

**Submitter :** Ms. Wilma Wayson  
**Organization :** Assured Home Health & Hospice  
**Category :** Hospice

**Date:** 07/25/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-3844-P-86-Attach-1.DOC

CMS-3844-P-86-Attach-2.TXT



## ASSURED HOME HEALTH & HOSPICE

July 25, 2005

Attachment #86

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

To the Members of the CMS Staff concerned with the Medicare Hospice Conditions of Participation [COPs]:

As a Medicare and Medicaid-participating Hospice provider deeply concerned with the well-being of hospice patients, Assured Home Health and Hospice welcomes the opportunity to comment upon the Hospice COPs' revisions proposed in the Federal Register publication of May 27, 2005 [70 Fed. Reg. 30839-30891.]

By all appearances, CMS shares the views of virtually all providers and health care professionals in the hospice industry that quality of care is the prime component of this very important and compassionate benefit. CMS has also through the years championed the articulation and expansion of patients' rights in the election, exercise, care planning and end of life determinations which those facing terminal illnesses enjoy.

We therefore wish to bring to your attention a gap in the hospice regulations, which needs to be filled in the finalization of these hospice COPs. Specifically, language should be inserted in the hospice COPs to ensure that a patient's right to choice of his/her hospice provider is protected and enhanced.

### Section 42 CFR 418.52 Condition of participation: Patient's rights

We propose that CMS add a subsection within this Condition, at 42 CFR 418.52(a) under "*Standard: Notice of Rights*" and/or at 42 CFR 418.52(b), "*Standard: exercise of rights and respect for property and person*", stating:

"Hospice shall ensure that the patient has been provided a choice of hospice providers and is aware of his/her right to change or transfer to another hospice of his/her choice."

### Section 42 FR 418.113 Condition of Participation; Hospices that provide hospice care to residents of a SNF/NF, ICF/MR, or other facilities

Because the revised hospice COPs as proposed would include a new section, 42 CFR 418.112, regarding hospice services provided to residents of a "SNF/NF, ICF/MR, or other facilities", it is clear CMS recognizes that an important and exceedingly vulnerable group of persons at the end of life are Medicare beneficiaries, Medicaid recipients and others who have made their homes in

Assured Home Health, Hospice, Home Care and Medical Staffing

1821 Cooks Hill Rd. Suite 200. • Centralia, WA 98531 • Phone (360) 330-2640 • Fax (360) 807-0859



## ASSURED HOME HEALTH & HOSPICE

nursing homes, homes for the aged, homes for the handicapped or impaired and other facilities serving those no longer able to reside in private homes.

Most of these individuals do not come to reside in such facilities at the moment of determination of terminal status, i.e. within six months of the time of death should their conditions deteriorate as would normally be expected. Nor do these individuals give up any legal rights under the Medicare or Medicaid programs as to the election of hospice care and the choice of providers. How could they be exercising such rights if they are not yet at the point where their conditions have identified that such rights are at stake? Their admission contracts to facilities do not identify that they are giving up a hospice provider right of choice. They are not electing a particular HMO or other managed care plan, which with their knowledge and election, limits the panel of available providers. Since the nursing facility or other residence will not have hospice as a vendor to the facility under consolidated billing by the facility, the resident is not waiving any rights to a future provider election regarding hospice.

We call on CMS to add to 42 CFR 418. 112 a subparagraph, which states that a hospice may not enter into arrangements to provide hospice services for residents in a nursing facility if that facility discriminates against residents in their choice of hospice provider. We believe that a patient's right to quality of care includes selecting a hospice whose care is, in that patient's opinion, superior. A nursing facility and a "captive" hospice should not be provided sanctuary under the Medicare program if they collaborate in depriving a patient of a reasonable choice of alternative hospices.

We believe it is incumbent of CMS to strengthen the statutory provisions that promote a patient's right to elect the provider of his or her choice. What more important time could there be than at the time of impending death? Why should a residential facility unreasonably restrict such an election, when the practical implications of having multiple hospice choices for their residents are inconsequential and the alternatives—forcing a hospice upon a resident or forcing a resident to move at the very end of life—are so contrary to the intentions of Congress in its recognition of patients' rights in receiving services they have earned through the contribution of tax dollars?

Thank you for this opportunity to participate in the comment period on this Hospice COP revision. While we recognize there will be additional revisions to the SNF/NF COPs in the future where parallel provisions should be added, we do not believe CMS should defer or waiver in its providing the hospice COPs with the strongest language possible in order to preserve and protect one of the most sacred provisions of Medicare law; the patient's right to choose their healthcare provider.

Respectfully submitted,

Wilma Wayson, BSN  
Vice President and Director of Hospice

Assured Home Health, Hospice, Home Care and Medical Staffing

1821 Cooks Hill Rd. Suite 200. • Centralia, WA 98531 • Phone (360) 330-2640 • Fax (360) 807-0859

Ohio Council for Home Care  
1395 East Dublin Granville Road  
Columbus, OH 43229  
614-885-0434 EXT 209

**Comments on the Hospice Conditions of Participation  
Proposed Regulations  
42 CFR Part 418  
CMS-3844-P**

**PREFACE:** Let us begin by commenting that in some instances, it appears, that CMS is trying to fit a square peg (hospice) into a round hole (hha, snf). CMS is attempting to make hospice a medical model such as home health and skilled nursing homes, instead of the holistic model it is. While, OCHC can appreciate CMS' effort to make hospices' more data driven, the spirit and energy may be lost under the tremendous paperwork burdens being placed upon it.

**I. INTRODUCTION**

The proposed changes to the Hospice Conditions of Participation dramatically change the provider requirements orienting the Conditions of Participation to outcome performance-based standards. It is apparent that Hospices are to be the guinea pig provider group for the performance-based orientation which in many ways is ironic considering the nature of hospice.

I am enclosing an outline prepared by our law clerk of the changes to the significant provider standards and her summaries. In addition, below I will briefly highlight the significant changes which primarily consolidate the conditions of participation into 2 subparts, the first pertaining to patient care and the second to administration, organization and record keeping. I will then outline specific comments that I recommend should be submitted to CMS.

**II. SUMMARY OF CHANGES**

**A. Patient Care**

Many new conditions have been implemented under this Subpart. First there is the addition of a patient rights condition 418.52 that replaces the former "informed consent" requirement. The emphasis on this new rule is that the patient and the family must be included in the overall care process, permitted the right to file grievances, advised of advance directives and notified of their right to

**Submitter :** Ms. kathleen anderson  
**Organization :** Ohio Council for Home Care  
**Category :** Health Care Professional or Association

**Date:** 07/25/2005

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

OCHC has provided comments on the hospice CoPs CMS-3844-p

CMS-3844-P-87-Attach-1.DOC

confidentiality. The hospice must provide the patient notice of the rights in written format and verbally at the initial visit. In addition, the new COPS's include a specific requirement for a Comprehensive Assessment that is tied to the overall data driven "outcome" format. The Assessment must be done by the Interdisciplinary team and completed not later than 4 days of the election for hospice services and include a full assessment of the patient's medical, nursing, psychological, emotional and spiritual needs. The completion of the assessment must be done following an RN assessment visit, which must occur within 24 hours after receipt of a physicians order. Follow up assessments and with revisions to plans of care must be performed every 14 days.

CMS suggests that the performance outcome regimen can be structured by a hospice using industry standards and indicates that the National Hospice Association has such data driven standards available on its website. CMS states this is necessary because many hospices did not perform quality assurance activities and is linking this assessment data to an overall Quality Assurance (QAPI) requirement that must be overseen and directed by the governing board. 418.58. Specific outcome domains are mentioned including "self-determination, comfort, safety and effective grieving"

In addition, the outcome orientation is carried into the requirements for the Interdisciplinary team which must include all individuals providing services with a specific person identified for the coordination of services. 418.56 The ID team is responsible for establishing and reviewing the plans of care as well as the overall assessment and assuring that the plan of care reflect all interventions necessary for problems and address family expectations, understandings and agreement to participate in the care planning process. The ID team must establish a system of communication to ensure overall provision of care.

The Quality Assessment and Performance Improvement Condition is the biggest change and most burdensome aspect of the new COP's. 418.58 The QAPI program must be established in writing and then addressed in the context of each hospice patient. In general the hospice is expected to develop a QAPI program that monitors the effectiveness of service and, is able to target areas for improvement. Hospices must track adverse patient events, implement preventive actions, and conduct an annual improvement project tied to past performance. This annual project must document the reason for the project, the measurable progress expected as a result of the project and the actual progress achieved. The hospice's governing board is charged with ensuring the ongoing QAPI program.

Another new COP, 418.60, requires the hospice to develop an infection control program \including standards of practice and an ongoing program that "focuses on surveillance, identification, prevention, control and investigation of infections and communicable diseases." The hospice must educate its staff and the hospice patient and family about its Infection control program.

The COP for Licensed Professional Services has been revised to eliminate stated services or task and simply states a broad overview of the contributions of hospice staff. It does mandate that staff participating in caregiving must be involved in coordinating services. 418.62. Hospices are to be restricted in using contracted staff for core services to extraordinary circumstances such as staffing shortages but must be able to document and demonstrate the circumstance. Any core services must be subject to an under arrangement agreement with another certified hospice. 418.64. The regulation does acknowledge and permit the use of Nurse Practitioners. And, rural providers may obtain a waiver of the requirement that all core nursing services be provided by employees. The waiver has to be requested from CMS.

CMS issued a new regulation concerning hospice "non-core" services specifying again that these services can be provided wither directly or under arrangement. Non-core services include PT, OT, Speech therapy & dietary counseling as well as home health aides. The regulation on aides will now require training and some form of competency certification similar to home health agency requirements. Failure to properly train can result in a standard deficiency which carries the same sanction as exists for home health – revocation of the ability of the hospice to self-train and competency check its aides. This is a significant new burden for hospices. 418.76

#### B. Organizational Requirements.

418.100 describe the overall organizational requirements for hospices and states that it must ensure that its services "optimize comfort and dignity. The Governing Board is charged with full legal responsibility and authority for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. This standard is more rigorous than general Board of Director duties and imposes more exposure on "governing boards" than previous regulations.

The governing board still appoints an administrator who oversees day-to-day operations. There are no stated qualifications for who can be an administrator and this is left to the discretion of the governing board. The administrator must be a hospice employee. 418.100(c) outlines the services to be provided by the hospice, which include 24 hour/7 day a week nursing, physician, and drug & biological services. Other services have to be available on a 24-hour basis only when reasonable and necessary to meet the needs of the patient or patient's family. The hospice must provide the care needed regardless of the patient's ability to pay. 418.100(d). Under arrangement services must be subject to a written agreement and all such services must be overseen and controlled by the hospice. 418.100(e).

A hospice may have branch or "satellite" locations but they must be approved by CMS. In addition, the hospice must provide inservice training to all staff including volunteer staff. The inservice program must be outlined in

policies and procedures and there must be a log of all inservices maintained for a 12-month period. 418.100(g).

Hospices continue to have a medical director who works on the interdisciplinary team is primarily responsible of the component of the care. The MD certifies the terminal condition of the patient and the qualification for hospice services. The MD also must oversee and direct the quality assurance and performance improvement program, A MD must have a designee to perform services in his or her absence. 418.102.

418.104 outlines the criteria for the hospice clinical record which includes the plans of care, assessment, clinical notes, and progress notes, any informed consents, authorizations, records on responses to medications and symptom management, the outcome measure data elements, advance directives and physician certification. All clinical record documents must be clear and legible and signed. The hospice must have a means to authenticate any signature in the clinical record. Records must be maintained for 5 years. If a patient transfers from 1 hospice to another or is discharged or revokes hospice election, the hospice must forward the clinical record and a discharge summary to the new facility or to the attending physician. The discharge summary must include (1) a summary of the patient's stay including treatments, symptoms, & pain management, (2) the current plan of care, (3) latest physician orders, and (4) any other documentation that will assist in post-discharge continuity of care.

The hospice must provide all DME, medical supplies and appliances, and drugs and biologicals related to the palliation and management of the terminal illness and related conditions as provided in the plan of care. The hospice must have policies on repair and maintenance of DME and assure that patients and family have instruction of the safe use of all DME. The Interdisciplinary team must evaluate and assess the ability of the patient and/or family to self-administer drugs and biologicals. The Hospice must maintain written policies to track, collect, and dispose of controlled substances maintained in the patient's home. The use of the controlled substances must be reviewed the patient at the initial assessment to assure that they are educated on the dangers of controlled substance. This review must be documented. 418.106

Condition 418.108-418.110 addresses inpatient care for hospice patients. 418.108 outlines the basic standard that inpatient care for symptom management and pain must be provided whether by (1) a Medicare approved hospice, (2) a Medicare participating hospital or SNF. Both of the possible providers must meet the standards set in 418.110, primarily have 24 hour nursing care. The standards for respite care are similar and there is a provision that allows for under arrangement/contractual inpatient care services. 418.110(c) and outlines the requirements for the under arrangement agreement. Most importantly, the hospice is required to train hospital staff on hospice services and document the names of the trainers and the hospital staff trained. There is no change to the



existing limitation on the number of covered inpatient stays – 20% of the total hospice days of service.

418.110 outlines detailed requirements for inpatient hospice facilities similar to the hospital COP's including training requirements, 24 hour nursing services, physical environment standards including procedures for safety, physical plan such as lights and ventilation, fire protection, a home-like atmosphere with rooms or "accommodations for families, infection control procedures, even linen and meal service requirements. This COP also outlines very strict procedures applicable to the use of restraints with patients. Basically there must be a signed order from a physician for the use of restraints and restraints or seclusion can only be used in emergency situations. Restraints include physical restraints and drugs. 418.110 (o).

418.112 outlines additional standards for hospices that provide care to residents of SNF/NF or in other facilities. For those patients, the hospice must assume full responsibility for the professional management of the resident's care in line with the overall hospice COP's including providing the core services. The hospice and the facility must have written agreement that complies with certain standards set out in 418.112(e) and the hospice must assure proper training and orientation of the facility's staff who provide patient care on the hospice philosophy, the policies and procedures of the hospice in regards to comfort, pain control, and symptom management, principals of death and dying, patient rights and the hospice's record keeping requirements.

418.114 specifies the personal and professional qualifications of the hospice staff and 418.116 outlines the requirement that hospice staff and the hospice operate in compliance with all applicable laws.

### III. COMMENTS

#### A. In General

Some of the new definitions seem redundant: clinical vs. progress note. Drug and physical restraint are not terms used in the hospice community. Hospice goals focus on optimizing quality of life and allowing each person the maximum freedom, all the while treating the suffering. Hospice encourages interaction with family, clergy, friends etc. Seclusion is also not a term used in the hospice setting. These words come out of the nursing home/hospital CoPs.

The new regulations add particular burdens on hospice organizations primarily in the area of requiring detailed policy and procedure and documentation requirements. The workings of the interdisciplinary team have been structured such that there needs to be ongoing and documented communication and activity regarding each hospice patient that is included in the clinical records. See, 418.58, 418.104. In addition, the hospice must be able to authenticate each and every signature in the clinical record which will require the

hospice to take handwriting or signature samples of each and every staff member involved. Similarly, the Quality Assessment and Performance Improvement requirement at 418.58 places some structural requirements to quality improvement processes that may or may not be functional. CMS has provided some insight into their intent with reference to the data driven outcome processes for (1) improved palliative outcomes, (2) focus on end of life support services, and which (3) take actions that improve performance. The rule requires at least 1 annual "Performance Improvement" project.

Some of the new regulations reflect common practices such as infection control procedures but places an overall burden on the hospice itself to orient and educate staff and others as to their procedures. The new rules do provide a specific outline of the clinical record requirements which in the past has been loosely stated. And, in general, the new rules, although burdensome in some areas as will be mentioned below, do provide some benchmarks and guidance which the former rules did not have. I suggest that these rules reflect the likely changes to be seen in the home health regulations.

B. Specific Comments For CMS (This can be cut and pasted for delivery to CMS at [www.cms.hhs.gov/regulations/ecomments](http://www.cms.hhs.gov/regulations/ecomments).)

1. ASSESSEMENT TIME FRAMES

CMS is focusing on paperwork rather than patient care. The time frames are not realistic when a hospice length of stay has continued to diminish.

The requirements of 418.54 (b) for completion of the comprehensive assessment 4 calendar days following "election of the hospice benefit" could be impractical and is not necessarily consistent with patient care concerns as it provides too short a time frame to meet with family members and review all issues associated with hospice patient care and grieving process. The nature of the assessment requires inclusion of the emotional and spiritual needs which also may involve cultural or religious considerations that cannot be fully addressed in the short 4 day period. A more reasonable time frame is 7 calendar days with a provision that allows for a short delay for consultation with out of town or otherwise unavailable parties such as family members.

418.56(d) provides for a required 14 day review and update of the comprehensive assessment and plan of care. This requirement is also overly burdensome. Such a short time frame suggests a need for frequent alterations to the comprehensive assessment which is unrealistic as to patient needs. A time period of not less than 30 days is more realistic with the requirement that the review and updates of the assessment and plan of care be completed as the needs of the hospice patient and family change. The 14 day time frame is simply too short and requires the hospice to

spend extraordinary time with paper work rather than hands-on care-giving.

## 2. OUTCOME BASED PERFORMANCE MEASURES

418.58 requirement for Quality assessment and Performance Improvement (QAPI) with providing specific guidelines as to the expectations of CMS. The reference to "measurable improvement" is vague as to undefined concepts such as "palliative outcomes" and "end of life support systems." State survey agencies reviewing the QAPI program need guidance for this assessment as they will be the first line of review as to the operation of the program. Either in this rule or in interpretive guidelines, CMS needs to establish some benchmarks for its expectations pertaining to "improvement" and not allow each state to determine its own definition.

418.58(g)(2)(i) the Aide and Homemaker services are included in the hospice's IDG plan of care. To require another order from the physician or APN is redundant and burdensome.

418.76 (h) Supervision of home health aides. Has CMS received complaints from hospice patients and/or families that indicate there are issues with hospice aides? If the purpose of the rule is to determine if the aide is competent, then testing once per year seems sufficient. Is this related to the POC? Perhaps once every 60 days is more reasonable for hospice.

## 3. ORGANIZATION AND ADMINISTRATION

418.100(a) establishes a standard that is beyond the normal standard of care for hospices that "optimizes" comfort and dignity. This standard exceeds traditional standards of care and should be restated. Under traditional standards of care, the hospice should be required to meet the needs of the patient for comfort and ensure the preservation of the patient's dignity and use any suffering.

Similarly 418.100(b) undermines state law requirements for Board of Director management of corporate or other legal entities. Board of Directors, generally, are charged with oversight of a company's operations and do not perform hands-on management the entity.

418.100 (e) "Services must be provided by personnel with at least the same qualifications as hospice employees?" Oversight of the personnel is a better word choice along as is using qualified personnel rather than "at least the same qualification."

418.100(f) Will current satellite offices be grand fathered or will all current offices be required to undergo surveys now or at the next survey?

418.102(a) An electronic health record is valuable only if standardization is achieved. If private insurers are not required to follow the exact same format, it will be just like HIPAA. Each payer will do his/her own thing and records could not be shared between other health care providers or insurers.

418.102(c) It appears that CMS is attempting to make this a physician driven health care model instead of the IDG model it is.

418.104 require authentication procedures for the clinical record which are vague and need clarification. This type of authentication is required for a bricks and mortar facility such as a hospital. It appears the authentication requirements include all clinical documents such as home health aide notes and nursing notes. However it also refers to the "primary author who has reviewed and approved the entry." Does this standard require authentication of the handwriting and signatures of all staff or just the QAPI or other reviewing author? Please also provide examples of the nature of authentication required.

418.104(d) Identifying the potential dangers of a controlled drug to a terminal patient, may make them reluctant to use the medication to make them comfortable. This defeats the purpose of hospice. This particular section seems overly prescriptive for hospices.

418.104(e) Requiring the hospice to send both the clinical record and a discharge summary is burdensome and not all health care entities want that information sent to them. It should read either/or. That allows each hospice and other health care provider to determine what is appropriate.

418.06(c) Hospices have contracts with DME providers to provide maintenance. To now suggest that hospices get into the repair and maintenance business seems unreasonable. This standard should say the vendor is responsible.

418.110(b) The removal of the 24-hour nursing requirements for inpatient respite are very legitimate. The removal of the 24-hour nursing requirement for general inpatient levels of care is a concern.

418.110(o) Physical restraint and seclusion are terms rarely applied to hospice patients. Medications are used to make the patients comfortable from terminal restlessness, symptom management, etc. that in other settings may be called restraints. Using medication to control a patient's freedom is not a standard of treatments normally seen in hospice.

Respectfully Submitted,

Kathleen Anderson, Executive Director  
Ohio Council for Home Care  
Columbus, OH 43229  
[kka@homecareohio.org](mailto:kka@homecareohio.org)

**Submitter :** Ms. Susan Fort  
**Organization :** Georgia Chapter of NASW  
**Category :** Social Worker

**Date:** 07/25/2005

**Issue Areas/Comments**

**Issues 1 - 10**

**Social Work**

To practice with individuals and their families affected by dying, death, and bereavement, a social worker needs to have the appropriate educational background. Clinical intervention with these hospice patients and their families should require a Master's degree from an accredited program. The Georgia Chapter is in agreement with and supports the National Association of Social Workers comments submitted to raise the standard qualification of a hospice social worker to this standard. In rural areas where an MSW is not available, a BSW who is supervised by an licensed social worker or an other licensed mental health professional, is the very minimum requirement recommended for a hospice social worker.

Thank you for the opportunity to comment on these important regulations.

Sincerely,  
Susan R. Fort  
Executive Director  
NASW-GA

**Submitter :** Ms. Martha Kendall H

**Date:** 07/25/2005

**Organization :** National Association of Social Workers, Oklahoma C

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

I think it very important that psycho-social support in Hospice be provided by professional social workers. Social workers are trained to work with the person in his/her environment. The social worker works also with the family. We are trained to help people in decision making and through the grief process. Licensed Clinical Social Workers are able to provide psychological counseling to patients and families. We are trained to help patients and families understand the medical procedures and medications. We know how to "be there" for patients and families in a way perhaps not understood by other professions. My husband has just been diagnosed with early Alzheimer's. The first person I called for help was a LCSW who works in aging areas. The only counselor I want to help me and him is a LCSW. Thank you.

**Submitter :** Ms. Gina Reese  
**Organization :** Kaiser Foundation Health Plan, Inc.  
**Category :** Health Care Industry

**Date:** 07/25/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

Comments on Proposed Hospice Conditions of Participation, 42 CFR Part 418, File Code CMS-3844-P. See Attachment.

CMS-3844-P-90-Attach-1.PDF



July 25, 2005

**Via: Overnight Mail**

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

**Re: Comments on Proposed Hospice Conditions of Participation  
42 CFR Part 418  
File Code CMS-3844-P**

Dear CMS Hospice Staff:

Kaiser Foundation Hospitals, Inc. ("Kaiser") operates 14 hospices in California and one hospice in Oregon. As such, Kaiser is a key provider of hospice services and is profoundly invested in ensuring a high quality of care for hospice patients. Kaiser hereby submits a summary of its review of and comments on the proposed revisions to the Medicare hospice Conditions of Participation ("CoPs") to the Centers for Medicare & Medicaid Services ("CMS").

**General Thoughts on Proposed Rules for Hospice COPs:**

In general, Kaiser notes that the proposed revisions to the COPs fit well within the current hospice practice of JCAHO accredited programs. We are encouraged by CMS' emphasis on quality and outcomes for patient care, instead of focusing solely on monitoring of processes that may not result in improved quality of care. Also, we notice that the proposed regulations are moving towards implementing current standards imposed by the industry on itself or using home health agency standards as CMS' model for hospice. In some cases, the regulations propose the same standards as the home health COPs. However, in some cases, the proposed regulations unnecessarily exceed the home health requirements. We are in agreement with the basic philosophy, but believe that CMS must be realistic about the practical application and feasibility of some of these proposed requirements.

Kaiser also believes that the CMS estimates of time and cost to implement these new COPs are too low, especially the requirements under Comprehensive Assessment, QAPI and Care for Facility-Based Residents. These proposed regulations will have a significant financial impact on Hospice.

**Comment #1: PATIENT'S RIGHTS – Section 418.52**

**Standard (b) – Exercise of Rights and Respect for Property.** This standard should include the patient's right to refuse treatment.

**Standard (b)(4).** The reporting rule for "alleged" violations of abuse seems excessive. This proposed regulation states that hospices must report all alleged violations to the state survey agency within 5 working days "of the incident." Kaiser notes that the timing of this requirement is vague, since the "incident" may have occurred long before it is actually reported to hospice staff. Kaiser further notes that it is unclear whether this requirement applies only to incidents involving hospice staff or whether it applies to any alleged abuse, etc., that may be reported that involves the patient's family or caregivers. Kaiser also notes that some of the alleged incidents are proven to be without basis through internal investigations. Kaiser believes it would be more appropriate to require the investigation of all alleged incidents and the reporting of actual, investigated, actionable violations to the survey agency. In addition, hospices should be required to comply with any other state reporting requirements for elder abuse, etc.

**Comment #2: COMPREHENSIVE ASSESSMENT OF PATIENT.**

**Sections 418.54(a) and (b)**

The proposed rule regarding the comprehensive assessment of the patient will drastically increase the administrative requirements of the hospice and set standards that are vague and unrealistic. The proposed rules require that the Initial Assessment be completed within 24 hours of care and that the Comprehensive Assessment be completed within four calendar days (not business days). The Comprehensive Assessment must be updated every 14 days.

The proposed hospice COPs for comprehensive assessment is unnecessarily more onerous than the similar COP for home health agencies. The Home Health COPs, Section 484.55, require an assessment to be completed every 60 days (rather than the 14 days proposed for hospice), or more frequently where there is a beneficiary elected transfer, a significant change in condition resulting in a change in the case-mix assignment, or a discharge and return to the same HHA during the 60-day episode. The initial home health assessment is required to be completed within 48 hours of referral (rather than the 24 hours for hospice) and the comprehensive home health assessment is required to be completed within five days (rather than the four days proposed for hospice). Agency professional staff is also required to promptly alert the physician to any changes that suggest a need to alter the plan of care.

Kaiser is confused with the vagueness and interpretation of the time periods and seeks clarification regarding the time frames as they will be used practically. For the initial assessment, 24 hours is too short a time frame. Many times the physician has ordered the hospice care, but the patient has not accepted the care and the physician has not completed the Certificate of Terminal Illness. It is unclear whether the hospice will be held to 24 hours from the date the physician faxed the order to the hospice, even though the patient has not accepted the order for hospice and/or the hospice has not accepted the patient for hospice care either. The hospice may not be able to be equipped to provide care to that patient and may not be able to accept that patient. As the proposed rules are currently worded, it is not clear when the clock starts ticking and, in any case, 24 hours is too short a time period to finalize this process. In addition, it is

important to note that often the patient and/or family do not wish to have a visit within 24 hours of the time the hospice receives the physician certificate of terminal illness or "order" for hospice services.

Kaiser recommends the following suggestions listed below:

### **Request for Change of Proposed Rule for Assessments**

We agree that there should be timelines on the initial assessment, comprehensive assessment and updates of the comprehensive assessment. However, we do not agree with the timeframes suggested in the proposed rule. We would suggest that the time frames should mimic home health time frames or the standards of practice in the industry, which is longer than 24 hours. We ask to accommodate all the changes and nuances of starting care that the proposed rule for initial care is re-written to state:

- a) "A registered nurse will make an initial assessment visit to determine the patient's immediate care and support needs within 24 48 hours after the hospice has received the physicians order and the patient and family have signed on or accepted hospice service, or later, as requested by the patient/family or physician."
- b) We also ask that the four calendar days to complete the comprehensive assessment be lengthened to seven days, as the Interdisciplinary Group (IDG) meet weekly and this will result in hospices being able to comply with this requirements.
- c) We ask that the 14 day comprehensive assessment update be less frequent that every 14 days and be more in-line with the 60 day home health requirement. If the assessment update is required at the end of each certification period, then the assessment results will be more useful for recertification purposes. The rule should include that the assessment update can and should be done more frequently if the patients condition changes. We understand the urgency and more dynamic nature of a hospice patient's health, who is terminally ill, versus a patient under home health requires a more frequent update to care than 60 days. However, we want the patients' needs to be met and not spend unnecessary time and energy on just administrative paperwork. The IDG should be focused on meeting the plan of care needs should they change the rule should include references to require more frequent assessments when there are changes in the patients condition, including psychosocial, emotional, etc.

### **Comment #3: PLAN OF CARE or COORDINATION OF SERVICES** **Section 418.56**

**Standard (b) Plan of Care** – This proposed rule should be changed to clearly state that only one POC is required and that a separate POC is not required for the family.

**Standard (C) Content of the plan of care** – The proposed regulation should be changed to require that the hospice IDG must document patient and family understanding and involvement with the plan of care. The word **agreement** should be deleted.

During the NAHC Teleconference, Mary Rossi-Coajou and Danielle Shearer (from CMS) presented the concept of the Comprehensive assessment in ways that seemed to indicate it was a combination of Assessment and Plan of Care. This needs to be clarified for all aspects of compliance to the Assessment COP and the Medical Record COP. It is significant as it pertains to content of the POC, versus content of the assessment; the timeframes and the content requirements seem to overlap. Are they one in the same document? There were many questions relating to this, but the answers did not clarify the difference. For example, Section 418.54(e) states the comprehensive assessment must include the data elements. Section 418.56 states the content of the POC must include measurable outcomes, but no reference to the data elements. Section 418.104(a) states the content of the POC must include the data elements. It is unclear where CMS expects the data elements to be documented.

**Standard (e)(4).** Kaiser requests clarification of the type of "system" CMS is expecting for communication with outpatient settings/contract services. Would this be above and beyond the normal documentation of telephone communication and case conferences? The COP mandating the IDG review the patient care every 14 days would accomplish this. How does CMS expect to see compliance demonstrated to the requirement to have a "system?"

**Comment #4: Quality Assessment Performance Improvement (QAPI) - Proposed: Section 418.58 [User Term in Comments: "QAPI"]**

The regulation would require that a hospice to create a Quality Assessment Performance Improvement Program ("QAPI"), which include no specific data elements and no requirements for reporting to improve palliative care outcomes and access to end of life supportive services. The hospice is allowed develop their own data elements and measurement process as part of its quality assessment and performance improvement program or could use the suggested NHPCO measures and must focus on high risk, high volume problem areas and track adverse patient events, analyze their causes, and implement preventive actions that include feedback and learning and to demonstrate how staff contribute to the quality improvement program, and must performance improvement projects and to measure and document these projects. The hospice governing body would be responsible for the QAPI program and the specific requirements of monitoring the quality of care. Additionally, in a later part of the proposed rule, under Medical Director, 418.102, it requires the Medical Director or the physician designee to be responsible for the QAPI.

Kaiser has three concerns with the QAPI proposal as described above and in the rule and requests three changes to correspond to these concerns. The concerns are:

- a) The future intent of the QAPI for a mandatory assessment tool;
- b) The requirement of the Medical Director to be responsible for the AQPI.
- c) The vagueness of the QAPI and the application to survey;

**General Comment on the QAPI Proposal:**

Kaiser extremely concerned about the eventual mandatory implementation of a tool like the Outcome Assessment Information Set (OASIS) for hospice. The OASIS tool has failed the

patient and home health by turning it into an academic tool that is largely unusable for home health care and is instead focused on "getting paid." In hospice, it will harm providers who take patients where they only will get to provide them 2-3 services and then death will result. It will bring down their scores and make it a disincentive to provide care to the very sick seeking hospice care at the end stages of life – which is what most hospice care is for non-home health agency hospices. Also, it is also unclear what would be considered an "adverse event" in Hospice. Without prescribing a defined element, this requirement seems difficult to monitor in a meaningful, consistent method across the industry.

Kaiser also has some concern that there is a requirement to create data sets and collect outcomes without a valid and reliable common set of measures in the industry. This is especially onerous considering the concept that CMS may require specific data measures in the future that may cause Hospices additional burdens of changing systems, documentation and processes to convert to a prescribed system, not mandated now. Kaiser requests that CMS either delete these proposed requirements or specifically define for the hospice industry the standards that CMS will require to measure outcomes-based performance.

#### **Request for Change of Proposed Rule for QAPI:**

- 1) Kaiser requests that CMS either delete these proposed requirements or specifically define for the hospice industry the standards that CMS will require to measure outcomes-based performance. We would ask that the proposed rule indicates that any future discussions of developing a set of measures will occur as a result of industry wide input to come up with outcome management program that is based on compassionate care (rather than developed in an academic setting such as Home Health's OASIS and OBQI) and will include provider stakeholders from across the nation and will outreach to state associations representing home health and hospice to enlist their membership to participate.
- 2) We would also request that the Medical Director or the physician designee not be responsible for the QAPI, as the proposed rule references in Section 418.102. The proposed rule charges the Hospice Governing Body with oversight. However, the reference to the Medical Director as the responsible entity is in conflict with the proposed rule in the QAPI Section, 418.58 (e), which states that the Governing Body is responsible. Additionally, it is in conflict with current COPs, Section 418.52, indicates: "A Hospice must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospices' total operation. The governing body must designate an individual who is responsible for the day to day management of the hospice program. The governing body must also ensure that all services provided are consistent with accepted standards of practice." Therefore, we recommend that the proposed rules strike the reference to the Medical Director of the Hospice being responsible for the QAPI program, as the governing body will be responsible and, per current regulations, is allowed to select an individual to oversee the body. The hospice should have the option of having the Medical Director review it. However, it should not be required that the staff for this requirement be the Medical Director.
- 3) We would like to go on record regarding the vagueness of the QAPI program and the application to certification surveys. When an agency is surveyed, it should be written clearly in

the interpretive guidelines that surveyors use to probe that the Hospice should have to show their policy and procedures on the QAPI program, but that it is specific to the hospice, as the indicators are not set. The survey mechanism should be lenient and not stringent, as often occurs in surveys.

**Standard (e) - Governing Body** – We recommend referring to JCAHO Home Care Standards for Leadership 1.20 elements 1 through 7 in this regulation.

**Comment #5: NON-CORE SERVICES – PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY – Proposed Sections 418.72 and 418.74**

Kaiser does not believe that it is necessary to have PT, OT and SLP services available on a 24 hour basis. Hospice patients seldom need rehabilitation services and when they are needed, these can be provided on a non-urgent basis. Common patient and family needs are instruction in use of mobility devices (e.g. use of walker) or in assisting with patient transfers. These are basic skills that nurses do or should have. It would be more practical to require that Hospices assure RN competency in these areas and availability of RN intervention in these areas 24 hours/day than to continue with the rehab service (PT, OT, and SLP). Kaiser requests that this standard be changed to waive this requirement for all hospices without requiring a waiver process.

We also recommend adding dieticians to this section as a non-core service

**Comment #6: SUPERVISION OF HOME HEALTH AIDES - Proposed: Section 418.76 (h)**

Under current Medicare hospice law, Section 418.94 (a) of the Conditions of Participation state, "A registered nurse must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services." The current hospice requirements do not include a joint visit. Current Medicare home health agency law requires a supervisory non-joint visit every 14 days for patients receiving skilled care and supervisory joint visits every 60 days if the services performed are provided to a person not receiving skilled care. Joint is only required for the skilled care when the home maker/home health aide is getting a performance evaluation.

The proposed rule would expand the rule to require a joint supervisory visit once a month. This would be an entirely new requirement that exceeds the home health joint visit requirement which is every 60 days and/or during performance evaluations.

The proposed rule would require Certified Home Health Aide providing care to a patient receiving no skilled services to be more frequent than 60 days.

*Important Note: The proposed rule background in the paragraph two of the third column on page 30852, indicates that the new 14 day requirement would relieve the requirement of a joint supervisory visit required in Section 484.36(d)(2). A joint visit is currently not a requirement for a CHHA. This is only a requirement if they are performing a performance evaluation of the*

*CHHA. Therefore this is inaccurate. California Regulations, Title 22, Section 74709, (a) (2) provides even more detail of this federal law as it is modeled after it.*

Under current Medicare home health agency law, home health aide supervision for patients receiving skilled care is required every 14 days and is not a joint visit, unless part of performance evaluation is occurring. Current law requires that beneficiaries receiving non-skilled care are required to have a joint supervised visit every 60 days.

**Request for Change of Proposed Rule for Joint Visits every 28 days:**

Current requirements for hospices are nurse visits every two weeks and assessment of the services, but are not joint visits. We agree with the logic that there should be a periodic joint visit, which is not required currently. However, we ask that the hospice COP for joint aide visits mirror the current Federal Home Health COPs, which require a joint visit every 60 days.

Additionally, we ask that CMS clarify that the supervision is not by a specific person, but may be performed by either a nurse or therapist (under the conditions in which they apply). The wording in the proposed regulation is vague regarding supervisor and infers that it can only be done by the aide's immediate supervisor. We would ask that it be clarified and re-worded to say that the supervision may be conducted by either a nurse (if patient is receiving skilled nursing care), or the appropriate therapist, if receiving another skilled service and that it is not required to be performed by a specific supervisor.

**Comment #7: Section 418.64 - CORE SERVICES**

**Standard 418.64(d): Bereavement Services**

We do not feel that the hospice should be responsible for services to the employees of a facility as part of our core services.

**Comment #8: ORGANIZATION AND ADMINISTRATION - Section 418.100**

**Standard 418.100(f).** The definition of "satellite locations" needs to be clarified. Does the definition include staffing locations or locations where staff pick up supplies and drop off paperwork?

**Comment #9: Initial/Recertification Certification of Terminal Illness - Proposed: Section 418.102 - "MEDICAL DIRECTOR".**

This proposed regulation would add new requirements for how physicians make decisions on terminal illness and require them to include more information to prove the six month terminal illness qualification and would require the medical director of physician designee to complete a clinical review and a written certification of terminal illness in order to begin hospice care (initial certification). Subsequent certifications would also require review of clinical and the patient and family's expectations and wishes for hospice care on an ongoing basis and before each updated assessment every 14 calendar days and at the time of recertification. The rule also makes the medical director of physician designee responsible for the hospice's quality assessment and performance improvement program (which we addressed in the QAPI section and will address below).

Our concerns in this section are as follows:

- 1) Certification and Recertification Content Requirements
- 2) Integration of Recertification Content Requirements into new Assessment requirements every 14 days
- 3) Medical Director or Physician Designee Responsibility for QAPI

**General Comment:** Current law, 418.22 (a) indicates what hospice personnel can certify the terminal illness, the time periods of certification, as well as the requirement for written certification "content" for terminal illness definitions to qualify for hospice care. The content requires that the prognosis for life expectancy must be 6 months or less. No other content is required to certify the terminal illness. Under the proposed rules, the Medical Director would have to review the clinical information and provide written certification. The proposed rule does not specify what the clinical review entails and what written certification means.

**Request for Change of Proposed Rule for Medical Director**

- 1) We request that the current certification and content requirement stay the same for the **initial certification and recertification** of terminal illness diagnosis. Each Medical Director is different in how they make their decision on terminal illness. We do not need to place new burdens on current Medical Directors, but need to examine placing federal requirements on Doctor curriculum that includes classes and rotations on end-of-life care that include understanding how to make a terminal diagnosis and the important questions and methodologies to use to make that important assessment for terminal diagnoses.
- 2) This new initial and re-certification requirements are included **every 14 days** at the time of each update of the comprehensive assessment (and visa versa with each recertification the assessment is updated). This new rule will have unintended consequences and will likely result in a disincentive for referral to hospice care as the medical director must prove each time when a patient is clearly terminal. Our providers are already experiencing many barriers to getting patients referred to hospice when they need hospice care. We do not want new regulations that create new barriers and disincentives to make it more difficult for the terminally ill to get hospice care. Therefore we request that you leave the initial and recertification process as is and remove it from the proposed 14 day comprehensive assessment update.

We take exception with the timeline of 14 day assessment, as required in 418.24 (d), Home Health COPs, Section 484.18(b) requires an assessment to be completed every 60 days, or more frequently where there is a beneficiary elected transfer, a significant change in condition resulting in a change in the case-mix assignment, or a discharge and return to the same HHA during the 60-day episode. Agency professional staff promptly alerts the physician to any changes that suggest a need to alter the plan of care. We agree that there should be timelines on the initial, comprehensive and update of the comprehensive. However, we do not agree with the timeframes suggested in the proposed rule or all of the content included in the assessment, including the recertification content.

- 3) We would also request that the Medical Director or the physician designee to not be responsible for the QAPI, as the proposed rule references in Section 418.102. The proposed rule



charges the Hospice Governing Body with oversight. However, the reference to the Medical Director as the responsible entity is in conflict with the proposed rule in the QAPI Section, 418.58 (e), which states that the Governing Body is responsible. Additionally, it is in conflict with current CoPs, Section 418.52, indicates: "A Hospice must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospices' total operation. The governing body must designate an individual who is responsible for the day to day management of the hospice program. The governing body must also ensure that all services provided are consistent with accepted standards of practice." Therefore, we recommend that the proposed rules strike the reference to the Medical Director of the Hospice being responsible for the QAPI program, as the governing body will be responsible and, per current regulations, is allowed to select an individual to oversee the body. The hospice should have the option of having the Medical Director review it. However, it should not be required that the staff for this requirement be the Medical Director. This would be a substantial increase in responsibilities for the medical director. Currently, it is difficult to obtain a medical director. This would make it even more difficult with unrealistic responsibilities being required.

**Comment #10: RECERTIFICATION - Section 418.102(b)** – It is recommended that the phrase "patient/family expectations and wishes" for hospice care must be reviewed. This should be changed to "hospice goals and POC must be reviewed by patient/family".

**Comment #11: CLINICAL RECORDS – Section 418.104**

Standard (b) Authentication - The proposed regulation states that "All entries must be signed and the hospice must be able to authenticate each handwritten...signature...". This is not realistic. Examples that would present compliance problem include contracted nursing home and facility staff and infusion vendors who provide hospices with progress notes.

Standard (e): Discharge or transfer of care

We do not feel that a complete record should be sent to another hospice or to a physician. This is a time intensive and expensive process that does not add value for the patient nor will the physician or hospice use this on a regular basis. A discharge summary should be sufficient.

**Comment #12: CONTROLLED DRUGS IN PATIENT HOME – Proposed Section 418.106 (b) – [DRUGS, SUPPLIES, and DME]**

This proposed regulation adds a new requirement for a hospice to track, collect and dispose of controlled substances.

**General Concern:** Hospice agencies have no responsibility for and control over the medication when they are not in the home and this requires the hospice to take on a responsibility that they can not feasibly be responsible over in a person's home. Also, the medications are the property of the patient, not the hospice. Making a hospice responsible for this care will put them at risk for scenarios and situations that they can not control. CMS can not require a hospice agency to pick up the medications for the patients and not all hospices dispose of controlled substances. It is also dangerous for staff to carry controlled substances anywhere for disposal. Also, if the family refuses to dispose of them at the time of death, hospices do not want staff in a position of being required to take them from the home and dispose of them.

It would be helpful to have the intent of the drug control standard specified in the COPS. This is an area of conflict between local medical examiners and hospice's. It should be clearly defined what Hospice's are and are not responsible for. For example we are responsible for patient/family/caregiver education regarding drug disposal and safety but not disposal of the drugs or control of the drug inventory in the home. The words "tracking" and "collecting" suggest more of an enforcement role than an educational one by the hospice. The drugs are the property of the patient and family and we feel that the role of the hospice is education, not enforcement.

Additionally, the CMS discussion of this item states, "During the initial assessment, the hospice policy regarding the use and disposal of controlled drugs would be required to be discussed with the patient and family." We take exception to the hospice having to cover this during the initial assessment with the family and the patient. The patient is in pain and until the patient has an order for drugs, then it should not be necessary to review a policy and procedure that is not relevant to the patient and family. During the initial assessment, the family and patient should not be overwhelmed with technical details that are not relevant.

**Request for Change of Proposed Rule for Drugs Supplies and DME**

- 1) We would like the entire section requiring a hospice to be responsible for tracking, collecting and disposing of controlled substances to be deleted from the proposed regulation.
- 2) The hospice must discuss the use of controlled drugs with the patient and family, but it should not be required to collect, track or dispose. It should only have this discussion once the patient has an order for drugs and not before that time.

**Comment #13 – DME MANAGEMENT REPAIR – Proposed 418.106 (c) – DME Management Repair**

The new regulation requires a hospice to be responsible for the maintenance of equipment and supplies, and to ensure adequate training and instruction ("the how and when") to family regarding the equipment and supplies.

**Concerns:** This proposed rule does not take into consideration the differences between states. This regulation implies that hospices have their own equipment. In California, home health agencies and hospices do not oversee the use of the DME and, in fact, can not bill for DME or supplies. They contract with licensed DMEs to supply the product and service. DMEs are required to be licensed through Department of Health Services, Food and Drug Department and are required to get Medical Device Retailers License, which have strict requirements. The hospice doesn't have anything to do with the DME. Therefore, it does not make sense to make hospices responsible for this care as they are not supplying the DME. Requiring this will only result in problems and confusion for California hospice providers.

**Request for Change of Proposed Rule for DME Management Repair**

The proposed rule indicates that "the hospice may carry out this responsibility through a contractual arrangement with others, but would continue to maintain primary responsibility." We ask that this section is changed to adequately deal with states where hospices do not own and/or

provide the DME equipment to the state and rely on professional DME companies. We suggest that the sentence is clarified as such: "The hospice may use persons under contract and those persons would maintain primary responsibility for the services and the care."

**Comment #14: SHORT TERM INPATIENT CARE – Section 418.108.** This Condition should be rewritten to also allow this level of care for psychosocial/family crisis.

**Comment #15 – Hospice Care in a Facility – Proposed 418.112 - "RESIDENTS RESIDING IN A FACILITY"**

The new regulation expands the role of the Hospice Medical Director and expects them to play an expanded role in providing medical supervision to the hospice interdisciplinary group and overall coordination of the patient's plan of care. The medical director must now also communicate with all facility physicians and the attending physician for the patient. This would result in a barrier to patients receiving care and could result in a delay of services or no services because of a lack of compliance, and therefore, hospices **not taking patients who need facility level care.** This does not take into consideration that, most of the time, the Medical Director of the Hospice is the attending physician, and that the Medical Director of the SNF is different from SNF to SNF. This requirement takes only into consideration the SNF approach. The Hospice approach is that the Hospice has the professional judgment of the Hospice. The proposed rule seems to suggest that CMS is requesting the Hospice to take on more and more of the SNF role, when the hospice is not on site for 24 hours a day. By making the Medical Director of the Hospice responsible to consult with

The proposed rule indicated the following, "We are preparing a separate regulatory document to address long-term care facility obligations regarding residents receiving hospice services." We suggest that the Hospice CoPs do not include regulations regarding residents residing in a facility UNTIL the report regarding long-term care facility obligations regarding hospice services is complete. This will allow us to adequately respond to this section of the proposed rules which include added new requirements for hospices in SNFs, because we will know what CMS will be requiring of SNFs.

**Concern:**

With more hospice recipients needing hospice services in the community and not in the home, this added requirement on the Medical Director could lead to major issues and disincentives to getting a patient in one of these types of institutional settings. Part of the proposed rule, which states, "The medical director of the 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" is of great concern for hospices. The concern is specifically related to the reality of the request. Currently, hospices also provide care to the hospice patient. Asking the Hospice Medical Director to consult with all Doctors is unrealistic because, often times, the Medical Director of the SNF is the attending physician for the patient.

**Request for Change of Proposed Rule for Residents Residing in a Facility**

We would suggest that the proposed rule is changed to require notification of the Medical Director of the SNF regarding the update of the plan of care. However, it should not be

mandatory to talk with all physicians at the SNF and require it in order to do a plan of care. It should be optional and encouraged, especially when there is a development. With the plan of care being required, under the ASSESSMENT TIME FRAMES, Proposed Rule 418.54, for every 14 days, this requirement is impractical and unfeasible for real world scenarios. While CMS is hoping to encourage a lively and thorough discussion for the patient to help them achieve the best outcomes, it will result in the opposite. It will result in either non-compliance or physicians of hospices and nursing homes developing a quick check off ability. We should ensure that physicians are encouraged to communicate with each other periodically at important time points to examine important outcomes for the patient.

As this proposed rule is shifting much of the burden and responsibility onto a hospice to deliver care, even though the SNF or facility has responsibility for non-terminal care as well, it becomes more illogical to require the Hospice Medical Director to consult even more frequently with a SNF as they are to provide less care than before under this proposal..

We would also agree with language that stated, The Hospice Medical Director shall notify in writing or verbally the SNF facility physicians regarding the POC every 30 days to confer regarding the patients overall coordination of care.

Needing a written agreement per patient with consent and specific clarification per care plan for which services the hospice will provide, and which the facility will provide will increase the amount of time needed to admit, document, and provide oversight for facility residents. Especially significant is that the hospice may only use the facility nursing personnel for those tasks which would ordinarily have been done by a resident's family in implementing a care plan. How does that impact SNF licensed caregivers needing to provide care as needed?

**Comment #16 – HOSPICES THAT PROVIDE INPATIENT CARE DIRECTLY – Section 418.110.**

**Standard (f) Patient rooms – Agree** that patient rooms must provide at least 80 square feet with no more than 2 beds to a room requirement.

**Comment #17 - PERSONNEL QUALIFICATIONS – Section 418.114**

The proposed rule asked for comments on the issue of changing the current requirement of a bachelor's degree for a social worker under Hospice to a Masters level. We would advise that this not occur. Currently, our state and federal requirements for a social worker in a home health setting requires a Master's Degree from a school of social work accredited by the Council of Social Work Education, with one year of social work experience in a health care setting. This has limited provider's abilities to be able to find social workers. A Masters in Social Work should be required OR a baccalaureate degree from a school of social work accredited by the Council of Social Work AND a least one year experience in a health care setting.

**Request for Change of Proposed Rule for Social Work Definition**

We would advise that CMS keep the Bachelor's degree requirement and additionally add a social work assistant as a type of social worker in a hospice. Adding the social work assistant to the

rules would open up the opportunity for a hospice to attract caring candidates who are suitable for hospice care services who have studied related disciplines (psychology; sociology; other social work related field) without penalizing potential employees who have already finished their bachelor's degree. Additionally, we would also ask that the regulations pattern the assistant social worker for persons with doctorates in fields that are not social work, such as psychology. We have heard of providers who could not hire a PhD in Psychology who was interested in the social worker position at a hospice because he had changed his focus in life and wanted to work in hospice, but could not because of the current regulations. The regulations need to be flexible to allow for PhDs in other fields, as well.

**Standard (d) – Criminal background checks – Strongly recommend keeping this new standard.**

### **Comment #18 - ELECTRONIC RECORDS**

Regarding CMS's request for comments regarding electronic records we can add the following:

#### Benefits

- Facilitates improved coordination of care, especially with nurses on different shifts
- There are numerous challenges/limitations in Hospice's ability to make changes in software to meet regulatory requirements and quality initiatives. Paper records are more flexible, easier to adapt to changes.

#### Disadvantages

- Cost
- Often decreases in staff productive adding to cost and reducing time spent with patients
- When computers fail (hardware or software) information is not accessible. Patient care and business processes revolve around the information system, if the computer is not accessible patient care, intake and referral can become paralyzed

Patients should be able to access at least some parts of their records (e.g. medication list, test results, plan of care). Ideally, this would occur through a secure internet site.

It is concerning to think that it might be mandated in future regulations. The cost may be prohibitive for smaller hospices.

Sincerely,



Gina M. Reese  
Senior Counsel

GMR:jaw

#289304

**Submitter :** Mrs. Susan Levine  
**Organization :** Hospice of the Valley  
**Category :** Hospice

**Date:** 07/25/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

see attachment

CMS-3844-P-91-Attach-1.DOC

**Submitter :** Dr. Pat Gleason-Wynn  
**Organization :** Elder Care Specialists  
**Category :** Social Worker

**Date:** 07/25/2005

**Issue Areas/Comments**

**Issues 1 - 10**

**Social Work**

I am providing comment on the CMS-3844-P, Hospice Conditions for Participation; specifically, on the personnel qualifications for a hospice social worker.

A hospice social worker needs to have a high level of expertise to practice with individuals and their families affected by dying, death, and bereavement. A professionally-degreed (preferably MSW) social worker is trained to help individuals and their families through this difficult, physically- and emotionally-draining time.

I agree with and support the National Association of Social Workers comments submitted to raise the standard qualification of a hospice social worker to a Master of Social Work degree from an accredited program. In rural areas where an MSW is not available, a BSW who is supervised by an MSW or a licensed mental health professional, is the minimum requirement recommended for a hospice social worker.

Thank you for providing this opportunity to comment on this important regulation.

Sincerely,  
Pat Gleason-Wynn, Ph.D., LCSW

**CMS-3844-P-93      Hospice Care Conditions of Participation**

**Submitter :** Ms. Gina M. Reese

**Date & Time:** 07/25/2005

**Organization :** Kaiser Foundation Health Plan, Inc.

**Category :** Health Plan or Association

**Issue Areas/Comments**

**GENERAL**

GENERAL

Comments on Proposed Hospice Conditions of Participation, 42 CFR Part 418, File Code CMS-3844-P. See Attachment

CMS-3844-P-93-Attach-1.PDF





July 25, 2005

**Via: Overnight Mail**

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

**Re: Comments on Proposed Hospice Conditions of Participation  
42 CFR Part 418  
File Code CMS-3844-P**

Dear CMS Hospice Staff:

Kaiser Foundation Hospitals, Inc. ("Kaiser") operates 14 hospices in California and one hospice in Oregon. As such, Kaiser is a key provider of hospice services and is profoundly invested in ensuring a high quality of care for hospice patients. Kaiser hereby submits a summary of its review of and comments on the proposed revisions to the Medicare hospice Conditions of Participation ("CoPs") to the Centers for Medicare & Medicaid Services ("CMS").

**General Thoughts on Proposed Rules for Hospice COPs:**

In general, Kaiser notes that the proposed revisions to the COPs fit well within the current hospice practice of JCAHO accredited programs. We are encouraged by CMS' emphasis on quality and outcomes for patient care, instead of focusing solely on monitoring of processes that may not result in improved quality of care. Also, we notice that the proposed regulations are moving towards implementing current standards imposed by the industry on itself or using home health agency standards as CMS' model for hospice. In some cases, the regulations propose the same standards as the home health COPs. However, in some cases, the proposed regulations unnecessarily exceed the home health requirements. We are in agreement with the basic philosophy, but believe that CMS must be realistic about the practical application and feasibility of some of these proposed requirements.

Kaiser also believes that the CMS estimates of time and cost to implement these new COPs are too low, especially the requirements under Comprehensive Assessment, QAPI and Care for Facility-Based Residents. These proposed regulations will have a significant financial impact on Hospice.

**Comment #1: PATIENT'S RIGHTS – Section 418.52**

**Standard (b) – Exercise of Rights and Respect for Property.** This standard should include the patient’s right to refuse treatment.

**Standard (b)(4).** The reporting rule for “alleged” violations of abuse seems excessive. This proposed regulation states that hospices must report all alleged violations to the state survey agency within 5 working days “of the incident.” Kaiser notes that the timing of this requirement is vague, since the “incident” may have occurred long before it is actually reported to hospice staff. Kaiser further notes that it is unclear whether this requirement applies only to incidents involving hospice staff or whether it applies to any alleged abuse, etc., that may be reported that involves the patient’s family or caregivers. Kaiser also notes that some of the alleged incidents are proven to be without basis through internal investigations. Kaiser believes it would be more appropriate to require the investigation of all alleged incidents and the reporting of actual, investigated, actionable violations to the survey agency. In addition, hospices should be required to comply with any other state reporting requirements for elder abuse, etc.

**Comment #2: COMPREHENSIVE ASSESSMENT OF PATIENT.**

**Sections 418.54(a) and (b)**

The proposed rule regarding the comprehensive assessment of the patient will drastically increase the administrative requirements of the hospice and set standards that are vague and unrealistic. The proposed rules require that the Initial Assessment be completed within 24 hours of care and that the Comprehensive Assessment be completed within four calendar days (not business days). The Comprehensive Assessment must be updated every 14 days.

The proposed hospice COPs for comprehensive assessment is unnecessarily more onerous than the similar COP for home health agencies. The Home Health COPs, Section 484.55, require an assessment to be completed every 60 days (rather than the 14 days proposed for hospice), or more frequently where there is a beneficiary elected transfer, a significant change in condition resulting in a change in the case-mix assignment, or a discharge and return to the same HHA during the 60-day episode. The initial home health assessment is required to be completed within 48 hours of referral (rather than the 24 hours for hospice) and the comprehensive home health assessment is required to be completed within five days (rather than the four days proposed for hospice). Agency professional staff is also required to promptly alert the physician to any changes that suggest a need to alter the plan of care.

Kaiser is confused with the vagueness and interpretation of the time periods and seeks clarification regarding the time frames as they will be used practically. For the initial assessment, 24 hours is too short a time frame. Many times the physician has ordered the hospice care, but the patient has not accepted the care and the physician has not completed the Certificate of Terminal Illness. It is unclear whether the hospice will be held to 24 hours from the date the physician faxed the order to the hospice, even though the patient has not accepted the order for hospice and/or the hospice has not accepted the patient for hospice care either. The hospice may not be able to be equipped to provide care to that patient and may not be able to accept that patient. As the proposed rules are currently worded, it is not clear when the clock starts ticking and, in any case, 24 hours is too short a time period to finalize this process. In addition, it is

important to note that often the patient and/or family do not wish to have a visit within 24 hours of the time the hospice receives the physician certificate of terminal illness or "order" for hospice services.

Kaiser recommends the following suggestions listed below:

### **Request for Change of Proposed Rule for Assessments**

We agree that there should be timelines on the initial assessment, comprehensive assessment and updates of the comprehensive assessment. However, we do not agree with the timeframes suggested in the proposed rule. We would suggest that the time frames should mimic home health time frames or the standards of practice in the industry, which is longer than 24 hours. We ask to accommodate all the changes and nuances of starting care that the proposed rule for initial care is re-written to state:

- a) "A registered nurse will make an initial assessment visit to determine the patient's immediate care and support needs within 24 48 hours after the hospice has received the physicians order and the patient and family have signed on or accepted hospice service, or later, as requested by the patient/family or physician."
- b) We also ask that the four calendar days to complete the comprehensive assessment be lengthened to seven days, as the Interdisciplinary Group (IDG) meet weekly and this will result in hospices being able to comply with this requirements.
- c) We ask that the 14 day comprehensive assessment update be less frequent that every 14 days and be more in-line with the 60 day home health requirement. If the assessment update is required at the end of each certification period, then the assessment results will be more useful for recertification purposes. The rule should include that the assessment update can and should be done more frequently if the patients condition changes. We understand the urgency and more dynamic nature of a hospice patient's health, who is terminally ill, versus a patient under home health requires a more frequent update to care than 60 days. However, we want the patients' needs to be met and not spend unnecessary time and energy on just administrative paperwork. The IDG should be focused on meeting the plan of care needs should they change the rule should include references to require more frequent assessments when there are changes in the patients condition, including psychosocial, emotional, etc.

### **Comment #3: PLAN OF CARE or COORDINATION OF SERVICES** **Section 418.56**

**Standard (b) Plan of Care** – This proposed rule should be changed to clearly state that only one POC is required and that a separate POC is not required for the family.

**Standard (C) Content of the plan of care** – The proposed regulation should be changed to require that the hospice IDG must document patient and family understanding and involvement with the plan of care. The word **agreement** should be deleted.

During the NAHC Teleconference, Mary Rossi-Coajou and Danielle Shearer (from CMS) presented the concept of the Comprehensive assessment in ways that seemed to indicate it was a combination of Assessment and Plan of Care. This needs to be clarified for all aspects of compliance to the Assessment COP and the Medical Record COP. It is significant as it pertains to content of the POC, versus content of the assessment; the timeframes and the content requirements seem to overlap. Are they one in the same document? There were many questions relating to this, but the answers did not clarify the difference. For example, Section 418.54(e) states the comprehensive assessment must include the data elements. Section 418.56 states the content of the POC must include measurable outcomes, but no reference to the data elements. Section 418.104(a) states the content of the POC must include the data elements. It is unclear where CMS expects the data elements to be documented.

**Standard (e)(4).** Kaiser requests clarification of the type of "system" CMS is expecting for communication with outpatient settings/contract services. Would this be above and beyond the normal documentation of telephone communication and case conferences? The COP mandating the IDG review the patient care every 14 days would accomplish this. How does CMS expect to see compliance demonstrated to the requirement to have a "system?"

**Comment #4: Quality Assessment Performance Improvement (QAPI) - Proposed: Section 418.58 [User Term in Comments: "QAPI"]**

The regulation would require that a hospice to create a Quality Assessment Performance Improvement Program ("QAPI"), which include no specific data elements and no requirements for reporting to improve palliative care outcomes and access to end of life supportive services. The hospice is allowed develop their own data elements and measurement process as part of its quality assessment and performance improvement program or could use the suggested NHPCO measures and must focus on high risk, high volume problem areas and track adverse patient events, analyze their causes, and implement preventive actions that include feedback and learning and to demonstrate how staff contribute to the quality improvement program, and must performance improvement projects and to measure and document these projects. The hospice governing body would be responsible for the QAPI program and the specific requirements of monitoring the quality of care. Additionally, in a later part of the proposed rule, under Medical Director, 418.102, it requires the Medical Director or the physician designee to be responsible for the QAPI.

Kaiser has three concerns with the QAPI proposal as described above and in the rule and requests three changes to correspond to these concerns. The concerns are:

- a) The future intent of the QAPI for a mandatory assessment tool;
- b) The requirement of the Medical Director to be responsible for the AQPI.
- c) The vagueness of the QAPI and the application to survey;

**General Comment on the QAPI Proposal:**

Kaiser extremely concerned about the eventual mandatory implementation of a tool like the Outcome Assessment Information Set (OASIS) for hospice. The OASIS tool has failed the

patient and home health by turning it into an academic tool that is largely unusable for home health care and is instead focused on "getting paid." In hospice, it will harm providers who take patients where they only will get to provide them 2-3 services and then death will result. It will bring down their scores and make it a disincentive to provide care to the very sick seeking hospice care at the end stages of life – which is what most hospice care is for non-home health agency hospices. Also, it is also unclear what would be considered an "adverse event" in Hospice. Without prescribing a defined element, this requirement seems difficult to monitor in a meaningful, consistent method across the industry.

Kaiser also has some concern that there is a requirement to create data sets and collect outcomes without a valid and reliable common set of measures in the industry. This is especially onerous considering the concept that CMS may require specific data measures in the future that may cause Hospices additional burdens of changing systems, documentation and processes to convert to a prescribed system, not mandated now. Kaiser requests that CMS either delete these proposed requirements or specifically define for the hospice industry the standards that CMS will require to measure outcomes-based performance.

#### **Request for Change of Proposed Rule for QAPI:**

1) Kaiser requests that CMS either delete these proposed requirements or specifically define for the hospice industry the standards that CMS will require to measure outcomes-based performance. We would ask that the proposed rule indicates that any future discussions of developing a set of measures will occur as a result of industry wide input to come up with outcome management program that is based on compassionate care (rather than developed in an academic setting such as Home Health's OASIS and OBQI) and will include provider stakeholders from across the nation and will outreach to state associations representing home health and hospice to enlist their membership to participate.

2) We would also request that the Medical Director or the physician designee not be responsible for the QAPI, as the proposed rule references in Section 418.102. The proposed rule charges the Hospice Governing Body with oversight. However, the reference to the Medical Director as the responsible entity is in conflict with the proposed rule in the QAPI Section, 418.58 (e), which states that the Governing Body is responsible. Additionally, it is in conflict with current COPs, Section 418.52, indicates: "A Hospice must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospices' total operation. The governing body must designate an individual who is responsible for the day to day management of the hospice program. The governing body must also ensure that all services provided are consistent with accepted standards of practice." Therefore, we recommend that the proposed rules strike the reference to the Medical Director of the Hospice being responsible for the QAPI program, as the governing body will be responsible and, per current regulations, is allowed to select an individual to oversee the body. The hospice should have the option of having the Medical Director review it. However, it should not be required that the staff for this requirement be the Medical Director.

3) We would like to go on record regarding the vagueness of the QAPI program and the application to certification surveys. When an agency is surveyed, it should be written clearly in

the interpretive guidelines that surveyors use to probe that the Hospice should have to show their policy and procedures on the QAPI program, but that it is specific to the hospice, as the indicators are not set. The survey mechanism should be lenient and not stringent, as often occurs in surveys.

**Standard (e) - Governing Body** – We recommend referring to JCAHO Home Care Standards for Leadership 1.20 elements 1 through 7 in this regulation.

**Comment #5: NON-CORE SERVICES – PHYSICAL THERAPY, OCCUPATIONAL THERAPY, AND SPEECH-LANGUAGE PATHOLOGY – Proposed Sections 418.72 and 418.74**

Kaiser does not believe that it is necessary to have PT, OT and SLP services available on a 24 hour basis. Hospice patients seldom need rehabilitation services and when they are needed, these can be provided on a non-urgent basis. Common patient and family needs are instruction in use of mobility devices (e.g. use of walker) or in assisting with patient transfers. These are basic skills that nurses do or should have. It would be more practical to require that Hospices assure RN competency in these areas and availability of RN intervention in these areas 24 hours/day than to continue with the rehab service (PT, OT, and SLP). Kaiser requests that this standard be changed to waive this requirement for all hospices without requiring a waiver process.

We also recommend adding dieticians to this section as a non-core service

**Comment #6: SUPERVISION OF HOME HEALTH AIDES - Proposed: Section 418.76 (h)**

Under current Medicare hospice law, Section 418.94 (a) of the Conditions of Participation state, “A registered nurse must visit the home site at least every two weeks when aide services are being provided, and the visit must include an assessment of the aide services.” The current hospice requirements do not include a joint visit. Current Medicare home health agency law requires a supervisory non-joint visit every 14 days for patients receiving skilled care and supervisory joint visits every 60 days if the services performed are provided to a person not receiving skilled care. Joint is only required for the skilled care when the home maker/home health aide is getting a performance evaluation.

The proposed rule would expand the rule to require a joint supervisory visit once a month. This would be an entirely new requirement that exceeds the home health joint visit requirement which is every 60 days and/or during performance evaluations.

The proposed rule would require Certified Home Health Aide providing care to a patient receiving no skilled services to be more frequent than 60 days.

*Important Note: The proposed rule background in the paragraph two of the third column on page 30852, indicates that the new 14 day requirement would relieve the requirement of a joint supervisory visit required in Section 484.36(d)(2). A joint visit is currently not a requirement for a CHHA. This is only a requirement if they are performing a performance evaluation of the*

*CHHA. Therefore this is inaccurate. California Regulations, Title 22, Section 74709, (a) (2) provides even more detail of this federal law as it is modeled after it.*

Under current Medicare home health agency law, home health aide supervision for patients receiving skilled care is required every 14 days and is not a joint visit, unless part of performance evaluation is occurring. Current law requires that beneficiaries receiving non-skilled care are required to have a joint supervised visit every 60 days.

**Request for Change of Proposed Rule for Joint Visits every 28 days:**

Current requirements for hospices are nurse visits every two weeks and assessment of the services, but are not joint visits. We agree with the logic that there should be a periodic joint visit, which is not required currently. However, we ask that the hospice COP for joint aide visits mirror the current Federal Home Health COPs, which require a joint visit every 60 days.

Additionally, we ask that CMS clarify that the supervision is not by a specific person, but may be performed by either a nurse or therapist (under the conditions in which they apply). The wording in the proposed regulation is vague regarding supervisor and infers that it can only be done by the aide's immediate supervisor. We would ask that it be clarified and re-worded to say that the supervision may be conducted by either a nurse (if patient is receiving skilled nursing care), or the appropriate therapist, if receiving another skilled service and that it is not required to be performed by a specific supervisor.

**Comment #7: Section 418.64 - CORE SERVICES**

**Standard 418.64(d): Bereavement Services**

We do not feel that the hospice should be responsible for services to the employees of a facility as part of our core services.

**Comment #8: ORGANIZATION AND ADMINISTRATION - Section 418.100**

**Standard 418.100(f).** The definition of "satellite locations" needs to be clarified. Does the definition include staffing locations or locations where staff pick up supplies and drop off paperwork?

**Comment #9: Initial/Recertification Certification of Terminal Illness - Proposed: Section 418.102 - "MEDICAL DIRECTOR".**

This proposed regulation would add new requirements for how physicians make decisions on terminal illness and require them to include more information to prove the six month terminal illness qualification and would require the medical director of physician designee to complete a clinical review and a written certification of terminal illness in order to begin hospice care (initial certification). Subsequent certifications would also require review of clinical and the patient and family's expectations and wishes for hospice care on an ongoing basis and before each updated assessment every 14 calendar days and at the time of recertification. The rule also makes the medical director of physician designee responsible for the hospice's quality assessment and performance improvement program (which we addressed in the QAPI section and will address below).

Our concerns in this section are as follows:

- 1) Certification and Recertification Content Requirements
- 2) Integration of Recertification Content Requirements into new Assessment requirements every 14 days
- 3) Medical Director or Physician Designee Responsibility for QAPI

**General Comment:** Current law, 418.22 (a) indicates what hospice personnel can certify the terminal illness, the time periods of certification, as well as the requirement for written certification "content" for terminal illness definitions to qualify for hospice care. The content requires that the prognosis for life expectancy must be 6 months or less. No other content is required to certify the terminal illness. Under the proposed rules, the Medical Director would have to review the clinical information and provide written certification. The proposed rule does not specify what the clinical review entails and what written certification means.

**Request for Change of Proposed Rule for Medical Director**

1) We request that the current certification and content requirement stay the same for the **initial certification and recertification** of terminal illness diagnosis. Each Medical Director is different in how they make their decision on terminal illness. We do not need to place new burdens on current Medical Directors, but need to examine placing federal requirements on Doctor curriculum that includes classes and rotations on end-of-life care that include understanding how to make a terminal diagnosis and the important questions and methodologies to use to make that important assessment for terminal diagnoses.

2) This new initial and re-certification requirements are included **every 14 days** at the time of each update of the comprehensive assessment (and visa versa with each recertification the assessment is updated). This new rule will have unintended consequences and will likely result in a disincentive for referral to hospice care as the medical director must prove each time when a patient is clearly terminal. Our providers are already experiencing many barriers to getting patients referred to hospice when they need hospice care. We do not want new regulations that create new barriers and disincentives to make it more difficult for the terminally ill to get hospice care. Therefore we request that you leave the initial and recertification process as is and remove it from the proposed 14 day comprehensive assessment update.

We take exception with the timeline of 14 day assessment, as required in 418.24 (d), Home Health COPs, Section 484.18(b) requires an assessment to be completed every 60 days, or more frequently where there is a beneficiary elected transfer, a significant change in condition resulting in a change in the case-mix assignment, or a discharge and return to the same HHA during the 60-day episode. Agency professional staff promptly alerts the physician to any changes that suggest a need to alter the plan of care. We agree that there should be timelines on the initial, comprehensive and update of the comprehensive. However, we do not agree with the timeframes suggested in the proposed rule or all of the content included in the assessment, including the recertification content.

3) We would also request that the Medical Director or the physician designee to not be responsible for the QAPI, as the proposed rule references in Section 418.102. The proposed rule



charges the Hospice Governing Body with oversight. However, the reference to the Medical Director as the responsible entity is in conflict with the proposed rule in the QAPI Section, 418.58 (e), which states that the Governing Body is responsible. Additionally, it is in conflict with current CoPs, Section 418.52, indicates: "A Hospice must have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospices' total operation. The governing body must designate an individual who is responsible for the day to day management of the hospice program. The governing body must also ensure that all services provided are consistent with accepted standards of practice." Therefore, we recommend that the proposed rules strike the reference to the Medical Director of the Hospice being responsible for the QAPI program, as the governing body will be responsible and, per current regulations, is allowed to select an individual to oversee the body. The hospice should have the option of having the Medical Director review it. However, it should not be required that the staff for this requirement be the Medical Director. This would be a substantial increase in responsibilities for the medical director. Currently, it is difficult to obtain a medical director. This would make it even more difficult with unrealistic responsibilities being required.

**Comment #10: RECERTIFICATION - Section 418.102(b)** – It is recommended that the phrase "patient/family expectations and wishes" for hospice care must be reviewed. This should be changed to "hospice goals and POC must be reviewed by patient/family".

**Comment #11: CLINICAL RECORDS – Section 418.104**

Standard (b) Authentication - The proposed regulation states that "All entries must be signed and the hospice must be able to authenticate each handwritten...signature...". This is not realistic. Examples that would present compliance problem include contracted nursing home and facility staff and infusion vendors who provide hospices with progress notes.

Standard (e): Discharge or transfer of care

We do not feel that a complete record should be sent to another hospice or to a physician. This is a time intensive and expensive process that does not add value for the patient nor will the physician or hospice use this on a regular basis. A discharge summary should be sufficient.

**Comment #12: CONTROLLED DRUGS IN PATIENT HOME – Proposed Section 418.106 (b) – [DRUGS, SUPPLIES, and DME]**

This proposed regulation adds a new requirement for a hospice to track, collect and dispose of controlled substances.

**General Concern:** Hospice agencies have no responsibility for and control over the medication when they are not in the home and this requires the hospice to take on a responsibility that they can not feasibly be responsible over in a person's home. Also, the medications are the property of the patient, not the hospice. Making a hospice responsible for this care will put them at risk for scenarios and situations that they can not control. CMS can not require a hospice agency to pick up the medications for the patients and not all hospices dispose of controlled substances. It is also dangerous for staff to carry controlled substances anywhere for disposal. Also, if the family refuses to dispose of them at the time of death, hospices do not want staff in a position of being required to take them from the home and dispose of them.

It would be helpful to have the intent of the drug control standard specified in the COPS. This is an area of conflict between local medical examiners and hospice's. It should be clearly defined what Hospice's are and are not responsible for. For example we are responsible for patient/family/caregiver education regarding drug disposal and safety but not disposal of the drugs or control of the drug inventory in the home. The words "tracking" and "collecting" suggest more of an enforcement role than an educational one by the hospice. The drugs are the property of the patient and family and we feel that the role of the hospice is education, not enforcement.

Additionally, the CMS discussion of this item states, "During the initial assessment, the hospice policy regarding the use and disposal of controlled drugs would be required to be discussed with the patient and family." We take exception to the hospice having to cover this during the initial assessment with the family and the patient. The patient is in pain and until the patient has an order for drugs, then it should not be necessary to review a policy and procedure that is not relevant to the patient and family. During the initial assessment, the family and patient should not be overwhelmed with technical details that are not relevant.

#### **Request for Change of Proposed Rule for Drugs Supplies and DME**

- 1) We would like the entire section requiring a hospice to be responsible for tracking, collecting and disposing of controlled substances to be deleted from the proposed regulation.
- 2) The hospice must discuss the use of controlled drugs with the patient and family, but it should not be required to collect, track or dispose. It should only have this discussion once the patient has an order for drugs and not before that time.

#### **Comment #13 – DME MANAGEMENT REPAIR – Proposed 418.106 (c) – DME Management Repair**

The new regulation requires a hospice to be responsible for the maintenance of equipment and supplies, and to ensure adequate training and instruction ("the how and when") to family regarding the equipment and supplies.

**Concerns:** This proposed rule does not take into consideration the differences between states. This regulation implies that hospices have their own equipment. In California, home health agencies and hospices do not oversee the use of the DME and, in fact, can not bill for DME or supplies. They contract with licensed DMEs to supply the product and service. DMEs are required to be licensed through Department of Health Services, Food and Drug Department and are required to get Medical Device Retailers License, which have strict requirements. The hospice doesn't have anything to do with the DME. Therefore, it does not make sense to make hospices responsible for this care as they are not supplying the DME. Requiring this will only result in problems and confusion for California hospice providers.

#### **Request for Change of Proposed Rule for DME Management Repair**

The proposed rule indicates that "the hospice may carry out this responsibility through a contractual arrangement with others, but would continue to maintain primary responsibility." We ask that this section is changed to adequately deal with states where hospices do not own and/or

provide the DME equipment to the state and rely on professional DME companies. We suggest that the sentence is clarified as such: "The hospice may use persons under contract and those persons would maintain primary responsibility for the services and the care."

**Comment #14: SHORT TERM INPATIENT CARE – Section 418.108.** This Condition should be rewritten to also allow this level of care for psychosocial/family crisis.

**Comment #15 – Hospice Care in a Facility – Proposed 418.112 - "RESIDENTS RESIDING IN A FACILITY"**

The new regulation expands the role of the Hospice Medical Director and expects them to play an expanded role in providing medical supervision to the hospice interdisciplinary group and overall coordination of the patient's plan of care. The medical director must now also communicate with all facility physicians and the attending physician for the patient. This would result in a barrier to patients receiving care and could result in a delay of services or no services because of a lack of compliance, and therefore, hospices **not taking patients who need facility level care.** This does not take into consideration that, most of the time, the Medical Director of the Hospice is the attending physician, and that the Medical Director of the SNF is different from SNF to SNF. This requirement takes only into consideration the SNF approach. The Hospice approach is that the Hospice has the professional judgment of the Hospice. The proposed rule seems to suggest that CMS is requesting the Hospice to take on more and more of the SNF role, when the hospice is not on site for 24 hours a day. By making the Medical Director of the Hospice responsible to consult with

The proposed rule indicated the following, "We are preparing a separate regulatory document to address long-term care facility obligations regarding residents receiving hospice services." We suggest that the Hospice CoPs do not include regulations regarding residents residing in a facility UNTIL the report regarding long-term care facility obligations regarding hospice services is complete. This will allow us to adequately respond to this section of the proposed rules which include added new requirements for hospices in SNFs, because we will know what CMS will be requiring of SNFs.

**Concern:**

With more hospice recipients needing hospice services in the community and not in the home, this added requirement on the Medical Director could lead to major issues and disincentives to getting a patient in one of these types of institutional settings. Part of the proposed rule, which states, "The medical director of the 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" is of great concern for hospices. The concern is specifically related to the reality of the request. Currently, hospices also provide care to the hospice patient. Asking the Hospice Medical Director to consult with all Doctors is unrealistic because, often times, the Medical Director of the SNF is the attending physician for the patient.

**Request for Change of Proposed Rule for Residents Residing in a Facility**

We would suggest that the proposed rule is changed to require notification of the Medical Director of the SNF regarding the update of the plan of care. However, it should not be

mandatory to talk with all physicians at the SNF and require it in order to do a plan of care. It should be optional and encouraged, especially when there is a development. With the plan of care being required, under the ASSESSMENT TIME FRAMES, Proposed Rule 418.54, for every 14 days, this requirement is impractical and unfeasible for real world scenarios. While CMS is hoping to encourage a lively and thorough discussion for the patient to help them achieve the best outcomes, it will result in the opposite. It will result in either non-compliance or physicians of hospices and nursing homes developing a quick check off ability. We should ensure that physicians are encouraged to communicate with each other periodically at important time points to examine important outcomes for the patient.

As this proposed rule is shifting much of the burden and responsibility onto a hospice to deliver care, even though the SNF or facility has responsibility for non-terminal care as well, it becomes more illogical to require the Hospice Medical Director to consult even more frequently with a SNF as they are to provide less care than before under this proposal..

We would also agree with language that stated, The Hospice Medical Director shall notify in writing or verbally the SNF facility physicians regarding the POC every 30 days to confer regarding the patients overall coordination of care.

Needing a written agreement per patient with consent and specific clarification per care plan for which services the hospice will provide, and which the facility will provide will increase the amount of time needed to admit, document, and provide oversight for facility residents. Especially significant is that the hospice may only use the facility nursing personnel for those tasks which would ordinarily have been done by a resident's family in implementing a care plan. How does that impact SNF licensed caregivers needing to provide care as needed?

**Comment #16 – HOSPICES THAT PROVIDE INPATIENT CARE DIRECTLY – Section 418.110.**

**Standard (f) Patient rooms – Agree** that patient rooms must provide at least 80 square feet with no more than 2 beds to a room requirement.

**Comment #17 - PERSONNEL QUALIFICATIONS – Section 418.114**

The proposed rule asked for comments on the issue of changing the current requirement of a bachelor's degree for a social worker under Hospice to a Masters level. We would advise that this not occur. Currently, our state and federal requirements for a social worker in a home health setting requires a Master's Degree from a school of social work accredited by the Council of Social Work Education, with one year of social work experience in a health care setting. This has limited provider's abilities to be able to find social workers. A Masters in Social Work should be required OR a baccalaureate degree from a school of social work accredited by the Council of Social Work AND a least one year experience in a health care setting.

**Request for Change of Proposed Rule for Social Work Definition**

We would advise that CMS keep the Bachelor's degree requirement and additionally add a social work assistant as a type of social worker in a hospice. Adding the social work assistant to the

rules would open up the opportunity for a hospice to attract caring candidates who are suitable for hospice care services who have studied related disciplines (psychology; sociology; other social work related field) without penalizing potential employees who have already finished their bachelor's degree. Additionally, we would also ask that the regulations pattern the assistant social worker for persons with doctorates in fields that are not social work, such as psychology. We have heard of providers who could not hire a PhD in Psychology who was interested in the social worker position at a hospice because he had changed his focus in life and wanted to work in hospice, but could not because of the current regulations. The regulations need to be flexible to allow for PhDs in other fields, as well.

**Standard (d) – Criminal background checks – Strongly recommend keeping this new standard.**

### **Comment #18 - ELECTRONIC RECORDS**

Regarding CMS's request for comments regarding electronic records we can add the following:

#### Benefits

- Facilitates improved coordination of care, especially with nurses on different shifts
- There are numerous challenges/limitations in Hospice's ability to make changes in software to meet regulatory requirements and quality initiatives. Paper records are more flexible, easier to adapt to changes.

#### Disadvantages

- Cost
- Often decreases in staff productive adding to cost and reducing time spent with patients
- When computers fail (hardware or software) information is not accessible. Patient care and business processes revolve around the information system, if the computer is not accessible patient care, intake and referral can become paralyzed

Patients should be able to access at least some parts of their records (e.g. medication list, test results, plan of care). Ideally, this would occur through a secure internet site.

It is concerning to think that it might be mandated in future regulations. The cost may be prohibitive for smaller hospices.

Sincerely,



Gina M. Reese  
Senior Counsel

GMR:jaw

#289304

**Submitter :** Mr. Gary Thietten  
**Organization :** Idaho Home Health and Hospice, Inc.  
**Category :** Hospice

**Date:** 07/25/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

418.108 As a very small 6 bed, JCAHO accredited in-patient facility, we cannot afford placement of a Registered Nurse for short term inpatient care. Clearly, CMS is wise at illuminating this requirement allowing state law to prevail. We use LPNs around the clock supervised by on-call RNs. And, we pull in RNs if and when necessary to care for patients now only on routine care but using our facility in lieu of a skilled nursing facility. As a Registered Nurse and owner of Idaho Home Health and Hospice for 29 years, let me assure you that your decision to staff at a level consistent with the patient's needs is gratifying. It also is good policy based on the nurse shortage. If thousands of our skilled nursing facilities can have LPNs as charge nurses when the bed size is under 60, then this policy for the small rural hospice is clearly appropriate.

Gary L. Thietten, RN BSN  
President  
Idaho Home Health and Hospice, Inc.  
gary@idahohmhealth.com

**Submitter :** Ms. Chris Henrickson

**Date:** 07/25/2005

**Organization :** Society SW Leadership in Hlth Care-MICH Chapter

**Category :** Social Worker

**Issue Areas/Comments**

**GENERAL**

GENERAL

Proposal to change qualified social worker from an MSW to BSW qualification will greatly diminish the capacity of programs to effectively meet hospice patient and family needs. Much of the end of life and bereavement care services requires clinical assessment, individual and group counseling and therapy, for which BSW social workers are not adequately trained. The complexity of the hospice care environment also necessitates that the medical social worker provider be qualified to provide consultation to the clinical staff as well, and again, BSW level practitioners do not achieve sufficient training to deliver such services. Inadequately trained social work staff will put patients and families--and the providers themselves--at undue risk. Hospice programs must to retain the MSW-level clinical social work practitioners to avoid such risk and preserve competent care.

**Submitter :** Ms. Jena Kelly  
**Organization :** Social Work Advocacy  
**Category :** Social Worker

**Date:** 07/26/2005

**Issue Areas/Comments**

**Issues 1 - 10**

**Social Work**

To: Centers for Medicare and Medicaid Services

Social Work Advocacy is providing comment on the CMS-3844-P, Hospice Conditions for Participation. Specifically, the personnel qualifications for a hospice social worker. A hospice social worker needs to have a high level of expertise to practice with individuals and their families affected by dying, death, and bereavement. CMS is specifically soliciting comments on the standard qualification for a hospice social worker. Our organization is in agreement with and supports the National Association of Social Workers comments submitted to raise the standard qualification of a hospice social worker to a Master of Social Work degree from an accredited program. In rural areas where an MSW is not available, a BSW who is supervised by an MSW or a licensed mental health professional, is the minimum requirement recommended for a hospice social worker.

Our organization appreciates the opportunity to comment on these important regulations.

Sincerely,  
Jena Kelly, LCSW



**Submitter :** Ms. Susan Koesters  
**Organization :** Carepartners Mountain Area Hospice  
**Category :** Nurse Practitioner

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment Re: Nurse Practitioners

CMS-3844-P-97-Attach-1.TXT

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE AND MEDICAID SERVICES  
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: 07/26/2005

Organization :

Category : Physician

Issue Areas/Comments

**GENERAL**

GENERAL

# #418.64a

Medical Care has changed since the original Hospice legislation was written 25 years ago. Providers of Medical care are primarily physicians but also include Nurse Practitioners. I would propose that a broader category would be better titled Medical Services. Medical services to hospice recipients can than be provided by the appropriate health care providers licensed by the state.

#416.64b2

The proposed legislation has NP services provided to a hospice beneficiary when the NP is not the "attending" as part of core nursing services. NP's who "see, treat and write orders for patients" are not providing "routine nursing care." They are providing "medical/physician" services. I think NP's providing medical care (care which would otherwise be provided by the physician) should be moved to Medical/Physician service #418.64a

#416.3

Nurse Practitioners should be included in the definitions.

418.114 Personnel Qualification

Nurse Practitioners should be listed and defined (not just physicians, speech pathologists or other health care providers who were not defined in the original legislation).

**Submitter :** Maria Attema  
**Organization :** Allina Home Care Hospice and Palliative Care  
**Category :** Other Practitioner

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Quite a few years ago I had the option of hiring either a MSW without hospice experience or a BSW with hospice experience. I chose the BSW with hospice experience. In my experience I have had good success with BSW level social workers at our hospice program. We currently have 2 salaried Social Workers and 3 who do vacation coverage and on-call. I think to call a BSW level employee a "Social Work assistant" would be very disrespectful to these social workers and the work that they do. They have every right to be called a Social Worker. They earned a degree and are licensed as a Social Worker. I think that BSW level social workers should be able to work as a hospice social worker and if really necessary maybe the regulation should state that they should be supervised by a MSW.

**Issues 1 - 10**

**Social Work**

Quite a few years ago I had the option of hiring either a MSW without hospice experience or a BSW with hospice experience. I chose the BSW with hospice experience. In my experience I have had good success with BSW level social workers at our hospice program. We currently have 2 salaried Social Workers and 3 who do vacation coverage and on-call. I think to call a BSW level employee a "Social Work assistant" would be very disrespectful to these social workers and the work that they do. They have every right to be called a Social Worker. They earned a degree and are licensed as a Social Worker. I think that BSW level social workers should be able to work as a hospice social worker and if really necessary maybe the regulation should state that they should be supervised by a MSW.

**Submitter :** Ms. Barbara Volk  
**Organization :** Hospice of the Cleveland Clinic  
**Category :** Individual

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

In general I believe the revisions are geared toward improving quality of care for patients and families.

**Submitter :** Mrs. Heather Groves  
**Organization :** SouthernCare Hospice  
**Category :** Social Worker

**Date:** 07/26/2005

**Issue Areas/Comments**

**Issues 1 - 10**

**Social Work**

I do not believe that it is imperative to have a MSW to work in hospice. It is a matter of experience, rather than not being able to do therapy with out patients. If we have patients and families that need additional counseling, we can refer them to a local agency. I have been a bachelor level Social Worker now for 9 years, and I am able to function effectively in hospice with my bachelors degree over the past two years. How I leaned to do my job was by the experience of working in other health care fields. When our agency hired masters level, they had to learn the same information that a bachelors level had to. There was no course taught in the masters level to set people up on services or to be a support for their family. If you change to a masters level of social work, you will lose many excellent BSW or LSW. With continued education offered in the community, anyone can continue to learn about their job specifics and how to be more effective. It's about experience rather than degree level. I'm sure that it will be difficult on the hospice to find enough good MSW who want to do hospice since most practice individually or work in higher paying jobs. A BSW/LSW can be just as effective. Please don't change the job requirements for a bachelors level in hospice. Many great social workers will lose thier jobs when it is not a necessary loss.

**Submitter :** Ms. Anita Clos  
**Organization :** Society for Social Work Leadership in Health Care  
**Category :** Social Worker

**Date:** 07/26/2005

**Issue Areas/Comments**

**Issues 1 - 10**

**Social Work**

Professional social workers receive a minimum of two years of POST-bachelor's level training to work with individuals, families, groups and communities. Our profession is highly specialized and contrary to some popular belief, requires far more than just being nice and kind to people. Working with an individual in crisis and his/her family requires professionalism, therapeutic training, understanding of the physiological process, familiarity with medications and how they affect the person's ability to interact, spiritual awareness and sensitivity...these are but a few of the SKILLS required to work effectively with the dying. Requiring only BSW intervention is a bit like allowing a Medical Assistant to perform the physician's function--which seems absurd. Yet the difference between a BSW and an MSW's training is also monumental. BSW's are trained to be technicians, perform concrete functions; MSW's are trained to be clinicians. The result of this change in hospice regulations, if approved, may save dollars but the cost in the level of care administered to and received by the dying person and their families at the most intense and critical period of life--the end of it--is monumental. Support of Masters Level prepared social workers is critical and essential.

**Submitter :** Ms. Barbara Volk  
**Organization :** Hospice of the Clevelandl Clinic  
**Category :** Other Practitioner

**Date:** 07/26/2005

**Issue Areas/Comments**

**Issues 1 - 10**

**Social Work**

I do not believe that a higher level of education (MSW degree) would make a difference in the quality of care provided to our patients and family. In my experience I have employed LSW and MSW staff that have both provided excellent quality of care. Orientation to hospice and hospice philosophy definitely influences quality of care and are imperative to a successful employee.

**Clinical Records**

no comment

**Drugs, Supplies, and DME**

no comments

**Personnel Qualifications**

I believe that background checks should be mandatory for all staff based on the sensitive nature of hospice care and the intimate nature of providing care in patients homes.

**Short Term Inpatient Care**

no comment

**Inpatient Care**

I would like clarification of the appropriate use of restraints. Frequently patients become confused and unsteady and are prone to falls or hurting themselves. In those instances could the use of restraints be appropriate

**Residents Residing in a Facility**

I am concerned about the language stating that the medical director and the physician designee must provide overall coordination of care and communicate with the medical director. It is frequently very difficult to contact physicians who provide medical supervision to patients in facilities. The RN casemanager does communicate on a regular basis and even this is extremely difficult. If you could further define what type of communication and frequency this would be helpful. We participate in the facility case conferences and communicate POC and changes in IDT

**Medical Director**

I do not feel that the Medical Director should assume the responsibility for directing the Quality Program. The medical director should have direct involvement in the program but would take away from other critical duties that he/she performs.

**Seclusion and Restraint**

Please clarify the definition of chemical restraint. In hospice care we use a number of medications to achieve relaxation and comfort and treat terminal restlessness. To have to report all of these deaths would be onerous and could impact quality of care and a peaceful death. If programs are required to submit these names at death they may stop using these medications altogether



**Submitter :** Ms. Susan Zimmerman

**Date:** 07/26/2005

**Organization :** Delaware Hospice Inc.

**Category :** Hospice

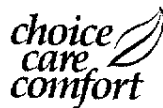
**Issue Areas/Comments**

**GENERAL**

GENERAL

See Attachment

CMS-3844-P-104-Attach-1.DOC



# DELAWARE HOSPICE

Since 1982

Attachment #104

To: Centers for Medicare and Medicaid Services  
Department of Health and Human Services  
Attention: **CMS 3844-P**

From: Delaware Hospice, Inc.  
3515 Silverside Road  
Wilmington, DE 19810  
Attn: Susan Zimmerman  
302-478-5707

Date: July 25, 2005

RE: Response to the Proposed Hospice Conditions of Participation CMS 3844-P

Please accept the following recommendations and suggestions for changes to the Proposed Hospice Conditions of Participation. Overall, Delaware Hospice welcomes the revisions to the CoPs, knowing that this will further assure quality care in hospice. The focus below is on areas of the proposed CoPs that would cause unnecessary operational and administrative burdens, or that are not congruent with current hospice philosophy.

These comments are submitted with respect and appreciation for the immense work that has already been accomplished on this project. Should you have any questions for further clarification, please do not hesitate to call.

Respectfully submitted,  
Susan Zimmerman  
Performance Improvement Coordinator

## PATIENTS RIGHTS

### 418.52(a)(1)

Delaware Hospice would like clarification that it is acceptable for the patient to understand his/her rights via an interpreter (family or other) in cases where a written notice of the patient's rights in his/her native language would put an undue burden on the hospice.

### 418.52(b)(4)

Delaware Hospice recommends an overall review of the complaint process and its applicability to hospice, with a suggestion that the home health process for complaints may be more applicable to hospice. Also recommended is a change to (i) five days from the discovery of the incident rather than five days from the incident.

418.52(e)

Delaware Hospice recommends that the responsibility for collecting the patient's liability in the Medicaid Room and Board payments remain with the nursing home and that the standard be specific about this requirement. As proposed, this standard would place an undue administrative burden on the hospice as well as place the hospice/nursing home relationship in a precarious position by requiring the hospice to function as a collecting agent of the nursing home.

418.54

Delaware Hospice recommends that the word "care" in the last sentence is changed to "assessment" to reflect items not related to the terminal illness that may need to be assessed.

418.54(a)

Delaware Hospice recommends that the words "physician's admission order for care" be changed to "physician's certification for care;" that the words "RN must make an initial assessment" be changed to "RN must complete an initial assessment;" and that the words "ordered by the physician" be changed to "ordered by the physician or requested by the family."

Delaware Hospice suggests that language be added that allows for patient and family preference on the timing of the initial visit by the RN for the initial assessment.

ASSESSMENT TIME FRAME

418.54(b)

Delaware Hospice concurs with NHPCO's original recommendation of a time period of seven days to complete the comprehensive assessment and recommends that the time period be changed from four to seven days.

418.54(c)

Delaware Hospice recommends that this comprehensive assessment and care planning be limited to the care needed for the management and palliation of the terminal illness. The comprehensive assessment should be patient-driven, focusing on the present needs of the patient and family.

418.54(d)

Delaware Hospice recommends that the update closest to the recertification timeframe be acceptable as an update at the time of recertification.

PLAN OF CARE

418.56(a)(i)

Delaware Hospice recommends the removal of the words "(who is not the patient's attending physician)" as it is quite common for the medical director of the hospice to practice privately outside of the hospice.

418.56(c)

Delaware Hospice recommends the insertion of the words “services for the palliation and management of the terminal condition” after “The plan of care must include...”; and that the word “agreement” which applies to the patient and family be changed. The word agreement could present conflicts between what is considered professional practice and what the hospice is capable of, and patient and family desires.

418.56(d)

Delaware Hospice is pleased to see and agrees that it is important to include the patient’s attending physician to the extent possible in the review of the plan of care.

418.56(e)

In order to clarify the meaning of “sharing of information,” Delaware Hospice recommends that wording be added to the end of 4) to address sharing of information through various methods such as paper documents or electronic media, telephonic or in person meetings or some combination of these methods.

QAPI

418.58(b)

Delaware Hospice uses a variety of outcome measures to monitor quality of care. The NHPCO National Dataset measures, End Result Outcome Measures and the Family Evaluation of Hospice Care Survey form the core measurements. Delaware Hospice also measures Patient Safety and Post-Admission Satisfaction. Currently, Delaware Hospice, in conjunction with a national pharmacy, is exploring the collection and monitoring of direct patient perceptions of comfort.

418.72

Delaware Hospice recommends that dietitians be added to this section as a non-core service in order to allow contracting.

418.76(g)(2)

While this is unchanged from the home health CoPs, Delaware Hospice recommends that, if care is outcome driven, the IDG should have the authority to determine when the patient needs the services of a home health aide, and that no physician order is required.

418.76(h)

Delaware recommends that the length of stay should not be a factor since the assessment is of the aide, not the patient. This is a human resource issue and the assessment would go in the personnel file rather than the clinical record. Ongoing competency assessments should take care of this issue. Supervisory visits every 28 days on established staff who have excellent competencies would take up valuable staff time as well as negatively affect staff perceptions.

## ORGANIZATION AND ADMINISTRATION

### 418.100(e)

Delaware Hospice recommends a wording change in the first sentence to read “and supervision oversight of staff and services for all arranged services” because the actual supervision of contracted staff would be done by the contracted agency.

Also, the requirement for services being provided “by personnel having at least the same qualifications as hospice employees” could be limiting. Delaware Hospice recommends a change in language to “by qualified personnel,” striking the rest of the sentence.

## MEDICAL DIRECTOR

### 418.102

Delaware Hospice would like to suggest that hospices may contract with physicians in physician practice groups to serve as medical director of the hospice.

### 418.102(c)

Delaware Hospice recognizes that it may place an undue burden on the Medical Director to take responsibility for directing the QAPI program. Instead, we suggest that the Medical Director be involved in the planning and monitoring of the program, but the governing body maintain full responsibility for the QAPI program.

## CLINICAL RECORDS

### 418.104(e)

Delaware Hospice recommends that the release of information follow the Minimum Necessary Standard as stated in the HIPAA Privacy federal regulations.

### 418.106(b)

Delaware Hospice recommends softening the words “potential dangers” in reference to narcotics. Hospices have worked for years to dispel myths associated with narcotic use in terminally ill patients. The words could also have an adverse effect on physicians prescribing appropriate levels of controlled substances to hospice patients.

## DRUGS, SUPPLIES & DME

### 418.106(c)(1)

Delaware Hospice would like to suggest language that ensures that there is a process for providing routine and preventive maintenance of equipment, either directly or through contractual arrangement.

## SHORT TERM INPATIENT CARE

### 418.108

Delaware Hospice recommends that language be added to reflect the use of short-term inpatient care for crises of a psychosocial/family nature.

### 418.108(c)(3)

Delaware Hospice recommends that the hospital discharge summary would be sufficient for the hospice to ensure continuity of care.

## SECLUSION AND RESTRAINT

418.110 (o)

Comment: With respect to the use of drugs as restraints, it is imperative that clarification be made to reflect that the patient's medical symptoms should not be viewed in isolation; rather the symptoms should be viewed in the context of the patient's condition, circumstances and environment. Furthermore, some clarification of the definition of "restraint" must reflect an understanding of "conscious restraint" as it may relate to terminal agitation.

Hospice patients frequently experience agitation and hallucinations as their disease progresses and death nears. The symptoms are frequently very distressing for the patient and the family. Haldol, ativan and benadryl are drugs that are frequently used to treat these symptoms and have proved to be very effective. These medications are frequently included in comfort packs of medications that are available for access when symptoms occur unexpectedly. They are usually ordered PRN to again allow flexibility in managing the patient's symptoms. There is rarely a psychiatric diagnosis or a specific diagnosis linked to these medications and they are generally used purely for symptomatic relief. Haldol has also proved to be very effective in treating nausea in hospice patients. Antidepressants are also frequently used as adjuvant medications in the treatment of pain.

The goal of hospice care is to care for the physical, emotional and psychological needs of the patient and family. There is little value in restricting the use of medications that have proven to be effective in managing distressing symptoms and improved the quality and comfort of the dying experience for the patient and family.

## RESIDENTS RESIDING IN A FACILITY

418.112(d)

Delaware Hospice is concerned that the requirement that care coordination and communication must be between physicians only may cause unnecessary strain between the hospice and the facility. Rather, care coordination between members of the hospice IDG and the nursing home team, who are likely to have more daily contact with the patient, should be encouraged.

## PERSONNEL QUALIFICATIONS

418.114(c)(7)

Delaware Hospice like to recommend that the definition of a social worker is a person who has at least a baccalaureate degree from a school of social work.

End of Comments

**Submitter :** Ms. Bettye Bradshaw  
**Organization :** Association of Oncology Social Workers  
**Category :** Other Association

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

July 26, 2005

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

Dear Mr. McClellan:

The Association Of Oncology Social Work(AOSW) is appreciative of the opportunity to offer comments regarding the proposed regulations for the Medicare and Medicaid Programs: Hospice conditions of Participation, referenced as CMS-38844-P, published in the Federal Register on May 27, 2005(70fed.Reg. 30,840(2005), to be codified as 42 CFR Part 418).

The AOSW is the largest Oncology Social Work organization worldwide, serving oncology social workers in the United States and internationally. The Association works to promote and develop the practice and profession of Oncology Social Work for its MSW and BSW members.

Our organization is in agreement with and supports the National Association of Social Workers(NASW) comments submitted to raise the standard qualification of a hospice Social Worker to a Master of Social Work degree from an accredited program. Further, AOSW is also in agreement and supports NASW's position that would allow for, in rural areas where a MSW is not available, a BSW who is supervised by a MSW or a licensed mental health professional, to be the minimum requirement recommended for a hospice Social Worker.

Again our organization appreciates the opportunity to comment on these important regulations.

Kathy Walsh Burke Bettye Bradshaw  
Kathy Walsh Burke, PhD, MSW Bettye Bradshaw, MSW,LCSW  
AOSW President AOSW Legislative Chair

Kim Barrio  
Kim Barrio, MSW, LCSW  
AOSW President-Elect  
(See Attachment)

**Submitter :** Ms. Bettye Bradshaw  
**Organization :** Association of Oncology Social Workers  
**Category :** Other Association

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

July 26, 2005

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

Dear Mr. McClellan:

The Association Of Oncology Social Work(AOSW) is appreciative of the opportunity to offer comments regarding the proposed regulations for the Medicare and Medicaid Programs: Hospice conditions of Participation, referenced as CMS-38844-P, published in the Federal Register on May 27, 2005(70fed.Reg. 30,840(2005). to be codified as 42 CFR Part 418).

The AOSW is the largest Oncology Social Work organization worldwide, serving oncology social workers in the United States and internationally. The Association works to promote and develop the practice and profession of Oncology Social Work for its MSW and BSW members.

Our organization is in agreement with and supports the National Association of Social Workers(NASW) comments submitted to raise the standard qualification of a hospice Social Worker to a Master of Social Work degree from an accredited program. Further, AOSW is also in agreement and supports NASW's position that would allow for, in rural areas where a MSW is not available, a BSW who is supervised by a MSW or a licensed mental health professional, to be the minimum requirement recommended for a hospice Social Worker.

Again our organization appreciates the opportunity to comment on these important regulations.

Kathy Walsh Burke Bettye Bradshaw  
Kathy Walsh Burke, PhD, MSW Bettye Bradshaw, MSW,LCSW  
AOSW President AOSW Legislative Chair

Kim Barrio  
Kim Barrio, MSW, LCSW  
AOSW President-Elect  
(unable to attach file at this time see second submission)



**Submitter :** Ms. Betty Bradshaw  
**Organization :** Association of Oncology Social Workers  
**Category :** Other Association

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

July 26, 2005

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

Re: CMS-3844-P, Proposed rule: Medicare and Medicaid Programs: Hospice Conditions of Participation, ?PERSONNEL QUALIFICATIONS? and ?SOCIAL WORK?

Dear Mr. McClellan:

The National Association of Social Workers (NASW) welcomes the opportunity to offer comments regarding the proposed regulations for the Medicare and Medicaid Programs: Hospice Conditions of Participation, referenced as CMS-3844-P, published in the Federal Register on May 27, 2005 (70 Fed. Reg. 30,840 (2005)), to be codified as 42 CFR Part 418).

The NASW, with over 150,000 members, is the largest and most recognized membership organization of professional social workers in the world. The Association works to promote and develop the practice and profession of social work, and to enhance the functioning and well-being of individuals, families, and communities.

NASW appreciates and supports the recognition by CMS of the highly complex medical and psychosocial needs and issues faced by individuals and families at the end of life. We agree with the delineation of these issues as described in the Federal Register. We concur that due to the critical and often crisis nature of care at the end of life, intensive interventions are required that necessitate the expertise of a qualified social worker.

We support the findings of the National Hospice and Palliative Care Organization (NHPCO) March 2000 study cited by CMS, indicating that ??hospice programs will benefit by hiring the best qualified and most experienced social workers available.? Social workers skillfully assess the patient and family situation, and develop an individualized plan of intervention to address the unique psychosocial and emotional needs of that patient and family at this most crucial life juncture. Patients and families deserve to have the most qualified social work professional available to guide them through the patient?s terminal illness, dying process, death, and bereavement period.

Social workers are the largest group of mental health service providers in the United States (SAMHSA, 2000). As such, the profession may often be the only available provider in rural areas. The inherent emotional and psychological needs of patients and families affected by dying, death, and bereavement call for strong expertise in mental health counseling. In meeting the educational needs of social workers in hospice care, NASW has developed the national practice standards for social workers in end of life care, and provides cancer and end of life educational online programs for social workers. More than 30,000 social workers have received NASW?s online training on these subjects in the last 18 months.

NASW?s specific recommendations are provided in the attached document. To summarize, NASW recommends that hospice social workers should be licensed and trained at the master?s level. In rural areas, where access to an MSWs is sometimes limited, NASW recommends that at a minimum, hospice social workers should possess a Bachelor of Social Work degree and be supervised by a master?s level licensed social worker, or, if none is available, a mental health professional licensed at the master?s level or higher. NASW opposes any designation of a social worker that includes bachelor?s level workers in a discipline other than social work.

In regards to the remaining proposed rules to improve hospice care, NASW supports many of the changes and additions to the current rule, including:

? The requirement for a more timely patient assessment;

? Replacing the quality assurance requirement with a more comprehensive quality assessment and performance improvement (QAPI) condition of participation that enables hospices to take tailored proactive steps to ensure quality care;

**Submitter :** Ms. Bettye Bradshaw  
**Organization :** Association of Oncology Social Workers  
**Category :** Other Association

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

? Allowing hospices to contract for core services in certain situations (NASW recommends the requirement that social work services be in conjunction with the qualifications outlined in our recommendations for a qualified hospice social worker); and

? Adding guidance for hospices that care for residents of nursing facilities. These long-term care residents may be particularly vulnerable and added guidance regarding their hospice care would ensure quality hospice care during the dying and death process.

We acknowledge and appreciate CMS's extensive research on these vital needs and issues. Please let us know if we can provide any additional information to substantiate these recommendations or to assist your agency in implementation.

Sincerely,

Elizabeth J. Clark, PhD, ACSW, MPH  
Executive Director  
National Association of Social Workers

**Submitter :** Daniel Cogan  
**Organization :** Visiting Nurse Service of New York Hospice Care  
**Category :** Nurse Practitioner

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

**GENERAL**

Regarding the role of nurse practitioners - it is my opinion that nurse practitioners employed by a hospice agency should be able to serve in certain capacities similar to the hospice medical director and be able to bill for these services even if this nurse practitioner has not been designated as attending physician. A nurse practitioner should be able to see all hospice patients and write treatment orders and bill for this activity, just as a hospice medical director does.

**Submitter :** Ms. Bettye Bradshaw  
**Organization :** Association of Oncology Social Workers  
**Category :** Other Association

**Date:** 07/26/2005

**Issue Areas/Comments**

**GENERAL**

GENERAL

NATIONAL ASSOCIATION OF SOCIAL WORKERS RECOMMENDATIONS

Re: CMS-3844-P, Proposed rule: Medicare and Medicaid Programs: Hospice Conditions of Participation, ?PERSONNEL QUALIFICATIONS? and ?SOCIAL WORK?

In recognition of the clinical expertise and skills required of a hospice social worker when working with individuals and their loved ones in end of life care, the following are what NASW considers essential minimum requirements for a qualified hospice social worker.

Comments to Proposed ? 418.114: ?PERSONNEL QUALIFICATIONS?

Recommended Change of Language, ? 418.114 (a): ?Qualified social worker--A person who has a Master of Social Work (MSW) degree from an accredited program, with at least two years of health care experience, and who meets the licensing requirements for social work practice in the State in which he or she is practicing.? NASW further recommends to move "social worker" into general qualification requirements.

Rationale:

The MSW degree assures extensive knowledge and counseling skills based on psychological and social theories. The MSW degree requires two years of coursework and an additional 900 hours of supervised social work internship experience, where knowledge is integrated with practice. CMS has acknowledged in their commentary section in the Federal Register that " Hospice marks the passage from life to death. The services by a hospice take on a higher level of importance that greatly affects a patient's physical and emotional comfort, and which will be remembered by family members forever." CMS goes on to say that social workers are integral team members, often assisting families in crisis and providing emotional support and guidance. The role of the social worker is further highlighted in helping family members during the bereavement process "through in-depth counseling" which may include individual, group, and specialized children's grief work. NASW believes the extensive training of an MSW is more conducive to the nature of hospice social work due to the counseling and crisis oriented skills involved in dying, death, and bereavement.

All states have social work licensing for master's level social workers, and many states have multi-level licenses available. NASW recommends that all hospice social workers obtain the highest level of licensure appropriate for their academic degree and level of experience, and that is available according to their respective state regulations.

In recognition of the fact that there is now licensing for social workers in every state, and in accordance with NASW's comments, below, on the qualifications for hospice social workers, NASW recommends that the definition of qualified social worker be moved from ? 418.114 (c) to ? 418.114 (a). The requirements for bachelor's level social workers in those states where bachelor's level licensure is not available could remain under section (c).

Comments to Proposed ? 418.114 (c) ?SOCIAL WORK?

Recommended Change in Language: ?Social worker. In extenuating circumstances, such as in rural areas, where there is limited access to an MSW, a person who holds a Bachelor of Social Work (BSW) degree from an accredited program, and is supervised by or has established a consultative relationship with a social worker who is qualified under ? 418.114 (a), or, if no qualified social worker is available, is supervised by a mental health professional licensed at the master's level or higher.?

Rationale:

The BSW is the minimum educational preparation that NASW can recommend for a hospice social worker in such extenuating circumstances. The National Association of Social Workers Standards of Classification considers the baccalaureate degree as a basic level of practice for social work. Other bachelor level degrees do not prepare the individual for social work practice.

**Submitter :** Dr. Elizabeth Clark  
**Organization :** National Association of Social Workers  
**Category :** Association

**Date:** 07/26/2005

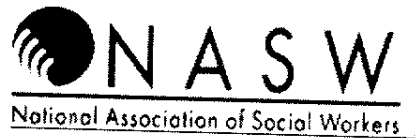
**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment

CMS-3844-P-111-Attach-1.DOC



Deleted: DRAFT

July 26, 2005

Attachment #111

Formatted: Right

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

Deleted: 3  
Deleted: 3

Re: CMS-3844-P, Proposed rule: Medicare and Medicaid Programs: Hospice Conditions of Participation, "PERSONNEL QUALIFICATIONS" and "SOCIAL WORK"

Deleted: ¶  
Deleted: ¶

Dear Mr. McClellan:

The National Association of Social Workers (NASW) welcomes the opportunity to offer comments regarding the proposed regulations for the Medicare and Medicaid Programs: Hospice Conditions of Participation, referenced as CMS-3844-P, published in the *Federal Register* on May 27, 2005 (70 Fed. Reg. 30,840 (2005), to be codified as 42 CFR Part 418).

Deleted: r

The NASW, with over 150,000 members, is the largest and most recognized membership organization of professional social workers in the world. The Association works to promote and develop the practice and profession of social work, and to enhance the functioning and well-being of individuals, families, and communities.

NASW appreciates and supports the recognition by CMS of the highly complex medical and psychosocial needs and issues faced by individuals and families at the end of life. We agree with the delineation of these issues as described in the *Federal Register*. We concur that due to the critical and often crisis nature of care at the end of life, intensive interventions are required that necessitate the expertise of a qualified social worker.

Deleted: Re: CMS-3844-P, Proposed rule: Medicare and Medicaid Programs: Hospice Conditions of Participation, "SOCIAL WORK"  
¶  
Comment:¶  
Deleted: As you mentioned, the "services furnished by a hospice take on a higher level of importance that greatly affects a patient's physical and emotional comfort, and which will be remembered by family members forever."

We support the findings of the National Hospice and Palliative Care Organization (NHPCO) March 2000 study cited by CMS, indicating that "...hospice programs will benefit by hiring the best qualified and most experienced social workers available." Social workers skillfully assess the patient and family situation, and develop an individualized plan of intervention to address the unique psychosocial and emotional needs of that patient and family at this most crucial life juncture. Patients and families deserve to have the most qualified social work professional available to guide them through the patient's terminal illness, dying process, death, and bereavement period.

Social workers are the largest group of mental health service providers in the United States (SAMHSA, 2000). As such, the profession may often be the only available provider in rural areas. The inherent emotional and psychological needs of patients and families affected by dying, death, and bereavement call for strong expertise in mental health counseling. In meeting the educational needs of social workers in hospice care, NASW has developed the national practice standards for social workers in end of life care, and provides cancer and end of life educational online programs for social workers. More than 30,000 social workers have received NASW's online training on these subjects in the last 18 months.

Deleted: 4j

NASW's specific recommendations are provided in the attached document. To summarize, NASW recommends that hospice social workers should be licensed and trained at the master's level. In rural areas, where access to an MSW is sometimes limited, NASW recommends that at a minimum, hospice social workers should possess a Bachelor of Social Work degree and be supervised by a master's level licensed social worker, or, if none is available, a mental health professional licensed at the master's level or higher. NASW opposes any designation of a social worker that includes bachelor's level workers in a discipline other than social work.

Deleted: 1

Deleted: situations where this is not possible

Deleted: s

In regards to the remaining proposed rules to improve hospice care, NASW supports many of the changes and additions to the current rule, including:

- The requirement for a more timely patient assessment;
- Replacing the quality assurance requirement with a more comprehensive quality assessment and performance improvement (QAPI) condition of participation that enables hospices to take tailored proactive steps to ensure quality care;
- Allowing hospices to contract for core services in certain situations (NASW recommends the requirement that social work services be in conjunction with the qualifications outlined in our recommendations for a qualified hospice social worker); and
- Adding guidance for hospices that care for residents of nursing facilities. These long-term care residents may be particularly vulnerable and added guidance regarding their hospice care would ensure quality hospice care during the dying and death process.

Formatted: Bullets and Numbering

Formatted: Bullets and Numbering

Deleted: 0

Formatted: Bullets and Numbering

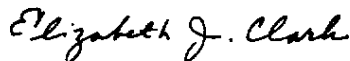
Deleted: above

Formatted: Bullets and Numbering

Deleted: hopefully

We acknowledge and appreciate CMS's extensive research on these vital needs and issues. Please let us know if we can provide any additional information to substantiate these recommendations or to assist your agency in implementation.

Sincerely,



Elizabeth J. Clark, PhD, ACSW, MPH  
Executive Director  
National Association of Social Workers

Deleted: 1

Deleted: 1

**NATIONAL ASSOCIATION OF SOCIAL WORKERS RECOMMENDATIONS**

**Re: CMS-3844-P, Proposed rule: Medicare and Medicaid Programs: Hospice Conditions of Participation, "PERSONNEL QUALIFICATIONS" and "SOCIAL WORK"**

In recognition of the clinical expertise and skills required of a hospice social worker when working with individuals and their loved ones in end of life care, the following are what NASW considers essential minimum requirements for a qualified hospice social worker.

**Comments to Proposed § 418.114: "PERSONNEL QUALIFICATIONS"**

NASW recommends moving "social worker" into general qualification requirements, as per the suggested definition below:

**Recommended Change of Language, § 418.114 (a):** *"Qualified social worker--A person who has a Master of Social Work (MSW) degree from an accredited program, with at least two years of health care experience, and who meets the licensing requirements for social work practice in the State in which he or she is practicing."*

**Rationale:**

The MSW degree assures extensive knowledge and counseling skills based on psychological and social theories. The MSW degree requires two years of coursework and an additional 900 hours of supervised social work internship experience, where knowledge is integrated with practice. CMS has acknowledged in their commentary section in the *Federal Register* that "Hospice marks the passage from life to death. The services by a hospice take on a higher level of importance that greatly affects a patient's physical and emotional comfort, and which will be remembered by family members forever." CMS goes onto to say that social workers are integral team members, often assisting families in crisis and providing emotional support and guidance. The role of the social worker is further highlighted in helping family members during the bereavement process "through in-depth counseling" which may include individual, group, and specialized children's grief work. NASW believes the extensive training of an MSW is more conducive to the nature of hospice social work due to the counseling and crisis oriented skills involved in dying, death, and bereavement.

All states have social work licensing for master's level social workers, and many states have multi-level licenses available. NASW recommends that all hospice social workers obtain the highest level of licensure appropriate for their academic degree and level of experience, and that is available according to their respective state regulations.

In recognition of the fact that there is now licensing for social workers in every state, and in accordance with NASW's comments, below, on the qualifications for hospice social workers, NASW recommends that the definition of qualified social worker be moved from § 418.114 (c) to § 418.114 (a). The requirements for bachelor's level social workers in those states where bachelor's level licensure is not available could remain under section (c).



Comments to Proposed § 418.114 (c) "SOCIAL WORK"

Recommended Change in Language: "*Social worker.* In extenuating circumstances, such as in rural areas, where there is limited access to an MSW, a person who holds a Bachelor of Social Work (BSW) degree from an accredited program, and is supervised by or has established a consultative relationship with a social worker who is qualified under § 418.114 (a), or, if no qualified social worker is available, is supervised by a mental health professional licensed at the master's level or higher."

Rationale:

The BSW is the minimum educational preparation that NASW can recommend for a hospice social worker in such extenuating circumstances. The National Association of Social Workers Standards of Classification considers the baccalaureate degree as a basic level of practice for social work. Other bachelor level degrees do not prepare the individual for social work practice.

Deleted: 49

Deleted: ¶

¶ In recognition of the clinical expertise and skills required of a hospice social worker when working with individuals and their loved ones in end of life care, the following are what NASW considers to be essential minimal requirements for a qualified hospice social worker. ¶

¶ **Hospice Social Worker-** A person who has a Master of Social Work (MSW) degree from an accredited program, with at least one year of health care experience. The MSW degree assures extensive knowledge and counseling skills in psychological and social theories. The MSW degree typically includes 900 hours of a supervised social work internship, where knowledge is integrated with practice. ¶

¶ In extenuating circumstances, such as in rural areas, where an MSW cannot be hired by reasonable recruitment efforts, NASW recommends a requirement of a person with a Bachelor of Social Work (BSW) degree from an accredited program. This recommendation is the minimal preparation that NASW can recommend for a hospice social worker in such "extenuating circumstances", and not a person with another baccalaureate degree. ¶

¶ <#> NASW recommends the requirement that a BSW work under the supervision of an MSW or, in the lack of availability or access to MSW supervision, by a licensed mental health professional. ¶

¶ <#> **State licensure and regulatory requirements-** NASW recommends that all ¶

¶ hospice social workers obtain the highest level of licensure available according to their respective state regulations. Many states have multi-level licenses available to social workers. ¶

¶ In regards to the remaining proposed rules to improve hospice care, NASW supports many of the changes and additions to the current rule, including: ¶

¶ <#> A more timely patient assessment; ¶

¶ <#> Replacing the quality assurance requirement with a more comprehensive quality assessment and performance improvement (QAPI) condition of participation that enables hospices to take tailored proactive steps to ensure quality care; ¶

¶ <#> Allowing hospices to contract for core services in certain situations (NASW recommends the requirement that social work services be in conjunction with the qualifications outlined above); ¶

¶

¶

¶

¶

... [1]

In recognition of the clinical expertise and skills required of a hospice social worker when working with individuals and their loved ones in end of life care, the following are what NASW considers to be essential minimal requirements for a qualified hospice social worker.

**Hospice Social Worker-** A person who has a Master of Social Work (MSW) degree from an accredited program, with at least one year of health care experience. The MSW degree assures extensive knowledge and counseling skills in psychological and social theories. The MSW degree typically includes 900 hours of a supervised social work internship, where knowledge is integrated with practice.

In extenuating circumstances, such as in rural areas, where an MSW cannot be hired by reasonable recruitment efforts, NASW recommends a requirement of a person with a Bachelor of Social Work (BSW) degree from an accredited program. This recommendation is the minimal preparation that NASW can recommend for a hospice social worker in such "extenuating circumstances", and not a person with another baccalaureate degree.

NASW recommends the requirement that a BSW work under the supervision of an MSW or, in the lack of availability or access to MSW supervision, by a licensed mental health professional.

**State licensure and regulatory requirements-**NASW recommends that all hospice social workers obtain the highest level of licensure available according to their respective state regulations. Many states have multi-level licenses available to social workers.

In regards to the remaining proposed rules to improve hospice care, NASW supports many of the changes and additions to the current rule, including:

A more timely patient assessment;

Replacing the quality assurance requirement with a more comprehensive quality assessment and performance improvement (QAPI) condition of participation that enables hospices to take tailored proactive steps to ensure quality care;

Allowing hospices to contract for core services in certain situations (NASW recommends the requirement that social work services be in conjunction with the qualifications outlined above);

And, adding guidance for hospices that care for residents of nursing facilities. These long-term care residents may be particularly vulnerable and added guidance regarding their hospice care would hopefully ensure quality hospice care during the dying and death process.

We acknowledge and appreciate CMS's extensive research on these vital needs and issues. Please let us know if we can provide any additional information to substantiate these recommendations or to assist your agency in implementation.

Sincerely,

Elizabeth J. Clark, PhD, ACSW, MPH  
Executive Director  
National Association of Social Workers

**Submitter :**

**Date: 07/26/2005**

**Organization :**

**Category :** Nurse

**Issue Areas/Comments**

**GENERAL**

GENERAL

See attachment.

CMS-3844-P-112-Attach-1.DOC

The following are my comments regarding the proposed changes to the CoPs.

1. 418.3 please add "spiritual" to "any changes in physical emotional condition"
2. 418.3 There are many medications used in hospice such as xanax and Ativan, which in other settings may be seen as a drug restraint, but in hospice used for normal patient care (i.e. control of anxiety due to dyspnea or emotional/spiritual unsettling in end of life process)
3. 418.3 "Staff" to replace "employee"
4. 418.3 Proposed definition of "facility" = a place where the patient resides where care is provided for the patient other than a private home environment
5. 418.3 proposed definition for "hospice patient" = an individual certified by 2 physicians as having a terminal diagnosis of 6 months or less and accepting care of a hospice agency"
6. 418.3 add dietary therapy to definition of licensed professional
7. 418.3 please clarify nursing services as being provided by a licensed nurse, that nursing services are at times delegated to a home health aide. Also, please clarify the role & qualifications of a homemaker.
8. 418.3 proposed definition of "patient's residence" = wherever the patient resides
9. Physical restraint: Please note that items not attached to a patient's body such as side rails and/or bed alarms are very often needed for patient safety, especially those with any type of neurological deficit or increased weakness who are at great risk for falls. Often times other devices attached to the patient such as lap buddies, soft waist restraints, etc. are also necessary to keep an at risk patient safe from falls and tumbles while allowing them maximum mobility in their wheelchair as he/she self propels.
10. 418.3 consider after "courts of the state" the words "or by common law within the state" to catch situations which are permitted but not statutory.
11. 418.52 notice of rights
  - a. In some areas of the country, there are many dialects, making it impossible to provide written rights in the patient's language. May an interpreter or family member be used?
  - b. The patient should also have the right to be involved in his/her plan of care
12. 418.52 exercise of rights and respect for property and person
  - a. Include a patient's right to refuse treatment.
  - b. Home health 484.10 may be more appropriate for grievance procedures in a hospice/home setting. The more detailed NF language (developed due to their history of abuse) is not appropriate for hospice.
13. 418.52 patient liability
  - a. Same as comment 11a
14. 418.54 COMPREHENSIVE ASSESSMENT
  - a. words "includes but is not limited to" is too broad
  - b. Change "care" to "assessment" so as to make it more comprehensive.
15. 418.54 INITIAL ASSESSMENT

a. This should be amended to "make contact with patient or representative" as there are instances when this is not feasible due to inability to make contact with the representative (i.e. DPOA, health care proxy) in that 24 hr. period, or the patient and/or representative request a later date, or the patient and/or representative refuses hospice care. Other possible language could be "to honor the patient and/or representative's wishes" or "as requested by patient and/or representative."

b. Instead of "physician's order for care", "physician's certification for care"

c. "within 24 hours" as currently phrased wouldn't always be realistic for hospices as emergencies and other unforeseen needs of current patient's would not always allow hospice staff the needed time and manpower for an admission. A complete assessment and admission of a patient (in my 5 years of hospice) takes a minimum of 3 hours and depending on the patient and families needs up to 8 hours

16. 418.54 TIME FRAME FOR COMPLETION OF COMPREHENSIVE ASSESSMENT

a. 4 day timeframe is not operationally feasible. Recommend : 8 calendar days. Many times patient's and families are already overwhelmed and the introduction of new staff must be done slowly, barring emergency needs of the patient as determined by the nurse at the initial assessment.

b. Is this a separate document or process of completion of each disciplines assessment.

c. Should read, "attending physician if he/she is willing to participate."

d. Recommend comprehensive assessment update every 15 days at the most rather than every 14 days to coincide better with the patient's recertifications, which are always divisible by 15. This is to help prevent duplicate paperwork, time, energy, and expense.

17. 418.54 PATIENT OUTCOME MEASURES

a. Comments: Outcome Measures are necessary to determine the effectiveness of interventions. Only basic measurements would be needed to determine this. (i.e. Pain decreased from 10 to 2 on a 0-10 scale after implementation of pain medications). Any requirements imposed by the CoPS should give only a minimal amount of direction. This would then allow for minimal paperwork, thus decreasing the burden and increasing the focus onto the patient's care. It would also allow each hospice to develop a form of measurement, which would work best with their current paperwork and internal policies and procedures.

18. 418.56 INTERDISCIPLINARY GROUP CARE PLANNING AND COORDINATING OF SERVICES

a. What is the patient's attending is also the medial director?

b. What if the patient's attending does not want to participate in IDG planning?

c. Is this a process or a specific form?

d. I believe it is a wonderful idea to have the IDG leadership not necessarily be the RN. If a hospice is communicating as it should be than any team member should be able to lead the team. There are instances when it is burdensome to have an RN at IDG due to his/her needed attention in the field with a patient.

19. 418.56 CONTENT OF PLAN OF CARE

a. after "include" add "services for the palliation or management of the terminal condition, including..." so that it is clear that the hospice doesn't need to treat all the patient's problems.

b. Comment on (6) What documentation will CMS expect as to the patient and families involvement and agreement to the plan of care?

i. Please remove the word "agreement" in this section. The family may not be in agreement with the plan of care, but the patient may be in agreement.

20. 418.56 REVIEW OF THE PLAN OF CARE

a. What is the hospice's obligation when the family disagrees with the patient's plan of care?

b. Comment: I have grave concerns requiring the attending physician to be more involved. At times, the attending makes the hospice referral and then relies upon the hospice medical director for the patient's needs and day to day needs. More often, the attending physician is involved in the day to day need for orders and care, but is very adamant that he or she does not want to deal with any more paperwork than necessary. I would be greatly concerned about a requirement for them to be involved in more documentation causing an adverse reaction on the relationship that hospices have worked so hard to develop with attending physicians since the start of the modern hospice movement in the United States.

c. Comment: It is adverse to the concept of an IDG to separate the Medical Director from the "hospice interdisciplinary team" as worded at the beginning of this section.

21. 418.56 COORDINATION OF SERVICES

a. (4) should allude to sharing of information with non-hospice providers who are sharing the care.

22. 418.58 PROGRAM SCOPE

a. COMMENT: Consistent language throughout this document with the term "Quality Assessment and Performance Improvement Programs" would be helpful in eliminating confusion regarding data element language.

b. Technical Assistance would be helpful in setting up these programs as this is something new to the hospice arena.

23. 418.58 PROGRAM DATA

a. Wow that was confusing. Technical help, leniency, and broad generalizations allowing the hospice room for interpretation would be helpful.

24. 418.58 PROGRAM ACTIVITIES

a. This is not something most hospices are able to meet at this time.

b. The entire QAPI process sounds like it will be very burdensome to hospices, requiring hours if not weeks of preparatory work, hours of maintenance each week, and the addition of an employee dedicated just to this.

c. In CMS's comment back to NHPCO, they said "death" is an adverse reaction. How can death be an adverse reaction when hospices are there specifically to care for the terminally ill?

d. This area is still confusing.

25. 418.58 PERFORMANCE IMPROVEMENT PROJECTS

a. How does one determine the complexity of one's program to determine the appropriate number of programs? How can one consider any hospice program to be more complex than another when they all operate under the same rules and regulations (except for the small variations on a state level)?

26. 418.58 EXECUTIVE RESPONSIBILITIES

a. More guidance would be helpful.

27. 418.62 LICENSED PROFESSIONAL SERVICES

a. (b) add the word "hospice" after "patient's"

28. 418.64 CORE SERVICES

a. The provision of continuous care (especially if for multiple patients at the same time) can be very demanding. Contractual staffing would be of great benefit during these periods of time. It would be much more beneficial to allow hospices to contract with nursing agencies as

well during these periods of time rather than limiting them to other Medicare certified hospices as a hospice is very unlikely to contract with another hospice for services due to the unfortunate competition between agencies.

29. 418.64 NURSING SERVICES

- a. Please clarify the use of LPN's under the supervision of a RN.

30. 418.64 COUNSELING SERVICES

- a. Bereavement counseling is provided in the nursing home through the offering of in-services and the specific use of counseling with those who have been identified as in need either by identifying themselves, or a hospice or nursing facility staff identifying him or her.

31. 418.66 NURSING SERVICES WAIVER

- a. This process should be user friendly & consistent across the country.
- b. Please give further clarification regarding what a non-urban area is.
- c. Even in the urban areas, there is a nursing shortage, especially for RN's. It can take months or longer. Will CMS offer the same waiver to urban hospices? If the same criteria are met regarding efforts to hire, why should CMS discriminate against a hospice?

32. 418.72 Add dietician

33. 418.74 Urban hospices should not be discriminated against here. It is becoming more prevalent for the agencies contracted with to limit their service area more & more, or refuse to go into a facility where they don't already have a client, thus making the service of the urban hospice's rural patient's more difficult.

33. 418.76 Please define homemaker services

34. 418.76 COMPETENCY EVALUATION

- Add the "aide " after home health

35. 418.76 IN-SERVICE TRAINING

Add the words "of which must be in HOSPICE OR home health care"

36. 418.76 ELIGIBLE TRAINING ORGANIZATIONS

- Substitute hospice for the words home health agency in the beginning of this standard

37. 418.76 HOME HEALTH ASSIGNMENTS AND DUTIES

- Defer to state law regarding medication administrative
- (2) IDT should have authority over home health aide frequency instead of physician's orders as this is to be outcome driven

38. 418.76 SUPERVISION OF HOME HEALTH AIDE

- What is meant by therapist?
- The requirement of a home health aide supervisory visit every 28 days while he or she is performing care, would be of great difficulty and require a great amount of additional resources, both financially and administratively. Finding enough RNs is challenging as it is. Home health Aide visits are also often made early in the AM or late at night depending on the patient's needs and wishes. This would place an additional burden on the hospice. The caregiver is completely capable of giving feedback and an adequate evaluation can be made with his/ her input. A more truthful response is elicited in the Home Health Aide's absence and a follow-up Visit can be done if needed.



- If this an observational assessment must be done, please note home health agencies have 60 days and this would be much more feasible. The shorter average length of stay for hospices should not have anything to do with this assessment as it is an employee assessment not a patient assessment. Competency assessments should take care of the issue.
39. 418.100 SERVING THE HOSPICE PATIENT AND FAMILY
- replace "promote" with "ensure"
  - what about conflicting patient and family needs and desires
  -
40. 418.100 PROFESSIONAL MANAGEMENT RESPONSIBILITY
- a. The requirement for "supervision of staff" (as opposed to only requiring supervision of services) is of concern, especially if it applies to staff at nursing facilities and/or hospitals.
  - b. Also of concern is the requirement for personnel having "at least the same qualifications as hospice employees." This was not the language used in the preamble. Suggested language...."supervisory responsibility for services" [not staff] and "by qualified personnel" rather than personnel having "at least the same qualifications as hospice employees"
  - c. Suggestion to replace "supervision" with oversight under the notion that the actual supervision of the employees would be by the employer with whom the arrangement is made and the oversight would include the employer and employee
41. 418.100 HOSPICE SATELLITE LOCATIONS
- a. Would like to see a consistent policy across CMS regions in defining and approving satellite locations
  - b. Would like clarification on the Medicare appeals process 498.3
- 42 418.102 MEDICAL DIRECTOR
- a. What about volunteer medical directors? Do they need to be under contract as well?
  - b. The wording of this section appears to suggest that the medical director/physician supersedes the IDT of which he or she is a member, not the leader.
  - c. Is it allowed for a hospice to contract with an entity for a physician to serve as a medical director?
- 43 418.102 INITIAL CERTIFICATION OF TERMINAL ILLNESS
- a. Please clarify the criteria for determining appropriateness and eligibility
- 43 418.102 RECERTIFICATION OF THE TERMINAL ILLNESS
- a. Please clarify what documentation the medical director would look at to review the "patient's and families expectations and wishes for the continuation of hospice care?"
  - b. Is this a process or document?
44. 418.102 COORDINATION OF MEDICAL CARE
- a. Operationally, the medical director having responsibility for this would be very difficult if not impossible, nor appropriate as this is an administrative responsibility. This should be deleted.
  - b. There is a difference between "medical" care and "hospice" care.
  - c. In light of QAPI requirements and that most medical directors are part time or volunteers, the "directing" of the QAPI" program should be expanded to "or other qualified professional".
45. 418.102 CLINICAL RECORDS
- a. It is a great barrier to allow the personal health record to automatically be left available to the patient/caregiver. As with medical records in a hospital setting, records should

be requested in writing by patient/caregiver and an allowable charge made for each piece of paper copied. I believe caregivers would be less likely to record certain procedures or observations in the personal health records and a clear/honest picture would be less likely to occur.

b. Although I have in over 5 years of hospice work never worked for a hospice that used electronic health records, I believe it would be very useful and make documentation quicker and more complete thus increasing the organization of the hospice.

c. Please clarify "accurate"

46. 418.102 CONTENT

a. Since the patient's right condition of participation is intended to replace the current informed consent condition, could you clarify what is required here.

b. (2) clarify "authorization"

47. 418.52 AUTHENTICATION

a. This standard comes for the hospital conditions of participation. Home care/Hospice is much broader than hospital care. What does "primary author" mean. Either an individual wrote the document or he/she did not. Hospice is so broad that it may not be feasible to completely comply with this standard. Does this standard apply to all consulting or covering physicians? What about contracted entities (i.e. PT, OT, ST). Nursing Facility and Home Health rules do not have such a standard. Our care is more similar to theirs than hospitals.

48. 418.52 RETENTION OF RECORDS

a. Suggestion: It would be more appropriate for this to follow the HIPAA requirement for record retention.

49. 418.52 DISCHARGE OR TRANSFER OF CARE

a. Sending a copy of the patient's clinical record if the patient transfers, revokes, or discharges is problematic and not necessary as the discharge summary requirements cover this. The entire printed record often includes hundreds of printed pages and is not likely to be welcomed by facilities or physicians. It has been my experience that many attending physicians are not even receptive the receipt of a copy of the IDT plan of care every 14 days. I suggest deleting this requirement.

b. The release of information should follow the minimum necessary standard in HIPAA

c. There may be parts of the medical record that would not be appropriate to share, such as family information

50. 418.52 RETRIEVAL OF CLINICAL RECORDS

a. Please clarify "readily available"

51. 418.106 CONTROLLED DRUGS IN THE PATIENT'S HOME

a. More flexibility is needed in this standard]

b. I'd like the word "collecting" taken out of the sentence.

c. The wording of "potential dangers" needs to be rephrased or removed in reference to controlled substances. Hospice has worked for years to dispel the myths associated with narcotic use in terminally ill patients and this phraseology is not in line with that work.

52. 418.106 USE AND MAINTENANCE OF EQUIPMENT AND SUPPLIES

a. "Where there is no manufacturer recommendation for a piece of equipment, the hospice must develop in writing its own repair and routine maintenance policy" be rewritten to clarify that when DME is provided under contract, the vendor assumes this responsibility.

b. Suggested language: "The hospice, either directly or through contractual agreement, ensures that there is a process for providing routine and preventive maintenance of equipment

ant that the equipment is a safe and words as intended for use in the patient's environment. This may occur directly or through contractual arrangement.

53. 418.108 INPATIENT CARE FOR SYMPTOM MANAGEMENT AND PAIN CONTROL  
a. the word "approved" should be replaced with "certified"

54. 418.110 TWENTY-FOUR HOUR NURSING SERVICES  
a. I believe it is appropriate to remove the 24 hour RN requirement for both general inpatient levels of care and respite care. In today's continued nursing shortage, care that is supervised and delegated by a RN is completely appropriate and direct care can be provided with as much quality by LPN/LVN's under delegation and supervision of a RN as if the care was being directly provided by a RN.

55. 418.110 PHYSICAL ENVIRONMENT  
a. Could you define and provide examples of "equipment failures" that would be required to be reported?  
b. What is the origin of section ii? This section seems to promote litigation and not be at all with the theme or philosophy of this document.

56. 418.418.110 PHARMACEUTICAL SERVICES  
a. Please clarify whether or not patients are allowed to bring prescription drugs from home into a facility, especially as related to prescriptions which are not related to the hospice diagnosis and therefore not provided by the hospice.

57. 418.110 DRUG MANAGEMENT PROCEDURES  
a. (iii). Please add "if required by law" to the end of this paragraph.

58. 418.110 SECLUSION AND RESTRAINT  
a. Please see comments in #2 above.  
b. Please see comments in #9 above.  
c. Suggested changes underlined: "one's body. \*Bed rails are not included in this definition of restraint if used for the safety of the patient or to assist the patient in independent functioning. A drug used, as a restraint is a medication used to control behavior or to restrict the patient's freedom of movement and is not a standard treatment for a hospice patient's hospice medical or psychiatric condition. Seclusion is the restricted confinement of a person alone in a room or an area where a person is physically prevented from leaving.  
d. (3c) This is unnecessary as a verbal report by the nurse to the physician for orders is allowable in all other situations and no exception is needed in this situation. Delete this section. It is not feasible for a physician to respond in such situations and timeframes and offers a undue hardship on the hospice to find a physician whom is willing to be available in such a manner.  
e. (3d) Change this to 24 hour period across the board, releasing the patient at least every 2 hours and checking the patient at least every 30 minutes.  
f. (7) add the word "unpredicted" before death. Please clarify as to why this has to be reported to CMS and to which office at CMS.

59. 418.112 HOSPICES THAT PROVIDE CARE TO RESIDENTS OF A SNF/NF, ICR/MR, OR OTHER FACILITIES  
a. This condition cannot be successfully implemented until there is in the SNF/NF, requirements a parallel condition that conforms their requirements. We recommend that the effective date of this section be delayed until the companion section is enacted or that it be at least incorporated by the reference into the SNF/NF requirements. We understand that the nursing home COPs will add a section on nursing homes and hospice care. Does this condition match the requirements that will be proposed for nursing homes?

- b. I ask that CMS work with surveyors on this issue and that hospices be allowed some leniency until the nursing facility regulations are complete.
- c. Can this condition be phased into effect?

60. 418.112 PROFESSIONAL MANAGEMENT

- a. Please add the word "hospice" after inpatient.
- b. Could you provide some information regarding how this standard is or is not related to nursing home regulations? Does this mean the hospice must avoid making assumptions about care provisions and specify the services to be provided by the facility and the ones to be provided by the hospice and the processes for management and routine communications?
- c. Input comment: It has been my experience frequently that this is the most difficult standard for facilities to agree with and that it does affect our relationship with them. I have had on more than one occasion a facility to refuse to sign a contract due to this requirement. Their reasoning was that the patient resides in their facility and they are therefore the primary caregiver and the one is primarily responsible and therefore should maintain all professional management, hospice related or otherwise.

61. 418.112 CORE SERVICES

- a. regarding the contracted services please see my comment in #28 above.

62. 418.112 MEDICAL DIRECTOR

- a. I am concerned that the requirements of this standard may cause unnecessary strain in the relationship between the hospice and the facility. In a nursing facility, the patient's attending physician is responsible for the care of the hospice patient. To supersede this by the Hospice Medical Director or designee would be rude and detrimental to the relationships of hospice and the attending physician. I know that the physicians I work with would not be in agreement with this condition as currently worded.
- b. The hospice Medical Director is a member of the IDT, not a separate entity all unto his/herself. The best language would be to require the IDT assume this duty in conjunction with the patient's attending physician through a designee of the IDT's choice.

63. 418.112 WRITTEN AGREEMENT

- a. there are times when respite care is done unexpectedly due to a change in the patient's condition or family need. Respite contracts are done individually for each patient as the dates and amount of payment to the facility will vary. It is not always feasible to have a signed contract prior to these services being started (i.e. if this occurs over a weekend). In such cases, may a verbal agreement be obtained and documented with signature to follow on the next business day when the appropriate individual to sign the document is available at the facility? This also occurs on occasion when a physician writes an order at night or on a weekend for a patient in a facility where the hospice has not before had a patient and therefore no contract.
- b. (iii) Please clarify that the life threatening condition is one other than the patient's terminal diagnosis as that is why they are on hospice.

64. 418.113 HOSPICE PLAN OF CARE

- a. (3) Request this be changed to every 15 days instead of every 14 days. Who is expected to review the plan of care, hospice, nursing facility, or both?
- b. (4) What is meant by "all caregivers"?

65. 418.13 COORDINATION OF SERVICES

- a. Can CMS assist in encouraging the Nursing Facilities to accept orders from the hospice physician (Medical Director) in the absence of the attending physician?
- b. (6) Please clarify what is meant by "physician order"?

66. 418.13 ORIENTATION AND TRAINING OF ALL STAFF

a. Rewording of this statement to "must assure orientation of facility staff" may be more appropriate in order to keep the facilities from being inundated with hospice in-services from the multiple hospices they work with. Most nursing facilities already have at least an annual in-service on hospice and end of life care.

67. 418.14 PERSONNEL QUALIFICATIONS FOR LICENSED PROFESSIONALS

a. I think the wording of this condition is appropriate. Some do have concerns that it will allow for non-degreed social workers because they are licensed by the State. I believe if he/she can work with the state as a licensed social worker there is no reason he/she is not qualified enough to work with hospice. If the hospice itself chooses only to hire more degreed personnel than the minimum requirement that is completely up to them, but this wording will open up greatly the opportunity many hospices will have to have a social worker in their area, and the patient's will not suffer from it. Just because an individual has letters behind his/her name, does not mean they can give the best care possible.

68. 418.14 SOCIAL WORKER

a. A bachelor's prepared social worker can provide just as good care to a hospice patient as a master's prepared social worker. The amount of experience required should not be determined by CMS, but left to the judgment of each hospice. By expanding this condition, hospices will be able to expand a patient's access to social work services and increase the hospice's flexibility to meet the needs of patients and their families.

69. 418.14 CRIMINAL BACKGROUND CHECKS

a. Compliance with State laws regarding criminal background checks should be sufficient for compliance with this standard. Will there be an established mechanism available to hospices by which the checks may be made? If not, CMS is putting a great deal of financial burden on each hospice.]

b. Will background checks be required for volunteers and contract staff?

c. What is the purpose of the background check? If there is something serious it will be notated on the individual's license or they will be in the registered sex offender's database. This sounds like more paperwork and needless expense for the hospice.

**Submitter :** Mrs. Sherri Johnston  
**Organization :** Burgess Hospice  
**Category :** Individual

**Date:** 07/26/2005

**Issue Areas/Comments**

**Issues 1 - 10**

**Personnel Qualifications**

Will current employees and volunteers working in Hospice be grandfathered in regarding criminal background checks?

Aide supervision every 28 days while providing care is unrealistic. It is too restrictive to schedule every 28 days. Where did this come from? I think SV every 2 weeks with or without the aide present should be sufficient.

Volunteers-I think all the hours, not just patient care hours should be considered for the 5% of pd hours.

**Medical Director**

I disagree that the medical director should be responsible for the quality assessment and PI program. This is unrealistic. They may be involved through the IDG team and have input but not responsible for.

**Short Term Inpatient Care**

This MUST include psychosocial/family crisis for a reason for short term inpatient. Some families absolutely can handle the situations at the end of life and need an alternative.

**Inpatient Care**

This should read Medicare certified hospice not Medicare approved.

**Seclusion and Restraint**

Should add terminology regarding this the drugs commonly used in hospital are 'not a standard treatment for a medical or psychiatric condition within a hospice program'.

**Residents Residing in a Facility**

It is unrealistic to require the medical director to communicate iwth the facility medical director. In rural areas, it is difficult enough to find a good medical director, let alone add more burden to his job. Medical directors will contact facility directors if requested or needed, shouldn't be required to do so.

I think making the agency bill for Hospice room and board is ridiculous. If the facility's primary responsibility is room and board, then let them bill for it!

Nursing homes do not always accept offers for educational inservice. How can we force our orientation and education on them?

**Social Work**

I disagree strongly with requiring MSW for counseling in Hospice for a variety of reasons. This would be extremely difficult for Hospices, especially in the rural setting to find MSW's to fulfill this role. I also think this is a 'slap in the face' to the many wonderful BSW's that have provided service for 20 plus years to our patients and their families.

**Clinical Records**

Forwarding the entire clinical record to another facility with transfer is waste and more paperwork burden. Transfer needed documents would be enough. POC, certification of terminal illness, transfer sheet, recent Dr. orders.

**Drugs, Supplies, and DME**

What does the term collecting mean when discussing controlled drugs in the patients home. This needs some flexibility and rewording.

The DME vendor should be responsible for repair and maintenance of equipment, not the hospice. This should be clarified within the contract.

Under the Standard, Content of the comprehensive assessment, the section on Drug therapy is too much like HOME Health. This has caused multiple problems in homecare with the inconsistent interpretation by surveyors and continues to cause problems and multiple deficiencies. This needs clarification on how we are to accomplish this and it should not be burdensome.

**Issues 11 - 18**

**Outcome-Based Performance Measures**

Are we copying Home Care? The OASIS has created such a burden for HH agencies. If we need these, only a few data measurements should be chosen.

**Outcome Measures**

Despite not liking the Home health OASIS, I would like some consistency here if we are going to be required to measure outcomes.

**QAPI**

To wordy. I would like this to be more specific.

**Assessment Time Frames**

The wording in this should change. Initial assessment within 24 hours may not be realistic if patient or family requests another time outside this parameter.

Completion within 7 days would be more realistic than 4 days.