

**SPECTRUM HEALTH**



# Develop your Practice Management Tool Box

Survey Readiness and Maintaining Compliance

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# Objectives

- ❑ Learn how to develop an Evidence Binder
- ❑ Understand the importance of tracking and monitoring tools for compliance
- ❑ Learn the value of exam room standardization
- ❑ Understand the importance of Mock Surveys and how to develop a good Mock Survey tool
- ❑ Learn how to incorporate a quality chart review process

# Evidence Binder

Create a binder to house all of the documentation that will be requested by the surveyor at time of survey.

Format and organize the binder in a manner that works best for you.

Create sections that are labeled for quick reference.

Review this binder at least quarterly to identify items that may be expiring or information that should be updated.

Make sure that key staff know where to find your binder in case you are not there when a surveyor shows up for an unannounced survey.

This binder will make your survey go much more smoothly and your surveyor will appreciate your organization and knowledge of what they will need.

# Evidence Binder

Suggested Evidence Binder contents – make sure they are all current!

- ❑ HPSA designation confirmation (printed from HRSA website)
- ❑ Copies of providers CV, state license, DEA, BLS and yearly training
- ❑ Copies of all staff job descriptions (including the Medical Director)
- ❑ Copy of clinic floor plan
- ❑ Yearly electrical inspection and bio-medical report
- ❑ Emergency drills documentation and staff sign-in sheets
- ❑ Current organization chart
- ❑ Most current yearly advisory meeting minutes
- ❑ All clinical staff BLS, certifications, licenses and yearly competency training
- ❑ Copy of CLIA (copy should also be posted in your lab area)
- ❑ Copy of DEQ license

# Evidence Binder

## Suggested Evidence Binder contents cont.

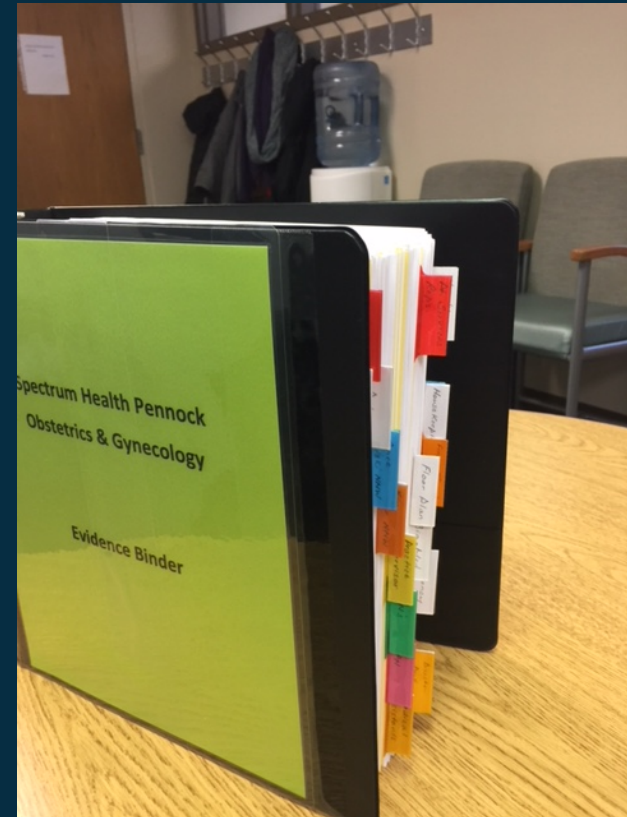
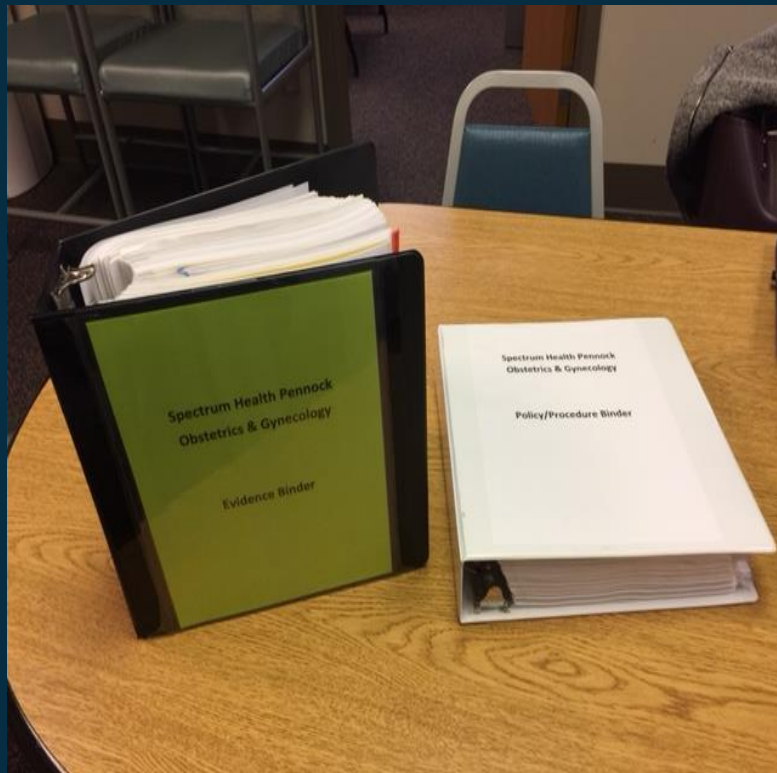
- ❑ At least the last 2 completed chart review forms
- ❑ Roster of all current staff and physicians that also lists job title and FTE status

## Recommend creating additional binders for the following:

- ❑ Sample medication logs
- ❑ SDS information
- ❑ Various compliance monitoring and tracking logs (exam rooms, medication areas, housekeeping, lab area)
- ❑ Policy Manual



# Evidence Binder



# Compliance monitoring tools

Utilizing various monitoring tools will:

- ❑ Keep your clinic RHC compliant
- ❑ Help hold staff accountable
- ❑ Provide your surveyor the “proof” that you continually maintain compliance and follow clinic policy.

Monitoring tools can be utilized daily, weekly or monthly depending on your specific needs.



# Compliance monitoring tools

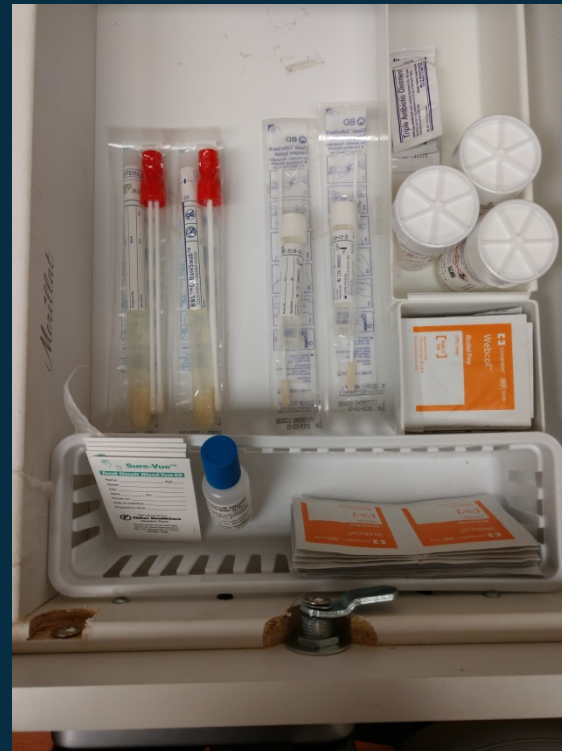
## Examples of monitoring tools

- ❑ Exam room
- ❑ Supply room
- ❑ Medication storage rooms
- ❑ Cleaning logs
- ❑ Lab area review log
- ❑ AED log
- ❑ Eye-wash station

Examples of these documents are provided in your conference material.

# Exam Room Standardization

Sometimes ..... Less is more!



# Exam Room Standardization

Determine what supplies and the quantity that are used daily.

Standardize the contents and quantity of supplies in each exam room to reflect what you use.

Remove or limit supplies that are rarely used.

Keep a master stocking list with expected daily quantities in each room.

# Exam Room Standardization

## Standardization benefits:

- ❑ Reduces staff time spent during monthly review for expired medications.
- ❑ Reduces overstock and potential for waste of expired supplies.
- ❑ Reduces time spent by providers and staff searching for supplies during an exam or procedure.
- ❑ Reduces potential for theft.

# Mock Surveys

Are you performing mock surveys at your RHC?

Mock surveys should be performed at least annually. This will identify areas that are non-compliant.

Mock surveys will also help to identify where additional staff education may be needed.

Identify key staff to assist with surveys. This will prepare them to handle an official un-announced survey if you are not in the office.

These surveys can also be reviewed at your program evaluation meeting and used as part of your quality assurance program.

# Mock Surveys

RHC deeming agencies can have additional quality and patient safety standards.

It is important that you know these additional standards and incorporate them into your mock survey tool.

Review your deeming agency standards annually. They may have changed or added new standards.

# Mock Survey

Complete document shown below can be found in your conference materials

RHC MONTHLY QUALITY, SAFETY and INFECTION PREVENTION ROUNDING TOOL						
* IF "NO" IS MARKED FOR ANY ANSWER, THE ACTION TAKEN AND OTHER COMMENTS MUST BE DOCUMENTED						
Standard		Rationale	Yes	No*	N/A	Action Taken/Comments and Initials
Environment of Care						
2	Is general appearance and are all surfaces clean, uncluttered, and intact? (This includes furniture, walls, flooring and high areas; look for tears in furniture, peeling floors, holes in walls/chipped paint, decals peeling, scuffs on floors/walls, peeling/chipped laminate)	TCT ADM 11.0; CFR 491.6(b)(3)				
3	Housekeeping logs are being maintained.	TCT ADM 11.0 CFR491.6(b)(1)				
4	Is lighting suitable for care, treatment, or services? (This includes emergency/exit lighting, includes shatterproof lightbulbs in gooseneck lamps or cover)	TCT REG 1.0				
6	Is there at least 36 inches of clear space (no obstruction) in front of all electrical panels?	TCT EQP 1.0				
7	Are tanks of compressed gasses (oxygen, etc.) properly labeled and secured in holders or chained to the wall? (labeled "full-ready for patient use" or "empty", storage clearly separated between full and empty, ambu-bag-valve-mask ventilation supplies attached to tank, any used tanks to be considered empty)	TCT EQP 1.0; Adm 10.0 CFR 491.9(c)(3)				

# Quality Chart Review

RHC's are required to complete "periodic" reviews of patient medical records.

There should also be documented reviews of mid-level patient charts by a physician. Both the mid-level and the physician must sign the review to validate that collaboration has taken place.

The clinic can decide the frequency and number of charts that are reviewed. Surveyor will ask to see your policy and validate that you are completing them according to your policy.



# Quality Chart Review

Surveyors will also complete a chart review audit at time of survey to audit the requirements listed in CFR § 491.10

(3) For each patient receiving health care services, the clinic or center maintains a record that includes, as applicable:

- (i) Identification and social data, evidence of consent forms, pertinent medical history, assessment of the health status and health care needs of the patient, and a brief summary of the episode, disposition, and instructions to the patient;
- (ii) Reports of physical examinations, diagnostic and laboratory test results, and consultative findings;
- (iii) All physician's orders, reports of treatments and medications, and other pertinent information necessary to monitor the patient's progress;
- (iv) Signatures of the physician or other health care professional.

# Quality Chart Review

Spectrum Health grew from 8 provider-based RHC's in 2013 to 29 clinics by 2017.

As we started through the survey process early on; we continually were cited for issues with chart completion regarding the documentation requirements in CFR § 491.10.

Several issues were identified including issues with our EMR tools, process flows and additional education needs.

# Quality Chart Review

As a result, a new chart review tool was developed that would monitor these items quarterly to identify and resolve issues.

We also added a second section to this chart review that captured the mid-level chart review process.

Additionally, we enhanced the tool to include various quality and best practice metrics as well as PCMH initiatives.

We also created a dashboard to monitor progress. This is reviewed at our annual program evaluation as part of the quality assurance program review.

# Chart Review and Quality Tracking Tool

Section 1 to be completed by office manager or designated staff for all providers (Physicians and APP's)												
Provider Name: _____	Quarter of review:											
MRN Number	1.	2.	3.	4.	5.							
Date of Service												
For each patient receiving health care services, the clinic maintains a record that includes, as applicable:												
Chief complaint or reason for the encounter	P	A	P	A	P	A	P	A	P	A		
Pertinent medical history and/or surgical history	P	A	P	A	P	A	P	A	P	A		
Known long-term medications, including current medications, over-the-counter drugs, and herbal preparations	P	A	P	A	P	A	P	A	P	A		
Social data (i.e., marital status, habits, occupation, etc.)	P	A	P	A	P	A	P	A	P	A		
Smoking Status	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Family hx	P	A	P	A	P	A	P	A	P	A		
Known adverse and allergic drug reactions;	P	A	P	A	P	A	P	A	P	A		
Assessment of the health status, including complete vital signs on all patients every visit <u>starting at age 2</u> :												
Pain is assessed in all patients. (A comprehensive pain assessment is conducted as <u>appropriate to the patient's condition</u> and the scope of care, treatment, and services provided.)	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Height	P	A	P	A	P	A	P	A	P	A		
Weight	P	A	P	A	P	A	P	A	P	A		
BP (NA under age 3)	P	NA	A	P	NA	A	P	NA	A	P	NA	A
BMI	P	A	P	A	P	A	P	A	P	A		
Report of physical examination	P	A	P	A	P	A	P	A	P	A		
Clinical impression or diagnosis; Brief summary of each episode	P	A	P	A	P	A	P	A	P	A		
Plan for care	P	A	P	A	P	A	P	A	P	A		
The problem list is initiated for the patient by the third visits and maintained thereafter.	P	NA	A	P	NA	A	P	NA	A	P	NA	A



# Chart Review and Quality Tracking Tool

Disposition	P	A	P	A	P	A	P	A	P	A		
Therapies administered and documented	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Orders - Lab reports, as appropriate, with a notation acknowledging results reviewed	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Orders - X-ray and other diagnostic reports, with a notation acknowledging results reviewed	P	NA	A	P	NA	A	P	NA	A	P	NA	A
All entries are dated and signed by the physician or other health care professional	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Consultation reports sent or received?	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Consent for procedure form if applicable	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Immunizations	P	A	P	A	P	A	P	A	P	A	P	A
Mammogram every two years from age 40 to 69	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Colonoscopy every ten years beginning at age 50 through age 75	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Depression screening completed?	P	NA	A	P	NA	A	P	NA	A	P	NA	A
Discharge instructions to the patient	P	A	P	A	P	A	P	A	P	A	P	A
General Consent for treatment form (to be done yearly) done by front desk	P	A	P	A	P	A	P	A	P	A	P	A
"People involved in pt care" form completed by front desk?	P	A	P	A	P	A	P	A	P	A	P	A
<b>Section 2 ( to be filled out by provider for APP charts only)</b>												
Physical Exam Adequate												
Diagnosis supported by H & P												
Appropriate Us of Lab/Xray												
Plan/use of meds appropriate												
Plan of care appropriate												
<b>Provider signature:</b>												
<b>Date:</b>												
<b>APP signature:</b>												
<b>Date:</b>												
Comments:												

# Tips to help you be successful

- ❑ Involve your staff! They have the best ideas. Ask for their input or to help make modifications to fit your needs.
- ❑ Identify key staff that can help perform monthly reviews.
- ❑ Get staff on board! Approach this as not only “RHC” compliance but also patient and staff safety.
- ❑ Discuss findings of reviews during staff meetings.

# Questions



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