



Hospice Survey Readiness and Response Toolkit

A RESOURCE FOR FOUR STAGES: PRESURVEY, DURING SURVEY, AFTER SURVEY, AND ENFORCEMENT

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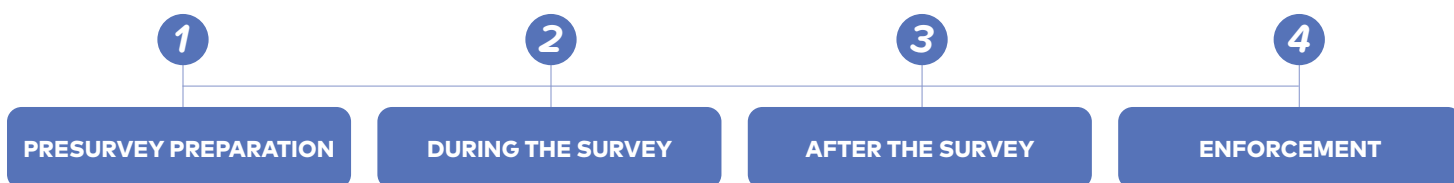
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A Medicare certified hospice must follow the Medicare Conditions of Participation (CoPs) for all patients. Medicare surveys for compliance with the CoPs are completed by state agencies or deemed status accrediting bodies no less frequently than once every three years to review the hospices compliance with the CoPs (Subparts C and D of the Medicare hospice regulations); however, surveys may occur at any time as a result of a complaint. A state may also do separate state licensure surveys. When deficiencies are cited (standard or condition level), a plan of correction is required, and a follow up survey may occur.

The NHPCO Survey Readiness and Response Toolkit is intended to provide support to hospices before, during, and after a hospice Medicare survey. The tools and resources are provided in the Toolkit and are also found on the NHPCO Regulatory & Compliance Center: Survey Readiness and Response. This Toolkit is a companion to the other resources found in NHPCO Regulatory & Compliance Center, Survey Readiness and Response. Review [NHPCO's Regulatory Alerts and Updates page](#) for any recent or upcoming changes to the CoPs.

The Toolkit is Divided Into Four Sections



Section One: Survey Preparation

Survey protocols and Interpretive Guidelines are established to provide guidance to SA (State Agency) and AO (Accrediting Organization) personnel conducting surveys. They serve to clarify and/or explain the intent of the regulations and all surveyors are required to use them in assessing compliance with Federal requirements. Continuous compliance with the regulations and Interpretive Guidelines is essential for a favorable survey outcome. Reviewing the Interpretive Guidelines will be important for staff responsible for survey readiness, paying special attention to what the surveyor will be looking for in the additional explanatory guidance. Of note for this toolkit, the terms Interdisciplinary group (IDG) and interdisciplinary team (IDT) are used interchangeably.

Condition of Participation (CoP) compliance guides are provided to assist the hospice in survey readiness. Supplemental materials provide additional guidance.

Section Two: During the Survey

Responding appropriately during a survey is a fundamental component of a successful survey. Knowing what a survey will encompass will help a hospice be prepared. The survey will include a review of documents, clinical records, patient visit(s), IDT attendance, and interviews with various leaders and staff. Resources are provided to assist the hospice during the survey.

Section Three: After the Survey

If a surveyor finds the hospice out of compliance, survey deficiencies will be cited, and a plan of correction written and implemented by the hospice will be required. The resource in this section provides guidance in understanding and responding to survey deficiencies.

Section Four: Enforcement

Five types of enforcement remedies may be used by the State Agency, in collaboration with CMS. Enforcement remedies will be implemented on October 1, 2022.

SECTION ONE: Presurvey Preparation



Survey protocols and Interpretive Guidelines are established to provide guidance to SA (State Agency) and AO (Accrediting Organization) personnel conducting surveys. They serve to clarify and/or explain the intent of the regulations and all surveyors are required to use them in assessing compliance with Federal requirements. Continuous compliance with the regulations and Interpretive Guidelines is essential for a favorable survey outcome. Reviewing the Interpretive Guidelines will be important for staff responsible for survey readiness, paying special attention to what the surveyor will be looking for in the additional explanatory guidance. Of note for this toolkit, the terms Interdisciplinary group (IDG) and interdisciplinary team (IDT) are used interchangeably.

Condition of Participation (CoP) compliance guides are provided to assist the hospice in survey readiness. Supplemental materials provide additional guidance.

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.

- **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

- 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

- [Hospice Patient's Rights](#)
- [Title VI Prohibition Against National Origin Discrimination As It Affects Persons With Limited English Proficiency](#)
- State 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 Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

Sec. § 418.54 Condition of Participation: Initial and Comprehensive Assessment of the Patient

The Initial Assessment

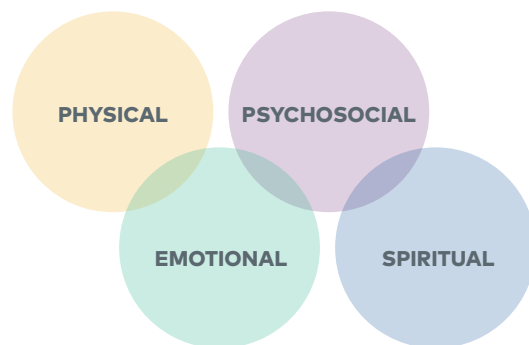
- The registered nurse (RN) has 48 hours from the effective date of the hospice election statement to complete the initial assessment.
- The purpose of the initial assessment is **not** to determine the patient's eligibility for the hospice benefit, which is addressed in § 418.22 and § 418.24, or to 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 complete 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 IDT 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 team notes as well.
- Remember - the IDT 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

- [Medicare Benefit Policy Manual, Chapter 9](#) - Coverage of Hospice Services Under Hospital Insurance
- [1135 Waiver Page](#)

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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.

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

- 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

- IDG Guidance Compliance Guide Conditions of Participation
- [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 Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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° 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 you 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

- Update QAPI Plan annually.
- Participate in [NHPCO Quality Connections](#)
- Use the Hospice Quality Reporting Program (HGRP) in your QAPI program
- Review [NHPCO Standards of Practice](#)
- 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.
- Participate in [NHPCO Performance Measures](#)
- Participate in [NHPCO Measures of Excellence](#)
- 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 IDT 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

- [State Operations Manual](#)

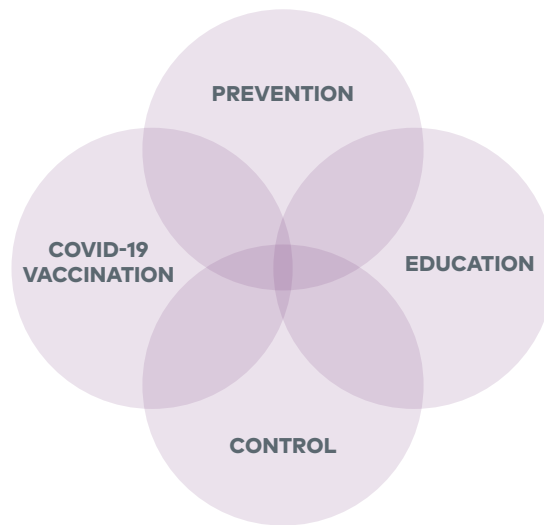
References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

Sec. § 418.60 Condition of Participation: Infection Control

NOTE: At this writing, infection control is a high priority for surveyor review and the hospice's COVID-19 infection control processes must be detailed and in place. In addition, CMS has issued a COVID-19 Vaccine Mandate interim final rule which is currently under court challenge. Please watch for updates in NewsBriefs or on the regulatory pages of the website for the most up-to-date information.

- 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 four components:



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.
- Additional resources for hand hygiene include:
 - [CDC Guideline for Hand Hygiene in Health-Care Settings](#)

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.

COVID-19 Vaccination

- The hospice must develop a process for vaccination of all staff and include a process for medical and non-medical or religious exemptions.
- The hospice must be prepared to demonstrate their processes, employee vaccination records and contingency plans when surveyed.

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

- [Infection Control: Severe acute respiratory syndrome coronavirus 2 \(SARS-CoV-2\) | CDC](#)
- [Guidelines for Preventing the Transmission of M. tuberculosis in Health-Care Settings, 2005 \(CDC\)](#)
- [TB Infection Control in Health Care Settings | Health Care Settings | TB | CDC](#)
- [Fact Sheets | Infection Control & Prevention | Fact Sheet - Infection Control in Health-Care Settings | TB | CDC](#)
- [CMS Vaccine Mandate Guidance \(QSO 22-07\) for Health Care Providers](#)
- [CMS Vaccine Mandate Guidance \(QSO 22-07 Attachment C\) for Hospice Providers](#)
- [CMS Vaccine Mandate Guidance \(QSO 22-09\) for Health Care Providers](#)
- [CMS Vaccine Mandate Guidance \(QSO 22-09 Attachment C\) for Hospice Providers](#)
- [CMS Vaccine Mandate Guidance \(QSO 22-11\) for Health Care Providers - Texas](#)
- [CMS Vaccine Mandate Guidance \(QSO 22-11 Attachment C\) for Hospice Providers in Texas](#)
- 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.

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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

§ 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 (Sec § 418.64):

- 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 as an "Extraordinary Circumstance" per 42 CFR § 418.64 Core Services

Separate from Sec § 418.64 is Nursing Shortage

- The Center for Clinical Standards and Quality/Quality, Safety & Oversight Group Memo Impact of Nursing Shortage QSO-21-01-Hospice 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.
 - The hospice requirement at 42 CFR § 418.64 (Condition of Participation: Core Services) states:

"A hospice must routinely provide substantially all core services directly by hospice employees. These services must be provided in a manner consistent with acceptable standards of practice. These services include nursing services, medical social services, and counseling. The hospice may contract for physician services as specified in paragraph (a) of this section. A hospice may use contracted staff, if necessary, to supplement hospice employees in order to meet the needs of patients under extraordinary or other non-routine circumstances. A hospice may also enter into a written arrangement with another Medicare certified hospice program for the provision of core services to supplement hospice employee/staff to meet the needs of patients. Circumstances under which a hospice may enter into a written arrangement for the provision of core services include: Unanticipated periods of high patient loads, staffing shortages due to illness or other short-term temporary situations that interrupt patient care; and temporary travel of a patient outside of the hospice's service area."

- A hospice, in these intermittent and/or temporary situations, does not require a waiver or exemption from the SA or the CMS Location. The regulation allows the provider to utilize these services temporarily.

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 a 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.

Compliance Suggestions for Hospice Providers

- 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. Pay particular attention to physician job titles and reporting requirements, as there can be only one hospice medical director. (42 CFR § 418.102)
- 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, assure that documentation supports the circumstances.
- If contracting for nursing services due to a chronic nursing shortage, assure that 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 IDT regulatory requirements into your orientation program and continuing education.
- Be able to evidence an organized system for tracking staff competency evaluation.

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

Resources

- NHPCO Regulatory & Compliance Center, Survey Readiness and Response
- QSO-21-01 Nursing Shortage as an "Extraordinary Circumstance" [QSO-21-01-Hospice](#)

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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

§ 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 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).

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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 16 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 or pseudo-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 during the on-site visit noted, then the hospice must:
 - Have a 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 in the deficient area.
 - 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 team.
- Instructions for homemaker duties must be prepared by a member of the interdisciplinary team.
- Homemakers must report all concerns about the patient or family to the member of the interdisciplinary team who is coordinating homemaker services.

Compliance Suggestions for Hospice Providers

- 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](#) Hospice Aide on the Go Inservice Volume 3

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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 were trained and validated as competent to perform the care.
 - Regular competency evaluation (and documentation) of these skills is recommended.

Administrative services (can be counted towards the 5% calculation):

- Volunteers can provide administrative patient care related 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.
 - E.G.: 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, then 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

- 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 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 Regulatory & Compliance Center, Volunteers
- [The Independent Sector](#) - (Estimated National Value of Each Volunteer Hour) (updated annually)

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

FY 2021 Survey Deficiency Report Top Ten Survey Deficiencies

October 1, 2020 – September 30, 2021. Retrieved from <https://qcor.cms.gov/> on December 20, 2021

In FY 2021, state survey agencies and accrediting organization surveyed 2,867 hospice providers of a total of 5,875 hospices, approximately one third; Surveyors will use the Hospice Interpretive Guidelines, found in [Appendix M](#) of the State Operations, and will cite hospices based on L-tags. More detail on the L-tags and what surveyors will use to judge hospice compliance can be found in Appendix M. Hospice certification and recertification surveys must occur once every 36 months. The following is the list of the top 10 survey deficiencies for 2021.

RANKING	TAG #	TAG DESCRIPTION	# CITATIONS	% OF PROVIDERS CITED	% OF SURVEYS CITED
1	L0543	Plan of Care	158	2.20%	5.50%
2	L0579	Prevention	139	1.60%	4.80%
3	L0530	Content of Comprehensive Assessment	126	1.80%	4.40%
4	L0545	Content of Plan of Care	120	1.80%	4.20%
5	L0523	Timeframe for Completion of Assessment	82	1.20%	2.90%
6	L0625	Hospice Aide Assignments and Duties	81	1.10%	2.80%
7	L0547	Content of Plan of Care	74	1.10%	2.60%
8	L0552	Review of Plan of Care	67	1.00%	2.30%
9	L0555	Coordination of Services	66	1.00%	2.30%
10	L0531	Content of Comprehensive Assessment	65	0.80%	2.30%

CoP Audit Tool

The National Hospice and Palliative Care Organization has prepared this downloadable [CoP Audit Tool](#) for your use in preparing for Medicare hospice surveys. Each tab is a different section of the CoPs (Subparts C and D of the hospice regulations) and provides items to prepare or consider in preparing for a Medicare survey.

For questions, please contact Regulatory@NHPCO.org.

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Completion date
	Yes	No			Yes	No		
Ensure that organizational policies include procedure for completion of the initial and comprehensive assessment per regulations and are reviewed and revised as needed at least annually.								
Initial assessment documentation tool captures immediate care needs of the patient and family.								
Initial assessment occurs within 48 hours of election and is documented in the clinical record.								
Comprehensive assessment documentation tool includes all required elements from standard §418.54(c).								
Comprehensive assessment occurs within 5 days of election and is documented in the clinical record.								
Assessment documentation includes complete assessment of patient's prescribed and over-the-counter medications and any additional substance that could affect drug therapy.								
Assessment documentation also includes evaluation of drug effectiveness, side effects, interactions of drugs, duplicate drugs and drugs associated with laboratory testing which could affect the patient.								
Documentation includes an initial bereavement assessment.								
Update comprehensive assessment occurs as frequently as patient's condition requires but no less than every 15 days and is documented in the clinical record.								
Documentation of communication with IDG at the time of a change in the patient's status is present in the clinical record.								
Update to comprehensive assessment includes information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care.								
Documentation reflects consultation with the attending physician on the comprehensive assessment according to hospice policy (note this does not mean that a signature of the attending is								

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Completion date
	Yes	No			Yes	No		
Ensure that organizational policies include procedures about the function of the infection control per regulations and are reviewed and revised as needed at least annually.								
Written infection control program is based on current standards and included in the QAPI program.								
Patient materials reflect the most current infection control practices.								
Documentation reflects that patients, families and caregivers are educated in infection control.								
For hospices who provide inpatient directly, appropriate prevention and control precautions including signage or other posted information in patient rooms or staff areas is recommended.								
Infection control and prevention strategies are implemented based on problems identified from infection program data and are incorporated as a part of the QAPI program.								
Staff is knowledgeable and practices infection control principles and procedures.								
Current employees, contract staff and volunteers are educated on the infection control program.								
Staff and contractor orientation is updated to reflect the infection control plan.								
Infection control findings are periodically used to educate staff.								
Hospice managers/ supervisors observe staff infection control practice in a patient homes.								
Check your state health department for infection trends in your service area and document in the infection control portion of your QAPI program.								
Check your state health department webpage for a list of reportable communicable diseases in your state and ensure that your infection control program policies reflect the requirement and reporting process.								
Orientation for employees, contracted staff and volunteers includes infection control requirements.								

Hospice Patient Admission Packet

November 2021

The patient admission packet contains important information for your patient and the family/caregiver and is usually provided during the start of care visit. There are several “must have” items in that admission packet to be in compliance with federal regulations. Audit your patient admission packet to ensure that the following information is included:

- Informed consent
- Hospice Election of Hospice Services
- Notice of Patient Privacy
- Notice of patient rights and responsibilities (specifics are included in the CoPs at § 418.52(c))
- Advance care directive information.
- Information about Medicare covered hospice services (may be in election statement).
- Information about the scope of services that the hospice will provide and specific limitations on those services (may be in election statement).
- Material about patient financial liability for any services (may be in election statement).
- Information about how to contact the hospice after regular business hours.
- Information about how to make a complaint to the hospice and how to contact the state survey agency hot line.
- Copy of the controlled drug disposal policy if controlled drugs at admission (good process to use for all admissions regardless if ordered or not at admission).

Additional information that is not required but recommended:

- Explanation that all services related to the terminal illness or related conditions need to be approved by the hospice provider or the patient will be financially liable for those services. Provide specific reference to unapproved visits to the emergency room, inpatient hospital admission, and visiting specialty physicians. (This is stated in the CMS Medicare Hospice Benefit Booklet [O2154-Medicare-Hospice-Benefits.PDF](#))
- Explanation about medication coverage under Medicare Part D as applicable.
- Explanation for reasons a patient may be discharged live:
 1. Patient moves out the hospice’s service area or is admitted to a non-contracted facility for emergent care.
 2. Patient is no longer considered hospice eligible by the hospice physician, and they will be provided a minimum 2-day notice of discharge from the hospice program and the opportunity to appeal the discharge decision.
 3. Patient is discharged because of their behavior issues or behavior issues of someone in the home which makes delivery of hospice services not possible.
- Copy of contracted hospital/facility list
- Explanation of how hospice services will appear on a Medicare Summary Notice (MSN)

Hospice Patient Rights

"A hospice patient has the right to be informed of his or her rights, and the hospice must protect and encourage using these rights." - HOSPICE MEDICARE CONDITIONS OF PARTICIPATION (CFR § 418.52, SUBPART C, § 418.52)

What are Hospice Patient Rights?

A list of rights guaranteed to all hospice patients including what a hospice must provide to a person who is receiving hospice care.

Where can I find Hospice Patient Rights?

The Medicare Conditions of Participation are issued as regulations set by the federal government agency, the Centers for Medicare and Medicaid Services. Hospices must follow these regulations, which include a section on patient rights.

What do Hospice Patient Rights include?

Each hospice patient has the right to:

- Be treated with respect.
- Receive quality end-of-life care.
- Receive spoken and written notice of their rights and responsibilities in a manner they understand during the assessment meeting with hospice staff.
- Receive information on advance directives including a living will and healthcare surrogate.
- Voice concerns and not be discriminated against for doing so.
- Receive pain management and symptom control.
- Be involved in developing his or her hospice plan of care.
- Refuse care or treatment.
- Choose their attending physician.
- Have a confidential medical record.
- Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse.
- Receive information about the services covered under the Hospice benefit.
- Receive information about the services that the hospice will provide and any limitations on those services.

What do Hospice Patient Rights mean to hospice providers?

- The hospice must inform each patient of their rights during the admission verbally and in writing.
- The hospice must talk about and provide written information about the organization's policies on advance directives, including a description of the state law.
- The hospice must prove they have reviewed the hospice patient's rights by asking for the patient or caregiver's signature.

If you have questions about your rights, please ask your hospice team, call the hospice's compliance officer, or call the National Hospice and Palliative Care Organization's toll-free InfoLine at 800-658-8898.

I have received a copy of the notice of patient rights and responsibilities.

SIGNATURE OF PATIENT OR REPRESENTATIVE

DATE

Hospice Physicians Compliance Guide

November 2021

Key CoPs related to role of the hospice physician

- § 418.52 Patient rights
- § 418.54 Initial and comprehensive assessment of the patient
- § 418.56 IDT, care planning, and coordination of services
- § 418.58 Quality assessment and performance improvement
- § 418.60 Infection control
- § 418.64 Core services
- § 418.100 Organization and administration of services
- § 418.104 Clinical records
- § 418.106 Drugs and biologicals, medical supplies, and durable medical equipment
- § 418.110 Hospices that provide inpatient care directly
- § 418.112 Hospices that provide hospice care to residents of a SNF/NF or ICF/MR
- § 418.114 Personnel qualifications

Background

The role of the hospice physician is a focus in the Medicare Hospice Conditions of Participation. The hospice must designate one physician to be the medical director and oversee the medical component of the hospice plan of care for each patient. The hospice medical director, and other members of the interdisciplinary team, must collaborate with the patient's attending physician to coordinate end of life care for the patient.

§ 418.52 Condition of participation: Patient rights

Every member on the Interdisciplinary team (IDT) has a responsibility to ensure that the patient rights outlined in this regulation are applied to every patient the same. Coordination of translation services and documentation that the patient/representative received notification of the rights is the responsibility of the IDT.

§ 418.54 Condition of participation: Initial and comprehensive assessment of the patient

- As a member of the IDT, the hospice physician should participate in the development of a comprehensive assessment tool that focuses on clinically meaningful information.
- This could include the selection of symptom assessment scales (and training staff to use them); development of processes for reviewing patient medication profiles (including determination of effectiveness, recognition of side effects, and anticipation of drug interactions); and consistent identification of patients in need of referral for evaluation by other health professionals.
 - The hospice physician reviews the medication profile at admission and determines which medications (if any) are not related to the patient's terminal prognosis.
- The hospice physician should also participate in the IDT task of assessing the patient's progress towards goals at least every 15 days.
- This CoP requires measurement of outcomes. The hospice physician should offer expertise in the selection of data elements that are clinically relevant for the patient and recognized as valid for the hospice quality assessment and performance improvement program.

§ 418.56 Condition of participation: Interdisciplinary Team, care planning, and coordination of services

This CoP affirms that the hospice physician is a member of the IDT. Although there are many important elements in this CoP, the hospice physician should be attuned to the requirement that the plan of care "include all services necessary for the palliation and management of the terminal illness and related conditions."¹ This contains:

- Interventions to manage pain and symptoms;
- Measurable outcomes anticipated from implementing and coordinating the plan of care.
- Determination of related diagnoses and conditions.
- Determination of drugs and treatment necessary to meet the needs of the patient and related to the terminal prognosis.
- The hospice physician should be knowledgeable about available interventions and medications, the expected palliative benefits in the hospice population, and the likely ability to meet the needs of an individual patient.
- The physician should also help the team define and measure meaningful outcomes to assess effectiveness of these interventions and medications. In this way the hospice physician serves as a resource to the IDT and an advocate for the patient.

§ 418.58 Condition of participation: Quality assessment and performance improvement

- This CoP requires hospices to "develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program."²
- The hospice physician should participate in the selection of indicators related to improved palliative outcomes and the effectiveness and safety of service. Again, indicators should be valid and meaningful.

§ 418.60 Condition of participation: Infection control

- Per this regulation, education to patient/family and other members of the hospice team is a one of the three required components of the standard and nurses should be actively involved in any infection control program in the organization.
- Hospice physicians may also participate in the organization's infection control program and quality assessment/performance improvement activities related to infections control.
- All hospice staff should have ongoing education in a clear, concise format regarding the infection control program and impact on all staff and caregivers.
- All hospices should have a process and contingency plan for 100% vaccination for COVID-19 for all staff, a process for medical and religious exemptions, and a contingency plan for unvaccinated workers.

§ 418.64 Condition of participation: Core services

- This CoP reaffirms that the hospice physician is "responsible for the palliation and management of the terminal illness and conditions related to the terminal illness."³
- Thus, the hospice physician has a responsibility for the plan of care beyond providing medical advice to hospice staff during IDT meetings.
- The hospice physician also has a responsibility to collaborate with the patient's attending physician as needed to maintain an effective plan of care.
- Medical social services must be provided by a qualified social worker, under the direction of a physician.

§ 418.100 Condition of Participation: Organization and administration of services

- As a part of the organization, designated hospice services, and the IDT, physicians have the responsibility to optimize the comfort and dignity for a patient and provide care that is consistent with patient and family needs and goals, with patient needs and goals as priority.
- Physician services must be available all day, every day. (24/7)
- The hospice physician must be available to participate in such orientation, and the hospice must orient physicians to the hospice philosophy and "hospice-specific" elements of their position.

§ 418.102 Condition of participation: Medical director

- This CoP, focuses on medical directors and hospice physicians, and requires a hospice to **designate one physician as medical director**.
- All physician employees and those under contract, must function under the supervision of the hospice medical director.
- Physician designee.

- Another hospice physician may be pre-selected as the “physician designee” to fulfill the duties of the medical director as needed.
- The hospice physician must:
 - Have a formal relationship with the hospice (employment or contract).
 - Certify and recertify the patient’s prognosis taking into account a variety of clinical information.
 - The Medical Director must be responsible for the medical component of the hospice plan of care.

§ 418.104 Condition of participation: Clinical records

- The clinical record must contain accurate clinical information about the patient as recorded by hospice staff, the attending physician, the medical director, and any other entities involved with the patient’s care.
- A physician is one of the key documenters in the clinical record and needs to be aware of the requirements in the regulation.
- Physician documentation should include but is not limited to:
 - All certification of terminal illness requirements.
 - Clinical notes including documentation of medical judgment regarding why a diagnosis/condition, drug, treatment, etc. is not related to the terminal prognosis.
 - Clinical notes describing medical judgment related to a changed terminal diagnosis(s).
 - Clinical notes describing medical judgment related to patient discharge for no longer being terminally ill.

§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment

- To comply with this CoP, hospice physicians can help “ensure that the IDT confers with an individual with education and training in drug management.”⁴
 - The hospice physician may be that designated individual and/or may collaborate with the pharmacist member of the IDT. Further information on the qualifications of this individual will be available in the Interpretive Guidelines.
- The IDT, 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.
- The physician must ensure that verbal drug orders or electronic transmission are only given to a licensed nurse, nurse practitioner (where appropriate), or pharmacist.
- Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals:
 - Licensed nurse,
 - Physician, or
 - Other health care professional in accordance with their scope of practice and State law.

§ 418.110 Condition of participation: Hospices that provide inpatient care directly

Key points of this condition directly related to patient care are the detailed focus on restraint and seclusion.

- The hospice physician working in a hospice that utilizes restraints and/or seclusion must complete a training program on the use of restraints and consult with hospice staff whenever the use of restraints becomes necessary.
- Hospice physicians must evaluate patients with restraint and/or seclusion orders at least every 24 hours and should be prepared to evaluate violent or self-destructive patients within 1 hour of ordering restraints or seclusion if other staff is not trained to do so.
- Hospice physicians should also be prepared to help the hospice determine if restraint and/or seclusion contributed directly or indirectly to a patient’s death, thereby making the death an event reportable to CMS.

§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID

- A key point in this condition is the importance of the development of the patient plan of care and coordination of care between the hospice, the patient/family and the facility.
- When a hospice patient resides in a facility, hospice remains responsible for medical direction and management of the patient.
- The hospice physician should maintain collegial relationships with the medical staff of these facilities in order to help the hospice staff collaboration with these physicians.

§ 418.114 Condition of participation: Personnel qualifications

- **Licensure**
 - All professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.
 - Physicians must meet the qualifications and conditions as defined in section 1861(r) of the Act and implemented at 42 CFR 410.20 - Physicians' services. (govregs.com) of this chapter.
- **Criminal Background Checks**
 - All hospice employees (both paid and volunteer staff) who have direct patient contact or access to patient records must have a criminal background check.

Resources

- Physician section of MyNHPCO: [MyNHPCO | NHPCO](#) Professional networking community for members
- [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 Hospice Care Regulations [Code of Federal Regulations \(eCFR\)](#).
- ¹Electronic Code of Federal Regulations (eCFR) [42 CFR 418 Hospice Services](#)
- ²Electronic Code of Federal Regulations (eCFR) [42 CFR 418 Hospice Services](#)
- ³Electronic Code of Federal Regulations (eCFR) [42 CFR 418 Hospice Services](#)
- ⁴Electronic Code of Federal Regulations (eCFR) [42 CFR 418 Hospice Services](#)

IDT Compliance Guide Conditions of Participation

November 2021

The requirement for an interdisciplinary team (IDT) as the model for the delivery of care is unique to hospice. The IDT works with the patient and family to customize a plan of care that meets all of the medical, emotional, psychosocial, and spiritual needs.

The CoPs in Subparts C and D describe the requirements hospice providers must be compliant with related to patient care and the hospice organizational environment to maintain Medicare certification. This means that the IDT must be familiar with these regulations. For the past several years, the Centers for Medicare and Medicaid Services (CMS) has consistently cited multiple standards from § 418.56 Condition of Participation: Interdisciplinary Team, Care Planning, and Coordination of Services in their top 10 survey deficiencies. Understanding all of the requirements in that specific CoP is mandatory for all members of the IDT.

However, not all of the CoPs in Subparts C and D apply to every discipline of the IDT. The following table (next pages) indicate the CoPs that each IDG should be intimately familiar with in order to provide compliant high quality care to the patient and family.

Additional NHPCO Resources

- [MyNHPCO | NHPCO](#) Professional networking community for members that connects you with colleagues in your discipline as well as others across the country who are working in hospice and palliative care.
- [NHPCO Marketplace](#) – tools and resources for the IDT
- [Medicare Benefit Policy Manual, Chapter 9](#) - Coverage of Hospice Services Under Hospital Insurance
- 42 CFR Part 418 Medicare Hospice Care Regulations [Code of Federal Regulations \(eCFR\)](#).

SUBPART C--CONDITIONS OF PARTICIPATION: PATIENT CARE

CoP	NURSE	PHYSICIAN	AIDE	SOCIAL WORKER	CHAPLAIN	VOLUNTEER COORDINATOR	BEREAVEMENT COORDINATOR
§ 418.52 Condition of participation: Patient's rights.	✓	✓	✓	✓	✓	✓	✓
§ 418.54 Condition of participation: Comprehensive assessment of the patient.	✓	✓	✓	✓	✓	✓	✓
§ 418.56 Condition of participation: Interdisciplinary team care planning and coordination of services.	✓	✓	✓	✓	✓	✓	✓
§ 418.58 Condition of participation: Quality assessment and performance improvement	✓	✓	✓	✓	✓	✓	✓
§ 418.60 Condition of participation: Infection control.	✓	✓	✓	✓	✓	✓	
§ 418.62 Condition of participation: Licensed professional services.	✓	✓		✓			
§ 418.64 Condition of participation: Core services.	✓	✓		✓	✓		✓
§ 418.66 Condition of participation: Nursing services--waiver of requirement that substantially all nursing services be routinely provided directly by a hospice.	✓						
§ 418.70 Condition of participation: Furnishing of non-core services.	✓		✓			✓	
§ 418.72 Condition of participation: Physical therapy, occupational therapy, and speech-language pathology.	✓	✓					
§ 418.74 Waiver of requirement-Physical therapy, occupational therapy, speech- language pathology and dietary counseling.	✓	✓					
§ 418.76 Condition of participation: Hospice aide and homemaker services. § 418.76 Condition of participation: Hospice aide and homemaker services.	✓		✓				
§ 418.78 Condition of participation: Volunteers.	✓	✓	✓	✓	✓	✓	✓

SUBPART D--CONDITIONS OF PARTICIPATION: ORGANIZATIONAL ENVIRONMENT

CoP	NURSE	PHYSICIAN	AIDE	SOCIAL WORKER	CHAPLAIN	VOLUNTEER COORDINATOR	BEREAVEMENT COORDINATOR
§ 418.100 Condition of participation: Organization and administration of services.	✓	✓	✓	✓	✓	✓	✓
§ 418.102 Condition of participation: Medical director.	✓	✓					
§ 418.104 Conditions of participation: Clinical records.	✓	✓	✓	✓	✓	✓	✓
§ 418.106 Condition of participation: Drugs, controlled drugs and biologicals, medical supplies, and durable medical equipment.	✓	✓					
§ 418.108 Condition of participation: Short-term inpatient care.	✓	✓		✓			
§ 418.110 Condition of participation: Hospices that provide inpatient care directly.	✓	✓	✓	✓	✓	✓	✓
§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF, ICF/MR, or other facilities.	✓	✓	✓	✓	✓	✓	✓
§ 418.114 Condition of participation: Personnel qualifications for licensed professionals.	✓	✓	✓				
§ 418.113 Condition of participation: Emergency Preparedness	✓	✓	✓	✓	✓	✓	✓
§ 418.116 Condition of participation: Compliance with Federal, State, and local laws and regulations related to health and safety of patients.	✓	✓	✓	✓	✓	✓	✓

Survey Materials Checklist

December 2021

The following are materials surveyors for Medicare will most likely request from a hospice provider during an active recertification survey, but it is not inclusive of all materials that may be requested for review. Continuous update of these materials is recommended in order to remain survey ready.

NOTE: *This guide does not address state licensure or accreditation requirements.*

Administrative information:

- List/addresses of all sites, branches and services provided, if applicable including inpatient facilities (either directly or under agreement)
- Organizational Chart (includes to patient level)
- Map/listing of geographical area served
- All state licenses, accreditation certificates, etc. as applicable
- CLIA waiver and waived tests being performed, if applicable
- Names of key staff (clinical staff who will be primary resource during survey)
- RN coordinator, person with most knowledge of hospice aides, volunteers, infection control, QAPI, Inservice training, clinical supervision, bereavement)
- Active employee list by discipline, title
- Policy and procedure manual(s)
- Emergency Response Plan
- Governing Body meeting minutes
- List of contracted facilities, hospitals, agencies, pharmacies, DME, ambulance, contracted staff (have current contracts available).
- Number of unduplicated admissions in last 12 months
- Number of current patients who are receiving hospice care at home, in an inpatient facility, SNF/NF or other facility
- List of all active patient names: election date, diagnosis, date of initial assessment.
- List of patients with scheduled visits during survey
- IDT meeting dates/times
- Access to patient records
- Access to bereavement records for expired patients during past 12 months
- Admission Packet/materials given to patient on admission
- Marketing Materials (will be reviewed for listing of services and locations)
- Documentation of grievances/complaints received last 12 months
- Quality assessment performance improvement (QAPI) program (see § 418.58 Compliance Guide for QAPI for additional information); QAPI Plan; aggregated data and analysis; evidence of current and completed Performance Improvement Projects for the last 12 months; individuals responsible for the QAPI Program; Evidence of functioning QAPI program; evidence of management and governing body review
- Infection control program
- Volunteer program information including list of active volunteers and personnel files (as requested). (See Sec. § 418.78 Compliance Guide for Volunteers for more information)

Hospice staff information:

- Staff in-service calendar
- Documentation of hospice aide training and/or competency evaluations and in-service training
- Personnel files (as requested)

- Government requirement: "Make forms available for inspection if requested by authorized U.S. government officials from the Department of Homeland Security, Department of Labor, or Department of Justice
- I-9
- Health File
 - Checklist per Federal, state and agency policy
 - If the health file has drug screen, TB/chest x-ray, and COVID-19 vaccination status in each personnel file, then all other health information should not be available to the surveyor for HIPAA reasons – including workers compensation, HIV, other health issues
- Medical Director/Associate Medical Director
 - Copy of license
 - DEA registration
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, and COVID-19 vaccination status
 - Criminal background check
- Nurse, social worker
 - Copy of license (Nurses always, SW per state)
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, and COVID-19 vaccination status
 - Criminal background check
- Hospice aide
 - Copy of certification (if any)
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, and COVID-19 vaccination status
 - Criminal background check
 - Evidence of 12 continuing education hours in a 12-month period
- Spiritual professional
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, and COVID-19 vaccination status
 - Criminal background check
- Therapists (PT, OT, SLP) (if contracted, agency should be responsible to provide)
 - Copy of license
 - Proof of Certificate of Clinical Competence for SLP
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, and COVID-19 vaccination status
 - Criminal background check

Hospice Office Information:

- Required Postings (Federal, State, Agency)
- Environmental Safety Check e.g., Lighted EXIT signs, fire extinguishers, etc.
- Office Evacuation Plan/Route
- Medical Supplies stored properly, and expirations dates checked
- Biohazardous Waste Container (only for in office usage) stored properly

Medicare Condition of Participation Tip Sheets by Discipline

Below are links to NHPCO condition of participation (CoP) tip sheets by discipline. These resources have been gathered and interpreted by NHPCO from various resources and are provided for informational purposes.

- Bereavement Counselor
- Hospice Aide
- Nursing
- Pharmacist
- Physician
- QAPI Professional
- Social Worker
- Spiritual Care Professional
- Volunteer

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.

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](#)
 - [Providing Hospice Services Across State Lines Compliance Guide](#)
- State Operations Manual, [Chapter 2 - The Certification Process](#)

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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 CCN (CMS Certification Number).
- A hospice can employ multiple physicians, but there can be only one medical director for the organization or one CCN.
- 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.

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).
 - The physician must attest that he or she composed the brief narrative and sign and date the narrative under the attestation.
- 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 medical director's responsibility.

Compliance Suggestions for Hospice Providers

- 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.
- Ensure that clinical staff know the difference between the one hospice medical director and hospice physicians employed or under contract with the hospice.

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

Resources

- [Medicare Benefit Policy Manual Chapter 9 - Coverage of Hospice Services Under Hospital Insurance, Physician Services](#)

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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. (Election Statement)
 - 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.
 - ▶ Certification with 6 month prognosis statement and physician narrative statement, with signature and date below the attestation.
 - ▶ 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 .

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.
 - 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

- Policy should incorporate electronic signature security process.
- 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 IDT staff.

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

Resources

- NHPCO Regulatory & Compliance Center, Certification and Recertification
- [Complying with Medicare Signature Requirements](#)

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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 team 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 hospice and palliative medicine;
 - ▶ RNs who are certified in hospice and 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

Drugs may NOT be ordered by a physician assistant. The Medicare Patient Access to Hospice Act, effective Jan. 1, 2019, allows PAs to serve as the attending physician to hospice patients and to provide hospice care within their scope of practice. The federal hospice statute and the hospice Conditions of Participation currently do not include PAs in the list of allowable clinicians that can order drugs in hospice care. Per § 418.106(b) Standard: Ordering of drugs. Only a physician as defined by Section 1861(r)(1) of the Act, or a nurse practitioner in accordance with the plan of care and State law, may order drugs for the patient.

- 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

- **IDT Responsibility:** The IDT, 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 team.

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

- The federal SUPPORT Act, a major piece of legislation aimed at addressing the opioid epidemic, became law in late 2018. It included a provision to amend the Controlled Substances Act (CSA) to allow certain hospice employees to handle controlled substances in order to assist patients and families with onsite disposal of them under specific circumstances.
- NHPCO submitted questions to the Drug Enforcement Administration (DEA) about this legislation. In 2019, the DEA provided these responses:

- **Are hospices now required to dispose of patients' controlled substances?**

The SUPPORT Act permits, but doesn't require, hospices to develop policies and procedures to allow certain hospice employees to assist with controlled substance disposal on site under certain circumstances without being DEA registrants. Hospice employees are not subject to the rules applicable to DEA registrants.

Hospices can decide whether they want to allow qualified employees to assist families with disposal, or they can continue to instruct patients and families on options and methods of disposal.

- **Who can assist with disposal?**

The law specifically allows physicians, physician assistants, and nurses who are employed by (or in the case of physicians, under contract with) the hospice to assist with disposal if they are acting within the scope of their employment and have completed hospice program training regarding disposal of controlled substances in a secure and responsible manner.

The law also allows disposal by "other persons" employed by the hospice who are "licensed to perform medical or nursing services by the jurisdiction"; however, in the absence of guidance from DEA it's unclear what other categories of licensed hospice employees might meet this criteria.

- **When can these hospice employees assist with controlled substance disposal?**

The hospice employees may handle controlled substances for the purpose of onsite disposal after the death of a hospice patient, or if the drug has expired.

If the hospice employee is the patient's physician and they are a DEA registrant, they may also dispose of the drugs onsite when a controlled substance is no longer needed because the patient's plan of care has been modified.

- **What is the hospice required to do?**

The law applies to employees of a "qualified hospice program", allowing them to assist hospice patients and families with controlled substance disposal onsite.

This means:

- ▶ The hospice must have written policies and procedures for assisting in the disposal of controlled substances and must provide patients and families with a copy of them at the time the controlled substances are first ordered.
- ▶ The hospice is required to discuss these policies and procedures with the patient and family in a language and manner they understand, to ensure they're educated regarding safe disposal of controlled substances, and must document in the patient's record that these policies and procedures were provided and discussed.
- ▶ Following the disposal of the controlled substances, the hospice must document in the patient's clinical record:
 - the type of controlled substance, dosage, dosage form i.e. tablet, patch, vial, etc.)
 - route of administration
 - quantity disposed of
 - time, date and manner of disposal

– Best practices for hospices:

- ▶ 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 during the admission process 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 by the time that the controlled drugs are first ordered.*
- ▶ **Providers must follow state and federal regulations related to disposal of controlled and uncontrolled drugs. See a full description of the SUPPORT Act, hospice drug disposal provisions in the [April 9, 2019 Regulatory Alert – SUPPORT Act – Controlled Substance Disposal](#)**

– 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.

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:
 - ▶ 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 team.
- 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

- 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 and federal 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 Regulatory & Compliance Center, Opioids

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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) 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 IDT 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 Regulatory & Compliance Center, Levels of Care
- [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 Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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. Providers should consult the [full regulatory text](#) for complete information or review NHPCO's detailed Emergency Preparedness compliance guide.

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 most current edition of the Life Safety Code (LSC) of the National Fire Protection Association (NFPA).

Emergency Preparedness Plan

- Refer to Sec. § 418.113 Emergency Preparedness

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.
 - 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 a 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

- Ensure that inpatient facility meets all requirements in the most current 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

- [Restraint and Seclusion Compliance Guide](#)
- [State Operations Manual Appendix Z- Emergency Preparedness for Hospice Providers Interpretive Guidance § 418.113 Condition of Participation for Hospices Revised \(July 2021\)](#)
- CMS – Most current edition of Life Safety Code <http://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/CertificationandCompliance/LSC.html>
- State Operations Manual, [Chapter 2 - The Certification Process](#)

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

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

The guidance provided in this document is intended to give an overview in comparing the Conditions of Participation for hospice and nursing facilities relationships from a historical basis. It is not a comprehensive review, but rather to assist hospice providers in understanding the basic requirements for the relationship.

Historical Perspective

The Hospice Conditions of Participation, at 42 CFR § 418.112, for care to residents of Skilled Nursing Facility/Nursing Facility (SNF/NF) was not implemented until December 2008. Prior to that date, although hospice providers were providing care in facilities, there was not any guidance. As a consequence, hospice providers were left up to their own as to how the relationship was structured.

It wasn't until August 2013 that guidance would be passed for the facility providers. In the timeframe between 2008 and 2013, extensive conversations were held with CMS to ensure that the subsequent NF guidance at § 483.75 would complement what had already been implemented for hospice providers. When the guidance for each provider is compared, the two are complimentary, rather than contradictory.

With guidance for both providers in place, there was little surveyor scrutiny of the relationship. That, however, changed with the publishing of the Nursing Facility Surveyor guidance in August 2017. Since then, providers have seen more scrutiny of the relationship. Even more intense scrutiny is anticipated as the Office of Inspector General (OIG) continues to publish reports questioning quality of care issues for hospice providers and CMS is implementing a more robust hospice survey process in 2021 and beyond.

As hospice providers are increasingly involved in relationships with nursing facility providers, staff for both providers should be educated on the expectations in § 418.112 and § 483.70 (o), Hospice Services. Additionally, staff of both providers should be familiar with the *Hospice and End of Life Care and Services Critical Element Pathway* (CMS 20073) Nursing Facility Surveyor computerized interview that all surveyors, in all states, utilize when hospice is providing care. A copy of both providers' conditions of participation and NF surveyor interview of hospice patients/residents are included in the guidelines accompanying this instruction.

Written Agreement

The first step in establishing the relationship is the development of a mutual contract. When a Nursing Facility is undergoing their annual survey, surveyors will ask to see a copy of the written agreement between the facility and the hospice. This agreement must be reviewed and signed by both parties before a resident is admitted for hospice care. In some cases, Facility Administration will sign a one-time specific contract for a resident. One-time patient agreements can be awkward and delay admission; therefore, it is preferable to have a facility agreement.

A facility is not required to have a contract with a hospice or can have multiple agreements (483.75). Since the NF Administrator is ultimately responsible for the care delivered to their residents, it is their decision designating which hospice they will contract with to utilize their services. If a resident requests services from a hospice that does not have a contract with the facility and is not willing to do a one-time specific contract for a resident, the facility is required to assist in transfer to a facility of the resident's choice.

If hospice care is furnished in a NF, "the facility must ensure that the hospice services meet professional standards". It is not uncommon when a facility is in their "survey window" to request the credentials of hospice staff to have available for surveyor review.

Hospice requirements for the written agreement § 418.112(c)(4) states that "it is the SNF/NF responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected." 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 resident were in his or her own home." Likewise, Nursing Facility requirements (§ 483.75 G) state that it is the "facility's responsibility to furnish 24 hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative."

As mentioned in the beginning of this document, there were no regulatory guidance when the relationship began. It is not uncommon for hospice providers to provide personal aide services that replace care that would normally be provided by the facility aide. Staff shortages due to COVID have increased the substitution of hospice aides for services of NF aides. This is not congruent with the regulations and may become problematic with increased citations as the relationship receives more surveyor scrutiny. This is definitely an issue that is "ripe" for scrutiny and will need to be addressed by both providers.

§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.

(c) **Standard: Written agreement.** The hospice and SNF/NF or Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/IID) must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/IID before the provision of hospice services. The written agreement must include at least the following:

- (1) The manner in which the SNF/NF or ICF/IID and the hospice are to communicate with each other and document such communications to ensure that the needs of patients are addressed and met 24 hours a day.
- (2) A provision that the SNF/NF or ICF/IID immediately notifies the hospice if -
 - (i) A significant change in a patient's physical, mental, social, or emotional status occurs;
 - (ii) Clinical complications appear that suggest a need to alter the plan of care;
 - (iii) A need to transfer 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
 - (iv) A patient dies.
- (3) 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.
- (4) An agreement that it is the SNF/NF or ICF/IID responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected.
- (5) 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.
- (6) A delineation of the hospice's responsibilities, which include, but are not limited to the following: Providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); 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; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.
- (7) A provision that the hospice may use the SNF/NF or ICF/IID nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/IID to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient's family in implementing the plan of care.
- (8) A provision stating that the hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/IID administrator within 24 hours of the hospice becoming aware of the alleged violation.

- (9) A delineation of the responsibilities of the hospice and the SNF/NF or ICF/IID to provide bereavement services to SNF/NF or ICF/IID staff.

Hospice Plan of Care

When you examine the most frequent citations made by surveyors of hospice and nursing facilities, care plans are usually in the top 10 cited deficiencies. Providers have difficulty meeting surveyor expectations when they are surveyed independently, so it is not surprising that this is a major area for improvement by both providers.

The most difficult obstacle to overcome is that the problem list for both providers often does not “match up”. It becomes challenging to develop a common language. Equally challenging is that electronic care planning tools for each provider have different interventions and goals. The hospice software generates palliative interventions and goals, whereas the nursing facility software has interventions and goals that are curative in nature. It takes a concerted effort to get both providers on the “same page”. This collaboration not only occurs on admission, but periodically as care evolves. Care plan meetings are an ideal time to compare the care plans to ensure they are compatible and clear in direction.

§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.

(d) **Standard: Hospice plan of care.** In accordance with [§ 418.56](#), a written hospice plan of care must be established and maintained in consultation with SNF/NF or ICF/IID representatives. All hospice care provided must be in accordance with this hospice plan of care.

- (1) The hospice plan of care must identify the care and services that are needed and specifically identify which provider is responsible for performing the respective functions that have been agreed upon and included in the hospice plan of care.
- (2) The hospice plan of care reflects the participation of the hospice, the SNF/NF or ICF/IID, and the patient and family to the extent possible.
- (3) Any changes in the hospice plan of care must be discussed with the patient or representative, and SNF/NF or ICF/IID representatives, and must be approved by the hospice before implementation.

Coordination of Services

The Nursing Facility and the Hospice must designate a member of each interdisciplinary team to coordinate the care. The appointed individual of the Nursing Facility must have the ability to solve patient care issues. During survey, staff may be asked to identify the appropriate individual to solve patient care issues. Surveyors will also question the resident/patient and their family members as to whether they have had any care issues. If so, who was the person they consulted to reach resolution?

Several times throughout the NF interpretative guidelines, in the CMS State Operations Manual, [Appendix PP](#), there are expectations that the physicians/medical directors will work through any patient care issues together.

Hospice documentation in the nursing facility record is critical and an easy citation for the surveyor. On the NF chart binder, there should be nothing on the outside that can be used to identify a hospice patient. This is considered a breach of confidentiality. Likewise, there should be no signage in the resident’s room that indicates they are on hospice or a DNR.

Specific LTC Survey Pathway – Hospice and End-of-Life

Nursing facilities are surveyed annually, and a summary of the citations can be viewed on the Medicare Compare website when viewing the data for a specific facility. In order for the survey process to be standardized across all states and comparable from one facility to another, CMS developed a computerized survey process for gathering information, called “LTC Survey Pathways.” There is specific surveyor guidance for patient care issues such as: hospice/end-of-life, pain management, pressure ulcers, respiratory care, unnecessary medications, hydration, and incontinence. When surveying a

nursing home's hospice, palliative care and end of life care patients, surveyors will use the [Hospice and End of Life Care and Services Critical Element Pathway \(CMS 20073\)](#) (Scroll down to the link for LTC Survey Pathways. Other nursing home survey information is also available at this link.)

When a NF is in their survey window, it is advisable for the hospice to do a chart audit to ensure that all the information is there and current. The documents listed below in (3) are duplicated in the NF regulations at [483.70 \(3\)\(iv\)](#).

§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.

(e) **Standard: Coordination of services.** The hospice and SNF/NF or ICF/IID must have a written agreement that specifies the provision of hospice services in the facility. The agreement must be signed by authorized representatives of the hospice and the SNF/NF or ICF/IID before the provision of hospice services. The written agreement must include at least the following:

- (1) Designate a member of each interdisciplinary team that is responsible for a patient who is a resident of a SNF/NF or ICF/IID. The designated interdisciplinary team member is responsible for:
 - (i) Providing overall coordination of the hospice care of the SNF/NF or ICF/IID resident with SNF/NF or ICF/IID representatives; and
 - (ii) Communicating with SNF/NF or ICF/IID representatives and other health care providers participating in the provision of care for the terminal illness and related conditions and other conditions to ensure quality of care for the patient and family.
- (2) Ensure that the hospice IDT communicates with the SNF/NF or ICF/IID medical director, the patient's attending physician, and other physicians participating in the provision of care to the patient as needed to coordinate the hospice care of the hospice patient with the medical care provided by other physicians.
- (3) Provide the SNF/NF or ICF/IID with the following information:
 - (i) The most recent hospice plan of care specific to each patient;
 - (ii) Hospice election form and any advance directives specific to each patient;
 - (iii) Physician certification and recertification of the terminal illness specific to each patient;
 - (iv) Names and contact information for hospice personnel involved in hospice care of each patient;
 - (v) Instructions on how to access the hospice's 24-hour on-call system;
 - (vi) Hospice medication information specific to each patient; and
 - (vii) Hospice physician and attending physician (if any) orders specific to each patient.

Orientation and Training of Staff

This section of the rules lists the training hospice provides to nursing facility staff. If a NF has multiple hospices providing care to their residents, the same basic hospice in-services do not need to be repeated multiple times.

§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID.

(f) **Standard: Orientation and training of staff.** Hospice staff, in coordination with SNF/NF or ICF/IID facility staff, must assure orientation of such staff furnishing care to hospice patients in the hospice philosophy, including hospice policies and procedures regarding methods of comfort, pain control, symptom management, as well as principles about death and dying, individual responses to death, patient rights, appropriate forms, and record keeping requirements.

Compliance Suggestions for Hospice Providers

- 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 Regulatory & Compliance Center, Facility Based Care
- [Medicare and Medicaid Programs; Requirements for Long Term Care Facilities; Hospice Services](#) (June 27, 2013)

References

- Nursing Facility Rules for Hospice: [42 CFR 483.70](#) (o) Hospice Services
- CMS State Operations Manual: [Appendix PP](#), Nursing Homes
- Nursing Facility Surveyor Guidance on Hospice/End-of-Life patients: [Hospice and End of Life Care and Services Critical Element Pathway \(CMS 20073\)](#) (Scroll to the download section for the link for LTC Survey Pathways. Other nursing home survey information is also available at this link.)

Sec. § 418.113 Condition of Participation: Emergency Preparedness

The content in this document is the hospice related CMS Emergency Preparedness Interpretive Guidelines extracted from the State Operations Manual Appendix Z- Emergency Preparedness for All Provider and Certified Supplier Types Interpretive Guidance which was updated 4/16/21 by the Centers for Medicare and Medicaid Services (CMS).

Introduction

The “Medicare and Medicaid Programs; Emergency Preparedness Requirements for Medicare and Medicaid Participating Providers and Suppliers” Final Rule (81 FR 63860, Sept. 16, 2016) (“Final Rule”) establishes national emergency preparedness requirements for participating providers and certified suppliers to plan adequately for both natural and man-made disasters, and coordinate with Federal, state, tribal, regional, and local emergency preparedness systems. The Final Rule also assists providers and suppliers to adequately prepare to meet the needs of patients, clients, residents, and participants during disasters and emergency situations, striving to provide consistent requirements across provider and supplier-types, with some variations. The emergency preparedness Final Rule is based primarily off the hospital emergency preparedness Condition of Participation (CoP) as a general guide for the remaining providers and suppliers, then tailored based to address the differences and or unique needs of the other providers and suppliers (e.g., inpatient versus out-patient providers).

The requirements are focused on three key essentials necessary for maintaining access to healthcare during disasters or emergencies:

- Safeguarding human resources
- Maintaining business continuity
- Protecting physical resources

The interpretive guidelines and *Survey Procedures* in this appendix have been developed to support the adoption of a standard all-hazards emergency preparedness program for all certified providers and suppliers while similarly including appropriate adjustments to address the unique differences of the other providers and suppliers and their patients. Successful adoption of these emergency preparedness requirements will enable all providers and suppliers wherever they are located to better anticipate and plan for needs, rapidly respond as a facility, as well as integrate with local public health and emergency management agencies and healthcare coalitions’ response activities and rapidly recover following the disaster.

While the use of healthcare coalitions is encouraged, this may not always be feasible for all providers and suppliers. For facilities participating in coalitions, the “level” of participation is not specified. However, if facilities use healthcare coalitions to conduct exercises or assist in their efforts for compliance, these efforts should be documented. The 2016 Emergency Preparedness Final Rule emphasized that healthcare facilities should continue to engage their healthcare coalitions and state hospital preparedness program (HPP) coordinators for training and guidance. We encourage healthcare facilities, particularly those in neighboring geographic areas, to build relationships that will allow facilities to share and leverage resources. For additional information, please visit <https://www.cms.gov/About-CMS/AgencyInformation/Emergency/EPRO/Resources/State-resources>.

Emergency Preparedness requires detailed planning and NHPCO has developed a more comprehensive CoP for Emergency Preparedness which includes interpretive guidance on related regulatory text, E-tags, and survey procedures.

Sec. § 418.114 Condition of Participation: Personnel Qualifications

Due to the detail in this CoP, only key information is provided in this guide. Providers should consult the [full regulatory text](#) for complete information.

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 (including volunteers) 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 evaluate applicable state regulations.
- Review all personnel files, including licensure renewal dates, 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

- [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 Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)

CoP Audit Tool

The National Hospice and Palliative Care Organization has prepared this downloadable [CoP Audit Tool](#) for your use in preparing for Medicare hospice surveys. Each tab is a different section of the CoPs (Subparts C and D of the hospice regulations) and provides items to prepare or consider in preparing for a Medicare survey.

For questions, please contact Regulatory@NHPCO.org.

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Completion date
	Yes	No			Yes	No		
Ensure that organizational policies include procedure for completion of the initial and comprehensive assessment per regulations and are reviewed and revised as needed at least annually.								
Initial assessment documentation tool captures immediate care needs of the patient and family.								
Initial assessment occurs within 48 hours of election and is documented in the clinical record.								
Comprehensive assessment documentation tool includes all required elements from standard §418.54(c).								
Comprehensive assessment occurs within 5 days of election and is documented in the clinical record.								
Assessment documentation includes complete assessment of patient's prescribed and over-the-counter medications and any additional substance that could affect drug therapy.								
Assessment documentation also includes evaluation of drug effectiveness, side effects, interactions of drugs, duplicate drugs and drugs associated with laboratory testing which could affect the patient.								
Documentation includes an initial bereavement assessment.								
Update comprehensive assessment occurs as frequently as patient's condition requires but no less than every 15 days and is documented in the clinical record.								
Documentation of communication with IDG at the time of a change in the patient's status is present in the clinical record.								
Update to comprehensive assessment includes information on the patient's progress toward desired outcomes, as well as a reassessment of the patient's response to care.								
Documentation reflects consultation with the attending physician on the comprehensive assessment according to hospice policy (note this does not mean that a signature of the attending is								

Regulatory Requirements	Are you compliant?		Actions required for compliance	Responsible party	Added to QAPI program?		Target compliance date	Completion date
	Yes	No			Yes	No		
Ensure that organizational policies include procedures about the function of the infection control per regulations and are reviewed and revised as needed at least annually.								
Written infection control program is based on current standards and included in the QAPI program.								
Patient materials reflect the most current infection control practices.								
Documentation reflects that patients, families and caregivers are educated in infection control.								
For hospices who provide inpatient directly, appropriate prevention and control precautions including signage or other posted information in patient rooms or staff areas is recommended.								
Infection control and prevention strategies are implemented based on problems identified from infection program data and are incorporated as a part of the QAPI program.								
Staff is knowledgeable and practices infection control principles and procedures.								
Current employees, contract staff and volunteers are educated on the infection control program.								
Staff and contractor orientation is updated to reflect the infection control plan.								
Infection control findings are periodically used to educate staff.								
Hospice managers/ supervisors observe staff infection control practice in a patient homes.								
Check your state health department for infection trends in your service area and document in the infection control portion of your QAPI program.								
Check your state health department webpage for a list of reportable communicable diseases in your state and ensure that your infection control program policies reflect the requirement and reporting process.								
Orientation for employees, contracted staff and volunteers includes infection control requirements.								

Hospice Physicians Compliance Guide

December 2021

Key CoPs related to role of the hospice physician

- § 418.52 Patient rights
- § 418.54 Initial and comprehensive assessment of the patient
- § 418.56 IDT, care planning, and coordination of services
- § 418.58 Quality assessment and performance improvement
- § 418.60 Infection control
- § 418.64 Core services
- § 418.100 Organization and administration of services
- § 418.104 Clinical records
- § 418.106 Drugs and biologicals, medical supplies, and durable medical equipment
- § 418.110 Hospices that provide inpatient care directly
- § 418.112 Hospices that provide hospice care to residents of a SNF/NF or ICF/MR
- § 418.114 Personnel qualifications

Background

The role of the hospice physician is a focus in the Medicare Hospice Conditions of Participation. The hospice must designate one physician to be the medical director and oversee the medical component of the hospice plan of care for each patient. The hospice medical director, and other members of the interdisciplinary team, must collaborate with the patient's attending physician to coordinate end of life care for the patient.

§ 418.52 Condition of participation: Patient rights

Every member on the Interdisciplinary team (IDT) has a responsibility to ensure that the patient rights outlined in this regulation are applied to every patient the same. Coordination of translation services and documentation that the patient/representative received notification of the rights is the responsibility of the IDT.

§ 418.54 Condition of participation: Initial and comprehensive assessment of the patient

- As a member of the IDT, the hospice physician should participate in the development of a comprehensive assessment tool that focuses on clinically meaningful information.
- This could include the selection of symptom assessment scales (and training staff to use them); development of processes for reviewing patient medication profiles (including determination of effectiveness, recognition of side effects, and anticipation of drug interactions); and consistent identification of patients in need of referral for evaluation by other health professionals.
 - The hospice physician reviews the medication profile at admission and determines which medications (if any) are not related to the patient's terminal prognosis.
- The hospice physician should also participate in the IDT task of assessing the patient's progress towards goals at least every 15 days.
- This COP requires measurement of outcomes. The hospice physician should offer expertise in the selection of data elements that are clinically relevant for the patient and recognized as valid for the hospice quality assessment and performance improvement program.

§ 418.56 Condition of participation: Interdisciplinary Team, care planning, and coordination of services

This COP affirms that the hospice physician is a member of the IDT. Although there are many important elements in this COP, the hospice physician should be attuned to the requirement that the plan of care "include all services necessary for the palliation and management of the terminal illness and related conditions."¹ This contains:

- Interventions to manage pain and symptoms;
- Measurable outcomes anticipated from implementing and coordinating the plan of care.
- Determination of related diagnoses and conditions.
- Determination of drugs and treatment necessary to meet the needs of the patient and related to the terminal prognosis.
- The hospice physician should be knowledgeable about available interventions and medications, the expected palliative benefits in the hospice population, and the likely ability to meet the needs of an individual patient.
- The physician should also help the team define and measure meaningful outcomes to assess effectiveness of these interventions and medications. In this way the hospice physician serves as a resource to the IDT and an advocate for the patient.

§ 418.58 Condition of participation: Quality assessment and performance improvement

- This COP requires hospices to “develop, implement, and maintain an effective, ongoing, hospice-wide data-driven quality assessment and performance improvement program.”²
- The hospice physician should participate in the selection of indicators related to improved palliative outcomes and the effectiveness and safety of service. Again, indicators should be valid and meaningful.

§ 418.60 Condition of participation: Infection control

- Per this regulation, education to patient/family and other members of the hospice team is a one of the three required components of the standard and nurses should be actively involved in any infection control program in the organization.
- Hospice physicians may also participate in the organization's infection control program and quality assessment/performance improvement activities related to infections control.
- All hospice staff should have ongoing education in a clear, concise format regarding the infection control program and impact on all staff and caregivers.
- All hospices should have a process and contingency plan for 100% vaccination for COVID-19 for all staff, a process for medical and religious exemptions, and a contingency plan for unvaccinated workers.

§ 418.64 Condition of participation: Core services

- This COP reaffirms that the hospice physician is “responsible for the palliation and management of the terminal illness and conditions related to the terminal illness.”³
- Thus, the hospice physician has a responsibility for the plan of care beyond providing medical advice to hospice staff during IDT meetings.
- The hospice physician also has a responsibility to collaborate with the patient's attending physician as needed to maintain an effective plan of care.
- Medical social services must be provided by a qualified social worker, under the direction of a physician.

§ 418.100 Condition of Participation: Organization and administration of services

- As a part of the organization, designated hospice services, and the IDT, physicians have the responsibility to optimize the comfort and dignity for a patient and provide care that is consistent with patient and family needs and goals, with patient needs and goals as priority.
- Physician services must be available all day, every day. (24/7)
- The hospice physician must be available to participate in such orientation, and the hospice must orient physicians to the hospice philosophy and “hospice-specific” elements of their position.

§ 418.102 Condition of participation: Medical director

- This COP, focuses on medical directors and hospice physicians, and requires a hospice to **designate one physician as medical director**.
- All physician employees and those under contract, must function under the supervision of the hospice medical director.

- Physician designee.
 - Another hospice physician may be pre-selected as the “physician designee” to fulfill the duties of the medical director as needed.
- The hospice physician must:
 - Have a formal relationship with the hospice (employment or contract).
 - Certify and recertify the patient’s prognosis taking into account a variety of clinical information.
 - The Medical Director must be responsible for the medical component of the hospice plan of care.

§ 418.104 Condition of participation: Clinical records

- The clinical record must contain accurate clinical information about the patient as recorded by hospice staff, the attending physician, the medical director, and any other entities involved with the patient’s care.
- A physician is one of the key documenters in the clinical record and needs to be aware of the requirements in the regulation.
- Physician documentation should include but is not limited to:
 - All certification of terminal illness requirements.
 - Clinical notes including documentation of medical judgment regarding why a diagnosis/condition, drug, treatment, etc. is not related to the terminal prognosis.
 - Clinical notes describing medical judgment related to a changed terminal diagnosis(s).
 - Clinical notes describing medical judgment related to patient discharge for no longer being terminally ill.

§ 418.106 Condition of participation: Drugs and biologicals, medical supplies, and durable medical equipment

- To comply with this CoP, hospice physicians can help “ensure that the IDT confers with an individual with education and training in drug management.”⁴⁴
 - The hospice physician may be that designated individual and/or may collaborate with the pharmacist member of the IDT. Further information on the qualifications of this individual will be available in the Interpretive Guidelines.
- The IDT, 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.
- The physician must ensure that verbal drug orders or electronic transmission are only given to a licensed nurse, nurse practitioner (where appropriate), or pharmacist.
- Patients receiving care in a hospice that provides inpatient care directly in its own facility may only be administered medications by the following individuals:
 - Licensed nurse,
 - Physician, or
 - Other health care professional in accordance with their scope of practice and State law.

§ 418.110 Condition of participation: Hospices that provide inpatient care directly

Key points of this condition directly related to patient care are the detailed focus on restraint and seclusion.

- The hospice physician working in a hospice that utilizes restraints and/or seclusion must complete a training program on the use of restraints and consult with hospice staff whenever the use of restraints becomes necessary.
- Hospice physicians must evaluate patients with restraint and/or seclusion orders at least every 24 hours and should be prepared to evaluate violent or self-destructive patients within 1 hour of ordering restraints or seclusion if other staff is not trained to do so.
- Hospice physicians should also be prepared to help the hospice determine if restraint and/or seclusion contributed directly or indirectly to a patient’s death, thereby making the death an event reportable to CMS.

§ 418.112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID

- A key point in this condition is the importance of the development of the patient plan of care and coordination of care between the hospice, the patient/family and the facility.
- When a hospice patient resides in a facility, hospice remains responsible for medical direction and management of the patient.
- The hospice physician should maintain collegial relationships with the medical staff of these facilities in order to help the hospice staff collaboration with these physicians.

§ 418.114 Condition of participation: Personnel qualifications

- **Licensure**
 - All professionals who furnish services directly, under an individual contract, or under arrangements with a hospice, must be legally authorized (licensed, certified or registered) in accordance with applicable Federal, State and local laws, and must act only within the scope of his or her State license, or State certification, or registration. All personnel qualifications must be kept current at all times.
 - Physicians must meet the qualifications and conditions as defined in section 1861(r) of the Act and implemented at 42 CFR 410.20 - Physicians' services. (govregs.com) of this chapter.
- **Criminal Background Checks**
 - All hospice employees (both paid and volunteer staff) who have direct patient contact or access to patient records must have a criminal background check.

Resources

- Physician section of MyNHPCO: [MyNHPCO | NHPCO](#) Professional networking community for member
- [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 Hospice Care Regulations [Code of Federal Regulations \(eCFR\)](#).
- ¹Electronic Code of Federal Regulations (eCFR) [42 CFR 418 Hospice Services](#)
- ²Electronic Code of Federal Regulations (eCFR) [42 CFR 418 Hospice Services](#)
- ³Electronic Code of Federal Regulations (eCFR) [42 CFR 418 Hospice Services](#)
- ⁴Electronic Code of Federal Regulations (eCFR) [42 CFR 418 Hospice Services](#)

Hospice Services Across State Lines

How will the information in this compliance guide sheet be helpful to my hospice?

To provide hospice services across state lines, hospices often need to obtain a separate Medicare provider number/certification for each state they serve. However, the Centers for Medicare and Medicaid Services (“CMS”) has established a process through guidance by which a hospice can provide such services without obtaining additional Medicare approval if the bordering states have a reciprocity agreement in place.

This compliance guide will provide an outline of key issues from the federal perspective that the hospice will need to consider, along with additional information regarding the reciprocity agreement and what your hospice can do if your state does not have one. References are identified throughout this document along with links to these important resources.

What does my hospice need to do to provide hospice services across state lines?

The *beginning* requirements are:

- Ensuring personnel are properly licensed in each state in which they provide services;
- Obtaining any necessary state licenses to operate a hospice program in the other state; and
- Meeting all other requirements of the border state survey agency.
 - If the hospice is required by the border state or otherwise wants to have an office or multiple location in the border state, refer to the NHPKO Hospice Multiple Locations tip sheet for additional information regarding the Medicare approval process for such location.

In addition to the above, the hospice must *also* determine whether the two bordering states have entered into a reciprocity agreement with each other.

Why does a reciprocity agreement matter?

When two bordering states have a reciprocity agreement with each other, hospices can provide services across those state lines without going through the lengthy process of obtaining a separate Medicare provider number/certification for the provision of hospice services in a second state. (Medicare State Operations Manual, Ch. 2, § 2085).

In other words, the hospice does not have to “start from scratch” from a Medicare certification perspective because the reciprocity agreement is approved by Medicare and provides assurances that both states are aware of their respective responsibilities for assessing the hospice’s compliance with the conditions of participation in their state. CMS has a model reciprocal agreement [Attachment B \(cms.gov\)](#).

How do I know if my state has a reciprocity agreement with a bordering state?

Since reciprocity agreements are entered into at the discretion of the two states at issue, it will be important to contact your state regulators and/or state survey agency in each state to determine if one exists.

What if a reciprocity agreement does NOT exist?

Hospices may attempt to convince the bordering state survey agencies to enter into such an agreement. It is possible that the hospice will need political assistance, such as intervention from elected officials or organized lobbying efforts, if states resist.

If efforts to convince the states to enter into a reciprocal agreement fail, this generally means the hospice will need to open a separate location in the bordering state and obtain a separate Medicare provider agreement/certification number for that location. The hospice may want to consider consulting legal counsel for assistance with this process.

What are some survey preparedness tips for hospices providing services across state lines?

CMS has not provided specific survey guidance related to the provision of hospice services across state lines. However, hospices will need to be prepared to answer questions and provide background information and documentation about their approval to provide hospice services in a second state without a separate Medicare provider number/certification.

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [eCFR :: 42 CFR Part 418 -- Hospice Care](#)
- [State Operations Manual, Ch. 2, § 2085](#)

Hospice Multiple Locations

How will the information in this compliance guide be helpful to my hospice?

The Centers for Medicare and Medicaid Services (CMS) has a process by which hospices can provide services through another practice location without obtaining a separate Medicare provider number/certification for that location.

This compliance guide provides key tips for hospices planning on opening multiple location(s) under their current Medicare provider number, along with survey guidance for those already operating multiple locations.

What is a hospice multiple location?

A hospice multiple location is another practice location of a hospice that is approved by CMS to operate under the hospice's existing Medicare provider number/certification. In other words, the hospice does not need to obtain a separate Medicare provider number/certification for that location.

Note, a multiple location must be approved by CMS prior to providing services and must also be able to meet the following regulatory standards:

- The multiple location must be part of the hospice and must share administration, supervision and services with the hospice issued the Medicare provider number/certification;
- The lines of authority and the professional and administrative control must be clearly delineated in the hospice's organizational structure and in practice, and must be traced to the hospice location with the Medicare provider number/certification; and
- The hospice must continually monitor and manage all services provided at the multiple location to ensure that services are provided in a safe and effective manner and to ensure that each patient and family receives the necessary care and services outlined in the plan of care.

Is there a specific mileage or distance requirement that is needed to be considered a multiple location rather than a separate Medicare hospice provider?

There is not a specific mileage or distance requirement identified by CMS in regulation or guidance. Through commentary, CMS has indicated it is the level of control and supervision exerted by the hospice over the multiple location, and not mileage limitations or staffing levels, that determines whether a site is a multiple location or a completely separate hospice location that requires its own Medicare provider number/certification. (See 73 Fed. Reg. 32088, 32092, 32134-32137 (June 5, 2008)). However, it is important to check with the state survey agency for guidance as some states have distance/mileage limitations.

What does not meet the definition of a hospice multiple location?

An equipment storage site or a site operated for the convenience of staff (such as a site where staff can complete paperwork or check messages) is not considered a multiple location and does not require Medicare approval. (See 73 Fed. Reg. 32088, 32092 (June 5, 2008)). However, state licensure laws may contain separate requirements for these locations.

What does a hospice need to do to provide services through a multiple location?

The Medicare hospice Conditions of Participation (CoPs) state that all hospice multiple locations must be approved by Medicare before providing hospice care to Medicare patients.

This is separate from any approvals provided by state survey agencies, whether for state licensure purposes or otherwise. The Medicare approval must be received from the CMS Regional Office.

How does a hospice begin the process for obtaining approval from the CMS Location (Regional Office)?

When an existing hospice with a Medicare provider number/certification wishes to add a multiple location, it must do the following to initiate the process for obtaining CMS approval of the new location:

- Notify, in writing, the CMS Regional Office responsible for the hospice's state, the state survey agency and, if deemed, its approved national accreditation organization of the proposed location; and
- Submit a CMS Form 855-A change of information request (including all supporting documentation) to the hospice's Medicare Administrative Contractor (MAC) before CMS approval can be granted.

Will a multiple location be surveyed as part of the approval process and how long does the approval process take?

Maybe. When the CMS Regional Office receives the request for a multiple location, it will evaluate the information and any supporting documentation. If a decision can be made based on the written application and supporting documentation, the CMS Regional Office will grant or deny approval without a survey. If circumstances warrant a survey, the CMS Regional Office will advise the hospice and make no further determination until a Medicare certification survey has been completed and submitted to the CMS Regional Office for review. The CMS Regional Office will notify the hospice of its decision in writing, but there are no specified time frames for the CMS Regional Office to act.

In contrast, a CMS Regional Office will not approve a hospice's inpatient facility or a change of location for a hospice's inpatient facility without a survey to assure that the facility meets all requirements in 42 C.F.R. § 418.110.

What factors will be considered to determine whether a multiple location will be approved?

The following factors are used by the CMS Regional Office and state survey agency to determine whether the new location meets all applicable Medicare requirements (Medicare State Operations Manual, Ch. 2, § 2088):

- Ability of the governing body to manage the location;
- Any changes made to the lines of authority, and professional and administrative control;
- Ability of the Medical Director to assume responsibility for the medical component of the hospice's patient care at all locations;
- Ability of the hospice to monitor and exercise control over services provided by personnel under arrangements or contracts at the multiple location;
- Changes in the interdisciplinary groups providing hospice services;
- Changes in staffing or the client population, or both;
- Changes in the way clinical records are maintained, protected and safeguarded against loss, destruction or unauthorized use; and
- Ability of the hospice to provide all hospice services at the multiple location.

Since a multiple location cannot provide services prior to approval from the CMS Regional Office, what can it do?

Before approval from the CMS Regional Office, a hospice may choose to utilize the multiple location as a convenience site or drop-off site for staff, if all necessary state approvals are obtained. However, providing any direct patient care activities (such as running IDT meetings) from the location may put the hospice at risk of a CMS determination that unapproved services were provided from the location and a possible denial of payments for claims. Note, to be "operational" for purposes of the site visit described below, it appears the multiple location would need to be as close to running without actually providing services. Only approved multiple locations may be listed in marketing materials, on website and on signage.

What is a site visit?

According to Medicare guidance, after the CMS Regional Office provides notice of approval to the MAC, the MAC orders a "site visit" to be performed by a National Site Visit Contractor (NSVC). The purpose of the site visit is to ensure the new location is in compliance with CMS's enrollment requirements. The NSVC will determine whether the following criteria are met, which will require the site visitor to enter the hospice's new multiple location/site, rather than simply conducting an external review (Medicare Program Integrity Manual, Ch. 15, §§ 15.4.1.7 and 15.19.2.2):

- The facility is open;
- Personnel are at the facility;

- Customers are at the facility (if applicable to that provider or supplier type);
- The facility appears to be operational.

If any of these elements are not met, the MAC may deny the enrollment application for the multiple location.

What are some survey preparedness tips for hospices already operating multiple locations?

Hospice surveys are to be conducted at least once every three years by an appropriate state or local survey agency or an approved accreditation agency. It is important to note that a deficiency identified at a multiple location applies to the entire hospice issued the certification number.

For purposes of preparing for upcoming surveys, the following are examples of the types of questions the hospice will need to be prepared to answer and the areas of review it will need to be able to support with evidence/documentation (State Operations Manual, Appendix M):

- How does the hospice assure that any multiple locations operating as part of the hospice share administration, supervision, services, and participate in the hospice's QAPI activities?
- How does the hospice communicate with the multiple location(s), and how does it show that the governing body and central administration are able to adequately manage the location, resolve any problems that occur and assure quality of care for all patients?
- Surveyors may conduct the entire survey or part of the survey at the multiple location(s). When conducting a survey at a multiple location, the surveyor may request that all necessary documentation for review be transported to the main location at the hospice's expense. This may include, but not be limited to, a sample of clinical records from all other locations, QAPI reports, administrative records, personnel files, and policies and procedures. There should be evidence that:
 - The hospice exerts the supervision and control necessary at each location to assure that all hospice care and services continue to be responsive to the needs of the patient/family at all times and in all settings;
 - Each location provides the same full range of services that is required of the hospice that was issued the certification number;
 - Each patient is assigned to a specific interdisciplinary team responsible for ongoing assessment, planning, monitoring, coordination and provision of care;
 - Each location is responsible to the same governing body and central administration that governs the hospice that was issued the certification number, and the governing body and central administration must be able to adequately manage the location and assure quality of care.

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services 42 CFR Part 418 Medicare Hospice Care Regulations [Code of Federal Regulations \(eCFR\)](#).
- [100 Condition of participation: Organization and administration of services](#)
- [State Operations Manual, Ch. 2, § 2085](#)
- [State Operations Manual, Appendix M](#)

Restraints or Seclusion Compliance Guide

The CoPs at § 418.110 - Hospices That Provide Inpatient Care Directly, specify a hospice provider's care requirements if restraint or seclusion is used for a patient.

- (m) Standard: Restraint or seclusion.
- (n) Standard: Restraint or seclusion staff training requirements.
- (o) Standard: Death reporting requirements.

The Requirements

Patient rights:

- All patients have the right to be free from physical or mental abuse, and corporal punishment. All patients have the right to be free from restraint or seclusion, of any form, imposed as a means of coercion, discipline, convenience, or retaliation by staff. Restraint or seclusion may only be imposed to ensure the immediate physical safety of the patient, a staff member, or others and must be discontinued at the earliest possible time.
- The patient has the right to safe implementation of restraint or seclusion by trained staff.
- *(Reference Sec. § 418.52 – Condition of Participation: Patient Rights)*

Use as a last resort:

- If a medication is prescribed to manage a patient's symptoms, it not considered a restraint.
- If a medication is prescribed to manage a patient's behavior, it is considered as a restraint.
- Restraint or seclusion may only be used when less restrictive interventions have been determined to be ineffective to protect the patient, a staff member, or others from harm.
- The type or technique of restraint or seclusion used must be the least restrictive intervention that will be effective to protect the patient, a staff member, or others from harm.
- Restraint is defined in the CoPs at § 418.3 as -
- Any manual method, physical or mechanical device, material, or equipment that immobilizes or reduces the ability of a patient to move his or her arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, or other methods that involve the physical holding of a patient for the purpose of conducting routine physical examinations or tests, or to protect the patient from falling out of bed, or to permit the patient to participate in activities without the risk of physical harm (this does not include a physical escort); or A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition.
- Guidance regarding bedrails
 - CMS suggested that hospice providers consult the language in the current long term care interpretive guidelines about bedrails. The language is as follows:
 - ▶ The use of side rails as restraints is prohibited unless they are necessary to treat a resident's medical symptoms. Residents who attempt to exit a bed through, between, over or around side rails are at risk of injury or death. The potential for serious injury is more likely from a fall from a bed with raised side rails rather than from a fall from a bed where side rails are not used. They also potentially increase the likelihood that the resident will spend more time in bed and fall when attempting to transfer from the bed. As with other restraints, for residents who are restrained by side rails, it is expected that the process facilities employ to reduce the use of side rails as restraints is systematic and gradual to ensure the resident's safety while treating the resident's medical symptom. The same device may have the effect of restraining one individual but not another, depending on the individual resident's condition and circumstances. For example, partial rails may assist one resident to enter and exit the bed independently while acting as a restraint for another.

Policy/procedure and documentation:

- If a hospice decides to use restraints or seclusion, the following must occur:
 - The use of restraint or seclusion must be—
 - ▶ In accordance with a written organizational policy and procedure.
 - ▶ In accordance with a written modification to the patient's plan of care.
 - ▶ Implemented in accordance with safe and appropriate restraint and seclusion techniques as determined by hospice policy in accordance with State law.

Physician orders and the patient plan of care:

- A physician authorized to order restraints or seclusion may do so in accordance with hospice policy and/or accordance with State law.
- Orders for the use of restraint or seclusion must never be written as a standing order or on an as needed basis (PRN).
- The medical director or physician designee must be consulted as soon as possible if the attending physician did not order the restraint or seclusion.
- Unless superseded by State law that is more restrictive—
 - Each order for restraint or seclusion may only be renewed in accordance with the following limits for up to a total of 24 hours:
 - ▶ 4 hours for adults 18 years of age or older;
 - ▶ 2 hours for children and adolescents 9 to 17 years of age; or
 - ▶ 1 hour for children under 9 years of age; and
 - ▶ After 24 hours, before writing a new order, a physician authorized to order restraint or seclusion by hospice policy in accordance with State law must see and assess the patient.
 - ▶ Each order for restraint used to ensure the physical safety of the non-violent or non-self-destructive patient may be renewed as authorized by hospice policy.
- Restraint or seclusion must be discontinued at the earliest possible time, regardless of the length of time identified in the order.
- The condition of the patient who is restrained or secluded must be monitored by a physician or trained staff that have completed the training criteria specified in paragraph (n) of this section at an interval determined by hospice policy.
- Physician, including attending physician, training requirements must be specified in hospice policy. At a minimum, physicians and attending physicians authorized to order restraint or seclusion by hospice policy in accordance with State law must have a working knowledge of hospice policy regarding the use of restraint or seclusion.
 - When restraint or seclusion is used, the patient must be seen face-to-face within 1 hour after the initiation of the intervention by a physician or Registered nurse who has been trained in accordance with the requirements specified in paragraph (n) of this section, to evaluate—
 - ▶ The patient's immediate situation;
 - ▶ The patient's reaction to the intervention;
 - ▶ The patient's medical and behavioral condition; and
 - ▶ The need to continue or terminate the restraint or seclusion.
- States are free to have requirements by statute or regulation that are more restrictive than those contained in paragraph (m)(11)(i) of this section. **Hospice providers must always adhere to the more stringent regulation.**
- If the face-to-face evaluation is conducted by a trained registered nurse, the trained registered nurse must consult the medical director or physician designee as soon as possible after the completion of the 1-hour face-to-face evaluation.
- Simultaneous restraint and seclusion use is only permitted if the patient is continually monitored:
 - Face-to-face by an assigned, trained staff member; or
 - By trained staff using both video and audio equipment. This monitoring must be in close proximity to the patient.

- When restraint or seclusion is used, there must be documentation in the patient's clinical record of the following:
 - The 1-hour face-to-face medical and behavioral evaluation if restraint or seclusion is used to manage violent or self-destructive behavior;
 - A description of the patient's behavior and the intervention used;
 - Alternatives or other less restrictive interventions attempted (as applicable);
 - The patient's condition or symptom(s) that warranted the use of the restraint or seclusion; and the patient's response to the intervention(s) used, including the rationale for continued use of the intervention.

Restraint or seclusion staff training requirements.

- Training intervals
 - All patient care staff working in the hospice inpatient facility must be trained and able to demonstrate competency in the application of restraints, implementation of seclusion, monitoring, assessment, and providing care for a patient in restraint or seclusion—
 - ▶ Before performing any of the actions specified in this paragraph;
 - ▶ As part of orientation; and
 - ▶ Subsequently on a periodic basis consistent with hospice policy.
- Training content.
 - The hospice must require appropriate staff to have education, training, and demonstrated knowledge based on the specific needs of the patient population in at least the following:
 - ▶ Techniques to identify staff and patient behaviors, events, and environmental factors that may trigger circumstances that require the use of a restraint or seclusion.
 - ▶ The use of nonphysical intervention skills.
 - ▶ Choosing the least restrictive intervention based on an individualized assessment of the patient's medical, or behavioral status or condition.
 - ▶ The safe application and use of all types of restraint or seclusion used in the hospice, including training in how to recognize and respond to signs of physical and psychological distress (for example, positional asphyxia).
 - ▶ Clinical identification of specific behavioral changes that indicate that restraint or seclusion is no longer necessary.
 - ▶ Monitoring the physical and psychological well-being of the patient who is restrained or secluded, including but not limited to, respiratory and circulatory status, skin integrity, vital signs, and any special requirements specified by hospice policy associated with the 1-hour face-to-face evaluation.
 - ▶ **Direct patient care staff must be trained in the provision of first aid techniques and cardiopulmonary resuscitation, including required periodic recertification.**
- Trainer requirements.
 - Individuals providing staff training must be qualified as evidenced by education, training, and experience in techniques used to address patients' behaviors.
 - **Training documentation.** The hospice must document in the staff personnel records that the training and demonstration of competency were successfully completed.

Death reporting requirements.

- Hospices must report deaths associated with the use of seclusion or restraint.
 - The hospice must report the following information to CMS:
 - ▶ Each unexpected death that occurs while a patient is in restraint or seclusion.
 - ▶ Each unexpected death that occurs within 24 hours after the patient has been removed from restraint or seclusion.
 - ▶ Each death known to the hospice that occurs within 1 week after restraint or seclusion where it is reasonable to assume that use of restraint or placement in seclusion contributed directly or indirectly to a patient's death. "Reasonable to assume" in this context includes, but is not limited to, deaths related to restrictions of movement for prolonged periods of time, or death related to chest compression, restriction of breathing or asphyxiation.

- ▶ Each death referenced in this paragraph must be reported to CMS by telephone no later than the close of business the next business day following knowledge of the patient's death.
- ▶ Staff must document in the patient's clinical record the date and time the death was reported to CMS.

Compliance Suggestions for Hospice Providers

- Know State law and determine whether it is more stringent than Federal requirements.
- Provide training that includes the criteria as defined in § 418.110(n)(2) for all inpatient hospice staff about restraints and seclusion. Document training and competency in staff personnel files. Make a list of trained personnel available at the inpatient IDT station at all times.
- Develop a documentation flow sheet for restraints and seclusion. Educate appropriate staff regarding its use.
- Educate all hospice physicians about the restraint and seclusion requirements and their need to communicate/coordinate with the attending physician ordering restraints and seclusion.
- If a hospice facility chooses to adopt a 'restraint-free' policy, then develop policy/procedure to address the plan for providing these interventions should the need arise.

References

- Part II - Department of Health and Human Services, Centers for Medicare & Medicaid Services
42 CFR Part 418 Medicare Hospice Care Regulations [112 Condition of participation: Hospices that provide hospice care to residents of a SNF/NF or ICF/IID](#)

Review of Contractual Agreements and Checklist

The Medicare hospice Conditions of Participation require a hospice provider to retain administrative and financial management responsibility, and oversight of staff and services provided under arrangement (See Regulatory text below). For arranged services, a contractual agreement should be in place and reviewed regularly to ensure that both sides of the agreement are fulfilled.

NHPCO has developed a general contract item checklist and SNF/NF or ICF/IID and Hospice Contract Item Checklist on the following pages to assist providers with periodic review of their contractual agreements to ensure compliance with the CoP. Surveyors will ask to review selected contractual agreements during a recertification survey and you want to ensure that all of your contracts are up to date, show that they were regularly reviewed, and that there is evidence that contract requirements were completed.

§ 418.100(e) Standard: Professional management responsibility

A hospice that has a written agreement with another agency, individual, or organization to furnish any services under arrangement must retain administrative and financial management, and oversight of staff and services for all arranged services, to ensure the provision of quality care. Arranged services must be supported by written agreements that require that all services be

- (1) Authorized by the hospice;
- (2) Furnished in a safe and effective manner by qualified personnel; and
- (3) Delivered in accordance with the patient's plan of care.

General Contract Item Checklist

CONTRACTOR NAME

CONTRACTOR START DATE

CONTRACTOR END DATE

CONTRACTOR REVIEW DATE

CHECK IF PRESENT	SERVICES TO BE PROVIDED
	Requirement that contractor is required to perform work in accordance with Hospice's applicable policies and procedures.
	Requirement that contractor assures that all personnel providing care have the education, training, and qualifications specified by Hospice.
	Show evidence of criminal background checks for contract employees, conducted either by the contract agency or the Hospice.
	Mechanisms for the contractor to participate in performance improvement activities.
	Procedures for scheduling visits and periodic patient evaluation.
	Procedures for submission of required patient related documentation that verifies the provision of services in accordance with the written service contract.
	Procedures for ensuring that contractor personnel records contain documentation required by Hospice.
	Procedure for hospice assurance that services are furnished by qualified staff.
	Stipulation that Hospice will retain responsibility for evaluating services, maintaining professional management responsibility, and ensuring continuity of care in all settings through its QAPI program and/or corporate compliance program.
	Stipulation that all care provided will be in accordance with the hospice plan of care and documented in the clinical record.
	Procedures for the submission of invoices and related information and reimbursement for care provided.
	Procedures for receiving clinical documentation or summaries from the contractor in accordance with Hospice policies.
	Effective date and term of the contract.
	Contract renewal terms specified and followed.
	Signed and dated by both the Hospice Administrator and Contractor.

SNF/NF or ICF/IID and Hospice Contract Item Checklist

CONTRACTOR NAME

CONTRACTOR START DATE

CONTRACTOR END DATE

CONTRACTOR REVIEW DATE

CHECK IF PRESENT	CONTRACT PROVISIONS
	A system is in place to assure that the facility knows how to notify the hospice when necessary on a 24/7 basis (§ 418.112(c)(1))
	A system for communicate between SNF/NF or ICF/IID staff and hospice staff is documented to ensure that the needs of patients are addressed and met 24 hours a day
	Provision is included stating that the SNF/NF or ICF/IID immediately notifies the hospice if: <ul style="list-style-type: none"> (i) A significant change in a patient’s physical, mental, social, or emotional status occurs; (ii) Clinical complications appear that suggest a need to alter the plan of care; (iii) A need to transfer a patient from the SNF/NF or ICF/IID arises, 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 (iv) A patient dies (§ 418.112(c)(2))
	Provision is included stating that the hospice assumes responsibility for determining the appropriate course of hospice care, including the determination to change the level of services provided (§ 418.112(c)(3))
	Provision is included stating that there is an agreement that it is the SNF/NF or ICF/IID responsibility to continue to furnish 24 hour room and board care, meeting the personal care and nursing needs that would have been provided by the primary caregiver at home at the same level of care provided before hospice care was elected (§ 418.112(c)(4))
	An agreement is in place that states 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 (§ 418.112(c)(5))
	Provision is included stating that a delineation of the hospice’s responsibilities, which include, but are not limited to the following: providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary and bereavement); 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; and all other hospice services that are necessary for the care of the resident’s terminal illness and related conditions (§ 418.112(c)(6))
CHECK IF PRESENT	SERVICES TO BE PROVIDED
	A provision is included stating that the hospice may use the SNF/NF or ICF/IID nursing personnel where permitted by State law and as specified by the SNF/NF or ICF/IID to assist in the administration of prescribed therapies included in the plan of care only to the extent that the hospice would routinely use the services of a hospice patient’s family in implementing the plan of care (§ 418.112(c)(7))
	A provision is included stating that hospice must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by anyone unrelated to the hospice to the SNF/NF or ICF/IID administrator within 24 hours of the hospice becoming aware of the alleged violation (§ 418.112(c)(8))
	A provision is included stating that there is a delineation of the responsibilities of the hospice and the SNF/NF or ICF/IID to provide bereavement services to SNF/NF or ICF/IID staff (§ 418.112(c)(9))
	Effective date and term of the contract.
	Agreement is signed by authorized representatives of the hospice and the SNF/NF or ICF/IID before the provision of hospice services (§ 418.112(c))

Survey Materials Checklist

December 2021

The following are materials surveyors for Medicare will most likely request from a hospice provider during an active recertification survey, but it is not inclusive of all materials that may be requested for review. Continuous update of these materials is recommended in order to remain survey ready.

NOTE: *This guide does not address state licensure or accreditation requirements.*

Administrative information:

- List/addresses of all sites, branches and services provided, if applicable including inpatient facilities (either directly or under agreement)
- Organizational Chart (includes to patient level)
- Map/listing of geographical area served
- All state licenses, accreditation certificates, etc. as applicable
- CLIA waiver and waived tests being performed, if applicable
- Names of key staff (clinical staff who will be primary resource during survey)
- RN coordinator, person with most knowledge of hospice aides, volunteers, infection control, QAPI, Inservice training, clinical supervision, bereavement)
- Active employee list by discipline, title
- Policy and procedure manual(s)
- Emergency Response Plan
- Governing Body meeting minutes
- List of contracted facilities, hospitals, agencies, pharmacies, DME, ambulance, contracted staff (have current contracts available).
- Number of unduplicated admissions in last 12 months
- Number of current patients who are receiving hospice care at home, in an inpatient facility, SNF/NF or other facility
- List of all active patient names: election date, diagnosis, date of initial assessment.
- List of patients with scheduled visits during survey
- IDT meeting dates/times
- Access to patient records
- Access to bereavement records for expired patients during past 12 months
- Admission Packet/materials given to patient on admission
- Marketing Materials (will be reviewed for listing of services and locations)
- Documentation of grievances/complaints received last 12 months
- Quality assessment performance improvement (QAPI) program (see § 418.58 Compliance Guide for QAPI for additional information); QAPI Plan; aggregated data and analysis; evidence of current and completed Performance Improvement Projects for the last 12 months; individuals responsible for the QAPI Program; Evidence of functioning QAPI program; evidence of management and governing body review
- Infection control program
- Volunteer program information including list of active volunteers and personnel files (as requested). (See Sec. § 418.78 Compliance Guide for Volunteers for more information)

Hospice staff information:

- Staff in-service calendar
- Documentation of hospice aide training and/or competency evaluations and in-service training
- Personnel files (as requested)

- Government requirement: "Make forms available for inspection if requested by authorized U.S. government officials from the Department of Homeland Security, Department of Labor, or Department of Justice
- I-9
- Health File
 - Checklist per Federal, state and agency policy
 - If the health file has drug screen, TB/chest x-ray, COVID-19 vaccination status in each personnel file, then all other health information should not be available to the surveyor for HIPAA reasons – including workers compensation, HIV, other health issues
- Medical Director/Associate Medical Director
 - Copy of license
 - DEA registration
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, COVID-19 vaccination status
 - Criminal background check
- Nurse, social worker
 - Copy of license (Nurses always, SW per state)
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, COVID-19 vaccination status
 - Criminal background check
- Hospice aide
 - Copy of certification (if any)
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, COVID-19 vaccination status
 - Criminal background check
 - Evidence of 12 continuing education hours in a 12-month period
- Spiritual professional
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ra, COVID-19 vaccination status y
 - Criminal background check
- Therapists (PT, OT, SLP) (if contracted, agency should be responsible to provide)
 - Copy of license
 - Proof of Certificate of Clinical Competence for SLP
 - Orientation checklist
 - Annual competency per policy
 - Health file with drug screen, TB, or Chest x-ray, COVID-19 vaccination status
 - Criminal background check

Hospice Office Information:

- Required Postings (Federal, State, Agency)
- Environmental Safety Check e.g., Lighted EXIT signs, fire extinguishers, etc.
- Office Evacuation Plan/Route
- Medical Supplies stored properly, and expirations dates checked
- Biohazardous Waste Container (only for in office usage) stored properly

Hospice and End of Life Care and Services Critical Element Pathway

This [document](#) is the Department of Health and Human Services (HHS) and Center for Medicare & Medicaid Services (CMS) hospice patient interview guide for surveyors. It can be used to prepare for the survey to understand what will be asked of providers in multiple areas of review, including patient and staff interviews.

Find the most up-to-date document at CMS website. Select LTC Survey Pathways then CMS-20073 Hospice and End of Life.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Hospice and End of Life Care and Services Critical Element Pathway

Use this pathway for a resident identified as receiving end of life care (e.g., palliative care, comfort care, or terminal care) or receiving hospice care from a Medicare-certified hospice.

Review the Following in Advance to Guide Observations and Interviews:

- Review the most current comprehensive and most recent quarterly (if the comprehensive isn't the most recent) MDS/CAAs for areas pertinent to the resident's end of life care, services, and needs.
- Physician's orders (e.g., hospice or end of life services, advance directives, pain interventions, medications).
- Pertinent diagnoses.
- Care plan (e.g., advance directives; provision of ADLs; symptom management including controlling nausea, agitation, pain, uncomfortable breathing; pressure ulcer prevention interventions; nutrition and hydration needs; psychosocial interventions; coordination of care with hospice).

Observations:

- Are care planned and ordered interventions implemented and meeting the resident's needs? If not, describe the discrepancies.
- Whether ADLs (including oral care) are provided to address the resident's comfort and dignity.
- Whether skin integrity interventions are implemented (e.g., repositioning) to ensure the resident is comfortable.
- Whether the facility is meeting the resident's choices and preferences (e.g., bathing, toileting, sleep schedule, activities).
- Whether the resident appears to be agitated, apprehensive, withdrawn, or restless? If so, how are these symptoms being addressed?
- Whether the type, amount, consistency of food and fluids provided meets the resident's needs. If not, describe the deficiencies.

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

Hospice and End of Life Care and Services Critical Element Pathway

Resident, Representative, or Family Interview:

- Whether the resident/representative is aware of:
 - o The name of the facility interdisciplinary team member/designee who is responsible for working and coordinating with the hospice team for communicating concerns regarding the provision of care; and
 - o How to contact the facility's designated coordinator.
- If receiving hospice care, have you had any concerns with your hospice care? If so, what are your concerns and do you know who to talk to and how to contact that person?
- How did the facility involve you in the development of the care plan and goals regarding your care?
- Do you feel like the care you are receiving reflects your choices and preferences?
- Were you involved in making choices on the type of care and treatment you are receiving? Do you have an advance directive (according to State law) and is staff aware of your directives? If not, have you or your representative received information on advance directives?
- Has your care changed recently? If so, were you involved in revisions or changes for care and treatment?
- Are you experiencing any symptoms (e.g., pain, breathing difficulty, constipation)? How are your symptoms being managed?
- Have you experienced any anxiety, depression, or grief? How are these needs being addressed?
- Have you declined any treatments? Why? Did staff find out the reason for the refusal and try to offer alternatives?
- Do you think the coordination of care between the hospice and facility is meeting your needs? If not, why not? Have you notified staff? Who? What was the resolution?

Staff Interviews (Nursing Aides, Nurse, Hospice Staff, Designated Hospice Coordinator, DON):

- Can you describe the resident's goals for care and treatment at the end of life?
 - What is the basis for the determination that a resident is approaching the end of life?
 - How do you monitor and document symptoms, implement interventions, and document effectiveness of the interventions? Who do you report any changes to?
 - If the resident is transferred to the ER or hospital, how are the resident's choices and preferences regarding care communicated, including advance directives, if applicable?
 - If the resident is receiving hospice care, determine:
 - o Whether nursing home staff understand the hospice philosophy and practices;
 - o Who is the facility designated IDT member that communicates with hospice and whether he/she meets the qualifications; and
 - o What and how often does the IDT member communicate with hospice.
- NOTE: If concerns, see F849 for the hospice written agreement
- Can you describe the ongoing (24/7) communication and coordination process between the facility and hospice?
 - Can you describe your responsibilities compared to what hospice provides?
 - How do you share concerns and responses and who coordinates the resident's care with the hospice?
 - How do you communicate with the resident or resident representative, hospice, and the practitioner any change to the resident's condition that may reflect the need to modify or revise the coordinated care plan?
 - If care plan concerns are noted, interview staff responsible for care planning as to the rationale for the current care plan. NOTE: If concerns are identified with coordination of care, communication with the hospice, or responses to concerns, interview the facility-delegated coordinator. It may be necessary to interview the designated hospice coordinator regarding resident concerns.

SECTION TWO: During the Survey

1

PRESURVEY PREPARATION

2

DURING THE SURVEY

3

AFTER THE SURVEY

4

ENFORCEMENT

Responding appropriately during a survey is a fundamental component of a successful survey. Knowing what a survey will encompass will help a hospice be prepared. The survey will include a review of documents, clinical records, patient visit(s), IDT attendance, and interviews with various leaders and staff. Resources are provided to assist the hospice during the survey.

IDT Guidance to the Survey Process

Surveyor Focus

The Conditions of Participation (CoPs) were updated by the Centers for Medicare and Medicaid Services (CMS) in 2008. With that update, the hospice survey process emphasizes outcome-oriented performance and its effect on patients. The survey process directs the surveyor to focus on the services being provided, and then to examine the structures and processes that contribute to the quality of service provision. The primary focus of the survey is on patient outcomes, the hospice's practices in implementing the requirements, and provision of hospice services. The surveyor considers the interrelatedness of the regulations while evaluating compliance through observations, interviews, home visits, and clinical record reviews. The interdisciplinary staff is at the heart of each of these areas.¹

In late 2020, Congress passed the Consolidated Appropriations Act of 2020, which included significant changes to the hospice survey process and added enforcement remedies. Hospice survey frequency is now required at least once every 36 months. The implementing regulations outline a focus on the four Conditions of Participation that most impact quality hospice patient care. They are:

- § 418.52 Condition of participation: Patient's rights.
- § 418.54 Condition of participation: Initial and comprehensive assessment of the patient.
- § 418.56 Condition of participation: Interdisciplinary team, care planning, and coordination of services
- § 418.58 Condition of participation: Quality assessment and performance improvement.

Providers should expect increased surveyor focus for these four conditions of participation. In addition, CMS has directed surveyors to provide additional scrutiny for § 418.60 – Infection Control to review processes in place to address COVID-19 infections. CMS has also issued additional guidance about the implementation of the CMS COVID-19 Vaccine Mandate, with a goal of 100% staff vaccination in early 2022, according to deadlines listed in the CMS guidance at [QSO 22-007-ALL](#), [22-009-ALL](#) and [22-011-ALL](#) Hospice guidance ([Attachment C](#)). More detail on the implementation of the CMS COVID-19 mandate can be found in Regulatory Alerts at the NHPCO Regulatory & Compliance Center.

Example Review Questions for Clinicians

During active survey, a surveyor may interview specific interdisciplinary staff as part of the survey process. The purpose of staff interviews is to substantiate and support any findings of non-compliance with the CoPs. These questions may include, but are not limited to:

- Who is your supervisor and how is he/she contacted regardless of your schedule?
- What is the agency policy for completing initial and comprehensive assessments and the IDT Plan of Care?
- How do you review the most current orders for treatments and medications?
- How do you document and report a change in the patient's condition?
- How do you get report and give report to your Supervisor and the other IDT team members?
- How do you share patient updates with other interdisciplinary team members?
- How are medications reconciled? What is the duty of the RN when discrepancies are found?
- How do you involve the patient and/or family in developing the plan of care?
- How does the RN supervise aides and LPNs? What is the frequency of supervision visits?

The Purpose of Home Visits

Accompanying hospice staff on home visits yield a surveyor valuable information about how a hospice operates and complies with the regulations. Some of the areas that the surveyor will investigate can include, but are not limited to how a hospice:

- Promotes and protects the rights of patients
- Conducts the initial and comprehensive assessments
- Updates the comprehensive assessment
- Implements and updates the plan of care
- Promotes patient/family satisfaction
- Provides drugs, treatments, services and durable medical equipment (DME)
- Uses volunteers for patient and administrative support
- Provides the required level of care related to the needs of the patient

Choosing Patients for Home Visits

The surveyor will complete 3-5 home visits with hospice staff based the hospice's total number of unduplicated admissions during a recent 12-month period. The surveyor identifies and selects patients who will receive hospice services during the remaining days of the survey. Additional home visits may be made as needed to determine the scope of any concerns initially identified by home visits or record reviews.

- The good news is many times the hospice will have control regarding the list of patient visits that is provided to the surveyor. This will enable the hospice to recommend patients with strong or experienced clinicians as staff for a home visit.
- Patients selected for a home visit will have their clinical record reviewed by the surveyor either before or after the visit.
- Patient consent - Patients must understand that a home visit from a surveyor is voluntary and refusal to consent to a home visit will not affect Medicare/Medicaid benefits to which they are entitled.
 - The hospice will contact the patient/representative or family to determine if they will allow a home visit from a surveyor.
 - If the patient/representative or family agrees, the patient (or representative) should sign the hospice visit consent form before beginning the visit.
- Patients with different terminal diagnoses in different care settings receiving routine home care (i.e., private residence, nursing facility, etc.,) will be selected for a home visit. **NOTE:** If in reviewing contracts or other documentation (i.e., clinical records, plans of care), questions arise concerning the hospice's provision of inpatient care, either directly or under arrangements, a surveyor will conduct an onsite visit to the facility providing the inpatient services to review the care provided.
- The surveyor will select home visits with different individuals providing the services (i.e., nurse, social worker, hospice aide).

The Home Visit

Interdisciplinary staff whose patient is selected for a home visit may be nervous to have a surveyor accompany them on a visit. That is very normal. Knowing what to expect from the surveyor during the visit should help staff to calm their nerves.

- Getting the surveyor to the home visit
 - The surveyor will usually ride with a hospice staff member to a patient visit.
 - To lessen the interdisciplinary staff member's anxiety, it is recommended that the clinical director or manager drive the surveyor to the home visit. The clinical director or manager can then observe the visit and provide support to the interdisciplinary staff member.
- Surveyor's role:
- He/she will talk with the patient, family/caregiver or both and let them know that the primary purpose of the home visit is to evaluate the effectiveness of the hospice's services.
 - He/she will observe the communication and care provision of the hospice team member.
 - He/she may ask the patient, family/caregiver questions during the home visit. These questions may include but are not limited to:
 - ▶ Who comes to see you from the hospice?
 - ▶ How frequently do you receive care and services?

- ▶ Has the nurse talked with you about treating your pain and/or other uncomfortable symptoms?
- ▶ Have there been any instances where the hospice failed to respond to the patient's request for pain medication or symptom management?
- ▶ Have you ever had to wait long to get medication for discomfort? If yes, how long was the wait?
- ▶ Has someone from the hospice given you a chance to talk about your religious or spiritual beliefs or concerns?
- ▶ Have you ever needed to call the hospice on weekends, evenings, nights, or holidays? What was your experience with this?
- ▶ Have you received care in any other setting while under hospice care? If so, what was your experience?
- ▶ Since you have been receiving care from the hospice, have you had any out-of-pocket expenses for your health care? If yes, what kind?
- ▶ How satisfied are you with the services provided? Do you have any suggestions for improvement?
- ▶ Would you recommend this hospice?
- Interdisciplinary staff role:
 - Provide care to patient and family per the updated patient plan of care.
 - Address previously identified patient problems and progress towards identified goals.
 - Observe and comply with your organization's infection control policy/procedure during the home visit.
 - ▶ Pay close attention to managing infection control of your clinical bag, your equipment (i.e., Stethoscope), and hand washing while you are on the visit.
 - Ensure that translation services are coordinated for all visits when they are required. Family should not be used as translators unless the patient specifically requests that accommodation.
 - Hospice staff should be respectful and courteous to the surveyor even if you disagree with his/her interpretation of a regulation. If this occurs during a home visit, save that discussion for after home visit and outside of the patient's home.

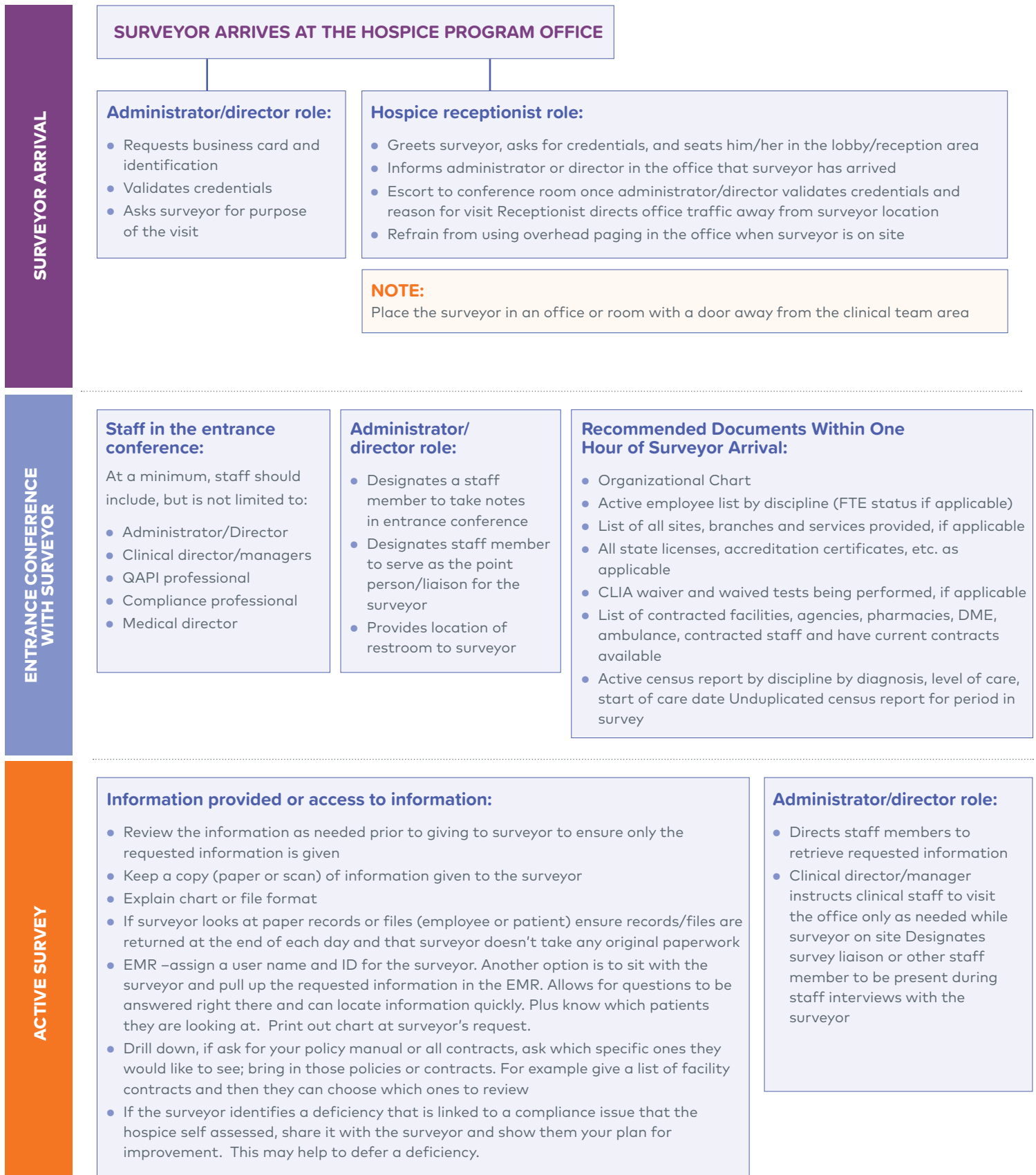
Post Home Visit

- If hospice deficiencies are identified as a result of a home visit and/or clinical record review, the surveyor will cite these deficiencies on the Statement of Deficiencies and Plan of Correction (Form CMS-2567). These deficiencies could include, but are not limited to:
 - Failure to promote and protect the patient's rights
 - Failure to accurately conduct a patient-specific comprehensive assessment that identifies the patient/family's need for hospice care and services, and the patient/family's need for physical, psychosocial, emotional, and spiritual care
 - Failure to develop and implement a plan of care that meets the needs identified in the initial or comprehensive assessment
 - Failure of the IDT to meet the physical, medical, psychosocial, emotional, and spiritual needs of the hospice patient/family
 - Failure to provide all covered services, as necessary, including the continuous home care level of care, respite care and short-term inpatient care
 - Failure to provide nursing and physician services, drugs and treatments on a 24- hour basis
 - Failure to retain professional management responsibility for all hospice services provided under contract to patients
 - Failure to develop, implement, and maintain an effective, ongoing, hospice-wide data-driven QAPI program.

Resources

- ¹Centers for Medicare and Medicaid Services. State Operations Manual Appendix M - Guidance to Surveyors: Hospice. Appendix M is the complete guide for surveyors on the hospice survey process, including the Interpretive Guidelines. Use this link for the latest updates to [Appendix M](#).

Survey Process Map – Hospice Administrative/Office Staff



Survey Process Map – Hospice Administrative/Office Staff

ACTIVE SURVEY

Surveyor liaison role:

- Provide materials requested by surveyor
- Answer surveyor questions or coordinate appropriate staff to answer questions
- Report progress and any issues to the administrator/director throughout the survey

Surveyor activity:

- Reviews administrative materials and clinical records Interviews staff members
- Accompanies clinical staff on home visits
- Audits an IDT meeting

Compliance professional's role:

- Review clinical record before the surveyor (if possible) to become aware of any compliance issues
- Ensure that no patient personal health information (PHI) is unsecured in the office
- Remain available to the surveyor, administrator, and surveyor liaison

NOTE:

It is allowable to respectfully disagree with a surveyor's interpretation of a regulation or question his/her frame of reference for an interpretation.

EXIT CONFERENCE WITH SURVEYOR

Staff in the exit conference:

At a minimum, staff should include, but is not limited to:

- Administrator/Director
- Clinical director/managers
- QAPI professional
- Compliance professional
- Medical director

Administrator/director role:

- Designates a staff member to take notes in exit conference
- Questions/clarifies all outcomes presented by the surveyor as needed
- Plan preliminary actions and approach to plan of correction based on exit conference

NOTE:

There may be issues cited on the final written plan of correction that were not discussed by the surveyor in the exit conference so be prepared to respond to these issues upon receipt of the final report and plan of correction

SECTION THREE: After the Survey

1

PRESURVEY PREPARATION

2

DURING THE SURVEY

3

AFTER THE SURVEY

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ENFORCEMENT

If a surveyor finds the hospice out of compliance, survey deficiencies will be cited, and a plan of correction written and implemented by the hospice will be required. The resource in this section provides guidance in understanding and responding to survey deficiencies.

Hospice Survey Plan of Correction - Compliance Guide for Hospice Providers

Why are Plans of Correction more important to hospices than ever before?

Hospice surveys are required at least once every 36 months by a survey agency or approved accrediting organization.

The surveyor will complete 3-5 home visits with hospice staff based the hospice's total number of unduplicated admissions during a recent 12-month period. The surveyor identifies and selects patients who will receive hospice services during the remaining days of the survey. Additional home visits may be made as needed to determine the scope of any concerns initially identified by home visits or record reviews.

The on-site survey is often a stressful experience. However, the hard work of a hospice is just beginning, as the hospice will have just ten calendar days upon receiving the written Statement of Deficiencies – Form CMS-2567 (SOD) to complete and submit a Plan of Correction (POC) that effectively addresses the alleged deficiencies.

Submitting a POC that will be acceptable to surveyors is critical to the hospice avoiding the significant consequences - including imposition of enforcement remedies (effective October 1, 2022) or termination of the hospice's provider agreement under Medicare - that could result from a rejected POC. This tip sheet is designed to furnish some relief to hospices in this stressful time by providing key tips for hospices regarding drafting and implementing a POC. This compliance guide describes the core requirements of a POC, and then identifies common POC pitfalls and solutions.

Note this resource is general in nature and focuses on the federal survey process administered by CMS. State survey agencies that are reviewing state licensure regulations and accreditation bodies may have additional requirements and expectations.

What are the core elements of a POC?

A POC must describe the corrective actions that the hospice will take to remedy an alleged deficiency and come into compliance with applicable regulations. A POC is typically required to be developed for all cited deficiencies, whether the deficiency is a standard or condition level deficiency. CMS guidance and Form CMS-2567 generally describe CMS's requirements concerning the content of a POC. In essence, a POC has three primary components, which require a hospice to:

- **Directly and specifically** describe the measures the hospice will put into place to take corrective action and ensure the alleged deficient practice does not recur.
- **Identify the monitoring procedures** the hospice will institute to ensure compliance is maintained into the future.
- **Identify proposed completion dates** and responsible parties for the corrective actions.

Each of these components is further explored below.

How does a POC directly and specifically address an alleged deficiency?

A POC should address the root cause of a deficiency and describe the corrective action that the hospice will take to address and correct it. The root cause could be multi-faceted, including lack of staff training, lack of adherence to the hospice's policies and procedures and/or failure to establish appropriate policies and procedures. The corrective action should be specific and tailored to address the root cause(s). For example:

- If the alleged deficiency resulted from an insufficient policy, then the corrective action should include a change in that policy and a description of the new policy.
- If the alleged deficiency related to staff failing to follow policy or a patient's plan of care, then the corrective action should address retraining staff.

In addition to identifying the corrective measures, the POC should address how each corrective measure will be implemented. In other words, it isn't enough to state that you reviewed, revised or created new policies, but the hospice needs to explain how it will make sure these measures are communicated and followed by staff. For example, once the policy is reviewed and revised, it will need to be distributed and then staff will need to be educated accordingly. Hospices should maintain written documentation of these implementation measures, so they can "prove" to surveyors, if needed, that the POC was followed.

What kinds of monitoring procedures should be included in a POC?

The kind of monitoring procedure that must be included in a POC is likely to vary depending on the nature of the citation. The goal of any monitoring procedure is to ensure ongoing compliance by demonstrating through testing and/or observation that the alleged deficiency has been resolved and will not recur.

The monitoring procedure may be as simple as observing a particular employee's performance at a certain task following retraining. A deficient practice that is severe and/or widespread may require a more complex monitoring procedure that includes multiple elements, such as:

- The methodology used to determine compliance (e.g., audit a sample of or x number of medical records)
- The frequency with which this methodology is implemented (e.g., once/week, once/month, etc.) and to whom the results of the monitoring procedure are provided
- Threshold for compliance (i.e. 90% or 100%).
- The action plan if further non-compliance is detected (e.g., increase frequency of record audits, conduct further education, etc.)

What completion date should the hospice include on the POC?

Consistent with applicable guidance, hospices are expected to identify an anticipated time of correction, or "completion date," for each identified deficiency. The completion date may trigger further contact from the surveyor - by phone, mail, or in person (a revisit survey) - to verify that the corrective action has been completed. While regulations set a general expectation that deficiencies will be corrected within sixty (60) days, CMS has concluded that certain deficiencies may require more or less time for corrective action.

If a deficiency relates directly to patient care and/or if the corrective action is simple, a surveyor is more likely to require an immediate or otherwise prompt completion date - a much shorter time frame than the sixty (60) days alluded to in the regulations. If a deficiency relates to administrative matters and/or if the corrective action is complex, a surveyor may allow for a more generous completion date.

In selecting a compliance date, hospices should be mindful of whether surveyors will need to complete an on-site revisit to verify compliance, as the compliance date will need to be far enough in advance to assure the surveyors can complete the revisit prior to the date on which significant consequences would be imposed (for example, the 90-day time frame in which condition level deficiencies must be corrected and verified by the surveyors to avoid additional enforcement remedies (after October 1, 2022) or termination of the hospice's provider agreement with Medicare).

Who should be identified as the person responsible for implementing a POC?

An often overlooked requirement, the POC must identify the person responsible for implementing each element of the POC. This can be a job title or a person. However, it should be the person who will actually personally oversee the implementation of that POC.

What if you disagree with the findings in the SOD, do you still need to submit a POC?

Although a hospice can use Form CMS-2567 to attempt to refute alleged deficiencies in lieu of submitting a POC that process is limited to providing indisputable documented evidence that refutes a factual finding of the surveyor. A POC is not the proper place to state a disagreement over the judgment of the surveyor regarding the level, extent, scope, or severity of a deficiency. With that said, the SOD is a public document and a hospice may wish to include a disclaimer similar to the following on its POC to make clear that you don't necessarily agree with the citations as written but are providing the POC because it is a requirement of both federal and state regulations. Note that state survey agencies have discretion on whether they will allow disclaimer language on the POC and therefore acceptance could vary state to state.

This plan of correction constitutes our written allegation of compliance for the deficiencies cited. However, submission of this plan of correction is not an admission that a deficiency exists or that one was correctly cited. This plan of correction is submitted to comply with state and federal laws.

What are some common problems with POCs, and how can they be addressed?

POCs are rejected for a number of reasons. Following the above tips regarding root causes, specificity, and monitoring will help protect the POC from rejections. In addition, certain shortcomings in a POC appear to arise frequently, but can be avoided:

- **Completion dates are not identified.** Each identified deficiency should have a "completion date" for the corrective action and each completion date should be tailored to that deficiency. In other words, a POC can (and perhaps should) have different completion dates for different deficiencies. For example, a deficiency resulting from a poor policy may require only a few days to revise the policy, whereas a deficiency that requires multiple steps to correct may have staggered completion dates for each step. Including different completion dates tailored to the specific deficiency demonstrates that the hospice is appropriately prioritizing corrective actions.
- **Completion dates are not prompt enough.** Extended completion dates are among the easiest reasons for a surveyor to reject a POC. Do not default to whatever the perceived maximum time frame for completion can be. Also, do not delay in taking corrective action until after a POC is submitted or approved. Instead, implement corrective actions immediately after the survey, so that the POC can reflect those certain actions already are underway or completed.
- **Overpromising.** A hospice must be realistic in both the corrective measures identified and the compliance date alleged. Failing to do so may create bigger problems for the hospice, including a failed revisit. In short, you want to avoid overpromising on corrections and completion dates, which means eliminating items that are not essential to correcting the cited concerns and identifying a date for compliance that can be met. Even if items are not included in a POC, however, the hospice still may voluntarily undertake additional actions if it is in its interest to do so - the POC serves as a floor, not a ceiling, for the actions a hospice can take.
- **Insufficient monitoring.** The monitoring procedure is an area that often is overlooked or addressed too generally in a POC, which can result in rejection. For example, a monitoring procedure that only states that records will be audited on an ongoing basis to verify compliance will likely be rejected. The monitoring procedure must identify how outcomes will be measured so the effectiveness of the corrective action can be determined, it should identify who among the management team will be informed about the results of the monitoring procedure, and it should identify the actions that will take place in the event that further non-compliance is detected.

In addition to POC development, a hospice must ensure oversight of Plan of Correction to ensure it is implemented as noted. Suggestions include the following:

- Establish a POC implementation tracking process.
- Incorporate into hospice QAPI Program priorities, with scheduled review of the POC to address any areas not meeting deadlines or achieving improvement.
- Report to Governing Body regularly regarding progress.
- **Hold staff accountable for responsibilities related to POC implementation and overall compliance with the CoPs on an ongoing basis.**

References

- [State Operations Manual, Ch. 2, Section 2728 - Statement of Deficiencies and Plan of Correction, Form CMS-2567](#)
- [State Operations Manual, Ch. 2, Section 2728B - PoC](#)
- [State Operations Manual, Appx. M, Parts I.C. and III](#)
- [42 C.F.R. § 488.28\(d\)](#)
- [CY 2022 Home Health Final Rule – Hospice Survey Reform and Enforcement Remedies](#), November 9, 2021
- [NHPCO Regulatory Alert on CY 2022 Home Health Final Rule](#), November 8, 2021

Understanding Medicare Certification Deficiencies

Part of being survey ready is understanding the survey process and the possible deficiencies that could result from non-compliance. Survey deficiencies are gauged by a surveyor in degree and manner of the deficiency. Criteria for determining a deficiency include:

- Effect and potential effect on a patient that includes actual or negative outcomes
- Frequency of the practice
- Degree of severity of the practice
- The relationship between the practice and clinical supervision
- Effect on patient service delivery

A surveyor can apply three types of deficiencies depending on the above criteria.

- **Standard level deficiency** means that a provider is not compliant with one of the standards under a condition of participation.
 - Survey outcome - A hospice remains certified with this type of deficiency, but they will need to submit a plan of correction to the survey agency describing how the deficiencies will be mitigated.
- **Condition level deficiencies** mean that the surveyor has assessed significant non-compliance with the entire condition of participation or multiple standards within a condition.
 - Survey outcome – The surveyors will initiate termination process. If the deficiency is not corrected, a termination of the provider agreement will result.
 - Onsite re-visit is required for a condition level deficiency:
 - ▶ Assess the hospice's correction of the deficiencies previously cited on the CMS Form 2567.
 - ▶ Re-evaluate specific care and services cited during survey.
 - ▶ Nature of deficiencies dictates the necessity for and scope of visit.
 - ▶ Home visits may be required.
- **Immediate jeopardy** is the highest level of deficiency. This level is applied when the degree and manner of the non-compliance has caused or is likely to cause significant injury, harm, or death to a patient.
 - Survey outcome – the provider agreement is terminated unless the immediate jeopardy is removed. Providers with this level of deficiency during a survey are advised to contact legal counsel immediately.

Enforcement Remedies

On or before October 1, 2022, the state survey agency or accrediting organization can impose enforcement remedies based on survey findings, particularly for condition level deficiencies and immediate jeopardy. These include:

- Civil monetary penalties could be imposed
- A temporary manager could be appointed
- Payments could be suspended for all new admissions
- A directed plan of correction could be imposed
- Directed inservice education could be required

See the Enforcement Remedies section of the toolkit or the regulatory pages of the NHPCO website for more information.

Challenging a Surveyor Onsite:

It could be appropriate for a hospice provider to respectfully challenge a surveyor's interpretation of a regulation. If a provider opts for this action, they should ask the surveyor to provide the specific language in the regulations that is being cited and explanation related to the citation for the surveyor's conclusions. Outside resources like NHPCO can also be consulted for validation of a citation.

The provider may consult with their legal counsel for guidance regarding challenges to survey findings during or following the survey. Legal counsel is recommended for any state survey follow up regarding condition level deficiencies or notice of enforcement remedies or potential decertification.

SECTION FOUR: Enforcement



Five types of enforcement remedies may be used by the State Agency, in collaboration with CMS. Enforcement remedies will be implemented on October 1, 2022.

Enforcement Remedies Compliance Guide

CMS has finalized the implementing regulations for the HOSPICE Act, published in the CY 2022 Home Health final rule, which included provisions for hospice survey reform and enforcement remedies. Five types of enforcement remedies have been finalized, which may be used by the State Agency, in collaboration with CMS. Enforcement remedies will be implemented on October 1, 2022. NHPCO will be providing additional resources in the near future.

Enforcement Remedies Include:

Temporary management

- (1) CMS may impose temporary management of a hospice program if it determines that a hospice program has a condition-level deficiency and CMS determines that management limitations or the deficiencies are likely to impair the hospice program's ability to correct the noncompliance and return the hospice program to compliance with all the conditions of participation within the timeframe required. (§ 488.1235)

Suspension of all or part of payments

- (1) CMS may suspend payment for all new admissions to a hospice program on or after the date on which the Secretary determines that remedies should be imposed.
- (2) CMS considers the remedy in paragraph (a)(1) of this section for any deficiency related to poor patient care outcomes, regardless of whether the deficiency poses immediate jeopardy. (§ 488.1240)

Civil monetary penalties

- (1) CMS may impose a civil money penalty against a hospice program for either the number of days the hospice program is not in compliance with one or more conditions of participation or for each instance that a hospice program is not in compliance, regardless of whether the hospice program's deficiencies pose immediate jeopardy.
- (2) CMS may impose a civil money penalty for the number of days of immediate jeopardy.
- (3) A per-day and a per-instance civil money penalty (CMP) may not be imposed simultaneously for the same deficiency in conjunction with a survey.
- (4) Fines are no more than \$10,000 per day of noncompliance and will be adjusted based on severity and seriousness of noncompliance and other considerations.
- (5) CMS may impose a civil money penalty for the number of days of noncompliance since the last standard survey, including the number of days of immediate jeopardy. (§ 488.1245)

Directed plan of correction

CMS may impose a directed plan of correction when a hospice program—

- (1) Has one or more condition-level deficiencies that warrant directing the hospice program to take specific actions; or
- (2) Fails to submit an acceptable plan of correction. (§ 488.1250)

Directed in-service education

CMS may require the staff of a hospice program to attend in-service training program(s) if CMS determines all the following:

- (1) The hospice program has condition-level deficiencies.
- (2) Education is likely to correct the deficiencies.
- (3) The programs are conducted by established centers of health education and training or consultants with background in education and training with Medicare hospice providers, or as deemed acceptable by CMS or the State (by review of a copy of curriculum vitas or resumes and references to determine the educator's qualifications). (§ 488.1255)

Resources

- [42 CFR 488 – Survey, Certification, and Enforcement Procedures](#) – Hospice provisions included



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