CHAP Community Health Accreditation Partner

CHAP
2300 Clarendon Blvd., Suite 405
Arlington VA 22201
202.862.3413

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

Home Health

Standards of Excellence

Copyright © 2018, 2019, 2021, 2022, 2023, 2024, 2025 by Community Health Accreditation Partner
2300 Clarendon Blvd., Suite 405, Arlington, Virginia 22201 All rights reserved.

No part of this document may be reproduced, stored in a retrieval system, or transmitted, in any form or by any means, electronic, mechanical, photocopying, recording or otherwise, without prior written permission of the publisher.

Table of Contents

Introduction to the Home Health Standards of Excellence ii
Patient-Centered Care Standards (PCC) 1
Assessment, Planning and Coordination Standards (APC) 12
Care Delivery and Treatment Standards (CDT) 35
Human Resource Management Standards (HRM) 52
Continuous Quality Improvement Standards (CQI) 73
Infection Prevention and Control Standards (IPC) 81
Emergency Preparedness Standards (EP) 99
Leadership and Governance Standards (LG) 112
Financial Stewardship Standards (FS) 125
Information Management Standards (IM) 130
Compliance Program Standards (CP) 142
Key Terms 145
Appendix 164

Introduction to the Home Health Standards of Excellence

Overview

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

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

Regulatory Requirements

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

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

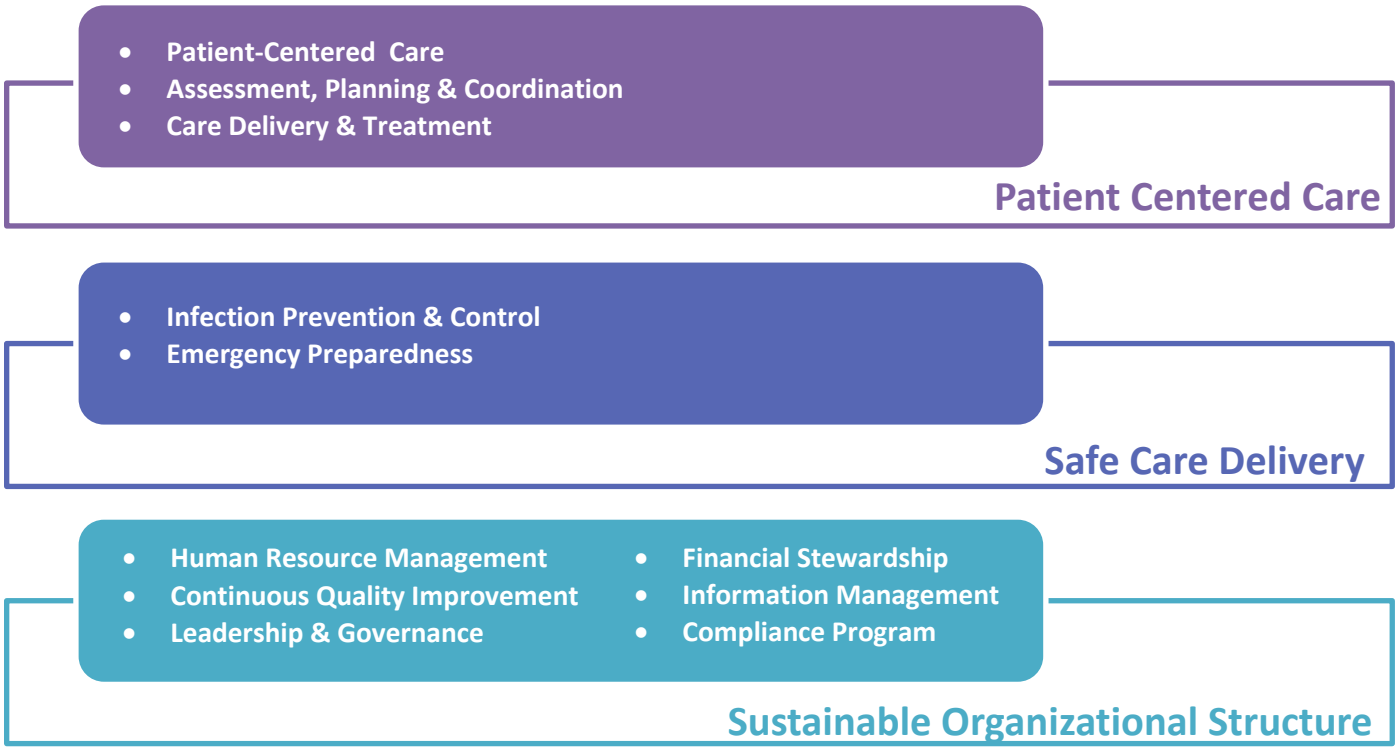
Revision Reference Tables for This Update

Standard	Summary	Effective Date
CP.7	Updated Standard Language; Updated Evidence Guidelines	6/1/2025

Please see the Appendix (page 164) for the list of all previous revisions.

Key Performance Areas

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



A **Key Performance Area** is the central topic evaluated by the standards. Each Key Performance Area 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.

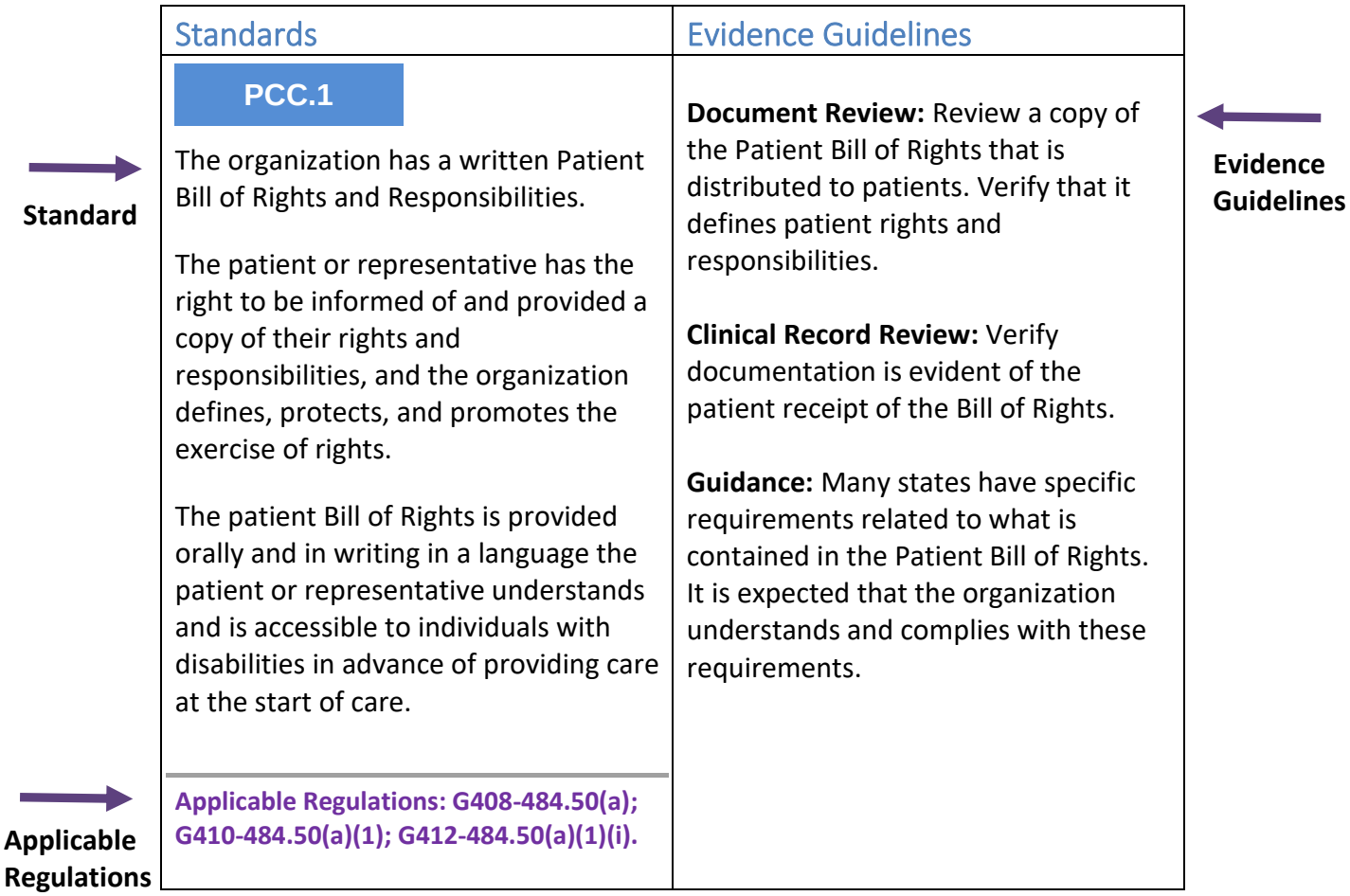
Evidence Guidelines

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

1. **Guidance Statements:** Explain expectations, nuances or terms used in the standard. Guidance supports the organization in understanding the requirements of each standard. 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, complaint log).
3. **Interview:** One or more interviews with personnel and/or patients or caregivers are used to assess compliance with the standard.
4. **Record Review:** Personnel or patient records are an important source of assessing compliance.
5. **Observation:** One or more home visits or patient interviews are conducted to demonstrate 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 to support organizational compliance with the standard, as well as evidence-informed practices. Information in a *Tip* is not used as part of a compliance determination.

Composition of Standards

Below is an example of how a standard is organized within each KPA. The type of evidence guidelines will vary from standard to standard.



PAGE INTENTIONALLY LEFT BLANK

Patient-Centered Care

Key Area of Performance:

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 The organization has a written Patient Bill of Rights and Responsibilities. The patient or representative has the right to be informed of and provided a copy of their rights and responsibilities, and the organization defines, protects, and promotes the exercise of rights. The patient Bill of Rights is provided orally and in writing in a language the patient or representative understands and is accessible to individuals with disabilities in advance of providing care at the start of care. **Applicable Regulations: G406-484.50; G410-484.50(a)(1); G412-484.50(a)(1)(i).**	**Document Review:** Review a copy of the Patient Bill of Rights that is distributed to patients. Verify that it defines patient rights and responsibilities. **Clinical Record Review:** Verify documentation is evident of the patient receipt of the Bill of Rights. **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.

Standards	Evidence Guidelines
PCC.2 The Patient Bill of Rights includes the right to: 1. Be informed of their rights; 2. Exercise rights at any time; 3. Have their 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: a) the mode of care-delivery including the use of telecommunications when applicable; b) completion of all assessments; c) the care to be furnished, based on the comprehensive assessment; d) establishing and revising the plan of care; e) the disciplines that will furnish the care; f) the frequency of visits; g) expected outcomes of care, including patient-identified goals and anticipated risks and benefits; *(continued on following page)*	**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. **Clinical Record Review:** Verify the record includes a copy of the Patient Bill of Rights that contains all the rights identified in the standard. **Interview - Patient:** 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 their care. **Interview - Personnel:** Interview personnel who provide patient care or services to verify ways in which patient can exercise their rights. **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 their 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.

Standards	Evidence Guidelines
PCC.2 h) any factors that could affect treatment effectiveness; and i) 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; 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; the *(continued on following page)*	**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. **Guidance:** Initial agencies that are not yet accredited by CHAP are prohibited from providing information on the CHAP toll-free number. **Guidance:** Some states do not have toll-free hotlines for lodging complaints. In these instances, the organization is required to include only the CHAP toll-free number.

Standards	Evidence Guidelines
PCC.2 organization must also comply with the requirements of 42 CFR §405.1200 through §405.1204; 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 a) Agency on Aging; b) Center for Independent Living; c) Protection and Advocacy Agency; d) Aging and Disability Resource Center; and e) Quality Improvement Organization; 16. Be free from any discrimination or reprisal for exercising their 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. **Applicable Regulations: G406-484.50; G424-484.50(b)(1); 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).**	

Standards	Evidence Guidelines
PCC.3 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 pursuant to state law to act on the patient's behalf. Or If the state court has not judged a patient incompetent, any legal representative designated by the patient in accordance with state law may exercise the patient's rights to the extent allowed by state law. **Applicable Regulations: G424-484.50(b)(1); G424-484.50(b)(2); G424-484.50(b)(3).**	**Clinical Record Review:** 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. Verify there is documentation of the patient's or legal representative's signature confirming the receipt of a copy of the notice of rights and responsibilities. **Observation – Home Visit:** Validate with the patient and/or representative that they received information on their rights and responsibilities. **Guidance:** The patient's legal representative is a person who has the legal authority to act on the patient's behalf. **Guidance:** Signatures may be obtained electronically or digitally.

Standards	Evidence Guidelines
PCC.4 During the initial assessment and in advance of providing care: 1. The organization provides the patient or representative with verbal and written notice of the patient's rights and responsibilities; 2. This information is provided in a language and manner the patient understands and accessible to those with disabilities; 3. The organization obtains the patient's or representative's signature confirming that they received a copy of the Bill of Rights and Responsibilities statement; 4. The signed Bill of Rights is part of the patient's clinical record. **Applicable Regulations: G406-484.50; G410-484.50(a)(1); G418-484.50(a)(2).**	**Clinical Record Review:** Verify there is documentation that the patient was informed of their rights, both verbally and in writing, prior to the initiation of care. **Guidance:** Some states have specific requirements for informing patients of their rights, including identifying timeframes for providing information to patients and requirements for obtaining signatures acknowledging receipt. It is expected that organizations know and follow the specific law and regulations in the states in which they operate. **Guidance:** The organization may provide this information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.
PCC.5 The organization provides verbal notice of the patient's rights and responsibilities in the individual's primary or preferred language and in a manner the individual understands, free of charge, with the use of a competent interpreter, if necessary, from a skilled professional.	**Interview:** Interview a key clinical leader. Verify, through specific patient examples, the way in which the patient's rights are verbally explained by the second skilled visit in cases where the patient is unable to understand the language in which patient rights are primarily provided. If there is not an example in an organization's actual experience, verify the process that is in place to address the standard, should the situation occur.

Standards	Evidence Guidelines
PCC.6 The organization provides the patient and the patient's legal representative (if any) written notice of the patient's rights and responsibilities, the organization's transfer and discharge policies, and an Outcome and Assessment Information Set (OASIS) privacy notice to all patients for whom OASIS data are collected. Written notice is provided during the initial evaluation visit, in advance of furnishing care to the patient, and is understandable to persons who have limited English proficiency and accessible to individuals with disabilities. Written notice of the patient's rights and responsibilities and the transfer and discharge policies are provided to a patient or legal representative, if any, within four business days of the initial evaluation visit. **Applicable Regulations: G410-484.50(a)(1); G412-484.50(a)(1)(i); G416-484.50(a)(1)(iii); G422-484.50(a)(4); G444-484.50(c)(9); G452-484.50(d).**	**Interview:** Interview a key leader. Verify, through examples, the process to ensure that required information is given to the patient and representative (if any). **Clinical Record Review:** Verify documentation that the patient's rights, the transfer and discharge policies, and the OASIS privacy notice (if applicable) were given to the patient prior to providing care in a way that is understandable to the patient. Verify that documentation of the patient's rights and responsibilities and discharge and transfer policies were provided to the patient's representative within four days of the initial evaluation visit. **Guidance:** The patient's legal representative is a person who has the legal authority to act on the patient's behalf. The patient's selected representative is a person whom the patient may choose, but who may not necessarily have legal authority to act on behalf of the patient, such as a friend or family member who is assisting the patient.

Standards	Evidence Guidelines
PCC.7 Patients and caregivers are provided contact information and can access the organization 24 hours a day, 7 days a week. Personnel respond to the needs of patients in accordance with organizational policy and patient needs. Care outside normal operating hours is accessible in accordance with organizational policy.	**Document Review:** Review phone logs that document calls from patients and their caregivers outside of normal operating hours. Validate that calls were responded to within the timeframes outlined in policy. This information may also be found in the patient record. **Interview:** Interview a key leader responsible for managing on-call coverage. Verify the ways in which this coverage is provided. **Observation:** Place a call to the organization after operating hours. Validate that the call is returned within the timeframe specified in organizational policy. **Interview:** Interview a patient and /or caregiver. Ask if they have had to call the organization for information or assistance during or after normal operating hours. If so, verify that the organization responded within its established timeframe and that a home visit was conducted if indicated. If a home visit is not conducted, interview the patient via telephone. **Guidance:** 24/7 availability means that the patient can reach the organization at all times. It does not require that care and services are provided 24/7. The organization determines the immediacy of any needed services.

Standards	Evidence Guidelines
PCC.8 During the initial evaluation and prior to furnishing care, the organization provides the patient and the patient's legal representative (if any) the contact information for the Administrator, for the purpose of receiving complaints. Contact information includes the Administrator's name, business address, and business phone number. **Applicable Regulations: G410-484.50(a)(1); G414-484.50(a)(1)(ii).**	**Document Review:** Review documents given to the patient at the time of initial assessment. This might be found in an admission packet or the patient's record. Verify that contact information, including name, business address, and business phone number for the Administrator is included. **Observation – Home Visit:** Conduct a home visit. Validate, through a patient interview, that the patient and/or legal representative was given required Administrator contact information, including name, business address, and business phone number, prior to the initiation of care.
PCC.9 Per policy and procedure, the organization responds to alleged violations involving anyone working on the organizations behalf by: 1. Immediately investigating all alleged violations; 2. Taking immediate action to prevent further potential violations while the alleged violation is verified; documenting these actions; 3. Investigating complaints made by the patient, the patient's representative (if any), and the patient's caregivers and family including, but not limited to, the following topics: a) Treatment or care that is (or fails to be) furnished, is furnished inconsistently, or is furnished inappropriately; b) Mistreatment, neglect, or verbal, mental, sexual, and physical abuse, *(continued on following page)*	**Document Review:** Review complaint logs, incident reports, or other documents that record the receipt of complaints. Review records of the investigation, resolution, and response for complaints within the most recent 12-month period. Validate that the topics required by the standard are investigated. Review logs, incident reports, or other documents that records reports of suspected mistreatment, neglect, or verbal, mental, sexual, or physical abuse. Review records of the investigation, resolution and response for any reported incidents within the most recent 12 months. **Interview:** Interview a key leader. Verify the ways in which complaints are identified, investigated, and resolved. Verify the actions the organization takes, or would take, to prevent further potential violations during the investigation. *(continued on following page)*

Standards	Evidence Guidelines
PCC.9 including injuries of unknown source, and/or misappropriation of patient property by anyone furnishing services on behalf of the organization; 4. Taking appropriate corrective action in accordance with state law if the alleged violation is verified by the organization administration or an outside body having jurisdiction, such as the state survey agency or local law enforcement agency; 5. Ensuring actions are taken to prevent further potential violations or retaliation while the complaint is being investigated; 6. Ensuring that verified violations are reported to the state and local bodies having jurisdiction (including the state survey and certification agency); 7. Documenting the results of the investigation, resolution of the complaint and taking action to prevent further potential violations; 8. Notifying the complainant of the complaint status. **Applicable Regulations: G478-484.50(e)(1)(i); G478-484.50(e)(1)(i)(A); G478-484.50(e)(1)(i)(B); G484-484.50(e)(1)(ii); G486-484.50(e)(1)(iii); G488-484.50(e)(2).**	**Guidance:** It is expected that the organization communicates with a complainant about the status of a complaint investigation. CHAP does not require that an organization discloses any specific actions taken to resolve a complaint, except as required by law. **Guidance:** Some state law defines the ways in which patient complaints are managed. It is expected that organizations know and follow these laws and regulations. **Guidance:** Not every complaint can be resolved to the patient's or complainant's satisfaction. It is expected that the organization takes action to resolve complaints to the extent possible and within the scope of services it provides. **Guidance:** Suspected instances of mistreatment, neglect, or verbal, mental, sexual, or physical abuse may be reported by a patient, caregiver, family, friend, or concerned other, as well as any contracted or employed personnel, including volunteers. **Guidance:**" Immediately" means as soon as possible, but not to exceed 24 hours after discovery or the incident, in the absence of a shorter state timeframe requirement.

Standards	Evidence Guidelines
PCC.10 Personnel (employed directly or under arrangement) in the normal course of providing services to patients, who identify, notice, or recognize incidences or circumstances of mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and/or misappropriation of patient property, report these findings immediately (within 24 hours) to the organization and the appropriate authorities in accordance with state law. **Applicable Regulation: G488-484.50(e)(2).**	**Document Review:** Review logs, incident reports, or other documents that record reports of suspected mistreatment, neglect, or verbal, mental, sexual, or physical abuse, including injuries of unknown source or misappropriation of property. Review records for any reported incidents within the most recent 12 months. Validate that reporting to the organization and appropriate authorities occurred within the timeframes required by the standard. **Interview:** Interview the administrator or personnel involved in overseeing service delivery. Clarify, through specific patient examples, how suspected instances of mistreatment or neglect are identified and handled. **Guidance:** In most states, state law clearly defines actions required for identifying and reporting mistreatment, neglect, or verbal, mental, sexual, or physical abuse. It is expected that the organization knows and follows the state's law and regulation. **Guidance:** Suspected instances of mistreatment, exploitation, neglect, or verbal, mental, sexual, or physical abuse may be reported by a patient, caregiver, family, friend, or concerned other, as well as any contracted or employed personnel, including volunteers. **Guidance:** "Immediately" means as soon as possible, but not to exceed 24 hours after discovery or the incident, in the absence of a shorter state timeframe requirement.

Assessment, Planning & Coordination

Key Area of Performance:

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 The Clinical Manager provides oversight, during all operational hours of all patient care services and personnel. Oversight includes: 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 updates of the individualized plan of care. **Applicable Regulations: G958-484.105(c); G960-484.105(c)(1); G962-484.105(c)(2); G964-484.105(c)(3); G966-484.105(c)(4); G968-484.105(c)(5).**	**Document Review:** Review the position descriptions for the Clinical Manager. Verify that they identify all of the responsibilities listed as appropriate to their position. Identifies availability during all hours of operation. **Interview:** Interview the Clinical Manager. Clarify the ways in which they oversee all patient care services, including making patient and personnel assignments; coordinating patient care and referrals; ensuring that patient needs are continually assessed; and ensuring the development, implementation, and updates of the individualized plan of care. Ensure sufficient coverage of clinical manager when off duty or unavailable during operating hours. **Guidance:** A clinical manager must be a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or a registered nurse.

Standards	Evidence Guidelines
APC.2 Patients' care is coordinated using an interdisciplinary team approach to support the implementation of the care plan. The team includes representatives from disciplines providing care, whether directly or under arrangement, from the following services: 1. Nursing, including home health aide; 2. Therapy, including physical therapy, speech-language pathology, and occupational therapy; 3. Medical social work; and 4. Physician or allowed practitioner services. **Applicable Regulations: G700-484.75; G804-484.80(g)(4).**	**Interview:** Interview the Clinical Manager and other members of the care team. Clarify the ways in which care is planned and coordinated with an interdisciplinary team approach. Verify, through specific patient examples, that each ordered discipline participates in the planning and coordination of care/services. **Clinical Record Review:** Validate that there is evidence in the record of the care planning and coordination processes identified during interview of the Clinical Manager. This may be found in a case conference or patient care notes.

Standards	Evidence Guidelines
APC.3 The process for intake and the determination of eligibility to receive services is defined by the organization. The organization notifies the referral source if services cannot be provided. Patients are accepted for treatment on the basis of a reasonable expectation that their medical, nursing, rehabilitative, and social needs can be met adequately by the organization in their place of residence. **Applicable Regulation: G570-484.60.**	**Interview:** Interview one or more direct care staff members who admit patients to the organization. Using a recent patient admission as an example, clarify the criteria used to determine that there was a reasonable expectation that the patient's needs could be met by the organization. Verify that intake and eligibility determination are done in accordance with the organizations defined process. **Guidance:** It is expected that the organization has reasonable confidence that it can meet the patient's needs when admitting a patient. For example, if the organization does not have, either directly, or through contract, the ability to provide physical therapy services in the ordered timeframe, it is expected that the organization contact the prescribing authority to determine if alternative arrangements, such as a referral to another organization, should be made.
APC.4 The organization conducts an initial assessment visit by a registered nurse to determine the immediate care and support needs of the patient and to determine eligibility for the Medicare home health benefit, including homebound status. The initial assessment is conducted: 1. Within 48 hours of referral; or 2. Within 48 hours of the patient's return home; or 3. On the physician or allowed practitioner ordered start-of-care date. *(continued on following page)*	**Clinical Record Review:** Validate that each patient's initial assessment has been completed within 48 hours of referral, within 48 hours of the patient's return home, on the physician-ordered start of care date, or at the patient/family's request with physician approval. If the initial assessment was performed by a physical therapist or speech-language pathologist, validate that only therapy services were ordered. If the initial assessment was performed by an occupational therapist, validate that occupational therapy was ordered with another qualifying rehabilitation therapy service. Validate that eligibility for the *(continued on following page)*

Standards	Evidence Guidelines
APC.4 For the Medicare home health benefit, when physical therapy, speech-language pathology, or occupational therapy *is the only service ordered by the physician or allowed practitioner* who is responsible for the home health plan of care, a physical therapist or speech-language pathologist may complete the initial assessment and determine eligibility and home bound status, within the timeframes required. When occupational therapy is ordered with another qualifying rehabilitation therapy service (speech language pathology or physical therapy), an occupational therapist may complete the initial assessment. **Applicable Regulations: G510-484.55; G514-484.55(a)(1); G516-484.55(a)(2).**	Medicare home health benefit (as applicable) is verified as required by the standard. **Guidance:** The registered nurse may perform the initial assessment for therapy-only cases. Additionally, for the Medicare home health benefit, occupational therapy services provided at the start of care alone do not establish eligibility; when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech language pathology or physical therapy), an occupational therapist may complete the initial assessment visit under Medicare. If skilled nursing services are also ordered, an RN is required to complete the initial assessment. Patients needing only occupational therapy services on admission to the organization may qualify for eligibility under programs other than Medicare. **Guidance:** If a patient requests that a visit not be made until a more convenient time, the request is documented in the patient record as well as a notation that the physician was notified of and approves the patient's request for a delayed start of care.

Standards	Evidence Guidelines
APC.5 Each patient has documentation of a patient specific comprehensive assessment that is completed by a registered nurse in a timeframe consistent with and informed by the patient's needs, but no later than five calendar days after the start of care. During the assessment, the organization verifies the patient's eligibility for the Medicare home health benefit, including homebound status and services to be provided by the organization. When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician or allowed practitioner, a physical therapist, speech-language pathologist, or occupational therapist may complete the comprehensive assessment and, for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech-language pathology or physical therapy) that establishes program eligibility. **Applicable Regulations: G510-484.55; G520-484.55(b)(1); G522-484.55(b)(2); G524-484.55(b)(3).**	**Clinical Record Review:** Validate that each patient's comprehensive initial assessment has been completed no later than five calendar days after the start of care. Validate that eligibility was verified. Ensure evaluations determine immediate and ongoing needs for care and services. **Guidance:** This standard references the comprehensive assessment completed when a patient is admitted or readmitted. Time frames for ongoing updates and revisions to the comprehensive assessment are addressed in other standards. **Guidance:** For the Medicare home health benefit, occupational therapy services ordered at the start of care alone do not establish eligibility; when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech language pathology or physical therapy), an occupational therapist may complete the comprehensive assessment visit under Medicare. If skilled nursing services are also ordered, an RN is required to complete the comprehensive assessment. Patients needing only occupational therapy services on admission to the organization may qualify for eligibility under programs other than Medicare.

Standards	Evidence Guidelines
APC.6 The comprehensive assessment is updated and revised (including the administration of the Outcome and Assessment Information Set [OASIS]) as frequently as the patient's condition warrants due to a major decline or improvement in the patient's health status, but no less frequently than the last five days of every 60 days beginning with the start-of-care date, unless there is: 1. A beneficiary-elected transfer; 2. A significant change in condition; or 3. A discharge and return to the same home health organization during the 60-day episode. **Applicable Regulations: G544-484.55(d); G546-484.55(d)(1).**	**Clinical Record Review:** Review clinical records for patients receiving services for more than 60 days. Validate that the comprehensive assessment has been completed within the last five days of every 60 days as required by the standard. Validate that the OASIS has been completed as required per federal regulation. **Guidance:** If the patient returns home from an inpatient stay between the 56 or 60 day and they have not been discharged from the organization, a Resumption of Care (ROC) assessment is completed and satisfies both the ROC and the recertification requirements.

Standards	Evidence Guidelines
APC.7 A registered nurse updates and revises the comprehensive assessment (including the administration of the Outcome and Assessment Information Set [OASIS]) at: 1. Recertification; 2. Discharge; 3. Patient-elected transfer; 4. Discharge and return to the same organization during a 60-day episode; and 5. Readmission. The comprehensive assessment is also updated and revised as warranted by a significant change in the patient's condition. Following hospitalizations lasting at least 24 hours for any cause other than diagnostic testing, the assessment is revised within 48 hours or on the physician or allowed practitioner ordered resumption date and includes the administration of the OASIS. When physical therapy, speech-language pathology, or occupational therapy is the only service ordered by the physician or allowed practitioner, a physical therapist, speech-language pathologist, or occupational therapist may complete the comprehensive assessment and, for Medicare patients, determine eligibility for the Medicare home health benefit, including homebound status. The occupational therapist may complete the comprehensive assessment when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech-language pathology or physical therapy) that establishes program eligibility. **Applicable Regulations: G522-484.55(b)(2); G524-484.55(b)(3); G546-484.55(d)(1); G548-484.55(d)(2); G550-484.55(d)(3).**	**Clinical Record Review:** Review clinical records for one or more patients who have been discharged, recertified for ongoing care, or transferred or admitted to the hospital for greater than 24 hours. Validate that the patient was reassessed, and that a new OASIS was completed as required. **Guidance:** The comprehensive assessment and OASIS must be completed for all Medicare and Medicaid beneficiaries receiving skilled care (except those allowed by CMS exclusion) within 48 hours of the organization becoming aware that the patient was released from the hospital. **Guidance:** If the patient is hospitalized at the time required for the recertification assessment, it is expected that the patient will be discharged if the patient's stay extends beyond the end of the current certification period. If ordered by the physician or allowed practitioner, the patient may be re-admitted when they return home. **Tip:** If the organization missed completion of the recertification within the 5-day window at the end of the certification period, the agency should not discharge and readmit the patient. Rather, the agency should send a clinician to perform the recertification assessment as soon as the oversight is identified.

Standards	Evidence Guidelines
APC.8 The comprehensive assessment accurately reflects the patient's status. It incorporates the current version of the Outcome and Assessment Information Set (OASIS) items, and includes, at a minimum: 1. Demographic information and medical history, including any allergies or sensitivities; 2. The patient's primary caregiver and/or representative (if any); 3. Strengths, goals, and care preferences, including information on the patients progress toward desired goal and the goals identified by the patient and the measurable outcomes identified by the organization; 4. Addresses patient's current health, psychosocial, functional, and cognitive status; 5. Systems review, including sensory status, integumentary status, respiratory status, elimination status, and neuro/emotional/behavioral status; 6. Review of medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy, including: prescription and over the counter (OTC), supplements, herbals, all other treatments; 7. Activities of daily living; 8. Continuing need for home care; 9. Living arrangements; *(continued on following page)*	**Clinical Record Review:** Verify that the medication review identifies any potential adverse effects and drug reactions, including ineffective drug therapy, significant side effects, significant drug interactions, duplicate drug therapy, and noncompliance with drug therapy. Verify that the comprehensive assessment contains at least all components required by the standard. **Guidance:** It is expected that each patient has a comprehensive assessment. The completion of the OASIS is required for Medicare and Medicaid beneficiaries, with CMS approved exceptions. **Guidance:** Current OASIS items are included in the bulleted list. For example, living arrangement, integumentary status, respiratory status, elimination status, etc., are all included on the OASIS. **Guidance:** The identification of patient resources and needs during a natural or man-made disaster is expected to be completed as part of the comprehensive assessment. It may be documented as part of the assessment or be included in another part of the patient's record. **Guidance:** It is expected that each clinical record identifies all medications that the patient is taking, both prescription and non-prescription (e.g., over-the-counter drugs, herbal remedies, nutritional supplements, vitamins, oxygen therapy, TPN and other alternative treatments that could affect drug therapy), as well as the dose, route, frequency, or time of administration when indicated on the prescription or order.

Standards	Evidence Guidelines
APC.8 10. Use of emergent care since the last assessment; 11. Data items collected at inpatient facility admission or discharge only; 12. Current use of medical equipment; 13. Supportive systems, including the primary caregiver(s), if any, and other available supports, including the caregivers' willingness and ability to provide care and their availability and schedules; 14. Medical, nursing, rehabilitative, social, and discharge planning needs; and 15. Plan for the patient in the event of a natural or man-made disaster. **Applicable Regulations:** **G528-484.55(c)(1); G530-484.55(c)(2); G532-484.55(c)(3); G534-484.55(c)(4); G536-484.55(c)(5); G538-484.55(c)(6); G540-484.55(c)(7); G542-484.55(c)(8); E0017-484.102(b)(1).**	

Standards	Evidence Guidelines
APC.9 Each patient must receive the home health services that are written in an individualized plan of care, including any revisions or additions. The individualized plan of care must specify the care and services necessary to meet the patient-specific needs as identified in the comprehensive assessment, including identification of the responsible discipline(s), and identifies patient specific measurable outcomes and goals that the organization clinical staff anticipates will occur as a result of implementing and coordinating the plan of care. The plan is developed and evaluated in partnership with the patient, representative (if any), and caregiver(s). **Applicable Regulations: G570-484.60; G572-484.60(a)(1); G704-484.75(b); G708-484.75(b)(2).**	**Clinical Record Review:** Verify that the plan of care is individualized and includes patient-specific measurable outcomes and goals. Validate that attempts were made to reschedule missed visits. Verify documentation that patient was advised and educated on the potential impact of missed visits. **Observation – Home Visit:** Verify, through patient and/or caregiver interview, that the patient was involved in care planning and goal setting. **Guidance:** Patient-specific goals reflect what matters most to the patient. At times a patient's goal may not be aligned with the providers or caregivers' goals for care. For example, a patient's goal may be to drive his car again, and the patient's family may not share that goal. In these situations, it is expected that personnel work with the patient and caregivers to establish realistic goals that are more closely aligned.
APC.10 Each patient will have an individualized plan of care. It includes the following: 1. All pertinent diagnoses; 2. All patient care orders, including verbal orders; 3. The patient's mental, psychosocial, and cognitive status; 4. The types of services, supplies, and equipment required; *(continued on following page)*	**Clinical Record Review:** Verify that each record contains a plan of care that is individualized, is developed in partnership with the patient and others, and addresses the requirements of the standard. Verify that the plan includes patient-specific, measurable outcomes and goals and is signed by the physician or allowed practitioner. **Guidance:** Medicare-certified agencies providing services not reimbursed by *(continued on following page)*

Standards	Evidence Guidelines
APC.10 5. The scope and frequency and duration of visits to be made; 6. The mode of care-delivery including the use of telecommunications when applicable; 7. Prognosis and rehabilitation potential; 8. Functional limitations; 9. Activities permitted; 10. Nutritional requirements; 11. All medications and treatments; 12. Food and drug allergies; 13. Safety measures to protect against injury; 14. A description of the patient's risk for emergency department visits and hospital readmission, and all necessary interventions to address the underlying risk factors; 15. Patient and caregiver education and training to facilitate timely discharge; 16. Patient-specific interventions and education; 17. Measurable outcomes anticipated from implementing and coordinating the plan of care with goals identified by the organization and the patient; 18. Information related to any advance directives; and 19. Any additional items the organization or physician or allowed practitioner may choose to include. **Applicable Regulations: G570-484.60; G574-484.60(a)(2); G576-484.60(a)(3).**	Medicare are expected to develop an individualized plan of care that addresses the elements appropriate to the care/services they are providing. For example, if a Medicare-certified organization is providing a patient with only personal care and support services, the individualized plan of care would not be expected to include a description of hospitalization risks. **Guidance:** The frequency and duration of visits are specific to the patient's condition and needs. Pro re nata (PRN) or as-needed visit orders are expected to be minimal and include an indication or reason for why the visit is to occur. Orders for care may indicate a specific range in the frequency of visits to ensure that the most appropriate level of services is provided. Ranges are expected to be small (ex: 2-4 visits) and the upper limit of the range is considered the specific frequency. The plan of care may include orders for treatment or services received from physicians other than the responsible physician. **Guidance:** Individualized care planning reflects the lifestyle, needs, values, strengths, limitations, culture, preferences, and goals of patients and caregivers that affect the care and service being delivered. Patients are involved in initial and ongoing decisions about their care, including decisions related to transitions of care. **Guidance:** Telecommunications cannot substitute for a home visit ordered as part of the plan of care, and cannot be considered a home visit for the purposes of Medicare eligibility or payment.

Standards	Evidence Guidelines
APC.11 If a physician or allowed practitioner refers a patient under a plan of care that cannot be completed until after an evaluation visit, the physician or allowed practitioner is consulted to approve additions or modifications to the original plan. **Applicable Regulation: G572-484.60(a)(1).**	**Clinical Record Review:** When the record reflects that a plan of care was not completed until after the evaluation visit, verify that the physician or allowed practitioner was notified to approve additions or modifications to the plan. Verify the plan of care is signed by an allowed practitioner. **Guidance:** The allowed practitioner is defined as a Doctor of Medicine, osteopathy, or podiatry or allowed practitioner acting withing the scope of hir or her state license, certification, or registration. **Guidance:** Services which are provided in subsequent certification periods (recertification) are considered to be provided under the subsequent plan of care when there is a verbal order to continue services into the recertification period. The verbal order must be obtained before the services are provided.

Standards	Evidence Guidelines
APC.12 The individualized plan of care is periodically reviewed and revised by the physician or allowed practitioner acting within the scope of their state license, certification, or registration, who is responsible for the home health plan of care and the home health organization as frequently as the patient's condition or needs require, but no less frequently than once every 60 days, beginning with the start-of-care date. A revised plan of care reflects current information from the patient's updated comprehensive assessment and contains information concerning the patient's progress toward the measurable outcomes and goals identified by the home health organization and patient in the plan of care. The physician or allowed practitioner is notified of the alterations to the plan of care related to changes in that patient's status and/or outcomes not achieved. Revisions to the plan of care related to a change in patient health status or the patient's discharge are communicated to the patient, caregiver, or representative (if any), and relevant physician or allowed practitioners issuing orders for the 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 home health organization (if any). **Applicable Regulations: G572-484.60(a)(1); G588-484.60(c)(1); G590-484.60(c)(1); G592-484.60(c)(2); G594-484.60(c)(3); G596-484.60(c)(3)(i); G598-484.60(c)(3)(ii).**	**Clinical Record Review:** Review clinical records, including records for patients on service for more than 60 days. Validate that the total plan of care is reviewed by a Doctor of Medicine, osteopathy, or podiatry or allowed practitioner and personnel at least once every 60 days and as the patient's conditions or needs warrant. Review to validate that a change in the patients' health status includes the plan of care is revised. Validate that the revised plan of care includes information on the patient's progress toward goal achievement and measurable outcomes as required by the standard. Verify revisions have been communicated to all physicians or allowed practitioners issuing orders for the home health care and have been documented. Verify revisions to the plan of care have been communicated to the patient, caregiver and/or patient representative. **Guidance:** The total plan of care includes written care instructions for the home health aide (aide plan of care). It is expected that the aide plan of care is reviewed as a part of the total plan of care in accordance with the standard.

Standards	Evidence Guidelines
APC.13 The organization communicates and coordinates care with the patient to share information needed to implement the care and services. Information is provided to the patient in plain language and in a manner that is accessible and timely to: 1. Persons with disabilities (accommodations may include accessible websites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and Section 504 of the Rehabilitation Act); and 2. Persons with limited English proficiency (accommodations may include the provision of language services at no cost to the individual, including oral interpretation and written translations). **Applicable Regulations: G490-484.50(f); G490-484.50(f)(1); G490-484.50(f)(2); G602-484.60(d)(1).**	**Interview:** Interview a key leader. Verify, through specific patient examples, the ways in which language and disability are addressed to meet patient's need for information. If no patient has needed these services, verify the process by which the organization would provide these services and aids. **Clinical Record Review:** Verify that oral interpretation, written translations of materials, and auxiliary aids are provided for the patient at no charge when they are needed. Verify coordination of care between the patient and the members of the care team is documented.

Standards	Evidence Guidelines
APC.14 The organization provides the patient and caregiver(s) with a copy of written instructions outlining: 1. Visit schedule, including frequency of visits by home health organization personnel and personnel acting on behalf of the home health organization; 2. Patient medication schedule/instructions, including medication name, dosage, and frequency, as well as which medications will be administered by home health organization personnel and personnel acting on behalf of the home health organization; 3. Any treatments to be administered by home health organization personnel and personnel acting on behalf of the home health organization, including therapy services; 4. Any other pertinent instruction related to the patient's care, treatments, and services that the home health organization will provide, specific to the patient's care needs; and 5. Name and contact information of the home health organization's Clinical Manager. **Applicable Regulations: G612-484.60(e); G614-484.60(e)(1); G616-484.60(e)(2); G618-484.60(e)(3); G620-484.60(e)(4); G622-484.60(e)(5).**	**Clinical Record Review:** Verify that the patient is provided copy of written instructions containing all of the elements required in the standard. **Observation:** Conduct a home visit. Verify through direct observation and/or interview with the patient and caregiver(s) that written instructions were given as required by the standard. If possible, view the written notification. **Guidance:** Written instructions may be provided in an electronic format, such as secure email.

Standards	Evidence Guidelines
APC.15 The organization coordinates care delivery to meet the patient's needs, and involves the patient, representative (if any), and caregiver(s), as appropriate, in the coordination of care activities. **Applicable Regulation: G608-484.60(d)(4).**	**Clinical Record Review:** Verify that care delivery is coordinated with the patient, representative, and caregiver(s) as appropriate to meet the needs of the patient. **Observation – Home Visit:** Verify, through patient interview, the ways in which personnel coordinate care with the patient and appropriate representatives and caregivers.
APC.16 Communication and coordination occur among members of the care team who are planning and delivering care and services. Consistent with current professional standards of practice, licensed professionals actively participate in the coordination of all aspects of patient care including: 1. Conducting ongoing interdisciplinary comprehensive assessments; 2. Developing and evaluating the plan of care; 3. Contributing to patient and family counseling and education. **Applicable Regulations: G600-484.60(d); G608-484.60(d)(4).**	**Clinical Record Review:** Verify that coordination of care between members of the care team is documented. Verify that coordination efforts support the care/service plan. **Guidance:** In this standard, "care team members" refers to the organization's personnel, including those under contract, as well as physicians (as applicable to services provided) or other health care providers who plan and deliver care/services to the patient.

Standards	Evidence Guidelines
APC.17 The organization communicates with and integrates orders from all physicians or allowed practitioners involved in the plan of care to assure the coordination of all services and interventions provided to the patient. **Applicable Regulations: G602-484.60(d)(1); G604-484.60(d)(2); G704-484.75(b); G718-484.75(b)(7).**	**Clinical Record Review:** If multiple physicians or allowed practitioners are involved in the patient's care, verify that their orders are integrated into the plan of care and that they are included in communications.
APC.18 The organization integrates services, whether services are provided directly or under arrangement, to assure the identification of patient needs and factors that could affect patient safety and treatment effectiveness and the coordination of care provided by all disciplines. **Applicable Regulation: G606-484.60(d)(3).**	**Interview:** Interview an individual who provides care to a patient receiving multiple services. Verify, through specific patient examples, the ways in which care and services are integrated to meet the patient's needs. **Clinical Record Review:** Verify that there is documentation of communication and integration between services.
APC.19 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 *(continued on following page)*	**Document Review:** Review discharge and transfer policies. Verify that they include the criteria required by the standard.

Standards	Evidence Guidelines
APC.19 the patient's needs, based on the patient's acuity; 2. The patient or payer will no longer pay for the services provided by the organization; 3. The transfer or discharge is appropriate because the physician or allowed practitioner who is responsible for the home health plan of care and the organization agree that the measurable outcomes and goals set forth in the plan of care have been achieved, and the organization and the physician or allowed practitioner who is responsible for the home health plan of care agree that the patient no longer needs the organization's services; 4. The patient refuses services, or elects to be transferred or discharged; 5. The organization determines that the patient's behavior (or that of other persons in the patient's home) is disruptive, abusive, or uncooperative to the extent that delivery of care to the patient or the ability of the organization to operate effectively is seriously impaired; 6. The patient dies; or 7. The organization ceases to operate. **Applicable Regulations: G452-484.50(d); G454-484.50(d)(1); G456-484.50(d)(2); G458-484.50(d)(3); G460-484.50(d)(4); G462-484.50(d)(5); G472-484.50(d)(6); G474-484.50(d)(7).**	

Standards	Evidence Guidelines
APC.20 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: *(continued on following page)*	**Document Review:** Review policy for discharging a patient for cause. Verify that it addresses each of the requirements of the standard. Review policy for patient discharge/transfer. Validate that the policy includes the required elements for the content of the summary. **Clinical 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.

Standards	Evidence Guidelines
APC.20 1. All necessary medical information pertaining to the patient's current course of illness and treatment; and 2. Post-discharge goals of care and treatment preferences. **Applicable Regulations: G462-484.50(d)(5); G464-484.50(d)(5)(i); G466-484.50(d)(5)(ii); G468-484.50(d)(5)(iii); G470-484.50(d)(5)(iv).**	
APC.21 The organization arranges a safe and appropriate transfer to other care entities when the needs of the patient exceed the organization's capabilities. **Applicable Regulation: G454-484.50(d)(1).**	**Clinical Record Review:** Review one or more records of patients who have been transferred from the organization's care. Verify that the transfer was accomplished safely and appropriately when the needs of the patient exceeded the organization's capabilities.

Standards	Evidence Guidelines
APC.22 The organization must develop and implement an effective discharge planning process. For patients who are transferred to another home health organization, or who are discharged to a SNF, IRF, or LTCH, the organization must assist patients and their caregivers in selecting a post-acute care provider by: 1. Using and sharing data that includes, but is not limited to home health, SNF, IRF, or LTCH data on quality measures and resource use measures. The organization ensures that the post-acute care data on quality and resource use measures is relevant and applicable to the patient's goals of care and treatment preferences. **Applicable Regulations: G560-484.58; G562-484.58(a).**	**Clinical Record Review:** Review discharge patient records. Verify that assistance in the selection of a facility or other home health organization was provided (and documented) to the patient/caregiver in planning for discharge/transfer. Verify effective communication takes place with a transition in care and is documented with a transition in care. It may be included in clinical records, transfer logs, communication logs, or other documents. **Interview:** Interview a clinician or key leader on the discharge planning requirements for those patients discharged to another home health organization, a SNF, IRF, or LTCH. Inquire if the patient/caregiver required assistance in the selection of organization/facility and how the assistance was provided and if the patient's goals and treatment preferences were considered in the provision of information. **Guidance:** Resource for comparative data for home health, SNF, IRF, LTCH: www.data.cms.gov/provider-data/ **Tip:** Should the patient/caregiver already have made a selection of entity to which they will be discharged, assistance may not be required.

Standards	Evidence Guidelines
APC.23 The clinical record must include completed transfer and/or discharge summaries as applicable, and communication to the patient, caregiver, or representative and all physicians issuing orders, 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. The receiving facility or health care practitioner who will be responsible for providing care and services to the patient is sent: 1. A discharge summary from the organization within five business days of the patient's discharge; or 2. A completed transfer summary within two business days of a planned transfer, if the patient's care will be immediately continued in a health care facility; or 3. A completed transfer summary within two business days of becoming aware of an unplanned transfer, if the patient is still receiving care in a health care facility at the time the organization becomes aware of the transfer. Content of the summaries will include all necessary medical information pertaining to the patient's current course of illness and treatment, inclusive of post-discharge goals of care, and treatment preferences. The organization must comply with requests for additional clinical information as may be necessary for treatment of the patient made by the receiving facility or health care practitioner. *(continued on following page)*	**Clinical Record Review:** Review clinical records for one or more patients who have been discharged or transferred from the organization. Verify that the organization sent the primary care practitioner or other health care professional who was responsible for providing care and services to the patient a discharge summary or transfer summary in accordance with the requirements of the standard. Verify documentation includes communication of discharge plan to the patient, the caregiver/representative, all physician or allowed practitioners issuing orders for the plan of care, and the patients primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge. **Clinical Record Review:** Validate that the discharge/transfer summary includes the required content. **Interview:** Interview a key leader to determine where requests for additional information made by the receiving facility or healthcare practitioner are documented. **Document Review:** Review applicable documentation to validate that requests for additional information were provided. **Guidance:** A current reconciled medication list must be included with the transfer/discharge summary to the subsequent provider.

Standards	Evidence Guidelines
APC.23 **Applicable Regulations: G560-484.58; G564-484.58(b)(1); G566-484.58(b)(2); G1018-484.110(a)(4); G1020-484.110(a)(5); G1022-484.110(a)(6)(i); G1022-484.110(a)(6)(ii); G1022-484.110(a)(6)(iii).**	

Care Delivery & Treatment

Key Area of Performance:

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 Home health care and services are provided within the organizations accepted standards of practice. 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 Regulations: G570-484.60; G982-484.105(f)(1).**	**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. **Clinical Record Review:** Validate that skilled nursing and one other qualifying service are being provided or are available to at least one patient. **Interview:** Interview a key leader and verify the ways in which the documented scope of services is delivered. **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 *(continued on following page)*

Standards	Evidence Guidelines
CDT.1	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.
CDT.2 Personnel follow established standards of practice in the delivery of care and services, and practice within the scope of their license, certification, or registration and as required by law and regulation.	**Clinical Record Review:** Verify that care is delivered according to accepted standards of practice. Validate that personnel practice within the scope of their license, certification, or registration and as required by law and regulation. **Guidance:** Not every service or discipline has established standards of practice. Where accepted standards of practice exist, it is expected that they are applied and followed. **Guidance:** It is expected that personnel know and follow standards of practice related to their discipline. These standards of practice are generally available through various organizations. Examples of standards of practice include individual state professional practice acts, the American Nurses Association Scope and Standards of Practice, Standards and Scope of Practice from the American Psychiatric Nurses Association, the National Association of Social Workers Standards for Social Work, Standards of Practice for Physical Therapy, Standards of Practice for Clinical Pharmacists, the Hospice *(continued on following page)*

Standards	Evidence Guidelines
CDT.2	and Palliative Nurses Association Clinical Practice Guidelines for Quality Palliative Care, and the American Association for Respiratory Care Clinical Practice Guidelines. Aide disciplines are expected to follow local and state regulations as well as applicable CHAP standards related to competency and/or training. **Guidance:** It is expected that personnel know and follow standards of practice related to their discipline. These standards of practice are generally available through various organizations. Examples of standards of practice include individual state professional practice acts, the American Nurses Association Scope and Standards of Practice, Standards and scope of Practice from the American Psychiatric Nurses Association, the National Association of Social Workers Standards for Social Work, Standards of Practice for Physical Therapy, Standards of Practice for Clinical Pharmacists, The Hospice and Palliative Nurses Association Clinical Practice Guidelines for Quality Palliative Care, and the American Association for Respiratory Care Clinical practice Guidelines. Aide disciplines are expected to follow local and state regulations as well as applicable CHAP standards related to competency and/or training.

Standards	Evidence Guidelines
CDT.3 Services are provided in accordance with the scope of the license, certification, or registration as required by law, current clinical practice guidelines, and accepted professional standards of practice. **Applicable Regulations: G848-484.100; G984-484.105(f)(2).**	**Clinical Record Review:** Verify that care is delivered according to current clinical practice guidelines and accepted license, certification and by law and regulation. **Observation – Home Visit:** Observe care delivered to validate that it is provided in accordance with current clinical practice guidelines and accepted professional standards of practice. **Guidance:** For Medicare certified home health and hospice agencies, failure to follow accepted standards of practice will result in a finding that the organization is out of compliance with a Center for Medicaid & Medicare Services condition of participation. **Guidance:** Clinical practice guidelines and accepted professional standards of practice may be found in, but are not limited to: State practice acts; Standards established by national organizations, boards, and councils (e.g., the American Nurses' Association standards); and The HHA's own policies and procedures. HHAs should consider identifying the clinical practice guideline or standard of practice used when developing and updating care policies and procedures.

Standards	Evidence Guidelines
CDT.4 The organization does not substitute its equipment for a patient's equipment when assisting with self-administered tests. **Applicable Regulation: G862-484.100(c)(1).**	**Interview:** Interview a registered nurse who provides direct patient care. Verify that the organization does not substitute its equipment for a patient's equipment when assisting with self-administered tests. **Guidance:** Organizations may use their own self-administered testing equipment for a short, defined period of time when the patient has not yet obtained their own testing equipment, such as in the days immediately following physician orders to obtain the testing equipment when a patient may not have the time and resources immediately available to complete the process. It is expected that the organization use available resources to assist the patient in obtaining their own testing equipment as quickly as possible.

Standards	Evidence Guidelines
CDT.5 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).**	**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 their particular discipline. For example, a social worker would have the authority to receive a social work order, but not a nursing order.
CDT.6 Drugs, services, and treatments are administered only as ordered by a physician or allowed practitioner. **Applicable Regulation: G580-484.60(b)(1).**	**Clinical Record Review:** Verify that medications and treatments are administered as ordered by a physician or allowed practitioner.

Standards	Evidence Guidelines
CDT.7 Orders, including verbal orders, are accepted, signed, and dated by authorized personnel as defined in organization policies and local, state, or federal law. Physician or allowed practitioner verbal orders are documented in the patient's record by a nurse acting in accordance with state licensure requirements or other authorized practitioner responsible for furnishing or supervising the ordered services, in accordance with state law and the organization's policies. Orders are signed and dated and indicate the time the order was received. Verbal orders are authenticated and dated by the physician. **Applicable Regulations: G584-484.60(b)(3); G584-484.60(b)(4).**	**Clinical Record Review:** Verify that verbal orders include the signature of the authorized person receiving the order and the date and time of receipt. Verify that an authorized person received the order. Verify the order is countersigned from the physician within the time frame designated in organization policy and state requirements. **Guidance:** Authorized personnel may include individuals responsible for providing or supervising ordered services. **Guidance:** A verbal order means a physician or allowed practitioner order that is spoken to appropriate personnel and later put in writing for the purpose of documenting as well as establishing or revising the patient's plan of care. When verbal orders are added to the plan of care, it is not necessary for the physician or allowed practitioner to sign an updated plan of care until the patient is recertified. However, all verbal orders must be authenticated and dated by the physician or allowed practitioner in accordance with applicable state laws and regulations, as well as the HHA's internal policies. **Guidance:** State professional practice acts may define who is authorized to receive a verbal order. In general, a health professional may receive a verbal order for their particular practice. For example, a social worker would have the authority to receive a social work order, but not a nursing order. Organizations are expected to know, understand, and comply with state and federal requirements. **Guidance:** State law may define a timeframe for the authentication of verbal orders. It is expected that the organization complies with the state law.

Standards	Evidence Guidelines
CDT.8 Skilled professional services are authorized, delivered, and supervised only by qualified health care professionals who practice according to the organization's policies and procedures. These services are provided according to written policy. See the HR Resource Management Key Performance Area, standards HRM.3 (registered nurse), HRM.4 (physician or allowed practitioner), HRM.5 (physical therapist, occupational therapist, and speech language pathologist), and HRM.7 (social worker) for requirements that define qualified skilled professionals. See the Key Terms document for definitions related to each discipline. **Applicable Regulations: G700-484.75; G702-484.75(a).**	**Clinical Record Review:** Verify that skilled professional services are provided by qualified persons in accordance with the organization's policies and procedures and in accordance with the plan of care. **Guidance:** Skilled professional services are defined as skilled nursing, physical therapy, speech-language pathology, occupational therapy, and physician and medical social work services. Citations related to qualifications will be cited in the Human Resource Management Key Performance Area (KPA). **Guidance:** Qualifications of skilled professionals can be found in the Human Resource Management KPA. Supervision requirements are assessed in CDT.14-16. **Observation – Home Visit:** Verify that care and services are provided according to the patient care service plan.

Standards	Evidence Guidelines
CDT.9 Skilled professionals follow the plan of care and at a minimum perform the following duties: 1. Ongoing interdisciplinary assessment of the patient; 2. Development and evaluation of the plan of care in partnership with the patient, representative (if any), and caregiver(s); 3. Providing services that are ordered by the physician or allowed practitioner as indicated in the plan of care; 4. Patient, caregiver, and family counseling; 5. Patient and caregiver education; 6. Preparing clinical notes; and 7. Communication with all physicians or allowed practitioners involved in the plan of care. **Applicable Regulations: G704-484.75(b); G706-484.75(b)(1); G708-484.75(b)(2); G710-484.75(b)(3); G712-484.75(b)(4); G714-484.75(b)(5); G716-484.75(b)(6); G718-484.75(b)(7).**	**Clinical Record Review:** Verify that skilled professionals follow the plan of care and perform all duties identified in the standard. Verify the record documents patient and caregiver training on care and service. Verify that the plan of care is individualized and includes patient-specific measurable outcomes and goals. Verify documentation of education and counseling provided by skilled professionals to the patient, caregiver, and family. **Observation – Home Visit**: Verify, through patient and/or caregiver interview, that the patient was involved in care planning and goal setting and the provision of patient, caregiver, and family counseling. **Guidance:** Additional responsibilities of skilled professionals are located in other Key Performance Areas (KPAs), including: development and evaluation of the plan of care in partnership with the patient, representative, and caregiver(s) (Assessment, Planning and Coordination KPA); communication with all physicians or allowed practitioners involved in the plan of care and other health care practitioners (Assessment, Planning and Coordination KPA); participation in the organization's quality program (Continuous Quality Improvement KPA); and participation in organization-sponsored in-service training (Human Resource Management KPA). *(continued on following page)*

Standards	Evidence Guidelines
CDT.9	**Guidance:** Skilled professional services are defined as skilled nursing, physical therapy, speech-language pathology, occupational therapy, and physician or allowed practitioner and medical social work services. **Guidance:** The term "interdisciplinary" refers to an approach to healthcare that includes a range of health service workers. "Ongoing interdisciplinary assessment" is the continual involvement of all skilled professional staff involved in a patient's plan of care from the initial assessment through discharge, which should include periodic discussions among the team regarding the patient's health status and recommendations for the plan of care. An interdisciplinary approach recognizes the contributions of various health care disciplines (MDs, RNs, Licensed Practical/Vocational Nurses (LPN/LVN), PT, OT, SLP, Master of Social Work (MSW), HH aides) and their interactions with each other to meet the patient's needs. **Guidance:** Patient-specific goals reflect what matters most to the patient. At times a patient's goal may not be aligned with the providers or caregivers' goals for care. For example, a patient's goal may be to drive his car again, and the patient's family may not share that goal. In these situations, it is expected that personnel work with the patient and caregivers to establish realistic goals that are more closely aligned.

Standards	Evidence Guidelines
CDT.10 An organization that provides outpatient physical therapy or speech-language pathology services meets all of the applicable health and safety laws and regulations, including those described in §485.711 (plan of care and physician involvement), §485.713 (physical therapy services), §485.715 (speech pathology services), §485.719 (services under arrangement), §485.723 (physical environment), and §485.727 (emergency preparedness) to implement section 1861(p) of the Act. **Applicable Regulation: G986-484.105(g).**	**Interview:** Interview the Clinical Manager. If the organization provides outpatient physical therapy or speech-language pathology services, verify the ways in which the organization ensures that those services are provided in accordance with applicable health and safety laws and regulations, including those described in §485.711, §485.713, §485.715, §485.719, §485.723, and §485.727. **Guidance:** If patient is going to the premises of the HHA for outpatient therapy services, the patient would not be receiving HHA services and OPT services at the same time and therefore not all the HHA CoPs would apply.
CDT.11 Home health aides are assigned to a specific patient by a registered nurse or other appropriate skilled professional. Written patient care instructions for a home health aide are prepared by that registered nurse or other appropriate skilled professional. **Applicable Regulation: G798-484.80(g)(1).**	**Clinical Record Review:** When home health aide services are part of the plan of care, verify that aides are assigned by a registered nurse, or other appropriate professional. Verify that written patient care instructions for a home health aide are prepared by the registered nurse or other appropriate skilled professional. **Guidance:** Other appropriate skilled professionals are defined as physical therapists, speech-language pathologists, or occupational therapists.

Standards	Evidence Guidelines
CDT.12 A home health aide provides services that are ordered by the physician or allowed practitioner, included in the written plan of care, permitted to be performed under state law, and consistent with the home health aide's demonstrated competencies. The duties of a home health aide include: 1. Providing hands-on personal care; 2. Performing simple procedures as an extension of therapy or nursing services; 3. Reporting changes in the patient's condition to a registered nurse or other appropriate skilled professional; 4. Assisting in ambulation or exercises; 5. Assisting in administering medications ordinarily self-administered; 6. Completing appropriate records in compliance with the organization's policies and procedures; and 7. Reporting changes in the patient's condition to the appropriate skilled professional. **Applicable Regulations: G800-484.80(g)(2); G802-484.80(g)(3); G804-484.80(g)(4).**	**Clinical Record Review:** If aide services are provided, validate that actions taken and documented meet, and do not exceed, the requirement of the standard. Validate that the frequency and duration of the aide visits are in accordance with the plan of care. Validate that actions taken by the aide are consistent with services ordered and the aide's written instructions, as part of a written care plan. **Observation – Home Visit:** Verify that the aide's actions and interventions comply with the established plan of care. While conducting the home visit, interview the patient to verify that home visits occur with the frequency expected and as planned. **Guidance:** The aide is also required to be a member of the interdisciplinary team. This requirement is assessed in the Assessment, Planning and Coordination Key Performance Area. **Guidance:** Not every organization chooses to permit the aide to assist with medication as allowed in the standard. Generally, this assistance might take the form of reminders or assistance with opening a medication container. It is expected that organizations know, follow, and can easily reference Practice Acts and regulations related to nurse delegation in their state. **Guidance:** Aide qualifications and competencies are described and assessed in the Human Resource Management Key Performance Area.

Standards	Evidence Guidelines
CDT.13 Each patient, and their caregiver(s), where applicable, receives ongoing education and training, as appropriate, regarding the care and services identified in the plan of care. Training is also provided, as necessary, to ensure a timely discharge. Education is documented in the patient record. **Applicable Regulation: G610-484.60(d)(5).**	**Interview:** Interview one or more personnel responsible for providing patient education on the care/service plan. Verify, through specific patient examples, the ways in which the patient is educated about the care and services that are planned. **Clinical Record Review:** Verify that there is documentation of each patient has receiving education on the care and services that are planned. If there are plans to discharge the patient, verify that training has occurred. **Guidance:** Patient education is expected to be offered on an ongoing basis and times and intervals that facilitate the patient's and caregiver's ability to participate in decisions around their care plan. The organization determines the appropriate intervals; however, changes in orders, the care plan, or the patient's condition or goals should be considered when determining the appropriate timeframes.

Standards	Evidence Guidelines
CDT.14 The home health aide is supervised, and supervision is documented, dated, and signed by the supervisor. Home health aide supervision ensures that aides furnish care in a safe and effective manner, including: 1. Following the patient's plan of care for completion of tasks assigned to a home health aide by the registered nurse or other appropriate skilled professional; 2. Maintaining an open communication process with the patient, representative (if any), caregiver(s), and family; 3. Demonstrating competency with assigned tasks; 4. Complying with infection prevention and control policies and procedures; 5. Reporting changes in the patient's condition; and 6. Honoring patient rights. **Applicable Regulations: G808-484.80(h)(1)(i); G818-484.80(h)(4).**	**Interview:** Interview a supervisor of aide services. Verify through specific examples the ways in which supervision ensures that communication takes place with the patient, representative (if any), caregiver(s), and/or family members and that the patient's rights are honored. **Clinical Record Review:** Verify that the records contain documentation of the aide providing services in a safe and effective manner, including all the elements of the standard. **Guidance:** Aide compliance with infection prevention and control policies and practices is evaluated in the Infection Prevention and Control Key Performance Area. This standard assesses the components of supervision of aide practices, including those related to infection prevention and control. **Guidance:** Signatures on documentation of supervisory encounters are expected to include the credentials of the supervising professional.

Standards	Evidence Guidelines
CDT.15 If home health aide services are provided to a patient who is receiving skilled nursing, physical or occupational therapy, or speech-language pathology services, a registered nurse or other appropriate skilled professional who is familiar with the patient, the patient's plan of care, and the written patient care instructions or home health aide plan of care, must complete a supervisory assessment of the aide services being provided no less frequently than every 14 days. The home health aide does not need to be present during the supervisory assessment. **Applicable Regulation: G808-484.80(h)(1)(i)**	**Interview:** Interview an aide. Validate the ways in which and how often they are supervised. **Clinical Record Review:** Validate that supervisory visits are conducted and documented at least every 14 days as required in the standard. **Guidance:** Signatures on documentation of supervisory encounters are expected to include the credentials of the supervising professional. **Guidance:** The aide does not need to be present for supervisory visits. However, if an area of concern is noted, it is expected that another visit will take place with the aide present to address the identified concern. **Guidance:** An occupational therapist may conduct a home health initial assessment visit and complete a comprehensive assessment under the Medicare program, but only when occupational therapy is on the home health plan of care, with either physical therapy or speech therapy, and when skilled nursing services are not initially in the plan of care.

Standards	Evidence Guidelines
CDT.16 The home health aide supervisory assessment must be completed onsite, or on the rare occasion by using two-way audio-video telecommunications technology that allows for real-time interaction between the registered nurse (or other appropriate skilled professional) and the patient, not to exceed 1 virtual supervisory assessment per patient in a 60-day episode. **Applicable Regulation: G810-484.80(h)(1)(ii).**	**Clinical Record Review:** Validate that supervisory visits are completed onsite, and do not exceed 1 virtual supervisory assessment per patient in a 60-day episode. **Guidance:** Signatures on documentation of supervisory encounters are expected to include the credentials of the supervising professional. **Guidance:** The aide does not need to be present for supervisory visits. However, if an area of concern is noted, it is expected that another visit will take place with the aide present to address the identified concern.
CDT.17 If home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site, in person visit every 60 days to assess the quality of care and services provided by the home health aide and to ensure that services meet the patient's needs. The home health aide does not need to be present during this visit. Semi-annually the registered nurse must make an on-site visit to the location where each patient is receiving care in order to observe and assess each home health aide while they are performing non-skilled care. **Applicable Regulations: G814-484.80(h)(2)(i); G814-484.80(h)(2)(ii).**	**Interview:** Interview an aide. Validate, through specific examples, the ways in which they are supervised. **Clinical Record Review:** Review patient records for a patient who is receiving only aide services from the organization. Validate that an on-site home health aide supervisory visit was conducted by the registered nurse at least every 60 days as required by the standard and that visits were documented. **Guidance:** Signatures on documentation of supervisory encounters are expected to include the credentials of the supervising professional.

Standards	Evidence Guidelines
CDT.18 When remote monitoring or telemonitoring equipment is provided to patients by the organization, policies and procedures address: 1. Types of remote monitoring or telemonitoring available and equipment used; 2. Patient eligibility inclusion and exclusion criteria, including criteria for the discontinuation of services; 3. Patient and caregiver education in the equipment's role in care delivery and its operation per manufacturer's guidelines; 4. How, and by whom, equipment is delivered, set-up, and tested upon initial use, as well as placement for privacy per patient preference; 5. Who provides equipment troubleshooting and replacement and how; 6. What data is collected and how it is integrated into care including: a) The scope and frequency of data collected; b) How and when findings are shared and with whom; 7. How, and who, transports used equipment from the home; 8. How storage of clean and dirty equipment is handled at the organization's location.	**Document Review:** Review policies, procedures, and other documents related to remote monitoring equipment. Validate that the documents address the requirements of the standard. **Interview - Personnel:** Does the organization provide remote monitoring or telemonitoring as part of patient care? **Guidance:** Remote monitoring or telemonitoring refers to the use of technology to collect and transmit patient data for the purposes of monitoring and managing the patient's condition.

Human Resource Management

Key Area of Performance:

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 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. The organization documents: 1. The duties, roles, and responsibilities of each position; 2. The qualifications as well as required experience, education, training, continuing education certifications, registrations, and licensure; 3. Applicable health screenings, criminal background checks, verification of employment eligibility (I-9) in accordance with local, state and federal law and regulation; 4. Organizations in receipt of funds from Medicare, Medicaid, and other federal plans and programs verify that individuals hired are not on the Office of the Inspector General (OIG) List of Excluded Individuals and Entities (LEIE). **Applicable Regulations: G848-484.100; 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. **Personnel Record Review:** Review a sample of personnel files to confirm content follows agency policy. **Guidance:** Copies of diplomas or transcripts are not required. By definition, licensed healthcare professionals are graduates of approved programs; therefore, a primary source verification of licensure, such as a dated printout from a state practice board website verifying current licensure, also validates completions of education **Guidance:** Verification of the OIG LEIE list applies to individuals employed directly by the organization or through arrangement. *(continued on following page)*

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

Standards	Evidence Guidelines
HRM.2 Personnel are licensed, certified, or registered in accordance with applicable local, state, and federal law and regulation. Credentials and licensure are verified and documented at the time of hire and upon renewal. A record of the verification is retained. Required licensure and certifications are current, based on primary source verification. **Applicable Regulations: G860-484.100(b); G1050-484.115.**	**Personnel Record Review:** Validate that personnel providing care or services are licensed, certified, or registered in accordance with applicable local, state, or federal law and regulation. **Guidance:** Copies of diplomas or transcripts are not required. By definition, licensed healthcare professionals are graduates of approved programs; therefore, a primary source verification of licensure, such as a dated printout from a state practice board website verifying current licensure, also validates completion of education. **Guidance:** Health professionals who have been granted licensure through "grandfathering" are considered qualified, providing their licensure is current based on primary source verification.
HRM.3 A registered nurse (RN) is a graduate of a school of professional nursing and is currently licensed, certified, or registered in the state(s) in which they practice. A licensed practical or vocational nurse has completed an appropriate nursing program and is currently licensed, certified, or registered in the state(s) in which they practice. **Applicable Regulations: G1060-484.115(e); G1072-484.115(k).**	**Personnel Record Review:** Validate that registered nurses are licensed as registered professional nurses by the states in which they practice. Validate that licensed practical nurses are licensed in the states in which they practice.

Standards	Evidence Guidelines
HRM.4 A physician is a doctor of medicine, osteopathy or podiatry legally authorized to practice medicine or surgery by the state in which such function or action is performed. **Applicable Regulation: G1070-484.115(j).**	**Personnel Record Review:** Validate that primary source verification has been completed to verify that physicians are legally authorized to practice medicine or surgery by the state in which such function or action is performed. Verify that physicians are licensed in accordance with federal and state law for writing prescriptions and orders, as applicable to their job duties. **Guidance:** For hospices, podiatrists are not included in the definition of a physician and may not serve as a hospice physician or medical director.
HRM.5 Therapists, including physical therapists, occupational therapists, speech language pathologists, or qualified assistants are licensed or otherwise regulated and have completed the requirements to practice as therapists or therapy assistants in the state in which they are practicing. See the Key Terms document for the definition of physical therapists, occupational therapists, speech language pathologists, and qualified assistants. **Applicable Regulations: G1062-484.115(f); G1064-484.115(g); G1066-484.115(h); G1068-484.115(i); G1078-484.115(n).**	**Personnel Record Review:** Validate that personnel providing therapy services are currently licensed, certified, or registered in accordance with applicable local, state, or federal law and regulation. **Guidance:** If state licensure is not required, specific education and examination requirements can be found at §484.115 for Medicare-certified home health agencies.

Standards	Evidence Guidelines
HRM.6 Audiologists: 1. Meet the education and experience requirements for a Certificate of Clinical Competence in audiology granted by the American Speech-Language-Hearing Association; or 2. Meet the educational requirements for certification and are in the process of accumulating the supervised experience required for certification. **Applicable Regulation: G1054-484.115(b).**	**Personnel Record Review:** Validate that audiologists meet the requirements of the standard.
HRM.7 Qualified social workers have a master's or doctoral degree from a school of social work accredited by the Council on Social Work Education and has had at least one year of social work experience in a healthcare setting. Qualified social work assistants (under the supervision of a qualified social worker) have a baccalaureate degree in social work, psychology, sociology, or other field related to social work and has had at least one year of social work experience in a healthcare setting. Alternatively, social work assistants may have two years of appropriate experience as a social work assistant and achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service. **Applicable Regulations: G1074-484.115(l); G1076-484.115(m).**	**Personnel Record Review:** Validate that personnel providing social work services are qualified professionals with the requisite education and experience in social work. **Guidance:** The determinations of proficiency by the U.S. Public Health Service do not apply to persons initially licensed by a state or seeking initial qualification as a social work assistant after December 31, 1977.

Standards	Evidence Guidelines
HRM.8 The following personnel, whether employed directly or under arrangement, participate in organization-sponsored in-service programs: 1. Physicians; 2. Registered nurses; 3. Licensed practical nurses; 4. Individuals providing therapy services, including physical therapists and assistants, occupational therapists and assistants, speech language pathologists and assistants; and 5. Medical social workers. **Applicable Regulations: G704-484.75(b); G722-484.75(b)(9).**	**Personnel Record Review:** Review personnel records for physicians, registered nurses, licensed practical nurses, therapists and therapy assistants, and medical social workers. Verify that the individuals participated in in-service training. This information may be maintained in education records separate from the personnel file.

Standards	Evidence Guidelines
HRM.9 Aides meet all local, state, and federal qualifications for the services they provide by successfully completing: 1. A training and competency evaluation program that meets Medicare requirements; or 2. A competency evaluation program that meets Medicare requirements; or 3. A state approved nurse aide training and competency evaluation program meeting the requirements of §483.151 through §483.154, and is currently listed in good standing on the state nurse aide registry; or 4. A state licensure program that meets Medicare requirements. Individuals furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit, as defined in §440.167, meet all of the qualifications established by the state and demonstrate competency in the services they provide. **Applicable Regulations: G750-484.80; G754-484.80(a)(1); G828-484.80(i); G1058-484.115(d).**	**Personnel Record Review:** Validate that aides meet all local, state, and federal qualifications for the services they provide.

Standards	Evidence Guidelines
HRM.10 The organization requires an aide to complete or demonstrate evidence of completion of a training program prior to competency assessment. The initial training must include classroom and supervised practical training on each task for which competency will be assessed. Training is conducted in a practicum laboratory or other setting in which the aide demonstrates knowledge while providing services. Classroom and supervised practical training totals at least 75 hours. A minimum of 16 hours of classroom training precedes a minimum of 16 hours of supervised practical training as part of the 75 hours. A home health aide training program must address each of the following subject areas: 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. Observation, reporting, and documentation of patient status and the care or service furnished. 3. Reading and recording temperature, pulse, and respiration; 4. Basic infection prevention and control procedures. 5. Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor. 6. Maintenance of a clean, safe, and healthy environment. *(continued on following page)*	**Document Review:** Review documents related to aide training to validate that all requirements of the standard are met. This could include an education plan, policy, curricula, schedules, checklists, or other records. **Personnel Record Review:** Review personnel records of aides who completed an aide training program, if required. Validate that the training met the time requirements of the standard. **Guidance:** If the organization evaluates an aide as competent or the aide is certified through a recognized training program, they do not need to go through an initial training program but would need a competency evaluation. If required by state or local law, aide certification is validated through primary source verification, such as a state nurse aide registry. Alternative formats for classroom training, such as online course material or internet based interactive formats are acceptable delivery methods for the classroom training. These alternative formats should also provide an interactive component that permits students to ask questions and receive responses related to the training.

Standards	Evidence Guidelines
HRM.10 7. Recognizing emergencies and the knowledge of instituting emergency procedures and their application. 8. The physical, emotional, and developmental needs of and ways to work with the populations served by the HHA, including the need for respect for the patient, his or her privacy, and his or her property. 9. Appropriate and safe techniques in performing personal hygiene and grooming tasks that include: Bed bath; Sponge, tub, and shower bath; Hair shampooing in sink, tub, and bed; Nail and skin care; Oral hygiene; toileting and elimination; 10. Safe transfer techniques and ambulation; 11. Normal range of motion and positioning; 12. Adequate nutrition and fluid intake; 13. Recognizing and reporting changes in skin condition; and 14. Any other task that the organization may choose to have an aide perform as permitted under state law. The organization is responsible for training home health aides, as needed, for skills not covered in the basic checklist, as described in 1-14 of this section. Training is documented, including the dates, content, and participants. **Applicable Regulations:** **G760-484.80(b)(1); G762-484.80(b)(2); G764-484.80(b)(3); G766-484.80(b)(4).**	

Standards	Evidence Guidelines
HRM.11 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. Organizations must assess 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, their privacy, and their 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. *(continued on following page)*	**Personnel 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. **Personnel 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, *(continued on following page)*

Standards	Evidence Guidelines
HRM.11 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. **Applicable Regulations: G702-484.75(a); G764-484.80(b)(3); G768-484.80(c)(1); G772-484.80(c)(5).**	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. **Guidance:** The competency evaluation for home health aides is performed by a registered nurse or by individuals under the supervision of the registered nurse.

Standards	Evidence Guidelines
HRM.12 An aide provides services on behalf of the organization only after successfully completing the required competency evaluation(s). An aide is not considered competent in any task for which they are evaluated as "unsatisfactory." The aide does not perform a task without direct supervision by a licensed nurse until after they receive training in the task for which they were evaluated as unsatisfactory and passes a subsequent evaluation with a rating of "satisfactory." Aides must receive a satisfactory evaluation rating on all tasks they perform independently. An aide who receives an unsatisfactory rating on more than one task is not considered to have passed the competency evaluation and does not function as an aide. If the competency evaluation is not passed, the aide receives training on any tasks for which they received unsatisfactory ratings and is reevaluated for competency prior to functioning as an aide. **Applicable Regulations: G768-484.80(c); G770-484.80(c)(4).**	**Personnel Record Review:** Validate that aides received a satisfactory rating on all tasks they are performing independently. Validate that when an individual has an unsatisfactory rating on more than one task, the individual is not considered to have successfully completed the competency evaluation and is not functioning as an aide. **Guidance:** The organization determines the number of times an aide can be trained and evaluated for competency. **Guidance:** An aide who is evaluated as satisfactory in all subject areas except one would be considered competent. However, this aide would not be allowed to perform the task in which they were evaluated as unsatisfactory except under direct supervision.

Standards	Evidence Guidelines
HRM.13 Classroom and supervised practical training of aides is performed by a registered nurse (RN) who possesses a minimum of two years nursing experience, at least one year of which is in home healthcare, or by other individuals under the general supervision of the RN. **Applicable Regulation: G780-484.80(e).**	**Personnel Record Review:** Review the personnel file of the RN who conducts or supervises classroom and the supervised practical training in the organization's aide training program, if any. Verify that the RN meets education and experience requirements. **Guidance:** The required 2 years of nursing experience for the RN instructor should be "hands on" clinical experience such as providing care and/or supervising nursing services or teaching nursing skills in an organized curriculum or in-service program.
HRM.14 The aide competency evaluation is performed by a registered nurse in consultation with other skilled professionals, as appropriate, prior to the independent assumption of duties. **Applicable Regulation: G768-484.80(c)(3).**	**Personnel Record Review:** Review personnel records and/or education records that document aide competency evaluations. Verify that the evaluation is performed by a registered nurse as required by the standard.

Standards	Evidence Guidelines
HRM.15 Home health aides participate in at least 12 hours of in-service training during each 12-month period. Training is provided by or under the supervision of a registered nurse (RN) who possesses a minimum of two years of nursing experience, at least one of which must be in home care. Training may be provided while the aide is furnishing care to a patient. Training is documented, and documentation includes the name of attendees(s) and instructor, date, and topic. **Applicable Regulations: G774-484.80(d); G776-484.80(d)(1); G778-484.80(d)(2); G780-484.80(e).**	**Personnel Record Review:** Review records for home health aides. Validate that aides attended 12 hours of training during the past 12 months and that the training was supervised by a qualified RN. **Guidance:** The organization determines if training is provided per calendar year or beginning with the date of hire. The methods used for this training may vary. It could be face to face; online; or by other written, video, or audio media. The training can be conducted within the organization, through an outside organization, in a classroom setting, or in the patient care setting so long as it is performed or supervised by an RN as required.
HRM.16 If there has been a 24-month lapse in furnishing services, an aide must complete another training program and/or satisfactory competency assessment, as specified in §484.80(a)(1), before providing services. The individual is not considered to have completed a training program, as specified in §484.80(a)(1), if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 months during which none of the services furnished by the individual and evaluated for competency were for compensation. **Applicable Regulation: G756-484.80(a)(2).**	**Personnel Record Review:** Review aide personnel records. Verify that the aide has completed another training program if there has been a 24-month lapse in furnishing services since the individual's most recent completion of the program. **Guidance:** Requirements for aide training and competency assessment is outlined in HRM.9. If an individual has a 24 consecutive month lapse in furnishing aide services for compensation, regardless of the circumstances surrounding the lapse, the aide will be required to complete a new training and competency evaluation program, or a competency evaluation program, prior to providing aide services on behalf of the HHA.

Standards	Evidence Guidelines
HRM.17 The organization may offer aide training and competency evaluation or competency evaluation programs unless, within the previous two years, the organization: 1. Was out of compliance with requirements related to content and duration, aide competency evaluation, aide in-service training, or qualifications of instructors; or 2. Permitted an individual who does not meet the definition of a "qualified home health aide" to furnish home health aide services (with the exception of licensed health professionals and volunteers); or 3. Was subjected to an extended (or partially extended) survey as a result of having been found to have furnished substandard care (or for other reasons as determined by the Centers for Medicare & Medicaid Services or the state); or 4. Was assessed a civil monetary penalty of $5,000 or more as an intermediate sanction; or 5. Was found to have compliance deficiencies that endangered the health and safety of the organization's patients, and had temporary management appointed to oversee the management of the organization; or 6. Had all or part of its Medicare payments suspended; or 7. Was found under any federal or state law to have had its participation in the Medicare program terminated; or *(continued on following page)*	**Document Review:** If the organization provides aide 1) competency or 2) training and competency programs, review documentation from the last 24 months and validate compliance with the requirements of the standard. This documentation may include state or accreditation organization survey results, content and curricula of the aide training programs, or minutes from governance meetings. **Guidance:** Effective February 14, 1990, a home health organization must not have had any Conditions of Participation out of compliance within 24 months before it begins a training and competency evaluation or competency evaluation program. Correction of a condition level finding is not sufficient for the organization to begin or resume these programs.

Standards	Evidence Guidelines
HRM.17 8. Was found under any federal or state law to have been assessed a penalty of $5,000 or more for deficiencies in federal or state standards for home health agencies; or 9. Was subjected to a suspension of Medicare payments to which it otherwise would have been entitled; or 10. Operated under temporary management that was appointed to oversee the operation of the organization and to ensure the health and safety of the organization's patients; or 11. Was closed, or had its patients transferred by the state; or 12. Was excluded from participating in federal healthcare programs or debarred from participating in any government program. **Applicable Regulations: G768-484.80(c)(2); G782-484.80(f); G782-484.80(f)(1); G782-484.80(f)(2); G782-484.80(f)(3); G782-484.80(f)(4); G782-484.80(f)(5); G782-484.80(f)(6); G782-484.80(f)(7).**	
HRM.18 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. **Document Review:** Review organization policy for supervision of PTA, OTA, SLPA, SWA. Verify supervision is documented in the clinical record, and signed per agency policy, state, local and federal law.

Standards	Evidence Guidelines
HRM.19 Skilled nursing services are provided under the supervision of a qualified registered nurse that meets the requirements of §484.115(k). **Applicable Regulations: G724-484.75(c); G726-484.75(c)(1); G1060-484.115(e).**	**Clinical Record Review:** Verify that there is documentation that licensed practical nurses are supervised by a qualified registered nurse. **Guidance:** See the Human Resource Management Key Performance Area, standard HRM.3 for the requirement that defines a qualified registered nurse. See the Key Terms document for definitions. **Guidance:** The HHA should identify a registered nurse (RN) to supervise the care provided by licensed practical/vocational nurses (LPN/LVNs). §484.115(k) requires the RN be a graduate of an approved school of professional nursing who is licensed in the state where practicing. The identified RN must in turn monitor and evaluate LPN/LVN performance in the provision of services, provision of treatments, patient education, communication with the RN, and data collection regarding the patient's status and health needs (as delegated by the RN). Only a registered nurse may perform comprehensive assessment, evaluations, care planning and discharge planning.

Standards	Evidence Guidelines
HRM.20 Rehabilitative therapy services are provided under the supervision of a qualified occupational therapist or qualified physical therapist that meets the requirements of§484.115(f) or (h), respectively. **Applicable Regulation: G728-484.75(c)(2).**	**Clinical Record Review:** Verify that there is documentation that therapists (if any) are supervised by a qualified therapist as required by the standard. **Guidance:** See the Human Resource Management Key Performance Area, standard HRM.5 for requirements that define qualified occupational therapists and qualified physical therapists. See the Key Terms document for definitions. **Guidance:** An assistant must be supervised by a skilled therapy professional for the assistant's respective therapy type. For example, only a physical therapist may supervise a physical therapist assistant and only an occupational therapist may supervise an occupational therapy assistant. The applicable therapist should monitor and evaluate the therapy assistant's performance regarding provision of treatments, patient education, communication with the therapist, and data collection regarding the patient's status and health needs (as delegated by the therapist). Only the skilled therapist may perform comprehensive assessments, patient evaluations, care planning and discharge planning.

Standards	Evidence Guidelines
HRM.21 A qualified social worker, that meets the requirements of §484.115(m), supervises the work of a qualified social work assistant. **Applicable Regulation: G730-484.75(c)(3).**	**Clinical Record Review:** Verify that there is documentation that the social work assistant (if any) is supervised by a qualified social worker as required by the standard. **Guidance:** See the Human Resource Management Key Performance Area, standard HRM.7 for requirements that define qualified social workers and social work assistants. See the Key Terms document for definitions. **Guidance**: Any social service provided by a social work assistant must be supervised by a social worker who has a master's degree or doctoral degree from a school of social work accredited by the Council on Social Work Education and has 1 year of social work experience in a health care.

Standards	Evidence Guidelines
HRM.22 Personnel performance is evaluated as defined by organizational policy and in accordance with local, state, and federal law and regulation.	**Personnel Record Review:** Review personnel records to validate that performance evaluations are completed in accordance with organizational policy. **Guidance:** The organization determines which personnel receive performance evaluations as well as the frequency and contents of the evaluation, unless otherwise stipulated in law or regulation or through additional requirements of this standard (see HRM.24). **Guidance:** In some states, professional practice acts limit the extent to which one professional discipline is permitted to evaluate the clinical performance of another professional discipline. For example, a state nurse practice act may limit the scope of supervision and oversight of performance to nursing functions. In such a case, evaluation of the clinical performance of a physical therapist would be considered beyond the scope of nursing practice. It is expected that organizations are aware of any limitations in their state and structure the performance evaluation process as necessary.
HRM.23 A registered nurse or other appropriate skilled professional makes an annual on-site visit to the location where a patient is receiving care in order to observe and assess each aide while they are performing care. **Applicable Regulation: G813-484.80(h)(1)(iv).**	**Personnel Record Review:** Review personnel records for one or more home health aides employed for over one year. Verify that there is documentation of an on-site observation of care delivery conducted by the registered nurse or other skilled professional dated within the last year.

Standards	Evidence Guidelines
HRM.24 If an area of concern in aide services is noted by the supervising registered nurse or other appropriate skilled professional, the supervising individual makes an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while they are performing care. **Applicable Regulation: G812-484.80(h)(1)(iii).**	**Interview:** Interview the clinical manager or an individual who supervises aide services. Validate the process followed when an area of concern in an aide's performance is identified. Validate that the process includes making an on-site visit to observe the aide performing care.
HRM.25 If a deficiency in aide services is verified by the registered nurse or other appropriate skilled professional during an on-site visit, the organization conducts, and the home health aide completes retraining and a competency evaluation for the deficient and all related skills. **Applicable Regulation: G816-484.80(h)(3).**	**Interview:** Interview the clinical manager or an individual who supervises aide services. Verify the process followed when a deficiency in an aide's performance is identified and that the process includes the aide's satisfactory completion of a competency evaluation. **Personnel Record Review:** Review the personnel record for an aide who has had a deficiency identified (if any). Verify that re-training and a satisfactory competency evaluation were completed prior to the return to performance of the identified task.

Continuous Quality Improvement

Key Area of Performance:

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 The organization develops, implements, evaluates, and maintains an effective, ongoing, organization-wide, data-driven Continuous Quality Improvement (CQI) program that reflects the scope and complexity of the organization and the care and services provided. **Applicable Regulation: G640-484.65.**	**Document Review:** Review documentation on the CQI program. Validate that it includes the use of data to evaluate the quality of care and services provided and reflects the scope and complexity of the organization.
CQI.2 The Continuous Quality Improvement (CQI) program is organization-wide and covers all services and programs offered including: 1. Services provided under contract or arrangement; and 2. Skilled professionals The program is capable of showing measurable improvement in indicators related to outcomes, patient safety, and quality of care. The organization selects quality indicators, including adverse patient events, and other aspects of performance that enable the organization to assess processes of care, services, and operation. *(continued on following page)*	**Document Review:** Review documentation of CQI activities. Validate that the activities are organization-wide and cover all services and programs offered, including those provided under contract or arrangement. **Interview:** Interview one or more key leaders involved in the implementation of the organization's CQI program. Using a recent performance improvement activity as an example, validate that the organization can demonstrate the operation of the program and the ways in which it is implemented, and that the organization focuses on indicators related to outcomes, patient safety, and quality of care. Verify how the organization ensures that the *(continued on following page)*

Standards	Evidence Guidelines
CQI.2 The organization maintains documentary evidence of its quality assessment and performance improvement program and is able to demonstrate its operation. **Applicable Regulations: G640-484.65; G642-484.65(a)(1); G642-484.65(a)(2); G720-484.75(b)(8).**	program covers all the services provided, including those provided through contractual arrangement. **Guidance:** This standard does not require that the organization has achieved measurable improvement related to outcomes, patient safety, and quality of care. The organization is expected to demonstrate that it is capable of showing measurable improvement through its performance improvement activities. The use of a standard quality assessment methodology, such as the Plan Do Check Act model, is one approach that may demonstrate the capability of the program to achieve improvements. **Guidance:** Skilled professionals include registered nurses, physical and occupational therapy, speech-language pathologists, social workers, spiritual counselors, registered dieticians, and physicians. **Guidance:** The organization determines the nature and degree of participation by contractors in CQI activities. Participation could include attendance at meetings or distribution of key information regarding process improvements and outcomes.

Standards	Evidence Guidelines
CQI.3 The organization defines the outcomes and measures that are included in the Continuous Quality Improvement (CQI) program and the data that will be used to support performance improvement (PI) activities by including required data, including: 1. Measures derived from the Outcome and Assessment Information Set (OASIS), where applicable and relevant; 2. Adverse patient events; and 3. High-risk, high volume, or problem-prone areas, considering incidence, prevalence, and severity. **Applicable Regulation: G644-484.65(b)(1).**	**Document Review:** Review documentation related to the CQI program. This information might be included in a strategic plan, a performance management report, or a dashboard or CQI committee meeting report. Validate that documentation defines the outcomes and measures that are included in the CQI program and the data that will be used to support PI activities. **Interview:** Interview a key leader involved in the organization's CQI program. Verify the ways the organization ensures that its focus is on using high-risk, high-volume, or problem-prone areas and considers incidence, prevalence, and severity. **Guidance:** Quality performance improvement activities are the processes implemented by the organization to measure, analyze, and track its quality indicator and outcome data. Performance improvement projects are the actions the organization takes to correct issues identified thorough the measurement, tracking, and analysis of quality improvement indicator and outcome data. **Guidance:** Measures (also called indicators) are used to track progress toward achieving outcomes. Outcomes define the specific measurable results. For example, an organization may have an outcome for reducing patient falls by 5 percent within 12 months. A measure (or indicator) used to track progress toward this outcome might be the percent of total patients on service who experience a fall, using incident reports as a data source. *(continued on following page)*

Standards	Evidence Guidelines
CQI.3	**Guidance:** It is not expected that all OASIS measures are incorporated in the CQI program. A review of benchmarking data, such as Outcome-Based Quality Improvement reports, the Process-Based Quality Improvement manual, Home Health Compare, etc., may guide the organization's selection of measures. **Guidance:** HHAs seeking initial enrollment in the Medicare program are unlikely to have collected extensive data for their QAPI program indicators, since they likely have been in operation for a relatively brief time. Nevertheless, these initial applicants must have a QAPI program in place, and must be able to describe how the program functions, including which indicators/measures are being tracked, at what intervals, and how the information will be used by the HHA to improve quality and safety.
CQI.4 The Continuous Quality Improvement (CQI) program focuses on indicators or measures related to improved outcomes including, at a minimum: 1. Use of emergent care services; 2. Hospital admissions and readmissions; and 3. Performance across the spectrum of care, including the prevention and reduction of medical errors. **Applicable Regulation: G640-484.65.**	**Document Review:** Review documents that state current CQI indicators or measures. This information might be included in a strategic plan, a performance management report, or a dashboard or CQI committee meeting report. Validate that the program focuses on indicators or measures related to use of emergent care services, hospital admissions and readmissions, and the prevention and reduction of medical errors. **Guidance:** The requirements related to analyzing and tracking indicators defined in this standard are listed in CQI.5.

Standards	Evidence Guidelines
CQI.5 The organization analyzes quality indicator data, based on the measures defined in their Continuous Quality Improvement (CQI) program, to monitor and assess results. Findings from the analysis are used to identify and support the implementation of performance improvement projects. The Continuous Quality Improvement (CQI) program measures and analyzes data to evaluate effectiveness of the program and must: 1. Collect data to monitor the effectiveness and safety of services, quality of care, and identify areas to improve; 2. Focus on high risk, high volume, or problem prone areas; 3. Focus on adverse patient events for cause and implement preventive actions; 4. Consider incidence, prevalence and severity of problems; 5. Lead to immediate correction of any identified problem that threatens the health and safety of patients. **Applicable Regulations: G644-484.65(b)(2); G646-484.65(c)(1)(i); G646-484.65(c)(1)(ii); G646-484.65(c)(1)(iii); G654-484.65(c)(2).**	**Document Review:** Review documents that compile and report the results of ongoing monitoring of quality measures (or indicators). Such documents might include CQI meeting minutes, performance management reports, complaint logs, or summaries of performance improvement initiative findings. Verify that the data reported monitors the organization's performance on selected measures defined in the CQI program. **Interview:** Interview a key leader involved in the implementation of the CQI program. Verify the types of data that are analyzed to monitor and assess results. Through specific examples, clarify how findings from the analysis are used to identify and support implementation of performance improvement projects. **Guidance:** Performance improvement projects are the actions the organization takes to correct issues identified thorough the measurement, tracking, and analysis of quality improvement indicator and outcome data. **Guidance:** HHAs must track all adverse patient events, to determine through subsequent analysis whether they were the result of errors that should have been preventable, to reduce the likelihood of such events in the future. HHAs should also consider a way to identify errors that result in near misses, since such errors have the potential to cause future adverse events.

Standards	Evidence Guidelines
CQI.6 The organization conducts performance improvement projects based on analysis of performance improvement activities. The number and scope of distinct improvement projects conducted annually reflect the scope, complexity, and past performance of the organization's services and operations. **Applicable Regulation: G658-484.65(d)(1).**	**Document Review:** Review Continuous Quality Improvement (CQI) program documents that report the number and types of performance improvement projects undertaken during the past year, relative to the scope, complexity, and past performance of the organization. **Interview:** Interview key leaders involved in the implementation of the CQI program. Verify, through specific examples, how the CQI program addresses the scope of the organization's care and services.
CQI.7 The organization documents the performance improvement projects undertaken, the reasons for conducting these initiatives, and the measurable progress achieved on these projects. **Applicable Regulation: G658-484.65(d)(2).**	**Document Review:** Review documentation of performance improvement projects. This information might be in a Continuous Quality Improvement committee meeting record or other report. Verify that documentation includes the reasons for conducting these initiatives and the measurable progress achieved on these initiatives.

Standards	Evidence Guidelines
CQI.8 The documented number and scope of performance improvement projects conducted annually: 1. Represent the needs of the population served; 2. Represent the internal needs of the organization; and 3. Reflect the scope, complexity, and past performance of the organization's services and operations. Documentation of selected performance improvement projects include: 1. The reason for conducting the projects; and 2. Measurable progress achieved. The Organization's performance improvement activities: 1. Track adverse patient events; 2. Analyze the causes; 3. Implement preventive action and mechanisms that include feedback and learning throughout the program. **Applicable Regulations: G642-484.65(a)(1); G642-484.65(a)(2); G658-484.65(d)(1); G658-484.65(d)(2).**	**Interview:** Interview a key leader. Verify how the organization ensures that advances made through the CQI program are sustained. **Guidance:** The organization is expected to demonstrate that outcomes are maintained over time. The organization determines how long it needs to monitor maintenance of outcomes based on an expectation that the process is stable. To determine if desired performance has been maintained over time, an organization might use a spot check in which an intermittent review of performance is conducted. For example, initial improvements may require weekly or monthly monitoring. Once performance has been improved and the process is stable, monitoring may no longer be necessary.

Standards	Evidence Guidelines
CQI.9 The organization measures its success and tracks performance to ensure that improvements made through the Continuous Quality Improvement (CQI) program are sustained. The organization: 1. Takes action to improve performance; 2. Assesses the success of the action after implementing it; 3. Tracks ongoing results to ensure improvement is sustained. **Applicable Regulation: G656-484.65(c)(3).**	**Document Review:** Review documentation for ongoing or completed CQI performance improvement activities and projects. Validate that the organization continues to monitor performance to ensure that improvements are sustained.

Infection Prevention & Control

Key Area of Performance:

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 Infection prevention and control (IPC) policies and procedures reflect the scope and complexity of the services provided by the organization. It includes, at a minimum: 1. Methods to identify risk for acquiring and transmitting infectious agents where patient resides; 2. Guidelines for reducing the risk of acquiring and spreading organisms that can contribute to infections, including communicable diseases; 3. Educating and training personnel on methods to avoid and reduce the transmission of organisms that can contribute to an infection and communicable diseases; 4. Protection of patient, staff, and families from bloodborne or airborne pathogens; and 5. Objective to minimize the risk of infection and communicable disease. **Applicable Regulation: G680-484.70.**	**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. **Interview:** Interview the key leader responsible for managing the IPC program. Clarify the ways in which the program is implemented. Validate that implementation reflects documented policies, processes, and procedures. **Guidance:** 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	Evidence Guidelines
IPC.2 The organization maintains and documents an Infection Prevention and Control (IPC) program that 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) (gloves, eye protection (face shield, goggles), fluid-resistant gown, mask or respirator, depending on anticipated exposure) and other necessary equipment and supplies to implement standard precautions and, as needed, transmission-based precautions; 3. Safely managing usage and operation of equipment or devices used for patient care by staff; safe handling of soiled items in patient care environment; 4. Minimizing potential occupational exposure to pathogens; 5. Implementing safe injection and medication safety practices; 6. Establishing a bloodborne pathogen exposure control plan; 7. Establishing a respiratory protection plan; 8. Providing education on IPC practices to personnel, patients, and caregivers; *(continued on following page)*	**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:** 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. *(continued on following page)*

Standards	Evidence Guidelines
IPC.2 9. Managing medical waste generated by personnel, patients, and caregivers; 10. Performing health screening of personnel; 11. Monitoring for the risk and occurrence of infections; 12. Reporting infections according to established surveillance guidelines; and 13. Maintaining current knowledge related to emerging community risks and new or revised laws and regulations. **Applicable Regulations: G680-484.70; G682-484.70(a).**	**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. **Guidance:** Examples of national organizations that promulgate nationally recognized infection and communicable disease control guidelines, and/or recommendations include: the CDC, the Association for Professionals in Infection Control and Epidemiology (APIC), and the Society for Healthcare Epidemiology of America (SHEA). An HHA should identify the source of the standards it selects and be capable of explaining why those standards were chosen for incorporation into the HHA's infection prevention and control program.
IPC.3 The organization follows accepted standards of practice, including the use of standard precautions, to prevent the transmission of infections and communicable diseases. Hand hygiene products, personal protective equipment (PPE), and other equipment and supplies are available to personnel at risk of occupational exposure to bloodborne pathogens and other potentially infectious materials in accordance with state law and regulations. **Applicable Regulation: G682-484.70(a).**	**Interview:** Interview the key leader responsible for managing the Infection Prevention and Control (IPC) program. Clarify the ways in which the program is implemented. Validate that implementation reflects accepted standards of practice, including the use of the Centers for Disease Control and Prevention's isolation precautions to prevent the transmission of infections and communicable diseases. **Observation:** Verify adequate supply of personnel protective equipment for all staff. **Document Review:** Review policy on personnel protective equipment. *(continued on following page)*

Standards	Evidence Guidelines
IPC.3	**Guidance:** Standard precautions must be used to prevent transmission of infectious agents. "Standard precautions" are a group of infection practices that apply to all patients regardless of suspected or confirmed infection status at the time health care is delivered. These practices protect healthcare personnel and prevent healthcare personnel or the environment from transmitting infections to patients. **Guidance:** Appropriate use of PPE is the use of specialized clothing or equipment worn for protection and as a barrier against infectious materials or any potential infectious exposure. PPE protects the caregiver's skin, hands, face, respiratory tract, and/or clothing from exposure. Examples of PPE include: gloves, gowns, face protection (facemask and goggles or face shields). The selection and use of PPE is determined by the nature of patient interaction and potential for exposure to blood, body fluids and/or infectious materials. Hand Hygiene products, personal protective equipment (PPE), and other equipment and supplies are available to personnel at risk of occupational exposure to bloodborne pathogens and other potentially infectious materials in accordance with state law and regulations.

Standards	Evidence Guidelines
IPC.4 The organization maintains a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases which includes: 1. Methods for identifying infectious and communicable disease problems; and 2. A plan for the appropriate actions that are expected to result in improvement and the prevention of infection. The program is an integral part of the organization's Continuous Quality Improvement program activities. **Applicable Regulations: G684-484.70(b); G684-484.70(b)(1); G684-484.70(b)(2).**	**Document Review:** Review IPC program documentation. Validate that the program is agency-wide and addresses the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases. Verify that it includes methods for identifying infectious and communicable disease problems and a plan for the appropriate actions that are expected to result in improvement and disease prevention. **Tip:** CMS suggests HHAs have a way to receive alerts from the CDC Health Alert Network or local public health network as a means of staying up to date with alerts and information related to public health incidents (as seen with the 2019 Novel Coronavirus public health emergency).
IPC.5 Influenza and pneumococcal vaccines may be administered to patients per organizational policy developed in consultation with a physician or allowed practitioner including physician assistant, nurse practitioner, or clinical nurse specialist, and after an assessment of the patient to determine the presence of contraindications. **Applicable Regulation: G582-484.60(b)(2).**	**Interview:** Interview a key leader with knowledge of the infection prevention and control program. Verify the process in place for administering influenza and pneumococcal vaccines to patients. Verify that the process includes consultation with a physician or allowed practitioner. **Document Review:** Validate there are written policies for vaccination screening and administration.

Standards	Evidence Guidelines
IPC.6 Personnel use hand hygiene products, personal protective equipment (PPE), and other necessary equipment and supplies as described in the organization's infection prevention and control policies and procedures and the Centers for Disease Control and Prevention (CDC) or World Health Organization (WHO) guidelines. Hand hygiene, using correct technique, is performed when indicated. At a minimum, hand hygiene is performed: 1. Before and after having direct contact with a patient's intact skin (taking a pulse or blood pressure, performing physical examinations, lifting the patient in bed); 2. After contact with blood, body fluids, or excretions; mucous membranes; non-intact skin; or wound dressings; 3. After contact with inanimate objects (including medical equipment) in the immediate vicinity of the patient; 4. If hands will be moving from a contaminated-body site to a clean-body site during patient care; and 5. After glove removal. **Applicable Regulation: G682-484.70(a).**	**Observation – Home Visit:** On home visit(s), validate that hand hygiene occurs when indicated using the correct technique according to Centers for Disease Control and Prevention or the World Health Organization guidelines. **Observation:** Inspect offices, warehouses, or other work and storage areas. Validate that hand hygiene is practiced as defined in the organization's policy and CDC or WHO guidelines. Validate that, at a minimum, standard precautions are followed. **Document Review:** Review handwashing policy and Personal Protective Equipment Policy. **Guidance:** Personnel includes contracted personnel that provide care and services on behalf of the agency. **Guidance:** The use of PPE varies depending on the patient's diagnosis and the type of services provided. At a minimum, it is expected that CDC or WHO standard precautions are implemented. **Tip:** Information on hand hygiene practices and standard precautions in community settings can be found on the CDC or WHO website.

Standards	Evidence Guidelines
IPC.7 Personnel follow the organization's infection prevention and control procedures when supplies and equipment are stored, transported, and carried in and out of the care environment.	**Observation:** Inspect the organization's offices. Verify that supplies and equipment for patient use are stored in a clean, dry space protected from damage or contamination. Verify that supplies are not expired. **Observation – Home Visit:** Observe personnel transport and use of supplies and equipment in the care environment. Verify that procedures are followed in accordance with organizational policy to prevent cross-contamination. Verify that clean items are separated from used or soiled items during transport**.** **Guidance:** In following organizational policy, it is expected that personnel ensure that areas for supply and equipment storage are separated to prevent cross-contamination. **Guidance:** "Care environment" refers to where the patient is located, whether in their home or in an inpatient facility or setting. This standard does not apply to suppliers whose personnel do not perform duties in the patient's care environment.

Standards	Evidence Guidelines
IPC.8 Bags used to carry equipment or supplies into or out of the care environment are transported and used in a manner consistent with organizational policy to prevent the spread of infections and communicable diseases. Personnel follow the organization's infection prevention and control procedures when supplies and equipment are stored, transported, and carried in and out of the care environment. **Applicable Regulation: G682-484.70(a).**	**Observation – Home Visit:** Observe the transport and use of bags in the care environment. Verify that organizational policy is followed and that bags are managed in a manner that avoids cross-contamination. Cleaning and disinfecting or placing a clean barrier on the surface in the home where clean equipment will be placed and/or preparation of injectable medications will be performed. Additionally, items that are taken from one home to another should be cleaned and disinfected in accordance with accepted standards of practice, which include manufacturer's instructions for use. **Document Review:** Review policy for bags and carrying of other equipment and supplies. **Observation:** Inspect the organization's offices. Verify that supplies and equipment for patient use are stored in a clean, dry space protected from damage or contamination. Verify that supplies are not expired. **Guidance:** "Care environment" refers to where the patient is located, whether in their home or in an inpatient facility or setting. This standard does not apply to suppliers whose personnel do not perform duties in the patient's care environment.

Standards	Evidence Guidelines
IPC.9 Sterilized items are stored and transported in a manner that preserves the integrity of packaging material. Items with expired sterilization dates are removed from inventory and not used. Packages containing sterile items are inspected before use to verify the expiration date and package integrity and dryness. If an event causes an item to become contaminated (e.g., a package becomes torn or wet), it is not used. **Applicable Regulation: G682-484.70(a).**	**Observation:** Inspect storage areas where sterilized items are stored (if applicable). Verify that sterilized items are within date and that package integrity is intact as required. **Observation:** Inspect vehicles where sterilized items are transported. Verify that sterilized items are within date and that package integrity is intact as required. **Observation – Home Visit:** Verify that the provider inspects the integrity of the packaging before use. If an event causes an item to become contaminated (e.g., a package becomes torn or wet), or its expiration date has surpassed, verify that it is not used. **Tip:** Additional information regarding event-based sterilization may be found at www.cdc.gov/infectioncontrol/guidelines/Disinfection/index.html

Standards	Evidence Guidelines
IPC.10 Equipment that is owned by the organization, or for which it is responsible, is cleaned and disinfected according to current manufacturers' guidelines and in accordance with the type of equipment and level of infection risk. **Applicable Regulation: G682-484.70(a).**	**Document Review:** Review documents that record cleaning and disinfection of equipment. Validate that equipment stored as clean is logged as having been cleaned according to manufacturer's guidelines and organizational policy. **Personnel Record Review:** Review documentation of staff training for separation between clean and soiled equipment to prevent cross contamination in the patient environment and during transport. **Guidance:** Equipment that the organization may not own but is responsible for might include leased equipment, such as telemonitors or diagnostic equipment. Cleaning and disinfecting of medical equipment is essential. Staff should follow the manufacturer's instructions for reprocessing (i.e., cleaning and disinfection or cleaning and sterilization) and use and current standards of practice for transport and storage of patient care equipment. Single-use equipment is discarded after use according to the manufacturer's instructions for proper disposal. Reusable medical equipment (e.g., blood glucose meters and other point-of-care meters, blood pressure cuffs, oximeter probes) are reprocessed prior to use on another patient and when soiled. The HHA must ensure that HHA staff are trained to maintain separation between clean and soiled equipment to prevent cross contamination in the patient care environment and during transport.

Standards	Evidence Guidelines
IPC.11 During delivery of care and services, the patient's immediate environment, to the extent possible, is maintained to minimize potential exposures in the home health setting, focusing on prevention of reducing the exposure and transmission of respiratory infections. Work surfaces in the care environment are cleaned as defined in the organization's infection prevention and control policies and procedures. **Applicable Regulation: G682-484.70(a).**	**Observation:** Conduct home visits and other observations of the care environment, as applicable. Validate that work surfaces are cleaned as defined in policy. **Guidance:** "Care environment" refers to where the patient is located, whether in their home or in an inpatient facility or setting. This standard does not apply to suppliers whose personnel do not perform duties in the patient's care environment. **Guidance:** It is expected that organizations have appropriate processes in place to reduce the presence of unclean or unsanitary environments. However, it is recognized that in a patient's home there may be limitations beyond the control of the organization. In such situations, it is expected that organizations educate patients and caregivers about appropriate processes and risks related to unclean or unsanitary environments. **Guidance:** Maintaining a care environment in a manner that minimizes the risks associated with infections and communicable diseases is a balance between removing all potential sources of infection and respecting a person's self-care and autonomy. It may not be realistic to eliminate every identified infection control risk in a patient's residence. Organizations are expected to identify risks when present and modify the care environment, to the extent possible, to prevent infections before providing care or services.

Standards	Evidence Guidelines
IPC.12 The organization properly stores and disposes of medical waste products and contaminated syringes used by its personnel in the performance of care and services. Storage and disposal of medical waste products is done in accordance with local, state, and federal law and regulation, including: 1. Placing all used needles in a non-permeable, tamper-proof, puncture-resistant container that is not recapped or broken; and 2. Disposing of the puncture-proof container appropriately. **Applicable Regulation: G682-484.70(a).**	**Observation:** Inspect offices, warehouses, or other administrative facilities. Validate that medical waste is handled and stored safely, as defined in the Infection Prevention and Control program documents. **Observation – Home Visit:** If medical waste is generated, observe that it is disposed of safely, including placing all used needles in a non-permeable, tamper-proof, puncture-resistant container that is not recapped or broken and disposing of the puncture-proof container appropriately. **Guidance:** This standard does not apply to organizations that do not produce medical waste products in the provision of care and services. **Guidance:** Some local and state authorities have specific requirements for the management of medical waste. It is expected that the organization has knowledge of and complies with these requirements. **Guidance:** Medical waste includes sharps and infectious waste contaminated with blood and other bodily fluids that represent a sufficient potential risk of causing infection during handling and disposal. Specific guidelines on infectious waste can be found on the Centers for Disease Control and Prevention website. **Guidance:** In offices, warehouses, or other administrative spaces, it is *(continued on following page)*

Standards	Evidence Guidelines
IPC.12	expected that medical waste is stored in a separate and clearly labeled space prior to disposal. The space chosen does not need to be an entirely separate location (e.g., a closet) that is locked or otherwise secured. **Tip:** Information on the safe disposal of sharps generated by patients can be found on the Food and Drug Administration website.
IPC.13 Patients, caregivers, and personnel are instructed on: 1. Infection prevention and control practices related to the care and services provided; and 2. Measures to minimize the risk of spreading infection and communicable diseases, including the proper techniques for handling and disposing of medical waste, as appropriate. 3. The HHA must ensure that HHA staff are trained to maintain separation between clean and soiled equipment to prevent cross contamination in the patient care environment and during transport. Instruction is documented. **Applicable Regulations: G680-484.70; G686-484.70(c).**	**Interview:** Interview personnel providing care and services to patients. Validate, through specific patient examples, the types of education that are provided to patients for minimizing the spread of infections and communicable disease. **Clinical Record Review:** Validate evidence of instruction on infection prevention and control. Verify that instruction is given on infection control practices, as appropriate to the care and services provided. If the patient's care generates medical waste, verify that patients and their caregivers have been instructed on safe practice for its storage and disposal. Validate that documentation includes what was taught and to whom, as well as a record of the learner's comprehension. **Observation – Home Visit:** If the patient's care generates medical waste, interview the patient and/or caregiver to clarify what instructions they received on safe practice for its storage and disposal. *(continued on following page)*

Standards	Evidence Guidelines
IPC.13	**Guidance:** The amount and type of education that is provided is dependent on the scope and complexity of the organization's services. Not every patient will require instruction on minimizing infections. For example, patients receiving homemaker services or purchasing products from a retail or mail-order home medical equipment provider would not need such education unless there is an identified risk. **Tip:** One method commonly used to assess patient comprehension is the teach-back or repeat-back technique. Learners are asked to repeat instructions provided rather than simply stating that they understand. Additional information on this technique can be found on the Institute for Healthcare Improvement website.

Standards	Evidence Guidelines
IPC.14 Home health care personnel at risk for occupational exposure to tuberculosis (TB), are screened for tuberculosis (TB) upon hire (i.e., prior to patient contact) per state or local law and regulation. This process includes a risk assessment, symptom evaluation, and evidence of TB blood test or TB skin test. In the absence of state or local law and regulation, TB screening and testing occurs per the recommended Centers for Disease Control and Prevention (CDC) guidelines or organization policy that describes TB screening or testing practice as part of the organization's infection control program. There is evidence of appropriate follow-up when TB risk is identified. **Applicable Regulations: G684-484.70(b)(1); G684-484.70(b)(2).**	**Personnel Record Review:** Employees are screened and tested for TB in compliance with state requirements, organization policy, or the CDC guidelines. **Guidance:** TB testing and screening should be based on the individual staff member's TB risk, the organization's annual TB risk assessment, and state and local laws. The TB screening process for healthcare personnel includes evidence of: • A baseline individual TB risk assessment, • TB symptom evaluation • A TB test (e.g., TB blood test or a TB skin test), and • Additional evaluation for TB disease as needed. In the absence of TB blood or skin test evidence, a TB blood or skin test is conducted by the organization. CDC recommendations **do not** override or replace state regulations. State and local regulations may differ to meet local needs. Contact your state or local TB control program for the testing regulations in your state. State TB Programs Health care personnel should have baseline tuberculosis (TB) screening, including an individual risk assessment. Health care personnel are considered at increased risk for TB if any of the statements on the risk assessment are marked "Yes." Use this assessment to help interpret TB test results. **Tip:** Organizations may want to contact their local or state health department for guidance on TB risk assessment, follow-up, testing, treatment, and chest x-ray requirements. *(continued on following page)*

Standards	Evidence Guidelines
IPC.14	**Tip:** CDC guidelines recommend that TB testing and screening cover personnel at risk of exposure. More detailed guidance on TB testing and screening is available on the CDC website, state health department laws and regulations, as well as in Occupational Safety and Health Administration directives specific to medical surveillance. Resources: • Baseline Tuberculosis Screening and Testing for Health Care Personnel • Health Care Personnel Baseline Individual TB Risk Assessment • TB Programs • CDC Updates to Tuberculosis (TB) Guidelines|Occupational Safety and Health Administration
IPC.15 The organization makes hepatitis B vaccination available at no charge to personnel at risk of exposure to blood and other potentially infectious materials (OPIM) as required by the Occupational Health and Safety Administration (OSHA). **Applicable Regulation: G684-484.70(b); G684-484.70(b)(1).**	**Personnel Record Review:** Review personnel health records for personnel with risk of exposure to blood and OPIM. Verify that records contain documentation that personnel were offered the vaccine. **Guidance:** The organization determines which personnel are at risk of exposure to blood and OPIM based upon the duties they perform. If personnel decline to receive the vaccine, but at a later date decide to accept it, the organization is required to provide it at no cost. **Tip:** Information regarding hepatitis B prevention and vaccination is found on the OSHA website.

Standards	Evidence Guidelines
IPC.16 Occupational exposures to communicable diseases are referred for assessment, testing, treatment, and counseling in accordance with organizational policy and local, state, and federal law and regulation. Post-exposure interventions, as defined in the organization's infection prevention and control (IPC) policies, are implemented. 1. Personnel report exposure to, or development of, a communicable disease to the organization, in accordance with organizational policy and local, state, and federal law and regulation. 2. Occupational exposure is reported to local, state, and federal authorities as required. Follow-up notifications, testing, and treatment follow state and local health department guidance and organizational policy. 3. Patients are monitored for the occurrence of infections. Identified infections are investigated. Information is documented and used to identify and act on opportunities to reduce the risk of infections. **Applicable Regulation: G684-484.70(b)(2).**	**Interview:** Interview the individual responsible for overseeing the organization's IPC program. Clarify if any occupational exposures to communicable diseases have occurred during the past year. If so, clarify the process(es) by which the exposure was tracked and reported. Clarify the ways in which the organization provides or refers personnel for assessment, treatment, testing, and counseling. **Document Review:** Review logs or other documentation the organization maintains for reporting exposure to or development of communicable diseases. Validate that reporting occurs per organizational policy and the requirements of the standard. **Document Review:** Review infection data from the past 12 months or other documents that report the occurrence of infections in patients. Validate that identified risks are investigated and used to identify and act on opportunities to reduce the risk of infections. **Guidance:** Local and state reporting requirements may vary. It is expected that the organization has knowledge of and complies with related local and state regulations. **Guidance:** It is expected that sudden or remarkable increases in infections are addressed to prevent further increases in the infection rate.

Standards	Evidence Guidelines
IPC.17 The organization monitors infections as part of its Continuous Quality Improvement (CQI) program and plans appropriate actions, based on findings identified, that are expected to result in minimized risk and disease prevention. **Applicable Regulations: G684-484.70(b); G684-484.70(b)(1); G684-484.70(b)(2).**	**Document Review:** Review reports of CQI activities, if any, based on infection data. Validate that findings in infection data are integrated in the CQI program and followed by action to reduce the risk of occurrence. **Interview:** Interview the person responsible for overseeing the infection control program. Clarify the ways in which infections are reported, monitored, and used in CQI activities. **Guidance:** CQI activities related to infection prevention and control data might include additional education to personnel or patients or demonstration of practice. For example, a higher rate of upper respiratory infections may be addressed by documented re-education with demonstration and return demonstration to patients and personnel on hand hygiene and “cover your cough” techniques.

Emergency Preparedness

Key Area of Performance:

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 The organization establishes and maintains 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	Evidence Guidelines
EP.2 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 *(continued on following page)*	**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. *(continued on following page)*

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

Standards	Evidence Guidelines
EP.3 As part of its emergency preparedness (EP) plan, the organization develops and maintains an EP communication plan that complies with local, state and federal requirements. The plan includes: 1. Names and contact information for personnel, entities providing services under arrangement, patients' physicians, and volunteers; 2. Contact information for the federal, state, tribal, regional, and local emergency preparedness staff and other sources of assistance; 3. Primary and alternate means for communicating with personnel and federal, state, tribal, regional, and local emergency management agencies; 4. A method for sharing information and medical documentation for patients under the organization's care, as necessary, with other health care providers to maintain the continuity of care; 5. A means for providing information about the general condition and location of the patients under the organization's care as permitted by the Health Insurance Portability and Accountability Act; and 6. A means of providing information about the organization's needs and its ability to provide assistance to the authority having jurisdiction, the Incident Command Center, or designee. The communication plan, including all contact information, is reviewed and updated at least every two (2) years. *(continued on following page)*	**Document Review:** Review the EP communication plan. Verify that it is reviewed and updated at least every two (2) years. Verify that the communication plan addresses each of the elements as required by the standard. **Interview:** Interview the Clinical Manager. Verify, through a description of the process, the ways in which names and contact information for personnel, entities providing services under arrangement, patients' physicians, and volunteers are updated and kept current as part of the emergency communications plan. If stored electronically, clarify how contact information is obtained in the event that the electronic system is unavailable. **Guidance:** Organizations in rural or remote areas with limited connectivity to communication methodologies such as the Internet, World Wide Web, or cellular capabilities need to ensure their communication plan addresses how they would communicate and comply with this requirement in the absence of these communication methodologies. For example, if an organization is located in a rural area, which has limited or no Internet and phone connectivity during an emergency, it must address what alternate means are available to alert local and State emergency officials. Optional communication methods organizations may consider include satellite phones, radios and short-wave radios.

Standards	Evidence Guidelines
EP.3 **Applicable Regulations: E0029-484.102(c); E0030-484.102(c)(1); E0031-484.102(c)(2); E0032-484.102(c)(3); E0033-484.102(c)(4-5); E0034-484.102(c)(6).**	
EP.4 Organizations that are part of a healthcare system consisting of multiple separately certified healthcare facilities that elect to have a unified and integrated emergency preparedness (EP) program may choose to participate in the healthcare system's coordinated EP program. If elected, the unified and integrated EP program: 1. Demonstrates that each separately certified organization within the system actively participated in the development of the unified and integrated emergency preparedness program; 2. Is developed and maintained in a manner that takes into account each separately certified organization's unique circumstances, patient populations, and services offered; 3. Demonstrates that each separately certified organization is capable of actively using the unified and integrated emergency preparedness program and is in compliance with the program; 4. Meets the requirements of paragraphs §484.102 (a)(2), (3), and (4); 5. Is based on a documented community-based risk assessment, utilizing an all-hazards approach; *(continued on following page)*	**Document Review:** Review documents for the EP program when an organization elects to participate in a healthcare system's program. Validate that the documentation includes demonstration of the organization's integration and active participation in the system's EP program. Validate that the EP program is unique to the patient populations served and is based on a risk assessment, communication plan and training program as required by the standard. **Interview:** Interview a key leader for EP activities. Verify, through specific examples, the ways in which the organization is fully integrated into the system's EP program while meeting the unique standards related to its program and services.

Standards	Evidence Guidelines
EP.4 6. Is based on a documented individual organization -based risk assessment for each separately certified organization within the health system, utilizing an all-hazards approach; and 7. Includes integrated policies and procedures, a coordinated communication plan, as well as training and testing. **Applicable Regulation: E0042-484.102(e).**	
EP.5 The organization implements its emergency preparedness (EP) plan. **Applicable Regulation: E0013-484.102(b).**	**Interview:** Interview the key leader responsible for EP activities. If an emergent event has occurred in the last three years, clarify, through specific examples, the ways in which the EP plan was implemented. **Guidance:** Organization's that have not had an emergent event in the last 3 years will not be directly evaluated on this standard. The organization will only be assessed on their testing of the EP plan.

Standards	Evidence Guidelines
EP.6 The organization develops and implements emergency preparedness (EP) policies and procedures, based on the emergency plan, risk assessment, and the communication plan. Policies and procedures address: 1. Development and inclusion of a plan for each of the organization's patients during a natural or man-made disaster as part of the comprehensive patient assessment; 2. The documented discussion of the patient emergency plan that is provided to the patient, and maintained by the organization; 3. Follow up with patients and on-duty staff to determine needs in the event that care is interrupted during or due to an emergency; 4. Arrangements with facilities and other providers to receive patients to maintain the continuity of care, including timelines and under what conditions patient would be moved; 5. Informing local and state emergency preparedness officials about patients or on-duty staff who the organization is unable to contact; 6. Informing local State emergency preparedness officials of patients who are in need of evacuation from their residences at any time due to an emergency situation based on the patient's medical or psychiatric condition, or home environment; 7. The minimum information provided to facilitate evacuation and transportation including: *(continued on following page)*	**Document Review:** Verify policies are reviewed and updated at least every two (2) years. Verify policies and procedures: • Align with the EP plan, identified hazards in the risk assessment and the communication plan; • Address the tracking system for the location of patients and on-duty staff; • Address the patient's individualized plan; • Address procedures to inform State and local EP officials about patients who need evacuation and patients and/or on-duty staff that cannot be contacted; • Address follow-up with on-duty staff and patients to determine care needed if there is an interruption during or due to the emergency; • Address the medical record documentation provided in a transfer or evacuation and how it is released while protecting patient confidentiality; • Addresses how the available records are secured; and • Address the use of volunteers and other emergency staffing strategies. **Clinical Record Review:** Verify that each patient has an individualized emergency plan documented as part of the comprehensive assessment. **Interview:** Ask the patient or caregiver during the home visit about their emergency plan. *(continued on following page)*

Standards	Evidence Guidelines
EP.6 a) Patient name, age, DOB, medications, allergies, diagnosis; b) Emergency contact(s); c) If the patient is mobile or not; d) If the patient has life-dependent equipment, and if it can be transported (e.g. battery operated, size, condition, etc.); e) The clinical care needed for the patient; and f) Any patient special needs including cognitive disorders, intellectual disabilities, communication issues (e.g. deaf, non-English speaking, etc.); 8. How the information is shared (e.g. paper or electronic); 9. A system of medical documentation that preserves patient information, protects confidentiality of patient information, and secures and maintains availability of records; 10. Informing local and state officials of any staff the organization is unable to contact; 11. The role of employees in providing care at alternate care sites during emergencies; and 12. The use of volunteers in an emergency, or other emergency staffing strategies including the process and role for the integration of state or federally designated health care professionals to address surge patient care needs during an emergency. Policies and procedures are reviewed and updated at least every two (2) years. **Applicable Regulations: E0013-484.102(b); E0017-484.102(b)(1); E0019-484.102(b)(2); E0021-484.102(b)(3); E0023-484.102(b)(4); E0024-484.102(b)(5).**	**Interview:** Ask staff responsible for EP to describe the tracking system used to document the locations of patients and on-duty staff, and the procedure for letting State and local EP officials of any they are unable to contact. **Guidance:** As PHI is addressed, policies and procedures must also ensure compliance with applicable Health Insurance Portability and Accountability Act (HIPAA) Rules.

Standards	Evidence Guidelines
EP.7 The organization develops and maintains an emergency preparedness (EP) training program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan. Training is specific to the individual's duties and responsibilities. Training is documented, including the dates, participants, and the content covered. The training program is reviewed and updated at least every two (2) years and includes initial training (during orientation or shortly thereafter) in EP policies and procedures to all new and existing personnel, individuals providing services under arrangement, and volunteers, consistent with their expected roles. EP training is provided at least every two (2) years. If the EP policies and procedures are significantly updated, the organization must conduct training on the updated policies and procedures. The organization maintains documentation of the training, including the date(s), participants, and content covered. Personnel demonstrate knowledge of emergency procedures as part of the training. **Applicable Regulations: E0036-484.102(d); E0037-484.102(d)(1).**	**Document Review:** Review documents related to EP training. These might be located in personnel records, education records or checklists. These records may be maintained electronically (in a learning management system) or on paper. Validate that the training program and content is reviewed, updated and provided every two (2) years to all new and existing personnel, individuals providing services under arrangement, and volunteers. Validate that the training includes an evaluation of the individual's ability to demonstrate knowledge of the organization's emergency procedures. **Interview:** Interview the key leader that oversees the emergency preparedness program. Clarify the types of training provided to personnel. Verify that the training was reviewed and updated within the last two (2) years. **Guidance:** Organizations have the flexibility to determine the focus of their training, as long as it aligns with the emergency plan and risk assessment. **Guidance:** Organizations with multiple locations provide training that reflects the risks identified for each specific location.

Standards	Evidence Guidelines
EP.8 The organization develops and maintains an emergency preparedness (EP) testing program that is based on the emergency plan, risk assessment, policies and procedures, and the communication plan. The testing program is reviewed and updated at least every two (2) years. Testing of the program is documented annually. **Applicable Regulation: E0036-484.102(d).**	**Document Review:** Review documents reporting on the most recent testing of emergency preparedness program. Validate that testing is conducted at least annually based on the emergency plan, risk assessment, and the communication plan. Validate that the testing plan is reviewed and updated every two (2) years. **Guidance:** Organizations that have been operating for less than a year are not expected to meet the requirements of this standard. **Guidance:** If in a given year an actual emergency takes place, which requires activation of the organization's EP plan, the organization can forgo testing. The results of the activation of the plan are expected to be analyzed and used for revision of the EP plan. **Guidance:** Organizations with multiple locations conduct testing that reflects the risks identified for each specific location.

Standards	Evidence Guidelines
EP.9 The organization conducts exercises to test the emergency preparedness (EP) plan annually, including: 1. Participation in a full-scale exercise that is community-based. a) When a community-based exercise is not accessible, testing includes participation in an individual, facility-based functional exercise every two (2) years. b) If the organization experiences an actual natural or man-made emergency that requires activation of the emergency plan, the organization is exempt from engaging in its next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of the emergency event. 2. Conducting an additional exercise every two (2) years – opposite the year that a full-scale exercise or functional exercise is conducted. This exercise may include, but is not limited to: a) A second full-scale exercise that is community-based or a facility based functional exercise; or b) A mock disaster drill; or c) A tabletop exercise or workshop that is led by a facilitator that includes a group discussion using a narrated, clinically relevant emergency scenario and a set of problem statements, directed messages, or prepared questions designed to challenge the emergency plan. *(continued on following page)*	**Document Review:** Review documentation evidencing organizational testing of the EP plan once annually. Acceptable tests include: 1st test in a 12-month period: Full-scale community-based exercise • If a community-based test is not accessible, an annual individual, facility-based functional exercise is acceptable. • If the organization activates its emergency preparedness plan due to a disaster or other emergency, the next required full-scale community-based exercise or facility-based functional exercise AFTER the activation of the plan is waived. Subsequent test in next 12-month period: • A second full scale community-based exercise or individual facility-based exercise (Note: If the EP plan has been activated in the preceding 12 months, it may substitute for this test); OR • A mock disaster drill; OR • A tabletop exercise or workshop. Review documented evidence of all tests, results, and if the EP Plan needed to be and was revised. **Interview:** Interview the key leader overseeing the EP plan. If the organization participated in a community-wide drill, validate the roles played and lessons learned. If the organization could not access a community-wide drill, clarify the scenario and lessons learned from an organization-based drill. Verify the type of additional drill conducted. *(continued on following page)*

Standards	Evidence Guidelines
EP.9 **Applicable Regulation: E0039-484.102(d)(2).**	**Guidance:** Organizations that have been operating for less than a year are not expected to meet the requirements of this standard. **Guidance:** A full scale exercise is defined as any operations-based exercise (drill, functional, or full-scale exercise) that assesses an organization's functional capabilities by simulating a response to an emergency that would impact the organization's operations and their community. Organizations are expected to consider their physical location, agency and other organization responsibilities and needs of the community when planning or participating in their exercises. **Guidance:** The responsibility for ensuring a coordinated emergency disaster response lies with local and state emergency preparedness officials. Organizations are expected to contact their local and state agencies and healthcare coalitions, where appropriate, to determine if an opportunity exists and determine if their participation would fulfill this requirement. They are expected to document the date, the personnel and the agency or healthcare coalition that they contacted. However, some local and state authorities may not elect to collaborate with community-based providers. If a community mock disaster drill is not accessible, the organization is expected to conduct their own drill.

Standards	Evidence Guidelines
EP.10 The organization analyzes its response to and maintains documentation of all drills, tabletop exercises, and emergency events, and revises the emergency plan as needed. **Applicable Regulation: E0039-484.102(d)(2).**	**Document Review:** Review documentation of the organization's analysis of its response to testing of the emergency plan, including drills, tabletop exercises, and actual emergency events, as applicable. Validate that the information is used to revise the emergency plan, as needed.

Leadership & Governance

Key Area of Performance:

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 The organization organizes, manages, and administers its resources to attain and maintain the highest practicable functional capacity, including providing optimal care to achieve the goals and outcomes identified in the patient's plan of care for each patient's medical, nursing, and rehabilitative needs. **Applicable Regulation: G940-484.105.**	**Guidance:** This standard is designed to determine if the organization organizes and manages services in a systematic manner to attain and maintain the highest practicable functional capacity. Although specific deficiencies related to these areas might be cited elsewhere within this Key Performance Area, when systemic issues pertaining to the organization and management of services are identified, they may be cited here.
LG.2 The primary organization is responsible for the conduct and delivery of all care rendered to patients, whether that care is provided directly or under arrangement. **Applicable Regulation: G980-484.105(e)(3).**	**Interview:** Interview a key leader or the Clinical Manager. Verify, through specific examples, the way in which the organization manages and delivers care, both directly and under arrangement. **Guidance:** "Primary organization" means the organization that accepts the initial referral of a patient and provides services directly to the patient or via another health care provider under arrangements (as applicable).

Standards	Evidence Guidelines
LG.3 The organization and its staff operate and provide care and services: 1. In compliance with applicable local, state, and federal laws and regulations related to the health and safety of patients; 2. As a licensed entity if state or local law provides for home health licensing; and 3. Any branch locations are licensed in accordance with state law or regulation. **Applicable Regulations: G848-484.100; G860-484.100(b).**	**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. Review licenses. Validate that the organization and any branches hold current licenses as required. **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 regulations. 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.

Standards	Evidence Guidelines
LG.4 If the organization engages in laboratory testing outside the context of assisting an individual in self-administering a test with an appliance that has been cleared for that purpose by the Food and Drug Administration, such testing is in compliance with all applicable local, state, and federal law and regulation. If the organization refers specimens for laboratory testing to another laboratory, the referral laboratory is certified in the appropriate specialties and subspecialties of services. **Applicable Regulations: G862-484.100(c)(1); G864-484.100(c)(2).**	**Document Review:** Review the Clinical Laboratory Improvement Amendments certificate of waiver. Verify that it reflects the level of testing being performed and is current. If the organization refers specimens for laboratory testing to another laboratory, verify that the referral laboratory is certified in the appropriate specialties and subspecialties of services.

Standards	Evidence Guidelines
LG.5 The organization's governing body assumes full authority and responsibility for: 1. Organization's overall management and operations; 2. Provision of care and services; 3. Fiscal operations; 4. Review of the budget and operational plans; 5. Ongoing performance improvement and patient safety program that is defined, implemented, maintained, and evaluated annually; and 6. Appointment of a qualified administrator. **Applicable Regulations: G942-484.105(a); G946-484.105(b)(1)(i).**	**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. Verify that governance has taken action to ensure the appointment of a qualified Administrator. **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. **Guidance:** An HHA may establish a governing body composed of individuals of its choosing. The individuals that comprise the governing body are those who have the legal authority to assume responsibility for assuring that management and operation of the HHA is effective and operating within all legal bounds.

Standards	Evidence Guidelines
LG.6 The governing body ensures that an ongoing program for quality improvement and patient safety is defined, implemented, and maintained. The governing body approves the frequency and detail of the organization's data collection and ensures that the quality improvement program: 1. Reflects the complexity of its organization and services; 2. Involves all services (including those services provided under contract or arrangement); 3. Focuses on indicators related to improved outcomes, including the use of emergent care services as well as hospital admissions and readmissions, and takes actions that address the organization's performance across the spectrum of care, including the prevention and reduction of medical errors; 4. Addresses priorities for improved quality of care and patient safety, and ensures that all improvement actions are evaluated for effectiveness and maintained; 5. Establishes, implements, and maintains clear expectations for patient safety; and 6. Addresses any findings of fraud or waste. **Applicable Regulations: G640-484.65; G644-484.65(b)(3); G660-484.65(e); G942-484.105(a).**	**Document Review:** Review minutes from governing body meetings. Verify that all requirements of the standard have been met. **Interview:** Interview a member of the governing body if no meeting minutes are available. Verify the ways in which the governing body ensures that each requirement of the standard is met. **Guidance:** It is not required that organizations with one person serving in the governance role (typically the owner) have meetings/minutes. However, the organization's owner must demonstrate that the responsibilities needed to govern the organization are carried out. **Guidance:** The governing body must assume overall responsibility for ensuring that the QAPI program reflects the complexity of the HHA and its services, involves all services (including those provided under contract or arrangement), focuses on indicators related to improved outcomes, and takes actions that address the HHA's performance across the spectrum of care. Additionally, the HHA's governing body must appropriately address any findings of fraud or waste in order to assure that resources are appropriately used for patient care activities and that patients are receiving the right care to meet their needs. If the HHA identifies or otherwise learns of an action by an HHA employee, contractor or responsible or relevant physician or allowed practitioner that may be illegal, the HHA should report the action to the appropriate authorities in accordance with applicable law.

Standards	Evidence Guidelines
LG.7 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).**	**Personnel Record Review:** Review personnel records for the Home Health Administrator. If employment date is on or before 1/13/2018, verify that they 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.
LG.8 The Clinical Manager is a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or registered nurse. **Applicable Regulation: G1056-484.115(c).**	**Personnel Record Review:** Review personnel files for the Clinical Manager. Verify that they are a licensed physician, physical therapist, speech-language pathologist, occupational therapist, audiologist, social worker, or registered nurse. **Guidance:** The responsibilities of the Clinical Manager can be found in the Assessment Planning and Coordination Key Performance Area.

Standards	Evidence Guidelines
LG.9 The Administrator reports to governance and is responsible for: 1. The day-to-day operations of the organization including patient care and any delivery issues; 2. Ensuring that the clinical manager is available during all operating hours; 3. Ensuring that the organization employs qualified personnel; 4. Ensuring the development of personnel qualifications and policies; 5. QAPI activities; and 6. Is available during operating hours. **Applicable Regulations: 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. The administrator must be appointed by and accountable to the governing body; acting as a liaison between the daily functions of the HHA and the governing body. **Interview:** Interview the Administrator. Verify the ways in which the duties required by the standard are carried out. **Observation:** The administrator is actively involved in the daily responsibilities of running the HHA and each HHA should be able to demonstrate such involvement. **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. *(continued on following page)*

Standards	Evidence Guidelines
LG.9	**Guidance:** The HHA administrator is required, among other things, to be responsible for all day-to-day operations of the HHA and to be available to patients, representatives, and caregivers to receive complaints. "Operating hours" include all hours which the HHA is open and providing care to patients. "Available" means physically present at the agency or able to be contacted via telephone or other electronic means.
LG.10 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).**	**Personnel 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. **Interview:** HHA staff should know and be able to verbalize who the pre-designated individual(s) is/are for this role. **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. **Guidance:** Pre-designation needs to be by both the administrator and the governing body. The goal of this requirement is to provide management continuity within the HHA to the greatest degree possible.

Standards	Evidence Guidelines
LG.11 The parent organization provides direct support and administrative control of its branches. **Applicable Regulation: G974-484.105(d)(2).**	**Interview:** Interview the Clinical Manager or other key leader. Verify, through specific examples, the ways in which any branches are controlled and supported by the parent organization. **Tip:** Ways in which the parent organization might support and control its branch operations include site visits, staff meetings and communications, review and oversight of Continuous Quality Improvement activities, or systems of reporting on care, services, and business operations.
LG.12 Administrative and supervisory authority and responsibility for care and services furnished are defined in writing.	**Document Review:** Review organizational charts, scope of services, job descriptions, policies, or similar documentation. Verify that administrative and supervisory authority and responsibility for care and services furnished are defined in writing.

Standards	Evidence Guidelines
LG.13 The organization defines, in writing: 1. Its organizational structure, including lines of authority and services furnished. Administrative and supervisory functions are not delegated to another entity or organization, and all services not furnished directly are monitored and controlled. 2. Its HHA acceptance-to-service. An HHA must do both of the following: (A) Develop, implement, and maintain through an annual review, a patient acceptance-to-service policy that is applied consistently to each prospective patient referred for home health care, which addresses criteria related to the HHA's capacity to provide patient care, including, but not limited to, all of the following: (i) Anticipated needs of the referred prospective patient; (ii) Case load and case mix of the HHA; (iii) Staffing levels of the HHA; (iv) Skills and competencies of the HHA staff. (B)(i) Make available to the public accurate information regarding the services offered by the HHA and any limitations related to types of specialty services, service duration, or service frequency; (ii) Review the information specified in paragraph (B)(i) of this section as frequently as the services are changed, but no less often than annually. **Applicable Regulations: G940-484.105; 484.105(i).**	**Document Review:** 1. 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. 2. Review organization's HHA acceptance to service policy to ensure all content of standard is met. 3. Review publicly available information (website, brochures, patient admission documents) to validate the accuracy of information regarding the services offered by the HHA and any limitations as specified in the standard. 4. Review evidence to validate that the organization has reviewed the HHA's acceptance for service policy at least annually and updated as applicable that reflect any changes specified in the content of the standard. 5. Verify through clinical record documentation, home visit observation and patient/staff interviews that the HHA applies acceptance to service criteria in accordance with organization policy. 6. Verify the HHA has a monitoring process in place to evaluate HHA acceptance to service as part of their QAPI program.

Standards	Evidence Guidelines
LG.14 Care and services provided through contractual arrangement to an organization or its patients are delivered in a manner consistent with current standards of practice and patient safety. Formal written contracts are signed, dated, and authorized by the principals of each party, and they detail the specific responsibilities of the parties involved. The organization maintains overall responsibility for the services provided under arrangement, as well as the manner in which they are furnished. A written agreement with another organization or individual to furnish services includes: 1. Scope of services to be provided; 2. Care is provided in a safe and effective manner and by qualified personnel that meet HR requirements of the organization; 3. Care is delivered in accordance with patient plan of care and oversight of the home health organization; and 4. The agreement is signed and dated by each party. **Applicable Regulations: G940-484.105; G978-484.105(e)(2).**	**Interview:** Interview one or more key leaders. Determine how oversight is maintained when contracting for services. Verify, through specific examples, the ways in which the organization maintains overall responsibility for any care or service that is delivered through a contract or agreement. Verify how services are monitored. **Contract Review:** Review a sample of contracts. Verify that formal written contracts are signed, dated, and authorized by the principals of each party, and that they detail the specific responsibilities of the parties involved. **Personnel Record Review:** Verify that licensure, certification and competency, and/or training (as applicable) for personnel providing services under arrangement is current. **Guidance:** "Contracted services" refers to any service provided to the organization by an outside entity or individual. The responsibilities related to oversight of the contract reside with the organization that is receiving care and services. **Guidance:** If the organization does not keep the personnel records of contracted staff who deliver care, it has a process in place to gain access to such records in a timely manner and has evidence that the records are kept current per the contracting organization's policy.

Standards	Evidence Guidelines
LG.15 In accordance with section 1861(w) of the Social Security Act (42 U.S.C. 1395x (w)), the organization ensures that the patient is not held financially liable for services furnished by the organization under an arrangement with other entities or individuals. **Applicable Regulation: G976-484.105(e)(1).**	**Interview:** Interview a key leader responsible for billing. Clarify the process by which the organizations ensure that patients are not billed by another entity for contracted services provided in the organization's name.
LG.16 Entities or individuals providing services for the organization under arrangement may not have: 1. Been denied Medicare or Medicaid enrollment; 2. Been excluded or terminated from any federal health care program or Medicaid; 3. Had their Medicare or Medicaid billing privileges revoked; or 4. Been debarred from participating in any government program. **Applicable Regulation: G978-484.105(e)(2).**	**Interview:** Interview the Administrator or other key leader with responsibility for contracting for care and services. Verify the process by which the organization ensures that the contracted entity or individual is eligible to enter into a contract as required by the standard.

Standards	Evidence Guidelines
LG.17 When home health aide services are provided under arrangement, the organization: 1. Ensures the overall quality of care provided by an aide; 2. Supervises aide services in accordance with §484.80(h)(l) and (2); and 3. Ensures that home health aides who provide services under arrangement have met the training or competency evaluation requirements, or both, of §484.80(h). **Applicable Regulations: G820-484.80(h)(5); G820-484.80(h)(5)(i); G820-484.80(h)(5)(ii); G820-484.80(h)(5)(iii).**	**Interview:** Interview the Clinical Manager or other key leader who supervises aide services. Verify the ways in which contracted home health aides' training, competency, and quality of care are ensured. Verify that the ways in which contracted aides are supervised meets the requirements of the standard. **Contract Review:** Review one or more contracts for aide services. Verify that the contracts address the elements required by the standard.

Financial Stewardship

Key Area of Performance:

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 The organization develops an annual operating budget that includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items. The budget is expected to show anticipated revenue from all payer sources and liabilities from all locations and branches. It is not required that the organization prepare an item-by-item identification of the components of each type of anticipated income or expense. **Applicable Regulations: G988-484.105(h); G988-484.105(h)(1).**	**Document Review:** Review the most recent annual budget. Verify that it includes all anticipated income and expenses related to items that would, under generally accepted accounting principles, be considered income and expense items.

Standards	Evidence Guidelines
FS.2 An overall plan and annual budget are prepared under the direction of the organization's governance, by a committee consisting of representatives of governance, administrative personnel, and medical personnel (if any) of the organization. **Applicable Regulations: G988-484.105(h); G988-484.105(h)(3).**	**Interview:** Interview a key leader and/or a member of governance involved in the development of the overall plan and the annual operating budget. Verify that the process by which the budget is developed reflects the scope and complexity of the organization and that it was prepared under the direction of the organization's governance with representatives of governance, administrative personnel and medical personnel (if any). **Guidance:** An organization with branches requires only one overall plan and one budget which should include the resources and expenditures of all branches. **Guidance:** The organization's governance may serve as the committee that prepares the budget, provided that administrative and medical staff (if any) are included. Governance may choose to appoint a committee to prepare and review the annual budget, so long as the committee includes representatives from governance, administration, and medical personnel (if any). If the budget is prepared and reviewed by a committee, the organization's governance oversees the process and reviews and approves the annual budget.

Standards	Evidence Guidelines
FS.3 The overall plan and operating budget are reviewed and updated at least annually under the direction of governance, by a committee that includes representatives from governance, administrative personnel, and medical personnel (if any). **Applicable Regulations: G942-484.105(a); G988-484.105(h)(4).**	**Document Review:** Review budget committee minutes, or other documentation, to verify that financial policies/procedures and the operating budget are reviewed at least annually by representatives from governance, administration and medical personnel (if any). Minutes should include date, attendance, topics discussed, and actions taken. **Guidance:** The organization's governance may serve as the committee that prepares the budget, provided that administrative and medical staff (if any) are included. Governance may choose to appoint a committee to prepare and review the annual budget, so long as the committee includes representatives from governance, administration, and medical personnel (if any). If the budget is prepared and reviewed by a committee, the organization's governance oversees the process and reviews and approves the annual budget.

Standards	Evidence Guidelines
FS.4 Capital expenditures are budgeted and managed in accordance with organizational policy and generally accepted accounting principles. For capital expenditures over $600,000, a capital expenditure plan is developed for at least a three-year period, including the operating budget year. The capital expenditure plan includes and identifies the anticipated sources of financing for, and the objectives of, each anticipated expenditure that, under generally accepted accounting principles, would be considered a capital item. The plan identifies the anticipated sources of funding for cash or operating shortfalls that may impact its products or services. **Applicable Regulation: G988-484.105(h)(2).**	**Document Review:** If the organization has capital expenditures over $600,000, review the capital expenditure plan. Verify that the plan is developed for a three-year period and includes all provisions listed. **Interview:** Interview the individual overseeing financial management. If the organization has capital expenditures, validate, through specific examples, the ways in which capital expenditures are budgeted and managed.
FS.5 The capital expenditure plan is prepared, reviewed, and updated annually under the direction of the organization's governance. **Applicable Regulation: G988-484.105(h).**	**Document Review:** Review minutes from meetings or other documentation of the organization's governance to verify oversight of the preparation and annual review, as well as approval of the capital expenditure plan.

Standards	Evidence Guidelines
FS.6 If the capital expenditure plan includes anticipated financing from Title V (Maternal and Child Health and Crippled Children's Services), Title XVIII (Medicare), or Title XIX (Medicaid) of the Social Security Act, the plan specifies: 1. Whether the proposed capital expenditure is required to conform, or is likely to be required to conform, to current standards, criteria, or plans developed in accordance with the Public Health Service Act or the Mental Retardation Facilities and Community Mental Health Centers Construction Act of 1963; 2. Whether a capital expenditure proposal has been submitted to the designated planning organization for approval in accordance with Section 1122 of the Act (42 U.S.C. 1320a-1) and implementing regulations; and 3. Whether the designated planning organization has approved or disapproved the proposed capital expenditure if it was presented to that organization. **Applicable Regulation: G988-484.105(h)(2).**	**Document Review:** Review the capital expenditure plan, if applicable. Verify that it includes anticipated funding from the listed sources and that all provisions listed are specified in the plan. **Guidance:** Capital expenditures are funds spent to acquire or upgrade physical assets (property, equipment, etc.). This standard applies only to capital expenditures over $600,000. In determining if a single capital expenditure meets or exceeds the threshold, include the cost of studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition. Improvement, modernization, expansion, or replacement of land, plant, buildings, and equipment should also be included in the valuation. Transactions that are separated in time but are components of an overall plan are viewed in their entirety without regard to their timing. Other costs related to capital expenditures include title fees; permit and license fees; broker commissions; architect, legal, accounting, and appraisal fees; interest, finance, or carrying charges on bonds and notes; and other costs incurred for borrowing funds.

Information Management

Key Area of Performance:

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 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 In the event the organization discontinues operations, policies stipulate procedures for: 1. Record retention; and 2. Notification to the state agency of where records will be maintained. **Applicable Regulation: G1026-484.110(c)(2).**	**Document Review:** Review policies regarding record retention. Verify that the policy includes provisions for the retention of records in the event the organization discontinues operations, including notification to the state agency of where records will be maintained.

Standards	Evidence Guidelines
IM.3 Administrative, financial, patient, and personnel records are retained in accordance with organizational policy and local, state, and federal law and regulation. Patient records are retained for five years after the discharge of the patient, unless state law stipulates a longer period of time. **Applicable Regulation: G1026-484.110(c)(1).**	**Document Review:** Review policies regarding record retention. Verify that records are retained for at least the duration required by organizational policy. **Interview:** Interview a key leader. Validate that patient records are retained for five years after the date of discharge, unless state law stipulates a longer period. **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.4 The organization must comply with the requirements of §420 Subpart C and discloses the following information at the time of the initial request for certification, for each survey, and at the time of any change in ownership or management: 1. The name and address of all persons with an ownership or control interest in the organization as defined in §420.201, §420.202, and §420.206; 2. The name and address of each person who is an officer, a director, an agent, or a managing employee of the organization as defined in §420.201, §420.202, and §420.206; and 3. The name and address of the corporation, association, or other company that is responsible for the management of the organization, and the name and address of the chief executive officer and the chairperson of the board of directors of that corporation, association, or other company responsible for the management of the organization. **Applicable Regulations: G850-484.100(a); G850-484.100(a)(1); G850-484.100(a)(2); G850-484.100(a)(3).**	**Document Review:** Review the organization's initial request for certification. Verify that it contains all information required in the standard. If a change of ownership or management has occurred, verify that the required information was disclosed. **Guidance:** This information will be reviewed by CHAP prior to the on-site survey visit. If necessary, it will be verified on-site.

Standards	Evidence Guidelines
IM.5 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 Regulation: 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. **Guidance:** A "branch" is an approved location or site (physically separate from its parent's location) from which an HHA provides services within a portion of the total geographic area served by the parent agency. A branch provides services under the same CMS certification number (CCN) as its parent agency.
IM.6 Patient information is accessed by authorized individuals as determined by the organization and as required by local, state, and federal law and regulation. The organization safeguards the patient record against loss, unauthorized use, or unauthorized access, including the protection of Protected Health Information (PHI). PHI is used and disclosed only for purposes permitted by law. Documented patient consent is obtained for release of information not authorized by law. **Applicable Regulation: G1028-484.110(d).**	**Interview:** Interview personnel providing patient care or services. Clarify ways in which the confidentiality of patient information and records is protected. Clarify what patient information personnel access in order to provide care or service. Verify that the information supports their ability to perform their duties. **Interview:** Interview a key leader. Validate that identified access and *(continued on following page)*

Standards	Evidence Guidelines
IM.6	security risks related to the patient record have been addressed. Clarify what procedures are in place to ensure PHI is used and disclosed only as permitted by law and regulation. Validate whether any violations have occurred in the past year and how these were addressed. **Guidance:** PHI is individually identifiable health information that identifies the individual or for which there is a reasonable basis to believe can be used to identify the individual, including demographic data, that relates to: the individual's past, present, or future physical or mental health or condition; the provision of health care to the individual; or the past, present, or future payment for the provision of health care to the individual. Individually identifiable health information includes many common identifiers (e.g., name, address, birthdate, Social Security number). **Guidance:** The occurrence of a data security breach is not in itself a finding. If a breach occurs because proper safeguards are not in place, and/or it is not reported and addressed, the standard is cited. Any actions taken are in proportion to the size and scope of the identified breach. **Tip:** An organization may employ a wide range of safeguards for data and information security. These might include locked doors or file cabinets, data encryption, passwords, firewalls, and badges.

Standards	Evidence Guidelines
IM.7 A patient's record (whether hard copy or electronic) is made available to a patient, free of charge, upon request at the next home visit, or within four business days (whichever comes first). **Applicable Regulation: G1030-484.110(e).**	**Document Review:** Review policy related to release of information. Verify that it stipulates that the patient's record is made available to a patient, free of charge, upon request at the next home visit, or within four business days (whichever comes first). **Interview:** Interview person(s) responsible for releasing patient records. Discuss the process to request patient records, the authorization process, and the timeframes for release of records.
IM.8 The patient record is made available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care and appropriate personnel. **Applicable Regulation: G1008-484.110.**	**Interview:** Interview a key clinical leader. Clarify the manner in which the patient record is made available to the physician(s) or allowed practitioner(s) issuing orders for the home health plan of care and appropriate personnel.

Standards	Evidence Guidelines
IM.9 The organization and any entity or individual acting on behalf of the organization, in accordance with a written contract, ensures the confidentiality of all patient identifiable information contained in the patient record, including Outcome and Assessment Information Set (OASIS) data. Identifiable OASIS information is not released to the public. **Applicable Regulation: G350-484.40.**	**Document Review:** Review policies related to the management patient information, including OASIS data. Validate that they contain provisions to protect the confidentiality of the patient record, including OASIS data. **Interview:** Interview a key leader and/or the individual responsible for transmitting OASIS data. Verify the ways in which the information contained in the patient record is safeguarded. Clarify ways in which OASIS data confidentiality is ensured. **Contract Review:** Review contracts with any entity or individual that manages OASIS data for the organization. Validate that the contract contains provisions to protect the confidentiality of OASIS data.

Standards	Evidence Guidelines
IM.10 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.	**Clinical Record Review:** 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.
IM.11 The organization maintains a patient record containing past and current information for every patient accepted and receiving home health services. Information contained in the patient record is accurate and adheres to current patient record documentation standards of practice. **Applicable Regulation: G1008-484.110.**	**Clinical Record Review:** Validate that the records that are maintained contain past and current information for every patient accepted and receiving home health services. Verify that information contained in the patient record is accurate and adheres to current patient record documentation standards of practice.

Standards	Evidence Guidelines
IM.12 Entries in records are legible, clear, complete, and appropriately authenticated, dated, and timed. Authentication includes a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry. **Applicable Regulation: G1024-484.110(b).**	**Clinical Record Review:** Validate that entries are legible, clear, complete, and appropriately authenticated, dated, and timed. Verify that authentication includes a signature and a title (occupation), or a secured computer entry by a unique identifier, of a primary author who has reviewed and approved the entry.
IM.13 The organization encodes and electronically transmits each completed Outcome and Assessment Information Set (OASIS) assessment to the Centers for Medicare & Medicaid Services (CMS) system regarding each patient within 30 days of completing the assessment of the beneficiary. The encoded OASIS data accurately reflects the beneficiary's status at the time of assessment. Data is encoded and transmitted using the software available from CMS or software that conforms to CMS standard electronic record layout, edit specifications, and data dictionary, and that includes the required OASIS data set. **Applicable Regulations: G370-484.45; G372-484.45(a); G374-484.45(b); G378-484.45(c)(1); G386-484.45(d).**	**Document Review:** Review OASIS transmissions to validate that they are sent within 30 days of completed the assessment of the patient. Review the OASIS Error Summary Report to determine the percentage of #3330 errors. Review Final Validation Reports to determine the number of assessments with error #3330. Review the policy for transmission of OASIS assessment data and the policy or process for review of and corrections to OASIS assessments prior to transmission to the Assessment Submission and Processing System. Verify that electronically reported OASIS data are in a format that meets CMS electronic data and edit specifications for all applicable patients. **Interview:** Interview person(s) responsible for the transmission of OASIS assessments. Validate the frequency of transmissions and the process in place to ensure timeliness, accuracy, and completion of submission. **Tip:** OASIS Certification and Survey Provider Enhanced Reports iQIES and *(continued on following page)*

Standards	Evidence Guidelines
IM.13	Error Summary Reports provide information to validate accurate OASIS data transmission. More information can be found on the CMS website. The OASIS reporting regulations are not applicable to patients receiving personal care only services, regardless of payor source. Successful transmission of OASIS data is verified through validation and feedback reports from iQIES. Although not required by the regulation, it is recommended that the HHA keep copies of the electronic validation records, that indicate transmission was successful, for twelve months, or until the next set of reports are available. The validation reports may be needed as evidence if the HHA receives a denial from the Medicare Administrative Contractor (MAC) for missing OASIS assessments.
IM.14 The organization transmits data using data communication software that complies with the Federal Information Processing Standard (FIPS 140-2, issued May 25, 2001) to the Centers for Medicare & Medicaid Services collection site. **Applicable Regulation: G382-484.45(c)(2).**	**Interview:** Interview person(s) responsible for managing Outcome and Assessment Information Set transmissions. Validate that the organization uses an application that correctly formats the data transmission. Clarify the process used to monitor the success or failure of each transmission. **Guidance:** HHAs may directly transmit OASIS data (to the national data repository) via iQIES or other software that conforms to the FIPS 140-2.

Standards	Evidence Guidelines
IM.15 Outcome and Assessment Information Set (OASIS) data transmission includes Centers for Medicare & Medicaid Services (CMS)-assigned branch identification number as applicable. **Applicable Regulation: G384-484.45(c)(3).**	**Document Review:** Review OASIS transmissions. Verify that OASIS data transmission includes CMS-assigned branch identification number, as applicable.
IM.16 The organization maintains a current record of patient care and services.	**Clinical Record Review:** Validate that a record is present for each patient accepted for care and services.

Standards	Evidence Guidelines
IM.17 The organization maintains a current record of patient care and services. Patient records contain, at a minimum: 1. Contact information for the patient, the patient's representative (if any), and the patient's primary caregiver(s); 2. Consent for care and services; 3. The patient's current comprehensive assessment, including all assessments from the most recent home health admission; 4. An initial and updated (as appropriate) care plan; 5. Patient and caregiver education and training included in the care plan; 6. Physician or allowed practitioner orders, including documentation of verbal orders (if any); 7. Clinical progress notes; 8. All interventions, including medication administration, treatments, and services, and responses to those interventions; 9. Goals in the patient's plans of care and the patient's progress toward achieving them; and 10. Contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization. **Applicable Regulations: G584-484.60(b)(4); G1012-484.110(a)(1); G1014-484.110(a)(2); G1016-484.110(a)(3); G1018-484.110(a)(4); G1020-484.110(a)(5).**	**Clinical Record Review:** Review patient or other records of care and service. Validate that the requirements of the standard are met.

Compliance Program

Key Performance Area:

Given the rise in federal oversight, including new regulations and rigorous audits, CHAP's compliance program standards will equip organizations to better navigate the complexities of the healthcare landscape while minimizing risks associated with non-compliance.

Standards	Evidence Guidelines
CP.1 The organization has a compliance program with a designated officer and committee who are responsible for its operation.	**Document Review:** Review the organization's written compliance program.
CP.2 The designated compliance officer/staff member and compliance committee are responsible for the following key compliance program duties: • Maintaining regulatory knowledge and monitoring regulatory compliance • Staff education • Identifying organizational compliance gaps • Facilitate regular compliance meetings • Participating in organizational policy review and update to ensure relevant regulatory updates as applicable • Preparation of compliance information for the governing board • Ensuring ethical marketing practice	**Document Review:** Review the job duties of the compliance officer/staff member to validate duties outlined in the standard are included. Review job duties and evidence of education of designated compliance officer and compliance committee are completed. **Interview:** Interview designated compliance staff to determine their role and understanding of compliance program duties. **Tips:** Compliance officers may also have another position title and duties in addition to compliance management. In smaller organizations, this may be the QAPI committee, IDG, or other group. Compliance policy should outline who serves on the organization's compliance committee.

Standards	Evidence Guidelines
CP.3 The organization has written compliance policies and procedures and standards of conduct that are: • Relevant to day-to-day responsibilities • Available to those who need them • Re-evaluated regularly	**Document Review:** Review the organization's written compliance program policies and procedures and standards of conduct to determine they are relevant to day-to-day responsibilities, available to those who need them, and re-evaluated regularly. **Interview:** Interview staff members with various positions in the organization to determine if they know about the compliance policies and procedures and standards of conduct and where to find them.
CP.4 The organization has a mechanism for reporting instances of potential compliance issues and makes the information available to staff members.	**Document Review:** Review the organization's written compliance program to determine the reporting mechanism established so that staff members can report potential compliance issues. **Interview:** Interview staff members with various positions in the organization to determine if they know about the mechanism to report potential compliance issues.
CP.5 The organization has an effective auditing and monitoring plan in place to detect compliance issues.	**Document Review:** Review the organization's auditing and monitoring plan to ensure it is active. **Interview:** Interview designated compliance staff to assess their awareness of the organization's auditing and monitoring activities.
CP.6 The organization documents investigation of compliance issues, implementation of corrective action, and periodic review of the problem to ensure compliance.	**Document Review:** Review the organization's written compliance program.

Standards	Evidence Guidelines
CP.7 The organization emphasizes ethical behavior by enforcing standards of conduct, consistently applying staff disciplinary guidelines, and checking employees, contractors, and medical and clinical staff members on hire and regularly, as defined by the organization policy, against government sanctions lists, including the OIG's List of Excluded Individuals/Entities.	**Document Review:** Review the organization's documentation for: 1. Enforcing standards of conduct; 2. Publicizing and applying disciplinary guidelines; and 3. Checking employees, contractors and medical and clinical staff members on hire and regularly, as defined by the organization policy, against government sanctions lists, including the OIG's List of Excluded Individuals/Entities. **Interview:** Interview staff members to determine their understanding of the organization's expectations for ethical conduct and their awareness of disciplinary guidelines.
CP.8 The organization educates new staff and contractors at orientation and annually about their compliance program. All staff, whether employed directly or under arrangement, participate in organization-sponsored in-service programs about actual and potential compliance issues and regulatory updates as applicable.	**Document Review:** Review the organization's orientation and continuing education to confirm education about the written compliance program was provided. Verify that the individuals participated in in-service training. This information may be maintained in education records separate from the personnel file.

Home Health 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 (OSHA), 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 Note: A notation of a contact with a patient that is written, timed, and dated, and which describes signs and symptoms, treatment, drugs administered and the patient's reaction or response, and any changes in physical or emotional condition during a given period of time.

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.

Competency: Having sufficient ability to administer safe and reliable care on a consistent basis. To achieve competency, one must possess the proper knowledge, skills, training, and professionalism.

Complaint: A statement that a situation is unsatisfactory or unacceptable.

Compliance Program: A compliance program is a formalized system of policies, procedures, and processes developed and implemented to prevent, detect, and correct conduct that is inconsistent with applicable federal and state laws, rules, and regulations governing a healthcare organization.[1]

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).

[1] Carboni, L. (2022, April 6). *Healthcare compliance programs in the United States 101*. Healthcare Compliance Programs in the United States 101 | Association of Corporate Counsel (ACC). https://www.acc.com/resource-library/healthcare-compliance-programs-united-states-101#:~:text=A%20compliance%20program%20is%20a,regulations%20governing%20a%20healthcare%20organization

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.

In Advance: The HHA staff must complete the task prior to performing any hands-on care or any patient education.

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."

Medical Supplies: Non-durable disposable health care materials ordered or prescribed by a physician**,** that are primarily and customarily used to serve a medical purpose and include ostomy supplies, catheters, oxygen, and diabetic supplies.

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.

"On-duty": Currently working during the staff member's assigned hours or per their schedule of visits.

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-Centered Care: A patient-centered care delivery model is one that provides care that is respectful of and responsive to individual patient preferences, needs, goals, and values, and ensures that the patient guides all decisions. Patient-centered care also accommodates the degree to which patients wish to be involved in decisions about their care. This approach also applies to family members, caregivers, or patient representatives when they are involved in supporting care planning/delivery decisions.

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, gowns, etc.

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 (MD), Doctor of Osteopathic Medicine (DO), or Doctor of Podiatric Medicine (DPM) 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.

Primary Home Health Agency: The HHA which accepts the initial referral of a patient, and which provides services directly to the patient or via another health care provider under arrangements (as applicable).

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 social worker.

Proprietary Agency: A private, for-profit agency.

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.

Public Agency: An agency operated by a state or local government.

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.

Quality Indicator: A specific, valid, and reliable measure of access, care outcomes, or satisfaction, or a measure of a process of care.

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.

Subdivision: A component of a multi-function health agency, such as the home care department of a hospital or the nursing division of a health department, which independently meets the conditions of participation for HHAs. A subdivision that has branch offices is considered a parent agency.

Summary Report: The compilation of the pertinent factors of a patient's clinical notes that is submitted to the patient's physician, physician assistant, nurse practitioner, or clinical nurse specialist.

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.

Telehealth: The direct interface between the physician or other provider and the patient via technology, such as telephone, video, email or other electronic means for the purpose of assessment, diagnosis and/or treatment. Telehealth may be as simple as a phone call to remind

patients to take their medication or as complex as a physician examination and treatment via videoconferencing.

Telemonitoring or Remote Monitoring: The use of technology to collect and transmit patient data for the purposes of monitoring and managing the patient's condition. These technologies might include the collection and transmission of cardiac or fetal monitoring, weight, or blood sugar readings or other pertinent data.

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, physician assistant, nurse practitioner, or clinical nurse specialist 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.

Appendix

Revision Reference Tables for Previous Revisions from the Most Recent to the Oldest

Standard	Summary	Effective Date
IPC.14	Updated Standard Language; Updated Evidence Guidelines	3/1/2025

In response to *Calendar Year (CY) 2025 Home Health Prospective Payment System Final Rule (CMS-1803-F)* the following revision was made.

Standard	Summary	Effective Date
LG.13	Updated Standard Language; Updated Evidence Guidelines; NEW CFR 484.105(i)	1/1/2025

New Key Performance Area "Compliance Program" was added. Given the rise in federal oversight, including new regulations and rigorous audits, CHAP's new compliance program standards will equip organizations to better navigate the complexities of the healthcare landscape while minimizing risks associated with non-compliance.

Standard	Summary	Effective Date
CP.1	New Standard	8/1/2024
CP.2	New Standard	8/1/2024
CP.3	New Standard	8/1/2024
CP.4	New Standard	8/1/2024
CP.5	New Standard	8/1/2024
CP.6	New Standard	8/1/2024
CP.7	New Standard	8/1/2024
CP.8	New Standard	8/1/2024

In response to the *Revisions to Home Health Agencies (HHA) – Appendix B of the State Operations Manual (QSO-24-07-HHA),* the following revisions were approved by CMS.

Standard	Summary	Effective Date
PCC.1	Removed G408	5/24/2024
PCC.2	Removed G426	5/24/2024
PCC.4	Removed G408; Added G410	5/24/2024
PCC.6	Removed G408	5/24/2024
PCC.9	Removed G480 and G482; Added G478	5/24/2024
APC.1	Added Guidance	5/24/2024
APC.4	Removed G512	5/24/2024
APC.5	Removed G518; Updated Guidance	5/24/2024
APC.7	Updated Guidance; Added Tip	5/24/2024
APC.8	Updated Standard language; Removed G526; Updated Guidance	5/24/2024
APC.9	Added Evidence Guideline to Clinical Record Review	5/24/2024
APC.10	Updated Guidance	5/24/2024
APC.12	Removed G586	5/24/2024
APC.13	Removed G600; Added G602	5/24/2024
APC.23	Removed G1010; Added G566; Added Guidance	5/24/2024
CDT.3	Added Guidance	5/24/2024
CDT.6	Updated standard language; Removed G578	5/24/2024
CDT.7	Updated Guidance	5/24/2024
CDT.8	Updated standard language	5/24/2024
CDT.9	Added Evidence Guideline to Clinical Record Review and Home Visit Observation; Added Guidance	5/24/2024
CDT.10	Added Guidance	5/24/2024
CDT.14	Removed G806; Added G808	5/24/2024
CDT.15	Removed G806; Added Guidance	5/24/2024
CDT.16	Removed G808; Added G810	5/24/2024
HRM.1	Removed G944	5/24/2024
HRM.9	Removed G752	5/24/2024
HRM.10	Removed G758; Added Guidance	5/24/2024
HRM.13	Added Guidance	5/24/2024

Standard	Summary	Effective Date
HRM.16	Added Guidance	5/24/2024
HRM.17	Removed G784, G786, G788, G790, G792, G794, G796; Added G782	5/24/2024
HRM.19	Added Guidance	5/24/2024
HRM.20	Added Guidance	5/24/2024
HRM.21	Added Guidance	5/24/2024
HRM.23	Removed G812; Added G813	5/24/2024
HRM.24	Removed G810, Added G812	5/24/2024
CQI.3	Added Guidance	5/24/2024
CQI.5	Removed G648, G650, G652; Added G646; Added Guidance	5/24/2024
IPC.2	Updated standard language; Added Guidance	5/24/2024
IPC.3	Added Evidence Guideline to Document Review and Observation; Added Guidance	5/24/2024
IPC.4	Added Tip	5/24/2024
IPC.5	Added Evidence Guideline to Document Review	5/24/2024
IPC.6	Added Evidence Guideline to Document Review	5/24/2024
IPC.8	Added Evidence Guideline to Document Review and Observation	5/24/2024
IPC.10	Added Evidence Guideline to Personnel Record Review; Added Guidance	5/24/2024
IPC.11	Updated standard language	5/24/2024
IPC.13	Updated standard language	5/24/2024
LG.5	Added Guidance	5/24/2024
LG.6	Updated standard language; Updated Evidence Guidelines; Added Guidance	5/24/2024
LG.9	Removed G944; Updated Evidence Guidelines; Added Guidance	5/24/2024
LG.10	Added Evidence Guideline - Interview; Added Guidance	5/24/2024
LG.17	Removed G822, G824, G826; Added G820	5/24/2024
IM.4	Removed G852, G854, G856, G858; Added G850	5/24/2024
IM.5	Removed G970; Added Guidance	5/24/2024
IM.13	Removed G376; Updated Tip	5/24/2024
IM.14	Added Guidance	5/24/2024

Standard	Summary	Effective Date
IM.17	Removed G1010; Updated standard language	5/24/2024
Clinical Note	Added new key term	5/24/2024
In Advance	Added new key term	5/24/2024
Primary Home Health Agency	Added new key term	5/24/2024
Proprietary Agency	Added new key term	5/24/2024
Public Agency	Added new key term	5/24/2024
Quality Indicator	Added new key term	5/24/2024
Subdivision	Added new key term	5/24/2024
Summary Report	Revised key term	5/24/2024
Verbal Order	Revised key term	5/24/2024

For the 2024 Home Health Deeming Application, the Home Health standards were edited, renumbered, and all modifiers and design, implementation and sustainability areas of performance were removed. The revisions were approved by CMS.

In response to the *Medicare and Medicaid Programs; Policy and Regulatory Changes to the Omnibus COVID-19 Health Care Staff Vaccination Requirements Final Rule (CMS-3415-F),* the following revisions were approved by CMS.

Standard	Summary	Effective Date
IPC.15	Removed	8/5/2023
IPC.16	Removed	8/5/2023
IPC.17	Removed	8/5/2023
IPC.18	Removed	8/5/2023
IPC.19	Removed	8/5/2023
IPC.20	Removed	8/5/2023
IPC.21	Removed	8/5/2023
IPC.22	Removed	8/5/2023

In response to the *2021 Home Health and Other Quality Reporting Program Requirements; Final Rule (CMS-1747-F),* and the *2021 Omnibus COVID-19 Health Care Staff Vaccination; Interim Final Rule (CMS-3415-IFC),* the following revisions were approved by CMS.

Standard	Summary	Effective Date
APC.5.I.M1	Added when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech language pathology or physical therapy), an occupational therapist may complete the initial assessment.	1/1/2022
APC.5.I.M2	Updated that the occupational therapist may complete the comprehensive assessment when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech-language pathology or physical therapy) that establishes program eligibility.	1/1/2022
APC.5.I.M4	Updated that the occupational therapist may complete the comprehensive assessment when occupational therapy is ordered with another qualifying rehabilitation therapy service (speech-language pathology or physical therapy) that establishes program eligibility.	1/1/2022
APC.7.I.M1	Updated that each patient must receive the home health services that are written in an individualized plan of care.	1/1/2022
APC.10.D.M2	Removed CMS regulations G564-484.58(b) and G564-484.58(b)(1).	1/1/2022
APC.11.I.M3	Added the clinical record must include completed transfer and/or discharge summaries as applicable. Updated the receiving facility or health care practitioner who will be responsible for providing care and services to the patient is sent the discharge/transfer summaries. Removed CMS regulation G1020-484.110(a)(5). Added CMS regulation G564-484.58(b).	1/1/2022
CDT.5.I.M2	Removed requirement that verbal orders are authenticated and dated by the physician or other ordering practitioner within 30 days of issuing the order.	1/1/2022
CDT.10.I.M4	Updated that a registered nurse or other appropriate skilled professional must complete a supervisory assessment of the aide services being provided and aide does not need to be present during the supervisory assessment.	1/1/2022

Standard	Summary	Effective Date
CDT.10.I.M5	New Standard -The home health aide supervisory assessment must be completed onsite, or on the rare occasion by using two-way audio-video telecommunications technology that allows for real-time interaction between the registered nurse (or other appropriate skilled professional) and the patient, not to exceed 1 virtual supervisory assessment per patient in a 60-day episode. New CMS Regulation 484.80(h)(1)(ii).	1/1/2022
CDT.10.I.M6	Previous CDT.10.I.M5 Updated if home health aide services are provided to a patient who is not receiving skilled nursing care, physical or occupational therapy, or speech-language pathology services, the registered nurse must make an on-site, in person visit to assess the quality of care and services provided by the home health aide and to ensure that services meet the patient's needs. The home health aide does not need to be present during this visit. Added that semi-annually the registered nurse must make an on-site visit to the location where each patient is receiving care in order to observe and assess each home health aide while he or she is performing non-skilled care. New CMS regulation 484.80(h)(2)(ii).	1/1/2022
HRM.10.I.M2	Removed CMS regulation G812-484.80(h)(1)(iii). Added CMS regulation 484.80(h)(1)(iv).	1/1/2022
HRM.11.I.M1	Removed CMS regulation G810-484.80(h)(1)(ii). Added CMS 484.80(h)(1)(iii).	1/1/2022
HRM.11.I.M2	Updated that the home health aide completes retraining and a competency evaluation for the deficient and all related skills.	1/1/2022
IPC.8.I	Updated evidence guidelines	1/1/2022
IPC.15	New COVID-19 Staff Vaccination Standard	1/27/2022
IPC.16	New COVID-19 Staff Vaccination Standard	1/27/2022
IPC.17	New COVID-19 Staff Vaccination Standard	1/27/2022
IPC.18	New COVID-19 Staff Vaccination Standard	1/27/2022
IPC.19	New COVID-19 Staff Vaccination Standard	1/27/2022
IPC.20	New COVID-19 Staff Vaccination Standard	1/27/2022
IPC.21	New COVID-19 Staff Vaccination Standard	1/27/2022
IPC.22	New COVID-19 Staff Vaccination Standard	1/27/2022

Standard	Summary	Effective Date
IM.7.I.M1	Added that the patient record contains contact information for the primary care practitioner or other health care professional who will be responsible for providing care and services to the patient after discharge from the organization. Added CMS regulation G1020-484.110(a)(5).	1/1/2022
IM.7.I.M2	Standard Deleted	1/1/2022

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

Standard	Summary	Effective Date
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
APC.2.1.M2	Expanded to include allowed practitioner	1/1/2021
APC.5.1.M1	Expanded to include allowed practitioner	1/1/2021
APC.5.1.M2	Expanded to include allowed practitioner	1/1/2021
APC.5.I.M4	Expanded to include allowed practitioner	1/1/2021
APC.7.I.M2	Added to the plan of care the mode of care-delivery including the use of telecommunications when applicable and expanded to include allowed practitioner	1/1/2021
APC.7.I.M5	Expanded to include allowed practitioner	1/1/2021
APC.7.I.M6	Expanded to include allowed practitioner	1/1/2021
APC.7.I.M7	Expanded to include allowed practitioner	1/1/2021
APC.9.I.M1	Expanded to include allowed practitioner	1/1/2021
APC.9.I.M2	Expanded to include allowed practitioner	1/1/2021
APC.9.I.M3	Expanded to include allowed practitioner	1/1/2021
APC.10.D.M1	Expanded to include allowed practitioner	1/1/2021
APC.10.D.M2	Expanded to include allowed practitioner	1/1/2021
APC.11.I.M2	Expanded to include allowed practitioner	1/1/2021

Standard	Summary	Effective Date
CDT.4.I.M1	Expanded to include allowed practitioner	1/1/2021
CDT.5.I.M1	Expanded to include allowed practitioner	1/1/2021
CDT.7.I.M2	Expanded to include allowed practitioner	1/1/2021
CDT.7.I.M7	Expanded to include allowed practitioner	1/1/2021
CDT.11.D	New standard addressing remote monitoring and telemonitoring	1/1/2021
IPC.1.I.M4	Expanded to include allowed practitioner	1/1/2021
IM.4.I.M2	Expanded to include allowed practitioner	1/1/2021
IM.6.I.M2	Standard deleted	1/1/2021
IM.6.I.M3	Applicable regulation changed to G382-484.45(c)(2)	1/1/2021
IM.6.I.M4	Applicable regulation changed to G384-484.45(c)(3)	1/1/2021
IM.7.I.M1	Expanded to include allowed practitioner	1/1/2021
Allowed Practitioner	Added new key term	1/1/2021
Clinical Nurse Specialist	Added new key term	1/1/2021
Collaboration	Added new key term	1/1/2021
Nurse Practitioner	Updated key term	1/1/2021
Physician	Updated key term	1/1/2021
Physician Assistant	Added new key term	1/1/2021
Summary Report	Added new key term	1/1/2021
Telecommunications	Added new key term	1/1/2021
Verbal Order	Added new key term	1/1/2021

In response to the *2019 Regulatory Provisions to Promote Program Efficiency, Transparency, and Burden Reduction; Final Rule (CMS-3346-F)* and the *2019 Revisions to Requirements for Discharge Planning for Hospitals, Critical Access Hospitals, and Home Health Agencies, and Hospital and Critical Access Hospital Changes to Promote Innovation, Flexibility, and Improvement in Patient Care; Final Rule (CMS-3317-F)*, the following revisions were approved by CMS.

Standard	Summary	Effective Date
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
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
APC.10.I	Added discharge planning occurs in accordance with organization's policies	11/29/2019
APC.11.I.M1	New Standard for developing and implementing an effective discharge planning process	11/29/2019
APC.11.I.M2	Old APC.11.I.M1	11/29/2019
APC.11.I.M3	Old APC.11.I.M2 Added discharge summaries include necessary medical information for the patient's current course of illness and treatment. Requests for additional clinical information is sent to the receiving facility or health care practitioner.	11/29/2019
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
HRM.11.I.M2	Added retraining and competency evaluation related to deficient skills for aide services	11/29/2019
EP.1.D.M1	Added EP plan is reviewed and updated at least every two years	11/29/2019
EP.1.D.M3	Added EP communication plan is reviewed and updated at least every two years	11/29/2019
EP.2.D.M1	Added EP policies and procedures are reviewed and updated at least every two years.	11/29/2019
EP.3.D.M1	Added EP training program is reviewed and updated at least every two years. EP training is provided at	11/29/2019

Standard	Summary	Effective Date
	least every two years and when EP policies and procedures are significantly updated.	
EP.4.I.M1	Added EP testing program is reviewed and updated at least every two years	11/29/2019
EP.4.I.M2	Added when a community-based exercise is not accessible, testing includes participation in an individual, facility-based functional exercise every two (2) years. The organization is exempt from its next required full-scale community-based exercise or individual, facility-based functional exercise following the onset of an actual natural or man-made emergency that requires activation of the emergency plan. An additional exercise is conducted every two years, opposite the year that a full-scale exercise or functional exercise is conducted.	11/29/2019
Pseudo-patient	Added new key term	11/29/2019
Simulation	Added new key term	11/29/2019

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

Standard	Summary	Effective Date
IPC.8.I	Updated TB testing to reflect updated guidelines by the CDC	3/4/2019
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

Standard	Summary	Effective Date
EP.2.D.M1	Added EP policies and procedures address the documented discussion of patient emergency plan that is provided to the patient. Added EP P&P addresses arrangements with facilities and other providers to receive patients. Added EP P&P addresses the minimum information provided to facilitate evacuation and transportation. Added EP P&P addresses how information is shared. Added EP P&P addresses the role of employees in providing care at alternate care sites during emergencies.	3/4/2019
EP.4.I.M2	Added if emergency plan is activated twice in one year, the organization is exempt from both types of exercises for one year following the actual event	3/4/2019
All-Hazards Approach	Added new key term	3/4/2019
Emerging Infectious Diseases (EIDs)	Added new key term	3/4/2019
Full Scale Exercise	Added new key term	3/4/2019

Previous Updates:

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