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BEHAVIORAL HEALTH

Accreditation – Getting Started

After Your Survey

April 12, 2023

Welcome

ACCREDITATION GURU, INC.

Prepare for Greatness®

GUEST PRESENTERS

Jennifer Flowers, Founder & CEO

Peggy Lavin, Director of Behavioral Health

Agenda

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- Post Survey Activity
- Celebrating and Promoting Your Accreditation!
- Continuous Compliance
- Q&A

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Post Survey Activity

Post Survey Activities

- Corrective Action Plan
  - Address deficiencies found during the survey
  - Project Management
    - Who, What, When and How
    - Monitor
      - Implementation of planned action(s)
      - Effectiveness of action(s) taken

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You Achieved Accreditation!

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Post Accreditation! Now What?

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- Proactively maintain compliance with accreditation requirements
  - New/revised standards
  - Robust PI activities
  - Orientation
    - New staff
    - Staff assuming new responsibilities/duties
  - Training
    - Annual trainings
    - New policy/procedures
    - Response to PI
  - Verification of staff licenses, registrations, certifications
    - New staff
    - Renewal

Maintain the value of your investment with accreditation maintenance!

Post Accreditation! Now What?

- Annual calendar – quarterly and annual activities
- Consideration against liability insurance costs
  - Call your broker and discuss!
- Maintain culture of excellence
- Stop and take stock!

AG Maintenance Program

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- Up to 4 hours of consult per month
- Updates on new/revised standards
- Assess Performance Improvement activities
- Annual milestones calendar with monthly progress report
- Verification of required staff training
- Credentialling (new staff/renewal of licenses/registration/certifications)
- Mock survey 6 months prior to reaccreditation survey

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How ACHC Supports You!

After the Survey

Post-Survey Process

- Surveyor's responsibilities
- ACHC Clinical Review Committee examines all the data
- Summary of Findings (SOF) is sent within 10 business days from the last day of survey

Sample Summary of Findings

Identify the standard

Deficiency Category - Policies & Procedures			Defi-cient
Standard		**Comments**	
BH2-1A	**Written policies and procedures are established and implemented in regard to the organization's descriptions of services and the distribution to personnel, service recipients and the community.**	Upon review of policy and procedure,the organization did not evidence there are complete descriptions of all services, available for distribution which include all required elements. Missing elements: • Charges and payments • On call availability • Contact information and referral procedures Corrective Action: The Organization will need to ensure evidence of descriptions of all services, available for distribution which include, but are not limited to: • Types of service available or model of service utilized • Charges and payments • Eligibility/admission criteria including populations served • Hours of operation, including on call availability • Contact information and referral procedures • Goals/expectations of the service Educate staff on policy. Review policies to ensure compliance.	X

Deficiency cited

Action required for compliance

ACHC Accreditation Decisions

ACCREDITED

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

ACCREDITATION PENDING

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

DEPENDENT

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

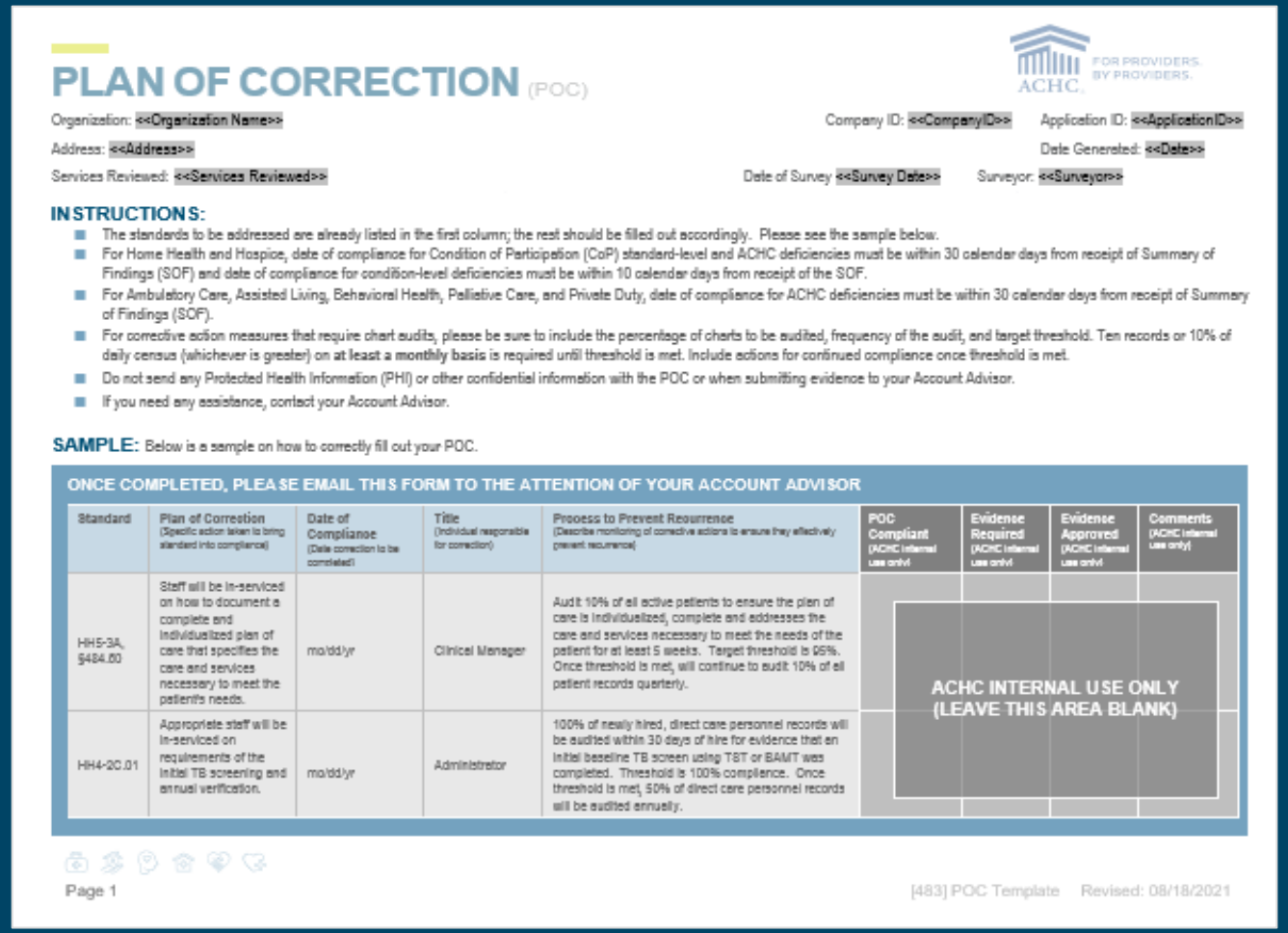
DENIED

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

Plan of Correction Requirements

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

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 TBT or BAMT was completed. Threshold is 100% compliance. Once threshold is met, 50% of direct care personnel records will be audited annually.				

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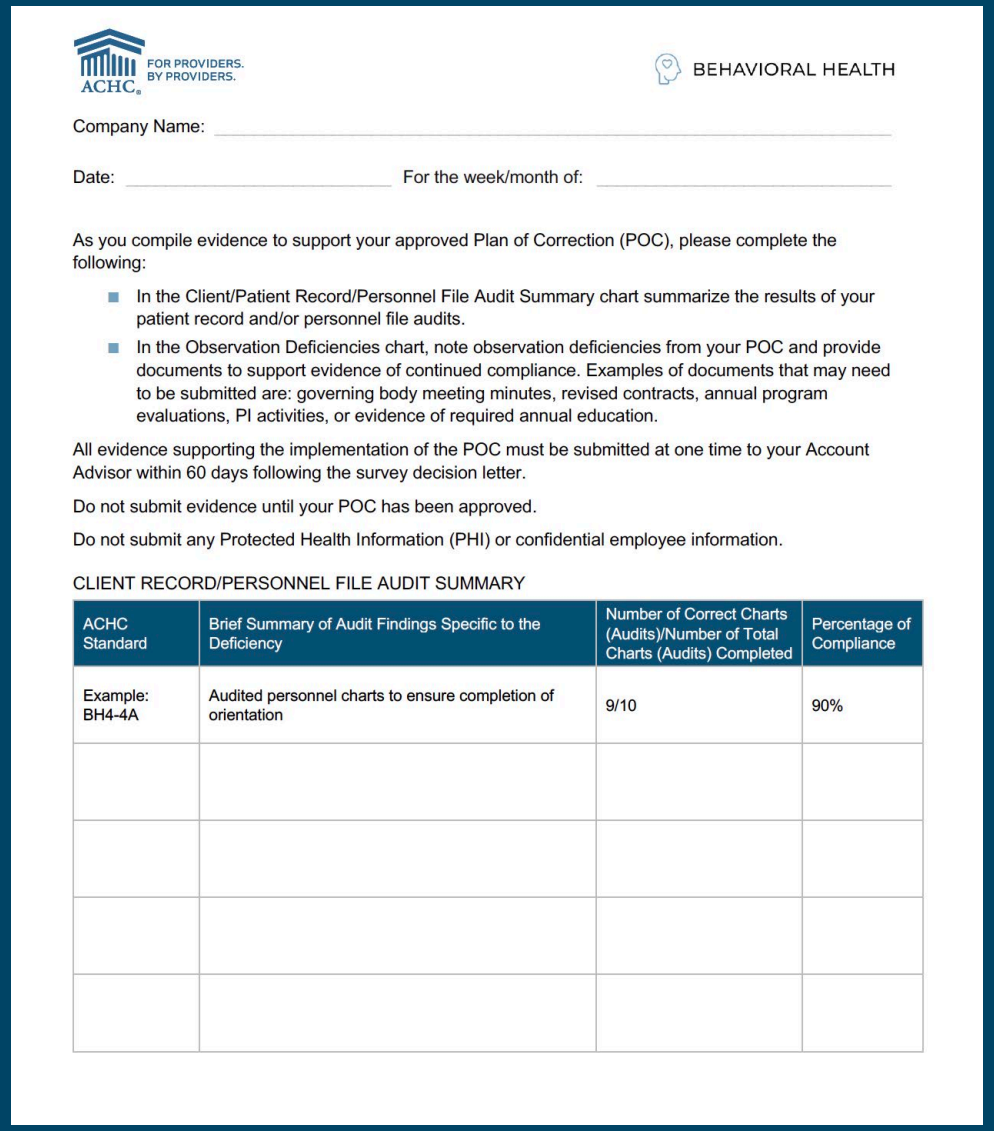
[483] POC Template Revised: 08/18/2021

Submission of Evidence

- 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 service recipients 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 Evidence Chart - Audit Summary



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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 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: governing body meeting minutes, revised contracts, annual program evaluations, PI activities, or evidence of required annual education.

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 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: BH4-4A	Audited personnel charts to ensure completion of orientation	9/10	90%

Dispute Process

- The organization submits a written request for dispute to its ACHC Account Advisor no later than 10 calendar days from the receipt of the Summary of Findings.
- Disputes will not be granted if:
  - The request is received after the 10 calendar-day time frame.
  - An organization has an outstanding balance.
  - An organization has a payment plan that is not current.

Dispute Process

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

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Adding Value With ACHC Accreditation

Promoting Your Accreditation Status

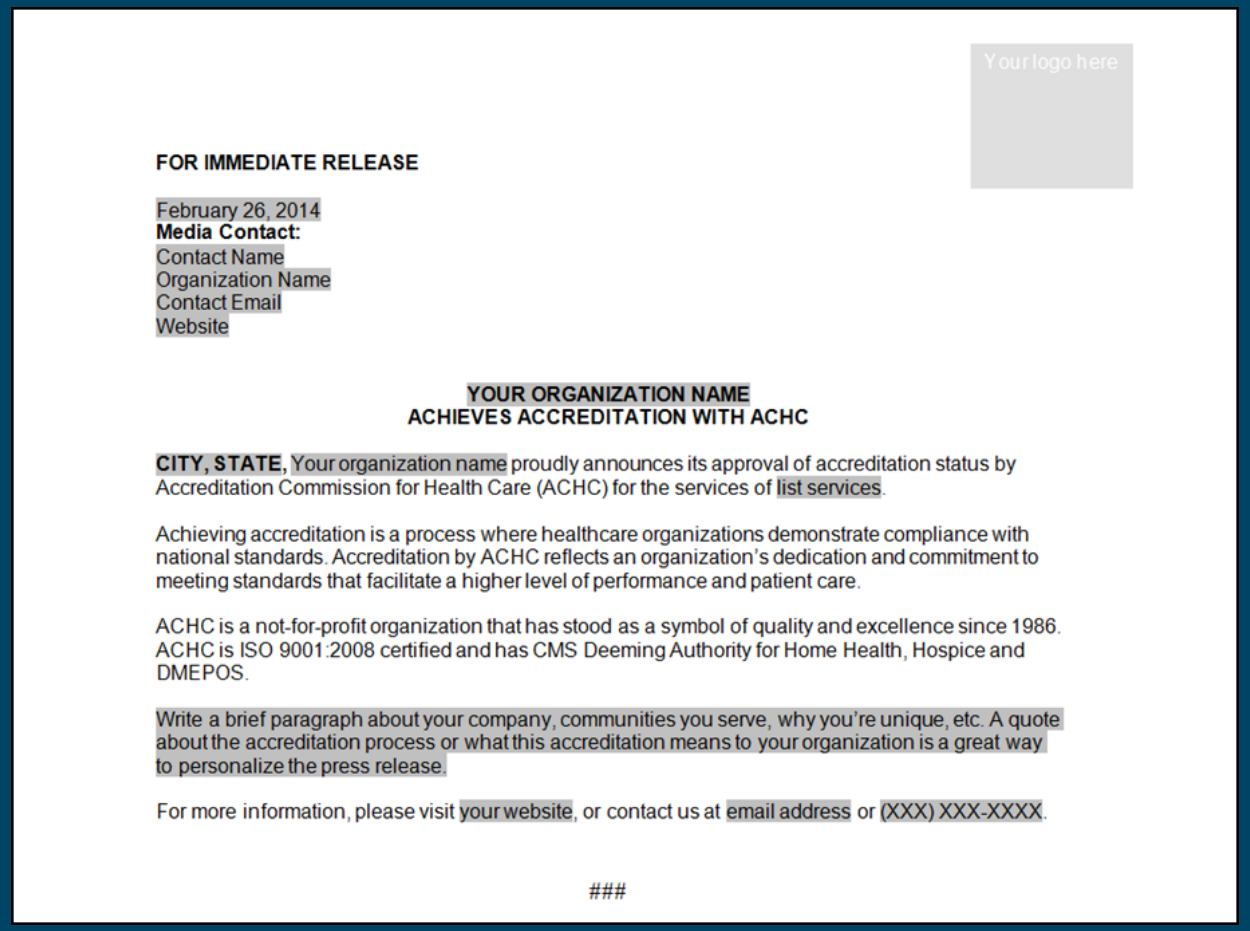
ACHC Marketing Resources

- 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
- ACHC's Marketing Department contact info:
  - ainfo@achc.org
  - (855) 937-2242

Branding Elements

- ACHC Accredited Logo(s)

Sample Press Release



Your logo here

FOR IMMEDIATE RELEASE

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

YOUR ORGANIZATION NAME
ACHIEVES ACCREDITATION WITH ACHC

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

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

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

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

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

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Educational Resources

- ACHCU.com:
  - Workshops and workbooks
  - 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

Maintaining Compliance

ACCREDITATION COMMISSION *for* HEALTH CARE

ACCREDITATION 12-MONTH COMPLIANCE CHECKLIST

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Use this checklist to audit your Behavioral Health agency and operations 12 months after your survey visit. This checklist is not intended to replace your own comprehensive review of ACHC 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.

Annual Organizational Responsibilities

- ☐ The organization's annual budget is completed.
- ☐ The organization's annual financial review report is available.
- ☐ The annual Performance Improvement (PI) report is completed to include:
  - ☐ An analysis of all incidents of restrictive intervention and corrective actions taken, as applicable
  - ☐ Review of incidents and adverse events
  - ☐ Ongoing monitoring of processes that involve risks
  - ☐ PI activities related to at least one aspect of care/service provided
  - ☐ PI activity related to the collection and tracking of outcome data involving service recipient plans of care
  - ☐ PI activities related to at least one administrative function
  - ☐ Satisfaction surveys utilized within the PI Program
  - ☐ An analysis of service recipient records
  - ☐ A review of service recipient grievances/complaints
  - ☐ A review of the emergency response system
- ☐ State and local licenses are up-to-date.
- ☐ Fire Marshall inspection is up-to-date.
- ☐ Clinical Laboratory Improvement Amendment (CLIA) waiver is reviewed and renewed, if applicable.
- ☐ Logs (grievance/complaint, safety, etc.) are reviewed.
- ☐ Contracts and Business Associate Agreements (BAAs) are reviewed and renewed, as needed.
- ☐ Liability insurance certificates are current for all contract personnel.
- ☐ The organizational chart is current.
- ☐ Forms are current.
- ☐ Review of rates/charges for care/service information is current.

Governing Body Responsibilities

- ☐ The Administrator's annual performance evaluation is completed.
- ☐ The established frequency of meetings is fulfilled and documented.
- ☐ The annual Performance Improvement report is reviewed by the governing body.
- ☐ Policies and procedures are reviewed annually, and new board members have completed the following:
  - ☐ Orientation
  - ☐ Signed Conflict of Interest & Disclosure Statement
- ☐ The budget is reviewed annually.

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[509] Effective: 02/25/2019
Accreditation 12-Month Compliance Checklist - Behavioral Health

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ACCREDITATION COMMISSION *for* HEALTH CARE

ACCREDITATION 24-MONTH COMPLIANCE CHECKLIST

FOR PROVIDERS. BY PROVIDERS.

BEHAVIORAL HEALTH

Use this checklist to audit your Behavioral Health agency and operations 24 months after your survey visit. This checklist is not intended to replace your own comprehensive review of ACHC 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.

Annual Organizational Responsibilities

- ☐ The organization's annual budget is completed.
- ☐ The organization's annual financial review report is available.
- ☐ The annual Performance Improvement (PI) report is completed to include:
  - ☐ An analysis of all incidents of restrictive intervention and corrective actions taken, as applicable
  - ☐ Review of incidents and adverse events
  - ☐ Ongoing monitoring of processes that involve risks
  - ☐ PI activities related to at least one aspect of care/service provided
  - ☐ PI activity related to the collection and tracking of outcome data involving service recipient plans of care
  - ☐ PI activities related to at least one administrative function
  - ☐ Satisfaction surveys utilized within the PI Program
  - ☐ An analysis of service recipient records
  - ☐ A review of service recipient grievances/complaints
  - ☐ A review of the emergency response system
- ☐ State and local licenses are up-to-date.
- ☐ Fire Marshall inspection is up-to-date.
- ☐ Clinical Laboratory Improvement Amendment (CLIA) waiver is reviewed and renewed, if applicable.
- ☐ Logs (grievance/complaint, safety, etc.) are reviewed.
- ☐ Contracts and Business Associate Agreements (BAAs) are reviewed and renewed, as needed.
- ☐ Liability insurance certificates are current for all contract personnel.
- ☐ The organizational chart is current.
- ☐ Forms are current.
- ☐ Review of rates/charges for care/service information is current.

Governing Body Responsibilities

- ☐ The Administrator's annual performance evaluation is completed.
- ☐ The established frequency of meetings is fulfilled and documented.
- ☐ The annual Performance Improvement report is reviewed by the governing body.
- ☐ Policies and procedures are reviewed annually, and new board members have completed the following:
  - ☐ Orientation
  - ☐ Signed Conflict of Interest & Disclosure Statement
- ☐ The budget is reviewed annually.

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[510] Effective: 02/25/2019
Accreditation 24-Month Compliance Checklist - Behavioral Health

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Organization Changes

- Notify Account Advisor when there are any organizational changes
  - Service Addition Checklist or a Distinction in Telehealth
  - Branch Addition Checklist
  - Change of Location
  - Change of Ownership
  - Change of Name
  - Closure Attestation

Questions?

Thank You!

ACCREDITATION GURU, INC.
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100% of clients ACHIEVED ACCREDITATION

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Thank you

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