HCAW QAPI Roundtable

Optimizing Home Health Case Conference
July 2025

home care association of washington
REPRESENTING HOME HEALTH, HOSPICE, & HOME CARE AGENCIES

Today's Facilitator:

Gira Shah, MBA-HM, PT

Providence at Home with Compassus

Regional Executive of Clinical Operations

Welcome Members!

QAPI Roundtable Committee Members:

- **Lara Safar, Clinical Director HCAW**
- **Amber Hahn-Keenan Co-Chair**
- **Gira Shah Co-Chair**
- **Deb Strom**
- **Marc Berg**
- **Geena Welch**
- **Alicia Morrison**
- **Nicole Christion**

Introductions

- Please type in the chat:
  - Name
  - Title
  - Agency

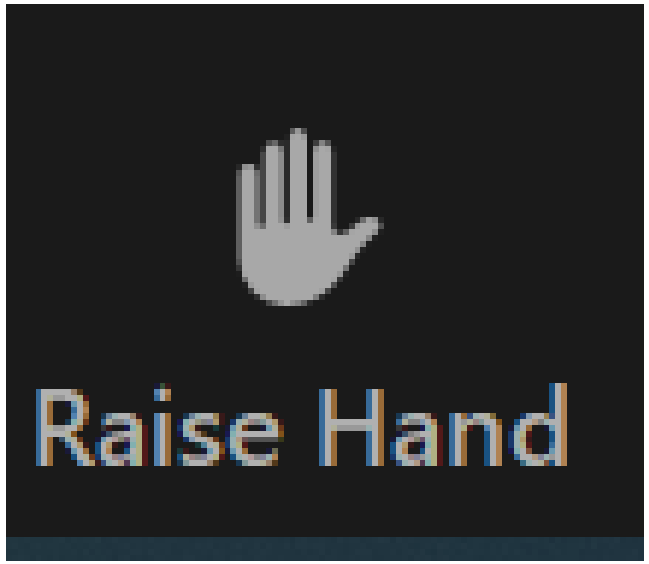
Agenda

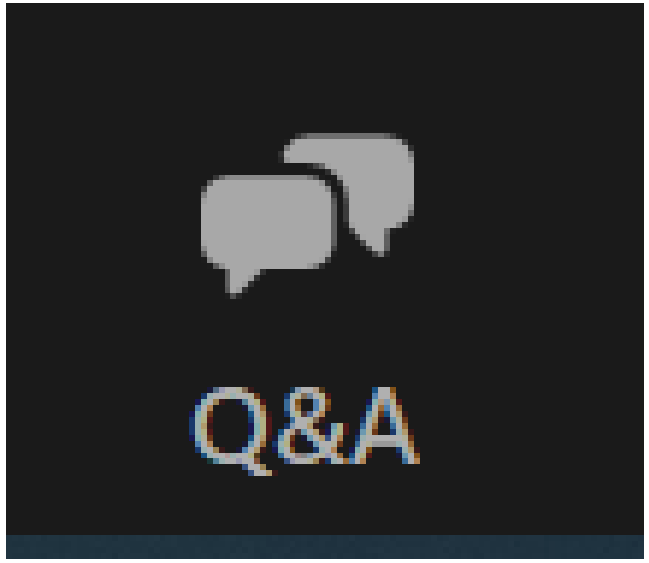
July 31, 2025, 10 am

TIME	ITEM
10:00	Welcome and Introductions
10:05	Purpose of Roundtable and ground rules
10:15	Panel Discussion
10:40	Round table (Audience participation)
10:50	Suggestions for future topics
11:00	Adjournment

Ground Rules

- Assume good intent; we are discussing areas needing growth/improvement so remember to take the high road.
- Be succinct; so more of us can participate in the discussion
- Use the chat function to enter a comment, support a point of view, or ask a question
- Be prepared to share your contact information with the group—encourage other members to learn more about how you are approaching the subject(s) of the month.
- Maintain confidentiality; discuss the learnings, not the agency
- Share best practices with others to elevate patient care throughout Washington
- Share barriers to allow group problem solving
- Make connections to partner outside of the roundtable for individual improvement projects





Q&A

- All Q&A will be managed using Zoom Q&A and addressed at the throughout the presentation
- If you need our attention or have an immediate question, use the “Raise Hand” feature

Regulatory Foundation

Conditions of Participation (CoPs)

Under 42 CFR §484.60, CMS requires:

- Interdisciplinary Team (IDT) must include the disciplines relevant to the case.
- Case conferences must occur at least every 60 days, or more frequently based on patient needs.
- The purpose is to coordinate care, review progress, and revise the plan of care.
- Documentation must include date, participants, discussion points, and outcomes.

Regulatory Foundation:

§ 484.60 Condition of participation: Care planning, coordination of services, and quality of care:

(c) Standard: Review and revision of the plan of care.

(1) The individualized plan of care must be **reviewed and revised by the physician or allowed practitioner** who is responsible for the home health plan of care and the HHA **as frequently as the patient's condition or needs** require, but no less frequently than **once every 60 days**, beginning with the start of care date. The HHA must promptly alert the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

Interpretive Guidelines

In the event of a change in patient condition or needs that suggest outcomes are not being achieved and/or that the patient's plan of care should be altered, the HHA should notify both the responsible physician *or allowed practitioner* and the physician(s) *or allowed practitioner(s)* associated with the relevant aspect of care.

Changes in physician *or allowed practitioner* orders during the plan of care certification period do not automatically restart the timeframe for physician *or allowed practitioner* review of the plan of care.

(2) A revised plan of care must reflect current information from the patient's updated comprehensive assessment and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.

(3) Revisions to the plan of care must be communicated as follows:

(i) Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians or allowed practitioners issuing orders for the HHA plan of care.

Interpretive Guidelines

There must be evidence in the clinical record that the HHA explained to the patient that a change to the plan of care has occurred and how the change will impact the care delivered by the HHA. The clinical record must also document that the revised plan of care was shared with all relevant physicians *or allowed practitioners* providing care to the patient.

(ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians or allowed practitioners issuing orders for the HHA plan of care, and 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 (if any).

Interpretive Guidelines

Discharge planning begins early in the provision of care and must be revised as the patient's condition or life circumstances change. There must be evidence in the clinical record that the HHA discussed any such changes with the patient, his or her representative (if any) and the responsible physician *or allowed practitioner*. Other physicians *or allowed practitioner(s)* who contributed orders to the patient's plan of care must also be notified of changes to the patient's discharge plan

Regulatory Foundation:

§ 484.60 Condition of participation: Care planning, coordination of services, and quality of care:

(d) Standard: Coordination of care. The HHA must:

(1) Assure communication v **n of care**.

Interpretive Guidelines

The physician *or allowed practitioner* who initiated home health care is responsible for the ongoing plan of care; however, to assure the development and implementation of a coordinated plan of care, HHA communication with all physicians *or allowed practitioner* involved in the patient's care is often necessary. While a patient may see several physicians *or allowed practitioner(s)* for various medical problems, not all the physicians *or allowed practitioner(s)* would necessarily be involved in the skilled services defined in the patient's home health plan of care. *Regarding* this requirement, "physicians *or allowed practitioners* involved in the plan of care" means those physicians *or allowed practitioners* who give orders that are directly related to home health skilled services.

(2) Integrate orders from all physicians or allowed practitioners involved in the plan of care to assure the coordinati

Interpretive Guidelines

The clinical manager or other staff designated by the HHA is responsible for integrating orders from all relevant physicians *or allowed practitioners* involved into the HHA plan of care and ensuring the orders are approved by the responsible physician *or allowed practitioner*.

(3) Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.
(4) Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.

(5) Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.

Interpretive Guidelines

The comprehensive assessment, patient-centered plan of care and the goals identified therein inform the training and education objectives for each patient. The goals of the HHA episode are established at admission and revised as indicated by the patient's condition. With the discharge plan clearly identified, patient education and documentation of the patient response to the education begins upon admission and continues throughout the provision of HHA services. The HHA must monitor patient and caregiver responses to and comprehension of any training provided.

Poll

In one word, how would you describe your current IDT/Case conference process?

What's one thing you wish your IDT/CC meetings did better?

VISIT TYPE	Disciplines	ADDED BY	COMMENTS
SOC			
ROC			
RECERT			
DISCHARGE			

1. When adding the patient to the table, please put your name in the 'added by' column to get credit for your contribution.

2. Please add your patients to each visit type based on your upcoming plans for recert/discharge. If you have a patient that you'd like to discuss further, please add to the appropriate visit section then **BOLD** the name so the team will know this patient will be discussed during our meeting.

3. If you have a safety concern or concerns/barrier concerns about a patient, please add them to the complicated/barriers section. Please be mindful about discussion time. If you believe this patient requires more coordination, we encourage a separate breakout session/meeting between the appropriate care staff.

4. If discussing a discharge, please **BOLD** OASIS discharge patients, so we can discuss NOMNC delivery and discipline completing the final discharge.

Patient Name	MRN	Case Manager	Upcoming ReCerts 6/16-6/29	DC Clinician 6/29-7/5	Our visits vs SHP Avg	At Risk for LUPA	NOMNC Date & Clinician	Undocumented Visits (2wk)	Palliative Care Referral Date	Active Providers	CCA Patients/Concerns	Comments
LPN/PTA/COTA/HHA Supervisory Visit Reminder! EVERY VISIT PLEASE (if we are late we can not bill for the visits)												

Examples

Innovation & Future Thinking

- How are you preparing for future changes in home health regulations or technology that may impact IDT/Case conferences?

Compliance & Best Practices

- How does your agency ensure compliance with the regulations?
- What strategies do you use to document IDT meetings effectively for survey readiness?
- Who here has had a surveyor ask specifically about your case conference documentation? What was the finding and how did you address it?

Round Table…

Contact Marie Schmidt of HCAW at info@hcaw.org for more information.

Quality & Outcomes

- How do you measure the effectiveness of your case conferences?
- How do you balance the “cost” of case conference with the outcomes of the meeting?
- If you have a formal “meeting”, how do you select patients for discussion?

Team Dynamics & Communication

- How do you foster meaningful interdisciplinary collaboration during case conferences, rather than just checking a box?
- What tools or platforms (e.g., EMRs, virtual meetings) have improved your IDT collaboration?
- Have you tried any creative formats—like virtual breakout rooms, rotating facilitators, or patient-involved discussions?
- What's the biggest barrier your team faces in holding effective case conferences—and how have you tried to overcome it?

Thank you!

Contact Marie Schmidt of HCAW at info@hcaw.org for more information.