



# Welcome

Achieving ACHC Home Health Accreditation  
Revisions to the ACHC Standards

# OBJECTIVES

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- Review the ACHC Accreditation Standard revisions to understand expectations for compliance

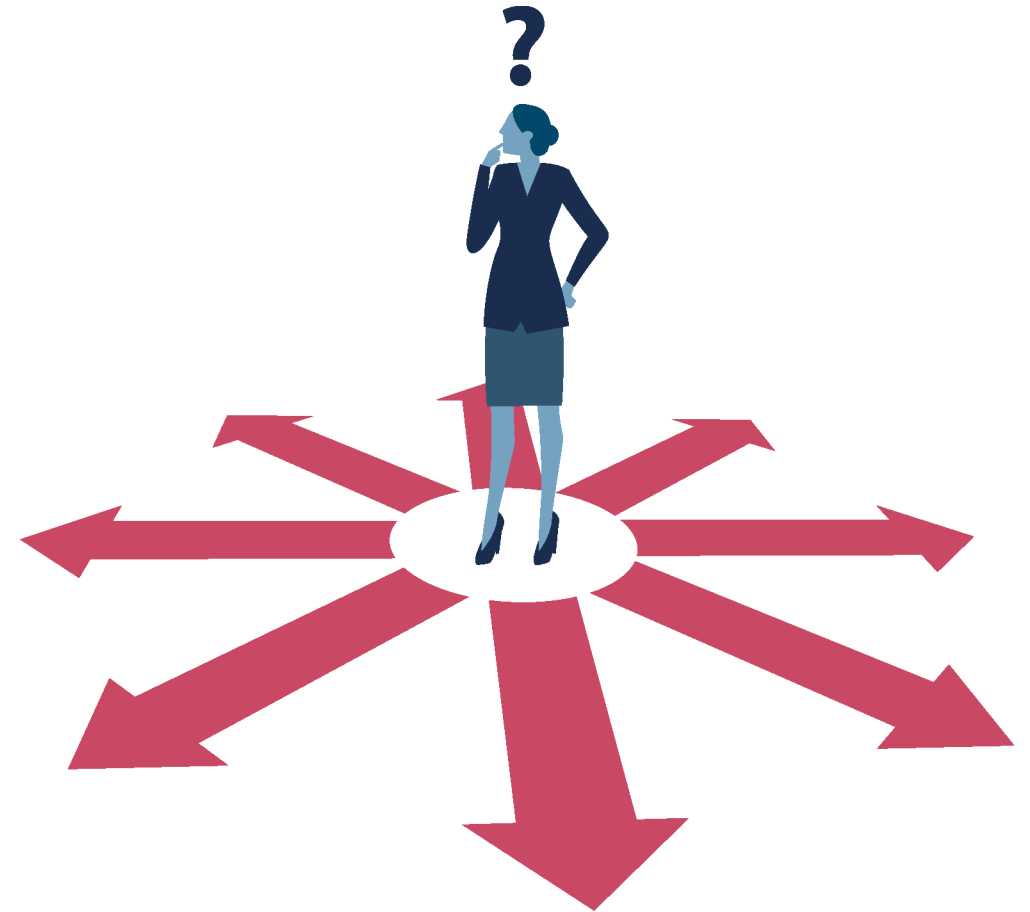


# ACHIEVING A SUCCESSFUL SURVEY OUTCOME

## UNDERSTANDING THE ACHC STANDARDS

# CONFLICTING REGULATIONS

- Conditions of Participation (CoPs)
- State regulations
- ACHC Accreditation Standards
- Agency policies & procedures
- Discipline-specific scopes of practice



# MOST STRINGENT REGULATION

- Must be in compliance with the most stringent regulation in order to be determined compliant with ACHC Accreditation Standards





# SECTION 1

## Organization and Administration

# STANDARD REVISIONS



No new standards

Deleted standards:

HH1-3A: PAC

HH1-3A.01: PAC Orientation

HH1-3A.02: List of PAC members

HH1-3B: PAC review of policies and annual meeting requirement

And any other reference or requirement for a PAC member

HH1-5B: Alternate Administrator

HH1-10B: Monitoring care under contract

*Before discontinuing the PAC, check state requirements and agency policies*

# STANDARD REVISIONS

Standard HH1-1A.01: The HHA is in compliance with all applicable federal, state, and local laws and regulations.



## **Added: Section 1557 of the Patient Protection and Affordable Care Act**

Section 1557 is the nondiscrimination provision of the Affordable Care Act (ACA). The law prohibits discrimination on the basis of race, color, national origin, sex, age, or disability in certain health programs or activities.



<https://www.hhs.gov/civil-rights/for-individuals/section-1557>



# STANDARD REVISIONS

Standard HH1-2A: The HHA is directed by a governing body/owner (if no governing body is present, owner suffices), which assumes full legal authority and responsibility for the operation of the HHA. The governing body/owner duties and accountabilities are clearly defined. 484.105(a)



Removed the requirement of: Arranging for professional advice and reviewing the annual program evaluation

Added: Oversight of operation plans

Changed: PI to QAPI

# STANDARD REVISIONS

Standard HH1-2A.03: Governing body members receive an orientation to their responsibilities and accountabilities.



Added: Oversight of operation plans

Changed: PI to QAPI

# STANDARD REVISIONS

Standard HH1-5A: There is an individual who is designated as responsible for the overall operation and services of the HHA. The Administrator organizes and directs the HHA's ongoing functions and maintains ongoing liaison among the governing body/owner and the personnel. 484.105(b), 484.105(b)(1)(i-iv), 484.105(b)(2), 484.105(b)(3)



Expanded the role of the Administrator:

- Is responsible for all day-to-day operations of the HHA
- Ensures that a clinical manager as described in regulation 484.105(c) is available during all operating hours
- Ensures that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies
- When the Administrator is not available, a qualified, pre-designated person, who is authorized in writing by the Administrator and the governing body, assumes the same responsibilities and obligations as the Administrator. The pre-designated person may be the clinical manager
- The Administrator or a pre-designated person is available during all operating

# STANDARD REVISIONS

Standard HH1-6B: There is one or more individual who is qualified to act as clinical manager. A clinical manager is a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or a Registered Nurse. A clinical manager must provide oversight of all patient care services and personnel. This person, or a similarly qualified alternate, is available at all times during business hours and participates in all activities relevant to the professional services furnished. Administrative and supervisory functions are not delegated to another agency or organization. 484.105(c), 484.105(c)(1), 484.105(c)(2), 484.105(c)(3), 484.105(c)(4), 484.105(c)(5)



The clinical managers are responsible for the direction, coordination, and supervision of services.

- Making patient and personnel assignments
- Coordinating patient care
- Coordinating referrals
- Ensuring that patient needs are continually assessed
- Ensuring the development, implementation, and updates of the individualized plan of care

# STANDARD REVISIONS

Standard HH1-10A: An HHA that uses outside personnel to provide care/services on behalf of the HHA has a written contract/agreement for care furnished. The contract/agreement contains all requirements and is kept on file within the HHA.



The agency, organization, or individual providing services under arrangement may not have:

- Been denied Medicare or Medicaid enrollment;
- Been excluded or terminated from any federal healthcare program or Medicaid;
- Had its Medicare or Medicaid billing privileges revoked; or
- Been debarred from participating in any government program

<https://oig.hhs.gov/exclusions>

<https://oig.hhs.gov/exclusions/advisories.asp>

<https://www.sam.gov/portal/SAM/##11#1>



# SECTION 2

## Program/Service Operations

# STANDARD REVISION



No new standards

Deleted standards:

HH2-2B: Patient right to be informed of their care

HH2-3A.01→HH2.3A

HH2-5B: Disclosure of clinical records

HH2-6B→ HH2-6B.02: Advance Directive information

# STANDARD REVISIONS

Standard HH2-2A: Written policies and procedures are established and implemented by the HHA in regard to the creation and distribution of the Patient Rights and Responsibilities statement. 484.50, 484.50(a), 484.50(a)(1), 484.50(a)(1)(i-iii), 484.50(a)(2), 484.50(a)(3), 484.50(a)(4), 484.50(b), 484.50(b)(1-3), 484.50(c), 484.50(c)(1-3), 484.50(c)(4), 484.50(c)(4)(i-viii), 484.50(c)(5), 484.50(c)(6), 484.50(c)(7), 484.50(c)(7)(i-iv), 484.50(c)(8), 484.50(c)(9), 484.50(c)(10), 484.50(c)(10)(i-v), 484.50(c)(11), 484.50(c)(12),



Provide contact information for the HHA Administrator (name, business address and business phone number);

Information of transfer and discharge policies and procedures;

Participate in and be informed about and consent or refuse care in advance of and during treatment;

Be advised of the names, addresses and telephone number of:

- I. Agency on Aging
- II. Center for Independent Living
- III. Protection and Advocacy Agency
- IV. Aging and Disability Resource Center
- V. Quality Improvement Organization



# STANDARD REVISIONS

Standard HH2-2A: Written policies and procedures are established and implemented by the HHA in regard to the creation and distribution of the Patient Rights and Responsibilities statement. 484.50, 484.50(a), 484.50(a)(1), 484.50(a)(1)(i-iii), 484.50(a)(2), 484.50(a)(3), 484.50(a)(4), 484.50(b), 484.50(b)(1-3), 484.50(c), 484.50(c)(1-3), 484.50(c)(4), 484.50(c)(4)(i-viii), 484.50(c)(5), 484.50(c)(6), 484.50(c)(7), 484.50(c)(7)(i-iv), 484.50(c)(8), 484.50(c)(9), 484.50(c)(10), 484.50(c)(10)(i-v), 484.50(c)(11), 484.50(c)(12),



- Provide written notice of the patient's rights and responsibilities to a patient-selected representative within 4 business days of the initial evaluation visit.
- Language assistance should be provided through the use of competent bilingual staff, staff interpreters, contracts, formal arrangements with local organizations providing interpretation, translation services, or technology and telephonic interpretation services.
- Informed consent and patient participation takes place on an ongoing basis as care changes and evolves during the episodes of care, initially and as changes occur in the care.

# STANDARD REVISIONS

Standard HH2-4B: The HHA provides the patient with written information concerning how to contact the HHA, appropriate state agencies, and ACHC concerning grievances/complaints at time of admission. 484.50(c)(3), 484.50(e), 484.50(e)(1), 484.50(e)(1)(i), 484.50(e)(1)(i)(A), 484.50(e)(1)(ii), 484.50(e)(1)(iii)



Be advised of the names, addresses, and telephone numbers of the following federally-funded and state-funded entities that serve the area where the patient resides:

- Agency on Aging
- Center for Independent Living
- Protection and Advocacy Agency
- Aging and Disability Resource Center
- Quality Improvement Organization

# STANDARD REVISIONS

Standard HH2-6A: Written policies and procedures are established by the HHA in regard to the patient's right to make decisions about medical care, accept or refuse medical care, patient resuscitation, and surgical treatment.  
484.50(c)(4), 484.50(c)(4)(i-viii)



- The patient has the right to participate in, be informed about, and consent or refuse care with respect to:
  - Completion of all assessments
  - The care to be furnished, based on the comprehensive assessment
  - Establishing and revising the plan of care
  - The disciplines that will furnish the care
  - The frequency of visits
  - Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits
  - Any factors that could impact treatment effectiveness
  - Any changes in the care to be furnished

*The patient's informed consent on the items is not intended to be a single signed form*

# STANDARD REVISIONS

Standard HH2-8A: Written policies and procedures are established and implemented by the HHA in regard to the provision of care/service to patients and families with communication or language barriers. 484.50(f), 484.50(f)(1), 484.50(f)(2)



- *Was an ACHC-only requirement; now a CoP*

Information must be provided to patients in plain language and in a manner that is accessible and timely to:

- Persons with disabilities, including accessible web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.
- Persons with limited English proficiency through the provision of language services at no cost to the individual, including oral interpretation and written translations

CMS allows a wide definition of “auxiliary aides and services”



# SECTION 3

## Fiscal Management

# STANDARD REVISIONS



No new standards

No deleted standards

# STANDARD REVISIONS

HH3-4C: The patient is advised orally and in writing of the charges for care/service at, or prior to, the receipt of care/services. The HHA must advise the patient of changes both orally and in writing as soon as possible, in advance of the next home visit. Patients who are Medicare or Medicaid eligible are informed when Medicare/Medicaid assignment is accepted. (484.50(c)(7), 484.50(c)(7)(i-iv))



- Any changes in the information provided in accordance with 42 CFR 484.50(c)(7) when they occur. The HHA must advise the patient and representative (if any) of these changes as soon as possible, in advance of the next home health visit.

If, after the services begin, a change occurs in the patient status which necessitates new services being added, the same notification must occur regarding extent of payment and patient liability, prior to the beginning of the new services.



# SECTION 4

## Human Resource Management



# STANDARD REVISIONS



ACHC revision to HH4-1A.02:

For contract staff the organization must have access to all of the above items, except position application, withholding statement, I-9, and personnel handbook.

No new standards

No deleted standards

HH4-2B→HH4-2B.01: Credentialing activities

HH4-2I→HH4-2I.01: Employee handbook/Personnel policies

HH4-2J→HH4-2J.01: Annual performance evaluations

HH4-4A→HH4-4A.01: Education and training requirements

HH4-10A→HH4-10A.01: Requirements to administer pharmaceuticals

# STANDARD REVISIONS



Deleted standards:

HH4-11A: Skilled nursing services

HH4-11B: LPN/LVN services

HH4-11C: Therapy services

HH4-11D: PTA services

HH4-11E: COTA services

HH4-11F: Social work services

HH4-11G: Social work assistants

HH4-12D: Documentation of completed aide training

HH4-12E: Documentation of completed aide competency

# STANDARD REVISIONS

Standard HH4-2C.01: Written policies and procedures are established and implemented in regard to all direct care personnel having initial Tuberculosis (TB) testing and the agency's need to conduct an annual TB risk assessment.



Upon hire tuberculosis testing is performed on all direct care personnel. The testing could be a skin or blood test. An annual risk assessment is used to determine the need, type, and frequency of screening/testing for direct care personnel.

*One step unless state or agency policy requires differently and regardless of any previous testing.*

# STANDARD REVISIONS

Standard HH4-11H: All Home Health Aide Services are provided by qualified personnel in accordance with the state's occupational certification regulations, where applicable, federal regulations and the HHA's policies and procedures and/or job descriptions and ACHC Glossary of Personnel Qualifications as defined by Medicare's Conditions of Participation 484.80, 484.80(a), 484.80(a)(1), 484.80(a)(1)(i), 484.80(a)(1)(ii), 484.80(a)(1)(iii), 484.80(a)(1)(iv), 484.80(a)(2)



- A training and competency evaluation program as specified in 42 CFR 484.80 (b) and (c); or
- A competency evaluation program that meets the requirements of 42 CFR 484.80(c); or
- A nurse aide training and competency evaluation program approved by the state as meeting the requirements of 42 CFR 483.151 through 42 CFR 483.154, and is currently listed in good standing on the state nurse aide registry; or
- The requirements of a state licensure program that meets the provisions of 42 CFR 484.40(b) and (c).

# STANDARD REVISIONS

HH4-12A: For HHAs that conduct a Home Health Aide training program, the HHA meets all of the requirements of the Medicare Conditions of Participation. 484.80(b), 484.80(b)(1), 484.80(b)(2), 484.80(b)(3), 484.80(b)(3)(i-viii), 484.80(b)(3)(ix)(A-F), 484.80(b)(3)(x-xv) 484.80(b)(4)



Communication skills in regard to the aide's ability to read, write, and verbally report clinical information to patients, representatives, caregivers, and other HHA staff; and recognizing and reporting changes in skin condition.

For individuals who met the qualification requirements for HHA aides prior to January 13, 2018, new training content in these requirements may be completed via in-service training.

Sponge, tub, and shower bath

Hair shampooing in sink, tub, and bed

Change for all aides hired after January 13, 2018

# STANDARD REVISIONS

Standard HH4-12B: A Home Health Aide training program and competency evaluation program may be offered by any organization except an HHA that, within the previous two years, has been found out of compliance with Medicare Conditions of Participation. 484.80(c)(2), 484.80(f), 484.80(f)(1), 484.80(f)(2), 484.80(f)(3), 484.80(f)(4), 484.80(f)(5), 484.80(f)(6), 484.80(f)(7), 484.80(f)(7)(i-vi)



Added: Been excluded from participating in federal health care programs or debarred from participating in any government program.

<https://oig.hhs.gov/exclusions>

<https://oig.hhs.gov/exclusions/advisories.asp>

<https://www.sam.gov/portal/SAM/##11#1>

# STANDARD REVISIONS

HH4-12F: For HHAs that conduct an Home Health Aide competency evaluation program, the HHA meets all of the requirements of the Medicare Conditions of Participation. 484.80(c), 484.80(c)(1)



Each of the tasks must be observed in its entirety to confirm the competence of the HHA aide. The tasks must not be simulated in any manner and the use of a mannequin is not an acceptable substitute.

- Sponge, tub, **and** shower bath;
- Hair shampooing in sink, tub, **and** bed;

# STANDARD REVISIONS

Standard HH4-14A: Aides providing skilled or personal care services are supervised in those tasks in the patient's home as appropriate to the service level provided. 484.80(h), 484.80(h)(1)(i-iii), 484.80(h)(2), 484.80(h)(3), 484.80(h)(4), 484.80(h)(4)(i-vi), 484.80(h)(5), 484.80(h)(5)(i-iii)



- Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional;
- Maintaining an open communication process with the patient, representative (if any), caregivers, and family;
- Demonstrating competency with assigned tasks;
- Complying with infection prevention and control policies and procedures;
- Reporting changes in the patient's condition; and
- Honoring patient rights.

Each element of this standard needs to be evaluated on each aide supervisory visit and documented in the medical record.





# SECTION 5

## Provision of Care and Record Management

# STANDARD REVISIONS



New standards: HH5-3C: Written patient instructions

Deleted standards:

HH5-2D: Completion of comprehensive assessment

HH5-4B.01: Case manager

HH5-7A: Discharge process

HH5-9A: Patient participation in the plan of care

HH5-11B: Duties of LPN/LVN

HH5-11C: Duties of therapists

# STANDARD REVISIONS



Deleted standards:

HH5-11C: Duties of therapists

HH5-11D: Duties of therapy assistants

HH5-11E: Duties of medical social worker

HH5-12A: Patient education

HH5-14A.01: Eligibility requirements

HH5-15A.01: Referral process

# STANDARD REVISIONS

Standard HH5-1A: There is a patient record for each individual who receives care/service that contains all required documentation. All entries are legible, clear, complete, and appropriately authenticated, and dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. 484.110, 484.110(a), 484.110(a)(1), 484.110(a)(2), 484.110(a)(3), 484.110(a)(4), 484.110(a)(5), 484.110(b)



Minor changes to the content of the medical record

Clinical note means a notation of a contact with a patient that is written, **timed**, and dated, and which describes signs and symptoms, treatment, drugs administered and the patient's reaction or response, and any changes in physical or emotional condition during a given period of time.

# STANDARD REVISIONS

Standard HH5-1B: Written policies and procedures are established and implemented that address access, storage, removal, and retention of patient records and information. 484.110(c), 484.110(c)(1), 484.110(c)(2), 484.110(d), 484.110(e)



Decreased record retention from 7 years to 5 years unless state law is more stringent

When an HHA discontinues operation, it must inform the state agency where clinical records will be maintained

A patient's clinical record (whether hard copy or electronic form) must be made available to a patient, free of charge, upon request at the next home visit, or within 4 business days (whichever comes first)

# STANDARD REVISIONS

Standard HH5-2C: Written policies and procedures are established and implemented in regard to the comprehensive assessment being completed in a timely manner, consistent with patient's immediate needs, but no later than 5 calendar days after the start of care. 484.55, 484.55(b), 484.55(b)(1), 484.55(b)(2), 484.55(b)(3), 484.55(c), 484.55(c)(1), 484.55(c)(2), 484.55(c)(3), 484.55(c)(4), 484.55(c)(6)(i-ii), 484.55(c)(7), 484.55(c)(8)



Minor changes to the content of the comprehensive assessment:

Head to toe assessment

The patient's primary caregiver(s), if any, and other available supports, including their:

- Willingness and ability to provide care
- Availability and schedules

Identification of the patient's representative

Emergency preparedness

# STANDARD REVISIONS

Standard HH5-2E: The comprehensive assessment is updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but no less frequently than described in interpretive guidelines. 484.55(d), 484.55(d)(1), 484.55(d)(1)(i-iii), 484.55(2), 484.55(3)



Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason except diagnostic tests or on physician-ordered resumption date.

# STANDARD REVISIONS

Standard HH5-2F: The comprehensive assessment includes a review of all medications the patient is currently using, both prescription and non-prescription. The drug regimen review occurs as an ongoing part of the care to the patient. 484.55(c)(5)



ACHC: Route to medication profile

The patient's clinical record should reflect all medications, including times of administration and route, that the patient is taking both prescription and non-prescription.

In therapy only cases, the therapist submits a list of the medications, which he/she collects during the comprehensive assessment, to a HHA nurse for review. The HHA should contact the physician if indicated.



# STANDARD REVISIONS

Standard HH5-3A: There is a written plan of care for each patient accepted to services. 484.60, 484.60(a), 484.60(a)(1), 484.60(a)(2), 484.60(a)(2)(i-xvi), 484.60(a)(3)



Minor additions to the plan of care:

- A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.

All patient care orders, including verbal orders, must be recorded in the plan of care.

The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and the measurable outcomes that the HHA anticipates will occur .



# STANDARD REVISIONS

Standard HH5-3C: The HHA must provide the patient and caregiver with a copy of written instruction in regard to care to be provided. 484.60(e), 484.60(e)(1), 484.60(e)(2), 484.60(e)(3), 484.60(e)(4), 484.60(e)(5)



The HHA must provide the patient and caregiver with a copy of written instructions outlining:

- Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA
- Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA
- Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services
- Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs
- Name and contact information of the HHA clinical manager

# STANDARD REVISIONS

Standard HH5-4A: All personnel involved in the patient's care are responsible for coordinating care effectively to support the objectives outlined in the patient's plan of care. 484.60(d), 484.60(d)(1-5)



The HHA coordinates care by:

- Ensuring communication with all physicians involved in the plan of care
- Integrating orders from all physicians involved in the plan of care to ensure the coordination of all services and interventions provided to the patient
- Integrating services, whether services are provided directly or under arrangement, to ensure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines

# STANDARD REVISIONS



Standard HH5-4A: Continued:

- Coordinating care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities
- Ensuring that each patient, and his or her caregiver(s) where applicable, receives ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge

# STANDARD REVISIONS



For this requirement physicians involved in the plan of care are those physicians who give orders that are directly related to home health skilled services.

Upon admission or upon any change in patient condition, the responsible physician identifies any other relevant physicians that should be contacted for orders to be included in the HHA plan of care. The clinical manager or other staff designated by the HHA is responsible for integrating orders from all relevant physicians involved in the HHA plan of care and ensuring the orders are approved by the responsible physician.

# STANDARD REVISIONS

Standard HH5-6A: Written policies and procedures are established and implemented in regard to the process for transferring or discharging a patient receiving Home Health Services. 484.50(c)(8), 484.50(d), 484.50(d)(1), 484.50(d)(2), 484.50(d)(3), 484.50(d)(4), 484.50(d)(5), 484.50(d)(5)(i-iv), 484.50(d)(6), 484.50(d)(7), 484.110(a)(6)(i-iii)



Transfer or discharge a patient when:

- It is necessary for the patient's welfare because the HHA and the physician agree the HHA can no longer meet the patient's needs
- The patient or payor will no longer pay for services
- The goals of the patient have been met
- Patient choice
- Patient dies
- HHA ceases to operate

# STANDARD REVISIONS



Standard HH5-6A: Continued:

- • Discharge for cause:
  - Behavior of patient or caregiver interferes with the HHA's ability to provide care
    - HHA must have an established policy
    - HHA must advise patient or representative discharge is being considered
    - HHA must make efforts to resolve the issue
    - HHA must provide patient or representative with contact information of other agencies that may be able to provide care
    - HHA must document all problems and efforts to resolve problems
- Discharge summary sent within 5 business day of discharge
- Transfer summary is sent within 2 business days of planned transfer or 2 business days of becoming aware of unplanned transfer if patient still receiving healthcare services

# STANDARD REVISIONS

Standard HH5-8A: Written policies and procedures are established and implemented in regard to verbal orders only being accepted by personnel authorized to do so by applicable state and federal laws and regulations, as well as by the HHA's policies and procedures. 484.60(b)(3), 484.60(b)(4)



Qualified staff must document the orders in the patient's clinical record, and sign, date and **time** the orders.



# STANDARD REVISIONS

Standard HH5-8B: The HHA's personnel promptly alert the physician(s) to any changes in the patient's condition or needs that suggest outcomes are not being achieved and/or that the plan of care should be altered. 484.60(c)(1), 484.60(c)(2), 484.60(c)(3), 484.60(c)(3)(i-ii)



- Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians issuing orders for the HHA plan of care
- Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient's primary care practitioner or other healthcare professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any)

# STANDARD REVISIONS

Standard HH5-11A: The HHA furnishes skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, occupational therapy, physician and medical social work. 484.75, 484.75(a), 484.75(b), 484.75(b)(1-9), 484.75(c), 484.75(c)(1-3)



This combines HH4-11A, HH5-11A, B, D & E

Skilled professionals must assume responsibility for, but not be restricted to, the following:

- Ongoing interdisciplinary assessment of the patient
- Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s)
- Providing services that are ordered by the physician as indicated in the plan of care
- Patient, caregiver, and family counseling
- Patient and caregiver education

# STANDARD REVISIONS



Standard HH5-11A: Continued:

- Preparing clinical notes
- Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care
- Participation in the HHA's QAPI program; and
- Participation in HHA-sponsored in-service training
- Supervision of skilled professional assistants
  - A visit to patient's home by qualified supervising professional, with or without the assistants present, at least every 60 days, unless state laws requires more frequently
  - Patient record reviews, conferences, ongoing communication
  - Collaborative care planning
- Supervisory visits are documented in patient records

# STANDARD REVISIONS

Standard HH5-11F: The HHA defines the duties of the Home Health Aide and ensures they are implemented in patient care. 484.80(g), 484.80(g)(1), 484.80(g)(2), 484.80(g)(2)(i-iv), 484.80(g)(3)(i-iv), 484.80(g)(4)



The Home Health Aide is assigned to a specific patient by the Registered Nurse or other appropriate skilled professional with written patient care instructions for the Home Health Aide prepared by the Registered Nurse or other appropriate skilled professional (that is, physical therapist, speech-language pathologist, or occupational therapist).

# STANDARD REVISIONS



Standard HH5-11F: Continued:

A home health aide provides services that are:

- (i) Ordered by the physician;
- (ii) Included in the plan of care;
- (iii) Permitted to be performed under state law; and
- (iv) Consistent with the home health aide training.

# STANDARD REVISIONS



Standard HH5-11F: Continued:

The duties of a home health aide include:

- (i) The provision of hands-on personal care;
- (ii) The performance of simple procedures as an extension of therapy or nursing services;
- (iii) Assistance in ambulation or exercises; and
- (iv) Assistance in administering medications ordinarily self-administered

# STANDARD REVISIONS

Standard HH5-14B.01: The HHA obtains a statement of certification from the physician that the patient is eligible for the Medicare Home Health Care benefit.



Did not change the requirement; changed the interpretation to reflect the requirements per the Medicare Benefits Policy Manual section 30.5.1



# SECTION 6

Quality Outcomes/Performance Improvement



# STANDARD REVISIONS



Deleted standards:

HH6-2A: Annual program evaluation

HH6-4A→HH6-4A.07: Quarterly chart audit

# STANDARD REVISIONS

Standard HH6-1A: The HHA must develop, implement, evaluate and maintain an effective, ongoing, HHA-wide, data-driven Quality Assessment and Performance Improvement (QAPI) program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS. The HHA measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, services, and operations. 484.65, 484.65(a), 484.65(a)(1-2), 484.65(b), 484.65(b)(1), 484.65(b)(2), 484.65(b)(2)(i-ii), 484.65(b)(3), 484.65(c), 484.65(c)(1), 484.65(c)(1)(i-iii), 484.65(c)(2), 484.65(c)(3), 484.65(d), 484.65(d)(1), 484.65(d)(2)

# STANDARD REVISIONS



Standard HH6-1A: Continued:

Now a CoP!

The HHA's performance improvement activities must:

- Focus on high-risk, high-volume, or problem-prone areas;
- Consider incidence, prevalence, and severity of problems in those areas; and
- Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.
- Performance improvement activities must track adverse patient and personnel events, analyze their causes, and implement preventive actions.
- The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained.

Beginning July 13, 2018 HHAs must conduct performance improvement projects

# STANDARD REVISIONS

Standard HH6-1C: There is evidence of involvement of the governing body/owner and organizational leaders in the Quality Assessment and Performance Improvement (QAPI) process. 484.65(e), 484.65(e)(1), 484.65(e)(2), 484.65(e)(3), 484.65(e)(4)



## Now a CoP!

The governing body is ultimately responsible for all actions and activities of the HHA QAPI program  
QAPI program requirements:

- Focuses on safety with clear expectations for patients safety
- Identifies priorities for improved quality of care
- Findings of fraud or waste are addressed

# STANDARD REVISIONS

Standard HH6-5A: Quality Assessment and Performance Improvement (QAPI) activities focus on high-risk, high-volume, or problem-prone areas; considering incidence, prevalence and severity of problems in those areas. (Was HH6-5A.03) 484.65(c)(1)(i), 484.65(c)(1)(ii), 484.65(c)(1)(iii)



High-risk areas may include global concerns such as a type of service such as pediatrics, geographic concerns such as the safety of a neighborhood served or specific patient care services such as administration of intravenous medications or tracheostomy care. All factors would be associated with significant risk to the health or safety of patients.

High-volume areas refers to care or service areas that are frequently provided by the HHA to a large patient population, thus possibly increasing the scope of the problem (e.g. laboratory testing, physical therapy, infusion therapy, diabetes management).

Problem-prone areas refers to the potential for negative outcomes that are associated with a diagnosis or condition for a particular patient group or a particular component of the HHA operation.



# SECTION 7

Risk Management: Infection and Safety Control

# STANDARD REVISIONS



Deleted standards:

HH7-3A.01: Disaster situations

# STANDARD REVISIONS

Standard HH7-1A: Written policies and procedures are established and implemented that address the surveillance, identification, prevention, control and investigation of infectious and communicable diseases and the compliance with regulatory standards. 484.70, 484.70(a), 484.70(c)



Now a CoP!

No change in the current practice for ACHC customers



# STANDARD REVISIONS

Standard HH7-1D: The HHA reviews and evaluates the effectiveness of the infection control program.  
484.70(b), 484.70(b)(1), 484.70(b)(2)



## Now a CoP!

The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include:

- The HHA has a method for identifying infectious and communicable disease problems; and
- A plan for appropriate actions that are expected to result in improvement and disease prevention

# STANDARD REVISIONS

Standard HH7-3A: Written policies and procedures and an Emergency Preparedness Plan outline the process for meeting patient and personnel needs in a disaster or crisis situation. (484.22), 484.102, E-0001, (484.22(a)), 484.102(a),(484.22(a)(1-4)), 484.102(a)(1-4) E-0004, E-0006, E-0007, E-0009



## Emergency Plan

- Strategies are based on a facility-based and community-based all-hazards risk assessment
- Policies and procedures
- Communication plan
- Training and testing
- Integrated healthcare systems

# EMERGENCY PREPAREDNESS

The plan **must do all** of the following:

- 1) Be based on and include a documented, facility-based and community-based risk assessment, utilizing an all-hazards approach.
- 2) Include strategies for addressing emergency events identified by the risk assessment.
- 3) Address patient population, including, but not limited to, the type of services the agency has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.
- 4) Include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the agency's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

The plan must be reviewed and updated at least annually.

# “ALL HAZARDS” APPROACH

- Identifies all possible risks associated within the communities you serve
- Comprehensive of all locations per Medicare provider number, branches, multiple locations
- Consider the patient population served
- Need to encompass natural disasters and man-made threats
- Rank order priorities based on potential of a threat, risk associated with the threat and agency's current preparedness for the threat
- Reach out to others in community who have experience with emergency preparedness
  - Emergency Management, police, fire departments
  - Hospitals
  - Red Cross

# HAZARD VULNERABILITY ASSESSMENT

HAZARD VULNERABILITY ASSESSMENT (Sample)												
EVENT	PROBABILITY			RISK/DISRUPTION					PREPAREDNESS			TOTAL SCORE
Score	HIGH	MED	LOW	Loss of life	Safety	HIGH	MED	LOW	Poor	Fair	Good	
	3	2	1	5	4	3	2	1	3	2	1	
Hurricane			1				2			2		5
Tornado		2					2			2		6
Blizzard			1			3			3			7
Ice storm		2			4						1	7
Earthquake			1					1	3			5
Drought			1					1		2		4
Flood			1				2			2		5
Epidemic	3					3			3			9
Fire, internal		2				3				2		8
Internal flood damage		2				3			3			8
Cyberattack	3					3			3			9
Supply shortage			1				2				1	4
Staffing shortage		2				3					1	6
Act of terrorism		2		5					3			10

# EMERGENCY PREPAREDNESS

## Policies and procedures

The agency must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be **reviewed and updated at least annually**. At a minimum, the policies and procedures must address the following:

# POLICIES AND PROCEDURES

Policies address the procedures for:

- The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at §484.55.
- Follow up with on duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform state and local officials of any on-duty staff and patients that they are unable to contact.
- Procedure to informing the state and local officials about patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

# POLICIES AND PROCEDURES

- A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.
- The use of volunteers in an emergency and other emergency staffing strategies, including the process and role for integration of State and Federally designed health care professionals to address surge needs during an emergency.



# COMMUNICATION PLAN

Communication plan.

The agency must develop and maintain an emergency preparedness communication plan that complies with Federal, State, and local laws and must be reviewed and updated at least **annually**.

The communication plan must include all of the following:

- 1) Names and contact information for the following:
  - i. Staff
  - ii. Entities providing services under arrangement
  - iii. Patients' physicians
  - iv. Volunteers

# COMMUNICATION PLAN

- 2) Contact information for the following:
  - i. Federal, State, tribal, regional, or local emergency preparedness staff
  - ii. Other sources of assistance
- 3) Primary and alternate means for communicating with the HHA staff, Federal, State, tribal, regional, and local emergency management agencies.
- 4) A method for sharing information and medical documentation for patients under the HHA's care, as necessary, with other healthcare providers to maintain the continuity of care.
- 5) A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).
- 6) A means of providing information about the HHA's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

# TRAINING AND TESTING

Training and testing.

The HHA must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. **The training and testing program must be reviewed and updated at least annually.**

# TRAINING AND TESTING

Training program.

The agency must do all of the following:

- i. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.
- ii. Provide emergency preparedness training at least annually.
- iii. Maintain documentation of the training.
- iv. Demonstrate staff knowledge of emergency procedures.

# TRAINING AND TESTING

Testing.

The agency must conduct exercises to test the emergency plan at least annually. The agency must do the following:

- i. Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.

# TRAINING AND TESTING

- ii. Conduct an additional exercise that may include, but is not limited to the following:
  - A. A second full-scale exercise that is community-based or individual, facility based.
  - B. A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.
- iii. Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the agency's emergency plan, as needed.

# INTEGRATED HEALTHCARE SYSTEMS

If an HHA is part of a healthcare system consisting of multiple separately certified healthcare facilities that elects to have a unified and integrated emergency preparedness program, the HHA may choose to participate in the healthcare system's coordinated emergency preparedness program. If elected, the unified and integrated emergency preparedness program must do all of the following:

- 1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
- 2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.

# INTEGRATED HEALTHCARE SYSTEMS

- 3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.
- 4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following:
  - i. A documented community-based risk assessment, utilizing an all-hazards approach.
  - ii. A documented individual facility based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
- 5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.





Questions?