TOP 10 **HOME HEALTH** DEFICIENCIES

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CHAP Community Health Accreditation Partner

	New Standard	Old Standard	G Tag	Standard Content	Tips for Compliance
1	APC.10	APC.7.I.M2	G574	Content of the individualized plan of care	• Educate all disciplines on including problems, interventions and goals based on the completed comprehensive assessment and on-going clinical assessments • Ensure goals are SMART (Specific, Measurable, Achievable, Realistic, Timely) • Focus on individualization of the plan of care specific to each patient's unique needs • Perform final review of Plan of Care for accuracy including allergies, interventions, medications, emergent care and hospitalization risk • QAPI indicator or PIP to achieve and sustain compliance with problems, interventions, goals
2	APC.14	APC.8.I.M3	G614	The organization provides the patient and caregiver(s) with a copy of written instructions including a visit schedule, including frequency of visits by HHA personnel and contractors	• Educate all disciplines, including contractors, that they must complete the visit schedule in the home at SOC and continuing through discharge • Perform home observation visits to ensure visit schedule is current and complete
3	APC.23	APC.11.I.M3	G1022	Clinical record includes transfer and/or discharge summaries within the required time frame with evidence of date sent	• Develop process for tracking days to ensure timeliness • Educate clinicians on elements to include in the summary and time frame for sending • Audit to ensure timeliness
4	APC.8	APC.6.I.M1	G536	The comprehensive assessment includes a medication regimen review	• Conduct medication reconciliation during home visits • Educate all disciplines to communicate any medication changes to the physician • Perform record audits to verify all medications are present on medication profile
5	PCC.2	PCC.2.I.M1	G442	Patient's have the right to receive written notice in advance of care being furnished, if there is possibility of not-covered care, or in advance of reducing or terminating ongoing care	• Ensure that staff provide patients with information related to potential payment liability at time of admission • Audit discharge processes to ensure patients were informed of reduction or termination of services
6	CDT.9	CDT.7.I.M2	G710	Skilled professionals follow plan of care including following physician orders	• Ensure a process is in place to audit visit frequencies against actual visits completed • Ensure a process is in place to audit clinical documentation against the plan of care to ensure all disciplines are following the plan care as established by the physician
7	IPC.6	IPC.3.I.M1	G682	Hand hygiene performed when indicated	• Conduct ongoing education and training related to standard precautions • Conduct routine field observation visits with staff to validate their ability to comply with infection control processes
8	IPC.8	IPC.4.I.M1	G682	Bags used to carry equipment or supplies into patient's homes follows agency's policy to prevent the spread of infections and communicable diseases	• Provide frequent education to field staff on Bag Technique policies and procedures and evaluate competency • Perform frequent home supervisory visits to observe staff in the home in order to assess compliance
9	IM.17	IM.7.I.M1	G1012	The organization maintains a current record of patient care and services including the patient's comprehensive assessment, including all of the assessments from the most recent home health admission, clinical notes, plans of care, and physician orders	• Educate clinicians on documenting all assessments, clinical notes, orders in the clinical record • Perform clinical record review audits to ensure every completed visit has clinical documentation to support the visit that is accurate and complete
10	APC.4	APC.5.I.M1	G514	The organization conducts an initial assessment visit by a registered nurse to determine the immediate care and support needs of the patient and to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment is conducted: 1. Within 48 hours of referral; or 2. Within 48 hours of the patient's return home; or 3. On the physician or allowed practitioner ordered start-of-care date	• Ensure a process is in place to complete the initial assessment within the required timeframe, this includes ensuring staffing is adequate to complete the assessment timely • Perform clinical record review audits to ensure the assessment was completed timely • If the assessment is not completed timely, ensure documentation is present to support communication with the physician