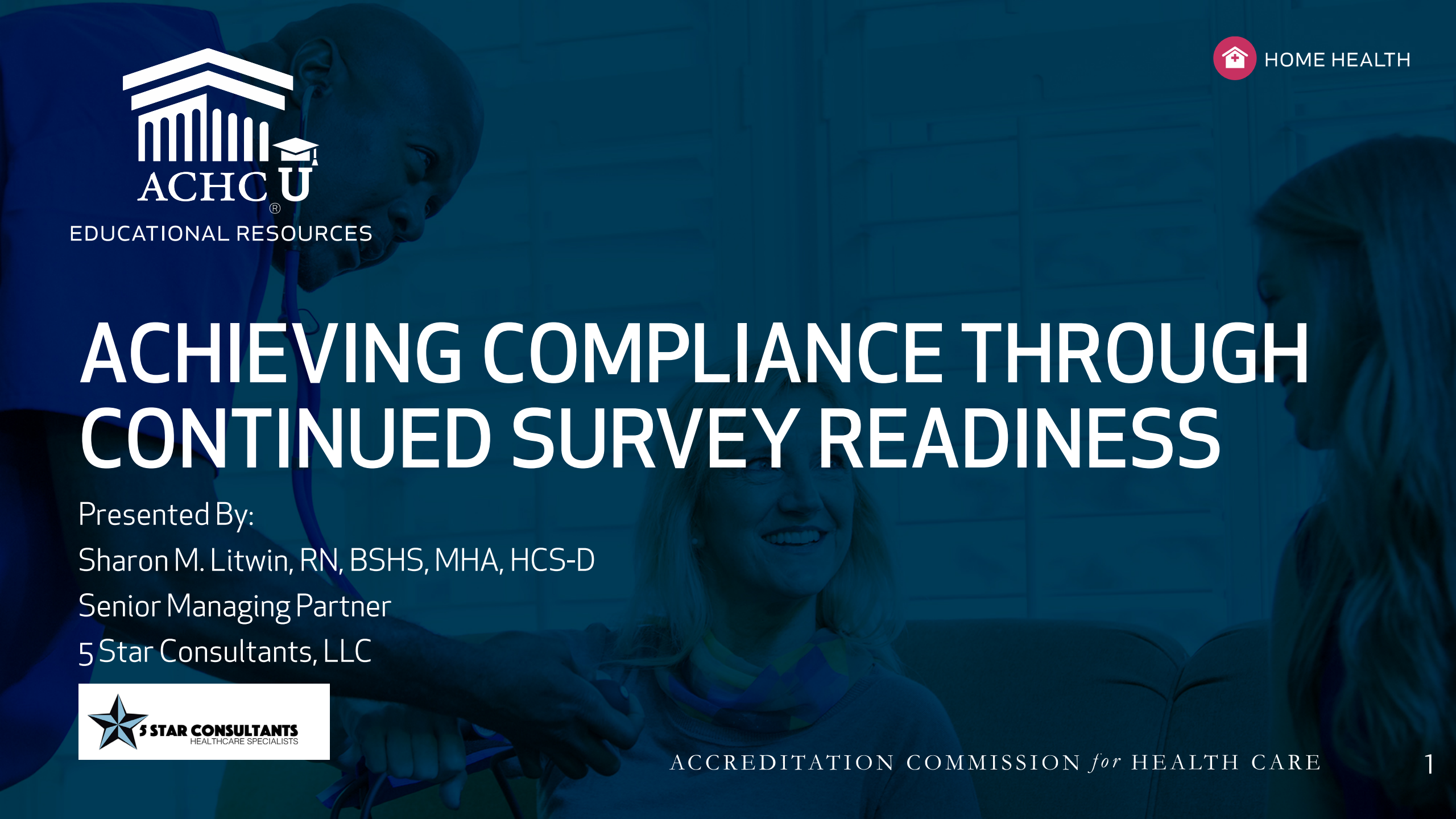

ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH

ACHIEVING COMPLIANCE THROUGH CONTINUED SURVEY READINESS

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OBJECTIVES

- Understand standards and regulations for: CMS, state, and accrediting body
- Know the difference between standard- and condition-level deficiencies
- Understand the survey process and be able to perform mock surveys within your agency
- Understand how to have an effective Quality Assurance and Performance Improvement (QAPI) program for successful surveys

CONDITIONS OF PARTICIPATION

- Must be compliant with the Conditions of Participation (CoPs) to be Medicare certified
- Interpretive guidelines:
  - Serve to interpret and clarify the CoPs for home health and hospice agencies
  - Define and explain the relevant regulation

YOU WILL HAVE STANDARD-LEVEL DEFICIENCIES IN THIS AGE OF SURVEYS SO DON'T EXPECT ZERO!

BUT … DON'T BE VULNERABLE FOR CONDITION-LEVEL DEFICIENCIES OR REPEAT STANDARD-LEVEL DEFICIENCIES.

STANDARDS - UNDER EACH CoP

- Some are prescriptive, such as:
  - Must do a home health aide supervisory visit no less than every 14 days.
- Why are these out of compliance so often?
  - Is it because staff do not understand the rules?
  - Is it because the agency doesn't have a tight process in place?
  - Need to drill down to find out why!

REGULATIONS - KNOW THE INTENT

- Many CoP standards are not prescriptive
  - They tell you what must be achieved, but do not tell you specifically how to do it
- You must …
  - Understand what the intent is
  - Read each standard and interpretive guidelines
  - Ask questions when unsure

LEVEL 1 STANDARDS

- Highest priority standards include :
  - Process standards that are associated with high-quality patient care, and
  - Administrative standards that closely relate to the agency's ability to deliver high-quality patient care
- Surveyors must review all of these standards during a survey

LEVEL 2 STANDARDS

- Partial extended survey is conducted when:
  - Agency is out of compliance with a Level 1 standard and/or a deficient practice might exist at a standard or condition level not included in the standard survey
- During a partial extended survey, the Surveyor reviews:
  - At a minimum the Level 2 standards under the same condition which are related to the Level 1 standards found to be out of compliance
  - The Surveyors may review any additional standards under the same or related conditions, which would assist in making a compliance decision

STANDARD LEVEL VS. CONDITION LEVEL DEFICIENCIES

- Each condition has standards that are associated with it:
  - G tags
- Standard-level deficiency:
  - Not compliant with one of the standards (G tags) under a condition
- Condition-level deficiency:
  - Non-compliant with –
    - The entire condition or,
    - Several of the standards associated under the condition or,
    - Scope and severity warranted.

EXAMPLE: AIDE SERVICES

- Standards
  - Aide care plan/assignment sheet not compliant
  - Aide not following aide care plan
  - Aide supervisory visits are not timely
- Condition level in Aide services
  - 3 standards fell out
  - One of the most common deficiencies
  - Agency is not permitted to perform competency for aides for two years

DEFICIENCIES – STANDARD LEVEL

- Standard level
  - Must write a plan of correction (POC)
  - ACHC does not resurvey for a standard level deficiency

DEFICIENCIES – CONDITION LEVEL

- Condition level
  - Must write a detailed plan of correction (POC)
  - The state or accrediting body notifies Medicare that agency has a condition level deficiency
    - Agency is at risk of losing Medicare certification if the condition is not fixed quickly — within 10 calendar days
  - Return visit within 45 days to ensure condition level deficiencies have been abated

IMMEDIATE JEOPARDY

- A situation where the agency's non-compliance with one or more requirements of participation has caused, or is likely to cause serious injury, harm, impairment, or death to a patient
- ACHC conducts an unannounced survey to investigate the issues within two business days of confirmation of potential Immediate Jeopardy (IJ) situation

SANCTIONS

- Given for:
  - Condition-level deficiency
  - Immediate jeopardy
  - Repeat standard-level deficiency
- Types:
  - Directed education
  - Directed plan of care
  - Interim management provided by CMS designee
  - Monetary
  - Suspension of payments for all new admissions

MONETARY PENALTIES

- Range of $500 to $4,000 per day
  - Repeat and/or condition-level deficiencies
  - Related mostly to structure or process-oriented conditions
- Range of $1,500 to $8,500 per day
  - Related to poor quality patient care outcomes that don't involve immediate jeopardy situations
- Range of $8,500 to $10,000 per day
  - Immediate jeopardy

MONETARY PENALTIES

- The per-day penalty begins accruing on the final day of the survey that identifies non-compliance
- The penalty continues until the agency achieves compliance or when the provider agreement is terminated
- Agencies have up to six months to comply, beginning from the last day of the original survey that determined non-compliance or CMS will terminate the agency

STATE REGULATIONS/ACCREDITATION STANDARDS

- State regulations:
  - Licensing – Yes/No
- Three organizations for Accreditation
  - Accreditation Commission for Healthcare (ACHC)
  - Community Health Accreditation Program (CHAP)
  - The Joint Commission (TJC)

HOW TO STAY COMPLIANT & AVOID DEFICIENCIES

- UNDERSTAND the meaning of the standard
- PRIORITIZE standards by those that you are non-compliant in first
- ASSESS your Agency
  - Mock surveys
  - Performing home visits
  - Clinical record reviews
- MEANINGFUL QAPI plan
- EDUCATE
  - Involve ALL staff

UNDERSTAND THE MEANING OF THE STANDARD

- Often agencies misunderstand what the standard means and how to apply it
- Read Interpretive Guidelines from:
  - CoPs
  - Accrediting Bodies
- Read state regulations
- Ask if you don't understand when you read it
  - Don't wait till the survey
  - Ask the accrediting body, state associations, consultants, list serves, etc.

PRIORITIZING STANDARDS

- PRIORITIZE standards by those that you are non-compliant in first
  - As you read the standards make a list of all that you know you are not doing now
    - Gives you your first-priority list
      - This often branches off into other areas to work on
  - Assign task forces for bigger areas

ASSESS YOUR AGENCY

- Mock Surveys
  - Assign qualified employees
    - Often this includes directors/managers/QA staff
      - If none, consider consultant
  - Perform it formally
    - Select dates
    - Request information as a Surveyor would
    - Perform home visits
    - Interview staff

MOCK SURVEY

- Prior to survey
  - Review results from previous regulatory surveys
    - Ensure plan of correction from deficiencies is still working to ensure no repeat deficiencies
  - Review QAPI program
  - Review Certification And Survey Provider Enhanced Reports (CASPER)
    - Quality measures
    - Potentially avoidable events
    - Process measures

A WALK THROUGH OF AGENCY

- Start With…
  - Office Hours Posted
  - Fire Safety
  - Infection Control Issues
  - Biohazard
  - Refrigerator(s)
  - Supplies
  - Confidentiality

MOCK SURVEY

- Beginning of survey
  - Ask for and review the following:
    - Unduplicated patients for the prior 12 months
    - Active patient list
      - Admit date, primary diagnosis, and disciplines
    - Discharged patient list
      - Admit date, discharge date, discharge reason, primary diagnosis, and disciplines involved in care

MOCK SURVEY

- Beginning of survey (Continued)
  - Ask for and review the following
    - Employee List – active and terminated
      - Title, date or hire and/or termination
    - Schedule of home visits
      - All disciplines

MOCK SURVEY

- Beginning of survey (Continued)
  - Set-up interviews
    - RNs/Case Managers
    - LPNs/LVNs
    - PT/OT/ST
    - Social Worker
    - QAPI Coordinator

MOCK SURVEY

- Beginning of survey (Continued)
  - QAPI program
    - Audits
    - Action plans
    - Meetings from past year

MOCK SURVEY

- Beginning of survey (Continued)
  - Complaints
  - Incidents
  - Infections
  - Customer satisfaction
  - Governing Body meeting minutes

MOCK SURVEY

- Beginning of survey (Continued)
  - Emergency preparedness
    - Hazard vulnerability analysis
    - Drills/training/education
  - Policy and procedure manuals
    - Administrative
    - Clinical
  - HR files
    - Choose a variety

MOCK SURVEY

- Beginning of survey (Continued)
  - In-services/Education
    - Orientation
    - Competencies
    - Staff meeting minutes
    - Budget
      - Operating
      - Capital
    - On call log and/or information
    - MSDS
    - Fire drills and critiques

HOME HEALTH MOCK SURVEY

- Home visits – VERY important
  - Do the approximate number a Surveyor would do

Number of unduplicated admissions 12 months prior to the survey	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
Less than 300	2	3	2	7
301 – 500	3	4	3	10
501 – 700	4	5	4	13
701 or more	5	7	5	17

Reference: Home Health Agency (HHA) Survey Protocol-State Operations Manual (SOM) Appendix B 01.16.2018

MOCK SURVEY

- Home Visits:
  - Choose a variety:
    - Multi-disciplines/diagnoses /various length of stays/patient setting/wounds /IVs
  - Prior to home visit
    - Review the clinical record
    - Interview clinician
  - Check the clinician's car setup and supplies

MOCK SURVEY

- During the home visit:
  - Locate and review the home folder
  - Observe if POC is being followed
  - Observe infection control/bag technique/hand hygiene
  - Do NOT intervene unless you observe a safety issue

MOCK SURVEY

- Home Visits:
  - At the end of the visit:
    - Interview the patient and/or representative/caregiver/family
      - Ask questions like a Surveyor would:
        - Any complaints
        - Access to after hours
        - Communication – arrival times of staff
        - Teaching – medications, infection control, pain management, etc.
    - After visit check clinician's documentation

MOCK SURVEY

- Clinical Record Reviews
  - Choose a variety
    - Diagnoses, various lengths of stays, various patient settings and level of care, wounds, IVs, etc.
  - Time-frame of review
    - Most recent last certification period to present
  - Ensure audit tool is comparable to what Surveyors review

MOCK SURVEY: CLINICAL RECORD REVIEWS

- Look for commonly seen deficiencies:
  - Plan of Care
    - Goals/interventions not specific or measurable
    - Not updated when problems or changes occur
  - Coordination of services
    - No communication with physicians and/or between disciplines
  - Physician orders:
    - Visit frequencies, interventions, medications, and treatments

MOCK SURVEY: CLINICAL RECORD REVIEWS

- Aide care plans
  - Not specific enough
  - Aide not following plan

- Aide supervisory visits not being done

DEVELOPING AN ACTION PLAN

Specific Categories

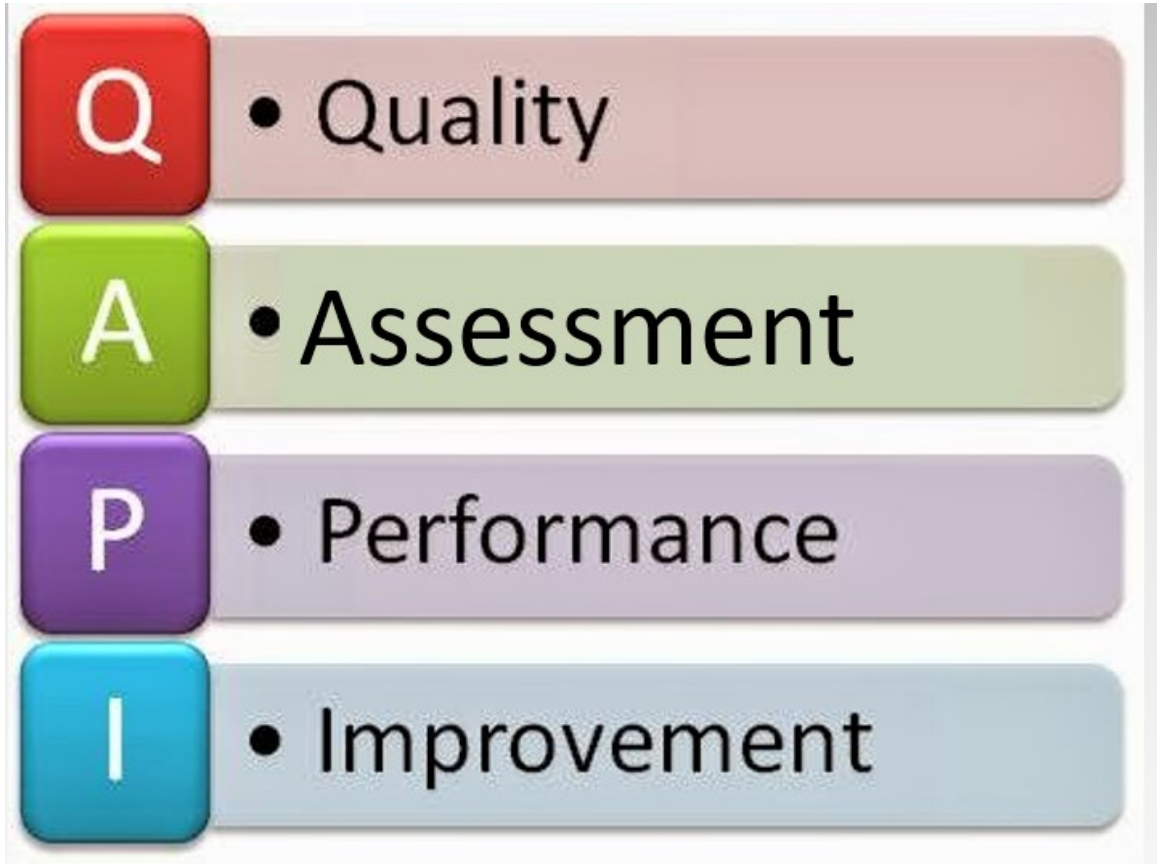
- Priority
- Subject
- Specific issues
- Action items
- Responsible party
- Due date
- Completion date

Key Portions

- Education
- Process change
- Policy change
- QA monitoring

ACTION PLAN

- Specifics found:
  - Example: In 3 of 8 charts reviewed, physician orders were not followed
    - State for each chart what was not followed.
- Action items:
  - Include monitoring
    - Review 20 records a month to focus on following physician orders with a goal of 90% compliance
  - Have an audit tool designed for the specific deficiency
    - Example: Wounds, medications, visit frequency, interventions, etc.


Q
• Quality
A
• Assessment
P
• Performance
I
• Improvement

QAPI PROGRAM

- Ensure the program is designed to help you!
  - Choose activities to monitor based on your deficiencies and action plan
  - Focus on activities to ensure that you have no vulnerabilities to getting a condition out
  - Focus on high-risk, high-volume, and problem-prone areas
    - Consider incidence, prevalence and severity
  - Have an immediate correction of any identified problem(s) that directly OR potentially threaten the health and safety of patients

QAPI PROGRAM: ON-GOING CLINICAL RECORD REVIEWS

- Excellent way to have on-going compliance in your clinical records
- Ensure a variety
- Reviews should be used for staff education when trends are noted
- Trend and analyze results

QAPI PROGRAM: ON-GOING CLINICAL RECORD REVIEWS

- Reviews should be on-going
  - Recommend at least quarterly
    - May increase prior to survey
- How many?
  - Recommend 20% each quarter
  - If deficient with an indicator
    - Recommend 50% until 90% compliance is reached
- Who?
  - Clinical manager / QA nurse / RN / etc.
    - Recommend training more than one person
      - Ensure consistencies

QI/QAPI – CUSTOMER SATISFACTION

- Review CAHPS report
  - Choose indicators to focus on that are low to benchmarks and cross over to outcome reports
    - Medication management, pain
  - Develop an indicator and add criteria were the CAHPS score is poor
    - Informed when providers would arrive
    - Agency explained care and services

QI/QAPI – OUTCOME MEASUREMENTS

- CASPER reports
  - Critical to review these each time they are updated
  - Determine indicators that need improvement
    - Add to QI program
- Potentially avoidable events
  - Be proactive in identifying adverse events
  - When events are identified audit patient record
- Outcomes
  - Choose ones that affect all disciplines
    - ADLs, ambulation, pain, etc.
  - Choose clinically significant ones
    - Dyspnea, pain, medications, etc.

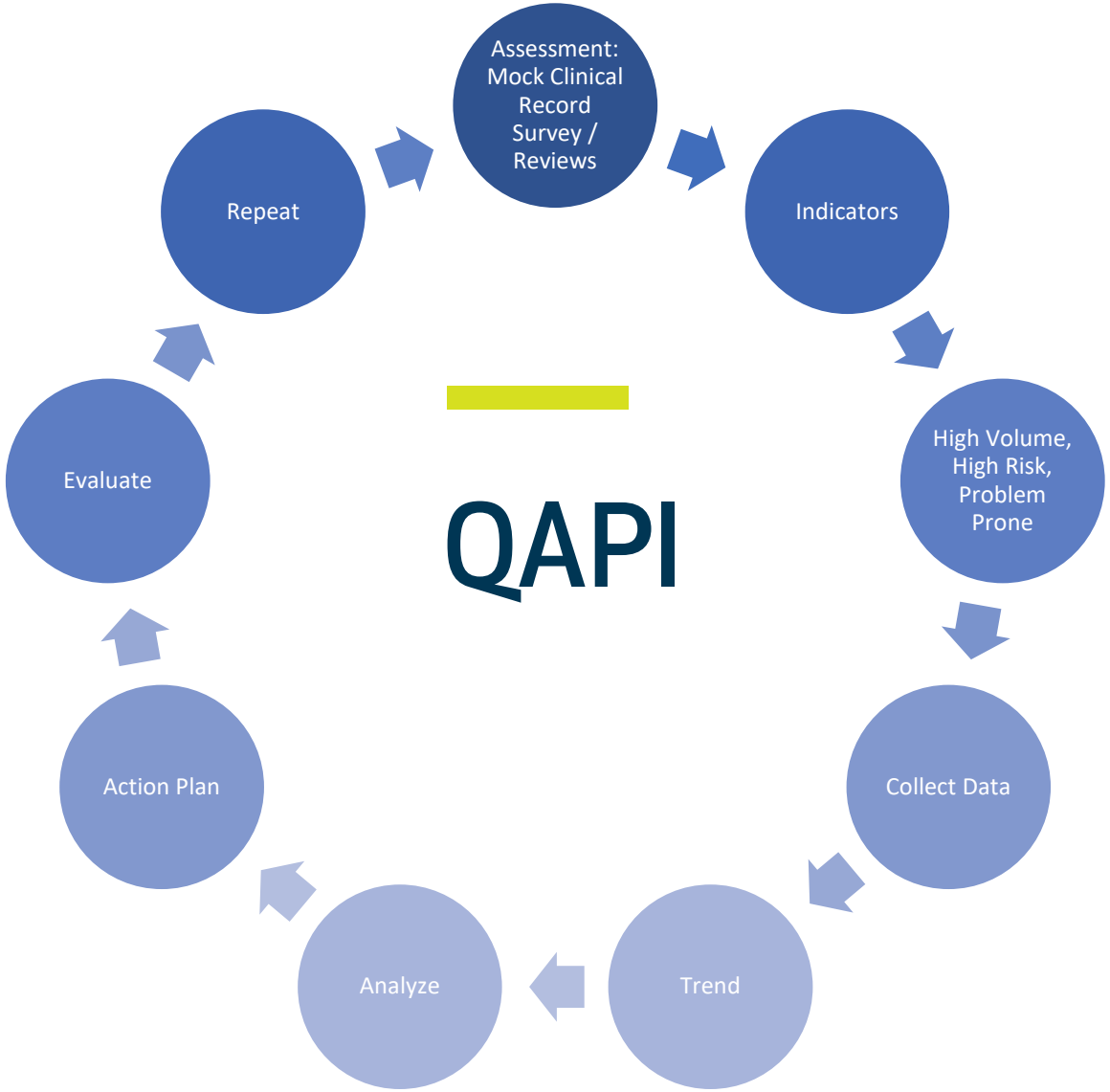
QI/QAPI – OTHER AREAS TO INCLUDE

- Incorporate
  - Incident reports
    - Fall reduction tracking
  - Complaints
    - Example: Patient reports being upset because they never know when the aide is coming
  - Medication errors and/or adverse events
    - Example: Nurse A sets up medications and Nurse B notes an error when making a med change in pill box
    - Example: Patient receiving IV Vanco and had an allergic reaction
  - Infections

QAPI TEAM

- Get EVERYONE invested
  - Choose clinicians and office staff
    - Assign an indicator to each person that they are responsible for
      - Minimum two employees for each indicator
  - QAPI Coordinator is the leader
    - Set up list of patient records for staff to review
    - Assign staff once a week or bi-weekly for half day

QAPI


Assessment: Mock Clinical Record Survey / Reviews
Indicators
High Volume, High Risk, Problem Prone
Collect Data
Trend
Analyze
Action Plan
Evaluate
Repeat

THE KEY TO SURVEY READINESS

DON'T JUST
GATHER DATA
BUT …
DO SOMETHING WITH
THE INFORMATION

HOW TO ADDRESS THE ISSUES – ON GOING

- Spend the majority of your time on the biggest challenges
- Prioritize
  - What needs your attention the most?
- Keep track of corrected deficiencies so they don't become problems again
- Educate monthly in various ways
  - Staff meetings, posters, newsletters, games, tests, etc.

SURVEY READINESS/REGULATORY COMPLIANCE

- Tips for compliance
  - Ensure staff are knowledgeable about the CoPs
    - Have an education program for new hires
    - Have a process in place for updates/reviews for current staff
  - Train staff on survey process
    - Inform them of their roles in survey readiness
  - Survey readiness book
    - Ensure that everyone knows where this is
    - Update quarterly

SURVEY READINESS/REGULATORY COMPLIANCE

- Tips for compliance (continued)
  - Perform on-going clinical record reviews
  - Frequent supervisory home visits
  - Staff/Management accountability

EXAMPLE: QI PROJECT THAT ENSURES COMPLIANCE - REASON FOR EMERGENT CARE

- Potentially Avoidable Event Report (CASPER)
  - Improper medications –
    - 2.05% current / 1.20% prior / 0.78% national
  - Hypo/Hyperglycemia –
    - 2.08% current / 5.68% prior / 1.50% national
  - Other –
    - 3.01% current / 1.44% prior / 3.78% national
- Indicator
  - QI coordinator or designee will review 100% of patient OASIS — reason for emergent care quarterly
- If Improper Medications or Hypo/Hyperglycemia is the reason for emergent care –
  - A clinical record review will be completed to identify if the agency could have done anything to prevent these occurrences

EXAMPLE: QI PROJECT THAT ENSURES COMPLIANCE - REASON FOR EMERGENT CARE

- Goal (CASPER Data)
  - Improper medication administration, adverse drug reactions, medication side effects, toxicity, anaphylaxis – 0.80%
  - Hypo/Hyperglycemia, diabetes out of control – 1.50%
- Audit criteria met on clinical record review when reason is improper medication administration or hypo/hyperglycemia
  - Goal: 90%

EXAMPLE: MEDICATION AUDIT TOOL

Criteria: Emergent Care for Medication Issues	Patient:	Patient:	Patient:
Not scored – Is the patient taking any medications?			
M2001 Drug regimen review: If problem found was the correct score completed? If no, was a problem seen in documentation but was not stated?			
M2003 Medication Follow-up: If answered, did score correlate with documentation of physician notification?			
M2010 Patient/Caregiver High-Risk Drug Education: If patient taking high risk drugs, was the item scored 1-Yes? If not, does documentation support score?			
M2020 Management of Oral Medications: Was item scored correctly based on documentation? If patient needed assistance, did documentation include if caregiver was available to assist?			
M2030 Management of Injectable Medications: Was item scored correctly based on documentation? If patient needed assistance, did documentation include if caregiver was available to assist?			
Was physician notified for all medication issues?			
Was medication education documented?			
Was understanding of education by patient/caregiver documented?			
Not scored – did the patient/caregiver contact the HHA prior to going to the ER?			
If yes, did the nurse call the physician and/or make a visit?			
Was there anything the HHA could have done to prevent emergent care for medication reasons?			
Total per patient –			
Total Compliance –			

EXAMPLE: HYPO/HYPERGLYCEMIA AUDIT TOOL

Criteria: Emergent Care for Hypo/Hyperglycemia	Patient:	Patient:	Patient:
Did patient experience emergent care for Hypo/Hyperglycemia?			
Did patient experience hospitalization for Hypo/Hyperglycemia?			
Did Plan of Care include blood glucose parameters ?			
If patient blood glucose readings were outside of parameters, was physician notified?			
Were endocrine assessments complete and thorough including blood sugar readings?			
Was diabetic education documented?			
Was understanding of education by patient/caregiver documented?			
Not scored – did the patient/caregiver contact the HHA prior to going to the ER?			
If yes, did the nurse call the physician and/or make a visit?			
Was there anything the HHA could have done to prevent emergent care for hypo/hyperglycemia?			
Total per patient –			
Total Compliance –			

CONCLUSION

Those agencies that perform clinical record reviews, home visits and perform mock surveys are the ones that do the best on their surveys, audits and...

ARE THE LEAST STRESSED!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THANK YOU

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