ACHC U®
EDUCATIONAL RESOURCES

PALLIATIVE CARE

ACHC Certified Consultant Training

Palliative Care

Presenter:
Becky Tolson, RN, BS
Clinical Compliance Educator

ACHCU

- ACHCU is dedicated to your organization's success.
- Learn more about ACHCU at achcu.com or talk with a representative today.
- Any questions regarding this presentation and post-test can be addressed to:
  - Lindsey Holder — lholder@achcu.com

Also Joining Our Training Today

- Lindsey Holder – Senior Manager, Education & Training
- Suzie Steger – Senior Education & Training Coordinator
- Steve Clark – Education Services Specialist
- Brooke Renn - Business Development Representative

Business Development Representative

- In addition to your Sales Specialist or your Account Advisor, another point of contact for you as a Certified Consultant is Brooke Renn.
- Contact information:
  - brenn@achc.org
  - (855) 937-2242 X252

Optimize Your Workshop Experience

- During our presentation
  - Use the Questions feature in the GoToWebinar navigation pane to ask your questions throughout the presentation
- During the live Q&A
  - Type in the Questions box you would like to ask a question (or use the raise your hand feature)
  - Our team will recognize you and unmute your mic
  - Help us to make the information personal to your business!
- Since this is a live event, connection issues can happen
  - If on your end, just use the same GoToMeeting link and reconnect
  - If on our end, look for instructions in your email on how we can reconnect

Items Needed for Virtual Training

- You should have received an email with a link to the following information:
  - ACHC Standards
  - ACHC Accreditation Process
  - The presentation for today
  - The *ACHC Accreditation Guide to Success* for Palliative Care
- If you have not received the email or are unable to download the information, contact customerservice@ACHCU.com for assistance

Objectives

- Review the Palliative Care requirements for accreditation.
- Review the ACHC Accreditation Guide to Success workbook and how to use the tools to prepare customers through the survey process.
- Review the expectations for compliance with the ACHC Standards in order to guide ACHC customers through the survey process.

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Introduction

About ACHC

About ACHC

- Nationally recognized accreditation organization (AO) with more than 30 years of experience
- CMS Deeming Authority for Home Health, Hospice, Home Infusion Therapy, Renal Dialysis, and DMEPOS
- Recognition by most major third-party payors
- Quality Management System certified to ISO 9001:2015

ACHC Mission & Values

Our Mission

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

Our Values

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

ACHC Offerings

Available Programs

- ACUTE CARE HOSPITAL
- AMBULATORY CARE
- AMBULATORY SURGERY CENTER
- ASSISTED LIVING
- BEHAVIORAL HEALTH
- CRITICAL ACCESS HOSPITAL
- CLINICAL LABORATORY
- DENTISTRY
- DMEPOS
- HOME HEALTH
- HOME INFUSION THERAPY
- HOSPICE
- NON-STERILE COMPOUNDING
- OFFICE-BASED SURGERY
- PALLIATIVE CARE
- PHARMACY
- PRIVATE DUTY
- RENAL DIALYSIS
- SLEEP
- STERILE COMPOUNDING

ACHC Offerings

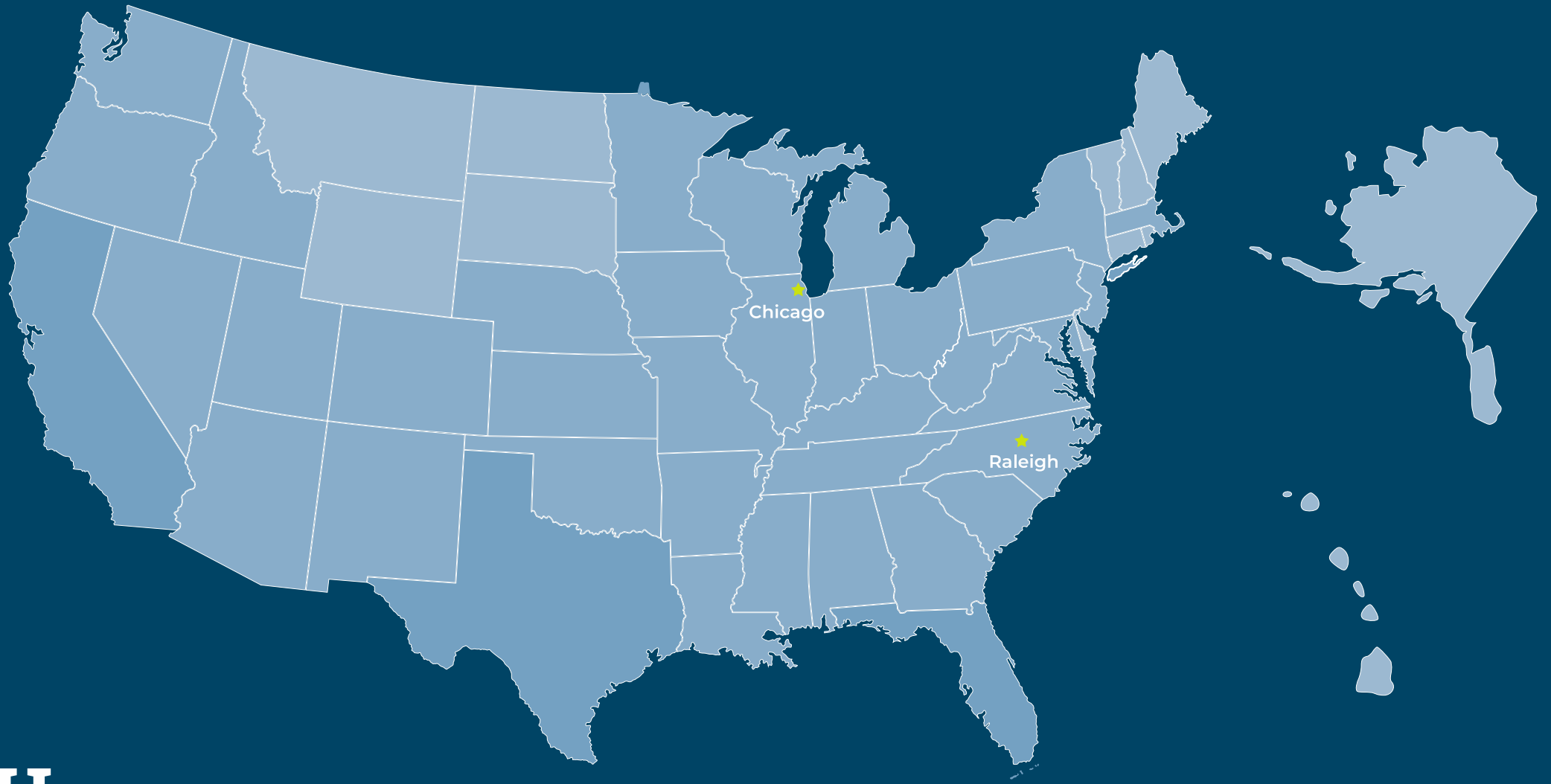
Distinctions

- TELEHEALTH
- HAZARDOUS DRUG HANDLING
- CUSTOM MOBILITY
- CLINICAL RESPIRATORY PATIENT MANAGEMENT
- INFECTIOUS DISEASES SPECIFIC TO HIV
- RARE DISEASES & ORPHAN DRUGS
- NUTRITION SUPPORT
- ONCOLOGY
- PALLIATIVE CARE
- BEHAVIORAL HEALTH

Certifications

- JOINT REPLACEMENT
- LITHOTRIPSY
- STROKE
- WOUND CARE

ACHC currently accredits **over 20,000** locations nationwide.



ACHCU

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ACHC

Experience the ACHC Difference

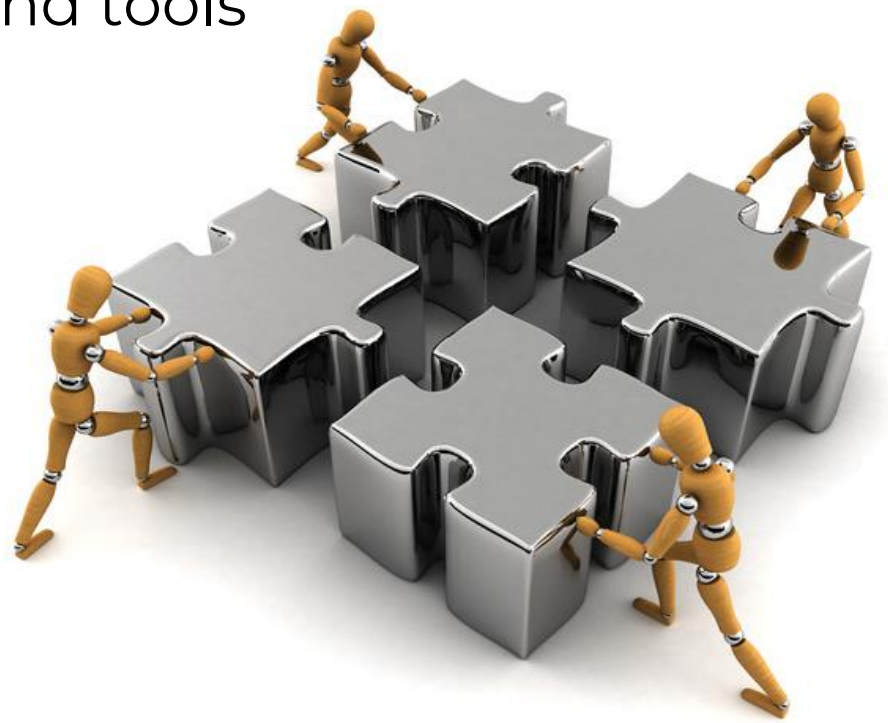
- Standards created for providers, by providers
- All-inclusive pricing — no annual fees
- Commitment to exceptional customer service
- Personal Account Advisors
- Surveyors with industry-specific experience
- Dedicated clinical support
- Dedicated regulatory support

Collaborative Survey Approach

- ACHC values drive the survey approach and provide the organization with:
  - Consistency in expectation of requirements
  - Accuracy in reporting findings/observations
  - Offering organizations the opportunity to clarify or correct 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

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Palliative Care Requirements

Palliative Care Accreditation

- Created specifically for community-based palliative care programs
- Program-specific standards based on the National Consensus Project for Quality Palliative Care guidelines
- Accreditation cycle is renewed every 3 years
- Distinction in Telehealth

Requirements For Palliative Care

- Be licensed and registered according to applicable state and federal laws and regulations and maintain all current legal authorization to operate
- Occupy a building in which services are provided and coordinated that is identified, constructed, and equipped to support such services
- Clearly define the services it provides directly or under contract
- Programs must have at least three (3) active patients and have served five (5) patients in order to be surveyed in the service seeking accreditation

Palliative Care Accreditation

1 SURVEY DAYS REQUIRED	5 PATIENT RECORDS REVIEWED*
3 ACCREDITATION CYCLE YEARS	1 OBSERVATION VISITS CONDUCTED

*3 must be active at time of initial accreditation

Distinction in Telehealth

- Distinction in Telehealth
  - Telehealth may include remote patient monitoring (RPM), biometrics, video, talk, or education.
- Additional one day on survey
  - Three additional records will be reviewed.
  - One virtual patient contacted.
  - Personnel charts reviewed for competencies and to ensure a telehealth manager and alternate are assigned.
- ACHC Telehealth standards are based on the American Telemedicine Association's Home Telehealth Clinical Guidelines.

Poll Question

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Survey Preparation

ACHC Application Requirements

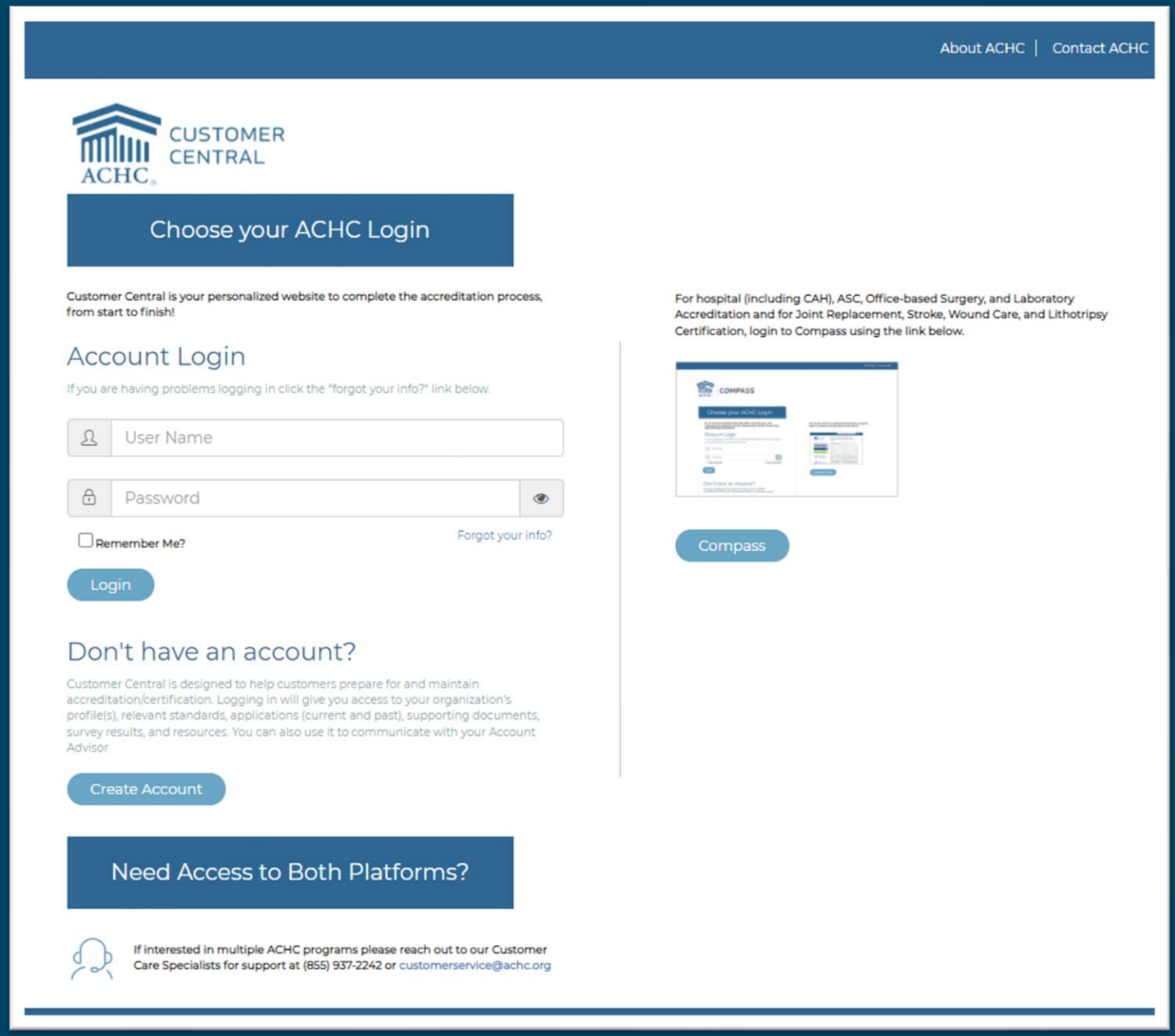
- Required documentation for a palliative care provider to be placed into scheduling:
  - Complete the online Accreditation Application.
  - Complete the statistical information for all physical locations.
  - Submit a copy of any applicable state license.
  - Submit the non-refundable deposit.
  - Download, review, and sign the Accreditation Services/Business Associate Agreement within the required time frame.
  - Upload the required PER checklist.

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 or create a new account below.



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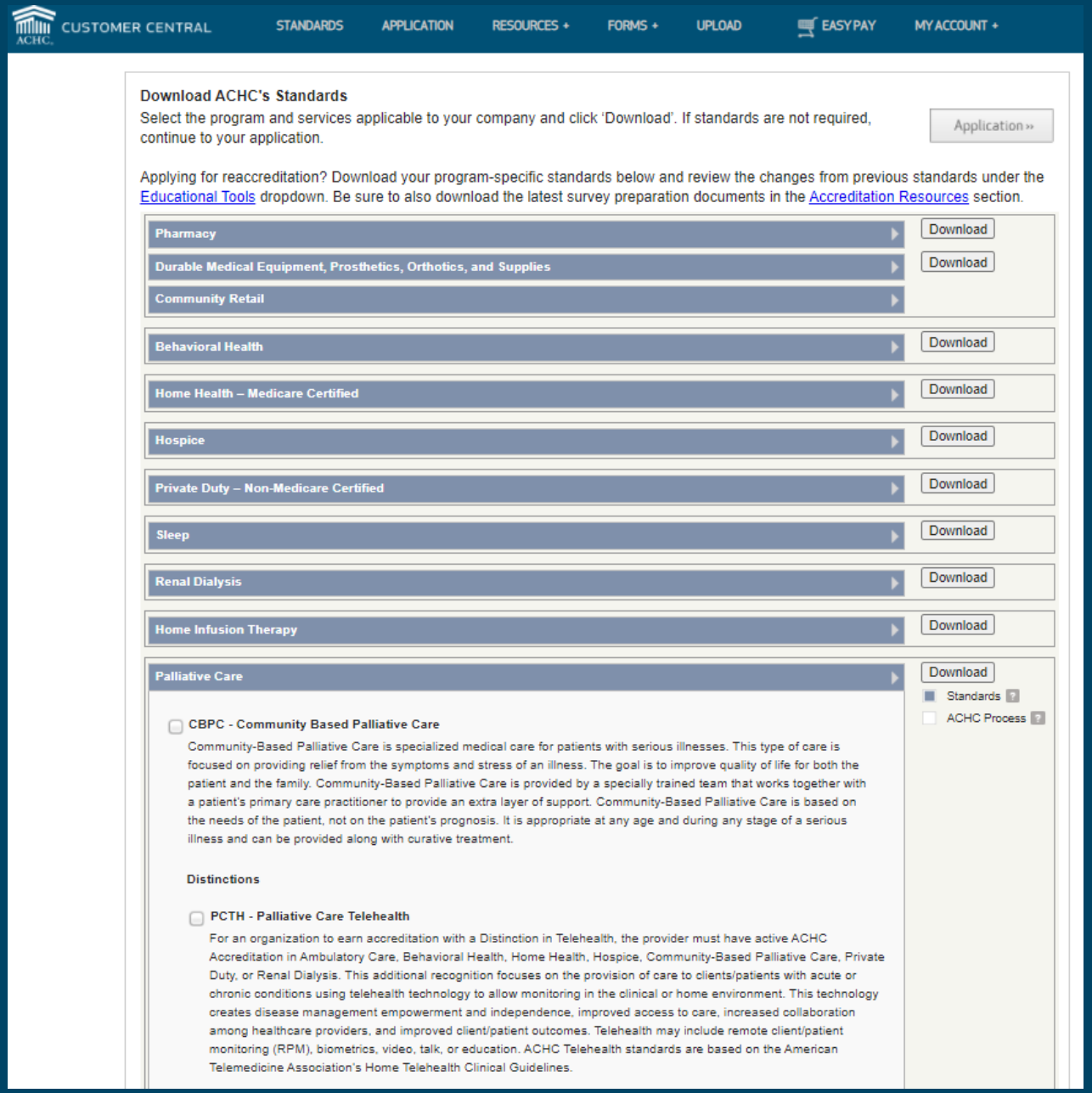
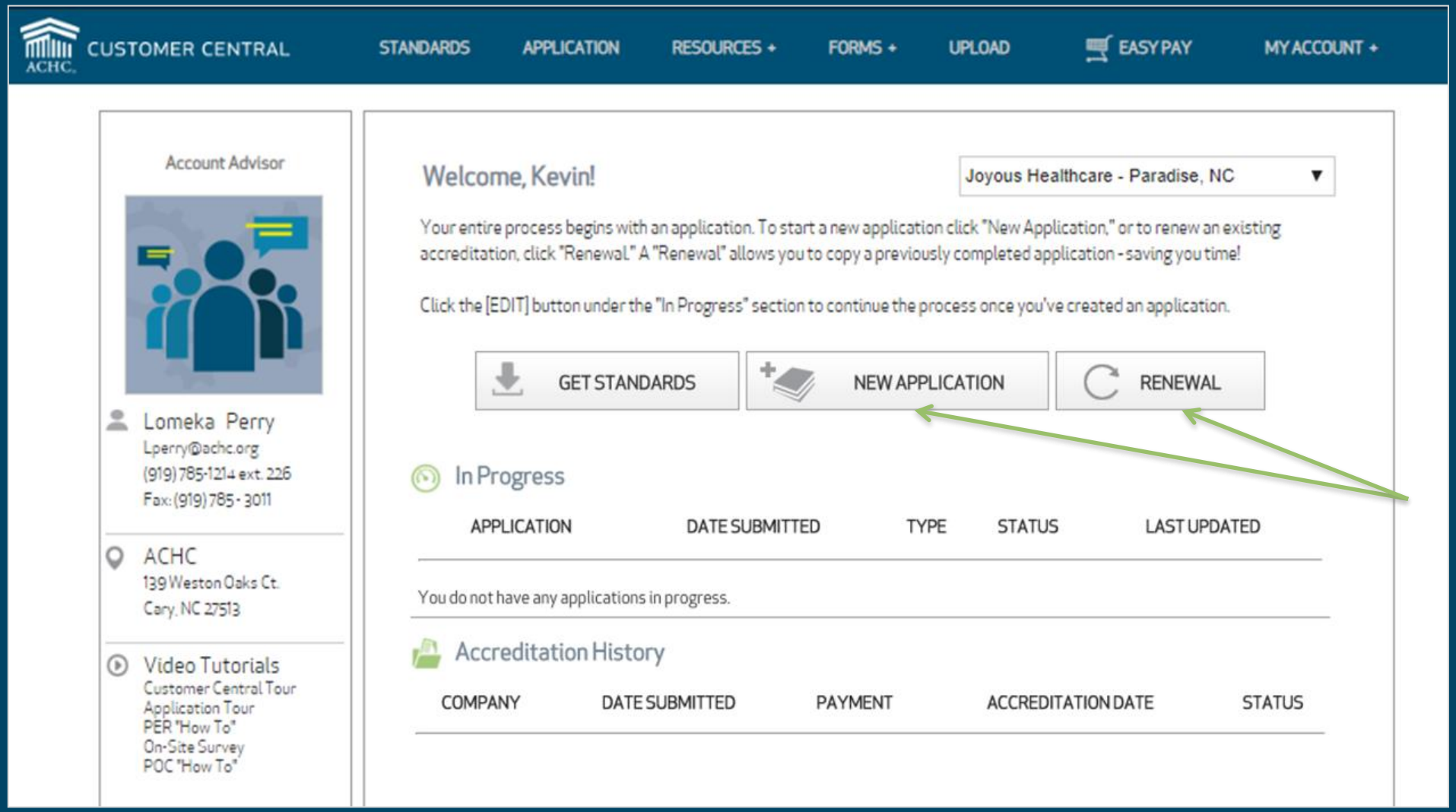


Once inside your client's account, encourage them to purchase standards.

This allows continuous access to the standards.



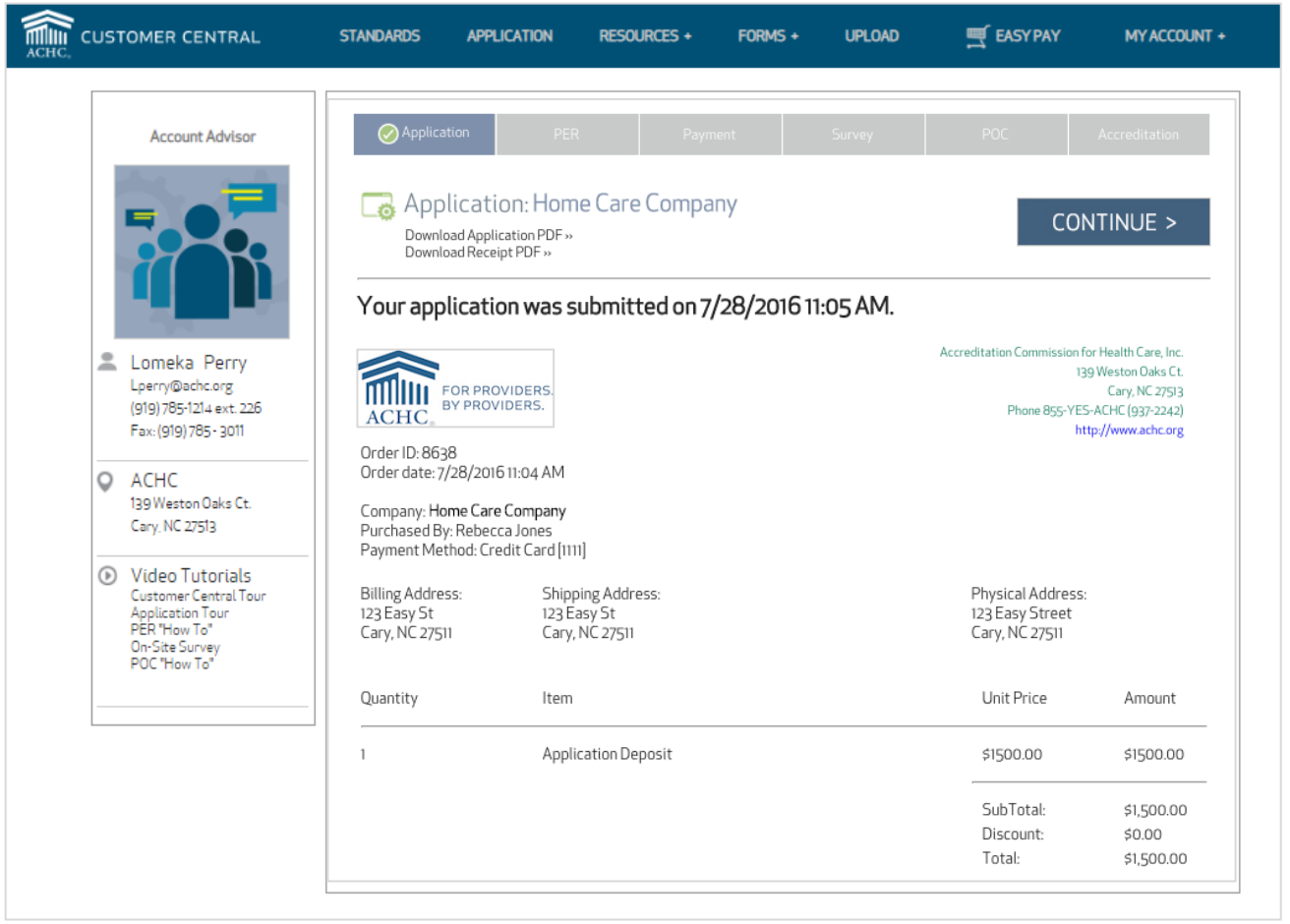
If this is your first time with ACHC Accreditation, click the "NEW APPLICATION" button.

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

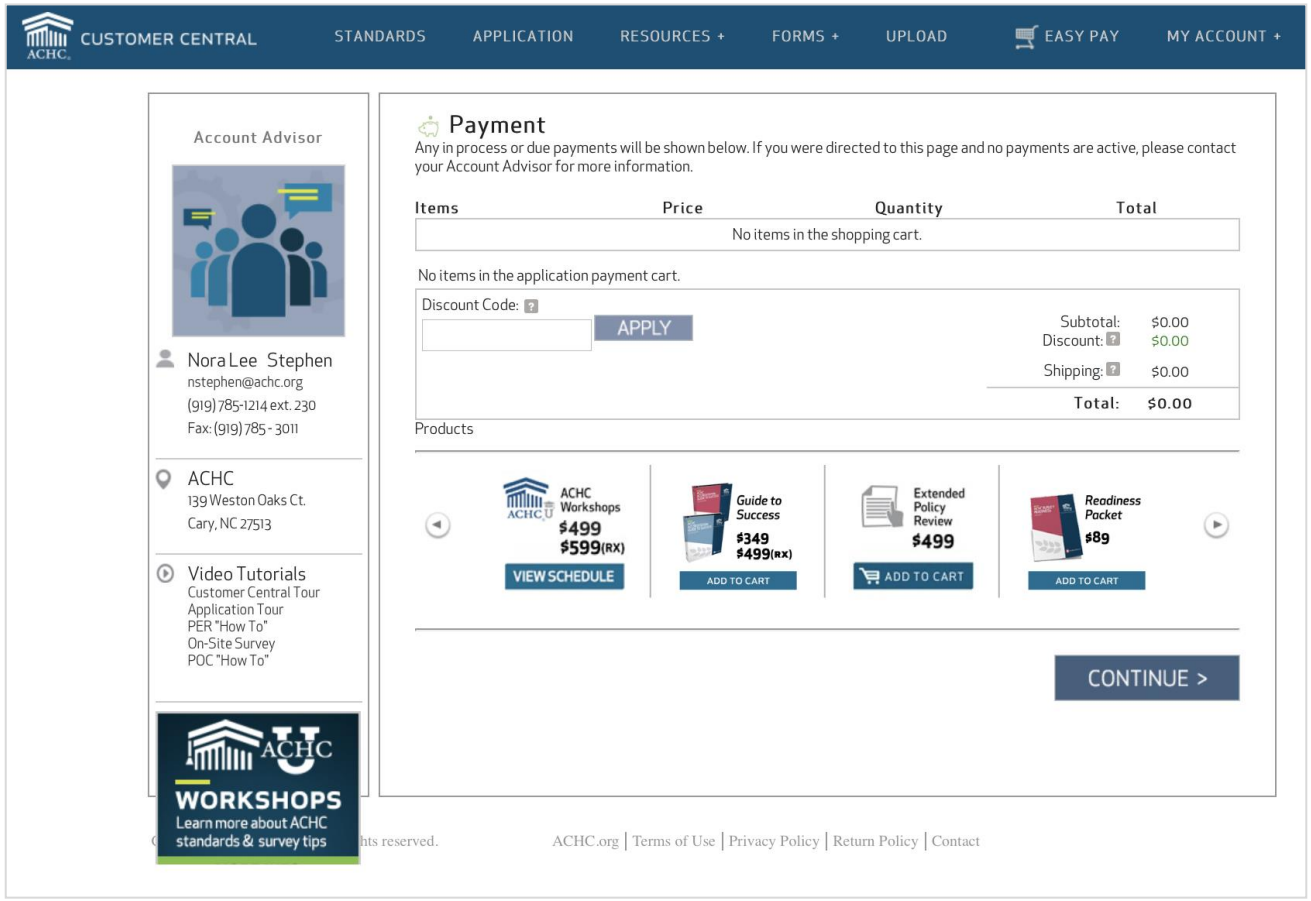
Online Application

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

Confirmation Of Application



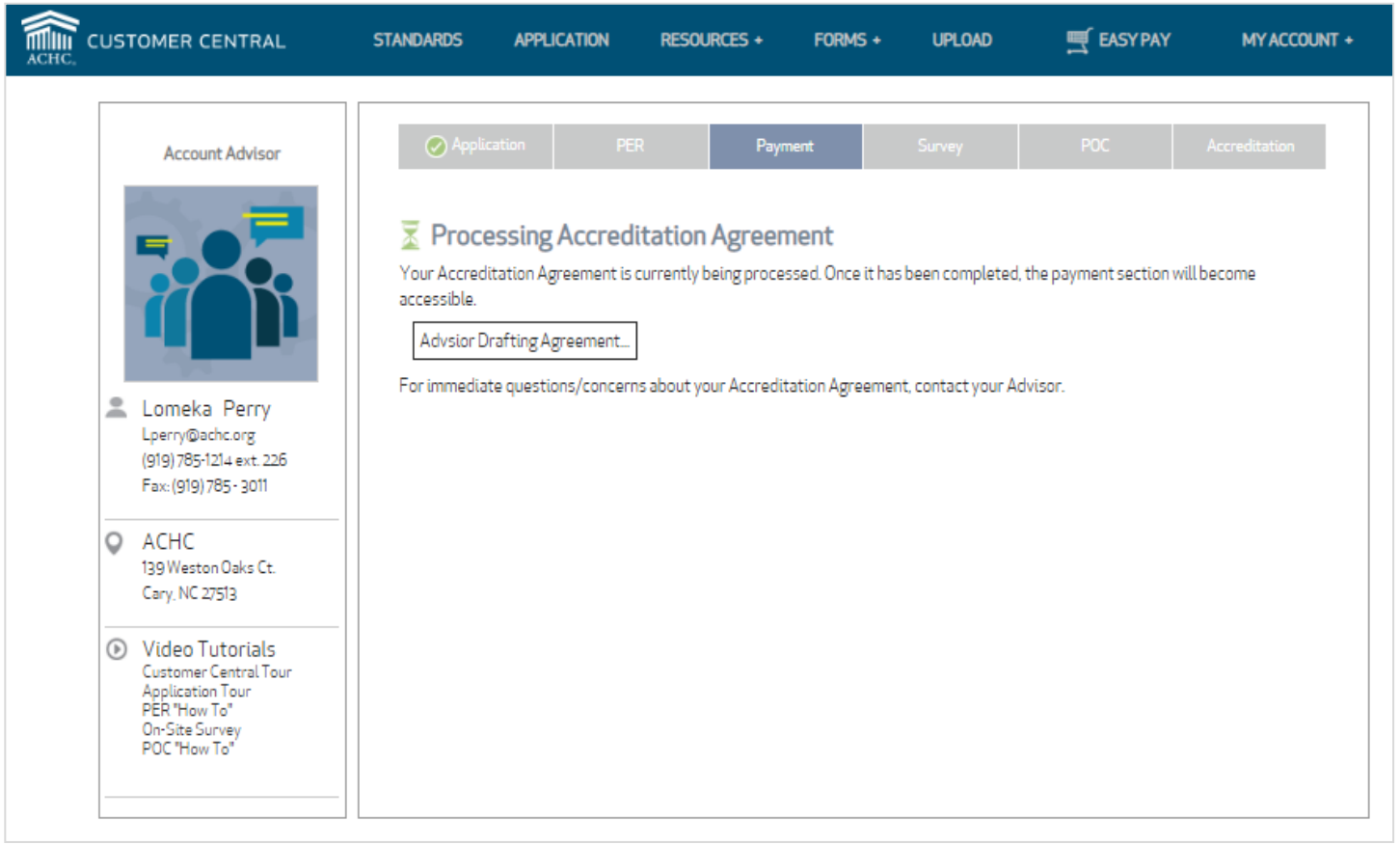
Submit Deposit

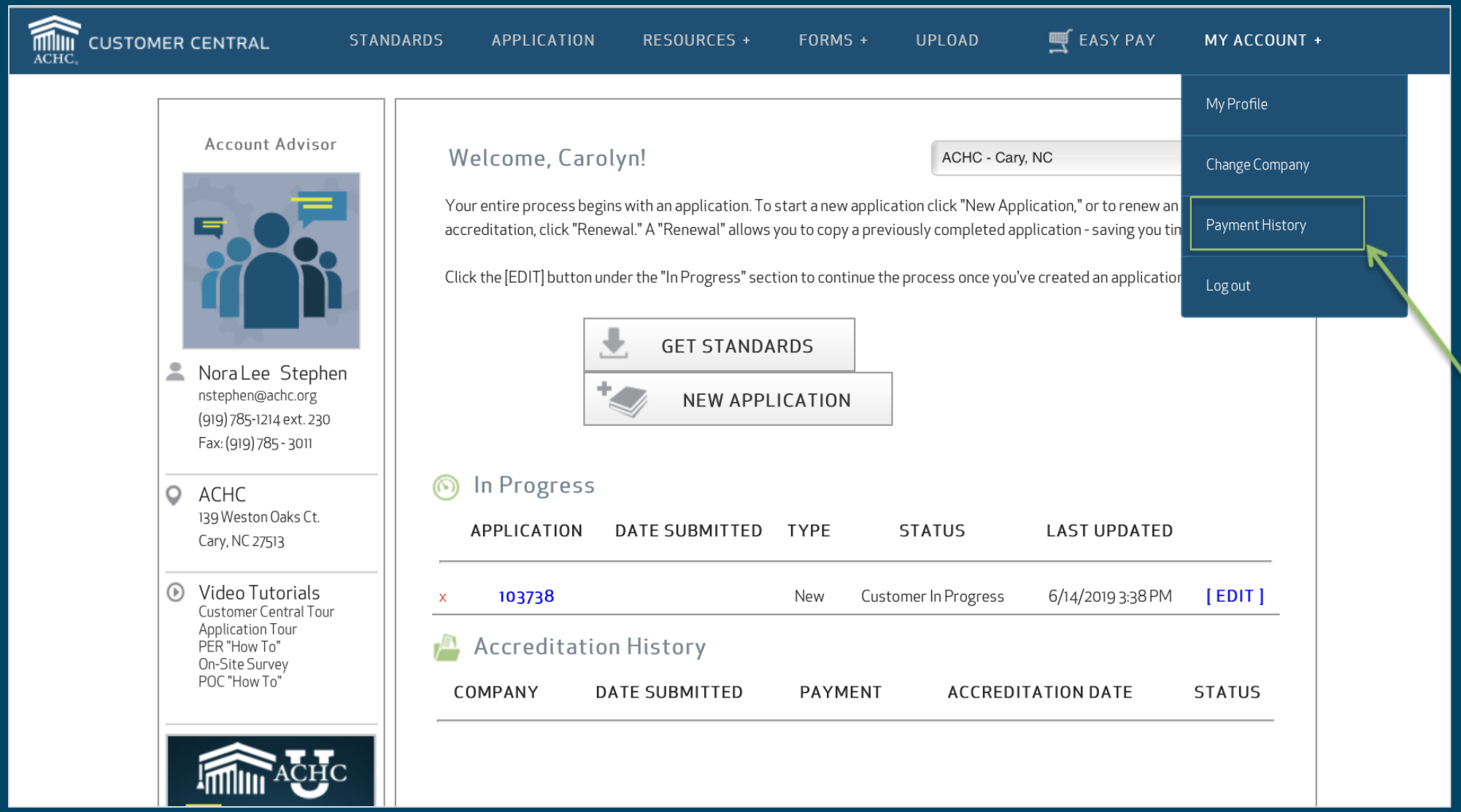


Accreditation Process

- After the first two steps are completed (application, and deposit), 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.
- Your client's organization will be sent to scheduling following the completion of the Preliminary Evidence Report (PER).

Accreditation Agreement

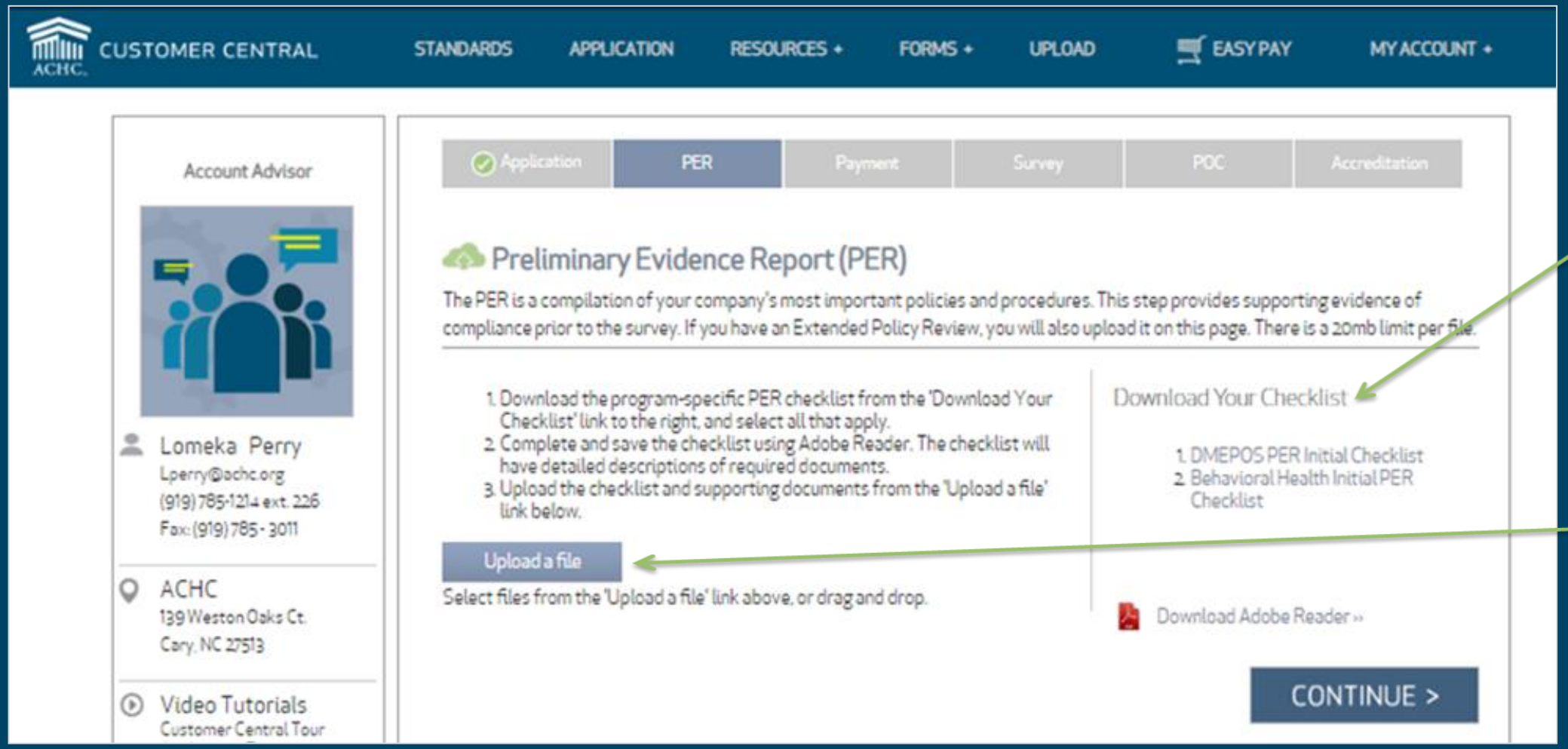




After payments are completed, you can always find a copy of the receipt in the "Payment History" tab.

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
  - State requirements
  - Discipline-specific scope of practice
  - Federal requirements

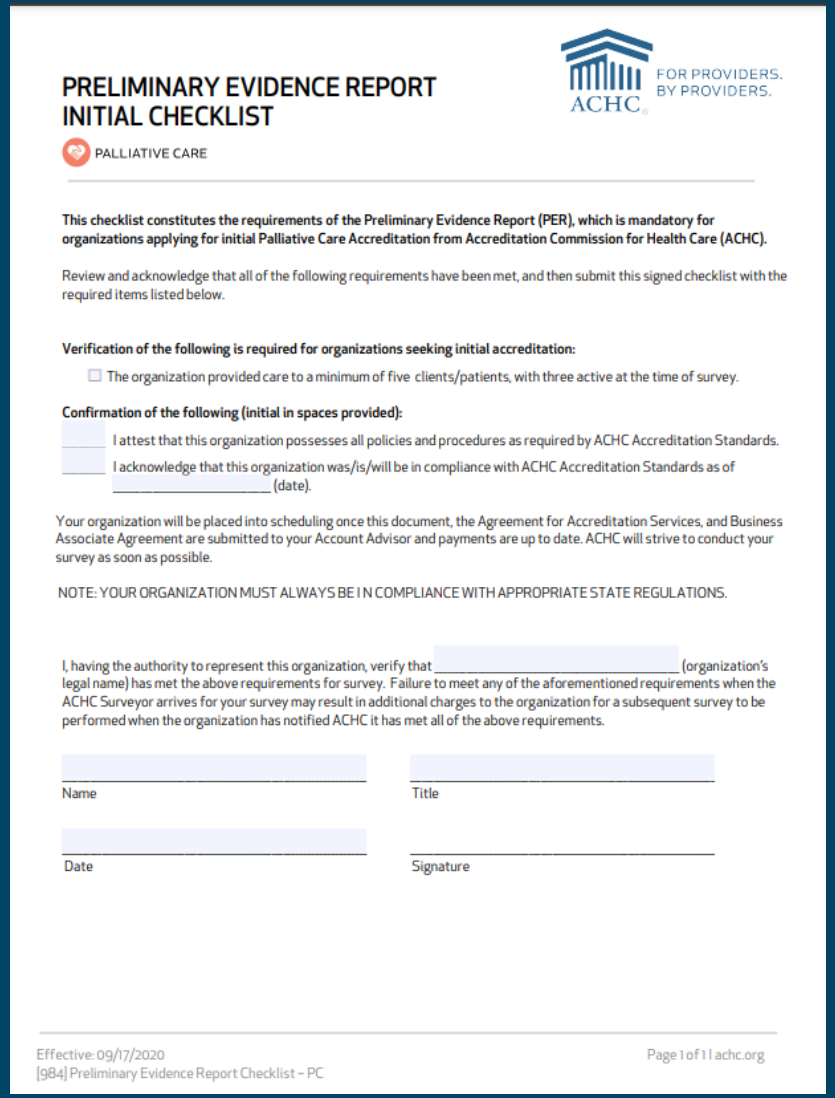


First download the correct PER Checklist.

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

Preliminary Evidence Report Checklist

Establish Compliance Date



PRELIMINARY EVIDENCE REPORT INITIAL CHECKLIST

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This checklist constitutes the requirements of the Preliminary Evidence Report (PER), which is mandatory for organizations applying for initial Palliative Care Accreditation from Accreditation Commission for Health Care (ACHC).

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

Verification of the following is required for organizations seeking initial accreditation:

☐ The organization provided care to a minimum of five clients/patients, with three active at the time of survey.

Confirmation of the following (initial in spaces provided):

_____ I attest that this organization possesses all policies and procedures as required by 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.

NOTE: YOUR ORGANIZATION MUST ALWAYS BE IN COMPLIANCE WITH APPROPRIATE STATE REGULATIONS.

I, having the authority to represent this organization, verify that _____ (organization's legal name) has met the above requirements for survey. Failure to meet any of the aforementioned requirements when the ACHC Surveyor arrives for your survey may 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

Effective: 09/17/2020
[984] Preliminary Evidence Report Checklist – PC

Page 1 of 1 | achc.org

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Establishing Policies and Procedures

- Polices need to be in compliance with the:
  - State regulations
  - ACHC requirements
  - Best practice/program expectations

Establishing Policies and Procedures

- Purchase policies and procedures:
  - Pre-approved policies and procedures
  - Purchase an Extended Policy Review
  - Conduct a review of policies identified on the Items Needed for the On-site Survey
- Readiness/Compliance date established on the Primary Evidence Report (PER) Initial Checklist
- Confirmation of the following:
  - 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 XX date.

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 organization's policies and procedures to ACHC Accreditation Standards.
- Option to purchase through the Customer Central portal.
- Customized Reference Guide for Required Documents, Policies and Procedures (Appendix A).
- Consultants can also have Policies and Procedures pre-approved.
  - Drop-down box on the application.

Appendix A

Appendix A: Reference Guide for Required Documents, Policies and Procedures
Customized for: CBPC

Standard #	Documents, Policies and Procedures	Agency Notes
CBPC1-4A	Written Policies and Procedures	
CBPC1-5A	Written Policies and Procedures	
CBPC1-5B	Written Policies and Procedures	
CBPC1-6A	Written Policies and Procedures	
CBPC1-6B	Written Policies and Procedures	
CBPC1-9A	Written Policies and Procedures	
CBPC2-1A	Written Policies and Procedures	
CBPC2-2A	Written Policies and Procedures	
CBPC2-3A	Written Policies and Procedures	
CBPC2-4A	Written Policies and Procedures	
CBPC2-5A	Written Policies and Procedures	
CBPC2-6A	Written Policies and Procedures	
CBPC2-6B	Written Policies and Procedures	
CBPC2-7A	Written Policies and Procedures	
CBPC2-7B	Written Policies and Procedures	
CBPC2-7C	Written Policies and Procedures	
CBPC2-8A	Written Policies and Procedures	
CBPC2-9A	Written Policies and Procedures	
CBPC2-10A	Written Policies and Procedures	
CBPC2-15A	Written Policies and Procedures	
CBPC2-17A	Written Policies and Procedures	
CBPC4-1A	Written Policies and Procedures	
CBPC4-2B	Written Policies and Procedures	
CBPC4-2C	Written Policies and Procedures	
CBPC4-2F	Written Policies and Procedures	
CBPC4-2G	Written Policies and Procedures and/or Employee Handbook	
CBPC4-2H	Written Policies and Procedures	

Desk Review Report Sample

Desk Review Report
Services: PDA, PDC, PDN

[redacted]
Address
City, State, Zip

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Standard		Comments	Defi-cient
PD4-2E	**There is a job description for each position within the PD which is consistent with the organizational chart with respect to function and reporting responsibilities.**	There is not a job description for the following positions listed on the organizational chart: Office Coordinator, Staff Coordinator, OT, and OTA. There was a job description for ST Assistant but this job was not on the organizational chart. None of the job descriptions include physical and environmental requirements. The DON job description does not include 2 years home care experience and 1 year supervisory as a minimum.	X

Types of Surveys

- **Initial Survey:** An Initial Survey is conducted on organizations that apply for ACHC Accreditation for the first time. Initial Surveys are announced.
- **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 announced.
- **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

- **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.

Virtual Surveys

- Initial and renewal Palliative Care accreditation
- Available in a majority of states.
- Covers the same scope, quality, and review of standards as on-site surveys
- Contact AA to best determine which survey process is right for your client's program

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.

Poll Question

Questions?

ACHC Accreditation Guide To Success

For Palliative Care

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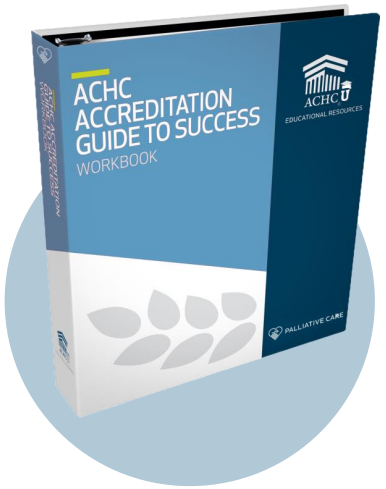
ACHC Accreditation Guide To Success

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



Standard CBPC1-1A: (Services applicable: CBPC)

The palliative care program is in compliance with federal, state, and local laws and regulations.

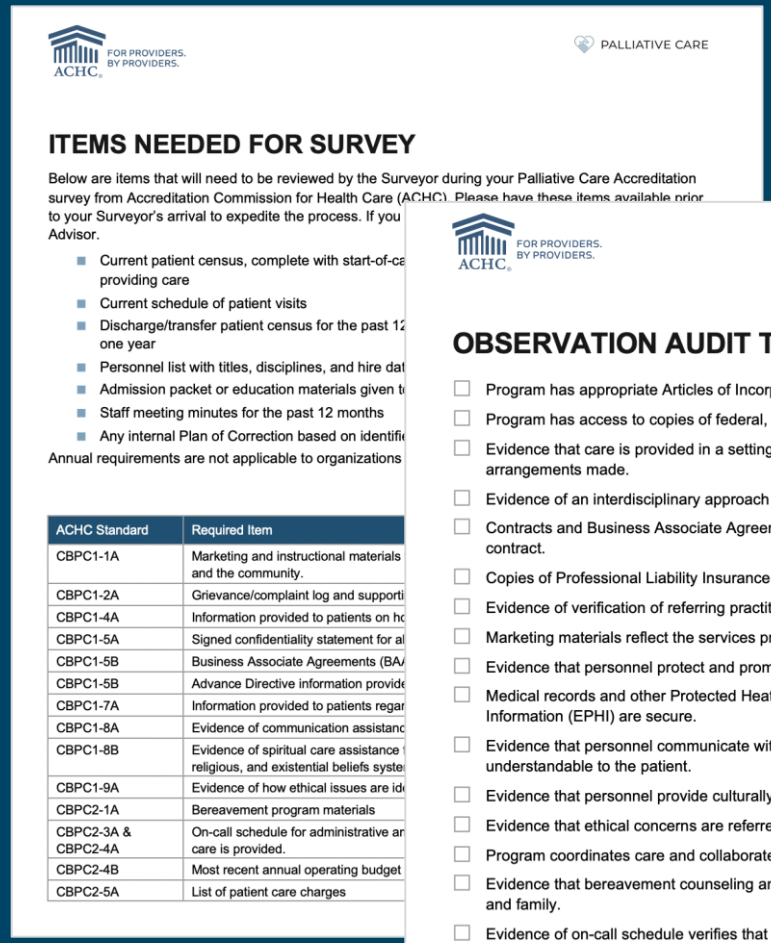
HINT

A copy of all current applicable license(s)/permit(s) for each premise should be posted in a prominent location.

Articles of Incorporation/bylaws and all applicable amendments or other documentation of legal authority to operate should be available for review.

NCP Guideline(s) Reference: 8.2

Survey Preparation Tools



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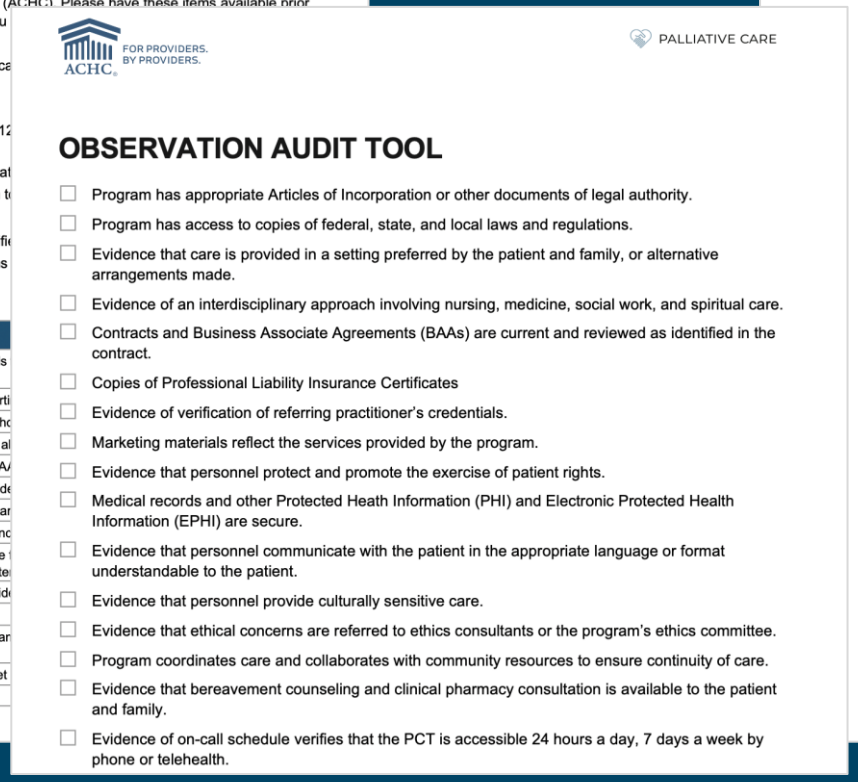
ITEMS NEEDED FOR SURVEY

Below are items that will need to be reviewed by the Surveyor during your Palliative Care Accreditation survey from Accreditation Commission for Health Care (ACHC). Please have these items available prior to your Surveyor's arrival to expedite the process. If you Advisor.

- Current patient census, complete with start-of-ca providing care
- Current schedule of patient visits
- Discharge/transfer patient census for the past 12 one year
- Personnel list with titles, disciplines, and hire dat
- Admission packet or education materials given t
- Staff meeting minutes for the past 12 months
- Any internal Plan of Correction based on identifi

Annual requirements are not applicable to organizations

ACHC Standard	Required Item
CBPC1-1A	Marketing and instructional materials and the community.
CBPC1-2A	Grievance/complaint log and supporti
CBPC1-4A	Information provided to patients on hc
CBPC1-5A	Signed confidentiality statement for al
CBPC1-5B	Business Associate Agreements (BA/
CBPC1-5B	Advance Directive information provide
CBPC1-7A	Information provided to patients regar
CBPC1-8A	Evidence of communication assistanc
CBPC1-8B	Evidence of spiritual care assistance religious, and existential beliefs syste
CBPC1-9A	Evidence of how ethical issues are id
CBPC2-1A	Bereavement program materials
CBPC2-3A & CBPC2-4A	On-call schedule for administrative ar care is provided.
CBPC2-4B	Most recent annual operating budget
CBPC2-5A	List of patient care charges



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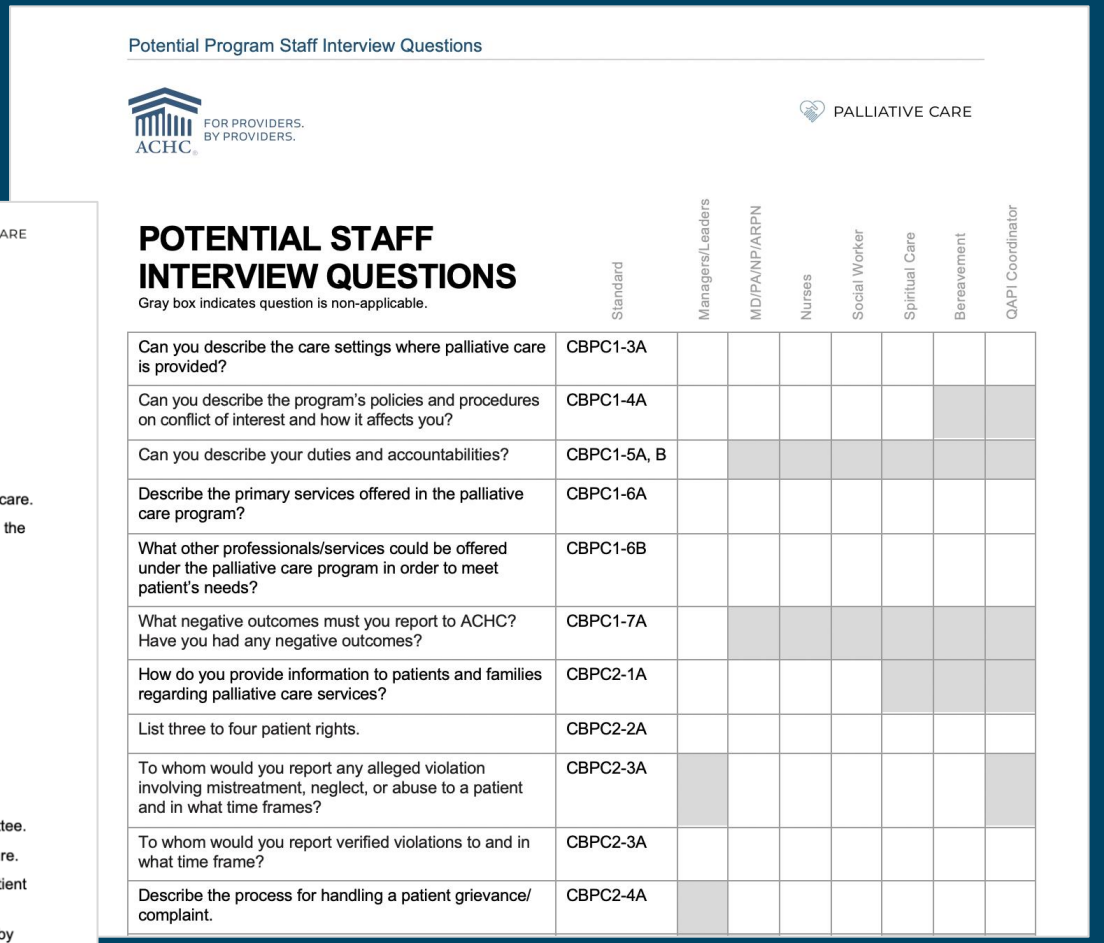
OBSERVATION AUDIT TOOL

- ☐ Program has appropriate Articles of Incorporation or other documents of legal authority.
- ☐ Program has access to copies of federal, state, and local laws and regulations.
- ☐ Evidence that care is provided in a setting preferred by the patient and family, or alternative arrangements made.
- ☐ Evidence of an interdisciplinary approach involving nursing, medicine, social work, and spiritual care.
- ☐ Contracts and Business Associate Agreements (BAAs) are current and reviewed as identified in the contract.
- ☐ Copies of Professional Liability Insurance Certificates
- ☐ Evidence of verification of referring practitioner's credentials.
- ☐ Marketing materials reflect the services provided by the program.
- ☐ Evidence that personnel protect and promote the exercise of patient rights.
- ☐ Medical records and other Protected Heath Information (PHI) and Electronic Protected Health Information (EPHI) are secure.
- ☐ Evidence that personnel communicate with the patient in the appropriate language or format understandable to the patient.
- ☐ Evidence that personnel provide culturally sensitive care.
- ☐ Evidence that ethical concerns are referred to ethics consultants or the program's ethics committee.
- ☐ Program coordinates care and collaborates with community resources to ensure continuity of care.
- ☐ Evidence that bereavement counseling and clinical pharmacy consultation is available to the patient and family.
- ☐ Evidence of on-call schedule verifies that the PCT is accessible 24 hours a day, 7 days a week by phone or telehealth.



Potential Program Staff Interview Questions

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POTENTIAL STAFF INTERVIEW QUESTIONS

Gray box indicates question is non-applicable.

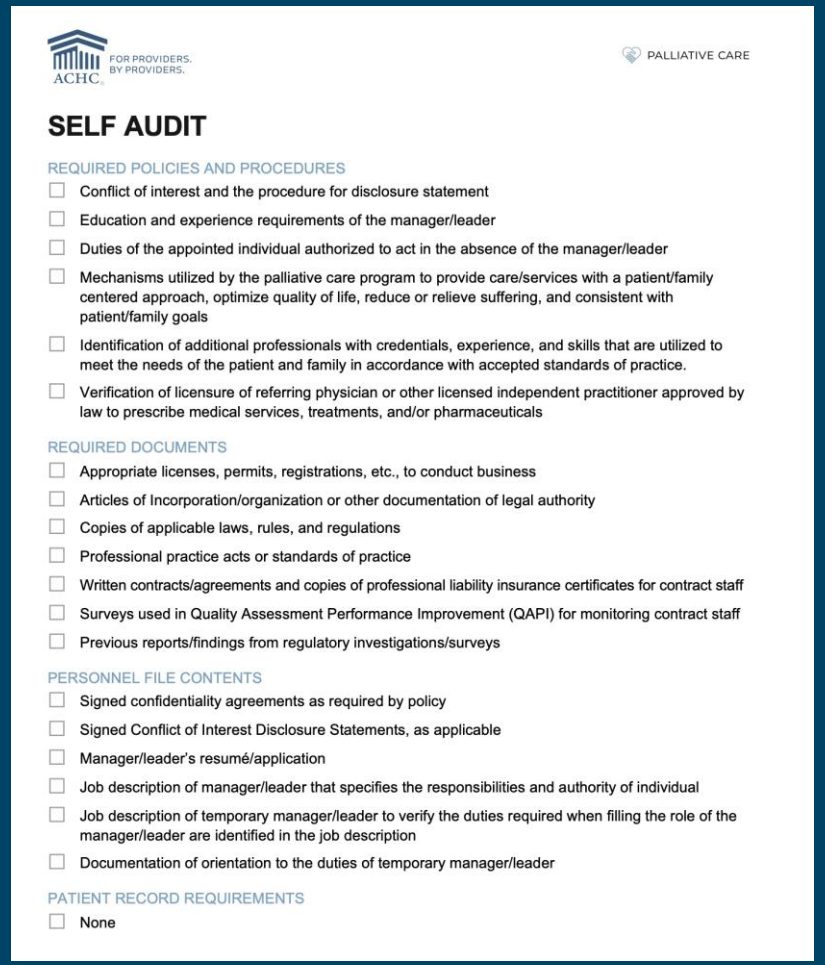
	Standard	Managers/Leaders	MD/PA/NP/ARPN	Nurses	Social Worker	Spiritual Care	Bereavement	QAPI Coordinator
Can you describe the care settings where palliative care is provided?	CBPC1-3A							
Can you describe the program's policies and procedures on conflict of interest and how it affects you?	CBPC1-4A							
Can you describe your duties and accountabilities?	CBPC1-5A, B							
Describe the primary services offered in the palliative care program?	CBPC1-6A							
What other professionals/services could be offered under the palliative care program in order to meet patient's needs?	CBPC1-6B							
What negative outcomes must you report to ACHC? Have you had any negative outcomes?	CBPC1-7A							
How do you provide information to patients and families regarding palliative care services?	CBPC2-1A							
List three to four patient rights.	CBPC2-2A							
To whom would you report any alleged violation involving mistreatment, neglect, or abuse to a patient and in what time frames?	CBPC2-3A							
To whom would you report verified violations to and in what time frame?	CBPC2-3A							
Describe the process for handling a patient grievance/ complaint.	CBPC2-4A							

Compliance Checklist

SECTION 1 COMPLIANCE CHECKLIST

Standard	Policy/ Procedure	Personnel File	Observation	Audit Tools Provided	Compliance Y/N	Comments
CBPC1-1A			Articles of Incorporation or other appropriate documentation	Observation Tool		
CBPC1-2A			Copies of applicable federal, state, and local laws and regulations	Observation Tool		
CBPC1-3A			Observation & interviews of staff	Observation Tool & Interview Tool		
CBPC1-4A	Yes	Yes	Conflict of Interest Disclosure Statement & staff interviews	Personnel File Tool & Interview Tool		
CBPC1-5A	Yes	Yes	Job description, Resumé/application & staff interviews	Personnel File Tool & Interview Tool		
CBPC1-5B	Yes	Yes	Job description, Orientation & staff interviews	Personnel File Tool & Interview Tool		
CBPC1-6A	Yes	Yes	Observation & staff interviews	Observation Tool & Interview Tool		
CBPC1-6B	Yes	Yes	Staff interviews	Interview Tool		
CBPC1-7A			Staff interviews	Interview Tool		
CBPC1-8A			Written contracts/ agreements & liability insurance certificate	Items Needed for Survey		
CBPC1-8B			QAPI activities	Observation Tool		
CBPC1-9A	Yes		Verification of physician's credentials	Observation Tool		

Self Audit



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PALLIATIVE CARE

SELF AUDIT

REQUIRED POLICIES AND PROCEDURES

- ☐ Conflict of interest and the procedure for disclosure statement
- ☐ Education and experience requirements of the manager/leader
- ☐ Duties of the appointed individual authorized to act in the absence of the manager/leader
- ☐ Mechanisms utilized by the palliative care program to provide care/services with a patient/family centered approach, optimize quality of life, reduce or relieve suffering, and consistent with patient/family goals
- ☐ Identification of additional professionals with credentials, experience, and skills that are utilized to meet the needs of the patient and family in accordance with accepted standards of practice.
- ☐ Verification of licensure of referring physician or other licensed independent practitioner approved by law to prescribe medical services, treatments, and/or pharmaceuticals

REQUIRED DOCUMENTS

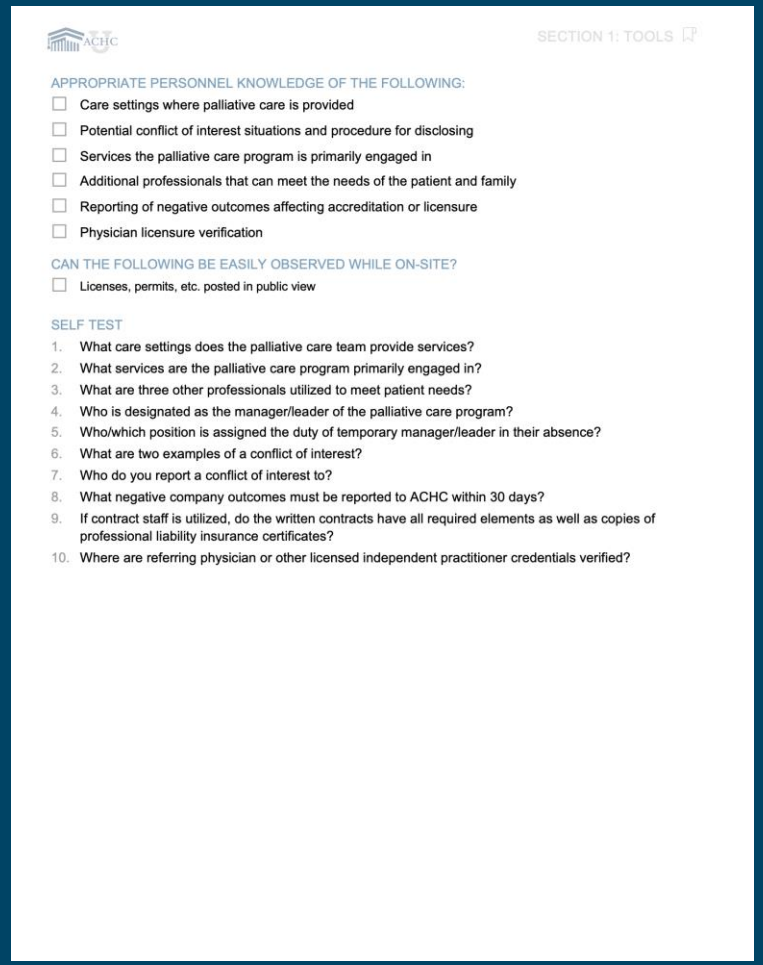
- ☐ Appropriate licenses, permits, registrations, etc., to conduct business
- ☐ Articles of Incorporation/organization or other documentation of legal authority
- ☐ Copies of applicable laws, rules, and regulations
- ☐ Professional practice acts or standards of practice
- ☐ Written contracts/agreements 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

PERSONNEL FILE CONTENTS

- ☐ Signed confidentiality agreements as required by policy
- ☐ Signed Conflict of Interest Disclosure Statements, as applicable
- ☐ Manager/leader's resumé/application
- ☐ Job description of manager/leader that specifies the responsibilities and authority of individual
- ☐ Job description of temporary manager/leader to verify the duties required when filling the role of the manager/leader are identified in the job description
- ☐ Documentation of orientation to the duties of temporary manager/leader

PATIENT RECORD REQUIREMENTS

- ☐ None



SECTION 1: TOOLS

APPROPRIATE PERSONNEL KNOWLEDGE OF THE FOLLOWING:

- ☐ Care settings where palliative care is provided
- ☐ Potential conflict of interest situations and procedure for disclosing
- ☐ Services the palliative care program is primarily engaged in
- ☐ Additional professionals that can meet the needs of the patient and family
- ☐ Reporting of negative outcomes affecting accreditation or licensure
- ☐ Physician licensure verification

CAN THE FOLLOWING BE EASILY OBSERVED WHILE ON-SITE?

- ☐ Licenses, permits, etc. posted in public view

SELF TEST

1. What care settings does the palliative care team provide services?
2. What services are the palliative care program primarily engaged in?
3. What are three other professionals utilized to meet patient needs?
4. Who is designated as the manager/leader of the palliative care program?
5. Who/which position is assigned the duty of temporary manager/leader in their absence?
6. What are two examples of a conflict of interest?
7. Who do you report a conflict of interest to?
8. What negative company outcomes must be reported to ACHC within 30 days?
9. If contract staff is utilized, do the written contracts have all required elements as well as copies of professional liability insurance certificates?
10. Where are referring physician or other licensed independent practitioner credentials verified?

Focus Areas

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

Questions?

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EDUCATIONAL RESOURCES

PALLIATIVE CARE

Palliative Care Survey Process

Start to Finish

On-Site Survey

- Notification call
- Opening conference
- Tour of facility
- Personnel record review
- Patient observation visits (1)
- Patient chart review (5)
- Interview with staff and management
- Review of program's implementation of policies including Quality Assessment and Performance Improvement (QAPI)
- Exit conference

Opening Conference

- Begins shortly after arrival of Surveyor
- Invite those involved in the process
- Good time to gather information needed by the Surveyor
- KEY REPORTS
    - Current census and current schedule of visits
        - Name, diagnosis, start of care date, disciplines involved
    - Discharge and transfers
    - Personnel (contract)
        - Name, start of hire, and discipline/role

Tour

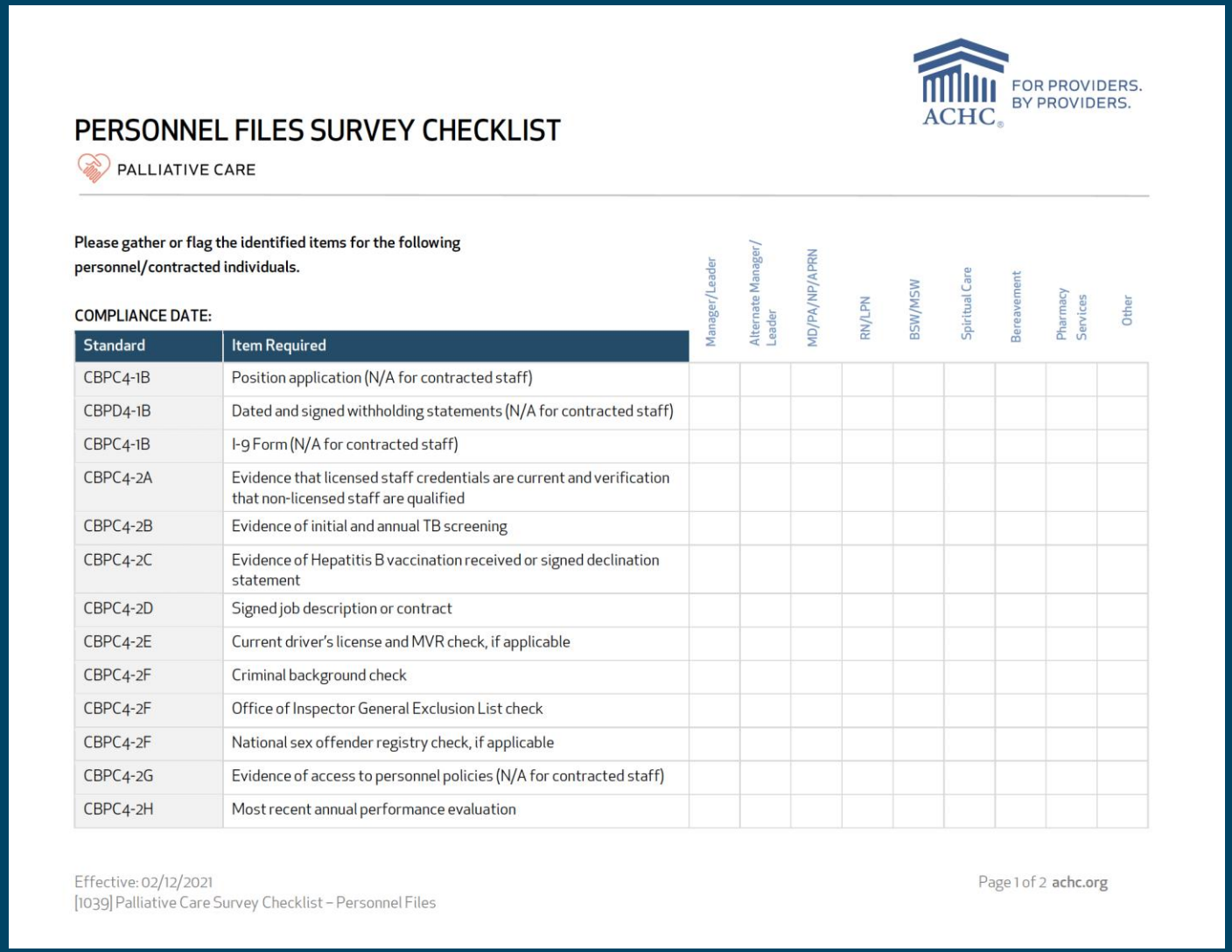
- Quick tour of facility
  - Medical record storage
  - Maintaining confidentiality of Protected Health Information (PHI)
  - Supply closet
  - Biohazard waste
  - Required posters
  - Fire extinguishers/smoke detectors/non-smoking signage
- Policies and procedures available for reference
- Quality Assessment and Performance Improvement presentation (brief)

Personnel Record Review

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

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

Personnel File Review



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PERSONNEL FILES SURVEY CHECKLIST

PALLIATIVE CARE

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

COMPLIANCE DATE:

Standard	Item Required	Manager/Leader	Alternate Manager/Leader	MD/PA/NP/APRN	RN/LPN	BSW/MSW	Spiritual Care	Bereavement	Pharmacy Services	Other
CBPC4-1B	Position application (N/A for contracted staff)									
CBPD4-1B	Dated and signed withholding statements (N/A for contracted staff)									
CBPC4-1B	I-9 Form (N/A for contracted staff)									
CBPC4-2A	Evidence that licensed staff credentials are current and verification that non-licensed staff are qualified									
CBPC4-2B	Evidence of initial and annual TB screening									
CBPC4-2C	Evidence of Hepatitis B vaccination received or signed declination statement									
CBPC4-2D	Signed job description or contract									
CBPC4-2E	Current driver's license and MVR check, if applicable									
CBPC4-2F	Criminal background check									
CBPC4-2F	Office of Inspector General Exclusion List check									
CBPC4-2F	National sex offender registry check, if applicable									
CBPC4-2G	Evidence of access to personnel policies (N/A for contracted staff)									
CBPC4-2H	Most recent annual performance evaluation									

Effective: 02/12/2021
[1039] Palliative Care Survey Checklist – Personnel Files

Page 1 of 2 achc.org

Medical Chart Reviews

- 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

Observation Visit

- Visits will be with patients already scheduled for visits if census is large enough to accommodate
- Program responsibility to obtain consent from patient/family
- Prepare patients and families for potential observation visits
- Surveyor transportation

Corrected On Site

- ACHC-only requirements can be corrected on site and a Plan of Correction (POC) will not be required
- Always must be in compliance with state requirements and policies and procedures since first patient
- Encourage customers to correct all deficiencies while the Surveyor is on location

Exit Conference

- Exit conference
  - Present all corrections beforehand
  - Invite those you want to attend
  - Cannot provide a score
  - Preliminary Summary of Findings (SOF) as identified by Surveyor and the ACHC standard
  - Seek clarification from your Surveyor while still on-site

Questions?

Break Time

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PALLIATIVE CARE

Accreditation Decisions

Post-Survey Process

- Data collectors versus scorekeepers
- Submission of data to office
- ACHC Accreditation Review Committee examines all the data
- SOF is sent within 10 business days from the last day of survey

Review Committee

- All survey results are reviewed by the Review Committee.
- Compliance with the state vs. compliance with ACHC-only requirements.

Sample Summary of Findings

Identify the standard

Deficiency cited

Action required for compliance

Summary of Findings Report for Survey on 12/10/2020
Services: CBPC

[redacted]

Deficiency Category - Patient/Client Records			
Standard		Comments	Defi-cient
CBPC5-3B	**All patients have an initial assessment. The initial assessment is conducted on the initial home or clinic visit and preferably within 72 hours of referral, unless the physician specifies a specific time to conduct the initial assessment. (Guideline(s) 1.2.4, 2)**	Upon patient record review, 2 of 5 (Patient #3 and #5) did not have evidence that the initial assessment was completed within 72 hours of referral. Patient #3 referral made on 11/13/20 and initial assessment completed on 12/4/20. Patient #5 referral made on 9/28/20 and initial assessment completed on 10/19/20. Corrective Action: The agency will need to ensure there is evidence in the patient record of documentation of an initial assessment that was conducted on the initial home or clinic visit and within 72 hours of referral, unless the physician specifies a specific time to conduct the initial assessment. A registered nurse (RN), physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA), conducts the initial assessment to determine the immediate care/service and support needs of the patient.	X

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 timeframe.
  - 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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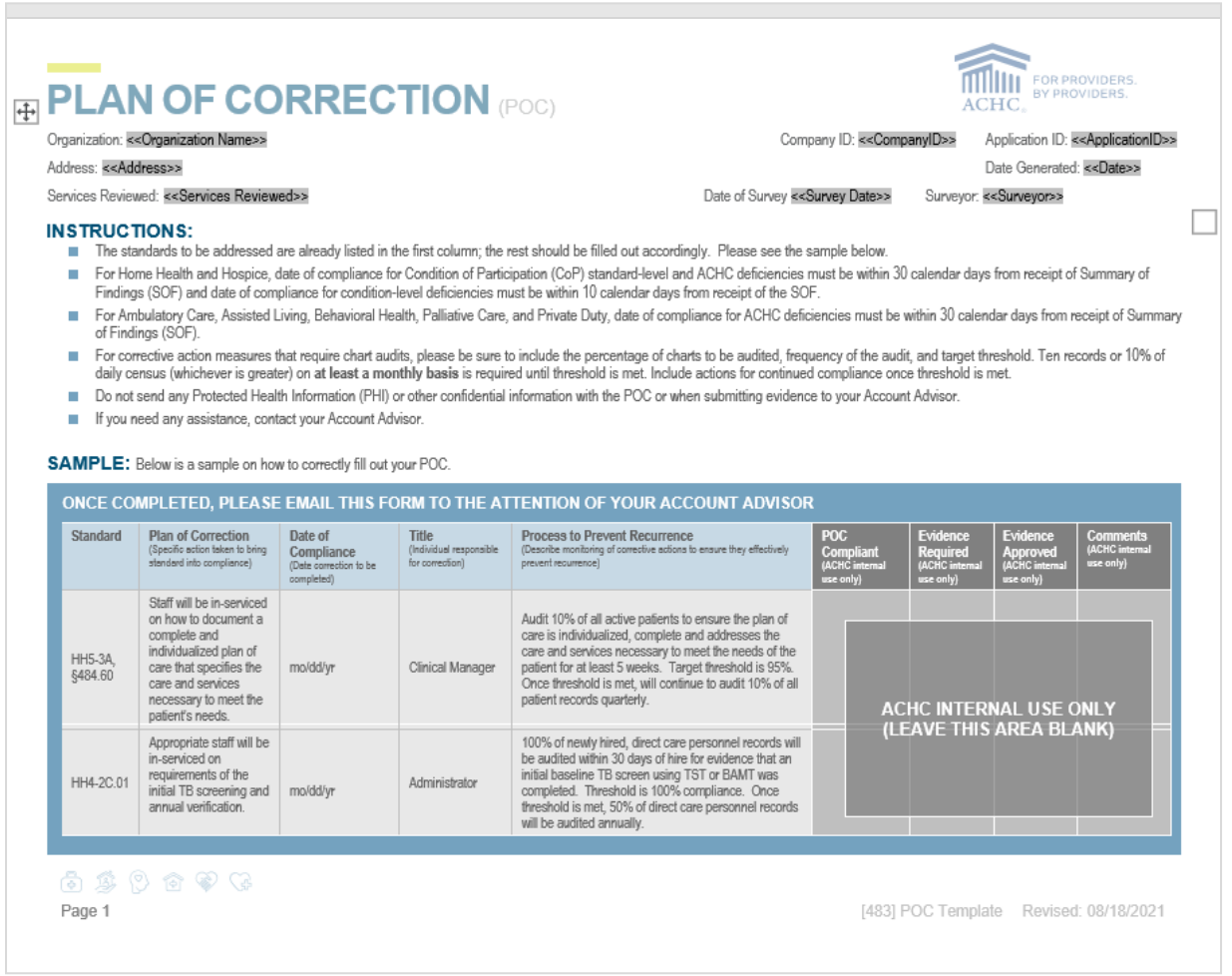
PALLIATIVE CARE

Developing An Approved Plan Of Correction

Plan Of Correction (POC)



PLAN OF CORRECTION (POC)

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Organization: <<Organization Name>> Company ID: <<CompanyID>> Application ID: <<ApplicationID>>

Address: <<Address>> Date Generated: <<Date>>

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 Ambulatory Care, Assisted Living, Behavioral Health, Palliative Care, and 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)
HH5-3A, §484.60	Staff will be in-serviced on how to document a complete and individualized plan of care that specifies the care and services necessary to meet the patient's needs.	mo/dd/yr	Clinical Manager	Audit 10% of all active patients to ensure the plan of care is individualized, complete and addresses the care and services necessary to meet the needs of the patient for at least 5 weeks. Target threshold is 95%. Once threshold is met, will continue to audit 10% of all patient records quarterly.	ACHC INTERNAL USE ONLY (LEAVE THIS AREA BLANK)			
HH4-2C.01	Appropriate staff will be in-serviced on requirements of the initial TB screening and annual verification.	mo/dd/yr	Administrator	100% of newly hired, direct care personnel records will be audited within 30 days of hire for evidence that an initial baseline TB screen using TST or BAMT was completed. Threshold is 100% compliance. Once threshold is met, 50% of direct care personnel records will be audited annually.				

Page 1 [483] POC Template Revised: 08/18/2021

POC Requirements

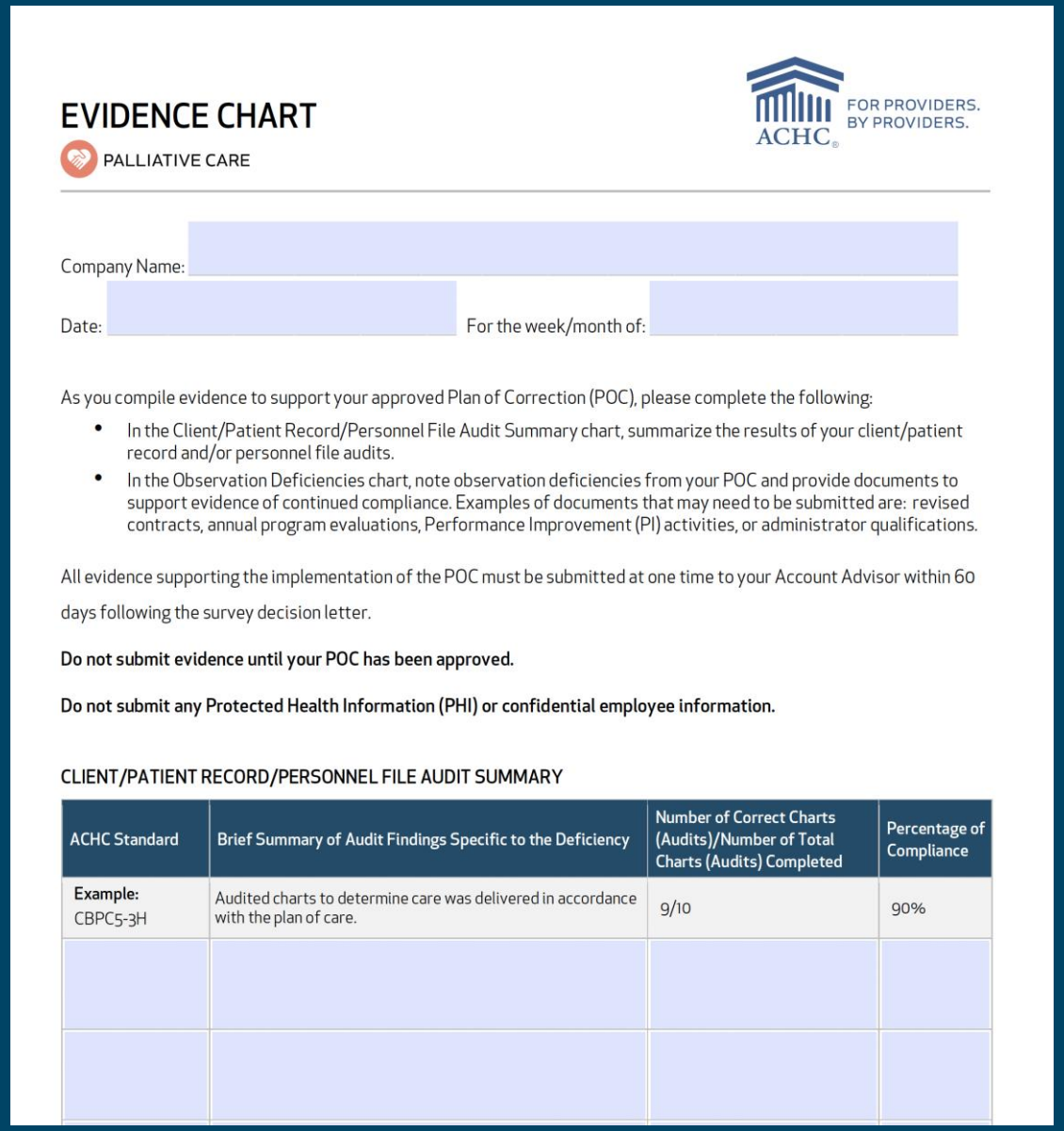
- Due in 30 calendar days to ACHC
- Deficiencies are autofilled
- Plan of Correction
  - Specific action step to correct the deficiency
- Date of compliance
- Title of the individual responsible
- Process to prevent recurrence-two-step process
  - Percentage and frequency
  - Target threshold
  - Maintaining 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

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PALLIATIVE CARE

Company Name:

Date: For the week/month of:

As you compile evidence to support your approved Plan of Correction (POC), please complete the following:

- In the Client/Patient Record/Personnel File Audit Summary chart, summarize the results of your client/patient record and/or personnel file audits.
- In the Observation Deficiencies chart, note observation deficiencies from your POC and provide documents to support evidence of continued compliance. Examples of documents that may need to be submitted are: revised contracts, annual program evaluations, Performance Improvement (PI) activities, or administrator qualifications.

All evidence supporting the implementation of the 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.

CLIENT/PATIENT RECORD/PERSONNEL FILE AUDIT SUMMARY

ACHC Standard	Brief Summary of Audit Findings Specific to the Deficiency	Number of Correct Charts (Audits)/Number of Total Charts (Audits) Completed	Percentage of Compliance
Example: CBPC5-3H	Audited charts to determine care was delivered in accordance with the plan of care.	9/10	90%

ACHCU is a brand of ACHC.

Poll Question

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EDUCATIONAL RESOURCES

PALLIATIVE CARE

Adding Value With ACHC Accreditation

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

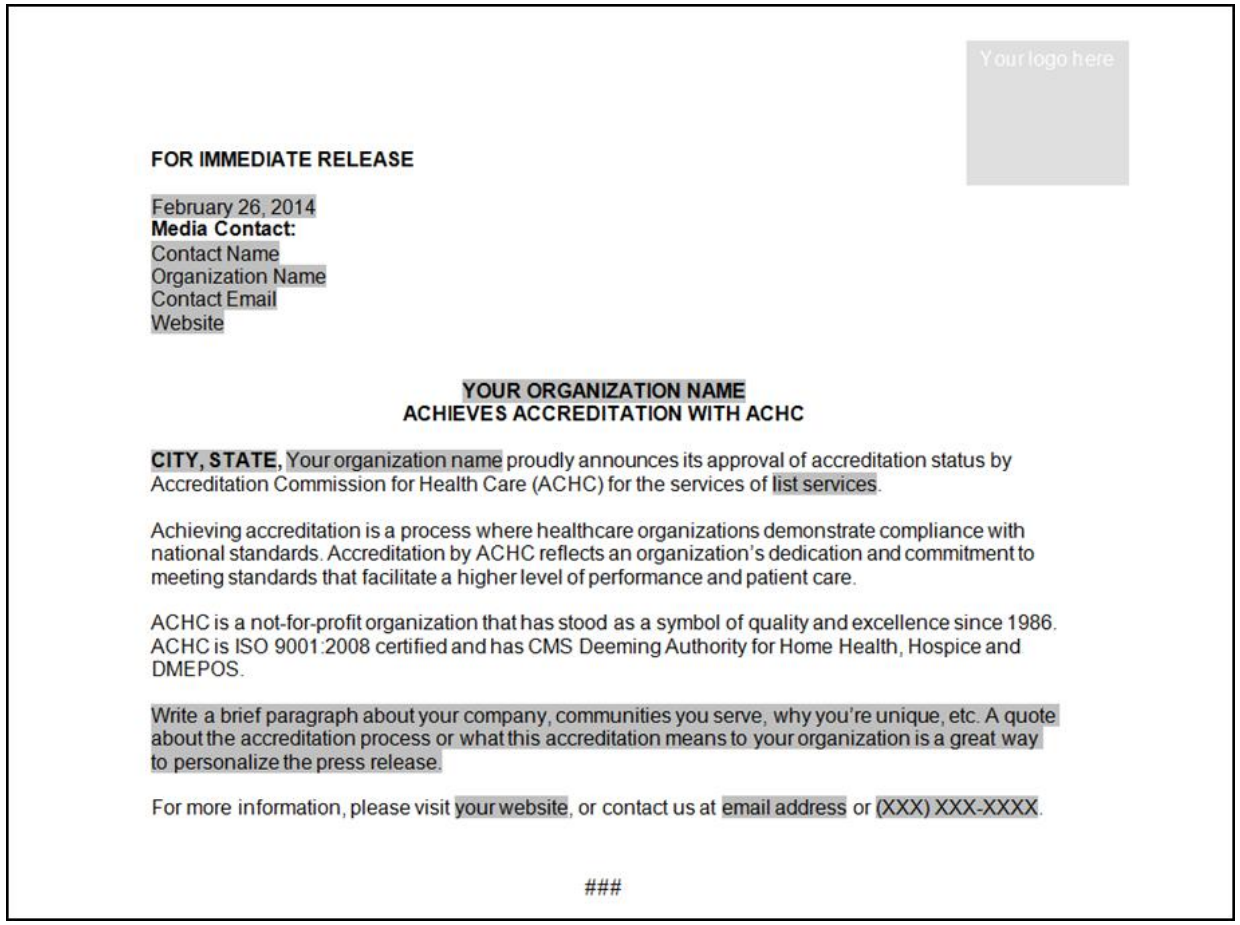
Branding Elements

- 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

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PALLIATIVE CARE

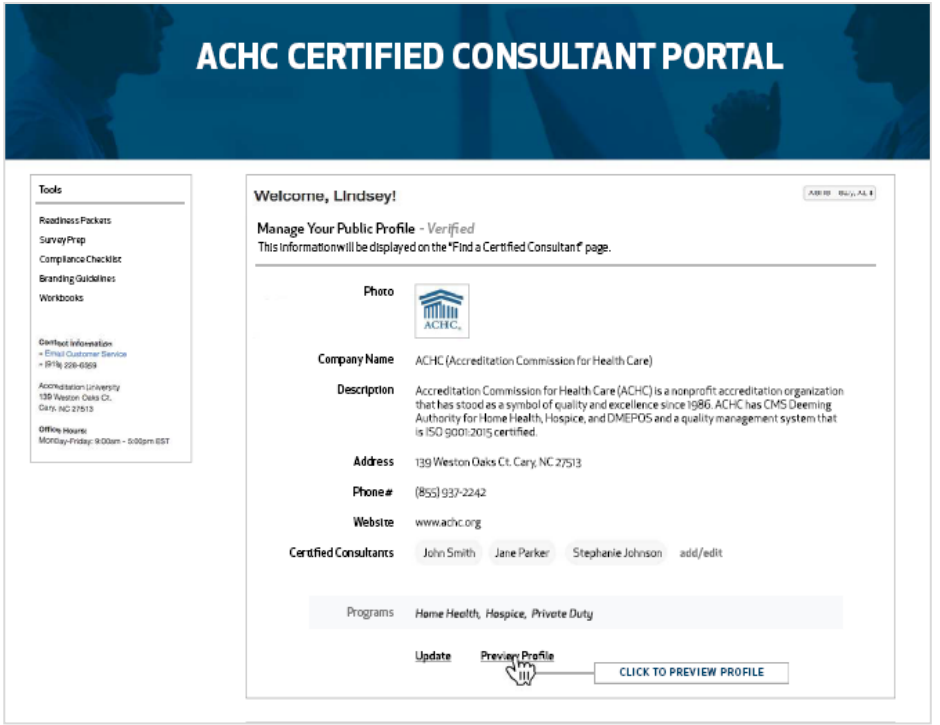
Marketing Your Consultant Business

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 your 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.

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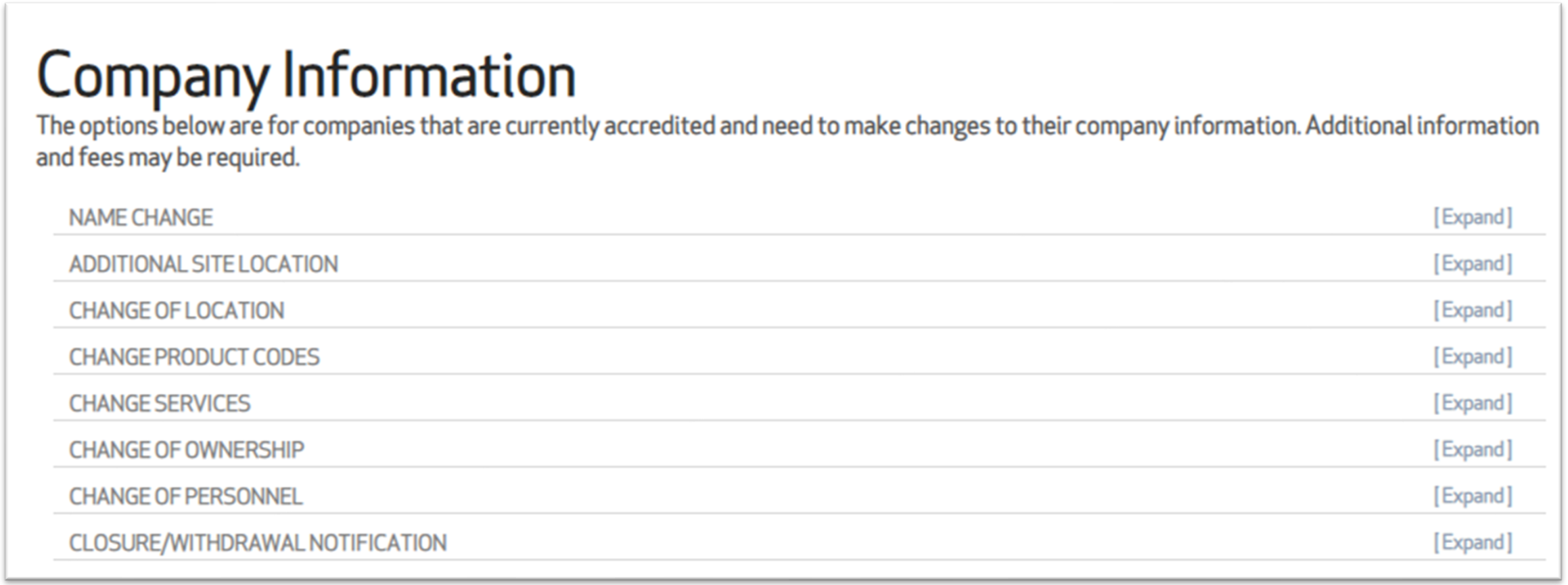
PALLIATIVE CARE

Customer Central Updates

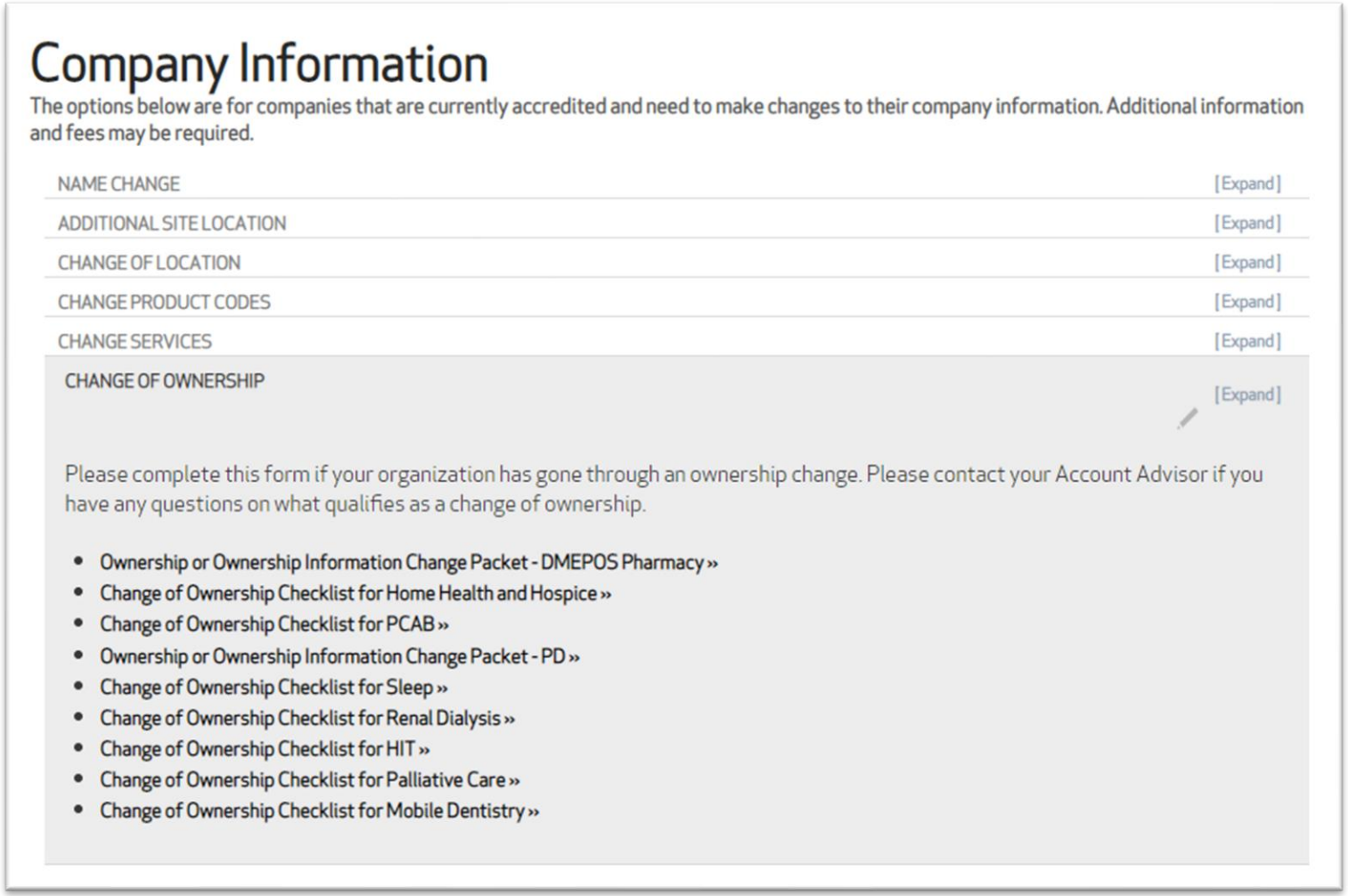
Notification of Changes

- ACHC requires existing Palliative Care providers to provide notification of changes and any required documentation within 30 days of a change occurring. Changes may include change in the name, location, or ownership of the organization.

Edit Company Information



Change Of Ownership



Company Information

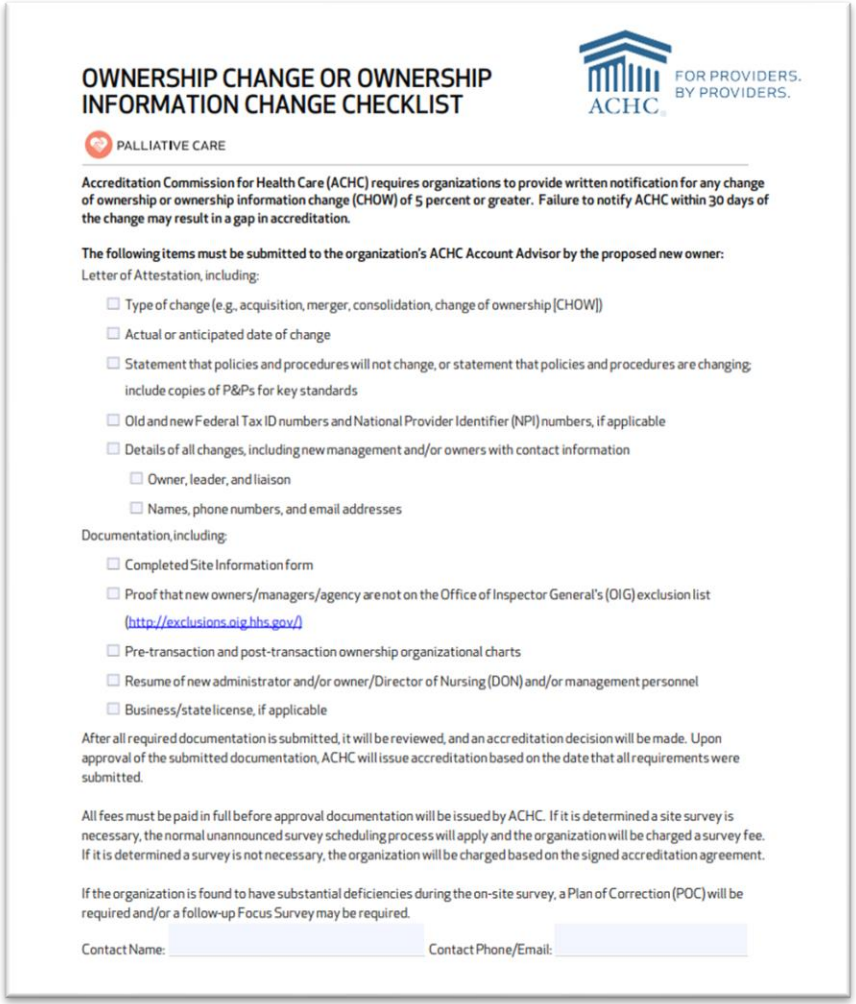
The options below are for companies that are currently accredited and need to make changes to their company information. Additional information and fees may be required.

NAME CHANGE	[Expand]
ADDITIONAL SITE LOCATION	[Expand]
CHANGE OF LOCATION	[Expand]
CHANGE PRODUCT CODES	[Expand]
CHANGE SERVICES	[Expand]
CHANGE OF OWNERSHIP	[Expand]

Please complete this form if your organization has gone through an ownership change. Please contact your Account Advisor if you have any questions on what qualifies as a change of ownership.

- Ownership or Ownership Information Change Packet - DMEPOS Pharmacy »
- Change of Ownership Checklist for Home Health and Hospice »
- Change of Ownership Checklist for PCAB »
- Ownership or Ownership Information Change Packet - PD »
- Change of Ownership Checklist for Sleep »
- Change of Ownership Checklist for Renal Dialysis »
- Change of Ownership Checklist for HIT »
- Change of Ownership Checklist for Palliative Care »
- Change of Ownership Checklist for Mobile Dentistry »

Change Of Ownership Checklist



OWNERSHIP CHANGE OR OWNERSHIP INFORMATION CHANGE CHECKLIST

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PALLIATIVE CARE

Accreditation Commission for Health Care (ACHC) requires organizations to provide written notification for any change of ownership or ownership information change (CHOW) of 5 percent or greater. Failure to notify ACHC within 30 days of the change may result in a gap in accreditation.

The following items must be submitted to the organization's ACHC Account Advisor by the proposed new owner:

Letter of Attestation, including:

- ☐ Type of change (e.g., acquisition, merger, consolidation, change of ownership [CHOW])
- ☐ Actual or anticipated date of change
- ☐ Statement that policies and procedures will not change, or statement that policies and procedures are changing; include copies of P&Ps for key standards
- ☐ Old and new Federal Tax ID numbers and National Provider Identifier (NPI) numbers, if applicable
- ☐ Details of all changes, including new management and/or owners with contact information
  - ☐ Owner, leader, and liaison
  - ☐ Names, phone numbers, and email addresses

Documentation, including:

- ☐ Completed Site Information form
- ☐ Proof that new owners/managers/agency are not on the Office of Inspector General's (OIG) exclusion list (http://exclusions.oig.hhs.gov/)
- ☐ Pre-transaction and post-transaction ownership organizational charts
- ☐ Resume of new administrator and/or owner/Director of Nursing (DON) and/or management personnel
- ☐ Business/state license, if applicable

After all required documentation is submitted, it will be reviewed, and an accreditation decision will be made. Upon approval of the submitted documentation, ACHC will issue accreditation based on the date that all requirements were submitted.

All fees must be paid in full before approval documentation will be issued by ACHC. If it is determined a site survey is necessary, the normal unannounced survey scheduling process will apply and the organization will be charged a survey fee. If it is determined a survey is not necessary, the organization will be charged based on the signed accreditation agreement.

If the organization is found to have substantial deficiencies during the on-site survey, a Plan of Correction (POC) will be required and/or a follow-up Focus Survey may be required.

Contact Name: _____ Contact Phone/Email: _____

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EDUCATIONAL RESOURCES

PALLIATIVE CARE

Benefits Of Partnering With ACHC

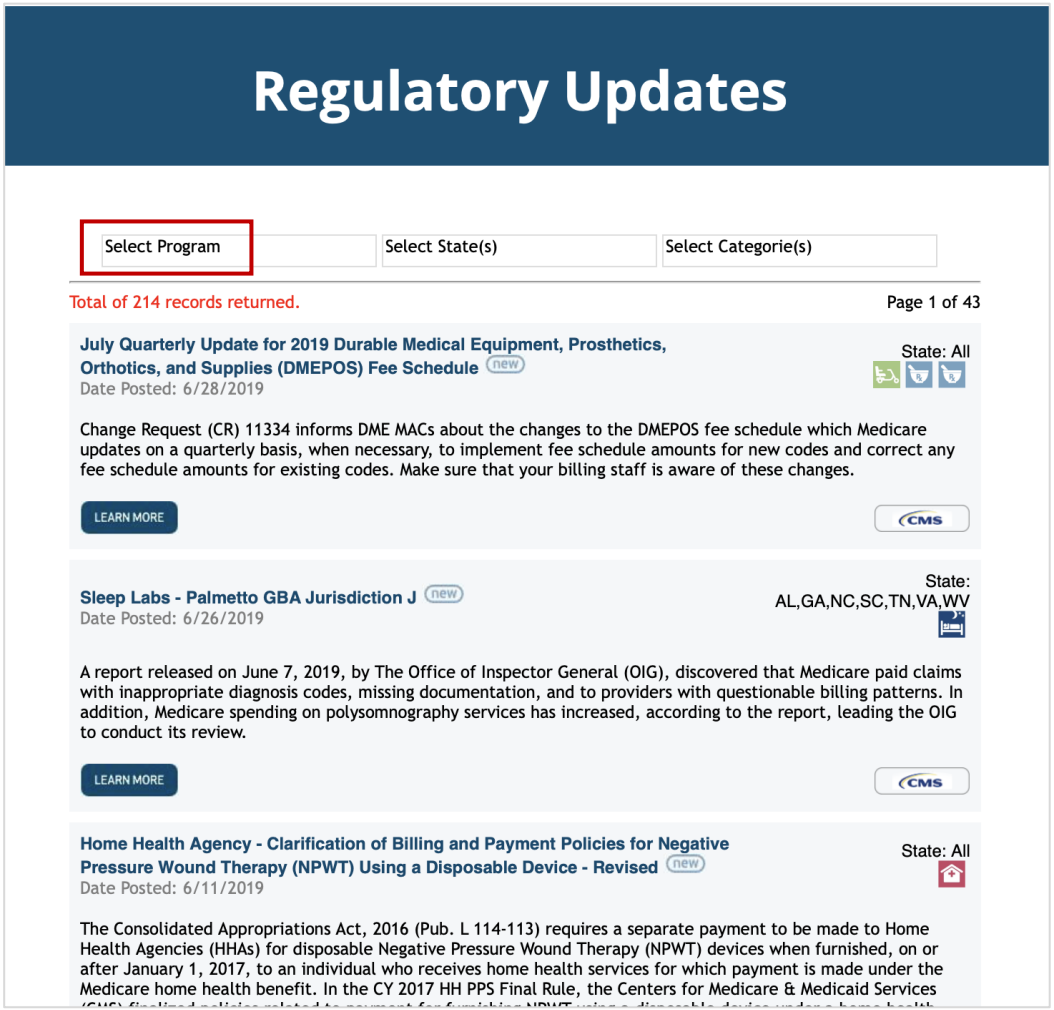
Educational Resources

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

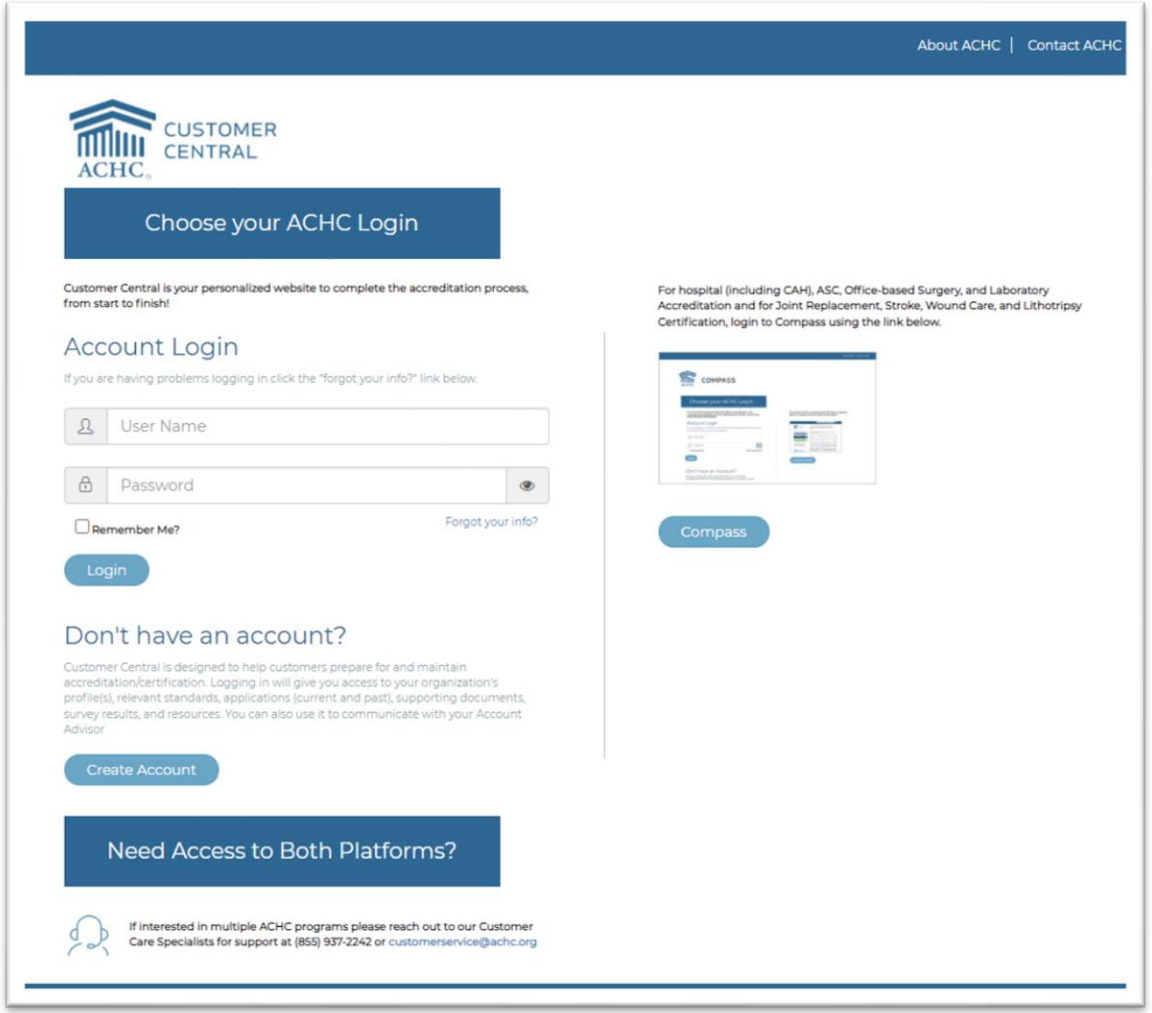
Regulatory Updates

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

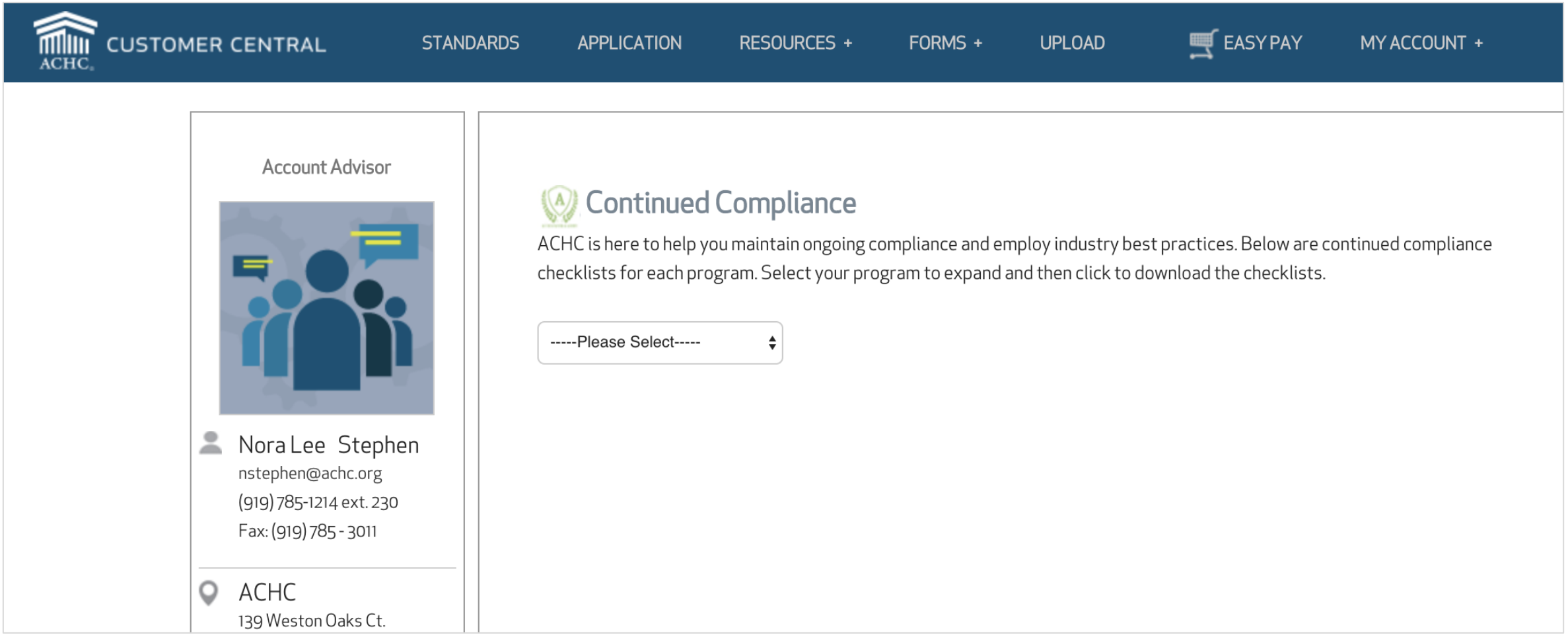


Customer Central

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



Maintaining Compliance Checklist



Maintaining Compliance Checklist

ACCREDITATION 12-MONTH COMPLIANCE CHECKLIST

FOR PROVIDERS. BY PROVIDERS.

PALLIATIVE CARE

Use this checklist, along with the Medical Record Audit tool and the Personnel File Audit tool, to audit your palliative care program and operations 12months after your ACHC survey. This checklist also can help you determine if your organization is in compliance with applicable local, state, and federal laws and regulations. This checklist is not intended to replace your own comprehensive review of ACHC Accreditation Standards, nor does it guarantee a successful accreditation decision. For any areas found to be out of compliance, it is recommended that an internal Plan of Correction be implemented and results monitored for compliance.

SECTION 1: ORGANIZATION AND ADMINISTRATION

Standard	Expectation	Comments
CBPC1-1A	All applicable licenses and permits are current and posted for all locations.	
CBPC1-4A	Any conflict of interest has been properly documented.	
CBPC1-5A	Manager/leader or other pre-designated individual is qualified.	
CBPC1-7A	Negative outcomes from sanctions, regulatory inspections, and/or audits have been reported, if applicable.	
CBPC1-8A	All contracts for direct care have been reviewed, as required per the terms of the contract, and all new contracts implemented contain the required content. The agency maintains copies of professional liability insurance certificates for all contracted personnel.	
CBPC1-8B	Any care provided in the past year by contracted staff has been monitored to ensure the quality of care provided to clients/patients.	
CBPC1-9A	Verification that all referring practitioners' licenses remain current.	

SECTION 2: PROGRAM/SERVICE OPERATIONS

Standard	Expectation	Comments
CBPC2-1A	Marketing materials are current and accurately reflect care/service provided.	
CBPC2-2A	Patient Rights and Responsibilities document is current.	
CBPC2-3A	All alleged violations by anyone furnishing services on behalf of the agency have been properly investigated, and appropriate corrective action has been taken.	
CBPC2-4A	All grievances and complaints have been documented, investigated, resolved, and reported each quarter to the governing body.	
CBPC2-4B	Information provided to the client/patient on how to report grievances/complaints is current.	
CBPC2-5A	All personnel have a signed confidentiality statement.	
CBPC2-5A	Business Associate Agreements exist for non-covered entities.	
CBPC2-6A	Advance Directive information provided to clients/patients is current.	

ACCREDITATION 24-MONTH COMPLIANCE CHECKLIST

FOR PROVIDERS. BY PROVIDERS.

PALLIATIVE CARE

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

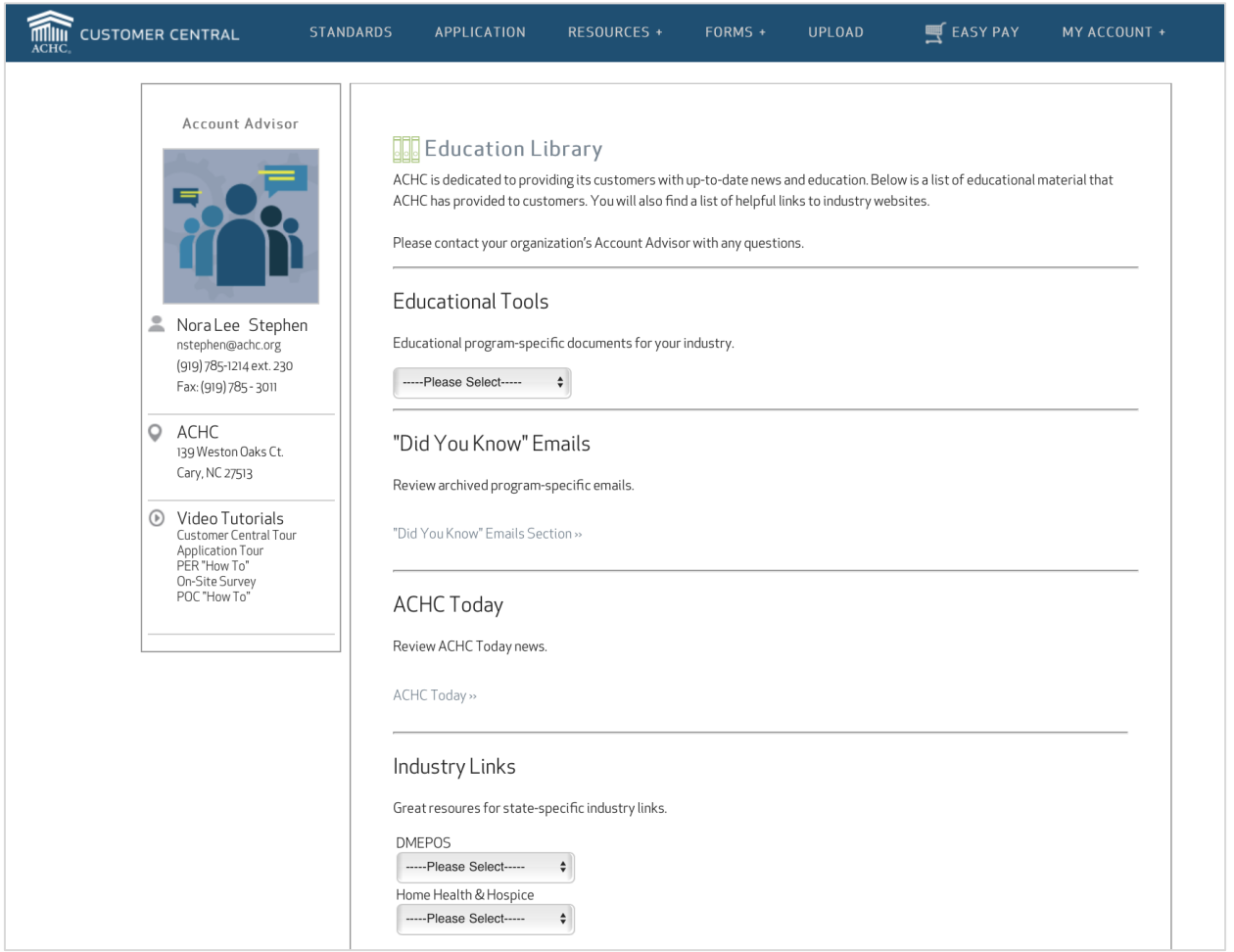
SECTION 1: ORGANIZATION AND ADMINISTRATION

Standard	Expectation	Comments
CBPC1-1A	All applicable licenses and permits are current and posted for all locations.	
CBPC1-4A	Any conflict of interest has been properly documented.	
CBPC1-5A	Manager/leader or other pre-designated individual is qualified.	
CBPC1-7A	Negative outcomes from sanctions, regulatory inspections, and/or audits have been reported, if applicable.	
CBPC1-8A	All contracts for direct care have been reviewed as required per the terms of the contract, and all new contracts implemented contain the required content. The agency maintains copies of professional liability insurance certificates for all contracted personnel.	
CBPC1-8B	Any care provided in the past year by contracted staff has been monitored to ensure the quality of care provided to clients/patients.	
CBPC1-9A	Verification that all referring practitioners' licenses remain current.	

SECTION 2: PROGRAM/SERVICE OPERATIONS

Standard	Expectation	Comments
CBPC2-1A	Marketing materials are current and accurately reflect care/service provided.	
CBPC2-2A	Patient Rights and Responsibilities document is current.	
CBPC2-3A	All alleged violations by anyone furnishing services on behalf of the agency have been properly investigated, and appropriate corrective action has been taken.	
CBPC2-4A	All grievances and complaints have been documented, investigated, resolved, and reported each quarter to the governing body.	
CBPC2-4B	Information provided to the client/patient on how to report grievances/complaints is current.	
CBPC2-5A	All personnel have a signed confidentiality statement.	
CBPC2-5A	Business Associate Agreements exist for non-covered entities.	
CBPC2-6A	Advance Directive information provided to clients/patients is current.	

Education Library



Questions?

ACHC U®
EDUCATIONAL RESOURCES

PALLIATIVE CARE

Achieving A Successful Survey Outcome

Understanding the ACHC Palliative Care Standards

Review The Standards

- Identifier: CBPC – Community-Based Palliative Care
- Standard
  - Provides a broad statement of the expectation in order to be in compliance with ACHC standards
  - Gives you more detailed information and specific direction on how to meet ACHC standards
- Evidence
  - Items that will be reviewed to determine if the standard is met
- Services applicable

Standard Example

Standard CBPC1-9A: Written policies and procedures are established and implemented regarding the verification and maintenance of credentials of the referring physician or other licensed independent practitioner approved by law to prescribe medical services, treatments, and/or pharmaceuticals being conducted prior to providing care/service. (Guideline(s) 1.6)

Written policies and procedures describe the process for verification of referring practitioner credentials. Periodic assessments of current physician and other licensed independent practitioners' credentials are obtained from the state and federal boards. The palliative care program has a mechanism to ensure that orders are only accepted from currently credentialed practitioners.

Evidence: Written Policies and Procedures

Evidence: Observation

Services applicable: CBPC

Most Stringent Regulation

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

Section 1

ORGANIZATION AND ADMINISTRATION

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

Organization and Administration

Standard CBPC1-1A: The palliative care program is in compliance with federal, state, and local laws and regulations. (Guideline(s) 8.2)

If state or local law provides for licensure of a palliative care program, the program must be licensed.

All required license(s) and or permit(s) are current and posted in a prominent location accessible to public view.

The entity, individual or program has a copy of the appropriate documentation or authorization(s) to conduct business.

Organization and Administration

Standard CBPC1-2A: The provision of palliative care occurs in accordance with professional state and federal laws, regulations and current accepted standards of care and professional practice. (Guideline(s) 8.2, 8.4)

This standard requires compliance with all laws and regulations.

Copies of all required federal and state posters are placed in a prominent location for easy viewing by personnel.

Organization and Administration

Standard CBPC1-3A: Palliative care is provided in any care setting, including private residences, assisted living facilities, rehabilitation, skilled and intermediate care facilities, adult and pediatric respite day care centers, acute and long-term care hospitals, clinics, hospice residences, correctional facilities, homeless shelters and group homes (e.g. Veterans homes, halfway houses, house for people with disabilities). (Guideline(s) 1.5)

Care is provided in the setting preferred by the patient and family, if feasible, or the palliative care team (PCT) helps the patient and family select an alternative setting.

The PCT facilitates visits with family, friends, and pets in accordance with patient and family preferences and policies and procedures within the care setting.

Organization and Administration

Standard CBPC1-4A: Written policies and procedures are established and implemented by the palliative care program regarding conflicts of interest and the procedure for disclosure. (Guideline(s) 8.1, 8.2)

The policies and procedures include the required conduct of any affiliate or representative of the following:

- Personnel having an outside interest in an entity providing services to the palliative care program
- Personnel having an outside interest in an entity providing services to patient

In the event of proceedings that require input, voting, or decisions, the individual(s) with a conflict of interest are excluded from the activity.

Personnel demonstrate understanding of conflict of interest policies and procedures.

Organization and Administration

Standard CBPC1-5A: There is an individual who is designated as responsible for the overall operation and services of the palliative care program. The manager/leader organizes and directs the palliative care program's ongoing functions; maintains ongoing liaison among the personnel; employs qualified personnel and ensures adequate personnel education and evaluations; ensures the accuracy of public information materials and activities; and implements an effective budgeting and accounting system.

The manager/leader is responsible for all palliative care programs and services.

There is a job description that specifies the responsibilities and authority of this individual.

Organization and Administration

Standard CBPC1-5B: An individual is appointed to assume the role of the manager/leader during temporary absences and/or vacancies.

A qualified person is authorized in writing to act in the absence of the manager/leader. The duties that the individual assumes during the absence of the manager/leader are written into the job description and included in the orientation of this individual.

Organization and Administration

Standard CBPC1-6A: The palliative care program's primary goal is early intervention to prevent and relieve suffering and optimize quality of life for patients living with serious illnesses and their families across patient populations and care settings. The palliative care team (PCT) complies with current accepted standards of care and professional practice. (Guideline 8.2, 1.1)

Accepted standards of practice are utilized by the palliative care program and PCT to guide the provision of care/service in which specialty palliative care is interdisciplinary and includes at a minimum nursing, medicine, social work, and spiritual care.

The PCT includes a certified palliative care specialist who is available to nurses (APRN, RN, LPN/LVN, NA), physicians, social workers, chaplains, death counselors, and administrators.

Organization and Administration

Standard CBPC1-6B: The palliative care program utilizes other professionals with credentials, experience and skills to meet the needs of the patient and family in accordance with accepted standards of practice. (Guideline(s) 1.1)

Accepted standards of practice are utilized by the palliative care program and palliative care team (PCT) to guide the provision of care/service.

Using a patient/family centered approach, the palliative care team works with other clinicians to optimize the quality of life and reduce or relieve suffering of the patient/family.

Organization and Administration

Standard CBPC1-7A: The palliative care program informs the accrediting body and other state/federal regulatory agencies, as appropriate, of negative outcomes from sanctions, regulatory inspections and/or audits.

- License suspension(s)
- License probation; conditions/restrictions to license(s)
- Non-compliance with Medicaid Regulations identified during survey by another regulatory body
- Revocation of Medicaid/third-party provider number
- Any open investigation by any regulatory or governmental authority

Organization and Administration

Standard CBPC1-8A: A palliative care program that uses outside personnel/organizations to provide care/services on behalf of the palliative care program has a written contract/agreement for care/services which is kept on file within the organization.

Arranged care/services are supported by written agreements.

In addition, the organization maintains current copies of professional liability insurance certificates.

The organization has an established process to review and renew contracts/agreements as required in the contract.

Organization and Administration

Standard CBPC1-8B: The palliative care program monitors all care/service provided under contract/ agreements to ensure that care/services are delivered in accordance with the terms of the contract/ agreement.

The palliative care program has implemented a process for monitoring all care/service provided under a contract/agreement. Processes include, but are not limited to:

- Satisfaction surveys
- Record reviews
- On-site observations and visits
- Patient comments and other performance improvement (PI) activities

Organization and Administration

Standard CBPC1-9A: Written policies and procedures are established and implemented regarding the verification and maintenance of credentials of the referring physician or other licensed independent practitioner approved by law to prescribe medical services, treatments, and/or pharmaceuticals being conducted prior to providing care/service. (Guideline(s) 1.6)

The palliative care program has a mechanism to ensure that orders are only accepted from currently credentialed practitioners.

Tips for Compliance

- Ensure license is current and posted
- Conflict of Interest Disclosure statement
- Manager/Leader and Alternate Manager/Leader
- Any negative outcomes have been properly reported
- Review contracts
- Evidence of how contracted care is monitored

Workbook Tools

- Compliance Checklist
- Self-Audit
- Hourly Contract Staff Audit Tool
- Conflict of Interest Disclosure Statement
- Acknowledgement of Confidentiality statement

Poll Question

Questions?

Section 2

PROGRAM/SERVICE OPERATIONS

- The standards in this section apply to the specific programs and services an organization is supplying. This section addresses rights and responsibilities, complaints, incidents, Protected Health Information (PHI), cultural diversity, and compliance with laws to prevent fraud and abuse.

Programs and Services

Standard CBPC2-1A: Written policies and procedures are established and implemented regarding the palliative care program's descriptions of care/services and the distribution to personnel, patients, and the community. (Guideline(s) 1.4)

Written descriptions of care/services with detailed information are available.

Marketing and instructional materials use lay language and provide a more general description of care/services offered.

Patients and families receive written explanation of palliative care services.

Programs and Services

Standard CBPC2-2A: Written policies and procedures are established and implemented by the palliative care program regarding the creation and distribution of the Patient Rights and Responsibilities statement. (Guideline(s) 1.4, 8.2)

Patient Rights and Responsibilities statement contains the required components.

The program obtains the patient's or legal representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.

Personnel are provided training during orientation and at least annually thereafter concerning the palliative care program's policies and procedures on the Patient Rights and Responsibilities.

Programs and Services

Standard CBPC2-2B: The palliative care program protects and promotes the exercise of the patient rights. (Guideline(s) 8.1, 8.2)

Personnel honor the patient right to:

- Have one's property and person treated with respect, consideration, and recognition of patient dignity and individuality
- Be able to identify visiting/clinic personnel members through palliative care program photo identification
- Choose a health-care provider, including choosing an attending physician or independent-practitioner
- Receive appropriate care/service without discrimination in accordance with physician or independent practitioner orders
- Be informed of any financial benefits to the referring individual or organization when referred to the palliative care program
- Be fully informed and able to demonstrate understanding of patient and family responsibilities within the plan of treatment.

Programs and Services

Standard CBPC2-3A: Written policies and procedures are established and implemented by the palliative care program regarding 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 palliative care program. (Guideline(s) 8.2)

Any PCT staff must report these findings immediately to the manager/leader and other appropriate authorities in accordance with state law.

The palliative care program immediately investigates all alleged violations involving anyone furnishing services and immediately takes action to prevent further potential violations while the alleged violation is being verified. Investigations and/or documentation of all alleged violations are conducted in accordance with established policies and procedures.

The palliative care program ensures that verified violations are reported to ACHC, state and local bodies having jurisdiction within five working days of becoming aware of the verified violation.

Programs and Services

Standard CBPC2-4A: Written policies and procedures are established and implemented by the palliative care program requiring that the patient be informed at the initiation of care/service how to report grievances/complaints.

The palliative care program investigates and attempts to resolve all patient grievances/complaints and documents the results within a described time frame as defined in policies and procedures.

The palliative care program maintains records of grievances/complaints and their outcomes, submitting a summary report quarterly to the manager/leader or designees.

This information is included in the Quality Assurance and Performance Improvement (QAPI) annual report.

Personnel are oriented and familiar with the grievance/complaint policies and procedures.

Programs and Services

Standard CBPC2-4B: The palliative care program provides the patient with written information concerning how to contact the palliative care program, appropriate state agencies, and ACHC concerning grievances/complaints at time of admission.

The palliative care program provides all patients with written information listing a telephone number, contact person, and the palliative care program's process for receiving, investigating, and resolving grievances/complaints about its care/service.

The palliative care program advises patients in writing of the telephone number for the appropriate state regulatory body’s hotline, the hours of operations, and the purpose of the hotline. ACHC's telephone number must be provided. The ACHC phone number requirement is not applicable if this is the first ACHC survey.

Programs and Services

Standard CBPC2-5A: Written policies and procedures are established and implemented by the palliative care program regarding securing and releasing confidential and Protected Health Information (PHI) and Electronic Protected Health Information (EPHI). (Guideline(s) 8.2)

The palliative care program has clearly established written policies and procedures that address the areas listed above and are clearly communicated to personnel.

There is a signed confidentiality statement for all personnel and contracted individuals. Personnel and the manager/leader abide by the confidentiality statement and the palliative care program's policies and procedures.

The palliative care program designates an individual responsible for seeing that the confidentiality and privacy policies and procedures are adopted and followed.

Programs and Services

Standard CBPC2-5B: The palliative care program has Business Associate Agreements (BAAs) for all Business Associates that may have access to Protected Health Information (PHI) as required by the Health Insurance Portability and Accountability Act (HIPAA) and other applicable laws and regulations.

A copy of all BAAs will be on file at the palliative care program for all non-covered entities as defined by the Health Insurance Portability and Accountability Act (HIPAA).

A BAA is not required with a person or organizations (e.g., janitorial service or electrician) whose functions or services do not involve the use or disclosure of PHI, and where any access to PHI by such persons would be incidental, if at all.

Programs and Services

Standard CBPC2-6A: Written policies and procedures are established by the palliative care program regarding the patient's rights to accept or decline medical care, patient preference for cardiopulmonary resuscitation, surgical treatment and the right to formulate an Advance Directive. (Guideline(s) 7.2, 8.3)

The palliative care program's policies and procedures describe patient rights under law to make decisions regarding medical care, including the right to accept or decline care/service and the right to formulate an Advance Directive.

Programs and Services

Standard CBPC2-6B: Written policies and procedures are established and implemented by the palliative care program regarding resuscitative guidelines and the responsibilities of personnel. (Guideline(s) 8.2)

The policies and procedures identify which personnel, if any, may perform resuscitative measures, respond to medical emergencies and utilization of 911/ emergency medical services (EMS) for emergencies.

Successful completion of appropriate in-person training, such as a CPR certification course is defined in the policies and procedures.

Online CPR certification is acceptable with in-person verification of competency.

Patients and families are provided information about the palliative care program's policies and procedures for resuscitation, medical emergencies and accessing 911/EMS services.

Programs and Services

Standard CBPC2-7A: Written policies and procedures are established and implemented by the palliative care program regarding the provision of care/service to patients with communication or language barriers. (Guideline(s) 6.2)

Personnel communicate with the patient in the appropriate language or format understandable to the patient.

Mechanisms are in place to assist with language and communication barriers.

All personnel receive training during initial orientation and annually thereafter regarding the provision of care/service to patients with communication barriers.

Programs and Services

Standard CBPC2-7B: Written policies and procedures are established and implemented in regard to the palliative care program providing care/service to patients and families of various spiritual, religious, and existential belief systems. (Guideline(s) 5.1)

Written policies and procedures describe the mechanisms the palliative care program uses to provide spiritual care for the patients/families based on their spiritual, religious, and existential beliefs systems.

All personnel receive training during initial orientation and annually thereafter regarding the delivery of care respectful of spiritual, religious, and existential beliefs and practices.

Programs and Services

Standard CBPC2-7C: Written policies and procedures are established and implemented in regard to the palliative care program striving to enhance its delivery of culturally and linguistically sensitive care. (Guideline(s) 6.1, 6.2)

The palliative care program has written policies and procedures that describe methods to deliver culturally and linguistically sensitive services.

All personnel receive training during initial orientation and annually thereafter to increase cultural awareness and cultural sensitivity.

Programs and Services

Standard CBPC2-8A: Written policies and procedures are established and implemented in regard to the palliative care program identifying and assessing complex ethical issues arising in the care of people with serious or life-threatening illnesses. (Guideline(s) 8.1, 8.2, 8.3, 8.4)

Written policies and procedures describe mechanisms for identifying and addressing ethical issues in providing palliative care.

Referrals are made to ethics consultants or the organization's ethics committee as appropriate. An ethics committee or consultant may be contacted for guidance on policy development, clinical care issues, and conflict resolution and staff education. Legal counsel is accessible to advise providers as needed.

All personnel receive training during initial orientation and annually thereafter regarding the ethical, legal, and regulatory principles guiding care of the seriously ill.

Programs and Services

Standard CBPC2-9A: Written policies and procedures are established and implemented in regard to the palliative care program coordinating care and collaborating with community resources to ensure continuity of care for the patient and family. (Guideline (s) 1.1, 1.4, 1.5, 1.7)

The palliative care program supports and promotes continuity of care throughout the patient's illness.

Non-hospice palliative care programs have relationships with one or more hospices and other community resources to ensure continuity of care, if such care is elected by the patient and family. Non-hospice palliative care programs inform patients and families about hospice and other community resources.

Programs and Services

Standard CBPC2-10A: Written policies and procedures are established and implemented in regard to palliative care services being provided to the patient and family to the extent that their preferences and needs can be met in their physical environment. (Guideline(s) 1.5, 4.2)

Written policies and procedures are established and implemented that describe the different environments of care available to the patient and family.

The palliative care team (PCT) provides care in the least restrictive environment preferred by the patient or family.

Unique care needs of pediatric/adolescent patients or family members/visitors will be addressed by the PCT.

Programs and Services

Standard CBPC2-11A: The palliative care program provides physician services, including advanced practice provider services which include physician assistants, nurse practitioners, and clinical nurse specialists. (Guideline(s) 1.1)

The palliative care program is comprised of a physician or an advanced practice provider (which includes physician assistants, nurse practitioners, and clinical nurse specialists) who are responsible for understanding and communicating the illness trajectory, the prognosis, the appropriateness of medical treatments, the palliation and symptom management related to the serious illness and other conditions, as well as making patient visits and/or providing supervision to the rest of the palliative care team members

Programs and Services

Standard CBPC2-12A: The palliative care program provides nursing services. (Guideline(s) 1.1)

The palliative care program is comprised of skilled nursing services by or under the supervision of a registered

Registered nurses are able to see, treat, and provide services for patients under the orders of a physician, physician assistant, nurse practitioner, or clinical nurse specialist. If a nurse is an advanced practice registered nurse (either a nurse practitioner or a clinical nurse specialist) and is permitted by state law and regulation to see, treat, and write orders, then the advance practice registered nurse (APRN) may perform this function while providing nursing services to palliative care patients.

Programs and Services

Standard CBPC2-13A: The palliative care program provides medical social services. (Guideline(s) 1.1)

Medical social services must be provided by a qualified Social Worker, under the direction of a physician or advanced practice practitioner.

Programs and Services

Standard CBPC2-14A: The palliative care program provides spiritual counseling services. (Guideline(s) 1.1)

Spiritual counseling services must be available to the patient and family to assist in minimizing the stress and problems that arise from the serious illness, related conditions, and the dying process.

Programs and Services

Standard CBPC2-15A: The palliative care program provides grief and bereavement counseling services when appropriate to the patient's stage of illness. (Guideline(s) 7.5)

Grief (including anticipatory grief) and bereavement counseling services must be available to the patient and family to assist in minimizing the stress and problems that arise from the serious illness and related conditions.

When the family is at risk for a prolonged grief disorder and the palliative care program is unable to meet the ongoing needs of a family, the palliative care program has a process for referring that person to other counseling services or community agencies as needed.

Programs and Services

Standard CBPC2-16A: The palliative care program provides clinical pharmacy consultation. (Guideline(s) 1.1)

Clinical pharmacy consultation must be available to the palliative care team in order to optimize medication management through a thorough review of the patient's medications to identify therapies to further palliate symptoms, resolve or prevent potential drug-drug interactions, drug-related toxicities, and recommend dose adjustment and de-prescribing where appropriate.

Programs and Services

Standard CBPC2-17A: Written policies and procedures are established and implemented by the palliative care program regarding pain and symptom management. (Guideline(s) 2.1)

Written policies, procedures, and/or protocols are developed for pain and symptom management that include the use of evidence-based pharmacological and non-pharmacological interventions.

All palliative care team members receive training during initial orientation and annually thereafter to increase awareness of applicable policies and procedures for opioid management.

Programs and Services

Standard CBPC2-18A: palliative care program provides access available 24 hours a day, 7 days per week. (Guideline(s) 1.1)

The patient and family have access to the palliative care team 24 hours a day, seven days a week, by phone or telehealth applications.

Tips for Compliance

- Marketing materials
- Admission/New patient packet
  - Evidence in the medical record
- Patient Rights and Responsibilities statement
- Complaint log
- Signed confidentiality statement
- Business Associate Agreements

Tips for Compliance

- Evidence staff know how to handle:
  - Complaints
  - Ethical issues
  - Communication barriers
  - Cultural diversity

Workbook Tools

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

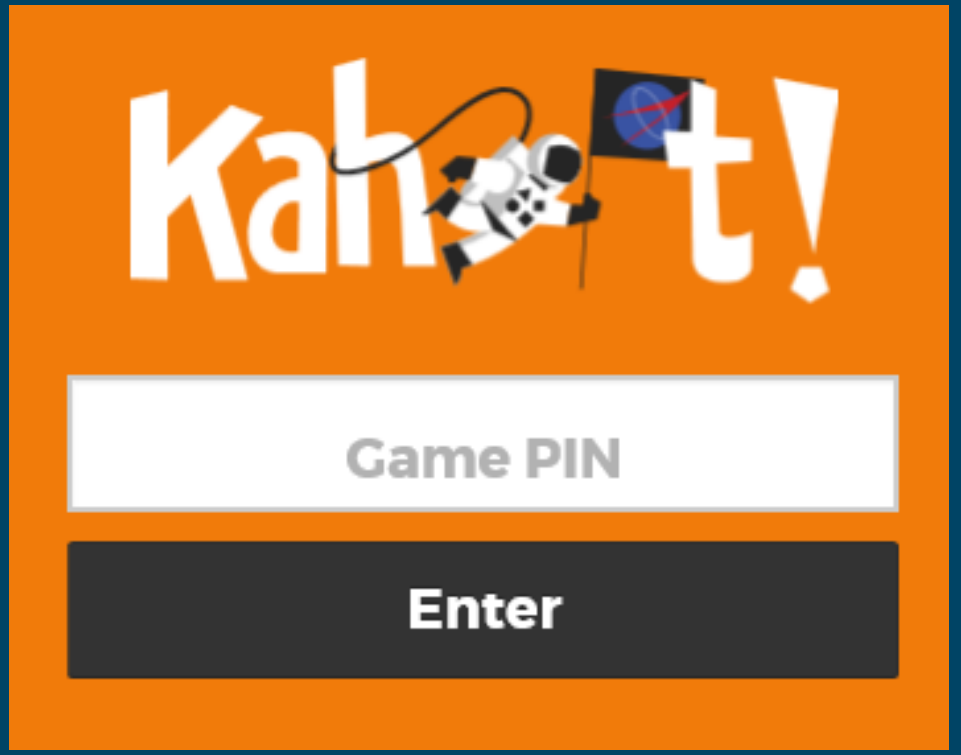
Poll Question

Questions?

Lunch Break

TEACHING TOOL: Kahoot!

- Cellphone or laptop
- Go to Kahoot.it
- Enter Game PIN
- Enter your nickname
  See “You’re in”
- You’re ready!



Section 3

FISCAL MANAGEMENT

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

Fiscal Management

Standard CBPC3-1A: The palliative care program's annual budget is developed in collaboration with management/leadership and personnel in consultation with the medical director.

The palliative care program has a budget that includes projected revenue and expenses for all programs and the care/service it provides. The budget is reflective of the palliative care program's care/service and programs.

The palliative care program's leaders and the individuals in charge of the day-to-day program operations are involved in developing the budget and in planning and review of periodic comparisons of actual and projected expenses and revenues for the care/service.

The budget is reviewed and updated at least annually by the management/leadership personnel.

Fiscal Management

Standard CBPC3-2A: The palliative care program implements financial management practices that ensure accurate accounting and billing.

The palliative care program ensures sound financial management practices.

Fiscal Management

Standard CBPC3-3A: The palliative care program develops care/service rates and has methods for conveying charges to the patient, public, and referral sources.

Current charges for care/services are available in writing for reference by personnel when conveying information to the patient.

Personnel responsible for conveying charges are oriented and provided with education concerning the conveying of charges.

Fiscal Management

Standard CBPC3-3B: The patient is advised orally and in writing of the charges for care/service at, or prior to, the receipt of services. The patient also has the right to be informed of changes in payment information, as soon as possible but no later than 30 days after the palliative care program becomes aware of the change. (Guidelines(s) 8.4)

The patient is provided written information concerning the charges for care/service at or prior to the receipt of care/service.

Patient records contain written documentation that the patient was informed of the charges, the expected reimbursement for third-party payors, and the financial responsibility of the patient.

Fiscal Management

Standard CBPC3-4A: There is verification that the care/service(s) billed for reconciles with the care/service(s) provided by the palliative care program.

The palliative care program verifies that the patients and/or third-party payors are properly billed for care/service provided.

Tips for Compliance

- Budget
- Evidence patients are informed of financial liability upon admission and when there are changes
- List of care/service rates

Workbook Tools

- Compliance Checklist
- Self-Audit
- Palliative Care Program Financial Disclosure Statement

Poll Question

Questions?

Section 4

HUMAN RESOURCE MANAGEMENT

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

Human Resource Management

Standard CBPC4-1A: Written policies and procedures are established and implemented that describe the procedures to be used in the management of personnel files and confidential personnel records. (Guideline(s) 8.2)

The palliative care program has personnel records for all palliative care team (PCT) members that are available for inspection by federal, state regulatory, and accreditation agencies.

Personnel files are kept in a confidential manner.

Human Resource Management

Standard CBPC4-1B: Prior to or at the time of hire all personnel complete appropriate documentation.

Personnel files contain:

- Position application
- Dated and signed withholding statements
- Form I-9 (employee eligibility verification which confirms citizenship or legal authorization to work in the United States)

Not applicable to contract individuals

Human Resource Management

Standard CBPC4-2A: Personnel are qualified for the positions they hold by meeting the education, training, and experience requirements defined by the palliative care program. Personnel credentialing activities are conducted at the time of hire and upon renewal to verify qualifications of all personnel. (Guideline(s) 1.6)

Credentialing information includes a review of professional occupational licensure, certification, registration or other training as required by state boards and/or professional associations for continued credentialing.

Primary source verification.

Human Resource Management

Standard CBPC4-2B: Written policies and procedures are established and implemented in regard to all direct care personnel having a baseline Tuberculosis (TB) test at any point in the past or in accordance with state requirements. Prior to patient contact, an individual TB risk assessment and a symptom evaluation are completed.

Upon hire personnel provide evidence of a baseline TB skin or blood test.

An individual TB risk assessment and symptom evaluation are completed to determine if high risk exposures have occurred since administration of the baseline TB test.

The annual risk assessment is used to determine the need, type, and frequency of testing/assessment for direct care personnel.

Human Resource Management

Standard CBPC4-2C: Written policies and procedures are established and implemented for all direct care personnel to have access to the Hepatitis B vaccine as each job classification indicates and as described in federal CDC and OSHA standards.

Personnel sign a declination statement for the Hepatitis B vaccination within 10 working days of employment if they choose not to become vaccinated.

Human Resource Management

Standard CBPC4-2D: There is a job description for each palliative care team member employed by the palliative care program which is consistent with the organizational chart with respect to function and reporting responsibilities.

The job description lists:

- Job duties
- Reporting responsibilities
- Minimum job qualifications, experience requirements, education, and training
- Requirements for the job
- Physical and environmental requirements with or without reasonable accommodation

Reviewed at hire and whenever the job description changes.

Human Resource Management

Standard CBPC4-2E: All personnel who transport patients in the course of their duties, have a valid state driver's license appropriate to the type of vehicle being operated and are in compliance with state laws.

The palliative care program conducts a Motor Vehicle Records (MVR) check on all personnel who are required to transport patients as part of their job duties, at time of hire and annually.

Human Resource Management

Standard CBPC4-2F: Written policies and procedures are established and implemented in regard to background checks being completed on personnel that have direct patient care and/or access to patient records. Background checks include: Office of Inspector General (OIG) exclusion list, criminal background record and national sex offender registry.

The palliative care program obtains a criminal background check, Office of Inspector General (OIG) exclusion list check and national sex offender registry check on all palliative care team members' employees who have direct patient care.

The palliative care program contracts/agreements require that all contracted entities obtain criminal background check, OIG exclusion list check and national sex offender registry check on contracted palliative care team members who have direct patient care.

Human Resource Management

The palliative care program obtains a criminal background check and OIG exclusion list check on all palliative care team members who have access to patient records.

Palliative care program contracts require that all contracted entities obtain criminal background checks and OIG exclusion list check on contracted employees who have access to patient records.

Criminal background checks are obtained in accordance with state requirements. In the absence of state requirements, criminal background checks are obtained within three months of the date of employment for all states in which the individual has lived or worked during past three years.

Human Resource Management

Standard CBPC4-2G: Written personnel policies and procedures and/or an Employee Handbook are established and implemented describing the activities related to personnel management. (Guideline(s) 8.1, 8.2)

Personnel policies and procedures and/or an Employee Handbook include, but are not limited to:

- Wages and benefits
- Grievances and complaints
- Recruitment, hiring and retention of personnel
- Disciplinary action/termination of employment
- Professional boundaries and conflict of interest
- Performance expectations and evaluations

Not applicable to contract individuals

Human Resource Management

Standard CBPC4-2H: Written policies and procedures are established and implemented in regard to written annual performance evaluations being completed for all personnel based on specific job descriptions. The results of annual performance evaluations are shared with personnel.

Policies and procedures describe how performance evaluations are conducted, who conducts them, and when they are to be conducted.

Personnel evaluations are completed, shared, reviewed and signed by the supervisor and employee on an annual basis.

Human Resource Management

Standard CBPC4-3A: Written policies and procedures are established and implemented that describe the orientation process. Documentation reflects that all personnel have received an orientation. (Guideline(s) 2.1, 3.1, 5.1, 6.1, 7.1)

The palliative care program creates and completes checklist or other method to verify that the topics have been reviewed with all personnel.

Human Resource Management

Standard CBPC4-3B: The palliative care program designates an individual who is responsible for conducting orientation activities. (Guideline(s) 1.6)

The palliative care program designates an individual to coordinate the orientation activities ensuring that instruction is provided by qualified personnel.

Human Resource Management

Standard CBPC4-4A: Written policies and procedures are established and implemented requiring the palliative care program to design a competency assessment program on the care/service provided for all direct care personnel.

The palliative care program designs and implements a competency assessment program based on the care/service provided for all direct care personnel.

Competency assessments are conducted initially during orientation, prior to providing a new task and annually thereafter.

Competency assessment may be accomplished through clinical observation, skills lab review, supervisory visits, knowledge-based tests, situational analysis/case studies, and self-assessment. All competency assessments and training are documented. A self-assessment tool alone is not acceptable.

Human Resource Management

Standard CBPC4-5A: A written education plan is developed and implemented which defines the content, frequency of evaluations and amount of ongoing in-service training for each classification of personnel.

The palliative care program has an ongoing education plan that annually addresses, but is not limited to:

- Emergency/disaster training
- How to handle grievances/complaints
- Infection control training
- Cultural diversity
- Communication barriers
- Ethics training
- Workplace (OSHA), patient safety
- Patient rights and responsibilities
- Compliance Program

Direct care personnel must have a minimum of 12 hours of in-service/continuing education per year

Human Resource Management

Standard CBPC4-6A : Written policies and procedures are established and implemented in regard to the observation and evaluation of direct care/service personnel performing their job duties by qualified personnel prior to providing care independently and at least annually and/or in accordance with state or federal regulations.

Qualified personnel observe and evaluate each direct care personnel performing their job duties prior to providing care independently and at frequencies required by state or federal regulations.

This activity may be performed as part of a supervisory visit and is included as part of the personnel record.

Human Resource Management

Standard CBPC4-7A: Supervision is available during all hours that care/service is provided.

There is administrative (and clinical, when applicable) supervision provided in all areas during the hours that care/service is furnished.

Supervision is consistent with state laws and regulations.

Human Resource Management

Standard CBPC4-8A: Written policies and procedures are established and implemented relating to special education, experience or certification requirements for nursing personnel to administer pharmaceuticals and/or perform special treatments.

Written policies and procedures define any special education, experience, or licensure/certification requirements necessary for nursing personnel to administer pharmaceuticals and/or perform special treatments.

Qualifications may vary based upon state's board of nursing requirements for LPNs/LVNs and RNs.

Human Resource Management

Standard CBPC4-9A: Written policies and procedures are established and implemented in regard to physician services, including advanced practice practitioners, are provided by qualified individuals who are legally authorized to practice by the state in which they provide care/service.

Written policies and procedures address that physicians, physician assistants, nurse practitioners, and clinical nurse specialists function in accordance with professional standards, the state's licensing Board of Medicine and state's Nursing Practice Act, and according to the palliative care program's policies and procedures and/or job descriptions.

Human Resource Management

Standard CBPC4-10A: Written policies and procedures are established and implemented in regard to nursing services being provided by a qualified Registered Nurse (RN), Licensed Practical Nurse (LPN)/Licensed Vocational Nurse (LVN) in accordance with the state's Nurse Practice Act and and/or job descriptions.

RNs, LPNs and LVNs function in accordance with professional standards, the state's Nurse Practice Act, and according to the palliative care program’s policies and procedures and/or job descriptions.

Human Resource Management

Standard CBPC4-11A: Written policies and procedures are established and implemented in regard to Social Work services are provided by a qualified medical social worker or social worker assistant in accordance with the state's Social Work Practice Act and the palliative care program's policies and procedures and/or job descriptions.

Social Workers function in accordance with the state's Social Work Practice Act and according to the palliative care program’s policies and procedures and/or job descriptions.

Human Resource Management

Standard CBPC4-11B: Written policies and procedures are established and implemented in regard to social work assistants are supervised by a master's degree prepared medical social worker (MSW).

Written policies and procedures are established and implemented that outline the supervision of care/service provided by a social worker assistant. The process includes a procedure for assessing the Social Worker Assistant's practice and a method for ensuring that patient needs are met.

A social worker assistant performs services planned, delegated, and supervised by the master's degree-prepared MSW.

Provide clinical supervision at least every 60 days but more frequently based on the acuity of the patient, unless state laws require more often

Human Resource Management

Standard CBPC4-12A: Written policies and procedures are established and implemented in regard to spiritual care services are provided by qualified individuals.

Spiritual care is provided by qualified individuals in accordance with professional standards and according to the palliative care program's job description.

Spiritual care may be provided by chaplains, local clergy, volunteers, and other specifically trained personnel.

Human Resource Management

Standard CBPC4-13A: Written policies and procedures are established and implemented in regard to clinical pharmacy services are provided by qualified individuals who are legally authorized to practice by the state in which they provide care/service.

Clinical pharmacists function in accordance with professional standards, the state's Board of Pharmacy Practice Act, and according to the palliative care program's policies and procedures and/or job descriptions.

Human Resource Management

Standard CBPC4-14A: The palliative care program provides support services to its palliative care team (PCT) members. (Guideline(s) 1.6)

The palliative care program provides regular support meetings for staff and volunteers to encourage discussion of emotional stress/impact when caring for patients and families with serious or life-threatening illnesses.

The organization has a regular and standardized process for assessing staff distress and grief and creating a plan to support them.

The palliative care program and PCT implements interventions to promote staff wellness and team sustainability.

Opportunities for additional counseling services are available.

Tips for Compliance

- Utilize the Personnel File tools to audit:
  - Personnel files
  - Contracted individual files
- Evidence of proper supervision of professional assistants

Workbook Tools

- Compliance Checklist
- Self-Audit
- Job Description Template
- Physical Demands Documentation Checkoff List
- Sample Employee Educational Record
- Sample Annual Observation/Evaluation Visit form
- Orientation Requirements Checklist
- Personnel Record Audit Tool
- Hints for Developing an Educational Plan
- Sample Hepatitis B Declination Statement
- Tuberculosis Screening Tool
- Sample In-Service Attendance form

Poll Question

Questions?

Break Time

Section 5

PROVISION OF CARE AND RECORD MANAGEMENT

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

Provision of Care and Record Management

Standard CBPC5-1A: Written policies and procedures are established and implemented relating to the required content of the patient record. An accurate record is maintained for each patient. (Guideline(s) 8.2)

Written policies and procedures define the required content of the patient record. This information is obtained by the various members of the palliative care team (PCT) and they create and document a palliative plan of treatment together with the patient and family.

If the palliative care program has electronic medical records (EMR), the palliative care program has written policies and procedures and a mechanism to maintain all patient records in an electronic format.

Provision of Care and Record Management

Standard CBPC5-1B: Patient records contain documentation of all care/services provided. All entries are legible, clear, complete, appropriately authenticated and dated in accordance with policies and procedures and currently accepted standards of practice.

The patient record contains documentation of all care/service provided, directly or by contract, and has entries dated and signed by the appropriate personnel.

Each home visit, treatment, or care/service is documented in the patient record and signed by the individual who provided the care/service.

Signatures are legible, legal, and include the proper designation of any credentials. Stamped physician, independent practitioners, or clinical personnel signatures on orders, treatments, or other documents that are part of the patient's record are not accepted.

Provision of Care and Record Management

Standard CBPC5-2A: Written policies and procedures are established and implemented that address access, storage, removal, and retention of patient records and information.

Access, storage, removal and retention of medical records and patient information.

All patient records are retained for a minimum of seven years from the date of the most recent discharge or death of the patient or per state law (whichever is the greater).

The palliative care program's policies and procedures provide for retention even if the palliative care program discontinues operations.

Provision of Care and Record Management

Standard CBPC5-3A: Written policies and procedures are established that describe the process for assessment and the development of the plan of treatment. (Guideline(s) 1.2, 1.3)

Written policies and procedures describe the process for a patient assessment, the development of the plan of treatment and the frequency and process for the plan of care review.

A Registered Nurse (RN) or qualified professional, per state licensure rules or regulations, conducts an initial assessment to determine care, and support needs of the patient.

Provision of Care and Record Management

Standard CBPC5-3B: All patients have an initial assessment. The initial assessment is conducted within 72 hours of referral, unless the physician, allowed practitioner or patient specifies a specific time to conduct the initial assessment. (Guideline(s) 1.2.4, 2)

A registered nurse (RN), physician, nurse practitioner (NP), clinical nurse specialist (CNS), or physician assistant (PA), must conduct an initial assessment to determine the immediate care/service and support needs of the patient.

The initial assessment must take place within 72 hours of referral, unless otherwise indicated by physician, allowed practitioner or patient.

Provision of Care and Record Management

Standard CBPC5-3C: The comprehensive assessment must be completed in a timely manner, consistent with patient's immediate needs and the organization's policies and procedures. (Guideline(s) 1.2, 2.2, 3.2, 4.2, 5.2, 6.3, 7.2, 7.5)

The comprehensive assessment is performed on patients referred for services and documented in the patient's record.

The comprehensive assessment is based on patient need or perceived need and addresses physical, emotional, social, and spiritual status.

Provision of Care and Record Management

Standard CBPC5-3D: A medication profile is part of the patient-specific comprehensive assessment. A registered nurse (RN), physician, nurse practitioner (NP), clinical nurse specialist (CNS) or physician assistant (PA), creates and maintains a current medication profile and reviews all patient medications, both prescription and non-prescription, on an ongoing basis in collaboration with other palliative care team members (PCT).
(Guideline(s) 1.1, 2.3)

An RN, physician, NP, CNS, or PA reviews the patient's prescription and over-the-counter drugs, herbal remedies, and other alternative treatments that could affect drug therapy on an ongoing basis.

This review is done in collaboration with other PCT members (e.g., physician and/or pharmacist) during the PCT meeting and whenever needed.

Provision of Care and Record Management

Standard CBPC5-3E: As part of the patient-specific comprehensive assessment the palliative care program may determine the need for a referral and/or further evaluation by other appropriate health professionals. Additional services may be provided to meet patient/family needs. (Guideline(s) 2.3)

Patients and/or families are referred to appropriate health professionals for further evaluation based on identified needs and the interdisciplinary plan of treatment.

Provision of Care and Record Management

Standard CBPC5-3F: There is a written plan of treatment collaboratively developed by the palliative care team (PCT) and the patient and family for each patient accepted to services. (Guideline(s) 1.3)

The palliative care program has a responsibility to obtain physician or independent practitioner orders prior to initiation of the care/services and to notify the physician or independent practitioner of any changes in the patient's condition.

Verbal orders are documented and signed with the name and credentials of the personnel receiving the order and signed by the physician or independent practitioner within the time frame established in the palliative care program's policies and procedures and/or state requirement.

Provision of Care and Record Management

Standard CBPC5-3G: The palliative care program shows evidence of the patient participation in the plan of treatment and goals of care. (Guideline(s) 1.3)

The patient has a right to be and should routinely be involved in the development of the plan of treatment/goals of care and any changes in that plan.

The degree of involvement may vary depending on the status and desires of the patient.

At a minimum, the patient and/or surrogate agree to the plan of treatment/goals of care prior to the beginning of services and as subsequent changes occur.

Provision of Care and Record Management

Standard CBPC5-3H: Care/services are delivered in accordance with the written plan of treatment. (Guideline(s) 1.3)

The patient record reflects that the services are delivered in accordance with the plan of service.

Treatment alternatives are documented and communicated to the patient and family and documented in the patient's record.

Provision of Care and Record Management

Standard CBPC5-3I: There is evidence that the palliative plan of treatment is reviewed and revised based on reassessment data by a registered nurse (RN), physician, nurse practitioner (NP), clinical nurse specialist (CNS) or physician assistant (PA). (Guideline (s) 1.3)

The plan of treatment should be reviewed:

- At a minimum of every 60 days
- When there are changes in patient's response to treatment
- When physician's or independent practitioner's orders change
- At the request of patient
- As defined in the palliative care program's policies and procedures

Provision of Care and Record Management

Standard CBPC5-4A: A registered nurse (RN), physician, nurse practitioner (NP), clinical nurse specialist (CNS) or physician assistant (PA) reviews all patient medications, both prescription and non-prescription, on an ongoing basis as part of the care/services to a patient (Guideline(s) 1.2, 2.3).

An RN, physician, NP, CNS, or PA reviews and documents all prescription and non-prescription medications that a patient is taking.

Provision of Care and Record Management

Standard CBPC5-5A: Written policies and procedures are established and implemented for addressing patient needs which cannot be met by the palliative care program at time of referral. The palliative care program coordinates planning and care/service delivery efforts with other community agencies. Patients are referred to other agencies when appropriate. (Guideline(s) 1.3, 2.3, 7.5)

The palliative care program maintains a referral log or other tool to record all referrals. Referral sources are notified when patient needs cannot be met and the patient is not being admitted to the palliative care program.

Provision of Care and Record Management

Standard CBPC5-6A: Written policies and procedures are established and implemented that describe the process for patient education. (Guideline(s) 3.3, 7.3, 7.8)

Patient education should include, but not limited to:

- Disease management and trajectory as appropriate to the care/service provided
- What to expect in the future and how to respond to any changes in condition or new symptoms
- Medication management, safety, and disposal
- Symptom management
- Proper use, safety hazards, and infection control issues related to the use and maintenance of any equipment that is provided
- Plan of treatment
- How to notify the palliative care program of new problems, concerns and complaints
- Emergency preparedness information

Provision of Care and Record Management

Standard CBPC5-6B: Patient education focuses on goal and outcome achievement as established in the plan of treatment/goals of care. (Guideline(s) 2.1)

The patient record must indicate educating the patient about appropriate actions to take if a medication or treatment reaction occurs when a health-care professional is not present.

The patient record includes documentation of all teaching, patient's response to teaching, and the patient's level of progress/achievement of goals/outcomes. Written instructions are provided to the patient.

Provision of Care and Record Management

Standard CBPC5-7A: Written policies and procedures are established and implemented that describe the process for transfer/discharge of a patient. (Guideline(s) 1.7, 2.4)

A transfer/discharge summary includes, but is not limited to:

- Date of transfer/discharge, patient identifying information, and emergency contact
- Destination of patient transferred/discharged
- Date and name of person receiving report, if applicable
- Patient's physician or independent practitioner name and phone number
- Diagnosis related to the transfer/discharge
- Significant health history
- Transfer orders and instructions
- History of care including treatment and management to date (e.g. history of pain or symptom management)
- A brief description of services provided and ongoing needs that cannot be met
- Status of patient at the time of transfer
- Advance directive

Provision of Care and Record Management

Standard CBPC5-8A: Written policies and procedures are established and implemented that identify the drugs or drug classifications and routes that are not approved for administration by palliative care program's personnel. (Guideline(s) 2.3, 8.1, 8.2)

Written policies and procedures identify the drugs or drug classifications and/or routes not approved by the manager/leader for administration by nursing personnel.

The policies and procedures also address any blood or blood products that may or may not be administered.

Provision of Care and Record Management

Standard CBPC5-8B: Written policies and procedures are established and implemented regarding the requirements for palliative care staff administering the first dose of a medication in the home setting. (Guideline(s) 2.3, 8.1, 8.2)

The palliative care program may elect not to administer the first dose of a medication in the home or may have specific written requirements that allow administration of the first dose.

The palliative care program defines when first dose policies and procedures are appropriate based on the medication route and potential reaction.

Provision of Care and Record Management

Standard CBPC5-9A: Written policies and procedures are established and implemented in regard to the palliative care program making referrals to a hospice to provide a continuum of care for the patient and family through the transition of dying to the time of death and follow-up bereavement care. (Guideline(s) 7.1)

The palliative care program's policies and procedures include, but are not limited to:

- Teaching family members about the physical and psychological aspects of the dying process and actions to take when death occurs
- Providing frequent contact through onsite and/or home visits to support patient and family prior to death
- Discussing hospice eligibility and services
- Availability of personnel to attend patient death (24 hours a day, seven days a week)
- Respect by personnel for cultural and religious traditions of the patient/family relating to death and dying
- Planning for post-death, including funeral planning
- Transition to bereavement care

Provision of Care and Record Management

Standard CBPC5-9B: Written policies and procedures are established and implemented in regard to the provision of postmortem care. (Guideline(s) 7.4)

After death care is provided with regard to the desires of the patient, family, cultural, and religious practices.

Tips For Compliance

- Utilize audit tools to audit medical records
  - Is the plan of treatment current and correct?
  - Are all verbal orders documented in the chart?
  - Are all visit notes properly documented?
  - Do you see evidence that newly identified problems have interventions and goals developed?
  - Do you see evidence of progress towards goals?
  - Have all relevant physicians been notified as appropriate?
  - Are forms compliant?
- Fix any identified issues in the correct manner per state regulations and palliative care program policy

Workbook Tools

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

Poll Question

Questions?

Section 6

QUALITY OUTCOMES/PERFORMANCE IMPROVEMENT

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

Quality Outcomes/Performance Improvement

Standard CBPC6-1A: The palliative care program develops, implements, and maintains an effective Quality Assessment and Performance Improvement (QAPI) program. The program measures, analyzes, and tracks quality indicators, including adverse patient events, and other aspects of performance that enable the program to assess processes of care, services, and operations. (Guideline(s) 1.4, 1.9)

The QAPI program measures, analyzes, and tracks quality indicators and other aspects of performance that enable the palliative care program to assess processes of care and operations.

Quality Outcomes/Performance Improvement

Standard CBPC6-1B: The palliative care program ensures the implementation of a program wide Quality Assessment/Performance Improvement (QAPI) program by the designation of a person responsible for coordinating QAPI activities. (Guideline(s) 1.9)

The position responsible for coordinating QAPI activities may be the manager/leader, supervisor, or other personnel, and these duties are included in the individual's job description.

Quality Outcomes/Performance Improvement

Standard CBPC6-1C: There is evidence of palliative care personnel involvement in the Quality Assessment and Performance Improvement (QAPI) process. (Guideline(s) 1.9)

Personnel receive training related to QAPI activities and their involvement.

Training includes, but is not limited to:

- The purpose of QAPI activities
- Person responsible for coordinating QAPI activities
- Individual's role in QAPI
- PI outcomes resulting from previous activities

Quality Outcomes/Performance Improvement

Standard CBPC6-2A: The palliative care program develops, implements, and evaluates Quality Assessment and Performance Improvement (QAPI) projects on an annual basis. (Guideline(s) 1.9)

A written summary of the palliative care program's projects is included in the QAPI annual report.

Quality Outcomes/Performance Improvement

Standard CBPC6-3A: Quality Assessment and Performance Improvement (QAPI) activities include ongoing monitoring of processes which involve risks, including infections and communicable diseases. (Guideline(s) 1.9)

A review of all variances, which includes, but is not limited to incidents, accidents, complaints/grievances, and worker compensation claims, are conducted at least quarterly to detect trends and create an action plan to decrease occurrences.

Quality Outcomes/Performance Improvement

Standard CBPC6-3B: Quality Assessment and Performance Improvement (QAPI) activities include ongoing monitoring of at least one important aspect related to the care/service provided. (Guideline(s) 1.4, 1.9)

The palliative care program conducts monitoring of at least one important aspect of the care/service provided by the program.

May be:

- High-volume (occurs frequently or affects a large number of patients)
- High-risk (causes a risk of serious consequences if the care/service is not provided correctly)
- Problem-prone (has tended to cause problems for personnel or patients in the past)

Quality Outcomes/Performance Improvement

Standard CBPC6-3C: The Quality Assessment and Performance Improvement (QAPI) activities include satisfaction surveys. (Guideline(s) 1.9)

The QAPI program identifies the process for conducting patient and family satisfaction surveys, with administration of the patient family surveys individualized to the context of the population served.

The QAPI program also identifies the process for conducting personnel, and referral source satisfaction surveys.

Quality Outcomes/Performance Improvement

Standard CBPC6-3D: Quality Assessment and Performance Improvement (QAPI) activities include the ongoing monitoring of patient grievances/ complaints. (Guideline(s) 1.9)

QAPI activities include ongoing monitoring of patient grievances/complaints and the action(s) needed to resolve grievances/complaints and improve patient care/service.

Quality Outcomes/Performance Improvement

Standard CBPC6-3E: Quality Assessment and Performance Improvement (QAPI) activities include a review of the patient record to determine completeness of documentation. (Guideline(s) 1.9)

The patient record review is conducted by all disciplines or members of the patient care/ service team.

An adequate sampling of open and closed records is selected to determine the completeness of documentation.

Quality Outcomes/Performance Improvement

Standard CBPC6-4A: Written policies and procedures are established and implemented by the palliative care program to identify, monitor report, investigate and document all adverse events, incidents, accidents, variances, or unusual occurrences that involve patient care/service. (Guideline(s) 1.9)

The palliative care program investigates all adverse events, incidents, accidents, variances, or unusual occurrences that involve patient services and develops a plan to prevent the same or a similar event from occurring again.

There is a standardized form developed by the palliative care program used to report incidents.

Tips for Compliance

- Review of QAPI materials
  - Job description
  - What is being monitored
  - What are established thresholds
  - Quality Assessment and Performance Improvement Projects
  - Evidence of personnel involvement
  - Complaint logs
  - Incident logs
  - Satisfaction surveys
  - Evidence of chart audits
  - Annual QAPI report

Workbook Tools

- Compliance Checklist
- Self-Audit
- QAPI Activity/Audit Description Template
- Sample QAPI Plan

Poll Question

Questions?

Section 7

RISK MANAGEMENT: INFECTION AND SAFETY CONTROL

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

Risk Management: Infection and Safety Control

Standard CBPC7-1A: Written policies and procedures are established and implemented that address the surveillance, identification, prevention, control and investigation of infectious and communicable diseases and the compliance with regulatory standards.

The palliative care program maintains and documents an effective infection control program that protects patients and personnel by preventing and controlling infections and communicable diseases.

Written policies and procedures detail OSHA Blood Borne Pathogen and TB Exposure Control Plan.

The organization conducts an annual TB risk assessment to determine the need, type, and frequency of testing/assessments for direct care personnel.

Risk Management: Infection and Safety Control

Standard CBPC7-1B: All personnel, patients, families and other caregivers are knowledgeable of the policies and procedures for infection control. (Guideline(s) 1.6, 1.9)

The palliative care program provides infection control education to employees, contracted providers, patients, family members, and other caregivers regarding basic and high-risk infection control procedures as appropriate to the care/services provided.

Training is consistent with Occupational Safety and Health Administration (OSHA) and Centers for Disease Control and Prevention (CDC) recommendations.

Risk Management: Infection and Safety Control

Standard CBPC7-1C: The palliative care program reviews and evaluates the effectiveness of the infection control program. (Guideline(s) 1.9)

The palliative care program must maintain a coordinated program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that is an integral part of the palliative care program performance improvement program.

The palliative care program monitors infection statistics of both patients and personnel and implements other activities (such as infection tracking records or logs) to ensure that personnel follow infection control procedures and report infections.

Data is utilized to assess the effectiveness of the infection control program.

Risk Management: Infection and Safety Control

Standard CBPC7-2A: Written policies and procedures are established and implemented that address the education of personnel concerning safety. (Guideline(s) 1.6)

Written policies and procedures include types of safety training as well as the frequency of training. Safety training is conducted during orientation and at least annually for all palliative care team members.

Risk Management: Infection and Safety Control

Standard CBPC7-2B: Written policies and procedures are established and implemented that address patient safety in the home setting. (Guideline(s) 2.3, 3.1, 4.2)

Written policies and procedures address patient safety in the home and/or clinic.

Risk Management: Infection and Safety Control

Standard CBPC7-3A: Written policies and procedures are established and implemented that outline the process for meeting patient needs in a disaster or crisis situation.

The palliative care program educates all PCT members about the process to meet patient needs in a disaster or crisis situation.

The palliative care program has, at a minimum, an annual practice drill to evaluate the adequacy of its plan.

The emergency plan also describes access to 911/(EMS) services in the event of needed emergency care/services for patients and personnel.

Risk Management: Infection and Safety Control

Standard CBPC7-3C: The palliative care program provides education to the patient regarding crisis management and emergency preparedness.

This education includes information on planning for emergencies/disasters such as:

- Evacuation plans
- Medications
- Food/water
- Important documents
- Care for pets, if applicable

Risk Management: Infection and Safety Control

Standard CBPC7-3D: Written policies and procedures are established and implemented relating to back-up equipment for use during power failures in the patient home.

Patient home medical equipment backup systems comply with the palliative care program's policies, procedures, and state law, as applicable

Risk Management: Infection and Safety Control

Standard CBPC7-5A: Written policies and procedures are established and implemented that address the palliative care program's fire safety and emergency power systems.

- Providing emergency power
- Testing of emergency power systems (at least annually)
- A no-smoking policy and how it will be communicated
- Fire drills
- Maintenance of:
  - Smoke detectors
  - Fire alarms
  - Fire extinguishers

Risk Management: Infection and Safety Control

Standard CBPC7-6A: Written policies and procedures are established and implemented for the acceptance, transportation, pickup, and/or disposal of hazardous chemicals and/or contaminated materials used in the provision of patient care/service.

Written policies and procedures include the safe method of acceptance, transportation, and pickup and/or disposal of hazardous wastes, chemicals and/or contaminated materials used in the home/clinic.

The palliative care program follows local, state, and federal guidelines.

Risk Management: Infection and Safety Control

Standard CBPC7-6B: Written policies and procedures are established and implemented for following OSHA's Hazard Communication Standard that describe appropriate labeling of hazardous chemicals and/or materials, instructions for use, and storage and disposal requirements.

- The labeling of containers of hazardous chemicals and/or materials with the identity of the material and the appropriate hazard warnings
- Current Safety Data Sheet (SDS) must be accessible to personnel
- The proper use, storage, and disposal of hazardous chemicals and/or materials
- The use of appropriate personal protective equipment (PPE)

Risk Management: Infection and Safety Control

Standard CBPC7-7A: Written policies and procedures are established and implemented for identifying, monitoring, reporting, investigating, and documenting all incidents, accidents, variances, or unusual occurrences involving personnel. (Guideline(s) 1.9)

- Process for reporting, monitoring, investigating and documenting a variance.
- There is a standardized form developed by the palliative care program used to report incidents.
- The palliative care program documents all incidents, accidents, variances, and unusual occurrences.
- The reports are distributed to manager/leader and are reported as required by applicable law and regulation.
- This data is included in the Quality Assessment and Performance Improvement (QAPI) program. The palliative care program assesses and utilizes the data for reducing further safety risks.

Risk Management: Infection and Safety Control

Standard CBPC7-8A: Written policies and procedures are established and implemented for the use of equipment in the performance of conducting waived tests. (Guideline(s) 1.6)

Policies and procedures for the use of equipment in the performance of conducting waived tests include:

- Instructions for using the equipment
- The frequency of conducting equipment calibration, cleaning, testing and maintenance
- Quality control procedures

Risk Management: Infection and Safety Control

Standard CBPC7-9A: Written policies and procedures are established and implemented for the use of equipment/supplies in the provision of care/service to the patient. (Guideline(s) 2.3)

Personnel implement the policies and procedures for the use of the palliative care program's equipment/supplies in the provision of care/service to the patient.

The cleaning and maintenance of equipment used in the provision of care is documented.

Supplies used in the provision of care/service are also documented.

Risk Management: Infection and Safety Control

Standard CBPC7-10A: Written policies and procedures are established and implemented for participating in clinical research/experimental therapies and/or administering investigational drugs. This criterion is applicable to palliative care programs that are participating in clinical research/experimental therapies, or administering investigational drugs. (Guideline(s) 8.1)

Written policies and procedures address the requirements identified in the standard.

Tips for Compliance

- Infection control plan
  - Staff in-service records
  - Patient education materials
- Evidence of office safety
  - Fire drill results
  - Testing of emergency power systems
- Standardized form for reporting of personnel incidents
- Safety and maintenance logs for any program issued equipment
- Check for expired supplies in the supply closet

Workbook Tools

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

Poll Question

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