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March 3, 2017

VIA EMAIL & HAND DELIVERED

Ms. Ruby Potter
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: BAYADA Home Health Care, Inc.
Application to Establish General Hospice in Prince George's County
Docket No. 16-16-2383

Dear Ms. Potter:

Enclosed please find six (6) physical copies of BAYADA Home Health Care, Inc.'s response to the Commission's February 17, 2017 completeness questions regarding the above-referenced application. You should also receive today, via email, a PDF and word copy of the response, as well as a PDF copy of the exhibits to the response.

Please return a date-stamped copy of this letter to the waiting messenger.

Respectfully Submitted,

Jonathan Montgomery

cc: Mr. Kevin McDonald, Chief, Certificate of Need (via email)
Pamela Creekmur, R.N., Health Officer, Prince George's County
BAYADA Home Health Care, Inc. (internal distribution)

BAYADA HOME HEALTH CARE, INC.

CERTIFICATE OF NEED

Matter No. 16-16-2383

RESPONSE TO THE SECOND ROUND OF COMPLETENESS QUESTIONS

PRINCE GEORGE'S COUNTY

March 3, 2017

Our Service Promise to You

The **BAYADA** Way®

We believe our clients deserve home health care services delivered with compassion, excellence, and reliability.

BAYADA® Hospice

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CHARITY CARE AND SLIDING FEE SCALE

QUESTION 1:

In response to question 11 Bayada has apparently miscalculated the charity care percentage it has provided in the chart supporting the answer to the completeness question. Please submit a corrected one.

APPLICANT RESPONSE

In addition to the charity care identified in BAYADA's application ($167,443), BAYADA has also provided pre-Medicare certification care to patients, including $114,639 of care never billed or collected from patients. The below chart therefore shows that since 2011, BAYADA has provided $282,081.90 in total charity care, representing .42% of gross revenue (2011-2016).

	Revenue (Gross)	Charity Care ($)	% of Gross Revenue	Pre Medicare Cert	Total	% of Gross Revenue
2011	$2,750,188.54	$77,743.12	2.83%		$77,743.12	2.83%
2012	$7,069,095.73	$30,150.00	0.43%		$30,150.00	0.43%
2013	$9,223,751.50	$3,000.00	0.03%		$3,000.00	0.03%
2014	$11,959,924.61	$28,650.00	0.24%	$5,000.99	$33,650.99	0.28%
2015	$16,190,917.67	$24,300.00	0.15%	$109,637.79	$133,937.79	0.83%
2016*	$20,359,424.27	$3,600.00	0.02%		$3,600.00	0.02%
Grand Total	$67,553,302.32	$167,443.12	0.25%	$114,638.78	$282,081.90	0.42%

* 2016 totals are only 1Q and 2Q16 totals

CHARITY CARE AND SLIDING FEE SCALE

QUESTION 2:

In order to assess applicants' ability to build a QAPI that meets the requirements of COMAR 10.07.21.09 MHCC staff has adapted the survey tool used by the Office of Health Care Quality to make such an assessment and created a form that will facilitate your ability to show that your policy will conform. That form is attached. As its instructions direct, cite the section of your QAPI and specific language that addresses the required QAPI content.

APPLICANT RESPONSE

Enclosed as Revised Exhibit 50, please find the completed QAPI form.

Revised Exhibit 50

BAYADA HOSPICE – 2017 QAPI PLAN – CHART

QAPI Characteristic as Described by OHCQ	State regulation reference	Location/citation in Applicant's QAPI Provide the section of the policy and the language that addresses the requirement.
Develop, implement and maintain an effective, ongoing, hospice-wide data driven QAPI program	10.07.21.09 A & B A. The governing body shall ensure that the hospice care program conducts ongoing quality assurance and utilization review. B. Quality Assurance Program. The governing body shall assure that the hospice care program develops and implements a quality assurance and improvement program to assess and improve the quality of services being provided by the program.	A. Governing Body Please see Section B(1) of the BAYADA Hospice Division 2017 Quality Assurance and Performance Improvement Plan (the "QAPI Plan"), enclosed in this Revised Exhibit 50. This plan replaces the 2016 plan submitted with the original application. Section B(1) states: "The Governing Body representatives of the BAYADA Hospice division have oversight responsibility for the quality and effectiveness of the services provided by each Hospice." That section also states: "The Governing Body shall appoint the Hospice Director/Associate Director, who shall have the responsibility for the administration of the Quality Assurance and Performance Improvement Program…" B. Quality Assurance Program Section B(1) of the QAPI states that "the Governing Body has ultimate responsibility to that this QAPI plan is implemented." Section E of the QAPI Plan states that the QAPI Plan "is annually assessed for effectiveness and consistency."
Maintain documentary evidence – able to demonstrate operation	10.07.21.09D(2)Maintain records to demonstrate the effectiveness of its quality assurance activities	Section C(1) of the QAPI Plan states that "BAYADA Hospice completes monthly QAPI activities /reports on a monthly basis for indicators in the five domains identified in this plan." Section B(1) of the QAPI Plan states that "The Governing Body will receive a quarterly summary of all QAPI activities."

Program capable of showing measurable improvement in indicators related to improved palliative outcomes and hospice services	10.07.21.09C(2)Have outcomes and results that are measurable and which may be incorporated into systemic changes in the program's operation;	Section A(3) of the QAPI Plan identifies a two-stage ongoing quality improvement "This organization collects data on important processes or outcomes related to patient care, patient/client satisfaction, risk areas and management functions. Important processes are measured on a continuing basis. BAYADA Hospice employs a two-stage ongoing quality improvement approach to evaluate this data and implement plans for remediation and/or improvement." Section (C)(1) of the QAPI Plan identifies five categories of indicators for QAPI review, including "people, service, quality, growth, finance" measures, and lists the specific indicators to be reviewed. Section (C)(2) of the QAPI Plan calls for development of additional measurable indicators on an as-needed basis if "an important aspect of practice or area of risk is identified."
Must measure, analyze and track quality indicators including adverse patient events	10.07.21.09C(3) Require the systematic collection, review, and evaluation of information and data and the analysis of trends identified through the quality assurance process	Section (C)(1) of the QAPI Plan identifies five categories of indicators for QAPI review, including "people, service, quality, growth, finance" measures, and lists the specific indicators to be reviewed. Section (C)(2) of the QAPI Plan calls for development of additional measurable indicators on an as-needed basis if "an important aspect of practice or area of risk is identified." The QAPI Plan also incorporates general BAYADA policies on data collection and review, including BAYADA Policy 0-403: QUALITY ASSESSMENT AND QUALITY IMPROVEMENT IMPLEMENTATION (enclosed in this Revised Exhibit 50) Sections 2 through 6 of Policy 0-403 outline specific data collections and tracking activities performed by BAYADA.
Must use quality indicator data in design of program to: monitor effectiveness and	10.07.21.09D(3) Implement changes based upon results of the evaluated data; for example, when problems are identified in the provision of services, the hospice care program shall document corrective actions taken,	As outlined in Section D(1) of the QAPI Plan, the evaluation of data as well as the process improvement activities are performed through the following process:

safety of services and quality of care; identify opportunities for improvement	including ongoing monitoring, revisions of policies and procedures, and educational interventions	"When the data collected for an indicator is not consistent with an established threshold, an evaluation of the data is conducted using the process outlined below or other advanced problem solving methodology. The Director and/or the QAPI Committee may establish or act as an action team to address specific services or areas of focus following this process. i. **Select** a Target Outcome ii. **Conduct** a Process Investigation to examine and analyze the processes that produced the target outcome results. iii. **Document** a Problem or Strength Statement that simply states the specific problem or exemplary care/management issue to be addressed by the Plan of Action. The issue must be within the hospice's control. Avoid focusing patient care issues primarily on documentation. iv. **Formulate and Implement a written Plan of Action for remediation or reinforcement** that includes the intervention or actions that are needed to guide the staff in best practice, to implement change and/or learn a new skill or process. The action statements include the start/finish times for each specific intervention and the person(s) responsible for seeing that the specific activity is carried out. v. **Monitor Outcomes (Implement 4dx principles)** to determine if the staff is following best practices, implementing the changes presented or has learned the presented material. It is critical that monitoring approaches begin shortly after implementation of the intervention (e.g., within two to four weeks) and include plans to inform the staff. Monitoring may involve interview, observation or focused review. Document the effectiveness of actions in the Quality Assurance and Performance Improvement Committee Minutes"
Frequency and detail of data collection must be approved by governing	10.07.21.09E The hospice care program shall be held accountable by the governing body for accomplishing the goals and standards that are established as part of the	Section B(1) of the QAPI Plan states that "the Governing Body will receive a quarterly summary of all QAPI activities" and that "the Governing Body representatives of the BAYADA Hospice division will

body	quality assurance and improvement system.	have oversight responsibility for the quality and effectiveness of the services provided by each Hospice. The Governing Body has ultimate responsibility to ensure that this QAPI plan is implemented." Section B(1) of the QAPI Plan also gives the Governing Body the power to appoint, and therefore to hold accountable and replace, "the Hospice Director/Associate Director. The Hospice Director and Associate Director shall have the responsibility for the administration of the Quality Assurance and Performance Improvement Program."
Must focus on high risk, high volume or problem prone areas		Section A(2) of the QAPI Plan states that BAYADA will "Focus on high risk, high volume, problem prone areas" A Section (C)(2) of the QAPI Plan calls for development of additional measurable indicators on an as-needed basis if "an important aspect of practice or area of risk is identified." Section 6 of Policy 0-403 states that "All incident reports are reviewed for potential adverse events and safety risks. The company selects at least one high-risk process to be analyzed per year."
PI activities must track adverse patient events, analyze their causes and implement preventive actions	10.07.21.09D(3) Implement changes based upon results of the evaluated data; for example, when problems are identified in the provision of services, the hospice care program shall document corrective actions taken, including ongoing monitoring, revisions of policies and procedures, and educational interventions	Section 6 of Policy 0-403 states that "All incident reports are reviewed for potential adverse events and safety risks. The company selects at least one high-risk process to be analyzed per year." Section D(1) of the QAPI Plan identifies the five step action process BAYADA uses to improve "specific services or areas of focus"
Must measure success and track performance to ensure improvements are sustained		Section D(1) of the QAPI Plan identifies the five step action process BAYADA uses to improve "specific services or areas of focus" Section D(2) of the QAPI Plan states that "When QA data identifies an unsatisfactory aspect of care/service that the QAPI committee deems critical, the Director is immediately notified. The Director may call an

		ad hoc QAPI meeting or implement other action to address the issue. Follow up evaluation will be conducted to ensure effective resolution and will be presented at the next regularly scheduled Quality Assurance and Performance Improvement Committee meeting."
Number and scope of PIP (performance improvement projects), conducted annually based on the needs of the hospice's population and internal organizational needs, must reflect the scope, complexity and past performance of the hospice's services and operations	10.07.21.09C(1-6) C. The quality assurance and improvement program shall: (1) Focus on: (a) The needs, expectations, and satisfaction of patients and their families, and (b) All services provided by the hospice care program; (2) Have outcomes and results that are measurable and which may be incorporated into systemic changes in the program's operation; (3) Require the systematic collection, review, and evaluation of information and data and the analysis of trends identified through the quality assurance process; (4) Require that regular reports are prepared and reviewed by the governing body and appropriate personnel; (5) Provide for prompt and appropriate response to incidents when the patient's health and safety is at risk; and (6) Include proactive strategies to improve the quality of services.	Section 6 of Policy 0-403 states that "All incident reports are reviewed for potential adverse events and safety risks. The company selects at least one high-risk process to be analyzed per year." Section E of the QAPI Plan states that "the Quality Assurance and Performance Improvement Plan is annually assessed for effectiveness and consistency. The results of the review including problems identified and actions taken are documented in an annual evaluation and reported to the Governing Body representatives. The annual plan will be completed prior to the second quarter of the following year." Section C(2) of the QAPI Plan states that the QAPI committees "will review the calendar quarterly to make necessary adjustments to meet organizational needs. The Hospice may choose to perform more frequent or additional Performance Improvement activities/projects. The data collection process utilizes available reports and tools and analyzes data using systematic and appropriate statistical techniques. The indicators and monitoring issues are represented by one of the five domains and one of the target areas listed that domain. After an important aspect of practice or area of risk is identified, indicators are developed to assist in the monitoring and evaluation of that practice or risk area. Indicators are either structural, process or outcome in nature. For each indicator developed, a threshold or performance target will be established to assist in the identification of potential problems and promotion of best practices."
Governing Body-responsible for	10.07.21.09D(4) Identify the individual responsible for performing the quality assurance functions as set forth in	

ensuring that one or more individual(s) who are responsible for operating the QAPI program are designated	this regulation	Section (B)(1) of the QAPI Plan states that "the Governing Body shall appoint the Hospice Director/Associate Director. The Hospice Director and Associate Director shall have the responsibility for the administration of the Quality Assurance and Performance Improvement Program"

BAYADA Hospice Division - Maryland
2017 Quality Assurance and Performance Improvement Plan

A. Overview

(1) Introduction

BAYADA Hospice is dedicated to supporting patients with terminal illness as well as their families. Our mission is to preserve each patient's dignity and to alleviate the fear associated with dying through pain control, comfort care and symptom management.

To help fulfill this mission each BAYADA Hospice Branch conducts an ongoing, comprehensive, integrated, self-assessment of quality and the appropriateness of care provided, as well as evaluating management systems and the identification of best practices. Special attention is given to the evaluation of the ability of the hospice to deal with symptom management, pain control, stress management, continuity of care and inpatient care. The findings are used by the hospice to correct identified problems and to revise hospice policies if necessary.

Our Quality Assurance and Performance Improvement (QAPI) Program is based on current quality improvement practice and the quality assurance guidelines published by the Centers for Medicare and Medical (CMS) for Quality Assurance and Performance Improvement (QAPI). The program consists of quality and performance improvement activities that are designed to maintain and improve the quality of care and management while meeting licensing and regulatory requirements, e.g. state hospice licensure regulations, OSHA regulations and Medicare Conditions of Participation.

This 2017 Quality Assurance and Performance Improvement Plan incorporates by reference BAYADA Policy 0-403: QUALITY ASSESSMENT AND QUALITY IMPROVEMENT IMPLEMENTATION.

(2) Goals

The overall goals of the QAPI Program are encapsulated in the following categories:

I. Program Scope § 418.58(a) (1-2)
- Measure, Analyze, and Track Operations
- Measurably improve palliative outcomes and EOL support

II. Program Data § 418.58(b) (1-3)
- Drive QAPI with data
- Monitor and ID opportunities for improvement
- Timing and detail determined by governing body

III. QAPI: Program activities § 418.58(c) (1-3)

- Focus on high risk, high volume, problem prone areas
- Consider incidence, prevalence, severity
- Address & prevent adverse events
- Improve & monitor over time

IV. Performance Improvement Projects § 418.58(d) (1-2)

- Reflect scope and complexity of hospice
- Document what, why and how successful

V. Executive responsibilities § 418.58(e) (1-3)

- Define, implement, and maintain QAPI
- Address quality and patient safety...

(3) Approach

This organization collects data on important processes or outcomes related to patient care, patient/client satisfaction, risk areas and management functions. Important processes are measured on a continuing basis. BAYADA Hospice employs a two-stage ongoing quality improvement approach to evaluate this data and implement plans for remediation and/or improvement.

Stage I - Outcome Analysis

Data collection, analysis and trending for an indicator or target outcome. Data is collected according to specific indicator guides and tracked based on the frequency outlined in the BAYADA Quality Assurance and Performance Improvement Calendar.

Stage II – Outcome Enhancement

Implementation of a performance improvement plan aimed at correcting substandard results or reinforcing exemplary practices. The plan of action is developed through interpreting outcomes and results, selecting target outcomes for follow up, determining which key processes or practices influence these target outcomes, developing a plan and implementing that plan. The second stage feeds back to Stage I the next time the indicator is monitored or an outcome report is received.

B. *Responsibility*

(1) Governing Body

Under current BAYADA policy, Governing Body responsibilities are held by a company-wide advisory board and local advisory boards for particular BAYADA programs. A description of these advisory boards is contained in BAYADA Policy 0-525: ADVISORY BOARDS, which is incorporated by reference. BAYADA plans to empower a local advisory board for the Maryland branch of its hospice division, including the QAPI committees referenced in this Section B.

The Governing Body representatives of the BAYADA Hospice division will have oversight responsibility for the quality and effectiveness of the services provided by each Hospice. The Governing Body has ultimate responsibility to ensure that this QAPI plan is implemented.

The Governing Body shall appoint the Hospice Director/Associate Director. The Hospice Director and Associate Director shall have the responsibility for the administration of the Quality Assurance and Performance Improvement Program, including the following activities:

i. Appoint the QA and Performance Improvement Committee chair.
ii. Oversee the timely performance of the activities listed in the QA and Performance Improvement Plan.
iii. Perform additional or more frequent QA and Performance Improvement activities depending on the needs of the Hospice.
iv. Develop, implement and oversee the systems necessary to improve or maintain quality patient care and effective management processes.
v. Submit QAPI meeting minutes quarterly to the Division Director or designee.

The QA and Performance Improvement Committee works under the authority of the Hospice Director and has the responsibility to follow the QA and Performance Improvement Plan, analyze data generated through executing the QAPI plan and develop plans of action.

The Division Director of Clinical Operations and the Division Quality Committee review data from each hospice in the division for comparison and assists in analyzing trends and identifying best practices.

The Governing Body will receive a quarterly summary of all QAPI activities.

(2) QAPI Committee – Branch Committee

The QAPI Committee for the Maryland branch of Bayada is responsible to review and / or gather, analyze, data and formulates and implements remediation and maintenance plans in

accordance with the BAYADA Quality Assurance Performance Improvement Plan. The QAPI plan is reflective of the local hospice data.

i. The QAPI committee is led by a chairperson and composed of members from clinical, management, marketing and support staff.
ii. Clinical staff and contractors are expected to participate on the committee or in the QAPI activities.
iii. Quality Assurance and Performance Improvement committee findings and minutes are prepared and presented to the Hospice's Quality Assurance and Performance Improvement Committee and stored in the Hospice's Quality Assurance and Performance Improvement Manual.
iv. The committee chair or is responsible for appointing a performance improvement team, hold meetings, maintaining the Quality Assurance and Performance Improvement Manual, preparing and completing minutes that ensure that indicators are monitored and analyzed according to plan.

- QAPI meetings will be scheduled monthly at the local level at least quarterly with the Medical Director attending.
- Will report quarterly or per individual state requirement to the Governing Body.

v. The committee utilizes Performance improvement teams to further analyze, identified problems and to ensure they are brought to acceptable threshold / resolution.
vi. Reports will be forwarded to the Practice level QAPI committee by the 15th of the month

(3) QAPI Committee – Practice Committee

The Practice QAPI Committee is responsible to review and / or gather, analyze data and formulate and implement remediation and maintenance plans in accordance with the BAYADA Quality Assurance Performance Improvement Plan.

i. The QAPI committee is led by the Division Director of clinical compliance and composed of member's management, Support and medical staff, contractor appointees may also be appointed as determined by the committee.
ii. Quality Assurance and Performance Improvement committee findings and minutes are prepared and presented to the Practice Leader of BAYADA Hospice and stored in the Hospice's Quality Assurance and Performance Improvement Manual.
iii. The committee chair is responsible for appointing a performance improvement team, holding meetings, maintaining the Quality Assurance and Performance Improvement Manual, preparing and completing minutes that ensure that indicators are monitored and analyzed according to plan.
iv. QAPI meetings will be scheduled the last week of each month and will review the local hospice QAPI reports, as well as the practice level plan
v. Will report quarterly to Hospice Practice leader and Governing Body

vi. The committee utilizes Performance improvement teams to further analyze, identified problems and to ensure they are brought to acceptable threshold / resolution.

(4)Staff and Contractor's Responsibility

All staff of BAYADA Hospice (full and part time) as well as all contracted individuals performing services on behalf of BAYADA are expected to participate in QAPI activities carried out by the Hospice. Moreover, staff and contracted individuals will be invited to participate in various QAPI activities.

C. Outcome Monitoring

(1) Standard Indicators

Our QAPI Plan considers five functional areas:

- People
- Service
- Quality
- Growth
- Finance

People:

- Human Resource Practices
- Staff Retention
- Employee Satisfaction Surveys
- Home Office field retention
- On boarding Practices
- Management of Injured
- Employee Staff Education

Service:

- Client Satisfaction Surveys
- Patient Incident & Complaints/Events
- Compliance Program
- HIS
- Cahps

Quality: (10% monthly review of clinical record)

- Symptom Management
- Pain Control
- Continuity of Care
- Levels of Care
- Coordination of Care with Nursing Facilities
- Comprehensive Assessment
- Care Planning/Coordination
- Documentation Processes
- Clinical Oversight
- Staff Education
- Staff Competency

- Infection Control
- OSHA/Safety Education
- Internal clinical audit

Growth:
- Year over Year Revenue
- Year over Year Admission Growth
- Live Discharge/Revocation
- Referral management
- Length of Stay

Finance:
- Gross Profit percentage
- Operating Income percentage
- Billing and AR Processes
- AP Management
- Pay practice
- ADR and Pre pay probe processes
- Expense Management
- Budget development and Management
- Internal Operations audit

BAYADA Hospice completes monthly QAPI activities /reports on a monthly basis for indicators in the five domains identified in this plan.

(2) Identification of Additional Indicators and Issues for Monitoring

Each year a Division-wide Master QAPI Calendar containing scheduled indicators is developed in consultation with the Directors, Clinical Managers and Hospice staff and distributed by the Division Director of Clinical Operations.

The Corporate QAPI Committee will review the calendar quarterly to make necessary adjustments to meet organizational needs. The Hospice may choose to perform more frequent or additional Performance Improvement activities/projects. The data collection process utilizes available reports and tools and analyzes data using systematic and appropriate statistical techniques. The indicators and monitoring issues are represented by one of the five domains and one of the target areas listed that domain.

After an important aspect of practice or area of risk is identified, indicators are developed to assist in the monitoring and evaluation of that practice or risk area. Indicators are either structural, process or outcome in nature. For each indicator developed, a threshold or

performance target will be established to assist in the identification of potential problems and promotion of best practices.

D. Outcome Analysis and Enhancement

(1) Standard Analysis and Enhancement Process

When the data collected for an indicator is not consistent with an established threshold, an evaluation of the data is conducted using the process outlined below or other advanced problem solving methodology.

The Director and/or the QAPI Committee may establish or act as an action team to address specific services or areas of focus following this process.

i. **Select** a Target Outcome
ii. **Conduct** a Process Investigation to examine and analyze the processes that produced the target outcome results.
iii. **Document** a Problem or Strength Statement that simply states the specific problem or exemplary care/management issue to be addressed by the Plan of Action. The issue must be within the hospice's control. Avoid focusing patient care issues primarily on documentation.
iv. **Formulate and Implement a written Plan of Action for remediation or reinforcement** that includes the intervention or actions that are needed to guide the staff in best practice, to implement change and/or learn a new skill or process. The action statements include the start/finish times for each specific intervention and the person(s) responsible for seeing that the specific activity is carried out.

v. **Monitor Outcomes (Implement 4dx principles)** to determine if the staff is following best practices, implementing the changes presented or has learned the presented material. It is critical that monitoring approaches begin shortly after implementation of the intervention (e.g., within two to four weeks) and include plans to inform the staff. Monitoring may involve interview, observation or focused review. Document the effectiveness of actions in the Quality Assurance and Performance Improvement Committee Minutes.

(2) Resolution of Identified Critical Thresholds

When QA data identifies an unsatisfactory aspect of care/service that the QAPI committee deems critical, the Director is immediately notified. The Director may call an ad hoc QAPI meeting or implement other action to address the issue. Follow up evaluation will be conducted to ensure effective resolution and will be presented at the next regularly scheduled Quality Assurance and Performance Improvement Committee meeting.

E. Annual Appraisal of the BAYADA Plan and System

The Quality Assurance and Performance Improvement Plan is annually assessed for effectiveness and consistency. The results of the review including problems identified and actions taken are documented in an annual evaluation and reported to the Governing Body representatives. The annual plan will be completed prior to the second quarter of the following year.

F. Confidentiality

The information related to Quality Assurance and Performance Improvement activities is collected and analyzed in a manner consistent with existing policy and Health Insurance Portability and Accountability Act (HIPAA) regulations. Since all patient identifiable information contained in the clinical record is considered confidential, the identity of the patient is protected by use of an MR number or other system to safeguard the information. In addition information generated through Quality Assurance and Performance Improvement activities is stored in areas outside of public access or view.

0-403 QUALITY ASSESSMENT AND QUALITY IMPROVEMENT IMPLEMENTATION

This policy was adopted on Jan. 1, 1993 and last revised Jan. 28, 2014.

Our Policy:

BAYADA Home Health Care has procedures for its Quality Assessment and Improvement monitoring and evaluation activities.

Our Procedure:

1.0 QA REVIEW TEAM.

1.1 Quality Assessment (QA) review is a centralized function under the direction of the Chief Nursing Officer (CNO). Designated BAYADA personnel perform QA Review. The process is coordinated, monitored, and evaluated by the BAYADA corporate Nursing office.

2.0 QA REVIEW.

This process takes place quarterly on site at the service office and in the client's home.

2.1 Chart Review and Employee File Review.

2.1.1 **Sample**: A sample of active and discharged charts are selected randomly from a list of clients serviced and are representative of the client population of the service office. Files for field employees who worked in the previous quarter are also selected randomly and reviewed.

2.1.1.1 **Medicare Certified offices**: A random sample of clinical records are reviewed on a quarterly basis . The selection includes 10% of annual unduplicated admission with a maximum of 120 sample records per year.

2.1.1.2 **Non-Medicare Certified Offices:** 10% sample of active/discharged client records for a maximum of 60 client records per year are reviewed.

2.1.2 **Process**- Client charts and employee files are evaluated by the QA Reviewer. Recommendations for improvement are made, when necessary, and the service office must respond with a plan of correction within a time frame determined by the QA Reviewer not to exceed three weeks.

2.1.3 **Home Visit.**

2.1.3.1 **Sample:** The QA Coordinator will randomly select clients from each office to be visited in their homes by a QA Reviewer.

2.1.3.2 **Process**: The QA Reviewer will visit the client with the Clinical Manager and complete a Home Visit Evaluation form. These forms will be reviewed, analyzed, and score based on the percentage of compliance to policy.

2.1.4 **Indicators Analysis.**

2.1.4.1 **Sample**: A sample of charts or employee files are reviewed, with concentration only on the item identified in that particular order.

2.1.4.2 **Process**: For indicator measurement requiring client charts and employee files, the QA Reviewer will pick the appropriate charts or files, based on a computer list. For the indicator requiring evaluation of the on-call staff, these employees are randomly called (at unannounced intervals) throughout the quarter. The results of all are analyzed to identify trends.

3.0 CLIENT SATISFACTION SURVEY ANALYSIS.

3.1 **Sample**: All surveys returned each quarter will comprise the sample.

3.2 **Process**: The office director or designee will summarize the results and send them to headquarters at the end of each quarter. These will be summarized

per office and an overall summary for the summary for the company will be created.

4.0 ANALYSIS OF CLIENT AND EMPLOYEE INFECTIONS.

4.1 **Sample**: All data entered on Client Infection Reports and Incident Reports related to employee infection issues will be reviewed.

4.2 **Process**: The Office Director and/or designee will summarize the data collected on the Client Infections Reports and Incident Reports related to employee infection issues and submit the summary at the end of each quarter. The summary will be analyzed and infection rates will be determined. Client and employee infections will be analyzed and reported according to [policy 0-1575] and REPORTING OF CLIENT AND EMPLOYEE INFECTIONS.

5.0 ANALYSIS OF INCIDENT REPORTS.

5.1 **Sample**: All incident Reports completed during the quarter will be reviewed.

5.2 **Process**: The offices will submit all Incident Reports to headquarters by the end of the quarter. The Director of Client Services will review them and categorize them by type of incident. At the end of the quarter, the number of incidents/per category/per office will be sorted and trends identified.

6.0 UNANTICIPATED ADVERSE EVENTS AND SAFETY RISKS.

6.1 **Sample**: All incident reports are reviewed for potential adverse events and safety risks. The company selects at least one high-risk process to be analyzed per year.

6.2 **Process-** The process is described for each high-risk indicator that is chosen. The analysis includes:

- Identifying the ways in which the process could break down or fail to perform its described its desired function.
- Identifying the possible side effects that a breakdown or failure of the process could have on clients and their seriousness,
- Describing the potential process breakdowns or failures in order of priority,
- Determining of the reason(s) the prioritized breakdowns could occur, which may include performing a hypothetical root cause analysis,
- Redesigning the process and/or underlying systems to minimize the risk

of the effects on clients,
- Testing and implementing the redesigned process,
- Monitoring the effectiveness of the redesigned process.

7.0 QUARTERLY SUMMARY OF ALL QA ACTIVITIES.

7.1 **Sample**: All monitoring and evaluation activities conducted during the quarter are reviewed.

7.2 **Process**: The Chief Nursing Officer and/or designee will summarize all QA activities at the end of each quarter. The summary is then distributed to the President, Division Directors and Advisory Board Members.

8.0 STATE/PRGORAM SPECIFIC AMENDMENTS.

8.1 **Indiana.**
BAYADA's internal quality assurance and quality improvement will be:

a. focused on the client,
b. appropriate for the services being provided, and
c. ongoing and updated at least annually.

The system described in the internal quality assurance and quality improvement plan will include at least the following elements:

a. records of findings for client satisfaction surveys in accordance with contract guidelines. See [policy 0-314],
b. documentation of efforts to improve service delivery in response to the surveys of the client satisfaction survey,
c. an annual assessment of the appropriateness and effectiveness of each service provided to a client,

In addition written process includes the following:

a. analyzing data concerning:
    - reportable incidents.
    - services provided.
b. developing and reviewing recommendations to reduce risk of future incidents.

8.2 **New York.**

See [policy 0-6022] for further details.

0-403 - QUALITY ASSESSMENT AND QUALITY IMPROVEMENT IMPLEMENTATION

Version:	51.0 (26112)
Author(s):	LAUREL TRICE (1993); LAUREL TRICE (2004); HEATHER COTTOM (2005); ANNI GONZALEZ (2014)
Owner:	
Manual, Section:	ADMINISTRATIVE , QUALITY ASSESSMENT & IMPROVEMENT
References:	JCAHO QA .1; PI.3.20; COP 484.52, 484.14, 484.16; CHAP HHII.9a; CHAP PDII.8a;
Revisions:	Jan. 28, 2014; Jan. 28, 2014; Jan. 28, 2014; Jan. 28, 2014; Jan. 28, 2014; Nov. 14, 2005; Nov. 14, 2005; Jan. 01, 1993; Apr. 18, 1994; Aug. 19, 1996; Nov. 15, 1999; Jan. 1, 2004
Comments:	Conversion

0-525 ADVISORY BOARDS

This policy was adopted on Apr. 16, 1993 and last revised Feb. 20, 2017.

Our Policy:

There are Advisory Boards (Professional Advisory Committees) from which BAYADA Home Health Care and its managed entities receives guidance on client care, policy issues, and quality improvement initiatives.

Our Procedure:

1.0 MEMBERS AND TERMS.

Advisory Boards are comprised of at least one physician and one registered nurse, with appropriate representation from other professional disciplines. At least one member of the group is neither an owner or an employee. Each advisory board member is appointed for a one year term.

1.1 The Governing Body appoints all members of the company-wide and local office advisory boards, including any changes in membership as they occur. The appointments are documented in corporate minutes and facilitated through the Legal Services (LS) office.

2.0 PURPOSE.

The purposes of the Advisory Boards are as follows for the Home Health, Hospice, and/or Private Duty programs respective to the services an office provides:

a. to help establish and annually review policies and procedures, including those governing the scope of service, admission and discharge, medical supervision and plan of care, emergency care, clinical records, and personnel qualifications,
b. to review the Annual Program Evaluation,
c. to assist in maintaining liaison with other health care providers in the community and in the community education program,
d. to make recommendations for strategic planning,
e. to conduct biannual review of quality monitoring including record review, outcome studies, client satisfaction surveys, incident, complaint and organizational trends that are identified,
f. to make recommendations and provide direction for quality improvement

initiatives.

3.0 **STRUCTURE.**

There is a company advisory board which meets four (4) times per year and performs the functions described in section 2.0 for the programs and services of the company as a whole. Additionally, the group serves as an advisory board for Home Health and private duty programs as follows:

a. **Home Health** (Medicare Certified Services) - Each parent office and its respective branches has its own advisory board which is required to meet at least once per year and more frequently if required by state regulation as defined in section 3.1 below. At least once per year, the company advisory board conducts a review and advises on Home Health services for offices whose board meets less than twice per year. If Hospice services are provided, they are also reviewed as indicated above. See section 4.2 below and also [policy 0-521] for additional requirements associated with the local Advisory Boards and documentation of their activities.
b. **Home Care (Private Duty)** - Twice during the year, the company advisory board reviews and advises on the private duty program for offices that do not have an independent advisory board or one that meets less than twice per year.

3.1 Offices seeking **initial Medicare Certification as an independent provider** must obtain Governing Body approval and appointment of all members, and hold the first meeting of the local Advisory Board (PAC) **prior to the first client admission** . The agenda for the first meeting includes at a minimum:

a. Orientation and review of members responsibilities and meeting frequency,
b. Review and approval of policies and procedures,
c. Service and operational goals and challenges
d. Review of QA and performance improvement process and how information related to trends will be communicated to the PAC, i.e. chart audit tools, adverse event data, infection data, complaints and incidents, etc.

See interpretative guidance from the Community Health Accreditation Program .

3.2 **State-specific Requirements for Local Professional Advisory**

Committee/Board Meetings.
Meetings of the local Professional Advisory committee of the parent office and its branch(es) must meet at the following frequency in accordance with state regulations:

State	Frequency
Connecticut	Twice per year
Delaware	Twice per year
New Jersey	Twice per year-Home Health
New Mexico	Twice per year
New York	Four times per year (quarterly)
Rhode Island	Twice per year
Managed Entities	Twice per year

4.0 **MINUTES.**

Accurate and complete minutes of all meetings are signed, dated and maintained. Minutes reflect the specific office locations and programs reviewed during the meetings. Copies of the minutes from the company Advisory Board meetings are provided to all offices quarterly via web publication and will include any recommendations or guidance for the offices.

4.1
a. Minutes - June 11, 2008
b. Minutes - Sept. 10, 2008
c. Minutes - December 3, 2008
d. Minutes - March 18, 2009
e. Minutes - June 17, 2009
f. Minutes - September 16, 2009
g. Minutes - December 16, 2009
h. Minutes - March 10, 2010
i. Minutes - June 16, 2010
j. Minutes - September 15, 2010
k. Minutes - December 15, 2010
l. Minutes - March 16, 2011
m. Minutes - June 15, 2011
n. Minutes - September 14, 2011
o. Minutes - December 14, 2011
p. Minutes - March 7, 2012
q. Minutes - June 6, 2012
r. Minutes - September 5, 2012
s. Minutes - December 11, 2012
t. Minutes - March 6, 2013
u. Minutes - June 12, 2013

v. Minutes - September 11, 2013
w. Minutes - December 4, 2013
x. Minutes - March 5, 2014
y. Minutes - June 4, 2014
z. Minutes - September, 3 2014
aa. Minutes - December 3, 2014
bb. Minutes - March 4, 2015
cc. Minutes - June 3, 2015
dd. Minutes - September 1, 2015
ee. Minutes - December 2, 2015
ff. Minutes - March 2, 2016
gg. Minutes- June 1, 2016
hh. Minutes- September 7, 2016
ii. Minutes- December 7, 2016

5.0 RELATED POLICIES.

a. [policy 0-7308]
b. [policy 0-972]

6.0 STATE/PROGRAM SPECIFIC AMENDMENT.

6.1 Colorado.

Minutes of each local Advisory Board (PAC) meeting are submitted by the agency administrator to the Governing Body for review and approval, and documented in Corporate Minutes. The minutes are submitted through the Legal Services Office (LS). Specific direction from the Governing Body to the local office/branches on any actions to be taken based on this review are communicated via the Practice Leader or Chief Operating Officer.

6.2 New York.

See [policy 0-6022] for further details.

6.3 Virginia.

The Advisory Board members meet the membership requirements for a quality improvement committee.

0-525 - ADVISORY BOARDS

Version:	79.0 (40448)
Author(s):	ANNE JOHNSON (2008); ANNE JOHNSON (2009); ANNE JOHNSON (2012); KIM CUNNINGHAM (2017); ANNE JOHNSON (2017)
Owner:	
Manual, Section:	ADMINISTRATIVE , GOVERNANCE AND MANAGEMENT
References:	JCAHO GM.11; CHAP HHI.2d; CHAP PDI.2c; COP 484.16; 484.52; DE Administrative Code Title 16, 4410 Skilled Home Health Agencies Licensure 5.2.3; CT Licensure of Home Health Care Agencies, 19-13-D68(c); RI Rules and Regulations for Licensing Home Nursing Care Providers and Home Care Providers Part V 21.4
Revisions:	Feb. 20, 2017; Feb. 20, 2017; Feb. 20, 2017; Feb. 20, 2017; Feb. 20, 2017; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Jan. 31, 2014; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 27, 2012; Feb. 01, 2010; Feb. 01, 2010; Feb. 01, 2010; Feb. 01, 2010; Feb. 01, 2010; Feb. 01, 2010; Jul. 17, 2008; Jul. 17, 2008; Jul. 17, 2008; Jul. 17, 2008; Jul. 17, 2008; Jul. 17, 2008; Apr. 16, 1993; Jul. 13, 1994
Comments:	Conversion