Executive Director
Susan K. Yoder, Ph.D., R.N.

Salem Area Visiting Nurse Association

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CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulatory Development - B
Attention: William N. Parham
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Parham

You state in "*Paragraph (g), which requires that a written summary report for each patient be sent to the attending physician every 62 days, imposes a burden of 3 minutes per patient.*" If I look at the process in our agency, that is totally impossible. Our computer system gathers the information for us. However, the time to print the form, collate the form, sign the form and prepare it for delivery far exceeds three minutes.

The requirements or paragraphs (a) and (b) for a clinicians' involvement in the development and review of plans of care established by a physician is estimated at 5 minutes per admission. Truly, if our clinicians only spent five minutes in the creation of the plan of care, there would be a plan with one item. To create a reasonable plan of care requires approximately one half hour. Orders must be entered into the computer system. Care plans must be created from those orders. As you know, time trials have been done which support the concept that even a hunt and peck typist can type faster than they can write. Therefore, the case cannot be argued that the increase in the burden is computer based.

Reporting OASIS information. CMS-R-209: Approved by OMB (OMB Control #: 0938-0761)
The requirements under §484.30, §484.32, §484.34 and §484.38 are intended to ensure quality of care, and are commonly accepted as good medical practice, and therefore impose no burden on HHAs as they would be performed even in the absence of Federal regulations. In the absence of the mandate to answer the OASIS questions, there would be no OASIS questions. We would return to using only the clinical documentation that we now use in addition to the OASIS documentation. Adequate documentation can occur in the absence of OASIS. What cannot occur is tabulation of uniform documentation across agencies. Answering OASIS questions in addition to the other documentation will add at least 20 minutes to an admission. Staff is jubilant when there is no OASIS mandate as it significantly shortens the length of an admission.

I would encourage any person who is creating the estimates of the time needed to meet these requirements to actually go with a clinician into the field and observe what is done for the patient. Once they have seen the admission and followed the paperwork through the processes necessary to meet the requirements, the time estimates will be more realistic. We would welcome you or your representative to our agency.

Sincerely,

Marjory S. Greenisen, BSN, RN
PI Coordinator

United Way

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Joint Commission
on Accreditation of Healthcare Organizations

LEHIGH VALLEY HOSPITAL AND HEALTH NETWORK

Lehigh Valley Home Care

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CHAP Accredited
State Licensed
Medicare Certified

June 22, 2007

CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulatory
Development B
Attention: William N. Parham
Room C4-26-05
Baltimore, MD 21244-1850

Dear Sir/Madam;

We write to comment on the proposed estimates from the CMS Paperwork Reduction Act (PRA).

The experience in our agency has been the following (ours are **bolded and underlined**)

- Demonstrating compliance with the patient rights requirements takes about **10** minutes per admission.
- Completing and sending the written summary report to a physician takes **five** minutes per patient.
- A clinician spends **fifteen** minutes per admission developing and reviewing the initial plan of care. **(The CMS does not mention updates of the plan of care.)**
- The burden for home health professionals to conduct the quarterly record review is about **one hour** per quarter for each agency.
- An agency spends **one hour** taking and recording minutes of the meeting of professional personnel, more commonly known as the Professional Advisory Committee, and another **one hour** recording the minutes of the annual evaluation.

Thank you for the opportunity to comment on the proposed rule.

Yours truly,

Sherry Reifsnyder
Secretary to Peg Stroup,
Director of Quality Management

Burnett County Department of Health and Human Services

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Rob Rudiger Acting Directo
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Adult Services

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Birth to Three

Children and Families

Economic Support

Home Health Care

Job Center

Mental Health/AODA

Public Health

WIC

To: CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulatory Development –B
Attention: William N Parham
Room C-4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Regarding estimates of CMS paperwork.

I'm not sure what the estimates mean, where the numbers come from, or what tasks are being considered as part of the estimate. But I have some comments from my experience as a Home Care Administrator, and working in home care for the past 27 years.

1. Compliance with demonstrating a client's rights- estimated as taking five minutes. It takes over five minutes to read the rights to an elderly person who is hard of hearing, and to explain how we comply with the rules and regulations can take at least another five minutes, if the client has questions that can easily add another five minutes.
2. Completing and sending a report to a physician taking three minutes is ridiculous. The report is supposed to include progress of the past 60 days. Addressing the envelope may take three minutes. Gathering the information and writing the report usually takes us more like thirty minutes.
3. Developing and reviewing a plan of care is estimated as taking five minutes. Can you read a list of 20 medications, with all the side effects, teaching needs and interaction/contraindication in five minutes? Much less write it all. And the medication is only part of the POC. We also have to code the diagnoses, figure out the best way to care for them, cover all the possible needs we might encounter over 60 days and formulate achievable goals. It usually takes about 2 hours to complete the research and writing of a simple plan of care. If the client is complicated, and most of them are, it will take the experienced nurse about four hours to complete.
4. The burden of record retention is probably three minutes if the action is just filing the chart. But where did this chart come from? Does the time it takes to write the information count? We are spending more time recording our work than we do completing the tasks.
5. The quarterly record review estimate as ten minutes is ridiculous. We have to audit 10% of the case load or 10 charts minimum. Ten minutes per quarter allows one minute per chart. This isn't much of an audit. It usually takes about one hour to read through a chart and complete the form.

6. The advisory meeting notes are taken during the meeting which lasts at least an hour. The clean up and typing of the minutes usually takes about 10-15 min. Please release information about how CMS arrived at these numbers, I'd like to be able to work that fast. Maybe you could put on classes showing us how to achieve this level of productivity.

Thank you for your time,

Cathryn Sundquist RN
Home Care Administrator
Burnett County Health and Human Services

Wyandot County Home Health Agency
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Upper Sandusky, Ohio 43351
Phone: 419-294-3881
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June 22, 2007

CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulatory Development-B
Attention: William N. Parham
Room C4-26-05
Baltimore, MD 21244-1850

Dear Mr. Parham:

I am writing in response to the posted CMS Paperwork Reduction Act (PRA) comments.

I have to admit this is the first time I have ever written in response to any CMS comments or contacted any representative. I feel that CMS representatives along with governmental representatives have no idea what it is really like to comply with all of the regulations. I guess this is my opportunity to make it known.

Wyandot County Home Health Agency is a small rural home care agency which has been in existence since 1966. I have been with the agency over 20 years and know very well the impact the changes have made. I will try and make this brief.

- ✓ Compliance with patients rights: **CMS states 5 minutes**—I agree
- ✓ Completing and sending summary report every 60 days: **CMS states 3 minutes**—it takes 3 to 5 minutes for RN to complete then 2 to 4 minutes for front staff to prepare envelope and postage to mail. If faxed 2 to 3 minutes to load, punch in number and obtain a confirmation and then all this has to be filed in the record.
- ✓ Developing and reviewing initial plan of care. **CMS states 5 minutes** to complete. I am Director and also a staff person. I have been doing this long enough to become proficient. To complete number 21 and 22 on the 485 (the remainder comes over from the oasis) takes at least 15 minutes. If CMS wants individualized care plans the nurse has to put some thought into this and just not use a pre-written catch all care plan. You must also add the time it takes the clerk to print, stuff in envelope and postage.
- ✓ Storing clinical records: **CMS-minimal burden**—for our agency I have to agree as we have the space. This may not be the case for other agencies.

- ✓ Conducting quarterly record reviews: **CMS states 10 minutes--**A quarterly record review of a chart is a review of the entire chart from front to back to assure it is complete in its entirety. There is no way, even on a "thin chart" that it can be completed in 10 minutes. For us, the average review will take at least 45 to 50 minutes.
- ✓ Time allocated for the Professional Advisory Committee**: CMS 10 minutes to take minutes**—at our agency, we allocate 1 hour for the meeting at which the Office Manager attends and takes minutes. The Director is also present along with our billing clerk who compiles statistics as far as number of patients, visits etc. It is not just the time to take the minutes; the paperwork to complete to update the committee takes at least an hour to compile.

I realize that many of these mandates are needed and do not dispute the usefulness of these tasks. I do feel that a more honest evaluation of time needs to be attributed to these tasks.

Thank-you for your time,

JoAnne Yeater
Director

BARRY
Healthcare Services, Inc.
The Professional Source of Nurses

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June 22, 2007

CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulatory Development – B
Attention: William N. Parham
Room C4-26-05
Baltimore, MD 21244-1850

Dear Mr. Parham.

I had a chance to review some of the estimates from the CMS Paperwork Reduction Act associated with the home health conditions of participation and am very concerned as to the inaccurate information being relayed.
For example: *Demonstrating compliance with the patients rights requirements takes about five minutes per admission.* In most situations the nurse has to read them all to the patient, answer questions and have it signed. At a minimum it takes 20 minutes, the longest it has taken at our agency is one and a half hours.
Completing and sending the written summary report to a physician takes three minutes per patient. Considering that the patients name, address and phone number need to be updated (we have a significant population that moves at least two times a year) , the physicians name, address, phone, fax number altered as needed (many of our older patients go to clinics for care with rotating doctors assigned to them-this information can change monthly. All medication changes, additions, deletions, dose changes have to be added, our "average" patient has 12 medications some patients are well over 20 medications. All equipment and supplies need to be updated. A summary of all services provided, patient physical, mental, psycho-social status, response to teaching, compliance with the plan of care, concerns/complaints, any changes in goals, services provided. This documentation for a patient without any changes needs to be verified as correct, matched up with the previous orders and accurate taking at a minimum fifteen minutes to fifty minutes for a patient with changes.
A clinician spends five minutes per admission developing and reviewing the initial plan of care. Development of this plan of care involves contact and discussion with the physician-getting through can take thirty minutes easily, much less the actual discussion and writing the plan up.
There is a "minimal burden" associated with retention of clinical records merely entails the filing of a copy of the record a total of three minutes per patient.
We need to file doctor's orders as they are signed and returned, nursing visit notes (sometimes two times a day visits, to 60 day visits), Home Health Aide notes and

Personal Care Worker notes. We update the medication list and care plans as they need it. I would estimate a minimum of fifteen minutes a week but an average would be twenty five minutes per chart would be more likely.

Please know that the estimated time frames were very low and from my perspective inaccurate. I would certainly hope that those of us that actually do the work on a daily basis would be consulted so the time estimates can be based in reality. CMS needs to have accurate information to base decisions and actions on.

I appreciate the opportunity to share this information with you.

Beth Huettig RN
Director of Clinical Services

June 26, 2007

Dear Mr. Parham,

In response to CMS' estimates CoP Cost Burdens, I am offering an update to the estimates listed in the CMS Paperwork Reduction Act supporting statement.
Being responsible for auditing both electronic and paper charts from multiple agencies, I am elaborating on the processes that I am involved in either directly or indirectly.

1. A quarterly record review takes much more time than 10 minutes. Each chart review takes approximately 45 minutes to 90 minutes to do and adequately cover components that are mandated in the CoPs.
2. To be able to demonstrate compliance with patient rights assumes that the patient has been given an accurate and thorough review of their rights, which takes approximately 15 to 20 minutes, assuming an interpreter is not needed.
3. Completing and sending the written dc summary to a MD requires a team effort. The clinician can write it in 3 to 5 minutes, but then the office staff has to coordinate and actually send the report which could be another 15 to 30 minutes.
4. A clinician will spend at least 20 minutes developing and reviewing the initial plan of care to ensure that it is completely addresses the primary and secondary diagnoses and other pertinent factors.
5. The retention of clinical records is an elaborate process that requires extensive amount of time. For example, a single supplementary order may go through the hands of 3 to 5 people before it is signed and filed back in the chart. A paper chart requires extensive filing management from the SOC to the archiving of records into storage.
6. An agency can spend multiple man hours to coordinate the data that is presented in a PAC meeting. The individual must then sit in the meeting to take minutes (60 minutes for the meeting and another at least 2 hours to finalize the notes).

I anticipate that this letter provides more input on the amount of man hours that are required to meet these regulations.

Sincerely,

Enny Simmons

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Enny Simmons, BSN, MSN, RN
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ST. MARY'S
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June 25, 2007

Mr. William N. Parham
Room C4-26-05
7500 Security Boulevard
Baltimore, MD 21244-1850

Dear Mr. Parham:

I am writing today to comment on the burden associated with the Home Health Care Conditions of Participation and the estimates from the CMS Paperwork Reduction Act supporting statement. As a CMS provider I fell it is essential that I comment on the actual time it takes for clinicians in the field to complete the regulatory requirements of their job. The bullets represent the actual time it takes clinicians to accurately and completely fulfill the following:

- Patient Rights – This requires review as well as discussion of the rights of the patient prior to services rendered. The actual time ranges between 10-15 minutes per patient.
- The Written Summary Report to the Physician – The completion of the summary report requires 12-15 minutes per patient and this does not include preparing for delivery to the physician which is another 5 minutes. Previous State Surveyors require documentation of the Summary Report being mailed to the physician and this requires additional intervention.
- Development and Review of Plan of Care – 30 -45 minutes of clinical time is spent developing an individualized plan of care. Patients have additional co-morbidities as well as treatments that require additional interventions. An example is a plan of care I reviewed today that had 26 medications for one individual. A plan had to be carefully developed to accommodate this individuals needs.
- Retention of the Clinical Record – Filing is not the important component of this measure. It is really the completeness of the document. Most agencies develop a quality indicator to assure the record is complete upon discharge and prior to submission of a claim. This actually involves 10 minutes per record.
- Professional Advisory Council – The actual time of our meeting is 30 minutes. The group is well-informed and has numerous questions of the staff each meeting. They feel committed to keeping the community aware of Home Health Care. The annual evaluation meeting may last 45-60 minutes depending on the dialog of participants. The minutes involve 30 minutes as well and occur during the meeting then there is a review time.
- Quarterly Clinical Review – Our clinicians review 6 records per quarter. We feel it is essential that they be a part of the quality process. The actual time of review 20 minutes per record or 120 minutes per quarter.

Thank you for your consideration of our information. We consider ourselves to be a valuable provider to your beneficiaries and feel honored to be a part of the CMS team.

Sincerely,

Beverly Falls, PT

Beverly Falls, PT
Manager, St. Mary's Home Health Care

HUDSON VALLEY REHABILITATION AND EXTENDED CARE CENTER – LTHHCP

260 Vineyard Avenue, Highland, New York 12528 **Tel: (845) 691-9225**
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June 22, 2007

CMS Office of Strategic Operations &Regulatory Affairs
Division of Regulatory Development – B
Attention: William N. Parham
Room C4-26-05
Baltimore, MD 21244-1850

Dear Mr. Parham:

This is in response to the CMS estimates on the burden associated with Home Health Agencies Conditions of Participation.

1. CMS estimates five minutes per admission for Home Health Agencies to demonstrate compliance with the patient rights requirements. **Our LTHHCP estimates 15 minutes.**

2. CMS estimates three minutes per patient to complete and send a written summary report to a physician. **Our LTHHCP estimates 15 minutes.**

3. CMS estimates five minutes per admission for a clinician to develop and review the initial plan of care. **Our LTHHCP estimates it takes at least 45 minutes.**

4. CMS states there is a "minimal burden" associated with retention of clinical records and estimates a total of three minutes per patient. **Our LTHHCP estimates 30 minutes.**

5. CMS estimates it takes ten minutes for a home health professional to conduct the quarterly record review. **Our LTHHCP estimates 3 hours.**

6. CMS estimates an agency spends ten minutes taking and recording minutes of the Professional Advisory Committee. **Our LTHHCP estimates it takes 1 hour.**

7. CMS estimates a HHA spends ten minutes recording the minutes of the annual evaluation. **Our LTHHCP estimates it takes 1 hour.**

Respectfully,

Jane V. Neubecker, BSN

William N. Parham
CMS Office of Strategic Operations and Regulatory Affairs
Division of Regulatory Development – B
Rm C4-26-05
7500 Security Blvd
Baltimore, MD 21244-1850

Dear Mr. Parham,

I recently learned of your estimates regarding the cost burden on home care agencies for implementing certain conditions of participation. Below is information about the amount of time our agency's staff spends on ensuring compliance. Our agency is a "frontier" agency with 25 to 30 admissions per month. Our clinicians each travel 600 to 900 miles per month in order to see patients. The documentation/regulatory burden has resulted in staff spending more time documenting than in actual patient care. Using an electronic health record has added time, not decreased it.

1. Demonstrating compliance with patient rights requirements:
   One to three hours per patient.
   A. Explanations of patient rights to aged patients—including answering questions and ensuring that patients understand:
      15 to 20 minutes per patient depending upon the patient's ability to comprehend
   B. Explanations of advance directives, grievance procedures, and establishing goals, priorities, and responsibilities with the patient and caregivers:
      5 to 15 minutes per patient or longer depending upon how much the patient and caregiver are capable of understanding and willing to participate in the plan of care.
   C. Documenting the above using an electronic health record
      10 to 12 minutes per patient admit
   D. Auditing for evidence of compliance with patient rights
      5 minutes per patient if and only if evidence of compliance in all areas is present. If it isn't, it may take up to an hour of follow up activities over the course of a week or more. This usually happens when patients and/or referral sources do not provide copies of Advance directives after indicating that they have Advance Directives.
2. INITIAL Development and review of the plan of care
   60 to 90 minutes per patient on average spent in development alone—not including conferencing with other staff involved, the physician, and the patient or documenting the plan of care. This is because **a plan of care can not be developed without assessing a patient . Therefore assessment is part of developing the initial plan of care.**

Review of the plan of care: 20 minutes: This includes reviewing the plan of care with other staff involved, the patient care supervisor, and the physician.

3. Completing and sending written summary reports to the physician:
   About 10 minutes per summary depending upon the clinician.

4. Record reviews: Includes quarterly record reviews, admission chart reviews and discharge chart reviews. All in order to ensure compliance. Two to four hours per chart audited, approximately 60 to 120 hours per month in chart audits.

Quarterly record reviews average 60 hours per quarter with 20% of open and closed charts being audited.

5. Taking and recording minutes of the meeting of professional personnel.
   I spend, on average, 20 hours preparing the annual report--- including typing it.
   I spend 45 minutes per meeting typing minutes.

Michelle Morin RN, Director
Spearfish Regional Hospital Home Care
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Spearfish, South Dakota 57783