

Home Health Day 3
Consultant Certification

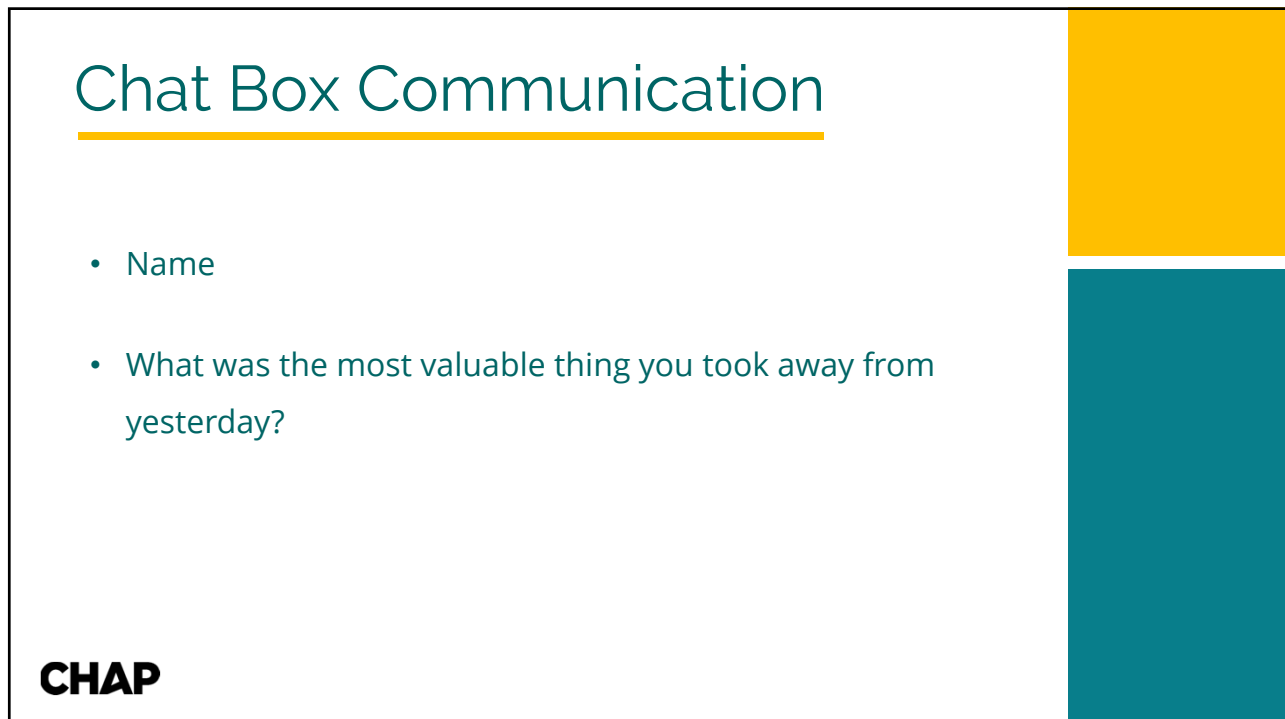
An Interactive Training

Bobbie Warner RN, BSN
Director of Education

CHAP Community Health Accreditation Partner

The slide features a teal and yellow color scheme. On the left, there are two vertical images: the top one shows hands holding a stethoscope, and the bottom one shows hands clasped together. The right side of the slide has a vertical bar with a teal and yellow gradient and a teal hatched pattern at the top.

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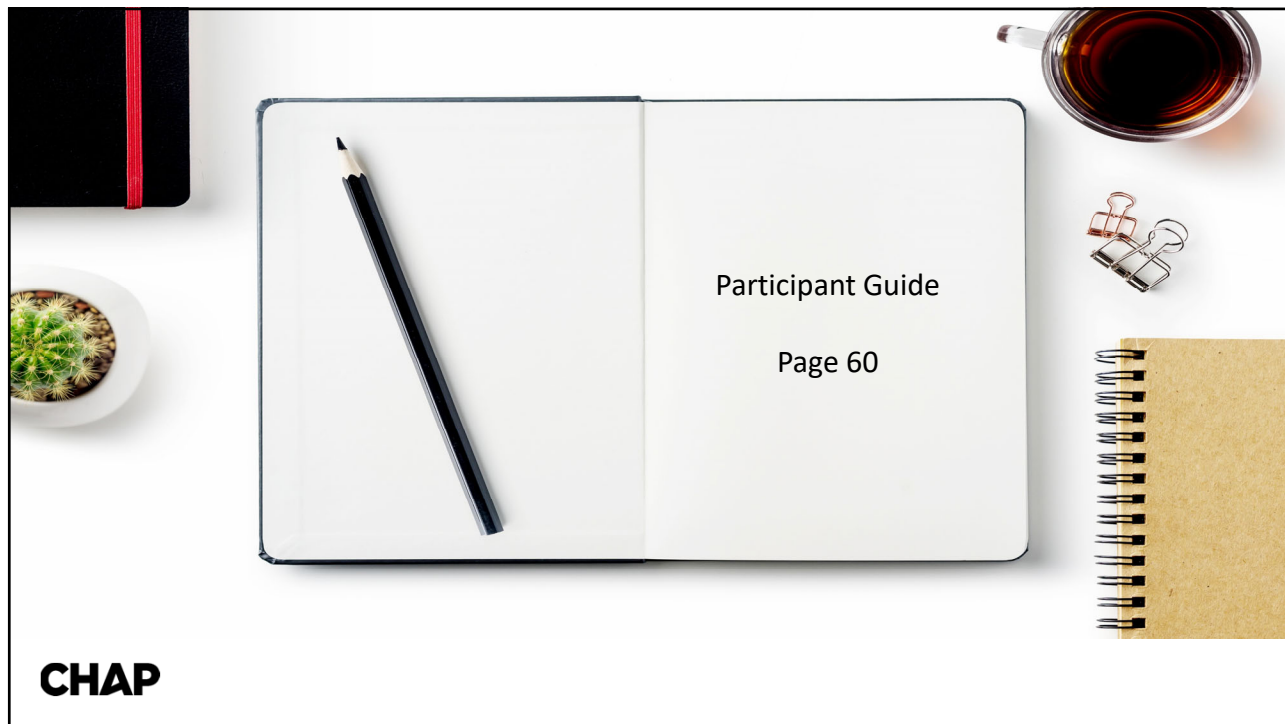
Chat Box Communication

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

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The slide features a teal and yellow color scheme. The right side of the slide has a vertical bar with a teal and yellow gradient. The text is in a teal color.

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CHAP Standards Overview




CHAP Community Health Accreditation Partner	CHAP 2300 Clarendon Blvd, Suite 405 Arlington VA 22201 202-862-2413	www.chapinc.org www.chapinc.org info@chapinc.org
Home Health Standards of Excellence		
		

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CHAP Standards of Excellence

-  Revisions
-  Version
-  Evidence Guidelines

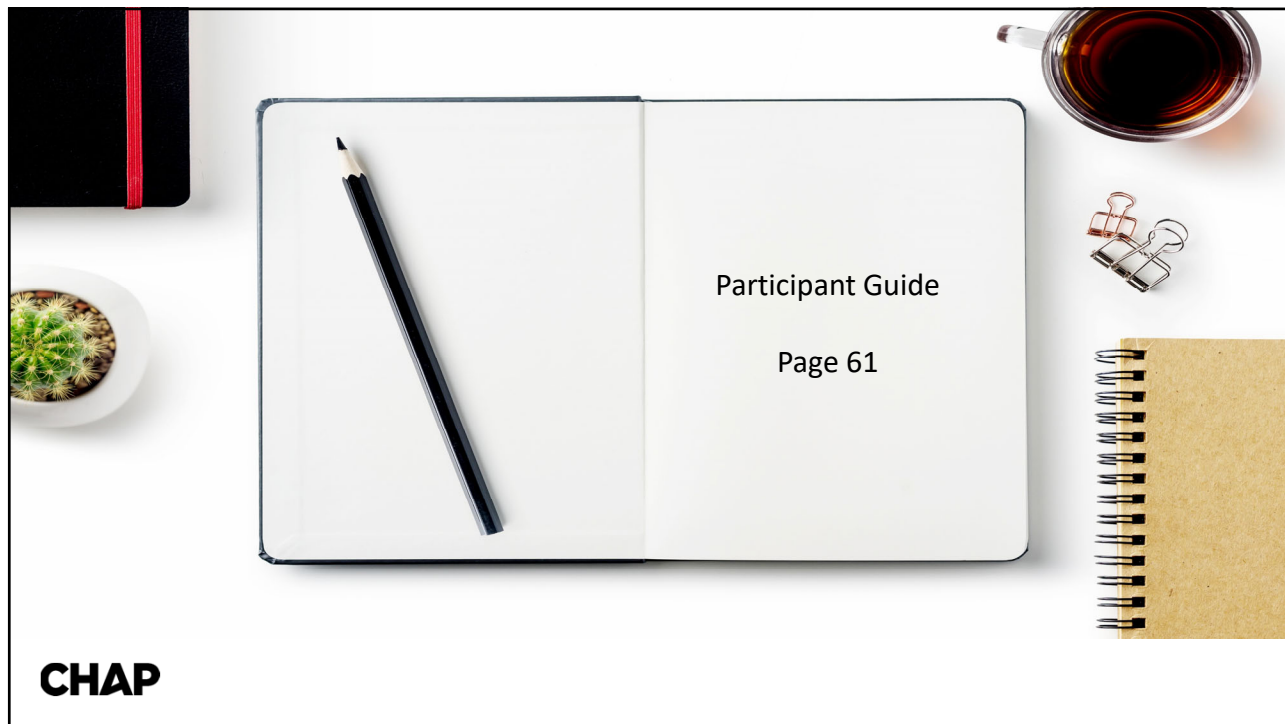
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Additional Resources

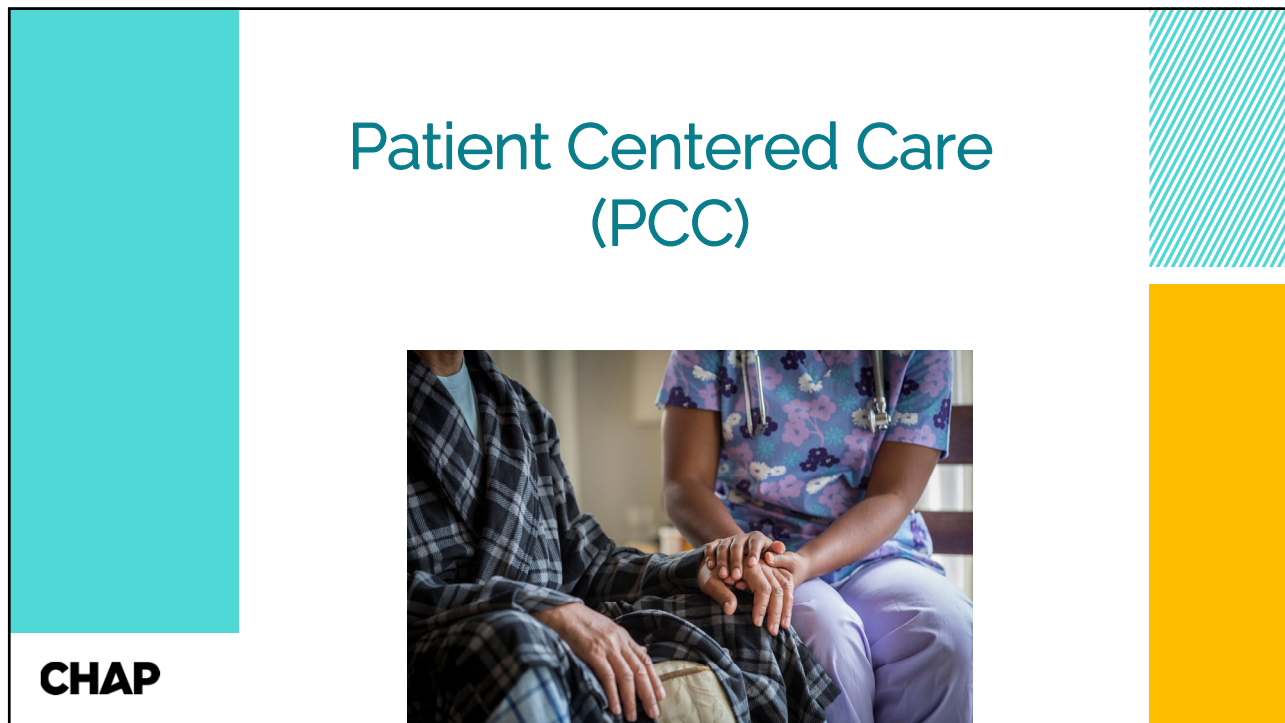
- Appendix B – Home Health State Operations Manual
- Appendix Z – Emergency Preparedness
- MAC – Medicare Administrator Contractor
- MLN newsletters and CHAP eNews



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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

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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



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2022 Top Findings in PCC

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

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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*

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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

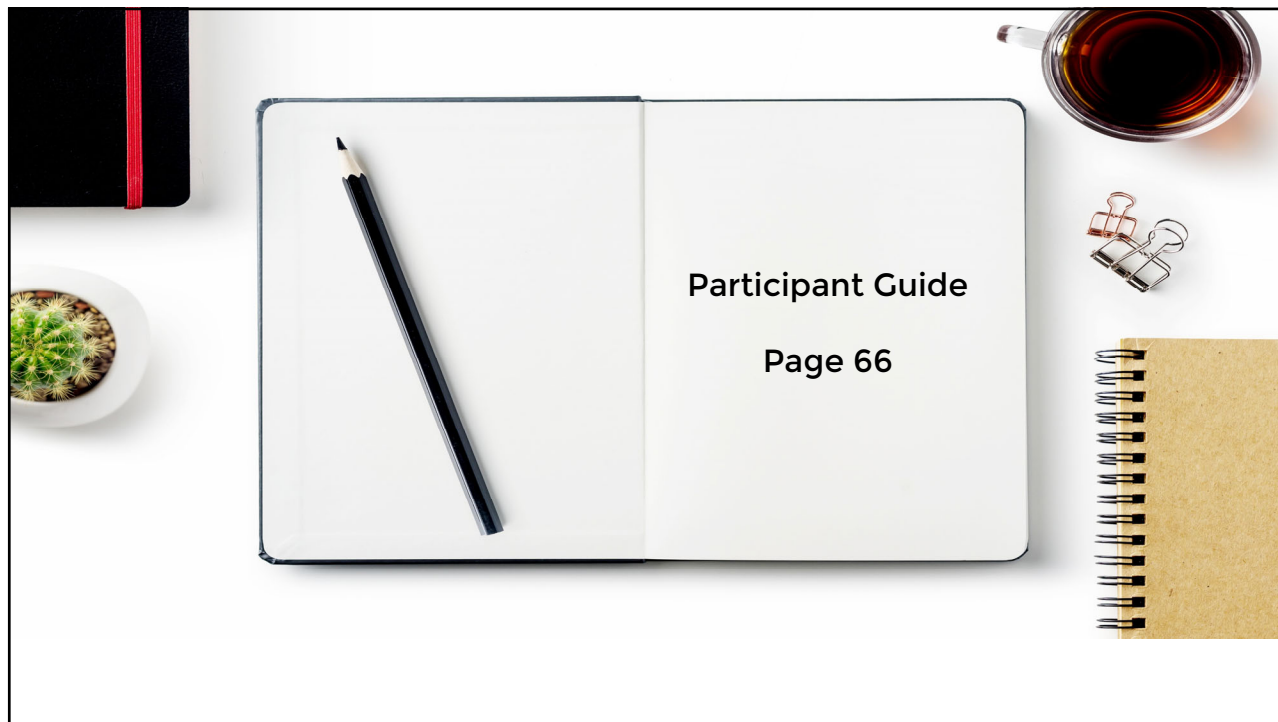
Think outside of the box

Periodically check the contact numbers

Talk to patients

Implementation as well as verbiage

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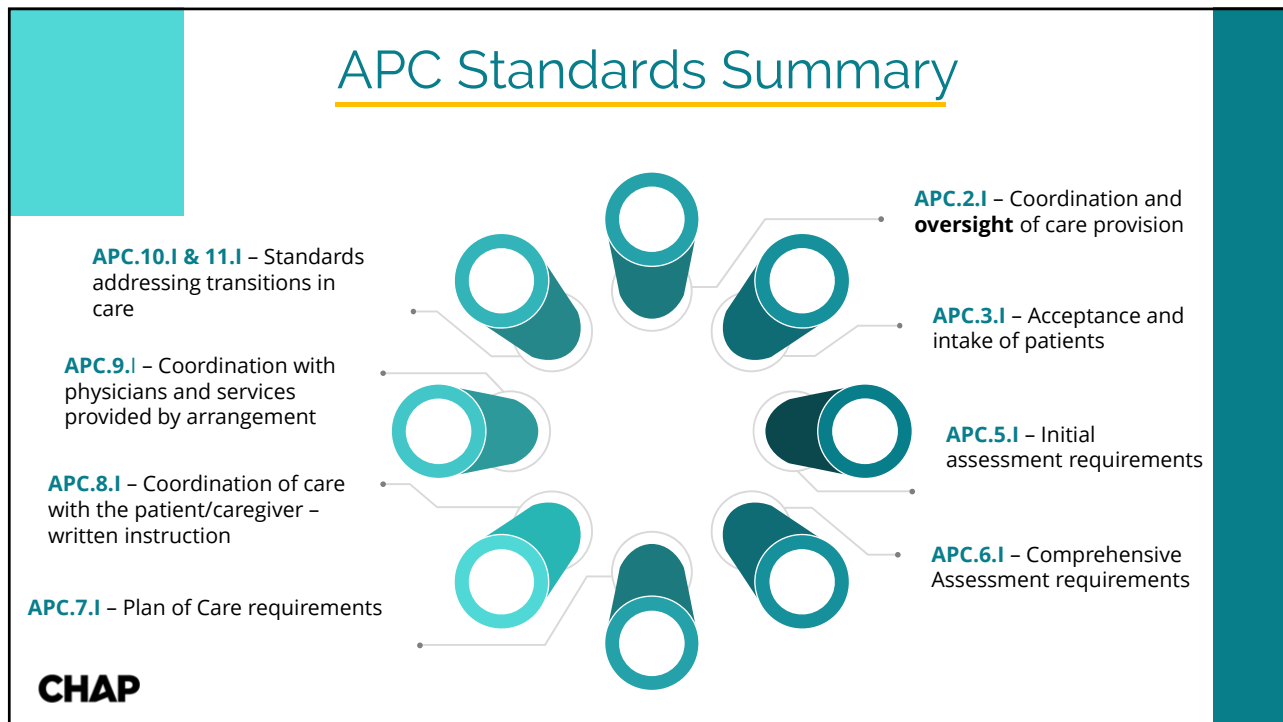
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Assessment, Planning and Coordination

APC

The slide features a central title "Assessment, Planning and Coordination" in teal, with the acronym "APC" below it in a teal script font. The background is white with decorative elements: a teal and white striped vertical bar on the right, a solid teal vertical bar on the left, and a solid yellow vertical bar on the right. Three images are included: a doctor writing on a clipboard, hands being held in support, and a doctor smiling while talking to an elderly patient. A small icon of a person with a heart and feet is located in the bottom right corner of the yellow bar.

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Comprehensive Assessment

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

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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.

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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.

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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 Reg Irreg
 Resp: 22 Pulse Radial: 82 Reg Irreg
 B/P: 146/85 Left Arm – Unable to take in right arm due to shoulder pain with movement

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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.

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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

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional or short-term assistance	No assistance available
a. Patient lives alone	<input checked="" type="checkbox"/>	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05
b. Patient lives with other person(s) in the home	<input type="radio"/> 06	<input type="radio"/> 07	<input type="radio"/> 08	<input type="radio"/> 09	<input type="radio"/> 10

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

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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 Orthopnea (# of pillows) 3 pillows at night Edema

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

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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

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Neuro/Emotional/Behavioral:

- | | | | |
|---|---|---|--|
| <input checked="" type="checkbox"/> Oriented: | <input checked="" type="checkbox"/> Time | <input checked="" type="checkbox"/> Place | <input checked="" type="checkbox"/> Person |
| <input checked="" type="checkbox"/> Alert | <input checked="" type="checkbox"/> Forgetful | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Pupils equal/reactive |
| <input type="checkbox"/> Slurred Speech | <input type="checkbox"/> Abnormal speech | <input type="checkbox"/> Insomnia | <input checked="" type="checkbox"/> Anxious |
| <input type="checkbox"/> Headache | <input type="checkbox"/> Depressed | <input type="checkbox"/> Uncooperative | <input checked="" type="checkbox"/> 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: | <input type="checkbox"/> Independent | <input checked="" type="checkbox"/> Needs Some Help | <input type="checkbox"/> Dependent |
| Ambulation: | <input type="checkbox"/> Independent | <input checked="" type="checkbox"/> Needs Some Help | <input type="checkbox"/> Dependent |
| Transfer: | <input type="checkbox"/> Independent | <input checked="" type="checkbox"/> Needs Some Help | <input type="checkbox"/> Dependent |
| Household Tasks: | <input type="checkbox"/> Independent | <input checked="" type="checkbox"/> Needs Some Help | <input type="checkbox"/> Dependent |

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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:

- | | |
|---|--|
| <input type="checkbox"/> Patient unable to independently take meds | <input checked="" type="checkbox"/> Drug education provided to patient |
| <input checked="" type="checkbox"/> Patient requires drug diary or chart for meds | <input type="checkbox"/> High-risk medication instruction given |
| <input type="checkbox"/> Patient med dosages prepared by another person | <input type="checkbox"/> Patient demonstrates non-compliance |
| <input checked="" type="checkbox"/> Patient needs prompting/reminding | <input type="checkbox"/> Patient meds must be administered |
| <input checked="" type="checkbox"/> Drug regimen review for interactions, duplicate therapy and potential adverse effects conducted | |

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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/AInjectable : 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.

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Plan of care/Teaching or Teaching Interventions Performed this visit.**Education performed:** Medication management Emergency Plan 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

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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. Respirations 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

Outcome and Assessment Information Set
OASIS-E Manual



Effective January 1, 2023
Centers for Medicare and Medicaid Services



<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual>

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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

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Plan of Care of Elements

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

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Department of Health and Human Services Centers for Medicare & Medicaid Services		Form Approved OMB No. 0938-0357		
HOME HEALTH CERTIFICATION AND PLAN OF CARE				
1. Patient's HI Claim No. 123456	2. Start Of Care Date 7/22/2021	3. Certification Period From: 7/22/2021 To: 9/22/2021		4. Medical Record No. 12589
6. Patient's Name and Address Violet Chap 2300 Chappy Lane, <u>Chapster</u> , MA 23568			7. Provider's Name, Address and Telephone Number Dr. Guthrie Physician Drive Hospital, IN 23657	
8. Date of Birth	9. Sex <input type="checkbox"/> M <input type="checkbox"/> F	10. Medications: Dose/Frequency/Route (N) <u>ew</u> .(C)hanged		
11. ICD Principal Diagnosis Encounter Fall with Injury	Date 7/18/2021	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 S <u>imvastatin</u> 40 mg at bedtime Folic Acid 1 mg once a day		
12. ICD Surgical Procedure	Date			
13. ICD Other Pertinent Diagnoses Diabetic Ulcer Right Foot Diabetes Mellitis Type 2	Date 7/18/2021 long Standing			
14. DME and Supplies Glucometer, cane		15. Safety Measures Fall Risk		
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16. Nutritional Req. 1500 Cal Diet		17. Allergies No Drug or food allergies	
18.A. Functional Limitations			
1 <input type="checkbox"/> Amputation	5 <input type="checkbox"/> Paralysis	9 <input type="checkbox"/> Legally Blind	
2 <input checked="" type="checkbox"/> Bowel/Bladder (u)cc(u)age	6 <input checked="" type="checkbox"/> Endurance	A <input type="checkbox"/> Dyspnea With Minimal Exertion	
3 <input type="checkbox"/> Contracture	7 <input checked="" type="checkbox"/> Ambulation	B <input type="checkbox"/> Other (Specify)	
4 <input type="checkbox"/> Hearing	8 <input type="checkbox"/> Speech		
18.B. Activities Permitted			
1 <input type="checkbox"/> Complete Bedrest	6 <input type="checkbox"/> Partial Weight Bearing	A <input type="checkbox"/> Wheelchair	
2 <input type="checkbox"/> Bedrest BRP	7 <input type="checkbox"/> Independent At Home	B <input type="checkbox"/> Walker	
3 <input checked="" type="checkbox"/> Up As Tolerated	8 <input type="checkbox"/> Crutches	C <input type="checkbox"/> No Restrictions	
4 <input type="checkbox"/> Transfer Bed/Chair	9 <input checked="" type="checkbox"/> Cane	D <input type="checkbox"/> Other (Specify)	
5 <input type="checkbox"/> Exercises Prescribed			
19. Mental Status			
1 <input checked="" type="checkbox"/> Oriented	3 <input checked="" type="checkbox"/> Forgetful	5 <input type="checkbox"/> Disoriented	7 <input type="checkbox"/> Agitated
2 <input type="checkbox"/> Comatose	4 <input type="checkbox"/> Depressed	6 <input type="checkbox"/> Lethargic	8 <input type="checkbox"/> Other
20. Prognosis			
1 <input type="checkbox"/> Poor	2 <input type="checkbox"/> Guarded	3 <input type="checkbox"/> Fair	4 <input checked="" type="checkbox"/> Good
			5 <input type="checkbox"/> Excellent
CHAP			

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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 hypo/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.

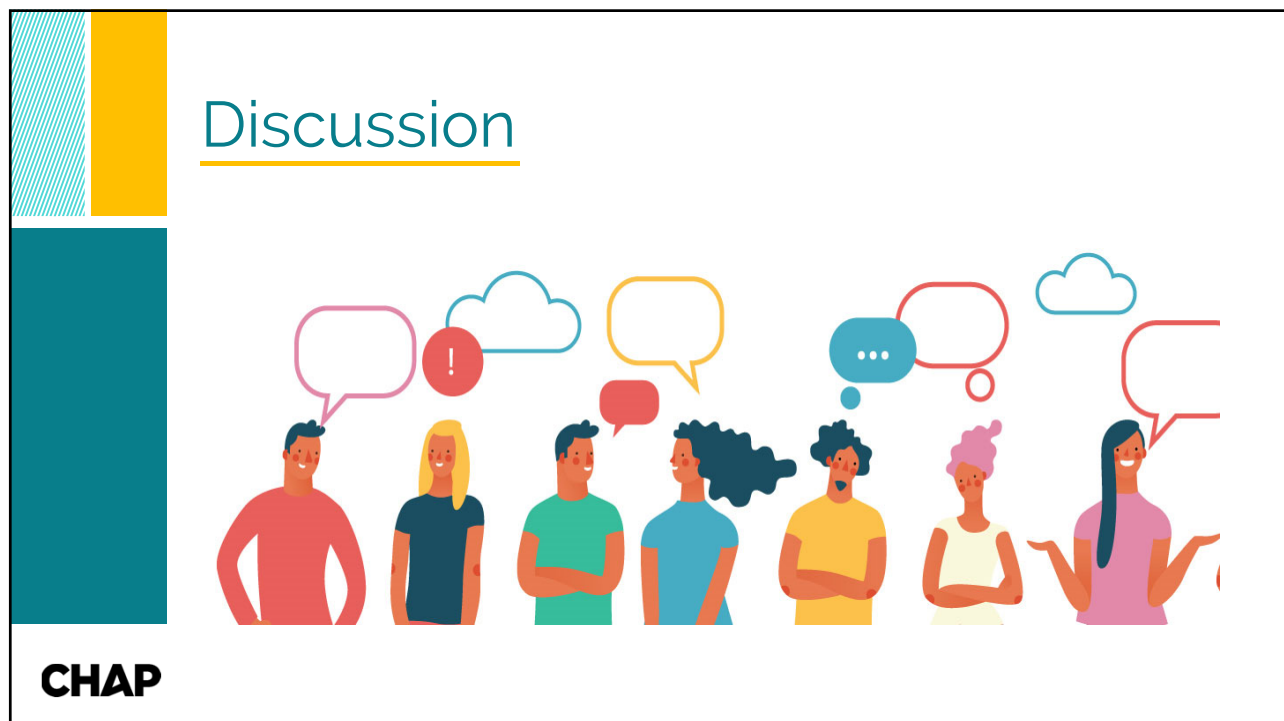
22. Goals/Rehabilitation Potential/Discharge Plans

Patient desires to be independent and able to walk without use of cane.

23. Nurses Signature and Date of Verbal/DOC When Applicable: _____

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2022 Top Findings in APC

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

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Top Findings APC

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

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APC cont.

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.

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APC cont..

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

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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.

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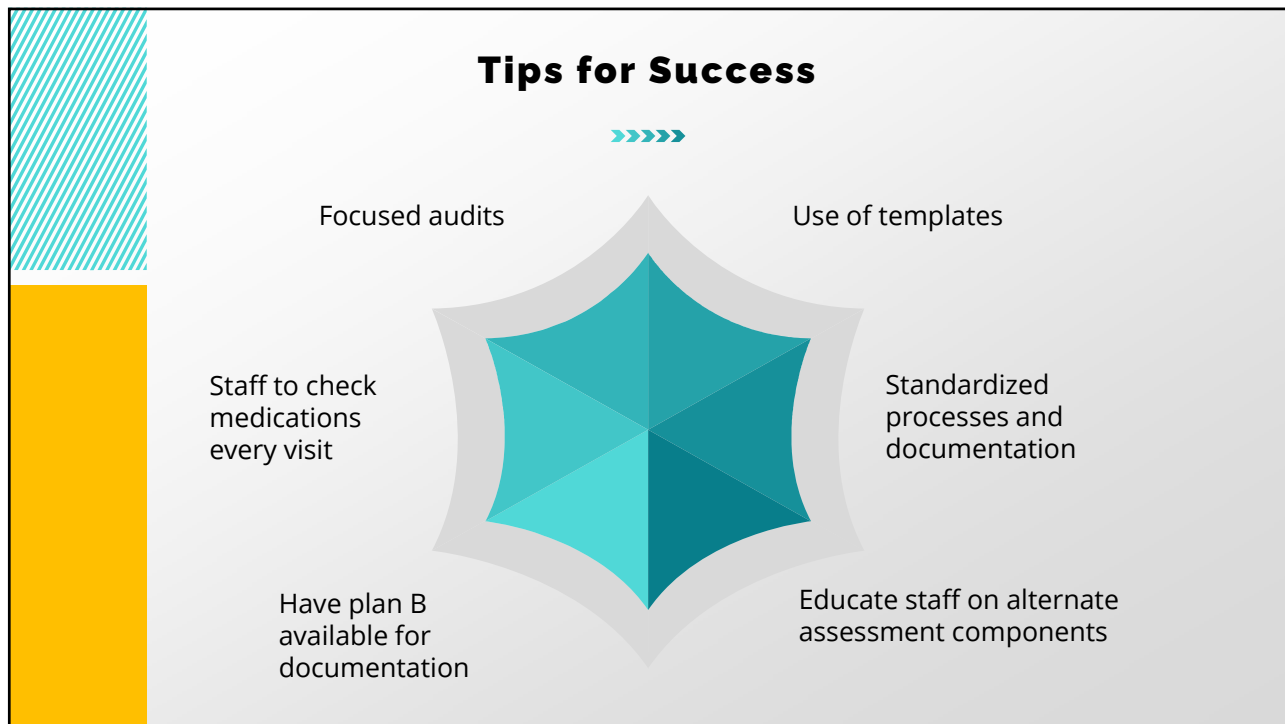
APC cont..

484.60(c)(1)

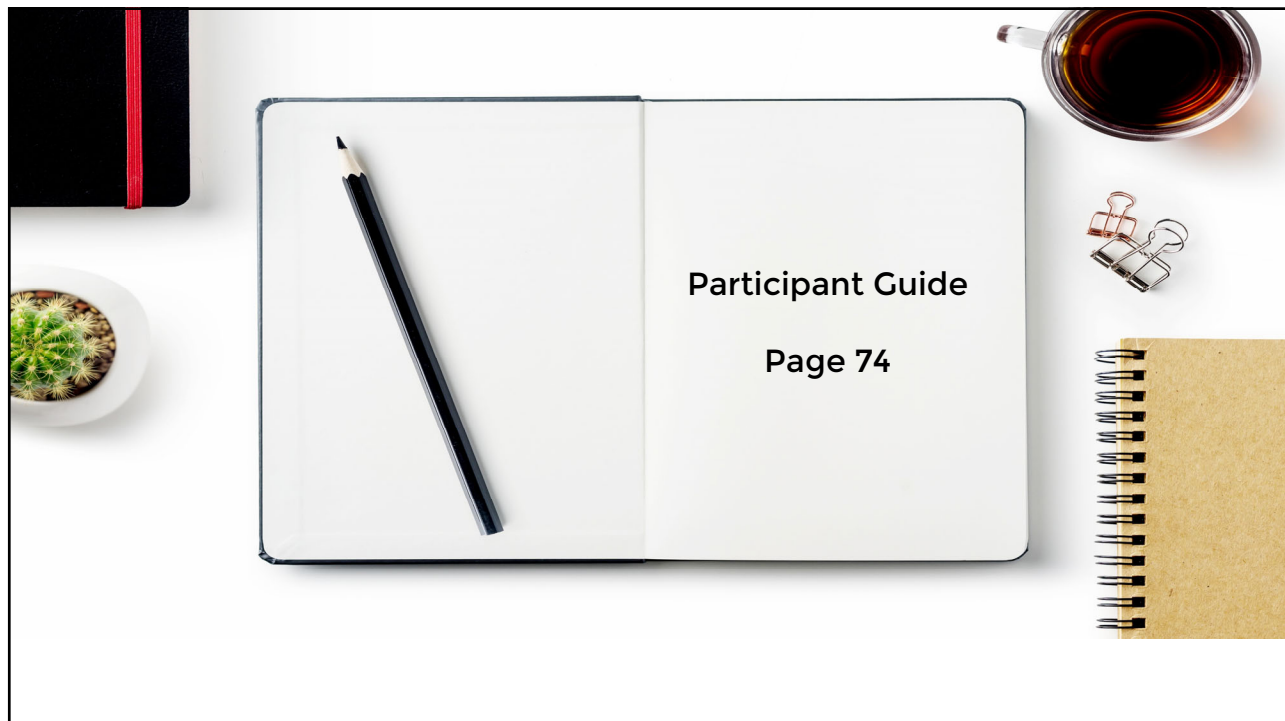
G590- *The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.*

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Financial Stewardship (FS)



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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

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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

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Top Finding in Financial Stewardship

Standard	Content	CMS Tag
FS.2.I	An annual operating budget is present(25%)	G988
FS.2.I.M1	Annual operating budget addresses all anticipated income and expenses(25%	G988
FS.2.I.M2	The annual budget is prepared under the guidance of governance(25%)	G988
FS.2.I.M3	Annual budget is reviewed and updated at least annually(25%)	G988

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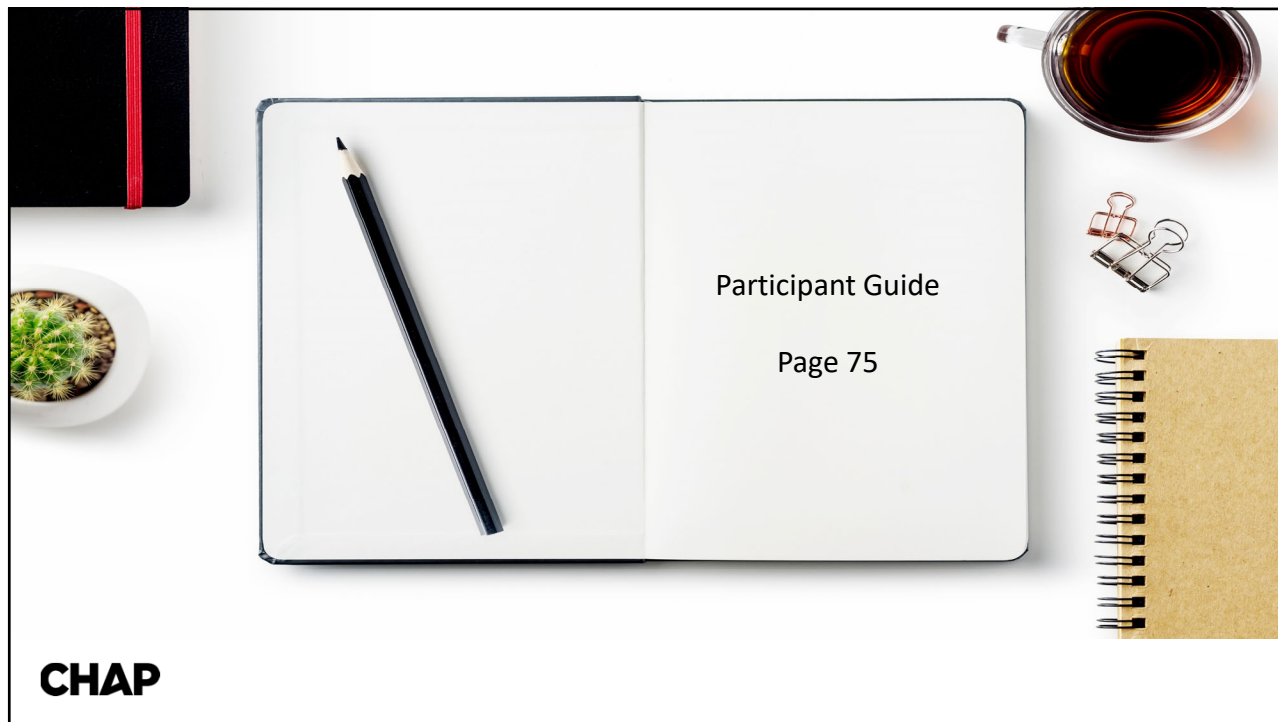
Tips for Success

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

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Care Delivery and Treatment

CDT

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CDT Standards Summary

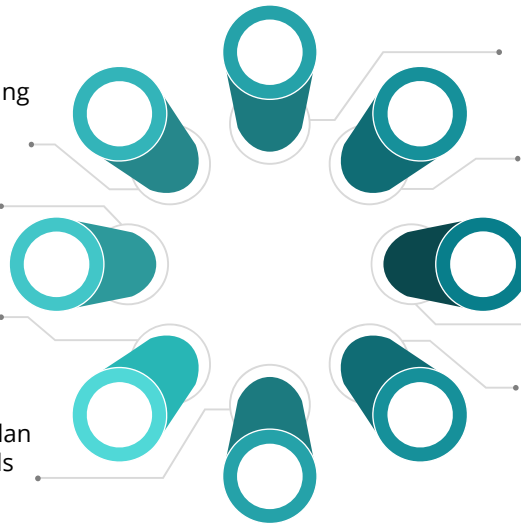
CDT.11.D – Remote monitoring policy requirements

CDT.10.I – Supervision, specifically aide supervision

CDT.9.I – patient education

CDT.7.I – care is provided by all disciplines in accordance with plan of care and each discipline fulfills their own responsibilities

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CDT.2.I – requirements for the provision of services

CDT.3.I – care follows standards of practice within scope of license

CDT.4. - policies regarding acceptance, documentation, verification and authentication of orders

CDT.5.I – verbal orders

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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

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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)
- Participate in **quality** program (CQI)
- Participation in organization sponsored **in-service training** (HRM)

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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

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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.

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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

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Activity

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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)

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Discussion



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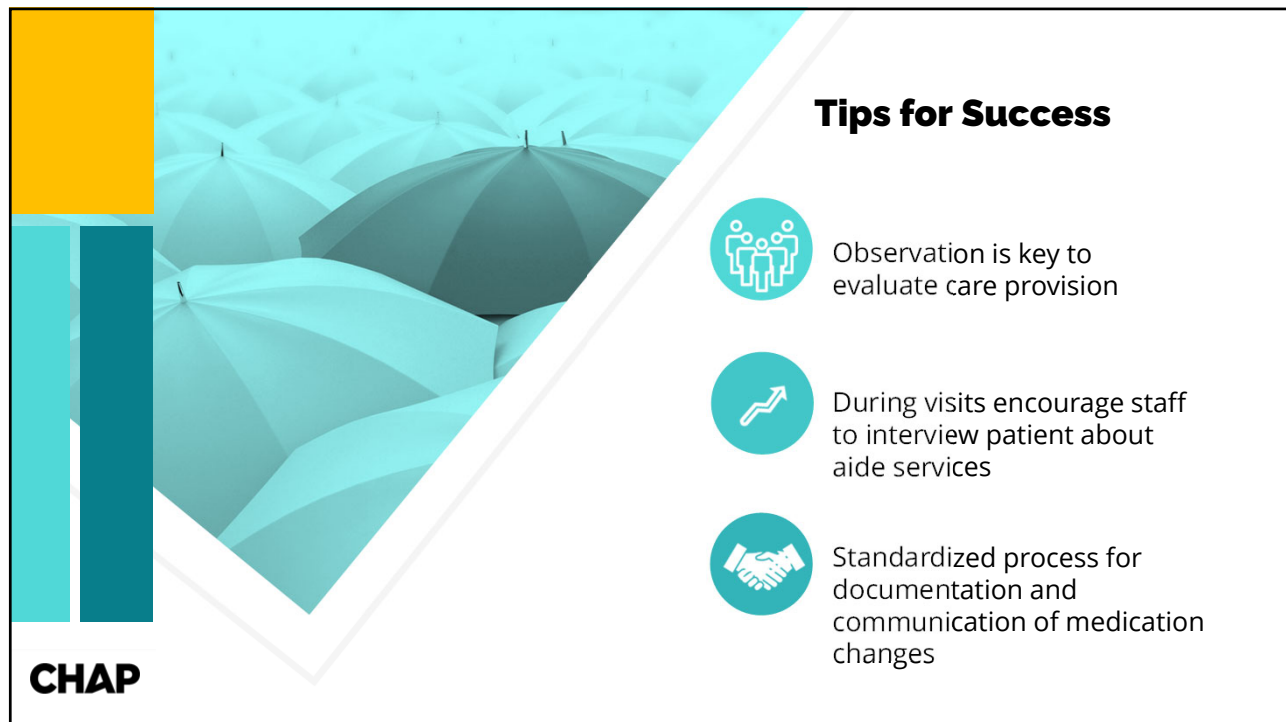
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Top Findings in CDT

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

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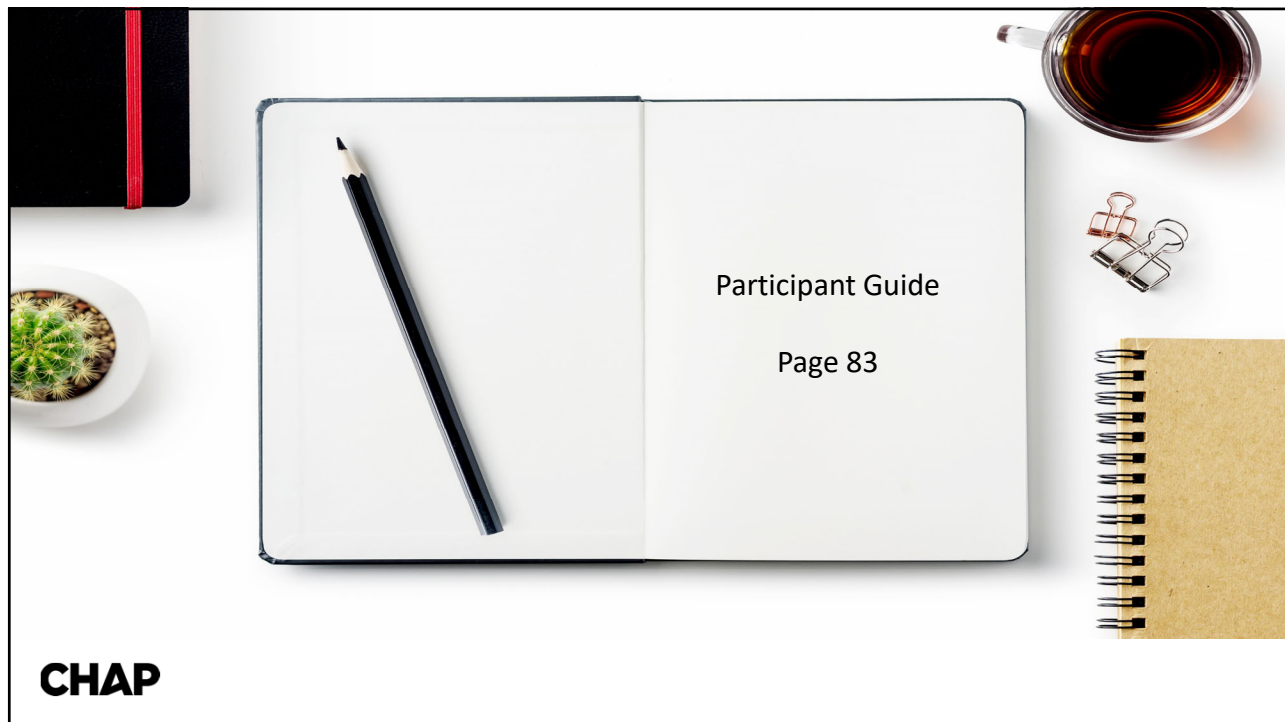
Tips for Success

- 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

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Leadership and Governance

LG

The slide features a central title 'Leadership and Governance' in teal. Below it, the letters 'LG' are displayed in a light teal font. The slide is decorated with several images: a top-left inset showing hands writing on a clipboard; a bottom-left inset showing hands being held; a central photograph of a female doctor in a white coat smiling at an elderly patient; and a vertical decorative bar on the right side with a teal and yellow gradient and a teal icon of hands holding a heart.

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Standard Summary for LG

- LG.1.I – Provision of services to meet patient needs
- LG.3.I – care furnished in compliance with law and regulation
- LG.4.I – Responsibility of governance
- LG.6.I – Leadership qualifications
- LG.7.I – Administrator responsibilities
- LG.10.I – all care settings are monitored
- LG.11.D – lines of authority
- LG.12.D – services provided under arrangement requirements

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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

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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

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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

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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

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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

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Contracted staff may not have been on exclusion list

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Top Findings in LG

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

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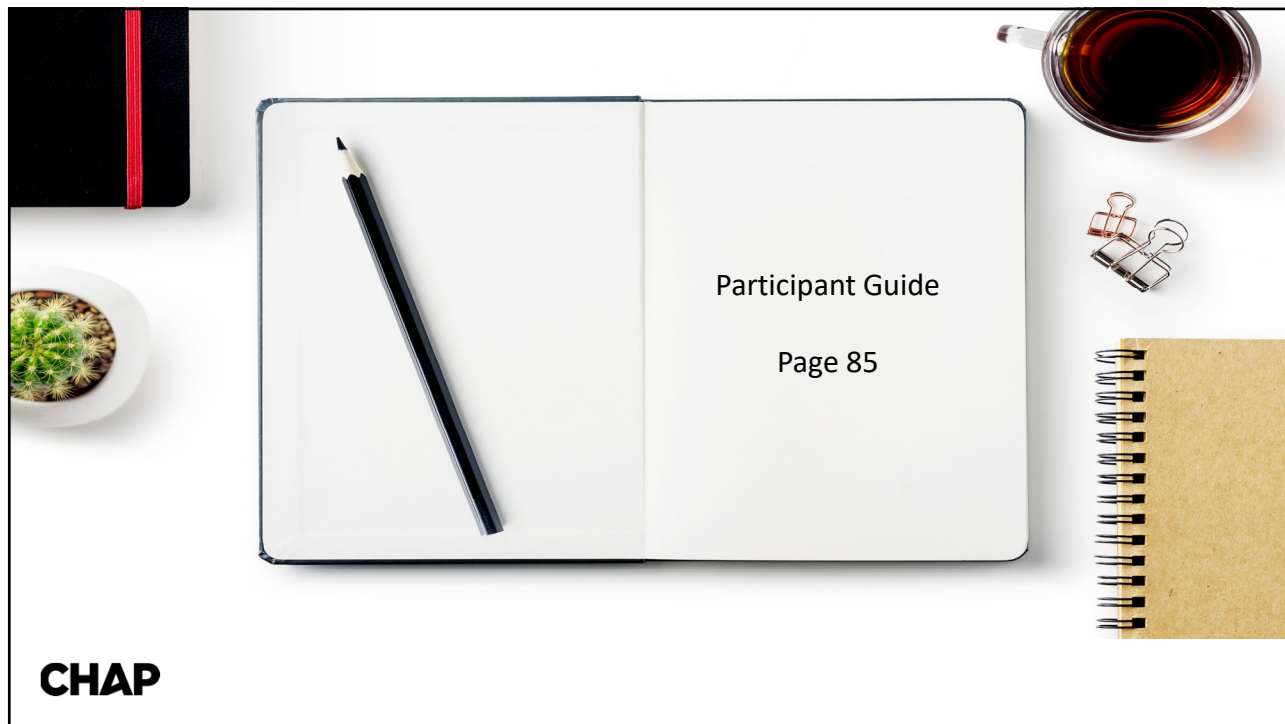
Tips for Success

Documentation
of governing
body
involvement

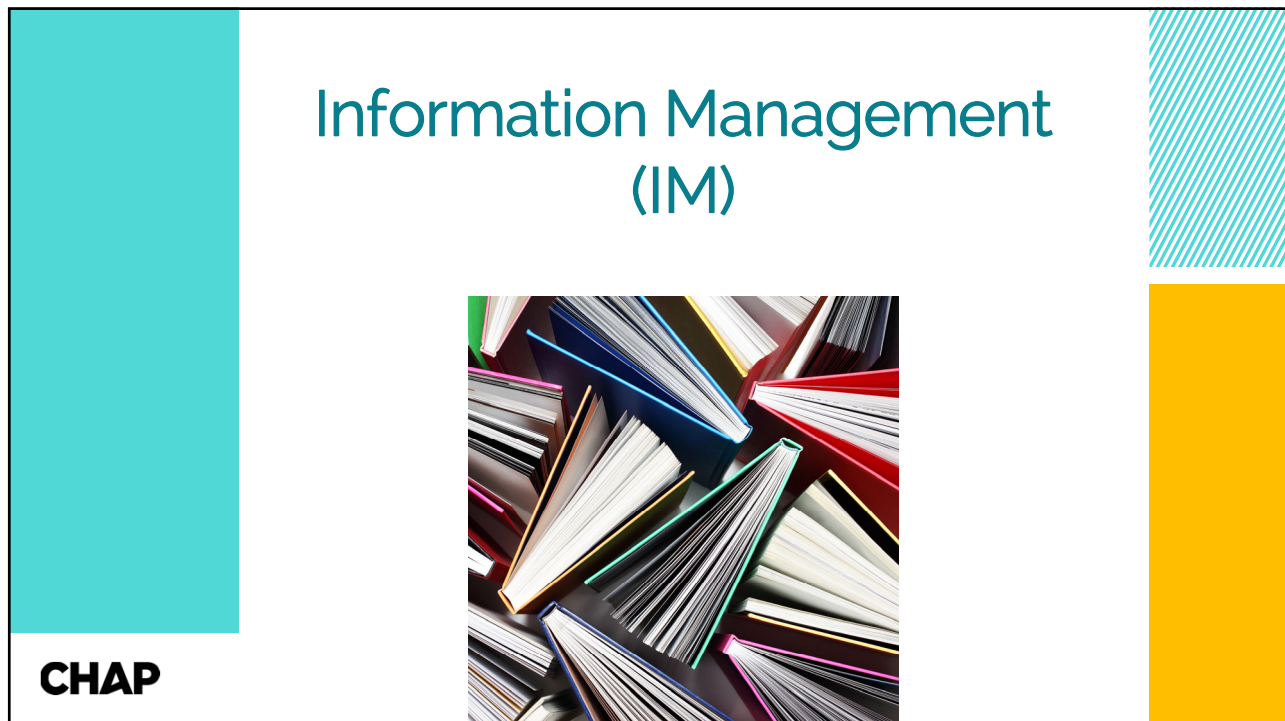
Plan ahead for
annual budget
review...
Schedule it!

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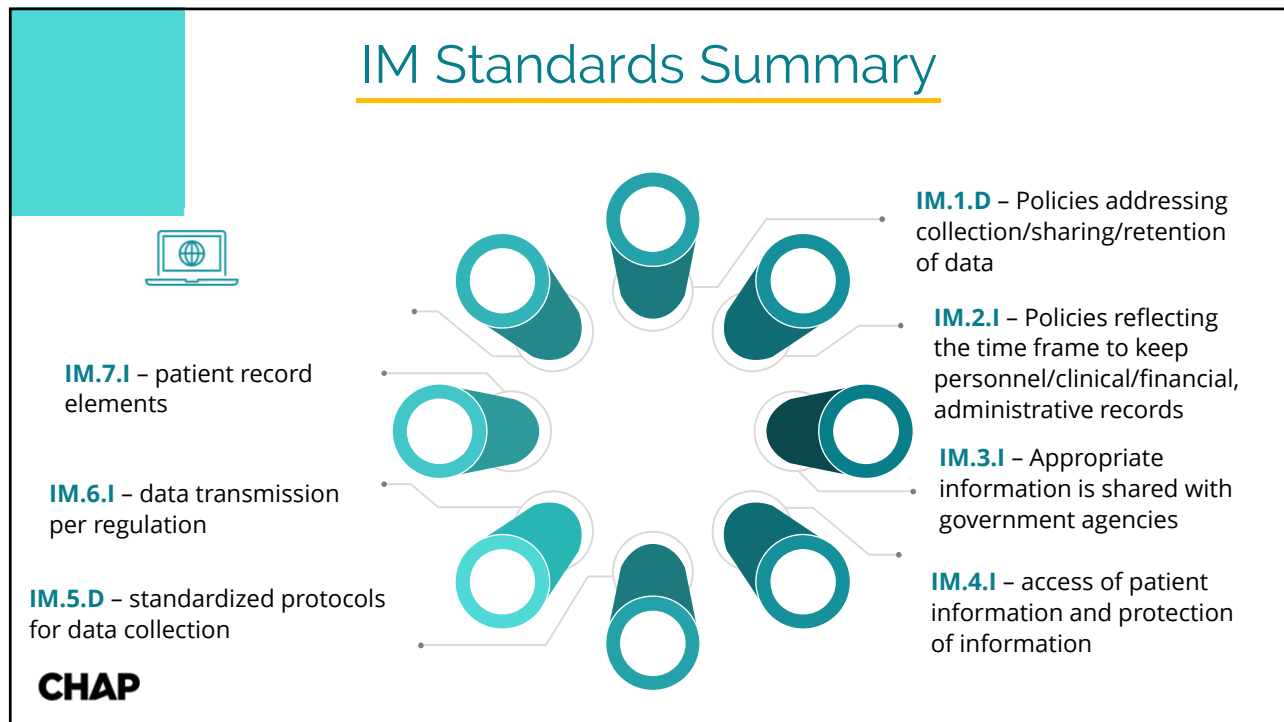
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Communicating with Government Officials

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

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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

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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

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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

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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*

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Top Findings in IM

Standard	Content	CMS Tag
IM.7.I.M1	Required elements of the patient record (40%)	G1012
IM.5.I.M2	Entries are legible, clear, complete and include signature & title (27%)	G1024
IM.4.I.M1	Availability of patient record (10%)	G1030
IM.5.I.M1	Patient record includes past, and current information that is accurate (6%)	G1008

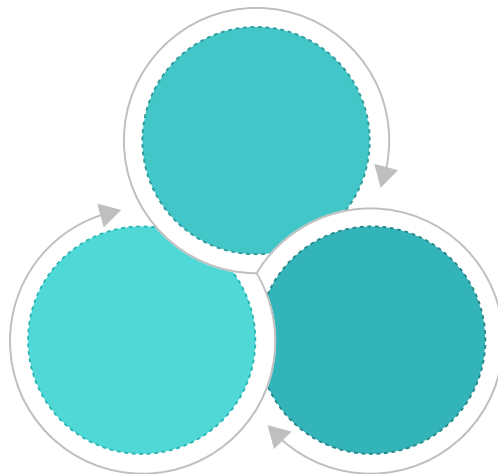
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Tips for Success



- ✓ 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



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Earning CE Contact Hours

To take the post evaluation

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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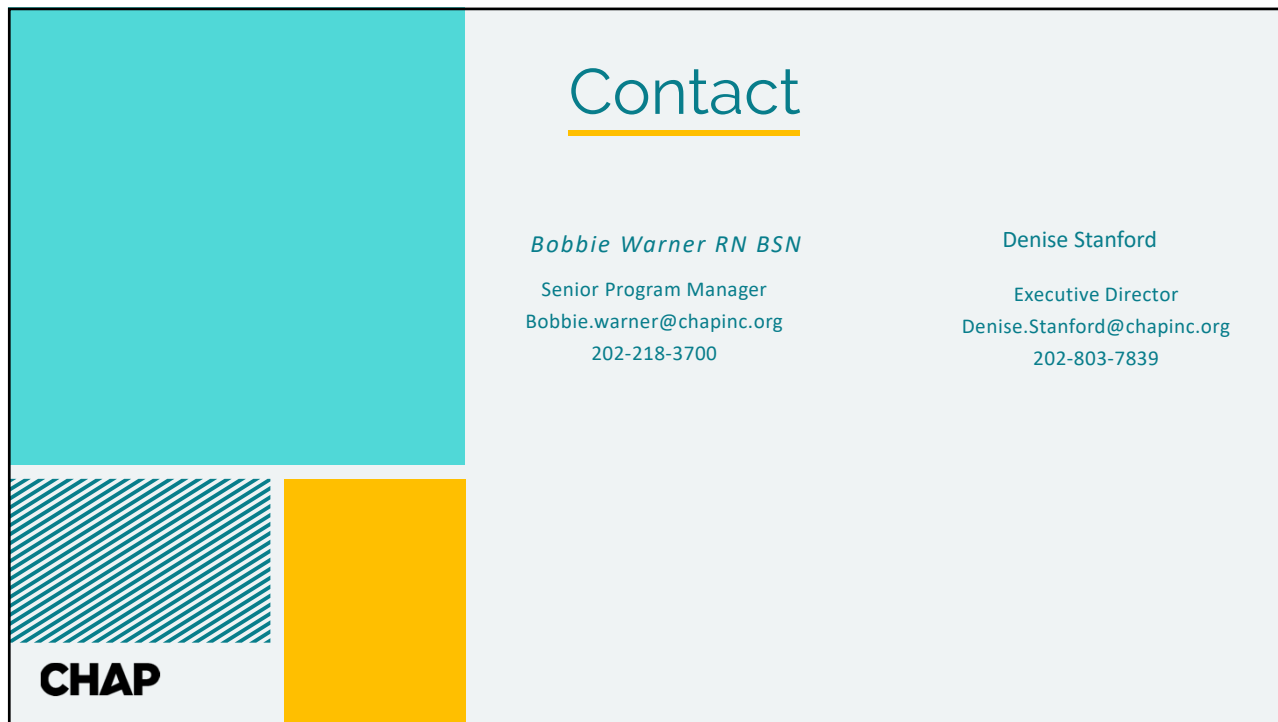
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thank you!

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