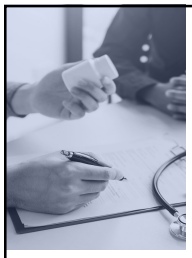
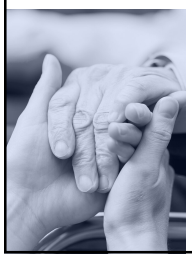


Home Health Day 2/3 Accreditation Intensive

An Interactive Training



Bobbie Warner RN, BSN
Director of Education

Linda Lockhart BSN,MPH

CHAP Community Health Accreditation Partner

1

Chat Box Communication

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

CHAP

2

Patient Centered Care (PCC)

CHAP

3

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

CHAP

4

Other Patient Rights

PCC.2.I.
Incompetent patient

PCC.3.I
Rights provided verbally and in writing prior to providing care. Signature confirming receipt

PCC.5
After hours availability and contact

PCC.6.I-7.I
Handling of complaints

PCC.8
Requirements related to alleged violations of any type of abuse

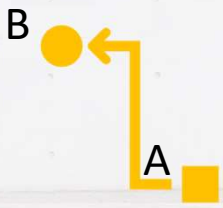
CHAP

5

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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6

Top Findings in PCC

Standard	Content	CMS Tag	% Cited
PCC.2.I.M1	Proper notice regarding potential non-covered care or agency reduction or termination of care	G442	28%
PCC.2.I.M1	Be informed of and participate in care and services	G434	26%
PCC.2.I.M1	Be advised of names and contact information of federally-funded or state-funded entities.	G446	20%
PCC.3.I.M3	Written notice of transfer and discharge policies is provided to patients	G412	11%
PCC.3.I.M3	Written notice of rights and responsibilities and transfer/discharge policies provided to patient-selected representative	G422	11%

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7

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*

CHAP

8

Patients Rights

PCC.2.I.M3; 484.50(a)(1)(i): Transfer and Discharge

G412 - *The HHA's transfer and discharge policies, provided in writing and must be understandable to those with limited English proficiency and accessible to individuals with disabilities*

G422 – *Provide written notice of agency transfer and discharge policies, must be understandable to those with limited English proficiency and accessible to individuals with disabilities*

CHAP

9

Correct verbiage/ Individualized to your agency

Periodically check the contact numbers

Implementation as well as verbiage

Talk to patients

Think outside of the box

Process for addressing any common language barrier

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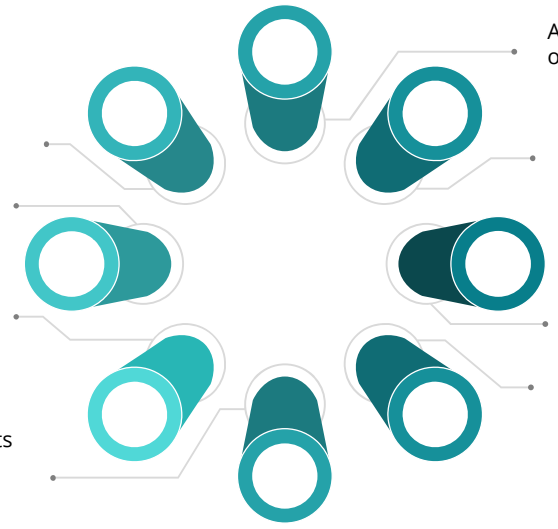
10

Assessment Planning, and Coordination (APC)

CHAP

11

APC Standards Summary



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

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

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12

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

CHAP

13

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.

CHAP

14

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

CHAP

15

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.

CHAP

16

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

17

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	☐01	○02	○03	○04	●05
b. Patient lives with other person(s) in the home	○06	○07	○08	○09	○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"

CI

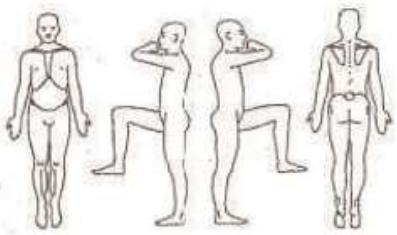
19

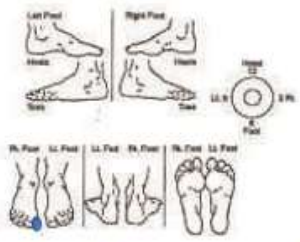
Integumentary: Skin Warm and Dry,

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.

CHAP

20

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.

CHAP

21

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

CHAP

22

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

CHAP

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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.

CHAP

25

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

CHAP

26

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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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

CHAP

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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

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

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

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

17. Allergies No Drug or food allergies

18.B. Activities Permitted

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

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		

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.

CHAP

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Discussion

CHAP

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Top Findings in APC

Standard	Content	CMS Tag	% Cited
APC.7.I.M2	Required Elements of the Plan of Care	G574	25%
APC.8.I.M3	Provision of written instructions	614/616/618 620/622	22%
APC.11.I.M3	Timely D/C & transfer summary includes all elements	G1022	16%
APC.6.I.M1	Required elements of the Comprehensive Assessment	G536	9%
APC.7.I.M7	Minimum review by physician is 60 days. Includes progress	G592/588	9%

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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

CHAP

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APC con't

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 con't.

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*

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

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

CHAP

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APC con't

484.60(c)(2): Minimum review by the Physician

G592-*A revised plan of care, updated at least once every 60 days for recertification OR as the patient's conditions or needs warrant. POC* ***must include the patient's progress toward outcomes and goals****.*

G588- *The individualized plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care as often as the patient's condition require, but no less than once every 60 days, beginning with the start of care date.*

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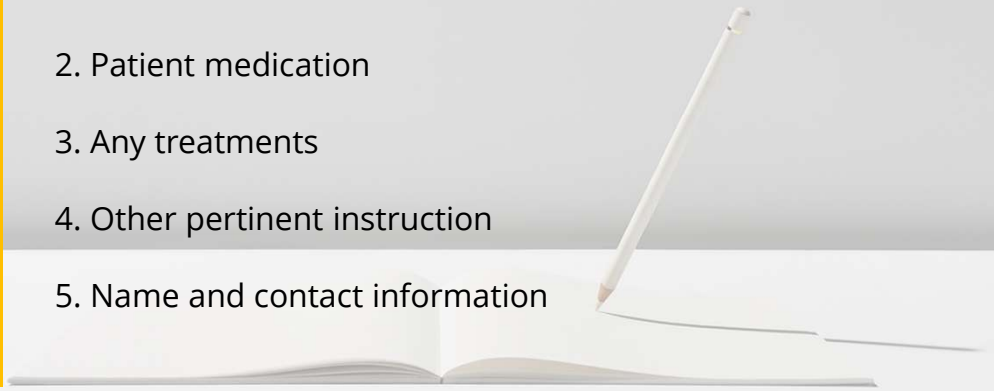
Written Instruction

1. Visit schedule
2. Patient medication
3. Any treatments
4. Other pertinent instruction
5. Name and contact information



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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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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.

CHAP

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Tips for Success

- Focused audits
- Use of templates
- Staff to check medications every visit
- Standardized processes and documentation
- Have plan B available for documentation
- Educate staff on alternate assessment components

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Financial Stewardship (FS)

CHAP

43

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

CHAP

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

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Care Delivery and Treatment (CDT)

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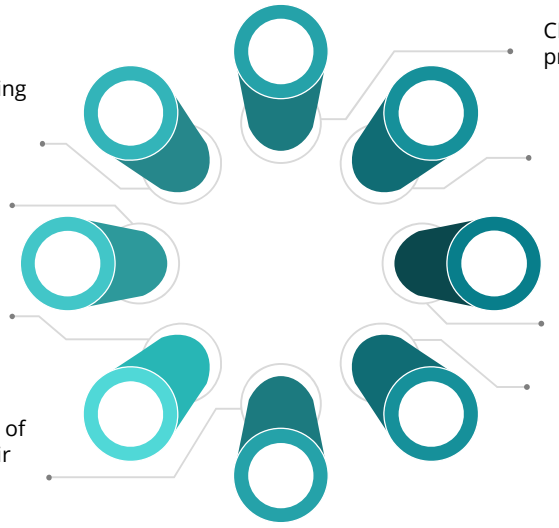
CDT Standards Summary



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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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

CHAP

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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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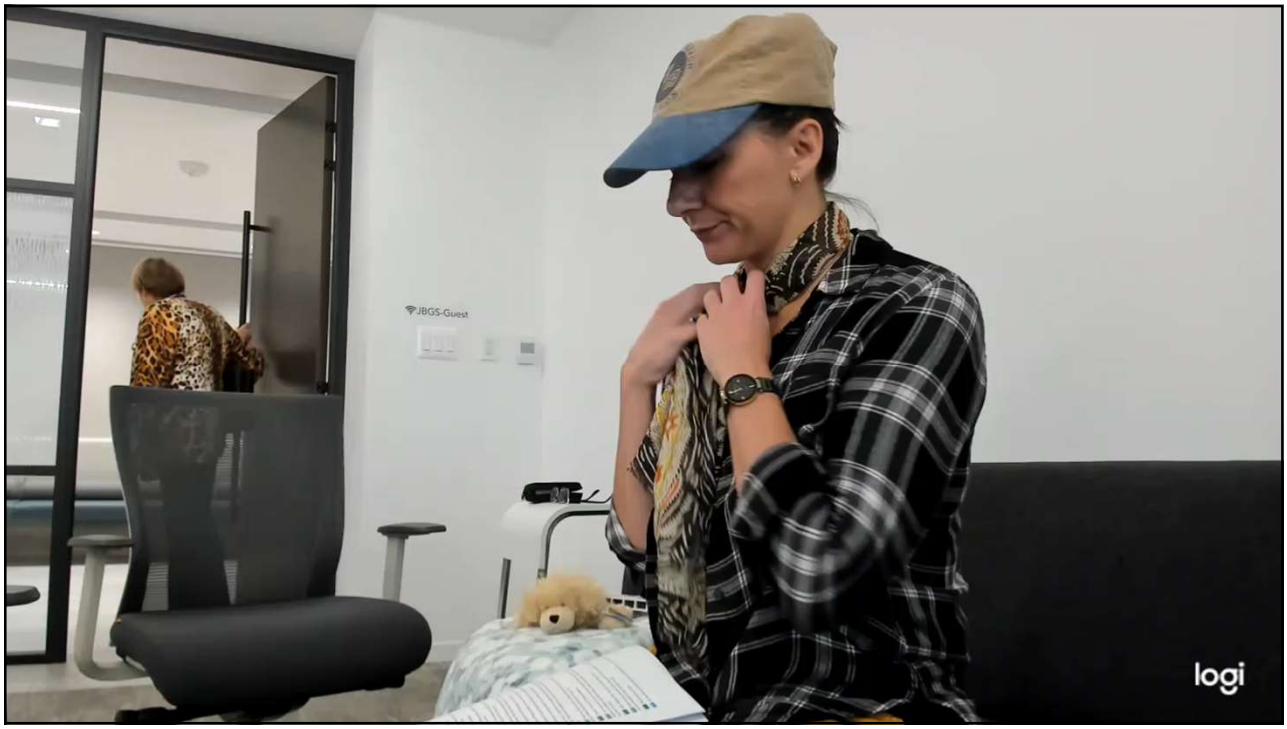

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Activity

One:

Review of video and discussion

Two:

Review of visit note and discussion-pg 87,88

Three:

Review of Home Health Plan of Care and discussion-pg89

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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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Top Findings in CDT

Standard	Content	CMS Tag	% Cited
CDT.7.I.M2	Skilled professionals follow the plan of care/fulfill duties	G710	44%
CDT.7.I.M7	Home Health Aide fulfills responsibilities	G800	14%
CDT.5.I.M2	Verbal orders authenticated and dated within 30 days.	G584	11%
CDT.4.I.M1	Medication/services treatments administered as ordered	G580	11%

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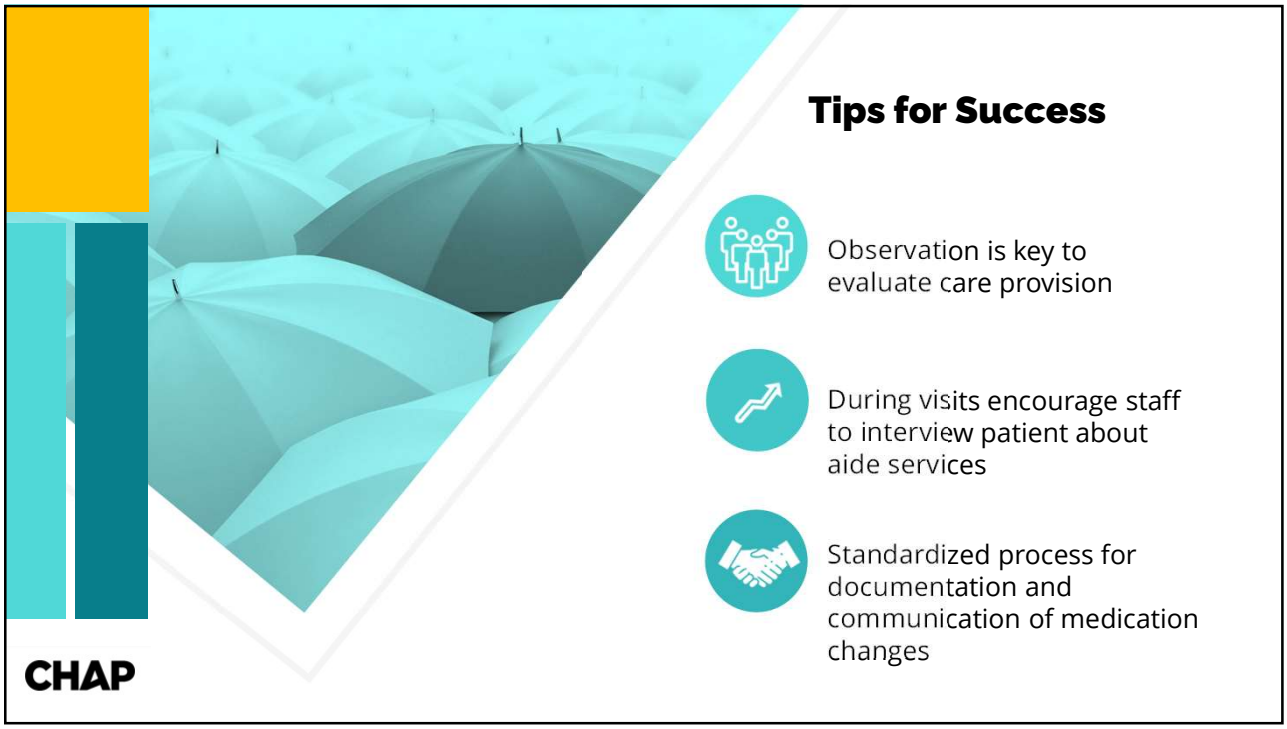
Tips for Success
Observation is key to evaluate care provision
During visits encourage staff to interview patient about aide services
Standardized process for documentation and communication of medication changes
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Lunch

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Leadership and Governance (LG)

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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

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	G660 G640
LG.7.I.M3	Alternate Administrator	G954

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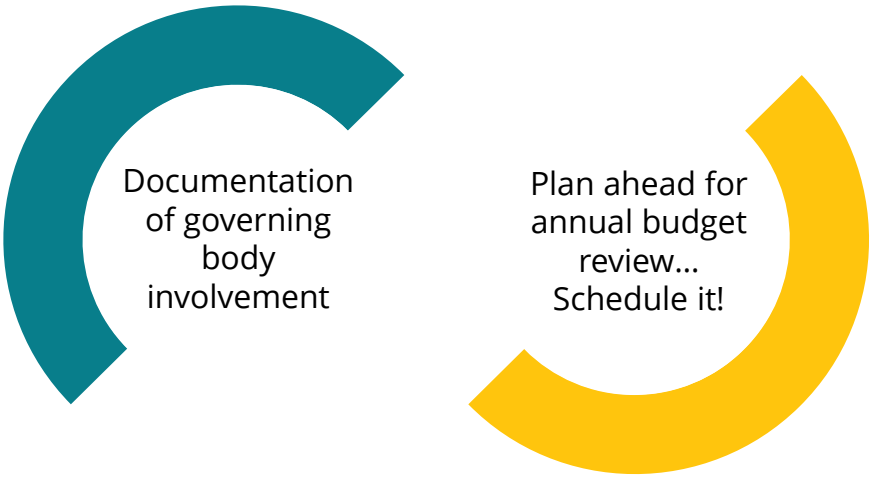
Tips for Success



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Information Management (IM)

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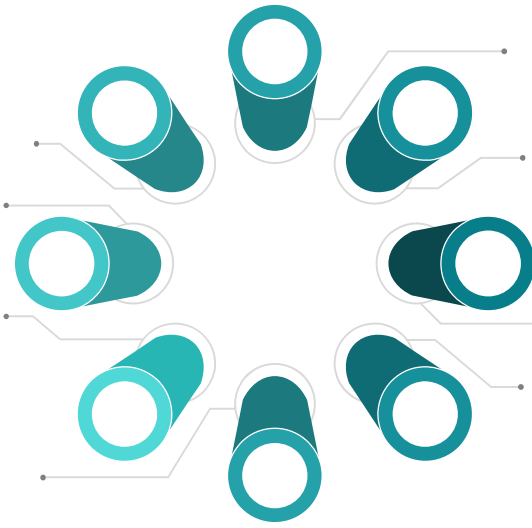
IM Standards Summary



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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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 f 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	% Cited
IM.7.I.M1	Patient Record Requirements	1012;1014; 1010	34%
IM.5.I.M2	Entries are legible, clear, complete, include signature and title	1024	27%
IM.4.I.M1	Availability of the patient record	1010	12%

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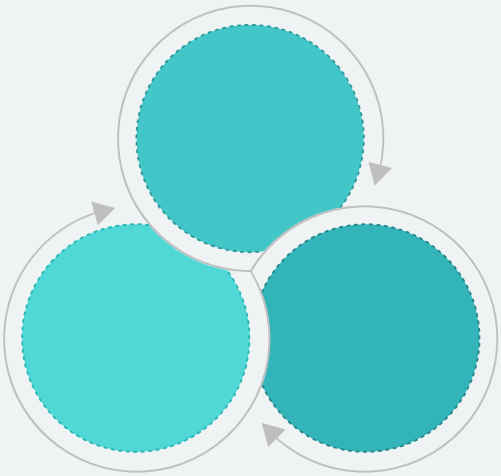
Tips for Success

- 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.

The planners and authors of this course have declared no real or perceived conflicts of interest that relate to this educational activity.

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