CHAP Community Health Accreditation Partner

HOSPICE/HOME HEALTH

Consultant Workshop Participation Guide

Learning Objectives:

- *Outline the CHAP Accreditation process.*
- *Identify the revisions within CHAP Home Health Standards and CMS Conditions of Participation.*
- *Identify trends in deficient practice based upon site visit results for 2022.*
- *Demonstrate ability to identify areas in need of improvement and develop a performance initiative to address the need.*

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.

Home Health Only Attendees – 12.0 Contact Hours

Hospice Only Attendees – 13.0 Contact Hours

Home Health and Hospice Attendees – 18.25 Contact Hours

Hospice Day One	
10:00-10:15	Welcome and Housekeeping
10:15-10:45	Resources
10:45-11:30	Hospice Inpatient Care (HSIC)
11:30-11:45	**Break**
11:45-12:30	Care to Residents in a Facility (HSRF)
12:30-1:30	Hospice assessment/care planning and coordination (HCPC)
1:30-2:00	***Lunch***
2:00-3:00	Hospice Care delivery and treatment (HCDT)
3:00-3:30	Hospice Leadership and Governance (HSLG)
3:30-3:45	***Break***
3:45-4:15	Hospice Patient Family Centered Care (HPFC)
4:15-4:45	Hospice Information Management (HSIM)
4:45-5:15	New Hospice Survey Process
5:30	***Closing***
HSP & HH Day Two	
10:00–10:45	Welcome to HH and returning Hospice
10:45-11:45	Infection control
11:45-12:00	***Break***
12:00-12:30	Human Resource Management
12:30-1:30	QAPI
1:30-2:00	**Lunch**
2:00-2:45	Emergency Preparedness
2:45-3:45	The CHAP Consultant
3:45-4:00	**Break**
4:00-5:00	Accreditation Process
5:00-5:30	Question and Answer
5:30	***Closing***
Home Health Day Three	
10:00-10:45	Welcome and Recap/Resources
10:45-11:30	Patient Centered Care
11:30-11:45	**Break**
11:45-1:00	Assessment, Planning and Coordination
1:00-1:30	Financial Stewardship
1:30-2:00	**Lunch**
2:00-3:00	Care Delivery and Treatment
3:00 – 3:30	Leadership and Governance
3:30-4:00	Information Management
04:00-04:15	***Final Q and A***

*Presented by Bobbie Warner RN, BSN and Linda Lockhart (unless otherwise noted). Curriculum designed in collaboration with Frances Petrella, RN, BSN, Julie Pazun, RN, BSN, MHA, and Denise Stanford, MS,SHRM-CP

Introduction:

Ice Breaker: Enter into the chat box your name, state you are from, and a fun fact about yourself.

Activity: Microsoft Polls:

How long have you worked as a consultant?

Are you familiar with CHAP Hospice Standards of Excellence?

Topic: CHAP Hospice Standards of Excellence

Revision Table

Current Version

Evidence Guidelines

Additional Resources

- Appendix M – State Operations Manual – Conditions of Participation
- Appendix Z – State Operations Manual – Emergency Preparedness
- Medicare Administrative Contractors
- MLN Newsletters
- CHAP eNews
- Hospice Resource Tool Packet

DAY ONE

Patient Focus

Topic: Hospice Inpatient Care (HSIC)

Microsoft Poll:

1. Have you ever worked with a directly owned Hospice Inpatient Unit?
2. I understand the purpose of inpatient unit care in hospice.

Standard Summary

HSIC1.I – HSIC 4.I General inpatient standards:

HSIC 5.D Required elements of the written agreement for inpatient care provided by agreement.

<u>Hospice responsibilities:</u>

- Hospice Plan of Care
- Training - Documented
- Compliance
- Discharge Summary
- Compliance with Plan of Care

<u>Facility responsibilities:</u>

- Policies
- Clinical record
- Inpatient record availability
- Designated individual

HSIC 6.I – HSIC 34.I Standards related to directly owned hospice inpatient facility:

HSIC 35.I – HSIC 46.I Restraint and seclusion in a hospice owned inpatient facility:

Under Arrangment	Direct owned
• Written Agreement • Ensuring facility complies with Life Safety Code • Infection control as per hospice policy • Complies with restraint/seclusion	• Appropriate staffing/24 Hour Nursing Responsible for Emergency Preparedness compliance: policies/testing/communication • Life Safety Code Compliance • Facility specific infection control

Organization information for Angel Wings Hospice
Initial organization, passed survey through deemed CHAP Accreditation visit two months ago.

Current census – 30

Has contract in place for short term inpatient care, and respite services.

Administrator is non-clinical; Clinical Director is new to hospice but has managerial experience in home health.

Staff consists of 4 RN case managers, MSW who also fulfills role of volunteer coordinator, Chaplain who also fulfills role of Bereavement Coordinator, 4 hospice aides.

Medical Director is contracted.

Potential Red Flags?

Today's Hospice Patient

Ms. Iris Wood, a 76-year-old female was admitted to the hospice with a terminal diagnosis of Stage 4 pancreatic cancer with metastasis to the lung on October 1, 2021. She lives with her husband of 49 years who is somewhat frail but fully involved in her care. No other family is close by although a daughter lives 500 miles away. She is in contact with her mother and father daily. Over a 3-week period, Ms. Iris has had progressive difficulty in pain management. When admitted, the patient's pain was being controlled with Tramadol and the use of Dilaudid 2mg for breakthrough pain, in week two of her hospice episode, her pain medication plan was changed to oxycontin SR every 12 hours with Dilaudid 8mg for breakthrough pain. In week three Fentanyl patches with Actiq lozenges were unable to provide her acceptable relief.

The decision was made to admit her to GIP for pain management. This decision was very difficult for the husband to agree to but after discussion with the social worker, he admitted he felt hopeful in that his wife may be able to get some pain relief. It was noted by members of the IDT that the husband appeared exhausted and had not had a good night's sleep in 3 weeks. In addition, the personal care needs of his wife were growing more complex each day.

Ms. Iris was admitted to a Medicare Certified Skilled Nursing Facility that the hospice had contracted with for their provision of GIP services.

Thoughts to Consider

Was short-term inpatient care the right choice for Ms. Iris?

What other options could be considered?

What interventions might need to occur for Ms. Iris to come back home?

What level of care would be appropriate if fatigue of the husband was the main issue?

Notes:

Top HSIC Findings

Standard	Content	CMS Tag
HSIC 28.I	Requirements addressing the provision of meals (38%)	L736
HSIC 15.I	Documented and dated Life Safety Code fire drills (29%)	E0039
HSIC 24.I	Life Safety Code requirements related to water and plumbing (8%)	L732

Less than 1% of all findings in 2022

Tips for Success

Topic: Hospice Care to Residents in a Facility (HSRF)

Discussion: What are the similarities and differences between providing care by arrangement for hospice **inpatient care** and providing care for a **resident of a facility**?

Microsoft Poll: Have you assisted hospice organizations who provide care to patients in a facility?

Hospice Responsibilities

- Assessment
- Coordination
- Care Provision
- Determining the Level of Care
- Provision of Supplies. DME, Medications.
- Financial Management

The Written Agreement

General Overview:

Hospice Elements

- Medical direction and management of the patient
- Nursing/Counseling/Social work
- Provision of medical supplies, durable medical equipment, and drugs
- All other hospice services related to terminal illness
- Reporting of mistreatment or abuse
- Provision of bereavement services

Facility Elements

- 24-hour room and board

- Meeting usual personal care and nursing needs care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home, at the same level of care provided before hospice care was elected by the patient/resident.

Scenario:

Iris has been admitted to a skilled facility for care following her inpatient stay until her daughter is able to arrive and provide care for her mother. The hospice will continue to provide care to Ms. Iris in the facility. The RN is explaining to the facility staff the differences in their roles and has decided to provide examples to reinforce their different responsibilities.

1. Provision of meals
2. Calling the physician upon worsening symptoms
3. Providing a chair bath 3 times per week
4. Assisting the patient with incontinence in the middle of the night
5. Determining the bowel regimen
6. Who implements the bowel regimen?
7. Determines a need for changing the level of care
8. Financial responsibility for long term incontinence supplies
9. Financial responsibility for medications addressing the terminal illness

Activity: Whose Responsibility? A numbers game….

Hospice (1) **Facility (2)**

_____
_____

_____
_____

_____
_____

Top Finding for HSRF

Standard	Content	CMS Tag
HSRF 6.I	Hospice plan of care is in place/coordination occurs with facility (56%)	L 774
HSRF 9.I	The designated team member provides information to SNF (38%)	L781

Less than 1% of all 2022 findings

Tips for Success:

Topic: Assessment, Care Planning and Coordination (HCPC)

Standard Summary

HCPC 1.I-3.I

HCPC 4.I-6.I

HCPC 7.I-17.I

Nature and condition causing admission	Co-morbid psychiatric history
Presence or lack of objective data and subjective complaints	Complications and risk factors that may affect care planning
Risk for drug diversion	Functional and cognitive status
Ability to participate in own care	Imminence of death
Symptoms and severity of symptoms	Bowel regimen if opioids are prescribed
Patient and family support systems	Patient/family need for counseling and education
Comprehensive pain assessment	Initial bereavement assessment
Patient/family needs for referrals	Comprehensive drug profile and review
Data elements for outcome measurement	

- HCPC 11 – General Assessment

- HCPC 12 – Pain
- HCPC 13 – Bereavement
- HCPC 14 – Referrals
- HCPC 15 – Drug Profile
- HCPC 16 – Outcomes

Scenario: Ms. Iris is being discharged from the skilled facility to return home. Her daughter has arrived, and a meeting has occurred with the family, physician, and IDT to validate the ability of the daughter and spouse to work together to handle the care of the mother. Ms. Iris arrives at home and the hospice team makes plans for assessment and development of the plan of care. Due to staffing circumstances a new employee, an RN new to hospice is scheduled to conduct the assessment. As the consultant, you are reviewing the admission documentation for compliance.

Discussion

What concerns might there be knowing this patient's history?

What needs should be anticipated?

Group Activity (20 minutes)

Attendees will be divided into two breakout rooms

- Each participant should conduct a high-level overview of the entire assessment
- Each group will be assigned key elements of the assessment for in-depth review
  - Group one – focus on pain management and psycho-social aspects
    - Evaluate what was documented
    - Present education needed for improvement
  - Group Two – focus on functional and medication aspects
    - Evaluate what was documented
    - Present education needed for improvement
- Each group assigns one spokesperson to share their thoughts.

Discussion

Comprehensive Assessment Example

Patient: Iris Wood
SOC: 7/22/2021
Diagnosis – Pancreatic Cancer with metastasis
Secondary – Congestive Heart Failure
Skilled Facility Transfer 10,1,2021
Election of benefit signed 9/1/2021
Level of Care: Routine Hospice Care
Age: 76
Advance Directives – Yes

Vital Signs:
Temp – 97.7
Pulse – 88
Resp – 24
BP – 118/68

Pain Assessment
Intensity of 4 current and frequently
Acceptable level to patient is 4
Description of pain – sharp abdominal pain with movement, becomes dull after medication taken.
Current medication effective “usually” “better than before I went into the hospital

Patient’s Primary Concern/Goal
Relief of pain and to enjoy her remaining days

Caregiver’s primary concern/goal
Patient is free from pain per spouse. Daughter is now primary care provider.

Neurological status
Patient alert and oriented to person, place and time
No issues with vision, smell, taste
Becomes anxious with increasing pain

Cardiac status
Pulse regular, patient with +2 edema both lower extremities (pedal and ankle)

No complaints of chest pain

Respiratory
Respirations even, slightly labored when patients “catches her breathe” due to pain
Oxygen is in place at 2 liters per minute, nasal cannula
Breath sounds bilateral diminished in bases

Gastrointestinal
Abdomen distended and firm, patient complains of occasional nausea, last bowel movement three days ago. Patient states this is normal for her. Minimal bowel sounds noted in all quadrants.

Genitourinary
Patient incontinent of urine on occasion. Urine observed to be clear and dark yellow. No complaints of burning or pain with urination. Utilizing urinary pads for incontinence.

Musculoskeletal
Patient able to move all extremities. States “I am feeling weaker and am afraid of falling.” Husband assists with transfer to chair and patient walking 15 steps with moderate shortness of breath. Patient not willing to use bedside commode at this point.

Activities of Daily Living
Daughter is assisting with cleaning, shopping, cooking and assisting with medication administration. Assists patient with bath using shower chair in the shower. Patient independent in feeding self

Fall Risk Assessment
Standardized fall risk completed, and patient scored as high risk due to the following factors:

- Over age of 65
- Increased anxiety
- Unable to ambulate independently
- Initial admission to hospice
- Attached equipment in relation to 02

Skin Integrity
Poor turgor, skin slightly jaundiced and dry, warm to touch. No rashes, skin tear

right leg upon discharge from SNF

Endocrine
No issues
Coping
Patient coping better with diagnosis but is worried about being a burden for her daughter.

Medical supplies
Oxygen in place
Patient needs: hospital bed, walker

Medications
See medication list
Drug review completed and no interactions or side effects noted

Comprehensive assessment needs:

- Nursing
- Social work
- Spiritual care – refused
- Physician
- Bereavement –

Teaching completed:

- Disease process and signs of disease progression
- Plan of care review
- Safety during ambulation/transfer
- On call number

Coordination:

- Physician call for update on patient and orders obtained
- DME call for hospital bed
- Social Work notified of patient admission and summary given
- Volunteer – unable to provide assistance at this time
- Spiritual counselor – not called as patient refused

Signed: Nurse Rose RN 7/22/2021

Pain Assessment: HCPC 12.I

History of pain and its treatment,
- pharmacological and non-pharmacological

Standardized pain assessment tool appropriate to
- patient's developmental and cognitive status

Characteristics of the pain, including:
- Location,
- frequency
- Intensity

Impact on usual activities and function (e.g., appetite, sleeping)

Goals for pain management – patient and family
Satisfaction with the current level of pain control.

Psychosocial – HCDT 9.I

Assessment includes:
- Patient's and the family's adjustment to the terminal illness
- Social and emotional factors related to the terminal illness
- Presence or absence of adequate coping mechanisms
- Family dynamics and communication patterns
- Financial resources and any constraints
- Caregiver's ability to function effectively
- Obstacles and risk factors that may affect compliance
- Family support systems to facilitate end-of-life coping

Interdisciplinary Group

Individual Activity – 10 minutes

Review the plan of care on the next page and note concerns that would need to be addressed with the clinician. Please be prepared to share. As a reminder, the plan of care elements to be present include at a minimum:

- Plan reflects patient and family goals
- Planned interventions based on assessments
- All services needed for palliation of terminal illness
- Pain and symptom management
- Scope and frequency of services
- Measurable outcomes anticipated
- Drugs and treatments
- Medical supplies and appliances
- Level of patient/representative agreement with the plan
- Level of patient/representative involvement with the plan

Plan of Care Example

Patient Name: Iris Wood	DOB 3/23/1945	SOC Date; 9/1/2021
Level of Care: Routine Hospice Care Primary Hospice Diagnosis: Primary Pancreatic Cancer Secondary Diagnosis: Congestive Heart Failure		Referral physician: Attending physician: Name/Address Hospice Medical Director: Name/Address
Address: 45 Apple Blossom Road, Pineville GA		
Visit frequency: RN 2w9, MSW 1m3, Chaplain – declined, Hospice Aide 2 w 10		
DNR: Yes/No Advance Directive: Yes/No Medical Power of Attorney (POA)Name: Contact phone number Language Preference: English Equipment: Oxygen concentrator, Portable Oxygen cylinders, hospital bed, overhead table, Shower chair etc. Medical Supplies/Appliances: Depends Special Precautions: Example, fall, oxygen, bleeding Allergies:		

Problem	Alteration in respiratory status
Intervention	Assess vital signs, Assess respiratory status; Assess adequate oxygen to patient comfort level; Teach oxygen Usage, Teach s/s respiratory infection
Goal	Patient will exhibit adequate oxygenation within 1 week as noted by normal respiratory rate and depth.
PATIENT/FAMILY GOAL:	
Problem	Alteration in Pain Management
Intervention	Teach Pt/PCG appropriate use of pain control medications. Teach use of medications per comfort box; assess effectiveness of medication for pain control; assess availability of pain medications; if opiates are prescribed patient placed on stool softener, teach Pt/PCG s/s to report to agency
Goal	Patient's pain will be managed to patient acceptable level of 4
PATIENT /FAMILY GOAL	
Problem	Alteration in urinary status as evidenced by incontinence
Intervention	Assess skin for potential breakdown; Teach Pt/PCG of need to ensure dry clothing/linen;
Goal	Patient will be free from skin breakdown related to incontinence
PATIENT/FAMILY	
Problem	Alteration in nutritional status
Intervention	Assess nutritional status of patient; Teach Pt/PCG use of small frequent meals rather than large meals; Teach use of high protein supplements
Goal	Patient will be able to enjoy small amounts of food that are appetizing to her. Nutritional status will assist maintenance of skin integrity.
PATIENT/FAMILY	
Problem	Alteration in ability to care for personal care needs
Intervention	Assess patient need for assistance with ADL. Teach Pt/PCG measures for safety during transfer and ambulation; Aide to provide care to patient 2 times per week for shower with use of shower chair; shampoo each visit, assist with transfer and ambulation; to inform RN of changes in the patient condition
Goal	Patient's personal care needs will be met safely and effectively.
Problem	
Intervention	
Goal/PATIENT/FAMILY	

SPECIFIC PHYSICIAN ORDERS AS FOLLOWS:

OXYGEN 2 LITERS VIA NASAL CANNULA CONTINUOUS.

Foley: Size 14 fr Balloon 5cc to drainage bag PRN Yes /No /prn for urinary retention

Routine comfort pack

Patient/Caregiver participated in plan of care and agree to care being provided. Date:

Signed and dated by the following physician. Marcus Welby MD

Notes

HCPC 23.I Coordination

Top Findings for HCPC:

Standard	Content	CMS Tag
HCPC 21.I	Elements of the Plan of Care (25%)	L545, L548
HCPC15.I	Medication Profile and Drug Review (18%)	L530
HCPC 9.I	Assessment within 5 days in accordance with elements of the hospice election statement (13%)	L523
HCPC19.I	Following the Plan of Care (13%)	L540; L543
HCPC 18.I	interdisciplinary Group in consultation with the physician develop the written plan of care (7%)	L538

35% of all findings were identified in this KPA

Notes

Tips for Success

Topic: Hospice Care Delivery and Treatment (HCDT)

HCDT 1.I-4.I	Provision/Availability of services
HCDT 5.I-14.I	Care in accordance with Plan of Care/standards of Practice
HCDT 15.I-21.I	Aide/Homemaker/Volunteer
HCDT 22.I-28.I	Provision of Services
HCDT 29.I-35.I	Drugs and biologicals
HCDT 36.d-40.I	Discharge/transfer of care
HCDT 41.I	Imminent Death

Provision of Services

Core

Non-Core Services

Requirements:

- Each clinician meets the qualifications of their discipline in their state.
- Each discipline provides services per the plan of care and in compliance with standards of practice.
- Care is provided under the direction of the physician.
- Patient and family needs are met due to the provision of care and services.

Individual Activity: Using the case study of patient Iris, answer the following questions in relation to what you think a site visitor would expect to see if they chose this patient for a home visit and record review. What patient/family needs should be addressed?

Scenario - Activity/Discussion: Observe home visit reenactment with patient Iris as if you are a Site Visitor. Write down any concerns you identified.

Activity: Review of IDT meeting minutes for the first IDT session that occurs after the visit.

Patient: Iris Wood
SOC: 9/1/2021
Diagnosis – Pancreatic Cancer with metastasis
Secondary – Congestive heart Failure
Level of Care: Routine Hospice Care
Age: 76
Advance Directives – Yes
Opioid usage - yes

Date of Meeting: 10/14/2021

Problem overview:

- diminished respiratory function
- increased weakness
- increased pain
- decreased mobility
- decrease in appetite

Nursing: Patient pain is increasing and becoming difficult to manage at night. Pain medication changes 3 times this week to gain control to the self-identified level of acceptable pain at 4. Patient restlessness increasing and anxiety level escalating. Increasing loss of appetite, eating only small bites with meals. Increased nausea and lack of bowel movement for past three days. Continues oxygen at 2l/min. Caregiver

becoming exhausted and unable to get restful sleep. Patient requiring maximum assistance with transfer. Using walker that husband had in storage from his hip surgery.

Recommendations: continued adjustment of pain medication for control of pain. Continued oxygen for comfort level. Continue aide services at 4 times per week, increase nursing visit to five times per week.
Signed: Nurse Julie RN

Social Worker: Has not been able to fit patient into her schedule since patient admission.

Recommendations: Social Worker to schedule immediate visit to discuss anxiety and caregiver ability to meet patient needs.
Signed: Socially Adept MSW

Spiritual Counselor: has not seen patient as patient declined services. Not present at this meeting

Recommendations: None

Volunteer Coordinator: has no ability to schedule volunteer

Recommendations: As soon as a volunteer is available, will let the team know to evaluate the need of the patient/family for volunteer services
Signed: Helping Hand

Physician: Has made multiple changes to medications and will plan on increasing medications as needed and add medication for anxiety.

Recommendations: Orders as follows:

- Social worker will increase visits to weekly with first visit to be within 24 hours
- RN increase visit to 4xw
- No change to aide visits
- Chaplain awaiting patient request
- Volunteer services to be initiated when available
- Adjustments to pain regimen, addition of anxiety med
- Orders for Ensure supplement

Signed: Marcus Welby MD

Discussion:

Top Finding in HCDT

Standard	Content	CMS Tag
HCDT 16.I	Hospice Aide fulfills responsibilities within the plan of care (27%)	L 626
HCDT 15.I	Written aide instructions are prepared by RN (15%)	L 625
HCDT 39.I	Revocation of hospice benefit/discharge requires D/C summary (10%)	L 683
HCDT 40.I	Required elements of discharge summary (7%)	L 684
HCDT 38.I	Summary needed for transferred patient (7%)	L 682

28% of all findings in 2022 were identified in Care Delivery and Treatment

Tips for Success

Topic: Hospice Leadership and Governance

Standard Summary

HSLG 1 – Compliance with local, state, federal, and licensing requirements

HSLG 2-4 – Governance and Leadership

HSLG 5-6 – Financial management

HSLG 7 – Volunteers

HSLG 8.I – Inpatient Days

HSLG 9-13 – DME, Drugs and Biologicals

HSLG 14-16 - Agreements

HSLG 17-18 – Multiple Locations

Discussion: As consultants what do you do if agency leadership lack the knowledge base of the service line?

Top Findings HSLG

Standard	Content	CMS Tag
HSLG 2.I	Governance assumes full authority (36%	L 574;652
HSLG 14.D	Required elements of written agreement to furnish services (21%)	L 655
HSLG 3.I	Qualified administrator and alternate is appointed (14%)	L651

Less than 1% of all findings in 2022

Tips for Success

Topic: Patient Family Centered Care – HPFC

Individual Activity: Write down all the elements you can think of that need to be included in the Patient Bill of Rights:

Discussion Point: Elements of Patient Rights

Discussion point: Is it enough to provide the verbiage to the patient?

Implementation of the Complaint Process

Discussion point: Dealing with the various challenges of providing Patient Rights

Top HPFC Findings

Standard	Content	CMS Tag
HPFC 2.D	Elements to be present in the Patient Bill or Rights (26%)	L 515, L503, L518
HPFC 9.D	Advance directive written information elements (19%)	L503
HPFC I.D	Hospice has a patient bill of rights (16%)	L501
HPFC 10.I	Advance directive provided to patients(16%)	L503
HPFC 3.I	Bill of rights is provided verbally and in writing prior to provision of care. Signature is obtained. (16%)	L504

Less than 1% of all findings in 2022 were related to patient rights

Tips for success

Topic: Hospice Information Management (HSIM)

Consultant Question: How do you assist agencies to make the decision to utilize an electronic record? How do you provide resources to make that decision?

Standard Summary

HSIM 1.D – Policies and procedures

HSIM 2.I – Standardized formats

HSIM 3.I – Required elements

HSIM 4.I – Entry requirements

HSIM 5.I – Protection of Records

HSIM 6.I – Record Availability

HSIM 7.I – Process for discontinuation of operations

Activity: What are the required elements of the clinical record?

Microsoft Poll: Which of the required clinical record elements do your organizations have the most challenges with?

Notes:

Election of Benefit Includes:

- Hospice Philosophy
- Effects of Medicare Hospice Election
- Financial Responsibility
- Notice of hospice non-covered items
- Right to choose attending physician
- Acceptance of hospice Medicare coverage

Non-Covered Items Notification:

Certification of Illness:

Narrative:

Face to Face Encounter:

Common errors:

*See attached resource CMS resource tool: https://www.cms.gov/files/document/model-hospice-election-statement-and-addendum.pdf

Top Findings from HSIM

Standard	Content	CMS Tag
HSIM 4.I	Record entries are legible, authenticated, and dated (92%)	L679
HSIM 2.I	Standardized formats, data elements. “Do Not Use” list (6%)	NA
HSIM 3.I	Elements of the clinical record (2%)	L 678;673

Elements of the Clinical Record:

Tips for Success

Topic: CMS Revised Hospice Survey Process

State Operations Manual

Survey Tasks

Task 1: Pre-Survey Preparation

Task 2: Entrance Conference

Task 3: Sample Selection

Task 4: Information Gathering

Task 5: Information Analysis

Task 6: Exit Conference

Task 7: Post Survey Activities

Information Gathering: Phase One

Three core CoPs:

1. §418.52 Condition of Participation: Patient's Rights
2. §418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient
3. §418.56 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services

Six associated CoPs:

1. §418.52 Condition of participation: Patient’s rights
2. §418.76 Condition of Participation: Hospice Aide and Homemaker Services
3. §418.102 Condition of Participation: Medical Director
4. §418.108 Condition of Participation: Short-term Inpatient Care
5. §418.110 Condition of Participation: Hospices that Provide Inpatient Care Directly
6. §418.112 Condition of Participation: Hospices that Provide Hospice Care to Residents of a SNF/NF or ICF/IID

Information Gathering: Phase Two

One Core CoP

Core CoP:

§418.58 Condition of Participation: Quality Assessment and Performance Improvement

13 associated CoPs:

1. §418.62 Condition of Participation: Licensed Professional Services
2. §418.64 Condition of Participation: Core Services
3. §418.66 Condition of Participation: Nursing Services Waiver Of Requirement That Substantially All Nursing Services Be Routinely Provided Directly by a Hospice
4. §418.70 Condition of Participation: Furnishing of Non-core Services

5. §418.72 Condition of Participation: Physical Therapy (PT), Occupational Therapy (OT), and Speech-Language Pathology (SLP)
6. §418.74 Waiver of Requirement-Physical Therapy, Occupational Therapy, Speech Language Pathology and Dietary Counseling
7. §418.78 Condition of participation: Volunteers
8. §418.100 Condition of Participation: Organization and Administration of Services
9. §418.104 Condition of participation: Clinical Records
10. §418.106 Condition of Participation: Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment
11. § 418.113 Condition of participation: Emergency preparedness
12. §418.114 Condition of Participation: Personnel Qualifications
13. §418.116 Condition of Participation: Compliance with Federal, State, and Local Laws and Regulations Related to the Health and Safety of Patients

What is your “gold nugget” from today’s sessions?

DAY TWO

Administrative/Organizational Focus

Welcome Back

Ice Breaker (CHAT BOX): Share the "valuable lesson" you learned from day one.

Activity:

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.

Microsoft Poll:

1. Have you held any of these roles in an organization (choose all that apply)?
   a. Administrator b. Clinical management c. QAPI d. Office staff
   e. Field staff f. none of the above

Topic: Infection Prevention and Control

Hospice and Home Health Standards

Program Goal

Prevention – CDC Healthcare Infection Control Practices Committee

<u>Six Standard Precautions</u>

- 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.

Control

Education

Step 1, Activity: Take 5-6 mins to read through the two policies on the following pages. With those in mind, observe the scenario and identify areas of compliance and non-compliance. ***Take good notes! You'll need them when we get to Quality!***

Deficient practices noted:

Handwashing Policy:

PURPOSE

To prevent cross contamination and home care-acquired infections and to promote hand hygiene thereby reducingand/or preventing health care acquired infections.

POLICY

Personnel providing care/service in the home setting will wash their hands using either an agency approvedalcohol-based hand rub or soap and water:

- Upon entering and before leaving the home
- When hands are obviously soiled, wash with soap and water
- Before entering the clean section of visit bag (if applicable)
- After handling household pets
- Before and after contact with each patient
- After handling bed pans, urinals, catheters, linens and contact with body fluids
- Before and after gloves and other personal protective equipment are used
- Before and after eating
- After use of the toilet
- After blowing nose, sneezing, or coughing

PROCEDURE

1.0 Handwashing with Water:

1.1 Wet hands and apply the soap working into a heavy lather using friction, covering, the entire hand, top and bottom. Pay special attention to the nails, between the fingers and back of thehands.

1.2 Wash hands with a 15 second vigorous rubbing together of all lathered surfaces, followed bythoroughly rinsing under a flowing stream of water. If hands are visibly soiled, a longer handwashing time is required.

1.3 Use a paper towel to dry hands thoroughly. Turn off the faucet using the paper towel. Discard the towel into regular waste.

2.0 Hand Hygiene Without Water (use 60-70% alcohol-based hand rub):

2.1 Use the solution according to instructions.

2.2 Rub hand cleanser into skin until dry. (If sufficient amount of alcohol-based hand rub is applied,hands will take greater than 10-15 seconds to dry.)

2.3 Pay special attention to the nails and between the fingers.

Bag Technique Policy:

PURPOSE

To describe the procedure for maintaining a clean nursing bag and preventing cross-contamination.

POLICY

As part of the infection/exposure control plan, Agency personnel will consistently implement principles tomaximize efficient use of the patient's care supply bag when used in caring for patients.

Staff will use a bag supplied by the agency, or one that has been approved for use.

PROCEDURE

1.0 The bag may have the following contents:

1.1 Hand washing equipment-alcohol based hand rub and skin cleanser, soap, and paper towels

1.2 Assessment equipment (as appropriate to the level of care being provided)- thermometers, stethoscopes, a hem gauge to measure wounds, sphygmomanometer, and urine testing equipment

1.3 Disposable supplies (as appropriate to the level of care being provided)-plastic thermometer covers (if applicable), sterile and non-sterile gloves, plastic aprons, dressings, adhesive tape, alcohol swabs, tongue blades, applicators, lubricant jelly, scissors, bandages, syringes and needles, vacutainer equipment for venipuncture, skin cleanser, paper towels, and a CPR mask

1.4 Paper supplies (if applicable)-printed forms and materials necessary to teach patients and family/caregivers and document patient care

2.0 Personnel must regularly check the expiration date of any disposable supplies kept in the nursing bag.Expired supplies should be returned for disposal.

3.0 The bag will be cleaned as soon as feasible when it is grossly contaminated or dirty. Antiseptic wipes, alcohol, or another approved cleaning agent will be used.

4.0 Bag Technique

4.1 The bag will be placed on a clean surface (i.e., a surface that can be easily disinfected) in the car.

4.2 Once in the home place the bag on an impervious barrier on a flat surface that is not the floor

4.3 Prior to administering care, alcohol-based hand rub or soap and paper towels will be removed, and hands will be washed. These supplies will be left at the sink for hand washing at the end of the visit.

4.4 The supplies and/or equipment needed for the visit will be removed from the bag.

4.5 When the visit is completed, discard disposable personal protective equipment in an impermeable plastic trash bag. Contaminated equipment that cannot be cleaned in the patient'shome may be transported in an impermeable sealed plastic bag. Never place used needles, soiled equipment, or dressings in the nursing bag.

4.6 Reusable equipment will be disinfected after each patient.

4.7 Hands will be washed prior to returning clean equipment and/or unused clean supplies to bag. Return cleaning supplies, e.g., liquid soap, to the bag.

Return to Standard Survey of Infection Prevention and Control

COVID-19 Survey Review

Top HIPC & IPC Findings:

Standard	Content	CMS Tag
IPC.3.I.M1	Instances in which the use of hand hygiene is implemented (29%)	G682
IPC.4.I.M1	Bags that carry equipment/supplies used consistent with policy (16%)	G682
IPC.8.I	TB Screening per state/local regulation or CDC (11%)	G684
IPC4.I M2	Appropriate storage, transport and use of sterile materials (6%)	G682
IPC 2.I	Agency demonstrates vaccination status/exemption/exception (5%)	G687

17% of all findings in 2022 were identified in IPC

Standard	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
HCPC 13-18	Requirements related to vaccination status/exemption/exception (3%)	L900

11% of all Hospice Finding in 2022 were identified in HIPC

Tips for Success

Topic – Human Resource Management

Microsoft Polls

1. What word comes to mind when you think of "Hiring Criteria"?
2. Which standard is to be followed regarding HR compliance?
    a. Federal regulation
    b. State regulation
    c. Whichever is strictest
    d. Agency policy
    e. Accreditation standards
    f. All of the above

Discussion: Variable scope of practice for NP

Question: Do you know the scope of practice for a Nurse Practitioner within the states you consult?

Use of Nurse Practitioners in Home Health and Hospice:

Web site: https://www.nursepractitionerschools.com/practice-authority/how-does-np-practice-authority-vary-by-state/

Top HSRM & HRM Findings:

Standard	Content	CMS Tag
HSRM 16.I	Requirement for criminal background checks (22%)	L 795
HSRM 2.D	Requirements for hire and organization 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	Professionals participate in QAPI and in-services (9%)	L 661; L662

Standard	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
HRM7.I.M2	Competency of Aides (6%)	G768
HRM.6.D.M1	Skilled professionals participate in organization sponsored in-services (6%)	G722

Tips for success:

Topic: Continuous Quality Improvement

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

Discussion– What makes an outcome measurable?

S_____

M_____

A_____

R_____

T_____

PDCA/PDSA

Plan

Do

Check/Study

Act

Discussion: What are examples of performance improvement projects your organizations have implemented over the past year?

Group Activity: Each group will be provided an area in need of improvement. One person should be given the role of reporter of your results. The group will be placed in individual breakout rooms and have 20 minutes for this activity. Remember to be specific, comprehensive and measurable.

Address the following in your performance improvement plan:

Smart goal

Plan

Actions to be taken

How will effectiveness be monitored

Determining Priorities

Top Findings Quality

Standard	Summary of 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.DM1	Quality indicators include measures from OASIS (11%)	G644
CQI.3.M2	CQI activities include measurement, analysis, and tracking of quality indicators (11%)	G 642
CQI.5.I.M2	PI projects are documented with measurable progress achieved (11%)	G 658
Standard	**Summary of Content**	**CMS Tag**
HQPI.7.I	PI Activities include tracking and analysis of Adverse events and implementing preventive actions (23%)	L569
HQPI 2.I	Appointed individual is responsible for QAPI program (15%)	L576
HQPI 3.I	Program demonstrates measurable improvements (15%)	L 561
HQPI 5.I	Use of Quality Indicator data (11%)	L564
HQPI 8.I	Action is taken, success measured, and positive results sustained (11%)	L570

Tips for success

Topic: Emergency Preparedness

Microsoft Poll: Did you work with organizations to implement an emergency plan to address the needs of the pandemic?

The five components of an EP Program

Plan

- 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

Policies

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

Communication

Training

Testing

Integrated Healthcare Systems

Top HSEP & EP findings:

Standard	Content	CMS Tag
HSEP 3.D	Required policies and procedures of the emergency plan (58%)	E0013; E0016
HSEP 5.D	Elements and updating of the EP training program (33%)	E0037
HSEP 2.D	Emergency plan is reviewed and updated every two years 6%)	E006, E007

Standard	Content	CMS Tag
EP.1.D.M1	Elements of the Emergency Plan (24%)	E006
EP.1.D.M3	Communication plan required elements (19%)	E0031
EP.3.D.M1	Training program based on EP plan/risk assessments/policies (19%)	E0037
EP.4.I.M 2	Policy and Procedure development (17%)	E0039
EP.2.D.M1	Communication Plan required elements (15%)	E0017

Tips for success

The CHAP Consultant

CHAP Accreditation and Site Visit Process

Customer Relations

Accreditation Clinical Support

Accreditation Steps

Accreditation agreement

Site Visit Preparation

On-site visit and review

Accreditation Determination

CHAP LinQ

Site Visit Preparation

CHAP Preparation Resources

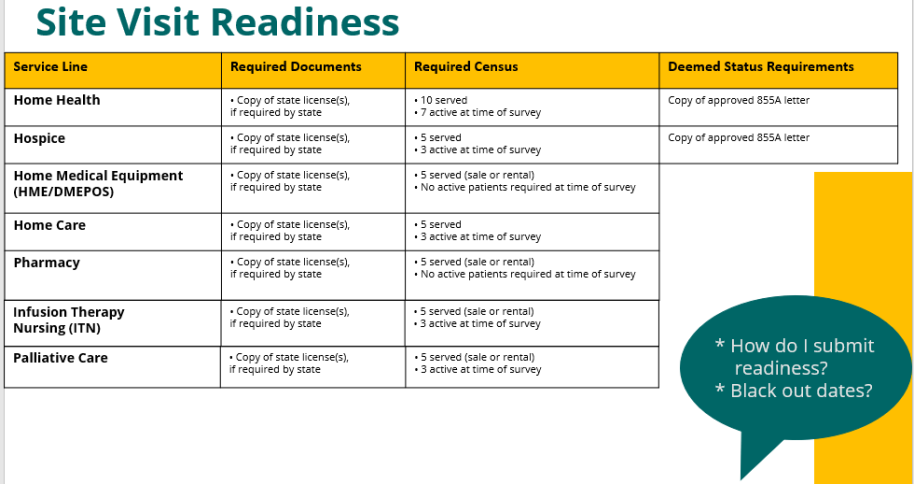
- Document Request List
- Policy List
- Top Ten Findings per the service line
- Optional self-study

Mock Record Review

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

Site Visit Readiness

- Blackout dates
- Required Patients served and Active census



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	

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

Timing to Prepare

Readiness Submission

The Site Visit

Visit Components:

Entrance Conference

Site Visit Activities

Ongoing Communication

Daily wrap up

Exit conference

Site Visit Activities

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

Communication

Handling Conflict

Action Plan

Four Action Plan Questions

What action will we take to correct the deficiency cited?

Who is responsible to implement the corrective action?

When will the corrective action be implemented?

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

Condition Level findings

Initial site visits

Renewal site visits

Relieving Anxiety

Preparation

Site Visit Plan

Communication

Closing Activity: What is the best thing you learned today? Write your answer below.

DAY THREE

CHAT BOX: Ice Breaker Activity: Best thing you learned from yesterday

Topic: CHAP Home Health Standards of Excellence

Activity: Review of the CHAP Home Health Standards –

Topic - Patient Centered Care (PCC)

Activity: Write down all the elements you can think of that need to be included in the Patient Bill of Rights:

Discussion

Is it enough to provide the verbiage to the patient?

Implementation Example – Complaint Process

1. Policy and procedure
2. Documentation format
3. Education of staff
4. Patient information regarding process
5. Education of patient/caregiver
6. Address all incoming complaints
7. Monitor for trends and act accordingly
8. Validate process is effective

Discussion point: How do you train your organization staff to meet patients where they are at and still provide the required information?

Top Findings in PCC:

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

G446-484.50(c)(10) Be advised of the names, addresses, phone numbers of the following Federally-funded and state-funded entities: (i) Agency on Aging (ii) Center for Independent Living (iii) Protection and Advocacy Agency, (iv) Aging and Disability Resource Center; and (v) Quality Improvement Organization

G440 - §484.50(c)(7) Be advised, orally and in writing, of—

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

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

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

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

Tips for success:

Topic: Assessment, Planning and Coordination (APC)

APC Standards Summary

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

APC.3.I – Acceptance and intake of patients

APC.5.I & 6.I – Initial and comprehensive assessment requirements

APC.7.I – Plan of Care requirements

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

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

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

Comprehensive Assessment Elements:

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

Scenario

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

Group Activity (20 minutes)

Attendees will be divided into two breakout rooms

- Each participant should conduct a high-level overview of the entire assessment (pages 59-64)
- Each group will be assigned key elements of the assessment for in-depth review
  - Group one – focus on integumentary system and diabetes related issues
    - Evaluate what was documented
    - Present education needed for improvement
  - Group Two – focus on functional and psycho-social
    - Evaluate what was documented
    - Present education needed for improvement
- Each group assigns one spokesperson to share their thoughts.

Discussion

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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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

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.

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	O 02	O 03	O 04	☒ 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

Body Systems

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

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

Assistive Devices: use of a cane for ambulation

Swollen Joints: Arthritis both knees

Other:

Pain Assessment:

Standardized validated assessment conducted: ☐Yes ☒ No

Pain Frequency interfering with activity:

☐No Pain ☐Pain does not interfere with activity

☒Daily but not constant ☐All the time

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

Integumentary: Skin Warm and Dry,

Wound: ☒Yes ☐ No

Location: Right great toe

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

Wound Care: per patient, in the hospital they changed the dressing every day but he did not know what was being used.

Respiratory:

☐Wheezes ☒Dyspnea ☐CPAP ☐Rales ☐Rhonchi ☒Cough

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

Endocrine:

☐WNL ☐Excessive Hunger/thirst ☐Excessive bleeding ☐Thyroid Issue

☒Diabetic

Blood Glucose Performed: Result:

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

☒Foot lesions ☐Foot care taught ☐foot care performed

Cardiac:

☐WNL ☐Syncope ☐Angina ☐Chest Pain ☐Varicosities

☐Pacemaker ☒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.

Elimination Status:

Urinary:

☐WNL ☒Urinary incontinence ☐Frequency ☐Burning

☒Nocturia

Bowel: WNL

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

Nutritional Assessment:

☒WNL Pain Nausea Vomiting Diarrhea Constipation

Standardized nutritional assessment Completed: ☐Yes ☒No

Diet: 1500 calorie diet

Neuro/Emotional/Behavioral:

☒Oriented:	☒Time	☒Place	☒Person
☒Alert	☒Forgetful	☐Dizziness	☐Pupils equal/reactive
☐Slurred Speech	☐Abnormal speech	☐Insomnia	☒Anxious
☐Headache	☐Depressed	☐Uncooperative	☒Memory deficit

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

ADL/IADL

Self-Care:	☐Independent	☒Needs Some Help	☐Dependent
Ambulation:	☐Independent	☒Needs Some Help	☐Dependent
Transfer:	☐Independent	☒Needs Some Help	☐Dependent
Household Tasks:	☐Independent	☒Needs Some Help	☐Dependent

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

Assistive Devices: ☐Walker ☒Cane ☐Shower Chair ☐Reacher

Medications:

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

Comments: Patient medications at home reconciled with discharge medication list. C

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 alone but has a family friend who lives two doors down who might help. A daughter lives 150 miles away but comes to see her mother once per month. Currently the patient has no other forms of assistance.

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

Education performed:

☒Medication management ☐Emergency Plan ☒Hand Hygiene

☒Fall Precautions

☒On Call Availability

Interventions performed:
Physical Assessment

Teaching as above
Medication review

Plan of Care Collaboration:

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

Assessment Summary:

Comments: 82-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 if 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

OASIS-E Resources

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

Updated Guidance for

- Cognitive
- Mood
- Health Conditions
- Swallowing/nutritional status
- Medications
- Special Treatments, Procedures and Programs

New Items

Section A

Section B

Section C

Section D

Section G

Section J

Section K

Section N

Section O

Plan of Care 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

Individual Activity

Review the following Plan of Care and evaluate compliance in relation to the required elements and the previously reviewed comprehensive assessment.

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

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

14. DME and Supplies

Glucometer, cane

15. Safety Measures

Fall Risk

16. Nutritional Req. 1500 Cal Diet

17. Allergies No Drug or food allergies

18.A. Functional Limitations

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

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; 2 ☐ Comatose; 3 ☑ Forgetful; 4 ☐ Depressed; 5 ☐ Disoriented; 6 ☐ Lethargic; 7 ☐ Agitated; 8 ☐ Other

20. Prognosis: 1 ☐ Poor; 2 ☐ Guarded; 3 ☐ Fair; 4 ☑ Good; 5 ☐ Excellent

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

OMB No. 0938-0357

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 cane.

23. Nurse's Signature and Date of Verbal SOC Where Applicable:

Nurse Patsy Cline

25. Date of HHA Received Signed POT

24. Physician's Name and Address

Dr Guthrie
Physician Drive
Hospital, IN 23657

26. I certify/recertify that this patient is confined to his/her home and needs intermittent skilled nursing care, physical therapy and/or speech therapy or continues to need occupational therapy. The patient is under my care, and I have authorized services on this plan of care and will periodically review the plan.

27. Attending Physician's Signature and Date Signed

28. Anyone who misrepresents, falsifies, or conceals essential information required for payment of Federal funds may be subject to fine, imprisonment, or civil penalty under applicable Federal laws.

Form CMS-485 (C-3) (12-14) (Formerly HCFA-485) (Print Aligned)

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APC Top Findings

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%)	G614/616/618 620/622
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

Notes:

Elements of the Plan of Care

Written Instructions

Elements of the Comprehensive Assessment

Transfer / Discharge

Tips for Success

Topic: Financial Stewardship

Annual operating budget

Capital expenditure plan

FS Top Findings

Standard	Content	CMS Tag
FS.2.I	Governance prepares overall plan and budget (25%)	G988
FS.2.I.M1	Operating Budget includes all anticipated in expenses (25%)	G988
FS.2.I.M2	overall plan and budget are prepared under the direction of the governing body (25%)	G988
Fs.2.I.M3	Overall plan and budget are reviewed and updated at least annually (25%)	G988

Tips for Success:

Topic: Care Delivery and Treatment

Standards Summary

CDT.2.I

CDT.3.I

CDT.4.I

CDT.5.I

CDT.7.I

CDT.9.I

CDT.10.I

CDT.11.D

Physician Orders

Skilled Professionals

Supervision of Skilled Professionals

Home Health Aide Services

Supervision of Home Health Aide

Activity/Discussion: Observe home visit reenactment with patient Violet. Write down all your concerns and be prepared to discuss:

Activity 2

Review the visit note on the next page and compare with information identified during the video. What concerns is there regarding the documentation?

General Home Health

SKILLED NURSING VISIT NOTE

ASSESSMENT OF SIGNS AND SYMPTOMS: ☐ IF THE FOLLOWING SIGNS AND SYMPTOMS ARE PRESENT

VITAL SIGNS

Temp: 99.2 WT:

HR 76 ☐A ☒R ☐Reg ☒Irreg

RR 22 ☒Regular ☐Irregular

BP	Lying	Sitting	Standing
R			
L		156/86	

PAIN ☐ None at this time

☐ Less often than daily

☒ Daily but not constantly

☐ All the time

Relieved by: ☐ Rest ☒ Medication

Pain Severity Level (Scale of 1/10) 6

Before Intervention 8

After Intervention 6

Location Right Shoulder

Character Throbbing

VISION ☒ No problem Noted

☐ Partially Impaired ☐ R ☐ L

☐ Severely Impaired ☐ R ☐ L

HEARING ☒No observed/impairment

☐ W/ min. difficulty ☐ R ☐ L

☐ W/ mod. difficulty ☐ R ☐ L

☐ Unable to hear ☐ R ☐ L

NOSE/THROAT/MOUTH ☒No problem

☐ Congestion ☐ Chewing prob.

☐ Sinusitis ☐ Swallowing prob.

☐ Sore throat ☐ Gingivitis

☐ Hoarseness ☐ Ulceration

MEDICATION ☐ Compliant

☐Non compl. ☒Needs teaching

NUTRITION (DIET) ☒ Followed

☐Not followed ☐Needs teaching

ENDOCRINE ☐ No problem

☐Thyroid abnormality

☐ Hypoglycemia ☐Hyperglycemia

Blood Sugar ☐Fasting ☐ Random

☐ Drowsy ☐ extreme thirst ☐Hunger

☐ Change in vision ☐Lethargic

☐ Asymptomatic

NEUROLOGICAL ☐No problem

☐ Alert ☒ Forgetful ☐Confused

☐Oriented to: ☒T ☒Pe ☒Pl

☐Disoriented to: ☐T ☐Pe ☐Pl

☐Unresponsive

☐Paralysis ☐RUE ☐RLE ☐LUE ☐LLE

☐Weakness ☐RUE ☐RLE ☐LUE ☐LLE

☐Tremors ☐Headache ☐Dizziness

☐Aphasia ☐Express ☐Receptive

Pupil ☐Equal ☐Reactive

Hand Grips ☐Strong ☐Weak ☐Equal ☐Unequal

GASTROINTESTINAL ☐ No problem

Last BM 8/4/2021

Appetite ☐ Good ☒ Fair ☐ Poor

Abdomen ☒ Soft ☐ Distended

Pain ☐ Dull ☐ Sharp ☐Crampy

☐RUQ ☐RLQ ☐LUQ ☐LLQ

☐Ascites ☐Abdominal Girth

Bowel sound ☒ Active ☐ Hyperactive

☐Hypoactive ☐Nausea ☐Diarrhea

☐ Constipation ☐Incontinence

☐G-Tube ☐ Patent ☐ Obstructed

☐Ostomy: Location

☐Patent ☐Obstructed

Amount of Drainage:

GENITOURINARY ☒ No problem

Urine ☐ Clear ☐Cloudy ☐Bloody

Amount ☐Scant ☐Moderate

Odor ☐None ☐Foul-Smelling

☐Dysuria ☒Nocturia ☐Anuria

☐Urgency ☐Frequency ☒Incontinence

Indwelling Foley Cath.Fr #

Last date changed

MUSCULOSKELETAL ☐ No problem

Gait ☐ Steady ☒Unsteady

☒ROM ☐WNL ☒Limited

☒RUE ☐RLE ☐LUE ☐LLE

☐Contractures ☒Stiffness

☐RUE ☐RLE ☒LUE ☐LLE

Strength ☐ Good ☒Fair ☐Poor

☐ Fracture ☐Amputation

☐RUE ☐RLE ☐LUE ☐LLE

PSYCHOSOCIAL ☐ No problem

☒ Cooperative ☐ Coping ☒ Anxious

☐ Discourage ☐ Depressed

☐ Agitated ☐ Flat effect

☐ Inappropriate response

INTEGUMENTARY ☐ No problem

☐ Fair ☐ Pale

☐Cyanotic

☐ Moist ☐ Dry

☐ Warm ☐ Cold

Nail Bed ☐Pink ☐ Blue

☐ Rash ☐ Abrasion

☐ Bruise ☐ Laceration

☐ Pressure Sore

☐ Open Wound

☐ Surgical Incision

RESPIRATORY ☒ No problem

☐Breathing event/Unlabored

☐SOB . ☐At rest ☒On exertion

☐B' Sound ☐Clear ☐Diminished

☒R ☒L ☐Upper ☐Mid ☒Base

☐Wheeze ☒Rales/Crackles

☐R ☐L ☐Upper ☐Mid ☐Base

☐Cough ☐Dry ☐Productive

☐Phlegm ☐Clr/watery ☐Yellow/Green

☐Rust/Bloody ☐Thin ☐Thick

☐Scant ☐Copious ☐Moderate

☐Oxygen use

CARDIOVASCULAR ☒ No problem

☐Chest Pain ☐At rest ☐On exertion

☐ Pressing ☐Dull ☐Burning

☐ Heaviness ☐Tight ☐Stabbing

WITH ☐ Dyspnea ☐Diaphoresis

☐No edema ☐Edema

☐1+ ☐2+ ☐3+ ☐4+

☐ Pitting ☐Non-pitting

☐RUE ☐RLE ☐LUE ☐LLE

Pedal Pulse ☒ RLE ☒LLE

☒ Present ☐ Absent

WOUND ASSESSMENT

Site #	1	2	3	4
Location	R toe			
Stage				
Length				
Width				
Depth				
Tunneling				
Drainage	moderate			
Odor	slight			

Homebound Reason: Diminished endurance, use of cane for ambulation, unable to leave home without assistance

Nursing Diagnosis/Problems: wound, diabetic, urinary incontinence

Interventions/Skilled Care Performed

Upon arrival aide was providing personal care, assisting Ms. Violet out of the shower. Cane found to be in living room on first floor. Physical assessment as above. Patient has not been monitoring glucose. Glucometer found to not be working. Wound care done per patient direction. Orders needed to clarify wound care. Dressing removed, cleansed with saline, applied silvadene and redressed. Skin surrounding wound reddended, slight edema in toe and faint odor noted. Patient to be evaluated by Physical Therapy. Upon interview, patient states she forgot her medication in the morning yesterday. She has been taking Tylenol Arthritis for her right shoulder. She states this also helps her throbbing in her right toe. Patient educated to keep toe elevated, to call nurse if increased pain or temperature.

Response to Care/Instruction: good

☒ Next or ☐ Last MD Visit date: 9/2/2021

Is there any change in Insurance: ☐ Yes ☒ No If yes, when?

Plan for next visit:

Communication with: ☐ Physician ☐ Pharmacy ☐ Care/Clinical Coordinator ☐ Caregiver ☐ PT ☐ OT ☐ ST ☐ MSW

Discussed:

Resulted to: ☐ New ☐ Changed ☐ No MD Order

Patient Name Violet Chap MR # : SN Name – Title Susie Contract

Date 8/5/2021 Time In 1000 Time Out 1030 SN Signature Susie Contract

8/5/2121

Activity 3

Review the Home Health Aide Plan of Care (page 82) What concerns do you note?

Discussion: What concerns are noted from the home health aide plan of care? How might they be addressed?

HOME HEALTH CARE

Name of Patient/Client: Violet Chap ☐ Male ☒ Female Age: 72

Goals of Care: ☒ Patient will be free from injury ☒ Patient will receive assistance with ADLs/IADLs

☐ Other: _____

(Check appropriate interventions, write specifics as needed)

Nutrition ☒ Type of Diet 1500 ADA ☐ Plan /Prepare Meals/Snacks ☐ Serve Meals
☐ Assist with Eating ☐ Offer Fluids ☐ Fluid Restriction ☐ Thicken Fluids

Body Mechanics/Mobility

Transfer: ☒ Assist ☐ Stand/Pivot ☐ Sliding Board ☐ Bedrest ☐ Hoyer

Ambulation: ☒ Assist ☒ Cane ☐ Wheelchair ☐ Walker ☐ Crutches
☐ ROM/HEP ☐ Apply Orthopedic Device
☐ Other _____

Personal Care/Assistance with ADLs

Bathing: ☐ Tub ☐ Shower ☐ Bed ☒ Chair ☐ Shower Bench
☐ Hand Held Shower ☐ Other _____

Hair: ☒ Comb/Brush ☒ Shampoo ☐ Condition

General: ☒ Dress ☐ Shave ☒ Skin Care/Grooming _____

Oral Hygiene: ☐ Clean Dentures ☒ Brush Teeth ☐ Mouthwash ☐ Oral Swabs

Toileting: ☒ Assist to Commode/Toilet ☐ Assist with Bedpan/Urinal ☐ Catheter Care
☐ Empty Catheter/Drainage Bag ☐ Diapers/Depends ☐ Other _____

Homemaking: ☐ Shop ☒ Straighten ☒ Clean Bathroom after use ☐ Clean Kitchen after Meal Prep
☐ Make Bed ☒ Change Bed Linen ☐ Personal Laundry ☒ Medication Reminder Assistance
☐ Other _____

Other/Record: ☒ Temp A/O ☐ Intake/Output ☒ Pulse ☐ B/P ☒ Respiration ☒ Observe Universal Precautions
Call office immediately for any fall, loss of consciousness, injury, oral temp above_____, pulse above_____ or below_____.

Safety Instructions: Recent Fall Right Shoulder Injury

Infection Control Instructions: _____

Special Instructions: Keep Dressing Right toe from getting wet	Dates:	Reviewed By:	For Period:
Other: _____			

Prepared By: Arlette Clover LPN Date: 7/23/2021

Patient/Responsible Party Signature: _____

Relationship to Client: _____

Physician Name: _____

Physician Signature: _____ Date: _____

Top CDT Findings:

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

Tips for Success

Topic: Leadership and Governance

Standard Summary

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

Governing Body

Leadership

Administrator Responsibilities

Contractual services

Top LG Findings

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

Tips for Success

Topic: Information Management

Standard Summary

Im.1.D

IM.2.I

IM.3.I

IM.4.I

IM.5.D

IM.6.I

IM.7.I

Communicating with government officials

Access of information

Documentation

Data Transmission

Question: Who can name at least one of the requirements of patient clinical record. I will clue you in that there are ten. No peeking in the CHAP standards allowed!

Required clinical record elements

Microsoft Poll: Which of the required clinical elements do your organizations staff have the most challenges with?

a. Assessment b. plan of care c. medications d. coordination
e. physician orders f. visit notes

Top IM Findings:

Standard	Content	CMS Tag
IM.7.I.M2	Timeframe for sending of discharge/transfer summary (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

Tips for success:

References:

https://education.chaplinq.org/home-health - CMS Home Health Regulatory Changes to Reduce Burden and New Discharge Planning Condition of Participation – Single Webinar.

https://www.nursepractitionerschools.com/practice-authority/how-does-np-practice-authority-vary-by-state/

THANK YOU!