5 STAR CONSULTANTS
HEALTHCARE SPECIALISTS

Navigating the Home Health CoP Maze

KHCHA – September 19, 2019

Presented by:
Sharon M. Litwin, RN, BSHS, MHA, HCS-D
Senior Managing Partner
5 Star Consultants, LLC

**For any problem,
No matter how big or complex it may be, there is a solution**

Earl Nightingale

Introduction

- Review the Home Health CoP's a Year and a Half after implementation
- Types of deficiencies reviewed
- Examples of common deficiencies and/or vulnerabilities seen in Agency
- What can your Agency do to avoid deficiencies?
- Discussion of what processes your Agency has implemented to comply with the difficult CoP's

Home Health Survey Process, CoPs, Deficiencies & Action Plans

5 STAR CONSULTANTS
HEALTHCARE SPECIALISTS

Deficiencies

- Types:
  - Standard Level
  - Condition Level
  - Immediate Jeopardy (IJ)
- Increase in Condition Level Deficiencies and IJ seen
- Can Lead to Non Monetary and/or Monetary Sanctions
- SOM- Appendix Q- guidance for identifying immediate jeopardy revised 3/2019
  - IJ increased to $21,800 per day per citation!

Level 1 Standards - Highest Priority Standards

- Process standards that are associated with high-quality patient care, and
- Administrative standards that closely relate to the agency's ability to deliver high-quality patient care
- Surveyors must review all of these standards during a standard survey
- Examples:
  - Investigation of complaints
  - Initial assessment visit
  - Plan of care

Top Federal Citations

- G536 - POC Includes Review Of Current Medications
- G572 - Each Patient Has An Individualized POC Signed By Doctor
- G574 - Components Of POC
- G580 Drugs/Treatment Services Administered Only As Ordered By Physician
- G584 - Verbal Orders Accepted In Compliance With State Laws & Regulations /Home Health Policies

Top Federal Citations

G590 - Promptly Alert Relevant Physician Of Changes

G608 - Care Coordinated To Meet Patient Needs

G682 - Precautions To Prevent Transmission Of Infections & Communicable Diseases

G710 - Services To Be Provided In Accordance With POC

G716 - Clinical Notes

§484.105 Organization & Administration of Services

Standard – G978 - (e)(2) Services Under Arrangement

Written Agreement - The agency, organization, or individual providing services under arrangement may not have been:

- (i) Denied Medicare or Medicaid enrollment;
- (ii) Been excluded or terminated from any federal health care program or Medicaid;
- (iii) Had its Medicare or Medicaid billing privileges revoked; or
- (iv) Been debarred from participating in any government program.

❖ *Ensure you add to contracts and verify that contracted agencies or individuals meet this new part of the standard.*

§484.110 Clinical Records

G1018- (a)(4) - Contact information for the patient, ***the patient's representative (if any)***, and the patient's primary caregiver(s)

- ***Deficiency***: In 12 of 12 records, there is no information documented that patient had been asked - and if the patient wanted a patient selected representative.
- Staff interview- 2 of 3 did not know about a patient selected rep & the need to have them involved as the patient wishes. They also did not know where they were to document this.
- *Pt must be asked if they want a patient selected rep with documentation in the clinical record.*
- *This should be established at admission time & communicated to all staff involved in the plan of care.*

G1030 - (e) Retrieval of Clinical Records

- A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, **free of charge**, upon request at the **next home visit, or within 4 business days (whichever comes first).**

- *Ensure you have a process for this, as it necessary to have it before next visit.*
- *This is probably to be changed - the next home visit to be removed.*

G1022 - Standard - (a)(6) Contents of Clinical Record Discharge & Transfer Summaries

- Ensure a completed discharge summary is sent to the 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) within 5 business days of the patient's discharge
- For Transfers - A completed transfer summary that is sent within 2 business days of a planned transfer or 2 business days of becoming aware of an unplanned transfer.

❖ ***Have a Tight Process in Agency to track days in order to ensure timeliness!***

§484.45 Reporting OASIS Information

Standard – G372 - (a) Reporting OASIS Information

HHAs must electronically report all OASIS data collected in accordance with § 484.55

- An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary……**within 30 days** of completing the assessment of the beneficiary.

Deficiency - G372 – (a) –Encoding & Transmitting OASIS

- 20 of 160 OASIS- 12.5% (> 10%) transmitted did not show evidence they were transmitted within 30 days of completing the assessment of the beneficiary. OASIS validation reports contained a warning for these OASIS for transmission greater than 30 days.

- ***If the required quality data is not reported by each submission deadline, the HHA will be subject to a 2% reduction in their Annual Payment Update.***
  - *It will be extremely critical under PDGM to ensure that there is a process for sending all patients in regularly, recommend weekly, in order to keep the Quality Assessments in compliance.*

§484.50 Patient Rights

G410 - (a)(1) Notice of Rights

Provide the patient & the patient's legal representative (if any), the following information during the initial evaluation visit, ***in advance of furnishing care to the patient:***

Deficiency:

- *In 1 of 5 clinical records review, the patient's legal representative was in a different state than the patient.*
- *There was no evidence that the Agency provided the written rights and responsibilities or the OASIS privacy notice to the patient's legal representative in advance of providing care to the patient.*
- *The Administrator confirmed that the HHA had not been able to contact the patient's legal representative until after services for the patient began.*

G434 - (c) Rights of the Patient

(4) **Participate in, be informed about, and consent or refuse care <u>in advance of and during treatment</u>,** where appropriate, with respect to:

- (ii) The care to be furnished, based on the comprehensive assessment;
- (iii) Establishing and ***revising*** the plan of care;
- (iv) The disciplines that will furnish the care;
- (v) The frequency of visits;
- (vi) ***Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits***;
- (vii) Any factors that could impact treatment effectiveness; and
- (viii) Any changes in the care to be furnished.

Deficiency - G434 - (c)(4) – Participate in Care

- 6 of 10 clinical record reviews did not have documentation that the patient had the right to, participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate.
- There was no evidence of the patient being informed of the frequency of proposed disciplines.
- The Home folder consent or other documentation signed by the patient did not state the disciplines or frequency of visits.
- Consent form signed at SOC is blank in areas of discipline frequency and no evidence in subsequent documentation of frequency.

Deficiency - G436 - (c)(5) Receive All Services Outlined In the Plan of Care

- On Home Visits, there was no evidence that patient had the major aspects of the plan of care in the home folder, including medication list, treatments, changes in frequency of services, etc.
  - Ties to Written information given to patient in 484.60(e)

❖ ***Tips for Compliance***
❖ Must ensure that you have ongoing updates in the patients' home folders with meds, treatments, calendar.
❖ If your EMR does not have a patient friendly method of updating all timely, you may have to implement a paper POC update form

G440 - (c) Rights of the Patient

(7) Be advised of: Payment, charges not covered, co-pays, etc.

(iv) Any changes in the information provided when they occur.

The HHA must advise the patient and rep (if any), of these changes as soon as possible, ***in advance of the next home health visit.***

Deficiency:

- 10 of 17 did not have evidence of documentation in the patient record that before the care was initiated, the HHA informed the patient, orally and in writing, of financial requirements and expectations.
- Consent form signed at SOC is blank in area of Patient Payor.

G446 - (c)(10) Rights of the Patient

Names, addresses, & telephone numbers of the following Federally & State-funded entities that serve the area **where the patient resides**: (i)Agency on Aging,….(v) QIO

Deficiency:

- Home folders did not include that the patient was advised of the names…..
- There was no evidence in the clinical record that the agency provided the patient of the names….for the territory in which the patient lives.

§484.55 Comprehensive Assessment of Patients

G514 - (a)(1) - Initial Assessment Visit

- RN must conduct an initial assessment visit to determine the immediate care & support needs of the patient; For Medicare patients, ***to determine eligibility for the Medicare HH benefit***, including homebound status.
  - Within 48 hours of referral, or within 48 hours of the patient's return home, ***or*** on the physician-ordered start of care date.
- If Therapy Only & if the need for that service establishes program eligibility (i.e., an OT cannot do), the initial assessment visit can be Therapist.

❖ ***Check for an Acceptable Diagnosis in the FTF and on Initial Assessment, as well as a Skilled Need !***

Interpretive Guidelines – G514 - (a)(1) Initial Assessment Visit

- An HHA that is unable to complete the initial assessment within 48 hours of referral or the patient's return home, shall not request a different start of care date from the ordering physician to ensure compliance with the regulation or ***to accommodate the convenience of the agency.***

❖ ***Tips for Compliance***

❖ *HHA processes have to define referral acceptance in line with staffing availability.*

❖ *If Agency doesn't have the staff to meet the deadlines, they should not accept the referral.*

Deficiency - G514- (a)(1) – Initial Assessment Visit

- 4 of 10 clinical records did not have the initial assess visit within 48 hours of referral, within 48 hours of the patient's return home, or on the physician-ordered start of care date.
- These patients were referrals on a Friday and the physician was asked to initiate services on Monday due to HHA staffing over the weekend. The physician did approve this.

❖ However, this is staffing for agency convenience and not the actual physician order.

G530 (c) Content of the Comprehensive Assessment- Must include, at a minimum, the following information:

- *Patient's strengths, goals, & care preferences, including the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA*
- Patient's continuing need for home care
- Patient's primary caregiver(s), if any, &other available supports, including their:
  - (i) Willingness and ability to provide care, and
  - (ii) Availability and schedules

POC Documentation: Patient Strengths, Goals, Care Preferences

- Patient self-stated strengths-
- Ask the patient "What are your strengths?"
  - This empowers the patient to take an active role in their care
    - Patient "My strength is my daughter; I want to get better so she doesn't need to help me so much"

POC Documentation: Patient Strengths, Goals, Care Preferences

- Patient self- stated goals and care preferences:
- Ask the patient "What are your goals?"
  - This engages the patient to take an active role in their care rather than a passive role
  - Patient "I want to be able to walk around my house without using this walker; and I'd like it if the therapist could visit on Tues & Thurs as my daughter will be here on those days"

Plan of Care Documentation: Patient Strengths, Goals, and Care Preferences

- Include details regarding:
  - Care preferences of the patient and/or representative
  - Specific personal goals the patient would like to achieve during the Home Health episode
  - Are the personal goals realistic based on the patient health status?
  - Do the personal goals need to be modified based on the patient health status?
    - If so, be sure to document discussion with patient regarding this.

Plan of Care Documentation: Patient Measurable Goals and Outcomes

- Patient will verbalize understanding of s/s of exacerbation of CHF to report to physician of increased SOB, weight gain of 2lbs/day or 5lbs/week, increased swelling of legs - by the end of week 2
- Patient spouse will verbalize understanding of techniques for pressure prevention including: change positions frequently, keep skin clean/dry, adequate intake of protein, inspection of skin, use of skin protectant - by the end of week 2
- Pt will ambulate 150 ft with use of cane on level surface by the end of week 3.
- Pt will achieve 90 degrees of knee flexion AROM by the end of week 2

Plan of Care Documentation: Patients Risk for Emergency Visits and Re-hospitalizations

- "The patient is at risk of emergency department visits and hospital re-admission due to recent cardiac surgery/stent placement, lack of understanding of medication regimen, and lack of transportation to medical appointments."
- POC Interventions
  - Instruct patient in cardiac disease management, s/s infection to catheterization site to report, medication regimen, referral to Social Service to assist with transportation needs

Emergency Preparedness (b)(1) The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at § 484.55.

- Deficiencies are seen with lack of or incomplete Individualized Emergency Preparedness plans in Clinical Records and Home Visits
- ***Tips for Compliance***
- *Ensure that the tool for the Individualized EP plans include sufficient categories for staff to utilize with patient.*
- *Audit clinical records and patient home folders for patient EP plans.*

G530–(c) Content of the Comprehensive Assessment

(Cont)

- (4) (5) ***A review of all medications*** the patient is currently using in order to identify any:
- Potential adverse effects and drug reactions,
- Including ineffective drug therapy,
- Significant side effects,
- Significant drug interactions,
- Duplicate drug therapy, and
- Noncompliance with drug therapy

Interpretive Guidelines - G536- (c)(5) - Review of All Current Medications

- The HHA should have policies that guide HHA clinical staff in the event there is a concern identified with a patient's medication that should be reported to the physician.
  - *Including Significant Drug-Drug interactions- What Severity Level ? When and how do you notify physician and get return communication?*
- Therapist must submit a list of patient meds to an HHA nurse for review.
- The HHA should contact the physician if indicated.
  - *The RN needs to document the Med review in Therapy only cases in a standardized location of the clinical record.*

Deficiency - G536- (c)(5) - Review of All Current Meds

Tips For Compliance:

- Ensure an ongoing medication review is completed for all patients; have specific locations for documentation.
- Ensure all PRN medications identify a reason and timeframe

- ***Ensure the physician is notified of any medication discrepancies, side effects, problems, or reactions***
- *Every Staff, every visit should ask the patient & caregiver if any new prescribed or OTC meds, any side effects, if they are taking their prn drugs and what the response is.*

G536- Level 1 Deficiency - (c)(5) Review of All Current Medications

- Clinical record did not have evidence of a review of all medications that the patient was currently using:
- Medication Profile included:
  - Normal Saline flush IVP without including dose
  - Profile included Heparin Flush 100u/ml, 5000units every day IVP - Dosage was supposed to be 500 units. (*possibility of Condition or IJ upon further investigation due to potential harm to patient?)*
  - Tylenol every 4-6 hours PRN without a qualifier for PRN
  - Loratadine, Lyrica, Neurontin, prochlorperazine, Santyl, Senna, Senna Plus without including a dose, frequency or route.
  - Insulin Lispro 1-16 units SQ before meals without defining the dosage parameters
  - Visit note included Pain med that was not on medication profile/order.

§484.60
Care Planning, Coordination of Services, and Quality of Care

G574 – (a)(2) Individualized Plan of Care

Must include the following:

- (xii) Description of the patient's risk for emergency dept visits & hospital re-admission, & all necessary interventions to address the underlying risk factors.
- (xiii) Patient & caregiver education and training to facilitate timely discharge;
- (xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;
- (xv) Information related to any advanced directives

Deficiencies-G570, G572, G574, G576

- G570-Care planning, coordination of services, quality of care
- G572-Individualized Plan of Care Signed by Doctor
- G574-Individualized Plan of Care
- G576-Orders Must be Recorded in the Plan of Care

❖ ***Tips For Compliance:***

❖ *Ensure all patients have **an individualized** written plan of care that addresses the issues **identified in the comprehensive assessment***

- ❖ *Ex: Diagnoses with specific patient interventions & goals rather than Generic pulled over from EMR.*

Deficiencies-G570, G572, G574, G576

❖ ***Tips For Compliance: continued***

❖ *Ensure all physician orders are obtained prior to initiation of services*

❖ *Ensure all orders for all disciplines include the frequency, and duration of the service provided*

❖ *Ensure all therapy orders include the **specific procedures and modalities to be provided***

❖ *Ensure PRN orders for medications and treatments identify an indicator for the administration of PRN treatment or medication*

❖ *Ensure orders state WHO is going to do a procedure & WHEN*

❖ *Ensure all verbal orders are recorded in the plan of care & timed.*

Deficiency- G572 - (a)(1) 17 of 17 records did not have evidence of an individualized plan of care. Orders:

- Therapy to use ultrasound did not include location, level, duration and frequency
- Blood Glucose Monitoring had no specifics – i.e., how frequently, by whom, parameters for which to notify physician
- Wound care daily & PRN. Did not have specific wound care orders; did not state who was to perform the wound care as nursing visit orders were 2 times a week; did not include a PRN qualifier
- Insulin 1-16 units SQ before meals did not include parameters for doses

Deficiency- G572 - (a)(1) 17 of 17 records did not have evidence of an individualized plan of care. Orders:

(continued)

- Order for SN to instruct on a low sodium diet. Visit notes stated patient on a Regular diet and no teaching documented on a low sodium diet.
- Patient's secondary diagnosis of Diabetes had no interventions or goals on the POC.
- Goals were non specific – all patients had the same goals addressing standard areas such as infection control, medication knowledge and falls. Goals were not specific to the patient's diagnoses, orders and interventions.
- Therapy interventions included wound care, diabetic foot care, and other orders that the therapists did not document.

G584 - (b)(4)Compliance with Physician Orders

- *Ensure all verbal orders include documentation of the date and **time that the order was received***
- *Ensure all medications, treatments, and services are administered as ordered by the physician*
- ***You Must have an Order for Everything you DO & you Have to DO Everything that is Ordered!***
  - **NO-** Weight Daily- means you have to weigh the patient daily-
  - So Be Specific!
  - **YES-** patient to weigh self daily, log weight, notify RN if weight +/- 2lbs

G590 (c)(1) POC Review by Physician/ Alert Physician of Changes

- The HHA must ***promptly alert*** the relevant physician(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.
- *Ex of documentation of facts but lack of physician notification resulting in IJ due to harm or potential harm to patient:*
  - *Wound - red, odorous, increased drainage*
  - *Blood glucose outside of parameters*
  - *Patient with low BP/dizziness/staggering, falls, etc.*

G590 – Level 2 Deficiency – (c)(1) -Promptly alert relevant physician of changes

- Tips for Compliance
- Notify physicians ***early and frequently*** for anything out of parameters, any negative changes, ineffective medications, treatments and therapies
- Team needs to communicate with each other for all changes so physician can be notified promptly
- BE EACH OTHERS' EYES AND EARS!
- Reduces Emergent Care and Hospitalizations as well!
  - Improve patient and Agency Outcomes!

G592 (c)(2) Revised Plan of Care

- Revised POC must reflect current information from the patient's updated comp assess, 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**.
- **G594 (c)(3) Communicate Revisions to Plan of Care**

(i) Any revision to POC due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, & all physician issuing orders for the HHA POC.

(ii) Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA POC, & the patient's primary care practitioner or other health care professional who will be responsible for providing care & services to the patient after discharge from the HHA (if any).

Deficiency – G580, G588 – 484.60 -Only As Ordered By a Physician/Reviewed, Revised

- 8 of 17 records did not have evidence that the agency promptly alerted the relevant physician(s) to 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.
- FREQUENCY OF VISITS : SN ordered for 3x week; 2 visits made week 4 & 5, without evidence physician notified.
- MSW eval ordered at SOC - no visit made by MSW, with no evidence of physician notification
- PT ordered at SOC – 11 days until visit was made

G600 – (d) Coordination of Care

- (1) Assure communication with ***all physicians*** involved in the plan of care.
- (2) ***Integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.***
- (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.

Deficiency - G600 - (d) – Coordination Of Care

- 14 of 17 records did not have evidence of coordination of care by the HHA. There was no documentation that the disciplines talked to each other or communicated to the physician about the care the patient was receiving.
- RN documented plan for next visit included teaching the caregiver wound care procedure. No evidence of care coordination between the RN & the LPN prior to the LPN visit. LPN visit note did not state that she taught the caregiver wound care, and LPN documented she did it alone.
- MSW visit note stated caregiver planned to meet the HH aide regarding helping the patient put on & take off her brace. MSW did not communicate this information to the RN or the Aide, instead documented instructing the caregiver to contact the office to schedule training for the aide.

G612 – (e) Written Information to the Patient and Caregiver

(1) Visit schedule, including frequency of visits by HHA personnel ***and personnel acting on behalf of the HHA.***

(2) Patient medication schedule/instructions, including: med name, dose & frequency & ***which medications will be administered by HHA personnel and personnel acting on behalf of the HHA***.

(3) ***Any treatments to be administered by HHA personnel & personnel acting on behalf of the HHA, including therapy services.***

(4) Other pertinent instruction the HHA will provide, specific to the patient's care needs.

(5) Name and contact information of the HHA clinical manager.

G612 (e) Written Information to the Patient

- ***Tips For Compliance:***
- *Visit schedule- Simple calendar for patient to use daily to identify who is coming and when. Advanced! So plan the episode. Revise if changes – however, coordinate care with team, patient/caregiver so that all staff know changes. Contractors MUST be on calendar too!*
- *Medication list- patient friendly; MUST be at SOC and Updated! Do not wait for the 485 for EMR printout if there will be a delay! Options: handwrite on admission, enter into EMR same day and have staff end of day, Use mobile printers.*

G612 (e) Written Information to the Patient, *continued*

- ***Tips For Compliance:***
- *Treatments – Must have a lay person description of all that HHA is doing and/or teaching patient/caregiver to do.*
- *Ex: HEP, IV care, Foley Care, Wound Care, etc.*
- *Other pertinent instructions related to the patient's care*
- ***Patient Friendly Ongoing POC Update!***
- ***Supervisory Home Visits - the ONLY way to ensure Compliance!***
- *Name and contact information of the HHA clinical manager*

Interpretive Guidelines - G612 – (e) -Written instructions to patient

- These documents e1-5 must be provided to the patient, caregiver & rep (if any) ***no later than the next visit after the plan of care has been approved by the physician***.
- Written information should be updated as the plan of care changes.
- Clear written communication between the HHA and the patient and the patient's caregiver and representative (if any) helps ensure that patients and families understand what services to expect from the HHA, the purpose of each service and when to expect the services.

Condition 484.60- CP, Coord, Quality- Individualized POC, Coordination of Care, Following Orders- **Plan of correction**

- Reeducation to all staff & contractors re: risk for ER/Hosp, patient identified goals
- Individualized POC- will meet patient specific needs identified in comp assess- with measurable outcomes.
- POC in home will be updated ongoing.
- Pt/caregiver ed & training, including tool for coordinating with patient/caregiver & all disciplines to keep all informed & included.
- The services provided are coordinated and meeting patient needs.
- After each staff is re-educated, they will be held accountable to following the plan.
- Supervisory visits- 2 patients/week for 3 months to look for the appropriate documentation & evidence POC is being updated/ discussed with patient/caregiver

Condition level Plan of Correction, cont

- If the patient cannot be seen within the time guidelines because of staffing issues, the physician must be notified and another agency to be found to provide the care.
- Coordination of services will be enforced between disciplines including RN / LPN, & RN / Aide.
- LPN's will be informed verbally & in writing of the patient's POC with the patient's frequency & services/care to be provided.
- Aides will be provided with Aide Assignment Sheet, which the RN will review with Aide prior to Aide visiting the patient.
- The RN will regularly communicate with the Aide and the LPN while caring for the patient. Aides and LPNs will be reinstructed to contact the RN and/or Agency Clinical Manager if any potential changes to the POC or Aide Assignment sheet are necessary, & physician will be contacted as appropriate.

Condition level Plan of Correction, cont
To prevent recurrence:

- 1) DPS will audit 1 week of notes/evals for each staff/week for 3 months for compliance. If 100% compliance after 3 months, it will change to quarterly in quality indicators with a 20% review at a goal of 95%.
- 2)Ongoing clinical record reviews will be done by DPS to ensure compliance with following physician orders, coordination of care, as well as meeting all regulations in order to provide quality and safety to patients. There will be 100% of reviews done from _date range_. If 95% compliance is noted, with appropriate action items being instituted, then percentage of reviews will be decreased to 20% per month for 3 months with goal of 95%.

Condition- Pain Assessment – cited in Coordination of care, Notification to Physician, Skilled Professionals

- Pain assessments are not specific to medications patient is taking to relieve pain, what is working and what doesn't, how often they are taking the prn pain medications, etc.
- Clinicians documenting: medications needed multiple times a day.
- Documentation on all pain assessments - to relieve pain: "relaxation and repositioning".
- Severe pain levels not reported to physician.
- Team not reporting pain improvements & declines to each other.
- *Needs to be specific and patient customized.*

5 STAR CONSULTANTS HEALTHCARE SPECIALISTS

§484.65 - QAPI

5 STAR CONSULTANTS HEALTHCARE SPECIALISTS

QAPI

- HHA must develop, implement, evaluate,& maintain an effective, ongoing, HHA-wide, data-driven QAPI program.
- Reflects the complexity of its organization and services;
- Involves all HHA services (including those services provided under contract or arrangement);
- Focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions;
- Takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors.
- HHA must maintain documents of its QAPI program and be able to demonstrate its operation to CMS

Knowledge Deficit and/or Deficient Areas seen in Agency QAPI Programs

- The program must be formal, with information specifying the Quality Indicators and Performance Improvement Project (PIP).
- QAPI program incorporates infection surveillance, medication errors/adverse drug interaction, complaints, and data driven outcomes from CASPER.
- Lack of a formal program is often seen in Agencies.
- Raw data on numerous audit tools without percentages, goals/thresholds, compilation, trending is commonly seen.

Knowledge Deficit and /or Deficient Areas seen in Agency QAPI Programs- PIP

- PIP - Selection should occur from identifying high risk, high volume, problem prone areas that are more complex.
- Identification can result from a Quality Indicator that upon monitoring is found to be non compliant and problematic.
- A PIP is a *Project*- this means that there should be ongoing documentation of for ex: meetings with various staff positions and possibly persons outside of the agency, brainstorming, root cause analysis, etc. in order to work on the project.

Knowledge Deficit and/or Deficient Areas seen in Agency QAPI Programs- PIP

- Example of Agency Non Compliance – a one page statement and outcome, no stakeholders involved, numerous PIP's without a project in place, project is not complex and related to quality , outcomes, etc.
- Examples of PIPs:
  - Reduction in emergent care and hospitalization
  - Medication Management

Knowledge Deficit and/or Deficient Areas seen in Agency QAPI Programs- Complaints

- Ensure all staff understand what constitutes a complaint-Many agencies have few documented
- Trend Complaints! So that you know where problem areas occur and can then implement Quality Indicator or PIP
- Ensure complaint documentation includes resolution
- READ through the complaints objectively
  - "Pull the Thread" to determine if appropriate resolution, actions taken

§484.70 Infection Prevention and Control

3 Standards in the Condition:

Prevention
Control
Education

Interpretive Guidelines - G682 - Standard – Infection Prevention

6 standard precautions, identified by the CDC & Healthcare Infection Control Practices Committee (HICPAC), apply during any episode of patient care:

1. Hand Hygiene;
2. Environmental Cleaning and Disinfection;
3. Injection and Medication Safety;
4. Appropriate Use of Personal Protective Equipment;
5. Minimizing Potential Exposures; and
6. Reprocessing of reusable medical equipment between each patient and when soiled.

Deficiency - G682 - Infection Prevention

Key areas of non compliance seen on home visits:

- Handwashing – not done between glove changes; dirty to clean, supply bag on floor (your agency policy is key), Laptop placed onto dirty area. Going into Supply bag without washing hands (contaminates entire bag).
- Procedures - Infection breaks during wound care, IV care. Fields not distinguished- dirty and clean. Contamination of clean supplies.
- Cleansing of equipment after patient use prior to putting in bag, car, another patient house – Agency Policy.
- All staff educated and held accountable.

G684 (b) – Infection Control

Control- HHA must maintain a coordinated agency-wide program for the ***surveillance, identification, prevention, control, & investigation*** of infectious & communicable diseases that is an integral part of the HHA's QAPI program.

The infection control program must include:

(1) Method for identifying infectious & communicable disease problems

(2) A plan for the appropriate actions that are expected to result in improvement and disease prevention.

Infection Surveillance Program- Tips for Compliance

- Electronic or paper infection surveillance form initiated by field clinician identifying signs and symptoms of infections, notifying physician, identifying new antibiotics.
  - Clinicians must be educated to the process.
  - Lack of sufficient infection surveillance documents do not mean you do not have infections
- Infection surveillance form goes to QAPI coordinator to track, trend, analyze.
- Identify Agency infection rate(s)
- Implement Quality Indicators when trends of a particular infection
  - Ex Development of UTIs

§484.75 Skilled Professional Services

5 STAR CONSULTANTS HEALTHCARE SPECIALISTS

Skilled Professional Services

(a) Provision of services by skilled professionals..

(b) Skilled professionals must assume responsibility for, but not be restricted to, the following:

1. Ongoing interdisciplinary assessment of the patient
2. Development/evaluation of POC in partnership with patient, rep (if any), caregiver(s)
3. Providing services ordered by physician as indicated in POC
4. Patient, caregiver, and family counseling
5. Patient and caregiver education
6. Preparing clinical notes
7. Communication with all physicians involved in POC & other health care practitioners (as appropriate) related to the current plan of care
8. QAPI 9. HHA-sponsored in-service training

5 STAR CONSULTANTS

Interpretive Guidelines – G720 Skilled Professional Services

- All skilled professional staff must provide input into & participate in the implementation of the QAPI program in order for QAPI to be effective.
- Every HHA skilled professional, whether the skilled professional is a direct employee or contractor of the HHA, is expected to contribute to all phases of the QAPI program.
- These contributions may include: identification of problem areas; recommendations to address problem areas; data collection; attendance at periodic QAPI meetings; & participation in PIPs.

Skilled Professional Services

- ***Tips for Compliance***
- ***Care Management Teams!***
- Ensure ongoing interdisciplinary assessment
  - Team communication to discuss patient issues, progress, POC
  - Ensure documentation of communication
- Ensure documentation of patient/caregiver being involved in POC
- Ensure documentation of patient/caregiver education
- Ensure Communication with *all physicians* involved in POC

Deficiency - G704 –(b) Responsibilities of Skilled Professionals

- 8 of 17 records did not have evidence in the patient record that skilled professionals assume responsibility for preparing clinical and progress notes and providing care as ordered by the physician as indicated in the plan of care.
- On 'date' SN did not document procedure for wound vac change.
- On 'date', wound care was not provided to wound #3.
- On 'date range', SN did not document procedure utilized for PICC line dressing change.
- Clinical record review, 5 of 11 did not have evidence in the patient record of communication between disciplines.

Deficiency - G718 – (b)(7) Communication With Physicians

- POC was noted to have orders to notify physician of pain greater than 7.
  - SN visit (date) pain assessment documented left hip pain of 8 and there was no documentation of physician notification.
- SN visit (date) documents sacral pressure ulcer wound deterioration from stage 1 to stage 2, no documentation of physician being notified.

Condition Level –G706- Interdisciplinary Assessment of Patient – Plan of Correction

Mandatory re-education to all staff & contractors on (date)___ re:

- Providing care in a timely manner; if cannot be done, will notify agency immediately to staff with another staff member visit- Or if none available, Agency will contact physician- to notify that delay of treatment, & agency must transfer patient to another agency- as they cannot provide the patient with the timely care.
- Pain policy education: Each patient receiving skilled nursing &/or therapy services will have pain assessed initially & on an ongoing basis including location, intensity (on a pain scale) duration, frequency & character, current pain therapy or treatment /effectiveness of current therapy or treatment.

Condition – Skilled Professional Services – Plan of Correction

- When patient's pain is not relieved, the SN or therapist will intervene appropriately to include notification of the physician and/or patient education regarding alternative pain relief measures (i.e. relaxation therapy, music therapy, etc. .)
- To prevent recurrent noncompliance, the DPS will audit 15 charts/week for 3 months for therapy/SN - for compliance with timeliness of services and addressing pain according to policy.
- If 100% compliance after 3 months, quarterly 20% review with 95% compliance. If lapses are found, appropriate education will be provided &/or the employee(s) responsible will be counseled with possible consequences from probationary period to possible termination.

§484.80
Home Health Aide Services

G774 - (d) – In-service Training

In-service training may occur while an aide is furnishing care to a patient:

(1) In-service training may be offered by any organization, & ***the training would be required to be supervised by an RN***.

(2) HHA must maintain documentation that demonstrates the requirements of this standard have been met.

- *IG- When conducting in-service training during patient care, the patient must first be informed of & consent to the training & be informed of how the training will be conducted; patient rights, respect for the patient's preferences, & potential for care disruption must always guide such training.*

G804 (g) Aides must be members of Interdisciplinary Team

- Aides Must report changes in patient's condition to RN or other appropriate skilled professional, &
- Must complete appropriate records in compliance with the HHA's policies and procedures.

- ***Tips for Compliance:***
- *Aides need to communicate to Team in the section of the EMR where the clinicians document coordination of care.*
- *Aides See a lot! ex, "red spots on bottom" – patients tell them info! ex new meds, side effects, pain issues, etc. They need to report that & Clinicians follow through on information!*

Tips For Compliance

- "Per patient request" & PRN orders should not be used for any tasks, as the Aide lacks the decision-making ability to interpret information/data needed to revise the plan of care
- Ensure all revisions to the aide plan of care are discussed, approved, and documented by the RN or other qualified professional
- Ensure documentation in the patient record supports the aide provided care in accordance with the POC
- If the patient refuses care, the refusal is properly documented & RN notified.

G806 (h) – Supervision of Home Health Aides

- RN who is *familiar with the patient, the patient's plan of care, & the written patient care instructions* must make an onsite visit to the patient's home no less frequently than every 14 days.
- In Therapy Only, therapist must report concerns re HH aide to the clinical manager.

❖ ***Tips for Compliance***

❖ *Agency process to ensure that the RN or Therapist Reviews the assignment sheet **with the Aide** to be sure Ai is doing tasks assigned.*

- ❖ *Identify in this coordination of care if Ai Assignment needs to be revised.*

6 Elements of Supervisory Visit

Every supervisory visit, every element must be addressed:

- Following the patient's plan of care for completing of tasks assigned to an aide by RN or other appropriate skilled professional
- Maintaining an open communication process with the patient, representative (if any), caregivers and family
- Demonstrating competency with assigned tasks
- Complying with infection prevention & control policies & procedures
- Reporting changes in the patient's condition
- Honoring patient rights

Deficiency -Aide Assignments & Duties, Supervision, Competency

- Patient required placement of a cast for a fractured vertebrae following her bath from the Aide. The Aide performed this procedure during a surveyor home visit.
- Aide care plan did not include instructions for this required cast placement
- RN stated she did not review the procedure required for cast placement with the Aide.
- There was no competency for the Aide done for this procedure.
- Patient has been consistently receiving aide services, but there was no update in the Aide Care plan since Aide services began.
- The RN stated that she did not discuss any necessary changes required with the Aide.

Home health aide assignments- **Deficiencies**

- Aide assignment sheet did not have vital signs listed but each HHA documents vital signs on their visits.
- Aide assignment sheet has tub/shower; it must designate which one as Aide cannot make that decision.
  - Aide must have been competencied on tub if tub is checked.
- There are incidents of aide performing other tasks such as shampooing hair, ROM, making bed, etc. on visit notes not on the aide assignment sheet.
- The aide documents on 4 visits not performing a shower due to no hot water at the patient's home, but no documentation that the RN was notified.

§484.102 Emergency Preparedness

Standard - E004 -(a) Emergency Plan

- *Must be reviewed, and updated at least annually*.
- Be based on and include a documented, *facility-based* and community-based risk assessment, utilizing an *all-hazards* approach
  - All-hazards planning does not specifically address every possible threat or risk but ensures the facility will have the capacity to address a broad range of related emergencies.
- *Include strategies for addressing emergency events* identified by the risk assessment.

Deficiency-Emergency Plan

- Emergency Plan was not individualized to agency
  - Generic
  - Not customized for potential hazards – i.e. blizzards, tornado, flooding, etc.
  - Strategies not developed to address the specific risks

- *Address patient population*
- *Type of services HHA has the ability to provide in an emergency*
- *Continuity of operations, including delegations of authority and succession plans.*
- *Document HHA's efforts to contact officials!*

E0013 - (b) – Policies and Procedures

1) *plans for the HHA's patients during a natural or man-made disaster.* ***Individual plans for each patient must be included as part of the comprehensive patient assessment.***

2) *procedures to* ***inform State and local emergency preparedness officials about HHA patients*** *in need of evacuation from their residences at any time due to an emergency situation.*

3) procedures to follow up with on-duty staff & patients to determine services needed, in the event interruption in services. ***HHA must inform State and local officials of any on-duty staff or patients that they are unable to contact.***

Standard – E0030 and E0031- (c) – Communication Plan

- Must be reviewed and updated at least annually.
- Must include all of the following:

(c)(1) Names and contact information for the following:

(i) Staff

(ii) Entities providing services under arrangement

(iii) Patients' physicians

(iv) Volunteers

(c)(2) Contact information for Federal, State, tribal, regional, or local emergency preparedness staff

Communication Plan

- IG- Facilities are encouraged but not required to maintain these contact lists both in electronic format and hard-copy format in the event that network systems to retrieve electronic files are not accessible.
- Have primary and ***alternate means for communicating*** with the HHA's staff, & Fed, State, tribal, reg, local emergent management agencies
  - Methods may consider include satellite phones, walkie talkies, radios, short wave radios.
- IG- How the facility coordinates patient care within the Agency, across healthcare providers, & with state/local public health departments.

Standard – E0036 - (d) Training and Testing

- Train all new & existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles, Annually.
- Demonstrate staff knowledge of emergency procedures.
- "What is your role in the Emergency Plan?"
- Annual training should be modified each year, incorporating any lessons learned from the most recent exercises, real-life emergencies that occurred in the last year and during the annual review of the facility's emergency program.

Deficiency -E0037-Standard – (d)(1) Training

- Upon interviewing staff, 5 of 8 did not know emergency procedures
- 24 out of 74 personnel had annual training.
- No emergency training done for contractors.
- No curriculum for annual training. Sign in sheet stated date , trainer only.

Standard - E0039 -(d)(2) Testing

- The HHA must conduct exercises to test the emergency plan at least annually.

NOTE: Actually it is 2 times a year !!!

(i)Participate in a full-scale exercise that is community-based or, individual, facility-based. If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

Note: Can now use 2 actual events per year.

Interpretive Guidelines- E-0039- (d)(2)- Testing

- If a facility activates its emergency plan **twice in one year, then the facility would be exempt from both exercises** (community-based full-scale exercise and the secondary exercise-individual, facility-based mock disaster drill, table top exercise) for one year following the actual events.

Standard –E0039 (d)(2) Testing

(ii) Conduct an additional exercise

(A) A second full-scale exercise that is community-based or individual, facility based.

(B) ***A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan***

(iii) ***Analyze the HHA's response*** to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

5 STAR CONSULTANTS HEALTHCARE SPECIALISTS

Plan of Correction

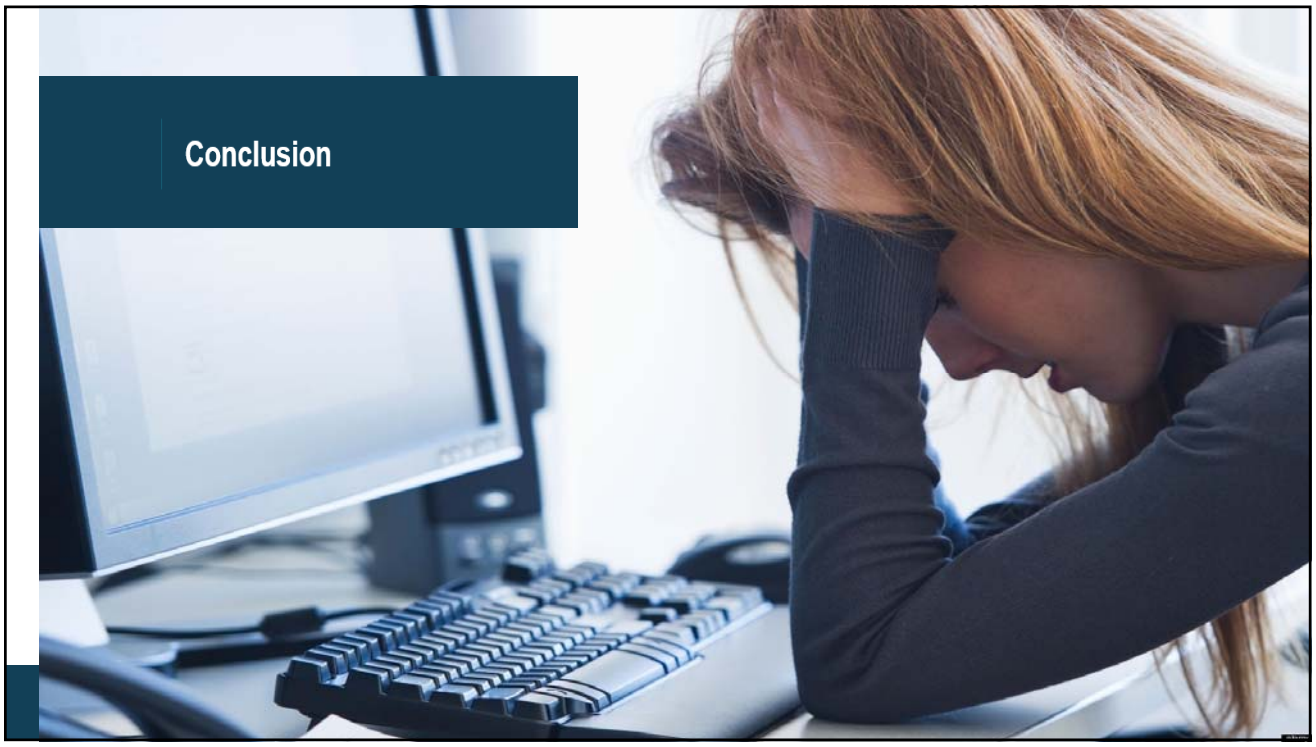
5 STAR CONSULTANTS HEALTHCARE SPECIALISTS

Plan of Correction - Education

- One-on-one in-service will be provided to staff that were non compliant in obtaining and documenting Resumption of care orders. And a staff meeting will be conducted for all clinical staff who are responsible for completing the Resumption of care orders to obtain orders for all treatments and interventions required for care of the patient.
- Provide in-service to the agencies EMR provider on how the EMR can carry all of the interventions/orders/goals over to ROC verbal order (this has been completed already).
- Staff Meeting will be held to discuss the importance of customizing all plan of care for patients and not to use only generic interventions and orders.

Plan of Correction - QAPI

- DPS will review 100% of the Resumption of Care orders for 4 weeks to ensure that there is documentation of the orders and interventions from prior to the ROC as well as all new orders- prior to being sent to the physician for review and signature.
- Threshold is 100%. Once threshold is met, will continue 50% of Resumption of Care orders to ensure accuracy quarterly.
- One on one meetings with any clinician who is found to be non compliant with ROC orders will occur on an ongoing basis.



In Conclusion:

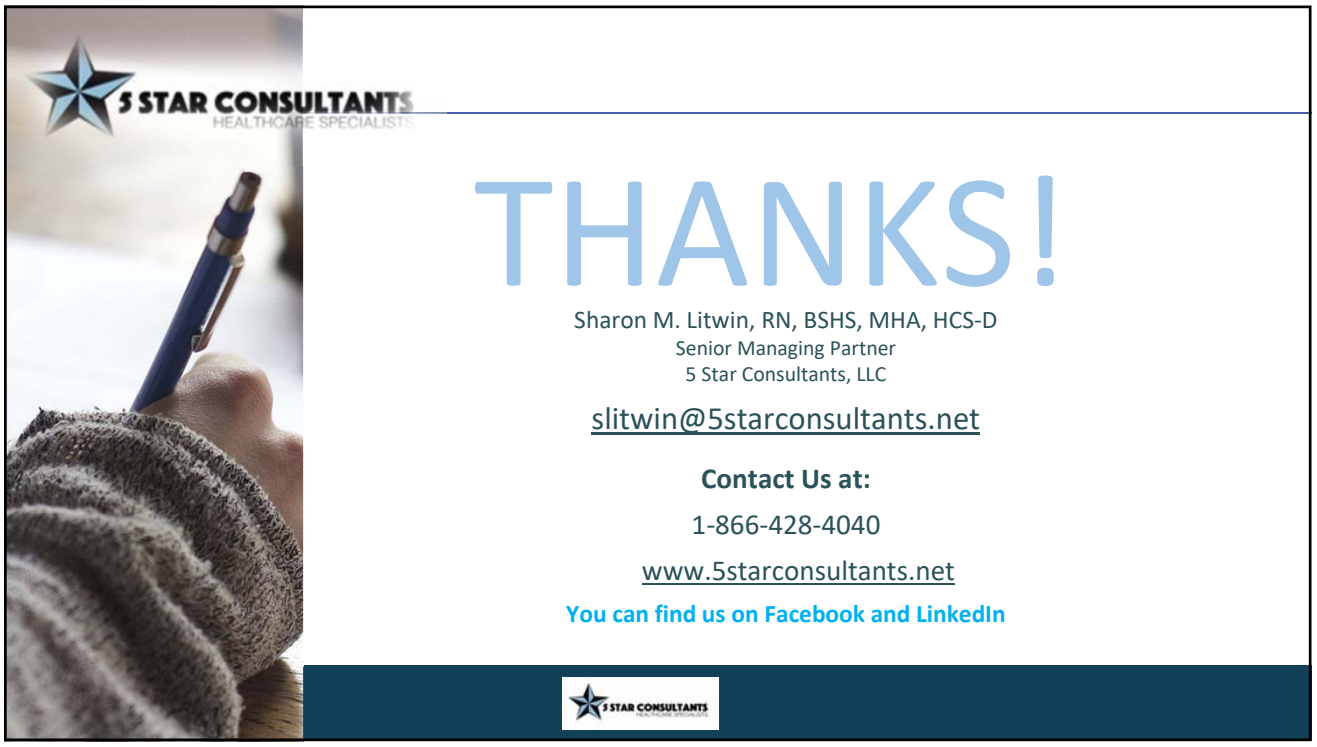
- **KNOW THE RULES**! All Clinical Managers have easy access to continually review the SOM (CoPs with IGs)!
- When unsure how to implement a reg, **ASK**!
- Frequent Mock Surveys- by an objective qualified person in your agency or an outside qualified entity performed the way a surveyor will. But be sure this person understands the COP's and knows what to look for.
- Determines your vulnerabilities **and** have Task forces for those complex areas you identify
- Let your QAPI program help you- Based on high volume, high risk, problem prone areas you find on mock survey, past near misses, past survey deficiencies, CASPER Outcome Reports. Involve all staff having them rotate through.

In Conclusion:

- Ongoing Concurrent Clinical Record Reviews- Real time review allows for:
  - Action to be taken for physician notification,
  - Improving patient outcomes,
  - Preventing emergent care visits **AND**
  - Having your documentation be in compliance!
- Include 100% of your staff and contractors!
- This is KEY to being in compliance! If there is a lack of understanding of the rules, the rules will not be followed!

In Conclusion:

- Frequent Supervisory Home Visits
- Identify and utilize your Best Performers to assist with Home Visits, Record Reviews, etc.
- EDUCATE, EDUCATE, EDUCATE!


5 STAR CONSULTANTS
HEALTHCARE SPECIALISTS
THANKS!
Sharon M. Litwin, RN, BSHS, MHA, HCS-D
Senior Managing Partner
5 Star Consultants, LLC
slitwin@5starconsultants.net
Contact Us at:
1-866-428-4040
www.5starconsultants.net
You can find us on Facebook and LinkedIn
5 STAR CONSULTANTS