

## Why Do We Have To Do That?

In these last few months preceding the October 1 CMS deadline to be accredited, there seems to be a massive crush of suppliers who have finally begun the process. There may be reports of some accrediting organizations (AO's) who are not too busy and have room to accommodate more customers, but the AO's my clients work with are up to their eyeballs with suppliers needing to be scheduled for survey in the next few months. These AO's will be conducting those first visits with suppliers during the months of April, May, June and July. This will allow suppliers who have problems on survey the months of August and September to correct any deficiencies that were cited, time to get these deficiencies corrected, the corrections submitted to the AO, the AO time to review what was submitted and the supplier approved and accredited by October 1. Thus the questions are flying! And oftentimes, the question is "Why do we have to do that?"

Many times providers ask about meeting the requirement of a specific standard that applies to all organizations, no matter what services are provided. These can be JCAHO standards, HQAA Administrative Standards, CHAP Core Standards or ACHC DME Supplier Standards.

One of these common questions is "Do we have to track staff and customer infections?" The answer is "Yes". The response may then be, "We don't have any idea whether or not a staff member is sick with an infection or of the patient has an infection. Why do we have to do that?"

In this particular situation, the CMS Final Quality Standards included this new requirement in the revisions that were released in October of 2008. I'm sure the philosophy behind this requirement is that suppliers would find if their infection control processes are adequate if they were to track such infections. If a supplier found that customers on one driver's route were the ones who were reporting illnesses, they may realize that this driver is lax in proper infection control practices and may be making his customer's sick. Possibly the supplier's cleaning processes are insufficient and customer's are getting sick. Staff who may be contracting illness may be those who are not washing their hands adequately or not using PPE (Personal Protective Equipment) such as gloves routinely. Tracking this information would help a supplier identify these types of problems. That is most likely the reason this requirement was included in the revisions. But just because a supplier doesn't provide many items, may not deliver items or may even have rental items (as many pharmacies do not), it does not remove the requirement. A simple log maintained by the supplier meets this requirement and is an easy process to implement and the answers the requirement.

A very common concern is from small providers who think they are not "big enough" to need a disaster or emergency plan. They often say things such as "There are only 3 employees here, we aren't big enough to need a disaster plan". This could not be further from the truth. We all know that natural disasters and emergencies do not discriminate. Both small and large suppliers are affected by disasters such as Hurricane Katrina, or tornadoes that rip through communities. I recently saw a billboard while driving in the

rural mountains of West Virginia that said “One in four businesses do not recover from a disaster- make a plan”. Every supplier needs a plan for what to do in the event of a disaster. It is common sense to routinely back up data systems, but even more important to have done so in the event of a disaster. Copies of staff contact information should be kept at an owner or manager’s home in the event that staff can not get to the store to obtain such information. There’s no value in a plan that is kept at the office when you can’t get to the office to use it. Every supplier needs to be prepared for emergencies and have a fire drill annually to ensure that the staff can evacuate the facility safely. Exit signs must be posted, exit routes identified and a safety officer must ensure that the staff is prepared adequately. It doesn’t matter how small a supplier is; the small supplier is as responsible for the safety of the staff as much as a large supplier is. Each must adequately prepare for the recovery of the business in the event of a disaster.

Another question often asked by suppliers who provide complex rehab products is, “I don’t need a full time employee as a Certified Rehab professional. We do a small amount of this type of service. I don’t have enough to keep someone busy full time and thus, want to employ an independent contractor.” Again, the October 2008 revisions to the CMS Final Quality Standards now require that suppliers utilize W-2 employees, not independent contractors in these positions, whether or not the supplier needs this service full time or part time. Even if the individual meets the IRS requirements to be an independent contractor, CMS requires that they be a W-2 employee and the accreditor is required to check to ensure that this process is in place.

The lesson is that just because a supplier doesn’t “do” something or doesn’t think it applies to him/her, doesn’t mean a requirement does not apply. If the supplier thinks any standards do not apply, they need to consult their accreditor in PLENTY of time prior to their on site survey to ensure that they are meeting all necessary requirements.