ALSTON HOME
CARE SOLUTIONS
1 Provider For Health Care Services

Annual Staff Training

for OLTL

Chapter 55 PA Code 52.21 Staff Training Requirements

All Staff providing OLTL services much receive training annually that includes the following:

- Prevention of abuse and exploitation of participants
- Reporting critical incidents
- Participant complaint resolution
- Department-issued policies and procedures
- Provider’s (Alston Home Care Solutions’) quality management plan
- Fraud and financial abuse prevention

Prevention of abuse and exploitation of participants

OBJECTIVE

Upon completion of this educational program the participant should be able to:

1. Define abuse and neglect.
2. Recognize risk factors associated with abuse.
3. Identify suspected cases of abuse and abusers.
4. Discuss domestic violence.
5. Discuss the reasons why caregiver abuse may occur.
6. Explain the process of reporting client abuse and neglect

Prevention of abuse and exploitation of participants

INTRODUCTION

Elder abuse is a crime that can occur in any setting by formal or informal caregivers. **Formal caregivers** are individuals who are volunteers or paid employees and are connected to the social service or health care systems. **Informal caregivers** are those persons who are family members or friends, and who account for 75% of majority of care provided to impaired elders living in the community. Statistics reveal that a high percentage of reported elder abuse cases are caused by informal caregivers. It is the unreported cases that there are no data reported, and is cause for concern. Formal caregivers need to be aware of the problem of elder abuse, share the knowledge with others, report issues or concerns, and be involved in prevention measures by making a commitment to reach out to those who are vulnerable.

DEFINITION OF ABUSE

Elder abuse is any intended, knowing, or careless act that causes potential or actual harm to an older person. The harm may be physical, mental, emotional, or financial. The abuse may include neglect and mistreatment, and misappropriation of the client's personal property.

Prevention of abuse and exploitation of participants

TYPES OF ABUSE (National Center on Elder Abuse, 2016)

Physical abuse is the use of physical force that may result in bodily injury, physical pain or discomfort, or actual impairment. Examples of physical abuse may include, but are not limited to, striking (with or without an object), hitting, pushing, shoving, beating, shaking, slapping, kicking, pinching, and burning. Additional examples may include inappropriate use of drugs, use of physical restraints, force-feeding, and any other kind of physical punishment.

Emotional or psychological abuse is the causing of infliction of anguish, pain, or distress by performing verbal or nonverbal acts. Emotional or psychological abuse may include, but is not limited to, verbal assaults, threats, intimidation, insults, humiliation, and harassment. Additionally, treating an elder as an infant/child, isolating the client from others and activities, restricting communication, using the “silent treatment”, and enforced social isolation are also examples of emotional and psychological abuse.

Sexual abuse is a non-consensual or unwanted sexual contact of any kind (forced, tricked, threatened or coerced) with an elderly person, whether or not the person is capable of giving consent or not. Examples of sexual abuse may include, but are not limited to unwanted touching, all forms of sexual assault and battery, such as coerced nudity, sodomy, rape, and sexually explicit photography.

Prevention of abuse and exploitation of participants

Financial or Material Exploitation is the misappropriation of a client's personal property, and includes the illegal or improper use of an elder person's funds, property or assets. Examples of financial/material exploitation may include, but are not limited to, cashing a client's checks without permission, forging a client's signature, misusing or theft of a client's money or possessions, coercing or deceiving a client into signing any document, and the improper use of conservatorship, guardianship, or power of attorney.

Abandonment is the desertion of an elder by an individual with assumed responsibility for the care of that person, or by a person with physical custody of the elder. The individual may be a formal or informal caregiver for the elder person.

Self-neglect is a behavior of the client that threatens his/her own health or safety, and is evidenced by the client's refusal or failure to eat adequate food, drink enough fluids, wear adequate clothing, seek shelter, maintain personal hygiene, take prescribed medication, and observe safety precautions. This behavior is not deemed to be self-neglect if the client is mentally competent, understands the consequences of his/her actions, and makes a voluntary decision to behave in ways that threaten his/her health or safety as a matter of personal choice. The actions and behaviors should be reported to the formal caregiver's supervisor and documented in the medical record.

Prevention of abuse and exploitation of participants

RISK FACTORS

Elder abuse can occur in any client setting, therefore, all elders are at potential risk. The elder client is never to be considered responsible for any abuse inflicted upon them. The perpetrator is responsible. There are some factors that may contribute to clients being at a higher risk of abuse, such as persons who are:

- Socially isolated, lonely, or lack family or social support networks.
- Mentally compromised and therefore have increased dependence on the abuser.
- Vulnerable to problems of the abuser, such as the abuser being financially dependent on the victim, having a mental or emotional illness, alcohol or drug abuse problem, or being of an aggressive or hostile personality.
- Prone to self-neglect.

DEFINITION OF NEGLECT

Neglect, as differentiated from self-neglect, is the refusal or failure to provide necessary care, obligations or duties to the elder client. Neglect may include, but is not limited to, failure of the responsible person to pay for necessary services needed by the elderly client, failure to provide for basic life necessities such as food, water, clothing, personal hygiene, shelter, medicine, safety, comfort, and other essentials. Neglect may also include withholding meals or fluids, ordered treatments or hygiene; failure to assist with physical aids such as hearing aids, glasses, or dentures; and deliberate incorrect documentation of care rendered. Failure to provide social stimulation and ignoring the client are further examples of neglect.

Prevention of abuse and exploitation of participants

IDENTIFICATION OF ABUSE AND ABUSERS

It is often difficult to identify elder abuse, or the perpetrator of the abuse. In many cases it is a family member who is involved, but not necessarily the informal caregiver. Stress and emotional instability of a family member may cause the unwanted behaviors. Adding to the problem is the fact that the elder client may not be physically or mentally capable of reporting the abuse because of being isolated, or too fearful or ashamed to tell anyone. The individual may be threatened or coerced into silence. As a formal caregiver, you should be aware of signs and symptoms of elder client abuse of all types, since a client may suffer from more than one type. Any and all cases of **suspected or actual** abuse should be reported immediately to the supervisor, and in turn to the state agency.

Possible characteristics of abusers

- Dependence on alcohol or drugs.
- History of abuse or domestic violence.
- Family dysfunction, dependency, or history of mental illness.
- Personal pressures such as economic stressors.
- History of long-term negative personality traits such as, hypercritical, bad temper, tendency to blame others for problems.
- Formal caregivers with criminal records (agency failed to do an employee background check).
- Employees who are overworked, have high turnover rates, and receive inadequate training for the caregiver position.
- Caregivers lack compassion, and empathy for the elderly and disabled.

Prevention of abuse and exploitation of participants

Possible Signs of Elder Abuse

- Bruises, welts, pressure marks, burns, blisters, rope marks, slap marks, and explanations that do not “fit” with the explanation for the injury should arouse suspicion and should be reported to the supervisor.
- The client seems to withdraw from routine, normal activities, decreased alertness, sadness, unexplained fears, and unusual behaviors that may signal emotional abuse or neglect.
- Bruises or infected lesions around the breasts, genital area, unexplained venereal diseases, vaginal or anal bleeding, and the client report of being sexually assaulted or raped.
- Unexplained sudden changes in finances, altered wills, trusts, bank withdrawals, loss of property, and checks written as “gifts or loans” may be indicative of elder exploitation.
- Changes in personal effects such as need for medical or dental care, poor hygiene, overgrown hair and nails, untreated bedsores, and unusual weight loss are signs of neglect or mistreatment.

DOMESTIC VIOLENCE

Domestic violence is controlling behavior by one household member that is directed toward another member. Domestic violence includes any form of assault, battery, or criminal offence that causes bodily harm or death. Also included are such examples as name-calling or verbal abuse, isolation from family or friends, withholding funds, or threats of physical harm or sexual abuse. Individuals, who have been abused as children, many times become abusers themselves. Although no one knows exactly the number of elder abuse cases that exist, evidence reported by the National Center on Elder Abuse estimates that there are about 1-2 million elders who have been injured, exploited, or mistreated in the United States. Research figures suggest that only one in fourteen domestic elder abuse incidents is reported to authorities. As the population ages, the risks of elder abuse likewise increases. Suspected abuse must be reported, and caregivers have an obligation and responsibility to do so.

Prevention of abuse and exploitation of participants

CAREGIVER ABUSE

Abuse of clients by formal caregivers can occur. Examples of physical abuse by formal caregivers include, but are not limited to hitting, rough handling, hurrying the client, threats, curses, actions or behaviors that cause client low self esteem, unwanted physical contact, gestures or remarks, misuse of a client's money or personal possessions, including eating a client's food, or stealing money or material objects. Trust your instincts. If you feel that something is wrong, it probably is. Notify your supervisor. One does not need to witness the abuse to report it. Suspected abuse should be reported. Let the authorities investigate and make the determination.

Caregivers who abuse clients are often individuals who are tired and overworked. They may have personal problems that interfere with their job performance; they easily lose patience and do not handle stress well. Some caregivers have been, or are, abused themselves, and resolve problems or issues by using abusive methods.

Prevention of abuse is the best alternative. As a caregiver, be aware of your feelings. Eat balanced meals and get enough rest before going to work. If a client is annoying, or unmanageable, withdraw from the situation. Make sure that the client is safe, and exit the room. Avoid confrontation. You may need to be reassigned from the case. There is **never an excuse for client elder abuse.**

You are a mandatory reporter. Should elder abuse be suspected, be observant and report your suspicions. It is a legal and ethical responsibility. If you do not report abuse, you are as guilty as the perpetrator of the abuse, and can be held legally responsible.

Prevention of abuse and exploitation of participants

REPORTING ABUSE/NEGLECT

It is extremely important to report all and any suspected or actual client abuse as soon as it is discovered. Notify the supervisor, and follow instructions. You do not need to prove abuse in order to report it. If the supervisor does not take action, the caregiver is obligated to do so. If the client suffers serious injury or harm, the police need to be notified. Adult Protective Services should also be called. Many states have toll-free numbers for reporting elder abuse. The National Center on Elder Abuse Website has every state's number for reporting elder abuse. See https://ncea.acl.gov/home#gsc.tab=0

Protective Services Information

https://www.pa.gov/en/agencies/dhs/report-abuse/adult-protective-services.html

Please contact the resources below for information only. To report abuse or neglect, please call the Statewide Elder Abuse Helpline.

For Adults with Disabilities Ages 18-59: 717-783-3670
For Adults Ages 60+: 717-783-1550

The PA Department of Aging is responsible for oversight and implementation of the Older Adults Protective Services Act (OAPSA) for individuals ages 60 and over.

Reporting Critical Incidents

What is a Critical Incident?

An occurrence of an event that jeopardizes the participant's health or welfare.

There are two basic elements to Critical Incident Management.

1. Before a critical incident is reported, measures must be taken immediately to ensure the health, safety, and welfare of the participant. This may include calling 911, contacting Adult Protective Services or Older Adult Protective Services if the situation meets, law enforcement, the fire department, or other authorities as appropriate.
2. After the health and welfare of a participant have been ensured, the entity who discovered or first learned of the incident must determine whether it is a reportable incident.

Reporting Critical Incidents

Critical Incident Categories

1. **Death** – other than by natural causes.
2. **Serious Injury** that results in emergency room visits, hospitalizations, or death.
3. **Hospitalization** except in certain cases, such as hospital stays that were planned in advance.
4. **Provider and staff member misconduct** including deliberate, willful, unlawful, or dishonest activities.
5. **Abuse**, including the infliction of injury, unreasonable confinement, intimidation, punishment, or mental anguish, of the participant.

Abuse includes the following:

Physical abuse – is a physical act by an individual that may cause physical injury to a participant.

Psychological abuse – is a form of abuse, other than verbal, that may inflict emotional harm, invoke fear, or humiliate, intimidate, degrade or demean a participant.

Sexual abuse – is an act or attempted act, such as rape, incest, sexual molestation, sexual exploitation, or sexual harassment and/or inappropriate or unwanted touching of a participant.

Verbal abuse – is defined as using words to threaten, coerce, intimidate, degrade, demean, harass, or humiliate a participant

Reporting Critical Incidents

6. **Neglect**– is the failure to provide a participant with the reasonable care that he or she requires, including but not limited to food, clothing, shelter, medical care, personal hygiene, and protection from harm.
7. **Exploitation**– is an act of depriving, defrauding, or the illegal or improper use of a participant's resources for the benefit of self or others.
8. **Service interruption** is an event that results in the participant's inability to receive services and
9. **Medication errors** that result in hospitalization, an emergency room visit or other medical intervention.
10. **Restraint**– any physical, chemical, or mechanical intervention that is used to control acute, episodic behavior that restricts the movement or function of the individual or a portion of the individual's body. Use of restraints and seclusion are both: restrictive interventions, actions or procedures that limit an individual's movement, a person's access to other individuals, locations, or activities, or restricts the participant's rights.

What is not a Critical Incident?

1. Complaints are different from critical incidents and should not be reported as critical incidents. However, the agency must resolve the complaints. Dissatisfaction with the services is a concern that needs to be addressed but it does not need to be reported as a critical incident.
2. Program fraud and program financial abuse should not be reported as critical incidents but should be reported in accordance with the OLTL Fraud & Financial Abuse bulletin 05-11-04, 51-11-04, 52-11-04 issued on August 8, 2011.
3. Missed shifts that do not place the participant's health, safety, or welfare at risk.
4. Deaths due to natural causes (long term illness, cardiac arrest, etc.).
5. Pre-scheduled medical procedures in hospitals. However, if a participant is hospitalized again because of complications, it is reportable.

Reporting Critical Incidents

First Steps

Any provider, service coordinator, subcontractor, or UPMC employee who observes or has reasonable cause to **suspect abuse, neglect, exploitation, abandonment, or suspicious or unexpected death** has occurred with a UPMC CHC participant must:

1. **Take immediate action to ensure the participant's health and safety.** If the participant's health or well-being is in imminent danger, notify emergency first responders (911).

2. **Make a verbal report** to the state **Adult Protective Services Hotline at 1-800-490-8505.** Any questions requiring immediate attention outside of regular business hours should be directed to the APS contractor, Liberty Healthcare's on-call staff at 1-888-243-6561. Please note this number should only be used for emergency situations requiring immediate attention.

3. **Then contact the participant's service coordinator** within 24 hours or make a verbal report to PA Health & Wellness Concierge Line: 1-844-626-6183 within 24 hours.

• At a minimum, the verbal report must include participant's full name, date of birth, date and time of incident, a brief description of the incident, participant's current condition, and actions taken to mitigate risk to the participant; and

• The reporter's name, agency, and contact information.

Reporting Critical Incidents

4. **Submit a critical incident report** no later than 48 hours following the discovery of the incident to the Office of Long-Term Living (OLTL) using EIM and to the Department of Health using the Event Reporting System.

Reporting applies to incidents that happened at any time even in the past. Reporters must report when they discover that the incident happened, even if it was not “on their watch.”

Participants can report incidents at any time through the OLTL Participant Helpline or the Statewide Protective Services Hotline if they are experiencing abuse, neglect, exploitation, or abandonment. There is no adverse consequence for reporting.

Notice to the Participant

1. Agency staff that discovered or first became aware of the critical incident is to notify the participant (and representative if requested by the participant) that a critical incident report has been filed.

2. A copy of the notice needs to be provided to the participant within 24 hours. It must be understandable and language appropriate accessible format).

3. If the participant’s representative is suspected of being involved in the critical incident, the representative should not be notified.

4. Within 48 hours of the conclusion of the critical incident investigation, the Service Coordinator must inform the participant of the resolution and measures implemented to prevent recurrence.

Reporting Critical Incidents

5. Participant has the right to provide input into the resolution and measures implemented to prevent recurrence of the critical incident.

6. If the representative of the participant is not suspected of being involved in the critical incident, the participant may request the representative be informed upon discovery and conclusion – this must be documented in the critical incident report. All information must be provided in an understandable and appropriate language accessible format

Participant Involvement

1. Participant has right to not report incidents
2. Participant has right to decline further investigation
3. Participants also have the right to refuse involvement in the critical incident investigation.
4. Participant has a right to have an advocate present during any interviews and/or investigations resulting from a critical incident report.
5. If the participant chooses not to report an incident or declines further intervention, the critical incident must still be reported, and the Service Coordinator must investigate the incident.
6. Documentation is to be kept indicating that the participant did not wish to report the incident or declined interventions.
7. If the incident involves potential danger to the participant, the Service Coordinator needs to inform the participant that they are a mandated reporter and are required by law to report and submit the incident to protective services.
8. The participant must also be informed by the Service Coordinator that their services may be jeopardized if they are putting themselves or others at risk.

Reporting Critical Incidents

Investigation of Critical Incidents

1. Service Coordinators are responsible for investing reports of critical incidents that they discover or have independent knowledge of, as well as incidents submitted to them by providers.
2. If the critical incident involved the Service Coordinator or Service Coordination Entity (SCE), the SC or SCE should not investigate and should turn the investigation over to OLTL immediately.

Types of Investigations

1. Onsite: conducted for fact finding

- Sequence of events
- Interview of witnesses
- Observation of the participant and/or environment if needed
- If patient hospitalized the SC is to meet with hospital social workers and the attending physician to ensure hospital staff are aware of the incident to ensure a safe disposition.
- If the incident is medically involved, it is recommended that a nurse or the nurse consultant accompany the SC.

2. Telephone Investigation

- Review of incident report reveals facts are missing
- Additional information is required

Reporting Critical Incidents

EMPLOYEE REMOVAL OR SUSPENSION

If incident includes allegation of improper conduct by an employee. The following actions must be taken immediately:

- Remove the accused employee from the participant's services.
- Suspend the employee until the investigation is complete and put the participant's back up plan into place. Investigation may take up to 30 calendar days to complete.
- Interview the involved employee as soon as possible following the incident.
- Have the employee submit a written account of the event.
- If the incident involves an employee of an HCBS provider, the provider must also submit a written report of the incident including actions taken within 20 calendar days of the incident.

Participant complaint resolution

WHAT IS A COMPLAINT/GRIEVANCE?
A complaint or concern presented regarding the agency or the care provided by agency staff.

WHO MAY VOICE A COMPLAINT/GRIEVANCE?
A client, family member or client representative may voice/present a grievance about the Agency or care/services provided by agency staff.

INVESTIGATION ABOUT PRESENTED COMPLAINTS/GRIEVANCES
Our agency is required to actively investigate any complaint or grievance received. The CEO will oversee the investigation process which may include, but not be limited to:

- Interviews with client/family member
- Interviews with staff
- Review of client records
- Review of staff notes, visit reports
- Agency logs/on-call reports

Participant complaint resolution

NOTIFICATION ABOUT AGENCY GRIEVANCE POLICY/PROCESS
CLIENTS: Upon admission to our Agency, all clients/family members are advised of our Agency Complaint/Grievance policy/process and provided a copy of our agency GRIEVANCE POLICY/Form.

STAFF: According to agency policy, upon hire (at orientation) & annually, our Agency provides training/ review with all staff on the client complaint/grievance policy/process.

Individuals never receive any retaliation/discrimination for voicing grievances.

QA OVERSIGHT
Ongoing & as part of our Annual Evaluation, the Agency QA program will review all complaints to determine for trends & improvements

AGENCY GRIEVANCE POLICY
Our agency respond to and investigate each and every complaint/concern presented by a Client/family member with all complaints reviewed quarterly.

Participant complaint resolution

PROCEDURE

Our Agency has an established grievance/complaint protocol for Clients to express concerns/complaints related to the services received. All staff are educated upon hire and ongoing and Clients, on admission and ongoing of the complaint procedure. Our Agency has an established system to record, respond and resolve a participant's complaint.

Our complaint forms will included the following:

A. Name of the participant.
B. Nature of the complaint.
C. Date of the complaint.
D. Provider's actions to resolve the complaint.
E. Participant's satisfaction to the resolution of the complaint.

Our Agency will:

A. Review our complaint system at least quarterly to:
    a. Analyze the number of complaints resolved to the participant's satisfaction.
    b. Analyze the number of complaints not resolved to the participant's satisfaction.
    c. Measure the number of complaints referred to the Department for resolution.

Participant complaint resolution

B. Develop a QA Plan when the numbers of complaints resolved to a participant's satisfaction are less than the number of complaints not resolved to a participant's satisfaction.
C. Submit a copy of the provider's complaint system procedures to the Department upon request.
D. Submit the information under subsection a. above to the Department upon request

COMPLAINT PROCEDURE
Grievances will be submitted to the CEO or designee who will respond to the complaint within ten (10) days. Notification of the decision within 30 days and establish in writing a 30 day period to affect the resolution/remedy.

The CEO shall conduct a complete investigation of the complaint. This investigation will, afford all interested persons an opportunity to submit evidence relevant to the complaint. After which, the CEO will present a determination to the Client, which will include information on their right to appeal the decision.

The Governing Body shall issue a written decision in response to the appeal no later than 30 days after its filing.

All Clients/family filing a verbal or written concern/complaint with our Agency shall be free of any discrimination or repercussions due to the filing.

The CEO will maintain all files/records of our Agency relating to grievances/complaints. The Client record will also include documentation of the complaint.

Participant complaint resolution

GRIEVANCE FORM

ALSTON HOME CARE SOLUTIONS LLC GRIEVANCE FORM

Participant Name					Date		
We were privileged to participate in the care of the above individuals. We are interested rendering quality care to our individuals and would appreciate your input by answering the following questions. Your evaluation will allow us to be more responsive to future individuals/family needs.							
1. What services(s) did you receive from the ALSTON HOME CARE SOLUTIONS LLC?							
Nursing		Homemaker-Direct Care Worker		Speech Therapy			
Occupational Therapy		Physical Therapy		Medical Social Worker			
2. Were you satisfied with the care you received?		YES		NO			
IF NOT, WHY?							
3. Did you participate in your plan of care?		YES		NO			
4. Did you receive and understand your "Bill of Rights" including the toll free "Hotline" number that you could call if any problems were not resolved by the ALSTON HOME CARE SOLUTIONS LLC?		YES		NO			
5. Did the staff visit as frequently as they stated they would when they started your services?		YES		NO			
6. Were you comfortable asking staff about your health?		YES		NO			
7. Did the staff person visit at a mutually agreeable time?		YES		NO			
9. Did you feel that you were discharged appropriately?		YES		NO			

10. Would you use the services of ALSTON HOME CARE SOLUTIONS LLC in the future?	YES		NO	
IF NOT, WHY?				
Suggestions for improvement:				
For Official Use Only: -Resolution of the grievance: _____ _____ _____ __ -Date of resolution of the grievance: _____ -Date ALSTON HOME CARE SOLUTIONS LLC confirmed resolution: _____				
Signature				

Department-issued policies and procedures

OBJECTIVES

Provide an overview of Agency compliance.

Describe Agency methods for monitoring compliance.

Review issued PA DHS Policy & Procedures.

INTRODUCTION

Rules follow up wherever we go. Home care is no different.

There are rules created by multiple entities that must be followed for compliance

Some of these entities may include state government, individual state government programs (ie. Medicaid), federal government agencies, local government, individual program participant rules and agency policy & procedures, best practices in the industry.

These compliance rules or regulations are set up to protect clients, the rights of clients and to best ensure quality of service.

Department-issued policies and procedures

REGULATORY COMPLIANCE

Our Agency services are provided to clients based upon state regulation, agency policy, and applicable federal regulation. Our CEO is responsible for overall agency compliance with applicable rules/regulations.

These regulations determine what services we provide and how we provide those services.

Our agency must be in compliance with regulation to continue to operate & provide services to clients in these programs.

STAFF TRAINING

Upon hire (at orientation) and ongoing, when changes occur but at least annually, our Agency provide training on agency policy & applicable regulation.

At any time staff have any questions regarding regulations or if they wish to review agency policy/procedures, they are to advise the CEO of their request. Policies will be made available and review of regulations will be arranged with the staff member.

Department-issued policies and procedures

ONGOING COMPLIANCE MONITORING

There are many ways our agency monitors compliance with applicable rules/statutes/regulation/Agency policy.

These methods include but are not limited to:

- Client record reviews- for compliance with agency policy/state regulations
- Record audits- to ensure components match policy/procedures
- QA programs- ongoing monitoring for areas of improvement can identify issues
- Client/family feedback- through satisfaction surveys
- Supervisory encounters
- Annual Agency Evaluation process
- Agency committees- provide review of various aspects of agency function that may identify compliance issues

REVIEW OF ISSUED PA DHS POLICY & PROCEDURES

Alston Home Care Solutions LLC diligently reviews and implements policies and procedures mandated by the Pennsylvania Department of Human Services (PA DHS) specifically tailored to the waiver program in which our agency actively participates. By adhering to these guidelines, we ensure the delivery of high-quality care and support services to individuals enrolled in the program, fostering their well-being and independence.

Quality Management Plan

ALSTON HOME CARE SOLUTIONS LLC takes its responsibilities very seriously. The agency follows state and federal policies, guidelines and procedures that aim to maintain the quality of our operations and to make certain we treat staff and individuals as best as possible. The agency has in place strategies for ensuring the appropriate management of academic quality and standards, promoting good practice and customer service. It is our goal to meet and/or exceed Department priorities that are published as a notice in the Pennsylvania Bulletin

GOALS AND OBJECTIVES

- Ensure optimal utilization of resources to provide the best service to consumers.
- Evaluate service outcomes, identify deficits, take corrective actions, and assess their effectiveness.
- Monitor and evaluate service quality, develop standards, and utilize consumer records for assessment and improvement.
- Identify, hire, and retain qualified personnel and evaluate their competency regularly.
- Document QA activities and results, integrating risk management and utilization review for comprehensive QA.

Quality Management Plan

INTEGRATION
All staff members are committed to the QA program, focusing on monitoring, and evaluating activities for consumer/service outcomes. The CEO and QA Specialist coordinates the QA program, with summaries reported to the office for review.

AUTHORITY/RESPONSIBILITY
The Governing Body holds final responsibility for service quality and organization practice.

The QA Committee centrally coordinates monitoring and evaluation activities, reporting to the CEO and Governing Board.

QA COMMITTEE COMPOSITION
The QA Committee comprises the CEO, QA Specialist, and administrative staff.

CONSUMER SERVICE PROCESS
Consumer Record Review (CRR) evaluates structure, process, and outcome criteria, aiming for a threshold of 80% or above. Any criteria falling below 80% will be examined, corrective action planned, implemented, and accelerated for effectiveness. A summary of these record reviews is completed. Continuity of Care involves assessing staff productivity, availability, and capability.

Quality Management Plan

COMMITTEE RESPONSIBILITIES:

1. **QA Committee:**
   Provide professional advice, oversee subcommittee activities, receive and analyze reports, and recommend improvements to the Governing Body.

2. **QA Consumer Record Review (CRR):**
   Delegate tasks for completing consumer audits and compile summary reports.

3. **Safety/Feedback:**
   Ensure safety checks, handle incident reports, collect feedback, and manage consumer complaints.

4. **Ethics:**
   Address ethical issues related to employees or consumers and report to the QA Committee.

Overall, the QA program aims to ensure continuous improvement in service quality and consumer outcomes through systematic monitoring, evaluation, and corrective actions.

Fraud and financial abuse prevention

OBJECTIVES

1. Define what constitutes Fraud & Financial Abuse in home care.
2. Describe Agency systems in place to prevent fraud & financial abuse.
3. Explain actions to take if you identify fraud or financial abuse.

INTRODUCTION

Fraud & financial abuse exists in many industries. The home care industry does provide many opportunities to commit fraud & financial abuse including, but not limited to service delivery, billing, and reporting, just to name a few.

The consequences for committing fraud or financial abuse in home care are severe, including fines, incarceration and being permanently expelled from gaining license in the industry again.

Fraud and financial abuse prevention

DEFINITIONS

- **FRAUD**: Wrongful or criminal deception intended to result in financial or personal gain.
- **FINANCIAL ABUSE:** the illegal or unauthorized use of property, payments, money, or other valuables.

FRAUD/FINANCIAL ABUSE in the home care setting may include

- Knowingly submitting, or causing to be submitted, false claims or making misrepresentations of fact to obtain a state/federal health care payment for which no entitlement would otherwise exist
- Knowingly soliciting, receiving, offering, and/or paying remuneration to induce or reward referrals for items or services reimbursed by state/federal health care programs

Fraud and financial abuse prevention

EXAMPLES OF FRAUD AND ABUSE IN HOME CARE, APPROPRIATE FOR REPORTING MAY INCLUDE but not be limited to:

Falsifying Claims/Encounters

- Billing for services not rendered
- Billing separately for services in lieu of an available combination code
- Misrepresentation of the service/supplies rendered (billing brand name for generic drug, up-coding to more expensive service than was rendered, billing for more time or units of service than provided)
- Altering claims
- Submission of any false data on claims, such as date of service, provider or prescriber of service
- Duplicate billing for the same service
- Billing for services provided by unlicensed or unqualified persons
- Billing for used items as new

Fraud and financial abuse prevention

Administrative/Financial

- Falsifying credentials
- Fraudulent enrollment practices
- Fraudulent third-party liability reporting
- Offering free services in exchange for a recipient’s program identification number
- Providing unnecessary services/overutilization
- Kickbacks-accepting or making payments for referrals
- Concealing ownership of related companies

Recipient Fraud and Abuse

- Forging or altering prescriptions or orders
- Using multiple ID cards
- Loaning his/her ID card
- Reselling items received through the program
- Intentionally receiving excessive drugs, services or supplies

Fraud and financial abuse prevention

Abuse of Recipients

- Physical, mental, emotional or sexual abuse
- Discrimination
- Neglect
- Providing substandard or inappropriate care

Denial of Services

- Denying access to services
- Limiting access to services
- Failure to refer to needed specialist
- Underutilization

Fraud and financial abuse prevention

AGENCY SYSTEMS IN PLACE TO PREVENT FRAUD & FINANCIAL ABUSE:
Our agency has in place various systems to prevent fraud & financial abuse.

- **Client Chart reviews**– which focus on appropriate services rendered to client who are in need of the service, adherence to agency & state policy/regulation.
- **Billing systems** of checks & balances to coordinate services/visits rendered with actual services/visits billed for & ongoing accounts.
- **Ongoing financial reporting/review**-to provide oversight for agency financials, including accounts payable, payroll, budgeting, accounts receivables, etc.
- **Annual Agency Evaluation-** to provide a review of all agency services/programs, including financial.
- **QA Program** to evaluate various types of Agency data & identify any systems/processes that need improvement & create/put in place a plan to make improvements to systems/quality of care issues.

REPORTING MEDICAID FRAUD
It is the responsibility of every staff member to report any suspected fraud or financial abuse.

Fraud and financial abuse prevention

REPORTS CAN BE MADE TO:

- **THE AGENCY**: Any suspicion of fraud or financial abuse should immediately report to your supervisor/CEO.
- **STATE MEDICAID OFFICE:** who is tasked with running this provider program and protecting their participants and the program from fraud & financial abuse.

PA State Inspector General Tip Line at 800-932-0582

- **OFFICE OF INSPECTOR GENERAL (OIG):**

The OIG protects the integrity of HHS' programs, including Medicare & Medicaid, and the health and welfare of its beneficiaries. The OIG operates through a nationwide network of audits, investigations, inspections, and other related functions. The Inspector General is authorized to, among other things, exclude individuals and entities who engage in fraud or abuse from participation in Medicare, Medicaid, and other Federal health care programs, and to impose CMPs for certain violations related to Federal healthcare programs.

Fraud and financial abuse prevention

OIG Fraud Hotline

Phone: 1-800-HHS-TIPS 1-800-447-8477 or TTY 1-800-377-4950

Fax: 1-800-223-8164

Online: Forms.oig.hhs.gov/hotlineoperations/index.aspx

Mail: U.S. Department of Health & Human Services
Office of Inspector General
ATTN: OIG Hotline Operations
P.O. Box 23489
Washington, DC 20026