

# Bureau Talk

## Bureau of Home Care and Rehabilitative Standards

Missouri Department of Health and Senior Services

<http://health.mo.gov/safety/homecare/>

### Agency Changes

Any requests for changes occurring in your agency need to be reported to our Bureau of Home Care and Rehabilitative Standards. Providers **MUST** make requests for changes in advance, as some changes require pre-approval by both the state and the Center for Medicare and Medicaid Services (CMS). **Submit all requests for changes in writing.** Changes may be as minor as a phone number or major such as changes in ownership or location. All requests must be submitted via postal mail, email or fax and such documentation must be on agency letterhead. Please **DO NOT** forget to include your Medicare provider number on all correspondence with the Bureau of Home Care and Rehabilitative Standards.

One change that often occurs, and unfortunately, the Bureau does not become aware of it until after the surveyors enter the agency on survey, is the change of the agency administrator. Below are the qualifications required by the State and CMS to approve an administrator for home care and hospice agencies:

**Home Health care: A person who is appointed by the governing body and:**

- (a) Is a licensed physician; or
- (b) Is a registered nurse; or
- (c) Has training and experience in health service administration and at least one (1) year of supervisory or administrative experience in home health care or related health programs.

**Hospice: A person who is appointed by the governing body and:**

- (a) Is a hospice employee; and
- (b) Possesses education and experience required by the hospice's governing body.

Remember, in the event of your administrator or supervising RN's absence, you must delegate an alternate person to cover these positions. The agency does not need to report the alternate person to the Bureau, but your administrative record should clearly define the responsible alternate. This definition can be by title and not necessarily name. This alternate must meet all of the qualifications of the administrator and must also be approved by the governing body in order to cover the administrator's position in his/her absence.

### Introducing New Staff

A common theme of the *Bureau Talk* over the years is introducing new staff to the Bureau of Home Care and Rehabilitative Standards, and well, this year is no different. Since our last publishing, we have had two new additions to our Bureau family: Robin Mills, an RN from Jackson, MO and Patti Ott, an RN from the Springfield area who will both be functioning as Health Facilities Nursing Consultants in home care, hospice and outpatient physical therapy (OPT). Both of these ladies come to the Bureau with surveyor experience.

*Please join us in welcoming Robin and Patti!*

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# Inquiring Minds Want to Know

The Bureau of Home Care and Rehabilitative Standards frequently receives phone calls with questions from agencies. Bureau staff spend a portion of time as a team discussing these questions and, using regulatory guidance and experience, derive answers for the providers. We would like to share some Q&A's.

**Q:** Our home health agency (HHA) has a LPN who just graduated as a registered nurse but has not yet taken his/her state board exams. Can we let the RN graduate nurse perform all duties of a RN (such as OASIS assessments) until we get his/her exam results?

**A:** Yes, as long as the HHA has oriented the new RN graduate nurse to all RN duties and the HHA has verified he/she is competent, the new RN graduate nurse can do anything a licensed RN can do. However, when the state board exam results are known, if he/she did not pass the exam, you must revert to using the employee in his/her former role (Ex. LPN), UNTIL there are new board exam scores showing the RN graduate nurse has passed the RN board exam, and is issued a valid RN license by the state.

**Q:** We heard that you have to have a Clinical Laboratory Improvement Amendments (CLIA) waiver even if you do not have any equipment, is that true?

**A:** Yes, according to our directives from CMS, even if nursing staff are only teaching or helping a patient do a finger stick or just reporting readings to a physician, because they are involved in the care of that patient's results, the agency needs to have a CLIA waiver.

**Q:** Can an administrator be a contracted employee for a home health or hospice agency?

**A:** Yes, the administrator could be a contracted employee for a home health or hospice agency. Although most agencies have administrators that are direct employees, there is nothing in regulation prohibiting them from contracting for their administrator.

## Breakdown of ICD-10 Codes reported on the Annual Report

<u>Diagnosis Code Category</u>	<u>Code Range</u>
Infectious and Parasitic Diseases	A00 - B99
Neoplasms	C00 - D49
Diseases of Blood/Blood-forming Organs/Immune System	D50 - D89
Endocrine, Metabolic, Nutritional Diseases	E00 - E89
Mental, Behavioral, Neurodevelopmental Disorders	F01 - F99
Diseases of Nervous System	G00 - G99
Diseases of Eye and Adnexa	H00 - H59
Diseases of Ear and Mastoid Process	H60 - H95
Diseases of Circulatory System	I00 - I99
Diseases of Respiratory System	J00 - J99
Diseases of Digestive System	K00 - K95
Diseases of Skin and Subcutaneous Tissue	L00 - L99
Diseases of Musculoskeletal System/Connective Tissue	M00 - M99
Pregnancy, Childbirth and the Puerperium	O00 - O9A
Conditions Originating in Perinatal Period	P00 - P96
Congenital Malformations, Deformations, Abnormalities	Q00 - Q99
Symptoms, Signs and Abnormal Clinical Findings	R00 - R99
Injuries and Burns	S00 - T34
Poisoning, Adverse Effects and Complications	T35 - T88
Encounters for Care and Factors Affecting Health Status	Z00 - Z99
Unknown	

## Home Health/Hospice Aide Competency Evaluation (Part 2)

Missouri agencies using the Aide Competency Evaluation developed and approved effective March 1, 2012 by the Bureau of Home Care and Rehabilitative Standards will be in compliance with both Medicare and State home health and hospice regulations.

- The RN **MUST** observe the aide perform **ALL** tasks listed while providing care to the **PATIENT**. The only exception is shampooing. The RN can observe the aide provide shampooing in the tub/shower, bed or other (such as sink or dry shampoo). Observation of **ONE** shampooing method is enough to pass for that category.
- Under the comments section, the agency must make specific notations regarding the task observed and the aide's performance. (Example: Pulse, "Aide listened to apical pulse for one full minute. Had watch and stethoscope available for task. Used appropriate landmark for apical pulse. Cleaned stethoscope after use on patient.")

# Supervising Physical Therapy and Assistants

## Per 20 CSR 2150-3.090, Physical Therapist Assistants – Direction, Delegation and Supervision

When supervising the physical therapist assistant, the following requirements must be maintained:

- Initial, evaluation and treatment plan must be made by the licensed PT;
- There must be regularly scheduled reassessments of patients by the physical therapist at least every thirty (30) days;
- There must be conferences with the physical therapist assistants regarding patients, at least weekly or more often, as determined by the complexity and acuity of the patient's needs. Agencies must document evidence of

conferences with the physical therapist assistant at least every thirty (30) days;

- A licensed physical therapist must be accessible by telecommunication to the physical therapist assistant at all times while the physical therapist assistant is treating patients; and
- Supervisory visits should include: on-site reassessment of the patient, on-site review of the plan of care with appropriate revision or termination and assessment for utilization of outside resources. On-site shall be defined as wherever it is required to have an on-site licensed physical therapist to provide services.

## Clinical Record Audits

**Q:** How often does your agency have to do clinical record audits?

**A:** The frequency for which agencies must conduct clinical record audits varies depending on the provider type.

### Home Health

Per CFR 484.52(b) "At least quarterly, appropriate health professionals, representing at least the scope of the program, review a sample of both active and closed clinical records to determine whether established policies are followed in furnishing services directly or under arrangement."

### Hospice

Per CFR 418.58 "The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program." This condition requires each hospice to develop its own Quality Assessment and Performance Improvement (QAPI) program to meet its needs. Ongoing means that there is a continuous and periodic collection and assessment of data. Per the regulation, "Each agency structures its own individual QAPI plan. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS."

As 418.58(c) (3) states, in part, "...the hospice must measure its success and track performance to ensure that improvements are sustained."

Each of the above programs is different but here are some general questions to ask yourselves when developing your auditing programs. The following questions are likely more helpful for home health agencies, but other providers may also find them useful when conducting audits.

- Is your sample of clinical records large enough to be effective?
- Can you determine if your staff is following agency policy?
- What do you look for during your clinical record audits?
  - o Signatures?
  - o Dates?
  - o Timely documentation?
  - o Content?
    - Is staff following the plan of care/interim orders?
    - Are changes in patient's conditions being coordinated with other staff and the physician? Is staff following up on these changes?
    - Does the comprehensive assessment and routine visit notes reflect the patient's current condition?
    - Is the care provided by staff allowing the patient to reach his/her goals?
  - o Are nurses supervising and reviewing nursing documentation, are physical therapists supervising and reviewing physical therapy documentation, etc.?
  - o Are you using an audit tool which includes dates, patients, auditors, findings of compliance or non-compliance, what was reviewed and any follow-up to the findings of the audit?

# Hospice

## Infection Control Changes

On April 6, 2016, the Improving Medicare Post-Acute Care Transformation ACT (IMPACT Act) reached the first anniversary of existence. This new bill mandated that all Medicare certified hospices be surveyed every three (3) years for at least the next ten (10) years. Prior to this, hospices went eight years or more without having a survey. A lot can and has changed in eight years. One of those changes is §418.60, the Condition of Participation for Infection Control. There are many nationally known resources, which provide good information related to the current nursing standards. They include the CDC, Lippincott and World Health Organization, as well as some newer resources on the horizon. Although we do not recommend a particular resource, with increasingly frequent surveys and more regulatory standards related to infection control, we do encourage you to review your policies, current standards of practice and staff education related to your agency practices when it comes to caring for your patients and infection control.

## Revocation vs. Discharge

When out on survey, the surveyors often hear Hospice agency staff say, "We revoked the patient's hospice benefit....." The Bureau felt it was important to clarify what is meant by revocation vs. what is a discharge.

Medicare Benefit Policy Manual Chapter 9, 20.2.2 **Hospice Revocation** states that an individual or representative may revoke the election of hospice care at any time in writing; however, a **HOSPICE CANNOT** revoke a patient's election. Neither should the hospice request or demand that the patient revoke his/her election. To revoke the election of hospice care, the individual must file a document with the hospice that includes a signed and dated statement that the individual revokes the election for Medicare coverage of hospice care for the remainder of that election period. The statement date cannot be earlier than the date of the revocation. A verbal revocation of benefits is **NOT** acceptable.

**Discharge from hospice** may occur as a result of:

- The beneficiary revoking their hospice benefit;
- Transfer to another hospice;
- Death of the beneficiary;
- Beneficiary moves outside of the geographical area of the hospice service area; or
- Beneficiary's condition improves and he/she is no longer considered terminally ill.

**Discharge for cause** is a discharge due to extraordinary circumstances in which the hospice is unable to continue to provide care to the patient. Examples of a discharge for cause may include the patient and/or hospice staff's safety being compromised or the patient's (or other persons in the patient's home) behavior is disruptive, abusive or uncooperative to the extent that delivery of care to the patient or the ability of the hospice to operate effectively is seriously impaired.

The hospice must do the following before it seeks to discharge a patient for cause:

- Advise the patient that a discharge for cause is being considered;
- Make serious effort to resolve the problem presented by the patient's behavior or situation;
- Ascertain that the patient's proposed discharge is not due to the patient's use of necessary hospice services; and
- Document the problem(s) and efforts made to resolve the problem/situation and enter this documentation into the medical record.

What do surveyors look for in the clinical record for your patients that have revoked, discharged, or had a discharge for cause?

For revocation:

- Document the reason the patient chose revocation vs other options;
- Document the Interdisciplinary Group (IDG) was informed of revocation; and
- Document a discharge summary was sent to the physician.

For discharge:

- Document the reason for discharge;
- Document the discussion with the patient/family/IDG; and
- Document a discharge summary was sent to the physician.

The Bureau recommends your agency review your policies regarding revocation, discharge and discharge for cause. Make sure your clinicians are aware of these policies and what the regulation requires.

# OASIS

## Changes in OASIS C2

Since our last publication, almost a year ago, there have been numerous changes with OASIS. On October 1, 2015, the OASIS C1 ICD 10 Version went into effect. And now, less than a year later, home health agencies are preparing for OASIS C2 which will be effective on January 1, 2017.

With the coming of OASIS C2, CMS has posted the necessary reference materials that your agency will want to print to assist in preparing your clinicians for the new changes to be effective January 1, 2017.

For access to the new OASIS C2 Guidance Manual and the OASIS C2 Data Item Set, please go to

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/OASIS-Data-Sets.html>. On this website, you will find downloads for both of these documents. If your agency printed the OASIS C2 Guidance Manual when it was first published, please note that CMS reposted the manual June 29, 2016. Some information was previously not displaying in Appendix G and this has been corrected. There were no changes to the actual item-specific guidance or other sections of the manual.

## OASIS Trainings

As you recall with the dawning of OASIS C1/ICD9, the OASIS Education Coordinator (OEC), Joyce Rackers, conducted state-wide OASIS trainings. Many agencies have inquired as to whether there will be future trainings provided for agencies prior to the implementation of OASIS C2. We are happy to announce that starting mid-October through mid-November, the new OEC for Missouri, Fern Dewert, along with two other surveyors (Suzi Hamlet and Robin Swarnes), will be conducting state-wide trainings. We are in the process of setting up the training materials, as well as the specific locations for the trainings.

Just as soon as we finalize the plans, we will distribute the information regarding the trainings via list serve to all of the Missouri home health agency administrators.

## OASIS Q & A

Since our last Bureau Talk publication, there have been several postings of the CMS quarterly Q&As. Visit [www.qtso.com](http://www.qtso.com) and click on OASIS and then User Guides and Trainings for access to the July 2015, October 2015, January 2016, April 2016 and July 2016 postings. It is imperative for your agency to review these Q&As in order to be up-to-date on the latest information available pertaining to OASIS. You will find that beginning with the April 2016 Quarterly Q&As, CMS is already beginning to address questions related to the new OASIS C2 document. Do not get behind in the game! Print your copy of the Quarterly Q&As and review with your staff today!

# Identifying Risks with Deep Vein Thrombosis

In the past couple of years, the Bureau of Home Care and Rehabilitative Standards has cited two immediate jeopardy findings that specifically involved patients diagnosed with Deep Vein Thrombosis (DVT). Agency staff failed to identify DVT risks or symptoms; and failed to monitor for, or report, DVT symptoms to the doctor.

Recently, one of the surveyors researched and conducted an in-service on Deep Vein Thrombosis for the Bureau staff.

## Did you know....?

- The Homan's sign has been found to be positive less than 50 % of the time?
- Physical examination is only 30% accurate for DVTs?
- Large, extensive thrombi can develop rapidly within minutes?
- The embolic risk is highest during the first few days after DVT formation?

For more helpful education on DVTs, please see the attached outline of some of the highlights of this in-service.

## Hospice Discharge Summary Requirement

Per 19 CSR 30-35.010 (1) (10), "The physician shall be notified in all instances of discontinuance of hospice care and such notification shall be documented in the patient record." (ML108)

Federal and/or State regulations **DO NOT** require a discharge summary to be sent to the attending physician when the patient has been discharged from hospice due to death.



*Alternate forms of this publication for persons with disabilities may be obtained by contacting the Missouri Department of Health and Senior Services' Bureau of Home Care and Rehabilitative Standards, P.O. Box 570, Jefferson City, MO, 65102-0570, 573-751-6336. Hearing- and speech-impaired citizens can dial 711.*

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