New Conditions of Participation for Hospice

CoPs are on the way

The Centers for Medicare and Medicaid Services (CMS) has released new Conditions of Participation for hospice providers. For a hospice to participate in Medicare funding, it must meet “Conditions of Participation” – CoPs – that guide and govern patient care, quality improvement activities, and outcome measurement. Medicare certified hospices will need to become compliant with the new regulations by December 2, 2008.

The final rule may be accessed at [http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf](http://edocket.access.gpo.gov/2008/pdf/08-1305.pdf)

Listed below is a summary of the new Conditions of Participation.

- **Patient rights.** Patient rights are important across all care settings, and include notice of rights to patients and families in a language and manner that they understand during the initial assessment visit prior to furnishing care. The patient or representative’s signature must be obtained to verify receipt of the notice of rights and responsibilities.
  - Patient’s complaints must be investigated and reported to the hospice administrator.
  - Corrective action must be taken if a violation is verified.
  - Verified significant violations must be reported to state and/or local bodies within five days of the incident.
  - Patients have the right to choose their own physician, whether this is the hospice medical director or a community physician.

  **Tip: be sure to have policies and procedures about patient rights and educate all hospice staff and volunteers.**

- **Initial and comprehensive assessment.** The new regulations stress that assessment is a dynamic process, not just a document. The hospice may choose to use any form or any process that assures an ongoing assessment of the needs of the patient and family.
  - The *initial assessment* is to be completed by the RN within 48 hours after selection of hospice services.
  - The *comprehensive assessment* is to be completed by the interdisciplinary group (IDG) within five calendar days after selection of hospice services. The initial assessment by the RN will dictate which team members are called in for assessments of the patient and family.
  - The comprehensive assessment must be updated by the IDG at a minimum of every 15 days, but as frequently as the patient’s condition requires, such as a change in condition.
The comprehensive assessment must include a drug profile which assesses current medications for any redundant or ineffective medications or other drug therapies.

**Tip:** be sure to have a policy and procedure on file, as well as demonstrate by documentation that the assessments are being completed in the required time frames.

- **IDG, care planning, and service coordination.** One of the top 10 survey deficiencies for hospices is the link between the IDG and the plan of care. The new regulations stress that the IDG will follow a written plan of care that has been discussed and agreed upon with the patient and family.
  
  o Administrative IDG: Section 418.56 requires a designated IDG that sets forth policies and procedures that manage day to day operations. This can be a committee of hospice managers and administrators.
  
  o The plan of care (POC) should reflect patient and family goals. It must include all services and interventions needed for end-of-life care, as well as a detailed statement of the **scope and frequency of services** that will be required to meet these needs.
  
  o The POC is updated by all disciplines providing care every 15 days or as the patient's condition warrants. The update of the comprehensive assessment flows into the POC update.
  
  o Coordination of care with non-hospice healthcare providers who are furnishing services must be documented.

  **Tip:** document all IDG communication and coordination of care, both within the hospice setting and with outside providers.

- **Quality Assessment and Performance Improvement (QAPI).** This standard will go into effect **January 31, 2009.** The later date gives hospices time to implement performance improvement studies. The number and scope of the studies must reflect the complexity and past performance of the hospice. In other words, a larger hospice with different levels of care will perform more studies and more in-depth studies than a smaller hospice. However, all hospices must conduct quality improvement projects.
  
  o **Designated QAPI leader.** The regulation requires a designated person or persons to lead the QAPI program.
  
  o **Patient outcome measures** must be gathered and used in assessment, patient care planning and in the hospice’s QAPI. Consistent data gathering and reporting is emphasized.
  
  o **Evidenced based improvement measures** should be used to show that patient outcomes are improved with palliative care and end of life support services. For example, increased pain control is known to improve the outcome of end of life care.
- **Program data reports** are required to monitor the effectiveness and safety of services, quality of care, as well as identify opportunities for improvement in care. The hospice’s governing body must be involved in program direction by setting the standards for data collection, analyzing data reports and setting policy for the hospice based on data
  - QAPI activities must focus on high volume, high risk problem areas such as pain control, patients in nursing homes, etc. that affect patient safety, outcomes, and quality of care. This includes adverse patient events.

- **Infection Control.** The infection control standard includes standard precautions, hospice-wide surveillance, identification, control, investigation and prevention of infectious disease. This includes staff, volunteer, patient, family and caregiver education.

- **Core services.**
  - **Bereavement counseling.** Bereavement counseling is now expected to begin prior to death and, of course, continue after death. Similar to discharge planning, bereavement counseling starts at admission. Bereavement counseling is provided under the supervision of a qualified professional with experience or education in grief or loss counseling. This can be provided by a social worker, chaplain, or bereavement counselor.
  - **Dietary counseling.** Counseling for dietary issues may be performed by a registered nurse as well as a dietitian or nutritionist.
  - **Medical social services.** Social services must be provided under the direction of a physician by statute. Under the new "personnel qualifications" section (418.114) a social worker is defined as:
    - MSW with one year experience, or;
    - bachelor's in social work, psychology, sociology, or other related field and one year experience and supervised by MSW, or;
    - bachelors in social work and employed by the hospice prior to the effective date of the final rule (12/2/08)
  
  *Note: the definition for qualified social worker may be updated prior to the effective date of the final rule. The National Association of Social Workers is working with the National Hospice and Palliative Care Organization on a response to CMS.*

- **Hospice Aide.** In the hospice setting, an aide or nursing assistant is now referred to as a "hospice aide" per the CoPs. Similar to the home health regulations, the hospice aide must have completed a state approved hospice aide or nurse aide training and competency evaluation.
  - Hospice aides must be supervised by the RN every 14 days, but the hospice aide does not have to be present during that visit unless there are concerns related to care. If concerns are verified during the visit, the RN must observe an aide visit and complete a competency evaluation. Once a year, the RN must make an on-site visit to assess the hospice aide while caring for a patient to assess competency.
  - **Hospice aides must receive 12 hours of in-service education yearly.**
• Instructors who train in the classroom or supervise practical training must be an RN with at least two years of experience and at least one year in home care or hospice.

• **Volunteers.** Under the new CoPs, volunteers may count their driving hours as long as the hospice also counts staff driving hours.

• **Clinical records.** Fax and authenticated electronic signatures are approved. **Stamped signature by a physician is not approved.** Medical records may be maintained electronically. Records are to be retained six years after death or discharge unless state law requires a longer period. Upon discharge to another Medicare or Medicaid facility, the discharge summary is required, but the full record needs only to be sent if requested.

• **Drugs, durable medical equipment, and medical supplies.**
  o A physician or nurse practitioner may give verbal or electronic orders to a licensed nurse, pharmacist, or physician.
  o Patient and family education is required for training in drug management and disposal, to assure that the patient and family administer and dispose of medications safely. **Note: drugs delivered to the patient's home technically become the property of the patient. The patient and family have the right to refuse disposal of the drugs by the hospice.**
  o The patient, family, and/or caregiver must demonstrate to a member of the IDG that they know how to use durable medical equipment and supplies properly.

  **Tip: be sure to demonstrate by documentation all patient and family discussion, education, and return demonstration related to drugs and durable medical equipment.**

  **Another tip: have a policy and procedure with manufacturer’s recommendations on any DME used by the hospice in patients’ homes.** **CoPs recommends that policies be developed by the hospice if manufacturer recommendations are not available.**

• **Inpatient respite care.** Beginning December 2, 2008, the 24 hour per day RN care requirement in a respite setting will not be required. **It is required until that time, however.** Don't change your staffing ratios yet.

• **Inpatient care.** Hospices that have inpatient units can have no more than two patients per room. There is a waiver available if the two-person room mandate would be unreasonable for the hospice. In the new regulations, meal service is less prescriptive. CMS recognizes that setting strict time standards for meals is not practical nor the best quality of care for end-of-life.

• **Restraints.** Although rarely used by hospices, the section on restraints has been added to standardize care between care settings. Those familiar with restraint
regulations in, for example, the long-term care setting, will recognize these basic rules for restraints.

- Patients have the right to be free of restraints, and restraints are to be used only as the last resort.
- Drug (chemical) restraints are defined as drugs that are not standard treatment or dosage for the patient’s condition. Note: the Final Rule is clear that the intent is not to limit the hospice’s use of drugs to relieve pain, calm anxiety, or treat other distressing symptoms. The Final Rule also states that these regulations clearly apply only to hospice inpatient facilities.
- Standing orders for restraints are not permitted. A restraint may only be used with specific physician’s order.
- Restraints may only be used for 24 hours total.
- Restraints must be monitored by trained staff, with training documented in personnel records.
- If a patient dies when using restraints or within one week of restraint use, the death must be reported by phone to CMS.

- **Orientation and training of staff.** The new regulations call for “assurance of orientation of facility staff to hospice”. This is especially important when a hospice contracts with a skilled nursing facility. The hospice is required to orient the SNF staff to hospice care, but is not necessarily required to train each and every member of the SNF staff in an in-depth manner.

- **Definition: multiple locations.** Satellite locations are now referred to as "multiple locations".

**Be prepared.** Plan ahead for these new regulations. Here are some things you can do now:

- Contact the National Hospice and Palliative Care Organization (NHPCO) for a variety of CoPs resources. [http://www.nhpc.org](http://www.nhpc.org)
- Review current policies and procedures in light of the new regulations, and revise as needed. Be sure to look carefully at the IDG process for assessment and plan of care.
- Data, data, data. Identify data that relates to quality of life issues for your patients, identify scales to measure the data, and train your staff so that consistent measurement will occur across all departments.
- If not already in place, set up the person responsible for QAPI, train the Board in their role in performance improvement and analysis, and begin QAPI studies.
- Review human resources policies and procedures to update personnel qualifications as needed.