CHAP

Home Health & Hospice Accreditation Intensive for Organizations & Consultants

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COMMUNITY HEALTH ACCREDITATION PARTNER
CHAP
EST. 1965
SEAL OF ACCREDITATION

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While you are waiting…

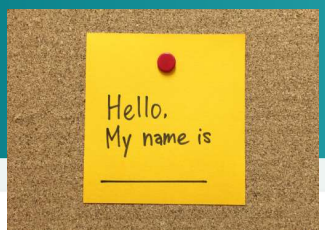
Use the chat box to tell the group:

Hospice Participants: your golden nugget from yesterday

Home Health Participants: your favorite hobby

2

Housekeeping Items



Introductions

Agenda
&
Handouts

Microsoft Teams

Teams Use

- Muting
- Use of Chat
- Raise of Hand
- Reactions

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Small Groups

- Name
- State
- What do you love most about providing care in the home
- Fun Fact

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- What was your favorite "fun fact" among your group?
- Have you held any of these roles in an organization?
  - Administrator
  - Clinical leadership
  - QAPI
  - Office staff
  - Field Staff
  - None of the above

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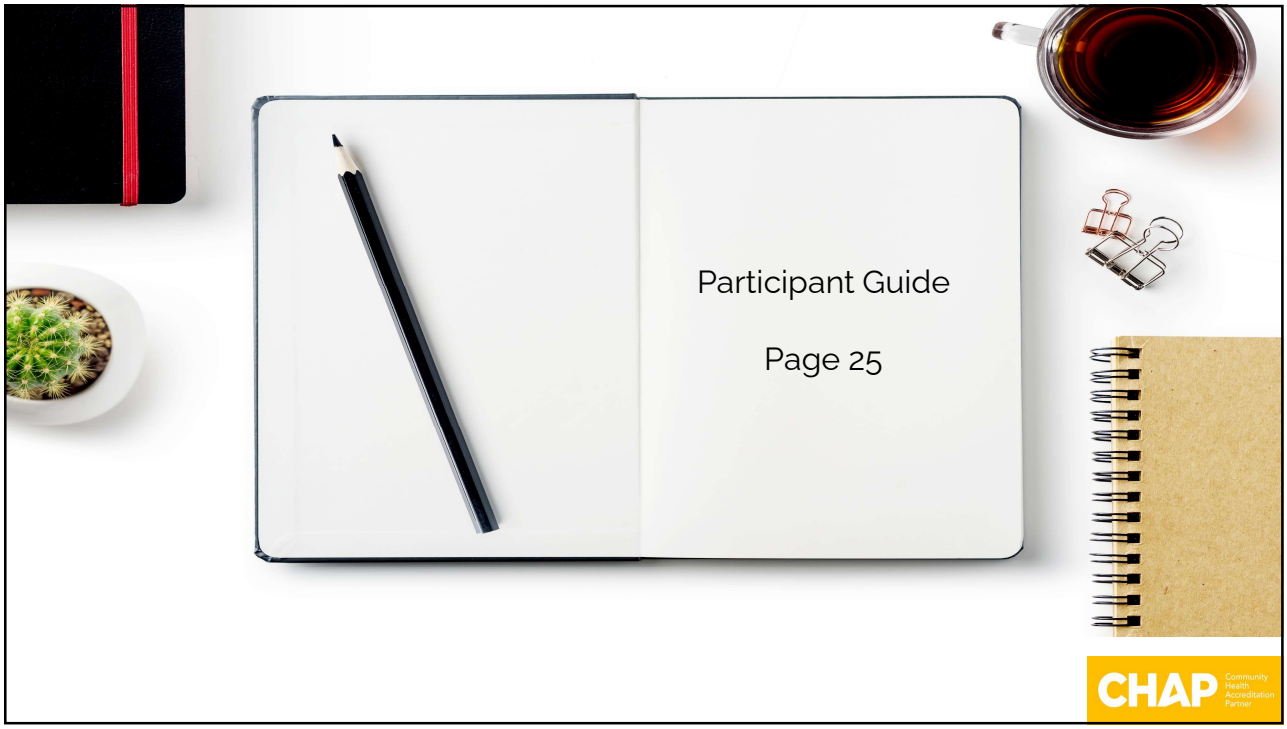

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Infection Prevention & Control (IPC & HIPC)

KEY PERFORMANCE AREA

Home Health: Organizations implement effective Infection Prevention and Control programs to promote safety and reduce the risks for acquiring a healthcare-associated infection.

Hospice: Providing hospice care requires effective infection prevention and control processes to reduce the risk of acquiring or transmitting infectious disease in any settings where hospice care is provided.

Effective communication with the Interdisciplinary Group (IDG), patients, families, and visitors about infection prevention and control is key to supporting their roles in reducing the risk of spreading infectious and communicable disease through daily activities and interaction.

The environment of care is also where the patient/family resides. The IDG must balance respect for a patient's self-care as well as patient and family autonomy with identified infection control risk. The IDG's role is to ensure that the patient and family understand the importance of minimizing those risks.

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Program Goal

Each organization must maintain and document an effective infection control program that protects patients, families, visitors, and personnel by preventing and controlling infections and communicable diseases.

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Foundation Needed

- Policies & Procedures
- Process for Educating Staff, Patients, & Caregivers
- Monitoring for Compliance

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Prevention

Six Standard Precautions based on CDC Guidance

One
Hand Hygiene

Two
Environmental Cleaning & Disinfection

Three
Injection & Medication Safety

Four
Appropriate use of PPE

Five
Minimizing Potential Exposures

Six
Reprocessing of Reusable Medical Equipment Between each Patient and When Soiled.

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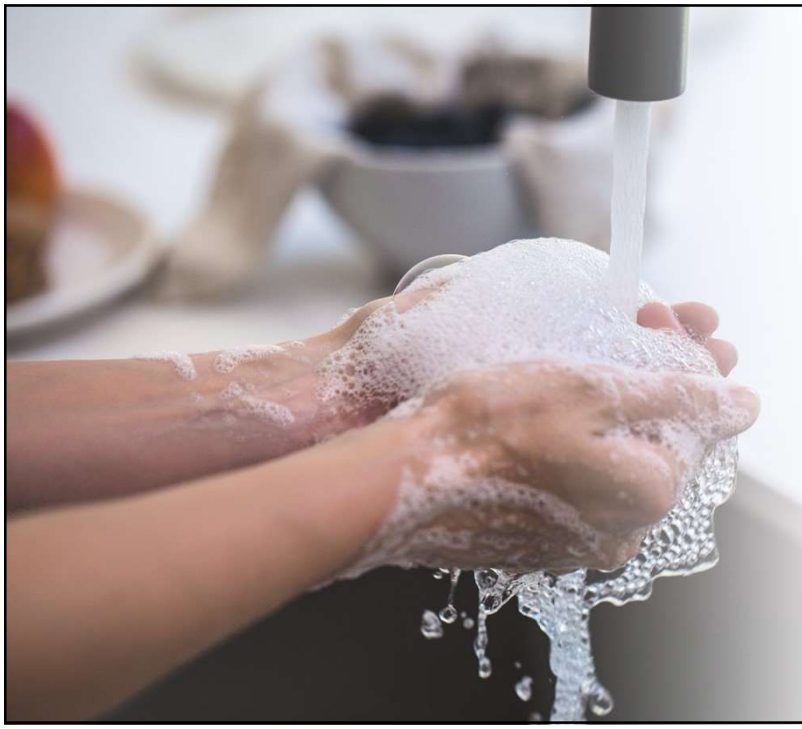

The Four E's…

Engage
Educate
Execute
Evaluate

CDC Handwashing Video

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Coordinated, Agency-Wide IC Program

IPC.4 & HIPC 5.I

The organization maintains a coordinated, agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. The infection control program includes:

- A method for identifying infectious and communicable disease problems
- A plan for implementing appropriate actions that are expected to result in improvement and disease prevention

QAPI

The IC program is an integral part of the organization's Continuous Quality Improvement program activities.

- Identifies infectious & communicable diseases
- Develops a plan to result in improvement and disease prevention

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IC Education: Staff, Patients, & Caregivers

IPC.13

Patients, caregivers, and personnel are instructed on:

- Infection prevention and control practices related to the care and services provided
- Measures to minimize the risk of spreading infection and communicable diseases, including the proper techniques for handling and disposing of medical waste, as appropriate
- Instruction is documented

HIPC 7.I

The hospice provides infection control education to employees, contracted providers, patients, family members, and other caregivers that is individualized to the needs of each patient.

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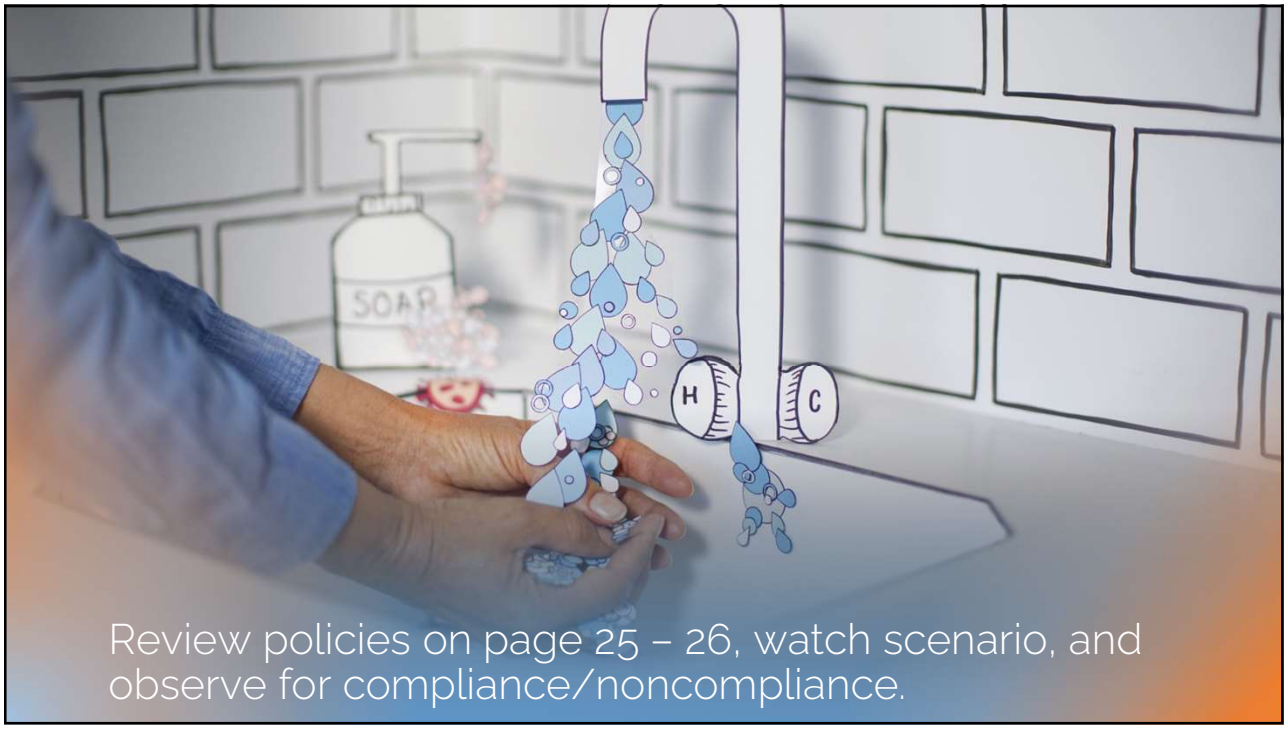
SOAP
H
C
Review policies on page 25 – 26, watch scenario, and observe for compliance/noncompliance.

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JBGS-Guest
logi

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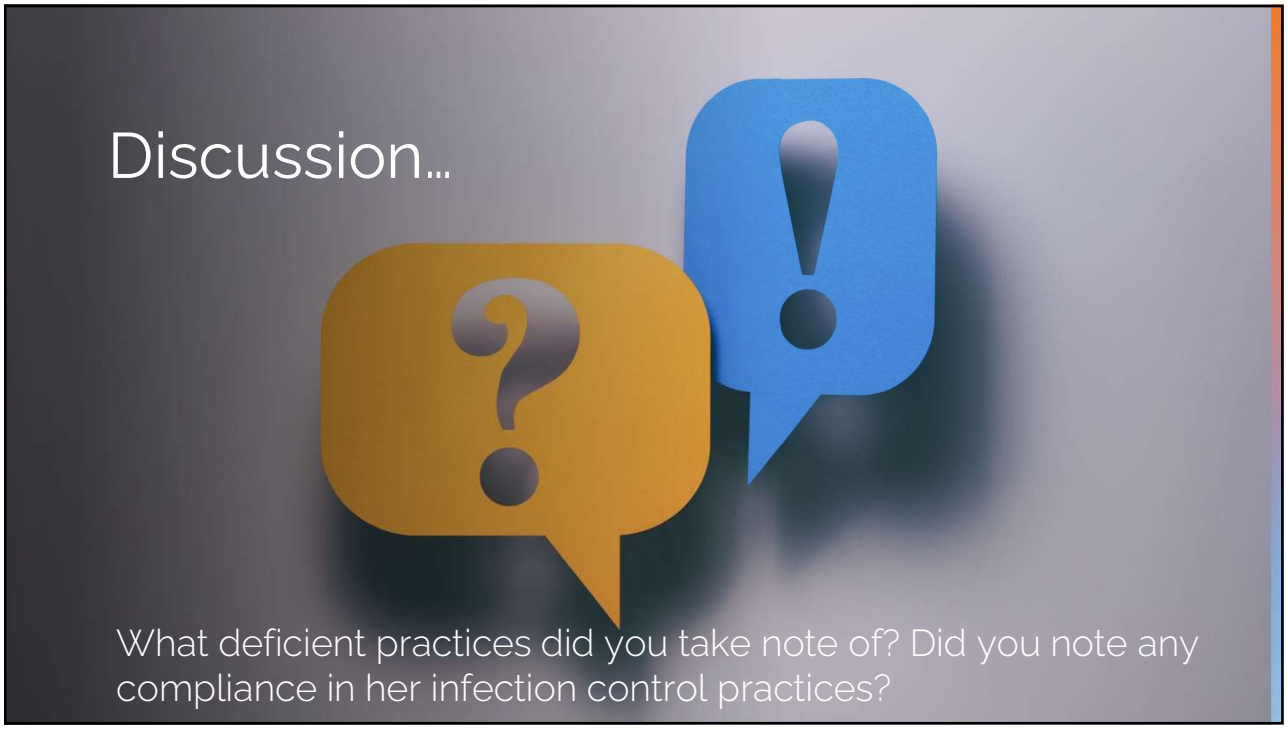

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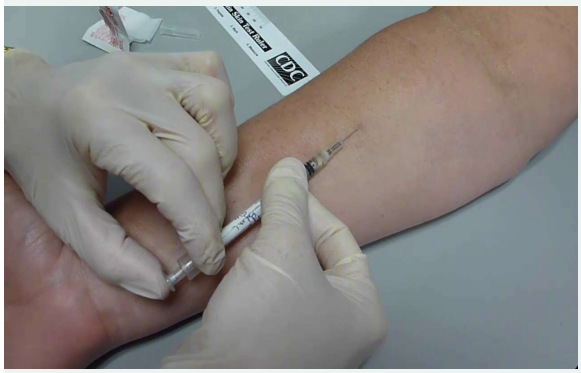
TB Screening

IPC.14 & HIPC 9.I
Home health/Hospice personnel at risk for occupational exposure to tuberculosis (TB), are screened and tested as defined in state or local law and regulation.

In the absence of state or local law and regulation, the screening and testing occurs per the Centers for Disease Control and Prevention (CDC) guidelines.

There is an appropriate follow-up when TB risk is identified.

CDC TB testing guidance



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2022 Top IPC Findings

Old Standard	New Standard	Content	CMS Tag
IPC.3.1.M1	IPC.6	Instances in which the use of hand hygiene is implemented (29%)	G 682
IPC.4.1.M1	IPC.8	Bags that carry equipment/supplies used consistent with policy (16%)	G 682
IPC 8.1	IPC.14	TB screening per state local regulation or CDC (11%)	G 684

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2022 Top HIPC Findings

Standard	Content	CMS Tag
HIPC 9.I	Addressing risk for occupational exposure to TB (35%)	NONE
HIPC 2.I	Appropriate use of standard precautions(19%)	L 579
HIPC.4.I	Bag Technique (12%)	NONE

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Tips for Success

Provide IC education to include hand hygiene & bag technique

Conduct observations in the field

Develop a TB screening program and know your state requirements

Ensure IC is a part of your QAPI program

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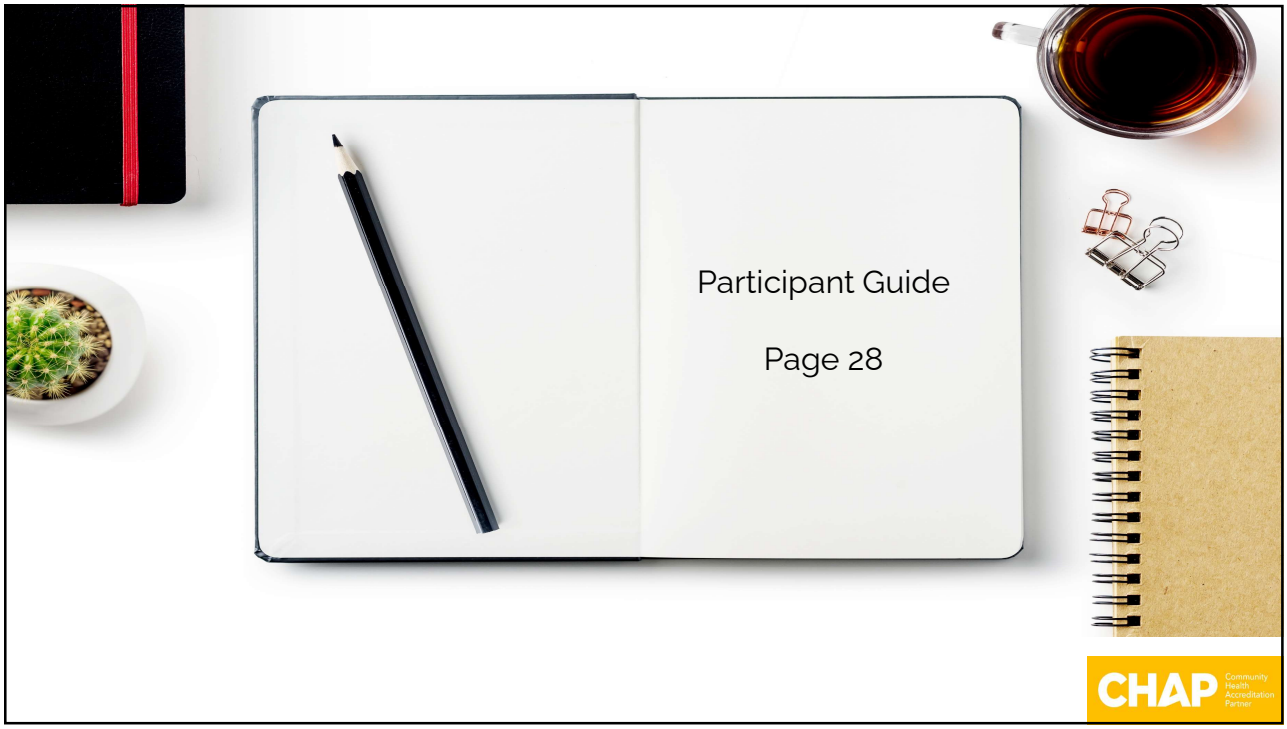

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Human Resource Management (HRM & HSRM)

KEY PERFORMANCE AREA

Home Health: Organizations ensure that their program is adequately staffed with personnel that possess the knowledge, skills, experience and motivation necessary to deliver safe, high quality, patient-centered care. Planning, oversight, and allocation of program resources reflect the organization's commitment to appropriate orientation, supervision, mentorship, continuous knowledge enhancement, and retention.

Hospice: Hospices ensure adequate staffing with personnel who have the knowledge, skills, and experience necessary to deliver safe, quality, patient-centered care to the population that the hospice serves. Resource allocation reflects the hospice's commitment to appropriate orientation, supervision, continuous knowledge enhancement, and retention of its workforce.

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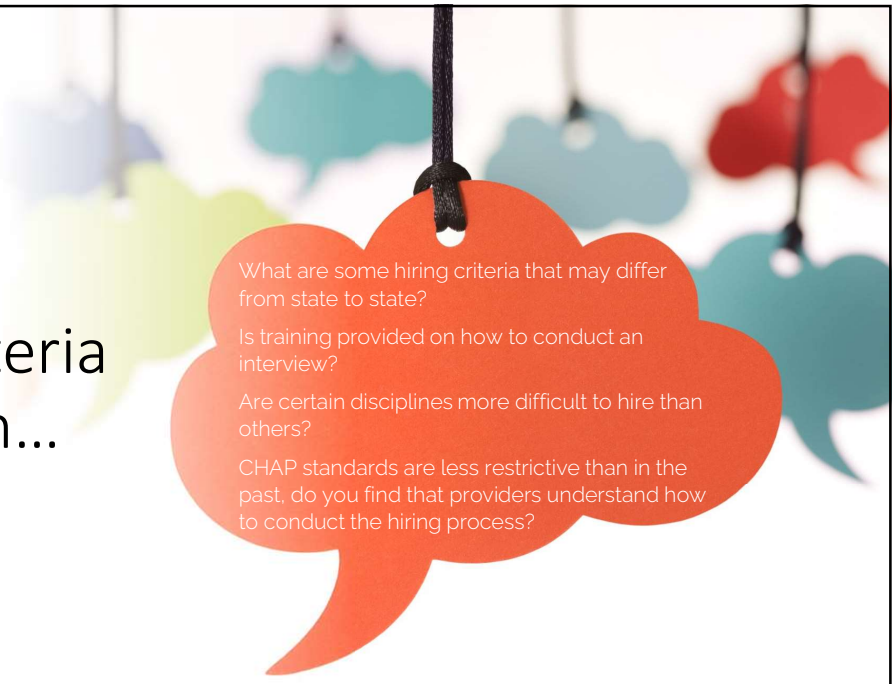
Hiring Criteria Discussion…



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Hiring Criteria: In Summary

Qualifications
Each professional complies with state board requirements based on discipline

Credentials & Licensure
Verified based on primary source

Personnel Policies
In place that support care delivery and comply with state, local, and federal law and reg.

Orientation, Competency Testing, & Performance Evaluation
Conducted and documented

Hiring Criteria
Personnel meet the criteria developed by the organization

Supervision
Personnel are supervised by appropriate staff

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HR File Checklist

HR File Components
Background Check (if required by policy and/or state reg)
Job Description(s)
Licensure/Certification/Education Verification
MD and/or NP Credentials (if applicable)
New Hire Orientation (if hired in last 3 years)
Initial Competencies (if hired in last 3 years)
Ongoing Competencies
Annual Education

HR File Components
Aide In-Services: 12 hours (if applicable)
Aide Annual Onsite Visits (if applicable)
Performance Evaluation
Driver License (if driving for org)
CPR (if applicable)
Annual Physical Exam (if required by policy and/or state reg)
TB testing
Hep B

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Nurse Practitioner

Scope of Practice

Full Practice
- Evaluate
- Diagnose
- Manage treatment
- Prescribe medications

Reduced Practice
- Reduces
- At least one element of NP practice
- Requires
- Collaborative agreement

Restricted Practice
- Restricts
- At least one element of NP practice
- State requires supervision, delegation, or team-management

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Competency Assessment HRM.11 & HSRM 14.I

HRM.11
Personnel providing patient care or services demonstrate competency in the performance of their assigned duties. Competency assessments are documented with date, name of personnel, topic, and record of satisfactory performance.

HSRM 14.I
The hospice assesses the skills and competencies of all individuals providing care, **including volunteers** providing services and, as necessary, provides in-service training and education programs where required.

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2022 Top HRM Findings

Old Standard	New Standard	Content	CMS Tag
HRM.3.I	HRM.1	Personnel meeting the organization's hiring criteria (34%)	G848
HRM.10.I	HRM.22	Personnel are evaluated per organizational policy (14%)	N/A
HRM.7.I	HRM.11	Personnel demonstrate competency (12%)	G702 (skilled) G764, G768, G772 (aides)

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2022 Top HSRM Findings

Standard	Content	CMS Tag
HSRM 16.I	Requirement for criminal background checks (22%)	L 795
HSRM 2.D	Requirements for hire and organizational chart (19%)	NONE
HSRM 14.I	The skills of all individuals providing care are assessed (14%)	L663

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Tips for Success

Ensure hiring criteria is followed

Be familiar with state specific requirements

Conduct competency assessments on hire and ongoing

Personnel file checklists are helpful to ensure compliance

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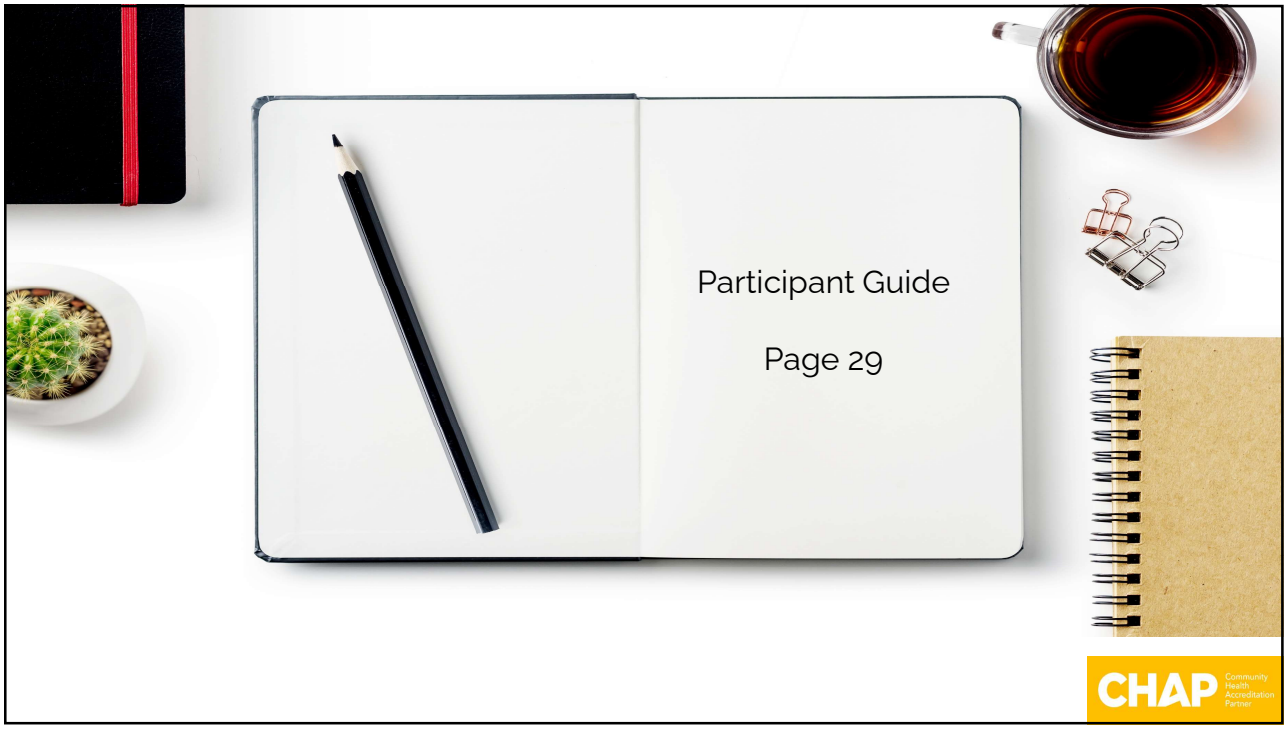

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Home Health Continuous Quality Improvement (CQI)

Hospice Quality Assurance & Performance Improvement (HQPI)

KEY PERFORMANCE AREA

Home Health: Organizations implement and maintain an agency-wide Continuous Quality Improvement Program that objectively and systematically measures, monitors and assesses program operations and leads to measurable improvements in agency defined goals in the areas of patient safety, outcomes, care delivery, and operations.

Hospice: A hospice maintains a Quality Assurance and Performance Improvement (QAPI) program. The QAPI program is a proactive, data-driven process to improve organizational performance and patient/family care

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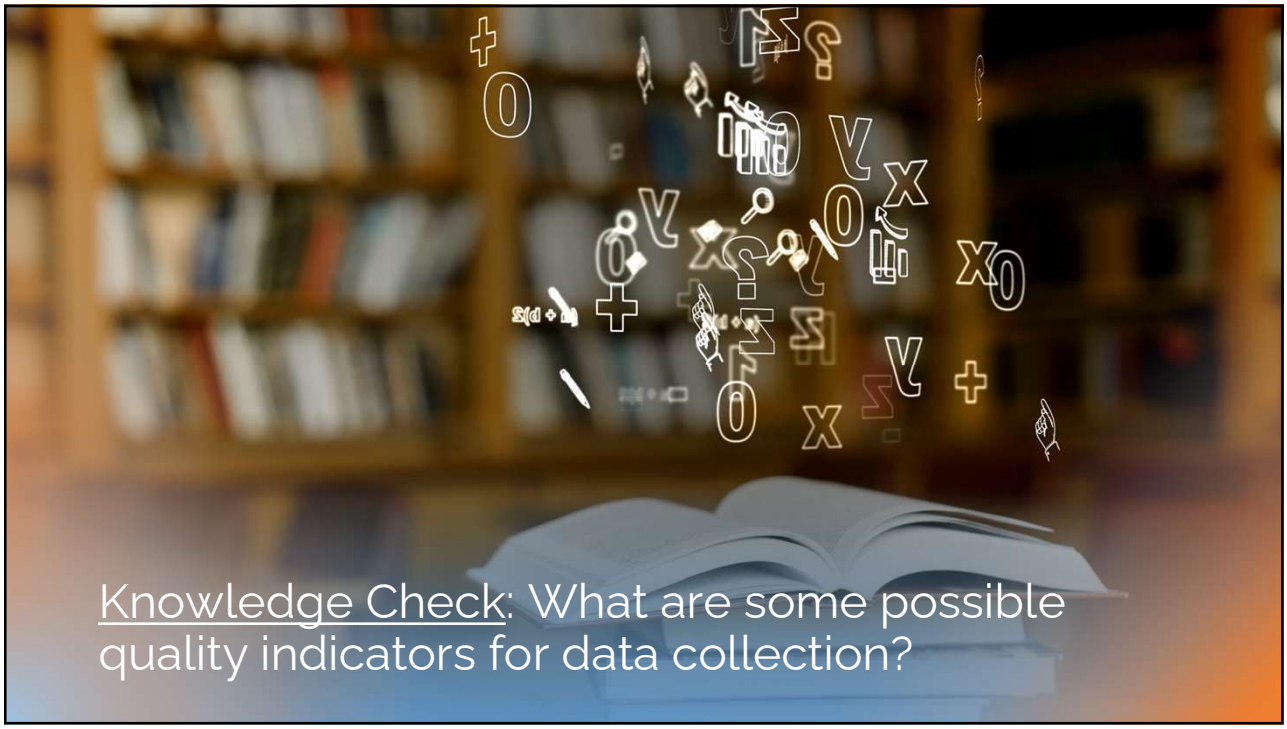

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QAPI Standard Summary

- Governing body involvement; agency wide, data driven; reflects complexity of organization and services
- Types of data collection
- Analysis of data
- Action taken
- Annual performance improvement project requirements
- Sustainability

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Components of Your Improvement Plan

When developing your improvement plan, keep the following components in mind to address within your plan.

Start by identifying your **Goal** – what do you want to achieve and what is your desired percentage of compliance

Plan

What actions will be planned.
Who will be responsible.

Do

Timeframe for implementation of the plan. May have several actions to take at different times.

Check

How will you evaluate the effectiveness of the actions taken?
Examples: observation, record review

Act

What steps will be taken if you reach your goal?
What steps will be taken if you do not reach your goal?

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What is an example of a Performance Improvement Project you implemented recently?

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Quality Activity

Each group is to:

Choose one individual to report out

Identify a SMART goal – specific, measurable, attainable, relevant, time-based

Determine the PLAN for implementation to address the deficient practices

Define ACTIONS to be taken

Define How MONITORING will be done and when

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Thoughts to Consider…
How extensive is the non-compliance?
Does the non-compliance affect quality of patient care?
Is one clinician involved or several? New or tenured?
Does the organization have the resources to address the issue?

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Quality Activity
Breakout Room – 1 (1 person to report out)
Scenario – Freestanding Organization recently had a first renewal site visit conducted. Active patient census is 75.
Agency Support
• Administrator – nonclinical
• Clinical Manager with the following oversight responsibilities:
• Quality Improvement
• Education
• Orientation
• Supervision
Improvement Needed – In the renewal site visit, 11 of 11 records reviewed revealed deficiencies such as medication profiles not kept current or not present, medication reconciliation not conducted with changes in medication, and no over-the-counter medications identified.

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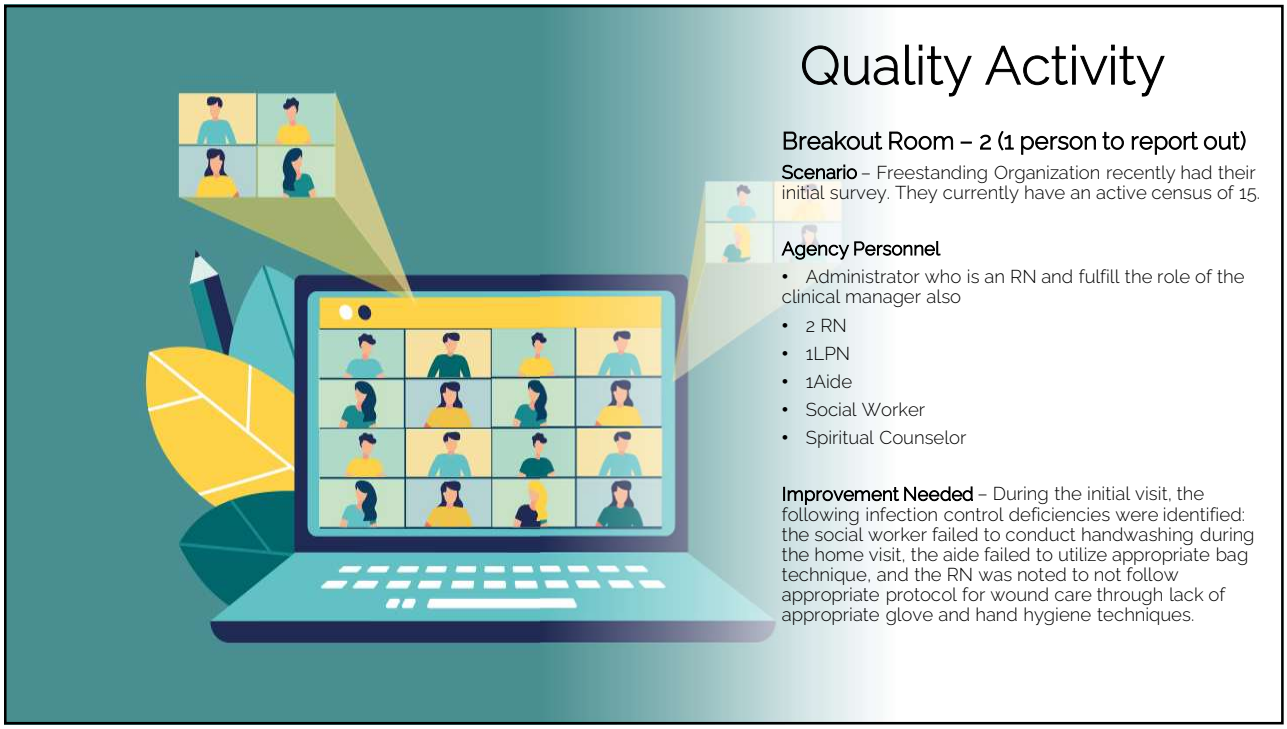
Quality Activity
Breakout Room – 2 (1 person to report out)
Scenario – Freestanding Organization recently had their initial survey. They currently have an active census of 15.
Agency Personnel
• Administrator who is an RN and fulfill the role of the clinical manager also
• 2 RN
• 1LPN
• 1Aide
• Social Worker
• Spiritual Counselor
Improvement Needed – During the initial visit, the following infection control deficiencies were identified: the social worker failed to conduct handwashing during the home visit, the aide failed to utilize appropriate bag technique, and the RN was noted to not follow appropriate protocol for wound care through lack of appropriate glove and hand hygiene techniques.

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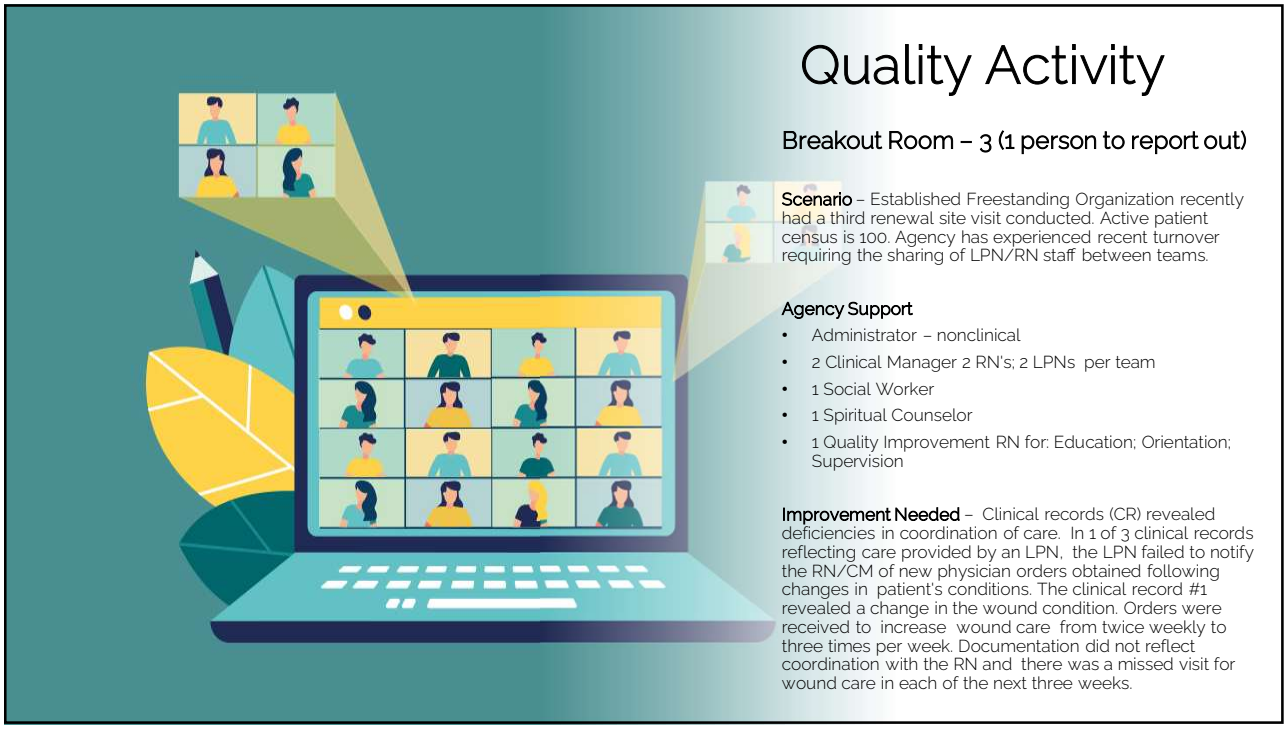
Quality Activity
Breakout Room – 3 (1 person to report out)
Scenario – Established Freestanding Organization recently had a third renewal site visit conducted. Active patient census is 100. Agency has experienced recent turnover requiring the sharing of LPN/RN staff between teams.
Agency Support
• Administrator – nonclinical
• 2 Clinical Manager 2 RN's; 2 LPNs per team
• 1 Social Worker
• 1 Spiritual Counselor
• 1 Quality Improvement RN for: Education; Orientation; Supervision
Improvement Needed – Clinical records (CR) revealed deficiencies in coordination of care. In 1 of 3 clinical records reflecting care provided by an LPN, the LPN failed to notify the RN/CM of new physician orders obtained following changes in patient's conditions. The clinical record #1 revealed a change in the wound condition. Orders were received to increase wound care from twice weekly to three times per week. Documentation did not reflect coordination with the RN and there was a missed visit for wound care in each of the next three weeks.

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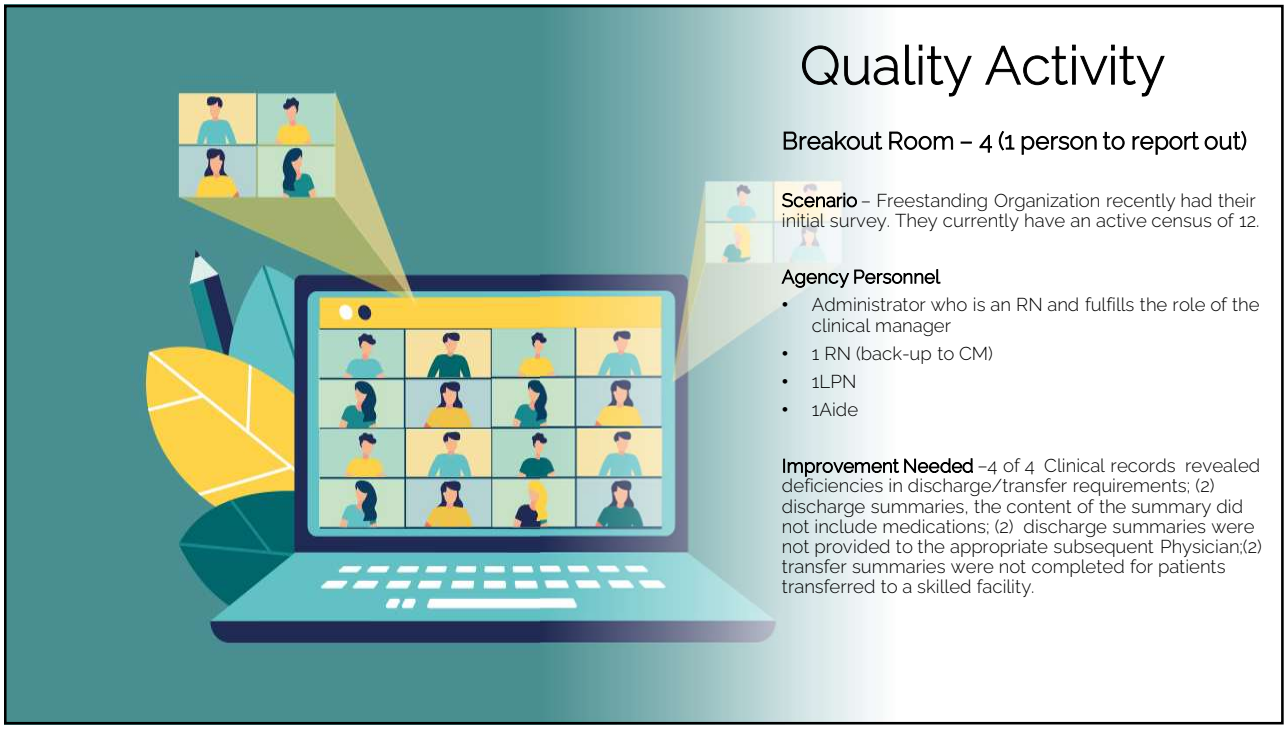
Quality Activity
Breakout Room – 4 (1 person to report out)
Scenario – Freestanding Organization recently had their initial survey. They currently have an active census of 12.
Agency Personnel
• Administrator who is an RN and fulfills the role of the clinical manager
• 1 RN (back-up to CM)
• 1LPN
• 1Aide
Improvement Needed –4 of 4 Clinical records revealed deficiencies in discharge/transfer requirements; (2) discharge summaries, the content of the summary did not include medications; (2) discharge summaries were not provided to the appropriate subsequent Physician;(2) transfer summaries were not completed for patients transferred to a skilled facility.

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Quality Activity
Breakout Room – 5 (1 person to report out)
Scenario – An established organization with a census of 50, is receiving their first renewal site visit.
Agency Personnel
• Administrator who is not an RN
• 1 RN Clinical Manager and 1 full-time I RN
• 2 LPN
• 1Aide
• 1Social worker
• 1 Spiritual Counselor
Improvement Needed – The patient was admitted to the Hospice on Thursday. The agency provided the medications for pain and anxiety management, but the daughter (primary caregiver) was not present and was not instructed on the use of the new medications. At the nursing visit, three days later, the patient was found to be extremely agitated and yelling. When the RN asked the daughter what medication she had given, she said she didn't know what to give.

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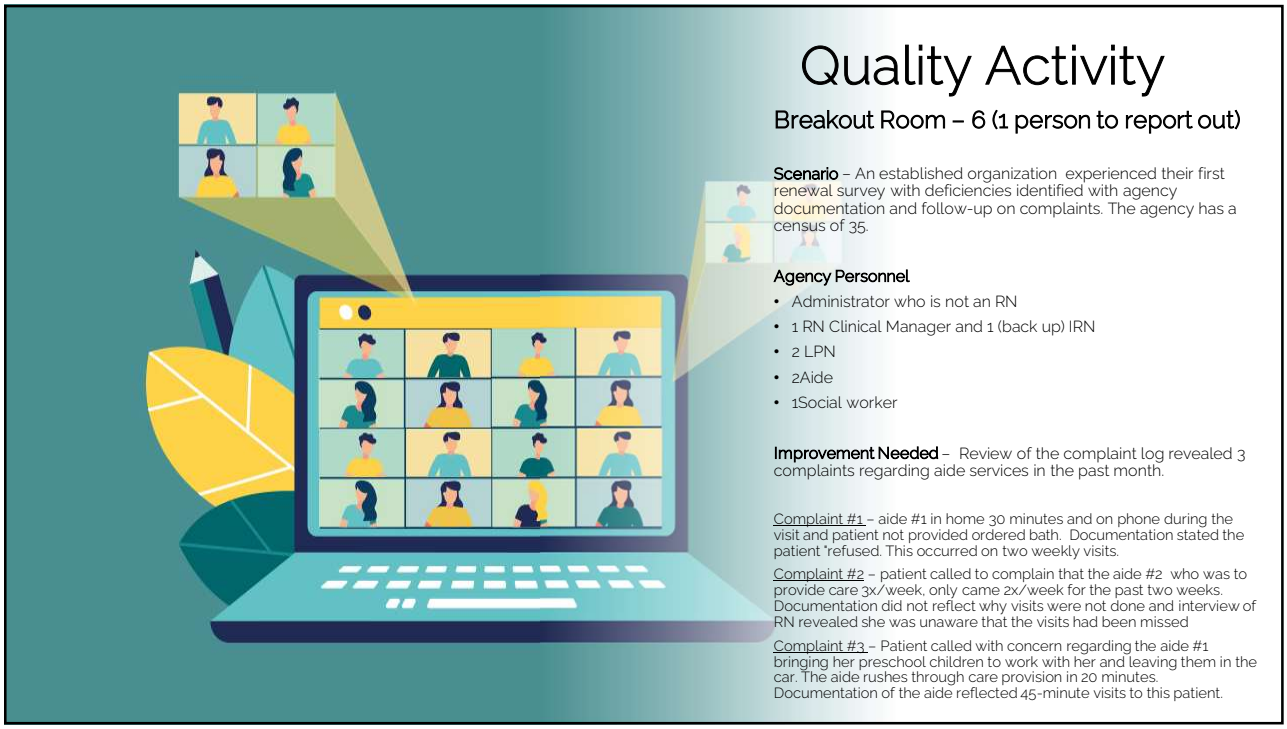

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2022 Top CQI Findings

Old Standard	New Standard	Content	CMS Tag
CQI.1.I.M2	CQI.2	Skilled professionals participate in CQI (26%)	G720
CQI.5.I.M1	CQI.6	Performance Improvement projects are conducted annually. (18%)	G658
CQI.2.D.M1	CQI.3	Quality indicators include measures from OASIS (11%)	G644
CQI.3.I.M2	CQI.8	CQI activities include measurement, analysis, and tracking of quality indicators (11%)	G642
CQI.5.I.M2	CQI.7	PI projects are documented with measurable progress achieved (11%)	G658

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2022 Top HQPI Findings

Standard	Content	CMS Tag
HQPI 7.1	PI activities include tracking & analysis of adverse events and implementing preventative actions (23%)	L569
HQPI 2.1	Appointed individual is responsible for QAPI program (15%)	L 576
HQPI 3.1	Program demonstrates measurable improvements (15%)	L561
HQPI 5.1	Use of quality indicator data (11%)	L564
HQPI 8.1	Action is taken, success measured, and positive results sustained (11%)	L 570

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Tips for Success

Ensure your quality improvement program is agency-wide

Data is tracked & trended to identify opportunities for improvement

Ensure involvement from various disciplines

Utilize a template for QAPI data collection, analysis, & actions taken

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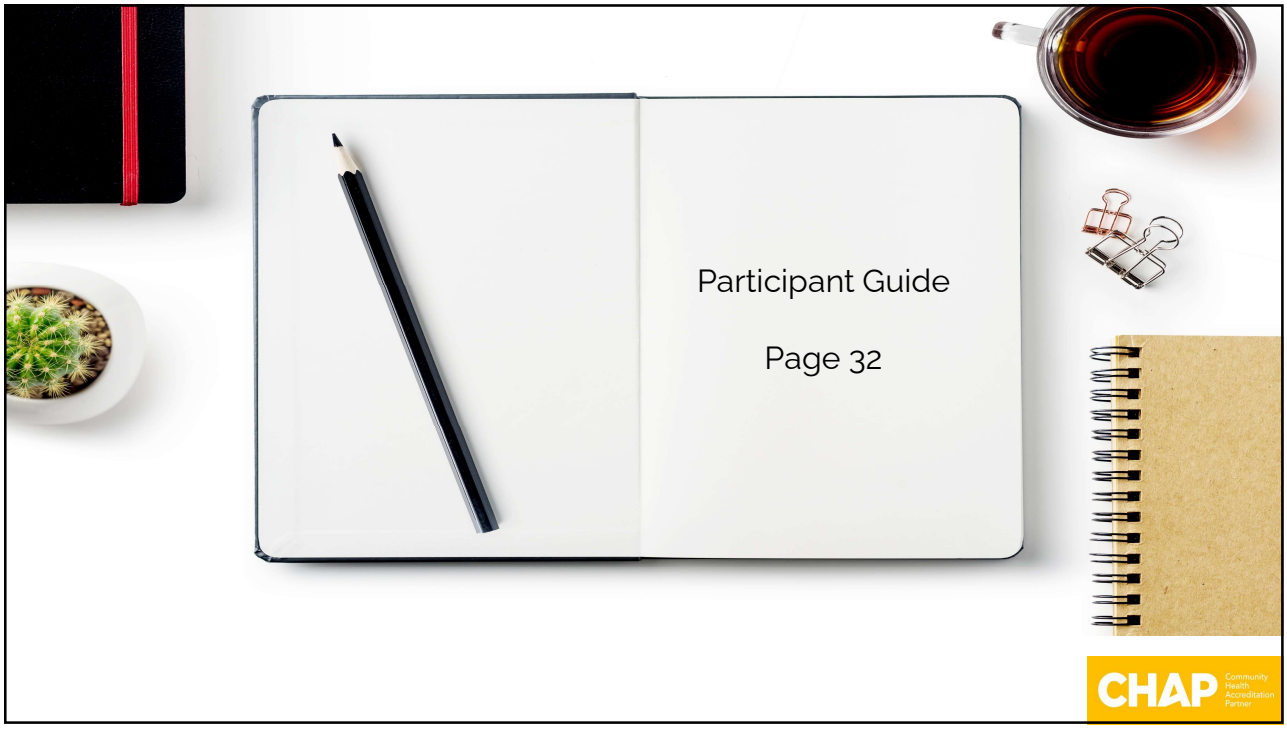
Participant Guide
Page 32
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Emergency Preparedness (EP & HSEP)

KEY PERFORMANCE AREA

Home Health: Organizations prepare for emergent events through continuous cycles of planning, organizing, equipping, training, evaluating, and taking necessary corrective actions to ensure an effective, coordinated response should such events occur. Before, during and after emergent events, organizations prioritize the safety of patients, caregivers, families, and personnel to minimize interruptions to the delivery of care and services.

Hospice: Hospices prepare for emergency events through planning, organizing, training, evaluating, and taking necessary corrective actions to ensure an effective, coordinated response when such events occur. The goal of emergency preparedness (EP) is to prioritize the safety of patients, caregivers, families, and hospice staff to minimize interruptions to the delivery of care and services.

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Emergency Preparedness Program

- Utilizes an all-hazard approach
- Documents a facility and community-based risk assessment
- Includes strategies to address emergency events identified
- Is reviewed and updated every two years
- Addresses patient population
- Includes a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency officials for an integrated response

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Emergency Preparedness

Policies and Procedures are based on the emergency plan, risk assessment, and the communication plan. The are updated at least every 2 years.

Policies and Procedures Address:

- Patient emergency plan
- In comprehensive assessment
- Inform officials of evacuation needs
- Determine staff and patient needs
- Medical documentation
- Staffing strategies

Policies

Procedures

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Communication Plan

Complies with local, state, and federal requirements

Reviewed, and revised if needed

Every 2 Years

Includes name and contact information

Primary and alternate means of communication

Sharing information

- Condition & location of patients
- Facility's occupancy needs
- Facility's ability to assist

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Emergency Preparedness Training

Should occur during orientation, when the plan is revised, and every 2 years

- Utilizes an all-hazard approach
- Documents a facility and community-based risk assessment
- Includes strategies to address emergency events identified
- Is reviewed and updated **every two years**
- Addresses patient population
- Includes a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency officials for an integrated response

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Testing of the Plan

Annual testing is to be conducted

Full-scale, community-based exercise every 2 years
OR
Facility-based functional every two years if full-scale not available

If an actual event occurs requiring activation of the plan, the agency is exempt from the next required community-based facility based functional exercise.

Additional exercise every 2 years, opposite the full-scale or functional exercise

A second full scale OR

Mock-disaster drill OR

Tabletop exercise or workshop

Analysis of the response and documentation is required

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Integrated
Healthcare
Systems

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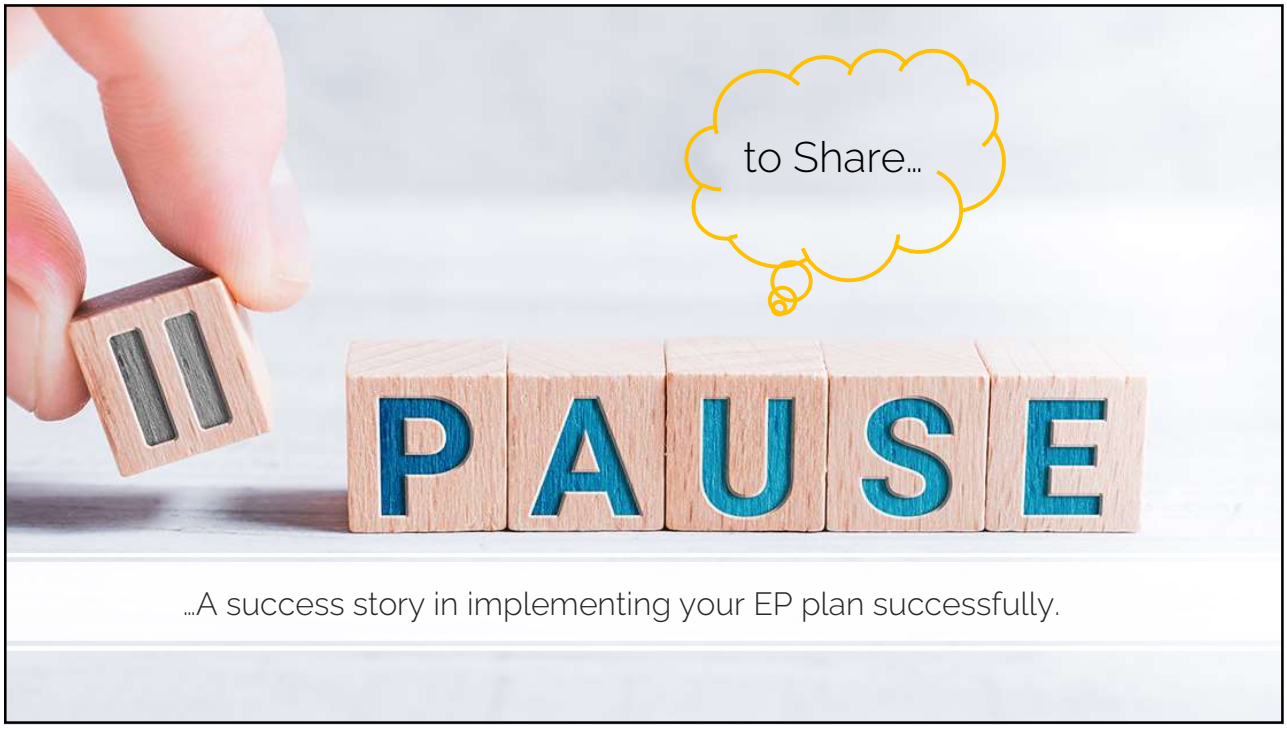
to Share…
PAUSE
…A success story in implementing your EP plan successfully.

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2022 Top EP Findings

New Standard	Old Standard	Content	CMS Tag
EP.1.D.M1	EP.2	Elements of the Emergency Plan (24%)	E0006
EP.1.D.M3	EP.3	Communication Plan required elements (19%)	E0031
EP.3.D.M1	EP.7	Training program based on EP plan/risk assessment/policies (19%)	E0037
EP.4.I.M2	EP.9	Organization conducts exercises to test EP plan (17%)	E0039
EP.2.D.M1	EP.6	Required policies and procedures, based on plan, risk assessment and communication plan (15%)	E0017

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2022 Top HSEP Findings

Standard	Content	CMS Tag
HSEP 3.D	Required policies and procedures of the emergency plan (58%)	E13 E16
HSEP 5.D	Elements and updating of the EP training program (33%)	E37
HSEP 2.D	Emergency plan is reviewed and updated every two years (6%)	E6, E7

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HELPFUL TIPS
Tips for Success
Develop a checklist/audit tool to ensure all elements of the EP plan are in place
Keep staff and patient lists updated on an ongoing basis
Validate contact information for emergency officials
Ensure plan is revised as needs change based on exercises conducted or actual events
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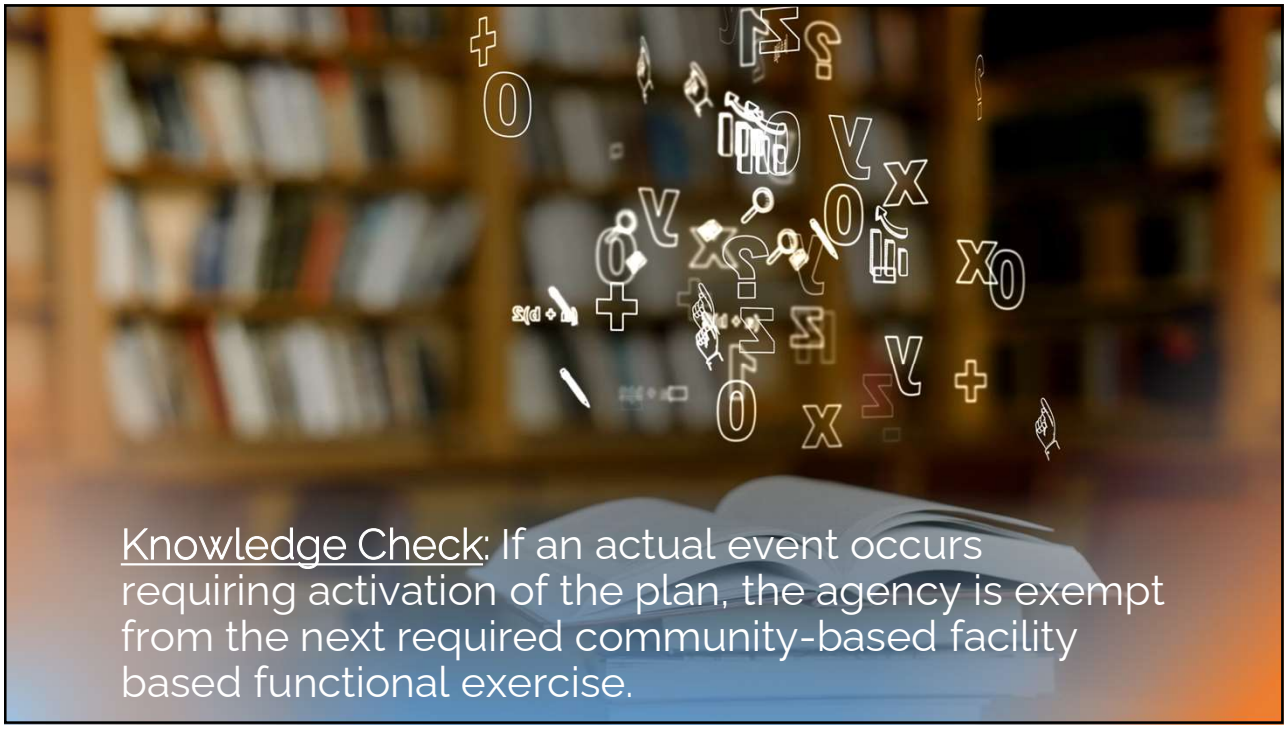
Knowledge Check: If an actual event occurs requiring activation of the plan, the agency is exempt from the next required community-based facility based functional exercise.

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The CHAP Consultant

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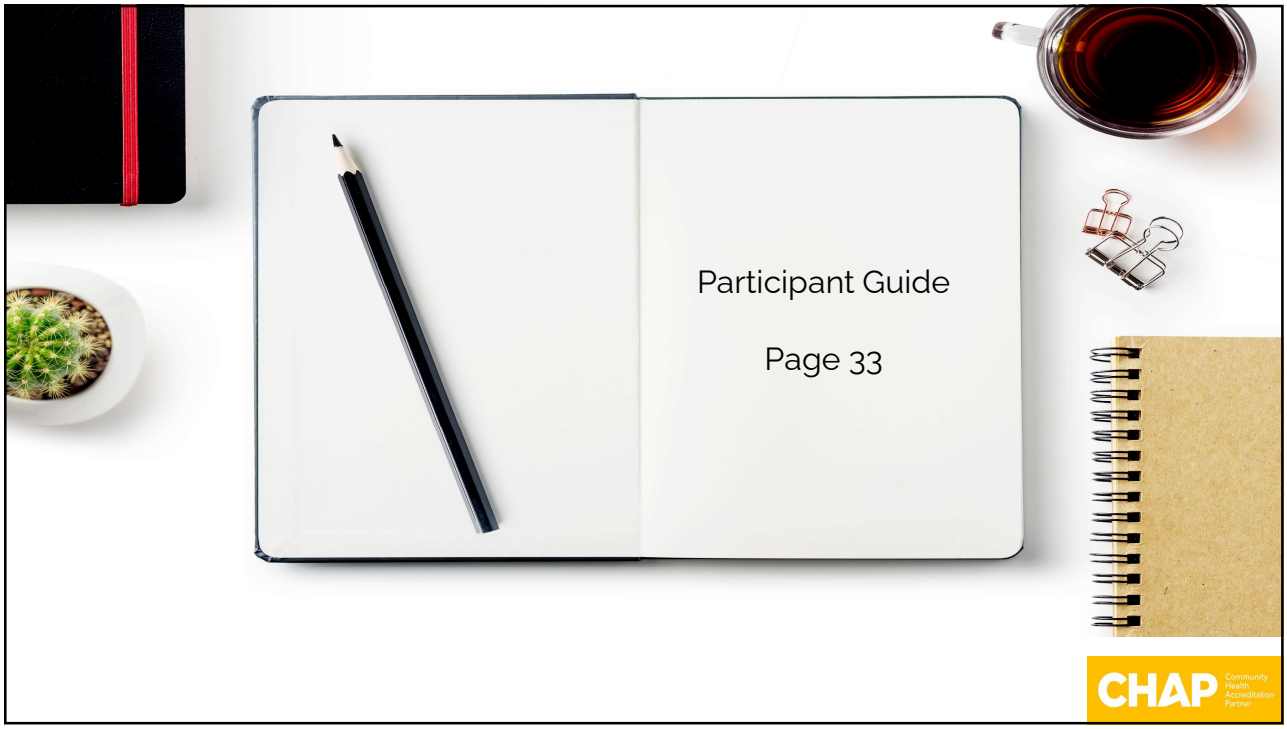
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CHAP Partnership

Organizational

- 6 Accreditation Specialists divided by geographic territory
- 1 Manager of Accreditation Operations
- 1 Senior Scheduling Manager
- 1 Readiness Specialist
- 1 Vice President of Customer Relations

Accreditation Specialists deliver timely and responsive customer support to organizations seeking initial and continuing accreditation.

Clinical

- 5 Directors of Accreditation divided by geographic territory
- 4 Senior Accreditation Managers
- 1 Vice President of Accreditation

Directors of Accreditation (DA) are responsible for ensuring consistent application of accreditation standards including agency plan of correction/action plan to address findings, site visitor selection and retention, and the satisfaction of our accredited organizations.

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Steps to Accreditation

1 2 3 4

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Site Visit Preparation

CHAP Preparation Resources

- Document Request list
- Policy list
- Top Ten Findings per the service line
- Optional self study

Mock Record Review

- Multi-discipline; IDG
- High acuity interventions; level of care changes
- Using quality results
- Consider additions of new services

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CHAP Home Health Resource

Home Health Document Request List

Note: This is a guideline. Additional information to include State specific requirements (as applicable) may be requested at any time during the site visit.

*Denotes policies/documents to be provided within first 2 hours of site visitor arrival

Standard(s)	Item	Comment(s)
	General Documents and Information	
	*Billing Week	(IE: Week starts Sunday or Monday per agency)
	*Scope of Practice	
NA	*Unduplicated Admissions	Patients served for the past 12 months
NA	*List of Active Patients	Include SOC, Dx, Services provided
NA	*List of Discharged Patients	Termed within the last 30 - 60 days
NA	*Current Visit Schedule	
NA	List of Personnel - Active/Termed	Include DOH, Position/Discipline
LG.14	All Contracts	List of Contract Staff and Interpretive Services
	Sample Admission Packet	Include language specific documents
	Quality Documents	
PCC.9; CQI.5	Complaint logs/On-call logs	
CQI.4; CQI.5; CQI.8	Performance Improvement Projects/Activity	Quality Indicator Tracking Data; iQIES Reports including OASIS Submission Error Summary by Agency; Outcome/Process Measures, Potentially Avoidable Events; Agency Reports: Adverse Events; Clinical Record Review; Patient Satisfaction Surveys; Infection Control Surveillance Documentation
	Most Recent Survey Results	From local, State, or federal agency
CQI.7	QAPI Meeting Minutes (QAPI Documentation)	

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CHAP Hospice Resource

Hospice Document Request List

Note: This is a guideline. Additional information to include State specific requirements (as applicable) may be requested at any time during the site visit.

* Denotes policies/documents to be provided within the first 1**-2* hours of the site visitor arrival

Standard (s)	Document Type(s)	Comments
	General Documents/ Information	
NA	A computer terminal if on an EMR	Identify a driver
NA	*Billing Week	(IE: Week starts Sunday or Monday per agency policy)
NA	*Scope of Practice	Core Services and Levels of Care (Any applicable Waivers)
NA	*Unduplicated Admission	Patients served for the past 12 months, All Payor Sources and Locations
NA	List of all Hospice Locations	Including Addresses
NA	*Current Home Visit Schedule	For all Locations
NA	Staffing Schedules	Provide for the week for all locations
NA	*List of Active Patients	Include EOB, Dx, Services Provided, location of care, current LOC, All Payor Sources and Locations
NA	*List of Discharged Patients	Discharged within the last 12 months, Live and Death (with Bereavement activities)
NA	List of Active Personnel	Include Date of Hire, Position/Discipline, Medical Director, Volunteer, All Staff under contract
	**CMS Form 417/643	**To be returned within one hour**
HCPC 2.D	IDG	Schedule and Location, location of meeting minutes
HPFC 2.D	*Sample Admission Packet	Include language specific documents
	Quality Documents	
HQPI 8.I HCDT.30.I, HSLG.9.I	Complaint log/On-call logs	Include complaints, investigations, and outcomes for the last 12 months
HQPI 1.D	QAPI Program Activities	Quality Indicator Tracking Data;
HQPI 9.I, HQPI 8.I	QAPI Performance Improvement Projects	PEPPER Reports; HIS Reports; Clinical Record Review; Patient Satisfaction Surveys; Adverse Events; Infection Control Surveillance, CASPER Reports
HIPC 8.I, HQPI 5.I,	Infection Control Activities	

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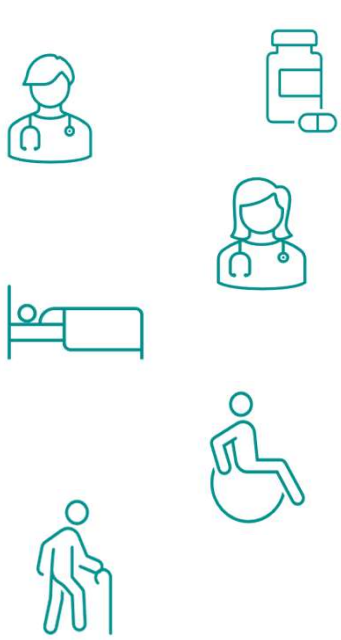
Site Visit Readiness Requirements by Service Line

Copy of state license(s), if required by state

Service Line	Required Census	Recommendation for Record Reviews
Home Health	10 skilled patients served At least 7 skilled patients active at time of site visit	Copy of 855A approval letter
Hospice	5 served 3 active required at time of site visit	Copy of 855A approval letter
HME / DMEPOS	[illegible] time of site visit	
Home Care	5 served 3 active required at time of site visit	
Palliative Care	5 served 3 active required at time of site visit	
Home Infusion Therapy	5 served 3 active required at time of site visit	
Pharmacy	No active patients required at time of site visit	



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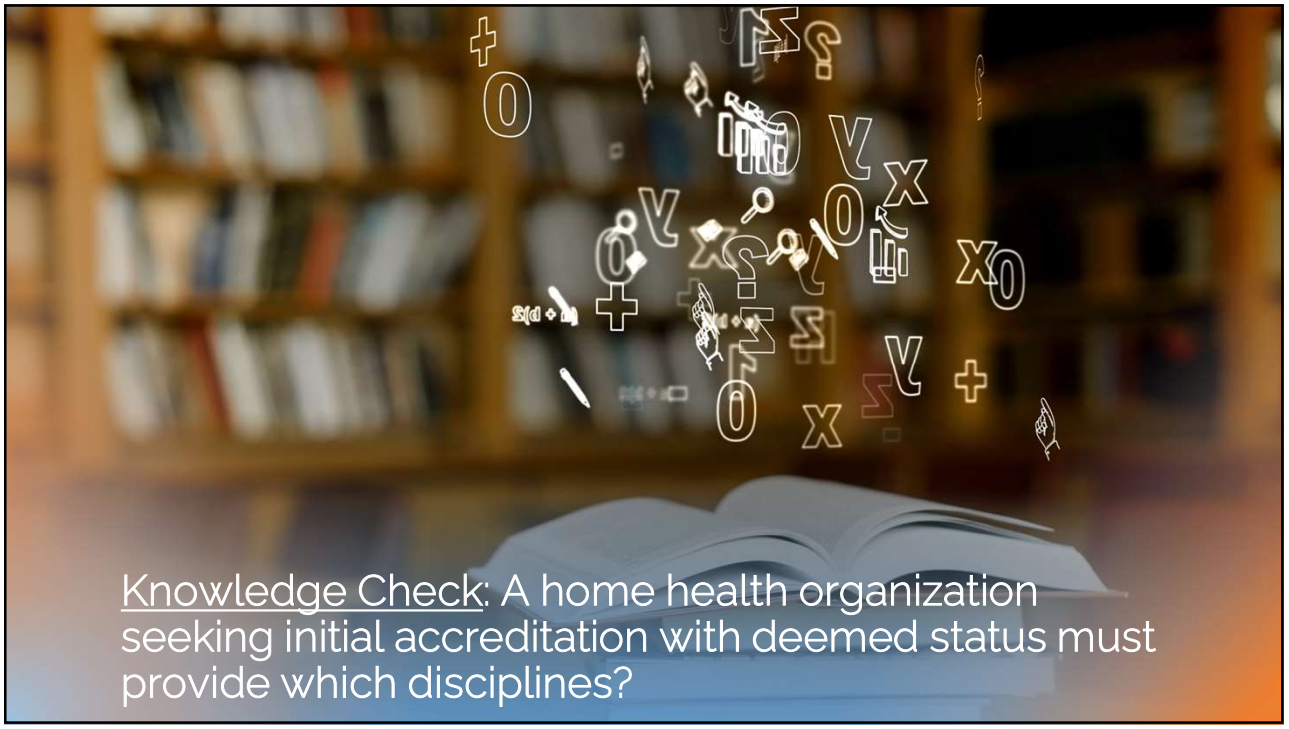

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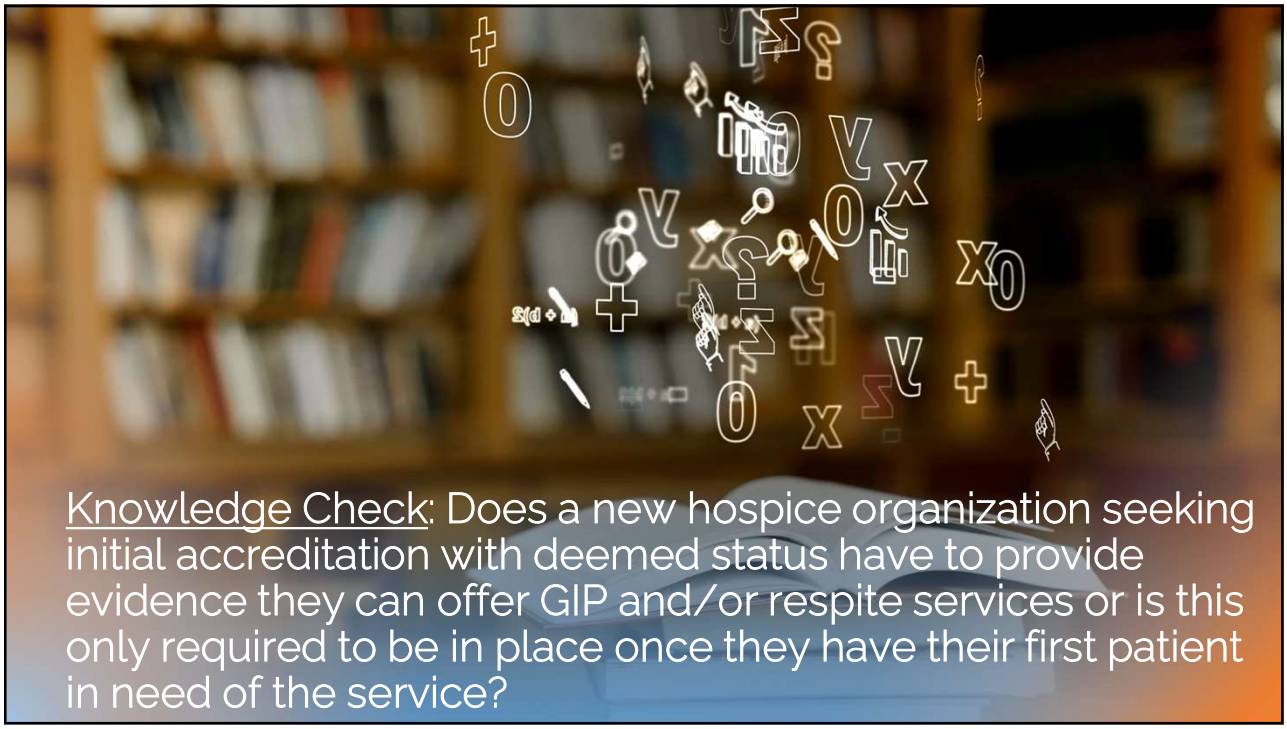

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Timing to Prepare

Preparation for a site visit should be continuous!

Initial Organizations

- Visit in 1-90 days of readiness submission
- Our goal – 30 days
- Unannounced site visit
- Only hit submit button when ready!!

Renewal Organizations

- Visit in 32-36 months of prior comprehensive visit
- Review of entire Accreditation cycle

Focus Visits

- Verification of Implementation of the Plan of Correction
- Expansion of coverage area (i.e., another state)
- Addition of service or product
- Complaint
- Change of Ownership

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Site Visit Readiness Requirements

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Site Visit Readiness Requirements by Service Line for agencies seeking Initial Accreditation | STEP 2

Service Line	Required Documents	Required Census	Deemed Status Requirements
Home Health	• Copy of state license(s), if required by state	• 10 served • 7 active at time of survey	Copy of approved 855A letter and OASIS test transmission with final validation report
Hospice	• Copy of state license(s), if required by state	• 5 served • 3 active at time of survey	Copy of approved 855A letter
Home Medical Equipment (HME/DMEPOS)	• Copy of state license(s), if required by state	• 5 served (sale or rental) • No active patients required at time of survey	
Private Duty	• Copy of state license(s), if required by state	• 5 served • 3 active at time of survey	
Pharmacy	• Copy of state license(s), if required by state	• 5 served (sale or rental) • No active patients required at time of survey	
Infusion Therapy Nursing	• Copy of state license(s), if required by state	• 5 served • 3 active at time of survey	
Palliative Care	• Copy of state license(s), if required by state	• 5 served • 3 active at time of visit	

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Per CMS:
as of July 2023, blackout dates and morning notification of the site visit are no longer being conducted for deemed agencies

Readiness Submission
And Then?

- Readiness Call
- Accepting Readiness
- Scheduling Site Visit
  - Only organizations seeking initial accreditation submit readiness

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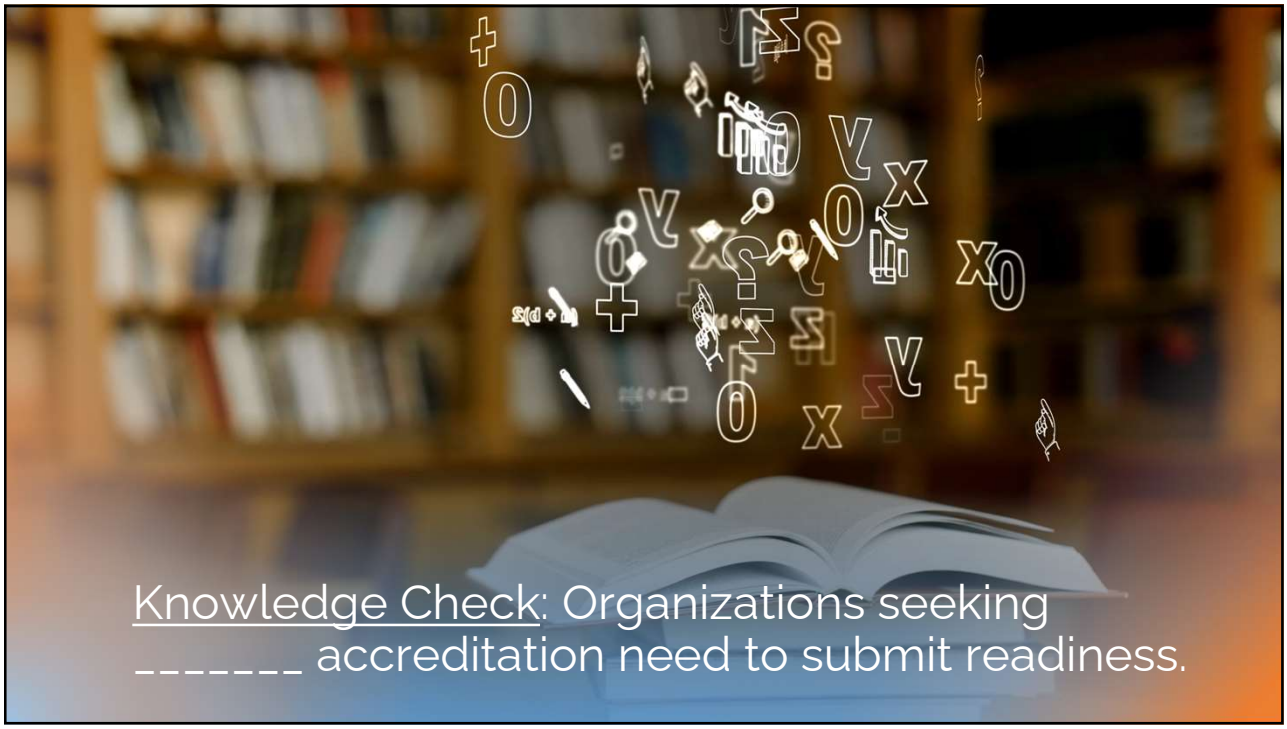

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Renewal & Focus Visits

Renewal Site Visit

A site visit to assess continued compliance with the CHAP Standards of Excellence and the Centers for Medicare & Medicaid Services conditions of participation, if applicable. For organizations undergoing their first renewal site visit with CHAP (i.e., their last full accreditation survey was an initial survey), the site visit is conducted within 32 to 36 months of the last day of their last comprehensive visit. The term "renewal" is used interchangeably with "reaccreditation".

Focus Visit

A visit conducted for specific reasons between two comprehensive visits.

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Types of Focus Visits

Verification of implementation of the Plan of Correction
Board of Review determines the need for this type of focus visit. Conducted in relation to the scope and severity of the findings and potential impact on the safety of the patient and/or quality of care provision

Complaint
Focus visits for a complaint are determined by a CHAP team comprised of membership from CHAP Quality Department, CHAP leadership and the Directors of Accreditation

Addition of Services
The addition of a specialty service requires a focus visit to determine compliance with the applicable CHAP standards, and state and federal regulation.

Change of Ownership
Purpose is to ensure that the new ownership is capable of continuing compliance with the CHAP Standards of Excellence.

Addition of Location
Purpose is to verify the new location opening and compliance with CHAP standards and state and federal regulation.

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Home Health Renewal Visit Criteria

# of unduplicated admissions (past 12 Months)	Active Patient Sample – Record Review Only (No Home Visit)	Active Patient Sample – Record Review with Home Visit	Discharged Patients: Closed Record Review	Total Survey Sample
<300	2	3	2	7
307-500	3	4	3	10
501-700	4	5	4	13
701 or more	5	7	5	17

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Hospice Renewal Visit Criteria

# of unduplicated admissions (past 12 Months)	Closed Records (Live Discharges)	Closed Records (Bereavement Records)	Record Review – No Home Visit (RR-NHV)	Record Review with Home Visit (RR-HV)	Total Minimum Sample	Inclusion of Records from Multiple Location(s)
<150	2	2	7	3	14	The number of records from each multiple location should be proportionate. Include at least one RR-NHV or RR-HV from each location.
150-750	2	3	10	4	19	
751-1250	2	3	12	6	23	
1250 or more	3	4	14	6	27	

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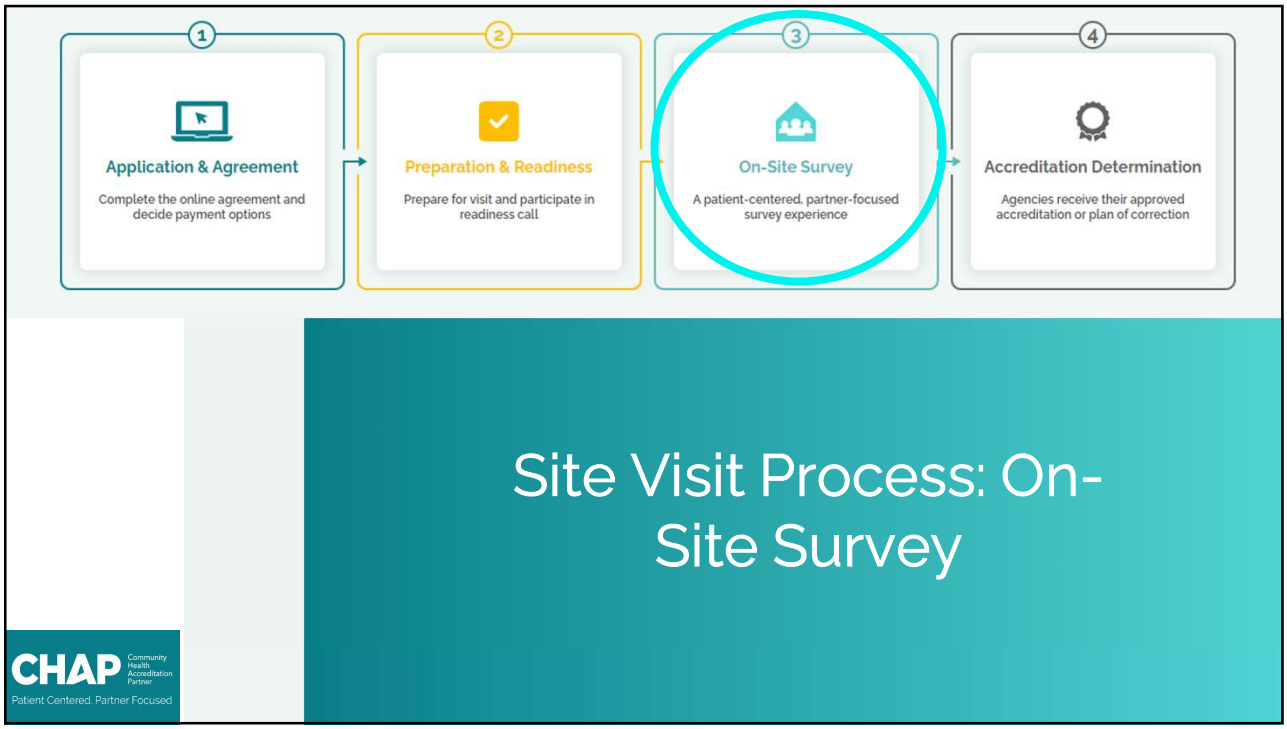
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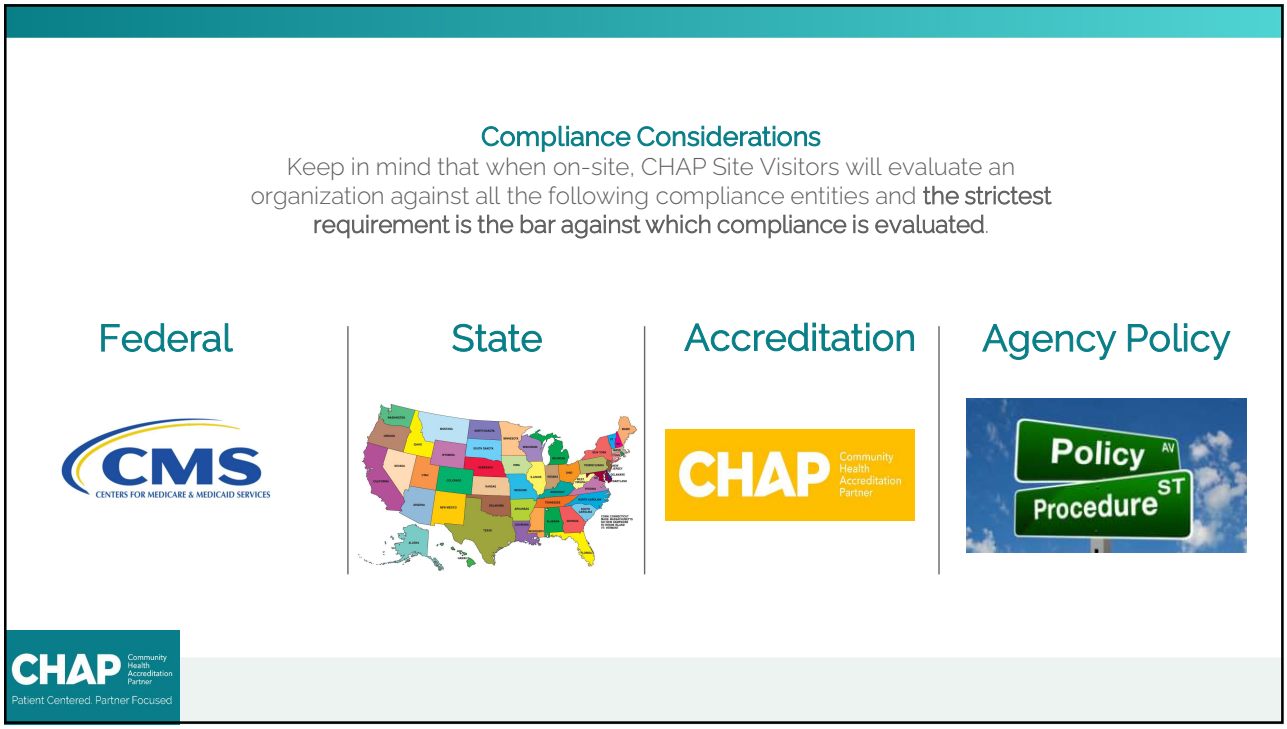
Compliance Considerations
Keep in mind that when on-site, CHAP Site Visitors will evaluate an organization against all the following compliance entities and the strictest requirement is the bar against which compliance is evaluated.
Federal
CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
State
Accreditation
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Agency Policy
Policy AV
Procedure ST
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Site Visit Components

Each site visit regardless of the service line is conducted within a standardized framework with five key components.

Entrance Conference
Time to conduct Introductions, share the expectations of the visit, answer provider questions about the visit

Site Visit Activities
Several activities are completed to enable validation of compliance with the CHAP standards

Daily Wrap Up
Site Visitor shares status of findings thus far, coordinate the next day's activities and answer questions

Exit Conference
Formal presentation of the findings from the visit, sharing of next steps, last opportunity to ask questions of the Site Visitor

Ongoing Communication
Communication occurs in each of the above components with the goal of no surprises at the exit conference and all provider questions addressed

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Site Visit Activities

Communication
Communication occurs throughout all site visit activities. This results in "interviews" of leadership, staff, patients, and caregivers.

Medical record

Document Review
- Policies
- Infection Control Program
- Emergency Preparedness Plan
- Quality Activities

Record Review
- Personnel Records
- Clinical Records

Observations/Interviews
- Home Visits
- Conversations with staff

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Handling Conflict

When

Should occur **during** the Site Visit

How

Share concern with the Site Visitor. Each side should explain their point of view

What If

…conflict continues, add the Director of Accreditation

Final Opportunity

…is to appeal the finding during the plan of correction/action plan phase

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Relieving Anxiety

Preparation is key on both the side of the site visitor and the organization for a smooth visit.

Constant Preparation
Conduct mock site visits, education of all staff, and ensure readiness of all documents

Preparing for the Visit
Have updated lists: list of current patients, list of provided services, employee listing, policies and procedures, contracts, review the document request list to prepare

Site Visit Plan
Appoint a point-person, Designate an alternate, Think through methods for sharing information, Records/Documents, Onsite/Offsite

COVID Practices
Congruent with organization requirements and/or Site Visitor preference

Workspace
Good lighting and electric outlet availability

Prepare Staff
Interviews may be conducted of anyone who interacts with the Site Visitor

Communication
Ask questions, share any concerns, take notes during daily wrap ups

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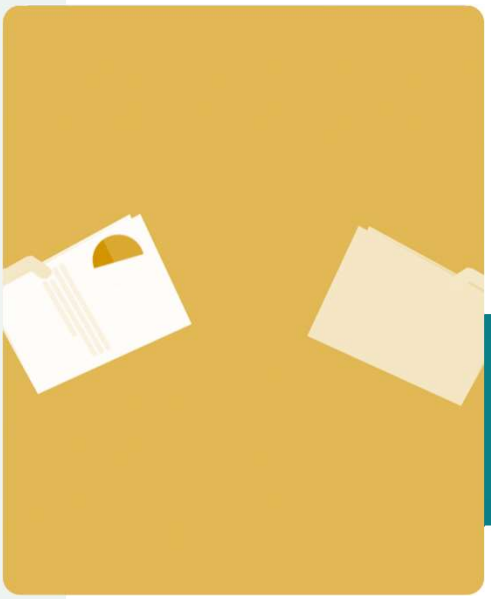

Plan of Correction

- Submission of the final report by the Site Visitor
- Full review by the Director of Accreditation or Senior Accreditation Manager

Action Plan Review by CHAP may take up to **10 business days** post site visit

Provider has **10 calendar days** to submit their action plan upon receipt of the report

10 Business Days

10 Calendar Days

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ACTION PLAN

What Action?

Potential action steps include but are not limited to:

- Policy review and/or revision
- Education
- Development of job aids
- Documentation templates
- Checklist
- Hiring of Staff

When?

When will the corrective action be implemented?

- Approximate time the plan is implemented
- Depends upon the complexity of the plan
- Consider the timeframe for potential re-survey
- Prioritize quality care issues over "paper" issues

Who is Responsible?

Who is the primary person responsible for oversight of the improvement?

- Use title, not an individual's name. Ex, Clinical Manager rather than Roger Rabbit.
- No identifying information
- May be more than one individual involved.

What Monitoring?

What is the monitoring process we will put into place to ensure implementation and effectiveness of the corrective action plan?

- Short-term monitoring to evaluate actions taken
- Long-term monitoring to evaluate sustainment of improvement
- Include aspects of measurability (time, percentage of compliance)

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Accreditation Decision

Plan of Correction Approval

Site Visitor report and the Plan of Correction goes to the Board of Review

Board of Review makes accreditation determination and if a Focus Visit is needed

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Condition Level Finding(s)

Initial Accreditation: Deemed Status

- Accreditation deferred.
- Initial start-up: Up to two comprehensive visits within **180 calendar days**.
- Initial w/CCN: Focus or comprehensive visit within **45 days then 90 days** (if Condition not cleared or unable to conduct the first focus visit at 45 days), of the last day of the initial site visit. If condition not cleared, or new condition found, accreditation is denied.

Reaccreditation: Deemed Status (Renewal Org)

- Focus visit within 45 calendar days of the last date of the site visit where the condition level finding was identified.
- If the condition level finding is not cleared on the first focus visit, then a second focus visit will take place within 46 to 90 calendar days of the last date of the site visit where the condition level finding was identified.
- If the condition level finding is not cleared, or the site visit is aborted, CHAP will terminate accreditation.
- If the original condition level finding is cleared but a new condition level finding is identified on either the first or second focus visit, a new focus visit will take place within 45 calendar days of when the new condition level finding was identified.

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Deferral/Denial for Initial Non-Deemed Orgs

Not all accreditation visits end with the desired result.

What then?

1

Initial Site Visit Conducted: if significant non-compliance identified results in a Deferral of Accreditation

2

A second comprehensive visit is conducted within 90 days. If continued non-compliance: Denial of Accreditation

3

The organization can resubmit an application within the appropriate timeframe

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Deferral/Denial for Renewal Non-Deemed Orgs

Not all accreditation visits end with the desired result.

What then?

1

Renewal Site Visit Conducted: if significant non-compliance identified may result in a Formal Warning with a focus visit within 6 months

2

If the Formal Warning is not "cleared" during the focus visit, CHAP may Terminate Accreditation

3

If the original findings are cleared, but a new finding is identified on either the first or second focus visit, a new focus visit may take place.

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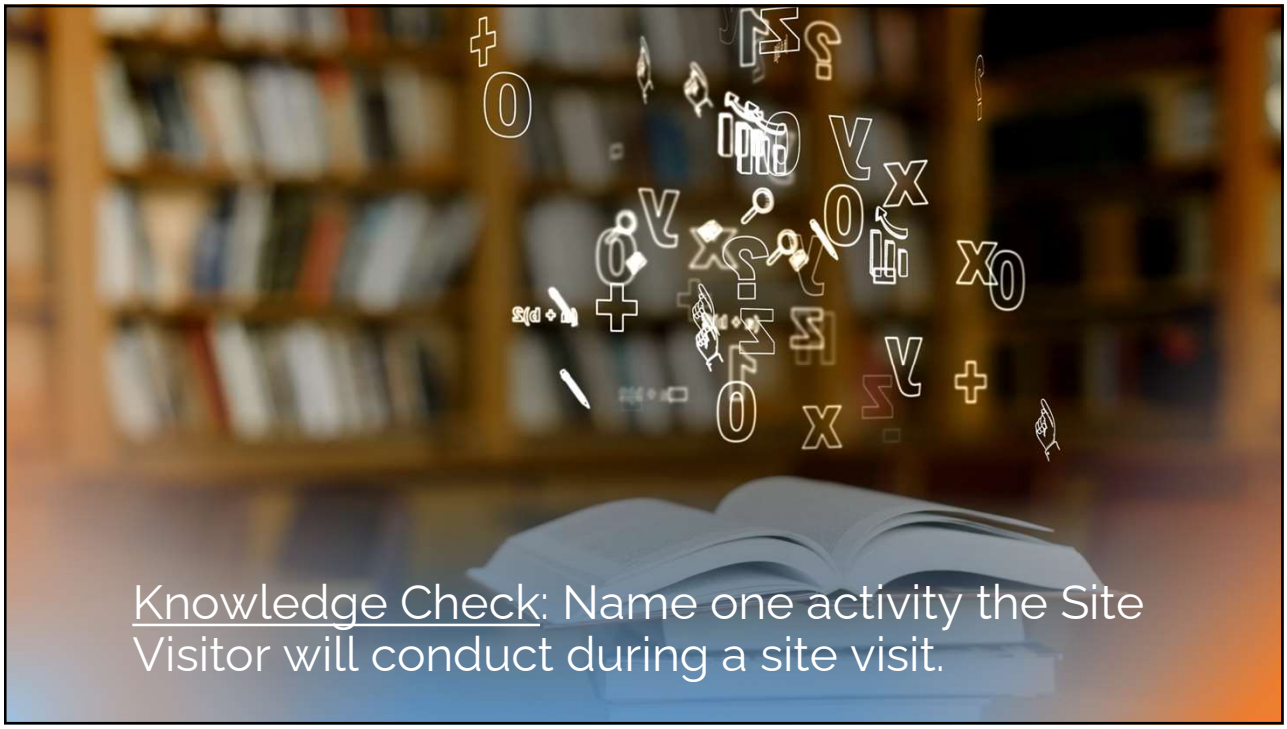
Knowledge Check: Name one activity the Site Visitor will conduct during a site visit.

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What is your
"Golden Nugget"
from today's
sessions?

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Questions

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Earning CE Contact Hours

To take the post evaluation

After completing the entire webinar, log on to your CHAP Education account and access the course page. From this page, follow the instructions to complete the evaluation and obtain your CE Certificate.

The planners and authors of this course have declared no real or perceived conflicts of interest that relate to this educational activity.

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Day 2

Community Health Accreditation Partner (CHAP) / v.2.1.0 Hospice Standards of Excellence - Updated August 5, 2023

Community Health Accreditation Partner (CHAP) / v.4.1.0 Home Health Standards of Excellence - Updated September 15, 2023

https://nursejournal.org/nurse-practitioner/np-practice-authority-by-state/

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https://www.hhs.gov/guidance/sites/default/files/hhs-guidance-documents/SOM%20Appendix%20Z%202019.pdf

https://www.youtube.com/watch?v=XVYn2AoSneA&list=TLPQMzAwODIwMjMQ2areg0jYuQ&index=4

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CHAP

Thank You

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