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

California Home Health Licensure

Standards of Excellence

CHAP

CALIFORNIA HOME HEALTH LICENSURE STANDARDS OF EXCELLENCE

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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 California Home Health Licensure Standards of Excellence

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	3
APC.10.D.M1	Expanded to include allowed practitioner	1/1/2021	11
APC.10.D.M2	Expanded to include allowed practitioner	1/1/2021	12
Allowed Practitioner	Added new key term	1/1/2021	56
Clinical Nurse Specialist	Added new key term	1/1/2021	58
Collaboration	Added new key term	1/1/2021	58
Nurse Practitioner	Updated key term	1/1/2021	61
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Summary Report	Added new key term	1/1/2021	67
Telecommunications	Added new key term	1/1/2021	68
Verbal Order	Added new key term	1/1/2021	68

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	3-5
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	12
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	21-22
EP.1.D.M1	Added EP plan is reviewed and updated at least every two years	11/29/2019	29-30
Pseudo-patient	Added new key term	11/29/2019	66
Simulation	Added new key term	11/29/2019	67

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
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	30-31
All-Hazards Approach	Added new key term	3/4/2019	56
Emerging Infectious Diseases (EIDs)	Added new key term	3/4/2019	58
Full Scale Exercise	Added new key term	3/4/2019	58

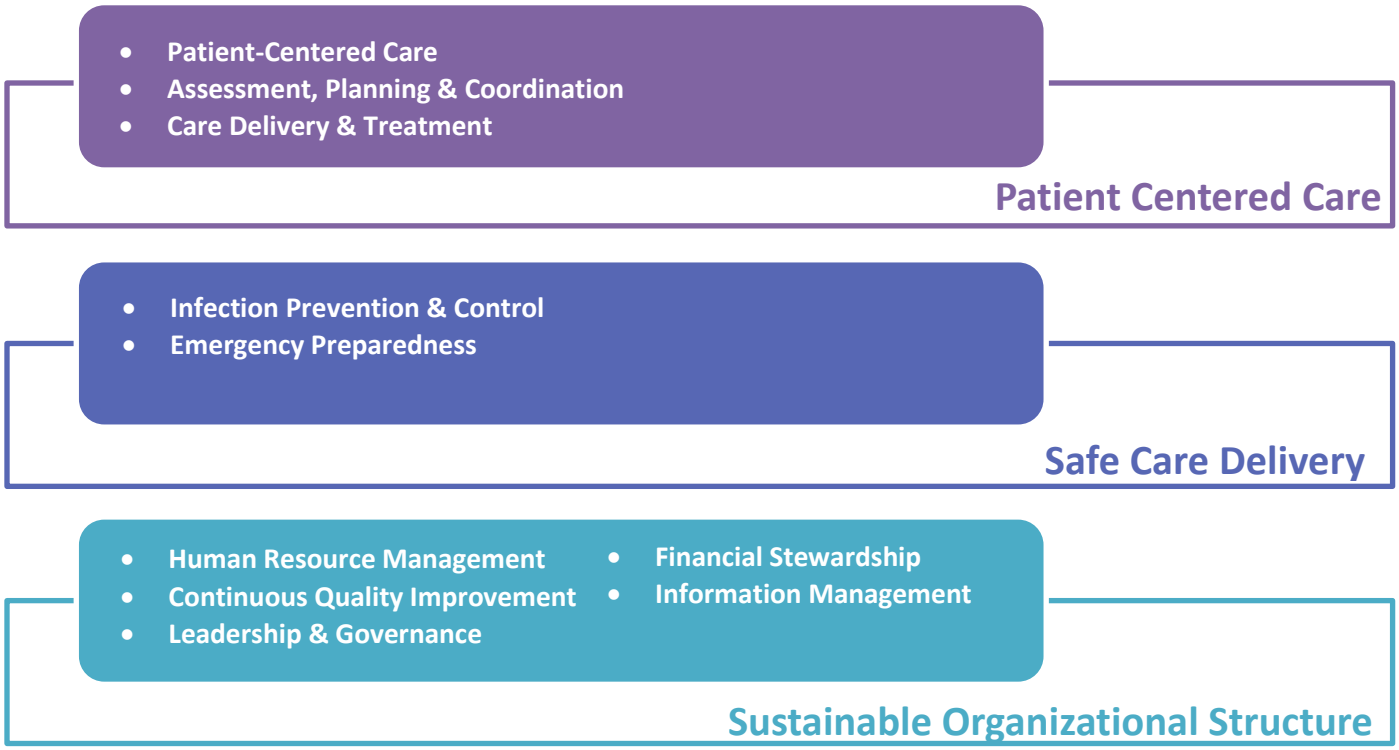
Regulatory Requirements

California regulations for home health licensure are cross-walked to standards and modifiers when applicable. Regulations are listed by Title 22 - California Code of Regulations (CCR) - Division 5 Licensing and Certification of Health Facilities, Home Health Agencies, Clinics, and Referral Agencies - Chapter 6 Home Health Agencies - Article 2 License (e.g., 22 CCR 74743), or by Health and Safety Code (HSC) - Division 2 Licensing Provisions - Chapter 8 Home Health Agencies (e.g., HSC 1727.1).

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).

Key Performance Areas

The California Home Health Licensure 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.

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.

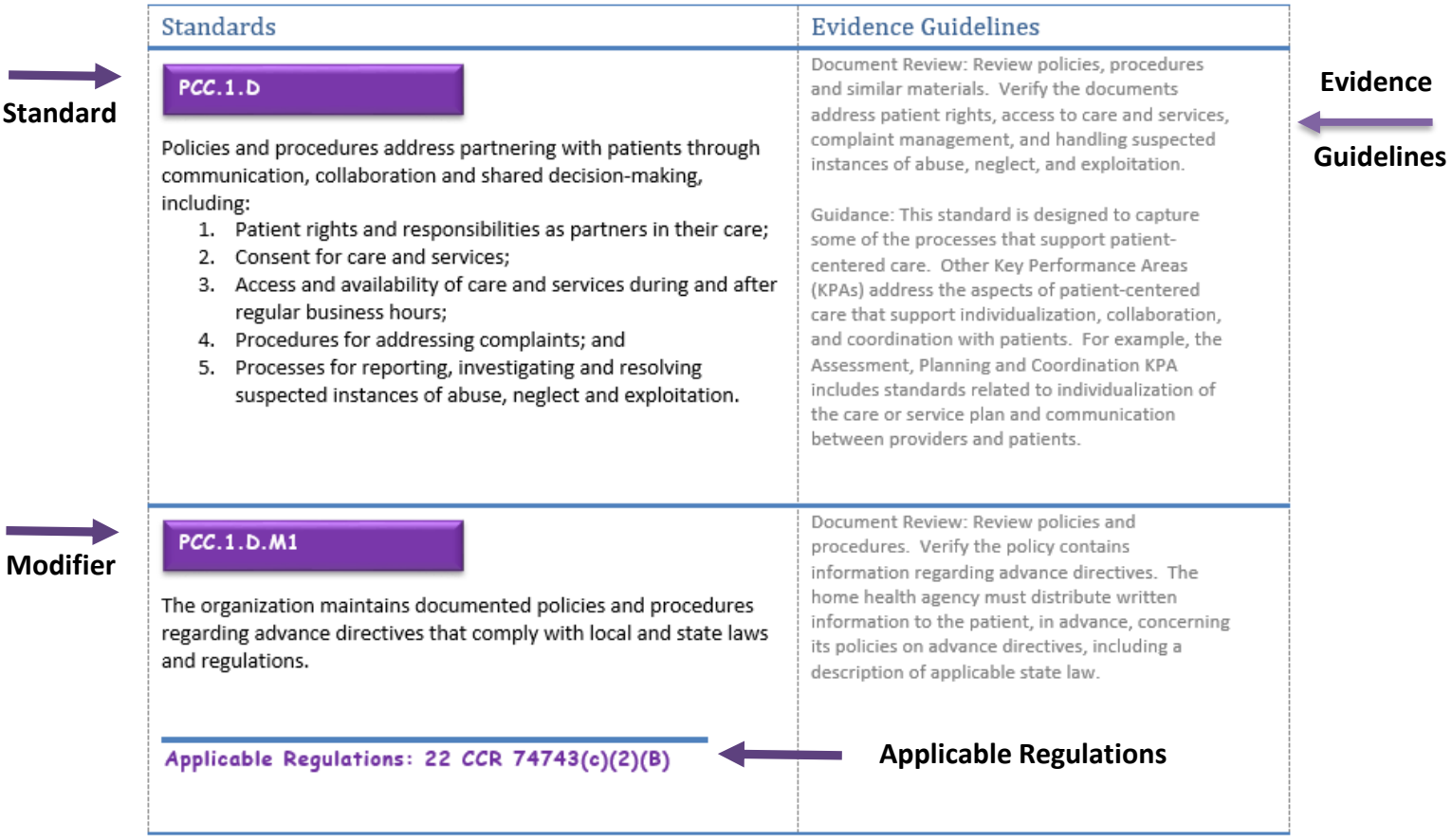
Standards are numbered sequentially, and standards that are related have the same standard number. For example, a **Design (D)** standard evaluating the organization's development of a written patient bill of rights **(PCC.2.D)** has the same standard number as the corresponding **Implementation (I)** 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.1.D Policies and procedures address partnering with patients through communication, collaboration and shared decision-making, including: 1. Patient rights and responsibilities as partners in their care; 2. Consent for care and services; 3. Access and availability of care and services during and after regular business hours; 4. Procedures for addressing complaints; and 5. Processes for reporting, investigating and resolving suspected instances of abuse, neglect and exploitation.	Document Review: Review policies, procedures and similar materials. Verify the documents address patient rights, access to care and services, complaint management, and handling suspected instances of abuse, neglect, and exploitation. Guidance: This standard is designed to capture some of the processes that support patient-centered care. Other Key Performance Areas (KPAs) address the aspects of patient-centered care that support individualization, collaboration, and coordination with patients. For example, the Assessment, Planning and Coordination KPA includes standards related to individualization of the care or service plan and communication between providers and patients.
PCC.1.D.M1 The organization maintains documented policies and procedures regarding advance directives that comply with local and state laws and regulations. **Applicable Regulation: 22 CCR 74743(c)(2)(B).**	Document Review: Review policies and procedures. Verify the policy contains information regarding advance directives. The home health agency must distribute written information to the patient, in advance, concerning its policies on advance directives, including a description of applicable state law.

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: 22 CCR 74743; 22 CCR 74743(b); 22 CCR 74743(b)(1); 22 CCR 74743(b)(3); 22 CCR 74743(b)(4); 22 CCR 74743(c); 22 CCR 74743(c)(1); 22 CCR 74743(c)(1)(A); 22 CCR 74743(c)(1)(B); 22 CCR 74743(c)(2); 22 CCR 74743(c)(2)(A); 22 CCR 74743(d); 22 CCR 74743(d)(1); 22 CCR 74743(e); 22 CCR 74743(e)(1); 22 CCR 74743(e)(2); 22 CCR 74743(e)(2)(A); 22 CCR 74743(e)(2)(B); 22 CCR 74743(e)(2)(C); 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: 22 CCR 74743(b)(2); G424-484.50(b)(1); G424-484.50(b)(2); G424-484.50(b)(3).

Standards

PCC.2.I.M5

The patient has the right to be free from discrimination based on sex, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, or registered domestic partner status.

Applicable Regulation: 22 CCR 74743(b)(5).

Evidence Guidelines

Document Review: Review the Patient Bill of Rights. Verify it contains provisions that the patient has the right to be free from discrimination based on sex, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, or registered domestic partner status.

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.1.D Policies and procedures for assessment, planning and coordination of care/services address, at a minimum: 1. Roles and responsibilities of personnel; 2. Intake, admission and discontinuation of services; 3. Initial and ongoing patient assessment and/or evaluation; 4. Processes for initial and ongoing care planning and coordination; 5. Communication and coordination with other disciplines and providers involved in the patient's care, as applicable; and 6. Care and services transitions within and outside of the organization.	Document Review: Review policies, procedures and other documents that describe assessment, care planning and coordination. Verify that the documents address each requirement of the standard, as applicable to the organization's scope of services. 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: The requirements of this standard apply differently in different settings. Patients receiving home and environmental services or personal care and support services might require a service plan, while home health care would have a more comprehensive plan of care.

Standards	Evidence Guidelines
APC.3.D There is a documented process for patient intake, referrals, and the determination of eligibility for admission. At a minimum, the process addresses: 1. Ensuring that patient referrals are accepted on the basis of a reasonable expectation that patient care needs can be met; 2. Providing an explanation to patients of general services, including an expected timeline for service initiation; and 3. Determining that patients meet defined eligibility criteria.	Document Review: Review policies, procedures, flowcharts, checklists or other documents that describe the referral and intake process and that describe admission and eligibility determination criteria. Verify that the process ensures that each requirement of the standard is addressed. Other documents for review might include patient brochures, policies, or information from the organization's website. Guidance: A written policy is not required to meet the intent of this standard. A documented process is required, and this may take the form of a checklist or other document(s).
APC.3.D.M1 The organization's administrative policies and procedures include a statement that patients will be accepted for treatment or care on the basis of reasonable expectation that the patient's needs can be met by the organization. **Applicable Regulation: 22 CCR 74721(c)(2).**	Document Review: Review the organization's policies and procedures. Verify it contains a statement that patients will be accepted for treatment or care on the basis of reasonable expectation that the patient's needs can be met by the organization.
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.M19

The patient's individualized plan of care is developed in consultation with the care team and addresses all pertinent diagnoses and includes the patient's:

1. Diagnosis;
2. Prognosis;
3. Types of services and equipment required;
4. Statement of the treatment goals;
5. Medications and treatment;
6. Functional limitations;
7. Mental status;
8. Activities permitted;
9. Nutritional requirements;
10. Rehabilitation potential;
11. Any safety measures required to protect against injury to the patient;
12. Proposed frequency of services;
13. Instructions to the patient and family;
14. Food and drug allergies;
15. Psycho-social status; and
16. Instructions for timely discharge or referral.

Other agency personnel, including the therapist and social worker, participate in developing the plan of care. The patient's plan of care addresses any therapy services that will be necessary to support achievement of patient goals, including the specific procedures and modalities to be used and the amount, frequency, and duration.

Applicable Regulations: 22 CCR 74697(a)(2); 22 CCR 74697(a)(5); 22 CCR 74697(b); 22 CCR 74697(b)(1); 22 CCR 74697(b)(10); 22 CCR 74697(b)(11); 22 CCR 74697(b)(12); 22 CCR 74697(b)(13); 22 CCR 74697(b)(14); 22 CCR 74697(b)(2); 22 CCR 74697(b)(3); 22 CCR 74697(b)(4); 22 CCR 74697(b)(5); 22 CCR 74697(b)(6); 22 CCR 74697(b)(7); 22 CCR 74697(b)(8); 22 CCR 74697(b)(9).

Evidence Guidelines

Record Review: Review patient records. Verify that each record contains a plan of care that addresses the requirements of the standard. Verify that other agency personnel participate in care planning when a need for their services is identified.

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: The frequency and duration of visits is specific to the patient's condition and needs. PRN or as needed visit orders are expected to be minimal and include an indication or reason for why the visit is to occur.

Standards

APC.10.D

The organization develops policies and procedures to coordinate and communicate care and service transitions.

Evidence Guidelines

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: 22 CCR 74721(c)(3); 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: 22 CCR 74721(c)(3); 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: States may have additional requirements related to the transfer or discharge or patients. It is expected that the organization knows and follows these requirements.

Care Delivery and 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.1.D The organization has documented policies and procedures for the delivery of care and services to its patients. Policies and procedures reflect the scope and complexity of the care/services provided.	Document Review: Review policies and procedures related to the delivery of care and services to patients. These may be found in a procedure manual or other documents that describe various procedures the organization follows to deliver care/services. Validate they address the scope and complexity of the care/services provided by the organization.
CDT.1.D.M1 Policies and procedures related to patient care and service delivery are based on accepted standards of practice and/or evidence informed practice and address, at a minimum: 1. Receipt and processing of orders, as applicable; and 2. Processes for handling medical emergencies. **Applicable Regulations: 22 CCR 74721(c)(1); 22 CCR 74721(c)(5).**	Document Review: Review policies and procedures related to the delivery of care and services. Validate that all of the required elements listed in the standard are met. 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.

Standards	Evidence Guidelines
CDT.1.D.M6 Policies and procedures define when notification to the physician, dentist, podiatrist or other health professionals and responsible agency staff of significant changes in the patient's condition is required. **Applicable Regulation: 22 CCR 74697(d).**	Document Review: Review policies and procedures related to notification of significant change(s) in the patient's condition. Verify that they define when and why notification occurs.
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.M8

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: 22 CCR 74711(a).

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	Evidence Guidelines
CDT.2.I.M9 In addition to skilled nursing services, a licensed home health agency may provide, or arrange for the provision of, other therapeutic services to persons in their temporary or permanent place of residence. Therapeutic services include, but are not limited to, physical, speech, or occupational therapy, medical social services, and home health aide services. **Applicable Regulation: HSC 1727.1.**	Interview: Interview a key leader of the organization. Verify which therapeutic services, in addition to skilled nursing, are provided. 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.
CDT.2.I.M10 Services that may be provided and approved include, but are not limited to, the following: 1. Diet Counseling 2. Home Health Aide Services 3. Nursing Services 4. Occupational Therapy 5. Physical Therapy 6. Speech Therapy 7. Medical Social Services 8. Medical Supplies and Appliances **Applicable Regulations: 22 CCR 74693(e); 22 CCR 74693(e)(1); 22 CCR 74693(e)(2); 22 CCR 74693(e)(3); 22 CCR 74693(e)(4); 22 CCR 74693(e)(5); 22 CCR 74693(e)(6); 22 CCR 74693(e)(7); 22 CCR 74693(e)(8).**	Interview: Interview a key leader of the organization. Verify which therapeutic services are provided and that each provided service has been approved by the California Department of Public Health.

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.

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.1.D.M2 Documented personnel policies include: 1. Qualifications, 2. Responsibilities, and 3. Conditions of employment for each type of personnel. Policies shall be available to all personnel. **Applicable Regulation: 22 CCR 74721(c)(7).**	Document Review: Review personnel policies. Verify they include all of the requirements of the standard. Interview: Interview one or more personnel. Verify they have access to personnel policies.

Standards	Evidence Guidelines
HRM.1.D.M3 Policies and procedures are developed and implemented that define the circumstances when the home health agency requires on-site supervisory visits to be conducted jointly with the home health aide present (e.g. when joint visits are part of a performance evaluation). **Applicable Regulation: 22 CCR 74709(a)(2).**	Document Review: Review policies and procedures. Verify that the policy meets the requirement of the standard.
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.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

Effective 11/29/2019

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.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.M14 Each type of service provided by the organization for patients shall be approved by the California Department of Public Health and at a minimum: 1. Be under the direction of a person registered, licensed or certified to provide such service if registration, licensure or certification is required, or be otherwise qualified as provided in these requirements; and 2. Have written policies and procedures and reference material readily available to guide and assist personnel. **Applicable Regulations: 22 CCR 74693(d); 22 CCR 74693(d)(1); 22 CCR 74693(d)(2).**	Interview: Interview key leader for the provision of care and services. Clarify the ways in which persons who supervise and/or direct care are qualified to do so. Interview: Interview one or more persons who provide care and services in the home. Clarify the ways in which they have access to policies, procedures and reference materials.

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.D There is a documented Continuous Quality Improvement (CQI) plan that describes the organization's quality improvement program.	Document Review: Review documentation on the CQI plan. Validate that it describes the organization's quality improvement program. Guidance: For organizations with multiple locations, the CQI plan may be designed at the individual agency/branch level, the corporate level, or a combination of the two. If policies around CQI are centralized, CHAP will review them in a centralized manner and examine implementation at the individual agency/location level.
CQI.1.D.M2 Administrative policies and procedures include provisions for a quality improvement program. **Applicable Regulation: 22 CCR 74721(c)(6).**	Document Review: Review the organization's administrative policies and procedures. Verify they include provisions for a quality management program.

Standards

CQI.4.I

Patient records are reviewed periodically to assess the appropriateness of care and services provided and to ensure compliance with the care plan, established policies and practices.

Evidence Guidelines

Document Review: Review documents that describe the organization's process for reviewing patient records and the most recent results of the review. Verify that the most recent review of records meets the requirements as outlined in the organization's process.

Guidance: The organization determines the scope and frequency of the review of records that will be necessary to support an assessment of the care and services provided.

CQI.4.I.M4

Patient record review is performed against preset criteria of practice for each discipline providing care. Criteria of practice includes:

1. Appropriateness of the level of care provided to protect the health and safety of patients;
2. Timeliness of the provision of care;
3. Adequacy of the care to meet patients' needs;
4. Appropriateness of the specific services provided;
5. Compliance with the standards of practice for patient care;
6. Accessibility to care;
7. Continuity of care;
8. Privacy and confidentiality of care;
9. Safety of care environment; and
10. Participation in care by patient and family.

Document Review: Review the most recent documentation of the organization's review of patient records. Verify that each of the elements listed in the standard are reviewed for each discipline providing care.

Applicable Regulations: 22 CCR 74742(b)(2); 22 CCR 74742(b)(2)(A); 22 CCR 74742(b)(2)(B); 22 CCR 74742(b)(2)(C); 22 CCR 74742(b)(2)(D); 22 CCR 74742(b)(2)(E); 22 CCR 74742(b)(2)(F); 22 CCR 74742(b)(2)(G); 22 CCR 74742(b)(2)(H); 22 CCR 74742(b)(2)(I); 22 CCR 74742(b)(2)(J).

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: 22 CCR 74721(c)(4); 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

IPC.1.D.M3

Organization's implement a written policy regarding personnel who develop or sustain symptoms of infectious diseases to determine when personnel will be removed from contact with patients.

Applicable Regulation: 22 CCR 74723(e).

Evidence Guidelines

Document Review: Review personnel policies that address the development of symptoms of infectious diseases. Verify they identify when and under what circumstances personnel are to be removed from contact with patients.

Interview: Interview a key leader with oversight of the organization's Infection, Prevention and Control program. Verify, through specific example, how the organization determines when to remove personnel from contact with patients.

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

Effective 11/29/2019

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

EP.1.D.M1

Applicable Regulations: 22 CCR 74721(c)(8); 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).

Evidence Guidelines

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.

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.D The structure of the organization's governance and leadership reflects its scope, size, and complexity. The organization documents how governance and leadership oversee: 1. Planning; 2. Financial operations; 3. Human resources; 4. Provision of care/services; 5. Safety; 6. Quality improvement; 7. Risk management; 8. Regulatory compliance, as applicable; and 9. Ethical concerns.	Document Review: Review bylaws, policies, and/or other legal documents to identify responsible persons and positions accountable for the functions listed. Validate that the documents describe the ways in which the organization's governance and leadership are organized and overseen. Interview: Interview members of governance, the Administrator or other individuals in key leadership roles. Clarify how the structure established for governance and leadership reflects the scope, size, and complexity of the organization. Guidance: An organization's governance is composed of one or more persons who are authorized by the organization to provide oversight and direct the affairs of the organization in partnership with the organization's leadership. In some organizations, the owner assumes the duties of governance. It is not required that the organization's governance take the form of a Board of Directors or governing body, unless otherwise stipulated in law or regulation. Guidance: The organization determines who is designated as a leader and fulfills the roles outlined in the standard. Leaders can assume a variety of roles, but generally manage the day-to-day operations of the organization, such as an owner or Administrator, a financial officer, a human resource manager, a director of clinical operations, etc.

Standards	Evidence Guidelines
LG.1.D.M1 Administrative policies and procedures are established and implemented by the organization. Policies and procedures are reviewed and revised as necessary and made available upon request to patients or their representatives and to authorized representatives of local, state, or federal organizations. Policies and procedures cover the following areas: 1. Personnel policies and management; 2. Patient admission and discharge; 3. Clinical practices; 4. Infection, prevention and control; 5. Quality improvement; and 6. Emergency preparedness plans and procedures. **Applicable Regulations: 22 CCR 74721(a); 22 CCR 74721(b); 22 CCR 74721(c).**	Document Review: Review administrative policies and procedures. Verify they are reviewed and revised as necessary by the organization and cover the areas identified in the standard. Interview: Interview a key leader or clinical manager. Verify, through specific example, the most recent updates made to the organization's policies and procedures and the reason for the update. Clarify how policies are made available to patients, their representatives, or other authorized individuals as required by the standard. Guidance: Standards contained in other Key Performance Areas (KPAs) include more detailed requirements related to policies and procedures. For example, specific requirements related to the organization's quality improvement program will be assessed in CQI.1.D. Citations under this standard will focus on whether the policies and procedures exist, are updated as necessary, and are made available per the requirements of the standard. The specific content of the policies and procedures will be assessed within each applicable KPA.
LG.2.I The organization's governance is comprised of individual(s) with expertise and professional relationships relevant to the stated mission and culture of the organization.	Interview: Interview member(s) of governance to determine the expertise they bring to the organization's governance. Clarify how the various skills and experience of the members of governance contribute to the organization's mission and culture.

Standards	Evidence Guidelines
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.
LG.3.I.M4 The organization displays all licenses, certificates, and permits to operate. The licenses, certificates, and permits are displayed in an area accessible to customers and patients. **Applicable Regulations: 22 CCR 74675(a); 22 CCR 74677.**	Observation: Inspect facilities. Validate that all licenses, certificates, and permits to operate are current and are displayed in an area accessible to customers and patients.

Standards	Evidence Guidelines
LG.3.I.M11 If the state department determines that there has not been substantial progress towards meeting licensure requirements at the time of the first full inspection provided by this section, or, if the state department determines upon its inspection made within 30 days of the termination of a renewed provisional license that there is lack of full compliance with the requirements, no further license will be issued. **Applicable Regulation: HSC 1728.2(d).**	Document Review: Review findings from site visits as outlined in the standard. Verify that there is substantial compliance with the requirements for licensure.
LG.3.I.M12 No violation of local, state or federal law or regulation adopted for the licensure of a home health agency exists in the agency which jeopardizes the health or safety of patients. **Applicable Regulation: HSC 1728.3(b).**	Document Review: Review findings from site visits as outlined in the standard. Verify that there is finding which jeopardizes the health or safety of patients.

Standards

LG.3.I.M13

Licensure is denied if the organization:

1. Is not in compliance with the laws and regulations pertaining to home health agencies;
2. Has had a home health agency license suspended or revoked within the previous 24 months;
3. Has otherwise failed to establish that the premises, management, the bylaws, the equipment, the staffing, both professional and nonprofessional, and the standards of care and services are adequate and appropriate.

Applicable Regulations: 22 CCR 74671(b)(1); 22 CCR 74671(b)(2); 22 CCR 74671(b)(3).

Evidence Guidelines

Document Review: Review findings from site visit. Verify that the organization is in compliance with laws and regulations, and that the standards of care and services are adequate and appropriate. Verify that the organization has not had a home health agency license revoked in the last 24 months.

Guidance: Verification of revoked license may be verified by CHAP prior to a site visit as part of the application process.

Standards

LG.3.I.M14

Each parent home health agency office is licensed. The address of each approved branch office is listed on the parent license.

Each branch office maintains a copy of the parent license that shows the parent license number followed by the branch office identifier and the current branch office address.

Prior to operating, each branch office is reviewed and approved as part of the parent by the California Department of Public Health. The approval is based on receipt of prescribed fees and the survey of any home health agency requirements. This may include an on-site inspection of the business location. In place of an on-site inspection at the business location, an abbreviated survey may be conducted which includes, at a minimum:

- Submission of the written plan for administration and supervision of the branch office that includes the name, license number/qualifications of the nursing supervisor, and those individuals providing other branch office services approved for the home health agency license.
- Policies and procedures consistent with criteria in the agency's Quality Management evaluation under Section 74742(c)(5).
- Updated disclosure information pursuant to Section 74665; and
- A license application form to update the address and other information for the branch office.

Applicable Regulations: 22 CCR 74675(a); 22 CCR 74675(a)(1); 22 CCR 74675(a)(1)(A); 22 CCR 74675(a)(1)(B); 22 CCR 74675(a)(1)(C); 22 CCR 74675(a)(2).

Evidence Guidelines

Guidance: The parent agency need not be inspected when a branch office gets a separate approval.

Standards	Evidence Guidelines
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.
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 Regulations: 22 CCR 74717(a); 22 CCR 74717(a)(2); 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: 22 CCR 74717(a)(1); 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	Evidence Guidelines
LG.4.I.M6 The organization's governance ensures that the organization does not refuse service to or employment to or in any way discriminate against any person based on sex, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, or registered domestic partner status. **Applicable Regulation: 22 CCR 74717(a)(3).**	Document Review: Review bylaws, articles of incorporation, governance policies and procedures, or similar documents. Verify that they include provisions for how the organization's governance will ensure that the organization does not refuse service to or employment to or in any way discriminate against any person based on sex, race, color, religion, ancestry, national origin, sexual orientation, disability, medical condition, marital status, or registered domestic partner status.
LG.5.D Members of the organization's governance and leadership are oriented to their roles and responsibilities within 90 days of assumption of duties. Individual(s) receive ongoing training related to their responsibilities and key issues affecting the organization.	Document Review: Review orientation documentation for member(s) of governance and key leader(s). Validate that orientation records include date, attendees, topics covered and accompanying materials. Verify that this orientation took place within 90 days of assumption of duties. Interview: Interview member(s) of governance and key leader(s). Verify they receive ongoing training related to their responsibilities and key issues affecting the organization. Guidance: Orientation and ongoing training may be delivered in a variety of ways, such as on-line, in person, or via video, audio or written media.

Standards	Evidence Guidelines
LG.6.I Individuals who are designated leaders in the organization have relevant education and experience.	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. **Applicable Regulation: G1052-484.115(a).**	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.

Standards	Evidence Guidelines
LG.6.I.M6 The Home Health Administrator is a licensed physician or registered nurse, or has an undergraduate degree and training and experience in health services administration. He or she has at least 1 year of supervisory or administrative experience in home healthcare or related health programs. **Applicable Regulation: 22 CCR 74718(b).**	Record Review: Review personnel files for the Home Health Administrator. Verify that they are a licensed physician, registered nurse, or have an undergraduate degree and training and experience in health services administration. Guidance: The type of undergraduate degree is at the discretion of the organization; however, it is expected that governance would specify which degrees qualify in the position description.
LG.6.I.M8 A nurse supervisor is: 1. A registered nurse with two years experience within the last five years in a home health agency, primary care clinic, or health facility, unless the individual has been previously approved for such employment by a program flexibility issued for the individual's current position at the home health agency prior to April 1, 1995; and 2. Has sufficient background knowledge and expertise in clinical decision-making for the patient population assigned to him or her in the home health agency to meet the needs of his or her patients and to contribute to Quality Management review and evaluation. **Applicable Regulations: 22 CCR 74705(b); 22 CCR 74705(c).**	Interview: Interview the nurse supervisor. Clarify, through specific examples, the background knowledge and expertise the individual possesses to meet patient needs and contribute to quality management review and evaluation. Record Review: Review personnel files for the nurse supervisor. Verify that the individuals is qualified for the position as required by the standard.
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	Evidence Guidelines
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).**	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.7.I.M7 The Administrator is responsible for: 1. Organizing and directing the ongoing functions of the organization, including all day-to-day operations; 2. Serving as an ongoing liaison between organization's governance and personnel; 3. Reporting to the organization's governance; 4. Ongoing oversight of the organization's quality management system; 5. Implementing an effective budgeting and accounting system; 6. Employing qualified personnel and ensuring adequate personnel education and evaluation; 7. Ensures the accuracy of public information materials and activities including advertisements and brochures that the organization uses to represent itself to the community at-large; and 8. Ensuring that a skilled professional, as described in §484.75, is available during all operating hours. **Applicable Regulations: 22 CCR 74718(a); 22 CCR 74718(a)(1); 22 CCR 74718(a)(2); 22 CCR 74718(a)(3); 22 CCR 74718(a)(4); 22 CCR 74718(a)(5); 22 CCR 74718(a)(6).**	Document Review: Review the position descriptions for the Administrator. Verify that they identify all of the responsibilities listed as appropriate to their position.

Standards	Evidence Guidelines
LG.7.I.M8 When the Administrator is not available, a pre-designated individual is authorized in writing to assume the same responsibilities and obligations of the Administrator. The Administrator or pre-designated individual is available during all operating hours. **Applicable Regulation: 22 CCR 74718(c).**	Interview: Interview the Administrator and/or alternate Administrator to determine if there is an understanding of specific roles and responsibilities in the absence of the Administrator. Record Review: Review personnel records to determine whether an alternate Administrator possesses the qualifications specified by the organization. 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.M6 If the Administrator has responsibilities over more than one parent organization, the Administrator demonstrates the adequacy of administrative and nursing supervision over each parent organization through ongoing quality management review. **Applicable Regulation: 22 CCR 74718(d).**	Document Review: Review quality improvement and monitoring reports. Verify that when an Administrator is responsible for more than one parent organization, ongoing quality reviews take place to ensure there is adequate administration and nursing supervision over each parent organization.

Standards	Evidence Guidelines
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.
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.

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.1.D The organization develops documented financial management processes that follow Generally Accepted Accounting Principles (GAAP). Financial management processes address, at a minimum: 1. Budget development and forecasting; 2. Establishing and monitoring financial goal(s); 3. Capital expenditure plans, as applicable; 4. Anticipated sources and tracking of revenue and expense; 5. Regular reporting to the organization's key leadership; 6. Payroll administration; 7. Review of reimbursement claims for accuracy; 8. Maintenance of billing, legal, and other financial documentation as required by contract provisions as well as federal, state, and local law; 9. An external assessment of the financial system and any corresponding documentation; 10. Addressing cash or operating revenue short falls that may impact services, programs, or products; and 11. Internal controls to prevent, identify, and report financial impropriety and/or misuse of organizational resources.	Document Review: Review the financial management processes. Verify that they follow GAAP and contain all of the elements listed in the standard. Guidance: Capital expenditure plans are not required for every organization, but if one exists, there is a defined process for its development. Guidance: Demonstrating compliance with this requirement does not necessitate CHAP's review of the organization's payroll reports, benefit packages, pay rates, or employee time and attendance. Tip: Generally accepted accounting principles (GAAP) are uniform minimum standards of and guidelines to financial accounting and reporting issued by the Financial Standards Accounting Board (FSAB). GAAP establishes appropriate measurement and classification criteria for financial reporting. Adherence to GAAP provides a reasonable degree of comparability among the financial reports of the federal, state and local governmental units.

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.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.

Standards	Evidence Guidelines
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.
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: 22 CCR 74675(a)(2); 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.3.I.M6

The organization discloses the following information at the time of the home health agency's initial request for licensure, at the time of each survey, and at the time of any change in ownership or management:

1. The name and address of each person with an ownership or control interest of five percent or greater in the home health agency;
2. The name and address of each person who is an officer, a director, an agent, or a managing employee of the home health agency;
3. The name and address of the person, corporation, association, or other company that is responsible for the management of the home health agency, and the name and address of the chief executive officer and the chairman of the board of directors of the corporation, association or other company responsible for the management of the home health agency; and
4. If any person described above has served as or currently serves as an administrator, general partner, trustee or trust applicant, sole proprietor or any applicant or licensee who is a sole proprietorship, executor, or corporate officer or director of, or has held a beneficial ownership interest of 5 percent or more in any other home health agency, health facility, clinic, hospice, Pediatric Day Health and Respite Care Facility, Adult Day Health Care Center, or any facility licensed by the Department of Social Services, the applicant shall disclose the relationship to the Department, including the name and current or last address of the facility and the date such relationship commenced and, if applicable, the date it was terminated.

Applicable Regulations: 22 CCR 74665; 22 CCR 74665(a); 22 CCR 74665(b); 22 CCR 74665(c); 22 CCR 74665(d).

Evidence Guidelines

Standards

IM.3.I.M7

A new application is submitted to the California Department of Public Health (CDPH) within 10 working days whenever a change of ownership occurs.

The organization notifies CDPH in writing within 10 days of the following:

1. Change in the name, location and/or address of the organization;
2. Change in the licensing information on file as required;
3. Change of the mailing address of the licensee;
4. Change in the principal officer (chairman, president, general manager) of the governing board. Such written notice shall include the name and principal business address of each new principal officer;
5. Change of the administrator including the name and mailing address of the administrator, the date the administrator assumed office and a brief description of qualifications and background of the administrator;
6. Change of Director of Patient Care Services including the name and mailing address of the Director of Patient Care Services, the date the Director of Patient Care Services assumed office and a brief description of qualifications and background of the Director of Patient Care Services, or;
7. Any addition or deletion of services.

Applicable Regulations: 22 CCR 74667(a); 22 CCR 74667(b); 22 CCR 74667(b)(1); 22 CCR 74667(b)(2); 22 CCR 74667(b)(3); 22 CCR 74667(b)(4); 22 CCR 74667(b)(5); 22 CCR 74667(b)(6); 22 CCR 74667(b)(7); 22 CCR 74667(b)(8).

Evidence Guidelines

Guidance: A change of ownership is deemed to have occurred where, among other things, when compared with the information contained in the last approved license application of the licensee, there has occurred (1) a transfer of 50 percent or more of the issued stock of a corporate licensee, (2) a transfer of 50 percent or more of the assets of the licensee, (3) a change in partners or partnership interests of 50 percent or greater in terms of capital or share of profits, or, (4)a relinquishment by the licensee of the management of the agency.

Standards

IM.3.I.M8

Any person, firm, partnership, association, corporation, receiver, political subdivision of the State or other governmental agency desiring to obtain a license files an application. Using the Department's forms, the application contains the following:

1. Name and address of applicant. If an individual, verification that the applicant has attained the age of 18 years;
2. For all incorporated applicants, the date and state of incorporation, corporation number and, if a foreign corporation evidence of authority to do business in the State of California;
3. The type of services for which approval is requested;
4. The location of the home health organization and branch offices and basis upon which the applicant exercises control and possession thereof;
5. The name of the administrator in charge of the home health organization;
6. The name and principal business address and the percentage of ownership interest of all officers, directors, stockholders owning 5 percent or more of stock, members, partners and all other persons having authority or responsibility for the operation of the organization and provides evidence that all such persons are of reputable and responsible character;
7. Proof of sufficient financial responsibility as may be necessary to operate the organization; and
8. A copy of the current organizational chart.

Applicable Regulations: 22 CCR 74661(a); 22 CCR 74661(a)(1); 22 CCR 74661(a)(1)(A); 22 CCR 74661(a)(1)(B); 22 CCR 74661(a)(1)(B)(2); 22 CCR 74661(a)(1)(B)(3); 22 CCR 74661(a)(1)(B)(4); 22 CCR 74661(a)(1)(B)(5); 22 CCR 74661(a)(1)(B)(6); 22 CCR 74661(a)(1)(B)(7).

Evidence Guidelines

Document Review: Review application for licensure. Verify that it includes each of the components required by the standard.

Standards

IM.4.D

Policies and procedures address access, use and protection of patient, personnel, and operational data and information, including, at a minimum:

1. Physical security of records and information;
2. Access, use, transmission, removal, and disclosure, including the conditions for the release of information, patient access and authorization of use;
3. Maintaining the integrity of health information and protecting it against loss, damage, unintentional or accidental change; and
4. Methods for managing interruptions in the availability of the information management system.

Policies ensure compliance with local, state, and federal privacy law and regulation, including the Health Insurance Portability and Accountability Act (HIPAA) and the Health Information Technology for Economic and Clinical Health Act (HITECH).

Evidence Guidelines

Document Review: Review policies and procedures that address access, use, and protection of patient, personnel, and operational data and information. Verify that all requirements of the standard are addressed.

Tip: Different types of information have different levels of sensitivity. For example, protected health information (PHI) must be highly protected and would be expected to be accessed only by authorized individuals on a need-to-know basis. Other information, such as aggregated performance measurement data may be less sensitive and therefore more easily accessed.

Tip: Many reliable resources are available to help organizations understand HIPAA and HITECH privacy requirements, including information found on the Office of Civil Rights Privacy website. A template and educational resources on assessing data sensitivity can be found on the Health IT.gov website.

IM.4.D.M1

If the organization utilizes computerized patient records, policies and procedures address data security, privacy, and confidentiality in conformance with California state law.

Applicable Regulation: 22 CCR 74731(i).

Document Review: Review policies and procedures that address access, use, and protection of patient records. Verify they contain specific provisions for computerized or electronic records that address data security, privacy, and confidentiality in conformance with California state law.

Standards	Evidence Guidelines
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.	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.6.I The organization transmits or shares data with external parties in compliance with local, state, and federal law or regulation.	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.
IM.6.I.M6 Organizations, on or before the 15th day of March of each year, file with the CA Department of Health, forms furnished by the Department and a verified report for the preceding calendar year upon all matters requested by the Department. This report may include data pertaining to age of patients, diagnostic categories of patients and classification of visits by service provided. **Applicable Regulation: 22 CCR 74729.**	Document Review: Review administrative policy provisions about submitting reports and forms to the CA Department of Health by March 15th of each year.
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.M11

The patient record contains, at a minimum:

1. An admission record with the name, current address, date of birth, sex, and date of admission;
2. Name, address, and telephone number of the responsible party;
3. Treatment consent or service authorization forms;
4. Contact information for individuals or providers involved in providing care, treatment, or services, including physician(s), dentists or podiatrists whose orders are being implemented;
5. Admission diagnosis and other pertinent medical history;
6. Reason for admission;
7. Notation of the conditions and diagnoses which are relevant to the plant of treatment, care, or plan for personal care services;
8. An initial and updated (as appropriate) care or service plan;
9. An initial and updated (as appropriate) comprehensive assessment;
10. Allergies and known untoward reactions to drugs and food. This information shall be given such prominence in the record that it is obvious to any health practitioner or organizational personnel who have reasons to provide food or medication to the patient;
11. Changes in the patient's condition;
12. Physician orders, including drug, dietary, and activity orders;
13. A list of all medications, including frequency, dosage, route and time;
14. Equipment used to support the care, treatment, or services provided;
15. Signed and dated clinical progress notes updated at least every seven working days that include, (1) A record of services provided, including evaluations, treatments, and progress; (2) a record of testing, procedures, and treatments administered by the organization; and (3) the patient's response to care, treatment, or services;
16. Laboratory and X-ray reports, as applicable;
17. Copies of summary reports sent to the attending physician;

(continued on following page)

Evidence Guidelines

Record Review: Review patient records. Validate that all required elements are present.

Guidance: Physicians includes physicians or advanced care practitioners, as permitted by law and regulation, involved in the patient's care in addition to the physician ordering care.

Guidance: Medication lists are expected to include all prescribed medications, over-the-counter and herbal medicines and supplements.

Standards	Evidence Guidelines

IM.7.I.M11

18. Documentation that written notice to the patient of the rights contained in the organization's Patient Bill of Rights has been provided to the patient, the patient's representative, or next of kin;
19. A record of supervision of the care and services provided an aide, LPN, LPTA, COTA and social work assistant; and
20. Transfer and discharge summaries, as applicable, including date of discharge, reason for termination of services, and condition upon discharge.

Applicable Regulations: 22 CCR 74697(e); 22 CCR 74735(a); 22 CCR 74735(a)(1); 22 CCR 74735(a)(1)(A); 22 CCR 74735(a)(1)(B); 22 CCR 74735(a)(1)(C); 22 CCR 74735(a)(1)(D); 22 CCR 74735(a)(1)(E); 22 CCR 74735(a)(1)(F); 22 CCR 74735(a)(1)(G); 22 CCR 74735(a)(1)(H); 22 CCR 74735(a)(1)(I); 22 CCR 74735(a)(2); 22 CCR 74735(a)(3); 22 CCR 74735(a)(4); 22 CCR 74735(a)(5); 22 CCR 74735(a)(6); 22 CCR 74735(a)(7); 22 CCR 74735(a)(8); 22 CCR 74735(a)(9).

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.