Submitter : Mr. Steve Treinen **Date:** 07/01/2005

Organization : AZMESA Arizona Medical equipment Suppliers Associa

Category : Health Care Provider/Association

Issue Areas/Comments

Issues 1 - 10

Drugs, Supplies, and DME

I applaude the fact that DME is being addressed. I don't think the rule goes far enough though. Some Hospice Organizations have provided equipment, the education and 24 hour emergency services to Medicare Patients, that are below Medicare Standards. Often the DME services are subcontracted to a provider that is not a Medicare Provider, is not licensed, and is not regulated in any way. Education to the patient and family may not be adequate and very often even more complex pieces of medical equipment are not taught by a healthcare professional in that field, for example BIPAP is normally taught by a licensed Respiratory Therapist who educates, monitors and develops a care plan. Under the scenario I am describing, the current regulations do not address that. The Hospice can subcontract with any provider and in real life cases, substandard or incorrect equipment is delivered. Any supplier who supplies medical equipment to a Medicare Hospice Patient should also be required to meet the current 21 Medicare Supplier Standards as is required of DMEPOS Suppliers. The NSC should involved in site inspections to check that the Hospice Medical Equipment Supplier meets all of the same requirements that current suppliers do. As accreditation comes on line next year for DMEPOS Suppliers those same Hospice Subcontractors should be required to be accredited. Just because a Medicare Beneficiary decides to use their Hospice benefit they should not have to give up or settle for less quality or service than they received before Hospice. To often the incentive for the Hospice organization is to provide the lowest cost service they can. That is understandable but the Medicare Beneficiary should have access to the same level of equipment and service as they had before Hospice. The only way to ensure that is to strengthen the proposed rule and require that the Equipment Supplier meet the Medicare Supplier Standards and the NSC be involved to weed out unscrupulous providers and Hospice Organizations that provide equipment that doesn't meet DMEPOS requirements. Thank you.

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

Organization : **Family Hospice**

Category : **Hospice**

Issue Areas/Comments

Issues 1 - 10

Residents Residing in a Facility

See attached.

Clinical Records

See attached.

Medical Director

See attached.

CMS-3844-P-32-Attach-1.DOC

CMS-3844-P-32-Attach-2.DOC

CMS-3844-P-32-Attach-3.DOC

Attachment #32

Comments on Proposed Conditions of Participation (COP)

Subpart: D (Organizational Environment)

Condition Title: Resident's residing in a facility

Standard Title: Medical Director

Citation Reference: 418.112 Standard # (d) Item #

Concern/Issue:
The Medical Director must communicate with all facility physicians and the attending physician and other professionals involved in developing and/or implementing the patient's plan of care.

Potential Impact:
By requiring this communication to be only with physicians, the concern is that input from other members of the team may be left out. In this scenario, the Medical Director is being singled out when it is usually more appropriate for the communication to be between members of the team and the facility. In addition, if communication is to be between the Medical Director and ALL facility physicians, there may be an unnecessary strain between the facility and the hospice if those physicians are not able to communicate in a timely manner. This requirement is too restrictive and if the intent is better communication, the wording of the requirement should be loosened to allow the most appropriate members of the team to communicate.

Suggested Correction:
A member of the hospice IDT must communicate with facility staff in developing and/or implementing the patient's plan of care.

Name: Jim Clindaniel, LNHA Title: Executive Director
Organization: Family Hospice
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Submitter : **Mr. Jim Clindaniel** **Date: 07/01/2005**

Organization : **Family Hospice**

Category : **Hospice**

Issue Areas/Comments

Issues 1 - 10

Residents Residing in a Facility

Sce attached.

CMS-3844-P-33-Attach-1.DOC

Comments on Proposed Conditions of Participation (COP)

Subpart: D (Organizational Environment)

Condition Title: Resident's residing in a facility

Standard Title: Written agreement

Citation Reference: 418.112 Standard # (e) Item #

Concern/Issue:
The hospice would be able to utilize the facility's nursing personnel (where permitted by the facility and by law), for the administration of prescribed therapies included in the plan of care, but only to the extent that the hospice would routinely use the services of a hospice patient's family in the implement the plan of care.

Potential Impact:
Further clarification is needed regarding bathing, performing Activities of Daily Living (ADL), and personal care. Some facility's expect hospice staff to perform these functions even though they are also required to perform them. This causes a conflict since it can be argued that some hospices currently replace facility staff to give baths, perform ADL's, and provide personal care. Strict guidance is needed so that all hospices are allowed to use facility staff or none of the hospices are. The way it is currently set up, it could be perceived that by replacing facility staff, that would be an inducement for future referrals and thus violate anti-kickback statutes.

Suggested Correction:
Further clarification and strict guidance so that all hospices interpret the intent of this paragraph the same.

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Submitter : **Mrs. Heather Schaffer** **Date: 07/04/2005**

Organization : **Hospice of the Upstate**

Category : **Hospice**

Issue Areas/Comments

GENERAL

GENERAL

To Whom it may concern: July 4, 2005

In regards to the possible enhancement of hospice services, I would emphasize the benefit of increasing counseling services to patients, family and staff before a death. Helping a family to transition in the healthiest manner would involve a counselor addressing anticipatory grief, including prior unresolved grief/ psychosocial issues compounded by the current end of life transition of the patient & family. This would be ideal for all families and is essential for many. Complementary therapy programs are now included in 60% of current hospices. The variety and breadth of approaches vary; yet clearly families who have experienced these support services report a greater satisfaction with their overall hospice experience and an increased sense of well-being. Integrating counseling services with hospice would benefit not only families; but also staff needing to process their grief on a daily basis and benefiting from emotional support and proactive development of healthy coping skills to balance stress levels and prevent secondary post traumatic stress/ compassion fatigue commonly associated with caregiver roles. The best scenario would be to simply increase counseling services by expanding the bereavement counseling services infusing their support into the day to day operations of the current hospice routine already provided or by possibly contracting for specialty complementary therapy providers in aromatherapy, art, breathing, hypnotherapy, massage, meditation, music, nutrition, relaxation techniques?If nothing else it should be suggested that a hospice partner with a counseling center to offer these beneficial support services to hospice patients, family and staff. After recently hearing Dr. Lawrence LeShan, the father of mind body medicine, share his enthusiasm based on 50 years of working with cancer patients and terminally ill patients, family and staff who care for them, I am truly inspired and a believer that it is through relating our stories and creating the life that makes us feel good that we heal?

Heather Kline Schaffer M.Ed., N.C.C., L.P.C.I., C.H.T.
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CMS-3844-P-35

Submitter : Mr. Thomas J Rowan

Date: 07/06/2005

Organization : Providence Rest Nursing Home

Category : Hospice

Issue Areas/Comments

GENERAL

GENERAL

I am responding to the proposed reforms to the Medicare Benefit that will affect how spiritual care is provided in hospice organizations.
First, I wish to respond to the propose stating that once a patient elects hospice benefits the spiritual assessment needs to be completed in four calendar days. Here we care for patients that are in long care. When a patient gets close to the end of life, we meet to decide if hospice is the best treatment. Usually, the patient cannot respond for themselves. I think it is better to have a team meeting to place a patient on hospice. Then, we know what will be provided and write a care plan. The assessment is done before the patient is on hospice.

Submitter : **Rev Barbara Lindeman** **Date: 07/06/2005**

Organization : **Immanuel St Joseph Hospice**

Category : **Other Health Care Provider**

Issue Areas/Comments

Issues 1 - 10

Personnel Qualifications

REg..418.114: As a licensed board certifed chaplain through APC and a bereavement counselor through the ADEC, I would suggest you make it mandatory that chaplains, who are also trained as counselors, bereavement co-ord., be considered for the Hospice Team. I am a bit troubled by your emphasis on social workers for bereavement and counseling, simply because there are others of us who are trained, licensed and certified to also do such work. Personally, I have trained as a counselor emphasizing death and dying, and grief, certified through the assoc of death educators and counselors, maintaining ccu's every year; AND I am also a professional chaplain and a pastor. There is a big difference between a pastor and a chaplain. Chaplains go through extensive training to become board certified, and after being certified we have to have yearly education in dealing with cultural issues, ethical issues, various religious issues, new issues concerning end of life. Our education is constantly on-going. Yet,it seems that for some reason we, as chaplains, pastoral counselors, are slighted, seen at times as kind of a 'perk' for programs; we are seldom if ever considered to be necessary health care professionals; there wasn't even a category for Rev. or Rabbi on your check in form. Because of this over-emphasis on social work as the apparent chosen career for hospice bereavement and counseling..I now know of quite a few professionals.as counselors in the field of thanatology and bereavement who are excellent, and chaplains who are also excellent who have begun work on obtaining MSW's..learning more about paperwork and of all the agencies and forms necessary for sw's. The education is almost redundant, as most are repeating what they have already learned in their own professions; and in fact, at times, have taught the professor and the students what it is really like out there in the real world.
So, as a chaplain for 17 years and a counselor for 20, I say PLEASE look at the requirements we have as chaplains and pastoral counselors and find a place, a mandatory place in hospice for nationally licensed, certified staff thru the ADEC and/or APC NACC, etc.,because they truly
prepare open minded people to serve those who are dying, to support their families in all ways; they also prepare such professionals to work with people of all backgrounds, of all religious & spiritual beliefs. Such professionals need to be part of the interdisciplinary team in order for compassion, dignity, respect, ethics, and true spirituality to continue to exist in hospice. Thank you

Submitter : **Ms. Diane Gomes** **Date: 07/06/2005**

Organization : **Home Care Services of Emanuel**

Category : **Hospice**

Issue Areas/Comments

GENERAL

GENERAL

418.76 Supervision of the Home Health aide
Historically state surveyors in California interpret the current Home Health COP's to the day, ie: if we go over 14 days by 2 or 3 days we are non-compliant, the same applies if we try to be efficient and prevent unnecessary visits by doing the supervision early. Sometimes we incur additional unnecessary costs by having to send a nurse back out specifically for the supervision visit. If we are focusing on OUTCOMES rather than micromanagement, can we not have a regulation that states that the HHA will be supervisicd on site as per policy but no less than every _______ days. Also, I would submit that every 14 days is too often. In California, HHA's must complete a state certification program and then must obtain 36 units of education every two years to renew their certification. This is more than RN's are required in CEU's. Also, per COP's, the aide must be determined competent in each facet of care at time of hire. In Hospice the HHA works closely with the interdisciplinary team on a daily basis. The regulations as written relative to HHA sucrvision are burdensome and create more paperwork. Lastly, a HHA working part time could be supervised as much as every 4th working day.

418.104 Please clarify that this applies to patients discharged from Hospice care while still alive.

418.112(d) Please state that the Hospice medical director communicates with facility medical director, patient's attending physician, and other physicians as needed to coordinate the medical care of the resident. If this clarification is not made, Hospice's will have to create a paperwork system solely to document compliance with communication, irregardless if there is any real need.

418.114 Qualifications of Social Worker
The Hospice Social Worker provides multiple services that someone with a bachelor's degree in Social Work is capable of performing.
The Social Worker continually functions as part of the interdisciplinary team, sharing and receiving input from the team members. The other team members have the skills to provide input to the social worker. I would advocate that a social worker in Hospice can function appropriately without a masters degree.

CMS-3844-P-38

Submitter : Mr. John Kirkman

Date: 07/07/2005

Organization : Metron Integrated Health System

Category : Hospice

Issue Areas/Comments

GENERAL

GENERAL

Re. Personnel Qual. for Licensed Professionals (418:114, page 30859) Please consider adding to requirements, Bachelor's Degree from accredited college or university, plus a Master's in Divinity or Master's in Theology from an accredited American Theological School, plus a minimum of one quarter of Certified Pastoral Care certified through an accredited American Theological School. This would be minimum criteria; many of us have much more, but certainly there should not be less. There are "theological" degrees, "certified ministers" and variety of certificates available on the web. "Accredited" school, university, theological school, are operative words. Thank you for this consideeration.

Submitter : Ms. Shauna Stone

Organization : Continuous Care Advocates

Category : Other Association

Date: 07/08/2005

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3844-P-39-Attach-1.DOC

"II. Background (pg 30840)
A. The Medicare Hospice Benefit
Hospice care is an approach to caring for the terminally ill individual that provides palliative care rather than traditional medical care and curative treatment. Palliative care is treatment for the relief of pain and other uncomfortable symptoms through the appropriate coordination of all aspects of care needed to maximize personal comfort and relieve distress. **Hospice care allows the patient to remain at home as long as possible by providing support to the patient and family, and keeping the patient as comfortable as possible while maintaining his or her dignity and quality of life.**" (Proposed Hospice Conditions of Participation as published on May 27, 2005)

This explanation of the hospice benefit is designed to be the framework that the rest of the legislation is to build upon. The emphasis placed on patient comfort and dignity resonates through out the entirety of the Conditions of Participation with the exception of the way that outside staffing is handled when dealing with continuous care.

"We believe that the new MMA provision authorizes us to propose that hospices may not routinely contract for a specific level of care (e.g., continuous care) or for specific hours of care (e.g., evenings and week-ends), as these are regularly occurring situations that hospices are able to plan staffing for." Pg 30850

Unfortunately the authors of this passage are incorrect about a hospice's ability to "plan staffing for" continuous care for two main reasons.

Continuous Care Patient Census Are Extremely Unstable
According to previous regulations continuous care is only to be given to patients in crisis that need eight or more hours of nursing care per day to be maintained at home. By their very definition continuous care patients are critical unstable patients. It has been our experience that continuous care patients survive an average of three to four days before passing on, and have the habit of going into a period of crisis which necessitates continuous care at very inconvenient times for their hospice provider. Hence, ***<u>Continuous Care Patient Census Are Not Stable and Are Not Predictable</u>***. A hospice can literally have 6 continuous care patients on Friday, 10 by Saturday, and 3 by Tuesday. Exactly how is a hospice supposed to plan staffing for continuous care patients if they cannot predict how many continuous care patients they are going to have?

Continuous Care Shifts are Generally 12 Hour Shifts
In order to maintain consistency of staff with a patient and their family that is facing immanent death, Continuous Care Shifts normally last 12 hours, with a CNA during the day and a LVN at night. The average routine visit lasts a little longer than an hour making it easy for a hospice to request a staff member to take on an extra routine visit when the hospice is running short on staff. Obviously it is not possible to request a staff member to take on an extra 12 hour continuous care shifts on top of their previously scheduled routine care visits, making continuous care once again significantly more difficult to staff for than routine care.

If a hospice is going to "provide support to the patient and family, and keep the patient as comfortable as possible while maintaining his or her dignity and quality of life", they need to be allowed to use any experienced qualified nurses they can find, otherwise you are holding them to a standard that is impossible to live up to unless they use the tools that you have forbidden them to use. If the reason for this restriction on the use of staffing agencies stems from anxiety regarding the quality of staff provided by staffing agencies than why include the following in the conditions of participation?
"As with all other contracting arrangements, the hospice would be required to maintain professional management responsibility for the service(s) being provided under arrangement as well as the individual(s) providing them. " pg3085
If there is still a question of quality provided by staffing agencies who care for hospice patients, the answer to ensuring quality of patient care is not banning legitimate and needed uses of outside agency such as in the realm of continuous care, but instead overseeing them. Why not survey staffing agencies for the right to see hospice patients? If the staffing agency is enforcing the standards set for in the conditions of participation than your anxieties are eased with a survey, if a staffing agency is not living up to those standards than they can be forced to shape up or stop seeing hospice patients. Either way quality of care for hospice patients is improved and more patients gain access to the care that they need.

In conclusion you stipulate that "*The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of terminal illness.*
(a) Standard: Serving the hospice patient and family. The hospice must ensure--
(1) *That each patient receives and experiences hospice care that* ***optimizes comfort and dignity; and***
(2) ***That each patient experience hospice care that is consistent with patient and family needs and desires.*** *"* (Sec 418.100)

Unfortunately nurses do not take turns being sick or having family emergencies, and patients do not wait their turn to enter into periods of crises. If you truly want a hospice to live up to the standards quoted above for all their patients, continuous care patients included, you must find a way to allow hospices access to the quality nurses that they need when they are short on staff, otherwise those standards are simply unobtainable.

Thank you for your time,

Submitter : **Mrs. Kimberly Lawrence** **Date: 07/08/2005**

Organization : **Continuous Care Solutions**

Category : **Other Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3844-P-40-Attach-1.DOC

Comments for CMS-3844-P

Medicare and Medicaid Programs:
Hospice Conditions of Participation

June 27, 2005

Patient's Rights – Proposed §418.52
Proposed **§418.52** states:

> © *Standard: Pain management and symptom control.* The patient has a right to receive effective pain management and symptom control from the hospice.
>
> It is also stated on page 30844 of the explanation section that, "We are proposing to specify that the patient must also be informed about factors that affect palliation and comfort."

I am very glad that you are addressing the very real concern that critically ill hospice patients and their loved ones have about pain management and patient comfort, especially in the last stages of a terminal illness. I think this is a wonderful concept, but I do have some concerns. Does it go far enough to ensure that all hospice patients are informed of their continuous care benefit rights? Also, will it guarantee that all patients who qualify for and want their continuous care hospice benefit receive the care they need?

Since the purpose of hospice is to allow the terminally ill patient the ability to die with dignity at home, surrounded by loved ones, is seems to be contradictory to force hospices into a no-win situation. If a dying patient as a condition that warrants continuous care, and the hospice does not have the staff to provide that level of care, the hospice must (1)- deny continuous care, and force the patient's loved ones to try to deal with the critical situation alone (2)- force the patient into the hospital to die – away from friends and family; or (3)- use qualified agency nurses to provide the care, which the new CoPs clearly state is not allowed.

Conditions of Participation: Core Services
Proposed §418.64

Why not? Why can the hospice contract almost every other specialty nursing service except for continuous care? According to the explanation on page 30851 of proposed CoPs §418.64(b), continuous care nursing "does not require highly specialized nursing skills". I must respectfully disagree with that statement. To be able to sit for 12 hours at a time, with a terminally ill and probably actively dying patient, probably need to assess the pain level of an unconscious patient and administer appropriate pain medication, help the patient's friends and family handle the emotional stress and grief of watching a loved one pass away, and be calm, caring and professional throughout – that is not something every nurse can do. It is not even something every hospice nurse can do. It requires a special person, with very specialized nursing skills. Continuous Care nursing should be

classified as the specialized skill that it is, and thusly allow hospices to use contract nurses to fill this vital role.

Also at issue in the explanation of Proposed §418.64 is the statement, "We believe that the new MMA provision authorizes us to propose that hospices may not routinely contract for a specific level of care (*e.g.*, continuous care) or for specific hours of care (*e.g.*, evenings or week-ends), as these are regularly occurring situations that hospices are able to plan staffing for." I do not understand how a hospice can plan for continuous care. Since continuous care is warranted only when a patient's symptoms become uncontrolled, for example, severe pain, unrelenting nausea and vomiting, acute respiratory distress, etc., continuous care, by its very nature, is unpredictable. How can a hospice be expected to predict when a patient will experience break-though pain or go into repertory distress? How can they predict how many of their patients might have these issues at the exact same time? While I agree that the hospice can and should have staff available to handle their AVERAGE continuous care patient load, it is unreasonable to expect them to be able to plan for and schedule patient crisis situations. The costs of maintaining employees on staff to handle potential peak patient load situations is simply too cost prohibitive. Is it really reasonable to ask a hospice to pay 2-4 extra permanent staff nurses every day for a situation that may only happen once or twice a week, or a month?

By agreeing that continuous care nursing is a specialized skill and allowing hospices to use contract staff when they experience peak patient loads, you will take great strides in insuring that all hospice patients receive the level and quality of care that they deserve. After all, it's all about allowing these terminally ill patients the right to die with dignity, in their own homes, surrounded by the one's they love.

Thank you for your time and consideration.

CMS-3844-P-41

Submitter : Mr. Sam Stone

Date: 07/08/2005

Organization : United Hospice Services

Category : Other 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 :

Date: 07/11/2005

Organization : **Ohio Department of Health**

Category : **State Government**

Issue Areas/Comments

GENERAL

GENERAL

Sec Attachment

CMS-3844-P-42-Attach-1.DOC

The Ohio Department of Health ("ODH") has reviewed the draft rules regarding Hospice Conditions of Participation ("CoP"). At the outset, ODH notes that the reorganization of the CoPs (particularly the "groupings") will increase the effectiveness and efficiency of hospice program surveys. ODH also has the following comments:

Quality Assessment and Performance Improvement ("QAPI").

1) The introduction of QAPI increases the likelihood that the industry will argue that the mere practice of QAPI is sufficient to demonstrate compliance. For example, hospices may point to their QAPI policies and procedures as proof of compliance, and may be reluctant to share information about their performance improvement efforts or "lessons learned" from such measures for fear that both will be used against them by regulatory agencies.

2) Although an "outcome oriented" QAPI program is an appropriate and needed change, there must be some measurable means of evaluating the program. It will be difficult for the state agency and CMS to fully evaluate a hospice program's responsiveness to the "needs, desires, and satisfaction levels of the patients and families it serves" unless the hospice program provides full disclosure of its quality improvement activities. A QAPI program that lacks a viable means of evaluation will raise serious questions about the program's appropriateness and adequacy.

   Along similar lines, ODH believes that the Conditions of Participation appropriately require hospices to develop and implement a data-driven QAPI program. However, ODH also respectfully submits that the Conditions of Participation cannot assure the maintenance of an effective QAPI program without appropriate external oversight.

3) While the standards set forth in draft Section 418.58 require a program to be able to show "measurable improvement," the indicators that can be used to show compliance may be "cloaked" by HIPAA, state confidentiality laws, or patient privacy concerns. If the primary goal of the QAPI standard is to "identify and correct ineffective and/or unsafe care," the hospice program's identification, analysis, and application of lessons learned in the interest of performance improvement must be fully accessible to those evaluating the CoP.

4) The language in draft Section 418.58(e) places an obligation on the governing body to fully support the program's QAPI efforts. The language states that the governing body's "most important role is to ensure that staff is furnishing and patients are receiving the most appropriate levels of care." CMS and the state agency must not only be able to ensure that a hospice program has the appropriate mechanism in place for achieving the latter goal, but that the results of all QAPI efforts are being properly shared with staff and appropriately applied in all relevant patient care.

5) In conclusion, the proposed Conditions of Participation are an improvement over the current "problem-oriented" approach. However, CMS should consider whether the proposed Conditions of Participation may, in effect, lessen the ability of CMS and the state agency to oversee a program's QAPI activities if the industry exercises peer review and is reluctant to share "root cause analysis" findings with regulatory agencies.

Hospice Care In Other Facilities.

1) ODH reviewed the provisions set forth in draft Section 418.112. Based upon its experiences with home hemodialysis in nursing facilities, ODH respectfully suggests that CMS also issue a Survey & Certification letter clearly delineating which entity (the hospice program or the nursing facility) will be responsible for each aspect of hospice care. To cite an example, absent additional guidance/instructions, it will be difficult to interpret and implement provisions allowing a hospice to use a facility's nursing personnel for the administration of prescribed therapies included in the plan of correction. Such provisions can be a "slippery slope."

2) ODH believes that written agreements between a hospice and a nursing facility (see draft Section 418.112(e)) will not sufficiently guarantee that each is carrying out its duties and responsibilities unless there is frequent onsite verification.

3) Language stating that the hospice staff is responsible for training facility staff sounds good in theory. However, ODH believes that the unique nature of hospice care (e.g., patient comfort, pain control and symptoms management) along with high turnover among the trainers (hospice staff) and successfully trained facility staff make implementation of this requirement difficult.

Thank you for the opportunity to review the draft Hospice Conditions of Participation. If you have any questions or require additional information, please do not hesitate to contact ODH's Division of Quality Assurance at (614) 466-4627.

Submitter : Mr. Dennis Griffin

Date: 07/12/2005

Organization : Community Hospice of Northeast Florida

Category : Hospice

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3844-P-43-Attach-1.DOC

Attachment #43

Reference: CMS-3844-P

www.cms.hss.gov/regulations/ecomments

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-38844-P
P.O. Box 8010
Baltimore, MD 21244-8010

Submitted By:
Community Hospice of Northeast Florida
4266 Sunbeam Rd
Jacksonville, Fl 32257
Medicare Provider Number: 101500
Dennis Griffin
AVP Operations

OUTCOME-BASED PERFORMANCE MEASURES

We think the change to a patient centered, outcome-oriented process that results in improved outcomes is very positive. We support this change

418.3 Definitions

"Satellite location" – Medicare approved location from which the hospice provides hospice care and services…is part of the hospice and shares administration, supervision and services…

Would every location providing a service be a "satellite"? I.E. office where administrative personnel are located, office housing medical records, office housing a team in a community, supply warehouse, DME facility, pharmacy.

PATIENTS RIGHTS

418.52 (a)

The requirement that the hospice provide verbal and written notice in a language and manner that the patient understands would require the publication of all materials in multiple languages. We would prefer the standard to require verbal notice and verbal translation of written materials provided.

ASSESSMENT TIME FRAMES

418.54(a) and (b)

We support the separation of the immediate need – initial assessment and the comprehensive assessment within 4 days. This will allow for an improved admission process and permit adequate time to gather all information needed for the comprehensive assessment. We would recommend that the medical director's certification of terminal illness be completed in conjunction with the comprehensive assessment.

OUTCOME MEASURES
The development of data elements that measure aspects of care essential to optimal hospice care will require significant effort. To require that they are part of the initial and comprehensive assessment may limit the use of useful data elements in the QAPI process.

PLAN OF CARE
418.56(a) (2)
The administration (Clinical, Medical director, compliance, quality improvement, etc) not the interdisciplinary group should establish policies governing the day-to-day provision of hospice care and services.
418.56(c)(6)
The requirement for patient and family understanding, involvement, and agreement with the plan of care is not always possible. Sometimes there is disagreement between a patient and family members on the plan of care to be followed.

COORDINATION OF SERVICES
418.56(e)
The hospice's ability to ensure "the IDG maintains responsibility for directing, coordinating and supervising the care provided" and "the sharing of information between all disciplines providing care" with nursing facilities and contracted inpatient hospital beds is limited under current regulations and practices.

QAPI
418.58
The comments solicited by CMS in this section require more preparation and development than is possible in the existing timeframe for response. We would hope that the COP language would be broad enough to allow flexibility in developing specific quality indicators and data elements over time.

INFECTION CONTROL
418.60
We support this section

CORE SERVICES
418.64(a) (b)
We would like to see the use of physician assistants included, similar to the authority to see, treat, and write orders for patients allowed for nurse practitioners.

ORGANIZATION AND ADMINISTRATION
418.100(F)(1) Hospice satellite locations

1. As a large hospice serving a large geographical area, we have multiple locations performing different functions. Medical records, information technology, medical supply and DME, administration, nursing administration, community based team offices, and multiple residential and inpatient facilities currently exist. Would each be considered a "Satellite location"? Since the focus is on the care delivered to the patient whereever that patient resides we

do not see a need for CMS approval for offices that have a supporting role. With our decentralized structure, we are concerned this definition will restrict our ability to accommodate growth and community needs.

2. Need information on what is involved in the approval process.

MEDICAL DIRECTOR
418.102
The requirement for the medical director to coordinate the medical care in its entirety will have an impact on the staffing requirements for medical director.

CLINICAL RECORDS
418.104(E)(1)(2)
Providing a copy of the complete clinical record upon discharge or transfer is not necessary or wanted by the new facility or the attending physician. The discharge summary provides the needed information and the condition should require the clinical record be provided when requested.

INPATIENT CARE
418.108(c) (5) Short- term inpatient care
The requirement that the hospice arrange training of personnel in contracted facilities should have some leniency since the hospice has no control over the staff of the facility.
418.110 (c)(1) Physical environment
The requirement to report all incidents should be changed to require reporting significant or sentinel events. The state regulatory agency is not requiring reports on every minor equipment failure.
418.110(m) Pharmaceutical services
(n) Pharmacist
These standards should be included in 408.106 and apply to all patients receiving hospice services.

RESIDENTS RESIDING IN A FACILITY
418.112(d) Medical director
This will require additional hospice medical director staffing and may conflict with the facility medical director's requirements.

418.112(h)
The discharge or revocation of a patient results from situations that are unrelated to the eligibility to continue to reside in a facility. The eligibility is determined by the facility and beyond the control of the hospice.

Submitter : **Jane Witte**

Date: 07/13/2005

Organization : **Lighthouse Hospice**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

It has been suggested that the social work assessment be completed within 4 days of patient admittance to the program. This timeframe is too short as it doesn't take into consideration the constraints weekends impose. The current 7 days requirement gives the social worker time to work new patients into their schedule of visits with ongoing patients.

Thank you for your consideration.

Submitter : **Mr. John L. Martin**

Date: 07/14/2005

Organization : **Bon Secours Richmond Hospital System**

Category : **Hospital**

Issue Areas/Comments

Issues 1 - 10

Personnel Qualifications

Subject: Personnel Qualifactions for licensed Professionals: Qualifications for Spiritual Care Counselor/chaplain.

"these (professionals) must be licensed or certified to practice in the state": I have three units of Clinical Pastoral Education (currently most hospitals require a minimum of two); I have been endorsed to work as a chaplain by my national faith institution and I have over 5 years experience working in both a hospital and hospice setting as a chaplain as a lay person.
Under the proposed guidelines, I would be excluded from following my avocation and would have to leave the health care field. I primarily work on call hours as a PRN(part time)chaplain in two major hospital systems. If there are no provisions to allow people like me to assist full time personnel, You will end up with a substanitial number of people leaving the field due to burn out and the quality of care will suffer.

It is naive to think that you can fill the ranks totally with Board Certified people. I believe that there should be some latitude to allow hospital systems to develop or continue to use criteria that is currently in place.
Most ordination processes in the Christianand Jewish traditions that I have knowledge of require one unit of CPE as part of their course work. This means that litle or none of the majority of ministers and Rabbis would be qualified as well.
There should be some dispensation for actual experience in the field.

Submitter : **Ms. Melanie Childers**

Date: 07/15/2005

Organization : **Watauga Medical Center, Boone, NC**

Category : **Health Care Provider/Association**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3844-P-46-Attach-1.DOC

July 15, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Attention: CMS-3844-P

Dear Sirs:

Thank you for the invitation to respond to the new Medicare and Medicaid standards for Hospice. I am a member of the Association of Professional Chaplains, which serves and certifies chaplains in all types of health and human service settings. Almost 4,000 members are chaplains involved in pastoral care, representing more than 150 faith groups. As a national, not-for-profit professional association, the APC advocates for quality spiritual care of all persons in healthcare facilities, correctional institutions, long term care units, rehabilitation centers, hospice, the military, and other specialized settings. For more information about the APC or further information regarding the comments below, visit our website at http://www.professionalchaplains.org, or contact our Executive Director, Jo Schrader, at 847-240-1014.

I would like to applaud CMS's awareness of and commitment to the inclusion of meeting the spiritual and emotional needs of hospice patients and families and addressing patient rights and the continuum of care. I would encourage the acknowledgement that spiritual needs--just as medical, social, physical, and psychosocial needs--depends upon the delivery of outcome-based, patient centered care by trained and certified professionals who are specialists in spirituality. While the proposed rules identify "spiritual needs" and "spiritual counseling," what is lacking is more specific standards regarding who is qualified to provide these services. The proposed rules, in the use of terms such as "clergy", which is a specifically Christian term, fails to acknowledge and provide care for the needs of patients of other religious and spiritual traditions, and I would encourage CMS to utilize language that is more inclusive. I would also encourage CMS to acknowledge the importance of providing for patient and family cultural needs (spiritual and religious needs are, while essential, only one part of a person's culture). There are no specific standards within the rules that require hospices to assess and be attentive and sensitive to cultural needs, such as dietary, space, and treatment.

Professional spiritual care providers are board certified by national professional groups, and I would recommend that the proposed rules include this requirement of those providing spiritual care and counseling in all hospice settings. This way anyone serving in the role of spiritual care provider has the endorsement of a faith group, ordination, graduate-level training, and specific clinical pastoral education. It provides accountability and assures that professional-level care will be given.

Patient and families in a hospice setting face the vulnerability of loss, grief, and transition everyday. Assuring that they are cared for by professionally-trained, nationally certified chaplains will eliminate the risks of having well-intentioned volunteers who, due to lack of training, actually inhibit the patient and families' movement toward wholeness and peaceful death.

While community religious leaders provide gifts in the provision of religious care to hospice patients and families, professionally trained and certified spiritual care providers bring to the hospice environment the

skills to provide spiritual assessment, an outcome-based spiritual plan of care and interventions based on professional spiritual care standards of practice, the ability to work effectively within an interdisciplinary team, and specialty in loss, grief, and bereavement care and counseling. Board certified chaplains work with community religious leaders to facilitate their care to their religious community members, while also serving as an educator and facilitator of the hospice environment and specialist in the unique spiritual and emotional needs of hospice patients and families.

In conclusion, I recommend that standards be included to require hospices to employ trained and certified professional chaplains in order to meet clearly and effectively all of the proposed rules. Please feel free to contact me or the Association of Professional Chaplains if we may be of further assistance to you.

Sincerely,

Rev. Melanie Childers, BCC
Director of Pastoral Care
Watauga Medical Center
PO Box 2600
Boone, NC 28607
828 266-1178

Submitter : Mr. George Hankins Hull

Date: 07/16/2005

Organization : College of Pastoral Supervision & Psychotherapy

Category : Religious Nonmedical Health Care Institution

Issue Areas/Comments

GENERAL

GENERAL

SEE ATTACHMENT

CMS-3844-P-47-Attach-1.RTF

CMS-3844-P-47-Attach-2.RTF

The College of Pastoral Supervision & Psychotherapy, Inc.

P.O. Box 162 . 432 West 47th Street . Suite 2-West . New York, NY 10036 . Phone: (212) 307-1573

July 15, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-185

Reference:CMS-3844-P

The College of Pastoral Supervision and Psychotherapy (CPSP) welcomes the opportunity to comment on the proposed CMS changes governing the provision of hospice services. CPSP commends CMS for stressing the importance of a broad interdisciplinary approach to patients, which includes pastoral care.

The standards, constitution, code of ethics and policies and procedures of CPSP are available on our web site at http://cpsp.org/ for public examination.

The provision of Pastoral Care and Counseling:
Pastoral care and counseling, also known as religious or spiritual care, is the only clinical discipline that is not science based. CPSP understands that this presents a special problem for those evaluating the competency of individuals providing such services.

The value of religious, spiritual, and pastoral services is widely recognized but very difficult to assess and evaluate. CPSP grants Board Certification for Clinical Chaplains on the basis five primary standards: academic education, clinical pastoral education, personal interview, conformity with standards and ethics, and continuing education through ongoing Chapter life. All credentials are required to be renewed annually.

Certifying and Accrediting Organizations:
In the alphabet soup of certifying and accrediting organizations, CPSP is one significant and recognized national organization. CPSP is an active member of Coalition on Ministry in Specialized Settings (COMISS). We remain committed to COMISS as the only roundtable where
clinical organizations, religious endorsing bodies, and academic institutions meet to work on common interests and concerns. COMISS has managed to bring the disparate groups into dialogue and common projects, and has generally supported the work of a very wide range of organizations. We regret recent efforts to diminish the value of COMISS by a

subgroup of organizations pursuing self-promotion.

CPSP is also a member organization of the Liaison Network of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

We in CPSP appreciate the particular burden on CMS in efforts to assess religious and spiritual services, and to see that they are delivered in a competent, professional manner.

We in CPSP believe that a part of the burden that CMS faces is the innate tendency among religious groups toward exclusionist claims. Religionists often do not seem able to help themselves in this regard. Regrettably, the illusion of possessing the one and only true religious
doctrine will not likely be exorcised in the near future. This trait also extends itself to certifying and accrediting organizations, as well as coalitions of such organizations, who posture themselves implicitly and sometimes explicitly, as the only legitimate accrediting organizations.

The Danger of a Franchise:
A "franchise" from CMS would represent a windfall for any organization or group of organizations that received it. We urge CMS to maintain its past practice of open-handed inclusive posture in relating to nationally recognized certifying organizations, and to avoid franchising any particular organization or coalition of organizations.

We in CPSP urge CMS to remain focused on substance, and remain undistracted by the jockeying of the alphabet groups for power and status.

SPECIFIC COMMENTS:

Proposed 418.62: LICENSED PROFESSIONAL SERVICES

Competency in Pastoral Care:

The basic requirements in CPSP for certification as Board Certified Clinical Chaplain:

1. The characterological make-up for ministry, including an ability to bond with others, an ability to give attention to others, and a tolerance for diverse religious traditions and values.
2. Basic self-understanding, so as to limit unconscious imposition of one's own agenda on others.
3. Endorsement by a faith-group community to perform ministry.
4. 1600 hours of clinically supervised ministry or a year of Clinical Pastoral Education.
5. Continuing education and annual recertification.
6. A Master of Divinity degree or equivalent, which means three years of

post-graduate academic study.

CPSP also offers "Associate Clinical Chaplain" certification for those who meet all requirements *except* the M.Div. or equivalent.

We encourage CMS to recognize Associate Clinical Chaplain, Board Certified, as an entry level basic certification. The rationale for this request is two-fold. Academic training, while very useful, is not essential for a person's ability to provide competent pastoral care at a basic level. And in many parts of the country, access to post-graduate theological education is difficult, requiring relocation. The cost of such an educational course does not seem to match the benefit for certain individuals.

Proposed 418.52: PATIENT RIGHTS

Access to Pastoral Care:
CPSP affirms the right of the of the hospice patient and their loved ones to have access to pastoral care that is directed in accordance with the patient's and their family's faith tradition. CPSP affirms the right of the hospice patient to have that care provided by a religious professional from the patient's own faith tradition. CPSP advocates that religious professionals employed by the hospice program work cooperatively with parish clergy so as to facilitate ongoing pastoral support by community clergy. CPSP acknowledges the hospice patient's right to refuse the provision of pastoral services.

Proposed 418.54: COMPREHENSIVE ASSESSMENT OF THE PATIENT

Pastoral Evaluation in the Clinical Pastoral Tradition:
CPSP affirms that pastoral care, in the clinical pastoral tradition, must include personal evaluation with the specific purpose of bringing the appropriate pastoral resources to bear. CPSP advocates for a dynamic process of pastoral assessment over against the use of a written
instrument that requires nothing more than the recording of a patient's answer to a predetermined set of questions. CPSP affirms the communication of the pastoral evaluation of the patient's and family's pastoral needs to the interdisciplinary team.

Proposed 418.56: PLAN OF CARE AND COORDINATION OF SERVICES

The Interdisciplinary Approach to Patient Care:
CPSP supports an interdisciplinary approach to patient care as in the best interest of the patient and the patient's loved ones. CPSP is pleased that CMS has made provision in its proposed rules for hospice that includes the delivery of pastoral services. CPSP supports the concept that the interdisciplinary team in its entirety must supervise the delivery of care and services. CPSP acknowledges that bereavement support is something that the whole interdisciplinary team engages in and not just that of the pastoral provider.

Conclusion:
CPSP is grateful to CMS for this opportunity to comment upon the proposed changes to

provision of hospice services as they pertain to the delivery of pastoral care. We affirm the right of the hospice patient to have access to comprehensive set of hospice services provided in an
interdisciplinary team approach to patient care. We further support the hospice patient's right to be a partner in their treatment plan so as to determine the goals of the care.

The leadership of CPSP stands ready to respond to any questions or concerns that CMS may have. Please feel free to summon us at your convenience for clarifications or explanations of our certifying and accrediting procedures.

Respectfully submitted,

Raymond J Lawrence Jr.
General Secretary
Email: Raymondlawrence@cpsp.org

Richard Liew
President
Email: rliew@ehs.org

Submitter : **Mrs. Jill Takes** **Date: 07/16/2005**

Organization : **Comfort Care Hospice**

Category : **Social Worker**

Issue Areas/Comments

Issues 1 - 10

Social Work

I am responding to the proposed changes for the qualifications for social workers in hospice care. I am an LMSW (Licensed Master Social Worker) and recently began working for a hospice agency in Cameron, Missouri. I do believe that hospice social workers should be master-level professionals. They are part of the core care team and carry out very important services for patients and their families. If the only responsibility of the social worker was to access resources, I believe a BSW level person would be adequate, but that does not describe the true nature and scope of this work. Social workers in hospice care also act as grief counselors, family therapists, and bereavement counselors, educators, and advocates. We wear many hats. The initial intervention with the patient, and later with the survivors, may have lasting and profound impact on subsequent grieving. This is a highly stressful and pivitol time in the lives of the patients and families that we serve, and they deserve to be supported by highly trained professionals.

Thank you,
Jill E. Takes, LMSW
4706 Lakeridge Court
St. Joseph, MO 64506

Submitter : **Mr. David Plummer** **Date: 07/17/2005**

Organization : **COMISS Network**

Category : **Other Health Care Professional**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3844-P-49-Attach-1.DOC

COMISS – The Network on Ministry in Specialized Settings

P.O. Box 5432, Hampton, VA 23667
Phone: 757-728-3180 * Fax: 707-929-7388
E-Mail: info@comissnetwork.org

Attachment #49

July 16, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, Maryland 21244-1850

Attention: CMS-3844-P

Dear Sirs:

Background

Founded as the Council on Ministry in Specialized Settings in June of 1979, the COMISS Network – the Network on Ministry in Specialized Settings – is a national organization of chaplaincy, pastoral care, and pastoral counseling stakeholders. The organization has been known as the Council, Congress, Coalition, and, now, Network on Ministry in Specialized Settings, or less formally, the COMISS Network.

The COMISS Network is the product of many years of interfaith cooperation in the development and delivery of pastoral services to persons in a variety of specialized ministry settings, including Hospice. Other ministries are chaplaincies in health care facilities, correctional institutions, mental health settings, pastoral counseling, the armed forces, business settings, industrial settings, clinical pastoral education, the National Conference on Ministry to the Armed Forces, denominations and faith groups which credential military and civilian chaplains across the country, and the Department of Veterans Affairs. Our constituent members are the leaders of the professional pastoral care community, and they represent ***tens of thousands of professional chaplains and pastoral counselors*** serving in various settings across the country, in addition to the ***millions of lay people*** who form the congregations that our member Religious Endorsing Body Representatives actively represent.

The Vision of the COMISS Network is to be a pre-eminent network, a unified voice for the preparation and practice of spiritual care through chaplaincy and pastoral counseling. The Mission of COMISS Network is to be a network of professional organizations, institutions, and faith communities that promotes and supports collaboration among its membership and is the collective voice of advocacy to a variety of publics on behalf of the Network. COMISS Network is a forum for dialogue and action among five distinct pastoral care and counseling communities:

1. Professional Certification Organizations, which certify professional board chaplains and pastoral counselors to perform ministry activities in specialized settings.

2. Professional Accreditation Organizations, which accredit programs to train clergy (lay people) on their way to becoming professional chaplains or pastoral counselors.

3. Religious Endorsing Bodies [American denominations and faith groups], which endorse professional chaplains and pastoral counselors to perform ministry in specialized settings.

4. Professional Pastoral Care Organizations, which exist as groups of chaplains and/or other pastoral care professionals whose work focuses on ministry in specialized settings.

5. Chaplain and Pastoral Care Counselor Employing Organizations, which utilize the services of chaplains or pastoral counselors certified by one of the certifying organizations of the COMISS Network.

These five distinct communities share a common commitment to the value of religious faith/cultural differences and beliefs in the shaping of the individual and community life. In addition, they share a common will to make available appropriate ministry, counseling in specialized settings, ministry counseling characterized by the highest levels of professionalism, loving service, mutual trust, mutual support, integrity, and justice.

Current COMISS Network Initiatives

The COMISS Commission for Accreditation of Pastoral Services (CCAPS) provides accreditation for health care organizations involved in the delivery of pastoral/spiritual care in specialized settings. The Commission is concerned with the development and application of professional standards for pastoral/spiritual care departments. CCAPS will attest to the ability of a facility and its pastoral/spiritual services to meet the standards for accreditation of pastoral/spiritual care services developed by the COMISS Network. Although accreditation of the health care organization's pastoral services by CCAPS is a voluntary process, accreditation of a health care facility's pastoral/spiritual services demonstrates a commitment to providing quality, holistic, cost-effective care. Accreditation sends an important message to consumers about their health and the importance of choosing a health care facility that emphasizes the delivery of excellent care – physical, holistic, and spiritual.

Pastoral Care Week

In 1983 the National Association of Catholic Chaplains passed a resolution to establish a Pastoral Care Week. The first Pastoral Care Week was held in October 1985. In December 1986, COMISS recommended at its annual meeting to establish a committee to implement a National Pastoral Care Week. Since then it has grown beyond national to international proportions. The celebration of Pastoral Care Week provides an opportunity for chaplains and pastoral counselors, educators and providers, to share their story and to celebrate various ministries. Each year a new theme brings to light a certain aspect of pastoral/spiritual care as a focus. A new theme invites us to new and creative ways to tell the story of pastoral/spiritual care. Pastoral Care Week recognizes and highlights professional chaplaincy and pastoral/spiritual care in specialized settings.

Regarding the CMS Proposed Rules

As CMS studies the proposed rules, including revision of the conditions of participation in the Medicare/Medicaid programs for Hospice, COMISS strongly recommends that conditions for participation include the following:

1. That the spiritual caregivers be professionally trained and nationally certified as board certified chaplains.

2. That board certified chaplains be recognized as spiritual and professional advocates for patients' rights, especially in areas of illness, end of life issues, and ethical decisions. (Proposed 418.52)

3. Board certified chaplains are trained to provide spiritual assessments that identify issues, interventions, and specific outcomes to meet the unique needs of each hospice patient and their family. Additionally, board certified chaplains are trained in how to document in both clinical and progress notes in ways that articulate clearly to the entire interdisciplinary team what spiritual issues may impact the overall care of the patient and family. Professional chaplains are guided by and adhere to national standards of practice in assessment, interventions regarding spiritual distress, loss, bereavement, coping, and the use of religious and spiritual resources identified by the patient and family. (Proposed 418.54)

4. That board certified chaplains have appropriate skills in documentation, the writing of spiritual care plans, and have effective communication skills. (Proposed 418.56)

5. That board certified chaplains engage in quality assessment and performance improvement, using their resources and skills in projects, assignments, and planning guided by professional practice standards applicable to hospice care. (Proposed 418.58)

6. That board certified chaplains offer training and oversight to volunteers, especially those who provide spiritual and emotional support to patients, families, and friends. (Proposed 418.78)

7. That board certified chaplains maintain national standards of practice in order to organize, manage, and administer spiritual care to patients, families, and staff within the hospice environment while maintaining dignity, comfort, and advocacy for those they serve. They serve as teachers to the disciplines that serve the patients and families, explaining patient rights, advance directives, end of life issues, ethical decisions, and cultural, religious, and spiritual needs. (Proposed 418.100)

8. Board certified chaplains are trained to use inclusive language, thus honoring the spiritual and religious traditions of the patient and the family. Rather than use the word "clergy" (which is a Christian term) we support the use of the term "Board Certified Chaplain" for those employed by the hospice and "community religious leaders" for those who serve as community support and/or volunteers.

9. Board certified chaplains are trained in sensitivity and awareness of cultural issues. It is important, especially to those in hospice and other facilities, that their rights be observed and respected as far as possible. Certain dietary restrictions or needs, places for meditation, other spiritual or religious rituals, and responding to their cultural diversities, will help the patient and family sense the caring and understanding by staff of what is important to them during this sacred time.

Finally, we thank you for giving us the opportunity to comment on CMS-3844-P. We have included copies of our COMISS CCAPS Standards for the accreditation of Pastoral Services and an Accreditation Process Summary. If you have any questions, please visit our website at www.COMISSNetwork.org, or email us at info@comissnetwork.org or contact our office at 757-728-3180, and ask to speak with our Executive Administrator, Chaplain Will Kinnaird.

Respectfully submitted,

Rev. George A. Langhorne, Ed.D.
COMISS Network Chair

Attachment COMISS Network's CCAPS Standards for Accrediting Pastoral Services
COMISS Network's CCAPS Accreditation Process Summary

Submitter : Mrs. Judy Chastain

Date: 07/17/2005

Organization : Mrs. Judy Chastain

Category : Social Worker

Issue Areas/Comments

Issues 1 - 10

Social Work

Would MSW's provide a higher level of care? Yes, masters level social social workers can do diagnostic evaluations of patients and their care givers/families. BSW's can do assessments. MSW's can get to the important issues more quickly and provide intervention as they interview.
Should CMS require 1 year health care experience for any level social worker? No That should be an agency preference. In rural areas with limited numbers of social workers available we need the option to hire new graduates.
Should CMS allow social work assistants with bachelor's degree to function under the supervision of MSW? Yes but any social work assisitant should hold a BSW from an CSWE accredited program in social work.
If social work assistants with other degrees are allowed to work under an MSW if would be devistating in ARkansas. It would over burden MSW's and make the program more expensive to find enough MSW's supervisors graphically close enough to assistants to provide the necessary and appropriate supervision. Other degrees are not trained in person-in-environment and systems approach which is so helpful in hospice.
Would increasing the qualifications while allowing social work assistants with BSW's impact pt access to social work. Yes In AR we would have trouble getting MSW's in each of our positions but the higher the requirements the better the service to pts. Setting a high standard with some flexability has got to be a good thing.
Would employing MSW's and BSW's offer flexibility to meet the needs of pt and families? Yes I think AR still needs the flexibility of both levels of CSWE accredited social workers. AR requires licensing of social workers but some have been grandfathered in with no test and no degree requirements.
MSW's should be the perferred level of social work practice in Hospice but we need the flexibility of using BSW's so that no area goes unserved because of lack of availability of a qualified masters social worker.
I work in a state agency and continually fight the battle of low salary. There is a state level LCSW licensed social worker that supervises all Hospice social workers that work for the state health department.
Thank you

Submitter : Mrs. Mary Sue McNutt

Date: 07/17/2005

Organization : ADH

Category : Social Worker

Issue Areas/Comments

Issues 1 - 10

Social Work

1. If MSWs only do supervision of BSWs, my opinion is that it will impact SW services because a great deal of our emotional support, guidance work is in the 'here and now' especially spiritual issues.

2. I understand that MSWs (if available) may do the hospice visits, but if BSWs are allowed, they can be hired at a lower salary. So if we choose to do that, we as MSWs are usually working at a lower salary than we could in other areas of SW.

3. Supervision of BSWs could be done, especially in the ADH setting of hospice, with an MSW for perhaps 2 areas, making supervision visits with the LSWs twice a month or PRN. This would help, I think sometimes it is hard for BSW's to define/recognize important but basic issues i.e.coping skills and difficulty in explaining that.
4. Could MSW's do assessment visits then determine which pt/family is appropriate for BSW follow-up?

Submitter : Ms. Terri Busch

Date: 07/18/2005

Organization : Ms. Terri Busch

Category : Hospice

Issue Areas/Comments

Issues 1 - 10

Social Work

Having provided hospice care in the past, I believe it is necessary for quality of care issues that an MSW be required. I also believe that when an MSW is not available that a BSW with supervision is necessary versus any other "related field." Social work provides the training in social, physical, intellectual, emotional and spiritual realms. The therapeutic and life issues that arise for the patient and the family can be best served by the breadth and depth of social work. This stage of life in individuals and families deserves no less than the best of social work's broad ethical principles based on social work's core values that guide social work practice: service, social justice, dignity and worth of the person, importance of human relationships, integrity, and competence. Thank you for your consideration.

Submitter : **Darrell Bare** **Date: 07/18/2005**

Organization : **Watauga Medical Center**

Category : **Hospice**

Issue Areas/Comments

GENERAL

GENERAL

re: Spiritual Care provisions of CMS-3844-P

Gentlepeople,

A letter in response to the provisons and requirements of CMS-3844-P has been issues by my certifying organization, the Association of Professional Chaplains. It is both thorough and succinct and I cannot improve upon it. I can, however, speak from the position of a 'local clergy' as referred to in the rules well as a Board Certified Chaplain.

From both of these perspectives I appreciate the recognition of the need for spiritual provision for those in hospice care. I would suggest to you that, in order to insure that the level of such care is satisfactory and is the highest level available, standards of certification be placed upon those who will be providing such care under hospices. Those standards already exist.

A hospice patient or family could easily have spiritual support available outside the hospice's provision, just as he or she might have additional medical care, social worker support or dietary advice from outside the hospice. This does not preclude the need for a clear level of expertise in the areas apart from spiritual care. The same consideration should be given to those who make spiritual asessements, interventions and plans of care that are coordinated with other disciplines.

As a local pastor I have volunteered with hospice in the past and have appreciation for such work. However, having obtained additonal education and certification, I can recognize that not all local clergy are equally adept or trained in such care. The only way that the mandates of the new rules will be uniformly fulfilled (and the only way to assess this fulfillment) is to require nationally recognized chaplain standards to apply. Again, I refer you to the above mentioned letter for the particulars of those standards as well as for other relevant spiritual care issues that should be addressed by the new rules. I am including a copy of this letter as an attachment. The original was sent on APC letterhead and signed.

Thank you for this opportunity to contribute

Rev. Darrell Bare, Board Certified Chaplain

CMS-3844-P-53-Attach-1.DOC

CMS-3844-P-53-Attach-2.DOC

June 21, 2005

Centers for Medicare and Medicaid Services
Department of Health and Human Services
7500 Security Blvd.
Baltimore, MD 21244-1850

Attention: CMS-3844-P

Dear Sirs:

GENERAL:

With commitment to interfaith ministry and the professional practice of pastoral care, the Association of Professional Chaplains serves chaplains in all types of health and human service settings. Almost 4,000 members are chaplains involved in pastoral care, representing more than 150 faith groups. As a national, not-for-profit professional association, the APC advocates for quality spiritual care of all persons in healthcare facilities, correctional institutions, long term care units, rehabilitation centers, hospice, the military, and other specialized settings. For more information about the APC or further information regarding our comments below, visit our website at http://www.professionalchaplains.org, or contact our Executive Director, Jo Schrader, at 847-240-1014.

SPIRITUAL NEEDS OF HOSPICE PATIENTS AND FAMILIES

We applaud CMS's awareness of and commitment to the inclusion of meeting the spiritual and emotional needs of hospice patients and families and a part of patient rights and the continuum of care. We would encourage the acknowledgement that spiritual needs, just as medical, social, physical, and psychosocial needs, depends upon the delivery of outcome-based, patient centered care by trained and certified professionals who are specialists in spirituality. While the proposed rules identify 'spiritual needs' and 'spiritual counseling', what is lacking is more specific standards regarding who is qualified to provide these services. The proposed rules, in the use of terms such as "clergy", which is a specifically Christian term, fails to acknowledge and provide care for the needs of patients of other religious and spiritual traditions, and we would encourage CMS to utilize language that is more inclusive. We would also encourage CMS to acknowledge the importance of providing for patient and family cultural needs, of which spiritual and religious needs are, while essential, only one part of a person's culture. There are no specific standards within the rules that require hospices to assess and be attentive and sensitive to cultural needs, such as dietary, space, and treatment.

LICENSED PROFESSIONAL SERVICES
PROPOSED 418.62

PROFESSIONAL SPIRITUAL CARE PROVIDERS

The proposed hospice rules contain specific standards for licensed professional services. We understand the rationale for basing these upon State standards for those in other healthcare professions, such as physicians, nurses, therapists, medical social workers, home health aides, etc. However, professional spiritual care providers are board certified by national professional groups, and we would encourage that the proposed rules include this requirement of those providing spiritual care and counseling in all hospice settings. We have attached a copy of the Common Standards for Professional Chaplaincy, adopted by the Council on Collaboration in 2004, which provides a unified voice of the six primary professional spiritual care groups in the United States and Canada. The membership of these groups represents over 10,000 members who currently serve as chaplains, pastoral counselors, and clinical pastoral educators in specialized settings, including hospice and other healthcare organizations, counseling centers, prison, or the military.

In summary, Board Certified chaplains are required to possess:

- An undergraduate degree and a graduate-level theological degree from a college, university, or theological school accredited by a member of the Council of Higher Education Accreditation
- A minimum of 4 units (requiring 1600 hours of training) of Clinical Pastoral Education, which is nationally recognized clinical training in the provision of professional spiritual care
- Board certification by a national professional pastoral care cognate group by which the chaplain demonstrates competencies in pastoral theology and care, personal and professional identify and conduct, and commitment to a Code of Professional Ethics
- Continued professional development by active participation in membership of a cognate group through the payment of dues, professional continuing education, and peer review

In addition, professional spiritual care providers are required to abide by a Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and Students, also a foundational document affirmed by the previously defined Council on Collaboration. We have also attached this document. By including standards that require the employment of Board Certified spiritual care professionals, the proposed CMS Rules would ensure that those providing spiritual care to hospice patients, families, and staff would be held accountable just as other professional, licensed staff are. This protects hospice patients, family, and staff with unwanted, intrusive, and potentially abusive spiritual interventions by those who are not professionally trained, certified, nor held accountable to professional standards of practice and ethics.

While community religious leaders provide gifts in the provision of religious care to hospice patients and families, professionally trained and certified spiritual care providers bring to the hospice environment the skills to provide spiritual assessment, an outcome-based spiritual plan of care and interventions based on professional spiritual care standards of practice, the ability to

work effectively within an interdisciplinary team, and specialty in loss, grief, and bereavement care and counseling Board certified chaplains work with community religious leaders to facilitate their care to their religious community members, while also serving as an educator and facilitator of the hospice environment and specialist in the unique spiritual and emotional needs of hospice patients and families.

We recommend that standards be included to require hospices to employ trained and certified professional chaplains in order to meet clearly and effectively the proposed rules including:

Proposed 418.52: PATIENT RIGHTS

Professionally trained and nationally certified spiritual care providers are advocates for patient rights, educators for patients, families, and hospice staff, and are trained to provide spiritual care to those seeking to make treatment and end of life decisions.

Proposed 418.54: COMPREHENSIVE ASSESSMENT OF THE PATIENT

Board certified chaplains are trained to provide spiritual assessments that identify issues, interventions, and specific outcomes to meet the unique needs of each hospice patient and their family. Additionally, board certified chaplains are trained in how to document in both clinical and progress notes in ways that articulate clearly to the entire interdisciplinary team what spiritual issues may impact the overall care of the patient and family. Professional chaplains are guided by and adhere to national standards of practice in assessment, interventions regarding spiritual distress, loss, bereavement, coping, and the use of religious and spiritual resources identified by the patient and family.

Proposed 418.56: PLAN OF CARE AND COORDINATION OF SERVICES

Professionally trained and nationally trained spiritual care providers have extensive training and experience in developing and writing an outcome-based written spiritual plan of care for patients and families and working with interdisciplinary group care planning and coordination of services.

Proposed 418.58: QAPI

Board certified chaplains not only have training in quality assessment and performance improvement, but also have shown value to organizations that they serve in actively participating and maintaining QI and PI planning and projects. All work of board certified chaplains is informed and guided by professional practice standards applicable to hospice care.

Proposed 418.78 VOLUNTEERS

Clinically trained and nationally certified professional spiritual care providers are skilled in the training and oversight of volunteers, particularly those who seek to provide emotional and spiritual care to hospice patients and families. Having a board certified chaplain in this role assures the hospice of maintaining patient rights and providing appropriate care by volunteers.

Proposed 418.100 ORGANIZATION AND ADMINISTRATION

Again, board certified chaplains are trained and professionally credentialed and follow national standards of practice in order to organize, manage, and administer spiritual services to patients, caregivers, and families within the hospice environment while maintaining dignity, comfort, and advocacy for patient/family needs and desires. Board certified chaplains serve as educators to other professional staff and volunteers in areas of patient rights, advance care planning, end of life, and spiritual, religious, and cultural needs.

INCLUSIVE SPIRITUAL AND RELIGIOUS LANGUAGE

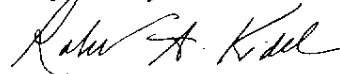
We strongly encourage the Proposed Rules be adapted to utilize language that is inclusive of persons of all spiritual and religious traditions. Rather than using the word 'clergy' in the Proposed Rules, we suggest the use of the word "Board Certified Chaplain" for those employed by the hospice and "community religious leaders" for those who serve as community support and/or volunteers.

CULTURAL ISSUES

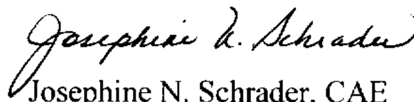
We also strongly encourage that the proposed rules be attentive in the inclusion of additional language addressing the cultural needs of patients and families.. It is important to all patients, especially when dealing with the stresses of a terminal diagnosis and end of life, that their rights be respected in all areas of life. For many of differing cultural and spiritual backgrounds, the issues of diet, space for cultural, spiritual, and/or religious ritual, medication and other treatments, the inclusion of complementary therapies, and conversations around diagnosis, treatment, and death are essential dimensions of patient rights.

Thank you for this opportunity for us to comment on CMS-3844-P, the new proposed rules for hospice and for your consideration of our concerns. Do not hesitate to contact the Association of Professional Chaplains if we can provide more information regarding the training, certification, standards of practice, and work of professional chaplains.

Respectfully submitted,



Robert A. Kidd, M.Div. BCC
President



Josephine N. Schrader, CAE
Executive Director

ATT: Common Standards for Professional Chaplaincy
Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and Students

Submitter : Ms. Mary Raymer

Date: 07/19/2005

Organization : Raymer Psychotherapy and Consultation Services

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

CMS-3844-P-54-Attach-1.DOC

CMS Medicare and Medicaid Programs, Hospice Conditions of Participation, Proposed Rules Comments

(File Code CMS – 3844-P)

To whom it may concern,

I applaud your work on the proposed revisions regarding the Medicare and Medicaid Program Conditions of Participation for Hospice particularly in the arena of strengthening the standards for social work.

There are several standards in particular that I want to address:

418.114 (c) - MSW vs. BSW

I strongly support the use of MSWs from a CSWE accredited program with one year of mental health/health care experience. I fully recognize that this may not be possible to implement initially for all programs, but I believe that good faith efforts need to be made and documented, and then, as necessary, a waiver can be granted. I have worked in the field for 25 years and sadly, have seen many instances when there has been no attempt to locate MSWs to work in hospice. BSWs are skilled in resource management and environmental assistance. They are not social work assistants, but rather the first level of social work. It is not until social workers study for their masters that they receive counseling and psychotherapeutic tools/skills that are crucial for providing the most effective and therefore, cost-effective interventions that ensure people receive the highest quality of care. Much like LPNs vs. RNs, the issue is not about casting aspersions on one level of professional, but common sense dictates that additional education differentiates the two levels significantly. End of life is one of the most complex arenas of care. A recently published study completed by Dona Reese, Ph.D., and I (Reese, D. and Raymer, M., "Relationships Between Social Work Services and Hospice Outcomes: Results of the National Hospice Social Work Survey," Social Work, July 2004) indicated that the increase in training resulted in decreased overall costs, fewer nights of continuous care and increased client satisfaction among other benefits. Increasingly, there are shorter lengths of stay in hospice and less time for intervention so we need to have the most experienced and qualified professionals to get in fast, assess quickly and intervene in the most effective manner possible.

As a core service of hospice, social work is a profession whose whole training is based on the same components that make up palliative care, so it is a perfect fit with hospice. I believe that the requirement of a MSW will enhance programs and the people we serve as well as save costs in the long run. While currently not every program may be able to accommodate this standard, just like with physicians and nursing where there may be shortages, we do not compromise quality by going for the less educated alternatives. Where MSWs cannot be placed, then a waiver can be granted, but BSWs from an

accredited program of social work and supervised by an MSW should be the second tier that is part of the standard.

418.54 - 7 Day/4 Day for Assessment

I once again applaud you for your wisdom. With shorter lengths of stay, the seven-day standard is keeping many families/patients from any access to social work. Seven days was too long to wait even before from a clinical perspective. The four-day assessment is more appropriate to ensure people get the services they need in as timely a manner as possible. Faster intervention allows for more effective crisis intervention and better utilization of the team. The psychosocial needs of a patient/family are every bit as crucial as any other, and indeed, that is a basic tenant of hospice care. The clinical ideal would be a two-day turn around time. Programs could be more timely, effective and cost-effective if they would have a nurse and social worker doing the initial assessment together (Reese, D. and Raymer, M., "Relationships Between Social Work Services and Hospice Outcomes: Results of the National Hospice Social Work Survey," Social Work, July 2004).

418.56 – Case Manager/IDT Manage

I do not believe that "any team member" can lead the IDT, but I do believe that professional expertise in facilitation, communication, group dynamics and leadership are crucial. Keeping "the big picture" and being fully grounded in the biological, sociological, psychological and spiritual components of care is the core training of social work. Social workers are ideally suited to handle case management. Not all hospice team members are trained in these skills; therefore, opening it to "any member" does not seem wise. Instead I would recommend that the IDT be managed by the social worker as well as the nurse. These two disciplines are ideally suited for this role.

Thank you for the opportunity to address these topics, and thank you for your good work.

Submitted by:

Mary Raymer, M.S.W., A.C.S.W.
PDIA Social Work Faculty Scholar and
Past Social Work Section Leader Chair, NHPCO

Submitter : **Ms. Mary Raymer** **Date: 07/19/2005**

Organization : **Raymer Psychotherapy and Consultation Services**

Category : **Social Worker**

Issue Areas/Comments

GENERAL

GENERAL

"See Attachment"

Attached please find comments pertaining to Medicare and Medicaid Programs: Hospice Conditions of Participation; Proposed Rules specifically pertaining to Social Work and Hospice (file Code CMS 3844-P).

Thank you for your work on this matter, and please feel free to contact me with any questions.

Mary Raymer, M.S.W., A.C.S.W.
PDIA Social Work Faculty Scholar
Past NHPCO Social Work Section Chair

raymermsw@aol.com
231-938-9610

CMS-3844-P-55-Attach-1.DOC

CMS Medicare and Medicaid Programs, Hospice Conditions of Participation, Proposed Rules Comments

(File Code CMS – 3844-P)

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Thank you for the opportunity to address these topics, and thank you for your good work.

Submitted by:

Mary Raymer, M.S.W., A.C.S.W.
PDIA Social Work Faculty Scholar and
Past Social Work Section Leader Chair, NHPCO

Submitter : **Dr. Walter Smith** **Date: 07/19/2005**

Organization : **The HealthCare Chaplaincy**

Category : **Religious Nonmedical Health Care Institution**

Issue Areas/Comments

GENERAL

GENERAL

See Attachment

CMS-3844-P-56-Attach-1.DOC

CMS-3844-P-56-Attach-2.DOC

CMS-3844-P-56-Attach-3.DOC

July 21, 2005
Centers for Medicare and Medicaid Services
Department of Health and Human Services
Attention: CMS-3844-P

GENERAL:

The HealthCare Chaplaincy is a multifaith community of professionals from many cultures dedicated to caring for persons in spirit, mind, and body. We are committed to excellence and leadership in pastoral care, education, and research.

The HealthCare Chaplaincy is the largest and most comprehensive center for pastoral care, education, and research in the world. Founded in 1961, The Chaplaincy's multifaith clinical staff provides professional pastoral care to patients, families, and staff of all faiths in numerous healthcare sites throughout the New York metropolitan area. Our accredited education programs train clergy and qualified laypersons of all religious traditions in the art and science of pastoral care, and our researchers demonstrate the positive effects of spiritual health on overall wellbeing and healing. The Chaplaincy is also a leading pastoral education resource for rabbinical students and Jewish chaplains, offering clinical pastoral education in a Jewish context.

The staff of over 30 full-time certified chaplains and chaplain supervisors represents many ethnic, racial, and religious backgrounds, including the Buddhist, Christian, Jewish and Muslim faiths, and possesses a wide range of clinical and academic skills and expertise. Many are recognized leaders within the national and international pastoral care communities. Further information on our organization may be obtained from our website (www.healthcarechaplaincy.org).

SPIRITUAL NEEDS OF HOSPICE PATIENTS AND FAMILIES

We fully support CMS's commitment to meeting the spiritual and emotional needs of hospice patients and families. Much current research shows that Americans rely heavily on religion to cope with illness. For many, it is their main source of support. Despite this reliance, over half of American's say they do not have a spiritual counselor to rely on in time of need. Therefore, it is essential that health care providers, including hospice, provide this support for patients and families.

While the proposed rules identify 'spiritual needs' and 'spiritual counseling', what is lacking is specific standards regarding who is qualified to provide these services. Currently, in many hospice settings, this essential service is being provided by spiritual care givers who lack the necessary training and certification. Specifically, they are often not trained to provide this service in a multifaith context.

LICENSED PROFESSIONAL SERVICES
PROPOSED 418.62

PROFESSIONAL SPIRITUAL CARE PROVIDERS

The proposed hospice rules contain specific standards for licensed professional services. We understand the rationale for basing these upon State standards for those in other healthcare professions, such as physicians, nurses, therapists, medical social workers, home health aides, etc. While there are no State standards for spiritual care providers, the major pastoral care associations in North America have approved Common Standards for Professional Chaplaincy (attached) which specify the educational and competency requirements for certification as a professional pastoral care provider. The membership of these groups represents over 10,000 members who currently serve as chaplains, pastoral counselors, and clinical pastoral educators in specialized settings, including hospice and other healthcare organizations, counseling centers, prison, or the military. We would urge that the proposed rules require that all those providing spiritual care and counseling in all hospice settings be certified under these standards.

Board Certified Chaplains are required to:

- Have completed an undergraduate degree and a graduate-level theological degree from a college, university, or theological school accredited by a member of the Council of Higher Education Accreditation
- Have completed a minimum of 4 units (each requiring 1600 hours of training) of Clinical Pastoral Education, which is nationally recognized clinical training in the provision of professional spiritual care
- Abide by the Common Code of Ethics for Chaplains, Pastoral Counselors, Pastoral Educators, and Students (attached). This protects hospice patients, family, and staff from unwanted, intrusive, and potentially abusive spiritual interventions by those who are not professionally trained, certified, nor held accountable to professional standards of practice and ethics.
- Continue their professional development by active participation in membership of a cognate group through the payment of dues, professional continuing education, and peer review

While community religious leaders provide gifts in the provision of religious care to hospice patients and families, professionally trained and certified spiritual care providers bring to the hospice environment the skills to provide spiritual assessment, an outcome-based spiritual plan of care and interventions based on professional spiritual care standards of practice, the ability to work effectively within an interdisciplinary team, and specialty in loss, grief, and bereavement care and counseling Board Certified Chaplains work with community religious leaders to facilitate their care to their religious community members, while also serving as an educator and facilitator of the hospice environment and specialist in the unique spiritual and emotional needs of hospice patients and families.

Trained and certified professional chaplains will contribute to the hospice's ability to meet several other proposed rules in the following ways:

Proposed 418.52: PATIENT RIGHTS

- Advocating for patient rights
- Educating patients, families, and hospice staff
- Providing spiritual care to those seeking to make treatment and end of life decisions.

Proposed 418.54: COMPREHENSIVE ASSESSMENT OF THE PATIENT

- Providing and documenting spiritual assessments that identify issues, interventions, and specific outcomes to meet the unique needs of each hospice patient and their family.

Proposed 418.56: PLAN OF CARE AND COORDINATION OF SERVICES

- Developing and writing an outcome-based written spiritual plan of care for patients and families
- Working with interdisciplinary group care planning and coordination of services.

Proposed 418.58: QAPI

- Actively participating in QI and PI planning and projects.

Proposed 418.78 VOLUNTEERS

- Providing oversight of volunteers, particularly those who seek to provide emotional and spiritual care to hospice patients and families.
- Providing care and pastoral support to all volunteers.
- Providing communication and liaison with community religious leaders.

Proposed 418.100 ORGANIZATION AND ADMINISTRATION

- Administering spiritual services to patients, caregivers, and families within the hospice environment according to national standards of practice.
- Serving as educators to other professional staff and volunteers in areas of patient rights, advance care planning, end of life, and spiritual, religious, and cultural needs.

We commend CMS for its attention to spiritual, religious and cultural issues in the care of hospice patients and family members. We urge CMS to strengthen these proposed rules even further by insisting that all spiritual care providers in hospice be certified according to internationally accepted standards. Only in this way will the quality of the spiritual care provided to these patients and their loved ones be of the quality they deserve at this critical time.

The Rev. Dr. Walter J Smith, S.J.
President and CEO
The HealthCare Chaplaincy

Submitter : Ms. Karen Gurmankin

Date: 07/11/2005

Organization : Licensed Social Work Provider

Category : Social Worker

Issue Areas/Comments

GENERAL

GENERAL

I have reviewed proposed changes for Social Work profession. I believe that MSW should be the level of professional ability that should be required to provide optimal care. In the event that there are no MSW's in the local area then I believe we should remain in the profession with BSW's supervised by MSW's. In this day and age of technology, accrediting organizations and professional organizations. I believe that surely we can find some supervision mechanism which assures that an MSW is available to supervise. I do not feel that it is wise to extend 'social work' status to a bachelors degree from another discipline. The education is different, the standards of practice are not as precisely stated. As you stated MSW's, 'the social work profession' through anecdotal and probably also outcome oriented research does an excellent job. Find a way to refine that rather than change it.

Submitter : **Ms. Rose Dunaway**

Date: 07/20/2005

Organization : **Texas Association for Home Care, Inc.**

Category : **Hospice**

Issue Areas/Comments

GENERAL

GENERAL

Sec attachment

CMS-3844-P-58-Attach-1.PDF

Attachment #58

Home Care: Keeping Texans Proud and Independent

July 19, 2005

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-3844-P
P.O. Box 8010
Baltimore, MD 21244-8010

COMMENTS RE: FILE CODE CMS-3844-P

To Whom It May Concern:

The Texas Association for Home Care is a non-profit association that represents more than 500 licensed home and community support agencies that provide home health, hospice, and personal assistance services.

On behalf of our members, the Texas Association for Home Care wants to express our appreciation for the opportunity to comment on the proposed Hospice Conditions of Participation.

GENERAL COMMENTS

The proposed regulations do not outline the difference between a physician referral and a physician verbal order. If timeframes are contingent on a physician verbal order, the regulatory language must address the difference between the two to alleviate confusion and ensure compliance on the part of hospices. Some hospices accept a physician referral as a verbal order, others do not. We believe this issue needs to be addressed for clarity.

The proposed regulations cause confusion regarding the initial versus the comprehensive assessment. It appears that the regulations treat the initial encounter with the hospice patient for the election of the hospice benefit, the initial assessment of the hospice patient for purposes of determining hospice eligibility, and the comprehensive assessment as three separate and distinct events. In reality these events are frequently performed simultaneously or combined so as to be more cohesive in nature. There is confusion as to who is permitted to complete the orientation to and election of the hospice benefit with the patient, and whether this is can be done simultaneously with the initial assessment. If a non-clinical hospice employee performs the initial encounter with the patient to orient the patient to hospice and to assist in the election of the hospice benefit, does this start the timeframe for the completion of the comprehensive assessment? If not, then how does the election of the hospice benefit play a part in the initial assessment and physician orders for the hospice plan of care? These issues need to be clarified in the proposed regulations, and not as an afterthought in the state operations manual.

ASSESSMENT TIME FRAMES

We oppose the time frame for the completion of the comprehensive assessment within four calendar days. Although this may be the time frame many hospices can complete the comprehensive assessment, there may be occasions where the assessment cannot be completed within a four day window for reasons outside of its control, and the hospice would be out of compliance. Hospices work very hard to complete a comprehensive assessment within a time frame of five to seven days, and these timeframes are more challenging to meet in rural areas and during admissions on or near weekends or holidays when not all

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members of the interdisciplinary team are available. If hospices believe they could not complete the comprehensive assessment within four days for a particular patient, they may choose to not admit that patient in order to remain in compliance, thereby denying the patient access to hospice care. We believe that seven days would enable the hospice adequate time to convene the members of the interdisciplinary group to complete the comprehensive assessment within a reasonable period of time.

418.54(d) UPDATE OF THE COMPREHENSIVE ASSESSMENT

We oppose the mandated timeframe of no less frequently than 14 days for updates of the comprehensive assessment. Each hospice patient is unique and their comprehensive assessment should reflect this uniqueness. The hospice interdisciplinary team should determine the frequency of updates based on the patient's condition, and update the assessment as often as they have determined to be necessary in the patient plan of care.

MEDICAL DIRECTOR
PROPOSED 418.102 CONDITION OF PARTICIPATION: MEDICAL DIRECTOR

We believe the Medical Director or physician designee should be providing oversight of the quality assessment and performance improvement (QAPI) program and should not be responsible for the entire program. It would be an unbearable cost for a hospice to pay a Medical Director or physician designee to bear the responsibility for the QAPI program when a hospice administrator or other hospice staff can be responsible for the implantation of the QAPI program with the Medical Director or physician designee responsible for the oversight function.

QAPI

In proposed standard 418.58(a) Standard: Program Scope, the term "adverse event" is described as "occurrences that are harmful or contrary to the targeted patient outcomes." We believe the term "adverse event" needs to be defined in a more hospice-specific way. Adverse events for home health, for example, are clearly defined and outcomes of these quality indicators can easily be tracked and analyzed. It is not clear in this standard if CMS expects hospices to examine every single occurrence, or if particular focus should be given for specific types of events.

PROPOSED 418.74 CONDITION OF PARTICIPATION: WAIVER OF REQUIREMENT -PHYSICAL THERAPY, OCCUPATIONAL THERAPY, SPEECH-LANGUAGE PATHOLOGY, AND DIETARY COUNSELING

We support the proposed language to waive the requirement that a hospice furnish physical therapy, occupational therapy, speech-language pathology and dietary services as needed on a 24-hour basis.

REVISION OF 418.76(h), SUPERVISION OF HOME HEALTH AIDES

We are opposed to the proposed revision of this subsection to require the RN or appropriate therapist to perform an on-site supervisory visit while the aide is present every 28 days. The hospice RN or therapist is in frequent communication with the home health aide, patient, and family during the course of treatment. This communication provides ample opportunity to discuss the plan of care, and make changes accordingly. We do not believe that such a restrictive timeframe will improve patient outcomes.

ORGANIZATION AND ADMINISTRATION
418.100(e) PROFESSIONAL MANAGEMENT RESPONSIBILITY

This section would require the hospice to maintain *"supervisory"* responsibility for *"all services that are provided to the patient and family."* While hospice does have a responsibility of professional management and financial responsibility, the hospice does not supervise services such as contracted physical therapy, but rather coordinates care and monitors the services provided. The language of supervision is inappropriate, and needs to be deleted or

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defined to indicate an overall program role and not a personnel supervisory role for contracted staff.

DRUGS, SUPPLIES, AND DME
PROPOSED 418.106(b) CONTOLLED DRUGS IN THE PATIENT'S HOME

This sections states *"the hospice would ensure the safe delivery and accountability of controlled drugs in the patient's home."* The word ensure means *"guarantee"*. Although the hospice will have a policy to track, collect, and dispose of controlled drugs maintained at the patient's home, the hospice cannot guarantee the accountability, nor be held liable in all situations for controlled drugs in the home that cannot be accounted for. The hospice staff is not in the patient's home on a 24-hour basis, nor are the controlled drugs under lock and key in the patient's home. The patient and the patient's family and caregivers need access to the controlled drugs outside of the hospice personnel's direct administration to adequately provide the patient pain control. We believe that clarification is needed regarding the extent of a hospice's liability in *"ensuring"* safe delivery and accountability of controlled drugs in the patient's home.

SHORT TERM PATIENT CARE
CONDITION OF PARTICIPATION: SHORT-TERM INPATIENT CARE (PROPOSED 418.108)

We support the elimination of the existing requirement of a registered nurse to provide patient care on each shift.

INPATIENT CARE
CONDITION OF PARTICIPATION: HOSPICES THAT PROVIDE INPATIENT CARE DIRECTLY (PROPOSED 418.110)

We support the waiver of the requirement that existing hospice facilities need to meet the requirement of no more than two persons in a room.

PROPOSED 418.100(L) MEAL SERVICE

We support the revision to make this standard less restrictive, such as serving at least three meals at regular times, with no more than 14 hours between substantial evening and breakfast meals, and having a staff member trained in food management or nutrition.

PROPOSED 418.110(o) SECLUSION AND RESTRAINT

Although we understand the emphasis on safety with regard to restraint and seclusion, we find the language in (o)(7) to be confusing. The language states that a hospice must report to CMS after a patient dies while being restrained or in seclusion, and then states *"within 24 hours after a patient has been removed from restraint or seclusion."* If the patient has died while in restraint or seclusion, this language is redundant.

Furthermore, we are concerned about how this data will be used, and whether the use of seclusion or restraints may automatically trigger a survey. What investigative outcome is CMS seeking? How will the data be used? We question how CMS will use information regarding the appropriate use of a chemical or physical restraint according to the plan of care if a patient dies during its use or application. In many instances, the use of a restraint may be medically indicated as a patient approaches death in order to ameliorate symptoms or to facilitate pain management. If hospices and physicians are constantly questioned regarding the use of restraints in these situations by surveyors, then this requirement may become a barrier to the appropriate use of restraints.

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RESIDENTS RESIDING IN A FACILITY
CONDITION OF PARTICIPATION: HOSPICES THAT PROVIDE HOSPICE CARE TO RESIDENTS OF A SNF/NF, ICF/MR, OR OTHER FACILITIES (PROPOSED 418.112)

This section does not address the fundamental patient right under Section 1802 of the Act to be able to choose his/her own hospice. Too frequently the facility chooses to contract with a select hospice(s) which may not be the hospice chosen by the patient. We believe that additional language is necessary to ensure a patient's right to choose a hospice, and the obligation of the facility to contract with the patient's choice of hospice.

In the preamble on page 30858 it states, *"We are preparing a separate regulatory document to address long-term care facility obligations regarding residents receiving hospice services."* We urge CMS to expeditiously provide further clarifications to both long-term care facilities and hospices regarding responsibility for the provision of personal hygiene and grooming tasks. There have been significant disagreements in some instances between hospices and long-term care facilities as to which provider is responsible for providing those services to hospice patients residing in long-term care facilities.

PROPOSED 418.112(i), ORIENTATION AND TRAINING OF STAFF

We believe that the facility, and not each individual hospice, should be required to orient their staff to the aspects of hospice, the philosophy of hospice and unique program features if the facility accepts hospice patients. This may be done in cooperation with hospices; however, the facility should be primarily responsible for this training of their employees. If the facility contracts with several hospices, it is duplicative to have each hospice train the facility staff on the philosophy and unique program features of hospice. The hospice should be required to orient the facility staff regarding the individualized plan of care for the patient at the facility.

CONDITION OF PARTICIPATION FOR LICENSED PROFESSIONALS (PROPOSED 418.114)
PERSONNEL QUALIFICATIONS

418.114(d) We vigorously oppose the proposed new requirement that a hospice be required to obtain a criminal background check for all hospice and contract employees before employment at the hospice. In many cases, this will place an additional financial and administrative burden on hospices that is not accurately captured in the Collection of Information Requirement section. Texas and many other states require a criminal background check be performed by a hospice on unlicensed personnel, not on licensed professionals because those background checks are performed by state licensing boards. Furthermore, many states do not require criminal background checks on employees who do not have direct contact with patient. The proposed standard would require the check to be performed prior to employment, which may result in unnecessary delays in the provision of services because in some states hospices would have to wait days to weeks for the information. We believe that CMS should defer to state requirements for criminal background checks and not impose a nationwide requirement.

SOCIAL WORK

We oppose the requirement of an MSW for hospice. A Bachelor's prepared social worker meets the educational requirements needed for hospice.. Furthermore, we oppose any requirement that a social worker have a least one year of experience in a health setting. We find this to be unnecessary as social workers are trained within their scope of practice to perform all the required elements of social work, and do not require a higher level of education or experience in a particular field to appropriately provide social work services to hospice patients and their families. Furthermore, the availability of Master's-prepared social workers in rural areas is almost non-existent, and would put an extreme administrative burden on hospice agencies to locate and utilize only Master's-prepared social workers. This requirement would in effect limit access to hospice care in a Master's-prepared social worker were not available. Bachelor-prepared social workers are not in need of supervision from a Master's-prepared social worker as the Bachelor- prepared social worker is licensed and competent to practice the field of social work.

COLLECTION OF INFORMATION REQUIREMENTS

Under this section we have the following comments:

1. Section 418.56 Condition of Participation: Interdisciplinary Group Care Planning and Coordination of Services

Under this section on page 30868, the estimated time for completion to document the plan of care and any revisions is 25 minutes. We believe that the actual time to document the INDIVIDUALIZED plan of care is 1 to 2 hours. This is includes the initial orders, the initial assessment completed by all members of the interdisciplinary team, review of medications, ordering medications, DME, medical supplies, planning, telephoning, arranging, consulting with family members, and completing documentation of all the above.

Time to complete revisions to the clinical record vary depending on what revisions are necessary. The average time per hospice interview is 30 minutes per revision.

We appreciate the opportunity to offer these comments on the proposed Hospice Conditions of Participation and hope that you will give consideration to the issues we have raised to ensure that our hospice members can continue to serve those needing end-of-life care.

Sincerely,

Rose Dunaway, BSN, RN
Community Care/Hospice Specialist

Submitter : **Ms. Judine Mecseri** **Date: 07/20/2005**

Organization : **Homecare**

Category : **Social Worker**

Issue Areas/Comments

Issues 1 - 10

Social Work

It is not necessary to use a Masters level Social Work to do Hospice work. It takes someone with Social Work training and medical background. However, after having done Social Work in a Hospice setting for the past 11 years and trained several Bachelor level Social Work students, it is proven that clients and families are able to relate well to someone with training and knowledge not necessarily being masters level clinical skills. I find this could be easily related to using a BSN for nursing care versus a MSN in Hospice--the services are obviously performed adequately and efficiently with quality services. Additionally, the Bachelor Level social worker with experience and supervision has proven effective in the home health field. Doing both home health and hospice work it is my experience that home health is actually more difficult than hospice social work. Thus, the additional education is not needed in Hospice. Further the cost of Hospice services would increase using a Masters Level Social Worker. Please reconsider this recommended change as unnecessary and not needed. Thank you for your attention to this matter.

Submitter : **Ms. Barbara Helming** **Date: 07/21/2005**

Organization : **Midstate VNA**

Category : **Hospice**

Issue Areas/Comments

GENERAL

GENERAL

418.76 (g)(2)(i)
Observing each HHA once every 28 days would simply prove their competent but does not address their adherence to the plan of care for each patient served. HHAs should not need to prove general competence 12 times a year. Review of plan of care with HHA should occur every 60 days and as needed.

Issues 1 - 10

Drugs, Supplies, and DME

418.106
(b) Need clarification of "tracking and collecting" controlled drugs in the patient's home. What does that refer to? Also, standard fails to recognize that once a patient dies the meds legally belong to the family. They can refuse to discard them!

Clinical Records

418.104
(e) Discharge/transfer of care.
Neither the facility a patient is transferred to or the patient's physician on dicharge want a copy of the patient's clinical record. That is totally unnecessary and needs to be removed from the standard. A discharge summary and other pertinent info would be sent upon transfer/discharge.

Personnel Qualifications

418.114 Criminal background checks
Does "contracted employee" include DME or pharmacy delivery people? If so, are background checks routinely done on those people?

Residents Residing in a Facility

418.112
(c) Need clarification re: hospice uses facility personnel only to the extent that it would use a patient's family in implementing the plan of care. What does that mean?

Short Term Inpatient Care

418.108
(a) Need to add that inpatient care can be utilized for acute caregiver breakdown.

Medical Director

494.102
(c)"Medical Direcor and IDG jointly responsible for coordinating all medical care."
The primary MD and the IDG with oversight from the Medical Director are jointly responsible for coordinating all medical care. The Medical Director can not/should not replace the patient's primary MD.
Also need clarification re: the Medical Director being responsible for directing QAPI program. Not sure that is realistic.
418.112
(d) This needs to be changed. The patient's primary MD coordinates the patient's care at the SNF in collaboration with the IDG and with oversight from the Medical Director.
Also last sentence under (d) is cut off so I can not evaluate it.

Issues 11 - 18

QAPI

418.58
(b)"Frequency and detail of data collection must be specified by the hospice's governing board."
Word specified should be changed to "approved".

Patients Rights

418.52 Notice of rights
Need clarification of 'info must be presented verbally and in writing in a language and manner that the patient understands.' Each program has consents & program info translated into the predominant languages of the population they serve. An interpreter would need to be acceptable for rare patients speaking a language unusual for the area.

Assessment Time Frames

418.54 Comprehensive assessment
Completion of the initial assessment within 24 hours of the order for care would always be the ideal but real world problems prevent that. Admissions can not always be opened within 24 hours because of delays in hospital discharges or patient preference(patient's often want a specific fam member present for the admission and wish to schedule admission visit around that person's availability). The addition of "whenever feasible" should be added.

Plan Of Care or Coordination of Services

418.56 IDG care planning and coordination of services
(c) "Documentation in the clinical record....indicating pt/fam...agreement with the plan."
Unfortunately we serve some dysfunctional families where there will never be agreement on anything much less the hospice plan of care! The word agreement needs to be removed.
(e)Need clarification of the phrase "develop and maintain a system of communication and integration." What does that refer to?

Outcome Measures

418.54 Patient Outcome measures
(e)Timeframe for patient outcome measures is referenced in the 6/28/05 teleconference handout but the specific timeframe is not stated.