Hospice of the North Country

HOSPICE

7/25/05
Centers for Medicare and Medicaid Services
Dept. of Health and Human Services
Attn: CMS-3844-P
PO Box 8010
Baltimore, MD 21244-8010

Dear Sir or Madam,

Thank you for this opportunity to comment on the Medicare and Medicaid Programs: Conditions of Participation: Proposed Rule published on May 27, 2005 in the Federal Register. The following comments are derived from participation in the Hospice and Palliative Care Association of New York State audio conferences re the proposed changes as well as from personal observation of the effects these changes may have on our small, rural hospice in Upstate New York.

The work that has been done by CMS to modify the CoPs is to be commended. The shift in focus from a somewhat punitive stance, looking to discover flaws, to one of performance improvement focusing on clinical outcomes and real outcomes is welcome.

Following are comments and suggestions for changes to the proposed revisions. They are in bold type. Vignettes from our own hospice experience will follow certain recommendations and will be indented and in quotes.

Subpart A - Definitions

(a) (3) Attending physician, please add: (3) The hospice medical director, hospice physician or nurse practitioner may also act as the patient's attending physician.

Add "Counseling Services: counseling services are services that assist the patient/family to minimize the stress and problems that arise from the terminal illness or from the dying process.

Drug restraint: a medication used to control behavior or to restrict the patient's freedom of movement, *which is not a standard hospice treatment for a medical or psychiatric condition, or not requested by the patient of the patient's surrogate.*

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"Our hospice frequently uses Ativan or Haldol for terminal restlessness and anxiety. Terminal restlessness is a common occurrence in the dying person and is uncomfortable for both the patient and the family. Ativan and Haldol are very effective at calming the terminally restless, thus creating a much calmer atmosphere for the patient and family to experience the death. We believe it is within the patient's rights to have available to them the medications that can provide the greatest degree of symptom control. In addition, having to report the deaths of our patients who have been prescribed these medications would create unnecessary and onerous additional paperwork unless said death was unexpected."

Nursing Services: care provided by a licensed nurse or under the supervision of a licensed nurse as allowed by law.

Palliative Care: add interdisciplinary group to the definition: palliative care is patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care *uses an interdisciplinary team* to address physical, intellectual, emotional, social and spiritual needs and to facilitate patient autonomy, access to information and choice.

Patient's residence: patient's chosen setting in which he/she lives.

Section 418.52 Condition of Participation: Patient's Rights
Section (a) Standard: Notice of Rights
Section (a) (3) needs to be adjusted to assure patient and family comfort. Would prefer this section to read: "The Hospice must inform the patient and family of the hospice's drug policies and procedures re management and disposal of controlled substances during the comprehensive assessment." We would prefer to have this information included in the admission packet, introduced and then gone over at a later date. Patients and families are exhausted by the admission process and would not necessarily be able to take in extra information.

(a) (1) (v.) **Please add the "right of the patient to be involved in her or her plan of care."**

(a) (1) (vi.) **Please add the "right of the patient to refuse treatment"**

Section (e) Patient Liability
Please consider changing the Standard language to read:
"Before care is initiated, the patient must be informed, verbally and in writing, and in a language that he/she can understand, if payment may be expected from the patient as well as hospice's intention to bill Medicare, Medicaid or third party payers, or other resources of funding known to hospice..."

"As a small rural hospice, it is virtually impossible for us to identify insurance coverage during a weekend or after hours admission. Would it be acceptable that the patient and family be informed that coverage has not

been determined and, therefore, that they may be personally responsible for the cost of hospice services? In our world of declining length of stay, the imperative is that they get hospice care as soon as possible in order to reap the benefits of our services."

Section (a) Standard: Initial Assessment:

There is no "physician admission order for care". We recommend that this be changed to "physician's certification" to be consistent with the Hospice statute.

Section (b) Standard: Time frame for completion of the comprehensive assessment.

Please consider making this a 7 day time frame. Reducing this to 4 days would put undue pressure on the patient and family at a highly stressful time.

"At our hospice and I believe all hospices, our priority is symptom control. Having a four day restriction would place pressure on patients and families who may be dealing with any number of stressors, both physical and emotional. I believe strongly that our IDG members are qualified to make the decision on what disciplines have the imperative to get into a home quickly. If we have a patient dealing with intractable nausea who is reticent to have new folks in his home and we mandate that he also have to see the social worker to meet regulations, we are not keeping the patients rights in mind."

Please consider changing the language re the attending physician to read "... the attending physician, *if he/she is willing to participate...*" Attendings are invited to participate in IDG meetings, most do not, probably due to time constraints.

Section (d) Standard: Update of the comprehensive assessment.

Please consider changing this time frame from "every 14 days" to every two weeks or "15 days". This change would provide the flexibility to accommodate holidays, emergencies, staff schedules and would synchronize with the Hospice 90/90/60 certification periods with minimal impact on the CoPs.

418.56 Condition of Participation: interdisciplinary group care planning and coordination of services.
Section (a) Standard: Approach to Service Delivery

(1) (i) please change to "the hospice Medical Director or physician designee" to be consistent with the other section of the CoPs. This change will also alleviate a potential problem if the Medical Director or hospice physician is also the attending.

(2) This should be removed, or changed to read : if a hospice has more than one interdisciplinary group, there will be consistency across teams and an inclusive process for developing policies that represent all disciplines and teams, *with final authority resting with the governing body and senior management.*" It is the role of

the governing body to establish policy for an organization so the existing language is not only contrary to common practice, but also to corporate law.

Section (c) Standard: Content of Care Plan

(C)(6) Regarding family agreement, strongly recommend that "agreement" be deleted.

> " It is so common in hospice to have family members at odds with one another. To mandate family agreement could potentially stop a patient's hospice care in it's tracks. To be sure, we work with families to overcome disagreements, we mediate arguments and we work very diligently to try and bring families together, but families are dynamic entities and we are never fully assured of agreement. Ultimately it is the patient's or the patient's surrogate who get the final say."

Section (d) Standard: Review of Plan of Care:
Again, please consider changing "every 14 days" to every two weeks or "15 days". This accommodates for holidays, emergencies and staffing and synchronizes with the hospice 90/90/60 day certification periods.

Please do not separate the medical director or physician designee from the rest of the hospice interdisciplinary team at the beginning of this standard. The team is based on the philosophy that no one is more important than anyone else, that everyone's voice is heard equally because they represent the different and equally important parts of the whole patient. We have worked very hard to create this equality. Please reconsider taking it away.

418.58 Condition of Participation: Quality assessment and performance improvement.

Hospices across the country are acknowledging and acting upon the need to be more data driven. It will take time to fully develop QAPI protocols. As well it will take people power.

> " As a small rural hospice, it is very difficult and time consuming to put into place all the data collection and analysis that we would like to. I am of the belief that this is definitely the direction in which we need to grow, but I also have a hard time paying the salaries of my clinical staff, my compliance staff, my administrative and support staff. Tacking on more hours for collection and analysis adds up. Will CMS consider increasing hospice reimbursement to augment the added person power?"

418.64 Condition of Participation: Core Services
We recommend that hospices be allowed to contract for continuous care staff on a routine basis.

> "Again, as a small rural hospice serving 1700 square miles of upstate New York, it is nearly impossible for us to give continuous care. Our nurses are overworked and we have one LPN for 1700 square miles. If someone is in

need of continuous care, we are more likely to admit them to the hospital. Being able to contract for these services would alleviate a real staffing crunch."

418.76 Condition of Participation: Home health aide and homemaker services
Again, please consider changing "every 14 days" to "every two weeks" or "15 days" for the reasons stated prior.

418.102 Condition of Participation: Medical Director
Section (c)Standard: Coordination of Medical Care

We strongly recommend that the last sentence in this section be revised to read: "The Medical Director or physician designee is also responsible for *participating in* the hospice's QAPI program. The program *may be* directed by the medical director, physician designee or other qualified professional."

"In this small rural hospice, we have a very busy gastroenterologist as our volunteer medical director. On our QAPI committee we have a Director of Public Health Nursing, 2 local physician board members (one retired) and three nurses as well as our Medical Director. Our committee is led by the retired doc with an enormous amount of help and talent from the other local physician and the nurses. It would be poor form to belittle their input and commitment in order to have the one doc with the least amount of time hold the title in name only."

Section (b) Standard: Authentication
This section is doable in a hospital setting but not for home based hospice. Nursing facilities and Home Health agencies do not have this standard, why then should hospice? Hospices have no mechanism beyond the verbal order taken by the registered nurse to authenticate a covering physicians signature.

Section (e) Standard: Discharge or transfer of care.
There is really no need to do more than *offer* the full clinical record to the attending physician. If they desire it, it will be sent. HIPAA clearly states that only the minimum necessary information be exchanged. It would seem appropriate to leave the decision of what is necessary to the attending physician.

"Our hospice has always sent a discharge summary to the attending physician. We have never been asked to provide the full clinical record. If we had, we would have furnished it. It seems a waste of time and resources, both in short supply, to send a record for which we have never been asked."

Section (b) Standard: Controlled drugs in the patient's home.
We recommend the following change in language: "The hospice must have written policy for disposing of controlled drugs, in the hospice plan of care, that are maintained in the patient's home..." Hospices are not legally able to collect controlled substances in a patient's home. It is illegal to transport a controlled

substance without a prescription. When a patient dies, the prescription is no longer valid. The words "collecting" and "tracking" should be removed. We are working in homes, not in a hospital setting. We do not, for the most part, administer medications as is done in a hospital. We do count medications, watch for misuse and address issues as they arise. While we do have a policy for drug disposal, those drugs legally belong to the family. Families can refuse to have the medications disposed of. What is the liability of the hospice in that case?

Section 418.108 Condition of Participation: Short term inpatient care.

Please include "caregiver collapse" as an eligible need as is currently allowed in existing hospice regulations.
(a) Standard: Inpatient care for symptom management, pain Control and psychosocial issues.
It is of utmost importance that psychosocial issues/care giver collapse be covered under general inpatient care. Paragraph (a) should note that pain control and symptom management would be done on an inpatients basis either because of the specific need for the staff and equipment available there for because or the inability of the hospice and /or the patient's caregivers to assure that the services are properly provided in the home. We strongly advocate for the need for RN presence on a 24 hours basis for the general inpatient level of care. The critical issues encountered with the hospice patient in this setting facing end-stage changes call for the assessment and treatment skills of an RN. RN presence on a 24 hours basis respite care is not seen as presenting the equivalent need.

Please also replace the word "approved" with "certified" in item (a) (1).

418.110 Condition of Participation: Hospices that provide inpatient care directly
Item (o) Standard: Restraint and Seclusion.

"Restraint" and "seclusion" are perceived differently in hospice. Seclusion is often what a patient and family want as they near the end. As mentioned earlier, medications which are considered "restraints" in the hospital are considered comfort care in hospice, when a patient may choose comfort over alertness. Both of these words have the connotation of punishment for poor behavior. Nothing is farther from the case in hospice. Privacy and the patient's right to have their symptoms controlled are the imperatives.

Item (o)(7)
Request that the word "unpredicted" precede "death" in the sentence which refers to the reporting of any death while the patient is restrained.

418.12 Conditions of participation: Hospices which provide hospice care to residents of a SNF/ICF, MR or other facilities.

(d) Standard: Medical Director

Please re-title this standard to : Interdisciplinary Group
Please revise text to read: The hospice interdisciplinary group must provide overall coordination of the care of the hospice resident that resides in an SNF, NF or other facility. Members of the interdisciplinary group will regularly communicate and coordinate care with SNF/NF staff to ensure quality care for the patient and family. Th hospice Medical Director or physician designee will communicate with the Medical Director of the SNF/NF, the patient's attending physician, and other physicians participating in the provision of car for the terminal and related conditions *as necessary*.

> "We have a good relationship with the several nursing home facilities in our catchment area. This has been accomplished with a variety of communication routes, the majority of which involve nursing staff to nursing staff and administration to administration. When we have needed a physician to physician interaction, that has occurred but in no way has it held more sway than in the other instances. Mandating physician physician communication in nursing homes would put an undue and unnecessary burden on our part time, volunteer, very busy medical director. Again, I believe these sorts of judgment decisions should be left to the interdisciplinary team. Again, this will really impact the workings of small rural hospices on shoestring budgets. We may be small but we are doing the work for folks who have no other avenues."

In closing, thank you again for the opportunity to respond to the new revisions. I would ask that when finalizing the new CoPs, you remember us little guys out here. We do not have large censuses, we do not have any fat in our budgets. We do provide excellent end-of-life care for many rural, disenfranchised, isolated folks. We need CMS to understand our financial and service delivery issues when making these changes and to compromise where you see fit.

Sincerely,

Mary Hamilton-Homer

Mary Hamilton-Homer, RN
Executive Director
Hospice of the North Country

ASSURED
HOME HEALTH & HOSPICE

July 25, 2005

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

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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 (Signature on file)
Wilma Wayson, BSN
Vice President and Director of Hospice

Michigan Home Health Association

July 22, 2005

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: File Code CMS-3844-P

Dear Colleagues:

The Michigan Home Health Association (MHHA) welcomes the opportunity to comment on the proposed Hospice Conditions of Participation. While many of the proposed changes will improve care for our patients and their families, we are concerned that some changes reflect an increasing medical model of care. One of the basic tenets of hospice care is the team approach for care. This team approach recognizes that the spiritual and psycho-social concerns of a patient and family at the end of life are just as important as the physical/medical issues. It is only through the coordination of all the team members that quality hospice care can be delivered..

The attached issues and recommendations have been developed through the collaborative efforts of our hospice leaders. While many of the areas of comment call for further clarification, some comments indicate areas of concern that may actually become access to care issues.

In summary, we welcome this opportunity to assist in the development of Hospice COPs that will improve the care of our hospice clients. Thank you.

Chris Chesny
President

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Executive Director

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Michigan Home Health Association

COMMENTS ON THE 2005 PROPOSED MEDICARE CONDITIONS OF PARTICIPATION FOR HOSPICE PROGRAMS

7/22/05

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
§418.2 Scope of the Part		
§418.3 Definitions **Drug restraint** means a medication used to control behavior or to restrict the patient's freedom of movement which is not a standard treatment for a patient's medical or psychiatric condition.	**As hospice gives many meds for the purpose of sedation to promote the comfort and dignity of the dying patient it is important that CMS change this language.**	**§418.3 Definitions** **Drug restraint** means a medication used to control behavior or to restrict the patient's freedom of movement which is not a standard hospice treatment for a patient's medical or psychiatric condition and/or is against the patient/patient advocates desire for end of life care.
§ 418.52 Condition of participation: Patient's rights. The patient has the right to be informed of his or her rights, and the hospice must protect and promote the exercise of these rights.		
(a) Standard: Notice of rights. (1) The hospice must provide the patient or representative with written and verbal notice of the patient's rights and responsibilities in a language and manner that the patient understands during the initial evaluation visit in advance of furnishing care. (2) The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law. (3) The hospice must inform the patient and family of the hospice's drug policies and	**There are multiple dialects of the same language, and may be impossible to provide all with written materials** **Policies are written for professional users. Language may include information not appropriate for**	*(a) Standard: Notice of rights.* (1)The hospice must provide the patient or representative with verbal notice of the patient's rights and responsibilities in a language and manner that the patient understands during the initial evaluation visit in advance of furnishing care. Verbal notice may be made through an interpreter. Written notice must be provided when available. (2)… 3)The hospice must inform the patient and family of the hospice's drug practices, including those regarding the tracking and disposing of controlled

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
procedures, including the policies and procedures regarding the tracking and disposing of controlled substances. (4) The hospice must maintain documentation showing that it has complied with the requirements of this section and that the patient or representative has demonstrated an understanding of these rights.	**patient/family.**	substances within 7days of hospice admission or at the time of death. (4)…
(b) *Standard: Exercise of rights and respect for property and person.* (1) The patient has the right— (i)To exercise his or her rights as a patient of the hospice; (ii)To have his or her property and person treated with respect; and (iii)To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and (iv)To not be subjected to discrimination or reprisal for exercising his or her rights. (2) If a patient has been adjudged incompetent under State law by a court of proper jurisdiction, the rights of the patient are exercised by the person appointed pursuant to State law to act on the patient's behalf. (3) If a State court has not adjudged a patient incompetent, any legal representative designated by the patient in accordance	**Need to include patients rights to refuse treatment**	(b) *Standard: Exercise of rights and respect for property and person.* (5) The patient has the right— (i))To exercise his or her rights as a patient of the hospice; (ii) To refuse care and treatment recommended by hospice (ii)To have his or her property and person treated with respect; and (iii)To voice grievances regarding treatment or care that is (or fails to be) furnished and the lack of respect for property by anyone who is furnishing services on behalf of the hospice; and (iv)To not be subjected to discrimination or reprisal for exercising his or her rights. (2) …

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
with State law may exercise the patient's rights to the extent allowed by State law. (4) The hospice must— (i.) Ensure that all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property are reported to State and local bodies having jurisdiction (including to the State survey and certification agency) within at least 5 working days of the incident, and immediately to the hospice administrator. Investigations and/or documentation of all alleged violations must be conducted in accordance with established procedures. (ii.) Immediately investigate all alleged violations and immediately take action to prevent further	**Hospice needs to investigate complaints and allegations before acting on them. Some patients make allegations because they are upset with a family member etc**	(4)The hospice must— (i)Investigate complaints made by a patient or the patient's family or representative regarding treatment or care that is (or fails to be) furnished, lack of respect for the patient or the patient's property by anyone furnishing services on behalf of the hospice, and document both the existence of the complaint and the steps taken to resolve the complaint. (ii) Investigate and document all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property in accordance with established procedures. (iii)Ensure that all violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property are reported immediately to the hospice administrator, and to State and local bodies having jurisdiction (including to the State survey and

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
potential abuse while the alleged violation is being verified; (iii.) Take appropriate corrective action in accordance with State law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and (iv.) Investigate complaints made by a patient or the patient's family or representative regarding treatment or care that is (or fails to be) furnished, lack of respect for the patient or the patient's property by anyone furnishing services on behalf of the hospice, and document both the existence of the complaint and the steps taken to resolve the		certification agency) as required by law, within at least 5 working days of the incident (i.) Immediately investigate all alleged violations and immediately take action when violation involves the physical/emotional safety of the patient. (ii.) Take appropriate corrective action in accordance with State law if the alleged violation is verified by the hospice administration or an outside body having jurisdiction, such as the State survey agency or local law enforcement agency; and

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
complaint.		
(c) *Standard: Pain management and symptom control.* The patient has a right to receive effective pain management and symptom control from the hospice.		
(d) *Standard: Confidentiality of clinical records.* The hospice must maintain the confidentiality of clinical records. Access to or release of patient information and clinical records is permitted in accordance with 45 CFR parts 160 and 164.		
(e) *Standard: Patient liability.* Before care is initiated, the patient must be informed, verbally and in writing, and in a language that he or she can understand, of the extent to which payment may be expected from the patient, Medicare or Medicaid, third-party payers, or other resources of funding known to the hospice.	**Hospice may not know patient pay amounts, spend downs, amount of cap or copay already spent.**	*(E) Standard: Patient liability.* Before care is initiated, the patient must be informed, verbally and in writing, and in a language that he or she can understand, of the extent to which hospice is aware, what may be expected from the patient, Medicare or Medicaid, third-party payers, or other resources for the coverage of hospice care.
§ 418.54 Condition of participation: Comprehensive assessment of the patient. The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services, and the patient's need for medical, nursing, psychosocial, emotional, and spiritual care. This care includes, but is not limited to, the palliation and management of the terminal illness and related medical conditions.	**Need clarification as to what this is**	**§ 418.54 Condition of participation: Comprehensive assessment of the patient.** The hospice must conduct and document in writing a patient-specific comprehensive assessment that identifies the patient's need for hospice care and services including physical status, coping, grief and bereavement, resources, and spiritual needs for the palliation and management of the terminal illness.
(a) *Standard: Initial assessment.* The hospice registered nurse must make an initial assessment visit within 24 hours after the hospice receives a physician's admission order for care (unless ordered otherwise by the physician), to determine the patient's immediate care and support needs.	**During times of staffing shortages it may put an agency at risk to need to admit within 24 hours.** **Need consideration for patient and family wishes**	*(a) Standard: Initial assessment.* The hospice registered nurse must make an initial assessment visit within 48 hours after the hospice receives a physician's admission order for care (unless ordered otherwise by the physician) and the patient/family accept admission, to determine the patient's immediate care and support needs.

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
(b) *Standard: Time frame for completion of the comprehensive assessment.* The hospice interdisciplinary group in consultation with the individual's attending physician must complete the comprehensive assessment no later than 4 calendar days after the patient elects the hospice benefit.	**Again consideration for patient/family wishes needed. They are often overwhelmed at start of care and want to space visits out.**	(b)*Standard: Time frame for completion of the comprehensive assessment.* The hospice interdisciplinary group in consultation with the individual's attending physician must complete the comprehensive assessment no later than 7 calendar days after the patient elects the hospice benefit, as allowed by the patient/family.
(c) *Standard: Content of the comprehensive assessment.* The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness that must be addressed in order to promote the hospice patient's well-being, comfort, and dignity throughout the dying process. The comprehensive assessment describes— (1) The nature and condition causing admission (including the presence or lack of objective data and subjective complaints); (2) Complications and risk factors that affect care planning; (3) Factors that must be considered in developing individualized care plan interventions, including— *(i.)* *Bereavement.* An initial bereavement assessment of the needs of the patient's family and other individuals focusing on the social, spiritual, and cultural factors that may impact their ability to cope with the patient's death.	**Need to address current medications**	(c) *Standard: Content of the comprehensive assessment* The comprehensive assessment must identify the physical, psychosocial, emotional, and spiritual needs related to the terminal illness and an assessment of current medication must be addressed in order to promote the hospice patient's well-being, …

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
Information gathered from the initial bereavement assessment must be incorporated into the bereavement plan of care. *(ii.) Drug therapy.* A review of the patient's prescription and over-the-counter drug profile, including but not limited to identification of the following— (i.) Ineffective drug therapy; (ii) Unwanted drug side and toxic effects; and (iii) Drug interactions. (4) The need for referrals and further evaluation by appropriate health professionals.		
(d) *Standard: Update of the comprehensive assessment.* The update of the comprehensive assessment must be accomplished by the hospice interdisciplinary group and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished— (1) As frequently as the condition of the patient requires, but no less frequently than every	**Usually comprehensive assessment is done only as a baseline and then ongoing assessments are based on patient need.** **Frequency should be based on patient need not dates**	*(d) Standard: Update of the comprehensive assessment.* An updated assessment must be accomplished by the hospice interdisciplinary group and must consider changes that have taken place since the initial assessment. It must include information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care. The assessment update must be accomplished— (1) As frequently as the condition of the patient requires, but no less frequently than the beginning of every certification period

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
14 days; and (2) At the time of each recertification.		
(e) *Standard: Patient outcome measures.* (1) The comprehensive assessment must include data elements .that allow for measurement of outcomes. The hospice must measure and document data in the same way for each patient. The data elements must take into consideration aspects of care related to hospice and palliation. (2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way for each patient. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.	Data elements need to be specific to patients needs. Not all patients need the same data elements measured. Should not waste time assessing what does not impact this patient's outcome	(e) *Standard: Patient outcome measures.* (1) The comprehensive assessment must include data elements .that allow for measurement of outcomes. The hospice must measure and document data in the same way for all patients to which the data element applies. The data elements must take into consideration aspects of care related to hospice and palliation. (2) The data elements must be an integral part of the comprehensive assessment and must be documented in a systematic and retrievable way. The data elements for each patient must be used in individual patient care planning and in the coordination of services, and must be used in the aggregate for the hospice's quality assessment and performance improvement program.
§ 418.56 Condition of participation: Interdisciplinary group care planning and coordination of services. The hospice must designate an interdisciplinary group or groups as specified in paragraph (a) of this section which, in consultation with the patient's attending physician, must prepare a written plan of care for each patient. The plan of care must specify the hospice care and services necessary to meet the patient and family-specific needs identified in the comprehensive		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
assessment and as it relates to the terminal illness and related conditions.		
(a) *Standard: Approach to service delivery.* (1) The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, medical, social, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group in its entirety must supervise the care and services. The hospice must designate a qualified health care professional that is a member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care. The interdisciplinary group must include, but is not limited to, individuals who are qualified and competent to practice in the following professional roles: (i) A doctor of medicine or osteopathy (who is not the patient's attending physician). (ii) A registered nurse. (iii) A social	**Medical is physical** **Needs to be RN who coordinates care, other members of IDT would have a hard time based on the acuity of the dying patient.**	(a) *Standard: Approach to service delivery.* (1)The hospice must designate an interdisciplinary group or groups composed of individuals who work together to meet the physical, social, emotional, and spiritual needs of the hospice patients and families facing terminal illness and bereavement. Interdisciplinary group members must provide the care and services offered by the hospice, and the group in its entirety must supervise the care and services. … The hospice must designate a RN member of the interdisciplinary group to provide coordination of care and to ensure continuous assessment of each patient's and family's needs and implementation of the interdisciplinary plan of care…

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*SUGGESTED REVISION*
worker. (iv) A pastoral, clergy, or other spiritual counselor. (2) If the hospice has more than one interdisciplinary group, it must designate in advance only one of those groups to establish policies governing the day-to-day provision of hospice care and services.		
(b) *Standard: Plan of care.* All hospice care and services furnished to patients and their families must follow a written plan of care established by the hospice interdisciplinary group in collaboration with the attending physician. The hospice must ensure that each patient and family and primary caregiver(s) receive education and training provided by the hospice as appropriate to the care and services identified in the plan of care.		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
(c) *Standard: Content of the plan of care.* The hospice must develop a written plan of care for each patient that reflects prescribed interventions based on the problems identified in the initial comprehensive and updated comprehensive assessments, and other assessments. The plan of care must include but not be limited to— (1) Interventions to facilitate the management of pain and symptoms; (2) A detailed statement of the scope and frequency of services necessary to meet the specific patient and family needs; (3) Measurable targeted		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
outcomes anticipated from implementing and coordinating the plan of care; (4) Drugs and treatment necessary to meet the needs of the patient; (5) Medical supplies and appliances necessary to meet the needs of the patient; and (6) The interdisciplinary group's documentation of patient and family understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.	Patients and families do not always agree with the POC, which family members, what about the one family member who disagrees	(6)The interdisciplinary group's documentation of patient and family understanding, involvement, and agreement with the plan of care, in accordance with the hospice's own policies, in the clinical record.
(d) *Standard: Review of the plan of care.* The medical director or physician designee, and the hospice interdisciplinary team (in collaboration with the individual's attending physician to the extent possible) must review, revise and document the plan as necessary at intervals specified in the plan but no less than every 14 calendar days. A revised plan of care must include information from the patient's updated comprehensive assessment and the patient's progress toward outcomes specified in the plan of care.	**Medical director/physician is a member of IDT** **What does to extent possible mean** **14 days is too prescriptive, needs to be based on patient need**	(d) *Standard: Review of the plan of care.* The hospice interdisciplinary team must review, revise and document the plan as necessary at intervals specified in the plan but no less than every certification period. A revised plan of care must include information from the patient's updated comprehensive assessment and the patient's progress toward outcomes specified in the plan of care.
(e) *Standard: Coordination of services.* The hospice must develop and maintain a system of communication and integration, in accordance with the hospice's own policies and procedures, to— (1) Ensure the interdisciplinary group, through its designated professionals, maintains responsibility for directing, coordinating, and supervising the care and services provided; (2) Ensure that care and services are provided in accordance with the		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
plan of care; (3) Ensure that the care and services provided are based on all assessments of the patient and family needs; and (4) Provide for and ensure the ongoing sharing of information between all disciplines providing care and services in the home, in outpatient settings, and in inpatient settings, irrespective whether the care and services are provided directly or under arrangement.	**This would mean that we need to coordinate with all health care persons involved in care.**	(4)Provide for and ensure the ongoing sharing of information between all disciplines providing hospice care and services in the home, in outpatient settings, and in inpatient settings, irrespective whether the care and services are provided directly.
§ 418.58 Condition of participation: Quality assessment and performance improvement. The hospice must develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program. The hospice's governing body must ensure that the program: Reflects the complexity of its organization and services; involves all hospice services (including those services furnished under contract or arrangement); focuses on indicators related to improved palliative outcomes; focuses on the end-of-life support services provided; and takes actions to demonstrate improvement in hospice performance. The hospice must maintain documentary evidence of its quality assessment and performance improvement program and be able to demonstrate its operation to CMS.		
(a) *Standard: Program scope.* (1) The program must at least be capable of showing measurable improvement in indicators for which there is evidence that		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
improvement in those indicators will improve palliative outcomes and end-of-life support services. (2) The hospice must measure, analyze, and track quality indicators, including adverse patient events, and other aspects of performance that enable the hospice to assess processes of care, hospice services, and operations.	**Define.** **Is this a sentinel event as defined by JCAHO**	
(b) *Standard: Program data.* (1) The program must utilize quality indicator data, including patient care, and other relevant data, in the design of its program. (2) The hospice must use the data collected to— (i) Monitor the effectiveness and safety of services and quality of care; and (ii) Identify opportunities for improvement. (3) The frequency and detail of the data collection must be specified by the hospice's governing body.		
(c) *Standard: Program activities.* (1) The hospice's performance improvement activities must— (i) Focus on high risk, high volume, or problem-prone areas; (ii) Consider incidence, prevalence, and severity of problems in those areas; and		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
(iii) Affect palliative outcomes, patient safety, and quality of care. (2) Performance improvement activities must track adverse patient events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the hospice. (3) The hospice must take actions aimed at performance improvement and, after implementing those actions; the hospice must measure its success and track performance to ensure that improvements are sustained.		
(d) *Standard: Performance improvement projects*. (1) The number and scope of distinct improvement projects conducted annually must reflect the scope, complexity, and past performance of the hospice's services and operations. (2) The hospice must document what quality improvement projects are being conducted, the reasons for conducting these projects, and the measurable progress achieved on these projects.		
(e) *Standard: Executive responsibilities*. The hospice's governing body is responsible for ensuring the following: (1) That an ongoing program for quality	**Governing bodies do not usually want the level of detail of ensuring**	(e) *Standard: Executive responsibilities*. The hospice's governing body is responsible for oversight of the following: (1)„„

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
improvement and patient safety is defined, implemented and maintained; (2) That the hospice-wide quality assessment and performance improvement efforts address priorities for improved quality of care and patient safety, and that all improvement actions are evaluated for effectiveness; and (3) That clear expectations for patient safety are established.		
§418.60 Condition of participation: Infection control. The hospice must maintain and document an effective infection control program that protects patients, families and hospice personnel by preventing and controlling infection and communicable diseases.		
(a) *Standard: Prevention.* The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions. (b) *Standard: Control.* The hospice must maintain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that— (1) Is an integral part of the hospice's quality assessment and performance improvement program; and (2) Includes: (i.) A method of identifying infectious; and communicable disease problems; and (ii.) A plan for the		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
appropriate actions that are expected to result in improvement and disease prevention.		
(c) *Standard: Education.* The hospice must provide infection control education to staff, patients, and family members or other caregivers.		
§ 418.62 Condition of participation: Licensed professional services. (a) Licensed professional services provided directly or under arrangement must be authorized, delivered, and supervised only by health care professionals who meet the appropriate qualifications specified under 418.114 and who practice under the hospice's policies and procedures. (b) Licensed professionals must actively participate in the coordination of all aspects of the patient's care, in accordance with current professional standards and practice, including participating in ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education; and (c) Licensed professionals must participate in the hospice's quality assessment and performance improvement program and hospice sponsored in-service training.		(b)Licensed professionals must actively participate in the coordination of all aspects of the patient's hospice care, in accordance with current professional standards and practice, including participating in ongoing interdisciplinary comprehensive assessments, developing and evaluating the plan of care, and contributing to patient and family counseling and education; and
§ 418.64 Condition of participation: Core services. A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in § 418.64(a). A hospice may, under extraordinary or other non-routine circumstances, enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: Unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area.		
(a) *Standard: Physician services.* The hospice medical director, physician employees, and contracted physician(s) of the hospice, in conjunction with the patient's attending physician, are responsible for the palliation and management of the terminal illness, conditions related to the terminal illness, and the general medical needs of the patient. (1) All physician employees and those under contract, must function under the supervision of the hospice medical director. (2) All physician employees and those under contract shall meet this requirement by either providing the services directly or through coordinating patient care with the attending physician. (3) If the attending physician is unavailable, the medical director, contracted physician, and/or hospice		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
physician employee is responsible for meeting the medical needs of the patient.		
(b) *Standard: Nursing services.* (1) The hospice must provide nursing care and services by or under the supervision of a registered nurse. Nursing services must ensure that the nursing needs of the patient are met as identified in the patient's initial comprehensive assessment and updated assessments. (2) If State law permits nurse practitioners (NPs) to see, treat and write orders for patients, then NPs may provide services to beneficiaries receiving hospice care. The role and scope of the services provided by a NP that is not the individual's attending physician must be specified in the individual's plan of care. (3) Highly specialized nursing services that are provided so infrequently that the provision of such services by direct hospice employees would be impracticable and prohibitively expensive, may be provided under contract.		
(c) *Standard: Medical social services.* Medical social services must be provided by a qualified social worker, under the direction of a physician. Social work services must be based on the patient's psychosocial assessment and the		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
patient's and family's needs and acceptance of these services.		
(d) *Standard: Counseling services.* Counseling services for adjustment to death and dying must be available to both the patient and the family. Counseling services must include but are not limited to the following: (1) *Bereavement counseling.* The hospice must: (i) Have an organized program for the provision of bereavement services furnished under the supervision of a qualified professional with experience in grief/loss counseling. (ii) Make bereavement services available to the family and other individuals in the bereavement plan of care up to one year following the death of the patient. Bereavement counseling also extends to residents and employees of a SNF/NF, ICF/MR, or other facility when appropriate and identified in the bereavement plan of care. (iii) Ensure that bereavement services reflect the needs of the bereaved. (iv) Develop a bereavement plan of care that notes the kind of bereavement services to be		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
provided and the frequency of service delivery. A special coverage provision for bereavement counseling is specified in § 418.204(c). (2) *Nutritional counseling.* Nutritional counseling, when identified in the plan of care, must be performed by a qualified individual, which include dietitians as well as nurses and other individuals who are able to address and assure that the dietary needs of the patient are met. (3) *Spiritual counseling.* The hospice must: (i) Provide an assessment of the patient's and family's spiritual needs; (ii) Provide spiritual counseling to meet these needs in accordance with the patient's and family's acceptance of this service, and in a manner consistent with patient and family beliefs and desires; (iii) Facilitate visits by local clergy, pastoral counselors, or other individuals who can	**In some situations local clergy do not want to be involved**	iii)Provide reasonable facilitation of visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs to the best of its ability.

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
support the patient's spiritual needs to the best of its ability. The hospice is not required to go to extraordinary lengths to do so; and (iv) Advise the patient and family of this service.		
§ 418.66 Condition of participation: Nursing services—Waiver of requirement that substantially all nursing services be routinely provided directly by a hospice. (a) CMS may waive the requirement in § 418.64(b) that a hospice provide nursing services directly, if the hospice is located in a nonurbanized area. The location of a hospice that operates in several areas is considered to be the location of its central office. The hospice must provide evidence to CMS that it has made a good faith effort to hire a sufficient number of nurses to provide services. CMS may waive the requirement that nursing services be furnished by employees based on the following criteria: (1) The location of the hospice's central office is in a nonurbanized area as determined by the Bureau of the Census. (2) There is evidence that a hospice was operational on or before January 1, 1983 including— (1) Proof that the organization was established to provide hospice	**Need to provide waivers for urban areas as well. Nurses, are hard to recruit and retain in all areas of the state.** **Suggest allowing to contract for continuous care. This will increase access to this benefit.**	

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
services on or before January 1, 1983; (2) Evidence that hospice-type services were furnished to patients on or before January 1, 1983; and (3) Evidence that hospice care was a discrete activity rather than an aspect of another type of provider's patient care program on or before January 1, 1983. (3) By virtue of the following evidence that a hospice made a good faith effort to hire nurses: (i) Copies of advertisements in local newspapers that demonstrate recruitment efforts; (ii) Job descriptions for nurse employees; (iii) Evidence that salary and benefits are competitive for the area; and (iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contacts with nurses at other providers in the area). (b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
(c) Waivers will remain effective for 1 year at a time from the date of the request. (d) CMS may approve a maximum of two 1-year extensions for each initial waiver. If a hospice wishes to receive a 1-year extension, it must submit a request to CMS before the expiration of the waiver period, and certify that the conditions under which it originally requested the initial waiver have not changed since the initial waiver was granted.		
Non-Core Services **§ 418.70 Condition of participation: Furnishing of non-core services.** A hospice must ensure that the services described in § 418.72 through § 418.78 are provided directly by the hospice or under arrangements made by the hospice as specified in § 418.100. These services must be provided in a manner consistent with current standards of practice.		
§ 418.72 Condition of participation: Physical therapy, occupational therapy, and speech-language pathology. Physical therapy services, occupational therapy services, and speech-language pathology services must be available, and when provided, offered in a manner consistent with accepted standards of practice.		**§ 418.72 Condition of participation: Dietary counseling, Physical therapy, occupational therapy, and speech-language pathology.**
§ 418.74 Waiver of requirement—Physical therapy, occupational therapy, speech-language pathology, and dietary counseling. (a) A hospice located in a non-urbanized area may submit a written request for a waiver of the requirement for providing physical therapy, occupational therapy, speech-language pathology, and dietary counseling services. The hospice may seek a waiver of the requirement that it make physical		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
therapy, occupational therapy, speech-language pathology, and dietary counseling services (as needed) available on a 24-hour basis. The hospice may also seek a waiver of the requirement that it provide dietary counseling directly. The hospice must provide evidence that it has made a good faith effort to meet the requirements for these services before it seeks a waiver. CMS may approve a waiver application on the basis of the following criteria: (1) The hospice is located in a non-urbanized area as determined by the Bureau of the Census. (2) The hospice provides evidence that it had made a good faith effort to make available physical therapy, occupational therapy, speech-language pathology, and dietary counseling services on a 24-hour basis and/or to hire a dietary counselor to furnish services directly. This evidence must include— (i) Copies of advertisements in local newspapers that demonstrate recruitment efforts; (ii) Physical therapy, occupational therapy, speech-language pathology, and dietary counselor job descriptions; (iii) Evidence that salary and benefits are competitive for the area;		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
and (iv) Evidence of any other recruiting activities (for example, recruiting efforts at health fairs and contact discussions with physical therapy, occupational therapy, speech-language pathology, and dietary counseling service providers in the area). (b) Any waiver request is deemed to be granted unless it is denied within 60 days after it is received. (c) An initial waiver will remain effective for 1 year at a time from the date of the request. (d) CMS may approve a maximum of two 1-year extensions for each initial waiver. If a hospice wishes to receive a 1-year extension, it must submit a request to CMS prior to the expiration of the waiver period and certify that conditions under which it originally requested the waiver have not changed since the initial waiver was granted.		
§ 418.76 Condition of participation: Home health aide and homemaker services. All home health aide services must be provided by individuals who meet the personnel requirements specified in paragraph (a) of this section. Homemaker services must be provided by individuals who meet the personnel requirements specified in paragraph (j) of this section.		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
(a) *Standard: Home health aide qualifications.* (1) A qualified home health aide is a person who has successfully completed— (i) A training program and competency evaluation as specified in paragraphs (b) and (c) (ii) of this section respectively; or (iii) A competency evaluation program; or (iv) A State licensure program that meets the requirements of paragraphs (b) and (c) of this section. A home health aide is not considered to have completed a training program, or a competency evaluation program if, since the individual's most recent completion of the program(s), there has been a continuous period of 24 consecutive months during which none of the services furnished by the individual as described in § 409.40 of this chapter were for compensation. If there has been a 24-month lapse in furnishing services, the individual must complete another training and/or competency evaluation program before providing services, as specified in paragraph (a)(1) of this section.		
(b) *Standard: Content and duration of home health aide classroom and supervised practical training.* (1) Home health aide		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
training must include classroom and supervised practical classroom training in a practicum laboratory or other setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse or licensed practical nurse, who is under the supervision of a registered nurse. Classroom and supervised practical training combined must total at least 75 hours. (2) A minimum of 16 hours of classroom training must precede a minimum of 16 hours of supervised practical training as part of the 75 hours. (3) A home health aide training program must address each of the following subject areas: (i) Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff; (ii) Observation, reporting, and documentation of patient status and the care or service furnished; (iii) Reading and recording temperature, pulse, and respiration;		

2005 CMS PROPOSED COPS – Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
(iv) Basic infection control procedures; (v) Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor; (vi) Maintenance of a clean, safe, and healthy environment; (vii) Recognizing emergencies and the knowledge of emergency procedures and their application; (viii) The physical, emotional, and developmental needs of and ways to work with the populations served by the hospice, including the need for respect for the patient, his or her privacy, and his or her property; (ix) Appropriate and safe techniques in performing personal hygiene and		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
grooming tasks, including items on the following basic checklist— (A) Bed bath; (B) Sponge, tub, and shower bath; (C) Hair shampoo (sink, tub, and bed); (D) Nail and skin care; (E) Oral hygiene; and (F) Toileting and eliminati on; (x) Safe transfer techniques and ambulation. (xi) Normal range of motion and positioning. (xii) Adequate		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
(xiii) Any other task that the hospice may choose to have an aide perform. The hospice is responsible for training home health aides, as needed, for skills not covered in the basic checklist, as described in paragraph (b)(3)(ix) of this section. (4) The hospice must maintain documentation that demonstrates that the requirements of this standard are met.		
(c) *Standard: Competency evaluation.* An individual may furnish home health services on behalf of a hospice only after that individual has successfully completed a competency evaluation program as described in this section. (1) The competency evaluation must address each of the subjects listed in paragraphs (b)(1) through (b)(3) of this section. Subject areas specified under paragraphs (b)(3)(i), (b)(3)(iii), (b)(3)(ix), (b)(3)(x) and (b)(3)(xi) of this section must be evaluated by observing an aide's performance of the task with a patient. The remaining		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
subject areas may be evaluated through written examination, oral examination, or after observation of a home health aide with a patient. (2) A home health aide competency evaluation program may be offered by any organization, except as specified in paragraph (f) of this section. (3) The competency evaluation must be performed by a registered nurse in consultation with other skilled professionals, as appropriate. (4) A home health aide is not considered competent in any task for which he or she is evaluated as unsatisfactory. An aide must not perform that task without direct supervision by a registered nurse until after he or she has received training in the task for which he or she was evaluated as ''unsatisfactory,'' and successfully completes a subsequent evaluation. (5) The hospice must maintain documentation that demonstrates the requirements of this standard are being met.		
(d) *Standard: In-service training.* A home health aide must receive at least 12 hours of in-service training during each 12-month period. In-service training may occur while an aide is furnishing care to a patient. (1) In-service training may be offered by any organization except one		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
that is excluded by paragraph (f) of this section, and must be supervised by a registered nurse. (2) The hospice must maintain documentation that demonstrates the requirements of this standard are met.		
(e) *Standard: Qualifications for instructors conducting classroom supervised practical training, competency evaluations and in-service training.* Classroom supervised practical training must be performed by or under the supervision of a registered nurse who possesses a minimum of two years nursing experience, at least one year of which must be in home health care. Other individuals may provide instruction under the general supervision of a registered nurse.	**Does this include hospice**	Classroom supervised practical training must be performed by or under the supervision of a registered nurse who possesses a minimum of two years nursing experience, at least one year of which must be in hospice care. Other individuals may provide instruction under the general supervision of a registered nurse
(f) *Standard: Eligible training organizations.* A home health aide training program may be offered by any organization except by a home health agency that, within the previous 2 years— (1) Was out of compliance with the requirements of paragraphs (b) or (c) of this section; (2) Permitted an individual that does not meet the definition of a ''qualified home health aide'' as specified in paragraph (a) of this section to furnish home health aide services (with the exception of licensed health professionals and volunteers); (3) Was subjected to an extended (or partial extended) survey as a result of having been		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
found to have furnished substandard care (or for other reasons at the discretion of CMS or the State); (4) Was assessed a civil monetary penalty of $5,000 or more as an intermediate sanction; (5) Was found by CMS to have compliance deficiencies that endangered the health and safety of the home health agency's patients and had temporary management appointed to oversee the management of the home health agency; (6) Had all or part of its Medicare payments suspended; or (7) Was found by CMS or the State under any Federal or State law to have: (i) Had its participation in the Medicare program terminated; (ii) Been assessed a penalty of $5,000 or more for deficiencies in Federal or State standards for home health agencies; (iii) Been subjected to a suspension of Medicare payments to which it otherwise would have been entitled; (iv) Operated under temporary managemen		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
t that was appointed by a governmental authority to oversee the operation of the home health agency and to ensure the health and safety of the home health agency's patients; or (v) Been closed by CMS or the State, or had its patients transferred by the State.		
(g) *Standard: Home health aide assignments and duties.* A registered nurse or the appropriate qualified therapist that is a member of the interdisciplinary team makes home health aide assignments. (1) Home health aides are assigned to a specific patient by a registered nurse or the appropriate qualified therapist. Written patient care instructions for a home health aide must be prepared by a registered nurse or other appropriate skilled professional (*i.e.*, a physical therapist, speech-language pathologist, or occupational therapist) who is responsible for the supervision of a home health aide as specified under paragraph (h) of this section. (2) A home health aide provides services that		Home health aides are assigned to a specific patient by a registered nurse.

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
are: (i) Ordered by the physician or nurse practitioner; (ii) Included in the plan of care; (iii) Permitted to be performed under State law by such home health aide; and (iv) Consistent with the home health aide training. (3) The duties of a home health aide include: (i) The provision of hands-on personal care; (ii) The performance of simple procedures as an extension of therapy or nursing services; (iii) Assistance in ambulation or exercises; and (iv) Assistance in administering medications that are ordinarily self-administered. (4) Home health aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to a registered nurse or other appropriate licensed professional, as the changes relate to the plan of care and quality assessment and	**Need to report changes in all needs**	(4)Home health aides must report changes in the patient's needs to a registered nurse or other appropriate licensed professional, as the changes relate to the plan of care and quality assessment and improvement activities.

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
improvement activities. Home health aides must also complete appropriate records in compliance with the hospice's policies and procedures.		
(h) *Standard: Supervision of home health aides.* i. A registered nurse must make an onsite visit to the patient's home no less frequently than every two weeks to assess the home health aide's services. The home health aide does not have to be present during this visit. A registered nurse or qualified therapist must make an onsite visit to the location where the patient is receiving care in order to observe and assess each aide while he or she is performing care no less frequently than every 28 days. The supervising nurse or therapist must assess an aide's ability to demonstrate initial and continued satisfactory performance in meeting outcome criteria that include, but is not limited to— (i) Following the patient's plan of care for completion of tasks assigned to the home health aide by the registered nurse or qualified therapist; (ii) Creating successful interpersonal relationships with the	**Current language is every 2 weeks, don't change to every 14 days.** **If we are tracking the competency of the HHA then we need to say that, and address under d) standard: Inservice training** **This needs to reflect how burdensome this is for family to have two caregivers.** **Also burden to facility.** **No positive outcome.**	A registered nurse must make an onsite visit to the patient's home no less frequently than every two weeks to assess the home health aide's services. The home health aide does not have to be present during this visit.

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
patient and family; (iii) Demonstrating competency with assigned tasks; (iv) Complying with infection control policies and procedures; and (v) Reporting changes in the patient's condition. (3) If the hospice chooses to provide home health aide services under contract with another organization, the hospice's responsibilities include, but are not limited to— (i.) Ensuring the overall quality of care provided by an aide; (ii.) Supervising an aide's services as described in paragraphs (h)(1) and (h)(2) of this section; and (iii.) Ensuring that home health aides who provide services under arrangement have met the training and/ or competency evaluation requirements of this condition.		
(i) *Standard: Individuals furnishing*		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
Medicaid personal care aide-only services under a Medicaid personal care benefit. An individual may furnish personal care services, as defined in § 440.167 of the Code of Federal Regulations, on behalf of a hospice or home health agency. Before the individual may furnish personal care services, the individual must be found competent by the State to furnish those services. The individual only needs to demonstrate competency in the services the individual is required to furnish.		
(j) *Standard: Homemaker qualifications.* A qualified homemaker is a home health aide as described in § 418.76 or an individual who meets the standards in § 418.202(g) and has successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness.		
(k) *Standard: Homemaker supervision and duties.* (1) Homemaker services must be coordinated by a member of the interdisciplinary group. (2) Instructions for homemaker duties must be prepared by a member of the interdisciplinary group. (3) Homemakers must report all concerns about the patient or family to the member of the interdisciplinary group who is coordinating homemaker services.		
§ 418.78 Conditions of participation: Volunteers. The hospice must use volunteers to the extent specified in paragraph (e) of this section. These volunteers must be used in defined roles and under the supervision of a designated hospice employee.		

2005 CMS PROPOSED COPS Subpart C	*ISSUES*	*REQUEST FOR COMMENTS*
(a) *Standard: Training.* The hospice must maintain, document and provide volunteer orientation and training that is consistent with hospice industry standards.		
(b) *Standard: Role.* Volunteers must be used in day-to-day administrative and/or direct patient care roles.		
(c) *Standard: Recruiting and retaining.* The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers.		
(d) *Standard: Cost saving.* The hospice must document the cost savings achieved through the use of volunteers. Documentation must include— (1) The identification of each position that is occupied by a volunteer; (2) The work time spent by volunteers occupying those positions; and (3) Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions identified in paragraph (d)(1) of this section for the amount of time specified in paragraph (d)(2) of this section.		
(e) *Standard: Level of activity.* Volunteers must provide day-to-day administrative and/or direct patient care services in an amount that, at a minimum, equals 5 percent of the total patient care hours of all paid hospice employees and contract staff. The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
§ 418.100 Condition of participation: Organization and administration of services. The hospice must organize, manage, and administer its resources to provide the hospice care and services to patients, caregivers and families necessary for the palliation and management of terminal illness.		
(a) *Standard: Serving the hospice patient and family.* The hospice will promote— (1) That each patient receives and experiences hospice care that optimizes comfort and dignity; and (2) That each patient experience hospice care that is consistent with patient and family needs and desires **********	********** *	(a) *Standard: Serving the hospice patient and family.* The hospice will promote— (1)That each patient receives and experiences hospice care that optimizes comfort and dignity; and (2) That each patient experience hospice care that is consistent with patient and family goals and is reasonable and necesssary. **********
(b) *Standard: Governing body and administrator.* A governing body (or designated persons so functioning) assumes full legal authority and responsibility for the management of the hospice, the provision of all hospice services, its fiscal operations, and continuous quality assessment and performance improvement. A qualified administrator reports to the governing body and is responsible for the day-to-day operation of the hospice. The administrator must be a hospice employee and possess education and experience required by the hospice's governing body.		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D **Organizational Environment**		*SUGGESTED REVISION*
(c) *Standard: Services.* (1) A hospice must be primarily engaged in providing the following care and services and must do so in a manner that is consistent within accepted standards of practice: (i) Nursing services. (ii) Medical social services. (iii) Physician services. (iv) Counseling services, including spiritual counseling, dietary counseling, and bereavement counseling. (v) Home health aide, volunteer, and homemaker services. (vi) Physical therapy, occupational therapy and speech-language pathology therapy services. (vii) Short-term inpatient care. (viii) Medical supplies (including drugs and biologicals) and medical appliances. (2) Nursing services, physician services, and drugs and biologicals (as specified in § 418.106) must be made routinely available on a 24-hour basis 7 days a week. Other covered services must be available on a 24-hour basis when reasonable and necessary to meet the needs of the patient and family.		
(d) *Standard: Continuation of care.* A hospice may not discontinue or reduce care provided to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay for that care.		
(a) *Standard: Approach to service delivery.* A hospice that has a written agreement		(a) *Standard: Approach to service delivery.*

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
with another agency, individual, or organization to furnish any services under arrangement, must retain administrative and financial management, and supervision of staff and services for all arranged services, to ensure the provision of quality care. (a) *Standard: Approach to service delivery.* (1) Authorized by the hospice; (2) Furnished in a safe and effective manner by personnel having at least the same qualifications as hospice employees; and (3) Delivered in accordance with the patient's plan of care.	**Hospice can not supervise staff from other agencies, however they do monitor** **Most SNFs have LPNs, and CNAs and hospices have RNs and HHAs**	A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement, must retain administrative and financial management, and monitor the care provided by all arranged services, to ensure the provision of quality care. (a) *Standard: Approach to service delivery.* (1)Authorized by the hospice (2)Furnished in a safe and effective manner by qualified personnel. (3)…
(f) *Standard: Hospice satellite locations.* (1) All hospice satellite locations must be approved by CMS before providing hospice care and services to Medicare patients. The determination that a satellite location does or does not meet the definition of a satellite location, as set forth in this part, is an initial determination, as set forth in § 498.3. (2) The hospice must continually monitor and manage all services provided at all of its locations to ensure that services are delivered in a safe and effective manner and to ensure that each patient and family receives the necessary care and services outlined in the plan of care.		
(g) *Standard: In-service training.* A hospice must assess the skills and competence of all individuals furnishing care, including volunteers furnishing services, and, as necessary, provide in-service training and education programs where required. The hospice must have written policies and procedures describing its method(s) of assessment of competency and maintain a written description of the in-service training provided during the previous 12 months.		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D **Organizational Environment**		*SUGGESTED REVISION*
§ 418.102 Condition of participation: Medical director. The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is either employed by, or under contract with, the hospice. When the medical director is not available, a physician designated by the medical director assumes the same responsibilities and obligations as the medical director. The medical director and physician designee coordinate with other physicians and health care professionals to ensure that each patient experiences medical care that reflects hospice policy.	**Medical director coverage should be chosen by the hospice as well**	**§ 418.102 Condition of participation: Medical director.** The hospice must designate a physician to serve as medical director. The medical director must be a doctor of medicine or osteopathy who is either employed by, or under contract with, the hospice. When the medical director is not available, a physician designated by the medical director and/or the hospice assumes the same responsibilities and obligations as the medical director…
(a) *Standard: Initial certification of terminal illness.* The medical director or physician designee reviews the clinical information for each hospice patient and provides written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course. The physician must consider the following criteria when making this determination: (1) The primary terminal condition. (2) Related diagnosis(es), if any. (3) Current subjective and objective medical findings. (4) Current medication and treatment orders. (5) Information about the medical management of any of the patient's conditions unrelated to the terminal illness.		
(b) *Standard: Recertification of the terminal illness.* Before the recertification period for each patient, as described in § 418.21(a), the medical director or physician designee must review: (1) The patient's clinical information; and (2) The patient's and family's expectations and wishes for the continuation of hospice care.		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
(c) *Standard: Coordination of medical care.* The medical director or physician designee, and the other members of the interdisciplinary group are jointly responsible for the coordination of the patient's medical care in its entirety. The medical director or physician designee is also responsible for directing the hospice's quality assessment and performance improvement program.	**Most medical directors do not have time or qualifications to direct the QA/PI.**	(c) *Standard: Coordination of medical care.* The medical director or physician designee, and the other members of the interdisciplinary group are jointly responsible for the coordination of the patient's medical care in its entirety. The medical director or physician designee is also responsible for oversight and input into the hospice's quality assessment and performance improvement program.
§ 418.104 Condition of participation: Clinical records. A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain accurate clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically		
(a) *Standard: Content.* Each patient's record must include the following: (1) The plan of care, initial assessment, comprehensive assessment, and updated comprehensive assessments, clinical notes, and progress notes. (2) Informed consent, authorization, and election forms. (3) Responses to medications, symptom management, treatments, and services. (4) Outcome measure data elements, as described in § 418.54(e) of this subpart. (5) Physician certification and recertification of terminal illness as required in § 418.22 and described in § 418.102(a) and § 418.102(b) respectively. (6) Any advance directives as described in § 418.52(a)(3).		
(b) *Standard: Authentication.* All entries must be legible, clear, complete, and appropriately authenticated and dated. All entries must be signed, and the hospice	**Need clarification as to what this means. Hospice deals with many physicians and**	(b) *Standard: Authentication* All entries must be legible, clear, and complete. All entries must be signed, and dated.

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
must be able to authenticate each handwritten and electronic signature of a primary author who has reviewed and approved the entry.	**staff across many settings. This could be an access to care issue. We add office notes, etc to chart for determining terminal status.**	
(c) *Standard: Protection of information.* The clinical record, its contents and the information contained therein must be safeguarded against loss or unauthorized use. The hospice must be in compliance with the Department's rules regarding personal health information set out at 45 CFR parts 160 and 164.		
(d) *Standard: Retention of records.* Patient clinical records must be retained for 5 years after the death or discharge of the patient, unless State law stipulates a longer period of time. If the hospice discontinues operation, hospice policies must provide for retention and storage of clinical records. The hospice must inform its State agency and its CMS Regional office where such clinical records will be stored and how they may be accessed.	**Needs to match whatever may be in HIPPA legislation.**	
(e) *Standard: Discharge or transfer of care.* (1) If the care of a patient is transferred to another Medicare/ Medicaid-approved facility, the hospice must forward a copy of the patient's clinical record and the hospice discharge summary to that facility. (2) If a patient revokes the election of hospice care, or is discharged from hospice because eligibility criteria are no longer met, the hospice must provide a copy of the clinical record and the hospice discharge summary of this section to the patient's attending physician. (3) The hospice discharge summary must include— (i) A summary of the	**Providers rarely require the entire clinical record and it would be burdensome to the hospice to copy and mail the entire record. Hospices should be required to provide the minimum necessary to provide quality care** **CMS need to add allow for sharing of electronic records**	(e) *Standard: Discharge or transfer of care.* (1) If the care of a patient is transferred to another Medicare/ Medicaid-approved facility, the hospice must forward a copy of the patient's hospice discharge summary to that facility. (2)If a patient revokes the election of hospice care, or is discharged from hospice because eligibility criteria are no longer met, the hospice must provide a copy of the hospice discharge summary of this section to the patient's attending physician. (3)…

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
patient's stay including treatments, symptoms and pain management; (ii) The patient's current plan of care; (iii)The patient's latest physician orders; and (iv)Any other documentation that will assist in post-discharge continuity of care.		
(f) *Standard: Retrieval of clinical records.* The clinical record, whether hard copy or in electronic form, must be made readily available on request by an appropriate authority.		
§ 418.106 Condition of participation: Drugs, controlled drugs and biologicals, medical supplies, and durable medical equipment. Medical supplies and appliances, as described in § 410.36 of this chapter; durable medical equipment, as described in § 410.38 of this chapter; and drugs and biologicals related to the palliation and management of the terminal illness and related conditions, as identified in the hospice plan of care, must be provided by the hospice while the patient is under hospice care.		
(a) *Standard: Administration of drugs and biologicals.* (1) All drugs and biologicals must be administered in accordance with accepted hospice and palliative care standards of practice and according to the patient's plan of care. (2) The interdisciplinary group, as part of the review of the plan of care, must determine the ability of the patient and/or family to safely self-administer drugs and biologicals.		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D **Organizational Environment**		*SUGGESTED REVISION*
(b) *Standard: Controlled drugs in the patient's home.* The hospice must have a written policy for tracking, collecting, and disposing of controlled drugs maintained in the patient's home. During the initial hospice assessment, the use and disposal of controlled substances must be discussed with the patient and family to ensure the patient and family are educated regarding the uses and potential dangers of controlled substances. The hospice nurse must document that the policy was discussed with the patient and family.	**Need a definition for tracking. It is difficult if not impossible to track meds in the homes as multiple care givers administer meds.** **Hospice needs to discuss the risks and <u>benefits</u> of all meds**	b) *Standard: Controlled drugs in the patient's home.* The hospice must have a written policy for collecting, and disposing of controlled drugs maintained in the patient's home. During the initial hospice assessment, the use and disposal of controlled substances must be discussed with the patient and family to ensure the patient and family are educated regarding the uses and potential risks and benefits of all medications including controlled substances. The hospice nurse must document that the policy was discussed with the patient and family.
(c) *Standard: Use and maintenance of equipment and supplies.* (1) The hospice must follow manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment. The equipment must be safe and work as intended for use in the patient's environment. Where there is no manufacturer recommendation for a piece of equipment, the hospice must develop in writing its own repair and routine maintenance policy. The hospice may use persons under contract to ensure the maintenance and repair of durable medical equipment. (2) The hospice must ensure that the patient, where appropriate, as well as the family and/or other caregiver(s), receive instruction in the safe use of durable medical equipment and supplies. The patient, family, and/or caregiver must be able to demonstrate the	**Many hospice contracts require that the medical equipment provider instruct on safe use.**	(2) The hospice, either directly or through contracting, must ensure that the patient, where appropriate, as well as the family and/or other caregiver(s), receive instruction in the safe use of durable medical equipment and supplies. The patient, family, and/or caregiver must be

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
appropriate use of durable medical equipment to the satisfaction of the hospice staff.		able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.
§ 418.108 Condition of participation: Short-term inpatient care. Inpatient care must be available for pain control, symptom management, and respite purposes, and must be provided in a participating Medicare or Medicaid facility.	**Need to split out General Inpatient level of care and inpatient respite level of care.**	**§ 418.108 Condition of participation: Short-term General inpatient care.** General Inpatient care must be available for symptom management, including pain, patient or family psychosocial crisis , and must be provided in a participating Medicare or Medicaid facility.
(a) *Standard: Inpatient care for symptom management and pain control.* Inpatient care for pain control and symptom management must be provided in one of the following: (1) A Medicare-approved hospice that meets the conditions of participation for providing inpatient care directly as specified in § 418.110. (2) A Medicare-participating hospital or a skilled nursing facility that also meets the standards specified in § 418.110(b) and (f) regarding 24-hour nursing services and patient areas.	**Again break out General inpatient from respite.** **General Inpatient level of care for treatment of crisis situations or symptom issues should require an RN, but inpatient respite which does not include crisis or symptoms should not.**	(a) *Standard:General Inpatient care for symptom management and pain control.* Inpatient care for pain control and symptom management must be provided in one of the following: (1) A Medicare-approved hospice that meets the conditions of participation for providing inpatient care directly as specified in § 418.110. (2) A Medicare-participating hospital or a skilled nursing facility that also meets the standards specified in § 418.110(b) and (f) regarding 24-hour Registered nursing services and patient areas.
(b) *Standard: Inpatient care for respite purposes.* Inpatient care for respite purposes must be provided by one of the following: (1) A provider specified in paragraph (a) of this section. (2) A Medicare/Medicaid approved nursing facility that also meets the standards specified in § 418.110(b) and (f).		(b) *Standard: Inpatient care for respite purposes.* Inpatient care for respite purposes must be provided by one of the following: (1) A provider specified in paragraph (a) of this section. (2) A Medicare/Medicaid participating nursing facility that also meets the standards specified in § 418.110(b) and (f).
(c) *Standard: Inpatient care provided*		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
under arrangements. If the hospice has an arrangement with a facility to provide for short-term inpatient care, the arrangement is described in a legally binding written agreement that at a minimum specifies— (1) That the hospice supplies the inpatient provider a copy of the patient's plan of care and specifies the inpatient services to be furnished; (2) That the inpatient provider has established patient care policies consistent with those of the hospice and agrees to abide by the palliative care protocols and plan of care established by the hospice for its patients; (3) That the hospice patient's inpatient clinical record includes a record of all inpatient services furnished, events regarding care that occurred at the facility, and that a copy of the inpatient clinical record and discharge summary is available to the hospice at the time of discharge; (4) That the inpatient facility has identified a individual within the facility who is responsible for the implementation of the provisions of the agreement; (5) That the hospice retains responsibility for arranging the training of personnel who will be providing the patient's care in the inpatient facility and that a description of the training and the names of those giving the training is documented; and (6) That a way to verify that requirements in paragraphs (c)(1) through (c)(5) of this section have been met is established.		
(d) *Standard: Inpatient care limitation.* The total number of inpatient days used by Medicare beneficiaries who elected hospice coverage in a 12month period in a		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
particular hospice may not exceed 20 percent of the total number of hospice days consumed in total by this group of beneficiaries.		
(e) *Standard: Exemption from limitation.* Before October 1, 1986, any hospice that began operation before January 1, 1975, is not subject to the limitation specified in paragraph (d) of this section.		
§ 418.110 Condition of participation: Hospices that provide inpatient care directly. A hospice that provides inpatient care directly must demonstrate compliance with all of the following standards:		
(a) *Standard: Staffing.* The hospice is responsible for ensuring that staffing for all services reflects its volume of patients, their acuity, and the level of intensity of services needed to ensure that plan of care outcomes are achieved and negative outcomes are avoided.		
(b) *Standard: Twenty-four hour nursing services.* The hospice facility must provide 24-hour nursing services that meet the nursing needs of all patients and are furnished in accordance with each patient's plan of care. Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well groomed, and protected from accident, injury, and infection.		
(c) *Standard: Physical environment.* The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors. (1) *Safety management.* (i) The hospice must address real or potential threats to the health and safety of the patients, others, and property. The hospice must report a breach of safety to appropriate State and local bodies having regulatory		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
jurisdiction and correct it promptly. (ii) The hospice must take steps to prevent equipment failure and when a failure occurs, report it appropriate State and local bodies having regulatory jurisdiction and correct it promptly. (iii) The hospice must have a written disaster preparedness plan in effect for managing the consequences of power failures, natural disasters, and other emergencies that would affect the hospice's ability to provide care. The plan must be periodically reviewed and rehearsed with staff (including non-employee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others. (2) *Physical plant and equipment.* The hospice must develop procedures for managing the control, reliability, and quality of— (i.) The routine storage and prompt disposal of trash and medical waste; (ii.) Light, temperature, and ventilation/air exchanges throughout the hospice; (iii.) Emergency gas and water supply; and (iv.) The scheduled and		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
emergency maintenance and repair of all equipment		
(d) *Standard: Fire protection.* (1) Except as otherwise provided in this section— (i) The hospice must meet the provisions applicable to nursing homes of the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association The Director of the Office of the Federal Register has approved the NFPA 101 2000 edition of the Life Safety Code, issued January 14,2000, for incorporation by reference in accordance with 5 U.S.C. 552(a) and 1 CFR part 51. A copy of the code is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore, MD or at the National Archives and Records Administration (NARA). For information on the availability of this material at NARA, call 202–741–6030, or go to: *http://www.archives.gov/federal register/code of federal regulations/ibr*		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
locations.html. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any changes in the edition of the Code are incorporated by reference, CMS will publish a notice in the **Federal Register** to announce the changes. (ii) Chapter 19.3.6.3.2, exception number 2 of the adopted edition of the LSC does not apply to hospice. (2) In consideration of a recommendation by the State survey agency, CMS may waive, for periods deemed appropriate, specific provisions of the Life Safety Code which, if rigidly applied would result in unreasonable hardship for the hospice, but only if the waiver would not adversely affect the health and safety of patients. (3) The provisions of the adopted edition of the Life Safety Code do not apply in a State if CMS finds that a fire and safety code imposed by State law adequately protects patients in hospices. (4) Beginning March 13, 2006, a hospice must be in compliance with Chapter 9.2.9, Emergency lighting. (5) Beginning March 13, 2006, Chapter 19.3.6.3.2, exception number 2 does not apply to hospices. (6) Notwithstanding any provisions of the 2000 edition of the Life Safety Code to the contrary, a hospice may place		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
alcohol-based hand rub dispensers in its facility if— (i) Use of alcohol-based hand rub dispensers does not conflict with any State or local codes that prohibit or otherwise restrict the placement of alcohol-based hand rub dispensers in health care facilities; (ii) The dispensers are installed in a manner that minimizes leaks and spills that could lead to falls; (iii) The dispensers are installed in a manner that adequately protects against access by vulnerable populations; and (v)The dispensers are installed in accordance with chapter 18.3.2.7 or chapter 19.3.2.7 of the 2000 edition of the Life Safety Code, as amended by NFPA Temporary Interim Amendment 00–1(101), issued by the Standards Council of the National Fire Protection Association on April 15, 2004. The Director of the Office of the Federal Register has approved NFPA Temporary Interim Amendment 00–1(101) for incorporation by reference in accordance with 5		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
	U.S.C. 552(a) and 1 CFR part 51. A copy of the amendment is available for inspection at the CMS Information Resource Center, 7500 Security Boulevard, Baltimore MD and at the Office of the Federal Register, 800 North Capitol Street NW., Suite 700, Washington, DC. Copies may be obtained from the National Fire Protection Association, 1 Batterymarch Park, Quincy, MA 02269. If any additional changes are made to this amendment, CMS will publish notice in the **Federal Register** to announce the changes.	
(e) *Standard: Patient areas*. The hospice must provide a home-like atmosphere and ensure that patient areas are designed to preserve the dignity, comfort, and privacy of patients. (1) The hospice must provide— (i) Physical space for private patient and family visiting; (ii) Accommodations for family members to remain with the patient throughout the night; and (iii) Physical space for family privacy after a patient's death. (2) The hospice must provide the opportunity for patients to receive visitors at any hour,		

2005 CMS PROPOSED COPS *Subpart D – Subpart D* Organizational Environment		*SUGGESTED REVISION*
including infants and small children.		
(f) *Standard: Patient rooms.* (1) The hospice must ensure that patient rooms are designed and equipped for nursing care, as well as the dignity, comfort, and privacy of patients. (2) The hospice must accommodate a patient and family request for a single room whenever possible. (3) Each patient's room must— (i) Be at or above grade level; (ii) Contain a suitable bed and other appropriate furniture for each patient; (iii) Have closet space that provides security and privacy for clothing and personal belongings; (iv) Accommodate no more than two patients; (v) Provide at least 80 square feet for each residing patient in a double room and at least 100 square feet for each patient residing in a single room; and (vi) Be equipped with an easily-activated, functioning device accessible to the patient, that is used for calling for assistance. (4) For an existing building, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section for a period of time if it determines		(iv)Accommodate no more than two patients, except during times of community disasters

2005 CMS PROPOSED COPS – *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
that— (i) Imposition of the requirements would result in unreasonable hardship on the hospice if strictly enforced; or jeopardize its ability to continue to participate in the Medicare program; and (ii) The waiver serves the needs of the patient and does not adversely affect their health and safety.		
(g) *Standard: Toilet/bathing facilities.* Each patient room must be equipped with, or conveniently located near, toilet and bathing facilities.		
(h) *Standard: Plumbing facilities.* The hospice must— (1) Have an adequate supply of hot water at all times; and (2) Have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients.		
(i) *Standard: Infection control.* The hospice must maintain an infection control program that protects patients, staff and others by preventing and controlling infections and communicable disease as stipulated in §418.60.		
(j) *Standard: Sanitary environment.* The hospice must provide a sanitary environment by following current standards of practice, including nationally recognized infection control precautions, and avoid sources and transmission of infections and communicable diseases.		
(k) *Standard: Linen.* The hospice must have available at all times a quantity of clean linen in sufficient amounts for all patient uses. Linens must be handled, stored, processed, and transported in such a manner as to prevent the spread of		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
contaminants.		
(l) *Standard: Meal service and menu planning.* The hospice must furnish meals to each patient that are— (1) Consistent with the patient's plan of care, nutritional needs, and therapeutic diet; (2) Palatable, attractive, and served at the proper temperature; and (3) Obtained, stored, prepared, distributed, and served under sanitary conditions.		
(m) *Standard: Pharmaceutical services.* Under the direction of a qualified pharmacist, the hospice must provide pharmaceutical services such as drugs and biologicals and have a written process in place that ensures dispensing accuracy. The hospice will evaluate a patient's response to the medication therapy, identify adverse drug reactions, and take appropriate corrective action. Drugs and biologicals must be obtained from community or institutional pharmacists or stocked by the hospice. The hospice must furnish the drugs and biologicals for each patient, as specified in each patient's plan care. The use of drugs and biologicals must be provided in accordance with accepted professional principles and appropriate Federal, State, and local laws.	**We need language to allow patients to use already obtained prescriptions, and to allow these medications to be brought into facilities**	(m) *Standard: Pharmaceutical services.* Under the direction of a qualified pharmacist, the hospice must provide pharmaceutical services such as drugs and biologicals and have a written process in place that ensures dispensing accuracy. The hospice will evaluate a patient's response to the medication therapy, identify adverse drug reactions, and take appropriate corrective action. Drugs and biologicals must be obtained from community or institutional pharmacists or stocked by the hospice. The hospice must furnish the drugs and biologicals for each patient, as specified in each patient's plan care. The use of drugs and biologicals must be provided in accordance with accepted professional principles and appropriate Federal, State, and local laws.
(n) *Pharmacist.* A licensed pharmacist must provide consultation on all aspects of the provision of pharmaceutical care in the facility, including ordering, storage, administration, disposal, and record keeping of drugs and biologicals. (1) *Orders for medications.* (i) A physician as defined by section 1861(r)(1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, must		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
order all medications for the patient. (ii) If the medication order is verbal or given by or through electronic transmission— (a) The physician must give it only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or another physician; and (b) The individual receiving the order must record and sign it immediately and have the prescribing physician sign it in accordance with State and Federal regulations. (2) *Administration of medications*. Medications must be administered by only the following individuals: (i) A licensed nurse, physician, or other health care professional in accordance with their scope of practice. (ii) An employee who has completed a State-approved training program in medication administration.		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
(iii) The patient, upon approval by the attending physician. (3) *Labeling of drugs and biologicals*. Drugs and biologicals must be labeled in accordance with currently accepted professional practice and must include appropriate accessory and cautionary instructions, as well as an expiration date (if applicable). (4) *Drug management procedures*. (i) All drugs and biologicals must be stored in secure areas. All drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 must be stored in locked compartments within such secure storage areas. Only personnel authorized to administer controlled medications may have access to the locked compartments. (ii) The hospice must keep current and accurate records of the receipt and disposition of all controlled drugs. (iii) Any discrepancies in the acquisition, storage, use, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice		(iii) Any discrepancies in the acquisition, storage, use, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator and where required reported to the appropriate

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
administrator and where required reported to the appropriate State agency. A written account of the investigation must be made available to State and Federal officials. (5) *Drug disposal.* Controlled drugs no longer needed by a patient must be disposed of in compliance with the hospice policy and in accordance with State and Federal requirements.		State agency. A written account of the investigation must be made available to State and Federal officials as required by law. (5) …
(o) *Standard: Seclusion and restraint.* (1) The patient has the right to be free from seclusion and restraint, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. The term restraint includes either a physical restraint or a drug that is being used as a restraint. A physical restraint is any manual method or physical or mechanical device, material or equipment attached or adjacent to the patient's body that he or she cannot easily remove, that restricts free movement of, normal function of, or normal access to one's body. *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 patient's medical or psychiatric condition. Seclusion is the confinement of a person alone in a room or an area where a person is	**Need to define coercion.** **In hospice we often use drug to change combative behavior.** **Standard hospice treatment include the use of medications to control restlessness, delirium, nausea, hiccups,**	(o) *Standard: Seclusion and restraint* *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 patient's medically effective hospice or psychiatric condition and not approved by the patient/family. Seclusion …

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
physically prevented from leaving. (2) Seclusion and restraint can only be used in emergency situations if needed to ensure the patient's or others' physical safety, and only if less restrictive interventions have been tried, determined and documented to be ineffective. (3) The use of restraint and seclusion must be— (i) Selected only when less restrictive measures have been found ineffective to protect the patient or others from harm; (ii) Carried out in accordance with the order of a physician. The following will be superseded by more restrictive State laws: (a) Orders for seclusion or restraints must never be written as a standing order or an as needed basis (that is, PRN). (b) The hospice medical director or physician designee must be consulted as soon as possible if restraint or seclusion is not ordered by the hospice medical director or physician	**congestion, terminal sedation. (drugs include ativan, haldol, valium, thorazine, phenobarb, xanax, scopolamine, atropine, robinol**	

2005 CMS PROPOSED COPS *Subpart D* – Subpart D **Organizational Environment**		*SUGGESTED REVISION*
designee. (c) A hospice medical director or physician designee must see the patient and evaluate the need for restraint or seclusion within 1 hour after initiation of this intervention. (d) Each order for a physical restraint or seclusion must be in writing and limited to 4 hours for adults; 2 hours for children and adolescents ages 9 through 17; or 1 hour for patients under the age of 9. The original order may only be renewed in accordance with these limits for up to a total of 24 hours. After the original order expires, a physician must reassess the patient's need before issuing another seclusion and restraint order. (iii) In accordance with the interdisciplinary group and a written modification to the patient's plan of care; (iv) Implemented in the least restrictive manner possible not to interfere with the palliative care being provided; (v) In accordance with safe, appropriate restraining techniques; (vi) Ended at the earliest possible time; and (vii) Supported by medical necessity and the patient's response or		(d) Each order for a physical restraint or seclusion must be in writing and limited to 8 hours for adults; 2 hours for children and adolescents ages 9 through 17; or 1 hour for patients under the age of 9. The order for restraints expires every 24 hours and must be reordered after reassessment by a physician.

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
outcome, and documented in the patient's clinical record. (4) A restraint and seclusion may not be used simultaneously unless the patient is— (i) Continually monitored face to face by an assigned staff member; or (ii) Continually monitored by staff using video and audio equipment. Staff must be in immediate response proximity to the patient. (5) The condition of the patient who is in a restraint or in seclusion must continually be assessed, monitored, and reevaluated by an assigned staff member. (6) All staff who have direct patient contact must have ongoing education and training in the proper and safe use of seclusion and restraint application and techniques and alternative methods for handling behavior, symptoms, and situations that traditionally have been treated through the use of restraints or seclusion. (7) The hospice must report to the CMS regional office any death that occurs while the patient is restrained or in seclusion, within 24 hours after a patient has been removed from restraint or seclusion.		
§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF, ICF/MR, or other facilities. In addition to meeting the conditions of participation at § 418.10 through §	**We need to define facility.**	**§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF, ICF/MR, or Medicare participating facilities.**

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
418.116, a hospice that provides hospice care to residents of a SNF/NF, ICF/MR, or other residential facility must abide by the following additional standards.		
(a) *Standard: Resident eligibility, election, and duration of benefits*. Medicare patients receiving hospice services and residing in a SNF, NF, or other facility must meet the Medicare hospice eligibility criteria as identified in § 418.20 through § 418.30.		
(b) *Standard: Professional management.* The hospice must assume full responsibility for professional management of the resident's hospice care, in accordance with the hospice conditions of participation and make any arrangements necessary for inpatient care in a participating Medicare/Medicaid facility according to §418.100.		(b) *Standard: Professional management*. The hospice must assume full responsibility for professional management of the resident's hospice Plan of care, in accordance with the hospice conditions of participation and make any arrangements necessary for inpatient hospice care in a participating Medicare/Medicaid facility according to §418.100.
(c) *Standard: Core services*. A hospice must routinely provide all core services. These services include nursing services, medical social services, and counseling services. The hospice may contract for physician services as stated in § 418.64(a). A hospice may use contracted staff provided by another Medicare certified hospice to furnish core services, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances, as described in § 418.64.	**Physician services need to be included in core services**	(c) *Standard: Core services*. A hospice must routinely provide all core services. These services include physician services, nursing services, medical social services, and counseling services. The hospice may contract for physician services as stated in § 418.64(a). A hospice may use contracted staff provided by another Medicare certified hospice to furnish core services, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances, as described in § 418.64.
(d) *Standard: Medical director*. The medical director and physician designee of the hospice must provide overall coordination of the medical care of the hospice resident that resides in an SNF, NF, or other facility. The medical director and physician designee must communicate with the medical director of the SNF/NF, the patient's attending physician, and other physicians participating in the provision of care for the terminal and related conditions to ensure quality care for the patient and family.	**Medical directors of facilities may not welcome the input of hospice medical directors, creating an access to care issue.**	(d) *Standard: Medical director*. The medical director and physician designee of the hospice must provide overall coordination of thehospice care of the hospice resident that resides in an SNF, NF, or other facility. An assigned member of the IDG must communicate with the SNF/NF, the patient's attending physician, and other physicians participating in the provision of hospice care for the terminal and related conditions to ensure quality care for the patient and family.

2005 CMS PROPOSED COPS		*SUGGESTED REVISION*
Subpart D – Subpart D Organizational Environment		
(e) *Standard: Written agreement.* The hospice and the facility must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the facility before the provision of hospice services. The written agreement must include at least the following: (1) The written consent of the patient or the patient's representative that hospice services are desired. (2) The services that the hospice will furnish and that the facility will furnish. (3) The manner in which the facility and the hospice are to communicate with each other to ensure that the needs of the patient are addressed and met 24 hours a day. (4) A provision that the facility immediately notifies the hospice if— (i) A significant change in the patient's physical, mental, social, or emotional status occurs; (ii) Clinical complications appear that suggest a need to alter the plan of care; (iii) A life threatening condition appears; (iv) A need to transfer the patient from the facility and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness; or (v) The patient dies. (5) A provision stating that the	**Patients consent to hospice care is not part of the contract with the facility** **(iii) is already addressed in (i)**	(e) *Standard: Written agreement.* The hospice and the facility must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the facility before the provision of hospice services. The written agreement must include at least the following: **(1) The services that the hospice will furnish and …** (4) A provision that the facility immediately notifies the hospice if— (i) A significant change in the patient's physical, mental, social, or emotional status occurs; (ii) Clinical complications appear that suggest a need to alter the plan of care; (iii) A need to transfer the patient from the facility and the hospice makes …

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
hospice assumes responsibility for determining the appropriate course of care, including the determination to change the level of services provided. (6) An agreement that it is the facility's primary responsibility to furnish room and board. (7) A delineation of the hospice's responsibilities, which include, but are not limited to, providing medical direction and management of the patient, nursing, counseling (including spiritual and dietary counseling), social work, bereavement counseling for immediate family members, provision of medical supplies and durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness, as well as all other hospice services that are necessary for the care of the resident's terminal illness. (8) A provision that the hospice may use the facility's nursing personnel where permitted by law and as specified by the facility to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely utilize the services of a hospice resident's family in implementing the plan of care.		
(f) *Standard: Hospice plan of care.* A written plan of care must be established and maintained for each facility patient and must be developed by and coordinated with the hospice interdisciplinary group in consultation with facility representatives and in collaboration with the attending physician. All care provided must be in		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D **Organizational Environment**		*SUGGESTED REVISION*
accordance with this plan. The plan must reflect the hospice's policies and procedures in all aspects and be based on an assessment of the patient's needs and unique living situation in the facility. It must include the patient's current medical, physical, social, emotional, and spiritual needs. Directives for management of pain and other symptoms must be addressed and updated as necessary to reflect the patient's status. (1) The plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the plan of care. (2) The plan of care reflects the participation of the hospice, the facility, and the patient and family to the extent possible. (3) In conjunction with representatives of the facility, the plan of care must be reviewed at intervals specified in the plan but no less often than every 14-calendar day. (4) Any changes in the plan of care must be discussed among all caregivers and must be approved by the hospice before implementation.		(3) In conjunction with representatives of the facility, the plan of care must be reviewed at intervals specified in the plan but no less often than every 15-calendar day.
(g) *Standard: Coordination of services.* The hospice must designate a member of its interdisciplinary group to coordinate the implementation of the plan of care with the representatives of the facility. The hospice must provide the facility with the following information: (1) Plan of care. (2) Patient or patient's representative hospice consent form and advance directives. (3) Names and contact information for hospice personnel involved in hospice care of the		(g) *Standard: Coordination of services.* The hospice must designate a member of its interdisciplinary group to coordinate the implementation of the plan of care with the representatives of the facility. The hospice must provide the facility with the following information: (1) Plan of care. (2) Patient or patient's representative hospice consent form and advance directives. (3) Names and contact

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
patient. (4) Instructions on how to access the hospice's 24-hour on-call system. (5) Medication information specific to the patient (6) Physician orders.	Physician orders are part of the Plan of Care.	information for hospice personnel involved in hospice care of the patient. (4) Instructions on how to access the hospice's 24-hour on-call system. (5) Medication information specific to the patient
(h) *Standard: Transfer, revocation, or discharge from hospice care.* Requirements for discharge or revocation from hospice care, § 418.104(e), apply. Discharge from or revocation of hospice care does not directly impact the eligibility to continue to reside in an SNF, NF, ICF/ MR, or other facility.	**Hospice does not control if the patient can cover the cost of room and board or is compliant with facility rules.**	(h) *Standard: Transfer, revocation, or discharge from hospice care.* Requirements for discharge or revocation from hospice care, § 418.104(e), apply.
(i) *Standard: Orientation and training of staff.* Hospice staff must orient facility staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.		
§ 418.114 Condition of participation: Personnel qualifications for licensed professionals. (a) *General qualification requirements.* Except as specified in paragraph (c) of this section, all professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) to practice by the State in which he or she performs such functions or actions, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.		
(b) Personnel qualifications for physicians, speech-language pathologists, and home health aides. The following qualifications must be		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
met: (1) *Physicians.* Physicians must meet the qualifications and conditions as defined in section 1861(r) of the Act and implemented at § 410.20 of this chapter. (2) *Speech language pathologists.* Speech language pathologists must meet the qualifications specified in section 1861(ll)(1) of the Act. The individual must have a master's or doctoral degree in speech-language pathology and must— (i) Be licensed as a speech-language pathologist by the State in which the individual furnishes such services, or, (ii) In the case of an individual who furnishes services in a State which does not license speech-language pathologists, must: (a) Have successfully completed 350 clock hours of supervised clinical practicum (or is in the process of accumulating such supervised clinical experience), (b) Have performed not less than 9 months of supervised full-time speech		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
language pathology services after obtaining a master's or doctoral degree in speech-language pathology or a related field, and successfully completed the Praxis National Examination in Speech-Language Pathology. (3) *Home health aides.* Home health aides must meet the qualifications required by section 1891(a)(3) of the Act and implemented at § 484.75.		
(c) *Personnel qualifications when no State licensing, certification or registration requirements exist.* If no State licensing laws, certification or registration requirements exist for the profession, the following requirements must be met: (1) *Occupational therapist.* An occupational therapist must— (i) Be a graduate of an occupational therapy curriculum accredited by the American Occupational Therapy Association, and be eligible for the National Registration Examination of the American Occupational Therapy Association; or (ii) Have 2 years of appropriate		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
experience as an occupational therapist, and have achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as an occupational therapist after December 31, 1977. (2) *Occupational therapy assistant.* An occupational therapy assistant must— (i) Meet the requirements for certification as an occupational therapy assistant established by the American Occupational Therapy Association; or (ii) Have 2 years of appropriate experience as an occupational therapy assistant, and have achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service, except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
qualification as an occupational therapy assistant after December 31, 1977. (3) *Physical therapist.* A person who— (i) Has graduated from a physical therapy curriculum approved by— (a) The American Physical Therapy Association ; (b) The Council on Medical Education of the American Medical Association and the American Physical Therapy Association ; or (ii) Prior to January 1, 1966— (a) Was admitted to membership by the American Physical Therapy Association ; (b) Was admitted to registration by the American Registry of Physical Therapists; or (c) Has graduated from a physical therapy		

2005 CMS PROPOSED COPS – *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
curriculum in a 4-year college or university approved by a State department of education; or (iii) Has 2 years of appropriate experience as a physical therapist, and has achieved a satisfactory grade on a proficiency examination conducted, approved, or sponsored by the U.S. Public Health Service except that such determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking qualification as a physical therapist after December 31, 1977; or (iv) Was licensed or registered prior to January 1, 1966, and prior to January 1, 1970, had 15 years of full-time experience in the treatment of illness or injury through the practice of physical therapy in which services were rendered under the order and direction of attending and referring doctors of medicine or osteopathy; or (v) If trained outside the United States— (a) Has		

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
graduated, since 1928, from a physical therapy curriculum approved in the country in which the curriculum was located and in which there is a member organization of the World Confederation for Physical Therapy; (b) Meets the requirements for membership in a member organization of the World Confederation for Physical Therapy. (4) *Physical therapist assistant.* A person who— (i) Has graduated from a 2-year college-level program approved by the American Physical Therapy Association; or (ii) Has 2 years of appropriate experience as a physical therapy assistant, and has achieved a satisfactory grade on a proficiency examination conducted,	**Although we prefer MSW some rural areas can not recruit**	

2005 CMS PROPOSED COPS *Subpart D* – Subpart D Organizational Environment		*SUGGESTED REVISION*
approved, or sponsored by the U.S. Public Health Service, except that these determinations of proficiency do not apply with respect to persons initially licensed by a State or seeking initial qualification as a physical therapy assistant after December 31, 1977. (5) *Registered nurse.* A graduate of a school of professional nursing. (6) *Licensed practical nurse.* A person who has completed a practical nursing program. (7) *Social worker.* A person who has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education.	**MSWs just BSWs**	
(d) *Standard: Criminal background checks.* The hospice must obtain a criminal background check on each hospice employee and contracted employee before employment at the hospice.		
§ 418.116 Condition of participation: Compliance with Federal, State, and local laws and regulations related to health and safety of patients. The hospice and its staff must operate and furnish services in compliance with all applicable Federal, State, and local laws and regulations related to the health and safety of patients. If State or local law provides for licensing of hospices, the hospice must be licensed.		
(a) *Standard: Licensure of staff.* Any persons who provide hospice services must be licensed, certified, or registered in accordance with applicable Federal, State and local laws.		
(b) *Standard: Multiple locations.* Every hospice must comply with the requirements of § 420.206 of this chapter regarding disclosure of ownership and		

2005 CMS PROPOSED COPS *Subpart D* – **Subpart D** **Organizational Environment**		*SUGGESTED REVISION*
control information. All hospice satellite locations must be approved by CMS and licensed in accordance with State licensure laws, if applicable, before providing Medicare reimbursed services.		
(c) *Standard: Laboratory services.* (1) If the hospice engages in laboratory testing other than assisting a patient in self-administering a test with an appliance that has been approved for that purpose by the FDA, the hospice must be in compliance with all applicable requirements of part 493 of this chapter. (2) If the hospice chooses to refer specimens for laboratory testing to a reference laboratory, the reference laboratory must be certified in the appropriate specialties and subspecialties of services in accordance with the applicable requirements of part 493 of this chapter.		
§ 418.200 [Amended] 6. Section 418.200 is amended by revising the reference ''§ 418.58'' to read ''§418.56''.		
§ 418.202 [Amended] 7. In § 418.202, paragraph (e) is amended by revising the reference ''§ 418.98(b)'' to read ''§ 418.108(b)'' and paragraph (g) is amended by revising the reference ''§ 418.94'' to read ''§ 418.76''.		

Subpart G – Payment for Hospice Care	*2005 CMS PROPOSED COPS*
	No changes are proposed to this Subpart at this time.

Subpart H – Coinsurance	*2005 CMS PROPOSED COPS*
	No changes are proposed to this Subpart at this time.