Critical Access Hospital CoPs

Part 4 of 4

What CAHs Need to Know

Radiology, Contracts, Emergency Services, Rehab, Visitation, Medical Records, Surgery, Anesthesia, QAPI, Organs and Swing Beds

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Part 4 of 4

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Location of CMS Hospital CoP Manual

New Email questions to CAH at qsog_cah@cms.hhs.gov

Medicare State Operations Manual

Appendix

- Each Appendix is a separate file that can be accessed directly from the SC... Appendices Table of Contents, as applicable.
- The appendices are in PDF format, which is the format generally used in the IOM to display files. Click on the corresponding letter in the "Appendix Letter" column to see any available file in PDF.
- To return to this page after opening a PDF file on your desktop. use the browser "back" button. This is because closing the file usually will also close most browsers

New **www.cms.gov/files/document/appendices-table-content.pdf**

Appendix Letter	Description
A	Hospitals
AA	Psychiatric Hospitals
B	Home Health Agencies

Appendix Letter	Description
L	Ambulatory Surgical Services Interpretive Guidelines and Survey Procedures
M	Hospice
N	Psychiatric Residential Treatment Facilities (PRTF) Interpretive Guidance
P	Survey Protocol for Long-Term Care Facilities
PP	Interpretive Guidelines for Long-Term Care Facilities
Q	Determining Immediate Jeopardy
R	Resident Assessment Instrument for Long-Term Care Facilities
S	Mammography Suppliers - **Deleted**
T	Swing-Beds – ***Deleted (See Appendix A and Appendix W)***
U	Responsibilities of Medicare Participating Religious Nonmedical Healthcare Institutions
V	Responsibilities of Medicare Participating Hospitals In Emergency Cases
W	Critical Access Hospitals (CAHs)
X	Survey Protocol and Interpretive Guidelines for Organ Transplant Programs
Y	Organ Procurement Organization (OPO)
Z	Emergency Preparedness for All Provider and Certified Supplier Types

www.cms.gov/manuals/Downloads/som107ap_w_cah.pdf

CAH CoP or State Operations Manual

State Operations Manual
Appendix W - Survey Protocol, Regulations and Interpretive Guidelines for Critical Access Hospitals (CAHs) and Swing-Beds in CAHs

(Rev. 200, 02-21-20)

Transmittals for Appendix W

INDEX

Survey Protocol

Introduction
Regulatory and Policy Reference
Tasks in the Survey Protocol
Survey Team
Task 1 - Off-Site Survey Preparation
Task 2 - Entrance Activities
Task 3 - Information Gathering/Investigation
Task 4 - Preliminary Decision Making and Analysis of Findings
Task 5 - Exit Conference
Task 6 - Post-Survey Activities

Manuals at www.cms.gov/files/document/appendices-table-content.pdf

Regulations and Interpretive Guidelines for CAHs

§485.601 Basis and Scope
§485.603 Rural Health Network
§485.604 Personnel Qualifications

Questions to qsog_cah@cms.hhs.gov

C-Tag Crosswalk

	A	B	C	D	E	F
1	NEW TAG #	CFR	Critical Access Hospital (CAH) Tag Title	Condition of Participation	OLD TAG #	Tag Changes Effective 03/30/20
2	C-0800	§485.601	BASIC AND SCOPE	NA	NA	NA
3	C-0802	§485.603	RURAL HEALTH NETWORK	NA	NA	NA
4	C-0804	§485.604	PERSONNEL QUALIFICATIONS	NA	NA	NA
5	C-0808	§485.606	DESIGNATION AND CERTIFICATION OF CAHS	NA	NA	NA
6	C-0810	§485.608	COMPLIANCE WITH FED, ST, AND LOCAL LAWS AND REGULATIONS	Compliance W/ Fed., State, and Local Laws and Regulations	C-0150	NA
7	C-0812	§485.608(a)	COMPLIANCE WITH FED, ST LAWS AND REGULATIONS	Compliance W/ Fed., State, and Local Laws and Regulations	C-0151	NA
8	C-0814	§485.608(b)	COMPLIANCE WITH STATE AND LOCAL LAWS AND REGULATIONS	Compliance W/ Fed., State, and Local Laws and Regulations	C-0152	NA
9	C-0816	§485.608(c)	LICENSURE OF CAH	Compliance W/ Fed., State, and Local Laws and Regulations	C-0153	NA
10	C-0818	§485.608(d)	LICENSURE, CERTIFICATION OR REGISTRATION OF PERSONNEL	Compliance W/ Fed., State, and Local Laws and Regulations	C-0154	NA
11	C-0822	§485.610	STATUS AND LOCATION	Status and Location	C-0160	NA
12	C-0824	§485.610(a)	STATUS	Status and Location	C-0161	NA
			LOCATION IN A RURAL AREA OR TREATMENT			

www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/CAHs

CMS Survey Memos

Policy & Memos to States and Regions

CMS Quality Safety & Oversight memoranda, guidance, clarifications and instructions to State Survey Agencies and CMS Regional Offices. www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Policy-and-Memos-to-States-and-Regions

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Showing 1-10 of 521 entries

Title	Memo #	Posting Date	Fiscal Year
Guidance for Infection Control and Prevention of Coronavirus Disease 2019 (COVID-19) in nursing homes	QSO-20-14-NH	2020-03-04	2020
Suspension of Survey Activities	QSO-20-12-All	2020-03-04	2020
Guidance for Infection Control and Prevention Concerning Coronavirus Disease (COVID-19): FAQs and Considerations for Patient Triage, Placement and Hospital Discharge	QSO-20-13-Hospitals	2020-03-04	2020
Release of Additional Toolkits to Ensure Safety and Quality in Nursing Homes	20-11-NH	2020-02-14	2020
Information for Healthcare Facilities Concerning 2019 Novel Coronavirus Illness (2019-nCoV)	20-09-ALL	2020-02-06	2020
Notification to Surveyors of the Authorization for Emergency Use of the CDC		2020-02-	

Radiology and Nuclear Medicine

Radiology Services 1030

- Radiology services must be provided by qualified staff,
  - Can be provided as a direct service or through a contract,
- And do not expose patients or staff to radiation hazards,
- Must have services to meet the needs of its patients at all times,

Radiology Services 1030

- Can offer minimal set or more complex, according to needs of the patients including nuclear medicine,
- Hospital has flexibility to decide the types and complexities of radiologic services offered
- Interpretation can be contracted out
- Diagnostic, therapeutic, and nuclear medicine, must be provided in accordance with acceptable standards of practice and must meet professionally approved standards for safety

Radiology Services 1030

- Scope or what you do has to be in P&Ps approved by board or responsible party,
  - Must be consistent with state law
  - If telemedicine is used must comply with telemedicine standards
- And by standards recommended by nationally recognized professions such as the AMA, Radiology Society of North America, Alliance for Radiation Safety in Pediatric Imaging, ACC, American College of Neurology, ACP, and ACR,
  - Example would be the ACR MRI safety standards and contrast manual at www.acr.org

ACR Manual On Contrast Media

www.acr.org/-/media/ACR/Files/Clinical-Resources/Contrast_Media.pdf

2020

ACR Committee on Drugs and Contrast Media

ACR MR Safe Practice

JOURNAL OF MAGNETIC RESONANCE IMAGING 37:501–530 (2013)

Special Communication

http://onlinelibrary.wiley.com/doi/10.1002/jmri.24011/pdf

ACR Guidance Document on MR Safe Practices: 2013

Expert Panel on MR Safety: Emanuel Kanal, MD,[1*] A. James Barkovich, MD,[2] Charlotte Bell, MD,[3] James P. Borgstede, MD,[4] William G. Bradley Jr, MD, PhD,[5] Jerry W. Froelich, MD,[6] J. Rod Gimbel, MD,[7] John W. Gosbee, MD,[8] Ellisa Kuhni-Kaminski, RT,[1] Paul A. Larson, MD,[9] James W. Lester Jr, MD,[10] John Nyenhuis, PhD,[11] Daniel Joe Schaefer, PhD,[12] Elizabeth A. Sebek, RN, BSN,[1] Jeffrey Weinreb, MD,[13] Bruce L. Wilkoff, MD,[14] Terry O. Woods, PhD,[15] Leonard Lucey, JD,[16] and Dina Hernandez, BSRT[16]

Because there are many potential risks in the MR environment and reports of adverse incidents involving patients, equipment and personnel, the need for a guidance document on MR safe practices emerged. Initially published in 2002, the ACR MR Safe Practices Guidelines established de facto industry standards for safe and responsible practices in clinical and research MR environments. As the MR industry changes the document is reviewed, modified and updated. The most recent version

THERE ARE POTENTIAL risks in the MR environment, not only for the patient (1,2) but also for the accompanying family members, attending health care professionals, and others who find themselves only occasionally or rarely in the magnetic fields of MR scanners, such as security or housekeeping personnel, firefighters, police, etc. (3–6). There have been reports in the medical literature and print-media detailing Magnetic Resonance Imaging (MRI) adverse

2019 Update to MR Safe Practice

- ACR created a multi-disciplinary blue ribbon committee to address MRI issues
- Announced the coming soon of the ACR Guidance Document on MR Safe Practices: 2019 full manual with updates and critical new information
- Issues 8 page update
- ACR says need a guidance document of risks and adverse events from MRIs
- Suggests annual MR safety training
- Published in J Magn Reson Imaging 2019

ACR Guidance Document on MR Safe Practices: Updates and Critical Information 2019

ACR Committee on MR Safety: Todd D. Greenberg, MD,[1*] Michael N. Hoff, PhD,[2] Tobias B. Gilk, M. Arch,[3] Edward F. Jackson, PhD,[4] Emanuel Kanal, MD,[5] Alexander M. McKinney, MD,[6] Joseph G. Och, MS,[7] Ivan Pedrosa, MD, PhD,[8] Tina L. Rampulla, RT,[9] Scott B. Reeder, MD, PhD,[10] Jeffrey M. Rogg, MD,[11] Frank G. Shellock, PhD,[12] Robert E. Watson, MD, PhD,[13] Jeffrey C. Weinreb, MD,[14] and Dina Hernandez, BSRT[15]

The need for a guidance document on MR safe practices arose from a growing awareness of the MR environment's potential risks and adverse event reports involving patients, equipment, and personnel. Initially published in 2002, the American College of Radiology White Paper on MR Safety established de facto industry standards for safe and responsible practices in clinical and research MR environments. The most recent version addresses new sources of risk of adverse events, increases awareness of dynamic MR environments, and recommends that those responsible for MR medical director safety undergo annual MR safety training. With regular updates to these guidelines, the latest MR safety concerns can be accounted for to ensure a safer MR environment where dangers are minimized.

Level of Evidence: 1

Technical Efficacy Stage: 5

J. MAGN. RESON. IMAGING 2019.

RISKS IN THE MAGNETIC RESONANCE (MR) environment continue to evolve with the more common refinements to sections of the previously published ACR Guidance Documents on MR Safe Practice.[1–4] These updates

Radiology Services 1030

- P&P on adequate radiation shielding for patients, personnel and facilities which includes:
  - Shielding built into the physical plant
  - Types of personal protective shielding to use and under what circumstances
  - Types of containers to be used for radioactive materials
  - Clear signage identifying hazardous radiation area

Radiology Policies Required

- Labeling of all radioactive materials, including waste with clear identification of the material
- Transportation of radioactive materials between locations within the CAH;
- Security of radioactive materials, including determining who may have access to radioactive materials and controlling access to radioactive materials;
- Periodic testing of equipment for radiation hazards;

Radiology Policies

- Periodic checking of staff regularly exposed to radiation for the level of radiation exposure, via exposure meters or badge tests
- Storage of radio nuclides and radio pharmaceuticals as well as radioactive waste; and
- Disposal of radio nuclides, unused radio pharmaceuticals, and radioactive waste,
- To ensure periodic inspections of equipment,
  - Make sure problems are corrected in timely manner and have evidence of inspections and corrective actions

Radiology Policies 1030

- There must be written policies developed and approved by the medical staff to designate which radiological tests must be interpreted by a radiologist,
- MR chapter standards apply
- Make sure patient shielding aprons are maintained properly and inspected
- Surveyor will review equipment maintenance reports (PM)
- Make sure staff know P&Ps

Radiology Policies 1030

- Supervision must ensure that all files, scans, and images are kept in a secure place and are retrievable,
- Written policy, consistent with state law on which personnel can operate radiology equipment and do procedures,
- Need copies of all reports and printouts,
- Written policy to ensure integrity of authentication,
- See tag 1030 for required signage on hazardous radiation areas and more

Tag 1030 Blue Box Advisory

Information Only – Not Required/Not to be Cited

Well-designed radiologic services include a medical physicist, who, in conjunction with the person responsible for radiologic services, performs or supervises the pertinent procedures necessary to assure the safe and effective delivery of radiation to achieve a diagnostic or therapeutic result. The responsibilities of the medical physicist include: protection of the patient and others from potentially harmful or excessive radiation; establishment of adequate protocols to ensure accurate patient dosimetry; the measurement and characterization of radiation; the determination of delivered dose; advancement of procedures necessary to ensure image quality; development and direction of quality assurance programs; and assistance to other health care professionals in optimizing the balance between the beneficial and deleterious effects of radiation (www.aapm.org). CAHs are encouraged to involve a medical physicist in the calibration of the imaging equipment and monitoring of radiation dosage exposures.

Emergency Services and Contracted Services

Emergency Procedures 1032

- Must provide medical emergency services as a first response to common life threatening injuries and acute illness,
  - Emergency services can be done directly or through contracted services
  - Individuals providing the services must to be able to recognize a patient need for emergency care
  - Must provide medically appropriate initial interventions, treatment, and stabilization of any patient who requires emergency services

Agreements 1034

- CAH has to have agreements with one or more providers or suppliers participating under Medicare to furnish services to patients
- CMS made an exception since distant-site telemedicine entity (DSTE) is not required to be a Medicare provider
- Agreements such as for obtaining outside lab tests

Contracted Services 1036

- Must have agreement or arrangement with one or more providers or suppliers participating under Medicare to provide services to patients
- Arrangement or agreement with 1 or more doctors to provide care
- If referral agreement is not in writing then can show that doctors are accepting patients when referred (given appointments and seen)
- Need P&P for referring patients it discharges who need additional care

Lab & Diagnostic Services 1038

- Lab or diagnostic services that are not available at the CAH
  - Want to have an agreement with 1 or more other providers
  - Want to be sure referred patients are accepted and treated
- Need to make sure basic lab services are available to ensure an immediate diagnosis and treatment
  - Staff can provide services or can contract for services

Contracted Services

- Need to have agreement with a lab that can provide additional or specialized lab tests
  - CAH draws and sends tests out
  - Required to have P&P on this
  - If labs that provide additional diagnosis and clinical lab services must be in compliance with CLIA and lab will be surveyed separately for compliance,
- CAH needs evidence that the outside lab has a CLIA certificate or waiver
- Same is true of radiology services and if done outside make sure CAH gets copy of report

Contracted Services Food 1040

- CAH can provide food and other services to meet inpatient's nutritional needs
- Or CAH can contract out this service
  - If contracted out make sure they are aware of the CMS food service requirements and assess through QAPI process to ensure compliance with the contract also
- Must still make sure patient nutritional needs are met
- Dietary services must be provided as per the P&P

Contracted Services 1042

- **Need to keep list** of all services provided under contract or agreement
  - Try and keep contracts in one place
  - Must include service offered, individual or entity that is providing it, and whether on or off-site
  - Must include if any limit on the volume or frequency of the services provided
  - Must include when the services are available
  - Update list each time services added or removed
  - Ensure the contractor meets the requirements in the contract and the performance indicators

Contracted Services 1044

- CEO is responsible for operation of all patient services furnished in the CAH
  - This includes those performed directly or by contract
  - Must take action to ensure this
- It includes not only care provided directly to patient but also services related to patient care
  - Housekeeping, instrument cleaning and sterilization, laundry, pharmacy services, lab, interpreters, security, dialysis, food service etc.

Rehab

Rehab Therapy 1052

- Standard: Rehab services are provided by qualified staff
  - Included PT, OT, and speech-language pathology
- Rehab is an optional service
  - Can be provided directly or through contracted services
- Must have an order, P&P, and be consistent with the SOC (American PT Association, American OT Association etc.)
- Must follow the rehab plan of care requirements and be consistent with the state law

Rehab Plan of Care (POC) Requirements

- Must do POC before treatment is started
  - Can be done by MD/DO, PA, NP, CNS,
  - Can be done by PT, speech-language pathologist, or OT who is furnishing the service
- The POC must
  - Prescribe the type, amount, frequency, and duration
  - Must indicate the diagnosis and anticipated goal
- Any change in plan must be in accordance with provider's P&P

Visitation

Visitation 1054

- Must have P&P and process on visitation
  - Including any reasonable restrictions or limitations
- Discusses JAMA article encouraging open visitation in the ICU
- Includes inpatients and outpatients
  - Discusses role of support person for both
  - Patient may want support person present during pre-op preparation or post-op recovery

Reasonable Restrictions 1054

- Infection control issues
- Can interfere with the care of other patients
- Court order restricting contact
- Disruptive or threatening behavior
- Room mate needs rest or privacy
- Substance abuse treatment plan
- Patient undergoing care interventions
- Restriction for children under certain age

Visitation 1054

- Need to train staff on the P&P
- Need to determine role staff will play in controlling visitor access
- Surveyor will verify you have a P&P
- Will review policy to determine if restrictions
- Is there documentation staff is trained?
- Will make sure staff are aware of P&P on visitation and can describe the policy for the surveyor

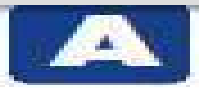
Visitation 1056

- Must inform each patient or their support person, when appropriate, of their visitation rights
- Must include notifying patient of any restrictions
- Patient gets to decide who their visitors are
- Can not discriminate against same sex domestic partners, friend, family member etc.
- The patient gets to decide

Visitation 1056

- Support person does not have to be the same person as the DPOA
- Support person can be friend, family member or other individual who supports the patient during their stay
  - TJC calls it a patient advocate
- Support person can exercise patient's visitation rights on their behalf if patient unable to do so

TJC Help Prevent Errors in Your Care



sk a trusted family member or friend to be your advocate (advisor or supporter).

- Your advocate can ask questions that you may not think about when you are stressed. Your advocate can also help remember answers to questions you have asked or write down information being discussed.
- Ask this person to stay with you, even overnight, when you are hospitalized. You may be able to rest better. Your advocate can help make sure you get the correct medicines and treatments.
- Your advocate should be someone who can communicate well and work cooperatively with medical staff for your best care.
- Make sure this person understands the kind of care you want and respects your decisions.
- Your advocate should know who your health care proxy decision-maker is; a proxy is a person you choose to sign a legal document so he or she can make decisions about your health care when you are unable to make your own decisions. Your advocate may also be your proxy under these circumstances. They should know this ahead of time.
- Go over the consents for treatment with your advocate and health care proxy, if your proxy is available, before you sign them. Make sure you all understand exactly what you are about to agree to.
- Make sure your advocate understands the type of care you will need when you get home. Your advocate should know what to look for if your condition is getting worse. He or she should also know who to call for help.

www.jointcommission.org/speak_up_help_prevent_errors_in_your_care/

Visitation 1056

- Hospital must accept patient's designation of an individual as a support person
  - Either orally or in writing
  - Suggest you get it in writing from the patient
- When patient is incapacitated and no advance directives on file then must accept individual who tells you they are the support person
  - Must allow person to exercise and give them notice of patients rights and exercise visitation rights

Visitation 1056

- Hospital expected to accept this unless two individuals claim to be the support person then can ask for documentation
  - This includes same sex partners, friends, or family members
  - Need policy on how to resolve this issue
- Any refusal to be treated as the support person must be documented in the medical record along with specific reason for the refusal

Visitation 1056

- Patient can withdraw consent and change their mind
- Must document in the medical record that the notice was given
- Surveyor is to look at the standard notice of visitation rights
- Will review medical records to make sure documented
- Will ask staff what is a support person and what it means

Visitation 1058

- Must have written P&P
- Must not restrict visitors based on race, color, sex, gender identify, sexual orientation etc.
- In other words, if a unit is restricted to two visitors every hour the patient gets to pick their visitors not the hospital
- Suggest develop culturally competent training programs

CMS Hospital Improvement Rule

Medical Records

Changes by CMS

- CMS final changes to the hospital CoP
- Patient has a right to access medical records upon an oral or written request
- OCR now fining hospitals if you do not provide patient timely access to medical records
- Can get in hard copy or electronic form
- Right to access within a reasonable amount of time
- Discusses 2 2016 OCR documents
- Document HAI, HACs, and complications

Copy of New Law 201 Pages

This document is scheduled to be published in the Federal Register on 09/30/2019 and available online at **https://federalregister.gov/d/2019-20732**, and on **govinfo.gov**

BILLING CODE 4120-01-P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 482, 484, and 485

[CMS-3317-F and CMS-3295-F]

RIN 0938-AS59

www.federalregister.gov/documents/2019/09/30/2019-20732/medicare-and-medicaid-programs-revisions-to-requirements-for-discharge-planning-for-hospitals

Medicare and Medicaid Programs; Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule empowers patients to be active participants in the discharge planning process and complements efforts around interoperability that focus on the seamless exchange of patient information between health care settings by revising the discharge planning requirements that Hospitals (including Short-Term Acute-Care Hospitals, Long-Term Care Hospitals (LTCHs), Rehabilitation Hospitals, Psychiatric Hospitals, Children's Hospitals, and Cancer Hospitals), Critical Access Hospitals

Patient Rights

- The CoPs are amended to ensure that the patient has a right of access to their medical records
  - Note the OCR requirements on the difference between a patient request for records and an authorization
  - CMS mentions many hospitals are not aware of the OCR rules
  - Note that the federal HIPAA already has this requirement so hospitals probably already have a policy to this effect

Patient Rights

- Patient has a right of access to their **current** medical records within a reasonable time
  - Hospitals will need to update medical records policy
  - Hospitals will need to educate nurses, doctors, and other staff
  - Hospitals will want to have a process for patients who want to review their current medical records since most are electronic health records
- Upon oral or written request
  - Most hospitals will have the patient sign the request for records in writing

Patient Rights

- Patients have the right to get their records in the form and format they request
  - If the records are electronic then on a flash drive, CD, email, etc
  - If paper medical records then a paper copy
  - Discusses as agreed to by the hospital and patient or patient representative
  - If records not available in the form requested by the patient (not electronic) then a hard copy must be provided

Access to Medical Records

- Patients have a right to get their records timely
  - HIPAA says 30 days unless stored off site then 60 days
  - Remember, state law can be more stringent
- They have a right to get their entire medical record
- Patients can request a specific portion of the records
- The medical record must include the discharge planning documents

Patient Rights

- Interestingly enough, CMS says with the use of technology today they expect the hospital to fill the request in far fewer than 30 days
- CMS says hospital cannot frustrate efforts of patients to get their medical records
- This section overlaps with requirements from the OCR or Office of Civil Rights
- CMS noted in the proposed rules that many hospitals were not aware of the OCR lengthy memo on access to records issued January of 2016

OCR Issues

Individuals' Right under HIPAA to Access their Health Information 45 CFR § 164.524

Newly Released FAQs on Access Guidance

New Clarification – $6.50 Flat Rate Option is Not a Cap on Fees for Copies of PHI

www.hhs.gov/hipaa/for-professionals/privacy/guidance/access/index.html#newlyreleasedfaqs

Introduction

Providing individuals with easy access to their health information empowers them to be more in control of decisions regarding their health and well-being. For example, individuals with access to their health information are better able to monitor chronic conditions, adhere to treatment plans, find and fix errors in their health records, track progress in wellness or disease management programs, and directly contribute their information to research. With the increasing use of and continued advances in health information technology, individuals have ever expanding and innovative opportunities to access their health information electronically, more quickly and easily, in real time and on demand. Putting individuals "in the driver's seat" with respect to their health also is a key component of health reform and the movement to a more patient-centered health care system.

The regulations under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), which protect the privacy and security of individuals' identifiable health information and establish an array of individual rights with respect to health information, have always recognized the importance of providing individuals with the ability to access and obtain a copy of their health information. With limited exceptions, the HIPAA Privacy Rule (the Privacy Rule) provides individuals with a legal, enforceable right to see and receive copies upon request of the information in their medical and other health records maintained by their health care providers and health plans.

OCR Rights of Patients

- OCR issued a FAQ on cost and access to medical records in February of 2016 which was amended in 2017
- Patients who do not get their records timely can file a complaint with OCR
- One in every 10 complaints is related to not getting records or not getting them timely
- OCR is now fining hospitals who fail to get patients their records timely and their first fine was $85,000 for a hospital

Feds Levy First-Ever Fine to Hospital for Not Sharing Patient Records

Ken Terry
September 11, 2019

www.medscape.com/viewarticle/918173

Bayfront Health St. Petersburg, in Florida, has paid $85,000 to settle a government complaint that it failed to give a mother timely access to records about her unborn child.

The hospital also adopted a corrective action plan to ensure that all patients have access to their records in the future. This is the first enforcement action and settlement under the Right of Access Initiative of the US Department of Health and Human Services' Office for Civil Rights (OCR), according to a news release.

OCR, which enforces the Health Insurance Portability and Accountability Act (HIPAA), initiated its investigation on the basis of a complaint from the mother. As a result, the news release said, Bayfront provided her with the requested health information more than 9 months after her initial request.

The resolution agreement between the OCR and Bayfront states that the mother first submitted a written request to the hospital for fetal heart monitor records on October 18, 2017. Bayfront told her that the records could not be found. Early in 2018, the complainant's attorney requested the records again.

OCR Settles First Case in HIPAA Right of Access Initiative

www.hhs.gov/about/news/2019/09/09/ocr-settles-first-case-hipaa-right-access-initiative.html

Today, the Office for Civil Rights (OCR) at the U.S. Department of Health and Human Services is announcing its first enforcement action and settlement in its Right of Access Initiative. Earlier this year, OCR announced this initiative promising to vigorously enforce the rights of patients to receive copies of their medical records promptly and without being overcharged.

Bayfront Health St. Petersburg (Bayfront) has paid $85,000 to OCR and has adopted a corrective action plan to settle a potential violation of the right of access provision of the Health Insurance Portability and Accountability Act (HIPAA) Rules after Bayfront failed to provide a mother timely access to records about her unborn child. Bayfront, based in St. Petersburg, Florida, is a Level II trauma and tertiary care center licensed as a 480-bed hospital with over 550 affiliated physicians.

OCR initiated its investigation based on a complaint from the mother. As a result, Bayfront directly provided the individual with the requested health information more than nine months after the initial request. The HIPAA Rules generally require covered health care providers to provide medical records within 30 days of the request and providers can only charge a reasonable cost-based fee. This right to patient records extends to parents who seek medical information about their minor children, and in this case, a mother who sought prenatal health records about her child.

"Providing patients with their health information not only lowers costs and leads to better health outcomes, it's the law," said OCR Director Roger Severino. "We aim to hold the health care industry accountable for ignoring peoples' rights to access their medical records and those of their kids."

In addition to the monetary settlement, Bayfront will undertake a corrective action plan that includes one year of monitoring by OCR. The resolution agreement and corrective action plan may be found at: https://www.hhs.gov/hipaa/for-professionals/compliance-enforcement/agreements/bayfront/index.html

OCR Rights of Individual Patients

- OCR has document on patient rights under HIPAA to access their health information
- CMS notes many hospitals are not aware of this
  - Patients have a right of access to their information
  - Includes right to inspect medical records
  - Can allow email to make requests or fax
  - Would need to verify the identity of the patient
  - Can not require person to come in person to request records
  - Can’t require patient to mail you the authorization

OCR Rights of Individual Patients

- Patient can request a paper or electronic copy
- Must send to patient within 30 days of request
- A 30 day extension is available if archived offsite and not readily accessible
- Can charge for records but no retrieval fee
- Discusses the reasons when a hospital may deny the request
- Can request copies of x-rays
- Can’t refuse to give copies because hospital bill not paid

Second FAQ Feb 2016 and Updated 2017

HHS.gov

U.S. Department of Health & Human Services

About HHS | Programs & Services | Grants & Contracts | Laws & Regulations

- Grants and Contracts (1)
- Health Care (158)
- Health Data (9)
- Health IT (1)
- HHS Administrative (9)
- HIPAA (5)
- Holidays and Observances (85)
- Medicare and Medicaid (13)
- Mental Health and Substance Abuse (15)
- Prevention and Wellness (100)
- Programs for Families and Children (34)
- Public Health and Safety (62)
- Research (11)

New HIPAA guidance reiterates patients' right to access health information and clarifies appropriate fees for copies

February 25, 2016 | *By: Jocelyn Samuels, Director, Office for Civil Rights*

Summary: Today's second set of FAQs addresses fees for copies of health information and the right to have health information sent directly to a third party.

The President's Precision Medicine Initiative prioritizes the ability of any American to participate in scientific research by individually donating their health information. This can only be made possible by robust access to patient data. At the Office for Civil Rights (OCR), we believe strongly that every individual should be able to easily exercise their right to access their health information, allowing them to be fully engaged in their care and empowered to make the health care decisions that are right for them. The HIPAA Privacy Rule has always provided individuals with the right to access and receive a copy of their health information from their providers, hospitals, and health insurance plans. But this right has not always been well-understood, and far too often individuals face obstacles accessing their health information, even from entities required to comply with HIPAA.

Last month we took an important step toward removing those obstacles by issuing a comprehensive fact sheet and the first in a series of topical frequently asked questions (FAQs) addressing patients'

www.hhs.gov/blog/2016/02/25/new-hipaa-guidance-accessing-health-information-fees-copies.html#

AHIMA Model Release Form

Patient Request for Health Information

Patient Information (Please Print)

First Name:	Middle Initial:	Last Name:	
Name at Time of Treatment (if different than above):			
Date of Birth (MM/DD/YYYY):	Phone:	E-mail (optional):	
Street Address:	City:	State:	Zip:

What records do you want? (Check appropriate boxes below):

Date(s) of Service: ____/____/____ through ____/____/____

☐ Discharge Summary ☐ Emergency Room Records ☐ Operative/Procedure Reports ☐ Billing Records

☐ Test Results (X-Rays, Lab/Pathology Results) Please specify: _____

☐ Other (Immunization Records, Medication Lists) Please specify: _____

How would you like your records delivered?

☐ Paper

- ☐ Home Delivery
- ☐ In-Person Pickup

☐ Electronic (Email, USB, CD, Portal, Other) Please specify: _____

Where do you want the information sent? (Fill in boxes below):

ORGANIZATION NAME should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

Recipient Name:	Recipient Phone: Recipient Fax:
Recipient Mailing Address:	Recipient E-mail (if applicable):

HIPAA Access versus Authorization

- Based on the OIG Access Guidance to clarify a misunderstanding on the patient's right to access
- **Access** request- the hospital may require a written, signed request by the patient under the access rule
  - It must identify the designated person and where to send the PHI
  - HHS says you cannot require them to sign an authorization form when the access rule applies
  - The fee limitation applies
  - Time frame applies such as 30 days with exception
  - Disclosures under the access rule are mandatory

The CMS Hospital CoPs on Medical Records

(Clinical Records)

Medical Records 1102

Must maintain clinical records system in accordance with P&Ps,

- Must have a system of patient records, ways to identify the author and protect security of MR,
- Must be sure MR are not lost, stolen, or altered or reproduced in authorized manner,
- Limit access to only those authorized persons,
- HIPAA is important and the OCR has been issuing heavy penalties for violation of privacy and security,

Medical Records 1102

- Must have current list of authenticated signatures (like signature cards),
- And computer codes and signature stamps,
- Must be adequately protected and authorized by governing body,
- Must cross reference inpatients and outpatients,
- If transfer to swing bed can use one MR but need divider,

Medical Record 1102

Both inpatient and swing bed must have MR;

- Admission, discharge orders, progress notes, nursing notes, graphics, laboratory support documents, any other pertinent documents, and discharge summaries,
- Must retain MR and file them,

Medical Records 1102

- Must have system to be able to pull any old MR within past **6 years,**
- 24 hours a day and 7 days a week,
  - Inpatient or outpatient,
- Surveyor will verify there is a MR for every patient,
- Will look to be stored in place protected from damage, flood, fire, theft, etc.,
- Must protect confidentiality of MR,
- MR must be adequately staffed,

Medical Records

- Must be legible, complete, accurate, readily accessible and systematically organized (1104)
- To ensure accurate and complete documentation of all orders, test results, evaluations, treatments, interventions, care provided and the patient's response to those treatments, interventions and care.
- Must have director of MR that has been appointed by governing board (1106)
  - Must have one unified MR service
  - Includes inpatient and outpatient records

Medical Records 1110

MR must contain:

- Identification and social data,
- Evidence of properly executed informed consent forms,
- Pertinent medical history,
- Assessment of the health status and health care needs of the patient,
- Brief summary of the episode, disposition, and instructions to the patient;

Informed Consent 1110

- Include evidence of properly executed informed consent forms for any procedures or surgical procedures,
- Specified by the medical staff,
- Any Federal or State laws that require written patient consent,
- Informed consent means the patient or patient representative is given the information, explanations, consequences, and options needed in order to consent to a procedure or treatment
- See tag 1140

Consider List of Procedures

Procedure Name	Requires Consent
Ablations	Yes
Amniocentesis	Yes
Angiogram	Yes
Angiography	Yes
Angioplasties	Yes
Arthrogram	Yes
Arterial Line insertion (performed alone)	Yes
Aspiration Cyst (simple/minor)	No

Consider List of Procedures

Aspiration Cyst (complex)	Yes
Blood Administration	Yes
Blood Patch	Yes
Bone Marrow Aspiration	Yes
Bone Marrow Biopsy	Yes
Bronchoscopy	Yes
Capsule Endoscopy	Yes
Catherizations, Cardiac & vascular	Yes
Cardioversion	Yes

Informed Consent 1110

- A properly executed consent form contains at least the following:
  - Name of patient, and when appropriate, patient's legal guardian;
  - Name of CAH;
  - Name of procedure(s);
  - Name of practitioner(s) performing the procedures(s);
  - Signature of patient or legal guardian;

Consent Form Must Include

- Date and time consent is obtained;
- Statement that procedure was explained to patient or guardian;
- Signature of professional person witnessing the consent;
- Name/signature of person who explained the procedure to the patient or guardian.

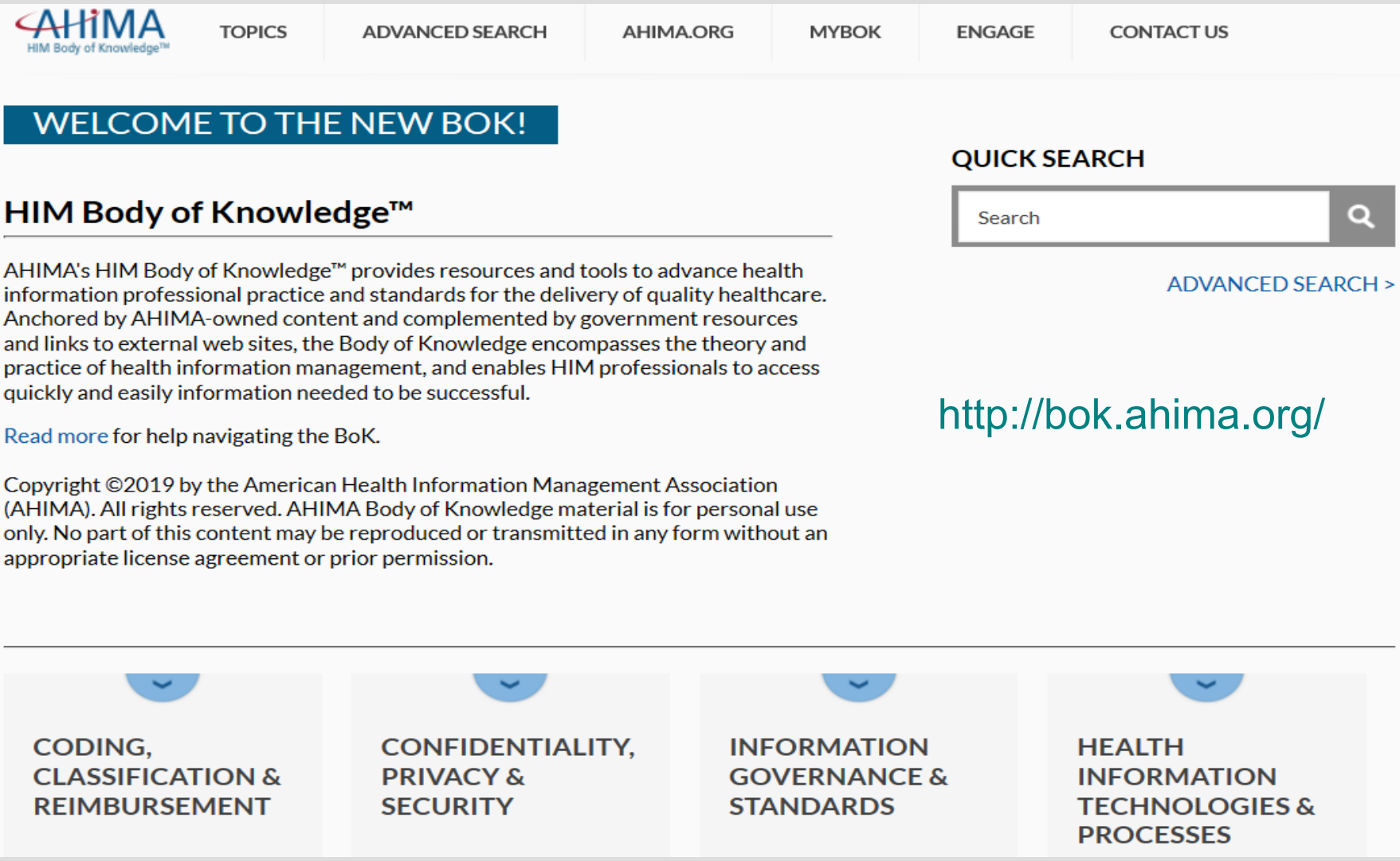
Medical Records 1110

- MR must contain information such as progress and nursing notes, medical history, documentation, records, reports, recordings, test results, assessments etc. to:
  - Justify admission;
  - Describe the patient's progress and support the diagnosis;
  - Describe the patient's response to medications; and
  - Describe the patient's response to services such as interventions, care, treatments,

Medical Records

- Must maintain confidentiality of records,
- What precautions are taken to ensure confidentiality and prevent unauthorized persons from gaining access,
- MR retention period is 6 years and longer if required by state,
- When can records be removed ?
- AHIMA has practice briefs that can be helpful to hospitals at www.ahima.org,

AHIMA Body of Knowledge



http://bok.ahima.org/

AHIMA Practice Briefs

Best Practices for Denials Prevention and Management

Author: AHIMA

Source: AHIMA practice brief

Publication Date: March 2019

http://bok.ahima.org/searchresults?q=&fs=source_facet|AHIMA+practice+brief

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Clinical Validation: The Next Level of CDI (January 2019 Update)

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Best Practices in the Art and Science of Clinical Documentation Improvement (2018 Update)

Author: AHIMA

Source: Journal of AHIMA | AHIMA practice brief

Publication Date: January 2019

Discharge Summary 1110

A discharge summary discusses:

- The outcome of the CAH stay,
- The disposition of the patient,
- Follow-up care (any post appointments such as home health, hospice, assisted living, LTC, swing bed services),
- Is required for all hospitals stays and prior to and after swing bed admission,
- Can delegate to NP or PA if state allows,
- See discharge planning standards,

Discharge Summary 1110

- Surveyor will verify MS have specified which procedures or treatments need informed consent,
- Surveyor will verify consent forms contain all the elements,
- Will do review of closed and open MR-at least 10% of average daily census,
  - Will look to make sure records are complete and accurate
- Make sure consent policies include not only CMS requirements but state laws and your accreditation organization standards

Discharge Summary

- Recommendations to avoid unnecessary readmissions;
  - Make the appointment for the patient with the PCP before discharge
  - Dictate the discharge summary as soon as patient is discharge
  - Hospital has the responsibility to get the discharge summary or medical record information into the hands of the PCP before the first visit
  - Make appointment within 4 days after discharge

History and Physicals 1114

- All or part of H&P may be delegated to other practitioners if allowed by state law and CAH such as NP or PA (see also tag 1118 and 1140),
- However MD/DO assume full responsibility,
  - MD/DO must sign also,
- Surveyor will look at bylaws to determine when H&P must be done,
- Make sure H&P on chart before patient goes to surgery unless an emergency
  - Important issue with CMS and TJC and AO
  - Exception for healthy outpatients not needing H&P does not apply to CAHs

Questions Answered by CMS

- Question: Does a patient need an H&P done when placed in a swing bed when one was done when they were in an acute care bed?
  - The patient does not require an additional H&P when he/she “swings” from receiving acute care services in the CAH to now receiving SNF level services in the CAH.
  - If from another facility, you must have a H&P done if admitted directly to a swing bed
- Question: Is an H&P required for an observation patient?
  - Yes

Response to Treatment 1116

- The following must describe the patient's response to treatment;
  - All orders must be documented,
  - Reports of treatment and medications,
  - Nursing notes,
  - Documentation of complications,
  - Other information used to monitor the patients such as progress notes, lab tests, graphics,

Medical Records 1116

- Standard: Must make sure MR get filed promptly,
- All MR must contain all lab reports,
- Radiology reports,
- All vital signs,
- All reports of treatment include complications and hospital acquired infections (HACs),
  - Including healthcare associated infections (HAI)
- All unfavorable reaction to drugs,
- Diagnosis, treatments, tests, and interventions must be documented

Entries in the MR 1118

- All entries must be DATED, TIMED, and authenticated or sign off each order,
  - MD/DO must sign off H&P done by PA or NP
  - MS defines if any orders have to be co-signed
- Only those specified in the Medical Staff (MS) P&P can write in the MR,
- If rubber stamps used-person must sign they will be the only one who uses it,
  - Just DON'T use rubber stamps
  - Must have sanctions for improper use of stamp, computer key or code signature,
- Must date and time when a verbal order is signed off,

Confidentiality of MR 1120

- Must maintain confidentiality of information,
  - Access to information limited to those who need to know,
  - Safeguard MR, videos, and audio,
  - Safeguard against loss or destruction
- Will verify only authorized people can access MR contained in MR department
  - Which many call Health Information Management (HIM)
- Need to release only with written authorization of patient or authorized representative,

MR Policies 1122

- Need written P&P that govern the use and removal of MR,
- Need to have a system to ensure security of the medical records
  - Need safeguards for EHRs
- To include the conditions of release of information,
- Remember the federal HIPAA law on MR confidentiality and privacy, ARRA, HITECH, and the breach notification law,
- Written consent of patient required to release (1124),

Retention of MR 1126

- Records are retained for at least **6** years from date of last entry,
- Longer if required by State or federal law (OSHA, FDA, EPA),
  - Or if the records may be needed in any pending proceeding,
- Can be in hard copy, microfilm or computer memory banks,
- AHIMA has practice brief on retention periods which ties in with the destruction policies,

Retention & Destruction Updated 10/15/2013

AHIMA HIM Body of Knowledge™

http://bok.ahima.org/doc?oid=300217#.XkgnkjZ8CuU

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Retention and Destruction of Health Information

*Editor's note: This update **supersedes** the August 2011 practice brief "Retention and Destruction of Health Information."*

Health information management professionals traditionally have performed retention and destruction functions using all media, including paper, images, optical disk, microfilm, DVD, and CD-ROM. The warehouses or resources from which to retrieve, store, and maintain data and information include, but are not limited to, application-specific databases, diagnostic biomedical devices, master patient indexes, and patient medical records and health information. To ensure the availability of timely, relevant data and information for patient care purposes; to meet federal, state, and local legal requirements; and to reduce the risk of legal discovery, organizations must establish appropriate retention and destruction schedules. This practice brief provides guidance on record retention standards and destruction of health information for all healthcare settings.

Records Retention

The life cycle of records management begins when information is created and ends when the information is destroyed. The picture below provides a simple reflection of the entire records retention process. The goal for organizations is to manage each step in the record life cycle to ensure record availability. The creation of information is easy to establish, and most organizations do not have concerns when creating or using information. However, when maintaining information, various issues may arise.

Practice Briefs

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Author: AHIMA

Source: Journal of AHIMA | AHIMA practice brief

Publication Date: January 2019

Practice Brief: Ensuring the Integrity of the EHR

Author: AHIMA

Source: AHIMA practice brief

Retention & Destruction

Retention and Destruction of Health Information (Updated 201

Appendix C: AHIMA's Recommended Retention Standards

Health Information	Recommended Retention Period
Diagnostic images (such as x-ray film) (adults)	5 years
Diagnostic images (such as x-ray film) (minors)	5 years after the age of majority
Disease index	10 years
Fetal heart monitor records	10 years after the age of majority
Master patient/person index	Permanently
Operative index	10 years
Patient health/medical records (adults)	10 years after the most recent encounter
Patient health/medical records (minors)	Age of majority plus statute of limitations
Physician index	10 years
Register of births	Permanently
Register of deaths	Permanently
Register of surgical procedures	Permanently

AHIMA Sample Destruction Form

Facility Name

The information described below was destroyed in the normal course of business pursuant to a proper retention schedule and destruction policies and procedures.

Date of destruction:_____

Description of records or record series disposed of:

_____

_____

Inclusive dates covered:_____

Method of destruction:

( ) Burning ( ) Shredding ( ) Pulping ( ) Demagnetizing

( ) Overwriting ( ) Pulverizing ( )

Other:_____

Records destroyed by:_____

Witness signature:_____

Department manager:_____

Note: This sample form is provided for discussion purposes only. It is not intended for use without advice of legal counsel.

Federal and State Retention Periods

Practice Brief—Retention of Health Information (updated)

Table 3: Federal Record Retention Requirements

Type of Documentation	Retention Period	Citation/Reference
Abortions and related medical services documentation	Maintained for three years.	42 CFR 36.56 42 CFR 50.309
Ambulatory surgical services	Retention periods are not specified.	42 CFR 416.47
Clinics, rehabilitation agencies, and public health agencies as providers of outpatient physical therapy and speech-language pathology services	As determined by the respective state statute, or the statute of limitations in the state. In the absence of a state statute, five years after the date of discharge; or in the case of a minor, three years after the patient becomes of age under state law or five years after the date of discharge, whichever is longer.	42 CFR 485.721(d) 42 CFR 486.161(d)
Clinics, rural health	Six years from date of last entry and longer if required by state statute.	42 CFR 491.10(c)
Competitive medical plans (see HMOs, competitive medical plans, healthcare prepayment plans)		
Comprehensive outpatient rehabilitation facilities (CORFs)	Five years after patient discharge.	42 CFR 485.60(c)
Critical access hospitals (CAHs)	Six years from date of last entry, and longer if required by state statute, or if the records may be needed in any pending proceeding.	42 CFR 485.638(c)
Department of Veterans Affairs—Diagnostic and operation index file	Destroy monthly listing after receipt of consolidated biannual listing.	Records Control Schedule (RCS)10-1, Section XXII—Medical Administration

Surgery

Surgical Procedures 1140

- Standard: If a CAH provides surgical services it must be performed in a safe manner,
  - By qualified practitioner with clinical privileges,
- What does safe manner mean?
- The equipment and supplies are sufficient so the type of surgery can be performed safely,
- Surgery dept must be organized and staffed if you have one,

Surgical Services 1140

- Must follow state and federal laws,
- Must follow standards of practice and recommendations by national recognized organizations (AMA, ACOS, APIC, AORN),
- Quality of outpatient surgical services must be consistent with inpatient,
- Scope of surgical services must be writing and approved by MS,
- OR must be supervised by experienced staff member, address qualifications of supervisor of OR rooms in P&P,

Surgical Procedures 1140

- If LPN or OR tech used as scrub nurses then must be under RN who is immediately available to physically intervene,
- There are also a number of policies and procedures that need to be in place.
- AORN have many resources to help meet CMS and TJC requirements
  - Now called Guidelines for Perioperative Practice
- Must wear clean surgical attire that covers hair

Surgery Policies 1140

- Aseptic surveillance and practice, including scrub techniques
- Identification of infected and non-infected cases
- Housekeeping requirements/procedures
- Patient care requirements
  - Preoperative work-up
  - Patient consents and releases
  - Clinical procedures
  - Safety practices
  - Patient identification procedures

Surgery Policies 1140

- Duties of scrub and circulating nurse,
- Safety practices,
- The requirement to conduct surgical counts in accordance with accepted standards of practice,
- Scheduling of patients for surgery,
- Personnel policies unique to the OR,
- Resuscitative techniques,
- DNR status,
- Care of surgical specimens,
- Malignant hyperthermia,

Surgery Policies 1140

- Appropriate protocols for all surgical procedures performed.
  - These may be procedure-specific or general in nature and will include a list of equipment, materials, and supplies necessary to properly carry out job assignments.
- Sterilization and disinfection procedures
- Acceptable operating room attire
- Handling infections and biomedical/medical waste

Pre-Operative H&P 1140

- Complete H&P must be done in accordance with acceptable standards of practice,
- All or part may be delegated to other practitioners (like PA or NP) if allowed by your state law and CAH,
- Surgeon must sign and assumes full responsibility,
  - See tag 1118
- H&P changes under Appendix A does **not** apply to CAH which allows a pre-sedation assessment, instead of a H&P, for healthy outpatients who are having outpatient surgery

H&P 1140

- Need to have H&P on the chart PRIOR to surgery,
- An exception is an emergency and then need brief admission note on chart,
- Note should include at a minimum critical information about the patient's condition including pulmonary status, cardiovascular status, BP, vital signs, etc.

Informed Consent 1140

- This includes all inpatient and outpatient,
- Is informed of who will actually perform the surgery (no ghost surgery),
- Must inform patient if practitioner other than the primary surgeon will perform important parts of the surgical procedure,
  - EVEN if it is under the primary surgeon's supervision,

Informed Consent 1140

Consent must include:

- Name of patient or their legal guardian,
- Name of hospital (CAH),
- Name of specific procedure,
- Name of person doing the procedure or important parts of the procedure other than primary surgeon,
- Significant surgical tasks include: opening and closing, harvesting grafts, dissecting tissue, removing tissue, implanting devices and altering tissue,

Informed Consent 1140

- Nature and purpose of proposed treatment, Risks, consequences if no treatment is rendered, alternative procedures or treatments, probability that proposed procedure would be successful
- Signature of patient or guardian,
- Date and time consent obtained,
- Statement that procedure explained to the patient or guardian,
- Signature of professional person witnessing the consent (proposal to change to only witness and they are witness to signature only),
- Name of person who explained procedure,

Informed Consent 1140

- Must disclose information to patient necessary to make a decision,
- It is a process and not a form,
- Authorization form signed by a patient who does not understand what he is signing is not informed consent,
- Given in language patient can understand (interpreter and issue of health care literacy),
- See tag 1110

PACU 1140

- Must be adequate provisions for immediate post-op care,
- Must be in accordance with acceptable standards of care (ASPAN),
- Separate room with limited access,
- P&P specify transfer requirements to and from PACU,
- PACU assessment includes level of activity, respiration, BP, LOC, patient color (Aldrete),
- If no PACU close observation by RN in patient's room,

OR Register 1140

- **Register will include;**
  - Patient's name, id number,
  - Date of surgery,
  - Total time of surgery,
  - Name of surgeons, nursing personnel, anesthesiologist,
  - Type of anesthesia,
  - Operative findings, pre-op and post-op diagnosis, age of patient,

Operative Report Must Include 1140

- Name and id of patient,
- Date and time of surgery,
- Name of surgeons, assistants,
- Pre-op and post-op dx,
- Name of procedure,
- Type of anesthesia,
- Complications and description of techniques and tissue removed,
- Grafts, tissue, devises implanted,
- Name and description of significant surgical tasks done by others (see list-opening, closing, harvesting grafts,

Surveyor in OR 1140

- Will verify access to OR and PACU is limited,
- That there is appropriate cleaning between surgical cases and appropriate terminal cleaning applied;
- That operating room attire is suitable for the kind of surgical case performed,
- That persons working in the operating suite must wear only clean surgical costumes,
  - AORN has a position statement on this

Surveyor in OR 1140

- That equipment is available for rapid and routine sterilization of OR materials,
  - Called Immediate Use Steam Sterilization
- Equipment is monitored, inspected, tested, and maintained by the CAH'S biomedical equipment program,
- Sterilized materials are packaged, handled, labeled, and stored in a manner that ensures sterility e.g., in a moisture and dust controlled environment,
- **P&P on expiration dates** is followed,

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

Center for Clinical Standards and Quality /Survey & Certification Group

Ref: S&C: 14-44-Hospital/CAH/ASC

DATE: **August 29, 2014**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Change in Terminology and Update of Survey and Certification (S&C) Memorandum 09-55 Regarding Immediate Use Steam Sterilization (IUSS) in Surgical Settings

Memorandum Summary

- ***Change in Terminology: "Flash" Sterilization vs. IUSS:*** Nationally recognized organizations with expertise in infection prevention and control and instrument sterilization processes, and other professional organizations recommend abandoning the use of the term "flash" sterilization, which is now considered outmoded, and replacing it with the term "IUSS."

- ***Update of S&C Memorandum 09-55 Regarding Standards for Immediate Use Sterilization in Surgical Settings:*** This memo reiterates and updates information regarding nationally recognized infection prevention and control guidelines and professionally acceptable standards of practice with respect to immediate use sterilization and supersedes S&C Memorandum 09-55.

Surveyor in OR 1140

- OR organizational chart show lines of authority and delegation within the dept,
- Make sure have the following:
- On-call system (intercom),
- Cardiac monitor,
- Resuscitator, Defibrillator, Aspirator (suction equipment),
- **Tracheotomy** set (a cricothyroidotomy set is not a substitute),

Surgical Privileges 1142

- Standard: Must designate who is allowed to perform surgery,
  - Doctors, dentists, or podiatrists,
- Must conform to P&Ps,
- Must be within scope of practice laws,
- Review the list of physician privileges to determine if current,
- Surgical privileges updated every 2 years,
- Are procedures performed by appropriate physicians,

Surgical Privileges 1142

- Surgery service must maintain roster specifying the surgical privilege,
- Current list of surgeons suspended must also be retained,
- MS bylaws must have criteria for determining privileges,
- Surveyor will review written assessment of the practitioner's training, experience, health status, and performance.

Surgical Privileges 1142

- Surgical privileges are granted in accordance with the competence of each,
- MS appraisal procedure must evaluate each practitioner's training, education, experience, and competence,
- As established by the QAPI program, credentialing, adherence to hospital P&P, and laws,

Surgical Privileges 1142

- Must specify for each practitioner that performs surgical tasks including MD, DO, dentists, oral surgeon, podiatrists,
- RNFA, NP, surgical PA, surgical tech et. al.,
- Must be based on compliance with what they are allowed to do under state law,
- If task requires it to be under supervision of MD/DO this means supervising doctor is present in the same room working with the patient,

ANESTHESIA RECORD

Procedure

Date | OR No. | Page of | Surgeon(s)

	START	STOP
Anesthesia		
Procedure		

PRE-PROCEDURE

☐ Identified: ☐ ID Band ☐ Questioning
☐ Chart Reviewed ☐ Permit Signed
☐ NPO Since_____
Pre-Anesthetic State: ☐ Calm
☐ Awake ☐ Asleep
☐ Apprehensive ☐ Confused
☐ Uncooperative ☐ Unresponsive

PATIENT SAFETY

☐ Anes. Machine #_____ Checked
☐ Safety Belt On ☐ Axillary Roll
☐ Armboard Restraints ☐ Arms Tucked
☐ Pressure Points Checked and Padded
☐ **Eye Care:** ☐ Ointment ☐ Saline
☐ Taped ☐ Pads ☐ Goggles

MONITORS AND EQUIPMENT

☐ Steth: ☐ Precord ☐ Esoph ☐ Other
☐ Non-Invasive B/P: ☐ Left ☐ Right
☐ Continuous EKG ☐ V Lead EKG
☐ Pulse Oximeter ☐ Oxygen Sensor
☐ End Tidal CO_2 ☐ Gas Analyzer
☐ Temp._____ ☐ Nerve Simulator
☐ Warming Blanket ☐ EEG ☐ Doppler
☐ Airway Humidifier ☐ Fluid Warmer
☐ NG / OG Tube ☐ Foley Catheter
☐ Art. Line_____
☐ CVP_____
☐ PA Line_____
☐ IV(s)_____
☐ _____

ANESTHETIC TECHNIQUE

General: ☐ Pre-Oxygenation ☐ LTA
☐ Rapid Sequence ☐ Cricoid Pressure
☐ Intravenous ☐ Inhalation
☐ Intramuscular ☐ Rectal

Regional: ☐ Spinal ☐ Epidural
☐ Axillary ☐ Bier Block ☐ Ankle Block
☐_____ ☐ Position_____
☐ Prep_____ ☐ Local_____
☐ Needle_____
☐ Drug(s)_____
☐ Dose_____ ☐ Attempts x_____
☐ Site_____ ☐ Level_____
☐ Catheter_____ ☐ See Remarks

Other: ☐ MAC ☐ _____

AIRWAY MANAGEMENT

Intubation: ☐ Oral Tube size_____
☐ Stylet Used ☐ Nasal ☐ Regular
☐ Magill's ☐ Direct ☐ RAE
☐ Fiber Optic ☐ Blind ☐ Armored
☐ Blade_____ ☐ Laser
☐ Secured at_____cm ☐ Endobronch.
☐ Attempts x_____ ☐ ET CO_2 Present
☐ Breath Sounds_____
☐ Uncuffed, Leaks at_____cm H_2O
☐ Cuffed ☐ Min. Occ. Pres. ☐ Air ☐ NS

Airway: ☐ Oral ☐ LMA ☐ Nasal ☐ Difficult,
Circuit: ☐ Circle ☐ NRB See Remarks
☐ Mask Case ☐ Nasal Cannula
☐ Via Tracheostomy ☐ Simple O_2 mask

RECOVERY

Location		Time
B/P		O_2 Sat.
P	R	T

☐ Awake ☐ Stable ☐ Nasal Oxygen
☐ Drowsy ☐ Unstable ☐ Mask Oxygen
☐ Somnolent ☐ Intubated ☐ T-Piece Oxygen
☐ Unarousable ☐ Ventilator ☐ Oral/Nasal Airway

Recovery Notes

TIME:

FLUIDS / AGENTS

Oxygen (L/min) / ☐ N_2O ☐ Air (L/Min)															TOTALS
Urine (ml)															

FLUID TOTALS

Crystalloid_____	EBL_____
Blood_____	Urine_____

REMARKS

Anesthesia

Pre-Anesthesia Assessment 1144

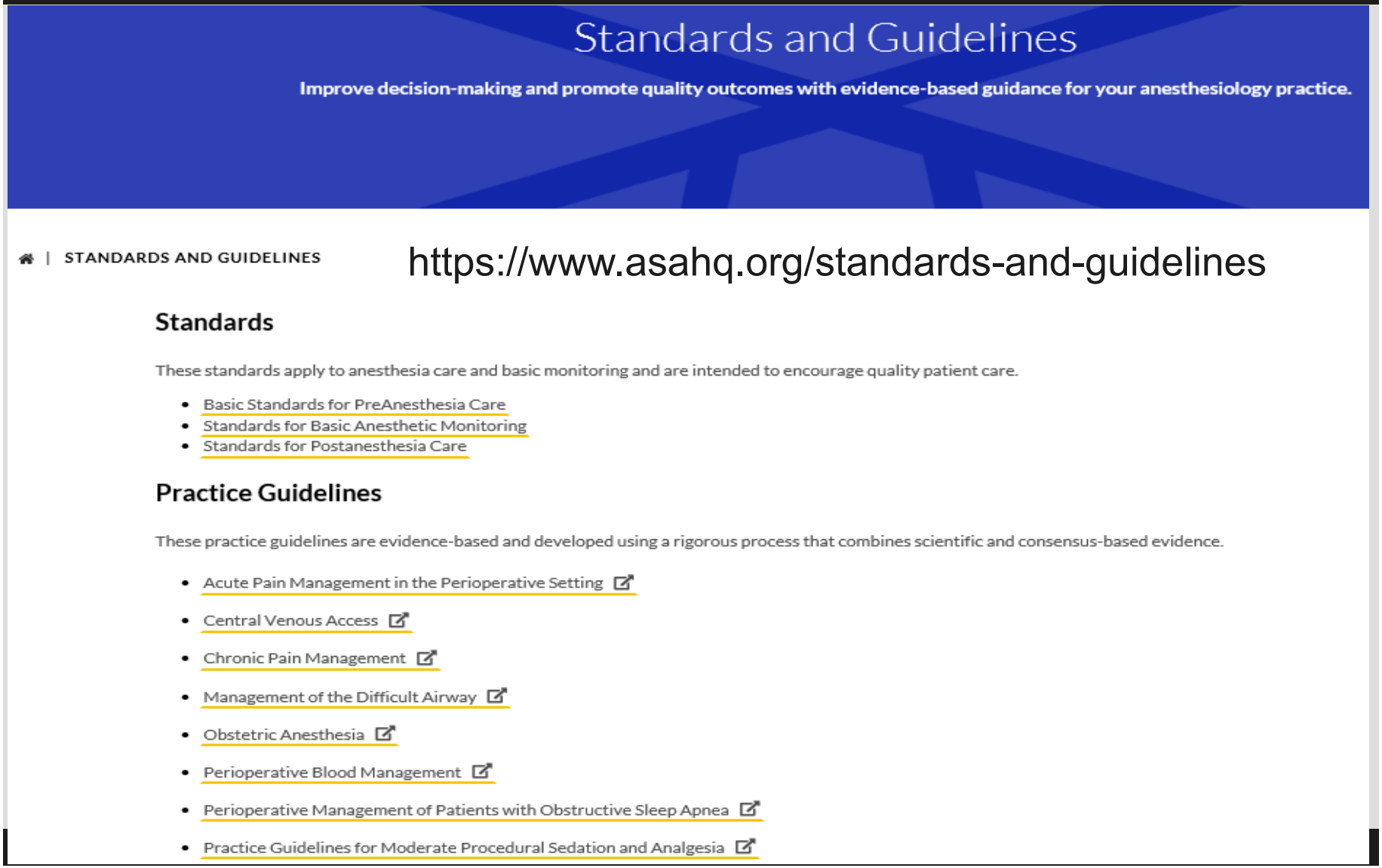
- Pre-anesthesia evaluation must be performed **immediately prior** to the surgery,
- By qualified person to administer anesthetic to evaluate risk of anesthesia,
- Must include; notation of risk of anesthesia, anesthesia, drug, and allergy history,
- Potential anesthesia problems identified,
- Patient's condition prior to induction,
  - Different from requirements in Appendix A

Pre-anesthesia ASA Guideline

- Preanesthesia Evaluation [1]
  - Patient interview to assess Medical history, Anesthetic history, Medication history
- Appropriate physical examination
- Review of objective diagnostic data (e.g., laboratory, ECG, X-ray)
- Assignment of ASA physical status
- Formulation of the anesthetic plan and discussion of the risks and benefits of the plan with the patient or the patient's legal representative

1 www.asahq.org/publicationsAndServices/standards/03.pdf

ASA Guidelines and Standards



Basic Standards for PreAnesthesia Care

Developed By: *Committee on Standards and Practice Parameters (CSPP)*

Last Amended: *October 28, 2015 (original approval: October 14, 1987)*

Download PDF

www.asahq.org/standards-and-guidelines/basic-standards-for-preanesthesia-care

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.
2. Interviewing and performing a focused examination of the patient to:
   2.1 Discuss the medical history, including previous anesthetic experiences and medical therapy.
   2.2 Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
4. Ordering appropriate preoperative medications.
5. Ensuring that consent has been obtained for the anesthesia care.
6. Documenting in the chart that the above has been performed.

ETCO2 for Moderate and Deep Sedation ASA

3.2.4 During regional anesthesia (with no sedation) or local anesthesia (with no sedation), the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs. During moderate or deep sedation the adequacy of ventilation shall be evaluated by continual observation of qualitative clinical signs and monitoring for the presence of exhaled carbon dioxide unless precluded or invalidated by the nature of the patient, procedure, or equipment.

Practice Guidelines for Moderate Procedural Sedation and Analgesia 2018: A Report by the American Society of Anesthesiologists Task Force on Moderate Procedural Sedation and Analgesia, the American Association of Oral and Maxillofacial Surgeons, American College of Radiology, American Dental Association, American Society of Dentist Anesthesiologists, and Society of Interventional Radiology*

ASA Practice Advisory Preanesthesia Evaluation

http://asahq.org/For-Members/Practice-Management/Practice-Parameters.aspx

■ SPECIAL ARTICLE

Anesthesiology 2002; 96:485–96

Practice Advisory for Preanesthesia Evaluation

A Report by the American Society of Anesthesiologists Task Force on Preanesthesia Evaluation

PRACTICE advisories are systematically developed reports that are intended to assist decision-making in areas of patient care where scientific evidence is insufficient to develop an evidence-based model. Practice advisories provide a synthesis of opinion from experts, open forums, and other public sources. Practice advisories report the current state of scientific literature, but are not supported by literature to the same degree as standards or guidelines due to the lack of sufficient numbers of adequately controlled studies.

Advisories are not intended as guidelines, standards, or absolute requirements. The use of practice advisories cannot guarantee any specific outcome. They may be adopted, modified, or rejected according to clinical needs and constraints. Practice advisories are subject to periodic revision as warranted by the evolution of medical knowledge, technology, and practice.

Definition of Preanesthesia Evaluation

the patient's medical records, interview, physical examination, and findings from medical tests and evaluations. As part of the preanesthesia evaluation process, the anesthesiologist may choose to consult with other healthcare professionals to obtain information or services that are relevant to perioperative anesthetic care. Preoperative tests, as a component of the preanesthesia evaluation, may be indicated for various purposes, including but not limited to (1) discovery or identification of a disease or disorder that may affect perioperative anesthetic care, (2) verification or assessment of an already known disease, disorder, medical or alternative therapy that may affect perioperative anesthetic care, and (3) formulation of specific plans and alternatives for perioperative anesthetic care. For this Advisory, *perioperative* refers to the care surrounding operations and procedures.

The assessments made in the process of a preanesthesia evaluation may be used to educate the patient, organize resources for perioperative care, and formulate

ASA Standard on Preanesthesia Care

BASIC STANDARDS FOR PREANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 14, 1987, and last affirmed on October 20, 2010)

These standards apply to all patients who receive anesthesia care. Under exceptional circumstances, these standards may be modified. When this is the case, the circumstances shall be documented in the patient's record.

An anesthesiologist shall be responsible for determining the medical status of the patient and developing a plan of anesthesia care.

The anesthesiologist, before the delivery of anesthesia care, is responsible for:

1. Reviewing the available medical record.
2. Interviewing and performing a focused examination of the patient to:
   - 2.1 Discuss the medical history, including previous anesthetic experiences and medical therapy.
   - 2.2 Assess those aspects of the patient's physical condition that might affect decisions regarding perioperative risk and management.
3. Ordering and reviewing pertinent available tests and consultations as necessary for the delivery of anesthesia care.
4. Ordering appropriate preoperative medications.
5. Ensuring that consent has been obtained for the anesthesia care.
6. Documenting in the chart that the above has been performed.

http://asahq.org/For-Healthcare-Professionals/Standards-Guidelines-and-Statements.aspx

AANA Website for CRNA

Developed by the American Association of Nurse Anesthetists - 1991

PREANESTHESIA EVALUATION

Age	Sex M F	Height in / cm	Weight lb / kg

Proposed Procedure

Pre-Procedure Vital Signs
B/P P R T

Previous Anesthesia / Operations — None ☐

Current Medications — None ☐

Family History of Anesthesia Complications — None ☐

Allergies — NKDA ☐

AIRWAY / TEETH / HEAD & NECK

History From:
☐ Patient ☐ Significant Other
☐ Parent / Guardian ☐ Chart
☐ Communication / Language Problems
☐ Poor Historian

SYSTEM	WNL	COMMENTS
RESPIRATORY Asthma, Bronchitis, COPD, Dyspnea, Orthopnea, Pneumonia, Productive Cough, Recent URI, SOB, Tuberculosis	☐	Tobacco Use: ☐ Yes ☐ No _____ Packs / Day for _____ Years
CARDIOVASCULAR Abnormal EKG, Angina, ASHD, CHF, Dysrhythmia, Exercise Tolerance, Hypertension, MI, Murmur, Pacemaker, Rheumatic Fever, Valvular Disease	☐	
HEPATO / GASTROINTESTINAL	☐	Ethanol Use: ☐ Yes ☐ No Frequency _____

DIAGNOSTIC STUDIES

EKG

Chest X-ray

Pulmonary Studies

Post Anesthesia Evaluation

- Post-anesthesia follow-up report must be written on all inpatients and outpatients **prior to discharge**,
- Written by the individual who is qualified to administer the anesthesia.
- Must include at a minimum: Cardiopulmonary status, LOC, follow-up care and/or observations; and,
- Any complications occurring during PACU.

Post Anesthesia ASA Guidelines

- Patient evaluation on admission and discharge from the postanesthesia care unit
- A time-based record of vital signs and level of consciousness
- A time-based record of drugs administered, their dosage and route of administration
- Type and amounts of intravenous fluids administered, including blood and blood products
- Any unusual events including post-anesthesia or post procedural complications
- Post-anesthesia visits

STANDARDS FOR POSTANESTHESIA CARE

Committee of Origin: Standards and Practice Parameters

(Approved by the ASA House of Delegates on October 27, 2004, and last amended on October 21, 2009)

These standards apply to postanesthesia care in all locations. These standards may be exceeded based on the judgment of the responsible anesthesiologist. They are intended to encourage quality patient care, but cannot guarantee any specific patient outcome. They are subject to revision from time to time as warranted by the evolution of technology and practice.

STANDARD I

ALL PATIENTS WHO HAVE RECEIVED GENERAL ANESTHESIA, REGIONAL ANESTHESIA OR MONITORED ANESTHESIA CARE SHALL RECEIVE APPROPRIATE POSTANESTHESIA MANAGEMENT.[1]

1. A Postanesthesia Care Unit (PACU) or an area which provides equivalent postanesthesia care (for example, a Surgical Intensive Care Unit) shall be available to receive patients after anesthesia care. All patients who receive anesthesia care shall be admitted to the PACU or its equivalent **except** by specific order of the anesthesiologist responsible for the patient's care.
2. The medical aspects of care in the PACU (or equivalent area) shall be governed by policies and procedures which have been reviewed and approved by the Department of Anesthesiology.
3. The design, equipment and staffing of the PACU shall meet requirements of the facility's accrediting and licensing bodies.

STANDARD II

A PATIENT TRANSPORTED TO THE PACU SHALL BE ACCOMPANIED BY A MEMBER OF THE ANESTHESIA CARE TEAM WHO IS KNOWLEDGEABLE ABOUT THE PATIENT'S CONDITION. THE PATIENT SHALL BE CONTINUALLY EVALUATED AND TREATED DURING TRANSPORT WITH MONITORING AND SUPPORT APPROPRIATE TO THE PATIENT'S CONDITION.

STANDARD III

UPON ARRIVAL IN THE PACU, THE PATIENT SHALL BE RE-EVALUATED AND A VERBAL REPORT PROVIDED TO THE RESPONSIBLE PACU NURSE BY THE MEMBER

Anesthesia 1145

- CAH must designate who can administer anesthesia,
- MS include criteria for determining privileges, in accordance with P&P and scope of practice and state law,
- Only by anesthesiologist, MD/DO, CRNA, anesthesiology assistant, supervised trainee in education program, dentist, podiatrist,
- State exemption process of MD supervision for CRNA (1150)
  - No supervision required and details the process

Anesthesia 1145 and 1147

- A CRNA may administer anesthesia when under the supervision of the operating practitioner or of an anesthesiologist who is immediately available if needed,
- An anesthesiologist's assistant (AA) may administer anesthesia when under the supervision of an anesthesiologist who is **immediately available** if needed.

Immediately Available Means

- Physically located within the OR or in the L&D unit;
- And is prepared to immediately conduct hands-on intervention if needed;
- And is not engaged in activities that could prevent the supervising practitioner from being able to immediately intervene and conduct hands-on interventions if needed

Discharge 1149

- All patients are discharged in the company of a responsible adult,
- Any exceptions to this requirement must be made by the attending practitioner and documented in the medical record,
- Surveyor will verify that the CAH has P&Ps in place to govern discharge procedures and instructions,

Quality

CAHs

- CMS rewrote all the QAPI requirements for CAHs
  - Published September 30, 2019 the effective date was November 29, 2019
- However, CMS gave CAHs 18 months to comply with the QAPI requirements
  - So must be implemented by **March 30, 2021**
- The board is also responsible for make sure that QAPI standards are met
- Will update the QAPI worksheet and even though not used at CAH so look at this excellent resource

Hospital Improvement Final Rule

This document is scheduled to be published in the Federal Register on 09/30/2019 and available online at **https://federalregister.gov/d/2019-20736**, and on **govinfo.gov**

[Billing Code: 4120-01-P]

https://federalregister.gov/d/2019-20736 and 393 Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, 441, 460, 482, 483, 484, 485, 486, 488, 491, and 494

[CMS-3346-F; CMS-3334-F; CMS-3295-F]

RIN 0938-AT23

Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule reforms Medicare regulations that are identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers. This final rule also

CAH QAPI Program

- Basically CMS is implementing the QAPI standards under Appendix A for CAH except no system wide QAPI
  - CAH QAPI had not been updated since 1993 and did not reflect current standards
- These replace the existing reactive annual evaluation and quality assurance requirements with a proactive approach of a QAPI program
- The section on evaluation of the diagnosis and treatment provided by physicians and non-physicians has been relocated to a new section under “staffing and staff responsibilities”

CAH QAPI Program

- Note the worksheets have never been used by a surveyor at a CAH
  - But an excellent resource now that the QAPI standards have changed to see how CMS has interpreted them
  - The tag numbers in the worksheets are to appendix A and we now know what tag numbers are for CAHs- start at tag number **1300**
- CAHs are encouraged to use the technical assistance and services available through the state Flex Programs
  - This includes the Medicare Beneficiary QA Project supported by HRSA's Office of Rural Health Policy

C-1300
(Rev. - Effective March 30, 2021)

§485.641 Condition of Participation: ***Quality Assessment and Performance Improvement Program***

The CAH must develop, implement, and maintain an effective, ongoing, CAH-wide, data-driven quality assessment and performance improvement (QAPI) program. The CAH must maintain and demonstrate evidence of the effectiveness of its QAPI program.

(a) Definitions. For the purposes of this section—

Adverse event means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof. Error means the failure of a planned action to be completed as intended or the use of a wrong plan to achieve an aim. Errors can include problems in practice, products, procedures, and systems; and Medical error means an error that occurs in the delivery of healthcare services.

Interpretive Guidelines §485.641(a)

Guidance is pending and will be updated in future release.

New Tag Numbers for QAPI

- C-1300
- 1302, 1306, 1309, and 1311
- 1315 and1319
- 1321 and 1325
- Interpretive guidelines and survey procedures to follow (probably late spring or early summer 2020)
- Existing tag numbers starting at **C-330** will remain in effect until March 30, 2021
  - They are included here for reference

NATIONAL RURAL HEALTH RESOURCE CENTER

www.ruralcenter.org/tasc/flexprofile

Facebook |

SERVICES PROGRAMS EVENTS RESOURCE LIBRARY ABOUT

Home › Programs › TASC › State Flex Profiles

State Flex Profile Navigation

Jump to: - Select State -

State Flex Profiles

State Flex Profiles showcase the beneficial activities occurring at the state-level to support the critical access hospitals (CAHs) and their communities around the country. No two states have the same exact approaches and the profiles are updated annually as an opportunity for states to share their excellent work and to learn from one another. The profiles include information on the work occurring in the five Flex Program areas as well as successes, best practices and innovations. Use the State Flex Profiles to identify approaches to similar rural health issues, identify best practice opportunities and access contact information for individuals at the state-level who are supporting Flex Program activities.

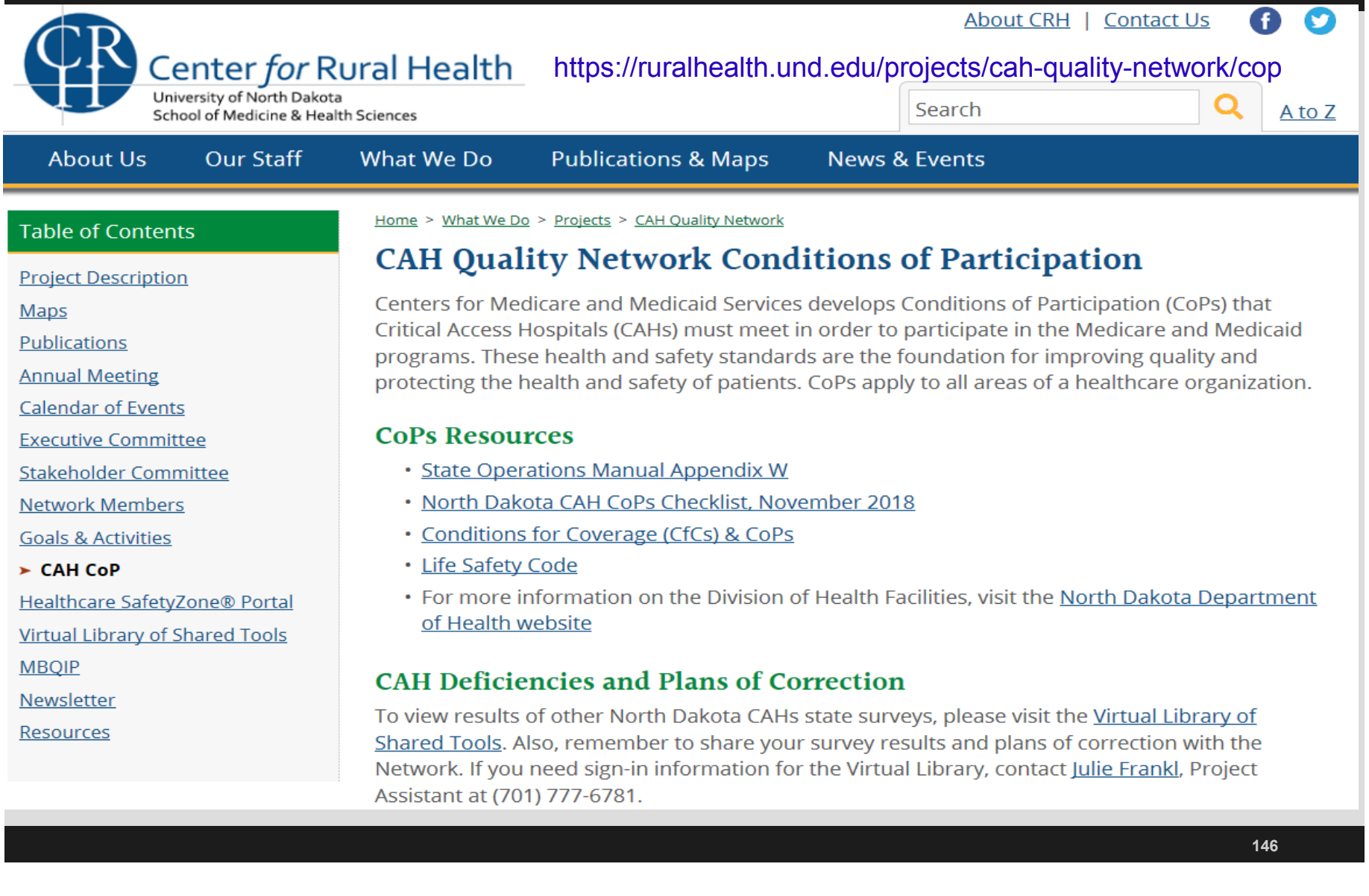
Use the drop-down menu in the gray box at the top of this page to see a specific state's profile. If you are looking for examples of a particular activity, for example, revenue cycle management, use the keyword search provided below.

Search State Flex Profiles

Flex Program
- Flex Program Fundamentals
- Federal Flex Updates
- Flex Program Grant and Cooperative Agreement
- Guidance
- Core Competencies
  - Self-Assessment
  - Managing the Flex Program
  - Building and Sustaining Partnerships
  - Improving Processes and Efficiencies
  - Understanding Policies and Regulations
  - Promoting Quality Reporting and Improvement
  - Supporting Hospital Financial Performance
  - Addressing Community Health Needs
  - Understanding Systems of Care
  - Preparing for Future Models of Health Care
- Critical Access Hospital Recognition
- Flex Program Forum
- 2019 Flex Program Reverse Site Visit (RSV)

MBQIP
- Key Resource List
- Overview
- Data Reporting and Use

CAH Checklist & Quality Network



CAH QAPI Program

- CAH must develop, implement, and maintain an effective, ongoing, CAH-wide, data-driven QAPI program (1300)
  - Program has to be appropriate for the size and what the CAH does
  - Must involve all departments
  - Must use objective measures to evaluate services
  - Must be ongoing and comprehensive
  - Board is responsible for QAPI program
  - Use objective measures to evaluate processes
  - Has a definition of medical error and adverse event (AE)

CAH QAPI Program 2021

- Design and scope of the QAPI program must be appropriate for the complexity of the services (1302)
- QAPI program must be ongoing and comprehensive (1306)
  - Every department needs to report into the QAPI process
- QAPI program must use objective measures to evaluate services and processes (1309)
  - So falls are measured in per 1,000 bed days
  - Determines number of patients who went to surgery today and how many had consents and H&Ps on the chart

CAH QAPI Program 2021

- QAPI program must address (1311)
  - Indicators related to improved health outcomes
  - Prevention and reduction of medical errors
    - Such as the medication error rate, adverse drug reactions, delays or misdiagnosis, retained surgical items, burns, etc.
  - Adverse events
  - CAH acquired conditions and
  - Transitions of care, including readmissions

CAH QAPI Program 2021

- The board is responsible for the QAPI program (1313)
  - Board responsible to make sure the QAPI meets these requirements
- Must focus on measures to improve health outcomes to are predictive of desired patient outcomes (1319)
  - For ones mentioned in tag 1311 (medical errors, AE, HAC, transitions including readmissions)
  - Look at readmissions to determine their cause and if the hospital could have prevented the readmission

CAH QAPI Program 2021

- For each of the ones in the above slide (tag 1311), CAH use measures to analyze and track its performance (1319)
  - There are many ways to help detect medication errors
  - The IHI has trigger tools
  - Computer assisted software
  - Incident reports and QAPI reports
  - Direct observation etc.
- For each one in 1311 set priorities to improve and consider high volume, high risk and problem prone areas (1321)

CAH QAPI Program 2021

- The QAPI program must incorporate quality indicator data including:(1325)
- Patient care data
- Other relevant data, in order to achieve the goals of the QAPI program
- As discussed previously, the current QAPI system, starting at tag 330, is in effect until March 30, 2021

CMS Worksheets

Infection Control, Discharge Planning and QAPI

CMS Hospital Worksheets History

- Memo discusses surveyor worksheets for hospitals by CMS during a hospital survey
- Addresses discharge planning, infection control, and QAPI (quality assessment performance improvement)
  - Final discharge planning worksheet issued November 26, 2014
  - Remember, will update in 2020 to reflect new changes
- Currently being rewritten to include the final changes

Final 3 Worksheets QAPI

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

REF: S&C: 15-12-Hospital

DATE: November 26, 2014

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Public Release of Three Hospital Surveyor Worksheets

www.cms.gov/SurveyCertificationGenInfo/PMSR/list.asp#TopOfPage

Memorandum Summary

- ***Three Hospital Surveyor Worksheets Finalized*:** The Centers for Medicare & Medicaid Services (CMS) has finalized surveyor worksheets for assessing compliance with three Medicare hospital Conditions of Participation (CoPs): Quality Assessment and Performance Improvement (QAPI), Infection Control, and Discharge Planning. The worksheets are used by State and Federal surveyors on all survey activity in hospitals when assessing compliance with any of these three CoPs.
- ***Final Worksheets Made Public:*** Via this memorandum we are making the worksheets publicly available. The hospital industry is encouraged, but not required, to use the worksheets as part of their self-assessment tools to promote quality and patient safety.

Hospitals in Systems

- Now allows system wide QAPI
  - It is called “unified and integrated QAPI for multi-hospital systems”
  - Must be part of a hospital system
  - But may **NOT** include the CAH because this section was never amended
- Under a board that is responsible for 2 or more hospitals
- Not required but an option for hospitals in systems
- Must be consistent with your state law

The Current QAPI Requirements

- This section will remain in effect until March 30, 2021
- They are included here for reference
- They will not be discussed during this program
- CAH must periodically evaluate the QAPI program (330)
  - Surveyor may identify a patient care practice
  - May ask staff to tell them about the practice and is it a requirement or a standard of practice
  - P&P must reflect laws and requirements

Quality Assessment 331

- Must periodically review total program
  - Will look at who is to do this such as the QAPI Director
  - At least once per year,
- Include services provided and number of patients served,
- Look at volume of service and patients served (332),
  - Include at least 10% of charts- active and closed charts (333),

Quality Assessment 335

- Review all P&Ps also
  - Show evidence of how these are evaluated and reviewed
- Purpose of the evaluation is to determine whether the utilization of services was appropriate,
- And whether the P&Ps were revised if needed,

Quality Assessment 336

An effective program includes;

- Ongoing monitoring and data collection,
- Problem prevention, identification and analysis,
- Identification of corrective actions,
- Implementation of corrective actions,
- Evaluation of corrective actions,
- Measures to improve quality on a continuous basis,

Quality Assessment 336

- QA program to evaluate appropriateness of diagnosis and treatment and in treatment outcomes,
- Facility wide QAPI program (QI),
- Can have QAPI by arrangement,
- Surveyor will look at your QI PLAN, QI minutes,

Healthcare Associated Infections 337

- Must evaluate infections,
  - Now called HAI or healthcare association infections
  - Remember the CMS infection control worksheet
- Must look at medication therapies,
- Must evaluate the quality of care of LIPs (NP, PA, CNS) by doctor on MS or under contract,
- Will look at how their performance is evaluated (339),
- Quality of care and appropriateness of diagnosis and treatment by doctors must be reviewed by QIO, hospital that is member of network, or as identified in state rural health plan (340),

Quality Assessment 341

- Staff consider the findings and evaluations and recommendations and take corrective actions including the QIO,
- Take steps to remedial action to address deficiencies found through QAPI process,
- Will look to see who is responsible for implementing actions,
- Document the outcomes of all remedial actions (343)

Quality Assessment 340

- CAH have an arrangement for outside entity to review the appropriateness of the diagnosis and treatment provided by each MD/DO providing services
  - This includes doctors providing telemedicine services
- Some CAHs may also prefer to conduct their own internal review in addition to the outside review but not required
  - Outside review may be done by hospital that is a member of the same rural health network as the CAH; a Medicare QIO

Organs, Tissues, and Eyes

Organ, Tissue, and Eye 1500

- Hospital must have written P&P to address its organ procurement,
- Must have agreement with OPO,
  - If OR and hospital has a ventilator
- Must timely notify OPO if death is imminent or if the patient has died,
- OPO to determine medical suitability for organ donation,
- Defines what must be in your written agreement
  - Definitions, criteria for referral, access to your death record information

OPO Agreements

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 13-48-OPO

DATE: **July 26, 2013**

TO: State Survey Agency Directors

FROM: Director
Survey and Certification Group

SUBJECT: Organ Procurement Organizations (OPO) Agreements with Hospitals

Memorandum Summary

- **OPO Hospital Agreements:** Hospital regulations at 42CFR 482.45 (a)(1) require that all hospitals have written agreements in place with their OPO to notify them of an imminent death or of a death which has occurred. OPO regulations at §486.322 (a) require that OPOs have a written agreement in place with 95 percent of all participating Medicare and Medicaid hospitals and Critical Access Hospitals *that have both a ventilator and an operating room.* Historically, OPOs have not initiated agreements with hospitals without a ventilator and an operating room as donor maintenance cannot be accomplished in that setting.
- **OPO Agreements with Hospitals That Do Not Have a Ventilator and Operating Room:** While OPOs are not required to initiate agreements with hospitals that do not have a ventilator and an operating room, they are required at §486.303 (g) to enter into an agreement with any hospital that requests an agreement with them pursuant to the hospital regulations. However, for hospitals that do not have a ventilator and operating room, the agreement may be limited to notification of the OPO by the hospital of imminent death

OPO Memo March 14, 2014

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop C2-21-16
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Survey & Certification Group

Ref: S&C: 14-16-OPO

DATE: **March 14, 2014**

TO: Regional Offices

FROM: Director
Survey and Certification Group

SUBJECT: Interpretive Guidance for the Survey Process of the Organ Procurement Organization (OPO) Conditions for Coverage, published May 31, 2006, in the Federal Register – Interim Final

Memorandum Summary

This memorandum communicates an advanced copy of the Interpretive Guidance and associated revisions to Chapters 2 and 3 of the State Operations Manual (SOM) for the OPO Conditions for Coverage.

Background

Conditions for Coverage for OPOs were published on May 31, 2006. These conditions included outcome and process performance measures based on organ donor potential and other related factors in each service area of qualified OPOs.

The Interpretive Guidance communicated by this memo serves to interpret and clarify the Conditions for Coverage and do not impose any requirements that are not otherwise set forth in statute or regulation

Organ, Tissue, and Eye 1503

- Board must approve your organ procurement policy,
- Must integrate into hospital's QAPI program,
- Surveyor will review written agreement with the OPO to make sure it has all the required information,
- Check off the long list to ensure all elements are present
  - Such as definition of imminent death, what is timely notification, allows them access to your death records etc.,

Imminent Death 1503

Definition of imminent death might include a patient with severe, acute brain injury who:

- Requires mechanical ventilation (due to brain injury);
- Is in an ICU or ED; and
- Has clinical findings consistent with a Glasgow Coma Score

that is less than or equal to a mutually-agreed-upon threshold; or

- MD/DOs are evaluating a diagnosis of brain death (within 1 hour) ; or
- An MD/DO has ordered that life sustaining therapies be withdrawn, pursuant to the family's decision (notify them before withdrawing life sustaining therapies),
- Make sure your staff is aware of the P&P,

Tissue and Eye Bank 1505

- Need an agreement with at least one tissue and eye bank,
- OPO is gatekeeper and notifies the tissue or eye bank chosen by the hospital,
- OPO determines medical suitability,
- Don’t need separate agreement with tissue bank if agreement with OPO to provide tissue and eye procurement,

Family Notification 1507

- Once OPO has selected a potential donor, person's family must be informed of the donor's family's option,
- OPO and hospital will decide how and by whom the family will be approached,

Organ Donation 1507

- Person to initiate request must be a designated requestor or organized representative of tissue or eye bank,
- Designated requestor must have completed course approved by OPO,
- Encourage discretion and sensitivity to the circumstances, views and beliefs of the families (1509),
- Surveyor will review complaint file for relevant complaints,

Organ Donation Training 1511

- Patient care staff must be trained on organ donation issues,
- Training program at a minimum should include: consent process, importance of discretion, role of designated requestor, transplantation and donation, QI, and role of OPO,
- Train all new employees, when change in P&P, and when problems identified in QAPI process,

Organ Donation 1511

- Hospital must cooperate with OPO to review death records to improve identification of potential donors,
- Surveyor will verify P&P that hospital works with OPO,
- Maintain potential donors while necessary testing and placement of donated organs take place,
- Must have P&P to maintain viability of organs,

Swing Beds

Swing Beds LTC Services

- Must meet following to provide post-hospital SNF care (1600),
- Must be certified by CMS,
- SNF services must be in compliance with Subpart B of part 483 (the swing bed requirements),
- Allows CAH to use beds interchangeable for either acute care or SNF level,
- Swings from acute care reimbursement to SNF services and reimbursement,
- Will survey swing beds during full survey, or if conducting a swing bed complaint or is requesting swing bed approval

4 Swing Bed Changes

Introduction

- CMS published the final regulations on September 30, 2019
- The effective date was November 29, 2019
- Regulations are effective 60 days after publication in the Federal Register with two exceptions for CAH on QAPI (18 months) and ASP (6 months)
- There were four changes to the swing bed regulations
- These effect CAH with swing beds and small and rural hospitals with swing beds

Hospital Improvement New Law

This document is scheduled to be published in the Federal Register on 09/30/2019 and available online at **https://federalregister.gov/d/2019-20736**, and on **govinfo.gov**

[Billing Code: 4120-01-P]

https://federalregister.gov/d/2019-20736 and 393 Pages

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, 441, 460, 482, 483, 484, 485, 486, 488, 491, and 494

[CMS-3346-F; CMS-3334-F; CMS-3295-F]

RIN 0938-AT23

Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule reforms Medicare regulations that are identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers. This final rule also

PDF Version of New Law

www.govinfo.gov/content/pkg/FR-2019-09-30/pdf/2019-20736.pdf

DEPARTMENT OF HEALTH AND HUMAN SERVICES

Centers for Medicare & Medicaid Services

42 CFR Parts 403, 416, 418, 441, 460, 482, 483, 484, 485, 486, 488, 491, and 494

[CMS–3346–F; CMS–3334–F; CMS–3295–F]

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Medicare and Medicaid Programs; Regulatory Provisions To Promote Program Efficiency, Transparency, and Burden Reduction; Fire Safety Requirements for Certain Dialysis Facilities; Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care

AGENCY: Centers for Medicare & Medicaid Services (CMS), HHS.

ACTION: Final rule.

SUMMARY: This final rule reforms Medicare regulations that are identified as unnecessary, obsolete, or excessively burdensome on health care providers and suppliers. This final rule also increases the ability of health care professionals to devote resources to improving patient care by eliminating or reducing requirements that impede quality patient care or that divert

The regulations at § 482.42(b) and § 485.640(b) regarding hospital and critical access hospital (CAH) antibiotic stewardship programs must be implemented by March 30, 2020.

FOR FURTHER INFORMATION CONTACT:

For issues related to Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction, contact Kristin Shifflett, (410) 786–4133.

For issues related to Fire Safety Requirements for Certain Dialysis Facilities, contact Kristin Shifflett, (410) 786–4133.

For issues related to the Hospital and Critical Access Hospital (CAH) Changes to Promote Innovation, Flexibility, and Improvement in Patient Care, contact CAPT Scott Cooper, USPHS, (410) 786–9465, Mary Collins, (410) 786–3189, Alpha-Banu Wilson, (410) 786–8687, or Kianna Banks, (410) 786–3498.

SUPPLEMENTARY INFORMATION: We note that this rule finalizes provisions that were proposed in three separate proposed rules that were published in the **Federal Register** on separate dates. Specifically, we are finalizing the provisions of the following proposed rules, discussed as follows:

- "Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction," published September 20, 2018 (83 FR 47686);
- "Hospital and Critical Access

7. Comprehensive Outpatient Rehabilitation Facility (CORF)—Utilization Review Plan
8. Critical Access Hospitals
9. Community Mental Health Center
10. Portable X-Ray Services
11. Rural Health Clinics (RHCs) and Federally Qualified Health Centers (FQHCs)
12. Emergency Preparedness for Providers and Suppliers
13. Technical Corrections
14. Waiver of Proposed Rulemaking
C. Collection of Information Requirements
II. Final Rule: Fire Safety Requirements for Certain Dialysis Facilities
A. Background
B. Provisions of the Proposed Rule and Analysis and Response to Public Comments
1. 2012 Edition of the Life Safety Code
2. Incorporation by Reference
3. Ambulatory Health Care Occupancies
4. 2012 Edition of the Health Care Facilities Code
5. Technical Corrections
C. Collection of Information Requirements
III. Final Rule: Hospital and Critical Access Hospital (CAH) Changes To Promote Innovation, Flexibility, and Improvement in Patient Care
A. Background
B. Provisions of the Proposed Rule and Analysis and Response to Public Comments for Hospitals
1. General Comments
2. Implementation Timeframe
3. Non-Discrimination
4. Licensed Independent Practitioner
5. Quality Assessment and Performance Improvement (QAPI) Program

Swing Bed Changes

- There were four changes for swing beds
- This includes CAH and any small and rural hospital that has them
- The swing bed regulations were completely rewritten on October 12, 2018
- One change was that Appendix A and W swing bed were only the regulations
- Hospitals needed to go to Appendix PP, the LTC manual, to find the corresponding sections which had the interpretive guidelines & survey procedure

Swing Bed Changes

- **Dental services**
  - Previously said facility must assist residents in obtaining routine and 24-hour emergency dental care
  - Hospitals are addressing emergent dental need under the existing CoPs and hospitals have P&P already
  - Has deleted this section since duplicative
- **Activity Program**
  - Deleted the section that said the facility provide an ongoing activity program based on the resident's comprehensive assessment and care plan directed by a type of qualified professional specified in the regulation

Swing Bed Changes

- **Activity Program** (continued):
- Previously said the facility must provide an ongoing program to support the resident in their choice of activities
  - This was based on their comprehensive assessment and care plan
- Deleted since swing bed patients are not long term residents and only receive services for a short time
- However, if the hospital has a patient for an extended period of time then expected to do this

Swing Bed Changes

- **Social worker**
  - Previously had a section that said if you had 120 beds or more you had to have a full time social worker
  - This just confused everyone since CAH cannot have more than 25 beds and rural hospitals not more than100 beds
  - So this section has been removed
  - Many wondered why this section was not removed a long time ago

Swing Bed Changes

- **Resident performing services**
- The CoPs had a section that said that patient had the right to choose or refuse to perform services and can't require it
  - Document need or desire to work
  - Is it voluntary or paid and if so must have prevailing rate and have in plan of care
  - In a LTC maybe the resident who was a chef made special pastries on Sunday or a resident helped fold towels for physical therapy
  - **DELETED** but can still do if you want and if you do then you need a P&P

Swing Bed Changes

- **Resident performing services (continued)**
  - Doesn't make sense since shorter LOS so it was REMOVED
  - CAH tag number 361
  - Hospitals can elect to still do this if they want
  - If they allow residents to perform services then must have a policy and procedure
  - Can never require a patient or resident to do work

Swing Beds

Swing Beds

- Must be discharge orders from acute care, progress notes and discharge summary and subsequent admission orders,
- If patient does not change facilities can use same MR with chart separator,
- Medicare requires 3 day qualifying stay in CAH or qualified hospital prior to admission to swing bed,
  - 3 day rule only applies to Medicare patients,
- Will review at least 2 swing bed closed medical records if no swing bed patients are present
- Discharge from acute care and admit to skilled bed

Swing Beds

- No LOS restriction for swing beds but intended to be transitional time while recovering to go home or waiting placement in a nursing home facility,
- No transfer agreement needed between CAH and nursing home,
- CAH does not have to use the MDS form for recording patient assessment,
- Swing bed patients receive SNF level of care and CAH is reimbursed for SNF level, (1608)
- Can use same record for swing bed patient but be sure to have order for swing bed and discharge orders

Eligibility

- Must be certified as CAH, and have no more than 25 beds (1602),
- Tag numbers start at 1600
- Must screen to make eligible for swing bed,
  - CMS RO makes the determination if eligible requirements are met
- Section on facilities participating as rural primary care hospital (1604 and see requirements),
- Have to be in compliance with SNF rights requirements (1608)
  - Residents rights, nutrition, admission and discharge rights, social services, comprehensive assessment etc.,

SNF Services

- Must be substantially in compliance with following SNF requirements: (1608)
- If resident adjudicated incompetent then representative acts on their behalf
- Patient has right to be informed of his treatment
- To be informed in a language he can understand (issue of low health literacy and LEP)
- To be informed in changes to the plan of care
- Choice of a physician who meets requirements like licensed and comes to the facility

SNF Services 1608

- Must make sure resident has information of the name and specialty of his or her physician and how to contact
- Right to retain and use personal possessions include furnishings and clothing as space permit
- Access by immediate family and friends and resident can change mind
- Right to choose or refuse to perform services and can’t require it
  - Removed unless CAH keeps patients a long time or wants to implement this

SNF Services 1608

- Right to receive and send mail including means other than the post office
  - Right to access to stationery and postage at resident expense
- Must notify of any charges not covered by M/M at time of admission and periodically and if resident becomes eligible for Medicaid
- Has right to personal privacy and confidentiality
- Right to receive written and telephone communications
- To choose their attending physician
- To be informed in a language they can understand

SNF Services 1608

- Right to secure medical records and to refuse release of records
- Right to share a room with spouse
- Give residents a written copy of their rights
- CMS now says to refer **to Appendix PP** for the interpretive guidelines
- Also refers to Appendix PP for survey procedure on patient rights
- Appendix PP is the interpretive guidelines for long term care facilities

Appendix PP LTC 749 Pages

State Operations Manual
Appendix PP - Guidance to Surveyors for Long Term Care Facilities
Table of Contents

(Rev. 173, 11-22-17)

Transmittals for Appendix PP

www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/som107ap_pp_guidelines_ltcf.pdf

INDEX

§483.5 Definitions
§483.10 Resident Rights
§483.12 Freedom from Abuse, Neglect, and Exploitation
§483.15 Admission Transfer and Discharge Rights
§483.20 Resident Assessment
§483.21 Comprehensive Person-Centered Care Plans
§483.24 Quality of Life
§483.25 Quality of Care
§483.30 Physician Services
§483.35 Nursing Services
§483.40 Behavioral health services
§483.45 Pharmacy Services

Admission, Transfers, Discharge

- Transfer means outside of the facility (1610)
- Purpose to restrict transfer by facility to prevent dumping of high care or difficult residents
- Only when initiated by the facility and not the patient
- May not transfer or discharge a resident unless necessary to meet their welfare such as care cannot be met in the facility
- Appropriate because no longer needs the services provided or facility closes
- Can transfer if resident or others in the facility would be endangered due to clinical or behavioral status

Admission, Transfers, Discharge

- Cannot transfer while an appeal is pending unless endangers resident's health or safety and if so must document (1610 continued)
- Has specific documentation requirements such as attempts to meet the resident's needs and basis for the transfer
- Information must be provided to the receiving practitioner which include contact information for resident's representative, advance directives, care plan goals, discharge summary, contact information of the practitioner responsible for the resident's care

Admission, Transfers, Discharge

- Notice must be made asap before transfer or discharge
- Includes content of the notice such as reason for transfer, date, location, statement of the appeal rights and phone number
- Name and telephone number of the Office of the State LTC Ombudsman
- If intellectual and developmental disabilities or mental health disorder then information on agency responsible such as address, email, and phone number

Admission, Transfers, Discharge

- Must provide notice in advance of a facility closing
- Must provide and document sufficient preparation and orientation for the transfer or discharge
- Room changes in a distinct part must be limited to moving within a particular building unless the resident agrees to the move
- CMS states the interpretive guidelines and survey procedure for this tag number are referenced to Appendix PP

Freedom from Abuse and Neglect 1612

- Resident has a right to be free from abuse, neglect, and exploitation
- Freedom from misappropriation of property
- Freedom from restraint and seclusion including chemical restraint
- Can use verbal, mental, or physical abuse
- Cannot use restraints for convenience or discipline
- Can’t employ individuals found guilty of abuse, neglect, exploitation, mistreatment or stealing the resident’s property

Admission, Transfers, Discharge 1610

- Includes a finding in the State nurse aide registry
- Includes finding in a court of law that person is unfit to be a nurse aide or other staff member
- Must have P&P to prohibit and prevent abuse, neglect, and exploitation including investigations
- Must make sure reported timely and no later than 24 hours after allegation or within 2 hours if causes serious bodily injury
  - Report to the administrator of the facility and State Survey Agency and adult protective services if state law provides them with jurisdiction

Admission, Transfers, Discharge

- Must investigate thoroughly (Tag 1612)
- Must prevent further abuse or neglect
- Must report to state survey agency within 5 working days
- CMS refers to Appendix PP for interpretive guidelines and survey procedure
- Standard: Provide medically- related social services to maintain highest practicable physical, mental and psychosocial well-being of each resident (1616)

Patient Activities 385 DELETED

- Patient activities can be directed by a qualified professional who is a qualified therapeutic recreation specialist (QTRS) or an activities professional who is licensed or registered (Deleted whole tag number)
  - And is eligible for certification as QTRS or activities professional by a recognized accrediting body on or after Oct 1990 or has 2 years of experience in the last 5 years or is a OT (occupational therapy) or an OT assistant who has completed state training course

Social Services

- Facility must provide medically-related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident,
- DELTED Need bachelor's degree in social work or human services field (psychology, rehab counseling, etc.) and 1 year supervised social work experience in health care setting if the facility has more than 120 beds
- Refers to Appendix PP

Resident Assessments 1620

Must perform comprehensive assessment, care plans and discharge planning

- Not required to use RAI or resident assessment instrument
- Assessment should include:
- Identification and demographic information.
- Customary routine.
- Cognitive patterns.
- Communication and vision.
- Mood and behavior patterns.

Resident Assessments 1620

- Psychosocial well-being.
- Physical functioning and structural problems.
- Continence.
- Disease diagnoses and health conditions.
- Dental and nutritional status.
- Skin condition.
- Activity pursuit.
- Medications

Resident Assessments 1620

- Special treatments and procedures
- Discharge planning
- Documentation of summary information regarding the additional assessment performed by completion on the MDS or Minimum Data Sheet
- Documentation of participation in assessment
- Must do direct observation and communicate with resident and licensed members on all shifts
- Intent to do this to develop care plan

Assessments 1620

- Assessment within **14 days after admission** but states time frames do **not** apply to CAH
- Assessment if significant change
- Excludes readmissions if no significant change in condition
- Very detailed information on what constitutes a significant change
- **Must do a comprehensive care plan**
- Care plan must include measurable objectives to met patient's needs

Assessments 1620

- Care plan must include if patient refuses treatment
- Include any specialized services as result of the PASARR recommendations (Preadmission Screening and Resident Review Process)
  - If disagree with the recommendations must indicate a rationale in the resident's medical record
  - PASARR is a federally mandated screening and evaluation tool that is used to assess people with mental illness or developmental disabilities who are being considered for nursing facility placements to determine if nursing facility placement is appropriate or if these individuals can be better served in a more integrative setting

Assessments 1620

- Care plan to include:
- Goals for admission and desired outcomes
- Preferences and potential for discharge
  - Must document whether wants to return to the community
  - Must document any referrals to local contact agencies
  - Must include discharge plans
- Care plan must be developed within 7 days after comprehensive assessment done,

Care Plans 1620

- Interdisciplinary team should develop objectives to attain highest level of functioning
  - Includes attending doctor, NA and RN responsible for the resident, food and nutrition staff, resident and their representative and other appropriate staff
- Review and revise as necessary such as after each assessment
- Services provided by staff who are culturally competent, qualified and who meet standards of quality

PASARR or RAI

*NOTE: The CAH is not required to use the resident assessment instrument (RAI) specified by the State that is required under §483.20(b), or to comply with the requirements for frequency, scope, and number of assessments prescribed in §413.343(b) of this chapter). Also, note that CAHs are not required to complete the PASARR. **However, if a patient had a PASARR completed by a facility that was required to do so prior to admission into a CAH swing bed, the recommendations from the PASARR should be included in the CAHs comprehensive treatment plan for the patient.***

Discharge Summary 1620

Resident must have a discharge summary that includes;

- Recapitulation of the resident's stay
- Includes diagnosis, course of illness and treatment, pertinent lab, x-rays, or consult results
- Final summary of the resident's status
- Medication reconciliation
- A post-discharge plan of care that is developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment

- Refers to Appendix PP for IGs and survey procedure

Rehab Services 1622

- If specialized rehabilitative services such as, but not limited to,
- Physical therapy, speech-language pathology, occupational therapy, respiratory therapist and mental health rehabilitative services and for mental illness and intellectual disability, are required in the resident's **comprehensive plan of care**
- Facility must provide the required service
- May get from outside source

Rehab Services 1622

- Need physician order
- Interpretive guidelines refers to Appendix PP
- Survey Procedure refers to Appendix PP

Dental Services 1624

- The facility must assist residents in obtaining routine and 24-hour emergency dental care
  - May provide or obtain from an outside resources and make appt and arrange transportation
  - This section **deleted** although still in manual
- May charge a Medicare resident for routine and emergency dental services
- Must have policy identifying when loss or damage to dentures is facility's responsibility so may not charge resident
  - Must refer residents within 3 days for lost or damaged dentures and document what they eat or drink in the mean time
  - Refers to Appendix PP

Nutrition 1626

- Assisted Nutrition and Hydration
- This includes NG tubes and gastrostomy tubes
  - Both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral feeding
- Based on assessment must make sure maintains usual body weight and electrolyte balance
  - Unless can show not possible or resident preference
- Is offered sufficient fluid intake
- Appendix PP for IGs and survey procedure

Nutrition 1626

- Suggested parameters for evaluating significance of unplanned and undesired weight loss are:

Interval	Significant Loss	Severe Loss
1 month	5%	Greater than 5%
3 months	7.5%	Greater than 7.5%
6 months	10%	Greater than 10%

Distinct Units

- Any CAH that has a distinct part unit should read the section starting with tag number 500
- This section will not be covered
- There are a few examples of what is in this section
- So if you have a separate 10 bed behavioral health or rehab unit you need to be aware of these tag numbers
- Goes from tag 500 to 596 and 700 to 781
- C2400 etc on provider agreement and refers to EMTALA which is Appendix V

EMTALA

- CAH must report to CMS if they have reason to believe they have received a patient who was transferred in an unstable medical condition from another hospital (2401)
- Must post signs as required by EMTALA (2402
- Basically this recited the provisions in the EMTALA law
- It is 68 pages long and has 12 tag numbers
- Goes from Tag 2400 to 2411

CAH with District Part Units

- CAHs can have up to a ten bed behavioral health unit or rehab unit (Tag 500)
- If so they are governed under appendix A
- Beds are not included in the 25 bed count (501)
  - 96 hour rule does not apply to these bed either
- Must have written criteria for both that apply to all patients including Medicare (504)
- Must have admission and discharge records that are separately identified from those of the hospital in which it is located and are readily available (505)

CAH with District Part Units

- Psych unit must have policies that necessary clinical information is sent when a hospital patient is transferred to the unit (506)
- Psych unit must meet all state laws (507)
- Must have UR standards for the type of care offered in the psych unit (508)
- Beds must be separate and not commingled (509)
- Psych beds must be serviced by same FI as the hospital (511)
- Must use accounting system that allocates costs (512)

CAH with District Part Units

- Psych unit must maintain adequate statistical data to support the basis of allocation (513)
- Must also report its cost in the hospital's cost report covering the same fiscal period and using the same method of apportionment as the hospital (514)
- Must be fully equipped unit and staffed regardless of whether there are any psych or rehab patients on the first day of the cost reporting period (515)
- Any hospital with these two units need to read this section and there are more tag numbers

AHA Website on CAH

- Provides updates,
- Directory of resources,
- Federal legislation, OIG report on CAH
- Growth of the program,
- Grants, Newsletters,
- State hospital association links, and supervision of hospital outpatient therapeutic services
  - http://www.aha.org/advocacy-issues/cah/index.shtml

Critical Access Hospitals

CAHs are rural community hospitals that receive cost-based reimbursement. To be designated a CAH, a rural hospital must meet defined criteria that were outlined in the Conditions of Participation 42CFR485 and subsequent legislative refinements to the program through the BBRA, BIPA, the Medicare Modernization Act, the MIPPA, and the PPACA.

The AHA ensures that the unique needs of its various constituents are heard and addressed in national health policy development, legislative and regulatory debates, and judicial matters. Indeed, from its initial creation as part of the Balance Budget Act of 1997, the AHA has been a champion of the development and subsequent improvements and enhancements of the CAH program.

Securing the future of CAHs and the essential role they play in caring for rural America is of paramount importance. The AHA is vigilant in the face of legislative, regulatory and policy proposals that threaten the local delivery of care and rural community health status. The AHA will continue to advocate on behalf of CAHs for fixes to payment and administrative limitations that constrain the efficiency and effectiveness of these essential health care providers.

Communications

- Value of AHA Membership for CAHs
- Update Newsletters
- The Fragile State of Critical Access

AHA Poster on CAH

IN CRITICAL CONDITION

THE FRAGILE STATE OF CRITICAL ACCESS HOSPITALS

1,330 Critical Access Hospitals (CAHs) provide essential medical care to rural communities across 45 states. Each CAH maintains 25 or fewer beds and directly contributes an average of 204 jobs to the local economy. While their health care services have bolstered rural areas, CAHs are supported by a fragile financial foundation.

BRIDGING GAPS IN ACCESS TO CARE

CAHs' service to America's rural communities plays an important role in the nation's health care landscape.

ANNUAL SERVICES PROVIDED TO PATIENTS

7 MILLION patients treated in CAH emergency departments.

38 MILLION outpatient visits to CAHs.

900,000 patients admitted to CAHs.

86,000 babies delivered at CAHs.

1,330 CAH LOCATIONS

19.3% of the U.S. population resides in rural areas, as of the U.S. Census Bureau's 2010 Census.

DELICATE LIFELINES

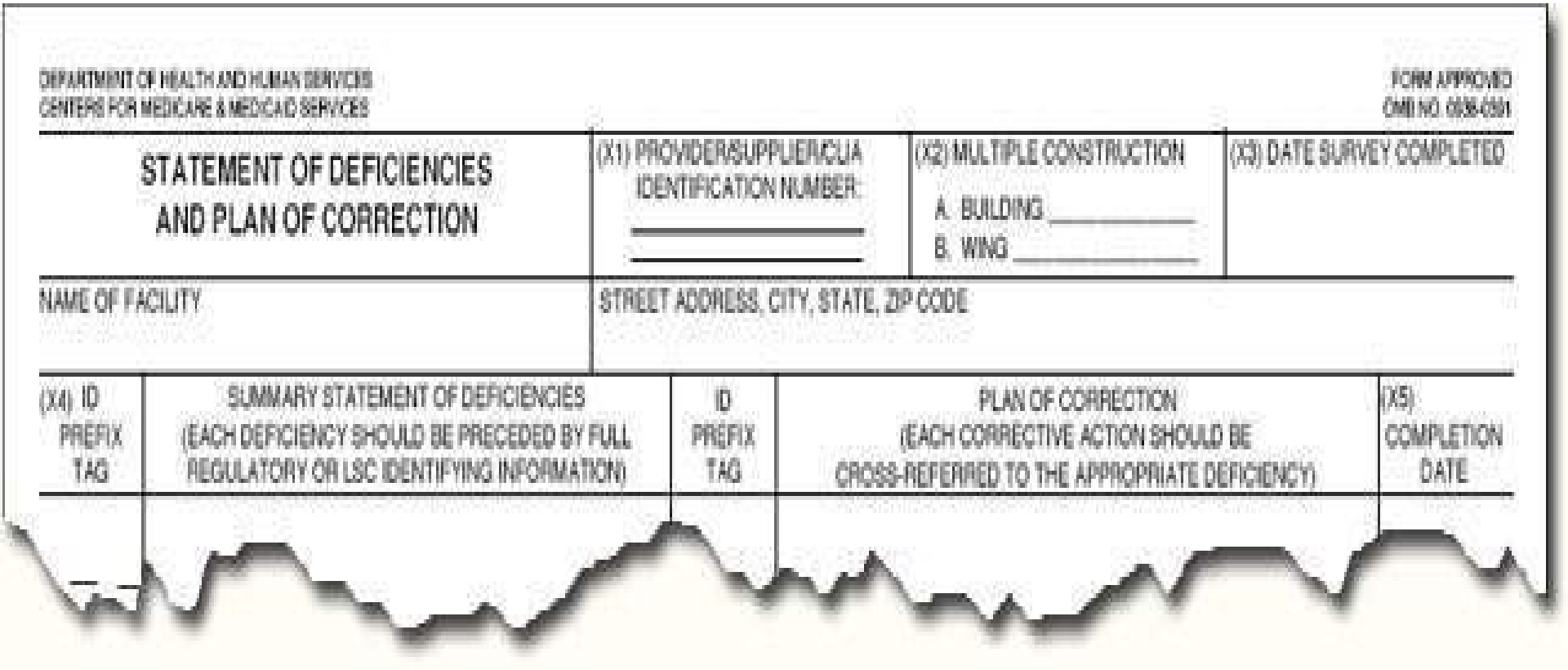
CAHs' small size means that they can only focus on providing the most essential medical services, in contrast to higher-volume hospitals that have more resources and flexibility to offer a wider range of services. CAHs simply don't have the same economies of scale as their larger counterparts.

More than 60% of their revenue comes from government payers, such that any payment reductions to Medicare or

MANY CAHS STILL STRUGGLE

Although Medicare pays CAHs 1% above the cost of providing care, CAH revenues from other payers often don't cover costs, illustrating why adequate Medicare payments must continue in order for CAHs to be able to provide care for rural populations.

PERCENTAGE OF CAHS WITH NEGATIVE ALL-PAYER MARGINS:



DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		A. BUILDING _____ B. WING _____	

NAME OF FACILITY	STREET ADDRESS, CITY, STATE, ZIP CODE

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY SHOULD BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERRED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

- Statement of Deficiencies and Plan of corrections,
- Based on documentation of surveyor worksheet or notes and form CMS-2567,

The End Questions???

- Laura A. Dixon RN, Esq., CPHRM
- BS, JD, RN
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- Denver, Colorado 80206
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Websites

- Tools and Resources Rural Health Resource Center at http://www.ruralcenter.org/tasc/
- American Association for Respiratory Care AARC- www.aarc.org,
- American College of Surgeons ACS- www.facs.org,
- American Nurses Association ANA- www.ana.org

Websites

- Center for Disease Control CDC – www.cdc.gov,
- Food and Drug Administration- www.fda.gov,
- Association of periOperative Registered Nurses at AORN- www.aorn.org,
- American Institute of Architects AIA- www.aia.org,
- Occupational Safety and Health Administration OSHA – www.osha.gov,
- National Institutes of Health NIH-www.nih.gov,

Websites

- United States Dept of Agriculture USDA- www.usda.gov,
- Emergency Nurses Association ENA- www.ena.org,
- American College of Emergency Physicians ACEP www.acep.org,
- Joint Commission Joint Commission- www.JointCommission.org,
- Centers for Medicare and Medicaid Services CMS www.cms.hhs.gov,

Websites

- American Association for Respiratory Care AARC- www.aarc.org,
- American College of Surgeons ACS- www.facs.org,
- American Nurses Association ANA- www.ana.org,
- AHRQ is www.ahrq.gov,

Websites

- American Hospital Association AHA- www.aha.org,
- CMS Life Safety Code page - http://new.cms.hhs.gov/CFCsAndCoPs/07_LSC.asp,
- COPs available in word and PDR at http://www.access.gpo.gov/nara/cfr/waisidx_04/42cfr485_04.html,
- American College of Radiology- www.acr.org,

Websites

- Federal Emergency Management Agency (FEMA)- www.fema.gov,
- Drug Enforcement Administration –www.dea.gov (copy of controlled substance act),
- US Pharmacopeia- www.usp.org, (USP 797 book for sale),
- Rural Assistance Center or RAC at http://www.raconline.org/
- CAH seminar Oct 2007 handouts at http://www.nrharural.org/conferences/sub/CAH.html

Websites

- National Patient Safety Foundation at the AMA- www.ama-assn.org/med-sci/npsf/htm,
- The Institute for Safe Medication Practices- www.ismp.org
- U.S. Pharmacopeia (USP) Convention, Inc.- www.usp.org
- U.S. Food and Drug Administration MedWatch- www.fda.gov/medwatch
- Institute for Healthcare Improvement- www.ihi.org,
- AHRQ at www.ahrq.gov,
- Sentinel event alerts at www.jointcommission.org,

Websites

- American Pharmaceutical Association-www.aphanet.org
- American Society of Heath-System Pharmacists-www.ashp.org
- Enhancing Patient Safety and Errors in Healthcare-www.mederrors.com
- National Coordinating Council for Medication Error Reporting and Prevention-www.nccmerp.org,
- FDA's Recalls, Market Withdrawals and Safety Alerts Page: http://www.fda.gov/opacom/7alerts.html

Pa Patient Safety Authority

www.psa.state.pa.us/psa/site/default.asp