. While it’s not always an easy decision to let a staff member go, it can be a turning point for your agency. For example, many agencies struggle with caregiver recruitment because they don’t have the right person leading the charge on employment. For this position, track the number of applicants by recruitment source, such as online job posting, employee referral, school recruitment or community activities. If the majority of the applicants come from online job postings and none from community activities or schools, this is probably a sign that the recruiter isn’t implementing the recruitment plan. First, coach the employee and identify whether the problem is lack of skills or lack of willingness — often it’s a combination of the two. If coaching doesn’t lead to improved results, it’s time to find someone else to fill the role.

Train office staff to recognize caregivers. Frequent recognition for a job well-done impacts the tenure of caregivers. Enabling office staff to acknowledge when caregivers do a good job can go a long way toward job satisfaction.

Educate office staff on proper phone techniques and wording in group sessions. Ask employees to think of difficult situations they have encountered and create a scenario to roleplay the situation. Together the group will come up with a good way to handle the call. Make sure everyone is trained and practices the skills. Do not accept excuses.

Office employees interact with caregivers daily and based on the quality of these interactions, caregivers either feel connected to your agency or alienated by their employer.
FOCUS ON OASIS

OASIS education, retention help agencies maintain 5-star status in quality
Processes you can use to boost your agency’s patient care performance

BY: ANGELA CHILDERS

During the time that CMS has updated its quality of patient care star rating system, fewer than 30 home health agencies have maintained a five-star rating, a Home Health Line analysis shows. Several agency leaders within this prestigious group agree that there’s no magic strategy for retaining that CMS place of honor. But they also believe OASIS training, education and workforce retention are key elements to success.

Focus on what you do best and keep learning

Phoenix, AZ-based Haggai Healthcare Corp. maintains its five stars by focusing on providing high-quality care to patients with a particular need: wound care. While the agency treats patients with other needs, Adela Virgen, the agency’s office manager and intake assistant, says the agency is careful to only accept the patients it has the time and skillset to properly treat. The agency maintains a balance of “only taking on what we can do — no more, no less.”

The agency, which has a daily census of about 300, developed a reputation for its knowledge of the latest wound care techniques — making it a go-to referral for the largest burn and wound centers in the county.

“Every time we learn about a new [wound care] product that a company wants to show us, we have a meeting with all our nurses, and we get educated as well in the office, regardless of whether we are going to use the supplier or not,” Virgen says. “We’re always learning about new innovations for taking care of wounds.”

In July 2018, the national average on Home Health Compare for how often patients’ wounds improved or healed after an operation was 90.9%. At Haggai, it was 100%.

Keep patient care — not reimbursements — in mind

Health Related Home Care in Abbeville, SC, took a similar approach. It goes above and beyond to handle patients in its respiratory care program, says Lynn Blanton, clinical director and acting administrator. The agency sends a respiratory therapist to each of those patients at the start of care — despite the fact that such a visit is not reimbursable — to educate patients about proper inhaler use and ensure they’re able to follow care directives from their physicians.

The national average in July 2018 for how often patients’ breathing improved was 76.2%. Health Related Home Care’s score was 86.7%.

Open the door to better communication

At Oak Crest Home Health in Parkville, MD, which serves an independent living retirement community, Celeste Saunders says her agency goes above and beyond what many providers do by having seasoned nurses and therapists get to know residents when the residents first move in. Nurses and therapists have a welcome visit with the residents which allows the agency to more easily communicate because of that built-in relationship with the patient.
Provide constant OASIS auditing

Proper assessments and constant audits are the key to Excellent Home Health Care Inc.’s success in maintaining five stars, says Fructuosa Lising, the Skokie, IL-based agency’s owner and clinical manager. While Lising says the most important thing is the assessment of the patient, her agency also places a big emphasis on continuing education and constant reviews of OASIS.

Lising audits every single OASIS and sits with nurses weekly to review any discrepancies or issues. She says this contributed to the agency’s zero-deficiency score in its 2017 CMS survey. Saunders also emphasizes OASIS education. She says the agency’s QA manager trains employees constantly to ensure they understand how to help patients as best they can and meet benchmarks and outcomes.

“Maintaining five stars every quarter is like winning the Olympics every quarter,” Saunders says. “We’re really proud of it.”

Do this to improve your star rating

- **Audit, audit, audit.** Nearly all of the agencies Home Health Line spoke with audit every single OASIS. Amy Potter, founder and CEO of Texas Home Therapy of Austin in Austin, TX, says using a data scrubber — such as the one her agency uses through Strategic Healthcare Programs (SHP) — helps catch OASIS documentation inconsistencies. Unique Home Health Services in Pasadena, CA, also uses SHP for data scrubbing. It is helpful, especially for inconsistencies in functional status, administrator Lisa Dorsey says.

- **Consider a niche and outside training.** Like Haggai Healthcare, Unique Home Health has established itself as a wound care expert. It invites companies with new wound technology to come to train nurses. Dorsey says the agency is partnering with wound vac doctors who invite the nurses into their offices at the start of care to get additional equipment training. At Unique in July 2018, 99.4% of patients’ wounds improved or healed after an operation.

- **Examine your staff’s retention rates.** Maintaining a consistent workforce was cited by nearly every five-star agency interviewed as a key ingredient to their success. Most attributed their retention efforts to offering continuing education, maintaining open-door policies and cultivating a culture of communication and cooperation. Oak Crest places a big emphasis on staff retention through its benefits. The company offers tuition reimbursement, national retailer discounts, an employee summer picnic and several employee and leadership acknowledgment programs, including a Best of the Best annual employee award that comes with a $1,000 reward. The company also offers free online training programs available through the parent company’s Erickson Living University, which offers everything from education on OASIS and home health to social media policies and management courses. Saunders also says the company maintains a culture of open-door collaboration. “We have really good clinicians from varied backgrounds, and they’re encouraged to share with each other and learn from each other,” she explains. Saunders says the agency has created a culture where employees feel comfortable asking questions when they don’t know the answer, and that administrators are not afraid to admit when they’ve made mistakes. Agency leaders use those examples as teachable moments.
New survey results show most agencies don’t have coder accuracy requirements

Correct that mistake now, before PDGM arrives, and you’ll be the better for it

BY: MEGAN HERR

As agencies prepare for the Patient-Driven Groupings Model (PDGM), now is the time to strongly consider putting a coder accuracy requirement in place or reviewing your existing accuracy requirement.

Inaccurate coding under PDGM could lead to patients being placed in the wrong clinical grouping and potentially incorrect reimbursements for care provided. Inaccurate coding also could potentially lead to claims being kicked back to agencies, which would delay reimbursement.

While they should, they don't always

Agencies already should have coder accuracy requirements in place, many industry experts argue. However, more than 58% of the 275 respondents on a DecisionHealth’s 2019 Home Health Coders’ Productivity Survey question report that their agency doesn’t currently require them to maintain a particular accuracy level.

“It is important to have an accuracy rating and be able to verify it for the obvious reason — you want the correct payment,” explains Trish Twombly, a coding expert and independent home health
consultant based in Dallas, TX. Even now, you want to be able to verify your coders’ accuracy in case you get a chart that’s pulled for an audit, Twombly adds.

So why do so many agencies not have an accuracy requirement in place? One major reason is because they don’t have the means to conduct audits or check accuracy, Twombly says.

“If you’re a small agency and only have one or two coders [who are] doing all of the coding, you might not have anyone at the expert level to be able to audit the coders’ work to establish a baseline and maintain their accuracy reading,” she says. That’s where outsourcing might make sense, experts say.

“You’re not going to find any outsource coding company that does not require a certain accuracy rating,” Twombly says.

How to implement an accuracy standard

- **Determine your appropriate accuracy requirement.** Most agencies require an accuracy level of about 90% to 95%, according to industry experts. Of the 115 survey respondents who reported having an accuracy standard for coders at their agency, 12% reported a requirement of 100%, 43% reported a requirement of 96% to 99%, and 42% reported a requirement of 90% to 95%. Only 3% of respondents work at agencies with an accuracy requirement of 89% or less. Whatever standard you determine makes sense for your agency, put it in writing.

- **Take coder productivity into account.** Implement a productivity standard as part of the policy for the accuracy rating. For example, if coders are required to code 12 charts per day, the accuracy level would be based on that productivity standard. Among 283 respondents to a separate question on the coder survey, 37% code an average chart in 30 minutes or less, and 46% code an average chart within 31 to 45 minutes.

- **Think through how you’ll actually check accuracy.** Consider who will perform auditing at your agency and how often it should occur. Monthly and quarterly chart review/ auditing were among the top ways reported in the survey when asked how agencies measure their coders for accuracy. As part of a corporate compliance program, agencies should conduct at least one review annually — but leading up to PDGM, agencies definitely may want to do more to ensure accuracy, says J’non Griffin, owner of Home Health Solutions in Carbon Hill, AK.

- **Ensure your agency takes appropriate action if coders fall short in terms of accuracy and productivity.** Remedial training (66%) and increased level of review (58%) are the most common consequences for coders who fail to maintain a required level of accuracy, survey results show. Other common responses included a decrease in the number of charts required per day (24%), suspension (14%) and termination (19%). Twombly believes that before taking other actions, agencies should provide education. “If this is the first time, or this is a coder who you have been auditing on a monthly or quarterly basis and they are usually maintaining their accuracy, but all of a sudden, they’re at 89%, then you want to figure out what the problem is,” Twombly adds. “Was there a pattern or trend that you as the auditor could pick up and say here is where we’re going to target your education.” If the coder continues to fall below the line, that is where you need to start thinking about something in addition to just reviewing coding knowledge, she adds. “For me, if they [coders] fall below the bar, there is education with increased review,” contends Arlynn Hansell, owner of Cincinnati, OH-based Therapy and More, LLC. “Fall below again, and it’s the same thing, as well as a decrease in charts permitted. Fall again, termination. We call it the Big Brother program — as in, someone is always watching you.”
5 key focus areas to minimize employee turnover while you transition to PDGM

Keep your staff feeling safe, secure and even enthusiastic with these practical changes

BY: GINA MAZZA

Obtain staff buy-in as your priority during the transition to the Patient-Driven Groupings Model (PDGM). Otherwise, you jeopardize employee engagement levels and open the door to increased turnover and reduced productivity. Staff turnover is the single biggest non-regulatory challenge to agency productivity, according to the Home Health Line’s 2019 Home Health Clinician Productivity Survey.

Focus on these five key areas — manager relationships, employee expectations, leadership, recognition and compensation — to help maintain employee commitment through stressful PDGM changes and reduce the risk for staff turnover.

1) Manager relationships

Clinical managers set the tone and make things happen every day. But, simply making demands won’t encourage employee engagement or effectively administer change. Instead, ensure managers have two-way communication with their employees and offer support to help get the job done.

A transparent, honest explanation of how and why policies and/or practices are changing due to PDGM is crucial, so consider holding small group discussions or team meetings. Encourage employees to ask questions and give feedback. Active listening is key to the success in these meetings.

2) Employee expectations

Employees want to know what’s expected of them so they can be successful, and managers must help each employee clearly understand what’s changing. Have managers set early expectations. A clear dialogue about role expectancies and how success is measured is the foundation for achievement and will help get employees on board. Ensure that your agency managers have the necessary coaching skills, so everyone is held accountable, while you maintain a positive working environment.

3) Leadership

Managers should demonstrate the ability to facilitate change while also motivating the team to be at their best. Encourage managers to strike this balance by treating others the way they want to be treated. Most home health and hospice clinicians appreciate autonomy, but value the support from their managers in clinical decisions.

The regular presence of senior leadership is essential to employee confidence. Staff members want to know the direction and status of the agency. Remind senior leadership to share information clearly and on a regular schedule to provide
employees with a sense of security within your organization. Appropriate methods include monthly staff meetings or even quick email updates.

4) Recognition
Take the time to give praise where it’s due. When it comes to recognition, a sincere “thank you” matters. Regardless of role or responsibilities, everyone appreciates thanks for a job well done. Even if it’s just being more intentional about thanking staff face-to-face, showing your appreciation goes far in staff retention. It sounds simple, yet is sometimes overlooked by busy managers during a hectic day. Employees go the extra mile for the manager that displays gratitude and recognition. Thank you notes or emails are useful, employees don’t always need elaborate or expensive gestures.

5) Compensation
Create opportunities for continued growth for your staff members. Employees want to work within a culture that creates growth, and not all such opportunities need to include a promotion. Consider professional development, committee work and new responsibilities for the star performers within your agency. PDGM offers plenty of opportunities for staff at all levels to contribute to new or revised workflows.

Consider additional areas of focus to impact turnover
- **Lead solid team meetings.** Managers can build a more effective relationship with employees by holding team meetings that are more discussion-based, rather than strictly offering updates. Foster better relationships between management and staff by focusing on timely and proactive evaluations and case management support.
- **Seek staff input.** Employees often ask for a larger voice in the policy and practice decisions that impact their team or the agency. Engaged employees want to contribute, and it’s beneficial to encourage this kind of engagement. Team meeting discussions are a good first step. Look for opportunities to include employees in the PDGM discussions and work groups. Consider including employees at all levels and from various teams to participate in small team projects. This helps employees feel like they are part of the change instead of victims of it.

- **Find ways to celebrate the home health mission.** Employees with a sense of pride in their organization tend to have higher engagement levels. Celebrate the mission of home health by sharing patient letters and instances of staff members going the “extra mile.”
- **Create a “Quality of Work Life” committee.** Leadership should champion this committee with employees as active participants. Center the group on sustaining the areas of work life and work culture that your agency achieves well, and focus efforts on what needs improvement. Often, staff members and managers request more regular feedback and more visibility from senior management. In that case, the committee can recommend how to narrow the gap. Quality of Work Life committees provide valuable insight to the leadership team. Respond to feedback or recommendations with swift action — it’s vital — even small changes are noted positively.
DOCUMENTATION TIP

Industry expert answers questions about care coordination under PDGM

BY: DIANE LINK

The Patient-Driven Groupings Model (PDGM) has left many of us with queries about how to proceed in specific situations after Jan. 1, 2020. Following a recent DecisionHealth webinar about improving care coordination under PDGM, agencies asked questions of industry expert Diane Link, owner of Link Healthcare Advantage in Littlestown, PA. Here are some of her answers.

Q If the primary diagnosis doesn’t make sense for the second 30-day payment period under PDGM, how should we go about updating the primary diagnosis? What needs to happen?

A There are two ways to update a primary diagnosis. Medicare said that agencies can update the claim to identify the primary diagnosis. That means if the focus of care has switched, you may switch the diagnosis order on the claim without having to complete a new OASIS.

There are times, however, where it may be appropriate to do a follow-up OASIS. If there has been a significant change in the patient’s condition, clinicians should complete a follow-up assessment. The challenge is that Medicare doesn’t give a clear guideline for what is considered a significant change. Figure out why you’re changing the primary diagnosis and whether there are other things going on with that patient.

If the focus of care and the patient’s functional ability have both changed over the previous 30 days, you should complete a follow-up assessment. That OASIS will be used to determine the patient’s functional impairment level, which is also a factor in payment.

It’s a good idea to get a verbal order anytime we change a diagnosis to a primary diagnosis.

A How many case managers and visit nurses do you recommend per clinical manager?

A That’s probably one of the most debated numbers out there. My recommendation is based on census as opposed to number of nurses or disciplines. For every 200 patients in your agency’s census, you should have at least one clinical manager.
At the end of the day, that clinical manager is responsible to oversee the plans of care for each patient.

**Q** Can you please provide examples of when we would use non-billable visits?

**A** You would use a non-billable visit if your agency has a policy in place that requires a nurse complete every admission whether nursing is ordered or not and all the nurse did was complete the OASIS assessment but did nothing skilled.

Use a non-billable visit if the state or policy requires aide supervisory visits be completed only by a nurse, but nursing is not ordered for the case. Another case would be if the agency is doing a discharge, but the patient refuses to let someone come out to complete the discharge visit.

If someone writes in the chart that all goals were met, any visit after that point for that discipline is non-billable. Similarly, if someone indicates in the chart that the patient is no longer homebound, any visit after that point is non-billable.

**Q** Under PDGM, if a patient starts on care, is admitted into the hospital within 30 days, then gets out and the agency resumes care within 14 days, does the patient become an institutional admission source?

**A** Yes. If the patient goes to the hospital on days 16-30 — so the patient is in the hospital for the last 14 days of that 30-day pay period — then the patient is classified as institutional because they went to an acute care hospital. Remember, if the patient went to any other post-acute facility, the patient would remain a community admission.

**Q** What are some tips or recommendations for ensuring that clinicians complete documentation in the home? How do agencies achieve accountability?

**A** If your agency’s electronic medical records (EMR) software has the ability to report the start and end time of the documentation, you should use it. Run reports to identify timeliness of documenting and, better yet, whether the documentation was done in the home during the visit. Some software will mark the note with the date the documentation is complete. Audits can use this to see how timely the documentation was completed.

Supervisory visits — announced or unannounced — also show if the clinician is documenting in the home or not. If a clinician has not used their laptop in the home before, the supervisor should be able to tell because it will appear awkward and unusual for the clinician and/or patient.

Encourage clinicians to explain to patients the reasons for in-home documentation. I have yet to encounter a patient that refused to let me sit and write that note before I left the visit. If a clinician does have a patient who objects, encourage the clinician to sit in a car or nearby safe area to complete documentation as soon as possible after the visit.

**Q** Do you have any recommendations for getting staff on board with changes associated with PDGM?

**A** It starts with education. Agency leaders may think the majority of staff members don’t want to know about reimbursement and the financial outcomes of the agency, but they usually really do want to know. Most staff members want to know the difference they make, not only in the lives of the patients, but also in the success of the organization.

Reimbursement shouldn’t be a taboo topic. Teach your clinicians how case-mix scores are calculated under PDGM and what their role is in that. Clinicians should understand that accuracy on the OASIS is not only used to calculate outcomes, but also reimbursement.

Help clinicians understand why your agency truly needs to make every visit count. Help connect the dots and explain how this ensures good patient outcomes and good financial outcomes for your organization. 😊
AHCC Q&A

BY: JEAN BIRD, RN, HCS-D

Do you have a question for AHCC? We’re here to help you find the answers you need. Please send your questions in to us at AHCCMembers@decisionhealth.com.

Q Is it okay for an ER note signed by an MD to be used as an FTF encounter?

A As per Medicare guidelines, “As of January 1, 2015, documentation in the certifying physician’s medical records and/or the acute/post-acute facility’s medical records (if the patient was directly admitted to home health) will be used as the basis upon which patient eligibility for the Medicare home health benefit will be determined. Documentation from the certifying physician’s medical records and/or the acute/post-acute care facility’s medical record (if the patient was directly admitted to home health) used to support the certification of home health eligibility must be provided, upon request, to the home health agency, review entities, and/or the Centers for Medicare and Medicaid Services. The certifying physician and/or the acute/post-acute care facility’s medical record (if the patient was directly admitted to home health) for the patient must contain the actual clinical note for the face to face encounter visit that demonstrates that the encounter:

❚ Occurred within the required timeframe,
❚ Was related to the primary reason the patient requires home health services, and
❚ Was performed by an allowed provider type.”

If all criteria are met, then the ER physician notes may be used as a face-to-face encounter.

Q For a diagnosis of vascular dementia, we know there needs to be a code prior to this code indicating the underlying physiological condition. That can include HTN, CAD or CVA. Are there other diagnoses that can be an underlying cause? Is there a list of diagnoses that may be used for an underlying physiological condition for vascular dementia?

A To my knowledge there is not a specific list of diagnoses that support vascular dementia. You should always query the physician for the etiology. The coder may not assume the cause of the dementia. The Coding Clinic, in a letter from January 2017, stated that F01.5- (Vascular dementia) may be used as a primary diagnosis in home health (not hospice) if the underlying cause is not stated. I have not seen an update to this issued.

Q What is the latest coding guidance for a sacrum fracture with osteoporosis?

A The classification assumes that a fracture is associated, or due to, osteoporosis when both conditions exist together (unless the physician states that they are not linked). This is directed by the “with” convention. The sacrum is part of the vertebral column, so a sacral fracture in a person with osteoporosis is coded to M80.08x- (Age related osteoporosis with current pathological fracture, vertebra(e)).

Q How would you code denuded skin, unspecified?

A Denuded skin is the loss of epidermis caused by exposure to urine, feces, body fluids, wound exudate or friction. If you know the cause, such as diaper dermatitis, code it — L22 (Diaper dermatitis) in that case. If no cause is documented, and the physician will not confirm the cause, L98.9 (Disorder of the skin and subcutaneous tissue, unspecified) may be coded. Look in the alpha index under disorder: skin to find this code.
 BOARD MEMBER PROFILE

Meet AHCC Board Member
Robert Markette, Jr. JD, CHC, HCS-C, Attorney with Hall, Render, Killian, Heath, & Lyman P.C. Secretary of the AHCC Board

Q What did you do before entering home health or hospice?
A Before law school, I was a computer programmer at a small college in Indiana. After law school, I spent four years as a public defender, before joining a law firm and beginning my work with the home health and hospice industries.

Q How long have you been in home health or hospice?
A It’s a little frightening to admit, but I have been working with the home health and hospice industries for more than 17 years now. I started in it right before my daughters were born (they are twins) and they are 16 now.

Q Why did you get into this line of work?
A To be honest, I never imagined I would work representing health care providers in the areas that I handle. I started representing the industries after a friend invited me to come join a law firm she was starting. They needed an associate to handle litigation and offered to teach me about the industry.

Q What has been your biggest challenge?
A For me, the biggest challenge has been trying to adjust to the lack of due process for my clients. Having started out in criminal law, where the client gets a lot of process, and moving to representing these industries where the level of due process is much lower, was, initially, quite shocking. It can be difficult to truly help clients, when we have little in the way of a neutral third party to whom we can appeal the government’s actions. Furthermore, the rules change much more rapidly and with much less notice, which complicates advising clients. As we all know, what is compliant today, can quickly become non-compliant tomorrow.

Q What has been your biggest reward?
A I think working with these industries is a huge reward. Over the last 17 years, I have found the home health and hospice industries to be full of compassionate, caring, devoted, hard-working individuals who are committed to providing the best care to their clients while complying with the myriad of rules and regulations to which they are subject. Helping these clients continue to provide the care they do by helping them to understand and comply with these laws, or fighting with the government when the government thinks they haven’t [complied], has been extremely fulfilling for me.

Q How has the field changed since you began working in home health or hospice?
A It might be easier to list what hasn’t changed. :-) Since I started, we have seen major changes to the wage and hour laws, a new set of CoPs for both home health and hospice, a
new home health payment system, the rise of multiple new audit agencies, the rise and fall of the employer mandate, an amendment to the Americans with Disabilities Act, multiple directors at CMS, Face-to-Face, etc. The constant change can be very stressful, but it has kept my work interesting, because there is always something new.

Q: How has BMSC certification helped in your professional career?
A: Being certified in compliance is helpful, because it provides a way to demonstrate my commitment to home health and hospice compliance. I have spent a significant portion of my career assisting providers with compliance, but that experience is not obvious from the fact I am a lawyer. The credential is a way to show that I am not just someone to call after you have a problem, but someone who can help you to achieve compliance in advance and avoid the problem in the first place.

Q: What do you like most about serving on the AHCC Board?
A: To be honest, one of my favorite parts of being on the AHCC Board are my fellow board members. They are all committed to the home health and hospice industries. They are all committed to compliance. I have known all of them for many years and have a great deal of respect for all of them. Because we are all friends, when we get together it is actually a lot of fun, even if it is just a board call. Having the opportunity to serve with a group like that in an effort to help the home health and hospice industries further their compliance efforts is really great.

Q: If you have attended, how many Coding Summits or Compliance Summits have you been to? What are your favorite memories?
A: I have attended every Coding Summit during my time on the Board and all of the Compliance Summits. The Compliance Summit was something we started working on before I was on the Board, but I was quite happy to be involved with it. I have a lot of good memories of each summit. There is the annual in-person Board meeting, of course. But, also the chance to meet with members and discuss concerns, answer questions, etc. I remember the Summit in Memphis a few years ago at the Peabody. It was really neat to be able to walk a couple of blocks and listen to live music. I remember our first Compliance Summit in Chicago. That was great because we had an excellent turnout of agencies that were really excited about the idea of a home health- and hospice-focused compliance conference. It was amazing to see so many committed agencies sharing information and helping each other.

Q: If you could have any other job, what would it be?
A: Pilot/Astronaut. Before I found out my eyesight was not good enough, I wanted to join the military, fly fighters and eventually be an astronaut. I was very into aviation and space when I was a kid.

Q: What was your first job (what did you do while in high school)?
A: I was the Night Computer Operator at Harley Snyder Insurance in Valparaiso, IN. I would go in every night after the company closed and run all of the print jobs, backups, etc. At the time, I was planning on a career in IT and having that job was a pretty cool way to start. It sure beat all of my friends who were working fast food.

Q: A few of your favorite things:
A: Vacation spots: Disney World; Destin, Florida; Punta Cana
Hobby: Reading
Non-alcoholic beverage: Coffee
Foods: Anything Mexican
Activity: Spending time with my wife and kids. 💖
Meet AHCC Member
Janice Drake HCS-D, HCS-H, COS-C

I code for home health and hospice as well as perform OASIS review for Therapy and More, LLC.

What did you do before entering home health or hospice?
I worked in the customer service industry for many years. I also did graphic design for a couple of regional newspapers here in Michigan.

How long have you been in home health or hospice?
I’ve been in this industry for approximately six years.

Why did you get into this line of work?
Almost by accident! I took an office position for A.D. Maxim in 2013. I was a newbie to home health and had no idea what a positive influence Arlene Maxim was going to be on me. I was later promoted to manager of the coding branch of the company, then got my HCS-D/OASIS certifications, and later my HCS-H.

What has been your biggest challenge?
As someone who does not have a clinical background, I spent a lot of time (and still do!) studying disease processes, anatomy, physiology, medical procedures and medications so I have a full understanding of each chart I code and review.

What has been your biggest reward?
The job I do! I find it both personally and professionally enriching. An added bonus is when a friend or family member has a health situation, I am able to help them understand their condition and/or treatment and hopefully help make managing their condition a little less stressful.

How has the field changed since you began working in home health or hospice?
The biggest change I’ve seen so far is implementation of ICD-10, but PDGM is coming very soon!

How has BMSC certification helped in your professional career?
Having coding and OASIS certifications opens many doors professionally.

What do you like most about being an AHCC member?
I’ve noticed the people in our industry are very supportive of each other — we help each other when a chart stumps us. Not every profession is as fortunate to have peer support the way we do.

If you have attended, how many Coding Summits or Compliance Summits have you been to?
So far, two.
Q What are your favorite memories?
A Networking and meeting others in our industry and seeing cities I would not normally travel to.

Q What piece of advice would you offer to someone new to home health or hospice?
A Never stop studying! You are fortunate enough to be in an industry where you can learn something new and valuable every day! Not everyone is as lucky as we are.

Q If you could have any other job, what would it be?
A Costume designer or animal ‘whisperer.’

Q What was your first job (what did you do while in high school)?
A I did food prep for a small mom-and-pop restaurant in my hometown.

Q A few of your favorite things:

Vacation spots: Anywhere near a beach and water!

Hobby: Trying new gadgets, particularly if they are cooking-related or technology-related. Ask me about my Instant Pot that does sous vide or how I got my cat addicted to playing games on iPad :-)

Non-alcoholic beverage: Water — seriously!

Foods: I like trying anything new, but I particularly enjoy Thai food.

Activity: Reading, doing research on new products, particularly kitchen or tech gadgets, doing craft projects. 😊