**Home Health Services**

* If certified for participation in Medicare, provide your most current certification survey and plans of correction.
* Is your agency JCAHO or CHAPS accredited? If so, provide your current accreditation letter.
* If your agency is not certified, how will assure the provision of the RN initial assessment and supervision to each HHA consumer according to the Home Health Services Program Instruction?

## **I. Service Capacity**

1. Is your agency certified for participation in Medicare?
2. Is your agency a MassHealth provider?
3. Provide the number of regular full- and part-time employees in the following positions. (Do not duplicate. That **is**, report personal care/homemakers at the highest level of training only. If a PCHM is trained as a SHCA, do not count her as an HM, PC, and SHCA, but SHCA only).
4. Home Health Aides: Full Time  Part Time 
5. Registered Nurses: Full Time  Part Time 
6. Licensed Practical Nurses: Full Time  Part Time 
7. PTs: Full Time  Part Time 
8. OTs: Full Time  Part Time 
9. STs: Full Time  Part Time 
10. Provide the number of per diem contract employees for the following:
11. Registered Nurses : 
12. Licensed Practical Nurses: 
13. PTs: 
14. OTs: 
15. STs 
16. Provide an overview of workforce capacity initiatives, including recent turnover rates, ratio of service requests to staffing capacity, workforce adequacy evaluation, recruitment initiatives, linguistic or other special capabilities, etc.
17. Provide a detailed, concrete description of how staffing is managed day-to-day, including scheduled and unscheduled worker absences, ensuring service to Risk Level 1 and 2 as well as other high need consumers, orientation of substitutes, notifications, evening and weekend coverage, etc.
18. What percentage of HHAs is available to work the following schedules:
19. Evenings: 
20. Overnights: 
21. Weekends: 
22. Describe your agency process for maintaining a current list of Risk Level 1 and 2 consumers that is accessible in the event of an emergency.
23. Attach copies of the care plan forms currently in use. (One form for each service being offered, Skilled Nursing, Home Health Aide).

## **II. Staff Qualifications**

1. Describe in detail the experience and qualifications of the individual responsible for service provision (Home Health Mangers), if different from the information provided in the Administrative Overview.
2. Describe in detail the qualifications (professional experience, education, licensure, etc.) for the following staff:
3. Coordinators
4. Field supervisors
5. What is the process, including documentation procedures and persons responsible, for verifying the training qualifications of HMPCs and SCHAs?
6. Describe your criteria for the selection of RNs and LPNs:

## **III. Training and In-Service Education**

1. Your agency provides directly:

Home Health Aide training program

Home Health Aide competency evaluation program

Both

Neither

1. If your agency provides the HHA training program, attach a copy of the curriculum.

1. Who in your agency is responsible for overseeing in-service education?
2. Describe your process for ensuring that all staff understands the requirements of 105 CMR 155.00 and receives mandatory annual training on the topic.

## **IV. Supervision**

1. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position (HHAs, nurses, coordinators, supervisors, etc.).
2. Describe the systems and procedures employed to ensure that services are delivered to consumers as authorized, including telephony, unannounced field visits, quality assurance calls, etc.
3. For SHCA, provide a detailed description of the supervision and support provided in accordance with the requirements found in Attachment A: Homemaker Standards.
4. Describe the supervisory support available to direct care workers during non-business hours, including how supervisors are contacted, the titles and, as applicable, licensure of available supervisors.
5. Attach a copy of the field supervision report form currently in use for your employees.

Provider employee who completed this form

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

*NOTE: Rates for Nursing Services, Home Health Aide, Physical Therapy, Occupational Therapy, and*

*Speech Therapy are established by the Division of Health Care Finance and Policy.*

**Home Health Services**

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| CONSUMER Record Review | | | | | | |
| Provider  Date  Monitor | |  |  |  |  |  |
| ASAP Authorization | |  |  |  |  |  |
| ID Info – name; address; phone; DOB, SAMS ID | |  |  |  |  |  |
| Emergency contact(s) name and phone | |  |  |  |  |  |
| Physician(s) name and phone | |  |  |  |  |  |
| Hospital name and phone | |  |  |  |  |  |
| Medical/social diagnosis | |  |  |  |  |  |
| Name of current CM/RN | |  |  |  |  |  |
| Referral date | |  |  |  |  |  |
| Service start date  & termination date, if applicable | |  |  |  |  |  |
| Care Plan, dated,  & signed by Nurse | |  |  |  |  |  |
| Dates of Provider home visits? | |  |  |  |  |  |
| Money Handling Release form | |  |  |  |  |  |
| Comments | | | | | | |
| NOTE: Shaded data elements are only required in the Consumer File if provider is not on Provider Direct. Otherwise the PD Demonstrator will be asked to illustrate “on screen”. | | | | | | |

|  |  |
| --- | --- |
| **Name and Position of Provider Direct Demonstrator** |  |

**Home Health Services**

Please note the documents and records which will be required for the Consumer files and/or Employee files to be reviewed at the time of On Site Evaluation

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| EMPLOYEE Record Review (for non-certified HHA Providers) | | | | | |
| Provider  Date  Monitor |  |  |  |  |  |
| Start Date  & Termination Date, if applicable |  |  |  |  |  |
| Number of Reference Checks |  |  |  |  |  |
| CORI Check |  |  |  |  |  |
| DPH Check |  |  |  |  |  |
| Orientation date |  |  |  |  |  |
| Job Description(s) |  |  |  |  |  |
| License(s)/  Certificate(s) of training: Current/expired? |  |  |  |  |  |
| Skills/Competency Checklist |  |  |  |  |  |
| Physical: Latest date |  |  |  |  |  |
| TB: Latest date |  |  |  |  |  |
| CPR/First Aid: Latest date |  |  |  |  |  |
| OIG monthly checks |  |  |  |  |  |
| Ongoing Training:  12 hours/year |  |  |  |  |  |
| HHA Supervisions: dates |  |  |  |  |  |
| Annual Performance Appraisal: Date |  |  |  |  |  |
| Comments | | | | | |