ACHC®

FOR PROVIDERS.
BY PROVIDERS.™

EXPERIENCE THE ACHC DIFFERENCE

PREPARING FOR AN ACHC CALIFORNIA LICENSURE SURVEY AND MEDICARE CERTIFICATION SURVEY

OBJECTIVES

- Review the ACHC California Licensure process
- Review the ACHC Accreditation Process for Medicare initial certification surveys
- Learn how to utilize resources and tools for a successful survey
- Review the ACHC Accreditation Standards to understand expectations for compliance
- Identify how to avoid the most commonly cited deficiencies

ABOUT ACHC

ABOUT ACHC

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.

- Nationally recognized accreditation organization (AO) with more than 30 years of experience
- CMS deeming authority for Home Health, Hospice, and DMEPOS
- Recognition by most major third-party payors
- Approved to perform many state licensure surveys
- Quality Management System certified to ISO 9001:2015

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

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.

HOME HEALTH ACCREDITATION

- ACHC earned CMS deeming authority in 2006
- Accredits more than 1,000 locations nationally
- Program-specific standards include Conditions of Participation (CoPs)
- Agencies have the ability to choose from comprehensive group of services, including
  - Skilled Nursing
  - Home Health Aide
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Social Work
  - Palliative Care
  - Behavioral Health Home Care

DISTINCTION IN PALLIATIVE CARE

- Distinction in Palliative Care
  - Home Health
- Additional 1 day on survey
  - Must have provided care to 3 patients, with 2 active at time of survey
  - <150 palliative care patients: 3 total record reviews with 1 home visit
  - 150 or more palliative care patients: 4 total record reviews with 2 home visits
- ACHC standards were based on the National Consensus Project for Quality Palliative Care guidelines

DISTINCTION IN BEHAVIORAL HEALTH

- Distinction in Behavioral Health
  - Home Health
- Additional 1 day on survey
  - Must have provided care to 3 patients, with 2 active at time of survey
  - <150 palliative care patients: 3 total record reviews with 1 home visit
  - 150 or more palliative care patients: 4 total record reviews with 2 home visits

CUSTOMER SATISFACTION

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

99%

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,

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.

PERSONAL ACCOUNT ADVISORS

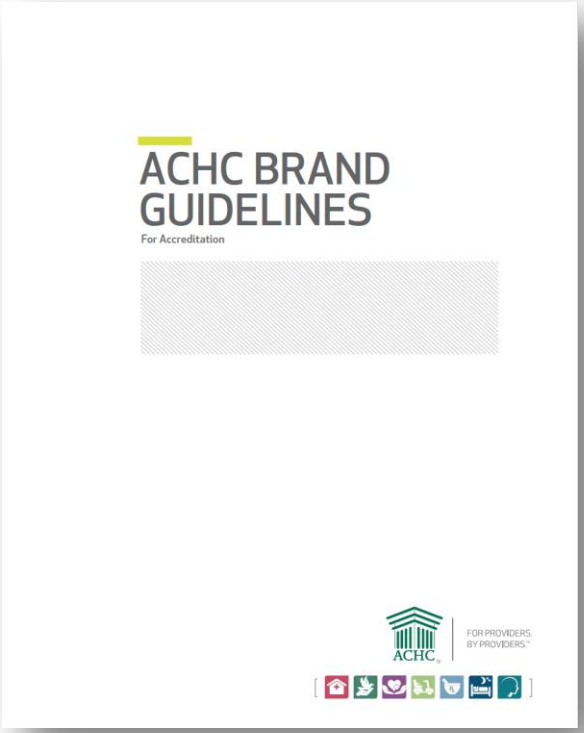
- Primary contact with customers
- Assigned once a customer submits an application
- Assist customers with the ACHC survey process
  - Pre-survey phone calls
  - Email with links to brief survey-prep webinars and resource links
- Questions that cannot be answered by them will be sent to the appropriate Clinical or Regulatory department

POLICIES & PROCEDURES

- Polices and Procedures that ACHC has reviewed and approved to be compliant with ACHC Standards will not be reviewed during the survey
  - Approved consultants
  - This allows for survey to focus on patient care vs. policies and procedures

MARKETING TOOLS

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



BRANDING ELEMENTS

- Gold Seal of Accreditation
  - Represents compliance with the most stringent national standards
- ACHC Accredited Logo

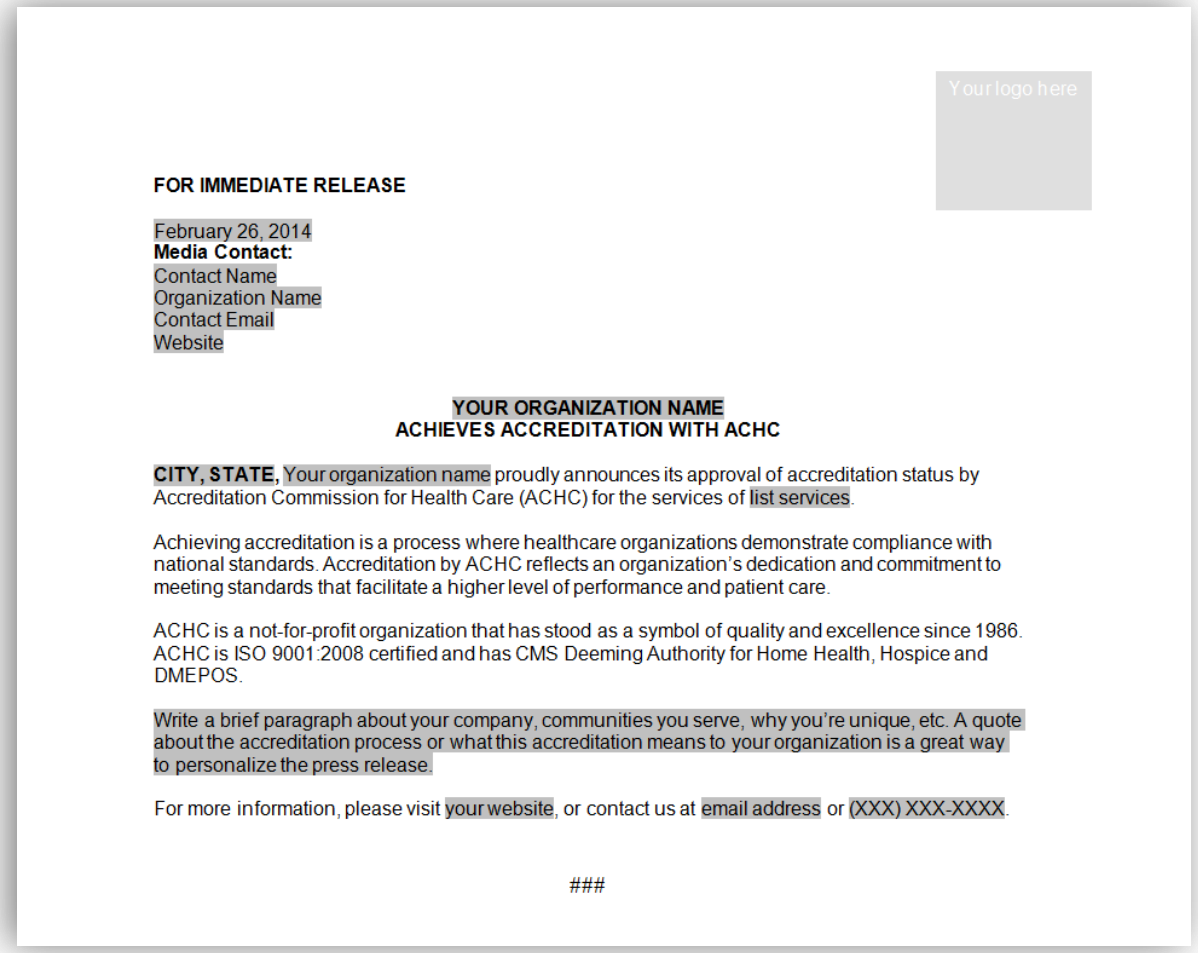
ACHC | ACHC ACCREDITED

ACHC | ACHC ACCREDITED

PROMOTING YOUR ACCREDITED STATUS

- A few basic places to promote ACHC-accredited status:
  - Website – *home page or dedicated landing page*
  - Marketing Materials – *any marketing piece that is seen by the public*
  - Press Releases – *in the "boilerplate" of the press release, or the background information normally found towards the bottom of a press release*
  - Social Media – *home page, banner image, or profile image*
  - Promotional Items – *trade show displays, giveaways, binders, or folders*
  - Email – *email signature*

SAMPLE PRESS RELEASE



Your logo here

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 DMEPOS.

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 your website, or contact us at email address or (XXX) XXX-XXXX.

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ACHC MARKETING RESOURCES

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

ACHC®

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BY PROVIDERS.™

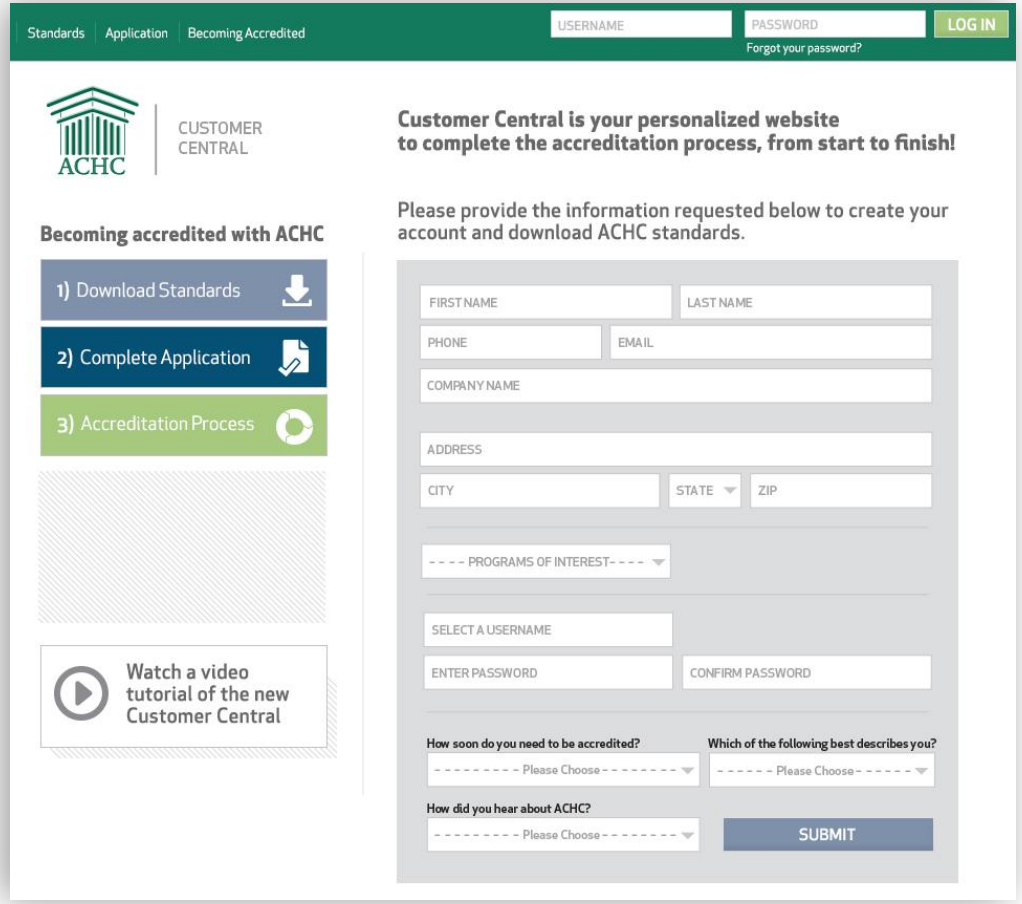
EXPERIENCE THE ACHC DIFFERENCE

CALIFORNIA LICENSURE REQUIREMENTS

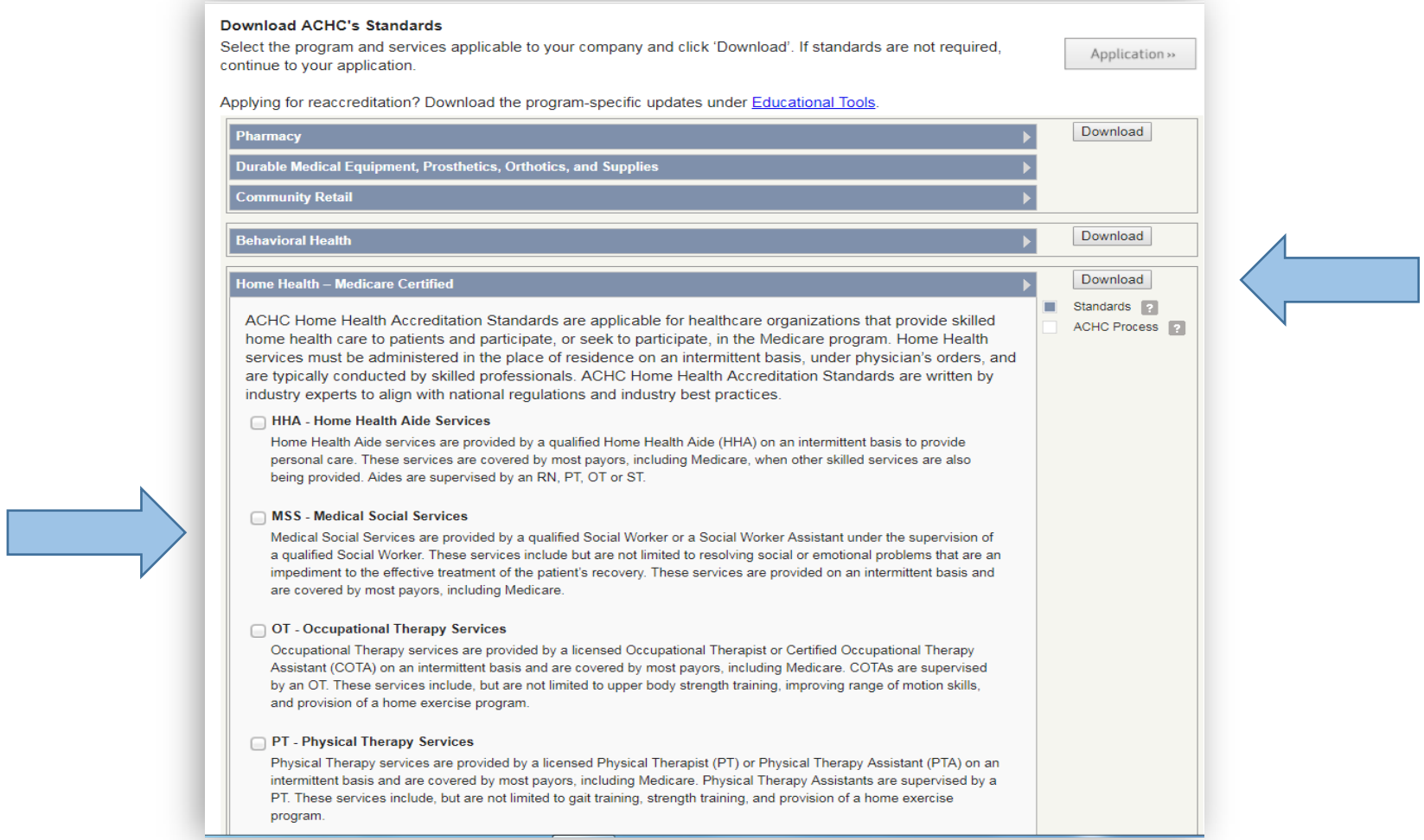
CREATE CUSTOMER CENTRAL ACCOUNT

- Step 1: Visit cc.achc.org
- Step 2: Complete the demographic information
- Step 3: Preview the appropriate standards
- Step 4: Download your customized ACHC standards
- Step 5: Obtain the California regulations for home health agencies by contacting the California Department of Public Health (CDPH)

DEMOGRAPHIC INFORMATION



DOWNLOAD APPROPRIATE STANDARDS



APPENDIX A

Appendix A: Standard Service Table for Selected Services

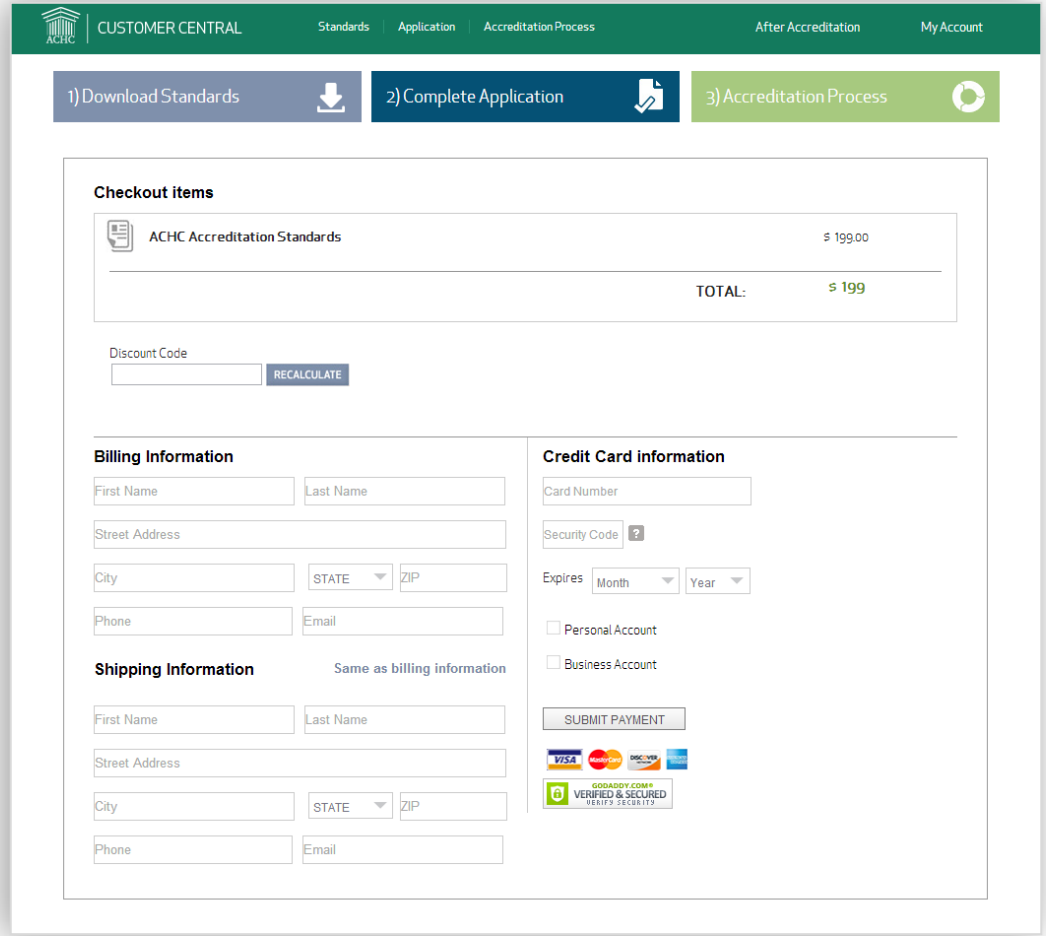
Standard	HHA	MSS	SN
HH1-1A	X	X	X
HH1-1A.01	X	X	X
HH1-1B	X	X	X
HH1-1B.01	X	X	X
HH1-1C	X	X	X
HH1-2A	X	X	X
HH1-2A.01	X	X	X
HH1-2A.02	X	X	X
HH1-2A.03	X	X	X
HH1-2A.04	X	X	X
HH1-2A.05	X	X	X
HH1-3A	X	X	X
HH1-3A.01	X	X	X
HH1-3A.02	X	X	X
HH1-3B	X	X	X
HH1-4A.01	X	X	X
HH1-5A	X	X	X
HH1-5A.01	X	X	X
HH1-5B	X	X	X
HH1-6A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

APPENDIX B

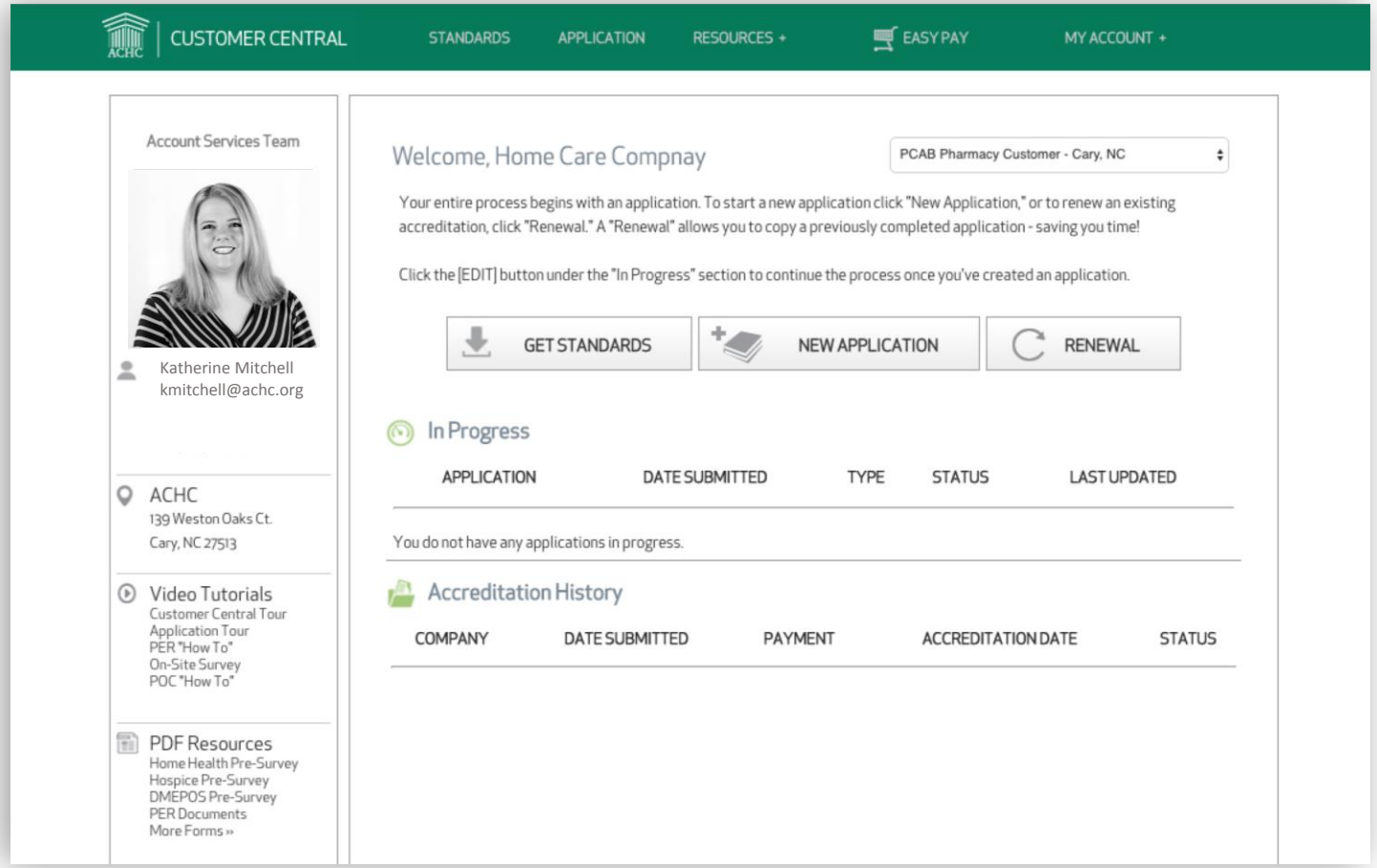
Appendix B: Reference Guide for Required Documents, Policies and Procedures
Customized for: HHA, MSS, OT, PD, PT, SN, ST

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	

PURCHASE STANDARDS



COMPLETE THE APPLICATION



SUBMIT REQUIRED PAPERWORK

- Online application
- Deposit of $1,500
- Signed Accreditation Agreement
- File an application and any additional documentation required with the Central Applications Unit (CAU) of the CDPH and include a cover letter indicating that you intend to hire ACHC as your accreditor

NEXT STEPS

- Once CAU determines that your licensure application is complete, you will receive an application approval letter
- CAU will send ACHC a copy of this letter
- CAU will send a copy of this letter along with the completed application to the District Office (DO)
- You should contact ACHC to schedule your initial licensure survey and verify that ACHC has received a copy of the letter from CAU

ON-SITE SURVEY

- Survey date will be scheduled
- Interview the Administrator and/or the Director of Nursing/Clinical Manager
- Will review policies and procedures; must have state-specific policies and procedures
- Will review personnel records for the Administrator and the Director of Nursing/Clinical Manager to ensure they meet the California requirements
- Will review a mock patient record to ensure the required components will be included in the patient record
- Will review any patient education materials and/or admission packet
- Will review governing body meeting minutes, if applicable

CORRECT DEFICIENCIES ON SITE

- For any deficiencies the Surveyor identifies, make all corrections that you can and show the Surveyor before he or she leaves
- Once survey is completed, the Surveyor will submit all required documentation to ACHC; the findings will be reviewed and you will receive your Summary of Findings (SOF) within 10 business days from the last day of survey
- ACHC will notify CDPH of the final accreditation decision in writing and once the approval decision is received, your agency will be granted accreditation for one year
- CDPH will issue you a home health agency provisional license

INITIAL MEDICARE CERTIFICATION

- Complete and submit an 855A application to The Centers for Medicare and Medicaid Services (CMS); once approved submit approval letter to ACHC
- Develop your patient caseload
  - 10 patients served with 7 active at time of survey
  - Must meet the definition of CMS skilled care per the Medicare Benefit Policy Manual Chapter 7
  - Do not have to be Medicare beneficiaries
- Successfully complete and transmit an Outcome and Assessment Information Set (OASIS) and submit a copy of the Final Validation Report to ACHC
- Provide skilled nursing services and one other therapeutic service, PT, OT, SLP, MSS, or Aide services; one discipline must be provided entirely by W2 employees
- Notify ACHC in writing when all of the requirements have been completed

INITIAL MEDICARE CERTIFICATION

- ACHC will create a second ACHC Agreement for Accreditation Service and send to you for approval
- Once this agreement is signed and returned to ACHC, your unannounced Initial Medicare Certification survey will be scheduled

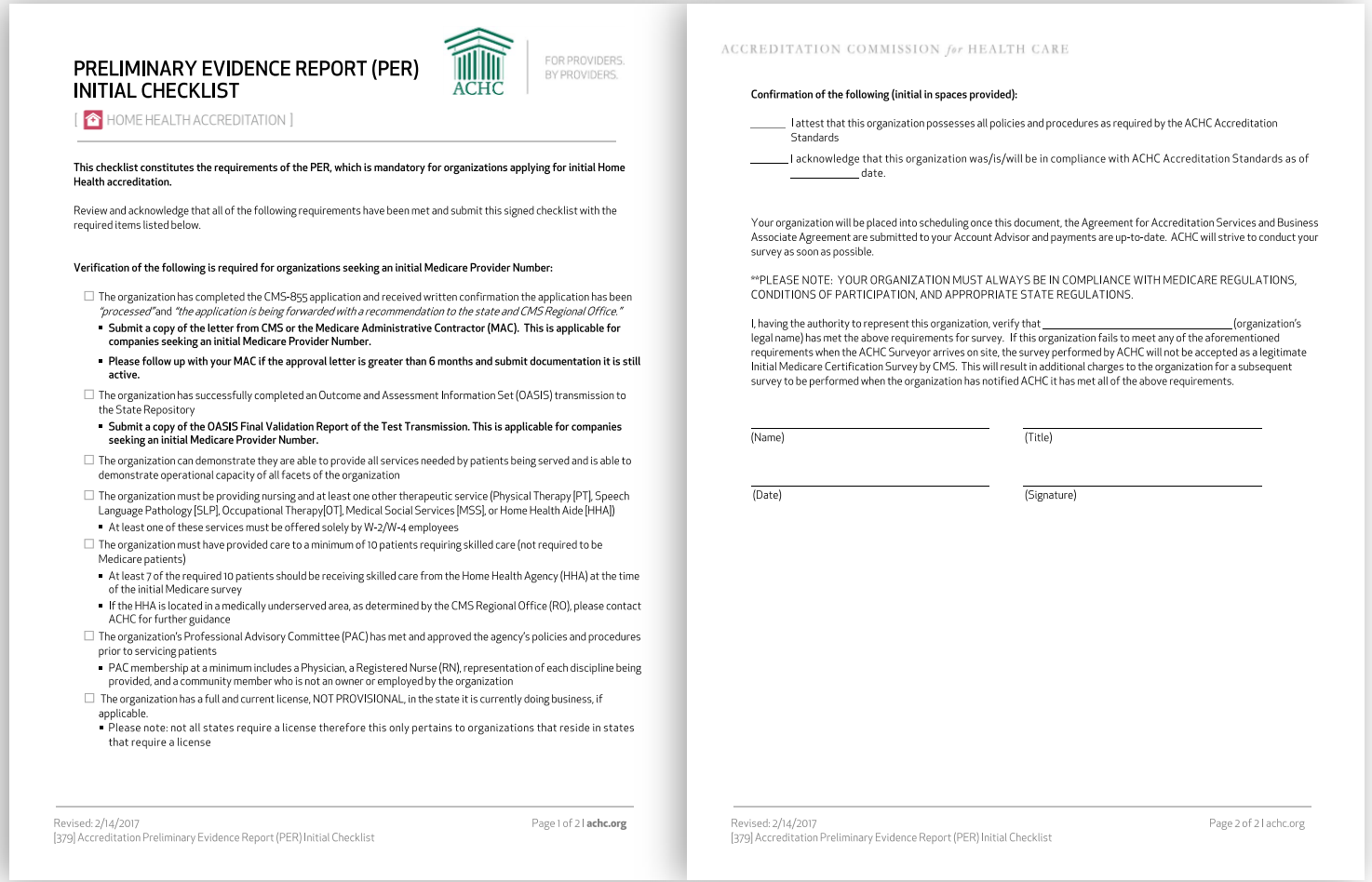
RESOURCES

- ACHC has created resources to assist you with the California Licensure Survey as well as your Initial Medicare certification survey and Medicare re-certification survey
- To view these resources, log in to Customer Central at cc.achc.org
- Your best resource is your personal Account Advisor
- If you have any questions regarding this presentation or about the survey process, contact your Account Advisor

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** you establish on the PER
  - ACHC-only requirements/non-CoPs
- Medicare CoPs, state requirements
  - Acceptance of first patient
- Agency policies
  - Implementation date of policy

PRELIMINARY EVIDENCE REPORT CHECKLIST



PRELIMINARY EVIDENCE REPORT (PER) INITIAL CHECKLIST

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[HOME HEALTH ACCREDITATION]

This checklist constitutes the requirements of the PER, which is mandatory for organizations applying for initial Home Health accreditation.

Review and acknowledge that all of the following requirements have been met and submit this signed checklist with the required items listed below.

Verification of the following is required for organizations seeking an initial Medicare Provider Number:

- ☐ The organization has completed the CMS-855 application and received written confirmation the application has been *"processed"* and *"the application is being forwarded with a recommendation to the state and CMS Regional Office."*
  - **Submit a copy of the letter from CMS or the Medicare Administrative Contractor (MAC). This is applicable for companies seeking an initial Medicare Provider Number.**
  - **Please follow up with your MAC if the approval letter is greater than 6 months and submit documentation it is still active.**
- ☐ The organization has successfully completed an Outcome and Assessment Information Set (OASIS) transmission to the State Repository
  - **Submit a copy of the OASIS Final Validation Report of the Test Transmission. This is applicable for companies seeking an initial Medicare Provider Number.**
- ☐ The organization can demonstrate they are able to provide all services needed by patients being served and is able to demonstrate operational capacity of all facets of the organization
- ☐ The organization must be providing nursing and at least one other therapeutic service (Physical Therapy [PT], Speech Language Pathology [SLP], Occupational Therapy[OT], Medical Social Services [MSS], or Home Health Aide [HHA])
  - At least one of these services must be offered solely by W-2/W-4 employees
- ☐ The organization must have provided care to a minimum of 10 patients requiring skilled care (not required to be Medicare patients)
  - At least 7 of the required 10 patients should be receiving skilled care from the Home Health Agency (HHA) at the time of the initial Medicare survey
  - If the HHA is located in a medically underserved area, as determined by the CMS Regional Office (RO), please contact ACHC for further guidance
- ☐ The organization's Professional Advisory Committee (PAC) has met and approved the agency's policies and procedures prior to servicing patients
  - PAC membership at a minimum includes a Physician, a Registered Nurse (RN), representation of each discipline being provided, and a community member who is not an owner or employed by the organization
- ☐ The organization has a full and current license, NOT PROVISIONAL, in the state it is currently doing business, if applicable.
  - Please note: not all states require a license therefore this only pertains to organizations that reside in states that require a license

Revised: 2/14/2017
[379] Accreditation Preliminary Evidence Report (PER) Initial Checklist
Page 1 of 2 | **achc.org**

ACCREDITATION COMMISSION *for* HEALTH CARE

Confirmation of the following (initial in spaces provided):

_____ I attest that this organization possesses all policies and procedures as required by the ACHC Accreditation Standards

_____ I acknowledge that this organization was/is/will be in compliance with ACHC Accreditation Standards as of _____ date.

Your organization will be placed into scheduling once this document, the Agreement for Accreditation Services and Business Associate Agreement are submitted to your Account Advisor and payments are up-to-date. ACHC will strive to conduct your survey as soon as possible.

**PLEASE NOTE: YOUR ORGANIZATION MUST ALWAYS BE IN COMPLIANCE WITH MEDICARE REGULATIONS, CONDITIONS OF PARTICIPATION, AND APPROPRIATE STATE REGULATIONS.

I, having the authority to represent this organization, verify that _____ (organization's legal name) has met the above requirements for survey. If this organization fails to meet any of the aforementioned requirements when the ACHC Surveyor arrives on site, the survey performed by ACHC will not be accepted as a legitimate Initial Medicare Certification Survey by CMS. This will result in additional charges to the organization for a subsequent survey to be performed when the organization has notified ACHC it has met all of the above requirements.

_____ (Name)

_____ (Title)

_____ (Date)

_____ (Signature)

Revised: 2/14/2017
[379] Accreditation Preliminary Evidence Report (PER) Initial Checklist
Page 2 of 2 | achc.org

SCHEDULING

- Online application
- Deposit
- Signed Accreditation agreement
- Payment method
- Preliminary Evidence Report (PER) checklist
- Required documents in order to be placed into scheduling
- Average time from submission of required documents to on-site survey

EXPERIENCE THE ACHC DIFFERENCE

INITIAL MEDICARE CERTIFICATION REQUIREMENTS

INITIAL CERTIFICATION REQUIREMENTS

- **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 (Successful)**
- **Required documents to be placed into scheduling**

INITIAL CERTIFICATION REQUIREMENTS

- 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 (as determined by the Regional Office)
- 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)
  - Both therapeutic services have to have been provided/are being provided
  - 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

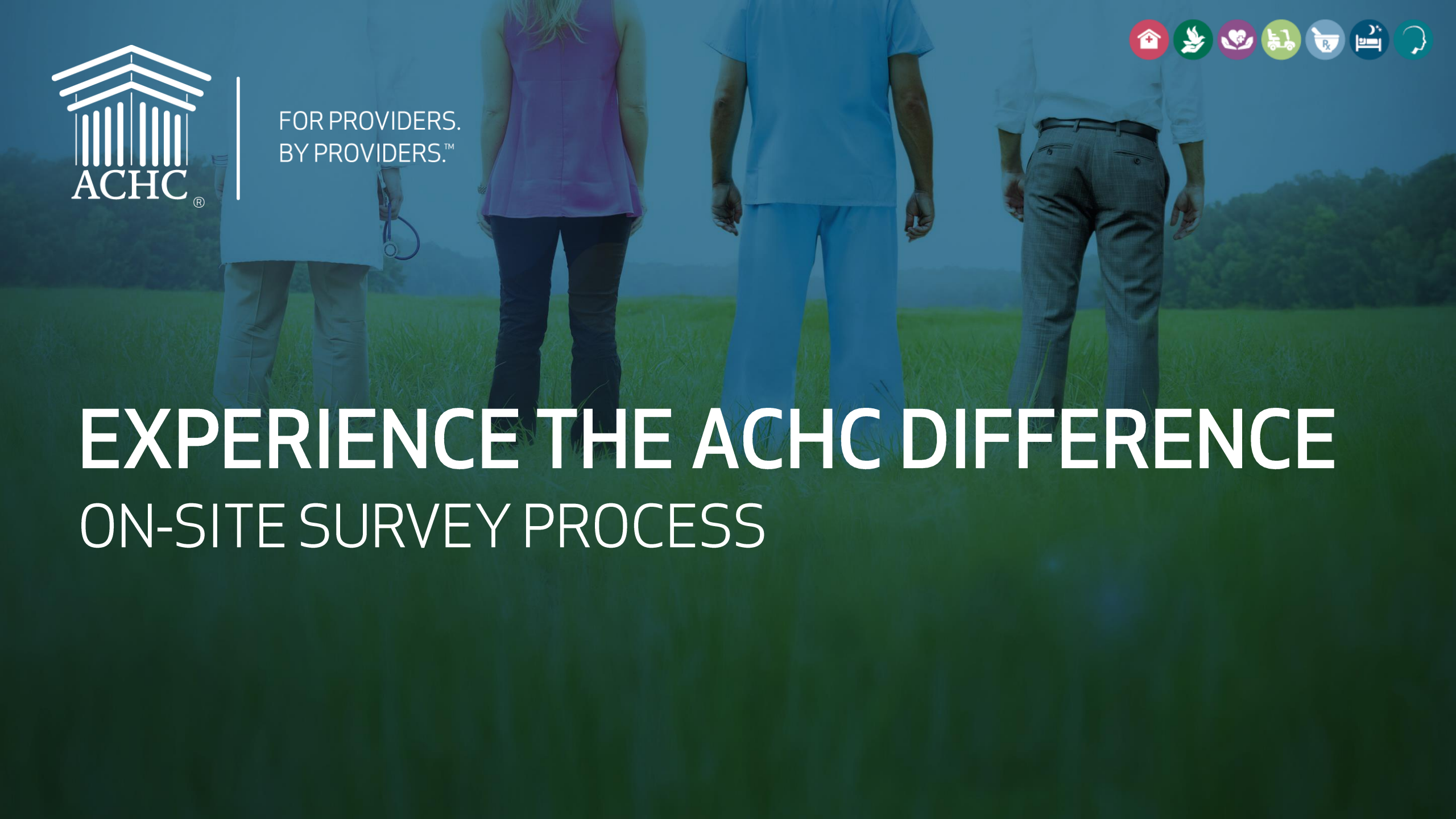
SEPARATE ENTITIES

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



EXPERIENCE THE ACHC DIFFERENCE

ON-SITE SURVEY PROCESS

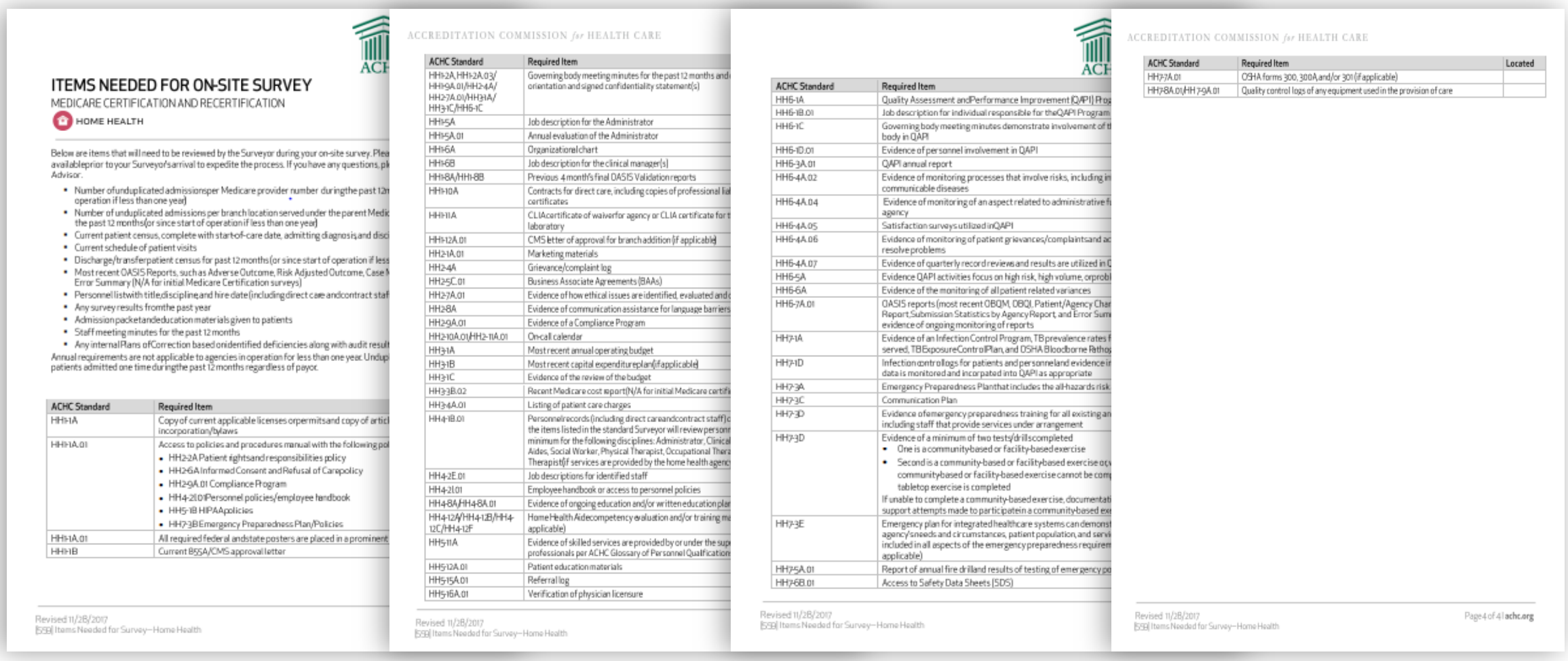
ON-SITE SURVEY PROCESS

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

ON-SITE SURVEY PROCESS

- 21st Century customers will not be required to have a policy review on-site; clarification purposes only
- On site:
  - Observation
  - Interviews
  - Home visits
  - Medical record review/Personnel record review
  - Contracts
  - QAPI
- Review by the Review Committee
- Accreditation decision is made

ITEMS NEEDED FOR ON-SITE SURVEY



ITEMS NEEDED FOR ON-SITE SURVEY

MEDICARE CERTIFICATION AND RECERTIFICATION

HOME HEALTH

Below are items that will need to be reviewed by the Surveyor during your on-site survey. Plea
availableprior to your Surveyor's arrival to expedite the process. If you have any questions, pl
Advisor.

- Number ofunduplicated admissionsper Medicare provider number duringthe past 12
operation if less than one year)
- Number of unduplicated admissions per branch location served under the parent Medi
the past 12 months(or since start of operation if less than one year)
- Current patient census, complete with start-of-care date, admitting diagnosis,and disci
- Current schedule of patient visits
- Discharge/transferpatient census for past 12 months (or since start of operation if less
- Most recent OASIS Reports, such as Adverse Outcome, Risk Adjusted Outcome, Case M
Error Summary (N/A for initial Medicare Certification surveys)
- Personnel listwith title,discipline,and hire date (including direct care andcontract staf
- Any survey results fromthe past year
- Admission packetandeducation materials given to patients
- Staff meeting minutes for the past 12 months
- Any internal Plans ofCorrection based onidentified deficiencies along with audit result

Annual requirements are not applicable to agencies in operation for less than one year. Undupl
patients admitted one time duringthe past 12 months regardless of payor.

ACHC Standard	Required Item
HH-1A	Copy of current applicable licenses orpermitsand copy of articl incorporation/bylaws
HH-1A.01	Access to policies and procedures manual with the following pol • HH-2A Patient rightsand responsibilities policy • HH-2B Informed Consent and Refusal of Carepolicy • HH-2I.01 Compliance Program • HH-4-2E.01Personnel policies/employee handbook • HH-5-1B HIPAApolicies • HH-7-3B Emergency Preparedness Plan/Policies
HH-1A.01	All required federal andstate posters are placed in a prominent
HH-1B	Current BSSA/CMS approval letter

Revised 11/28/2017
[558] Items Needed for Survey—Home Health

ACCREDITATION COMMISSION *for* HEALTH CARE

ACHC Standard	Required Item
HH-2A, HH-2A.03/ HH-9A.01/HH2-4A/ HH-2-7A.01/HH-3-1A/ HH-3-1C/HH6-1C	Governing body meeting minutes for the past 12 months and orientation and signed confidentiality statement(s)
HH-5A	Job description for the Administrator
HH-5A.01	Annual evaluation of the Administrator
HH-6A	Organizational chart
HH-6B	Job description for the clinical manager(s)
HH-8A/HH-8B	Previous 4 month's final OASIS Validation reports
HH-10A	Contracts for direct care, including copies of professional lia certificates
HH-11A	CLIAcertificate of waiverfor agency or CLIA certificate for t laboratory
HH-12A.01	CMS letter of approval for branch addition (if applicable)
HH-2-1A.01	Marketing materials
HH-2-4A	Grievance/complaint log
HH-2-5C.01	Business Associate Agreements (BAAs)
HH-2-7A.01	Evidence of how ethical issues are identified, evaluated and
HH-2-8A	Evidence of communication assistance for language barriers
HH-2-9A.01	Evidence of a Compliance Program
HH-2-10A.01/HH-2-11A.01	On-call calendar
HH-3-1A	Most recent annual operating budget
HH-3-1B	Most recent capital expenditure plan(if applicable)
HH-3-1C	Evidence of the review of the budget
HH-3-3B.02	Recent Medicare cost report(N/A for initial Medicare certifi
HH-3-4A.01	Listing of patient care charges
HH-4-1B.01	Personnelrecords (including direct careandcontract staff) c the items listed in the standard Surveyor will review person minimum for the following disciplines: Administrator, Clinica Aides, Social Worker, Physical Therapist, Occupational Thera Therapist(if services are provided by the home health agenc
HH-4-2E.01	Job descriptions for identified staff
HH-4-2I.01	Employee handbook or access to personnel policies
HH-4-8A/HH-4-8A.01	Evidence of ongoing education and/or written education plan
HH-4-12A/HH-4-12B/HH-4-12C/HH-4-12F	Home Health Aidecompetency evaluation and/or training m applicable)
HH-5-11A	Evidence of skilled services are provided by or under the sup professionals per ACHC Glossary of Personnel Qualification
HH-5-12A.01	Patient education materials
HH-5-15A.01	Referral log
HH-5-16A.01	Verification of physician licensure

Revised 11/28/2017
[558] Items Needed for Survey—Home Health

ACHC Standard	Required Item
HH-6-1A	Quality Assessment andPerformance Improvement (QAPI) Pro
HH-6-1B.01	Job description for individual responsible for theQAPI Program
HH-6-1C	Governing body meeting minutes demonstrate involvement of t body in QAPI
HH-6-1D.01	Evidence of personnel involvement in QAPI
HH-6-3A.01	QAPI annual report
HH-6-4A.02	Evidence of monitoring processes that involve risks, including in communicable diseases
HH-6-4A.04	Evidence of monitoring of an aspect related to administrative f agency
HH-6-4A.05	Satisfaction surveys utilized inQAPI
HH-6-4A.06	Evidence of monitoring of patient grievances/complaintsand ac resolve problems
HH-6-4A.07	Evidence of quarterly record reviews and results are utilized in Q
HH-6-5A	Evidence QAPI activities focus on high risk, high volume, orprobl
HH-6-6A	Evidence of the monitoring of all patient related variances
HH-6-7A.01	OASIS reports (most recent OBQM, OBQI, Patient/Agency Char Report,Submission Statistics by Agency Report, and Error Sum evidence of ongoing monitoring of reports
HH-7-1A	Evidence of an Infection Control Program, TB prevalence rates f served, TB ExposureControlPlan, and OSHA Bloodborne Pathog
HH-7-1D	Infection control logs for patients and personneland evidence in data is monitored and incorpated into QAPI as appropriate
HH-7-3A	Emergency Preparedness Planthat includes the all-hazards risk
HH-7-3C	Communication Plan
HH-7-3D	Evidence ofemergency preparedness training for all existing an including staff that provide services under arrangement
HH-7-3D	Evidence of a minimum of two tests/drills completed • One is a community-based or facility-based exercise • Second is a community-based or facility-based exercise oc community-based or facility-based exercise cannot be com tabletop exercise is completed If unable to complete a community-based exercise, documentati support attempts made to participatein a community-based ex
HH-7-3E	Emergency plan for integrated healthcare systems can demonst agency's needs and circumstances, patient population, and servi included in all aspects of the emergency preparedness requirem applicable)
HH-7-5A.01	Report of annual fire drilland results of testing of emergency po
HH-7-6B.01	Access to Safety Data Sheets (SDS)

Revised 11/28/2017
[558] Items Needed for Survey—Home Health

ACCREDITATION COMMISSION *for* HEALTH CARE

ACHC Standard	Required Item	Located
HH-7-7A.01	OSHA forms 300, 300A,and/or 301 (if applicable)	
HH-7-8A.01/HH-7-9A.01	Quality control logs of any equipment used in the provision of care	

Revised 11/28/2017
[558] Items Needed for Survey—Home Health

Page 4 of 4 | achc.org

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
  - Recent discharged and transferred patients
  - Personnel/Contract
    - Name, start of hire, and discipline/role

TOUR

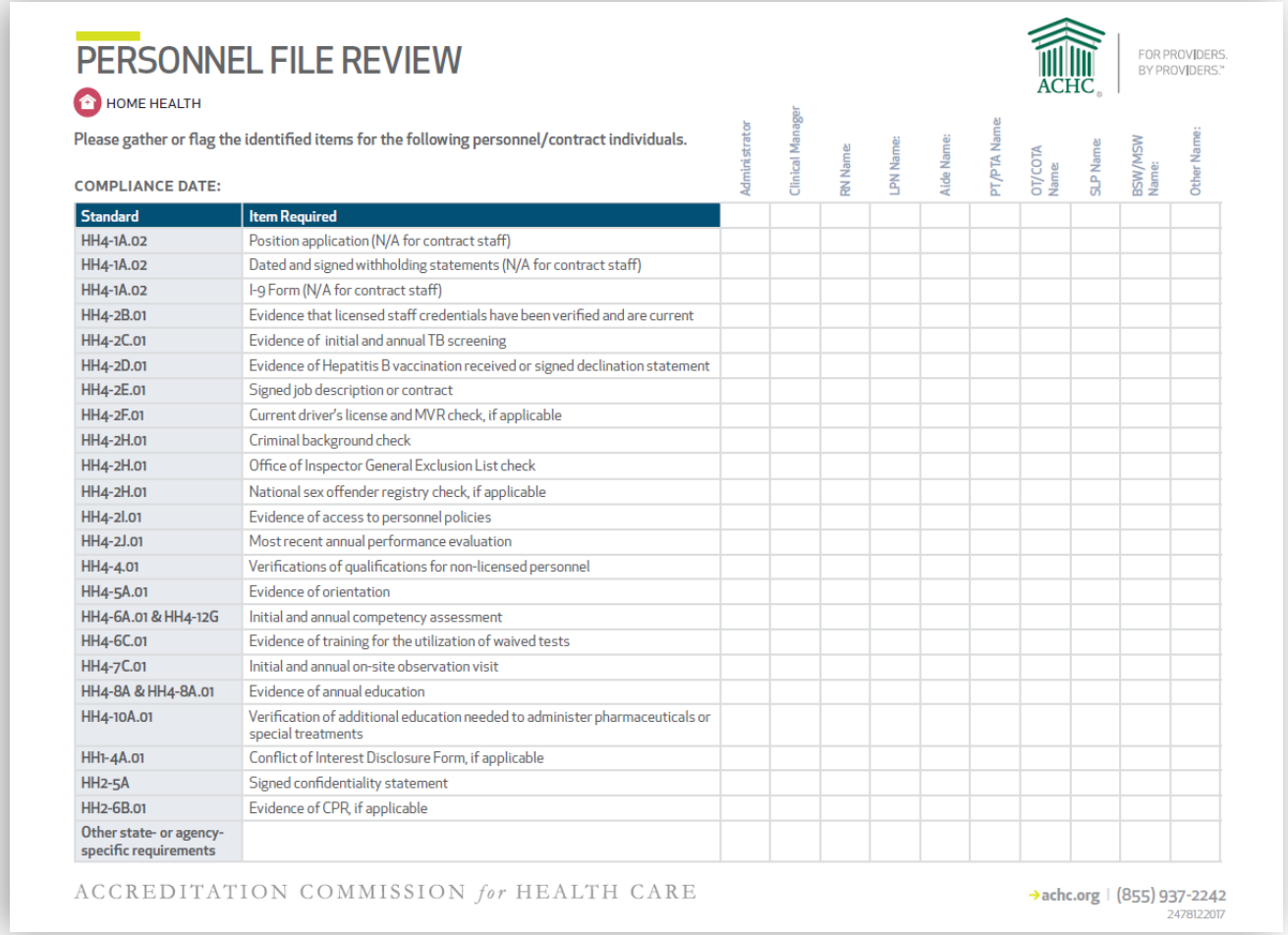
- Brief tour of facility
  - Medical record storage
  - Maintaining confidentiality of Protected Health Information (PHI)
  - Supply closet
  - Biohazard waste
  - Required posters
  - Fire extinguishers/smoke detectors/non-smoking signage
  - Restrooms

PERSONNEL RECORD 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, and 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 RECORD REVIEW



PERSONNEL FILE REVIEW

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HOME HEALTH

Please gather or flag the identified items for the following personnel/contract individuals.

COMPLIANCE DATE:

Standard	Item Required	Administrator	Clinical Manager	RN Name:	LPN Name:	Aide Name:	PT/PTA Name:	OT/COTA Name:	SLP Name:	BSW/MSW Name:	Other Name:
HH4-1A.02	Position application (N/A for contract staff)										
HH4-1A.02	Dated and signed withholding statements (N/A for contract staff)										
HH4-1A.02	I-9 Form (N/A for contract staff)										
HH4-2B.01	Evidence that licensed staff credentials have been verified and are current										
HH4-2C.01	Evidence of initial and annual TB screening										
HH4-2D.01	Evidence of Hepatitis B vaccination received or signed declination statement										
HH4-2E.01	Signed job description or contract										
HH4-2F.01	Current driver's license and MVR check, if applicable										
HH4-2H.01	Criminal background check										
HH4-2H.01	Office of Inspector General Exclusion List check										
HH4-2H.01	National sex offender registry check, if applicable										
HH4-2I.01	Evidence of access to personnel policies										
HH4-2J.01	Most recent annual performance evaluation										
HH4-4.01	Verifications of qualifications for non-licensed personnel										
HH4-5A.01	Evidence of orientation										
HH4-6A.01 & HH4-12G	Initial and annual competency assessment										
HH4-6C.01	Evidence of training for the utilization of waived tests										
HH4-7C.01	Initial and annual on-site observation visit										
HH4-8A & HH4-8A.01	Evidence of annual education										
HH4-10A.01	Verification of additional education needed to administer pharmaceuticals or special treatments										
HH1-4A.01	Conflict of Interest Disclosure Form, if applicable										
HH2-5A	Signed confidentiality statement										
HH2-6B.01	Evidence of CPR, if applicable										
Other state- or agency-specific requirements											

ACCREDITATION COMMISSION *for* HEALTH CARE

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2478122017

MEDICAL CHART REVIEWS

- CMS requirement based on unduplicated admissions
- Representative of the care provided
  - Interdisciplinary
  - Environment served
  - Medically complex
  - All payors
- Electronic Medical Record
  - Do not print the medical record
  - Need access to the entire record in “Read-only” format
  - Need to have a laptop/desktop supplied by the agency
  - Navigator is helpful to review layout of medical record

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 can provide their own transportation

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

EXIT CONFERENCE

- Mini-exit
  - At the end of each day to identify the deficiencies
- Final exit conference
  - Present all corrections prior to the exit conference
  - Invite those you want to attend
  - Surveyor cannot provide a score
  - Preliminary Summary of Findings (SOF) as identified by Surveyor and the ACHC standard
  - Seek clarification from Surveyor while still on site

CORRECTED ON SITE

- ACHC-only requirements can be corrected on site and a Plan of Correction (POC) will not be required
- G 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

EXPERIENCE THE ACHC DIFFERENCE

POST- SURVEY PROCESS

POST-SURVEY TIMEFRAMES

- ACHC Surveyor submits survey data to ACHC office within 2 business days from the last day of survey
- Accreditation decisions are provided to agency within 10 business days from the last day of survey
- Organization submits a Plan of Correction within 10 calendar days from the date of the accreditation decision
- Regulatory paperwork is submitted to the CMS Central Office, Regional Office and the State approximately 5 business days from the receipt of an approved Plan of Correction

SUMMARY OF FINDINGS SAMPLE

Summary of Findings Report for Survey on 01/23/2018

HH1-5A 484.105(b)(1)(i)	**There is an individual who is designated as responsible for the overall operation and services of the HHA. The Administrator organizes and directs the HHA's ongoing functions and maintains ongoing liaison among the governing body/owner and the personnel. 484.105(b), 484.105(b)(1)(i-iv), 484.105(b)(2), 484.105(b)(3)**	Upon observation and review of the Job Description of the Agency Administrator it does not evidence the required information regarding the Clinical Manager. • Ensures that a clinical manager as described in 42 CFR 484.105(c) is available during all operating hours Corrective Action: The Agency needs to ensure that the Administrator Job Description contains required language regarding the Clinical Manager. Educate staff on the requirement. Perform audit of Job Description to ensure compliance.	X
HH5-1B 484.110(c)(2)	**Written policies and procedures are established and implemented that address access, storage, removal, and retention of patient records and information. 484.110(c), 484.110(c)(1), 484.110(c)(2), 484.110(d), 484.110(e)**	Upon Policy and Procedure review there was no policy evidenced that provides for retention even if the HHA discontinues operations. When an HHA discontinues operation, it must inform the state agency where clinical records will be maintained. 484.110(c)(2) Corrective Action: The Agency will need to develop a policy that addresses the required language in 484.110(c)(2). Educate staff on the requirement. Perform a policy audit to ensure compliance.	X
HH1-8B 484.45(a)	**The HHA's policies and procedures describe activities and the implementation to ensure safe, timely and accurate collection and transmission of OASIS data. 484.45(a), 484.45(b), 484.45(c), 484.45(c)(1), 484.45(c)(2), 484.45(c)(3), 484.45(c)(4), 484.45(d)**	Upon observation the Agency was unable to evidence the OASIS Error Submission Reports for November and December of 2017 and January 2018. Corrective Action: The Agency needs to ensure that the OASIS Error Submission Reports are reviewed to ensure that timely submission of the OASIS assessment is being done within 30 days of completing the assessment of the beneficiary. Educate staff on the requirement. Perform audit of the OASIS Error Submission Report.	X

STANDARD- AND CONDITION-LEVEL DEFICIENCIES

- All survey results are reviewed by the ACHC Review Committee
- Standard-level deficiencies are ACHC-only deficiencies and individual G tags
  - Not as "severe"
  - Individual, random issue vs. a systemic issue
  - Only require a Plan of Correction
- Condition-level deficiencies result when either an entire condition is out of compliance, multiple G tags under a single condition are out of compliance, or the deficiency is severe
  - Requires another on-site survey

ACHC ACCREDITATION DECISION DEFINITIONS

ACCREDITED

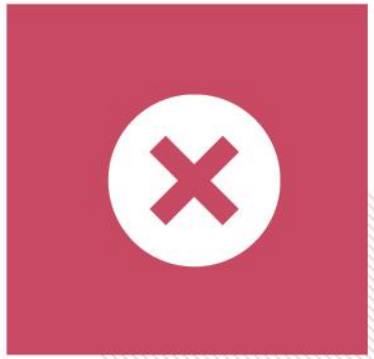
Provider meets all requirements for full accreditation status. Accreditation is granted but Plan of Correction (POC) may still be required.*

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.



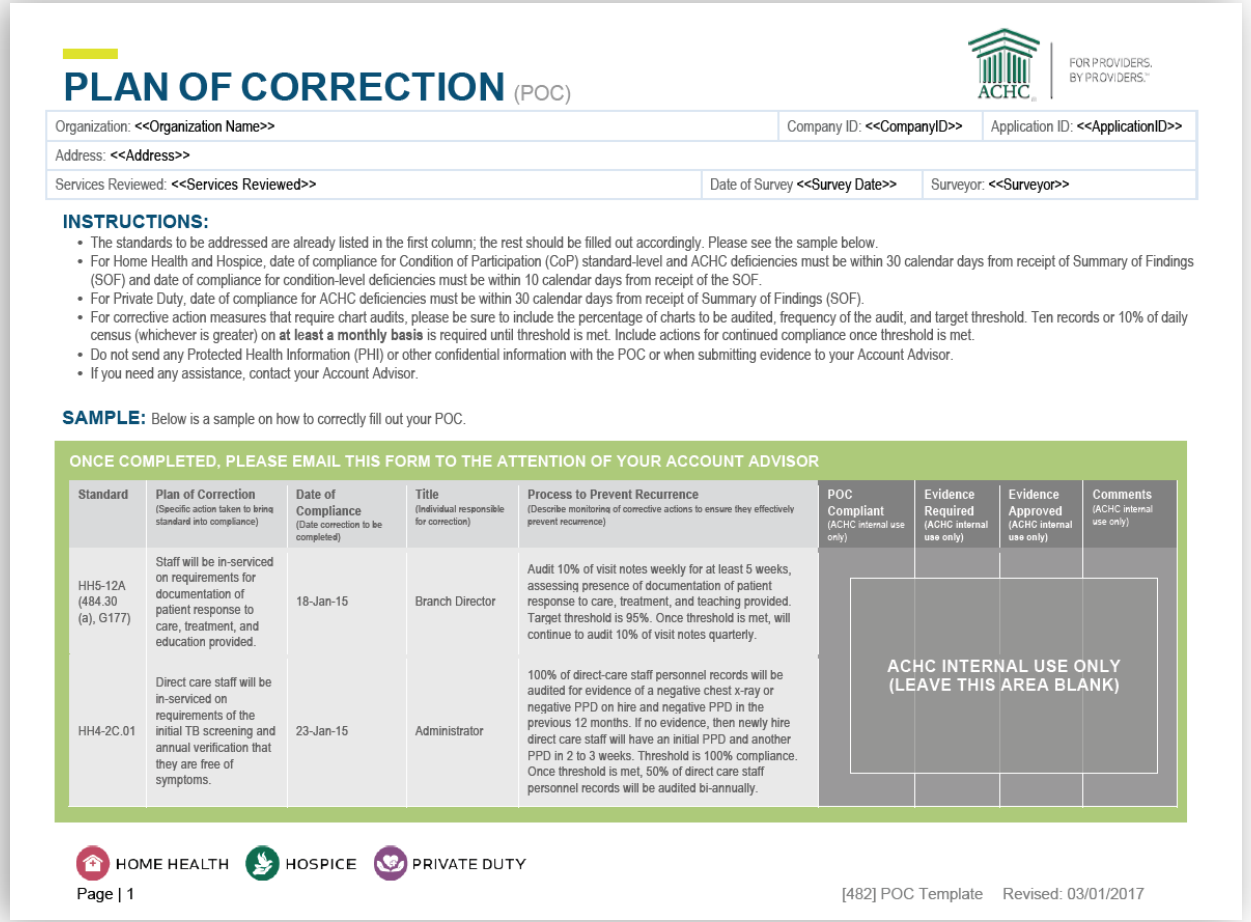
DENIED

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

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 if condition-level
  - 30 calendar days if standard-level
- Title of individual responsible
- Process to prevent recurrence (2-step process)
  - Percentage and frequency
  - Target threshold
  - Maintaining compliance

PLAN OF CORRECTION



PLAN OF CORRECTION (POC)

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Organization: <<Organization Name>>	Company ID: <<CompanyID>>	Application ID: <<ApplicationID>>
Address: <<Address>>		
Services Reviewed: <<Services Reviewed>>	Date of Survey <<Survey Date>>	Surveyor: <<Surveyor>>

INSTRUCTIONS:

- The standards to be addressed are already listed in the first column; the rest should be filled out accordingly. Please see the sample below.
- For Home Health and Hospice, date of compliance for Condition of Participation (CoP) standard-level and ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF) and date of compliance for condition-level deficiencies must be within 10 calendar days from receipt of the SOF.
- For Private Duty, date of compliance for ACHC deficiencies must be within 30 calendar days from receipt of Summary of Findings (SOF).
- For corrective action measures that require chart audits, please be sure to include the percentage of charts to be audited, frequency of the audit, and target threshold. Ten records or 10% of daily census (whichever is greater) on **at least a monthly basis** is required until threshold is met. Include actions for continued compliance once threshold is met.
- Do not send any Protected Health Information (PHI) or other confidential information with the POC or when submitting evidence to your Account Advisor.
- If you need any assistance, contact your Account Advisor.

SAMPLE: Below is a sample on how to correctly fill out your POC.

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

Standard	Plan of Correction (Specific action taken to bring standard into compliance)	Date of Compliance (Date correction to be completed)	Title (Individual responsible for correction)	Process to Prevent Recurrence (Describe monitoring of corrective actions to ensure they effectively prevent recurrence)	POC Compliant (ACHC internal use only)	Evidence Required (ACHC internal use only)	Evidence Approved (ACHC internal use only)	Comments (ACHC internal use only)
HH5-12A (484.30 (a), G177)	Staff will be in-serviced on requirements for documentation of patient response to care, treatment, and education provided.	18-Jan-15	Branch Director	Audit 10% of visit notes weekly for at least 5 weeks, assessing presence of documentation of patient response to care, treatment, and teaching provided. Target threshold is 95%. Once threshold is met, will continue to audit 10% of visit notes quarterly.	ACHC INTERNAL USE ONLY (LEAVE THIS AREA BLANK)			
HH4-2C.01	Direct care staff will be in-serviced on requirements of the initial TB screening and annual verification that they are free of symptoms.	23-Jan-15	Administrator	100% of direct-care staff personnel records will be audited for evidence of a negative chest x-ray or negative PPD on hire and negative PPD in the previous 12 months. If no evidence, then newly hire direct care staff will have an initial PPD and another PPD in 2 to 3 weeks. Threshold is 100% compliance. Once threshold is met, 50% of direct care staff personnel records will be audited bi-annually.				

HOME HEALTH HOSPICE PRIVATE DUTY

Page | 1

[482] POC Template Revised: 03/01/2017

EVIDENCE

- Evidence that is required to support compliance is identified on the Plan of Correction
- Summation of 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

EVIDENCE CHART

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Company name: _____

Date: _____ For the week/month of: _____

Complete the Medical Record /Personnel Record chart with the summation of your medical record and/or personnel record audit results. Complete the Observation Deficiencies chart and provide the required documents to support compliance with the requirements. Examples of evidence that may need to be submitted are: Governing Body meeting minutes, revised contracts, annual program evaluation, QAPI activities, or evidence of Volunteer activity.

All evidence supporting the implementation of the Plan of Correction (POC) must be submitted, at one time, to your Account Advisor within 60 days following the survey decision letter.

Do not submit evidence until your POC has been approved.
Do not submit any Protected Health Information (PHI) or confidential employee information.

Medical Record/Personnel Record Audit Summary:

DEFICIENCY/L-TAG	AUDIT DESCRIPTION	RECORDS CORRECT/ RECORDS REVIEWED	PERCENT CORRECT
Example: HSP5-4B/L555	Audit charts to determine care provided in accordance with plan of care	9/10	90%

Observation Deficiencies:

DEFICIENCY/L-TAG	DEFICIENCY	SUGGESTED EVIDENCE
Example: HSP6-3A/L574	Missing annual QAPI evaluation	Written QAPI annual evaluation
HSP1-8A/L655	Incomplete contracts	Revised contracts

EXPERIENCE THE ACHC DIFFERENCE

UNDERSTANDING THE HOME HEALTH ACHC STANARDS

REVIEW THE STANDARDS

- 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

STANDARD EXAMPLE

- **Standard HH2-2C: The HHA protects and promotes the exercise of the Patient's Rights. 484.50, 484.50(c), 484.50(c)(1)**
- Interpretation: Personnel honor the patient right to:
  - To exercise his or her rights as a patient of the HHA
  - Have his or her property and person treated with respect
  - Be able to identify visiting personnel members through agency-generated photo identification
  - Choose a health care provider, including an attending physician
  - Receive appropriate care without discrimination in accordance with physician orders
  - Be informed of any financial benefits when referred to an HHA
  - Be fully informed of one's responsibilities
- Evidence: Home Visits

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

MOST STRINGENT REGULATION

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

SECTION 1

ORGANIZATION AND ADMINISTRATION

The standards in this section apply to:

- Leadership and organizational structure of the company
- Business licensure including federal, state and local licenses
- Compliance with professional standards of practice
- Governing body, Administrator, Clinical Manager responsibilities
- Conflict of interest, chain of command, program goals and regulatory compliance
- OASIS requirements
- Contracted staff requirements

SECTION 1 CoP CHANGES

- Governing body takes a more active role
  - Must appoint the Administrator and individual when Administrator not available
  - QAPI oversight
- Removed the PAC requirements
  - CA still requires a PAC
    - 1727.5(d) Maintain policies regarding the delivery and supervision of patient care that are reviewed annually by a group of professional personnel including a physician and surgeon and a registered nurse and revised as needed
    - 1727.5(f) Maintain, and revise as needed, and implement policies regarding the purchase, storage, furnishing, and transportation of legend devices that are reviewed annually by a group of professional personnel, including a physician and surgeon, pharmacist, and a registered nurse. As used in this subdivision, "legend devices" means any device that bears the label "Caution: federal law restricts this device to sale by or on the order of a ___" or words of similar meaning

SECTION 1 CoP CHANGES

- Administrator:
  - Be appointed by the governing body
  - Ensure Clinical Manager available during all operating hours
- Clinical Manager:
  - Qualifications
  - Duties
- Services under contract:
  - Have to be in good standing

SECTION 2

PROGRAM/SERVICE OPERATIONS

The standards in this section apply to:

- Programs and Services
- Rights and Responsibilities
- Patient reporting of complaints
- Reporting of abuse, neglect, mistreatment of patients
- Protected Health Information (PHI)
- Cultural Diversity
- Communication and language barriers
- Compliance with fraud and abuse prevention laws
- Ethics

SECTION 2-CoP CHANGES

- Patient Rights and Responsibilities
  - Content
  - Administrator's contact information
  - Discharge and transfer policies
  - Contact information for the federally and state funded agencies
  - Consent to care
- Communication and language barriers
- Investigation of complaints

SECTION 3

FISCAL MANAGEMENT

The standards in this section apply to:

- Financial operations
- Annual budgeting
- Business practices
- Accounting procedures
- Capital Expenditure Plan, if applicable

SECTION 3-CoP CHANGES

- Development and annual review of the budget by the governing body

SECTION 4

HUMAN RESOURCE MANAGEMENT

The standards in this section apply to:

- Support personnel
- Licensed clinical personnel
- Unlicensed clinical personnel
- Administrative and/or supervisory employees
- Contract personnel/independent contractors
- Volunteers
- Students completing clinical internships

SECTION 4-CoP CHANGES

- Home Health Aide qualifications
- 24 month lapse in furnishing services for compensation, must complete another program
- Training program requirements
- 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
  - 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**
  - **Recognizing and reporting changes in skin condition, including pressure ulcers**

SECTION 4-CoP CHANGES

- Home Health Aide qualifications
- Competency skills assessment
  - The skills must be evaluated by observing the aide's performance while carrying out the task with a patient
  - Sponge, tub, **and** shower bath
  - Hair shampooing in sink, tub, **and** bed

SECTION 4-CoP CHANGES

- Home Health Aide Supervision
- Each supervisory visit must demonstrate the aide:
  - Furnishes care in a safe and effective manner
  - Follows 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;
  - Maintains an open communication process with the patient, representative (if any), caregivers, and family;
  - Demonstrates competency with assigned tasks;
  - Complies with infection prevention and control policies and procedures;
  - Reports changes in the patient's condition; and
  - Honors patient rights
- Annual on-site observation visit

SECTION 5

PROVISION OF CARE AND RECORD MANAGEMENT

The standards in this section apply to:

- Documentation and requirements for patient records
- Operational aspects of care/service provided

SECTION 5-CoP CHANGES

- Comprehensive assessment
  - Individual Emergency Preparedness Plan
  - Patient's primary caregiver or other supports
    - Willingness and ability to provide care
    - Availability and schedules
  - Patient representative contact information
- Plan of care
  - A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors
- Verbal orders
  - Need to include the time the order was received

SECTION 5-CoP CHANGES

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

SECTION 5-CoP CHANGES

- Written information to the patient
  - Once the comprehensive assessment is completed (within 5 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
  - Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA
  - Patient medication schedule/instructions, including: medication name, dosage, and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA
  - Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services
  - Any other pertinent instruction related to the patient's care and treatments that the HHA will provide, specific to the patient's care needs
  - Name and contact information of the HHA Clinical Manager

SECTION 5-CoP CHANGES

- Skilled professional services
  - Ongoing interdisciplinary assessment of the patient
  - Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s)
  - Providing services that are ordered by the physician as indicated in the plan of care
  - Patient, caregiver, and family counseling
  - Patient and caregiver education
  - Preparing clinical notes
  - Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care
  - Participation in the HHA's QAPI program
  - Participation in HHA-sponsored in-service training

SECTION 5-CoP CHANGES

- Clinical records
  - Discharge summary requirements
  - Transfer summary requirements
  - 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
  - Clinical records must be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time

SECTION 6

QUALITY OUTCOMES/PERFORMANCE IMPROVEMENT

The standards in this section apply to:

- Implementation of a Quality Assessment Performance Improvement program
- Responsibility for the program
- Activities being monitored
- How data is compiled
- Corrective measures being developed from the data and outcomes

SECTION 6-CoP CHANGES

- QAPI
  - Governing body has oversight of the program
  - Must reflect the complexity of the program
  - Focus on indicators that data warrants improvement
  - OASIS data
  - High-volume, high-risk, problem-prone areas
  - Show improvement and maintain improvement
  - Areas of fraud and abuse are incorporated into QAPI
  - Beginning July 13, 2018, HHAs must conduct Performance Improvement projects

SECTION 7

RISK MANAGEMENT: INFECTION AND SAFETY CONTROL

The standards in this section apply to:

- Surveillance
- Identification
- Prevention
- Control and investigation of infections and safety risks
- Fire safety
- Hazardous materials
- Emergency Preparedness

SECTION 7-CoP CHANGES

- Infection Control
  - Policies and procedures
  - Educate staff, patients and caregivers
  - Track infections
- Emergency Preparedness
  - Emergency Plan is based on a documented, facility-based and community-based all-hazards risk assessment
  - Policies and procedures are specific to your plan and the geographical area in which you provide patient care
  - Communication plan includes the required information
  - All staff have been trained
  - Two tests of the plan have been conducted:
    - Community or facility-based drill and
    - Community, facility, or tabletop drill
  - The entire plan is reviewed and updated at least annually

ACHIEVING A SUCCESSFUL SURVEY

AVOIDING CONDITION-LEVEL DEFICIENCIES: HOME HEALTH

TOP SURVEY DEFICIENCIES

- Based on previous survey results, these are the anticipated deficiencies likely to be cited based on the new Medicare Conditions of Participation (CoPs)
- The deficiencies focus on 4 CoPs:
  - §484.60 Condition of Participation: Care planning, coordination of services, and quality of care
  - §484.75 Condition of Participation: Skilled professional services
  - §484.80 Condition of participation: Home Health Aide services
  - §484.55 Condition of Participation: Comprehensive assessment of patients

TOP SURVEY DEFICIENCIES

- §484.60 Condition of Participation: Care planning, coordination of services, and quality of care
- Plan of Care:
  - An individualized plan of care that identifies patient-specific measureable outcomes and goals
  - Needs to identify all required components as required in §484.60 (a)(2)
  - All verbal orders are required to be recorded in the plan of care and a new requirement is that verbal orders are to be timed
  - Care is to be provided in accordance with the plan of care/physician orders
  - Drugs, services, and treatments are administered only as ordered by the physician
  - Plan of care must be reviewed at least every 60 days or when there are any changes that may warrant a change to the plan of care

TOP SURVEY DEFICIENCIES

- Plan of care continued:
  - Revisions to the plan of care are made based on updated comprehensive assessments
  - Revisions to the plan of care are communicated to the patient, representative (if any), caregiver, and all physicians issuing orders for the plan of care
  - Written information that is provided to the patient:
    - Visit schedule and frequency of visits
    - Patient medication schedule and instructions
    - Any treatments to be administered
    - Any other pertinent instruction related to the patient's care
    - Name of the Clinical Manager

TOP SURVEY DEFICIENCIES

- §484.75 Condition of Participation: Skilled professional services
- Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, occupational therapy services, and medical social work services. Skilled professionals must:
  - Provide ongoing interdisciplinary assessment of the patient
  - Develop the plan of care with the patient, representative (if any), and caregiver
  - Provide services in accordance with the plan of care
  - Provide patient, caregiver, and family counseling and education
  - Prepare clinical notes
  - Communicate with all physicians involved in the plan of care as well as with each other
  - Participate in the QAPI program
  - Participate in HHA-sponsored in-service training

TOP SURVEY DEFICIENCIES

- §484.80 Condition of participation: Home health aide services
- Home Health Aides must:
  - Be qualified per §484.80(a)(1)
  - Have evidence of training and competency
  - Have written patient care instructions prepared by the RN or other appropriate skilled professional
  - Provide services that are ordered by the physician and included in the plan of care
  - Be supervised at least every 14 days and have an annual observation visit
  - Report changes in the patient's medical condition and complete documentation per agency policies

TOP SURVEY DEFICIENCIES

- §484.55 Condition of Participation: Comprehensive assessment of patients
- Specific to the medication review
  - An ongoing medication review is completed for all patients; in therapy-only cases, the therapist submits a list of medications for the RN to review
  - All PRN medications identify an indicator as to when the PRN medication should be administered
  - O_2 is listed on the medication profile
  - The physician is notified of any medication discrepancies, side effects, problems, or reactions

ADDITIONAL DEFICIENCIES

- §484.65 Condition of participation: Quality assessment and performance improvement (QAPI)
- Must have a QAPI Program that is capable of:
  - Showing measureable improvement in areas where improvements are needed
  - Reflects the scope of the agency
  - Tracking and monitoring of quality indicators:
    - Adverse patient events
    - OASIS outcomes
    - High volume, high risk, problem prone areas
  - Must maintain improvement
  - Demonstrate governing body oversight of the program
  - Performance Improvement Projects; July 13, 2018

ADDITIONAL DEFICIENCIES

- §484.102 Condition of participation: Emergency preparedness
- Emergency Preparedness
  - Emergency Plan is based on a documented, facility-based and community-based all-hazards risk assessment
  - Policies and procedures are specific to your plan and the geographical area in which you provide patient care
  - Communication plan includes the required information
  - All staff have been trained
  - Two tests of the plan have been conducted:
    - Community or facility-based drill and
    - Community, facility, or tabletop drill
  - The entire plan is reviewed and updated at least annually

QUESTIONS?

Nora Stephen

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NEW HOME HEALTH CoPs – EASY-TO-READ FORMAT

HOME HEALTH

FOR PROVIDERS.
BY PROVIDERS.

ACHC has submitted our revised Home Health Accreditation Standards to CMS and we are waiting for approval. In the meantime, we have created an easily digestible format for providers to review the revised Conditions of Participation. All home health providers must be in compliance with the new CoPs by January 13, 2018.

Subpart A – General Provisions
42 CFR 484.1 Basis and scope.
484.1(a) Basis. This part is based on:
484.1(a)(1) Sections 1861(o) and 1891 of the Act, which establish the conditions that an HHA must meet in order to participate in the Medicare program and which, along with the additional requirements set forth in this part, are considered necessary to ensure the health and safety of patients; and
484.1(a)(2) Section 1861(z) of the Act, which specifies the institutional planning standards that HHAs must meet.
484.1(b) Scope. The provisions of this part serve as the basis for survey activities for the purpose of determining whether an agency meets the requirements for participation in the Medicare program.
42 CFR 484.2 Definitions.
As used in subparts A, B, and C, of this part--
Branch office means an approved location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The parent home health agency must provide supervision and administrative control of any branch office. It is unnecessary for the branch office to independently meet the Conditions of Participation as a home health agency.
Clinical note means a notation of a contact with a patient that is written, timed, and dated, and which describes signs and symptoms, treatment, drugs administered and the patient's reaction or response, and any changes in physical or emotional condition during a given period of time.
In advance means that HHA staff must complete the task prior to performing any hands-on care or any patient education
Parent home health agency means the agency that provides direct support and administrative control of a branch.
Primary home health agency means the HHA which accepts the initial referral of a patient, and which provides services directly to the patient or via another health care provider under arrangements (as applicable).

Proprietary agency means a private, for-profit agency.
Public agency means an agency operated by a state or local government.
Quality indicator means a specific, valid, and reliable measure of access, care outcomes, or satisfaction, or a measure of a process of care.
Representative means the patient's legal representative, such as a guardian, who makes health-care 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.
Subdivision means a component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the Conditions of Participation for HHAs. A subdivision that has branch offices is considered a parent agency.
Summary report means the compilation of the pertinent factors of a patient's clinical notes that is submitted to the patient's physician.
Supervised practical training means training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing covered services to an individual under the direct supervision of either a Registered Nurse or a licensed practical nurse who is under the supervision of a Registered Nurse.
Verbal order means a physician order that is spoken to appropriate personnel and later put in writing for the purposes of documenting as well as establishing or revising the patient's plan of care
Subpart B – Patient Care
42 CFR 484.40 Release of patient identifiable OASIS information. The HHA and agent acting on behalf of the HHA in accordance with a written contract must ensure the confidentiality of all patient identifiable information contained in the clinical record, including Outcome and Assessment Information Set (OASIS) data, and may not release patient identifiable OASIS information to the public.
42 CFR 484.45 Reporting OASIS information. HHAs must electronically report all OASIS data collected in accordance with Sec. 484.55.
484.45(a) Standard: Encoding and transmitting OASIS data. An HHA must encode and electronically transmit each completed OASIS assessment to the CMS system, regarding each beneficiary with respect to which information is required to be transmitted (as determined by the Secretary), within 30 days of completing the assessment of the beneficiary.
484.45(b) Standard: Accuracy of encoded OASIS data. The encoded OASIS data must accurately reflect the patient's status at the time of assessment.
484.45(c) Standard: Transmittal of OASIS data. An HHA must--
484.45(c)(1) For all completed assessments, transmit OASIS data in a format that meets the requirements of paragraph (d) of this section.
484.45(c)(2) Successfully transmit test data to the QIES ASAP System or CMS OASIS contractor.

484.45(c)(3) Transmit data using electronic communications software that complies with the Federal Information Processing Standard (FIPS 140-2, issued May 25, 2001) from the HHA or the HHA contractor to the CMS collection site.
484.45(c)(4) Transmit data that includes the CMS-assigned branch identification number, as applicable.
484.45(d) Standard: Data Format. The HHA must encode and transmit data using the software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set.
42 CFR 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.
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:
484.50(a)(1)(i) 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;
484.50(a)(1)(ii) 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) An OASIS privacy notice to all patients for whom the OASIS data is collected.
484.50(a)(2) 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.
484.50(a)(3) 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 Sec. 484.75.
484.50(a)(4) Provide 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 to a patient-selected representative within 4 business days of the initial evaluation visit.
484.50(b) Standard: Exercise of rights.
484.50(b)(1) If a patient has been adjudged to lack legal capacity to make health care 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 health care 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 health care 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.
484.50(c) Standard: Rights of the patient. The patient has the right to-
484.50(c)(1) Have his or her property and person treated with respect;
484.50(c)(2) Be free from verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property;
484.50(c)(3) 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)(4) Participate in, be informed about, and consent or refuse care in advance of and during treatment, where appropriate, with respect to--
484.50(c)(4)(i) Completion of all assessments;
484.50(c)(4)(ii) The care to be furnished, based on the comprehensive assessment;
484.50(c)(4)(iii) Establishing and revising the plan of care;
484.50(c)(4)(iv) The disciplines that will furnish the care;
484.50(c)(4)(v) The frequency of visits;
484.50(c)(4)(vi) Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits;
484.50(c)(4)(vii) Any factors that could impact treatment effectiveness; and
484.50(c)(4)(viii) Any changes in the care to be furnished.
484.50(c)(5) Receive all services outlined in the plan of care.
484.50(c)(6) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.
484.50(c)(7) Be advised of--
484.50(c)(7)(i) The extent to which payment for HHA services may be expected from Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA,
484.50(c)(7)(ii) The charges for services that may not be covered by Medicare, Medicaid, or any other federally-funded or federal aid program known to the HHA,
484.50(c)(7)(iii) The charges the individual may have to pay before care is initiated; and
484.50(c)(7)(iv) 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. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f).

484.50(c)(8) 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) Be advised of the state toll free home health telephone hot line, its contact information, its hours of operation, and that its purpose is to receive complaints or questions about local HHAs.

484.50(c)(10) Be advised of the names, addresses, and telephone numbers of the following Federally-funded and state-funded entities that serve the area where the patient resides:

484.50(c)(10)(i) Agency on Aging

484.50(c)(10)(ii) Center for Independent Living,

484.50(c)(10)(iii) Protection and Advocacy Agency

484.50(c)(10)(iv) Aging and Disability Resource Center; and

484.50(c)(10)(v) Quality Improvement Organization

484.50(c)(11) 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) 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.

484.50(d) Standard: Transfer and discharge. The patient and representative (if any), have a right to be informed of the HHA's policies for transfer and discharge. The HHA may only transfer or discharge the patient from the HHA if:

484.50(d)(1) 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 HHA's capabilities;

484.50(d)(2) The patient or payer will no longer pay for the services provided by the HHA;

484.50(d)(3) The transfer or discharge is appropriate because the physician who is responsible for the home health plan of care and the HHA agree that the measurable outcomes and goals set forth in the plan of care in accordance with Sec. 484.60(a)(2)(xiv) have been achieved, and the HHA and the physician who is responsible for the home health plan of care agree that the patient no longer needs the HHA's services;

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

484.50(d)(5) The HHA determines, under a policy set by the HHA for the purpose of addressing discharge for cause that meets the requirements of paragraphs (d)(5)(i) through (d)(5)(iii) 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. The HHA must do the following before it discharges a patient for cause:

484.50(d)(5)(i) Advise the patient, representative (if any), the physician(s) issuing orders for the home health 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) that a discharge for cause is being considered;
484.50(d)(5)(ii) 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;
484.50(d)(5)(iii) Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and
484.50(d)(5)(iv) Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records;
484.50(d)(6) The patient dies; or
484.50(d)(7) The HHA ceases to operate.
484.50(e) Standard: Investigation of complaints.
484.50(e)(1) The HHA must--
484.50(e)(1)(i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics:
484.50(e)(1)(i)(A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and
484.50(e)(1)(i)(B) 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.
484.50(e)(1)(ii) Document both the existence of the complaint and the resolution of the complaint; and
484.50(e)(1)(iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated.
484.50(e)(2) Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law.
484.50(f) Standard: Accessibility. Information must be provided to patients in plain language and in a manner that is accessible and timely to--
484.50(f)(1) 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) Persons with limited English proficiency through the provision of language services at no cost to the individual, including oral interpretation and written translations.

42 CFR 484.55 Comprehensive assessment of patients. 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.

484.55(a) Standard: Initial assessment visit.

484.55(a)(1) 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.

484.55(a)(2) 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.

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

484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.

484.55(b)(2) 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.

484.55(b)(3) 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.

484.55(c) Standard: 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) The patient's current health, psychosocial, functional, and cognitive status;

484.55(c)(2) 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) The patient's continuing need for home care;

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

484.55(c)(5) 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.

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

484.55(c)(6)(i) Willingness and ability to provide care, and

484.55(c)(6)(ii) Availability and schedules;
484.55(c)(7) The patient's representative (if any);
484.55(c)(8) Incorporation of the current version of the 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.
484.55(d) Standard: 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) The last 5 days of every 60 days beginning with the start-of-care date, unless there is a--
484.55(d)(1)(i) Beneficiary elected transfer;
484.55(d)(1)(ii) Significant change in condition; or
484.55(d)(1)(iii) Discharge and return to the same HHA during the 60-day episode.
484.55(d)(2) 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) At discharge.
42 CFR 484.60 Care planning, coordination of services, and quality of care. 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.
484.60(a) Standard: Plan of care.
484.60(a)(1) 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.
484.60(a)(2) The individualized plan of care must include the following:
484.60(a)(2)(i) All pertinent diagnoses;

484.60(a)(2)(ii) The patient's mental, psychosocial, and cognitive status;
484.60(a)(2)(iii) The types of services, supplies, and equipment required;
484.60(a)(2)(iv) The frequency and duration of visits to be made;
484.60(a)(2)(v) Prognosis;
484.60(a)(2)(vi) Rehabilitation potential;
484.60(a)(2)(vii) Functional limitations;
484.60(a)(2)(viii) Activities permitted;
484.60(a)(2)(ix) Nutritional requirements;
484.60(a)(2)(x) All medications and treatments;
484.60(a)(2)(xi) Safety measures to protect against injury;
484.60(a)(2)(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;
484.60(a)(2)(xiii) Patient and caregiver education and training to facilitate timely discharge;
484.60(a)(2)(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;
484.60(a)(2)(xv) Information related to any advanced directives; and
484.60(a)(2)(xvi) Any additional items the HHA or physician may choose to include.
484.60(a)(3) All patient care orders, including verbal orders, must be recorded in the plan of care.
484.60(b) Standard: Conformance with physician orders.
484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician.
484.60(b)(2) 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 contraindications.
484.60(b)(3) 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(b)(4) 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.

484.60(c) Standard: Review and revision of the plan of care.
484.60(c)(1) 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. 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) 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.
484.60(c)(3) Revisions to the plan of care must be communicated as follows:
484.60(c)(3)(i) 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.
484.60(c)(3)(ii) 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).
484.60(d) Standard: Coordination of care. The HHA must:
484.60(d)(1) Assure communication with all physicians involved in the plan of care.
484.60(d)(2) Integrate orders from all physicians involved in the plan of care to assure the coordination of all services and interventions provided to the patient.
484.60(d)(3) 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.
484.60(d)(4) 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) 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.
484.60(e) Standard: Written information to the patient. The HHA must provide the patient and caregiver with a copy of written instructions outlining:
484.60(e)(1) Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA.
484.60(e)(2) 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) Any treatments to be administered by HHA personnel and personnel acting on behalf of the HHA, including therapy services.
484.60(e)(4) 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) Name and contact information of the HHA clinical manager.
42 CFR 484.65 Quality assessment and performance improvement (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.
484.65(a) Standard: Program scope.
484.65(a)(1) 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) 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.
484.65(b) Standard: Program data.
484.65(b)(1) 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) The HHA must use the data collected to--
484.65(b)(2)(i) Monitor the effectiveness and safety of services and quality of care; and
484.65(b)(2)(ii) Identify opportunities for improvement.
484.65(b)(3) The frequency and detail of the data collection must be approved by the HHA's governing body.
484.65(c) Standard: Program activities.
484.65(c)(1) The HHA's performance improvement activities must--
484.65(c)(1)(i) Focus on high risk, high volume, or problem-prone areas;
484.65(c)(1)(ii) Consider incidence, prevalence, and severity of problems in those areas; and
484.65(c)(1)(iii) Lead to an immediate correction of any identified problem that directly or potentially threaten the health and safety of patients.
484.65(c)(2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions.
484.65(c)(3) 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.

484.65(d) Standard: Performance improvement projects. Beginning July 13, 2018 HHAs must conduct performance improvement projects.
484.65(d)(1) 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) The HHA must document the quality improvement projects undertaken, the reasons for conducting these projects, and the measurable progress achieved on these projects.
484.65(e) Standard: Executive responsibilities. The HHA's governing body is responsible for ensuring the following:
484.65(e)(1) That an ongoing program for quality improvement and patient safety is defined, implemented, and maintained;
484.65(e)(2) 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) That clear expectations for patient safety are established, implemented, and maintained; and
484.65(e)(4) That any findings of fraud or waste are appropriately addressed.
42 CFR 484.70 Infection prevention and control. The HHA must maintain and document an infection control program which has as its goal the prevention and control of infections and communicable diseases
484.70(a) Standard: Prevention. The HHA must follow accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases.
484.70(b) Standard: Control. The HHA must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the HHA's quality assessment and performance improvement (QAPI) program. The infection control program must include:
484.70(b)(1) A method for identifying infectious and communicable disease problems; and
484.70(b)(2) A plan for the appropriate actions that are expected to result in improvement and disease prevention.
484.70(c) Standard: Education. The HHA must provide infection control education to staff, patients, and caregiver(s).
42 CFR 484.75 Skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in Sec. 409.44 of this chapter, and physician and medical social work services as specified in Sec. 409.45 of this chapter. Skilled professionals who provide services to HHA patients directly or under arrangement must participate in the coordination of care.
484.75(a) 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 Sec. 484.115 and who practice according to the HHA's policies and procedures.

484.75(b) Standard: Responsibilities of skilled professionals. Skilled professionals must assume responsibility for, but not be restricted to, the following:
484.75(b)(1) Ongoing interdisciplinary assessment of the patient;
484.75(b)(2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s);
484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care;
484.75(b)(4) Patient, caregiver, and family counseling;
484.75(b)(5) Patient and caregiver education;
484.75(b)(6) Preparing clinical notes;
484.75(b)(7) 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) Participation in the HHA's QAPI program; and
484.75(b)(9) Participation in HHA-sponsored in-service training.
484.75(c) Standard: Supervision of skilled professional assistants.
484.75(c)(1) Nursing services are provided under the supervision of a Registered Nurse that meets the requirements of Sec. 484.115(k).
484.75(c)(2) Rehabilitative therapy services are provided under the supervision of an occupational therapist or physical therapist that meets the requirements of Sec. 484.115(f) or (h), respectively.
484.75(c)(3) Medical social services are provided under the supervision of a social worker that meets the requirements of Sec. 484.115(m).
42 CFR 484.80 Home health aide services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section.
484.80(a) Standard: Home health aide qualifications.
484.80(a)(1) A qualified home health aide is a person who has successfully completed:
484.80(a)(1)(i) A training and competency evaluation program as specified in paragraphs (b) and (c) respectively of this section; or
484.80(a)(1)(ii) A competency evaluation program that meets the requirements of paragraph (c) of this section; or
484.80(a)(1)(iii) A nurse aide training and competency evaluation program approved by the state as meeting the requirements of Sec. 483.151 through Sec. 483.154 of this chapter, and is currently listed in good standing on the state nurse aide registry; or
484.80(a)(1)(iv) The requirements of a state licensure program that meets the provisions of paragraphs (b) and (c) of this section.

484.80(a)(2) 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 Sec. 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.
484.80(b) Standard: Content and duration of home health aide classroom and supervised practical training.
484.80(b)(1) 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) 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.
484.80(b)(3) A home health aide training program must address each of the following subject areas:
484.80(b)(3)(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.
484.80(b)(3)(ii) Observation, reporting, and documentation of patient status and the care or service furnished.
484.80(b)(3)(iii) Reading and recording temperature, pulse, and respiration.
484.80(b)(3)(iv) Basic infection prevention and control procedures.
484.80(b)(3)(v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.
484.80(b)(3)(vi) Maintenance of a clean, safe, and healthy environment.
484.80(b)(3)(vii) Recognizing emergencies and the knowledge of instituting emergency procedures and their application.
484.80(b)(3)(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.
484.80(b)(3)(ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks that include--
484.80(b)(3)(ix)(A) Bed bath;
484.80(b)(3)(ix)(B) Sponge, tub, and shower bath;
484.80(b)(3)(ix)(C) Hair shampooing in sink, tub, and bed;
484.80(b)(3)(ix)(D) Nail and skin care;
484.80(b)(3)(ix)(E) Oral hygiene;
484.80(b)(3)(ix)(F) Toileting and elimination;

484.80(b)(3)(x) Safe transfer techniques and ambulation;
484.80(b)(3)(xi) Normal range of motion and positioning;
484.80(b)(3)(xii) Adequate nutrition and fluid intake;
484.80(b)(3)(xiii) Recognizing and reporting changes in skin condition; and
484.80(b)(3)(xiv) Any other task that the HHA may choose to have an aide perform as permitted under state law.
484.80(b)(3)(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.
484.80(b)(4) The HHA must maintain documentation that demonstrates that the requirements of this standard have been met.
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) 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), (iii), (ix), (x), and (xi) of this section must be evaluated by observing an aide's performance of the task with patient. The remaining subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient.
484.80(c)(2) A 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) The competency evaluation must be performed by a Registered Nurse in consultation with other skilled professionals, as appropriate.
484.80(c)(4) 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) The HHA must maintain documentation which demonstrates that the requirements of this standard have been met.
484.80(d) 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) In-service training may be offered by any organization and must be supervised by a Registered Nurse.
484.80(d)(2) The HHA must maintain documentation that demonstrates the requirements of this standard have been met.
484.80(e) 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 2 years nursing experience, at least 1 year of which must be in home health care, or by other individuals under the general supervision of the Registered Nurse.
484.80(f) 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) Was out of compliance with the requirements of paragraphs (b), (c), (d), or (e) of this section; or
484.80(f)(2) 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); or
484.80(f)(3) 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); or
484.80(f)(4) Was assessed a civil monetary penalty of $5,000 or more as an intermediate sanction; or
484.80(f)(5) 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; or
484.80(f)(6) Had all or part of its Medicare payments suspended; or
484.80(f)(7) Was found under any federal or state law to have:
484.80(f)(7)(i) Had its participation in the Medicare program terminated; or
484.80(f)(7)(ii) Been assessed a penalty of $5,000 or more for deficiencies in federal or state standards for HHAs; or
484.80(f)(7)(iii) Been subjected to a suspension of Medicare payments to which it otherwise would have been entitled; or
484.80(f)(7)(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; or
484.80(f)(7)(v) Been closed, or had its patients transferred by the state; or
484.80(f)(7)(vi) Been excluded from participating in federal health care programs or debarred from participating in any government program.
484.80(g) Standard: Home health aide assignments and duties
484.80(g)(1) 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).
484.80(g)(2) A home health aide provides services that are:
484.80(g)(2)(i) Ordered by the physician;
484.80(g)(2)(ii) Included in the plan of care;
484.80(g)(2)(iii) Permitted to be performed under state law; and
484.80(g)(2)(iv) Consistent with the home health aide training.
484.80(g)(3) The duties of a home health aide include:

484.80(g)(3)(i) The provision of hands-on personal care;
484.80(g)(3)(ii) The performance of simple procedures as an extension of therapy or nursing services;
484.80(g)(3)(iii) Assistance in ambulation or exercises; and
484.80(g)(3)(iv) Assistance in administering medications ordinarily self-administered.
484.80(g)(4) 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.
484.80(h) Standard: Supervision of home health aides.
484.80(h)(1)(i) 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 Sec. 484.80(g), must make an onsite 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.
484.80(h)(1)(ii) 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.
484.80(h)(1)(iii) 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.
484.80(h)(2) 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) 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.
484.80(h)(4) Home health aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements:
484.80(h)(4)(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;
484.80(h)(4)(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family;
484.80(h)(4)(iii) Demonstrating competency with assigned tasks;
484.80(h)(4)(iv) Complying with infection prevention and control policies and procedures;
484.80(h)(4)(v) Reporting changes in the patient's condition; and

484.80(h)(4)(vi) Honoring patient rights.

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

484.80(h)(5)(i) Ensuring the overall quality of care provided by an aide;

484.80(h)(5)(ii) Supervising aide services as described in paragraphs (h)(1) and (2) of this section; and

484.80(h)(5)(iii) Ensuring that home health aides who provide services under arrangement have met the training or competency evaluation requirements, or both, of this part.

484.80(i) 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 Sec. 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.

Subpart C – Organizational Environment

42 CFR 484.100 Compliance with Federal, State, and local laws and regulations related to the health and safety of patients. The HHA and its staff must operate and furnish services in compliance with all applicable federal, state, and local laws and regulations related to the health and safety of patients. If state or local law provides licensing of HHAs, the HHA must be licensed.

484.100(a) Standard: Disclosure of ownership and management information. The HHA must comply with the requirements of part 420 Subpart C, of this chapter. The HHA also must disclose the following information to the state survey agency at the time of the HHA's initial request for certification, for each survey, and at the time of any change in ownership or management:

484.100(a)(1) The names and addresses of all persons with an ownership or controlling interest in the HHA as defined in Sec. 420.201, Sec. 420.202, and Sec. 420.206 of this chapter.

484.100(a)(2) The name and address of each person who is an officer, a director, an agent, or a managing employee of the HHA as defined in Sec. 420.201, Sec. 420.202, and Sec. 420.206 of this chapter.

484.100(a)(3) The name and business address of the corporation, association, or other company that is responsible for the management of the HHA, and the names and addresses of the chief executive officer and the chairperson of the board of directors of that corporation, association, or other company responsible for the management of the HHA.

484.100(b) Standard: Licensing. The HHA, its branches, and all persons furnishing services to patients must be licensed, certified, or registered, as applicable, in accordance with the state licensing authority as meeting those requirements.

484.100(c) Standard: Laboratory services.

484.100(c)(1) If the HHA engages in laboratory testing outside of the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the Food and Drug Administration, the testing must be in compliance with all applicable requirements of part 493 of this

chapter. The HHA may not substitute its equipment for a patient's equipment when assisting with self-administered tests.

484.100(c)(2) If the HHA refers specimens for laboratory testing, the referral laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.

42 CFR 484.102 Emergency preparedness. The Home Health Agency (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:

484.102(a) Standard: Emergency plan. The HHA must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. The plan must do all of the following:

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

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

484.102(a)(3) 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) 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.

484.102(b) Standard: 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) 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 Sec. 484.55.

484.102(b)(2) 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) 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.

484.102(b)(4) 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) The 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.

484.102(c) Standard: 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) Names and contact information for the following:
484.102(c)(1)(i) Staff.
484.102(c)(1)(ii) Entities providing services under arrangement.
484.102(c)(1)(iii) Patients' physicians.
484.102(c)(1)(iv) Volunteers.
484.102(c)(2) Contact information for the following:
484.102(c)(2)(i) Federal, State, tribal, regional, or local emergency preparedness staff.
484.102(c)(2)(ii) Other sources of assistance.
484.102(c)(3) Primary and alternate means for communicating with the HHA's staff, Federal, State, tribal, regional, and local emergency management agencies.
484.102(c)(4) 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) 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) 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.
484.102(d) Standard: 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.
484.102(d)(1) Training program. The HHA must do all of the following:
484.102(d)(1)(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.
484.102(d)(1)(ii) Provide emergency preparedness training at least annually.
484.102(d)(1)(iii) Maintain documentation of the training.
484.102(d)(1)(iv) Demonstrate staff knowledge of emergency procedures.
484.102(d)(2) Testing. The HHA must conduct exercises to test the emergency plan at least annually. The HHA must do the following:

484.102(d)(2)(i) Participate in a full-scale exercise that is community-based or when a community-based exercise is not accessible, an individual, facility-based. If the HHA experiences an actual natural or man-made emergency that requires activation of the emergency plan, the HHA is exempt from engaging in a community-based or individual, facility-based full-scale exercise for 1 year following the onset of the actual event.
484.102(d)(2)(ii) Conduct an additional exercise that may include, but is not limited to the following:
484.102(d)(2)(ii)(A) A second full-scale exercise that is community-based or individual, facility-based.
484.102(d)(2)(ii)(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.
484.102(d)(2)(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.
484.102(e) Standard: 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:
484.102(e)(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.
484.102(e)(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.
484.102(e)(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.
484.102(e)(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:
484.102(e)(4)(i) A documented community-based risk assessment, utilizing an all-hazards approach.
484.102(e)(4)(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.
484.102(e)(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.
42 CFR 484.105 Organization and administration of 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 assure 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.
484.105(a) 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 and performance improvement program.
484.105(b) Standard: Administrator.
484.105(b)(1) The Administrator must:
484.105(b)(1)(i) Be appointed by the governing body;
484.105(b)(1)(ii) Be responsible for all day-to-day operations of the HHA;
484.105(b)(1)(iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours;
484.105(b)(1)(iv) Ensure that the HHA employs qualified personnel, including assuring the development of personnel qualifications and policies.
484.105(b)(2) 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) The Administrator or a pre-designated person is available during all operating hours.
484.105(c) Standard: Clinical manager. One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following--
484.105(c)(1) Making patient and personnel assignments;
484.105(c)(2) Coordinating patient care;
484.105(c)(3) Coordinating referrals;
484.105(c)(4) Assuring that patient needs are continually assessed; and
484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care.
484.105(d) Standard: Parent-branch relationship.
484.105(d)(1) The parent HHA is responsible for reporting all branch locations of the HHA to the state survey agency at the time of the HHA's request for initial certification, at each survey, and at the time the parent proposes to add or delete a branch.
484.105(d)(2) The parent HHA provides direct support and administrative control of its branches.
484.105(e) Standard: Services under arrangement.
484.105(e)(1) The HHA must ensure that all services furnished under arrangement provided by other entities or individuals meet the requirements of this

part and the requirements of section 1861(w) of the Act (42 U.S.C. 1395x(w)).

484.105(e)(2) An HHA must have a written agreement with another agency, with an organization, or with an individual when that entity or individual furnishes services under arrangement to the HHA's patients. The HHA must maintain overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. The agency, organization, or individual providing services under arrangement may not have been:

484.105(e)(2)(i) Denied Medicare or Medicaid enrollment;

484.105(e)(2)(ii) Been excluded or terminated from any federal health care program or Medicaid;

484.105(e)(2)(iii) Had its Medicare or Medicaid billing privileges revoked; or

484.105(e)(2)(iv) Been debarred from participating in any government program.

484.105(e)(3) The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients.

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

484.105(g) Standard: Outpatient physical therapy or speech-language pathology services. An HHA that furnishes outpatient physical therapy or speech-language pathology services must meet all of the applicable conditions of this part and the additional health and safety requirements set forth in Sec. 485.711, Sec. 485.713, Sec. 485.715, Sec. 485.719, Sec. 485.723, and Sec. 485.727 of this chapter to implement section 1861(p) of the Act.

484.105(h) Standard: Institutional planning. The HHA, under the direction of the governing body, prepares an overall plan and a budget that includes an annual operating budget and capital expenditure plan.

484.105(h)(1) Annual operating budget. There is an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. However, it is not required that there be prepared, in connection with any budget, an item by item identification of the components of each type of anticipated income or expense.

484.105(h)(2) Capital expenditure plan.

484.105(h)(2)(i) There is a capital expenditure plan for at least a 3-year period, including the operating budget year. The plan includes and identifies in detail the anticipated sources of financing for, and the objectives of, each anticipated expenditure of more than $600,000 for items that would under generally accepted accounting principles, be considered capital items. In determining if a single capital expenditure exceeds $600,000, the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, modernization, expansion, or replacement of land, plant, building, and equipment are included. Expenditures directly or indirectly related to capital expenditures, such as

grading, paving, broker commissions, taxes assessed during the construction period, and costs involved in demolishing or razing structures on land are also included. Transactions that are separated in time, but are components of an overall plan or patient care objective, are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees, permit and license fees, broker commissions, architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds, notes and other costs incurred for borrowing funds.
484.105(h)(2)(ii) If the anticipated source of financing is, in any part, the anticipated payment from title V (Maternal and Child Health Services Block Grant) or title XVIII (Medicare) or title XIX (Medicaid) of the Social Security Act, the plan specifies the following:
484.105(h)(2)(ii)(A) Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963.
484.105(h)(2)(ii)(B) Whether a capital expenditure proposal has been submitted to the designated planning agency for approval in accordance with section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations.
484.105(h)(2)(ii)(C) Whether the designated planning agency has approved or disapproved the proposed capital expenditure if it was presented to that agency.
484.105(h)(3) Preparation of plan and budget. The overall plan and budget is prepared under the direction of the governing body of the HHA by a committee consisting of representatives of the governing body, the administrative staff, and the medical staff (if any) of the HHA.
484.105(h)(4) Annual review of plan and budget. The overall plan and budget is reviewed and updated at least annually by the committee referred to in paragraph (h)(3) of this section under the direction of the governing body of the HHA.
42 CFR 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.
484.110(a) Standard: Contents of clinical record. The record must include:
484.110(a)(1) 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) All interventions, including medication administration, treatments, and services, and responses to those interventions;
484.110(a)(3) Goals in the patient's plans of care and the patient's progress toward achieving them;
484.110(a)(4) Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s);
484.110(a)(5) 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; and

484.110(a)(6)(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 5 business days of the patient's discharge; or
484.110(a)(6)(ii) A completed transfer summary that is sent within 2 business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or
484.110(a)(6)(iii) A completed transfer summary that is sent within 2 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.
484.110(b) 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.
484.110(c) Standard: Retention of records.
484.110(c)(1) Clinical records must be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time.
484.110(c)(2) 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.
484.110(d) 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 protected health information set out at 45 CFR parts 160 and 164.
484.110(e) 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 4 business days (whichever comes first).
42 CFR 484.115 Personnel qualifications. HHA staff are required to meet the following standards:
484.115(a) Standard: Administrator, home health agency.
484.115(a)(1) For individuals that began employment with the HHA prior to January 13, 2018, a person who:
484.115(a)(1)(i) Is a licensed physician;
484.115(a)(1)(ii) Is a Registered Nurse; or
484.115(a)(1)(iii) Has training and experience in health service administration and at least 1 year of supervisory administrative experience in home health care or a related health care program.
484.115(a)(2) For individuals that begin employment with an HHA on or after January 13, 2018, a person who:
484.115(a)(2)(i) Is a licensed physician, a Registered Nurse, or holds an undergraduate degree; and
484.115(a)(2)(ii) Has experience in health service administration, with at least 1 year of supervisory or administrative experience in home health care or a related health care program.

484.115(b) Standard: Audiologist. A person who:

484.115(b)(1) Meets the education and experience requirements for a Certificate of Clinical Competence in audiology granted by the American Speech-Language-Hearing Association; or

484.115(b)(2) Meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

484.115(c) Standard: Clinical manager. A person who is a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or a Registered Nurse.

484.115(d) Standard: Home health aide. A person who meets the qualifications for home health aides specified in section 1891(a)(3) of the Act and implemented at Sec. 484.80.

484.115(e) Standard: Licensed practical (vocational) nurse. A person who has completed a practical (vocational) nursing program, is licensed in the state where practicing, and who furnishes services under the supervision of a qualified Registered Nurse.

484.115(f) Standard: Occupational therapist.

484.115(f)(1) A person who--

484.115(f)(1)(i) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing, unless licensure does not apply;

484.115(f)(1)(ii) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and

484.115(f)(1)(iii) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

484.115(f)(2) On or before December 31, 2009--

484.115(f)(2)(i) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing; or

484.115(f)(2)(ii) When licensure or other regulation does not apply--

484.115(f)(2)(ii)(A) Graduated after successful completion of an occupational therapist education program accredited by the accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and

484.115(f)(2)(ii)(B) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc., (NBCOT).

484.115(f)(3) On or before January 1, 2008--

484.115(f)(3)(i) Graduated after successful completion of an occupational therapy program accredited jointly by the Committee on Allied Health

Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or
484.115(f)(3)(ii) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.
484.115(f)(4) On or before December 31, 1977--
484.115(f)(4)(i) Had 2 years of appropriate experience as an occupational therapist; and
484.115(f)(4)(ii) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.
484.115(f)(5) If educated outside the United States, must meet both of the following:
484.115(f)(5)(i) Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist entry level education in the United States by one of the following:
484.115(f)(5)(i)(A) The Accreditation Council for Occupational Therapy Education (ACOTE).
484.115(f)(5)(i)(B) Successor organizations of ACOTE.
484.115(f)(5)(i)(C) The World Federation of Occupational Therapists.
484.115(f)(5)(i)(D) A credentialing body approved by the American Occupational Therapy Association.
484.115(f)(5)(i)(E) Successfully completed the entry level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).
484.115(f)(5)(ii) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing.
484.115(g) Standard: Occupational therapy assistant. A person who--
484.115(g)(1) Meets all of the following:
484.115(g)(1)(i) Is licensed or otherwise regulated, if applicable, as an occupational therapy assistant by the state in which practicing, unless licensure does apply.
484.115(g)(1)(ii) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education, (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations.
484.115(g)(1)(iii) Is eligible to take or successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).
484.115(g)(2) On or before December 31, 2009--
484.115(g)(2)(i) Is licensed or otherwise regulated as an occupational therapy assistant, if applicable, by the state in which practicing; or any qualifications

defined by the state in which practicing, unless licensure does not apply; or
484.115(g)(2)(ii) Must meet both of the following:
484.115(g)(2)(ii)(A) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy association.
484.115(g)(2)(ii)(B) After January 1, 2010, meets the requirements in paragraph (f)(1) of this section.
484.115(g)(3) After December 31, 1977 and on or before December 31, 2007--
484.115(g)(3)(i) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association; or
484.115(g)(3)(ii) Completed the requirements to practice as an occupational therapy assistant applicable in the state in which practicing.
484.115(g)(4) On or before December 31, 1977--
484.115(g)(4)(i) Had 2 years of appropriate experience as an occupational therapy assistant; and
484.115(g)(4)(ii) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.
484.115(g)(5) If educated outside the United States, on or after January 1, 2008--
484.115(g)(5)(i) Graduated after successful completion of an occupational therapy assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by--
484.115(g)(5)(i)(A) The Accreditation Council for Occupational Therapy Education (ACOTE).
484.115(g)(5)(i)(B) Its successor organizations.
484.115(g)(5)(i)(C) The World Federation of Occupational Therapists.
484.115(g)(5)(i)(D) By a credentialing body approved by the American Occupational Therapy Association; and
484.115(g)(5)(i)(E) Successfully completed the entry level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).
484.115(h) Standard: Physical therapist. A person who is licensed, if applicable, by the state in which practicing, unless licensure does not apply and meets one of the following requirements:
484.115(h)(1)(i) Graduated after successful completion of a physical therapist education program approved by one of the following:
484.115(h)(1)(i)(A) The Commission on Accreditation in Physical Therapy Education (CAPTE).
484.115(h)(1)(i)(B) Successor organizations of CAPTE.

484.115(h)(1)(i)(C) An education program outside the United States determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15(e) as it relates to physical therapists.

484.115(h)(1)(ii) Passed an examination for physical therapists approved by the state in which physical therapy services are provided.

484.115(h)(2) On or before December 31, 2009--

484.115(h)(2)(i) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE); or

484.115(h)(2)(ii) Meets both of the following:

484.115(h)(2)(ii)(A) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR 212.15(e) as it relates to physical therapists.

484.115(h)(2)(ii)(B) Passed an examination for physical therapists approved by the state in which physical therapy services are provided.

484.115(h)(3) Before January 1, 2008 graduated from a physical therapy curriculum approved by one of the following:

484.115(h)(3)(i) The American Physical Therapy Association.

484.115(h)(3)(ii) The Committee on Allied Health Education and Accreditation of the American Medical Association.

484.115(h)(3)(iii) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.

484.115(h)(4) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following:

484.115(h)(4)(i) Has 2 years of appropriate experience as a physical therapist.

484.115(h)(4)(ii) Has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

484.115(h)(5) Before January 1, 1966-

484.115(h)(5)(i) Was admitted to membership by the American Physical Therapy Association;

484.115(h)(5)(ii) Was admitted to registration by the American Registry of Physical Therapists; or

484.115(h)(5)(iii) Graduated from a physical therapy curriculum in a 4-year college or university approved by a state department of education.

484.115(h)(6) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of fulltime experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.

484.115(h)(7) If trained outside the United States before January 1, 2008, meets the following requirements:

484.115(h)(7)(i) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy.
484.115(h)(7)(ii) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.
484.115(i) Standard: Physical therapist assistant. A person who is licensed, registered or certified as a physical therapist assistant, if applicable, by the state in which practicing, unless licensure does not apply and meets one of the following requirements:
484.115(i)(1)(i) Graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association; or if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified at 8 CFR 212.15(e); and
484.115(i)(1)(ii) Passed a national examination for physical therapist assistants.
484.115(i)(2) On or before December 31, 2009, meets one of the following:
484.115(i)(2)(i) Is licensed, or otherwise regulated in the state in which practicing.
484.115(i)(2)(ii) In states where licensure or other regulations do not apply, graduated before December 31, 2009, from a 2-year college-level program approved by the American Physical Therapy Association and after January1, 2010, meets the requirements of paragraph (h)(1) of this section.
484.115(i)(3) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a 2-year college level program approved by the American Physical Therapy Association.
484.115(i)(4) On or before December 31, 1977, was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.
484.115(j) Standard: Physician. A person who meets the qualifications and conditions specified in section 1861(r) of the Act and implemented at Sec. 410.20(b) of this chapter.
484.115(k) Standard: Registered Nurse. A graduate of an approved school of professional nursing who is licensed in the state where practicing.
484.115(l) Standard: Social Work Assistant. A person who provides services under the supervision of a qualified social worker and:
484.115(l)(1) Has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least 1 year of social work experience in a health care setting; or
484.115(l)(2) Has 2 years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that the determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.
484.115(m) Standard: Social worker. A person who has a master's or doctoral degree from a school of social work accredited by the Council on Social Work Education, and has 1 year of social work experience in a health care setting.

484.115(n) Standard: Speech-language pathologist. A person who has a master's or doctoral degree in speech-language pathology, and who meets either of the following requirements:
484.115(n)(1) Is licensed as a speech-language pathologist by the state in which the individual furnishes such services; or
484.115(n)(2) In the case of an individual who furnishes services in a state which does not license speech-language pathologists:
484.115(n)(2)(i) Has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating supervised clinical experience);
484.115(n)(2)(ii) Performed not less than 9 months of supervised full-time speech-language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field; and
484.115(n)(2)(iii) Successfully completed a national examination in speech-language pathology approved by the Secretary.

2018 CROSSWALK

ACHC Home Health Accreditation Standards & Medicare Conditions of Participation

HOME HEALTH

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH1-1A	G117, G118	484.12, 484.12(a)	484.100, 484.100(b)	G848, G860	Added requirement that branches and personnel must be licensed according to state requirements per the CoPs
HH1-1A.01					Added Section 1557 Patient Protection and ACA
HH1-1B	G119, G120	484.12(b)	484.100(a),484.100(a)(1), 484.100(a)(2), 484.100(a)(3)	G850, G852, G854, G856, G858	No change in intent
HH1-1C	G121	484.12(c)	484.105(f)(2)	G984	No change in intent
HH1-2A	G128, G129, G130, G131, G132	484.14(b)	484.105(a)	G942	Added QAPI and operational plans as responsibilities of the governing body, and deleted the requirement for arranging for PAC per the CoPs
HH1-2A.03					Added operational plans and QAPI to governing body orientation requirements
HH1-3A	G151, G152, G153	484.16	deleted		Deleted from ACHC standards
HH1-3A.01			deleted		Deleted from ACHC standards
HH1-3A.02			deleted		Deleted from ACHC standards
HH1-3B	G154, G155	484.16(a)	deleted		Deleted from ACHC standards

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH1-4A.01					Deleted PAC from the disclosing of conflicts of interest
HH1-5A	G133, G134, G135 G136	484.14(c)	484.115(a), 484.105(b), 484.105(b)(1)(i-iv), 484.105(b)(2), 484.105(b)(3)	G944, G946, G948, G950, G952, G954, G956, G1052	Added Administrator requirements per the CoPs
HH1-5A.01					Deleted annual outcome to serve as Administrator's performance evaluation
HH1-5B	G137	484.14(c)	deleted		Deleted from ACHC standards
HH1-6A	G123	484.14	484.105	G940	Added the responsibilities of the HHA to properly manage and administer its resources, ensure that supervisory functions are not delegated to another agency, and that all services are monitored per the CoPs
HH1-6B	G124, G138, G139, G140	484.14, 484.14(d)	484.105(c), 484.105(c)(1), 484.105(c)(2), 484.105(c)(3), 484.105(c)(4), 484.105(c)(5), 484.115(c)	G958, G960, G962, G964, G966, G968, G1056	Added Clinical Manager responsibilities per the CoPs
HH1-6C	G125, G126	484.14	484.105(d), 484.105(d)(1), 484.105(d)(2)	G970, G972, G974	Removed subunit language and added the reporting of all branch locations to the state survey agency at the appropriate time frames; the parent HH provides direct support, administrative control, and supervision of branches per the CoPs

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH1-7A	G127	484.14(a)	484.105(f), 484.105(f)(1)	G982	No change in intent
HH1-8A	G320	484.20	484.45	G370	No change in intent
HH1-8B	G321, G322, G324, G325, G326, G327, G328	484.20(a), 484.20(b), 484.20(c), 484.20(c)(1), 484.20(c)(2), 484.20(c)(3), 484.20(c)(4), 484.20(d)	484.45(a), 484.45(b), 484.45(c), 484.45(c)(1), 484.45(c)(2), 484.45(c)(3), 484.45 (c)(4), 484.45(d)	G372, G374, G376, G378, G380, G382, G384, G386	No change in intent
HH1-9A.01					No change in intent
HH1-10A	G142, G146, G231, G232	484.14(f), 484.14(h), 484.36(d)(4), 484.36(d)(4)(i)	484.105(e), 484.105(e)(1), 484.105(e)(2), 484.105(e)(2)(i), 484.105(e)(2)(ii), 484.105(e)(2)(iii), 484.105(e)(2)(iv), 484.105(e)(3)	G976, G978, G980,	Added requirements regarding which agencies the HHA cannot contract with for direct care services per the CoPs
HH1-10B	G231, G232	484.36(d)(4), 484.36(d)(4)(i))	deleted		Deleted from ACHC standards
HH1-11A	G150	484.14)(j)	484.100(c), 484.100(c) (1), 484.100(c)(2)	G862, G864	Added requirement that the HHA cannot substitute its equipment for a patient's equipment when assisting with self-administered tests per the CoPs
HH1-12A.01					No change in intent
HH2-1A.01					No change in intent
HH2-2A	G100, G101, G102, G103	484.10, 484.10(a), 484.10(a)(1), 484.10(a)(1)(2)	484.50, 484.50(a), 484.50(a)(1), 484.50(a)(1)(i-iii), 484.50(a)(2), 484.50(a)(3),	G406, G408, G410, G412, G414, G416, G418, G420, G422, G424, G426, G428, G430, G432, G434,	Incorporated the Patient Rights and Responsibilities requirements per the CoPs; ACHC now requires an agency-generated photo ID for all direct care staff and contracted

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
			484.50(a)(4), 484.50(b), 484.50(b)(1-3), 484.50(c), 484.50(c)(1-3), 484.50(c)(4), 484.50(c)(4)(i-viii), 484.50(c)(5), 484.50(c)(6), 484.50(c)(7), 484.50(c)(7)(i-iv), 484.50(c)(8), 484.50(c)(9), 484.50(c)(10), 484.50(c)(10)(i-v), 484.50(c)(11), 484.50(c)(12)	G436, G438, G440, G442, G444, G446, G448, G450	individuals
HH2-2B	G108, G109	484.10(c), 484.10(c)(1)(i-ii), 484.10(c)(2)(i)	deleted		Deleted from ACHC standards
HH2-2C	G101, G104, G105	484.10, 484.10(b), 484.10(b)(1-3)	484.50, 484.50(c), 484.50(c)(1)	G406, G426, G428	Removed the disclosure of OASIS information, the right of the guardian to exercise the patient's rights, and the requirement to inform patient of anticipated outcomes of care per the CoPs
HH2-3A (was HH2-3A.01)			484.50(c)(2), 484.50(e)(1)(i)(B), 484.50(e)(2)	G430, G482, G488	No change in intent
HH2-4A	G106, G107	484.10(b)(4), 484.10(b)(5)	484.50(c)(3), 484.50(e), 484.50(e)(1), 484.50(e)(1)(i), 484.50(e)(1)(i)(A), 484.50(e)(1)(ii), 484.50(e)(1)(iii)	G432, G476, G478, G480, G484, G486	No change in intent

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH2-4B	G116	484.10(f)	484.50(c)(9), 484.50(c)(10)	G444, G446	Added the 5 federally and state-funded entities for which patients must be provided contact information per the CoPs
HH2-5A	G111, G310	484.10(d), 484.11	484.40, 484.50(c)(6)	G350, G438	Added requirement to be in compliance with 45 CFR parts 160 and 164
HH2-5B	G112	484.10(d)	deleted		Deleted from ACHC standards
HH2-5C.01					No change in intent
HH2-6A	G110	484.10(c)(2)(ii)	484.50(c)(4), 484.50(c)(4)(i-viii)	G434	Added the additional requirements regarding the patient's right to make decisions about medical care per the CoPs
HH2-6B	G110	484.10(c)(2)(ii)	deleted		Deleted from ACHC standards
HH2-6B.01					No change in intent
HH2-6B.02 (was HH2-6B)					Added policy requirements regarding the patient's right to accept/refuse care and to formulate Advance Directives
HH2-7A.01					Removed the PAC as an option to resolve ethical issues
HH2-8A (was HH2-8A.01)			484.50(f), 484.50(f)(1), 484.50(f)(2)	G490	Added the HHA responsibilities to provide access for persons with communication or language barriers per the CoPs
HH2-8A.01			deleted		Deleted from ACHC standards
HH2-8B.01					No change in intent
HH2-9A.01					No change in intent

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH2-10A.01					No change in intent
HH2-11A.01					No change in intent
HH2-12A.01					No change in intent
HH3-1A	G147, G148	484.14(i), 484.14(i)(1), 484.14(i)(3)	484.105(h), 484.105(h)(1), 484.105(h)(3)	G988	Removed requirement for additional members of the HHA to be involved in budget preparation
HH3-1B	G147	484.14(i), 484.14(i)(2), 484.14(ii)(2)(A,B,C)	484.105(h)(2), 484.105(h)(2)(i), 484.105(h)(2)(ii), 484.105(h)(2)(ii)(A), 484.105(h)(2)(ii)(B), 484.105(h)(2)(ii)(C)	G988	No change in intent
HH3-1C	G149	484.14(i)(4)	484.105(h)(4)	G988	Removed requirement for additional members of the HHA to be involved in the budget review
HH3-2A.01					No change in intent
HH3-3A.01					No change in intent
HH3-3B.02					No change in intent
HH3-4A.01					No change in intent
HH3-4C	G113, G114, G115	484.10(e), 484.10(e)(1), 484.10(e)(2)	484.50(c)(7), 484.50(c)(7)(i-iv)	G440	Added timeframe requirement for the HHA to notify the patient of changes in financial liability per the CoPs
HH3-4D.01					No change in intent
HH4-1A.01					No change in intent
HH4-1A.02					No change in intent; ACHC does not hold contract staff

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
					accountable to this standard
HH4-1B.01					No change in intent
HH4-2B.01 (was HH4-2B)	G141	484.14(e)	deleted		No longer a CoP requirement but still an ACHC requirement; no change in intent
HH4-2C.01					ACHC now only requires a one-step Tuberculosis test upon hire; annual testing requirements are based on TB prevalence in the communities in which the HHA provides services
HH4-2D.01					No change in intent
HH4-2E.01					No change in intent
HH4-2F.01					No change in intent
HH4-2H.01					No change in intent
HH4-2I.01 (was HH4-2I)	G141	484.14(e)	deleted		No longer a CoP requirement but still an ACHC requirement; no change in intent (ACHC does not hold contract staff accountable to this standard)
HH4-2J.01 (was HH4-2J)	G214	484.36(b)(2)(ii)	deleted		No longer a CoP requirement but still an ACHC requirement; changed the requirement for performance evaluations from being completed every 12 months to being completed annually
HH4-4A01 (was HH4-	G141	484.14(e)	deleted		No longer a CoP requirement but still an ACHC requirement; no

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
4A)					change in intent
HH4-5A.01					No change in intent
HH4-5B.01					No change in intent
HH4-6A.01					No change in intent
HH4-6C.01					No change in intent
HH4-7C.01					Added requirement for the annual observation visit to be conducted in a home setting while staff are providing care
HH4-8A	G213, G215	484.36(b)(2), 484.36(b)(2)(iii)	484.80(d), 484.80(d)(1), 484.80(d)(2)	G774, G776, G778	No change in intent
HH4-8A.01					No change in intent
HH4-10A.01 (was HH4-10A)	G168, G174	484.30, 484.30(a)	deleted		No longer a CoP requirement but still an ACHC requirement; no change in intent
HH4-11A	G168, G169	484.30	deleted		Deleted from ACHC standards
HH4-11B	G169	484.30	deleted		Deleted from ACHC standards
HH4-11C	G184, G185, G193	484.32, 484.32(b)	deleted		Deleted from ACHC standards
HH4-11D	G190	484.32(a)	deleted		Deleted from ACHC standards
HH4-11E	G190	484.32(a)	deleted		Deleted from ACHC standards
HH4-11F	G194, G195	484.34	deleted		Deleted from ACHC standards
HH4-11G	G195	484.34	deleted		Deleted from ACHC standards
HH4-11H	G202, G203, G227	484.36, 484.36(c)(2)	484.80, 484.80(a), 484.80(a)(1), 484.80(a)(1)(i),	G750, G752, G754, G756	Added Home Health Aide qualification requirements per the CoPs, and the requirement that

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
			484.80(a)(1)(ii), 484.80(a)(1)(iii), 484.80(a)(1)(iv), 484.80(a)(2)		any aide that does not receive compensation for 24 consecutive months is not considered qualified until the aide completes another program
HH4-12A	G204, G205, G206	484.36(a), 484.36(a)(1)(i)(xiii)	484.80(b), 484.80(b)(1), 484.80(b)(2), 484.80(b)(3), 484.80(b)(3)(i-viii), 484.80(b)(3)(ix)(A-F), 484.80(b)(3)(x-xv), 484.80(b)(4)	G758, G760, G762, G764, G766	Added to the aide training requirements per the CoPs: • Communication skills, including the ability to read, write, and verbally report information • Recognizing and reporting skin conditions • All bathing and hair shampooing tasks
HH4-12B	G207, G216	484.36(a)(2), 484.36(a)(i)(A-F), 484.36(a)(2)(i)(G1-5), 484.36(b)(3), 484.36(b)(3)(i)	484.80(c)(2), 484.80(f), 484.80(f)(1), 484.80(f)(2), 484.80(f)(3), 484.80(f)(4), 484.80(f)(5), 484.80(f)(6), 484.80(f)(7), 484.80(f)(7)(i-vi)	G768, G782, G784, G786, G788, G790, G792, G794, G796	Added provisions for when an agency cannot offer an aide training and competency program per the CoPs
HH4-12C	G208, G209, G217	484.36(a)(2)(ii), 484.36(b)(3)(ii)	484.80(c)(3),484.80(e)	G768, G780	No change in intent
HH4-12D	G210, G302	484.36(a)(3), 484.36(d)(4)(iii)	deleted		Deleted from ACHC standards
HH4-12E	G211, G212, G221	484.36(b), 484.36(b)(1), 484.36(b)(5)	deleted		Deleted from ACHC standards
HH4-12F	G213, G218, G222, G302	484.36(b)(2), 484.36(b)(2)(i),	484.80(c), 484.80(c)(1)	G768	Added additional aide competency requirements per the CoPs to

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
		484.36(b)(3))(iii), 484.36(b)(6), 484.36(d)(4)(iii)			include: · Communications skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other HHA staff · Sponge, tub, and shower bath, hair shampooing in sink, tub and bed
HH4-12G	G219, G220	484.36(b)(4), 484.36(b)(4)(i), 484.36(b)(4)(ii)	484.80(c)(4), 484.80(c)(5)	G770, G772	Added the requirement that aides must demonstrate competency on all skills prior to providing any care independently per the CoPs
HH4-13A	G233	484.36(e), 484.36(e)(1-2)	484.80(i)	G828	No change in intent
HH4-14A	G228, G229, G230, G301	484.36(d), 484.36(d)(1), 484.36(d)(2), 484.36(d)(3), 484.36(d)(4)(ii)	484.80(h), 484.80(h)(1)(i-iii), 484.80(h)(2), 484.80(h)(3), 484.80(h)(4), 484.80(h)(4)(i-vi), 484.80(h)(5), 484.80(h)(5)(i-iii)	G806, G808, G810, G812, G814, G816, G818, G820, G822, G824, G826	Added the requirement that an annual on-site visit must be conducted on the aide, and the additional elements that must be assessed during each on-site, 14-day supervisory visit per the CoPs
HH5-1A	G235, G236	484.48	484.110, 484.110(a), 484.110(a)(1), 484.110(a)(2), 484.110(a)(3), 484.110(a)(4), 484.110(a)(5), 484.110(b)	G1008, G1010, G1012, G1014, G1016, G1018, G1020, G1024	Added patient record requirements per the CoPs and the requirement that all entries into the medical record must be timed

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH5-1A.01					Moved former ACHC patient record requirements to HH5-1A
HH5-1B	G235, G237, G239, G240, G241	484.48, 484.48(a), 484.48(b)	484.110(c), 484.110(c)(1), 484.110(c)(2), 484.110(d), 484.110(e)	G1026, G1028, G1030	Added compliance with 45 CFR parts 160-164, and added requirement to make patient records available, upon patient request, within 4 business days or by next home visit
HH5-2A.01					No change in intent
HH5-2B	G156, G157, G330, G331, G332, G333	484.18, 484.55, 484.55(a), 484.55(a)(1), 484.55(a)(2)	484.55(a), 484.55(a)(1), 484.55(a)(2), 484.60	G512, G514, G516, G570	No change in intent
HH5-2C	G330, G334, G342	484.55, 484.55(b), 484.55(b)(1), 484.55(e)	484.55, 484.55(b), 484.55(b)(1), 484.55(b)(2), 484.55(b)(3), 484.55(c), 484.55(c)(1), 484.55(c)(2), 484.55(c)(3), 484.55(c)(4), 484.55(c)(6)(i-ii), 484.55(c)(7), 484.55(c)(8)	G510, G518, G520, G522, G524, G526, G528, G530, G532, G534, G536, G538, G540, G542	Added the following items to the comprehensive assessment per the CoPs: · Data items collected at inpatient facility admission or discharge only · Respiratory status · Elimination status · Sensory status · Integumentary status · Emergent care · The patient's primary caregiver(s), if any, and other available supports, including their willingness and ability to provide care, availability, and schedules · Supportive assistance · Emergency preparedness

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH5-2C.01					No change in intent
HH5-2C.02					No change in intent
HH5-2D	G330, G335, G336	484.55, 484.55(b)(2), 455(b)(3)	deleted		Deleted from ACHC standards
HH5-2E	G330, G338, G339, G340, G341	484.55, 484.55(d), 484.55(d)(1), 484.55(d)(1)(i,ii,iii), 484.55(d)(2), 484.55(d)(3)	484.55(d), 484.55(d)(1), 484.55(d)(1)(i-iii), 484.55(d)(2), 484.55(d)(3)	G544, G546, G548, G550	Added the requirement that the comprehensive assessment is updated timely, including on the physician-ordered resumption of care per the CoPs
HH5-2F	G337	484.55(c)	484.55(c)(5)	G536	Added "ineffective drug therapy and route" to the medication review
HH5-2F.01					No change in intent
HH5-2F.02					No change in intent
HH5-3A	G156, G159, G160, G161, G162, G170	484.18, 484.18(a), 484.30	484.60, 484.60(a), 484.60(a)(1), 484.60(a)(2), 484.60(a)(2)(i-xvi), 484.60(a)(3)	G570, G572, G574, G576	Added the following items to the plan of care per the CoPs: • Patient-specific interventions and education • Measureable outcomes and goals • Patient and caregiver education and training to facilitate a timely discharge • 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 • Information related to Advance

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
					Directive • Any additional items the HHA or physician may choose to include
HH5-3B	G156, G158, G165	484.18, 484.18(c)	484.60(a)(1), 484.60(b), 484.60(b)(1), 484.60(b)(2)	G572, G578, G580, G582	Added the requirement that each patient receives care as ordered by the physician and the plan of care is periodically reviewed per the CoPs
HH5-3C New Standard			484.60(e), 484.60(e)(1), 484.60(e)(2), 484.60(e)(3), 484.60(e)(4), 484.60(e)(5)	G612, G614, G616, G618, G620, G622	Added the required written information that must be provided to the patient per the CoPs to include: • Visit schedule and frequency • Patient medication schedule and instructions • Treatments to be administered (including therapy services) • Any other pertinent instruction • The name and contact information of the Clinical Manager
HH5-4A	G143, G144	484.14(g)	484.60(d), 484.60(d)(1-5)	G600, G602, G604, G606, G608, G610	Added requirements regarding communication and collaboration with all physicians involved in the plan of care per the CoPs
HH5-4B.01			deleted		Deleted from ACHC standards
HH5-5A	G156, G163	484.18, 484.18(b)	484.60(c)(1)	G588	No change in intent
HH5-5B	G145	484.14(g)	deleted		Deleted from ACHC standards
HH5-6A	G238	484.48(a)	484.50(c)(8), 484.50(d), 484.50(d)(1),	G442, G452, G454, G456, G458, G460,	Added requirements for when patients can be transferred and

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
			484.50(d)(2), 484.50(d)(3), 484.50(d)(4), 484.50(d)(5), 484.50(d)(5)(i-iv), 484.50(d)(6), 484.50(d)(7), 484.110(a)(6)(i-iii)	G462, G464, G466, G468, G470, G472, G474, G1022	discharged, and the requirements on when the discharge and/or transfer summary must be sent to physician or healthcare facility per the CoPs
HH5-7A	G156, G303	484.18, 484.48	deleted		Deleted from ACHC standards
HH5-8A	G166, G300	484.18(c)	484.60(b)(3), 484.60(b)(4)	G584	Added requirement that verbal orders need to be timed with the time that the verbal order is received per the CoPs
HH5-8B	G164	484.18(b)	484.60(c)(1), 484.60(c)(2), 484.60(c)(3), 484.60(c)(3)(i-ii)	G588, G590, G592, G594, G596, G598	Added requirements regarding notifying physician, patient, and representative of changes that may require altering the plan of care per the CoPs
HH5-9A	G109	484.10(c)(2), 484.10(c)(2)(i)	deleted		Deleted from ACHC standards
HH5-10A	G234	484.38	484.105(g)	G986	No change in intent
HH5-11A	G169, G170, G171, G172, G173, G174, G175, G176, G177, G178	484.30, 484.30(a)	409.45, 484.75, 484.75(a), 484.75(b), 484.75(b)(1-9), 484.75(c), 484.75(c)(1-3), 484.115(e), 484.115(f), 484.115(g), 484.115(h), 484.115(i),484.115(k), 484.115(l), 484.115(m), 484.115(n)	G700, G702, G704, G706, G708, G710, G712, G714, G716, G718, G720, G722, G724, G726, G728, G730, G1060, G1061, G1064, G1066, G1068, G1072, G1074, G1076, G1078	Added responsibilities and duties of skilled professional services per the CoPs and changed ACHC supervision requirements for LPNs/COTAs/PTAs/BSWs from every 30 days to every 60 days

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH5-11B	G179, G180, G181, G182, G183	484.30(b)	deleted		Moved to HH5-11A
HH5-11C	G184, G185, G186, G187, G188, G189	484.32	deleted		Moved to HH5-11A
HH5-11D	G190, G191, G192	484.32(a)	deleted		Moved to HH5-11A
HH5-11E	G194, G195, G196, G197, G198, G199, G200, G201	484.34	deleted		Moved to HH5-11A
HH5-11F	G223, G224, G225, G226, G227	484.36(c), 484.36(c)(1), 484.36(c)(2),	484.80(g), 484.80(g)(1), 484.80(g)(2), 484.80(g)(2)(i-iv), 484.80(g)(3)(i-iv), 484.80(g)(4), 484.115(d)	G798, G800, G802, G804,G1058	Added the services and duties of a Home Health Aide per the CoP requirements
HH5-12A	G177, G183, G188, G192, G198	484.30(a), 484.30(b), 484.32, 484.32(a), 484.34	deleted		Deleted from ACHC standards
HH5-12A.01					No change in intent
HH5-13A.01					Added the ACHC requirement for a referral log or other means to record referrals
HH5-14A.01			deleted		Deleted from ACHC standards
HH5-14B.01					Added Medicare Benefit Policy Manual section 30.5.1 regarding the statement of certification
HH5-15A.01			deleted		Deleted from ACHC standards

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH5-16A.01					No change in intent
HH6-1A (was HH6-1A.01)			484.65, 484.65(a), 484.65(a)(1-2), 484.65(b), 484.65(b)(1), 484.65(b)(2), 484.65(b)(2)(i-ii), 484.65(b)(3), 484.65(c), 484.65(c)(1), 484.65(c)(1)(i-iii), 484.65(c)(2), 484.65(c)(3), 484.65(d), 484.65(d)(1), 484.65(d)(2)	G640, G642, G644, G646, G648, G650, G652, G654, G656, G658	Added the required elements and content for the QAPI program per the CoPs
HH6-1B.01					No change in intent
HH6-1C (was HH6-1C.01)			484.65(e), 484.65(e)(1), 484.65(e)(2), 484.65(e)(3), 484.65(e)(4)	G660	Added the requirement of the governing body to be responsible for the QAPI program and added the required components of a QAPI program per the CoPs
HH6-1D.01					No change in intent
HH6-2A	G242, G243, G244, G245, G246, G247, G248, G249	484.52, 484.52(a)	deleted		Deleted from ACHC standards
HH6-3A.01					Removed the requirement for an annual program evaluation per the CoPs
HH6-4A.01					No change in intent
HH6-4A.02					No change in intent
HH6-4A.03			deleted		Deleted from ACHC standards

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH6-4A.04					No change in intent
HH6-4A.05					No change in intent
HH6-4A.06					No change in intent
HH6-4A.07 (was HH6-4A)	G250, G251	484.52(b)	deleted		No longer a CoP requirement but still an ACHC requirement; no change in intent
HH6-5A (was HH6-4A.03)			484.65(c)(1)(i), 484.65(c)(1)(ii), 484.65(c)(1)(iii),	G648, G650, G652	Added the required areas that QAPI must focus on per the CoPs
HH6-6A (was HH6-6A.01)			484.65(c)(2)	G654	Added the requirements to monitor and investigate all patient incidents per the CoPs
HH6-7A.01					No change in intent
HH7-1A (was HH7-1A.01)			484.70, 484.70(a), 484.70(c)	G680, G682, G686	Added the requirements of an agency-wide infection control program per the CoPs
HH7-1D			484.70(b), 484.70(b)(1), 484.70(b)(2)	G684	Added the requirements of an agency-wide infection control program per the CoPs
HH7-2A.01					No change in intent
HH7-2B.01					No change in intent
HH7-3A			484.22, 484.102, E-0001, 484.22(a), 484.102(a), 484.22(a)(1-4), 484.102(a)(1-4), E-0004, E-0006, E-0007, E-0009	E-0001, E-0004, E-0006, E-0007, E-0009	Added the Emergency Preparedness Plan requirements per the CoPs
HH7-3A.01			deleted		Deleted from ACHC standards

ACHC HH Accreditation Standards	Previous SOM G tags	Previous Medicare CoPs	2018 Medicare CoPs	2018 G tags	Changes to standard
HH7-3B			484.22(b)(1-5), 484.102(b)(1-5), E-0013, E-0017, E-0019, E-0021, E-0023, E-0024	E-0013,E-0017, E-0019, E-0021, E-0023, E-0024	Added the Emergency Preparedness policy requirements per the CoPs
HH7-3C			484.22(c)(1-6), 484.102(c)(1-6), E-0029, E-0030, E-0031, E-0032, E-0033, E-0034	E-0029, E-0030, E-0031, E-0032, E-0033, E-0034	Added the communication plan requirements per the CoPs
HH7-3C.01			deleted		Deleted from ACHC standards
HH7-3D			484.22(d)(1-2), 484.102(d)(1-2), E-0036, E-0037, E-0039	E-0036, E-0037, E-0039	Added the training and testing of the Emergency Preparedness Plan requirements per the CoPs
HH7-3E			484.22(e)(1-5), 484.102(e)(1-5), E-0042	E-0042	Added the requirements individual HHAs must meet if part of an integrated Emergency Preparedness Plan per the CoPs
HH7-5A.01					No change in intent
HH7-6A.01					No change in intent
HH7-6B.01					No change in intent
HH7-7A.01					No change in intent
HH7-8A.01					No change in intent
HH7-9A.01					No change in intent
HH7-10A.01					No change in intent

DEPARTMENT OF HEALTH & HUMAN SERVICES
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Center for Clinical Standards and Quality /Quality, Safety & Oversight Group

Ref: QSO-18-13-HHA

DATE: **January 12, 2018** **REVISED 01.16.18**

TO: State Survey Agency Directors

FROM: Director
Quality, Safety & Oversight Group *(formerly Survey & Certification Group)*

SUBJECT: Home Health Agency (HHA) Survey Protocol – State Operations Manual (SOM) Appendix B Revised

****Revised Attachments A & B to Reflect Removal of Tags G670, G700, G848 and G940; Addition of G956 and G984****

Memorandum Summary

This memorandum revises Appendix B of the SOM pursuant to new Conditions of Participation (CoPs) for HHA which are effective January 13, 2018:

- New Aspen tags for each condition and standard for the new CoPs are attached to this memorandum. These tags will be used by the surveyors to enter survey data into the system as of January 13, 2018.
- Revised Level I and Level II standards, based on the new CoPs, are attached to this memorandum. The surveyors must use Level I and II standards to conduct standard and partially extended HHA surveys per Appendix B of the SOM.
- The survey process within Appendix B of the SOM is revised to reduce pre-survey preparation time and refocus the use of Certification and Survey Provider Enhanced Reports (CASPER) reports in the HHA sample selection. The total number of patient clinical record reviews has been reduced.

Discussion

Revised HHA CoPs will be effective January 13, 2018. Pursuant to the new regulations, certain portions of the SOM Appendix B have been revised.

Attachment A of this memorandum forwards the new ASPEN tags assigned to each of the new HHA conditions and standards. These new ASPEN tags will be uploaded into the ASPEN system in preparation for use beginning on January 22, 2018. The Level I and level II standards for the new HHA CoPs have been identified (highlighted) for the convenience of the surveyors.

Attachment B of this memorandum is a table of the new Level I and Level II standards for the new HHA CoPs to be used during the standard and partially extended surveys as discussed in Appendix B of the SOM.

Selected sections of the HHA survey process have also been revised and will be effective with all surveys conducted upon receipt of this memorandum. These changes replace the current, corresponding sections within Appendix B of the SOM. The changes are:

Task 1 - Pre-Survey (Offsite) Preparation

The offsite preparation task has been refocused to optimize surveyor time in planning for the HHA survey and to shift the focus of the offsite review to potentially avoidable events. The number of CASPER HHA reports that are to be reviewed prior to the HHA survey is reduced from six to three reports.

The three CASPER reports that surveyors will continue to review during Task 1 are:

1. Risk Adjusted Potentially Avoidable Event Report (12 months);
2. Potentially Avoidable Event Report: Patient Listing (12 months);
3. Agency Patient Related- Characteristics Report (12 months).

1. *Risk Adjusted Potentially Avoidable Event Report*

Surveyors will continue to utilize the Risk Adjusted Potentially Avoidable Event Report to identify potential areas of concern for the survey. Review the report to identify all potentially avoidable events. It is no longer required that the surveyor analyze this report for statistical significance or to determine if the provider exceeded twice the national reference value for a particular concern. All incidents contained within the report time period should be used as the universe, in conjunction with the *Potentially Avoidable Event: Patient Listing Report,* from which the closed record sample for the survey is selected. The closed record sample is selected during the pre-survey preparation. If the reports do not contain a sufficient number of events, the sample may be augmented onsite.

2. *Potentially Avoidable Event: Patient Listing Report*

This report is a companion to the above *Potentially Avoidable Event Report* and provides the names of the patients who experienced the events noted in that report. Patients listed under multiple areas in the above report should be selected as a priority. If an insufficient number of patients are listed in the *Potentially Avoidable Event Report* to meet the number of closed records required for the survey sample, additional records may be added to the sample from the list of patients discharged from the agency for the 6 months prior to the survey.

3. *Agency Patient-Related Characteristics Report*

Surveyors will continue to review this report, which compiles several OASIS data elements into one report that provides a high-level overview of the HHA patient demographics, home care diagnoses, and agency statistics. Surveyors should identify potential focus areas of concern where the agency's indicators exceed the national reference in the areas of Acute Conditions, Patient Diagnostic Information, and Home Care Diagnoses. Select patients for review and home visits during the survey who be associated with these areas of concern.

Task 3: Information Gathering

The minimum clinical record/sample size for HHA surveys has been revised as follows in Table 1. More clinical records may be reviewed and more home visits conducted as deemed necessary

to adequately assess compliance with the CoPs when deficient practice has been identified during the survey.

Table 1. HHA Survey Sample—Revised

Number of unduplicated skilled care admissions for the 12 months prior to the survey	Active Patient Sample: Record Review Only (No Home Visit)	Active Patient Sample: Record Review with Home Visit	Discharged Patients: Closed Record Review	Total Survey Sample
Less than 300	2	3	2	7
301 - 500	3	4	3	10
501 - 700	4	5	4	*13*
701 or more	5	7	5	*17*

Contact: Questions concerning this memorandum may be addressed to: HHA.SCG@cms.hhs.gov and David Escobedo at david.escobedo@cms.hhs.gov.

Effective Date: Immediately. This policy should be communicated with all survey and certification staff, their managers and the State/Regional Office training coordinators within 30 days of this memorandum.

/s/
David R. Wright

Attachment(s):
Attachment A- Revised ASPEN Tags with Level I and Level II Tags Highlighted
Attachment B-Revisions to the Level I and Level II HHA Standard/Partially Extended Survey Standards

cc: Survey and Certification Regional Office Management

Attachment A: All HHA Tags with Level 1 and Level 2 Tags Highlighted

Regulatory Reference	G Tag	All HHA Tags Blue Shading = Level 1 Green Shading = Level 2
484.40	***G350***	***Condition: Release of patient identifiable OASIS info.***
484.45	***G370***	***Condition: Reporting OASIS information***
484.45(a)	G372	Standard: Encoding and transmitting OASIS
484.45(b)	G374	Standard: Accuracy of encoded OASIS data
484.45(c)	G376	Standard: Transmittal of OASIS data
484.45(c)(1)	G378	OASIS data transmission format
484.45(c)(2)	G380	Successfully transmit test data
484.45(c)(3)	G382	Transmit data using compliant software
484.45(c)(4)	G384	Transmit data that includes branch identifier
484.45(d)	G386	Standard: Data Format
484.50	***G406***	***Condition: Patient rights***
484.50(a)	G408	Standard: Notice of rights
484.50(a)(1)	G410	Information to patient
484.50(a)(1)(i)	G412	Written notice of patient's rights
484.50(a)(1)(ii)	G414	HHA administrator contact information
484.50(a)(1)(iii)	G416	OASIS privacy notice
484.50(a)(2)	G418	Patient's or legal representative's signature
484.50(a)(3)	G420	Verbal notice of rights and responsibilities
484.50(a)(4)	G422	Written notice within 4 business days
484.50(b)	G424	Standard: Exercise of rights
484.50(c)	G426	Standard: Rights of the patient
484.50(c)(1)	G428	Property and person treated with respect
484.50(c)(2)	G430	Be free from abuse
484.50(c)(3)	G432	Make complaints to the HHA
484.50(c)(4)	G434	Participate in care
484.50(c)(5)	G436	Receive all services in plan of care
484.50(c)(6)	G438	Have a confidential clinical record
484.50(c)(7)	G440	Payment from federally funded programs
484.50(c)(8)	G442	Written notice for non-covered care
484.50(c)(9)	G444	State toll free HH telephone hotline
484.50(c)(10)	G446	Contact info Federal/State-funded entities
484.50(c)(11)	G448	Freedom from discrimination or reprisal
484.50(c)(12)	G450	Access to auxiliary aids and language service
484.50(d)	G452	Standard: Transfer and discharge
484.50(d)(1)	G454	HHA can no longer meet the patient's needs
484.50(d)(2)	G456	Patient/payer will no longer pay for services
484.50(d)(3)	G458	Outcomes/goals have been achieved
484.50(d)(4)	G460	Patient refuses services
484.50(d)(5)	G462	Before discharge for cause HHA must:
484.50(d)(5)(i)	G464	Advise the patient of discharge for cause
484.50(d)(5)(ii)	G466	Make efforts to resolve the problem(s)
484.50(d)(5)(iii)	G468	Provide contact info other services
484.50(d)(5)(iv)	G470	Document efforts to resolve problems
484.50(d)(6)	G472	Death of patient

484.50(d)(7)	G474	HHA ceases to operate
484.50(e)(1)	G476	Standard: Investigation of complaints
484.50(e)(1)(i)	G478	Investigate complaints made by patient
484.50(e)(1)(i)(A)	G480	Treatment or care
484.50(e)(1)(i)(B)	G482	Mistreatment, neglect or abuse
484.50(e)(1)(ii)	G484	Document complaint and resolution
484.50(e)(1)(iii)	G486	Protect patient during investigation
484.50(e)(2)	G488	Immediate reporting of abuse by all staff
484.50(f)(1,2)	G490	Standard: Accessibility
484.55	***G510***	***Condition: Comprehensive Assessment of Patients***
484.55(a)	G512	Standard: Initial assessment visit.
484.55(a)(1)	G514	RN performs assessment
484.55(a)(2)	G516	Skilled professional performs assessment
484.55(b)	G518	Standard: Completion of the comprehensive assessment
484.55(b)(1)	G520	5 calendar days after start of care
484.55(b)(2)	G522	Eligibility for Medicare home health benefit
484.55(b)(3)	G524	Therapy services determine eligibility
484.55(c)	G526	Standard: Content of the comprehensive assessment
484.55(c)(1)	G528	Health, psychosocial, functional, cognition
484.55(c)(2)	G530	Strengths, goals, and care preferences
484.55(c)(3)	G532	Continuing need for home care
484.55(c)(4)	G534	Patient's needs
484.55(c)(5)	G536	A review of all current medications
484.55(c)(6)	G538	Primary caregiver(s), if any
484.55(c)(7)	G540	The patient's representative (if any);
484.55(c)(8)	G542	Incorporate OASIS items
484.55(d)	G544	Standard: Update of the comprehensive assessment
484.55(d)(1)	G546	Last 5 days of every 60 days unless:
484.55(d)(2)	G548	Within 48 hours of the patient's return
484.55(d)(3)	G550	At discharge
484.60	***G570***	***Condition: Care planning, coordination, quality of care***
484.60(a)(1)	G572	Standard: Plan of care
484.60(a)(2)	G574	Plan of care must include the following
484.60(a)(3)	G576	All orders recorded in plan of care
484.60(b)	G578	Standard: Conformance with physician orders
484.60(b)(1)	G580	Only as ordered by a physician
484.60(b)(2)	G582	Influenza and pneumococcal vaccines
484.60(b)(3)(4)	G584	Verbal orders
484.60(c)	G586	Standard: Review and revision of the plan of care
484.60(c)(1)	G588	Reviewed, revised by physician every 60 days
484.60(c)(1)	G590	Promptly alert relevant physician of changes
484.60(c)(2)	G592	Revised plan of care
484.60(c)(3)	G594	Plan of care revisions must be communicated
484.60(c)(3)(i)	G596	Revisions communicated to patient and MDs
484.60(c)(3)(ii)	G598	Discharge plans communication
484.60(d)	G600	Standard: Coordination of Care

484.60(d)(1)	G602	Communication with all physicians
484.60(d)(2)	G604	Integrate all orders
484.60(d)(3)	G606	Integrate all services
484.60(d)(4)	G608	Coordinate care delivery
484.60(d)(5)	G610	Patients receive education and training
484.60(e)	G612	Standard: Written instructions to patient include:
484.60(e)(1)	G614	Visit schedule
484.60(e)(2)	G616	Patient medication schedule/instructions
484.60(e)(3)	G618	Treatments and therapy services
484.60(e)(4)	G620	Other pertinent instructions
484.60(e)(5)	G622	Name/contact information of clinical manager
484.65	***G640***	***Condition: Quality assessment/performance improvement***
484.65(a)(1),(2)	G642	Standard: Program scope
484.65(b)(1),(2),(3)	G644	Standard: Program data
484.65(c)	G646	Standard: Program activities
484.65(c)(1)(i)	G648	High risk, high volume, or problem-prone area
484.65(c)(1)(ii)	G650	Incidence, prevalence, severity of problems
484.65(c)(1)(iii)	G652	Activities lead to an immediate correction
484.65(c)(2)	G654	Standard: Track adverse patient events
484.65(c)(3)	G656	Improvements are sustained
484.65(d)(1)(2)	G658	Standard: Performance improvement projects
484.65(e)(1)(2)(3)(4)	G660	Standard: Executive responsibilities for QAPI
484.70	***G680***	***Conditon: Infection prevention and control***
484.70(a)	G682	Standard: Prevention
484.70(b)(1)(2)	G684	Standard: Infection control
484.70(c)	G686	Standard: Infection control education
484.75	***G700***	***Condition: Skilled professional services***
484.75(a)	G702	Standard: Services by skilled professionals
484.75(b)	G704	Standard: Responsibilities of skilled professionals
484.75(b)(1)	G706	Interdisciplinary assessment of the patient
484.75(b)(2)	G708	Development and evaluation of plan of care
484.75(b)(3)	G710	Provide services in the plan of care
484.75(b)(4)	G712	Patient, caregiver, and family counseling
484.75(b)(5)	G714	Patient and caregiver education
484.75(b)(6)	G716	Preparing clinical notes
484.75(b)(7)	G718	Communication with physicians
484.75(b)(8)	G720	Participate in the HHA's QAPI program;
484.75(b)(9)	G722	Participate in HHA-sponsored in-service
484.75(c)	G724	Standard: Supervise skilled professional assistants
484.75(c)(1)	G726	Nursing services supervised by RN
484.75(c)(2)	G728	Rehab services supervised by PT, OT
484.75(c)(3)	G730	Medical social services supervised by MSW
484.80	***G750***	***Condition: Home health aide services***
484.80(a)	G752	Standard: Home health aide qualifications
484.80(a)(1)	G754	A qualified HH aide successfully completed:
484.80(a)(2)	G756	24 consecutive months paid service

484.80(b)	G758	Standard: Content and duration of training
484.80(b)(1)	G760	Classroom and supervised practical training
484.80(b)(2)	G762	Minimum hours of training
484.80(b)(3)	G764	HH aide training program topics
484.80(b)(4)	G766	HHA maintains documentation of training
484.80(c)(1)(2)(3)	G768	Standard: Competency evaluation
484.80(c)(4)	G770	Unsatisfactory competency evaluation
484.80(c)(5)	G772	Documentation of competency evaluation
484.80(d)	G774	Standard: 12 hours inservice every 12 months
484.80(d)(1)	G776	Inservice training supervised by RN
484.80(d)(2)	G778	Documentation of inservice training
484.80(e)	G780	Standard: Instructor qualifications
484.80(f)	G782	Standard: Eligible training/competency evaluation orgs.
484.80(f)(1)	G784	Noncompliance with training requirements
484.80(f)(2)	G786	Unqualified HH aide providing services
484.80(f)(3)	G788	Org. had partial/extended survey
484.80(f)(4)	G790	Assessed a civil monetary penalty = $5,000
484.80(f)(5)	G792	Deficiencies that endangered health/safety
484.80(f)(6)	G794	Medicare payments suspended
484.80(f)(7)	G796	Violations of federal or state law:
484.80(g)(1)	G798	Standard: Home health aide assignments and duties
484.80(g)(2)	G800	Services provided by HH aide
484.80(g)(3)	G802	Duties of a HH aide
484.80(g)(4)	G804	Aides are members of interdisciplinary team
484.80(h)	G806	Standard: Supervision of home health aides
484.80(h)(1)(i)	G808	Onsite supervisory visit every 14 days
484.80(h)(1)(ii)	G810	If concern identified, direct observation
484.80(h)(1)(iii)	G812	Direct observation every 12 months
484.80(h)(2)	G814	Non-skilled direct observation every 60 days
484.80(h)(3)	G816	Competency eval. if deficiency identified
484.80(h)(4)	G818	HH aide supervision elements
484.80(h)(5)	G820	HH aide services under arrangement
484.80(h)(5)(i)	G822	Ensuring the overall quality of care provided
484.80(h)(5)(ii)	G824	Supervising HH aide services
484.80(h)(5)(iii)	G826	Ensure training/competency requirements
484.80(i)	G828	Standard: Medicaid personal care aide-only services
484.100	***G848***	***Condition: Compliance with Federal, State, Local Law***
484.100(a)	G850	Standard: Disclosure of ownership and management info.
484.100(a)	G852	Standard: Information to the state survey agency
484.100(a)(1)	G854	All persons with ownership interest
484.100(a)(2)	G856	Officer, a director, agent, managing employee
484.100(a)(3)	G858	Responsible for the management of the HHA
484.100(b)	*G860*	Standard: Licensing
484.100(c)(1)	G862	Standard: Laboratory services/CLIA waivers
484.100(c)(2)	G864	Referral laboratory must be certified
484.102	E-0001	***Condition: Emergency preparedness***

Refer to Emergency Preparedness E-Tags and Appendix Z		
484.102(a)	E-0004	Standard: Emergency plan
484.102(a)(1)(2)	E-0006	Risk assessment
484.102(a)(3)	E-0007	Address patient population
484.102(a)(4)	E-0009	Process for cooperation and collaboration
484.102(b)	E-0013	Standard: Policies and procedures
484.102(b)(1)	E-0017	Plans for HHA's patients in plan of care
484.102(b)(2)	E-0019	Procedures to inform State/Local officials
484.102(b)(3)	E-0021	Procedures to follow up with staff/pts.
484.102(b)(4)	E-0023	Secures and maintains availability of records
484.102(b)(5)	E-0024	Use of volunteers in an emergency
484.102(c)	E-0029	Standard: Communication plan
484.102(c)(1)	E-0030	Names and contact information
484.102(c)(2)	E-0031	Contact info for emergency officials
484.102(c)(3)	E-0032	Primary and alternate communication info
484.102(c)(4)(5)	E-0033	Continuity of care
484.102(c)(6)	E-0034	Providing information about HHA
484.102(d)	E-0036	Standard: Training and testing
484.102(d)(1)	E-0037	Standard: EP Training Program
484.102(d)(2)	E-0039	EP Testing Program
484.102(e)	E-0042	Standard: Integrated healthcare systems
484.105	***G940***	***Condition: Organization and administration of services***
484.105(a)	G942	Standard: Governing body
484.105(b)(1)	G944	Standard: Administrator must:
484.105(b)(1)(i)	G946	Administrator appointed by governing body
484.105(b)(1)(ii)	G948	Responsible for all day-to-day operations
484.105(b)(1)(iii)	G950	Ensure clinical manager is available
484.105(b)(1)(iv)	G952	Ensure that HHA employs qualified personnel
484.105(b)(2)	G954	Ensures qualified pre-designated person
484.105(b)(3)	*G956*	Available during all operating hours
484.105(c)	G958	Standard: Clinical manager
484.105(c)(1)	G960	Make patient and personnel assignments,
484.105(c)(2)	G962	Coordinate patient care
484.105(c)(3)	G964	Coordinate referrals;
484.105(c)(4)	G966	Assure patient needs are continually assessed
484.105(c)(5)	G968	Assure implementation of plan of care
484.105(d)	G970	Standard: Parent-branch relationship
484.105(d)(1)	G972	Report all branch locations to SA
484.105(d)(2)	G974	Direct support and administrative control
484.105(e)(1)	G976	Standard: Services under arrangement
484.105(e)(2)	G978	Must have a written agreement
484.105(e)(3)	G980	Primary HHA is responsible for patient care
484.105(f)	G982	Standard: Skilled services furnished
484.105(f)(2)	*G984*	In accordance with current clinical practice
484.105(g)	G986	Standard: Outpatient therapy services
484.105(h)	G988	Standard: Institutional planning

Attachment A: All HHA Tags with Level 1 and Level 2 Tags Highlighted

484.110	**G1008**	***Condition: Clinical records***
484.110(a)	G1010	Standard: Contents of clinical record
484.110(a)(1)	G1012	Required items in clinical record
484.110(a)(2)	G1014	Interventions and patient response
484.110(a)(3)	G1016	Goals in the patient's plans of care
484.110(a)(4)	G1018	Contact information for the patient
484.110(a)(5)	G1020	Contact info for primary care practitioner
484.110(a)(6)	G1022	Discharge and transfer summaries
484.110(b)	G1024	Standard: Authentication
484.110(c)(1)(2)	G1026	Standard: Retention of records
484.110(d)	G1028	Standard: Protection of records
484.110(e)	G1030	Standard: Retrieval of records
484.115	**G1050**	***Condition: Personnel qualifications***
484.115(a)	G1052	Standard: Administrator
484.115(b)	G1054	Standard: Audiologist
484.115(c)	G1056	Clinical Manager
484.115(d)	G1058	Standard: Home Health Aide
484.115(e)	G1060	Standard: Licensed Practical (Vocational) Nurse
484.115(f)	G1062	Standard: Occupational Therapist
484.115(g)	G1064	Standard: Occupational Therapy Assistant
484.115(h)	G1066	Standard: Physical Therapist
484.115(i)	G1068	Standard: Physical Therapist Assistant
484.115(j)	G1070	Standard: Physician
484.115(k)	G1072	Standard: Registered Nurse
484.115(l)	G1074	Standard: Social Work Assistant
484.115(m)	G1076	Standard: Social Worker
484.115(n)	G1078	Standard: Speech-Language Pathologist

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

Updates to the Level 1 and Level 2 Tags for Standard HHA Survey

The Level 1 and 2 tags correspond directly to the prior regulations to the extent possible, except where the regulatory requirements are broken out into different standards. During the standard survey, the surveyor reviews the HHA's compliance with a select number of regulations (standards) most related to high-quality patient care and address 8 of the 14 CoPs.

Table 1 lists the tags according to Condition; Table 2 contains the regulatory requirements associated with the tags. Table 3 suggests associated conditions that may be considered for further investigation when a condition of participation is cited in the 8 CoPs for the Standard HHA Survey.

Table 1. Level 1 and Level 2 Standards to determine compliance during a Standard Survey (Effective January 13, 2018)

CONDITION OF PARTICIPATION	Level 1 Standards (Priority Standards for a Standard Survey)	Level 2 (Primary Standards for a Partial Extended Survey)
§484.50 Patient Rights	G434, G476, G478, G480, G482, G484, G486, G488	G438
§484.55 Comprehensive Assessment Of Patients	G512, G514, G518, G520, G522, G524, G536, G544, G548	G546, G550
§484.60 Care planning, coordination of services, and quality of care. *(Removed G670 from Level 1)*	G572, G574, G578, G580, G582	G586, G588, G590
§484.75 Skilled Professional Services *(Removed G700 from Level 1)*	G704, G706, G708, G710, G712, G714, G716, G718	G724, G726, G728, G730
§484.80 Home Health Aide Services	G798, G808	G768, G774, G800, G802, G814, G820
§484.100 Compliance With Federal, State, And Local Laws and Regs. *(Removed G848 from Level 1)*	n/a	G860
§484.105 Organization and Administration of Services *(Added G984 to Level 1 and G956 to Level 2)*	G944, G946, G948, G950, G984	G954, G956, G958, G960, G962, G964, G966, G968

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

CONDITION OF PARTICIPATION	Level 1 Standards (Priority Standards for a Standard Survey)	Level 2 (Primary Standards for a Partial Extended Survey)
§484.110 Clinical Records.	G1010, G1012, G1014, G1016	G1028

Table 2. Level 1 and Level 2 Tags Regulatory Requirements

Level 1 and Level 2 Tags for HHA Standard Survey, Revised for New Conditions of Participation	
§484.50 Patient Rights	
Patient Rights Level 1 Tags	
G434 L1	§484.50(c)(4) 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; and (viii) Any changes in the care to be furnished.
G476 L1	§484.50(e) Standard: Investigation of complaints §484.50(e)(1) The HHA must—
G478 L1	§484.50(e)(1)(i) Investigate complaints made by a patient, the patient's representative (if any), and the patient's caregivers and family, including, but not limited to, the following topics:
G480 L1	§484.50(e)(1)(i)(A) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and
G482 L1	§484.50(e)(1)(i)(B) 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.
G484 L1	§484.50(e)(1)(ii) Document both the existence of the complaint and the resolution of the complaint; and

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

G486 L1	§484.50(e)(1)(iii) Take action to prevent further potential violations, including retaliation, while the complaint is being investigated.
G488 L1	§484.50(e)(2) Any HHA staff (whether employed directly or under arrangements) in the normal course of providing services to patients, who identifies, notices, or recognizes incidences or circumstances of mistreatment, neglect, verbal, mental, sexual, and/or physical abuse, including injuries of unknown source, or misappropriation of patient property, must report these findings immediately to the HHA and other appropriate authorities in accordance with state law.
Patient Rights Level 2 Tags	
G438 L2	§484.50(c)(6) Have a confidential clinical record. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.
§484.55 Comprehensive assessment of patients	
Comprehensive Assessment Level 1 Tags	
G512 L1	§484.55(a) Standard: Initial assessment visit
G514 L1	§484.55(a)(1) 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.
G518 L1	§484.55(b) Standard: Completion of the comprehensive assessment.
G520 L1	§484.55(b)(1) The comprehensive assessment must be completed in a timely manner, consistent with the patient's immediate needs, but no later than 5 calendar days after the start of care.
G522 L1	§484.55(b)(2) 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.
G524 L1	§484.55(b)(3)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

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

G536 L1	§484.55(c)(5) 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.
G544 L1	§484.55(d) Standard: 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—
G548 L1	§484.55(d)(2) 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;
Comprehensive Assessment Level 2 Tags	
G546 L2	§484.55(d)(1) 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; or (iii) Discharge and return to the same HHA during the 60-day episode.
G550 L2	§484.55(d)(3) At discharge.
§484.60 Care planning, coordination of services, and quality of care	
Care planning, coordination of services, and quality of care Level 1 Tags	
G572 L1	§484.60(a) Standard: Plan of care. §484.60(a)(1) 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.
G574 L1	§484.60(a)(2) 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; (ix) Nutritional requirements;

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

	(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; and (xvi) Any additional items the HHA or physician may choose to include.
G578 L1	§484.60(b) Standard: Conformance with physician orders.
G580 L1	§484.60(b)(1) Drugs, services, and treatments are administered only as ordered by a physician.
G582 L1	§484.60(b)(2) 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 contraindications.
Care planning, coordination of services, and quality of care Level 2 Tags	
G586 L2	§484.60(c) Standard: Review and revision of the plan of care.
G588 L2	§484.60(c)(1) 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 L2	§484.60(c)(1)…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.
§484.75 Skilled professional services	
Skilled professional services Level 1 Tags	
G704 L1	§484.75(b) Standard: Responsibilities of skilled professionals Skilled professionals must assume responsibility for, but not be restricted to, the following:
G706 L1	§484.75(b)(1) Ongoing interdisciplinary assessment of the patient;
G708 L1	§484.75(b) 2) Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s);

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

G710 L1	§484.75(b)(3) Providing services that are ordered by the physician as indicated in the plan of care;
G712 L1	§484.75(b)(4) Patient, caregiver, and family counseling;
G714 L1	§484.75(b)(5) Patient and caregiver education;
G716 L1	§484.75(b)(6) Preparing clinical notes;
G718 L1	§484.75(b)(7) Communication with all physicians involved in the plan of care and other health care practitioners (as appropriate) related to the current plan of care;
Skilled professional services Level 2 Tags	
G724 L2	§484.75(c) Standard: Supervision of skilled professional assistants.
G726 L2	§484.75(c)(1) Nursing services are provided under the supervision of a registered nurse that meets the requirements of §484.115(k).
G728 L2	§484.75(c)(2) Rehabilitative therapy services are provided under the supervision of an occupational therapist or physical therapist that meets the requirements of §484.115(f) or (h), respectively.
G730 L2	§484.75(c)(3) Medical social services are provided under the supervision of a social worker that meets the requirements of §484.115(m).
§484.80 Condition of participation: Home health aide services	
Home health aide services Level 1 Tags	
G798 L1	§484.80(g) Standard: Home health aide assignments and duties §484.80(g)(l) 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).
G808 L1	§484.80(h)(1)(i) 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 onsite 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.
Home health aide services Level 2 Tags	
G768	§484.80(c) Standard: Competency evaluation.

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

L2	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) 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), (iii), (ix), (x), and (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. §484.80(c)(2) A 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) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate.
G774 L2	§484.80(d) Standard: In-service training. A home health aide must receive at least l2 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient.
G800 L2	§484.80(g) (2) A home health aide provides services that are: (i) Ordered by the physician; (ii) Included in the plan of care; (iii) Permitted to be performed under state law; and (iv) Consistent with the home health aide training.
G802 L2	§484.80(g)(3) The duties of a home health aide include: (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications ordinarily self-administered.
G814 L2	§484.80(h)(2) 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.
G820 L2	§484.80(h)(5) If the home health agency chooses to provide home health aide services under arrangements, as defined in section 1861(w)(1) of the Act, the HHA's responsibilities also include, but are not limited to: (i) Ensuring the overall quality of care provided by an aide; (ii) Supervising aide services as described in paragraphs (h)(l) and (2) of this section; and (iii) Ensuring that home health aides who provide services under arrangement have met the training or competency evaluation requirements, or both, of this part.

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

§484.100 Compliance with Federal, State, and local laws and regulations	
Compliance with Federal, State, and local laws and regulations related to the health and safety of patients Level 2 Tag	
G860 L2	§484.100(b) Standard: Licensing The HHA, its branches, and all persons furnishing services to patients must be licensed, certified, or registered, as applicable, in accordance with the state licensing authority as meeting those requirements.
§484.105 Organization and administration of services.	
Organization and administration of services Level 1 Tags	
G944 L1	§484.105 (b) Standard: Administrator. §484.105(b)(1) The administrator must:
G946 L1	§484.105(b)(1)(i) Be appointed by and report to the governing body;
G948 L1	§484.105(b)(1)(ii) Be responsible for all day-to-day operations of the HHA;
G950 L1	§484.105(b)(1)(iii) Ensure that a clinical manager as described in paragraph (c) of this section is available during all operating hours;
G984 L1	§484.105(f)(2) All HHA services must be provided in accordance with current clinical practice guidelines and accepted professional standards of practice.
Organization and administration of services Level 2 Tags	
G954 L2	§484.105(b)(2) 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.
G956 L2	§484.105(b)(3) The administrator or a pre-designated person is available during all operating hours.
G958 L2	§484.105(c) Standard: Clinical manager One or more qualified individuals must provide oversight of all patient care services and personnel. Oversight must include the following--
G960 L2	§484.105(c)(1) Making patient and personnel assignments,
G962 L2	§484.105(c)(2) Coordinating patient care,

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

G964 L2	§484.105(c)(3) Coordinating referrals,
G966 L2	§484.105(c) (4) Assuring that patient needs are continually assessed, and
G968 L2	§484.105(c)(5) Assuring the development, implementation, and updates of the individualized plan of care.
§484.110 Clinical records.	
Clinical Records Level 1 Tags	
G1010 L1	§484.110 (a) Standard: Contents of clinical record. The record must include:
G1012 L1	§484.110(a)(1) 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;
G1014 L1	§484.110(a)(2) All interventions, including medication administration, treatments, and services, and responses to those interventions;
G1016 L1	§484.110(a)(3) Goals in the patient's plans of care and the patient's progress toward achieving them;
Clinical Records Level 2 Tag	
G1028 L2	§484.110(d) 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 protected health information set out at 45 CFR parts 160 and 164.

Table 3 suggests the related CoPs that may be considered for further investigation when indicated by the findings when a CoP is out of compliance. A CoP may be considered out of compliance for one or more deficiencies and cited at the condition-level, if, in a surveyor's judgment, the deficiency constitutes a significant or a serious finding that adversely affects, or has the potential to adversely affect, patient outcomes. Surveyors are to use their professional judgment in their assessment of an HHA's compliance with the CoPs.

Table 3: Related CoPs Associated with the Eight Condition Level 1 and 2 Tags Noncompliance

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

Condition of participation out of Compliance	Related Conditions for Further Investigation
§484.50 Patient Rights	CoP 484.60: Care planning, Coordination of Services, and Quality of Care CoP 484.75: Skilled Professional Services CoP 484.100: Compliance with Federal, State & Local Laws CoP 484.105: Organization and Administration of Services
§484.55 Comprehensive Assessment Of Patients	CoP 484.60 Care planning, Coordination of Services, and Quality of Care CoP 484.65 Quality assessment and performance improvement CoP 484.75 Skilled Professional Services CoP 484.105 Organization and Administration of Services CoP 484.70 Infection Prevention and Control
§484.60 Care planning, coordination of services, and quality of care.	CoP 484.55: Comprehensive Assessment of Patients CoP 484.65 Quality assessment and performance improvement CoP 484.75: Skilled Professional Services CoP 484.80 Home Health Aide Services CoP 484.105 Organization, Services and Administration CoP 484.110 Clinical Records
§484.75 Skilled Professional Services	CoP 484.55 Comprehensive Assessment of Patients CoP 484.60 Care planning, Coordination of Services, and Quality of Care CoP 484.65 Quality assessment and performance improvement CoP 484.70 Infection Prevention and Control CoP 484.80: Home Health Aide Services CoP 484.100 Compliance with Fed. State, & local laws and regulations related to health and safety of pts. CoP 484.105 Organization, Services and Administration CoP 484.110 Clinical Records
§484.80 Home Health Aide Services	CoP 484.50 Patient Rights CoP 484.55: Comprehensive Assessment of Patients CoP 484.60 Care planning, Coordination of Services, and Quality of Care CoP 484.70 Infection Prevention and Control CoP 484.75: Skilled Professional Services CoP 484.100 Compliance with Fed. State, & local laws and regulations related to health and safety of pts. CoP 484.105 Organization, Services and Administration CoP 484.48: Clinical Records

Attachment B: Revisions to the Level 1 and Level 2 HHA Standard Survey Tags for the updated Conditions of Participation (revised 1-16-18)

Condition of participation out of Compliance	Related Conditions for Further Investigation
§484.105 Organization and Administration of Services	CoP 484.50 Patient Rights CoP 484.55 Comprehensive Assessment of Patients CoP 484.60 Care planning, Coordination of Services, and Quality of Care CoP 484.65 Quality assessment and performance improvement CoP 484.70 Infection Prevention and Control CoP 484.75: Skilled Professional Services CoP 484.100 Compliance with Fed. State, & local laws and regulations related to health and safety of pts. CoP 484.110 Clinical Records
§484.110 Clinical Records.	CoP 484.45: Reporting OASIS Information CoP 484.55: Comprehensive Assessment of Patients CoP 484.60 Care planning, Coordination of Services, and Quality of Care CoP 484.75: Skilled Professional Services CoP 484.100 Compliance with Fed. State, & local laws and regulations related to health and safety of pts. CoP 484.105 Organization, Services and Administration

CALIFORNIA DEPARTMENT OF PUBLIC HEALTH PROCESS OF INITIAL ACCREDITATION

[HOME HEALTH ACCREDITATION]

FOR PROVIDERS. BY PROVIDERS.™

For providers who have NOT submitted an initial licensure application to become a Home Health agency with the CDPH.

STEP ONE — PROVIDER SHOULD:

- ☐ Obtain Accreditation Commission for Health Care (ACHC) Home Health Accreditation Standards through Customer Central at cc.achc.org
- ☐ Review ACHC Accreditation Standards and begin compiling policies and procedures
- ☐ Obtain the California regulations for home health agencies by contacting the California Department of Public Health (CDPH)

STEP TWO — PROVIDER SHOULD:

- ☐ Submit a completed ACHC accreditation application
- ☐ Submit a $1,500 deposit
- ☐ Review and sign the ACHC Agreement for Accreditation Services and Business Associate Agreement

STEP THREE — PROVIDER SHOULD:

- ☐ File an application and any additional documentation required with the Central Applications Unit (CAU) of the CDPH and include a cover letter indicating that you intend to hire ACHC as your accreditor

STEP FOUR — CDPH SHOULD:

- ☐ When CAU determines that your licensure application packet is complete, you will receive an application approval letter
    - A copy of this letter will be sent to ACHC by CAU
    - A copy of this letter along with completed application will be sent to the District Office (DO)

Step five — Provider should:

- ☐ Contact ACHC to schedule your initial survey and verify that ACHC has received a copy of the letter from CAU

If any of the above steps are not completed, the second survey will not be conducted.

STEP SIX — ACHC SHOULD:

- ☐ Schedule and conduct a 1-day announced licensure survey
- ☐ Notify your agency and CDPH of its final accreditation decision in writing
- ☐ Once an approval decision is received, your agency will be granted accreditation for one year

STEP SEVEN — CDPH SHOULD:

- ☐ Issue a home health agency provisional license

STEP EIGHT — FOR INITIAL MEDICARE CERTIFICATION, PROVIDER SHOULD:

- ☐ Submit an 855A application to CMS
- ☐ Start developing patient caseload
- ☐ Obtain approval letter for the 855A application and submit copy of approval letter to ACHC
- ☐ Successfully complete an Outcome and Assessment Information Set (OASIS) test transmission, and submit a copy of your Final Validation Report to ACHC
- ☐ Acquire minimum patient caseload: 10 patients served, 7 patients active at time of Initial Medicare Certification survey
- ☐ Provide a minimum of 2 services, one being Skilled Nursing (SN) and one that is offered by a W-2 employee
- ☐ Inform ACHC in writing when all of the above are complete

STEP NINE — FOR INITIAL MEDICARE CERTIFICATION, ACHC SHOULD:

- ☐ Create a second ACHC Agreement for Accreditation Services and send to your agency for approval
- ☐ Schedule and conduct an unannounced Initial Medicare Certification survey
- ☐ Once an approval decision is received, your agency will be granted accreditation for three years
- ☐ Notify your agency, CDPH, and CMS of its accreditation decision in writing (CMS will make the decision of granting deemed status after receiving a report from ACHC)

For providers who have submitted an initial licensure application to become a Home Health agency with the CDPH but have NOT received an approval letter.

STEP ONE — PROVIDER SHOULD:

- ☐ Obtain Accreditation Commission for Health Care (ACHC)Home Health Accreditation Standards through Customer Central at cc.achc.org
- ☐ Review ACHC Accreditation Standards and begin compiling policies and procedures
- ☐ Obtain the California regulations for home health agencies by contacting the California Department of Public Health (CDPH)

STEP TWO — PROVIDER SHOULD:

- ☐ Submit a completed ACHC accreditation application
- ☐ Submit a $1,500 deposit
- ☐ Review and sign the ACHC Agreement for Accreditation Services and Business Associate Agreement

STEP THREE — PROVIDER SHOULD:

- ☐ Submit a letter to Central Applications Unit (CAU) indicating you intend to hire ACHC as your accreditor

STEP FOUR — CDPH SHOULD:

- ☐ When CAU determines that your application packet is complete, you will receive an application approval letter
    - o A copy of this letter will be sent to ACHC by CAU
    - o A copy of this letter along with completed application will be sent to the District Office (DO)

STEP FIVE — Provider should:

- ☐ Contact ACHC to schedule your initial survey and verify that ACHC has received a copy of the letter from CAU

Step SIX— ACHC should:

- ☐ Schedule and conduct a 1-day announced licensure survey
- ☐ Notify your agency and CDPH of its final accreditation decision in writing
- ☐ Once an approval decision is received, your agency will be granted accreditation for one year

STEP SEVEN— CDPH SHOULD:

- ☐ Issue a home health agency provisional license

STEP EIGHT — FOR INITIAL MEDICARE CERTIFICATION, PROVIDER SHOULD:

- ☐ Submit an 855A application to CMS
- ☐ Start developing patient caseload
- ☐ Obtain approval letter for the 855A application and submit copy of approval letter to ACHC
- ☐ Successfully complete an Outcome and Assessment Information Set (OASIS) test transmission, and submit a copy of your Final Validation Report to ACHC
- ☐ Acquire minimum patient caseload: 10 patients served, 7 patients active at time of Initial Medicare Certification survey
- ☐ Provide a minimum of 2 services, one being Skilled Nursing (SN) and one that is offered by a W-2 employee
- ☐ Inform ACHC in writing when all of the above are complete

STEP EIGHT —FOR INITIAL MEDICARE CERTIFICATION, ACHC SHOULD:

- ☐ Create a second ACHC Agreement for Accreditation Services and send to your agency for approval
- ☐ Schedule and conduct an unannounced Initial Medicare Certification survey
- ☐ Once an approval decision is received, your agency will be granted accreditation for three years
- ☐ Notify your agency, CDPH, and CMS of its accreditation decision in writing (CMS will make the decision of granting deemed status)

If any of the above steps are not completed, the second survey will not be conducted.

For providers who have had their application approved (approval letter has been issued) and the Home Health agency is awaiting licensure survey from the CDPH District Office (DO)

FOR PROVIDERS. BY PROVIDERS.™

STEP ONE — PROVIDER SHOULD:

- ☐ Obtain Accreditation Commission for Health Care (ACHC)Home Health Accreditation Standards through Customer Central at cc.achc.org
- ☐ Review ACHC Accreditation Standards and begin compiling policies and procedures
- ☐ Obtain the California regulations for home health agencies by contacting the California Department of Public Health (CDPH)

STEP TWO — PROVIDER SHOULD:

- ☐ Submit a completed ACHC accreditation application
- ☐ Submit a $1,500 deposit
- ☐ Review and sign the ACHC Agreement for Accreditation Services and Business Associate Agreement

STEP THREE — PROVIDER SHOULD:

- ☐ Submit a letter to Central Applications Unit (CAU) indicating you intend to hire ACHC as your accreditor

STEP FOUR — CDPH SHOULD:

- ☐ CDPH will send an acknowledgement letter to your agency and ACHC

STEP FIVE — Provider should:

- ☐ Contact ACHC to schedule their initial survey and verify that ACHC has received a copy of the letter from CAU

Step SIX— ACHC should:

- ☐ Schedule and conduct a 1-day announced licensure survey
- ☐ Notify your agency and CDPH of its final accreditation decision in writing
- ☐ Once an approval decision is received, your agency will be granted accreditation for one year

STEP SEVEN— CDPH SHOULD:

- ☐ Issue a home health agency provisional license

STEP EIGHT — FOR INITIAL MEDICARE CERTIFICATION, PROVIDER SHOULD:

- ☐ Submit an 855A application to CMS
- ☐ Start developing patient caseload
- ☐ Obtain approval letter for the 855A application and submit copy of approval letter to ACHC
- ☐ Successfully complete an Outcome and Assessment Information Set (OASIS) test transmission, and submit a copy of your Final Validation Report to ACHC
- ☐ Acquire minimum patient caseload: 10 patients served, 7 patients active at time of Initial Medicare Certification survey
- ☐ Provide a minimum of 2 services, one being Skilled Nursing (SN) and one that is offered by a W-2 employee
- ☐ Inform ACHC in writing when all of the above are complete

STEP EIGHT —FOR INITIAL MEDICARE CERTIFICATION ACHC SHOULD:

- ☐ Create a second ACHC Agreement for Accreditation Services and send to your agency for approval
- ☐ Schedule and conduct an unannounced Initial Medicare Certification survey
- ☐ Once an approval decision is received, your agency will be granted accreditation for three years
- ☐ Notify your agency, CDPH, and CMS of its accreditation decision in writing (CMS will make the decision in writing (CMS will make the decision of granting deemed status)

If any of the above steps are not completed, the second survey will not be conducted.

CALIFORNIA LICENSURE SURVEY PREP

HOME HEALTH

FOR PROVIDERS. BY PROVIDERS.™

This information is intended to provide an abbreviated version of the California licensure requirements in preparation for an ACHC licensure survey. For a complete listing of the regulations, visit **leginfo.legislature.ca.gov**.

All policies must be available for the Surveyor to review once they arrive on site. Please flag the identified policies for review.

POLICIES AND PROCEDURES

- ☐ Written policies and procedures, per California requirement 1727.5(F), describe the purchase, storage, furnishing, and transportation of legend devices, including:
  - → Legend devices are reviewed annually by a group of professional personnel, including a physician and surgeon, Pharmacist, and Registered Nurse
  - → A legend device is defined as any device that bears the label "Caution: federal law restricts this device to sale by or on the order of a ____" (or words of similar meaning)

- ☐ Written policies and procedures, per California requirement 74709, describe the circumstances under which the HHA requires on-site supervisory visits to be conducted jointly with the Home Health Aide present.

- ☐ Written policies and procedures, per California requirement 74731, describe the retention, retrieval, and security for off-site centralized storage of inactive patient records.

- ☐ Written policies and procedures are established in regard to the Compliance Program detailing what actions the organization takes to prevent fraud and abuse to include, at a minimum:
  - → Implementation of written policies, procedures, and standards of conduct
  - → Designation of a Compliance Officer and Compliance Committee
  - → Conducting effective training and education programs
  - → Development of open lines of communication between the Compliance Officer and/or Compliance Committee and HHA personnel for receiving complaints and protecting callers from retaliation
  - → Performance of internal audits to monitor compliance
  - → Establishing and publicizing disciplinary guidelines for failing to comply with policies and procedures, applicable statutes, and regulations
  - → Prompt response to detected offenses through corrective action

- ☐ Written policies and procedures are consistent with HIPAA standards to include, at a minimum:
  - → Conditions for release of information
  - → Backup procedures that include, but are not limited to:
    - Electronic transmission procedures
    - Storage of backup disks and tapes
    - Methods to replace information if necessary
  - → A description of the protection and access of computerized records and information
  - → Personnel authorized to enter information and review the records
  - → Who can have access to patient records
  - → Retention of records even if the agency discontinues operations and must inform the state agency where clinical records will be maintained

OBSERVATION

☐ The organization is an established entity and has the appropriate Articles of Incorporation or other documentation of legal authority.

☐ The organization must disclose the following information at the time of its initial request for licensure, at the time of each survey, and at the time of any change in ownership per California requirement 74665:

- → The name and address of each person with an ownership or control interest of five percent or greater in the HHA
- → The name and address of each person who is an officer, a director, an agent, or a managing employee of the HHA
- → The name and address of the person, corporation, association, or other company that is responsible for the management of the home health agency, and the name and address of the chief executive officer and the chairman of the Board of Directors of the corporation, association, or other company responsible for the management of the HHA
- → If any person described above has served or currently serves as: an Administrator, general partner, trustee or trust applicant, or sole proprietor, or if any applicant or licensee is a sole proprietorship, executor, or corporate officer or director of, or has held a beneficial ownership interest of five percent or more in any other home health agency, health facility, clinic, hospice, Pediatric Day Health and Respite Care Facility, Adult Day Health Care Center, or any facility licensed by the Department of Social Services, then the applicant shall disclose the relationship to the Department, including the name and current or last address of the facility and the date such relationship commenced and, if applicable, the date it was terminated

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☐ The Administrator organizes and directs the HHA's ongoing functions and maintains ongoing liaison among the governing body/owner and the personnel including, at minimum:

- → Is responsible for all day-to-day operations of the HHA
- → Ensures that a clinical manager as described in 42 CFR 484.105(c) is available during all operating hours
- → Ensures that the HHA employs qualified personnel, including ensuring the development of personnel qualifications and policies
- → When the Administrator is not available, a qualified, pre-designated person, who is authorized in writing by the Administrator and the governing body, assumes the same responsibilities and obligations as the Administrator. The pre-designated person may be the clinical manager as described in 42 CFR 484.105(c)
- → The Administrator or a pre-designated person is available during all operating hours
- → A supervising physician or Director of Patient Care Services may also be the Administrator. An Administrator who is neither a physician nor a Registered Nurse shall have training and experience in health service administration and at least one year of supervisory experience in home health care or health-related programs per California requirement 74718

☐ The HHA has a standardized form used to report adverse events, incidents, accidents, variances, or unusual occurrences that involve patient care and develop a plan of correction to prevent the same or similar event from occurring again.

☐ The organization has a job description for the Home Health Aide that includes, but is not limited to:

- → The provision of hands-on care
- → The performance of simple procedures as an extension of therapy or nursing services
- → Assistance in ambulation or exercises
- → Assistance in administering medications ordinarily self-administered

CALIFORNIA LICENSURE SURVEY PREP

HOME HEALTH

GOVERNING BODY

- ☐ The organization must have a governing body per California requirement 74717. The governing body shall assume full legal authority and responsibility for the operation of the agency. The governing body shall ensure that the agency does not refuse service or employment to, or in any way discriminate against, any person based on sex, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, or registered domestic partner status.

- ☐ There is a description of the governing body that includes name, address, and telephone number for each member.

- ☐ There is evidence the governing body members receive an orientation to their responsibilities that includes:
  - → Organizational structure
  - → Confidentiality practices and signing of a confidentiality agreement
  - → Review of the HHA's values, mission, and/or goals
  - → Overview of programs, operational plans, services, and initiatives
  - → Personnel and patient grievance policies and procedures
  - → Responsibility for the Quality Assessment and Performance Improvement (QAPI) Program
  - → Organizational ethics
  - → Conflicts of interest

PERSONNEL RECORDS

- ☐ The organization may have an Administrator who is neither a physician nor Registered Nurse, but has training and experience in health service administration and at least one year of supervisory experience in home health care or health-related programs per California requirement 74718.

- ☐ The Director of Patient Care Services per California regulation 74703 shall qualify for the position by fulfilling the requirements under one of the following categories, unless the individual has been previously approved for such employment by a program flexibility issued for the individual's current position at the home health agency prior to April 1, 1995:
  - → A Registered Nurse with a baccalaureate or higher degree in nursing or other health-related field with three years of experience within the last five years in a home health agency, primary care clinic, or health facility, at least one year of which was in a supervisory or administrative capacity; or
  - → An Registered Nurse with four years' experience within the last five years in a home health agency, primary care clinic or health facility, at least one year of which was in a supervisory or administrative capacity

- ☐ The Director of Patient Care Services shall have sufficient background knowledge and expertise in clinical decision-making for the patient population of the home health agency to meet the needs of his or her patients, and to contribute to Quality Management review and evaluation per California requirement 74703.

- ☐ The Nurse Supervisor per California regulation 74705 shall be a Registered Nurse with two years' experience within the last five years in a home health agency, primary care clinic, or health facility, unless the individual has been previously approved for such employment by a program flexibility issued for the individual's current position at the home health agency prior to April 1, 1995. A Nurse Supervisor shall have sufficient background knowledge and

expertise in clinical decision-making for the patient population assigned to him or her in the home health agency to meet the needs of his or her patients and to contribute to Quality Management review and evaluation.

☐ The Clinical Manager meets the following criteria:
- → A minimum of two years of home care experience and at least once year of supervisory experience is required with sufficient education and experience in the scope of services offered

☐ The agency has performed background checks to include:
- → Office of Inspector General (OIG) exclusion list
- → Criminal record
- → National sex offender registry (only needed for personnel providing direct patient care)

☐ The HHA personnel files contain evidence of state and federal criminal background checks for all Home Health Aides, personnel care aides, LPNs, CNAs, OTAs, PTAs, and RNs per Welfare and Institutions Code Sec. 12301.6, 12305.81, & Sec. 15660. In addition:
- → The following persons shall submit to the State Department of Public Health an application and shall submit electronic fingerprint images to the Department of Justice for the furnishing of the person's criminal record to the state department, at the person's expense as provided in subdivision (b), for the purpose of a criminal record review:
  - The owner or owners of a private agency if the owners are individuals
  - If the owner of a private agency is a corporation, partnership, or association, any person having a 10 percent or greater interest in that corporation, partnership, or association
  - The Administrator of a home health agency
- → When the conditions set forth in paragraph (3) of subdivision (a) of Section 1265.5, subparagraph (A) of paragraph (1) of subdivision (a) of Section 1338.5, and paragraph (1) of subdivision (a) of Section 1736.6 are met, the licensing and certification program shall issue an All Facilities Letter (AFL) informing facility licensees. After the AFL is issued, facilities must not allow newly hired Administrators, program directors, and fiscal officers to have direct contact with clients or residents of the facility prior to completion of the criminal record clearance. A criminal record clearance shall be complete when the department has obtained the person's criminal offender record information search response from the Department of Justice and has determined that the person is not disqualified from engaging in the activity for which clearance is required

STAFF INTERVIEW QUESTIONS

☐ All staff are able to discuss how the HHA receives, reports, and resolves any patient grievances.

☐ The Administrator and Director of Nursing (DON) are aware of the procedure to prevent hiring an individual with a criminal background.

MOCK-UP CLINICAL RECORD/PATIENT ADMISSION INFORMATION

☐ Patient admission packet to include, at minimum:
- → Consent
- → Advance Directives
- → Patient confidentiality
- → Patient charges

- → Consent to release information not authorized by law
- → Patient Education Materials
- → Patient Rights and Responsibilities statement

☐ The Patient Rights and Responsibilities statement includes the ACHC requirements per ACHC Standard HH2-2A.

The identified policies will be reviewed on site to ensure compliance with ACHC Standards.
Compliance with all Medicare CoPs and ACHC Home Health Standards is required for a Medicare certification survey.