Sullivan County Department of Public Health

Title: Quality Standards; Performance Standards of Care for Laptop Documentation; Data Standards; Productivity Standards; Documentation Standards; Practice Standards in Home Care **Number**: AG-57 **Page Number:** 1 of 4	Original Approval: 6/09 Reviewed/ revised: 6/12, 9/13, 11/18, 7/20, 2/22, 11/22, 2/24

Statement/ Purpose:
To establish measurable performance standards for Sullivan County Department of Public Health Certified Home Health Agency (SCDPH CHHA) and Long-Term Home Health Care program.

Authority:
County of Sullivan, the New York State Department of Health, NYS Codes Rules and Regulations, Public Health Law, NYS Department of Education, Centers for Disease Control, Center for Medicare and Medicaid Services, NYS Nurses Association, the Nurse Practice Act

Application:
All SCDPH CHHA staff

Terminology:
n/a

Responsible Party:
Director of Patient Services

Cross-Reference:
n/a

Procedure:
Quality Standards
SCDPH ensures all care giving staff are qualified, trained and appropriately supervised to meet the needs of the patients they serve

Sullivan County has policies and procedures to prevent and penalize employee misconduct, including but not limited to unlawful discrimination, sexual harassment, exhibiting a substance use disorder, falsification or failure to keep appropriate records and disobedience of agency policy and procedure

SCDPH complies with the provisions of applicable federal and state laws and regulations, including those concerning standards of quality and professional practice

SCDPH performs periodic supervisory visits to ensure care is provided consistent with the written plan and updated as needed.

SCDPH has a written procedure in place to respond swiftly and effectively to patient complaints

SCDPH maintains records of all care and services in accordance with applicable legal standards

Standards of Care for Laptop Documentation

- The laptop is brought into the patient's home to document patient assessment data and maintain continuity of the patient care plan including patient teaching and care, including patient's response and compliance from one visit to the next.
  (It is understood that some environments are not conducive to electronic data entry and in these cases documentation will occur as close to the actual visit as possible).
- Laptop data entry in the home is arranged before and after patient care after proper hand hygiene has taken place.
- Visit information is entered the same day the visit was made and locked by the end of that business day.
- All visits are completed, transferred and locked prior to vacation and re-assignment.
- Laptops are closed during transport from one location to another.
- Laptops are not to be left on while unattended and are to be 'on' only when data is being entered or retrieved from the patient record.
- Staff will not engage in eating, drinking, or smoking while documenting on laptop

Data Standards

- Billing statistics for patients are maintained and updated throughout the day, completed at the end of each day and submitted to the billing department weekly on Monday. In case of vacation or unplanned absence, they are to be turned in the next working day.
- Mileage sheets are completed on an ongoing daily basis. Completed accurate mileage sheets are submitted no later than the 6th of each month.
- Visit notes are completed the same day the visit was made and locked by the end of that business day.
- OASIS data: start of care, resumptions of care and recertification that are waiting Coding are to be completed and locked within 5 business days. Discharges, transfer to in-patient facility, or any other documentation that is not awaiting codes are to be completed and locked the same day.
- Clinicians perform data transfers at least once daily when in the office, Government Center, or by use of the 'Hot Spot' provided on the County Cell phone.
- Coordination of Service (COS) notes are to be written every 2 weeks.
- Re-certifications of patients' physician orders must include a home visit within the 56-60 day window. A 60-day summary justifying why services need to continue accompany all re-certification.
- Discharge and discharge summary must be completed by COB and sent to the Physician, patient and their representative within 5 days of discharge. A Transfer Summary is sent to the facility within 2 days of notification of admission to said facility.

Productivity Standards

- It is expected that each clinician will maintain a minimum level of productivity of 5 weighted points per day. Please see productivity standards below. Supervision meets at least weekly with clinicians who are unable to adequately maintain a caseload on an ongoing basis to ascertain the reason(s) why and provide guidance and direction.
- If the clinician is unable to maintain the ordered home visit frequency, the clinician will bring it to the attention of the supervisor to ensure the patient is re-assigned to maintain the visit frequency as delineated in the plan of treatment.
- Calls are to be made to the patient/caregiver the day before the visit to schedule appropriately.
- The clinicians' day is to begin at the Liberty office, Government Center in Monticello, or at the patient's home.
- The clinician will submit a daily report at the EOB via email that includes total of weighted points achieved that day, any approved activities (in-service, outreach) or non-billable visits that is not captured in the weighted points, and request for OT.
- Clinicians will maintain their schedule to be an accurate representation of their intentions for 14 days out.

Type	Hours	Weighted Value
SOC	2.5	2
Routine/ PRN	1.25	1
Discharge	1.5	1.2
Recert/ ROC	2.5	2
Initial eval/ 30 day reassess	1.75	1.5
Not Taken Under Care with Home visit (NTUC)	2	1
PCA Eval	2	2
PRI/ Screen	2	2

Documentation Standards

- A new referral is seen within 24-48 hours unless there is documentation that the patient or physician requests a delay in start of care.
- When a patient does not meet admission criteria to the CHHA, (per agency policy and state regulations), the reason is documented under admission and discharge profile, the Supervisor is consulted and the ordering physician is notified.
- The patient face sheet is faxed to contract staff that do not have EMR access on the start of care date. If the contract staff are unable to start within 10 days of start of care, the contract staff calls the physician, nurse and patient and documents same in the patient record.
- For those staff members with EMR access, an evaluation visit is assigned to any additional discipline ordered at SOC. If the discipline is not able to schedule an evaluation within 10 days, the case manager and physician are notified and the record is noted.
- The case manager is aware of all service modalities currently servicing the patient in the home, their goals,

and what progress is being made toward meeting them. A coordination of service note is documented no later than every two weeks in Case Conference Notes.

- The medication management template developed in Netsmart is used to document medication teaching, including patient's response, on patients taking medications. A comprehensive medication review is done every visit, unless the patient is receiving daily care, in which case it is done twice per week.
- Patient teaching and patient's response to teaching is documented in the long-term goals in the appropriate areas in the patient record
- Wound measurements and changes in wound status are documented in the patient's record per SCDPH policy and WOCN guidelines, no less than weekly.
- There is documentation in the patient record that the physician is notified with any changes in patient's status
- Laboratory results are followed up on the next business day and PCP is made aware of same.
- The home health aide care plan is reviewed with the patient no less than every fourteen days and a home health aide supervisory note is documented describing what areas of assistance are required and if the patient requires more or less home health aide hours.
- If the patient continues to receive Home Health Aide services thirty days after the start of care (SOC) an on-site home health aide supervisory visit is performed and documented no later than day thirty from SOC while HHA is present in the home
- A Home Health Advanced Beneficiary Notice (HHABN) is furnished to all Medicare beneficiaries when visit frequency or items are provided are less than what was written on the original orders (485).

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Practice Standards

- Every attempt is made to introduce the Home Health Aide on the second home visit.
- Prior to the home visit, the patient's care plan is reviewed for changes.
- Progress notes from all disciplines are reviewed prior to the home visit.
- Nursing supervisors are consulted and the ordering physician is notified before making referrals to Adult Protective Services or Child Protective hot line calls.
- Overtime is approved by supervision. The clinician will request overtime providing a justification of the additional time needed to complete their assignment. This also applies to weekend duties.
- All field staff may work remotely on a routine basis. This privilege may be revoked if necessary.
- When there is a change in a patient's status, the PCP is notified.

The above listed standards do not duplicate policies and are not all inclusive. Staff remain accountable for following standards and regulations, including but not limited to the County of Sullivan, the New York State Department of Health, NYS Codes Rules and Regulations, Public Health Law, NYS Department of Education, Centers for Disease Control, Center for Medicare and Medicaid Services, NYS Nurses Association, the Nurse Practice Act. Failure to adhere to the above may result in disciplinary action.