Prepublication Requirements

• Issued March 18, 2022 •

Requirements Revised for Home Health Agencies

The Joint Commission has approved the following revisions for prepublication. While revised requirements are published in the semiannual updates to the print manuals (as well as in the online E-dition®), accredited organizations and paid subscribers can also view them in the monthly periodical The Joint Commission Perspectives®. To begin your subscription, call 800-746-6578 or visit http://www.jcrinc.com.

Please note: Where applicable, this report shows current standards and EPs first, with deleted language struck-through. Then, the revised requirement follows in bold text, with new language underlined.

APPLICABLE TO THE HOME CARE ACCREDITATION PROGRAM
Effective Immediately

Human Resources (HR) Chapter

HR.01.03.01

Staff are supervised effectively.

Element(s) of Performance for HR.01.03.01

15. For home health agencies that elect to use The Joint Commission deemed status option: When home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse makes an on-site visit to the location where the patient is receiving care. This visit occurs no less frequently than every 60 days in order to observe and assess each aide while they are performing care.

15. For home health agencies that elect to use The Joint Commission deemed status option: When home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the following apply:
- The registered nurse makes an on-site, in-person visit every 60 days to assess the quality of care and services provided by the home health aide and to ensure that services meet the patient’s needs. The home health aide does not need to be present during this visit.
- Two times a year, the registered nurse must make an on-site visit to the location where each patient is receiving care in order to observe and assess each home health aide as they perform nonskilled care.

Key: ◎ indicates that documentation is required;  ❉ indicates an identified risk area;
27. For home health agencies that elect to use The Joint Commission deemed status option: When home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the patient care instructions written by a registered nurse or appropriate skilled professional, must make an on-site visit to the patient's home no less frequently than every 14 days. The home health aide does not have to be present during this visit.

27. For home health agencies that elect to use The Joint Commission deemed status option: When home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, the following apply:
- A registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the patient care instructions written by a registered nurse or appropriate skilled professional, must complete a supervisory assessment of the aide's services no less frequently than every 14 days. The home health aide does not have to be present during the supervisory assessment.
- The supervisory assessment must be completed on site (that is, an in-person visit), or on the rare occasion, by using two-way, audio-video telecommunications technology that allows for real-time interaction between the registered nurse (or other appropriate skilled professional) and the patient, not to exceed one virtual supervisory assessment per patient in a 60-day episode.

30. For home health agencies that elect to use The Joint Commission deemed status option: If a deficiency in aide services is verified by the registered nurse or other appropriate skilled professional during an on-site visit, then the agency must conduct, and the home health aide must complete, a competency evaluation related to the deficient skill(s).

30. For home health agencies that elect to use The Joint Commission deemed status option: If a deficiency in aide services is verified by the registered nurse or other appropriate skilled professional during an on-site visit, then the agency must conduct, and the home health aide must complete, retraining and a competency evaluation related to the deficient skill(s) and all related skills.

Provision of Care, Treatment, and Services (PC) Chapter

PC.01.02.05

Qualified staff or licensed independent practitioners assess and reassess the patient.

Element(s) of Performance for PC.01.02.05
3. For home health agencies that elect to use The Joint Commission deemed status option: The initial assessment visit may be made by an appropriate skilled rehabilitation professional (physical therapist, occupational therapist, or speech language pathologist) when rehabilitation therapy service (physical therapy, occupational therapy, or speech therapy) is the only service ordered by the physician responsible for the home health plan of care, and the need for that service establishes program eligibility.  
   (See also  PC.01.02.05, EP 2)

5. For home health agencies that elect to use The Joint Commission deemed status option: When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by a physician or allowed practitioner, a physical therapist, speech-language pathologist or occupational therapist may complete the comprehensive assessment and determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment if the need for occupational therapy establishes program eligibility.  
   (See also  PC.01.02.03, EP 11)

PC.02.01.05

The organization provides interdisciplinary, collaborative care, treatment, or services.

Element(s) of Performance for PC.02.01.05

11. For home health agencies that elect to use The Joint Commission deemed status option: The patient’s individualized plan of care is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatric medicine acting within the scope of a state license, certification, or registration.

11. For home health agencies that elect to use The Joint Commission deemed status option: The patient’s individualized plan of care is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatric medicine, or an allowed practitioner acting within the scope of a state license, certification, or registration.

Key: D indicates that documentation is required; R indicates an identified risk area;
PC.04.01.01

The organization follows a process that addresses the patient’s need for continuing care, treatment, or services after discharge or transfer.

Element(s) of Performance for PC.04.01.01

30. For home health agencies that elect to use The Joint Commission deemed status option: The organization does the following before it discharges a patient for cause:
   - Advise the patient, representative (if any), the physician or allowed practitioner issuing orders for the home health plan of care, and the primary care practitioner or other health care professional responsible for the patient after discharge (if any) that a discharge for cause is being considered
   - Make efforts to resolve the problem(s) presented by the patient’s behavior, the behavior of other persons in the patient’s home, or situation
   - Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care
   - Document the problem(s) and efforts made to resolve the problem(s), and then enter this documentation into the patient record

30. For home health agencies that elect to use The Joint Commission deemed status option: The organization does the following before it discharges a patient for cause:
   - Advise the patient, representative (if any), the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and the primary care practitioner or other health care professional responsible for providing care and services to the patient after discharge (if any) that a discharge for cause is being considered
   - Make efforts to resolve the problem(s) presented by the patient’s behavior, the behavior of other persons in the patient’s home, or situation
   - Provide the patient and representative (if any), with contact information for other agencies or providers who may be able to provide care
   - Document the problem(s) and efforts made to resolve the problem(s), and then enter this documentation into the patient record

Key: [D] indicates that documentation is required; [R] indicates an identified risk area;