

**MICHIGAN DEPARTMENT OF LICENSING AND REGULATORY AFFAIRS
BUREAU OF COMMUNITY & HEALTH SYSTEMS
HEALTH FACILITIES DIVISION
SPECIALIZED HEALTH CARE SERVICES SECTION**

Home Health Agency Branch Questionnaire

Purpose

The purpose of this questionnaire is to gather information so that a determination can be made as to whether a new home health agency (HHA) location should be classified as a branch office, subunit or parent agency. Subunits and parent agencies require an on-site survey before either can participate in the Medicare program. A branch may or may not be surveyed immediately.

Definitions

A determination will be made based on the following Medicare home health agency definitions located at 42 CFR 484.2.

Parent home health agency means the agency that develops and maintains administrative controls of subunits and/or branch offices.

Subunit means a semi-autonomous organization that:

1. Serves patients in a geographic area different from that of the parent agency;
And
2. Must independently meet the conditions of participation for HHAs because is too far from the parent agency to share administration, supervision, and services on a daily basis.

Branch office means a location or site from which a home health agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the home health agency and is located sufficiently close to share administration, supervision, and services in a manner that renders it unnecessary for the branch independently meet the conditions of participation as a home health agency.

Processing and Determinations

The State Agency (SA) mails this questionnaire, reviews the responses and supporting documentation, and makes a recommendation to the Chicago Regional Office (RO) of the Health Care Financing Administration (HCFA). The RO has the authority to make the final determination. The RO sends the applicant a determination letter, either approving the location as a branch or denying the request for branch status and listing the reasons

for the denial. Approvals will generally be made retroactive to the date on which the branch began serving patients.

An agency has two options when a location is denied branch status. It can close the location or request a survey of the location as a subunit or as a parent.

All locations in a multi-site home health agency receive some degree of oversight from the top of the organization, regardless of the number of locations or geographic dispersion (proximity of the other locations to the parent location) of the organization. It is the extent to which administration, supervision, and services are shared on a daily basis that is the focus of this questionnaire.

Who Should Complete this Questionnaire?

Refer to the regulatory definitions above. If it is clear that the new location will be operated independently of a parent location except for administrative oversight, and the new location could independently meet the HHA Conditions of Participation, do not complete this questionnaire. Instead, request a survey as a subunit or parent agency.

Timing of the Branch Request

The State Agency must be notified prior to when home health agency services are being provided from a new location. Costs associated with services rendered from the new location should not be claimed in the cost report for the parent location until the new location has been approved and appropriately classified by HCFA. An adequate assessment cannot be made for a location that is planned, but is not operating. The questionnaire should be completed with respect to how the location is actually operating.

Supervision

References to supervision are found at 42 CFR 484.2, 484.14(d), 484.30(a)&(b), 484.32(a)&(b), 484.34 and 484.36(d). See the copy of the Part 484 of the Code of Federal Regulations which accompanies this questionnaire. Supervision requires, unless it is otherwise specified in the regulations, that a qualified person be physically present during the provision of services by any individual who does not meet the qualifications specified in 42 CFR 484.4. A major aspect of supervision is supervision of the HHA's personnel in the furnishing of services to a patient on the patient's premises.

Note: Currently, many home health agencies operate based upon a model by which each branch location has a day-to-day manager, and, as such, is essentially self-supervising. For example, the manager may be a nurse who supervises the nurses and home health aides assigned to the branch with very little intervention from the parent location. Further, the therapy services may be provided under contract rather than by agency employees. For home health agencies that fit this model (self-supervising on a daily basis) an optional supervision question has been added requesting information about how the parent location oversees the branch locations.

Contact for Assistance

If you have questions, please contact:

Michigan Department of LARA
Bureau of Community & Health Systems,
Health Facilities Division,
Specialized Health Care Services Section
PO Box 30664
Lansing, Michigan 48909
Phone (517) 241-3830

Basic Information

1. Ownership. Indicate whether or not the parent and the new location are owned by the same entity
 Yes No. *If they are not commonly owned, the new location cannot be determined to be a branch or a subunit, and there is no need to complete this questionnaire.* (In large corporate structures, the parent and the new location must have the same owner at the lowest level in the corporate hierarchy.) If the new location represents an acquisition from another HHA, please enclose with your response copies of the legal documents that support the acquisition of the location. Indicate the name, address, and Medicare provider number of the parent from which the location was acquired.
2. Parent Site
Medicare provider number:
Name:
Address:
City, State & Zip:
Phone Number:
3. Name, address, telephone number (including area code) and classification (branch or subunit) of all other HHA locations (except the new location for which this questionnaire is being completed). Include the Medicare provider numbers for any subunits:
4. Proposed new location
Name:
Address:
City, State & Zip:
Phone Number:
5. Date the new location treated its first patient. (This will be the approval effective date if the new location is approved as a branch.)

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6. Business Hours- **Parent**. Indicate the hours and days of the week during which the parent provides services, for example, 8:00 am to 5:00 pm, Monday thru Friday.

7. Business Hours- **New Location**. Indicate the hours and days of the week during which the parent provides services.

8. Service Area- **Parent**. Indicate the geographic area served by the parent.

9. Service Area- **New Location**. Indicate the geographic area served by the new location.

10. Proximity. What is the mileage and approximate travel time between the parent office and the new location? Note any unusual conditions such as urban congestion, travel by non-interstate, etc., that could affect travel time. (Include a map for this and the prior two questions.)

11. List the services provided by the **parent**, indicating whether each- service is provided directly, through a contract or both.

	<u>Directly</u>	<u>Contract</u>	<u>Both</u>
<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Home Health Aide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Speech Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other, specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

12. Indicate the number of active patients served from the **parent** location on the date this questionnaire is signed.

13. List the services provided by the **new location**, indicating whether each service is provided directly, through a contract or both.

	<u>Directly</u>	<u>Contract</u>	<u>Both</u>
<input type="checkbox"/> Skilled Nursing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Home Health Aide	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Physical Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Speech Pathology	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Occupational Therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
<input type="checkbox"/> Other, specify	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

14. Indicate the number of active patients served from the **new location** on the date this questionnaire is signed.
15. Staff at **parent**. Attach a list of the number and type of employees, including contracted staff, at the parent office. Include their working hours. Your list should include, but is not limited to, administrator, area managers; RN or NID supervisor, RN's, LPN's, aides, therapists (PT, OT, SP), social workers, quality assurance staff, etc.
16. Staff at **new location**. Attach a list of the number and type of employees, including contracted staff, at the new location. Include their working hours.

Supervision

Before responding to the following questions, please refer to the regulatory definition of supervision on the first page of this questionnaire. A synopsis: supervision entails the physical presence of a qualified person during the provision of services on the patient's premises.

17. Identify your supervision nurse or physician (42 CFR 484.14)
How does this individual supervise and direct the skilled nursing and other therapeutic services of the agency for all location of the home health agency?

How is this person or a qualified alternate made available during all agency operating hours?

Include supporting documentation of any supervisory visits to the new location, such as: calendars, checklists, advisory notes, etc.
18. Please indicate the name and title of any parent or branch personnel who perform supervisory activities (as defined by regulations) at the new location.
Indicate whether these supervisory personnel are assigned to the parent or the new location or both.

Spell out the exact nature of the supervisory function and the frequency of the supervisory activity.

Include supporting documentation of these visits to the new location such as: calendars, checklists, advisory notes, etc.
19. **Answer this question only if the new location is self-supervising on a daily basis.** Within your organizational structure how does your agency ensure the quality of care and appropriate delivery of services at the new location?

Describe the ways by which the parent exercises supervisory control over the new location such as: on-site observation of staff with patients, use of clinical supervisors, use of care coordinators, use of quality improvement staff, on-site visits by administrator, chart reviews, surveys of/or interviews with patients to see if their needs are being met, etc. Describe these activities by type frequency and the parent staff that performs them. If some of the new location staff are contacted, specifically describe how the services performed by contract staff are overseen by the parent (attached and label additional pages if needed).

Services

20. Identify which staff, if any, routinely provides home health agency services (skilled nursing, home health aide, physical therapy, occupational therapy, speech pathology, and medical social services) to patients at both the parent and the new location (attach and label additional pages if needed).

Identify the services, under what circumstances, and how often this sharing of services occurs.

21. Explain how the parent provides services in the event of the temporary or prolonged absence of any new location staff due to emergency, illness, vacation, or resignation.

Administration

To aid us in reviewing your answers to the following questions, please enclose an organizational chart, annotating it, if necessary, to show where specific personnel (by name) are based. The chart must show both the parent and the new location.

22. Do administrative services originate from a central location, a corporate office, a regional office, or office other than the parent location? Yes No. If so, indicate the address of this location and explain the functions that it performs.

23. How are agency policies and procedures disseminated to the new location?

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24. Indicate who performs each of the following functions for the new location:

	<u>Parent</u>	<u>New Location</u>	<u>Both</u>
Hiring & firing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Orientation & training	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Employee evaluations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Inservices	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Contracts for services under arrangement	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Intake of new patients	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Billing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Payroll	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personnel records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Custody of discharge patient records	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

The following must be signed and dated by the administrator of the parent home health agency.

I certify that the responses to this HHA branch questionnaire are true, correct, and complete.

Signature: _____

Print Name:

Date: