National Hospice and
Palliative Care Organization

Survey Readiness Initiative

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Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers

January 2015

Sec. 418.52 Condition of Participation: Patient's Rights

Informing patients about their rights

- Patients/families are informed of their rights during the initial assessment, prior to the hospice providing care.
- The patient/ family must be informed of their rights in a language they can understand both verbally and in writing. *(There must be evidence that the hospice conscientiously tried to inform in both mediums).*
- The hospice must obtain the patient's or representative's signature confirming that he or she has received a copy of the notice of rights and responsibilities.

Language translation

- The hospice should make all reasonable efforts to secure a professional, objective translator for hospice-patient communications, including those involving the notice of patient rights.
- The hospice should make all reasonable efforts to have written copies of the notice of rights available in the language(s) that are commonly spoken in the service area.
- Family members or friends as translators should be used as a last resort.

Advance Directives

- Advance directive information must be made available to the patient/family at the time of initial receipt of hospice care by the individual from the hospice.
- Your policy/procedure should include a process to review this information with a patient who regains consciousness or competency at some point after admission.
- The patient's admission to hospice should not be affected by his/her desire not to formulate an advance directive or by the contents of an advance directive.
- Hospices:
    - Are not required to provide care that conflicts with an advance directive.
    - Are not required to implement an advance directive if, as a matter of conscience, it cannot implement an advance directive and State law allows the hospice to conscientiously object.
        - *Example:* A hospice provider that does not require CPR certification for their home care staff and does not provide resuscitation to patients in the home that are a full code (if

staff were present during an event) would need to disclose this as a limitation of service at the time of initial receipt of hospice care by the individual from the hospice.

- ***Rights of the patient should include the right to:***
  - Exercise their rights.
  - Be treated with respect.
  - Voice grievances.
  - Be protected from discrimination or reprisal for exercising their rights.
  - Pain management and symptom control.
  - Be involved in developing the plan of care.
  - Refuse care or treatment.
  - Choose their attending physician.
  - Have a confidential clinical record/ HIPAA.
  - Be free of abuse.
  - Receive information about hospice benefit.
  - Receive information about scope and limitations of hospice services.

❖ **Download the NHPCO patient rights document in the Regulatory & Compliance Center**

- ***Hospice responsibility for reporting patient rights violation.***
  - Hospice providers should:
    - Report violations of patient to hospice administrator.
    - Investigate violations & complaints.
    - Take corrective action if violation is verified.
    - Report verified significant violations to State/ local bodies within 5 working days of becoming aware of incident.

- ***Hospice responsibilities.***
  - This CoP affects all hospice staff members, particularly those providing direct patient care services. Direct care staff will need to be educated and very aware of all the patient rights requirements in order to implement them as written and demonstrate compliance.
  - Administrative hospice staff needs to understand, educate, and comply with the requirements because ultimately, all functions in hospice operations support the patient/family.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Ensure that organization has a patient rights policy/procedure that includes appropriate regulatory language and requirements.

- Ensure that you have reliable translation services in place which represents your service area.
- Translate patient rights document into the major languages spoken in your service area.
- Determine what violations are reportable to which state/local bodies within 5 days. You may need to consult with your state survey agency.
- Incorporate education about patient rights requirements into your orientation program and continuing education.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center (under Hospice Operations) – "Survey Readiness"
- NHPCO's Patient Bill of Rights document.
- Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency document
- Download Your State's Advance Directives at Caring Connections
- Federal Patient Self Determination Act

References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
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Sec. 418.54 Condition of Participation:
Initial and Comprehensive Assessment of the Patient

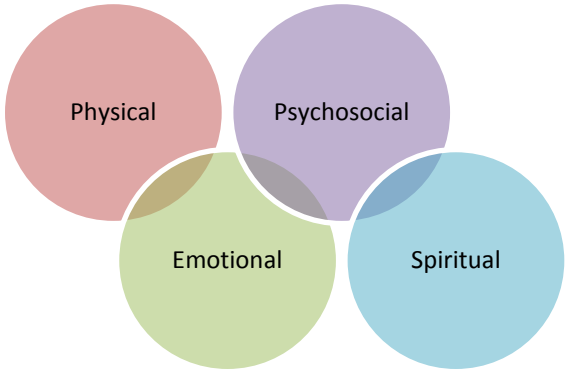
- ***The Initial Assessment***
  - The registered nurse (RN) has 48 hours from the effective date of the hospice election statement to complete the initial assessment.
  - The purpose of the initial assessment is **not** to determine the patient's eligibility for the hospice benefit, which is addressed in 418.22 and 418.24, or to orient the patient to the hospice benefit and obtain the election statement.
  - **The initial assessment must be completed in the environment where the patient will receive hospice care.**
    - Initial assessments should not be completed in the hospital for a patient that will be discharged to home to receive hospice care.
  - The RN must minimally be the first interdisciplinary team member to start the comprehensive assessment. Another team member can accompany the RN, but they cannot begin the comprehensive assessment process first.
  - The initial assessment serves to assess the patient/family immediate needs.

> ***Example:*** A patient is discharged from the hospital at 4:00 p.m. and the RN arrives at 5:30 p.m. to complete the admission visit to hospice. The patient is tired and the family is overwhelmed. The RN decides to compete an initial assessment to identify and meet the patient's and family's most pressing needs for the rest of that day. She will return the next day to complete the rest of the assessment when the patient and family are more rested. She essentially provided enough coordination of care and education to get the patient and family through the night and start the patient's plan of care.

  - The initial assessment is essentially a short assessment process and can be formatted and utilized per the hospice provider's decision and the patient/ family needs.
  - If an RN can complete the entire nursing assessment at the first visit, then an initial assessment is not needed or required.

- ***The Comprehensive Assessment:***
  - The comprehensive assessment is not a single static document, a symptom and severity checklist, or a set of generic questions that all patients are asked. It is a process that needs to be documented in an accurate and consistent manner for all patients.

- The hospice interdisciplinary team (IDT) has **5 calendar days** from the effective date of the hospice election statement to complete the comprehensive assessment.
- CMS does not dictate how the comprehensive assessment is completed or what forms a hospice provider utilizes to document the comprehensive assessment.
- The comprehensive assessment must be patient-specific and identify the patient's need for hospice care and services in the following areas:



- The comprehensive assessment is more about assessing WHAT the patient needs versus WHO completes the assessment.
- While the optimal scenario is for each IDT member to complete their portion of the comprehensive assessment, that may not always be possible.
- IDT members may complete their portion of the comprehensive assessment via telephone if it is the patient's/ family's request.
  - Routine completion of the comprehensive assessment via telephone is not recommended.
- The comprehensive assessment is completed by the IDT in consultation with the attending physician.

- ***Content of the comprehensive assessment***
  - Physical, psychosocial, emotional, and spiritual needs related to the terminal illness and related conditions
    - Nature and condition causing admission
    - Complications and risk factors
    - Functional status
    - Imminence of death
    - Symptom severity
    - Drug profile
      - Identify all of the patient's current medications and prescribers. (including prescription, OTC, and herbals)
  - Initial bereavement assessment of patient's family or caregiver
  - Appropriate referrals

- ***Update of the comprehensive assessment***
    - The comprehensive assessment is updated by the IDT as frequently as the patient's condition requires but at a minimum **every 15 days**.
    - The purpose of updating the assessment is to ensure that the hospice IDT has the most recent accurate information about the patient in order to make accurate care planning decisions.
    - The comprehensive assessment must be easily identifiable in the clinical record:
        - Hospices are free to choose the method that best suits their needs when documenting the update to the comprehensive assessment.
        - The IDG is required to update only those sections of the comprehensive assessment that require updating and if there were no changes in the assessment, then that must be documented. If there has been a change in the patient's condition/ status, then the comprehensive assessment must be updated.

Electronic health records (EHR) and individualization of documentation
IDT members should use the free text area of every form in the EHR to write a short note that provides additional detail about the patient or family. This additional documentation serves to individualize the patient clinical record.

- Expand on "point and click" selections in a form.
    - Record observations about details the "drop down" does describe.
        - I.e.: state the number of feet a patient can ambulate.
- Document subjective comments from the patient and family to support continued eligibility.
    - I.e.: "I sat outside last week, but this week I just don't have the energy to go out".
    - I.e.: "He has been sleeping more during the day and is not interested in waking up to eat".

- ***Patient outcome measures***
    - The comprehensive assessment must include data elements which are collected during the comprehensive assessment and subsequent updates that allow for measurement of outcomes.
    - The hospice must measure and document data in the same way for all patients.
    - The data elements must consider aspects of care related to hospice and palliation.
    - The data elements:
        - Must be documented in a systematic and retrievable way for each patient.
        - Must be used in individual patient care planning and in the coordination of services.
        - Must be used in the aggregate for the hospice's quality assessment and performance improvement program.

Compliance suggestions for hospice providers

- Review and revise current patient assessment policy/procedures at least annually.
- Use your assessment tools as tools; these forms are not just pieces of paper! A great deal of pertinent information is documented on the assessment form, which, in turn, drives the content of the patient's plan of care and is excellent data for measuring patient outcomes.
- The updated comprehensive assessment of the patient's/family's needs should be reflected in the interdisciplinary group notes as well.
- Remember - the IDG must update the parts of the patient's comprehensive assessment as frequently as the patient's condition requires, but at a minimum every 15 days.
- Choose patient level data that you can measure the same for every patient. Examples could include:
    - Pain scores
    - Severity of symptoms
    - Presence of advance directives
    - Family/caregiver confidence
    - Spiritual support
    - Initial bereavement risk assessment outcomes
- Incorporate education about the initial and comprehensive assessment requirements into your orientation program and continuing education.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center (under Hospice Operations) – "Survey Readiness"
- Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

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References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
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Medicare Hospice Conditions of Participation (CoPs)

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Sec. 418.56 Condition of Participation: Interdisciplinary Group, Care Planning, and Coordination of Services

- ***The interdisciplinary team***
  - Hospice designates an interdisciplinary group (IDG) who work together to meet the needs of the patient and family.
  - The hospice designates a registered nurse who is member of the IDG to provide program coordination, ensure continuous assessment of each patient's and family's needs, and ensure the implementation and revision of the plan of care.
  - Required members of the IDG:
    - Doctor of medicine or osteopathy (who is an employee or under contract with the hospice);
    - Registered nurse;
    - Social worker; and
    - Pastoral or other counselor.
  - If there is more than one IDG, the hospice must identify a specifically designated IDG to establish day-to-day policies and procedures of hospice care and services. This group does not need to be the same group that works together to care for patients.

Additional NHPCO Resource

Supplemental Compliance Guide for the Interdisciplinary Team

Available in NHPCO's Regulatory & Compliance Center

- ***Patient plan of care.***
  - The Centers for Medicare and Medicaid Services (CMS) considers the plan of care as one of the most important documents in hospice care.
  - When establishing the written plan of care, the IDG consults with the following:
    - Attending physician (if any);
    - Patient or representative; and
    - Primary caregiver

- The patient and primary caregiver(s) must receive education and training related to their care responsibilities identified in the plan of care.
- The plan of care must:
  - Reflect patient and family desired outcomes/ goals.
  - Include interventions for problems identified throughout the assessment process. Include all services necessary for palliation and management of terminal illness and related conditions.
  - Documentation regarding physician judgment of any unrelated diagnoses must be in the clinical record.
  - All hospice services furnished to patients and their families must follow an **individualized** written plan of care.
  - Include a detailed statement of the scope and frequency of services to meet the patient's and family's needs.
    - Visit ranges are allowable.
      - If used, they must have a short interval and staff must visit at the top of the range (Ranges should not include 0 (zero).
      - If the patient consistently requires a visit at the top of the range visit and PRN visits, then the visit range should be increased in the patient's plan of care.
    - PRN visits.
      - May not be used as a standalone visit frequency.
      - If PRN visits are included on the patient's plan of care, a reason should be identified for the visit to reflect that the plan of care is truly "individualized".
      - Use of PRN visit should not be a regular occurrence. If PRN visits are used regularly, then assess the need to increase the visit frequency.
- Include measurable outcomes with data collected during the comprehensive assessment and updates.
- Include all drugs, treatments, medical supplies and appliances.
- Documentation of the patient's or representative's level of understanding, involvement and agreement with the plan of care should appear in the clinical record.
- The plan of care **does not** need to be signed by the IDG or a physician.

- ***Electronic health records (EHR) and individualization of documentation***

  - IDT members should use the free text area of every form in the EHR to write a short note that provides additional detail about the patient or family. This additional documentation serves to individualize the patient clinical record.
    - Expand on "point and click" selections in a form.
    - Record observations about details the "drop down" does describe.

        - I.e.: state the number of feet a patient can ambulate.
        - Document subjective comments from the patient and family to support continued eligibility.
        - I.e.: "I sat outside last week, but this week I just don't have the energy to go out".
        - I.e.: "He has been sleeping more during the day and is not interested in waking up to eat".

- **Review of the plan of care.**
    - Includes information from the updated comprehensive assessment.
    - Includes information regarding the progress toward achieving specified outcomes and goals.
    - Plan of care must be reviewed as frequently as the patient's condition requires, but no less frequently than **every 15 calendar days**.
    - Completed by the IDG in collaboration with the attending physician (if any).

- **Coordination of services:**
    - Develop and maintain a system of communication and integration.
    - Ensure documentation of communication with IDG **at the time of a change** in the patient's status is present in the clinical record.
    - Ensure the IDG maintains responsibility for directing, coordinating, and supervising the care and services provided.
    - Care and services are provided in accordance with the plan of care.
    - Care and services are based on assessments of the patient and family needs.
    - Sharing information between all disciplines providing care and services, in all settings, whether provided directly or under arrangement.
    - Sharing information with other non-hospice healthcare providers furnishing services unrelated to the terminal illness and related conditions.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Continuously review and update your IDG meeting process as needed.
    - Does your current process focus on patient care planning or is it just a "report" format?
    - Involve members of your IDG to review and revise your process.
    - Consider implementing a performance improvement project focusing on improvement of your IDG meeting process.
- Ensure that your patient plan of care includes the required content from §418.56 (c).
- Be sure you follow your state licensing rules, if any, that pertain to the plan of care and role of the IDG.
- Develop a mechanism to demonstrate collaboration with the patient's attending physician regarding the update of the patient plan of care. (i.e.: communication note, update from the

physician, etc…)

- Incorporate education about IDG regulatory requirements into your orientation program and continuing education for all IDG staff.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center
  - Supplemental Compliance Guide for the Interdisciplinary Team
  - Clinical Practice resources for the IDG
  - Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

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References

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Sec. 418.58: Quality Assessment and Performance Improvement (QAPI)

Program Scope

- The hospice must demonstrate that quality improvement is an active component of the normal business of the organization.
- QAPI encompasses hospice-wide operations. It is a 360^0 view of all hospice activities, not limited to clinical operations.
- A hospice must measure and show improvement in palliative care outcomes and end of life support services.
- The key is to identify the areas of your operations that need improvement.
    - Identify a way to measure the improvement.
    - Change something to make an improvement and document this process.
    - **NOTE:** Measuring elements that you excel at will not be helpful in improving the quality of patient care.

Program Data

- Hospice organization documents must show that the board is responsible for the overall QAPI program and policies and procedures reflect quality process and responsibilities.
- The program must utilize quality indicator data, including patient care, and other relevant data, in the design of its program.
- "Data" may be information from assessment tools and responses to interventions at the patient level (in their record) that can be collected for all patients.
- Hospice must use data collected to monitor effectiveness, safety of services, and quality of care and identify opportunities and priorities for improvement.
- Frequency and detail of the data collection must be specified by the hospice's governing body.

Program Activities

- The hospice's performance improvement activities must:
    - Focus on high risk, high volume, and problem prone areas.
    - Consider evidence, prevalence, and severity of problems in those areas.
    - Affect palliative outcomes, patient safety and quality of care.

- Performance activities must track adverse patient events, analyze their causes and implement preventive actions and mechanisms that include feedback and learning throughout the hospice.

Performance improvement projects (PIPs)

- The number and scope of projects conducted annually must reflect the scope, complexity and past performance of the hospice's services and operations.
  - There are no minimum or maximum number of PIPs for a hospice program; the number should be proportional to the size of your program and how your prioritized your projects.
- Document what quality improvement projects are being conducted, reasons for conducting the projects and measurable progress achieved on these projects.

Executive Responsibilities

- Governing body ensures:
  - That an ongoing program for QI and patient safety is defined, implemented and maintained.
  - The QAPI efforts address quality of care and patient safety, and all improvement actions are evaluated for effectiveness.
  - That an individual(s) is designated to lead QAPI efforts.

Compliance suggestions for hospice providers

- Review and revise current performance improvement policies/procedures at least annually.
- Join NHPCO's Quality Partners program and utilize the Self-Assessment tool to identify your hospice's areas for improvement. The self-assessments reflect some of the elements that end-of-life programs should strive to incorporate in their organizational culture and are based on NHPCO's Standards of Practice for Hospice Programs. The tool allows you to compare your performance with others in your state as well as nationally and can quickly help you to prioritize areas for improvement.
- Utilize the implementation suggestions in NHPCO's publication, "WE CAN DO THIS"
- Ensure that all staff is engaged in the QAPI program at some level.
- Identify a natural leader for the QAPI effort among the staff.
- Involve every department in the organization in your QAPI program.
- Present QAPI updates at staff meetings.
- Involve staff in selected Quality Partner Self-Assessments as applicable.
- Display progress charts on the bulletin board in the office.
- Develop a reward program for staff participation in improving performance.
- Include quality improvement roles and responsibilities in all job descriptions.
- Incorporate education about IDG regulatory requirements into your orientation program and continuing education.
- Develop a short information sheet about your QAPI program for staff with bullet points about program updates, current projects, and your progress!

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center (under Hospice Operations) – "Survey Readiness"
- State Operations Manual
- NHPCO's Quality Partner's Self Assessments

References:

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
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Sec. 418.60 Condition of Participation: Infection Control

- The hospice must develop, maintain, and document a successful infection control program that protects patients, families, visitors, and hospice staff by preventing and controlling infections and communicable diseases.
- An infection control program include these three standards:

- **Prevention:**
  - The hospice must follow accepted standards of practice to prevent the transmission of infections and communicable diseases, including the use of standard precautions.
  - **Standard Precautions** combines major features of Universal Precautions (UP) and Body Substance Isolation (BSI) and is based on the principle that all blood, body fluids, secretions, excretions except sweat, broken skin, and mucous membranes may contain transmissible infectious agents. Standard Precautions includes a group of infection prevention practices that apply to all patients, regardless of suspected or confirmed infection status, in any setting in which healthcare is delivered. These include: hand hygiene; use of gloves, gown, mask, eye protection, or face shield, depending on the anticipated exposure; and safe injection practices.[1]
  - Additional resources for hand hygiene include:
    - CDC Guideline for Hand Hygiene in Health-Care Settings
    - WHO Guidelines on Hand Hygiene in Healthcare 2009

[1] Excerpt from the Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings 2007. PDF (1.33MB / 219 pages), Centers for Disease Control.

- **Control:**
    - The hospice must sustain a coordinated agency-wide program for the surveillance, identification, prevention, control, and investigation of infectious and communicable diseases that—
    - Is an essential part of the hospice's quality assessment and performance improvement program; and
    - Includes a process for identifying infectious and communicable disease problems
    - Includes a plan for implementing the proper actions that are expected to result in improvement and disease prevention.

- **Education:**
    - The hospice must provide infection control education to hospice staff, contracted providers, patients, and family members and other caregivers.
    - Education for hospice staff must be documented.

Compliance suggestions for hospice providers

- Review and revise current control program policy/procedure to include regulatory language at least annually.
    - Ensure that you have an adequate policy/procedure for infection control and management of a hospice staff's bag/ items that they take into each patient's home.
    - Review and revise *M. tuberculosis* testing and prevention policies and procedures.
- Utilize patient/family education materials about infection prevention and control in the inpatient and home settings.
- Review and revise current infection control data collection tools.
    - Suggestions for data capture:
        - Collect data about the occurrence of patient and hospice staff infections.
            - Analyze data to determine correlations.
        - Track infection occurrence for patient's transferring from inpatient to home settings and vice versa.
- Monitor infection control information for your state on your Department of Health's website. This information will keep you informed regarding possible infection trends in your service area.
- Educate hospice staff about all new and revised policies/procedures, processes, and performance improvement projects.
- Consider adopting an annual infection control education update for your direct patient care staff.
- Promote infection prevention and control within the hospice organization.
    - Display infection prevention and control posters.
    - Support health promotion activities for hospice staff.
    - Encourage hospice staff to obtain flu shots during flu season.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- Guidelines for Preventing the Transmission of *M. tuberculosis* in Health-Care Settings, 2005 (CDC)
- Infection Control in Healthcare Settings (CDC)

References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
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Sec. 418.62 Condition of Participation: Licensed Professional Services
Sec. 418.64 Condition of Participation: Core Services
Sec. 418.66 Condition of Participation: Nursing Services—Waiver of Requirement That Substantially All Nursing Services Be Routinely Provided Directly By a Hospice

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418.62: Licensed Professional Services

- 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.
- 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.
- Licensed professionals must participate in the hospice's quality assessment and performance improvement program (QAPI) and hospice sponsored in-service training.

418.64: Core Services

- A hospice must **routinely provide** substantially all core services directly by hospice employees.

> ***Employee*** *means a person who:*
> *(1) Works for the hospice and for whom the hospice is required to issue a W-2 form on his or her behalf.*
> *(2) If the hospice is a subdivision of an agency or organization, an employee of the agency or organization who is assigned to the hospice.*
> *(3) Is a volunteer under the jurisdiction of the hospice.*

- These services must be provided in a manner consistent with acceptable standards of practice.
- These services include:
  - Nursing services
  - Medical social services

- Counseling; counseling services must include, but are not limited to:
    - Bereavement counseling
    - Dietary counseling
    - Spiritual counseling

When can a hospice contract for core services?

- A hospice may enter into a written arrangement for the provision of core services under the following circumstances:
    - Unanticipated periods of high patient loads.
    - Staffing shortages due to illness or other short-term temporary situations that interrupt patient care or to supplement patient care.
    - Temporary travel of a patient outside of the hospice's service area.
    - 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. Highly specialized services are determined by the nature of the service and the nursing skill level required to be proficient in the service.
        - i.e.: Pediatric hospice nursing services; wound care nursing services
    - Nursing Shortage
        - The Survey and Certification Memo Impact of Nursing Shortage extraordinary circumstance exemption is available to hospices if they experience an inability to recruit and hire nurses for their service area and this inability has created a chronic, daily issue. The hospice must notify the state agency and follow the procedure as noted in the S&C Memo in order to qualify for this "extraordinary circumstance" nursing shortage exemption. The language in the S&C letter states:
            - A hospice may contract for nurses "if the hospice can demonstrate that the nursing shortage is creating an extraordinary circumstance that prevents it from hiring an adequate number of nurses directly. CMS S&C: 15-01 - Impact of Nursing Shortage on Hospice Care (2014)

When is contracting of core services not allowable?

- Contracting nurses routinely for continuous home care.
- Contracting nurses for on-call or after hours triage of patients.
- Contracting routinely for social workers, spiritual care professionals, or a dietician or nutritionist.

Physician Services

- The hospice medical director, physician employees, and contracted physician(s) of the hospice are responsible for the management of the terminal illness and related conditions in conjunction with the patient's attending physician,
- All physician employees and those under contract must function under the supervision of the hospice medical director.

- 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.
- If the attending physician is unavailable, the medical director, contracted physician, and/or hospice physician employee is responsible for meeting the medical needs of the patient.

Nursing Services

- 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 assessment, comprehensive assessment, and updated assessments.
- If State law permits registered nurses to see, treat, and write orders for patients, then registered nurses may provide services to beneficiaries receiving hospice care.

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 patient's and family's needs and acceptance of these services.

Counseling Services

- Counseling services must be available to the patient and family to assist the patient and family in minimizing the stress and problems that arise from the terminal illness, related conditions, and the dying process.
    - Bereavement Counseling
        - Have an organized bereavement program under the supervision of a qualified professional with experience or education in grief or loss counseling.
        - Make bereavement services available to the family and other individuals in the bereavement plan of care up to 1 year following the death of the patient.
        - Bereavement counseling also extends to residents of a SNF/NF or ICF/MR when appropriate and identified in the bereavement plan of care.
        - Develop a bereavement plan of care that notes the kind of bereavement services to be offered and the frequency of service delivery.
    - Dietary Counseling
        - Dietary counseling, when identified in the plan of care, must be performed by a qualified individual, who 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.
        - If an RN is capable of meeting the patient's needs, then the dietary counseling can be provided by the RN.
        - If the needs of the patient exceed the expertise of the nurse, then the hospice must have available an appropriately trained and qualified individual such as a registered dietitian or nutritionist to meet the patient's dietary needs on staff.

- Spiritual Counseling
  - The hospice must:
    - Provide an assessment of the patient's and family's spiritual needs.
    - 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.
    - Make all practical efforts to facilitate visits by local clergy, pastoral counselors, or other individuals who can support the patient's spiritual needs.
    - Advise the patient and family of this service.

418.66: Waiver of Requirement that Substantially All Nursing Services Be Routinely Provided Directly by a Hospice

- Sec. 418.66 only applies to a select few hospices. The language is very specific in standard (a). It applies if:
  - The hospice is located in a non-urbanized area.
  - The location of the hospice's central office is in a non-urbanized area as determined by the Bureau of the Census.
  - There is evidence that a hospice was operational on or before January 1, 1983.
- The extraordinary circumstance exemption is available to hospices if they experience an inability to recruit and hire nurses for their service area. This is only an exemption for nursing services.
  - Under extraordinary circumstances, a hospice can contract with a Medicare-certified hospice or non-hospice agency for core services, including nursing.
  - There is no waiver for any other core services. The language in the Survey & Certification letter states, "This temporary measure, which allows hospices to contract for nursing services, does not extend to counseling services and medical social services, which are the other core hospice services."

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Review current letters of agreement and staffing contracts to ensure that they are compliant with regulatory requirements.
- Review job descriptions to ensure supervision language is in compliance with CoPs, such as for contracted physicians.
- Be able to produce evidence of staff competency evaluation.
- Under counseling, a nurse is able to address and assure that the dietary needs of the patient are met. If the needs of the patient are beyond the nurse's capabilities, a dietician must be able to provide services. As this is a core service, it is recommended to maintain a dietician as an "as needed" employee.
- If contracting for core staff for a short-term temporary event that was unanticipated assures documentation supports the circumstances.

- If contracting for nursing services due to a chronic nursing shortage, assure proper notification of state agency is documented per the CMS Survey & Certification Memorandum requirements.
- Be able to demonstrate that all licensed professionals whether employed or provided under arrangement participate in the QAPI program and in-service training programs.
- Incorporate education about IDG regulatory requirements into your orientation program and continuing education.
- Be able to evidence an organized system for tracking staff competency evaluation.

Resources

- NHPCO's Regulatory & Compliance Center (under Hospice Operations) – Survey Readiness
- CMS Survey & Certification Memorandum (S&C-15-01)
  - ❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Service
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

Medicare Hospice Conditions of Participation (CoPs)

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Sec. 418.70: Furnishing of Non-Core Services
Sec. 418.72: Physical Therapy, Occupational Therapy, and Speech-Language Pathology
Sec. 418.74: Waiver of Requirement—Physical Therapy, Occupational Therapy, Speech-Language Pathology, and Dietary Counseling

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418.70: Furnishing of Non-Core Services

- A hospice must ensure that therapy and hospice aide services are provided directly by the hospice or under arrangements made by the hospice.
- These services must be provided in a manner consistent with current standards of practice.
- Non-core services may be contracted.

418.72: 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.

418.74: Waiver of Requirement—Physical Therapy, Occupational Therapy, Speech-Language Pathology and Dietary Counseling

- 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 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.
- Any waiver request is deemed to be granted unless it is denied within 60 days after it is received.
- An initial waiver will remain effective for 1 year at a time from the date of the request.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Review and revise current program policy/procedure to include regulatory language.
- Educate hospice staff about all new and revised policies/procedures, processes, and performance improvement projects.
- Ensure that you have a process to monitor contracted entities to include access to the following information as needed.
    - Evidence of current licensure or certification as applicable.
    - Evidence of competency/ skill evaluation.
    - Evidence of TB status (as applicable)
- Be able to demonstrate that contracted staff has been oriented to your organization's performance expectations.
    - Topics may include:
        - philosophy of hospice care
        - organization policies/ procedures
        - documentation expectations and process
        - grievance process
        - communication expectations

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center (under Hospice Operations) – Survey Readiness

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References:

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers
January 2015

Sec. 418.76 Condition of Participation: Hospice Aide and Homemaker Services

- All hospice aide services must be provided by individuals who meet the specified Hospice Aide requirements.

- ***Hospice aide qualifications:***
    - Has completed one of the following:
    - A training program and competency evaluation that includes classroom and supervised practical 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 a licensed practical nurse, who is under the supervision of a registered nurse.
        - Classroom and supervised practical training combined **must total at least 75 hours**.
        - Hospice should have a description of the training/competency evaluation program, and the qualifications of the instructors and a documentation which distinguishes between skills taught at a patient's bedside with supervision, and those taught in a laboratory using a real person (not a mannequin) and indicators of which skills each aide was judged to be competent.
            - A competency evaluation program that meets requirements specified in this regulation. (see competency bullet)
            - A nurse aide training and competency evaluation program approved by the State, meets 418.76 specified requirements, and is currently listed in good standing on the State nurse aide registry.
            - A State licensure program that meets the requirements and meets 418.76 specified requirements.
    - **NOTE:** A hospice aide is **not** considered to have completed a program if there has been a 24-month lapse in providing care to patients. If this is the case, the individual must complete another program.

- ***Hospice aide classroom and supervised practical training***
    - A hospice program can provide hospice aide training. Hospice aide training must include classroom and supervised practical training in a setting in which the trainee demonstrates knowledge while performing tasks on an individual under the direct supervision of a registered nurse, or a licensed practical nurse, who is under the supervision of a registered nurse. Classroom and supervised practical training combined **must total at least 75 hours**.
    - A minimum of **16 hours of classroom training** must precede a **minimum of l6 hours of supervised practical training** as part of the 75 hours.
    - A hospice aide training program must include the competency areas specified in the competency evaluation section below.
    - Classroom and supervised practical training must be performed by a registered nurse who possesses a **minimum of 2 years nursing experience**, at least **1 year of which must be in home care**, or by other individuals under the general supervision of a registered nurse.

- ***Competency evaluation:***
    - A Hospice Aide must be observed performing the tasks with a patient:
        - Communication skills, including the ability to read, write, and verbally report clinical information to patients, care givers, and other hospice staff.
        - Reading and recording temperature, pulse, and respiration.
        - Appropriate and safe techniques in performing personal hygiene and grooming tasks, including items on the following basic checklist:
            - Bed bath.
            - Sponge, tub, and shower bath.
            - Hair shampoo (sink, tub, and bed).
            - Nail and skin care.
            - Oral hygiene.
            - Toileting and elimination.
        - Safe transfer techniques and ambulation.
        - Normal range of motion and positioning.
    - The additional skills may be evaluated through written examination, oral examination, or after observation of a hospice aide with a patient.
        - Observation, reporting, and documentation of patient status and care or service furnished.
        - Basic infection control procedures.
        - Basic elements of body functioning and changes in body function that must be reported to an aide's supervisor.
        - Maintenance of a clean, safe, and healthy environment.
        - Recognizing emergencies and the knowledge of emergency procedures and their application.

        - 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.
        - Adequate nutrition and fluid intake.
        - Any other tasks that the hospice may choose to have an aide perform.
    - A hospice aide is not considered competent in any task for which he or she is evaluated as unsatisfactory until after he or she receives training in the task and successfully completes a competency evaluation for that task.
    - A hospice aide is not considered to have successfully completed a competency evaluation if the aide has an ''unsatisfactory'' rating in more than one of the required areas.
    - The hospice is responsible for training hospice aides, as needed
    - The hospice is responsible for assuring competency evaluations are completed for hospice aides under contract.
    - The hospice must maintain documentation that demonstrates the requirements of this standard are met.

- ***In-service training.***
    - A hospice 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 caring for a patient.
    - In-service training may be offered by any organization, but it must be supervised by a registered nurse.
    - The hospice must maintain documentation that demonstrates the requirements of this standard are met.

- ***Hospice aide assignments and duties:***
    - Hospice aides are assigned to a specific patient by a registered nurse (RN) that is a member of the interdisciplinary team (IDT).
    - Written patient care instructions for a hospice aide must be prepared by a registered nurse who is responsible for the supervision of a hospice aide.
    - A hospice aide provides services that are:
        - Ordered by the IDT.
        - Included in the plan of care.
        - Permitted to be performed under State law by such hospice aide.
        - Consistent with the hospice aide training.
    - The duties of a hospice aide include the following:
        - The provision of hands-on personal care.
        - The performance of simple procedures as an extension of therapy or nursing services (as permitted per state regulation).
        - Assistance in ambulation or exercises.

        - Assistance in administering medications that are ordinarily self –administered (as permitted per state regulation).
    - Hospice aides must report changes in the patient's medical, nursing, rehabilitative, and social needs to an RN, as the changes relate to the plan of care and quality assessment and improvement activities.
    - Hospice aides must also complete documentation of care provided in compliance with the hospice's policies and procedures.

- ***Supervision of hospice aides:***
    - A registered nurse (RN) must make an **on-site** visit to the patient's home no less frequently than every **14 days** to assess the quality of care and services provided by the hospice aide and to ensure that the hospice aide care plan is followed.
        - **The hospice aide does not have to be present during this visit (Unless required by state regulation).**
    - If there is an area of assessed performance concern by the hospice IDG then:
        - An RN must make an on-site visit to the location where the patient is receiving care in order to observe and assess the aide while he or she is performing care.
        - If an area of concern is verified during the on-site visit, then the hospice must conduct, and the hospice aide must complete a competency evaluation
    - An RN must make an **annual on-site** visit to the location where a patient is receiving care in order to observe and assess each aide while he or she is performing care.
    - The supervising nurse must assess the following areas of hospice aide performance:
        - Following the patient's plan of care for completion of tasks assigned to the hospice aide by the registered nurse.
        - Creating successful interpersonal relationships with the patient and family.
        - Demonstrating competency with assigned tasks.
        - Complying with infection control policies and procedures.
        - Reporting changes in the patient's condition.

- ***Furnishing Medicaid personal care aide-only services under a Medicaid personal care benefit***
    - An individual may furnish personal care services on behalf of a hospice agency.
    - Before the individual may furnish personal care services, the individual must be found competent by the State (if regulated by the State) to furnish those services.
    - The individual only needs to demonstrate competency in the services the individual is required to furnish.
    - Services under the Medicaid personal care benefit may be used to the extent that the hospice would routinely use the services of a hospice patient's family in implementing a patient's plan of care.
    - The hospice must coordinate its hospice aide and homemaker services with the Medicaid personal care benefit to ensure the patient receives the hospice aide and homemaker services he or she needs.

- ***Homemaker qualifications***
    - Hospice providers must be able to provide homemaker services; it is not optional.
    - A qualified homemaker is an individual who:
        - Can provide assistance in maintenance of a safe and healthy environment and services to enable the individual to carry out the treatment plan, and
        - Has successfully completed hospice orientation addressing the needs and concerns of patients and families coping with a terminal illness, or
        - Is a qualified hospice aide.
        - A homemaker could be a volunteer.

- ***Homemaker supervision and duties***
    - Homemaker services must be coordinated and supervised by a member of the interdisciplinary group.
    - Instructions for homemaker duties must be prepared by a member of the interdisciplinary group.
      Homemakers must report all concerns about the patient or family to the member of the interdisciplinary group who is coordinating homemaker services.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Review all personnel files of current aides to ensure that they meet required criteria.
    - Documentation of qualifications.
    - Documentation of orientation from hospice provider.
    - Documentation of competency validation (at hire and annually).
    - Documentation of 12 hours of education in a 12 month period.
- Develop a tracking system for performing aide supervision visits every 14 days.
    - Consider forming a performance improvement project centered on compliance with this requirement.
- Ensure your aides have completed 12 in-service hours annually.
    - Although this is not a new requirement, consider developing a tracking system to ensure that all aides meet this requirement.
- Incorporate education about hospice aide requirements into your orientation program and continuing education for nurse and aides.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO Marketplace
    - Resources for hospice aides
        - Guidelines for Care: A Handbook for Care Giving at Home by Tina M. Marrelli
        - Home Health Aide: Guidelines for Care- Instructor Manual by Tina M. Marrelli

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References:

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers
January 2015

Sec. 418.78 Condition of Participation: Volunteers

- 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, including contract staff.
- The volunteer activities must be related to the administrative and direct patient care functions. No fundraising or board member volunteer activities can count toward the 5 percent volunteer hours requirement.
- These volunteers must be used in defined roles and under the supervision of a designated hospice employee.

- ***Training requirements***
  - The hospice must maintain, document, and provide volunteer orientation and training that is consistent with hospice industry standards.
  - There is no specified training program length defined in the federal regulations, but review your state hospice licensure regulations for any requirements.
  - NHPCO's, "Hospice Volunteer Program Resource" suggests a 16-hour training program.
    - Consult NHPCO's, "Hospice Volunteer Program Resource" for a training program outline.

- ***Role of the volunteer***
  - Volunteers must be used in day-to-day administrative and/or direct patient care roles.
  - Volunteers are permitted to fulfill many roles in hospice care, including providing homemaker services, provided that the volunteers meet all qualifications and personnel requirements.
  - Volunteer services provided to the patient/family must be detailed in the hospice plan of care.
  - The duties of volunteers used in direct patient care services or helping patients and families must be evident in the patient's plan of care. There should be documentation of time spent and the services provided by volunteers.

- ***Direct patient care services (can be counted towards the 5% calculation):***
    - Qualified volunteers who provide professional services for the hospice must meet all requirements associated with their specialty area. If licensure or registration is required by the State, the volunteer must be licensed or registered.
    - The hospice may use volunteers to provide assistance in the hospice's ancillary and office activities as well as in direct patient care services, and/or help patients and families with household chores, shopping, transportation, and companionship.
        - If volunteers are used to provide hands on patient care, there must be documentation that the volunteers was trained and validated as competent to perform the care.
        - Regular competency evaluation (and documentation) of these skills is recommended.

NHPCO Resources that Provide Information about Volunteer Activities and The 5% Cost Savings Calculation

- Regulatory Resources for Volunteer Managers
- The Volunteer Regulations Revisited
- Volunteer 5% Cost Savings Information Sheet

http://www.nhpco.org/interdisciplinary-team/volunteers

- **Administrative services (can be counted towards the 5% calculation):**
    - Volunteers can provide administrative support to the hospice provider.
    - Activities can include answering telephones, filing, assisting with patient and family mailings, and data entry.

- **Non-administrative services (cannot be counted towards the 5% calculation):**
    - Hospices are also permitted to use volunteers in non-administrative and non-direct patient care activities, although these services **are not included** in the 5% cost savings calculation.

- **Demonstrating cost savings**
    - The hospice must document the cost savings achieved through the use of volunteers. Documentation must include the following:
        - The identification of each position that is occupied by a volunteer.
        - The work time spent by volunteers occupying those positions.
    - Estimates of the dollar costs that the hospice would have incurred if paid employees occupied the positions.
- There is no standard formula from CMS to calculate volunteer cost savings. Each hospice organization will determine its own formula and calculation method.

- **Standard: Level of activity**
    - The hospice must maintain records on the use of volunteers for patient care and administrative services, including the type of services and time worked.
    - The regulations do not specify the types of activities a hospice organization can count towards the 5 percent cost savings beyond the requirement to use volunteers for patient care and administrative services.
    - It is the discretion of the organization regarding types of activities to count.
        - I.E.: If a hospice pays an employee for time spent traveling for direct patient care and administrative purposes, and does not compensate a volunteer for the time, than it may include the volunteer's travel time, direct patient care and administrative services in its documentation of the cost savings it achieves.
    - Hospices may document the time that volunteers actually spend providing direct patient care and administrative services, because hospices would compensate paid employees for the time spent performing these duties.
    - A good rule of thumb to use is if a volunteer is performing in a role that you pay an employee for, those hours/ activities would count towards the 5 percent cost savings. While non-administrative hours, such as sewing, are very important activities to the hospice and their patients, these hours may not be counted towards the 5 percent cost savings.
    - Traveling, providing care or services, documenting information, and calling patients all consume volunteer time, and may be used in calculating the level of volunteer activity in a hospice.
        - **NOTE:** If a hospice chooses to include any of these areas that are directly related to providing direct patient care or administrative services in its percentage calculation of volunteer hours, it must ensure that the time spent by its paid employees and contractors for the same activity is also included in the 5 percent calculation.

- **Recruiting and retaining volunteers**
    - The hospice must document and demonstrate viable and ongoing efforts to recruit and retain volunteers.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Develop a tracking system for volunteer activities that will be counted towards the 5 percent calculation.
- Develop a formula to calculate volunteer cost savings. NHPCO's, "Hospice Volunteer Program Resource" recommends using the Independent Sector or Points of Light websites to determine volunteer hourly rates.
- Educate hospice staff about all new and revised policies/procedures, processes, and performance improvement projects.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO
  - "Hospice Volunteer Program Resource"
  - Regulatory Resources for Volunteer Managers
  - The Volunteer Regulations Revisited
  - Volunteer 5% Cost Savings Information Sheet
- Point s of Light Institute "Calculating the Economic Impact of Volunteers" -
- Independent Sector - "Independent Sector's Value of Volunteer Time" (update annually)

References:

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers

January 2015

Sec. 418.100 Condition of Participation:

Organization and Administration of Services

- The priority in providing hospice care must be meeting the needs and goals of the hospice patient, as well as those of the family.
- The hospice must provide care and services that are consistent with accepted standards of practice and optimize comfort and dignity.
- These services depend on the organization and management of the governing body and its administrator who are together responsible for:
    - Ensuring continuation of care to Medicare or Medicaid beneficiaries.
    - Professional management, including financial and administrative oversight, of all arranged staff and services.
    - Management and oversight of operations in all multiple locations.
    - Orientation for all employees and contracted staff that may have contact with a patient or a patient's family.
    - Assessing the competency of all individuals providing care or services in the hospice.

- ***The governing body:***
    - Is responsible for management of the hospice, including, but not limited to, its fiscal operations, provision of services and quality assessment performance improvement (QAPI) efforts.
    - Assumes full legal authority of all hospice operations.
    - Appoints the hospice administrator according to educational standards and other requirements—experience and leadership capability, for example—developed by the governing body.
        - CMS does not dictate the process of election or appointment of the administrator by the governing body.
    - Is responsible for administration, supervision and services for any and all multiple locations of the hospice, as well as all arranged services.

- ***The administrator:***
    - Reports to the governing body.
    - Must be an employee of the hospice who meets the educational standards and requirements established by the governing body.
        - State hospice licensure regulations may contain specific qualifications for the administrator. Providers must follow the most stringent regulatory requirement.
    - Is responsible for the day-to-day operation of the hospice.

- ***The following must be available on a 24-hour basis, every day of the week:***
    - Nursing services.
    - Physician services.
    - Medical supplies (including drugs and biologicals) and medical appliances.

- ***The following services must be available on a 24-hour basis when reasonable and necessary to the care of the patient and the patient's family:***
    - Medical social services.
    - Counseling services, including spiritual, dietary, and bereavement counseling.
    - Hospice aide, volunteer, and homemaker services.
    - Physical therapy, occupational therapy, and speech-language pathology services.
    - Short-term inpatient care.

- ***Continuation of care:***
    - A hospice may not reduce or discontinue any of the above services or care provided to a Medicare or Medicaid beneficiary because of the beneficiary's inability to pay for that care.

- ***Professional management of arranged services:***
    - If a hospice makes an arrangement with any other agency, individual or organization to provide services, there must be a written agreement to support the arrangement.
    - The written agreement must state that all services will be
        - Authorized by the hospice;
        - Furnished in a safe and effective manner by qualified personnel; and
        - Delivered in accordance with the patient's plan of care.
    - The hospice assumes responsibility for administrative and financial management, and oversight of staff and services for all arranged services.
    - Hospices are expected to assume professional management responsibility for arranged services to ensure that quality care is provided to each hospice patient and family.

- **Hospice multiple locations must—**
    - Function as part of the hospice that has the Medicare certification number.
    - Share administration, supervision and services with that hospice.
        - This means that the lines of authority and administrative control must be clearly traceable to the hospice that has the Medicare certification number.
        - This also means that the hospice is responsible for continually monitoring and managing all services provided at all locations to ensure that each patient and each family is receiving the quality care that was outlined in the plan of care.
    - **NOTE:** Locations that function only as a place for staff to make telephone calls, pick up supplies, document, etc… are not considered a multiple location.

NHPCO Additional Resources

Hospice Multiple Locations Compliance Guide

Providing Hospice Services Across State Lines Compliance Guide

****Located in NHPCO's Regulatory & Compliance Center****

- ***The hospice must provide orientation—***
    - About the hospice philosophy to all employees and contracted staff who will have contact with any hospice patient and the family of the patient.
    - That addresses specific job duties for each employee.

- ***Competency Assessments:***
    - Must be completed for all individuals furnishing care, including volunteers.
    - In-service training and education programs must be provided as needed.
    - There must be written documentation of the hospice's methods of competency assessment.
    - The documentation must include a description of the in-service training and educational programs that the hospice has provided for the previous twelve months leading up to the assessment.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Review your current organizational structure.
    - Is there a clear delineation of management and administrative roles on paper and in practice?

    - Form a group with hospice staff of multiple locations and map out a clear management hierarchy.
- Ensure that there is documented communication within the governing body. Ensure your process of communication with all levels of management within the hospice.
- Compare the federal hospice CoPs and state licensure regulations regarding multiple locations and other components of this condition.
- Ensure all multiple locations have been approved by Medicare.
- Review and revise in-service training and educational materials to incorporate as needed.
- Incorporate education about all CoP requirements into your orientation program and continuing education.
    - Educate hospice staff about the importance of organization and communication on an every-day basis. Remember that it is essential to the quality of care provision.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO Regulatory & compliance Center
    - Hospice Multiple Locations Compliance Guide *- coming soon*
    - Providing Hospice Services Across State Lines Compliance Guide *– coming soon*
- State Operations Manual, Chapter 2 - The Certification Process (Oct, 2014)

References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
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Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers
January 2015

Sec. 418.102 Condition of Participation: Medical Director

- ***One medical director***
  - Only one physician serves as the medical director for a Medicare certified hospice. (One specific physician for a unique Medicare provider number).
  - A hospice can employ multiple physicians, but there can be only one medical director for the organization or one Medicare provider number.
  - All physicians function under the supervision of the **one** medical director. (See *418.64 – Core Services).*
  - The hospice can choose what job/position title will be assigned to the additional physicians.
  - The additional physicians can perform medical director interdisciplinary team duties under the supervision of the organization's medical director.
  - The method of supervision is at the discretion of the hospice organization.
  - The table below shows the organizational structure for the hospice medical director and the various titles that other physicians may have in the organization.
- ***Medical director qualifications:***
  - Is a doctor of medicine or osteopathy
  - Is an employee, or is under contract with the hospice. (could also be a volunteer)
    - **NOTE:** When the medical director is not available, a specific physician designated by the hospice assumes the same responsibilities and obligations as the medical director.
- ***Medical director contract:***
  - A hospice may contract for medical director services with either:
    - A self-employed physician; or
    - A physician employed by a professional entity or physicians group. (A hospice provider may not contract with a general physician group)
  - The contract must specify the physician who assumes the medical director responsibilities and obligations.

- ***Responsibilities of the medical director or physician designee:***
  - Initial certification of terminal illness. The medical director or physician designee must:

        - Review the clinical information for each hospice patient, considering—
            - The primary terminal condition (prognosis);
            - Related diagnosis(es), if any;
            - Current subjective and objective medical findings;
            - Current medication and treatment orders; and
            - Information about the medical management of any of the patient's conditions unrelated to the terminal illness.
        - Provide written certification that it is anticipated that the patient's life expectancy is 6 months or less if the illness runs its normal course.
        - Write a brief narrative explanation of the clinical findings that support a life expectancy of 6 months or less as part of the certification and recertification forms or as an addendum, as required in 418.22(b)(3).
    - Recertification of the terminal illness.
        - Before the recertification period for each patient, the medical director or physician designee must review all available patient clinical information.
    - The medical component of the hospice's patient care program is the medial director's responsibility.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Form a group to draft standards and requirements of physicians to be considered for the role of hospice medical director.
- Review physician contracts to ensure they are compliant with CoP requirements.
- Incorporate education about hospice aide requirements into your orientation program and continuing education for physicians.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO Regulatory & Compliance Center, All Staff Clinical Practice
- Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, Physician Services

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References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers

January 2015

Sec. 418.104 Condition of Participation: Clinical Records

For each hospice patient, the hospice must maintain an accurate clinical record of past and current findings that is available to the patient's attending physician and hospice staff.

- The clinical record may be maintained electronically.

- ***Content of the clinical record***
  - Each patient's record must include:
    - The initial plan of care, updated plans of care, initial assessment, comprehensive assessment, updated comprehensive assessments, and clinical notes.
    - Signed copies of the notice of patient rights in accordance with § 418.52 and election statement in accordance with § 418.24.
    - Election of hospice care. (Notice of Election)
    - Responses to medications, symptom management, treatments, and services.
    - Outcome measure data elements, as described in § 418.54(e) of this subpart.
    - Physician certification and recertification of terminal illness, if appropriate.
    - Any advance directives.
    - Physician orders.
  - Additional information that should be included in the clinical record, but not required by this CoP include:
    - Certification of terminal illness forms.
      - Physician narrative statement.
      - Face-to-face attestation statements.
    - Change of attending physician forms (if any).

  - **NOTE:** The measure data elements required in the clinical record are also required of the comprehensive assessment for each patient and allow for measurement of outcomes. These elements should be identified and documented upon compilation of the comprehensive assessment.

- ***Authentication of the clinical record***
    - All entries must be:
        - Legible, clear and complete.
        - Appropriately authenticated and dated in accordance with hospice policy and currently accepted standards of practice.
        - Physician signatures shall be handwritten or electronic to sign orders and other medical record documentation.
        - Facsimile of original written or electronic signatures are acceptable for the certification of terminal illness for hospice. **No stamped** physician signatures are acceptable unless the physician has a physical disability and can provide proof to a CMS contractor of an inability to sign due to that disability[1].

CMS Resources for Physician Signatures

Signature Guidelines for Medical Review Purposes

Complying with Medicare Signature Requirements

- ***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 as set out at 45 CFR parts 160 and 164 (The HIPAA Privacy Rule).

- ***Retention of records***
    - Patient clinical records must be retained for 6 years after the death or discharge of the patient, unless State law stipulates that the records must be retained for a longer period of time.
        - Some states may have a longer medical record retention rule. If that is the case, the hospice provider **must follow the most stringent regulation**.
    - If the hospice discontinues operation, hospice must retain and store 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.

- ***Discharge or transfer of care.***
    - The hospice discharge summary must include:
        - A summary of the patient's stay including treatments, symptoms and pain management.
        - The patient's current plan of care.
        - The patient's latest physician orders. and

[1] CMS, Complying with Medicare Signature Requirements, October 2013. Retrieved from CMS website: http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/downloads/Signature_Requirements_Fact_Sheet_ICN905364.pdf

        - Any other documentation that will assist in post-discharge continuity of care or that is requested by the attending physician or receiving facility.
        - A discharge summary should only be completed for a patient who is discharged live from hospice care.
    - If a hospice transfers the care of a patient to another Medicare/Medicaid-certified facility, the hospice must send the facility a copy of:
        - The hospice discharge summary.
        - The patient's clinical record, if requested.
    - If a patient revokes the election of hospice care, or is discharged from hospice in accordance with §418.26, the hospice must forward to the patient's attending physician a copy of:
        - The hospice discharge summary.
        - The patient's clinical record, if requested.

- ***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.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Develop a plan to keep your state agency informed of where clinical records will be stored and how they can be accessed.
- Review and revise current discharge summaries to ensure that they include required criteria.
- Incorporate education about clinical record requirements into your orientation program and continuing education for all IDG staff.

★ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO, Regulatory & Compliance Center, Signatures and Documentation
- Signature Guidelines for Medical Review Purposes (CMS, MM6698 Revised, March 1, 2010)
- Complying with Medicare Signature Requirements (CMS, ICN 905364 October 2013)

References:

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers

January 2015

Sec. 418.106 Condition of Participation: Drugs and Biologicals, Medical Supplies, and Durable Medical Equipment

The hospice must provide medical supplies and appliances, durable medical equipment, 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.

- ***Managing drugs and biologicals***
    - The hospice must ensure that the interdisciplinary group confers with an individual with education and training in drug management as defined in hospice policies and procedures and State law, who is an employee of or under contract with the hospice, to ensure that drugs and biologicals meet each patient's needs.
        - **It is the decision of the hospice to determine which individual meets this requirement and this individual may include:**
            - Licensed pharmacists;
            - physicians who are board certified in palliative medicine;
            - RNs who are certified in palliative care;
            - Physicians, RNs and nurse practitioners who complete a specific hospice or palliative care drug management course, and other individuals as allowed by State law.
        - The hospice must be able to demonstrate that the individual has specific education and training in drug management.
    - A hospice that provides inpatient care directly in its own facility must:
        - Provide pharmacy services under the direction of a qualified licensed pharmacist who is an employee of or under contract with the hospice.
        - The provided pharmacist services must include evaluation of a patient's response to medication therapy, identification of potential adverse drug reactions, and recommended appropriate corrective action.

- ***Ordering of drugs***
    - Drugs may be ordered in accordance with the plan of care or State law either by:
        - A physician.
        - A nurse practitioner.
    - If the drug order is verbal or given through electronic submission:
        - It must be given only to a licensed nurse, nurse practitioner (where appropriate), pharmacist, or physician; and
        - The individual receiving the order must record and sign it immediately and have the prescribing person sign it in accordance with State and Federal regulations.

- ***Dispensing of drugs and biologicals***
    - A Hospice must obtain drugs and biologicals from community or institutional pharmacists or stock drugs and biologicals itself.
    - In addition, the hospice that provides inpatient care directly in its own facility must:
        - Have a written policy in place that promotes dispensing accuracy; and
        - Maintain current and accurate records of the receipt and disposition of all controlled drugs.

- ***Administration of drugs and biologicals***
    - **IDG Responsibility:** The IDG, 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 to the patient in his or her home.
    - **Patients in hospice inpatient facilities:** Patients in hospices that provide inpatient care directly may only be administered medications by:
        - A licensed nurse, physician, or other health care professional in accordance with their scope of practice and State law;
        - An employee who has completed a State-approved training program in medication administration; and
        - The patient, upon approval by the interdisciplinary group.

- **Labeling, disposing, and storing of drugs and biologicals**
    - Labeling
        - Drugs and biologicals must:
            - Be labeled in accordance with currently accepted professional practice.
            - Include appropriate usage and cautionary instructions.
            - Include an expiration date, if applicable.
    - Disposing
        - For safe disposal of controlled drugs in the patient's home, the hospice must:

- **Provide the actual copy of the hospice written policies and procedures** on the management and disposal of controlled drugs to the patient or patient representative and family.
- Discuss the hospice policies and procedures for managing the safe use and disposal of controlled drugs with the patient or representative and the family in a language and manner that they understand to ensure that these parties are educated regarding the safe use and disposal of controlled drugs.
- Document in the patient's clinical record that the written policies and procedures for managing controlled drugs was provided and discussed.
    - ❖ **NOTE:** The above steps must be completed by the hospice at the time that the controlled drugs are first ordered.
- **Providers must follow state and federal regulations related to disposal of controlled and uncontrolled drugs.**

▪ Hospices that provide inpatient care directly must:

- Dispose of controlled drugs in compliance with the hospice policy and in accordance with State and Federal requirements.
- Maintain current and accurate records of the receipt and disposition of all controlled drugs.

o Storing.

▪ The following additional requirements are to be met by hospices that provide inpatient care directly.

▪ Hospices must store all drugs and biological in secure areas.

- All controlled 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 drugs as noted in this section may have access to the locked compartments. These authorized personnel are:
    - o A licensed nurse, physician, or other health care professional in accordance with their scope of practice and State law;
    - o An employee who has completed a State-approved training program in medication administration; and
    - o The patient, upon approval by the interdisciplinary group.

o Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs must be investigated immediately by the pharmacist and hospice administrator.

▪ Where required, these discrepancies must be reported to the appropriate State authority.

▪ A written account of the investigation must be made available to State and Federal

officials if required by law or regulation.

- ***Use and maintenance of equipment and supplies***
    - A hospice provider must contract with a DMEPOS accredited supplier that meets the Medicare DMEPOS Supplier Quality and Accreditation Standards at 42 CFR § 424.57.
        - If the hospice owns its own DME, then no accreditation is needed.
    - Hospice provider responsibilities:
        - Ensure that manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment are followed.
        - Ensure that the equipment is safe and works as intended for use in the patient's environment.
        - Ensure that repair and routine maintenance policies are developed for equipment that does not come with a manufacturer recommendation.
        - Ensure that the patient, where appropriate, as well as the family and/or other caregiver(s), receive instruction in the safe use of DME and supplies.
    - Hospice providers may:
        - Use persons under contract to ensure patient and family instruction.
        - Use persons under contract to ensure the maintenance and repair of durable medical equipment.
    - Patient/ caregiver/ family expectation:
        - The patient, family, and/or caregiver must be able to demonstrate the appropriate use of durable medical equipment to the satisfaction of the hospice staff.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Ensure documented evidence of all designated individual's education and training in drug management.
- Ensure that documentation of the ability of the patient and/or family to safely self-administer drugs and biologicals to the patient in his or her home is included in regular IDT meetings.
- Ensure compliance with state laws regarding ordering, labeling, disposing and storing of drugs and biologicals, as well as the administration of drugs and biologicals.
- Utilize state pharmacy boards for information related to drug distribution and disposal.
- Incorporate education about hospice aide requirements into your orientation program and continuing education for physicians, pharmacists, nurse practitioners, and nurses.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center
    - DEA Releases New Rules for Safe and Secure Prescription Drug Disposal (Regulatory Alert, October 7, 2014)
    - Drugs and Medications webpage
    - Boards of pharmacy
- Disposal of Controlled Substances; Final Rule (Federal Register, September 9, 2014)

References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers

January 2015

Sec. 418.108 Condition of Participation: Short Term Inpatient Care

Short-term inpatient care may be provided in a participating hospital, hospice inpatient unit, or a participating skilled nursing facility (SNF) or a nursing facility (NF). The Medicare Hospice Benefit covers two levels of inpatient care: respite care for relief of the patient's caregivers, and general inpatient care which is for pain control and symptom management.

- ***Inpatient care must be provided in a participating Medicare or Medicaid facility, and available for:***
  - Acute pain and symptom management.
  - Respite purposes for the patient's caregiver.
    - **NOTE:** Provision of inpatient care is not optional; it is a requirement of a Medicare certified hospice.

- ***Inpatient care for acute pain and symptom management***
  - Inpatient care for acute pain and symptom management must be provided in either:
    - A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly (requirements specified in CoPs at § 418.110).
    - A Medicare-certified hospital or a skilled nursing facility that provides **24 hour direct patient care by a registered nurse** if at least one patient is receiving general inpatient care.
  - To be eligible for general inpatient care under the Medicare hospice benefit, patients **must** require an intensity of care directed towards acute pain and symptom management that cannot be managed in any other setting.
    - **NOTE:** Medicare payment cannot be made for inpatient hospice care provided in a VA facility to Medicare beneficiaries eligible to receive Veterans health services.
  - Caregiver breakdown:
    - Caregiver breakdown is the loss of the individual's support structure and should not be confused with the coverage requirements for medically reasonable and necessary care for pain and symptom management that cannot be managed in any other setting.
    - Caregiver breakdown should not be billed as general inpatient care unless the coverage requirements for this level of care are met.

- ***Inpatient care for respite purposes***
    - Inpatient care for respite purposes must be provided by one of the following:
        - A Medicare-certified hospice that meets the conditions of participation for providing inpatient care directly (requirements specified in CoPs at §418.100).
        - A Medicare-certified hospital or a skilled nursing facility that also meets the standards for providing inpatient care directly (requirements specified in CoPs at § 418.110).
        - A Medicare or Medicaid-certified nursing facility that also meets the standards specified in § 418.110(f) - Patient Areas.
        - **Respite care may not be provided in an assisted living facility.**
    - 24 hour nursing in respite care.
        - The care needs of a respite patient are equivalent to those of the patient in his or her home and therefore may not necessitate registered nursing care on a 24-hour basis.
        - Staffing for a facility solely providing the respite level of care to hospice patients should be based on each patient's care needs.
        - Each patient must receive all nursing services as prescribed and must be kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.

- ***Inpatient care provided under arrangements***
    - If a hospice contracts for short-term inpatient care with a facility, the hospice must coordinate a written agreement with that facility.
    - The written agreement must include a commitment by the hospice to:
        - Provide the inpatient facility a copy of the patient's plan of care.
        - Provide the inpatient facility a list of specific services that are to be furnished by the inpatient facility. This may be included in the plan of care.
        - Provide orientation and training of the hospice philosophy to the inpatient facility personnel who will be providing services to the hospice patient.
        - Document a description of the training provided to any inpatient facility personnel along with the names of those hospice staff providing the training.
    - The written agreement must also include a commitment by the inpatient provider to:
        - Demonstrate already established patient care policies consistent with those of the hospice.
        - Abide by the palliative care protocols established by the hospice.
        - Provide services according to the plan of care established by the hospice.
        - Include in the inpatient's clinical record all inpatient services furnished and events regarding care that occurred at the facility.
        - Provide the hospice with a copy of the discharge summary at the time of the patient's discharge.
        - Make the inpatient's clinical record available to the hospice at the time of discharge.

        - Identify an individual within the facility who is responsible for the implementation of the provisions of the agreement.
    - The written agreement must include a method to verify that all of the requirements of the agreement are met.
        - CMS does not dictate a process to verify that all of the requirements have been met.

- ***Inpatient care limitation***
    - A particular hospice should calculate the limit on inpatient days for Medicare beneficiaries who elected hospice coverage in a twelve-month period. The total number of inpatient days used by Medicare beneficiaries who have elected hospice coverage in a 12-month period in a particular hospice may not exceed 20 percent of the total number of hospice days used in total for this group of beneficiaries.
    - Example: 100 Medicare beneficiaries used 1,000 days of hospice care in a 12 month period. The maximum number of days of inpatient care (general inpatient and inpatient respite care) that these 100 beneficiaries can use is 200 days during the 12 month period.
    - ***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.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Review and revise (as needed) current facility contractual agreements at least annually.
    - Assess compliance with contractual agreement components and act upon non-compliance as necessary. (Schedule an annual meeting/ call with contractor administration to discuss agreement and performance, complete a site visit with contractor, etc…)
- Review and revise training and facility orientation programs as needed.
- Discuss the role of IDG and facility staff with hospice staff for patients receiving care in a contracted facility and issues with coordination of patient care (if any).
- Incorporate education about inpatient care requirements into your orientation program and continuing education for physicians.

❖ **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center
    - Managing General Inpatient Care for Symptom Management (2012)
    - Managing Hospice Respite Care (2012)
    - Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
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Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers
January 2015

Sec. 418.110 Condition of Participation:
Hospices That Provide Inpatient Care Directly

Due to the detail in this CoP, only key information is provided in this guide. The full regulatory text for §418.110 is available at:

- NHPCO's Regulatory & Compliance Center
- The requirements for hospices that provide inpatient care directly were published in the Federal Register, June 5, 2008. However, there are regular "tweaks" and changes to the Conditions of Participation. For the latest information and updated Conditions of Participation, the Code of Federal Regulations (CFR) is updated each year. The 2013 edition of the Medicare Hospice Conditions of Participation can be found here.

- ***Facility operation***
  - A hospice that provides inpatient care directly in its own facility must demonstrate compliance with all of the following standards regarding facility operations:
    - 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.
      - 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.
      - If at least one patient in the hospice facility is receiving general inpatient care, then **each shift must include a registered nurse who provides direct patient care**.
    - Physical environment.
      - The hospice must maintain a safe physical environment free of hazards for patients, staff, and visitors.

- Fire protection.
  - 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 (NFPA). 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.
- Emergency preparedness plan.
  - 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 nonemployee staff) with special emphasis placed on carrying out the procedures necessary to protect patients and others.
- 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.
  - The hospice must provide—
    - Physical space for private patient and family visiting;
    - Accommodations for family members to remain with the patient throughout the night; and
    - Physical space for family privacy after a patient's death.
    - The hospice must provide the opportunity for patients to receive visitors at any hour, including infants and small children.
- Patient rooms.
  - Each patient's room must—
    - Accommodate no more than two patients and their family members For a facility occupied by a Medicare-participating hospice on December 2, 2008, CMS may waive the space and occupancy requirements of paragraphs (f)(2)(iv) and (f)(2)(v) of this section if it determines that—
      - 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
      - The waiver serves the needs of the patient and does not adversely affect their health and safety.
      - Toilet and bathing facilities. Each patient room must be equipped with, or conveniently located near, toilet and bathing facilities.

- Infection control.
  - The hospice must maintain an infection control program that protects patients, staff and all others that come into the facility by preventing and controlling infections and communicable disease as stipulated in § 418.60.
- 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.
- 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 contaminants.
- Meal service and menu planning.
  - The hospice must furnish meals to each patient that are—
  - Consistent with the patient's plan of care, nutritional needs, and therapeutic diet;
  - Palatable, attractive, and served at the proper temperature; and
  - Obtained, stored, prepared, distributed, and served under sanitary conditions.

- **Restraint or seclusion**
  - Requirements for use of restraints or seclusion with patients:
    - In accordance with a modification to the patient's plan of care AND a physician's order (no standing orders or PRN).
    - Implemented with safe techniques.
    - **No more than 24 hours total**; renewed every 4 hours for adults
    - Monitored by trained staff
    - Face-to-face evaluation every hour for violent or self-destructive behavior.
    - Staff trained before implementing seclusion or restraint techniques, at orientation, and on a periodic basis thereafter.
    - Training addresses all relevant areas.
    - Training documentation in personnel records.
    - Report deaths associated with use of seclusion or restraint.

NHPCO Additional Resource

Supplemental Compliance Guide for Restraint and Seclusion

****Located in NHPCO's Regulatory & Compliance Center****

- Report deaths within 1 week of seclusion or restraint use when reasonable to assume a relationship.
- Report by phone to CMS no later than the close of the next business day after death; document reporting in patient's clinical record.
- If an hospice facility deems themselves a restraint or seclusion free facility, then there must be a policy and procedure in place that outlines the procedure for a patient who needs restraint or seclusion.
- If a facility **uses restraint or seclusion** for patients, then **all direct patient care staff must be CPR certified**.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Ensure that inpatient facility meets all requirements in the 2000 edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).
- See waiver process if for the patient room requirements in standard if:
  - It would result in unreasonable hardship on the hospice if strictly enforced; or jeopardize its ability to continue to participate in the Medicare program; and
  - The waiver serves the needs of the patient and does not adversely affect their health and safety.
- Incorporate education inpatient requirements into your orientation program and continuing education for all inpatient staff and appropriate home care staff.
- **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center
- CMS – 2000 edition of Life Safety Code http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandComplianc/LSC.html
- State Operations Manual, Chapter 2 - The Certification Process

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References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
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Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers
January 2015

Sec. 418.112 Condition of Participation: Hospices that Provide Hospice Care to Residents of SNF/NF or ICF/IID

- ***Resident eligibility, election and duration of benefits***
  - Medicare patients receiving hospice services and residing in a SNF, NF, or ICF/IID are subject to the same Medicare hospice eligibility criteria as any other hospice patient. The Medicare hospice eligibility criteria set out at § 418.20 through § 418.30.
  - **NOTE:** The language in the Interpretive Guidelines has changed, removing the designation of Intermediate Care Facilities for Individuals with Mental Retardation (ICF/MR). The facilities are now designated as Intermediate Care Facilities for Individuals with Intellectual Disabilities (ICF/IID).

- ***Professional management***
  - The hospice must assume responsibility for:
    - Professional management of the hospice services provided to the patient.
    - Ensuring that hospice services are provided according to the hospice plan of care and Medicare hospice conditions of participation.
    - Making any necessary arrangements for hospice-related inpatient care in another participating Medicare/Medicaid facility.

On June 27, 2013, CMS published the final rule for long term care facilities regarding requirements when the facility enters into an agreement with a hospice to offer hospice services to residents of the facility. This final rule mirrors the hospice requirements in this section of the hospice CoPs. Interpretive Guidelines for this final rule are not yet released.
Hospice providers need to be aware of these requirements when they partner with a LTC facility.

- ***Written agreement***
  - The hospice and the SNF/NF or ICF/IID must have a written agreement.
  - The agreement must:

        - Specify the hospice services that are to be provided in the facility.
        - Be signed by authorized representatives of the hospice and participating SNF/NF or ICF/IID facility before the provision of hospice services.
    - The content of the agreement must specifically include:
        - The method and manner of communication between the hospice and the SNF/NF or ICF/IID, and the manner in which that communication will be documented.
        - **NOTE:** The provision of details regarding communication in the written agreement is to ensure that patient needs are met and addressed. It is about providing quality care.
    - A provision that the SNF/NF or ICF/ IID immediately notifies the hospice if:
        - A significant change in a patient's physical, mental, social, or emotional status occurs;
        - Clinical complications appear that suggest a need to alter the plan of care;
        - A need to transfer a patient from the SNF/NF or ICF/ IID, and the hospice makes arrangements for, and remains responsible for, any necessary continuous care or inpatient care necessary related to the terminal illness and related conditions; or
        - A patient dies.
    - A provision stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided.
        - **NOTE:** This provision will ensure that although the SNF/NF or ICF/IID is required to immediately notify the hospice of conditions that may influence the effectiveness of hospice services or of the hospice plan of care, the SNF/NF or ICF/IID is not permitted to change the level of services provided unless under the direction of the hospice to do so.
    - An agreement that it is the responsibility of the SNF/ NF or ICF/IID to:
        - Continue to provide 24-hour room and board care.
        - Meet the personal care and nursing needs that the primary caregiver at home would have provided to the hospice patient before the election of hospice services.
            - This care should be provided at the same level as it would have been by the primary caregiver at home.
            - Hospice aides should **supplement personal care** provided by facility aides as needed. Hospice aides **do not** replace facility aides when a patient elects hospice care.
        - An agreement that it is the hospice's responsibility to provide services at the same level and to the same extent as those services would be provided if the SNF/NF or ICF/IID resident were in his or her own home.
        - A provision that the hospice is responsible for:
            - Provision of medical direction and management of the patient.
            - Nursing.
            - Counseling, including spiritual, dietary and bereavement counseling.

        - Social work.
        - Provision of medical supplies, durable medical equipment and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions.
        - Provision of all other hospice services necessary for the care of the resident's terminal illness and related conditions.
        - **NOTE:** The hospice is not limited to the provision of the above items.
    - A provision stating that the hospice must report all alleged violations to the SNF/NF or ICF/IID administrator within 24 hours of the hospice becoming aware of the alleged violation.
    - Violations include, but are not limited to:
        - Mistreatment.
        - Neglect.
        - Verbal, mental, sexual, and physical abuse, including injuries of unknown source.
        - Misappropriation of patient property by anyone unrelated to the hospice.
    - A provision of the responsibilities of the hospice and the SNF/NF or ICF/IID to provide bereavement services to SNF/NF or ICF/IID staff.

- ***Plan of care***
    - A written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/IID representatives.
    - All hospice care must be provided in accordance with this plan of care.
    - The hospice plan of care must identify:
        - The care and services that are needed.
        - Which provider is responsible for performing the respective functions specified in the plan of care.
        - All components set out in Condition of Participation 418.56.
    - The plan of care must reflect the participation of the hospice, the SNF/NF or ICF/IID, and the patient and family.
        - The patient and the patient's family are expected to participate in the care and services of the hospice patient to the extent possible.
    - To implement changes in the hospice plan of care:
        - Any changes must be discussed with the patient or the patient's representative.
        - Any changes must be discussed with the SNF/NF or ICF/IID representatives.
        - **All changes must be approved by the hospice before implementation**.

- ***Coordination of services***
    - The hospice must designate a member of each IDG that is responsible for a patient residing in an SNF/NF or ICF/IID. This designated IDG member is responsible for:

        - Providing overall coordination of the hospice care of the patient with the SNF/NF or ICF/IID representatives.
        - Communicating with all health care providers, including the SNF/NF or ICF/IID representatives, and providing care for the terminal illness and related conditions, as well as conditions unrelated to the terminal illness.
            - The purpose of this extensive communication is to ensure the quality of care provided to the hospice patient.
    - The hospice must ensure that the hospice IDG communicates as needed with the SNF/NF or ICF/IID:
        - Medical director.
        - Attending physician of the hospice patient.
        - Any physicians other than the attending physician who are providing care or services to the hospice patient.
            - The purpose of this communication is specifically to coordinate the hospice care of the patient with the medical care provided by other physicians.
    - The hospice must provide the SNF/NF or ICF/IID with:
        - The most recent hospice plan of care specific to each hospice patient.
        - The hospice election form and any advance directives specific to each patient.
        - The physician initial certification and recertification of the terminal illness specific to each patient.
        - The names and contact information of hospice personnel involved in the hospice care of each patient.
        - Instructions to access the hospice's 24-hour on-call system.
            - Hospice medication information specific to each patient.
        - Hospice physician and attending physician orders specific to each patient.

- ***Orientation and training of staff***
    - Hospice staff must assure that basic orientation to hospice philosophy and basic principles is provided for SNF/NF or ICF/IID staff furnishing care to hospice patients. The orientation can include, but is not limited to:
        - Methods of comfort.
        - Pain control.
        - Symptom management.
        - Principles about death and dying.
        - Individual responses to death.
        - Patient rights.
        - Appropriate forms and record keeping requirements.

Additional NHPCO Resource

Hospice Provider/Nursing Facility Education Toolkit which includes

Available in the NHPCO Regulatory & Compliance Center

- The hospice must provide in-service education to SNF/NF or ICF-IID staff on the individual hospice's policies and procedures that relate to:
  - Care planning process.
  - Communication and coordination between hospice and facility staff.
  - Documentation.
  - Appropriate forms and record keeping requirements.
- The nursing home should identify any areas that would require orientation/training of hospice personnel such as infection control policies, use of durable medical equipment, etc.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Review and revise written agreements between the hospice and the SNF/NF or
- ICF/IID on a regular basis.
  - Ensure that lines of authority and responsibility are established in order to better coordinate quality care. Implement addendums or new contracts.
- Develop a model of communication between the hospice and the SNF/NF or ICF/IID to minimize confusion of responsibilities and duplication of services.
- Incorporate education about hospice in a facility requirements into your orientation program and continuing education for physicians.
- **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center
  - Hospice in Facilities
  - Hospice Provider/Nursing Facility Education Toolkit
- Medicare and Medicaid Programs; Requirements for Long Term Care Facilities; Hospice Services (June 27, 2013)

References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

Medicare Hospice Conditions of Participation (CoPs)

Compliance Guide for Hospice Providers
January 2015

Sec. 418.114 Condition of Participation: Personnel Qualifications

- ***General qualification requirements***
  - The following standards apply to all professionals who furnish services directly or under any arrangement with a hospice, including individual contracts.
    - All professionals who provide hospice care or services must be legally licensed, certified or registered in accordance with applicable Federal, State and local laws.
    - Each professional must act only within the scope of his or her license, State certification or registration.
    - All personnel qualifications must be kept current at all times.

- ***Personnel qualifications when no state licensing, certification or registration requirements exist***
  - If there are no State or Federal requirements for certification or licensing of professionals, CMS requires that a registered nurse must be a graduate of a school of professional nursing and a licensed practical nurse must have completed a practical nursing program.

- ***Personnel qualifications for physicians***
  - A doctor of medicine or osteopathy.
    - **418.3** - ***Physician*** means an individual who meets the qualifications and conditions as defined in section 1861(r) of the Act and implemented at § 410.20.
    - ***418.3 - Physician designee*** means a doctor of medicine or osteopathy designated by the hospice who assumes the same responsibilities and obligations as the medical director when the medical director is not available.
    - Medicare Part B pays for physicians' services, including diagnosis, therapy, surgery, consultations, and home, office, and institutional calls.

- ***Personnel qualifications for hospice aides***
  - A qualified hospice aide is a person who has successfully completed **one** of the following:
    - A training program and competency evaluation specified in 418.76.
    - A competency evaluation program specified in 418.76.

        - A nurse aide training and competency evaluation program approved by the State and is currently listed in good standing on the State nurse aide registry. (must meet requirements of § 483.151 through §483.154)
        - A State licensure program that meets the requirements of paragraphs (b) and (c) of 418.76.

- ***Personnel qualifications for social workers***
    - ***Social worker.*** A person who—
        - Has a Master of Social Work (MSW) degree from a school of social work accredited by the Council on Social Work Education; **or**
        - Has a baccalaureate degree in social work from an institution accredited by the Council on Social Work Education; or a baccalaureate degree in psychology, sociology, or other field related to social work and is supervised by an MSW; **and**
            - Has 1 year of social work experience in a healthcare setting; or
                - The regulatory text and the interpretive guidelines do not specify any particular health care setting for this requirement. It is up to the hospice to decide if the social worker meets the specifications of the regulation, both State and Federal, and the hospice's own job qualifications.
            - Has a baccalaureate degree from a school of social work accredited by the Council on Social Work Education, is employed by the hospice before December 2, 2008, and is not required to be supervised by an MSW.
        - A state's hospice licensure regulations and social worker requirements should be reviewed and adhered to if they are more stringent than the CoPs. A hospice can also set their standard/ policy higher than the federal regulations.
        - **Social worker supervision**
            - The only detail that is provided by CMS about supervision is in the interpretive guidelines at §418.114(b)(3): "Each hospice must employ or contract with at least one MSW to serve in the supervisor role as an active advisor, consulting with the BSW on assessing the needs of patients and families, developing and updating the social work portion of the plan of care, and delivering care to patients and families. This supervision may occur in person, over the telephone, through electronic communication, or any combination thereof. The hospice must allow time for this supervision to happen on a regular basis and provide documentation as to the nature and scope of supervision. The hospice must also ensure that non-social work trained bachelor's prepared employees filling the role of social worker are supervised by a MSW who graduated from a school of social work accredited by the CSWE and who has at least one year of experience in a health care setting."

- ***Personnel qualifications for speech language pathologist (SLP)***
    - A person who meets either of the following requirements:
        - The education and experience requirements for a Certificate of Clinical Competence in speech-language pathology granted by the American Speech-Language-Hearing Association.
        - The educational requirements for certification and is in the process of accumulating the supervised experience required for certification.

- ***Personnel qualifications for occupational therapist (OT)***
    - Is licensed or otherwise regulated, if applicable, as an occupational therapist by the State in which practicing, unless licensure does not apply;
        - Graduated after successful completion of an occupational therapist education program accredited by the Accreditation Council for Occupational Therapy Education (ACOTE) of the American Occupational Therapy Association, Inc. (AOTA), or successor organizations of ACOTE; and
        - Is eligible to take, or has successfully completed the entry-level certification examination for occupational therapists developed and administered by the National Board for Certification in Occupational Therapy, Inc. (NBCOT).
    - Additional detail regarding ***Occupational therapists*** and ***Occupational therapist Assistants*** requirements is available in 418.114(5) in the final Conditions of Participation.

- ***Personnel qualifications for Physical therapist (PT)***
    - A person who is licensed, if applicable, by the State in which practicing, unless licensure does not apply and meets one of the following requirements:
        - Graduated after successful completion of a physical therapist education program approved by one of the following:
            - The Commission on Accreditation in Physical Therapy Education (CAPTE).
            - Successor organizations of CAPTE.
            - An education program outside the United States determined to be substantially equivalent to physical therapist entry level education in the United States by a credentials evaluation organization approved by the American Physical Therapy Association or an organization identified in 8 CFR 212.15(e) as it relates to physical therapists.
            - Passed an examination for physical therapists approved by the State in which physical therapy services are provided.
    - Additional detail regarding ***Physical therapists*** and ***Physical therapist Assistants*** requirements is available in 418.114(7) in the final Conditions of Participation.

- ***Criminal background checks***
    - The hospice must obtain a criminal background check on all hospice employees who have direct patient contact or access to patient records.

- Hospice contracts must require that all contracted entities obtain criminal background checks on contracted employees who have direct patient contact or access to patient records.
- Criminal background checks must be obtained in accordance with State requirements.
- In the absence of State requirements, criminal background checks must be obtained within three months of the date of employment.

Compliance suggestions for hospice providers

- Review and revise (as needed) program policy/procedure at least annually.
- Review and evaluate applicable state regulations.
- Review all personnel files to ensure that each professional staff member meets the requirements of this condition on a regular basis (at least annually).
- Review State laws and regulations regarding criminal background checks. The hospice should comply with the most stringent regulations, whether they are the regulations set forth in this CoP, or State laws or regulations.
- Incorporate education about personal requirements into your orientation program and continuing education for management.
- **Please note that hospice providers need to comply with the most stringent regulatory requirements (Federal or State).**

Resources

- NHPCO's Regulatory & Compliance Center - The Interdisciplinary Team
- Medicare Benefit Policy Manual, Chapter 9 - Coverage of Hospice Services Under Hospital Insurance

References

Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418. Medicare and Medicaid Programs: Hospice Conditions of Participation; last update 2013
Visit http://www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR to check for the most recent updates).

