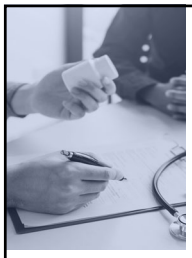
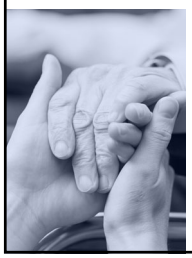


Hospice Day 2
Home Health Day 1
Consultant Certification

An Interactive Training



Bobbie Warner RN, BSN
Director of Education
August 2, 2023

CHAP Community Health Accreditation Partner

1

While you are waiting....

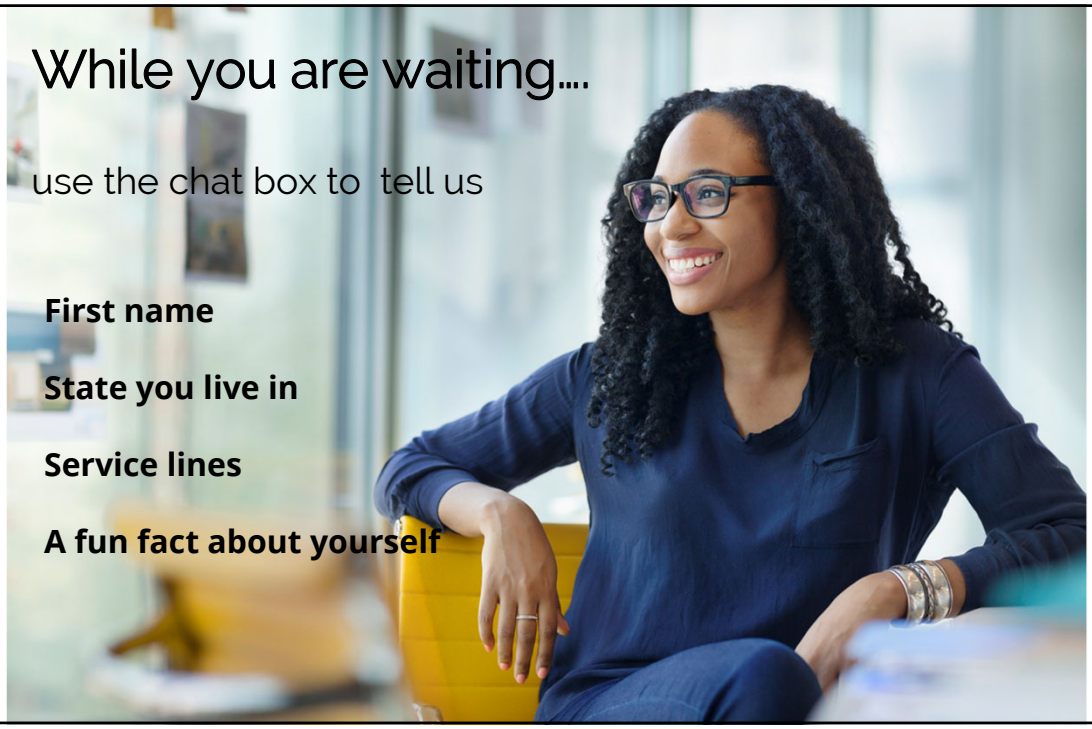
use the chat box to tell us

First name

State you live in

Service lines

A fun fact about yourself



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2

Housekeeping

- Introductions

Agenda and Handouts

- Muting
- Use of Chat
- Raise and lower of hand

3

Get to Know Each Other

When placed in Breakout Rooms, Take a couple of minutes to each think about a fun fact to share.

Some previous fun facts included, a professional gambler, several service men and women, a marathon runner, a Michael Jackson impersonator, a world traveler, and of course lots of proud grandparents and four legged parents.

Each person takes a minute to share their name/state/service line they consult in/one fun fact.

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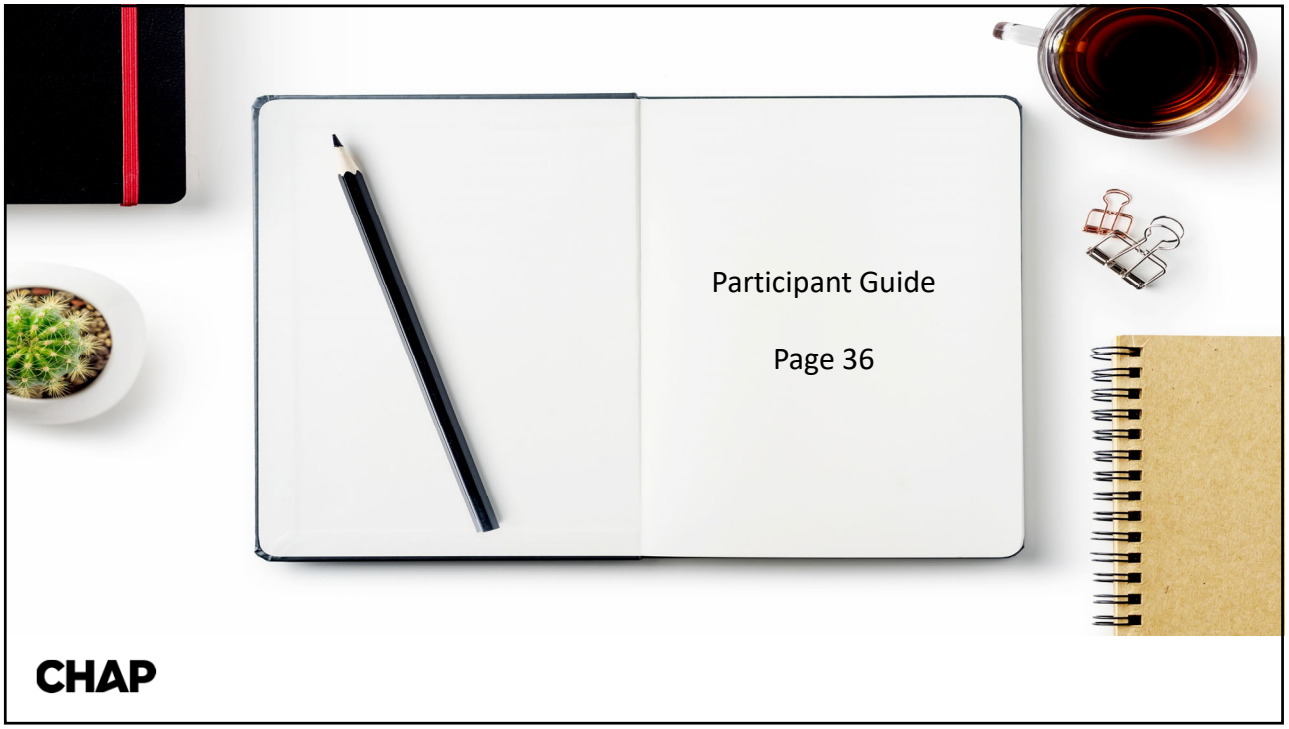
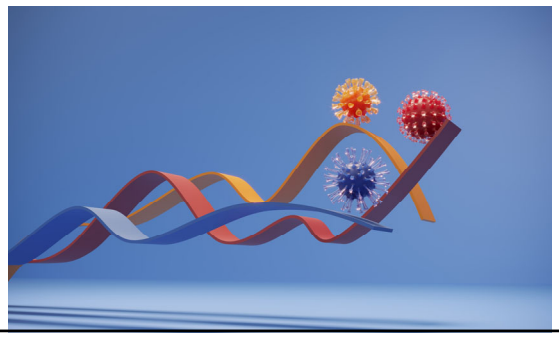
4



5

Infection Prevention and Control

Hospice- HIPC Home Health- IPC



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6

Standards of Excellence

Similarities and Differences

Hospice IPC P/P
HIPC 1.D
HIPC 8.D
HIPC 10.D

Home Health IPC P/P
IPC.1.D
IPC.1.D.M1
IPC.1.I
IPC.1.I.M4
IPC.3.I
IPC.4.I
IPC.4.I.M1
IPC.10.I

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7

Program Goal

Each organization must maintain and document an effective infection control program that protects patients, families, visitors, and hospice personnel by preventing and controlling infections and communicable diseases.

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8

Prevention

(CDC Healthcare Infection Control Practices Committee)

Six Standard Precautions

- Hand Hygiene
- Environmental Cleaning and Disinfection
- Injection and Medication Safety
- Appropriate use of Personal Protective Equipment
- Minimizing Potential Exposures
- Reprocessing of reusable medica equipment between each patient and when soiled.

Foundation Needed

- Policies and Procedures
- Protocols for education of staff/patients/caregivers
- Monitoring for compliance

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Control

Coordinated agency-wide program

- Surveillance
- Identification
- Prevention
- Control
- Investigation of infectious and communicable diseases

QAPI

Includes:

- Identifying infectious and communicable disease problems;
- A plan to result in improvement and disease prevention.

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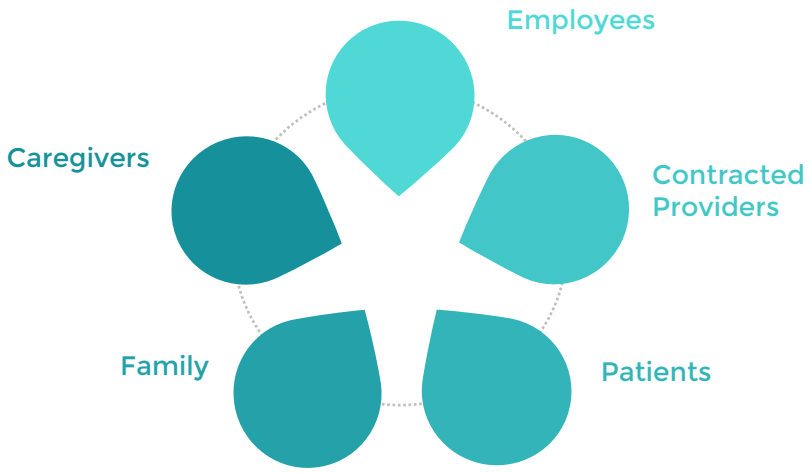
Education



11

Review the Handouts – Pages 38-39

Handwashing

Bag Technique

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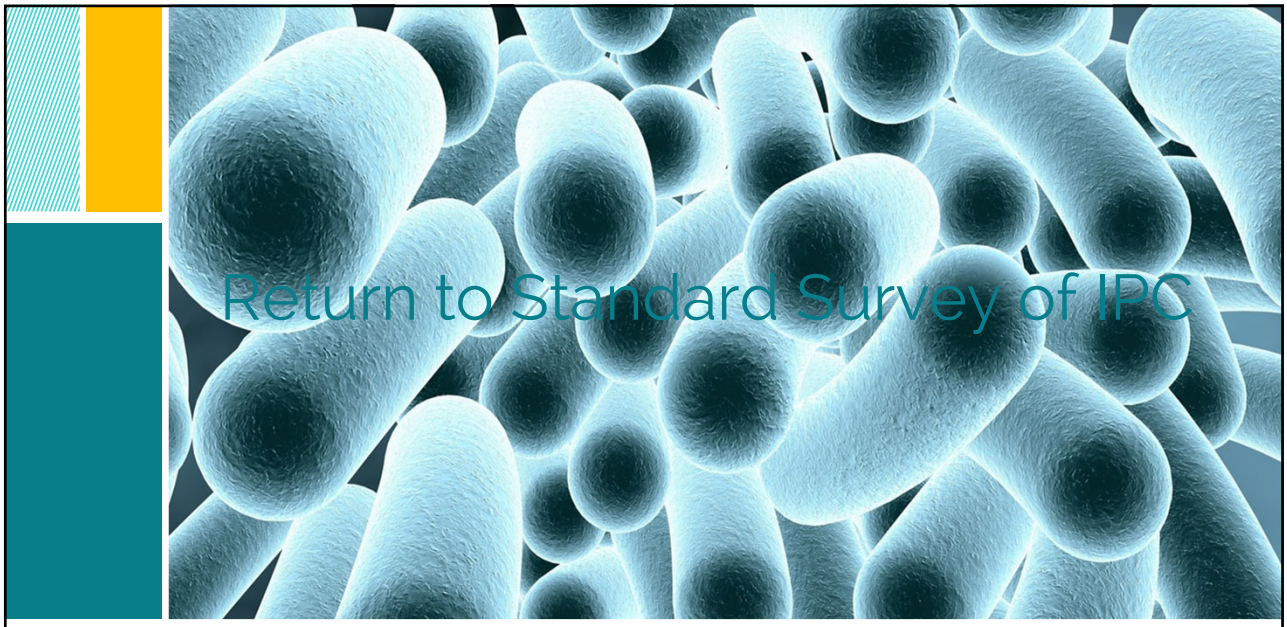

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COVID-19 Vaccination and Waivers

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2022 Top Findings in IPC - HH

Standard	Home Health Content	CMS Tag
IPC.3.1.M1	Instances in which the use of hand hygiene is implemented (29%)	G 682
IPC.4.1.M1	Bags that carry equipment/supplies used consistent with policy (16%)	G 682
IPC 8.1	TB screening per state local regulation or CDC (11%)	G 684
IPC.4.I.M2	Appropriate storage, transport and use of sterile materials (6%)	G682
IPC.21	Agency demonstrates vaccination status or documentation reflects exemption or exception (5%)	G687

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Top Findings IPC

IPC3.I.M1; 484.70(a) Prevention

G682- *Hand Hygiene: 5 elements*

IPC4.1.M1

G682-*Bags are transported and used in a manner consistent with organizational policy to prevent the spread of infections and communicable diseases.*

IPC8.I

G684-*personnel are screened and tested according to P/P*

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2022 Top Findings in HIPC - Hospice

Standard	Hospice Content	CMS Tag
HIPC 9.I	Addressing risk for occupational exposure to TB (35%)	NONE
HIPC 2.I	Appropriate use of standard precautions(19%)	L 579
HIPC.4.I	Bag Technique (12%)	L579
HIPC 1.D	Infection control program includes the required elements (5%)	L582
HIPC 13-18	Requirements related to vaccination status/exemption/exception (3%)	L900

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Top Findings HIPC

L579- Prevention- 418.60(a): Standards of Practice

HIPC 2.I - Use of standard precautions –handwashing, gloves, waste disposal, PPE

HIPC 4.I - Bags used to carry medical equipment (e.g., BP cuff) or supplies into or out of the care environment

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Tips for Success

- **Conduct Observation in the** field
- Include the trunk and field bag in the review
- Know state specific requirements
- Infection control should be an important part of your quality program
- Teach your RN's best observation practices for Aides

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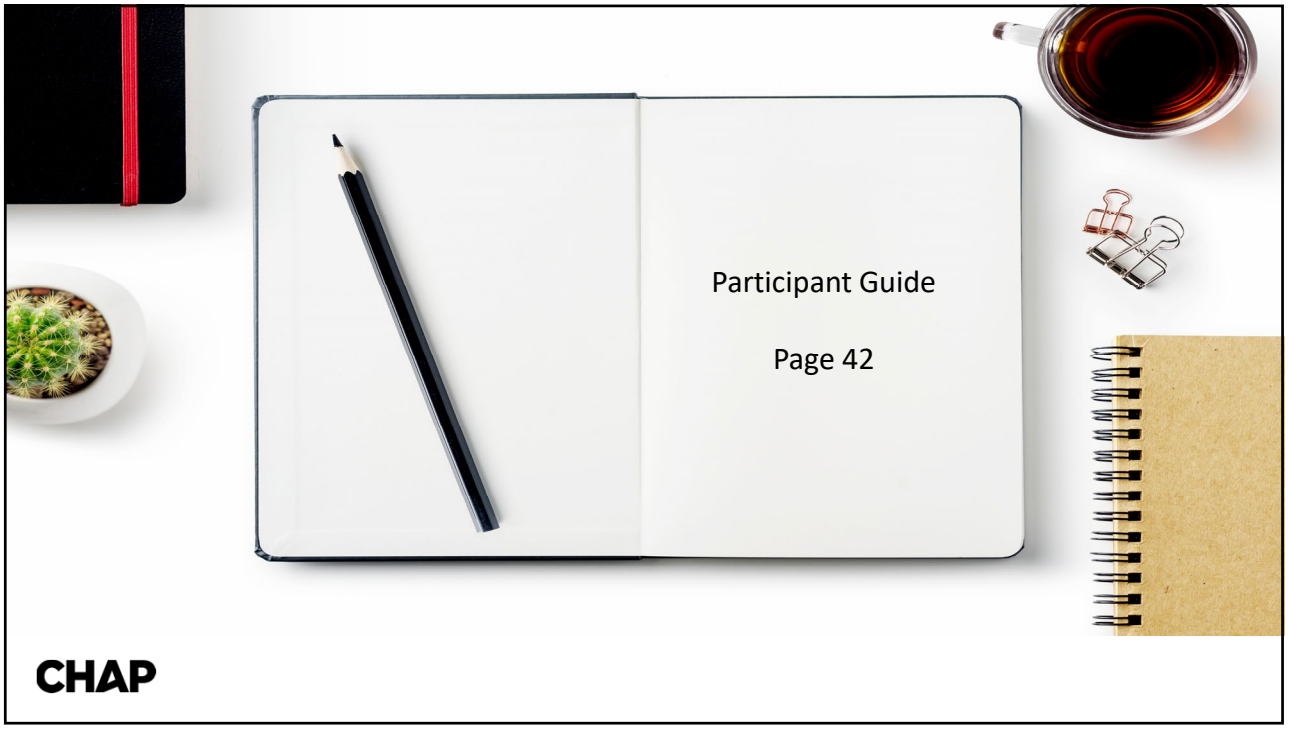

23

Human Resource Management

Hospice- HSRM Home Health- HRM

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24

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?

25

Hiring Criteria

Qualifications for each professional complies with state discipline board requirements

Personnel **policies** are in place that support care delivery and comply with state, local , federal law and regulation.

Personnel meet organization's **hiring criteria**

Credentials and licensure is verified based on primary source verification

Orientation, competency testing and performance evaluation are conducted and documented

Personnel are **supervised** by appropriate staff

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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 HSRM-Hospice

Standard	Hospice Content	CMS Tag
HSRM 16.I	Requirement for criminal background checks (22%)	L 795
HSRM 2.D	Requirements for hire and organizational chart (19%)	NONE
HSRM 14.I	The skills of all individuals providing care are assessed (14%)	L663
HSRM 29.D	Personnel performance is evaluated (13%)	NONE
HSRM 15.I	An initial orientation program addressing the employees specific job duties is provided (9%)	L661/L662

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Top Findings HSRM

HRSM16.I; 418.114(d)(1); Background checks

L795- *criminal background checks on all hospice employees who have direct patient contact or access to patient records*

HSRM14.I- 418.100(g)(3);

L663- Assess the skills and competence of all individuals furnishing care, including volunteers and, as necessary, provide in-service training and education programs

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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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Top findings HRM-HH

HRM 3.I484.100: Compliance with Federal, State, and local laws and regulations

G848 -not currently licensed per State requirements; other state/federal regulatory issues

HRM 7.I; 484.80(c)(1); G tag 768 Competency

Home Health Aide competency

HRM.6.D.M1- G-722 Skilled professionals participate in organization sponsored in-services

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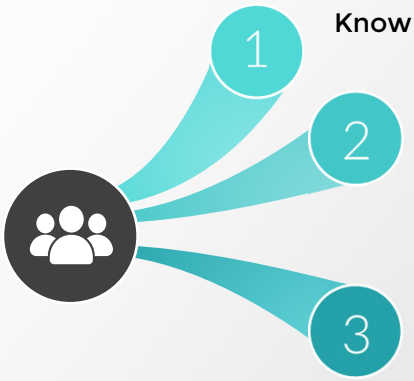
Tips for Success



1. Know state specific requirements
2. Focus audit on specific HR timeframes
   - Orientation
   - Annual requirements
   - Performance evaluations
   - Hiring criteria
3. Checklists guides are helpful

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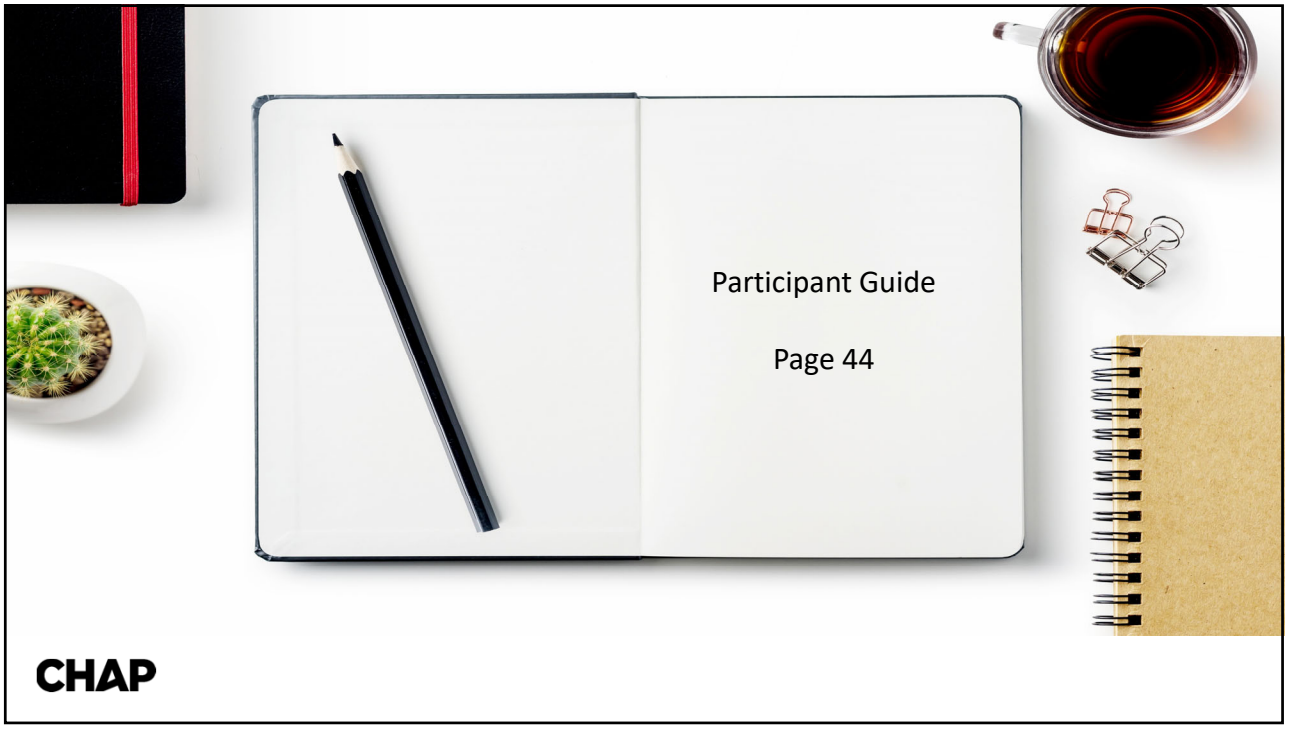

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Home Health Continuous Quality Improvement (CQI)

Hospice Quality Assurance and Performance Improvement(HQPI)

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Standard Summary

Hospice	Home Health	Content
HQPI 1.D-2.I	CQI.1I	Governing Body Involvement agency wide, data driven, reflects complexity of organization and services
HQPI 3.I – 6.1	CQI.2D	Types of data collection
HQPI 7.I	CQI.3	Analysis of data
HQPI 8.I	CQI.3.I.M4	Action taken
HQPI 9.I	CQI.5	Annual performance improvement project requirements
	CQI.6	Sustainability

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Goals

Specific

Measurable

Attainable

Relevant

Time-based

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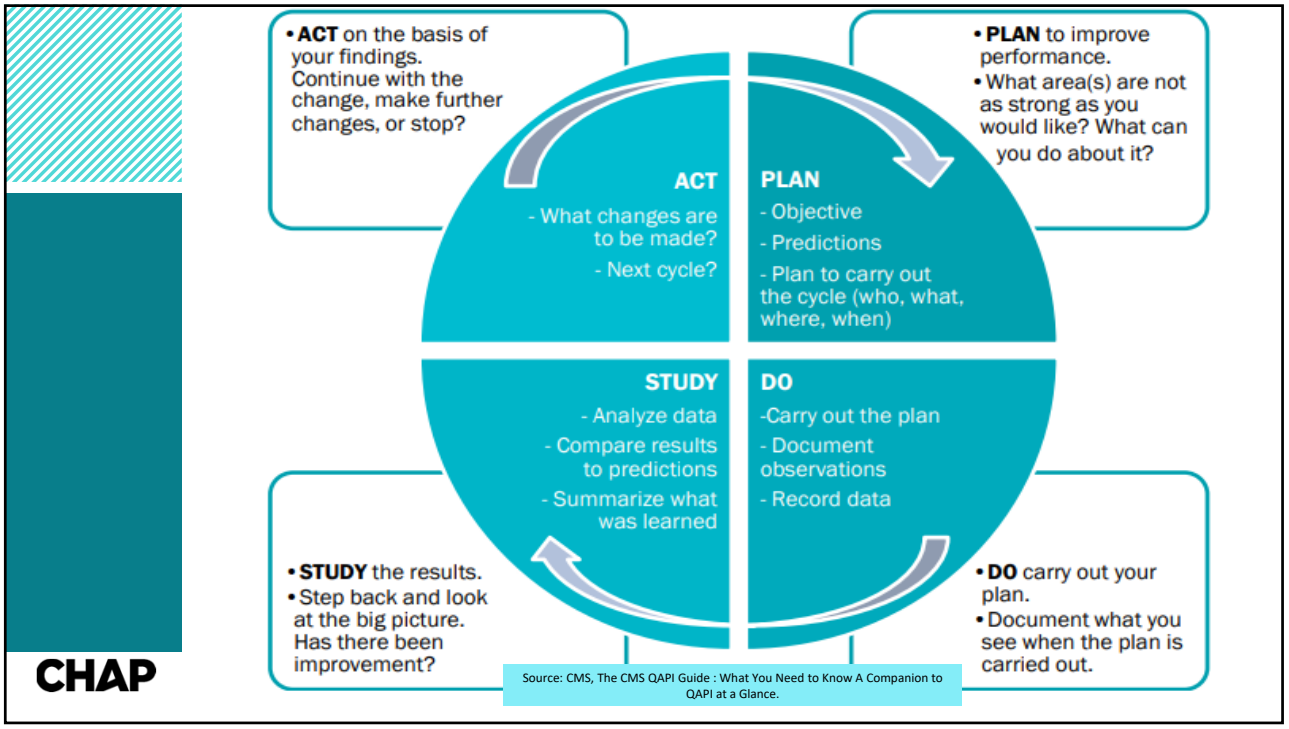

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Performance Improvement Projects

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Quality Activity

Each group is to:

Choose one individual to report out:

Identify a *SMART* goal – specific, measurable, attainable, relevant, time-based

Determine the PLAN for implementation to address the deficient practices

Define ACTIONS to be taken

Define How MONITORING will be done and when

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Quality Activity

Breakout Room – 1 (1 person to report out)

Scenario – Freestanding Organization recently had a first renewal site visit conducted. Active patient census is 75.

Agency Support
- Administrator – nonclinical
- Clinical Manager with the following oversight responsibilities
  - Quality Improvement
  - Education
  - Orientation
  - Supervision

Improvement Needed – In the renewal site visit, 11 of 11 records reviewed revealed deficiencies such as medication profiles not kept current or not present, medication reconciliation not conducted with changes in medication, and no over-the-counter medications identified.

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Quality Activity

Breakout Room – 2 (1 person to report out)

Scenario – Freestanding Organization recently had their initial survey. They currently have an active census of 15.

Agency Personnel
- Administrator who is an RN and fulfill the role of the clinical manager also
- 2 RN
- 1LPN
- 1Aide
- Social Worker
- Spiritual Counselor

Improvement Needed – During the initial visit, the following infection control deficiencies were identified: the social worker failed to conduct handwashing during the home visit, the aide failed to utilize appropriate bag technique, and the RN was noted to not follow appropriate protocol for wound care through lack of appropriate glove and hand hygiene techniques.

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Quality Activity

Breakout Room – 3 (1 person to report out)

Scenario – Established Freestanding Organization recently had a third renewal site visit conducted. Active patient census is 100. The hospice is separated into a North and South team. Agency has experienced recent turnover requiring the sharing of LPN/RN staff between teams.

Agency Support

- Administrator – nonclinical
- 2 Clinical Manager 2 RN's; 2 LPNs per team
- 1 Social Worker
- 1 Spiritual Counselor
- 1 Quality Improvement RN for: Education; Orientation; Supervision

Improvement Needed – Clinical records (CR) revealed deficiencies in coordination of care. In 4 of 10 clinical records, the LPN failed to notify the RN/CM of new physician orders obtained following changes in patient's conditions. The clinical records revealed #1- increase in wound care orders from twice weekly to three times per week were not communicated and there was a missed visit for wound care in each of the next three weeks; #2- delay in scheduling an extra social work visit; #3 delay in RN providing an extra visit to evaluate for an adjustment in pain management, #4- delay in scheduling of contract therapy staff to evaluate patient

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Quality Activity

Breakout Room – 4 (1 person to report out)

Scenario – Freestanding Organization recently had their initial survey. They currently have an active census of 12.

Agency Personnel

- Administrator who is an RN and fulfills the role of the clinical manager
- 1 RN (back-up to CM)
- 1LPN
- 1Aide

- **Improvement Needed** –4 of 4 Clinical records revealed deficiencies in discharge/transfer requirements; (2) discharge summaries, the content of the summary did not include medications; (2) discharge summaries were not provided to the appropriate subsequent Physician;(2) transfer summaries were not completed for patients transferred to a skilled facility;

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Quality Activity

Breakout Room – 5 (1 person to report out)

Scenario – An established organization with a census of 50, is receiving their first renewal site visit.

Agency Personnel
- Administrator who is not an RN
- 1 RN Clinical Manager and 1 full-time I RN
- 2 LPN
- 1Aide
- 1Social worker
- 1 Spiritual Counselor

Improvement Needed – The patient was admitted to the Hospice on Thursday. The agency provided the comfort care kit, but the daughter (primary caregiver) was not present and was not instructed on the use of the comfort care kit. Three days later the patient became agitated and restless. The daughter called the agency at 9pm and every 45min (as instructed in the agency information for after-hours contact) until midnight without a call back. The daughter contacted the office the next morning (Monday) and was told an RN would be out on Friday. The agency saw the patient on Thursday at which time they provided appropriate instruction to the daughter. The patient had not been seen by any agency staff for 7 days from admission.

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Quality Activity

Breakout Room – 6 (1 person to report out)

Scenario – An established organization experienced their first renewal survey with deficiencies identified with agency documentation and follow-up on complaints. The agency has a census of 35.

Agency Personnel
- Administrator who is not an RN
- 1 RN Clinical Manager and 1 (back up) IRN
- 2 LPN
- 2Aide
- 1Social worker

Improvement Needed – Review of the complaint log revealed 3 complaints regarding aide services in the past month.
Complaint #1 – aide #1 in home 30 minutes and on phone during the visit and patient not provided ordered bath. Documentation stated the patient "refused. This occurred on two weekly visits.
Complaint #2 – patient called to complain that the aide #2 who was to provide care 3x/week, only came 2x/week for the past two weeks. Documentation did not reflect why visits were not done and interview of RN revealed she was unaware that the visits had been missed
Complaint #3 – Patient called with concern regarding the aide #1 bringing her preschool children to work with her and leaving them in the car. The aide rushes through care provision in 20 minutes. Documentation of the aide reflected 45-minute visits to this patient.

Documentation was lacking to reflect appropriate follow-up of the complaints and upon interview the administrator stated "I didn't know about these complaints"

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Discussion

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Determining Priorities

- How extensive is the non-compliance?
- Does the non-compliance affect quality of patient care?
- Is one clinician involved or several?
- Tenured employees and New employees?
- Does the organization have the resources to address the issue?

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2022 Top Findings in CQI-HH

Standard	Home Health Content	CMS Tag
CQI.1.I.M2	Skilled professionals participate in CQI (26%)	G720
CQI.5.I.M1	Performance Improvement projects are conducted annually. (18%)	G658
CQI.2.D.M1	Quality indicators include measures from OASIS (11%)	G644
CQI.3.I.M2	CQI activities include measurement, analysis, and tracking of quality indicators (11%)	G642
CQI.5.I.M2	PI projects are documented with measurable progress achieved (11%)	G658

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2022 Top Findings in HQPI-Hospice

Standard	Hospice Content	CMS Tag
HQPI 7.I	PI activities include tracking & analysis of adverse events and implementing preventative actions (23%)	L569
HQPI 2.I	Appointed individual is responsible for QAPI program (15%)	L 576
HQPI 3.I	Program demonstrates measurable improvements (15%)	L561
HQPI 5.I	Use of quality indicator data (11%)	L564
HQPI 8.I	Action is taken, success measured, and positive results sustained (11%)	L 570

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- Place quality meetings on the calendar
- Plan for involvement from staff
- Document actions taken ongoing
- Develop a template for monitoring a performance project
- Ensure your plan is agency-wide
- Follow up on analysis of data, not only collection of data
- Focus audits are your friend

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Lunch

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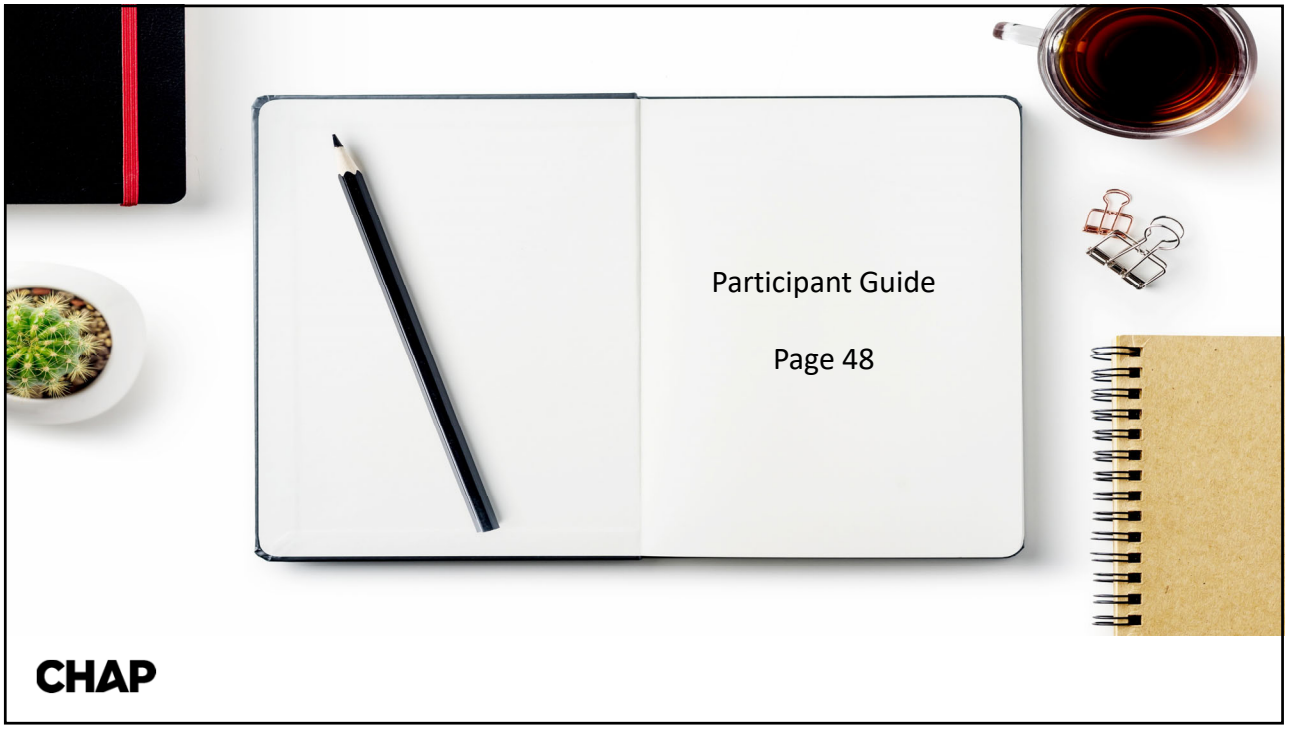

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Emergency Preparedness (HSEP/EP)

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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

- Reviewed every 2 years
- Name and Contact information
- Primary and alternate means of communication
- 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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Integrated Healthcare Systems

CHAP

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2022 Top Findings in HSEP

Standard	Content	CMS Tag
HSEP 3.D	Required policies and procedures of the emergency plan (58%)	E13 E16
HSEP 5.D	Elements and updating of the EP training program (33%)	E37
HSEP 2.D	Emergency plan is reviewed and updated every two years (6%)	E6, E7

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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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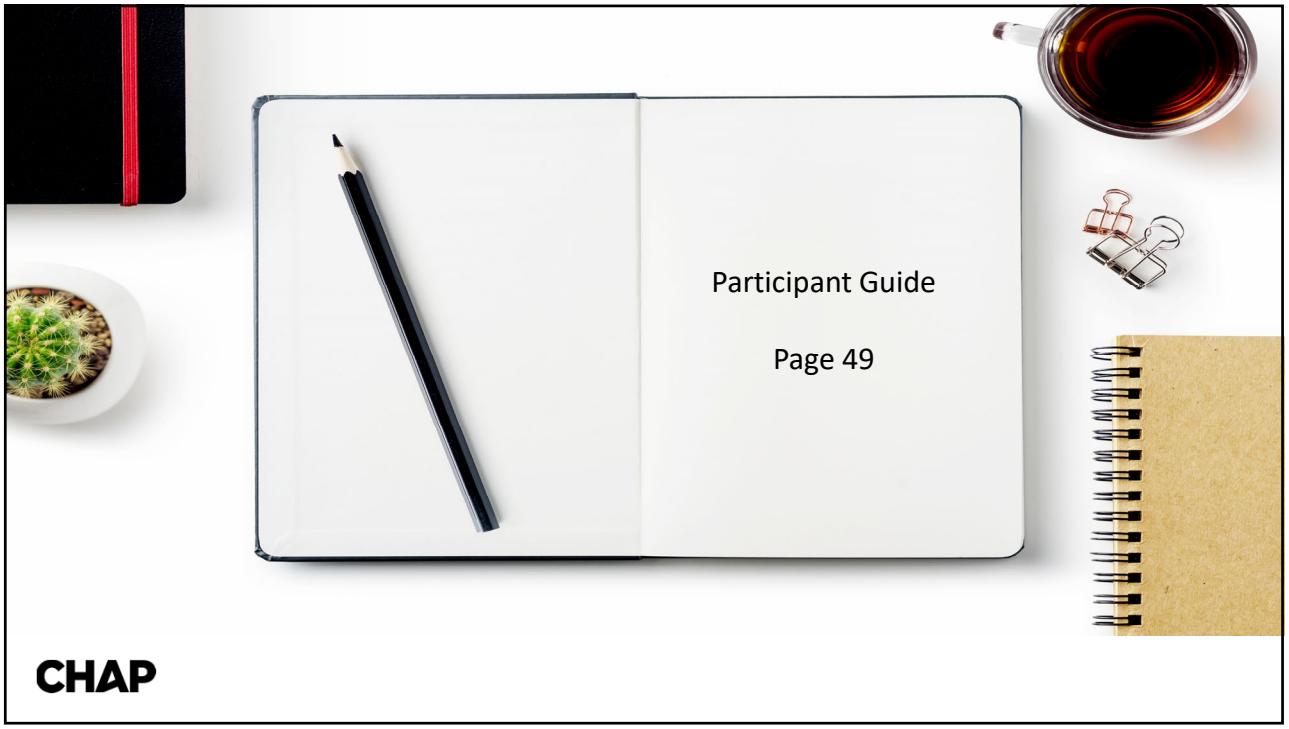

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The CHAP Consultant

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CHAP Accreditation And Site Visit Process

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Customer Relations

- 6 Accreditation Specialists, divided by geographic territory
- 1 Manager of Accreditation Operations
- 1 Senior Scheduling Manager
- 1 Vice President

- The customer service “hub”
- Contact with a live person
- Reducing the work and rework

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Accreditation Clinical Support

- 4 Directors of Accreditation divided by geographic territory
- 4 Senior Accreditation Managers
- 1 Vice President of Accreditation
- 1 Vice President of Corporate Accounts and Governmental Affairs

- Clinical expertise with years of experience in the industry
- Contact with a live person

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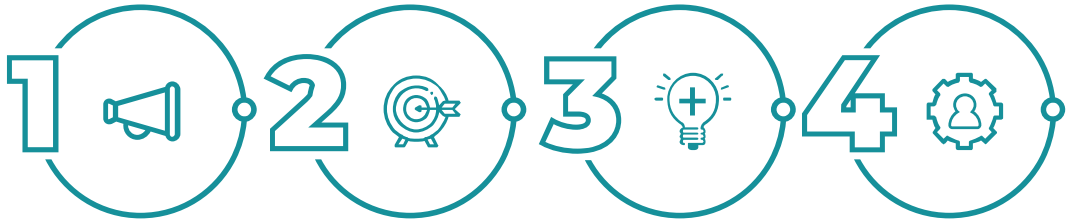
Steps to Accreditation



Accreditation Agreement	Site Visit Preparation	On-Site Visit and Review	Accreditation Determination

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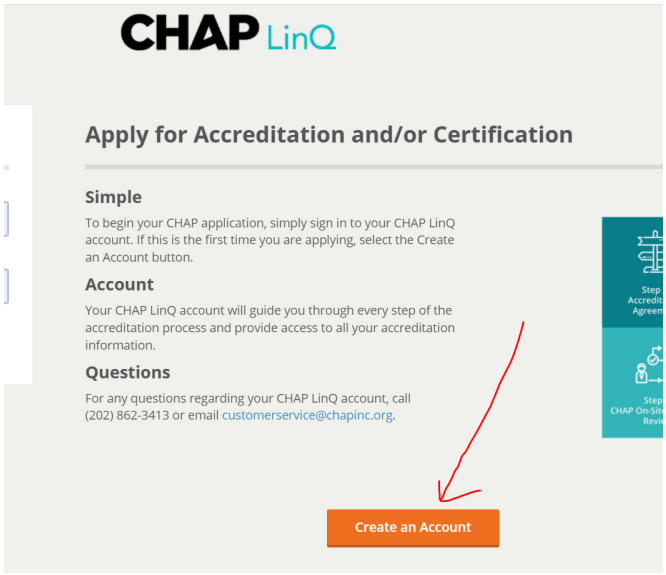

CHAP LinQ

www.chaplinq.org
www.chapinc.org and click on "Your CHAP LinQ Account"

❖ **Create An Account**

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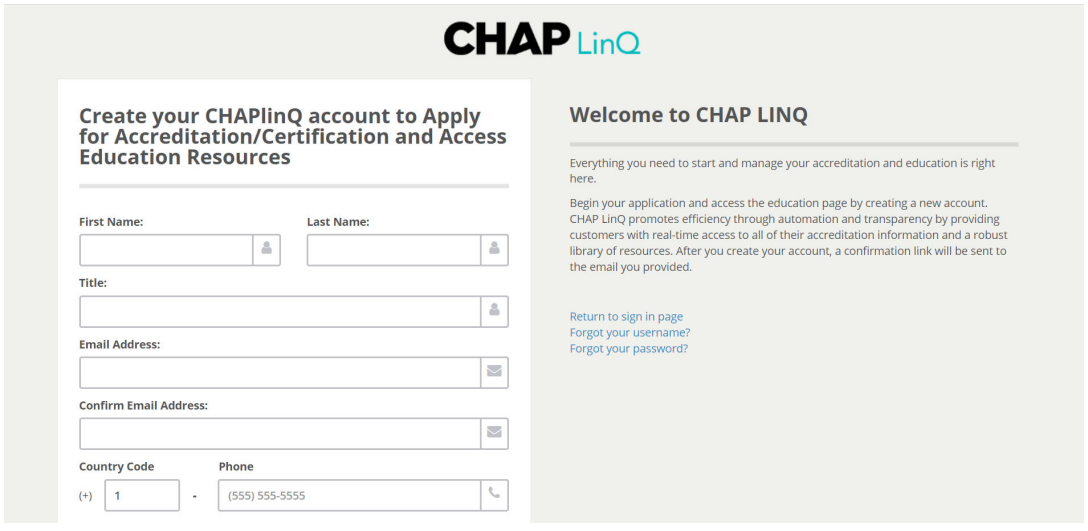

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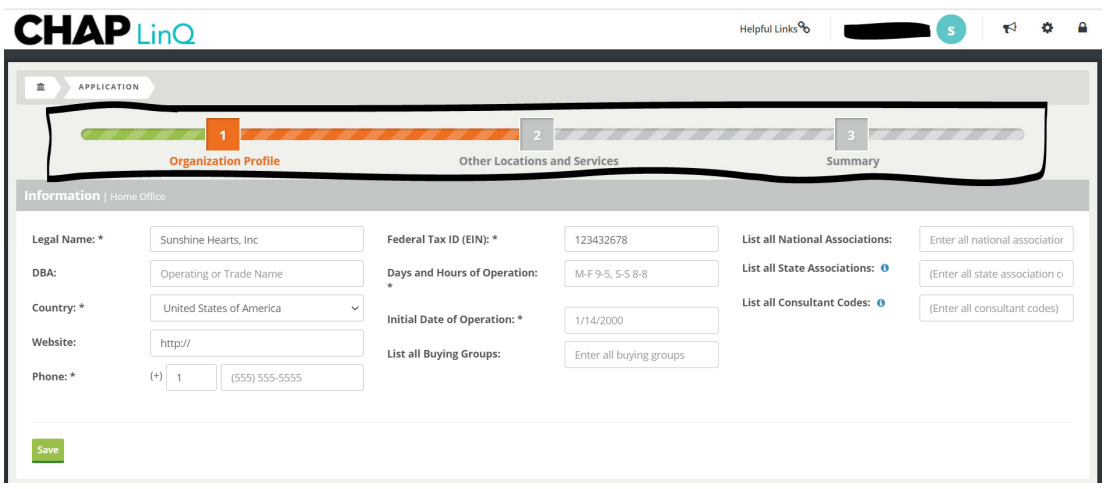

Initial Application

Page 1

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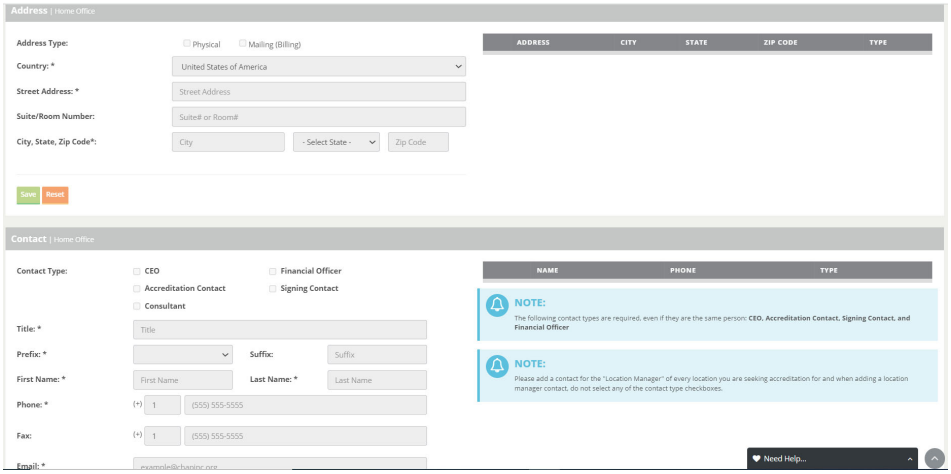

Initial Application

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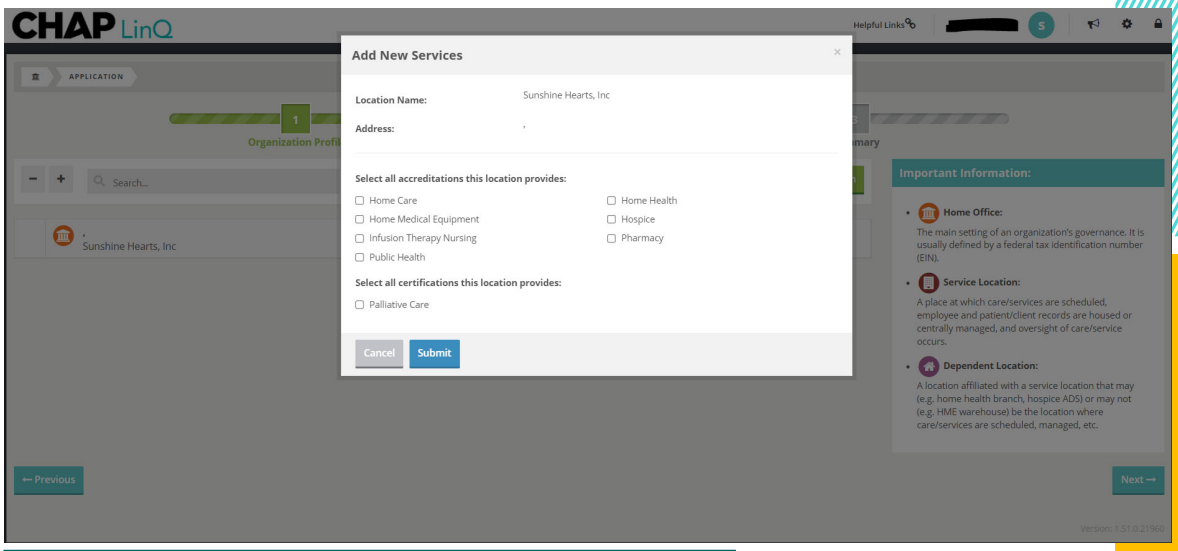

Initial Application

Page 2, continued

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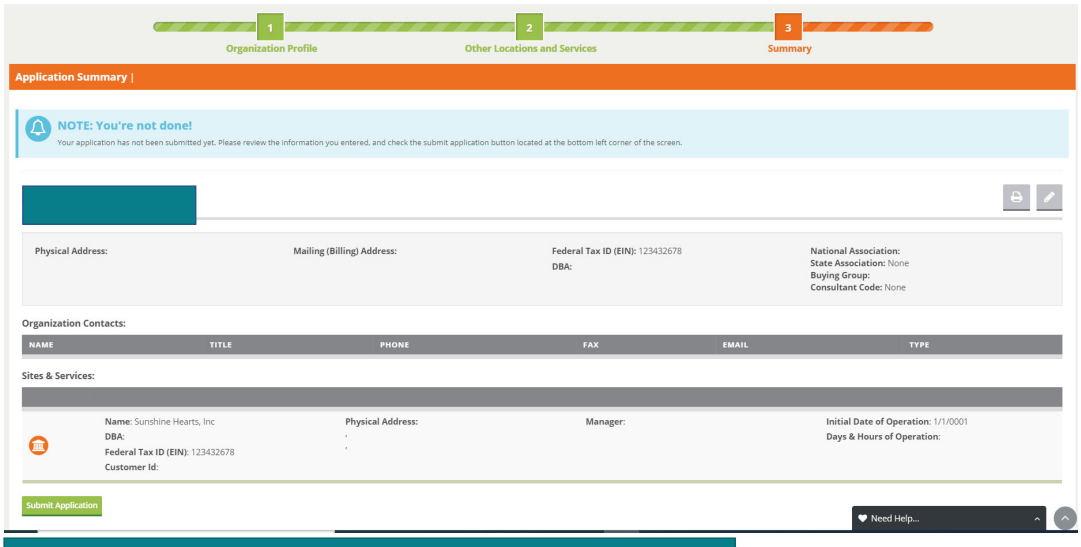

Initial Application

Page 3

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Site Visit Preparation

CHAP Preparation Resources

- Document Request List
- Policy List
- Top Ten Findings per the service line
- Optional self study

Mock record review

- Multi-discipline
- High acuity interventions
- Using quality results
- Consider additions of new services

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Initial Site Visit Readiness

Service Line	Required Documents	Required Census	Deemed Status Requirements
Home Health	• Copy of state license(s), if required by state	• 10 served • 7 active at time of survey	Copy of approved 855A letter
Hospice	• Copy of state license(s), if required by state	• 5 served • 3 active at time of survey	Copy of approved 855A letter
Home Medical Equipment (HME/DMEPOS)	• Copy of state license(s), if required by state	• 5 served (sale or rental) • No active patients required at time of survey	
Home Care	• Copy of state license(s), if required by state	• 5 served • 3 active at time of survey	
Pharmacy	• Copy of state license(s), if required by state	• 5 served (sale or rental) • No active patients required at time of survey	
Infusion Therapy Nursing (ITN)	• Copy of state license(s), if required by state	• 5 served (sale or rental) • 3 active at time of survey	
Palliative Care	• Copy of state license(s), if required by state	• 5 served (sale or rental) • 3 active at time of survey	

* How do I submit readiness?
* Black out dates?

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Hospice Renewal Visit Criteria

# of unduplicated admissions (past 12 Months)	Closed Records (Live Discharges)	Closed Records (Bereavement Records	Record Review – No Home Visit (RR-NHV)	Record Review with Home Visit (RR-HV)	Total Minimum Sample	Inclusion of Records from Multiple Location(s)
<150	2	2	7	3	14	The number of records from each multiple location should be proportionate. Include at least one RR-NHV or RR-HV from each location
150-750	2	3	10	4	19	
751-1250	2	3	12	6	23	
1250 or more	3	4	14	6	27	

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Home Health Renewal Visit Criteria

# of unduplicated admissions (past 12 Months)	Active Patient Sample – Record Review Only (No Home Visit)	Active Patient Sample – Record Review with Home Visit	Discharged Patients: Closed Record Review	Total Survey Sample
<300	2	3	2	7
307-500	3	4	3	10
501-700	4	5	4	13
701 or more	5	7	5	17

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Timing to Prepare

Work on preparation continuously

Initial organizations

- Visit in1-30 days of readiness submission
- Deemed – not announced
- Non-deemed – announced
- Only hit **submit** button when ready!!

Renewal organizations

- Visit in 32-36 months of prior comprehensive visit
- Review of entire Accreditation cycle

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Readiness Submission: And then?

- ❑ *Readiness Call*
- ❑ *Accepting Readiness*
- ❑ *Scheduling Site Visit*

Per CMS as of July 2023, blackout dates and morning notification of the visit are not to be conducted!

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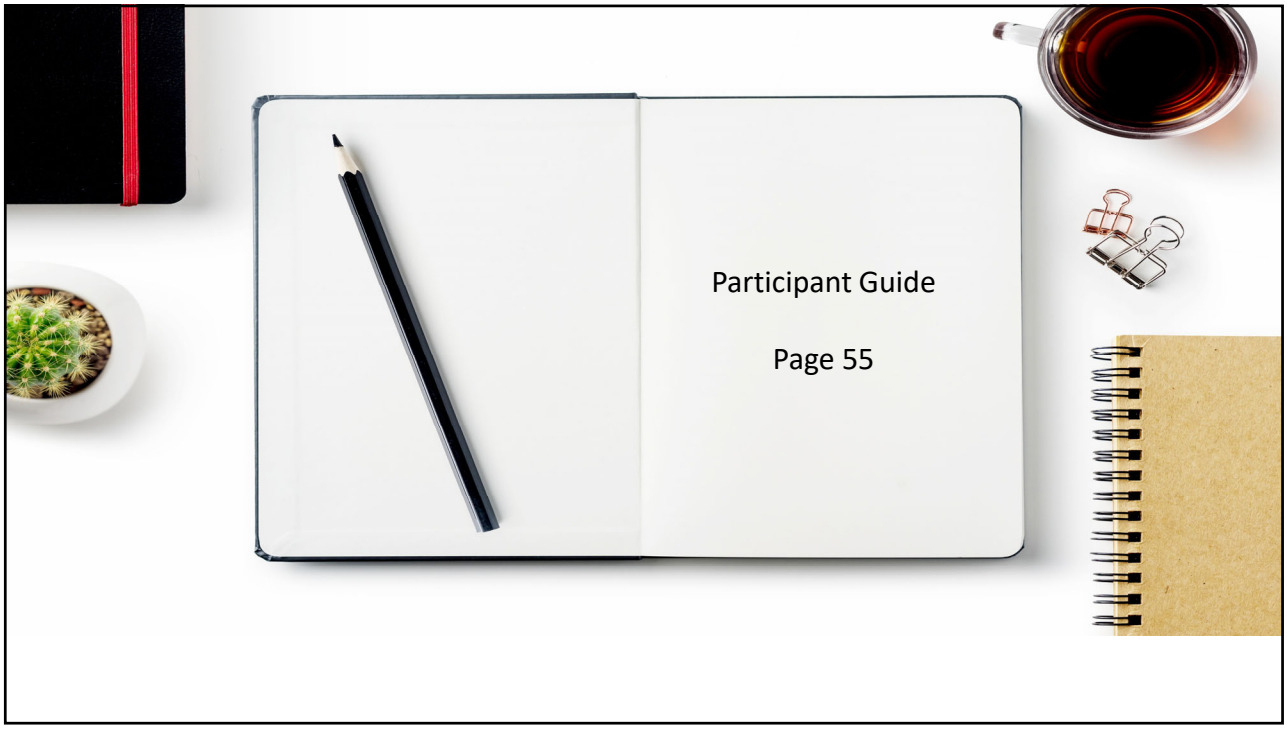

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Site Visit Process

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Visit Components

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Site Visit Activities

- Clinical Record Review
- Personnel Record Review
- Home Visit Observations
- QAPI Review
- Emergency Preparedness Review
- Document Review
- Communication

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Handling Conflict

Should occur **during** the site visit

Steps to successful resolution
- Share concern with site visitor
- Each side should explain their point of view

If conflict continues, add the Director of Accreditation

Final opportunity is to appeal the finding

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Action Plan

Action plan to provider within 10 *business* days
- Submission of report by site visitor
- Full review by the Director of Accreditation or Senior Accreditation Manager

Provider has 10 *calendar* days to submit their plan of correction.
- **PLUS,** the 10 business days of the DA

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Action Plan

What action will we take to correct the deficiency cited?

- Potential action steps include but are not limited to:
  - Policy review and/or revision
  - Education
  - Development of job aids
    - Documentation templates
    - Checklist
  - Hiring of Staff

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Action Plan

Who is responsible to implement the corrective action?

- May be more than one individual involved.
- Who is the primary person responsible for oversight of the improvement?
- Use title, not an individual's name. Ex, Clinical Manager rather than Roger Rabbit.
- No identifying information

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Action Plan

When will the corrective action be implemented?

- Approximate time the plan is implemented
- Depends upon the complexity of the plan
- Consider the timeframe for potential re-survey
- Prioritize quality care issues over “paper” issues

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Action Plan

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action plan?

- Short term monitoring to evaluate actions being taken
- Long term monitoring to evaluate sustainment of improvement
- Include aspects of measurability (time, percentage of compliance)

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Condition Level Finding

Initial agency – First site visit
- Deferral of accreditation
- 2nd comprehensive visit within 90 days
- If continues – 3rd and last visit within 90 days

Renewal Agency – any visit type
- Follow up visit within 45 days
- One or two days depending on number of CLD's
- The entire condition must be reviewed
- May require a home visit depending on the finding

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Relieving Anxiety

Constant Preparation
- Mock surveys and staff observations
- Education
- Document readiness

Prepare for the site visit
- Documents ready for review – contracts and policies

Updated lists
- Active patients
- Employee listing
- Discharge listing
- Unduplicated admission *number*

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Relieving Anxiety

Site Visit Plan

- Appoint a **point-person**
  - Designate an alternate
- Methods for **sharing information**
  - Records/Documents
  - Onsite/Offsite
- **COVID practices** sustained
- **Workspace** determined
- **Prepare staff** through practice drill

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Relieving Anxiety

Communication

- Share difficulty in obtaining information
- Share your anxiety with the site visitor
- Ask questions!
- Take notes at each daily wrap up

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What was today's valuable lesson? (page 52

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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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