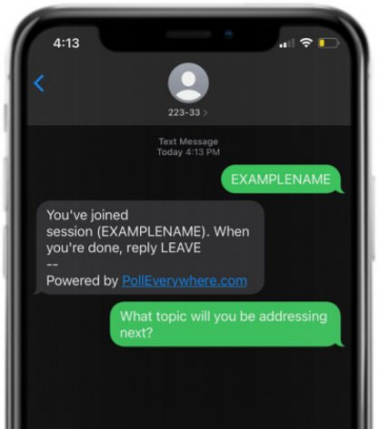
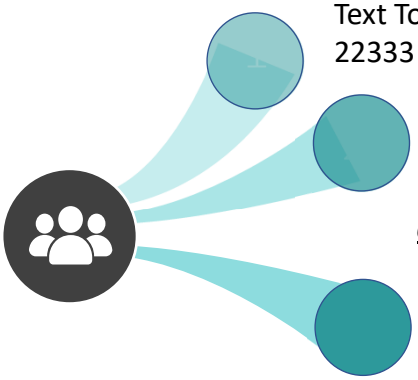
While You Wait…

1. Think of a fun fact about yourself (something you're willing to share).

2. Set up your phone (as below) to enable poll participation





Text To: 22333

Message: *chapinc2*

Return Message: You've joined…

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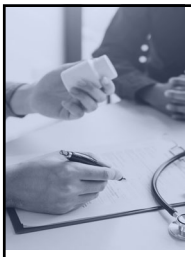

Home Health Accreditation Intensive

An Interactive Training

Bobbie Warner RN, BSN
Senior Program Manager
January 26, 2023

CHAP Community Health Accreditation Partner

2

Disclosures/Conflict of Interest

This nursing continuing professional development activity was approved by the Virginia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.

There are no conflicts of interest for any individual in a position to control content for this activity.

How to obtain CE contact hours:

Criteria for successful completion includes attendance at the entire event (both days), participation in engagement activities, and completion of an evaluation.

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3

Name – State – Fun Fact

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4

How many years has your organization been in existence?

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

5

How many years have you been a CHAP accredited organization? Enter a number.

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

6

Workshop Objectives

The attendee will be able to:

1. Verbalize the Accreditation Process
2. Know the top CHAP Standard Deficiencies
3. Strategize for Compliance
4. Utilize QAPI process

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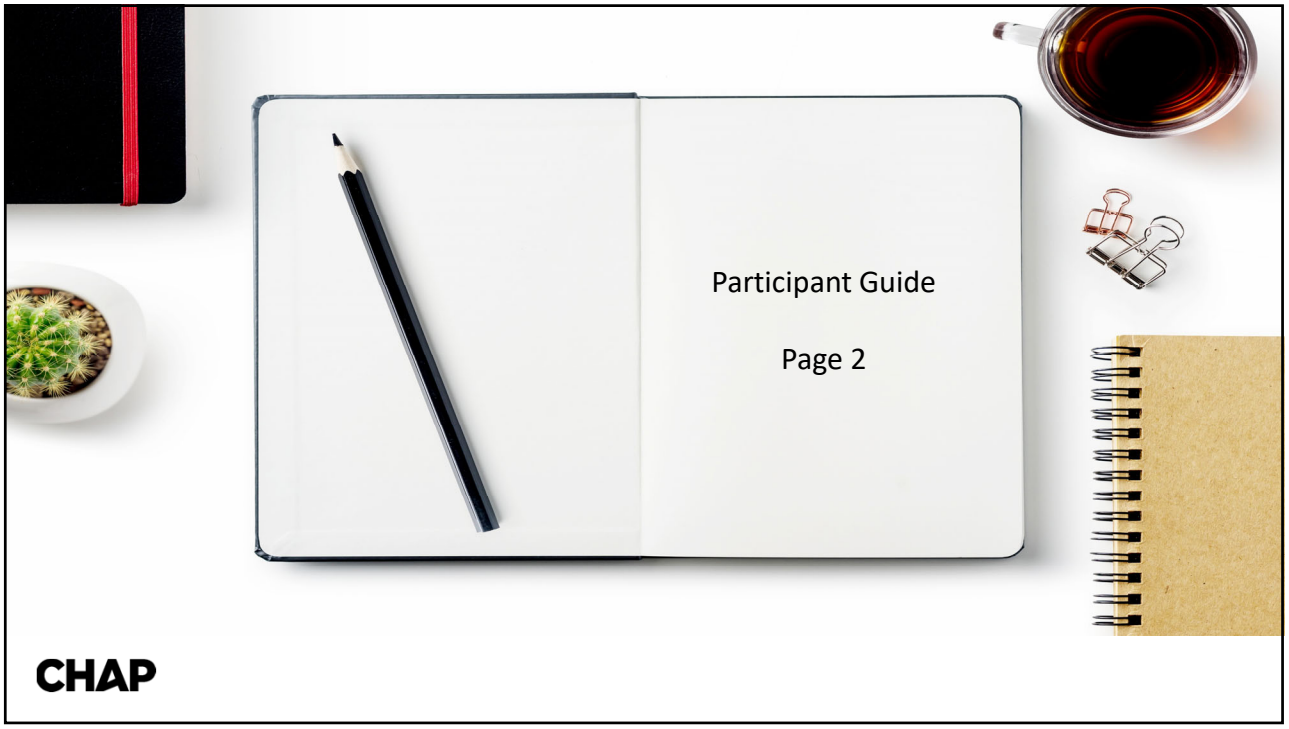

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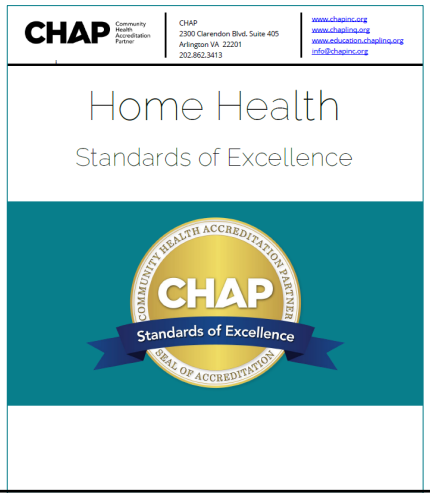
CHAP Standards Overview



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CHAP Standards Overview

CHAP

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Home Health Standards of Excellence – Key Tips

11

Additional Resources

- Appendix B, Appendix Z
- Medicare Administrative Contractor
- MLN newsletters and CHAP eNews

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Patient Centered Care (PCC)

CHAP

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BW16

PCC Resource Tool

Standard	Summary of Content
PCC.2.D	Organization develops a written **Patient Bill of Rights**.
PCC.2.I	Patients can **exercise** all rights.
PCC.2.I.M1	**Required elements** of the patient's rights.
PCC.2.I.M3	Exercise of rights for patients **lacking legal capacity**.
PCC.3.I	Patients informed of rights **verbally and in writing** prior to care initiation.
PCC.3.1.M1	Informed of Rights in **language and manner** individual **understands**.
PCC.3.I.M2	Rights provided **verbally** no later than completion of **second skilled visit**.
PCC.3.I.M3	**Written notice** of rights to patient and selected representative within required **time frames.**
PCC.3.I.M4	Patient/legal representative **signature** obtained to validate receipt of the Patient Bill of Rights.
PCC.5.I	**Care** and Services are **accessible** to patients.
PCC.5.I.M1	**24 Hour contact** information is provided, and Personnel respond per agency policy.
PCC.6.I	**Complaint process** provided verbally and in writing at initiation of care.
PCC.6.I.M1	CHAP and State **Hotline** contact information is provided.
PCC.6.I.M2	Patient and representative informed of **Administrator contact** information.
PCC.7.I	**Complaints** are **documented** and investigated as per policy.
PCC.7.I.M1	Organization **investigates** complaints regarding treatment or care/mistreatment/**abuse**.
PCC.8.I	Suspected instances of **mistreatment/neglect/abuse** are **reported** per organizational policy.
PCC.8.I.M1	Personnel report mistreatment, neglect and abuse as required **within 24 hours**.

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Slide 14

BW15 add additional slide to discuss the standards in more detail include 1. information to be provided in writing 2. verbal information to be provided, 3. complaints, 4. abuse
Bobbie Warner, 5/4/2022

BW16 Bobbie Warner, 5/4/2022

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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PCC Standard Summary

- Information to be provided in writing
  - PCC.1 - 2
- Information to be provided verbally
  - PCC.3 -5
- Complaints
  - PCC.6 - 7
- Abuses
  - PCC.8 -

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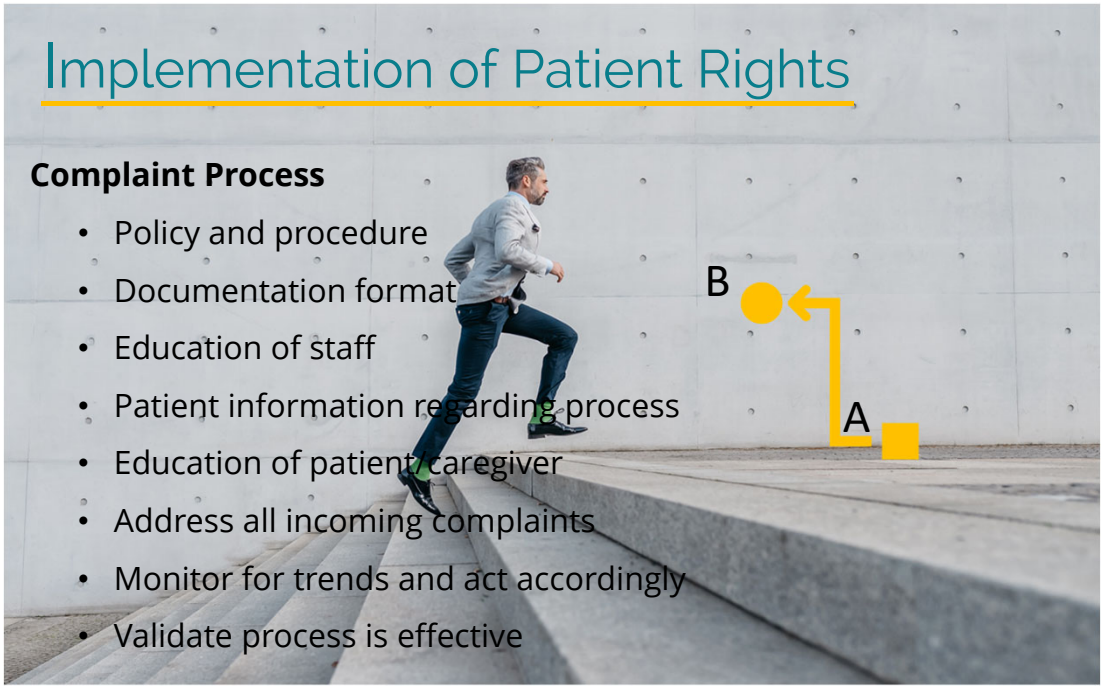
Implementation of Patient Rights

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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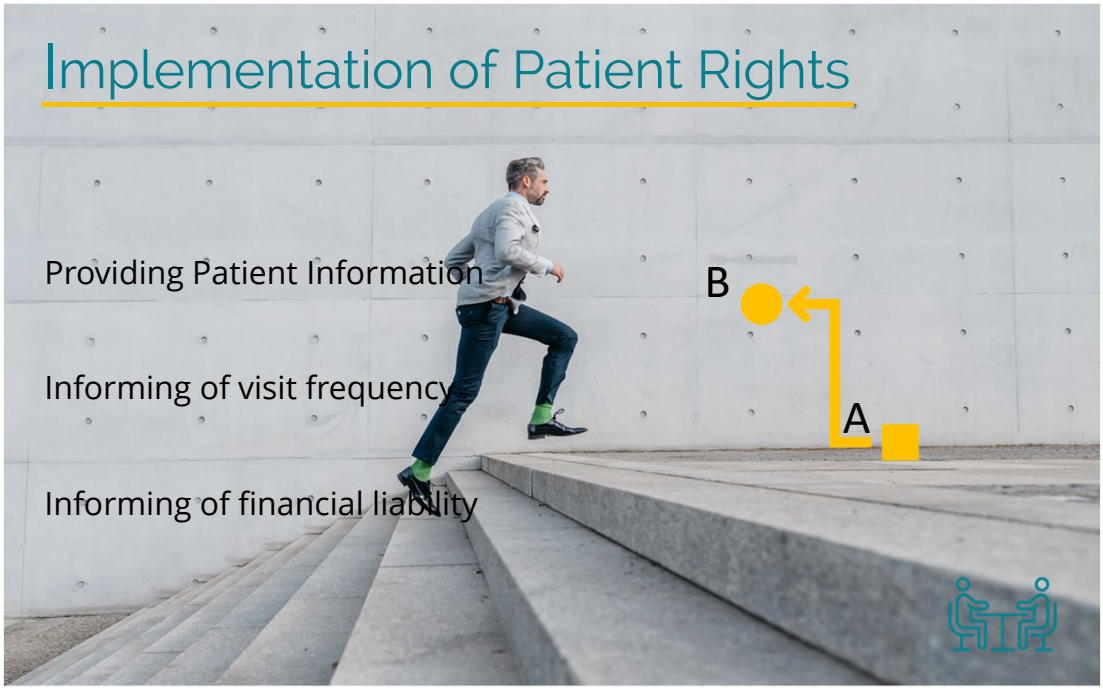
Implementation of Patient Rights

Providing Patient Information

Informing of visit frequency

Informing of financial liability



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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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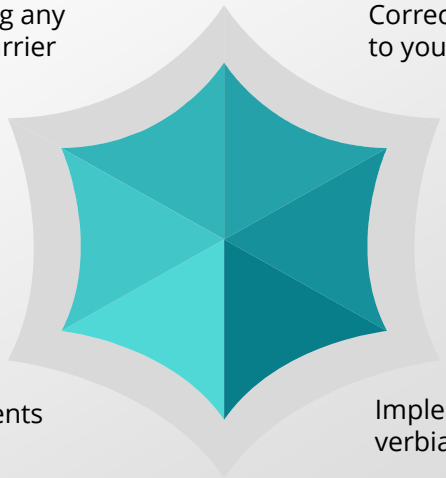
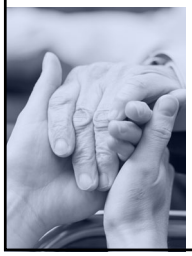
Tips for Success



- 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

20

21



Leadership and Governance

LG

22

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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23

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 Oversight

Responsibilities:

Day-to-day operations

Ensuing 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

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 go 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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Hospice Assessment, Care Planning and Coordination

HCPC

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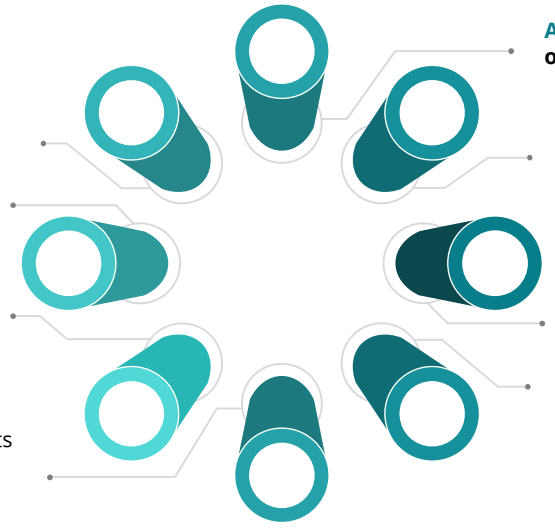
APC Standards Summary

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

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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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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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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	☒	O 02	O 03	O 04	O 05
b. Patient lives with other person(s) in the home	O 06	O 07	O 08	O 09	O 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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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"

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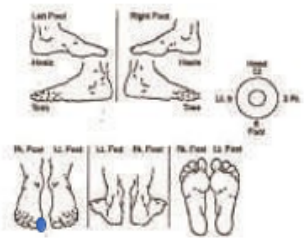
Integumentary: Skin Warm and Dry,

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.

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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:

☒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

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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:

☐ Patient unable to independently take meds

☒Patient requires drug diary or chart for meds

☐ Patient med dosages prepared by another person

☒Patient needs prompting/reminding

☒Drug regimen review for interactions, duplicate therapy and potential adverse effects conducted

☒Drug education provided to patient

☐High-risk medication instruction given

☐Patient demonstrates non-compliance

☐Patient meds must be administered

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Current Medications:

Lantus insulin 30 units at bedtime

Plavix 75 mg once a day

Aspirin 81 mg once a day

Folic Acid 1 mg once a day

Metoprolol tartrate 25 mg twice a day

Glyburide 10 mg twice a day

Simvastatin 40 mg at bedtime

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 along 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

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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OASIS-E – New Items

Section A
Removal of prior race/ethnicity to more comprehensive elements presented separately
A1110 – Language (new)
A1250 – transportation (new)
Provision of current reconciled medication list to subsequent provider at transfer/discharge
route of transmission of list to provider
Provision of current …to patient at discharge and route of providing list

Section B
Hearing/vision expanded/health literacy – all new
Section C – Cognitive

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OASIS-E

Section C – Cognitive
Brief interview for mental status (BIMS) Repetition of three words, temporal orientation, recall, BIMS summary score and signs and symptoms of delirium from CAM ©

Section D – Mood - Patient Mood interview (PHQ2-9) and total severity score/Social isolation

Section G – grooming added, removal of fall risk assessment

Section J- Health Conditions and impact on health – pain effect, interference with therapy, interference with day-to-day activities

Section K – nutritional approaches

Section N – High risk drug classes, use and indication

Section O – 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.	2. Start Of Care Date	3. Certification Period	4. Medical Record No.	5. Provider No.
123456	7/22/2021	From: 7/22/2021 To: 9/22/2021	12589	

6. Patient's Name and Address

Violet Chap
2300 Chappy Lane, Chapster, MA 23568

7. Provider's Name, Address and Telephone Number

Dr. Guthrie
Physician Drive
Hospital, IN 23657

8. Date of Birth | 9. Sex ☐ M ☐ F

10. Medications: Dose/Frequency/Route (N)ew (C)hanged

11. ICD	Principal Diagnosis: Encounter Fall with Injury	Date: 7/18/2021
12. ICD	Surgical Procedure	Date
13. ICD	Other Pertinent Diagnoses: Diabetic Ulcer Right Foot Diabetes Mellitis Type 2	Date: 7/18/2021 long Standing

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
imvastatin 40 mg at bedtime
Folic Acid 1 mg once a day

14. DME and Supplies

Glucometer, cane

15. Safety Measures

Fall Risk

CHAP

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16. Nutritional Req. 1500 Cal Diet

18.A. Functional Limitations

1 ☐	Amputation	5 ☐	Paralysis	9 ☐	Legally Blind		
2 ☑	Bowel/Bladder (Incontinence)	6 ☑	Endurance	A ☐	Dyspnea With Minimal Exertion		
3 ☐	Contracture	7 ☑	Ambulation	B ☐	Other (Specify)		
4 ☐	Hearing	8 ☐	Speech				

17. Allergies No Drug or food allergies

18.B. Activities Permitted

1 ☐	Complete Bedrest	6 ☐	Partial Weight Bearing	A ☐	Wheelchair		
2 ☐	Bedrest BRP	7 ☐	Independent At Home	B ☐	Walker		
3 ☑	Up As Tolerated	8 ☐	Crutches	C ☐	No Restrictions		
4 ☐	Transfer Bed/Chair	9 ☑	Cane	D ☐	Other (Specify)		
5 ☐	Exercises Prescribed						

19. Mental Status	1 ☑	Oriented	3 ☑	Forgetful	5 ☐	Disoriented	7 ☐	Agitated	
	2 ☐	Comatose	4 ☐	Depressed	6 ☐	Lethargic	8 ☐	Other	
20. Prognosis	1 ☐	Poor	2 ☐	Guarded	3 ☐	Fair	4 ☑	Good	5 ☐ Excellent

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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.

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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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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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Transfer/Discharge

The primary care practitioner or other health care professional who will be responsible for providing care and services to the patient is sent:

1. A discharge summary *five business days*

2. Transfer summary *within two business days of a planned transfer*

3. Transfer summary *within two business days of becoming aware of an unplanned transfer*

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BW10

Transfer/Discharge 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 of services provided and frequency of services;
- Laboratory data;
- Medications the patient is on at the time of discharge;
- Patient's discharge condition;
- Patient outcomes in meeting the goals in the plan of care; Patient and family post-discharge instructions.

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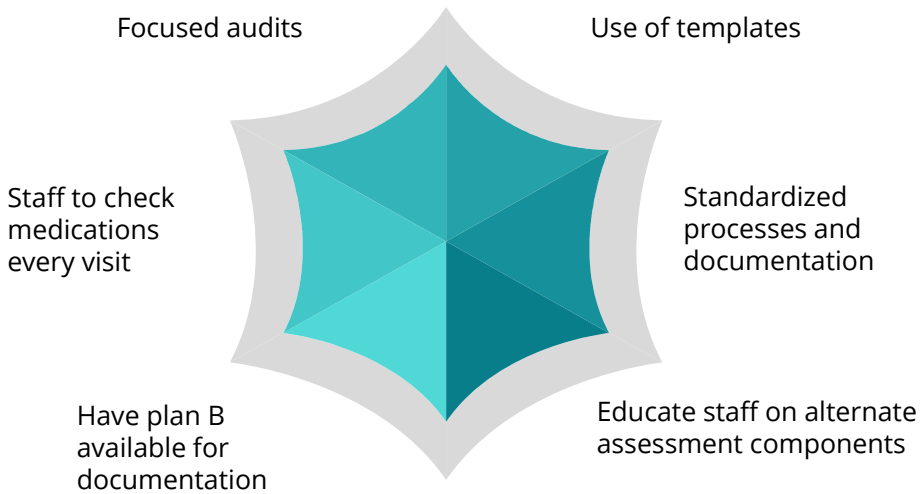
Tips for Success



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Slide 59

BW10 slide revision

Bobbie Warner, 1/18/2022

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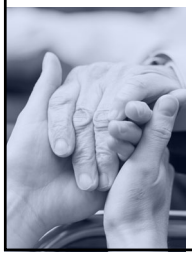
Care Delivery and Treatment

CDT



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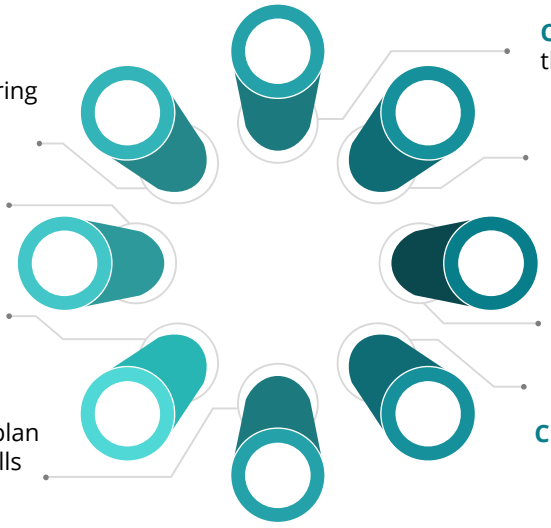
CDT Standards Summary



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

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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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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BW21

Remote Monitoring

Policies and Procedures:

- Type of Equipment
- Patient Eligibility
- Patient/caregiver education
- Process for delivery and set up
- Troubleshooting
- Data collection
- Storage and cleaning

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Slide 68

BW21 if this is covered well earlier in this session then remove this.
Bobbie Warner, 5/4/2022

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BW12

Home Visit Discussion

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Slide 70

BW12 added slide
Bobbie Warner, 1/18/2022

Visit Note and Aide Plan of Care

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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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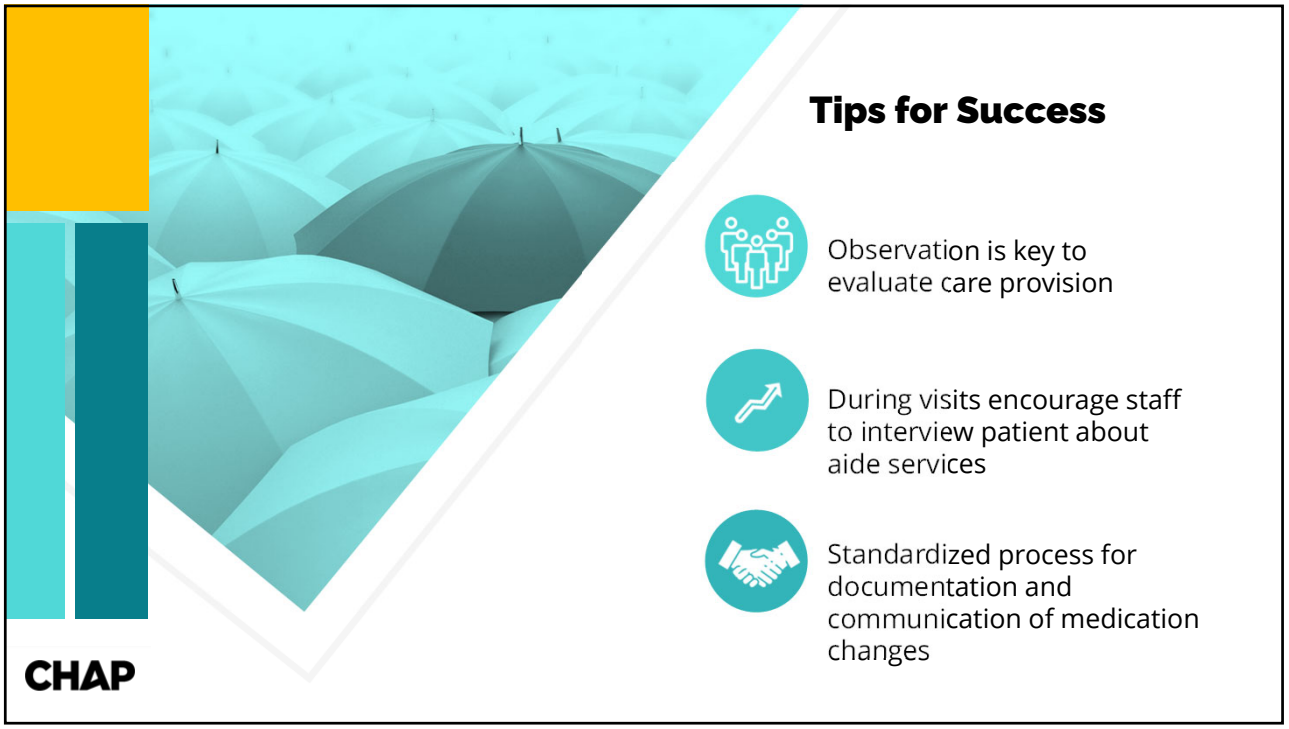
Tips for Success
Observation is key to evaluate care provision
During visits encourage staff to interview patient about aide services
Standardized process for documentation and communication of medication changes
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Human Resource Management
Hospice- HSRM Home Health- HRM
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What one word comes to mind when you think of "Hiring Criteria"

Start the presentation to see live content. For screen share software, share the entire screen. Get help at **pollev.com/app**

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Text **CHAPINC2** to **22333** once to join

What is the frequency of competency evaluation of professional staff?

Monthly

Yearly

As per organization policy

Bi-annually

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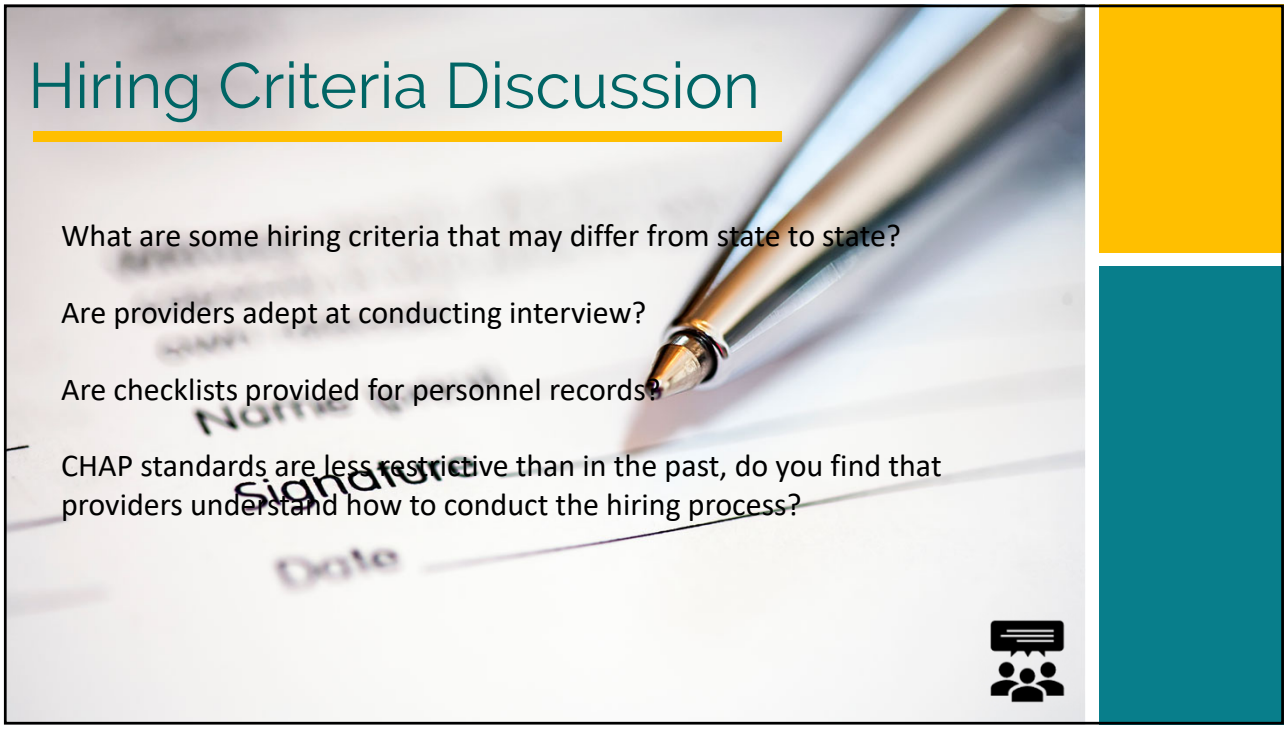
Hiring Criteria Discussion



What are some hiring criteria that may differ from state to state?

Are providers adept at conducting interview?

Are checklists provided for personnel records?

CHAP standards are less restrictive than in the past, do you find that providers understand how to conduct the hiring process?

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BW22

Standard Summary for HRM

- HRM.4.I – all disciplines are required to be licensed/qualified in the state they work
- HRM.6.D – education of staff
- HRM.7.I – competency and 9 modifiers related to aide services
- HRM.9.I – supervision
- HRM.10.I – performance evaluation
- HRM.11.I – requirements related to deficient aide practices

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Slide 78

BW22 include new slide with following topics: qualifications, education, competency, supervision, performance evaluation, aide requrements
Bobbie Warner, 5/4/2022

NP scope of Practice

Full practice
- Evaluate
- Diagnose
- Manage treatment
- Prescribe medications

Reduced practice
- Reduces
- At least one element of NP practice
- Requires
- Collaborative agreement

Restricted practice
- Restricts
- At least one element of NP practice
- State requires supervision, delegation, or team-management

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NP Scope of practice variation

STATE	PRESCRIPTIVE AUTHORITY	BOARD OF NURSING	PRACTICE ACT	DETAILS AND RESOURCES
Arizona	Full authority with DEA registration	AZ Board of Nursing	AZ Nursing Statutes, AZ Nurse Practice Act	Must complete a Controlled Substance Prescription Monitoring Program (CSPMP) application
Florida	Requires supervision of a physician or surgeon	FL Board of Nursing	FL Nurse Practice Act	NPs must have proof of malpractice insurance or an exemption
South Carolina	Requires an approved written protocol with a collaborating physician	SC Board of Nursing	SC Nurse Practice Act	"In addition to those activities considered the practice of registered nursing, an APRN may perform delegated medical acts"

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2022 Top Findings in HRM-HH

Standard	Home Health Content	CMS Tag
HRM.3.I	Personnel meeting the organization's hiring criteria (34%)	G848
HRM.10.I	Personnel are evaluated per organizational policy (14%)	N/A
HRM.7.I	Personnel demonstrate competency (12%)	N/A
HRM.7.I.M2	Competency of Aides (6%)	G768
HRM.6.D.M1	Skilled professionals participate in organization sponsored in-services (6%)	G722

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Tips for Success

Know state specific requirements

Focused HR Audit
- Orientation
- Annual requirements
- Performance evaluations
- Hiring criteria

Plan staff in-service education

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Information Management (IM)

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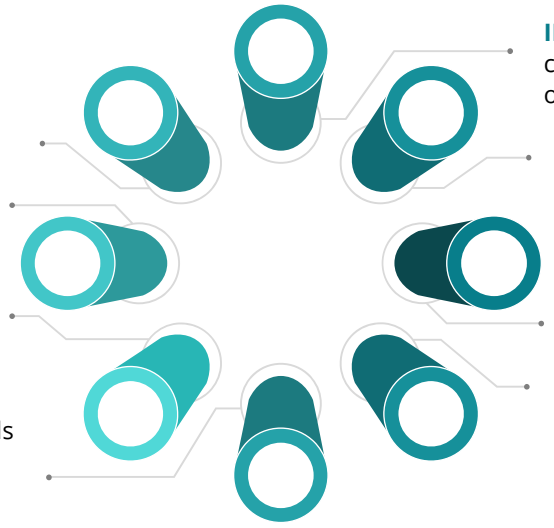
IM Standards Summary



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

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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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Which of the required clinical record elements does your staff have the most challenges with?
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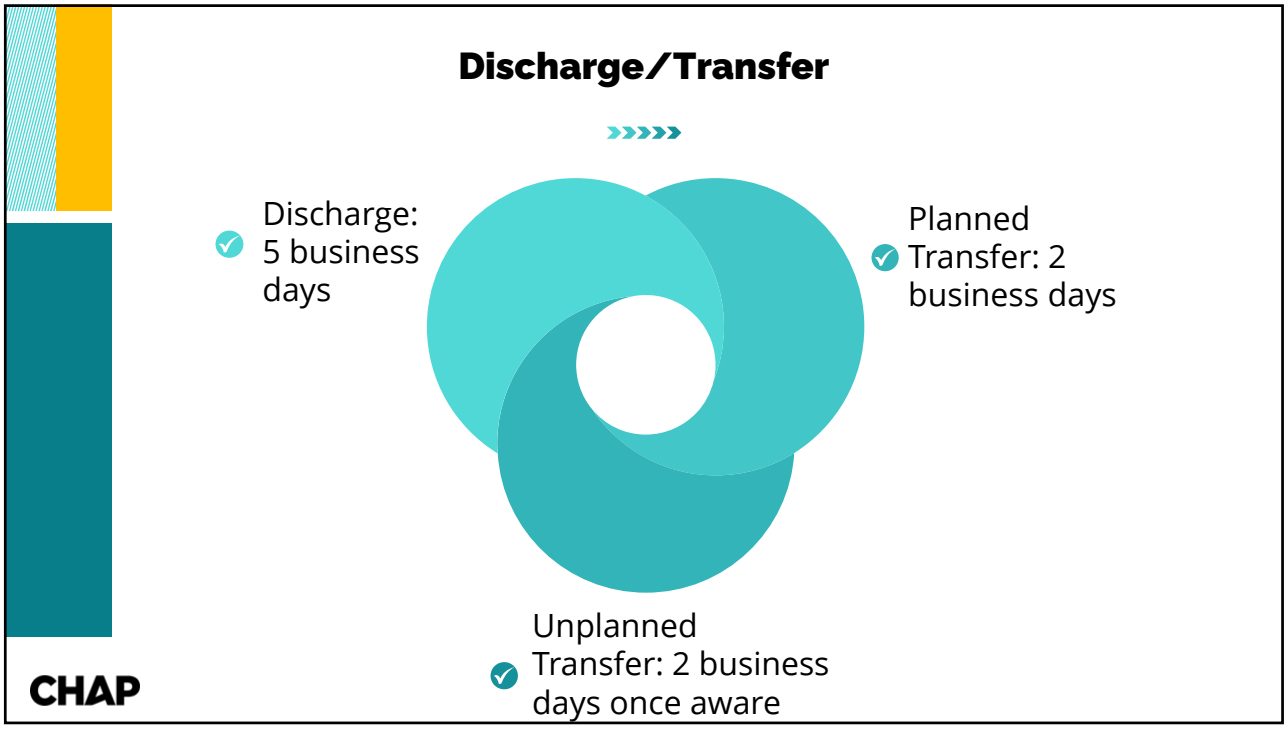
Discharge/Transfer
Discharge: 5 business days
Planned Transfer: 2 business days
Unplanned Transfer: 2 business days once aware
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Summary Contents

- Admission and discharge dates
- Reason for admission to home health
- Physician responsible for the home health plan of care
- Type of services provided and frequency of services
- Laboratory data; Medications at time of discharge
- Patient outcomes in meeting the goals in the plan of care
- Patient's discharge condition
- Patient and family post-discharge instructions

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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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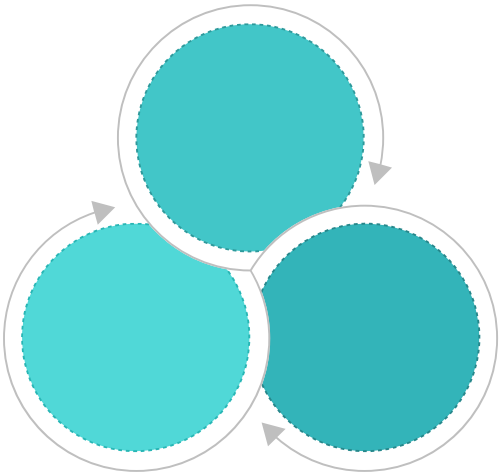
Tips for Success

- 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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Emergency Preparedness (HSEP/EP)

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Emergency Preparedness Program

- Utilize **all-hazard** approach
- Documented facility and community-based **risk assessment**
- Include **strategies** to address emergency events identified
- **Review**ed and updated every two years
- Address **patient** population
- Include process for cooperation and **collaboration** with local/tribal/regional/state/federal emergency **officials** for an integrated response

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Policies and procedures are based on emergency plan, risk assessment, and communication plan updated at least every 2 years.

Policies and Procedures address:

- Patient emergency plan
- In comprehensive assessment
- Inform officials of evacuation needs
- Determine staff and patient needs
- Medical documentation
- Staffing strategies

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Communication Plan

- Review
- Contact information
- Primary and alternate
- Sharing information
  - Condition and location of patients
  - Facility's occupancy needs
  - [Facility's] ability to provide assistance

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Training

- Utilize all-hazard approach
- Documented facility and community-based risk assessment
- Include strategies to address emergency events identified
- Reviewed and updated every two years
- Address patient population
- Include process for cooperation and collaboration
- With local/tribal/regional/state/federal emergency officials for an integrated response

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Testing

- **Annual testing is to be conducted**
  - **Full-scale, community-based exercise every 2 years OR**
    - **Facility-based functional every two years** if full-scale not available

    If an actual event occurs requiring activation of the plan, the agency is exempt from the next required community-based facility based functional exercise.
  - **Additional exercise every 2 years, opposite the full-scale or functional**
    - A second full scale OR
    - Mock-disaster drill OR
    - Tabletop exercise or workshop
  - **Analysis of response and documentation required**

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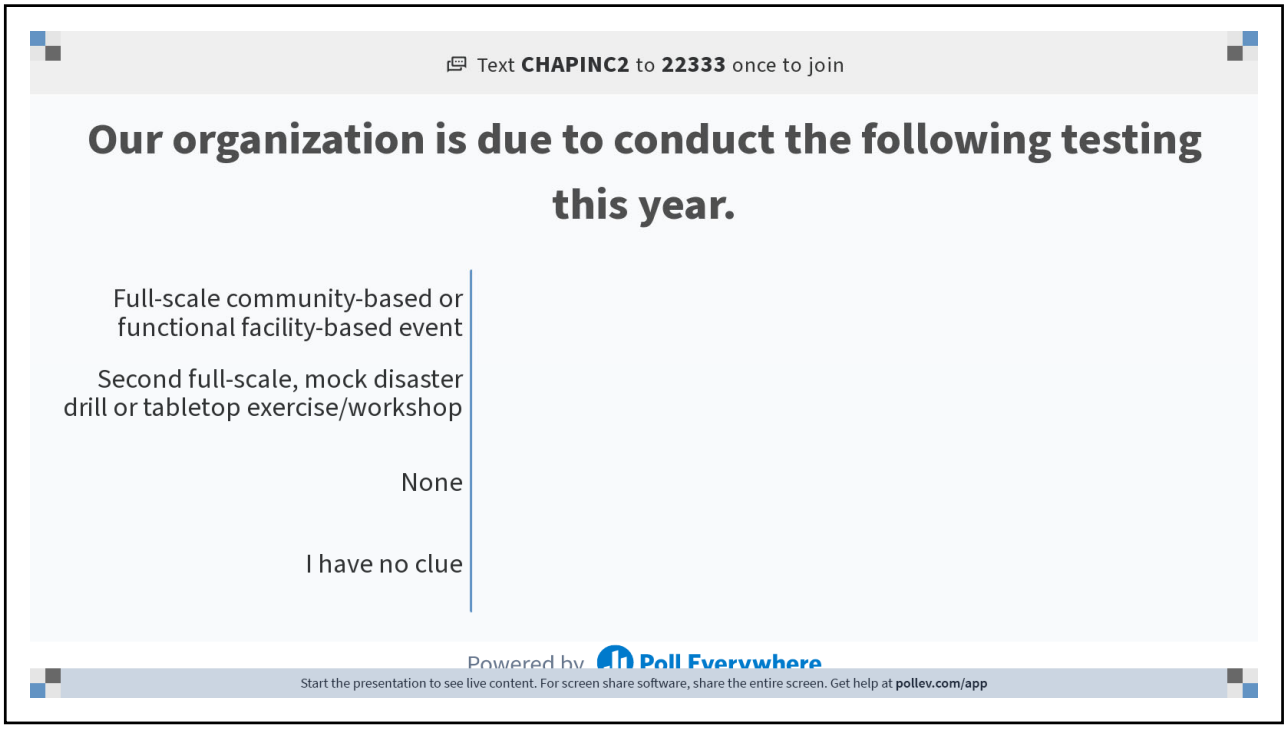

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Integrated Healthcare Systems

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2022 Top Findings in EP

Standard	Content	CMS Tag
EP.1.D.M1	Elements of the Emergency Plan (24%)	E6
EP.1.D.M3	Communication Plan required elements (19%)	E31
EP.3.D.M1	Training program based on EP plan/risk assessment/policies (19%)	E37
EP.4.I.M2	Organization conducts exercises to test EP plan (17%)	E39
EP.2.D.M1	Required policies and procedures, based on plan, risk assessment and communication plan (15%)	E17

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- Identify the individual responsible for oversight of the Emergency Preparedness program
- Schedule annual tasks at the beginning of the year so they aren't missed
- Keep staff and patient lists updated with current information
- Validate the current contact information for your emergency officials
- Build community relationships before a disaster occurs.

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You deserve a
Relaxing
Break!
We appreciate
all that you do!
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