

Policies for Review at Annual Update

June –December 2013

Standing Orders for Administering Inactivated Poliovirus Vaccine to Adults > 18 years of Age
Personnel Policy for Staff & Contracted Employees including Yearly Influenza Vaccine
Multifactor Fall Risk Assessment
PECOS/OPRA/K-CHECKS

January 2014 – September 2014

HCCN Policy and Procedures
ABN Policy and Procedure
Procedure for Completion of Patient Signature Validation Form for Clinician & Home Health Aide (including Form A and Form B)
Standard for CHHA/LTHHCP Nursing Unit
Utilization Review Medication Reconciliation Audit Tool 2014
Utilization Review Wound Care Audit Tool 2014
Nursing and Ancillary Services Referral Form Procedure (including 2 Referral Forms)
Clinical Documentation Email System Policy and Procedure
Multi-factor Fall Risk Assessment
Standards for Wound Assessment
Standard for On-Call PRN Nursing Visit
Medicare PPS Billing Policy and Procedure
Medication Reconciliation Policy for Therapy Only Patients (revised)
Peer Review Audit Policy and Procedure (revised)
Utilization Review Pain Management Audit Tool
Code of Ethics for Nurses
Walk in Blood Pressure Checks Policy & Procedure with Appendix A & B
Annual Employee Health Assessment (revised)
Patient Transfer Procedures for Emergency Situations (revised)

**SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE
POLICY AND PROCEDURE**

**PERSONNEL POLICY FOR STAFF AND CONTRACTED EMPLOYEES
(PRE/POST REQUIREMENTS)**

Date Drafted: 07/01/08

Date Approved: QA 9/18/13

Date(s) Revised: 09/03/2013

POLICY:

Prior to the first day of employment, all Saratoga County Public Health employees and contract personnel (physical therapist, medical social worker, nutritionist, speech pathologist, and occupational therapist) will have documentation of pre-employment physical, Rubella and Rubeola (Measles) immunity, Tuberculosis screening (PPD or chest x-ray/symptom screen for persons with history of positive PPD reaction), and a current year seasonal influenza vaccination, required by November 1st of that year.

PURPOSE:

Saratoga County hires personnel without regard to age, race, color, sexual orientation, religion, sex, or national origin. Saratoga County Public Health operates as both an Article 28 and Article 36 agency, subject to NYSDOH regulations. All agency employees, regardless of job requirements, are subject to NYSDOH Article 28 and/or Article 36 regulations dependent upon current work assignment. In addition, as an agency promoting health and well being, employee health and the health of program participants is a priority.

PROCEDURE:

1. After a candidate is selected for hire, the Director of Public Health/Designee will obtain at least two references from the employee. The Director/Designee will contact the references and document contact on the Reference form. The Assistant to the Director of Public Health will file the forms in the Personnel Record.
2. The Director/Designee will contact the candidate by telephone informing candidate of the position offer and pre-employment requirements. The Assistant to the Director of Public Health will mail a confirmation offer letter to the candidate. The letter will include the title of position, salary, start date and time, date and time of scheduled pre-employment physical exam, and the date and time for orientation at Saratoga County Personnel Department. Personnel Department orientation will include the completion of the I-9 Employee Verification Form, a review of Saratoga County benefits, health and life insurance, pension plans and time accruals.
 - a. Pre-employment Requirements and Yearly Follow Up:
 1. A Pre-Employment Physical (within 1 yr) is required prior to beginning work. All staff will complete a Self-Health Assessment annually (SCPHN staff on the anniversary date of hire and contractors in January).
 2. Documentation of Rubella Immunity

3. Documentation of Measles (Rubeola) Immunity **if born on or after 1/1/57**. (Must have at least one dose and an appointment for second dose prior to starting).
4. Documentation of Tuberculosis Screening (PPD or Chest X-ray) is required prior to beginning work. Any employee or contractor with a past history of TB disease or previous history of documented positive PPD will be referred to agency TB Coordinator for follow up according to Saratoga County Public Health's TB Protocol.

A PPD will be done yearly thereafter for all employees and contractors. Any employee testing positive at time of yearly PPD or following an occupational exposure will be referred to agency TB Coordinator for follow up according to Saratoga County Public Health's TB Protocol.

5. September to April: Documentation of seasonal Influenza Vaccination/s as required by 10 NYCRR Section 2.59 or Declination. (Timeframe subject to change based on NYS Department of Health determination of "Flu Season".)
6. Professional Staff: Documentation of Hepatitis B Vaccination (dates), titer, first dose, or Declination. Saratoga County Public Health will offer Hepatitis B vaccine and the vaccination series free of charge to all employees who may have occupational exposure. Administration of vaccine series will be in accordance with recommended protocols and schedule.
7. Saratoga County Public Health shall offer TdAP boosters to all employees. Recommended frequency is every 10 years.

**MMR vaccine, PPD/Chest-X-ray, Influenza vaccine, and Hepatitis B vaccine can be provided by Saratoga County Public Health at no charge.*

3. The new employee must submit the required information to the Director/Designee prior to start of employment. The Director/Designee will complete the New Hire Checklist.
4. The Director/Designee will provide the new employee with a Personnel Orientation Notebook and will prepare an orientation outline, a copy of which will be signed and filed in the personnel folder. Topics reviewed will include:
 - a. Agency Mission Statement and an overview of Health Services Programs.
 - b. Job Description, Duties, and Performance Evaluations
 - c. Dress Code, Time Card, and Vacation/Overtime Requests
 - d. Photo ID Badge, Vacation/Sick/Personal, Annual Requirements (Health Assessment, TB Screening, Influenza Immunization, and N95 Mask fit testing)
 - e. Fire/Emergency/Disaster Procedures, MSDS Book, Computer Security, Child Abuse, and Domestic Violence (Nurses: Infection Control/ Respiratory Protection/TB)
 - f. Confidentiality, HIPAA training, and the Emergency Preparedness Plan.
 - g. Position Related Training and Requirements
5. The employee will be evaluated at 1 month, 3 months, and 12 months. Any concerns will be brought to the Director's attention. All evaluations will be filed in the personnel folder.
6. Saratoga County Public Health will conduct criminal background checks (per NYSDOH Regulations) on all directly employed Home Health Aides hired after April 1, 2005.
7. Staff requiring laptop training will be scheduled and appropriately trained. HIPAA compliancy training will be provided at this time, as well. A signed completion form will be

forwarded to the Assistant to the Director of Public Health for placement in the personnel file.

8. All Public Health Nurses, Registered Nurses and Early Intervention Service Coordinators are required to complete ten (10) hours of in-service yearly.
9. Annually, all Saratoga County Public Health staff and contractors (in January) will receive a packet of information to review on the following topics. A sign-off sheet will be included for the employee to complete and return. The Assistant to the Director of Public Health will file the sheet in the employee personnel file as confirmation of review.
 - a. HIV confidentiality
 - b. Confidentiality
 - c. HIPAA
 - d. SCPHNS Policy/Procedure – Changes and additions
 - e. Right to Know/MSDS
 - f. Infection Control
 - g. Tuberculosis
 - h. SCPHNS Exposure Control Plan
 - i. Fire/Safety
 - j. Domestic Violence
 - k. Medical Device Reporting
 - l. Emergency Preparedness Program
 - m. Emergency Preparedness Plan
 - n. Child Abuse/Maltreatment
 - o. Advance Directives
10. Employee responsibilities at time of termination:
 - a. Be encouraged to seek an exit interview at the Personnel Office, essential for benefits review.
 - b. If assigned a county care, be sure car is clean and the supply box is full of required items and all expiration dates have not passed.
 - c. Desk is cleaned out and work area is neat and clean
 - d. Remove all messages, greetings and security code from telephone.
 - e. All documentation is complete.
 - f. On the last day of work in the agency, turn into your supervisor:
 - i. Return photo identification
 - ii. Last 3 years of day books
 - iii. Return nursing bag/supplies and any other materials issued by the agency
 - iv. BP cuff and stethoscope – if agency issued
 - v. Car Keys
 - vi. Building keys
 - vii. Emergency Preparedness Bag
 - viii. Return Employee Orientation Notebook.
 - ix. Laptop Computer – Please un-assign any patients

References: 10 NYCRR 751.6 Personnel – Article 28
10 NYCRR 763.13 Personnel – Article 36
10 NYCRR 2.59

Saratoga County Public Health

Pre- Employment Checklist

*Communication log on back

Name: _____ Position: _____ Start Date: _____

____ Pre-Employment Letter Sent

____ Telephone Contact

Completed and in file	Requirement	Acceptable Documentation	Comments
	Pre- Employment Physical	Professional Staff: Copy of Physical from County provided. Support Staff: Copy of physical within one year of employment.	
	Rubella Immunity	<ul style="list-style-type: none"> a. Immunization record of 1 dose of rubella vaccine (i.e. MMR) administered on or after 12 months of age. b. Lab test results with serologic evidence of rubella antibodies c. Document signed by licensed provider stating rubella vaccine is detrimental to employee's health, including nature and duration of exemption. Once duration expires, this requirement should be pursued (i.e. pregnancy) 	Saratoga County Public Health can administer MMR at no charge prior to employment.
	Measles (Rubeola) Immunity *Persons born after 1/1/57 only	<ul style="list-style-type: none"> a. Immunization record with 2 doses of measles vaccine (i.e. MMR). The first dose was administered on or after 12 months of age and the second dose administered >30 days after the first but after 15 months of age. b. Lab test results with serologic evidence of measles antibodies c. Document stating history of Measles diagnosis, signed by the licensed medical care provider who diagnosed measles. d. Document signed by licensed provider stating measles vaccine is detrimental to employee's health, including nature and duration of exemption. Once duration expires, this requirement should be pursued (i.e. pregnancy) e. Immunization record with first dose and appointment for second dose after 30 days and before 45 days from first dose. 	Saratoga County Public Health can administer MMRs at no charge if no record of immunity is found
	Tuberculosis Screening	<ul style="list-style-type: none"> a. PPD per protocol. b. Chest X-ray for persons with or history of positive reaction 	Saratoga County Public Health can administer PPD or order Chest X-ray if needed at no cost.
	Influenza Immunization *October-November 1st Dependant on Vaccine Availability	<ul style="list-style-type: none"> a. Immunization record b. MD signed exceptions per regulation 	Saratoga County Public Health can administer immunization if needed at no cost.
	Hepatitis B Immunization *Professional Staff Only	<ul style="list-style-type: none"> a. Immunization record for completed series b. Signed Declination Form c. Immunization record of first dose with appointments in place to complete series. 	Saratoga County Public Health can administer immunization if needed at no cost.

____ All Pre-Employment Requirements have been satisfied and employee can begin work.

____ Direct Supervisor, _____ notified.

Verified by: _____ Date: _____

**SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE
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Declination of Influenza Vaccination For Health Care Personnel

Employee's Name: _____ Employee's ID#: _____

I have been advised that I should receive the influenza vaccine to protect myself and the patients I serve. I have read the Centers for Disease Control and Prevention's (CDC) Vaccine Information Statement explaining the vaccine and the disease it prevents. I have had the opportunity to discuss the statement and have my questions answered by a healthcare provider. I am aware of the following facts:

- Influenza is a serious respiratory disease that kills thousands in the United States each year.
- Influenza vaccination is recommended for me and all other healthcare personnel to protect this facility's patients from influenza, its complications, and death.
- If I contract influenza, I can shed the virus for 24 hours before influenza symptoms appear. My shedding the virus can spread influenza to patients in this facility.
- If I become infected with influenza, I can spread severe illness to others even when my symptoms are mild or non-existent.
- I understand that the strains of virus that cause influenza infection change almost every year and, even if they don't, my immunity declines over time. This is why vaccination against influenza is recommended each year.
- I understand that I cannot get influenza from the influenza vaccine.
- The consequences of my refusing to be vaccinated could have life-threatening consequences to my health and the health of those with whom I have contact, including all patients in this healthcare facility, coworkers, my family and my community.

- **Because I have refused vaccination against influenza, I will be required to wear surgical or procedure masks in areas where patients or residents may be present during the influenza season.**

I acknowledge that I have read this document in its entirety and fully understand it. Despite these facts, I have decided to decline the influenza vaccine by my signature below. I realize that I may re-address this issue at any time and accept vaccination in the future.

Signature: _____ Date: _____

Witness: _____ Date: _____

SUBJECT: MULTI-FACTOR FALL RISK ASSESSMENT

I. PURPOSE:

To identify Saratoga County Public Health Nursing patients receiving home care that may be at risk for falls.

II. PROCEDURE:

1. At Start of Care, Recertification, or Resumption of Care, all clinicians will screen patients for potential fall risk.
2. The screening for falls will consist of 2 of the 3 following multi-factor fall risk assessments:
 - a. Mandatory completion of the Standardized Fall Risk Assessment provided within the Clinical Documentation System which is located under Environmental/Rights/Safety. All service providers opening a Start of Care must perform this assessment and;
 - b. Completion of the TUG Fall Risk Assessment located under Environment/Right/Safety. Nursing clinicians complete this test. Therapists may choose this test or;
 - c. Completion of the Tinetti Assessment Tool under the Musculoskeletal section. Therapists may choose this assessment tool in place of the TUGS.
3. Standardized Fall Risk Assessment:
 - a. Each system of the Standardized Fall Risk Assessment is assigned a numeric point value. The clinician must go through each system and check the appropriate sub-category indicated for the patient. Regardless of the number of sub-categories checked within the system, add only the total system score to determine the Fall Risk. For example, Neuro System is assigned one point. No matter how many subcategories within the system are checked, the score for that section is 1 and that will be added to points in other systems for a composite score at the end.
 - b. If a patient scores 3 or less, the clinician will review environmental safety and provide educational material on all problems and reassess as needed.
 - c. If the patient scores 4 or greater, then it is determined that the patient is a fall risk. The SOC plan of care must indicate a fall risk problem, M2250, and fall risk measures must be addressed in MD orders and care plan.
4. TUG Fall Risk Assessment:
 - a. The clinician will perform the TUG and will determine whether or not a patient is at risk for falls by a score of 10 seconds or greater. The clinician will answer the appropriate "Yes" response to the OASIS M1910 question. This question can only be answered if the TUG was used as a fall risk assessment.
 - b. If the patient is at risk for falls, the Physician's Plan of Care must include fall risk measures. The clinician's care plan M2250, MD orders and care plan must also address fall risk measures and patient education.

SUBJECT: PECOS/OPRA/K-CHECKS VERIFICATION**I. PURPOSE:**

To ensure physicians' compliance with PECOS and OPRA enrollment requirements and K-checks.

II. DEFINITION:

- A. **PECOS** (Provider enrollment, Chain and Ownership System): this system enables registered users to securely and electronically submit and manage Medicare claims. In order for SCPHNS to bill Medicare for services rendered, all referring physicians must be enrolled in PECOS. Programs that must comply with this requirement are LTHHCP, CHHA, Prevention (in rare situations), and EI.
- B. **OPRA** (Ordering/Prescribing/Referring/Attending): all physicians referring to SCPHNS must be OPRA enrolled in order for SCPHNS to bill Medicaid for services rendered. Managed Medicaid does not require OPRA enrollment. It is not required that the physician accept Medicaid to be enrolled. Programs that must comply with this requirement are LTHHCP, CHHA, Prevention, EI and for Medicaid EPs patients requiring a PRI.
- C. **K-CHECKS:** ensures all providers SCPHNS work with are in good standing with Medicare and Medicaid. Prevents SCPHN from billing a provider on the exclusion list which if providing or receiving services from an excluded provider could lead to heavy fines.

III. PROCEDURE:**A. PECOS:**

1. Go to www.oandp.com/pecos/
2. Enter either physician's last name and NY (e.g., Smith NY) or the physician's NPI number to perform the PECOS check.
3. The Information Processing Specialists and Medical Secretary are qualified to do the PECOS checks.

B. OPRA:

1. Go to www.emedny.org/info/opra.aspx
2. In "Field" section, click on drop down box and select "Provider".
3. In "Value" section, enter physician's last name.
4. In "Sort by" section, leave this drop box set at NPI.
5. Click "Search" to determine if physician is enrolled in OPRA.
6. The Information Processing Specialists and Medical Secretary, Senior Account Clerk, and Account Clerk Typist are qualified to do the OPRA checks.

C. K-CHECKS:

1. All new physicians, NP's or PA's that are given a new number in Progesa need to be given to the Account Clerk Typist for her to enter them into K-checks.
2. K-checks then does a monthly report to ensure the providers are not on the excluded list for Medicare and Medicaid.

The clerical person entering a new physician to HCMS will be performing the PECOS and OPRA checks.

If the patient changes physicians and/or has a secondary or tertiary physician, the PECOS (for Medicare), and OPRA (for Medicaid) must be done for these physicians as well.

The clinician will be responsible for reporting any physician changes to their supervisor.

Approved by Medical Director

Signature

Date

12/18/13

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: HHCCN POLICY AND PROCEDURE

I. PURPOSE:

Issuance of a Home Health Change of Care Notice (HHCCN) is to notify Medicare beneficiaries, in advance, of a reduction in or termination of services. HHCCN's are not issued for beneficiaries having Medicare Advantage plans or Managed Medicare plans.

II. DEFINITIONS:

A. **Reduction in Services:** any decrease in frequency, duration, or level of care that differ from the orders on the current plan of care (485).

B. **Termination:** when all services are stopped.

1. Reasons for reduction in or termination of services are:

- Physician has ordered service be decreased or stopped because they are no longer medically reasonable or necessary;
- Saratoga County Public Health reduces or stops services because of agency staffing shortage, or agency administrative reasons such as staff safety concerns.

III. ISSUANCE OF AN HHCCN:

A. An HHCCN is issued when services that were being covered by Medicare are being reduced or terminated AND this differs from the current plan of care.

B. An HHCCN is NOT issued if:

1. A reduction occurs for an item or service that will no longer be covered by Medicare but the beneficiary wants to continue to receive the care and assume the financial charges (only an ABN would be issued);
2. The patient requests the reduction or termination;
3. Goals are met and patient is being discharged according to the plan of care.

C. If clinician is unsure whether or not to issue an HHCCN, a discussion with the clinician's supervisor must occur before the home visit is made.

D. **Timing of Issuance:**

1. If Saratoga County Public Health Nursing Service (SCPHNS) is reducing or discontinuing care for administrative reasons such as safety concerns, staffing shortage, failure to meet face to face requirement, or closure of the agency, an HHCCN should be issued immediately on determination, or if possible provide enough time for the patient to obtain services from another home health agency.
2. If Saratoga County Public Health Nursing Service is reducing or terminating care because of a physician ordered change in the plan of care, or lack of orders to continue the care, an HHCCN should be issued before the reduction or discontinuation, if possible.

IV. PROCEDURE:

A. Completion of an HHCCN

1. **Top Section of Form:**

- a. On the first blank line, write the patient's name as it appears on the Medicare card.
- b. On the second blank line, write the patient's medical record number.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: HHCCN POLICY AND PROCEDURE

- c. On the third blank line, write in effective date for service reduction or termination.
- d. In the first box, write out the Medicare covered service(s); and item(s) (no abbreviations) including frequency and duration, that are being reduced or terminated. For example, if the 485 reads SN 1day 60, and skilled nursing visits for wound care are being reduced from daily to every 3 days because the wound care order changed from ointment and DSD to a Duoderm, then nursing and wound care supplies are being reduced from daily to every 3 days so they would both be listed in box number one. If the wound care orders remain daily but skilled nursing visits decreased from daily to 3 times per week because the family was going to do the dressing on the non-nursing visit days, the clinician would only list the skilled nursing reduction in the box number one.
- e. If SCPHN is terminating all of the patient's home health care services for agency reasons not related to Medicare coverage, then all services and items, including frequency and duration, regardless of the payor, must be listed on the HHCCN.
- f. In the second box, write the reason for reduction or termination in service(s) or item(s).
- g. The clinician must write the reasons in language that is understandable to the patient.

2. Middle Section of Form:

- a. The clinician must check one box only per HHCCN form.
- b. The clinician must make out separate HHCCN's if different services are being reduced or terminated for different reasons.
- c. If services are being reduced or terminated by SCPHNS for agency reasons, the clinician should review the text associated with the checked box and explain to the patient that he/she may be able to obtain the same or similar care from another home health agency, since Medicare coverage is not affected.
- d. If services are being reduced or terminated by SCPHNS for agency reasons, SCPHNS must notify the ordering physician of reductions or terminations.
- e. If services are being reduced or terminated by the ordering physician, the clinician should review the text associated with the checked box and if requested by the patient the clinician may facilitate contact between the physician and the patient. The patient may choose to contact the physician directly.

3. Lower Section of Form:

- a. In the "Additional Information" section, the clinician may write any information that may be helpful to the patient (i.e., physician name and phone number).
- b. The patient must sign and date the completed form.
- c. If the patient refuses to sign the HHCCN, the clinician must write "patient refused to sign" on the signature line.
- d. If the patient is physically unable to sign and date the HHCCN, but is fully capable of understanding the notice, a representative is not required for the signature and date. The patient may allow the clinician to sign and date the form in the presence of and under the direction of the patient.
- e. On the signature line, the clinician must write the patient's name and then the agency name, followed by the statement "signing for (write patient's name)".
- f. If the patient is unable to understand the content of the form then a patient representative (legal guardian or Durable Medical Power of Attorney) must sign and date the form for the patient. (The representative must show proof of legal guardianship or Durable Medical Power of Attorney to the clinician.)
- g. The representative must write "representative" next to their signature.
- h. If the representative's signature is not legible, then the clinician must print the representative's name near the signature area.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: HHCCN POLICY AND PROCEDURE

- i. If the representative is not able to receive the notice in person during the home visit, it may be issued by direct telephone contact, mail, or secure fax machine.
- j. If the HHCCN is initially issued by telephone to the representative (before mailing or faxing), the clinician should notate this and sign their name and title in the additional information section (i.e., "telephone discussion with patient representative on 1/12/14, reviewed HHCCN notice and effective date. Notice will be mailed to representative for signature and date.")
- k. If an HHCCN is issued to the representative by direct phone contact, the HHCCN must then be mailed or faxed to the representative for signature and date, and be returned to SCPHNS.
- l. If the patient does not have a legally authorized representative and one is necessary, a representative may be appointed for purposes of receiving this notice following CMS guidelines and as permitted by state and local law. See Chapter 30, Section 40.3.5 of the CMS Manual for more detailed guidance on representatives.
- m. Patient is given a copy; SCPHNS keeps the original for the chart, and a copy is given to the SCPHNS senior billing clerk.

Approved by Medical Director:


Signature
Date

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: ABN POLICY AND PROCEDURE

I. PURPOSE:

Issuance of an Advanced Beneficiary Notice (ABN) is to notify Medicare beneficiaries, in advance, about possible non-covered charges for items and/or services that are usually covered by Medicare under Part B, when limitation of Medicare liability applies. (ABNs are not issued for beneficiaries having Medicare Advantage Plans or Managed Medicare Plans).

Reasons that Medicare may not cover services:

- Services are not considered medically reasonable and necessary;
- Custodial services are the only services being provided;
- Beneficiary is not homebound.

II. POLICY:

A. An ABN must be issued when the following triggering events occur:

1. **Initiation:** an initiation is the beginning of a new patient encounter, start of a plan of care, or beginning of treatment. If Saratoga County Public Health Nursing Service (SCPHNS) believes that certain otherwise covered items or services will be non-covered at initiation, an ABN must be issued prior to the beneficiary receiving the non-covered care.
2. **Reduction:** a reduction is when there is a decrease in a component of care (frequency, duration). The ABN is NOT issued every time an item or service is reduced. If a reduction occurs and the beneficiary wants to continue to receive the items or services at the current level, even though they will no longer be covered by Medicare, then an ABN must be issued prior to delivery of the non-covered care.
3. **Termination:** a termination is a discontinuance of certain items or services. The ABN is only issued at termination if the beneficiary wants to continue to receive those items or services that are no longer covered by Medicare.

B. Beneficiaries that continue to receive non-covered services beyond a year must have a new ABN issued each year on or before the date the ABN from the previous year was issued.

C. An ABN is not issued when:

- Goals are met and you are discharging the beneficiary;
- When a one-time/no charge visit is made and beneficiary will not be admitted; and
- When a service is provided that is *never* covered by Medicare (i.e., NT, PRI, RT, PCA).

D. If the clinician is unsure whether to issue an ABN, a discussion with the clinician's supervisor must occur before the visit is made.

E. If an ABN is not issued when required, then the SCPHNS may not shift financial liability to the beneficiary for non-covered services.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: ABN POLICY AND PROCEDURE

III. PROCEDURE:

- A. **Issuance of an ABN:** If clinician is unsure whether or not to issue an ABN, the clinician should review the policy and MUST conference with their supervisor prior to the visit.
- B. **Completion of an ABN:**
1. **Top Section of Form:**
 - a. On the first blank line, write the patient's name as it appears on the Medicare card.
 - b. On the second blank line, write the patient's medical record number.
 - c. On the third and fourth blank lines, write in the word "service". If wound care supplies are also going to be non-covered, the clinician should also write the word "item".
 - d. In the first box, write out each service (no abbreviations); and item if applicable, that Medicare will not cover.
 - e. The clinician must include frequency and duration of services.
 - f. If a service will be repetitive or continuous in the case of a LTHHCP patient switched from Medicare to Medicaid, the clinician would write for example, "skilled nursing 2 visits per month; and 2 extra visits per month as needed or required (these are your prn visits per month) for up to one year".
 - g. In the second box, the clinician must write the reason that Medicare will not cover the service or item, for each service or item. (Wound care supplies can be considered one item.)
 - h. The clinician must write the reasons in language that is understandable to the patient.
 - i. In the third box, the clinician must write the estimated cost per visit for each service; and total cost for wound supplies per dressing change, if applicable. The clinician will give a list of supplies per dressing change to the supply account clerk who will provide the cost of supplies.
 - j. On the fifth blank line, write the word "service"; and "item" if applicable.
 2. **Middle Section of Form:**
 - a. The patient or their representative must check only ONE Option box. The clinician may explain each option if needed, to help the patient or representative make their selection, but cannot make the choice for them.
 - b. If the patient understands the option choices but is physically unable to check the Option box, the patient may request the clinician to check the Option box chosen by the patient and then write their initials next to the box.
 3. **Lower Section of Form:**
 - a. The clinician will document in the additional comment section, "this clinician checked the box for the patient due to their physical inability to do so".
 - b. The clinician then signs their name and title next to the entry.
 - c. If patient refuses to choose an Option box, the clinician must write, "patient refused to select an Option box" in the Additional Comments section.
 - d. The clinician may write other helpful information in the Additional Comments section. (I.e., physician name and phone number, other insurance information).
 - e. The patient must sign and date the completed form.
 - f. If the patient refuses to sign the ABN, the clinician must write "patient refused to sign" on the signature line.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: ABN POLICY AND PROCEDURE

- g. If the patient is unable to sign and date the form, then a patient representative (legal guardian or Durable Medical Power of Attorney) must sign and date the form for the patient. (The representative must show proof of legal guardianship or Durable Medical Power of Attorney to the clinician.)
- h. The representative must write "representative" next to their signature.
- i. If the representative's signature is not legible, then the clinician must print the representative's name near the signature area.
- j. If the representative is not able to receive the notice in person during the home visit, it may be issued by direct telephone contact, mail, or secure fax machine.
- k. If the ABN is initially issued by telephone to the representative (before mailing or faxing), the clinician should notate this and sign their name and title in the additional information section (i.e., "telephone discussion with patient representative on 1/12/14, reviewed ABN notice and effective date. Notice will be mailed to representative for signature and date.")
- l. If an ABN is issued to the representative by direct phone contact, the ABN must then be mailed or faxed to the representative for completion, signature and date, and be returned to SCPHNS.
- m. If the patient does not have a legally authorized representative and one is necessary, a representative may be appointed for purposes of receiving this notice following CMS guidelines and as permitted by state and local law. See Chapter 30, Section 40.3.5 of the CMS Manual for more detailed guidance on representatives.
- n. Patient is given a copy, SCPHNS keeps a copy for the chart, and a copy is given to the SCPHNS senior billing clerk.

Approved by Medical Director:


Signature
Date

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PROCEDURE FOR COMPLETION OF PATIENT SIGNATURE VALIDATION FORM FOR CLINICIAN & HOME HEALTH AIDE

I. PURPOSE: To have verification of home visit made by clinicians and Home Health Aides (employed & contracted). Clinicians include all contracted employees (PT, OT, SLP, RD, MSW, and RT) and nurses in CHHA, LT and Prevention Program(s).

II. PROCEDURE:

1. Complete the identifying information at the top of the appropriate form (A or B):

- ✓ Patient's name
✓ Patient's number
✓ Clinician's or Home Health Aide's name
✓ Prevention Nurse's & Therapy providers use form B (circle Prevention or Therapy, as appropriate)
✓ Month and Year

A. SIGNATURE VALIDATION FORM A -To be used by CHHA & LT Nurse's & Home Health Aides (circle CHHA or LT, to indicate program)

- 1. Each time a CHHA/LT Nurse or Home Health Aide makes a home visit (skilled nursing, HHA & for a care plan review) to a patient, including an initial evaluation, have the patient or caregiver sign on the line corresponding with that day's date next to the "Time In/Time Out" column of the visit. It is acceptable if the patient is only able to sign with an "X". If the patient is not able to sign at all, please make a notation in the "Comment" section on the visit date.
2. At the end of each month, or when patient is discharged, put the completed form in clients chart or in the filing bin.

B. SIGNATURE VALIDATION FORM B -To be used by Prevention Nurse's and Therapy provider's (circle Prevention or CHHA or LT, to indicate program)

- 1. Each time a Prevention Nurse that is making more than one visit or Therapy provider makes a home visit to a patient, including an initial evaluation, have the patient or caregiver sign on the line corresponding with that day's date next to the "Time In/Time Out" column of the visit. It is acceptable if the patient is only able to sign with an "X". If the patient is not able to sign at all, please make a notation in the "Comment" section on the visit date.
2. Prevention nurses are to retain signature sheet with chart.
3. All contracted therapy providers will send in Original Signature Validation Form B with corresponding vouchers for each client (twice per month).

Approved by Medical Director:

Handwritten signature over a horizontal line, labeled "Signature".

Handwritten date "3/17/14" over a horizontal line, labeled "Date".



A

PATIENT SIGNATURE VALIDATION FORM FOR NURSE/HOME HEALTH AIDE VISIT

PATIENT NAME _____ PATIENT # _____

NURSE/HOME HEALTH AIDE NAME _____ PROGRAM: CHHA LT (circle one)

MONTH _____ YEAR _____

DATE	TIME IN	TIME OUT	PATIENT/CAREGIVER SIGNATURE	Verification of Review/Update – Paraprofessional Care Plan <i>MUST BE SIGNED AT LEAST EVERY 30 DAYS</i> HHA () ; PCA ()	COMMENT
1					
2					
3					
4					
5					
6					
7					
8					
9					
10					
11					
12					
13					
14					
15					
16					
17					
18					
19					
20					
21					
22					
23					
24					
25					
26					
27					
28					
29					
30					
31					

OK JW

PATIENT SIGNATURE VALIDATION FORM FOR CLINICIAN VISIT

B

PATIENT NAME _____ PATIENT # _____

CLINICIAN NAME _____ PROGRAM: PREVENTION THERAPY (CHHA / LT)
MONTH _____ YEAR _____

DATE	TIME IN	TIME OUT	PATIENT/CAREGIVER SIGNATURE	COMMENT
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				
11				
12				
13				
14				
15				
16				
17				
18				
19				
20				
21				
22				
23				
24				
25				
26				
27				
28				
29				
30				
31				

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: STANDARD FOR CHHA/LTHHCP NURSING VISIT

I. PURPOSE:

To provide guidance for the expectations of and compliance with what is to be done before, during and after a nursing visit.

II. ASSIGNMENT AND PREPARATION:

1. Receive assignment from supervisor.
2. Assign patient to laptop and synchronize, unless you are a non-computer nurse.
3. Check to see if prior authorization for visit is needed. Obtain if necessary.
4. Call patient and give approximate time for home visit.
5. Schedule home visit in laptop.
6. Review patient record including current orders, current care plan, and at least the last two visit notes.
7. Gather supplies as needed.

III. HOME VISIT:

1. Once in patient's home, set up nursing bag using Standard Bag Technique.
2. Set up laptop on newspaper on a hard surface.
3. Document time in on clinician signature sheet.
4. Complete patient assessment per agency standards and perform coordination as needed.
5. Documentation MUST be completed in the home on the laptop, unless the patient has VRE, MRSA, or C-difficile.
 - a) For non-computer nurses, complete a written note with assessment findings during home visit.
6. Verify that patient's insurance has not changed.
7. If insurance has changed, record all new insurance information.
8. Pack up nursing bag and laptop per agency standards.
9. Inform patient of plan for next visit.
10. Document time out on clinician signature sheet, circle CORRECT date and have patient sign.

IV. FOLLOW-UP AFTER THE HOME VISIT:

1. After the home visit, coordinate/follow up with ancillary services and physician as needed.
2. Give report to the primary nurse and to nursing supervisor.
3. If there is a potential problem, notify on-call nursing supervisor and on-call nurse.
4. Complete documentation and synchronize at the end of the day.
 - a) For non-computer nurses, give written visit note to CHHA Data Processing Specialist for data entry into Clinical Documentation System.
5. If unable to complete documentation and synchronize at the end of the day, conference with a supervisor for further direction.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: STANDARD FOR CHHA/LTHHCP NURSING VISIT

6. If the patient's insurance has changed, complete a PMS form to notify the billing department of the change.
 - a) Check the update box;
 - b) Fill in the date;
 - c) Fill in patient's name;
 - d) Complete the Commercial Insurances Section and effective date;
 - e) Sign the form at the bottom.

UTILIZATION REVIEW MEDICATION RECONCILIATION AUDIT TOOL 2014

Program: CHHA/LTHHCP Services: SN PT OT ST MSW RD HHA PCA RT Payor Source: _____
 Patient Record #: _____ DOB: ____/____/____ Sex: M F Referral Source: _____
 SOC Date: ____/____/____ Discharge Date (if applicable): ____/____/____ Surgery and Dates: _____
 Primary Diagnosis: _____ Secondary Diagnosis: _____

PHYSICIAN ORDERS		YES	NO	N/A	COMMENTS
1	Was frequency and duration of visits on 485 followed?				
2	If not, was physician contacted and was interim order done?				
3	Were 485 and interim orders returned within 30 days?				
4	Was a medication discrepancy form completed and signed by a physician?				
CARE PLAN					
1	Is medication teaching listed and addressed in the care plan?				
MEDICATION PROFILE					
1	Does the medication profile indicate patient allergies or NKA?	YES	NO	N/A	COMMENTS
2	Does each medication listed include dosage, frequency, and route?				
3	Do prn medications on medication profile state purpose for use?				
4	Do medications listed on the referral match the initial medication profile?				
5	If not, was a medication reconciliation done with physician?				
6	Are all medication reconciliation changes indicated on the medication profile?				
7	If patient takes sliding scale insulin, are the sliding scale instructions listed on the medication profile?				
8	During the course of care, if new medications were ordered, were they documented on the medication profile?				
DOCUMENTATION REQUIREMENTS					
1	Is coordination of services evident in documentation?	YES	NO	N/A	COMMENTS
2	Is patient's condition and clinical course evident in the documentation?				
3	Were changes in patient's condition reported to physician and documented?				

DOCUMENTATION REQUIREMENTS (cont.)		YES	NO	N/A	COMMENTS
4	If there were medication discrepancies, is there documentation of communication with the physician regarding medication discrepancies and reconciliation?				
5	If medications had to be reconciled, is there follow-up documentation that patient/caregivers, and therapist, if applicable, were made aware of changes?				
6	Is there documentation of medication teaching at SOC, and/or following medication reconciliation, including desired effects, adverse effects, and possible interactions?				
7	If new medication(s) are ordered during the course of care, is there documentation of medication teaching?				
8	Is there a patient signature sheet for every nursing and therapy visit?				
DISCHARGE					
1	Was patient discharged from services?				
2	If yes, is there documentation that physician was contacted to discuss discharge?				
3	Is patient agreeable to discharge?				
4	If not, is it documented in clinical note?				
5	Do M2250 and M2400 match?				
6	Within discharge summary order, is there documentation of the following:				
	a) A summary of patient care provided?				
	b) A summary of patient teaching?				
	c) A summary of patient teach back?				
	d) Reference to items answered YES in M2250/M2400?				
	e) Patient's status at discharge?				
	f) Primary caregiver, if any?				
	g) Community supports, if any?				
	h) Physician follow-up?				
7	Is notice of non-coverage in chart and signed?				

CONCLUSIONS:

Were services coordinated and documented at least once a certification period? (each discipline must communicate with each other and the physician at least once a certification period) _____

Were all identified patient needs addressed? _____

Reviewer's decision on relationship of Care Plan and amount and kind of services as related to patient's condition and clinical course:

- Appropriate
- Over use
- Under use
- Lacking Information

Committee member signature and title: _____

TITLE _____

DATE REVIEW DONE _____

FOLLOW-UP RESPONSE/CORRECTIVE ACTION:

CLINICIAN SIGNATURE _____

DATE _____

SUPERVISOR SIGNATURE _____

DATE _____

UTILIZATION REVIEW WOUND CARE AUDIT TOOL 2014

Program: CHHA / LTHHCP Services: SN PT OT ST MSW RD HHA PCA RT Payor Source: _____
 Patient Record #: _____ DOB: ____ / ____ / ____ Sex: M F Referral Source: _____
 SOC Date: ____ / ____ / ____ Discharge Date (if applicable): ____ / ____ / ____ Surgery and Dates: _____
 Primary Diagnosis: _____ Secondary Diagnosis: _____

PHYSICIAN ORDERS		YES	NO	N/A	COMMENTS
1	Does the patient have a wound?				
2	Does the 485 contain orders for wound care?				
3	If there are changes in the wound care are there interim orders for the changes?				
4	Was frequency and duration of visits on 485 followed?				
5	If not, was Physician contacted and was interim order done?				
6	Were 485 and interim orders returned within 30 days?				
CARE PLAN		YES	NO	N/A	COMMENTS
1	If patient has a wound, are the current wound care orders listed and addressed in the care plan?				
2	If patient has a wound, is a regular weekday listed in the care plan that wound measurements and photos are to be done?				
3	If patient has a wound, were wound measurements and pictures done and documented every 7 days on the weekday specified in the care plan?				
4	If wound measurements and pictures weren't done every 7 days on the specified day, is there appropriate and detailed documentation explaining why? ("measurements and or pictures not done" is not appropriate documentation)				
5	If the patient has a diagnosis of: COPD, CHF, Diabetes, wounds, catheter, or pneumonia, is zone tool use documented in the care plan? (only skilled nursing)				
6	Are due dates in care plans updated (catheter changes, wound measurements/pictures, routine injections, HHA supervisions? (only skilled nursing)				
7	Was patient/family teaching and response regarding wound care documented?				

MEDICATION PROFILE		YES	NO	N/A	COMMENTS
1	Does the medication profile indicate patient allergies or NKA?				
2	Does each medication listed include dosage, frequency, and route?				
3	Do prn medications on medication profile state purpose for use?				
4	If a medication has a finite end date is that end date documented? (i.e., antibiotic, steroid)				
5	During the course of care, if new medications were ordered, were they documented on the medication profile?				
DOCUMENTATION REQUIREMENTS					
	If patient has a wound/incision, is a thorough description of the wound including correct anatomic location, status of wound base, undermining, tunneling, slough, presence and type, color and odor of exudate, status of surrounding tissue, presence of granulation or epithelialization, stage if pressure ulcer, documented in every visit note?	YES	NO	N/A	COMMENTS
1	pressure ulcer, documented in every visit note?				
2	Coordination of services evident in documentation?				
3	Is patient's condition and clinical course evident in the documentation?				
4	Were changes in patient's wound and/or condition reported to physician?				
5	If PT only case, did PT inquire about incision/wound at each visit and document?				
6	Did PT observe incision/wound at each visit?				
7	If PT noted incision abnormalities or signs and symptoms of infection, did they notify physician?				
8	If physician ordered SN visit to evaluate incision/wound, did PT do a physician order?				
9	Did PT conference with PT supervisor regarding SN visit request, and document conference with PT supervisor?				
10	Did PT supervisor discuss physician order for nursing visit with CHHA nursing supervisor and document in patient record?				
11	Did PT fill out nursing referral form?				
12	If new medication(s) were ordered during the course of care, is medication teaching documented?				
13	Is there a patient signature sheet for every nursing and therapy visit?				

DISCHARGE		YES	NO	N/A	COMMENTS
1	Was patient discharged from services?				
2	If yes, is there documentation that physician was contacted to discuss discharge?				
3	Is patient agreeable to discharge?				
4	If not, is it documented in clinical note?				
5	Do M2250 and M2400 match?				
6	Within discharge summary order, is there documentation of the following:				
	a) A summary of patient care provided?				
	b) A summary of patient teaching?				
	c) A summary of patient teach back?				
	d) Reference to items answered YES in M2250/M2400?				
	e) Patient's status at discharge?				
	f) Primary caregiver, if any?				
	g) Community supports, if any?				
	h) Physician follow-up?				
7	Is notice of non-coverage in chart and signed?				

OVER FOR CONCLUSIONS

CONCLUSIONS:

Were services coordinated and documented at least once a certification period? (each discipline must communicate with each other and the physician at least once a certification period) _____

Were all identified patient needs addressed? _____

Reviewer's decision on relationship of Care Plan and amount and kind of services as related to patient's condition and clinical course:

- Appropriate
- Over use
- Under use
- Lacking Information

Committee member signature and title: _____ TITLE _____ DATE REVIEW DONE _____

FOLLOW-UP RESPONSE/CORRECTIVE ACTION:

CLINICIAN SIGNATURE _____ DATE _____ SUPERVISOR SIGNATURE _____ DATE _____

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: NURSING AND ANCILLARY SERVICES REFERRAL FORM PROCEDURE

I. PURPOSE:

To improve efficiency in acquiring nursing or ancillary services for patient care.

II. POLICY:

The case manager will identify whether nursing or an ancillary service is necessary for patient care. The case manager will complete a nursing referral form or an ancillary services referral form in order to formally make the request.

III. PROCEDURE:

A. The case manager will:

1. Choose the appropriate referral form:

- a. Skilled Nursing Referral Form - use this form when nursing is indicated
- b. Ancillary Services Referral Form - use this form when OT/PT/SLP, MSW or RD is indicated

2. Complete the requested information on the form

3. Forward the referral to the Therapy Supervisor within 24 hours of completing it. You may fax or hand-deliver it, but it must be received in the office within 24 hours.

B. Referral process after the Therapy Supervisor receives the referral:

1. Skilled Nursing Referral:

Therapy Supervisor will contact the appropriate nursing supervisor and provide pertinent patient information to the supervisor. That supervisor will assign a nurse to the case. Once a nurse is assigned to the case, he/she becomes the case manager for the patient.

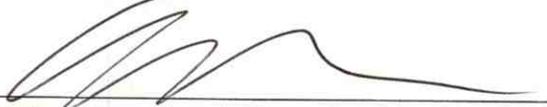
2. Ancillary Service Referral:

Therapy Supervisor will contact the requested service provider and forward pertinent patient information to the provider.

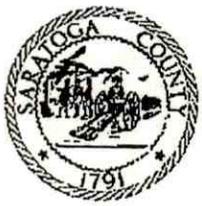
C. Once the nurse or other clinician has been assigned to the case it is that clinician's responsibility to:

1. Contact the patient to schedule an appointment within 24 hours.
2. Make a home visit and perform the evaluation.
3. Document your evaluation in the patient record.
4. Communicate with the referring clinician regarding your evaluation, your recommendations and other pertinent information.
5. Communicate with the physician regarding the findings of your evaluation, your recommendations and other pertinent information.
6. Do an interim order to discontinue your one week one (1W1) order and write the new orders.

Approved by Medical Director


Signature


Date



Saratoga County Public Health Nursing Service
 31 Woodlawn Avenue, Suite 1, Saratoga Springs, NY 12866-2198
 Telephone: (518) 584-7460 Fax: (518) 583-1202
 www.saratogacountyny.gov

ANCILLARY SERVICES REFERRAL FORM

- Therapy Referral ~ OT / PT/ Speech (circle one)
- Medical Social Worker Referral
- Dietician Referral

Date: _____

Patient Name: _____ Patient #: _____

Family friend/contact: _____ Phone #: _____

Diagnosis: _____ SOC: _____

Primary Clinician: _____ Ext.: _____

Primary MD (who to contact with orders): _____

MD phone #: _____ MD Fax #: _____

Insurance/Payor Source: _____

Date order written: _____ Date phone call to Clinician: _____

Please include the following when faxing to Clinician:

- | | |
|--|--|
| <input type="checkbox"/> Face Sheets | <input type="checkbox"/> Diagnosis List |
| <input type="checkbox"/> Discharge Summary (if applicable) | <input type="checkbox"/> MD Order (if applicable) |
| <input type="checkbox"/> Medication List | <input type="checkbox"/> Insurance Authorization Form
(if managed care) |

Purpose of referral: _____

Therapist assigned: _____ (PT Supervisor completes)

Circle:	Jill Hodge, LMSW	Tracey Nieckarz, LCSW-R	Karann Durr, RD
	Fax #: 885-2936	Fax #: 884-0431	Home #: 226-0984
	Cell #: 421-4732	Cell #: 221-6419	Cell#: 221-6577



Saratoga County Public Health Nursing Service
31 Woodlawn Avenue, Saratoga Springs, NY 12866-2198
Telephone: (518) 584-7460 Fax: (518) 583-1202
www.saratogacountyny.gov

SKILLED NURSING REFERRAL FORM

Patient Name: _____ Patient #: _____

Diagnosis: _____

Primary Clinician: _____ Ext.: _____

Primary MD: _____

Insurance/Current Payor Source: _____

Does the patient need authorization for skilled nursing: _____

Date order written or verbal order received: _____

Reason(s) for referral: _____

Date given to PT Supervisor: _____

Date given to RN: _____

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: CLINICAL DOCUMENTATION EMAIL SYSTEM POLICY AND PROCEDURE

I. PURPOSE:

To enable CHHA nursing supervisors, CHHA nursing staff, CHHA therapy supervisor, CHHA therapy contractors, CHHA clerical staff, and billing staff to communicate more effectively with each other regarding patient care, patient documentation and patient billing issues.

II. POLICY:

The Clinical Documentation email system is to be used for official business purposes to facilitate communication about patient concerns, patient documentation and patient related billing issues. Full patient names, details of patient care and patient documentation **CAN** be discussed in the Clinical Documentation email system as this is a secure closed email system. CHHA nursing supervisors, CHHA nurses, CHHA Therapy supervisor, CHHA therapy contractors, CHHA clerical, and billing staff **MUST** check their Clinical Documentation email system at least once each day for messages.

III. PROCEDURE:

A. Opening the Email Feature

1. Log into the Clinical Documentation system
2. A screen will open and you will see a tool bar appear across the top of the screen
3. Slide your mouse or your finger across the mouse pad to the **mail** icon which will highlight the yellow envelope
4. Click on the mail icon once
5. This will open the inbox screen.

B. Creating an Email

1. On the top left hand side of the screen you will see an **Inbox** button.
2. Just above the **Inbox** button is a **New Mail** button. Click once on the **New Mail** button.
3. A message box will open
4. Click on the **To** button
5. A users list will pop up
6. Select a user(s) by clicking once in the small box next to the name(s)
7. You can click as many users as you would like to send the message to
8. Click the **OK** button at the bottom of the message screen
9. This will put the selected user(s) in the **To** box
10. Click in the **Subject** box and type in your subject information
11. Click in the **Message** box and type in your message. The Message box is the blank area below the subject line.

C. Sending an Email

1. When you have completed your message click the **Send** button. The send button is at the bottom left just below the message screen.
2. A box will pop up telling you if your email was sent successfully
3. Click **OK**
4. The **Inbox** screen will appear.

D. Returning to the main screen

1. To close the Email screen, click the "x" in the top right hand corner of the Email screen.
2. The tool bar above the Inbox screen will appear.
3. You may now click on other icons in the tool bar to pursue other activities in the Clinical Documentation System or exit out of the system

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: CLINICAL DOCUMENTATION EMAIL SYSTEM POLICY AND PROCEDURE

E. Accessing Received Messages While Still Logged in the System

1. If you remain logged in to the Clinical Documentation system to complete other activities, and you want to periodically check for new messages, just click on the mail icon on the tool bar.
2. New messages that you have received will appear in your **Inbox**.
3. Click on the email message to highlight it and the message will appear in the lower box.

F. Replying To or Forwarding Messages

1. To reply or reply all, click on the preferred button. A box will pop up that says **“Do you want to include the original message?”**
2. If you click **yes**, a return message box will open that includes the original message. You must type your reply message above the dotted line.
3. If you click **no**, an empty message box will open for you to type your message in.
4. To forward a message, click on the forward button. A message box will appear that includes the original message. You must type your message above the dotted line.
5. When ready to reply, reply all, or forward your message click on the **send button**.

G. Accessing Received Messages When Not Logged In the System

1. You must log in to the Clinical Documentation system, the main screen with the tool bar will open and a box will appear on the main screen that says **You have ___ unread email. Do you want to read them now?**
2. A **Yes** and **No** button will also appear on the screen.
3. If you click the **no** button, the box will disappear and you will remain on the main screen.
4. If you click the **yes** button, your **Inbox** will open on the main screen and your new email will appear in your **Inbox**.
5. Your messages will remain in your **Inbox** and your **Sent** box unless you highlight them and click on the **delete** button.
6. When you click the **delete** button, a box will appear that says **“Are you sure that you want to permanently delete the selected mail?”**
7. **If you click yes, it will delete the mail.**
8. If you click **no**, the box will disappear and your **Inbox** will remain on the screen.
9. To leave your **Inbox**, click the **X** in the top right hand corner of your **Inbox**. You will be on the main screen again.

Approved by Medical Director:

Signature



Date



SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: MULTI-FACTOR FALL RISK ASSESSMENT

I. PURPOSE:

To identify Saratoga County Public Health Nursing patients receiving home care that may be at risk for falls.

II. PROCEDURE:

1. At Start of Care, Recertification, or Resumption of Care, all clinicians will screen patients for potential fall risk.
2. The screening for falls will consist of 2 of the 3 following multi-factor fall risk assessments:
 - a. Mandatory completion of the Standardized Fall Risk Assessment provided within the Clinical Documentation System which is located under Environmental/Rights/Safety. All service providers opening a Start of Care must perform this assessment and;
 - b. Completion of the TUG Fall Risk Assessment located under Environment/Right/Safety. Nursing clinicians complete this test. Therapists may choose this test or;
 - c. Completion of the Tinetti Assessment Tool under the Musculoskeletal section. Therapists may choose this assessment tool in place of the TUGS.
3. Standardized Fall Risk Assessment:
 - a. Each system of the Standardized Fall Risk Assessment is assigned a numeric point value. The clinician must go through each system and check the appropriate sub-category indicated for the patient. Regardless of the number of sub-categories checked within the system, add only the total system score to determine the Fall Risk. For example, Neuro System is assigned one point. No matter how many subcategories within the system are checked, the score for that section is 1 and that will be added to points in other systems for a composite score at the end.
 - b. If a patient scores 3 or less, the clinician will review environmental safety and provide educational material on all problems and reassess as needed.
 - c. If the patient scores 4 or greater, then it is determined that the patient is a fall risk. The SOC plan of care must indicate a fall risk problem, M2250, and fall risk measures must be addressed in MD orders and care plan.
4. TUG Fall Risk Assessment:
 - a. The clinician will perform the TUG and will determine whether or not a patient is at risk for falls by a score of 10 seconds or greater. The clinician will answer the appropriate "Yes" response to the OASIS M1910 question. This question can only be answered if the TUG was used as a fall risk assessment.
 - b. If the patient is at risk for falls, the Physician's Plan of Care must include fall risk measures. The clinician's care plan M2250, MD orders and care plan must also address fall risk measures and patient education.

- c. If a patient is unable to safely complete the TUG multi-factor or Fall Risk Assessment or refuses, the clinician will answer "No" to the OASIS M1910 question. Clinical documentation must also indicate the reason a multi-factor assessment was not completed. However, based on clinical judgment, if it is determined that a patient is at risk for falls, the Physician's Plan of Care (M2250, MD orders and care plan) must include fall risk measures. The clinician's care plan must also address fall risk measures and patient education. The clinician will also request a referral for physical therapy if they are not already involved. If patient refuses, also document in care plan and re-offer as indicated.
5. Tinetti Assessment Tool:
- a. The therapist must complete the Tinetti assessment for sitting, standing and walking as indicated in the Musculoskeletal section adding the balance and gait scores composite out of 28 points. The clinician will answer the appropriate "Yes" response to the OASIS M1910 question. This question can only be answered if the Tinetti was used as a fall risk assessment.
- b. Risk of falls is determined by the following total score of balance and gait:
- ≤ 18 is High risk
 - 19 – 23 is Moderate risk
 - ≥ 24 is Low risk
- c. If a fall risk is determined, then this must be noted in the M2250, MD orders and care plan and must include fall risk measures and patient education.
- d. If a patient is unable to safely complete the Tinetti Assessment Tool or Fall Risk Assessment or refuses, the clinician will answer "No" to the OASIS M1910 question. Clinical documentation must also indicate the reason a multi-factor assessment was not completed. However, based on clinical judgment, if it is determined that a patient is at risk for falls, the Physician's Plan of Care (M2250, MD orders and care plan) must include fall risk measures. The clinician's care plan must also address fall risk measures and patient education.
6. When multi-disciplinary services are involved in a potentially high risk for falls patient, regular conferencing needs to take place between disciplines and documentation is to be noted

Approved by Medical Director

Signature

Date

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: STANDARDS FOR WOUND ASSESSMENT

A. On initial evaluation and each subsequent wound care visit the following areas will be assessed and documented under care plan every visit. If documented in clinical note the following must be written:

1. Document location of wound or incision.
2. Document status of the wound base.
3. Document presence and type, color and odor of exudate.
4. Document status of surrounding tissue.
5. Document any new granulation or epithialization in documentation including Recert, ROC or D/C.
6. If wound is a pressure ulcer, document the stage on initial assessment and incorporate this into care plan and orders (see attached NPUAP Guidelines for further information on pressure ulcer staging).
7. Clinician will notify physician of any deterioration of wound status.

B. Weekly Documentation:

1. Every seven days, photograph, measure and document dimensions of wound or incision. For wounds, include length, width, depth and any tunneling or undermining noted. If incision is noted, document type of incision closure (i.e., staples, sutures or dermabond). Document in orders and care plan the specific day those measurements are to be done. In care plan, after visit has been done, document the date the next measurements are due. Should an extenuating circumstance prevent the wound measurement to be done on the specified due date, the wound will be measured within 24 hours of due date. The Supervisor and physician will be notified of the reason for delay and documentation will be noted in the clinical record.
2. For patients being followed by a Wound Healing Center, the case manager may obtain the Wound Healing Center's measurements by phone or fax. These may be incorporated in Saratoga County Public Health Nursing clinical record in place of direct measurement by SCPHNS staff.

C. Continuing Education:

1. All CHHA/LTHHCP nurses will take NPUAP course annually and documentation will be maintained by SPHN.

Approved by Medical Director

Signature

Date

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: STANDARD FOR ON-CALL PRN NURSING VISIT

I. PURPOSE:

To provide guidance for the expectations of and compliance with what is to be done before, during and after an unplanned on-call nursing visit.

II. ASSIGNMENT AND PREPARATION:

1. Receive assignment from supervisor.
2. If able, assign patient and synchronize laptop.
3. If unable to synchronize from home or if a non-computer nurse, obtain necessary information on the patient from the on-call nursing supervisor.
4. Call patient to notify them of estimated time of arrival, verify directions and ask if needed supplies are at the home.
5. Check on-call supply box for needed supplies.
6. If lacking needed supplies, come to the office to obtain them.

III. HOME VISIT:

1. Once in patient's home, set up nursing bag using Standard Bag Technique.
2. Set up laptop on newspaper on a hard surface, or paper documentation.
3. Document time in on clinician signature sheet.
4. Perform procedure to address reason for unplanned on-call visit and take patient's temperature. A complete assessment is not needed unless the nurse feels patient's condition warrants it.
 - a) If at any time during the home visit the nurse needs guidance or further information, they should call the on-call supervisor.
5. Complete as much documentation as possible in the home.
6. Document time out on clinician signature sheet, circle CORRECT date and have patient sign.

IV. FOLLOW-UP AFTER THE HOME VISIT:

1. Call the on-call supervisor to inform them that the visit is complete, the outcome of the visit, and that you are leaving to drive back home.
2. Call the on-call supervisor to report that you are back at home.
3. Report to the primary nurse and the primary nurse's supervisor the next morning. This can be done by voicemail if needed.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: MEDICARE PPS BILLING POLICY AND PROCEDURE

I. **POLICY:**

Saratoga County acting through its dba: Public Health Nursing Service will bill Medicare within one calendar year for services that meet Medicare requirements (Medicare eligible services), rendered to patient's in the Certified Home Health Agency (CHHA) and the Long Term Home Health Care Program (LTHHCP) who are Medicare recipients.

II. **PURPOSE:**

Saratoga County acting through its DBA Public Health Nursing Service will receive payment according to Medicare Regulations and Guidelines for Medicare services rendered to Medicare eligible patients in the CHHA and LTHHCP.

III. **PROCEDURE:**

➤ **COMPLETION OF THE INITIAL RAP**

A. **Oasis Export Report**

The Senior Account Clerk obtains the Oasis Export Report from the CHHA/LTHHCP Information Processing Specialist. The CHHA/LTHHCP Information Processing Specialist runs this report at the end of every work day. The report shows the patient name, record number, date oasis was completed, clinician that completed the oasis, and type of OASIS for all.

B. **Print Episodes without RAP Report**

1. The Senior Account Clerk then logs in to Progresa HCMS, clicks on the **Report tab**, then clicks on **Report button**, then arrow down under **Report Types** and click on **PPS Management**, then go to section labeled **Report Titles** and click on **Episodes without RAP**, click **select**, go to **parameters section** and click in empty box next to **Episode from Date**, this highlights the **Episode from Date**, type in the **from date 01/01/90**, and the **to date** which would be the date you are running the report.

That is the only criteria you select, click on the spy glass icon, the report will appear on the screen. This Report shows patients with initial episodes that need a RAP, and patients with recertification episodes that need a RE RAP.

C. **Review Episodes without RAP REPORT**

1. **Medicare Not Primary**

The Senior Account Clerk reviews the **Episodes without RAP** report and compares it to the **Oasis export** report to see that all patients without HHRG codes pulled over to the report and the calculator. The report is also reviewed to see if any patients pulled over that have Medicare **but Medicare is not the primary** billing source.

The primary billing source can be verified by going to the patient's admit screen in HCMS. First exit out of the report tab, click on the Task tab, then click on the Patient Information Button, type in the first 3 letters of patient's last name or the patient record number, then go to the bottom of the screen and click the Find button. This will bring up the patients demographic information. Move sideways from the Patient tab to the Admit tab. This screen will show the primary payer.

The patients that are identified as **not Medicare primary** must be deleted. To delete these patients you must go to the HHRG finder. Look at the main tool bar on the screen and click on the Invoice Processing button. This opens a drop down box, click on HHRG finder. The RAP Claim Calculator box will open up. Type in patents last name and hit enter. A **not Medicare primary** patient (this would include a PRI patient that has Medicare but it is not primary) will show no expected reimbursement, hit the delete key on your keyboard. Repeat this process for each patient that wasn't **primary Medicare**. In addition, a

SUBJECT: MEDICARE PPS BILLING POLICY AND PROCEDURE

patient that a recertification shell was created for but we didn't recertify them because they were discharged would also show no expected reimbursement on the **Episodes without RAP** report (usually empty shells are deleted when the discharge slip is processed by the information processing specialist). These patients would be deleted as well.

2. No Visit and NO HRRG on Episodes without RAP report

If there is no visit and no HRRG listed for the patient on the Episodes without RAP report, the note has probably not been processed yet. Notify a supervisor if a week has gone by since SOC. If it hasn't been a week, check the frequency on the 485. To check the frequency on the 485 in HCMS, go to tasks, certification, enter patient's medical record number or last name, patient names will pop up in a box, click on correct patient name to highlight, then click select button. A box with all the certification periods for the patient will pop up, select the correct certification period, click the "preview/print 485" button. The 485 will appear so you can view the frequency of visits for each discipline in box 21. If the frequency is in compliance with the 485 just wait until the visit is made and processed. If it is a recertification episode, look for the recert OASIS visit prior to the episode. If the recertification OASIS visit is processed then the HRRG should populate. Exit out of HRRG finder screen and check the clinical documentation system (clindoc) for the note. Log in to Clindoc. The main screen will open, click on the patient details icon, type in the patient's last name, click the select button, click on the activities tab, this brings up the notes, arrow through the notes, by note date. If the visit was done and the HRRG didn't populate, look to see the status of the note. If the note is not processed the HRRG cannot be imported. You must wait until the note is processed. If the note was processed and the date that the note was processed is before the date of the OASIS export report, go to tools and then click on the HRRG viewer, then click on the HRRG tab, then click on the calculate button this calculates the HRRG. Press screen print and print it. Now go back to HCMS to the HRRG finder; click on tasks, then click on invoice processing button, then click on HRRG finder, type the first 3 letters of last name, press enter, type in initial of 1st name, press enter, highlight patient, then click select, patient will populate the screen. This will bring up RAP claim calculator screen, click on HIPPS code drop down box arrow, select code from the menu that is also on your screen print. Print it. The HRRG will automatically populate when you click in the HRRG column. Then enter the original OASIS SOC date (date they were admitted and haven't been discharged since, then enter assessment date which is your visit date, then click on oasis reason drop down box arrow, select reason and click line underneath it to save the line, click on the oasis claim key box and click delete, then enter the OASIS claim key number from your screen print, then click save.

3. HRRG present but No visit date on Episodes without RAP report

If HRRG is present but no visit date is listed for the patient on the Episodes without RAP Report it means that a billable visit has not been done since the start of the episode. If date that note was processed is after the date of the Oasis export report, then wait for the next OASIS report from the CHHA Information Processing Specialist.

4. Both the HRRG and the visit date are present on the Episodes without RAP report

Run the "Episode without RAP Report". Go to Reports in HCMS, click on report tab, then click on report button, click on PPS Management under report types, and then click on Episodes without RAP under report titles, then click the select tab. This will bring up the report criteria that you can select. Click in the small empty box next to Episode to Date. Type in 01/01/1990 for the from date and type in the present Date for the to date. Click on the spyglass icon and the report will appear on the screen. Review the report for Patients with HRRG and 1st billable visit. **Check for signed and dated face to face.** Return to the main screen in HCMS, click on patient information button, type in patient's last name, click the find button, then click on and highlight patient's name from the list of names, click the select button, then click on the small **admit tab**, then click on the **documents tab**, the patient's SOC and any previous SOC will appear, click on and highlight the **SOC that you need**, then click on **referral packet** in the box above and **highlight the entire line**, then click on the **view button** mid screen. This opens the referral document.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: MEDICARE PPS BILLING POLICY AND PROCEDURE

Locate the **face to face statement** on the scanned referral form, check the **date** to be sure it is for the **correct SOC**. If patient was referred from a nursing home or community physician, SCPHN uses our own face to face form. **Check the patient's location**. Verify if patient resides in their home or an adult home. While you are on the admit tab, click on the location button on the bottom of the screen. The information should be there. If not, click on the add button and type in the "from date" (SOC), choose location home or assisted living. Then click the save button. If you believe that a patient lives in an Adult Home, refer to the List of Adult Care Facilities so that you can verify the address needed.

D. Calculate RAP (Initial or Recert), Assign Invoice, and Build EMC file**1. Calculate RAP**

Log into HCMS, from the main tool bar on the screen, click on the Invoice Processing button. Select HHRG finder. Type in Patient ID and press enter to open appropriate Episode to be calculated from the "Episode without RAP Report" Select Invoice and press Calculate RAP button. Once the Expected Reimbursement amount appears in the appropriate column go to next step Assign Invoice.

2. Assign Invoice

From the Tool bar select Invoice Processing, Assign Invoice. Select Individual Patients, select Program CHHA and Payer PPS from the dropdowns. Enter the From and To Dates of the Episode from the Episodes without RAP report (the "to" date is the same) and enter the Patient ID. Add to List by pressing the Add button on the screen. "Invoice process complete" will appear on the screen. Press OK and an invoice number will be assigned. Press the red VIEW button to find the Invoice Number that was assigned to the claim. The view options will appear. Record the number without the letter F on the **Episode without RAP report**. Then click on the Bill button. This shows you the billed amount. Look at the billed amount to make sure there is a calculation. Press Accept and then Yes to accept assigned invoices.

3. Build EMC file

The EMC file is built in order to bill the claim electronically. From the Tool bar select Interface, click on Billing tab, then click on Export EMC. Click on the selected Invoice Number, press enter and it adds the invoice # to the screen. Repeat until you have invoiced all RAPs and then click on export button. Next you need to name the file. To save the file, first make sure you are at network tsclient **billing_export**. Give it a name Example: NGS_Medicare_date.txt and press the SAVE key. A graph will appear and the file will build. Once file is completed and saved you need to view and print report. Click on the printer icon, click on properties, click on portrait, choose **Flip on long Edge or None**. Press Ok, then press Ok again the report prints. Close Report Builder. Click Save and change tsclient **tsclient** **pdf file** and click save again. Make sure you are saving in the pdf file folder. The heading should read Network tsclient **pdf file**. Name the file the same as the just built file name but use .pdf at the end. Click save.

E. Electronic Submission of claim and Receipt of Revenue**1. Payer Link is used to send the file to NGS Medicare.**

Get on the internet and then log on to payerlink.com. Billing staff is to use their designated email address and password to log on to payer link. If billing staff forgets their password they should request that the Director of Public Health (DPH)/Director of Patient Services (DPS), or the Fiscal Manager to retrieve their password for them. The passwords are kept on a master list in the billing reference notebook which is kept in a locked safe on the Public Health building premises. Select File Transfer. Select Upload 837 Files. Click on the drop down box arrow and scroll to Submitter ID HM52930 with Claim Type Institutional, click on to select. Click Browse and go to Computer OS(c). Find your export billing folder. Double click to open and scroll to the file you just named and created. Highlight it and it will appear in File Name Box. Click OPEN. Click Upload File. After it uploads go to the gauge, click on the gauge button between the T and I buttons. Now you will see the Claim File Reconciliation

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screen. This file gets picked up by the payer link system. The payer link system checks every half hour. Log out of Payer Link. Log back in to payer link at a later time and go to Claim File Reconciliation to see if the file was accepted.

2. Checking for Revenue

Each day you should log on to payer link to see what we have been paid or to correct denials. Download an EOB. From the File Transfer button look for the line with the number that begins with a 5. Refer to the written log of downloads as a reference. Check the date to see that it has not been downloaded previously. If it has not been down loaded then select it and click on save. Then click on SAVE AS to save it to the Report Folder on the C drive. Record the EOB number on the written log of downloads so you can transpose the EOB number onto the printed EOB. Log off of Payer link. To Print the EOB go to the PC Print icon. Double click to open. Click yes to open from an unknown user. Select X12 from the Tool Bar. Look in the Reports folder where you just saved the file on your C drive and highlight the file. Click on open to open the the file. Click on the PS, and click Print. Click on BS, and click Print. Click on AC, then you will need to click on file, go to print set up and change to landscape. Click OK, then click print. Once the report prints you will need to write the file name on it. Repeat if more than 1 file was downloaded. Close out of PC Print when finished.

3. Notify Treasurer's office

Log on to computer, Go to PH2003sys, then go to Users, then click on Billing Shared Folder, then to Cash Memos and Reconciliation Folder (current year), then click on the Year of EFT , then select the month of the EFT, then click on the ACH Summary. Use the current deposit # and date from the card that is updated each Thursday. Write it on the EOB from the Insurance Company. On the current Month ACH Summary spreadsheet, record the Remit Date/EOB date, Deposit #, Deposit Date, Reduction Amount if any, Payee, ACH Total and record the amount of the EOB in the correct Account listed on the spreadsheet. See Budget to Actual Report in AS400 if needed. Attach this sheet to an Email with a cover letter to the Senior Revenue Account Clerk, Deputy Treasurer, and Tax Collection Specialist in the Treasurer's Office. Once this has been done you need to check the Insurance folder /binder containing the copy of the sent UB04 or EMC file. Mark them paid. Discard EMC report and episode reports when all items on the EMC report are paid.

4. Post Cash to Open Accounts Receivable

Now you can add this EOB to the Deposit tape. To get to the Cash screen go to Task on the tool bar and Cash to open the Application. Add or update a previous Deposit. Enter deposit number and click find, or if a new deposit click add. Enter a dollar amount of the new deposit. Click on company drop down box, select corporation. Enter deposit date and save. Make sure you balance with your Deposit tape. To enter Cash go to Cash on the Tool Bar to open the Application. Click add in the check information section of the screen. Enter Check #, posting date, Check date and amount being entered. And Save. Go back to Deposits on the Tool Bar and type in Deposit #. Click Find. Deposit will appear. Click "show available checks" and click on "include" button to include the check/EOB information just entered. Go back to Cash Application , Enter patient ID, click Find, and click Add. If this is Medicare PPS, Medicaid, or Pay span transaction continue to enter the complete EOB. Go to Cash Application Screen and type in patient ID, uncheck the (Hide zero balance invoices) box, click Find. Any unpaid A/R will show on the screen. Select the appropriate invoice that is being paid. Click Add and choose the appropriate A/R code from the dropdown box, (AR code 1 is for cash receipts/accrual Medicare payments; AR code 8 is for Medicare recoupments; AR code 22 is for PPS penny adjustment, and also for reductions on final payments). Enter in comment box "payer initiated reduction". Enter payment amount, press enter so the covered amount will populate in the payment box below the payment box. Click Save then click Yes. Click on the Service key and follow the prompts to record the amount paid. If the amount remaining is zero the check has been posted. If a balance is shown then press the adjustment key to allowance or transfer the balance to other insurance or self-pay.

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If allowed off go to the adjustment button on the cash application screen click add and enter appropriated A/R code from dropdown box and enter payment of zero and enter payment amount of what is being allowed off. Press Save. **If billing the balance to the patient (self pay)**, go to the patient information screen, then click on payor tab. Once on the payer screen click add new (green cross), Select self-pay, enter a from date (1st billable visit) click on drop down arrow and select a plan code from the menu. Click on the disc icon to save. Click yes to confirm. Click on the "Bill to" tab, type in address of patient or responsible party. (Refer to contact screen as needed), Click save. Go to admit screen under secondary payer, open the drop down box menu, choose self pay and click save. Click yes to confirm. Go to tasks, click on invoice processing, click on transfer reverse. Type in invoice number (can be found in the cash screen) for the patient that you are doing the transfer on. Click enter, the invoice will populate on the screen. Click on the drop down box menu, select a new payer (self-pay). Enter the adjusted charge which may be the full amount or a lesser percentage of the amount depending on the patient responsibility. Do this for each line if more than one line. Click OK, click transfer and scroll to the right to view the new invoice number. Click accept and then print the invoice by going to invoice processing. Click on the invoice processing tab, click on drop down box arrow and select print invoice, click on the invoice number button, click on the drop down box for "form type" and select plain paper. Type in the new invoice number that was just assigned, click on "add to list" button and it will populate below. Click print, the invoice will appear. Click on the printer icon. Check printer properties to be sure "portrait" and "print on one side only" are selected, click the number of copies that you want (2), Click OK, then click OK again.

If billed to a secondary insurance, go to patient information screen, enter patient ID number, click find, go to admit screen and see what the secondary payor is. If not filled in add the secondary payor to the payor screen. Transfer the services to the new payor, get the new invoice number. Print the UB04, submit to appropriate carrier (see guidance document in billing office as needed). Mail one copy with EOB to patient or responsible party, stamp patient copy "payable to SCPHN", stamp SCHN copy with "mail stamp, file our copy, mail patient copy in window envelope, update collection screen as "First Bill" and with any additional comments.

F. Medicare PPS Chart Review

1. Run Episodes without Claim Report. Go to the Task bar for Reports, PPS Management, Episodes Without Claims report. Select dates 1/1/90 to the time period you would like to review.
2. Run Services by Patient by Service Date Report for the Episode you would like to review. Go to report on the Task Bar select Financial, Services by Patient by Service Date. Enter the dates of the Episodes from the Episodes without claim report. Enter the From and to Press Select. Enter the Patient Name (3 letters of the last name and press Enter) scroll down and highlight the name of the patient. Click on the to line to capture. View and Print. Mark the Weeks on the Services by Patient report.
3. Pull the charts that go with the services report. Sign it out if necessary.
4. Run the Processed and Unprocessed note report. Go to Reports Clinical Documentation, Processed Note listing. Enter visit date from and to Enter Patient Name, highlight and click on the line. View. Count visits by Discipline. Make a note on the Services by Patient Report. View unprocessed note report. From Clinical Documentation Choose Unprocessed Patient Note listing. Select and enter dates and patient name. View and note any unprocessed notes for this patient or print the report.
5. Look for the signed 485. If a recertification, check box 23 for signature and date. For initial 485 or recertification 485 look for MD signature. Date in Box 25 when 485 was returned. Make note of frequency and disciplines on the services Report, then .Look at Frequency and Duration on 485 and indicate it on the Services Report. Look for supplies. If any of this information is missing, make a note and report it to Nursing Supervisor and Nurse/Therapist by completing form for missing information (see attached sheet).

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6. If SOC is after 4/1/11 need to look for signed "Face to Face" Sheet.
7. Look for signed welcome letter on SOC to make sure date is the same as first visit. Place a check mark next to visit on services report which means we have a patient signature on Welcome Letter.
8. If multiple disciplines saw the patient you will need to compare signature page to visits on services report. If signature page is missing compare to process and unprocessed report. Make a check mark next to each visit.
9. Make sure visits are LK and the correct Employee did the visit.
10. Look for signed D/C Summary/order if Patient is D/C.
11. If any of the above is missing **Do Not Continue** until all the information is present.

➤ FINAL CLAIMS**A. Calculate Final Claim**

Log into HCMS and Calculate Final Claim by going to Tasks, Click on Invoice Processing, then click on HRG Finder. Type in Patient ID # and press enter. The screen will populate. Select the correct Episode in the lower part of the screen. If supplies were not taken in, you need to change the HIPPS code. To do that, click on Oasis HHRG, then click on HIPPS column, un-highlight and back off the last letter of the code. If the last letter is an S then change it to 1 and click on line below code to save. If the last letter is a T then change it to a 2, if the last letter is a U then change it to a 3, if the last letter is a V then change it to a 4, if the last letter is a W then change it to a 5, and if the last letter is an X then change it to a 6. Click on Invoice at the bottom of the screen. Click on calculate claim. The attached message will appear. **"Supply services are not found for the selected episode. Do you want to reset the HIPPS code to indicate no supplies used?"** Click Yes. The Final Reimbursement amount will now appear as well as Final Claim type. (LUPA, PEP, Outlier, Normal)

B. Assign the Invoice

Assign Invoice by going to Invoice Processing, highlight assign invoice, and press enter. Enter the date of the Episode from the Services Report, click add to list. Choose Individual type patient ID, press enter. Choose program, CHHA, choose payer (PPS), click add to list, patient ID and name will appear below. Press OK. "Invoice process complete" will appear. Press OK Click on Red View button. Make note of Invoice # without the F next to it and write it on "Episode without claim report", next to the patient name. Click on bill to see dollar amount. Amount will be in parenthesis. Click Accept. It will ask if you are sure you want to accept assigned invoices. Press yes.

C. Build the EMC File

Once all invoices are assigned you can now build the EMC File. Click on Interfaces, from the Tool Bar. Go to "Billing" arrow down to Export EMC from the dropdown menus. Click on Invoice #, enter Invoice #, click add to list. Click Export. Make sure you are saving to the billing export folder on your c drive thru the TS client folder. Give the file a name so you can find it when you log in the payer link to release it for processing. (example: NGS_Medicare_00-00-0000). Press Save. File builds, print report, save as a pdf file in your pdf folder.

D. Electronic Submission of the Claim

1. File is sent through Payer Link to NGS Medicare (follow same process as for initial)
2. Checking for Revenue (follow same process as for initial)
3. Notify Treasurer's Office (follow same process as for initial)
4. Post Cash to Open Accounts Receivable (follow same process as for initial)
5. Overpayment - If over payment is identified, repayment should occur within 60 days that the overpayment is identified.

SUBJECT: MEDICATION RECONCILIATION POLICY FOR THERAPY ONLY PATIENTS

I. PURPOSE:

One of the Conditions of Participation requires that the comprehensive assessment done on an a Start of Care (SOC) and Resumption of Care (ROC) includes a review of all medications the patient is currently taking. The reason for review is to identify any potential adverse effects and drug reactions. This includes ineffective drug therapy, side effects, drug interaction, duplicated drug therapy, omissions, dosage errors, and noncompliance with drug therapy.

II. PROCEDURE:

A. CHHA/Therapy Supervisor Role

1. CHHA Nursing/Therapy Supervisor receives a referral and reviews the list of medications and patient comorbidities. The supervisor may make an immediate determination that a skilled nursing visit medication reconciliation is required or a nursing SOC.

B. Therapist's Role

1. The therapist will obtain the SOC/ROC referral information including the high risk medication teaching sheets prior to the initial home assessment visit. The high risk medication teaching sheets **MUST** be kept in the welcome folder in the patient's home for the patient and/or family/caregiver to refer to during medication discussion/teaching with the RN.
2. Prior to going to the patient's home, the therapist will enter only the medications on the discharge orders of the referral into the patient's Medication Profile, to include dosage, frequency, route and duration. This information **MUST** be synchronized within 24 hours by the therapist.
3. The therapist will call the patient's home and ask that all of the prescribed medications, and any over the counter medications including supplements, vitamins and herbals that the patient is currently taking, be placed on a table for the therapist to review during the home visit.
4. In the patient's home, the therapist will write on the "Therapy SOC/ROC List of Medications in the Home" form Attachment A, all of the prescribed medications, and any over the counter medications including supplements, vitamins, and herbals that the patient and or family/caregiver states that the patient is currently taking.
5. The evaluating therapist will call the therapy supervisor at the conclusion of the initial evaluation visit to discuss the comparison of the "Therapy SOC/ROC List of Medications in the Home" form to the discharge medication list.
6. The evaluating therapist will fax or deliver the "Therapy SOC/ROC List of Medications in the Home" form to the SCPHN office by 5 pm that day.
7. The therapy supervisor will write the name of the appropriate CHHA nursing supervisor, and the date, on the "Therapy SOC/ROC List of Medications in the Home" form. The therapy supervisor will then give the form to the appropriate CHHA nursing supervisor.
8. The CHHA nursing supervisor will decide whether a phone medication reconciliation or an in home medication reconciliation will be completed. The nursing supervisor will indicate her decision on the form and assign a nurse to complete the medication reconciliation.
9. The CHHA nursing supervisor will obtain the 1w1 skilled nursing order and insurance authorizations as applicable.
10. The CHHA nursing supervisor will give the "Therapy SOC/ROC List of Medications in the Home" form and a copy of the referral with discharge medications to the assigned nurse, to complete the medication reconciliation.

SUBJECT: MEDICATION RECONCILIATION POLICY FOR THERAPY ONLY PATIENTS

C. Medication Reconciliation performed:

1. Phone Medication Reconciliation:

- a. The RN will compare the "Therapy SOC/ROC List of Medications in the Home" form to the medications listed in the patient's medication profile in order to identify discrepancies.
- b. The RN will call the patient and/or family/caregiver to discuss the prescribed medications, and any over the counter medications including supplements, vitamins, and herbals, and question the patient and or family/caregiver regarding any clinically significant medication issues, and effectiveness of the patient's medications.
- c. The RN will contact the physician via telephone, to discuss medication discrepancies, and any clinically significant medication issues. RN will request a response if physician is not available.
- d. The RN will document the coordination with the physician and the *specific medications* that were reconciled.
- e. The RN will contact the patient and/or family/caregiver to review the medication changes and the entire med regime utilizing the high risk medication teaching sheets as applicable. The RN will also teach the patient and/or family/caregiver regarding proper administration, desired effects, potential side effects, risks and possible interactions.
- f. The RN will contact the therapist with any medication changes and the date of MD medication reconciliation. That date will be entered as the M0090 Date Assessment Completed on the OASIS. If the date of reconciliation is greater than 5 days from the initial assessment then enter the date of the 5th day. The therapist will document the report of reconciliation findings from the RN.
- g. The RN will create a 912 note and the following items **MUST** be included in the note.
 - ✓ RN completed the medication reconciliation and medication education by telephone.
 - ✓ Synopsis of the phone conversation to include teach back.
 - ✓ Statement regarding whether any nursing visits are needed, and if needed, the reason(s).
 - ✓ Statement that coordination with the physician was completed and the specific medication(s) that were reconciled.
 - ✓ Statement that the patient was encouraged to be compliant with all future medical direction and follow up appointments with physician. Document patient's response.
 - ✓ Statement about what services are being provided in the home.
 - ✓ Enter medication changes in the patient's Medication Profile, as applicable.
- h. If the nurse feels that a nursing visit is needed, the nurse will telephone the physician to obtain an order.

2. Nursing Visit Medication Reconciliation:

- a. The RN will compare the "Therapy SOC/ROC List of Medications in the Home" form to the medications listed in the patient's medication profile, to identify discrepancies.
- b. The RN will call the patient and/or family/caregiver to schedule a home visit.
- c. During the home visit the RN will discuss prescribed medications, and any over the counter medications including supplements, vitamins and any herbals and question the patient regarding any clinically significant medication issues, and effectiveness of the medications.
- d. The RN will make every effort to contact the physician from the patient's home to discuss medication discrepancies and any clinically significant issues. The nurse will request a response if physician is not available.

SUBJECT: MEDICATION RECONCILIATION POLICY FOR THERAPY ONLY PATIENTS

- e. The RN will document the coordination with the physician, and the *specific medications* that were reconciled.
- f. The RN will review the medication changes and entire medication regime with the patient and/or family/caregiver utilizing the high risk medication sheets. The RN will also teach the patient and/or family/caregiver regarding proper administration, desired effects, potential side effects, risks and possible interactions.
- g. The RN will contact the therapist with any medication changes and the date of the MD medication reconciliation. That date will be entered as the M0090 Date Assessment Completed on the OASIS. If that date is greater than 5 days from the initial assessment then enter the date of the 5th day as your date assessment completed. The therapist will document the report of the reconciliation findings from the RN.
- h. The RN will provide the answers to OASIS Medication questions M2000, M2002, M2010, M2020, M2030, and M2040. See Attachment B. The answers will be provided to the therapist by Clindoc, email or phone.
- i. The RN will create a 012 (LK) or 019 (NLK) visit note and the following items **MUST** be included in the note:
 - ✓ RN made one skilled nursing visit to complete medication reconciliation and medication education.
 - ✓ Synopsis of visit findings including teach back.
 - ✓ Statement regarding whether any further nursing visits are needed, and if needed the reason(s).
 - ✓ Statement that coordination with the physician was completed and the specific medications that were reconciled.
 - ✓ Statement that the patient was encouraged to be compliant with all future medical direction and follow up appointments with physician. Document the patient's response.
 - ✓ Statement about what services will continue in the home.
 - ✓ Enter medication changes in to the Medication Profile, as applicable.
 - ✓ Discontinue the 1wk 1 order.
 - ✓ Discontinue the evaluation and treat order.
 - ✓ A one-time Medication Management physician order and that contains all the above components by copying and pasting them from the note into the order.
- j. If the nurse feels further visits are needed the nurse will telephone the physician.

MEDICATIONS

(M2000) Drug Regimen Review: Does a complete drug regimen review indicate potential clinically significant medication issues, e.g., drug reactions, ineffective drug therapy, side effects, drug interactions, duplicate therapy, omissions, dosage errors, or noncompliance?

- 0 - Not assessed/reviewed [Go to M2010]
- 1 - No problems found during review [Go to M2010]
- 2 - Problems found during review
- NA - Patient is not taking any medications [Go to M2040]

(M2002) Medication Follow-up: Was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

- 0 - No
- 1 - Yes

(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

- 0 - No
- 1 - Yes
- NA - Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications

(M2020) Management of Oral Medications: Patient's current ability to prepare and take all oral medications reliably and safely, including administration of the correct dosage at the appropriate times/intervals. **Excludes injectable and IV medications. (NOTE: This refers to ability, not compliance or willingness.)**

- 0 - Able to independently take the correct oral medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take medication(s) at the correct times if:
 - (a) individual dosages are prepared in advance by another person; OR
 - (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person at the appropriate times
- 3 - Unable to take medication unless administered by another person.
- NA - No oral medications prescribed.

(M2030) Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications reliably and safely, including administration of correct dosage at the appropriate times/intervals. **Excludes IV medications.**

- 0 - Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
- 1 - Able to take injectable medication(s) at the correct times if:
 - (a) individual syringes are prepared in advance by another person; OR
 - (b) another person develops a drug diary or chart.
- 2 - Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
- 3 - Unable to take injectable medication unless administered by another person.
- NA - No injectable medications prescribed.

(M2040) Prior Medication Management: Indicate the patient's usual ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only **one** box in each row.

Functional Area	Independent	Needed Some Help	Dependent	Not Applicable
a. Oral Medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na
b. Injectable medications	<input type="checkbox"/> 0	<input type="checkbox"/> 1	<input type="checkbox"/> 2	<input type="checkbox"/> na

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PEER REVIEW AUDIT POLICY AND PROCEDURE

I. PURPOSE:

Saratoga County Public Health Nursing will monitor patient care and documentation of patients in the Certified Home Health Agency (CHHA) and Long Term Home Health Care Program (LTHHCP) to ensure compliance with Federal, and State regulations, and agency policies, procedures and standards.

II. POLICY:

Peer Review Committee will be held monthly to audit active and discharged CHHA and LT patient records. Peer Review Committee will consist of Team A and Team B. Each team will have 4-5 members from the CHHA and LTHHCP. Each team will meet every other month on different months. The Peer Review Committee Meetings, patient record reviews, and processing of completed record review tools will be overseen by the Supervisor for Quality Assurance and Compliance. The Supervisor of Quality Assurance (QA) and Compliance will report on Peer Review Committee to the Medical Director, the Director of Public Health and the Director of Patient Services.

III. PROCEDURE:

1. All CHHA and LTHHCP nurses are assigned to Team A or Team B and are notified of their assignment.
2. Each team consists of 2 north team CHHA nurses and 2 South team CHHA nurses and one team will include the LT nurse. This will allow adequate staffing for each CHHA team on the afternoon of Peer Review meetings.
3. Peer Review Meetings are scheduled on the conference room meeting schedule for the year by the Supervisor of QA and Compliance.
4. Each team of nurses is given a list of meeting dates and times for the current calendar year.
5. The Supervisor of QA and Compliance will Run an active admissions report and a discharged admissions report and select 1 record per nurse to be reviewed.
6. The CHHA Medical Secretary will pull the selected charts and complete the header section of each audit tool.
7. The Supervisor of QA and Compliance will assign the charts to each nurse so that no nurse reviews her own charts.
8. The Supervisor of QA and Compliance will review the audit tools for completion, signature and date of reviewer, and tally the results on a percentage grid, following each meeting.
9. The Supervisor of QA and Compliance will give the completed audit tools to the respective case manager with a memo containing directions to review the completed audit tool, make corrections as applicable, sign, date, and return the audit tool to their nursing supervisor within the specified time frame.
10. The CHHA/LTHHCP Nursing Supervisors will review the audit tools to see how their staff is performing.
11. The CHHA/LTHHCP Nursing Supervisors will return the audit tools to the Supervisor of QA and Compliance.
12. The Supervisor of QA and Compliance will report the findings to the Director of Public Health, and the Director of Patient Services following each Peer Review Meeting.

SUBJECT: PEER REVIEW AUDIT POLICY AND PROCEDURE

13. The Supervisor of QA and Compliance will report the findings from Peer Review Meetings quarterly to the Quality Assurance Committee, and the Professional Advisory Committee.

Approved by Medical Director:

Signature

Date

PEER REVIEW AUDIT TOOL 2014

Date of Audit: _____

Patient Record #: _____

SOC Date: ____ / ____ / ____

Primary RN: _____

Active OR Discharge (circle one)

Services: SN PT OT SLP MSW RD HHA PCA RT (circle)

PHYSICIAN ORDERS

		YES	NO	N/A	COMMENTS
1	Is the patient taking a nutritional supplement?				
2	If yes, does 485 contain an order for a nutritional supplement?				
3	If no order on 485, was the physician contacted regarding the supplement and interim order obtained?				
4	Does the patient use anti-embolism stockings?				
5	If yes, does the 485 contain: -an order for anti-embolism stockings -specific order regarding frequency of stocking application and removal				
6	Does the patient use oxygen?				
7	If yes, does the 485 contain: -an order for oxygen; -method of delivery; -liters per minute				
8	If there is an order for patient to titrate their oxygen, does it contain specific parameters as to when oxygen should be titrated?				
9	Does patient use an insulin pump?				
10	If yes, does the 485 contain an order for: -the insulin pump; -person responsible for the pump settings; -type of insulin				
11	Does the patient use a glucometer?				
12	If yes, does the 485 contain an order that indicates: -how often fingersticks are to be done; -who is responsible to perform them				

PHYSICIAN ORDERS (cont.)		YES	NO	N/A	COMMENTS
13	Does the patient have a wound?				
14	Does the 485 contain orders for wound care?				
15	If there are changes in the wound care, are there interim orders for the changes?				
16	If patient has ancillary services, is there a 1 wk 1 order for therapy? (PT, OT, SLP, RD, MSW, RT)				
17	If yes, was evaluation visit made by therapy (PT, OT, SLP, RD, MSW, RT) within one week?				
18	If visit not made within one week, was MD notified?				
19	Was new 1 wk 1 order obtained?				
20	Was frequency and duration of visits on 485 followed?				
21	If not, was MD contacted and interim order done?				
22	Was there a reduction in SN, PT, OT SLP, MSW, RD, RT, MOW and HHA visit frequency or duration that differed from the current plan of care (485)?				
23	If yes, was an HHCCN completed for the reduction and signed by the patient?				
24	If there was more than one service reduced for different reasons, was a separate HHCCN done for each reduction?				
25	Was there a termination of service(s) by the physician or agency?				
26	If yes, was an HHCCN completed for the termination and signed by the patient?				
CARE PLAN					
1	If patient takes a nutritional supplement, does the care plan contain information regarding the name and frequency the supplement is taken?	YES	NO	N/A	COMMENTS
2	If patient uses anti-embolism stockings, does the care plan list and address specific orders regarding frequency of stocking application and removal?				
3	If patient uses oxygen, are the oxygen orders including oxygen titration parameters, if applicable, and oxygen safety teaching listed and addressed in the care plan?				
4	If the patient uses an insulin pump, is it documented in the care plan?				
5	If the patient uses a glucometer, does the care plan list and address: -how often fingersticks are to be done; -who is responsible to perform fingersticks?				
6	If patient is a diabetic, does care plan list and address foot care education?				

CARE PLAN (cont.)		YES	NO	N/A	COMMENTS
7	If patient has a wound, are the current wound care orders listed and addressed in the care plan?				
8	If patient has a wound, is a regular weekday listed in the care plan that wound measurements and photos are to be done?				
9	If patient has a wound, were wound measurements and pictures done and documented every 7 days on the weekday specified in the care plan?				
10	If wound measurements and pictures weren't done every 7 days on the specified day, is there appropriate and detailed documentation explaining why? ("measurements and or pictures not done" is not appropriate documentation)				
11	If patient has pain, is type and location of pain documented in the "Intervention" section of care plan?				
12	Is patient's response to pain management measures documented in the "Response" section of the care plan?				
13	If the patient has a diagnosis of: COPD, CHF, Diabetes, wounds, catheter, or pneumonia, is zone tool use documented in the care plan?				
14	Are due dates in care plans updated (catheter changes, wound measurements/pictures, routine injections, HHA supervisions)?				
MEDICATION PROFILE					
1	Does the medication profile indicate patient allergies or NKA?	YES	NO	N/A	COMMENTS
2	Does each medication listed include dosage, frequency, and route?				
3	Do prn medications on medication profile state purpose for use?				
4	Do medications listed on the referral match the initial medication profile?				
5	If not, was a medication reconciliation done with MD?				
6	Are all medication reconciliation changes indicated on the medication profile?				
7	If patient takes sliding scale insulin, are the sliding scale instructions listed on the medication profile?				
8	During the course of care, if new medications were ordered, were they documented on the medication profile?				
9	If a medication has a finite end date, is that end date documented on medication profile?				

DOCUMENTATION REQUIREMENTS		YES	NO	N/A	COMMENTS
1	Have ankle measurements been documented in the "Cardiac" section of visit note, per agency standard?				
2	Have weights been documented in "Vital Signs" section of visit note, per agency standard?				
3	If vital signs were outside the agency parameters for any visit, is there documentation that MD was notified?				
4	If patient has a wound, is a thorough description of the wound including correct anatomic location, type of tissue visualized, undermining, tunneling, slough, drainage, documented in every visit note?				
5	If PT only case, did PT inquire about surgical wound at each visit and document?				
6	Did PT observe surgical wound at least once a week and document?				
7	If PT noted incision abnormalities or s/s of infection, did they notify MD?				
8	If MD ordered SN visit to eval incision, did PT do MD order?				
9	Did PT conference with PT supervisor regarding SN visit request, and document conference with PT supervisor?				
10	Did PT supervisor discuss MD order for nursing visit with CHHA nursing supervisor and document in patient record?				
11	If patient has poor pain control, is there documentation indicating communication with the physician?				
12	If MD prescribed new pain management orders, is there documentation indicating follow-up and teaching with patient?				
13	If there were medication discrepancies, is there documentation of communication with the physician regarding medication discrepancies and reconciliation?				
14	If medications had to be reconciled, is there follow-up documentation that patient/caregivers, and therapist, if applicable, were made aware of changes?				
15	Is there documentation of medication teaching at SOC, and/or following medication reconciliation, including desired effects, adverse effects, and possible interactions?				
16	If new medication(s) are ordered during the course of care, is medication teaching documented?				
17	Is there a patient signature sheet for every nursing and therapy visit?				

DOCUMENTATION REQUIREMENTS (cont.)		YES	NO	N/A	COMMENTS
18	If at any point during the episode, Medicare would no longer cover services, and patient wished to continue under another insurance or self-pay, was an ABN completed and signed by patient?				
19	Was the patient notified and ABN issued in advance of the date that payer changed?				
20	If at any point during the episode, the patient services were reduced from frequencies listed on the 485, or terminated, was an HHCCN completed and signed by patient?				
21	Was the patient notified and the HHCCN issued in advance before services were reduced or terminated?				
22	If services were terminated and HHCCN was not issued in advance, is there documentation substantiating why? (i.e., staff threatened by someone in home, drug trafficking in the home)				
DISCHARGE					
1	Was patient discharged from services?				
2	If yes, is there documentation that physician was contacted to discuss discharge?				
3	Is patient agreeable to discharge?				
4	If not, is it documented in clinical note?				
5	Do M2250 and M2400 match?				
6	Within discharge summary order, is there documentation of the following: a) A summary of patient care provided? b) A summary of patient teaching? c) A summary of patient teach back? d) Reference to items answered YES in M2250/M2400? e) Patient's status at discharge? f) Primary caregiver, if any? g) Community supports, if any? h) Physician follow-up? i) Is notice of non-coverage in chart and signed?				

UTILIZATION REVIEW PAIN MANAGEMENT AUDIT TOOL 2014

Program: CHHA / LTHHCP Services: SN PT OT SLP MSW RD HHA PCA RT Payor Source: _____
 Patient Record #: _____ DOB: ____ / ____ / ____ Sex: M F Referral Source: _____
 SOC Date: ____ / ____ / ____ Discharge Date (if applicable): ____ / ____ / ____ Surgery and Dates: _____
 Primary Diagnosis: _____ Secondary Diagnosis: _____

PHYSICIAN ORDERS		YES	NO	N/A	COMMENTS
1	Were the frequency and duration of visits on 485 followed?				
2	If not, was physician contacted and was interim order done?				
3	Were 485 and interim orders returned within 30 days?				
4	If patient has pain, do the physician orders contain interventions that address assessment of pain, education of patient regarding pain relief measures including pain medications, and reporting unmanaged pain to the physician?				
CARE PLAN					
1	Is pain medication teaching listed and addressed in the care plan?				
2	If patient has pain, is type and location of pain documented in "Indicator" section of care plan?				
3	If the patient has pain, does the care plan contain interventions that address assessment of pain, education of patient regarding pain relief measures, including pain medications, and reporting unmanaged pain to the physician?				
4	Is patient's response to pain management measures documented in the Response section of the care plan?				
MEDICATION PROFILE					
1	Does the medication profile indicate patient allergies or NKA?				
2	Does each medication listed include dosage, frequency, and route?				
3	Do prn medications on medication profile state purpose for use?				
4	During the course of care, if new medications were ordered, were they documented on the medication profile?				
DOCUMENTATION REQUIREMENTS					
Does pain scale in vital sign section agree with OASIS pain assessment and M1240?		YES	NO	N/A	COMMENTS
2	Is coordination of services evident in documentation?				

DOCUMENTATION REQUIREMENTS (cont.)				YES	NO	N/A	COMMENTS
3	Is patient's condition and clinical course evident in the documentation?						
4	Were changes in patient's condition reported to physician and documented?						
5	If patient has poor pain control, is there documentation indicating communication with the physician?						
6	If physician gave new pain management orders, is there documentation indicating follow-up and teaching with patient?						
7	If changes in pain medications or new medication(s) are ordered during the course of care, is there documentation of medication teaching with patient/family and/or caregiver?						
8	Is there a patient signature sheet for every nursing and therapy visit?						
DISCHARGE							
1	Was patient discharged from services?			YES	NO	N/A	COMMENTS
2	If yes, is there documentation that physician was contacted to discuss discharge?						
3	Was patient agreeable to discharge?						
4	If not, was it documented in clinical note?						
5	Do M2250 and M2400 match?						
6	Within discharge summary order, is there documentation of the following:						
	a) A summary of patient care provided?						
	b) A summary of patient teaching?						
	c) A summary of patient teach back?						
	d) Reference to items answered YES in M2250/M2400?						
	e) Patient's status at discharge?						
	f) Primary caregiver, if any?						
	g) Community supports, if any?						
	h) Physician follow-up?						
7	Is notice of non-coverage in chart and signed? (Medicare and Managed Medicare patients only)						

CONCLUSIONS:

Were services coordinated and documented at least once a certification period? (each discipline must communicate with each other and the physician at least once a certification period) _____

Were all identified patient needs addressed? _____

Reviewer's decision on relationship of Care Plan and amount and kind of services as related to patient's condition and clinical course:

- Appropriate
- Over use
- Under use
- Lacking Information

Committee member signature and title: _____ TITLE _____ DATE REVIEW DONE _____

FOLLOW-UP RESPONSE/CORRECTIVE ACTION:

CLINICIAN SIGNATURE _____

DATE _____

SUPERVISOR SIGNATURE _____

DATE _____

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: CODE OF ETHICS FOR NURSES

I. POLICY:

Saratoga County Public Health will maintain a Code of Ethics for Nurses. All nurses employed by Saratoga County Public Health will abide by the Code of Ethics for Nurses.

II. PURPOSE:

A code of Ethics is a set of standards and provides ethical and legal guidance for nursing practice. This guidance should be incorporated into the nursing practice of all Saratoga County Public Health Nurses to ensure that professional, respectful, compassionate, competent, and health promoting care is provided to the residents, their families, and the communities of Saratoga County.

CODE OF ETHICS FOR NURSES

1. The nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth, and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems.
2. The nurse's primary commitment is to the patient, whether an individual, family, group, or community.
3. The nurse promotes, advocates for, and strives to protect the health, safety, and rights of the patient.
4. The nurse is responsible and accountable for individual nursing practice and determines the appropriate delegation of tasks consistent with the nurse's obligation to provide optimum patient care.
5. The nurse owes the same duties to self as to others, including the responsibility to preserve integrity and safety, to maintain competence, and to continue personal and professional growth.
6. The nurse participates in establishing, maintaining, and improving healthcare environments and conditions of employment conducive to the provision of quality health care and consistent with the values of the profession through individual and collective action.
7. The nurse participates in the advancement of the profession through contributions to practice, education, administration, and knowledge development.
8. The nurse collaborates with other health professionals and the public in promoting community, national and international efforts to meet health needs.
9. The profession of nursing, as represented by associations and their members, is responsible for articulating nursing values, for maintaining the integrity of the profession and its practice, and for shaping social policy.

REFERENCE:

Daley, Barbara PHD, RN, FAAN et al. (2001) Code of Ethics for Nurses with Interpretive Statements, American Nurses Publishing: Washington, D.C.

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: WALK IN BLOOD PRESSURE CHECKS POLICY AND PROCEDURE

I. PURPOSE:

To provide blood pressure assessment and education regarding hypertension/hypotension, and the need for physician follow up, when any client walks in the building requesting a blood pressure check or states that they are not feeling well.

II. POLICY:

Saratoga County Public Health Nurse's (SCPHNs) will assess the blood pressure of any client who enters the building requesting a blood pressure check or states that they are not feeling well; and provide education regarding hypertension/hypotension, and the need for physician follow up when blood pressure is outside of normal parameters. If the client's blood pressure is found to be outside of normal parameters, SCPHNs will notify the client's physician of the abnormal findings.

III. PROCEDURE:

1. A nursing supervisor will speak with the client that is requesting the blood pressure check and make an assessment to be sure that a comprehensive approach is taken with the person.
2. The nursing supervisor will assign a nurse to talk with the client, discuss any history of hypertension/hypotension, blood pressure medications, and complete the first half of the "Walk-In Blood Pressure Record". (See Appendix A).
3. The nurse will ask for the client's consent to check their blood pressure and to follow up with the client's physician with any abnormal blood pressure findings.
4. The nurse will print the client's name in the declaration statement on the "Walk-In Blood Pressure Record". The client will sign where it says client signature, and write the date across from their signature. The nurse will sign name and title where it says witness signature and write the date across from their signature.
5. The nurse will assess the client's blood pressure while the client is sitting, on both arms unless contraindicated (AV fistula, history of lymph node dissection). If blood pressure reading is hypotensive, a standing blood pressure will also be taken.
6. The nurse will record the blood pressure reading(s) on the "Walk-In Blood Pressure Record". Any additional follow up or comments will also be recorded on the "Walk-In Blood Pressure Record".
7. The nurse will inform the client of their blood pressure reading and educate the person about normal blood pressure parameters according to the American Heart Association standards (see Appendix B), the health risks of hypertension/hypotension, and the need to follow up with their physician.
8. If the blood pressure reading is outside of normal parameters, the nurse will inform the client that their physician will be notified of the abnormal reading and the client should follow up with their physician.
9. The client will be given a copy of the form when completed, and the original will be filed in the "Walk-In Blood Pressure Notebook" kept in the both the CHHA and Prevention office.

Saratoga County Public Health Nursing Service
WALK-IN BLOOD PRESSURE RECORD

Date: _____
 Name: _____ DOB: _____
 Address: _____
 Home Phone No: _____ Cell Phone No: _____

PRIMARY CARE PROVIDER (PCP)		CARDIOLOGIST	
Name: _____		Name: _____	
Office Location: _____		Office Location: _____	
Phone: _____	Fax: _____	Phone: _____	Fax: _____

Health Insurance: Yes No Was a Health Insurance Navigator Program Referral Completed? Yes No

HISTORY OF:	YES	NO	COMMENTS
Hypertension			
Hypotension			
Medications			

I, _____, give permission for Saratoga County Public Health Nursing Service to take my blood pressure, provide teaching, and release information to the above named physician(s) if necessary.

Client signature: _____ Date: _____
 Witness signature: _____ Date: _____

Sitting Blood Pressure		Standing Blood Pressure		Pulse	
Left arm	Right arm	Left arm	Right arm	Left arm	Right arm

- Educational material Provided: Yes No Comment: _____
- PCP notified by: **FAX** Yes No **PHONE** Yes No

Clinical Narrative: _____



What is the AHA recommendation for healthy blood pressure?

This chart reflects blood pressure categories defined by the American Heart Association.

Blood Pressure Category	Systolic mm Hg (upper #)		Diastolic mm Hg (lower #)
Normal	less than 120	and	less than 80
Prehypertension	120 – 139	or	80 – 89
High Blood Pressure (Hypertension) Stage 1	140 – 159	or	90 – 99
High Blood Pressure (Hypertension) Stage 2	160 or higher	or	100 or higher
<u>Hypertensive Crisis</u> (Emergency care needed)	Higher than 180	or	Higher than 110

NOTE: Per Dr. DelGiacco, Medical Director for Saratoga County Public Health, if we check a client’s blood pressure and it is above 180/110 and they are not experiencing any symptoms, they are not treated as an emergency and should be encouraged to follow-up with their primary MD or Urgent Care Center. If a client with a blood pressure reading above 180/110 and experiencing symptoms of hypertensive crisis (i.e., blurred vision, dizziness, chest pain, numbness in extremities, headache, etc.) should be sent to ER.


 Dr. Desmond DelGiacco
 Medical Director


 Date

Saratoga County Public Health Nursing Service
ANNUAL EMPLOYMENT HEALTH ASSESSMENT

Name: _____ Gender: M F Date of Birth: _____

Address: _____ Phone No.: _____

Position: _____

Family Physician: _____ Address: _____

Have you been seen by a Physician in the past year? Yes No If yes, date: _____

REVIEW OF SYSTEMS: Do you have or have you been treated for:

	Yes	No		Yes	No
➤ Skin: changes in color	<input type="checkbox"/>	<input type="checkbox"/>	➤ Bleeding gums	<input type="checkbox"/>	<input type="checkbox"/>
rashes	<input type="checkbox"/>	<input type="checkbox"/>	➤ Hoarseness	<input type="checkbox"/>	<input type="checkbox"/>
bleeding	<input type="checkbox"/>	<input type="checkbox"/>	➤ Sore throat	<input type="checkbox"/>	<input type="checkbox"/>
moles that have changed in			➤ Change in voice	<input type="checkbox"/>	<input type="checkbox"/>
color/size	<input type="checkbox"/>	<input type="checkbox"/>	➤ Difficulty swallowing	<input type="checkbox"/>	<input type="checkbox"/>
➤ Enlargement of glands in neck	<input type="checkbox"/>	<input type="checkbox"/>	➤ Breast lumps	<input type="checkbox"/>	<input type="checkbox"/>
groin	<input type="checkbox"/>	<input type="checkbox"/>	pain	<input type="checkbox"/>	<input type="checkbox"/>
➤ Fractures of a bone	<input type="checkbox"/>	<input type="checkbox"/>	discharge	<input type="checkbox"/>	<input type="checkbox"/>
➤ Joint: swelling	<input type="checkbox"/>	<input type="checkbox"/>	➤ Night sweats	<input type="checkbox"/>	<input type="checkbox"/>
pain	<input type="checkbox"/>	<input type="checkbox"/>	➤ Cough	<input type="checkbox"/>	<input type="checkbox"/>
weakness	<input type="checkbox"/>	<input type="checkbox"/>	➤ Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>
➤ Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	➤ Wheezing	<input type="checkbox"/>	<input type="checkbox"/>
➤ Back injury	<input type="checkbox"/>	<input type="checkbox"/>	➤ Coughing up blood	<input type="checkbox"/>	<input type="checkbox"/>
➤ Back surgery	<input type="checkbox"/>	<input type="checkbox"/>	➤ Chest pain	<input type="checkbox"/>	<input type="checkbox"/>
➤ Restrictions placed on lifting/bending	<input type="checkbox"/>	<input type="checkbox"/>	pressure	<input type="checkbox"/>	<input type="checkbox"/>
➤ Unexplained weight loss	<input type="checkbox"/>	<input type="checkbox"/>	tightness	<input type="checkbox"/>	<input type="checkbox"/>
➤ Increasingly bothered by heat	<input type="checkbox"/>	<input type="checkbox"/>	➤ Palpitations	<input type="checkbox"/>	<input type="checkbox"/>
cold	<input type="checkbox"/>	<input type="checkbox"/>	➤ Pain in legs	<input type="checkbox"/>	<input type="checkbox"/>
➤ Excessive eating	<input type="checkbox"/>	<input type="checkbox"/>	➤ High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>
drinking	<input type="checkbox"/>	<input type="checkbox"/>	➤ Nausea	<input type="checkbox"/>	<input type="checkbox"/>
urination	<input type="checkbox"/>	<input type="checkbox"/>	➤ Vomiting	<input type="checkbox"/>	<input type="checkbox"/>
➤ Headaches	<input type="checkbox"/>	<input type="checkbox"/>	➤ Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>
➤ Fainting	<input type="checkbox"/>	<input type="checkbox"/>	➤ Constipation	<input type="checkbox"/>	<input type="checkbox"/>
➤ Loss of vision	<input type="checkbox"/>	<input type="checkbox"/>	➤ Black stools	<input type="checkbox"/>	<input type="checkbox"/>
➤ Double vision	<input type="checkbox"/>	<input type="checkbox"/>	➤ Blood in stool	<input type="checkbox"/>	<input type="checkbox"/>
➤ Blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	➤ Change in bowel habits	<input type="checkbox"/>	<input type="checkbox"/>
➤ Change in hearing	<input type="checkbox"/>	<input type="checkbox"/>	➤ History of hepatitis	<input type="checkbox"/>	<input type="checkbox"/>
➤ Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	yellow jaundice	<input type="checkbox"/>	<input type="checkbox"/>
➤ Pain in ears	<input type="checkbox"/>	<input type="checkbox"/>	➤ Pain upon urination	<input type="checkbox"/>	<input type="checkbox"/>
➤ Discharge from ears	<input type="checkbox"/>	<input type="checkbox"/>	➤ Blood in urine	<input type="checkbox"/>	<input type="checkbox"/>
➤ History of mental/emotional disorder	<input type="checkbox"/>	<input type="checkbox"/>	➤ History of seizures	<input type="checkbox"/>	<input type="checkbox"/>
➤ Sores in mouth	<input type="checkbox"/>	<input type="checkbox"/>	blackouts	<input type="checkbox"/>	<input type="checkbox"/>
			weakness of arms or legs	<input type="checkbox"/>	<input type="checkbox"/>

Give details of "yes" answers: _____

Blood pressure: _____/_____

Weight: _____ lbs

Pulse: _____/per minute

Regular: Irregular:

MEDICAL HISTORY: (PAST YEAR)

Hospitalization (date, reason): _____

Surgery (date, type): _____

Daily medications: _____

Allergies: _____

Date of last Pap Smear? _____

PPD: date of last done _____ due _____

Chest x-ray: _____

Have you had any Worker's compensation or Disability claims in the past year? _____

Do you have any medical conditions that could affect your ability to perform your duties, or create a potential risk to patients, the public, or other personnel? _____

Smoking: # packs/day _____ # years _____

Alcohol: _____

Have you ever taken any habit forming drugs other than those prescribed by a physician? _____

Do you have any habituations such as alcohol, tobacco, stimulants, or narcotics that could affect your ability to perform your duties? _____

EMPLOYEE CERTIFICATION:

I hereby certify that the answers to the questions on this form are true and accurate to the best of my knowledge. I understand that any falsification or misrepresentation of my medical condition (if any) will result in withdrawal of my offer of employment and may be grounds for future discipline, up to and including termination.

Employee signature _____ Date _____

Director Public Health/Director Patient Services signature _____ Date _____

SARATOGA COUNTY PUBLIC HEALTH NURSING SERVICE

SUBJECT: PATIENT TRANSFER PROCEDURES FOR EMERGENCY SITUATIONS

I. POLICY:

In case of an emergency, a plan will be in place to transfer patients to another facility.

II. PURPOSE:

- A. To facilitate the continuity of home care services for patients who will be transferred from Saratoga County Public Health Nursing Service.
1. Director of Public Health (DPH) to notify the NYS DOH of emergency situation and request authorization for transfer of patients.
 2. The Supervising Public Health Nurse's (SPHN's) for CHHA/LTHHCP will identify the patients in need of transfer and provide a list of patients to the Director of Patient Services (DPS). (Priority Listing Form will be used to aid in the selection process, as well as the geographical location of the patients.)
 3. The DPS will be responsible for contacting the new agency to determine the number of patients they can accept for transfer (see Regional Home Care Provider List for contact numbers.)
 4. SPHN's will be responsible for gathering informational materials on each patient to be transferred, using the Patient Transfer Check List.
 5. Agency Medical Secretary of designee will fax the patient information to the Agency.
 6. DPH to notify the NYS DOH when emergency situation is over and patients may return to agency.
 7. When emergency situation is over, SCPHNS will notify the receiving agency, and they will transfer the patients back to SCPHNS, with accompanying information for each patient.