

HOME-BASED PALLIATIVE CARE PROVIDER "MINIMUM STANDARDS"
Updated September 2022

- Program certification from one of the following:
 - The Joint Commission Community-based Palliative Care Certification Program
 - ACHC Distinction in Palliative Care
 - CHAP Palliative Care Certification

-- or -- Documented evidence of the following structures, processes, and competencies:
- Interdisciplinary team that includes representation from at least three of the following disciplines, with at least one having achieved specialty certification in palliative care or documentation of [specific competencies in palliative care](#), preferably with a goal of working towards certification:
 - Physician (MD or DO)
 - Advanced practice nurse/Nurse practitioner
 - Nursing (RN or LPN)
 - Licensed Clinical Social Worker
NB: Medicaid-serving programs should require a social worker on the team
 - Spiritual care professional.
- At least one prescriber on the team must have specialty certification in palliative care. Achievement of specific pain and symptom management competencies, such as through CAPC designation, may be used while working towards certification.
- Reliable access to other services when needed, such as pharmacist, community health workers, physical therapist, personal care services, etc.; linkage agreements are acceptable documentation.
- If any team members are not specialty-certified, a training policy and education requirements for each team member must be submitted; requirements may be based on the [Center to Advance Palliative Care \(CAPC\) training recommendations](#).
- 24/7 access to a trained clinician (using telehealth as warranted), with access to the patients' medical records, to provide meaningful clinical support during crises.
- Demonstrated capability to conduct a comprehensive assessment to include, at minimum:
 - Pain and symptom distress
 - Functional status
 - Cognitive status
 - Caregiver burden
 - Spiritual needs
 - Social needs, including (but not limited to) financial vulnerability, housing, transportation, nutrition, and safety.

- Demonstrated capability to create a care plan through shared decision-making, and to coordinate that plan across all providers and services.
- Collection of quality measures, including patient-reported outcomes and adherence to [national guidelines](#).

Assessment and care planning capabilities can be demonstrated by submission of de-identified initial assessment and care plan documents for past patients.

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