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

Palliative Care

Standards for Certification

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Introduction to the Palliative Care Certification Process

Palliative Care

Palliative Care is the organized delivery of patient and family-centered care that optimizes quality of life by anticipating, preventing and treating symptoms of individuals with serious illness.

Palliative care addresses the physical, emotional, social, and spiritual needs of the patient and the family, as well as facilitating access to information and choice. It is provided and coordinated by an interdisciplinary team in any setting.

The CHAP (Community Health Accreditation Partner) Palliative Care standards are informed by providers of palliative care and the National Consensus Project for Quality Palliative Care. Clinical Practice Guidelines for Quality Palliative Care 4th Edition. Richmond, VA: National Coalition for Hospice and Palliative Care; 2018.

Eligibility:

Organizations eligible for palliative care certification include:

- A Palliative Care Program provided as a service of an existing care setting (e.g. SNF, physician practice, Assisted Living Facility (ALF), home health agency, hospice), or
- A program of *a CHAP-accredited health care organization* (i.e. hospice, home health agency, or private duty organization), or
- An independent organization providing palliative care.

The Palliative Care Program seeking certification must have provided care to at least five (5) patients in the twelve (12) months preceding the application date and have at least three (3) active patients at the time of the site visit.

The Palliative Care Program seeking certification defines the patient population served and any related prognosis requirements of patients receiving palliative care.

Application for Certification:

- Upon making the decision to seek palliative care certification, the first step is to contact a CHAP representative and request an application. Go to CHAP's website, www.CHAPinc.org.

- **Application of a Palliative Care Program that is a service of an already CHAP accredited organization**: You are requested to update information in your organization's LinQ account regarding the Palliative Care Program and complete the palliative care specific application questions.

NOTE: "Off-Cycle" Palliative Care Certification available for a currently CHAP accredited organization. A CHAP accredited organization may seek palliative care certification 4 months or more prior to the expiration date of the hospice or home health accreditation. This is referred to as "off-cycle" and is accomplished through executing an addendum to your existing accreditation contract.

- The Accreditation Specialist currently assigned to your account will create the addendum to the accreditation contract for execution.
- At the next accreditation renewal, the organization has the option to add palliative care certification for a full 36-month cycle as part of its accreditation/certification contract.

- **Application of a Palliative Care Program, independent or a service of another setting:** The application process begins with creating a LinQ account – LinQ is CHAP's database that houses all your certification documents electronically.
  - Please note that you will need an Employer Identification Number (EIN) and a National Provider Number (NPI) for use on the application.
  - CHAP staff are available to assist in creating the LinQ account, completing the application and answering other questions you may have.

Contract for Certification:

- Your organization receives the CHAP accreditation/certification contract electronically in your LinQ account.
- CHAP asks that you attach your organization's Business Associate Agreement (BAA) for our execution, or CHAP provides you with a generic BAA for your completion, signature and return to CHAP with your executed contract.

Assessing Readiness for a Certification Site-Visit:

Upon receipt of the executed contract and initial payment, you receive a document in your LinQ account to assist your staff in assessing readiness for the on-site review. The document reviews the standards and provides your team with another source of internal evaluation of readiness for the site review.

The Site Visit:

A site visit is how the Palliative Care Program demonstrates compliance with the standards.

A palliative care certification site visit is announced* which means that you will know when the site visitor will be at your office.

- Note: An organization may cancel a scheduled site palliative care certification visit up to 5 business days prior to the scheduled site visit date without a cancellation fee. Within the 5 business day window a cancellation fee is charged.

NOTE: If the Palliative Care Program is being assessed at the same time as a home health agency or hospice seeking CMS initial or continuing deemed status using CHAP accreditation, the site visit for the Palliative Care Program is *not announced,* but is added to the site review of the hospice and/or the home health agency.

- The certification site visit is most often be 1-2 days in duration. The length of the visit depends on the Palliative Care Program's patient census, number of locations, and current CHAP accreditation status, if any.
    - If your Palliative Care Program is a service of a currently CHAP accredited home health agency or hospice, the duration of the site visit takes into account "equivalent" standards your organization has already met such as infection control, quality assurance, human resources, etc. These processes do not need to be duplicated for the Palliative Care Program. The site visitor will assess how these policies and processes are applied to the Palliative Care Program. "Equivalent" standards are noted in the "Evidence Guidelines" section of each standard and summarized on the last page of this introduction.

- The site visit includes the review of policy and procedures, documentation of patient and family care and coordination, as well as interviews with Palliative Care staff members as well as patients and families.
    - The patient and/or family member selected for interview is asked permission to participate in the interview and may decline.

- The site visitor conducts an introductory meeting introducing the review process and what to expect over the coming day(s). Any staff that the Palliative Care Program wishes can be present.

- The site visitor also conducts a summation conference at the end of the site visit to summarize preliminary findings and answer any questions.
    - Please note that although you may appeal any decision at any time during the certification process, the best time to bring up a question is while the site visitor is there.

Internal CHAP Review:

The results of the site review are next reviewed by a Director of Accreditation assigned to your organization to ensure that any reference not meeting a standard is supported by documentation of the site visitor and considers the scope and severity of the problem as it relates to patient care.

The findings as approved by the Director of Accreditation are returned electronically to the Palliative Care Program via the LinQ account within 10 business days of the last or only day of the site visit.

Plan of Correction:

If there is evidence that the intent of one or more palliative care standards has not been met, the Director of Accreditation sends your organization a detailed report with the standard and the evidence of non-compliance. The report is available in your LinQ account within 10 business days of the last or only day of the site visit.

Your organization is requested to submit a written plan of correction noting what action you will take to address the problem noted and how you will ensure that your compliance with the plan is sustained. Your staff may ask the Director of Accreditation assigned to your account for more information about compliance with the standard, the citation and the Plan of Correction.

- The completed Plan of Correction is due via electronic submission within 10 calendar days of electronic receipt of the report.
- The Director of Accreditation either accepts your plan or requests additional information within 10 business days of electronic receipt of your plan.
- Upon the Director's acceptance of the Plan of Correction, the certification report and findings, as well as the Plan of Correction are submitted to the Board of Review, a Committee of the Board of Directors who make the certification decision.

Certification Award:

- All awards of certification are for three (3) years.
- The Palliative Care Program is first advised of the certification decision via e-mail.
- You may appeal a certification decision within 10 business days of notification of the decision.
- Upon award of certification, a letter verifying the decision is provided to the organization; a certificate and the Palliative Care Program certification status is posted on the CHAP website.
    - CHAP is also available to confirm your certification for a health plan or a consumer/client/patient.

Equivalent Content Standards if a Palliative Care Program is a Service of a Currently CHAP accredited Home Health or Hospice Organization

The following standards address policy and procedure or process. To avoid the burden of replication, if the Palliative Care Program uses the same process, policy or procedure as that of the CHAP accredited hospice or health agency, the content intent of the standard is met. The site visitor will assess the implementation of the standard in the Palliative Care Program.

For example, a Palliative Care Program does not need to replicate a QAPI program when it is a service line of an accredited hospice. The same QAPI program can be used and the site visitor will assess performance iImprovement activity related to the Palliative Care Program.

Chapter 1: **Palliative Patient/Family-Centered Care (PPFC) – Equivalent Standard Review**
✓ PPFC.1: If a patient/family rights statement of a CHAP accredited organization meets the content of the standard, this element is met. A separate palliative care statement is not required.
✓ PPFC.2: If the Palliative Care Program uses the same process to identify a patient guardian or legal representative as that of a CHAP accredited organization, the policy and procedure portion of the standard is met.
✓ PPFC.3: If the complaint process of a CHAP accredited organization is used for the palliative care program, the content portion of the standard is met.
✓ PPFC.4: If the suspected abuse investigation and reporting process of a CHAP accredited organization is applied to the Palliative Care Program, the content portion of the standard is met.
Chapter 2: **Palliative Care Assessment, Care Planning, and Coordination (PCAC)**
✓ PCAC.15: If the translation services and related policy and procedure of a CHAP accredited organization is used for the Palliative Care Program, the content element of the standard is met.
Chapter 3: **Palliative Care Treatment and Transitions (PCTT)**
✓ PCTT.13: If the telemonitoring policies and procedures of a CHAP accredited organization are also used by the Palliative Care Program, the content element of the standard is met.

Chapter 4: Palliative Care Infection Prevention and Control (PCIC)
✓ PCIC.1: The Infection Control program of a CHAP accredited organization meets the content portion of this standard if it also applies to palliative care staff, patients, families.
✓ PCIC.2: The standard precautions policy of a CHAP accredited organization meets the content portion of this standard if applied to palliative care program staff.
✓ PCIC.4: If the infection control education of palliative care staff, patients and families is that used by the CHAP accredited organization, the content element of the standard is met.
Chapter 5: **Palliative Care Quality Assurance and Performance Improvement (PCPI)**
✓ PCPI.1: If the QAPI program of a CHAP accredited organization includes palliative care activity, the standard is met with evidence of palliative care performance improvement activity.
Chapter 6: **Palliative Care Management and Governance (PCMG)**
✓ PCMG.2: If the governance of a CHAP accredited organization also governs palliative care, this standard is met.
✓ PCMG.5: If the emergency preparedness plan of a CHAP accredited organization applies to the palliative care service, the plan content element of the standard is met.
✓ PCMG.6: If the budget of a CHAP accredited organization includes the provision for palliative care, the standard is met.
✓ PCMG.7: If the patient record and information policies and procedures of a CHAP accredited organization apply to the palliative care services, this element of the standard is met
✓ PCMG.8: If the human resource policies of a CHAP accredited organization also apply to the palliative care services, the content element of the standard is met.
✓ PCMG.9: If the job description process and verification of requirements of a CHAP accredited organization also applies to palliative care staff, the process content element of the standard is met.
✓ PCMG.10: If the contract content of a CHAP accredited organization also applies to the palliative care services, the content element of the standard is met.

Revision Reference Table

In response to the revisions to the Centers for Disease Control and Prevention (CDC) guidelines on recommended TB screening and testing for health care personnel, the following revision was made.

Standard	Effective Date	Page
PCIC.1	August 2019	26

Palliative Patient/Family-Centered Care (PPFC)

KEY PERFORMANCE AREA:

The Palliative Care Program informs and protects patient/family rights and defines their responsibilities in the delivery of palliative care in the home and the community.

The patient defines "family" and "caregivers."

Standards	Evidence Guidelines
PPFC.1 There is a Patient/Family Bill of Rights Statement to define and inform patients and families of their rights and responsibilities. The Statement is provided upon admission to the Program. The written Statement includes the right to: 1. Be involved in care planning, including incorporating goals for intervention and decisions about treatment; 2. Be informed in advance of the type and frequency of services to be provided, any changes or service limitations; 3. Decline any offered care, service, or treatment; 4. Receive effective pain management and symptom control; 5. Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and the misappropriation of patient property by anyone furnishing services on behalf of the organization; 6. Have their person and property treated with respect; 7. Privacy of person and information; 8. A confidential record per federal and state law and regulation; 9. Be informed how to voice complaints to the palliative care service and/or CHAP without fear of reprisal or discrimination; 10. Be informed about advance care planning, including advance directives; 11. Be informed about payment sources and any expected or known patient financial liability prior to the start of care, and any subsequent changes in payment liability.	**Document Review:** Review the Patient/Family Rights Statement for the elements in the standard. **Interview/Observation:** Does the patient and/or family have the Rights Statement or recall receiving it? **Interview:** Ask the Interdisciplinary Team (IDT) member how and when the Rights Statement is provided. **Guidance:** The Rights Statement provided by a CHAP-accredited organization may meet this standard if also provided to palliative care patients and their families.

Standards	Evidence Guidelines
PPFC.2 If a patient has been judged incompetent under state law by a court of jurisdiction, the rights of the patient are exercised by the person appointed to act on the patient's behalf, pursuant to state law. If the state court has not judged a patient incompetent, any legal representative designated by the patient may exercise the patient's rights to the extent allowed by state law and regulation. The representative, if any, is documented in the patient record.	**Interview:** Ask how the IDT establishes if there is court-appointed person or a representative designated by the patient involved. **Record Review:** Confirm evidence of a patient's representative per the standard. **Guidance:** The process used by a CHAP-accredited organization may meet the intent of the standard if applied to palliative care patients.
PPFC.3 Policies and procedures define a complaint management process and include: 1. Designation of staff responsible for managing the complaint process; 2. Procedures and time frames for documented complaint intake and investigation; 3. Documented status of a complaint, including resolution (if any); 4. Documented corrective action taken (if any); 5. What information, if any, is shared with the complainant.	**Document Review:** Review policies and procedures that describe the complaint management process. **Guidance:** Complaints include, but are not limited to, issues of customer service, access to care and services, quality of care, etc. **Guidance:** Not every complaint can be resolved to the complainant's satisfaction; the expectation is documented evidence of response, investigation, and any corrective action taken. **Guidance:** The policies and procedures used by a CHAP-accredited organization may meet the intent of the standard if applied to palliative care.

Standards	Evidence Guidelines
PPFC.4 There is a policy and procedure defining the Palliative Care Program's response to alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, or misappropriation of patient/family property involving an Interdisciplinary Team (IDT) member or anyone working on the IDT's behalf. The policies and procedures address: 1. Reporting the alleged violation; 2. Immediate investigation of the alleged violation; 3. Action taken to prevent further potential violations during the investigation; 4. Reporting verified violations to state and local bodies having jurisdiction; 5. Documentation of the alleged violation, investigation, and any action taken.	**Document Review:** Incident reports or other documents are reviewed if used as reports of suspected mistreatment, neglect, or verbal, mental, sexual, or physical abuse. **Record Review:** Review any investigation, resolution, and response for a reported alleged violation in the most recent 12 months and confirm that the investigation, resolution, and reporting correlate to the organization policy. **Tip:** Most states clearly define action required for identifying and reporting mistreatment, neglect, or verbal, mental, sexual, or physical abuse. It is expected that the Program knows and follows state law and regulation. **Guidance:** The process used by a CHAP-accredited organization may meet the intent of the standard if applied to palliative care patients.

Palliative Care Assessment, Care Planning, and Coordination (PCAC)

KEY PERFORMANCE AREA:

Interdisciplinary Team (IDT) members use effective communication to facilitate assessment of patient and family needs, develop a care plan that addresses those needs, represent the patient's goals and preferences, and coordinate care.

Standards	Evidence Guidelines
PCAC.1 Policies and procedures address assessment, palliative care planning, and coordination of care. These include: 1. The process for referral intake and criteria for discontinuation of services; 2. IDT responsibility for initial and ongoing patient and family assessments as indicated by change in the patient's or family's status or as requested; 3. The process for developing and updating the palliative care plan; 4. IDT roles and responsibility for communication and coordination with the patient and family, as well as other providers involved in the patient's care. Assessment, care planning, coordination, and discontinuation of care are in accordance with the Program's policy and procedure.	**Document Review:** Review policies, procedures, and/or other documents that describe the intake, assessment, care planning, and coordination processes, as well as discontinuation of services. Confirm that the documents address the requirements of the standard. **Interview:** Ask the IDT team their understanding of intake, their role in coordination and communication, and how the decision is made regarding discontinuing services. Does it correspond to the policy and procedure? **Record Review:** Does documentation confirm the policies and procedures are implemented?

Standards	Evidence Guidelines
PCAC.2 An Interdisciplinary Team works together to assess the physical, medical, psychosocial, emotional, and spiritual needs of the patient and family facing serious illness. The IDT includes, but is not limited to, individuals who are qualified and competent to practice in the following professional roles: 1. Doctor of Medicine (MD) or Osteopathy (DO); 2. Registered nurse (RN) and/or advanced practice registered nurse (APRN) and/or physician assistant (PA); 3. Social worker; 4. Evidence of access to a chaplain or spiritual counselor in the community. At least one (1) member of the IDT is certified or has equivalent training, education, and experience in palliative care/hospice to provide services and/or consult as requested. 1. The IDT oversees, manages, and coordinates the palliative care services provided.	**Interview:** Interview members of the IDT. Clarify, through specific patient/family examples, the ways in which they work together to assess the scope of physical, medical, psychosocial, emotional, and spiritual needs of the patients and families. **Record Review:** Review records to validate that, at a minimum, the IDT documentation includes input from a social worker, a registered nurse, and a Doctor of Medicine or Osteopathy. **Document Review:** Confirm that at least one member of the IDT is certified in—or has equivalent training and experience in—palliative/hospice care. **Interview:** Ask the IDT members how the disciplines are represented and how these are active in the care of patients and families. **Guidance:** Equivalent palliative care experience and training (e.g., as a hospice medical director, a hospice nurse, etc.) is established by the palliative care organization. **Tip:** The Program may utilize a hospice medical director as the physician member of the IDT.

Standards	Evidence Guidelines
PCAC.3 Policy and procedure define the eligibility criteria and admission process to Palliative Care Program. Admissions follow policy and procedure.	**Interview:** Interview staff who manage patient/family intake. Verify that intake and eligibility determination is in accordance with the policy and procedure. **Document Review:** Does policy and procedure define eligibility criteria (e.g., prognosis, diagnosis) as well as the admission process? **Record Review:** Do patients admitted match the criteria?
PCAC.4 There is evidence that the Interdisciplinary Team physician, APRN, or PA reviews the clinical information for each patient being evaluated for the Palliative Care Program and considers the following in determining admission: 1. The patient's serious illness(es); 2. Any related diagnosis(es); 3. Prognosis as it relates to the organization's admission criteria; 4. Current subjective and objective medical findings; 5. The presence and severity of symptoms; 6. Information about the medical management of any of the patient's conditions unrelated to the serious illness.	**Record Review:** Review patient records to validate that the IDT physician member, APRN, or PA evaluated the patient using the elements of the standard. **Interview:** Interview an IDT physician, APRN, or PA to discuss the process of determining the appropriateness of admission.

Standards	Evidence Guidelines
PCAC.5 There is evidence that the referral source is advised in a timely manner when palliative care cannot be provided. The Palliative Care Program defines the timeframe and procedure for referral source notification and where such is documented.	**Interview:** Interview staff responsible for patient/family intake to identify the process of notification when palliative care services cannot be provided. **Document Review:** Review policy and procedure addressing the standard. Review related documentation of the referral source being so advised.
PCAC.6 The Palliative Care Program designates an Interdisciplinary Team member(s) to complete and document an assessment to identify and respond to a patient's and family's care needs. The designated IDT member(s) and the timeframe when the assessment is to occur is defined in policy and procedure.	**Document Review:** Review policy and procedure; does it identify who conducts the assessment and within what time frame? **Record Review**: Do patient records reflect that the assessment is completed per the Program's policy and procedure? **Guidance:** The Program may designate more than one IDT team member to complete an assessment, such as an APRN and a social worker; or the APRN may complete the assessment and be responsible to request that the social worker or another discipline complete an assessment within the time frame as indicated by patient or family need.

Standards	Evidence Guidelines
PCAC.7 The physical health assessment identifies: 1. The patient's current health status and need for palliative care, including an assessment of the presenting signs and symptoms and the nature of the condition resulting in admission for palliative care; 2. The patient's diagnosis and prognosis; 3. Co-morbid medical and behavioral health disorders; 4. Specific physical symptoms and their severity, including but not limited to: a) Pain, dyspnea, nausea/vomiting, constipation; b) Fatigue, anorexia, sleep disorder, restlessness; c) Skin integrity; d) Confusion, delirium, or cognitive impairment, including the patient's ability to understand and participate in their care. 5. The patient's functional status including their ability to independently evacuate in an emergency; 6. Existing patient medical equipment and/or prosthetics and any related needs; 7. Allergies, including drug, food or other; 8. Current patient medications and biologicals, including over-the-counter medication; 9. The ability of the patient and/or family to safely administer medications and biologicals; 10. Complications or risk factors that affect care planning.	**Document Review:** Confirm that policies and procedures address a maximum time limit for an initial assessment of newly admitted patients and families. **Record Review:** Confirm that the assessment addresses the elements of the standard. **Guidance:** The assessment of pain in neonates, children, adolescents, and the elderly considers the patient's age, neurocognitive development, or cognitive status. **Tip:** The use of standardized tools in assessments is strongly recommended to support outcome measurement. (References for standardized tools are noted in the "Key Terms" section of this Manual.)

Standards	Evidence Guidelines
PCAC.8 The Interdisciplinary Team's assessment also includes evaluation of the patient's and family's psychosocial status and reaction to the illness that can impact palliative care planning and/or care delivery. The assessment includes identification of patient and family: 1. Distress, anxiety, depression, and stress; 2. Mental health crises, including suicidal ideation or evidence of substance abuse; 3. Mental status and how it may impact care or treatment; 4. Support systems; 5. Presence of able and willing caregivers; 6. Living arrangements and suitability for the delivery of care; 7. Coping mechanisms; 8. Anticipatory grief regarding the patient's illness; 9. Changes in employment or finances that affect financial security and related access to treatment; 10. Cultural factors that may impact care or treatment; 11. The need for: a) Counseling and/or education; b) Referrals and further evaluation by other appropriate health professionals; c) Access to other community resources.	**Record Review:** Review patient records to confirm a psychosocial assessment was conducted and documented as outlined in the standard. **Guidance:** The assessment is developmentally appropriate to support pediatric or geriatric patients. For pediatric patients, the assessment includes the siblings and other family members residing with the patient. **Guidance:** The suitability of living arrangements considers such elements as: the patient's safe access to the toilet if he/she is home alone and the only toilet is on the second floor; infested or otherwise dangerous living conditions; family advising that the patient cannot stay in their home and alternative living arrangements are needed, etc.

Standards	Evidence Guidelines
PCAC.9 The Interdisciplinary Team assessment includes identification of patient's and family's: 1. Religious or spiritual preferences; 2. Satisfaction with current spiritual support; 3. Identification of their faith community or spiritual counselor, as appropriate; 4. If spiritual support is requested or declined.	**Record Review:** Review patient records to confirm that a spiritual assessment was conducted and documented per the standard, including declining spiritual support. **Guidance:** The assessment of the need for spiritual support is ongoing and not limited to the initial assessment or is declined.
PCAC.10 The IDT assessment includes determination if the patient has advance directives and documentation of such or, if not, provides information about advance care planning.	**Record Review:** Patient records indicate if a patient has advance directives or has received advance care planning information and is pursuing or declined. **Interview:** Ask IDT members how advance care planning is integrated into the assessment and any follow-up.
PCAC.11 The IDT assessment is updated as frequently as the condition of the patient or family requires, as the patient requests, or as requested by the referring provider. Update of the assessment includes consideration of: 1. The patient's progress toward desired outcomes; 2. The patient's response to treatment.	**Record Review:** Confirm that the assessment is updated per the elements of the standard. **Interview:** Ask IDT members how they decide to update the assessment and what factors are considered.

Standards	Evidence Guidelines
PCAC.12 A standardized approach is used in developing and, as appropriate, updating each patient's palliative care plan to include: 1. The patient's goals and values; 2. The patient's treatment choices; 3. The participation of the patient and indication of their agreement to the plan; 4. As appropriate, the participation and updating of the family regarding the patient's medical goals and treatment choices.	**Record Review:** In patient records, confirm that the care plan reflects the patient's choices, goals, and their agreement to the plan. **Interview:** Ask IDT members how they ensure that items #1-4 are incorporated in the initial care planning along with any updates to the palliative care plan, and how they update the family regarding the care plan if that is the patient's choice. **Interview:** Ask patients about their participation in care planning and agreement with the plan.
PCAC.13 Each patient's palliative care plan includes: 1. The scope and frequency of services and treatment to meet the patient's and the family's needs and goals; 2. The patient's and family's participation in care, based on their ability and willingness; 3. Education and training to facilitate patient's and family's understanding of their roles and responsibilities in care, if any; 4. Pharmacologic/non-pharmacologic treatment, procedures, and complementary therapy to manage the patient's pain and other symptoms; 5. Needed medical equipment, supplies, and appliances, and sources to access such; 6. Measurable outcomes anticipated by implementing and coordinating the care plan.	**Record Review:** Confirm that the elements of the standard, appropriate to each patient, are incorporated in the palliative care plan. **Guidance:** Examples of outcomes anticipated include: improved quality of life, increased independence in Activities of Daily Living (ADL) and Instrumental Activities of Daily Living (IADL), reduced caregiver distress, improved patient activity with pain management, etc.

Standards	Evidence Guidelines
PCAC.14 Policies and procedures define a process of effective communication to support coordination of care with: 1. The patient and family; 2. IDT members; 3. Other identified health care professionals and providers involved in the patient's care.	**Document Review:** Confirm that policies and procedures define processes and responsibility for the ongoing sharing of information between disciplines and across providers (e.g., primary care physician, oncologist, cardiologist, oxygen supplier, pharmacy, etc.). **Record Review:** Confirm that communication is evident among those involved in care.
PCAC.15 Information is communicated effectively to patients and families in a manner that they understand and that encourages questions and dialogue. Appropriate auxiliary aids and translation services are used to ensure effective communication with patient and family.	**Interview:** Ask IDT members how they facilitate communication among patients and others involved in care, and how they confirm the patient's and/or family's understanding. **Interview:** Ask the patient and family if they believe they have the information they need, and if questions are answered in a way that they understand. **Guidance:** Translation through a language line or an individual(s) the patient designates is acceptable. **Tip:** Effective communication considers the age, culture, cognition, and patient/family health literacy, as well as assessment of their understanding.

Palliative Care Treatment and Transitions (PCTT)

KEY PERFORMANCE AREA:

Palliative care is provided according to the patient's and family's assessed needs and preferences, the palliative care plan, and accepted standards of practice. Palliative care is delivered by an Interdisciplinary Team (IDT).

The goal of palliative intervention is ongoing effective management of the patient's physical and emotional symptoms, optimizing function, as well as the patient's and family's psychosocial response to serious illness. Care delivery parallels the trajectory of the patient's illness and treatment, as well as the changing needs of the patient and of the family.

Standards	Evidence Guidelines
PCTT.1 Palliative care focuses on the patient's physical and functional needs, treatment choices and preferences, and the patient's and family's psychosocial and spiritual needs. The Palliative Care Program defines what Interdisciplinary Team services are available and accessible. These services may include care provided by the following: 1. Physician; 2. Registered nurse (RN) and/or advanced practice registered nurse (APRN) or physician assistant (PA); 3. Social worker; 4. Access to chaplains, spiritual counselors, or local clergy, if applicable.	**Document Review:** Review documents that describe the palliative care services available. Confirm that represented services are available and accessible. **Interview:** Ask patients and family about the scope of services available and accessibility when needed. **Interview:** Ask IDT members about accessibility to the services represented as available. **Record Review:** Do patient records reflect the range of services represented?

Standards	Evidence Guidelines
PCTT.2 The Palliative Care Program defines policy and procedure for a patient's and family's: 1. Access to the Interdisciplinary Team on a 24-hour basis, 7 days a week; 2. Alternatives to meet the patient's or the family's needs when in-person IDT care is not possible.	**Guidance:** "Access" is defined by the organization. It can include availability via telephone or an alternative mode (e.g., telemonitoring), as well as in-person visits. **Document Review:** Confirm policy and procedure addresses the standard. Review on-call records for evidence of implementation. **Interview:** Ask the patient and family their understanding of the availability of 24/7 services. **Interview:** Ask IDT members what access limitations exist to in-person visits, if any, and what alternatives are available.
PCTT.3 The Interdisciplinary Team identifies other health care professionals, providers, and community resources involved in the patient's care and, as appropriate, consults, collaborates, and shares information relevant to the patient's and family's care. The IDT makes referrals to—or recommends referrals to—other health care providers or community resources to address patient and/or family need.	**Record Review:** There is evidence of sharing information with other providers involved in care (e.g., home health agency, primary care physician, physician specialists) or community resources. **Interview:** Ask IDT members how and when information is shared with others involved in care, and how/when referrals or recommendations for referral are made.

Standards	Evidence Guidelines
PCTT.4 The palliative medical management of the patient's serious illness is the responsibility of the Interdisciplinary Team physician, APRN, and/or PA. If the patient's designated physician or licensed health care practitioner is unavailable, there is a process for the IDT to meet the medical needs of the patient. The responsibility assumed by the IDT is in accordance with federal and state law and regulation governing practice.	**Record Review:** Identify evidence that the patient's palliative medical management needs and other medical needs are being met in a timely manner. **Interview:** Ask the IDT physician, APRN, or PA about their role with that of the patient's designated physician. **Interview:** Ask the IDT how the medical needs of the patient are met when the patient's designated physician is not available. **Guidance:** Medical management may be shared through consultation and/or collaboration with the patient's designated physician(s) or other licensed health care practitioner.
PCTT.5 IDT-registered nurses, including APRNs: 1. May provide direct patient care; 2. Provide care and treatment per the palliative care plan; 3. Ensure the immediate and ongoing assessment of patient need; 4. Provide patient and family education per the palliative care plan.	**Document Review:** In the patient record, confirm that nursing services are provided per the palliative care plan. **Interview:** Ask the nurse member(s) of the IDT about the scope of their role and confirm that it meets the standard. **Interview:** Identify their role in the provision of direct patient care.

Standards	Evidence Guidelines
PCTT.6 The Interdisciplinary Team social worker: 1. Assesses psychosocial issues that may either impede or facilitate the patient's treatment and quality of life and provides intervention; 2. Assesses the psychosocial, mental, and behavioral status of the patient and the family and intervenes to promote the maximum benefit of care; 3. Facilitates access to community resources to meet patient and family needs; 4. Contributes to and provides care per the palliative care plan.	**Record Review:** Confirm that identified psychosocial, mental health, and behavioral needs were referred to the social worker for assessment and intervention. **Interview:** Ask an IDT social worker how social work services are used in assessing patient and family needs and in care planning to maximize the benefit of care. **Interview:** Ask members of the IDT how and when social work services are included and involved in patient and family care.
PCTT.7 The Interdisciplinary Team (IDT): 1. Assesses spiritual needs of the patient and the family; 2. Has a defined process to address identified spiritual needs at the patient's or family's request; 3. Coordinates with the patient's or the family's identified spiritual counselor and/or faith community or available spiritual counseling resources per the palliative care plan.	**Record Review:** Is there evidence that spiritual needs are assessed? Is there evidence of involvement of the local clergy or pastoral counselors per the patient's or the family's request? **Interview:** Ask IDT members how spiritual needs are assessed and how support is offered. **Interview:** Ask how local clergy or other spiritual counselors are integrated with the IDT and palliative care planning when involved with the patient and/or family. **Tip:** If a patient is not a member of a faith community, they may benefit from interaction with a spiritual counselor.

Standards	Evidence Guidelines
PCTT.8 The Interdisciplinary Team: 1. Uses and has access to treatment guidelines appropriate to the palliative care of pediatric and adult patients; 2. Conducts ongoing assessments of pain, other physical symptoms, functional status, and psychosocial symptoms using standardized tools as available; 3. Conducts reassessments in response to a change in the patient's condition or the patient's or family's status or needs; 4. Facilitates timely treatment in response to symptoms in accordance with the patient's goals and preferences; 5. Reassesses a treatment's effectiveness; 6. Documents the patient's and/or the family's response.	**Record Review:** Is there evidence of ongoing assessment, timely intervention in response to reported symptoms, and reassessment of the effectiveness of treatment? **Interview:** Ask the patient and/or family about their perception of a timely response to changing symptoms or status. **Interview:** Ask IDT members how they identify the need for ongoing assessments and when reassessment occurs. **Interview:** Ask who has lead responsibility for assessing the effectiveness of changes in treatment and when this occurs. **Interview:** Ask what practice guidelines they rely on as a resource.

Standards	Evidence Guidelines
PCTT. 9 Per policy and procedure, the Interdisciplinary Team ensures that regular and standardized medication reviews are conducted. The medication review includes: 1. Screening for drug-drug, drug-food, and other interactions; 2. Identifying duplicate therapies; 3. Screening for adverse side effects; 4. Assessing patient adherence; 5. Assessing the capability of the patient and/or family to safely self-administer medications and, if unable to do so, how the need for medication administration is, or can be, addressed.	**Document Review:** Review the policies and procedures to determine the standard medication review process and timing. **Record Review:** Does the documented medication review follow policy and timing and include all the elements of the standard, i.e., is it standardized? **Interview:** Ask an IDT member how the medication review process occurs and how often.
PCTT. 10 Palliative care procedure identifies a process to access an individual with palliative drug management expertise. The individual is available to: 1. Review the patient's medications—prescribed and over-the-counter (OTC); 2. Identify therapies to further address pain and other symptoms; 3. Resolve or prevent drug-related interactions; 4. Recommend deprescribing, as appropriate; 5. Be accessed during non-business hours.	**Document Review:** Review the procedure for accessing this expertise. **Interview:** Interview an IDT nurse or physician and ask who has the expertise, and how and when the expertise is used. **Guidance:** Individuals with palliative drug management expertise may include pharmacists, physicians, RNs, APRNs, or PAs who have special training or experience in palliative care or hospice, including a hospice medical director.

Standards	Evidence Guidelines
PCTT.11 When patient care includes the treatment of physical symptoms with opioids, the Interdisciplinary Team, in accordance with policy and procedure: 1. Assesses the need for a bowel regimen; 2. Screens for substance abuse and risk of diversion; 3. Instructs the patient and the family on the safe use of these medications, including storage and disposal in the home setting in accordance with applicable federal and state law and regulation.	**Document Review:** Review the policies and procedures regarding opioid administration, storage, and disposal, as well as patient and family education about such. **Record Review:** Request a record of a patient receiving opioids; confirm the elements of the standard are evident. **Interview:** Ask an IDT member how they screen for substance abuse and risk for diversion. **Interview:** Ask an IDT member and a patient or their family about opioid education, as well as instruction in safe storage and disposal.
PCTT.12 The Palliative Care Program considers complementary and alternative medicine (CAM) services for the treatment and management of symptoms and recommends such per the patient's preference and in consideration of access to such services.	**Interview:** Determine if the IDT recommends complementary or alternative medicine services. **Interview:** If CAM services are recommended, ask IDT team members how and when the recommendation is made. **Tip:** CAM may be used to manage pain and other symptoms and can include acupuncture, herbal treatments, movement therapy, massage, aromatherapy, or meditation. References include the National Center for Complementary and Integrative Health.

Standards	Evidence Guidelines
PCTT.13 If the Palliative Care Program utilizes remote monitoring or telemonitoring equipment, policies, and procedures, address: 1. Types of remote monitoring or telemonitoring available and equipment used; 2. Patient eligibility inclusion/exclusion criteria, including criteria for the discontinuation of telemonitoring services; 3. Patient and family education in the equipment's role in care delivery and its operation per manufacturer's guidelines; 4. How, and by whom, equipment is delivered, set-up, and tested, as well as placement for privacy per patient preference; 5. Who provides equipment troubleshooting and replacement, and how it is provided; 6. What data is collected and how it is integrated into the palliative care plan including: a) The scope and frequency of data collected; b) How and when findings are shared and with whom; 7. How and who transports used equipment from the home; 8. Storage of clean and dirty equipment.	**Interview:** Does the Palliative Care Program use remote monitoring or telemonitoring as part of patient care? **Document Review:** If yes, review policies, procedures, and other documents related to remote monitoring equipment. Validate that the documents address the requirements of the standard. **Guidance:** Remote monitoring or telemonitoring refers to the use of technology to collect and transmit patient data for the purposes of managing the patient's condition. **Guidance:** The use of remotely programmable equipment should include evaluation of cyber-security risk per HIPAA regulations. **Guidance:** Telemonitoring policies and procedures of a CHAP-accredited organization meet the content of the standard if applied to the Palliative Care Program.

Standards	Evidence Guidelines
PCTT.14 The Palliative Care Program, when indicated, recommends the patient to rehabilitation therapies including, but not limited to, physical, occupational, and speech-language therapies.	**Interview:** Ask an IDT member how the decision is made for referral or recommendation for referral to rehabilitation therapies. **Record Review:** Ask to review a record of a patient who has received rehabilitation therapies at the IDT's recommendation.
PCTT.15 The Interdisciplinary Team: 1. Facilitates advance care planning, including end-of-life discussions with the patient and/or family, as well as execution of advance directives; 2. Identifies and documents the patient's expressed preferences and who will act as the decisionmaker if the patient is unable to make decisions, which may include identifying if there is a health care power of attorney executed; 3. Reviews and, as appropriate, makes available advance directive documents, do-not-resuscitate (DNR) or other orders for incorporation into the patient's palliative care plan to guide IDT members and others involved in patient care, per state law and regulation.	**Record Review**: Is there documentation identifying the offer of advance-care planning or the patient's decline to execute such? Is there evidence of advance directives or other orders in the palliative care plan? Does the record identify if there is an individual who has the health care power of attorney? **Guidance:** Some states may require that a copy of an advance directive, or a DNR, or do-not-intubate (DNI) order is included in an accessible patient record or posted in plain view in the patient's home. **Guidance:** It is expected that the IDT is aware of the specific state requirements for orders and advance directives.

Standards	Evidence Guidelines
PCTT.16 In the course of ongoing care delivery, the Interdisciplinary Team: 1. Reassesses the patient's and family's understanding of the patient's serious illness and its trajectory; 2. Reassesses the patient's goals of care and treatment, as well as preferences—making changes to the palliative care plan as appropriate; 3. Provides the patient and the family the opportunity to ask questions and request information.	**Record Review:** Is there evidence of the elements of the standard? **Interview:** Ask an IDT member to review how the elements of the standard are met. **Interview:** Ask the patient or a family member if the IDT reassesses their goals and preferences. **Interview:** Ask the if patient or family are given the opportunity to ask questions and if they receive the information.
PCTT.17 The Palliative Care Program defines policy and procedure for: 1. The frequency of IDT meetings to assess the effectiveness of intervention and the palliative care plan; 2. The documentation of the IDT review and any changes in the palliative care plan; 3. How and when the information from the IDT review is shared with other health care professionals, providers, and community resources, as appropriate to their role in patient care.	**Document Review:** Review the organization's policies regarding items #1-3. Ask if the review is documented for each patient or if there is a record of review. **Record Review:** Review the documentation of the IDT meetings and how it relates to patient record content. **Interview:** Ask an IDT member about the frequency of meetings, participation of the disciplines involved, and communication and coordination following the meeting.

Standards	Evidence Guidelines
PCTT.18 The Palliative Care Program has defined policy and procedure to promote continuity of care during a patient's discharge from the Palliative Care Program or transfer of care to a health care facility or other health care provider. The policy and procedure identifies: 1. The information provided to the patient and family prior to the discharge or transfer, including advising them of any continuing care needs; 2. The minimum information concerning the patient's and family's care and treatment that is provided to the receiving facility or health care provider(s) assuming responsibility for care and to the patient's designated physician; 3. How the IDT and others involved in patient care are informed of the transfer or discharge; 4. What—and how—information is provided regarding other sources of care to meet continuing care needs appropriate to the patient's preference and health status; 5. What documentation of the transfer or discharge is noted in the patient record.	**Document Review:** Review the organization's policies and procedures. Do they meet the elements of this standard? **Record Review:** In the record of a patient who was transferred or discharged, are the elements of the standard noted per the organization's policy and procedure? **Interview:** Ask the IDT the usual process for transfer or discharge. How are the patient and family informed of the need for either? **Guidance:** Care sources to meet continuing patient and family needs may include home health services, mental or behavioral health services, or hospice care.

Standards	Evidence Guidelines
PCTT.19 When signs and symptoms indicate the likely imminent death of the patient, the Interdisciplinary Team: 1. Evaluates the best care setting, considering the patient's wishes and the family's caregiving capacity; 2. Prescribes medication and recommends supplies that may be needed for symptom management; 3. Provides education and instruction to the family or other caregivers in preparation for the patient's death, including what to expect regarding symptom changes and what will happen after the patient's death. If present at the patient's death, the IDT member(s): 1. Acts in accordance with local and state law and regulation regarding the declaration of death; 2. Provides instruction about appropriate opioid and other drug disposal per federal, state, or local law and regulation as well as Program policy and procedure. The IDT provides information regarding bereavement support services and recommends community resources for bereavement follow-up as indicated.	**Interview:** Ask IDT members the process for preparing a family for the patient's anticipated death, including the elements of the standard. **Interview:** Ask the IDT team the process for declaration of death if present in the home when death occurs, and their understanding of drug and, particularly, opioid disposal where the patient resides. **Record Review:** Review one or more records of a patient who has died while under the care of the Palliative Care Program. Is there evidence that the elements of the standard were addressed? **Document Review:** Review the Program's drug disposal policy and procedure, including any specific to opioid disposal. **Guidance:** It is expected that the IDT is familiar with the state and local laws and regulation that apply to death in the home as well as drug disposal.

Palliative Care Infection Prevention and Control (PCIC)

KEY PERFORMANCE AREA:

Providing home and community-based care requires effective Infection Prevention and Control processes to reduce the risk of acquiring or transmitting infectious disease in settings where palliative care is provided.

Effective communication between the Interdisciplinary Team (IDT), patients, families, and visitors about infection prevention and control is key to supporting their roles and responsibilities in reducing the risk of spreading infectious and communicable disease through daily activities and interaction.

Often, the environment of care is also where the patient/family resides. The IDT balances respect for a patient's self-care and the patient's and family's autonomy with identified infection control risk. The IDT's role is to ensure that the patient and family understand the importance of minimizing risk.

The IDT is expected to identify risks when present, educate the patient, family, and visitors of the risk, and ask their cooperation in modifying the care environment to the extent possible to prevent infections or the spread of communicable disease.

Standards	Evidence Guidelines
PCIC.1 *Effective August 2019* Infection prevention and control processes that identify, prevent, and control infection are documented. The policies and procedures include: 1. Care of patients with an identified multi-drug-resistant organism; 2. Safe transport of equipment and supplies in and out of the patient's home (e.g., stethoscope, etc.); 3. Availability of personal protective equipment (PPE) for IDT members at risk for exposure; 4. Protection of patients, families, visitors, and the IDT from bloodborne or airborne pathogens; 5. Patient and family instruction regarding medical waste disposal; 6. Education about standard precautions and the prevention and control of infection—particularly communicable diseases—available to the IDT, patients, families, and visitors. Palliative care staff at risk for occupational exposure to TB, are screened and tested as defined in state or local law and regulation or per the organization's assessment of exposure risk based on the population and/or community served. In the absence of state or local law and regulation or organization assessed risk, screening and testing occurs per current Centers for Disease Control and Prevention (CDC) guidelines. There is appropriate follow-up when TB risk is identified.	**Document Review:** Confirm that the processes address the items listed. **Interview:** Ask how and when the patients, families, and the IDT receive timely education about identifying, preventing, and controlling infection and risk for infection. **Guidance:** A separate infection prevention and control program is not required if the infection control and prevention program of a CHAP-accredited organization is applied to the Palliative Care Program.

Standards	Evidence Guidelines
PCIC.2 The Interdisciplinary Team uses Centers for Disease Control and Prevention (CDC) standard precautions for care delivery in any care setting. These precautions include: 1. Hand hygiene; 2. Environmental cleaning and disinfection to remove visible blood, organic, or inorganic matter on surfaces used in patient care; 3. Appropriate use of personal protective equipment (PPE) including gloves, mask, eye protection, and/or face shield, depending on risk for exposure; 4. Safe handling of soiled items in the patient's care environment, especially if they are likely to be contaminated with body fluids; 5. Reuse of medical equipment between each patient contact; 6. Injection and medication safety; 7. Other requirements as specified by state and federal law and regulation.	**Observation:** Observe IDT care delivery for use of standard precautions. **Interview:** Ask IDT members how they use standard precautions in their care. **Guidance:** Standard precaution practices apply to all patients, regardless of suspected or confirmed infectious status. **Tip:** Staff influenza immunization is recommended to reduce patient infection risk and protect staff. **Tip:** The CDC website contains guidelines and instruction for items #1-6. **Guidance:** The standard precaution process of a CHAP-accredited organization can be used for palliative care to meet this standard.
PCIC.3 Bags used to carry medical equipment (e.g., BP cuff) or supplies into or out of the care setting are used in a manner consistent with policy to prevent the spread of infectious and communicable disease.	**Observation:** Observe the IDT transport and use of bags. Verify that policy is followed and that bags are managed in a manner that avoids cross-contamination. **Interview:** Ask IDT members to describe bag use in the care of patients in the home.

Standards	Evidence Guidelines
PCIC.4 Patients, families, and visitors are instructed on infection prevention and control practices related to the care provided by the IDT, the patient's health status, and the setting in which care is provided.	**Interview:** Ask IDT members about the types of education that they provide to patients, families, and/or visitors for minimizing infection risk. **Guidance:** Education used by a CHAP-accredited organization and applied to palliative care services meets the content elements of the standard.

Palliative Care Quality Assurance and Performance Improvement (PCPI)

KEY PERFORMANCE AREA:

Palliative Care Programs sustain a Quality Assurance and Performance Improvement (QAPI) program. The QAPI program is a proactive process to improve program performance, patient/family care and outcomes, and effectively respond to adverse events.

- **Quality Assurance (QA):** Quality assurance is the specification of standards for quality service and outcomes. It sets a threshold throughout the organization to ensure that acceptable levels of quality are being maintained. QA is both anticipatory and retrospective in identifying how the organization is performing, including where in the care process performance is at risk or has failed to meet standards.
- **Performance Improvement (PI):** Performance improvement (also called Quality Improvement or QI) is the continuous evaluation and improvement of processes to ensure better care delivery or outcomes and prevent or decrease the likelihood of a problem. PI identifies areas of opportunity to test new approaches to "fix" the underlying causes of persistent problems or barriers to improvement. PI can make good quality even better.

QAPI represents an ongoing, organized method of delivering care to achieve optimum results.

Standards	Evidence Guidelines
PCPI .1 The Palliative Care Program develops, implements, and sustains a Quality Assurance and Performance Improvement (QAPI) program.	**Document Review:** Review the documented QAPI program. **Guidance:** A separate QAPI program is not required if palliative care is a service of a CHAP-accredited organization. Evidence of integrating palliative care performance improvement activity in an existing QAPI program meets the intent of the standard.

Standards	Evidence Guidelines
PCPI.2 One or more selected Performance Improvement activities address outcomes of palliative care and/or improvement in palliative care processes.	**Document Review:** Review the PI activity and determine if activity as stated in the standard is addressed. **Interview:** Interview an individual involved in QAPI activities and ask how the priority for PI activity is selected.
PCPI.3 Data used in Performance Improvement activity may include: 1. Patient outcomes; 2. Complaints; 3. Results of experience of care surveys; 4. The incidence of adverse events.	**Document Review:** Review the scope of data used in quality improvement activity. **Guidance:** The emphasis is on the use of established quality improvement methodologies, such as the use of standardized data elements and, as available, validated measures.
PCPI.4 Action taken in response to a PI activity is evaluated to assess the progress toward the goal(s) established by the Palliative Care Program and if the expected outcome is achieved. Performance is tracked to ensure that improvement is sustained.	**Interview:** Ask the individual(s) responsible for QAPI to identify action taken and how it was evaluated. If successful in achieving improvement, what do they do to ensure improvement is sustained?

Palliative Care Management and Governance (PCMG)

KEY PERFORMANCE AREA:

The effective oversight and efficient management of the Palliative Care Program's day-to-day operations is the responsibility of the Program's management and governing body.

Governance, whether one person or more, has the overall accountability for the sustainability of the palliative care services.

NOTE: THE FOLLOWING STANDARDS CAN BE MET IF THE PALLIATIVE CARE PROGRAM UTILIZES THE GOVERNANCE AND MANAGEMENT STRUCTURE OF A CHAP-ACCREDITED ORGANIZATION WITH APPROPRIATE REFERENCE TO—OR PROVISION FOR—THE PALLIATIVE CARE PROGRAM.

Standards	Evidence Guidelines
PCMG.1 Palliative care services are delivered: 1. In compliance with local, state, and federal law and regulation related to the health and safety of patients; 2. As licensed per state or local law and regulation, as applicable.	**Document Review:** Review documentation related to compliance with law or regulation to operate the business. **Interview:** Ask the designated manager how he/she ensures that the Palliative Care Program complies with applicable local, state, and federal law and regulation. **Guidance:** This standard assesses the organization's compliance with, and knowledge of, applicable law and regulation.

Standards	Evidence Guidelines
PCMG.2 There is one or more person who assumes governance of the Palliative Care Program, including: 1. The overall management and operation of the Palliative Care Program; 2. The provision of palliative care.	**Interview:** Identify the governance of the Palliative Care Program.
PCMG.3 A designated individual is responsible for day-to-day operations of the palliative care service. If this individual is not available, another individual is designated to assume management duties and responsibilities.	**Document Review:** An individual has been designated to manage day-to-day operations. **Interview:** Ask the individual responsible for day-to-day operations—or a member of the Interdisciplinary Team (IDT)—who is responsible when that individual is not available.
PCMG.4 Resources are organized, managed, and administered to provide the palliative care and services to patients and families as represented publicly.	**Interview:** Ask the individual responsible for day-to-day operations how the program meets the intent of the standard; consider the scope of services provided versus any brochures, public information, etc.

Standards	Evidence Guidelines
PCMG.5 There is policy and procedure defining the Palliative Care Program's response to emergencies, including man-made or natural disasters. It addresses: 1. Identification of patients needing assistance with evacuation and how this will occur; 2. Communication with the Interdisciplinary Team regarding patient continuing care needs and how these can be met; 3. Communication with receiving facilities when patient transfer is indicated; 4. Communication with other health care providers regarding the plan to continue to meet patient needs; 5. A process for continuing operations during the disaster; 6. A process for follow-up following the emergency situation.	**Interview:** Ask the day-to-day management about the emergency preparedness process and how it will be implemented. **Document Review:** Do the policies and procedures address the elements of the standard?
PCMG.6 An annual operating budget is developed that reflects the scope and complexity of the palliative care services provided.	**Document Review:** Review the most recent annual budget.

Standards	Evidence Guidelines
PCMG.7 The delivery of palliative care is documented in a patient record using a standardized format. The management, storage, and retrieval of patient records, as well other data collected in the course of providing care, is in accordance with policies and procedures that, at a minimum, address: 1. The types of operational and patient care data documented and/or collected; 2. Procedures and time frames for receipt of care documentation from the Interdisciplinary Team; 3. Patient record storage and retention; 4. Access, use, and protection of patient health information in compliance with federal and state law and regulation.	**Document Review:** Review policies and procedures that describe how patient information is documented, who provides oversight of content, and how the elements of the standard are met.
PCMG.8 There are documented Human Resources policies that support the operation and delivery of palliative care, and comply with local, state, and federal law and regulation. Human Resources policies are available to staff.	**Document Review:** Review Human Resources policies for general operational elements such as hours, reporting time, payroll, vacation and holidays, immigration status (I-9), etc.

Standards	Evidence Guidelines
PCMG.9 The duties, roles, and responsibilities for each position are documented and include qualifications, as well as required experience, education, training, current certifications, registrations, and/or licensure. There is evidence that the current Interdisciplinary Team meets the elements of the job descriptions.	**Document Review:** Review position descriptions. **Personnel Record Review:** Identify members of the IDT and compare evidence in the personnel record to the provisions of the job description.
PCMG.10 In the event that another organization or individual provides palliative care services on behalf of the Program, there is a written agreement between the parties involved. The written agreement includes: 1. The scope of services provided; 2. How the Interdisciplinary Team provides oversight and coordination; 3. That services are provided: a) Only upon authorization by the IDT; b) In a safe and effective manner; c) By qualified personnel, as defined by palliative care service; d) In accordance with the palliative care plan.	**Contract Review:** Ask if any palliative care service is contracted. If so, review the contract to confirm the requirements of the standard are included. **Interview:** Ask the person responsible for day-to-day operations how they ensure that care provided under arrangement: 1. Follows the palliative care plan; 2. Is provided when authorized by the IDT; 3. Is provided by qualified staff; 4. Is delivered in a safe and effective manner.

Palliative Care Certification Key Terms

***Abuse*:** One individual purposely harming another individual; can take the form of verbal abuse, sexual abuse, physical battering, financial abuse, or psychological (emotional) unavailability.

***ADLs or Activities of Daily Living*:** ADLs include transferring to/from the bed or a chair, ambulating, dressing the upper and lower body, bathing, and toileting—all further defined by an individual's degree of dependence on medical equipment or another person to execute safely.

***Advance Care Planning*:** A process in which an individual makes decisions about the care they would want to receive should they become unable to speak for themselves. The decisions reflect the individual's expressed values and preferences; they are based on discussions with health care professionals that include the types of life-sustaining treatments and what the individual would want if diagnosed with a life-limiting illness or condition. The decisions are shared with loved ones and others (e.g., personal physician) who will be involved in treatment. These preferences are stated in a document called an "advance directive."

***Advance Directive*:** A document that states an individual's wishes regarding treatment at end-of-life. The document becomes legal upon the individual's signature before witnesses. The laws governing advance directives vary from state to state, therefore, the directive should comply with the state in which the individual resides.

***APRN or Advanced Practice Nurse*:** An APRN is a registered nurse with a graduate degree in nursing. An APRN may take a health history, assess, diagnose, and treat acute and chronic illness, often acting as the primary care provider. The types of medicines that she/he can prescribe and the level of supervision by a physician is prescribed by each state.

***Adverse Event*:** An event that results in unintended harm to the patient by an act of commission or omission rather than by the underlying disease or condition of the patient.

***Anticipatory Grief*:** A grief reaction in response to an impending loss. Anticipatory grief includes depression, extreme concern for the dying person, preparing for the death, and adjusting to changes caused by the death.

CAM or Complementary and Alternative Medicine: CAM includes products and services that are not part of standard medical care.

***Caregiver*:** An unpaid or paid individual who assists the patient most often with activities of daily living and who may also be involved in other aspects of the patient's care. Caregivers can include designated individuals in the patient's social network.

CDC or the Centers for Disease Control and Prevention: The CDC is a division of the U.S. Department of Health and Human Services. The Agency serves as the national focal point for developing and applying disease prevention and control, environmental health, and health promotion and health education to improve the health of the people of the United States. The CDC is responsible for controlling the spread of infectious diseases.

***Complaint*:** A statement that a situation is unsatisfactory or unacceptable; a reason for dissatisfaction or an expression of such.

***Continuing Care Needs*:** Services and care that, in the professional judgement of the Interdisciplinary Team, the patient and/or family will likely continue to need after palliative care is discontinued.

***Experience of Care Survey*:** A standardized survey to improve care delivery that asks about the patient's and/or family's experience of elements of care. (e.g., the Interdisciplinary Team answered my questions; my medications were explained in a manner that I understood; etc.)

***Family*:** In the context of these standards, family is defined by patient and may include individuals related by blood or marriage or adoption, as well as other individuals so named by the patient.

***Functional Status*:** The ability to perform activities of daily living (ADLs), as well as indicators of vision and hearing, cognitive status including memory and visual-spatial relationships (e.g., clock and time).

***Incompetent*:** A legal status referring to a person who is not able to manage his/her affairs due to mental deficiency (e.g., lack of I.Q., deterioration, illness, or psychosis) or sometimes physical disability.

***IADLs or Instrumental Activities of Daily Living*:** IADLs are actions that combine mental and physical function, such as using the telephone, grooming, shopping, meal preparation, arranging transportation, and managing finances, etc. Like ADLS, all are further defined by an individual's degree of dependence on equipment or another person to execute safely.

***Licensed Health Care Practitioner*:** An individual other than a physician who is licensed or otherwise authorized by the state or federal government to provide health care services.

***Mental Status*:** Cognitive (knowledge-based) ability, appearance, emotional mood, as well as speech and thought patterns.

***PA or Physician Assistant*:** A PA provides care under the supervision of a physician. A PA's scope of practice is defined by state medical boards and may include taking a health history, diagnosing an illness, developing and carrying out treatment plans as well as tasks such as suturing wounds.

***PCP or Primary Care Physician*:** A PCP is a specialist in family medicine, internal medicine or pediatrics who provides definitive care to the patient at the point of first contact and takes continuing responsibility for providing the patient's comprehensive care. This care may include chronic, preventive, and acute care in both inpatient and outpatient settings. Such a physician must be specifically trained to provide comprehensive primary care services through residency or fellowship training in acute and chronic care settings.

***PPE or Personal Protective Equipment*:** PPE refers to protective clothing, gloves, face shields, goggles, facemasks and/or respirators, or other equipment designed to protect the wearer from injury or the spread of infection or illness.

***Psychosocial*:** The interrelation of social factors and an individual's thought and behavior. Psychosocial health is defined as a state of mental, emotional, social, and spiritual well-being. The thinking portion of psychosocial health is known as mental health.

***Serious Illness*:** A condition that carries a high risk of mortality and either negatively effects a person's daily function or quality of life or excessively strains their caregivers. Serious illnesses can include heart failure, cancer, dementia, COPD, or many other conditions.

***Standard Precautions*:** Standard precautions are defined by the Centers for Disease Control (CDC) based on the principle that all blood, body-fluid, secretions, excretions (except sweat), non-intact skin, and mucous membranes may contract transmissible infectious agents.

***Standardized Assessment Tool*:** A validated, uniform set of statements or figures used to regularize the measure or evaluation of condition or symptom assessed.

Suicidal Ideation: Recurring thoughts of—or preoccupation with thoughts of—suicide or actions that could result in death. Suicidal ideation is often associated with the diagnoses of major depression, bipolar disease, or PTSD (post-traumatic stress disorder).