


# CHAP

---

Home Health Accreditation Intensive  
for Organizations & Consultants


Keri Culhane, MBA, BSN, RN  
Linda Lockhart, MPH, BSN



The logo is a circular gold seal with a white border. The text 'COMMUNITY HEALTH ACCREDITATION PARTNER' is written along the top inner edge, and 'SEAL OF ACCREDITATION' is written along the bottom inner edge. In the center, the letters 'CHAP' are prominently displayed in white, with 'EST. 1965' written below it.

1


## While you are waiting...




Use the chat box to tell the group:

- Share your golden nugget from yesterday

2




- How many years has your organization been in existence?
  - Not yet accepting patients
  - 1-5 years
  - 6-10 years
  - 11-15 years
  - 16-20 years
  - Over 20 years
  
- How long have you been in the home health industry?
  - Less than 1 year
  - 1-5 years
  - 6-10 years
  - 11-15 years
  - 16-20 years
  - Over 20 years
  
- Are you familiar with the CHAP Home Health Standards of Excellence?
  - Yes
  - No




3

## Disclosures/Conflict of Interest

This nursing continuing professional development activity was approved by the Virginia Nurses Association, an accredited approver by the American Nurses Credentialing Center's Commission on Accreditation.




**How to obtain CE contact hours.**

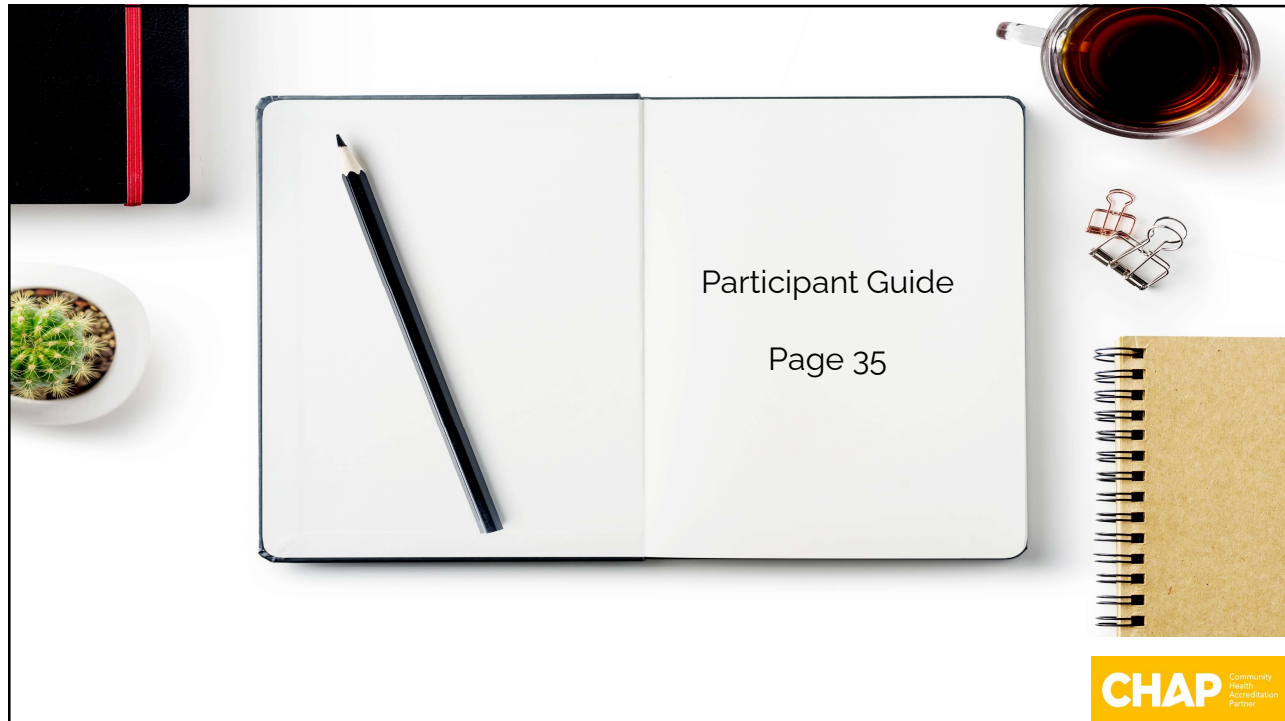


There are no conflicts of interest for any individual in a position to control content for this activity.

Criteria for successful completion includes attendance at the entire event (both days), participation in engagement activities, completion of an evaluation and completion of the consulting exam.



4



5

**Revisions**

In response to the Medicare and Medicaid Programs, Policy and Regulatory Changes to the Omnibus COVID-19 Health Care Staff Vaccination Requirements Final Rule (CMS-3415-F), the following revisions were approved by CMS:

Standard	Summary	Effective Date
IPC-15	Removed	8/5/2023
IPC-16	Removed	8/5/2023
IPC-17	Removed	8/5/2023
IPC-18	Removed	8/5/2023
IPC-19	Removed	8/5/2023
IPC-20	Removed	8/5/2023
IPC-21	Removed	8/5/2023
IPC-22	Removed	8/5/2023

**Version**

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

**Evidence Guidelines**

Standards	Evidence Guidelines
<b>APC-15</b>	<p><b>Clinical Record Review:</b> Verify that care delivery is coordinated with the patient, representative, and caregiver(s) as appropriate to meet the needs of the patient.</p> <p><b>Observation – Home Visit:</b> Verify, through patient interview, the ways in which personnel coordinate care with the patient and appropriate representatives and caregivers.</p>

Community Health Accreditation Partner

CHAP  
2300 Clarendon Blvd, Suite 405  
Arlington VA 22201  
202.862.3413

[www.chapinc.org](http://www.chapinc.org)  
[www.chapinc.org](http://www.chapinc.org)  
[www.education.chapinc.org](http://www.education.chapinc.org)  
[info@chapinc.org](mailto:info@chapinc.org)

## Home Health Standards of Excellence

CHAP Education

Home Health Standards  
CHAP Inc.

6

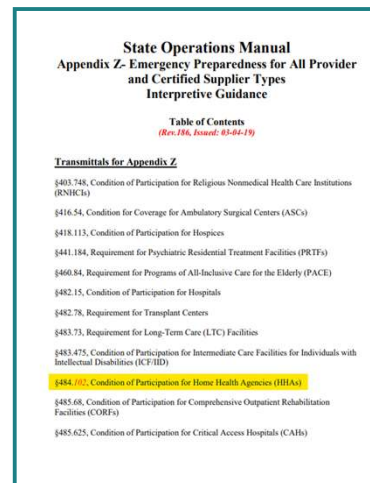
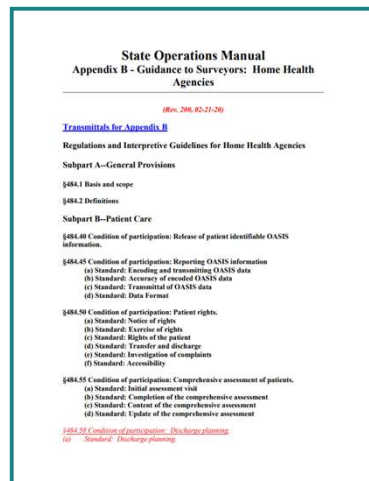
# Key Performance Areas

The Home Health Standards of Excellence are organized into one of the following Key Performance Areas.



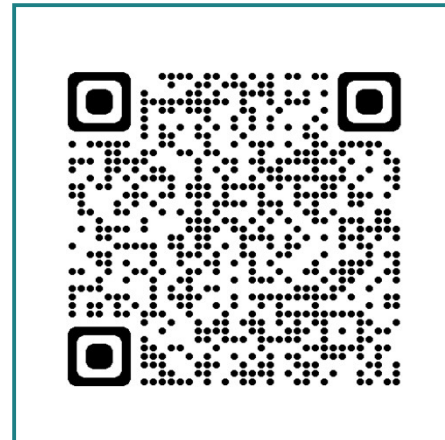
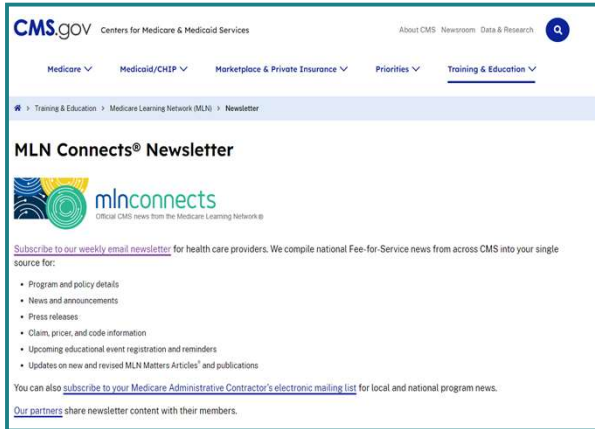
7

# Additional Resources: State Operations Manual



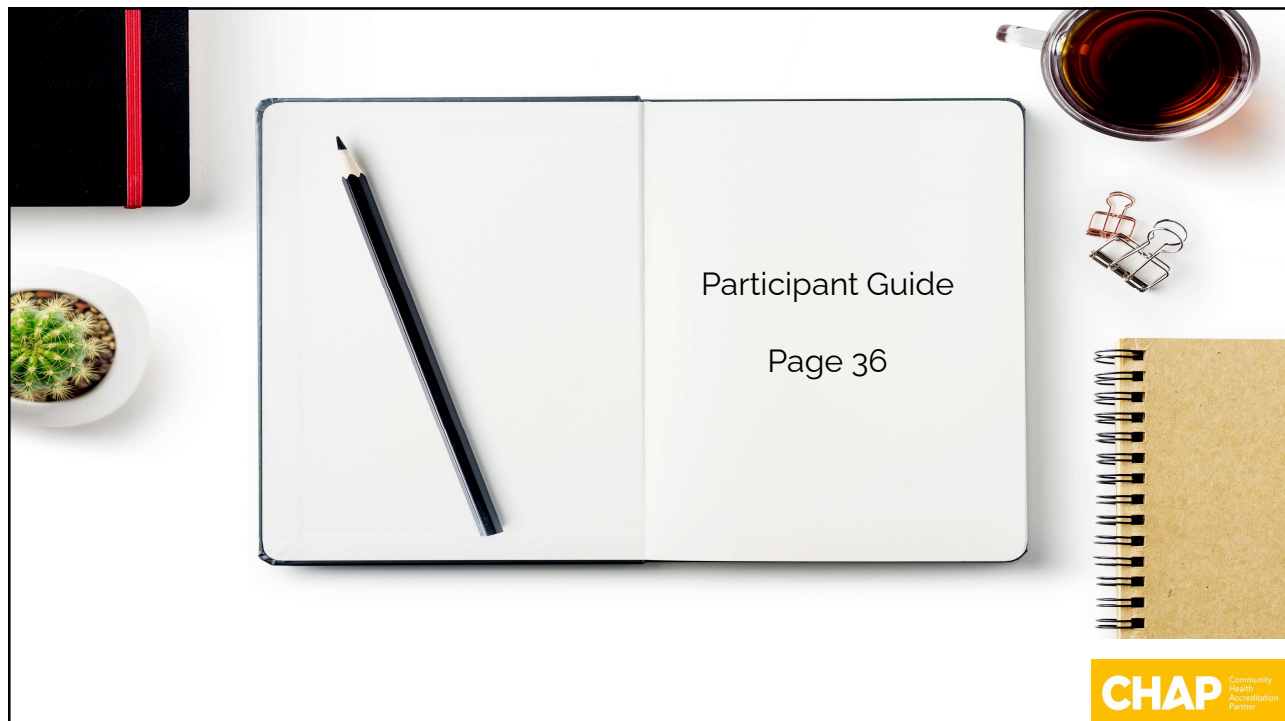
8

# Additional Resources: MLN Connects & CHAP eNews




[MLN Connects® Newsletter](#) | [CMS](#)

9




10



## Patient-Centered Care (PCC)

KEY PERFORMANCE AREA


Organizations engage in active partnerships with patients, families, and caregivers to ensure that care respects and responds to individual preferences. Patients, families and caregivers are provided needed information and support to ensure that their concerns, values and knowledge are incorporated into shared decision-making for care planning, goal-setting, and treatment.



11

## PCC Standard Summary

Patient Rights



**PCC.1**  
Written Patient Bill of Rights

**\*PCC.2**  
Bill of Rights Elements

**PCC.4**  
Provide verbal and written Bill of Rights and obtain signature

**PCC.6**  
Written notice of Bill of Rights, transfer & discharge policies, and OASIS privacy notice

**PCC.7**  
24/7 Contact information of organization

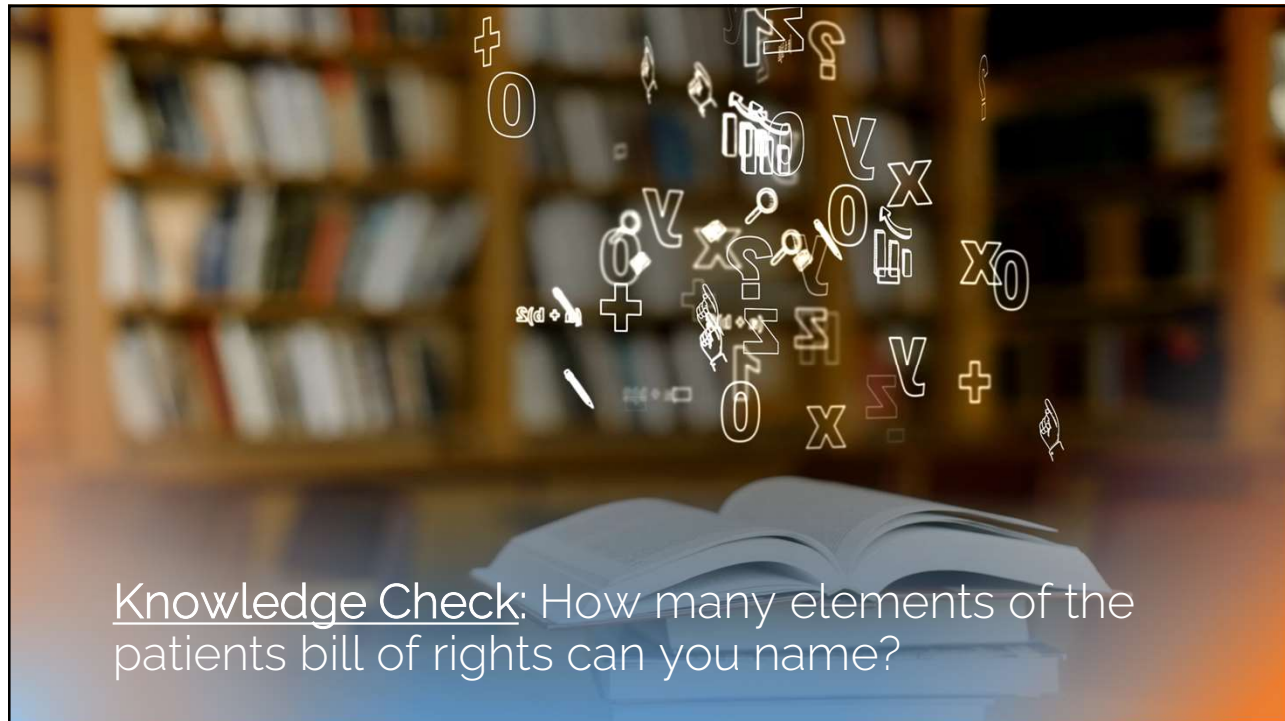
**PCC.8**  
Administrator contact information

**PCC.9**  
Respond to alleged violations

**PCC.10**  
Reporting abuse

\* Included in top 2022 findings

12



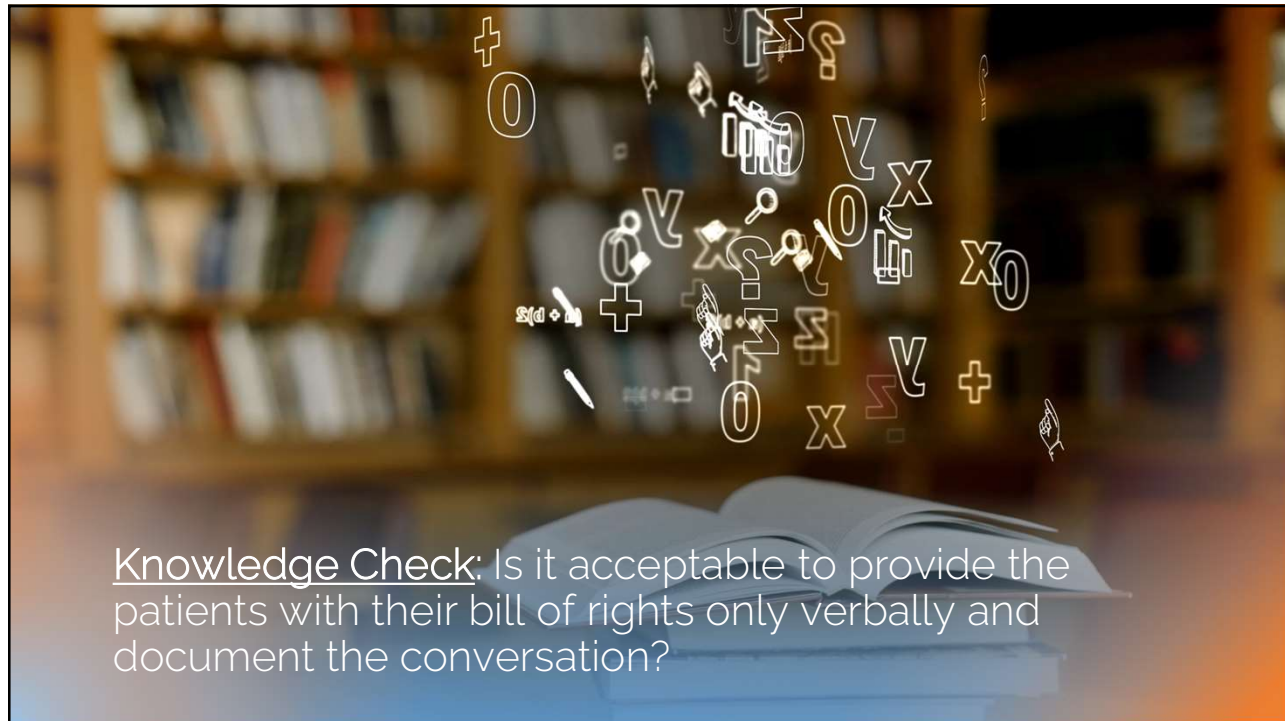
13

## Elements of the Patients Bill of Rights PCC.2

All patients have a right to be treated with respect

<p><b>Be informed of and consent to care in advance including:</b></p> <ul style="list-style-type: none"> <li>- Mode of care delivery                     <ul style="list-style-type: none"> <li>- Assessments</li> </ul> </li> <li>- Care to be furnished</li> <li>- Establishment of plan of care</li> <li>- Disciplines that will furnish care                     <ul style="list-style-type: none"> <li>- Frequency of visits</li> <li>- Expected outcomes</li> <li>- Changes in care</li> </ul> </li> <li>- Right to receive all services in POC</li> </ul>	<p style="text-align: center;"><b>Financial</b></p> <ul style="list-style-type: none"> <li>- Advised orally &amp; writing payment liability</li> <li>- Charges not covered; reduction, termination</li> <li>- Potential patient payment liability</li> <li>- Changes related to payment</li> </ul>	<p style="text-align: center;"><b>Complaints</b></p> <ul style="list-style-type: none"> <li>- Right to report grievances</li> <li>- How to contact state and CHAP hotlines                     <ul style="list-style-type: none"> <li>- Free of neglect/abuse/discrimination</li> </ul> </li> </ul>	<p style="text-align: center;"><b>Resources</b></p> <ul style="list-style-type: none"> <li>- Informed of names/addresses/contact for federal and state funded</li> <li>- Right to access and how to access auxiliary aid aides and language services</li> </ul>
---	--	---	---

14



Knowledge Check: Is it acceptable to provide the patients with their bill of rights only verbally and document the conversation?

15



PATIENT RIGHTS & RESPONSIBILITIES

During the initial assessment visit and in advance of providing care:

The organization provides the patient—or their representative—with **verbal and written notice** of the patient's rights and Responsibilities.

This information is provided in a language and manner that the patient understands.



**PCC.4**

The organization obtains the patient's or representative's signature confirming that they received a copy of the Bill of Rights and Responsibilities statement.



**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.

16



## Complaint/Grievance Management Process PCC.9

Policy & Procedure defines the process and includes...



Investigating complaints made by the patient and/or the patient's representative



Taking appropriate corrective action if needed, and ensuring actions are taken to prevent further violations



Documented status of the complaint, including resolution




Corrective action taken & information shared with complainant




Community Health Accreditation Partner  
Patient Centered. Partner Focused.


17




### Notice of Medicare Non-Coverage Form



**Form Instructions**



- Notice of Medicare Non-Coverage (NOMNC) Form
- PCC.2; #13; CMS G442
- Receive proper written notice in advance of a specific service being furnished, if the organization believes that the service may be non-covered care or in advance of the organization reducing or terminating ongoing care.




Community Health Accreditation Partner  
Patient Centered. Partner Focused.


18

## 2022 Top PCC Findings

Old Standard	New Standard	Content	CMS Tag
PCC.2.I.M1	PCC.2	Proper Notice regarding potential non-covered care or agency reduction or termination of care (36%)	G442
PCC.2.I.M1	PCC.2	Be informed of and participate in care and services (24%)	G434
PCC.2.I.M1	PCC.2	Provision of Federal/State Agency Information (17%)	G446
PCC.2.I.M1	PCC.2	Right to be advised regarding financial payment information orally and in writing (15%)	G440



19



## PCC.2

### Elements of the Patient Bill of Rights & Associated L Tags

**G434**

Participate in, be informed, consent or refuse care in advance of and during treatment.

**G446**

Be advised of the names, addresses, phone numbers of the following Federally-funded and state-funded entities:


(i) Agency on Aging (ii) Center for Independent Living (iii) Protection and Advocacy Agency, (iv) Aging and Disability Resource Center; and (v) Quality Improvement Organization.

**G440**


Be advised, orally and in writing, of—

- The extent to which payment for HHA services may be expected from Medicare
- The charges for services that may not be covered by Medicare
- The charges the individual may have to pay before care is initiated


20




## Tips for Success




Ensure signature is obtained confirming receipt of bill of rights




Develop NOMNC form process and audit for compliance




Develop a checklist for bill of rights elements to ensure compliance




Ensure staff are educated on process requirements (patient rights, NOMNC process)







21



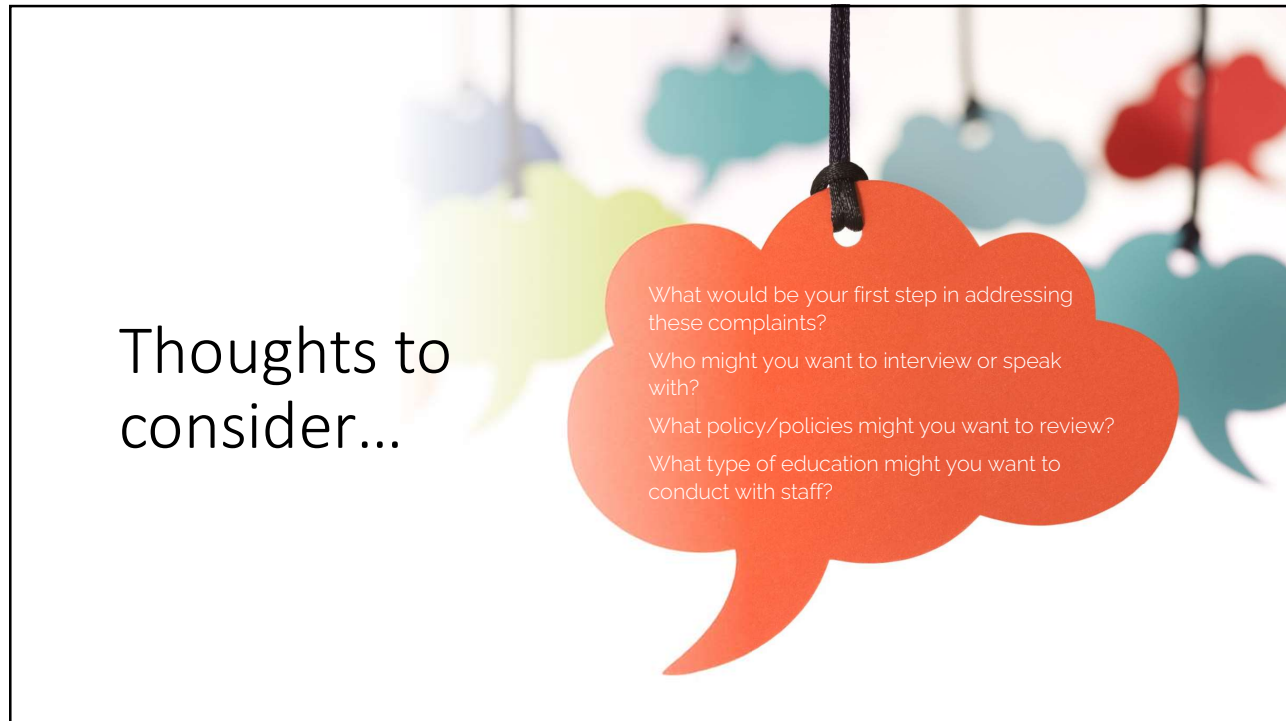
## Complaint Handling Discussion

Patient MRN	Complaint
465382	The patient's husband called and stated they haven't seen or heard from their physician therapist in almost 2 weeks, and they are supposed by seeing them weekly.
465932	The daughter of the patient called to state that her mother is almost out of wound supplies and per the nurse, the shipment was due to arrive two days ago, and they still have not received the supplies.
465962	The patient called complaining that when her home health aide was helping her into the shower, the aide was rushing her and almost caused her to slip and fall.





22



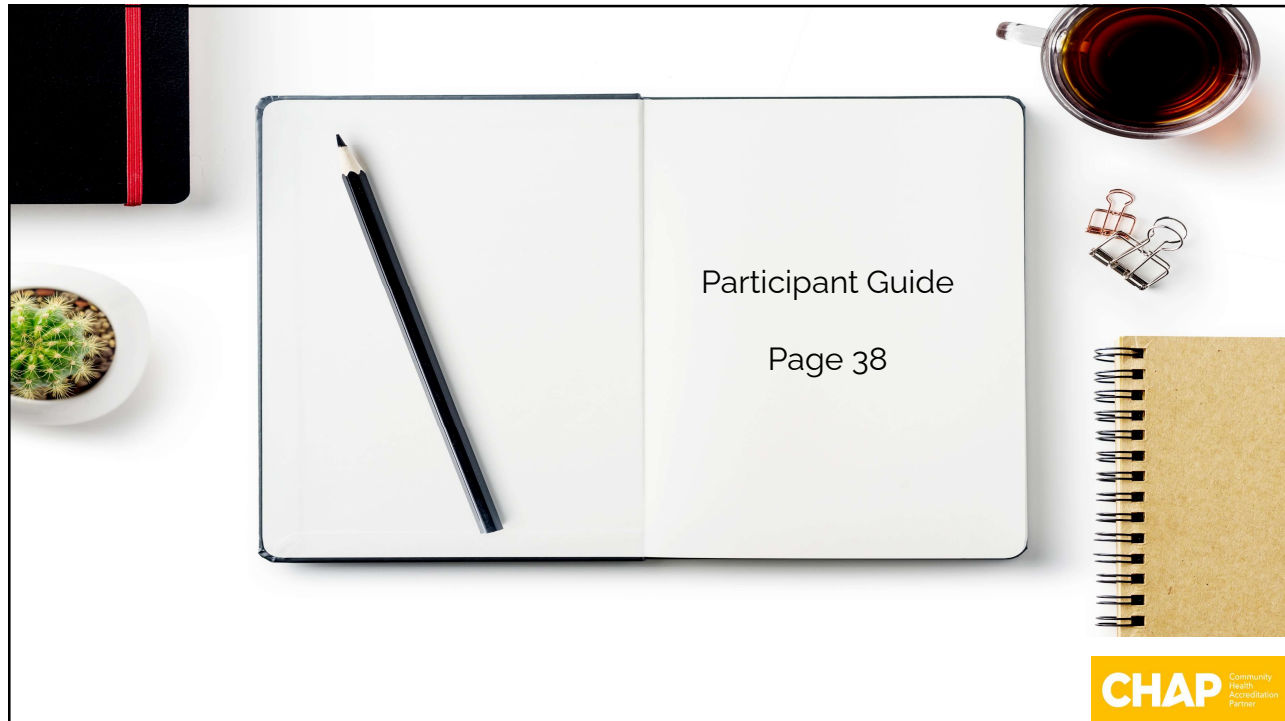
Thoughts to consider...

- What would be your first step in addressing these complaints?
- Who might you want to interview or speak with?
- What policy/policies might you want to review?
- What type of education might you want to conduct with staff?


23



24




25



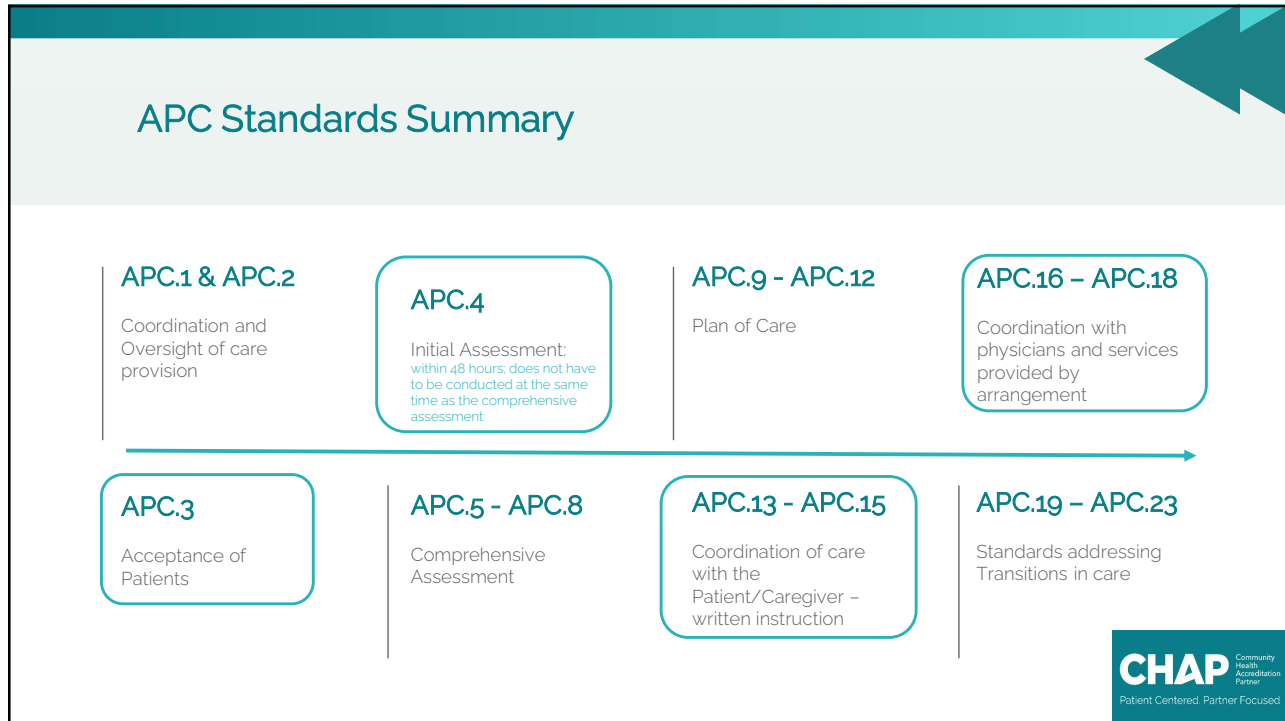
## Assessment, Planning and Coordination (APC)

KEY PERFORMANCE AREA

Organizations use effective communication and patient-centered care planning strategies among all members of the care team, including the patient, family and caregiver, to ensure safe, seamless and well-coordinated treatment and services.



26



27

### The Comprehensive Assessment


**APC.8**  
The comprehensive assessment accurately reflects the patient's status. It incorporates the current version of the Outcome and Assessment Information Set (OASIS) items.

Assessment Elements
Demographic Information/Medical History/Allergies
Strengths, goals, care preferences, measurable outcomes
Systems review
Activities daily living/need for home care/living arrangements
Medical equipment
Medical/nursing/rehab/social and d/c planning needs

Assessment Elements
Patient's Representative as applicable
Current health/psychosocial/functional/cognitive status
Medication review
Emergency care use/data items inpatient facility admit/discharge
Caregiver availability/willingness, schedules
Plan in the event of natural disaster

**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.

28



## Ms. Violet's home health journey...

Ms. Violet Chap is a 72-year-old female with a recent fall resulting in an acute care hospitalization due to a shoulder injury. She was admitted to home health approximately one month prior to her fall with a primary diagnosis of Diabetes. She also has a history of hypertension and during the hospital stay developed a diabetic ulcer on her right toe. She is scheduled to be discharged today and an RN just out of orientation is scheduled to conduct the Resumption of care.

**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.

29

## Group Activity – 20 mins

Attendees will be divided into six breakout rooms  
Each participant should conduct a high-level overview of the entire assessment.

Assessment on Pages 39-45

Each group conducts a review of their assigned section  
Evaluate what was documented  
Make suggestions for improvement



**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.



## Individual Groups

Each group will be assigned key elements of the assessment for in-depth review.

- Group 1 – focus on **integumentary and diabetes**
- Group 2 – focus on **functional**
- Group 3 – focus on **cognitive**
- Group 4 – focus on **medications**
- Group 5 – focus on **nutrition and pain**
- Group 6 – focus on **safety**


Each group assigns one spokesperson to share the thoughts from the group.

30

## Comprehensive Assessment Summary

**Assessment Summary:**

**Comments:** 72-year-old female with recent fall requiring hospitalization due to shoulder injury. During hospital stay, diabetic ulcer noted on right great toe. Patient is alert and oriented with self-identified times of forgetfulness. Ms. Violet informed nurse that she has at times forgotten to take her medicine. Patient uses Lantus injectable pen but also at times forgets to take her evening insulin. Discussion with patient about use of pill organizer and the setting of an alarm as a reminder for her insulin. Also discussed the availability of a close neighbor for assistance and that daughter may be able to call her each night as a reminder. Vital signs were stable. Respirations easy with rales noted in right lower lobe. Patient with no bowel difficulties as long as she takes her Miralax. Infrequent urinary incontinence due to difficulty in getting up quickly from her chair. Patient having pain in her right shoulder since the fall and has limited range of motion which affects her ability to conduct ADL/IADL easily. Dressing not removed during this visit as the wound had been redressed prior to discharge.



31

## Group One

### Integumentary

**Integumentary:** Skin Warm and Dry.

Wound:  Yes  No

Location: Right great toe

Type of Wound:  Vascular  Diabetic  Surgical  Trauma  Pressure




Wound Care: per patient, in the hospital they changed the dressing every day but she did not know what was being used.



32



## Group Two

### Diabetes

**Vital Signs:**  
 Temperature: 99.2      Pulse Apical: 82       Reg  Irreg  
 Resp: 22      Pulse Radial: 82       Reg  Irreg  
 B/P: 146/85 Left Arm – Unable to take in right arm due to shoulder pain with movement


**Comments:** Patient is anxious that she may lose her foot. Ms. Violet had a close friend who began with a diabetic ulcer on the toe and went on to lose her foot. In discussion regarding consistency with blood sugar monitoring and medication compliance, the patient revealed that she often forgets to take her blood sugar and to take her medications on time, sometimes missing several doses.


**Endocrine:**  
 WNL       Excessive Hunger/thirst       Excessive bleeding       Thyroid issue  
 Diabetic

**Blood Glucose Performed:**      **Result:**  
 FSBS Range: Per patient 120-185 although lately she has had fasting sugars over 200

Foot lesions     Foot care taught     Foot care performed

forgetfulness. Ms. Violet informed nurse that she has at times forgotten to take her medicine. Patient uses Lantus injectable pen but also at times forgets to take her evening insulin. Discussion with patient about use of pill organizer and the setting of an alarm as a reminder for her insulin. Also discussed the availability of a close neighbor for assistance and that daughter may be able to call her each night as a reminder. Vital signs were





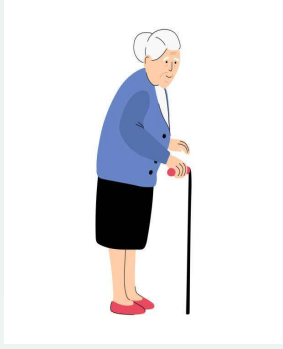
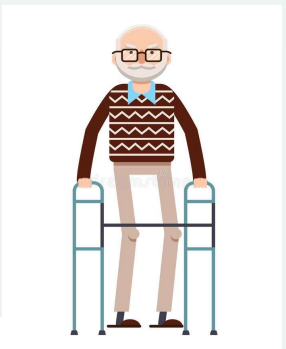
33


## Group Two

### Functional

**Body Systems**  
 Range of Motion: limited range in right arm. Patient states "frozen right shoulder" since the fall.  
 Functional Limitations: slow to move, uses arms of chair to be able to get out of chair.  
 Assistive Devices: use of a cane for ambulation.  
 Swollen Joints: Arthritis both knees

ADL/IADL			
Self-Care:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Needs Some Help	<input type="checkbox"/> Dependent
Ambulation:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Needs Some Help	<input type="checkbox"/> Dependent
Transfer:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Needs Some Help	<input type="checkbox"/> Dependent
Household Tasks:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Needs Some Help	<input type="checkbox"/> Dependent



34


## Group Three


### Cognitive

**Neuro/Emotional/Behavioral:**

<input checked="" type="checkbox"/> Oriented:	<input checked="" type="checkbox"/> Time	<input checked="" type="checkbox"/> Place	<input checked="" type="checkbox"/> Person
<input checked="" type="checkbox"/> Alert	<input checked="" type="checkbox"/> Forgetful	<input type="checkbox"/> Dizziness	<input type="checkbox"/> Pupils equal/reactive
<input type="checkbox"/> Slurred Speech	<input type="checkbox"/> Abnormal speech	<input type="checkbox"/> Insomnia	<input checked="" type="checkbox"/> Anxious
<input type="checkbox"/> Headache	<input type="checkbox"/> Depressed	<input type="checkbox"/> Uncooperative	<input checked="" type="checkbox"/> Memory deficit

**Comments:** Patient is anxious that she may lose her foot. Ms. Violet had a close friend who began with a diabetic ulcer on the toe and went on to lose her foot. In discussion regarding consistency with blood sugar monitoring and medication compliance, the patient revealed that she often forgets to take her blood sugar and to take her medications on time, sometimes missing several doses.





35

## Group Four

### Medications

**Allergies:**

**Medications:**

<input type="checkbox"/> Patient unable to independently take meds	<input checked="" type="checkbox"/> Drug education provided to patient
<input checked="" type="checkbox"/> Patient requires drug diary or chart for meds	<input type="checkbox"/> High-risk medication instruction given
<input type="checkbox"/> Patient med dosages prepared by another person	<input type="checkbox"/> Patient demonstrates non-compliance
<input checked="" type="checkbox"/> Patient needs prompting/reminding	<input type="checkbox"/> Patient meds must be administered
<input checked="" type="checkbox"/> Drug regimen review for interactions, duplicate therapy and potential adverse effects conducted	

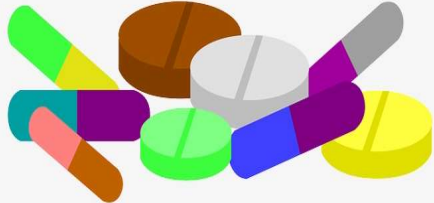

**Current Medications:**


Lantus insulin 30 units at bedtime	Metoprolol tartrate 25 mg twice a day
Plavix 75 mg once a day	Glyburide 10 mg twice a day
Aspirin 81 mg once a day	Simvastatin 40 mg at bedtime
Folic Acid 1 mg once a day	

**Medication Management:**

Oral Medications:	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Need some Help	<input type="checkbox"/> Dependent	<input type="checkbox"/> N/A
Injectable :	<input type="checkbox"/> Independent	<input checked="" type="checkbox"/> Need some Help	<input type="checkbox"/> Dependent	<input type="checkbox"/> N/A

**Comments:** Ms. Violet has difficulty remembering to take her medications, including her evening insulin. She lives along but has a family friend who lives two doors down who might help. A daughter lives 150 miles away but comes to see her mother once per month. Currently the patient has no other forms of assistance.



36

## Group Five

### Pain

---

**Pain Assessment:**

Standardized validated assessment conducted:  Yes  No

Pain Frequency interfering with activity:

No Pain  Pain does not interfere with activity  
 Daily but not constant  All the time

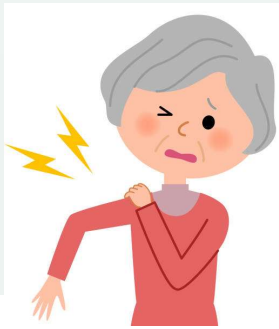
Other: Patient has pain with movement in both knees and right shoulder. States "I just take Tylenol arthritis for the pain" Has pain upon dressing change of diabetic ulcer right great toe"

---

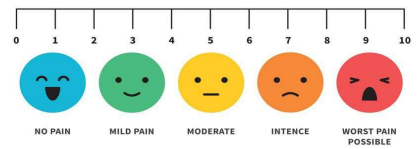
**Cardiac:**

WNL  Syncope  Angina  Chest Pain  Varicosities  
 Pacemaker  Orthopnea (# of pillows) 3 pillows at night  Edema

Other: B/P – 146/85 P- 82 Irregular – slight non-pitting edema at bilateral ankles. Patient states ankle swelling increases throughout the day.




**PAIN MEASUREMENT SCALE**



0 1 2 3 4 5 6 7 8 9 10

NO PAIN MILD PAIN MODERATE INTENSE WORST PAIN POSSIBLE



**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.

37

## Group Five

### Nutrition

---

**Gastrointestinal:** Abdomen soft/non-tender. Bowel sounds present in all four quadrants. Patient states daily bowel movements without difficulty if she takes her MiraLAX in the morning.


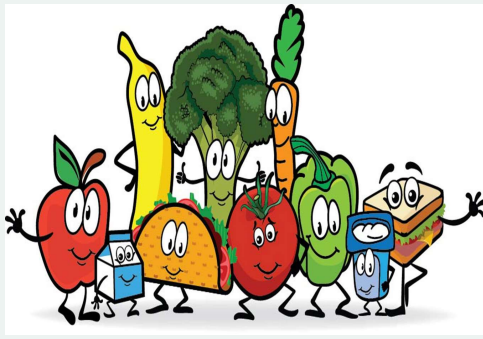
---


**Nutritional Assessment:**

WNL  Pain  Nausea  Vomiting  Diarrhea  Constipation

Standardized nutritional assessment Completed:  Yes  No

Diet: 1500 calorie diet



**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.

38

## Group Six

### Safety

**Comment:** Prior to fall requiring hospitalization Ms. Violet was independent in all daily activities. Following the fall, her right shoulder has limited mobility and is painful upon movement which limits her ability to fulfill all activities of daily living independently.

Assistive Devices:  Walker  Cane  Shower Chair  Reacher

Living Arrangement	Availability of Assistance				
	Around the clock	Regular daytime	Regular nighttime	Occasional or short-term assistance	No assistance available
a. Patient lives alone	<input checked="" type="radio"/> 01	<input type="radio"/> 02	<input type="radio"/> 03	<input type="radio"/> 04	<input type="radio"/> 05
b. Patient lives with other person(s) in the home	<input type="radio"/> 06	<input type="radio"/> 07	<input type="radio"/> 08	<input type="radio"/> 09	<input type="radio"/> 10

**Safety Measures Include:**



Standard precautions  Fall Precautions  ADL Safety  Safe Disposal of Sharps


Airborne Infection Control Precautions  Contact Infection Control Precautions

**Respiratory:**


Wheezes  Dyspnea  CPAP  Rales  Rhonchi  Cough

**Breath Sounds:** RR- 22 Bilateral lung sounds with rales in lower right lobe. Patient coughs upon taking a deep breathe. States she gets "winded" going up the stairs to the bedroom at night.




39




## Oasis-E Resources


Outcome and Assessment Information Set  
OASIS-E Manual




Effective January 1, 2023  
Centers for Medicare and Medicaid Services



- Several numbering changes
- Verbiage changes for clarity
- Grammar and typographical errors addressed
- Updated guidance for the following sections
  - Cognitive
  - Mood
  - Health Conditions
  - Swallowing/nutritional status
  - Medications
  - Special Treatments, Procedures and Programs



40



### OASIS-D1 to OASIS-E Crosswalk Guide


Developed by Strategic Healthcare Programs • [www.SH-PA.org](https://www.SH-PA.org)



SH-PA is pleased to provide home health agencies with a complete table for side comparison of the OASIS-D1 and OASIS-E assessment forms. Items that have been added or removed between the two OASIS versions are indicated with color coding. This document includes all items recorded at start of care (SOC), resumption of care (ROC), follow-up (FU), transfer (TFU), discharge (DC), and death at home (DAM). Items not included are those that are no longer assessed in OASIS-E. Items in parentheses ( ) indicate an additional item.

This guide is an excellent reference for anyone who works with OASIS Assessments and will improve accuracy, help reduce coding errors, and potentially reduce the number of returned claims. While assessment coding varies for your staff to use in the transition to OASIS-E, we suggest: **Never** when coding from OASIS-D1, and the "N/A to OASIS-E" in the green coding box for best results.

Item Summary										Continued									
Item #	Sec	Description	OASIS-D1	OASIS-E	Item #	Sec	Description	OASIS-D1	OASIS-E	Item #	Sec	Description	OASIS-D1	OASIS-E					
302010	A	Administrative Information			302010	A	Administrative Information			302010	A	Administrative Information							



## Oasis-E Resources



41

## Plan of Care

### APC.10


Each patient's individualized written plan of care includes:

- All pertinent diagnosis
- All patient care orders
- Patient's mental, psychosocial, and cognitive status
- Types of services, supplies, and equipment required
- Scope and frequency and duration of visits to be made
- Mode of Care-delivery including the use of telecommunication with applicable
- Prognosis and rehab potential
- Functional limitations
- Activities permitted
- Nutritional requirements
- All medications and treatments
- Food and drug allergies
- Safety measures to protect against injury
- Description of the patient's risk for ER visits and readmission
- Patient and caregiver education and training to facilitate discharge
- Patient-specific interventions and education
- Measurable outcomes
- Advanced directive information
- Any additional items

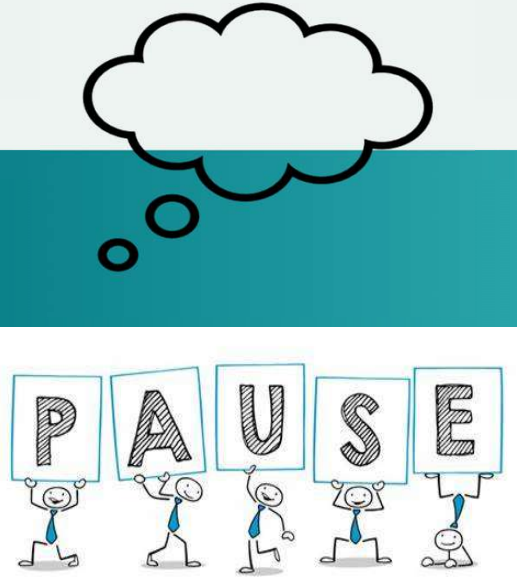
## Plan of Care Updates

### APC.12

The individualized plan of care is periodically reviewed and revised by the physician or allowed practitioner acting within the scope of their state license, certification, or registration, who is responsible for the home health plan of care and the home health organization as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start-of-care date. A revised plan of care reflects current information from the patient's updated comprehensive assessment and contains information concerning the patient's progress toward the measurable outcomes and goals identified by the home health organization and patient in the plan of care.




42



## Pause and Consider...

Take a few moments to review Violet's plan of care on page 45. Remember, the comprehensive assessment is the starting point for developing the plan of care. Keep in mind the issues you identified when in your groups and how those impact the plan of care.


What issues are you identifying as you review?



43

### Physician Notification: Change in Patient's Condition APC.12

The physician or allowed practitioner is notified of the alterations to the plan of care related to changes in that patient's status and/or outcomes not achieved.



### Written Instructions to Patient APC.14

- The organization provides the patient and caregiver(s) with a copy of **written instructions** outlining:
  - **Visit schedule, including frequency of visits** by home health organization personnel and personnel acting on behalf of the home health organization
  - **Patient medication schedule/instructions**, including medication name, dosage, and frequency, as well as which medications will be administered by home health organization personnel and personnel acting on behalf of the home health organization
  - Any **treatments to be administered** by home health organization personnel and personnel acting on behalf of the home health organization, including therapy services
  - Any **other pertinent instruction related to the patient's care, treatments, and services** that the home health organization will provide, specific to the patient's care needs
- Name and contact information of the home health organization's **Clinical Manager**

44

### PAC.23

Content of the summaries will include all necessary medical information pertaining to the patient's current course of illness and treatment, inclusive of post-discharge goals of care, and treatment preferences.


**Timing**

DC summary: sent within **5 business days**

Transfer summary: sent within **2 business days** of transfer or awareness of transfer

**Discharge/Transfer summary typically contain the following items:**


- Admission and discharge dates
- Physician responsible for the home health plan of care
- Reason for admission to home health
- Type of services provided and frequency of services
- Laboratory data
- Medications the patient is on at the time of discharge
- Patient's discharge condition
- Patient outcomes in meeting the goals in the plan of care
- Patient and family post-discharge instructions



45


## 2022 Top APC Findings

Old Standard	New Standard	Content	CMS Tag
APC.7.I.M2	APC.10	Required Elements of the Plan of Care (25%)	G574
APC.8.I.M3	APC.14	Provision of written instructions (24%)	G614,G616, G618,G620, G622
APC.11.I.M3	APC.23	Timely D/C & transfer summary includes all elements(14%)	G1022
APC.6.I.M1	APC.8	Required elements of the Comprehensive Assessment(10%)	G536
APC.9.I.M3	APC.12	Physician is alerted to changes in patient's condition (5%)	G590




46





## Tips for Success

Ensure processes are in place for providing written instructions to patients/family




Develop templates to assist in accurate/complete documentation



Develop audit process with a focus on assessment and plan of care elements

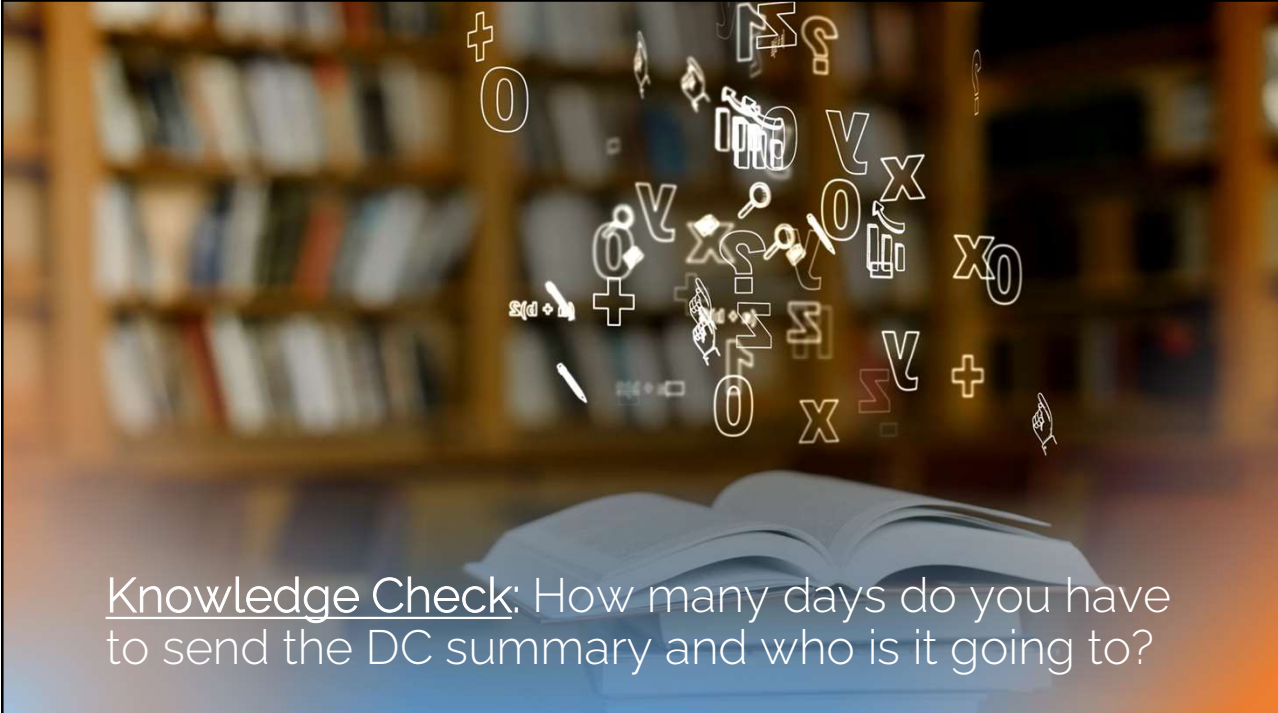


Provide education on comprehensive assessment documentation, plan of care development, and medication reconciliation





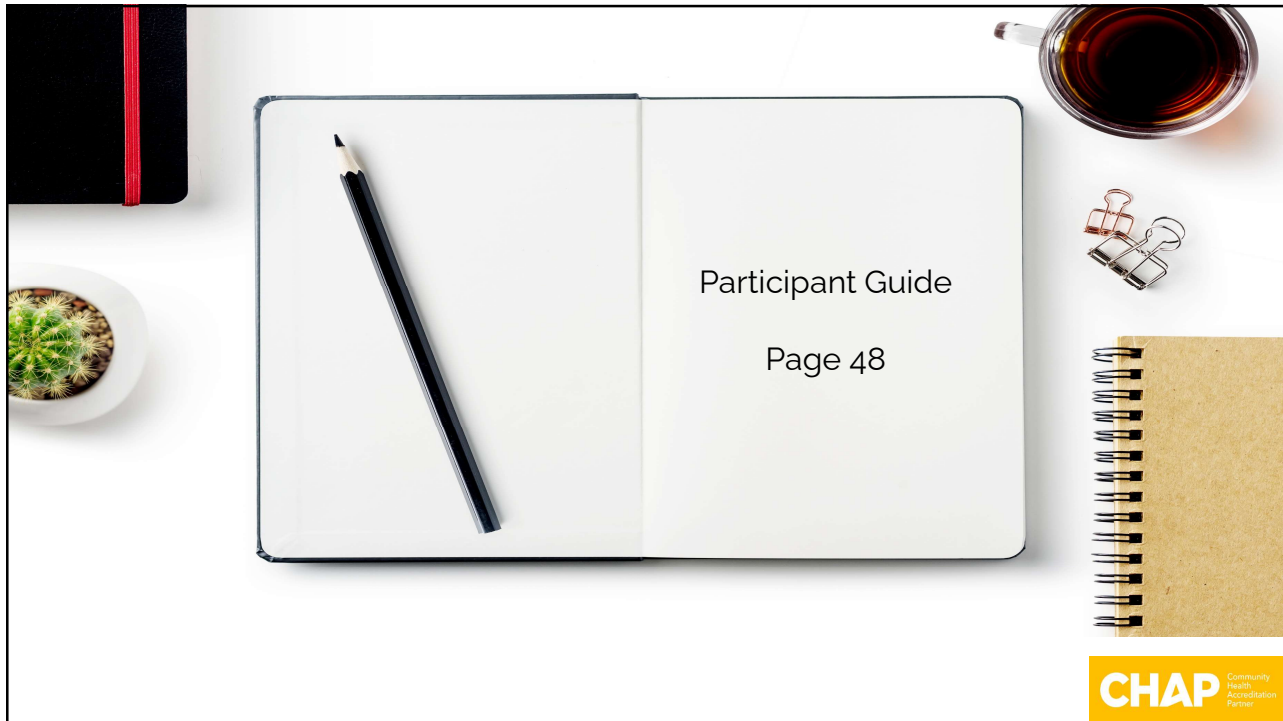
47



Knowledge Check: How many days do you have to send the DC summary and who is it going to?

48





49




## Financial Stewardship (FS)

**KEY PERFORMANCE AREA**

The organization's governance is accountable for fiscal oversight. Risk management is aligned with the scope of service delivery to ensure patient and staff safety and the effective use of resources.




50




## Annual Operating Budget


### FS.1, FS.2, FS.3




Annual budget is present



Annual operating budget addresses all anticipated income and expenses



Budget is prepared under the direction of the governing body



Annual budget is reviewed and updated at least annually

51






## Capital Expenditures

**FS.4**  
 Capital expenditures are funds spent to acquire or upgrade physical assets (property, equipment, etc.). This standard applies only to capital expenditures over \$600,000. Developed for at least a 3-year period.


52

## 2022 Top FS Findings

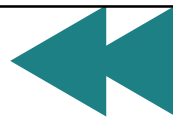
Old Standard	New Standard	Content	CMS Tag
FS.2.I	FS.1	An annual operating budget is present(25%)	G988
FS.2.I.M1	FS.1	Annual operating budget addresses all anticipated income and expenses(25%)	G988
FS.2.I.M2	FS.2	The annual budget is prepared under the guidance of governance(25%)	G988
FS.2.I.M3	FS.3	Annual budget is reviewed and updated at least annually(25%)	G988




53




## Tips for Success




Ensure process in place for developing an annual budget with capital expenditures, if required




Ensure appropriate representation from governing body






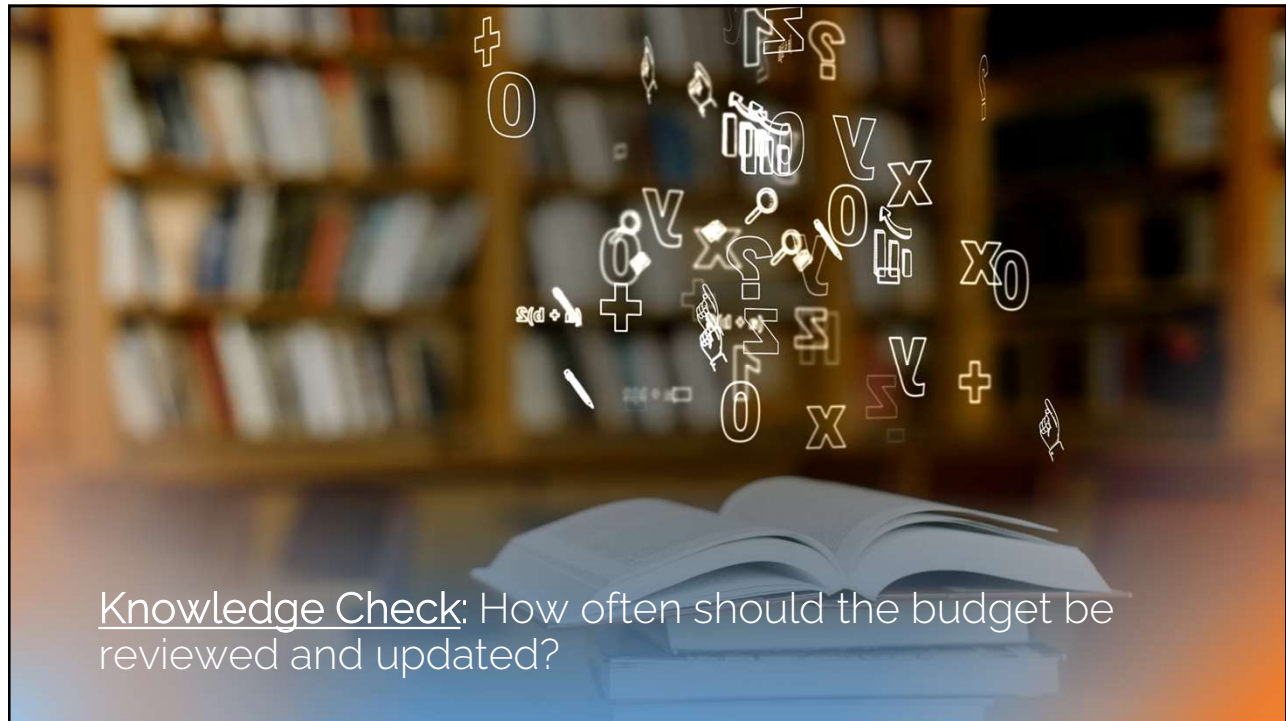
Document meeting interactions with governing body



Schedule time for review and updates to the budget



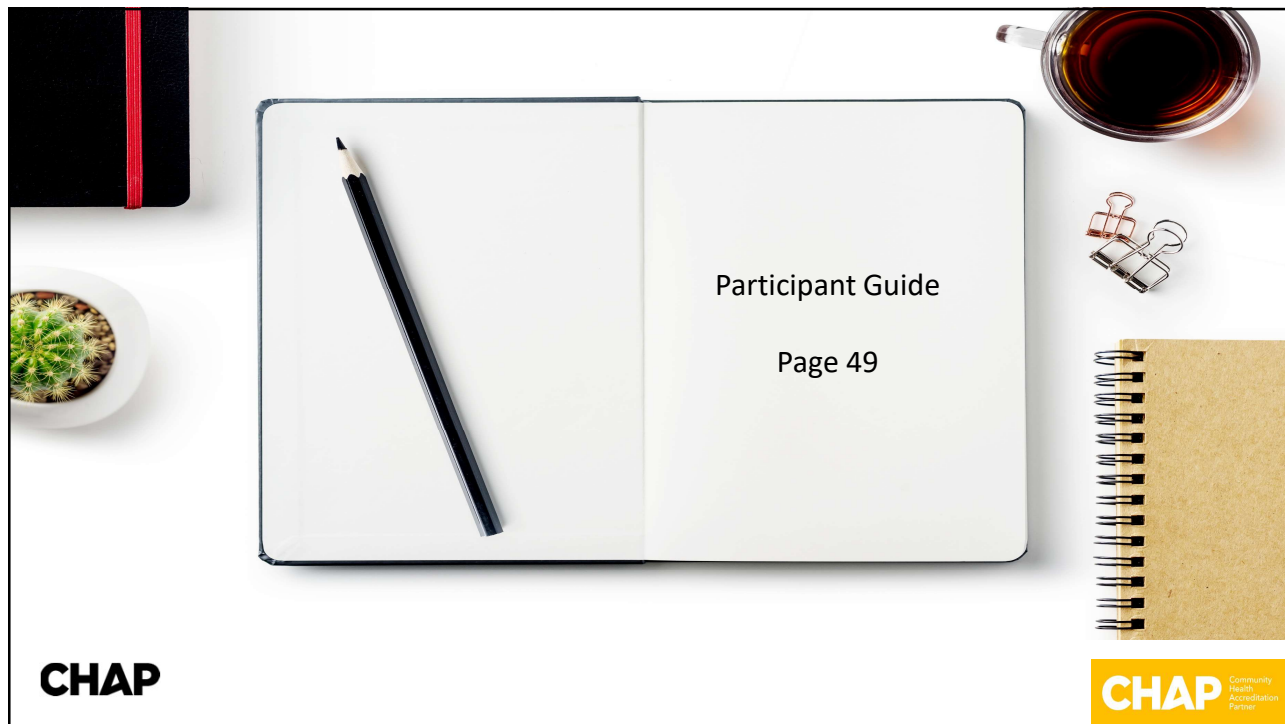
54



55



56



57

A photograph showing two healthcare professionals, a woman and a man, wearing blue scrubs and gloves. They are standing at a wooden table, examining a patient's arm. The patient is an older woman with short grey hair, wearing a striped shirt. On the table, there is a bowl of red and green apples and some papers. The background shows a clinical setting with a sink and a framed picture on the wall. The CHAP logo is in the bottom right corner.

## Care Delivery and Treatment (CDT)

### KEY PERFORMANCE AREA

Care delivery and treatment are provided according to the patient's needs, accepted standards of practice, and the organization's defined scope of services.

58

## CDT Standard Summary

Home health care and services are provided within the organizations accepted standards of practice.

**CDT.1**  
Requirements for the provision of services

**CDT.3**  
Care follows standards of practice within scope of license

**CDT.5**  
Policies regarding acceptance, documentation, verification and authentication of orders

**\*CDT.6 & \*CDT.7**  
Medications, treatments administered only as ordered

Orders, including verbal orders, signed and dated


**\*CDT.9**  
Care is provided by all disciplines in accordance with plan of care

**CDT.13**  
Patient education and training

**\*CDT.11, \*CDT.12, & CDT.14 – CDT.17**  
Aide services


**CDT.18**  
Remote monitoring policy requirements

\* Included in top 2022 findings



59

## Physician Orders The Requirements



**CDT.5**

There are documented **policies and procedures for the acceptance, documentation, verification, and authentication of required physician or other authorized practitioner orders.** Policies address which personnel can receive and document orders, including the timeframes for documentation and authentication, in accordance with local, state, and federal law and regulation.

Compliance with local, state, federal law, CHAP standards, and agency policy

- Know which is strictest

Physician signature within timeframe


- No longer a 30-day requirement by CHAP
- State specific/agency policy

**CDT.7**

**Orders, including verbal orders, are accepted, signed, and dated** by authorized personnel as defined in organization policies and local, state, or federal law.

Orders are signed and dated and indicate the time the order was received. Verbal orders are authenticated and dated by the physician.

60




## Skilled Professionals CDT.9

Responsibilities include:

- Ongoing interdisciplinary assessment of the patient
- Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s)
- Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care
- Patient, caregiver, and family counseling
- Patient and caregiver education
- Preparing clinical notes
- Communication with all physicians or allowed practitioners involved in the plan of care

**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.

61



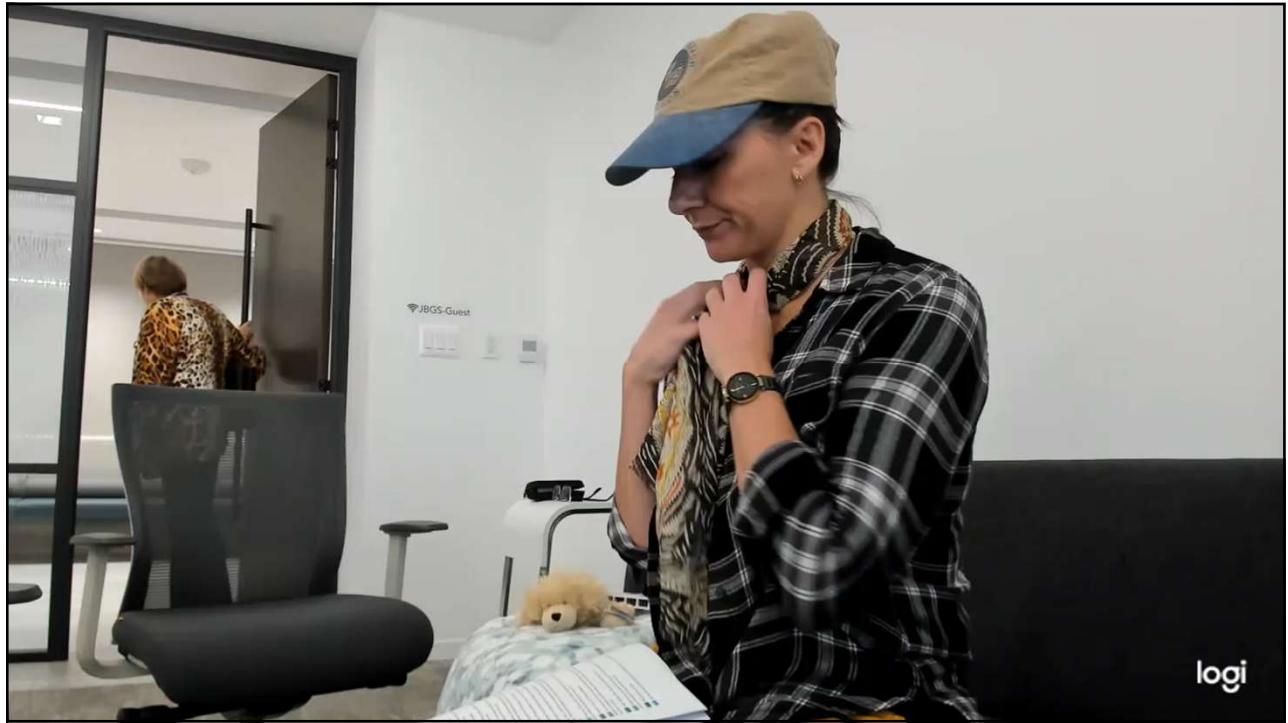
## Activity: Ms. Violet's nursing visit

Watch the home visit reenactment with patient Violet. Write down your concerns with the visit and be prepared to discuss.

Next, review the visit note on page 50 and compare with the information you obtained from the reenactment. What concerns do you have regarding the documentation?

**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.

62




63



64

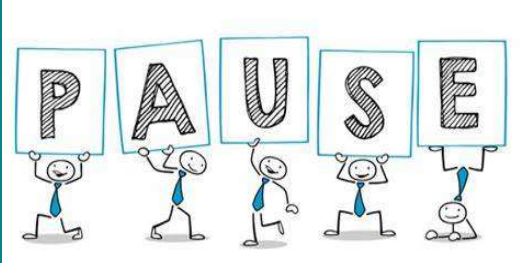





## Pause and Consider...

Take a few moments to review Violet's home health aide visit note on page 51.

What issues are you identifying as you review?






65

**CDT.11**  
**Aide Plan of Care**

Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional. Written patient care instructions for a home health aide are prepared by that registered nurse or other appropriate skilled professional.




**CDT.12**  
**Aide Following the Plan of Care**

A home health aide provides services that are ordered by the physician or allowed practitioner, included in the written plan of care, permitted to be performed under state law, and consistent with the home health aide's demonstrated competencies.

**CDT.15**  
**Aide Supervision**


Home health aides are supervised no less frequently than every **14** days.



66

## 2022 Top CDT Findings

Old Standard	New Standard	Content	CMS Tag
CDT.7.I.M2	CDT.9	Skilled professionals follow the plan of care/fulfill duties (45%)	G710
CDT.7.I.M7	CDT.12	Home Health Aide fulfills responsibilities (16%)	G800
CDT.4.I.M1	CDT.6	Medication/services treatments administered as ordered (12%)	G580
CDT.5.I.M2	CDT.7	Verbal orders authenticated and dated within 30 days. (10%)	G584
CDT.7.I.M5	CDT.11	Home health aides are provided written instruction (6%)	G798



67



## Tips for Success



Observation is key to ensure care is provided according to the plan of care and within scope of practice



Develop audit process with a focus on aide services



Audit physician orders and clinical documentation to ensure orders are followed

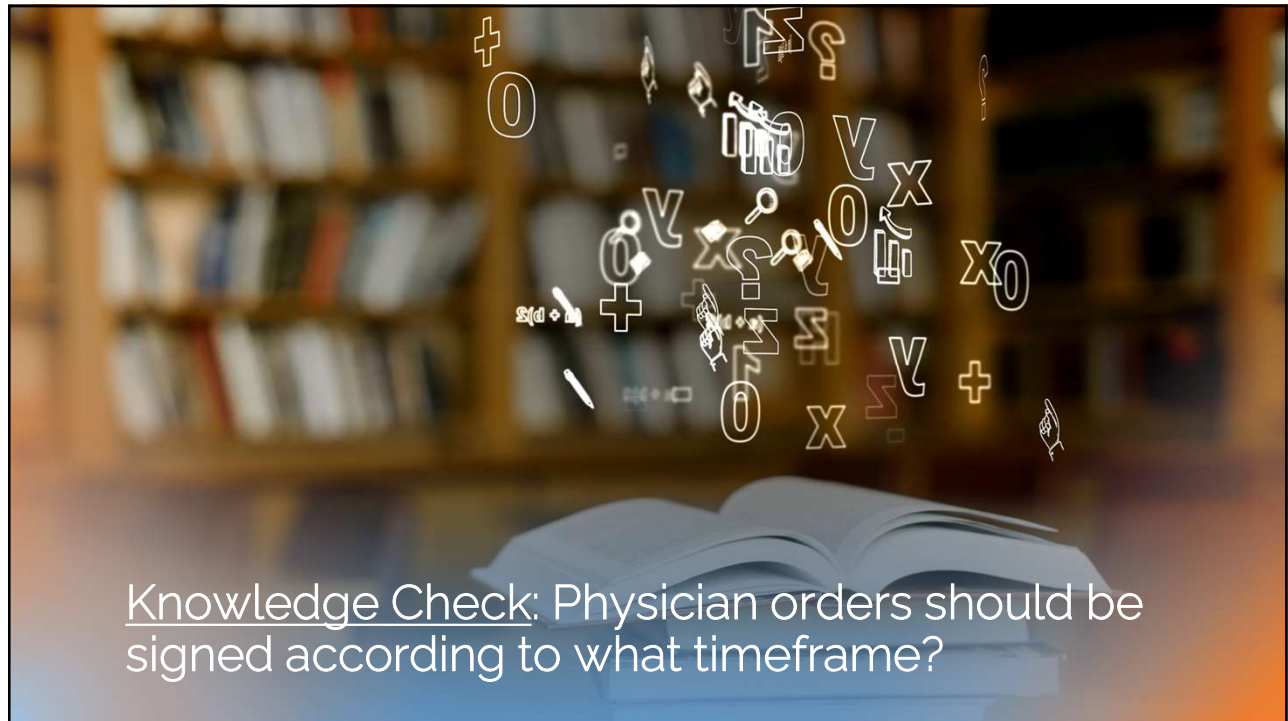


Provide education regarding aide services – how to develop plan of care and how to document

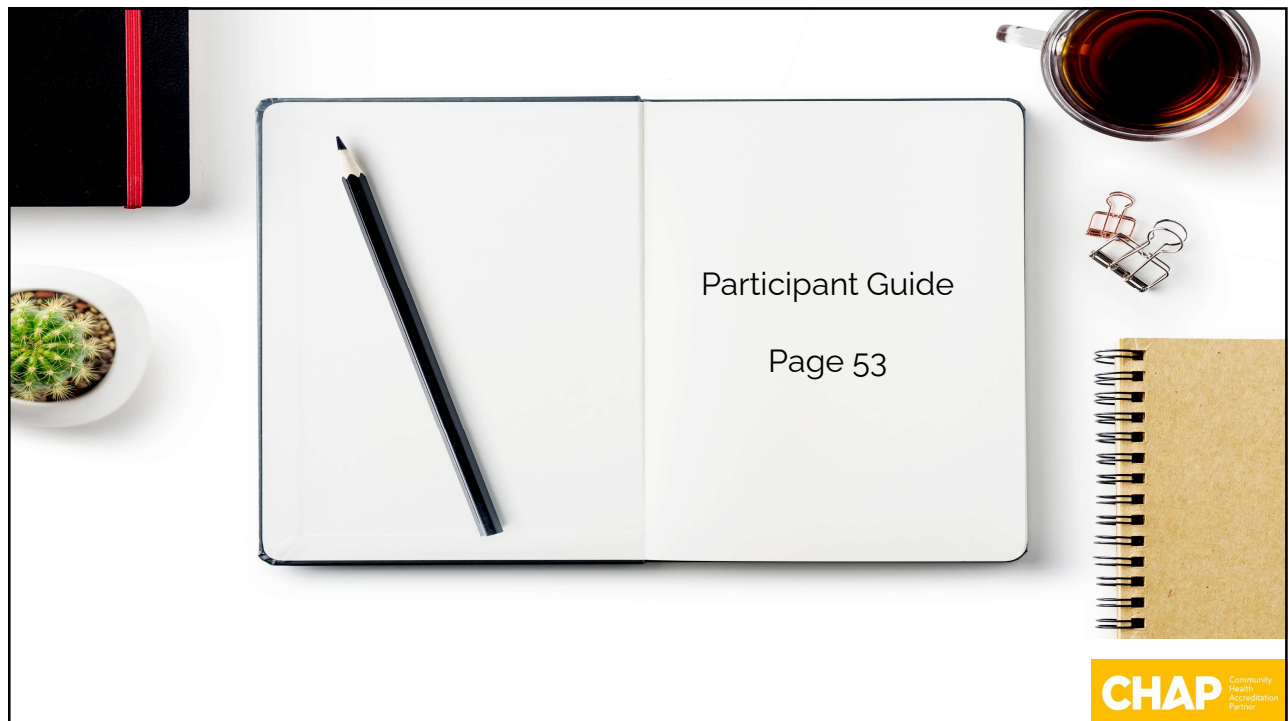




68



69



70



## Leadership and Governance (LG)

KEY PERFORMANCE AREA

The organization fulfills its stated mission through active leadership and governance, fostering an internal culture that promotes the delivery of person-centered, safe, effective, timely, and equitable care and services. Leadership and governance engage in governing all aspects of the organization, including goal setting, establishing and promoting ethical practices, and overseeing the management of all legal, fiscal, and operational matters




71

## LG Standard Summary

<p><b>LG.1</b> Provision of services to meet patient needs</p>	<p><b>*LG.5</b> Responsibility of governance</p>	<p><b>LG.7</b> Leadership qualifications</p>	<p><b>LG.13</b> Lines of Authority</p>
<p><b>LG.3</b> Care furnished in compliance with law and regulation</p>	<p><b>*LG.6</b> Governing body and quality program oversight</p>	<p><b>*LG.9</b> Administrator responsibilities</p>	<p><b>LG.14</b> Services provided under arrangement</p>

\* Included in top 2022 findings



72

Thoughts to consider...

In what ways did the pandemic highlight the importance of several of the standards in the Leadership and Governance chapter?

What deficiencies, if any, did you observe within your organization or organizations you work with?

What "wins" did you observe?

73

**CHAP** Community Health Accreditation Partner  
Patient Centered. Partner Focused.

**LG.5**  
Organization's Governing Body assumes full authority and responsibility for:

Organization's overall management and Operations

Provision of care and services

Fiscal operations

Review of the budget and operational plans

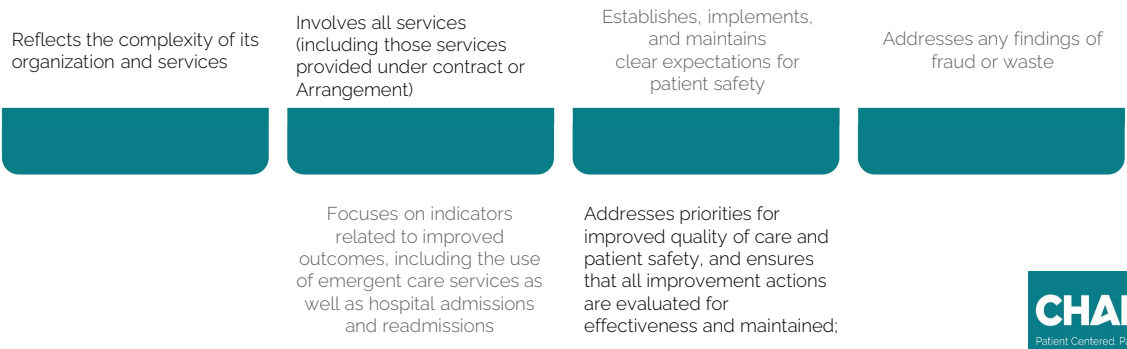
Ongoing performance improvement and patient safety program that is defined, implemented, maintained, and evaluated annually

Appointment of a qualified administrator

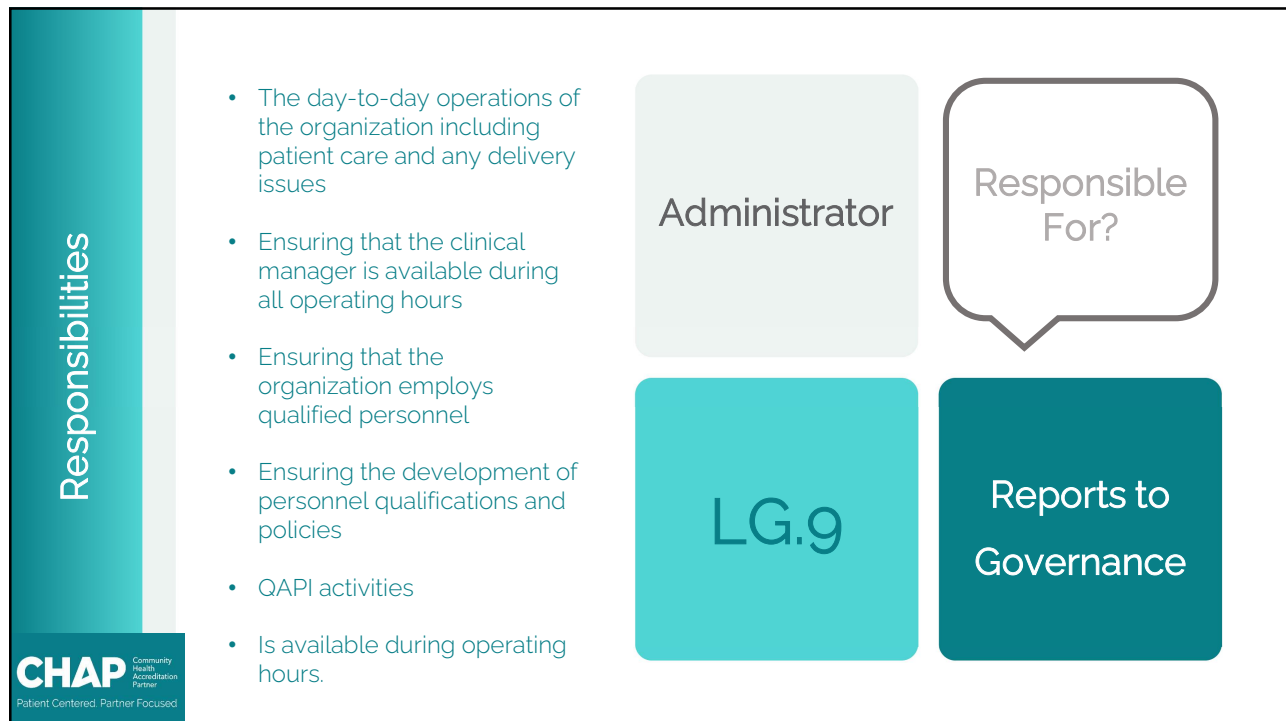
74

## LG.6 Quality Program Oversight

Governance ensures that an ongoing program for quality improvement and patient safety is defined, implemented, and maintained. Governance approves the frequency and detail of the organization's data collection and ensures that the quality improvement program:



75



76

## Contractual Services Requirements

LG.14

**CHAP** Community  
Health  
Accreditation  
Partner  
Patient Centered. Partner Focused.

- 

Delivered consistent with standards of practice and patient safety

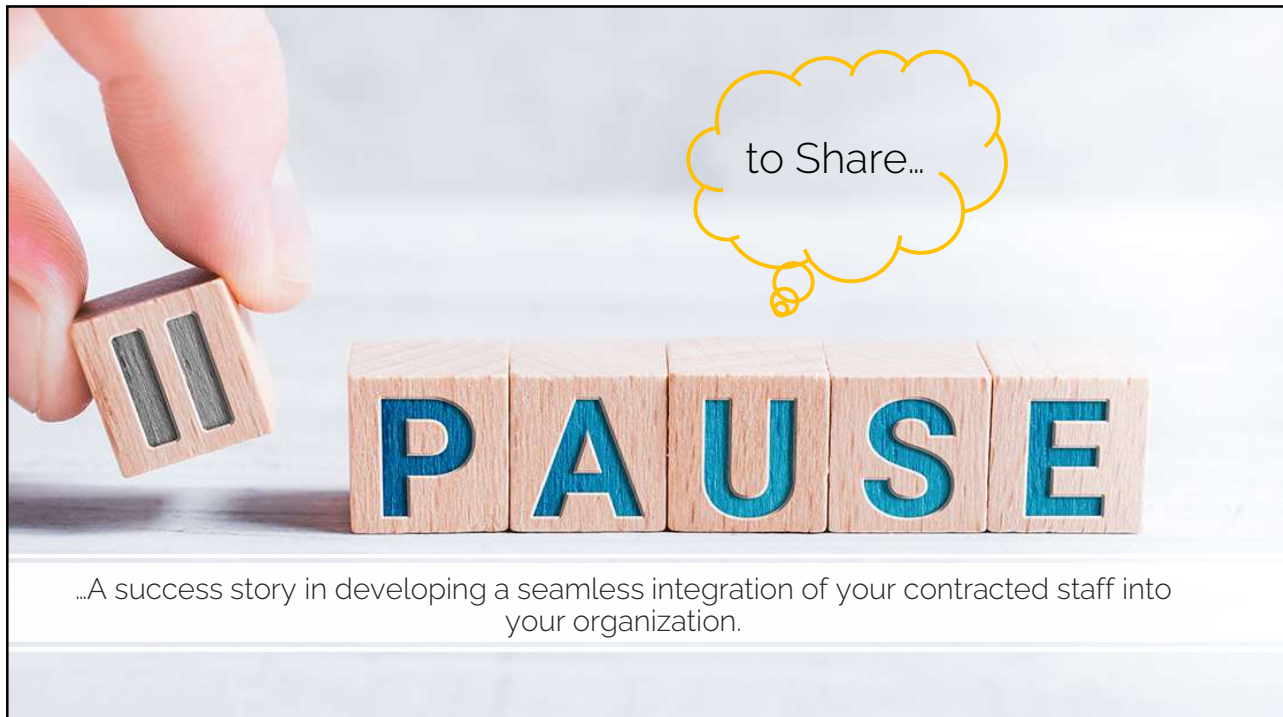
Contracts signed/dated/authorized by each party and details specific responsibilities of each party
- 

Care is provided in a safe and effective manner and is in accordance with the patient's plan of care
- 

All services are monitored and controlled; responsibility for service provided reside with the organization

Contracted staff may not have been on exclusion list


77



78

## 2022 Top LG Findings

Old Standard	New Standard	Content	CMS Tag
LG.4.I.M3	LG.6	Governance has responsibility for Quality program(31%)	G660 G640 CLD
LG.4.I.M1	LG.5	Agency governance assumes full legal authority (14%)	G942
LG.7.I.M1	LG.9	Administrator responsibilities and reporting to gov body (10%)	G948, G950
LG.12.D.M1	LG.15	Patients are not liable for services provided under arrangement (8%)	G976
LG.7.I.M3	LG.10	Alternate administrator in writing assumes responsibilities (8%)	G954



79



## Tips for Success



Ensure governing body participates in quality meetings and/or discussions



Document governing body involvement



Ensure Administrator can fulfill responsibilities and oversight of day-to-day operations



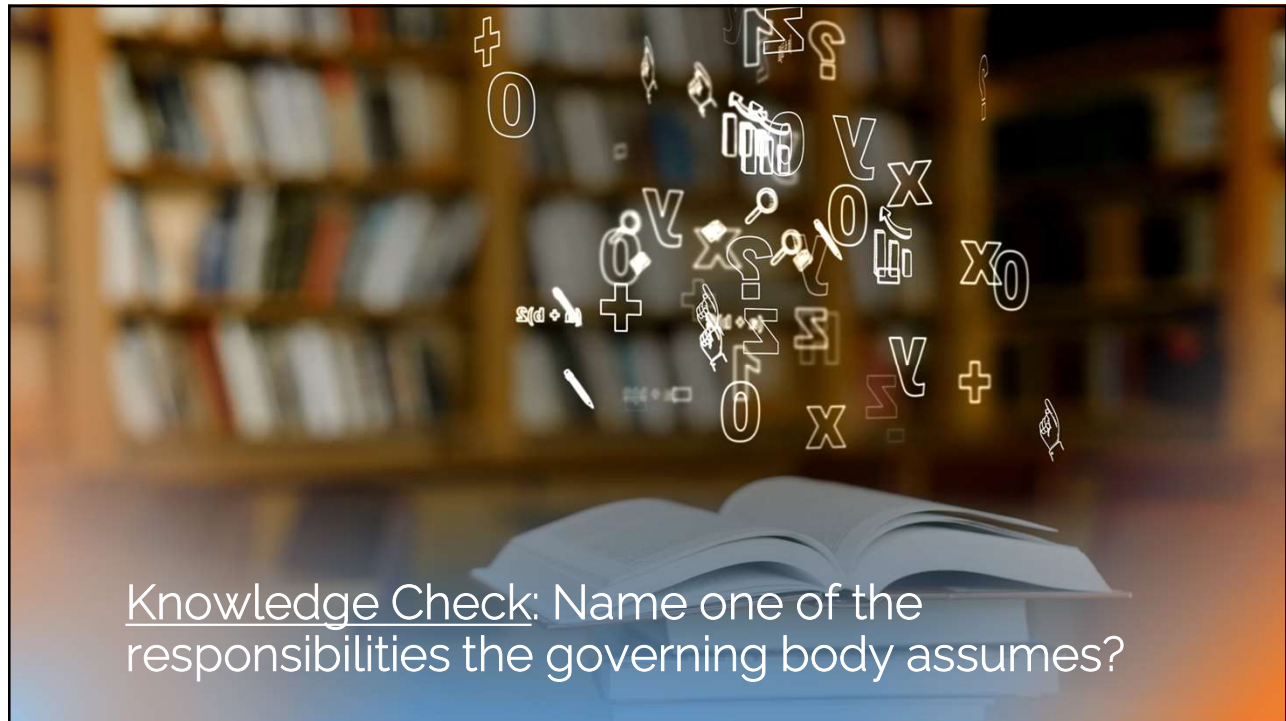
Ensure a qualified alternate is in place for the Administrator





80

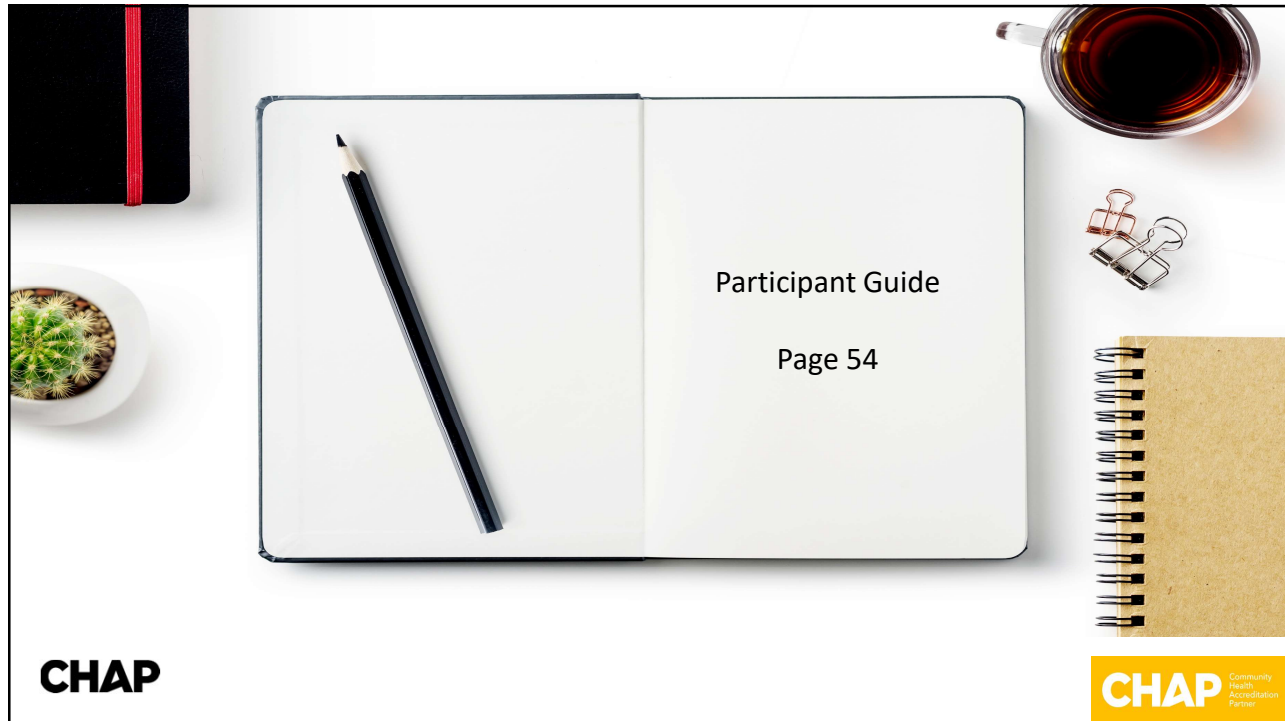





81



82



83




## Information Management (IM)


KEY PERFORMANCE AREA

Organizations implement information management systems that support clinical and business intelligence, including processes for collecting, storing, transmitting, and protecting data.

Information management systems support the use and analysis of data to inform decision making.



84



## IM Standard Summary

Information management policies and procedures address how the organization collects, protects, shares, and retains information in accordance with local, state, and federal law and regulation.

**IM.2**  
Record retention policies if org ceases operations

**IM.3**  
Timeframe of administrative, financial, personnel, and patient records: retained according to policy and state/federal regulation

**IM.4**  
Appropriate organizational information shared

**IM.6**  
Accessing patient information and safeguarding patient records

**\*IM.7**  
Record made available to patient

**IM.10**  
Standardized processes for documentation

**\*IM.11**  
Information in patient record is accurate

**\*IM.12**  
Entries in record are legible and complete, authenticated, dated, and timed

**IM.13**  
Data transition per regulation

**\*IM.17**  
Clinical record elements

\* Included in top 2022 findings

85



## Communicating with Government Officials

Information is disclosed in accordance with state, local, federal law and regulation

Discloses information at initial certification request, for each survey, and at time of change in ownership/management

**IM.4**

Name and address of those with ownership or controlling interest

**IM.4**

Name and address of each officer, director, agency or managing employee


**IM.4**

Name and address of the corporation, association, or other company responsible for management; name and address of the CEO and board chair

**IM.5**

Parent organization responsible for reporting all branch locations to the state survey agency

86



## Access of Information

Patient information is accessed by authorized individuals as determined by the organization and as required by local, state, and federal law and regulation.

<p>Record is safeguarded against loss, unauthorized use or access</p> <p><b>IM.6</b></p> <p><b>Protection of PHI</b> PHI is used and disclosed only for purposes permitted by law.</p>	<p>Patient's record is made available to the patient, free of charge upon request</p> <p><b>IM.7</b></p> <p><b>Timeframe</b> At the next home visit or within 4 business days (whichever comes first)</p>	<p>Patient record is made available</p> <p><b>IM.8</b></p> <p><b>To Whom</b> the physician or allowed practitioner issuing orders for the home health plan of care and appropriate personnel</p>	<p>The organization, including contracted staff, ensure confidentiality of all patient information</p> <p><b>IM.9</b></p> <p><b>Oasis</b> This includes Oasis data. Identifiable Oasis information is not released to the public</p>
--	---	--	--

87

## Clinical Record Documentation

**IM.16**  
The organization maintains a **current record** of patient care and services.

**IM.10** **Standardized Formats**  
The organization uses standardized formats for documenting the delivery of care and services, consistent with their policies and procedures. Personnel **do not use abbreviations, acronyms, or symbols** prohibited by the organization.

**IM.11** **Accurate Patient Record**  
The organization maintains a patient record containing past and current information for every patient accepted and receiving home health services. **Information contained in the patient record is accurate** and adheres to current patient record documentation standards of practice.

**IM.12** **Entries in the Patient Record**  
Entries in records **are legible, clear, complete, and appropriately authenticated, dated, and timed**. Authentication includes a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.



88

**Data Transmission**  
Of Oasis Assessments

The organization encodes and electronically transmits OASIS assessments to CMS within **30 days**

**IM.13**

The organization transmits data using data communication software compliant with federal requirements

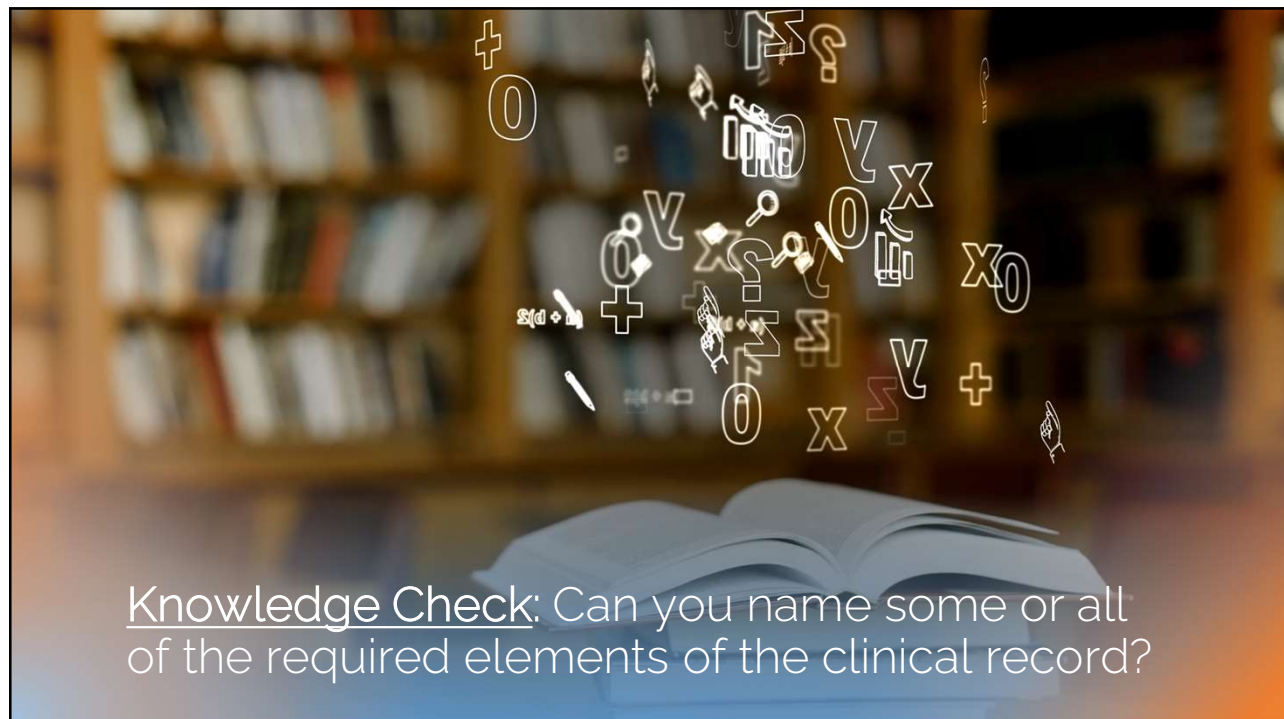
**IM.14**

OASIS data transmission includes CMS-assigned branch ID number, as applicable

**IM.15**


**CHAP** Community Health Accreditation Partner

89



Knowledge Check: Can you name some or all of the required elements of the clinical record?

90



## Clinical Record Components IM.17

The organization maintains a current record of patient care and services and include:

Contact  
Information

Consent

Comprehensive  
Assessments

Plans of Care

Education and Training


Physician or Allowed  
Practitioner Orders

Clinical Progress Notes

All Interventions


Responses to  
Interventions

Goals and the  
Patient's Progress



91

Pause to  
consider...




Which of the required clinical record elements do your organizations have the most challenges with?

92


## 2022 Top IM Findings

Old Standard	New Standard	Content	CMS Tag
IM.7.I.M1	IM.17	Required elements of the patient record (40%)	G1012
IM.5.I.M2	IM.12	Entries are legible, clear, complete and include signature & title (27%)	G1024
IM.4.I.M1	IM.7	Availability of patient record (10%)	G1030
IM.5.I.M1	IM.11	Patient record includes past, and current information that is accurate (6%)	G1008

**G1012:** The patient's current comprehensive assessment, including all the assessments from the most recent home health admission





93



## Tips for Success


Use of templates may aide in standardizing documentation







Develop audit process/tool to ensure all components of the record are present

Educate staff and physicians on complete authentication of documentation – signature, date, and time

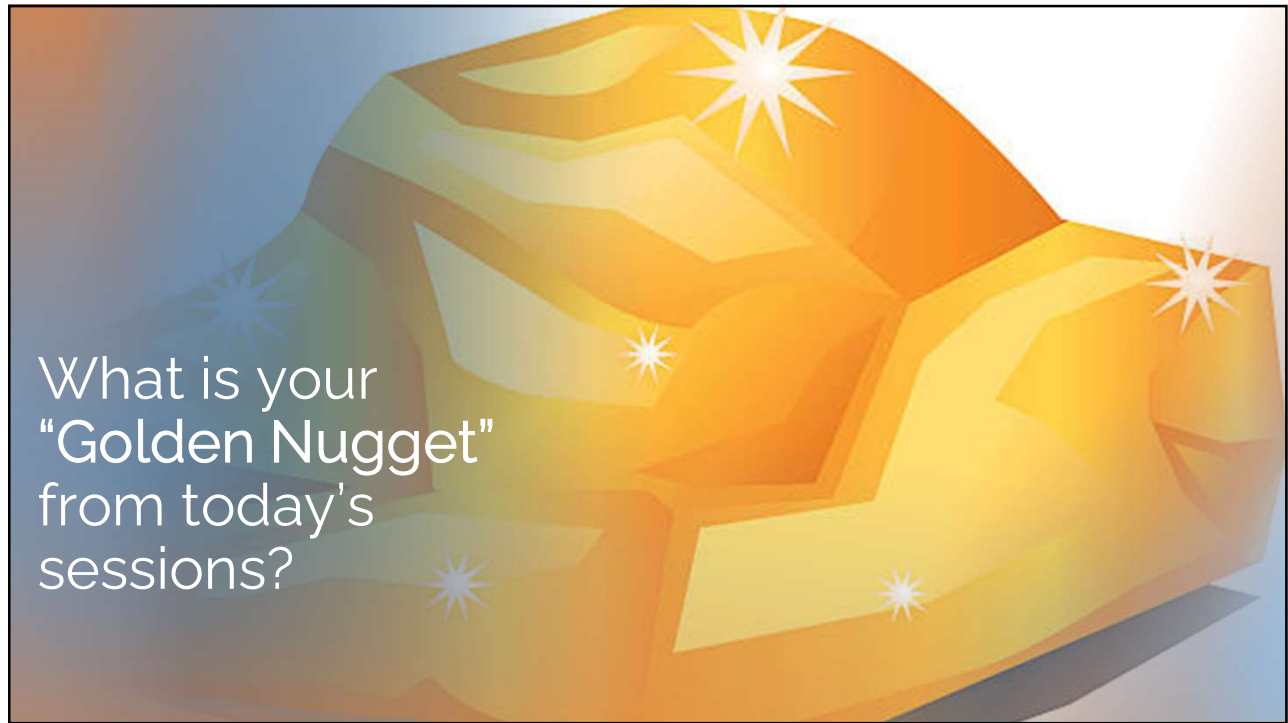




Focus audits to validate comprehensive assessment documentation is complete at specific timeframes – SOC, ROC, DC



94



95



96



# CHAP

Community  
Health  
Accreditation  
Partner

## 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.

This presentation is the sole property of CHAP, Inc. and cannot be reproduced or used without written permission.

97

# Day 3



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


[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap\\_b\\_hha.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_b_hha.pdf)

[https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap\\_m\\_hospice.pdf](https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/Downloads/som107ap_m_hospice.pdf)

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

<https://www.shpdata.com/media/2199/shp-oasis-d1-to-oasis-e-crosswalk-20.pdf>

<https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/HomeHealthQualityInits/HHQIOASISUserManual>



98

# CHAP

---

## Thank You

Keri Culhane MBA BSN RN  
Clinical Nurse Educator  
[Keri.Culhane@chapinc.org](mailto:Keri.Culhane@chapinc.org)  
202.218.3700

Denise Stanford MS SHRM-CP  
Senior Director of Operations  
[Denise.Stanford@chapinc.org](mailto:Denise.Stanford@chapinc.org)  
202.803.7839