Critical Access Hospital CoPs 2026 Part 5 of 5

Radiology, Rehab, Surgical Services, Anesthesia, QAPI, Organ Procurement, Swing Beds, Obstetrical Services

Speaker

- Laura A. Dixon, Esq.
- BS, JD, RN, CPHRM
- President, Healthcare Risk Education and Consulting, LLC
- ldesq@comcast.net
- Email questions to CMS at: qsog_CAH@cms.hhs.gov.

2

DISCLAIMER

The information provided during this program/webinar is informational only. It is not intended to be legal advice or to establish an attorney-client relationship. Please consult with your in-house counsel or professional legal representative for advice.

Objectives

- Describe: requirements for a history and physical for CAH
- List: what must be contained in an operative report
- Discuss: what must be included and be demonstrated in a QAPI program
- Recall: Swing Bed patient rights
- Describe: new requirements for obstetrical services

Radiology

Radiology – Generally

- Patient exposure to ionizing radiation doubled in 20 years
  - Due to diagnostic imaging, CT, fluoroscopy, and nuclear medicine (NM) studies
  - Amount of ionizing radiation from CT scan is significantly greater and patient may receive several over their lifetime
  - 80 million studies done every year
- FDA developed initiatives to reduce unnecessary radiation exposure*
  - Want to make sure it **justified** to use it and dose optimization so **lowest dose** is used (as low as reasonably achievable)

FDA Changes

- Changes discuss safety precautions a hospital should do to decrease radiation exposure such as:
  - Need to identify high risk patient for whom a diagnostic study might be contraindicated
  - Use appropriate shielding of patients and staff that is specific to the type of imaging device
  - Periodically inspect and calibrate the equipment
  - Make sure staff are appropriately trained

Factors to Eliminate Avoidable Exposure

- Have a patient safety program and effective P&Ps
- Provide education
  - On managing radiation exposures and optimizing radiation doses
  - On potential dangers of excessive radiation exposure and have a radiation safety officer
  - On typical radiation doses and dose ranges

Factors to Eliminate – continued

- Have clear protocols that identify the maximum dose for each type of study
- Consult with a medical physicist when designing or altering scan protocols
- Train on how to use complex new technology
- Communicate among clinicians, medical physicists, technologists and staff and total 20 recommendations

Radiology Services C1030

- Services must be provided by qualified staff
  - Can as a direct service or contracted
  - Includes interpretation of studies/films
- Do not expose patients or staff to radiation hazards
- Must have services to always meet the needs of the patients

Services

- Can offer minimal set or more complex
  - According to needs of the patients
  - Diagnostic, therapeutic and nuclear medicine
- Hospital has flexibility to decide types and complexities of services offered
- Services must be in accordance with acceptable standards of practice
- Must meet professionally approved standards for safety
- Must comply with Federal and state laws – licensure

Scope and Complexity

- Scope and complexity should be in writing and approved by board/responsible party
  - If telemedicine is used must comply with telemedicine standards
- According to standards recommended by nationally recognized professions:
  - AMA – Radiology Society of North America – Alliance for Radiation Safety in Pediatric Imaging – ACC – American College of Neurology – ACP and ACR
  - Example: ACR MRI safety standards and contrast media at www.acr.org

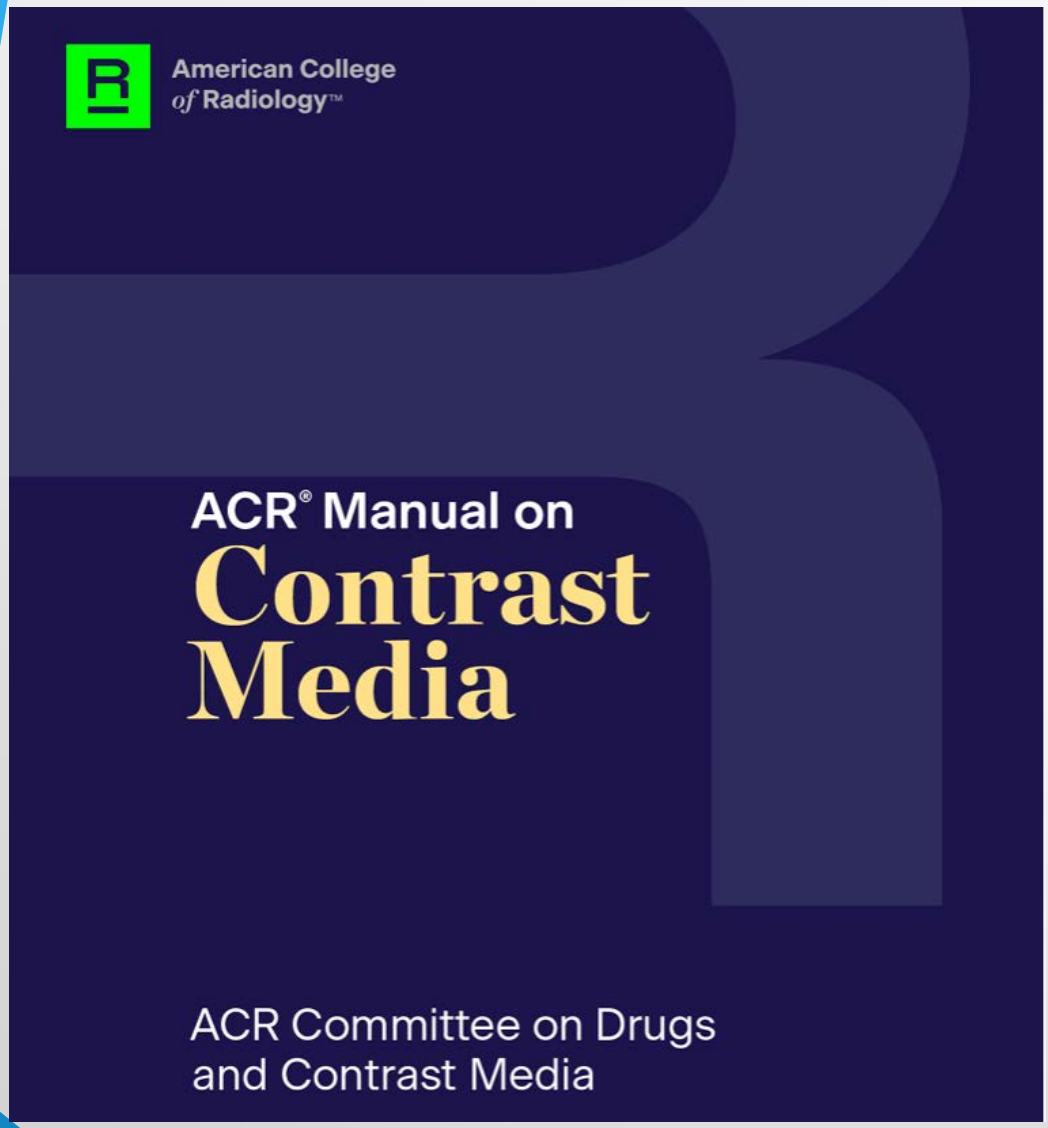
ACR Manual on MR Safety 2024

https://edge.sitecorecloud.io/americancoldf5f-acrorgf92a-productioncb02-3650/media/ACR/Files/Clinical/Radiology-Safety/Manual-on-MR-Safety.pdf

Key Points – MR Safety

- Notes MR safety accidents reveal cause rarely from equipment malfunction
- Rather – how equipment used, breakdown in adherence to policies and procedures
- 3 deaths from oxygen cylinders
- Serious injuries from improper scanning of patients with implanted devices
- One death in 2023 when firearm in the room and magnetic field caused weapon discharge

(ACR Manual on MR safety 2024; pg. 8)



https://www.acr.org/Clinical-Resources/Clinical-Tools-and-Reference/Contrast-Manual

Qualified Radiologic Personnel

- P&P to designate which personnel
  - Qualified to use radiology equipment
  - Administer procedures
  - Telemedicine – must satisfy privileging requirements
  - Personnel must meet State requirements
  - Must be meet training, education certification requirements as needed

Radiation Safety

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

Radiology Policies – continued

- Labeling of all radioactive materials
  - Including waste with clear identification of the material
- Transportation of radioactive materials between locations within the CAH
- Security of radioactive materials
  - Includes a determination of who may have access to radioactive materials
  - And – controlling access to radioactive materials
- Periodic testing of equipment for radiation hazards

Radiology Policies – cont'd

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

Radiology Records

- Radiology records treated in same manner as any other part of a medical record
- Must maintain:
  - Reports of physical examinations
  - Reports of diagnostic and laboratory results
  - Reports of consultative findings
- Author's note:
  - Check state law on retention time period – may be longer than 6 years (CAH)

Survey Procedures

- Will interview person responsible for radiology
  - What services provided at main campus
  - Services provided off site
  - How services provided meet standards of practice
- Safety
  - Will determine if staff are familiar with P&P re: safety
  - Are shielding aprons properly maintained and routinely inspected
  - Will review equipment maintenance reports
  - Will verify labeling of hazardous materials

Survey Procedures – cont'd

- Qualified personnel
  - Will confirm studies interpreted only by qualified personnel approved by governing body/person
  - Will look at which equipment staff are using and review personnel files for qualifications
  - Will interview staff – explain protocols for procedures
  - Will compare written protocols to see if staff adhering to protocols

Tag C1030 Blue Box Advisory

Information Only – Not Required/Not to be Cited

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

Rehab

Rehab Therapy C1052

- Standard: Rehabilitation Therapy Services
- Rehab services are provided by qualified staff
  - Includes PT, OT, and speech-language pathology
  - Provided by staff per State law and therapy requirements
- Is an optional service
  - Can be provided directly or through contracted services

Rehab – cont'd

- Must have:
  - An order
  - Policies and procedures
  - Be consistent with the SOC (American PT Association, American OT Association etc.)
- Must follow the rehab plan of care requirements and be consistent with the state law

Plan of Care Requirements

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

Surgery

Tags C1140 – 1142

Surgical Procedures C1140

- **Condition:** Surgical Services
- If provide surgical services must be performed in a safe manner
  - By qualified practitioner with clinical privileges
- Equipment and supplies are sufficient for type of surgery to be performed safely
- Surgery dept must be organized and staffed

Surgical Services

- Must follow
  - State and federal laws
  - Standards of practice and recommendations by national recognized organizations
    - AMA, ACOS, APIC, AORN
- Quality of outpatient surgical services must be consistent with inpatient
- Scope of surgical services must be writing and approved by MS

Surgical Procedures

- OR must be supervised by experienced staff member
- P&P must address qualifications of supervisor of OR
- If LPN or OR tech used as scrub nurses – must be under RN
  - Immediately available to physically intervene
- Must wear clean surgical attire that covers hair

Surgery Policies

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

Surgery Policies – cont'd

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

Surgery Policies

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

Pre-Operative H&P

- Complete H&P must be done per acceptable standards of practice
- All or part may be delegated to other practitioners
  - PA or NP
  - If allowed by state law and CAH
- Surgeon must sign and assumes full responsibility

Exception

- Must be in the record prior to surgery
  - Exception – emergency and then progress note/entry will suffice
  - Should include at a minimum critical information about patient's condition:
  - Pulmonary status, cardiovascular status, BP, vital signs, etc.

Informed Consent

- Includes all inpatient and outpatient
- Patient informed of who actually performs surgery
  - No ghost surgery
- Must inform patient if practitioner other than the primary surgeon will perform important parts of the surgical procedure
  - EVEN if under the primary surgeon's supervision

Content of Informed Consent

- Name of patient or their legal guardian
- Name of hospital (CAH)
- Name of specific procedure
- Name of person doing the procedure or important parts of the procedure other than primary surgeon
- Significant surgical tasks include
  - Opening and closing > Harvesting grafts
  - Dissecting tissue > Removing tissue
  - Implanting devices > Altering tissue

Informed Consent – cont'd

- Nature and purpose of proposed treatment
  - Risks
  - Consequences if no treatment
  - Alternative procedures or treatments
  - Probability proposed procedure would be successful
- Signature of patient or guardian
- Date and time consent obtained
- Statement procedure explained to the patient or guardian

Informed Consent – cont'd

- Signature of professional person witnessing the consent
- Name of person who explained procedure
- Overall – must disclose sufficient information so patient can make an informed decision
- FYI – a form signed by a patient who does not understand what he is signing is not informed consent
- Must provide in language patient can understand
  - May require interpreter
  - Remember health care literacy

Exams Outside Procedure

- April 2024 memo*: discussed increased concerns about absence of informed patient consent
  - Supervised personnel to perform training and education related exams
  - Outside medically necessary procedures
- Mentioned article in *Annals of Surgery Open1:*
  - "Growing number of states with statutes regulating performance of sensitive examination on anesthetized patients
    - Includes breast, pelvic, prostate and rectal exams…."
- **1.** *Annals of Surgery Open* 3(1):p e120, March 2022. | *DOI:* 10.1097/AS9.0000000000000120

https://www.nytimes.com/2020/02/17/health/pelvic-medical-exam-unconscious.html

Updated Interpretive Guideline

- Tag A-0955 Acute Hospitals:
- Whether physicians other than the operating practitioner, including, but not limited to, residents*, medical, advanced practice provider (such as nurse practitioners and physician assistants), and other applicable students,* will be performing important tasks related to the surgery, *or examinations or invasive procedures for educational and training purposes*, in accordance with the hospital's policies. Important surgical tasks include: opening and closing, dissecting tissue, removing tissue, harvesting grafts, transplanting tissue, administering anesthesia, implanting devices, and placing invasive lines. *Examinations or invasive procedures conducted for educational and training purposes include, but are not limited to, breast, pelvic, prostate, and rectal examinations, as well as others specified under state law.*

ACOG Position

- 2011 Ethics Committee of ACOG stated:
- "Pelvic examinations on an anesthetized woman that offer her no personal benefit and are performed solely for teach purposes should performed only with her specific informed consent obtained before her surgery"
- As of June 2019, some states outlawed examinations under anesthesia without specific consent
  - CA, HI, IL, IA, MD, OR, UT and VA

Cundall HL, MacPhedran SE, Arora KS. Consent for Pelvic Examinations Under Anesthesia by Medical Students: Historical Arguments and Steps Forward. Obstet Gynecol. 2019 Dec;134(6):1298-1302. doi: 10.1097/AOG.0000000000003509. PMID: 31764742; PMCID: PMC6905127.

https://pmc.ncbi.nlm.nih.gov/articles/PMC6905127/

Presenter's Suggestions

- Confirm medical staff aware of requirement
  - Especially surgical staff
- Review and update policies and procedures
- Review and update consent forms
- Train applicable staff on requirements

PACU

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

OR Register

- Register should include
  - Patient's name
  - Patient id number
  - Date of surgery
  - Total time of surgery
  - Name of surgeons, nursing personnel, anesthesiologist
  - Type of anesthesia
  - Operative findings
  - Pre-op and post-op diagnosis
  - Age of patient

Operative Report

- Name and identification number of patient
- Date and times of surgery
- Name of surgeons and assistants
- Pre-op and post-op diagnosis
- Name of procedure
- Type of anesthesia
- Complications if any
- Description of techniques

Operative Report – cont'd

- Description of techniques, findings and tissue removed or altered
- Grafts, tissues, devises implanted, transplants
- Name and description of significant surgical tasks done by others:
  - Opening and closing
  - Harvesting grafts
  - Dissecting/removing tissue
  - Implanting devices
  - Altering tissues

Surveyor in OR

- Will verify access to OR and PACU is limited
- Will verify appropriate cleaning between surgical cases and appropriate terminal cleaning applied
- Operating room attire suitable for surgical case performed
- Persons working in the operating suite must wear only clean surgical costumes
- Equipment available for rapid and routine sterilization of OR materials
  - "Immediate Use Steam Sterilization"

Surveyor in OR – cont'd

- Equipment monitored, inspected, tested
  - Maintained by the CAH'S biomedical equipment program
- Sterilized materials:
  - Packaged
  - Handled
  - Labeled
  - Stored in a manner that ensures sterility
    - E.g., in a moisture and dust-controlled environment
- P&P on expiration dates is followed

Surveyor – cont'd

- Will review OR organizational chart
  - Show lines of authority and delegation
- Will verify
  - LPNs/STs performing circulating duties due so per State laws and approved medical staff P&Ps
  - RN immediately available to respond to emergencies
- Will review sample of medical records for
  - H&P
  - Properly completed consent form
  - Surgical report dated and signed by surgeon

Surveyor – cont'd

- Will check for supplies/equipment
  - On-call system (intercom)
  - Cardiac monitor
  - Resuscitator
  - Defibrillator
  - Aspirator (suction equipment)
  - Tracheotomy set (cricothyroidotomy set is not a substitute)

Surgical Privileges C1142

- Standard: Designation of qualified practitioners
- Must designate who is allowed to perform surgery
  - Doctors, dentists, or podiatrists
- Providers must conform to P&Ps
  - Must be within scope of practice laws
- Surgical privileges should be reviewed and updated every 2 years
- Must maintain roster specifying the surgical privilege
  - Plus – current list of surgeons suspended

Determination of Privileges

- Must delineate privileges of all performing surgery and procedures
- MS bylaws must have criteria for determining privileges
  - Includes a procedure to apply criteria when requesting privileges
  - Privileges granted in accordance with the competence of each
- Ensure procedures performed by appropriate physicians

Appraisal for Privileges

- Appraisal procedure must evaluate each practitioner's training, education, experience, and competence
  - As established by the QAPI program
  - Credentialing
  - Adherence to hospital P&P, and laws
- Surveyor will review written assessment of the practitioner's training, experience, health status, and performance

Specify Privileges

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

Anesthesia

Tags C1144 – 1150

Pre-Anesthesia Assessment C1144

- Standard: Anesthetic risk and evaluation
- Pre-anesthesia evaluation must be performed **immediately prior** to the surgery
  - By qualified person to administer anesthetic
- Must include notation of:
  - Risk of anesthesia
  - Anesthesia type
  - Drug and allergy history
  - Potential anesthesia problems identified
  - Patient's condition prior to induction

Post Anesthesia Evaluation

- Post-anesthesia follow-up report must be written on all inpatients and outpatients prior to discharge
  - Completed by individual qualified to administer anesthesia
- Must include at a minimum
  - Cardiopulmonary status
  - LOC
  - Follow-up care and/or observations
  - Any complications occurring during PACU.

Anesthesia C1145

- Standard: Administration of anesthesia
- CAH must designate who can administer anesthesia
  - Per P&P and scope of practice and state law
- Anesthesia must only be administered by:
  - Qualified anesthesiologist
  - MD/DO
  - CRNA
  - Anesthesiology assistant
  - Supervised trainee in education program
  - Dentist
  - Podiatrist

CRNAs and AAs C1145 & 1147

- A CRNA may administer anesthesia when:
  - Under the supervision of the operating practitioner

  - OR -

  - An anesthesiologist who is immediately available if needed
- An anesthesiologist's assistant (AA) may administer anesthesia when
  - Under the supervision of an anesthesiologist who is **immediately available** if needed

State Exemption – CRNAs C1150

- CAH may be exempted from MD/DO supervision for CRNA
- If Governor submits letter to CMS
  - After consultation with state Medical and Nursing board
- Consultation re: access to and quality of anesthesia service in the State
- In best interest of citizens to opt-out of supervision requirement
  - And is consistent with State law

"Immediately Available"

- Physically located within the OR or L&D unit
- Prepared to immediately conduct hands-on intervention if needed
- **Not** engaged in activities that
  - Could prevent the supervising practitioner from being able to immediately intervene
  - And conduct hands-on interventions if needed

Discharge C1149

- Standard: Discharge
- All patients are discharged in the company of a responsible adult
- Any exceptions to this requirement must be made by the attending practitioner
- Must be documented in the medical record
- Surveyor will verify policies and procedures are in place to govern discharge procedures and instructions

Quality Assurance Performance Improvement

Question

- Our QAPI program: (check all that apply)
  - Covers only departments/services where there have been issues or problems
  - Requires participation by all departments – though some participate more than others
  - Only addresses units/areas where there have been issues in the past year
  - Has improved over the past year
  - Needs help
  - Prefer not to answer

Updates and Changes

- CMS rewrote all the QAPI requirements for CAHs in 2019
  - Replaced "reactive" annual evaluation and quality assurance requirements with "proactive" approach
- New tag numbers/requirements
  - In Burden Reduction memo at page 504* - not the manual
  - Regulation in the August 2025 regulation
    - Did add in Unified and Integrated program
- Interpretive guidelines and survey procedures still pending
- Encouraged to use the technical assistance and services available through the State Flex Programs*

QAPI Program C1300

- **Condition:** CAH must
  - Develop
  - Implement
  - Maintain
  - An effective
  - Ongoing
  - CAH-wide
  - Data-driven QAPI program

Definitions – Adverse Event

- Adverse event:
  - Untoward, undesirable and usually unanticipated event
  - Causes death or serious injury or risk of such

Definitions – Error

- Error:
  - Failure of a planned action
  - To be completed as intended
  - Or use of a wrong plan
  - To achieve an aim
  - Can include problems in practice, products, procedures and systems
  - Medical error – one that occurs in delivery of healthcare services

QAPI Standards

- Standard: Design and scope must be appropriate for complexity of hospitals organization and services provided (C1302)
- C1306 – Must be ongoing and involve all departments and services
  - Including those via contract or arrangements
- C1309 – Use objective measures to evaluate processes, functions and services

Standards – continued

- C1311 – Program must address
  - Indicators related to improved health outcomes
  - Prevention and reduction of medical errors
  - Adverse events
  - HACs
  - Transitions of care
    - Including readmissions
- Standard: Governance and leadership
- C1313 – Board/responsible person is responsible for the QAPI program
  - To ensure QAPI program meets these requirements

Program Activities

- Standard: Program activities
- C1315 – Activities must focus on measures related to improved health outcomes
- C1319 – Use the measures to analyze and track performance
- C1321 – Set priorities for performance improvement
  - Considering either high-volume, high-risk services or problem prone areas

Collection & Analysis C1325

- Standard: Data collection and analysis
- Program must incorporate quality indicator data including
  - Patient care data
  - Other relevant data
  - To achieve the goals of the program

QAPI OB Patients New

- For hospitals providing OB services
  - Effective January 1, 2027
- OB service leadership must engage in QAPI including data collection and monitoring
- If a Maternal Mortality Review Committee (MMRC) is available at State Tribal or local jurisdiction
- Leadership, OB services leadership or designate(s)
  - Must further have a process for incorporating publicly available information and data from the MMRC into the QAPI program

Data & Analysis

- Standard: Program data collection and analysis
- Must incorporate quality indicator data including patient care data to achieve QAPI goals
- If offer OB services must use QAPI program to assess and improve health outcomes and disparities among OB patients on an ongoing basis
- Effective date – January 1, 2027
- 4 minimum requirements (next 2 slides)

4 Requirements

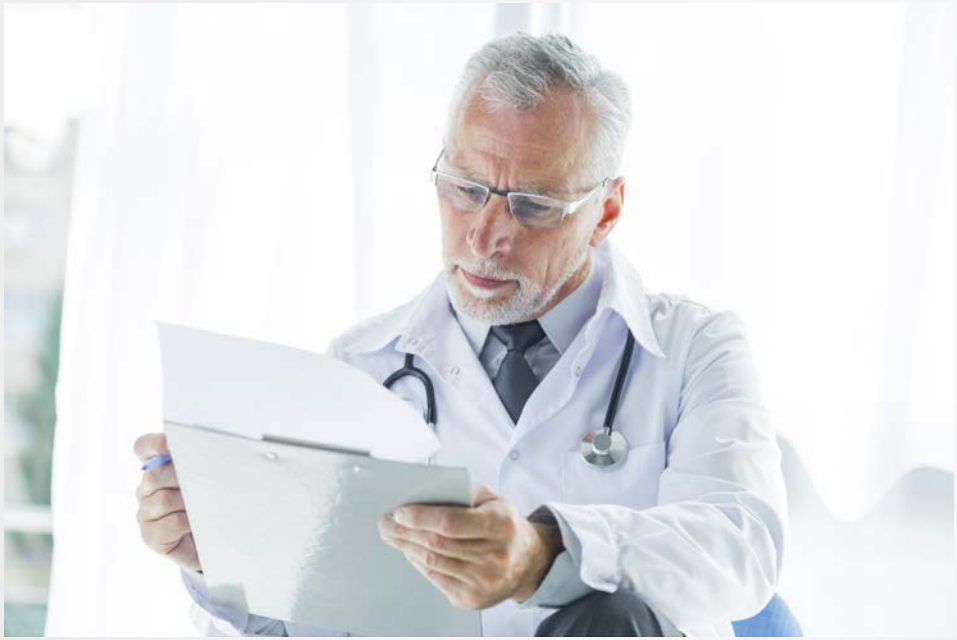
- 1. Analyze data and quality indicators collected for the QAPI program by diverse subpopulations as identified by the facility among OB patients
- 2. Measure, analyze and track data, measures and quality indicators on patient outcomes and disparities
  - In processes of care, services and operations and outcomes among obstetrical patients

Minimum Requirements – cont.

- 3. Analyze and prioritize patient health outcomes and disparities
  - Develop and implement actions to improve patient health outcomes and disparities
  - Measure results
  - Track performance to ensure improvement are sustained when disparities exist among OB patients
- 4. Conduct at least one performance improvement project focused on improving health outcomes and disparities among hospital's population of OB patients annually

Unified & Integrated Program NEW

- Standard: Unified and integrated QAPI program for CAH in multi-facility system
- If part of a system of multiple separately certified hospitals governing body can elect to participate in unified and integrated system
  - Takes into account each member unique circumstances, population, services
  - Establishes and implements policies and procedures to ensure needs and concerns are addressed



Additional Information

QAPI and Protected Records

Interpretive Guidelines – Acute

PSO and Work Product

- Memo September 29, 2023
  - https://www.cms.gov/files/document/qso-23-24-hospital.pdf
- CMS recognized material voluntarily submitted as "patient safety work product" (PSWP) to a Patient Safety Organization (PSO) is privileged
  - Surveyors cannot demand disclosure
- Must provide alternate documentation to demonstrate compliance

In a Nutshell

- Patient Safety and Quality Improvement Act of 2005 (PSQIA) established Patient Safety Organizations
  - Outlined privileged and confidential status to materials voluntarily submitted as PSWP
  - Could include statements, records, analysis, etc.
- However – information is **not** PSWP if collected to comply with external obligations
  - State incident reporting > NPDB reporting
  - Adverse drug event → FDA
  - Required disclosures under CoPs

Overall – What Must Demonstrate

- QAPI – must maintain and demonstrate evidence of QAPI program
  - Including effectiveness
- Must provide surveyors access to QAPI program information without disclosing PSWP
- Be prepared to provide evidence of relationship with a PSO
  - Surveyors will verify if relationship exists

Acute – New Interpretive Guidelines

- All are new and here as a reference only
  - CAHs new regulations closely mirror those of Acute regulations
- Focus
  - Determine if a hospital has an effective, ongoing system in place
    - For identifying problematic events, policies or practices
  - Taking actions to remedy the problem areas
  - With follow up to determine:
    - Were actions effective in improving performance and quality?

Interpretive Guidelines – cont'd

- Program must provide a mechanism to systematically examine quality of care delivered
  - Implement specific improvement projects on an ongoing basis for all services
  - Consider – complexity of services when determining quality parameters

Interpretive Guidelines – cont'd

- QAPI program should include
  - Continuous collection and analysis of
  - Quality indicators/data
  - Corrective actions to remedy processes, operations and services
  - Goal – improve patient outcomes

Interpretive Guidelines – cont'd

- Hospital to evaluate their QAPI program data
  - Ensure establishing priority areas to undertake actions
- Prioritization should address effect on
  - Health outcomes
  - Patient safety
  - Quality of care
- Areas based on complexity of services provide

Areas to Consider

- High-risk – where opportunity for error higher than other areas
  - L&D > ICU > ED
- High-volume – where number of potential patients adversely affected high due common elements in their care
  - Food preparation
  - Hand hygiene
  - Medication administration

Areas to Consider – cont'd

- Problem-prone – where hospital's own internal QAPI data shows history of problems
  - Or – nationally available research/expert consensus identified area
- Incidence – frequency an event occurs
- Prevalence – how widespread
- Severity – degree of seriousness/significance of event

Interpretive Guidelines

- ***Projects*** vs ***Activities***
- *Projects* require significant pre-planning – including objectives
  - Have a definitive start and end date (time-limited)
- *Activities* are continuous, ongoing functions of a QAPI program
  - Tracking errors/events
  - Analysis of data
  - Implementation of changes
  - Continuous monitor of quality/safety in all departments

Interpretive Guidelines – cont'd

- Dedicated resources to be commensurate with scope and complexity of services
- Sufficient staff
- Staff time
- Information systems
- Education and training – support all elements of the programs' required activities and projects

Worksheet Links

- Infection Control:
- https://www.cms.gov/medicare/provider-enrollment-and-certification/surveycertificationgeninfo/downloads/survey-and-cert-letter-15-12-attachment-1.pdf.
- Discharge Planning:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-3.pdf.
- QAPI:
- https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/SurveyCertificationGenInfo/Downloads/Survey-and-Cert-Letter-15-12-Attachment-2.pdf.

Organ, Tissue, and Eye Procurement

Tag C1500 – 1511

Organ, Tissue, and Eye

- **Condition:** Organ, Tissue, and Eye Procurement
- Hospital must have written P&P to address its organ procurement (C1500)
- Must have agreement with OPO (C1503)
  - If have an OR and a ventilator
- Must timely notify OPO if death is imminent or if the patient has died
- OPO to determine medical suitability for organ donation

What Written Agreement Must Address

- Criteria for referral – imminent death or have died
- Definitions for
  - "Imminent death"
  - "Timely notification"
- OPO's responsibility – determine suitability of organ
- How tissue/eye bank notified re: potential donors

Agreement Must Address – cont'd

- Timely notification of each death
- Designated requestor training develop with tissue and eye bank
- OPO, tissue and eye bank access to CAH's death record per schedule – i.e., monthly
- Interventions CAH uses to maintain potential organ donor patient to ensure viability of organs

Procurement Policy

- Board must approve organ procurement policy
- Must integrate into hospital's QAPI program
- Surveyor will review written agreement with the OPO to make sure it has all the required information
- Check off the long list to ensure all elements are present for example:
  - Definition of imminent death
  - What is timely notification
  - Access to your death records etc.,

Imminent Death - Definition

- Patient with severe, acute brain injury who:
  - Requires mechanical ventilation (due to brain injury)
  - Is in ICU or ED
  - Has clinical findings consistent with a Glasgow Coma Score less than or equal to a mutually-agreed-upon threshold
- MD/DOs evaluating a diagnosis of brain death (within 1-hour)
- MD/DO has ordered life sustaining therapies be withdrawn pursuant to the family's decision
  - Notify before withdrawing life sustaining therapies

Tissue and Eye Bank C1505

- Need an agreement with at least one tissue and eye bank
- OPO is gatekeeper
  - Notifies the tissue or eye bank chosen by the hospital
- OPO determines medical suitability
- Do not need separate agreement with tissue bank if agreement with OPO to provide tissue and eye procurement

Family Notification C1507

- Once OPO has selected a potential donor
  - Person's family must be informed of the donor's family's option
  - Family can opt to donate or not
- OPO and hospital decide how and by whom the family approached
- Person to initiate request must be a designated requestor or organized representative of tissue or eye bank
  - Designated requestor must have completed course approved by OPO

Discretion and Sensitivity C1509

- Encourage discretion and sensitivity to the circumstances, views and beliefs of the families
- Surveyor will:
  - Interview requestor re: approaches used to request
  - Review training program – verify it addresses use of discretion
  - Review complaint file for relevant complaints

Staff Training C1511

- Training program at a minimum should include:
  - Consent process
  - Importance of discretion
  - Role of designated requestor
  - Transplantation and donation
  - QI, and role of OPO
- Train all new employees
  - When change in P&P
  - When problems identified in QAPI process

Policies and Procedures

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

Swing Beds

Tag C1600 – 1624

Swing Beds – LTC Services

- Must meet certain conditions to provide post-hospital SNF care
- Allows CAH to use beds interchangeable – acute care or SNF level
  - Swings from acute care and reimbursement to SNF services and reimbursement
- Will survey swing beds
  - During full survey
  - If conducting a swing bed complaint
  - Or requesting swing bed approval

Appendix PP LTC 863 Pages

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

Table of Contents
(Rev. 211, 02-03-23)

Transmittals for Appendix PP

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

INDEX

§483.5 Definitions

§483.10 Resident Rights

§483.12 Freedom from Abuse, Neglect, and Exploitation

§483.15 Admission Transfer and Discharge Rights

§483.20 Resident Assessment

§483.21 Comprehensive Person-Centered Care Plans

§483.24 Quality of Life

§483.25 Quality of Care

§483.30 Physician Services

§483.35 Nursing Services

§483.40 Behavioral health services

4 Changes 2019

- Part of 2019 Improvement Rule
- Affect CAH and small and rural hospitals with Swing beds
- Appendix A and W – only have the regulations
- Appendix PP (LTC manual) – has the interpretive guidelines & survey procedures

Change #1 – Dental Services

- Previously – facility required to assist residents in obtaining routine and 24-hour emergency dental care
  - Now – hospitals address emergent dental needs under existing CoPs
    - Have P&P already
  - Section deleted – duplicative

Change #2 – Activity Program

- Previously – facility had to provide an ongoing program to support the resident in their choice of activities
  - Was based on comprehensive assessment and care plan
  - Directed by qualified professional specified in regulation
- Deleted – swing bed patients not long-term residents and only receive services for a short time
- However – if have a patient for an extended period of time then expected to do this

Change #3 – Social Worker

- Previously – if you had 120 beds or more had to have a full-time social worker
  - Confusing – CAH cannot have more than 25 beds and rural hospitals not more than100 beds
  - So – section was removed

Change #4 – Resident Performing Services

- CoPs had a section – patient had the right to choose or refuse to perform services
  - Cannot require it
  - Document need or desire to work
  - Is voluntary or paid
  - If paid – must have prevailing rate and in plan of care
  - Ex. – LTC had a resident who was a chef made special pastries on Sunday, or a resident helped fold towels for physical therapy
  - Deleted but can still do
    - If do – need a P&P

Question

Pt D, an 86-year-old, presented to CAH Z on Friday afternoon for complaints of fatigue, dizziness and vague abdominal pain. Diagnostic tests were inconclusive. He was admitted for Observation for 1 day and then inpatient for 2 days for further testing. His symptoms stopped after IV hydration and improved nutrition. His physician wants to continue care via Swing Bed to ensure further enhancement of his nutrition and further monitoring. Does Pt. D qualify for Swing Bed status under Medicare?

- Yes – he needs further care before going home
- No – he has not had the requisite 3-day inpatient stay

Swing Beds

- Requirements:
  - Discharge orders from acute care
  - Progress notes
  - Discharge summary
  - Subsequent admission orders
- Discharge from acute care and admit to skilled bed
- If patient does not change facilities can use same MR with chart separator

Swing Beds Requirements

- Medicare requires 3-day qualifying *inpatient* stay in CAH or qualified hospital prior to admission to swing bed
  - Only applies to Medicare patients
  - Medicare Advantage plans may be different
- Surveyor
  - Will review at least 2 swing bed
  - Closed records if no swing bed patients are present

Swing Beds

- No LOS restriction for swing beds
  - Intended to be transitional time while recovering to go home or waiting nursing home placement
- No transfer agreement needed between CAH and nursing home
- CAH does not have to use the MDS form for recording patient assessment
- Can use same record for swing bed patient
  - Must have order for swing bed and discharge orders

Eligibility

- Must be certified as CAH with no more than 25 beds (C1602)
  - Must screen to ensure eligible for swing bed
  - CMS RO makes the determination if eligible requirements are met
- Must comply with SNF rights requirements (C1608)
  - Residents' rights – nutrition – admission & discharge rights – social services – comprehensive assessment, etc.
- Section on facilities participating as rural primary care hospital (C1604 and see requirements)

Patient Rights & Services - Change

- Under Tag C-1608 omitted much of the text on Patient right
  - Moved to a separate and distinct section
- Omitted text from Section 483 but kept requirements on
  - Admission, transfer and discharge
  - Freedom from abuse, neglect and exploitation
  - Social services
  - Comprehensive assessment, care plan and discharge planning
  - Specialized rehab services
  - Dental services and Nutrition

SNF Services – Resident's Rights C1608

(Representative acts on their behalf if patient adjudicated incompetent)

- Right to be informed of his treatment
- Right to be informed in a language can understand
  - Low health literacy and LEP
- Right to be informed in advance of changes to the plan of care
- Right to choose or refuse to perform services
  - Cannot require it

Rights – continued

- Right to choose a physician who meets requirements
  - Licensed
  - Comes to the facility
  - Must ensure resident has information of the name and specialty of his or her physician and how to contact
- Right to retain and use personal possessions
  - Including furnishings and clothing as space permit
- Right to share room with spouse if both consent

Rights – continued

- Right to access by immediate family and friends
  - Resident can change mind
- Right to receive and send mail
  - Including means other than the post office
  - Must give access to stationery/postage at resident expense
- Right to personal privacy and confidentiality
- Right to receive written and telephone communications
- Right to security of records & refuse release

Facility Duties

- Must notify of any charges not covered by M/M at time of admission and periodically
- Notify if resident becomes eligible for Medicaid
- Give residents a written copy of their rights
- CMS directs referral to Appendix PP for interpretive guidelines
  - And for survey procedure on patient rights
  - PP has interpretive guidelines for long term care facilities

Admission, Transfers, Discharge

- Transfer means outside of the facility (C1610)
- Purpose in restricting transfer by facility – prevents dumping of high care or difficult residents

Basis for Transfers

- May not transfer or discharge a resident unless
  - Necessary to meet their welfare – care cannot be met in the facility
  - Appropriate as no longer needs the services provided
  - If resident or others in the facility would be endangered due to clinical or behavioral status
  - Health of persons in the facility otherwise endangered
  - Resident failed after reasonable and appropriate notice to pay
  - Facility closes

Transfers Prohibited

- Cannot transfer while an appeal is pending
  - Unless endangers resident's health or safety
  - If so must document
- Has specific documentation requirements
  - As attempts to meet the resident's needs
  - Basis for the transfer

Information to be Provided

- Information must be provided to the receiving practitioner including:
  - Contact information for resident's representative
  - Advance directives
  - Care plan goals
  - Discharge summary
  - Contact information of the practitioner responsible for the resident's care

Notice

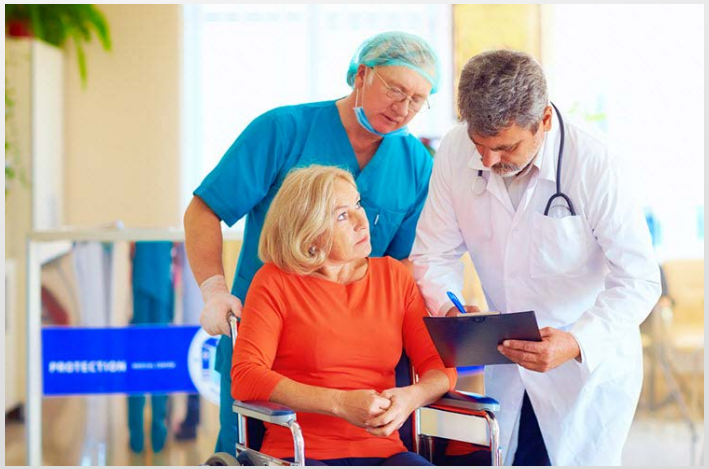
- Must be made ASAP before transfer or discharge
- Content of the notice includes:
  - Reason for transfer
  - Date
  - Location
  - Statement of the appeal rights and phone number
  - Name and telephone number of the Office of the State LTC Ombudsman

Admission, Transfers, Discharge

- If intellectual and developmental disabilities or mental health disorder
  - Must provide information on agency responsible such as address, email, and phone number
- Must provide notice in advance of a facility closing

Sufficient Time & Room Changes

- Must provide and document sufficient preparation and orientation for the transfer or discharge
- Room changes in a distinct part must be limited to moving within a particular building
  - Unless the resident agrees to the move



Freedom from Abuse and Neglect C1612

- Resident has a right to be free from:
  - Abuse, neglect, and exploitation
  - From misappropriation of property
  - From restraint and seclusion including chemical restraint
  - From verbal, mental, or physical abuse
- Cannot use restraints for convenience or discipline

2 Centennial nursing home employees accused of elder abuse, sheriff says

Patience Jackson, 33; Zainab Namale, 34, arrested on 3 felonies each

By **LAUREN PENINGTON** | lpenington@denverpost.com
UPDATED: June 12, 2025 at 3:04 PM MDT

Employees

- Cannot employ individuals found guilty of abuse, neglect, exploitation, mistreatment or stealing the resident's property
- Background checks
  - Includes a finding in the State nurse aide registry
  - Includes finding in a court of law that person is unfit to be a nurse aide or other staff member
- Must have P&P to prohibit and prevent abuse, neglect, and exploitation including investigations

Timely Reporting

- No later than 24 hours after allegation or within 2 hours if causes serious bodily injury
  - To the administrator of the facility and State Survey Agency and adult protective services if state law provides them with jurisdiction
- Must investigate thoroughly (C1612)
  - Prevent further abuse/neglect during investigation
  - Report results of investigation within 5 working days
- (Interpretive guidelines and survey procedure in Appendix PP)

Provision of Care – Overall C1616

- Provide medically- related social services
  - To maintain highest practicable physical, mental and psychosocial well-being of each resident
- Recap of deleted sections:
  - Patient Activities directed by qualified professional (A0385)
  - Education requirements for Activities Director

Resident Assessments C1620

- Must perform comprehensive assessment, care plans and discharge planning
  - Not required to use resident assessment instrument (RAI)

Elements of Assessments

- Identification and demographic information
- Customary routine
- Cognitive patterns
- Communication
- Vision
- Mood and behavior patterns
- Discharge planning
- Psychosocial well-being

Assessments – continued

- Physical functioning and structural problems
- Continence
- Disease diagnoses and health conditions
- Dental and nutritional status
- Skin condition
- Activity pursuit
- Medications
- Document participation in the assessment
- Special treatments and procedures

Assessments – continued

- Discharge planning
- Documentation of summary information regarding the additional assessment performed by completion on the MDS or Minimum Data Sheet
  - CAH do not have to use the MDS
- Documentation of participation in assessment
- Must do direct observation
  - Communicate with resident and licensed members on all shifts
- Rationale – do to develop care plan

Time Frames – Assessments

- Assessment within **14 days after admission** does **not** apply to CAH
  - Must do it "timely"
- Assessment if significant change
  - Excludes readmissions if no significant change in condition
    - Very detailed information on what constitutes a significant change

Specialized Services

- Include any specialized services as result of the PASARR recommendations (Preadmission Screening and Resident Review Process)
  - If disagree with the recommendations – must indicate a rationale in the resident's medical record

- PASARR is a federally mandated screening and evaluation tool that is used to assess people with mental illness or developmental disabilities who are being considered for nursing facility placements to determine if nursing facility placement is appropriate or if these individuals can be better served in a more integrative setting

Care Plan

- Must do a comprehensive care plan
  - Must include measurable objectives to meet patient's needs
- Must include:
  - Goals for admission and desired outcomes
  - Preferences and potential for discharge
    - Must document whether wants to return to the community
    - Must document any referrals to local contact agencies
    - Must include discharge plans
- Plan must be developed within 7 days after comprehensive assessment done

Care Plans – continued

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

Discharge Summary

- Must have a discharge summary that includes:
  - Recapitulation of the resident's stay
    - Diagnosis, course of illness and treatment, pertinent lab, x-rays, or consult results
  - Final summary of the resident's status
  - Medication reconciliation
  - A post-discharge plan of care developed with the participation of the resident and his or her family, which will assist the resident to adjust to his or her new living environment
- (Refers to Appendix PP for IGs and survey procedure)

Specialized Rehab Services C1622

- Physical therapy
- Speech-language pathology
- Occupational therapy
- Respiratory therapist
- Mental health rehab services for mental illness and intellectual disability

- IF required in resident's comprehensive plan of care
- Facility must provide the required service
- May get from outside source
- Need an order
- IG & SP in PP

Dental Services C1624

- This section was deleted but still in the manual
- Included as still need to assist if necessary
- The facility must assist residents in obtaining routine and 24-hour emergency dental care
  - May provide or obtain from an outside resources
  - May make appointment and arrange transportation
- May charge a Medicare resident for routine and emergency dental services

Policy re: Dental Services

- Must have policy identifying
  - When loss or damage to dentures is facility's responsibility so may not charge resident
  - Must refer residents within 3 days for lost or damaged dentures and document what they eat or drink in the meantime
  - Refers to Appendix PP

Assisted Nutrition & Hydration C1626

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

Parameters re: Nutrition

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

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

Obstetrical Services

New to Conditions of Participation

"Not Our Client"

- Front desk personnel refused to check in another patient seeking help in delivering the infant
- Husband told could not help because they were not a client of the hospital
  - Miscarried in the ER lobby restroom while husband called 911
  - When EMS personnel asked hospital staff the gestational age refused to provide as "not our patient"
- The hospital no longer takes Medicare

Care Refused

- Pregnant woman who presented with abdominal pain told could not provide an ultrasound
  - Was not told about risk for leaving without stabilization
  - While in route to a hospital 45 minutes away delivered in the car
  - Infant did not survive
- Security guard refused a pregnant woman access to triage because she had a child with her
  - When returned the next day staff unable to locate fetal heartbeat

Amanda Seitz, Associated Press, reprinted The Denver Post; April 20, 2024

New Section – Obstetrical Services

- **Condition:** Obstetrical services
- Under §485.649 – if offer OB services
  - No Tag numbers yet
- Must be well organized and provided per nationally recognized acceptable standards of practice for health care including physical and behavioral health of
  - Pregnant, birthing and postpartum patients
- If offer outpatient OB services – must be consistent in quality with inpatient care in accordance with complexity of services offered

Standard: 1. Organization & Staffing

- Standard: Services must be: Effective January 1, 2026
  - Well organized
  - Provided per nationally recognized acceptable SOP for physical and behavioral of OB patients
    - Pregnant, birthing and postpartum
  - Be appropriate for scope of services offered and integrated into other departments
  - Department must be supervised by someone with necessary education and training
    - Experienced RN, MD, DO, CNM, NP, PA
  - Privileges be granted subject to written criteria for all providing care consistent with credentialing agreements

Standard: 2. Delivery of Services

- Standard: Effective January 1, 2026
- Policies governing OB care must be designed to assure achievement and maintenance of high standards of medical practice, patient care and safety
- Must have basic equipment
  - Call-in system, cardiac monitor, fetal doppler/monitor
  - Kept and readily available to meet patient needs
    - For timely response to emergency situations – depending on volume
  - Minimum equipment to have readily available
    - Can maintain supplies in "crash carts," "OB emergency carts/bags/boxes/kits, OB hemorrhage carts

Delivery of Services – continued

- Must have adequate provisions and protocols per national guidelines for
  - OB emergencies and/or complications
  - Immediate post-delivery
  - Other events
  - Includes additional equipment, supplies and medications
  - Used in treating emergency cases

Standard: 3. Staff Training

- Standard: Effective January 1, ***2027***
- Must develop policies and procedures:
  - Ensure staff trained on topics aimed at improving delivery of maternal care
  - Reflect scope and complexity of services offered
- Training concepts must reflect scope and complexity of services offered including
  - Facility-identified evidence-based best practices and protocols to improve delivery of services
  - Must use findings from QAPI programs to identify staff training needs
    - Plus – additions, revisions updates on ongoing basis

Staff Training – cont'd

- Must provide relevant new staff with initial training
  - Then – every 2 years (vs. annually)
- Governing body must identify and document
  - Which staff must complete initial training
  - AND subsequent biennial training
  - From topics identified in QAPI
- Must document training successfully completed
- CAH must be able to demonstrate staff knowledge on training topics

Discussion

County Hospital is a CAH that provides routine surgery and general inpatient care. AR presents for left total hip repair and replacement following a bicycle accident. She is relatively healthy except for a-fib and on Pradaxa.

The surgeon on call – Dr. S – has been with County for 20+ years. Surgical staff have worked with Dr. S and reported instances of him rushing through procedures and not completing the mandatory timeout.

Dr. S completes the pre-surgical assessment of AR and obtains informed consent using his own form – not hospital approved. He tells the staff to get the patient to sign the hospital-approved form; he will not do it.

Discussion – continued

At the start of surgery, Dr. S makes the initial incision before the timeout is completed. There is no verification of the implant to be used or anticipated complications and necessary supplies. AR has more than usual bleeding with the procedure. The anesthesiologist orders a stat INR which returns 4.0. Dr. S is notified but does not stop nor order vitamin K.

AR continues to experience bleeding until her vital signs start to decrease. Dr. S completed the surgery, and a stat H&H is ordered by the anesthesiologist – 6.0 and 25.3 respectively.

Discussion - continued

Dr. S did not request any blood or packed cells or blood products to be available, or type and cross AR for such an event. Vitamin K IV was not requested pre-surgically, though the protocols did require these items.

AR eventually received 3 units packed RBCs and had a prolonged inpatient stay. The case was presented to the medical staff for action – care by Dr. S. Given the complaints by staff and anesthesia's refusal to work with Dr. S going forward, Dr. S was placed on probation.

Discussion – conclusion

AR filed a complaint with the state due to the care. This case, and all of Dr. S's cases for the last 24 months were reviewed. In preparation for the visit County realized surgical policies had not been updated for 4 years.

What citations might County face?

- Unsafe/inadequate patient workup
- Informed consent
- Timeout completion
- Quality of surgical services
- Others?

H

Thank You

- Laura A. Dixon, Esq.
- BS, JD, RN, CPHRM
- President, Healthcare Risk Education and Consulting, LLC
- ldesq@comcast.net

162

Appendix

Resources

and

Internet Links

Websites

- Centers for Medicare and Medicaid Services CMS-www.cms.hhs.gov
- Tools and Resources Rural Health Resource Center at http://www.ruralcenter.org/tasc/
- American Association for Respiratory Care AARC-www.aarc.org
- American College of Surgeons ACS-www.facs.org

Websites

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

Websites

- United States Dept of Agriculture USDA- www.usda.gov
- Emergency Nurses Association ENA- www.ena.org
- American College of Emergency Physicians ACEP- www.acep.org
- Joint Commission – www.JointCommission.org
- American College of Radiology- www.acr.org

Websites

- American Association for Respiratory Care AARC-www.aarc.org
- American College of Surgeons ACS-www.facs.org
- AHRQ – www.ahrq.gov
- American Hospital Association – www.aha.org
- CMS Life Safety Code - ttp://new.cms.hhs.gov/CFCsAndCoPs/07_LSC.asp

Websites

- Federal Emergency Management Agency (FEMA)- www.fema.gov
- Drug Enforcement Administration –www.dea.gov
- US Pharmacopeia- www.usp.org
- Rural Assistance Center http://www.raconline.org/
- National Patient Safety Foundation at the AMA- www.ama-assn.org/med-sci/npsf/htm
- Institute for Safe Medication Practices- www.ismp.org

Websites

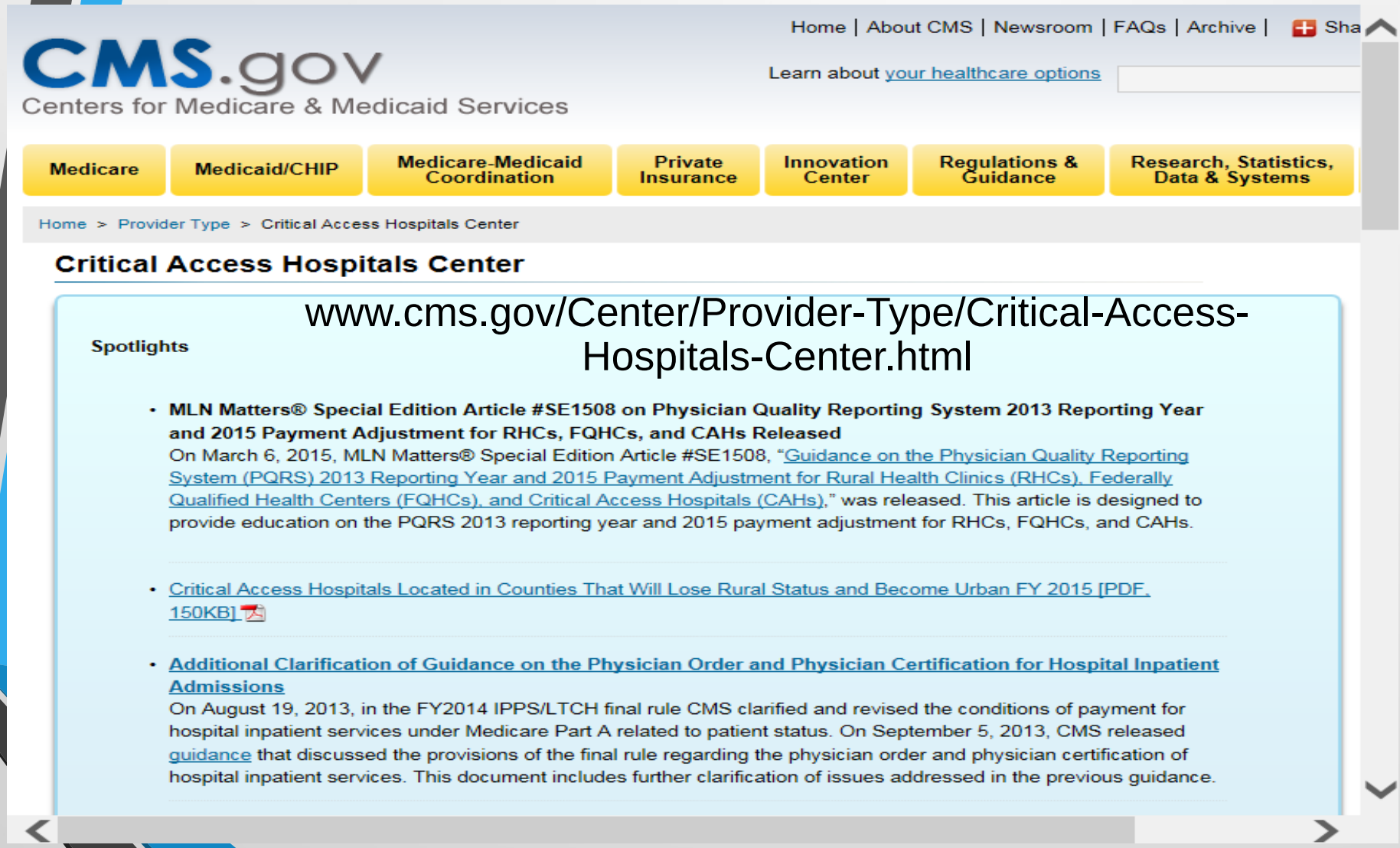
- Institute for Healthcare Improvement- www.ihi.org
- AHRQ at www.ahrq.gov
- American Pharmaceutical Association- www.aphanet.org
- American Society of Heath-System Pharmacists- www.ashp.org

Websites

- U.S. Food and Drug Administration MedWatch-www.fda.gov/medwatch
- Enhancing Patient Safety and Errors in Healthcare-www.mederrors.com
- National Coordinating Council for Medication Error Reporting and Prevention-www.nccmerp.org
- FDA's Recalls, Market Withdrawals and Safety Alerts Page: http://www.fda.gov/opacom/7alerts.html

CMS CAH Website

- Includes information on topics of interest to hospitals with swing beds
- List of the regional office rural health coordinator
- This includes a hotline or help desk
  - 800-905-2069
  - Swing_help@ifmc.org


Home | About CMS | Newsroom | FAQs | Archive | Sha
CMS.gov
Centers for Medicare & Medicaid Services
Learn about your healthcare options
Medicare
Medicaid/CHIP
Medicare-Medicaid Coordination
Private Insurance
Innovation Center
Regulations & Guidance
Research, Statistics, Data & Systems
Home > Provider Type > Critical Access Hospitals Center
Critical Access Hospitals Center
www.cms.gov/Center/Provider-Type/Critical-Access-Hospitals-Center.html
Spotlights
MLN Matters® Special Edition Article #SE1508 on Physician Quality Reporting System 2013 Reporting Year and 2015 Payment Adjustment for RHCs, FQHCs, and CAHs Released
On March 6, 2015, MLN Matters® Special Edition Article #SE1508, "Guidance on the Physician Quality Reporting System (PQRS) 2013 Reporting Year and 2015 Payment Adjustment for Rural Health Clinics (RHCs), Federally Qualified Health Centers (FQHCs), and Critical Access Hospitals (CAHs)," was released. This article is designed to provide education on the PQRS 2013 reporting year and 2015 payment adjustment for RHCs, FQHCs, and CAHs.
Critical Access Hospitals Located in Counties That Will Lose Rural Status and Become Urban FY 2015 [PDF, 150KB]
Additional Clarification of Guidance on the Physician Order and Physician Certification for Hospital Inpatient Admissions
On August 19, 2013, in the FY2014 IPPS/LTCH final rule CMS clarified and revised the conditions of payment for hospital inpatient services under Medicare Part A related to patient status. On September 5, 2013, CMS released guidance that discussed the provisions of the final rule regarding the physician order and physician certification of hospital inpatient services. This document includes further clarification of issues addressed in the previous guidance.

CMS Website – Resources

- Includes:
  - State operations manuals
  - Program transmittals
  - Guidance for laws and regulations for CAH
  - Medicare Learning network

www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/SNFPPS/SwingBed.html

Skilled Nursing Facility PPS

- Program News and Announcements
- Patient Driven Payment Model
- Wage Index
- Consolidated Billing
- Swing Bed Providers
- SNF PPS Payment Model Research
- Prior SNF Research Studies and Reports
- Education & Training
- List of SNF Federal Regulations
- SNF Program Transmittals
- Need Additional Information

Swing Bed Providers

The Social Security Act (the Act) permits certain small, rural hospitals to enter into a swing bed agreement, under which the hospital can use its beds, as needed, to provide either acute or SNF care. As defined in the regulations, a swing bed hospital is a hospital or critical access hospital (CAH) participating in Medicare that has CMS approval to provide post-hospital SNF care and meets certain requirements. Medicare Part A (the hospital insurance program) covers post-hospital extended care services furnished in a swing bed hospital.

Under the Balanced Budget Act (BBA) of 1997, swing bed facilities must be incorporated into the skilled nursing facility (SNF) prospective payment system (PPS) by the end of a statutory transition period. This applies to short term hospitals, long term hospitals, and rehabilitation hospitals certified as swing bed hospitals. CAHs with swing beds are exempt from the SNF PPS under more recent legislation. To qualify for SNF-level services, a beneficiary is required to receive acute care as a hospital inpatient for a medically necessary stay of at least 3 consecutive calendar days. Effective with cost reporting periods beginning on or after July 1, 2002, swing bed hospitals will no longer be paid based on the current cost-related method, but rather on the basis of the SNF PPS.

The SNF PPS covers all costs (ancillary, routine, and capital) related to covered services furnished to beneficiaries under Medicare Part A. Like the PPS for inpatient hospital services, the SNF PPS excludes certain specified services, which are separately billable to Part B. The PPS relies on information from a resident assessment instrument to classify residents into one of 44 categories for payment purposes. Swing bed hospitals will be required to complete the MDS assessment to meet this requirement. There is no longer a separate Swing Bed MDS assessment manual. **Swing Bed MDS forms and manuals archived in the files below are for historic record and context only. See the MDS page in the Related Links below for the most current forms and manuals used by both SNFs and Swing Bed providers for SNF PPS reimbursement.**

Downloads

Information for Swing Bed Hospitals in the Process of Converting to Critical Access Hospitals (CAHs) [PDF, 37KB]

Rural Hospitals with Swing Beds [PDF, 13KB]

Medicare Notice of NonCoverage Letters [PDF, 69KB]

Hotlines/Help Desk [PDF, 13KB]

WELCOME TO AHA.ORG! AHA members, email AHAhelp@aha.org for help logging in.
American Hospital Association
Advancing Health in America
About
Press Center
Advocacy
Career Resources
Data & Insights
Education &
www.aha.org/advocacy/critical-access-hospitals
Critical Access Hospitals
Current & Emerging Payment Models / Rural issues
Critical access hospitals (CAHs) are vital for maintaining access to high-quality health care services in rural communities. Since established by the Balanced Budget Act of 1997, the AHA has been a champion for its CAH members.
CAHs represent a quarter of all U.S. and more than two-thirds of all rural community hospitals. Securing the future of CAHs and the essential role they play in caring for rural America is of paramount importance. The AHA remains vigilant in the face of legislative, regulatory and policy proposals that threaten either the local delivery of care or rural community health status.
We advocate for CAH program improvements and enhancements as well as fixes to payment and administrative limitations that constrain the efficiency and effectiveness of these essential health care providers. AHA is deeply committed to ensuring that the needs of these safety-net hospitals are met through:
1. Representation and advocacy
2. Executive education, communication and management strategies
3. CEO and trustee engagement
www.aha.org/

AHA Website on CAH

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

Proposed New Regulations

- Allowing patients to inspect PHI in person and take notes or photographs of their PHI.
- Changing the maximum time to provide access to PHI from 30 days to 15 days.
- Restricting the right of individuals to transfer ePHI to a third party to only ePHI that is maintained in an EHR.
- Confirming that an individual is permitted to direct a covered entity to send their ePHI to a personal health application if requested by the individual.
- Stating when individuals should be provided with ePHI without charge.
- Requiring covered entities to inform individuals that they have the right to obtain or direct copies of their PHI to a third party when a summary of PHI is offered instead of a copy.

Proposed New Regulations – cont.

- The Armed Forces' permission to use or disclose PHI to all uniformed services has been expanded.
- A definition has been added for electronic health records.
- Wording change to expand the ability of a covered entity to disclose PHI to avert a threat to health or safety when harm is "seriously and reasonably foreseeable." (currently it is when harm is "serious and imminent.")
- A pathway has been created for individuals to direct the sharing of PHI maintained in an EHR among covered entities.
- Covered entities will not be required to obtain a written acknowledgment from an individual that they have received a Notice of Privacy Practices.
- HIPAA-covered entities will be required to post estimated fee schedules on their websites for PHI access and disclosures.
- HIPAA-covered entities will be required to provide individualized estimates of the fees for providing an individual with a copy of their own PHI.

Proposed New Regulations –cont.

- HIPAA-covered entities will be required to provide individualized estimates of the fees for providing an individual with a copy of their own PHI.
- The definition of healthcare operations has been broadened to cover care coordination and case management.
- Covered healthcare providers and health plans will be required to respond to certain records requests from other covered healthcare providers and health plans when individuals direct those entities to do so when they exercise the HIPAA right of access.
- Covered entities will be permitted to make certain uses and disclosures of PHI based on their good faith belief that it is in the best interest of the individual.
- The addition of a minimum necessary standard exception for individual-level care coordination and case management uses and disclosures, regardless of whether the activities constitute treatment or health care operations.

AHIMA Model Release Form

Patient Request for Health Information

Patient Information (Please Print)

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

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

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

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

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

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

How would you like your records delivered?

☐ Paper

- ☐ Home Delivery
- ☐ In-Person Pickup

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

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

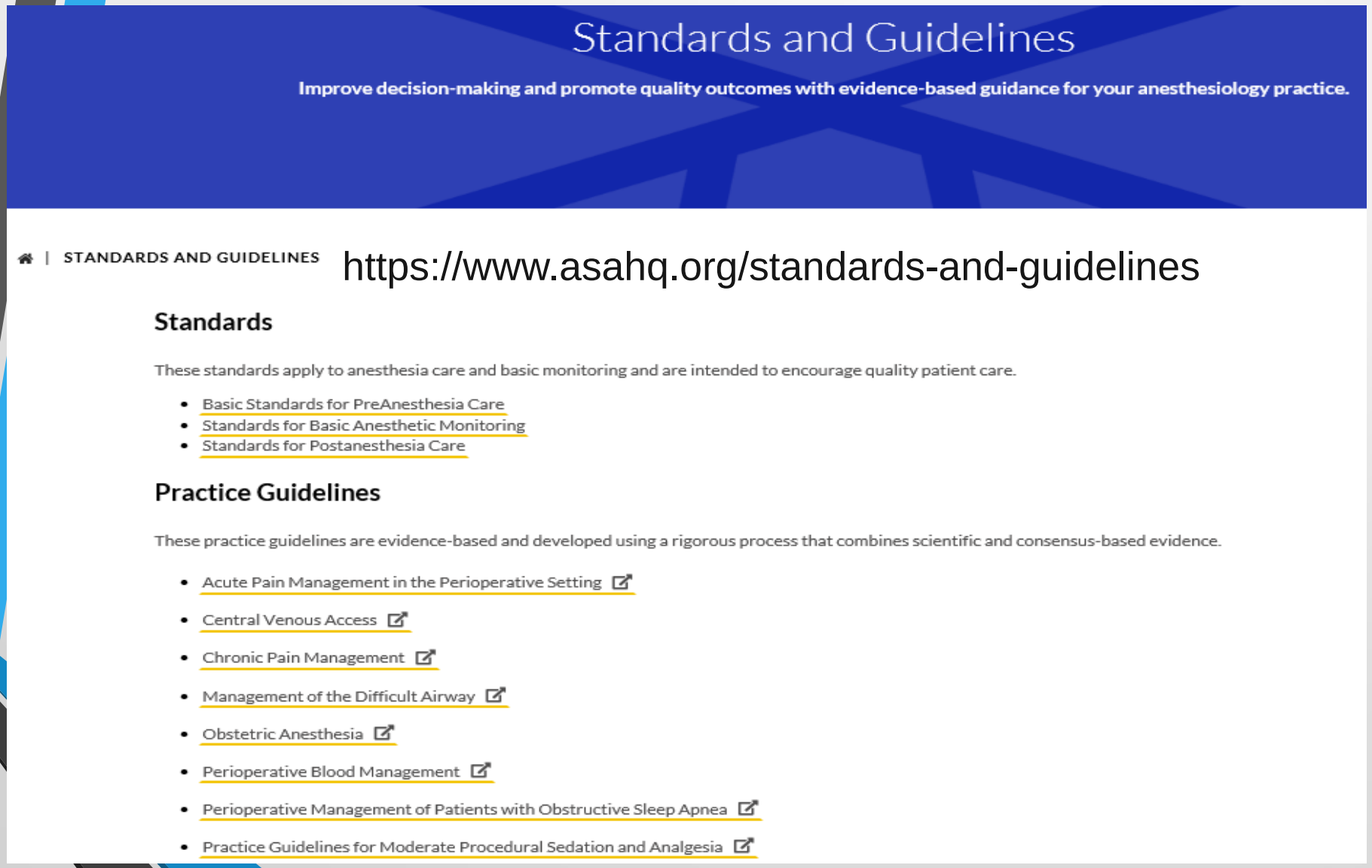
ORGANIZATION NAME should provide my records to: ☐ Self ☐ Personal Representative (indicated below)

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

Pre-anesthesia ASA Guideline

- Preanesthetic Evaluation [1]
  - Patient interview to assess Medical history, Anesthetic history, Medication history
- Appropriate physical examination
- Review of objective diagnostic data (e.g., laboratory, ECG, X-ray)
- Assignment of ASA physical status
- Formulation of the anesthetic plan and discussion of the risks and benefits of the plan with the patient or the patient's legal representative
- 1 www.asahq.org/publicationsAndServices/standards/03.pdf

ASA Guidelines and Standards



Basic Standards for PreAnesthesia Care

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

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

Download PDF

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

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

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

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

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

$ETCO_2$ for Moderate and Deep Sedation ASA

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

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

AANA Website for CRNA

Post Anesthesia ASA Guidelines

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

Retention & Destruction Updated

10/15/2013

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

AHIMA HIM Body of Knowledge™

Log In | Communities | Main | Advanced Search | Contact Us | Help

Retention and Destruction of Health Information

---

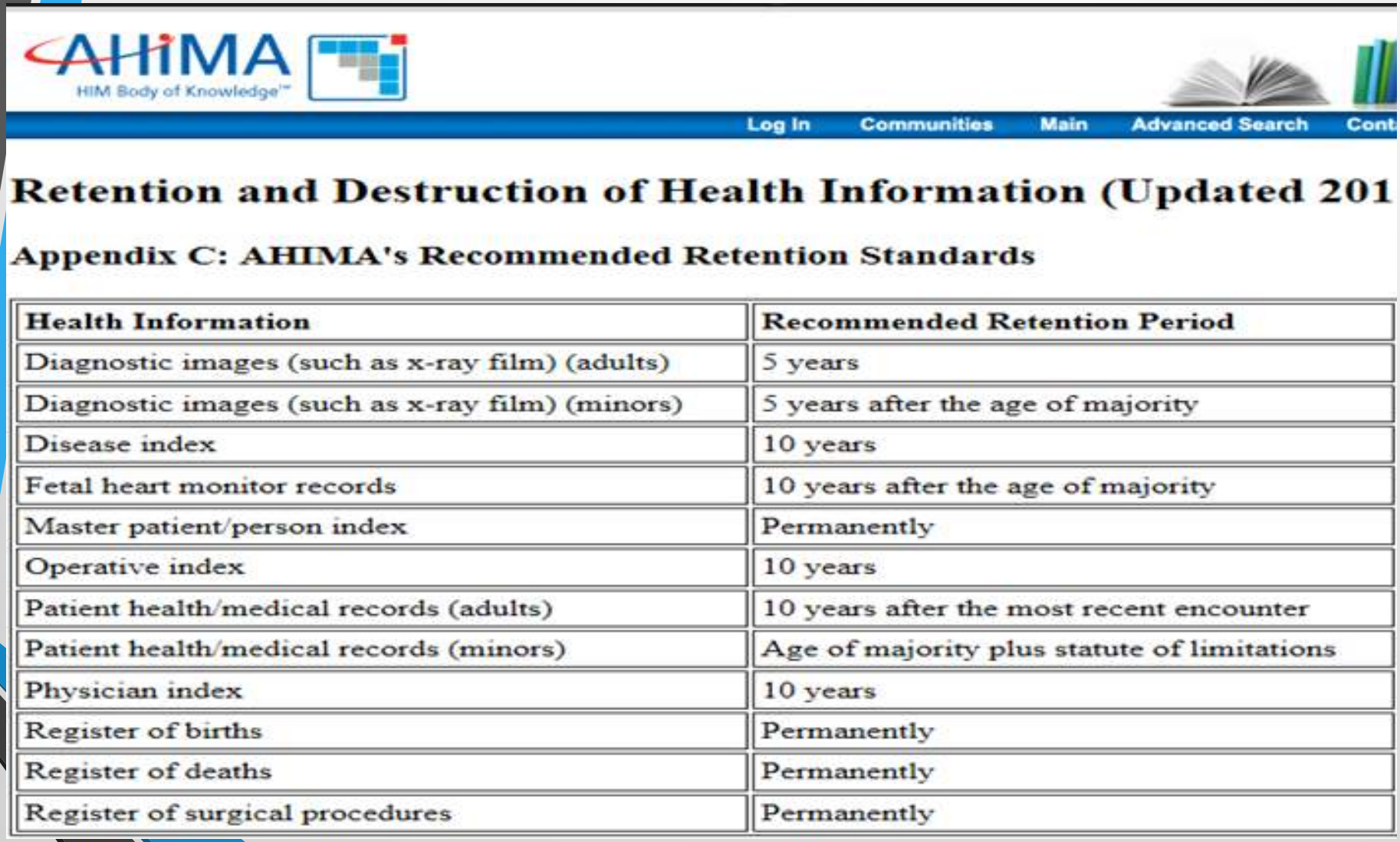
*Editor's note: This update **supersedes** the August 2011 practice brief "Retention and Destruction of Health Information."*

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

Records Retention

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

Retention & Destruction



AHIMA
HIM Body of Knowledge™

Log In Communities Main Advanced Search Cont

Retention and Destruction of Health Information (Updated 201

Appendix C: AHIMA's Recommended Retention Standards

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

AHIMA Sample Destruction Form

Facility Name

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

Date of destruction:_____

Description of records or record series disposed of:

_____

_____

Inclusive dates covered:_____

Method of destruction:

( ) Burning ( ) Shredding ( ) Pulping ( ) Demagnetizing ( ) Overwriting ( ) Pulverizing ( ) Other:_____

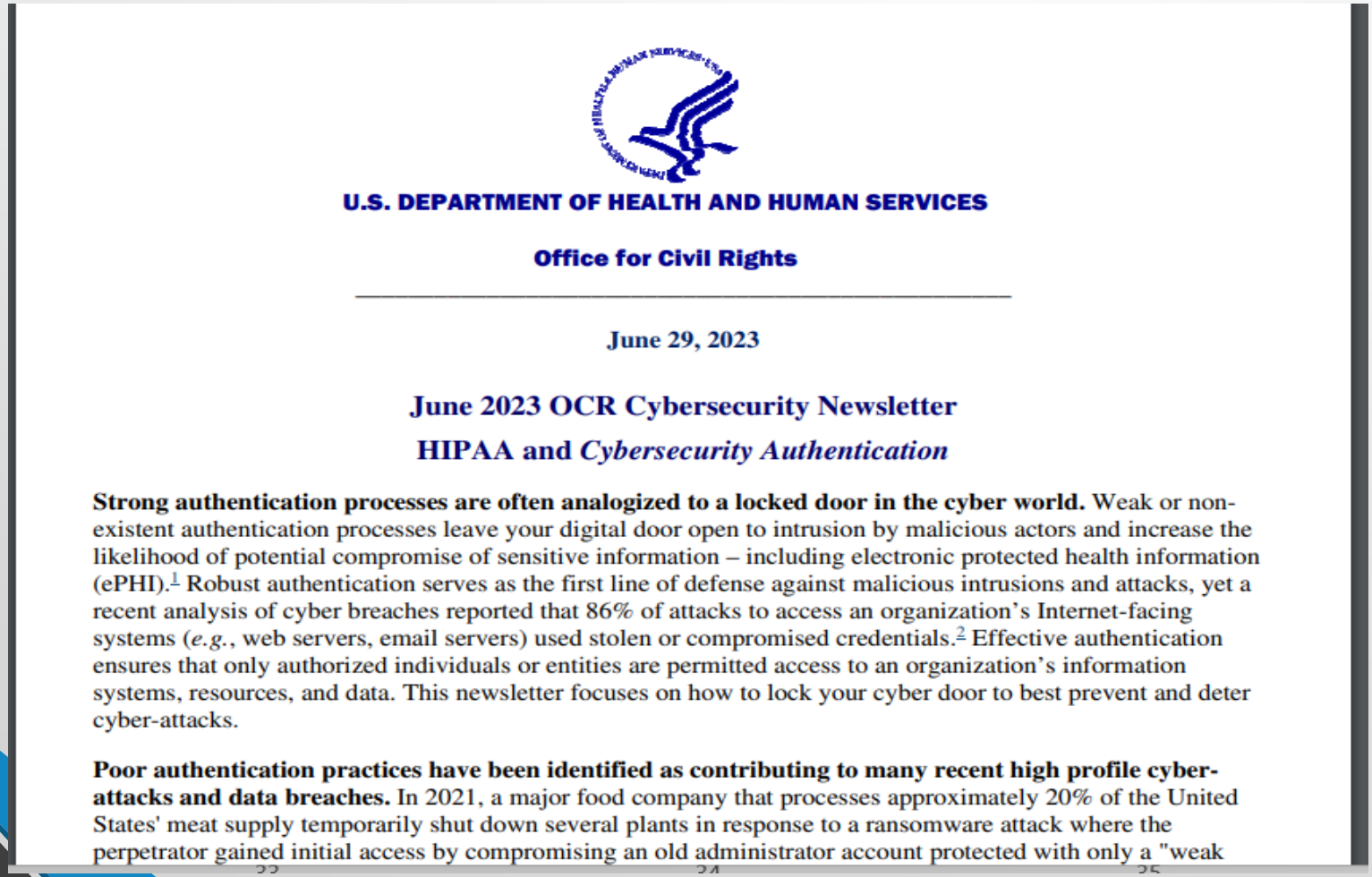
Records destroyed by:_____

Witness signature:_____

Department manager:_____

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

OCR: Cybersecurity Authentication



U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES

Office for Civil Rights

June 29, 2023

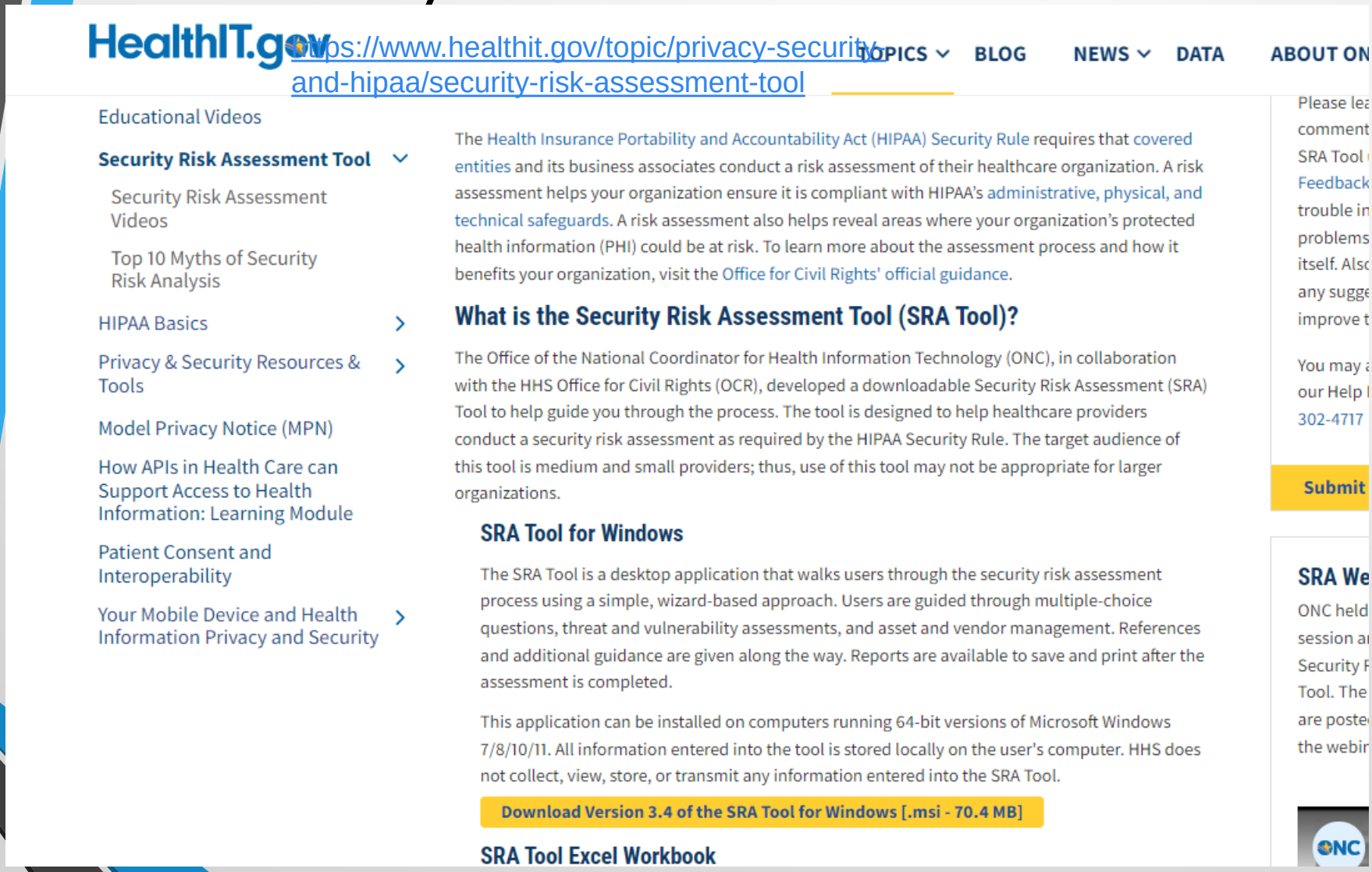
June 2023 OCR Cybersecurity Newsletter

HIPAA and *Cybersecurity Authentication*

Strong authentication processes are often analogized to a locked door in the cyber world. Weak or non-existent authentication processes leave your digital door open to intrusion by malicious actors and increase the likelihood of potential compromise of sensitive information – including electronic protected health information (ePHI).[1] Robust authentication serves as the first line of defense against malicious intrusions and attacks, yet a recent analysis of cyber breaches reported that 86% of attacks to access an organization's Internet-facing systems (*e.g.*, web servers, email servers) used stolen or compromised credentials.[2] Effective authentication ensures that only authorized individuals or entities are permitted access to an organization's information systems, resources, and data. This newsletter focuses on how to lock your cyber door to best prevent and deter cyber-attacks.

Poor authentication practices have been identified as contributing to many recent high profile cyber-attacks and data breaches. In 2021, a major food company that processes approximately 20% of the United States' meat supply temporarily shut down several plants in response to a ransomware attack where the perpetrator gained initial access by compromising an old administrator account protected with only a "weak

Security Risk Assessment Tool



NATIONAL
RURAL HEALTH
RESOURCE CENTER

www.ruralcenter.org/tasc/flexprofile

Fa

SERVICES PROGRAMS EVENTS RESOURCE LIBRARY ABOUT

Home › Programs › TASC › State Flex Profiles

State Flex Profile Navigation

Jump to: - Select State -

State Flex Profiles

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

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

Search State Flex Profiles

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

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

Burden Reduction Memo

https://www.cms.gov/files/document/burden-reduction-discharge-planning-som-package.pdf

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

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

Center for Clinical Standards and Quality/Quality, Safety & Oversight Group

Ref: QSO-20-07-ALL

DATE: **December 20, 2019**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group

SUBJECT: Burden Reduction and Discharge Planning Final Rules Guidance and Process

Memorandum Summary

- On September 30, 2019, the Centers for Medicare & Medicaid Services (CMS) published the *Medicare and Medicaid Programs; Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction* Final Rule, as well as the *Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies* Final Rule.
- This policy memorandum provides guidance to the CMS Regional Offices (ROs), the State Survey Agencies (SAs) and the Accrediting Organizations (AOs) regarding the changes to the regulations and our approach for updating the State Operations Manual

QAPI Tag Numbers – page 503

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

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

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

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

Adverse event means an untoward, undesirable, and usually unanticipated event that causes death or serious injury or the risk thereof. Error means the failure of a planned

Previous Standards, IG and SP

- Provided as reference only -

- 330 – CAH must periodically evaluate the QAPI program
- 331 – Periodic evaluation of total program
  - Who is to do this – i.e., the QAPI Director and at least annually
- 332 – Services provided, and number of patients served

Previous Standards, IG and SP – continued

- 333 – Look at volume of service and patients served
  - Include at least 10% of charts- active and closed charts
  - Who responsible for review and criteria used
- 334 – Healthcare policies evaluated, reviewed and/or revised
- 335 – Purpose of the evaluation – determine if utilization of services was appropriate
  - How were results used?
  - Were P&Ps revised, added, deleted?

Previous Standards, IG and SP – continued

- 336 – Hospital has an effective QA program that evaluates the quality and appropriateness of diagnosis and treatment furnished:
  - Ongoing monitoring and data collection
  - Problem prevention, identification and analysis
  - Identification of corrective actions
  - Implementation of corrective actions
  - Evaluation of corrective actions
  - Measures to improve quality on a continuous basis
- Surveyors will review plan, reports, actions

Previous Standards, IG and SP – continued

- 337 – All patient care service/other services affecting patient health and safety evaluated
  - Who responsible to evaluate and how evaluated
  - Information provided to Board and medical staff
- 338 – Nosocomial infections and medication therapy evaluated
  - Will review committee minutes for current issues/projects

Previous Standards, IG and SP – continued

- 339 – Quality and appropriateness of care provided by NPs, CNS and PAs evaluated by physicians or medical staff
  - Moved to "staff and staff responsibilities"

Previous Standards, IG and SP – continued

- 340 – quality and appropriateness of diagnosis and treatment by physicians evaluated by
  - 1. Network hospital member
  - 2. QIO
  - 3. Other appropriate and qualified entity in State rural health care plan
  - 4. Telemedicine via hospital – the distant-site hospital
  - 5. Telemedicine entity – one of 1 – 3 above
    - 4 and 5 require written agreement
  - Surveyor will look for evidence of agreements and reviews

Previous Standards, IG and SP – continued

- 341 – CAH staff considers findings of evaluations, recommendations and takes any necessary corrective action
- 342 – CAH takes appropriate remedial action to address deficiencies found via QA program
  - Surveyor will look to see who is responsible for implementing actions
- 343 – CAH documents outcomes of all remedial actions

PASARR or RAI

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

mln BOOKLET

KNOWLEDGE • RESOURCES • TRAINING

Information for Critical Access Hospitals

CPT codes, descriptions, and other data only are copyright 2024 American Medical Association. All Rights Reserved.

Fee schedules, relative value units, conversion factors and/or related components are not assigned by the AMA, are not part of CPT, and the AMA is not recommending their use. The AMA does not directly or indirectly practice medicine or dispense medical services. The AMA assumes no liability for data contained or not contained herein.

CPT is a registered trademark of the American Medical Association.

What's Changed?

We added:

https://www.cms.gov/files/document/mln006400-information-critical-access-hospitals.pdf

OB Services

- https://www.federalregister.gov/documents/2024/11/27/2024-25521/medicare-and-medicaid-programs-hospital-outpatient-prospective-payment-and-ambulatory-surgical#h-655
- In the "Table of Contents" scroll to the bottom: PART485 – CONDITIONS OF PARTICPAITON: SPECIALIZED PROVIDERS