



FOR PROVIDERS.
BY PROVIDERS.

 [achc.org](https://www.achc.org)



ACCREDITATION PROCESS

 HOSPICE



ACCREDITATION COMMISSION *for* HEALTH CARE



Table of Contents

I. Introduction.....	4
II. Requirements	4
A. Organization Types.....	4
B. Accreditation Types	4
C. Eligibility Requirements.....	4
D. ACHC Hospice Program Services.....	5
E. Hospice Distinction(s).....	5
III. Principles Governing the Accreditation Survey.....	5
A. Compliance	5
B. Education.....	6
C. Types of Surveys.....	6
IV. Accreditation Process before the Survey.....	7
A. Register for access to ACHC through Customer Central.....	7
B. Download ACHC Accreditation Standards.....	7
C. Complete ACHC Accreditation Application and Submit Deposit.....	7
D. Execute Agreement for Accreditation Services.....	8
E. Submission and Review of Preliminary Evidence Report (PER).....	8
F. Scheduling.....	8
G. Postponement of Survey.....	9
V. Survey Process.....	9
A. Non-Corporate Customers	9
B. Corporate Customers.....	11
C. Licensure Surveys	12
D. Refusal of Survey	13
VI. Accreditation Process Post Survey	13
A. Reviewing the Data Collected	13
B. Accreditation Decisions	13
C. Validation Survey Results for Corporate Organizations.....	16
D. Accreditation Documentation.....	17
E. Dispute Process.....	17
F. Appeal Process	18
G. Continued Compliance	19
H. Renewing Accreditation.....	19
I. Withdrawal - For renewing organizations that have received deemed status	19
VII. Disciplinary Actions.....	19
A. Noncompliance Process.....	20
B. Termination	20
VIII. Notification of Changes	21
A. Name Changes	21
B. Location Change.....	21

Table of Contents

C. Cessation or Interruption within the Organization.....	22
D. Branch Office Addition (CMS "Multiple Location").....	22
E. Service Addition.....	23
F. Ownership or Ownership Information Changes.....	23
G. Withdrawals.....	24
IX. Public Information.....	24
A. Logo/Advertising Language.....	24
B. Press Releases.....	25
X. Nonconformance Policy.....	25
A. Handling of Complaints.....	25
B. Processing a Complaint.....	25
C. Immediate Jeopardy (IJ).....	25
D. Non-Immediate Jeopardy – High.....	27
E. Non-Immediate Jeopardy – Medium.....	27
F. Non-Immediate Jeopardy – Low.....	27
G. Administrative Review/Offsite Investigation.....	27
H. Referral – Immediate.....	27
I. Referral – Other.....	28



I. Introduction

Accreditation Commission for Health Care (ACHC) is an independent, 501(c)(3) nonprofit accrediting organization that is certified to ISO 9001:2015 standards. ACHC is governed by a volunteer Board of Commissioners (Board) that is composed of healthcare professionals and consumers. The Accreditation Process contained in this document pertain to all organizations, whether they are applying for accreditation for the first time, renewing accreditation, adding or eliminating branches, or adding or eliminating services. As a result of changes in industry standards and/or regulatory changes, as well as ACHC's continuous internal review of its processes, ACHC may update its Accreditation Process. Accordingly, ACHC's services will be furnished in accordance with the most current version of the ACHC Accreditation Process in effect on the date of the survey or in effect at the time of any other activity.

II. Requirements

A. Organization Types

Noncorporate: Noncorporate organizations are defined as having 24 or less physical locations.

Corporate: Corporate organizations are defined as having 25 or more physical locations.

Please Note: The Accreditation Process is written for noncorporate and corporate organizations unless otherwise specified. ACHC makes the final determination in defining a physical location.

B. Accreditation Types

Organizations may apply for one of the following types of accreditation:

1. Hospice Program
2. Hospice Program with a recommendation for deemed status

C. Eligibility Requirements

The organization may apply for accreditation if the following eligibility requirements are met.

The organization must:

1. Be currently operating within the United States and/or its territories.
2. Be licensed according to applicable state and federal laws and regulations and maintain all current legal authorization to operate.
3. Have completed the Medicare Enrollment Application Form CMS-855A and had this form verified by the assigned Medicare Administrative Contractor (MAC), if applicable.
4. Have met capitalization requirements, if applicable.
5. Occupy a building in which services are provided/coordinated that is identified, constructed, and equipped to support such services.
6. Clearly define the services it provides directly or under contract.
7. Submit all required documents and fees to ACHC within specified time frames.
8. Have provided care to a minimum of five patients and have three active patients at the time of the survey. If the hospice is located in a medically underserved area, as determined by the Centers for Medicare and Medicaid Services (CMS) Regional

Office (RO), the CMS RO may reduce the minimum number of patients from five to two. At least one of the two required patients should be receiving care from the hospice at the time of the initial survey. It is the organization's responsibility to notify ACHC if it is located in an underserved area.

9. Be able to provide all core services as referenced in the Medicare Conditions of Participation.
10. Be able to provide all levels of care either directly or through contract.

D. ACHC Hospice Program Services

1. **Hospice Care (HSP):** Hospice Care services provide care for terminally ill patients in their place of residence. End-of-life care involves an interdisciplinary approach to meet physical, psychosocial, spiritual, and emotional needs of the patient and/or family as well as the palliation of symptoms related to the terminal illness.
2. **Hospice Inpatient Care (HIC):** Hospice Inpatient Care services are provided directly by the hospice personnel at a facility owned/operated by the hospice. These services do not include facilities in which care is provided by contract. The level of care provided can be general inpatient, or respite. If general inpatient or respite care is provided, there must be a nurse on duty 24/7. End-of-life care involves an interdisciplinary approach to meet physical, psychosocial, spiritual, and emotional needs of the patient and/or family, as well as palliation of symptoms related to the terminal illness.

E. Hospice Distinction(s)

1. For an organization to earn accreditation with a Distinction in Palliative Care, the organization must have Home Health, Hospice or Private Duty Accreditation. This additional recognition focuses on patient and family-centered care that optimizes quality of life throughout the continuum of illness by addressing physical, intellectual, emotional, social, and spiritual needs and facilitating patient autonomy, access to information, and choice. ACHC Palliative Care Standards are based on the National Consensus Project Clinical Practice Guidelines for Quality Palliative Care.
2. **Telehealth:** For an organization to earn accreditation with a distinction in Telehealth, the provider must have an active ACHC Ambulatory Care, Behavioral Health, Home Health, Hospice, Palliative Care, Private Duty, or Renal Dialysis Accreditation. This additional recognition focuses on the provision of care to clients/patients with acute or chronic conditions utilizing telehealth technology in order to allow monitoring in the clinical or home environment. This technology creates disease management empowerment and independence, improved access to care, increased collaboration among health care providers, and improved client/patient outcomes. Telehealth may include remote client/patient monitoring (RPM), biometrics, video, talk, or education. ACHC Telehealth standards are based on the American Telemedicine Association's Home Telehealth Clinical Guidelines.

III. Principles Governing the Accreditation Survey

A. Compliance

During the accreditation survey, ACHC determines whether the organization is meeting the intent of the ACHC Accreditation Standards. Proof of compliance is based upon items such as:

- a. Review of patient records
- b. Personnel files
- c. Policies and procedures
- d. Observations
- e. Interviews

It is the organization's responsibility to ensure compliance with the ACHC Accreditation Standards at all times during the accreditation period. ACHC will release and communicate any updates/changes to ACHC Accreditation Standards every year on or around February 1. These updates/changes will have an effective date of June 1 of the same year in which they are released. However, in response to regulatory changes or requirements, ACHC Accreditation Standards may be updated at any time. Organizations must be compliant with any changes on the effective date.

B. Education

While the organization is preparing for its survey, the organization's Account Advisor is available to provide assistance with the accreditation process. Clinical Managers are available for interpretation of ACHC Accreditation Standards or suggestions on how to implement them. During the survey, ACHC Surveyors will provide education to help the organization achieve optimum performance.

C. Types of Surveys

1. **Initial Survey*:** An Initial Survey is conducted on organizations which apply for ACHC accreditation for the first time. Initial Surveys are unannounced.
2. **Renewal Survey*:** A Renewal Survey is conducted on organizations that are currently accredited by ACHC. Renewal Surveys are conducted in the same format as an Initial Survey; however, during the Renewal Survey, the Surveyor also reviews previous deficiencies for compliance. Renewal Surveys are unannounced.
3. **Licensure Survey:** A Licensure Survey is conducted on organizations that are required to obtain a license before beginning to conduct business. If ACHC is approved to conduct a Licensure Survey in that state, ACHC will conduct a one (1) day survey that includes a review of the organization's policies and procedures. The ACHC Surveyor will verify that proper personnel are in place and the organization is ready to begin operation. Licensure Surveys are announced.
4. **Dependent Survey:** A Dependent Survey is a re-survey conducted on an organization that was not in compliance with ACHC Accreditation Standards. Dependent Surveys are unannounced.
5. **Corporate Survey:** A Corporate Survey is conducted on corporate organizations. Corporate Surveys provide the organization the opportunity to present policies and procedures and other relevant information that demonstrate compliance with the ACHC Accreditation Standards. Corporate Surveys are announced.
6. **Initial Sampling Survey:** An Initial Sampling Survey is conducted for corporate organizations seeking ACHC accreditation for the first time. This survey takes

place following the Corporate Survey to validate the information presented. An accreditation decision cannot be released until the Initial Sampling Survey(s) have been completed. Initial Sampling Surveys are unannounced.

7. **Validation Survey:** A Validation Survey is for a corporate customer that takes place at least 30 days following the Corporate Survey. Validation Surveys will be conducted on a percentage of the organization's locations to verify compliance with the ACHC Accreditation Standards. Validation Surveys are unannounced.
8. **Focus Survey:** A Focus Survey is conducted on organizations to ensure ongoing and continued compliance with the ACHC Accreditation Standards. Focus Surveys can take place anytime throughout the accreditation period or for any organizational changes. Focus surveys are unannounced.
9. **Complaint Survey:** A Complaint Survey is conducted on organizations that have a complaint filed against them. Should ACHC determine during the investigation that a site visit is required, ACHC will conduct a Complaint Survey to determine if the complaint is substantiated. Complaint Surveys are unannounced.
10. **Disciplinary Action Survey:** A Disciplinary Action Survey is conducted on organizations due to noncompliance from a previous survey, the ACHC Accreditation Standards and/or Accreditation Process and/or a breach in the ACHC Accreditation Agreement. Disciplinary Action Surveys are unannounced.
11. **Virtual Survey:** A Virtual Survey is conducted using a virtual hosting solution that allows an audio, video, and camera web-based platform for virtual meetings, including, but not limited to: GoToMeeting, Microsoft Teams, Skype, Webex, and Zoom. Virtual surveys are offered to certain organization types, depending on the parameters set by ACHC, state licensure requirements, and regulations of the Centers for Medicare & Medicaid Services (CMS). Virtual surveys review the same material as an on-site survey, and the organization needs to show compliance with all ACHC standards, and state and federal requirements. Virtual surveys can be announced or unannounced, depending on the program.

*This is a comprehensive extended survey examining all of the ACHC Accreditation Standards and the CMS CoPs.

IV. Accreditation Process before the Survey

A. Register for access to ACHC through Customer Central

1. Access Customer Central at cc.achc.org.
2. Create username and password.
3. Receive Account Advisor's contact information.

B. Download ACHC Accreditation Standards

1. Available for organizations that have not previously obtained them.
2. Once purchased, organization has unlimited access to all ACHC Accreditation Standards.
3. Credit is applied for organizations that submit a deposit for accreditation.

C. Complete ACHC Accreditation Application and Submit Deposit

1. Complete online Accreditation Application in its entirety. (Paper format is available.)
2. Complete statistical information for all physical locations. Based on governance, complexity of corporate structure, tax reporting, and other factors, ACHC will determine the number of applications and number of surveys required.
3. Submit non-refundable deposit (applied toward accreditation fee).

D. Execute Agreement for Accreditation Services

1. The following agreements outline the obligations of both ACHC and the organization. ACHC issues one of the following:
 - a. Agreement for Accreditation Services/Business Associate Agreement (BAA)
 - b. Agreement for Corporate Accreditation Services/ Business Associate Agreement (BAA)
2. Sign and return the Agreement and BAA to ACHC within the specified time frames listed on the cover page.
3. Failure to meet any terms of the Agreement or BAA may result in rescheduling or cancellation of the survey with fees assessed.

E. Submission and Review of Preliminary Evidence Report (PER)

1. Attestation on PER checklist (for initial applications only) is completed confirming existence of required policies and procedures.
2. Upload required PER checklist (for initial applications only) and documents through Customer Central. (Contact Account Advisor if organization is unable to submit electronically.)
3. ACHC evaluates the content of all required documents and the ACHC Surveyor will discuss any questions with the organization during the survey.
4. A review of all policies and procedures related to the ACHC Accreditation Standards is available to organizations for a fee.

F. Scheduling

1. Upon receipt of the required documents, the scheduling process is initiated.
2. Organizations are allowed to choose up to 10 blackout days on which ACHC will not schedule a survey. Only two of these days can be Wednesdays. (NOTE: choosing fewer blackout dates provides greater flexibility in scheduling the survey.)
3. The following days do not need to be included in the organization's blackout days:
 - a. New Year's Day
 - b. Good Friday
 - c. Memorial Day
 - d. Independence Day
 - e. Labor Day
 - f. Thanksgiving Day and the following day
 - g. Christmas Eve
 - h. Christmas Day

4. ACHC reserves the right to send a Surveyor preceptee as part of the survey team. A preceptee is sent at no charge to the organization. All ACHC Surveyors/preceptees must disclose any potential conflict of interest with the organization to ACHC before they are assigned to conduct the survey. Surveyors/preceptees with a confirmed conflict are not utilized for the survey being scheduled.

G. Postponement of Survey

1. Survey postponements must be requested in writing to the organization's Account Advisor. A call with a member of the clinical education team may be required.
 - a. For an unannounced survey, organizations may request a survey postponement after their pre-survey call. If no pre-survey call is performed, organizations may request a survey postponement after their application is sent to scheduling by their Account Advisor. On the day of the survey, organizations must follow the refusal process.
 - b. For an announced survey, organizations may request a survey postponement after their pre-survey call. If no pre-survey call is performed, organizations may request a survey postponement after their application is sent to scheduling by their Account Advisor. Starting the day before the survey, organizations must follow the refusal process.
 - c. If a postponement request is accepted, ACHC will invoice a postponement fee as listed in the Agreement for Accreditation Services. The postponement fee is required to be paid prior to rescheduling the survey. The organization is responsible for notifying the Account Advisor in writing of its readiness for survey. When notified, the Account Advisor will proceed with rescheduling the survey following the ACHC scheduling process. If the organization does not notify the Account Advisor within 180 days of the postponement date, the organization's deposit and application may be forfeited and the organization must re-apply for accreditation.

V. Survey Process

A. Noncorporate Customers

1. **Opening Conference:** The opening conference may consist of the following based on the organizational structure:
 - a. Introduction of the Surveyor(s)
 - b. Review of the tentative schedule
 - c. Review questions on any documents from the application process
 - d. Q & A from the organization about the survey
2. **Tour of the organization**
3. **Data Collection**
 - a. In order for ACHC to ensure that the organization is compliant with all ACHC Accreditation Standards, the survey focuses on the following:
 - i. Personnel file review
 - ii. Patient record review

- iii. Financial/Billing records
 - iv. Service contracts
 - v. Risk management
 - vi. Quality Assessment and Performance Improvement (QAPI) activities
 - vii. Policies and procedures
 - viii. Observations
 - ix. Personnel and patient interviews
- b. The organization authorizes ACHC to access the records listed above that are necessary to ascertain the degree of compliance with ACHC Accreditation Standards. ACHC complies with all HIPAA, privacy and security regulations.
- c. The Surveyor’s role is to review information presented and to clarify, observe, and verify data that supports compliance with applicable ACHC Accreditation Standards.

4. Record Reviews and Home Visits

- a. For organizations seeking a recommendation for deemed status, the number of record reviews and home visits are based unduplicated admissions during a recent 12-month period. The Medicare requirements are:

Unduplicated Admissions	Minimum # of Record Reviews Without Home Visit	Minimum # of Record Reviews With Home Visit	Total Record Reviews
<150	8	3	11
150-750	10	3	13
751-1250	12	4	16
1251 or more	15	5	20

- b. Organizations not seeking a recommendation for deemed status, ACHC will perform at least three (3) home visits and eight (8) total record reviews taking into consideration the unduplicated admissions during a recent 12- month period.
- c. The organization will be held accountable for submitting accurate and timely information. ACHC reserves the right to review and/or adjust accreditation fees based on new, updated or validated information obtained during the survey process. This may affect the number of survey days or Surveyors required. The organization may be billed for additional days if inaccurate, updated or validated information is provided to ACHC or if the information has changed at the time of survey.
- d. Organizations seeking to earn accreditation with Distinction in Palliative Care and have fewer than 150 Unduplicated Admissions must have provided care for at least three Palliative Care patients, two of which are active.

Unduplicated Admissions	Minimum # of Records Reviews without Home Visit	Minimum # of Record Reviews With Home Visit	Total Record Reviews
<150	2	1	3
150 or more	2	2	4

5. Closing Conference

The ACHC Surveyor conducts a closing conference with the organization's representatives.

- a. This allows a final opportunity to clarify information or present data that may not have been reviewed by the Surveyor during the survey.
- b. The ACHC Surveyor will provide organizational strengths and deficiencies.
- c. The ACHC Surveyor does not issue an accreditation decision at the completion of the survey.

B. Corporate Customers

1. **Corporate Survey:** Corporate organizations that do not provide patient services out of the corporate office will have an announced Corporate Survey that will include the following:
 - a. Opening conference led by ACHC
 - i. Introduction of the survey team
 - ii. Introduction of the organization's personnel
 - iii. Review of the day's schedule
 - b. Tour of the organization, if applicable
 - c. Q & A from the organization about the survey
 - d. Presentation of the organization's policies and procedures as required by the ACHC Accreditation Standards
 - e. Review of questions on any documents from the application process
 - f. Review of corporate officer/senior management personnel records maintained at corporate office
 - g. Presentation of the organization's Performance Improvement (PI) Plan and results of the ongoing monitoring
 - h. Interviews with the corporate management personnel
 - i. Closing conference
2. Following the Corporate Survey for new corporate organizations, the ACHC survey team will conduct Initial Sampling Surveys on a specified number of locations to verify compliance with the ACHC Accreditation Standards. Once the Initial Sampling Surveys are completed, the data collected will be sent back to the organization's Account Advisor for processing. An organization's accreditation decision cannot be determined until the Initial Sampling Surveys are completed.

Initial Sampling Surveys are conducted in the same format as the non-corporate survey process.

3. At least 30 days following the Corporate Survey, ACHC will begin conducting unannounced Validation Surveys on a percentage of the remaining locations. These surveys verify that the information presented during the Corporate Survey is being followed and meets the ACHC Accreditation Standards. Validation Surveys are conducted in the same format as the non-corporate survey process.
4. For corporate organizations not seeking a recommendation for deemed status, ACHC will perform at least three home visits and eight total record reviews taking into consideration the unduplicated admissions during a recent 12-month period.

C. Licensure Surveys

1. Organizations that are required to obtain a state license before they can provide services may use ACHC for a Licensure Survey only if the state has approved ACHC to perform Licensure Surveys. The organization is responsible for contacting the state in order to determine if ACHC can perform a Licensure Survey on behalf of the state agency.
2. ACHC will schedule an announced survey that will include the following:
 - a. **Opening Conference:** The opening conference may consist of the following based on the organizational structure:
 - i. Introduction of the Surveyor
 - ii. Review of the tentative schedule
 - iii. Review questions on any documents from the application process
 - iv. Q & A from the organization about the survey
3. **Tour of the organization**
4. **Data Collection**
 - a. In order for ACHC to ensure that the organization is compliant with all ACHC Accreditation Standards and specific licensure requirements, the survey focuses on the following:
 - i. Personnel record review
 - ii. Service contracts, if applicable
 - iii. Policies and procedures
 - iv. Observations
 - v. Personnel interviews
 - vi. Appropriate administrative meeting minutes
5. **Closing Conference**

The ACHC Surveyor conducts a closing conference with the organization's representatives.

 - a. This allows a final opportunity to clarify information or present data that may not have been reviewed by the Surveyor during the survey.
 - b. The ACHC Surveyor will provide organizational strengths and deficiencies.

- c. The ACHC Surveyor does not issue an accreditation decision at the completion of the survey.

D. Refusal of Survey

1. Organizations have the right to refuse an ACHC survey.
 - a. Announced surveys can be refused starting the day before the survey. Unannounced surveys can be refused the day of the survey. If an organization wishes to request a survey refusal, it must contact its Account Advisor and complete a Survey Refusal Form. A call with a member of the clinical education team may be required.
 - b. If an ACHC Surveyor arrives on site and the organization wishes to refuse, does not meet the eligibility criteria for an accreditation survey, or is not in operation during its posted business hours, the Surveyor will notify the Account Advisor of refusal. A call with a member of the clinical education team may be required. If possible, a Survey Refusal Form will be completed on site.
 - c. If an ACHC survey is refused, ACHC will invoice a refusal fee as listed in the Agreement for Accreditation Services. The refusal fee is required to be paid prior to rescheduling the survey. The organization is responsible for notifying the Account Advisor in writing of its readiness for survey. When notified, the Account Advisor will proceed with rescheduling the survey following the ACHC scheduling process. If the organization does not notify the Account Advisor within 180 days of the refusal date, the organization's deposit and application may be forfeited and the organization must re-apply for accreditation.

VI. Accreditation Process Post Survey

A. Reviewing the Data Collected

1. **Scoring:** Following the conclusion of the accreditation survey, the ACHC Surveyor will submit all of the data collected to the organization's Account Advisor for processing. The information is entered into an electronic tool that provides objective data for determining the accreditation decision.
2. **Preparing the Summary of Findings (SOF):** The Summary of Findings is prepared describing all ACHC Accreditation Standards that were marked as deficiencies during the accreditation survey. Each ACHC Accreditation Standards marked as a deficiency will contain a "Corrective Action" statement. This will assist the organization in preparing a Plan of Correction to meet the ACHC Accreditation Standards.
3. **Accreditation Review:** The Summary of Findings is analyzed by the appropriate Clinical Manager or designee and evaluated by the Accreditation Review Committee to ensure consistency before a final decision is rendered.

B. Accreditation Decisions

1. **Approval of Accreditation:**
 - a. Accreditation is granted to organizations that are compliant with all ACHC Standards for accreditation and the Medicare CoPs at the time of the survey.
 - b. The accreditation effective date for new and renewal organizations that receive an Approval of Accreditation is determined as follows:

- i. **New Organization:** The accreditation effective date is the last day of survey.
 - ii. **Renewal Organization:** The accreditation effective date will continue for an additional 36 months from the previous accreditation expiration date if the Renewal Survey is conducted prior to the expiration date. If the organization's survey takes place after the expiration date, the approval date will start from last date of survey.
- 2. **Accreditation Pending:**
 - a. Accreditation Pending is based on the following criteria:
 - i. Results of the data collected during survey
 - ii. Non-compliance with any Medicare CoPs
 - iii. Number and/or severity of any deficiencies
 - iv. The Clinical Manager/designee and Accreditation Review Committee's decision
 - b. Accreditation cannot be granted until a Plan of Correction is submitted and approved. Due dates are as follows:
 - i. Plan of Correction is due to ACHC within 10 calendar days from the date of the organization's accreditation pending letter.
 - ii. If adjustments to the Plan of Correction are necessary, the organization must submit modifications to achieve an acceptable Plan of Correction within 10 calendar days as specified on the notification to the organization. Per CMS regulations, organizations must have submitted an acceptable Plan of Correction for achieving compliance no longer than 60 calendar days after the survey.
 - iii. Failure to submit an acceptable Plan of Correction within the required time frame will result in a change of accreditation status from Accreditation Pending to Denial of Accreditation.
 - iv. **If requested**, evidence to support the implementation of the organization's Plan of Correction is due to ACHC within 60 days following the date of the organization's accreditation pending letter.
 - v. Failure to submit requested evidence may result in the organization being designated as "Under Review" (Section VII, A).
 - c. All Plans of Correction are reviewed by the Clinical Manager/designee. After reviewing the Plan of Correction ACHC may issue:
 - i. Approval of Accreditation
 - ii. A rejection of Plan of Correction and require additional information
 - iii. Dependent Status (Section VI, B, 3)
 - d. Following the review of the Plan of Correction, if accreditation is granted, the effective dates for new and renewal organizations are determined as follows:
 - i. **New Organizations:** The effective date is the day the approved Plan of Correction is received by ACHC. An approved Plan of Correction is one that has been accepted by the Clinical Manager/designee.

date if the Dependent Survey is conducted prior to the expiration date. If the organization's survey takes place after the expiration date, the Approval date will start from the date the acceptable Plan of Correction is received.

4. Denial of Accreditation:

- a. Denial of Accreditation is based on the following criteria:
 - i. Results of the data collected during survey
 - ii. Non-compliance with any Medicare CoPs
 - iii. Number and/or severity of any deficiencies
 - iv. The Clinical Manager/designee and Accreditation Review Committee's decision
- b. If accreditation is Denied, the organization has the option to appeal the decision by following the steps outlined in the Appeals Process (Section VI, F)
- c. If Accreditation is Denied, the organization has the opportunity to re-apply for accreditation at any time it is ready for survey. At the time of re-application, a new application must be submitted with a non-refundable deposit. ACHC will make the determination whether a new PER is required.

C. Validation Survey Results for Corporate Organizations

1. Corporate organizations that receive a Corporate Survey will follow the same criteria as listed above to determine an accreditation decision. New corporate organizations will receive a minimum of one Initial Sampling Survey before an accreditation decision can be issued.
2. Once a final decision has been issued to a corporate organization and all of its locations, the Validation Surveys will result in one of the following:
 - a. **Continued accreditation with no deficiencies:** If no deficiencies are found during a Validation Survey, a Plan of Correction is not required and the accreditation dates will remain in effect with the corporate accreditation.
 - b. **Continued accreditation with deficiencies:** If minimal deficiencies are found during a Validation Survey, a Plan of Correction with necessary supporting documentation is required within 30 days from receipt of the notification letter. The accreditation dates will remain in effect with the corporate accreditation.
 - c. **Focus Survey:** If the scope and severity of deficiencies are significant during the Validation Survey, a Focus Survey may be required in order for the accreditation to stay in effect. A Plan of Correction with necessary supporting documentation is required within 30 days from receipt of the notification letter and a Focus Survey will be scheduled for this location at the organization's expense. Following the Focus Survey, if the location is found to be in compliance, accreditation dates will remain in effect with the corporate accreditation. Following the Focus Survey, if the location is found to be out of compliance, the location may be placed Under Review (Section VII, A).

- d. **Removal of accreditation:** After being placed Under Review, if the location is still found to be out of compliance with the ACHC Accreditation Standards, ACHC may terminate the accreditation for that location (Section VII, B).

D. Accreditation Documentation

1. Once an accreditation decision is made by the Clinical Manager/designee and the Accreditation Review Committee, the accreditation decision is given to the Account Advisor. The Account Advisor then prepares the proper documentation to send to the organization.
2. Based on the accreditation decision, the Account Advisor sends the following:
 - a. **Approval of Accreditation:** Accreditation Approval letter, Certificate of Accreditation, Summary of Findings, and window decal
 - b. **Accreditation Pending:** Accreditation Pending letter, Summary of Findings, and Plan of Correction template
 - c. **Dependent Status:** Dependent Status letter, Summary of Findings, and Plan of Correction template
 - d. **Denial of Accreditation:** Denial letter and Summary of Findings
3. The Plan of Correction must be completed in its entirety, returned to ACHC and approved by the Clinical Manager/designee in order to be acceptable. The Plan of Correction must be completed on the ACHC Plan of Correction template and must contain the following elements:
 - a. The standard that was out of compliance
 - b. Corrective action to be taken
 - c. Implementation date
 - d. Title of individual responsible
 - e. Process for continued compliance
4. Once an organization that is seeking a recommendation for deemed status is in full compliance with all of the ACHC Standards for Accreditation and Medicare CoPs, ACHC will issue a recommendation for deemed status for the organization. The CMS Regional Office makes the final determination for deemed status.
5. If an organization is seeking a recommendation for deemed status and is issued a Dependent or Denial decision, ACHC will not make a recommendation for deemed status. The organization must be in compliance with all ACHC Standards for Accreditation and Medicare CoPs before a recommendation for deemed status can be made.
6. Once an organization receives an Approval Decision, the organization's accreditation information can be found on the ACHC website for verification.

E. Dispute Process

Organizations, whether applying for the first time or renewing their accreditation, may formally request to dispute a standard(s) deficiency documented on the Summary of Findings. A company that wants to dispute a denial decision must follow the appeal process (refer to Section VI. F).

The procedure to dispute a standard(s) deficiency is as follows:

1. The organization submits a written request for dispute to its ACHC Account Advisor no later than 10 calendar days from the receipt of the Summary of Findings. Disputes will not be granted if:
 - a. The request is received after the 10 calendar day time frame
 - b. An organization has an outstanding balance
 - c. An organization has a payment plan that is not current
2. The written request outlines the standard(s) noted in the Summary of Findings that the organization believes ACHC incorrectly determined as a deficiency. The organization must also provide evidence to support that, at the time of the survey, the organization was in compliance with the standard(s). Any evidence the organization submits must have been presented to and reviewed by the Surveyor(s) at the time of the survey. Evidence provided with the request letter will not be returned to the organization.
3. Upon receipt of the request for a dispute, ACHC sends an acknowledgement letter to the organization.
4. If the organization is required to submit a Plan of Correction as a result of its survey, the organization must indicate on the Plan of Correction any standard(s) deficiency being disputed.
5. The ACHC Review Committee will evaluate and determine whether ACHC followed its stated Accreditation Process in conducting the organization's accreditation survey.
6. Any ACHC Review Committee member who has a conflict of interest with the organization under review refrains from voting on the dispute.
7. Upon completion of the review, the ACHC Account Advisor notifies the organization of the ACHC Review Committee's decision to either uphold or reverse the original standard(s) deficiency noted on the Summary of Findings.
8. All decisions made by the ACHC Review Committee are final.

F. Appeal Process

Organizations, whether applying for the first time or renewing their accreditation, may formally request to appeal a Denial decision. The procedure to appeal a Denial of Accreditation is as follows:

1. The organization submits a written request for appeal to its ACHC Account Advisor no later than 30 calendar days from the date on ACHC's Denial letter. Appeals will not be granted if:
 - a. The request is received after the 30 calendar day time frame
 - b. An organization has an outstanding balance
 - c. An organization has a payment plan that is not current
2. The written request outlines the standard(s) noted in the Summary of Findings that the organization believes ACHC incorrectly determined as a deficiency. The organization must also provide evidence to support that, at the time of the survey, the organization was in compliance with the standard(s). Any evidence the organization submits must have been presented to and reviewed by the

Surveyor(s) at the time of the survey. Evidence provided with the request letter will not be returned to the organization.

3. Upon receipt of the request for an appeal, ACHC sends an acknowledgement letter to the organization.
4. The ACHC Appeals Committee is composed of a minimum of three individuals who have clinical and/or program expertise will evaluate and determine whether ACHC followed its stated Accreditation Process in conducting the organization's accreditation survey.
5. Any ACHC Appeals Committee member who has a conflict of interest with the organization under review refrains from voting on the appeal.
6. Upon completion of the review, the ACHC Account Advisor notifies the organization in writing of the ACHC Appeals Committee's decision to either uphold or reverse the original Denial decision.
7. All decisions made by the ACHC Appeals Committee are final.

G. Continued Compliance

1. Accreditation is contingent upon continued compliance with the ACHC Accreditation Standards and Accreditation Process. After an organization is granted accreditation, ACHC reserves the right to make unannounced Focus Survey visits at any time during the accreditation period to ensure continued compliance with the ACHC Accreditation Standards.
2. If a Focus Survey reveals non-compliance with any ACHC Accreditation Standards, a Plan of Correction and supporting documentation will be required. Based on the number and/or severity of deficiencies, the organization may be invoiced for the Focus Survey.

H. Renewing Accreditation

1. Accreditation is not automatically renewable. Approximately 12 months prior to the organization's expiration of accreditation, ACHC will notify the organization about the renewal process.
2. If the organization's renewal application and deposit are not submitted by the required due date listed on the renewal letter, sufficient time may not exist to schedule and complete a survey prior to the accreditation expiration date.
3. In the event an organization's accreditation expires, the organization's accreditation information will be removed from the accredited organization list located on the ACHC website.

I. Withdrawal

For renewing organizations that have received deemed status through ACHC recommendation to CMS, they will be withdrawn to the State Agency Authority if:

1. The renewal survey is not conducted within 36 months
2. Customer chooses not to renew with ACHC
3. Customer asks to be withdrawn to State Agency Authority
4. Customer applies after the renewal-target-date whereby ACHC is not able to expedite a timely survey

5. Customer has an overdue balance and is in need of additional survey(s)

VII. Disciplinary Actions

Disciplinary actions can come from a nonconformance resulting from an ACHC survey and /or failure to remain in compliance with ACHC Accreditation Standards, Accreditation Process, and/or a breach in the ACHC Accreditation Agreement.

A. Noncompliance Process

1. The organization may be placed Under Review:
 - a. ACHC notifies customer
 - b. ACHC determines which of the following actions will be taken:
 - i. ACHC may request written documentation
 - ii. ACHC may conduct a Disciplinary Action Survey
 - iii. If ACHC determines that Immediate Jeopardy might be present, the process as described in Section X.C will be followed
 - iv. ACHC may require a Plan of Correction be completed
 - v. ACHC may require a payment
 - c. Upon review of any documentation or Plan of Correction, ACHC may accept it, reject it or require additional information
 - d. ACHC will render a decision
 - i. Continuance of Accreditation
 - ii. Accreditation remains Under Review
 - iii. Termination
2. Accreditation may be terminated based on the number or severity of nonconformance or if it is believed that compliance with ACHC standards is not possible within a reasonable timeframe.

B. Termination

Organizations accredited by ACHC must remain in compliance with ACHC Accreditation Standards; adhere to local, state and federal legal requirements; ensure the safety of their patients and staff; and meet commonly held standards of professional ethics and conduct.

Accreditation can be terminated any time during the accreditation cycle. A decision to terminate accreditation does not need to be preceded by a survey because problems with an organization's services can become apparent from a number of other sources. Therefore, if ACHC receives evidence of noncompliance with ACHC Accreditation Standards or other pertinent criteria, ACHC may decide to terminate accreditation if, in its judgment, it finds that one or more of the following conditions are present:

1. An immediate threat exists to patient safety, public health or staff safety. Such an immediate threat can arise from one incident on a single occasion that affects a single patient, a single staff member or a single member of the public.
2. ACHC determines, in its discretion, that the scope or severity of the organization's noncompliance with ACHC Accreditation Standards is so significant that it is infeasible for the organization to complete corrective action within 10 calendar

days or within a reasonable time frame, as ACHC determines in its discretion under the circumstances.

3. The organization fails to comply or fails to maintain compliance with CMS Conditions of Participation, Conditions for Coverage (CfC), CMS Supplier Standards or CMS Quality Standards.
4. The organization falsifies documents or misrepresents information in seeking to achieve or retain accreditation, or in seeking or retaining some other license, certification, or authorization to operate, or to receive payment for services.
5. The organization, or a staff member, engages in any criminal conduct involving a felony, or engages in immoral, unethical, dishonest, incompetent or other unprofessional behavior that significantly adversely affects, or has the potential to significantly adversely affect, the safety or welfare of any patient, or the safe and effective delivery of the organization's services.
6. The organization does not fulfill contractual obligations during the accreditation cycle by failing to comply with post-accreditation obligations, as specified in the Agreement for Accreditation Services.

VIII. Notification of Changes

ACHC requires organizations to provide the required documentation described below within 30 days of a change occurring. This includes branch office additions or deletions, service additions or deletions, or changes in the name, location, ownership, or control of the organization. Failure to submit the required documentation within the 30 day time frame may result in a gap in accreditation.

A. Name Changes

1. If an organization goes through a name change, the organization must notify ACHC of the change within 30 days. The organization must complete and submit the "Name Change" form that can be downloaded from Customer Central. The form is located under My Account/Edit Company Information/Name Change/Change of Name Request Form. This form can be completed electronically using an e-signature.
2. ACHC may request additional documentation upon review. If approved, ACHC will issue a new accreditation certificate. After ACHC approves the name change, complete the following:
 - a. Submit your 855A form with the new name to CMS
 - b. Upon receipt of the "Information Change Approval" letter from CMS, submit a copy to ACHC
3. If it is determined a survey is necessary, the normal unannounced survey scheduling process will apply and the organization is charged a survey fee.
4. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review.

B. Location Change

1. If an organization goes through a location change, the organization must notify ACHC of the change within 30 days. The organization should complete and submit the "Change of Location" form that can be downloaded from Customer Central. The form is located under: My Account/Edit Company Information/Change of Location/Change of Location Request Form. The form can be completed electronically using an e-signature.
2. ACHC may request additional documentation upon review. If approved, ACHC will issue a new accreditation certificate. After ACHC approves the location change, complete the following:
 - a. Submit your 855A form with the location change to CMS
 - b. Upon receipt of the "Information Change Approval" letter from CMS, submit a copy to ACHC
3. If it is determined a survey is necessary, the normal unannounced survey scheduling process will apply and the organization will be charged a survey fee.
4. If the organization is found to have substantial deficiencies during the survey, the accreditation for that location and/or the organization as a whole is reviewed by the Clinical Manager/designee and the Accreditation Review Committee. Following the review, the organization may be placed in Under Review.

C. Cessation or Interruption within the Organization

1. If the organization has a cessation or interruption of all operations, offering of services, and/or a deletion of any service that has received accreditation, the organization must notify ACHC via a notification letter. The organization's notification letter to ACHC must include the following:
 - a. Effective date of the cessation or interruption
 - b. Detailed description of the reason for the cessation or interruption
2. Upon receipt of the written notification, ACHC will review and send an acknowledgment to the organization. The notification letter is placed in the organization's file. ACHC may request additional documentation before an acknowledgement letter is sent.
3. The organization notifies ACHC of any change in the status from the acknowledgment of the cessation or interruption of operations. Upon notification, ACHC will review the organization's accreditation status and determine if a survey is required to ensure compliance with the ACHC Accreditation Standards and Medicare CoPs.

D. Branch Office Addition (CMS "Multiple Location")

1. ACHC defines a branch as a location serving patients, maintaining patient records and/or personnel files, and accepting referrals. Additions for a branch must fall under a parent location. (In CMS' terminology this is considered a hospice multiple location mid-cycle addition.) The organization must complete and submit the Hospice Multiple location Branch Addition Packet. The packet is located on Customer Central under: My Account/Edit Company Information/Add Branch/Hospice Multiple Location Branch Addition Packet. The packet must be completed in full and submitted with any additional documentation listed on the form.

2. A review of the documentation is performed and any missing information is requested from the organization in writing. Additional information may be requested prior to approving the Hospice multiple location addition. ACHC holds the documentation without further processing until the missing information is received from the organization. Once all required documentation has been submitted, it is reviewed by the Regulatory Department and a survey will be scheduled.
3. The normal unannounced survey scheduling process will apply and the organization is charged a survey fee.
4. If the organization is found to have any deficiencies during the survey, a Plan of Correction will be required and/or a follow-up Focus Survey may be required.
5. Once accreditation has been granted, ACHC will submit a recommendation to the CMS Regional Office. The CMS Regional office will make the final decision of approval of the new site.

E. Service Addition

Hospice organizations will not have a Service Addition throughout the Accreditation cycle.

F. Ownership or Ownership Information Changes

1. The following process is followed when an organization has an ownership or ownership information change of 5% or greater, such as:
 - a. Stock transfer
 - b. Asset purchase
 - c. Acquisition
 - d. Merger
 - e. Consolidation
2. The following information is submitted to the organization's ACHC Account Advisor by the proposed new owner.
 - a. Letter of attestation that includes:
 - i. Type of change (acquisition, merger, etc.)
 - ii. Detail of all changes including new management and/or owner
 - iii. Proposed date of change
 - iv. Statement that policies and procedures are not changing, or, if they are, a statement outlining those changes
 - v. Statement that the new owner has accepted the transfer of the seller's Medicare Provider Agreement (if applicable)
 - vi. Lists of old and new federal tax ID numbers and NPI numbers (if applicable)
 - vii. Who the new contacts will be, including: owner; leader; liaison; and the phone numbers and email addresses for each
 - b. Documentation that includes:
 - i. Completed Additional Site Information form

result in penalties up to and including termination of accreditation. The ACHC Brand Guidelines are available on the organization's Customer Central website. Branch programs and services accredited during the accreditation cycle cannot be advertised as accredited until appropriate accreditation certificates are issued by ACHC.

B. Press Releases

ACHC encourages organizations to publicize their accreditation status. Publicity tips and a sample press release are available to approved organizations on Customer Central.

X. Nonconformance Policy

A. Handling of Complaints

As required by ACHC Accreditation Standards, accredited organizations must provide ACHC's telephone number to their patients as part of their patient informational material for purposes of reporting a complaint. If complaints cannot be resolved through the organization's complaint process, patients may file a complaint with ACHC. These complaints should identify facts or circumstances that relate to the complaint. ACHC documents and investigates all complaints/allegations received against currently accredited organizations. ACHC follows CMS Complaint Procedure guidelines for conducting investigations and records of complaints are maintained. ACHC will investigate and maintain records on complaints from any source when an ACHC accredited organization appears to be out of compliance with its ACHC Accreditation Standards.

1. Complaint should include:
 - a. Name, mailing address and phone number of the person filing the complaint
 - b. Name of the organization involved
 - c. A detailed description of the incident that is the subject of the complaint, including identification of date, time, and location of each incident, as well as the identity of other individuals with information about the incident.
2. While under investigation by ACHC, a complaint is a confidential matter. However, ACHC cannot guarantee complainants that their identity will remain confidential if the organization determines the identity based on their own internal methods/investigation.

B. Processing a Complaint

ACHC will determine the severity and urgency of the allegations so that appropriate and timely action can be taken. Comprehensive information is collected during the Intake Process. Quality Assurance or an appropriate designee enters pertinent information into the complaint database and then discusses the complaint with the appropriate Clinical Manager who is professionally qualified to evaluate the allegations to ensure that patients are not in danger of abuse, neglect, exploitation, inadequate care or supervision.

C. Immediate Jeopardy (IJ)

IJ is defined as: "A situation in which the provider's noncompliance with one or more requirements of participation has caused, or is likely to cause, serious injury, harm, impairment, or death to a patient." (42 CFR Part 489.3) Complaints are assigned this

priority if the alleged noncompliance indicates there was serious injury, harm, impairment, or death of a patient or resident, or the likelihood for such, and there continues to be an immediate risk of serious injury, harm, impairment, or death of a patient or resident unless immediate corrective action is taken. The identification and removal of IJ, either psychological or physical, are essential to prevent serious harm, injury, impairment, or death of individuals.

1. In accordance with the Medicare State Operations Manual Appendix Q, ACHC acknowledges the following principles of IJ, including:
 - a. Only one individual needs to be at risk. Identification of IJ for one individual will prevent risk to other individuals in similar situations.
 - b. Serious harm, injury, impairment, or death does not have to occur before considering IJ. The high potential for these outcomes to occur in the very near future also constitutes IJ.
 - c. Individuals must not be subjected to abuse by anyone including, but not limited to the organization's personnel, consultants or volunteers, family members or visitors.
 - d. Serious harm can result from both abuse and neglect.
 - e. Psychological harm is as serious as physical harm.
 - f. When a Surveyor has established through investigation that a cognitively impaired individual harmed an individual receiving care and services from the organization due to the organization's failure to provide care and services to avoid physical harm, mental anguish, or mental illness, this should be considered neglect.
 - g. Any time a team cites abuse or neglect, it should consider IJ.
2. ACHC will conduct an unannounced survey on the organization to investigate the issues within two business days of receipt of the allegations.
3. If IJ has been identified, a verbal notice is given to the entity, including the specific details and individuals at risk. If corrective measures have not already been implemented, the entity should begin immediate removal of the risk and immediately implement corrective measures to prevent repeat jeopardy situations. Only on-site observation of the entity's corrective actions justifies a determination that an IJ has been removed.
4. A formal written report is then prepared to reflect the above findings and it is submitted to ACHC within 2 business days of completion of the on-site review. Documentation is forwarded to and reviewed by the Clinical Compliance Department and Accreditation Review Committee and a final report of findings is sent to the organization within ten business days of completion of the on-site review.
5. Decision and Notification to Involved Parties
 - a. If upon completion of the investigation of a deemed organization, ACHC identifies an IJ situation, a Condition level deficiency is cited and CMS is notified as applicable. The Board Chair and Executive Management are also immediately notified.

- b. If sufficient evidence exists that the organization has violated ACHC Accreditation Standards, the organization may be placed Under Review.
- c. If an organization's accreditation is terminated, ACHC will notify CMS, as applicable, of the termination. The organization will be removed from all listings of ACHC accredited sites.

D. Non-Immediate Jeopardy – High

Complaints and/or incidents are assigned this priority if the alleged noncompliance with the applicable ACHC Accreditation Standard, if substantiated, would not represent an IJ, but would result in a determination of substantial noncompliance, i.e., at least one condition-level deficiency. An on-site survey is initiated within 45 calendar days of receipt of the complaint.

A formal written report is then prepared to reflect the above findings and submitted to ACHC within 2 business days of completion of the on-site review. Documentation is forwarded to and reviewed by the Clinical Compliance Department and Accreditation Review Committee and a final report of findings is sent to the organization within 10 business days of completion of the on-site review.

E. Non-Immediate Jeopardy – Medium

Complaints and/or incidents are assigned this priority if the alleged noncompliance caused or may cause harm that is of limited consequence and does not significantly impair the individual's mental, physical, and/or psychosocial status or function. The incident or complaint, if substantiated, would not result in a determination of substantial non-compliance (i.e., there would not be any condition-level deficiency). An on-site survey must be scheduled no later than when the next on-site survey occurs, or one year after receipt of the complaint and/or incident, whichever comes first.

F. Non-Immediate Jeopardy – Low

Complaints and/or incidents are assigned this priority if the alleged noncompliance may have caused physical, mental, and/or psychosocial discomfort that does not constitute injury or damage. In most cases, an investigation of the allegation can wait until the next on-site survey.

G. Administrative Review/Offsite Investigation

This priority is used for complaints and/or incidents triaged as not needing an on-site investigation initially. This determination can be made through investigative action (written/verbal communication or documentation) initiated by ACHC to the provider to gather additional information that is adequate in scope and depth to determine that an on-site investigation is not necessary. ACHC has the discretion to review the information at the next on-site survey.

A fee will be processed for Administrative Review/Offsite Investigations requiring a Plan of Correction.

H. Referral – Immediate

This priority is used if the nature and seriousness of the complaint and/or incident or state/federal procedures require the referral or reporting of this information for investigation to another agency, without delay. This priority may be assigned in addition to one of the priorities listed above.



I. Referral – Other

Intakes are assigned this priority when referred to another agency or board for investigation or for informational purposes. This priority may be assigned in addition to one of the priorities listed above.

NOTE: If Clinical Compliance determines that the complaint does not involve patient care and the appropriate investigative method is through a request to the organization for documents, rather than a site visit, then ACHC sends the organization a written or verbal request for documents, including specific due dates for documentation. This action may be completed by the Quality Assurance or Clinical Compliance Department.