ACCREDITATION UNIVERSITY

AccreditationUniversity.com

ACHC CERTIFIED CONSULTANT TRAINING

JUNE 2018

HOME HEALTH HOSPICE PRIVATE DUTY

ACHC CERTIFIED CONSULTANT

ACCREDITATION COMMISSION *for* HEALTH CARE

ACHIEVING ACHC ACCREDITATION

NOTES

NOTES

JOSÉ DOMINGOS

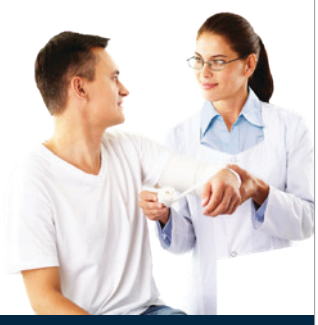
CEO

ABOUT ACHC

- Nationally recognized accreditation organization with over 30 years of experience
- CMS Deeming Authority for Home Health, Hospice, and DMEPOS
- Recognition by major third-party payors
- Approved to perform state licensure surveys
- Quality Management System certified to ISO 9001:2015
- Partnership with Det Norske Veritas (DNV)

HOME HEALTH ACCREDITATION

- Earned CMS deeming authority in 2006
- Accredits more than 1,000 locations nationally
- Program-specific standards include CoPs
- Ability to choose from comprehensive group of services, including:
  - Skilled Nursing
  - Home Health Aide
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Medical Social Services
  - Distinction in Psychiatric/Behavioral Care
  - Distinction in Palliative Care



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HOSPICE ACCREDITATION

- Earned CMS Deeming Authority in 2009
- Program-specific standards include CoPs
- Life Safety Code (LSC) regulations
- Accreditation for both in-home and facility-based services, including:
  - Hospice Care
  - Hospice Inpatient Care
  - Distinction in Palliative Care

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PRIVATE DUTY ACCREDITATION

- Created specifically for non-Medicare providers
- Accreditation for both skilled and non-skilled services, including:
  - Private Duty Nursing
  - Private Duty Aide
  - Companion Homemaker
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Social Work
  - Infusion Nursing
  - Distinction in Palliative Care

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DISTINCTION IN PALLIATIVE CARE

- Distinction in Palliative Care:
  - Home Health, Hospice, and Private Duty Nursing
- One additional day on survey:
  - Must have provided care to three patients, with two active at time of survey
  - <150 palliative care patients: Three total record reviews with one home visit
  - 150 or more palliative care patients: Four total record reviews with two home visits
- ACHC standards were based on the National Consensus Project for Quality Palliative Care guidelines

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DISTINCTION IN BEHAVIORAL HEALTH

- Distinction in Behavioral Health
  - Home Health
- One Additional day on survey:
  - Must have provided care to three patients, with two active at time of survey
  - <150 palliative care patients: Three total record reviews with one home visit
  - 150 or more palliative care patients: Four total record reviews with two home visits

ACHC MISSION & VALUES

Our Mission

Accreditation Commission for Health Care (ACHC) is dedicated to delivering the best possible experience and to partnering with organizations and healthcare professionals that seek accreditation and related services.

Our Values

- Committed to successful collaborative relationships
- Flexibility without compromising quality
- Every employee is accountable for their contribution to providing the best possible experience
- We will conduct ourselves in an ethical manner in everything we do

EXPERIENCE THE ACHC DIFFERENCE

- Standards created for providers, by providers
- All-inclusive pricing – no annual fees
- Personal Account Advisors
- Commitment to exceptional customer service
- Surveyors with industry-specific experience
- Dedicated clinical support
- Dedicated regulatory support
- Educational resources

ACHIEVING ACHC ACCREDITATION

ACHC PROGRAMS & SERVICES

HOME HEALTH
- Home Health Aide
- Medical Social Services
- Occupational Therapy
- Physical Therapy
- Skilled Nursing
- Speech Therapy

HOSPICE
- Hospice Inpatient Care
- Hospice Care

PRIVATE DUTY
- Private Duty Aide
- Private Duty Companion/Homemaker
- Private Duty Infusion Nursing
- Private Duty Nursing
- Private Duty Occupational Therapy
- Private Duty Physical Therapy
- Private Duty Speech Therapy
- Private Duty Social Work

DMEPOS
- Community Retail
- Clinical Respiratory Care Services
- Fitter
- Home/Durable Medical Equipment
- Medical Supply Provider
- Complex Rehabilitation and Assistive Technology Supplier

SLEEP
- Sleep Lab/Center
- Home Sleep Testing

AMBULATORY CARE
- Convenient Care Clinics

BEHAVIORAL HEALTH

ACHC offers a variety of Behavioral Health services to suit your accreditation needs. Contact ACHC for details or visit achc.org for a complete listing of services available.

PHARMACY
- Ambulatory Infusion Center
- Infusion Nursing
- Infusion Pharmacy
- Specialty Pharmacy
  - > SRX without DMEPOS
- Long Term Care Pharmacy
- **PCAB Accreditation (A Service of ACHC)**
  - > Non-Sterile Compounding (Ref. USP <795>)
  - > Sterile Compounding (Ref. USP <797>)
- ACHC Inspection Services (AIS)

DISTINCTIONS*
- Distinction in Behavioral Health
- Distinction in Hazardous Drug Handling
- Distinction in Infectious Disease Specific to HIV
- Distinction in Nutrition Support
- Distinction in Oncology
- Distinction in Palliative Care

*The provider must be accredited with ACHC to be eligible for a distinction service.

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CMS DEEMING AUTHORITY

- Maintaining deeming authority carries great distinction, as well as significant requirements and responsibilities
- Deeming authority has been granted to accreditation organizations (AOs) that can demonstrate that their accreditation programs meet or exceed Medicare requirements in accordance with the Social Security Act
- Home Health and Hospice: Organizations must demonstrate compliance with the Medicare Conditions of Participation (CoPs)
- ACHC's home health disparity rate for validation surveys is superior to other AOs
- Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Organizations must demonstrate compliance with the Centers for Medicare & Medicaid Services (CMS) Quality Standards

ISO CERTIFICATION

- International Organization for Standardization (ISO) certification is a voluntary peer review process to which ACHC has been committed since our Quality Management System (QMS) was certified in 2004:
  - An annual survey is conducted
  - A principle requirement of our QMS is that it must **"meet customer, statutory, and regulatory requirements"**
  - This is accomplished by following consistent processes and time frames, monitoring performance, and implementing improvements
  - A site assessor verifies whether our QMS Manual and associated documents continue to meet ISO standards

CUSTOMER SATISFACTION

- Customer Satisfaction data is collected by electronic and phone surveys
- A report containing the Customer Satisfaction scores is created monthly and submitted to the Accreditation and Clinical Managers
- Cumulative reports are generated quarterly whereby comments and scores for all Surveyors and Account Advisors are reviewed and shared with staff
- Any negative comments or low scores are escalated and the customers are contacted

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CUSTOMER SATISFACTION

ACHC is committed to providing the best possible **experience.**

98% of our customers regard their experience with ACHC as positive.

"The feedback was positive and encouraging—we were impressed with the way this survey was handled from start to finish"

– HOME HEALTH PROVIDER, KENNETT SQUARE, PA

98% of our customers would recommend ACHC.

"ACHC is vested in the development and success of its accredited agencies. We find it a joy to work with ACHC."

– HOME HEALTH PROVIDER, GRAFTON, NC

Customer Satisfaction Survey data gathered from 7/2015-present.

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SURVEYOR EXPERTISE

- Surveyor knowledge and expertise drive both the experience and the quality of the survey
- ACHC processes and tools drive Surveyor success:

Surveyor Training: Content is comprehensive and covers regulatory requirements, guidelines for the site survey process, and coordination with staff

Surveyor Annual Evaluations: Process has been refined to be efficient and includes relevant feedback to Surveyors

Surveyor Satisfaction Surveys: Feedback provides input to short-range and long-range planning, and provides ideas to improve service to customers and Surveyors

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ENSURING QUALITY AT ORGANIZATIONS

- Preparation:
  - Role of Consultant
  - ACHC workshops, manuals, and personal Account Advisors
- First-class surveys:
  - Expert Surveyors provide data collection
  - Reviewer/Review Committee interprets results ensuring consistency
- Comprehensive Plans of Correction (POCs:)
  - ACHC provides assistance to organizations as needed
- Maintaining compliance:
  - Educational materials

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THE BEST POSSIBLE EXPERIENCE FOR CONSULTANTS

- Accreditation Commission for Health Care (ACHC) is dedicated to delivering the best possible experience and to partnering with organizations and healthcare professionals who seek accreditation and related services.

ACTING AS AN AGENT

- To collaborate with ACHC Surveyors and staff to assist agencies with the ACHC Accreditation process, from application to Plan of Correction (POC)
- To partner with and provide feedback to ACHC in order to assist customers in becoming leaders in their respective fields
- To partner with ACHC as we continue to strive to provide the best possible experience and to assist our customers in providing the highest quality of patient care

ACHIEVING ACHC ACCREDITATION

ROLE OF THE CONSULTANT

- To provide guidance to organizations seeking ACHC Accreditation
- To assist organizations in achieving compliance with ACHC requirements
- To review the organizations' policies and procedures to ensure they meet ACHC standards
- To help organizations navigate the accreditation process
- To assist organizations in pre-survey training and audits
- To collaborate with ACHC Surveyors and staff in order to assist organizations with the ACHC Accreditation process
- To partner with ACHC as we continue to strive to provide the best possible experience and to assist our customers in providing the highest quality of patient care
- To abide by the policies and procedures regarding the ACHC survey process

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ACHC POLICIES & PROCEDURES

- ACHC Policies and Procedures address:
  - Eligibility requirements
  - ACHC Accreditation process
  - Postponement of survey
  - Refusal of survey
  - Post-survey process
  - Dispute process
  - Appeal process
  - Disciplinary action
  - Notification of changes (name, location, and ownership)
  - Complaint process/Immediate Jeopardy (IJ)

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ROLE OF SURVEYOR

- To ensure the agency is meeting the intent of the ACHC Accreditation Standards
- Data collectors only - Cannot provide an accreditation decision
- Documented evidence:
  - "Readily identifiable"
  - Current compliance
  - Ongoing compliance for renewal customers

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COMMUNICATION

- Seek clarification from the Surveyor while still on site
- Encourage open dialogue
- Surveyors are experts in the industry and have hands-on knowledge regarding the implementation of the ACHC standards

COMMUNICATING WITH ACHC

- Customer's permission
  - Notify the Account Advisor
  - Customer can provide you with access to their data
- During the survey, be accessible for questions and guidance
- Contact your customer's Account Advisor with any questions you have regarding your customer's survey
- General questions can be addressed by Teresa Harbour or myself:
  - tharbour@achc.org
  - lmeadows@achc.org

ACCOUNT ADVISORS

- Personal Account Advisors:
  - Primary contact with customers
  - Assigned once an application is submitted
  - Assist customers with the ACHC survey process
  - Questions that cannot be answered by them will be sent to the Clinical Department or Regulatory Department

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CONFLICT OF INTEREST

- ACHC Certified Consultants who are also ACHC Surveyors cannot perform a survey for an agency for which they also acted as a Consultant
- ACHC Certified Consultants who are also ACHC Surveyors should **not** use their Surveyor position as a marketing tool
- Workbooks and other tools are proprietary information

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BREAK

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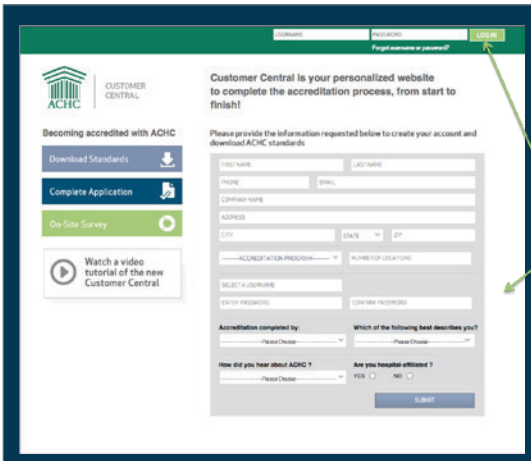
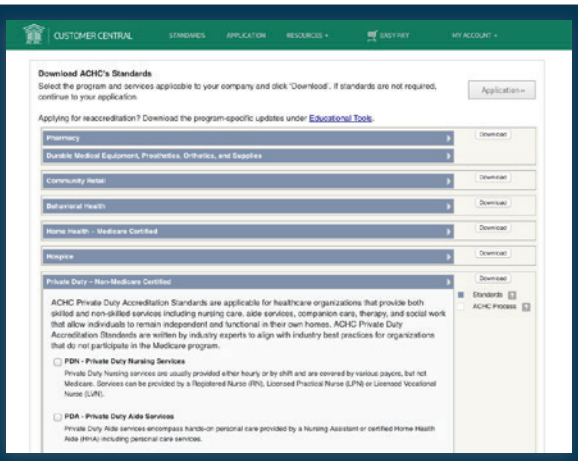
APPLICATION

- Customer needs to create a Customer Central account
- Consultant needs to create a Customer Central account
- Customer Central allows customers and/or Consultants to initiate the application and access resources
- Initial or renewals – application and survey process is the same





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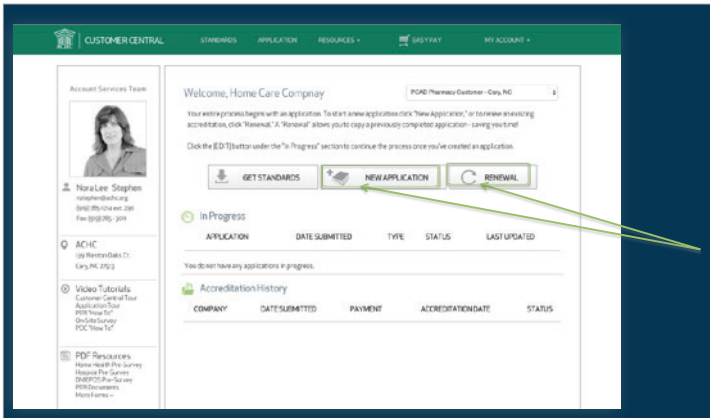

If this is your client's first time with ACHC Accreditation, click the "NEW APPLICATION" button.

If you're in an existing accredited account (like shown), you can click on the "RENEWAL" button to save time.

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ONLINE APPLICATION

- NEW APPLICATION or RENEWAL
- Main office:
  - Profile
  - Location
  - Contacts
  - Services
- Additional locations –branch locations
- Blackout dates
- Unduplicated admissions
- Services provided

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PRELIMINARY EVIDENCE REPORT

- Preliminary Evidence Report (PER:)
  - Mandatory documents and/or criteria that must be submitted and met in order to begin the survey process
    - Date of Compliance – ACHC standards only
    - Compliance starts with acceptance of first patient
  - CoPs
  - State licensure requirements
  - Discipline-specific scope of practice
  - Federal requirements

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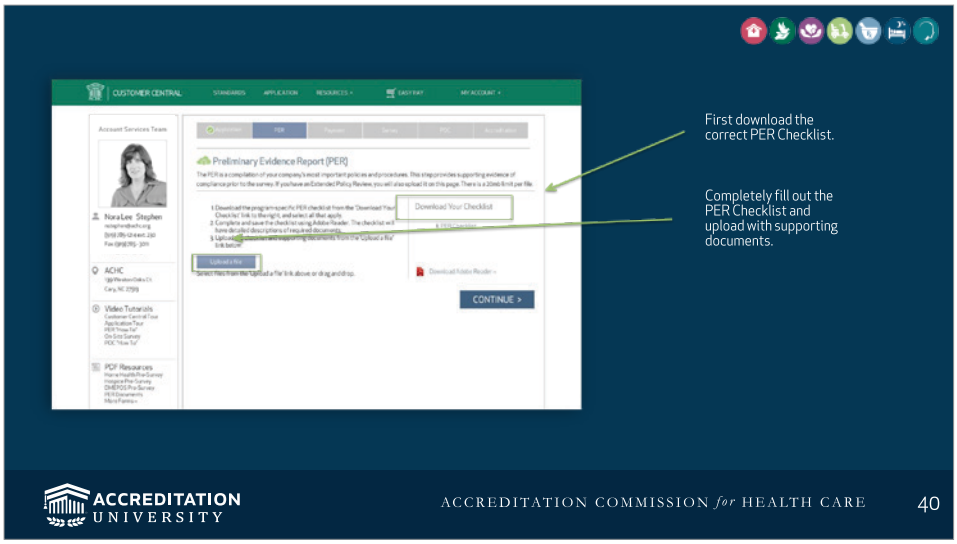
CUSTOMER CENTRAL
Preliminary Evidence Report (PER)
Download Your Checklist
CONTINUE >
First download the correct PER Checklist.
Completely fill out the PER Checklist and upload with supporting documents.
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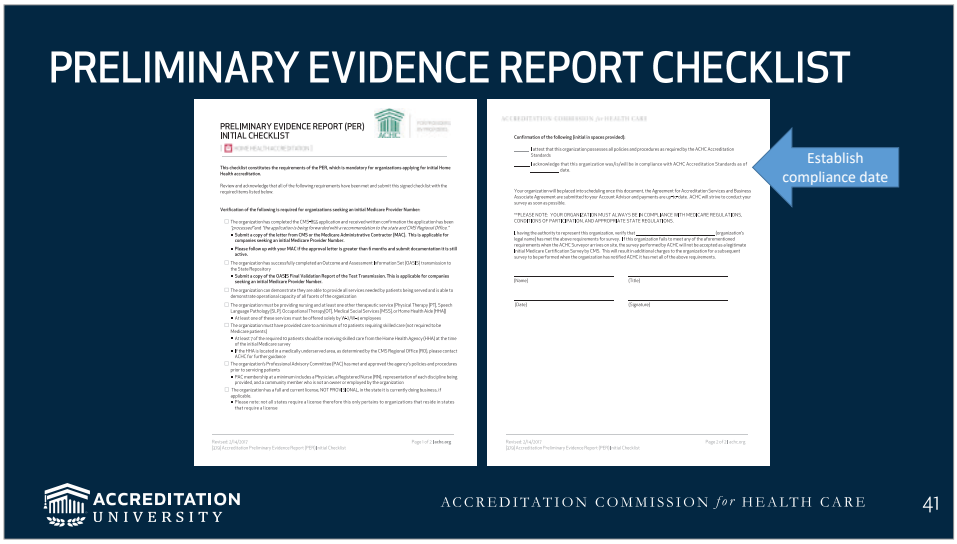
PRELIMINARY EVIDENCE REPORT CHECKLIST
PRELIMINARY EVIDENCE REPORT (PER) INITIAL CHECKLIST
Establish compliance date
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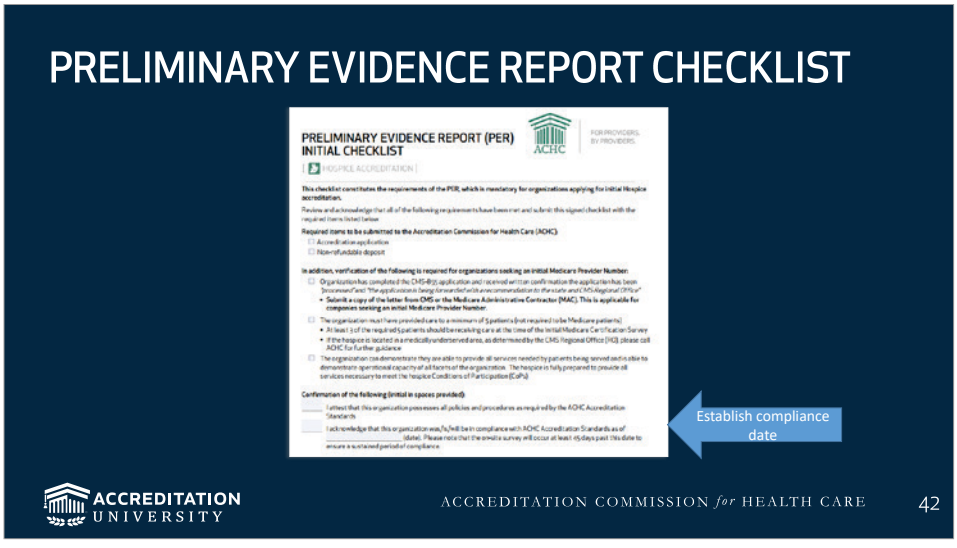
PRELIMINARY EVIDENCE REPORT CHECKLIST
PRELIMINARY EVIDENCE REPORT (PER) INITIAL CHECKLIST
Establish compliance date
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HOME HEALTH APPENDIX A

Appendix A: Standard Service Table for Selected Services

Standard	HHA	MSS	SN
HH1-1A	X	X	X
HH1-1A.01	X	X	X
HH1-1B	X	X	X
HH1-1B.01	X	X	X
HH1-1C	X	X	X
HH1-2A	X	X	X
HH1-2A.01	X	X	X
HH1-2A.02	X	X	X
HH1-2A.03	X	X	X
HH1-2A.04	X	X	X
HH1-2A.05	X	X	X
HH1-3A	X	X	X
HH1-3A.01	X	X	X
HH1-3A.02	X	X	X
HH1-3B	X	X	X
HH1-4A.01	X	X	X
HH1-5A	X	X	X
HH1-5A.01	X	X	X
HH1-5B	X	X	X
HH1-6A	X	X	X
HH1-6A.01	X	X	X
HH1-6B	X	X	X
HH1-6C	X	X	X
HH1-7A	X	X	X
HH1-8A	X	X	X
HH1-8B	X	X	X
HH1-9A.01	X	X	X

HOME HEALTH APPENDIX B

Appendix B: Reference Guide for Required Documents, Policies and Procedures
Customized for: HHA, MSS, OT, PD, PT, SN, ST

Standard #	Documents, Policies and Procedures	Agency Notes
HH1-1A.01	Written Policies and Procedures	
HH1-1B	Written Policies and Procedures	
HH1-2A	Written Policies and Procedures	
HH1-4A.01	Written Policies and Procedures	
HH1-6B	Written Policies and Procedures	
HH1-6C	Written Policies and Procedures	
HH1-8B	Written Policies and Procedures	
HH2-1A.01	Written Policies and Procedures	
HH2-2A	Written Policies and Procedures	
HH2-3A	Written Policies and Procedures	
HH2-4A	Written Policies and Procedures	
HH2-5A	Written Policies and Procedures	
HH2-6A	Written Policies and Procedures	
HH2-6B.01	Written Policies and Procedures	
HH2-7A.01	Written Policies and Procedures	
HH2-8A	Written Policies and Procedures	
HH2-8B.01	Written Policies and Procedures	
HH2-9A.01	Written Policies and Procedures	

HOSPICE APPENDIX A

Appendix A: Standard Service Table for Selected Services

Standard	HIC	HRC
HSP1-1A	X	X
HSP1-1A.01	X	X
HSP1-1B	X	X
HSP1-1B.01	X	X
HSP1-2A	X	X
HSP1-2B	X	X
HSP1-2B.01	X	X
HSP1-2B.02	X	X
HSP1-2B.03	X	X
HSP1-2C.01	X	X
HSP1-2C.02	X	X
HSP1-3A.01	X	X
HSP1-4A	X	X
HSP1-4B	X	X
HSP1-4B.01	X	X
HSP1-5A.01	X	X
HSP1-5A.02	X	X
HSP1-6A	X	X
HSP1-7A.01	X	X
HSP1-8A	X	X
HSP1-8A.01	X	X
HSP1-8A.02	X	X
HSP1-8A.03	X	X
HSP1-8B		X
HSP1-8C		X
HSP1-9A	X	X
HSP1-10A		X
HSP1-10B	X	
HSP1-11A		X

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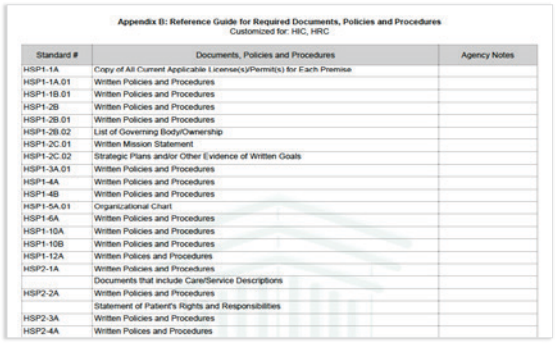
HOSPICEAPPENDIX B



Appendix B: Reference Guide for Required Documents, Policies and Procedures
Customized for: HIC, HRC

Standard #	Documents, Policies and Procedures	Agency Notes
HSP1-1A	Copy of All Current Applicable License(s)/Permit(s) for Each Premise	
HSP1-1A.01	Written Policies and Procedures	
HSP1-1B.01	Written Policies and Procedures	
HSP1-2B	Written Policies and Procedures	
HSP1-2B.01	Written Policies and Procedures	
HSP1-2B.02	List of Governing Body/Ownership	
HSP1-2C.01	Written Mission Statement	
HSP1-2C.02	Strategic Plans and/or Other Evidence of Written Goals	
HSP1-3A.01	Written Policies and Procedures	
HSP1-4A	Written Policies and Procedures	
HSP1-4B	Written Policies and Procedures	
HSP1-5A.01	Organizational Chart	
HSP1-6A	Written Policies and Procedures	
HSP1-10A	Written Policies and Procedures	
HSP1-10B	Written Policies and Procedures	
HSP1-12A	Written Polices and Procedures	
HSP2-1A	Written Policies and Procedures	
	Documents that include Care/Service Descriptions	
HSP2-2A	Written Policies and Procedures	
	Statement of Patient's Rights and Responsibilities	
HSP2-3A	Written Policies and Procedures	
HSP2-4A	Written Polices and Procedures	

EXTENDED POLICY REVIEW

- Optional review of complete policies and procedures by an ACHC Surveyor to determine compliance prior to the on-site survey
- Feedback from an ACHC Surveyor regarding the alignment of agency's policies and procedures to ACHC Accreditation Standards
- Option to purchase through the Customer Central portal
- Customized Reference Guide for Required Documents (Appendix B)
- Consultants can also have Policies and Procedures pre-approved

ACCREDITATION PROCESS

- After the first three steps are completed (application, deposit, and PER), your Account Advisor will review all documentation and send an Accreditation Agreement to the customer
- After the Accreditation Agreement is signed by both parties, the customer will receive a direct link to pay the remaining balance
- At that point, your client's organization will be sent to scheduling

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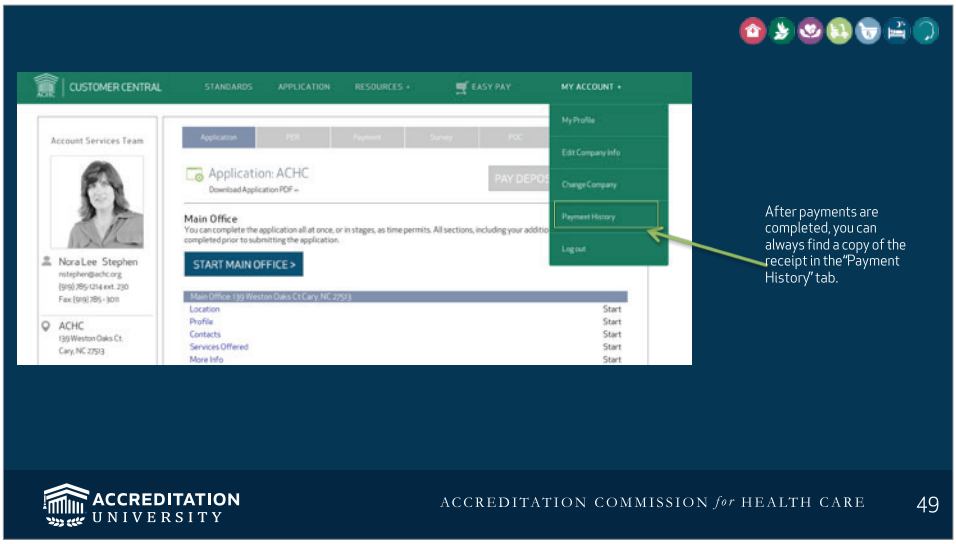

CUSTOMER CENTRAL

- Your go-to resource for ACHC Accreditation needs
- Utilize all documentation and video resources
- To link all your client accounts together contact ACHC Marketing team at info@achc.org:
  - Provide written approval from client (email is OK)
  - Allow two to three business days

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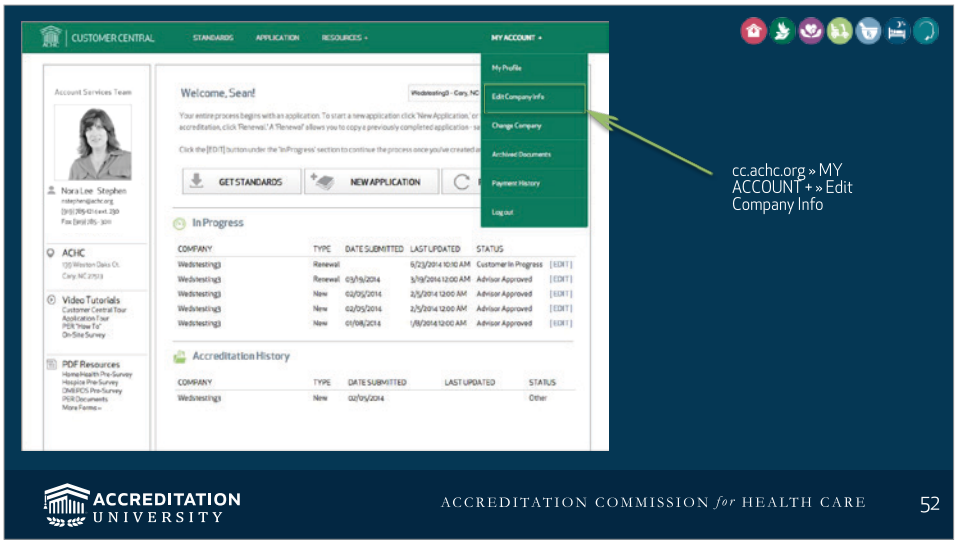
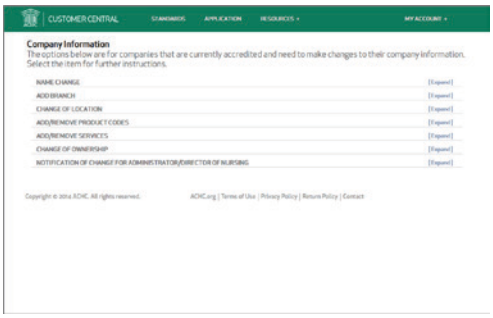
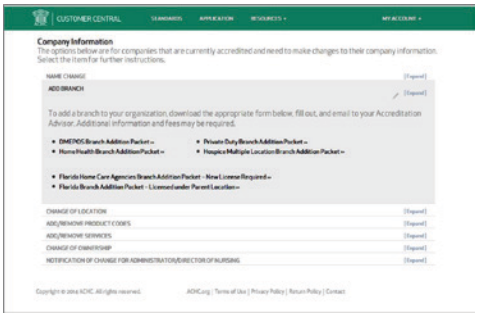


EDIT COMPANY INFORMATION

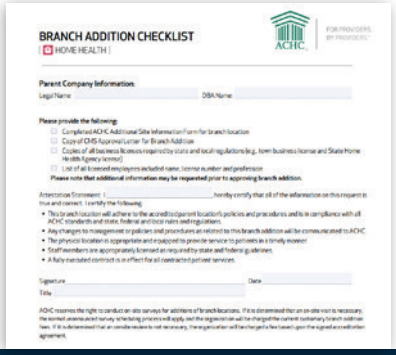


BRANCH ADDITION



ACHIEVING ACHC ACCREDITATION

BRANCH ADDITION CHECKLIST


BRANCH ADDITION CHECKLIST

HOME HEALTH

Parent Company Information

Legal Name DBA Name

Please provide the following:

- Completed ACHC Additional Site Information Form for branch location
- Copy of CMS Approval Letter for Branch Addition
- Copies of all business licenses required by state and local regulations (e.g., town business license and State Home Health Agency license)
- List of all licensed employees included name, license number and profession

Please note that additional information may be requested prior to approving branch addition.

Attestation Statement: I _____ hereby certify that all of the information on this request is true and correct. I certify the following:

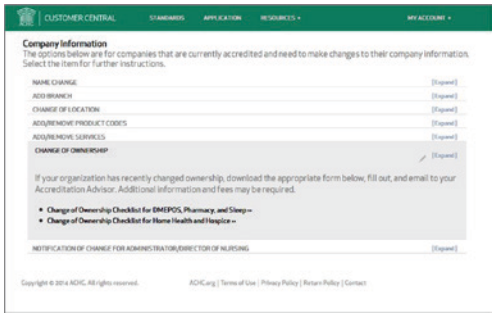
- This branch location will adhere to the accredited parent location's policies and procedures and is in compliance with all ACHC standards and state, federal and local rules and regulations.
- Any changes to management or policies and procedures as related to this branch addition will be communicated to ACHC.
- The physical location is appropriate and equipped to provide service to patients in a timely manner.
- Staff members are appropriately licensed as required by state and federal guidelines.
- A fully executed contract is in effect for all contracted patient services.

Signature Date

Title

ACHC reserves the right to conduct an on-site survey for additions of branch locations. If it is determined that an on-site visit is necessary, the normal unannounced survey scheduling process will apply, and the organization will be charged the current outpatient branch addition fees. If it is determined that an onsite review is not necessary, the organization will be charged a fee based upon the signed accreditation agreement.

CHANGE OF OWNERSHIP


CUSTOMER CENTRAL STANDARDS APPLICATION RESOURCES MY ACCOUNT

Company Information

The options below are for companies that are currently accredited and need to make changes to their company information. Select the item for further instructions.

NAME CHANGE [Expand]

ADD BRANCH [Expand]

CHANGE OF LOCATION [Expand]

ADD/REMOVE PRODUCT CODES [Expand]

ADD/REMOVE SERVICES [Expand]

CHANGE OF OWNERSHIP [Expand]

If your organization has recently changed ownership, download the appropriate form below, fill out, and email to your Accreditation Advisor. Additional information and fees may be required.

- Change of Ownership Checklist for DMEPOS, Pharmacy, and Sleep »
- Change of Ownership Checklist for Home Health and Hospice »

NOTIFICATION OF CHANGE FOR ADMINISTRATOR/DIRECTOR OF NURSING [Expand]

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NOTES

NOTES

EDUCATIONAL RESOURCES

- Accreditation University resources @ AccreditationUniversity.com:
  - Workbooks and workshops
  - Webinars
- Online resources:
  - *The Surveyor* newsletter
  - Regulatory updates
  - Accreditation resources
  - Maintaining compliance checklists
- Email updates:
  - "Did You Know?"
  - *ACHC Today* e-newsletter

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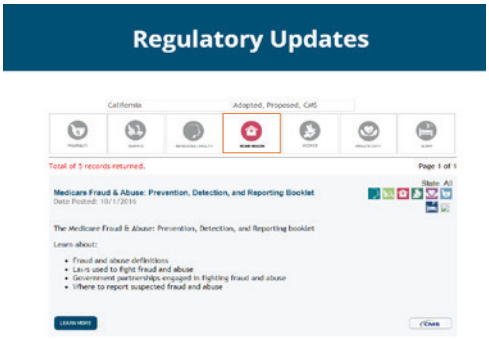
REGULATORY UPDATES

- Regulatory Updates can be filtered to state-specific issues
- *achc.org:*
  - Resources & Events
  - Regulatory Updates



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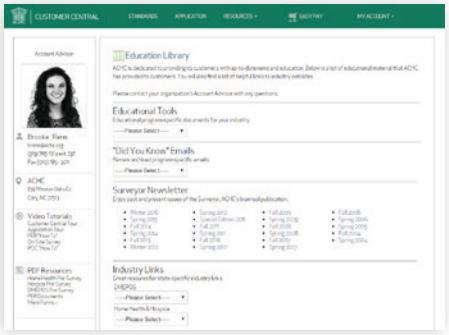
CUSTOMER CENTRAL

- Customer Central is available 24/7 with resources and educational materials designed for your company
- *cc.achc.org*



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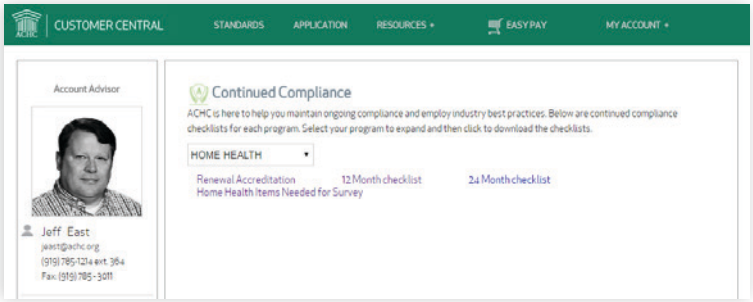
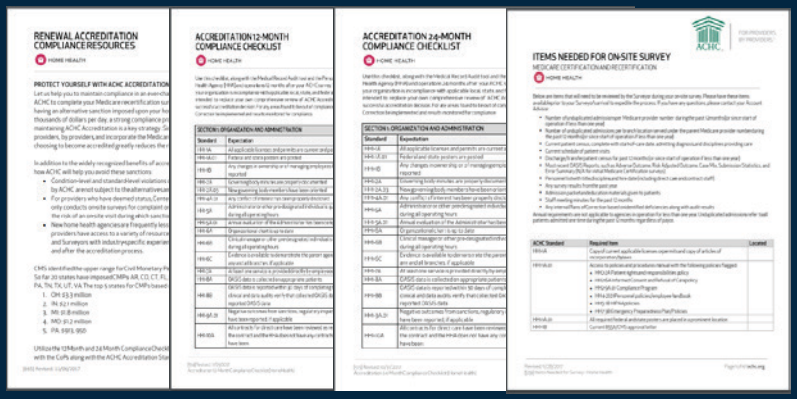
ACHIEVING ACHC ACCREDITATION

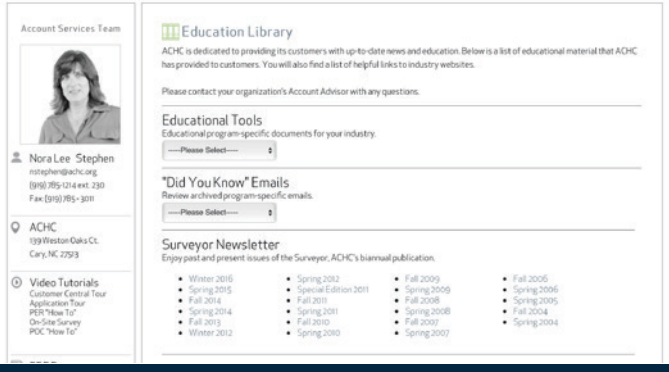
MAINTAINING COMPLIANCE CHECKLIST



MAINTAINING COMPLIANCE



EDUCATION LIBRARY



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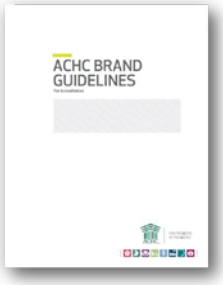
TOOLS OF THE TRADE

- ACHC provides the tools to leverage the accredited status
- All accredited organizations receive the ACHC Branding Kit:
  - ACHC Brand Guidelines
  - ACHC Accredited Logos
  - Window cling



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BRANDING ELEMENTS

- Gold Seal of Accreditation:
  - Represents compliance with the most stringent national standards

ACCREDITATION UNIVERSITY ACCREDITATION COMMISSION *for* HEALTH CARE 66

ACHIEVING ACHC ACCREDITATION

BRANDING ELEMENTS

- ACHC Accredited Logo

ACHC ACCREDITED

ACHC ACCREDITED

SAMPLE PRESS RELEASE

FOR IMMEDIATE RELEASE

February 26, 2014
Media Contact:
Contact Name
Organization Name
Contact Email
Website

YOUR ORGANIZATION NAME
ACHIEVES ACCREDITATION WITH ACHC

CITY, STATE, Your organization name proudly announces its approval of accreditation status by Accreditation Commission for Health Care (ACHC) for the services of list services.

Achieving accreditation is a process where healthcare organizations demonstrate compliance with national standards. Accreditation by ACHC reflects an organization's dedication and commitment to meeting standards that facilitate a higher level of performance and patient care.

ACHC is a not-for-profit organization that has stood as a symbol of quality and excellence since 1986. ACHC is ISO 9001:2008 certified and has CMS Deeming Authority for Home Health, Hospice and DME/POS.

Write a brief paragraph about your company, communities you serve, why you're unique, etc. A quote about the accreditation process or what this accreditation means to your organization is a great way to personalize the press release.

For more information, please visit yourwebsite, or contact us at email address or (000)000-0000X.

###

IN CONCLUSION

- Achieving ACHC Accreditation can help your clients add value to their brand
- Consultants can add value to their service by encouraging providers to utilize the marketing tools that ACHC provides
- In doing so, you can **exceed** your client's expectations – earning **trust** and building your **brand**

NOTES

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REFERENCES

- If you would like to revisit the ACHC Brand Guidelines at any time, please:
  - Visit Customer Central at cc.achc.org
  - Visit www.achc.org/store
  - Contact the ACHC Marketing Department at (855) 937-2242

ACHC CERTIFIED CONSULTANT

- Becoming an ACHC Certified Consultant is a notable accomplishment that you should be proud to display:
  - It shows a dedication to providing the very best service to your clients
  - It provides assurance to healthcare providers when choosing your business

ACHIEVING ACHC ACCREDITATION

BRANDING ELEMENTS

- ACHC is committed to providing the tools you need to leverage your certified status:
  - Certificate
  - Logo
  - Certified Consultant pin
  - Window cling

ACHC CERTIFIED CONSULTANT

ACHC CERTIFIED CONSULTANT

SAMPLE PRESS RELEASE

FOR IMMEDIATE RELEASE

November 14, 2014
Media Contact:
Kevin O'Connell
O'Connell Consulting, Inc.
oconnellconsulting@oc.net
oconnellconsulting.net

O'Connell Consulting, Inc. Receives ACHC Consultant Certification

Cary, NC, O'Connell Consulting, Inc proudly announces that Kevin O'Connell, Consulting Associate, has earned certification by Accreditation Commission for Health Care (ACHC) to provide consulting services. As a Certified Consultant, Kevin completed an intensive consultant training program demonstrating competence in ACHC survey preparation, including comprehensive knowledge of standards and processes for DME/POS and Infusion Pharmacy.

The ACHC Consultant Certification program is designed for consultants who prepare healthcare providers for ACHC accreditation. The program is instructed by ACHC Clinical Compliance Educators who have extensive experience operating healthcare organizations, surveying to ACHC standards, and leading accreditation workshops.

"At O'Connell Consulting, Inc., we are committed to providing the very best consulting services for our clients," said Kevin O'Connell. "In choosing an ACHC Certified Consultant, our clients can be assured that our organization is well-prepared to assist them throughout the entire accreditation process to successfully achieve and maintain accreditation."

Accreditation is a process of review that healthcare organizations participate in to demonstrate the ability to meet predetermined criteria and standards established by national regulations and the accrediting organization. Accreditation represents agencies as credible and reputable organizations dedicated to ongoing and continuous compliance with the highest standard of quality. ACHC collaborates with industry experts to create standards to ensure that quality is maintained throughout all aspects of the organization.

ACHC is a not-for-profit organization that has stood as a symbol of quality and excellence since 1986. They are ISO 9001:2008 certified and have CMS Deeming Authority for Home Health, Hospice and DME/POS.

PRESS RELEASE DISTRIBUTION

- Send it directly to:
  - Clients
  - Industry contacts
  - Local news agencies
- Other distribution options:
  - Press Release Distribution Services;
    - Examples: PR Newswire and OutMarket

NOTES

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IN CONCLUSION

- As an ACHC Certified Consultant, you can establish trust with providers
- Utilize the resources available to you to enhance the value of your consultant business
- Use multiple communication channels to create multiple touch points and reach a broader audience with your message

ACHC RESOURCES

- ACHC's Marketing Department is available to help with your marketing needs
- Feel free to contact them at info@achc.org or (855) 937-2242

ACHIEVING ACHC ACCREDITATION

DEEMED VS. NON-DEEMED

- Deemed Status:
  - For startup agencies, in lieu of state/CMS survey in order to obtain Medicare provider number for billing
  - For existing agencies, in lieu of state/CMS survey for the recertification survey every three years
  - Agency comes under the jurisdiction of ACHC
  - ACHC makes a recommendation to CMS/Regional Office to participate in the Medicare program
  - ACHC cannot issue to terminate a Medicare provider number
- Accreditation only:
  - Remain with state/CMS for certification and recertification surveys

ON-SITE SURVEY

- Notification call
- Opening conference
- Tour of facility
- Personnel file review
- Patient home visits
- Patient chart review
- Interview with staff, leadership and governing body
- Review of agency's implementation of policies
- Quality Assessment and Performance Improvement (QAPI)
- Exit conference

OPENING CONFERENCE

- Begins shortly after arrival of Surveyor
- Completion of CMS paperwork
- Good time to gather information needed by the Surveyor
- **KEY REPORTS:**
  - Unduplicated admissions for previous 12 months (number)
  - Current census and current schedule of visits:
    - Name, diagnosis, start of care date, disciplines involved
  - Discharge and transfers
  - Bereavement and revocations
  - OASIS reports
  - Personnel (contract:)
    - Name, start of hire, and discipline/role

NOTES

NOTES

TOUR

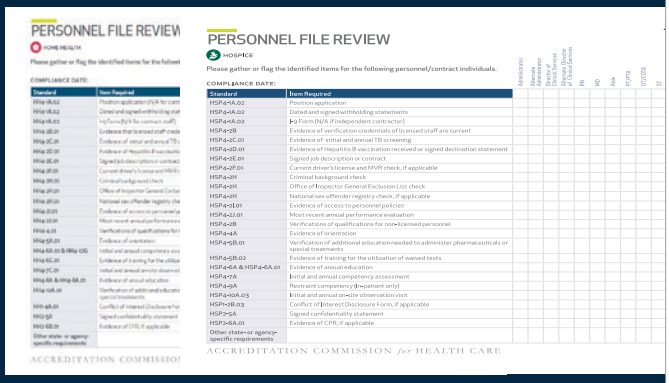
- Brief tour of facility:
  - Medical record storage
  - Maintaining confidentiality of Protected Health Information (PHI)
  - Supply closet
  - Biohazard waste
  - Required posters
  - Fire extinguishers/smoke detectors/non-smoking signage
  - Restrooms

PERSONNEL FILE REVIEW

- Review personnel records for key staff and contract staff:
  - Application, tax forms, and I-9
  - Job descriptions and evaluations
  - Verification of qualifications
  - Orientation records, competencies, ongoing education
  - Medical information
  - Background checks

For a complete listing of items required in the personnel record, review Section 4 of the ACHC Accreditation Standards.

PERSONNEL FILE REVIEW



MEDICAL CHART REVIEWS

- CMS requirement based on unduplicated admissions
- Representative of the care provided:
  - Pediatric-geriatric
  - Environment served
  - Medically complex
  - All payors
- Electronic Medical Record:
  - Do not print the medical record
  - Surveyor needs access to the entire record- **Read-only format**
  - Agency needs to provide a laptop/desktop for the Surveyor
  - Navigator/outline

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HOME VISITS

- CMS requirement based on unduplicated admissions
- Visits will be with patients already scheduled for visits if census is large enough to accommodate
- Agency responsibility to obtain consent from patient/family
- Prepare patients and families for potential home visits
- Surveyor transportation

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RECORD REVIEW/HOME VISITS

Unduplicated Admissions	Minimum # of Active Record Reviews Without Home Visits	Minimum # of Record Reviews With Home Visits	Minimum # of Closed Record Reviews	Total Record Reviews
300 or less	2	3	2	7
301-500	3	4	3	10
501-700	4	5	4	13
701 or greater	5	7	5	17

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NOTES

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RECORD REVIEW/HOME VISITS

Unduplicated Admissions for a recent 12 months	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

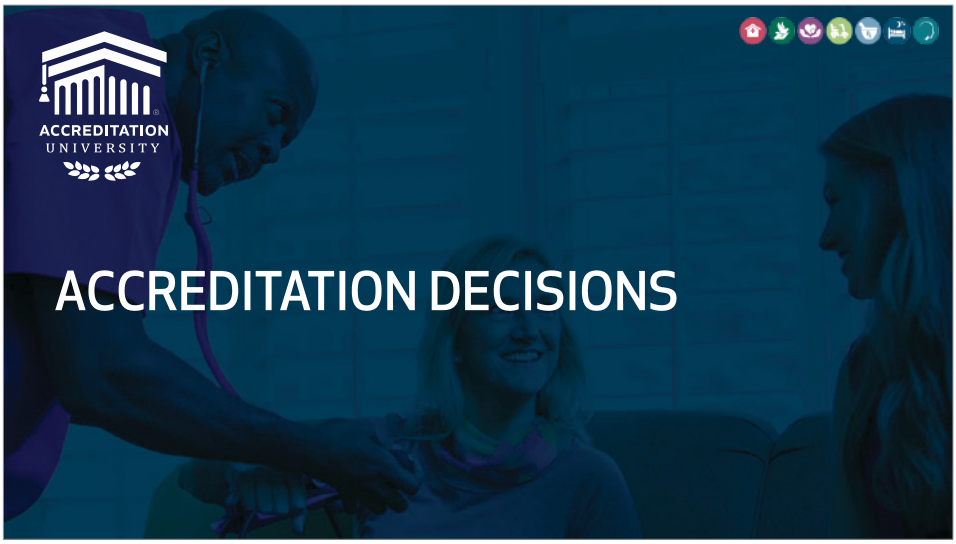
CORRECTED ON-SITE

- ACHC-only/non-CoP requirements can be corrected on-site and a Plan of Correction (POC) will not be required
- G/L tags that are corrected on site will still be scored as a "No" and a POC will be required:
  - Always want to demonstrate regulatory compliance
  - Validation surveys

EXIT CONFERENCE

- Mini-exit:
  - At end of each day identify deficiencies; plan for next day
- Final exit conference:
  - Present all corrections prior to the Exit Conference
  - Surveyor cannot provide a score
  - Invite those you want to attend
  - Preliminary Summary of Findings (SOF) as identified by Surveyor and the ACHC standard/CoP
  - Seek clarification from your Surveyor while still on-site:
    - Validation survey

ACHIEVING ACHC ACCREDITATION



REVIEW COMMITTEE

- All survey results are reviewed by the Review Committee
- Compliance with the Medicare CoPs vs. compliance with ACHC-only requirements
- CoP deficiencies will result in either a standard level or condition level deficiency
- ACHC-only deficiencies will result in a standard level deficiency

STANDARD-LEVEL & CONDITION-LEVEL

- Standard-level deficiencies are ACHC-only deficiencies and individual G/L tags:
  - Not as "severe"
  - Individual, random issue vs. a systemic issue
- Condition-level deficiencies result when either an entire condition is out of compliance, multiple G/L tags under a single condition are out of compliance, or the deficiency is severe

NOTES

NOTES

CORRECTED ON SITE

- ACHC-only requirements can be corrected on site and the deficiencies will not be on the SOF and POC will not be required
- G/L tags that are corrected on site will still be scored as a "No" and a POC will be required
- Encourage customers to correct all deficiencies while the Surveyor is on location:
  - Validation survey

HOME HEALTH SUMMARY OF FINDINGS

HOSPICE SUMMARY OF FINDINGS

ACHIEVING ACHC ACCREDITATION

ACHC ACCREDITATION DECISION DEFINITIONS

ACCREDITED
Provider meets all requirements for full accreditation status. Accreditation is granted but Plan of Correction (POC) may still be required.*

ACCREDITATION PENDING
Provider meets basic accreditation requirements but accredited status is granted upon submission of an approved POC.

DEPENDENT
Provider has significant deficiencies to achieve accreditation. An additional on-site visit will be necessary to be eligible for accreditation.

DENIED
Accreditation is denied. Provider must start process from the beginning once deficiencies are addressed.

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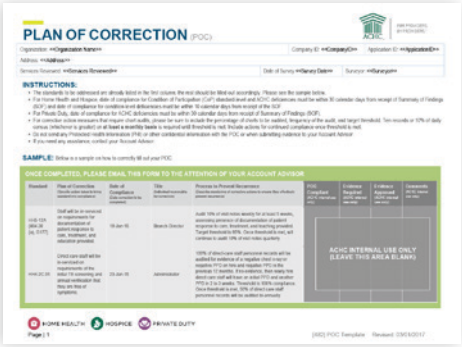
PLAN OF CORRECTION


PLAN OF CORRECTION (POC)

INSTRUCTIONS:

SAMPLE:

ONCE COMPLETED, PLEASE EMAIL THIS FORM TO THE ATTENTION OF YOUR ACCOUNT ADVISOR

ACHC INTERNAL USE ONLY (LEAVE THIS AREA BLANK)

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PLAN OF CORRECTION REQUIREMENTS

- Due in 10 calendar days to ACHC
- Deficiencies are auto-filled
- Plan of Correction:
  - Specific action step to correct the deficiency
- Date of compliance of the action step:
  - 10 calendar days for condition-level
  - 30 calendar days for standard-level
- Title of individual responsible
- Process to prevent recurrence – 2-step process:
  - Percentage and frequency
  - Target threshold
  - Maintaining compliance

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NOTES

NOTES

EVIDENCE

- Evidence is required to support compliance
- Once POC is approved, POC identifies which deficiencies will require evidence
- All evidence to the Account Advisor within 60 days
- No PHI or other confidential information of patients or employees
- Accreditation can be terminated if evidence is not submitted

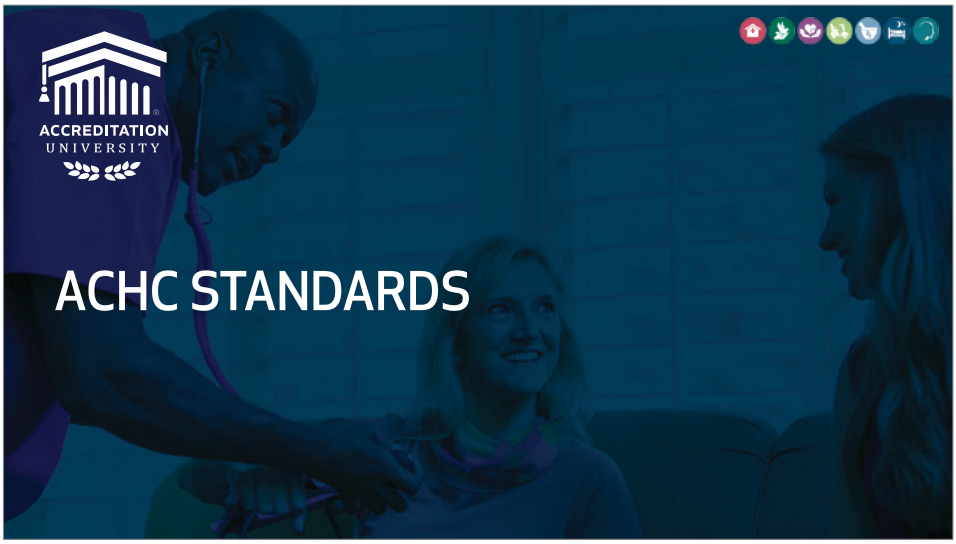
Additional evidence may be required based on the decision of the ACHC Review Committee

SAMPLE AUDIT SUMMARY

LUNCH TIME

- 1 hour

ACHIEVING ACHC ACCREDITATION



Standards

SECTION 1

ORGANIZATION AND ADMINISTRATION

The standards in this section apply to the leadership and organizational structure of the company. All items referring to business licensure including federal, state, and local licenses that affect the day-to-day operations of the business should be addressed. This section includes the leadership structure including board of directors, advisory committees, management, and employees. Also included are the leadership responsibilities, conflict of interest, chain of command, program goals, and regulatory compliance.

Standards

SECTION 2

PROGRAM/SERVICE OPERATIONS

The standards in this section apply to the specific programs and services an organization is supplying. This section addresses rights and responsibilities, complaints, protected health information, cultural diversity, and compliance with fraud- and abuse-prevention laws.

NOTES

NOTES

Standards

SECTION 3

FISCAL MANAGEMENT

The standards in this section apply to the financial operations of the company. These standards will address the annual budgeting process, business practices, accounting procedures, and the company's financial processes.

Standards

SECTION 4

HUMAN RESOURCE MANAGEMENT

The standards in this section apply to all categories of personnel in the organization unless otherwise specified. Personnel may include, but are not limited to, support personnel, licensed clinical personnel, unlicensed clinical personnel, administrative and/or supervisory employees, contract personnel, independent contractors, volunteers, and students completing clinical internships. This section includes requirements for personnel records including skill assessments and competencies.

Standards

SECTION 5

PROVISION OF CARE AND RECORD MANAGEMENT

The standards in this section apply to documentation and requirements for the service recipient /client/ patient record. These standards also address the specifics surrounding the operational aspects of care/service provided.

ACHIEVING ACHC ACCREDITATION

Standards

SECTION 6

QUALITY OUTCOMES/PERFORMANCE IMPROVEMENT

The standards in this section apply to the organization's plan and implementation of a Performance Improvement (PI) program. Items addressed in these standards include who is responsible for the program, activities being monitored, how data is compiled, and corrective measures being developed from the data and outcomes.

Standards

SECTION 7

RISK MANAGEMENT: INFECTION AND SAFETY CONTROL

The standards in this section apply to the surveillance, identification, prevention, control, and investigation of infections and safety risks. The standards also address environmental issues such as fire safety, hazardous materials, and disaster and crisis preparation.

STANDARD FORMAT

- Identifier: Home Health (HH), Hospice (HSP), Private Duty (PD)
- Standard:
  - Provides a broad statement of the expectation in order to be in compliance with ACHC standards
- Interpretation:
  - Gives you more detailed information and specific direction on how to meet ACHC standards
- Evidence:
  - Items that will be reviewed to determine if the standard is met

NOTES

NOTES

Section 1

STANDARD EXAMPLE

Standard HH1-1C: The HHA is in compliance with accepted professional standards and principles. 484.105(f)(2) G984

Interpretation:

All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice which include, but are not limited to:

- HHA federal regulation
- State Practice Act
- Commonly accepted health standards established by national organizations, boards, and councils (e.g., the American Nurses Association standards)

Evidence:

Observation

Section 2

STANDARD EXAMPLE

Standard HH2-10A.01: Supervision is available during all hours that care/service is provided.

Interpretation:

There is administrative and clinical supervision of personnel in all care/service areas provided 24 hours per day, 7 days a week, as applicable. Supervision is consistent with state laws and regulations.

Evidence:

On-call schedule, observation, response to interviews

Section 1

STANDARD EXAMPLE

Standard HSP1-4B: An individual is appointed to assume the role of the Administrator during temporary absences and/or vacancies. (418.100(b)) (L651)

Interpretation: A qualified person is authorized in writing to act in the absence of the Administrator. The duties that the individual assumes during the absence of the Administrator are written into the job description and policies and procedures and are included in the orientation of this individual.

Evidence: Written policies and procedures, alternate Administrator resume, orientation records

Section 1

STANDARD EXAMPLE

Standard HSP1-8A.02: Service contracts/agreements are reviewed and renewed as required in the contract.

Interpretation: The hospice has an established process to review and renew contract/agreements as required in the contract. A mechanism to indicate that the review/renewal has been accomplished may be evidenced by either a notation of the review dates on the initial contract/agreement or development of an updated contract/agreement.

Evidence: Written contracts/agreements

STARTUPS

- **Approved 855A letter**
- Medicare Enrollment Application:
  - Required for all home health agencies requesting participation in the Medicare program
  - www.CMS.gov/MedicareProviderSupEnroll
- **Test OASIS transmission to the state repository**

NOTES

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STARTUPS

- **Required number of patients prior to survey:**
  - Served 10 patients requiring skilled care and 7 active at time of survey (at least 1 patient has had 2 of the services)
  - Unless in a medically underserved area, 5-2
- **Required services:**
  - Nursing and one other therapeutic services (Aide, Physical Therapy [PT], Occupational Therapy [OT], Speech Therapy [ST], and Social Work [SW] for home health)
  - At least one service, in its entirety, must be provided directly by a W-2 employee
- **Fully operational:**
  - State Operations Manual, Chapter 2, section 2008A

SEPARATE ENTITIES

- If a company operates a Medicare-certified home health agency and private duty services, need to ensure the two programs are separate entities
- If they are not separate entities then the Medicare CoPs apply to all patients of the Medicare-certified home health agency

SEPARATE ENTITIES

- The following criteria should be considered in making a decision regarding whether a separate entity exists
- **Operation of the Home Health Agency:**
  - Are there separate policies and procedures?
  - Are there separate clinical records for patients receiving home health and private duty services?
  - Are personnel identified as belonging to one program or the other and are their personnel records separated?
  - Are there separate budgets?
  - If the state requires a license for home health, is the agency licensed separately for private duty?

SEPARATE ENTITIES

- **Consumer Awareness:**
  - Review marketing materials for distinction between the programs
  - Written material should clearly identify the home health agency as separate and distinct from other programs, departments, or other entities of the organization
- **Staff Awareness:**
  - Staff should be able to identify the difference in services they provide for the home health agency and other programs, departments, or entities of the organization
  - Staff who divide time between the separate entities must be appropriately trained and meet the qualifications for home health services

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

The HHA must organize, manage, and administer its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care, for each patient's medical, nursing, and rehabilitative needs.

The HHA must ensure that administrative and supervisory functions are not delegated to another agency or organization, and all services not furnished directly are monitored and controlled. The HHA must set forth, in writing, its organizational structure, including lines of authority, and services furnished.

NOTES

NOTES

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105 (a) G942: Standard Governing body.
A governing body (or designated persons so functioning) must assume full legal authority and responsibility for the agency's overall management and operation, the provision of all home health services, fiscal operations, review of the agency's budget and its operational plans, and its Quality Assessment Performance Improvement Program.

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(b) Standard: Administrator

484.105(b)(1) G944 The administrator must:

(i) G946 Be appointed by and report to the governing body

(ii) G947 Be responsible for all day to day operations of the HHA

(iii) G950 Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours

(iv) G952 Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(b)(2) G954 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 as described in paragraph (c) of this section.

484.105(b)(3) G956 The administrator or a pre-designated person is available during all operating hours.

The HHA administrator names, in advance, the person or persons who will assume the administrator responsibilities in his/her absence. **The appointments must also be pre-approved by the governing body.**

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(c) G958 Standard: Clinical manager

One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following:

(1) G960 Making patient and personnel assignments

(2) G962 Coordinating patient care

(3) G964 Coordinating referrals

(4) G966 Assuring that patient needs are continually assessed

(5) G968 Assuring the development, implementation, and updates of the individualized plan of care

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(f) G982 Standard: Services furnished

484.105(f)(1) Skilled nursing services and at least one other therapeutic service (physical therapy, speech-language pathology, or occupational therapy, medical social services, or Home Health Aide services) are made available on a visiting basis, in a place of residence used as a patient's home. An HHA must provide at least one of the services described in this subsection directly, but may provide the second service and additional services under arrangement with another agency or organization.

484.105(f)(2) G984 All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice

Section 2

484.50 PATIENT RIGHTS

The patient and representative (if any) have the right to be informed of the patient's rights in a language and manner the individual understands. The HHA must protect and promote the exercise of these rights.

Six Standards:

a)Notice of Rights

b)Exercise Rights

c)Rights of the Patient

d)Transfer and Discharge

e)Investigation of Complaints

f)Accessibility

NOTES

NOTES

Section 2

484.50 PATIENT RIGHTS

484.50(a) Standard: Notice of rights

The HHA must:

484.50(a)(1) Provide the patient and the patient's legal representative (if any), the following information during the initial evaluation visit, in advance of furnishing care to the patient:

Representative means the patient's legal representative, such as a guardian, who makes healthcare decisions on the patient's behalf, or a patient-selected representative who participates in making decisions related to the patient's care or well-being, including, but not limited to, a family member or an advocate for the patient. The patient determines the role of the representative, to the extent possible.

Section 2

484.50 PATIENT RIGHTS

484.50(a)(1)(i) G412 Written notice of the patient's rights and responsibilities under this rule, and the HHA's transfer and discharge policies as set forth in paragraph (d) of this section. Written notice must be understandable to persons who have limited English proficiency and accessible to individuals with disabilities.

Patients and/or representative acknowledge they have received this information in a language they understand.

Written notice to the patient or their representative of their rights and responsibilities under this rule should be provided hard copy unless the patient requests that the document be provided electronically.

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.

Section 2

484.50 PATIENT RIGHTS

484.50(a)(1)(ii) G414 Contact information for the HHA administrator, including the administrator's name, business address, and business phone number in order to receive complaints.

484.50(a)(1)(iii) G416 An OASIS privacy notice to all patients for whom the OASIS data is collected.

484.50(a)(2) G418 Obtain the patient's or legal representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.

Section 2

484.50 PATIENT RIGHTS

484.50(a)(3) G420 Provide verbal notice of the patient's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter if necessary, no later than the completion of the second visit from a skilled professional as described in § 484.75.

In those instances where an HHA patient speaks a language which the HHA has not translated into written material, the HHA may delay the notification of rights and responsibilities until an interpreter is present (either physically, electronically, or telephonically) to verbally translate. However, this may be delayed no later than the second visit.

Section 2

484.50 PATIENT RIGHTS

484.50(b)(1) If a patient has been adjudged to lack legal capacity to make healthcare decisions as established by state law by a court of proper jurisdiction, the rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf.

484.50(b)(2) If a state court has not adjudged a patient to lack legal capacity to make healthcare decisions as defined by state law, the patient's representative may exercise the patient's rights.

484.50(b)(3) If a patient has been adjudged to lack legal capacity to make healthcare decisions under state law by a court of proper jurisdiction, the patient may exercise his or her rights to the extent allowed by court order.

Section 2

484.50 PATIENT RIGHTS

The patient has the right to:

484.50(c)(1) G428 Have his or her property and person treated with respect

484.50(c)(2) G430 Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect, and misappropriation of property

484.50(c)(3) G432 Make complaints to the HHA regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the HHA

484.50(c)(3) G432 Make complaints to the HHA regarding treatment or care that is (or fails to be) furnished, and the lack of respect for property and/or person by anyone who is furnishing services on behalf of the HHA

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484.50 PATIENT RIGHTS

484.50(c)(4) G434 Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to:

i. Completion of all assessments
ii. The care to be furnished, based on the comprehensive assessment
iii. Establishing and revising the plan of care
iv. The disciplines that will furnish the care
v. The frequency of visits
vi. Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits
vii. Any factors that could impact treatment effectiveness
viii. Any changes in the care to be furnished

Section 2

484.50 PATIENT RIGHTS

484.50(c)(5) G436 Receive all services outlined in the plan of care.

484.50(c)(6) G438 Have a confidential clinical record. Access to or release of patient information and clinical records is permitted.

Agencies need to be in compliance with:

- The Privacy Rule
- The Security Rule
- The Breach Notification Rule
- The HIPAA Rule

Section 2

484.50 PATIENT RIGHTS

484.50(c)(7) G440 Be advised of:

•The extent to which payment for services may be expected from Medicare, Medicaid, or any other federally funded or federal aide program

•The charges for services that may not may not be covered by any of the above

•The charges the individual may have to pay before care is initiated

•Any changes in the information provided in accordance with paragraph (c)(7) of this section 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, and must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f)

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484.50 PATIENT RIGHTS

484.50(c)(8) G442 Receive proper written notice, in advance of a specific service being furnished, if the HHA believes that the service may be non-covered care; or in advance of the HHA reducing or terminating on-going care. The HHA must also comply with the requirements of 42 CFR 405.1200 through 405.1204.

484.50(c)(9) G444 Be advised of the state toll free home health telephone hotline, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs.

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484.50 PATIENT RIGHTS

484.50(c)(10) G446 Be advised of the names, addresses, and telephone numbers of the following federally- 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

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484.50 PATIENT RIGHTS

484.50(c)(11) G448 Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the HHA or an outside entity.

484.50(c)(12) G450 Be informed of the right to access auxiliary aids and language services as described in paragraph (f) of this section, and how to access these services.

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484.50 PATIENT RIGHTS

The patient and the representative (if any,) have a right to be informed of the HHA's policies for transfer & discharge. The agency may only transfer or discharge the patient from the agency if: 484.50(d)(1) G454 The transfer or discharge is necessary for the patient's welfare because the HHA and the physician who is responsible for the home health plan of care agree that the HHA can no longer meet the patient's needs, based on the patient's acuity. The HHA must arrange a safe and appropriate transfer to other care entities when the needs of the patient exceed the agency's capabilities.

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484.50 PATIENT RIGHTS

484.50(d) (2) G456 The patient or payor will no longer pay for the services provided by the agency.

484.50(d) (3) G458 The transfer or discharge is appropriate because the physician responsible for the plan of care and the HHA agree that the measurable outcomes and goals in the plan of care have been achieved, agree that the patient no longer needs the HHA's services.

484.50(d)(4) G460 The patient refuses services, or elects to be transferred or discharged.

A patient who occasionally declines a service is distinguished from a patient who refuses service altogether, or who habitually declines skilled care visits. It is the patient's right to refuse. It is the agency's responsibility to educate the patient on the risks and potential adverse outcomes from refusing services. In the case of patient refusals of skilled care, the HHA would document the communication with the physician, as well as the measures the HHA took to investigate the patient's refusal and the interventions the HHA initiated to obtain patient participation with the plan of care.

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484.50 PATIENT RIGHTS

484.50(d)(5) G462 The HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements …of this section, that the patient's (or other persons in the patient's home) behavior is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the HHA to operate effectively is seriously impaired.

i.G464 Advise the patient, representative (if any), the physician(s) issuing orders for the HH POC, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered

ii.G466 Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation

iii.G468 Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care

iv.G470 Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records

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484.50 PATIENT RIGHTS

484.50(d)(6) G472 The patient dies
484.50(d)(7) G474 The HHA ceases to operate

The agency must provide sufficient notice of planned cessation of business to enable patients to select an alternative service provider and for the HHA to facilitate the safe transfer of the patients to the other agencies.

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484.50 PATIENT RIGHTS

484.50(e)(1) G476 The HHA must:
i.G478 Investigate complaints made by a patient, the patient's rep (if any), & the patient's caregivers & family, including, but not limited to, the following topics:
A.G480 Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately
B.G482 Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA
ii.G484 Document both the existence of the complaint and the resolution of the complaint
iii.G486 Take action to prevent further potential violations, including retaliation, while the complaint is being investigated

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484.50 PATIENT RIGHTS

484.50(e)(2) G488 The HHA must:
Staff must immediately report any suspected abuse, neglect, or mistreatment on anyone furnishing services on behalf of the HHA

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Section 2

484.50 PATIENT RIGHTS

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

484.50(f)(1) G490 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

484.50(f)(2) G490 Persons with limited English proficiency through the provision of language services at no cost to the individual, including oral interpretation and written translations

Plain language is communication the patient/representative can understand the first time they read or hear it. Language that is plain to one set of readers may not be plain to others.

Written material is in plain language if the audience can:

- Find what they need
- Understand what they find
- Use what they find to meet their needs

Section 4

484.80 HOME HEALTH AIDE SERVICES

All Home Health Aide services must be provided by individuals who meet the personnel requirements:

Nine Standards

a)Home Health Aide qualifications

b)Content and duration of Home Health Aide classroom and supervised practical training

c)Competency evaluation

d)In-service training

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484.80 HOME HEALTH AIDE SERVICES

e) Qualifications for instructors conducting classroom and supervised practical training

f) Eligible training and competency evaluation organizations

g) Home Health Aide assignments and duties

h) Supervision of Home Health Aides

i) Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit

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484.80 HOME HEALTH AIDE SERVICES

484.80(a) G752 Standard: Home Health Aide qualifications

§ 484.80(a)(1) G754 A qualified Home Health Aide is a person who has successfully completed:

- A training and competency evaluation program as specified in paragraphs (b) and (c) respectively of this section
- A competency evaluation program that meets the requirements of paragraph (c) of this section
- A nurse aide training and competency evaluation program approved by the state as meeting the requirements of § 483.151 through § 483.154 of this chapter, and is currently listed in good standing on the state nurse aide registry
- The requirements of a state licensure program that meets the provisions of paragraphs (b) and (c) of this section

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484.80 HOME HEALTH AIDE SERVICES

484.80(a)(2) G756 A Home Health Aide or nurse aide is not considered to have completed a program, as specified in paragraph (a)(1) of this section, if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by the individual as described in § 409.40 of this chapter were for compensation. If there has been a 24-month lapse in furnishing services for compensation, the individual must complete another program, as specified in paragraph (a)(1) of this section, before providing services.

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484.80 HOME HEALTH AIDE SERVICES

484.80(b) G758 Standard: Content and duration of Home Health Aide classroom and supervised practical training.

§484.80(b)(1) G760 Home Health Aide training must include classroom and supervised practical training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing services to an individual under the direct supervision of a Registered Nurse, or a licensed practical nurse who is under the supervision of a Registered Nurse. Classroom and supervised practical training must total at least 75 hours.

484.80(b)(2) G762 A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours.

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484.80 HOME HEALTH AIDE SERVICES

484.80(b)(3) G764 A Home Health Aide training program must address each of the following subject areas:

(i) Communication skills, **including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff**

(ii) Observation, reporting, and documentation of patient status and the care or service furnished

(iii) Reading and recording temperature, pulse, and respiration

(iv) Basic infection prevention and control procedures

(v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor

(vi) Maintenance of a clean, safe, and healthy environment

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484.80 HOME HEALTH AIDE SERVICES

(vii) Recognizing emergencies and the knowledge of instituting emergency procedures and their application

(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy, and his or her property

(ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks that include:

- (A) Bed bath
- (B) Sponge, tub, **and** shower bath
- (C) Hair shampooing in sink, tub, **and** bed
- (D) Nail and skin care
- (E) Oral hygiene
- (F) Toileting and elimination

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484.80 HOME HEALTH AIDE SERVICES

(x) Safe transfer techniques and ambulation

(xi) Normal range of motion and positioning

(xii) Adequate nutrition and fluid intake

(xiii) **Recognizing and reporting changes in skin condition, including pressure ulcers**

(xiv) Any other task that the HHA may choose to have an aide perform as permitted under state law

(xv) The HHA is responsible for training Home Health Aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section

Section 4

484.80 HOME HEALTH AIDE SERVICES

484.80(b)(4) G766 HHA maintains documentation of training

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.

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484.80 HOME HEALTH AIDE SERVICES

484.80(c) Standard: Competency evaluation

An individual may furnish home health services on behalf of an HHA only after that individual has successfully completed a competency evaluation program as described in this section.

484.80(c)(1) G768 The competency evaluation must address each of the subjects listed in paragraph (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x), and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a Home Health Aide with a patient.

The following skills must be evaluated by observing the aide's performance while carrying out the task with a patient.

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484.80 HOME HEALTH AIDE SERVICES

484.80(c)(2) G768A Home Health Aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section.

484.80(c)(3) G768 The competency evaluation must be performed by a Registered Nurse in consultation with other skilled professionals, as appropriate.

484.80(c)(4) G770 A Home Health Aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. An aide must not perform that task without direct supervision by a Registered Nurse until after he or she has received training in the task for which he or she was evaluated as "unsatisfactory," and has successfully completed a subsequent evaluation. A Home Health Aide is not considered to have successfully passed a competency evaluation if the aide has an "unsatisfactory" rating in more than one of the required areas.

484.80(c)(5) G772 The HHA must maintain documentation which demonstrates that the requirements of this standard have been met.

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484.80 HOME HEALTH AIDE SERVICES

484.80(d) G774 Standard: In-service training

A Home Health Aide must receive at least 12 hours of in-service training during each 12-month period. In service training may occur while an aide is furnishing care to a patient.

484.80(d)(1) G776 In-service training may be offered by any organization and must be supervised by a Registered Nurse.

484.80(d)(2) G778 The HHA must maintain documentation that demonstrates the requirements of this standard have been met.

484.80 HOME HEALTH AIDE SERVICES

484.80(e) G780 Standard: Qualifications for instructors conducting classroom and supervised practical training.

Classroom and supervised practical training must be performed by a Registered Nurse who possesses a minimum of two years of nursing experience, at least one year of which must be in Home Health Care, or by other individuals under the general supervision of the Registered Nurse.

484.80 HOME HEALTH AIDE SERVICES

484.80(f) G782 Standard: Eligible Training and Competency Evaluation Organizations

A Home Health Aide training program and competency evaluation program may be offered by any organization except by an HHA that, within the previous 2 years:

484.80(f)(1) G784 Was out of compliance with the requirements of paragraphs (b), (c), (d), or (e) of this section

484.80(f)(2) G786 Permitted an individual who does not meet the definition of a "qualified Home Health Aide" as specified in paragraph (a) of this section to furnish Home Health Aide services (with the exception of licensed health professionals and volunteers)

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484.80 HOME HEALTH AIDE SERVICES

484.80(f)(3) G788 Was subjected to an extended (or partially extended) survey as a result of having been found to have furnished substandard care (or for other reasons as determined by CMS or the state)

484.80(f)(4) G790 Was assessed a civil monetary penalty of $5,000 or more as an intermediate sanction

484.80(f)(5) G792 Was found to have compliance deficiencies that endangered the health and safety of the HHA's patients, and had temporary management appointed to oversee the management of the HHA

484.80(f)(6) G794 Had all or part of its Medicare payments suspended

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484.80 HOME HEALTH AIDE SERVICES

484.80(f)(7) G796 Was found under any federal or state law to have:

(i) Had its participation in the Medicare program terminated

(ii) Been assessed a penalty of $5,000 or more for deficiencies in federal or state standards for HHAs

(iii) Been subjected to a suspension of Medicare payments to which it otherwise would have been entitled

(iv) Operated under temporary management that was appointed to oversee the operation of the HHA and to ensure the health and safety of the HHA's patients

(v) Been closed, or had its patients transferred by the state

(vi) Been excluded from participating in federal health care programs or debarred from participating in any government program

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484.80 HOME HEALTH AIDE SERVICES

484.80(h) G806 Standard: Supervision of Home Health Aides

§ 484.80(h)(1)(i) G808

If Home Health Aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a Registered Nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in § 484.80(g), must make an on-site visit to the patient's home no less frequently than every 14 days. The Home Health Aide does not have to be present during this visit.

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484.80 HOME HEALTH AIDE SERVICES

(ii) G810 If an area of concern in aide services is noted by the supervising Registered Nurse or other appropriate skilled professional, then the supervising individual must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.

(iii) G812 A Registered Nurse or other appropriate skilled professional must make an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.

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484.80 HOME HEALTH AIDE SERVICES

484.80(h)(2) G814 If Home Health Aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the Registered Nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care.

484.80(h)(3) G816 If a deficiency in aide services is verified by the Registered Nurse or other appropriate skilled professional during an on-site visit, then the agency must conduct, and the Home Health Aide must complete, a competency evaluation in accordance with paragraph (c) of this section.

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484.80 HOME HEALTH AIDE SERVICES

484.80(h)(4) G818 Home Health Aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements:

(i) 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

(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family

(iii) Demonstrating competency with assigned tasks

(iv) Complying with infection prevention and control policies and procedures

(v) Reporting changes in the patient's condition

(vi) Honoring patient rights

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484.80 HOME HEALTH AIDE SERVICES

484.80(h)(5) G820 If the home health agency chooses to provide Home Health Aide services under arrangements, as defined in § 1861(w)(1) of the Act, the HHA's responsibilities also include, but are not limited to:

(i) G822 Ensuring the overall quality of care provided by an aide

(ii) G824 Supervising aide services as described in paragraphs (h)(l) and (2) of this section

(iii) G826 Ensuring that Home Health Aides who provide services under arrangement have met the training or competency evaluation requirements, or both, of this part

Section 4

484.80 HOME HEALTH AIDE SERVICES

484.80(i) G828 Standard: Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit.

An individual may furnish personal care services, as defined in § 440.167 of this chapter, on behalf of an HHA. Before the individual may furnish personal care services, the individual must meet all qualification standards established by the state. The individual only needs to demonstrate competency in the services the individual is required to furnish.

Section 4

484.115 PERSONNEL QUALIFICATIONS

484.115(c) G1056 Standard: Clinical Manager

A person who is a licensed physician, Physical Therapist, Speech-Language Pathologist, Occupational Therapist, Audiologist, Social Worker, or a Registered Nurse

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Section 5

484.55 COMPREHENSIVE ASSESSMENT

Each patient must receive, and an HHA must provide, a patient-specific, comprehensive assessment. For Medicare beneficiaries, the HHA must verify the patient's eligibility for the Medicare home health benefit including homebound status, both at the time of the initial assessment visit and at the time of the comprehensive assessment.

Four Standards:

a)Initial assessment of patients

b)Completion of the comprehensive assessment

c)Contents of the comprehensive assessment

d)Update of the comprehensive assessment

Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(a) G512 Initial assessment visit

484.55(a)(1) G514 A Registered Nurse must conduct an initial assessment visit to determine the immediate care and support needs of the patient; and, for Medicare patients, to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment visit must be held either within 48 hours of referral, or within 48 hours of the patient's return home, or on the physician-ordered start of care date.

For patients receiving only nursing services or both nursing and therapy services, a Registered Nurse must conduct the initial assessment visit. For therapy-only patients, the initial assessment may be made by the applicable rehabilitation professional rather than the Registered Nurse.

If an HHA is unable to complete the initial assessment within the 48 hours, it is not acceptable to request a different start of care date from the physician to ensure compliance with the regulation or to accommodate the convenience of the agency.

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484.55 COMPREHENSIVE ASSESSMENT

484.55 (a) (2) G516 When rehabilitation therapy service (speech-language pathology, physical therapy, or occupational therapy) is the only service ordered by the physician who is responsible for the home health plan of care, and if the need for that service establishes program eligibility, the initial assessment visit may be made by the appropriate rehabilitation skilled professional.

Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(b) G518 Standard: Completion of the comprehensive assessment

484.55(b)(1) G520The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than five calendar days after the start of care. The start of care date is the date of the initial assessment and the comprehensive assessment must be completed within five calendar days of that date.

484.55(b)(2) G522 Except as provided in paragraph (b)(3) of this section, a Registered Nurse must complete the comprehensive assessment and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status.

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484.55 COMPREHENSIVE ASSESSMENT

484.55(b)(3) G524 When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician, a Physical Therapist, Speech-Language Pathologist, or Occupational Therapist may complete the comprehensive assessment, and for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The Occupational Therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility. A qualified therapist (registered and/or licensed by the state in which they practice) must perform the comprehensive assessment for those patients receiving therapy services.

Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(c) G526 Content of the comprehensive assessment: The comprehensive assessment must accurately reflect the patient's status, and must include, at a minimum, the following information:

484.55(c)(1) G528 The patient's current health, psychosocial, functional, and cognitive status

An assessment of the patient's current health status includes relevant medical history as well as all active health and medical problems.

Assessing a patient's psychosocial status refers to an evaluation of mental health and functional capacity within the community. This is intended to be a screening of the patient's relationships and living environment and their impact on the delivery of services and the patient's ability to participate in his or her own care.

Assessing the patient's functional status includes the patient's level of ability to function independently in the home such as activities of daily living.

Assessing a patient's cognitive status refers to an evaluation of the degree of his or her ability to understand, remember, and participate in developing and implementing the plan of care.

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Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(c)(2) G530 The patient's strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the HHA.

484.55(c)(3) G532 The patient's continuing need for home care.

Each assessment must clearly demonstrate the continuing need and eligibility for skilled home health service(s).

Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(c)(4) G534 The patient's medical, nursing, rehabilitative, social, and discharge planning needs

484.55(c)(5) G536 A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy.

The patient's clinical record should reflect all prescription and non-prescription medications the patient is taking, including times and route(s). The documentation in the clinical record should confirm that the HHA nurse considered each medication the patient is currently taking for possible side effects and the list of medications in its entirety for possible drug interactions.

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.

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484.55 COMPREHENSIVE ASSESSMENT

484.55(c)(6) G538 The patient's primary caregiver(s), if any, and other available supports, including their:

(i) Willingness and ability to provide care

(ii) Availability and schedules

484.55(c)(7) G540 The patient's representative (if any)

Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(c)(8) G542 Incorporation of the current version of the Outcome and Assessment Information Set (OASIS) items, using the language and groupings of the OASIS items, as specified by the Secretary. The OASIS data items determined by the Secretary must include: Clinical record items, demographics and patient history, living arrangements, supportive assistance, sensory status, integumentary status, respiratory status, elimination status, neuro/emotional/behavioral status, activities of daily living, medications, equipment management, emergent care, and data items collected at inpatient facility admission or discharge only.

Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(d) G544 Update of the comprehensive assessment
The comprehensive assessment must be 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 not less frequently than:

484.55(d)(1) G546 The last 5 days of every 60 days beginning with the start-of-care date, unless there is a:

i. Beneficiary elected transfer

ii. Significant change in condition

iii. Discharge and return to the same HHA during the 60-day episode

Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(d)(2) G548 Within 48 hours of the patient's return to the home from a hospital admission of 24 hours or more for any reason other than diagnostic tests, or on physician-ordered resumption date.

484.55(d)(3) G550 At discharge. The update of the comprehensive assessment at discharge would include a summary of the patient's progress in meeting the care plan goals.

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Section 5

484.60 CARE PLANNING & COORDINATION

Patients are accepted for treatment on the reasonable expectation that an HHA can meet the patient's medical, nursing, rehabilitative, and social needs in his or her place of residence.

Each patient must receive an individualized written plan of care, including any revisions or additions.

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 as a result of implementing and coordinating the plan of care.

The individualized plan of care must also specify the patient and caregiver education and training.

Services must be furnished in accordance with accepted standards of practice.

Section 5

484.60 CARE PLANNING & COORDINATION

Five Standards:
a)Plan of Care
b)Conformance with physician orders
c)Review and revision of the plan of care
d)Coordination of care
e)Written information to the patient

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(a)(1) G572 Each patient must receive the home health services that are written in an individualized plan of care that identifies patient-specific measurable outcomes and goals, and which is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry acting within the scope of his or her state license, certification, or registration.

If a physician refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician is consulted to approve additions or modifications to the original plan.

Patient measurable outcomes may include such measurements as end-result functional and physical health improvement/stabilization, health care utilization measures (hospitalization and emergency department use), and potentially avoidable events.

Section 5

484.60 CARE PLANNING & COORDINATION

484.60 (a)(2) G574 The individualized plan of care must include the following:
(i) All pertinent diagnoses
(ii) The patient's mental, psychosocial, and cognitive status
(iii) The types of services, supplies, and equipment required
(iv) The frequency and duration of visits to be made
(v) Prognosis
(vi) Rehabilitation potential
(vii) Functional limitations
(viii) Activities permitted

Section 5

484.60 CARE PLANNING & COORDINATION

ix) Nutritional requirements
(x) All medications and treatments
(xi) Safety measures to protect against injury
(xii) 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
(xiii) Patient and caregiver education and training to facilitate timely discharge
(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient
(xv) Information related to any advanced directives

Section 5

484.60 CARE PLANNING & COORDINATION

(xvi) Any additional items the HHA or physician may choose to include:

(i) All pertinent diagnoses means all known diagnoses

484.60(a)(3) G576 All patient care orders, including verbal orders, must be recorded in the plan of care.

All orders must be complete and accurate and documented in the medical record.

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484.60 CARE PLANNING & COORDINATION

484.60 (b) G578 Conformance with physician's orders

484.60(b)(1) G580 Drugs, services, and treatments are administered only as ordered by a physician. Drugs, services and treatments are ordered by the physician that establishes and periodically reviews the plan of care. 484.60(b)(2) G582 Influenza and pneumococcal vaccines may be administered per agency policy developed in consultation with a physician, and after an assessment of the patient to determine for the screening contraindications.

484.60(b)(3) G584 Verbal orders must be accepted only by personnel authorized to do so by applicable state laws and regulations and by the HHA's internal policies.

484.60 CARE PLANNING & COORDINATION

484.60(b)(4) G584 When services are provided on the basis of a physician's verbal orders, a nurse acting in accordance with state licensure requirements, or other qualified practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the HHA's policies, must document the orders in the patient's clinical record, and sign, date, and time the orders. Verbal orders must be authenticated and dated by the physician in accordance with applicable state laws and regulations, as well as the HHA's internal policies.

When services are furnished based on a physician's oral order, the order must be put into writing by personnel authorized to do so by applicable state laws and regulations as well as by the HHA's internal policies. **The orders must be signed , timed, and dated with the date of receipt by the nurse or qualified therapist.**

484.60 CARE PLANNING & COORDINATION

484.60 (c) G 586 Review and revision of the plan of care

484.60(c)(1) G588 The individualized plan of care must be reviewed and revised by the physician who is responsible for the home health plan of care and the HHA as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start of care date. G590 The HHA must promptly alert the relevant physician(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

484.60(c)(2) G592 A revised plan of care must reflect current information from the patient's updated comprehensive assessment, and contain information concerning the patient's progress toward the measurable outcomes and goals identified by the HHA and patient in the plan of care.

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(c)(3) G594 Revisions to the plan of care must be communicated as follows:

484.60(c)(3)(i) G596 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.

There must be evidence in the clinical record that the HHA has explained to the patient that a change to the plan of care has occurred and how this change will impact the care delivered by the HHA. The clinical record also documents, through notation that the revised plan of care was shared or by evidence of new orders received, that all relevant physicians providing care to the patient have been notified of the change in patient health status and associated changes to the plan of care.

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(c)(3)(ii) G598 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 health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any.)

Discharge planning begins early in the provision of care and must be revised as the patient's medical condition or life circumstances change. As these changes are identified there must be evidence in the clinical record that the HHA discussed these changes with the patient, his/her representatives, and the responsible physician.

Other healthcare professionals who may need to be notified of discharge plan changes are those relevant physicians who are also contributing orders to the care plan.

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(d) G600 Standard: Coordination of Care

The HHA must:

484.60(d)(1) G602 Ensure communication with all physicians involved in the plan of care.

The physician who initiated home health care is responsible for the ongoing plan of care; however, in order to ensure the development and implementation of a coordinated plan of care, communication with all physicians involved in the patient's care is often necessary.

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Section 5

484.60 CARE PLANNING & COORDINATION

484.60(d)(2) G604 Integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.

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.

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(d)(3) G606 Integrate services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines.

The agency manages the scheduling of patients, taking into consideration the types of services that are being provided on a given day; a patient may become fatigued after a HH aide visits to assist with a bath prior to a physical therapy visit, thus making the therapy session less effective.

The agency ensures that staff who provide care are communicating any patient concerns and patient progress toward the goals of the plan of care with others involved in the patient's care.

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(d)(4) G608 Coordinate 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.
484.60(d)(5) G610 Ensure that each patient, and his or her caregiver(s) where applicable, receive 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.

The goals of the HHA episode are established at admission and revised as indicated. With the discharge plan clearly identified, patient education and documentation of the patient response to the education begins upon admission and continues throughout the HHA services.

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(e) G612 Standard: Written information to the patient
The HHA must provide the patient and caregiver with a copy of written instructions outlining:

Once the comprehensive assessment is completed (within five days of the initial visit) and the plan of care is approved by the responsible physician, the documents listed in (e) (1-5) must be provided to the patient and/or their representative.

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(e)(1) G614 Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.

484.60(e)(2) G616 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.

484.60(e)(3) G618 Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.

484.60(e)(4) G620 Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs.

484.60(e)(5) G622 Name and contact information of the HHA clinical manager.

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in § 409.44 of this chapter, and physician and medical social work services as specified in § 409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care.

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Section 5

484.75 SKILLED PROFESSIONAL SERVICES

Three Standards:

a)Provision of services by skilled professionals

b)Responsibilities of skilled professionals

c)Supervision of skilled professional assistants

Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care.

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

484.75(a) G702 Standard: Provision of services by skilled professionals
Skilled professional services are authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under § 484.115 and who practice according to the HHA's policies and procedures.

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

484.75(b) G704 Standard: Responsibilities of skilled professionals

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

484.75(b)(1) G706 Ongoing interdisciplinary assessment of the patient

484.75(b)(2) G708 Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s)

484.75(b)(3) G710 Providing services that are ordered by the physician as indicated in the plan of care

484.75(b)(4) G712 Patient, caregiver, and family counseling

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

484.75(b)(5) G714 Patient and caregiver education

484.75(b)(6) G 716 Preparing clinical notes

484.75(b)(7) G718 Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care

484.75(b)(8) G720 Participation in the HHA's QAPI program

484.75(b)(9) G722 Participation in HHA-sponsored in-service training

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

484.75(c) G724 Standard: Supervision of skilled professional assistants

484.75(c)(1) G726 Nursing services are provided under the supervision of a Registered Nurse that meets the requirements of § 484.115(k.)

484.75(c)(2) G728 Rehabilitative therapy services are provided under the supervision of an Occupational Therapist or Physical Therapist that meets the requirements of § 484.115(e, f) or (g, h,) respectively.

484.75(c)(3) G730 Medical social services are provided under the supervision of a Social Worker that meets the requirements of § 484.115(m.)

Section 5

484.80 HOME HEALTH AIDE SERVICES

484.80(g) Standard: Home Health Aide assignments and duties

484.80(g)(1) G798 Home Health Aides are assigned to a specific patient by a Registered Nurse or other appropriate skilled professional, with written patient care instructions for a Home Health Aide prepared by that registered nurse or other appropriate skilled professional (that is, Physical Therapist, Speech-Language Pathologist, or Occupational Therapist.)

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Section 5

484.80 HOME HEALTH AIDE SERVICES

484.80(g)(2) G800 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
(iv) Consistent with the Home Health Aide training

Section 5

484.80 HOME HEALTH AIDE SERVICES

484.80(g)(3) G802The 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
(iv) Assistance in administering medications ordinarily self-administered

Section 5

484.80 HOME HEALTH AIDE SERVICES

484.80(g)(4) G804 Home Health Aides must be members of the interdisciplinary team, must report changes in the patient's condition to a Registered Nurse or other appropriate skilled professional, and must complete appropriate records in compliance with the HHA's policies and procedures.

Section 5

484.110 CLINICAL RECORDS

The HHA must maintain a clinical record containing past and current information for every patient accepted by the HHA and receiving home health services. Information contained in the clinical record must be accurate, adhere to current clinical record documentation standards of practice, and be available to the physician(s) issuing orders for the home health plan of care, and appropriate HHA staff. This information may be maintained electronically.

Section 5

484.110 CLINICAL RECORDS

Five Standards:
a)Contents of clinical record
b)Authentication
c)Retention of records
d)Protection of records
e)Retrieval of clinical records

Section 5

484.110 CLINICAL RECORDS

484.110(a) G1010 Standard: Contents of clinical record

The record must include:

484.110(a)(1) G1012 The patient's current comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician orders

484.110(a)(2) G1014 All interventions, including medication administration, treatments, and services, and responses to those interventions

484.110(a)(3) G1016 Goals in the patient's plans of care and the patient's progress toward achieving them

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Section 5

484.110 CLINICAL RECORDS

484.110(a)(4) G1018 Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s)

484.110 (a)(5) G1020 Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA

Section 5

484.110 CLINICAL RECORDS

484.110(a)(6) G1022

(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within five business days of the patient's discharge

(ii)A completed transfer summary that is sent within two business days of a planned transfer, if the patient's care will be immediately continued in a health care facility

(iii) A completed transfer summary that is sent within two business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the HHA becomes aware of the transfer

Section 5

484.110 CLINICAL RECORDS

484.110(b) G1024 Standard: Authentication

All entries must be legible, clear, complete, and appropriately authenticated, 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.

Section 5

484.110 CLINICAL RECORDS

484.110(c) G1026 Standard: Retention of records

484.110(c)(1) G1026 Clinical records must be retained for five years after the discharge of the patient, unless state law stipulates a longer period of time.

484.110(c)(2) G1026 The HHA's policies must provide for retention of clinical records even if it discontinues operation. When an HHA discontinues operation, it must inform the state agency where clinical records will be maintained.

Section 5

484.110 CLINICAL RECORDS

484.110(d) G1028 Standard: Protection of records

The clinical record, its contents, and the information contained therein must be safeguarded against loss or unauthorized use. The HHA must be in compliance with the rules regarding personal health information set out at 45 CFR parts 160 and 164.

Section 5

484.110 CLINICAL RECORDS

484.110(e) G1030 Standard: Retrieval of clinical records

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 four business days (whichever comes first.)

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Section 6

484.65 QAPI

The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven 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.

Section 6

484.65 QAPI

Five Standards:
a)Program Scope
b)Program Data
c)Program Activities
d)Performance Improvement Projects
e)Executive Responsibilities

Section 6

484.65 QAPI

484.65(a) G642 Standard: Program scope

484.65(a)(1) G642 The program must at least be capable of showing measurable improvement in indicators for which there is evidence that improvement in those indicators will improve health outcomes, patient safety, and quality of care.

484.65(a)(2) G642 The HHA must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the HHA to assess processes of care, HHA services, and operations.

Section 6

484.65 QAPI

484.65(b) G644 Standard: Program data

484.65(b)(1) G644 The program must utilize quality indicator data, including measures derived from OASIS, where applicable, and other relevant data, in the design of its program.

484.65(b)(2) G644The HHA must use the data collected to:

484.65(b)(2)(i) G644 Monitor the effectiveness and safety of services and quality of care

484.65(b)(2)(ii) G644 Identify opportunities for improvement

484.65(b)(3) G644The frequency and detail of the data collection must be approved by the HHA's governing body

Section 6

484.65 QAPI

484.65(c) G646 Standard: Program activities

484.65(c)(1) The HHA's Performance Improvement activities must:

484.65(c)(1)(i) G648 Focus on high-risk, high-volume, or problem-prone areas

484.65(c)(1)(ii) G650 Consider incidence, prevalence, and severity of problems in those areas

484.65(c)(1)(iii) G652 Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients

484.65(c)(2) G654 Performance Improvement activities must track adverse patient events, analyze their causes, and implement preventive actions

Section 6

484.65 QAPI

484.65(c)(3) G656 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.

High-risk 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.

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.

Adverse patient events are those patient events which are negative and unexpected; impact the patient's HHA plan of care; and have the potential to cause a decline in the patient condition.

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Section 6

484.65 QAPI

484.65(d) G658 Standard: Performance Improvement projects

Beginning July 13, 2018, HHAs must conduct Performance Improvement projects.

484.65(d)(1) G658 The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the HHA's services and operations.

484.65(d)(2) G658 The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects.

Section 6

484.65 QAPI

484.65(e) G660 Standard: Executive Responsibilities

The HHA's governing body is responsible for ensuring the following:

484.65(e)(1) G660 That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained

484.65(e)(2) G660 That the HHA-wide quality assessment and Performance Improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness

484.65(e)(3) G660 That clear expectations for patient safety are established, implemented, and maintained

484.65(e)(4) G660That any findings of fraud or waste are appropriately addressed

Section 7

484.102 EMERGENCY PREPAREDNESS

The HHA must comply with all applicable federal, state, and local emergency preparedness requirements. The HHA must establish and maintain an emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements:

Five standards:

a)Emergency plan

b)Policies and procedures

c)Communication plan

d)Testing

e)Integrated healthcare systems

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(a) E-0004 Emergency plan

The HHA must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.

484.102(a)(1) E-0006 Be based on and include a documented, facility-based, and community-based risk assessment, utilizing an all-hazards approach.

484.102(a)(2) E-0006 Include strategies for addressing emergency events identified by the risk assessment.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(a)(3) E-0007 Address patient population, including, but not limited to, the type of services the HHA has the ability to provide in an emergency; and continuity of operations, including delegations of authority and succession plans.

484.102(a)(4) E-0009 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 HHA's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(b) E-0013 Policies and procedures

The HHA 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:

484.102(b)(1) E-0017 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.

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Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(b)(2) E-0019 The procedures to inform state and local emergency preparedness officials about HHA 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.

484.102(b)(3) E-0021 The procedures to 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 or patients that they are unable to contact.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(b)(4) E-0023 A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains the availability of records.

484.102(b)(5) E-0024The use of volunteers in an emergency or other emergency staffing strategies, including the process and role for integration of state or federally designated health care professionals to address surge needs during an emergency.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(c) E-0029 Communication plan
The HHA 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:

484.102(c)(1) E-0030 Names and contact information for the following:
(i) Staff
(ii) Entities providing services under arrangement
(iii) Patients' physicians
(iv) Volunteers

484.102(c)(2) E-0031 Contact information for the following:
(i)Federal, state, tribal, regional, or local emergency preparedness staff
(ii) Other sources of assistance

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(c)(3) E-0032 Primary and alternate means for communicating with the HHA's staff, federal, state, tribal, regional, and local emergency management agencies.

484.102(c)(4) E-0033 A method for sharing information and medical documentation for patients under the HHA's care, as necessary, with other health care providers to maintain the continuity of care.

484.102(c)(5) E-0033 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).

484.102(c)(6) E-0034 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.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(d) E-0036 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.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(d)(1) E-0037 Training program
The HHA 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

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Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(d)(2) E-0039 Testing

The HHA must conduct exercises to test the emergency plan at least annually. The HHA 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 one year following the onset of the actual event.

Section 7

484.102 EMERGENCY PREPAREDNESS

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 HHA's emergency plan, as needed

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(e) E-0042 Integrated healthcare systems

If a 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

Section 7

484.102 EMERGENCY PREPAREDNESS

(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

HOSPICE CORE SERVICES

- With the exception of physician services, substantially all core services must be provided directly by hospice employees on a routine basis
- A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances
- Waiver - An extraordinary circumstance generally would be a short-term, temporary event that was unanticipated

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HOSPICE CORE SERVICES

- Core Services:
  - Physician services
  - Nursing services
  - Medical social services
  - Counseling (including, but not limited to, bereavement, dietary, and spiritual counseling)
- One designated Medical Director, one designated alternate Medical Director and others are considered hospice physicians

HOSPICE NON-CORE SERVICES

- The following services must be provided by the hospice, either directly or under arrangements, to meet the needs of the patient and family:
  - PT, OT, and SLP
  - Hospice aide services
  - Homemaker services
  - Volunteers

HOSPICE REQUIRED SERVICES

- Routine hospice care
- Short-term inpatient care (including respite care and interventions necessary for pain control) in a Medicare/Medicaid-participating facility
- Continuous home care provided during a period of crisis:
  - Cannot provide continuous care exclusively by contract staff

418.52

PATIENT RIGHTS

The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.

L 502-Notice of rights and responsibilities

L503- Advance directive information

L504- Patient or representative's signature

Representative means an individual who has the authority under state law (whether by statute or pursuant to an appointment by the courts of the state) to authorize or terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill patient who is mentally or physically incapacitated. This may include a legal guardian.

418.52

PATIENT RIGHTS

The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.

L 505- Exercise of rights

L 508- L 511- Any allegations of mistreatment are investigated and reported

L 512- Right to effective pain management

L513- Involved in plan of care

L 534- Refuse care

L 515-Choose attending physician

Is identified by the individual, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the individual's medical care.

NOTES

NOTES

418.52

PATIENT RIGHTS

The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.

L 516- Confidential medical record
L 517- Be free from mistreatment
L 518/L 519- Receive information about all services/limitations covered under the hospice:

- Core services
- Non-core services
- Levels of care
- Medications
- DME

418.54

INITIAL & COMPREHENSIVE ASSESSMENT

The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

L 522- Initial assessment with 48 hours after the election of hospice care
L 523- Comprehensive assessment within five days after the election of hospice care
L 524- Physical, psychosocial, emotional, and spiritual needs of patient and family
L 525- Nature causing admission
L 526-Complications that affect care planning
L 527- Patient's ability to participate in care
L 528- Imminence of death

418.54

INITIAL & COMPREHENSIVE ASSESSMENT

The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for physical, psychosocial, emotional, and spiritual care. This assessment includes all areas of hospice care related to the palliation and management of the terminal illness and related conditions.

L 529-Severity of symptoms
L 530- Review of all medications
L 531-Bereavement risk assessment
L 532- Need for referrals
L 533- Update of the comprehensive assessment at least every 15 days
L 534/L 535- Patient outcome measures/data elements

418.56

IDG, CARE PLANNING & COORDINATION

The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.

L 539- IDG in its entirety must supervise the care and services
L 540- RN continuous assessment
L 541- Composition of IDG
L 542- IDG assigned to review P&P
L 543- Plan of care
L 544- Patient receives education needed
L 545- Content of the plan of care

418.56

IDG, CARE PLANNING & COORDINATION

The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.

L 546- Interventions to manage pain and symptoms
L 547- Detailed scope and frequency of services necessary:
•Visit ranges with small intervals are acceptable
•PRN cannot stand alone; PRN small frequency
•If the patient requires frequent use of PRN visits, the plan of care should be updated to include the need for additional visits
•Standing orders or routine orders must be individualized to address the specific patient's needs and signed by the patient's physician

418.56

IDG, CARE PLANNING & COORDINATION

The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.

L 548- Measurable outcomes anticipated from implementing and coordinating the plan of care
L 549- Drugs and treatment necessary to meet the needs of the patient:
•Complete orders
L 550- DME and supplies needed
L 551-IDG's documentation of patient's level of understanding, involvement and agreement

NOTES

NOTES

418.56

IDG, CARE PLANNING & COORDINATION

The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient.

L 552-Review of the plan of care, in collaboration with the attending, at least every 15 days

L 553- Note the patient's progress toward outcomes and goals specified in the plan of care

L 554- IDG maintains responsibility for directing, coordinating, and supervising care

L 555- Plan of care is followed

L 556- Care and services provided are based on all assessments of the patient and family needs

L 557- Sharing of information between all disciplines providing care and services in all settings

L 558- Sharing of information with other non-hospice healthcare providers furnishing services

418.58

QAPI

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

L 561- Show measurable improvement in indicators related to improved palliative outcomes and hospice services

L 562-Measure, analyze, and track quality indicators, including adverse patient events

L 563- Use quality indicator data, including patient care, and other relevant data, in the design of its program

418.58

QAPI

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement;) focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

L 564- Use the data collected to do the following:

•Monitor the effectiveness and safety of services and quality of care

•Identify opportunities and priorities for improvement

L 565- Frequency and detail of data approved by governing body

ACHIEVING ACHC ACCREDITATION

418.58

QAPI

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

L 566-The hospice's performance improvement activities must focus on high-risk, high-volume, or problem-prone areas

L 567- Consider incidence, prevalence, and severity of problems in those areas

L 568- Affect palliative outcomes, patient safety, and quality of care

418.58

QAPI

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

L 569- Must track adverse patient events, analyze their causes, and implement preventive actions

L 570-Track performance to ensure that improvements are sustained

L 571- Performance improvement projects

L 572- Number and scope are based on the hospice's population and organizational needs

L 573- Document what performance improvement projects are being conducted

418.58

QAPI

The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.

L 574- Governing body ensures the program implemented and maintained and is evaluated annually

L 575- Address priorities for improved quality of care and patient safety

L 576- Someone is designated as responsible for the program

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NOTES

428.64

CORE SERVICES

A hospice must routinely provide all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.

A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: Unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care, and temporary travel of a patient outside of the hospice's service area.

428.64

CORE SERVICES

A hospice must routinely provide all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.

L 590- Physician services: One designated Medical Director
L 591- Nursing services
L 592-Nurses to write orders per state law
L 593- Highly specialized nursing services
L 594-Medical social services
L 595- Counseling services

428.64

CORE SERVICES

A hospice must routinely provide all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section.

L 596- Bereavement counseling

L 596-Dietary counseling:

•If an RN is capable of meeting the patient's needs, then the dietary counseling can be provided by the RN

L 598- Spiritual care provided to patients and families

418.70

FURNISHING OF NON-CORE SERVICES

A hospice must ensure that the services described in § 418.72 through § 418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in § 418.100. These services must be provided in a manner consistent with current standards of practice.

L 604- Physical therapy services, occupational therapy services, and speech-language pathology services must be available

L 605- Waiver of requirement- Physical therapy, occupational therapy, speech-language pathology, and dietary counseling

L 606- Request for a waiver to CMS Regional Office

418.76

HOSPICE AIDE & HOMEMAKER SERVICES

All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.

L 609- Hospice qualifications

L 610- 24 consecutive months without compensation

L 611- Content and duration of hospice aide classroom and supervised practical training

L 612- 16 hours of classroom training

L613 –Training program addresses required subjects

L614- Maintain documentation that aides are properly trained

418.76

HOSPICE AIDE & HOMEMAKER SERVICES

All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.

L 615- Competency evaluation

L 616- Cannot accept if from HHA, if the HHA is not in good standing (new HHA CoP)

L 617- Competency performed by RN

L 618-Cannot perform any tasks in which they have been evaluated as incompetent to perform

L 619- Maintain documentation of competency

NOTES

NOTES

418.76

HOSPICE AIDE & HOMEMAKER SERVICES

All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.

L 620- 12 hours of in-service training every 12 months
L 621- Must be supervised by an RN
L 622- Maintain documentation of in-service training
L 623- Qualifications of instructors conducting classroom and practical training
L 624- Cannot accept competency if HHA is not in good standing
L 625- Aide written instructions are specific to task and frequency, prepared by RN
L 626- Aide follows the written instructions

418.76

HOSPICE AIDE & HOMEMAKER SERVICES

All hospice aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.

L 627- Duties of the aide
L 628- Aide reports changes in the patient's conditions
L 629- Aide supervisory visit at least every 14 days
L 630- Areas of concern identified then aide must be observed while performing the care
L 631- Requires another competency to be completed on area of concern
L 632- Annual on-site visit with aide present
L 633- Requirements to be documented during the annual on-site visit

418.78

VOLUNTEERS

The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.

L 643- Volunteer orientation
L 644- Volunteers used in administrative roles and direct patient care roles
L 645- Recruiting and retaining
L 646- Cost savings
L 647- Level of activity

418.102

MEDICAL DIRECTOR

The hospice must designate a physician to serve as Medical Director. The Medical Director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the Medical Director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the Medical Director.

L666- Medical Director as employee or under contract:

- When contracting for Medical Director services, the contract must specify the physician who assumes the Medical Director responsibilities and obligations

L 667- Initial certification:

- The primary terminal condition
- Related diagnosis(es), if any

418.102

MEDICAL DIRECTOR

The hospice must designate a physician to serve as Medical Director. The Medical Director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the Medical Director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the Medical Director.

- Current subjective and objective medical findings
- Current medication and treatment orders
- Information about the medical management of any of the patient's conditions unrelated to the terminal illness

L 668- Recertification of the terminal illness

418.102

MEDICAL DIRECTOR

The hospice must designate a physician to serve as Medical Director. The Medical Director must be a doctor of medicine or osteopathy who is an employee, or is under contract with, the hospice. When the Medical Director is not available, a physician designated by the hospice assumes the same responsibilities and obligations as the Medical Director.

Before the recertification period for each patient, as described in § 418.21(a), the Medical Director or physician designee must review the patient's clinical information

L669-The Medical Director or physician designee has responsibility for the medical component of the hospice's patient care program

NOTES

NOTES

418.104

CLINICAL RECORDS

A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.

L 672- Initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes

L 673- Signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24

L674- Responses to medications, symptom management, treatments, and services

L675- Outcome measure data elements

L 676- Physician certification and recertification of terminal illness as required in § 418.22 and § 418.25 and described in § 418.102(b) and § 418.102(c) respectively, if appropriate

418.104

CLINICAL RECORDS

A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.

L 677-Advance directives

L 678- Physician orders

L 679- Authentication, clear, complete documentation:

- All entries must be legible, clear, complete, and appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice

L 680- Safeguard against loss or unauthorized use

L 681-Retention of records

418.104

CLINICAL RECORDS

A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.

L 682/L 683-Discharge or transfer of care/revocation:

•Send hospice discharge summary and

•Patient's clinical record, if requested

L 684- Content of discharge summary

L 685- Retrieval of clinical records

418.106

DRUGS AND BIOLOGICALS, MEDICAL SUPPLIES & DME

Medical supplies and appliances, as described in § 410.36 of this chapter; durable medical equipment, as described in § 410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.

L 692- Only appropriate individuals can administer medications
L 693- Labeling, disposing , and storing of drugs
L 694- Policies on disposal of controlled drugs in a patient's home
L 695- Provide copy to patients
L 696- Discuss policies and procedures
L 697- Document discussion occurred

418.108

SHORT-TERM INPATIENT CARE

Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.

L 706/707-Inpatient care for pain control and symptom management must be provided in one of the following:

•A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly as specified in § 418.110

•Medicare-certified hospital or a skilled nursing facility that also meets the standards specified in § 418.110(b) and (e) regarding 24-hour nursing services and patient areas

418.108

SHORT-TERM INPATIENT CARE

Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.

L 708/L 709- Inpatient care for respite purposes must be provided by one of the following:

•A provider specified in paragraph (a) of this section

•A Medicare or Medicaid-certified nursing facility that also meets the standards specified in § 418.110 (e)

L 710- Respite care facility needs to have 24-hour nursing services available
L 711- Short-term inpatient agreement
L 712- Inpatient provider have established patient care policies consistent with the hospice

NOTES

NOTES

418.112

INPATIENT IN AN SNF/NF/ICF/IID

In addition to meeting the conditions of participation at § 418.10 through § 418.116, a hospice that provides hospice care to residents of an SNF/NF or ICF/IID must abide by the following additional standards.

L 761- Residents must be eligible for hospice
L 762- Hospice maintains professional management of the terminal illness
L 763- Signed written agreement content
L 764-Communication and coordination with each entity
L 765-Communication of changes to the hospice
L 766-Hospice determines the course of hospice care
L 767-Facility to provide 24-hour room and board; services same level before hospice

418.112

INPATIENT IN AN SNF/NF/ICF/IID

In addition to meeting the conditions of participation at § 418.10 through § 418.116, a hospice that provides hospice care to residents of an SNF/NF or ICF/IID must abide by the following additional standards.

L 768- Hospice to provide same level of services patient would receive at home
L 769- Delineation of the hospice's responsibilities
L 770- Hospice may use facility staff to administer meds in accordance with state law
L 771-Hospice to report any alleged patient violations to the facility administrator
L 772- Delineation of bereavement service to facility staff

418.112

INPATIENT IN AN SNF/NF/ICF/IID

In addition to meeting the conditions of participation at § 418.10 through § 418.116, a hospice that provides hospice care to residents of an SNF/NF or ICF/IID must abide by the following additional standards.

L 773-Hospice plan of care maintained in consultation with facility representative
L 774- Hospice plan of care identifies the care and service to be provided and specifically identifies which provider is responsible
L 775- Hospice plan of care reflects participation of all
L 776- Any changes must be discussed with all
L 777- A member of the IDG acts as a liaison
L 778- Provides overall coordination of care with all

418.112

INPATIENT IN AN SNF/NF/ICF/IID

In addition to meeting the conditions of participation at § 418.10 through § 418.116, a hospice that provides hospice care to residents of an SNF/NF or ICF/IID must abide by the following additional standards.

L 779- Communication with all to ensure quality of care is provided

L 780- IDG communicates with medical director, attending physician, and other physicians

L 781-Required information in the facility record:

Most recent plan of care
Election form
Certification and recertification
Contact information for hospice personnel
How to access hospice 24/7
Hospice medication information
Physician orders

L 782- Orientation and training of facility staff

418.114

PERSONNEL QUALIFICATIONS

Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified , or registered) in accordance with applicable federal, state, and local laws, and must act only within the scope of his or her state license, or state certification, or registration. All personnel qualifications must be kept current at all times.

L785-Physicians must be an MD or OD and licensed in the state in which they are going to be providing care

L 786-Hospice Aides

L 787- Social Worker:

•MSW or BSW or baccalaureate in psychology, sociology or other field related to social work and is supervised by MSW and 1 year social work experience in a health care setting or BSW hired prior to Dec 2, 2008

418.114

PERSONNEL QUALIFICATIONS

Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified, or registered) in accordance with applicable federal, state, and local laws, and must act only within the scope of his or her state license, or state certification, or registration. All personnel qualifications must be kept current at all times.

L 795- The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records. Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.

L 796- Criminal background checks must be obtained in accordance with state requirements. In the absence of state requirements, criminal background checks must be obtained within three months of the date of employment for all states that the individual has lived or worked in the past three years.

NOTES

NOTES

EMERGENCY PREPAREDNESS

- 418.113 Emergency Preparedness
  - Emergency Preparedness Plan that is specific to the geographical area served by your agency and specific to your patient population based on an all-hazards risk assessment
  - Communication plan is specific to the contact information for your area
  - Policies address the specific strategies based on the all-hazards risk assessment
  - Training of all staff, including contract staff on the specific strategies and the role they would play in the event the plan is put in place
  - Two tests/drills are conducted annually:
    - Community-based drill or facility-based drill if unable to participate in a community-based drill (need documentation to show attempts to participate in a community-based drill and
    - Community-based drill, facility-based drill, or a tabletop drill that meets the requirements
  - All components of the plan are to be reviewed and updated at least annually

PRIVATE DUTY

- Must have served five patients with three active at time of survey
- Will conduct one home visit and review at least five client records
- Agencies can choose to seek accreditation for one or more programs:
  - If PDN or PDIN is requested, at least one patient has to have received PDN or PDIN services
- One day survey
- Scheduled survey
  - Except in Texas, New Jersey, and Florida (PDN)

PRIVATE DUTY

- Need to have established policies and procedures that are in alignment with ACHC standards specific to the service(s) for which the agency is seeking accreditation

PRIVATE DUTY

- If state and/or payor regulations exist, must be in compliance with those regulations
- Indiana and Ohio Medicaid waiver requires an agency to be in compliance with HH Medicare CoPs

PRIVATE DUTY

- Need to have complete medical record specific to the required elements:
  - Initial assessments and evaluations
  - Plan of care or plan of service is developed
  - Orders are present when required
  - Plan of care or plan of service is followed
  - Plan of care or plan of service is reviewed and revised in accordance with service specific requirements
  - Refusal of care or service is properly documents
  - Client is included in the development of the plan of care or plan of service

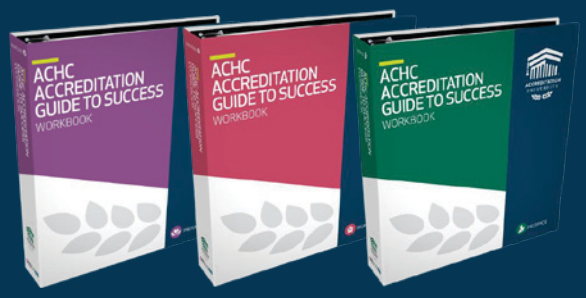
NOTES

NOTES

PRIVATE DUTY

- Need to have complete personnel files:
  - Evidence exists to demonstrate staff are qualified per state requirements and/or agency policies and procedures
  - Primary source verification of licensure when required
  - Competency
  - Job descriptions are present and reflect the duties and responsibilities

ACHC ACCREDITATION GUIDE TO SUCCESS WORKBOOK

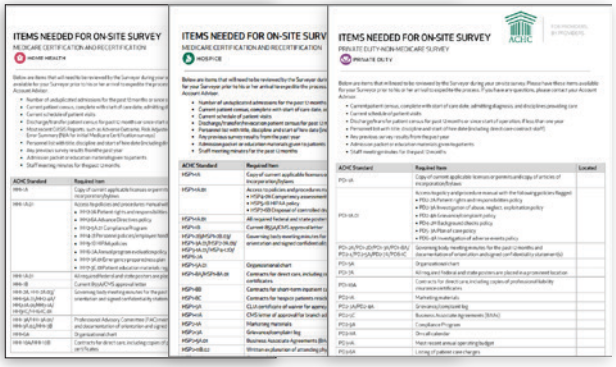


ACHC ACCREDITATION GUIDE TO SUCCESS WORKBOOK

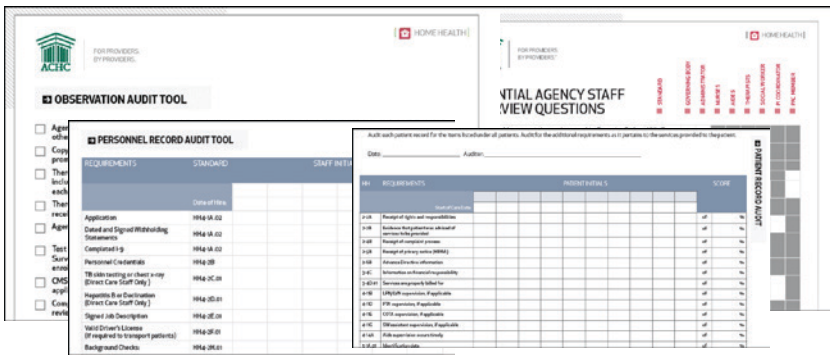
- **Essential Components:**
  - Each ACHC standard contains Essential Components that indicate what should be readily identifiable in a policy & procedure, personnel record, medical record, etc.
  - Each standard also contains audit tools, sample policies and procedures, templates, and helpful hints
- **Other Tools:**
  - Each section contains compliance checklists and a self-assessment tool to further guide the preparation process
- **Quick Standard Reference:**
  - Quickly locate important information for successfully completing the accreditation process with ACHC

ACHIEVING ACHC ACCREDITATION

ITEMS NEEDED ON-SITE



SURVEY PREP TOOLS



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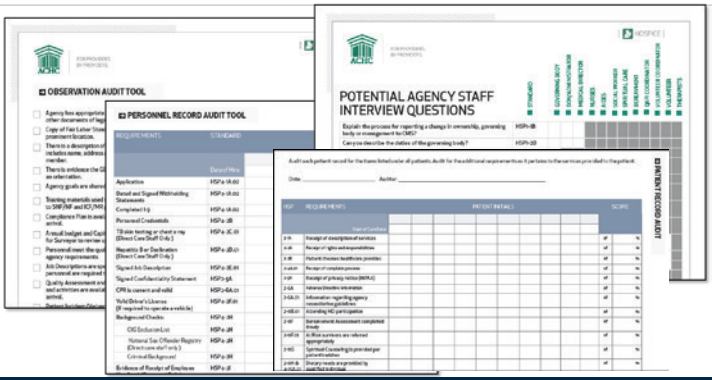

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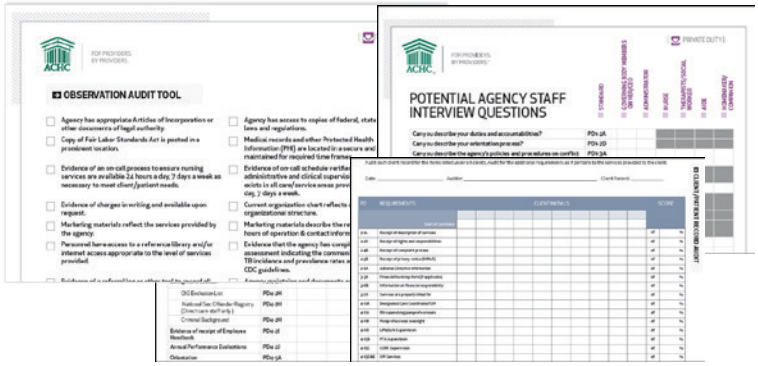
SURVEY PREP TOOLS



ASSESSMENT

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ACCREDITATION COMMISSION *for* HEALTH CARE