

## The Joint Commission's Requirements for Evaluating Contracted Home Care Services

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*Contracted services have gained greater emphasis in the home care standards and survey process over the past several years, especially as they relate to the quality and safety of the services provided. This column reviews 2004-2005 standard LD.3.50, its applicable elements of performance, and discusses the Joint Commission's requirements for evaluating the care and services provided by contracted providers.*

The Joint Commission's 2004-2005 *Comprehensive Accreditation Manual for Home Care (CAMHC)* does not contain a grid element within the Leadership Chapter called Contract Management that specifically addresses contracted services. The good news is that there are no longer any grid scores in 2004.

**Standard LD.3.50** from the 2004-2005 CAMHC addresses contracted services and requires that services provided by consultation, contractual arrangements, and other arrangements are provided safely and effectively. To meet standard **LD.3.50**, (formerly standard **LD.11**) eight potential elements of performance (EP) must be in satisfactory compliance (Joint Commission, 2003).

### Contract Content Requirements

In the 2004-2005 CAMHC, the elements of performance for standard **LD.3.50** no longer include the numerous elements that had to be contained in writing within the agreement. The only contract content requirement in the 2004-2005 CAMHC is in **EP 4** which requires the nature and scope of

services provided are defined in writing (Joint Commission, 2003). **EP 4** was also required in previous editions of the CAMHC and is not a new requirement. Therefore, the surveyor will no longer be scoring written agreements against a laundry list of Joint Commission required items.

When the home care or hospice organization is also Medicare-certified, the contract content must contain specific language included in the Conditions of Participation (CoPs). These requirements are addressed in **EP 9** and **10**. Contract language requirements for Medicare-certified hospice services provided by another individual or organization were discussed in the May and November 2002 issues of the *Home Healthcare Nurse (HHN)* Accreditation Strategies column.

### Planning for Evaluating Contracted Services

**EP 6** within standard **LD.3.50** requires that the organization evaluate the contracted care and services to determine if the contract requirements are being met and if the quality and level of safety meets the organization's expectations (Joint Com-

mission, 2003). To fully comply with **EP 6**, the home care or hospice organization should establish a plan (which does not have to be in writing), with time frames, regarding how and by whom the evaluation activities will be performed for *each* contracted provider.

This standard is not applicable for contracted individuals or organizations providing partial home care services or services under a reverse contract situation. Refer to the February 2002 *HHN* Accreditation Strategies column for a description of contracted providers that are exempt from scoring at standard **LD.3.50**. The frequency in which evaluation activities are performed is defined by the home care and hospice organization and may be different based on the contracted provider type.

### Track Record and Survey Process

During the pre-survey telephone call, the surveyor will:

- confirm the applicable track record for the survey (e.g., 4 months for an initial survey and 12 months for a triennial survey),
- identify the services provided through a contracted individual or organization,
- determine whether the contracted services are surveyable, and

- confirm whether actual services have been performed by the contracted provider within the applicable track record.

If a contracted provider *has not* been used, it is *not* expected that evaluation activities of the contracted services have been performed.

If a contracted provider *has been* used within the track record (e.g., last 4 months or last 12 months), but the contract is no longer “active” during the time of the actual survey, a discussion related to the home care or hospice organization’s evaluation activities may be reviewed for the applicable time period.

Once the surveyor has determined which contracts are surveyable, the agreements will be reviewed to assure that the required elements have been addressed in writing. More importantly, the surveyor will make sure that there is a written agreement for services provided by eligible contracted provider.

Documentation of the actual evaluation activities and their results are *not* required, but documentation may be required and linked to other standards that relate to evaluation activities, such as competence assessment and performance evaluations being completed within the specified time frame. If documentation is required and is missing, the lack of documentation would be scored at the applicable standard and not at standard **LD.3.50**.

During the survey, the home care or hospice organization’s leaders need to be able to verbally describe to the surveyor how they evaluate the quality

and safety of their contracted providers, as this question will likely be asked during the leadership interview.

### Evaluating Contracted Services

Most home care and hospice organizations already have an informal process in place to monitor and evaluate the care and services provided by a contracted individual or organization. The following are *examples* of ongoing evaluation activities that may be performed to make judgments about the quality and safety of a contracted provider’s care or service:

1. Checking the date that clinical record documentation is submitted by the contracted occupational therapist when it is received by the home care agency to assure that documentation is received within the required time frame(s).

2. Reviewing OASIS data weekly to assess timeliness of the contracted physical therapist’s initial evaluation (when the contracted therapist is permitted to admit patients to the agency).

3. Reviewing the hospice patient and family’s satisfaction survey results quarterly and examining the appropriateness of the timeframe the contracted durable medical equipment (DME) provider delivered equipment to the patient’s home.

4. Performing home health aide (aide) supervisory visits every 2 weeks to assess the patient and family’s satisfaction with care or services provided by a contracted aide and assure the plan of care is being followed.

5. Reviewing contracted therapists’ clinical documentation quarterly to assure that

service utilization is appropriate, the care plan is developed, reviewed, and revised as necessary, etc.

6. Assessing hospice patients and family members’ satisfaction with the patient’s pain management and symptom control and whether medications were obtained from the contracted pharmacy provider within the time frame(s) established by making random telephone calls every 6 months.

7. Obtaining serial numbers from oxygen concentrators present in hospice patients’ homes during routine hospice nurse visits. Then requesting documentation from DME contractors that shows routine and preventive maintenance activities have been performed as required by the DME provider’s policies and procedures and/or the manufacturer’s requirements.

8. Reviewing the personnel file contents for 100% of contracted staff at the contracted provider’s office annually with 24 hours advance notice given to the contracted provider.

### Delegating Evaluation Activities

Before delegation activities are discussed, it is important to note that Medicare-certified home care agencies and hospices *cannot* delegate the management, supervision, or administration of contracted providers. This discussion of delegating evaluation activities pertains to how the organization’s management can choose to delegate a portion of the evaluation activities to a contracted provider, such as to a contracted organization.

For example, the home care organization could request that

every 6 months a contracted rehabilitation provider review a certain percentage of personnel records for therapists providing care to the organization's patients and submit results to the organization. When the home care or hospice organization chooses to delegate a portion of the evaluation requirements, the leaders must define what specific evaluation information will be included. The Joint Commission does not define what must be included within the content of the review nor the methods in which contracted services will be evaluated.

The leaders should not merely request the results of a "personnel record audit," but should provide specific evaluation parameters within each file and whether the review is to include a percentage or all of the specific components reviewed. For example, does each personnel record contain documented competencies assessed prior to providing patient care and ongoing by a qualified individual? Have the aides attended 12 hours of inservice education per year?

The documentation of the actual evaluation results can be either details or a summary. Finally, the contractor performing the review should conclude with "I attest to the accuracy of this information," sign his or her name and title, date the document, and provide a copy to the primary organization.

### **Compliance With the National Patient Safety Goals**

Most hospice organizations establish written agreements for pharmaceutical services and DME services. Within the National Patient Safety Goals

The contract content requirements in the 2004-2005 CAMHC are less restrictive than in past manuals. With forethought and planning, the requirements for evaluating contracted care and services can be met very simply without requiring additional work. Use your current evaluation activities as the foundation for meeting this Joint Commission requirement, *not* as an add-on to the layers of work already being done.

(NPSGs), there are goals applicable to contracted pharmaceutical and DME providers. Even though a contracted provider may be Joint Commission-accredited, the hospice organization is responsible to follow-up and assure that the provider is in full compliance with the applicable goals.

For example, many contracted DME providers are responsible for setting up oxygen concentrators in the home and providing initial patient education. During initial equipment setup, the DME representative should test the audibility of the concentrator alarm to assure that caregivers can hear it over normal household noise. If the contracted DME provider is Joint Commission accredited, they are likely aware of these new requirements, but it is still the hospice's responsibility to assure the requirements are being met.

The same principle applies to contracted pharmaceutical service providers. If ambulatory or PCA infusion pumps are provided to the hospice's patients to aid in medication administration, the patient must be protected from free-flow problems.

During the leadership interview, the hospice may be asked how it has assured that its contracted DME and pharmacy provider(s) have met the Joint Commission's NPSGs. Replying that the organization is Joint Commission-accredited, and therefore it is assumed that it has met the goals, is not ac-

ceptable. The hospice is responsible for overseeing this activity and assuring that the goal(s) have been met.

Many DME providers are not Joint Commission accredited; although this is acceptable, they may be unfamiliar with the Joint Commission's NPSGs. Therefore, if the hospice has contract(s) with organizations that are not Joint Commission-accredited, it is especially important that the providers are educated about the NPSGs and that, for the hospice's patients, the goals are fully implemented.

### **Measure of Success**

If the home care or hospice is Medicare-certified and is not found in compliance with the CoPs or has not evaluated the contracted care and services identified by a Joint Commission representative either through an on-site survey or a periodic performance review, the organization will be required to submit a measure of success to the Joint Commission for follow-up. ■

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### **REFERENCE**

Joint Commission on Accreditation of Healthcare Organizations. (2003). *2004-2005 Comprehensive Accreditation Manual for Home Care*. Pp. LD 14-15. Oakbrook Terrace, IL: Author.