Home Health Day 3
Consultant Certification
An Interactive Training

Bobbie Warner RN, BSN
Director of Education

Chat Box Communication

- Name
- What was the most valuable thing you took away from yesterday?
Additional Resources

- Appendix B – Home Health State Operations Manual
- Appendix Z – Emergency Preparedness
- MAC – Medicare Administrator Contractor
- MLN newsletters and CHAP eNews
Patient Centered Care (PCC)
Elements of the Patient Bill of Rights

**Be informed and exercise their rights**

- Treated with respect
- Confidential record

**Be informed of and consent to care in advance including**
- Mode of care delivery
- Assessments
- Care to be furnished
- Establishment of plan of care
- Disciplines that will furnish care
- Frequency of visits
- Expected outcomes
- Changes in care
- Right to receive all services in POC

**Financial**
- Advised orally & writing payment liability
- Charges not covered; reduction, termination
- Potential patient payment liability
- Changes related to payment

**Complaints**
- Right to report grievances
- how to contact state and CHAP hotlines
- Free of neglect/abuse/discrimination

**Resources**
- Informed of names/addresses/contact for federal and state funded
- Right to access and how to access auxiliary aid aides and language services

Implementation of Patient Rights

**Complaint Process**
- Policy and procedure
- Documentation format
- Education of staff
- Patient information regarding process
- Education of patient/caregiver
- Address all incoming complaints
- Monitor for trends and act accordingly
- Validate process is effective
### 2022 Top Findings in PCC

<table>
<thead>
<tr>
<th>Standard</th>
<th>Content</th>
<th>CMS Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>PCC.2.I.M1</td>
<td>Proper Notice regarding potential non-covered care or agency reduction or termination of care (36%)</td>
<td>G442</td>
</tr>
<tr>
<td>PCC.2.I.M1</td>
<td>Be informed of and participate in care and services (24%)</td>
<td>G434</td>
</tr>
<tr>
<td>PCC.2.I.M1</td>
<td>Provision of Federal/State Agency Information (17%)</td>
<td>G446</td>
</tr>
<tr>
<td>PCC.2.I.M1</td>
<td>Right to be advised regarding financial payment information orally and in writing (15%)</td>
<td>G440</td>
</tr>
</tbody>
</table>

### Top Findings Patients Rights

**PCC.2.I.M1: 484.50(c)(8) Patients Rights**

- **G442** - Receive proper written notice, in advance of a service, if service may be non-covered care; or in advance of the HHA reducing or terminating
- **G434** - 484.50(c)(4) Participate in, be informed, consent or refuse care in advance of and during treatment
- **G446** - 484.50(c)(10) Be advised of the names, addresses, phone numbers of the following Federally-funded and state-funded entities: (i) Agency on Aging (ii) Center for Independent Living (iii) Protection and Advocacy Agency, (iv) Aging and Disability Resource Center; and (v) Quality Improvement Organization
**Top Findings Patients Rights**

**G440 - §484.50(c)(7)**

Be advised, orally and in writing, of—

(i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other Federally-funded or Federal aid program known to the HHA,

(ii) The charges for services that may not be covered by Medicare, Medicaid, or any other Federally-funded or Federal aid program known to the HHA,

(iii) The charges the individual may have to pay before care is initiated; and

(iv) Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f).

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**Tips for Success**

- Process for addressing any common language barrier
- Correct verbiage/individualized to your agency
- Think outside of the box
- Periodically check the contact numbers
- Talk to patients
- Implementation as well as verbiage
Assessment, Planning and Coordination

APC
APC Standards Summary

APC.10.I & 11.I – Standards addressing transitions in care

APC.9.I – Coordination with physicians and services provided by arrangement

APC.8.I – Coordination of care with the patient/caregiver – written instruction

APC.7.I – Plan of Care requirements

APC.2.I – Coordination and oversight of care provision

APC.3.I – Acceptance and intake of patients

APC.5.I – Initial assessment requirements

APC.6.I – Comprehensive Assessment requirements

Comprehensive Assessment

<table>
<thead>
<tr>
<th>Demographic Information/Medical History/Allergies</th>
<th>Patient’s Representative as applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengths, goals, care preferences, measurable outcomes</td>
<td>Current health/psychosocial/functional/cognitive status</td>
</tr>
<tr>
<td>Systems review</td>
<td>Medication review</td>
</tr>
<tr>
<td>Activities daily living/need for home care/living arrangements</td>
<td>Emergency care use/data items inpatient facility admit/discharge</td>
</tr>
<tr>
<td>Medical equipment</td>
<td>Caregiver availability/willingness, schedules</td>
</tr>
<tr>
<td>Medical/nursing/rehab/social and d/c planning needs</td>
<td>Plan in the event of natural disaster</td>
</tr>
</tbody>
</table>
Scenario

Ms. Violet Chap is a 72-year-old female with a recent fall resulting in a shoulder injury. She was admitted approximately one month prior to her fall with a primary diagnosis of Diabetes. She also has a history of hypertension and during the hospital stay developed a diabetic ulcer on her right toe. She is scheduled to be discharged today and an RN just out of orientation is scheduled to conduct the Resumption of care.

Group Activity – 20 minutes

Attendees will be divided into four breakout rooms

- Each participant should conduct a high-level overview of the entire assessment
  - Pages 65-70
- Each group conducts a review of their assigned section
  - Evaluate what was documented
  - Present education needed for improvement

**Group one** – focus on integumentary and diabetes related issues
**Group Two** – focus on functional and psycho-social issues
**Group Three** – focus on Cognitive
**Group Four** – focus on Medications
**Group Five** – focus on Vital signs, pain
**Group Six** – focus on Safety

- Each group assigns one spokesperson to share their thoughts.
Patient Name: Violet Chap  
Visit Date: 7/22/2021  
Start of Care Date: 6/29/2021  
Resumption of Care Date: 7/22/2021  
Allergies:  
Vital Signs:  
Temperature: 99.2  
Pulse Apical: 82  
Resp: 22  
Pulse Radial: 82  
B/P: 146/85 Left Arm – Unable to take in right arm due to shoulder pain with movement  

Medical history:  
☐ None  ☒ Diabetes  ☐ Asthma  ☐ Falls  ☐ Dementia  ☐ Arthritis  
☒ Angina  ☐ Liver disease  ☐ Substance abuse  ☐ TIA/CVA  ☐ Tobacco use  ☐ Hypertension  

Orders:  
Comments: Skilled Nursing, Home Health Aide, Physical therapy to evaluate and treat. Wound care to right toe. Continue prior medications.
Health Screening/Immunization
☐ Not Assessed

Facility Discharge Date: 7/21/2021

Facility:
☐ Short term acute hospital        ☐ Inpatient rehabilitation
☐ Skilled nursing facility        ☐ Other
☐ Long term care hospital

Inpatient Facility Diagnosis
Unspecified Fall
Type 2 Diabetes
Diabetic Ulcer lower extremity
History of Hypertension

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Spiritual/Cultural
☐ Not Assessed

Spiritual/Religious Affiliation

Spiritual/Religious Contact

<table>
<thead>
<tr>
<th>Living Arrangement</th>
<th>Availability of Assistance</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Around the clock</td>
</tr>
<tr>
<td>a. Patient lives alone</td>
<td>☒</td>
</tr>
<tr>
<td>b. Patient lives with other person(s) in the home</td>
<td>06</td>
</tr>
</tbody>
</table>

Safety Measures include:
☐ Standard precautions ☐ Fall Precautions ☐ ADL Safety ☐ Safe Disposal of Sharps
☐ Airborne Infection Control Precautions ☐ Contact Infection Control Precautions
Safety Measures include:

☐ Standard precautions  ☐ Fall Precautions  ☐ ADL Safety  ☐ Safe Disposal of Sharps
☐ Airborne Infection Control Precautions  ☐ Contact Infection Control Precautions

Body Systems

Range of Motion: limited range in right arm. Patient states “frozen right shoulder” since the fall.

Functional Limitations: slow to move, uses arms of chair to be able to get out of chair

Assistive Devices: use of a cane for ambulation

Swollen Joints: Arthritis both knees

Other:

Pain Assessment:

Standardized validated assessment conducted:  ☐ Yes  ☒ No

Pain Frequency interfering with activity:

☐ No Pain  ☐ Pain does not interfere with activity
☒ Daily but not constant  ☐ All the time

Other: Patient has pain with movement in both knees and right shoulder. States “I just take Tylenol arthritis for the pain” Has pain upon dressing change of diabetic ulcer right great toe

Integumentary: Skin Warm and Dry,

Wound:  ☒ Yes  ☐ No

Location: Right great toe

Type of Wound:  ☐ Vascular  ☒ Diabetic  ☐ Surgical  ☐ Trauma  ☐ Pressure

Wound Care: per patient, in the hospital they changed the dressing every day but she did not know what was being used.
Respiratory:
- [ ] Wheezes
- [ ] Dyspnea
- [ ] CPAP
- [ ] Rales
- [ ] Rhonchi
- [ ] Cough

Breath Sounds: RR: 22 Bilateral lung sounds with rales in lower right lobe. Patient coughs upon taking a deep breathe. States she gets “winded” going up the stairs to the bedroom at night.

Endocrine:
- [ ] WNL
- [ ] Excessive Hunger/thirst
- [ ] Excessive bleeding
- [ ] Thyroid issue
- [ ] Diabetic

Blood Glucose Performed: 
Result:
FSBS Range: Per patient 120-185 although lately she has had fasting sugars over 200

- [ ] Foot lesions
- [ ] Foot care taught
- [ ] Foot care performed

Cardiac:
- [ ] WNL
- [ ] Syncope
- [ ] Angina
- [ ] Chest Pain
- [ ] Varicosities
- [ ] Pacemaker
- [ ] Orthoopenia (# of pillows) 3 pillows at night
- [ ] Edema

Other: BP – 146/85 P: 82 irregular – slight non-pitting edema at bilateral ankles. Patient states ankle swelling increases throughout the day.

Elimination Status:
Urinary:
- [ ] WNL
- [ ] Urinary incontinence
- [ ] Frequency
- [ ] Burning
- [ ] Nocturia

Bowel: WNL

Gastrointestinal: Abdomen soft/non-tender. Bowel sounds present in all four quadrants. Patient states daily bowel movements without difficulty if she takes her MiralAX in the morning.

Nutritional Assessment:
- [ ] WNL
- [ ] Pain
- [ ] Nausea
- [ ] Vomiting
- [ ] Diarrhea
- [ ] Constipation

Standardized nutritional assessment Completed: [ ] Yes [ ] No

Diet: 1500 calorie diet
Neuro/Emotional/Behavioral:

- Oriented: 
- Time 
- Place 
- Person 

- Alert 
- Forgetful 
- Dizziness 
- Pupils equal/reactive 

- Slurred Speech 
- Abnormal speech 
- Insomnia 
- Anxious 

- Headache 
- Depressed 
- Uncooperative 
- Memory deficit 

**Comments:** Patient is anxious that she may lose her foot. Ms. Violet had a close friend who began with a diabetic ulcer on the toe and went on to lose her foot. In discussion regarding consistency with blood sugar monitoring and medication compliance, the patient revealed that she often forgets to take her blood sugar and to take her medications on time, sometimes missing several doses.

**ADL/IADL**

Self-Care: 

- Independent 
- Needs Some Help 
- Dependent 

Ambulation: 

- Independent 
- Needs Some Help 
- Dependent 

Transfer: 

- Independent 
- Needs Some Help 
- Dependent 

Household Tasks: 

- Independent 
- Needs Some Help 
- Dependent 

**Comment:** Prior to fall requiring hospitalization Ms. Violet was independent in all daily activities. Following the fall, her right shoulder has limited mobility and is painful upon movement which limits her ability to fulfill all activities of daily living independently.

**Assistive Devices:** 

- Walker 
- Cane 
- Shower Chair 
- Reacher 

**Medications:**

- Patient unable to independently take meds 
- Drug education provided to patient 

- Patient requires drug diary or chart for meds 
- High-risk medication instruction given 

- Patient med dosages prepared by another person 
- Patient demonstrates non-compliance 

- Patient needs prompting/reminding 
- Patient meds must be administered 

- Drug regimen reviewed for interactions, duplicate therapy and potential adverse effects conducted
Current Medications:

- Lantus insulin 30 units at bedtime
- Metoprolol tartrate 25 mg twice a day
- Plavix 75 mg once a day
- Glyburide 10 mg twice a day
- Aspirin 81 mg once a day
- Simvastatin 40 mg at bedtime
- Folic Acid 1 mg once a day

Medication Management:

Oral Medications:  □ Independent  □ Need some Help  □ Dependent  □ N/A
Injectable:  □ Independent  □ Need some Help  □ Dependent  □ N/A

Comments: Ms. Violet has difficulty remembering to take her medications, including her evening insulin. She lives alone but has a family friend who lives two doors down who might help. A daughter lives 150 miles away but comes to see her mother once per month. Currently the patient has no other forms of assistance.

Plan of care/Teaching or Teaching Interventions Performed this visit.

- Education performed:
  - ☑ Medication management  ☑ Hand Hygiene
  - ☑ On Call Availability  ☑ Fall Precautions

- Interventions performed:
  - Physical Assessment
  - Teaching as above
  - Medication review

Plan of Care Collaboration:

- Nursing for wound care and medication management
- Home Health Aide for assistance with ADL
- Physical therapy to evaluate patient
Assessment Summary:

Comments: 72-year-old female with recent fall requiring hospitalization due to shoulder injury. During hospital stay, diabetic ulcer noted on right great toe. Patient is alert and oriented with self-identified times of forgetfulness. Ms. Violet informed nurse that she has at times forgotten to take her medicine. Patient uses Lantus injectable pen but also at times forgets to take her evening insulin. Discussion with patient about use of pill organizer and the setting of an alarm as a reminder for her insulin. Also discussed the availability of a close neighbor for assistance and that daughter may be able to call her each night as a reminder. Vital signs were stable. Respiration easy with rales noted in right lower lobe. Patient with no bowel difficulties as long as she takes her Miralax. Infrequent urinary incontinence due to difficulty in getting up quickly from her chair. Patient having pain in her right shoulder since the fall and has limited range of motion which affects her ability to conduct ADL/IADL easily. Dressing not removed during this visit as the wound had been redressed prior to discharge.

☐ Physician contacted regarding plan of care:

Comments: None

Homebound Status:

☐ Residual weakness  ☐ dependent upon adaptive device  ☐ confusion, unable to leave alone

☐ Medical restriction  ☐ severe SOB upon exertion  ☐ requires assistance to ambulate

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OASIS-E Resources

Outcome and Assessment Information Set

OASIS-E Manual

- Table of changes and additions between OASIS D and OASIS E
- Instructions on how to score several questions (good for training staff)
- Reminders of OASIS time points
- OASIS and Quality Improvement

OASIS-E Resources

OASIS-E Changes from Draft to Final Instrument and Manual _12012022

- Several numbering changes
- Verbiage changes for clarity
- Grammar and typographical errors addressed
- Updated guidance for the following sections
  - Cognitive
  - Mood
  - Health Conditions
  - Swallowing/nutritional status
  - Medications
  - Special Treatments, Procedures and Programs

Plan of Care of Elements

<table>
<thead>
<tr>
<th>Element</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>All pertinent Diagnosis</td>
<td>Patient care orders, including verbal orders</td>
</tr>
<tr>
<td>Mental/psychosocial/cognitive status</td>
<td>Types of services/supplies/equipment required</td>
</tr>
<tr>
<td>Frequency and duration of visits</td>
<td>Mode of care delivery including telecommunications</td>
</tr>
<tr>
<td>Prognosis and rehabilitation potential</td>
<td>Functional limitations/activities permitted</td>
</tr>
<tr>
<td>Nutritional requirements/food and drug allergies</td>
<td>All medications and treatments</td>
</tr>
<tr>
<td>Safety measures to protect against injury</td>
<td>Description of risk for emergency department visits</td>
</tr>
<tr>
<td>Necessary interventions to address risk factors</td>
<td>Patient and caregiver education to facilitate discharge</td>
</tr>
<tr>
<td>Patient-specific interventions and education</td>
<td>Measurable outcomes and goals</td>
</tr>
<tr>
<td>Advance directives information</td>
<td>Additional items determined by allowed practitioner</td>
</tr>
</tbody>
</table>
**HOME HEALTH CERTIFICATION AND PLAN OF CARE**

<table>
<thead>
<tr>
<th>1. Patient's H.E. Claim No.</th>
<th>2. Start Of Care Date</th>
<th>3. Certification Period From</th>
<th>4. Medical Record No.</th>
<th>5. Provider No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>123456</td>
<td>7/22/2021</td>
<td>9/22/2021</td>
<td>12589</td>
<td></td>
</tr>
</tbody>
</table>

8. Patient's Name and Address

Violet Chap  
2300 Chappy Lane, Chapster, MA 23568

9. Date of Birth: 7/18/2021  
Sex: M

11. C/D: Principal Diagnosis  
Encounter Fall with Injury  
Encounter Date 7/18/2021

12. C/D: Surgical Procedure  
Diabetic Ulcer Right Foot, Type 2

13. C/D: Other Relevant Diagnoses  
Diabetes Mellitus, Type 2

14. DME and Supplies  
Glucose Meter, cane

15. Safety Measures  
Fall Risk

**CHAP**
21. Orders for Discipline and Treatments (Specify Amount/Frequency/Duration)

SN 3W4, 2W3, 1W2; HHA 2-3 times per week for personal care; PT to evaluate and treat.

Skilled Nursing to assess wound R great toe each visit. Wound care as ordered. Teach medication compliance, s/s of infection; S/S of hyper/hyperglycemia, fall safety. Maintain foot elevation. Supervision of HHA.

HHA personal care 2-3 times per week - bathing, hair shampoo, assist with ambulation and transfer, meal preparation, clean bedroom and bath. Notify RN of change in patient condition.

22. Social/Rehabilitation Potentials/Discharge Plans

Patient desires to be independent and able to walk without use of cane.
2022 Top Findings in APC

<table>
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<tr>
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<tr>
<td>APC.7.I.M2</td>
<td>Required Elements of the Plan of Care (25%)</td>
<td>G574</td>
</tr>
<tr>
<td>APC.8.I.M3</td>
<td>Provision of written instructions (24%)</td>
<td>614/616/618/620/622</td>
</tr>
<tr>
<td>APC.11.I.M3</td>
<td>Timely D/C &amp; transfer summary includes all elements(14%)</td>
<td>G1022</td>
</tr>
<tr>
<td>APC.6.I.M1</td>
<td>Required elements of the Comprehensive Assessment(10%)</td>
<td>G536</td>
</tr>
<tr>
<td>APC.9.I.M3</td>
<td>Physician is alerted to changes in patient's condition (5%)</td>
<td>G590</td>
</tr>
</tbody>
</table>

484.60(a)(2); Required elements of the Plan of Care

G574 - 19 elements to this standard and 3 potential G tags

- (PRN) or as-needed visit orders are to be minimal include a reason;
  Frequency may be a specific range Ranges are expected to be small (ex: 2-4 visits)

- Telecommunications cannot substitute for a home visit but must be ordered as part of the plan of care
484.60(e)(1); Provision of written instructions

**G614** – Visit schedule- employed and contract

**G616** – Patient medication schedule/instructions, .

**G618** - Treatments to be administered by HHA personnel including therapy services.

**G620**- Instruction related to the patient’s care

**G622**- Name and contact information of the HHA clinical manager.

484.55(c)(5): Required elements of Comprehensive Assessment

**G536** Review all current medications to identify any potential adverse effects and drug reactions.

484.110(a)(6): Timely discharge and Transfer Summaries

**G1022**- D/C summary in 5 business days of D/C; Transfer- 2 business days of transfer or awareness of transfer
Summary Content

• Content of the summaries will include:
• Admission and discharge dates;
• Physician responsible for the home health plan of care;
• Reason for admission to home health;
• Type and frequency of services provided; lab data
• Medications the patient is on at the time of discharge;
• Patient’s discharge condition;
• Patient outcomes in meeting the goals; Patient/family discharge instructions.

APC cont..

484.60(c)(1)

G590: 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.
Tips for Success

- Focused audits
  - Staff to check medications every visit

- Use of templates
  - Standardized processes and documentation
  - Educate staff on alternate assessment components
  - Have plan B available for documentation

Participant Guide
Page 74
Financial Stewardship (FS)

Operating Budget

- Budget includes full scope and complexity of services;
- Includes anticipated income and expenses
- Prepared under direction of GB
- Reviewed and updated at least annually under direction of GB
Capital Expenditure

- Capital expenditures are funds spent to acquire or upgrade physical assets (property, equipment, etc.). This standard applies only to capital expenditures over $600,000.

- If the CE plan includes financing from Title V (Maternal and Child Health and Crippled Children's Services), Title XVIII (Medicare), or Title XIX (Medicaid) of the Social Security Act, the plan specifies conformity with Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.
Tips for Success

- Schedule for review and update of the budget
- Document meeting interactions
- Ensure appropriate representation
Care Delivery and Treatment

CDT
Physician Orders

The Requirements

Policies and procedures for acceptance, documentation, verification and authentication
- Allowed practitioner gives orders
- Appropriate personnel receive orders

Compliance with local, state, and federal law, CHAP standards and agency policy
- Know which is strictest

Authentication includes:
- Signature (with credentials)
- Date
- Time order received

Physician signature within timeframe
- No longer a 30-day requirement by CHAP
- State specific/agency policy
Skilled Professionals

Responsibilities include:
- Ongoing interdisciplinary assessment of the patient;
- Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s);
- Providing services that are ordered by the physician or allowed practitioner per the plan of care;
- Patient, caregiver, and family counseling;
- Patient and caregiver education; and
- Preparing clinical notes.
- Coordination of care (APC)
- Participation in quality program (CQI)
- Participation in organization sponsored in-service training (HRM)

Supervision of Skilled Professionals

Supervised by qualified individuals consistent with
- Organizational policy and procedure
- Local/state/federal law and regulation

Skilled nursing
- Supervised by qualified RN

Therapy services
- Supervised by qualified OT or PT

Social work assistant
- Supervised by qualified social workers

Performance Evaluations – as per organizational policy
Home Health Aide Services

The Requirements

Assigned to a specific patient

Individualized written patient care instructions

Member of interdisciplinary team

Duties include:

- Providing hands-on personal care;
- Performing simple procedures as an extension of therapy or nursing services;
- Reporting changes in the patient's condition;
- Assisting in ambulation or exercises;
- Assisting in administering medications ordinarily self-administered;
- Completing appropriate records in compliance with the organization's policies and procedures.

Supervision of Home Health Aide

Purpose:

- Following the patient's plan of care for completion of tasks assigned
- Maintaining open communication with the patient, representative (if any), caregiver(s), and family;
- Demonstrating competency with assigned tasks;
- Complying with infection prevention and control policies and procedures;
- Reporting changes in the patient's condition; and
- Honoring patient rights.

Skilled care patients

- No less frequently than every 14 days
  - Onsite visit
  - Rarely using telecommunication and not to exceed 1 virtual supervisory assessment per patient in a 60-day episode
  - Annual on-site visit to observe aide providing care

Non-skilled

- On-site visit every 60 days
- Semi-annually RN completes on-site to each patient while aide is present
Activity

One:
Review of video and discussion

Two:
Review the Nursing clinical note and discussion (page 79)

Three:
Review of Home Health Plan of Care and discussion (page 81)
**Discussion**

**Top Findings in CDT**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Content</th>
<th>CMS Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>CDT.7.I.M2</td>
<td>Skilled professionals follow the plan of care/fulfill duties (45%)</td>
<td>G710</td>
</tr>
<tr>
<td>CDT.7.I.M7</td>
<td>Home Health Aide fulfills responsibilities (16%)</td>
<td>G800</td>
</tr>
<tr>
<td>CDT.4.I.M1</td>
<td>Medication/services treatments administered as ordered (12%)</td>
<td>G580</td>
</tr>
<tr>
<td>CDT.5.I.M2</td>
<td>Verbal orders authenticated and dated within 30 days. (10%)</td>
<td>G584</td>
</tr>
<tr>
<td>CDT.7.I.M5</td>
<td>Home health aides are provided written instruction (6%)</td>
<td>G798</td>
</tr>
</tbody>
</table>
Observation is key to evaluate care provision

During visits encourage staff to interview patient about aide services

Standardized process for documentation and communication of medication changes
Leadership and Governance

LG
### Standard Summary for LG

<table>
<thead>
<tr>
<th>LG.1.I</th>
<th>Provision of services to meet patient needs</th>
</tr>
</thead>
<tbody>
<tr>
<td>LG.3.I</td>
<td>care furnished in compliance with law and regulation</td>
</tr>
<tr>
<td>LG.4.I</td>
<td>Responsibility of governance</td>
</tr>
<tr>
<td>LG.6.I</td>
<td>Leadership qualifications</td>
</tr>
<tr>
<td>LG.7.I</td>
<td>Administrator responsibilities</td>
</tr>
<tr>
<td>LG.10.I</td>
<td>all care settings are monitored</td>
</tr>
<tr>
<td>LG.11.D</td>
<td>lines of authority</td>
</tr>
<tr>
<td>LG.12.D</td>
<td>services provided under arrangement requirements</td>
</tr>
</tbody>
</table>

### Governing body

**Full legal authority:**

- Overall management and operation
- Provision of services
- Fiscal operations
- Review of organization's budget and operational plans
- Quality assessment and performance improvement program
- Appoints qualified administrator
**Governing body**

**Quality Oversight:**
- Program reflects complexity of services
- Includes services provided under contract or arrangement
- Indicators related to improved outcomes
  - Emergent care use
  - Hospital admissions and readmissions
  - Prevention and reduction of medical errors
  - Address spectrum of care provided
- Addresses priorities for improved quality of care and patient safety
- Ensures actions are evaluated for effectiveness and maintained
- Address any findings of fraud or waste

**Leadership**

**Qualifications after Jan 2018**

**Administrator**
- Licensed physician, registered nurse or holds an undergraduate degree and
- Experience in health service administration with 1 year of supervisory or administrative experience in home health or a related field

**Clinical Manager**
- Licensed physician PT, SLP, OT, audiologist, social worker or RN
**Administrator**

**Responsibilities:**

- Day-to-day operations
- Ensuring clinical manager is available during all operating hours
- Ensuring organization employs qualified personnel
- Ensure development of personnel qualifications and policies
- Administrator or predesignated person available
  - Alternate is designated in writing by administrator and governance
  - Assumes same responsibilities and obligations as administrator

**Contractual Services**

**Requirements:**

- Delivered consistent with standards of practice and patient safety
- Contracts signed/dated/authorized by each party
  - Detail specific responsibilities of each party
- Patient is not held financially liable for contracted services
- All services are monitored and controlled
  - Responsibility for service provided are the responsibility of the organization
- Contracted staff may not have been on exclusion list
Top Findings in LG

<table>
<thead>
<tr>
<th>Standard</th>
<th>Content</th>
<th>CMS Tag</th>
</tr>
</thead>
<tbody>
<tr>
<td>LG.4.I.M3</td>
<td>Governance has responsibility for Quality program (31%)</td>
<td>G660 G640 CLD</td>
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<tr>
<td>LG.4.I.M1</td>
<td>Agency governance assumes full legal authority (14%)</td>
<td>G942</td>
</tr>
<tr>
<td>LG.7.I.M1</td>
<td>Administrator responsibilities and reporting to gov body (10%)</td>
<td>G948 G950</td>
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<tr>
<td>LG.12.D.M1</td>
<td>Patients are not liable for services provided under arrangement (8%)</td>
<td>G976</td>
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<tr>
<td>LG.7.I.M3</td>
<td>Alternate administrator in writing assumes responsibilities (8%)</td>
<td>G954</td>
</tr>
</tbody>
</table>

Tips for Success

Documentation of governing body involvement

Plan ahead for annual budget review...
Schedule it!
Information Management (IM)
**IM Standards Summary**

- **IM.1.D** – Policies addressing collection/sharing/retention of data
- **IM.2.I** – Policies reflecting the time frame to keep personnel/clinical/financial, administrative records
- **IM.3.I** – Appropriate information is shared with government agencies
- **IM.4.I** – Access of patient information and protection of information
- **IM.5.D** – Standardized protocols for data collection
- **IM.6.I** – Data transmission per regulation
- **IM.7.I** – Patient record elements

**Communicating with Government Officials**

Information is disclosed in accordance with state, local, federal law and regulation.

Information at initial certification request, each survey and at time of change in ownership/management:

- Name and address of those with ownership or controlling interest
- Name and address of each officer, director, agency or managing employee
- Name and address of management corporation or association
  - Including CEO and chairperson of the board of directors

Parent responsible for reporting all branch locations at initial certification request, each survey and upon adding or deleting a branch.
Access of Information

Accessed only by authorized individuals
Record safeguarded against loss, unauthorized use or access

Health information is protected
- PHI disclosed for purposes permitted by law
- Documented patient consent is obtained for release of information

Record availability
- Patient – hard copy or electronic
  - Free of charge
  - Upon request at the next home visit or
    - Within four business days (whichever comes first)
- Physician issuing orders
- Appropriate personnel

Confidentiality of all patient information
- Per contract
- Including OASIS data

Documentation

Standardized collection and documentation

Protocols include
- Definitions
- Prohibited
  - Symbols
  - Abbreviations
  - Acronyms

Record includes past and current information

Entries
- Legible, clear, complete
- Authenticated
  - Signature and title OR
  - Secure computer entry by unique identifier
Data Transmission

Compliance with local, state, and federal law

OASIS encoded and transmitted within 30 days of completing assessment

- Data accurate reflects patient status
- Software used either from CMS or conforms to CMS standards
  - Include required OASIS data set
  - Transmission includes CMS-assigned branch identification number

Required Elements of Patient Record

1. Contact information
2. Consent
3. Comprehensive assessments
4. Plans of Care
5. Education and training
6. Physician or allowed practitioner orders
7. Clinical progress notes;
8. All interventions
9. Responses to interventions;
10. Goals and the patient's progress
Top Findings in IM

<table>
<thead>
<tr>
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</thead>
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<tr>
<td>IM.7.I.M1</td>
<td>Required elements of the patient record (40%)</td>
<td>G1012</td>
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<tr>
<td>IM.5.I.M2</td>
<td>Entries are legible, clear, complete and include signature &amp; title (27%)</td>
<td>G1024</td>
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<tr>
<td>IM.4.I.M1</td>
<td>Availability of patient record (10%)</td>
<td>G1030</td>
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<tr>
<td>IM.5.I.M1</td>
<td>Patient record includes past, and current information that is accurate (6%)</td>
<td>G1008</td>
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</table>

Tips for Success

- Use of templates may aid in standardizing documentation
- Standardized processes for monitoring submission of documentation
- Focus audits to validate comprehensive documentation at specific timeframes such as recertification, resumption and transfer of care
Earning CE Contact Hours

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After completing the entire webinar, log on to your CHAP Education account and access the course page. From this page, follow the instructions to complete the evaluation and obtain your CE Certificate.

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