ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

ACHC Certified Consultant Training

Home Health & Hospice

About ACHC

- Nationally recognized AO with more than 30 years of experience
- CMS Deeming Authority for Home Health, Hospice, Renal Dialysis, Home Infusion Therapy, and DMEPOS
- Recognition by major third-party payors
- Approved to perform state licensure surveys
- Quality Management System that is ISO 9001:2015 Certified

Experience the ACHC Difference

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

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

Collaborative Survey Approach

- ACHC values guide the survey approach and provide the facility with:
  - ✓ Consistency in interpretation of requirements
  - ✓ Accuracy in reporting findings/observations
  - ✓ The opportunity to clarify or correct ACHC deficiencies
  - ✓ Active engagement to promote ongoing success post-survey

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
  - Internal Post-Survey Reviews
  - Customer Provided Satisfaction Surveys

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 other resources
- Questions that cannot be answered by them will be sent to the appropriate Clinical or Regulatory department

Customer Satisfaction

ACHC Home Health Accreditation

- Earned CMS Deeming Authority in 2006.
- ACHC accredits more than 2,300 locations nationally.
- Program-specific standards include CoPs.
- Ability to choose from comprehensive group of services, including:
  - Skilled Nursing
  - Home Health Aide
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Medical Social Services

ACHC Hospice Accreditation

- Earned CMS Deeming Authority in 2009.
- ACHC accredits more than 1,600 locations nationally.
- Program-specific standards include CoPs.
- Life Safety Code (LSC) regulations.
- Accreditation for both in-home and facility-based services, including:
  - Hospice Care
  - Hospice Inpatient Care

ACHC Private Duty Accreditation

- Created specifically for non-Medicare providers.
- ACHC accredits more than 500 locations nationally.
- Accreditation for both skilled and non-skilled services, including:
  - Private Duty Nursing
  - Private Duty Aide
  - Companion Homemaker
  - Physical Therapy
  - Occupational Therapy
  - Speech Therapy
  - Social Work

ACHC Palliative Care Accreditation

- Supports organizations dedicated to delivering a higher level of care.
- Accreditation services for:
  - Community-Based Palliative Care

Distinction in Palliative Care

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

Distinction in Behavioral Health

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

Distinction in Telehealth

- Distinction in Telehealth
  - Home Health, Hospice, Private Duty, and Palliative Care
- One additional day on survey:
  - Must have served three patients

Types of surveys

- Home Health Program or Hospice Program (non-deemed)
- Home Health Program or Hospice with a recommendation for deemed status
- Home Health Program or Hospice Program and a Distinction (non-deemed)
- Home Health Program or Hospice Program with a recommendation for deemed status and a Distinction

Types of Surveys

- **Initial Survey:** An Initial Survey is conducted on organizations that apply for ACHC Accreditation for the first time. Initial Surveys are unannounced.
- **Renewal Survey:** A Renewal Survey is conducted on organizations that are currently accredited by ACHC. Renewal Surveys are conducted in the same format as an Initial Survey; however, during the Renewal Survey, the Surveyor also reviews previous deficiencies for compliance. Renewal Surveys are unannounced.
- **Dependent Survey:** A Dependent Survey is a re-survey conducted on an organization that was not in compliance with ACHC Accreditation Standards. Dependent Surveys are unannounced.

Types of Surveys

- **Licensure Survey:** A Licensure Survey is conducted on organizations that are required to obtain a license before beginning to conduct business. If ACHC is approved to conduct a Licensure Survey in that state, ACHC will conduct a one (1) day survey that includes a review of the organization's policies and procedures. The ACHC Surveyor will verify that proper personnel are in place and the organization is ready to begin operation. Licensure Surveys are announced.

Types of Surveys

- **Complaint Survey:** A Complaint Survey is conducted on organizations that have a complaint filed against them. Should ACHC determine during the investigation that a site visit is required, ACHC will conduct a Complaint Survey to determine if the complaint is substantiated. Complaint Surveys are unannounced.
- **Disciplinary Action Survey:** A Disciplinary Action Survey is conducted on organizations due to non-compliance from a previous survey, the ACHC Accreditation Standards and/or Accreditation Process and/or a breach in the ACHC Accreditation Agreement. Disciplinary Action Surveys are unannounced.

Postponement of Survey

- Organizations may postpone an ACHC survey as long as the ACHC Surveyor has not begun to travel to the organization's location. Postponements must be requested in writing to the organization's Account Advisor. ACHC will invoice a postponement fee as listed in the Agreement for Accreditation Services.
- The organization is responsible for notifying the Account Advisor in writing of its readiness for survey within 180 days from receipt of the ACHC Postponement. If the organization notifies the Account Advisor within the specified time frames, the organization will be scheduled for a survey following the ACHC scheduling process. If the organization does not notify the Account Advisor within the specified time frames, the organization's deposit will be forfeited, application voided, and the organization must reapply for accreditation.

Refusal of Survey

- Organizations have the right to refuse an ACHC survey. In the event a refusal is requested, the organization must speak to the Account Advisor or an appropriate manager at ACHC to request a Survey Refusal Form. A completed Survey Refusal Form must be submitted to ACHC before the Surveyor can leave the location. If an ACHC Surveyor arrives on site and the organization does not meet the eligibility criteria for an accreditation survey, the organization must refuse the survey and complete a Survey Refusal Form.
- If an ACHC Surveyor arrives on site and the organization is not operating during its posted business hours, the Surveyor will notify the ACHC Account Advisor and leave the location. This will be considered a refusal of survey.

Refusal of Survey

- The organization is charged a refusal fee as listed in the Agreement for Accreditation Services. The organization is responsible for notifying the Account Advisor in writing of its readiness for a resurvey within 180 days from refusal of survey. If the organization notifies the Account Advisor within the specified time frame, the organization will be sent to scheduling and will follow the normal scheduling process. If the organization notifies the Account Advisor outside of the specified time frame, the organization's deposit will be forfeited, the application will be voided and the organization must re-apply for accreditation.
- Agencies with a Medicare Provider Number who refuse a survey will be an automatic denial.

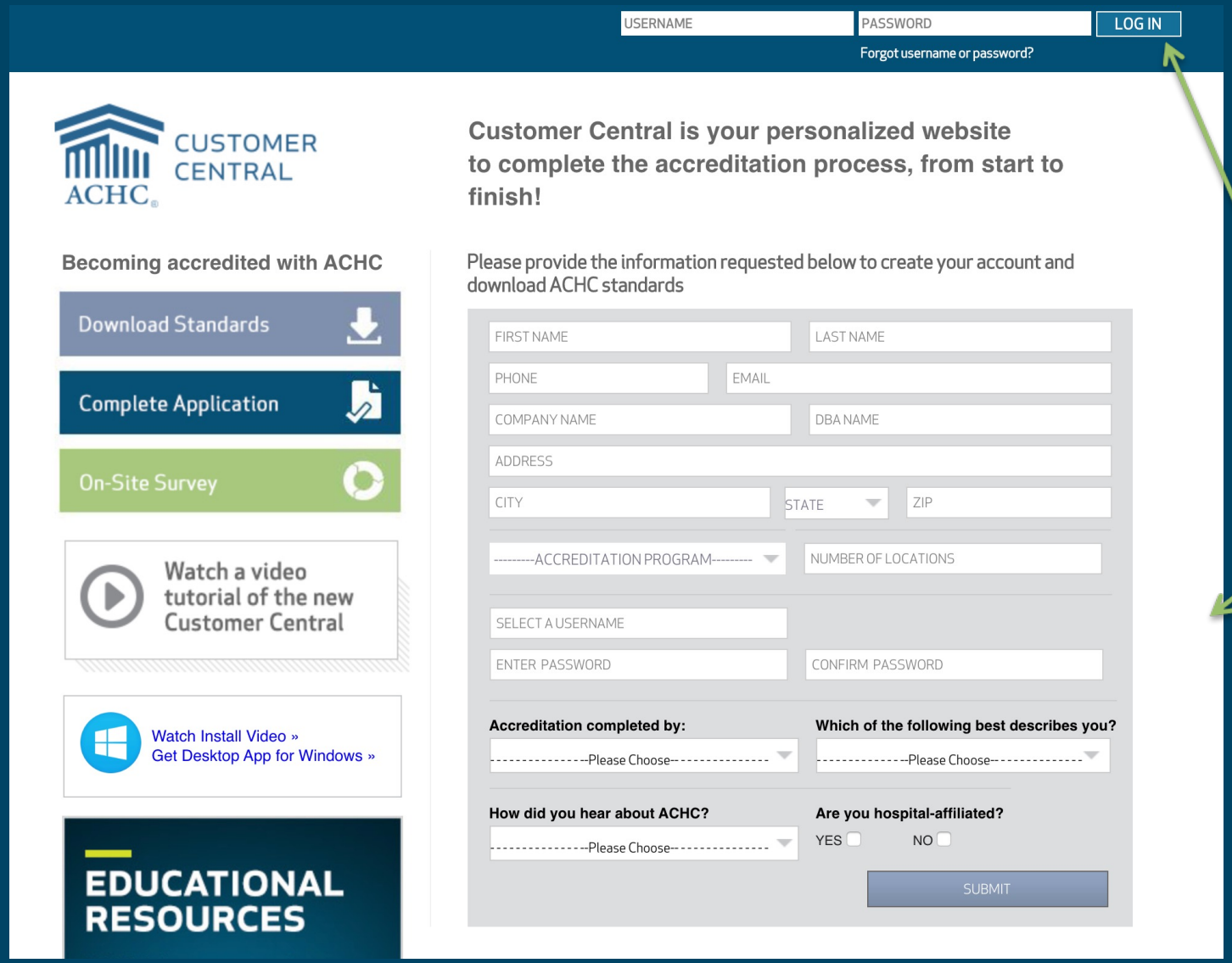
ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Completing the Application

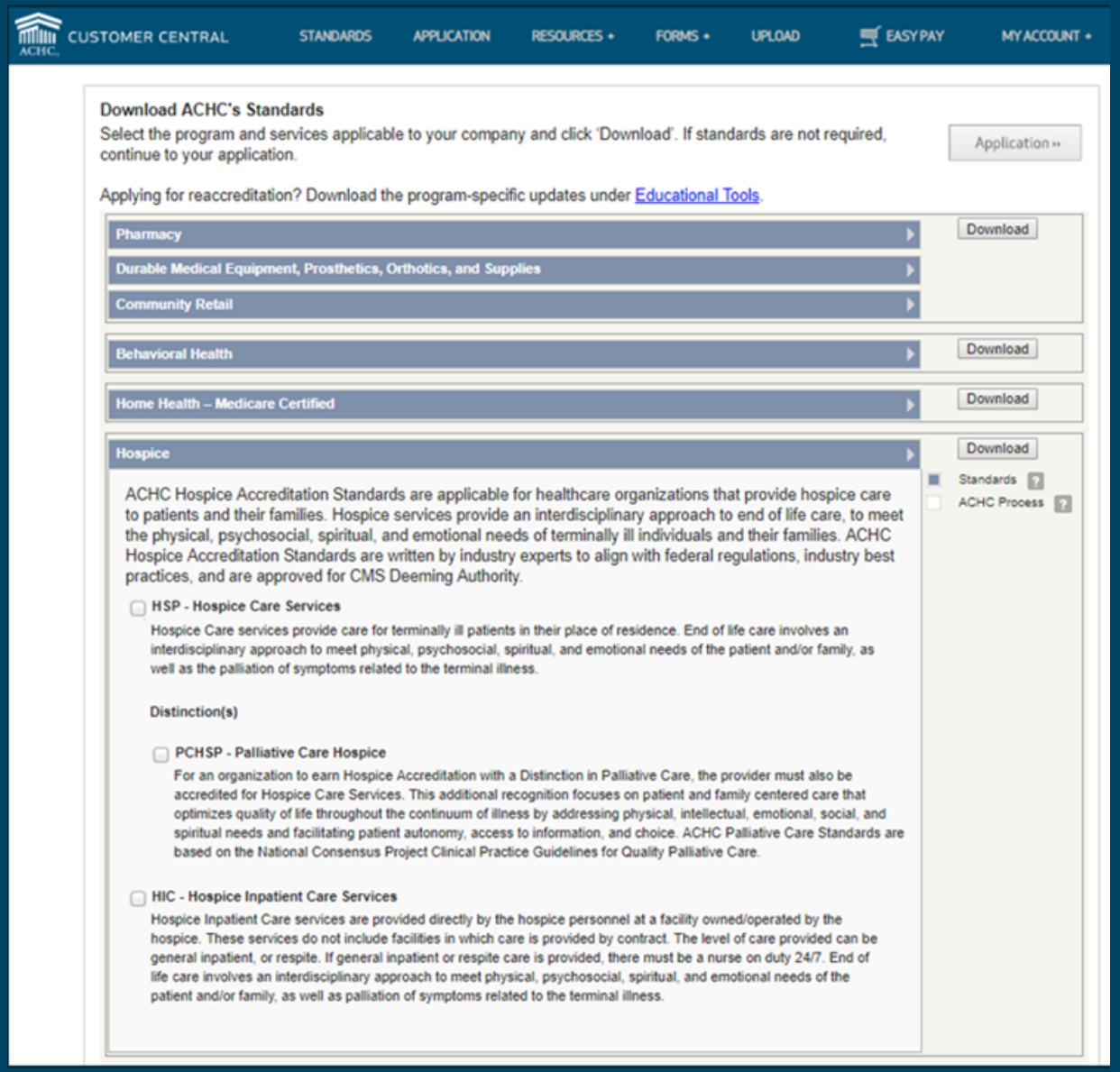
Application

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



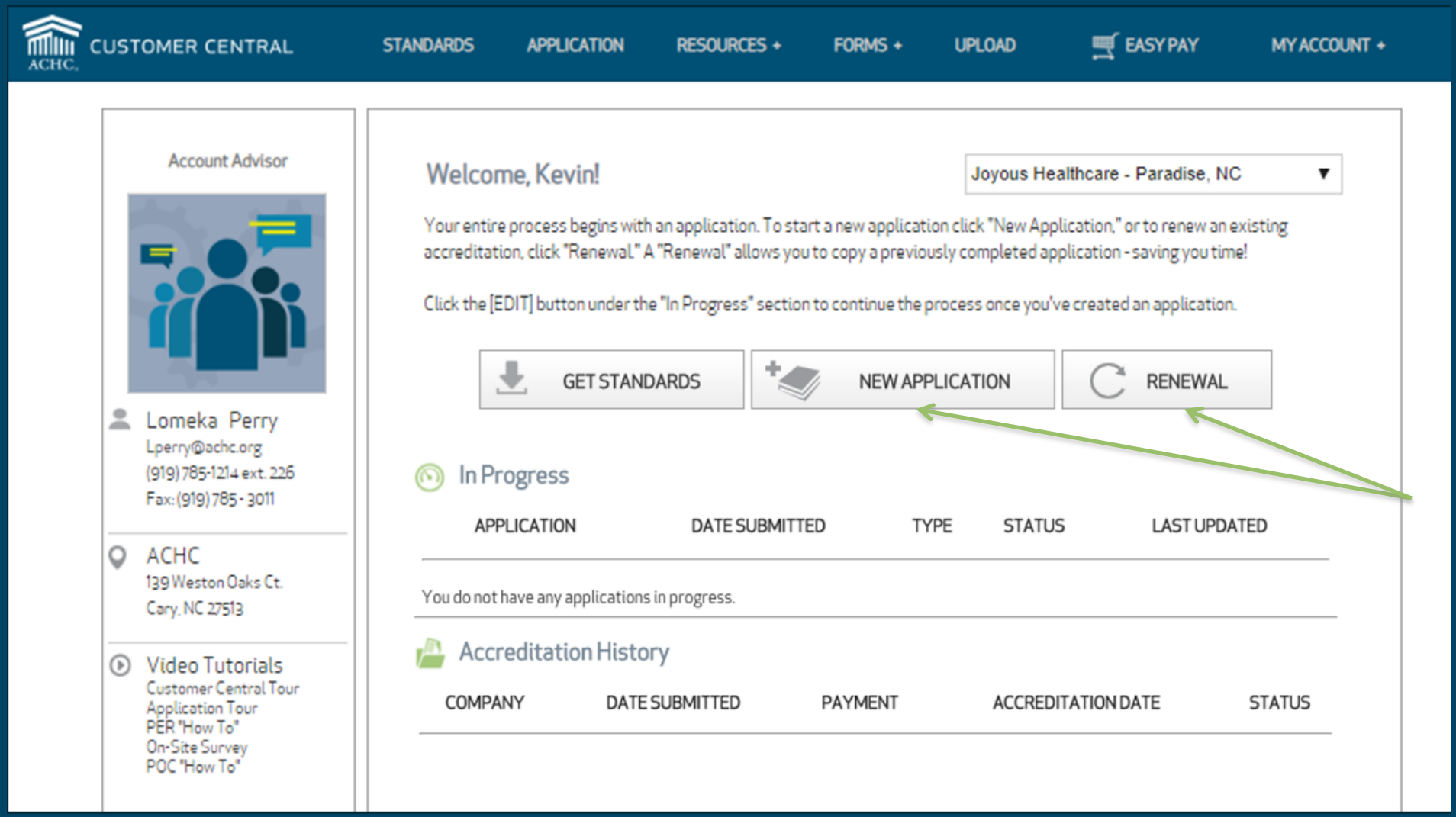
Go To: cc.achc.org

Log in above, or create a new account below.



Once inside your client's account, encourage them to purchase standards.

This allows continuous access to the standards.



If this is your first time with ACHC Accreditation, click the “NEW APPLICATION” button.

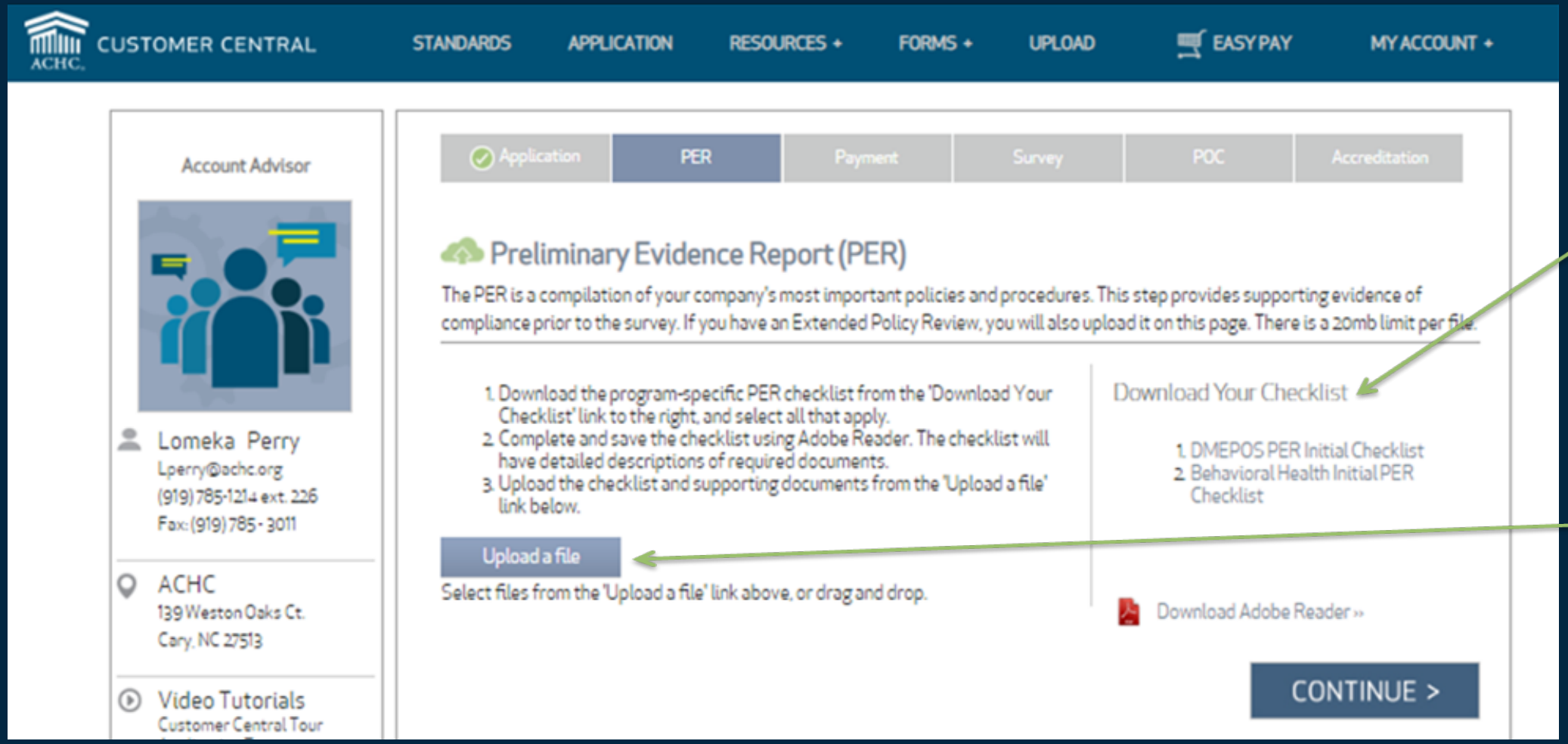
If you’re in an existing accredited account (like shown), you can click on the “RENEWAL” button to save time.

Online Application

- NEW APPLICATION or RENEWAL
- Main office:
  - Profile
  - Location
  - Contacts
  - Services
- Additional locations — branch locations or multiple locations
- Blackout dates
- Unduplicated admissions
- Purchased policies

Preliminary Evidence Report

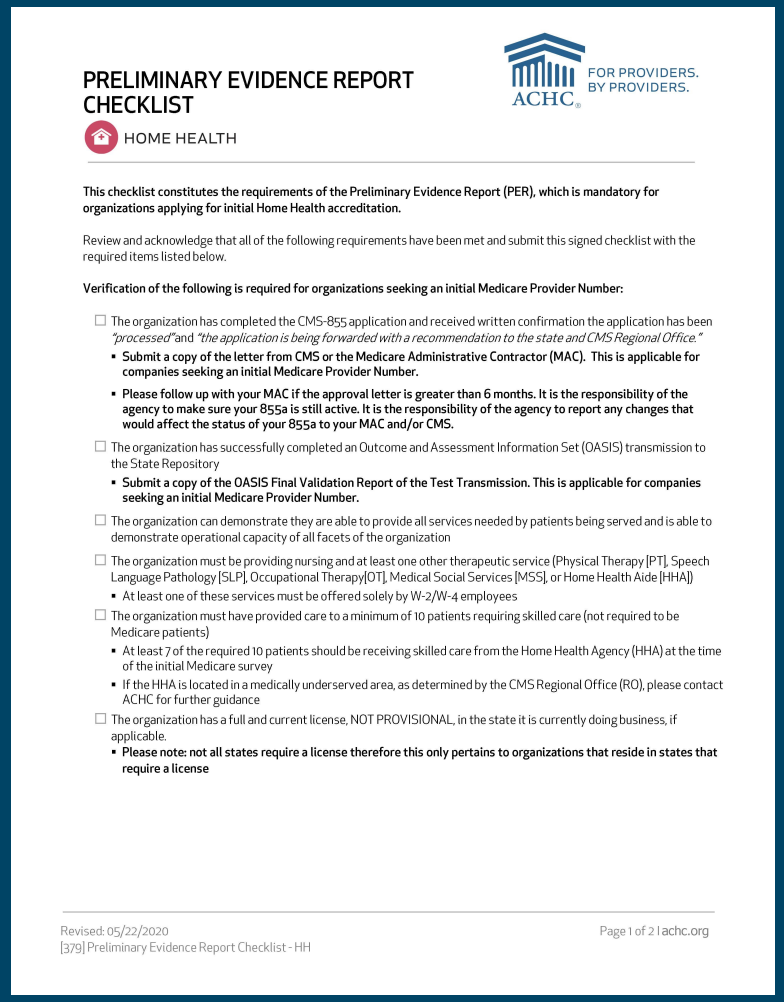
- Preliminary Evidence Report (PER):
  - Mandatory documents and/or criteria that must be submitted and met in order to begin the survey process
  - Date of Compliance — ACHC standards only
  - Compliance starts with acceptance of first patient
  - CoPs
  - State licensure requirements
  - Discipline-specific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



First download the correct PER Checklist.

Completely fill out the PER Checklist and upload with supporting documents.

Preliminary Evidence Report Checklist



PRELIMINARY EVIDENCE REPORT CHECKLIST

ACHC FOR PROVIDERS. BY PROVIDERS.

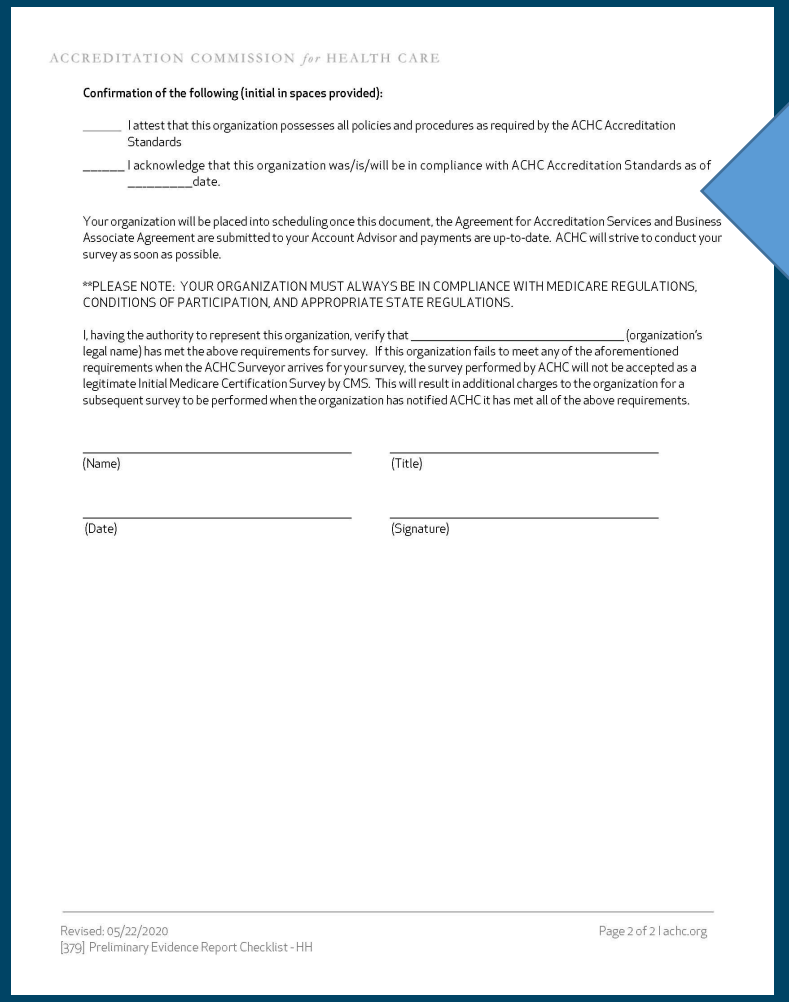
HOME HEALTH

This checklist constitutes the requirements of the Preliminary Evidence Report (PER), which is mandatory for organizations applying for initial Home Health accreditation.

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

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

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



ACCREDITATION COMMISSION *for* HEALTH CARE

Confirmation of the following (initial in spaces provided):

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

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

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

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

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

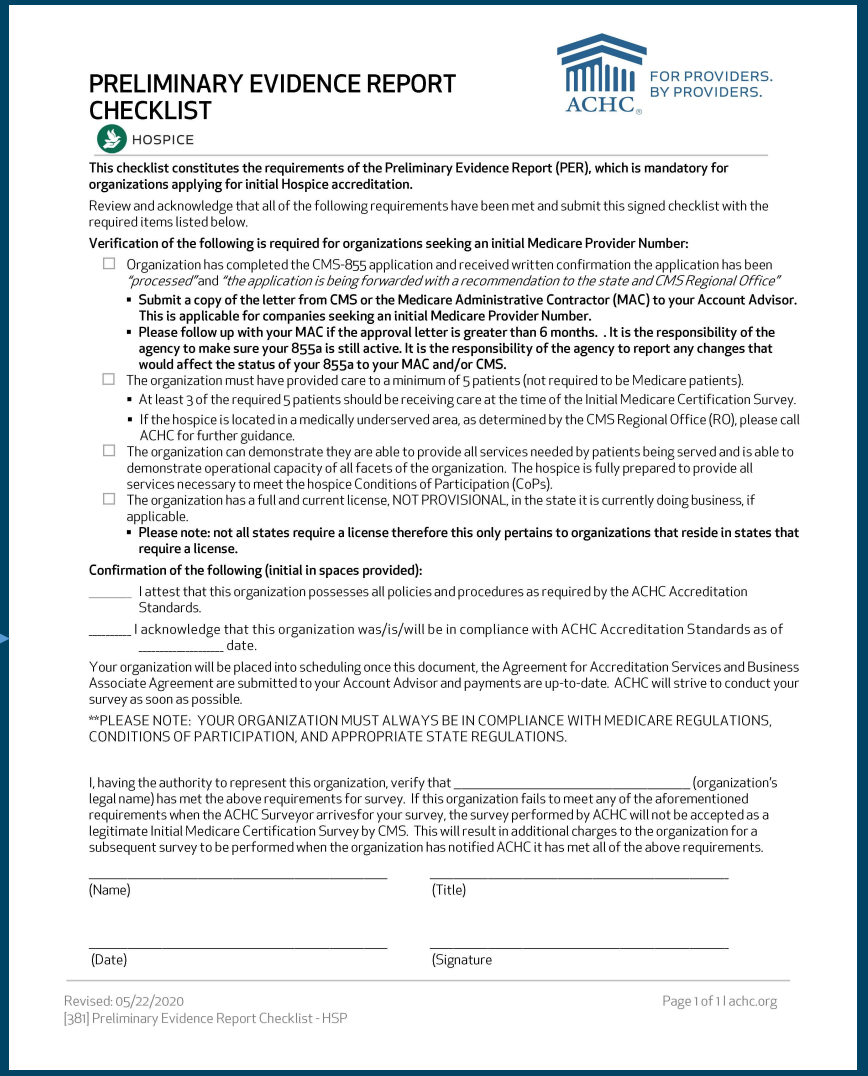
_____ _____
(Name) (Title)

_____ _____
(Date) (Signature)

Establish compliance date

Preliminary Evidence Report Checklist

Establish Compliance Date



PRELIMINARY EVIDENCE REPORT CHECKLIST

FOR PROVIDERS. BY PROVIDERS.

HOSPICE

This checklist constitutes the requirements of the Preliminary Evidence Report (PER), which is mandatory for organizations applying for initial Hospice accreditation.

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

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

- ☐ Organization has completed the CMS-855 application and received written confirmation the application has been *"processed"* and *"the application is being forwarded with a recommendation to the state and CMS Regional Office"*
  - **Submit a copy of the letter from CMS or the Medicare Administrative Contractor (MAC) to your Account Advisor. This is applicable for companies seeking an initial Medicare Provider Number.**
  - **Please follow up with your MAC if the approval letter is greater than 6 months. . It is the responsibility of the agency to make sure your 855a is still active. It is the responsibility of the agency to report any changes that would affect the status of your 855a to your MAC and/or CMS.**
- ☐ The organization must have provided care to a minimum of 5 patients (not required to be Medicare patients).
  - At least 3 of the required 5 patients should be receiving care at the time of the Initial Medicare Certification Survey.
  - If the hospice is located in a medically underserved area, as determined by the CMS Regional Office (RO), please call ACHC for further guidance.
- ☐ The organization can demonstrate they are able to provide all services needed by patients being served and is able to demonstrate operational capacity of all facets of the organization. The hospice is fully prepared to provide all services necessary to meet the hospice Conditions of Participation (CoPs).
- ☐ The organization has a full and current license, NOT PROVISIONAL, in the state it is currently doing business, if applicable.
  - **Please note: not all states require a license therefore this only pertains to organizations that reside in states that require a license.**

Confirmation of the following (initial in spaces provided):

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

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

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

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

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

_____ (Name) _____ (Title)

_____ (Date) _____ (Signature

Revised: 05/22/2020
[381] Preliminary Evidence Report Checklist - HSP

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ACHCU

ACHCU is a brand of ACHC.

ACHC

Home Health Appendix A

Appendix A: Standard Service Table for Selected Services

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

Home Health Appendix B

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

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

Hospice Appendix A

Appendix A: Standard Service Table for Selected Services

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

Hospice Appendix B

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

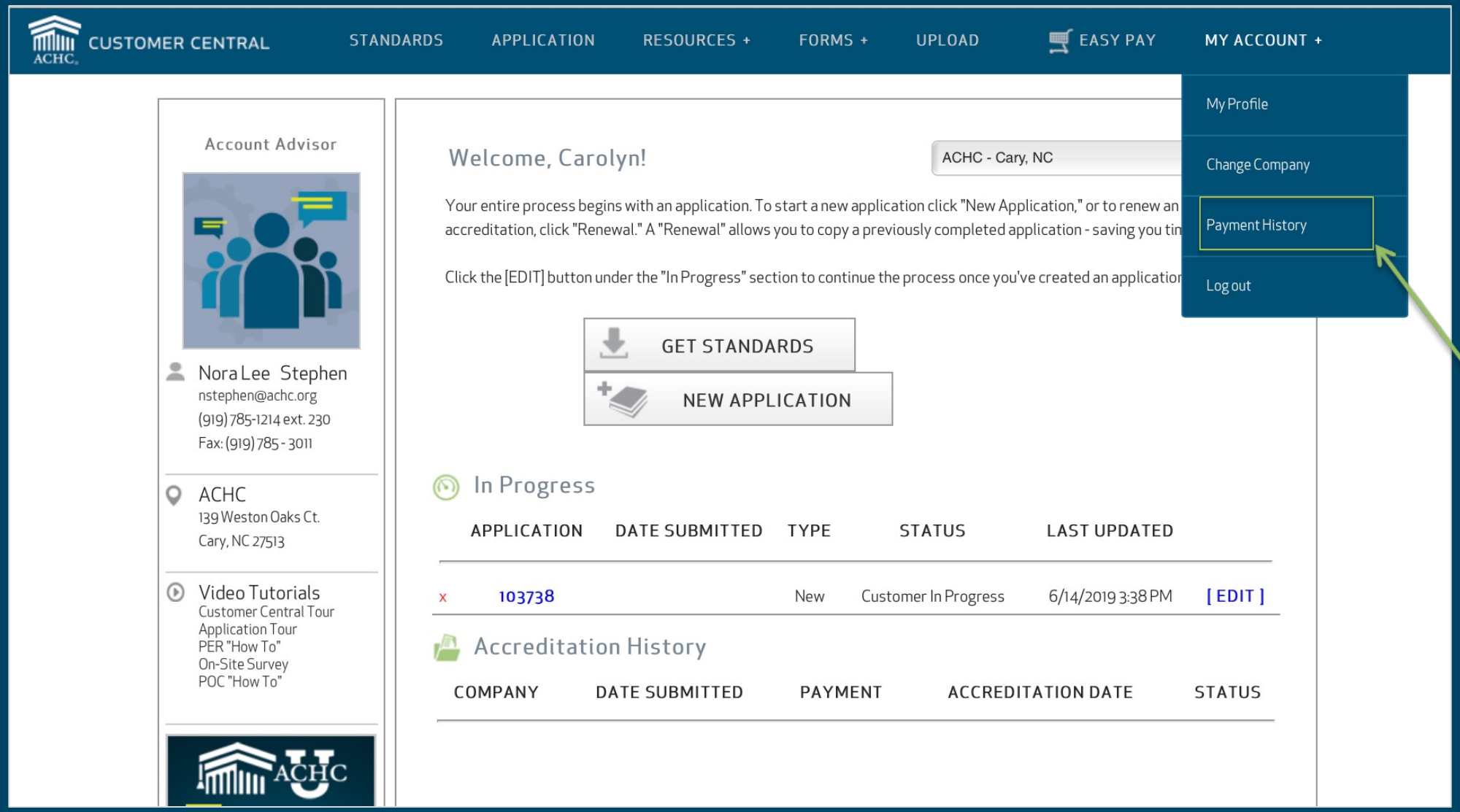
Standard #	Documents, Policies and Procedures	Agency Notes
HSP1-1A	Copy of All Current Applicable License(s)/Permit(s) for Each Premise	
HSP1-1A.01	Written Policies and Procedures	
HSP1-1B.01	Written Policies and Procedures	
HSP1-2B	Written Policies and Procedures	
HSP1-2B.01	Written Policies and Procedures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

Extended Policy Review

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

Accreditation Process

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



After payments are completed, you can always find a copy of the receipt in the "Payment History" tab.

Customer Central

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

ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Home Health & Hospice Deemed Survey Process:

Start To Finish

Deemed VS. Non-Deemed

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

On-Site Survey

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

Opening Conference

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

Tour

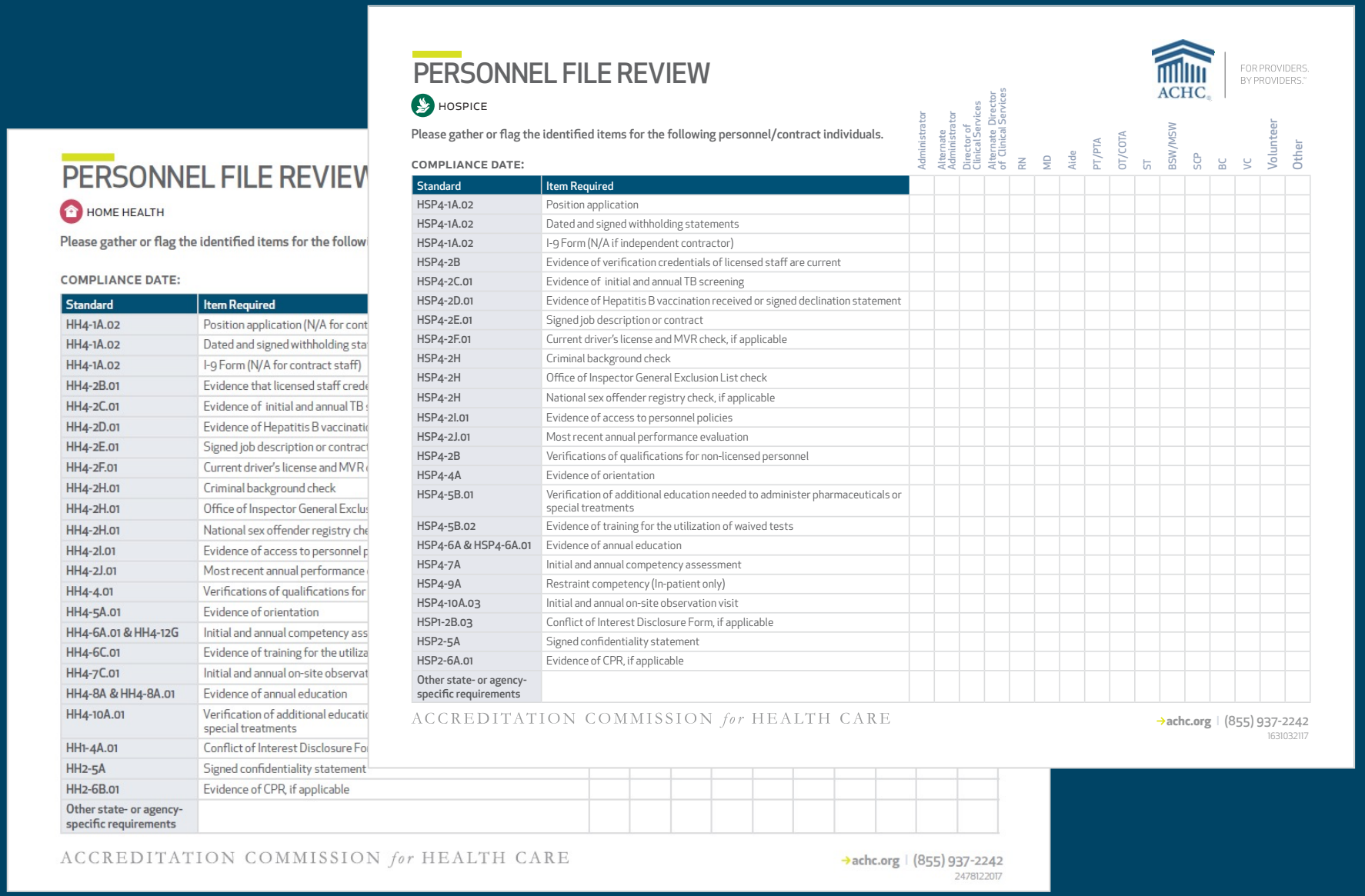
- Brief tour of facility:
  - Medical record storage
  - Maintaining confidentiality of Protected Health Information (PHI)
  - Supply closet
  - Biohazard waste
  - Required posters
  - Fire extinguishers/smoke detectors/non-smoking signage
  - Restrooms

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 list 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 follow

COMPLIANCE DATE:

Standard	Item Required
HH4-1A.02	Position application (N/A for cont
HH4-1A.02	Dated and signed withholding sta
HH4-1A.02	I-9 Form (N/A for contract staff)
HH4-2B.01	Evidence that licensed staff crede
HH4-2C.01	Evidence of initial and annual TB
HH4-2D.01	Evidence of Hepatitis B vaccinati
HH4-2E.01	Signed job description or contract
HH4-2F.01	Current driver's license and MVR
HH4-2H.01	Criminal background check
HH4-2H.01	Office of Inspector General Exclu
HH4-2H.01	National sex offender registry che
HH4-2I.01	Evidence of access to personnel p
HH4-2J.01	Most recent annual performance
HH4-4.01	Verifications of qualifications for
HH4-5A.01	Evidence of orientation
HH4-6A.01 & HH4-12G	Initial and annual competency ass
HH4-6C.01	Evidence of training for the utiliza
HH4-7C.01	Initial and annual on-site observat
HH4-8A & HH4-8A.01	Evidence of annual education
HH4-10A.01	Verification of additional educati special treatments
HH1-4A.01	Conflict of Interest Disclosure Fo
HH2-5A	Signed confidentiality statement
HH2-6B.01	Evidence of CPR, if applicable
Other state- or agency-specific requirements	

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2478122017

PERSONNEL FILE REVIEW

HOSPICE

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

COMPLIANCE DATE:

Standard	Item Required	Administrator	Alternate Administrator	Director of Clinical Services	Alternate Director of Clinical Services	RN	MD	Aide	PT/PTA	OT/COTA	ST	BSW/MSW	SCP	BC	VC	Volunteer	Other
HSP4-1A.02	Position application																
HSP4-1A.02	Dated and signed withholding statements																
HSP4-1A.02	I-9 Form (N/A if independent contractor)																
HSP4-2B	Evidence of verification credentials of licensed staff are current																
HSP4-2C.01	Evidence of initial and annual TB screening																
HSP4-2D.01	Evidence of Hepatitis B vaccination received or signed declination statement																
HSP4-2E.01	Signed job description or contract																
HSP4-2F.01	Current driver's license and MVR check, if applicable																
HSP4-2H	Criminal background check																
HSP4-2H	Office of Inspector General Exclusion List check																
HSP4-2H	National sex offender registry check, if applicable																
HSP4-2I.01	Evidence of access to personnel policies																
HSP4-2J.01	Most recent annual performance evaluation																
HSP4-2B	Verifications of qualifications for non-licensed personnel																
HSP4-4A	Evidence of orientation																
HSP4-5B.01	Verification of additional education needed to administer pharmaceuticals or special treatments																
HSP4-5B.02	Evidence of training for the utilization of waived tests																
HSP4-6A & HSP4-6A.01	Evidence of annual education																
HSP4-7A	Initial and annual competency assessment																
HSP4-9A	Restraint competency (In-patient only)																
HSP4-10A.03	Initial and annual on-site observation visit																
HSP1-2B.03	Conflict of Interest Disclosure Form, if applicable																
HSP2-5A	Signed confidentiality statement																
HSP2-6A.01	Evidence of CPR, if applicable																
Other state- or agency-specific requirements																	

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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 Home Health

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

Record Review/Home Visits Hospice

Unduplicated Admissions for a Recent 12 Months	Minimum # of Record Reviews Without Home Visit	Minimum # of Record Reviews With Home Visit	Total Record Reviews
<150	8	3	11
150-750	10	3	13
751-1,250	12	4	16
1,251 or more	15	5	20

Corrected On Site

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

Exit Conference

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

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EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Accreditation Decisions

Review Committee

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

Standard-Level & Condition-Level

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

Corrected On Site

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

Home Health Summary Of Findings

Identify the standard and specific tag

Summary of Findings Report for Survey on 02/28/2018

Deficiency Category - COP: Standard Level

		Comments	Deficient
	care furnished. The contract/agreement contains all requirements and is kept on file within the HHA. 484.105(e), 484.105(e)(1), 484.105(e)(2), 484.105(e)(2)(i), 484.105(e)(2)(ii), 484.105(e)(2)(iii), 484.105(e)(2)(iv), 484.105(e)(3)	Upon contract review, 1 out of 4 (KR) did not include the requirements of section 1861(w) of the Social Security Act. Corrective Action: The agency will need to ensure that all contracts address the billing requirement, that only the agency can bill the patient, or other payer sources for services in compliance with section 1861(w) of the social security act. Educate management and contract staff to this requirement and audit contracts for compliance.	X
HH1-10A 484.105(e)(2) G978	**An HHA that uses outside personnel to provide care/services on behalf of the HHA has a written contract/agreement for care furnished. The contract/agreement contains all requirements and is kept on file within the HHA. 484.105(e), 484.105(e)(1), 484.105(e)(2), 484.105(e)(2)(i), 484.105(e)(2)(ii), 484.105(e)(2)(iii), 484.105(e)(2)(iv), 484.105(e)(3)**	Upon contract review, 4 out of 4 (Ac, SRS, KR, AHC) did not include that the independent contractor may not have been denied Medicare or Medicaid enrollment; had its Medicare or Medicaid billing privileges revoked; or been debarred from participating in any government program. Corrective Action: The agency will need to ensure the written agreement/contract with another agency, organization, or individual to furnish services to patients addresses the agency maintains overall responsibility for the services provided under arrangement and that the independent contractor may not have been denied Medicare or Medicaid enrollment, been excluded or terminated from any federal health care program or Medicaid, had its Medicare or Medicaid billing privileges revoked; or been debarred from participating in any government program. Educate management and contract staff to this requirement and audit contracts for compliance.	X
HH5-2C 484.55(c)(6) G538	**Written policies and procedures are established and implemented in regard to the comprehensive assessment being completed in a timely manner, consistent with patient's immediate needs, but no later than 5 calendar days after the start of care. 484.55, 484.55(b), 484.55(b)(1), 484.55(b)(2), 484.55(b)(3), 484.55(c), 484.55(c)(1), 484.55(c)(2), 484.55(c)(3), 484.55(c)(4), 484.55(c)(6)(i-ii), 484.55(c)(7), 484.55(c)(8)**	Upon medical record review, 12 out of 12 (AL, SSt, MD, MRe, MRie, RG, RS, SSa, LW, JC, LB, TK) did not have evidence that the comprehensive assessment included the primary caregiver's availability and schedules. Corrective Action: The agency will need to ensure all patients have a comprehensive assessment that accurately reflect the patient's status, and must include, at a minimum, the patient's primary caregivers, if any and other available supports, including their willingness and ability to provide care and their availability and schedules. Educate staff to this requirement and audit medical records for compliance.	X

Deficiency cited

Action required for compliance

Hospice Summary of Findings

Identify the standard and specific tag

Summary of Findings Report for Survey on 07/24/2017
Services: HSP

ACHC

		ments	Defi-cient
		personnel record review, 1 of 1 (PR) did not contain nce of a signed job description that included the nsibilities of the Alternate Administrator. This was cted on site. ctive Action: The agency will need to ensure that the alternate administrator's personnel record verifies that: • The employee has appropriate education and experience requirements • There is a signed job description for this role • The employee has been orientated to this role Educate staff and perform audits for compliance.	X
HSP4-7A 418.100(g)(3) L663	**Written policies and procedures are established and implemented which describe the method for assessing the skills and competency of all individuals furnishing care, including volunteers furnishing services and, as necessary, provide in-service training and education programs where required. All personnel receive training and/or education and competently perform the required patient care/service activities prior to being assigned to work independently. The hospice maintains a written description of the in-service training provided during the previous 12 months. (418.100(g)(3)) (L663) Knowledge and skills can be acquired through a variety of methods such as classroom instruction, on-the-job observation and demonstration, self-instruction, internships, etc. The focus and type of training is directly related to the goals of the personnel and/or the hospice.**	Upon personnel record review, 2 of 13 (MH, BH) did not contain evidence of a skills competency, specific to the discipline having been conducted for all personnel, including volunteers initially during orientation and annually. MH-There was no evidence of a competency for employee's chaplain position. This was corrected on site. BH-There was no evidence of a competency for the volunteer position. This was corrected on-site. Corrective Action: The agency will need to ensure that there is evidence of a skills competency, specific to the discipline having been conducted for all personnel, including volunteers initially during orientation and annually (note: a self-assessment tool alone is not acceptable). Educate staff and perform audits for compliance.	X
HSP5-8B 418.104(e)(2) L683	**Written policies and procedures are established and implemented in regard to the process for discharging a patient receiving hospice services. (418.104(e)) (418.104(e)(1)) (418.104(e)(1)(i-ii) (L682) (418.104(e)(2)) (418.104(e)(2)(i-ii) (L683) (418.104(e)(3)) (418.104(e)(3)(i-iv) (L684)**	Upon client record review, 1 of 1 (Rock Hill-WG) did not contain evidence a discharge summary and a copy of the patient record (if requested) was forwarded to the attending physician when the patient revoked hospice services. There was documentation that the physician was notified of the revocation. Corrective Action: The agency will need to ensure that there is evidence in the patient record that a discharge summary and a copy of patient record (if requested) was sent to that attending physician. Educate staff and perform chart audits for compliance.	X

Deficiency cited

Action required for compliance

ACHC Accreditation Decisions

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.

Dispute Process

- Organizations, whether applying for the first time or renewing their accreditation, may formally request to dispute a standard(s) deficiency documented on the Summary of Findings.
- The organization submits a written request for dispute to its ACHC Account Advisor no later than 10 calendar days from the receipt of the Summary of Findings. Disputes will not be granted if:
  - The request is received after the 10 calendar day time frame.
  - An organization has an outstanding balance.
  - An organization has a payment plan that is not current.

Dispute Process

- The written request outlines the standard(s) noted in the Summary of Findings that the organization believes ACHC incorrectly determined as a deficiency.
- The organization must also provide evidence to support that, at the time of the survey, the organization was in compliance with the standard(s).
- Any evidence the organization submits must have been presented to and reviewed by the Surveyor(s) at the time of the survey.
- Evidence provided with the request letter will not be returned to the organization.

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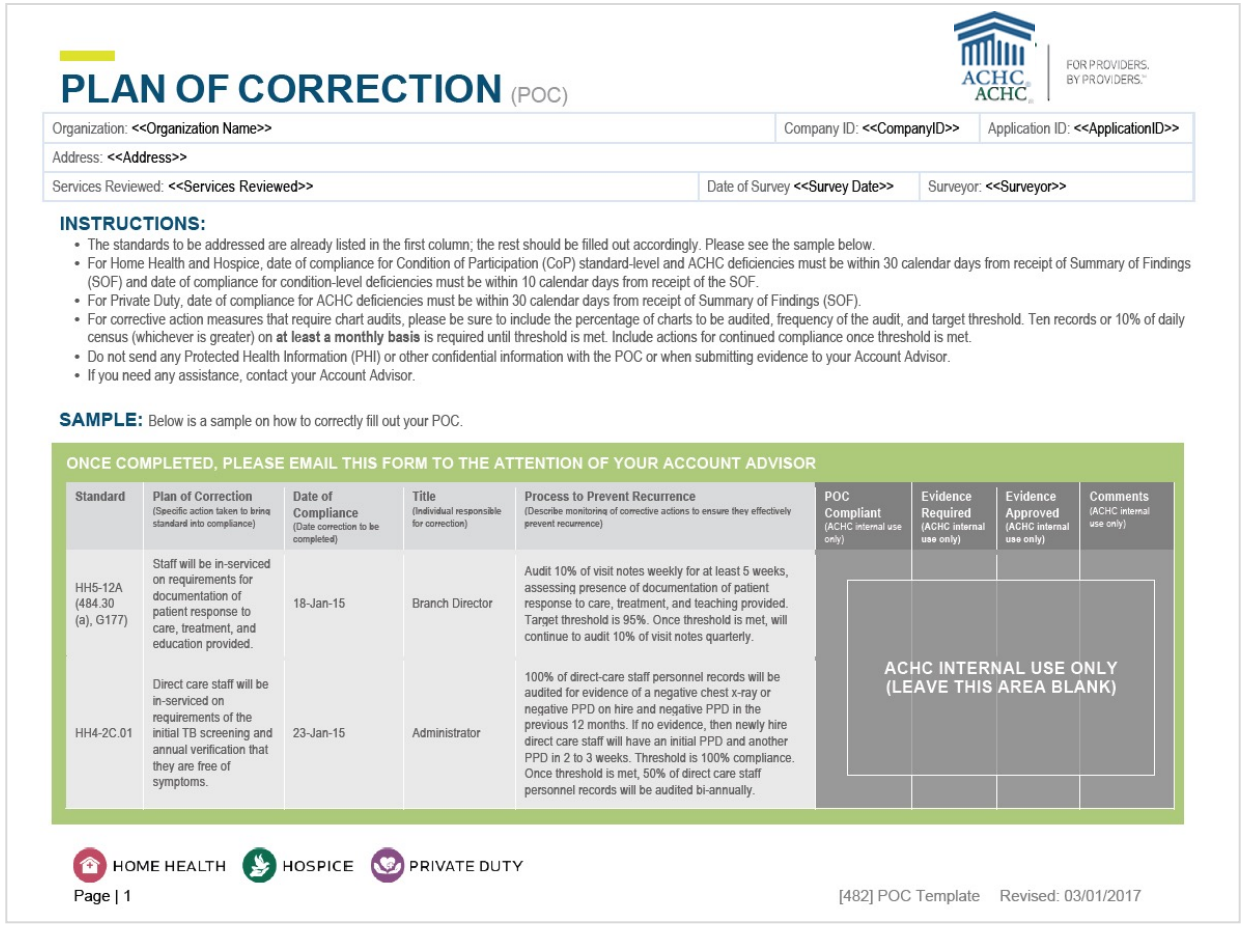
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Developing an Approved Plan of Correction

Plan of Correction



PLAN OF CORRECTION (POC)

FOR PROVIDERS. BY PROVIDERS.™

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

INSTRUCTIONS:

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

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

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

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

HOME HEALTH HOSPICE PRIVATE DUTY

Page | 1

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

Plan Of Correction Requirements

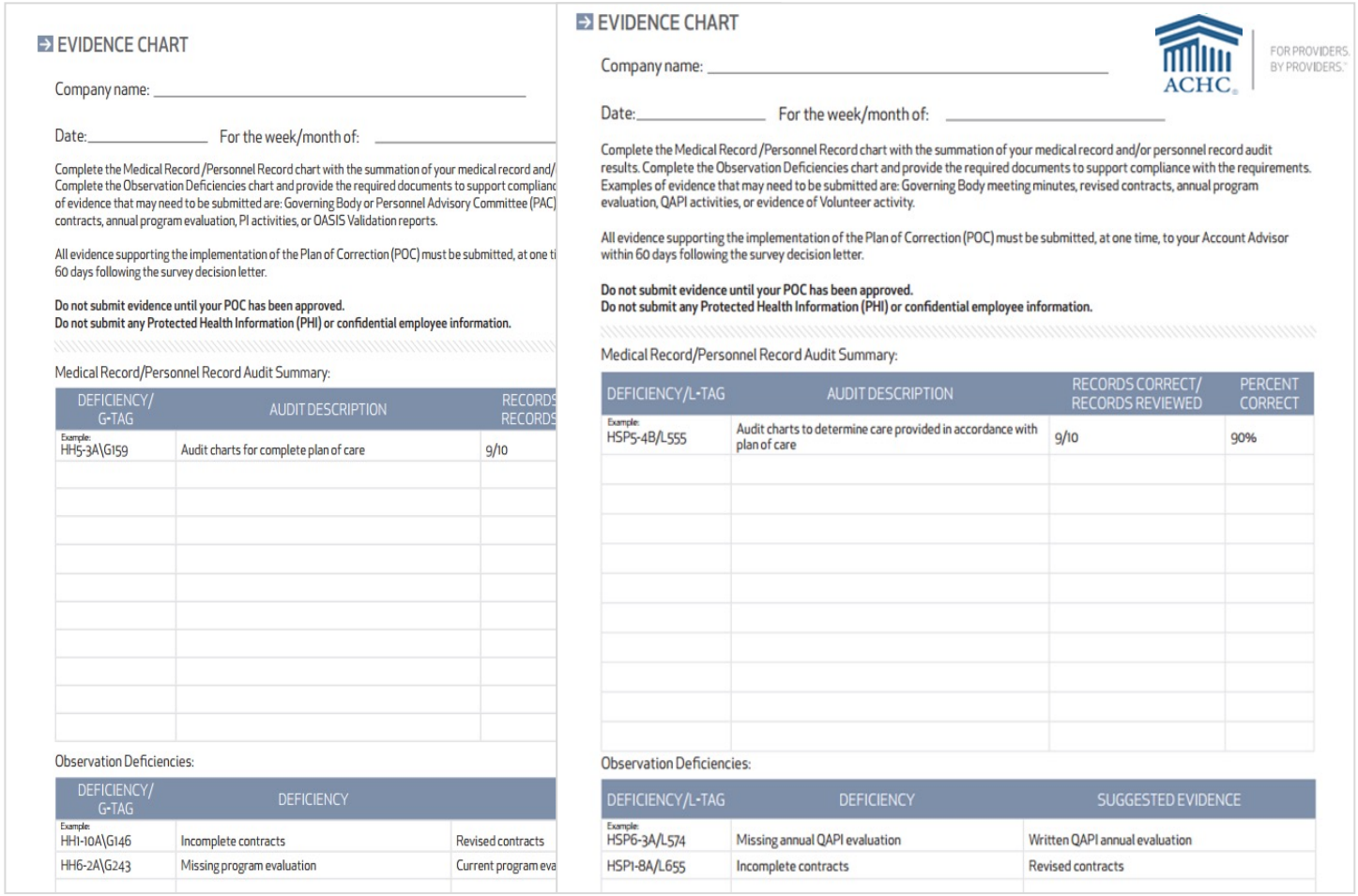
- Due in 10 calendar days to ACHC
- Deficiencies are auto-filled
- Plan of Correction:
  - Specific action step to correct the deficiency
- Date of compliance of the action step:
  - 10 calendar days for condition-level
  - 30 calendar days for standard-level
- Title of individual responsible
- Process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

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



EVIDENCE CHART

Company name: _____

Date:_____ For the week/month of: _____

Complete the Medical Record /Personnel Record chart with the summation of your medical record and/
Complete the Observation Deficiencies chart and provide the required documents to support compliand
of evidence that may need to be submitted are: Governing Body or Personnel Advisory Committee (PAC)
contracts, annual program evaluation, PI activities, or OASIS Validation reports.

All evidence supporting the implementation of the Plan of Correction (POC) must be submitted, at one ti
60 days following the survey decision letter.

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

Medical Record/Personnel Record Audit Summary:

DEFICIENCY/ G-TAG	AUDIT DESCRIPTION	RECORDS RECORDS
Example: HH5-3A\G159	Audit charts for complete plan of care	9/10

Observation Deficiencies:

DEFICIENCY/ G-TAG	DEFICIENCY	
Example: HH1-10A\G146	Incomplete contracts	Revised contracts
HH6-2A\G243	Missing program evaluation	Current program eva

EVIDENCE CHART

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Company name: _____

Date:_____ For the week/month of: _____

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

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

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

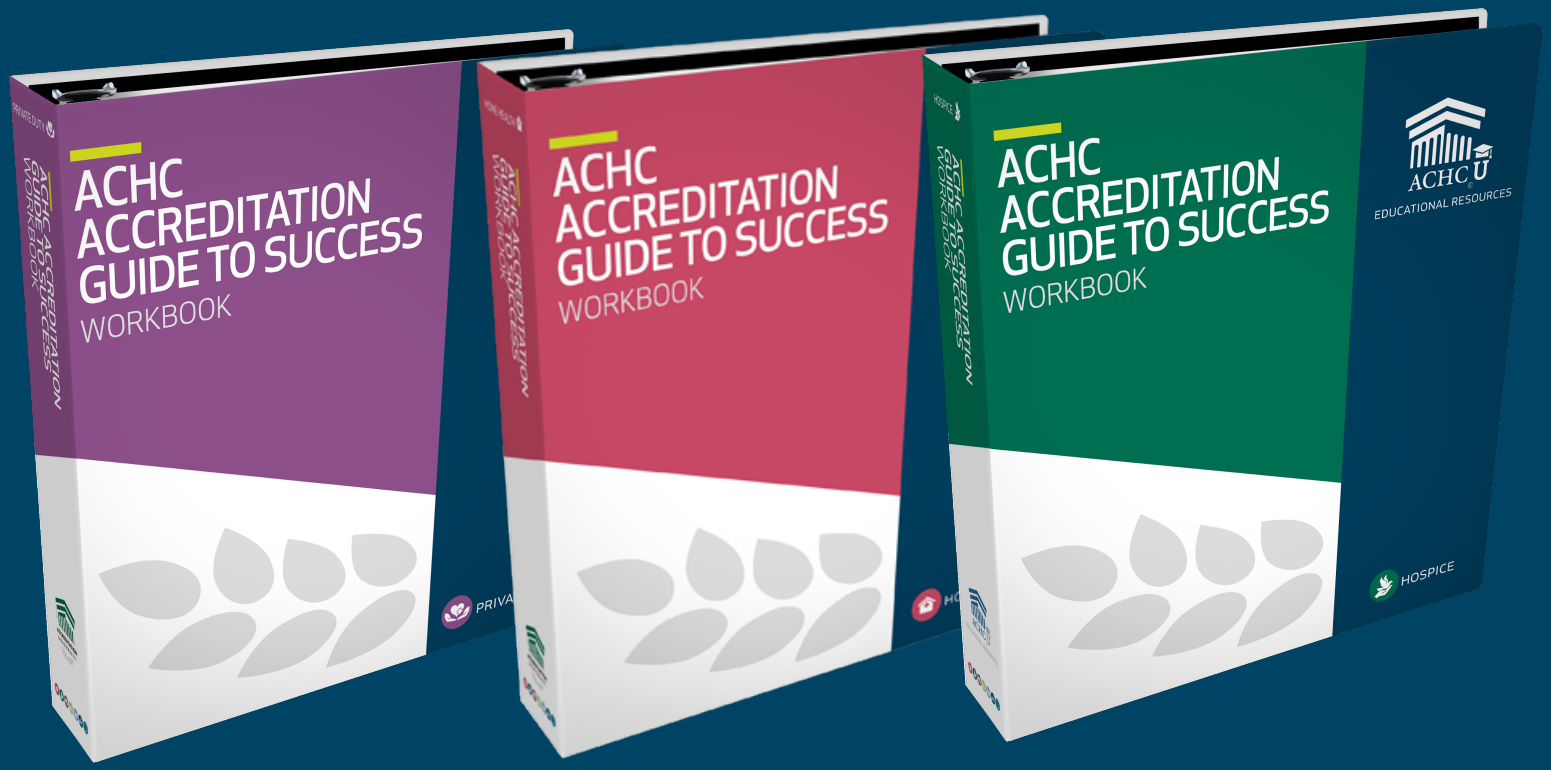
Medical Record/Personnel Record Audit Summary:

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

Observation Deficiencies:

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

ACHC Accreditation Guide To Success



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Medicare CoP Checklist

MEDICARE CONDITIONS OF PARTICIPATION SURVEY REQUIREMENTS

HOME HEALTH

ACHC Accreditation Standards are developed in conjunction with the Medicare Conditions of Participation (CoPs). This checklist will assist you in auditing and preparing your home health agency for accreditation.

Non-compliance with a minimum of one condition-level CoP will require another on-site survey at your organization's expense. Following this checklist does not guarantee approval of accreditation by Accreditation Commission for Health Care (ACHC). You should refer to the State Operations Manual, Appendix B-Guidance to Surveyors: Home Health Agencies, for further information regarding Medicare CoPs. This document only reviews the Medicare CoPs. Please refer to ACHC Accreditation Standards for additional ACHC requirements.

How to use this pre-evaluation checklist:
Review each Medicare CoP and the associated G Tags in the State Operations Manual and Interpretive Guidelines.
If in compliance, score the G Tag as a "Yes." If not in compliance, score the G Tag as a "No." Deficiencies cited in Level I and Level II G Tags, as well as, multiple "No" answers under an individual CoP could put the agency at risk for a condition-level deficiency, and therefore should be a priority in correcting. Level I tags are identified as blue and Level II tags are identified as green.

Are you in compliance with the Medicare Condition of Participation pertaining to release of patient identifiable OASIS information (reference CFR 484.40)?

YES	NO	G Tag	
☐	☐	G350	Is there evidence that patients' OASIS information is protected, kept confidential, and is not released to the public?

Are you in compliance with the Medicare Condition of Participation pertaining to reporting OASIS information (reference CFR §484.45)?

YES	NO	G Tag	
☐	☐	G370	Does the agency electronically report all OASIS data collected in accordance with §484.55?
☐	☐	G372	Does the agency encode and electronically transmit each completed OASIS within 30 days of completing the assessment?
☐	☐	G374	Does the encoded OASIS data accurately reflect the patient's status at the time of the assessment?
☐	☐	G376	Is there evidence the agency transmits OASIS data?
☐	☐	G378	Does the agency transmit OASIS data in a format that meets CMS requirements?
☐	☐	G380	Is there evidence of a successful test transmission to the QIES ASAP System or CMS OASIS contractor? (Only applicable to initial Medicare certification agencies.)
☐	☐	G382	Does the agency transmit using electronic software that complies with FIPS 140-2 or the agency contractor to the CMS collection site?
☐	☐	G384	Is the CMS-assigned branch identification number used when submitting information from branch locations? (N/A for agencies that do not have a branch.)

☐	☐	G386	Does the agency 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?

Are you in compliance with the Medicare Condition of Participation pertaining to patient rights (reference CFR 484.50)?

YES	NO	G Tag	
☐	☐	G406	Is there evidence the patient and representative have been informed of their rights in a language and manner understandable to them?
☐	☐	G408	Is there evidence the agency has provided the patient and representative a notice of rights?
☐	☐	G410	Is there evidence that the agency informed the patient or legal representative of their rights and responsibilities, in advance to furnishing care?
☐	☐	G412	Is there evidence the agency's transfer and discharge policies was provided to the patient or legal representative in a written format that is understandable to persons who have limited English proficiency and accessible to individuals with disabilities?
☐	☐	G414	Is there evidence the agency provided the patient or legal representative contact information for the Administrator, including their name, business address and business phone number?
☐	☐	G416	Is there evidence an OASIS privacy notice was provided for all patients for whom the OASIS data is collected?
☐	☐	G418	Is there evidence the patient or legal representative received a copy of the notice of rights and responsibilities as evidenced by signature in the medical record?
☐	☐	G420	Is there evidence patients were provided verbal notice of the rights and responsibilities in a language and manner they understand, free of charge, no later than the second visit of a skilled professional?
☐	☐	G422	Is there evidence the patient or legal representative is informed of the agency's transfer and discharge policies within four days of the initial evaluation visit?
☐	☐	G424	If the patient is incompetent, is there evidence the rights are exercised by the person appointed to act on the patient's behalf or by the patient to the extent the patient may exercise their rights as allowed by court order?
☐	☐	G426	Is there evidence the patient has the right to:
☐	☐	G428	▪ Have his or her property and person treated with respect?
☐	☐	G430	▪ Be free of verbal, mental, sexual, and physical abuse, including injuries of unknown source, neglect and misappropriation of property?
☐	☐	G432	▪ To voice grievances without fear of reprisal?
☐	☐	G434	▪ To participate in the planning of their care, with respect to: ▪ Completion of all assessments; ▪ The care to be furnished, based on the comprehensive assessment; ▪ Establishing and revising the plan of care; ▪ The disciplines that will furnish the care;

			▪ The frequency of visits; ▪ Expected outcomes of care, including patient-identified goals, and anticipated risks and benefits; ▪ Any factors that could impact treatment effectiveness; and ▪ Any changes in the care to be furnished?
☐	☐	G436	▪ To receive all services as outlined in the plan of care?
☐	☐	G438	▪ To a confidential clinical record?
☐	☐	G440	▪ To be informed of expected payment from Medicare or other sources as well as their expected liability as well as their right to be notified, orally and in writing, of any changes regarding payment for services as soon as possible, in advance of the next home health visit?
☐	☐	G442	▪ To receive written notice in advance of a specific service being furnished, if the agency believes that the service may be non-covered care, or in advance of the agency reducing or terminating on-going care?
☐	☐	G444	▪ To be informed of the state hotline number and the hours of operation in order to lodge complaints against the agency?
☐	☐	G446	▪ To be informed of the names, addresses and telephone numbers of the following entities: ▪ Agency on Aging; ▪ Center for Independent Living; ▪ Protection and Advocacy Agency; ▪ Aging and Disability Resource Center; and ▪ Quality Improvement Organization?
☐	☐	G448	▪ To be free from discrimination for exercising their rights to voice grievances?
☐	☐	G450	▪ To be informed of the right to access auxiliary aids and language services and how to access these services?
☐	☐	G452	Is there evidence the patient was only transferred or discharged from the agency when:
☐	☐	G454	▪ The transfer or discharge is necessary for the patent's welfare because the agency can no longer meet the patient's needs?
☐	☐	G456	▪ The patient or payor will no longer pay for the services?
☐	☐	G458	▪ The physician and the agency agree the goals of the patient have been met?
☐	☐	G460	▪ The patient refuses services or requests a transfer or discharge?
☐	☐	G462	▪ The patient is discharged for cause?
☐	☐	G464	If discharged for cause, is there evidence the patient and patient's primary care practitioner were informed that discharge for cause was being considered?
☐	☐	G466	If discharged for cause, is there evidence the agency made efforts to resolve the problem?
☐	☐	G468	If discharged for cause, is there evidence the agency provided the patient with contact information for other providers?

Medicare CoP Checklist

MEDICARE CONDITIONS OF PARTICIPATION SURVEY REQUIREMENTS

FOR PROVIDERS. BY PROVIDERS.

HOSPICE

The ACHC Accreditation Standards are developed in conjunction with the Medicare Conditions of Participation (CoPs). This checklist will assist a provider in auditing and preparing the hospice agency for accreditation. Non-compliance with a minimum of one condition-level CoP will require another on-site survey at the organization's expense. Following this checklist does not guarantee approval of accreditation by the Accreditation Commission for Health Care (ACHC). Agencies should refer to the State Operations Manual, Appendix M-Guidance to Surveyors: Hospice Agencies, for further information regarding Medicare CoPs. This document only reviews the Medicare CoPs; please refer to the ACHC Accreditation Standards for additional ACHC requirements.

How to use this pre-evaluation checklist:
Review each Medicare CoP and the associated L-tags in the State Operations Manual. If in compliance, score the Ltag as a "Yes". If not in compliance, score the Ltag as a "No." Multiple "No" answers under an individual CoP could put the agency at risk for a condition-level deficiency, and therefore should be a priority in correcting.

YES	NO	L Tag	
Are you in compliance with the Medicare Condition of Participation pertaining to Patient's Rights (reference CFR 418.52)?			
☐	☐	L501	Is there evidence the patient was informed and the hospice promoted and protected patient rights?
☐	☐	L502	Is there evidence the agency provided the patient with verbal and written notice of rights in advance of care?
☐	☐	L503	Is there evidence the agency informed and distributed advance directive information?
☐	☐	L504	Is there evidence the agency obtained a signature confirming receipt of rights and responsibilities?
☐	☐	L505	Is there evidence the agency allows the patient to exercise his or her rights, agency demonstrates respect for property/person and allows the patient to voice grievances?
☐	☐	L506	If the patient is incompetent, is there evidence the rights are exercised by person appointed to act on patient's behalf?
☐	☐	L507	If a patient is not incompetent, is there evidence of legal representative designated by patient if the patient desires a representative?
☐	☐	L508	Is there evidence all alleged violations are reported immediately?
☐	☐	L509	Is there evidence all alleged violations are immediately investigated to prevent further violations?
☐	☐	L510	Is there evidence of appropriate corrective action for verified violations was initiated?
☐	☐	L511	Is there evidence of verified violations were reported within 5 working days?
☐	☐	L512	Is there evidence the patient has the right to receive effective pain management and symptom control?
☐	☐	L513	Is there evidence the patient has the right to be involved in developing the plan of care?
☐	☐	L514	Is there evidence the patient has the right to refuse care or treatment?

MEDICARE CONDITIONS OF PARTICIPATION SURVEY REQUIREMENTS

FOR PROVIDERS. BY PROVIDERS.

HOSPICE

YES	NO	L Tag	
☐	☐	L515	Is there evidence the patient has the right to choose their attending physician?
☐	☐	L516	Is there evidence the patient has the right to a confidential clinical record?
☐	☐	L517	Is there evidence the patient has the right to be free from mistreatment, neglect, or mental, sexual and physical abuse, injuries unknown source, misappropriation of property?
☐	☐	L518	Is there evidence the patient has the right to receive information about hospice benefit covered services?
☐	☐	L519	Is there evidence the patient has the right to receive information on services that will be provided?
Are you in compliance with the Medicare Condition of Participation pertaining to Initial and Comprehensive Assessment of the Patient (reference CFR 418.54)?			
☐	☐	L521	Is there evidence of a documented patient specific comprehensive assessment?
☐	☐	L522	Is there evidence an RN completed the initial assessment within 48 hours of election?
☐	☐	L523	Is there evidence the IDG and attending physician complete the comprehensive assessment no later than 5 calendar days after election?
☐	☐	L524	Does the comprehensive assessment identify the physical, psychosocial, emotional and spiritual needs related to the terminal illness?
☐	☐	L525	Does the comprehensive assessment consider the nature and condition causing admission?
☐	☐	L526	Does the comprehensive assessment consider complications and risk factors?
☐	☐	L527	Does the comprehensive assessment consider the functional status, including the patient's ability to understand and participate in his or her own care?
☐	☐	L528	Does the comprehensive assessment consider the imminence of death?
☐	☐	L529	Does the comprehensive assessment consider the severity of symptoms?
☐	☐	L530	Does the comprehensive assessment include a drug profile?
☐	☐	L531	Does the comprehensive assessment include a bereavement assessment?
☐	☐	L532	Does the comprehensive assessment consider the need for referrals to other health professionals?
☐	☐	L533	Is there evidence the comprehensive assessment is updated at least every 15 days?
☐	☐	L534	Does the comprehensive assessment include data elements for measurement of outcomes?
☐	☐	L535	Is there evidence the data elements are an integral part of the comprehensive assessment?
Are you in compliance with the Medicare Condition of Participation pertaining to Initial and Comprehensive Assessment of the Interdisciplinary Group, Care Planning, and Coordination of Services (reference CFR 418.56)?			
☐	☐	L537	Is there evidence the IDG/attending physician prepared a written plan of care?

MEDICARE CONDITIONS OF PARTICIPATION SURVEY REQUIREMENTS

FOR PROVIDERS. BY PROVIDERS.

HOSPICE

YES	NO	L Tag	
☐	☐	L538	Does the plan of care specify the care/services needs of patient and family as identified in comprehensive assessment?
☐	☐	L539	Is there evidence of a designated IDG to meet the needs of the patient and family?
☐	☐	L540	Is there evidence of an RN assigned to coordinate care?
☐	☐	L541	Does the IDG include a MD/OD, RN, SW and a pastoral or other counselor?
☐	☐	L542	Is there evidence an IDG has been identified to establish the day-to-day polices governing the provision of hospice services?
☐	☐	L543	Is there evidence that care follows an individualized plan of care?
☐	☐	L544	Is there evidence of education and training provided to the patient/caregiver?
☐	☐	L545	Has an individualized plan of care been developed for each patient?
☐	☐	L546	Does the plan of care include interventions to manage pain and symptoms?
☐	☐	L547	Does the plan of care include a detailed statement of scope and frequency of services for all disciplines including volunteers?
☐	☐	L548	Does the plan of care include the measurable outcomes anticipated?
☐	☐	L549	Does the plan of care include the necessary drugs and treatments to meet the patient's needs?
☐	☐	L550	Does the plan of care include the medical supplies/appliances to meet the needs of the patient?
☐	☐	L551	Is there evidence of the patient's/representative's involvement with the plan of care?
☐	☐	L552	Is there evidence the IDG reviews and revises the plan of care as necessary but no less frequently than every 15 days?
☐	☐	L553	Does the revised plan of care include information from the updated assessments and identify the progress towards outcomes and goals?
☐	☐	L554	Is there evidence the IDG maintains responsibility for the care and services provided?
☐	☐	L555	Is there evidence the IDG ensures the care and services are provided in accordance with the plan of care?
☐	☐	L556	Is there evidence the IDG ensures the care and services provided are based on all assessments?
☐	☐	L557	Is there evidence of the sharing of information between all disciplines providing care?
☐	☐	L558	Is there evidence of the sharing of information with non-hospice providers providing care?

ACHC Accreditation Guide To Success

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

STANDARD HH1-2A

The HHA is directed by a governing body (if no governing body is present, owner suffices) who assumes full legal authority and responsibility for the operation of the HHA. The governing body/owner duties and accountabilities are clearly defined.

P&P ESSENTIAL COMPONENTS

- Policies must define the activities of the governing body to include, at a minimum:
  - Decision making
  - Appointing a qualified Administrator
  - Adopting and periodically reviewing written bylaws or equivalent
  - Establishing or approving written policies and procedures governing overall operations
  - Human resource management
  - Quality Assessment and Performance Improvement (QAPI) Program
  - Community needs planning, if applicable
  - Oversight of the management, operation plans, and fiscal affairs of the HHA
  - Annual review of the P&P

HINT If interviewed, the Administrator and governing body should be able to discuss how the governing body exercises its responsibilities for the overall operations of the organization.

The Surveyor will expect to see evidence of oversight of the HHA by the governing body.

CoP/G tag Reference: 484.105(a)

STANDARD HSP2-3A: (SERVICES APPLICABLE: HIC, HSP)

Written policies and procedures are established and implemented by the hospice in regard to the reporting and investigation of all violations involving mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone furnishing services on behalf of the hospice.

P&P ESSENTIAL COMPONENTS

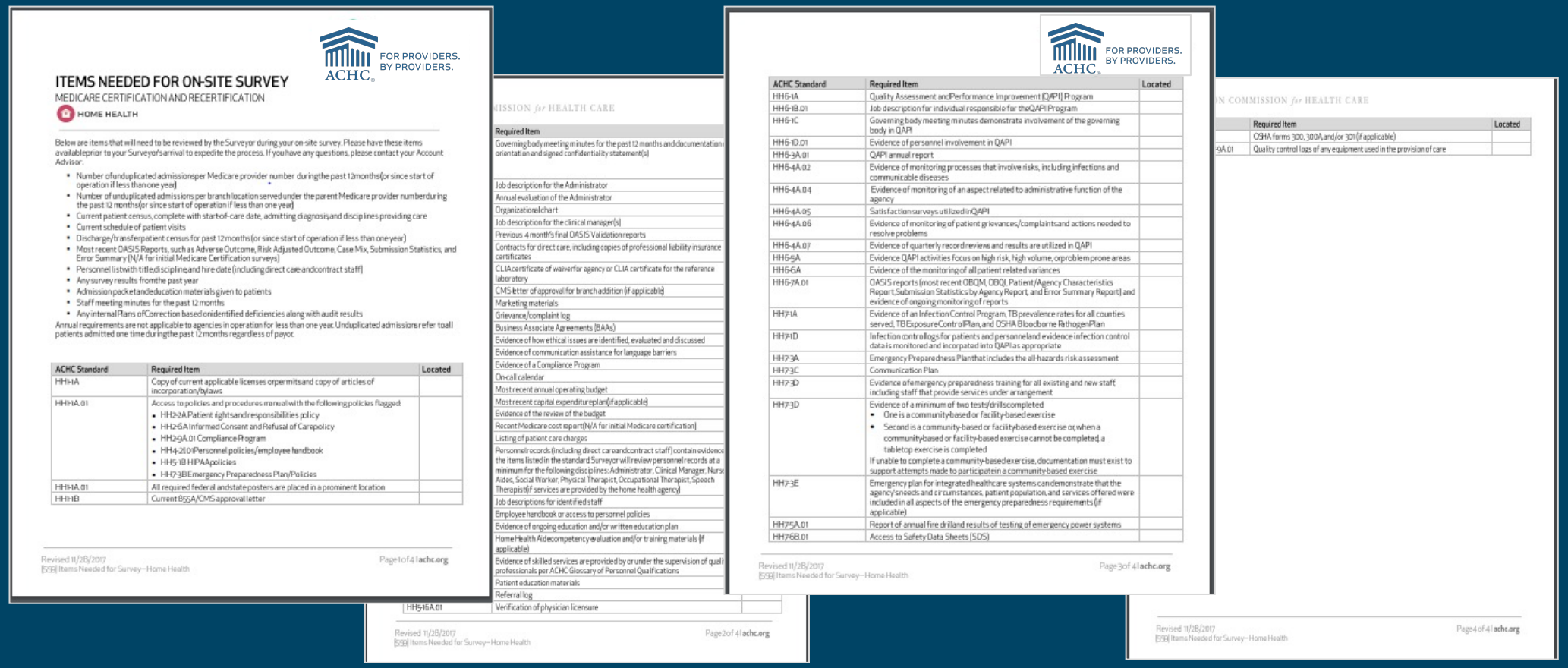
- P&P must describe but not be limited to:
  - The process for reporting and investigating all alleged violations involving mistreatment, neglect, or verbal, mental, sexual and physical abuse, including injuries of unknown source and misappropriation of patient property by anyone furnishing services on behalf of the hospice
  - Allegations reported immediately to the Administrator or appropriate designee
  - The action taken to prevent further potential violations while the alleged violation is being verified
  - Established time frames for reporting verified violations
  - Verified violations reported to ACHC, state, and local bodies within five working days of becoming aware of the verified violation, unless state laws are more stringent

HINT The agency should provide documentation detailing the investigation of incidents and resolutions for each incident for Surveyor review.

The hospice must intervene immediately as indicated by the circumstances if an injury is the result of a hospice employee's actions. Hospice agencies must immediately remove staff from patient care if there are allegations of misconduct related to abuse or misappropriation of property.

If interviewed, staff should be able to discuss proper incidents to report and agency procedure for reporting.

Items Needed For On-Site Survey



ITEMS NEEDED FOR ON-SITE SURVEY

MEDICARE CERTIFICATION AND RECERTIFICATION

HOME HEALTH

FOR PROVIDERS. BY PROVIDERS.

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 • HH2-6A Informed Consent and Refusal of Care policy • HH2-9A.01 Compliance Program • HH4-2E01 Personnel policies/employee handbook • HH5-1B HIPAA policies • HH7-3B Emergency Preparedness Plan/Policies	
HH1-1A.01	All required federal and state posters are placed in a prominent location	
HH1-1B	Current BSA/CMS approval letter	

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ESSE Items Needed for Survey—Home Health

ISSION for HEALTH CARE

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

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ESSE Items Needed for Survey—Home Health

FOR PROVIDERS. BY PROVIDERS.

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 incorporated 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)	

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ESSE Items Needed for Survey—Home Health

N COMMISSION for HEALTH CARE

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

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ESSE Items Needed for Survey—Home Health

Items Needed For On-Site Survey

ACHC FOR PROVIDERS. BY PROVIDERS.

ITEMS NEEDED FOR ON-SITE SURVEY

MEDICARE CERTIFICATION AND RECERTIFICATION

HOSPICE

Below are items that will need to be reviewed by the Surveyor during your on-site survey. Please have th
prior to your Surveyor's arrival to expedite the process. If you have any questions, please contact your pe
Advisor.

- Number of unduplicated admissions per Medicare Provider number during the past 12 months (or
operation if less than one year)
- Number of unduplicated admissions per multiple location served under the parent Medicare pro
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 pr
- Current schedule of patient visits
- Discharge/transfer/revocation patient census for past 12 months (or since start of operation if le
- List of individuals receiving bereavement services
- Personnel list with title, discipline, and hire date (including direct care contract staff and voluntee
- 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 adm
patients admitted one time during the past 12 months regardless of payor.

ACHC Standard	Required Item
HSP1-1A	Copy of current applicable licenses or permits and copy of articles of incorporation/bylaws
HSP1-1A.01	Access to policies and procedures manual with the following policies flagg • HSP4-7A Competency assessment policy • HSP5-1B HIPAA policy • HSP7-6B Disposal of controlled drugs policy • HSP7-4C Emergency Preparedness Plan/Policies
HSP1-1A.01	All required federal and state posters are placed in a prominent location
HSP1-1B	Current 855A/CMS approval letter
HSP1-2A	Evidence hospice is able to provide all core services, non-core services, and four levels of care
HSP1-2B/HSP1-2B.03/ HSP1-3A.01/HSP2-7A.01/ HSP3-1A.01/HSP4-12D/	Governing body meeting minutes for the past 12 months and documentatio orientation and signed confidentiality statement(s)
HSP1-3A.01	Governing body as well as personnel have a signed conflict of interest disc statement (if applicable)

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[560] Items Needed for Survey – Hospice
Pag

ACCREDITATION COMMISSION for HEALTH CARE

ACHC Standard	Required Item
HSP1-4B.01	Annual evaluation of the Administrator
HSP1-5A.01	Organizational chart
HSP1-8A/HSP1-8A.01	Contracts for direct care, including copies of professional liability insurance certificates as well as evidence of monitoring contracted services
HSP1-8B	Contracts for short-term inpatient care (respite and short-term pain and sy management)
HSP1-8C	Contracts for hospice patients residing in SNF/NF or ICF/IID receiving routi hospice care
HSP1-9A	CLIA certificate of waiver for agency and/or CLIA certificate for reference laboratory
HSP1-11A	CMS letter of approval for multiple locations addition (if applicable)
HSP1-12A	Verification of physician licensure
HSP2-1A	Marketing materials
HSP2-3A	Grievance/complaint log
HSP2-5A.01	Business Associate Agreements (BAAs) for non-covered entities
HSP2-7A.01	Evidence of how ethical issues are identified, evaluated, and discussed
HSP2-8A.01	Evidence of communication assistance for language barriers
HSP2-10A	On-call calendar
HSP2-9A.01	Evidence of a Compliance Program
HSP2-11B.01	Written explanation of attending physician responsibilities
HSP2-11D	Nursing waiver (if applicable)
HSP2-11F & HSP5-5B.01	Bereavement program materials
HSP2-11F.01	Counseling resources for bereaved individuals whose needs cannot be met b hospice
HSP2-12A	Contract(s) for non-core services; this includes but is not limited to PT, OT, S
HSP2-12B	Therapy and dietary counseling waiver (if applicable)
HSP2-13B	Contract(s) for DME provider and copy of certificate of accreditation
HSP3-1A.01	Most recent annual operating budget
HSP3-3B.02	Recent Medicare cost report (N/A for initial Medicare certification)
HSP3-4A	Listing of patient care charges
HSP3-6A	Hospice inpatient CAP report
HSP4-1B.01	Personnel records contain evidence of the items listed in the standard. Surve will review personnel records for the following disciplines (at a minimum): Administrator, Alternate Administrator, Director of Clinical Services, Altern Director of Clinical Services, Medical Director, Nurses, Social Worker, Spirit Care Provider, Volunteer Coordinator, Volunteer, Bereavement Coordinator Hospice Aide, Physical Therapist, Occupational Therapist, Speech Therapist
HSP4-2E.01	Job descriptions for identified staff
HSP4-2I.01	Employee handbook or access to personnel policies
HSP4-4B	Training logs/materials used to educate SNF/NF or ICF/IID staff

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[560] Items Needed for Survey – Hospice
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ACHC FOR PROVIDERS. BY PROVIDERS.

ACHC Standard	Required Item
HSP4-5B.01, HSP4-5B.02, HSP4-6A/HSP4-6A.01	Evidence of ongoing education and/or a written education plan and evidence of required training
HSP4-6B/HSP4-7B/HSP4-7C/HSP4-8A	Hospice aide competency evaluation and/or training materials
HSP4-11A	Evidence of a designated Medical Director and Alternate Medical Director (if under arrangement, must have a signed contract for both)
HSP4-12A & HSP4-4A	Evidence of volunteer orientation
HSP4-12B	Evidence of the ability to provide direct care and administrative volunteers
HSP4-12C	Current volunteer cost savings report
HSP4-12D	Current volunteer activity report
HSP5-1A & HSP5-1A.01	Patient records contain all required items as identified in the standards
HSP5-3C.01	Evidence of the submission of Hospice Information Set (HIS) admission and discharge data (N/A for initial Medicare certification surveys)
HSP5-4A	Plans of care contain all required items as identified in the standard
HSP5-9A.01	Referral log and community referral resources
HSP6-1A	Quality Assessment and Performance Improvement (QAPI) program
HSP6-1B	Job description for the individual responsible for the QAPI program
HSP6-2A	Governing body meeting minutes demonstrate involvement of governing body and organizational leaders in QAPI
HSP6-2B	Evidence of personnel involvement in QAPI
HSP6-3A/HSP6-4A	QAPI annual report
HSP6-4A	Completed QAPI projects for past 12 months
HSP6-6A	Evidence of monitoring of an aspect related to patient care (high risk, high volume, problem prone)
HSP6-6B	Evidence of data elements collected from the comprehensive assessment are monitored and utilized in QAPI
HSP6-6B.01	Evidence of chart audit results utilized in QAPI
HSP6-6B.02	Satisfaction surveys utilized in QAPI
HSP6-6B.03	Grievance log and evidence of monitoring of patient grievances/complaints
HSP6-6B.04	Evidence of monitoring of an aspect related to administrative function of the agency
HSP6-6C	Evidence of written corrective action plans for any QAPI projects that did not meet desired outcomes
HSP6-7A/HSP2-4A/HSP7-5A.01	Incident log and evidence of monitoring of all patient grievances and complaints
HSP7-1A	TB prevalence rates for all counties served, TB exposure control plan, and OSHA Bloodborne Pathogens plan
HSP7-1C	Infection control logs for patients and personnel and evidence infection control data is monitored and incorporated into QAPI as appropriate

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[560] Items Needed for Survey – Hospice
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ACCREDITATION COMMISSION for HEALTH CARE

ACHC Standard	Required Item	Located
HSP7-3A.01	Report of annual fire drill and results of testing of emergency power systems	
HSP7-4B	Emergency Preparedness Plan that includes the all-hazards risk assessment	
HSP7-4D	Communication Plan	
HSP7-4E	Evidence of emergency preparedness training for all existing and new staff, including staff that provide services under arrangement	
HSP7-4E	Evidence of a minimum of two tests 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	
HSP7-4F	Emergency plan for integrated healthcare systems can demonstrate that the hospice's needs and circumstances, patient population and services offered were included in all aspects of the emergency preparedness requirements (if applicable)	
HSP7-5A.01	OSHA forms 300, 300A, and/or 301 (if applicable)	
HSP7-7A.01/HSP7-8A	Maintenance logs of any equipment used in the provision of care	
HSP7-9A.02	Access to Safety Data Sheets (SDS)	

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[560] Items Needed for Survey – Hospice
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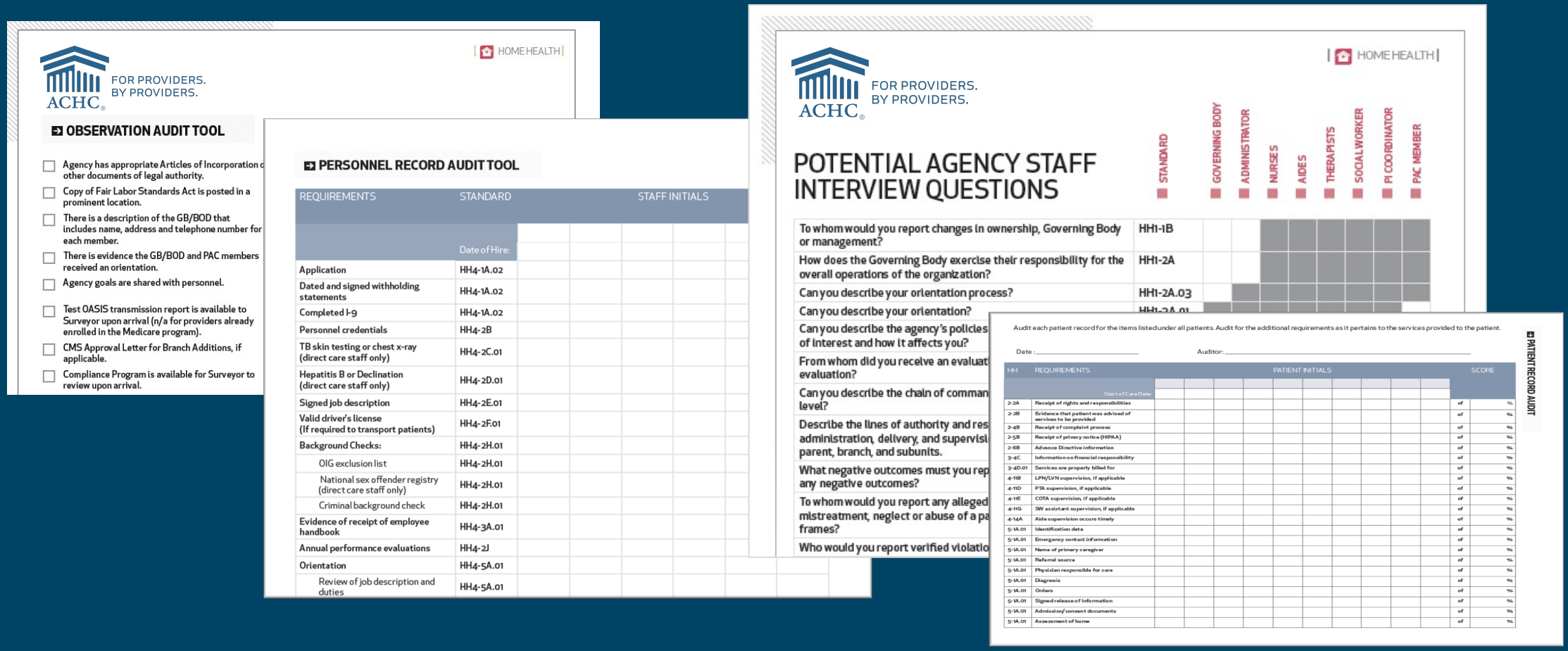
Survey Preparation Tools



FOR PROVIDERS. BY PROVIDERS.

HOME HEALTH

OBSERVATION AUDIT TOOL

- Agency has appropriate Articles of Incorporation o other documents of legal authority.
- Copy of Fair Labor Standards Act is posted in a prominent location.
- There is a description of the GB/BOD that includes name, address and telephone number for each member.
- There is evidence the GB/BOD and PAC members received an orientation.
- Agency goals are shared with personnel.
- Test OASIS transmission report is available to Surveyor upon arrival (n/a for providers already enrolled in the Medicare program).
- CMS Approval Letter for Branch Additions, if applicable.
- Compliance Program is available for Surveyor to review upon arrival.

PERSONNEL RECORD AUDIT TOOL

REQUIREMENTS	STANDARD	STAFF INITIALS
	Date of Hire:	
Application	HH4-1A.02	
Dated and signed withholding statements	HH4-1A.02	
Completed I-9	HH4-1A.02	
Personnel credentials	HH4-2B	
TB skin testing or chest x-ray (direct care staff only)	HH4-2C.01	
Hepatitis B or Declination (direct care staff only)	HH4-2D.01	
Signed job description	HH4-2E.01	
Valid driver's license (If required to transport patients)	HH4-2F.01	
Background Checks:	HH4-2H.01	
OIG exclusion list	HH4-2H.01	
National sex offender registry (direct care staff only)	HH4-2H.01	
Criminal background check	HH4-2H.01	
Evidence of receipt of employee handbook	HH4-3A.01	
Annual performance evaluations	HH4-2J	
Orientation	HH4-5A.01	
Review of job description and duties	HH4-5A.01	

FOR PROVIDERS. BY PROVIDERS.

HOME HEALTH

POTENTIAL AGENCY STAFF INTERVIEW QUESTIONS

STANDARD · GOVERNING BODY · ADMINISTRATOR · NURSES · AIDES · THERAPISTS · SOCIAL WORKER · PI COORDINATOR · PAC MEMBER

To whom would you report changes in ownership, Governing Body or management?	HH1-1B
How does the Governing Body exercise their responsibility for the overall operations of the organization?	HH1-2A
Can you describe your orientation process?	HH1-2A.03
Can you describe your orientation?	HH1-2A.01
Can you describe the agency's policies of interest and how it affects you?	
From whom did you receive an evaluat evaluation?	
Can you describe the chain of comman level?	
Describe the lines of authority and res administration, delivery, and supervisi parent, branch, and subunits.	
What negative outcomes must you rep any negative outcomes?	
To whom would you report any alleged mistreatment, neglect or abuse of a pa frames?	
Who would you report verified violatio	

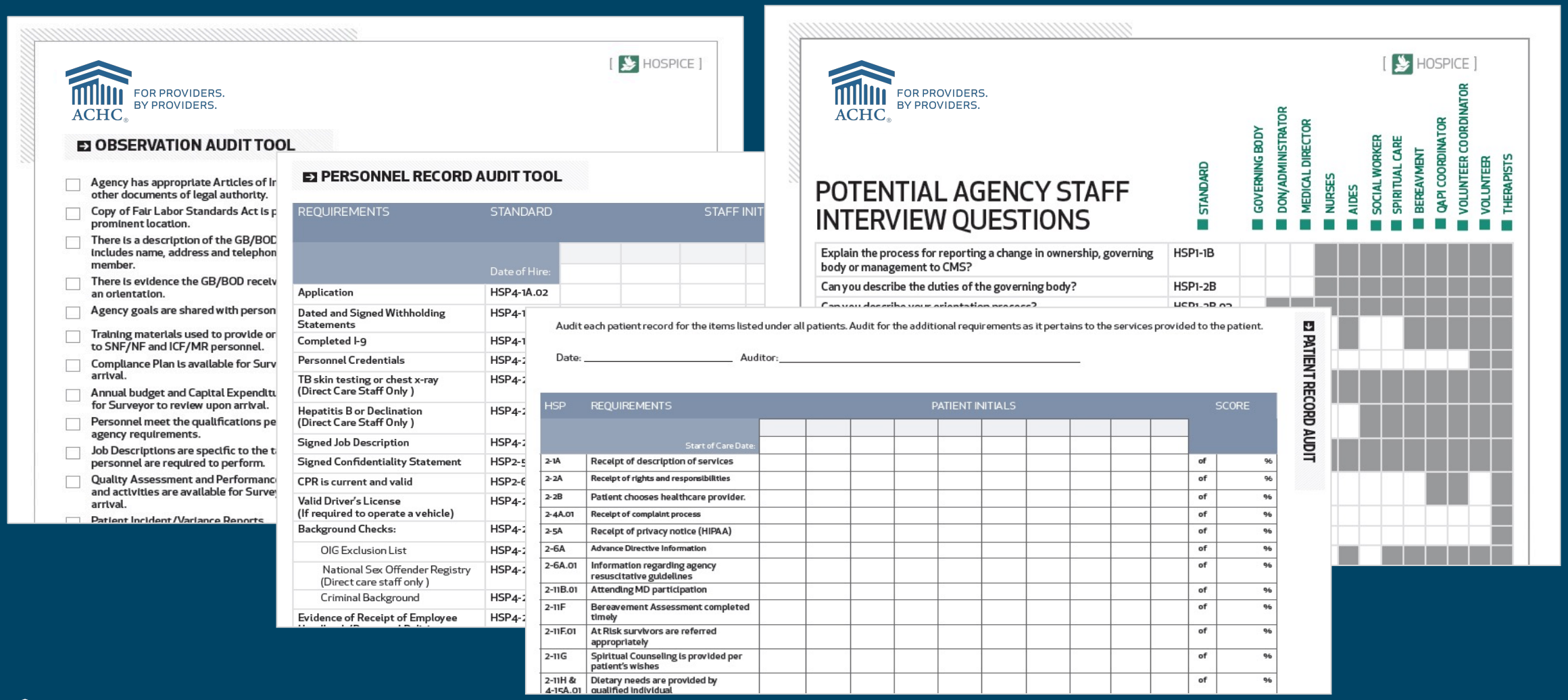
Audit each patient record for the items listed under all patients. Audit for the additional requirements as it pertains to the services provided to the patient.

Date : _____ Auditor: _____

PATIENT RECORD AUDIT

HH	REQUIREMENTS	PATIENT INITIALS	SCORE
	Start of Care Date:		
2-2A	Receipt of rights and responsibilities		of %
2-2B	Evidence that patient was advised of services to be provided		of %
2-4B	Receipt of complaint process		of %
2-5B	Receipt of privacy notice (HIPAA)		of %
2-6B	Advance Directive information		of %
3-4C	Information on financial responsibility		of %
3-4D.01	Services are properly billed for		of %
4-11B	LPN/LVN supervision, if applicable		of %
4-11D	PTA supervision, if applicable		of %
4-11E	COTA supervision, if applicable		of %
4-11G	SW assistant supervision, if applicable		of %
4-14A	Aide supervision occurs timely		of %
5-1A.01	Identification data		of %
5-1A.01	Emergency contact information		of %
5-1A.01	Name of primary caregiver		of %
5-1A.01	Referral source		of %
5-1A.01	Physician responsible for care		of %
5-1A.01	Diagnosis		of %
5-1A.01	Orders		of %
5-1A.01	Signed release of information		of %
5-1A.01	Admission/consent documents		of %
5-1A.01	Assessment of home		of %

Survey Preparation Tools



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[HOSPICE]

OBSERVATION AUDIT TOOL

- Agency has appropriate Articles of In other documents of legal authority.
- Copy of Fair Labor Standards Act is p prominent location.
- There is a description of the GB/BOD includes name, address and telephon member.
- There is evidence the GB/BOD receiv an orientation.
- Agency goals are shared with person
- Training materials used to provide or to SNF/NF and ICF/MR personnel.
- Compliance Plan is available for Surv arrival.
- Annual budget and Capital Expenditu for Surveyor to review upon arrival.
- Personnel meet the qualifications pe agency requirements.
- Job Descriptions are specific to the t personnel are required to perform.
- Quality Assessment and Performanc and activities are available for Survey arrival.
- Patient Incident/Variance Reports

PERSONNEL RECORD AUDIT TOOL

REQUIREMENTS	STANDARD	STAFF INIT
	Date of Hire:	
Application	HSP4-1A.02	
Dated and Signed Withholding Statements	HSP4-1	
Completed I-9	HSP4-1	
Personnel Credentials	HSP4-2	
TB skin testing or chest x-ray (Direct Care Staff Only)	HSP4-2	
Hepatitis B or Declination (Direct Care Staff Only)	HSP4-2	
Signed Job Description	HSP4-2	
Signed Confidentiality Statement	HSP2-5	
CPR is current and valid	HSP2-6	
Valid Driver's License (If required to operate a vehicle)	HSP4-2	
Background Checks:	HSP4-2	
OIG Exclusion List	HSP4-2	
National Sex Offender Registry (Direct care staff only)	HSP4-2	
Criminal Background	HSP4-2	
Evidence of Receipt of Employee	HSP4-2	

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[HOSPICE]

POTENTIAL AGENCY STAFF INTERVIEW QUESTIONS

	STANDARD	GOVERNING BODY	DON/ADMINISTRATOR	MEDICAL DIRECTOR	NURSES	AIDES	SOCIAL WORKER	SPIRITUAL CARE	BEREAVMENT	QAPI COORDINATOR	VOLUNTEER COORDINATOR	VOLUNTEER	THERAPISTS
Explain the process for reporting a change in ownership, governing body or management to CMS?	HSP1-1B												
Can you describe the duties of the governing body?	HSP1-2B												
Can you describe your orientation process?	HSP1-2B.02												

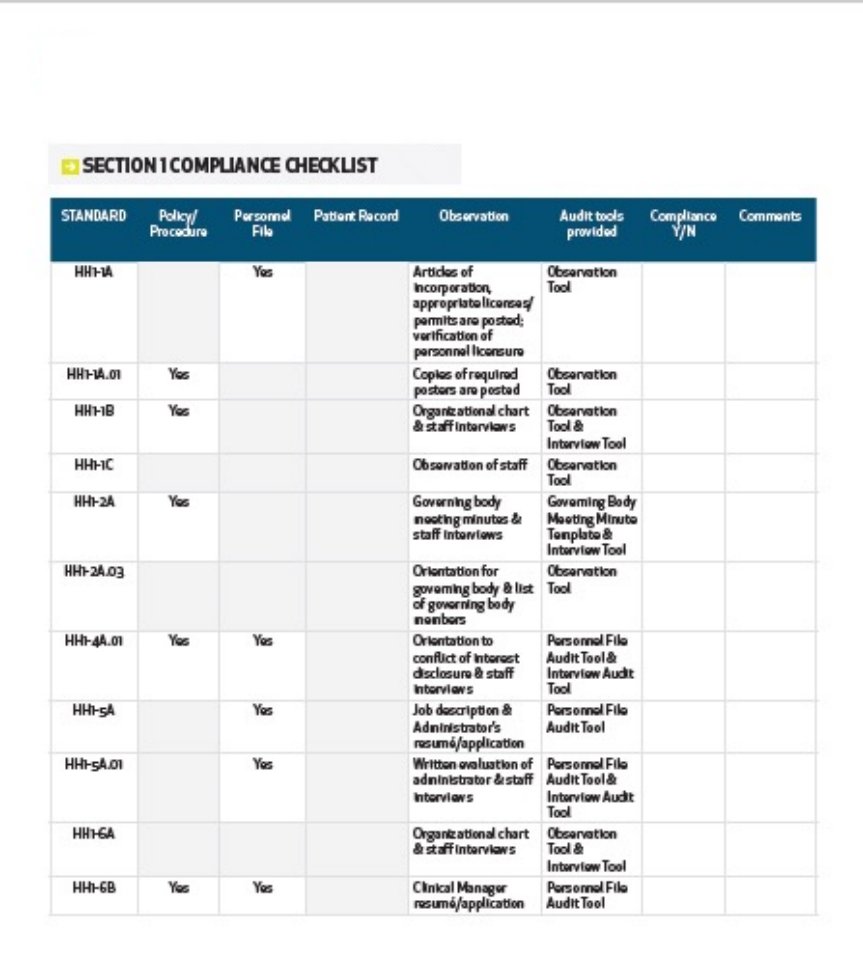
Audit each patient record for the items listed under all patients. Audit for the additional requirements as it pertains to the services provided to the patient.

Date: _____ Auditor: _____

PATIENT RECORD AUDIT

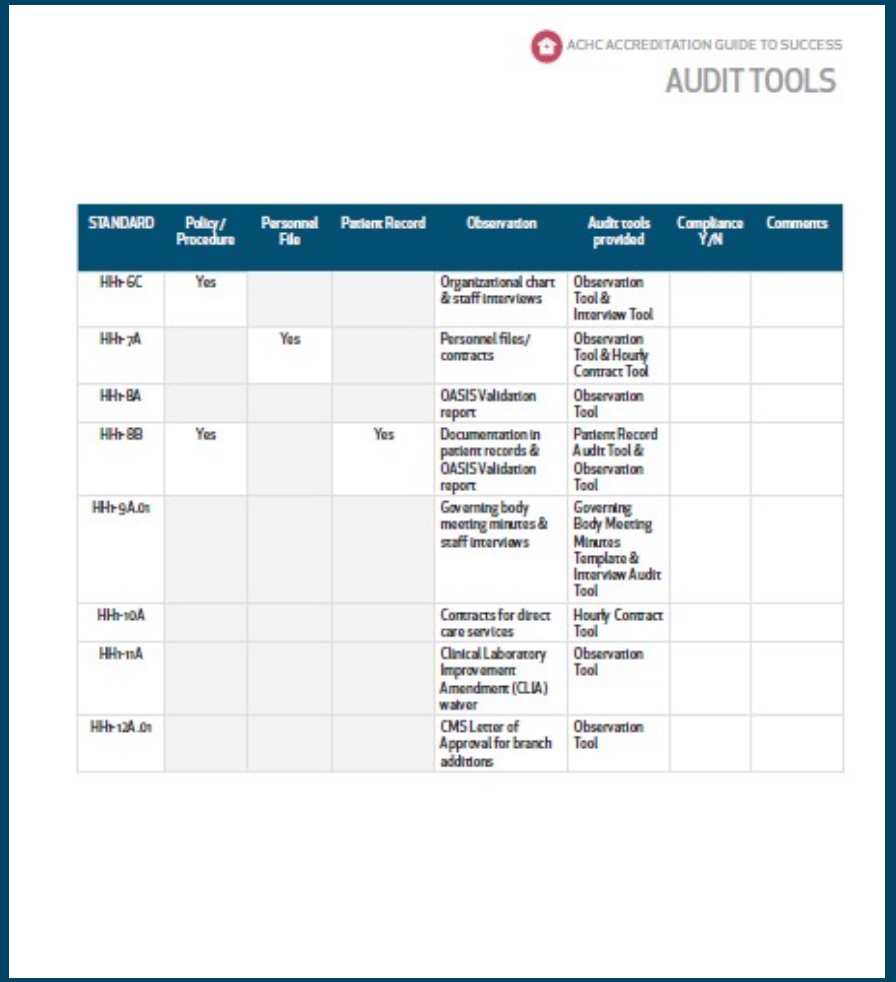
HSP	REQUIREMENTS	PATIENT INITIALS										SCORE	
	Start of Care Date:												
2-1A	Receipt of description of services											of	%
2-2A	Receipt of rights and responsibilities											of	%
2-2B	Patient chooses healthcare provider.											of	%
2-4A.01	Receipt of complaint process											of	%
2-5A	Receipt of privacy notice (HIPAA)											of	%
2-6A	Advance Directive Information											of	%
2-6A.01	Information regarding agency resuscitative guidelines											of	%
2-11B.01	Attending MD participation											of	%
2-11F	Bereavement Assessment completed timely											of	%
2-11F.01	At Risk survivors are referred appropriately											of	%
2-11G	Spiritual Counseling is provided per patient's wishes											of	%
2-11H & 4-15A.01	Dietary needs are provided by qualified individual											of	%

Compliance Checklist



SECTION 1 COMPLIANCE CHECKLIST

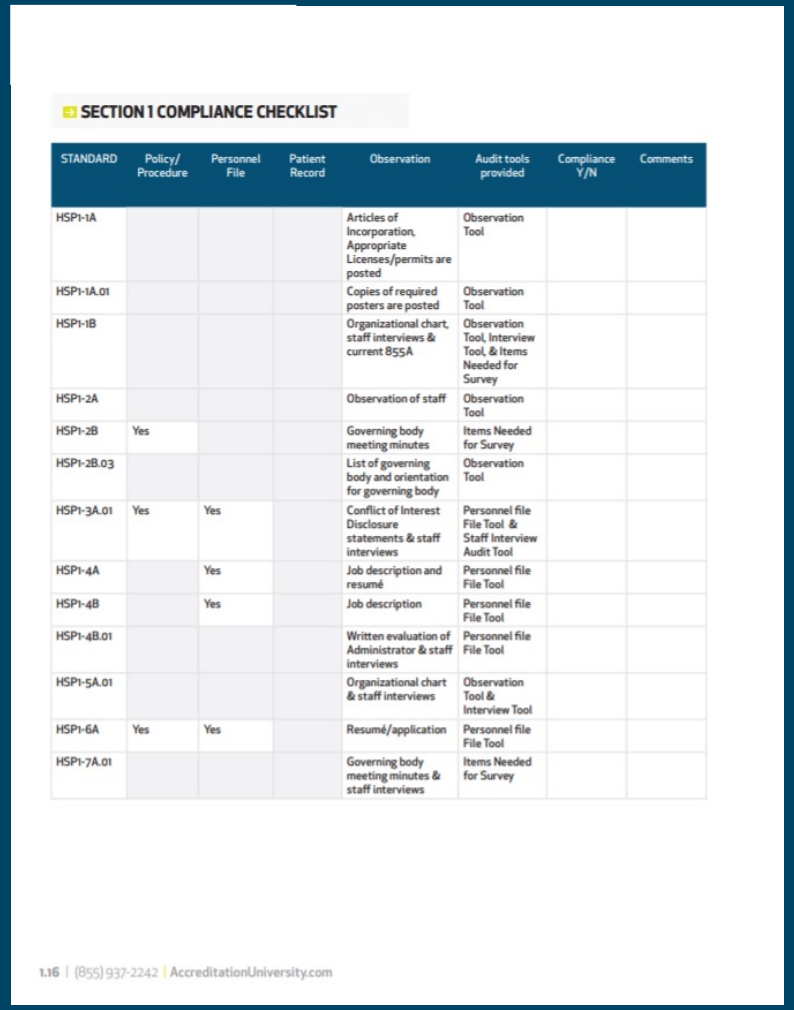
STANDARD	Policy/ Procedure	Personnel File	Patient Record	Observation	Audit tools provided	Compliance Y/N	Comments
HH1-1A		Yes		Articles of incorporation, appropriate licenses/ permits are posted; verification of personnel licensure	Observation Tool		
HH1-1A.01	Yes			Copies of required posters are posted	Observation Tool		
HH1-1B	Yes			Organizational chart & staff interviews	Observation Tool & Interview Tool		
HH1-1C				Observation of staff	Observation Tool		
HH1-2A	Yes			Governing body meeting minutes & staff interviews	Governing Body Meeting Minute Template & Interview Tool		
HH1-2A.03				Orientation for governing body & list of governing body members	Observation Tool		
HH1-4A.01	Yes	Yes		Orientation to conflict of interest disclosure & staff interviews	Personnel File Audit Tool & Interview Audit Tool		
HH1-5A		Yes		Job description & Administrator's resumé/application	Personnel File Audit Tool		
HH1-5A.01		Yes		Written evaluation of administrator & staff interviews	Personnel File Audit Tool & Interview Audit Tool		
HH1-6A				Organizational chart & staff interviews	Observation Tool & Interview Tool		
HH1-6B	Yes	Yes		Clinical Manager resumé/application	Personnel File Audit Tool		



AUDIT TOOLS

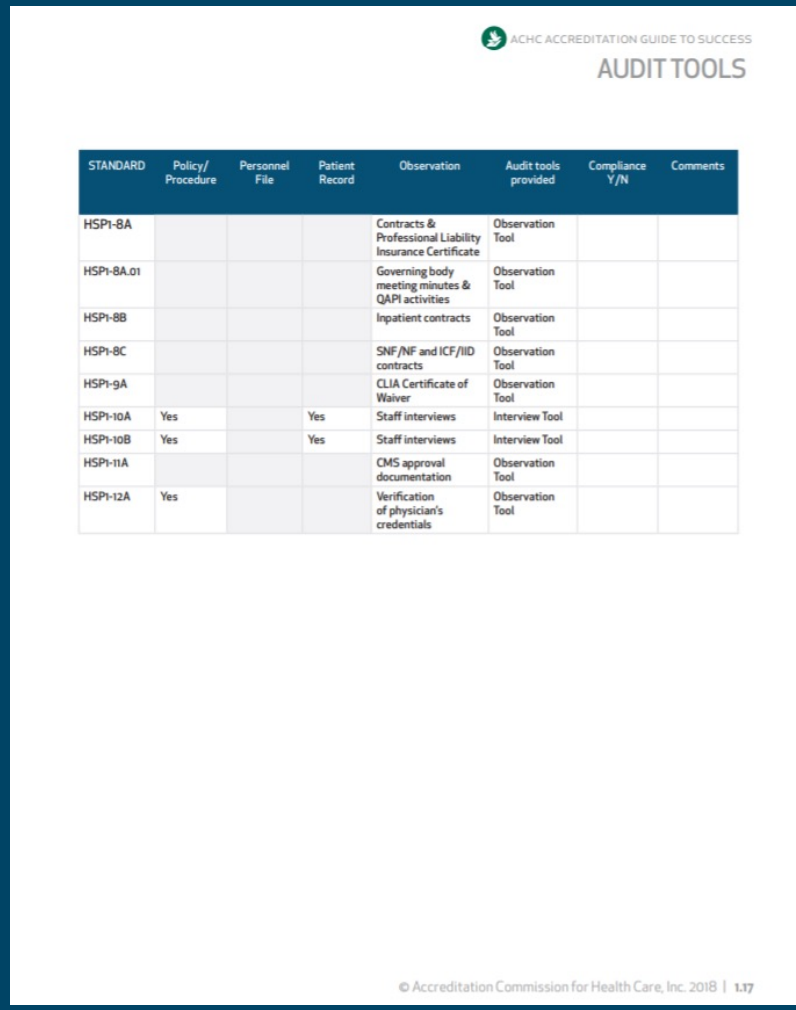
STANDARD	Policy/ Procedure	Personnel File	Patient Record	Observation	Audit tools provided	Compliance Y/N	Comments
HH1-6C	Yes			Organizational chart & staff interviews	Observation Tool & Interview Tool		
HH1-7A		Yes		Personnel files/ contracts	Observation Tool & Hourly Contract Tool		
HH1-8A				OASIS Validation report	Observation Tool		
HH1-8B	Yes		Yes	Documentation in patient records & OASIS Validation report	Patient Record Audit Tool & Observation Tool		
HH1-9A.01				Governing body meeting minutes & staff interviews	Governing Body Meeting Minutes Template & Interview Audit Tool		
HH1-10A				Contracts for direct care services	Hourly Contract Tool		
HH1-11A				Clinical Laboratory Improvement Amendment (CLIA) waiver	Observation Tool		
HH1-12A.01				CMS Letter of Approval for branch additions	Observation Tool		

Compliance Checklist



SECTION 1 COMPLIANCE CHECKLIST

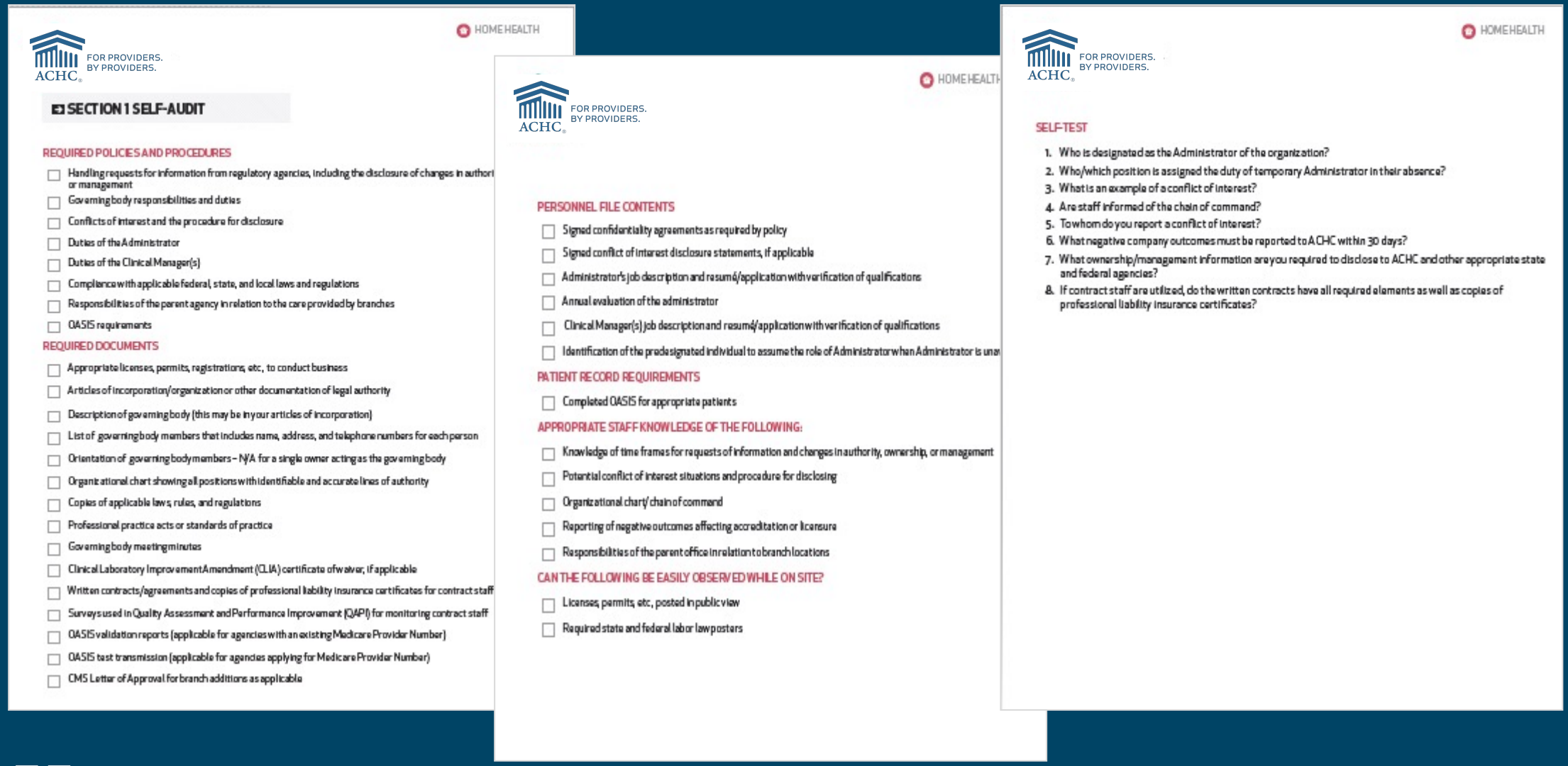
STANDARD	Policy/ Procedure	Personnel File	Patient Record	Observation	Audit tools provided	Compliance Y/N	Comments
HSP1-1A				Articles of Incorporation, Appropriate Licenses/permits are posted	Observation Tool		
HSP1-1A.01				Copies of required posters are posted	Observation Tool		
HSP1-1B				Organizational chart, staff interviews & current 855A	Observation Tool, Interview Tool, & Items Needed for Survey		
HSP1-2A				Observation of staff	Observation Tool		
HSP1-2B	Yes			Governing body meeting minutes	Items Needed for Survey		
HSP1-2B.03				List of governing body and orientation for governing body	Observation Tool		
HSP1-3A.01	Yes	Yes		Conflict of Interest Disclosure statements & staff interviews	Personnel file File Tool & Staff Interview Audit Tool		
HSP1-4A		Yes		Job description and resumé	Personnel file File Tool		
HSP1-4B		Yes		Job description	Personnel file File Tool		
HSP1-4B.01				Written evaluation of Administrator & staff interviews	Personnel file File Tool		
HSP1-5A.01				Organizational chart & staff interviews	Observation Tool & Interview Tool		
HSP1-6A	Yes	Yes		Resumé/application	Personnel file File Tool		
HSP1-7A.01				Governing body meeting minutes & staff interviews	Items Needed for Survey		



AUDIT TOOLS

STANDARD	Policy/ Procedure	Personnel File	Patient Record	Observation	Audit tools provided	Compliance Y/N	Comments
HSP1-8A				Contracts & Professional Liability Insurance Certificate	Observation Tool		
HSP1-8A.01				Governing body meeting minutes & QAPI activities	Observation Tool		
HSP1-8B				Inpatient contracts	Observation Tool		
HSP1-8C				SNF/NF and ICF/IID contracts	Observation Tool		
HSP1-9A				CLIA Certificate of Waiver	Observation Tool		
HSP1-10A	Yes		Yes	Staff interviews	Interview Tool		
HSP1-10B	Yes		Yes	Staff interviews	Interview Tool		
HSP1-11A				CMS approval documentation	Observation Tool		
HSP1-12A	Yes			Verification of physician's credentials	Observation Tool		

Self-Audit



HOME HEALTH

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SECTION 1 SELF-AUDIT

REQUIRED POLICIES AND PROCEDURES

- [ ] Handling requests for information from regulatory agencies, including the disclosure of changes in authori or management
- [ ] Governing body responsibilities and duties
- [ ] Conflicts of interest and the procedure for disclosure
- [ ] Duties of the Administrator
- [ ] Duties of the Clinical Manager(s)
- [ ] Compliance with applicable federal, state, and local laws and regulations
- [ ] Responsibilities of the parent agency in relation to the care provided by branches
- [ ] OASIS requirements

REQUIRED DOCUMENTS

- [ ] Appropriate licenses, permits, registrations, etc., to conduct business
- [ ] Articles of incorporation/organization or other documentation of legal authority
- [ ] Description of governing body (this may be in your articles of incorporation)
- [ ] List of governing body members that includes name, address, and telephone numbers for each person
- [ ] Orientation of governing body members – N/A for a single owner acting as the governing body
- [ ] Organizational chart showing all positions with identifiable and accurate lines of authority
- [ ] Copies of applicable laws, rules, and regulations
- [ ] Professional practice acts or standards of practice
- [ ] Governing body meeting minutes
- [ ] Clinical Laboratory Improvement Amendment (CLIA) certificate of waiver, if applicable
- [ ] Written contracts/agreements and copies of professional liability insurance certificates for contract staff
- [ ] Surveys used in Quality Assessment and Performance Improvement (QAPI) for monitoring contract staff
- [ ] OASIS validation reports (applicable for agencies with an existing Medicare Provider Number)
- [ ] OASIS test transmission (applicable for agencies applying for Medicare Provider Number)
- [ ] CMS Letter of Approval for branch additions as applicable

HOME HEALTH

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PERSONNEL FILE CONTENTS

- [ ] Signed confidentiality agreements as required by policy
- [ ] Signed conflict of interest disclosure statements, if applicable
- [ ] Administrator's job description and resumé/application with verification of qualifications
- [ ] Annual evaluation of the administrator
- [ ] Clinical Manager(s) job description and resumé/application with verification of qualifications
- [ ] Identification of the predesignated individual to assume the role of Administrator when Administrator is una

PATIENT RECORD REQUIREMENTS

- [ ] Completed OASIS for appropriate patients

APPROPRIATE STAFF KNOWLEDGE OF THE FOLLOWING:

- [ ] Knowledge of time frames for requests of information and changes in authority, ownership, or management
- [ ] Potential conflict of interest situations and procedure for disclosing
- [ ] Organizational chart/ chain of command
- [ ] Reporting of negative outcomes affecting accreditation or licensure
- [ ] Responsibilities of the parent office in relation to branch locations

CAN THE FOLLOWING BE EASILY OBSERVED WHILE ON SITE?

- [ ] Licenses, permits, etc., posted in public view
- [ ] Required state and federal labor law posters

HOME HEALTH

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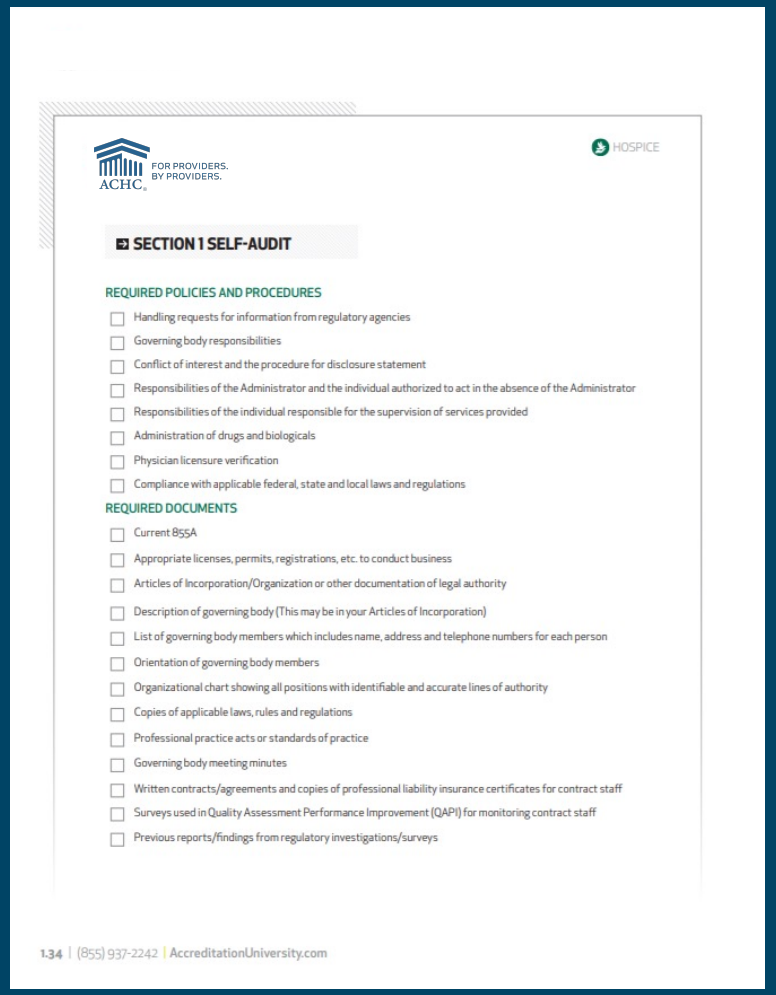
SELF-TEST

1. Who is designated as the Administrator of the organization?
2. Who/which position is assigned the duty of temporary Administrator in their absence?
3. What is an example of a conflict of interest?
4. Are staff informed of the chain of command?
5. To whom do you report a conflict of interest?
6. What negative company outcomes must be reported to ACHC within 30 days?
7. What ownership/management information are you required to disclose to ACHC and other appropriate state and federal agencies?
8. If contract staff are utilized, do the written contracts have all required elements as well as copies of professional liability insurance certificates?

Self-Audit



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HOSPICE

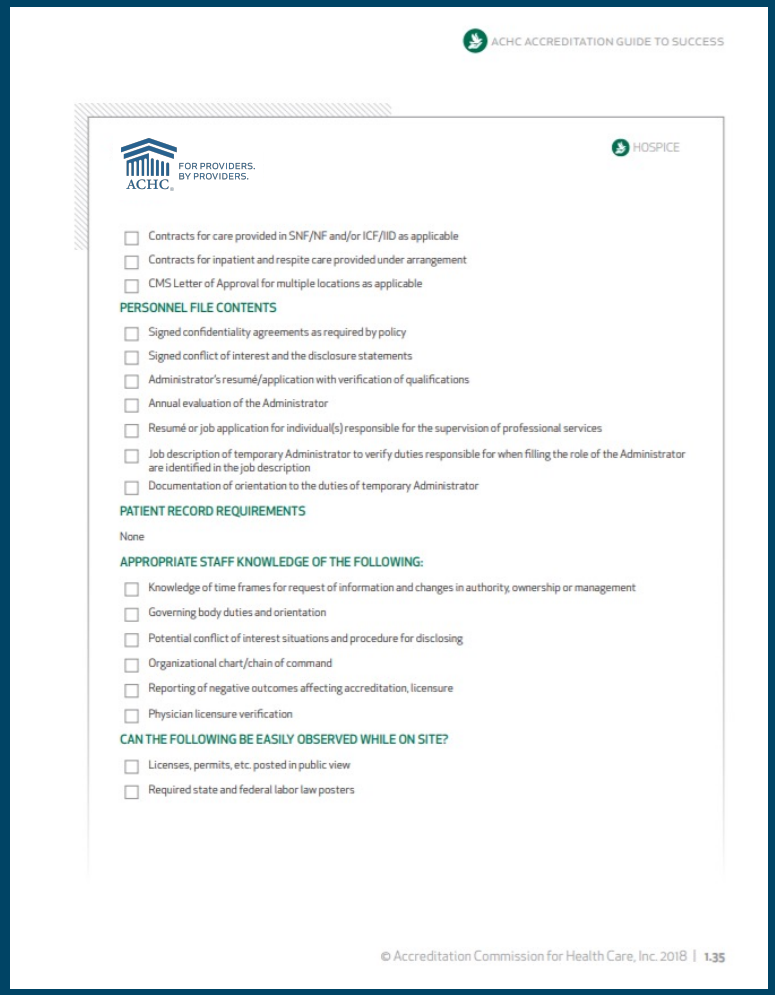
SECTION 1 SELF-AUDIT

REQUIRED POLICIES AND PROCEDURES

- [ ] Handling requests for information from regulatory agencies
- [ ] Governing body responsibilities
- [ ] Conflict of interest and the procedure for disclosure statement
- [ ] Responsibilities of the Administrator and the individual authorized to act in the absence of the Administrator
- [ ] Responsibilities of the individual responsible for the supervision of services provided
- [ ] Administration of drugs and biologicals
- [ ] Physician licensure verification
- [ ] Compliance with applicable federal, state and local laws and regulations

REQUIRED DOCUMENTS

- [ ] Current 855A
- [ ] Appropriate licenses, permits, registrations, etc. to conduct business
- [ ] Articles of Incorporation/Organization or other documentation of legal authority
- [ ] Description of governing body (This may be in your Articles of Incorporation)
- [ ] List of governing body members which includes name, address and telephone numbers for each person
- [ ] Orientation of governing body members
- [ ] Organizational chart showing all positions with identifiable and accurate lines of authority
- [ ] Copies of applicable laws, rules and regulations
- [ ] Professional practice acts or standards of practice
- [ ] Governing body meeting minutes
- [ ] Written contracts/agreements and copies of professional liability insurance certificates for contract staff
- [ ] Surveys used in Quality Assessment Performance Improvement (QAPI) for monitoring contract staff
- [ ] Previous reports/findings from regulatory investigations/surveys



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HOSPICE

- [ ] Contracts for care provided in SNF/NF and/or ICF/IID as applicable
- [ ] Contracts for inpatient and respite care provided under arrangement
- [ ] CMS Letter of Approval for multiple locations as applicable

PERSONNEL FILE CONTENTS

- [ ] Signed confidentiality agreements as required by policy
- [ ] Signed conflict of interest and the disclosure statements
- [ ] Administrator's resumé/application with verification of qualifications
- [ ] Annual evaluation of the Administrator
- [ ] Resumé or job application for individual(s) responsible for the supervision of professional services
- [ ] Job description of temporary Administrator to verify duties responsible for when filling the role of the Administrator are identified in the job description
- [ ] Documentation of orientation to the duties of temporary Administrator

PATIENT RECORD REQUIREMENTS

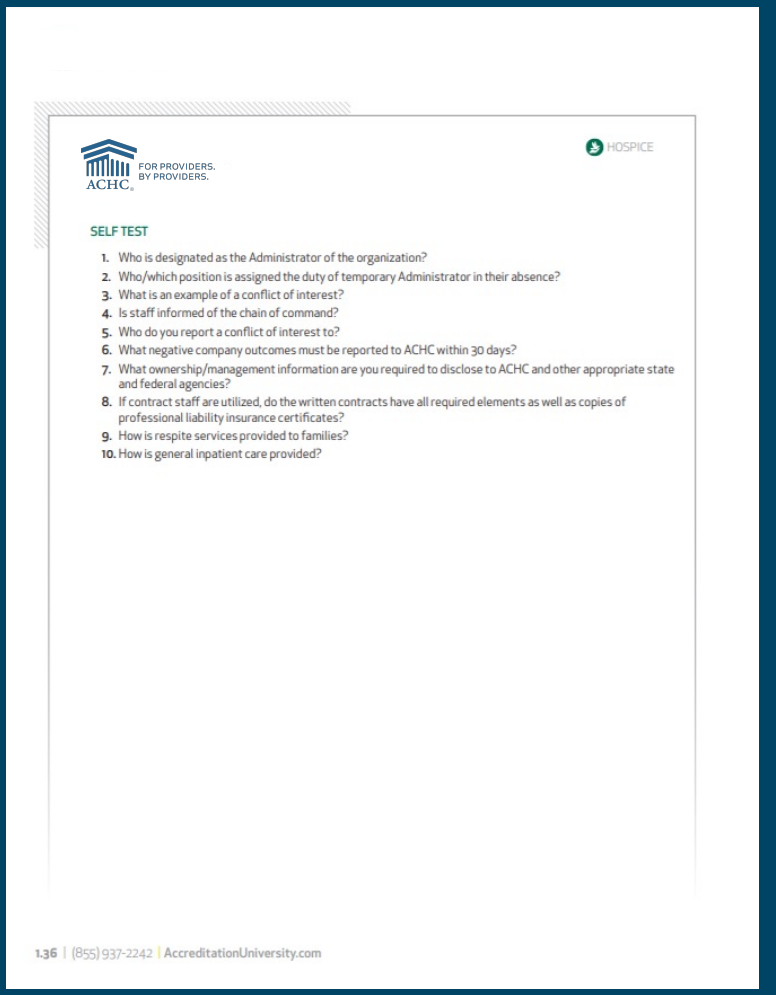
None

APPROPRIATE STAFF KNOWLEDGE OF THE FOLLOWING:

- [ ] Knowledge of time frames for request of information and changes in authority, ownership or management
- [ ] Governing body duties and orientation
- [ ] Potential conflict of interest situations and procedure for disclosing
- [ ] Organizational chart/chain of command
- [ ] Reporting of negative outcomes affecting accreditation, licensure
- [ ] Physician licensure verification

CAN THE FOLLOWING BE EASILY OBSERVED WHILE ON SITE?

- [ ] Licenses, permits, etc. posted in public view
- [ ] Required state and federal labor law posters



FOR PROVIDERS. BY PROVIDERS. ACHC

HOSPICE

SELF TEST

1. Who is designated as the Administrator of the organization?
2. Who/which position is assigned the duty of temporary Administrator in their absence?
3. What is an example of a conflict of interest?
4. Is staff informed of the chain of command?
5. Who do you report a conflict of interest to?
6. What negative company outcomes must be reported to ACHC within 30 days?
7. What ownership/management information are you required to disclose to ACHC and other appropriate state and federal agencies?
8. If contract staff are utilized, do the written contracts have all required elements as well as copies of professional liability insurance certificates?
9. How is respite services provided to families?
10. How is general inpatient care provided?

ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Adding Value With ACHC Accreditation

ACHCU IS A BRAND OF ACCREDITATION COMMISSION *for* HEALTH CARE

ACHC

Tools Of The Trade

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

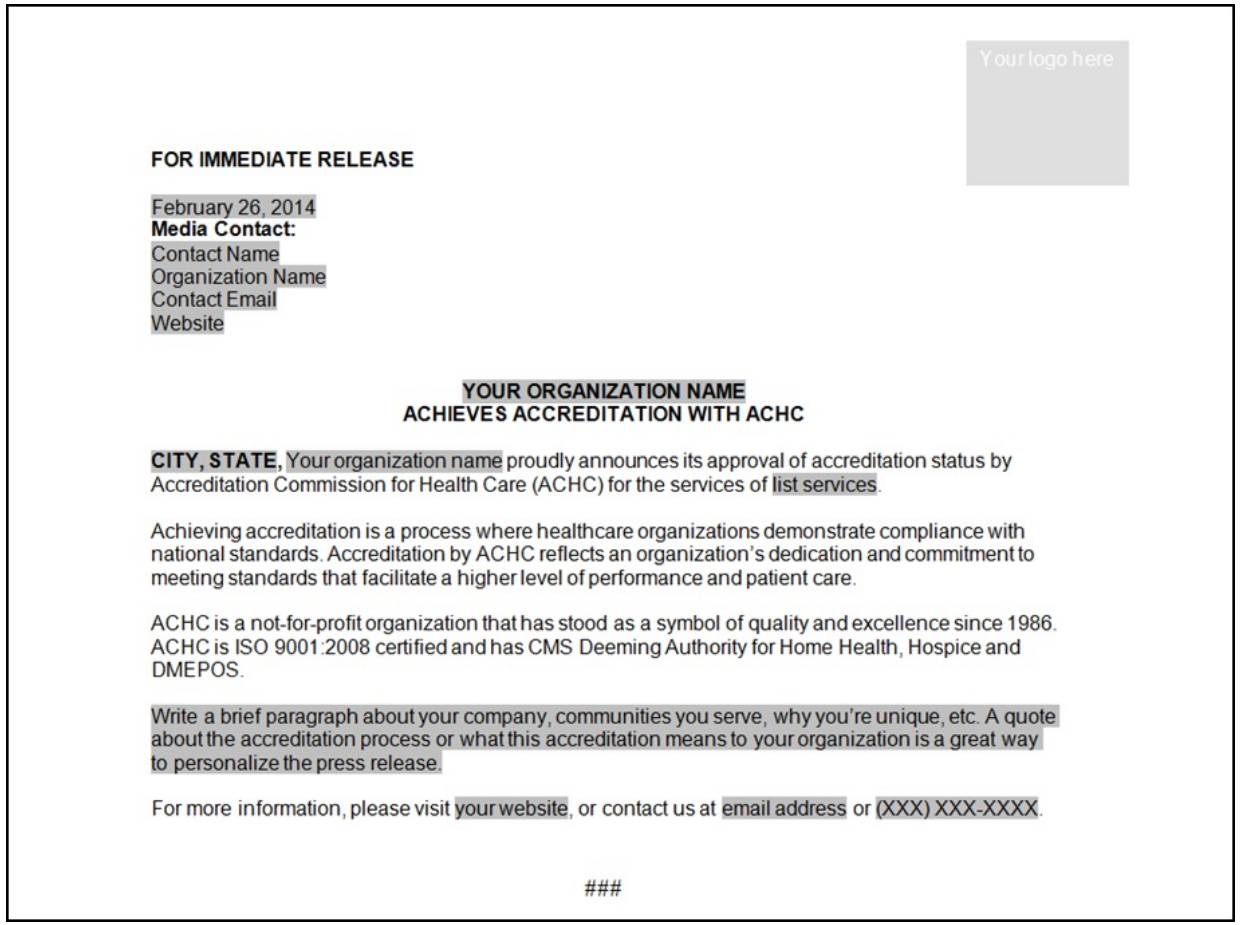
Branding Elements

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

Branding Elements

- ACHC Accredited Logo

Sample Press Release



Your logo here

FOR IMMEDIATE RELEASE

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

YOUR ORGANIZATION NAME
ACHIEVES ACCREDITATION WITH ACHC

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

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

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

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

For more information, please visit your website, or contact us at email address or (XXX) XXX-XXXX.

###

In Conclusion

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

References

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

ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

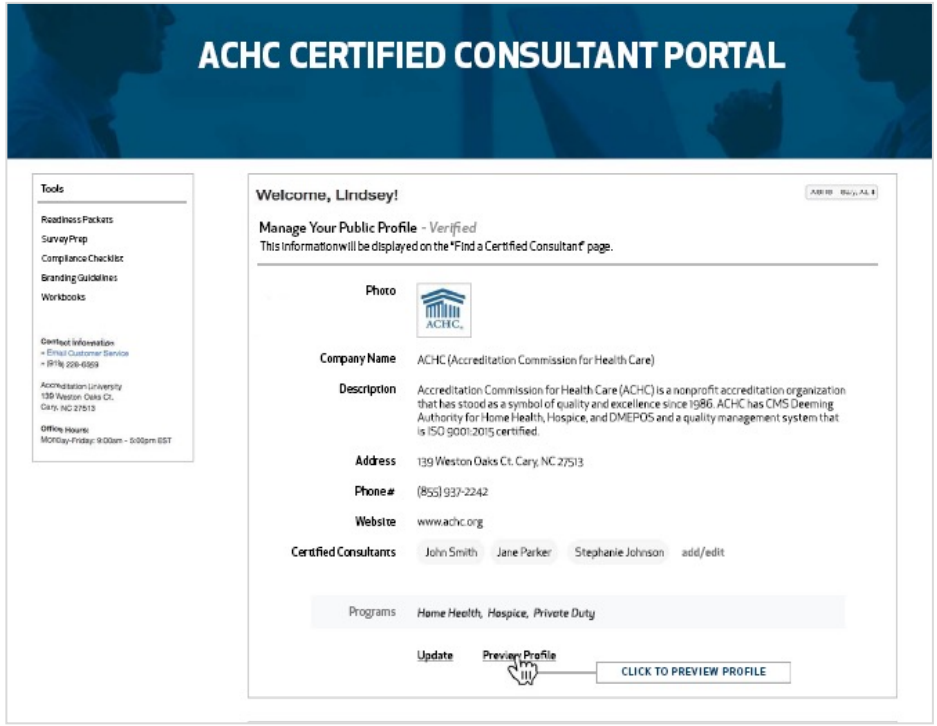
Marketing Your Consultant Business

ACHC Certified Consultant

- Becoming an ACHC Certified Consultant is a notable accomplishment that you should be proud to display:
  - It shows a dedication to providing the very best service to your clients.
  - It provides assurance to healthcare providers when choosing your business.
  - It highlights your knowledge of ACHC Accreditation and your ability to guide them through the process .
  - Allows you access to materials such as audit tools designed for our certified consultants to help with customer preparation.

Consultant Portal

- Access and update your consultant profile displayed on achc.org.
- As a consultant you will have access to tools to use with your customers through the portal.*
- Access to your branding kit.
- Stay in the know with updates from ACHC and ACHCU:
  - Upcoming webinars
  - Did You Knows
  - News updates from ACHC specifically for you



*Only accessible to Certified Consultants

Consultant Listing

- ACHC is proud to host the listing of all of our certified consultants on our website.
  - Customers can search the list to find the best consultant based on their needs.
    - Searchable by P&P manuals, mock surveys, training events, etc.
  - Be sure to keep you profile up-to-date through the portal.

Branding Elements

- ACHC is committed to providing the tools you need to leverage your certified status:
  - Certificate
  - Logos and Brand Guidelines
  - Sample Press Release
  - Certified Consultant Pin

FOR IMMEDIATE RELEASE

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

ACHC CERTIFIED CONSULTANT

O'Connell Consulting, Inc. Receives ACHC Consultant Certification

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

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

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

Accreditation is a process of review that healthcare organizations participate in to demonstrate the ability to meet predetermined criteria and standards established by national regulations and the accrediting organization. Accreditation represents agencies as credible and reputable organizations dedicated to ongoing and

In Conclusion

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

ACHC Resources

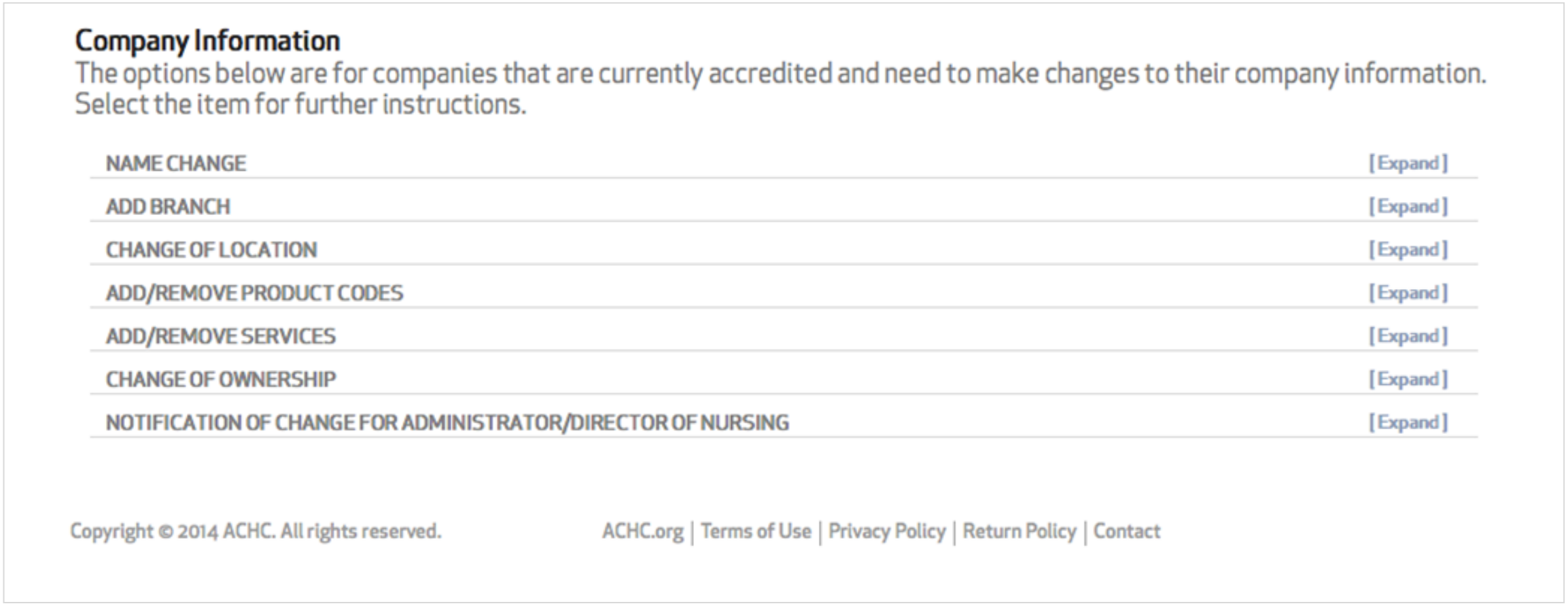
- ACHC's Marketing Department is available to help with your marketing needs.
- Feel free to contact them at info@achc.org or (855) 937-2242.

ACHC U®
EDUCATIONAL RESOURCES

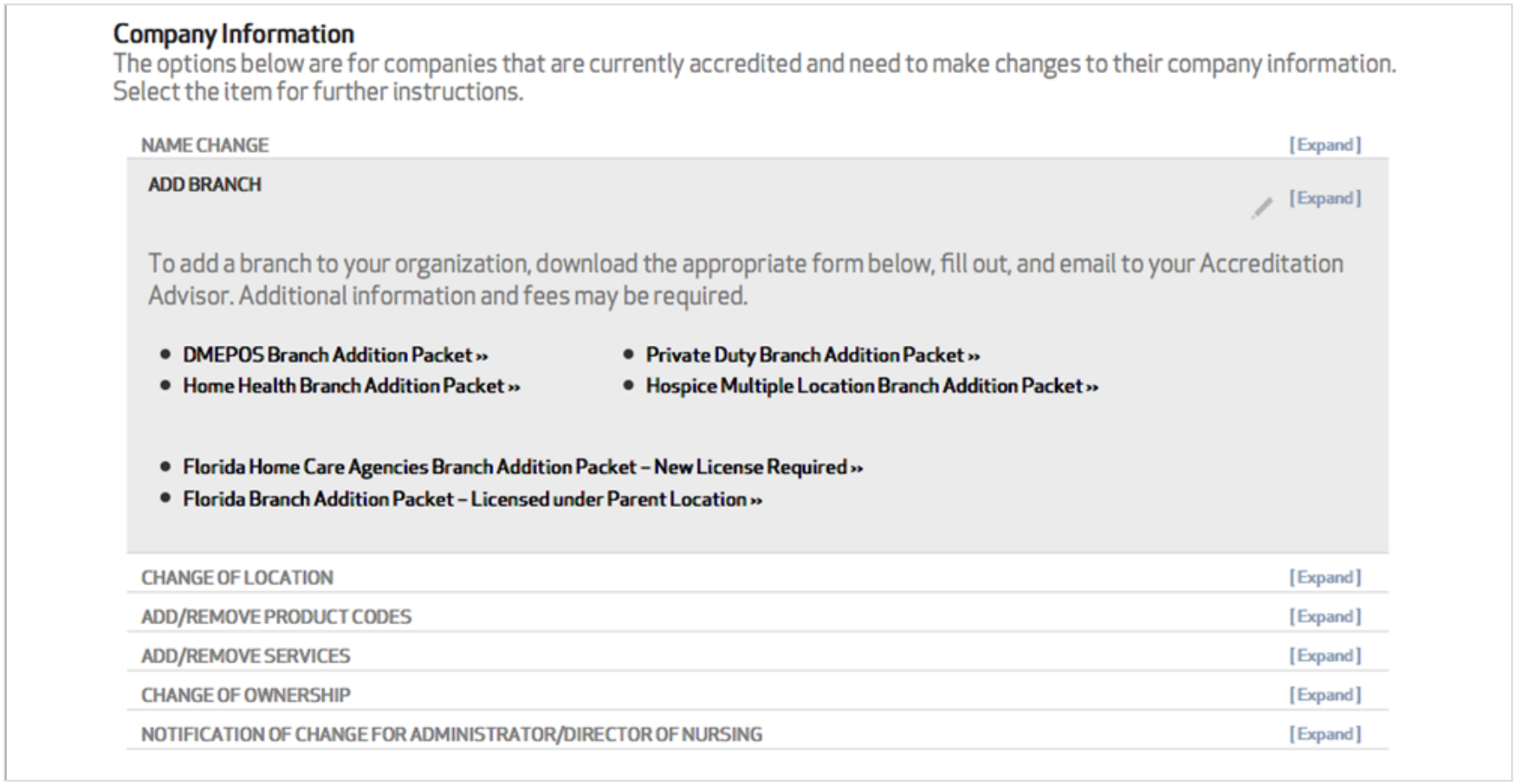
HOME HEALTH HOSPICE

Customer Central Regulatory Resources

Edit Company Information



Branch Addition



Company Information

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

NAME CHANGE [Expand]

ADD BRANCH [Expand]

To add a branch to your organization, download the appropriate form below, fill out, and email to your Accreditation Advisor. Additional information and fees may be required.

- DMEPOS Branch Addition Packet »
- Home Health Branch Addition Packet »
- Private Duty Branch Addition Packet »
- Hospice Multiple Location Branch Addition Packet »
- Florida Home Care Agencies Branch Addition Packet – New License Required »
- Florida Branch Addition Packet – Licensed under Parent Location »

CHANGE OF LOCATION [Expand]

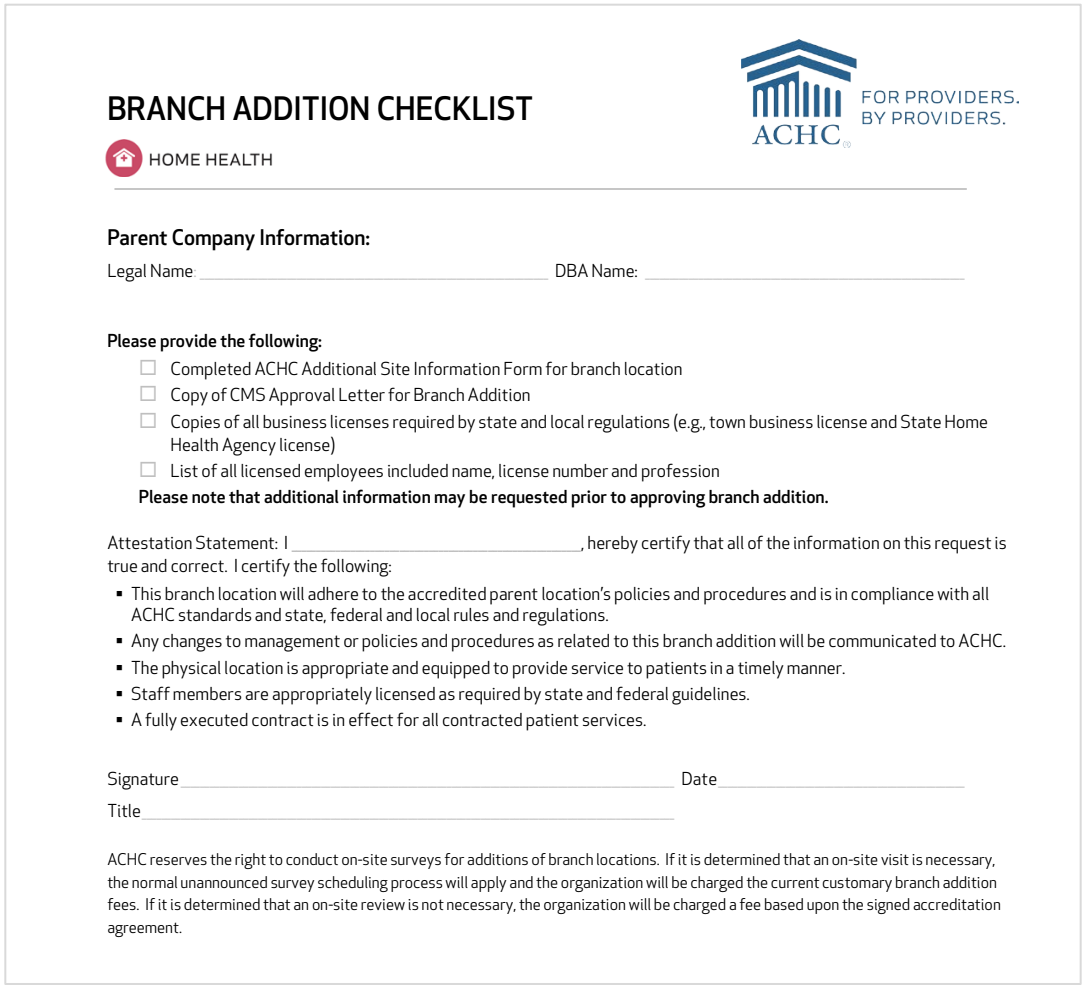
ADD/REMOVE PRODUCT CODES [Expand]

ADD/REMOVE SERVICES [Expand]

CHANGE OF OWNERSHIP [Expand]

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

Branch Addition Checklist



BRANCH ADDITION CHECKLIST

FOR PROVIDERS. BY PROVIDERS.

HOME HEALTH

Parent Company Information:

Legal Name _____ DBA Name: _____

Please provide the following:

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

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

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

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

Signature _____ Date _____

Title _____

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

Change Of Ownership

Company Information

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

NAME CHANGE	[Expand]
ADD BRANCH	[Expand]
CHANGE OF LOCATION	[Expand]
ADD/REMOVE PRODUCT CODES	[Expand]
ADD/REMOVE SERVICES	[Expand]

CHANGE OF OWNERSHIP [Expand]

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

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

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

ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Benefits Of Partnering With ACHC

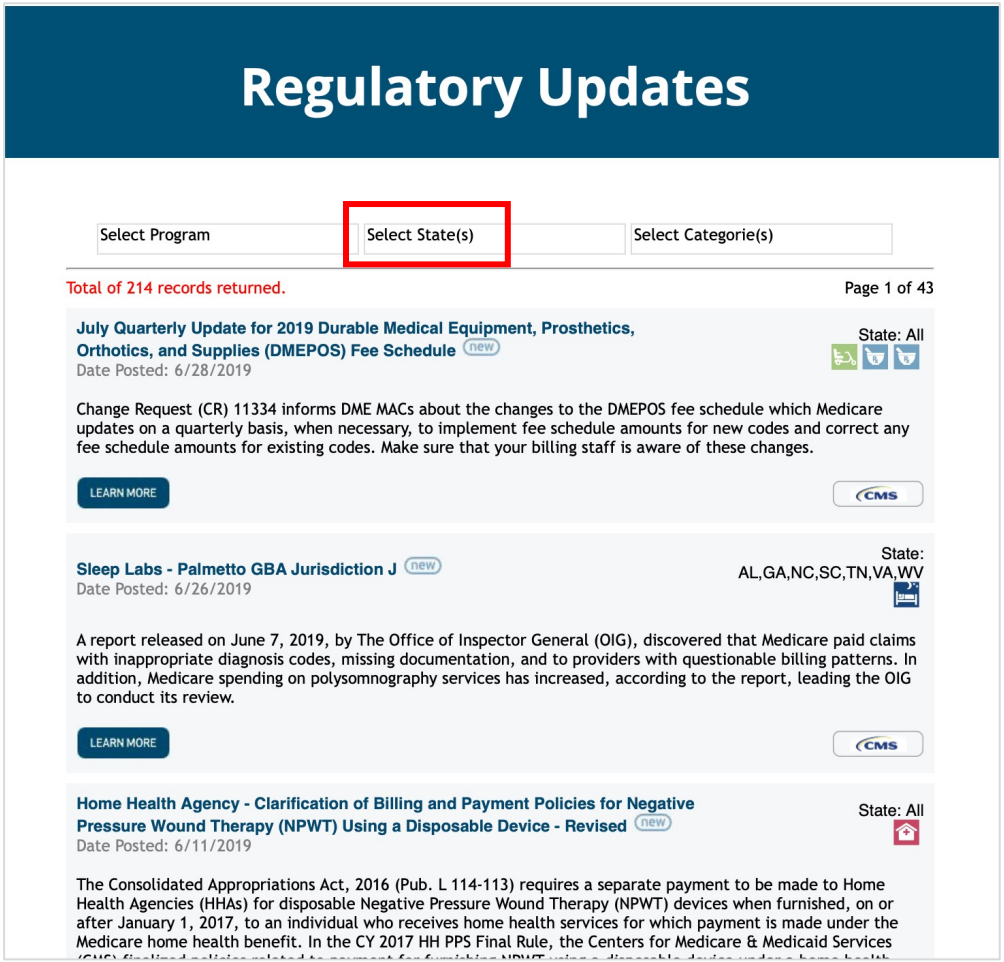
Educational Resources

Educational Resources

- ACHCU.com:
  - Workbooks
  - Workshops
  - Webinars
- Online resources:
  - The Surveyor newsletter
  - Regulatory updates
  - Accreditation resources
  - Maintaining compliance checklists
- Email updates:
  - “Did You Know?”
  - ACHC Today e-newsletter
  - Sign Up at https://www.achc.org/e-news-signup.html

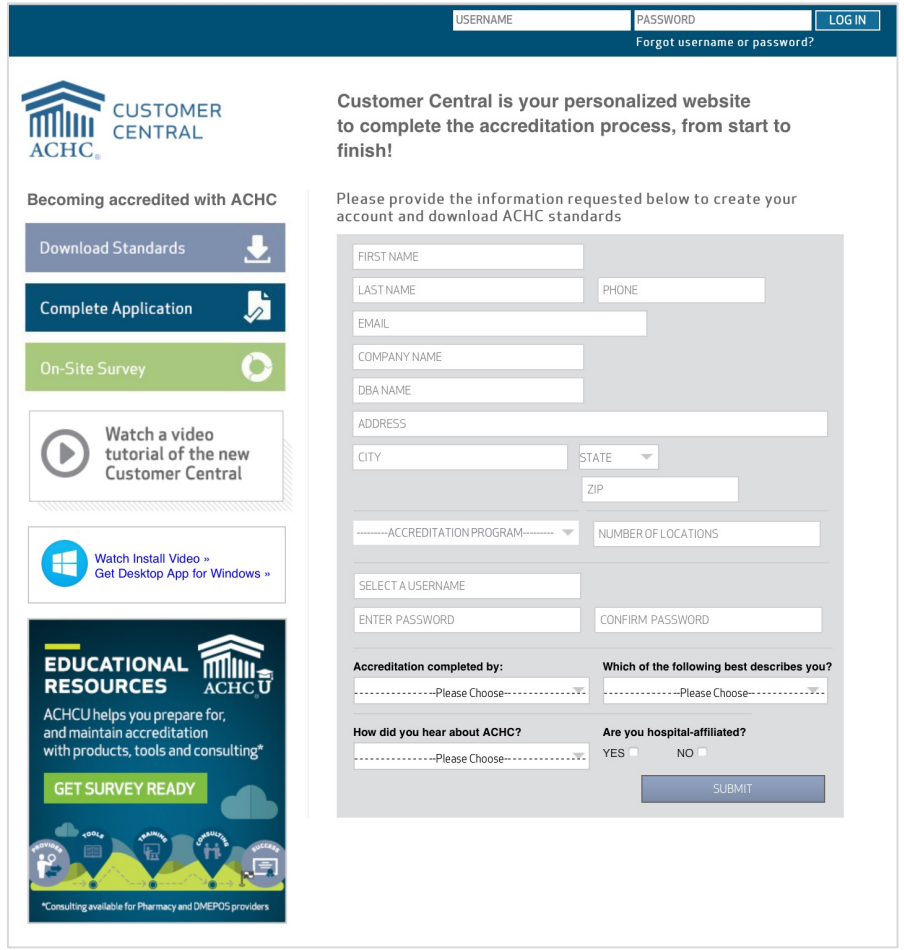
Regulatory Updates

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

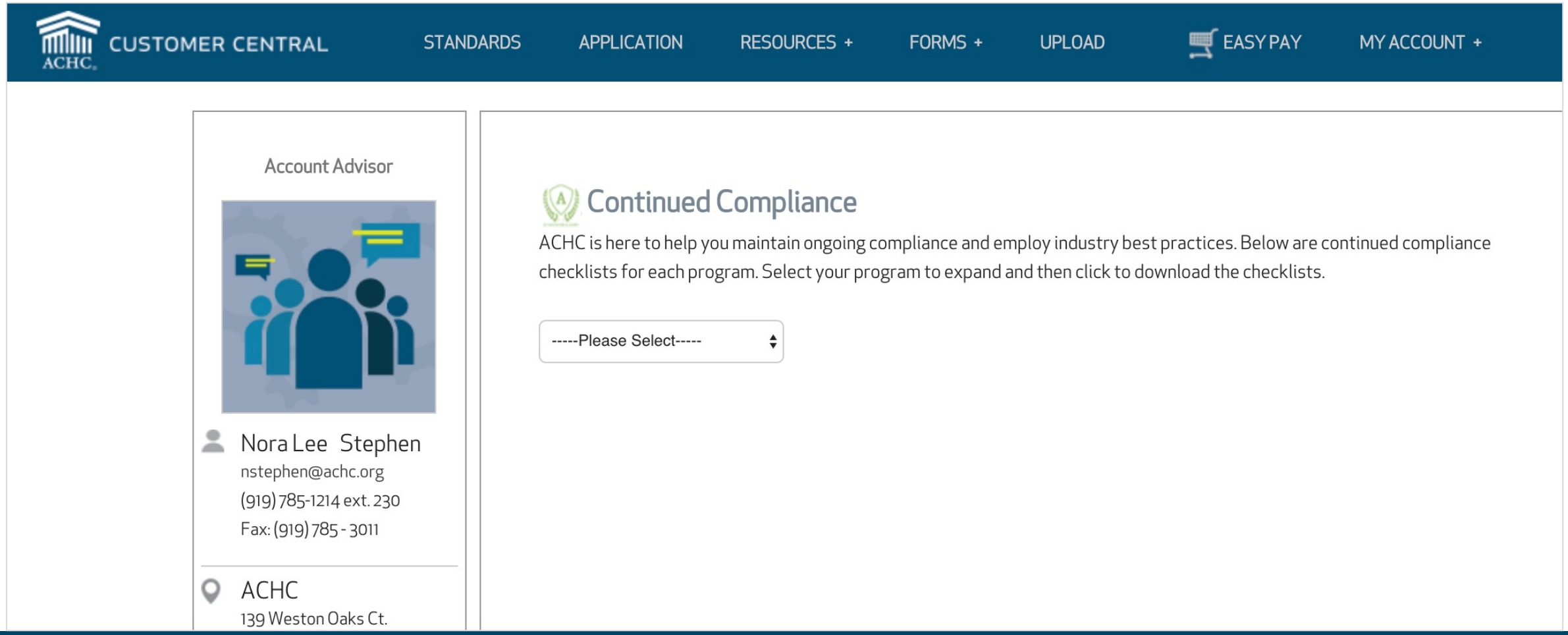


Customer Central

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



Maintaining Compliance Checklist



Maintaining Compliance

RENEWAL ACCREDITATION COMPLIANCE RESOURCES

HOME HEALTH

PROTECT YOURSELF WITH ACHC ACCREDITATION

Let us help you to maintain compliance in an ever-changing regulatory environ
ACHC to complete your Medicare re-certification survey can significantly redu
having an alternative sanction imposed upon your home health agency. With fi
thousands of dollars per day, a strong compliance program achieved through e
maintaining ACHC Accreditation is a key strategy. Since ACHC standards are
providers, by providers, and incorporate the Medicare Conditions of Participa
choosing to become accredited greatly reduces the risk of financial penalties.

In addition to the widely recognized benefits of accreditation, the following ar
how ACHC will help you avoid these sanctions:

- Condition-level and standard-level violations cited during any on-site su
by ACHC are not subject to the alternative sanctions.
- For providers who have deemed status, Centers for Medicare & Medica
only conducts on-site surveys for complaint or validation purposes, sign
the risk of an on-site visit during which sanctions could be imposed.
- New home health agencies are frequently less familiar with CMS requir
providers have access to a variety of resources, as well as a personal Ac
and Surveyors with industry-specific experience aimed at helping them
and after the accreditation process.

CMS identified the upper range for Civil Monetary Penalties (CMPs) per day as
So far, 20 states have imposed CMPs: AR, CO, CT, FL, IA, ID, IN, LA, MA, MI, MN
PA, TN, TX, UT, VA. The top 5 states for CMPs based on dollar amount are:

1. OH: $3.3 million
2. IN: $2.1 million
3. MI: $1.8 million
4. MO: $1.2 million
5. PA: $913, 950

Utilize the 12-Month and 24-Month Compliance Checklists to assist you in maint

[665] Revised: 02/13/2019 Page

ACCREDITATION 12-MONTH COMPLIANCE CHECKLIST

HOME HEALTH

Use this checklist, along with the Medical Record Audit tool and the Personnel File Audit tool to audit your Hom
Health Agency (HHA) and operations 12 months after your ACHC survey. This checklist also helps you determi
your organization is in compliance with applicable local, state, and federal laws and regulations. This checklist
intended to replace your own comprehensive review of ACHC Accreditation Standards, nor does it guaran
successful accreditation decision. For any areas found to be out of compliance, it is recommended that an internal Pla
Correction be implemented and results monitored for compliance.

SECTION 1: ORGANIZATION AND ADMINISTRATION

Standard	Expectation	Comme
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 with 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	

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[514] Accreditation 12-Month Compliance Checklist (Home Health)

ACCREDITATION 24-MONTH COMPLIANCE CHECKLIST

HOME HEALTH

Use this checklist, along with the Medical Record Audit tool and the Personnel File Audit tool to audit your Hor
Health Agency (HHA) and operations 24 months after your ACHC survey. This checklist also helps you determ
your organization is in compliance with applicable local, state, and federal laws and regulations. This checklist
intended to replace your own comprehensive review of ACHC Accreditation Standards, nor does it guaran
successful accreditation decision. For any areas found to be out of compliance, it is recommended that an internal Pl
Correction be implemented and results monitored for compliance.

SECTION 1: ORGANIZATION AND ADMINISTRATION

Standard	Expectation	Comm
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 with 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	

Revised: 06/08/2018 Page 1 of 5 | achc
[515] Accreditation 24-Month Compliance Checklist (Home Health)

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	

Revised: 06/27/2018 Page 1 of 4 | achc.org
[559] ItemsNeeded for Survey – Home Health

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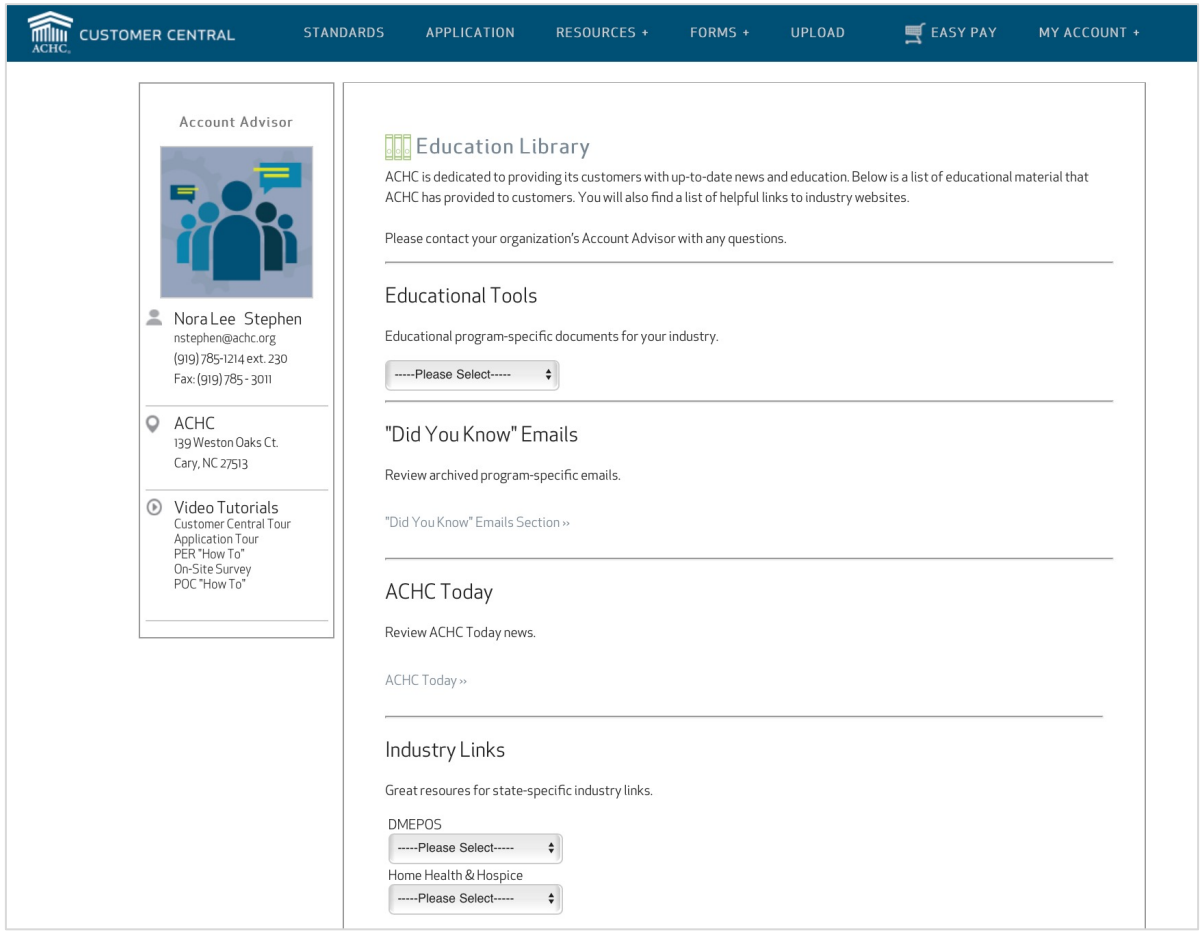
ACHCU is a brand of ACHC.

Education Library



ACHC U®
EDUCATIONAL RESOURCES

HOME HEALTH HOSPICE

Questions?

Call (855) 937-2242 | achc.org