FOR PROVIDERS.
BY PROVIDERS.

HOME HEALTH

EXPERIENCE THE ACHC DIFFERENCE

After Accreditation: Developing a Plan of Correction

FOR PROVIDERS.
BY PROVIDERS.

HOME HEALTH

EXPERIENCE THE ACHC DIFFERENCE

Post Survey Process

POST-SURVEY PROCESS

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

ACCREDITATION DECISIONS

- All survey results are reviewed by the Review Committee
- Two levels of deficiencies
  - Standard-level deficiencies are ACHC standard-specific deficiencies and/or individual Medicare Conditions of Participation (CoP) standard deficiencies
    - Requires a Plan of Correction (POC)
  - Condition-level deficiencies result when either the entire condition is out of compliance or multiple CoP standards, under one CoP, are out of compliance
    - Requires another on-site survey

ACHC ACCREDITATION DECISION DEFINITIONS

ACCREDITED

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

ACCREDITATION PENDING

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

DEPENDENT

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

DENIED

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

SUMMARY OF FINDINGS SAMPLE

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

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

PLAN OF CORRECTION REQUIREMENTS

- Due in 10 calendar days to ACHC
- Standard Identifier is pre-populated
- Plan of Correction
  - Action step to correct the deficiency
- Date of Compliance
  - Has to be in 10 calendar days if condition-level
  - Has to be in 30 calendar days is standard-level
- Title
- Process to Prevent Recurrence
  - Percentage and frequency
  - Target threshold
  - Ongoing compliance

PLAN OF CORRECTION

PLAN OF CORRECTION (POC)

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

INSTRUCTIONS:

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

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

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

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

SAMPLE AUDIT SUMMARY

➔ EVIDENCE CHART

Company name: ______________________________

Date:______________ For the week/month of: ______________________

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

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

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

Medical Record/Personnel File Audit Summary:

DEFICIENCY	AUDIT DESCRIPTION	RECORDS CORRECT/ RECORDS REVIEWED	PERCENT CORRECT
Example: HH5-3A\484.60	Audit charts for complete plan of care	9/10	90%

Observation Deficiencies:

DEFICIENCY	DEFICIENCY	EVIDENCE
Example: HH1-10A\484.105(e)(2)	Incomplete contracts	Revised contracts

SUBMISSION OF EVIDENCE

- All evidence must be submitted within 60 days to your Account Advisor; do not submit evidence until the POC has been approved
- No Protected Health Information (PHI) or other confidential information of patients or employees is to be submitted; if it is, it will be returned
- Accreditation can be denied based on lack of evidence to support the POC was implemented and effective

DISPUTE

- If you want to formally dispute a deficiency on your Summary of Findings, you must:
  - Submit a written request to your Account Advisor that outlines the specific standard you wish to dispute within 10 calendar days from the receipt of your Summary of Findings
  - Along with the letter, you must submit the evidence to support that, at the time of the survey, you were in compliance with the standard
  - Any areas that were corrected on site during the survey are not able to be disputed
  - Do not submit any documents with PHI
  - Activity logs/data entry logs are also required if the dispute is related to an entry into an electronic medical record
- ACHC will not review any evidence for dispute if:
  - Information is submitted after the 10-day calendar timeframe or
  - The agency is not current with payment or has an outstanding balance

RE-CAP

- Initial Medicare certification survey
  - Standard-level deficiencies require a plan of correction
  - Condition-level deficiencies require another full survey
- Medicare recertification survey
  - Standard-level deficiencies require a plan of correction
  - Condition-level deficiencies require another on-site survey
- Plan of correction is submitted to ACHC within 10 calendar days
  - Standard-level deficiencies action step must be completed within 30 calendar days
  - Condition-level deficiencies action step must be completed within 10 calendar days
  - Required evidence must be submitted within 60 calendar days

FOR PROVIDERS.
BY PROVIDERS.

EXPERIENCE THE ACHC DIFFERENCE

Benefits of Partnering with ACHC

FOR PROVIDERS.
BY PROVIDERS.

EXPERIENCE THE ACHC DIFFERENCE

Educational Resources

EDUCATIONAL RESOURCES

- ACHCU resources (ACHCU.com)
  - Workbooks and workshops
  - Webinars
- Online resources
  - *The Surveyor* newsletter
  - Regulatory updates
  - Accreditation resources
  - Maintaining compliance checklists
- Email updates
  - *"Did You Know?"* emails
  - *"ACHC Today"* bi-monthly e-newsletter

REGULATORY UPDATES

- Regulatory Updates
- *achc.org*
  - Resources & Events
  - Regulatory Updates

Regulatory Updates

California | Adopted, Proposed, CMS

PHARMACY | DMEPOS | BEHAVIORAL HEALTH | HOME HEALTH | HOSPICE | PRIVATE DUTY | SLEEP

Total of 5 records returned. Page 1 of 1

State: All

Medicare Fraud & Abuse: Prevention, Detection, and Reporting Booklet
Date Posted: 10/1/2016

The Medicare Fraud & Abuse: Prevention, Detection, and Reporting booklet

Learn about:

- Fraud and abuse definitions
- Laws used to fight fraud and abuse
- Government partnerships engaged in fighting fraud and abuse
- Where to report suspected fraud and abuse

LEARN MORE

CMS

CUSTOMER CENTRAL

- Customer Central is available 24/7 with resources and educational materials designed for your company
- *cc.achc.org*
- Resources
  - Continued Compliance
  - Education Library
  - Did You Know Emails
  - *ACHC Today*
  - Accreditation Resources

MAINTAINING COMPLIANCE

RENEWAL ACCREDITATION COMPLIANCE RESOURCES

PROTECT YOURSELF WITH ACHC ACCREDITATION

Let us help you to maintain compliance in an ever-changing regulatory environment. Choosing ACHC to complete your Medicare re-certification survey can significantly reduce your risk of having an alternative sanction imposed upon your home health agency. With fines that can total thousands of dollars per day, a strong compliance program achieved through earning and maintaining ACHC Accreditation is a key strategy. Since ACHC standards are written for providers, by providers, and incorporate the Medicare Conditions of Participation (CoPs), choosing to become accredited greatly reduces the risk of financial penalties.

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

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

CMS identified the upper range for Civil Monetary Penalties (CMPs) per day as $16,819-19,797. So far 20 states have imposed CMPs: AR, CO, CT, FL, IA, ID, IN, LA, MA, MI, MN, MO, NH, OH, OK, PA, TN, TX, UT, VA. The top 5 states for CMPs based on dollar amount are:

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

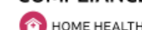
Utilize the 12-Month and 24-Month Compliance Checklists to assist you in maintaining compliance

ACCREDITATION 12-MONTH COMPLIANCE CHECKLIST

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

SECTION 1: ORGANIZATION AND ADMINISTRATION		
Standard	Expectation	Comments
HH1-1A	All applicable licenses and permits are current and posted for all locations	
HH1-1A.01	Federal and state posters are posted	
HH1-1B	Any changes in ownership or of managing employees have been properly reported	
HH1-2A	Governing body minutes are properly documented	
HH1-2A.03	New governing body members have been oriented	
HH1-4A.01	Any conflict of interest has been properly disclosed	
HH1-5A	Administrator or other pre-designated individual is qualified and available during all operating hours	
HH1-5A.01	Annual evaluation of the Administrator has been completed	
HH1-6A	Organizational chart is up to date	
HH1-6B	Clinical manager or other pre-designated individual is qualified and available during all operating hours	
HH1-6C	Evidence is available to demonstrate the parent agency is responsible for any and all branches, if applicable	
HH1-7A	At least one service is provided directly by employees of the agency	
HH1-8A	OASIS data is collected on appropriate patients	
HH1-8B	OASIS data is reported within 30 days of completing the assessment, and clinical and data audits verify that collected OASIS data is consistent with reported OASIS data	
HH1-9A.01	Negative outcomes from sanctions, regulatory inspections, and/or audits have been reported, if applicable	
HH1-10A	All contracts for direct care have been reviewed as required per the terms of the contract and the HHA does not have any contracts with agencies that have been: • Denied Medicare or Medicaid enrollment; • Been excluded or terminated from any federal healthcare program or Medicaid; • Had its Medicare or Medicaid billing privileges revoked; or • Been debarred from participating in any government program	
HH1-11A	CLIA certificate of waiver is current and posted	
HH1-12A.01	Any new branches have obtained Medicare approval prior to billing Medicare for services	

ACCREDITATION 24-MONTH COMPLIANCE CHECKLIST

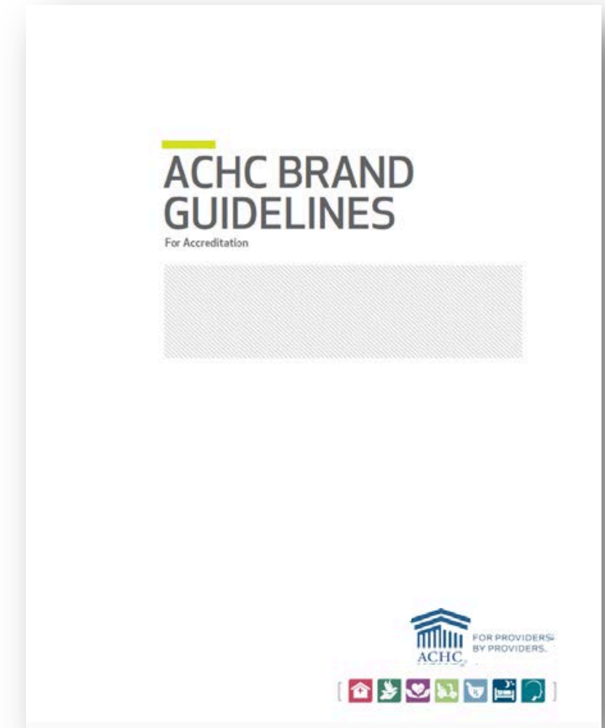


Use this checklist, along with the Medical Record Audit tool and the Personnel File Audit tool to audit your Home Health Agency (HHA) and operations 24 months after your ACHC survey. This checklist also helps you determine if your organization is in compliance with applicable local, state, and federal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

SECTION 1: ORGANIZATION AND ADMINISTRATION		
Standard	Expectation	Comments
HH1-1A	All applicable licenses and permits are current and posted for all locations	
HH1-1A.01	Federal and state posters are posted	
HH1-1B	Any changes in ownership or of managing employees have been properly reported	
HH1-2A	Governing body minutes are properly documented	
HH1-2A.03	New governing body members have been oriented	
HH1-4A.01	Any conflict of interest has been properly disclosed	
HH1-5A	Administrator or other pre-designated individual is qualified and available during all operating hours	
HH1-5A.01	Annual evaluation of the Administrator has been completed	
HH1-6A	Organizational chart is up to date	
HH1-6B	Clinical manager or other pre-designated individual is qualified and available during all operating hours	
HH1-6C	Evidence is available to demonstrate the parent agency is responsible for any and all branches, if applicable	
HH1-7A	At least one service is provided directly by employees of the agency	
HH1-8A	OASIS data is collected on appropriate patients	
HH1-8B	OASIS data is reported within 30 days of completing the assessment, and clinical and data audits verify that collected OASIS data is consistent with reported OASIS data	
HH1-9A.01	Negative outcomes from sanctions, regulatory inspections, and/or audits have been reported, if applicable	
HH1-10A	All contracts for direct care have been reviewed as required per the terms of the contract and the HHA does not have any contracts with agencies that have been: • Denied Medicare or Medicaid enrollment; • Been excluded or terminated from any federal healthcare program or Medicaid; • Had its Medicare or Medicaid billing privileges revoked; or • Been debarred from participating in any government program	
HH1-11A	CLIA certificate of waiver is current and posted	
HH1-12A.01	Any new branches have obtained Medicare approval prior to billing Medicare for services	

MARKETING TOOLS

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



BRANDING ELEMENTS

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

PROMOTING YOUR ACCREDITED STATUS

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

SAMPLE PRESS RELEASE

Your logo here

FOR IMMEDIATE RELEASE

September 28, 18
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 9001:2015 certified and has CMS Deeming Authority for Home Health, Hospice and DMEPOS.

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

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

###

ACHC MARKETING RESOURCES

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

WE VALUE YOUR FEEDBACK

- You will receive a Customer Satisfaction survey once you receive your final accreditation decision

FOR PROVIDERS.
BY PROVIDERS.

THANK YOU

Accreditation Commission for Health Care
139 Weston Oaks Ct., Cary, NC 27513
(855) 937-2242 | **achc.org**