CMS-3844-P-1 Hospice Care Conditions of Participation

Submitter : **Dr. Ron Fisher** **Date & Time:** **05/28/2005**

Organization : **Westcare Hospice**

Category : **Physician**

Issue Areas/Comments

Issue

Issue

Medical Director
I have been the the Medical Director of a small, rural Hospice for the past 18 years.
The proposed changes to role of Medical Director seem very appropriate and, in my opinion, very much needed, however I have several serious concerns.

Since the Medical Director would have much more responsibility under the proposed guidelines the following conditions would have to be encouraged (or guaranteed) in order for it to truly be effective.

1- The Medical Director would need to have additional training in Hospice / Palliative / End-of-Life Care. As it stands now, many Rural Hospices have difficulty in obtaining such qualified physicians and resort to contracting with whatever person with an "MD" after the name they can find. Some sort of certification process similar to those offered by AMDA or AAHPM would need to be a requirement. As an alternative, CMS could sponsor a "Medical Director Training Symposium" on a regular basis to guarantee core Palliative Care principles are understood by every Medical Director.

2- Since these responsibilities would obviously require significantly greater investment in time, as well as additional liability; the problem of reimbursement raises its ugly head. Without significant additional funds to reimburse the Medical Director for these responsibilities, many Hospices would not be able to maintain contracts and the possibility of mass resignations is a serious concern. Many Medical Directors of small, rural Hospices volunteer their services - I find it highly unlikely that would continue under the proposed changes. Hospices presently do not receive enough reimbursement in their per-diem to meet these additional costs. Some adjustment to help them would be necessary.

3- Many Hospices, especially those with part-time, primarily administrative (often volunteer, or very low paid) Medical Directors require the Primary Care physician remain as the primary MD - this also facilitates continuity of care. This shift of ultimate responsibility for quality of care to the Medical Director will likely lead to some serious conflicts between the primary MD and the Medical Director. A process to resolve these issues needs to be outlined with a CMS "stamp of approval" or there will be many "duals at high noon."

I applaud your efforts at improving the care to our citizens at End-of-Life. It's an area where we have tremendous room for improvement with relatively less need for capital than other advances in medicine that have been funded. If I personally can help in any way with your efforts I would be happy to do so.

Thank you
Ron Fisher, MD
Westcare Hospice

Sylva Medical Center
PO Box 1045
Sylva, NC 28779
fishermd@mac.com
828-506-2299

CMS-3844-P-2 Hospice Care Conditions of Participation

Submitter : Mr. Sing Yue **Date & Time: 05/29/2005**

Organization : Mercy Hospital, Catholic Healthcare West

Category : Other Health Care Professional

Issue Areas/Comments

Issue

Issue

Spiritual care and counseling in Hospice Setting.
I read your proposals with much interest and intensity. To my dismay, I did not see a more defined role and involvement of a professionally certified chaplain that has been mentioned in your article. As in many other healthcare services,chaplaincy and spiritual care have been well established. Therefore; I would like to see that professionally trained, and certified chaplains be call on and included within the interdisciplinary service providers as described. This is not only good for the overall patients care but also as a clinically proven, evidence-base of a sensible wholistic approach to a cost-effective healthcare pratice of all time.
Thank you for your attentions to this matter.

Submitter : **Susan Blakeslee** **Date: 06/01/2005**

Organization : **UHSA, Inc**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

SOCIAL WORK

While the term Medical Social Services is used in the CoPs, you require that this Core Service be offered only by a Social Worker. While I agree wholeheartedly that a Master?s prepared mental health professional will usually provide better care, I disagree that the Core Service requirement be only for MSWs. In fact, other mental health professionals such as Mental Health Counselors and/or Marriage and Family Counselors, and/or Psychologists may, in some cases, be better qualified to work with patients and families than are Social Workers. Naturally, these professionals should be graduates of accredited programs. In any event, the Master?s degrees in any of those fields are quite similar.

I would like to propose that the qualification standard be changed so that other Master?s prepared mental health professionals would be included.

I worked for many years for an agency that used only Master?s prepared professionals, but used both Social Workers and Mental Health Counselors for primary care and bereavement. The care provided by both disciplines was excellent and indistinguishable.

Additionally, I agree that while it is preferable to use Master?s prepared professionals, many rural hospices might be unable to attract these people, and to require the degree would put an unrealistic burden on those agencies.

I also am aware that the Social Work lobby is a powerful one, but I do urge you to broaden the scope of this segment of the Core Services.

Submitter : **Mrs. Shannon Carroll** **Date: 06/03/2005**

Organization : **SouthernCare (hospice)**

Category : **Nurse**

Issue Areas/Comments

GENERAL

GENERAL

I agree with all of the proposed changes in the hospice benefit.

1. It will be very beneficial to patients and families if the regulation is changed with respect to not requiring a Registered nurse while participating in the Respite and Inpatient care. We hit many road blocks with nursing facilities because they are not required to have a RN 24 hrs per day.

2. We appreciate the proposal to loosen restrictions on earlier referrals and longer service days per patient.

Submitter : **Ms. Jennifer Benham** **Date: 06/03/2005**

Organization : **SouthernCare (hospice)**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

I agree with all of the proposed changes in the hospice benefit.

1. It will be very beneficial to patients and families if the regulation is changed with respect to not requiring a Registered nurse while participating in the Respite and Inpatient care. We hit many road blocks with nursing facilities because they are not required to have a RN 24 hrs per day.

2. We appreciate the proposal to loosen restrictions on earlier referrals and longer service days per

Submitter : Ms. Shirley McLaren

Organization : CHCC dba Anderson Inn/Gardens

Date: 06/05/2005

Category : Long-term Care

Issue Areas/Comments

Issues 1 - 10

Short Term Inpatient Care

I would support being able to provide care in our NF/SNF unit for hospice patients needing 24 hr nursing oversight and care (RN or LPN)with hospice oversight.

Submitter : **Dr. Larry Austin** **Date: 06/09/2005**

Organization : **Professional Chaplain**

Category : **Health Care Professional or Association**

Issue Areas/Comments

Issues 11 - 18

Plan Of Care or Coordination of Services

In your plan of care you mention several times the importance of interdisciplinary planning including the importance (as a patient right) , spirituality , cultural issues and bereavement. No where in your proposed changes do I see any mention of Certified Chaplains. You mention that there is good anacodatal evidence to show that Masters level Social workers are capable professionals to perform some of these functions. I submit that there is very good narrative evidence and even scientific research evidence for the importance of qualified religious / spiritual trained professionas (Certified Chaplains) who can provide the religous spirtual and cultural practices just as well as the social worker. Certified Chaplains have Masters Degrees from Accreditated Theological Schools,at least 4 units(one year of intensive group and individual supervision of their work) of Accredited Clinical Pastoral Education, where they have learned Spiritual Assesment stragetics and outcomes based pastoral care interventions. I would encourage you to be more congruent and inculusive in your definations of interdisciplinary teams and take a more serious look at Certified Chaplains as nationally recognized professionals that are just as capable as other allied health care professionals.

If you have questions or need more information on Chaplaincy and our training proces you may want to visit the Association of Professional Chaplains, and the Association of Clinical Pastoral Education INC web sites.

Chaplains have been providing quality care in death and dying situations ,long before there were structured programs. Isn't it about time that you recognize the Profession status of a certified Chaplain?

Submitter : **Mr. James stansel**

Organization : **Mr. James stansel**

Category : **Individual**

Date: 06/09/2005

Issue Areas/Comments

GENERAL

GENERAL

This must be taken care of now!!!

Submitter : **Mrs. Debbie Movelle** **Date: 06/10/2005**

Organization : **Mrs. Debbie Movelle**

Category : **Individual**

Issue Areas/Comments

GENERAL

GENERAL

June 9, 2005

Centers for Medicare & Medicaid Services
Department of Health & Human Services
Attention: CMS-1500-P
P.O. Box 8011
Baltimore, MD 21244-1850

Dear Center for Medicare and Medicaid Services,

Please direct this plea to the correct party for me. Thank you.

I am writing to tell you how important it is for CMS to reimburse hospitals (both inpatient and outpatient settings) for rechargeable neurostimulators. Rechargeable neurostimulators are a huge improvement over the previous technology and it is important that this be an option for people with pain. This new technology will cut down on the need for expensive battery replacement and the painful and costly surgery that accompanies it. Additionally, having a rechargeable battery source means that patients can achieve optimal stimulation for pain relief, no longer having to conserve energy and reduce the stimulation power to prolong battery life. People in pain will then be able to personally control their pain relief on a 24-hour basis.

My mother passed away last December. Her primary pain was from Trigeminal Neuralgia. First diagnosed in 1979, she had two rhizotomy?s. She was allergic to Tegretal and Dilantin. The only relief she got was from morphine. Often Doctors did not believe the pain she described and were reluctant to increase or write her a script. She lived in fear of not having enough medication. This became more complicated with two falls and osteoporosis?resulting in broken vertebrae and back pain. It is very hard to watch your mother in pain. When people are in pain. Believe them. They live in fear that the pain will be unbearable. Because some days for them are just not worth living.

Thank you for your attention to this very important issue for people who have chronic pain. It is vital that everyone, no matter what their insurance or income levels, have equal access to good pain relief treatments.

Sincerely,

Debbie Movelle
808 Juniper Court
Daphne, AL 36526

Submitter : **Mrs. Cherrie Barker** **Date: 06/13/2005**

Organization : **Home Hospice**

Category : **Other Practitioner**

Issue Areas/Comments

GENERAL

GENERAL

Under Definitions (Proposed 418.3) The term Nurse Practitioner is used exclusively,not Advanced Practice Nurse or Clinical Nurse Specialist. Does this exclude Clinical Nurse Specialists who are also licensed under the umbrella of Advanced Practice Nurses just as Nurse Practitioners? This seems to be a confusing point for some hospice providers. If I hold a Masters degree in Nursing and am licensed as an Advanced Practice Nurse Clinical Nurse Specialist, will I not also be considered 'attending physician' just as a Nurse Practitioner? In the state of Texas where I reside and practice, I am allowed the same reimbursement rate and privileges as a Nurse Practitioner.

CMS-3844-P-11 Hospice Care Conditions of Participation

Submitter : **Ms. Mona Heger** **Date & Time:** **06/20/2005**

Organization : **Quad County Home Health & Hospice Agency**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

Hospice Conditions of Participation Proposals

Re: Social Work

I am writing regarding the proposal to make requirements for social workers in hospices to be Masters prepared. I am a director of a small, rural hospital based home health and hospice agency. We are one hour from Decatur and Springfield, Illinois, our two metropolitan areas that are closest to our facility. Our hospice has an average census of four (4) patients and our home health agency has an average census of thirty (30).

I searched for more than one year to find a Bachelor prepared social worker to work with our agencies on a part-time or per diem basis. I had to hire a non-licensed social worker that was working in a county mental health agency and pay for him to study and obtain his license so our agency could meet the regulatory standards of our state and federal requirements for hospice. I have to guarantee a total of three (3) hours every week for him to agree to drive to our agency from a town thirty miles away to attend the Interdisciplinary Team Conference every week and visit patients while he is here.

While I agree, social work is an integral part of hospice, I disagree with the requirements proposed that a social worker must be Masters prepared to adequately provide counseling for hospice patients. I also disagree with the proposed requirement that a hospice could provide a Bachelor prepared social worker with the supervision of a Master prepared social worker.

This is an added financial burden to agencies that are already struggling to find Bachelor prepared and licensed social workers in a rural setting. Obviously, the social worker that I hired is adequate to counsel and supervise mentally ill patients with a Bachelors degree and no license. He is also deemed competent to provide services to our home health patients even when he was not licensed. (Home health does not require licensure).

Requiring an Masters prepared social worker to provide direct or supervisory service for a Bachelor prepared social worker will cost smaller rural agencies undue amounts in the expense of mileage to/from, travel time and salaries, if they are able to locate and hire these social workers at all.

With an average census of four (4) patients, we cannot hire personnel with guaranteed salaries so it is very difficult to find staff willing to drive an hour to and from to see so few patients. We are forced to hire on a per diem (as needed) basis. Thus, we are a second job for most professional staff and their fulltime position is their priority. We are forced to accept their services whenever they can fit it in to their fulltime hours and their personal life.

If you add these increased requirements, it will be impossible for small, rural based agencies to continue to provide full services to their patients and families.

Thank you for taking these points into consideration when developing the Conditions of Participation revisions.

Mona Heger, R.N., Director
Quad County Home Health and Hospice

CMS-3844-P-12 Hospice Care Conditions of Participation

Submitter : **Ms. Beth Bayer** **Date & Time:** **06/24/2005**

Organization : **Journey Hospice**

Category : **Hospice**

Issue Areas/Comments

GENERAL

GENERAL

SHORT TEERM INPATIENT CARE - We are extremely concerned that not requiring R.N.s to cover every shift would allow every nursing home to open a "hospice unit" and patients would recieve poor care. We believe that requiring and R.N. on every shift to provide direct patient care is exactly what stops "fly by nights" from opening stand alone and nursing home hospice units. Please re-consider. Thank you

CMS-3844-P-13 Hospice Care Conditions of Participation

Submitter : **Mr. Tom Galluppi** **Date & Time:** **06/27/2005**

Organization : **Illinois HomeCare Council**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

On behalf of the board and members of Illinois HomeCare Council, we are writing to request that CMS reconsider applying the new MSA definition in defining the Hospice Wage Index. File Code Number CMS 1286-P and specific issue identifier ?Impact Analysis.? Utilizing this definition will severely limit the ability of hospice service providers to provide care in many counties thus limiting the access for Illinois citizens to hospice care and could also impact the quality of care as providers are forced to work with less funding.

It is especially difficult to lose revenue because of the current nursing and social worker shortages in Illinois, which is already impacting all healthcare and social service providers and contributing to the continuing rise in wages for these professionals. For example, Illinois counties such as Lake have continued to see decreases in the wage index for the last few years, while contiguous counties have received increases but all the providers in this area all from and compete for the same labor pool. This creates major problems in maintaining financial viability for health and social service organizations.

Again, please reconsider the proposed use of the new MSA definitions in defining the Hospice Wage Index. Options to be considered could include:
? reclassifying these counties, or
? attaching the county to an adjacent county with a higher wage rate, or
? phasing in the new payment over a three year period for the counties negatively affected.

Sincerely,

Tom Galluppi, President

CMS-3844-P-13

Submitter : **Mr. Tom Galluppi** **Date: 06/27/2005**

Organization : **Illinois HomeCare Council**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

On behalf of the board and members of Illinois HomeCare Council, we are writing to request that CMS reconsider applying the new MSA definition in defining the Hospice Wage Index. File Code Number CMS 1286-P and specific issue identifier ?Impact Analysis.? Utilizing this definition will severely limit the ability of hospice service providers to provide care in many counties thus limiting the access for Illinois citizens to hospice care and could also impact the quality of care as providers are forced to work with less funding.

It is especially difficult to lose revenue because of the current nursing and social worker shortages in Illinois, which is already impacting all healthcare and social service providers and contributing to the continuing rise in wages for these professionals. For example, Illinois counties such as Lake have continued to see decreases in the wage index for the last few years, while contiguous counties have received increases but all the providers in this area all from and compete for the same labor pool. This creates major problems in maintaining financial viability for health and social service organizations.

Again, please reconsider the proposed use of the new MSA definitions in defining the Hospice Wage Index. Options to be considered could include:
? reclassifying these counties, or
? attaching the county to an adjacent county with a higher wage rate, or
? phasing in the new payment over a three year period for the counties negatively affected.

Sincerely,

Tom Galluppi, President

Submitter : **Ms. Joan Hull** **Date: 06/28/2005**

Organization : **Merrimack Valley Hospice**

Category : **Health Care Professional or Association**

Issue Areas/Comments

GENERAL

GENERAL

see attachment

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Ms. Jeanne Czoch** **Date: 06/29/2005**

Organization : **Hospice of Jefferson County**

Category : **Hospice**

Issue Areas/Comments

GENERAL

GENERAL

See attachment

CMS-3844-P-15-Attach-1.DOC

CMS-3844-P-15-Attach-2.DOC

COMMENTS IN REGARD TO CMS-3844-P

Comment: Would like to see the overall language change from medical needs, etc., to state needs r/t terminal condition.

Subpart A
418.3 Definitions
Would like definitions included for initial assessment and comprehensive assessment.

Drug Restraints: Often patients at the end of life experience terminal agitation. During this time medications such as Ativan, Haldol, etc. are needed to manage this. This should not be considered a chemical restraint, as it is **symptom management.**

Subpart C
418.52 Patient Rights
(a) 3. Admissions are cumbersome to client and family with paperwork. Clients and families are coming to terms with prognosis; they are often overloaded with too much information. Would like to see within 7 days added to end of statement. "The hospice must inform the patient and family of the hospice's drug policies and procedures, including the policies and procedures regarding the tracking and disposing of controlled substances within 7 days of admission to a Hospice program.
(4) i. would like Home Health COP 484.10 to be used instead of current language.

(e) Patient liability
There are times with private insurance companies that reimbursement is not determined until **after** the initial evaluation.
Facility room and board patient liability **should not** be considered a part of this condition. This is an issue with the facility and the client.

418.54 Comprehensive assessment of the client.
(a) Would like standard to read: The hospice RN must make an initial assessment within 24 hours after the hospice receives a physician order *unless otherwise ordered by the physician or client/family request for delay in assessment.*
(b) Time frame for completion of comprehensive assessment- would like to see change from 4 days to **7 days.**
(d) Update of the comprehensive assessment- would like to see change to 15 days for better flow (90 days, 60 days).

418.56 IDG care planning and coordination of services
(d) Would like statement in parentheses taken out. Often in small, rural communities the client's primary physician is the hospice medical director. Another issue arises when the patient's primary physician prefers the hospice medical director take over care of the hospice client.

(2) The Hospice IDG is not the governing body and does not establish policies.

(c) Content of plan of care
(4) and (5) need to be changed from to meet the needs of the patient to state related to the terminal condition.

(d) Change to 15 days.
The medical director is part of the IDG, should not be separated. As mentioned above, often the client's primary physician refers to hospice medical director for client's hospice needs.

418.58 Quality Assessment and Performance Improvement
Comment: This regulation could be cost prohibitive to smaller agencies (access to care issue). (Adding more duties for smaller staff, cost of computerization, etc.)

418.76 Home Health Aide, Homemaker Services
(h) Supervision of Home Health Aides
Every 28 days should be changed to every 60 days to be more like home health COPs. To do joint visit with every home health aide with every hospice client is cost prohibitive and a scheduling nightmare.

418.78 Volunteers
(e) 5% should be taken out. Hospices could still document cost savings. As people retire later in life, take care of grandchildren etc. it decreases the ability of hospices to recruit and retrain volunteers.

Subpart D
418.100 Organization and Administration of Services
(e) Professional management responsibility-recommend verbiage change from...and supervision of staff and services for all arranged services to the verbiage in (f)(2) "The hospice must continually monitor and manage all services provided..."
This condition could be an access to services problem, as facilities will not allow a contracted entity to supervise their staff, etc.

418.102 Medical Director
In rural areas the Hospice Medical Director is usually a volunteer position. These physicians also have their own clinics, hospital rounds, nursing facility rounds and may also be medical directors of nursing facilities, ambulance services, etc., The last sentence of this section should state that the IDG, not just the hospice medical director as it gives the medical director increased responsibility and this should be an IDG responsibility.
(c) Medical care should be changed to hospice care.
The medical director should not be responsible for directing the quality assessment and performance improvement program nor should they assume oversight. As mentioned above in small, rural agencies this would increase the burden of a volunteer medical director.

(e) Discharge or transfer of care
It is cost prohibitive to send entire record. With definition of discharge summary this should be sufficient to send to other entities and the primary physician.

418.106 Drugs, controlled drugs and biologicals, medical supplies, and durable medical equipment
(b) Controlled drugs in patients' homes.
The wording of this standard needs to change. Clients/Families often have negative thoughts regarding controlled substances; this standard could increase that feeling thus becoming a symptom control and access issue.

418.108 Short-term inpatient care
Needs to include short-term care for crises of a psychosocial/family nature.

418.112 Hospices that provide hospice care to residents of a SNF/NF, ICF/MR, or other facilities
(b) Professional management
This standard is in conflict with nursing facility rules and regulations; it causes an access problem, as nursing facilities must follow state regulations.

(d) medical director
Again access issue. As mentioned above it is burdensome for the volunteer medical director. Often in rural areas the hospice medical director is the facility medical director and the client's primary physician. Agree that IDG and facility staff should be responsible for coordination of **hospice care.**

(f) Hospice plan of care
(3) change to 15 days

418.114 Personal qualifications for licensed professionals
(d) Criminal background checks should defer to state law. In the state of Kansas it takes at least 30 days to receive a background check from the KBI. Waiting this length of time to add a staff member is not acceptable. It will also be costly to obtain background checks on all employees (currently not required by the state for background checks). Again this is an access to services issues as the small, rural hospices are the agencies that are not going to be able to afford these costs. This proposed regulation also has the potential of decreasing the volunteer pool as some persons may see this as an invasion of privacy.

Submitter : **d H** **Date: 06/30/2005**

Organization : **Hospice**

Category : **Other Health Care Professional**

Issue Areas/Comments

Issues 11 - 18

Assessment Time Frames

CHAPLAINS: 2 days max is not enough time to actually conduct an assessment. We contact patients /caregiver within 2 days, and usally the response is 'give us more time, so many people are coming in now.' Maybe 5 days is reasonable. Of course if the need is urgent, assessement is done as soon as they allow

Submitter : **d h** **Date: 06/30/2005**

Organization : **Hospice (Chaplain)**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

Chaplains/Clergy:
Some organizations such as APC are pushing to require 'board certified' Chaplains only. However, this would eliminate many qualified chaplains. For one, not all chaplains are board certified. Many have units of CPE but many do not fulfill the requirements of 'Board Certified' and function well in hospital or hospice settings. In addition, APC and other professional organizations disagree as to which organizations & requirements credential chaplains If you say board certified, then the question is which board? I suggest regulations in this regard be left as is. I am also fearful many hospices would be without spiritual care providers if this is pushed through as a requirement.

Submitter : Miss. Ivia Rivera

Date: 06/30/2005

Organization : HFE

Category : Hospice

Issue Areas/Comments

GENERAL

GENERAL

send by e-mail :cmunmed@coqui.net the condition of participation for hospice

Submitter : Ms. Tammy Francis

Date: 06/30/2005

Organization : Smoky Mountain Home Health & Hospice

Category : Health Care Provider/Association

Issue Areas/Comments

GENERAL

GENERAL

Has there been a cost analysis done to determine the financial impact on agencies to implement these changes?

Submitter : **Dr. Mark LaRocca-Pitts**

Organization : **Athens Regional medical Center**

Category : **Other Health Care Professional**

Date: 06/30/2005

Issue Areas/Comments

GENERAL

GENERAL

I am delighted to see the level at which you include spiritual care and counseling in your new guidelines for the interdisciplinary team for Hospice. I believe that you could even strengthen your stance on spiritual care and its importance by requiring a certain level of clinical and professional training for the person who provides the spiritual care. This could be done if you specify that the member of the team who coordinates and/or provides the spiritual care be a Board Certified Chaplain with one of the nationally recognized professional groups.

Board Certified Chaplains have post-graduate theological degrees, ordination and endorsement by a recognized faith group, and at least 1600 hours of clinically supervised training. In addition, we have demonstrated a variety of professional and personal competencies, are held accountable to a Code of Ethics, and participate in continuing education and peer review.

I am a member of the Association of Professional Chaplains and have read their response. I agree with it completely and I hope you are able to incorporate some of their suggestions. We are trained to work in such specialized clinical settings and are able to provide spiritual care within a multi-cultural setting. We would make a valuable contribution to the hospice interdisciplinary team and could coordinate a continuum of spiritual care with local faith communities.

Thank you for allowing us the time to provide some feedback on this valuable document.

Respectfully,
Mark LaRocca-Pitts, M.Div, PhD
Staff Chaplain
Athens Regional Medical Center
1199 Prince Ave.
Athens, GA 30606
Ph: 706-475-7204
Fax: 706-475-6727
marklp@armc.org

Submitter : Mrs. Linda Swart

Organization : Community Hospice

Category : Hospice

Date: 07/01/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3844-P-21-Attach-1.DOC

CMS-3844-P-21-Attach-2.DOC

Southern Regional Hospices Comments

For your convenience I have listed below the comments by section:

Definitions:
Clinical Note - Please add the word "spiritual" to "any changes in physical or emotional condition".

Drug Restraint – Clarification is needed here. Some medications that may be viewed as a chemical restraint in some instances may be normal patient care protocol in hospice.

Please consider adding the following definitions
Homemaker Services

Nursing Services – Services provided by a licensed nurse.

Patient's Residence – Patient's Residence means a house, apartment, Hospice Residence, SNF/NF, ICF/MR, assisted living facility, shelter, foster home or any other location where the patient lives.

Subpart C
418.52
a Standard: Notice of Rights.
1. This is very problematic in reality to provide in writing. Availability of interpreters is already required by Americans with Disabilities Act. To provide everything in a written format in ALL languages including Braille would create a tremendous expense and a financial impossibility for many programs, thereby creating a barrier to hospice services.

3. It is too much and would be confusing and frightening for the families to inform them of drug tracking on disposal policies prior to providing care. Many patients are not on narcotics at the time of admission. It would seem to serve the purpose better if this information instead was conveyed within the comprehensive assessment timeframe.

b. Standard Exercise of rights and respect for property and person.
4. I would ask that you consider reviewing Home Health Regulations in this section. The rights listed there are more appropriate for hospice. Note: It should be added to these rights that the patients has the right to refuse treatment.

e. Standard: Patient Liability
Please note that in the nursing home we do not know what the patient's liability will be. This is the nursing homes responsibility not ours. Is this also where the patient would be informed of their financial liability if they want something outside the hospice Plan of Care?

418.54 Comprehensive Assessment

In the sentence "This care includes, but is not limited to, the palliation and management of the terminal illness and related medical conditions - What is "but is not limited to"? What else would there be other than the terminal illness and its related medical conditions?

a. Initial assessment.

In the section (unless ordered otherwise by the physician) please consider adding "or as requested by the family".

Referrals are normally seen within 24 hours is this what you are meaning by initial assessment?

b. Time frame for completion of the comprehensive assessment.

The four days for completion is too short. Example – If a patient arrives from an out of town hospital 8 or 9 p.m. on a Friday the four days would end on the following Monday. This could have a very negative effect on rural hospices and could impact access to care for rural patients that we have to travel long distances to see. Seven days would be a more appropriate time frame to have all members of the IDG completing their assessments

c. Content of the comprehensive assessment.

This comprehensive assessment is focused on needs of the pt/family and actually needs to be the prelude to the plan of care.

3.ii. Shouldn't all drugs be included in the profile, related and unrelated, to both identify which ones the hospice will cover (related) and those we will not cover (unrelated) and to identify possible drug interactions and to eliminate those no longer needed.

d. Patient Outcome measures.

Hospice patients as a whole desire their outcome to be a safe, comfortable death with as little burden to their family as possible. I do not feel adding this approach to our regulations is necessary in assessment, care planning, service delivery and to our quality of care. This is creating a burdensome task for hospices and is not necessary for the good of the patient. Many patients are dying in 7 days or less and to collect this data will entail more paperwork not necessarily provide for better care.

418.56 IDG care planning and coordination of services.

a.1.(i.) Many times the patient's attending is also the medical director. There would be not other physician. This section in ( ) needs to be deleted or clarified with the exception (who is not the patient's attending physician, unless the Medical Director is also the patient's attending physician)

c. Content of the POC

The sentence beginning "The plan of care must include " it needs to add "services for the palliation or management of the terminal condition including" . Delete but not be limited to so that it is clear that the hospice doesn't need to treat all the patient's problems.

6. What documentation will CMS expect as to the patient and families involvement and agreement to the plan of care. I feel agreement should come out of the sentence. The family may not be in agreement with the plan of care but the patient may very well be in agreement.

d. Review of the POC

Comments: What is the hospice's obligation when the family disagrees with the patient's POC?

The Medical Director is a part of the IDG but should not be made separate. Could this instead read "The Interdisciplinary team (in collaboration with the individual's attending physician to the extent possible)....

418.58 Quality Assessment and performance improvement.

a. Program scope

1. It bothers me to see trend to define and demand improvement in specific quality indicators. This sounds so much like nursing home and is causing vast problems in their arena. We certainly do not need to head in that direction.

2.What is meant by adverse events?
What is meant by tracing quality indicators? (sounds like nursing home again)

418.64 Core Services

It would be extremely helpful to hospices if we were allowed to contract for continuous care staff. We would need to show evidence of their inservice by hospice to provide the care. In small hospice programs it is extremely difficult to have nurses provide this level of care while maintaining their regular visit load. Continuous care is a crisis but it does not eliminate the regular visits to other patients. We have had the case where continuous care was initiated at 1a.m.after several call outs and the nurse was there until 6 or 7 then had to continue his/her regular workday. The Continuous Care may extend into the 2 day and by then, if you are a small hospice, all nurses and the SW are exhausted.

b. **Nursing services.**

If not listed in the definitions then we need a clarification here as to what is included in nursing services – RN, LPN, LVN?

d. Counseling Services

1. (ii) & (iii) Regarding counseling in the nursing homes setting, how can we ensure we are reflecting their needs? An aide may be exceptionally close to the patient but even then we have tried for years to provide bereavement counseling services in the nursing home to no avail. The nursing home will not allow staff to take time from their work schedules to meet with a bereavement counselor. We do address it in in-services to the nursing home but to add a further regulatory requirement will create an impossible situation in the nursing home setting.

2.(iii) What is meant by "not required to go to extraordinary lengths to do so" mean?

418.72 PT,OT, and Speech-language pathology.
Please add dietitians to this list of non-core services. There have been instances where hospices have been given a deficiency by surveyors because they did not have one on staff. They did have a contracted dietitian but were cited as the surveyor informed them they could not contract for core services.

418.76 Home Health Aide and Homemaker Services
e.Qualifications for instructors conducting classroom supervised practical training, competency evaluations and in-service training.
We propose to add the words" …of which must be in **hospice or** home health care…

ineligible training organizations.
At the beginning of the standard, we would propose to substitute hospice for the words "home health agency" in the beginning of this standard.

h. Supervision of Home Health Aides
i. What is meant by qualified therapist"
The 14 day requirement to on the supervisory visit to observe and asses the aide while he or she is performing care no less frequently than every 28 days is problematic at too stringent.
If an aide has been with you for several years and has always provided good care and is shown themselves knowledgeable and competent to provide the care then to have to observe them every 28 days is an inappropriate use of the nurses time. The aides schedules are constantly changing with the additions of new patients and the deaths of others. It would seem to us that competency assessments would take care of this issue.

418.78 Volunteers
Level of Activity. There is no reference here to the 5% and what is counted in the 5% is not statutory. The 5% is problematic for inpatient facilities providing 24/7 direct care.

418.100 Organization and administration of services.
"The hospice must ensure" should be changed to promote.
a. Serving the hospice patient and family.
2. What about the issue when there is conflicting patient and family needs and desires? #2 could be modified to read. That each patient experience hospice care that is consistent with patient and family needs and desires. #3 where the patient and family are not in agreement as to the election and plan of treatment, the hospice will identify and list the group of individuals to who #1 shall apply.

e.Professional management responsibility.
The requirement for "supervision of staff" as opposed to only requiring supervision of services is of great concern, especially if it applies to staff at nursing homes and or hospitals. Suggestion – "supervisory responsibility for services" or "oversight of" instead.

Another area of concern is the requirement for personnel having "at least the same qualifications as hospice employees." Suggestion – "by qualified personnel" instead.

418.102 Medical Director
Hospices may sometimes need to contract with an entity for a physician to serve as a medical director, is that allowed?

b.2 Recertification of the terminal illness.
We need clarification on what you mean by review of the patient's and family's expectations and wishes for the continuation of hospice care. Patients and family's are aware from onset of care that they can discharge/revoke hospice at any time. Since that is the fact, why re address this issue with each recertification?

c.Coordination of medical care
Regarding the last sentence," The medical director or physician designee is also responsible for directing the hospice's quality assessment and performance improvement program." Operationally this would be very difficult as most of us do not have full time medical directors and our medical directors have full time practices outside our office, also it is not necessarily appropriate and we request this be deleted. If not deleted, then why not use "or other qualified professional" with direction for medical director oversight?

Please note also, there is a difference between the patient's "medical" care and a patient's "hospice" care.

418.104 Clinical Records
Electronic records should, at the very least, be phased in. Many smaller hospices cannot afford to go to electronic charting other than the free billing software provided by the Fiscal Intermediary. <u>The largest barrier is expense.</u>

a. Content
2. What do you mean by authorization. Since the patient's rights condition of participation is intended to replace the current informed consent condition, we need clarification on what is required. Currently the only "authorization" required falls under HIPAA privacy regulations this is not necessarily in every clinical record.

b.Authentication
Are you referring to a signature log for everyone? This could be a barrier and this appears to have come from the hospital COP's. Home Care/Hospice is much broader than this and would be very difficult for hospices to apply.
What is meant by primary author?
Does this apply to all consulting physicians or covering physicians?
Nursing homes and Home Health agencies do not have such a standard. Many times our referring physicians sending us medical records are from 100 – 200 miles away. Do faxed signatures count and who could authenticate them?

e.Discharge or transfer of care
The clinical record is many times hundreds of pages long and would not be needed or desirable to receive. A through discharge summary and medications is more appropriate.

The Minimum Necessary Standard in HIPAA should be the requirement.

418.106 Drugs, controlled drugs and biologicals, medical supplies and durable medical equipment.

b.Controlled drugs in the patient's home.
We would like to see the work "collecting" out of this sentence. Also, Hospice has worked for years to dispel the myths associated with narcotic use with terminally ill patients and to require detailed discussion/education regarding the "potential dangers" Of controlled substances will undermine years of work. So many patients already have a unnecessary fear of addiction.

c.Use and maintenance of equipment and supplies
Suggest the language "The hospice, either directly or through contractual agreement, ensures that there is a process for providing routine and preventive maintenance of equipment and that the equipment is safe and works as intended for use in the patient's environment. This may occur either directly or through contractual agreement." This would clarify the responsibilities of contractors if they are used to supply medical equipment.

418.108 Short-Term Inpatient Care
Please note that inpatient care, in addition to pain control, symptom management and respite may also be provided for crises of a psychosocial/family nature.

The introduction should define the care as "care provided by the hospice on an inpatient basis in a facility that meets the requirements of… and then lists the provider standards in (a) and (b). Then it should say that inpatient care for symptom management and pain control and respite may be provided in any of these facilities.

Paragraph (a)
This should note that pain control and symptom management would be done on an inpatient basis either because of the specific need for the staff and equipment available there or because of the inability of the hospice and/or the patient's caregivers to assure that the services are properly provided in the home.

Paragraph (b)
This section is where there is not a need for a 24 hour nursing services.

NOTE: 24 hours nursing services are still needed for GIP level of care.

418.110 Hospices that provide inpatient care directly.

c.Physical environment.

1.(ii) Please define and provide examples of "equipment failures" that would be required to be reported?

f. Patient rooms.
3.(iv) Add this to the end of (iv):, except during community disasters and/or evacuations:

m. Pharmaceutical services.
Please clarify whether or not patients are allowed to bring prescription drugs from home into a facility?

o. Seclusion and restraint.
Many times a patient during the course of their terminal illness may need to be treated for restlessness, combativeness, hallucinations, delusions, terminal agitation. These symptoms are considered suffering and we treat these with appropriate medications. The families should not have to watch their loved one suffer in this manner. We already have enough difficulty with providing these medications to patients in the nursing home due to their very restrictive requirements.

3 c. To require a physician to see the patient within one hour of the order is too restrictive. Many times these orders are necessary in the middle of the night and many miles from the physician.

d.We consider the requirement for a physical restrain to be limited to 4 hours to be too restrictive along with the requirement of seeing the patient within one hour. Many times terminal agitation may take longer to bring under control.

4. i. If you require that the patient being restrained by any means be continually monitored face to face then you are actually causing each case to be established as continuous care. Is this what you are intending?

418.112
b.This whole area will be problematic until the nursing home regs also state that the hospice must assume full responsibility for professional management of the resident's hospice care. It should also add the word hospice to the sentence. …make any arrangements necessary for (hospice related) inpatient care….
f.4. The statement ALL caregivers is problematic in the nursing home as there are so many caregivers involved. We need to have defined who in the nursing home is the designated caregiver.

i. It may be more appropriate to reword this standard to state "must assure orientation of facility staff".

418.114

7.The current qualifications for Social Worker should remain as they are currently. In rural areas if is many times impossible to find a Masters Level Social Worker. The current regulation certainly in no way prohibits a program from utilizing this level if it is available but allows those of us in areas where they are not available to still meet the requirement. It also maintains the high standard of care by requiring they be a baccalaureate degreed social worker from a school of social work accredited by the Council on Social Work Education.

d.It will cause a decline in volunteers to require a criminal background check on volunteers. How far does the "contracted employee" definition reach? Is this an employee of a company you have a contract with(example – dme, or pharmacy)?

Submitter : Mr. Jim Clindaniel

Date: 07/01/2005

Organization : Family Hospice

Category : Hospice

Issue Areas/Comments

Issues 11 - 18

Assessment Time Frames

See attachment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Jim Clindaniel**

Organization : **Family Hospice**

Category : **Hospice**

Date: 07/01/2005

Issue Areas/Comments

Issues 11 - 18

Assessment Time Frames

See attachment.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Jim Clindaniel** **Date: 07/01/2005**

Organization : **Family Hospice**

Category : **Hospice**

Issue Areas/Comments

Issues 11 - 18

Assessment Time Frames

See attached.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE AND MEDICAID SERIVICES
OFFICE OF STRATEGIC OPERATIONS & REGULATORY AFFAIRS

Please note: We did not receive the attachment that was cited in this comment. We are not able to receive attachments that have been prepared in excel or zip files. Also, the commenter must click the yellow "Attach File" button to forward the attachment.

Please direct your questions or comments to 1 800 743-3951.

Submitter : **Mr. Jim Clindaniel** **Date: 07/01/2005**

Organization : **Family Hospice**

Category : **Hospice**

Issue Areas/Comments

GENERAL

GENERAL

See attachment.

CMS-3844-P-25-Attach-1.DOC

Comments on Proposed Conditions of Participation (COP)

Subpart: C (Patient Care)

Condition Title: Core Services

Standard Title: Counseling services

Citation Reference: 418.64 Standard # (d) Item #

Concern/Issue:
Those counseling services available to hospice patients would be bereavement, nutritional, and spiritual counseling.

Potential Impact:
The paragraph on counseling services that are available to hospice patients does not address social work counselors. We are currently allowed to employ individuals that possess a bachelor's degree in social work (BSW) from an accredited school and they are referred to as counselors. The title is appropriate since much of their work is associated with counseling patients and families. By not including social service counselors in this definition it diminishes their role in providing quality care to patients and their families.

Suggested Correction:
Those counseling services available to hospice patients would be bereavement, nutritional, social service, and spiritual counseling.

Name: Jim Clindaniel, LNHA Title: Executive Director
Organization: Family Hospice
7 Bronze Pointe South, Suite B
Swansea, IL 62226
Phone: (618) 277-1800
Fax: (618) 277-1074
Email: jclindaniel@familyhospice.org

Submitter : **Mr. Jim Clindaniel**

Date: 07/01/2005

Organization : **Family Hospice**

Category : **Hospice**

Issue Areas/Comments

Issues 11 - 18

Assessment Time Frames

See attached.

CMS-3844-P-26-Attach-1.DOC

Attachment #26

Comments on Proposed Conditions of Participation (COP)

Subpart: C (Patient Care)

Condition Title: Cycle of Care

Standard Title: Initial Assessment

Citation Reference: 418.54 Standard # (a) Item #

Concern/Issue: This condition of participation requesters the hospice registered nurse must make an initial assessment visit with 24 hours after the hospice receives a physician's admission order.

Potential Impact: As written, this condition of participation makes an unrealistic expectation of hospices since the definition of "physicians admission order for care" is not clear. Sometimes we will receive a physicians order but due to circumstances outside our control (family not ready or available), the initial assessment and admission may not occur for a couple days. In addition, does this need to be a hospice registered nurse? In our situation, occasionally a licensed social worker or counselor will make an informational visit to determine if hospice is appropriate or desired by patient/family.

Suggested Correction: A hospice licensed professional or counselor must complete an initial assessment visit within 24 hours (may be delayed to honor family wishes or physician preference) to determine the patient's care and support needs.

Name: Jim Clindaniel, LNHA Title: Executive Director
Organization: Family Hospice
7 Bronze Pointe South, Suite B
Swansea, IL 62226
Phone: (618) 277-1800
Fax: (618) 277-1074
Email: jclindaniel@familyhospice.org

Submitter : **Mr. Jim Clindaniel**

Organization : **Family Hospice**

Category : **Hospice**

Date: 07/01/2005

Issue Areas/Comments

Issues 11 - 18

Assessment Time Frames

See attached.

CMS-3844-P-27-Attach-1.DOC

Attachment #27

Comments on Proposed Conditions of Participation (COP)

Subpart: C (Patient Care)

Condition Title: Cycle of Care

Standard Title: Content of the comprehensive assessment

Citation Reference: 418.54 Standard # (c) Item #

Concern/Issue: Who on the Interdisciplinary Team is expected to do the comprehensive assessment?

Potential Impact: It is unclear as to whether the entire team needs to make a comprehensive assessment by making visit/contact or whether one person on the team could complete the assessment.

Suggested Correction: The hospice nurse in communication with the rest of the Interdisciplinary Team members will complete the comprehensive assessment by making a visit or phone contact.

Name: Jim Clindaniel, LNHA Title: Executive Director
Organization: Family Hospice
7 Bronze Pointe South, Suite B
Swansea, IL 62226
Phone: (618) 277-1800
Fax: (618) 277-1074
Email: jclindaniel@familyhospice.org

Submitter : **Mr. Jim Clindaniel**

Date: 07/01/2005

Organization : **Family Hospice**

Category : **Hospice**

Issue Areas/Comments

Issues 11 - 18

Assessment Time Frames

See attached.

CMS-3844-P-28-Attach-1.DOC

Attachment #28

Comments on Proposed Conditions of Participation (COP)

Subpart: C (Patient Care)

Condition Title: Cycle of Care

Standard Title: Update of the comprehensive assessment

Citation Reference: 418.54 Standard # (d) Item #

Concern/Issue:
The comprehensive assessment be updated by the interdisciplinary group as frequently as the patient's condition requires, but no less frequently than every 14 days.

Potential Impact:
This would create additional work to update assessments if they are not coordinated with the timing of the benefits periods. This additional work would not have an effect on patient care other than to take away from nursing time allotted to see patients by completing redundant assessments. For example, the timing around the first 90 days certification period would have a complete reassessment completed on day 84 (for 14 day requirement), day 90 (for certification period), and day 98 (for 14 day requirement). That would be three complete reassessments within a 14 day period which potentially did nothing to enhance the quality of care other than meet the Medicare regulation.

Suggested Correction:
The comprehensive assessment be updated by the interdisciplinary group as frequently as the patient's condition requires, but no less frequently than twice per month.

Name: Jim Clindaniel, LNHA Title: Executive Director
Organization: Family Hospice
7 Bronze Pointe South, Suite B
Swansea, IL 62226
Phone: (618) 277-1800
Fax: (618) 277-1074
Email: jclindaniel@familyhospice.org

Submitter : Mr. Jim Clindaniel

Organization : Family Hospice

Category : Hospice

Date: 07/01/2005

Issue Areas/Comments

GENERAL

GENERAL

See attached.

CMS-3844-P-29-Attach-1.DOC

Comments on Proposed Conditions of Participation (COP)

Subpart: C (Patient Care)

Condition Title: Home Health Aide and Homemaker Services

Standard Title: Supervision of home health aides

Citation Reference: 418.76 Standard # h Item # i

Concern/Issue: A registered nurse or qualified therapist must make an onsite visit to the patient's home no less frequently than every 14 days to assess the home health aide's services. The home health aide does not have to be present during this visit. A registered nurse or qualified therapist must make an onsite visit to the location where the patient is receiving care in order to observe and assess each aide while he or she is performing care no less frequently than every 28 days.

Potential Impact: Need to clarify the definition of "therapist". The review of a home health aides competency does not need to be completed on every patient within the 14 and 28 day timeframes. The dignity and privacy of every patient must be taken into account while having a home health aide being supervised to perform very private care. The reviews will not improve any patient outcome, service, or patient care. The review of home health aide competency is a human resource function and should not be included in the clinical file.

Suggested Correction: A registered nurse or nursing professional must complete a competency assessment of each home health aide annually. The competency assessment will include an observation of care provided.

Name: Jim Clindaniel, LNHA Title: Executive Director
Organization: Family Hospice
7 Bronze Pointe South, Suite B
Swansea, IL 62226
Phone: (618) 277-1800
Fax: (618) 277-1074
Email: jclindaniel@familyhospice.org

Submitter : **Mr. Jim Clindaniel**

Organization : **Family Hospice**

Category : **Hospice**

Date: 07/01/2005

Issue Areas/Comments

Issues 1 - 10

Personnel Qualifications

See attached.

Short Term Inpatient Care

See attached.

Clinical Records

See attached.

Medical Director

See attached.

Drugs, Supplies, and DME

See attached.

Residents Residing in a Facility

See attached.

CMS-3844-P-30-Attach-1.DOC

CMS-3844-P-30-Attach-2.DOC

CMS-3844-P-30-Attach-3.DOC

CMS-3844-P-30-Attach-4.DOC

CMS-3844-P-30-Attach-5.DOC

CMS-3844-P-30-Attach-6.DOC

Comments on Proposed Conditions of Participation (COP)

Subpart: D (Organizational Environment)

Condition Title: Personnel Qualifications

Standard Title: Social Work

Citation Reference: 418.114 Standard # (c) Item # 7

Concern/Issue:
The Social Worker role is a very important aspect in providing Hospice care. We are currently allowed to employ individuals that possess a bachelor's degree in social work (BSW) from an accredited school and they are referred to as counselors. The title is appropriate since much of their work is associated with counseling patients and families. There is no reason to change their title to social work assistant and lower the perception of the care they do provide.

Potential Impact:
If CMS requires a Master's of Social Work (MSW) degree then the pool of qualified and very capable will be unable to be tapped into. For Family Hospice, we have two very qualified and extremely capable counselors with a BSW and they have years of experience. It would be a tragedy to say that they were incapable of performing their job solely because they do not have a MSW. The level of care that our patients receives is currently of the highest quality with our two BSW's and being supervised under the direction of a Licensed clinical social worker (LCSW).

Suggested Correction:
There is no evidence at our hospice that the standard of care furnished by a MSW is higher than a BSW and we would like to keep the Condition of Participation as it is currently.

Name: Jim Clindaniel, LNHA Title: Executive Director
Organization: Family Hospice
7 Bronze Pointe South, Suite B
Swansea, IL 62226
Phone: (618) 277-1800
Fax: (618) 277-1074
Email: jclindaniel@familyhospice.org