ADMINISTRATIVE OVERVIEW
SERVICE SPECIFIC ATTACHMENT

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

A. Is your agency certified for participation in Medicare?

B. Is your agency a MassHealth provider?

C. 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).

1) Home Health Aides: Full Time Part Time
2) Registered Nurses: Full Time Part Time
3) Licensed Practical Nurses: Full Time Part Time
4) PTs: Full Time Part Time
5) OTs: Full Time Part Time
6) STs: Full Time Part Time

D. Provide the number of per diem contract employees for the following:

1) Registered Nurses :
2) Licensed Practical Nurses:
3) PTs:
4) OTs:
5) STs

E. 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.

F. 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.

G. What percentage of HHAs is available to work the following schedules:

1) Evenings:

2) Overnights:

3) Weekends:

H. 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.

I. 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

A. 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.

B. Describe in detail the qualifications (professional experience, education, licensure, etc.) for the following staff:
   1) Coordinators

   2) Field supervisors

C. What is the process, including documentation procedures and persons responsible, for verifying the training qualifications of HMPCs and SCHAs?

D. Describe your criteria for the selection of RNs and LPNs:

III. Training and In-Service Education

A. Your agency provides directly:
   - ☐ Home Health Aide training program
   - ☐ Home Health Aide competency evaluation program
   - ☐ Both
   - ☐ Neither

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

C. Who in your agency is responsible for overseeing in-service education?

D. 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

A. Describe the procedures for supervision, including frequency, documentation, and credentials/qualifications of supervisors for each position (HHAs, nurses, coordinators, supervisors, etc.).

B. 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.

C. For SHCA, provide a detailed description of the supervision and support provided in accordance with the requirements found in Attachment A: Homemaker Standards.

D. 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.

E. Attach a copy of the field supervision report form currently in use for your employees.

Provider employee who completed this form

Name: _____ Date: _____

SERVICE SPECIFIC ON-SITE REVIEW

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	

SERVICE SPECIFIC ON-SITE REVIEW

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					