

*Accreditation Commission  
for  
Health Care, Inc.*

**Accreditation the ACHC Way!**

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Sr. VP of Clinical Compliance and Accreditation

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# *ACHC Advantage*

- Viable alternative to accreditation.
- Simple standards.
- Customer service
- Uncomplicated survey process.
- High provider satisfaction.

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# *ACHC HISTORY*

**Established in 1986  
by providers for providers  
as an alternative to other  
accrediting organizations for home  
care in North Carolina.**

**Went national in 1996.....**

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# CORE PURPOSE

**To help  
our customers succeed.**

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# CORE MISSION

To **support** healthcare organizations and providers in optimizing wellness through standards that promote the effective, efficient delivery of quality services and products

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# ISO 9001:2000

In 2004, ACHC became the first health care accrediting organization in the world to comply with ISO criteria for validating a Quality Management System. This international distinction sets ACHC apart and answers the question, “Who accredits the accreditor?”

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# CMS Deeming Authority

On February 24, 2006, CMS granted ACHC deeming authority for home health.

In November 2006, CMS granted ACHC deeming authority for DMEPOS.

Hospice is coming soon!!

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# ACHC PROGRAMS

- Home Health
- Private Duty
- Hospice
- Pharmacy Services includes:
  - Infusion Pharmacy
  - First Dose Pharmacy
  - Respiratory Nebulizer Medication
  - Specialty Pharmacy
- Ambulatory Infusion Center
- Infusion Nursing
- Home Medical Equipment
- Clinical Respiratory
- Medical Supply provider services.
- Rehabilitation Technology Supplier Services
- Fitter Services

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# ACHC Accreditation Process

- Purchase Manual
  - Customer Central Access
  - Account Manager
- Submit Application / Deposit /Preliminary Evidence Report
- Contract includes fees and payment schedule
- Schedule survey and assign surveyor
- Pre-Survey Review
- On-Site Survey

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# ACHC Accreditation Process

- Opening Conference
- Tour Facility, Meet Personnel
- Policy and Procedure Review
- Interviews of Leadership/Personnel
- Presentation of QI Plan

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# ACHC Accreditation Process

- Review Personnel Records
- Review Patient Records
- Contract Review
- Patient Visits and Interviews
- Exit Conference/Education and Consultation

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# ACHC Standards

Standard

Criteria

Interpretation

Evidence

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# ACHC Standards

## Section 100: Organization & Administration.

- Legal Authority
- Governing Body
- Conflict of Interest
- Organization Chart
- Mission and Philosophy

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# ACHC Standards

## Section 200: Program/Service Operations

- Bill of Rights
- Description of Services
- Complaint Procedure
- Confidentiality
- Ethics

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# ACHC Standards

## Section 300: Fiscal Management

- Budget
- Sound Business Practices
- Communication of Charges

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# ACHC Standards

## Section 400: Personnel Management

- Personnel Policies
- Job Descriptions
- Selection and Hiring
- Orientation
- Competency
- Continuing Education
- Evaluation
- Contracts

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# Personnel Standards

Most common issues in Section 400:

- No or poor orientation
- No initial or ongoing competency assessment
- No licensure verification
- No annual performance appraisals
- No criminal background/sex offender checks
- Incomplete or outdated contracts

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# ACHC Standards

## Section 500: Patient Record Management

- Patient Record
- Intake and Referral
- Eligibility Criteria
- Patient Assessments
- Patient Education

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# ACHC STANDARDS

## Section 600 : Quality Outcomes/Improvement

- QI Coordinator
- Governing body and staff involvement
- Annual QI Plan
- Patient Record Review
- Patient Satisfaction
- Monitoring: Aspect of Care, Risks, Operations
- Reporting
- Plan of Action

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# ACHC Standards

## Section 700: Risk Management: Infection & Safety Control

- Emergency Preparedness Plan
- Incident Reporting
- Infection Control Plan and Review

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# ACHC Standards

## Home Health: Scopes of Services

Home Health Care Nursing

Medical Social Services

Occupational Therapy

Physical Therapy

Speech Therapy

Home Health Aide

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# ACHC STANDARDS

## HOSPICE:SCOPE OF SERVICES

INCLUDES HOSPICE AND INPATIENT FACILITY

IDT APPROACH TO SURVEY

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# ACHC Standards

## Scopes of Services:

Private Duty Nursing

Private Duty Aide

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# QI STANDARDS

**Standard 601, Criterion A:** The organization ensures the implementation of a quality outcome/improvement plan by the designation of a person or persons responsible for quality improvement coordination activities.

**Interpretation:** Duties and responsibilities relative to QI coordination include: assisting with the overall development and implementation of the QI plan; assisting in the identification of goals and related client/patient outcomes; and coordinating, participating, and reporting of activities and outcomes results.

The individual(s) responsible for quality improvement coordination activities may also be the owner, manager, supervisor, or other organization employee.

**Evidence:** Job Description

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# QI STANDARDS

**Standard 601, Criterion C:** There is evidence of staff involvement in the quality improvement process.

**Interpretation:** Personnel will receive training related to quality improvement activities and their involvement. Training may include, but not be limited to, the purpose of quality improvement activities, person(s) responsible for coordinating quality improvement activities, the staff's individual role in quality improvement, and performance improvement outcomes resulting from previous activities.

The staff must be involved in the evaluation process through carrying out quality assessment activities, evaluating findings, recommending action plans, and/or receiving reports of findings. Staff must be informed of results of quality improvement activities that directly impact or reflect the service/care they provide.

**Evidence:** Minutes of Staff Meetings  
Response to Interviews

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# QI STANDARDS

**Standard 602, Criterion A:** Quality improvement activities must include an annual evaluation of the program.

**Interpretation:** An annual evaluation is a process that measures the organization's performance in relation to its mission, philosophy, goals and objectives and in meeting the needs of patients and communities served. As part of the evaluation process, the policies and administrative practices of the agency are reviewed to determine the extent to which they promote quality patient care. The annual evaluation is summarized in a written report which includes: (1) the effectiveness of the quality improvement program; (2) the effectiveness, quality and appropriateness of service/care provided to the patients, service/care areas and community served, including culturally diverse populations; (3) effectiveness of the overall administrative and fiscal operations; (4) effectiveness of all programs including service/care provided under contractual arrangements; (5) utilization of staff; and (6) review and revision of policies and procedures, and forms used by the organization.

**Evidence:** Annual Report

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# QI STANDARDS

**Standard 602, Criterion B:** Quality improvement activities must include an assessment of processes that involve risks.

**Interpretation:** A review of all variances, which may include incidents, accidents, and worker compensation claims, must be conducted at least quarterly for detection of trends, patterns of behavior, and for an action plan to decrease occurrences.

**Evidence:** Quality Improvement Reports

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# QI STANDARDS

**Standard 602, Criterion C:** Quality improvement activities must include ongoing monitoring of at least one important aspect related to the service/care provided.

**Interpretation:** An important aspect of service/care reflects a dimension of activity that may be high volume, high risk or problem prone. Examples include: delivery of service/care (timeliness, incorrect medication delivery); medication administration; clinical procedures.

**Evidence:** Quality Improvement Reports

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# QI STANDARDS

**Standard 602, Criteria D:** Quality improvement activities must include ongoing monitoring of at least one important administrative aspect or function of the organization.

**Interpretation:** The organization must monitor an administrative/operational function. Examples include: billing; performance appraisals; in-service hours.

**Evidence:** Quality Improvement Reports

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# QI STANDARDS

**Standard 602, Criteria E:** Quality improvement activities must include satisfaction surveys.

**Interpretation:** The QI plan identifies the process for conducting patient satisfaction surveys. The QI plan also identifies the process for conducting staff, physician and referral source satisfaction surveys.

**Evidence:** Quality Improvement Reports

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# QI STANDARDS

**Standard 602, Criterion F:** The quality improvement plan includes a review of the patient record.

**Interpretation:** The patient record review is conducted by all disciplines involved in the patient's care. An adequate sampling of open and closed records is selected to determine completeness of documentation.

**Evidence:** Quality Improvement Reports

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# QI STANDARDS

**Standard 603, Criterion A:** Each quality improvement activity or study contains the required items.

**Interpretation:** Each quality improvement activity/study must include the following items: (1) a description of indicator(s)/activities to be conducted; (2) frequency of activities; (3) designation of who is responsible for conducting the activities; (4) methods of data collection; (5) acceptable limits for findings; (6) who will receive the reports; and (7) plans to re-evaluate if findings fail to meet acceptable limits in addition to any other activities required under state or federal laws or regulations.

**Evidence:** Quality Improvement Activities/Studies

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# QI STANDARDS

**Standard 604, Criterion A:** There is a written plan of correction developed in response to any quality improvement findings that do not meet an acceptable threshold.

**Interpretation:** A written plan of correction is developed in response to any quality improvement activity that does not meet an acceptable threshold. The plan of correction may identify changes in policy, procedure, or processes that will improve performance. The plan of correction may require governing body action or approval or may be within the scope of authority already delegated to organization staff.

**Evidence:** Written Corrective Action Plans

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# SCORING

- ✧ Accreditation: 90% core and service area
- ✧ Deferral: core or any service area 80-89%
- ✧ Denial: core or any service area are below 80%

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# ACHC Accreditation Results

- ✧ Survey Review and Scoring
- ✧ Summary of Findings
- ✧ Clinical Compliance Review
- ✧ Plan of Correction
- ✧ Accreditation Certificate

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# ACHC Fees

- Based on number of survey days
- Number of branches
- Services provided at each location and number of surveyors needed

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# ACHC RESOURCES

- E-Mail – [customerservice@achc.org](mailto:customerservice@achc.org)
- Program Web site - [www.achc.org](http://www.achc.org)
- Customer Central Website
- Personalized Technical Assistance via Account Manager
- Clinical Advisors in each area of accreditation

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