CQI Forum Minutes

February 25, 2016

Meeting Notes:

Gina- How is it going with Probe and Educate?

- Getting denials for ADRs. NGS not looking at charts, down code and or take away visits and payments
- 2 foley cath denied for lack of skill.
- PAs visit note wasn't cosigned (doesn't need to be), was denied.
- We are all confused as to what the "rules" are.
  The F2F doesn't have to be cosigned but a physician has to say all the elements have been met. It's confusing. It's not easy to pull all the info from the clinical record, MD visit.
- Look on NGS into education and register for every Tuesday at noon, 12-1230. More questions are raised after the fact. How to get physicians to do their piece and embed info into the documentation. You can use F2F form but you need additional documentation.

Gina: a question from a Vermont agency was anyone having trouble- the physician has to identify who the community physician will be who is overseeing the poc and name them by name. Should be in dc summary, can't just say "PCP". How can they promise that the pcp will follow the poc? How do they know who it will be? Do they have time to do all this in a note and how do they remember to do it? Some agencies are embedding into the 485 the need for skilled care.

- Should this be NGS's responsibility to educate instead of ours?
- It's a ton of work and cost for agency staff.

Other Association business:

- *HCANH Education: documentation with Trish Tulloch. Sign up for webinars. Webinars are recorded so staff can listen later.
- *Star ratings: Gina sent out article, star ratings are different between quality and patient satisfaction.
- *DHMC is the biggest user of the HCANH website. Their firewall has now blocked the website since it was hacked.

A3 Tool Overview:

Owner, facilitator, coach, leader.

We are focusing on M215 which is on hhcompare and is a star rating measure. Last time we ranged our scores 90-99%. Our Problem Statement is: Aug 2014 to sept agencies range, 2/10 less than natl avg…negative impact on star ratings etc" (see problem statement). Targets and goals: to increase ratings.

Therapist knowledge, clinical knowledge, lack of processes (other healthcare professionals can do the teaching), lack of process for clear documentation, back to back visits not always done to provide education, computer glitches, accessibility at home environment, old meds vs new in home,

Counter measures: education, define std work of med educ and rec, define std doc location, work with IT for access, work with staff to allow space and focus, involve caregivers

Strategies: If there is a "No" answer to med education, see a manager.

1. Define standard work of med education and rec
   a. require clinicians at soc to make sure all meds are out,
   b. request over the phone before you go, they have the meds ready for you, there are barriers,
   c. have clinician educated on meds in the system to know how to look up the side effects and education in the computer software, can print later for pt if needed,
   d. provide nursing handbooks if needed/wanted for med/drug ref, can look up online if on wifi,
   e. have clinical director or educator show staff how to look up meds in system,
   f. require med education for at least the first 5 visits when nursing is involved.

g. have a short bullet for quick nursing audit
    i. is dx addressed
    ii. is med edu provided
    iii. is pt response to education provided
    iv. is visit skilled?
h. Sometimes have to say no if dementia pt and no cg available,
i. see if someone else did med education at other office site such as hospital or md office. Some agencies have pharmacist to review med req.
j. Check for same drug twice- generic name and trade name.
k. Compare a list to a list, dc list, md list, pt's list is confusing. Go by the dc list and pcp list, try to determine accuracy and call MD.
l. Take 2 days if needed. Ask for additional visit next day if needed.

If problem with meds, put issue **and document**. Document if issues were resolved, clearly document so all clinicians can easily tell. Meds not in home yet, pt confused, etc. Have a central documentation location, educate clinicians. Report severe interactions to MD. Not all interactions need to be sent, use critical thinking. If pt has been on long term and there are interactions, pt is tolerating.

Do competencies for med rec. Do a fair, have bottles with different expiration dates, have staff simulate med rec and answer questions, demonstrate.

- If OT tells a pt to use an electric razor instead of blades, they are providing coumadin teaching and may not know it. In assisted living, even if we aren't managing meds, we are teaching about bowels, stool softeners, bleeding, etc. Discuss with nursing staff to see what education they are providing, collaborate, let them know you aren't telling them their job, you are required to provide education so you want to discuss it.
- ST teaches about swallowing pills, take credit for what you do. PT teaches pt about pain also. Since the last oasis assessment means anytime…since last oasis and 24 hours before.

Staff education: *related to helping them have a conversation with pts re space and need to focus*

Staff education, call pt ahead, get meds out including old, new and herbals, will take a bit of time, give nurses and therapists a sharpie and zip lock bags to put messages on "do not take" etc. or write on top of bottle, use mediplanner, bring extras in your car, use a different one for Coumadin or high risk med if needed.

Do a 2-day admit, same clinician, make it about med req, start the oasis on 2nd day. Hands on competency, on orientation and annually, have bottles with different meds and diff scenarios in office with errors, provide hands on education.

- Work flow- what's expected from med req algorithm if this, then that. Communicate when pt not taking meds properly with md. Empower staff.
- What are the barriers? Pt education, pt does not want to take, doesn't want to admit to a dx. Be a TEAM with the therapists, LNAs, all staff. Collaborate. Educate pt on their risk for going back to hospital.

Clarification, verification with md, completion of med req. Make sure the 5 (7) rights are all correct, right dose, time, etc. Critical thinking- labs vs dosing. If nurse enters the data herself, it gets embedded more into the plan and pt education, more problems will be found.

- Why are they taking a med? End all meds prior to a new admission.
- Who is responsible to pick up and order the meds? Identify a single pharmacy and caregivers. Resource of pharmacies that deliver. Some free, some monthly fee.
- How to roll out the education? Power point, scenarios, not just one thing, annual competency, annual ride along. Do 2 or 3 visits watching med rec.

Instead of saying "good response to teaching" say what the pt understood.

For next time:

Bring data related to pain next time. Pain interfering with daily activities- scores.

Dates are Aug 2015 to Sept 2015 from Casper Reports.

- Follow plan of care and document.
- Communication with provider with solid process in place for missed visits.
- Pt care coordination very important.
- MSW said pt needed wheelchair, will follow up with PT, There was not follow up doc in PT notes, it looked like it wasn't addressed. It was probably addressed in email and not in communications.
- Get clinicians to think about not using text or email but use a communication note.

- Try to meet high end of frequency. Try not to use range.
- If pt cancels visit, not communicated to MD. Documentation not there.
- Actual missed visits outside of freq need to be communicated. *****Can say it will be documented on dc summary****** this passed a Medicare survey.
- Clinician doing the recert can count the visits, or the person doing QA at dc.
- Discussed computer systems, cloud based systems.
- Reviewing OASIS- some send to McBee, all starts and recerts.
- One agency has clinician call the auditors from the home and doing the oasis live during the visit. Doing routine auditing for skill.
- One agency- Auditor makes the change and clinician signs after one on one review. Compare intensity of the service with the severity of the illness. Pick 2 problems to document on every visit, one being the qualifying event. Stay focused on that condition. Use the words “qualifying event” in the clinician note.

Next Meeting Agenda Items

March 24, 2016 from 9:00 to noon

125 Airport Road, Concord