Task 2 - Entrance Interview Activities and Questions

Upon arrival at the agency, complete the following activities:

1. Inform the Agency administrator, director, or supervisor of the purpose of the survey.
2. Present identification and introduce the survey team members.
3. Explain the survey process, and estimate the number of days onsite.
4. Discuss the extent to which the Agency staff may be involved during the survey.
5. Request verbal explanation of organizational structure, lines of authority, delegation of responsibility, and services furnished (both directly and under arrangement) and the Agency's relationship to any corporate structure
6. Ask if the Agency is operating any additional locations, including branches.
7. Request a meeting with appropriate staff based on the organizational characteristics of the Agency. Request a copy of the organization chart, if available
8. Ask for the number of unduplicated patients admitted receiving skilled services during a recent 12-month period.
9. Ask for a list or access to names of patients scheduled for a home visit during the survey. Include all branch locations.
10. Ask for a list of current (direct and contracted) employees (including name, title).
11. Request the names of key staff (i.e., staff persons most knowledgeable about the home health aides, in-service training, clinical supervision) and the clinical staff person who will be the primary resource to respond to the surveyor's questions.
12. Verify the process to follow in order to have unrestricted access to the clinical records.
13. Request access to all active patient names (Medicare/Medicaid/private pay) receiving skilled services that identifies the start of care (SOC) date, primary diagnosis, and services provided. This will aid in selecting the sample for home visits with record review based on the review of the OBQM and OBQI reports.
14. Request specific closed records for review from the agency's Potentially Avoidable Event Patient Listing report.
15. Set up the schedules for any necessary interviews with staff.
16. Request space to work after the completion of the entrance interview.

During this interview, begin to gather information from the agency about its compliance with the Level 1 standards.

For example:

1. Ask how complaints are investigated and how the existence, investigation and resolution are documented. Request and review a copy of the agency documentation of complaint investigation and resolution.
2. Review patient admission packet for instructions for making a complaint.
3. Ask how the agency ensures that all clinical staff members (direct and contractual) follow professional practice standards, laws, Agency policies and procedures.
4. Ask how the Agency monitors the professional skills of its staff to determine if those skills are appropriate and adequate for the agency's patients (e.g., competency testing, supervisory visits, skills labs, etc.).
5. Ask if there are any services that the agency sometimes has trouble staffing, and if so, what they do when a patient needing those services is referred.

6. Ask administrative staff if the Agency has a policy re: how quickly an order for therapy, MSW, or an aide will be staffed.
7. Ask how the Agency staffs RNs and LPNs. If Agency relies primarily on LPNs for most visits, how does Agency ensure that RNs supervise and manage each case?
8. Ask how the Agency staffs therapists and therapy assistants.
9. How does the Agency ensure that qualified therapists supervise and manage their patients?
10. Ask if aides are direct employees of the Agency or provided by arrangement.
11. Ask what the Agency's system is for tracking aide supervisory visits.
12. Ask if the Agency accepts electronic signatures by either clinicians or physicians, and what the related policies allow.
13. Ask how the clinical records are maintained (i.e., all electronic, all paper, or combination), stored, and accessed. How is confidentiality of records maintained out of the office?
14. Ask what time frame is allowed for clinicians to turn in documentation following a visit. If there is a stated/published policy, is there a monitoring system present? What are results of internal monitoring?
15. Ask what the Agency's time frame is for documents to be filed in patient record.
16. Ask where clinicians document aide supervisory visits, case conferences, phone calls, medications, etc
17. Ask what the Agency's policy is for making corrections in the clinical record.
18. Ask what the Agency's policies are for conducting the initial and comprehensive assessments (including whether therapists complete these assessments).
19. Ask how the Agency ensures that initial assessments are conducted within the required time frame.
20. If problems with OASIS data submission are evident in the reports reviewed pre-survey, ask the administrative staff to address those issues

Arrange a time with clinical managers to ask them the following questions:

1. Describe the Agency’s process of drug regimen review, including how this is accomplished when a therapist completes the comprehensive assessment.
2. How does the Agency address medication discrepancies (e.g., what is in the home differs from orders received) or patient non-compliance?
3. How does the Agency respond to prescriptions from physicians other than the physician responsible for the patient's home health care?
4. How does the Agency determine when there has been a "major decline or improvement in the patient's health status" that would warrant an update of the comprehensive assessment?
5. Ask how the Agency tracks due dates for updating the comprehensive assessments.

Task 3 - Information Gathering - Interviewing Questions

Probes for interviewing Clinical Managers:

1. How do clinical managers ensure that physician orders, agency policies, and regulations are being followed in delivering care to each patient (including obtaining interim orders and getting physician signatures)? How are prescriptions from other physicians seeing the patient handled?
2. How are clinicians (all services) assigned to cases, including case managers?
3. How are clinicians and aides instructed to maintain clinical record confidentiality outside the office? What is the time frame for submitting completed documentation? How are errors identified and corrected?
4. How do clinicians ensure that initial assessments are conducted within the required time frame and that all assessments are comprehensive?
5. Who completes the drug regimen review? How is it documented for therapy-only cases? At follow-up and discharge time points?
6. How do clinicians determine when there has been a "major decline or improvement in the patient's health status" that would warrant an update of the comprehensive assessment? How does the agency track due dates for updating the comprehensive assessments?
7. Where in the clinical records should surveyors find documentation of aide supervisory visits, case conferences, phone calls, medications, wound care and wound measurements, etc?
8. What resources are available to nurses and therapists for care problems and how do they access the resources when need is identified?
9. Who documents patient care instructions for aides and where are the instructions filed? Is a copy left in patient's home?
10. Who determines whether an aide needs in-home demonstration or instruction in a care procedure? Who does the aide call with patient-specific questions?

Probes for interviewing case managers and clinical staff members

1. How do clinicians involve patients and their caregivers in planning care?
2. How do case managers and other clinicians communicate necessary information about patient condition, response to interventions and teaching, changes in the plan of care, and discharge planning to the patient/caregivers? How is this same information shared among the appropriate care providers (including physicians and aides)?
3. Is the clinical staff member knowledgeable about where to turn for help with difficult clinical problems? Has he/she sought help regarding a specific issue noted on home visit or record review? What response was received?
4. How do clinicians ensure the safety and confidentiality of patient records when transported for use during home visits?
5. Is clinician knowledgeable about the correct way to make a correction in a clinical record?
6. What actions are taken when the medication(s) in the home differs from orders received or when patients are non-compliant with medications, diet or treatments?
7. How do you handle prescriptions from physicians other than the physician responsible for the patient's home health care?

Task 3 - Information Gathering Questions - Record Review Guidelines

1. Review the most recent plan of care for the primary admitting diagnosis, and the goals to be accomplished by the care.
2. Based on the initial assessment and current clinical notes, determine if the patient's medical situation, drug regimen and functional abilities have progressed in relation to the specific care that has been provided. If the patient's clinical and functional abilities have not progressed, have intervening events been recorded appropriately?
3. If the initial assessment occurred greater than 48 hours after the referral was received, was the discrepancy explained (physician ordered, patient request, or approved by physician)?
4. Are comprehensive assessments complete?
5. Are comprehensive assessments completed on time and by the appropriate clinician during a home visit at start of care, within 48 hours of (or knowledge of) patient's return home from an inpatient stay, every 60 days (or more frequently), and at discharge?
6. Are medications on plan of care, medication list (if applicable), and visit notes the same?
7. If a record indicates that a patient had a "major decline or improvement," was the comprehensive assessment updated?
8. Determine how the HHA ensures coordination of services among and between personnel providing services. What evidence do you find in the clinical record(s) that this is occurring?
9. Determine if the patient's continuation of services or discharge seems appropriate at the time of record review.
10. If information cannot be found or cannot be interpreted or integrated, ask the HHA staff to either find the information or help you understand its content.
11. Is there evidence that patients verbalized complaints and how the complaints were addressed?

12. Is there evidence that the patient/caregiver was informed about and contributed to planning the patient's care?
13. Are there examples of care provision not in compliance with laws, regulations, accepted professional standards or HHA policies and procedures (e.g., documentation of wound care, wound assessment, or physical assessment)?
14. Is information about patient condition, response to interventions (e.g., medication side effects, responses to wound therapy, laboratory values, etc.,) and teaching, changes in the plan of care, and discharge planning discussed with or forwarded to the appropriate care providers as applicable, including home health aide and physician?
15. Are case conferences, informal conferences and phone calls documented?
16. Did the HHA begin services as ordered within the ordered time frame, at the frequency ordered?
17. Do plans of care contain all required elements and are they reviewed by the physician every 60 days?
18. Are plans of care patient-specific (i.e., contain measurable goals and instructions for care that are specific to the individual patient) with stated parameters for measurements where appropriate?
19. Is there evidence that physician orders obtained after the beginning of each 60day episode of care are documented and implemented?
20. Do clinicians promptly report patient status changes, including variance from any parameters stated in the plan of care?
21. Is there evidence of patients denied or not offered needed services?

22. Review records of patients that have been hospitalized or Medicare low utilization payment adjustment (LUPA) patients to determine if sufficient care is being provided.
23. Is nursing care provided to each patient as ordered on the plan of care?
24. For patients with co-morbidities, is there evidence that inter-related factors are addressed in managing the patient's care (e.g., addressing nutrition and skin care in a wound care patient who has diabetes)?
25. Is there evidence of patient needs that are not addressed in the plan of care or communicated to the physician?
26. Are therapy visits made at the frequency ordered?
27. Are assessments & communication with other care providers documented?
28. Is therapy provided to each patient as ordered?
29. Is there evidence of patient therapy or equipment needs that are not addressed in the plan of care or communicated to the physician?
30. Were physical therapy assistants, occupational therapy assistants, and licensed practical nurses appropriately supervised according to State practice acts and the HHA's policies and procedures?
31. Were home health aide supervisory visits made every two weeks?
32. Did the RN or therapist ever observe aide's provision of care?
33. Was aide instructed in any clean dressing changes or other specialized procedures?
34. Was aide's care provided according to the written instructions and the physician's orders?
35. Were written instructions provided to the aide specific to the patient?
36. If record seems incomplete, note the date of the latest filing in records and ask about any documentation waiting to be filed.
37. Do clinicians consistently document vital signs; insulin injections; blood glucose values; wound appearance, location(s) and treatment; and pain location(s), frequency, severity, interventions, & response to interventions?
38. How are corrections made in clinical record? Is there evidence of different handwriting in the record signed by the same clinician?
39. Do records of discharged patients contain discharge summaries?
40. Do records contain periodic summaries of patient care that were sent to physicians?
41. Do records show consistency in assessment of patient's status and progress over many visits (e.g., wounds in consistent locations, patient weights seem logical, pain management, presence of Foley catheter, etc.)?

Task 3 - Information Gathering Questions - Home Visit Probes

1. Are there instances of staff providing care that may not be in accordance with laws, regulations, state practice acts, accepted professional standards or agency policies/procedures (e.g., wound care procedures, prevention of infection, physical assessment, and medication review)?
2. How do providers communicate with patient/caregivers and identify the need to communicate with other providers?
3. When pertinent clinical findings are noted during visit (e.g., changes in patient condition, new medication, lab values, updates to the plan of care, etc.,) how will the provider follow up or share the information with the appropriate care providers? Is there evidence that the communication plan was implemented?
4. Did the care provider(s) deliver care as ordered and according to accepted professional

standards of practice (e.g., CDC guidelines) and agency policy?
5. Did the care provider report any untoward or unexpected patient changes immediately?
6. Do clinicians follow CDC infection control guidelines, state practice act, agency policies and procedures and accepted clinical standards in providing care?
7. How does the aide interact with patient/caregiver(s)?
8. Did the aide provide care as described on written instructions?
9. Are medications in the home the same as those listed on plan of care, interim orders and the clinical record notes?
10. Ask the clinical staff about instances of patient care noted in home visits or record reviews that deviated from the physician's orders, accepted professional standards or agency policy.

Interview Questions for Patient/Caregiver

1. What care does the aide provide?
2. Are your needs being met?
3. Are you satisfied with the care?
4. What medications are you currently taking? Compare this with the orders and medications in the clinical record.
5. Have there been setbacks or problems during your episode of home care and how has the agency addressed them?
6. Are you concerned about problems that have not been addressed by agency staff to your satisfaction?
7. Have you been able to participate in planning care?
8. If you had a complaint, would you know who to contact and how?
9. Is the care being provided as you were told it would be?

Discontinue the interview if:

1. The patient shows signs of being uncomfortable or seems reluctant to talk, and if, after asking the patient, he or she says they would rather discontinue the discussion;
2. The patient appears tired, overly concerned, agitated, etc., and would like to end the interview, or, if in your judgment, it appears to be in the patient's best interest to end the interview; or
3. Conditions in the patient' home, such as safety factors, perceptions of intimidation, etc., are of concern to you or the agency representative.