What’s new with the New Regs

- NO new SOM or the Appendix B is provided yet, but here are some new expectations:
  - Patient-centered assessment with interdisciplinary approach
  - Stress quality improvements by incorporating an outcome-oriented, data-driven, quality assessment and performance improvement program specific to each HHA.
  - They grouped all CoPs related to patient care at the beginning and the organization and administration ones in a subpart called Organizational Environment.
  - On the effective date of the rule, any existing subunits, which already operate under their own provider number, will be considered distinct HHAs and will be required to independently meet all CoPs, including having an independent governing body and administrator.
  - New definitions and modifications to terms “representative, verbal orders and personnel qualifications”

What’s new with the New Regs

- The OASIS data to be transmitted in accordance with current CMS transmission policy, which currently requires HHAs to transmit data using electronic communications software that complies with the Federal Information Processing Standard.
  - They proposed to revise patient rights provisions under six standards: (1) Notice of rights; (2) Exercise of rights; (3) Rights of the patient; (4) Transfer and discharge; (5) Investigation of complaints; and (6) Accessibility.
  - The HHA is to provide each patient with specific business contact information for the HHA’s administrator so that patients and caregivers could report complaints and specific patient rights violations to the HHA administrator; and could ask questions about the care being provided.
  - The HHA is to obtain the patient’s or representative’s signature confirming that he or she received a copy of the notice of rights and responsibilities.
What's new with the New Regs

- They added the abuse prevention and investigation protocol
- PI will take part in the comprehensive assessment and care planning
- Proper discharge procedures are added
- They proposed to require that the comprehensive assessment must accurately reflect the patient's status in the following in a more holistic approach:
  - The patient's current health, psychosocial (new), functional (new), and cognitive (new) status;
  - The patient’s strengths, goals, and care preferences, including the patient’s progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA (new);
  - The patient’s continuing need for home care;
  - The patient’s medical, nursing, rehabilitation, social, and discharge planning needs;
  - A review of all medications the patient is currently using;
  - The patient’s primary caregiver(s), if any, and other available supports (new), and;
  - The patient’s representative (if any) (new).

The assessment would also be required to incorporate OASIS items and the drug regimen review.

Standard for Update of the comprehensive assessment stays the same except with one change. They proposed to allow for a physician-ordered resumption of care date. Adding the physician ordered resumption of care date as an alternative to the fixed 48-hour time frame for a post-hospital reassessment allows physicians to specify a resumption of care, to meet the needs and preferences of the patients.
What's new with the New Regs

New Care Planning CoP

- The intent of the CoP is the patients be accepted for treatment on the basis of a reasonable expectation that the patient’s medical, nursing, rehabilitative, and social needs could be met adequately by the agency in the patient’s place of residence.
- The plan of care is to include the patient-specific measurable outcomes which the HHA anticipates would result from its implementation.
- The HHA is to include an assessment of the patient’s level of risk for hospital emergency department visits and hospital re-admission and appropriate interventions that are necessary to address and mitigate identified risk factors.
- They want verbal orders to be recorded in the care plan.
- Care plan at discharge

Patient assessment, specifically the DRUG REGIMEN REVIEW is required by Conditions of Participation (§484.55 – G330), Comprehensive Assessments of the Patients

Drug Regimen Review IS A QRP (Quality Reporting Program) Measure

QM Purpose: Are the HHAs responsive to potential or actual clinically significant medication issues when such issues are identified.
- a patient assessment measure
- cross-setting quality measure to meet the Improving Medicare Post Acute Care Transformation (IMPACT) Act requirements

Definition: This measure reports the percentage of patient care episodes in which a drug regimen review was conducted at the time of Start of Care (SOC) or Resumption of Care (ROC) and timely follow-up with a physician occurred each time potential clinically significant medication issues were identified throughout that care episode.
**DRR – QRP MEASURE**

**OASIS-C2 Items Included in the QM:**

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**M2001 Drug Regimen Review**

Did a complete drug regimen review identify potential clinically significant medication issues?

Medication Interactions: one substance has an impact on another substance
- One may alter absorption, distribution, metabolism, or elimination.
- One may decrease the effectiveness of the medication or increase the potential for adverse consequences.

Adverse Drug Reaction (ADR): some form of adverse consequence
- It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication. Or,
- Any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnostic, or treatment.

Side Effects: a well-known reaction with predictable frequencies. This term is used interchangeably with ADR.

**Drug Regimen Review includes:**

a) medication reconciliation
b) review of all medications administered by any route, including over-the-counter medications that are used currently by the patient

Review of the drug regimen will identify, and if possible, help prevent potential clinically significant medication issues.

A potential clinically significant medication issue is an issue that (in the care provider’s clinical judgment), requires physician notification by midnight of the next calendar day (at the latest).

In addition to “potential” issues, the item also includes the identification of an existin Clinically significant medication issue that requires physician notification by midnight of the next calendar day.
Potential or actual clinically significant medication issues may include, but are not limited to:

- Adverse reactions to medications (such as a rash).
- Ineffective drug therapy (analgesic that does not reduce pain).
- Side effects (potential bleeding from an anticoagulant).
- Drug interactions (serious drug-drug, drug-food, and drug-disease interactions).
- Duplicate therapy (generic name and brand name equivalent drugs are both prescribed).
- Omissions (missing drugs from an ordered regimen).
- Dosage errors (either too high or too low).
- Non-adherence (regardless of whether the non-adherence is purposeful or accidental).

REMEMBER:

- One clinician is ultimately responsible for the DRR, however, collaboration in which the assessing clinician evaluates patient status and another agency clinician assists with review of the medication list) does not violate the requirement.
- Pay attention to the M0090 date and the date that the DRR assessment is completed. The M0090 would be the date the two clinicians collaborated and the assessment was completed.

Any circumstance that does not require immediate attention of the physician is not considered a potential or actual clinically significant medication issue.

A level of clinical significance that warrants notification of the physician for orders or recommendations, completed by midnight of the next calendar day, at the latest. This time frame includes the physician’s response.

During the survey we usually consider:

- How are the potential adverse effects and drug reactions are identified by the agency (software, drug book etc.)?
- What is the HHA’s policy for DRR?
- What are the steps that the agency staff take when medication problems are identified?
- What kind of evidence or documentation is there to show the completion of the DRR, the physician notification, and the timely response from the physician?
DATA SOURCES AND RESOURCES

Since medication issues continue to evolve and new medications are being approved regularly, it is important to refer to a current authoritative source for detailed medication information such as indications and precautions, dosage, monitoring, or adverse consequences.

- Physician’s Drug Reference (PDR) or other clinical medication handbook or software intended to provide warnings of severity levels of risk for medication review.
- CMS OASIS Q&As can be accessed through the CMS OASIS web page.
- Several online resources for evaluating drug reactions, side effects, interactions, etc., can be found in Chapter 5 of OASIS manual.

Make sure there is evidence in the medical record to show completion of DRR and physician’s timely response.

Medication Follow-Up (M2003)

Did the agency contact a physician by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

- “Within one calendar day” clarified as “by midnight of the next calendar day.”
- All issues are labeled “potential clinically significant medication issues” for consistency.
- Physician contact AND completion of prescribed/recommended actions are required.

Time points of completion is SIDC and ROC

Intent: A complete drug regimen review and identification of actual or potential clinically significant medication issues with physician notification and response to meet best practices in health care settings.

Physician communication options (backed up by documentation in the medical record)

- Telephone.
- Voicemail.
- Electronic means.
- Fax.
- Any other means that appropriately conveys the message of patient status.

Communication can be directly to/from the physician, or indirectly through physician’s office staff on behalf of the physician, in accordance with the legal scope of practice.
**Medication Intervention (M2005)**

Did the agency contact and complete physician prescribed/recommended actions by midnight of the next calendar day when potential clinically significant medication issues were identified since the SOC/ROC?

**Intent:** Identifies if potential clinically significant medication issues such as adverse effects or drug reactions identified at the time of or at any time since the SOC/ROC were addressed with the physician.

**Time points of Completion in:**
- Transfer to an inpatient
- Death at home
- Discharge

When multiple clinically significant medication issues were identified since the SOC/ROC, all must have been communicated to the physician, with completion of all prescribed/recommended actions occurring by midnight of the next calendar day in order to enter Response 1, Yes.

**DATA SOURCES AND RESOURCES**
- Clinical record.
- Communication notes.
- Medication list.
- Plan of Care.
- Discussions with other agency staff responsible for completing drug regimen review.

**SUMMARY**

- As mentioned earlier, there are no interpretive guidelines as of yet on the new CoPs and yet as soon as we have them we will have another training session.
- A Drug Regimen Review (M2001) is completed at SOC/ROC to identify potential or actual clinically significant medication issues.
- Medication Follow-up (M2003) is completed at SOC/ROC to determine if issues identified in M2001 were addressed with the physician by midnight of the next calendar day.
- Medication Intervention (M2005) is completed at transfer, death at home, or discharge to identify if medication issues identified at the time of or any time since the SOC/ROC were addressed with the physicians.

The evidence in the medical record???
RESOURCES

• OASIS Educational Coordinators:

• Quality Measures: Home Health Quality Reporting Program
  o HomeHealthQualityQuestions@cms.hhs.gov

• OASIS Items & Payment Policy: Home Health Policy Mailbox
  o HomeHealthPolicy@cms.hhs.gov

• Data Submission & CASPIER: QTSD Help Desk
  o Telephone: (800) 339-9313
  o Email: help@qtso.com
  o Website: https://www.qtso.com/index.php
The purpose of this session is to:

- Realization → each agency is different relating to their strong and weak areas.
- Enhance the Quality Assessment and Performance Improvement (QAPI) activities within the Hospice Agency, through increased knowledge of QAPI regulations.
- Performance improvement techniques / tools and sustaining improvements.
- Explore the sources of feedback, data systems and monitoring.
- Demonstrate the effective use of Root Cause Analysis (RCA) to identify systems problems.

A QAPI Program takes a systematic, comprehensive, and data-driven approach to corporate compliance for maintaining and improving safety and quality. A proactive effort to use the data to understand and improve your own problems.
THE PURPOSE?

To set a clear expectation that your hospice is taking a proactive approach to improve your performance and focus on improved patient care and activities that impact patient health and safety.

The improvement in your systems improve the processes and patient outcome!

- QA is the specification of standards for quality of service and outcomes, and a process throughout the organization for assuring that care is maintained at acceptable levels in relation to those standards.

- QA is on-going, both anticipatory and retrospective in its efforts to identify how the organization is performing, including where and why facility performance is at risk or has failed to meet standards.

- PI is the continuous study and improvement of processes with the intent to better services or outcomes, and prevent or decrease the likelihood of problems, by identifying areas of opportunity and testing new approaches to fix under/over/out of persistent/systemic problems or barriers to improvement.

Program Scope

- involves determining and documenting a list of specific project goals in all areas of operations that might adversely affect the patients’ cares or the core hospice services.

- must be able to show measurable improvements in patient outcome and hospice services.
**What are you looking at?**

- Identify concerns in all areas of the agency
- What are they?
- Once identified
- How will you choose the area to focus on? How many areas? Who will make the decision?
- Once decided
- How will you track and monitor the areas of concern?
  - Who will track and monitor?
  - Who will decide if the focus needs to change or if the problem has not been identified?

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**QUALITY ASSURANCE PROGRAM IMPROVEMENT**

**Involving all levels of your organization**

- Ongoing
  - Documentation of progress of program
  - May include review of current documentation (clinic records, incident reports, complaints, patient satisfaction surveys...)

**Organized method**

- Continuous and periodic collection and assessment of data
- Methods for monitoring and evaluating the quality of care
- Program objectives

**Achieving optimum results**

- Responsibility of reporting
- To governing body
- Monitor to determine effectiveness and quality of life

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**NOW WHAT?**

If you only fix the symptoms - what you see on the surface - the problem will almost certainly return, and need fixing over, and over again.

However, if you look deeper to figure out what’s causing the problem, you can fix the underlying systems and processes so that it goes away for good.

To find the root cause, involves investigating the patterns of negative effects, finding hidden flaws in the system, and discovering specific actions that contributed to the problem. This often means revealing more than one root cause.
Root Cause Analysis is a technique that helps people answer the question of why the problem occurred in the first place. It seeks to identify the origin of a problem using a specific set of steps, with associated tools, to find the primary cause of the problem, so that you can:

1. Determine what happened.
2. Determine why it happened.
3. Determine what to do to reduce the likelihood that it will happen again.

The root cause assumes that systems and events are interrelated. An action in one area triggers an action in another, and another, and so on. By tracing back these actions, you can discover where the problem started and how it grew into the symptom you’re now facing.

Three basic types of causes:

- **Physical causes**: Tangible, material items failed in some way (for example, a car’s brakes stopped working).
- **Human causes**: People did something wrong, or did not do something that was needed. Human causes typically lead to physical causes (for example, no one filled the brake fluid, which led to the brakes failing).
- **Organizational causes**: A system, process, or policy that people use to make decisions or do their work is faulty. For example, no one person was responsible for vehicle maintenance, and everyone assumed someone else had filled the brake fluid.

Implement Solutions

- What can you do to prevent the problem from happening again?
- How will a new process/procedure/system be implemented?
- Who will be responsible for it?
- What are the risks of implementing the solution?

Analyze your process, and identify the changes needed for various systems.

It’s also important that you plan ahead to predict the effects of your solution. This way, you can spot potential failures before they happen.