ACCREDITATION UNIVERSITY

ACHIEVING ACHC ACCREDITATION

APRIL 2018

HOME HEALTH

AccreditationUniversity.com

ACCREDITATION COMMISSION *for* HEALTH CARE

ACCREDITATION UNIVERSITY

HOME HEALTH

ACHIEVING ACHC ACCREDITATION

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- Accreditation University (AU) is dedicated to your organization's success
- Learn more about AU at AccreditationUniversity.com or talk with a representative today

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HOME HEALTH

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HOME HEALTH

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HOME HEALTH

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ACHIEVING ACHC ACCREDITATION

OBJECTIVES

- Review the ACHC Accreditation Process
- Learn how to prepare an organization for the ACHC Accreditation Survey
- Establish expectations for on-site survey and strategies for survey success
- Learn how to utilize the *ACHC Accreditation Guide to Success* workbook to ensure ongoing compliance
- Identify how to avoid condition-level deficiencies
- Review the ACHC Accreditation Standards to understand expectations for compliance

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

CALIFORNIA LICENSURE

- 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)

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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 LICENSURE 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

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INITIAL MEDICARE CERTIFICATION

- Complete and submit an 855A application to 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 W-2 employees
- Notify ACHC in writing when all of the requirements have been completed

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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

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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

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

ABOUT ACHC

- Nationally recognized accreditation organization (AO) with over 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

ACHC MISSION & VALUES

Our Mission

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

Our Values

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

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ACHC PROGRAMS & SERVICES

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

HOSPICE
Hospice Inpatient Care
Hospice Care

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

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

SLEEP
Sleep Lab/Center
Home Sleep Testing

AMBULATORY CARE
Convenient Care Clinics

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

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

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

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

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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

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CONSULTATIVE SURVEY APPROACH

- ACHC values drive the survey approach
  - Consultative but not consultants
  - Flexibility without compromise
  - Consistency in interpretation of requirements
  - Accuracy in reporting findings/observations
  - Offering organizations the opportunity to clarify or correct deficiencies

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CUSTOMER SATISFACTION

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

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

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

– HOME HEALTH PROVIDER, KENNETT SQUARE, PA

98% of our customers would recommend ACHC.

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

– HOME HEALTH PROVIDER, GRAFTON, NC

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

WE VALUE YOUR FEEDBACK

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

SURVEYOR EXPERTISE

- Surveyor knowledge and expertise drive both the experience and the quality of the survey
- Surveyor success is driven by ACHC processes and tools
  - Surveyor Training
  - Surveyor Annual Evaluations
  - Surveyor Satisfaction Surveys

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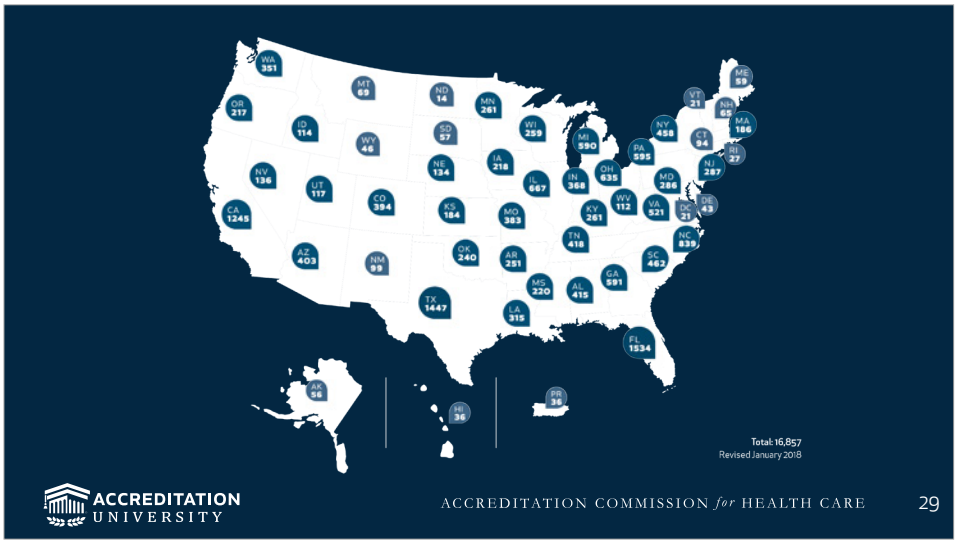
PERSONAL ACCOUNT ADVISORS

- 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



REGULATORY COMPLIANCE

- ACHC Accreditation Standards include the Medicare Conditions of Participation (CoPs)
- Creates a "Culture of Compliance"
  - Objective evaluation
  - Identify the "gaps" between practice and policy
  - Process improvement
  - Audits
  - Survey preparation

CMS EXPECTATIONS

- Expectation is that providers "remain in substantial compliance with Medicare program requirements as well as State law"
  - As defined by 42 CFR 488.705, "Substantial compliance means compliance with all condition-level requirements, as determined by CMS or the State"
- Have continued compliance, rather than cyclical compliance
- Providers take the "initiative and responsibility for continuously monitoring their own performance to sustain compliance"

HOME HEALTH ALTERNATIVE SANCTIONS

- Prior to the implementation of alternative sanctions, the only option for non-compliance was termination within 90 days
- Alternative sanctions allow agencies additional time to come into compliance
- Postponed until January 13, 2019

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WHAT ARE THE ALTERNATIVE SANCTIONS?

- Civil money penalties
- Suspension of payment for new admissions
- Temporary management
- Directed in-service
- Directed plan of correction

CIVIL MONEY PENALTIES

- Can be per day or per instance
- Per instance only if issue corrected during survey
- Cannot exceed $10,000 per day
- Cannot exceed six months in duration
- Can include concurrent suspension of payment for new admissions

FACTORS IN DETERMINING SANCTIONS

- If there are condition-level deficiencies that immediately jeopardize the health and safety of patients that the provider is unwilling or unable to correct, the Medicare agreement is terminated
- Alternative sanctions may also be imposed
- If there are condition-level deficiencies that do not involve the Immediate Jeopardy (IJ) of patients, CMS may
  - Terminate agreement and/or
  - Impose alternative sanctions

FACTORS IN DETERMINING SANCTIONS

- Immediate Jeopardy (IJ) potential
- The nature, incidence, manner, degree, and duration of the deficiencies or non-compliance
- The presence of repeat deficiencies
- The extent to which the deficiencies are directly related to a failure to provide quality patient care
- The extent to which the home health agency is part of a larger organization with performance problems
- An indication of any system-wide failure to provide quality care

SANCTIONS

- Civil Monetary Penalties imposed
  - Penalty per day for home health agency noncompliance (upper range):
    - Minimum: $16,819
    - Maximum: $19,797
  - 20 states have imposed CMPs:
    - AR, CO, CT, FL, IA, ID, IN, LA, MA, MI, MN, MO, NH, OH, OK, PA, TN, TX, UT, VA
  - Top 5 states for CMPs (based on dollar amount):
    - OH with $3.3 million
    - IN with $2.1 million
    - MI with $1.8 million
    - MO with $1.2 million
    - PA with $913,950

DEEMED STATUS

- Accrediting Organizations (AOs) do not have to impose alternative sanctions on customers with condition-level deficiencies
- Deemed status agencies remain under the jurisdiction of their AO rather than the state for oversight of their ongoing compliance with health and safety standards, unless the state conducting a **validation or complaint survey** finds evidence of serious noncompliance
  - In such cases, the agency is placed under the jurisdiction of the state agency
- Once the agency returns to compliance, the Regional Office (RO) will restore its deemed status and return oversight to the AO

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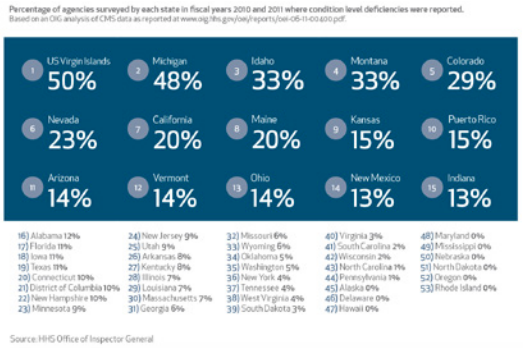
CONDITION-LEVEL DEFICIENCIES BY STATE



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CMS REPORT

- Every year, Centers for Medicare & Medicaid Services (CMS) evaluates the approved accreditation organizations on the performance of the Home Health and Hospice programs with deeming authority
  - CMS conducts validation surveys on a random sampling of accredited organizations, comparing "condition-level" deficiencies cited by the AO to ones found by the state agency
  - If the state agency finds a condition-level deficiency that was not cited by the AO, it raises the disparity rate for that AO

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BENEFITS OF ACHC'S LOW DISPARITY RATE

- Consistent and thorough survey experience
- Lower risk for alternative sanctions
- Confidence that the Medicare CoPs are being followed

	ACHC				CHAP				TJC				Total
	FY 2012	FY 2013	FY 2014	FY 2015	FY 2012	FY 2013	FY 2014	FY 2015	FY 2012	FY 2013	FY 2014	FY 2015	FYs 2012–2015
60-Day Validation Sample Surveys	25	11	23	16	50	48	28	51	27	21	24	37	361
SA Surveys with Condition-Level Deficiencies	6	3	3	3	17	11	4	8	7	1	9	12	84
AO Surveys with Missed Comparable Deficiencies	3	1	3	2	11	9	4	8	5	1	4	7	58
Disparity Rate	12%	9%	13%	13%	22%	19%	14%	16%	19%	5%	17%	19%	16%
Sampling Fraction	.09	.05	.08	.06	.05	.05	.04	.05	.04	.03	.03	.05	.05

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BECOME A PROVIDER OF CHOICE

Accreditation is a process of review that allows healthcare organizations to demonstrate their ability to meet a predetermined set of criteria and standards. It is regarded as one of the key benchmarks for measuring the quality of an organization. Preparing for accreditation will give you the opportunity to identify organizational strengths and areas for improvement.

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BECOME A PROVIDER OF CHOICE

- Differentiate your organization from other healthcare providers
- Demonstrate your commitment to quality
- Build recognition and trust among patients
- Potentially reduce liability costs

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MARKETING ADVANTAGE

- ACHC Accreditation is a noteworthy and distinguishing accomplishment that your agency should be proud to display
  - It shows the organization's dedication and adherence to a rigorous set of standards above and beyond the Medicare CoPs
  - It demonstrates a commitment to providing the highest quality of health care to those served
  - It provides assurance for key constituents: providers, payors, physicians, referral sources, and patients
  - It builds TRUST

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 ACCREDITED

ACHC ACCREDITED

ACCREDITATION COMMISSION ACHC FOR HEALTH CARE

ACHIEVING ACHC ACCREDITATION

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

October 13, 2017
Media Contact:
Contact Name
Organization Name
Contact Email
Website

YOUR ORGANIZATION NAME
ACHIEVES ACCREDITATION WITH ACHC

CITY, STATE, Your organization name proudly announces it has achieved accreditation through Accreditation Commission for Health Care (ACHC) for the services of list services.

Accreditation is a process through which 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 nonprofit organization that has stood as a symbol of quality and excellence since 1986. ACHC is ISO 9001:2015 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

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HOME HEALTH AGENCY REQUIREMENTS

- General Requirements
  - *State Operations Manual, Chapter 2, Section 2180C*
- Is primarily engaged in providing Skilled Nursing services and other therapeutic services
  - *Medicare Benefit Policy Manual Chapter 7, Section 40*
- Policies are established by a group of professionals (associated with the agency), including one or more physicians and one or more Registered Nurses to govern the services that it provides

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HOME HEALTH AGENCY REQUIREMENTS

- Provides supervision of above-mentioned services by a physician or RN
- Maintains clinical records on all patients
- Is licensed pursuant to state or local law
- Has in effect an overall plan and budget
- Meets the Medicare CoPs
- Meets additional requirements as the Secretary finds necessary

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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)**
- **These are 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

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SEPARATE ENTITIES

- **Chapter 2, The Certification Process , Section2183 - Separate Entities (Separate Lines of Business) (Rev 125, Issued: 10-31-14, Effective: 10-31-14, Implementation: 10-31-14)**
- The surveyor must be able to identify the corporate and organizational boundaries of the entity seeking certification or recertification
- The Medicare CoPs apply to the HHA as an entire entity and in accordance with §1861(o)(6) of the Act, are applicable to all individuals served by the HHA and not just to Medicare beneficiaries
- Non-Medicare clients
  - Skilled
  - Custodial

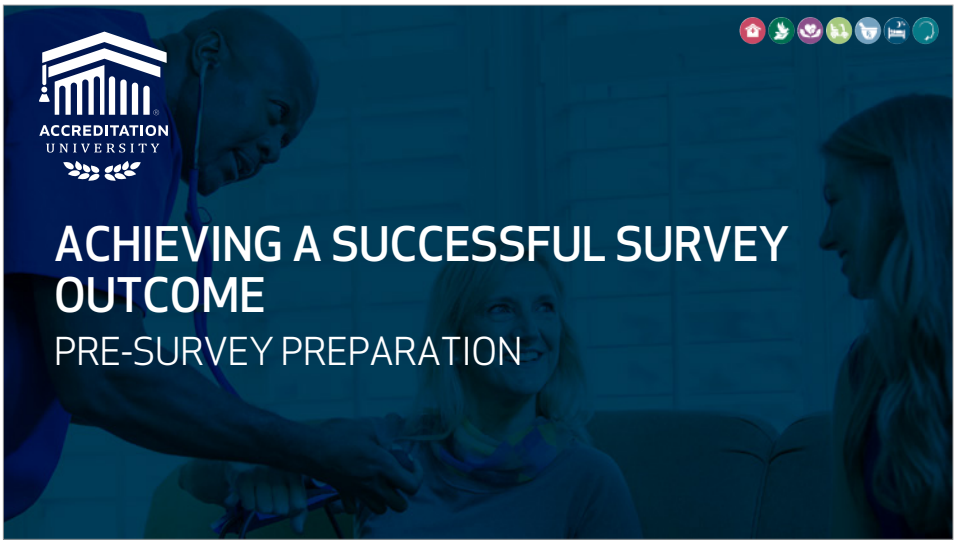
SEPARATE ENTITIES

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

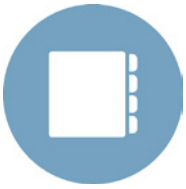
- Consumer Awareness
  - Review marketing materials for distinction between the programs
  - Written material should clearly identify the home health agency as separate and distinct from other programs, departments, or other entities of the organization
- Staff Awareness
  - Staff should be able to identify 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



ESSENTIAL MANUALS

- State Operations Manual Appendix B-Revised
- ACHC Accreditation Standards
- State Operations Manual, Chapter 2 - The Certification Process
- State licensing laws/regulations
- Agency policies and procedures
- Scope of practice for each discipline provided
- Local laws/regulations

Always follow the most stringent regulation



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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 the ACHC standards specific to services provided

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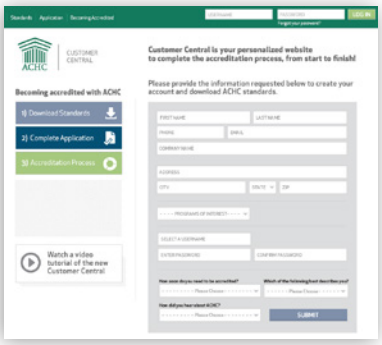
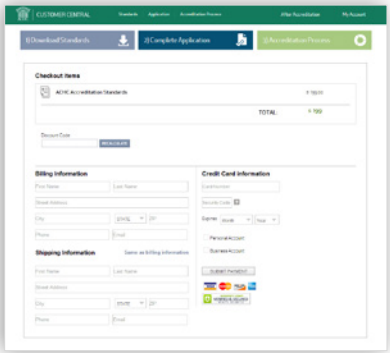
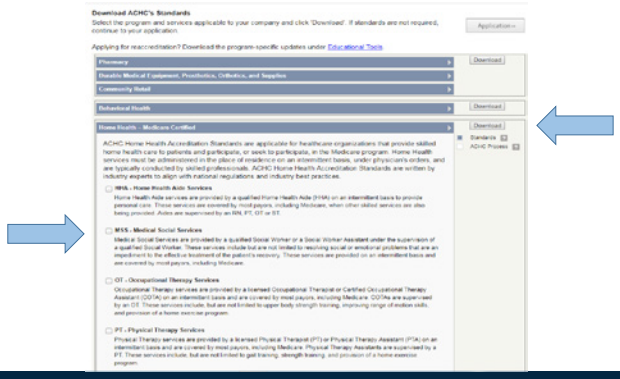
DEMOGRAPHIC INFORMATION



PURCHASE STANDARDS



DOWNLOAD STANDARDS



APPENDIX A

Appendix A: Standard Service Table for Selected Services

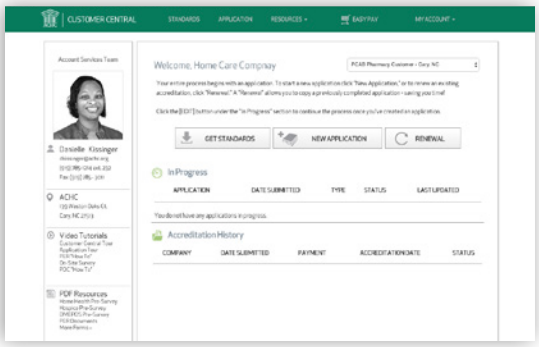
Standard	HHA	MSS	SN
HH1-1A	X	X	X
HH1-1A.01	X	X	X
HH1-1B	X	X	X
HH1-1B.01	X	X	X
HH1-1C	X	X	X
HH1-2A	X	X	X
HH1-2A.01	X	X	X
HH1-2A.02	X	X	X
HH1-2A.03	X	X	X
HH1-2A.04	X	X	X
HH1-2A.05	X	X	X
HH1-3A	X	X	X
HH1-3A.01	X	X	X
HH1-3A.02	X	X	X
HH1-3B	X	X	X
HH1-4A.01	X	X	X
HH1-5A	X	X	X
HH1-5A.01	X	X	X
HH1-5B	X	X	X
HH1-6A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

ONLINE APPLICATION



NOTES

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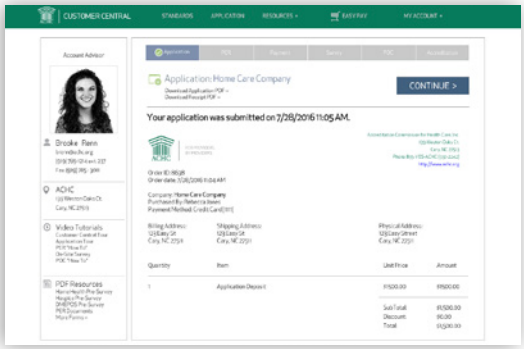
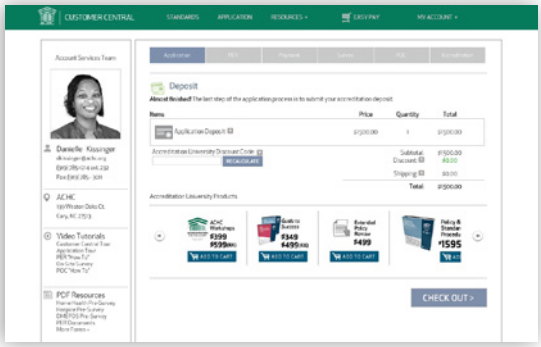
ONLINE APPLICATION

- Select "NEW APPLICATION" or "RENEWAL"
- Main office
  - Profile
  - Location
  - Contacts
  - Services
- Additional locations – branch locations, per Medicare provider number
- 10 Blackout dates
- Unduplicated admissions for past 12 months
- Identify services you want accredited
- **Renewal should complete application 6-9 months prior to expiration**

CONFIRMATION OF APPLICATION

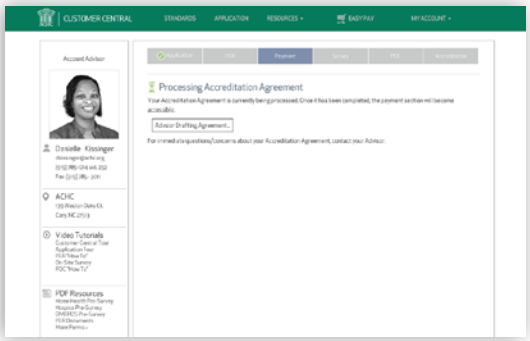


SUBMIT DEPOSIT



ACHIEVING ACHC ACCREDITATION

ACCREDITATION AGREEMENT



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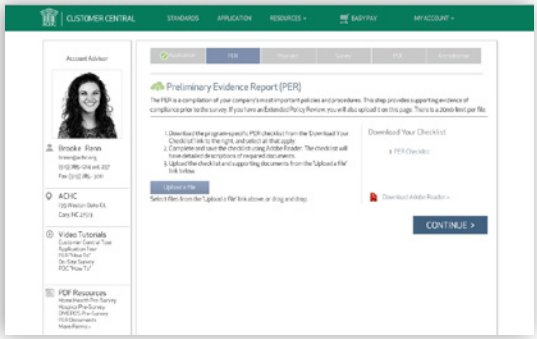
PRELIMINARY EVIDENCE REPORT (PER)



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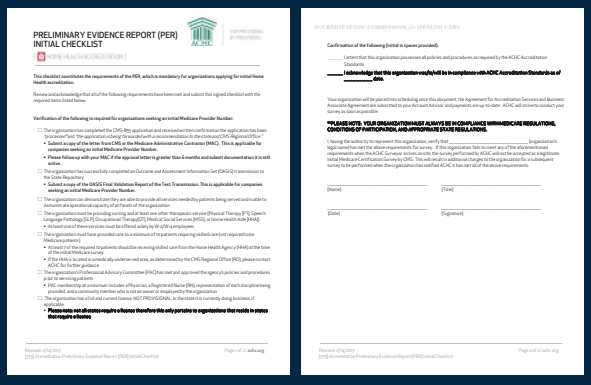
PRELIMINARY EVIDENCE REPORT CHECKLIST


PRELIMINARY EVIDENCE REPORT (PER)
INITIAL CHECKLIST

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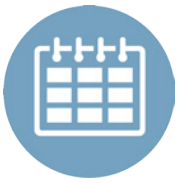
NOTES

NOTES

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

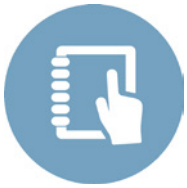


SCHEDULING

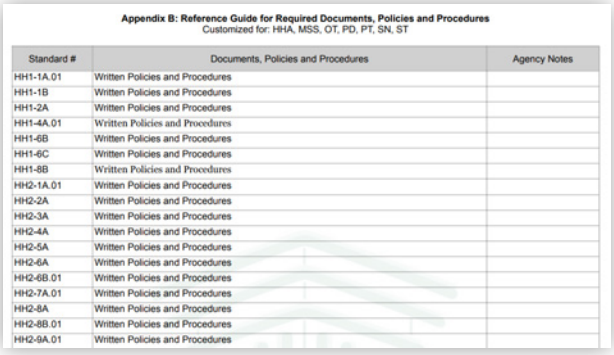
- Online application
- Deposit
- Signed Accreditation agreement
- Payment method
- Preliminary Evidence Report (PER) checklist
- Required documents in order to be placed into scheduling

EXTENDED POLICY REVIEW

- Optional review of complete policies and procedures by an ACHC Surveyor to determine compliance prior to the on-site survey
- Feedback from an ACHC Surveyor regarding the alignment of agency's policies and procedures to ACHC Accreditation Standards
- Option to purchase through the Customer Central portal
- Reference guide for required documents, and policies and procedures, available as a download
- Utilize Appendix B to organize policies



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	

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POLICY REVIEW RESULTS

- Desk Review Report will come from your Account Advisor
- 21 days to revise and re-submit all corrections to your Account Advisor
- 30-day window to prepare staff
  - Policy often reflects practice

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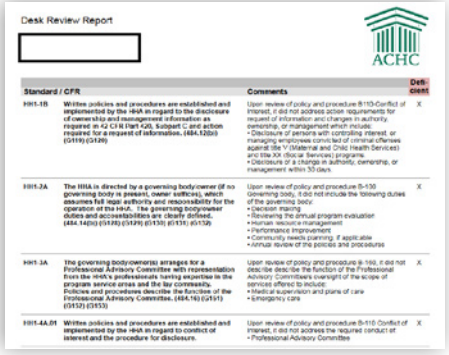
DESK REVIEW REPORT SAMPLE



Desk Review Report

ACHC

Standard / CFR		Comments	Deficient
HH1-1B	Written policies and procedures are established and implemented by the HHA in regard to the disclosure of ownership and management information as required in 42 CFR Part 420, Subpart C and action required for a request of information. (484.12(b)) (G119) (G120)	Upon review of policy and procedure B-110-Conflict of Interest, it did not address action requirements for request of information and changes in authority, ownership, or management which include: • Disclosure of persons with controlling interest, or managing employees convicted of criminal offenses against title V (Maternal and Child Health Services) and title XX (Social Services) programs. • Disclosure of a change in authority, ownership, or management within 30 days.	X
HH1-2A	The HHA is directed by a governing body/owner (if no governing body is present, owner suffices), which assumes full legal authority and responsibility for the operation of the HHA. The governing body/owner duties and accountabilities are clearly defined. (484.14(b)) (G129) (G129) (G130) (G131) (G132)	Upon review of policy and procedure B-130 Governing body, it did not include the following duties of the governing body: • Decision making • Reviewing the annual program evaluation • Human resource management • Performance improvement • Community needs planning, if applicable • Annual review of the policies and procedures	X
HH1-3A	The governing body/owner(s) arranges for a Professional Advisory Committee with representation from the HHA's professionals having expertise in the program service areas and the lay community. Policies and procedures describe the function of the Professional Advisory Committee. (484.16) (G151) (G152) (G153)	Upon review of policy and procedure B-190, it did not describe describe the function of the Professional Advisory Committee's oversight of the scope of services offered to include: • Medical supervision and plans of care • Emergency care	X
HH1-4A.01	Written policies and procedures are established and implemented by the HHA in regard to conflict of interest and the procedure for disclosure.	Upon review of policy and procedure B-110 Conflict of Interest, it did not address the required conduct of: • Professional Advisory Committee	X

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NOTES

NOTES


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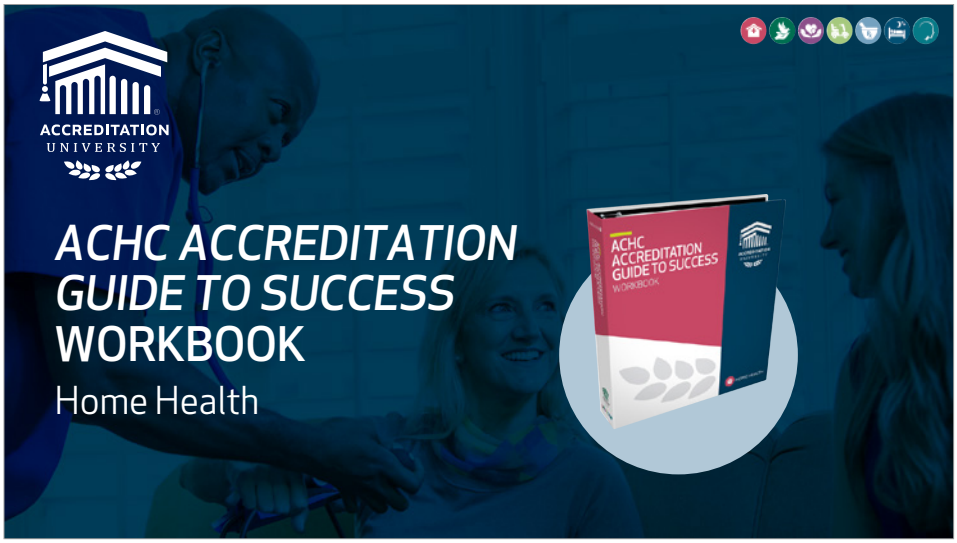
"Tell me and I'll forget;
show me and I may remember;
involve me and I'll understand."


ACCREDITATION
UNIVERSITY
TRAIN EVERYONE LAVISHLY
Thomas J. Peters
Thriving on Chaos


ACCREDITATION
UNIVERSITY
ACHC ACCREDITATION GUIDE TO SUCCESS WORKBOOK
Home Health
ACHC ACCREDITATION GUIDE TO SUCCESS
WORKBOOK

ACHIEVING ACHC ACCREDITATION

GUIDE TO SUCCESS WORKBOOK

- Survey Process
  - Items Needed
  - Interview Questions
  - Observation
  - Plan of Correction
- Sections
  - Standard
  - Essential component
  - HINT
  - Audit tool
  - Sample policies and procedures

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PREPARATION

- Educate Key Staff
  - Clinical staff (employees and contract)
  - Administrative
  - Governing body
  - Patients
- Prepare Agency
  - Human resources
  - IT/EMR
  - Office space
    - Walk around your agency

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PREPARATION

- Helpful tools in the ACHC *Accreditation Guide to Success* workbook
- Mock Surveys
  - Interviews-Survey Process
  - Home visits-Section 4
  - Medical chart audits-Section 5
  - Personnel chart audits-Section 4
  - Observation-Survey Process

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NOTES

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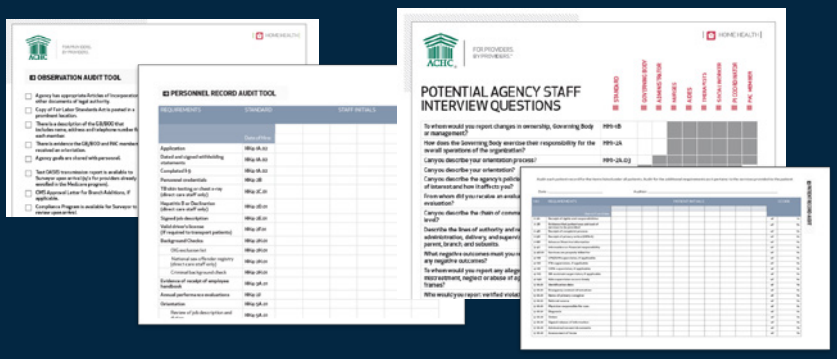
SURVEY PREPARATION TOOLS



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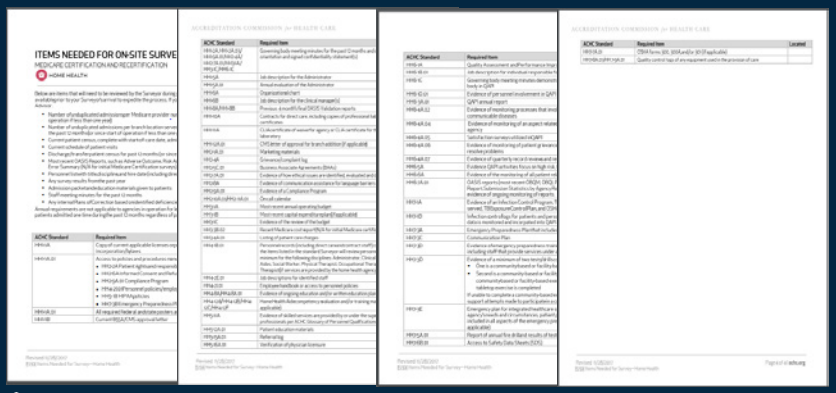
ITEMS NEEDED FOR ON-SITE SURVEY



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STANDARD- & CONDITION-LEVEL DEFICIENCIES

- Standard-level deficiencies are ACHC-only deficiencies and individual G tags
  - Not as "severe"
  - Individual, random issue vs. a systemic issue
- Condition-level deficiencies result when either an entire condition is out of compliance, multiple G tags under a single condition are out of compliance, or the deficiency is severe
  - Home Health protocols – Level 1 and Level 2 G tags

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FOCUS AREAS

- Utilize the audit tools, Compliance Checklists, and Self-Assessment to prioritize education
- Implement an internal Plan of Correction (POC)
- Share improvements with your Surveyor during survey

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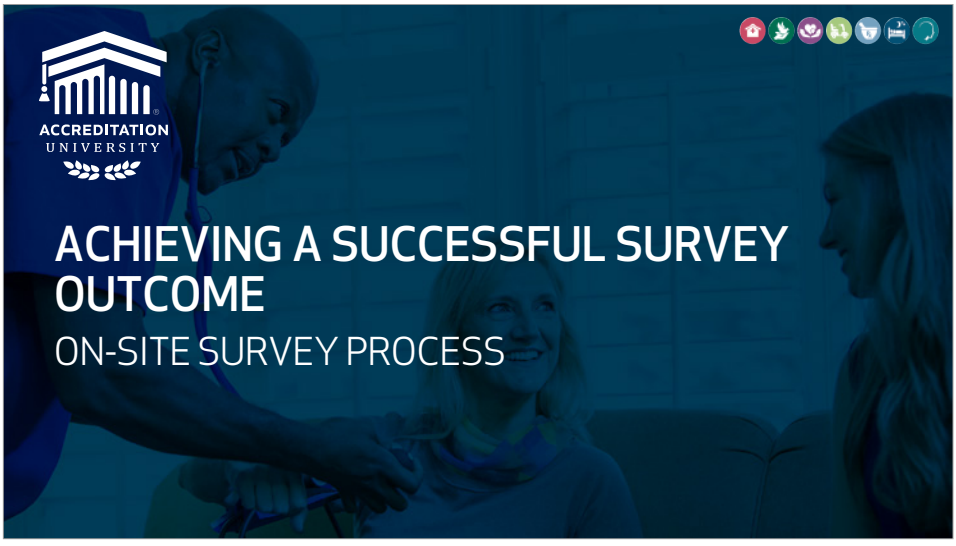
SURVEY SUCCESS

Key to survey success is compliance with the Medicare Conditions of Participation (CoPs)!



NOTES

NOTES

ROLE OF SURVEYOR

- To ensure ACHC Accreditation Standards are being followed
- Data collectors
- Documented evidence that is "readily identifiable"

ON-SITE SURVEY

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

OPENING CONFERENCE

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

TOUR

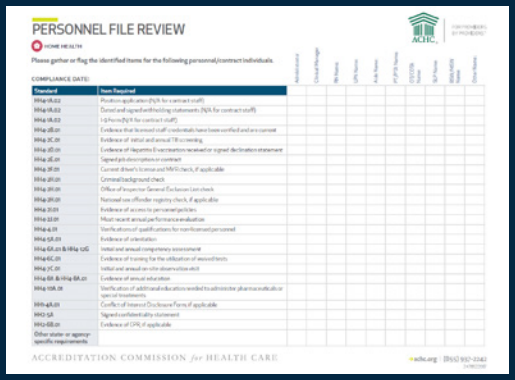
- Brief tour of facility
  - Medical record storage
  - Maintaining confidentiality of Protected Health Information (PHI)
  - Supply closet
  - Biohazard waste
  - Required posters
  - Fire extinguishers/smoke detectors/non-smoking signage
  - Restrooms

PERSONNEL FILE REVIEW

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

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

PERSONNEL FILE REVIEW


PERSONNEL FILE REVIEW

HOME HEALTH

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

COMPLIANCE DATE:

Standard	Item Required
HH4.1A.02	Position application (N/A for contract staff)
HH4.1A.02	Dated and signed withholding statements (N/A for contract staff)
HH4.1B.02	I-9 Forms (N/A for contract staff)
HH4.2B.01	Evidence that licensed staff credentials have been verified and are current
HH4.3C.01	Evidence of initial and annual TB screening
HH4.3D.01	Evidence of Hepatitis B vaccination received or signed declination statement
HH4.3E.01	Signed job descriptions or contract
HH4.3F.01	Current driver's license and MVR check, if applicable
HH4.3H.01	Criminal background check
HH4.3H.01	Office of Inspector General Exclusion List check
HH4.3H.01	National sex offender registry check, if applicable
HH4.3I.01	Evidence of access to personnel policies
HH4.3J.01	Most recent annual performance evaluation
HH4.4.01	Verification of qualifications for non-licensed personnel
HH4.5A.01	Evidence of orientation
HH4.6A.01 & HH4.10G	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
HH4A.01	Conflict of Interest Disclosure Form, if applicable
HH2-5A	Signed confidentiality statement
HH2-5B.01	Evidence of CPR, if applicable
Other state- or agency-specific requirements	

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NOTES

NOTES

MEDICAL CHART REVIEWS

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

HOME VISITS

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

RECORD REVIEW/HOME VISITS

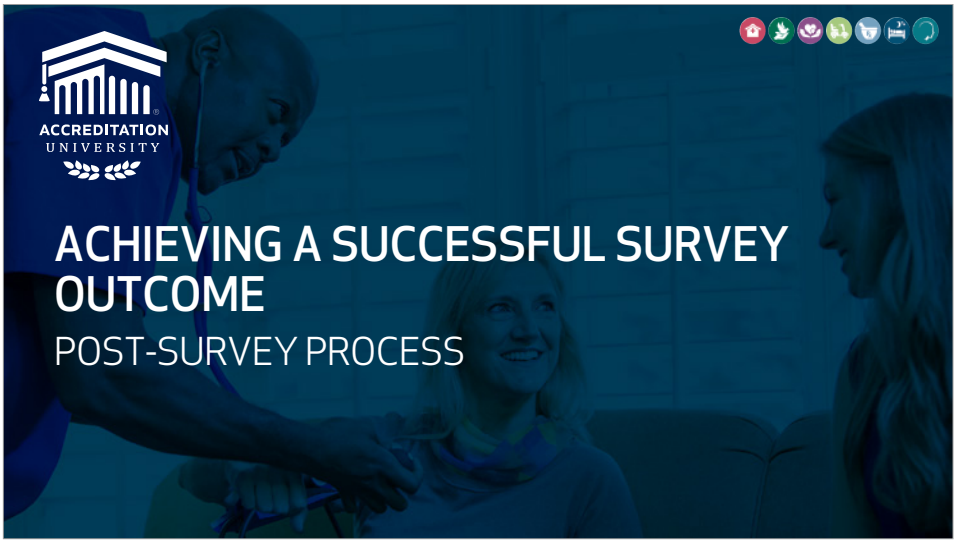
Unduplicated Admissions	Minimum # of Active Record Reviews Without Home Visits	Minimum # of Record Reviews With Home Visits	Minimum # of Closed Record Reviews	Total Record Reviews
300 or less	2	3	2	7
301-500	3	4	3	10
501-700	4	5	4	13
701 or greater	5	7	5	17

CORRECTED ON SITE

- ACHC only/non-CoP 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

EXIT CONFERENCE

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



NOTES

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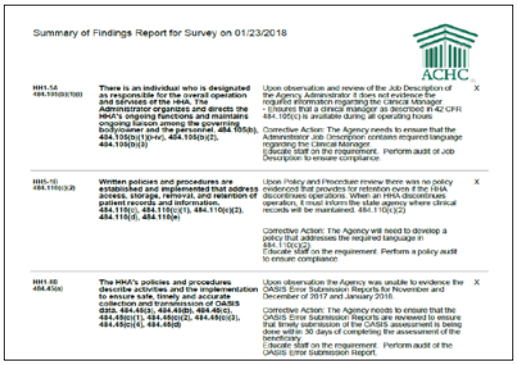
POST-SURVEY PROCESS

- ACHC Accreditation Review Committee examines all the data
- Accreditation decision is determined based primarily on CoP/G tag deficiencies
- Summary of Findings is sent within 10 business days from the last day of survey

SUMMARY OF FINDINGS SAMPLE



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

ACHC

HH1.1A 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)-(v), 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
HH1.6B 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), 484.46(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- & CONDITION-LEVEL DEFICIENCIES

- 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
  - Home Health Agency Survey Protocols
    - Level 1 and Level 2 G tags
  - Requires another on-site survey
    - Start-ups require another full survey

ACHIEVING ACHC ACCREDITATION

ACHC ACCREDITATION DECISION DEFINITIONS

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

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

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

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

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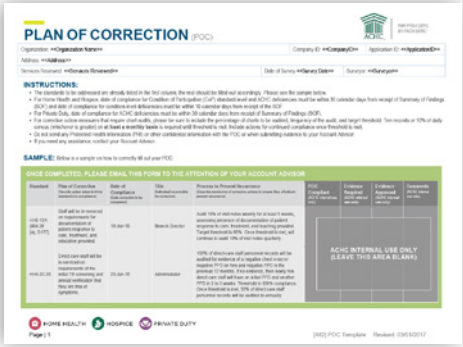
PLAN OF CORRECTION


PLAN OF CORRECTION (POC)

INSTRUCTIONS:

SAMPLE:

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

ACHC INTERNAL USE ONLY (LEAVE THIS AREA BLANK)

HOME HEALTH HOSPICE PRIVATE DUTY

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PLAN OF CORRECTION REQUIREMENTS

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

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NOTES

NOTES

EVIDENCE

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

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

SAMPLE AUDIT SUMMARY

AFTER ACCREDITATION

SERVICE AND BRANCH ADDITIONS

- Notify Account Advisor
  - Receive a Service Addition Checklist
  - Receive a Branch Addition Checklist form
  - Submit copy of **CMS approval letter for branch addition**
  - Distinction in Behavioral Health and Palliative Care require an additional one-day survey

EDUCATIONAL RESOURCES

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

NOTES

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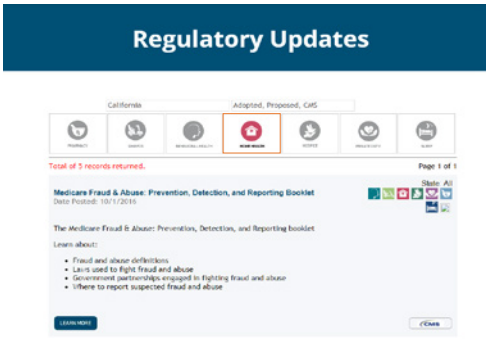
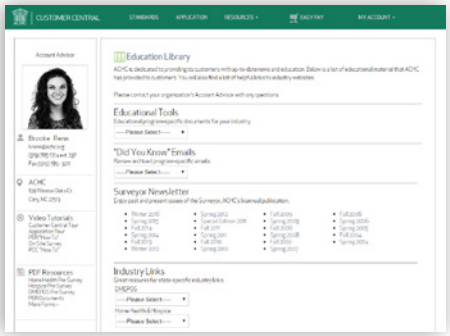
REGULATORY UPDATES

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

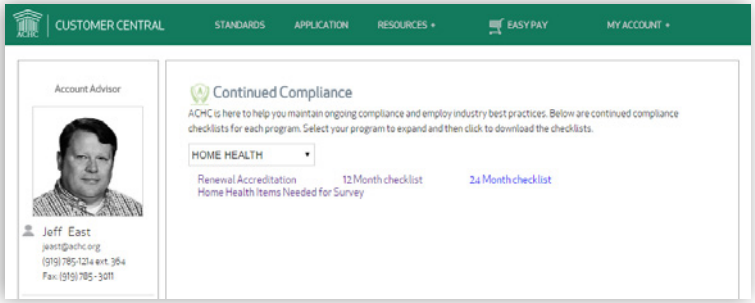


CUSTOMER CENTRAL

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

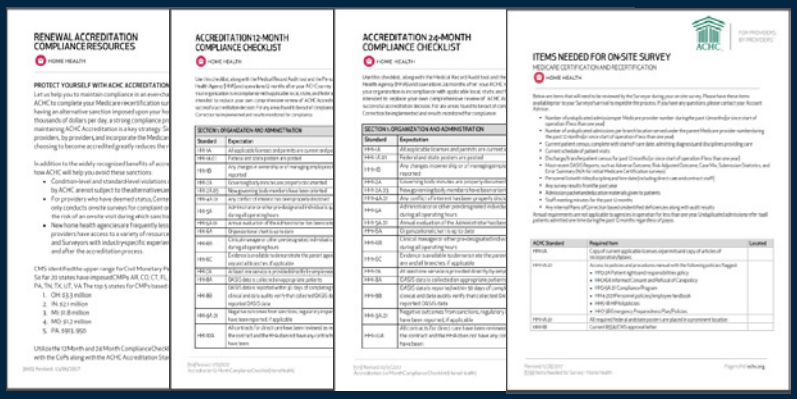


MAINTAINING COMPLIANCE CHECKLIST



ACHIEVING ACHC ACCREDITATION

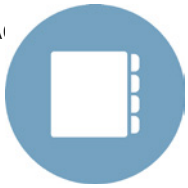
MAINTAINING COMPLIANCE



ACCREDITATION UNIVERSITY ACCREDITATION COMMISSION *for* HEALTH CARE 121

REVIEW THE STANDARDS

- Identifier
  - HH, Home Health
- 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 A
- Evidence
  - Items that will be reviewed to determine if the standard is met



ACCREDITATION UNIVERSITY ACCREDITATION COMMISSION *for* HEALTH CARE 123

NOTES

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Section 1

STANDARD EXAMPLE

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

Interpretation:

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

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

Evidence:

Observation

Section 2

STANDARD EXAMPLE

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

Interpretation:

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

Evidence:

On-Call Schedule; Observation ; Response to Interviews

CONFLICTING REGULATIONS

- Conditions of Participation (CoPs)
- State regulations
- ACHC standards
- Discipline-specific scopes of practice
- Agency policy and procedures

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

484.105 ORGANIZATION & ADMINISTRATION SERVICES

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

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

NOTES

NOTES

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

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

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(b) Standard: Administrator.

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

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

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

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

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

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(b)(2) G954 When the administrator is not available, a qualified, pre-designated person, who is authorized in writing by the administrator and the governing body, assumes the same responsibilities and obligations as the administrator. The pre-designated person may be the clinical manager as described in paragraph (c) of this section.

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

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

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(c) G958 Standard: Clinical manager.

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

(1) G960 Making patient and personnel assignments,

(2) G962 Coordinating patient care,

(3) G964 Coordinating referrals,

(4) G966 Assuring that patient needs are continually assessed, and

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

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(d) G970 Standard: Parent branch relationship.

(1) G972 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.

(2) G974 The parent HHA provides direct support and administrative control of its branches. A branch office is a location, physically separate from the parent location, from which an HHA provides services under the same certification number as the parent agency. The parent location provides supervision and administrative control of branch offices on a daily basis to the extent that the branch depends upon the parent's supervision and administrative functions in order to meet the CoPs, and could not do so as an independent entity.

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(e) Standard: Services under arrangement.

484.105(e)(1) G976 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)).

NOTES

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Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(e)(2) G978 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:

(i) Denied Medicare or Medicaid enrollment;

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

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

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

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(e)(3) G980 The primary HHA is responsible for patient care, and must conduct and provide, either directly or under arrangements, all services rendered to patients.

Section 1

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(f) G982 Standard: Services furnished.

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

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

Section 1

484.100 FEDERAL, STATE, AND LOCAL LAWS

Compliance with federal, state, and local laws and regulations related to 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.

3 standards:

a) Disclosure
b) Licensing
c) Laboratory Services

Section 1

484.100 FEDERAL, STATE, AND LOCAL LAWS

484.100(a) G850 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) G854 The names and addresses of all persons with an ownership or controlling interest in the HHA as defined in §§ 420.201, 420.202, and 420.206 of this chapter.

484.100(a)(2) G856 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 §420.20l, 420.202, and 420.206 of this chapter.

Section 1

484.100 FEDERAL, STATE, AND LOCAL LAWS

484.100(a)(3) G858 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) G860 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.

NOTES

NOTES

Section 1

484.100 FEDERAL, STATE, AND LOCAL LAWS

484.100(c) Standard: Laboratory services.

484.100(c)(1) G862 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.

484.100(c)(2) G864 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.

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

Section 1

484.45 REPORTING OASIS INFORMATION

HHAs must electronically report all OASIS data collected in accordance with 484.55.

4 Standards:

a) Encoding and Transmitting OASIS Data
b) Accuracy of Encoded OASIS Data
c) Transmittal of OASIS Data
d) Data Format

Section 1

484.45 REPORTING OASIS INFORMATION

484.45(a) G372 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.

OASIS must be transmitted for all Medicare patients, Medicaid patients, and patients utilizing any federally funded health plan options that are part of the Medicare program (e.g., Medicare Advantage (MA) plans). OASIS must also be transmitted for all Medicaid patients receiving services under a waiver program receiving services subject to the Medicare Conditions of Participation as determined by the state.

Section 1

484.45 REPORTING OASIS INFORMATION

484.45(b) G374 Accuracy of Encoded OASIS Data
The encoded OASIS data must accurately reflect the patient's status at the time of assessment.

"Accurate" means that the OASIS data transmitted to CMS is consistent with the current condition(s) of the patient.

Section 1

484.45 REPORTING OASIS INFORMATION

484.45(c) G376 Transmittal of OASIS data. An HHA must:

484.45(c)(1) G378 For all completed assessments, transmit OASIS data in a format that meets the requirements of paragraph.

484.45(c)(2) G380 Successfully transmit test data to the QIES ASAP System or CMS OASIS contractor.

484.45(c)(3) G382 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) G384 Transmit data that includes the CMS-assigned branch identification number, as applicable.

Section 1

484.45 REPORTING OASIS INFORMATION

484.45(d) G386 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.

OASIS data are being successfully transmitted to CMS (as verified by the presence of reports).

NOTES

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SECTION 1-ACHC REQUIREMENTS

- Governing body duties and orientation requirements
- List of governing body members
- Signed confidentiality statements
- Conflicts of interest and disclosure statements
- Annual evaluation of the Administrator
- Organizational chart
- Clinical manager needs to have a minimum of 2 years of homecare experience
- Negative outcomes are reported within 30 days
- Direct care contract requirements

WORKBOOK TOOLS

- Compliance Checklist
- Governing Body Meeting Agenda Template
- Hourly Contract Staff Audit Tool
- Conflict of Interest Disclosure Statement
- Acknowledgement of Confidentiality Statement
- Governing Body Orientation
- Self-Audit
- Sample policies and procedures

SECTION 2

PROGRAM/SERVICE OPERATIONS

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

Section 2

484.40 RELEASE OF OASIS INFORMATION

484.40 G350
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 OASIS data, and may not release patient-identifiable OASIS information to the public.

HHAs and their agents must develop and implement policies and procedures to protect the security of electronic personal health information (ePHI) they create, receive, maintain, and transmit. The agreements between the HHA and OASIS vendors must address policies and procedures to protect the security of ePHI.

Section 2

484.50 PATIENT RIGHTS

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

6 Standards:

a) Notice of Rights
b) Exercise Rights
c) Rights of the Patient
d) Transfer and Discharge
e) Investigation of Complaints
f) Accessibility

Section 2

484.50 PATIENT RIGHTS

484.50(a) Standard: Notice of rights.

The HHA must-

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

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

NOTES

NOTES

Section 2

484.50 PATIENT RIGHTS

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

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

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

Language assistance should be provided through the use of competent bilingual staff, staff interpreters, contracts, formal arrangements with local organizations providing interpretation, translation services, or technology and telephonic interpretation services.

Section 2

484.50 PATIENT RIGHTS

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

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

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

Section 2

484.50 PATIENT RIGHTS

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

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

Section 2

484.50 PATIENT RIGHTS

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

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

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

Section 2

484.50 PATIENT RIGHTS

The patient has the right to:

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

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

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

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

Section 2

484.50 PATIENT RIGHTS

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

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

NOTES

NOTES

Section 2

484.50 PATIENT RIGHTS

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

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

Agencies need to be in compliance with:

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

Section 2

484.50 PATIENT RIGHTS

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

- The extent to which payment for services may be expected from Medicare, Medicaid, or any other federally funded or federal aide program
- The charges for services that may not may not be covered by any of the above
- The charges the individual may have to pay before care is initiated
- Any changes in the information provided in accordance with paragraph (c)(7) of this section when they occur. The HHA must advise the patient and representative (if any), of these changes as soon as possible, in advance of the next home health visit. The HHA must comply with the patient notice requirements at 42 CFR 411.408(d)(2) and 42 CFR 411.408(f).

Section 2

484.50 PATIENT RIGHTS

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

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

Section 2

484.50 PATIENT RIGHTS

484.50(c)(10) G446 Be advised of the names, addressed and telephone numbers of the following federally- and state-funded entities that serve the area where the patient resides:

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

Section 2

484.50 PATIENT RIGHTS

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

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

Section 2

484.50 PATIENT RIGHTS

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

NOTES

NOTES

Section 2

484.50 PATIENT RIGHTS

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

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

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

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

Section 2

484.50 PATIENT RIGHTS

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

i. G464 Advise the patient, representative (if any), the physician(s) issuing orders for the HH POC, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) that a discharge for cause is being considered;
ii. G466 Make efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or situation;
iii. G468 Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care; and
iv. G470 Document the problem(s) and efforts made to resolve the problem(s), and enter this documentation into its clinical records.

Section 2

484.50 PATIENT RIGHTS

484.50(d)(6) G472 The patient dies; or

484.50(d)(7) G474 The HHA ceases to operate

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

Section 2

484.50 PATIENT RIGHTS

484.50(e)(1) G476 The HHA must:

i. G478 Investigate complaints made by a patient, the patient's rep (if any), & the patient's caregiver's & family, including, but not limited to, the following topics:
   A. G480 Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately;
   B. G482 Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the HHA.

ii. G484 Document both the existence of the complaint and the resolution of the complaint; and

iii. G486 Take action to prevent further potential violations, including retaliation, while the complaint is being investigated.

Section 2

484.50 PATIENT RIGHTS

484.50(e)(2) G488 The HHA must:

Staff must immediately report any suspected abuse, neglect, mistreatment on anyone furnishing services on behalf of the HHA

Section 2

484.50 PATIENT RIGHTS

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

484.50(f)(1) G490 Persons with disabilities, including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act.

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

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

Written material is in plain language if the audience can:

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

NOTES

NOTES

SECTION 2-ACHC REQUIREMENTS

- Marketing materials
- Written description of services
- Patient rights and responsibilities
- Investigation of complaints
- Contact information provided to patient regarding to report complaints
- Business Associate Agreements
- Resuscitative guidelines and CPR requirements
- Advance Directives
- Reporting of ethical issues

SECTION 2-ACHC REQUIREMENTS

- Cultural diversity
- Compliance program
- On-call availability

WORKBOOK TOOLS

- Compliance Checklist
- Patient Rights & Responsibilities Audit Tool
- Sample Ethical Issues/Concerns Reporting Form
- Sample Patient Complaint/Concern Form
- Self-Audit
- Sample policies and procedures

Standards

SECTION 3

FISCAL MANAGEMENT

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

Section 3

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105(h) G988 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.

Section 3

484.105 ORGANIZATION & ADMINISTRATION SERVICES

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.

NOTES

NOTES

Section 3

484.105 ORGANIZATION & ADMINISTRATION SERVICES

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.

Section 3

484.105 ORGANIZATION & ADMINISTRATION SERVICES

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.

Section 3

484.105 ORGANIZATION & ADMINISTRATION SERVICES

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 (i)(3) of this section under the direction of the governing body of the HHA.

SECTION 3-ACHC REQUIREMENTS

- Financial management practices
- Maintaining of financial records
- Home Health Medicare Cost report
- List of patient charges/care service rates
- Reconciliation of claims against care provided

WORKBOOK TOOLS

- Compliance Checklist
- Home Health Financial Disclosure Statement
- Self-Audit
- Sample policies and procedures

Standards

SECTION 4

HUMAN RESOURCE MANAGEMENT

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

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484.80 HOME HEALTH AIDE SERVICES

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

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a) Home Health Aide qualifications;

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

c) Competency evaluation;

d) In-service training;

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484.80 HOME HEALTH AIDE SERVICES

e) Qualifications for instructors conducting classroom and supervised practical training;

f) Eligible training and competency evaluation organizations;

g) Home Health Aide assignments and duties;

h) Supervision of Home Health Aides;

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

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484.80 HOME HEALTH AIDE SERVICES

484.80(a) G752 Standard: Home Health Aide qualifications.

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

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

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484.80 HOME HEALTH AIDE SERVICES

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

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484.80 HOME HEALTH AIDE SERVICES

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

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

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

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484.80 HOME HEALTH AIDE SERVICES

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

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

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

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

(iv) Basic infection prevention and control procedures.

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

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

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484.80 HOME HEALTH AIDE SERVICES

(vii) Recognizing emergencies and the knowledge of instituting emergency procedures and their application.
(viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy, and his or her property.
(ix) Appropriate and safe techniques in performing personal hygiene and grooming tasks that include

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

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484.80 HOME HEALTH AIDE SERVICES

(x) Safe transfer techniques and ambulation;
(xi) Normal range of motion and positioning;
(xii) Adequate nutrition and fluid intake;
(xiii) **Recognizing and reporting changes in skin condition, including pressure ulcers; and**
(xiv) Any other task that the HHA may choose to have an aide perform as permitted under state law.
(xv) The HHA is responsible for training Home Health Aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section.

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484.80 HOME HEALTH AIDE SERVICES

484.80(b)(4) G766 HHA maintains documentation of training
For individuals who met the qualification requirements for HHA aides prior to January 13, 2018, new training content in these requirements may be completed via in-service training.

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484.80 HOME HEALTH AIDE SERVICES

484.80(c) Standard: Competency evaluation.

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

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

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

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484.80 HOME HEALTH AIDE SERVICES

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

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

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

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

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484.80 HOME HEALTH AIDE SERVICES

484.80(d) G774 Standard: In-service training.

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

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

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

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484.80 HOME HEALTH AIDE SERVICES

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

Classroom and supervised practical training must be performed by a Registered Nurse who possesses a minimum of 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.

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484.80 HOME HEALTH AIDE SERVICES

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

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

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

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

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484.80 HOME HEALTH AIDE SERVICES

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

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

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

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

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484.80 HOME HEALTH AIDE SERVICES

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

(i) Had its participation in the Medicare program terminated; or

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

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

(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

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

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

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484.80 HOME HEALTH AIDE SERVICES

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

§484.80(h)(1)(i) G808

If Home Health Aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a Registered Nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions described in §484.80(g), must make an 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.

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484.80 HOME HEALTH AIDE SERVICES

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

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

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484.80 HOME HEALTH AIDE SERVICES

484.80(h)(2) G814 If Home Health Aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the Registered Nurse must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care.
484.80(h)(3) G816 If a deficiency in aide services is verified by the Registered Nurse or other appropriate skilled professional during an on-site visit, then the agency must conduct, and the Home Health Aide must complete a competency evaluation in accordance with paragraph (c) of this section.

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484.80 HOME HEALTH AIDE SERVICES

484.80(h)(4) G818 Home Health Aide supervision must ensure that aides furnish care in a safe and effective manner, including, but not limited to, the following elements:
(i) Following the patient's plan of care for completion of tasks assigned to a Home Health Aide by the Registered Nurse or other appropriate skilled professional;
(ii) Maintaining an open communication process with the patient, representative (if any), caregivers, and family;
(iii) Demonstrating competency with assigned tasks;
(iv) Complying with infection prevention and control policies and procedures;
(v) Reporting changes in the patient's condition; and
(vi) Honoring patient rights.

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484.80 HOME HEALTH AIDE SERVICES

484.80(h)(5) G820 If the home health agency chooses to provide Home Health Aide services under arrangements, as defined in §1861(w)(1) of the Act, the HHA's responsibilities also include, but are not limited to:
(i) G822 Ensuring the overall quality of care provided by an aide;
(ii) G824 Supervising aide services as described in paragraphs (h)(l) and (2) of this section; and
(iii) G826 Ensuring that Home Health Aides who provide services under arrangement have met the training or competency evaluation requirements, or both, of this part.

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484.80 HOME HEALTH AIDE SERVICES

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

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

Section 4

484.115 PERSONNEL QUALIFICATIONS

484.115(c) G1056 Standard: Clinical Manager.

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

484.115(m) G1076 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.

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484.115 PERSONNEL QUALIFICATIONS

484.115(n) G1078 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

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484.115 PERSONNEL QUALIFICATIONS

484.115(n)(2) In the case of an individual who furnishes services in a state which does not license Speech-Language Pathologists:

- (i) Has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating supervised clinical experience);
- (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
- (iii) Successfully completed a national examination in speech-language pathology approved by the Secretary.

SECTION 4-ACHC REQUIREMENTS

- Polices regarding the management of personnel records
- Personnel record requirements
- TB testing and annual screening
- Hepatitis B vaccination or declination
- Job descriptions/employee review of job descriptions
- Driver's license and MVR check only for individuals that drive patients
- Background checks, OIG and national sex offender registry check
- Policies regarding hiring individuals convicted of a crime
- Employee handbook/personnel files

SECTION 4-ACHC REQUIREMENTS

- Annual personnel evaluations
- Orientation requirements
- Individual designated as responsible for orientation
- Licensure and certification necessary to administer pharmaceuticals per state scope of practice
- Training for waived tests
- Written education plan
  - Topics
  - Required hours

SECTION 4-ACHC REQUIREMENTS

- Initial and annual competency required for all disciplines that provide direct care
- Initial and annual on-site evaluation of all disciplines that provide direct care
- Supervision of LPNs/OTAs/PTAs and BSWs
  - Every 60 days unless state law/scope of practice requires a more stringent frequency

WORKBOOK TOOLS

- Compliance Checklist
- Job Description Template
- Physical Demands Documentation Check-off List
- Sample Employee Educational Record
- Sample Annual Observation/Evaluation Visit Form
- Personnel Record Audit Tool

WORKBOOK TOOLS

- Hints for Developing an Educational Plan
- Sample Hepatitis B Vaccine Declination Statement
- Tuberculosis Screening Tool
- Sample In-Service Attendance Record Form
- Self-Audit
- Sample policies and procedures

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Standards

SECTION 5

PROVISION OF CARE AND RECORD MANAGEMENT

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

Section 5

484.55 COMPREHENSIVE ASSESSMENT

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

4 Standards:

a) Initial assessment of patients
b) Completion of the comprehensive assessment
c) Contents of the comprehensive assessment
d) Update of the comprehensive assessment

Section 5

484.55 COMPREHENSIVE ASSESSMENT

484.55(a) G512 Initial assessment visit

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

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

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

Section 5

484.55 COMPREHENSIVE ASSESSMENT

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

Section 5

484.55 COMPREHENSIVE ASSESSMENT

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

484.55(b)(1) G520 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. The start of care date is the date of the initial assessment and the comprehensive assessment must be completed within 5 calendar days of that date.

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

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484.55 COMPREHENSIVE ASSESSMENT

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

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484.55 COMPREHENSIVE ASSESSMENT

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

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

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

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

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

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

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484.55 COMPREHENSIVE ASSESSMENT

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

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

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

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484.55 COMPREHENSIVE ASSESSMENT

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

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

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

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

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484.55 COMPREHENSIVE ASSESSMENT

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

(i) Willingness and ability to provide care, and

(ii) Availability and schedules;

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

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484.55 COMPREHENSIVE ASSESSMENT

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

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484.55 COMPREHENSIVE ASSESSMENT

484.55(d) G544 Update of the comprehensive assessment
The comprehensive assessment must be updated and revised (including the administration of the OASIS) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but not less frequently than—

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

i. Beneficiary elected transfer;

ii. Significant change in condition; or

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

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Section 5

484.55 COMPREHENSIVE ASSESSMENT

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

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

Section 5

484.60 CARE PLANNING & COORDINATION

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

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

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

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

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

Section 5

484.60 CARE PLANNING & COORDINATION

5 Standards

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

Section 5

484.60 CARE PLANNING & COORDINATION

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

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

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

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484.60 CARE PLANNING & COORDINATION

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

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484.60 CARE PLANNING & COORDINATION

ix) Nutritional requirements;
(x) All medications and treatments;
(xi) Safety measures to protect against injury;
(xii) A description of the patient's risk for emergency department visits and hospital re-admission, and all necessary interventions to address the underlying risk factors.
(xiii) Patient and caregiver education and training to facilitate timely discharge;
(xiv) Patient-specific interventions and education; measurable outcomes and goals identified by the HHA and the patient;
(xv) Information related to any advanced directives; and

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484.60 CARE PLANNING & COORDINATION

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

(i) All pertinent diagnoses means all known diagnoses.

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

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

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484.60 CARE PLANNING & COORDINATION

484.60 (b) G578 Conformance with physician's orders

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

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

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484.60 CARE PLANNING & COORDINATION

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

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

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484.60 CARE PLANNING & COORDINATION

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

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

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

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484.60 CARE PLANNING & COORDINATION

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

484.60(c)(3)(i) G596 Any revision to the plan of care due to a change in patient health status must be communicated to the patient, representative (if any), caregiver, and all physicians issuing orders for the HHA plan of care.

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

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(c)(3)(ii) G598 Any revisions related to plans for the patient's discharge must be communicated to the patient, representative, caregiver, all physicians issuing orders for the HHA plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any).

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

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

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Section 5

484.60 CARE PLANNING & COORDINATION

484.60(d) G600 Standard: Coordination of Care.

The HHA must:

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

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

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484.60 CARE PLANNING & COORDINATION

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

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

Section 5

484.60 CARE PLANNING & COORDINATION

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

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

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

Section 5

484.60 CARE PLANNING & COORDINATION

484.60(d)(4) G608 Coordinate care delivery to meet the patient's needs, and involve the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities.
484.60(d)(5) G610 Ensure that each patient, and his or her caregiver(s) where applicable, receive ongoing education and training provided by the HHA, as appropriate, regarding the care and services identified in the plan of care. The HHA must provide training, as necessary, to ensure a timely discharge.

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

Section 5

484.60 CARE PLANNING & COORDINATION

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

Once the comprehensive assessment is completed (within 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.

Section 5

484.60 CARE PLANNING & COORDINATION

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

484.60(e)(2) G616 Patient medication schedule/instructions, including: medication name, dosage and frequency and which medications will be administered by HHA personnel and personnel acting on behalf of the HHA.

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

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

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

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Section 5

484.75 SKILLED PROFESSIONAL SERVICES

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

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

3 Standards

a) Provision of services by skilled professionals
b) Responsibilities of skilled professionals
c) Supervision of skilled professional assistants

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

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

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

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

484.75(b) G704 Standard: Responsibilities of skilled professionals.

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

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

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

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

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

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

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

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

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

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

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

Section 5

484.75 SKILLED PROFESSIONAL SERVICES

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

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

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

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

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Section 5

484.80 HOME HEALTH AIDE SERVICES

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

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

Section 5

484.80 HOME HEALTH AIDE SERVICES

484.80(g)(2) G800 A Home Health Aide provides services that are:
(i) Ordered by the physician;
(ii) Included in the plan of care;
(iii) Permitted to be performed under state law; and
(iv) Consistent with the Home Health Aide training.

Section 5

484.80 HOME HEALTH AIDE SERVICES

484.80(g)(3) G802 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.

Section 5

484.80 HOME HEALTH AIDE SERVICES

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

Section 5

484.110 CLINICAL RECORDS

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

Section 5

484.110 CLINICAL RECORDS

5 Standards

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

NOTES

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Section 5

484.110 CLINICAL RECORDS

484.110(a) G1010 Standard: Contents of clinical record.

The record must include:

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

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

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

Section 5

484.110 CLINICAL RECORDS

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

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

Section 5

484.110 CLINICAL RECORDS

484.110(a)(6) G1022

(i) A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the HHA (if any) within 5 business days of the patient's discharge; or

(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

(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.

Section 5

484.110 CLINICAL RECORDS

484.110(b) G1024 Standard: Authentication.

All entries must be legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication must include a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.

Section 5

484.110 CLINICAL RECORDS

484.110(c) G1026 Standard: Retention of records.

484.110(c)(1) G1026 Clinical records must be retained for 5 years after the discharge of the patient, unless state law stipulates a longer period of time.

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

Section 5

484.110 CLINICAL RECORDS

484.110(d) G1028 Standard: Protection of records.

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

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Section 5

484.110 CLINICAL RECORDS

484.110(e) G1030 Standard: Retrieval of clinical records.

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).

Section 5

484.105 ORGANIZATION & ADMINISTRATION SERVICES

484.105 (g) G986 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 §485.711, §485.713, §485.715, §485.719, §485.723, and §485.727 of this chapter to implement section 1861(p) of the Act.

SECTION 5-ACHC REQUIREMENTS

- Required content of medical record
- Referral process
- Eligibility guidelines
- Comprehensive assessment requirements
- Medication profile
- Psychosocial assessment requirements
- Therapy assessment requirements
- Plan of care requirements

SECTION 5-ACHC REQUIREMENTS

- Specifics of patient and family education
- Identification of drugs or drug classifications and routes that are not approved for administration by hospice personnel
- First dose administration requirements
- Face-to-face requirements
- Transfer and discharge summary requirements
- Referrals that cannot be met by the home health agency are appropriately referred out
- Verification of physician licensure

WORKBOOK TOOLS

- Compliance Checklist
- Patient Record Audit
- Sample Medication Profile
- Self-Audit

Standards

SECTION 6

QUALITY OUTCOMES/PERFORMANCE IMPROVEMENT

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

NOTES

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Section 6

484.65 QAPI

The HHA must develop, implement, evaluate, and maintain an effective, ongoing, HHA-wide, data-driven QAPI program. The HHA's governing body must ensure that the program reflects the complexity of its organization and services; involves all HHA services (including those services provided under contract or arrangement); focuses on indicators related to improved outcomes, including the use of emergent care services, hospital admissions and re-admissions; and takes actions that address the HHA's performance across the spectrum of care, including the prevention and reduction of medical errors. The HHA must maintain documentary evidence of its QAPI program and be able to demonstrate its operation to CMS.

Section 6

484.65 QAPI

5 Standards

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

Section 6

484.65 QAPI

484.65(a) G642 Standard: Program scope.

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

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

Section 6

484.65 QAPI

484.65(b) G644 Standard: Program data.

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

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

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

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

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

Section 6

484.65 QAPI

484.65(c) G646 Standard: Program activities.

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

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

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

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

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

1. Section 6

484.65 QAPI

484.65(c)(3) G656 The HHA must take actions aimed at performance improvement, and, after implementing those actions, the HHA must measure its success and track performance to ensure that improvements are sustained.

High-risk factors would be associated with significant risk to the health or safety of patients.

High-volume areas refers to care or service areas that are frequently provided by the HHA to a large patient population, thus possibly increasing the scope of the problem.

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

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

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Section 6

484.65 QAPI

484.65(d) G658 Standard: Performance Improvement projects.

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

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

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

Section 6

484.65 QAPI

484.65(e) G660 Standard: Executive Responsibilities.

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

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

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

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

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

SECTION 6-ACHC REQUIREMENTS

- Satisfaction surveys are utilized for QAPI
- Annual QAPI report
- Clinical record review
- QAPI project required items
- Monitoring of patient complaints
- Monitoring of patient incidents
- Monitoring of an administrative function
- OASIS information is incorporated into QAPI

WORKBOOK TOOLS

- Compliance Checklist
- Sample Annual PI Report
- Sample Annual Program Evaluation
- Sample Patient Incident/Variance Report
- Sample PI Activity/Audit Descriptions Plan
- Sample Performance Improvement
- Self-Audit

Standards

SECTION 7

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

Section 7

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.
3 Standards
a) Prevention
b) Control
c) Education

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Section 7

484.70 INFECTION PREVENTION AND CONTROL

484.70(a) G702 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) G704 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) G706 A method for identifying infectious and communicable disease problems; and

484.70(b)(2) G708 A plan for the appropriate actions that are expected to result in improvement and disease prevention.

Section 7

484.70 INFECTION PREVENTION AND CONTROL

484.70(c) G686 Standard: Education.
The HHA must provide infection control education to staff, patients, and caregiver(s).

Appropriate use, transport, storage, and cleaning methods of patient care equipment according to manufacturer's guidelines.

Job-specific, infection prevention education and training to all healthcare personnel for all of their respective tasks.

Processes to ensure that all healthcare personnel understand and are competent to adhere to infection prevention requirements as they perform their roles and responsibilities.

Section 7

484.102 EMERGENCY PREPAREDNESS

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

5 standards:

a) Emergency plan
b) Policies and procedures
c) Communication plan
d) Testing
e) Integrated healthcare systems

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(a) E-0004 Emergency plan. The HHA must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually.

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

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

Section 7

484.102 EMERGENCY PREPAREDNESS

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

484.102(a)(4) E-0009 Include a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency situation, including documentation of the HHA's efforts to contact such officials and, when applicable, of its participation in collaborative and cooperative planning efforts.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(b) E-0013 Policies and procedures. The HHA must develop and implement emergency preparedness policies and procedures, based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, and the communication plan at paragraph (c) of this section. The policies and procedures must be reviewed and updated at least annually. At a minimum, the policies and procedures must address the following:

484.102(b)(1) E-0017 The plans for the HHA's patients during a natural or man-made disaster. Individual plans for each patient must be included as part of the comprehensive patient assessment, which must be conducted according to the provisions at 484.55.

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Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(b)(2) E-0019 The procedures to inform State and local emergency preparedness officials about HHA patients in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical and psychiatric condition and home environment.

484.102(b)(3) E-0021 The procedures to follow up with on-duty staff and patients to determine services that are needed, in the event that there is an interruption in services during or due to an emergency. The HHA must inform state and local officials of any on-duty staff or patients that they are unable to contact.

Section 7

484.102 EMERGENCY PREPAREDNESS

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

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

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(c) E-0029 Communication plan.
The HHA must develop and maintain an emergency preparedness communication plan that complies with federal, state, and local laws and must be reviewed and updated at least annually. The communication plan must include all of the following:

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

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

Section 7

484.102 EMERGENCY PREPAREDNESS

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

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

484.102(c)(5) E-0033 A means of providing information about the general condition and location of patients under the facility's care as permitted under 45 CFR 164.510(b)(4).

484.102(c)(6) E-0034 A means of providing information about the HHA's needs, and its ability to provide assistance, to the authority having jurisdiction, the Incident Command Center, or designee.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(d) E-0036 Training and testing. The HHA must develop and maintain an emergency preparedness training and testing program that is based on the emergency plan set forth in paragraph (a) of this section, risk assessment at paragraph (a)(1) of this section, policies and procedures at paragraph (b) of this section, and the communication plan at paragraph (c) of this section. The training and testing program must be reviewed and updated at least annually.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(d)(1) E-0037 Training program. The HHA must do all of the following:

i. Initial training in emergency preparedness policies and procedures to all new and existing staff, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

ii. Provide emergency preparedness training at least annually.

iii. Maintain documentation of the training.

iv. Demonstrate staff knowledge of emergency procedures.

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Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(d)(2) E-0039 Testing.

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

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

Section 7

484.102 EMERGENCY PREPAREDNESS

ii. Conduct an additional exercise that may include, but is not limited to the following:

(A) A second full-scale exercise that is community-based or individual, facility based; or

(B) A tabletop exercise that includes a group discussion led by a facilitator, using a narrated, clinically-relevant emergency scenario, and a set of problem statements, directed messages, or prepared questions designed to challenge an emergency plan.

iii. Analyze the HHA's response to and maintain documentation of all drills, tabletop exercises, and emergency events, and revise the HHA's emergency plan, as needed.

Section 7

484.102 EMERGENCY PREPAREDNESS

484.102(e) E-0042 Integrated healthcare systems.

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

(1) Demonstrate that each separately certified facility within the system actively participated in the development of the unified and integrated emergency preparedness program.

(2) Be developed and maintained in a manner that takes into account each separately certified facility's unique circumstances, patient populations, and services offered.

Section 7

484.102 EMERGENCY PREPAREDNESS

(3) Demonstrate that each separately certified facility is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program.

(4) Include a unified and integrated emergency plan that meets the requirements of paragraphs (a)(2), (3), and (4) of this section. The unified and integrated emergency plan must also be based on and include all of the following:

(i) A documented community- based risk assessment, utilizing an all-hazards approach.

(ii) A documented individual facility-based risk assessment for each separately certified facility within the health system, utilizing an all-hazards approach.

(5) Include integrated policies and procedures that meet the requirements set forth in paragraph (b) of this section, a coordinated communication plan and training and testing programs that meet the requirements of paragraphs (c) and (d) of this section, respectively.

SECTION 7-ACHC REQUIREMENTS

- TB Exposure Control plan and OSHA Bloodborne Pathogen plan
- TB incidence rate
- Personnel safety
- Fire drills/smoke alarms/fire alarms/fire extinguishers
- Office safety plan
- Tracking of employee incidents/illnesses
- Equipment and supplies are properly maintained and inspected
- Safe handling of biohazard waste; PPE; SDS

WORKBOOK TOOLS

- Compliance Checklist
- Hints for Developing a Disaster Plan
- Hints for an Infection Control Plan
- Infection Control Tracking Form
- Safety Tracking Log
- Report of Employee Accident Investigation
- Quality Maintenance Log
- Self-Audit

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Glossary

484.115 PERSONNEL QUALIFICATIONS

484.115(c) G1056 Standard: Clinical Manager.

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

484.115(m) G1076 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.

Glossary

484.115 PERSONNEL QUALIFICATIONS

484.115(n) G1078 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:

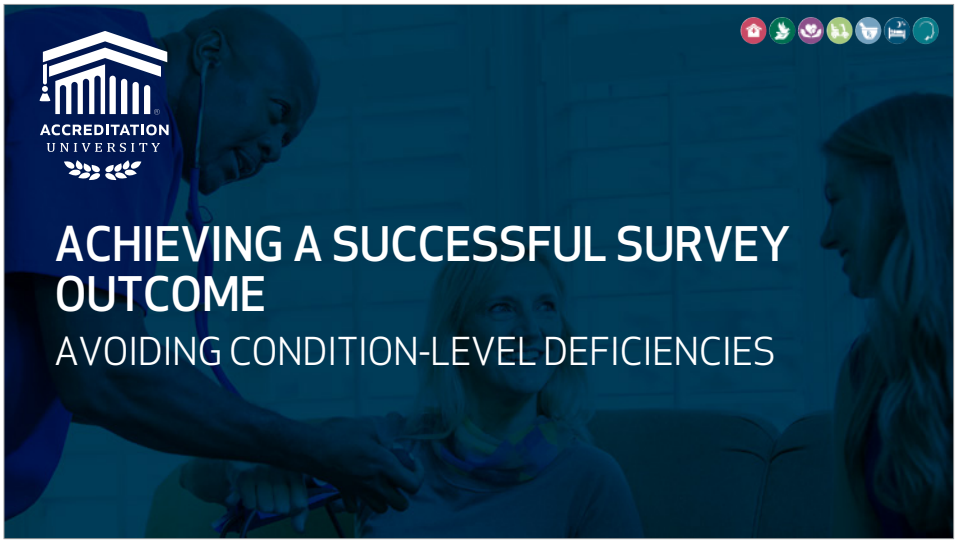
§484.115(n)(1) Is licensed as a speech-language pathologist by the state in which the individual furnishes such services; or

§484.115(n)(2) In the case of an individual who furnishes services in a state which does not license Speech-Language Pathologists:

(i) Has successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating supervised clinical experience);

(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

(iii) Successfully completed a national examination in speech-language pathology approved by the Secretary.



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

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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

- §484.102 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

ADDITIONAL DEFICIENCIES

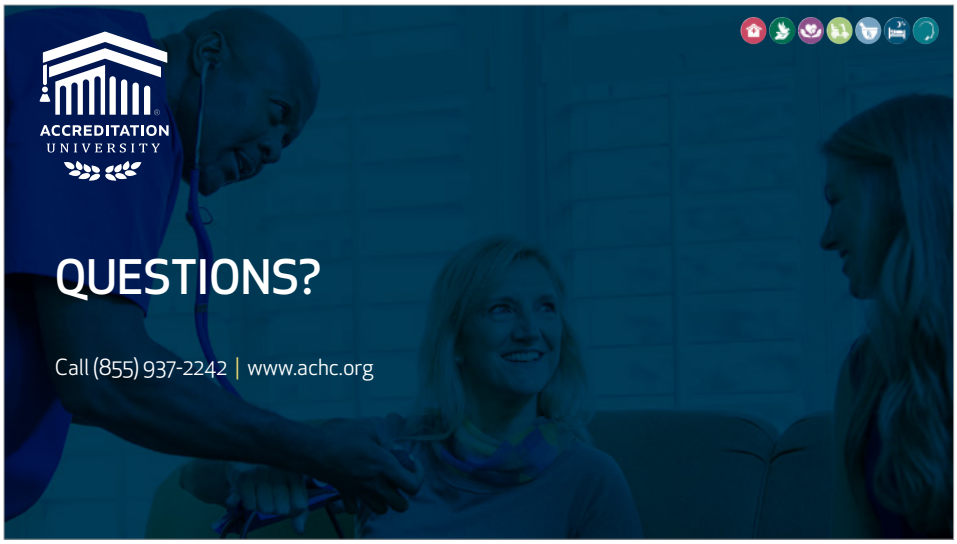
- §484.65 Condition of participation: Quality Assessment and Performance Improvement (QAPI)
- Must have a QAPI Program that is capable of:
  - Showing measureable improvement in areas where improvements are needed
  - Reflects the scope of the agency
  - Tracking and monitoring of quality indicators:
    - 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

TAKEAWAY

- Regulations
  - CoPs
  - State regulations
  - ACHC Home Health Standards
  - Agency policies and procedures
- Audit
- Educate
- Observe
- Repeat

NOTES

NOTES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RESOURCES

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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. Please have these items available prior to your Surveyor's arrival to expedite the process. If you have any questions, please contact your Account Advisor.

- Number of unduplicated admissions per Medicare provider number during the past 12 months (or since start of operation if less than one year)
- Number of unduplicated admissions per branch location served under the parent Medicare provider number during 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 disciplines providing care
- Current schedule of patient visits
- Discharge/transfer patient census for past 12 months (or since start of operation if less than one year)
- Most recent OASIS Reports, such as Adverse Outcome, Risk Adjusted Outcome, Case Mix, Submission Statistics, and Error Summary (N/A for initial Medicare Certification surveys)
- Personnel list with title, discipline, and hire date (including direct care and contract staff)
- Any survey results from the past year
- Admission packet and education materials given to patients
- Staff meeting minutes for the past 12 months
- Any internal Plans of Correction based on identified deficiencies along with audit results

Annual requirements are not applicable to agencies in operation for less than one year. Unduplicated admissions refer to all patients admitted one time during the past 12 months regardless of payor.

ACHC Standard	Required Item	Located
HH1-1A	Copy of current applicable licenses or permits and copy of articles of incorporation/bylaws	
HH1-1A.01	Access to policies and procedures manual with the following policies flagged: • HH2-2A Patient rights and responsibilities policy • HH2-9A.01 Compliance Program • HH5-1B HIPAA policies • HH5-6A Transfer and discharge policies • HH5-8A Acceptance of verbal orders • HH7-3B Emergency Preparedness Plan/Policies	
HH1-1A.01	All required federal and state posters are placed in a prominent location	
HH1-1B	Current 855A/CMS approval letter	

ACHC Standard	Required Item	Located
HH1-2A, HH1-2A.03/ HH1-9A.01/HH2-4A/ HH2-7A.01/HH3-1A/ HH3-1C/HH6-1C	Governing body meeting minutes for the past 12 months and documentation of orientation and signed confidentiality statement(s)	
HH1-5A	Job description for the Administrator	
HH1-5A.01	Annual evaluation of the Administrator	
HH1-6A	Organizational chart	
HH1-6B	Job description for the clinical manager(s)	
HH1-8A/HH1-8B	Previous 4 month's final OASIS Validation reports	
HH1-10A	Contracts for direct care, including copies of professional liability insurance certificates	
HH1-11A	CLIA certificate of waiver for agency or CLIA certificate for the reference laboratory	
HH1-12A.01	CMS letter of approval for branch addition (if applicable)	
HH2-1A.01	Marketing materials	
HH2-4A	Grievance/complaint log	
HH2-5C.01	Business Associate Agreements (BAAs)	
HH2-7A.01	Evidence of how ethical issues are identified, evaluated and discussed	
HH2-8A	Evidence of communication assistance for language barriers	
HH2-9A.01	Evidence of a Compliance Program	
HH2-10A.01/HH2-11A.01	On-call calendar	
HH3-1A	Most recent annual operating budget	
HH3-1B	Most recent capital expenditure plan (if applicable)	
HH3-1C	Evidence of the review of the budget	
HH3-3B.02	Recent Medicare cost report (N/A for initial Medicare certification)	
HH3-4A.01	Listing of patient care charges	
HH4-1B.01	Personnel records (including direct care and contract staff) contain evidence of the items listed in the standard. Surveyor will review personnel records at a minimum for the following disciplines: Administrator, Clinical Manager, Nurses, Aides, Social Worker, Physical Therapist, Occupational Therapist, Speech Therapist (if services are provided by the home health agency)	
HH4-2E.01	Job descriptions for identified staff	
HH4-2I.01	Employee handbook or access to personnel policies	
HH4-8A/HH4-8A.01	Evidence of ongoing education and/or written education plan	
HH4-12A/ HH4-12B/HH4-12C/HH4-12F	Home Health Aide competency evaluation and/or training materials (if applicable)	
HH5-11A	Evidence of skilled services are provided by or under the supervision of qualified professionals per ACHC Glossary of Personnel Qualifications	
HH5-12A.01	Patient education materials	
HH5-13A.01	Referral log	
HH5-16A.01	Verification of physician licensure	

ACHC Standard	Required Item	Located
HH6-1A	Quality Assessment and Performance Improvement (QAPI) Program	
HH6-1B.01	Job description for individual responsible for the QAPI Program	
HH6-1C	Governing body meeting minutes demonstrate involvement of the governing body in QAPI	
HH6-1D.01	Evidence of personnel involvement in QAPI	
HH6-3A.01	QAPI annual report	
HH6-4A.02	Evidence of monitoring processes that involve risks, including infections and communicable diseases	
HH6-4A.04	Evidence of monitoring of an aspect related to administrative function of the agency	
HH6-4A.05	Satisfaction surveys utilized in QAPI	
HH6-4A.06	Evidence of monitoring of patient grievances/complaints and actions needed to resolve problems	
HH6-4A.07	Evidence of quarterly record reviews and results are utilized in QAPI	
HH6-5A	Evidence QAPI activities focus on high risk, high volume, or problem prone areas	
HH6-6A	Evidence of the monitoring of all patient related variances	
HH6-7A.01	OASIS reports (most recent OBQM, OBQI, Patient/Agency Characteristics Report, Submission Statistics by Agency Report, and Error Summary Report) and evidence of ongoing monitoring of reports	
HH7-1A	Evidence of an Infection Control Program, TB prevalence rates for all counties served, TB Exposure Control Plan, and OSHA Bloodborne Pathogen Plan	
HH7-1D	Infection control logs for patients and personnel and evidence infection control data is monitored and incorpated into QAPI as appropriate	
HH7-3A	Emergency Preparedness Plan that includes the all-hazards risk assessment	
HH7-3C	Communication Plan	
HH7-3D	Evidence of emergency preparedness training for all existing and new staff, including staff that provide services under arrangement	
HH7-3D	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 or, when a community-based or facility-based exercise cannot be completed, a tabletop exercise is completed If unable to complete a community-based exercise, documentation must exist to support attempts made to participate in a community-based exercise	
HH7-3E	Emergency plan for integrated healthcare systems can demonstrate that the agency's needs and circumstances, patient population, and services offered were included in all aspects of the emergency preparedness requirements (if applicable)	
HH7-5A.01	Report of annual fire drill and results of testing of emergency power systems	
HH7-6B.01	Access to Safety Data Sheets (SDS)	

ACHC Standard	Required Item	Located
HH7-7A.01	OSHA forms 300, 300A, and/or 301 (if applicable)	
HH7-8A.01/HH 7-9A.01	Quality control logs of any equipment used in the provision of care	

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 (N/A for contract staff)										
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											

TOP ACHC SURVEY DEFICIENCIES

HOME HEALTH

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Based on previous survey results, these are the deficiencies most likely to be cited under the new Medicare Conditions of Participation.

§484.60 Condition of Participation: Care planning, coordination of services, and quality of care

ACHC Standard: HH5-3A

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

TIPS FOR COMPLIANCE:

- Ensure all patients have a written plan of care that addresses the issues identified in the comprehensive assessment
- Ensure all physician orders are obtained prior to the initiation of services
- Ensure all orders for all disciplines include the amount, frequency, and duration of the service provided
- Ensure all therapy orders include the specific procedures and modalities to be provided
- Ensure PRN orders for medications and treatments identify an indicator for the administration of PRN treatment or medication
- Ensure all verbal orders are recorded in the plan of care

ACHC Standard: HH5-3B

Care follows a written plan of care established and periodically reviewed by a doctor of medicine, osteopathy, or podiatric medicine. 484.60(a)(1), 484.60(b) , 484.60(b)(1), 484.60(b)(2)

TIPS FOR COMPLIANCE:

- Ensure all medications, treatments, and services are administered as ordered by the physician
- Ensure all missed visits are communicated to the physician to determine if the plan of care needs to be altered

ACHC Standard: HH5-3C

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

TIPS FOR COMPLIANCE:

- Ensure all patients are provided the following written information:
  - Visit schedule, including frequency of visits by HHA personnel and personnel acting on behalf of the HHA
  - 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 instructions 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

§484.60 Condition of Participation: Care planning, coordination of services, and quality of care

ACHC Standard: HH5-8B

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

TIPS FOR COMPLIANCE:

- Ensure all clinicians document communication to the patient, the representative (if any), and the caregiver; and that all physicians issuing orders for the HHA plan of care are notified of any changes that suggest a need to alter the plan of care.

§484.75 Condition of Participation: Skilled professional services

ACHC Standard: HH5-11A

The HHA furnishes skilled professional services. Skilled professional services include skilled nursing services, physical therapy, speech-language pathology services, and occupational therapy, as specified in 42 CFR 409.44, and physician and medical social work services as specified in 42 CFR 409.45, 484.75, 484.75(a), 484.75(b), 484.75(b)(1-9), 484.75(c), 484.75(c)(1-3)

TIPS FOR COMPLIANCE:

- Ensure all skilled professional services:
  - Provide an ongoing interdisciplinary assessment of the patient
  - Develop an evaluation of the plan of care in partnership with the patient, representative (if any), and the caregiver
  - Provide services in accordance with the plan of care
  - Provide patient, caregiver, and family counseling
  - Provide patient and caregiver education
  - Complete clinical documentation in accordance with agency policies and procedures
  - Communicate with all physicians involved in the plan of care

§484.80 Condition of participation: Home Health Aide services

ACHC Standard: HH4-14A

Aides providing skilled or personal care services are supervised in those tasks in the patient's home as appropriate to the service level provided. 484.80(h), 484.80(h)(1)

TIPS FOR COMPLIANCE:

- Ensure all patients receiving Home Health Aide services are properly supervised by the Registered Nurse (RN) or other appropriate skilled professional.
- Ensure Home Health Aide supervision validates that care is furnished in a safe and effective manner and addresses the following elements:
  - The Home Health Aide is following the patient's plan of care for completion of tasks assigned by the RN or other appropriate skilled professional
  - The Home Health Aide maintains an open communication process with the patient, representative (if any), caregivers, and family
  - The Home Health Aide demonstrates competency with assigned tasks
  - The Home Health Aide complies with infection prevention and control policies and procedures
  - The Home Health Aide reports changes in the patient's condition
  - The Home Health Aide honors the patient's rights

ACHC Standard: HH5-11F

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

TIPS FOR COMPLIANCE:

- Ensure the written instructions provided to the Home Health Aide are specific to the task provided and frequency in which to provide it. "Per patient request" and PRN orders should not be used for any tasks, as the Home Health Aide lacks the decision-making ability to interpret information/data needed to revise the plan of care
- Ensure all revisions to the aide plan of care are discussed, approved, and documented by the RN or other qualified professional
- Ensure documentation in the patient record supports that the Home Health Aide provided care in accordance with the plan of care and that if the patient refuses care, the refusal is properly documented

§484.55 Condition of Participation: Comprehensive assessment of patients

ACHC Standard: HH5-2F

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

TIPS FOR COMPLIANCE:

- Ensure an ongoing medication review is completed for all patients; in therapy-only cases, the therapist submits a list of medications for the HHA RN to review
- Ensure all PRN medications identify an indicator as to when the PRN medication should be administered
- Ensure O2 is listed on the medication profile
- Ensure the physician is notified of any medication discrepancies, side effects, problems, or reactions

PULSE OXIMETRY IN THE HOME

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HOME HEALTH HOSPICE PRIVATE DUTY

Is a physician's order required for pulse oximetry in the home?

CMS has recently changed its position on orders regarding the use of a pulse oximetry in the home.

ACHC and CMS feel that clinical standards of practice as well as agency policy should guide the use of a pulse oximeter and physician notification when being incorporated as a part of vital signs; during a therapy session as a means of assessing how a patient is tolerating an exercise/therapy program; or as PRN when a patient appears to exhibit symptoms of respiratory distress.

However, if a patient with a known cardiopulmonary condition is being addressed or monitored via pulse oximetry, we would expect to see this monitoring documented in the plan of care, along with parameters for physician notification, therefore a physician's order, with parameters is required.

Agencies should ensure state regulations and agency policy do not require an order prior to discontinuing this practice.

This guidance is applicable only for Medicare Certified Home Health Agencies, Medicare Certified Hospices, and Private Duty Nursing.

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CMS REQUIREMENTS REGARDING THE USE OF "PRN"

CMS states **PRN not to be used** for Aide tasks

Official Direction from the Centers for Medicare & Medicaid Services (CMS)

Home Health & Hospice Aides plan of care cannot use PRN or per patient choice for any task whether personal care or non-personal care. It is out of the scope of practice for the aide to determine what tasks need to be done and when. The qualified professional must develop the plan of care; indicate what task to be done and the frequency of these tasks. If the patient and/or caregiver are cognitively able to make a choice, then the RN must indicate this on the plan of care plus that the patient is functionally able to perform the task. The qualified professional, based on the needs of the patient, also selects non-personal tasks that need to be specific for frequency. Again, if the patient/caregiver is cognitively and functionally able to make a choice, the professional must indicate this on the plan of care.

CMS recently stated that the Home Health & Hospice Aides plan of care CANNOT use "PRN" or "per patient choice" for ANY task, whether they are personal care or non-personal care. **Please be aware that:**

- The use of PRN or "per patient request" in a patient record must be cited as a deficiency during an on-site survey.
- Multiple types of care, such as the choice between a shower or sponge bath, can only be used when it has been documented by the nurse that the patient/caregiver has the ability to functionally and cognitively make a choice between the types of care that have been ordered.
- The Aide Plan of Care must be individualized and refrain from using blanket statements like "patient is cognitively and functionally able to make the choice" for all patients and tasks.
- If patients are requesting a specific type of care as a result of changes in their condition, Aides must still contact their supervisor prior to administering care.

EXAMPLES:

UNACCEPTABLE	ACCEPTABLE
Tub bath or shower per patient request.	Tub bath or shower 3 times a week. Patient is functionally and cognitively able to make the choice.
May use walker or cane for ambulation per patient request.	May use walker or cane for ambulation. Patient is functionally and cognitively able to make the choice.
Change bed linens PRN.	Change bed linens weekly and anytime they are soiled.

ACCREDITATION 24-MONTH COMPLIANCE CHECKLIST

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HOME HEALTH

Use this checklist, along with the Medical Record Audit tool and the Personnel File Audit tool to audit your Home Health Agency (HHA) and operations 24 months after your ACHC survey. This checklist also helps you determine if your organization is in compliance with applicable local, state, and federal laws and regulations. This checklist is not intended to replace your own comprehensive review of ACHC Accreditation Standards, nor does it guarantee a successful accreditation decision. For any areas found to be out of compliance, it is recommended that an internal Plan of Correction be implemented and results monitored for compliance.

SECTION 1: ORGANIZATION AND ADMINISTRATION		
Standard	**Expectation**	**Comments**
HH1-1A	All applicable licenses and permits are current and posted for all locations	
HH1-1A.01	Federal and state posters are posted	
HH1-1B	Any changes in ownership or of managing employees have been properly reported	
HH1-2A	Governing body minutes are properly documented	
HH1-2A.03	New governing body members have been oriented	
HH1-4A.01	Any conflict of interest has been properly disclosed	
HH1-5A	Administrator or other pre-designated individual is qualified and available during all operating hours	
HH1-5A.01	Annual evaluation of the Administrator has been completed	
HH1-6A	Organizational chart is up to date	
HH1-6B	Clinical manager or other pre-designated individual is qualified and available during all operating hours	
HH1-6C	Evidence is available to demonstrate the parent agency is responsible for any and all branches, if applicable	
HH1-7A	At least one service is provided directly by employees of the agency	
HH1-8A	OASIS data is collected on appropriate patients	
HH1-8B	OASIS data is reported within 30 days of completing the assessment, and clinical and data audits verify that collected OASIS data is consistent reported OASIS data	
HH1-9A.01	Negative outcomes from sanctions, regulatory inspections, and/or audits have been reported, if applicable	
HH1-10A	All contracts for direct care have been reviewed as required per the terms of the contract and the HHA does not have any contracts with agencies that have been:	

	• Denied Medicare or Medicaid enrollment; • Been excluded or terminated from any federal healthcare program or Medicaid; • Had its Medicare or Medicaid billing privileges revoked; or • Been debarred from participating in any government program	
HH1-11A	CLIA certificate of waiver is current and posted	
HH1-12A.01	Any new branches have obtained Medicare approval prior to billing Medicare for services	
SECTION 2: PROGRAMS/SERVICE OPERATIONS		
Standard	**Expectation**	**Comments**
HH2-1A.01	Marketing materials are current and accurately reflect care/service provided	
HH2-2A	Patient Rights and Responsibilities document is current and has the current contact information for the Administrator	
HH2-3A	All alleged violations by anyone furnishing services on behalf of the HHA have been properly investigated and appropriate corrective action has been taken as needed	
HH2-4A	All grievances and complaints have been documented, investigated, resolved, and reported to the governing body quarterly	
HH2-4B	Patient-related materials have the correct contact information for: • Agency on Aging • Center for Independent Living • Protection and Advocacy Agency • Aging and Disability Resource Center • Quality Improvement Organization • State's toll-free hotline number to file complaints about the agency as well as issues concerning Advance Directives • HHA information to file a complaint • ACHC's phone number to file a complaint • Clinical manager information	
HH2-5C.01	Business Associate Agreements exist for non-covered entities	
HH2-7A.01	Summary of any ethical issues have been reported to the governing body	
HH2-8A	Language resource information is available to assist patients with limited English proficiency as well as persons with disabilities	
HH2-9A.01	Evidence that any compliance issues have been reported, documented, and corrective action has been taken as appropriate	
HH2-10A.01	Evidence that administrative and clinical supervision is available during all times care is provided	
HH2-11A.01	Evidence of on-call scheduling	
SECTION 3: FISCAL MANAGEMENT		

Standard	Expectation	Comments
HH3-1A	Operating budget has been developed and approved by the appropriate individuals	
HH3-1B	Capital expenditure plan is available, if applicable	
HH3-1C	Operating budget has been reviewed by the appropriate individuals at least annually	
HH3-3B.02	Medicare cost report has been completed on time	
SECTION 4: HUMAN RESOURCE MANAGEMENT		
Personnel records have been audited and contain all required elements. Utilize the ACHC Personnel File Audit tool to assist in this process. Internal plans of correction have been developed and implemented based on audit findings.		
Standard	**Expectation**	**Comments**
HH4-2B.01	All credentialing activities are up to date	
HH4-2C.01	TB annual risk assessment has been completed to determine type and frequency of screening/testing for direct care personnel	
HH4-2E.01	All job descriptions are up to date and any revisions have been signed by personnel	
HH4-2J.01	All employee personnel evaluations have been completed, reviewed, and signed by personnel	
HH4-5A.01	Orientation materials cover the required topics	
HH4-6A.01	Competency assessments have been completed on all direct care personnel (including contract personnel)	
HH4-7A.01	Annual on-site evaluation visits have been completed on direct care personnel (including contract personnel)	
HH4-8A	Home health aides have received 12 hours of in-service education in the past 12 months	
HH4-8A.01	All direct care personnel have 12 received hours of in-service education in the past 12 months and non-direct care personnel have received 8 hours in the past 12 months The required topics have been addressed: • Emergency/disaster training • How to handle grievances/complaints • Infection control training • Cultural diversity • Communication barriers • Ethics training • Workplace (OSHA) and patient safety • Patient Rights and Responsibilities • Compliance Program	

SECTION 5: PROVISION OF CARE AND RECORD MANAGEMENT		
Medical records have been audited and contain all required elements. Utilize the ACHC Medical Record Audit tool to assist in this process. Internal plans of correction have been developed and implemented based on audit findings.		
Standard	**Expectation**	**Comments**
HH5-1B	All patient records are retained for the appropriate period of time after discharge	
HH5-1B	All clinical records are safeguarded against loss or unauthorized use	
HH5-11A	Current copies of applicable rules and regulations and the state's Practice Acts are available to personnel	
HH5-12A.01	Patient education materials address, at a minimum: • Treatment and disease management education • Proper use, safety hazards, and infection control issues related to the use and maintenance of any equipment provided • Plan of care • Emergency preparedness information	
HH5-14B.01	Agency does not admit patients for whom it cannot care and provides information to referral sources when patients cannot be admitted	
HH5-16A.01	Verification of referring physician license occurs before the acceptance of patient	
SECTION 6: QUALITY OUTCOMES/PERFORMANCE IMPROVEMENT		
Standard	**Expectation**	**Comments**
HH6-1A	Agency has evidence of a quality assessment process improvement program that measures, analyzes, and tracks quality indicators, including adverse patient events and other aspects of performance that enable the agency to assess processes of care, agency services, and operations	
HH6-1C	QAPI results are communicated to the governing body/organizational leaders	
HH6-1D.01	Personnel are involved in QAPI	
HH6-3A.01	QAPI report has been completed at least annually	
HH6-4A.02	Processes involving risks, including infections and communicable diseases, are being monitored	
HH6-4A.04	QAPI activities include ongoing monitoring of at least one important administrative function of the agency	
HH6-4A.05	The QAPI plan identifies the process for conducting satisfaction surveys	
HH6-4A.06	QAPI activities include ongoing monitoring of patient grievances/complaints and the actions needed to resolve grievances/complaints and improve patient care/service	
HH6-4A.07	Patient medical records are audited quarterly	
HH6-5A	QAPI activities focus on high-risk, high-volume, or problem-prone areas, with	

	a consideration of incidence, prevalence, and severity of problems in those areas	
HH6-7A.01	QAPI activities include obtaining and systematically analyzing OASIS reports	
SECTION 7: RISK MANAGEMENT:INFECTION AND SAFETY CONTROL		
Standard	**Expectation**	**Comments**
HH7-1A	The HHA must maintain and document an infection control program that has as its goal the prevention and control of infections and communicable diseases	
HH7-1A	Copies of the TB Exposure Control and OSHA Blood Borne Pathogen plans have been reviewed annually and are available to personnel	
HH7-1A	The agency provides infection control education to patients, family members, and personnel	
HH7-1D	The agency monitors infection statistics of patients and personnel, and data is analyzed for trends and incorporated into QAPI when appropriate	
HH7-2B.01	Safety education is provided to patients	
HH7-3A	Emergency Preparedness Plan is reviewed and updated annually	
HH7-3A	Risk assessment using an all-hazards approach has been updated annually	
HH7-3B	Emergency Preparedness policies have been reviewed and updated annually	
HH7-3C	Communication plan has been reviewed and updated annually	
HH7-3D	Training of Emergency Preparedness has occurred annually	
HH7-3D	A minimum of two exercises/drills have been completed annually	
HH7-3E	Agencies part of an integrated healthcare system have evidence that the Emergency Preparedness Plan addresses the specific needs of the home health agency	
HH7-5A.01	There is evidence of an annual fire drill; smoke detectors, fire alarms, and extinguishers are inspected and maintained as recommended by the manufacturer	
HH7-5A.01	Emergency power system is tested at least once a year	
HH7-6A.01	Hazardous wastes, chemicals, and materials are handled appropriately	
HH7-6B.01	Current Safety Data Sheets (SDS) are accessible to personnel	
HH7-7A	Evidence of identifying, monitoring, reporting, investigating, and documenting all incidents, accidents, variances, or unusual occurrences involving personnel is incorporated into QAPI when appropriate	
HH7-8A.01	Quality control logs for equipment used for conducting waived tests, if applicable	
HH7-9A.01	Quality control logs for any equipment used in the provision of patient care, if applicable	

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