CHAP Community Health Accreditation Partner

CHAP
2300 Clarendon Blvd. Suite 405
Arlington VA 22201
202.862.3413

www.chapinc.org
www.chapling.org
www.education.chapling.org
info@chapinc.org

Home Health

Standards of Excellence

Home Health Standards
CHAP Inc.

CHAP

HOME HEALTH STANDARDS OF EXCELLENCE

Table of Contents

The CHAP Standards of Excellence are designed to help you deliver the best care and services possible by supporting organizational excellence with standards that are easy to understand, relevant and practical.

Introduction to the Home Health Standards of Excellence

Overview

The standards in this document pertain to revised home health conditions of participation (CoPs). These standards are approved by the Centers for Medicare and Medicaid Services (CMS) as meeting or exceeding the intent of the 2018 CoPs.

- All initial and renewing home health providers that have a site visit and that are seeking or have been awarded CMS deemed status through the CHAP review process are evaluated using these standards.
- These standards also apply to Medicaid home health providers seeking initial or renewed accreditation in states that require compliance with the Medicare home health CoPs.

Regulatory Requirements

Federal regulations for home health are cross-walked to standards and modifiers when applicable.

Regulations are listed by the Code of Federal Regulations (CFR) number (e.g., §484.65(c)(1)) and G-tag. Each CFR corresponds to a Medicare Condition of Participation (CoP).

Revision Reference Table

In response to the *CY 2021 Home Health Prospective Payment System Rate Update, Home Health Quality Reporting Program Requirements (CMS-1730-F),* the following revisions were made.

Standard	Summary	Effective Date	Page
PCC.2.I.M1	Added the patient's right to be informed about the mode of care-delivery including the use of telecommunications when applicable	1/1/2021	2
APC.2.1.M2	Expanded to include allowed practitioner	1/1/2021	15
APC.5.1.M1	Expanded to include allowed practitioner	1/1/2021	17
APC.5.1.M2	Expanded to include allowed practitioner	1/1/2021	18
APC.5.I.M4	Expanded to include allowed practitioner	1/1/2021	20
APC.7.I.M2	Added to the plan of care the mode of care-delivery including the use of telecommunications when applicable and expanded to include allowed practitioner	1/1/2021	24
APC.7.I.M5	Expanded to include allowed practitioner	1/1/2021	25
APC.7.I.M6	Expanded to include allowed practitioner	1/1/2021	25

Standard	Summary	Effective Date	Page
APC.7.I.M7	Expanded to include allowed practitioner	1/1/2021	26
APC.9.I.M1	Expanded to include allowed practitioner	1/1/2021	29
APC.9.I.M2	Expanded to include allowed practitioner	1/1/2021	30
APC.9.I.M3	Expanded to include allowed practitioner	1/1/2021	30
APC.10.D.M1	Expanded to include allowed practitioner	1/1/2021	32
APC.10.D.M2	Expanded to include allowed practitioner	1/1/2021	33
APC.11.I.M2	Expanded to include allowed practitioner	1/1/2021	36
CDT.4.I.M1	Expanded to include allowed practitioner	1/1/2021	43
CDT.5.I.M1	Expanded to include allowed practitioner	1/1/2021	44
CDT.7.I.M2	Expanded to include allowed practitioner	1/1/2021	46
CDT.7.I.M7	Expanded to include allowed practitioner	1/1/2021	48
CDT.11.D	New standard addressing remote monitoring and telemonitoring	1/1/2021	52
IPC.1.I.M4	Expanded to include allowed practitioner	1/1/2021	83
IM.4.I.M2	Expanded to include allowed practitioner	1/1/2021	130
IM.6.I.M2	Standard deleted	1/1/2021	
IM.6.I.M3	Applicable regulation changed to G382-484.45(c)(2)	1/1/2021	134
IM.6.I.M4	Applicable regulation changed to G384-484.45(c)(3)	1/1/2021	135
IM.7.I.M1	Expanded to include allowed practitioner	1/1/2021	136
Allowed Practitioner	Added new key term	1/1/2021	138
Clinical Nurse Specialist	Added new key term	1/1/2021	140
Collaboration	Added new key term	1/1/2021	140
Nurse Practitioner	Updated key term	1/1/2021	143
Physician	Updated key term	1/1/2021	147
Physician Assistant	Added new key term	1/1/2021	148
Summary Report	Added new key term	1/1/2021	149
Telecommunications	Added new key term	1/1/2021	150
Verbal Order	Added new key term	1/1/2021	150

In response to the 2019 Omnibus Burden Reduction (Conditions of Participation) Final Rule CMS-3346-F and the 2019 Revisions to Discharge Planning Requirements Final Rule CMS-3317-F, the following revisions were made.

Standard	Summary	Effective Date	Page
PCC.2.I.M1	Added the patient has the right to be advised, orally and in writing, of payment and charges for services and any changes to payment and charges	11/29/2019	2-4
APC.10.D.M2	Added policies to describe required content of the discharge or transfer summary including necessary medical information and post-discharge goals and treatment preferences	11/29/2019	33
APC.10.I	Added discharge planning occurs in accordance with organization's policies	11/29/2019	34
APC.11.I.M1	New Standard for developing and implementing an effective discharge planning process	11/29/2019	35
APC.11.I.M2	Old APC.11.I.M1	11/29/2019	36
APC.11.I.M3	Old APC.11.I.M2 Added discharge summaries include necessary medical information for the patient's current course of illness and treatment. Requests for additional clinical information is sent to the receiving facility or health care practitioner.	11/29/2019	37
HRM.7.I.M2	Added competency is assessed through direct observation of the skills demonstrated on a pseudo-patient as part of a simulation	11/29/2019	61-62
HRM.11.I.M2	Added retraining and competency evaluation related to deficient skills for aide services	11/29/2019	70
EP.1.D.M1	Added EP plan is reviewed and updated at least every two years	11/29/2019	97-98
EP.1.D.M3	Added EP communication plan is reviewed and updated at least every two years	11/29/2019	99
EP.2.D.M1	Added EP policies and procedures are reviewed and updated at least every two years.	11/29/2019	102-103
EP.3.D.M1	Added EP training program is reviewed and updated at least every two years. EP training is provided at least every two years and when EP policies and procedures are significantly updated.	11/29/2019	104
EP.4.I.M1	Added EP testing program is reviewed and updated at least every two years	11/29/2019	106
EP.4.I.M2	Added when a community-based exercise is not accessible, testing includes participation in an individual, facility-based functional exercise every	11/29/2019	107-108

Standard	Summary	Effective Date	Page
	two (2) years. The organization is exempt from its next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of an actual natural or man-made emergency that requires activation of the emergency plan. An additional exercise is conducted every two years, opposite the year that a full-scale exercise or functional exercise is conducted.		
Pseudo-patient	Added new key term	11/29/2019	148
Simulation	Added new key term	11/29/2019	149

In response to the 2019 revisions to the State Operations Manual, Appendix Z- Emergency Preparedness, Interpretive Guidance by the Centers for Medicare and Medicaid (CMS), the following revisions were made.

Standard	Summary	Effective Date	Page
IPC.8.I	Updated TB testing to reflect updated guidelines by the CDC	3/4/2019	92
EP.1.D.M1	Added EP plan utilizes an all-hazards approach specific to the geography and population. Added EP plan includes the management of consequences of power failures, natural or man-made disaster, and EIDs. Added EP plan addresses patients with limited mobility and those requiring evacuation due to medical or psychiatric conditions or their home environment. Added EP plan addresses when EP officials are contacted regarding patient evacuation. Added EP plan identifies staff that can assume key organization roles if current staff/leadership is not available.	3/4/2019	97-98
EP.2.D.M1	Added EP policies and procedures address the documented discussion of patient emergency plan that is provided to the patient. Added EP P&P addresses arrangements with facilities and other providers to receive patients. Added EP P&P addresses the minimum information provided to facilitate evacuation and transportation. Added EP P&P addresses how information is shared. Added EP P&P addresses the role of employees in providing care at alternate care sites during emergencies.	3/4/2019	102-103

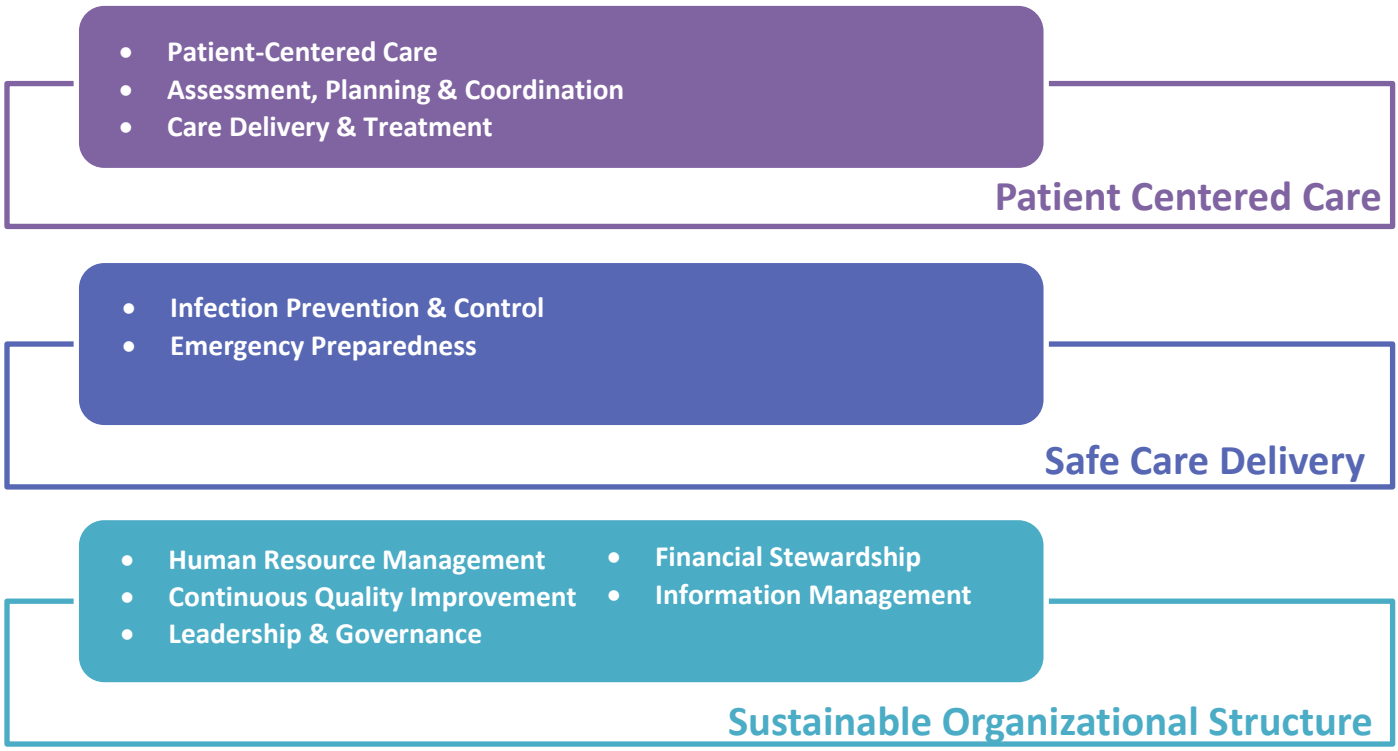
Standard	Summary	Effective Date	Page
EP.4.I.M2	Added if emergency plan is activated twice in one year, the organization is exempt from both types of exercises for one year following the actual event	3/4/2019	107-108
All-Hazards Approach	Added new key term	3/4/2019	138
Emerging Infectious Diseases (EIDs)	Added new key term	3/4/2019	140
Full Scale Exercise	Added new key term	3/4/2019	140

Previous Updates:

Standard	Summary	Effective Date	Page
APC.6.I.M1	Added EP plan reference to comprehensive assessment	9/1/2018	21-22
APC.7.I.M2	Removed EP plan reference from plan of care	9/1/2018	24
CDT.10.I.M4	Added any skilled professional (PT, OT, SLP) can conduct the supervisory visits	9/1/2018	51
CDT.10.I.M5	Reworded to mirror CFR	9/1/2018	51

Key Performance Areas

The Home Health Standards of Excellence are organized into one of the following Key Performance Areas (KPAs).



A **Key Performance Area (KPA)** is the central topic evaluated by the standards. Each KPA includes:

- **Standards** that identify the set of requirements CHAP uses to make accreditation determinations. CHAP evaluates compliance with each standard and bases the accreditation decision on the organization's total performance across all standards evaluated.

- **Evidence Guidelines** that provide additional detail about how each standard is assessed, as well as approaches organizations may consider in demonstrating compliance with the standard. More detail about Evidence Guidelines is provided below.

Evidence Guidelines

Evidence guidelines provide organizations direction about how compliance with the standard or associated modifier is assessed. The following types of evidence guidelines are used:

1. **Guidance Statements:** Explain expectations, nuances or terms used in the standard or modifier. Guidance supports the organization in understanding how the requirements of each standard can be met. Examples are used for the purpose of explanation, but are not meant to be statements of the only way to achieve compliance.

2. **Document Review:** Documentation from a variety of sources is used to demonstrate compliance (e.g., position descriptions, policies, meeting minutes).

3. **Interview:** One or more interviews with personnel and/or patients or caregivers are used to assess compliance with the standard or modifier.

4. **Record Review:** Personnel or patient records are the primary source of assessing compliance.

5. **Observation:** One or more home visit is conducted to establish standard compliance

6. **Contract Review:** Contract language is the primary source reviewed as the demonstration of compliance.

7. **Tip:** These statements are also included in the Evidence Guidelines for particular standards. Tips provide resources and educational information to support organizational performance in compliance with the standard, as well as evidence-informed practices. Information in a *Tip* is not used as part of a compliance determination

Types of Standards

Within each KPA, areas of performance are examined:

1. D**esign (D) standards**: The policies, procedures, qualifications, training and other resources the organization uses to support consistent implementation and quality outcomes in care and service delivery.

2. **Implementation (I) Standards:** Evaluation of how effectively the organization implements its own defined parameters of organization structure and expectations, as well as those established nationally and at the state level.

3. **Sustainability (S)** standards assess the processes and organizational structure that support ongoing quality improvement in the delivery of care and services.

Standards and Modifiers

There are two types of statements within the new framework: **Standards** and **Modifiers**.

In the example above, **PCC** refers to Patient-Centered Care. The **D** indicates it is a **Design** standard. The **2** indicates the standard number. The **M1** indicates it is the first modifier related to the second standard within the section.

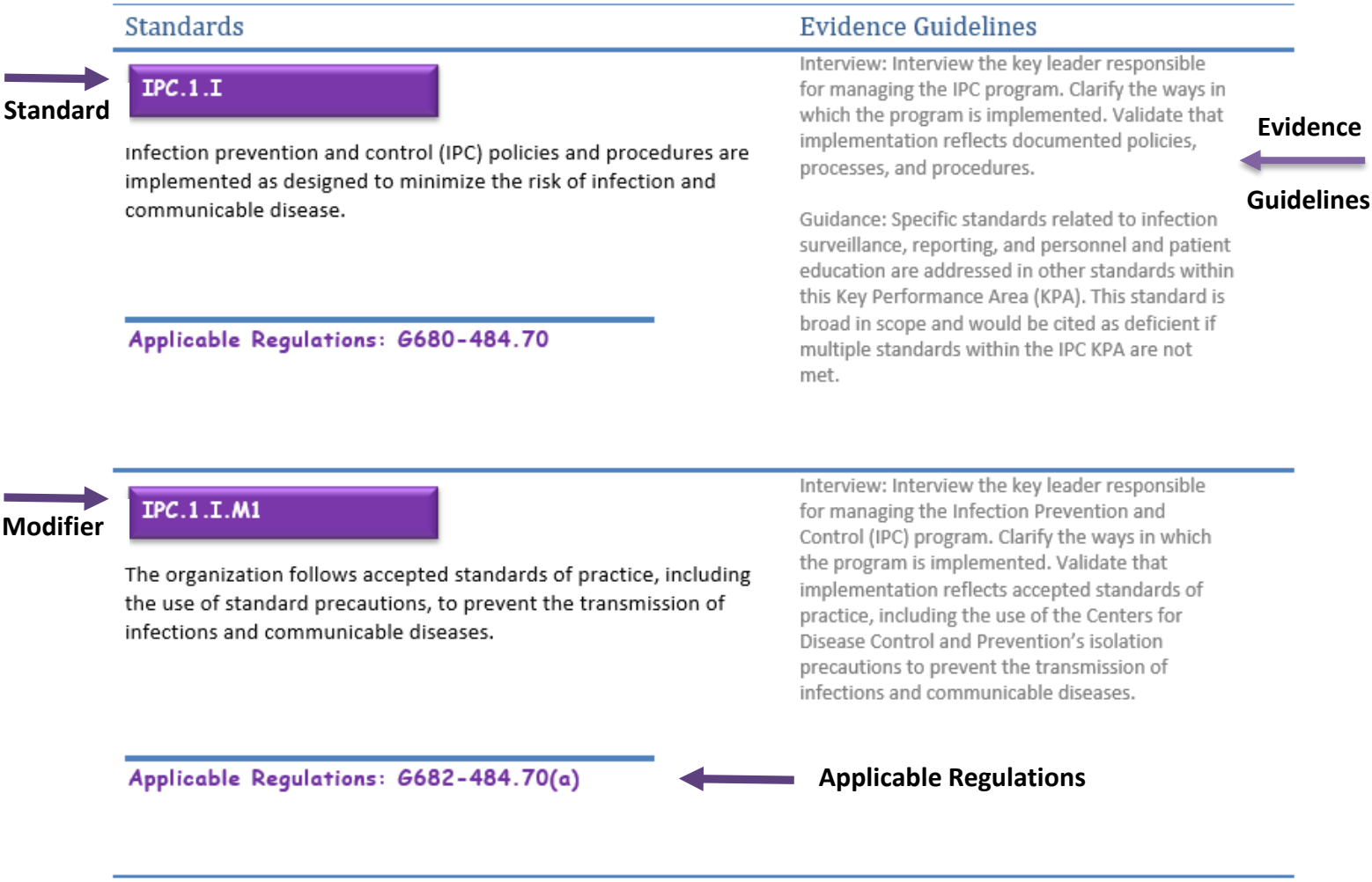
Standards are numbered sequentially, and standards that are related have the same standard number. For example, a **Design (D)** standard evaluating the organization's development of a written patient bill of rights **(PCC.2.D)** has the same standard number as the corresponding **Implementation (I)** standard examining patients' exercise of their rights (**PCC.2.I).** Note: Not all design standards have corresponding implementation standards, and vice versa.

Numbering of standards may not follow a sequential pattern since standards or modifiers may be skipped if they are not applicable to the care or services provided by a home health provider.

Composition of a Standard

Figure 4 provides an example of how a standard is organized within each KPA. Not all standards have modifiers. In addition, the type of evidence guidelines will vary from standard to standard.

FIGURE 4: COMPOSITION OF STANDARDS AND MODIFIERS



Patient-Centered Care

KPA Statement

Organizations engage in active partnerships with patients, families, and caregivers to ensure that care respects and responds to individual preferences. Patients, families and caregivers are provided needed information and support to ensure that their concerns, values and knowledge are incorporated into shared decision-making for care planning, goal-setting, and treatment.

Standards	Evidence Guidelines
PCC.2.D The organization develops a written Patient Bill of Rights that defines patient rights and responsibilities. **Applicable Regulation: G408-484.50(a).**	Document Review: Review a copy of the Patient Bill of Rights that is distributed to patients. Verify that it defines patient rights and responsibilities. Guidance: Many states have specific requirements related to what is contained in the Patient Bill of Rights. It is expected that the organization understands and complies with these requirements.
PCC.2.I Patients can exercise all rights identified in the organization's Patient Bill of Rights.	Interview: Interview personnel who provide patient care or services. Verify, through specific patient example, the ways in which patients can or have exercised their rights. Observation: Conduct a home visit. Through a patient interview, validate that the patient is informed of their rights and how to exercise them.

Standards

PCC.2.I.M1

Effective 1/1/2021

The organization protects and promotes the patient's exercise of rights, including the right to:

1. Be informed of his or her rights;
2. Exercise rights at any time;
3. Have his or her property and person treated with respect;
4. Be free from neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the organization;
5. Voice and report grievances or complaints regarding treatment or care that are (or fail to be) delivered, the lack of respect for property and/or person, or the violation of any rights to the organization, CHAP, and state or local agencies;
6. Participate in, be informed about, and consent to or refuse care in advance of and during treatment, where appropriate, with respect to:
    1) the mode of care-delivery including the use of telecommunications when applicable;
    2) completion of all assessments;
    3) the care to be furnished, based on the comprehensive assessment;
    4) establishing and revising the plan of care;
    5) the disciplines that will furnish the care;
    6) the frequency of visits;
    7) expected outcomes of care, including patient-identified goals and anticipated risks and benefits;
    8) any factors that could affect treatment effectiveness; and
    9) any changes in the care to be furnished;
7. Receive all services in the plan of care;
8. Have a confidential patient record and access to or release of patient information and records in accordance with Health Insurance Portability and Accountability Act (HIPAA) law and regulation (45 CFR parts 160 and 164);
9. Be advised, orally and in writing, of the extent to which payment for services may be expected from Medicare, Medicaid, or any other federally funded or federal aid program known to the organization;

(continued on following page)

Evidence Guidelines

Document Review: Review a copy of the Patient Bill of Rights that is distributed to patients. Verify it contains all the elements required by the standard.

Record Review: Review patient records. Verify the record includes a copy of the Patient Bill of Rights that contains all the rights identified in the standard.

Observation: Interview a patient or patient representative. Discuss a few of the rights listed in the Patient Bill of Rights. Clarify, through specific examples, how the patient exercises these rights and participates in his or her care.

Guidance: Organizations are required to provide valid written notice to Medicare beneficiaries prior to discharge of all Medicare covered services and must use a standardized notice, such as a Medicare Non-Coverage and Advance Beneficiary Notice, as specified by the Center for Medicaid & Medicare Services. This written notice includes information related to patient appeals.

Guidance: A patient may request services other than those covered by his or her insurance. It is expected that the organization informs the patient of those costs, as well as any additional anticipated out-of-pocket expenses, such as co-pays or deductibles.

Guidance: Telecommunications cannot substitute for a home visit ordered as part of the plan of care, and cannot be considered a home visit for the purposes of Medicare eligibility or payment.

Standards

Evidence Guidelines

PCC.2.I.M1

10. Be advised, orally and in writing, of the charges for services that may not be covered by Medicare, Medicaid, or any other federally funded or federal aid program known to the organization;
11. Be advised, orally and in writing, of the charges the individual may have to pay before care is initiated;
12. Be advised, orally and in writing, of any changes in the information provided with respect to payment and charges, if they occur. The patient and representative (if any) are advised of these changes as soon as possible, in advance of the next home health visit, and in accordance with the patient notice requirements at 42 CFR §411.408(d)(2) and 42 CFR §411.408(f);
13. Receive proper written notice, in advance of a specific service being furnished, if the organization believes that the service may be non-covered care or in advance of the organization reducing or terminating ongoing care;
14. Be informed how to contact (including contact information and hours of operation) the state toll-free hotline and the CHAP hotline to ask questions, report grievances, or voice complaints;
15. Be advised of the names, addresses, and telephone numbers of federally funded and state-funded entities that serve the area where the patient resides, including the
    1) Agency on Aging;
    2) Center for Independent Living;
    3) Protection and Advocacy Agency;
    4) Aging and Disability Resource Center; and
    5) Quality Improvement Organization;
16. Be free from any discrimination or reprisal for exercising his or her rights or for voicing grievances to the organization or an outside entity; and
17. Be informed of the right to access and how to access auxiliary aids and language services.

(continued on following page)

Standards	Evidence Guidelines

PCC.2.I.M1

Applicable Regulations: G406-484.50; G424-484.50(b)(1); G426-484.50(c); G428-484.50(c)(1); G430-484.50(c)(2); G432-484.50(c)(3); G434-484.50(c)(4); G436-484.50(c)(5); G438-484.50(c)(6); G440-484.50(c)(7); G442-484.50(c)(8); G444-484.50(c)(9); G446-484.50(c)(10); G448-484.50(c)(11); G450-484.50(c)(12).

PCC.2.I.M3

If a patient has been adjudged to lack legal capacity to make health care decisions as established by state law by a court of proper jurisdiction, the rights of the patient may be exercised by the person appointed by the state court to act on the patient's behalf.

If a state court has not adjudged a patient to lack legal capacity to make health care decisions as defined by state law, the patient's representative may exercise the patient's rights.

If a patient has been adjudged to lack legal capacity to make health care decisions under state law by a court of proper jurisdiction, the patient may exercise his or her rights to the extent allowed by court order.

Record Review: Review patient records. If the record reflects that a patient has been adjudged to lack legal capacity to make health care decisions, verify that the legal representative is acting on behalf of the patient.

Guidance: The patient's legal representative is a person who has the legal authority to act on the patient's behalf.

Applicable Regulations: G424-484.50(b)(1); G424-484.50(b)(2); G424-484.50(b)(3).

Standards	Evidence Guidelines
PCC.3.I Patients are informed of their rights, both verbally and in writing, prior to the initiation of care and in accordance with state law and regulation.	Record Review: Review patient records. Verify there is documentation that the patient was informed of their rights, both verbally and in writing, prior to the initiation of care. Guidance: Some states have specific requirements for informing patients of their rights, including identifying timeframes for providing information to patients and requirements for obtaining signatures acknowledging receipt. It is expected that organizations know and follow the specific law and regulations in the states in which they operate. Guidance: The organization may provide this information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
PCC.3.I.M1 The patient and representative (if any) have the right to be informed of the patient's rights in a language and manner the individual understands. **Applicable Regulation: G406-484.50.**	Interview: Interview a key clinical leader. Verify the ways in which patients are informed of their rights and responsibilities in the language and manner they understand. Observation: Conduct a home visit. Validate with the patient and/or representative that they received information on their rights and responsibilities. Guidance: The patient's selected representation is a person whom the patient may choose, but who may not necessarily have legal authority to act on behalf of the patient, such as a friend or family member who is assisting the patient.

Standards

PCC.3.I.M2

The organization provides verbal notice of the patient's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter if necessary, no later than the completion of the second visit from a skilled professional.

Applicable Regulation: G420-484.50(a)(3).

Evidence Guidelines

Interview: Interview a key clinical leader. Verify, through specific patient examples, the way in which the patient's rights are verbally explained by the second skilled visit in cases where the patient is unable to understand the language in which patient rights are primarily provided. If there is not an example in an organization's actual experience, verify the process that is in place to address the standard, should the situation occur.

PCC.3.I.M3

The organization provides the patient and the patient's legal representative (if any) written notice of the patient's rights and responsibilities, the organization's transfer and discharge policies, and an Outcome and Assessment Information Set (OASIS) privacy notice to all patients for whom OASIS data are collected. Written notice is provided during the initial evaluation visit, in advance of furnishing care to the patient, and is understandable to persons who have limited English proficiency and accessible to individuals with disabilities.

Written notice of the patient's rights and responsibilities and the transfer and discharge policies are provided to a patient's selected representative, if any, within four business days of the initial evaluation visit.

Applicable Regulations: G408-484.50(a); G410-484.50(a)(1); G412-484.50(a)(1)(i); G416-484.50(a)(1)(iii); G422-484.50(a)(4); G444-484.50(c)(9); G452-484.50(d).

Interview: Interview a key leader. Verify, through examples, the process to ensure that required information is given to the patient and representative (if any).

Record Review: Review patient records. Verify documentation that the patient's rights, the transfer and discharge policies, and the OASIS privacy notice (if applicable) were given to the patient prior to providing care in a way that is understandable to the patient. Verify that documentation of the patient's rights and responsibilities and discharge and transfer policies were provided to the patient's representative within four days of the initial evaluation visit.

Guidance: The patient's legal representative is a person who has the legal authority to act on the patient's behalf. The patient's selected representative is a person whom the patient may choose, but who may not necessarily have legal authority to act on behalf of the patient, such as a friend or family member who is assisting the patient.

Standards	Evidence Guidelines
PCC.3.I.M4 The organization obtains the patient's or legal representative's signature, confirming that he or she has received a copy of the notice of rights and responsibilities. Acknowledgment of receipt of the Patient Bill of Rights is made a permanent part of his or her record. **Applicable Regulation: G418-484.50(a)(2).**	Record Review: Review patient records. Verify there is documentation of the patient's or legal representative's signature confirming the receipt of a copy of the notice of rights and responsibilities. Guidance: Signatures may be obtained electronically or digitally. Guidance: The patient's legal representative is a person who has the legal authority to act on the patient's behalf.
PCC.5.I Care and services are accessible to patients during the organization's operating hours. Care outside of normal operating hours is accessible in accordance with organizational policy.	Document Review: Review documentation related to the organization's hours of operation. Verify that policies, procedures, or other documentation address how care is accessible to patients during and outside of the organization's normal operating hours. Observation: Conduct a home visit and interview a patient. Verify whether they have had to call the organization for information or assistance during or after normal operating hours. If so, verify that the organization responded within its established timeframe. If a home visit is not conducted, interview the patient via telephone.

Standards

PCC.5.I.M1

Patients and caregivers are provided contact information and can access the organization 24 hours a day, 7 days a week. Personnel respond to the needs of patients in accordance with organizational policy and patient needs.

Evidence Guidelines

Document Review: Review phone logs that document calls from patients and their caregivers outside of normal operating hours. Validate that calls were responded to within the timeframes outlined in policy. This information may also be found in the patient record.

Interview: Interview a key leader responsible for managing on-call coverage. Verify the ways in which this coverage is provided.

Observation: Place a call to the organization after operating hours. Validate that the call is returned within the timeframe specified in organizational policy.

Observation: Interview a patient and /or caregiver. Ask if they have had to call the organization for information or assistance during or after normal operating hours. If so, verify that the organization responded within its established timeframe and that a home visit was conducted if indicated. If a home visit is not conducted, interview the patient via telephone.

Guidance: 24/7 availability means that the patient can reach the organization at all times. It does not require that care and services are provided 24/7. The organization determines the immediacy of any needed services.

Standards

PCC.6.I

At the initiation of care, patients and their caregivers, if any, are informed of the organization's complaint process both verbally and in writing and are provided information on how to report complaints to CHAP and the state (per state regulation).

Evidence Guidelines

Record Review: Review patient records. Validate that each record contains documentation that patients and their caregivers (if any) were advised verbally and in writing of the complaint process, and are provided the contact information as specified in the standard.

Observation: Conduct a home visit. Interview the patient or a caregiver. Validate the patient's/caregiver's understanding of the complaint process.

Guidance: State regulation varies for different types of providers or service lines regarding the use of state hotline numbers and the organization's requirement to inform patients about them.

Guidance: Initial agencies that are not yet accredited by CHAP are prohibited from providing information on the CHAP toll-free number.

PCC.6.I.M1

Patients are provided the contact information for lodging complaints or asking questions, including:

1. The CHAP toll-free number; and
2. The toll-free hotline in the state.

Information about the telephone number of the hotline established by the state includes:

1. Telephone line hours of operation; and
2. The purpose of the hotline, which is to receive complaints or questions about local organizations.

Applicable Regulation: G444-484.50(c)(9).

Record Review: Review patient records. Verify there is documentation that the patient was given the information required in the standard.

Guidance: Initial agencies that are not yet accredited by CHAP are prohibited from providing information on the CHAP toll-free number.

Guidance: Some states do not have toll-free hotlines for lodging complaints. In these instances, the organization is required to include only the CHAP toll-free number.

Standards

PCC.6.I.M2

During the initial evaluation and prior to furnishing care, the organization provides the patient and the patient's legal representative (if any) the contact information for the Administrator, for the purpose of receiving complaints. Contact information includes the Administrator's name, business address, and business phone number.

Applicable Regulations: G410-484.50(a)(1); G414-484.50(a)(1)(ii).

Evidence Guidelines

Document Review: Review documents given to the patient at time of initial assessment. This might be found in an admission packet or the patient's record. Verify that contact information, including name, business address, and business phone number for the Administrator is included.

Observation: Conduct a home visit. Validate, through a patient interview, that the patient and/or legal representative was given required Administrator contact information, including name, business address, and business phone number, prior to the initiation of care.

PCC.7.I

Complaints are documented and investigated in accordance with organizational policy and state regulation. The organization documents the results of its investigation and notifies the complainant of its status.

Document Review: Review complaint logs or other documents that record the receipt of complaints. Review records of the investigation and responses for any complaints within the most recent 12-month period. Validate that investigation and notification to the complainant regarding the status occurred within the timeframes required by organizational policy.

Guidance: It is expected that the organization communicates with a complainant about the status of a complaint investigation. CHAP does not require that an organization discloses any specific actions taken to resolve a complaint, except as required by law.

Guidance: Some state law defines the ways in which patient complaints are managed. It is expected that organizations know and follow these laws and regulations.

Guidance: Not every complaint can be resolved to the patient's or complainant's satisfaction. It is expected that the organization takes action to resolve complaints to the extent possible and within the scope of services it provides.

Standards

PCC.7.I.M1

The organization investigates complaints made by a patient, the patient's representative (if any), and the patient's caregiver(s) and family, including, but not limited to, the following topics:

1. Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; and
2. Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the organization.

The organization documents both the existence of the complaint and the resolution of the complaint and takes action to prevent further potential violations, including retaliation, while the complaint is being investigated.

Applicable Regulations: G476-484.50(e)(1); G478-484.50(e)(1)(i); G480-484.50(e)(1)(i)(A); G482-484.50(e)(1)(i)(B); G484-484.50(e)(1)(ii); G486-484.50(e)(1)(iii).

Evidence Guidelines

Document Review: Review complaint logs, incident reports, or other documents that record the receipt of complaints. Review records of the investigation, resolution, and response for complaints within the most recent 12-month period. Validate that the topics required by the standard are investigated.

Interview: Interview a key leader. Verify the ways in which complaints are identified, investigated, and resolved. Verify the actions the organization takes, or would take, to prevent further potential violations during the investigation.

Observation: Conduct a home visit. Inquire if the patient has had a complaint about care or service, and clarify the patient's understanding of how the complaint was resolved.

Standards

PCC.8.I

Suspected instances of mistreatment, neglect, or verbal, mental, sexual, or physical abuse are reported and investigated in accordance with organizational policy and local and state law and regulation.

Evidence Guidelines

Document Review: Review logs, incident reports, or other documents that record reports of suspected mistreatment, neglect, or verbal, mental, sexual, or physical abuse. Review records of the investigation, resolution, and response for any reported incidents within the most recent 12 months. Validate that the investigation, resolution, and response occurred within the timeframes required by the standard.

Interview: Interview the administrator or personnel involved in overseeing service delivery. Clarify, through specific patient examples, how suspected instances of mistreatment or neglect are identified and handled.

Guidance: In most states, state law clearly defines actions required for identifying and reporting mistreatment, neglect, or verbal, mental, sexual, or physical abuse. It is expected that the organization knows and follows the state's law and regulation.

Guidance: Suspected instances of mistreatment, neglect, or verbal, mental, sexual, or physical abuse may be reported by a patient, caregiver, family, friend, or concerned other, as well as any contracted or employed personnel, including volunteers.

Standards

PCC.8.I.M1

Personnel (employed directly or under arrangement) in the normal course of providing services to patients, who identify, notice, or recognize incidences or circumstances of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property, report these findings immediately (within 24 hours) to the organization and the appropriate authorities in accordance with state law.

Applicable Regulation: G488-484.50(e)(2).

Evidence Guidelines

Document Review: Review logs, incident reports, or other documents that record reports of suspected mistreatment, neglect, or verbal, mental, sexual, or physical abuse, including injuries of unknown source or misappropriation of property. Review records for any reported incidents within the most recent 12 months. Validate that reporting to the organization and appropriate authorities occurred within the timeframes required by the standard.

Interview: Interview the administrator or personnel involved in overseeing service delivery. Clarify, through specific patient examples, how suspected instances of mistreatment or neglect are identified and handled.

Guidance: In most states, state law clearly defines actions required for identifying and reporting mistreatment, neglect, or verbal, mental, sexual, or physical abuse. It is expected that the organization knows and follows the state's law and regulation.

Guidance: Suspected instances of mistreatment, exploitation, neglect, or verbal, mental, sexual, or physical abuse may be reported by a patient, caregiver, family, friend, or concerned other, as well as any contracted or employed personnel, including volunteers.

Guidance: “Immediately” means as soon as possible, but not to exceed 24 hours after discovery or the incident, in the absence of a shorter state timeframe requirement.

Assessment, Planning & Coordination

KPA Statement

Organizations use effective communication and patient-centered care planning strategies among all members of the care team, including the patient, family and caregiver, to ensure safe, seamless and well-coordinated treatment and services.

Standards	Evidence Guidelines
APC.2.I Patient care and services are planned, coordinated and overseen by designated individual(s) in accordance with the organization's policies.	Interview: Interview a key leader who oversees planning and coordination of care/services. Validate who is responsible for the oversight of care/service delivery. Verify through specific patient example the ways in which care/services are planned and coordinated. Guidance: The amount and type of planning, coordination and oversight is dependent upon the type(s) of services provided. Retail DMEPOS suppliers would not be expected to plan and coordinate care since customers walk into a store front facility to purchase off the shelf items. However, DMEPOS suppliers who provide legend devices or other providers of care and services are expected to plan, coordinate and oversee the care and services they provide.

Standards

APC.2.I.M1

The Clinical Manager provides oversight of all patient care services. Oversight includes:

1. Coordinating patient care;
2. Coordinating referrals;
3. Ensuring that patient needs are continually assessed; and
4. Ensuring the development, implementation, and updates of the individualized plan of care.

Applicable Regulations: G958-484.105(c); G962-484.105(c)(2); G964-484.105(c)(3); G966-484.105(c)(4); G968-484.105(c)(5).

Evidence Guidelines

Document Review: Review the position descriptions for the Clinical Manager. Verify that they identify all of the responsibilities listed as appropriate to their position.

Interview: Interview the Clinical Manager. Clarify the ways in which he or she oversees all patient care services, including making patient and personnel assignments; coordinating patient care and referrals; ensuring that patient needs are continually assessed; and ensuring the development, implementation, and updates of the individualized plan of care.

APC.2.I.M2

Effective 1/1/2021

Patients' care is coordinated using an interdisciplinary team approach to support the implementation of the care plan. The team includes representatives from disciplines providing care, whether directly or under arrangement, from the following services:

1. Nursing, including home health aide;
2. Therapy, including physical therapy, speech-language pathology, and occupational therapy;
3. Medical social work; and
4. Physician or allowed practitioner services.

Applicable Regulations: G700-484.75; G704-484.75(b); G706-484.75(b)(1); G804-484.80(g)(4).

Interview: Interview the Clinical Manager and other members of the care team. Clarify the ways in which care is planned and coordinated with an interdisciplinary team approach. Verify, through specific patient examples, that each ordered discipline participates in the planning and coordination of care/services.

Record Review: Review patient records. Validate that there is evidence in the record of the care planning and coordination processes identified during interview of the Clinical Manager. This may be found in a case conference or patient care notes.

Standards	Evidence Guidelines
APC.3.I The organization follows the process defined for intake and the determination of eligibility to receive services.	Interview: Interview an individual who manages patient intake. Verify that intake and eligibility determination are done in accordance with the organization's defined process.
APC.3.I.M1 Patients are accepted for treatment on the basis of a reasonable expectation that their medical, nursing, rehabilitative, and social needs can be met adequately by the organization. **Applicable Regulation: G570-484.60.**	Interview: Interview one or more direct care staff members who admit patients to the organization. Using a recent patient admission as an example, clarify the criteria used to determine that there was a reasonable expectation that the patient's needs could be met by the organization. Guidance: It is expected that the organization has reasonable confidence that it can meet the patient's needs when admitting a patient. For example, if the organization does not have, either directly, or through contract, the ability to provide physical therapy services in the ordered timeframe, it is expected that the organization contact the prescribing authority to determine if alternative arrangements, such as a referral to another organization, should be made.
APC.5.I Patient assessments and/or evaluations are conducted by authorized personnel and completed within specified timeframes, in accordance with organizational policy and state and federal law and regulation.	Record Review: Review patient records. Validate patient assessments and/or evaluations are completed by authorized personnel within required timeframes. Guidance: The scope and frequency of assessments and/or evaluations are based on each patient's needs and other relevant facts, including payer and regulatory requirements.

Standards

Evidence Guidelines

APC.5.I.M1

Effective 1/1/2021

An initial assessment visit is completed by a registered nurse to determine the immediate care and support needs of the patient and to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment is conducted:

1. Within 48 hours of referral; or
2. Within 48 hours of the patient's return home; or
3. On the physician or allowed practitioner ordered start-of-care date.

For the Medicare home health benefit, when physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician or allowed practitioner who is responsible for the home health plan of care, a physical therapist or speech-language pathologist may complete the initial assessment within the timeframes required. For Medicare patients, the appropriate rehabilitation skilled professional may determine eligibility for the Medicare home health benefit, including homebound status.

Applicable Regulations: G510-484.55; G512-484.55(a); G514-484.55(a)(1); G516-484.55(a)(2).

Standards

APC.5.I.M2

Effective 1/1/2021

A comprehensive assessment is completed by a registered nurse in a timeframe consistent with and informed by the patient's needs, but no later than five calendar days after the start of care. During the assessment, the organization verifies the patient's eligibility for the Medicare home health benefit, including homebound status.

When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician or allowed practitioner, a physical therapist, speech-language pathologist, or occupational therapist may complete the comprehensive assessment and, for Medicare patients, 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.

Applicable Regulations: G510-484.55; G518-484.55(b); G520-484.55(b)(1); G522-484.55(b)(2); G524-484.55(b)(3).

Evidence Guidelines

Record Review: Review patient records. Validate that each patient's comprehensive initial assessment has been completed no later than five calendar days after the start of care. Validate that eligibility was verified.

Guidance: This standard references the comprehensive assessment completed when a patient is admitted or readmitted. Time frames for ongoing updates and revisions to the comprehensive assessment are addressed in other standards.

Guidance: For the Medicare home health benefit, occupational therapy services provided at the start of care alone do not establish eligibility; therefore, occupational therapists may not conduct the initial or "start of care" comprehensive assessment visit under Medicare. Patients needing only occupational therapy services on admission to the organization may qualify for eligibility under programs other than Medicare.

Standards

APC.5.I.M3

The comprehensive assessment is updated and revised (including the administration of the Outcome and Assessment Information Set [OASIS]) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but no less frequently than the last five days of every 60 days beginning with the start-of-care date, unless there is:

1. A beneficiary-elected transfer;
2. A significant change in condition; or
3. A discharge and return to the same home health organization during the 60-day episode.

Applicable Regulations: G544-484.55(d); G546-484.55(d)(1).

Evidence Guidelines

Record Review: Review patient records for patients receiving services for more than 60 days. Validate that the comprehensive assessment has been completed within the last five days of every 60 days as required by the standard. Validate that the OASIS has been completed as required per federal regulation.

Guidance: If the patient returns home from an inpatient stay between the 56 or 60 day and they have not been discharged from the organization, a Resumption of Care (ROC) assessment is completed, and satisfies both the ROC and the recertification requirements.

Standards

APC.5.I.M4

Effective 1/1/2021

A registered nurse updates and revises the comprehensive assessment (including the administration of the Outcome and Assessment Information Set [OASIS]) at:

1. Recertification;
2. Discharge;
3. Patient-elected transfer;
4. Discharge and return to the same organization during a 60-day episode; and
5. Readmission.

The comprehensive assessment is also updated and revised as warranted by a significant change in the patient's condition.

Following hospitalizations lasting at least 24 hours for any cause other than diagnostic testing, the assessment is revised within 48 hours or on the physician or allowed practitioner ordered resumption date and includes the administration of the OASIS.

When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician or allowed practitioner, a physical therapist, speech-language pathologist, or occupational therapist may complete the comprehensive assessments. The occupational therapist may complete the ongoing comprehensive assessment if the need for occupational therapy establishes program eligibility.

Applicable Regulations: G522-484.55(b)(2); G524-484.55(b)(3); G546-484.55(d)(1); G548-484.55(d)(2); G550-484.55(d)(3).

Evidence Guidelines

Record Review: Review patient records for one or more patients who have been discharged, recertified for ongoing care, or transferred or admitted to the hospital for greater than 24 hours. Validate that the patient was reassessed, and that a new OASIS was completed as required.

Guidance: This assessment and OASIS must be completed for all Medicare and Medicaid beneficiaries receiving skilled care (except those allowed by CMS exclusion) within 48 hours of the organization becoming aware that the patient was released from the hospital.

Guidance: If the patient is hospitalized at the time required for the recertification assessment, it is expected that the patient will be discharged. If ordered by the physician or allowed practitioner, the patient may be re-admitted when he or she returns home.

Standards

APC.6.I

Each patient's needs are assessed and/or evaluated relative to the services the organization provides.

Applicable Regulation: G510-484.55.

Evidence Guidelines

Record Review: Review patient records. Verify that assessments and/or evaluations are conducted to determine the immediate and ongoing needs for care and services, including eligibility.

APC.6.I.M1

The comprehensive assessment accurately reflects the patient's status. It incorporates the current version of the Outcome and Assessment Information Set (OASIS) items, and includes, at a minimum:

1. Demographic information and medical history, including any allergies or sensitivities;
2. The patient's representative (if any);
3. Strengths, goals, and care preferences, including information that may be used to demonstrate the patient's progress toward achievement of the goals identified by the patient and the measurable outcomes identified by the organization;
4. Current health, psychosocial, functional, and cognitive status;
5. Systems review, including sensory status, integumentary status, respiratory status, elimination status, and neuro/emotional/behavioral status;
6. Review of medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy;
7. Activities of daily living;
8. Continuing need for home care;
9. Living arrangements;
10. Use of emergent care since the last assessment;
11. Data items collected at inpatient facility admission or discharge only;
12. Current use of medical equipment;
13. Supportive systems, including the primary caregiver(s), if any, and other available supports, including the caregivers'

(continued on following page)

Record Review: Review patient records. Verify that the medication review identifies any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Verify that the comprehensive assessment contains at least all components required by the standard.

Guidance: It is expected that each patient has a comprehensive assessment. The completion of the OASIS is required for Medicare and Medicaid beneficiaries, with CMS approved exceptions.

Guidance: Current OASIS items are included in the bulleted list. For example, living arrangement, integumentary status, respiratory status, elimination status, etc., are all included on the OASIS.

Guidance: The identification of patient resources and needs during a natural or man-made disaster is expected to be completed as part of the comprehensive assessment. It may be documented as part of the assessment or be included in another part of the patient's record.

Standards	Evidence Guidelines
APC.6.I.M1 14. willingness and ability to provide care and their availability and schedules; 15. Medical, nursing, rehabilitative, social, and discharge planning needs; and 16. Plan for the patient in the event of a natural or man-made disaster. **Applicable Regulations: E0017-484.102(b)(1); G526-484.55(c); G528-484.55(c)(1); G530-484.55(c)(2); G532-484.55(c)(3); G534-484.55(c)(4); G536-484.55(c)(5); G538-484.55(c)(6); G540-484.55(c)(7); G542-484.55(c)(8).**	
APC.7.I The patient's care/service plan addresses needs identified in the assessment process.	Record Review: Review patient records and/or service plans. Verify that each record contains a patient care plan that addresses the needs identified in the assessment process.

Standards

APC.7.I.M1

Each patient has an individualized plan of care. The plan is developed and evaluated in partnership with the patient, representative (if any), and caregiver(s) and identifies patient-specific measurable outcomes and goals.

Applicable Regulations: G570-484.60; G572-484.60(a)(1); G704-484.75(b); G708-484.75(b)(2).

Evidence Guidelines

Record Review: Review patient records. Verify that the plan of care is individualized and includes patient-specific measurable outcomes and goals.

Observation: Conduct a home visit. Verify, through patient and/or caregiver interview, that the patient was involved in care planning and goal setting.

Guidance: Patient-specific goals reflect what matters most to the patient. At times a patient's goal may not be aligned with the providers or caregivers' goals for care. For example, a patient's goal may be to drive his car again, and the patient's family may not share that goal. In these situations, it is expected that personnel work with the patient and caregivers to establish realistic goals that are more closely aligned.

Standards

APC.7.I.M2

Effective 1/1/2021

The individualized plan of care includes the following:

1. All pertinent diagnoses;
2. All patient care orders, including verbal orders;
3. The patient's mental, psychosocial, and cognitive status;
4. The types of services, supplies, and equipment required;
5. The frequency and duration of visits to be made;
6. The mode of care-delivery including the use of telecommunications when applicable;
7. Prognosis and rehabilitation potential;
8. Functional limitations;
9. Activities permitted;
10. Nutritional requirements;
11. All medications and treatments;
12. Food and drug allergies;
13. Safety measures to protect against injury;
14. A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors;
15. Patient and caregiver education and training to facilitate timely discharge;
16. Patient-specific interventions and education;
17. Measurable outcomes and goals identified by the organization and the patient;
18. Information related to any advance directives; and
19. Any additional items the organization or physician or allowed practitioner may choose to include.

Applicable Regulations: G570-484.60; G574-484.60(a)(2); G576-484.60(a)(3).

Evidence Guidelines

Record Review: Review patient records. Verify that each record contains a plan of care that is individualized, is developed in partnership with the patient and others, and addresses the requirements of the standard. Verify that the plan includes patient-specific, measurable outcomes and goals and is signed by the physician or allowed practitioner.

Guidance: Medicare-certified agencies providing services not reimbursed by Medicare are expected to develop an individualized plan of care that addresses the elements appropriate to the care/services they are providing. For example, if a Medicare-certified organization is providing a patient with only personal care and support services, the individualized plan of care would not be expected to include a description of hospitalization risks.

Guidance: The frequency and duration of visits are specific to the patient's condition and needs. Pro re nata (PRN) or as-needed visit orders are expected to be minimal and include an indication or reason for why the visit is to occur. Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided. Ranges are expected to be small (ex: 2-4 visits) and the upper limit of the range is considered the specific frequency.

Guidance: Individualized care planning reflects the lifestyle, needs, values, strengths, limitations, culture, preferences, and goals of patients and caregivers that affect the care and service being delivered. Patients are involved in initial and ongoing decisions about their care, including decisions related to transitions of care.

Guidance: Telecommunications cannot substitute for a home visit ordered as part of the plan of care, and cannot be considered a home visit for the purposes of Medicare eligibility or payment.

Standards	Evidence Guidelines
APC.7.I.M5 *Effective 1/1/2021* If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. **Applicable Regulation: G572-484.60(a)(1).**	Record Review: Review patient records. When the record reflects that a plan of care was not completed until after the evaluation visit, verify that the physician or allowed practitioner was notified to approve additions or modifications to the plan.
APC.7.I.M6 *Effective 1/1/2021* The patient's individualized care plan is established, periodically reviewed, and signed by a doctor of medicine, osteopathy, or podiatry, or allowed practitioner acting within the scope of his or her state license, certification, or registration. **Applicable Regulation: G572-484.60(a)(1).**	Record Review: Review patient records. Verify that the patient's care plan is signed by the physician or allowed practitioner when it is established and periodically reviewed. Guidance: Services which are provided in subsequent certification periods (recertification) are considered to be provided under the subsequent plan of care when there is a verbal order to continue services into the recertification period. The verbal order must be obtained before the services are provided;

Standards

APC.7.I.M7

Effective 1/1/2021

The individualized plan of care is reviewed and revised by the physician or allowed practitioner who is responsible for the home health plan of care and the home health organization as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start-of-care date. A revised plan of care reflects current information from the patient's updated comprehensive assessment and contains information concerning the patient's progress toward the measurable outcomes and goals identified by the home health organization and patient in the plan of care.

Applicable Regulations: G572-484.60(a)(1); G586-484.60(c); G588-484.60(c)(1); G592-484.60(c)(2).

Evidence Guidelines

Record Review: Review patient records, including records for patients on service for more than 60 days. Validate that the total plan of care is reviewed by a doctor of medicine, osteopathy, or podiatry or allowed practitioner and personnel at least once every 60 days and as the patient's conditions or needs warrant. Validate that the revised plan of care includes information on the patient's progress toward goal achievement and measurable outcomes as required by the standard.

Guidance: The total plan of care includes written care instructions for the home health aide (aide plan of care). It is expected that the aide plan of care is reviewed as a part of the total plan of care in accordance with the standard.

APC.8.I

The organization communicates and coordinates care with the patient to share information needed to implement the care/service plan.

Applicable Regulation: G600-484.60(d).

Record Review: Review the patient record. Verify that coordination of care between the patient and the members of the care team is documented. Verify that coordination efforts support the care/service plan.

Standards

APC.8.I.M1

Information is provided to patients in plain language and in a manner that is accessible and timely to:

1. Persons with disabilities (accommodations may include accessible websites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act); and
2. Persons with limited English proficiency (accommodations may include the provision of language services at no cost to the individual, including oral interpretation and written translations).

Applicable Regulations: G490-484.50(f); G490-484.50(f)(1); G490-484.50(f)(2).

Evidence Guidelines

Interview: Interview a key leader. Verify, through specific patient examples, the ways in which language and disability are addressed to meet patient's need for information. If no patient has needed these services, verify the process by which the organization would provide these services and aids.

Record Review: Review patient records. Verify that oral interpretation, written translations of materials, and auxiliary aids are provided for the patient at no charge when they are needed.

Standards

APC.8.I.M3

The organization provides the patient and caregiver(s) with a copy of written instructions outlining:

1. Visit schedule, including frequency of visits by home health organization personnel and personnel acting on behalf of the home health organization;
2. Patient medication schedule/instructions, including medication name, dosage, and frequency, as well as which medications will be administered by home health organization personnel and personnel acting on behalf of the home health organization;
3. Any treatments to be administered by home health organization personnel and personnel acting on behalf of the home health organization, including therapy services;
4. Any other pertinent instruction related to the patient's care, treatments, and services that the home health organization will provide, specific to the patient's care needs; and
5. Name and contact information of the home health organization's Clinical Manager.

Applicable Regulations: G612-484.60(e); G614-484.60(e)(1); G616-484.60(e)(2); G618-484.60(e)(3); G620-484.60(e)(4); G622-484.60(e)(5).

Evidence Guidelines

Record Review: Review patient records. Verify that the patient is provided copy of written instructions containing all of the elements required in the standard.

Observation: Conduct a home visit. Verify through direct observation and/or interview with the patient and caregiver(s) that written instructions were given as required by the standard. If possible, view the written notification.

Guidance: Written instructions may be provided in an electronic format, such as secure email.

APC.8.I.M4

Any revision to the plan of care due to a change in patient health status is communicated to:

1. The patient;
2. The representative (if any); and
3. The caregiver.

Applicable Regulations: G594-484.60(c)(3); G596-484.60(c)(3)(i).

Record Review: Review patient records. When the plan of care is revised due to a change in the patient's health status, verify that the revisions have been communicated to the patient, the representative (if any), and the caregiver.

Guidance: Standard APC.9.I.M2 also requires that any revision to the plan of care due to a change in patient health status is communicated to all physicians issuing orders for the home health organization plan of care.

Standards	Evidence Guidelines
APC.8.I.M5 The organization coordinates care delivery to meet the patient's needs, and involves the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. **Applicable Regulation: G608-484.60(d)(4).**	Record Review: Review patient records. Verify that care delivery is coordinated with the patient, representative, and caregiver(s) as appropriate to meet the needs of the patient. Observation: Conduct a home visit. Verify, through patient interview, the ways in which personnel coordinate care with the patient and appropriate representatives and caregivers.
APC.9.I Communication and coordination occur among members of the care team who are planning and delivering care and services. The care team shares information needed to implement the care/service plan. **Applicable Regulation: G600-484.60(d).**	Record Review: Review the patient record. Verify that coordination of care between members of the care team is documented. Verify that coordination efforts support the care/service plan. Guidance: In this standard, "care team members" refers to the organization's personnel, including those under contract, as well as physicians (as applicable to services provided) or other health care providers who plan and deliver care/services to the patient.
APC.9.I.M1 *Effective 1/1/2021* The organization communicates with and integrates orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and interventions provided to the patient. **Applicable Regulations: G602-484.60(d)(1); G604-484.60(d)(2); G704-484.75(b); G718-484.75(b)(7).**	Record Review: Review the patient record. If multiple physicians or allowed practitioners are involved in the patient's care, verify that their orders are integrated into the plan of care and that they are included in communications.

Standards

APC.9.I.M2

Effective 1/1/2021

Any revision to the plan of care due to a change in patient health status is communicated to the patient, representative (if any), caregiver, and all physicians or allowed practitioners issuing orders for the home health organization plan of care.

Applicable Regulations: G594-484.60(c)(3); G596-484.60(c)(3)(i).

Evidence Guidelines

Record Review: Review patient records. When the plan of care is revised due to a change in the patient's health status, verify that the revisions have been communicated to all physicians or allowed practitioners issuing orders for the home health organization plan of care and have been documented.

APC.9.I.M3

Effective 1/1/2021

The home health organization promptly alerts the relevant physician(s) or allowed practitioner(s) to any changes in the patient's condition or needs that suggest that outcomes are not being achieved and/or that the plan of care should be altered.

Applicable Regulations: G586-484.60(c); G590-484.60(c)(1).

Record Review: Review patient records. When the record reflects a change in the patient's condition or needs that suggests that outcomes are not being achieved and/or that the plan of care should be altered, verify the presence of documentation that the physician or allowed practitioner was notified.

Guidance: The timeframe for prompt physician or allowed practitioner notification of changes in the patient's condition varies depending on the type of information and its criticality. For example, it is expected that critical lab values, patient injury, or a significant/sudden change in the patient's physical or mental status would be reported as quickly as possible.

Guidance: If the home health organization provides fewer visits than the physician or allowed practitioner orders, it has altered the plan of care and the physician or allowed practitioner must be notified. The organization is required to maintain documentation in the patient record indicating that the physician or allowed practitioner was notified and is aware of the missed visit.

Standards	Evidence Guidelines
APC.9.I.M4 The organization integrates services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. **Applicable Regulation: G606-484.60(d)(3).**	Interview: Interview an individual who provides care to a patient receiving multiple services. Verify, through specific patient examples, the ways in which care and services are integrated to meet the patient's needs. Record Review: Review patient records. Verify that there is documentation of communication and integration between services.
APC.10.D The organization develops policies and procedures to coordinate and communicate care and service transitions.	Document Review: Review policies and procedures that address transitions of care and services. Verify that there are mechanisms in place to coordinate and communicate regarding transitions in care. Guidance: Care and service transitions occur when a patient moves or transfers between different settings (and external transition of care) or different levels of care within the same setting (and internal transition of care.) Examples of external care transitions might include transfer from the home setting to a hospital or from a rehab facility to home care. Internal transitions might include the "hand-off" of care to another provider, such as a shift change in skilled home care, or the passing of information to an on-call nurse for after hours care and coverage. Guidance: Policies and procedures are not required if the organization does not actively participate in the transfer of patients (i.e., Personal Care and Support Services and Home and Environmental Services).

Standards

APC.10.D.M1

Effective 1/1/2021

Policies document the criteria and processes for transfer and discharge. Policies prescribe that the organization may only transfer or discharge a patient if:

1. The transfer or discharge is necessary for the patient's welfare because the organization and the physician or allowed practitioner who is responsible for the home health plan of care agree that the organization can no longer meet the patient's needs, based on the patient's acuity;
2. The patient or payer will no longer pay for the services provided by the organization;
3. The transfer or discharge is appropriate because the physician or allowed practitioner who is responsible for the home health plan of care and the organization agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the organization and the physician or allowed practitioner who is responsible for the home health plan of care agree that the patient no longer needs the organization's services;
4. The patient refuses services, or elects to be transferred or discharged;
5. The organization determines that the patient's behavior (or that of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the organization to operate effectively is seriously impaired;
6. The patient dies; or
7. The organization ceases to operate.

Applicable Regulations: G452-484.50(d); G454-484.50(d)(1); G456-484.50(d)(2); G458-484.50(d)(3); G460-484.50(d)(4); G462-484.50(d)(5); G472-484.50(d)(6); G474-484.50(d)(7).

Evidence Guidelines

Document Review: Review discharge and transfer policies. Verify that they include the criteria required by the standard.

Standards

APC.10.D.M2

Effective 1/1/2021

Policies include procedures for transferring or discharging a patient "for cause" when the organization determines that the patient's behavior (or that of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the organization to operate effectively is seriously impaired. The policy prescribes that the organization:

1. Advises the patient, the patient's representative (if any), the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization (if any) that a discharge for cause is being considered;
2. Makes efforts to resolve the problem(s) presented by the patient's behavior, the behavior of other persons in the patient's home, or the situation;
3. Provides the patient and representative (if any) with contact information for other agencies or providers who may be able to provide care; and
4. Documents the problem(s) and efforts made to resolve the problem(s), and enters this documentation into its clinical records.

Policies also describe the required content of the discharge or transfer summary:

1. All necessary medical information pertaining to the patient's current course of illness and treatment; and
2. Post-discharge goals of care and treatment preferences.

Applicable Regulations: G462-484.50(d)(5); G464-484.50(d)(5)(i); G466-484.50(d)(5)(ii); G468-484.50(d)(5)(iii); G470-484.50(d)(5)(iv); G564-484.58(b); G564-484.58(b)(1).

Evidence Guidelines

Document Review: Review policy for discharging a patient for cause. Verify that it addresses each of the requirements of the standard.

Document review: Review policy for patient discharge/transfer. Validate that the policy includes the required elements for the content of the summary.

Record review: Review discharge/transfer patient records of those patients discharged or transferred on 11/29/2019 or after. Verify the required content is present in the discharge/transfer summary.

Guidance: Additional requirements related to planned discharge of patients are located in APC.10.I and APC.11.I.

Guidance: States may have additional requirements related to the transfer or discharge or patients. It is expected that the organization knows and follows these requirements.

Standards	Evidence Guidelines
APC.10.I Transitions of care and discharge planning occur in accordance with the organization's policies. **Applicable Regulation: G560-484.58.**	Record Review: Review one or more patient records in which a transition of care has occurred. Verify that the organization's policies were followed. Interview: Interview a key leader and/or a clinician. Verify that a discharge planning process has been implemented and that the process is in compliance with the organization's policies.
APC.10.I.M1 The organization arranges a safe and appropriate transfer to other care entities when the needs of the patient exceed the organization's capabilities. **Applicable Regulation: G454-484.50(d)(1).**	Record Review: Review one or more records of patients who have been transferred from the organization's care. Verify that the transfer was accomplished safely and appropriately when the needs of the patient exceeded the organization's capabilities.
APC.11.I Effective communication takes place when the patient experiences a transition of care.	Interview: For initial site visits where no patient transfers have yet occurred, interview a key leader. Verify the processes that are in place to communicate with other providers when transitions of care take place. Record Review: Review documentation of intake, referral, transfer, or discharge communications. This may be found in patient records, transfer logs, communication logs, or other documents. Verify that key information is communicated during care transitions.

Standards

APC.11.I.M1

The organization must develop and implement an effective discharge planning process. For patients who are transferred to another home health organization, or who are discharged to a SNF, IRF, or LTCH, the organization must assist patients and their caregivers in selecting a post-acute care provider by:

1. Using and sharing data that includes, but is not limited to home health, SNF, IRF, or LTCH data on quality measures and resource use measures.

The organization ensures that the post-acute care data on quality and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences.

Applicable Regulation: G562-484.58(a).

Evidence Guidelines

Record Review: Review discharge patient records. Verify that assistance in the selection of a facility or other home health organization was provided (and documented) to the patient/caregiver in planning for discharge/transfer.

Interview: Interview a clinician or key leader on the discharge planning requirements for those patients discharged to another home health organization, a SNF, IRF, or LTCH. Inquire if the patient/caregiver required assistance in the selection of organization/facility and how the assistance was provided and if the patient's goals and treatment preferences were considered in the provision of information.

Guidance: Resources for comparative data:

1. IRF - https://www.medicare.gov/inpatientrehabilitationfacilitycompare/
2. SNF - https://www.medicare.gov/nursinghomecompare/search.html?
3. LTCH - https://www.medicare.gov/longtermcarehospitalcompare/
4. Home Health compare - https://www.medicare.gov/homehealthcompare/search.html

Tip: Should the patient/caregiver already have made a selection of entity to which they will be discharged, assistance may not be required.

Standards

APC.11.I.M2

Effective 1/1/2021

Any revisions related to plans for the patient's discharge are communicated to the patient, the patient's representative, the patient's caregiver(s), all physicians or allowed practitioners issuing orders for the organization's plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization (if any).

Applicable Regulations: G594-484.60(c)(3); G598-484.60(c)(3)(ii).

Evidence Guidelines

Record Review: Review records for patients who have been discharged. Verify that documentation demonstrates that the organization communicated changes in the discharge plan to the patient, the representative, the caregiver(s), all physicians or allowed practitioners issuing orders for the organization's plan of care, and the patient's primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization (if any).

Standards

APC.11.I.M3

The primary care practitioner or other health care professional who will be responsible for providing care and services to the patient is sent:

1. A discharge summary from the organization within five business days of the patient's discharge; or
2. A completed transfer summary within two business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or
3. A completed transfer summary within two business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time the organization becomes aware of the transfer.

Content of the summaries will include all necessary medical information pertaining to the patient's current course of illness and treatment, inclusive of post-discharge goals of care, and treatment preferences. The organization will send the relevant summary to the receiving facility or health care practitioner.

The organization must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner.

Applicable Regulations: G1010-484.110(a); G1020-484.110(a)(5); G1022-484.110(a)(6); G564-484.58(b)(1); G564-484.58(b)(2).

Evidence Guidelines

Record Review: Review patient records for one or more patients who have been discharged or transferred from the organization. Verify that the organization sent the primary care practitioner or other health care professional who was responsible for providing care and services to the patient a discharge summary or transfer summary in accordance with the requirements of the standard.

Record Review: Validate that the discharge/transfer summary includes the required content.

Guidance: The required content of the summary is defined in APC.10.D.M2.

Interview: Interview a key leader to determine where requests for additional information made by the receiving facility or healthcare practitioner are documented.

Document Review: Review applicable documentation to validate that requests for additional information were provided.

Care Delivery & Treatment

KPA Statement

Care delivery and treatment are provided according to the patient's needs, accepted standards of practice, and the organization's defined scope of services.

Standards	Evidence Guidelines
CDT.2.I Care and services provided are within the organization's documented scope of services.	Document Review: Review the organization's scope of services documentation. This information may be in written or electronic format, and could, for example, be found in patient brochures, in admission packets, or on the organization's website. Validate that the care and services provided are reflected in this statement. Interview: Interview a key leader of the organization. Verify, through the leader's description, the ways in which the documented scope of services is delivered. Guidance: Organizations seeking initial accreditation will be expected to demonstrate their ability to provide all services (disciplines) detailed within their scope of services. For example, if the organization's scope of services includes Physical Therapy then the organization is expected to be able to demonstrate that it could provide this care should the need for such service arise.

Standards

CDT.2.I.M1

Skilled nursing services and at least one other therapeutic service (physical therapy, speech-language pathology, or occupational therapy; medical social services; or home health aide services) are made available on a visiting basis, in a place of residence used as the patient's home.

At least one of the following services is provided directly by the organization:

1. Skilled nursing;
2. Physical, speech, or occupational therapy;
3. Medical social services; or
4. Aide services.

The organization may provide a second service and additional services under arrangement with another organization.

Applicable Regulation: G982-484.105(f)(1).

Evidence Guidelines

Document Review: Review documents that describe the services provided by the organization. These might include a scope of services document, patient/marketing brochures, or statements posted on the organization's website. Validate that skilled nursing and one other therapeutic service is provided. Compare these documents to any contracts for other qualifying services. If the organization does not provide all services directly, validate that a contract is in place with an individual or organization to support the provision of a second qualifying service and any additional services. Validate that at least one service is provided directly and entirely by the organization's employees.

Record Review: Review patient records. Validate that skilled nursing and one other qualifying service are being provided or are available to at least one patient.

Guidance: An organization provides at least one of the qualifying services directly and entirely through its personnel. For example, if this service is nursing, it is expected that all skilled nursing personnel that provide direct care, including after-hours care, are employees of the organization.

Guidance: Compliance with contractual requirements will be evaluated in the Leadership and Governance Key Performance Area (KPA). Examination of contracts in this KPA is meant to validate the types of services provided and whether they are provided directly by the organization's employees or by arrangement with another agency or individual.

Standards

CDT.3.I

Personnel follow established standards of practice in the delivery of care and services, and practice within the scope of their license, certification, or registration and as required by law and regulation.

Evidence Guidelines

Record Review: Review patient records. Verify that care is delivered according to accepted standards of practice. Validate that personnel practice within the scope of their license, certification, or registration and as required by law and regulation.

Guidance: Not every service or discipline has established standards of practice. Where accepted standards of practice exist, it is expected that they are applied and followed.

Guidance: It is expected that personnel know and follow standards of practice related to their discipline. These standards of practice are generally available through various organizations. Examples of standards of practice include individual state professional practice acts, the American Nurses Association Scope and Standards of Practice, Standards and Scope of Practice from the American Psychiatric Nurses Association, the National Association of Social Workers Standards for Social Work, Standards of Practice for Physical Therapy, Standards of Practice for Clinical Pharmacists, the Hospice and Palliative Nurses Association Clinical Practice Guidelines for Quality Palliative Care, and the American Association for Respiratory Care Clinical Practice Guidelines. Aide disciplines are expected to follow local and state regulations as well as applicable CHAP standards related to competency and/or training.

Standards	Evidence Guidelines
CDT.3.I.M1 Services are provided in accordance with current clinical practice guidelines and accepted professional standards of practice. **Applicable Regulations: G570-484.60; G984-484.105(f)(2).**	Record Review: Review patient records. Verify that care is delivered according to current clinical practice guidelines and accepted professional standards of practice. Observation: Conduct a home visit. Observe care delivered to validate that it is provided in accordance with current clinical practice guidelines and accepted professional standards of practice. Guidance: For Medicare certified home health and hospice agencies, failure to follow accepted standards of practice will result in a finding that the organization is out of compliance with a Center for Medicaid & Medicare Services condition of participation.
CDT.3.I.M2 The organization does not substitute its equipment for a patient's equipment when assisting with self-administered tests. **Applicable Regulation: G862-484.100(c)(1).**	Interview: Interview a registered nurse who provides direct patient care. Verify that the organization does not substitute its equipment for a patient's equipment when assisting with self-administered tests. Guidance: Organizations may use their own self-administered testing equipment for a short, defined period of time when the patient has not yet obtained his or her own testing equipment, such as in the days immediately following physician orders to obtain the testing equipment when a patient may not have the time and resources immediately available to complete the process. It is expected that the organization use available resources to assist the patient in obtaining his or her own testing equipment as quickly as possible.

Standards

CDT.4.D

There are documented policies and procedures for the acceptance, documentation, verification, and authentication of required physician or other authorized practitioner orders. Policies address which personnel can receive and document orders, including the timeframes for documentation and authentication, in accordance with local, state, and federal law and regulation.

Applicable Regulation: G584-484.60(b)(4).

Evidence Guidelines

Document Review: Review policies, procedures, and other documents that describe how orders are managed. Validate that the documents address which personnel can receive and document orders, as well as the process and timeframes by which orders are obtained and authenticated.

Guidance: Some services, such as chore services, do not require an order, as specified in organizational policy or defined by local, state, and federal law and regulation. If this is the case, the standard does not apply.

Guidance: Local and state professional practice acts may define who is authorized to receive, document, and verify orders. When permitted by organizational policy and law or regulation, unlicensed or non-skilled personnel may receive and document orders. In general, a health professional may receive an order for his or her particular discipline. For example, a social worker would have the authority to receive a social work order, but not a nursing order.

CDT.4.I

Physician (or other authorized practitioner) orders for services are obtained, as required, prior to the provision of care/services and in accordance with applicable state and federal law and regulation.

Record Review: Review patient records. Verify that there is documentation of a verbal and/or written order, if required, and that the order was obtained prior to the provision of any care/service, including changes in the care/service plan.

Guidance: Orders are generally issued by a physician. In some states, orders may be issued by nurse practitioners or physician assistants.

Standards	Evidence Guidelines
CDT.4.I.M1 *Effective 1/1/2021* Medications, services, and treatments are administered only as ordered by a physician or allowed practitioner. **Applicable Regulations: G578-484.60(b); G580-484.60(b)(1).**	Record Review: Review patient records. Verify that medications and treatments are administered as ordered by a physician or allowed practitioner.
CDT.5.I Orders, including verbal orders, are accepted, signed, and dated by authorized personnel as defined in organizational policy and local, state, or federal law and regulation. **Applicable Regulation: G584-484.60(b)(3).**	Record Review: Review patient records. Verify that orders, including verbal orders, include the signature of the authorized person receiving the order and the date of receipt. Verify that an authorized person received the order.

Standards

CDT.5.I.M1

Effective 1/1/2021

Physician or allowed practitioner verbal orders are documented in the patient's record by a nurse acting in accordance with state licensure requirements or other authorized practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the organization's policies. Orders are signed and dated and indicate the time the order was received.

Applicable Regulation: G584-484.60(b)(4).

Evidence Guidelines

Record Review: Review patient records. Verify that verbal orders include the signature of the authorized person receiving the order and the date and time of receipt. Verify that an authorized person received the order.

Guidance: Organizational policy requirements related to orders can be found in CDT.4.D.

Guidance: Authorized personnel may include individuals responsible for providing or supervising ordered services.

Guidance: A verbal order means a physician or allowed practitioner order that is spoken to appropriate personnel and later put in writing for the purpose of documenting as well as establishing or revising the patient's plan of care.

Guidance: State professional practice acts may define who is authorized to receive a verbal order. In general, a health professional may receive a verbal order for his or her particular practice. For example, a social worker would have the authority to receive a social work order, but not a nursing order. Organizations are expected to know, understand, and comply with state and federal requirements.

Standards	Evidence Guidelines
CDT.5.I.M2 Verbal orders are authenticated and dated by the physician or other ordering practitioner within 30 days of issuing the order and in accordance with the organization's policies and state law and regulation. **Applicable Regulation: G584-484.60(b)(4).**	Record Review: Review patient records. Verify that each verbal order contains a countersignature from the physician within 30 days or less as designated in organizational policy and state requirements. Guidance: Organizational policy requirements related to orders can be found in CDT.4.D. Guidance: State law may define a time-frame for the authentication of verbal orders that is less than 30 days. When state law and regulation is more stringent than the CHAP standard, it is expected that the organization complies with the more stringent requirement. Guidance: This standard applies to organizations providing personal care and support services if those services require a physician (or other authorized practitioner) order.
CDT.7.I Care and services are provided according to the established care/service plan.	Record Review: Review patient records. Verify that care and services are provided in accordance with the care/service plan, including the frequency and duration of visits ordered and treatments specified in the plan. Observation: Conduct a home visit. Verify that the care and services are provided according to the patient care/service plan. Guidance: This standard addresses the implementation of the care/service plan. Development of the care/service plan is assessed in the Assessment, Planning and Coordination Key Performance Area. Guidance: If the organization provides care in a variety of settings, records will be reviewed and observations will be conducted for a sample of patients in each setting of care/service delivery.

Standards

CDT.7.I.M1

Skilled professional services are authorized, delivered, and supervised only by qualified health care professionals who practice according to the organization's policies and procedures.

See the Human Resource Management Key Performance Area, standards HRM.4.I.M1 (registered nurse), HRM.4.I.M4 (physician), HRM.4.I.M9 (physical therapist, occupational therapist, and speech language pathologist), and HRM.4.I.M11 (social worker) for requirements that define qualified skilled professionals. See the Key Terms document for definitions related to each discipline.

Applicable Regulations: G700-484.75; G702-484.75(a).

Evidence Guidelines

Record Review: Review patient records. Verify that skilled professional services are provided by qualified persons in accordance with the organization's policies and procedures.

Guidance: Skilled professional services are defined as skilled nursing, physical therapy, speech-language pathology, occupational therapy, and physician and medical social work services. Citations related to qualifications will be cited in the Human Resource Management Key Performance Area (KPA).

Guidance: Qualifications of skilled professionals can be found in the Human Resource Management KPA, standard HRM.4.I. Supervision requirements are assessed in CDT.10.I.

CDT.7.I.M2

Effective 1/1/2021

Skilled professionals follow the plan of care and at a minimum perform the following duties:

1. Ongoing interdisciplinary assessment of the patient;
2. Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s);
3. Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care;
4. Patient, caregiver, and family counseling;
5. Patient and caregiver education; and
6. Preparing clinical notes.

Applicable Regulations: G704-484.75(b); G706-484.75(b)(1); G708-484.75(b)(2); G710-484.75(b)(3); G712-484.75(b)(4); G714-484.75(b)(5); G716-484.75(b)(6).

Record Review: Review patient records. Verify that skilled professionals follow the plan of care and perform all duties identified in the standard.

Guidance: Additional responsibilities of skilled professionals are located in other Key Performance Areas (KPAs), including: development and evaluation of the plan of care in partnership with the patient, representative, and caregiver(s) (Assessment, Planning and Coordination KPA); communication with all physicians or allowed practitioners involved in the plan of care and other health care practitioners (Assessment, Planning and Coordination KPA); participation in the organization's quality program (Continuous Quality Improvement KPA); and participation in organization-sponsored in-service training (Human Resource Management KPA).

Guidance: Skilled professional services are defined as skilled nursing, physical therapy, speech-language pathology, occupational therapy, and physician or allowed practitioner and medical social work services.

Standards

CDT.7.I.M3

An organization that provides outpatient physical therapy or speech-language pathology services meets all of the applicable health and safety laws and regulations, including those described in §485.711 (plan of care and physician involvement), §485.713 (physical therapy services), §485.715 (speech pathology services), §485.719 (services under arrangement), §485.723 (physical environment), and §485.727 (emergency preparedness).

Applicable Regulation: G986-484.105(g).

Evidence Guidelines

Interview: Interview the Clinical Manager. If the organization provides outpatient physical therapy or speech-language pathology services, verify the ways in which the organization ensures that those services are provided in accordance with applicable health and safety laws and regulations, including those described in §485.711, §485.713, §485.715, §485.719, §485.723, and §485.727.

CDT.7.I.M5

Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional. Written patient care instructions for a home health aide are prepared by that registered nurse or other appropriate skilled professional.

Applicable Regulation: G798-484.80(g)(1).

Record Review: Review patient records. When home health aide services are part of the plan of care, verify that aides are assigned by a registered nurse, or other appropriate professional. Verify that written patient care instructions for a home health aide are prepared by the registered nurse or other appropriate skilled professional.

Guidance: Other appropriate skilled professionals are defined as physical therapists, speech-language pathologists, or occupational therapists.

Standards

CDT.7.I.M7

Effective 1/1/2021

A home health aide provides services that are ordered by the physician or allowed practitioner, included in the plan of care, permitted to be performed under state law, and consistent with the home health aide's demonstrated competencies.

The duties of a home health aide include:

1. Providing hands-on personal care;
2. Performing simple procedures as an extension of therapy or nursing services;
3. Reporting changes in the patient's condition to a registered nurse or other appropriate skilled professional;
4. Assisting in ambulation or exercises;
5. Assisting in administering medications ordinarily self-administered; and
6. Completing appropriate records in compliance with the organization's policies and procedures.

Applicable Regulations: G800-484.80(g)(2); G802-484.80(g)(3); G804-484.80(g)(4).

Evidence Guidelines

Record Review: Review patient records. If aide services are provided, validate that actions taken and documented meet, and do not exceed, the requirement of the standard. Validate that the frequency and duration of the aide visits are in accordance with the plan of care. Validate that actions taken by the aide are consistent with services ordered and the aide's written instructions, as part of a written care plan.

Observation: Conduct a home visit. Verify that the aide's actions and interventions comply with the established plan of care. While conducting the home visit, interview the patient to verify that home visits occur with the frequency expected and as planned.

Guidance: The aide is also required to be a member of the interdisciplinary team. This requirement is assessed in the Assessment, Planning and Coordination Key Performance Area.

Guidance: Not every organization chooses to permit the aide to assist with medication as allowed in the standard. Generally, this assistance might take the form of reminders or assistance with opening a medication container. It is expected that organizations know, follow, and can easily reference Practice Acts and regulations related to nurse delegation in their state.

Guidance: Aide qualifications and competencies are described and assessed in the Human Resource Management Key Performance Area.

Standards	Evidence Guidelines
CDT.9.I Patients and their caregiver(s), as applicable, are provided with ongoing education and training, as appropriate, regarding their care/services. Education is documented in the patient record.	Interview: Interview one or more personnel responsible for providing patient education on the care/service plan. Verify, through specific patient examples, the ways in which the patient is educated about the care and services that are planned. Record Review: Review patient records. Verify that they contain a record of patient and caregiver (as applicable) training on their care/services. Guidance: Patient education is expected to be offered on an ongoing basis and times and intervals that facilitate the patient's and caregiver's ability to participate in decisions around their care plan. The organization determines the appropriate intervals; however, changes in orders, the care plan, or the patient's condition or goals should be considered when determining the appropriate timeframes.
CDT.9.I.M1 Each patient, and his or her caregiver(s) where applicable, receives ongoing education and training, as appropriate, regarding the care and services identified in the plan of care. Training is also provided, as necessary, to ensure a timely discharge. Education is documented in the patient record. **Applicable Regulation: G610-484.60(d)(5).**	Record Review: Review patient records. Verify that there is documentation of each patient has receiving education on the care and services that are planned. If there are plans to discharge the patient, verify that training has occurred. Guidance: Patient education is expected to be offered on an ongoing basis and times and intervals that facilitate the patient's and caregiver's ability to participate in decisions around their care plan. The organization determines the appropriate intervals; however, changes in orders, the care plan, or the patient's condition or goals should be considered when determining the appropriate timeframes.

Standards

CDT.10.I

Provision of care/service is supervised as required by organizational policy and local, state, and federal law and regulation. Supervision is documented, dated, and signed by the supervisor.

Evidence Guidelines

Record Review: Review patient records to validate that the supervision of care and services occurs per organizational policy, and local, state and federal law and regulation. Verify that encounters are documented and include the date, signature, and credentials of the supervisor.

Guidance: This standard addresses the supervision of how care is delivered to each patient, with a focus on ensuring that personnel are meeting the goals and needs of the patient as defined in the care/service plan. Standards related to supervision in the Human Resource Management Key Performance Area address how personnel are supervised within the organization.

CDT.10.I.M1

Home health aide supervision ensures that aides furnish care in a safe and effective manner, including:

1. Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional;
2. Maintaining an open communication process with the patient, representative (if any), caregiver(s), and family;
3. Demonstrating competency with assigned tasks;
4. Complying with infection prevention and control policies and procedures;
5. Reporting changes in the patient's condition; and
6. Honoring patient rights.

Applicable Regulation: G818-484.80(h)(4).

Interview: Interview a supervisor of aide services. Verify through specific examples the ways in which supervision ensures that communication takes place with the patient, representative (if any), caregiver(s), and/or family members and that the patient's rights are honored.

Record Review: Review patient records. Verify that the records contain documentation of the aide providing services in a safe and effective manner, including all of the elements of the standard.

Guidance: Aide compliance with infection prevention and control policies and practices is evaluated in the Infection Prevention and Control Key Performance Area. This standard assesses the components of supervision of aide practices, including those related to infection prevention and control.

Guidance: Signatures on documentation of supervisory encounters are expected to include the credentials of the supervising professional.

Standards	Evidence Guidelines
CDT.10.I.M4 If 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 written patient care instructions or home health aide plan of care, must make an onsite 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. **Applicable Regulations: G806-484.80(h); G808-484.80(h)(1)(i).**	Interview: Interview an aide. Validate the ways in which and how often he or she is supervised. Record Review: Review patient records. Validate that supervisory visits are conducted and documented at least every 14 days as required in the standard. Guidance: Signatures on documentation of supervisory encounters are expected to include the credentials of the supervising professional. Guidance: The aide does not need to be present for supervisory visits. However, if an area of concern is noted, it is expected that another visit would take place with the aide present to address the identified concern.
CDT.10.I.M5 If 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 must make an on-site visit to the location where the patient is receiving care no less frequently than every 60 days in order to observe and assess each aide while he or she is performing care. **Applicable Regulation: G814-484.80(h)(2).**	Interview: Interview an aide. Validate, through specific examples, the ways in which he or she is supervised. Record Review: Review patient records for a patient who is receiving only aide services from the organization. Validate that an on-site home health aide supervisory visit was conducted by the registered nurse with the aide present at least every 60 days as required by the standard and that visits were documented. Guidance: Signatures on documentation of supervisory encounters are expected to include the credentials of the supervising professional.

CDT.11.D

Effective 1/1/2021

When remote monitoring or telemonitoring equipment is provided to patients by the organization, policies and procedures address:

1. Types of remote monitoring or telemonitoring available and equipment used;
2. Patient eligibility inclusion and exclusion criteria, including criteria for the discontinuation of services;
3. Patient and caregiver education in the equipment's role in care delivery and its operation per manufacturer's guidelines;
4. How, and by whom, equipment is delivered, set-up, and tested upon initial use, as well as placement for privacy per patient preference;
5. Who provides equipment troubleshooting and replacement and how;
6. What data is collected and how it is integrated into care including:
   a) The scope and frequency of data collected;
   b) How and when findings are shared and with whom;
7. How, and who, transports used equipment from the home;
8. How storage of clean and dirty equipment is handled at the organization's location.

Document Review: Review policies, procedures, and other documents related to remote monitoring equipment. Validate that the documents address the requirements of the standard.

Interview - Personnel: Does the organization provide remote monitoring or telemonitoring as part of patient care?

Guidance: Remote monitoring or telemonitoring refers to the use of technology to collect and transmit patient data for the purposes of monitoring and managing the patient's condition.

Human Resource Management

KPA Statement

Organizations ensure that their program is adequately staffed with personnel that possess the knowledge, skills, experience and motivation necessary to deliver safe, high quality, patient-centered care. Planning, oversight, and allocation of program resources reflect the organization's commitment to appropriate orientation, supervision, mentorship, continuous knowledge enhancement, and retention.

Standards	Evidence Guidelines
HRM.1.D The organization maintains documented personnel policies and procedures that support operations and care delivery and that comply with local, state, and federal law and regulation. **Applicable Regulations: G944-484.105(b)(1); G952-484.105(b)(1)(iv).**	Document Review: Review personnel policies. Verify that documented processes exist for the verification of qualifications and eligibility in accordance with local, state, and federal law and regulation and include at a minimum selection criteria based on the position description; verification of employment eligibility, experience, education, and qualifications; applicable health screenings; and criminal background checks.
HRM.2.D The organization documents the duties, roles, and responsibilities for each position. Documentation includes qualifications as well as required experience, education, training, continuing education, certifications, registrations, and licensure. **Applicable Regulations: G944-484.105(b)(1); G952-484.105(b)(1)(iv).**	Document Review: Review documentation that outlines the duties, roles, and responsibilities for each position. This may be found in position descriptions. Verify that content includes description of duties and all applicable qualification requirements. Guidance: When personnel are supervisors, it is expected that their position description includes this information.

Standards

HRM.3.I

Personnel meet the organization's hiring criteria defined in the position description and policies. Applicable health screenings, criminal background checks, and verification of employment eligibility (I-9) are completed in accordance with local, state, and federal law and regulation.

Organizations in receipt of funds from Medicare, Medicaid, and all other federal plans and programs verify that individuals hired are not on the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE).

Applicable Regulation: G848-484.100.

Evidence Guidelines

Record Review: Review personnel records or other documents where hiring information is kept. Verify the presence of (1) a position description; (2) employment eligibility; (3) applicable health screenings; (4) criminal background checks in accordance with state regulations; and (5) a check of the OIG's LEIE (as applicable).

Guidance: Verification of the OIG LEIE list applies to individuals employed directly by the organization or through arrangement.

Tip: To help avoid the potential for civil monetary penalties, OIG strongly encourages home and community-based providers to routinely check the LEIE to ensure that new hires and current employees are not on the excluded list. OIG is required by law to exclude from participation in all federal health care programs individuals and entities convicted of the following types of criminal offenses (1) Medicare or Medicaid fraud, as well as any other offenses related to the delivery of items or services under Medicare, Medicaid, SCHIP, or other State health care programs; (2) patient abuse or neglect; (3) felony convictions for other health care-related fraud, theft, or other financial misconduct; and (4) felony convictions relating to unlawful manufacture, distribution, prescription, or dispensing of controlled substances.

Standards

HRM.4.I

Personnel are licensed, certified, or registered in accordance with applicable local, state, and federal law and regulation. Credentials and licensure are verified and documented at the time of hire and upon renewal. A record of the verification is retained. Required licensure and certifications are current, based on primary source verification.

Applicable Regulations: G1050-484.115; G860-484.100(b).

Evidence Guidelines

Record Review: Review personnel records. Validate that personnel providing care or services are licensed, certified, or registered in accordance with applicable local, state, or federal law and regulation.

Guidance: Copies of diplomas or transcripts are not required. By definition, licensed healthcare professionals are graduates of approved programs; therefore, a primary source verification of licensure, such as a dated printout from a state practice board website verifying current licensure, also validates completion of education.

Guidance: Health professionals who have been granted licensure through "grandfathering" are considered qualified, providing their licensure is current based on primary source verification.

HRM.4.I.M1

Registered nurses are graduates of accredited institutions of professional nursing and are licensed as registered professional nurses by the states in which they practice.

Applicable Regulation: G1072-484.115(k).

Record Review: Review personnel records to validate that registered nurses are licensed as registered professional nurses by the states in which they practice.

HRM.4.I.M2

Licensed practical nurses and licensed vocational nurses are graduates of institutions of practical or vocational nursing and are licensed in the states in which they practice.

Applicable Regulation: G1060-484.115(e).

Record Review: Review personnel records to validate that licensed practical or licensed vocational nurses are licensed in the states in which they practice.

Standards	Evidence Guidelines
HRM.4.I.M4 A physician is a doctor of medicine, osteopathy or podiatry legally authorized to practice medicine or surgery by the state in which such function or action is performed. **Applicable Regulation: G1070-484.115(j).**	Record Review: Review personnel records. Validate that primary source verification has been completed to verify that physicians are legally authorized to practice medicine or surgery by the state in which such function or action is performed. Verify that physicians are licensed in accordance with federal and state law for writing prescriptions and orders, as applicable to their job duties. Guidance: For hospices, podiatrists are not included in the definition of a physician and may not serve as a hospice physician or medical director.
HRM.4.I.M5 Aides meet all local, state, and federal qualifications for the services they provide by successfully completing: 1. A training and competency evaluation program that meets Medicare requirements; or 2. A competency evaluation program that meets Medicare requirements; or 3. A state approved nurse aide training and competency evaluation program and is currently listed in good standing on the state nurse aide registry; or 4. A state licensure program that meets Medicare requirements. Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit meet all of the qualifications established by the state and demonstrate competency in the services they provide. **Applicable Regulations: G1058-484.115(d); G750-484.80; G752-484.80(a); G754-484.80(a)(1); G828-484.80(i).**	Record Review: Review personnel records to validate that aides meet all local, state, and federal qualifications for the services they provide.

Standards

HRM.4.I.M9

Therapists, including physical therapists, occupational therapists, speech language pathologists, or qualified assistants are licensed or otherwise regulated and have completed the requirements to practice as therapists or therapy assistants in the state in which they are practicing.

See the Key Terms document for the definition of physical therapists, occupational therapists, speech language pathologists, and qualified assistants.

Applicable Regulations: G1062-484.115(f); G1064-484.115(g); G1066-484.115(h); G1068-484.115(i); G1078-484.115(n).

Evidence Guidelines

Record Review: Review personnel records to validate that personnel providing therapy services are currently licensed, certified, or registered in accordance with applicable local, state, or federal law and regulation.

Guidance: If state licensure is not required, specific education and examination requirements can be found at §484.115 for Medicare-certified home health agencies and §418.114(b) for Medicare-certified hospice agencies.

HRM.4.I.M10

Audiologists:

1. Meet the education and experience requirements for a Certificate of Clinical Competence in audiology granted by the American Speech-Language-Hearing Association; or
2. Meet the educational requirements for certification and are in the process of accumulating the supervised experience required for certification.

Applicable Regulation: G1054-484.115(b).

Record Review: Review personnel records. Validate that audiologists meet the requirements of the standard.

Standards

HRM.4.I.M11

Qualified social workers have a master's or doctoral degree from a school of social work accredited by the Council on Social Work Education and has had at least one year of social work experience in a healthcare setting.

Qualified social work assistants (under the supervision of a qualified social worker) have a baccalaureate degree in social work, psychology, sociology, or other field related to social work and has had at least one year of social work experience in a healthcare setting. Alternatively, social work assistants may have two years of appropriate experience as a social work assistant and achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Applicable Regulations: G1074-484.115(l); G1076-484.115(m).

Evidence Guidelines

Record Review: Review personnel records to validate that personnel providing social work services are qualified professionals with the requisite education and experience in social work.

Guidance: The determinations of proficiency by the U.S. Public Health Service do not apply to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.

HRM.6.D

Personnel participate in ongoing education as determined by the organization and in accordance with local, state, and federal law and regulation. Education is documented, and documentation includes the dates, participants, and content covered.

Record Review: Review education records for the past year of operation. If required by the organization, validate that personnel complete ongoing education in accordance with the requirements of the standard. Validate that records of education include dates, participants, and content covered.

Guidance: Unless otherwise prescribed by law and regulation, organizations determine the type and content of education provided, if any.

Guidance: The format and setting of ongoing education are determined by the organization. Education may be provided online, in person, or by other written or visual media. It may be separate or combined with other organizational education. Education may be provided by persons or resources inside or outside of the organization.

Standards

HRM.6.D.M1

The following personnel, whether employed directly or under arrangement, participate in organization-sponsored in-service programs:

1. Physicians;
2. Registered nurses;
3. Licensed practical nurses;
4. Individuals providing therapy services, including physical therapists and assistants, occupational therapists and assistants, speech language pathologists and assistants; and
5. Medical social workers.

Applicable Regulations: G704-484.75(b); G722-484.75(b)(9).

Evidence Guidelines

Record Review: Review personnel records for physicians, registered nurses, licensed practical nurses, therapists and therapy assistants, and medical social workers. Verify that the individuals participated in in-service training. This information may be maintained in education records separate from the personnel file.

HRM.6.D.M2

Home health aides and hospice aides participate in at least 12 hours of in-service training during each 12-month period. Training is provided by or under the supervision of a registered nurse (RN) who possesses a minimum of two years of nursing experience, at least one of which must be in home care. Training may be provided while the aide is furnishing care to a patient. Training is documented, and documentation includes the name of attendees(s) and instructor, date, and topic.

Applicable Regulations: G774-484.80(d); G776-484.80(d)(1); G778-484.80(d)(2); G780-484.80(e).

Record Review: Review records for home health and hospice aides. Validate that aides attended 12 hours of training during the past 12 months and that the training was supervised by a qualified RN.

Guidance: The organization determines if training is provided per calendar year or beginning with the date of hire. The methods used for this training may vary. It could be face to face; online; or by other written, video, or audio media. The training can be conducted within the organization, through an outside organization, in a classroom setting, or in the patient care setting so long as it is performed or supervised by an RN as required.

Standards

HRM.7.I

Personnel providing patient care or services demonstrate competency in the performance of their assigned duties. Competency assessments are documented with date, name of personnel, topic, and record of satisfactory performance.

Evidence Guidelines

Interview: Interview human resources personnel or other key staff. Clarify the process for validating competencies.

Record Review: Review records or other documentation of personnel who provide patient care or services. These records may be found in the personnel records or separate education records. Validate that each record contains name, date, topic, method of competency validation, and record of satisfactory completion.

Guidance: Personnel who provide patient care or services are those individuals who have direct contact with patients for the purpose of providing care or services, as well as persons who set up, deliver, or prepare products and/or equipment for patient use. This care can be delivered in person, by phone (i.e., follow-up calls for reinforcement of patient teaching), or electronically (i.e., remote monitoring). Homemakers and chore workers are excluded from this definition and the requirement.

Guidance: Competency may be assessed in a number of ways, including written testing, verbal testing, and live demonstration. For professional healthcare providers (e.g., registered nurses, therapists, social workers, spiritual counselors), self-assessment may be used to establish the individual's experience in providing interventions appropriate to the patient population served, as well as to validate skills that would be mastered as part of an approved educational program.

Standards

HRM.7.I.M2

Organizations assess the competency of aides through direct observation or examination (written or oral) for the following duties:

1. Observing, reporting, and documenting patient status and the care or service furnished;
2. Recognizing and reporting changes in skin conditions;
3. Basic infection prevention and control procedures;
4. Understanding basic elements of body functioning and changes in body function that must be reported to an aide's supervisor;
5. Maintaining a clean, safe, and healthy environment;
6. Recognizing emergencies and instituting and applying emergency procedures;
7. Understanding the physical, emotional, and developmental needs of and ways to work with the populations served by the organization, including the need for respect for the patient, his or her privacy, and his or her property;
8. Knowledge of adequate nutrition and fluid intake; and
9. Other tasks that the organization may choose to have an aide perform as permitted under state law.

Competency is assessed through direct observation of the following skills demonstrated on a patient, or a pseudo-patient as part of a simulation:

1. Communication skills, including the ability to read, write, and verbally report clinical information to patients, representatives, and caregivers, as well as to other personnel;
2. Ability to read and record temperature, pulse, and respiration;
3. Appropriate and safe techniques in personal hygiene and grooming that include: bed bath; sponge, tub, and shower bath; shampoo, sink, tub, and bed; nail and skin care; oral hygiene; and toileting and elimination;
4. Safe transferring techniques and ambulation; and
5. Performance of normal range of motion and positioning.

Competency assessments are documented.

(continued on following page)

Evidence Guidelines

Record Review: Review personnel records of aides or other documentation for competency evaluations. These records may be found in the personnel records or separate education records. Validate that each record contains name, date, topic, method of competency evaluation, and record of satisfactory completion.

Guidance: The competency evaluation for home health aides is performed by a registered nurse or by individuals under the supervision of the registered nurse.

Guidance: The organization is responsible for training home health aides, as needed, for skills not covered in the basic checklist related to appropriate and safe techniques in personal hygiene and grooming.

Standards	Evidence Guidelines
HRM.7.I.M2 **Applicable Regulations: G764-484.80(b)(3); G768-484.80(c)(1); G772-484.80(c)(5).**	
HRM.7.I.M4 An aide provides services on behalf of the organization only after successfully completing the required competency evaluation(s). An aide is not considered competent in any task for which he or she is evaluated as "unsatisfactory." The aide does not perform a task without direct supervision by a licensed nurse until after he or she receives training in the task for which he or she was evaluated as unsatisfactory and passes a subsequent evaluation with a rating of "satisfactory." Aides must receive a satisfactory evaluation rating on all tasks they perform independently. An aide who receives an unsatisfactory rating on more than one task is not considered to have passed the competency evaluation and does not function as an aide. If the competency evaluation is not passed, the aide receives training on any tasks for which he or she has received unsatisfactory ratings and is reevaluated for competency prior to functioning as an aide. **Applicable Regulations: G768-484.80(c); G770-484.80(c)(4).**	Record Review: Review personnel records of aides. Validate that the aides have received a satisfactory rating on all tasks they are performing independently. Validate that when an individual has an unsatisfactory rating on more than one task, the individual is not considered to have successfully completed the competency evaluation and is not functioning as an aide. Guidance: The organization determines the number of times an aide can be trained and evaluated for competency. Guidance: An aide who is evaluated as satisfactory in all subject areas except one would be considered competent. However, this aide would not be allowed to perform the task in which he or she was evaluated as unsatisfactory except under direct supervision.

Standards

HRM.7.I.M5

If the organization requires an aide to complete a training program prior to competency assessment, the initial training includes classroom and supervised practical training on each task for which competency will be assessed. Training is conducted in a practicum laboratory or other setting in which the aide demonstrates knowledge while providing services.

Classroom and supervised practical training totals at least 75 hours. A minimum of 16 hours of classroom training precedes a minimum of 16 hours of supervised practical training as part of the 75 hours.

Training is documented, including the dates, content, and participants.

Applicable Regulations: G758-484.80(b); G760-484.80(b)(1); G762-484.80(b)(2); G764-484.80(b)(3); G766-484.80(b)(4).

Evidence Guidelines

Document Review: Review documents related to aide training to validate that all requirements of the standard are met. This could include an education plan, policy, curricula, schedules, checklists, or other records.

Record Review: Review personnel records of aides who completed an aide training program, if required. Validate that the training met the time requirements of the standard.

Guidance: If the organization evaluates an aide as competent or the aide is certified through a recognized training program, he or she does not need to go through an initial training program but would need a competency evaluation. If required by state or local law, aide certification is validated through primary source verification, such as a state nurse aide registry.

HRM.7.I.M6

Classroom and supervised practical training of aides is performed by a registered nurse (RN) who possesses a minimum of two years nursing experience, at least one year of which is in home healthcare, or by other individuals under the general supervision of the RN.

Applicable Regulation: G780-484.80(e).

Record Review: Review the personnel file of the RN who conducts or supervises classroom and the supervised practical training in the organization's aide training program, if any. Verify that the RN meets education and experience requirements.

Standards	Evidence Guidelines
HRM.7.I.M7 The aide competency evaluation is performed by a registered nurse in consultation with other skilled professionals, as appropriate, prior to the independent assumption of duties. **Applicable Regulation: G768-484.80(c)(3).**	Record Review: Review personnel records and/or education records that document aide competency evaluations. Verify that the evaluation is performed by a registered nurse as required by the standard.
HRM.7.I.M8 If there has been a 24-month lapse in furnishing services, an aide must complete another training program and/or satisfactory competency assessment before providing services. The individual is not considered to have completed a training program if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 months during which none of the services furnished by the individual and evaluated for competency were for compensation. **Applicable Regulation: G756-484.80(a)(2).**	Record Review: Review aide personnel records. Verify that the aide has completed another training program if there has been a 24-month lapse in furnishing services since the individual's most recent completion of the program. Guidance: Requirements for aide training and competency assessment is outlined in HRM.4.I.M5.

Standards

HRM.7.I.M9

The organization may offer aide training and competency evaluation or competency evaluation programs unless, within the previous two years, the organization:

1. Was out of compliance with requirements related to content and duration, aide competency evaluation, aide in-service training, or qualifications of instructors; or
2. Permitted an individual who does not meet the definition of a "qualified home health aide" to furnish home health aide services (with the exception of licensed health professionals and volunteers); or
3. Was subjected to an extended (or partially extended) survey as a result of having been found to have furnished substandard care (or for other reasons as determined by the Centers for Medicare & Medicaid Services or the state); or
4. Was assessed a civil monetary penalty of $5,000 or more as an intermediate sanction; or
5. Was found to have compliance deficiencies that endangered the health and safety of the organization's patients, and had temporary management appointed to oversee the management of the organization; or
6. Had all or part of its Medicare payments suspended; or
7. Was found under any federal or state law to have had its participation in the Medicare program terminated; or
8. Was found under any federal or state law to have been assessed a penalty of $5,000 or more for deficiencies in federal or state standards for home health agencies; or
9. Was subjected to a suspension of Medicare payments to which it otherwise would have been entitled; or
10. Operated under temporary management that was appointed to oversee the operation of the organization and to ensure the health and safety of the organization's patients; or
11. Was closed, or had its patients transferred by the state; or
12. Was excluded from participating in federal healthcare programs or debarred from participating in any government program.

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Evidence Guidelines

Document Review: If the organization provides aide 1) competency or 2) training and competency programs, review documentation from the last 24 months and validate compliance with the requirements of the standard. This documentation may include state or accreditation organization survey results, content and curricula of the aide training programs, or minutes from governance meetings.

Guidance: Effective February 14, 1990, a home health organization must not have had any Conditions of Participation out of compliance within 24 months before it begins a training and competency evaluation or competency evaluation program. Correction of a condition level finding is not sufficient for the organization to begin or resume these programs.

Standards	Evidence Guidelines
HRM.7.I.M9 **Applicable Regulations: G768-484.80(c)(2); G782-484.80(f); G784-484.80(f)(1); G786-484.80(f)(2); G788-484.80(f)(3); G790-484.80(f)(4); G792-484.80(f)(5); G794-484.80(f)(6); G796-484.80(f)(7).**	
HRM.9.I Personnel are supervised by qualified individuals consistent with organizational policy and local, state, and federal law and regulation. Supervisors understand the duties, responsibilities, and services provided by personnel under their supervision.	Interview: Interview one or more individuals who supervise care/services staff. Clarify the ways in which they supervise staff and understand the duties and services provided by the staff they supervise.
HRM.9.I.M1 The clinical manager is available during all operating hours and provides oversight of all patient care services and personnel, including making patient and personnel assignments. **Applicable Regulations: G944-484.105(b)(1); G950-484.105(b)(1)(iii); G958-484.105(c); G960-484.105(c)(1).**	Interview: Interview the clinical manager. Verify, through specific examples, the ways in which personnel and patient care is overseen. Verify the way in which patient and personnel assignments are made. Guidance: It is expected that clinical managers ensure when making patient assignments that assigned personnel have demonstrated competence in necessary tasks or services.

Standards	Evidence Guidelines
HRM.9.I.M3 Skilled nursing services are provided under the supervision of a qualified registered nurse. See the Human Resource Management Key Performance Area, standard HRM.4.I.M1 for the requirement that defines a qualified registered nurse. See the Key Terms document for definitions. **Applicable Regulations: G1060-484.115(e); G724-484.75(c); G726-484.75(c)(1).**	Record Review: Review patient records. Verify that there is documentation that licensed vocational/practical nurses are supervised by a qualified registered nurse. Guidance: See HRM 4.1.M1 for the definition of a qualified registered nurse.
HRM.9.I.M4 Rehabilitative therapy services are provided under the supervision of a qualified occupational therapist or qualified physical therapist. See the Human Resource Management Key Performance Area, standard HRM.4.I.M9 for requirements that define qualified occupational therapists and qualified physical therapists. See the Key Terms document for definitions. **Applicable Regulation: G728-484.75(c)(2).**	Record Review: Review patient records. Verify that there is documentation that therapists (if any) are supervised by a qualified therapist as required by the standard. Guidance: See HRM.4.I.M9 for the definition of a qualified occupational therapist or physical therapist.

Standards

HRM.9.I.M5

A qualified social worker supervises the work of a qualified social work assistant.

See the Human Resource Management Key Performance Area, standard HRM.4.I.M11 for requirements that define qualified social workers and social work assistants. See the Key Terms document for definitions.

Applicable Regulation: G730-484.75(c)(3).

Evidence Guidelines

Record Review: Review patient records. Verify that there is documentation that the social work assistant (if any) is supervised by a qualified social worker as required by the standard.

Guidance: See HRM.4.I.M11 and HRM.4.I.M12 for the definition of a qualified social worker and qualified social work assistant.

HRM.10.I

Personnel performance is evaluated as defined by organizational policy and in accordance with local, state, and federal law and regulation.

Record Review: Review personnel records to validate that performance evaluations are completed in accordance with organizational policy.

Guidance: The organization determines which personnel receive performance evaluations as well as the frequency and contents of the evaluation, unless otherwise stipulated in law or regulation or through additional requirements of this standard (see HRM.11.I.M1).

Guidance: In some states, professional practice acts limit the extent to which one professional discipline is permitted to evaluate the clinical performance of another professional discipline. For example, a state nurse practice act may limit the scope of supervision and oversight of performance to nursing functions. In such a case, evaluation of the clinical performance of a physical therapist would be considered beyond the scope of nursing practice. It is expected that organizations are aware of any limitations in their state and structure the performance evaluation process as necessary.

Standards	Evidence Guidelines
HRM.10.I.M2 A registered nurse or other appropriate skilled professional makes an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care. **Applicable Regulation: G812-484.80(h)(1)(iii).**	Record Review: Review personnel records for one or more home health aides employed for over one year. Verify that there is documentation of an on-site observation of care delivery conducted by the registered nurse or other skilled professional dated within the last year.
HRM.11.I Reports of unsatisfactory performance for personnel providing patient care or services are investigated. If deficient performance is identified, corrective action is taken, as determined by the organization.	Interview: Interview supervisors or other key leaders. Validate through specific examples how deficient performance for individuals providing patient care and services is identified and corrected.
HRM.11.I.M1 If an area of concern in aide services is noted by the supervising registered nurse or other appropriate skilled professional, the supervising individual makes an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care. **Applicable Regulation: G810-484.80(h)(1)(ii).**	Interview: Interview the clinical manager or an individual who supervises aide services. Validate the process followed when an area of concern in an aide's performance is identified. Validate that the process includes making an on-site visit to observe the aide performing care.

Standards

HRM.11.I.M2

If a deficiency in aide services is verified by the registered nurse or other appropriate skilled professional during an on-site visit, the organization conducts, and the home health aide completes retraining and a competency evaluation related to the deficient skill(s).

Applicable Regulation: G816-484.80(h)(3).

Evidence Guidelines

Interview: Interview the clinical manager or an individual who supervises aide services. Verify the process followed when a deficiency in an aide's performance is identified and that the process includes the aide's satisfactory completion of a competency evaluation.

Record Review: Review the personnel record for an aide who has had a deficiency identified (if any). Verify that re-training and a satisfactory competency evaluation were completed prior to the return to performance of the identified task.

Continuous Quality Improvement

KPA Statement

Organizations implement and maintain an agency-wide Continuous Quality Improvement Program that objectively and systematically measures, monitors and assesses program operations and leads to measurable improvements in agency defined goals in the areas of patient safety, outcomes, care delivery, and operations.

Standards	Evidence Guidelines
CQI.1.I The organization implements a data-driven Continuous Quality Improvement (CQI) program that reflects the scope and complexity of the organization and the care and services provided. **Applicable Regulation: G640-484.65.**	Document Review: Review documentation on the CQI program. Validate that it includes the use of data to evaluate the quality of care and services provided and reflects the scope and complexity of the organization.

Standards

CQI.1.I.M1

The Continuous Quality Improvement (CQI) program is organization-wide and covers all services and programs offered, including those provided under contract or arrangement. The organization maintains documentary evidence of its quality assessment and performance improvement program and is able to demonstrate its operation. The program is capable of showing measurable improvement in indicators related to outcomes, patient safety, and quality of care.

Applicable Regulations: G640-484.65; G642-484.65(a)(1).

Evidence Guidelines

Document Review: Review documentation of CQI activities. Validate that the activities are organization-wide and cover all services and programs offered, including those provided under contract or arrangement.

Interview: Interview one or more key leaders involved in the implementation of the organization's CQI program. Using a recent performance improvement activity as an example, validate that the organization can demonstrate the operation of the program and the ways in which it is implemented, and that the organization focuses on indicators related to outcomes, patient safety, and quality of care. Verify how the organization ensures that the program covers all the services provided, including those provided through contractual arrangement.

Guidance: This standard does not require that the organization has achieved measurable improvement related to outcomes, patient safety, and quality of care. The organization is expected to demonstrate that it is capable of showing measurable improvement through its performance improvement activities. The use of a standard quality assessment methodology, such as the Plan Do Check Act model, is one approach that may demonstrate the capability of the program to achieve improvements.

Guidance: The organization determines the nature and degree of participation by contractors in CQI activities. Participation could include attendance at meetings or distribution of key information regarding process improvements and outcomes.

Standards	Evidence Guidelines
CQI.1.I.M2 Skilled professionals participate in the organization's Continuous Quality Improvement (CQI) program. **Applicable Regulations: G704-484.75(b); G720-484.75(b)(8).**	Document Review: Review committee rosters, meeting minutes, or other documents that reflect which members of the organization participate in the CQI program. Validate that skilled professionals participate in the program. Guidance: Skilled professionals include registered nurses, physical and occupational therapists, speech-language pathologists, social workers, spiritual counselors, registered dieticians, and physicians. Guidance: The organization determines the skilled professionals that participate in the CQI program. It is expected that the selection of individuals reflects the scope of services offered by the organization.

Standards

CQI.2.D

The organization defines the outcomes and measures that are included in the Continuous Quality Improvement (CQI) program and the data that will be used to support performance improvement (PI) activities.

Evidence Guidelines

Document Review: Review documentation related to the CQI program. This information might be included in a strategic plan, a performance management report, or a dashboard or CQI committee meeting report. Validate that documentation defines the outcomes and measures that are included in the CQI program and the data that will be used to support PI activities.

Guidance: Quality performance improvement activities are the processes implemented by the organization to measure, analyze, and track its quality indicator and outcome data. Performance improvement projects are the actions the organization takes to correct issues identified thorough the measurement, tracking, and analysis of quality improvement indicator and outcome data.

Guidance: Measures (also called indicators) are used to track progress toward achieving outcomes. Outcomes define the specific measurable results. For example, an organization may have an outcome for reducing patient falls by 5 percent within 12 months. A measure (or indicator) used to track progress toward this outcome might be the percent of total patients on service who experience a fall, using incident reports as a data source.

Standards

CQI.2.D.M1

The organization's Continuous Quality Improvement (CQI) program is designed using quality indicator data, including measures derived from the Outcome and Assessment Information Set (OASIS), where applicable, and other relevant data.

Applicable Regulation: G644-484.65(b)(1).

Evidence Guidelines

Document Review: Review CQI program documentation. Validate that the program is designed using quality indicator data, including measures derived from OASIS.

Guidance: It is not expected that all OASIS measures are incorporated in the CQI program. A review of benchmarking data, such as Outcome-Based Quality Improvement reports, the Process-Based Quality Improvement manual, Home Health Compare, etc., may guide the organization's selection of measures.

CQI.2.D.M2

The organization selects quality indicators, including adverse patient events, and other aspects of performance that enable the organization to assess processes of care, services, and operations. Indicators focus on high-risk, high-volume, or problem-prone areas and consider incidence, prevalence, and severity.

Applicable Regulations: G642-484.65(a)(2); G646-484.65(c); G648-484.65(c)(1); G648-484.65(c)(1)(i); G650-484.65(c)(1)(ii).

Document Review: Review Continuous Quality Improvement (CQI) program activity documentation. Validate that the organization tracks quality indicators, including adverse patient events, and other aspects of performance that enable the organization to assess processes of care, services, and operations.

Interview: Interview a key leader involved in the organization's CQI program. Verify the ways the organization ensures that its focus is on using high-risk, high-volume, or problem-prone areas and considers incidence, prevalence, and severity.

Guidance: The requirements related to analyzing and tracking indicators defined in this standard are listed in CQI.3.I.

Standards

CQI.2.D.M3

The Continuous Quality Improvement (CQI) program focuses on indicators or measures related to improved outcomes including, at a minimum:

1. Use of emergent care services;
2. Hospital admissions and readmissions; and
3. Performance across the spectrum of care, including the prevention and reduction of medical errors.

Applicable Regulation: G640-484.65.

Evidence Guidelines

Document Review: Review documents that state current CQI indicators or measures. This information might be included in a strategic plan, a performance management report, or a dashboard or CQI committee meeting report. Validate that the program focuses on indicators or measures related to use of emergent care services, hospital admissions and readmissions, and the prevention and reduction of medical errors.

Guidance: The requirements related to analyzing and tracking indicators defined in this standard are listed in CQI.3.I.

CQI.3.I

The organization analyzes quality indicator data, based on the measures defined in their Continuous Quality Improvement (CQI) program, to monitor and assess results. Findings from the analysis are used to identify and support the implementation of performance improvement projects.

Document Review: Review documents that compile and report the results of ongoing monitoring of quality measures (or indicators). Such documents might include CQI meeting minutes, performance management reports, complaint logs, or summaries of performance improvement initiative findings. Verify that the data reported monitors the organization's performance on selected measures defined in the CQI program.

Interview: Interview a key leader involved in the implementation of the CQI program. Verify the types of data that are analyzed to monitor and assess results. Through specific examples, clarify how findings from the analysis are used to identify and support implementation of performance improvement projects.

Guidance: Performance improvement projects are the actions the organization takes to correct issues identified thorough the measurement, tracking, and analysis of quality improvement indicator and outcome data. CQI.5.I addresses the specific requirements related to the implementation of performance improvement projects.

Standards	Evidence Guidelines
CQI.3.I.M1 The organization uses data collected to monitor the effectiveness and safety of services and quality of care and identify opportunities for improvement. **Applicable Regulation: G644-484.65(b)(2).**	Document Review: Review documents that compile and report the results of ongoing monitoring of quality measures (or indicators) related to effectiveness and safety of services. Such documents might include Continuous Quality Improvement meeting minutes, performance management reports, or summaries of performance improvement initiative findings. Verify that the data reported monitor the organization's performance on selected measures defined by the organization.
CQI.3.I.M2 Performance improvement (PI) activities include the measurement, analysis, and tracking of quality indicators defined in the organization's Continuous Quality Improvement (CQI) program. Activities assess processes of care and safety, including adverse events, and focus on high-risk, high-volume, or problem-prone areas, as well as consider the incidence, prevalence, and severity of problems in those areas. **Applicable Regulations: G642-484.65(a)(2); G646-484.65(c); G648-484.65(c)(1); G648-484.65(c)(1)(i); G650-484.65(c)(1)(ii).**	Document Review: Review document or reports that measure, analyze, and track the quality indicator data defined in the organization's CQI program, including the assessment of processes of care and safety. This might include incident reports or logs, investigation reports, and other documents. Interview: Interview a key leader involved in the organization's CQI program. Clarify, through specific examples, the types of high-risk, high-volume, and problem-prone areas that are assessed through the CQI program. Verify that adverse patient events are assessed. Guidance: PI activities are the processes implemented by the organization to measure, analyze, and track its quality indicator and outcome data.
CQI.3.I.M3 Adverse patient events are analyzed to determine their causes, and preventive actions are implemented. **Applicable Regulation: G654-484.65(c)(2).**	Interview: Interview key leaders. Clarify through specific examples how adverse patient events are assessed and addressed. Verify that actions are taken (personnel/patient education, process redesign, etc.) to prevent future events.

Standards	Evidence Guidelines
CQI.3.I.M4 The organization's performance improvement activities lead to an immediate correction of any identified problem that directly or potentially threatens the health and safety of patients. **Applicable Regulation: G652-484.65(c)(1)(iii).**	Document Review: Review documentation that records how problems that directly or potentially threaten the health and safety of patients are identified and managed. Documentation might include incident reports, complaint logs, or other indicator data. Verify that immediate correction is implemented. Interview: Interview a key leader. Clarify, through specific patient examples, corrective action that is taken when performance improvement activities identify a problem that directly or potentially threatens the health and safety of a patient.
CQI.5.I The organization implements performance improvement (PI) projects based on the analysis of quality indicator data and measures its performance and progress. PI projects are prioritized using criteria specified by the organization.	Document Review: Review documents that compile and report quality indicator data. Verify they describe the types of PI projects implemented based on data collected. This information might be in a Continuous Quality Improvement committee meeting record or other report. Interview: Interview one or more individuals involved in implementing PI projects. Clarify how analysis of quality indicator data is used to select and prioritize PI projects according to the criteria defined by the organization.
CQI.5.I.M1 The organization conducts performance improvement projects based on analysis of performance improvement activities. The number and scope of distinct improvement projects conducted annually reflect the scope, complexity, and past performance of the organization's services and operations. **Applicable Regulation: G658-484.65(d)(1).**	Document Review: Review Continuous Quality Improvement (CQI) program documents that report the number and types of performance improvement projects undertaken during the past year, relative to the scope, complexity, and past performance of the organization. Interview: Interview key leaders involved in the implementation of the CQI program. Verify, through specific examples, how the CQI program addresses the scope of the organization's care and services.

Standards	Evidence Guidelines
CQI.5.I.M2 The organization documents the performance improvement projects undertaken, the reasons for conducting these initiatives, and the measurable progress achieved on these projects. **Applicable Regulation: G658-484.65(d)(2).**	Document Review: Review documentation of performance improvement projects. This information might be in a Continuous Quality Improvement committee meeting record or other report. Verify that documentation includes the reasons for conducting these initiatives and the measurable progress achieved on these initiatives.
CQI.6.S Continuous Quality Improvement (CQI) results are sustained.	Interview: Interview a key leader. Verify how the organization ensures that advances made through the CQI program are sustained. Guidance: The organization is expected to demonstrate that outcomes are maintained over time. The organization determines how long it needs to monitor maintenance of outcomes based on an expectation that the process is stable. To determine if desired performance has been maintained over time, an organization might use a spot check in which an intermittent review of performance is conducted. For example, initial improvements may require weekly or monthly monitoring. Once performance has been improved and the process is stable, monitoring may no longer be necessary.
CQI.6.S.M1 The organization measures its success and tracks performance to ensure that improvements made through the Continuous Quality Improvement (CQI) program are sustained. **Applicable Regulation: G656-484.65(c)(3).**	Document Review: Review documentation for ongoing or completed CQI performance improvement activities and projects. Validate that the organization continues to monitor performance to ensure that improvements are sustained.

Infection Prevention & Control

KPA Statement

Organizations implement effective Infection Prevention and Control programs to promote safety and reduce the risks for acquiring a healthcare-associated infection.

Standards	Evidence Guidelines
IPC.1.D Infection prevention and control (IPC) policies and procedures reflect the scope and complexity of the services provided by the organization. They include, at a minimum, provisions for: 1. Reducing the risk of acquiring and spreading organisms that can contribute to infections, including communicable diseases; and 2. Educating and training personnel on methods to avoid and reduce the transmission of organisms that can contribute to an infection and communicable diseases.	Document Review: Review IPC policies and procedures. Verify that they contain provisions for minimizing the risk of acquiring and spreading infections, including communicable diseases, and address personnel education and training. Guidance: The complexity of the IPC policies and procedures may vary depending on the scope and complexity of the organization and the services it provides. For example, organizations providing chore or homemaker services would be expected to address sanitation and hygiene practices.

Standards

IPC.1.D.M1

The organization's Infection Prevention and Control (IPC) program meets applicable local, state, and federal laws and regulations, including the Occupational Safety and Health Administration's (OSHA's) Bloodborne Pathogens standards and the Centers for Disease Control and Prevention's (CDC's) Isolation Precautions.

The IPC program is based on identified and prioritized risks for acquiring and spreading infections. The program includes, at a minimum, policies and procedures for:

1. Performing hand hygiene;
2. Using personal protective equipment (PPE) and other necessary equipment and supplies to implement standard precautions and, as needed, transmission-based precautions;
3. Managing equipment provided to patients and used by staff during care;
4. Managing occupational exposure to pathogens;
5. Establishing a bloodborne pathogen exposure control plan;
6. Establishing a respiratory protection plan;
7. Providing education on IPC practices to personnel, patients, and caregivers;
8. Managing medical waste generated by personnel, patients, and caregivers;
9. Performing health screening of personnel;
10. Monitoring for the risk and occurrence of infections;
11. Reporting infections according to established surveillance guidelines; and
12. Maintaining current knowledge related to emerging community risks and new or revised laws and regulations.

Applicable Regulations: G680-484.70; G682-484.70(a).

Evidence Guidelines

Document Review: Review IPC program documents on isolation precautions, use of PPE, hand hygiene, bag technique, management of equipment and supplies, work surfaces, etc., as applicable to the services offered by the organization. These may include a written plan or a set of policies. Validate that all requirements of the standard are addressed. Validate that hand hygiene protocol meets CDC guidelines and OSHA's Bloodborne Pathogens requirements.

Guidance: The term "program" denotes a coordinated approach to how the organization meets applicable local, state, and federal infection control requirements. It does not mean that policies related to IPC must exist in one book. For many organizations, different components of the program defined within the standard may be found across multiple policies and plans.

Guidance: For home health and hospice organizations, established surveillance guidelines for tracking and reporting infections include the Association for Professionals in Infection Control and Epidemiology-Healthcare Infection Control Practices Advisory Committee Surveillance Definitions for Home Health Care and Home Hospice Infections and The National Healthcare Safety Network (NHSN).

Guidance: If the IPC program is centralized in an organization, the review of policies and procedures will take place as part of a centralized or corporate review. Implementation will be assessed at each location seeking accreditation.

Guidance: Other necessary equipment and supplies could include equipment owned by the agency and removed from the home after use, such as bags used to carry equipment or supplies into or out of the home.

Standards	Evidence Guidelines
IPC.1.I Infection prevention and control (IPC) policies and procedures are implemented as designed to minimize the risk of infection and communicable disease. **Applicable Regulation: G680-484.70.**	Interview: Interview the key leader responsible for managing the IPC program. Clarify the ways in which the program is implemented. Validate that implementation reflects documented policies, processes, and procedures. Guidance: Specific standards related to infection surveillance, reporting, and personnel and patient education are addressed in other standards within this Key Performance Area (KPA). This standard is broad in scope and would be cited as deficient if multiple standards within the IPC KPA are not met.
IPC.1.I.M1 The organization follows accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. **Applicable Regulation: G682-484.70(a).**	Interview: Interview the key leader responsible for managing the Infection Prevention and Control (IPC) program. Clarify the ways in which the program is implemented. Validate that implementation reflects accepted standards of practice, including the use of the Centers for Disease Control and Prevention's isolation precautions to prevent the transmission of infections and communicable diseases.

Standards

IPC.1.I.M2

The organization maintains a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases which includes:

1. Methods for identifying infectious and communicable disease problems; and
2. A plan for the appropriate actions that are expected to result in improvement and the prevention of infection.

The program is an integral part of the organization's Continuous Quality Improvement program activities.

Applicable Regulations: G684-484.70(b); G684-484.70(b)(1); G684-484.70(b)(2).

Evidence Guidelines

Document Review: Review IPC program documentation. Validate that the program is agency-wide and addresses the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. Verify that it includes methods for identifying infectious and communicable disease problems and a plan for the appropriate actions that are expected to result in improvement and disease prevention.

IPC.1.I.M4

Effective 1/1/2021

Influenza and pneumococcal vaccines may be administered to patients per organizational policy developed in consultation with a physician or allowed practitioner including physician assistant, nurse practitioner, or clinical nurse specialist, and after an assessment of the patient to determine the presence of contraindications.

Applicable Regulation: G582-484.60(b)(2).

Interview: Interview a key leader with knowledge of the infection prevention and control program. Verify the process in place for administering influenza and pneumococcal vaccines to patients. Verify that the process includes consultation with a physician or allowed practitioner.

Standards

IPC.3.I

Personnel use hand hygiene products, personal protective equipment (PPE), and other necessary equipment and supplies as described in the organization's infection prevention and control policies and procedures and the Centers for Disease Control and Prevention (CDC) or World Health Organization (WHO) guidelines.

Evidence Guidelines

Document Review: Review the policies and procedures. Verify the infection prevention and control policies and procedures include guidelines on personnel usage of hand hygiene products, personal protective equipment (PPE), and other necessary equipment and supplies .

Observation: Inspect offices, warehouses, or other work and storage areas. Validate that hand hygiene is practiced as defined in the organization's policy and CDC or WHO guidelines. Validate that, at a minimum, standard precautions are followed.

Observation: On home visit(s), validate that hand hygiene is practiced as defined in the organization's policy and CDC or WHO guidelines. Validate that, at a minimum, standard precautions are followed. Validate that any other PPE required for the patient's care is used.

Guidance: Personnel includes contracted personnel that provide care and services on behalf of the agency.

Guidance: The use of PPE varies depending on the patient's diagnosis and the type of services provided. At a minimum, it is expected that CDC or WHO standard precautions are implemented.

Tip: Information on hand hygiene practices and standard precautions in community settings can be found on the CDC or WHO website.

Standards

IPC.3.I.M1

Hand hygiene, using correct technique, is performed when indicated. At a minimum, hand hygiene is performed:

1. Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed);
2. After contact with blood, body fluids, or excretions; mucous membranes; non-intact skin; or wound dressings;
3. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient;
4. If hands will be moving from a contaminated-body site to a clean-body site during patient care; and
5. After glove removal.

Applicable Regulation: G682-484.70(a).

Evidence Guidelines

Observation: On home visit(s), validate that hand hygiene occurs when indicated using the correct technique according to Centers for Disease Control and Prevention or the World Health Organization guidelines.

Standards

IPC.4.I

Personnel follow the organization's infection prevention and control procedures when supplies and equipment are stored, transported, and carried in and out of the care environment.

Evidence Guidelines

Observation: Inspect the organization's offices. Verify that supplies and equipment for patient use are stored in a clean, dry space protected from damage or contamination. Verify that supplies are not expired.

Observation: Observe personnel transport and use of supplies and equipment in the care environment. Verify that procedures are followed in accordance with organizational policy to prevent cross-contamination. Verify that clean items are separated from used or soiled items during transport.

Guidance: In following organizational policy, it is expected that personnel ensure that areas for supply and equipment storage are separated to prevent cross-contamination.

Guidance: "Care environment" refers to where the patient is located, whether in his or her home or in an inpatient facility or setting. This standard does not apply to suppliers whose personnel do not perform duties in the patient's care environment.

IPC.4.I.M1

Bags used to carry equipment or supplies into or out of the care environment are transported and used in a manner consistent with organizational policy to prevent the spread of infections and communicable diseases.

Observation: Observe the transport and use of bags in the care environment. Verify that organizational policy is followed and that bags are managed in a manner that avoids cross-contamination.

Applicable Regulation: G682-484.70(a).

Standards	Evidence Guidelines
IPC.4.I.M2 Sterilized items are stored and transported in a manner that preserves the integrity of packaging material. Items with expired sterilization dates are removed from inventory and not used. Packages containing sterile items are inspected before use to verify the expiration date and package integrity and dryness. If an event causes an item to become contaminated (e.g., a package becomes torn or wet), it is not used. **Applicable Regulation: G682-484.70(a).**	Observation: Inspect storage areas where sterilized items are stored (if applicable). Verify that sterilized items are within date and that package integrity is intact as required Observation: Inspect vehicles where sterilized items are transported. Verify that sterilized items are within date and that package integrity is intact as required Observation: Conduct a home visit. Verify that the provider inspects the integrity of the packaging before use. If an event causes an item to become contaminated (e.g., a package becomes torn or wet), or its expiration date has surpassed, verify that it is not used. Tip: Additional information regarding event-based sterilization may be found at https://www.cdc.gov/oralhealth/infectioncontrol/faq/sterilization.htm.
IPC.5.I Equipment that is owned by the organization, or for which it is responsible, is cleaned and disinfected according to current manufacturers' guidelines and in accordance with the type of equipment and level of infection risk. **Applicable Regulation: G684-484.70(b)(2).**	Document Review: Review documents that record cleaning and disinfection of equipment. Validate that equipment stored as clean is logged as having been cleaned according to manufacturer's guidelines and organizational policy. Guidance: Equipment that the organization may not own but is responsible for might include leased equipment, such as telemonitors or diagnostic equipment.

Standards

IPC.6.I

During the delivery of care and services, the patient's immediate care environment, to the extent possible, is maintained in a manner that minimizes the risks associated with infections and communicable diseases.

Evidence Guidelines

Observation: Conduct home visits and other observations of the care environment, as applicable. Validate that personnel maintain the care environment in a manner that minimizes the risk of acquiring and spreading infections and communicable diseases.

Guidance: Maintaining a care environment in a manner that minimizes the risks associated with infections and communicable diseases is a balance between removing all potential sources of infection and respecting a person's self-care and autonomy. It may not be realistic to eliminate every identified infection control risk in a patient's residence. Organizations are expected to identify risks when present and modify the care environment, to the extent possible, to prevent infections before providing care or services.

Guidance: The immediate care environment is the area in which personnel provide care and services for the patient. This could include the areas where the patient sleeps, eats, and bathes. This standard does not apply to suppliers whose personnel do not perform duties in the patient's care environment.

Standards

IPC.6.I.M1

Work surfaces in the care environment are cleaned as defined in the organization's infection prevention and control policies and procedures.

Applicable Regulation: G684-484.70(b)(2).

Evidence Guidelines

Observation: Conduct home visits and other observations of the care environment, as applicable. Validate that work surfaces are cleaned as defined in policy.

Guidance: "Care environment" refers to where the patient is located, whether in his or her home or in an inpatient facility or setting. This standard does not apply to suppliers whose personnel do not perform duties in the patient's care environment.

Guidance: It is expected that organizations have appropriate processes in place to reduce the presence of unclean or unsanitary environments. However, it is recognized that in a patient's home there may be limitations beyond the control of the organization. In such situations, it is expected that organizations educate patients and caregivers about appropriate processes and risks related to unclean or unsanitary environments.

Guidance: Other standards related to safe storage and cleaning of equipment are found in the Equipment Monitoring and Management Key Performance Area.

Standards

IPC.6.I.M2

The organization properly stores and disposes of medical waste products and contaminated syringes used by its personnel in the performance of care and services. Storage and disposal of medical waste products is done in accordance with local, state, and federal law and regulation, including:

1. Placing all used needles in a non-permeable, tamper-proof, puncture-resistant container that is not recapped or broken; and
2. Disposing of the puncture-proof container appropriately.

Applicable Regulation: G682-484.70(a).

Evidence Guidelines

Observation: Inspect offices, warehouses, or other administrative facilities. Validate that medical waste is handled and stored safely, as defined in the Infection Prevention and Control program documents.

Observation: Conduct home visits or other observations of the care environment. If medical waste is generated, observe that it is disposed of safely, including placing all used needles in a non-permeable, tamper-proof, puncture-resistant container that is not recapped or broken and disposing of the puncture-proof container appropriately.

Guidance: This standard does not apply to organizations that do not produce medical waste products in the provision of care and services.

Guidance: Some local and state authorities have specific requirements for the management of medical waste. It is expected that the organization has knowledge of and complies with these requirements.

Guidance: Medical waste includes sharps and infectious waste contaminated with blood and other bodily fluids that represent a sufficient potential risk of causing infection during handling and disposal. Specific guidelines on infectious waste can be found on the Centers for Disease Control and Prevention website.

Guidance: In offices, warehouses, or other administrative spaces, it is expected that medical waste is stored in a separate and clearly labeled space prior to disposal. The space chosen does not need to be an entirely separate location (e.g., a closet) that is locked or otherwise secured.

Tip: Information on the safe disposal of sharps generated by patients can be found on the Food and Drug Administration website.

Standards	Evidence Guidelines
IPC.7.I Patients, caregivers, and personnel are instructed on infection prevention and control practices related to the care and services provided. **Applicable Regulation: G686-484.70(c).**	Interview: Interview personnel providing care and services to patients. Validate, through specific patient examples, the types of education that are provided to patients for minimizing the spread of infections and communicable disease. Record Review: Review patient records for evidence of instruction on infection prevention and control. Verify that instruction is given on infection control practices, as appropriate to the care and services provided, Guidance: The amount and type of education that is provided is dependent on the scope and complexity of the organization's services. Not every patient will require instruction on minimizing infections. For example, patients receiving homemaker services or purchasing products from a retail or mail-order home medical equipment provider would not need such education unless there is an identified risk. Tip: One method commonly used to assess patient comprehension is the teach-back or repeat-back technique. Learners are asked to repeat instructions provided rather than simply stating that they understand. Additional information on this technique can be found on the Institute for Healthcare Improvement website.
IPC.7.I.M1 Patients and caregivers are instructed on minimizing the risks of spreading infections and communicable diseases, including the proper techniques for handling and disposing of medical waste, as applicable. Instruction is documented. **Applicable Regulation: G686-484.70(c).**	Record Review: Review patient records. Validate that infection prevention and control (IPC) training occurs as needed during the course of care. If the patient's care generates medical waste, verify that patients and their caregivers have been instructed on safe practice for its storage and disposal. Validate that documentation includes what was taught and to whom, as well as a record of the learner's comprehension. Observation: Conduct a home visit. If the patient's care generates medical waste, interview the patient and/or caregiver to clarify what instructions they received on safe practice for its storage and disposal.

Standards

IPC.8.I

Home health care personnel at risk for occupational exposure to TB, are screened and tested as defined in state or local law and regulation, or per the organization's assessment of TB exposure risk based on the population and/or community served.

In the absence of state or local law and regulation or organization identified risk, the screening and testing occurs per the Centers for Disease Control and Prevention (CDC) guidelines.

There is appropriate follow-up when TB risk is identified.

Applicable Regulations: G684-484.70(b)(1); G684-484.70(b)(2).

Evidence Guidelines

Document Review: Review documents describing the organization's TB testing and screening program. Validate that it specifies when and which personnel are screened for TB. Validate that the organization's program is consistent with the state's TB testing and screening guidelines, including the requirements for documentation of chest x-rays for personnel who have a previous history of positive TB tests.

Record Review: Review documents recording TB testing and screening for individual personnel. Validate that testing and screening occurs as described in the organization's Infection Prevention and Control program.

Guidance: TB testing consists of administering and reading the results of a TB test. Testing can be done directly by the organization or by an outside entity. It is expected that new personnel at risk for exposure to TB are tested in accordance with the organization's policy and procedure and as required by state or local law. Ongoing TB testing of employees should be based on the risk assessment of the communities being served by the organization, and state and local laws that apply to the risk assessment results.

Tip: Organizations may want to contact their local or state health department for guidance on TB risk assessment, follow-up, testing, treatment, and chest x-ray requirements.

Tip: CDC guidelines recommend that TB testing cover personnel at high risk of exposure. More detailed guidance on TB testing and screening is available on the CDC website at https://www.cdc.gov/mmwr/pdf/rr/rr5417.pdf, state health department laws and regulations, as well as in Occupational Safety and Health Administration directives specific to medical surveillance.

Standards	Evidence Guidelines
IPC.9.I The organization makes hepatitis B vaccination available at no charge to personnel at risk of exposure to blood and other potentially infectious materials (OPIM) as required by the Occupational Health and Safety Administration (OSHA) . **Applicable Regulation: G684-484.70(b).**	Record Review: Review personnel health records for personnel with risk of exposure to blood and OPIM. Verify that records contain documentation that personnel were offered the vaccine. Guidance: The organization determines which personnel are at risk of exposure to blood and OPIM based upon the duties they perform. If personnel decline to receive the vaccine, but at a later date decide to accept it, the organization is required to provide it at no cost. Tip: Information regarding hepatitis B prevention and vaccination is found on the OSHA website.
IPC.10.I Occupational exposures to communicable diseases are referred for assessment, testing, treatment, and counseling in accordance with organizational policy and local, state, and federal law and regulation. Post-exposure interventions, as defined in the organization's infection prevention and control (IPC) policies, are implemented. **Applicable Regulation: G684-484.70(b)(2).**	Interview: Interview the individual responsible for overseeing the organization's IPC program. Clarify if any occupational exposures to communicable diseases have occurred during the past year. If so, clarify the process(es) by which the exposure was tracked and reported. Clarify the ways in which the organization provides or refers personnel for assessment, treatment, testing, and counseling.
IPC.11.I Personnel report exposure to, or development of, a communicable disease to the organization, in accordance with organizational policy and local, state, and federal law and regulation. **Applicable Regulation: G684-484.70(b).**	Document Review: Review logs or other documentation the organization maintains for reporting exposure to or development of communicable diseases. Validate that reporting occurs per organizational policy and the requirements of the standard. Document Review: Review infection prevention and control (IPC) documents that define what communicable diseases are to be reported. Validate that they address local, state, and federal law and regulation.

Standards	Evidence Guidelines
IPC.12.I Occupational exposure is reported to local, state, and federal authorities as required. Follow-up notifications, testing, and treatment follow state and local health department guidance and organizational policy. **Applicable Regulation: G684-484.70(b).**	Interview: Interview the individual responsible for overseeing the Infection Prevention and Control program. Clarify the process for reporting occupational exposure. Discuss any reports that have been made in the last year and verify that the process was followed. Guidance: Local and state reporting requirements may vary. It is expected that the organization has knowledge of and complies with related local and state regulations.
IPC.14.I Patients are monitored for the occurrence of infections. Identified infections are investigated. Information is documented and used to identify and act on opportunities to reduce the risk of infections.	Document Review: Review infection data from the past 12 months or other documents that report the occurrence of infections in patients. Validate that identified risks are investigated and used to identify and act on opportunities to reduce the risk of infections. Guidance: The organization is not expected to monitor every type of infection, but rather select infections that are common and important to protecting the organization's personnel and patient populations. The extent to which infection surveillance occurs depends on the size and scope of the organization's services. For example, the organization may choose to track urinary track infections based on the prevalence in their patient population. Guidance: It is expected that sudden or remarkable increases in infections are addressed to prevent further increases in the infection rate.

Standards

IPC.14.I.M1

The organization monitors infections as part of its Continuous Quality Improvement (CQI) program and plans appropriate actions, based on findings identified, that are expected to result in minimized risk and disease prevention.

Applicable Regulations: G684-484.70(b); G684-484.70(b)(1); G684-484.70(b)(2).

Evidence Guidelines

Document Review: Review reports of CQI activities, if any, based on infection data. Validate that findings in infection data are integrated in the CQI program and followed by action to reduce the risk of occurrence.

Interview: Interview the person responsible for overseeing the infection control program. Clarify the ways in which infections are reported, monitored, and used in CQI activities.

Guidance: CQI activities related to infection prevention and control data might include additional education to personnel or patients or demonstration of practice. For example, a higher rate of upper respiratory infections may be addressed by documented re-education with demonstration and return demonstration to patients and personnel on hand hygiene and "cover your cough" techniques.

Emergency Preparedness

KPA Statement

Organizations prepare for emergent events through continuous cycles of planning, organizing, equipping, training, evaluating, and taking necessary corrective actions to ensure an effective, coordinated response should such events occur. Before, during and after emergent events, organizations prioritize the safety of patients, caregivers, families, and personnel to minimize interruptions to the delivery of care and services.

Standards	Evidence Guidelines
EP.1.D The organization has a documented emergency preparedness (EP) plan that address actions to be taken in the event of a natural or man-made disaster. The plan is compliant with local, state, and federal requirements. **Applicable Regulation: E0001-484.102.**	Document Review: Review the EP plan. Verify that documentation includes the actions the organization will take in the event of a natural or man-made disaster. Verify that the plan is compliant with local, state, and federal requirements.

Standards

EP.1.D.M1

The organization develops and maintains an emergency preparedness (EP) plan, in compliance with applicable local, state, and federal emergency preparedness requirements.

The plan:

1. Is based on and includes a documented, organization-based and community-based risk assessment, utilizing an all-hazards approach specific to the geography and population served by the organization;
2. Includes strategies for addressing emergency events identified by the risk assessment, including the management of the consequences of;
    a) power failures;
    b) natural or man-made disasters; and
    c) emerging infectious disease (EIDS) that places the health and safety of patients and employees at risk;
3. Addresses the organization's patient population, specifically:
    a) the care and safety of patients with limited mobility; and,
    b) those requiring evacuation due to medical or psychiatric conditions or their home environment;
4. Addresses when emergency preparedness officials are contacted regarding patient evacuation;
5. Addresses the type of services the organization can provide in an emergency;
6. Addresses continuity of business functions essential to the organization's operations, including identification of staff or positions that can assume key organization roles if current staff and leadership are not available; and
7. Defines a process for cooperation and collaboration with local, tribal, regional, state, and federal emergency preparedness officials' efforts to maintain an integrated response during a disaster or emergency.

There is documented and dated evidence that the plan is reviewed and as appropriate, updated at least every two (2) years.

Evidence Guidelines

Document Review: Review the EP plan. Validate that it is reviewed and updated every two (2) years and addresses the requirements of the standard. Verify that the plan is compliant with all local, state, and federal requirements.
In reviewing the plan:

- How are risks associated with the geography and/or population served incorporated;
- Are strategies noted regarding power failures, expected natural or man-made disasters and EIDs;
- Does the plan describe patient populations who are at risk for evacuation during an emergency event are identified and when the would contact officials for evacuation;
- Verify what services does the organization state they would be able to provide during an emergency;
- Does it describe how the organization plans to continue operations, including delegating authority; and,
- Does it describe their cooperation with emergency officials.

Document Review: Review the risk assessment. Verify that the EP plan is based on an organization and community-based assessment, using an all-hazards approach, and is specific to the community/geographic location and population served, as well as considers EIDs.

Interview: Ask the home health agency's leadership to describe their EP program.

Guidance: Organizations may rely on a community-based risk assessment developed by other entities, such as public health agencies, emergency management agencies, and regional health care coalitions or in conjunction with conducting its own organization-based assessment. If this approach is used, organizations are expected to have a copy of the community-based risk assessment and to work with the entity that developed it to ensure that the organization's emergency plan is in alignment.

(continued on following page)

Standards	Evidence Guidelines
EP.1.D.M1 **Applicable Regulations: E0001-484.102; E0004-484.102(a); E0006-484.102(a)(1-2); E0007-484.102(a)(3); E0009-484.102(a)(4); E0013-484.102(b).**	Guidance: An all-hazards approach is specific to the location of the provider and considers the types of hazards that are most likely to occur in the organization's geographic area and population served. While organizations may identify many types of emergent scenarios, it is not practical -or even advisable- for organizations to implement a plan that covers every conceivable type of disaster and emergency scenario. Guidance: For emerging infectious disease, the Plan should consider modifications that may be made to the organization's protocols to protect the health and safety of patients and staff, such as isolation, or personal protective equipment (PPE), additional screening, etc.

Standards

EP.1.D.M3

As part of its emergency preparedness (EP) plan, the organization develops and maintains an EP communication plan that complies with local, state and federal requirements.

The plan includes:

1. Names and contact information for personnel, entities providing services under arrangement, patients' physicians, and volunteers;
2. Contact information for the federal, state, tribal, regional, and local emergency preparedness staff and other sources of assistance;
3. Primary and alternate means for communicating with personnel and federal, state, tribal, regional, and local emergency management agencies;
4. A method for sharing information and medical documentation for patients under the organization's care, as necessary, with other health care providers to maintain the continuity of care;
5. A means for providing information about the general condition and location of the patients under the organization's care as permitted by the Health Insurance Portability and Accountability Act; and
6. A means of providing information about the organization's needs and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee.

The communication plan, including all contact information, is reviewed and updated at least every two (2) years.

Applicable Regulations: E0029-484.102(c); E0030-484.102(c)(1); E0031-484.102(c)(2); E0032-484.102(c)(3); E0033-484.102(c)(4-5); E0034-484.102(c)(6).

Evidence Guidelines

Document Review: Review the EP communication plan. Verify that it is reviewed and updated at least every two (2) years. Verify that the communication plan addresses each of the elements as required by the standard.

Interview: Interview the Clinical Manager. Verify, through a description of the process, the ways in which names and contact information for personnel, entities providing services under arrangement, patients' physicians, and volunteers are updated and kept current as part of the emergency communications plan. If stored electronically, clarify how contact information is obtained in the event that the electronic system is unavailable.

Guidance: Organizations in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies. For example, if an organization is located in a rural area, which has limited or no Internet and phone connectivity during an emergency, it must address what alternate means are available to alert local and State emergency officials. Optional communication methods organizations may consider include satellite phones, radios and short-wave radios.

Standards

EP.1.D.M5

Organizations that are part of a healthcare system consisting of multiple separately certified healthcare facilities that elect to have a unified and integrated emergency preparedness (EP) program may choose to participate in the healthcare system's coordinated EP program.

If elected, the unified and integrated EP program:

1. Demonstrates that each separately certified organization within the system actively participated in the development of the unified and integrated emergency preparedness program;
2. Is developed and maintained in a manner that takes into account each separately certified organization's unique circumstances, patient populations, and services offered;
3. Demonstrates that each separately certified organization is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program;
4. Meets the requirements of paragraphs §484.102 (a)(2), (3), and (4);
5. Is based on a documented community-based risk assessment, utilizing an all-hazards approach;
6. Is based on a documented individual organization -based risk assessment for each separately certified organization within the health system, utilizing an all-hazards approach; and
7. Includes integrated policies and procedures, a coordinated communication plan, as well as training and testing.

Applicable Regulation: E0042-484.102(e).

Evidence Guidelines

Document Review: Review documents for the EP program when an organization elects to participate in a healthcare system's program. Validate that the documentation includes demonstration of the organization's integration and active participation in the system's EP program. Validate that the EP program is unique to the patient populations served and is based on a risk assessment, communication plan and training program as required by the standard.

Interview: Interview a key leader for EP activities. Verify, through specific examples, the ways in which the organization is fully integrated into the system's EP program while meeting the unique standards related to its program and services.

Standards	Evidence Guidelines
EP.1.I The organization implements its emergency preparedness (EP) plan. **Applicable Regulation: E0013-484.102(b).**	Interview: Interview the key leader responsible for EP activities. If an emergent event has occurred in the last three years, clarify, through specific examples, the ways in which the EP plan was implemented. Guidance: Organization's that have not had an emergent event in the last 3 years will not be directly evaluated on this standard. The organization will only be assessed on their testing of the EP plan, as described in EP.4.I.
EP.2.D The organization documents emergency preparedness (EP) policies and procedures based on their EP plan, when required by local, state or federal law or regulation.	Document Review: Review EP policies and procedures if required by local, state, and federal requirements. Verify they include policies and procedures that support the implementation of the EP plan. Guidance: It is expected that the organization will have EP policies and procedures when required by local, state, or federal law or regulation. In the absence of such law or regulation, the organization is expected to have an EP plan in compliance with the requirements of EP.1.D.

Standards

EP.2.D.M1

The organization develops and implements emergency preparedness (EP) policies and procedures, based on the emergency plan, risk assessment, and the communication plan.

Policies and procedures address:

1. Development and inclusion of a plan for each of the organization's patients during a natural or man-made disaster as part of the comprehensive patient assessment;
2. The documented discussion of the patient emergency plan that is provided to the patient, and maintained by the organization;
3. Follow up with patients and on-duty staff to determine needs in the event that care is interrupted during or due to an emergency;
4. Arrangements with facilities and other providers to receive patients to maintain the continuity of care, including timelines and under what conditions patient would be moved;
5. Informing local and state emergency preparedness officials about patients or on-duty staff who the organization is unable to contact
6. Informing local State emergency preparedness officials of patients who are in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical or psychiatric condition, or home environment;
7. The minimum information provided to facilitate evacuation and transportation including:
    a) Patient name, age, DOB, medications, allergies, diagnosis;
    b) Emergency contact(s);
    c) If the patient is mobile or not;
    d) If the patient has life-dependent equipment, and if it can be transported (e.g. battery operated, size, condition, etc.);
    e) The clinical care needed for the patient; and
    f) Any patient special needs including cognitive disorders, intellectual disabilities, communication issues (e.g. deaf, non-English speaking, etc.);

(continued on following page)

Evidence Guidelines

Document Review: Verify policies are reviewed and updated at least every two (2) years.

Verify policies and procedures:

- Align with the EP plan, identified hazards in the risk assessment and the communication plan;
- Address the tracking system for the location of patients and on-duty staff;
- Address the patient's individualized plan;
- Address procedures to inform State and local EP officials about patients who need evacuation and patients and/or on-duty staff that cannot be contacted;
- Address follow-up with on-duty staff and patients to determine care needed if there is an interruption during or due to the emergency;
- Address the medical record documentation provided in a transfer or evacuation and how it is released while protecting patient confidentiality;
- Addresses how the available records are secured; and
- Address the use of volunteers and other emergency staffing strategies.

Record Review: Verify that each patient has an individualized emergency plan documented as part of the comprehensive assessment. See APC.6.I.M1

Interview: Ask the patient or caregiver during the home visit about their emergency plan.

Interview: Ask staff responsible for EP to describe the tracking system used to document the locations of patients and on-duty staff, and the procedure for letting State and local EP officials of any they are unable to contact.

Guidance: As PHI is addressed, policies and procedures must also ensure compliance with applicable Health Insurance Portability and Accountability Act (HIPAA) Rules.

Standards

Evidence Guidelines

EP.2.D.M1

8. How the information is shared (e.g. paper or electronic);
9. A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records;
10. Informing local and state officials of any staff the organization is unable to contact;
11. The role of employees in providing care at alternate care sites during emergencies; and,
12. The use of volunteers in an emergency, or other emergency staffing strategies including the process and role for the integration of state or federally designated health care professionals to address surge patient care needs during an emergency.

Policies and procedures are reviewed and updated at least every two (2) years.

Applicable Regulations: E0013-484.102(b); E0017-484.102(b)(1); E0019-484.102(b)(2); E0021-484.102(b)(3); E0023-484.102(b)(4); E0024-484.102(b)(5).

EP.3.D

Emergency preparedness training is provided to personnel. Training is specific to the individual's duties and responsibilities. Training is documented, including the dates, participants, and the content covered.

Document Review: Review documents related to emergency preparedness training. These might be located in personnel records, education records or checklists. These records may be maintained electronically (in a learning management system) or on paper.

Guidance: This training may be delivered in a variety of ways, such as on-line, in person, or via video, audio or written media. The breadth and depth of the content covered can be adjusted depending on the individual's role in the organization. For example, the training needed for an office manager to act in an emergency differs from that of field staff members who are responsible for direct patient care.

Standards

EP.3.D.M1

The organization develops and maintains an emergency preparedness (EP) training program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan.

The training program is reviewed and updated at least every two (2) years and includes initial training (during orientation or shortly thereafter) in EP policies and procedures to all new and existing personnel, individuals providing services under arrangement, and volunteers, consistent with their expected roles.

EP training is provided at least every two (2) years. If the EP policies and procedures are significantly updated, the organization must conduct training on the updated policies and procedures. The organization maintains documentation of the training, including the date(s), participants, and content covered. Personnel demonstrate knowledge of emergency procedures as part of the training.

Applicable Regulations: E0036-484.102(d); E0037-484.102(d)(1).

Evidence Guidelines

Document Review: Review documents related to EP training. These might be located in personnel records, education records or checklists. These records may be maintained electronically (in a learning management system) or on paper. Validate that the training program and content is reviewed, updated and provided every two (2) years to all new and existing personnel, individuals providing services under arrangement, and volunteers. Validate that the training includes an evaluation of the individual's ability to demonstrate knowledge of the organization's emergency procedures.

Interview: Interview the key leader that oversees the emergency preparedness program. Clarify the types of training provided to personnel. Verify that the training was reviewed and updated within the last two (2) years.

Guidance: Organizations have the flexibility to determine the focus of their training, as long as it aligns with the emergency plan and risk assessment.

Guidance: Organizations with multiple locations provide training that reflects the risks identified for each specific location.

Standards

EP.4.I

The organization tests its EP program at least annually and in accordance with its policy, or as required by local, state, or federal requirements.

Evidence Guidelines

Document Review: Review documents reporting on the most recent testing of the EP program. Validate that processes were tested in accordance with organizational policy, and as required by local, state, or federal requirements.

Guidance: Testing is the concept in which training is operationalized and the organization is able to evaluate the effectiveness of the training as well as the overall emergency preparedness program. Testing includes conducting drills and/or exercises to test the emergency plan to identify gaps and areas for improvement.

Guidance: EP testing will vary based on the organization's patient population and the services provided. Organizations providing non-clinical services, such as DME, retail pharmacy or home and environmental services may have simplified testing procedures, such as a table-top exercise, or verifying all supplies are in place and key personnel can be contacted in the event of an emergency.

Guidance: If in a given year an actual emergency takes place, which requires activation of the plan, the organization can forgo testing for 12 months following the event. Evaluation of this standard will be based on the actual event.

Standards

EP.4.I.M1

The organization develops and maintains an emergency preparedness (EP) testing program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan. The testing program is reviewed and updated at least every two (2) years.

Applicable Regulation: E0036-484.102(d).

Evidence Guidelines

Document Review: Review documents reporting on the most recent testing of emergency preparedness program. Validate that testing is conducted at least annually based on the emergency plan, risk assessment, and the communication plan. Validate that the testing plan is reviewed and updated every two (2) years.

Guidance: Organizations that have been operating for less than a year are not expected to meet the requirements of this standard.

Guidance: If in a given year an actual emergency takes place, which requires activation of the organization's EP plan, the organization can forgo testing. The results of the activation of the plan are expected to be analyzed and used for revision of the EP plan.

Guidance: Organizations with multiple locations conduct testing that reflects the risks identified for each specific location.

Standards

EP.4.I.M2

The organization conducts exercises to test the emergency preparedness (EP) plan annually, including:

1. Participation in a full-scale exercise that is community-based.
    a) When a community-based exercise is not accessible, testing includes participation in an individual, facility-based functional exercise every two (2) years.
    b) If the organization experiences an actual natural or man-made emergency that requires activation of the emergency plan, the organization is exempt from engaging in its next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the emergency event.
2. Conducting an additional exercise every two (2) years – opposite the year that a full-scale exercise or functional exercise is conducted. This exercise may include, but is not limited to:
    a) A second full-scale exercise that is community-based or a facility based functional exercise; or
    b) A mock disaster drill; or
    c) A tabletop exercise or workshop that is led by a facilitator that includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan.

Applicable Regulation: E0039-484.102(d)(2).

Evidence Guidelines

Document Review: Review documentation evidencing organizational testing of the EP plan once annually. Acceptable tests include:
1st test in a 12-month period: Full-scale community-based exercise

- If a community-based test is not accessible, an annual individual, facility-based functional exercise is acceptable.
- If the organization activates its emergency preparedness plan due to a disaster or other emergency, the next required full-scale community-based exercise or facility-based functional exercise AFTER the activation of the plan is waived.

Subsequent test in next 12-month period:

- A second full scale community-based exercise or individual facility-based exercise (Note: If the EP plan has been activated in the preceding 12 months, it may substitute for this test),

OR

- A mock disaster drill,

OR

- A tabletop exercise or workshop.

Document Review: Review documented evidence of all tests, results, and if the EP Plan needed to be and was revised.

Interview: Interview the key leader overseeing the EP plan. If the organization participated in a community-wide drill, validate the roles played and lessons learned. If the organization could not access a community-wide drill, clarify the scenario and lessons learned from an organization-based drill. Verify the type of additional drill conducted.

Guidance: Organizations that have been operating for less than a year are not expected to meet the requirements of this standard.

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Standards	Evidence Guidelines
EP.4.I.M2	Guidance: A full scale exercise is defined as any operations-based exercise (drill, functional, or full-scale exercise) that assesses an organization's functional capabilities by simulating a response to an emergency that would impact the organization's operations and their community. Organizations are expected to consider their physical location, agency and other organization responsibilities and needs of the community when planning or participating in their exercises. Guidance: The responsibility for ensuring a coordinated emergency disaster response lies with local and state emergency preparedness officials. Organizations are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement. They are expected to document the date, the personnel and the agency or healthcare coalition that they contacted. However, some local and state authorities may not elect to collaborate with community-based providers. If a community mock disaster drill is not accessible, the organization is expected to conduct their own drill.
EP.5.S The organization analyzes the effectiveness of its emergency preparedness (EP) plan and integrates changes into the plan as necessary.	Interview: Interview the key leader responsible for EP activities. Verify, through specific example, how the organization analyzes the effectiveness of the plan. Clarify the types of changes, if any, that have been made based on the results of the analysis.

Standards	Evidence Guidelines
EP.5.S.M1 The organization analyzes its response to and maintains documentation of all drills, tabletop exercises, and emergency events, and revises the emergency plan as needed. **Applicable Regulation: E0039-484.102(d)(2).**	Document Review: Review documentation of the organization's analysis of its response to testing of the emergency plan, including drills, tabletop exercises, and actual emergency events, as applicable. Validate that the information is used to revise the emergency plan, as needed.

Leadership & Governance

KPA Statement

The organization fulfills its stated mission through active leadership and governance, fostering an internal culture that promotes the delivery of person-centered, safe, effective, timely, and equitable care and services. Leadership and governance engage in governing all aspects of the organization, including goal setting, establishing and promoting ethical practices, and overseeing the management of all legal, fiscal, and operational matters.

Standards	Evidence Guidelines
LG.1.I Care/services are effectively organized and managed to support the scope of services provided.	Interview: Interview a member of governance. Verify how care and services are organized and managed to support the services provided by the organization. Guidance: This standard is designed to determine if the organization manages services in a systematic way. Although specific deficiencies related to these areas may be cited elsewhere within this or other Key Performance Areas, when systemic issues pertaining to leadership and governance are identified, they may be cited here.
LG.1.I.M1 The organization organizes, manages, and administers its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care for each patient's medical, nursing, and rehabilitative needs. **Applicable Regulation: G940-484.105.**	Guidance: This standard is designed to determine if the organization organizes and manages services in a systematic manner to attain and maintain the highest practicable functional capacity. Although specific deficiencies related to these areas might be cited elsewhere within this Key Performance Area, when systemic issues pertaining to the organization and management of services are identified, they may be cited here.

Standards	Evidence Guidelines
LG.1.I.M2 The primary organization is responsible for the conduct and delivery of all care rendered to patients, whether that care is provided directly or under arrangement. **Applicable Regulation: G980-484.105(e)(3).**	Interview: Interview a key leader or the Clinical Manager. Verify, through specific examples, the way in which the organization manages and delivers care, both directly and under arrangement. Guidance: "Primary organization" means the organization that accepts the initial referral of a patient and provides services directly to the patient or via another health care provider under arrangements (as applicable).
LG.3.I The organization operates and furnishes care/services in compliance with applicable local, state, and federal laws and regulations related to the health and safety of patients. **Applicable Regulation: G848-484.100.**	Document Review: Review documentation related to organizational compliance. Verify that it includes policies or procedures to ensure the organization's compliance with applicable laws and regulations. Interview: Interview one or more key leaders. Clarify the ways in which the organization ensures that it maintains compliance with all applicable local, state, and federal law and regulation related to the health and safety of patients. Guidance: This standard is designed to assess the organization's compliance with applicable laws and regulation. Although specific deficiencies related to compliance may be cited elsewhere within this or other Key Performance Areas, when systemic issues pertaining to compliance are identified, they may be cited here. Guidance: California providers: This standard applies to all programs participating in Medicare or Medi-cal.

Standards	Evidence Guidelines
LG.3.I.M1 The organization and branch locations are licensed in accordance with state law or regulation. **Applicable Regulation: G860-484.100(b).**	Document Review: Review licenses. Validate that the organization and any branches hold current licenses as required.
LG.3.I.M3 If the organization engages in laboratory testing outside the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the Food and Drug Administration, such testing is in compliance with all applicable local, state, and federal law and regulation. If the organization refers specimens for laboratory testing to another laboratory, the referral laboratory is certified in the appropriate specialties and subspecialties of services. **Applicable Regulation: G864-484.100(c)(2).**	Document Review: Review the Clinical Laboratory Improvement Amendments certificate of waiver. Verify that it reflects the level of testing being performed and is current. If the organization refers specimens for laboratory testing to another laboratory, verify that the referral laboratory is certified in the appropriate specialties and subspecialties of services.
LG.4.I The organization's governance assumes full legal authority for the operation of the organization.	Document Review: Review bylaws, articles of incorporation, governance policies and procedures, or similar documents. Verify that they provide a written framework for how governance provides oversight to the organization. Guidance: Organizations with one person serving in the governance role (typically the owner) are expected to maintain meeting minutes if required by state or federal law or regulation. If meeting minutes are not maintained, the organization's owner must demonstrate that it carries out the responsibilities needed to govern the organization.

Standards	Evidence Guidelines
LG.4.I.M1 The organization's governance (or designated persons so functioning) assumes full legal authority and responsibility for the organization's overall management and operation, the provision of services, fiscal operations, review of the organization's budget and its operational plans, and its quality assessment and performance improvement program. **Applicable Regulation: G942-484.105(a).**	Document Review: Review bylaws, articles of incorporation, governance policies and procedures, or similar documents. Verify that they document that the governance has the legal authority for the organization's overall management and operation, the provision of services, fiscal operations, review of the organization's budget and its operational plans, and its quality assessment and performance improvement program. Interview: Interview one or more members of governance. Verify the type of oversight provided, including oversight of management, operations, provision of services, fiscal operations, review of the budget, and quality improvement.
LG.4.I.M2 The organization's governance appoints a qualified Administrator. **Applicable Regulations: G944-484.105(b)(1); G946-484.105(b)(1)(i).**	Document Review: Review minutes from meetings of governance or other documentation. Verify that governance has taken action to ensure the appointment of a qualified Administrator.

Standards

LG.4.I.M3

Governance ensures that an ongoing program for quality improvement and patient safety is defined, implemented, and maintained. Governance approves the frequency and detail of the organization's data collection and ensures that the quality improvement program:

1. Reflects the complexity of its organization and services;
2. Involves all services (including those services provided under contract or arrangement);
3. Focuses on indicators related to improved outcomes, including the use of emergent care services as well as hospital admissions and readmissions, and takes actions that address the organization's performance across the spectrum of care, including the prevention and reduction of medical errors;
4. Addresses priorities for improved quality of care and patient safety, and ensures that all improvement actions are evaluated for effectiveness and maintained; and
5. Addresses any findings of fraud or waste.

Applicable Regulations: G640-484.65; G644-484.65(b)(3); G660-484.65(e).

Evidence Guidelines

Document Review: Review minutes from meetings of governance. Verify that all requirements of the standard have been met.

Interview: Interview a member of governance if no meeting minutes are available. Verify the ways in which governance ensures that each requirement of the standard is met.

Guidance: It is not required that organizations with one person serving in the governance role (typically the owner) have meetings/minutes. However, the organization's owner must demonstrate that the responsibilities needed to govern the organization are carried out.

Standards

LG.6.I

Individuals who are designated leaders in the organization have relevant education and experience.

Evidence Guidelines

Record Review: Review personnel files for those in leadership positions. Compare their education and experience to their position descriptions to determine if they possess the relevant education and experience.

Guidance: The organization determines who is designated as a leader. Leaders can assume a variety of roles but generally manage the day-to-day operations of the organization. A leader may be an owner or Administrator, a financial officer, a human resource manager, a director of clinical operations, etc.

Guidance: Relevant experience is determined by the organization, unless otherwise mandated through law or regulation, and is documented in position description.

LG.6.I.M1

An individual in the Administrator role who began employment in any position within the organization prior to January 13, 2018:

1. Is a licensed physician;
2. Is a registered nurse; or
3. Has training and experience in health service administration and at least one year of supervisory administrative experience in home health care or a related health care program.

An individual in the Administrator role who begins employment in any position within the organization on or after January 13, 2018:

1. Is a licensed physician or registered nurse, or holds an undergraduate degree; and
2. Has experience in health service administration, with at least one year of supervisory or administrative experience in home health care or a related health care program.

Record Review: Review personnel records for the Home Health Administrator. If employment date is on or before 1/13/2018, verify that he or she is a licensed physician, is a registered nurse, or has training and experience in health service administration and at least one year of supervisory administrative experience in home health care or a related health care program. If employment began on or after 1/13/2018, verify that the individual is a licensed physician, is a registered nurse, or holds an undergraduate degree and has experience in health service administration, with at least one year of supervisory or administrative experience in home health care or a related health care program.

Guidance: The type of undergraduate degree is at the discretion of the organization; however, it is expected that the job description specifies which degrees qualify in the position description.

Applicable Regulation: G1052-484.115(a).

Standards	Evidence Guidelines
LG.6.I.M2 The Clinical Manager is a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or registered nurse. **Applicable Regulation: G1056-484.115(c).**	Record Review: Review personnel files for the Clinical Manager. Verify that he or she is a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or registered nurse. Guidance: The responsibilities of the Clinical Manager can be found in the Assessment Planning and Coordination Key Performance Area.
LG.7.I Designated individuals with leadership responsibility have the authority and accountability to direct the organization and its key activities and operations.	Interview: Interview the Administrator, owner, or other key leaders. Verify that there is an understanding of specific roles and responsibilities related to the organization's leadership. Clarify, through specific examples, how duties are performed.

Standards

LG.7.I.M1

The Administrator reports to governance and is responsible for:

1. The day-to-day operations of the organization;
2. Ensuring that the clinical manager is available during all operating hours;
3. Ensuring that the organization employs qualified personnel; and
4. Ensuring the development of personnel qualifications and policies.

Applicable Regulations: G944-484.105(b)(1); G946-484.105(b)(1)(i); G948-484.105(b)(1)(ii); G950-484.105(b)(1)(iii); G952-484.105(b)(1)(iv).

Evidence Guidelines

Document Review: Review the position descriptions for the Administrator. Verify that they identify all of the responsibilities listed as appropriate to their position.

Interview: Interview the Administrator. Verify the ways in which the duties required by the standard are carried out.

Guidance: The Administrator may or may not have a direct reporting (supervisory) relationship with the organization's governance; however, it is expected that the Administrator reports information to governance on matters that require governance oversight. This information may be reported directly by the Administrator (e.g., at a governance meeting), or indirectly, via other individuals who meet with or submit information to governance for review and consideration.

Guidance: The Administrator may choose to delegate tasks related to the development of personnel qualifications and policies to others, including the Clinical Manager, as appropriate, while retaining the responsibility for ensuring that tasks are completed and duties performed.

LG.7.I.M2

The Administrator or a predesignated person, who may be the Clinical Manager, is available during all operating hours.

Applicable Regulation: G956-484.105(b)(3).

Interview: Interview the Administrator and the person designated to fill in when the Administrator is not available. Validate, through specific examples, that he or she is available during all operating hours when needed.

Guidance: Operating hours are considered to be all hours during which the organization is delivering care or services.

Guidance: The Administrator, or predesignated person, is not required to be on-site during all operating hours, but must be readily accessible and able to fulfill his or her responsibilities.

Standards	Evidence Guidelines
LG.7.I.M3 When the Administrator is not available, a qualified, predesignated person, who is authorized in writing by the Administrator and the organization's governance, assumes the same responsibilities and obligations as the Administrator. The predesignated person may be the Clinical Manager. **Applicable Regulation: G954-484.105(b)(2).**	Record Review: Review personnel records, minutes from governance meetings, or other documents in which the written designation of an alternate Administrator are contained. Validate that this appointment was authorized by the Administrator and governance. Guidance: It is expected that an alternate Administrator is designated at all times to act in the absence of the Administrator. If the alternate Administrator leaves the organization, a replacement is appointed. The written appointment of an alternate includes the name of the individual appointed.
LG.10.I Leaders continually monitor the care/services provided, including those delivered by alternate sites, to ensure appropriate delivery, safety, and quality.	Interview: Interview one or more key leaders at alternate sites, if applicable. Clarify how the organization's leaders monitor care, products, and/or services at alternate sites.
LG.10.I.M1 The parent organization provides direct support and administrative control of its branches. **Applicable Regulation: G974-484.105(d)(2).**	Interview: Interview the Clinical Manager or other key leader. Verify, through specific examples, the ways in which any branches are controlled and supported by the parent organization. Tip: Ways in which the parent organization might support and control its branch operations include site visits, staff meetings and communications, review and oversight of Continuous Quality Improvement activities, or systems of reporting on care, services, and business operations.
LG.11.D Administrative and supervisory authority and responsibility for care and services furnished are defined in writing.	Document Review: Review organizational charts, scope of services, job descriptions, policies, or similar documentation. Verify that administrative and supervisory authority and responsibility for care and services furnished are defined in writing.

Standards	Evidence Guidelines
LG.11.D.M1 The organization defines, in writing, its organizational structure, including lines of authority and services furnished. Administrative and supervisory functions are not delegated to another entity or organization. **Applicable Regulation: G940-484.105.**	Document Review: Review organizational charts, scope of services, policies, or similar documentation. Verify that the organizational structure, including lines of authority and services furnished, are defined in writing and that administrative and supervisory functions are not delegated to another entity or organization.
LG.12.D Care and services provided through contractual arrangement to an organization or its patients are delivered in a manner consistent with current standards of practice and patient safety. Formal written contracts are signed, dated, and authorized by the principals of each party, and they detail the specific responsibilities of the parties involved.	Interview: Interview one or more key leaders. Determine how oversight is maintained when contracting for services. Contract Review: Review a sample of contracts. Verify that formal written contracts are signed, dated, and authorized by the principals of each party, and that they detail the specific responsibilities of the parties involved. Guidance: "Contracted services" refers to any service provided to the organization by an outside entity or individual. The responsibilities related to oversight of the contract reside with the organization that is receiving care and services.
LG.12.D.M1 In accordance with section 1861(w) of the Social Security Act (42 U.S.C. 1395x (w)), the organization ensures that the patient is not held financially liable for services furnished by the organization under an arrangement with other entities or individuals. **Applicable Regulation: G976-484.105(e)(1).**	Interview: Interview a key leader responsible for billing. Clarify the process by which the organizations ensure that patients are not billed by another entity for contracted services provided in the organization's name.

Standards	Evidence Guidelines
LG.12.D.M2 Written agreements are in place when the organization furnishes patient services under arrangement with another entity or individual. All services not furnished directly are monitored and controlled. The organization maintains overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. **Applicable Regulations: G940-484.105; G978-484.105(e)(2).**	Interview: Interview the Administrator or other key leader with responsibility for contracting for care and services. Verify, through specific examples, the ways in which the organization maintains overall responsibility for any care or service that is delivered through a contract or agreement. Verify how services are monitored. Record Review: Review personnel records. Verify that licensure, certification and competency, and/or training (as applicable) for personnel providing services under arrangement is current. Guidance: If the organization does not keep the personnel records of contracted staff who deliver care, it has a process in place to gain access to such records in a timely manner and has evidence that the records are kept current per the contracting organization's policy.
LG.12.D.M3 Entities or individuals providing services for the organization under arrangement may not have: 1. Been denied Medicare or Medicaid enrollment; 2. Been excluded or terminated from any federal health care program or Medicaid; 3. Had their Medicare or Medicaid billing privileges revoked; or 4. Been debarred from participating in any government program. **Applicable Regulation: G978-484.105(e)(2).**	Interview: Interview the Administrator or other key leader with responsibility for contracting for care and services. Verify the process by which the organization ensures that the contracted entity or individual is eligible to enter into a contract as required by the standard.

Standards

LG.12.D.M4

When home health aide services are provided under arrangement, the organization:

1. Ensures the overall quality of care provided by an aide;
2. Supervises aide services in accordance with §484.80(h)(l) and (2); and
3. Ensures that home health aides who provide services under arrangement have met the training or competency evaluation requirements, or both, of §484.80(h).

Applicable Regulations: G820-484.80(h)(5); G822-484.80(h)(5)(i); G824-484.80(h)(5)(ii); G826-484.80(h)(5)(iii).

Evidence Guidelines

Interview: Interview the Clinical Manager or other key leader who supervises aide services. Verify the ways in which contracted home health aides' training, competency, and quality of care are ensured. Verify that the ways in which contracted aides are supervised meets the requirements of the standard.

Contract Review: Review one or more contracts for aide services. Verify that the contracts address the elements required by the standard.

Financial Stewardship

KPA Statement

The organization's governance is accountable for fiscal oversight. Risk management is aligned with the scope of service delivery to ensure patient and staff safety and the effective use of resources.

Standards	Evidence Guidelines
FS.2.I The organization develops an annual operating budget that reflects the scope and complexity of the organization's care and services.	Document Review: Review the most recent annual budget. Verify that it includes projected revenues and expenses consistent with the organization's size and scope of services.
FS.2.I.M1 The organization develops an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. **Applicable Regulations: G988-484.105(h); G988-484.105(h)(1).**	Document Review: Review the most recent annual budget. Verify that it includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. Guidance: The budget is expected to show anticipated revenue from all payer sources and liabilities from all locations, branches, and/or subunits. It is not required that the organization prepare an item-by-item identification of the components of each type of anticipated income or expense.

Standards

FS.2.I.M2

An overall plan and annual budget are prepared under the direction of the organization's governance, by a committee consisting of representatives of governance, administrative personnel, and medical personnel (if any) of the organization.

Applicable Regulations: G988-484.105(h); G988-484.105(h)(3).

Evidence Guidelines

Interview: Interview a key leader and/or a member of governance involved in the development of the overall plan and the annual operating budget. Verify that the process by which the budget is developed reflects the scope and complexity of the organization and that it was prepared under the direction of the organization's governance with representatives of governance, administrative personnel and medical personnel (if any).

Guidance: An organization with branches requires only one overall plan and one budget which should include the resources and expenditures of all branches.

Guidance: The organization's governance may serve as the committee that prepares the budget, provided that administrative and medical staff (if any) are included. Governance may choose to appoint a committee to prepare and review the annual budget, so long as the committee includes representatives from governance, administration, and medical personnel (if any). If the budget is prepared and reviewed by a committee, the organization's governance oversees the process and reviews and approves the annual budget.

Standards	Evidence Guidelines
FS.2.I.M3 The overall plan and operating budget are reviewed and updated at least annually under the direction of governance, by a committee that includes representatives from governance, administrative personnel, and medical personnel (if any). **Applicable Regulation: G988-484.105(h)(4).**	Document Review: Review budget committee minutes, or other documentation, to verify that financial policies/procedures and the operating budget are reviewed at least annually by representatives from governance, administration and medical personnel (if any). Minutes should include date, attendance, topics discussed, and actions taken. Guidance: The organization's governance may serve as the committee that prepares the budget, provided that administrative and medical staff (if any) are included. Governance may choose to appoint a committee to prepare and review the annual budget, so long as the committee includes representatives from governance, administration, and medical personnel (if any). If the budget is prepared and reviewed by a committee, the organization's governance oversees the process and reviews and approves the annual budget.
FS.2.I.M4 Capital expenditures are budgeted and managed in accordance with organizational policy and generally accepted accounting principles. For capital expenditures over $600,000, a capital expenditure plan is developed for at least a three-year period, including the operating budget year. The capital expenditure plan includes and identifies the anticipated sources of financing for, and the objectives of, each anticipated expenditure that, under generally accepted accounting principles, would be considered a capital item. The plan identifies the anticipated sources of funding for cash or operating shortfalls that may impact its products or services. **Applicable Regulation: G988-484.105(h)(2).**	Document Review: If the organization has capital expenditures over $600,000, review the capital expenditure plan. Verify that the plan is developed for a three-year period and includes all provisions listed. Interview: Interview the individual overseeing financial management. If the organization has capital expenditures, validate, through specific examples, the ways in which capital expenditures are budgeted and managed.

Standards	Evidence Guidelines
FS.2.I.M5 The capital expenditure plan is prepared, reviewed, and updated annually under the direction of the organization's governance. **Applicable Regulation: G988-484.105(h).**	Document Review: Review minutes from meetings or other documentation of the organization's governance to verify oversight of the preparation and annual review, as well as approval of the capital expenditure plan.
FS.2.I.M6 If the capital expenditure plan includes anticipated financing from Title V (Maternal and Child Health and Crippled Children's Services), Title XVIII (Medicare), or Title XIX (Medicaid) of the Social Security Act, the plan specifies: 1. Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963; 2. Whether a capital expenditure proposal has been submitted to the designated planning organization for approval in accordance with Section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations; and 3. Whether the designated planning organization has approved or disapproved the proposed capital expenditure if it was presented to that organization. **Applicable Regulation: G988-484.105(h)(2).**	Document Review: Review the capital expenditure plan, if applicable. Verify that it includes anticipated funding from the listed sources and that all provisions listed are specified in the plan. Guidance: Capital expenditures are funds spent to acquire or upgrade physical assets (property, equipment, etc.). This standard applies only to capital expenditures over $600,000. In determining if a single capital expenditure meets or exceeds the threshold, include the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition. Improvement, modernization, expansion, or replacement of land, plant, buildings, and equipment should also be included in the valuation. Transactions that are separated in time but are components of an overall plan are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees; permit and license fees; broker commissions; architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds and notes; and other costs incurred for borrowing funds.

Information Management

KPA Statement

Organizations implement information management systems that support clinical and business intelligence, including processes for collecting, storing, transmitting, and protecting data. Information management systems support the use and analysis of data to inform decision-making.

Standards	Evidence Guidelines
IM.1.D Information management policies and procedures address how the organization collects, protects, shares, and retains information in accordance with local, state, and federal law and regulation.	Document Review: Review policies and procedures or other documentation related to information management. Validate that they describe how the organization collects, protects, shares, and retains information in accordance with local, state, and federal law and regulation.
IM.1.D.M2 In the event the organization discontinues operations, policies stipulate procedures for: 1. Record retention; and 2. Notification to the state agency of where records will be maintained. **Applicable Regulation: G1026-484.110(c)(2).**	Document Review: Review policies regarding record retention. Verify that the policy includes provisions for the retention of records in the event the organization discontinues operations, including notification to the state agency of where records will be maintained.

Standards	Evidence Guidelines
IM.2.I Administrative, financial, patient, and personnel records are retained in accordance with organizational policy and local, state, and federal law and regulation.	Document Review: Review policies regarding record retention. Verify that records are retained for at least the duration required by organizational policy. Guidance: This standard applies to both paper and electronic records. Tip: State laws related to record retention may vary. A listing by state can be found at www.healthinfolaw.org. Information on Occupational Safety and Health Administration record retention requirements can be found at www.osha.gov.
IM.2.I.M1 Patient records are retained for five years after the discharge of the patient, unless state law stipulates a longer period of time. **Applicable Regulation: G1026-484.110(c)(1).**	Interview: Interview a key leader. Validate that patient records are retained for five years after the date of discharge, unless state law stipulates a longer period. Tip: Further guidance on record retention regulations can be found in MLN Matters No. SE1022 https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads/SE1022.pdf
IM.3.I The organization discloses information, upon request, to authorized agents and government officials in accordance with local, state, and federal law and regulation.	Interview: Interview a key leader. Verify the types of information the organization has, or is prepared to disclose, to authorized agents upon request in accordance with local, state, and federal law and regulation. Guidance: Information may be obtained by government officials or authorized agents on-site, via an inspection, or through a request for documentation.

Standards

IM.3.I.M1

The organization discloses the following information at the time of the initial request for certification, for each survey, and at the time of any change in ownership or management:

1. The name and address of all persons with an ownership or control interest in the organization as defined in §484.12(b) Sections 420.201, 420.202, and 420.206;
2. The name and address of each person who is an officer, a director, an agent, or a managing employee of the organization as defined in §484.12(b) Sections 420.201, 420.202, and 420.206; and
3. The name and address of the corporation, association, or other company that is responsible for the management of the organization, and the name and address of the chief executive officer and the chairperson of the board of directors of that corporation, association, or other company responsible for the management of the organization.

Applicable Regulations: G850-484.100(a); G852-484.100(a); G854-484.100(a)(1); G856-484.100(a)(2); G858-484.100(a)(3).

Evidence Guidelines

Document Review: Review the organization's initial request for certification. Verify that it contains all information required in the standard. If a change of ownership or management has occurred, verify that the required information was disclosed.

Guidance: This information will be reviewed by CHAP prior to the on-site survey visit. If necessary, it will be verified on-site.

IM.3.I.M2

The parent organization is responsible for reporting all branch locations of the organization to the state survey agency at the time of the organization's request for initial certification, at each survey, and at the time the parent proposes to add or delete a branch.

Applicable Regulations: G970-484.105(d); G972-484.105(d)(1).

Document Review: Review the organization's initial request for certification. Verify that it contains a list of all branch locations. If branches have been added or removed, verify that the information was reported to the state survey agency.

Guidance: The addition or relocation of a branch must be approved before it begins operations.

Guidance: This information will be reviewed by CHAP prior to the on-site survey visit. If necessary, it will be verified on-site.

Standards

IM.4.I

Patient information is accessed by authorized individuals as determined by the organization and as required by local, state, and federal law and regulation. The organization safeguards the patient record against loss, unauthorized use, or unauthorized access, including the protection of Protected Health Information (PHI). PHI is used and disclosed only for purposes permitted by law. Documented patient consent is obtained for release of information not authorized by law.

Applicable Regulation: G1028-484.110(d).

Evidence Guidelines

Interview: Interview personnel providing patient care or services. Clarify ways in which the confidentiality of patient information and records is protected. Clarify what patient information personnel access in order to provide care or service. Verify that the information supports their ability to perform their duties.

Interview: Interview a key leader. Validate that identified access and security risks related to the patient record have been addressed. Clarify what procedures are in place to ensure PHI is used and disclosed only as permitted by law and regulation. Validate whether any violations have occurred in the past year and how these were addressed.

Guidance: PHI is individually identifiable health information that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual, including demographic data, that relates to: the individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birthdate, Social Security number).

Guidance: The occurrence of a data security breach is not in itself a finding. If a breach occurs because proper safeguards are not in place, and/or it is not reported and addressed, the standard is cited. Any actions taken are in proportion to the size and scope of the identified breach.

Tip: An organization may employ a wide range of safeguards for data and information security. These might include locked doors or file cabinets, data encryption, passwords, firewalls, and badges.

Standards	Evidence Guidelines
IM.4.I.M1 A patient's record (whether hard copy or electronic) is made available to a patient, free of charge, upon request at the next home visit, or within four business days (whichever comes first). **Applicable Regulation: G1030-484.110(e).**	Document Review: Review policy related to release of information. Verify that it stipulates that the patient's record is made available to a patient, free of charge, upon request at the next home visit, or within four business days (whichever comes first). Interview: Interview person(s) responsible for releasing patient records. Discuss the process to request patient records, the authorization process, and the timeframes for release of records.
IM.4.I.M2 *Effective 1/1/2021* The patient record is made available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care and appropriate personnel. **Applicable Regulation: G1008-484.110.**	Interview: Interview a key clinical leader. Clarify the manner in which the patient record is made available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care and appropriate personnel.
IM.4.I.M3 The organization and any entity or individual acting on behalf of the organization, in accordance with a written contract, ensures the confidentiality of all patient identifiable information contained in the patient record, including Outcome and Assessment Information Set (OASIS) data. Identifiable OASIS information is not released to the public. **Applicable Regulation: G350-484.40.**	Document Review: Review policies related to the management patient information, including OASIS data. Validate that they contain provisions to protect the confidentiality of the patient record, including OASIS data. Interview: Interview a key leader and/or the individual responsible for transmitting OASIS data. Verify the ways in which the information contained in the patient record is safeguarded. Clarify ways in which OASIS data confidentiality is ensured. Contract Review: Review contracts with any entity or individual that manage OASIS data for the organization. Validate that the contract contains provisions to protect the confidentiality of OASIS data.

Standards

IM.5.D

The organization develops protocols for the standardized collection and documentation of patient data and information. Protocols include definitions, symbols, abbreviations, and acronyms prohibited by the organization.

Evidence Guidelines

Document Review: Review policies or other documents that address standardized documentation protocols for patient data. Verify that protocols include the prohibited use of symbols, abbreviations, and acronyms.

Guidance: Protocols are expected to address a standardized process for collection and documentation of patient data and information, as well as the list of prohibited definitions, symbols, abbreviations, and acronyms. It is not expected that protocols address all of the approved list of symbols, abbreviations, and acronyms

Tip: Confusing or ambiguous symbols, abbreviations and acronyms are known contributors to medical errors. Many resources are available that address the safe use of symbols, abbreviations, and acronyms. Some of these may be found on the NANDA International website. The FDA and the Institute for Safe Medication Practices also provide guidance on this topic.

IM.5.I

The organization uses standardized formats for documenting the delivery of care and services, consistent with their policies and procedures. Personnel do not use abbreviations, acronyms, or symbols prohibited by the organization.

Record Review: Review patient records. Validate that entries are made using a standardized format for documenting the delivery of care and services, consistent with the organization's policies and procedures. Verify that abbreviations, acronyms, and symbols prohibited by the organization are not used in the documentation of care and services or for internal and external communication of any information about the patient.

Guidance: The format for recording required elements is determined by the organization. Records may be in paper or electronic form, and the method(s) for recording data may vary depending on the electronic record and organizational policy.

Standards	Evidence Guidelines
IM.5.I.M1 The organization maintains a patient record containing past and current information for every patient accepted and receiving home health services. Information contained in the patient record is accurate and adheres to current patient record documentation standards of practice. **Applicable Regulation: G1008-484.110.**	Record Review: Review patient records. Validate that the records that are maintained contain past and current information for every patient accepted and receiving home health services. Verify that information contained in the patient record is accurate and adheres to current patient record documentation standards of practice.
IM.5.I.M2 Entries in records are legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication includes a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. **Applicable Regulation: G1024-484.110(b).**	Record Review: Review patient records. Validate that entries are legible, clear, complete, and appropriately authenticated, dated, and timed. Verify that authentication includes a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.

Standards

IM.6.I

The organization transmits or shares data with external parties in compliance with local, state, and federal law or regulation.

Evidence Guidelines

Interview: Interview a key leader. Clarify processes for transmitting information to external parties.

Record Review: Review patient records or other records that share information with external parties. Review at least one transfer record if possible.

Guidance: Evidence of compliance with this standard might include transfer of records, communication notes with a patient's physician, or report of an incident to local, state, or federal authorities. The information can be in paper, telephonic, or electronic format.

Guidance: Organizations are expected to ensure that the requirements outlined in their data and information policies are followed when transmitting data to ensure that Protected Health Information is safeguarded.

Standards

IM.6.I.M1

The organization encodes and electronically transmits each completed Outcome and Assessment Information Set (OASIS) assessment to the Centers for Medicare & Medicaid Services (CMS) system regarding each patient within 30 days of completing the assessment of the beneficiary. The encoded OASIS data accurately reflect the beneficiary's status at the time of assessment. Data are encoded and transmitted using the software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set.

Applicable Regulations: G370-484.45; G372-484.45(a); G374-484.45(b); G376-484.45(c); G378-484.45(c)(1); G386-484.45(d).

Evidence Guidelines

Document Review: Review OASIS transmissions to validate that they are sent within 30 days of completed the assessment of the patient. Review the OASIS Error Summary Report to determine the percentage of #286 errors. Review Final Validation Reports to determine the number of assessments with error #282. Review the policy for transmission of OASIS assessment data and the policy or process for review of and corrections to OASIS assessments prior to transmission to the Assessment Submission and Processing System. Verify that electronically reported OASIS data are in a format that meets CMS electronic data and edit specifications for all applicable patients.

Interview: Interview person(s) responsible for the transmission of OASIS assessments. Validate the frequency of transmissions and the process in place to ensure timeliness, accuracy, and completion of submission.

Tip: OASIS Certification And Survey Provider Enhanced Reports CASPER and Error Summary Reports provide information to validate accurate OASIS data transmission. More information can be found on the CMS website.

IM.6.I.M3

Effective 1/1/2021

The organization transmits data using data communication software that complies with the Federal Information Processing Standard (FIPS 140-2, issued May 25, 2001) to the Centers for Medicare & Medicaid Services collection site.

Applicable Regulation: G382-484.45(c)(2).

Interview: Interview person(s) responsible for managing Outcome and Assessment Information Set transmissions. Validate that the organization uses an application that correctly formats the data transmission. Clarify the process used to monitor the success or failure of each transmission.

Standards	Evidence Guidelines
IM.6.I.M4 *Effective 1/1/2021* Outcome and Assessment Information Set (OASIS) data transmission includes Centers for Medicare & Medicaid Services (CMS)-assigned branch identification number as applicable. **Applicable Regulation: G384-484.45(c)(3).**	Document Review: Review OASIS transmissions. Verify that OASIS data transmission includes CMS-assigned branch identification number, as applicable.
IM.7.I The organization maintains a current record of patient care and services.	Record Review: Review patient records. Validate that a record is present for each patient accepted for care and services.

Standards

IM.7.I.M1

Effective 1/1/2021

Patient records contain, at a minimum:

1. Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s);
2. Consent for care and services;
3. The patient's current comprehensive assessment, including all assessments from the most recent home health admission;
4. An initial and updated (as appropriate) care plan;
5. Patient and caregiver education and training included in the care plan;
6. Physician or allowed practitioner orders, including documentation of verbal orders (if any);
7. Clinical progress notes;
8. All interventions, including medication administration, treatments, and services;
9. Responses to interventions; and
10. Goals in the patient's plans of care and the patient's progress toward achieving them.

Applicable Regulations: G1010-484.110(a); G1012-484.110(a)(1); G1014-484.110(a)(2); G1016-484.110(a)(3); G1018-484.110(a)(4); G542-484.55(c)(8); G584-484.60(b)(4).

Evidence Guidelines

Record Review: Review patient or other records of care and service. Validate that the requirements of the standard are met.

Standards

IM.7.I.M2

If the patient has been discharged or transferred, the patient record contains, at a minimum, the contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization and either:

1. A completed discharge summary that is sent to the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization (if any) within five business days of the patient's discharge;
2. A completed transfer summary that is sent within two business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or
3. A completed transfer summary that is sent within two business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time when the organization becomes aware of the transfer.

Applicable Regulations: G1010-484.110(a); G1020-484.110(a)(5); G1022-484.110(a)(6).

Evidence Guidelines

Record Review: Review patient or other records of care and service for patients who have been discharged or transferred. Validate that the requirements of the standard are met.

Guidance: This information may be found in patient charts, customer files, or computer systems as determined by the organization's size and scope of service.

Key Terms

Abuse: The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain or mental anguish.

ADA: Americans with Disabilities Act

Administrator: A general manager, business manager, director, or other individual who exercises operational or managerial control over and/or conducts the day-to-day operations of an organization.

Adverse Drug Event (ADE): Injury or harm to the patient resulting from medical care involving medication use. Examples include anaphylaxis from penicillin, major hemorrhage from heparin, aminoglycoside-induced renal failure, and agranulocytosis from chloramphenicol. Some ADEs may not be the result of an error in the provision of care, while others, often referred to as "preventable ADEs," do involve some element of error (either of omission or commission) that ultimately reaches the patient.

Aide: A paraprofessional worker with specified training and/or certification to provide non-clinical care, such as assistance with personal hygiene or nutritional support, as assigned by his or her supervisor.

> **Certified Nursing Assistant (CNA):** A CNA helps patients in the home with healthcare needs under the supervision of a registered nurse (or a licensed practical nurse).
>
> **Home Health Aide:** A home health aide is trained and has demonstrated the competencies necessary to provide personal care to patients in their home environment. A home health aide must (i) successfully complete a training program and competency evaluation; (ii) successfully complete a competency evaluation; (iii) successfully complete a nurse aide training and competency evaluation program approved by the state and be currently listed in good standing on the state nurse aide registry; or (iv) successfully complete a state licensure program.
>
> **Personal Care Aide (PCA):** A PCA may be referred to by different titles, such as a personal care attendant, within organizations. Personal care aides help patients with self-care and everyday tasks, such as bathing, dressing, and other personal care services supporting activities of daily living. They also may provide social supports and assistance that enable patients to participate in their communities. PCA qualifications are not standardized nationally; however, within home health organizations, PCAs who are employed by home health agencies to furnish services under a Medicaid personal care benefit must abide by all other requirements for home health aides.

Allowed Practitioner: Allowed practitioners are defined in a State Practice Act and may include nurse practitioners, physician assistants, and clinical nurse specialists.

All-Hazards Approach: An integrated approach for prevention, mitigation, preparedness, response, continuity, and recovery that addresses a full range of threats and hazards, including natural, human-caused, emerging infectious disease, and technology-caused. This approach is specific to the location of the provider and the particular types of hazards which most likely occur in their geographic area.

Alternate Site: A location furnishing care or services that is supervised and under the administrative control of the main/parent location. Alternate sites include branches for home health and hospice organizations and distribution centers or warehouses for DME providers and pharmacies.

Audiologist: A person who (a) meets the education and experience requirements for a Certificate of Clinical Competence in audiology granted by the American Speech-Language-Hearing Association; or (b) meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

Bloodborne Pathogens: As described by the Occupational Safety and Health Administration, bloodborne pathogens are pathogenic microorganisms present in human blood that can cause disease in humans. These pathogens include hepatitis B virus (HBV), hepatitis C virus (HCV), and human immunodeficiency virus (HIV).

Branch Office: An approved location from which an organization provides services within a portion of the total geographic area served by the parent organization. The parent organization provides supervision and administrative control of any branch office. It is unnecessary for the branch office to independently meet the conditions of participation as a home health organization.

Care: For the purposes of the CHAP standards, the word "care" may represent "care and/or services."

Caregiver: A person or persons, other than agency personnel formally included in the provider care team, who gives help and protection to and/or who is responsible for attending to the needs of a child or dependent adult. A caregiver, as defined by the patient, could be a family member, neighbor, private-pay individual, or other individual external to the organization.

Care Plan: A care plan includes an identified set of shared goals among all members of the care team and the patient that serve as a road map for the provision of all care and services. Plans differ in their scope and complexity depending on the patient's needs, as well as the scope of services provided. Care plans are individualized, fluid, and changeable as the patient's status changes. In home health organizations, this plan is commonly referred to as the patient's "plan of care" (POC).

Care Planning: The necessary steps followed by all members of the care team to achieve the identified goals of the care plan. Care planning is an interactive and evolving interdisciplinary process that occurs across the continuum of care and engages all disciplines involved in the care of the patient, as well as patients, families, and caregivers, in care decisions.

Care Transitions: A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different settings or different levels of care within the same setting.

Centers for Medicare and Medicaid Services (CMS): A federal agency within the Department of Health and Human Services. CMS administers the Medicare program and works in partnership with state governments to administer Medicaid, the State Children's Health Insurance Program, and health insurance portability standards.

Centers for Disease Control and Prevention (CDC): A federal agency under the Department of Health and Human Services. The CDC's main goal is to protect the public's health and safety through prevention and control of disease, injury, and disability. The CDC focuses its attention on infectious diseases, foodborne pathogens, environmental health, occupational safety, health promotion, injury prevention, and educational activities.

Chief Financial Officer (CFO): The corporate officer primarily responsible for managing the financial risks of the organization. This officer is also responsible for financial planning and record-keeping, as well as financial reporting to higher management.

Clinical Manager: One or more qualified individuals who provide oversight of all patient care services and personnel, including (1) making patient and personnel assignments; (2) coordinating patient care; (3) coordinating referrals; (4) ensuring that patient needs are continually assessed; and (5) ensuring the development, implementation, and updating of the individualized plan of care.

Clinical Nurse Specialist (CNS): A CNS must be a registered nurse who is currently licensed to practice in the State where he or she practices and be authorized to perform the services of a clinical nurse specialist in accordance with State law. A CNS performs services while working in collaboration with a physician. A CNS must have a master's degree in a defined clinical area of nursing from an accredited educational institution or a Doctor of Nursing Practice (DNP) doctoral degree. A CNS must be certified as a clinical nurse specialist by a national certifying body that has established standards for clinical nurse specialists and that is approved by the Secretary.

Collaboration: Collaboration is a process in which a CNS or NP works with one or more physicians to deliver health care services within the scope of the practitioner's expertise, with medical direction and appropriate supervision as provided for in jointly developed guidelines or other mechanisms as provided by the law of the State in which the services are performed. In the absence of State law governing collaboration, collaboration is a process in which a CNS or NP has a relationship with one or more physicians to deliver health care services. Such collaboration is to be evidenced by the CNS or NP documenting their scope of practice and indicating the relationships that they have with physicians to deal with issues outside their scope of practice. The CNS or NP must document this collaborative process with physicians. The collaborating physician does not need to be present with the CNS or NP when the services are furnished or to make an independent evaluation of each patient who is seen by the CNS or NP.

Continuous Quality Improvement (CQI): A comprehensive approach to quality improvement that involves the implementation of systematic and cyclical approaches to monitor, assess, and improve the quality of health care. Home health and hospice regulations refer to this type of program as a quality assessment and performance improvement program (QAPI).

Emerging Infectious Diseases (EIDs): Emerging infectious diseases are infections that have recently appeared within a population or those whose incidence or geographic range is rapidly increasing or threatens to increase in the near future.

Environment: Environment includes all buildings, warehouses, and storage facilities owned or operated by the organization, as well as all settings in which patients receive services by the organization.

Exploitation: Controlling or taking advantage of by artful, unfair, or insidious means. This may include taking financial advantage of a disabled or elderly person. State law for preventing abuse, neglect, and exploitation, rules and protections vary tremendously from state to state.

Facility: A building, storage site, warehouse, inpatient care setting, or administrative space (not the patient home) owned, operated, or leased by an organization.

Full Scale Exercise: Any operations-based exercise (drill, functional, or full-scale exercise) that assesses an organization's functional capabilities by simulating a response to an emergency that would impact the organization's operations and their community.

Goal, Measure, Outcome: Goals are the broad and general aims the organization is trying to achieve, and are often tied to its mission or business objectives. Measures (also called indicators) are used to track progress toward achieving outcomes. Outcomes define the specific measurable results related to the actions taken to achieve a goal.

Governance/Governing Body: An organization's governance is a body composed of one or more persons who are authorized by the organization to formulate policies, provide oversight, and direct the affairs of the organization in partnership with the organization's leaders and leadership. Governance assumes full authority and legal responsibility for the management of the organization, the provision of all care or services, fiscal operations, and continuous quality assessment and performance improvement. Additionally, it is responsible for ensuring that the organization is effectively managed by its leadership. An organization's governance can range from a single individual to a board of directors. The size and composition of the governance should be appropriate to manage the size and complexity of the organization and the types of services provided.

Home: A patient's place of residence. This may be a private home, an assisted living facility, an extended care or skilled nursing facility, a group home, etc.

Health Insurance Portability and Accountability Act (HIPAA): A federal law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans and medical care providers. HIPAA seeks to establish standardized mechanisms for electronic data interchange, as well as the security and confidentiality of all healthcare-related data. The law mandates standardized formats for all patient health, administrative, and financial data; unique identifiers for each healthcare entity (e.g., individuals, employers, health plans, and health care providers); and security mechanisms to ensure confidentiality and data integrity for any information that identifies an individual.

ICF/IID: Acronym refers to Intermediate Care Facilities for Individuals with Intellectual Disability.

Immediately: Within the CHAP standards, the term "immediately" is intended to mean soon as possible, but not to exceed 24 hours after discovery of an incident, in the absence of shorter state timeframe requirements.

Improvement Model(s): A structured model or set of processes to guide improvement and organizational change. These models include processes for planning, assessment, and ongoing monitoring. Examples include: Find-Organize-Clarify-Understand-Select (FOCUS), Plan-Do-Check-Act (PDCA), Plan-Do-Study-Act (PDSA), and the Associates in Process Improvement (API) Model for Improvement.

Information Management System: A systematic approach that provides the tools to organize, evaluate, and efficiently manage all data and information necessary to make informed decisions about the provision of care and services. Information management systems define processes that govern the quality, ownership, use, and security of information. This includes the physical infrastructure, software, and/or hardware that facilitate organization, storage, protection, retrieval, and analysis of information. In this context, "information" refers to all types of information, regardless of origin (i.e., collected by the organization or provided to the organization) or type (e.g., paper, electronic, audio, video, verbal).

In-patient Rehab Facility (IRF): A facility located in a hospital that provides a high level of intensive therapy as well as specialized nursing and physician care. It may include close medical supervision by physician with specialized training; twenty-four-hour rehabilitation nursing; a multidisciplinary team of doctors, nurses, case managers and therapists; three hours of rehab therapy daily; and physical, occupational and/or speech therapy.

Leaders/Leadership: Management in the organization, including the Administrator.

Licensed Practical (Vocational) Nurse (LPN/LVN): A person who has completed a practical (vocational) nursing program, is licensed in the state where he or she practices, and furnishes services under the supervision of a qualified registered nurse.

List of Excluded Individuals and Entities (LEIE): The Office of the Inspector General (OIG) has the authority to exclude individuals and entities from federally funded healthcare programs (e.g., Medicare and Medicaid). The OIG maintains a list of all currently excluded individuals and entities called the List of Excluded Individuals and Entities. It is unlawful for a payment to be made from a federal healthcare program for any items or services furnished, ordered, or prescribed by an excluded individual or entity listed in the LEIE. Additionally, an organization who hires an individual or entity listed on the LEIE may be subject to civil monetary penalties.

Location: Any parent agency, branch, or site that has a customer identification number.

Long-Term Care Hospital (LTCH): An acute-care hospital with a focus on patients who, on average, stay more than 25 days. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home.

Management: The qualified persons that plan, organize, direct, and supervise the clinical and business operations within an organization.

Medical Necessity: According to 42 U.S.C. § 1395y(a)(1)(A), medical necessity is defined as medical treatment and/or services "reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member."

Medication: A drug or other substance (e.g., oxygen) used to treat disease or injury. A medication may be commonly referred to as a drug, medicament, medicine, or pharmaceutical.

Medication Reconciliation: The process of identifying the most accurate list of all medications that the patient is taking, including name, dosage, frequency, and route, by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider.

Medication Review: A review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. The medication review is often conducted in conjunction with a medication reconciliation**.**

Mental Health Care: Care and services provided to patients with one or more mental disorders or health conditions characterized by a change in mood, thought, or behavior that makes daily activities difficult and impairs a person's ability to work, interact with family, or fulfill other major life functions.

Mental Abuse: Includes, but is not limited to, humiliation, harassment, and threats of punishment or deprivation.

Misappropriation of Patient Property: The deliberate misplacement, exploitation, or wrongful temporary or permanent use of a patient's belongings or money without the patient's consent.

Mistreatment: To treat badly or abusively (refer to definitions for the different types of abuse listed in this document: verbal, physical, mental, sexual; also see misappropriation of patient property).

Neglect: A failure to provide goods and services necessary to avoid physical harm or mental anguish.

NF: Acronym refers to Nursing Facility.

Nurse Practitioner (NP) : A NP must be a registered professional nurse who is authorized by the State in which the services are furnished to practice as a nurse practitioner in accordance with State law, performs services while working in collaboration with a physician, and must meet one of the following: (1) Obtained Medicare billing privileges as a nurse practitioner for the first time on or after January 1, 2003, and is certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners, and possess a master's degree in nursing or a Doctor of Nursing Practice (DNP) doctoral degree; (2) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2003, and is certified as a nurse practitioner by a recognized national certifying body that has established standards for nurse practitioners; or (3) Obtained Medicare billing privileges as a nurse practitioner for the first time before January 1, 2001.

Occupational Therapist (OT): An occupational therapist is a person who is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which he or she practices, unless licensure does not apply, and who has met the educational requirements established in §42 CFR 484.115(f): Occupational therapist. A person who—

(1) (i) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing, unless licensure does not apply; (ii) Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and (iii) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(2) On or before December 31, 2009— (i) Is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing; or (ii) When licensure or other regulation does not apply— (A) Graduated after successful completion of an occupational therapist education program accredited by the accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or successor organizations of ACOTE; and (B) Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc., (NBCOT).

(3) On or before January 1, 2008—(i) Graduated after successful completion of an occupational therapy program accredited jointly by the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Occupational Therapy Association; or (ii) Is eligible for the National Registration Examination of the American Occupational Therapy Association or the National Board for Certification in Occupational Therapy.

(4) On or before December 31, 1977— (i) Had 2 years of appropriate experience as an occupational therapist; and (ii) Had achieved a satisfactory grade on an occupational therapist proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(5) If educated outside the United States, must meet both of the following :(i) Graduated after successful completion of an occupational therapist education program accredited as substantially equivalent to occupational therapist entry level education in the United States by one of the following: (A) The Accreditation Council for

Occupational Therapy Education (ACOTE). (B) Successor organizations of ACOTE. (C) The World Federation of Occupational Therapists. (D) A credentialing body approved by the American Occupational Therapy Association. (E) Successfully completed the entry level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT). (ii) On or before December 31, 2009, is licensed or otherwise regulated, if applicable, as an occupational therapist by the state in which practicing.

Occupational Therapy Assistant/Certified Occupational Assistant(COTA): A person who is licensed—unless licensure does not apply, or is otherwise regulated, if applicable—as an occupational therapy assistant by the state in which practicing, and who meets the educational requirements established in §42 CFR 484.115(g): Occupational therapy assistant. A person who—

(1) Meets all of the following: (i) Is licensed or otherwise regulated, if applicable, as an occupational therapy assistant by the state in which practicing, unless licensure does not apply. (ii) Graduated after successful completion of an occupational therapy assistant education program accredited by the Accreditation Council for Occupational Therapy Education, (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA) or its successor organizations. (iii) Is eligible to take or successfully completed the entry-level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

(2) On or before December 31, 2009—(i) Is licensed or otherwise regulated as an occupational therapy assistant, if applicable, by the state in which practicing; or any qualifications defined by the state in which practicing, unless licensure does not apply; or (ii) Must meet both of the following: (A) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association. (B) After January 1, 2010, meets the requirements in paragraph (f)(1) of this section.

(3) After December 31, 1977 and on or before December 31, 2007—(i) Completed certification requirements to practice as an occupational therapy assistant established by a credentialing organization approved by the American Occupational Therapy Association; or (ii) Completed the requirements to practice as an occupational therapy assistant applicable in the state in which practicing.

(4) On or before December 31, 1977—(i) Had 2 years of appropriate experience as an occupational therapy assistant; and (ii) Had achieved a satisfactory grade on an occupational therapy assistant proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(5) If educated outside the United States, on or after January 1, 2008—(i) Graduated after successful completion of an occupational therapy assistant education program that is accredited as substantially equivalent to occupational therapist assistant entry level education in the United States by— (A) The Accreditation Council for Occupational Therapy Education (ACOTE). (B) Its successor organizations. (C) The World Federation of Occupational Therapists. (D) By a credentialing body approved by the American Occupational Therapy Association; and (E) Successfully completed the entry level certification examination for occupational therapy assistants developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).

Occupational Exposure: As defined by the Occupational Safety and Health Administration, occupational exposure refers to the reasonable anticipation of skin, eye, mucous membrane, or parenteral contact with blood or other potentially infectious materials (e.g., pleural fluid or any body fluid that is visibly contaminated with blood) that may result from the performance of personnel duties.

Occupational Safety and Health Administration (OSHA): A federal agency that is part of the Department of Labor. OSHA's Bloodborne Pathogen Standards prescribe safeguards to protect healthcare workers and patients against health hazards caused by bloodborne pathogens, imposing federal requirements on employers whose personnel can reasonably anticipate contact with blood or other potentially infectious materials. The requirements address items such as exposure control plans, universal precautions, engineering and work practice controls, personal protective equipment, housekeeping, laboratories, hepatitis B vaccination, post- exposure follow-up, hazard communication and training, and record-keeping.

Office of the Inspector General (OIG): An office that is part of Cabinet departments and independent agencies of the federal government as well as some state and local governments. Each office includes an Inspector General and employees charged with identifying, auditing, and investigating fraud, waste, abuse, and mismanagement within the parent agency. Within the CHAP standards, OIG is in reference to the office within the Department of Health and Human Services.

Other Potentially Infectious Material (OPIM): According to the Occupational Safety and Health Administration, OPIM includes the following: "(1) semen, vaginal secretions, cerebrospinal fluid, synovial fluid, pleural fluid, pericardial fluid, peritoneal fluid, amniotic fluid, saliva in dental procedures, any body fluid that is visibly contaminated with blood, and all body fluids in situations where it is difficult or impossible to differentiate between body fluids; (2) any unfixed tissue or organ (other than intact skin) from a human (living or dead); and (3) HIV-containing cell or tissue cultures, organ cultures, and HIV- or HBV-containing culture medium or other solutions; and blood, organs, or other tissues from experimental animals infected with HIV or HBV."

Outcome and Assessment Information Set (OASIS): The data collection tool used by Medicare to ensure that standard quality care is being provided by home health organizations across the United States. It includes a group of data elements that represent core items of a comprehensive assessment for an adult home care patient and form the basis for measuring patient outcomes for purposes of outcome-based quality improvement.

Parent Agency: A location for which CHAP has a signed Accreditation Service Agreement and which: (1) exhibits the authority to provide supervision and administrative control of branch offices; or (2) serves as a central location/headquarters for other locations from which services originate or where personnel perform their assigned duties and responsibilities.

Patient: An individual who receives care or services provided by an organization, its employees, volunteers, and/or contracted staff, toward maintenance, improvement, or protection of health or lessening of illness, disability, or pain. For the purposes of the CHAP standards, the use of the word "patient" may also indicate client, customer, the family and caregivers.

Patient Legal Representative: The person who participates in making legally binding decisions related to the patient's care or well-being. The legal representative can also be the parent of a minor child, the patient's guardian, or the holder of the Durable Power of Attorney of an incapacitated patient.

Patient Record/Clinical Record: The patient record may also be referred to as the clinical record, medical record, health record, or medical chart. The terms are used somewhat interchangeably to describe the systematic documentation of a single patient's medical history, care and service delivery across time. For the purposes of the CHAP standards, this documentation is referred to as the patient record.

Patient Representative/Patient-Selected Representative: A representative, designated by the patient, who could be a family member or friend. A patient-selected representative may accompany the patient; act as a liaison between the patient and the organization to help the patient communicate, understand, remember, and cope with the interactions that take place; and explain any instructions to the patient that are delivered by the organization's personnel. The representative does not need to be the patient's legal representative. The patient determines the role of the representative, to the extent possible, as described in *Federal Register* Vol. 82, No. 9, January 13, 2017. The extent of such representation may vary from one patient to another. A professional interpreter is not considered to be a patient's representative.

Performance Improvement (PI): Activities undertaken, based on findings from the Continuous Quality Improvement Program, to improve the quality of services provided to patients and their families

Personal Protective Equipment (PPE): PPE refers to protective clothing, helmets, goggles, or other garments or equipment designed to protect the wearer's body from injury or infection. The hazards addressed by protective equipment include physical hazards, electrical hazards, heat, chemicals, biohazards, and airborne particulate matter. Examples of PPE include such items as gloves, foot and eye protection, respirators, masks, and gowns.

Personnel: All employees who are issued a W-2 form by the organization, as well as any volunteers and contracted staff who perform duties or other responsibilities related either directly or indirectly to patient care on behalf of the organization.

Physical Therapist (PT): A person who is licensed, if applicable, by the state in which he or she practices, unless licensure does not apply, and who meets the educational requirements established in §42 CFR 484.115(h): Physical therapist. A person who is licensed, if applicable, by the state in which practicing, unless licensure does not apply and meets one of the following requirements:

(1) (i) Graduated after successful completion of a physical therapist education program approved by one of the following: (A) The Commission on Accreditation in Physical Therapy Education (CAPTE). (B) Successor organizations of CAPTE. (C) An education program outside the United States determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15(e) as it relates to physical therapists. (ii) Passed an examination for physical therapists approved by the state in which physical therapy services are provided.

(2) On or before December 31, 2009—(i) Graduated after successful completion of a physical therapy curriculum approved by the Commission on Accreditation in Physical Therapy Education (CAPTE); or (ii) Meets both of the following: (A) Graduated after successful completion of an education program determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified in 8 CFR 212.15(e) as it relates to physical therapists. (B) Passed an examination for physical therapists approved by the state in which physical therapy services are provided.

(3) Before January 1, 2008 graduated from a physical therapy curriculum approved by one of the following: (i) The American Physical Therapy Association. (ii) The Committee on Allied Health Education and Accreditation of the American Medical Association. (iii) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association.

(4) On or before December 31, 1977 was licensed or qualified as a physical therapist and meets both of the following: (i) Has 2 years of appropriate experience as a physical therapist. (ii) Has achieved a satisfactory grade on

a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

(5) Before January 1, 1966— (i) Was admitted to membership by the American Physical Therapy Association; (ii) Was admitted to registration by the American Registry of Physical Therapists; or (iii) Graduated from a physical therapy curriculum in a 4-year college or university approved by a state department of education.

(6) Before January 1, 1966 was licensed or registered, and before January 1, 1970, had 15 years of fulltime experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy.

(7) If trained outside the United States before January 1, 2008, meets the following requirements: (i) Was graduated since 1928 from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy. (ii) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy.

Physical Therapy Assistant (PTA): A person who is licensed, registered, or certified as a physical therapist assistant, as required, by the state in which he or she practices, and who meets the educational requirements established in §42 CFR 484.115(i): Physical therapist assistant. A person who is licensed, registered or certified as a physical therapist assistant, if applicable, by the state in which practicing, unless licensure does not apply and meets one of the following requirements:

(1)(i) Graduated from a physical therapist assistant curriculum approved by the Commission on Accreditation in Physical Therapy Education of the American Physical Therapy Association; or if educated outside the United States or trained in the United States military, graduated from an education program determined to be substantially equivalent to physical therapist assistant entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or identified at 8 CFR 212.15(e); and (ii) Passed a national examination for physical therapist assistants.

(2) On or before December 31, 2009, meets one of the following: (i) Is licensed, or otherwise regulated in the state in which practicing.(ii) In states where licensure or other regulations do not apply, graduated before December 31, 2009, from a 2-year college-level program approved by the American Physical Therapy Association and after January 1, 2010, meets the requirements of paragraph (h)(1) of this section.

(3) Before January 1, 2008, where licensure or other regulation does not apply, graduated from a 2-year college level program approved by the American Physical Therapy Association.

(4) On or before December 31, 1977, was licensed or qualified as a physical therapist assistant and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service.

Physical Abuse: Includes, but is not limited to, hitting, slapping, pinching, and kicking. It also includes controlling behavior through corporal punishment.

Physician: A doctor of medicine, osteopathy, or podiatry podiatric medicine legally authorized to practice medicine and surgery by the state in which such function or action is performed and who is not precluded from performing this function under prior determination of medical necessity for physicians' services. A “Prior Determination of Medical Necessity” means an individual decision by a Medicare contractor, before a physician's service is furnished, as to whether or not the physician's service is covered consistent with the requirements of section 1862(a)(1)(A) of the Act relating to medical necessity. (A doctor of podiatric medicine may perform only plan of treatment functions that are consistent with the functions he or she is authorized to perform under State law.)

Physician Assistant (PA): A PA must have graduated from a physician assistant educational program that is accredited by the Commission on Accreditation of Allied Health Education Programs; or have passed the national certification examination that is administered by the National Commission on Certification of Physician Assistants. A PA must be licensed by the State to practice as a physician assistant. A PA is legally authorized to perform the services in the State in which they are performed. A PA performs services that are not otherwise precluded from coverage because of a statutory exclusion. A PA performs the services in accordance with state law and state scope of practice rules for PAs in the state in which the PA's professional services are furnished. Any state laws and scope of practice rules that describe the required practice relationship between physicians and PAs, including explicit supervisory or collaborative practice requirements, describe a form of supervision for purposes of section 1861(s)(2)(K)(i) of the Act. For states with no explicit state law and scope of practice rules regarding physician supervision of PA's services, physician supervision is a process in which a PA has a working relationship with one or more physicians to supervise the delivery of their health care services. Such physician supervision is evidenced by documenting at the practice level the PA's scope of practice and the working relationships the PA has with the supervising physician/s when furnishing professional services.

PRN: Abbreviation for Latin phrase "pro re nata"—as needed; as circumstances require.

Professional Personnel/Healthcare Professional/Skilled Professional: A person who is licensed (if licensure is required) by a state organization to conduct activities within the scope of defined professional practice. Professional personnel include physicians, registered nurses, physical and occupational therapists, speech-language pathologists, registered dieticians, audiologists, pharmacists, and masters of social work.

Protected Health Information (PHI): Information about health status, treatment, services, or payment that can be linked to a specific patient. PHI includes any part of a patient's medical record or payment history. Securing protected health information is a fundamental step to ensuring patient privacy. Federal laws require that organizations safeguard patient privacy by protecting critical patient information, whether it is stored on paper or electronically.

Pseudo-patient: A person trained to participate in a role-play situation, or a computer-based mannequin device. A pseudo-patient must be capable of responding to and interacting with the home health aide trainee, and must demonstrate the general characteristics of the primary patient population served by the home health organization in key areas such as age, frailty, functional status, and cognitive status.

Psychiatric Care: Refers to the care of patients with an active psychosis or diagnosed psychiatric disorder.

QIES ASAP System: The national OASIS Assessment Submission and Processing (ASAP) System by which Medicare-certified home health organizations submit/transmit OASIS assessment data to CMS.

Registered Nurse (RN): A graduate of an approved school of professional nursing who is licensed as a registered nurse by the state in which he or she practices.

Remediation/Remedial Measures: Corrective and disciplinary action, which includes a preventive component to ensure the problem does not occur in the future.

Requirements: References to local, state, and/or federal requirements throughout the CHAP standards include all finalized laws and regulations.

Safe Medical Devices Act: A law that gives the Food and Drug Administration (FDA) authority to regulate medical devices in order to quickly learn when a medical device has caused an adverse patient event or experience, and to ensure that hazardous devices are removed from healthcare facilities in a timely manner. Adverse experiences are defined by the FDA to include concussions, fractures, burns, temporary paralysis, and temporary loss of sight, hearing, or smell.

Sexual Abuse: Includes, but is not limited to, sexual harassment, sexual coercion, and sexual assault.

Simulation: A training and assessment technique that mimics the reality of the homecare environment, including environmental distractions and constraints that evoke or replicate substantial aspects of the real world in a fully interactive fashion, in order to teach and assess proficiency in performing skills, and to promote decision making and critical thinking.

Skilled Nursing Facility (SNF): Post-hospital care provided at a facility. Skilled nursing care includes services such as administration of medications, tube feedings, and wound care. SNFs can be part of nursing homes or hospitals.

Skilled Professional Assistant: A healthcare worker under the supervision of a licensed health professional such as a registered nurse, therapist, or master of social work. Skilled professional assistants include licensed practical (vocational) nurses, physical therapy assistants, occupational therapy assistants, and social work assistants.

Social Worker (SW/MSW): A person who has a master's degree from a school of social work accredited by the Council on Social Work Education and has one year of social work experience in a healthcare setting.

Social Work Assistant (SWA): A person who: (1) has a baccalaureate degree in social work, psychology, sociology, or other field related to social work, and has had at least one year of social work experience in a health care setting; or (2) has two years of appropriate experience as a social work assistant, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.

Speech-Language Pathologist (SLP): A person who (1) meets the education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association; or (2) meets the educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

Standards of Practice: Standards of professional practice explain the goals, values, and ethical precepts that direct the profession. Examples of professional standards of practice include: Scope and Standards of Practice from the American Psychiatric Nurses Association; American Nurses Association Scope and Standards of Practice; Standards for the Practice of Clinical Social Work, Standards of Practice for Physical Therapy, Standards of Practice for Clinical Pharmacists, the Hospice and Palliative Nurses Association Clinical Practice Guidelines for Quality Palliative Care, and the American Association for Respiratory Care Clinical Practice Guidelines.

Summary Report: The compilation of the pertinent factors of a patient's clinical notes that is submitted to the patient's physician.

Supervised Practical Training: Supervised practical training means training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while providing covered services to an individual (a patient or pseudo-patient) under the direct supervision of either a registered nurse or a licensed practical nurse who is under the supervision of a registered nurse.

Surveillance: Surveillance in public health is defined by the Centers for Disease Control and Prevention as "the ongoing, systematic collection, analysis, interpretation, and dissemination of data regarding a health-related event for use in public health action to reduce morbidity and mortality and to improve [the public's] health." Surveillance, as part of an infection prevention and control program, is a comprehensive method of measuring outcomes such as healthcare-acquired infections and related processes of care to provide information to organizations in an effort to improve the safety and quality of patient care or services.

Telecommunications: Telecommunications technology, as indicated on the plan of care, can include: remote patient monitoring, defined as the collection of physiologic data (for example, ECG, blood pressure, glucose monitoring) digitally stored and/or transmitted by the patient or caregiver or both to the home health agency; teletypewriter (TTY); and 2-way audio-video telecommunications technology that allows for real-time interaction between the patient and clinician.

Verbal Abuse: The use of oral, written, or gestured language that willfully includes disparaging and derogatory terms to patients or their families, or within their hearing distance, regardless of their age, ability to comprehend, or disability.

Verbal Order: A physician or allowed practitioner order that is spoken to appropriate personnel and later put in writing for the purposes of documenting as well as establishing or revising the patient's plan of care.